In Lieu of Form CMS-2552-10

OMB NO. 0938-0050

		EXPI RES 09-30-2025						
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATIO AND SETTLEMENT SUMMARY	N Provider CCN: 15-0162	Peri od: Worksheet S From 01/01/2022 Parts I-III To 12/31/2022 Date/Time Prepared: 5/29/2023 3:22 pm						
PART I – COST REPORT STATUS								
Provider 1. [X] Electronically prepared cost report		Date: 5/29/2023 Time: 3:22 pm						
use only 2. [] Manually prepared cost report								
 O] If this is an amended report enter the number F] Medicare Utilization. Enter "F" for full, " 	er of times the provider r L" for low, or "N" for no	esubmitted this cost report						
Contractor use only5. [1] Cost Report Status (1) As Submitted6. Date Received: 7. Contractor No. (2) Settled without Audit (3) Settled with Audit (4) Reopened 	for this Provider CCN 12.	NPR Date: Contractor's Vendor Code: 4 [0]If line 5, column 1 is 4: Enter number of times reopened = 0-9.						
PART II - CERTIFICATION BY A CHIEF FINANCIAL OFFICER OR ADMINISTRA	TOR OR PROVIDER(S)							
MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.	THIS COST REPORT MAY BE F FURTHERMORE, IF SERVICES	S IDENTIFIED IN THIS REPORT WERE						
CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR	Of PROVIDER(S)							
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 INDIANAPOLIS (15-0162) for the cost reporting period beginning 01/01/2022 and ending 12/31/2022 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.								
SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR CHE	СКВОХ	ELECTRONI C						

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

			Title	XVIII			
		Title V	Part A	Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPI TAL	0	4, 951, 710	-479, 670	0	86	1.00
2.00	SUBPROVIDER - IPF	0	0	0		0	2.00
3.00	SUBPROVIDER - IRF	0	-10, 202	-32		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	0		0	9.00
200.00	TOTAL	0	4, 941, 508	-479, 702	0	86	200.00

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

USPI	Financial Systems AL AND HOSPITAL HEALTH CARE COMPLEX	FRANCISCAN HEALT	Provi d	ler CCI	N: 15-0162	Peri od:		Workshe	et S-2	2552-1
						From 01/01/ To 12/31/		Part I Date/Ti	me Pre	pared
	1.00	2.00		2 00				5/29/20	023 3:2	2 pm
	Hospital and Hospital Health Care Co	2.00		3.00			4.00			
. 00	Street: 8111 S. EMERSON AVENUE	P0 Box:								1.0
. 00	City: INDIANAPOLIS	State: IN	Zip Cod	1		ty: MARION	-			2.0
		Component Name	CCN Number	CBS Numb		- Date Certified		nt Syst 0, or		
			Number		l iybe		V 1,			1
		1.00	2.00	3.0	0 4.00	5.00	6.00	7.00		
	Hospital and Hospital-Based Componen				1	1				
00	Hospi tal	FRANCI SCAN HEALTH	150162	2690	00 1	05/01/2006	N	P	P	3.0
. 00	Subprovider - IPF	TINDI ANAPULI 5								4.0
00	Subprovider - IRF	REHAB UNI T	15T162	2690	00 5	01/01/2005	N	P	Р	5.
00	Subprovider - (Other)									6.
00	Swing Beds - SNF									7.
00 00	Swing Beds - NF Hospital-Based SNF									8. 9.
0.00	Hospi tal -Based NF									10.
1.00	Hospi tal -Based OLTC									11.
2.00	Hospital-Based HHA									12.
3.00	Separately Certified ASC		454500							13.
4.00 5.00	Hospi tal -Based Hospi ce	HOSPI CE	151523	2690	00	01/01/2014				14. 15.
5.00	Hospital-Based Health Clinic - RHC Hospital-Based Health Clinic - FQHC									16.
7.00	Hospital -Based (CMHC) I									17.
3. 00	Renal Dialysis									18.
9.00	Other									19.
						From: 1.00				-
0. 00	Cost Reporting Period (mm/dd/yyyy)					01/01/2	022	12/31/		20.
. 00	Type of Control (see instructions)					1				21.
				ŀ	1.00	2.00		3. (0	-
	Inpatient PPS Information				1.00	2.00		5.0		
2.00	Does this facility qualify and is it	currently receiving pa	yments for	-	Y	N				22.
	disproportionate share hospital adju			2						
	§412.106? In column 1, enter "Y" fo facility subject to 42 CFR Section §									
	hospital?) In column 2, enter "Y" fo		lenullent							
2. 01	Did this hospital receive interim UC		ntal UCPs,	for	Y	Y				22.
	this cost reporting period? Enter in									
	for the portion of the cost reportin									
	1. Enter in column 2, "Y" for yes or cost reporting period occurring on o			ie						
	instructions)									
2. 02	Is this a newly merged hospital that				Ν	N				22.
	determined at cost report settlement			umn						
	1, "Y" for yes or "N" for no, for th period prior to October 1. Enter in			no						
	for the portion of the cost reportin			110,						
2. 03	Did this hospital receive a geograph			o	Ν	N		Ν		22.
	rural as a result of the OMB standar									
	adopted by CMS in FY2015? Enter in c for the portion of the cost reportin									
	in column 2, "Y" for yes or "N" for			²¹						
	reporting period occurring on or aft	1								
	Does this hospital contain at least									
	counted in accordance with 42 CFR 41	2.105)? Enter in columr	13, "Y" fo	or						
. 04	yes or "N" for no. Did this hospital receive a geograph	ic reclassification fro	om urban to	,						22.
21	rural as a result of the revised OMB									
	adopted by CMS in FY 2021? Enter in									
	for the portion of the cost reportin			er						
	in column 2, "Y" for yes or "N" for reporting period occurring on or aft									
	Does this hospital contain at least			is						
	counted in accordance with 42 CFR 41									
	yes or "N" for no.	-								
	Which method is used to determine Ma	dicaid days on lines 24	and/or 25	5		3 N				23.
3. 00										
3. 00	below? In column 1, enter 1 if date	of admission, 2 if cens								
. 00		of admission, 2 if cens of identifying the days	sin this o							

	Financial Systems FRANCISCAN AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	N HEALTH IN	DIANAPOLIS Provider CC	N: 15-0162	Per	i od:	In Lieu		rm CMS- eet S-2	
					Fro To		1/2022		ime Pre 023 3:2	
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	St Medi elig un	t-of ate caid gible paid	Medicai HMO day	/s Me)ther di cai d days	
24.00	If this provider is an IPPS hospital, enter the	1.00	2.00 132	3.00		00 49	5.00 24,		<u>6.00</u> 402	2 24.00
	in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6. If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid	0	0			0		561		25.00
	HMO paid and eligible but unpaid days in column 5.									
					μ	<u>Jrban/R</u> 1. (ural S		f Geogr 00	-
26.00	Enter your standard geographic classification (not wa		at the beg	jinning of t	the		2			26.00
	cost reporting period. Enter "1" for urban or "2" for Enter your standard geographic classification (not we reporting period. Enter in column 1, "1" for urban or enter the effective date of the geographic reclassifi If this is a sole community hospital (SCH), enter the	age) status ~ "2" for r cation in	ural. If ap column 2.	ppl i cabl e,			2			27.00
	effect in the cost reporting period.					D '				
						Begi nı 1. (i ng: 00	
36.00	Enter applicable beginning and ending dates of SCH st of periods in excess of one and enter subsequent date		cript line	36 for numb	ber					36.00
37.00	If this is a Medicare dependent hospital (MDH), enter is in effect in the cost reporting period.		r of period	ls MDH statu	JS		0			37.00
37. 01	Is this hospital a former MDH that is eligible for the accordance with FY 2016 OPPS final rule? Enter "Y" for instructions)									37.01
38. 00	If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of enter subsequent dates.									38.00
					-	<u> </u>			/N 00	-
39.00	Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(i) 1 "Y" for yes or "N" for no. Does the facility meet 1 accordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii or "N" for no. (see instructions)), (ii), or the mileage	(iii)? Ent requiremen	er in colur nts in	nn	N			N	39.00
40.00	Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octob no in column 2, for discharges on or after October 1.	per 1. Ente	r "Y" for y			N		I	N	40.00
			ue tronsy				V	XVIII	_	
	Prospective Payment System (PPS)-Capital						1.00	2.00	3.00	
45.00	Does this facility qualify and receive Capital paymer with 42 CFR Section §412.320? (see instructions)	nt for disp	roporti onat	e share in	acco	rdance	N	N	N	45.00
46. 00	Is this facility eligible for additional payment exce pursuant to 42 CFR §412.348(f)? If yes, complete Wks1 Pt. III.						N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS o					no.	Ν	Ν	N	47.00
48.00	Is the facility electing full federal capital payment Teaching Hospitals	t? Enter "	Y" for yes	or "N" for	no.		N	N	N	48.00
56.00	Is this a hospital involved in training residents in periods beginning prior to December 27, 2020, enter " cost reporting periods beginning on or after December the instructions. For column 2, if the response to co involved in training residents in approved GME progra and are you are impacted by CR 11642 (or applicable C "Y" for yes; otherwise, enter "N" for no in column 2.	'Y' for yes ~ 27, 2020, olumn 1 is ams in the CRs) MA dir	or "N" for under 42 ("Y", or if prior year	r no in colu CFR 413.78(h this hospit or penultin	umn 1 b)(2) tal wa mate g	. For , see as year,	Y	Y		56.00
57.00	For cost reporting periods beginning prior to Decembe is this the first cost reporting period during which at this facility? Enter "Y" for yes or "N" for no in residents start training in the first month of this of "N" for no in column 2. If column 2 is "Y", complete complete Wkst. D, Parts III & IV and D-2, Pt. II, if beginning on or after December 27, 2020, under 42 CFF which month(s) of the cost report the residents were	er 27, 2020 residents n column 1. cost report e Worksheet applicable R 413.77(e	in approved If column ing period? E-4. If co For cost)(1)(iv) ar	d GME progra 1 is "Y", (P Enter "Y' olumn 2 is ' reporting p nd (v), rega	ams ti did 'for 'N", perio ardle:	yes or yes or ds ss of	- Y			57.00

	Financial Systems FRANCISCAN AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA		I INDIANAPOLIS Provider CC	CN: 15-0162 P F	eriod: rom 01/01/2022	u of Form CMS-: Worksheet S-2 Part I	
				T	o 12/31/2022	5/29/2023 3:2	
					V 1.00	XVIII XIX 0 2.00 3.00	-
9.00	Are costs claimed on line 100 of Worksheet A? If yes	, compl	ete Wkst. D-2,		N		59.0
				NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	•
				1.00	2.00	3.00	1
	Are you claiming nursing and allied health education any programs that meet the criteria under 42 CFR 413. instructions) Enter "Y" for yes or "N" for no in col is "Y", are you impacted by CR 11642 (or subsequent C adjustment? Enter "Y" for yes or "N" for no in colum	85? (s umn 1. R) NAHE In 2.	ee If column 1 MA payment	Y	Y		60. C
0. 01	If line 60 is yes, complete columns 2 and 3 for each instructions)	program	i. (see		23.00	1	60.0
0. 02	If line 60 is yes, complete columns 2 and 3 for each instructions)	program	. (see		23. 01	1	60.0
0. 03	If line 60 is yes, complete columns 2 and 3 for each instructions)	program	. (see		23. 02	1	60.0
0. 04	If line 60 is yes, complete columns 2 and 3 for each instructions)	program	. (see		23. 03	1	60.0
0. 05	If line 60 is yes, complete columns 2 and 3 for each instructions)	program	. (see		23.04	1	60.0
		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see	Y			0.81	0. 00	61. (
1. 02	instructions) Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.
I. 03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.
I. 04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).						61.
1.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.
1.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.
		Pro	ogram Name			Direct GME FTE Count	
1 10	Of the FTEs in line 61.05, specify each new program		1.00	2.00	3.00	4.00	61.
	for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. Of the FTEs in line 61.05, specify each expanded				0.00		61.
	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.						

HOSPI 1	i Financial Systems TAL AND HOSPITAL HEALTH CARE COMP		I HEALTH INDIANAPOLIS TA Provider C	CN: 15-0162	Peri od:	u of Form CMS-2 Worksheet S-2	
					From 01/01/2022 To 12/31/2022	Part I Date/Time Pre 5/29/2023 3:2	
						1.00	-
	ACA Provisions Affecting the Hea	alth Resources and Ser	vices Administration	(HRSA)		1.00	-
62.00	Enter the number of FTE resident your hospital received HRSA PCRE	s that your hospital	trained in this cost		riod for which	0.00	62.00
62. 01	Enter the number of FTE resident during in this cost reporting pe Teaching Hospitals that Claim Re	s that rotated from a riod of HRSA THC prog	Teaching Health Cen ram. (see instructio		o your hospital	0.00	62.01
63.00	Has your facility trained reside	ents in nonprovider se	ttings during this c			Y	63.00
	"Y" for yes or "N" for no in col	umn I. IT yes, comple	te lines 64 through	Unweighted		Ratio (col. 1/	
				FTEs Nonprovider Site	FTEs in	(col. 1 + col. 2))	
				1.00	2.00	3.00	
	Section 5504 of the ACA Base Yea period that begins on or after .			This base yea	r 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 you	s yes, or your facilit aber of unweighted non stations occurring in e number of unweighted pur hospital. Enter in	y trained residents -primary care all nonprovider non-primary care column 3 the ratio	0.0	0. 00	0. 000000	64.00
	of (column 1 divided by (column	1 + column 2)). (see Program Name	instructions) Program Code	Unweighted	Unweighted	Ratio (col. 3/	
			Trogram code	FTEs Nonprovi der Si te	FTEs in	(col. 3 + col. 4))	
		1.00 FAMILY MEDICINE	2.00 1350	3.00	4.00 00 13.91	5.00 0.392842	1
	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)	GENERAL		Unwei ghted	Unweighted	Ratio (col. 1/	
				FTĔs Nonprovi der Si te	FTES in Hospital	(col. 1 + col. 2))	
	Section 5504 of the ACA Current	Year FTF Residents in	Nonnrovider Setting	1.00	2.00	3.00	
	beginning on or after July 1, 20	010			· .		
66.00	Enter in column 1 the number of FTEs attributable to rotations c Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 +	occurring in all nonpr unweighted non-primar al. Enter in column 3	ovider settings. y care resident the ratio of	0.0	00 0.00	0. 000000	66.00
		Program Name	Program Code	Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	

Heal th	Financial Systems	FRANCI SCA	N HEALTH I	NDI ANAPOLI S		In	Lieu	u of Form	m CMS-2	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE COMP	LEX IDENTIFICATION DA	ATA	Provider CC		eriod: rom 01/01/2	022	Workshe Part I	et S-2	
					T			Date/Ti 5/29/20		
		Program Name	Progr	am Code	Unweighted	Unweighte		Ratio (c	ol. 3/	2 011
					FTEs Nonprovider	FTEs in Hospital		(col. 3 4))		
					Si te					
67.00	Enter in column 1, the program	1.00 FAMILY MEDICINE	1350	2.00	3.00	4.00	2. 92	5.0		67.00
07.00	name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column	GENERAL				,	2. 72	0.		57.00
	4)). (see instructions)									
				<u></u>	070 (4 4 4 0			1.0	0	
68.00	Direct GME in Accordance with th For a cost reporting period begi						~	N		68.00
	MAC to apply the new DGME formul (August 10, 2022)?									
						-	1.00) 2.00	3.00	
	Inpatient Psychiatric Facility F						1.00	, 2.00	5.00	
70.00	ls this facility an Inpatient Ps Enter "Y" for yes or "N" for no		IPF), or d	loes it conta	ain an IPF subp	provi der?	Ν			70.00
71.00	If line 70 is yes: Column 1: Dic recent cost report filed on or b 42 CFR 412.424(d)(1)(iii)(c)) Cc	H the facility have a before November 15, 2 blumn 2: Did this fac	004? Ente ility trai	er "Y" for ye n residents	es or "N" for r in a new teach	no. (see ni ng			0	71.00
	program in accordance with 42 CF Column 3: If column 2 is Y, indi (see instructions)									
75 00	Inpatient Rehabilitation Facilit Is this facility an Inpatient Re		V (LRE) c	n does it co	ontain an IRE		Y			75.00
	subprovider? Enter "Y" for yes	and "N" for no.								
76.00	If line 75 is yes: Column 1: Dic recent cost reporting period enc no. Column 2: Did this facility CFR 412.424 (d)(1)(iii)(D)? Ente	ling on or before Nov train residents in a er "Y" for yes or "N"	rember 15, new teach for no. C	2004? Enter ing program column 3: If	"Y" for yes or in accordance column 2 is Y,	"N" for with 42	N	N	0	76.00
	indicate which program year bega	an during this cost r	eporting p	eriod. (see	instructions)					
								1.0	0	
80. 00 81. 00	Long Term Care Hospital PPS Is this a long term care hospita Is this a LTCH co-located withir "Y" for yes and "N" for no. TEFRA Providers					peri od? Ent	ter	N N		80. 00 81. 00
	ls this a new hospital under 42 Did this facility establish a ne	w Other subprovider	(excl uded		5		10.	N		85. 00 86. 00
87.00	<pre>\$413.40(f)(1)(ii)? Enter "Y" fo Is this hospital an extended neo 1886(d)(1)(B)(vi)? Enter "Y" for</pre>	plastic disease care		classified u	under section			Ν		87.00
						Approved t Permanen Adjustmer (Y/N) 1.00	nt	Number Appro Permar Adjustr 2.0	ved nent ments	
88.00	Column 1: Is this hospital appro amount per discharge? Enter "Y" 89. (see instructions)					1.00		2.0		88.00
	Column 2: Enter the number of ap	proved permanent adj	ustments.							

SPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CC		eriod: rom 01/01/2022 o 12/31/2022	Worksheet S-2 Part I Date/Time Pre 5/29/2023 3:2	epared
		Wkst. A Line No.	Effecti ve Date	Approved Permanent Adjustment Amount Per Discharge	
		1.00	2.00	3.00	1
OO Column 1: If line 88, column 1 is Y, enter the Worksheet A li on which the per discharge permanent adjustment approval was Column 2: Enter the effective date (i.e., the cost reporting beginning date) for the permanent adjustment to the TEFRA tar per discharge. Column 3: Enter the amount of the approved permanent adjustment TEFRA target amount per discharge.	based. period rget amount	0. 00			0 89.0
			V	XIX	-
Title V and XIX Services			1.00	2.00	
00 Does this facility have title V and/or XIX inpatient hospital	servi ces? Er	nter "Y" for	N	Y	90.0
yes or "N" for no in the applicable column. 00 Is this hospital reimbursed for title V and/or XIX through th			N	Y	91.0
full or in part? Enter "Y" for yes or "N" for no in the appli 00 Are title XIX NF patients occupying title XVIII SNF beds (dua instructions) Enter "Y" for yes or "N" for no in the applicat	al certificati			Ν	92. (
00 Does this facility operate an ICF/IID facility for purposes of		d XIX? Enter	N	Ν	93. (
"Y" for yes or "N" for no in the applicable column. OD Does title V or XIX reduce capital cost? Enter "Y" for yes, a applicable column.	and "N" for no	o in the	N	Ν	94. (
00 If line 94 is "Y", enter the reduction percentage in the appl			0.00	0.00	95.
00 Does title V or XIX reduce operating cost? Enter "Y" for yes applicable column.	or "N" for no	o in the	N	Ν	96.
 OU If line 96 is "Y", enter the reduction percentage in the appl OD Does title V or XIX follow Medicare (title XVIII) for the int stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for 	terns and resi	dents post	0. 00 N	0.00 Y	97. 98.
 column 1 for title V, and in column 2 for title XIX. O1 Does title V or XIX follow Medicare (title XVIII) for the rep C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title XVIII. 			Ν	Y	98.
 title XIX. 02 Does title V or XIX follow Medicare (title XVIII) for the cal bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or for title VIX. 			Ν	Y	98.
 for title V, and in column 2 for title XIX. 03 Does title V or XIX follow Medicare (title XVIII) for a criti reimbursed 101% of inpatient services cost? Enter "Y" for yes 			Ν	Ν	98.
<pre>for title V, and in column 2 for title XIX. 04 Does title V or XIX follow Medicare (title XVIII) for a CAH r outpatient services cost? Enter "Y" for yes or "N" for no in</pre>			Ν	Ν	98.
 in column 2 for title XIX. 05 Does title V or XIX follow Medicare (title XVIII) and add bac Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in co 	ck the RCE dis	sallowance on	N	Y	98.
 column 2 for title XIX. 06 Does title V or XIX follow Medicare (title XVIII) when cost r Pts. I through IV? Enter "Y" for yes or "N" for no in column column 2 for title XIX. 	reimbursed for	⁻ Wkst. D,	N	Y	98.
Rural Providers			· · · · · · · · · · · · · · · · · · ·		
5.00 Does this hospital qualify as a CAH?			N		105.
6.00 If this facility qualifies as a CAH, has it elected the all-i for outpatient services? (see instructions)	nclusive meth	nod of payment	N		106.
7.00 Column 1: If line 105 is Y, is this facility eligible for costructuring 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 yapproved medical education program in the CAH's excluded IPF Enter "Y" for yes or "N" for no in column 2. (see instruction)	1. (see inst you train I&Rs F and/or IRF u	tructions) s in an	Ν		107.
3. 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.	CRNA fee schee		N		108.
	Physi cal	Occupational	Speech	Respi ratory	4
9.00 If this hospital qualifies as a CAH or a cost provider, are	1.00 N	2.00 N	3.00 N	4.00 N	109.
		I NI	IN IN	N	1109.

Health Financial Systems FRANCISCAN HEALTH INDI HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Pro	ANAPOLIS ovider CCN: 15-0162	Peri od:	u of Form CMS Worksheet S	
		From 01/01/2022 To 12/31/2022		
· · · · · · · · · · · · · · · · · · ·		- H	1.00	
110.00 Did this hospital participate in the Rural Community Hospital Dem Demonstration) for the current cost reporting period? Enter "Y" fo complete Worksheet E, Part A, lines 200 through 218, and Workshee applicable.	yes or "N" for no.	If yes,	N	110.00
		1.00	2.00	_
111.00 If this facility qualifies as a CAH, did it participate in the From Health Integration Project (FCHIP) demonstration for this cost registry for yes or "N" for no in column 1. If the response to column integration prong of the FCHIP demo in which this CAH is particip. Enter all that apply: "A" for Ambulance services; "B" for addition for tele-health services.	porting period? Enter is Y, enter the ating in column 2.			111.00
	1.00	2.00	3.00	_
 112.00 Did this hospital participate in the Pennsylvania Rural Health Mo (PARHM) demonstration for any portion of the current cost reportine period? Enter "Y" for yes or "N" for no in column 1. If column "Y", enter in column 2, the date the hospital began participating demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable. 113.00 Did this hospital participate in the Community Health Access and Transformation (CHART) model for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no. 	ng is in the			112.00
Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or "N" in column 1. If column 1 is yes, enter the method used (A, B, or in column 2. If column 2 is "E", enter in column 3 either "93" pe for short term hospital or "98" percent for long term care (inclu psychiatric, rehabilitation and long term hospitals providers) ba the definition in CMS Pub. 15-1, chapter 22, §2208.1.	E onl y) rcent les			0115.00
116.00 Is this facility classified as a referral center? Enter "Y" for y	es or Y			116.00
"N" for no. 117.00 Is this facility legally-required to carry malpractice insurance?	Enter N			117.00
"Y" for yes or "N" for no. 118.00 s the malpractice insurance a claims-made or occurrence policy?	Inter 1	2		118.00
if the policy is claim-made. Enter 2 if the policy is occurrence.	Premi ums	s Losses	Insurance	
118.01 List amounts of malpractice premiums and paid losses:	<u> </u>	2.00 384 81,908	3.00	0 118. 01
		1.00	2.00	_
118.02 Are malpractice premiums and paid losses reported in a cost cente Administrative and General? If yes, submit supporting schedule l and amounts contained therein.		N		118. 02
119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harm §3121 and applicable amendments? (see instructions) Enter in colu "N" for no. Is this a rural hospital with < 100 beds that qualified Hold Harmless provision in ACA §3121 and applicable amendments? (Enter in column 2, "Y" for yes or "N" for no.	nn 1, "Y" for yes o es for the Outpatien	-	Ν	119.00 120.00
121.00Did this facility incur and report costs for high cost implantably patients? Enter "Y" for yes or "N" for no.	e devices charged to	D Y		121.00
122.00 Does the cost report contain healthcare related taxes as defined Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is " the Worksheet A line number where these taxes are included.			5.03	122.00
123.00 Did the facility and/or its subproviders (if applicable) purchase services, e.g., legal, accounting, tax preparation, bookkeeping, management/consulting services, from an unrelated organization? If for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., grea	bayroll, and/or n column 1, enter "`			123.00
professional services expenses, for services purchased from unrellocated in a CBSA outside of the main hospital CBSA? In column 2, "N" for no. Certified Transplant Center Information	ited organizations			
25.00 Does this facility operate a Medicare-certified transplant center and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy)		N		125. 00
126.00 If this is a Medicare-certified kidney transplant program, enter		ate		126.00
in column 1 and termination date, if applicable, in column 2. 127.00 If this is a Medicare-certified heart transplant program, enter t	ne certification da	te		127.00
		1	1	
in column 1 and termination date, if applicable, in column 2. 128.00 If this is a Medicare-certified liver transplant program, enter t in column 1 and termination date, if applicable, in column 2.	ne certification da	te		128.00

OSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DATA	A Provider (CCN: 15-0162	From O	1/01/2022	Worksheet S-2 Part I	
				To 12	2/31/2022	Date/Time Pre 5/29/2023 3:2	
					1.00	2.00	
0.00 If this is a Medicare-certified pa			erti fi cati o	n			130. 0
date in column 1 and termination of 1.00 If this is a Medicare-certified in	ntestinal transplant	program, enter the	certi fi cat	i on			131. 0
date in column 1 and termination of 2.00 If this is a Medicare-certified is			ification d	ate			132.0
in column 1 and termination date,							
 3.00Removed and reserved 4.00If this is a hospital-based organ in column 1 and termination date, All Providers 			the OPO num	ber			133. C 134. C
0.00 Are there any related organization chapter 10? Enter "Y" for yes or ' are claimed, enter in column 2 the	'N" for no in column	1. If yes, and hom number. (see instru	e office co		Y	158014	140. 0
1.00 If this facility is part of a chai				ne name and	3.00 d address	of the	
home office and enter the home off 1.00Name: SISTERS OF ST. FRANCIS HEA		me: WISCONSIN PHYSI		actor's Nu	mber: 0810	1	141.0
SERVIC 2.00Street: 1515 W DRAGOON TRL	DO Row	SERVI CES 1290					142 0
2.00 Street:1515 w DRAGUON TRL 3.00 City: MISHAWAKA	PO Box: State:	1290 I N	Zip C	ode:	4654	4	142. C
4.00 Are provider based physicians' cos	sts included in Works	heet A?				1.00 Y	144.0
·····							
5.00 f costs for renal services are cl	aimed on Wkst A li	ne 74 are the cos	ts for		1.00 Y	2.00	145.0
inpatient services only? Enter "Y' no, does the dialysis facility in period? Enter "Y" for yes or "N" 5.00Has the cost allocation methodolog	' for yes or "N" for clude Medicare utiliz for no in column 2.	no in column 1. If ation for this cos	column 1 i t reporting		N		146. (
Enter "Y" for yes or "N" for no ir			streport?		IN		
yes, enter the approval date (mm/c			40, §4020)	If			140.0
yes, enter the approval date (mm/o	dd/yyyy) in column 2.	•		lf		1.00	
yes, enter the approval date (mm/o 7.00Was there a change in the statisti 8.00Was there a change in the order of	dd/yyyy) in column 2. cal basis? Enter "Y" f allocation? Enter "	for yes or "N" fo Y" for yes or "N"	r no. for no.			N N	147. 0 148. 0
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yes, enter the approval date (mm/c 7.00 Was there a change in the statisti 3.00 Was there a change in the order of 9.00 Was there a change to the simplifi Does this facility contain a provi or charges? Enter "Y" for yes or " 5.00 Hospital 5.00 Subprovider - IPF 7.00 Subprovider - IRF 8.00 SUBPROVIDER 9.00 SNF 0.00 HOME HEALTH AGENCY 1.00 CMHC Multicampus 5.00 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) Heal th Information Technology (HI 7.00 Is this provider a meaningful user	in column 2. cal basis? Enter "Y" allocation? Enter " ed cost finding meth der that qualifies f 'N" for no for each c ampus hospital that h Name 0 1) incentive in the A 'nunder §1886(n)? En	for yes or "N" fo Y" for yes or "N" od? Enter "Y" for Part A 1.00 For an exemption fr component for Part N N N N N N N N N N N N N	r no. for no. yes or "N" Part 2.00 om the appl A and Part N N N N N N N N N N N N N	for no. B T i cation of B. (See 42 fferent CB Zip Code 3.00 ment Act	i tI e V 3.00 [€] the I owe <u>2 CFR §413</u> N N N N N N SAS? CBSA 4.00	N N Title XIX 4.00 r of costs .13) N N N N N N N N N N N N N N N N N N N	147. (148. (149. (155. (156. (157. (158. (157. (158. (167. (160. (160. (160. (161. (165. (16
yes, enter the approval date (mm/d 7.00 Was there a change in the statisti 8.00 Was there a change in the order of 9.00 Was there a change to the simplifi Does this facility contain a provious or charges? Enter "Y" for yes or " 5.00 Hospital 6.00 Subprovider - IPF 7.00 Subprovider - IRF 8.00 SUBPROVIDER 9.00 SNF 0.00 HOME HEALTH AGENCY 1.00 CMHC Multicampus 5.00 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) Heal th Information Technology (HI 7.00 Is this provider a meaningful user 8.00 If this provider is a CAH (line 10	<pre>in column 2. cal basis? Enter "Y" f allocation? Enter " ed cost finding meth der that qualifies f 'N" for no for each c der that qualifies f 'N" for no for each c no for each c f) incentive in the A o f) incentive in the A ounder §1886(n)? En D5 is "Y") and is a m</pre>	for yes or "N" fo Y" for yes or "N" od? Enter "Y" for Part A 1.00 For an exemption fr component for Part N N N N N N N N N N N N N	r no. for no. yes or "N" Part 2.00 om the appl A and Part N N N N N N N N N N N N N	for no. B T i cation of B. (See 42 fferent CB Zip Code 3.00 ment Act	i tI e V 3.00 [€] the I owe <u>2 CFR §413</u> N N N N N N SAS? CBSA 4.00	N N N Title XIX 4.00 r of costs .13) N N N N N N N N N N N N N N N N N N N	147. C 148. C 149. C 149. C 155. C 156. C 157. C 158. C 159. C 159. C 160. C 161. C
yes, enter the approval date (mm/d 7.00 Was there a change in the statisti 8.00 Was there a change in the order of 9.00 Was there a change to the simplifi Does this facility contain a provious or charges? Enter "Y" for yes or " 5.00 Hospital 6.00 Subprovider - IPF 7.00 Subprovider - IRF 8.00 SUBPROVIDER 9.00 SNF 0.00 HOME HEALTH AGENCY 1.00 CMHC Multicampus 5.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no. 6.00 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)	dd/yyyy) in column 2. cal basis? Enter "Y" allocation? Enter " ed cost finding meth der that qualifies f 'N" for no for each c ampus hospital that h Name 0 1) incentive in the A r under §1886(n)? En 5 is "Y") and is a m 1T assets (see instr	for yes or "N" fo Y" for yes or "N" od? Enter "Y" for Part A 1.00 For an exemption fr component for Part N N N N N N N N N N N N N	r no. for no. yes or "N" Part 2.00 om the appl A and Part N N N N N N N N N N N N N	for no. B T ication of B. (See 42 fferent CB Zip Code 3.00 Y"), enter	itle V 3.00 the lowe 2 CFR §413 N N N N N N N N N SAs? CBSA 4.00	N N N Title XIX 4.00 r of costs .13) N N N N N N N N N N N N N N N N N N N	147. (148. (149. (155. (156. (157. (158. (157. (158. (167. (160. (160. (160. (161. (165. (16
yes, enter the approval date (mm/c yes, enter the approval date (mm/c 7.00 Was there a change in the statisti 8.00 Was there a change in the order of 9.00 Was there a change to the simplifi Does this facility contain a provious or charges? Enter "Y" for yes or " 5.00 Hospital 5.00 Subprovider - IPF 7.00 Subprovider - IRF 8.00 SUBPROVIDER 9.00 SNF 9.00 SNF 9.00 HOME HEALTH AGENCY 1.00 CMHC 5.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no. 5.00 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) Heal th Information Technology (HI 7.00 Is this provider a meaningful user 8.00 If this provider is a CAH (line 10 reasonable cost incurred for the H	in column 2. cal basis? Enter "Y" allocation? Enter " ed cost finding meth der that qualifies f der that qualifies f 'N" for no for each c ampus hospital that h Name 0 1 is "Y") and is a m is "Y") and is a m is "Y") and is a m is "Y") for yes o call the "Y" for yes o	for yes or "N" fo Y" for yes or "N" od? Enter "Y" for Part A 1.00 For an exemption fr component for Part N N N N N N N N N N N N N	r no. for no. yes or "N" Part 2.00 om the appl A and Part N N N N N N N N N N N N N	for no. B T i cation of B. (See 42 fferent CB Zip Code 3.00 ment Act Y"), enter for a hard ns)	i tl e V 3.00 F the lowe 2 CFR §413 N N N N N SAS? CBSA 4.00 CBSA 4.00	N N N Title XIX 4.00 r of costs .13) N N N N N N N N N N N N N N N N N N N	147. (148. (149. (149. (155. (156. (157. (158. (161. (161. (161. (165. (167. (168. (

Health Financial Systems	FRANCI SCAN HEALTH	I NDI ANAPOLI S	In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX	LIDENTIFICATION DATA		Period:	Worksheet S-2	2
			From 01/01/2022		
			To 12/31/2022	Date/Time Pre	
			-	5/29/2023 3:2	<u>22 pm</u>
			Begi nni ng	Endi ng	
			1.00	2.00	
170.00 Enter in columns 1 and 2 the EHR be	eginning date and ending dat	te for the reporting			170.00
period respectively (mm/dd/yyyy)					
			1.00	2.00	
171.00 If line 167 is "Y", does this provi	der have any days for indiv	viduals enrolled in	N	(0171.00
section 1876 Medicare cost plans re	eported on Wkst. S-3, Pt. I,	line 2, col. 6? Enter			
"Y" for yes and "N" for no in colur	nn 1. lf column 1 is yes, er	nter the number of section	1		
1876 Medicare days in column 2. (se	ee instructions)				

HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	ovi der	CCN: 15-0162	Period: From 01/01/2022 To 12/31/2022		epared
				Y/N	Date	
				1.00	2.00	
	PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURSEMENT C General Instruction: Enter Y for all YES responses. Enter N for a mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS Described Opposition and Opposition			er all dates in	the	-
1.00	Provider Organization and Operation Has the provider changed ownership immediately prior to the begin reporting period? If yes, enter the date of the change in column			N		1.
	Treporting period? IT yes, enter the date of the change in cordinin	2. (366	Y/N	Date	V/I	_
			1.00	2.00	3.00	-
2.00	Has the provider terminated participation in the Medicare Program yes, enter in column 2 the date of termination and in column 3, " voluntary or "I" for involuntary.	'V" for	N	2.00		2.
3. 00	Is the provider involved in business transactions, including mana contracts, with individuals or entities (e.g., chain home offices or medical supply companies) that are related to the provider or officers, medical staff, management personnel, or members of the of directors through ownership, control, or family and other simi relationships? (see instructions)	s, drug its board	Y			3.
			Y/N	Туре	Date	
			1.00	2.00	3.00	
	Financial Data and Reports					
4. 00 5. 00	Column 1: Were the financial statements prepared by a Certified Accountant? Column 2: If yes, enter "A" for Audited, "C" for Com or "R" for Reviewed. Submit complete copy or enter date available column 3. (see instructions) If no, see instructions. Are the cost report total expenses and total revenues different f those on the filed financial statements? If yes, submit reconcili	npiled, e in from	Y N	A	05/06/2022	4. 5.
				Y/N	Legal Oper.	
				1.00	2.00	
	Approved Educational Activities			- 1	1	
o. 00	Column 1: Are costs claimed for a nursing program? Column 2: If	Fyes, i	s the provider	- N		6.
00	the legal operator of the program?			N		-
. 00	Are costs claimed for Allied Health Programs? If "Y" see instruct Were nursing programs and/or allied health programs approved and/		wood during the	Y Y		7
. 00	cost reporting period? If yes, see instructions.	or rene	ewed during the	r r		⁸ .
0. 00	Are costs claimed for Interns and Residents in an approved gradua program in the current cost report? If yes, see instructions.	ate medi	cal education	Y		9.
0. 00	Was an approved Intern and Resident GME program initiated or rene cost reporting period? If yes, see instructions.	ewed in	the current	Ν		10.
1.00	Are GME cost directly assigned to cost centers other than I & R i Teaching Program on Worksheet A? If yes, see instructions.	N		11.		
					Y/N 1.00	
	Bad Debts				1.00	
2 00	Is the provider seeking reimbursement for bad debts? If yes, see	instruc	tions		Y	1 12.
3.00				ost reporting	N	13

	perious in yes, submit copy.		1
14.00	If line 12 is yes, were patient deductibles and/or coinsurance amounts waived? If yes, see	N	14.00
	instructions.		1
	Bed Complement		1

15.00	15.00 Did total beds available change from the prior cost reporting period? If yes, see instructions.					
		Par	t A	Par	t B	
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only?	N		N		16.00
	If either column 1 or 3 is yes, enter the paid-through					
	date of the PS&R Report used in columns 2 and 4 .(see					
	instructions)					
17.00	Was the cost report prepared using the PS&R Report for	Y	04/27/2023	Y	04/27/2023	17.00
	totals and the provider's records for allocation? If					
	either column 1 or 3 is yes, enter the paid-through date					
	in columns 2 and 4. (see instructions)					
18.00	If line 16 or 17 is yes, were adjustments made to PS&R	N		N		18.00
	Report data for additional claims that have been billed					
	but are not included on the PS&R Report used to file this					
	cost report? If yes, see instructions.					
19.00	If line 16 or 17 is yes, were adjustments made to PS&R	N		N		19.00
	Report data for corrections of other PS&R Report					
	information? If yes, see instructions.					

Health Financial Systems

FRANCISCAN HEALTH INDIANAPOLIS

In Lieu of Form CMS-2552-10

ealth Financial Systems FRANCISCAN HEALT	TH INDIANAPOLIS		In Lie	In Lieu of Form CMS-2552			
OSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C		Period: From 01/01/2022 To 12/31/2022	Date/Time Pre	pared:		
	Doscri	ption	Y/N	5/29/2023 3:2 Y/N	2 pm		
)	1.00	3.00	-		
0.00 If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		5	N	N	20.00		
	Y/N	Date	Y/N	Date			
	1.00	2.00	3.00	4.00			
1.00 Was the cost report prepared only using the provider's records? If yes, see instructions.	Ν		Ν		21.00		
		•		1.00			
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	EPT CHILDRENS H	OSPI TALS)					
Capital Related Cost							
2.00 Have assets been relifed for Medicare purposes? If yes, see				N	22.00		
3.00 Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.			0	N	23.00		
4.00 Were new leases and/or amendments to existing leases entered lf yes, see instructions	Ũ		0.1	N	24.00		
5.00 Have there been new capitalized leases entered into during instructions.		0 1	5	N	25.00		
b. 00 Were assets subject to Sec. 2314 of DEFRA acquired during th instructions.		5 1	y .	N	26.00		
7.00 Has the provider's capitalization policy changed during the copy.	yes, submit	N	27.00				
Interest Expense 8.00 Were new Loans, mortgage agreements or letters of credit en wortgage language agreements or letters of credit en	reporting	N	28.00				
	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund)						
	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see						
instructions. 1.00 Has debt been recalled before scheduled maturity without is instructions.	see	Ν	31.00				
Purchased Servi ces		-1 -4	turne turne l	N			
2.00 Have changes or new agreements occurred in patient care set arrangements with suppliers of services? If yes, see instru- to the new instruction of the service set of the set of the service set of the service set of the service set of	uctions.	U		Ν	32.00		
3.00 If line 32 is yes, were the requirements of Sec. 2135.2 app no, see instructions.	pried pertainin				33.00		
Provider-Based Physicians 4.00 Were services furnished at the provider facility under an a lf yes, see instructions.	arrangement wit	h provider-ba	sed physi ci ans?	Y	34. 0		
5.00 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 p	rovi der-based	Ν	35. 0		
physicians during the cost reporting period: in yes, see in		-	Y/N	Date			
			1.00	2.00			
Home Office Costs							
5.00 Were home office costs claimed on the cost report? 7.00 If line 36 is yes, has a home office cost statement been pu	repared by the	home office?	Y N		36.0 37.0		
If yes, see instructions. 3.00 If line 36 is yes , was the fiscal year end of the home off			Ν		38.0		
the provider? If yes, enter in column 2 the fiscal year end 9.00 If line 36 is yes, did the provider render services to othe	d of the home o	ffi ce.	Y		39.0		
see instructions. 0.00 If line 36 is yes, did the provider render services to the	home office?	lf yes, see	Y		40.0		
instructions.							
	1.	00	2.	00			
Cost Report Preparer Contact Information 1.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	HONG		YANG		41.0		
respectively. 2.00 Enter the employer/company name of the cost report					42.0		
	FRANCI SCAN ALL		4∠.0				
preparer. 3.00 Enter the telephone number and email address of the cost	219-407-6568		HONG. YANG@FRAN		43.0		

Heal th	Health Financial Systems FRANCISCAN HEA			IS	In Lie	In Lieu of Form CMS-2552-10			
H0SPI T	HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE			CCN: 15-0162	Period: From 01/01/2022	Worksheet S-2 Part II			
						Date/Time Pre 5/29/2023 3:2	pared: 2 pm		
				3.00					
	Cost Report Preparer Contact Information								
41.00	Enter the first name, last name and the title/po	osition	DIRECTOR OF	REI MBURSEMENT			41.00		
	held by the cost report preparer in columns 1, 2	2, and 3,							
	respecti vel y.								
42.00	Enter the employer/company name of the cost repo	ort					42.00		
	preparer.								
43.00	Enter the telephone number and email address of	the cost					43.00		
	report preparer in columns 1 and 2, respectively	/.							

	Financial Systems FR AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC Complex Statistic	AL DATA	Prov	ider CC	CN: 15-0162	Period: From 01/01/2022	u of Form CMS-: Worksheet S-3 Part I	
						To 12/31/2022	Date/Time Pre 5/29/2023 3:2	
							I/P Days / O/P	
	Component	Worksheet A Line No.	No. of	Beds	Bed Days Available	CAH Hours	<u>Visits / Trips</u> Title V	
		1.00	2.0	0	3, 00	4,00	5.00	
	PART I – STATISTICAL DATA	1.00	2.0		3.00	4.00	3.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30.00		304	110, 90	60 0.00	0	1.00
	8 exclude Swing Bed, Observation Bed and							
	Hospice days) (see instructions for col. 2							
	for the portion of LDP room available beds)							
2.00	HMO and other (see instructions)							2.00
3.00	HMO I PF Subprovider							3.00
4.00 5.00	HMO IRF Subprovider						0	4.00
5.00 6.00	Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF						0	
7.00	Total Adults and Peds. (exclude observation			304	110, 90	60 0.00	0	
7.00	beds) (see instructions)			304	110, 90	0.00	0	7.00
8.00	INTENSI VE CARE UNI T	31.00		67	24, 45	55 0.00	0	8.00
8.01	NEONATAL INTENSIVE CARE UNIT	31.00		31	11. 3		0	
9.00	CORONARY CARE UNIT	32.00		66	24, 09		0	
10.00	BURN INTENSIVE CARE UNIT				, -			10.00
11.00	SURGICAL INTENSIVE CARE UNIT	34.00		31	11, 31	15 0.00	0	11.00
12.00	OTHER SPECIAL CARE (SPECIFY)							12.00
13.00	NURSERY	43.00					0	13.00
14.00	Total (see instructions)			499	182, 13	35 0.00	0	14.00
15.00	CAH visits						0	15.00
16.00	SUBPROVIDER - IPF							16.00
17.00	SUBPROVIDER - IRF	41.00		20	7,30	00	0	17.00
18.00	SUBPROVI DER							18.00
19.00	SKILLED NURSING FACILITY							19.00
20.00	NURSING FACILITY							20.00
21.00	OTHER LONG TERM CARE	101.00						21.00
22.00	HOME HEALTH AGENCY	101.00					0	
23.00 24.00	AMBULATORY SURGICAL CENTER (D. P.) HOSPICE	116.00		0		0		23.00
24.00	HOSPICE HOSPICE (non-distinct part)	30.00		0		0		24.00
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		519			Ŭ	27.00
28.00	Observation Bed Days			017			0	28.00
29.00	Ambul ance Trips							29.00
30.00	Employee discount days (see instruction)							30.00
31.00	Employee discount days - IRF							31.00
32.00	Labor & delivery days (see instructions)			0		0		32.00
32.01	Total ancillary labor & delivery room							32.01
	outpatient days (see instructions)							
33.00	LTCH non-covered days							33.00
33.01	LTCH site neutral days and discharges							33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care	30.00		0		0	0	34.00

HOSPI T	Financial Systems FR TAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC.	RANCISCAN HEALTH AL DATA	Provider CO	CN: 15-0162	Period: From 01/01/20	Work	sheet S-3	2552-10
					To 12/31/20	22 Date	/Time Pre /2023 3:2	
		I/P Days	/ O/P Visits	/ Trips	Full Tin			
	Component	Title XVIII	Title XIX	Total All Patients	Total Inter & Resident	s Pa	oyees On ayroll	
		6.00	7.00	8.00	9.00	-	10.00	<u> </u>
1.00	PART I - STATISTICAL DATA Hospital Adults & Peds. (columns 5, 6, 7 and	21, 019	604	56, 90	د <u>م</u>	-		1.00
1.00	8 exclude Swing Bed, Observation Bed and	21,014	004	50, 90				1.00
	Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)							
2.00	HMO and other (see instructions)	27, 447	23, 640					2.00
3.00	HMO I PF Subprovi der	27,447	23, 040					3.00
4.00	HMO I RF Subprovi der	979	661					4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0		0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF	-	0		0			6.00
7.00	Total Adults and Peds. (exclude observation	21, 019	604	56, 90	52			7.00
	beds) (see instructions)							
8.00	INTENSIVE CARE UNIT	2, 684	337	19, 80	65			8.00
8.01	NEONATAL INTENSIVE CARE UNIT	0	49	7,30	02			8.0
9.00	CORONARY CARE UNIT	4, 050	84	12, 20	04			9.00
10.00	BURN INTENSIVE CARE UNIT							10.00
11.00	SURGI CAL INTENSI VE CARE UNI T	2, 019	47	6, 40	54			11.00
12.00	OTHER SPECIAL CARE (SPECIFY)							12.00
13.00	NURSERY	00.770	189	3, 80		~	0 404 50	13.00
14.00	Total (see instructions)	29, 772	1, 310	106, 60	22.	92	2, 104. 52	•
15.00	CAH visits	U	0		0			15.00
16.00 17.00	SUBPROVI DER – I PF SUBPROVI DER – I RF	2, 795	0	5, 24	10 0	00	0.00	16.00
18.00	SUBPROVIDER - TRF	2, 195	0	3, 24	+0 0.	00	0.00	17.00
19.00	SKILLED NURSING FACILITY							19.00
20.00	NURSING FACILITY							20.00
21.00	OTHER LONG TERM CARE							21.0
22.00	HOME HEALTH AGENCY	о	0		0 0.	00	0.00	
23.00	AMBULATORY SURGICAL CENTER (D. P.)	-	-		-			23.00
24.00	HOSPICE	0	0		0 0.	00	51.51	24.00
24.10	HOSPICE (non-distinct part)				0			24.1
25.00	CMHC - CMHC							25.0
26.00	RURAL HEALTH CLINIC							26.0
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0			00	0.00	
27.00	Total (sum of lines 14-26)				22.	92	2, 156. 03	
28.00	Observation Bed Days		2, 099	11, 30	51			28.0
29.00	Ambul ance Trips	0						29.0
30.00	Employee discount days (see instruction)				0			30.0
31.00	Employee discount days - IRF	_			0			31.0
32.00	Labor & delivery days (see instructions)	0	402	80	98			32.0
32.01	Total ancillary labor & delivery room				0			32.0
33.00	outpatient days (see instructions) LTCH non-covered days	0						33.00
33.00 33.01	LTCH non-covered days LTCH site neutral days and discharges	0						33.0
JJ. UI	Temporary Expansion COVID-19 PHE Acute Care	0	0		0	1		34.00

OSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider C		Period: From 01/01/2022 To 12/31/2022	Worksheet S-3 Part I Date/Time Pre 5/29/2023 3:2	pare
		Full Time		Di sc	harges		
	Component	Equi val ents Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers 11.00	12.00	13.00	14.00	Patients 15.00	
	PART I - STATISTICAL DATA	11.00	12.00	13.00	14.00	15.00	
. 00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2		C	5, 51	6 484	17, 951	1.
	for the portion of LDP room available beds)						
. 00	HMO and other (see instructions)			4, 19			2.
. 00 . 00	HMO IPF Subprovider HMO IRF Subprovider				0		3.
. 00	Hospital Adults & Peds. Swing Bed SNF				0		4.
. 00	Hospital Adults & Peds. Swing Bed SM Hospital Adults & Peds. Swing Bed NF						6
. 00	Total Adults and Peds. (exclude observation beds) (see instructions)						7
00	INTENSIVE CARE UNIT						8
01	NEONATAL INTENSIVE CARE UNIT						8
00	CORONARY CARE UNIT						9
. 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						10
2.00	OTHER SPECIAL CARE (SPECIFY)						12
3.00	NURSERY						13
1.00	Total (see instructions)	0.00	C	5, 51	6 484	17, 951	
6.00	CAH visits						15
6. 00	SUBPROVIDER - IPF						16
. 00	SUBPROVI DER – I RF	0.00	C	23	1 0	422	17
3.00	SUBPROVI DER						18
0. 00	SKILLED NURSING FACILITY						19
0. 00	NURSING FACILITY						20
. 00	OTHER LONG TERM CARE						21
2.00	HOME HEALTH AGENCY	0.00					22
3.00	AMBULATORY SURGICAL CENTER (D. P.)	0.00					23
I. 00 I. 10	HOSPICE HOSPICE (non-distinct part)	0.00					24
5.00	CMHC - CMHC						24
5.00	RURAL HEALTH CLINIC						26
5. 25	FEDERALLY QUALIFIED HEALTH CENTER	0, 00					26
7.00	Total (sum of lines 14-26)	0.00					27
3.00	Observation Bed Days						28
. 00	Ambul ance Trips						29
0. 00	Employee discount days (see instruction)						30
. 00	Employee discount days - IRF						31
2.00	Labor & delivery days (see instructions)						32
2. 01	Total ancillary labor & delivery room						32
0.00	outpatient days (see instructions)				0		1 22
3.00 3.01	LTCH non-covered days LTCH site neutral days and discharges				0		33
	Temporary Expansion COVID-19 PHE Acute Care				U		33

Health Financial Systems FRANCISCAN HEALTH INDIANAPOLIS In Lieu of Form CMS-2552-10 HOSPITAL WAGE INDEX INFORMATION Provider CCN: 15-0162 Peri od: Worksheet S-3 From 01/01/2022 Part II Date/Time Prepared: То 12/31/2022 5/29/2023 3:22 pm Wkst. A Line Amount Recl assi fi cati Adj usted Paid Hours Average Hourly on of Salaries Number Reported Sal ari es Related to Wage (col. 4 (col.2 ± col (from Wkst. Salaries in col. 5) A-6) 3) col. 4 5.00 6.00 2.00 1.00 3.00 4.00 PART II - WAGE DATA SALARI ES 1.00 Total salaries (see 200.00 203.121.121 203, 121, 121 4, 573, 271.00 44.41 1.00 0 instructions) 2.00 Non-physician anesthetist Part 0 C C 0.00 0.00 2.00 3.00 Non-physician anesthetist Part 0 0.00 0.00 3.00 4.00 Physician-Part A -0 0.00 0 C 0.00 4.00 Admini strati ve 4.01 Physicians - Part A - Teaching 1,344,352 0 1, 344, 352 13, 107.00 102.57 4.01 Physician and Non 1,985,983 1, 985, 983 12, 671. 58 156.73 5.00 5.00 Physician-Part B Non-physician-Part B for 6.00 C 0.00 0.00 6.00 0 hospital-based RHC and FQHC servi ces 7.00 Interns & residents (in an 21.00 5,447,968 -3, 304, 866 2, 143, 102 58,009.00 36.94 7.00 approved program) 7.01 Contracted interns and 0 0.00 0.00 7.01 residents (in an approved programs) Home office and/or related 8.00 0 0.00 0.00 8.00 0 (organization personnel 9.00 SNF 44.00 0.00 0.00 9.00 10.00 Excluded area salaries (see 21,864,092 -282, 166 21, 581, 926 463, 667.00 46.55 10.00 instructions) OTHER WAGES & RELATED COSTS 11.00 Contract Labor: Direct Patient 12,070,392 0 12, 070, 392 114, 510. 74 105.41 11.00 Care 12.00 Contract Labor: Top Level 0 0 0.00 0.00 12.00 management and other management and administrative servi ces Contract Labor: Physician-Part 13.00 442,907 442,907 3,815.52 116.08 13.00 0 A - Administrative Home office and/or related 14.00 0 0 0.00 0.00 14.00 organization salaries and wage-related costs 598, 696. 00 24, 041, 922 24, 041, 922 14.01 Home office salaries 0 40.16 14.01 14.02 Related organization salaries С 0.00 0.00 14.02 15.00 Home office: Physician Part A 0 0 0.00 0.00 15.00 - Administrative Home office and Contract 0 0 0.00 0.00 16.00 16.00 C Physicians Part A - Teaching 16.01 Home office Physicians Part A 0 0.00 0.00 16.01 ٢ Teachi ng 16.02 Home office contract С 0.00 0.00 16.02 0 С Physicians <u>Part A - Teaching</u> WAGE-RELATED COSTS 0 43, 347, 029 17.00 Wage-related costs (core) (see 43.347.029 17.00 instructions) 18.00 Wage-related costs (other) 18.00 (see instructions) 19.00 Excluded areas 5.326.595 0 5, 326, 595 19.00 Non-physician anesthetist Part 20.00 0 C C 20.00 21.00 Non-physician anesthetist Part 0 0 21.00 22.00 Physician Part A -22.00 0 0 Admi ni strati ve 22.01 Physician Part A - Teaching 327.515 C 327.515 22 01 23.00 Physician Part B 483, 831 483, 831 23.00 С 24.00 Wage-related costs (RHC/FQHC) 24.00 0 C Interns & residents (in an 25.00 0 0 0 25.00 approved program) 25.50 Home office wage-related 6,909,397 0 6,909,397 25.50 (core) 25.51 Related organization 0 0 25.51

25.51Related organization00wage-related (core)00025.52Home office: Physician Part A000- Administrative -
wage-related (core)000

25.52

	Financial Systems	FR	ANCISCAN HEALT	H INDIANAPOLIS			u of Form CMS-2	
HOSPI 1	AL WAGE INDEX INFORMATION			Provider C		Period: From 01/01/2022 To 12/31/2022	Worksheet S-3 Part II Date/Time Pre 5/29/2023 3:2	pared:
		Wkst. A Line Number		Reclassificati on of Salaries (from Wkst. A-6)		Related to	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
25. 53	Home office: Physicians Part A - Teaching - wage-related (core) OVERHEAD COSTS - DIRECT SALARIE		0	0		0		25.5
24 00			0	0		0.00	0.00	1 24 0
26.00	Employee Benefits Department	4.00	0	0				
27.00	Administrative & General	5.00	1,071,302					
28.00	Administrative & General under		3, 622, 699	0	3, 622, 69	9 32, 818.00	110. 39	28.0
29.00	contract (see inst.) Maintenance & Repairs	6. 00	0	0		0 0.00	0.00	29.0
30.00	Operation of Plant	7.00	3, 309, 548		3, 309, 54			
30.00	Laundry & Linen Service	8.00	218, 801	0	218, 80			
32.00	Housekeeping	9.00		0	4, 167, 17			
33.00	Housekeeping under contract	9.00	4, 167, 174	0	4, 107, 17	4 204, 743.00 0 0.00		
33.00	(see instructions)		0	0		0.00	0.00	33.0
34.00	Di etary	10.00	2, 688, 532	-1, 745, 241	943, 29	1 47, 053. 00	20. 05	34.0
35.00	Dietary under contract (see instructions)	10.00	2,000,002	0	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	0 0.00		
36.00	Cafeteri a	11.00	805, 325	1, 745, 241	2, 550, 56	6 125, 405.00	20.34	36.0
37.00	Maintenance of Personnel	12.00	0	0		0 0.00	0.00	37.0
38.00	Nursing Administration	13.00	4, 207, 172	0	4, 207, 17	2 87, 216. 00	48.24	38.0
39.00	Central Services and Supply	14.00	616, 115		616, 11			
40.00	Pharmacy	15.00	7,070,995					
41.00	Medi cal Records & Medi cal Records Library	16.00	0	0		0 0.00		
42.00	Soci al Servi ce	17.00	0	0		0 0.00	0.00	42.0
43.00	Other General Service	18.00	0	0		0 0.00	0.00	43.0

Heal th	Financial Systems	FR	ANCI SCAN HEALT	H INDIANAPOLIS		In Lieu of Form CMS-2552-10			
HOSPI T	AL WAGE INDEX INFORMATION			Provider CC		Period: From 01/01/2022 To 12/31/2022		pared:	
		Worksheet A	Amount	Recl assi fi cati			Average Hourly		
		Line Number	Reported	on of Salaries			Wage (col. 4 ÷		
				(from	(col.2 ± col.		col. 5)		
				Worksheet A-6)	/	col. 4			
		1.00	2.00	3.00	4.00	5.00	6.00		
	PART III - HOSPITAL WAGE INDEX	SUMMARY				_			
1.00	Net salaries (see		197, 965, 517	3, 304, 866	201, 270, 38	3 4, 522, 301. 42	44.51	1.00	
	instructions)								
2.00	Excluded area salaries (see instructions)		21, 864, 092	-282, 166	21, 581, 92	6 463, 667. 00	46. 55	2.00	
3.00	Subtotal salaries (line 1		176, 101, 425	3, 587, 032	179, 688, 45	7 4, 058, 634. 42	44.27	3.00	
0.00	minus line 2)		170, 101, 120	0,007,002	177,000,10	1,000,001.12	11.27	0.00	
4.00	Subtotal other wages & related		36, 555, 221	0	36, 555, 22	1 717, 022. 26	50. 98	4.00	
	costs (see inst.)								
5.00	Subtotal wage-related costs		50, 256, 426	0	50, 256, 42	6 0.00	27.97	5.00	
	(see inst.)								
6.00	Total (sum of lines 3 thru 5)		262, 913, 072	3, 587, 032	266, 500, 10	4 4, 775, 656. 68	55.80	6.00	
7.00	Total overhead cost (see		27, 777, 663	13, 086	27, 790, 74	9 840, 407. 00	33.07	7.00	
	instructions)								

	nancial Systems FRANCISCAN H WAGE RELATED COSTS	HEALTH I NDI ANAPOLIS Provi der CCN: 15-0162	Peri od: From 01/01/2022 To 12/31/2022	Date/Time Pre
				5/29/2023 3:2: Amount
				Reported
				1.00
PΔR	RT IV - WAGE RELATED COSTS			1.00
	TA - Core List			
	TREMENT COST			
	1K Employer Contributions			4, 433, 124
	<pre>k Sheltered Annuity (TSA) Employer Contribution</pre>			0
	nqualified Defined Benefit Plan Cost (see instruction	ns)		0
	alified Defined Benefit Plan Cost (see instructions)	- /		8, 194, 985
	N ADMINISTRATIVE COSTS (Paid to External Organization	on)		
0 401	1K/TSA Plan Administration fees			0
00 Lec	gal/Accounting/Management Fees-Pension Plan			0
DO Emp	oloyee Managed Care Program Administration Fees			0
HEA	LTH AND INSURANCE COST			
0 Hea	alth Insurance (Purchased or Self Funded)			0
)1 Hea	alth Insurance (Self Funded without a Third Party Adr	ministrator)		0
)2 Hea	alth Insurance (Self Funded with a Third Party Admini	i strator)		19, 569, 521
3 Hea	alth Insurance (Purchased)			0
0 Pre	escription Drug Plan			0
	ntal, Hearing and Vision Plan			730, 871
	fe Insurance (If employee is owner or beneficiary)			123, 454
	cident Insurance (If employee is owner or beneficiary			0
	sability Insurance (If employee is owner or beneficia			914, 122
	ng-Term Care Insurance (If employee is owner or benet	ficiary)		0
	orkers' Compensation Insurance			1, 936, 867
	tirement Health Care Cost (Only current year, not the	e extraordinary accrual require	ed by FASB 106.	0
	ncumulative portion)			
TAX				10 500 007
	CA-Employers Portion Only			13, 582, 027
	dicare Taxes - Employers Portion Only			0
	employment Insurance			0
	ate or Federal Unemployment Taxes			0
OTH	ecutive Deferred Compensation (Other Than Retirement	Cost Departed on Lines 1 through	in t about (and	0
	structions))	cost Reported on Times I throu	ign 4 above. (see	0
	y Care Cost and Allowances			0
	tion Reimbursement			0
	tal Wage Related cost (Sum of lines 1 -23)			0 49, 484, 971
	T B - Other than Core Related Cost			49, 484, 971
	HER WAGE RELATED COSTS (SPECIFY)			

Heal th	Financial Systems	FRANCISCAN HEALTH INDI	ANAPOLI S	In Lie	u of Form CMS-2	2552-10
HOSPI T	AL CONTRACT LABOR AND BENEFIT COST	Pr	ovider CCN: 15-0162	Period:	Worksheet S-3	
				From 01/01/2022 To 12/31/2022	Part V Date/Time Pre	arad
				10 12/31/2022	5/29/2023 3:22	
	Cost Center Description			Contract Labor	Benefit Cost	
	· · ·			1.00	2.00	
	PART V - Contract Labor and Benefit Cost					
	Hospital and Hospital-Based Component Ide					
1.00	Total facility's contract labor and benef	t cost		12, 070, 392	43, 347, 029	1.00
2.00	Hospi tal			12, 070, 392	43, 347, 029	2.00
3.00	SUBPROVIDER - IPF					3.00
4.00	SUBPROVIDER - IRF			0	0	4.00
5.00	Subprovider - (Other)			0	0	5.00
6.00	Swing Beds - SNF			0	0	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	Hospital-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	Hospital-Based-CMHC					16.00
17.00	RENAL DIALYSIS I			0	0	17.00
18.00	Other			0	0	18.00

HOSPI 1	TAL-BASED HOSPICE IDENTIFICATION	DATA		Provider CC Hospice CCN	CN: 15-0162 N: 15-1523	Period: From 01/01/2022 To 12/31/2022	Worksheet S-9 PARTS I THROUG	GH IV pared:
						Hospi ce I		•
		Undupl i cated						
		Days						
		Title XVIII	Title XIX	Title XVIII	Title XIX	All Other	Total (sum of	
				Skilled	Nursi ng		cols. 1, 2 &	
				Nursi ng	Facility		5)	
				Facility				
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART I - ENROLLMENT DAYS FOR CO	ST REPORTING F	PERIODS BEGINNI	NG BEFORE OCTO	BER 1, 2015			
1.00	Hospice Continuous Home Care							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 BEGI NNI NG	BEFORE OCTOBER	1, 2015			
5.00	Number of patients receiving							6.00
	hospi ce care							
7.00	Total number of unduplicated							7.00
	Continuous Care hours billable							
	to Medicare							
3.00	Average Length of Stay (line 5							8.00
	/line 6)							
9.00	Unduplicated census count							9.00
IOTE:	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	
							cols. 1	
							through 3)	
				1.00	2.00	3.00	4.00	
	PART III - ENROLLMENT DAYS FOR	COST REPORTING	FERIODS BEGIN	NING ON OR AFT	ER OCTOBER 1,	2015		
10.00	Hospice Continuous Home Care			0		0 0	0	10.00
1.00	Hospice Routine Home Care			14, 109	7	39 1, 340	16, 188	11.00
12.00	Hospice Inpatient Respite Care			275		18 18	311	12.00
13.00	Hospice General Inpatient Care			15		2 1	18	13.00
14.00	Total Hospice Days			14, 399	7	59 1, 359	16, 517	14.00
	PART IV - CONTRACTED STATISTICA	AL DATA FOR COS	T REPORTING PE	RIODS BEGINNIN	G ON OR AFTER	R OCTOBER 1, 2015)	
1 - 00	Hospice Inpatient Respite Care			0		0 0	0	15.00
15.00	Thospice inpatient respice care			0				

Heal th	Financial Systems FRANCISCAN HEALTH IND	I ANAPOLI S		In Lie	eu of Form CMS-:	2552-10
H0SPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA	rovider CCN	I: 15-0162	Period:	Worksheet S-1	0
				From 01/01/2022 To 12/31/2022		nared
				10 12/31/2022	5/29/2023 3:2	
					1.00	
1 00	Uncompensated and indigent care cost computation Cost to charge ratio (Worksheet C, Part I line 202 column 3 divi	dod by Lin	- 202 aalum	2 0)	0 1(0222	1.00
1.00	Medicaid (see instructions for each line)			10)	0. 160322	1.00
2.00	Net revenue from Medicaid				64, 239, 032	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?				Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplementa	al payments	from Medica	ai d?	Y	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments fro	om Medicaid			0	5.00
6.00	Medi cai d charges				533, 969, 325	
7.00	Medicaid cost (line 1 times line 6)	1	E ! .		85, 607, 030	
8.00	Difference between net revenue and costs for Medicaid program (< zero then enter zero)	ine / minu	s sum of III	nes 2 and 5; IT	21, 367, 998	8.00
	Children's Health Insurance Program (CHIP) (see instructions for	each line)		1	
9.00	Net revenue from stand-al one CHIP				0	9.00
10.00	Stand-alone CHIP charges				0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)				0	
12.00	Difference between net revenue and costs for stand-alone CHIP (ine 11 min	us line 9; i	f < zero then	0	12.00
	enter zero)					-
13.00	Other state or local government indigent care program (see inst Net revenue from state or local indigent care program (Not incl				0	13.00
14.00	Charges for patients covered under state or local indigent care				0	
14.00	10)				0	14.00
15.00	State or local indigent care program cost (line 1 times line 14))			0	15.00
16.00	Difference between net revenue and costs for state or local ind	gent care	program (lii	ne 15 minus line	0	16.00
	13; if < zero then enter zero)					
	Grants, donations and total unreimbursed cost for Medicaid, CHIF instructions for each line)	o and state.	/local indig	gent care progra	ms (see	
17.00	Private grants, donations, or endowment income restricted to fu	nding chari	ty care		0	17.00
18.00	Government grants, appropriations or transfers for support of he				0	
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local			s (sum of lines	21, 367, 998	19.00
	8, 12 and 16)	_				
			Uni nsured	Insured	Total (col. 1	
		-	<u>patients</u> 1.00	patients 2.00	+ col. 2) 3.00	
	Uncompensated Care (see instructions for each line)	I	1.00	2.00	3.00	
20.00	Charity care charges and uninsured discounts for the entire faci	lity	55, 630, 0	02 11, 345, 926	66, 975, 928	20.00
	(see instructions)	5				
21.00	Cost of patients approved for charity care and uninsured discour	nts (see	8, 918, 7	13 11, 345, 926	20, 264, 639	21.00
22.00	instructions)					22.00
22.00	Payments received from patients for amounts previously written of charity care	orr as		0 0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)		8, 918, 7	13 11, 345, 926	20, 264, 639	23.00
20100		I	0/ / 10/ /	11/010//20	20/201/00/	20100
					1.00	
24.00	Does the amount on line 20 column 2, include charges for patien		nd a length	of stay limit	N	24.00
	imposed on patients covered by Medicaid or other indigent care					
25.00	If line 24 is yes, enter the charges for patient days beyond the	e indigent (care progra	n's length of	0	25.00
26.00	stay limit Total bad debt expense for the entire hospital complex (see ins	tructions)			9, 404, 610	26.00
28.00	Medicare reimbursable bad debts for the entire hospital complex (see this		uctions)		454, 968	
27.00	Medicare allowable bad debts for the entire hospital complex (se				699, 951	•
28.00	Non-Medicare bad debt expense (see instructions)				8, 704, 659	•
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt exp	ense (see i	nstructions)	1, 640, 531	•
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			,	21, 905, 170	•
	Total unreimbursed and uncompensated care cost (line 19 plus lin	ne 30)			43, 273, 168	

	Financial Systems FR SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF	ANCISCAN HEALTH	I INDIANAPOLIS Provider CC	CN: 15-0162 F	In Lie Period:	u of Form CMS-2 Worksheet A	2552-10
				F	rom 01/01/2022 o 12/31/2022	Date/Time Pre	
	Cost Center Description	Sal ari es	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	5/29/2023 3:2: Reclassified Trial Balance (col. 3 +- col. 4)	2 pm
		1.00	2.00	3.00	4.00	5.00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT		0	C	3, 229, 051	3, 229, 051	1.00
2.00 4.00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT	0	114 0	114 (9, 095, 683	9, 095, 797 62, 464	2.00 4.00
5.01 5.02	00570 ADMI TTI NG 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	0	0	0	0	0	5. 01 5. 02
5.02	00590 OTHER ADMIN & GENERAL	1,071,302	44, 352, 409	45, 423, 711	-170, 797	45, 252, 914	
7.00	00700 OPERATION OF PLANT	3, 309, 548	13, 136, 936	16, 446, 484		15, 120, 093	
8.00	00800 LAUNDRY & LINEN SERVICE	218, 801	1, 563, 833	1, 782, 634		1, 780, 622	
9.00 10.00	00900 HOUSEKEEPI NG 01000 DI ETARY	4, 167, 174 2, 688, 532	3, 681, 765	7,848,939		7, 805, 542	
	01100 CAFETERIA	2, 688, 532 805, 325	1, 774, 048 1, 127, 937	4, 462, 580 1, 933, 262		1, 319, 011 4, 642, 624	
13.00	01300 NURSI NG ADMI NI STRATI ON	4, 207, 172	488, 069	4, 695, 241		4, 603, 498	
	01400 CENTRAL SERVICES & SUPPLY	616, 115	3, 522, 926	4, 139, 041		2, 964, 693	
	01500 PHARMACY	7, 070, 995	21, 318, 791	28, 389, 786		7, 362, 775	
	01600 MEDI CAL RECORDS & LI BRARY 02100 I &R SERVI CES-SALARY & FRI NGES APPRV	0 5, 447, 968	0 1, 136, 709	0 6, 584, 677	-	0 2, 304, 240	
	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0,447,700	1, 130, 709	0, 304, 077		1, 547, 295	
	02300 MEDICAL LABORATORY SCIENTIST PRGM	88, 816	11, 217	100, 033		202, 938	
	02302 PHARMACY PRGM	323, 205	15, 775	338, 980		320, 859	
	02301 EMERGENCY MEDICAL SERVICES	1, 002, 913	335, 495	1, 338, 408		218, 045	
23. 03 23. 04	02303 PARAMEDIC PRGM 02305 SURGICAL TECH PROGRAM	147, 429	6, 538	153, 967	000,007	608, 687 152, 894	
23.04	INPATIENT ROUTINE SERVICE COST CENTERS	147,427	0, 000	100,707	1,073	132,074	25.04
	03000 ADULTS & PEDI ATRI CS	35, 836, 685	21, 665, 687	57, 502, 372			
	03100 I NTENSI VE CARE UNI T	8, 282, 450	4,961,914	13, 244, 364		11, 994, 148	
	02060 NEONATAL INTENSIVE CARE UNIT 03200 CORONARY CARE UNIT	5, 304, 829 9, 976, 789	2, 171, 455 5, 427, 683	7, 476, 284 15, 404, 472		6, 918, 384 14, 112, 834	
34.00	03400 SURGI CAL I NTENSI VE CARE UNI T	5, 295, 275	1, 794, 349	7, 089, 624		6, 565, 938	
41.00	04100 SUBPROVI DER – I RF	3, 775, 734	165, 558	3, 941, 292		3, 820, 528	
43.00	04300 NURSERY	0	0	(2, 044, 750	2, 044, 750	43.00
50.00	ANCI LLARY SERVI CE COST CENTERS	14, 200, 161	53, 199, 134	67, 399, 295	-42, 663, 772	24, 735, 523	50.00
	05200 DELIVERY ROOM & LABOR ROOM	4, 130, 715	917, 518	5, 048, 233		4, 218, 328	
	05400 RADI OLOGY-DI AGNOSTI C	9, 916, 291	11, 406, 196	21, 322, 487	-5, 962, 848	15, 359, 639	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	1, 273, 576	10, 350, 468	11, 624, 044		10, 747, 947	
56.00 59.00	05600 RADI OI SOTOPE 05900 CARDI AC CATHETERI ZATI ON	224, 744 3, 184, 887	863, 354 23, 554, 475	1, 088, 098 26, 739, 362		242, 005 3, 505, 401	
60.00	06000 LABORATORY	575, 822	29, 449, 188	30, 025, 010		25, 926, 801	
64.00	06400 I NTRAVENOUS THERAPY	3, 069, 305	40, 650, 206	43, 719, 511	-39, 827, 333	3, 892, 178	
65.00	06500 RESPI RATORY THERAPY	11, 189, 019	4, 294, 493	15, 483, 512			
	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	5, 375, 612 2, 781, 913	1, 089, 614 152, 479				
	06800 SPEECH PATHOLOGY	1, 035, 107	245, 028	2, 934, 392		2, 887, 079 1, 113, 104	
	06900 ELECTROCARDI OLOGY	1, 435, 752	623, 223	2, 058, 975		1, 658, 568	
	07000 ELECTROENCEPHALOGRAPHY	1, 765, 072	678, 591	2, 443, 663		2, 161, 106	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		17, 072, 007	49, 372, 009	
	07300 DRUGS CHARGED TO PATIENTS	0	0		65, 609, 171	34, 360, 437 65, 609, 171	
	07400 RENAL DIALYSIS	0	1, 025, 131	1, 025, 131		986, 387	
	07697 CARDI AC REHABI LI TATI ON	487, 934	145, 682	633, 616		601, 189	
77.00	07700 ALLOGENEIC STEM CELL ACQUISITION	3, 404, 905	5, 375, 566	8, 780, 471	0	8, 780, 471	77.00
90.00	OUTPATIENT SERVICE COST CENTERS	4, 794, 206	1, 190, 990	5, 985, 196	1, 449, 069	7, 434, 265	90.00
	09001 I BMT JOINT VENTURE	1, 490, 686	5, 111, 035	6, 601, 721		6, 531, 365	
90.05	09005 CV DI AGNOSTI C SERVI CES	8, 237, 851	3, 510, 370	11, 748, 221		10, 960, 241	1
	09100 EMERGENCY	8, 384, 511	12, 070, 651	20, 455, 162	-988, 474	19, 466, 688	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS						92.00
101.00	10100 HOME HEALTH AGENCY	2, 833	0	2, 833	-2, 833	0	101.00
102.00	10200 OPI OI D TREATMENT PROGRAM	0	0	0	0 0	0	102.00
112 00	SPECIAL PURPOSE COST CENTERS			C	0		113.00
	11600 HOSPI CE	5, 894, 091	1, 628, 835				
118.00		192, 492, 050	336, 191, 435	528, 683, 485		528, 710, 102	
	NONREI MBURSABLE COST CENTERS						
		384, 774	430, 768			816, 195	
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN		2 / 52 / 24	10 000 505			
192.00	19200 PHYSI CLANS' PRI VATE OFFI CES	8, 235, 843	2, 652, 694 -11 975	10, 888, 537 36, 356		10, 903, 105 36, 511	
192.00 194.00			2, 652, 694 -11, 975 3, 674	10, 888, 537 36, 356 3, 674	155	36, 511	
192.00 194.00 194.01 194.02	19200 PHYSICIANS' PRIVATE OFFICES 07955 MARKETING & COMMUNITY RELATIONS	8, 235, 843 48, 331	-11, 975	36, 356	2 155 0 0	36, 511 3, 674	194. 00 194. 01 194. 02

Health Financial Systems Fi	RANCI SCAN HEALT	H INDIANAPOLIS		In Lie	u of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provider C		Period:	Worksheet A	
				From 01/01/2022 Fo 12/31/2022		
Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cati	Recl assi fi ed	
			+ col. 2)	ons (See A-6)	Trial Balance	
					(col. 3 +-	
					col. 4)	
	1.00	2.00	3.00	4.00	5.00	
194. 05 07956 FOUNDATI ON	0	0	(0 0	0	194.05
200.00 TOTAL (SUM OF LINES 118 through 199)	203, 121, 121	399, 268, 769	602, 389, 890	0 0	602, 389, 890	200. 00

Heal th Financial	Systems	FRANCI SCAN HEALTH I	NDI ANAPOLI S
RECLASSI FI CATI ON	AND ADJUSTMENTS OF	TRIAL BALANCE OF EXPENSES	Provider CCN: 15-0162

In Lieu of Form CMS-2552-10 Period: Worksheet A From 01/01/2022

				From 01/01/2022 To 12/31/2022	Date/Time Prepared:
	Cost Center Description	Adjustments	Net Expenses		5/29/2023 3:22 pm
		(See A-8) 6.00	For Allocation 7.00		
	GENERAL SERVICE COST CENTERS	0.00	7.00		
1.00	00100 CAP REL COSTS-BLDG & FIXT	9, 103, 951			1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	0	9, 095, 797		2.00
4.00 5.01	00400 EMPLOYEE BENEFITS DEPARTMENT	9, 504, 152			4.00
5. 01 5. 02	00570 ADMI TTI NG 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	0	0		5. 01 5. 02
5.02	00590 OTHER ADMIN & GENERAL	38, 217, 784	-		5. 02
7.00	00700 OPERATION OF PLANT	7, 095, 542			7.00
8.00	00800 LAUNDRY & LINEN SERVICE	-5, 056			8.00
9.00	00900 HOUSEKEEPI NG	0	.,		9.00
10.00		29, 021			10.00
11.00 13.00	01100 CAFETERIA 01300 NURSING ADMINISTRATION	2, 059, 941- 329, 694-			11.00
14.00	01400 CENTRAL SERVICES & SUPPLY	-3, 702, 570			14.00
	01500 PHARMACY	1, 179, 551			15.00
16.00	01600 MEDI CAL RECORDS & LI BRARY	166, 491			16.00
21.00	02100 I &R SERVICES-SALARY & FRINGES APPRV	-90, 099			21.00
22.00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	-322,008			22.00
23. 00 23. 01	02300 MEDICAL LABORATORY SCIENTIST PRGM	-76, 080			23.00 23.01
23.01	02302 PHARMACY PRGM 02301 EMERGENCY MEDICAL SERVICES	-141, 521			23.01
23.02	02303 PARAMEDI C PRGM	-355, 135			23.02
23.04	02305 SURGI CAL TECH PROGRAM	-19, 559			23.04
	INPATIENT ROUTINE SERVICE COST CENTERS	· · ·	· · ·		
30.00	03000 ADULTS & PEDI ATRI CS	-373, 109			30.00
31.00	03100 I NTENSI VE CARE UNI T	-46, 125			31.00
31.01	02060 NEONATAL INTENSIVE CARE UNIT	-376, 519			31.01
32.00 34.00	03200 CORONARY CARE UNIT 03400 SURGICAL INTENSIVE CARE UNIT	0			32.00 34.00
41.00	04100 SUBPROVIDER - IRF	0			41.00
43.00	04300 NURSERY	0	2,044,750		43.00
	ANCI LLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	-4, 617, 408			50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	-1, 091			52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	232, 188			54.00 55.00
55.00 56.00	05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE	-3, 029, 656			56.00
59.00	05900 CARDI AC CATHETERI ZATI ON	-212, 450			59.00
60.00	06000 LABORATORY	79, 250			60.00
64.00	06400 I NTRAVENOUS THERAPY	-1, 237, 120	2, 655, 058		64.00
65.00	06500 RESPI RATORY THERAPY	3, 514			65.00
66.00	06600 PHYSI CAL THERAPY	-48, 188			66.00
67.00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	-75, 397 -6, 501			67.00 68.00
68.00 69.00	06900 ELECTROCARDI OLOGY	-159, 408			69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	-148, 208			70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0			71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0			72.00
	07300 DRUGS CHARGED TO PATIENTS	0			73.00
	07400 RENAL DI ALYSI S	975			74.00
	07697 CARDIAC REHABILITATION 07700 ALLOGENEIC STEM CELL ACQUISITION	-40			76. 97 77. 00
77.00	OUTPATIENT SERVICE COST CENTERS	0	8, 780, 471		17.00
90.00	09000 CLINIC	-2, 847, 928	4, 586, 337		90.00
90.01	09001 I BMT JOI NT VENTURE	-3, 389, 459			90. 01
	09005 CV DI AGNOSTI C SERVI CES	-782, 985	10, 177, 256		90.05
	09100 EMERGENCY	-336, 721	19, 129, 967		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART				92.00
101 00	OTHER REIMBURSABLE COST CENTERS	~			101.00
	10100 HOME HEALTH AGENCY 10200 OPI 0I D TREATMENT PROGRAM	0			101. 00 102. 00
152.00	SPECIAL PURPOSE COST CENTERS	0			102.00
113.00	11300 I NTEREST EXPENSE	0	0		113.00
	11600 HOSPI CE	0	7, 533, 510		116.00
118.00		41, 481, 831	570, 191, 933		118.00
100.07	NONREI MBURSABLE COST CENTERS	-	014 105		
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	00 522			190. 00 192. 00
	19200 PHYSICIANS' PRIVATE OFFICES 07955 MARKETING & COMMUNITY RELATIONS	-90, 532 25			192.00
	07952 WOMEN'S CENTER	23			194.00
	07950 OTHER NONREIMBURSABLE COST CENTERS	0	0		194.01
	07954 OTHER NRCC	30, 879, 404	-		194. 04
10/ 05	07956 FOUNDATI ON	8, 767	8, 767		194. 05
200.00		72, 279, 495			200.00

FRANCI SCAN HEALTH INDIANAPOLIS

Provider CCN: 15-0162

In Lieu of Form CMS-2552-10 Period: Worksheet A-6 From 01/01/2022 To 12/31/2022 Date/Time Prepared:

Inst. Control Enclose Solution Other A - MEDICAL, SPRINTS 3 00 4 00 5 00 7 00 1 00 A - MEDICAL, SPRINTS 3 00 7 00 0 43, 320, 039 2 00 1 00 A - MEDICAL, SPRINTS COMPART 1 00 0 44, 327, 00 0 34, 300, 437 3 00 2 00 A - MEDICAL, SPRINTS T, CO 0 3 44, 300, 437 3 00 6 00 3 00 3 00 6 00 3 00 6 00						To 12/31/2022	Date/Time Prepared: 5/29/2023 3:22 pm
L L L L D L D 100 According SuperLise 71 0 44.00 49.372.009 71 0 71.00 71.00 71.00 71.00 71.00 71.00 71.00 71.00 71.00 71.00 71.00 71.00 71.00 71.00 71.00 71.00 71.00 70.00		Cost Center		Salary	Other		
1.00 EXTCAL SUPPLIES CMARGED 10 /1.00 (4,9,72,000) 1.00 2.00 PATTITIS 72.00 34,36,437 2.00 4.00 0.00 0.00 360 4.00 5.00 PLIANTIS 0.00 0 6 5.00 0.00 0.00 0 0 6 5.00 0.00 0.00 0 0 6.00 7.00 0.00 0.00 0 0 6.00 7.00 0.00 0.00 0 0 6.00 7.00 0.00 0.00 0 0 0 7.00 1.00 0.00 0 0 0 7.00 1.00 0.00 0 0 1.00 7.00 1.00 0.00 0 0 1.00 7.00 1.00 0.00 0 0 0 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 <		2.00					
2.00 HM, DV CHARGED TO 72.00 0 34, 360, 437 2.00 3.00 3.00 DPERATION OF PLANT 7.00 0 5.00 4.00 5.00 0.00 0.00 0.00 0.00 4.00 5.00 0.00 0.00 0.00 0.00 4.00 6.00 0.00 0.00 0.00 0.00 4.00 6.00 0.00 0.00 0.00 0.00 0.00 10.00 0.00 0.00 0.00 0.00 0.00 11.00 0.00 0.00 0.00 0.00 0.00 11.00 0.00 0.00 0.00 0.00 0.00 15.00 0.00 0.00 0.00 0.00 0.00 15.00 0.00 0.00 0.00 0.00 0.00 15.00 0.00 0.00 0.00 0.00 0.00 15.00 0.00 0.00 0.00 0.00 0.00 0.00	1 00		71.00	0	49 372 009		1.00
1.00 OPERATION OF PLANT 7.00 0 3.04 4.00 1.00 0.00 0.00 0.00 0.00 1.00 4.00 1.00 0.00 0.00 0.00 0.00 5.00		PATIENT IMPL. DEV. CHARGED TO		-			
4.00 0.00 0 0 4.00 6.00 0.00 0 0.00 6.00 6.00 6.00 0.00 0 0.00 6.00 6.00 9.00 0.00 0 0.00 7.00 7.00 9.00 0.00 0 0 7.00 7.00 9.01 0.00 0 0 7.00 7.00 11.00 0.00 0 0 7.00 7.00 11.00 0.00 0 0 7.00 7.00 11.00 0.00 0 0 7.00 7.00 11.00 0.00 0 0 7.00 7.00 11.00 0.00 0 0 7.00 7.00 11.00 0.00 0 0 7.00 7.00 11.00 0.00 0 0 7.00 7.00 11.00 0.00 0 0 7.00 7.00 7.00 <td>3.00</td> <td></td> <td>7.00</td> <td>0</td> <td>364</td> <td></td> <td>3.00</td>	3.00		7.00	0	364		3.00
0.00 0.00 0 0.00 0 0.00 0 0.00 0 0.00				-	0		
7:00 0.00 0 0.00 0.				-			
9.00 0.00 0 0 9.00 11.00 0.00 0.00 0 0.00 11.00 13.00 0.00 0.00 0 0.00 11.00 14.00 0.00 0.00 0.00 0.00 11.00 14.00 0.00 0.00 0.00 0.00 11.00 15.00 0.00 0.00 0.00 0.00 11.00 16.00 0.00 0.00 0.00 0.00 11.00 17.00 0.00 0.00 0.00 0.00 11.00 17.00 0.00 0.00 0.00 0.00 11.00 23.00 0.00 0.00 0.00 0.00 23.00 24.00 0.00 0.00 0.00 0.00 23.00 25.00 0.00 0.00 0.00 0.00 23.00 25.00 0.00 0.00 0.00 0.00 23.00 25.00 0.00 0.00 0.0							
11.00 0.00 0 0 11.00 12.00 0.00 0 0 0 13.00 12.00 0.00 0 0 0 13.00 13.00 14.00 0.00 0 0 0 13.00 15.00				-			
12.00 0.00 0 0 12.00 14.00 0.00 0.00 0 14.00 14.00 14.00 0.00 0.00 0.00 14.00 14.00 15.00 0.00 0.00 0.00 0.00 14.00 15.00 0.00 0.00 0.00 0.00 14.00 16.00 0.00 0.00 0.00 0.00 14.00 17.00 0.00 0.00 0.00 0.00 19.00 17.00 0.00 0.00 0.00 0.00 19.00 21.00 0.00 0.00 0.00 0.00 21.00 22.00 0.00 0.00 0.00 0.00 22.00 22.00 0.00 0.00 0.00 0.00 22.00 22.00 0.00 0.00 0.00 0.00 23.00 22.00 0.00 0.00 0.00 0.00 0.00 33.00 33.00 33.00				-			1
14.00 0.00 0 0 15.00 16.00 0.00 0 0 15.00 16.00 0.00 0 0 15.00 17.00 0.00 0 0 16.00 17.00 0.00 0 0 17.00 19.00 0.00 0 0 17.00 22.00 0.00 0 0 0 23.00 0.00 0 0 22.00 23.00 0.00 0 0 22.00 24.00 0.00 0 0 22.00 25.00 0.00 0 0 24.00 25.00 0.00 0 0 24.00 25.00 0.00 0 0 24.00 25.00 0.00 0 0 24.00 25.00 0.00 0 0 0 25.00 0.00 0 0 0 25.00 0.00	12.00		0.00	0	0		12.00
15.00 0.00 0 0 15.00 17.00 0.00 0 0 17.00 18.00 0.00 0 0 17.00 19.00 0.00 0 0 18.00 19.00 0.00 0 0 18.00 21.00 0.00 0 0 22.00 23.00 0.00 0 0 22.00 24.00 0.00 0 0 22.00 25.00 0.00 0 0 24.00 25.00 0.00 0 0 24.00 25.00 0.00 0 0 24.00 25.00 0.00 0 0 24.00 25.01 0.00 0 0 24.00 25.02 0.00 0 0 24.00 25.03 0.00 0 0 24.00 25.03 0.00 0 0 33.00 34.00				-			
17.00 0.00 0 17.00 18.00 19.00 0.00 0 0 19.00 21.00 21.00 0.00 0 0 21.00 22.00 21.00 22.00 23.00	15.00		0.00	0	0		15.00
19.00 0.00 0 0 19.00 20.00 21.00 0.00 0 0 21.00 22.00 22.00 23.00 0.00 0 0 0 22.00 23.00 23.00 23.00 24.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 25.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 34.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 36.00 37.00 65.69,171 65.69,171 35.00 36.00 37.00 </td <td></td> <td></td> <td></td> <td>-</td> <td></td> <td></td> <td>1</td>				-			1
20.00 0.00 0 0.00 0 20.00 22.00 23.00 20.00 20.00 20.00 20.00 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>							
22 00 0.00 0 0.00 22.00 22.00 22.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 26.00 26.00 26.00 26.00 26.00 26.00 26.00 26.00 26.00 26.00 26.00 26.00 26.00 26.00 26.00 26.00 28.00 26.00 28.00 28.00 28.00 28.00 28.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 33.00				-			
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25.00 0.00 0 0.00 0 25.00 30.00 31.00 <td>23.00</td> <td></td> <td>0.00</td> <td>0</td> <td>0</td> <td></td> <td>23.00</td>	23.00		0.00	0	0		23.00
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Health Financial Systems

FRANCI SCAN HEALTH INDIANAPOLIS

In Lieu of Form CMS-2552-10

	IT I ATTONS	110	ANCI SCAN TILALITI	Provi der CCN: 15-01		
						e Prepared:
		Increases			5/29/202	<u>3 3:22 pm</u>
	Cost Center 2.00	Li ne # 3.00	Salary 4.00	0ther 5.00		
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8.00		0.00	0	0		8.00
9.00 10.00		0.00 0.00	0	0 0		9.00
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		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00			0	0		17.00
	D – DEPRECIATION		U	592, 738		
1.00	CAP REL COSTS-BLDG & FIXT	1.00		3, 229, 051		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00		8, 504, 894		2.00
3.00 4.00		0.00 0.00	0	0		3.00
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23.00		0.00	0	0		24.00
25.00		0.00	0	0		25.00
26.00		0.00	0	0		26.00
27.00 28.00		0.00 0.00	0	0 0		27.00
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	O E – CAFETERI A		0	11, 733, 945		
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	0		1, 745, 241	1, 151, 610		
1.00	F - PARAMEDI CAL ED MEDI CAL LABORATORY SCI ENTI ST	23.00	80, 058	25, 836		1.00
1.00	PRGM	23.00	80, 058	25, 650		1.00
	0 — — — — — — — — — — — — — — — — — — —		80, 058	25,836		
1.00			4 944 959	202, 943		1.00
1.00	G - INTERNS AND RESIDENT	22.00				1 1.00
	G - INTERNS AND RESIDENT I&R SERVICES-OTHER PRGM COSTS APPRV	22.00	1, 344, 352	202, 943		
2.00	I&R SERVICES-OTHER PRGM	22.00 90.00	<u>1, 960, 5</u> 14	32 <u>8, 3</u> 70_		
2.00	I &R SERVICES-OTHER PRGM COSTS APPRV CLINIC					
	I&R SERVICES-OTHER PRGM COSTS APPRV CLINIC O H - EMPLOYEE BENEFITS	90.00	<u>1, 960, 5</u> 14	_ <u>328, 3</u> 70 531, 313		2.00
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1.00 2.00 3.00 4.00	I &R SERVICES-OTHER PRGM COSTS APPRV CLINIC 0 H - EMPLOYEE BENEFITS EMPLOYEE BENEFITS DEPARTMENT OPERATION OF PLANT LAUNDRY & LINEN SERVICE HOUSEKEEPING	<u> </u>	<u>1, 960, 5</u> 14	328, 370 531, 313 62, 464 6, 553 471 8, 171		2.00 1.00 2.00 3.00 4.00
1.00 2.00 3.00 4.00 5.00	I &R SERVICES-OTHER PRGM COSTS APPRV CLINIC O H - EMPLOYEE BENEFITS EMPLOYEE BENEFITS DEPARTMENT OPERATION OF PLANT LAUNDRY & LINEN SERVICE	<u> </u>	<u>1, 960, 5</u> 14	<u>328, 370</u> 531, 313 62, 464 6, 553 471 8, 171 4, 432		2.00 1.00 2.00 3.00 4.00 5.00
1.00 2.00 3.00 4.00	I &R SERVICES-OTHER PRGM COSTS APPRV CLINIC 0 H - EMPLOYEE BENEFITS EMPLOYEE BENEFITS DEPARTMENT OPERATION OF PLANT LAUNDRY & LINEN SERVICE HOUSEKEEPING DI ETARY	<u> </u>	<u>1, 960, 5</u> 14	328, 370 531, 313 62, 464 6, 553 471 8, 171		2.00 1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00

FRANCI SCAN HEALTH I NDI ANAPOLI S Provi der CCN: 15-0162

In Lieu of Form CMS-2552-10 Period: Worksheet A-6 From 01/01/2022 To 12/31/2022 Date/Time Prepared:

2022		
2022	Date/Time	Prepared:
	5/29/2023	3.22 nm

Increases Increases Other 9.00 PARAMACY 2.00 3.00 6.00 10.00 10.00 9.00 9.00 9.00 9.00 9.00 9.00 9.00 9.00 9.00 10.00						5/29/2023 3:22 pm
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9.00 PIARAMACY 15.00 10.657 9.00 10.00 IAR SERVICES.SALRY & FEIN ACES APPRW 21.00 10.9622 10.00 10.00 IAR SERVICES.SALRY & FEIN ACES APPRW 23.00 249 11.00 11.00 DERDECAL LABORATORY SCIENTIST 23.00 776 12.00 11.00 DERDECAL LABORATORY SCIENTIST 23.00 784 13.00 11.00 DERDECAL TECH PROBA 23.01 786 13.00 10.00 NURRICAL INTERISTIC SCIENTIST 31.00 7.434 15.00 10.00 INTERNSTIC CARE UNIT 31.00 7.434 15.00 10.00 SURRICAL INTERNSTIC CARE UNIT 34.00 5.666 18.00 10.00 DEFLIFTY ROM & LABOR ROOM 50.00 17.465 21.00 20.00 DEFLIFTY ROM & LABOR ROOM 50.00 17.445 22.00 20.00 DEFLIFTY ROM & LABOR ROOM 52.00 17.00 27.00 20.00 DEFLIFTY ROM & LABOR ROOM 52.00 17.45 22.00 20.00		Cost Center	Line #	Sal ary	Other	
10.00 LAR SERVICES-SALARY & 21.00 10.962 10.00 11.00 HEDICAL LABORATORY SCIENTIST 23.00 240 12.00 12.00 PHAMA DEPOSA 23.01 796 12.00 13.00 SURFICUELS SATORY SCIENTIST 23.00 392 14.00 15.00 AULTS & PEDIATRICS 30.00 35.384 15.00 15.00 INTERVICEASE UNIT 31.00 7.434 16.00 10.00 SURFIXOTICE CARE UNIT 32.00 11.046 17.00 10.00 SURFIXOTICE CARE UNIT 34.00 5.00 12.00 10.00 DELIVERY ROM & LABOR ROM 52.00 14.75 23.00 10.00 DELIVERY ROM & LABOR ROM 52.00 14.75 23.00 10.00 DELIVERY ROM & LABOR ROM 52.00 14.00 24.00		2.00	3.00	4.00	5.00	
FIN INCES APPINY 23.0 249 11.00 NEL CLABORATORY SCIENTIST 23.00 249 12.00 PPARAMCY PRCM 23.01 766 12.00 13.00 EMERCENCY PELO LARSENT CES 23.01 766 12.00 13.00 EMERCENCY PELO LARSENT CES 23.02 399 14.00 14.00 DEMERCENCY PELO LARSENT CES 23.02 394 15.00 16.00 DURYNSY CARE UNIT 33.00 7.434 16.00 16.00 SUBRICAL INTENSIVE CARE UNIT 33.00 5.78 18.00 17.00 SUBRICAL INTENSIVE CARE UNIT 34.00 5.792 19.00 20.00 DELIVEY ROUA & LABOR ROOM 52.00 11.495 22.00 20.01 DELIVEY ROUA & LABOR ROOM 50.00 17.455 22.00 20.01 DELIVEY ROUA & LABOR ROOM 50.00 17.455 22.00 20.00 DELIVEY ROUA & LABOR ROOM 50.00 17.455 22.00 20.00 DELIVEY ROUA & LABOR ROOM 52.00 4.60 27.00 <td>9.00</td> <td>PHARMACY</td> <td>15.00</td> <td></td> <td>10, 657</td> <td>9.00</td>	9.00	PHARMACY	15.00		10, 657	9.00
11.00 MEDICAL LABORATORY SCIENTIST 23.00 249 11.00 12.00 PARAMACY PRGM 23.01 776 12.00 12.00 PARAMACY PRGM 23.01 776 13.00 13.00 BUREGORN PEDICAL SERVICES 23.02 394 13.00 14.00 SURGICAL TECH PROGRAM 23.04 392 14.00 10.01 AULTS A PEDIATINCS 30.00 7,434 15.00 10.01 INTERSIVE CARE UNIT 33.00 7,434 15.00 10.00 SUBPROVIDER - IRF 41.00 5.792 19.00 10.00 SUBPROVIDER - IRF 41.00 5.792 19.00 20.00 DELIVERY ROUM & LABOR ROOM 52.00 1.1,496 22.00 21.00 DELIVERY ROUM & LABOR ROOM 52.00 1.1,496 23.00 23.00 RABIO ISOTOPE 56.00 454 23.00 23.00 RABIO ISOTOPE 50.00 5.462 24.00 24.00 LABORATORY 60.00 10.059 23.00 </td <td>10.00</td> <td></td> <td>21.00</td> <td></td> <td>10, 962</td> <td>10.00</td>	10.00		21.00		10, 962	10.00
PROM						
12:00 PHARMACY PRGM 23:01 796 12:00 12:00 PHARMACY PRGM 23:01 796 13:00 14:00 SURGICAL TECH PRORAM 23:04 392 14:00 15:00 ADULTS A PEDIATICS 30:00 35:334 15:00 16:00 INTENSIVE CARE UNIT 31:00 7:434 16:00 10:00 SURGICAL INCENSIVE CARE UNIT 34:00 568 17:00 10:00 SURGICAL INCENSIVE CARE UNIT 34:00 572 19:00 10:00 DELIVERY ROOM & LABOR ROOM 50:00 17:495 21:00 20:00 DELIVERY ROOM & LABOR ROOM 50:00 45:44 23:00 20:00 DELIVERY ROOM & LABOR ROOM 50:00 45:44 23:00 20:00 DELIVERY ROOM & LABOR ROOM 50:00 15:13 25:00 20:01 DELIVER ROOM & LABOR ROOM 50:00 15:13 25:00 20:02 DELIVER ROOM & LABOR ROOM 50:00 15:13 25:00 20:02 DELECERDOREDFALORATORY THERAPY	11.00		23.00		249	11.00
13.00 ENERGENCY MEDICAL SERVICES 23.02 394 13.00 15.00 SURGIAL TECH PROCRAM 23.04 392 14.00 15.00 AULTS & PEDIATRICS 30.00 35.384 15.00 15.01 AULTS & PEDIATRICS 30.00 35.384 15.00 10.01 INTENSIVE CARE UNIT 32.00 11.045 17.00 000 SURGICAL INTENSIVE CARE UNIT 32.00 11.045 17.00 000 SURGICAL INTENSIVE CARE UNIT 32.00 17.045 20.00 10.00 SURGICAL INTENSIVE CARE UNIT 32.00 17.045 21.00 000 OPERATING ROOM 52.00 1.455 22.00 10.00 SURGICAL INTERNITION 59.00 5.492 20.00 20.00 AURTAR CARETER ZATION 59.00 5.492 20.00 20.01 ANDICAC CARTETER ZATION 59.00 5.202 27.00 20.00 CLEPARIORY THERAPY 66.00 8.693 28.00 20.00 CLEPARIORY THERAPY 67.00						
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15. 00 AULTS & PEDIATRICS 30. 00 35, 384 15. 00 10. 00 INTENSIVE CARE UNIT 31. 00 7, 434 16. 00 10. 00 SURFACIL, INTENSIVE CARE UNIT 32. 00 11. 045 17. 00 10. 00 SURFACIL, INTENSIVE CARE UNIT 32. 00 11. 045 18. 00 10. 00 SURFACIL, INTENSIVE CARE UNIT 32. 00 19. 664 20. 00 21. 00 DELIVERY ROOM & LABOR ROOM 52. 00 11. 745 22. 00 23. 00 RADIO ICOSY-DI ACINETRE ZATION 59. 00 5482 24. 00 25. 00 LABORATORY 60. 00 1. 513 25. 00 00 PIESTIRATORY THERAPY 64. 00 5. 200 26. 00 00 RESPIRATORY THERAPY 67. 00 5. 404 29. 00 00 SEPECENTATIONAL THERAPY 67. 00 5. 404 29. 00 00 SEPECENTATIONAL THERAPY 67. 00 5. 404 39. 00 00 SEPECENTATIONAL THERAPY 67. 00 6. 404 29. 00 00					- · ·	
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17. 00 CROMARY CARE UNI T 32. 00 11. 045 17. 00 18. 00 SUBEROVI DER - I AF 41. 00 566 18. 00 19. 00 SUBEROVI DER - I AF 41. 00 57. 792 19. 00 20. 00 DELI VERY ROOM & LABOR ROOM 50. 00 19. 694 21. 00 21. 00 DELI VERY ROOM & LABOR ROOM 50. 00 17. 694 22. 00 23. 00 RADI OLSOY-DI ACNOTEL 54. 00 11. 745 22. 00 24. 00 CARDEA CATHETERI ZATI ON 59. 00 5. 442 24. 00 25. 00 LABORATORY 60. 00 10. 059 27. 00 26. 00 INTRAVENUST THERAPY 65. 00 10. 059 27. 00 27. 00 RESPIRATORY THERAPY 65. 00 10. 059 27. 00 28. 00 CCUPATI ONAL THERAPY 66. 00 8. 693 28. 00 29. 00 CCUPATI ONAL THERAPY 67. 00 5. 404 29. 00 30. 00 SPELERONERPHALOGARHY 70. 00 6. 31. 00 31. 00 31. 00 ELECTROCAROI 01.00 GY 69. 00 4. 012 31. 00 32. 00 ELECTROCAROI 01.00 GY 69. 00 4. 012 31. 00 33. 00 CLINERONEVEHALOGRAPHY 70. 00 5. 399	15.00	ADULTS & PEDIATRICS	30.00		35, 384	15.00
18.00 SURGICAL INTENSIVE CARE UNIT 34.00 568 18.00 19.00 SURGYOVER - INF 41.00 5.792 19.00 20.00 OPERATING ROM 50.00 19.694 20.00 21.00 DELVERY ROM & LABOR ROM 50.00 11.745 22.00 22.00 RADIOLOGY-DIAGNOSTIC 54.00 11.745 22.00 23.00 RADIOLOGY-DIAGNOSTIC 54.00 11.745 22.00 24.00 CARDIAC CATHETERIZATION 59.00 5.482 24.00 25.00 LABORATORY 60.00 15.13 25.00 26.00 INTRAVENUS THERAPY 66.00 10.059 27.00 27.00 SPECH PATHOLOGY 68.00 11.304 30.00 31.00 DELECTROCARDIOLOGY 69.00 4.012 31.00 32.00 ELECTROCARDIOLOGY 69.00 5.202 35.00 33.00 CLINC 90.01 806 33.00 33.00 CLINC 90.01 806 37.00	16.00	INTENSIVE CARE UNIT	31.00		7,434	16.00
19.00 SUBPROVIDER - IRF 41.00 5.792 19.00 00 DEFLIVERY RONA & LABOR ROOM 52.00 1.495 21.00 21.00 DELIVERY RONA & LABOR ROOM 52.00 1.495 22.00 23.00 RADIO LOGV-DI ARNOSTIC 54.00 1.1745 22.00 23.00 RADIO LOGV-DI ARNOSTIC 54.00 1.495 23.00 24.00 CABDRAC CATHERRI ZATION 59.00 5.482 24.00 25.00 LABORATORY 60.00 5.200 26.00 27.00 RESPIRATORY THERAPY 65.00 10.059 27.00 20.00 PCISICAL THERAPY 66.00 8.693 28.00 20.00 DELICTROCARDIOLOGY 68.00 1.304 30.00 31.00 ELECTROCARDIOLOGY 68.00 1.304 30.00 32.00 ELECTROCARDIOLOGY 69.00 1.00 31.00 S1.00 21.01 80.00 33.00 CLITYREN ANDRY THERAPY 10.00 5.390 32.00 32.00 32.00	17.00	CORONARY CARE UNIT	32.00		11, 045	17.00
20.00 OPERATING ROOM 50.00 19.694 20.00 21.00 DELIVEY ROOM & LABOR ROOM 52.00 1.495 21.00 21.00 DELIVEY ROOM & LABOR ROOM 52.00 1.495 22.00 21.00 DELIVEY ROOM & LABOR ROOM 52.00 1.495 22.00 21.00 CARDIAC CATHETERIZATION 59.00 5.482 24.00 24.00 CARDIAC CATHETERIZATION 59.00 1.5482 24.00 26.00 INTRAVENUSTHERAPY 66.00 10.059 25.00 26.00 INTRAVENUSTHERAPY 66.00 8.693 28.00 20.00 CCUPATIONAL THERAPY 67.00 5.444 29.00 0.00 DELECTROCARDIAL CERAPHY 70.00 2.117 33.00 31.00 ELECTROCARDIAL CERAPHY 70.00 5.202 33.00 32.00 CLINCENCHERALOGRAPHY 70.00 5.399 36.00 33.00 CLINCENCHERALOGRAPHY 70.00 5.399 36.00 33.00 CLINCENCHERLORALOGRAPHY 70.00 </td <td>18.00</td> <td>SURGICAL INTENSIVE CARE UNIT</td> <td>34.00</td> <td></td> <td>568</td> <td>18.00</td>	18.00	SURGICAL INTENSIVE CARE UNIT	34.00		568	18.00
21.00 DELI VERY ROOM & LABOR ROOM 52.00 1.495 21.00 22.00 RADI OLGY-DI AGNOSTI C 54.00 11.745 22.00 23.00 RADI OLGY-DI AGNOSTI C 56.00 454 23.00 24.00 CARDI OLGY-DI AGNOSTI C 56.00 454 23.00 25.00 LABORATORY 00.00 5.482 24.00 25.00 LABORATORY 60.00 5.00 26.00 27.00 RESPI RATORY THERAPY 65.00 10.059 27.00 28.00 PKYSICALL THERAPY 65.00 8.693 28.00 29.00 OCUPATI ONAL THERAPY 67.00 5.404 29.00 20.00 ELECTROCRACEPH ATHOLOGY 68.00 1.304 30.00 31.00 ELECTROCRACEPH ATHOLOGY 69.00 4.012 31.00 33.00 CLINIC 90.00 5.302 36.00 33.00 CLINIC 90.00 5.302 36.00 36.00 CLINIC 90.00 5.302 36.00 36.00 CLINIC 90.00 5.302 36.00 37.00 1.00 5.302 36.00 30.00 38.00 CITIC THORACEPH ALORAPHY 10.00 653 32.00 <	19.00	SUBPROVI DER – I RF	41.00		5, 792	19.00
21.00 DELI VERY ROOM & LABOR ROOM 52.00 1.495 21.00 22.00 RADI OLGY-DI AGNOSTI C 54.00 11.745 22.00 23.00 RADI OLGY-DI AGNOSTI C 56.00 454 23.00 24.00 CARDI OLGY-DI AGNOSTI C 56.00 454 23.00 25.00 LABORATORY 00.00 5.482 24.00 25.00 LABORATORY 60.00 5.00 26.00 27.00 RESPI RATORY THERAPY 65.00 10.059 27.00 28.00 PKYSICALL THERAPY 65.00 8.693 28.00 29.00 OCUPATI ONAL THERAPY 67.00 5.404 29.00 20.00 ELECTROCRACEPH ATHOLOGY 68.00 1.304 30.00 31.00 ELECTROCRACEPH ATHOLOGY 69.00 4.012 31.00 33.00 CLINIC 90.00 5.302 36.00 33.00 CLINIC 90.00 5.302 36.00 36.00 CLINIC 90.00 5.302 36.00 36.00 CLINIC 90.00 5.302 36.00 37.00 1.00 5.302 36.00 30.00 38.00 CITIC THORACEPH ALORAPHY 10.00 653 32.00 <	20.00	OPERATING ROOM	50.00		19, 694	20.00
22.00 RADI OLGGY-DI AGNOSTIC 54.00 11,745 22.00 23.00 RADI OLGGY-DI ASNOSTIC 54.00 454 23.00 24.00 CARDI AC CATHETERI ZATION 55.00 54.82 24.00 25.00 LABRATORY 60.00 1.513 26.00 26.00 INTRAVENUS THERAPY 64.00 5,200 26.00 27.00 RESP RATORY THERAPY 66.00 10.059 27.00 28.00 CCUPATIONAL THERAPY 66.00 10.059 28.00 29.00 OCCUPATIONAL THERAPY 67.00 5.404 29.00 20.00 DCCUPATIONAL THERAPY 67.00 2.117 31.00 20.01 ELECTROCARDI OLOGY 69.00 4.012 31.00 20.00 20.01 ELECTROCARDI OLOGY 69.00 5.202 36.00 33.00 21.01 CLINC 90.01 806 33.00 36.00 36.00 35.00 CV DI AGNOSTI C SERVICES 90.01 5.399 36.00 36.00						21.00
23.00 RADI OI SJOPE 56.00 454 23.00 24.00 CARDIA C CATHETRI ZATI ON 50.00 1.842 24.00 25.00 LABORATORY 60.00 1.513 25.00 26.00 INTRAVENUS THERAPY 64.00 5.200 26.00 27.00 RESPIRATORY THERAPY 65.00 10.059 27.00 28.00 PHYSI CAL THERAPY 65.00 10.059 28.00 29.00 OCCUPATI ONAL THERAPY 67.00 5.404 30.00 30.00 SPECH PATHOLOGY 66.00 1.304 30.00 31.00 ELECTROEARDIOLOGY 69.00 4.012 31.00 32.00 ELECTROEARDIOLOGY 90.00 638 33.00 33.00 CLIN IC 90.05 5.202 35.00 36.00 MARKETI SERVICES 90.05 5.202 35.00 37.00 DENCERNIC SERVICES 90.05 5.202 36.00 38.00 CATTERN 19.00 653 37.00 39.00 CHINCER. COFFEE SHOP & 190.00 653 38.00 39.00 HARMACY 15.00 14.558 39.00 40.00 PHARMACY RESI DENCY 138.727 8.664 2.00						
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32.00 ELECTROENCEPHALOGRAPHY 70.00 2,117 32.00 33.00 CLINIC 90.00 638 33.00 34.00 IBMT JOINT VENTURE 90.01 806 34.00 35.00 CV DI AGNOSTI C SERVICES 90.05 5.202 35.00 36.00 EMECENCY 91.00 5.399 36.00 37.00 HOSPICE 116.00 10.584 37.00 38.00 CANTEEN 190.00 653 38.00 CANTEEN 190.00 155 40.00 38.00 0 PHYSICIANS' PRIVATE OFFICES 192.00 14.568 39.00 40.00 MARKETIN & COMMUNITY 194.00 155 40.00 0 CHARMACY PREM 15.00 164.490 8.664 1.00 1 PHARMACY RESI DENCY 1.50 164.490 8.664 2.00 1 O 154.237 0 0 2.00 2.00 1 O 23.03 480.670 128.017						
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34.00 IBMT JOINT VENTURE 90.01 806 34.00 35.00 CV DIAGNOSTIC SERVICES 90.05 5.202 35.00 36.00 EMERGENCY 91.00 5.399 36.00 37.00 HOSPICE 116.00 10.584 37.00 38.00 GIFT, FLOWER, COFFEE SHOP & 190.00 653 38.00 39.00 PHYSICIANS' PRIVATE OFFICES 192.00 14.568 39.00 40.00 MARKETING & COMMUNITY 194.00 155 39.00 1 PHARMACY RESIDENCY 15.00 164.490 8.664 1 - 23.01 154.237 0 0 23.01 154.237 0 2.00 1 PHARMACY PRGM 23.03 480.670 128.017 2.00 PHARMACY PRGM 23.03 480.670 128.017 2.00 0 349.188 152.065 3.00 0 - - 2.833 0 3.00 0 - - 2.833 0 1.00 1.00 - 1.876.679 168.071 1.00 0 - 1.876.679 168.071 1.00 1.00 - 1.876.679 168.071<						
35.00 CV DI AGNOSTI C SERVICES 90.05 5, 202 35.00 36.00 EMERGENCY 91.00 5, 399 36.00 37.00 HOSPICE 116.00 10, 584 37.00 38.00 GIFT, FLOWER, COFFEE SHOP & 190.00 653 38.00 38.00 39.00 PHYSI CI ANS' PRI VATE OFFI CES 192.00 14, 568 39.00 40.00 MARKETI NG & COMMUNI TY 194.00 155 40.00 1 PHARMACY RESI DENCY 15.00 164, 490 8, 664 1.00 2.00 PHARMACY PREM 23.01 154, 237 0 0 2.00 1 PHARMACY PREM 23.03 480, 670 128, 017 2.00 2.00 3.00 EMERGENCY 91.00 349, 138 152, 065 3.00 2.00 3.00 EMERGENCY 91.00 349, 138 152, 065 3.00 3.00 0 I- NURSERY 91.00 349, 138 152, 065 3.00 3.00 1.00 DTHER ANDI N & GENERAL 5.03 2, 833 0 0 3.00 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>						
36.00 EMERGENCY 91.00 5, 399 36.00 37.00 HOSPICE 116.00 10, 584 37.00 37.00 37.00 16.00 10, 584 37.00 37.00 37.00 16.00 10, 584 38.00 37.00 38.00 37.00 38.00 37.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 39.00 40.00 155 40.00 40.01 40.01 40.01 40.01 40.00 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>						
37.00 HOSPICE 116.00 10,584 37.00 38.00 GIFT, FLOWER, COFFEE SHOP & 190.00 653 38.00 39.00 PHYSICIANS' PRIVATE OFFICES 192.00 14,568 39.00 40.00 MARKETING & COMMUNITY 194.00 155 39.00 0 PHARMACY RESI DENCY 15.00 164,490 8,664 40.00 1.00 PHARMACY RESI DENCY 15.00 164,490 8,664 2.00 1.00 PHARMACY PRGM 23.01 154,237 0 0 2.00 1.00 PHARMACY PRGM 23.03 480,670 128,017 2.00 2.00 1.00 PARAMEDI C PRGM 23.03 480,670 128,017 1.00 2.00 1.00 DTHER NRCC 194.04 1,024 266 2.00 3.00 0 2.00 3.00 0 1.00 3.00 0 1.00 3.00 0 1.00 3.00 0 1.00 3.00 0 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>						
38.00 GI FT. FLOWER, COFFEE SHOP & 190.00 653 38.00 39.00 PHYSICI ANS' PRIVATE OFFICES 192.00 14,568 39.00 40.00 MARKETI NG & COMMUNI TY 194.00 155 40.00 40.00 RELATIONS 0 292,178 40.00 40.00 40.00 I - 0 292,178 40.00 40.00 I - 0 292,178 10.00 10.00 202,178 10.00 1 - - 0 292,178 10.00 10.00 20.00 10.00 20.00 10.00 20.00 30.00 20.00 30.00 20.00 30.00 20.00 30.00 20.00 30.00 20.00 30.00 20.00 30.00 20.03.34 20.00						
39. 00 PHYSICIANS' PRIVATE OFFICES 192. 00 14, 568 39. 00 40. 00 MARKETING & COMMUNITY 194. 00 155 40. 00 0 0 292, 178 10 40. 00 1 - 0 292, 178 40. 00 1 - 0 292, 178 40. 00 1 - PHARMACY RESI DENCY 15. 00 164, 490 8, 664 1. 00 2.00 PHARMACY REGM 23. 01 154, 237 0 0 2. 00 0 0 - 318, 727 8, 664 1. 00 2. 00 0 0 - 1.94, 04 1, 024 266 2. 00 1.00 PARAMEDI C PRGM 23. 03 480, 670 128, 017 1. 00 2.00 OTHER NRCC 194. 04 1, 024 266 3. 00 3. 00 0 0 - 1.00 349, 138 152, 065 3. 00 3. 00 0 0 - 2. 833 0 0 1. 00 1. 00 0 - <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td></t<>						
39.00 PHYSICIANS' PRIVATE OFFICES 192.00 14,568 39.00 40.00 MARKETING & COMMUNITY 194.00 155 40.00 RELATIONS 0 292.178 15 40.00 1 PHARMACY RESIDENCY 15.00 164,490 8,664 1.00 1.00 PHARMACY PRGM 23.01 154,237 0 2.00 0 0 318,727 8,664 2.00 2.00 1.00 PARAMEDIC RECLASS 10.00 23.03 480,670 128,017 2.00 2.00 0 349.138 152,065 3.00 2.00 3.00 EMERGENCY 91.00 349,138 152,065 3.00 0 0 2.833 0 3.00 3.00 0 0 2.833 0 1.00 3.00 0 0 2.833 0 1.00 1.00 0 0 2.833 0 1.00 1.00 0 0 1.876,679 168,071 1.00 1.00 0 0	38.00		190.00		653	38.00
40.00 MARKETING & COMMUNITY 194.00 155 40.00 0 0 0 292,178 100 1 - PHARMACY RESIDENCY 15.00 164,490 8,664 1.00 2.00 PHARMACY PRGM 23.01 154,237 0 0 2.00 1 - EMS & PARAMEDI C RECLASS 152,031 152,065 0 2.00 0 2.00 1.00 PARAMEDI C PRGM 23.03 480,670 128,017 1.00 2.00 2.00 0 194.04 1,024 266 2.00 3.00 3.00 2.00 3.03,832 280,348 3.00 1.00 3.00 1.00 3.00 1.00 3.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00						
RELATIONS						
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I - PHARMACY 15.00 164,490 8,664 1.00 2.00 PHARMACY PRGM 23.01 154,237 0 2.00 0 318,727 8,664 2.00 2.00 318,727 8,664 2.00 1.00 PARAMEDI C RECLASS 318,727 8,664 2.00 2.00 2.00 OTHER NRCC 194,04 1,024 266 2.00 2.00 OTHER NRCC 194,04 1,024 266 2.00 3.00 EMERGENCY 91.00 349,138 152,065 3.00 0 C 2.833 0 3.00 3.00 3.00 K HOME HEALTH RECLASS 1.00 2.833 0 0 1.00 1.00 OTHER ADMI N & GENERAL 5.03 2.833 0 0 1.00 1.00 I NURSERY I.00 1.876,679 168,071 1.00 1.00 M SURGI CAL TECH TRAINING PROGRAM 0 <t< td=""><td></td><td>RELATIONS</td><td></td><td> ↓</td><td></td><td></td></t<>		RELATIONS		↓		
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2.00 PHARMACY PRGM 23.01 154,2370 2.00 0 0 318,727 8,664 J - EMS & PARAMEDI C RECLASS 1.00 1.00 PARAMEDI C PRGM 23.03 480,670 128,017 1.00 2.00 OTHER NRCC 194.04 1,024 266 2.00 3.00 EMERGENCY 91.00 349,138 152,065 2.00 0 0 830,832 280,348 3.00 K - HOME HEALTH RECLASS 1.00 349,138 152,065 0 1.00 OTHER ADMI N & GENERAL 5.03 2.833 0 1.00 L - NURSERY					T	
O Image: Second se					8, 664	
J - EMS & PARAMEDI C RECLASS 1.00 PARAMEDI C PRGM 23.03 480,670 128,017 1.00 2.00 OTHER NRCC 194.04 1,024 266 2.00 3.00 EMERGENCY 91.00 349,138 152,065 3.00 0 0 830,832 280,348 3.00 3.00 K - HOME HEALTH RECLASS 1.00 0 2,833 0 1.00 1.00 OTHER ADMIN & GENERAL 5.03 2,833 0 1.00 1.00 L - NURSERY 1,876,679 168,071 1.00 0 0 0 0	2.00	PHARMACY PRGM	2301	15 <u>4, 2</u> 37	0	2.00
1.00 PARAMEDI C PRGM 23.03 480,670 128,017 1.00 2.00 OTHER NRCC 194.04 1,024 266 2.00 3.00 EMERGENCY 91.00 349,138 152,065 3.00 0 TOTHER ADMIN & GENERAL 91.00 349,138 152,065 3.00 0 0 830,832 280,348 3.00 3.00 0 0 2,833 0 0 3.00 0 0 2,833 0 0 1.00 1.00 0 1,876,679 168,071 1.00 1.00 0 0 1,876,679 168,071 1.00 1.00 0 0 0 0 0 0 1.00 0 0 0 0 0 0 1.00 0 0 0 0 0 0 1.00 0 0 0 0 0 0 1.00 0 0 0 0 0 0 1.00		0		318, 727	8, 664	
2.00 OTHER NRCC 194.04 1,024 266 2.00 3.00 EMERGENCY 91.00 349,138 152,065 3.00 0 0 830,832 280,348 152,065 3.00 3.00 K - HOME HEALTH RECLASS		J - EMS & PARAMEDIC RECLASS				
3. 00 EMERGENCY 91. 00 349, 138 152, 065 3. 00 0 830, 832 280, 348 100 100 100 100 0 0 0 2, 833 0 1. 00 1. 00 1. 00 0 0 1, 876, 679 168, 071 1. 00 1. 00 1. 00 1. 00 1. 00 0 0 0 1, 876, 679 168, 071 1. 00 1. 00 M SURGI CAL TECH TRAINING PROGRAM 0. 00 0 0 1. 00 1. 00 1. 00 0 0 0 0 0 1. 00 1. 00	1.00	PARAMEDIC PRGM	23.03	480, 670	128, 017	1.00
O Image: Colored color	2.00	OTHER NRCC	194.04	1, 024	266	2.00
K - HOME HEALTH RECLASS	3.00	EMERGENCY	91.00	349, 138	152, 065	3.00
1.00 OTHER ADMIN & GENERAL 5.03 2,833 0 1.00 0 1.00 2,833 0 1.00 1.00 1.00 NURSERY 43.00 1,876,679 168,071 1.00 0 1.876,679 168,071 1.00 1.00 M SURGI CAL TECH TRAINING PROGRAM 1.00 1.00 1.00 1.00 0 0 0 0 1.00				830, 832	280, 348	
O Image: Constraint of the second secon		K - HOME HEALTH RECLASS				
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L - NURSERY 43.00 1,876,679 168,071 1.00 0 1 1,876,679 168,071 1.00 M - SURGI CAL TECH TRAINING PROGRAM 1.00 1.00 1.00 1.00 1.00 1 0 0 0 1.00 1.00				2,833	— — — ī	
1.00 NURSERY		L - NURSERY	I			
0	1 00		43 00	1 876 679	168 071	1 00
M - SURGICAL TECH TRAINING PROGRAM 1.00				+		
1.00 <u>0 0 0</u> 1.00		M - SURGICAL TECH TRAINING PR	OGRAM	1, 070, 079	100, 07 1	
	1 00			0	0	1 00
	1.00			\	— — <u> </u>	1.00
500. 00 jorand 10tal. Thereases 0, 157, 250 104, 140, 575	500 00			<u> </u>	164 140 572	500 00
	300.00		ļ	0, 107, 200	107, 170, 575	T 300. 00

FRANCISCAN HEALTH INDIANAPOLIS

Provider CCN: 15-0162

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

Peri od: From 01/01/2022 To 12/31/2022

31/2022	Date/Time	Prepared:
	5/29/2023	

						 5/29/2023 3:22 pm
		Decreases				
	Cost Center 6.00	Li ne # 7.00	Salary 8.00	0ther 9.00	Wkst. A-7 Ref. 10.00	
	A - MEDICAL SUPPLIES	7.00	8.00	9.00	10.00	
1.00	OTHER ADMIN & GENERAL	5.03	0	88, 159	9	1.00
2.00	LAUNDRY & LINEN SERVICE	8.00	0	584	0	2.00
3.00	HOUSEKEEPI NG	9.00	0	8, 958	0	3.00
4.00	DI ETARY	10.00	0	158, 883	o	4.00
5.00	CAFETERI A	11.00	0	151, 987	0	5.00
6.00	NURSING ADMINISTRATION	13.00	0	524	0	6.00
7.00	CENTRAL SERVICES & SUPPLY	14.00	0	866, 334	0	7.00
8.00	PHARMACY	15.00	0	590, 632	0	8.00
9.00	FRINGES APPRV	21.00	0	42, 920	0	9.00
10.00	MEDICAL LABORATORY SCIENTIST	23.00	0	11	0	10.00
101.00	PRGM	20100	Ű		J. J	
11.00	EMERGENCY MEDICAL SERVICES	23.02	0	6, 133	o	11.00
12.00	SURGICAL TECH PROGRAM	23.04	0	454	0	12.00
13.00	ADULTS & PEDIATRICS	30.00	0	2, 393, 312	0	13.00
14.00	INTENSIVE CARE UNIT	31.00	0	1,031,543	0	14.00
15.00	NEONATAL INTENSIVE CARE UNIT	31.01	0	365, 109	0	15.00
16. 00 17. 00	CORONARY CARE UNIT SURGICAL INTENSIVE CARE UNIT	32.00 34.00	0	834, 299 342, 061	0	16.00 17.00
18.00	SUBPROVIDER - IRF	41.00	0	76, 630	0	18.00
19.00	OPERATING ROOM	50.00	0	39, 641, 014	0	19.00
20.00	DELIVERY ROOM & LABOR ROOM	52.00	o	715, 431	o	20.00
21.00	RADI OLOGY-DI AGNOSTI C	54.00	0	4,065,636	0	21.00
22.00	RADI OLOGY-THERAPEUTI C	55.00	0	2, 869	0	22.00
23.00	RADI OI SOTOPE	56.00	0	58, 132	o	23.00
24.00	CARDIAC CATHETERIZATION	59.00	0	22, 252, 825	0	24.00
25.00	LABORATORY	60.00	0	3, 589, 978	0	25.00
26.00	INTRAVENOUS THERAPY	64.00	0	2, 020, 031	0	26.00
27.00	RESPI RATORY THERAPY	65.00	0	1, 685, 164	0	27.00
28.00	PHYSICAL THERAPY	66.00	0	79, 135	0	28.00
29.00	OCCUPATIONAL THERAPY	67.00	0	41, 341	0	29.00
30. 00 31. 00	SPEECH PATHOLOGY ELECTROCARDI OLOGY	68.00 69.00	0	15, 196 371, 341	0	30.00 31.00
32.00	ELECTROENCEPHALOGRAPHY	70.00	0	88, 340	0	32.00
33.00	RENAL DI ALYSI S	74.00	0	24, 592	o	33.00
34.00	CARDIAC REHABILITATION	76.97	0	5, 916	0	34.00
35.00	CLINIC	90.00	0	453, 385	o	35.00
36.00	IBMT JOINT VENTURE	90.01	0	57, 201	0	36.00
37.00	CV DIAGNOSTIC SERVICES	90.05	0	368, 917	0	37.00
38.00	EMERGENCY	<u>91.</u> 00	0	1, 237, 833	0	38.00
			0	83, 732, 810		
1.00	B - DRUG OTHER ADMIN & GENERAL	5.03		49, 820	0	1.00
2.00	PHARMACY	15.00		20, 369, 761	0	2.00
3.00	I &R SERVICES-SALARY &	21.00		191, 148	0	3.00
	FRINGES APPRV			,	-	
4.00	ADULTS & PEDIATRICS	30.00		5, 327, 562	o	4.00
5.00	INTENSIVE CARE UNIT	31.00		36, 486	0	5.00
6.00	NEONATAL INTENSIVE CARE UNIT	31.01		1, 023	0	6.00
7.00	CORONARY CARE UNIT	32.00		30, 234	0	7.00
8.00	SUBPROVIDER - IRF	41.00		166	0	8.00
9.00	OPERATING ROOM	50.00		134, 513	0	9.00
10. 00 11. 00	DELIVERY ROOM & LABOR ROOM RADIOLOGY-DIAGNOSTIC	52.00 54.00		2, 823 433, 983	0	10.00
12.00	RADI OLOGY-THERAPEUTI C	55.00		433, 7 03 A	0	12.00
13.00	RADI OI SOTOPE	56.00		667, 167	0	13.00
14.00	CARDI AC CATHETERI ZATI ON	59.00		26, 606	Ö	14.00
15.00	LABORATORY	60.00		47, 545	0	15.00
16.00	INTRAVENOUS THERAPY	64.00		37, 619, 775	0	16.00
17.00	RESPI RATORY THERAPY	65.00		348, 748	0	17.00
18.00	ELECTROCARDI OLOGY	69.00		12, 211	0	18.00
19.00	RENAL DIALYSIS	74.00		7, 080	0	19.00
20.00		90.00		1, 984	0	20.00
21.00	I BMT JOI NT VENTURE	90.01		640	0	21.00
22.00	CV DIAGNOSTIC SERVICES	90.05		229, 932	0	22.00
23.00	EMERGENCY	<u>91.</u> 00		8 <u>3, 8</u> 49 65, 623, 060	<u> </u>	23.00
	C - EQUIPMENT LEASE	<u> </u>	U	03, 023, 000		
1.00	OTHER ADMIN & GENERAL	5.03		5, 015	10	1.00
2.00	OPERATION OF PLANT	7.00		4, 941	0	2.00
3.00	DI ETARY	10.00		14, 057	0	3.00
4.00	NURSING ADMINISTRATION	13.00		272	0	4.00
5.00	CENTRAL SERVICES & SUPPLY	14.00		649	0	 5.00

FRANCI SCAN HEALTH INDIANAPOLIS

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

<u>leal th</u>	Financial Systems	FR	RANCI SCAN HEALT	H INDIANAPOLI	S	In Lie	u of Form CMS-2552-10
RECLASSI FI CATI ONS				Provi der (CCN: 15-0162	Period:	Worksheet A-6
						From 01/01/2022 To 12/31/2022	Date/Time Prepared:
						10 12/31/2022	5/29/2023 3:22 pm
		Decreases				. 1	
	Cost Center	Line #	Salary	Other 0	Wkst. A-7 Ref	<u>.</u>	
6.00	6.00	7.00	8.00	9.00	10.00	0	6.00
0.00	FRINGES APPRV	21.00					0.00
7.00	EMERGENCY MEDICAL SERVICES	23.02		261		0	7.00
8.00	ADULTS & PEDIATRICS	30.00		13, 220		0	8.00
9.00	INTENSIVE CARE UNIT	31.00		2, 082		0	9.00
10.00	CORONARY CARE UNIT	32.00		285, 779		0	10.00
11.00	SUBPROVIDER - IRF	41.00		6, 415		0	11.00
12.00	OPERATING ROOM	50.00		22, 818		0	12.00
13.00 14.00	RESPI RATORY THERAPY PHYSI CAL THERAPY	65.00 66.00		222, 313 215		0	13.00
15.00	CLINIC	90.00		6, 971		0	15.00
16.00	CV DI AGNOSTI C SERVI CES	90.05		4, 020		0	16.00
17.00	EMERGENCY	91.00		3, 700		o	17.00
			— — —	592, 738		-	
	D - DEPRECIATION				1		
1.00	OTHER ADMIN & GENERAL	5.03		464		9	1.00
2.00	OPERATION OF PLANT	7.00		1, 328, 367		9	2.00
3.00	LAUNDRY & LINEN SERVICE	8.00		1, 899		0	3.00
4.00	HOUSEKEEPING	9.00		50, 710		0	4.00
5.00 6.00	DI ETARY CAFETERI A	10. 00 11. 00		78, 210		0	5.00
6.00 7.00	NURSING ADMINISTRATION	13.00		36, 652 99, 861		o	6. 00 7. 00
8.00	CENTRAL SERVICES & SUPPLY	14.00		308, 952		0	8.00
9.00	PHARMACY	15.00		96, 291		o	9.00
10.00	I &R SERVICES-SALARY &	21.00		221, 142		0	10.00
	FRINGES APPRV					-	
11.00	MEDICAL LABORATORY SCIENTIST	23.00		3, 227		0	11.00
	PRGM						
12.00	EMERGENCY MEDICAL SERVICES	23.02		3, 183		0	12.00
13.00	SURGICAL TECH PROGRAM	23.04		1, 011		0	13.00
14.00	ADULTS & PEDIATRICS	30.00		498, 933		0	14.00
15.00	INTENSIVE CARE UNIT	31.00		187, 539		0	15.00
16.00 17.00	NEONATAL INTENSIVE CARE UNIT	31. 01 32. 00		187, 595 152, 371		0	16.00 17.00
18.00	SURGICAL INTENSIVE CARE UNIT	34.00		187, 568		0	17.00
19.00	SUBPROVIDER - IRF	41.00		43, 345		0	19.00
20.00	OPERATING ROOM	50.00		2, 885, 121		0	20.00
21.00	DELIVERY ROOM & LABOR ROOM	52.00		114, 996		0	21.00
22.00	RADI OLOGY-DI AGNOSTI C	54.00		1, 474, 974		0	22.00
23.00	RADI OLOGY-THERAPEUTI C	55.00		660, 750		o	23.00
24.00	RADI OI SOTOPE	56.00		121, 248	6	0	24.00
25.00	CARDI AC CATHETERI ZATI ON	59.00		960, 012		0	25.00
26.00	LABORATORY	60.00		356, 305		0	26.00
27.00	INTRAVENOUS THERAPY	64.00		192, 727		0	27.00
28.00	RESPI RATORY THERAPY	65.00		272, 510		0	28.00
29.00 30.00	PHYSI CAL THERAPY OCCUPATI ONAL THERAPY	66.00 67.00		43, 318 11, 376		0	29.00 30.00
30.00	SPEECH PATHOLOGY	68.00		153, 139		0	30.00
32.00	ELECTROCARDI OLOGY	69.00		20, 867		o	32.00
33.00	ELECTROENCEPHALOGRAPHY	70.00		196, 334		o	33.00
34.00	RENAL DI ALYSI S	74.00		7, 072		0	34.00
35.00	CARDI AC REHABI LI TATI ON	76.97		24, 435		0	35.00
36.00	CLINIC	90.00		378, 113		o	36.00
37.00	I BMT JOI NT VENTURE	90. 01		13, 321		0	37.00
38.00	CV DIAGNOSTIC SERVICES	90.05		190, 313		0	38.00
39.00	EMERGENCY	<u>91.00</u>		169, 694		Q	39.00
	0 E – CAFETERIA		0	11, 733, 945			
1.00	DI ETARY	10.00	1, 745, 241	1, 151, 610		0	1.00
1.00			1, 745, 241	1, 151, 610			1.00
	F - PARAMEDI CAL ED			.,			
1.00	LABORATORY	60.00	80, 058	25, 836		0	1.00
	0		80, 058	25, 836			
	G - INTERNS AND RESIDENT						
1.00	I&R SERVICES-SALARY &	21.00	3, 304, 866	531, 313		0	1.00
2 00	FRINGES APPRV	0.00		-			
2.00				E21_212		Q	2.00
	U H - EMPLOYEE BENEFITS		3, 304, 866	531, 313	1		
1.00	OTHER ADMIN & GENERAL	5.03		30, 172	•	0	1.00
2.00	NEONATAL INTENSIVE CARE UNIT	31.01		4, 173		0	2.00
	RADI OLOGY-THERAPEUTI C	55.00		212, 474		0	3.00
3.00				, . , .			
3.00 4.00	CARDI AC REHABI LI TATI ON	76.97		2,076		0	4.00

FRANCISCAN HEALTH INDIANAPOLIS Provider CCN: 15-0162

In Lieu of Form CMS-2552-10

Heal th	Financial Systems	F	RANCI SCAN HEALT	H INDIANAPOLIS	\$	In Lie	u of Form CN	IS-2552-10
RECLASS	SIFICATIONS			Provider (CCN: 15-0162	Peri od:	Worksheet A	4-6
						From 01/01/2022 To 12/31/2022	Date/Time F	Proparod
						10 12/31/2022	5/29/2023 3	3:22 pm
		Decreases						
	Cost Center	Line #	Sal ary	Other	Wkst. A-7 Ref.			
	6. 00	7.00	8.00	9.00	10.00			
6.00		0.00	0	0		C		6.00
7.00		0.00	0	0	(C		7.00
8.00		0.00	0	0	(C		8.00
9.00		0.00	0	0	(C		9.00
10.00		0.00	0	0	(C		10.00
11.00		0.00	0	0	(C		11.00
12.00		0.00	0	0	(C		12.00
13.00		0.00	0	0	(C		13.00
14.00		0.00	0	0	(C		14.00
15.00		0.00	0	0	(C		15.00
16.00		0.00	0	0	(C		16.00
17.00		0.00	0	0	(C		17.00
18.00		0.00	0	0	(C		18.00
19.00		0.00	0	0	(C		19.00
20.00		0.00	0	0	(C		20.00
21.00		0.00	0	0	(c		21.00
22.00		0.00	0	0	(c		22.00
23.00		0.00	0	0	(c		23.00
24.00		0.00	0	0	(c		24.00
25.00		0.00	0	0	(b		25.00
26.00		0.00	0	0	(b		26.00
27.00		0.00	0	0	(b		27.00
28.00		0.00	0	0	(b		28.00
29.00		0.00	0	0	(b		29.00
30.00		0.00	0	0	(b		30.00
31.00		0.00	0	0	(b		31.00
32.00		0.00	0	0	(c		32.00
33.00		0.00	0	0	(c		33.00
34.00		0.00	o	0	(b		34.00
35.00		0.00	0	0	(c		35.00
36.00		0.00	0	0	(c		36.00
37.00		0.00	0	0	(c		37.00
38.00		0.00	0	0	(c		38.00
39.00		0.00	0	0	(c		39.00
40.00		0.00	0	0	(c		40.00
	0		0	292, 178		1		1
	I - PHARMACY RESIDENCY							
1.00	PHARMACY	15.00	154, 237	0	(C		1.00
2.00	PHARMACY PRGM	23.01	164, 490	8, 664	(b		2.00
	0		318, 727	8,664		7		1
	J - EMS & PARAMEDIC RECLASS							
1.00	EMERGENCY MEDICAL SERVICES	23.02	830, 832	280, 348	(C		1.00
2.00		0.00	0	0	(c		2.00
3.00		0.00	0	0	(b		3.00
	0		830, 832	280, 348		7		1
	K - HOME HEALTH RECLASS							
1.00	HOME HEALTH AGENCY	101.00	2, 833	0	(C		1.00
	0		2,833			7		
	L - NURSERY							
1.00	ADULTS & PEDIATRICS	30.00	1, 876, 679	168, 071		C		1.00
	0		1, 876, 679	168, 071]		
	M - SURGICAL TECH TRAINING PE	ROGRAM				·		
1.00		0.00	0	0		C		1.00
	TOTALS		0	0]		
500.00	Grand Total: Decreases		8, 159, 236	164, 140, 573		7		500.00

Health Financial Systems	FRANCI SCAN	HEAL
RECONCILIATION OF CAPITAL COSTS CENTERS		

ANCISCAN HEALTH INDIANAPOLIS Provider CCN: 15-0162

In Lieu of Form CMS-2552-10 Period: Worksheet A-7 From 01/01/2022 Part I

					To 12/31/2022		
				Acqui si ti ons			
		Begi nni ng	Purchases	Donati on	Total	Di sposal s and	
		Bal ances				Retirements	
	1	1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE				1		
1.00	Land	22, 254, 404	16, 145		0 16, 145		1.00
2.00	Land Improvements	35, 144, 228	94, 793		94, 793		2.00
3.00	Buildings and Fixtures	247, 845, 582	3, 334, 138		3, 334, 138		3.00
4.00	Building Improvements	19, 989, 515	2, 961, 600		2, 961, 600		4.00
5.00	Fixed Equipment	281, 604, 483	2, 438, 374	(2, 438, 374	391, 040	5.00
6.00	Movable Equipment	192, 994, 277	12, 861, 963	(0 12, 861, 963	14, 073, 209	6.00
7.00	HIT designated Assets	0	0	(0 0	0	7.00
8.00	Subtotal (sum of lines 1-7)	799, 832, 489	21, 707, 013	(21, 707, 013	19, 679, 703	8.00
9.00	Reconciling Items	0	0	(0 0	0	9.00
10.00	Total (line 8 minus line 9)	799, 832, 489	21, 707, 013	(21, 707, 013	19, 679, 703	10.00
		Endi ng Bal ance	Fully				
			Depreciated				
			Assets				
		6.00	7.00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE						
1.00	Land	21, 196, 680	0				1.00
2.00	Land Improvements	35, 234, 568	0				2.00
3.00	Buildings and Fixtures	251, 062, 100	0				3.00
4.00	Building Improvements	18, 931, 603	0				4.00
5.00	Fixed Equipment	283, 651, 817	0				5.00
6.00	Movable Equipment	191, 783, 031	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	801, 859, 799	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	801, 859, 799	0				10.00

Heal th	Financial Systems Fi	RANCI SCAN HEALT	H INDIANAPOLIS	5	In Lie	u of Form CMS-2	2552-10
RECONC	ILIATION OF CAPITAL COSTS CENTERS		Provider C	CN: 15-0162	Peri od:	Worksheet A-7	
					From 01/01/2022		
					To 12/31/2022	Date/Time Prep 5/29/2023 3:22	
			S	UMMARY OF CAP	I TAL	0/2//2023 0.22	2 011
			-				
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see	Taxes (see	
					instructions)	instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUN	N 2, LINES 1 a	and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	(D	0 0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	114	(D	0 0	0	2.00
3.00	Total (sum of lines 1-2)	114	()	0 0	0	3.00
		SUMMARY O	F CAPITAL				
		0.11		_			
	Cost Center Description		Total (1) (sun	ו			
		Capital - Relate					
		d Costs (see instructions)	through 14)				
		14.00	15.00	-			
	PART II - RECONCILIATION OF AMOUNTS FROM WORK			and 2			
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-DEDG & TTXT	0	114	í			2.00
3.00	Total (sum of lines 1-2)	0	114				3.00
0.00		1 0		.1		I	0.00

Health Financial Systems FR	ANCISCAN HEALT	H INDIANAPOLIS		In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider C	F	Period: From 01/01/2022 Fo 12/31/2022	Date/Time Prep 5/29/2023 3:22	pared: 2 pm
	COM	PUTATION OF RAT	FI OS	ALLOCATION OF	OTHER CAPITAL	
Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col. 2)		Insurance	
PART III - RECONCILIATION OF CAPITAL COSTS CE	1.00	2.00	3.00	4.00	5.00	
1.00 CAP REL COSTS-BLDG & FIXT 2.00 CAP REL COSTS-MVBLE EQUIP 3.00 Total (sum of lines 1-2)	305, 228, 272 475, 434, 848 780, 663, 120	0	305, 228, 272 475, 434, 848 780, 663, 120 CAPI TAL	0. 609014		1.00 2.00 3.00
Cost Center Description	Taxes	Other Capi tal -Rel ate d Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
	6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE	NTERS			0.750.445		
1.00 CAP REL COSTS-BLDG & FIXT 2.00 CAP REL COSTS-MVBLE EQUIP 3.00 Total (sum of lines 1-2)	0			3, 753, 145 8, 505, 008 12, 258, 153		1.00 2.00 3.00
		SI	JMMARY OF CAPI			
Cost Center Description	Interest	Insurance (see instructions)		Other Capital-Relate d Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
	11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE 1.00 CAP REL COSTS-BLDG & FIXT	<u>NTERS</u> 8, 579, 857			0 0	12, 333, 002	1.00
2.00 CAP REL COSTS-MVBLE EQUIP 3.00 Total (sum of lines 1-2)	0 8, 579, 857	0		0 0	9, 095, 797 21, 428, 799	2.00 3.00

	Financial Systems MENTS TO EXPENSES	FR	ANCISCAN HEALT	H INDIANAPOLIS Provider CCN: 15-0162	In Lie Period:	u of Form CMS-2 Worksheet A-8	
					From 01/01/2022 To 12/31/2022	Date/Time Prep	pared:
				Expense Classification or	Worksheet A	5/29/2023 3:22	2 pm
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basi s/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
1.00	Investment income - CAP REL	1.00	2.00	3.00 CAP REL COSTS-BLDG & FIXT	4.00	5.00	1.00
	COSTS-BLDG & FIXT (chapter 2)						
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			CAP REL COSTS-MVBLE EQUIP	2.00		
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)	В	0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter		0		0.00	0	7.00
0.00	21)		0		0.00		0.00
8.00	Television and radio service (chapter 21)		0		0.00		
9.00 10.00	Parking lot (chapter 21) Provider-based physician	A-8-2	0 -13, 578, 444		0.00	0	
11.00	adjustment Sale of scrap, waste, etc.		0		0.00	0	11.00
	(chapter 23) Related organization	A-8-1	135, 170, 595			0	12.00
	transactions (chapter 10) Laundry and linen service		0		0.00		
14.00	Cafeteria-employees and guests		-2, 280, 134	CAFETERI A	11.00	0	14.00
	Rental of quarters to employee and others		0		0.00		
16.00	Sale of medical and surgical supplies to other than		0		0.00	0	16.00
17.00	patients Sale of drugs to other than		0		0.00	0	17.00
18.00	patients Sale of medical records and		0		0.00	0	18.00
19.00	abstracts Nursing and allied health		0		0.00	0	19.00
	education (tuition, fees, books, etc.)						
19. 01	Nursing and allied health education (tuition, fees,		0		0.00	0	19. 01
20.00	books, etc.)	P	42,020		11 00		20.00
	Vending machines Income from imposition of	В	-43, 938 0	CAFETERI A	11.00 0.00		
	interest, finance or penalty charges (chapter 21)						
22.00	Interest expense on Medicare overpayments and borrowings to		0		0.00	0	22.00
23.00	repay Medicare overpayments Adjustment for respiratory	A-8-3	0	RESPI RATORY THERAPY	65.00		23.00
	therapy costs in excess of limitation (chapter 14)						
24.00	Adjustment for physical therapy costs in excess of	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	limitation (chapter 14)		0	*** Cost Center Deleted ***	114 00		25.00
25.00	Utilization review - physicians' compensation		0	Cost center Dereted	114.00		25.00
26.00	(chapter 21) Depreciation - CAP REL		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	COSTS-BLDG & FIXT Depreciation - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	COSTS-MVBLE EQUIP Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant Adjustment for occupational	A-8-3	0	OCCUPATI ONAL THERAPY	0.00 67.00		29.00 30.00
	therapy costs in excess of limitation (chapter 14)		Ū				
30. 99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30. 99
31.00	Adjustment for speech	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
	pathology costs in excess of limitation (chapter 14)						

FRANCISCAN HEALTH INDIANAPOLIS

ADJUST	MENTS TO EXPENSES			Provider CCN: 15-0162	eriod:	Worksheet A-8	
				Fi To	rom 01/01/2022 p 12/31/2022	Date/Time Pre	pared
				Expense Classification on To/From Which the Amount is		5/29/2023 3:2	2 pm
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
2.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.
3. 00	MI SCELLANEOUS I NCOME	В	1 456 700	OTHER ADMIN & GENERAL	5.03	0	33.
	MI SCELLANEOUS I NCOME	В	-1,400,769	OTHER ADMIN & GENERAL	0.00		33.
3.01	MI SCELLANEOUS I NCOME	B	-5 056	LAUNDRY & LINEN SERVICE	8.00		
	MI SCELLANEOUS I NCOME	B	-5, 050	LAUNDRI & LINEN SERVICE	0.00		
3.04	MI SCELLANEOUS I NCOME	B	_01 709	DI ETARY	10.00		
	MI SCELLANEOUS I NCOME	B		CAFETERIA	11.00		33.
3.06	MI SCELLANEOUS I NCOME	В	201, 101	on eren n	0.00		33.
3.07	MI SCELLANEOUS I NCOME	В	-102	CENTRAL SERVICES & SUPPLY	14.00		33.
3.08	MI SCELLANEOUS I NCOME	В		PHARMACY	15.00		33.
3.09	MI SCELLANEOUS I NCOME	B		I &R SERVICES-SALARY &	21.00		33.
.0.07		5	10	FRINGES APPRV	21.00		00.
3. 10	MI SCELLANEOUS I NCOME	В	-76,080	MEDICAL LABORATORY SCIENTIST	23.00	0	33.
-			-, -00	PRGM	0		
3. 11	MI SCELLANEOUS I NCOME	В	-19,000	SURGICAL TECH PROGRAM	23.04	0	33.
	MI SCELLANEOUS I NCOME	В		ADULTS & PEDIATRICS	30.00		
	MI SCELLANEOUS I NCOME	В	0		0.00		
3.14	MI SCELLANEOUS I NCOME	В	-24	NEONATAL INTENSIVE CARE UNIT	31.01	0	
3. 15	MI SCELLANEOUS I NCOME	В	0		0.00	0	33.
3. 16	MI SCELLANEOUS I NCOME	В	0		0.00	0	33.
3.17	MI SCELLANEOUS I NCOME	В	0		0.00	0	33.
3. 18	MI SCELLANEOUS I NCOME	В	0		0.00	0	33.
3.19	MI SCELLANEOUS I NCOME	В	-2	DELIVERY ROOM & LABOR ROOM	52.00	0	33.
3. 20	MI SCELLANEOUS I NCOME	В	-53, 597	RADI OLOGY-DI AGNOSTI C	54.00	0	33.
3. 21	MI SCELLANEOUS I NCOME	В	-3, 029, 218	RADI OLOGY-THERAPEUTI C	55.00	0	33.
3. 22	MI SCELLANEOUS I NCOME	В	0		0.00	0	33.
3. 23	MI SCELLANEOUS I NCOME	В	0		0.00	0	33.
3.24	MI SCELLANEOUS I NCOME	В	0		0.00	0	33.
3. 25	MI SCELLANEOUS I NCOME	В	-40	RESPI RATORY THERAPY	65.00	11	33.
3.26	MI SCELLANEOUS I NCOME	В	-31, 917	PHYSI CAL THERAPY	66.00	0	33.
3. 27	MI SCELLANEOUS I NCOME	В	-75, 397	OCCUPATI ONAL THERAPY	67.00	0	33.
3. 28	MI SCELLANEOUS I NCOME	В	-6, 501	SPEECH PATHOLOGY	68.00	0	33.
3. 29	MI SCELLANEOUS I NCOME	В	0		0.00	0	33.
3.30	MI SCELLANEOUS I NCOME	В	-159, 164	ELECTROENCEPHALOGRAPHY	70.00	0	33.
3. 31	MI SCELLANEOUS I NCOME	В	-40	CARDIAC REHABILITATION	76.97	0	33.
3.32	MI SCELLANEOUS I NCOME	В	-298, 144	CLINIC	90.00	0	33.
3.33	MI SCELLANEOUS I NCOME	В	-148, 353	CV DIAGNOSTIC SERVICES	90.05	0	33.
3.34	MI SCELLANEOUS I NCOME	В	-208, 332	EMERGENCY	91.00	0	33.
3.35	MI SCELLANEOUS I NCOME	В		EMERGENCY MEDICAL SERVICES	23.02	0	33.
3.36	MI SCELLANEOUS I NCOME	В	-355, 135	PARAMEDIC PRGM	23.03	0	33.
3.37	ADVERTI SI NG	A	-19, 311	OTHER ADMIN & GENERAL	5.03		
3. 38	ADVERTI SI NG	A	0		0.00		33.
3.39	ADVERTI SI NG	A	0		0.00		
3.40	ADVERTI SI NG	А	0	1	0.00		33.
3. 41	ADVERTI SI NG	A	0	1	0.00		33.
3.42	ADVERTI SI NG	A	0	1	0.00		33.
3. 43	ADVERTI SI NG	A	0	1	0.00		33.
3.44	ADVERTI SI NG	А	0	1	0.00		33.
3.45	ADVERTI SI NG	A	0	1	0.00		33.
3.46	ADVERTI SI NG	A	0	1	0.00		
3.47	ADVERTI SI NG	A	0		0.00		33.
3.48	ADVERTI SI NG	A		CV DIAGNOSTIC SERVICES	90.05		
3.49	REFUNDS AND REBATES OF EXPENSES	В	-3, 677, 512	CENTRAL SERVICES & SUPPLY	14.00		33.
3. 50	REFUNDS AND REBATES OF EXPENSES	В	U	1	0.00	0	33.
3. 51	REFUNDS AND REBATES OF EXPENSES	В	-7, 226	OPERATING ROOM	50.00	0	33.
3. 52	REFUNDS AND REBATES OF EXPENSES	В	C		0.00	0	33.
3. 53	REFUNDS AND REBATES OF EXPENSES	В	-1, 027	RADI OLOGY-DI AGNOSTI C	54.00	0	33.
3. 54	REFUNDS AND REBATES OF EXPENSES	В	-61, 250	CARDI AC CATHETERI ZATI ON	59.00	0	33.
33. 55	REFUNDS AND REBATES OF EXPENSES	В		INTRAVENOUS THERAPY	64.00		
3. 56	CAFETERI A	В		HOUSEKEEPI NG	9.00		33
~	CAFETERI A	В	0	DI ETARY	10.00	I 0	33.

Health Financial Syste

In lieu of Form CMS_2552_10

ADJUSTNENTS TO EXPENSES Provider CCN: 15-0162 Period: For 12/31/2021 Worksheet A-8 Cost Center Description Basis/Code (2) Anount Cost Center Line # Norksheet A-8 33.50 CAFETERIA B Oduult's A PEDIATRICS 4.00 5.00 0 33.50 CAFETERIA B Oduult's A PEDIATRICS 4.00 0 </th <th>Heal th</th> <th>Financial Systems</th> <th>FR</th> <th>ANCISCAN HEALT</th> <th>TH INDIANAPOLIS</th> <th>In Lie</th> <th>eu of Form CMS-2</th> <th>2552-10</th>	Heal th	Financial Systems	FR	ANCISCAN HEALT	TH INDIANAPOLIS	In Lie	eu of Form CMS-2	2552-10
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34.09 0THER HOSP FACILITIES A 0PHARMACY 15.00 0 34.10 0THER HOSP FACILITIES A -559 SURGICAL TECH PROGRAM 23.04 0 34.11 0THER HOSP FACILITIES A -120,029 ADULTS & PEDIATRICS 30.00 0 3 34.12 0THER HOSP FACILITIES A -120,029 ADULTS & PEDIATRICS 30.00 0 3 34.13 0THER HOSP FACILITIES A -120,029 ADULTS & PEDIATRICS 30.00 0 3 34.13 0THER HOSP FACILITIES A -438 RADIOLOGY-THERAPEUTIC 55.00 0 3 34.14 OTHER HOSP FACILITIES A -16,271 PHYSICAL THERAPY 66.00 0 3 34.14 OTHER HOSP FACILITIES A -0CLINIC 90.00 0 3 34.15 OTHER HOSP FACILITIES A -71,717 OTHER NCC 194.04 0 3 35.01 NON-HOSP FACILITIES B 0THER ADMIN & GENERAL 5.03 0 3 3 0 3 3 0 3 <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td>0</td><td>34.07</td></t<>							0	34.07
34.10 OTHER HOSP FACILITIES A -559 SURGICAL TECH PROGRAM 23.04 0 3 34.11 OTHER HOSP FACILITIES A -120,029 ADULTS & PEDIATRICS 30.00 0 3 34.12 OTHER HOSP FACILITIES A -438 RADIOLOGY-THERAPEUTIC 55.00 0 3 34.13 OTHER HOSP FACILITIES A -438 RADIOLOGY-THERAPEUTIC 50.00 0 3 34.14 OTHER HOSP FACILITIES A -16,271 PHYSICAL THERAPY 66.00 0 3 34.15 OTHER HOSP FACILITIES A -16,271 PHYSICANS' PRIVATE OFFICES 192.00 0 3 34.14 OTHER HOSP FACILITIES A -71,717 OTHER NOSP FACILITIES 194.04 0 3 3 0 3 3 0 3 0 3 3 0 3 0 3 0 3 0 3 0 3 3 0 3 0 3 0 3 0 3 0 3 0 3 0 3 0							0	34.08
34.11 OTHER HOSP FACILITIES A -120,029 ADULTS & PEDIATRICS 30.00 0 3 34.12 OTHER HOSP FACILITIES A -438 RADIOLOGY-THERAPEUTIC 55.00 0 3 34.13 OTHER HOSP FACILITIES A -59INTRAVENOUS THERAPY 64.00 0 3 34.14 OTHER HOSP FACILITIES A -16,271 PHYSICAL THERAPY 66.00 0 3 34.15 OTHER HOSP FACILITIES A -16,271 PHYSICAL THERAPY 66.00 0 3 34.16 OTHER HOSP FACILITIES A -0 CLINIC 90.00 0 3 34.17 OTHER HOSP FACILITIES A -71,717 OTHER NRCC 194.04 0 3 35.00 NON-HOSP FACILITES B 0 0THER ADMIN & GENERAL 5.03 0 3 35.01 NON-HOSP FACILITIES B 0 0THER ADMIN & GENERAL 5.03 0 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3								
34. 12 OTHER HOSP FACI LI TI ES A -438 RADI OLOGY-THERAPEUTI C 55.00 0 3 34. 13 OTHER HOSP FACI LI TI ES A 59 I NTRAVENOUS THERAPY 64.00 0 34. 14 OTHER HOSP FACI LI TI ES A -16, 271 PHYSI CAL THERAPY 66.00 0 34. 15 OTHER HOSP FACI LI TI ES A -16, 271 PHYSI CAL THERAPY 66.00 0 34. 15 OTHER HOSP FACI LI TI ES A 0 CLI NI C 90.00 0 3 34. 16 OTHER HOSP FACI LI TI ES A 0 PHYSI CI ANS' PRI VATE OFFI CES 192.00 0 3 35. 00 NON-HOSP FACI LI TI ES A -71, 717 OTHER NRCC 194.04 0 3 35. 01 NON-HOSP FACI LI TI ES B 0 OTHER ADMI N & GENERAL 5.03 0 3 35. 02 NON-HOSP FACI LI TI ES B 0 PHYSI CI ANS' PRI VATE OFFI CES 192.00 0 3 35. 02 NON-HOSP FACI LI TI ES B 0 PHYSI CI ANS' PRI VATE OFFI CES 192.00 0 3 35. 04 NON-HOSP FACI LI TI ES A -442 CV DI AGNOSTI C SERVI CES 192							-	34.10 34.11
34.13 OTHER HOSP FACILITIES A 59 INTRAVENOUS THERAPY 64.00 0 34.14 OTHER HOSP FACILITIES A -16,271 PHYSICAL THERAPY 66.00 0 34.15 OTHER HOSP FACILITIES A 0CLINIC 90.00 0 3 34.16 OTHER HOSP FACILITIES A 0CLINIC 90.00 0 3 34.16 OTHER HOSP FACILITIES A 0PHYSICIANS' PRIVATE OFFICES 192.00 0 3 34.17 OTHER HOSP FACILITIES A -71,717 OTHER NRCC 194.04 0 3 35.00 NON-HOSP FACILITIES B 0 OTHER ADMIN & GENERAL 5.03 0 3 35.01 NON-HOSP FACILITIES B -442 CV DIAGNOSTIC SERVICES 90.05 0 3 3 0 3 3 0 3 3 0 3 3 0 3 3 0 3 3 0 3 3 0 3 3 0 3 3 0 3 3 0 3 3 0 3 3 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>34.11</td>								34.11
34. 14 OTHER HOSP FACILITIES A -16, 271 PHYSICAL THERAPY 66.00 0 3 34. 15 OTHER HOSP FACILITIES A 0 CLINIC 90.00 0 3 34. 16 OTHER HOSP FACILITIES A 0 PHYSICIANS' PRIVATE OFFICES 192.00 0 3 34. 16 OTHER HOSP FACILITIES A -71, 717 OTHER NRC 194.04 0 3 34. 17 OTHER HOSP FACILITIES A -71, 717 OTHER NRCC 194.04 0 3 35. 00 NON-HOSP FACILITIES B 0 OTHER ADMIN & GENERAL 5.03 0 3 35. 01 NON-HOSP FACILITIES B -442 CV DIAGNOSTIC SERVICES 90.05 0 3 35. 02 NON-HOSP FACILITIES B 0 PHYSICIANS' PRIVATE OFFICES 192.00 0 3 35. 04 NON-HOSP FACILITIES B 0 PHYSICIANS' PRIVATE OFFICES 192.00 0 3 35. 04 NON-HOSP FACILITIES A 0 ADMITTING 5.01 0 3 3 35. 05 NON-HOSP FACILITIES A -24, 196 CENTRAL SERVICES & SUPPLY 14.							0	34.12
34.15 OTHER HOSP FACILITIES A OCLINIC 90.00 0 3 34.16 OTHER HOSP FACILITIES A OPHYSICIANS' PRIVATE OFFICES 192.00 0 3 34.17 OTHER HOSP FACILITIES A OPHYSICIANS' PRIVATE OFFICES 192.00 0 3 35.00 NON-HOSP FACILITES A -71,717 OTHER ADMIN & GENERAL 5.03 0 3 35.01 NON-HOSP FACILITES B OOTHER ADMIN & GENERAL 5.03 0 3 35.02 NON-HOSP FACILITIES B -442 CV DIAGNOSTIC SERVICES 90.05 0 3 35.03 NON-HOSP FACILITIES B OPHYSICIANS' PRIVATE OFFICES 192.00 3							0	34.13
34.16 OTHER HOSP FACILITIES A OPHYSICIANS' PRIVATE OFFICES 192.00 0 3 34.17 OTHER HOSP FACILITIES A -71,717 OTHER NRCC 194.04 0 3 35.00 NON-HOSP FACILITES B OTHER ADMIN & GENERAL 5.03 0 3 35.01 NON-HOSP FACILITIES B -442 (CV DIAGNOSTIC SERVICES 90.05 0 3 35.02 NON-HOSP FACILITIES B OPHYSICIANS' PRIVATE OFFICES 192.00 0 3 35.03 NON-HOSP FACILITIES B OPHYSICIANS' PRIVATE OFFICES 192.00 0 3 35.04 NON-HOSP FACILITIES B OPHYSICIANS' PRIVATE OFFICES 192.00 3 35.05 NON-HOSP FACILITIES A OPHYSICIANS' PRIVATE OFFICES 192.00 3 35.04 NON-HOSP FACILITIES A OADMITTING 5.01 3 3 35.05 NON-HOSP FACILITIES A -21,19 OTHER ADMIN & GENERAL 5.03 3 3 35.06 NON-HOSP FACILITIES A -24,956 CENTRAL SERVICES & SUPPLY 1							0	34.15
34.17 OTHER HOSP FACILITIES A -71,717 OTHER NRCC 194.04 0 3 35.00 NON-HOSP FACILITES B 0 OTHER ADMIN & GENERAL 5.03 0 3 35.01 NON-HOSP FACILITES B -442 CV DIAGNOSTIC SERVICES 90.05 0 3 35.02 NON-HOSP FACILITIES B -442 CV DIAGNOSTIC SERVICES 192.00 0 3 35.03 NON-HOSP FACILITIES B 0 PHYSICIANS' PRIVATE OFFICES 192.00 0 3 35.04 NON-HOSP FACILITIES B 0 PHYSICIANS' PRIVATE OFFICES 194.01 0 3 35.04 NON-HOSP FACILITIES A 0 ADMITTING 5.01 3 3 3 3 3 3 3 3 0 3 3 3 0 3 3 3 0 3 3 0 3 3 3 3 3 0 3 3 3 0 3 3 3 0 3 3 3 0 3 3 3							0	34.16
35.00 NON-HOSP FACILITES B O OTHER ADMIN & GENERAL 5.03 0 3 35.01 NON-HOSP FACILITIES B -442 CV DI AGNOSTI C SERVICES 90.05 3							0	34.17
35.01 NON-HOSP FACILITIES B -442 CV DIAGNOSTIC SERVICES 90.05 0 3 35.02 NON-HOSP FACILITIES B OPHYSICIANS' PRIVATE OFFICES 192.00 0 3 35.03 NON-HOSP FACILITIES B OPHYSICIANS' PRIVATE OFFICES 194.01 0 3 35.04 NON-HOSP FACILITIES A OADMITTING 5.01 0 3 35.05 NON-HOSP FACILITIES A -2,119 OHER ADMIN & GENERAL 5.03 0 3 35.06 NON-HOSP FACILITIES A -24,956 CENTRAL SERVICES & SUPPLY 14.00 0 3 35.07 NON-HOSP FACILITIES A ORADIOLOGY-DIAGNOSTIC 54.00 0 3 3 3 0 3 3 0 3 3 0 3 3 0 3 3 0 3 3 0 3 3 0 3 3 0 3 3 0 3 3 0 3 3							0	35.00
35.02 NON-HOSP FACILITIES B O PHYSICIANS' PRIVATE OFFICES 192.00 0 3 35.03 NON-HOSP FACILITIES B O WOMEN'S CENTER 194.01 0 3 35.04 NON-HOSP FACILITIES A O ADMITTING 5.01 0 3 35.05 NON-HOSP FACILITIES A -2,119 OTHER ADMIN & GENERAL 5.03 0 3 35.06 NON-HOSP FACILITIES A -24,956 CENTRAL SERVICES & SUPPLY 14.00 0 3 35.07 NON-HOSP FACILITIES A O RADIOLOGY-DIAGNOSTIC 54.00 0 3 3 35.08 NON-HOSP FACILITIES A O IMPL. DEV. CHARGED TO 72.00 0 3							0	
35.03 NON-HOSP FACILITIES B O WOMEN'S CENTER 194.01 0 3 35.04 NON-HOSP FACILITIES A O ADMITTING 5.01 0 3 35.05 NON-HOSP FACILITIES A -2,119 OTHER ADMIN & GENERAL 5.03 0 3 35.06 NON-HOSP FACILITIES A -24,956 CENTRAL SERVICES & SUPPLY 14.00 0 3 35.07 NON-HOSP FACILITIES A O RADIOLOGY-DIAGNOSTIC 54.00 0 3 35.08 NON-HOSP FACILITIES A O IMPL. DEV. CHARGED TO 72.00 0 3							0	35.02
35.04 NON-HOSP FACILITIES A O ADMITTING 5.01 0 3 35.05 NON-HOSP FACILITIES A -2,119 OTHER ADMIN & GENERAL 5.03 0 3 35.06 NON-HOSP FACILITIES A -24,956 CENTRAL SERVICES & SUPPLY 14.00 0 3 35.07 NON-HOSP FACILITIES A O RADIOLOGY-DIAGNOSTIC 54.00 0 3 35.08 NON-HOSP FACILITIES A O IMPL. DEV. CHARGED TO 72.00 0 3							0	1
35.05 NON-HOSP FACILITIES A -2,119 OTHER ADMIN & GENERAL 5.03 0 3 35.06 NON-HOSP FACILITIES A -24,956 CENTRAL SERVICES & SUPPLY 14.00 0 3 35.07 NON-HOSP FACILITIES A ORADIOLOGY-DIAGNOSTIC 54.00 0 3 35.08 NON-HOSP FACILITIES A OIMPL. DEV. CHARGED TO 72.00 0 3							-	
35.06 NON-HOSP FACILITIES A -24,956 CENTRAL SERVICES & SUPPLY 14.00 0 3 3 3 3 0 RADIOLOGY-DIAGNOSTIC 54.00 0 3 3 3 0 NON-HOSP FACILITIES A 0 IMPL. DEV. CHARGED TO 72.00 0 3								
35.07 NON-HOSP FACILITIES A O RADIOLOGY-DIAGNOSTIC 54.00 0 35.08 35.08 NON-HOSP FACILITIES A O I MPL. DEV. CHARGED TO 72.00 0 3			1					35.06
35. 08 NON-HOSP FACILITIES A OIMPL. DEV. CHARGED TO 72. 00 0 3			1					
		1						
PATIENTS				0		.2.00		
	35.09	NON-HOSP FACILITIES	A	72		90.00	0	35.09
	35.10	NON-HOSP FACILITIES				192.00	0	35.10
		NON-HOSP FACILITIES						35.11
50.00 TOTAL (sum of lines 1 thru 49) 72, 279, 495	50.00	TOTAL (sum of lines 1 thru 49)		72, 279, 495				50.00
(Transfer to Worksheet A,		(Transfer to Worksheet A,						
column 6, line 200.)		column 6, line 200.)						

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.(2) Basis for adjustment (see instructions).

A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

Note: See instructions for column 5 referencing to Worksheet A-7.

Heal th	Financial Systems	FRANCI SCAN HEAL	TH INDIANAPOLIS	In Lie	eu of Form CMS-	2552-10
	ENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HOM	ME Provider CCN: 15-0162	Peri od:	Worksheet A-8	3-1
OFFICE	COSTS			From 01/01/2022 To 12/31/2022		narod
				10 12/31/2022	5/29/2023 3:2	
	Line No.	Cost Center	Expense Items	Amount of	Amount	-
				Allowable Cost	Included in	
					Wks. A, column	
					5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUST	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED C	RGANIZATIONS OR	CLAI MED	
4 00	HOME OFFICE COSTS:			504.004		1 00
1.00			SHARED SERVICE ALLOCATION	524,094	0	1.00
2.00		EMPLOYEE BENEFITS DEPARTMENT		1, 604, 406	0	2.00
3.00			SHARED SERVICE ALLOCATION	92, 995, 046	0	3.00
4.00			SHARED SERVICE ALLOCATION	7, 100, 597	0	4.00
4.01			SHARED SERVICE ALLOCATION	120, 819	0	4.01
4.02			SHARED SERVICE ALLOCATION	329, 694	0	4.02
4.03			SHARED SERVICE ALLOCATION	166, 491	0	4.03
4.04			SHARED SERVICE ALLOCATION	1, 370, 285	0	4.04
4.05	0.00		SHARED SERVICE ALLOCATION	0	0	4.05
4.06			SHARED SERVICE ALLOCATION	25	0	4.06
4.07			SHARED SERVICE ALLOCATION	30, 950, 371	0	4.07
4.08		FOUNDATION	SHARED SERVICE ALLOCATION	8, 767	0	4.08
4.09		OTHER ADMIN & GENERAL	FRANCISCAN HOME OFFICE	6, 794, 758	0	4.09
4.10			FRANCISCAN HOME OFFICE	8, 579, 857	0	4.10
4.11			FRANCISCAN HOME OFFICE	108, 115, 868	128, 440, 786	4.11
4.12		OTHER ADMIN & GENERAL	FRANCISCAN HOME OFFICE	3, 737, 982	0	4. 12
4.13		PHARMACY	FRANCISCAN HOME OFFICE	1, 212, 321	0	4.13
4.14	0.00			0	0	4.14
4.15	0.00			0	0	4. 15
5.00	TOTALS (sum of lines 1-4).			263, 611, 381	128, 440, 786	5.00
	Transfer column 6, line 5 to					
	Worksheet A-8, column 2,					
	line 12.					

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

nas	iot been posted to worksheet A,	corumns r anu/or z, the amoun	it allowable sh		or this part.				
				Related Organization(s) and/	or Home Office				
	Symbol (1)	Name	Percentage of	Name	Percentage of				
			Ownershi p		Ownershi p				
	1.00	2.00	3.00	4.00	5.00				
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:								

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

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

rerinbur	Schone under trette Avint.				
6.00	В	SI STERS	100.00	0.00	6.00
7.00	В	APHL	100.00	0.00	7.00
8.00			0.00	0.00	8.00
9.00			0.00	0.00	9.00
10.00			0.00	0.00	10.00
100.00	G. Other (financial or			I	100.00
	non-financial) specify:				

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

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

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

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

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

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

Hoal th	Financial Syste	mc	FRANCI SCAN HEALTH		Inlia	u of Form CMS-	2552 10
	ENT OF COSTS OF		RELATED ORGANIZATIONS AND HOME		Period: From 01/01/2022	Worksheet A-8	3-1
					To 12/31/2022	Date/Time Pre 5/29/2023 3:2	pared:
	Net	Wkst. A-7 Ref.					
	Adjustments						
	(col. 4 minus						
	col. 5)*						1
	6.00	7.00					1
	A. COSTS INCUR	RED AND ADJUSTN	MENTS REQUIRED AS A RESULT OF TH	RANSACTIONS WITH RELATED	ORGANIZATIONS OR	CLAI MED	
	HOME OFFICE COS	STS:					
1.00	524, 094	9					1.00
2.00	1, 604, 406	0					2.00
3.00	92, 995, 046	0					3.00
4.00	7, 100, 597	0					4.00
4.01	120, 819	0					4.01
4.02	329, 694	0					4.02

4.03

4.04

4.05

4.06

4.07

4.08

4.09

4.10	8, 579, 857	11		4.10
4.11	-20, 324, 918	0		4.11
4.12	3, 737, 982	0		4.12
4.13	1, 212, 321	0		4.13
4.14	0	0		4.14
4.15	0	0		4.15
5.00	135, 170, 595			5.00
* The	amounts on line	s 1-4 (and sub	scripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as	
appropr	iate. Positive a	mounts increas	e cost and negative amounts decrease cost. For related organization or home office cost	whi ch

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 RELATED ORGANIZATION(S) AND/OR HOME OFFICE:						

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

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

6.00		6.00
7.00	SHARED LAB	7.00
8.00 9.00 10.00		8.00
9.00		9.00
10.00		10.00
100.00		100.00

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

0 0

0 0 0

0

0

166, 491

0

25

8, 767

1, 370, 285

30, 950, 371

6, 794, 758

4.03

4.04

4.05

4.06

4.07

4.08

4.09

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.

Health Financial Systems PROVIDER BASED PHYSICIAN ADJUSTMENT

FRANCI SCAN HEALTH INDI ANAPOLI S Provi der CCN: 15

In Lieu of Form CMS-2552-10 Worksheet A-8-2

пеагти	Financial Syste	ellis r	-RANCI SCAN HEAL	TH INDIANAPOLIS	3	111 L11	eu or Form CM3-	2002-10
PROVI DI	ER BASED PHYSIC	IAN ADJUSTMENT		Provider C		Peri od:	Worksheet A-8	8-2
						From 01/01/2022		
						To 12/31/2022		
							5/29/2023 3:2	
	Wkst. A Line #		Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remunerati on	Component	Component		ider Component	
							Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	7.00	OPERATION OF PLANT	5, 055	5, 055	(211, 500	0	1.00
2.00	15.00	PHARMACY	28, 212	28, 212	(211, 500	0	2.00
3.00	22.00	I&R SERVICES-OTHER PRGM	1, 654, 763	0	1, 654, 763	3 211, 500	13, 107	3.00
		COSTS APPRV						
4.00	30.00	ADULTS & PEDIATRICS	216, 234	216, 234	(211, 500	0	4.00
5.00	31.00	INTENSIVE CARE UNIT	46, 125	46, 125	(211, 500	0	5.00
6.00	31.01	NEONATAL INTENSIVE CARE UNIT	376, 495	376, 495	(246, 400	0	6.00
7.00	50.00	OPERATING ROOM	4, 610, 182	4, 610, 182	(271,900	0	7.00
8.00	52.00	DELIVERY ROOM & LABOR ROOM	1, 089	1, 089	(271,900	0	8.00
9.00	54.00	RADI OLOGY-DI AGNOSTI C	1, 070, 973	1, 070, 973	(271,900	0	9.00
10.00	59.00	CARDI AC CATHETERI ZATI ON	151, 200	151, 200	(271,900	0	10.00
11.00	60.00	LABORATORY	-79, 250	-79, 250	(260, 300	0	11.00
12.00	65.00	RESPI RATORY THERAPY	-3, 554	-3, 554	(211, 500	0	12.00
13.00	69.00	ELECTROCARDI OLOGY	159, 408	159, 408	(211, 500	0	13.00
14.00	70.00	ELECTROENCEPHALOGRAPHY	-10, 956	-10, 956	(211, 500	0	14.00
15.00	74.00	RENAL DIALYSIS	-975	-975	(211, 500	0	15.00
16.00	90.00	CLINIC	2, 549, 856	2, 549, 856	(211, 500	0	16.00
17.00	90.01	IBMT JOINT VENTURE	3, 389, 459	3, 389, 459	(211, 500	0	17.00
18.00	90.05	CV DIAGNOSTIC SERVICES	618, 494	618, 494	(211, 500	0	18.00
19.00	91.00	EMERGENCY	128, 389	128, 389	(o 0	0	19.00
200.00			14, 911, 199	13, 256, 436	1, 654, 763	3	13, 107	200.00

	Financial Syste		RANCI SCAN HEAL				eu of Form CMS-	2552-10
PROVI D	ER BASED PHYSIC	I AN ADJUSTMENT		Provi der	CCN: 15-0162	Period: From 01/01/2022	Worksheet A-8	-2
						To 12/31/2022		
	Wkst. A Line #		Unadjusted RCE				Physician Cost	
		I denti fi er	Limit		E Memberships		of Malpractice	
				Limit	Conti nui ng	Share of col.	Insurance	
					Education	12		
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00		OPERATION OF PLANT	0		0	0 0	0	1.00
2.00		PHARMACY	0		0	0 0	0	2.00
3.00		I&R SERVICES-OTHER PRGM COSTS APPRV	1, 332, 755	66, 63	18	0 0	0	3.00
4.00		ADULTS & PEDIATRICS	0		0	0 0	0	4.00
5.00	31.00	INTENSIVE CARE UNIT	0		0	0 0	0	5.00
6.00		NEONATAL INTENSIVE CARE UNIT	0		0	0 0	0	6.00
7.00		OPERATING ROOM	0		0	0 0	0	7.00
8.00		DELIVERY ROOM & LABOR ROOM	0		0	0 0	0	8.00
9.00		RADI OLOGY-DI AGNOSTI C	0		0	0 0	0	9.00
10.00		CARDI AC CATHETERI ZATI ON	0		0	0 0	0	10.00
11.00		LABORATORY	0		0	0 0	0	11.00
12.00		RESPI RATORY THERAPY	0		0	0 0	0	12.00
13.00		ELECTROCARDI OLOGY	0		0	0 0	0	13.00
14.00		ELECTROENCEPHALOGRAPHY	0		0	0 0	0	14.00
15.00		RENAL DIALYSIS	0		0	0 0	0	15.00
16.00		CLINIC	0		0	0 0	0	16.00
17.00		IBMT JOINT VENTURE	0		0	0 0	0	17.00
18.00		CV DIAGNOSTIC SERVICES	0		0	0 0	0	18.00
19.00		EMERGENCY	0		0	0 0	0	19.00
200.00			1, 332, 755	66, 63	8	0 0	0	200.00

	Financial Syste		RANCISCAN HEAL				u of Form CMS-	
PROVI D	ER BASED PHYSIC	I AN ADJUSTMENT		Provider (Period: From 01/01/2022	Worksheet A-8	3-2
	_					To 12/31/2022		
	Wkst. A Line #		Provi der	Adjusted RCE	RCE	Adjustment		
		Identifier	Component	Limit	Di sal I owance			
			Share of col. 14					
	1.00	2.00	15. 00	16.00	17.00	18.00		
1.00		OPERATION OF PLANT	0	0	17.00	5,055		1.00
2.00		PHARMACY	0	0		28, 212		2.00
3.00	22.00	I&R SERVICES-OTHER PRGM	0	1, 332, 755	322, 00			3.00
		COSTS APPRV						
4.00		ADULTS & PEDIATRICS	0	0		216, 234		4.00
5.00		INTENSIVE CARE UNIT	0	0	(46, 125		5.00
6.00	31.01	NEONATAL INTENSIVE CARE UNIT	0	0	(376, 495		6.00
7.00	50.00	OPERATING ROOM	0	0	(4, 610, 182		7.00
8.00	52.00	DELIVERY ROOM & LABOR ROOM	0	0	(1, 089		8.00
9.00	54.00	RADI OLOGY-DI AGNOSTI C	0	0	(1, 070, 973		9.00
10.00	59.00	CARDIAC CATHETERIZATION	0	0	(151, 200		10.00
11.00	60.00	LABORATORY	0	0	(-79, 250		11.00
12.00	65.00	RESPI RATORY THERAPY	0	0	(-3, 554		12.00
13.00	69.00	ELECTROCARDI OLOGY	0	0	(159, 408		13.00
14.00	70.00	ELECTROENCEPHALOGRAPHY	0	0	(-10, 956		14.00
15.00	74.00	RENAL DIALYSIS	0	0	(-975		15.00
16.00	90.00	CLINIC	0	0	(2, 549, 856		16.00
17.00	90.01	IBMT JOINT VENTURE	0	0	(3, 389, 459		17.00
18.00		CV DIAGNOSTIC SERVICES	0	0	(618, 494		18.00
19.00	91.00	EMERGENCY	0	0	(128, 389		19.00
200.00			0	1, 332, 755	322, 00	3 13, 578, 444		200. 00

1	Health Fina	nci al	S	ystems		
	COST ALLOCA	TION ·	-	GENERAL	SERVI CE	COSTS

FRANCI SCAN HEALTH I NDI ANAPOLI S Provi der CCN: 15-0162

In Lieu of Form CMS-2552-10 Period: Worksheet B From 01/01/2022 Part I To 12/31/2022 Date/Time Prepared: 5(002000 2000 2000 cmm)

					FI Te	rom 01/01/2022 o 12/31/2022	Part I Date/Time Pre	pared:
				CAPI TAL REI	LATED COSTS		5/29/2023 3:2	2 pm
		Cost Center Description	Net Expenses	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	ADMI TTI NG	
		·	for Cost			BENEFI TS		
			Allocation (from Wkst A			DEPARTMENT		
			col. 7) 0	1.00	2.00	4.00	5.01	
		AL SERVICE COST CENTERS						1 00
1.00 2.00		CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP	12, 333, 002 9, 095, 797	12, 333, 002	9, 095, 797			1.00 2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	9, 566, 616	0	0	.,,		4.00
5.01 5.02		ADMI TTI NG CASHI ERI NG/ACCOUNTS RECEI VABLE	0	34, 969 14, 551	25, 790 10, 731	0	60, 759 0	5. 01 5. 02
5.03	00590	OTHER ADMIN & GENERAL	83, 470, 698	7, 601	5, 606	50, 590	0	5.03
7.00 8.00		OPERATION OF PLANT LAUNDRY & LINEN SERVICE	22, 215, 635 1, 775, 566	1, 540, 106 120, 851			0	7.00 8.00
9.00	00900	HOUSEKEEPING	7, 805, 542	98, 951	72, 978	196, 266	0	9.00
10. 00 11. 00		DI ETARY CAFETERI A	1, 348, 032 2, 582, 683	131, 356 224, 573			0	10. 00 11. 00
13.00	01300	NURSI NG ADMI NI STRATI ON	4, 933, 192	0			0	13.00
14.00 15.00		CENTRAL SERVICES & SUPPLY PHARMACY	-737, 877 8, 542, 326	420, 696 163, 066		29, 018 333, 513	0	14.00 15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	166, 491	0	0	0	0	16.00
21.00 22.00		I &R SERVICES-SALARY & FRINGES APPRV I &R SERVICES-OTHER PRGM COSTS APPRV	2, 214, 141 1, 225, 287	13, 573	10, 010	100, 936 63, 316	0	21. 00 22. 00
22.00		MEDICAL LABORATORY SCIENTIST PRGM	126, 858	0	0	7, 954	0	22.00
23.01		PHARMACY PRGM	320, 859	0	0	14, 739	0	23. 01 23. 02
23. 02 23. 03		EMERGENCY MEDICAL SERVICES PARAMEDIC PRGM	76, 524 253, 552	0	0	8, 105 22, 639	0	23.02 23.03
23.04		SURGI CAL TECH PROGRAM	133, 335	0	0	6, 944	0	23.04
30.00		ENT ROUTI NE SERVI CE COST CENTERS ADULTS & PEDI ATRI CS	46, 886, 870	2, 557, 084	1, 885, 893	1, 599, 465	6, 619	30. 00
31.00		INTENSIVE CARE UNIT	11, 948, 023	304, 379			1, 459	31.00
31. 01 32. 00		NEONATAL INTENSIVE CARE UNIT CORONARY CARE UNIT	6, 541, 865 14, 112, 834	217, 297 710, 376			1, 581 1, 464	31. 01 32. 00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	6, 565, 938	357, 989	264, 023	249, 397	934	34.00
41.00 43.00		SUBPROVIDER - IRF NURSERY	3, 820, 528 2, 044, 750				635 413	41.00 43.00
	ANCI LI	ARY SERVICE COST CENTERS						
50.00 52.00		OPERATING ROOM DELIVERY ROOM & LABOR ROOM	20, 118, 115 4, 217, 237	1, 299, 250 406, 545			6, 502 1, 972	50. 00 52. 00
54.00	05400	RADI OLOGY-DI AGNOSTI C	15, 591, 827	818, 825	603, 897	467, 037	3, 812	54.00
55.00 56.00		RADI OLOGY-THERAPEUTI C RADI OI SOTOPE	7, 718, 291 242, 005	56, 958 17, 336			205 95	55.00 56.00
59.00	05900	CARDI AC CATHETERI ZATI ON	3, 292, 951	348, 283	256, 865	150, 002	2, 804	59.00
60.00 64.00		LABORATORY I NTRAVENOUS THERAPY	26, 006, 051 2, 655, 058	371, 472 161, 658			5, 103 212	60. 00 64. 00
65.00	06500	RESPI RATORY THERAPY	12, 968, 350	61, 626	45, 450	526, 980	2, 207	65.00
66.00 67.00		PHYSI CAL THERAPY OCCUPATI ONAL THERAPY	6, 303, 063 2, 811, 682		80, 726 0	253, 181 131, 023	836 688	66. 00 67. 00
68.00	06800	SPEECH PATHOLOGY	1, 106, 603	0	0	48, 751	205	68.00
69. 00 70. 00		ELECTROCARDI OLOGY ELECTROENCEPHALOGRAPHY	1, 499, 160 2, 012, 898	215, 015	158, 577 0	67, 621 83, 131	1, 128 321	69. 00 70. 00
71.00		MEDICAL SUPPLIES CHARGED TO PATIENT	49, 372, 009	0	0	03, 131	4, 597	71.00
72.00 73.00		IMPL. DEV. CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS	34, 360, 437 65, 609, 171	0	0	0	4, 118 6, 886	
74.00		RENAL DIALYSIS	987, 362	56, 217	41, 461	0	311	74.00
76. 97 77. 00		CARDIAC REHABILITATION ALLOGENEIC STEM CELL ACQUISITION	601, 149 8, 780, 471	0	0	22, 981 160, 364	6 1, 376	76. 97 77. 00
77.00	OUTPA	TIENT SERVICE COST CENTERS	8,780,471	0		100, 304	1, 370	77.00
90. 00 90. 01			4, 586, 337	281, 175			33	90.00
90. 01 90. 05		I BMT JOINT VENTURE CV DI AGNOSTI C SERVI CES	3, 141, 906 10, 177, 256	39, 399 0	29, 058 0	70, 208 387, 986	20 14	90. 01 90. 05
91.00		EMERGENCY	19, 129, 967	698, 715	515, 314	411, 337	4, 200	
92.00		OBSERVATION BEDS (NON-DISTINCT PART REIMBURSABLE COST CENTERS						92.00
		HOME HEALTH AGENCY	0	0				101.00
102.00		OPIOID TREATMENT PROGRAM AL PURPOSE COST CENTERS	0	0	0	0	0	102. 00
	11300	INTEREST EXPENSE	7 600 640			277 (00		113. 00 116. 00
118.00		HOSPICE SUBTOTALS (SUM OF LINES 1 through 117)	7, 533, 510 570, 191, 933		0 8, 956, 267			
100.00		MBURSABLE COST CENTERS	01/ 105		1			190. 00
		GIFT, FLOWER, COFFEE SHOP & CANTEEN PHYSICIANS' PRIVATE OFFICES	816, 195 10, 812, 573	72, 102 73, 450			0	192.00
194.00	07955	MARKETING & COMMUNITY RELATIONS	36, 536	0	0	2, 276	0	194.00

Health Financial Systems	FRANCI SCAN HEALT	H INDIANAPOLIS		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC		Period: From 01/01/2022 To 12/31/2022	Worksheet B Part I Date/Time Pre 5/29/2023 3:2	epared: 22 pm
		CAPI TAL REL	ATED COSTS			
Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFI TS DEPARTMENT	ADMI TTI NG	
	0	1.00	2.00	4.00	5.01	
194.01 07952 WOMEN'S CENTER 194.02 07950 OTHER NONREIMBURSABLE COST CENTERS	3, 674 0	43, 637 0	32, 18	3 0 0 0) 194. 01) 194. 02
194.04 07954 OTHER NRCC 194.05 07956 FOUNDATI ON 200.00 Cross Foot Adjustments 201.00 Negative Cost Centers	92, 799, 707 8, 767	0		0 92, 366 0 0	C	194. 04 194. 05 200. 00 201. 00
202.00 TOTAL (sum lines 118 through 201)	674, 669, 385	12, 333, 002	9, 095, 79	9, 566, 616		202.00

COST A	LLOCATION - GENERAL SERVICE COSTS		Provider CC	F	eriod: rom 01/01/2022	Worksheet B Part I	
				T	o 12/31/2022	Date/Time Pre 5/29/2023 3:2	pared: 2 pm
	Cost Center Description	Subtotal	CASHI ERI NG/ACC OUNTS	Subtotal	OTHER ADMIN & GENERAL	OPERATION OF PLANT	
		5A. 01	RECEI VABLE 5. 02	5A. 02	5. 03	7.00	
	GENERAL SERVICE COST CENTERS	011.01	0.02	011. 02	0.00	7.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.0
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.0
4.00 5.01	00400 EMPLOYEE BENEFITS DEPARTMENT 00570 ADMITTING						4.0 5.0
5.01	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	25, 282	25, 282				5.0
5.03	00590 OTHER ADMIN & GENERAL	83, 534, 495	3, 091	83, 537, 586	83, 537, 586		5.0
7.00	00700 OPERATION OF PLANT	25,047,469	927	25, 048, 396	3, 539, 789	28, 588, 185	7.0
3.00	00800 LAUNDRY & LINEN SERVICE	1, 995, 851	74	1, 995, 925	282, 060	321, 812	
9.00 10.00	00900 HOUSEKEEPI NG 01000 DI ETARY	8, 173, 737	302	8, 174, 039	1, 155, 139	263, 495	
11.00	01100 CAFETERIA	1, 620, 693 3, 093, 009	60 114	1, 620, 753 3, 093, 123	229, 042 437, 114	349, 787 598, 012	
13.00	01300 NURSI NG ADMI NI STRATI ON	5, 131, 341	190	5, 131, 531	725, 178	0	
14.00	01400 CENTRAL SERVICES & SUPPLY	22, 107	1	22, 108	3, 124	1, 120, 267	14.0
15.00	01500 PHARMACY	9, 159, 169	339	9, 159, 508	1, 294, 403	434, 226	
16.00	01600 MEDI CAL RECORDS & LI BRARY	166, 491	6	166, 497	23, 529	0	
21.00 22.00	02100 I & R SERVI CES-SALARY & FRI NGES APPRV 02200 I & R SERVI CES-OTHER PRGM COSTS APPRV	2, 338, 660 1, 288, 603	87 48	2, 338, 747 1, 288, 651	330, 507 182, 110	36, 143 0	
23.00	02300 MEDICAL LABORATORY SCIENTIST PRGM	134, 812	-40	134, 817	19, 052	0	1
23.01	02302 PHARMACY PRGM	335, 598	12	335, 610	47, 428	0	
23. 02	02301 EMERGENCY MEDICAL SERVICES	84, 629	3	84, 632	11, 960	0	23.0
23.03	02303 PARAMEDI C PRGM	276, 191	10	276, 201	39, 032	0	
23.04	02305 SURGI CAL TECH PROGRAM	140, 279	5	140, 284	19, 825	0	23.0
30. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	52, 935, 931	1, 959	52, 937, 890	7, 481, 077	6, 809, 237	30. C
31.00	03100 I NTENSI VE CARE UNI T	12, 868, 433	476	12, 868, 909	1, 818, 608	810, 528	
31.01	02060 NEONATAL INTENSIVE CARE UNIT	7, 170, 850	265	7, 171, 115	1, 013, 408	578, 639	
32.00	03200 CORONARY CARE UNI T	15, 818, 475	585	15, 819, 060	2, 235, 518	1, 891, 653	
34.00	03400 SURGICAL INTENSIVE CARE UNIT	7, 438, 281	275	7, 438, 556	1, 051, 202	953, 284	
41.00 43.00	04100 SUBPROVIDER - IRF 04300 NURSERY	4, 437, 362 2, 189, 445	164 81	4, 437, 526 2, 189, 526		671, 836 85, 661	
+3.00	ANCI LLARY SERVICE COST CENTERS	2, 107, 445	01	2, 107, 520	307,417	05,001	43.0
50.00	05000 OPERATI NG ROOM	23, 050, 884	853	23, 051, 737	3, 257, 625	3, 459, 758	50.0
52.00	05200 DELIVERY ROOM & LABOR ROOM	5, 120, 136	189	5, 120, 325	723, 594	1, 082, 585	
54.00	05400 RADI OLOGY-DI AGNOSTI C	17, 485, 398	647	17, 486, 045	2, 471, 093	2, 180, 440	
55.00 56.00	05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE	7, 877, 445 282, 807	291 10	7, 877, 736 282, 817	1, 113, 266 39, 967	151, 673 46, 165	
59.00	05900 CARDI AC CATHETERI ZATI ON	4, 050, 905	150	4, 051, 055	572, 487	927, 440	
50.00	06000 LABORATORY	26, 679, 942	987	26, 680, 929	3, 770, 496	989, 190	
54.00	06400 I NTRAVENOUS THERAPY	3, 080, 711	114	3, 080, 825	435, 376	430, 477	
5.00	06500 RESPI RATORY THERAPY	13, 604, 613	503	13, 605, 116	1, 922, 648	164, 102	
6.00 7.00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	6, 747, 262 2, 943, 393	250 109	6, 747, 512 2, 943, 502	953, 545 415, 970	291, 470 0	
8.00	06800 SPEECH PATHOLOGY	1, 155, 559	43	1, 155, 602	163, 307	0	
9.00	06900 ELECTROCARDI OLOGY	1, 941, 501	72	1, 941, 573	274, 379	572, 562	
0. 00	07000 ELECTROENCEPHALOGRAPHY	2, 096, 350	78	2, 096, 428	296, 263	0	
1.00	07100 MEDI CAL SUPPLIES CHARGED TO PATIENT	49, 376, 606	1,827	49, 378, 433	6, 978, 061	0	
2.00 3.00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	34, 364, 555 65, 616, 057	1, 271 2, 428	34, 365, 826 65, 618, 485	4, 856, 510 9, 273, 073	0	
4.00	07400 RENAL DIALYSIS	1, 085, 351	2, 420	1, 085, 391	⁹ , 273, 073 153, 385	149, 700	
6.97	07697 CARDI AC REHABI LI TATI ON	624, 136	23	624, 159	88, 205	0	1
7.00	07700 ALLOGENEIC STEM CELL ACQUISITION	8, 942, 211	331	8, 942, 542	1, 263, 742	0	77. (
	OUTPATIENT SERVICE COST CENTERS	E 000 0=-	0.5-1	E 000 0=-			0.00
0.00	09000 CLINIC 09001 IBMT JOINT VENTURE	5, 393, 050	200	5, 393, 250		748, 738	
90. 01 90. 05	0900111BM1_JOINT_VENTURE 09005_CV_DIAGNOSTIC_SERVICES	3, 280, 591 10, 565, 256	121 391	3, 280, 712 10, 565, 647	463, 624 1, 493, 116	104, 916 0	
91.00	09100 EMERGENCY	20, 759, 533	768	20, 760, 301	2, 933, 804	1, 860, 601	
2.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	20,707,000	700	20, 700, 001	2, 700, 001	1,000,001	92.0
	OTHER REIMBURSABLE COST CENTERS						
	10100 HOME HEALTH AGENCY	0	0	0	0		101. (
02.00	10200 OPI OI D TREATMENT PROGRAM	0	0	0	0	0	102. 0
13 00	SPECIAL PURPOSE COST CENTERS						113. (
	11600 HOSPI CE	7, 811, 113	289	7, 811, 402	1, 103, 892	0	116.0
18.00		569, 362, 558		569, 358, 340		28, 084, 397	
	NONREIMBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	959, 595	36	959, 631	135, 613	191, 998	
	19200 PHYSICIANS' PRIVATE OFFICES	11, 328, 086	419	11, 328, 505	1, 600, 922	195, 589	
	07955 MARKETING & COMMUNITY RELATIONS 07952 WOMEN'S CENTER	38, 812 79, 494	1	38, 813 79, 497	5, 485 11, 234	0 116, 201	194.0
	07952 WOMEN S CENTER 07950 OTHER NONREIMBURSABLE COST CENTERS	79, 494 0	3	79, 497	11, 234		194.0
	07954 OTHER NRCC	92, 892, 073	3, 759	92, 895, 832	13, 127, 876		194.0
94.04		_, , 0 / 0	5,.57	8, 767	1, 239		194. (

Health Fina	ancial Systems	FRANCI SCAN HEAL	TH INDIANAPOLIS		In Lie	u of Form CMS-	2552-10
COST ALLOC	ATION - GENERAL SERVICE COSTS		Provider C		Peri od:	Worksheet B	
					From 01/01/2022		
					To 12/31/2022		
						5/29/2023 3:2	2 pm
	Cost Center Description	Subtotal	CASHI ERI NG/ACC	Subtotal	OTHER ADMIN &	OPERATION OF	
			OUNTS		GENERAL	PLANT	
			RECEI VABLE				
		5A. 01	5.02	5A. 02	5.03	7.00	
200.00	Cross Foot Adjustments	C			0		200.00
201.00	Negative Cost Centers	C	0 0		0 0	C	201.00
202.00	TOTAL (sum lines 118 through 201)	674, 669, 385	5 25, 282	674, 669, 38	5 83, 537, 586	28, 588, 185	202.00

OST A	Financial Systems F LLOCATION - GENERAL SERVICE COSTS	RANCI SCAN HEALT	Provi der CCI		eriod:	u of Form CMS-2 Worksheet B	. =
				Fi Te	rom 01/01/2022 0 12/31/2022	Part I Date/Time Pre	pare
	Cost Center Description	LAUNDRY &	HOUSEKEEPING	DI ETARY	CAFETERI A	5/29/2023 3:2 NURSI NG	2 pm
		LINEN SERVICE	9.00	10.00	11.00	ADMI NI STRATI ON 13.00	
	GENERAL SERVICE COST CENTERS	8.00	9.00	10.00	11.00	13.00	
	00100 CAP REL COSTS-BLDG & FIXT						1.
. 00	00200 CAP REL COSTS-MVBLE EQUIP						2.
. 00 . 01	00400 EMPLOYEE BENEFITS DEPARTMENT 00570 ADMITTING						4. 5.
. 01	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5.
. 03	00590 OTHER ADMIN & GENERAL						5.
. 00	00700 OPERATION OF PLANT						7.
. 00	00800 LAUNDRY & LINEN SERVICE	2, 599, 797					8.
	00900 HOUSEKEEPING	0	9, 592, 673	0 040 405			9.
		0	119, 823	2, 319, 405	4 222 104		10.
	01100 CAFETERIA 01300 NURSING ADMINISTRATION	0	204, 855 0	0	4, 333, 104 96, 666	5, 953, 375	11. 13.
	01400 CENTRAL SERVICES & SUPPLY	0	383, 759	0	25, 286	0, 933, 373	14.
	01500 PHARMACY	0	148, 748	0	161, 337	0	15.
	01600 MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.
	02100 I &R SERVICES-SALARY & FRINGES APPRV	0	12, 381	0	64, 261	0	21.
	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.
	02300 MEDICAL LABORATORY SCIENTIST PRGM 02302 PHARMACY PRGM	0	0	0	5, 264 11, 275	0	23. 23.
	02301 EMERGENCY MEDICAL SERVICES	0	0	0	7, 257	0	23.
	02303 PARAMEDIC PRGM	0	0	0	20, 271	0	23
	02305 SURGI CAL TECH PROGRAM	0	0	0	4, 600	0	23
	INPATIENT ROUTINE SERVICE COST CENTERS	1	ГТ				
	03000 ADULTS & PEDIATRICS	992, 183		1, 181, 228	925, 006		30
	03100 INTENSIVE CARE UNIT 02060 NEONATAL INTENSIVE CARE UNIT	137, 707 15, 919	277, 655	411, 943	182, 801 116, 219	1, 057, 362	
	03200 CORONARY CARE UNIT	174, 583	198, 219 648, 005	151, 422 253, 076	228, 972	388, 666 649, 587	31
	03400 SURGI CAL I NTENSI VE CARE UNI T	123, 900	326, 557	134, 045	126, 134	344, 062	
	04100 SUBPROVI DER – I RF	50, 260	230, 144	108, 828	90, 307	279, 337	41
3. 00	04300 NURSERY	7, 712	29, 344	78, 863	0	202, 424	43
	ANCI LLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	243, 879		0	305, 954	0	50.
	05200 DELIVERY ROOM & LABOR ROOM 05400 RADIOLOGY-DIAGNOSTIC	122, 533 172, 317	370, 851 746, 932	0	94, 278 234, 386	0	52 54
	05500 RADI OLOGY-THERAPEUTI C	0	51, 957	0	234, 380 36, 939	0	55
	05600 RADI OI SOTOPE	6, 172	15, 814	0	5, 435	0	56.
9.00	05900 CARDI AC CATHETERI ZATI ON	60, 218	317, 704	0	71, 503	0	59.
	06000 LABORATORY	110	338, 857	0	12, 003	0	60.
	06400 I NTRAVENOUS THERAPY	1, 275	147, 464	0	63, 954	0	64
		601	56, 215	0	217, 106	0	65
6.00 7.00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	26, 754 0	99, 846 0	0	140, 414 74, 875	0	66 67
	06800 SPEECH PATHOLOGY	669	0	0	25, 714	0	68
	06900 ELECTROCARDI OLOGY	12,038	196, 137	0	46, 999	0	69
	07000 ELECTROENCEPHALOGRAPHY	5, 664	0	0	54, 597	0	70
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72
	07300 DRUGS CHARGED TO PATIENTS	0 110	0	0	62	0	73
	07400 RENAL DIALYSIS 07697 CARDIAC REHABILITATION	8, 118	51, 281	0	0 16, 823	0	74
	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	0	10, 823	0	77
	OUTPATIENT SERVICE COST CENTERS			0			1
0. 00	09000 CLI NI C	6, 441	256, 488	0	198, 614	0	90
	09001 I BMT JOINT VENTURE	8, 011	35, 940	0	40, 509	0	90
	09005 CV DI AGNOSTI C SERVI CES	0	0	0	54, 567	0	90
	09100 EMERGENCY	397, 786	637, 368	0	193, 758	0	91
2.00	09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS						92
01. 00	10100 HOME HEALTH AGENCY	0	0	0	0	0	101
	10200 OPI OI D TREATMENT PROGRAM	0	0	0	0		102
	SPECIAL PURPOSE COST CENTERS						
	11300 INTEREST EXPENSE						113
	11600 HOSPI CE	0	0	0	118, 776		116
18.00		2, 574, 850	9, 420, 095	2, 319, 405	4, 072, 922	5, 953, 375	118
0 00	NONREI MBURSABLE COST CENTERS		/		10 740		100
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	0 9, 198	65, 771 67, 001	0	18, 719 121, 939		190 192
	07955 MARKETING & COMMUNITY RELATIONS	9, 198		0	2, 306		192
	07952 WOMEN'S CENTER	15, 749	39, 806	0	∠, 300 ∩		194
	07950 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0		194
	07954 OTHER NRCC	0	Ő	0	117, 218		194
~ . ~ -	07956 FOUNDATI ON	0	0	0	0	0	194
94.05 00.00	Cross Foot Adjustments						200

Health Fin	ancial Systems	FRANCI SCAN HEALT	TH INDIANAPOLIS	i	In Lie	u of Form CMS-:	2552-10
COST ALLO	CATION - GENERAL SERVICE COSTS		Provider C	F	Period: From 01/01/2022 To 12/31/2022		
	Cost Center Description	LAUNDRY &	HOUSEKEEPING	DI ETARY	CAFETERI A	NURSI NG	
		LINEN SERVICE				ADMI NI STRATI ON	
		8.00	9.00	10.00	11.00	13.00	
201.00	Negative Cost Centers	0	0	C	0 0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	2, 599, 797	9, 592, 673	2, 319, 405	4, 333, 104	5, 953, 375	202.00

	· · · · · · · · · · · · · · · · · · ·	RANCISCAN HEALTH		N 15 01/2 D		u of Form CMS-2	2552-10
CUST P	LLOCATION - GENERAL SERVICE COSTS		Provider CC	F	eriod: rom 01/01/2022 o 12/31/2022	Worksheet B Part I Date/Time Pre	pared [.]
					I NTERNS &	5/29/2023 3:2	2 pm
	Cost Center Description	CENTRAL	PHARMACY	MEDI CAL	SERVI CES-SALAR		
		SERVICES &		RECORDS &	Y & FRINGES	PRGM COSTS	
		SUPPLY 14.00	15.00	LI BRARY 16. 00	APPRV 21.00	APPRV 22.00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT	1					1.00
2.00	00200 CAP REL COSTS-BLDG & FIXT						2.00
4.00 5.01	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00 5.01
5.01	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5.01
5.03 7.00	00590 OTHER ADMIN & GENERAL						5.03 7.00
8.00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE						8.00
9.00 10.00	00900 HOUSEKEEPI NG 01000 DI ETARY						9.00 10.00
11.00	01100 CAFETERI A						11.00
13.00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	1 554 544					13.00
14.00 15.00	01500 PHARMACY	1, 554, 544 0	11, 198, 222				14.00 15.00
16.00	01600 MEDI CAL RECORDS & LI BRARY	7	0	190, 033			16.00
21.00 22.00	02100 I & R SERVICES-SALARY & FRINGES APPRV 02200 I & R SERVICES-OTHER PRGM COSTS APPRV	338 0	0 0	0 0		1, 470, 761	21.00 22.00
23.00	02300 MEDICAL LABORATORY SCIENTIST PRGM	53	0	0			23.00
23. 01 23. 02	02302 PHARMACY PRGM 02301 EMERGENCY MEDICAL SERVICES	0	0	0			23.01 23.02
23.03	02303 PARAMEDI C PRGM	0	0	0			23.03
23. 04	02305 SURGI CAL TECH PROGRAM	0	0	0			23.04
30.00	03000 ADULTS & PEDIATRICS	3, 196	0	12, 419		1,033,525	1
31. 00 31. 01	03100 I NTENSI VE CARE UNI T 02060 NEONATAL I NTENSI VE CARE UNI T	399 256	0	2, 057 2, 229		34, 844 2, 248	
32.00	03200 CORONARY CARE UNI T	524	0	2, 065	0	0	32.00
34.00 41.00	03400 SURGI CAL I NTENSI VE CARE UNI T 04100 SUBPROVI DER – I RF	316 144	0	1, 318 895		0	
43.00	04300 NURSERY	0	0	583		0	43.00
50.00	ANCI LLARY SERVI CE COST CENTERS	10, 065	0	18, 391	164, 795	87, 110	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	315	0	2, 794		0	
54.00 55.00	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	1, 492 105	0 0	17, 717 4, 901	4, 253 0	2, 248 0	1
56.00	05600 RADI OI SOTOPE	4	0	511	0	0	
59.00 60.00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	1, 369 158	0 0	9, 632 15, 752	0	0 0	
64.00	06400 I NTRAVENOUS THERAPY	428	0	2, 485		0	
65.00 66.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	277 205	0	3, 676 2, 606	15, 948 156, 289	8, 430 82, 614	
67.00	06700 OCCUPATI ONAL THERAPY	81	0	1, 511	0	0	
68.00 69.00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	175 387	0	599 2, 453		0 43, 836	
70.00	07000 ELECTROENCEPHALOGRAPHY	88	0	1, 465		10, 116	•
71.00 72.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	926, 299 596, 221	0	11, 808 9, 677		0 0	
73.00	07300 DRUGS CHARGED TO PATIENTS	1, 208	11, 198, 222	33, 831		0	
74.00 76.97	07400 RENAL DIALYSIS 07697 CARDIAC REHABILITATION	17 52	0	468 231		26, 414 0	
77.00	07700 ALLOGENEI C STEM CELL ACQUI SI TI ON	0	0	1, 942	0	0	77.00
90.00	OUTPATIENT SERVICE COST CENTERS	126	0	986	0	0	90.00
90. 01	09001 I BMT JOINT VENTURE	134 779	0	647		0	
90. 05 91. 00	09005 CV DI AGNOSTI C SERVI CES 09100 EMERGENCY	822	0 0	5, 046 18, 445		97, 226 0	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
101.00	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	101.00
102.00	10200 OPI OI D TREATMENT PROGRAM SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	102.00
113.00	11300 INTEREST EXPENSE						113.00
	11600 HOSPI CE	299	0	893			116.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	1, 546, 339	11, 198, 222	190, 033	2, 702, 637	1, 428, 611	110.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1, 126	0	0			190.00
194.OC	19200 PHYSICIANS' PRIVATE OFFICES 07955 MARKETING & COMMUNITY RELATIONS	6, 505 0	0 0	0	79, 740 0	42, 150 0	192.00 194.00
194.01	07952 WOMEN'S CENTER	0	0	0	-	0	194.01
194.02	07950 OTHER NONREI MBURSABLE COST CENTERS	574	0	0	0	0	194.02

Health Financial Systems F	RANCI SCAN HEALTH	I INDI ANAPOLI S		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC		Period:	Worksheet B	
				From 01/01/2022 To 12/31/2022		narod
				10 12/31/2022	5/29/2023 3:2	
				INTERNS &	RESI DENTS	
Cost Center Description	CENTRAL	PHARMACY	MEDI CAL	SERVI CES-SALAR		
	SERVICES &		RECORDS &	Y & FRINGES	PRGM COSTS	
	SUPPLY		LI BRARY	APPRV	APPRV	
	14.00	15.00	16.00	21.00	22.00	
194.0407954 OTHER NRCC	0	0	(0 0	0	194.04
194. 05 07956 FOUNDATI ON	0	0	(0 0	0	194.05
200.00 Cross Foot Adjustments				0	0	200.00
201.00 Negative Cost Centers	0	0	(0 0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	1, 554, 544	11, 198, 222	190, 033	3 2, 782, 377	1, 470, 761	202.00

	Financial Systems FF LLOCATION - GENERAL SERVICE COSTS	RANCI SCAN HEALT	Provider CC	F	eriod: rom 01/01/2022	ı of Form CMS-: Worksheet B Part I	
				Ţ		Date/Time Pre 5/29/2023 3:2	pared: 2 pm
	Cost Center Description	MEDI CAL LABORATORY	PHARMACY PRGM	EMERGENCY MEDI CAL	PARAMEDIC PRGM	SURGI CAL TECH PROGRAM	
		SCIENTIST PRGM		SERVI CES			
	GENERAL SERVICE COST CENTERS	23.00	23.01	23.02	23.03	23.04	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00 5.01	00400 EMPLOYEE BENEFITS DEPARTMENT 00570 ADMITTING						4.00 5.01
5.02	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5. 02
5.03	00590 OTHER ADMIN & GENERAL						5.03
7.00 8.00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE						7.00 8.00
9.00	00900 HOUSEKEEPI NG						9.00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A						10.00
	01300 NURSI NG ADMI NI STRATI ON						11.00
	01400 CENTRAL SERVI CES & SUPPLY						14.00
	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY						15.00 16.00
	02100 I &R SERVICES-SALARY & FRINGES APPRV						21.00
	02200 I &R SERVICES-OTHER PRGM COSTS APPRV						22.00
	02300 MEDICAL LABORATORY SCIENTIST PRGM 02302 PHARMACY PRGM	159, 186	394, 313				23.00 23.01
	02301 EMERGENCY MEDICAL SERVICES		574, 515	103, 849			23.01
	02303 PARAMEDI C PRGM				335, 504	4/4 700	23.03
23.04	02305 SURGI CAL TECH PROGRAM					164, 709	23.04
30.00	03000 ADULTS & PEDIATRICS	0	0	0	0	0	30.00
	03100 I NTENSI VE CARE UNI T	0	0	0	0	0	31.00
	02060 NEONATAL INTENSIVE CARE UNIT 03200 CORONARY CARE UNIT	0	0	0	0	0	31.01 32.00
	03400 SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
	04100 SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	0	0	0	0	0	43.00
	05000 OPERATI NG ROOM	0	0	0	0	164, 709	
52.00 54.00	05200 DELIVERY ROOM & LABOR ROOM 05400 RADI OLOGY-DI AGNOSTI C	0	0	0	0	0	52.00 54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0	0	0	0	55.00
56.00	05600 RADI OI SOTOPE	0	0	0	0	0	56.00
59.00 60.00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	0 159, 186	0	0	0	0	59.00 60.00
64.00	06400 I NTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500 RESPI RATORY THERAPY	0	0	0	0	0	65.00
66.00 67.00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	0	0	0	0	0	66.00 67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
	06900 ELECTROCARDI OLOGY	0	0	0	0	0	69.00
	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	70.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	0	394, 313	0	0	0	73.00 74.00
	07697 CARDI AC REHABI LI TATI ON	0	0	0	0	0	76.97
77.00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
90.00	OUTPATIENT SERVICE COST CENTERS	0	0	0	0	0	90.00
	09001 I BMT JOINT VENTURE	0	0	0	0	0	
	09005 CV DI AGNOSTI C SERVI CES	0	0	0	0	0	
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	103, 849	335, 504	0	91.00 92.00
,2,00	OTHER REI MBURSABLE COST CENTERS						/2:00
	10100 HOME HEALTH AGENCY	0	0	0	0		101.00
102.00	10200 OPIOLD TREATMENT PROGRAM SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	102.00
	11300 INTEREST EXPENSE						113.00
	11600 HOSPICE	0	0	102.040			116.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	159, 186	394, 313	103, 849	335, 504	164, 709	1118.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190. 00
	19200 PHYSI CLANS' PRIVATE OFFICES	0	0	0	0		192.00 194.00
	07955 MARKETING & COMMUNITY RELATIONS 07952 WOMEN'S CENTER	0	0	0	0		194.00 194.01
194.02	07950 OTHER NONREIMBURSABLE COST CENTERS	0	Ō	0	Ō	0	194. 02
	07954 OTHER NRCC 07956 FOUNDATI ON	0	0	0	0		194. 04 194. 05
174.05		0	U U	0	U U	0	1174.05

Health Fin	ancial Systems	FRANCI SCAN HEAL	TH INDIANAPOLIS		In Lie	u of Form CMS-	2552-10
COST ALLOC	CATION - GENERAL SERVICE COSTS		Provi der C		Peri od:	Worksheet B	
					From 01/01/2022	Part I	
					To 12/31/2022	Date/Time Pre	pared:
						5/29/2023 3:2	2 pm
	Cost Center Description	MEDI CAL	PHARMACY PRGM	EMERGENCY	PARAMEDIC PRGM	SURGI CAL TECH	
		LABORATORY		MEDI CAL		PROGRAM	
		SCIENTIST PRGN	1	SERVI CES			
		23.00	23.01	23.02	23.03	23.04	
200.00	Cross Foot Adjustments	0	0 0		0 0	0	200.00
201.00	Negative Cost Centers	0	0 0		0 0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	159, 186	394, 313	103, 84	9 335, 504	164, 709	202.00

ST A	LLOCATION - GENERAL SERVICE COSTS		Provider CC	N: 15-0162		Worksheet B
					To 12/31/2022	Part I Date/Time Prepar
	Cost Center Description	Subtotal	Intern &	Total		5/29/2023 3:22 p
			Residents Cost	rotar		
			& Post			
			Stepdown			
		24.00	Adjustments 25.00	26.00	_	
	GENERAL SERVICE COST CENTERS					
00	00100 CAP REL COSTS-BLDG & FIXT					1
00	00200 CAP REL COSTS-MVBLE EQUIP					2
00	00400 EMPLOYEE BENEFITS DEPARTMENT					4
)1	00570 ADMI TTI NG					5
)2)3	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 00590 OTHER ADMI N & GENERAL					5
10	00700 OPERATION OF PLANT					7
0	00800 LAUNDRY & LINEN SERVICE					, 8
00	00900 HOUSEKEEPING					9
	01000 DI ETARY					10
00	01100 CAFETERI A					11
	01300 NURSI NG ADMI NI STRATI ON					13
	01400 CENTRAL SERVICES & SUPPLY					14
	01500 PHARMACY					15
	01600 MEDICAL RECORDS & LIBRARY					16
	02100 I &R SERVICES-SALARY & FRINGES APPRV					21
	02200 I & R SERVI CES-OTHER PRGM COSTS APPRV 02300 MEDI CAL LABORATORY SCI ENTI ST PRGM					22
	02302 PHARMACY PRGM					23
	02301 EMERGENCY MEDICAL SERVICES					23
	02303 PARAMEDI C PRGM					23
	02305 SURGI CAL TECH PROGRAM					23
	INPATIENT ROUTINE SERVICE COST CENTERS					
00	03000 ADULTS & PEDIATRICS	78, 695, 486	-2, 988, 738	75, 706, 7	48	30
	03100 I NTENSI VE CARE UNI T	17, 668, 731	-100, 762	17, 567, 9		31
	02060 NEONATAL INTENSIVE CARE UNIT	9, 642, 593		9, 636, 0		31
	03200 CORONARY CARE UNIT	21, 903, 043	0	21, 903, 0		32
	03400 SURGI CAL I NTENSI VE CARE UNI T	10, 499, 374	0	10, 499, 3		34
	04100 SUBPROVI DER – I RF 04300 NURSERY	6, 496, 379 2, 903, 532	0	6, 496, 3 2, 903, 5		43
00	ANCI LLARY SERVI CE COST CENTERS	2, 703, 332	<u> </u>	2, 703, 3	52	40
00	05000 OPERATING ROOM	31, 949, 199	-251, 905	31, 697, 2	94	50
00	05200 DELIVERY ROOM & LABOR ROOM	7, 517, 275	0	7, 517, 2	75	52
00	05400 RADI OLOGY-DI AGNOSTI C	23, 316, 923	-6, 501	23, 310, 4	22	54
	05500 RADI OLOGY-THERAPEUTI C	9, 236, 577	0	9, 236, 5	77	55
	05600 RADI OI SOTOPE	396, 885	0	396, 8		56
	05900 CARDI AC CATHETERI ZATI ON	6,011,408	0	6, 011, 4		59
	06000 LABORATORY	31, 966, 681	0	31, 966, 6		60
	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	4, 162, 284 15, 994, 119	-24, 378	4, 162, 2 15, 969, 7		65
	06600 PHYSI CAL THERAPY	8, 501, 255		8, 262, 3		66
	06700 OCCUPATI ONAL THERAPY	3, 435, 939		3, 435, 9		67
	06800 SPEECH PATHOLOGY	1, 346, 066		1, 346, 0		68
	06900 ELECTROCARDI OLOGY	3, 173, 293		3, 046, 5		69
00	07000 ELECTROENCEPHALOGRAPHY	2, 483, 758		2, 454, 5	05	70
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	57, 294, 601	0	57, 294, 6		71
	07200 I MPL. DEV. CHARGED TO PATIENTS	39, 828, 234		39, 828, 2		72
	07300 DRUGS CHARGED TO PATIENTS	86, 519, 194		86, 519, 1		73
	07400 RENAL DI ALYSI S	1, 524, 744		1, 448, 3		74
	07697 CARDIAC REHABILITATION	729, 470		729, 4		76
00	07700 ALLOGENEIC STEM CELL ACQUISITION	10, 208, 226	0	10, 208, 2	20	77
00	09000 CLINIC	7, 366, 806	0	7, 366, 8	06	90
01	09001 I BMT JOINT VENTURE	3, 934, 493		3, 934, 4		90
	09005 CV DI AGNOSTI C SERVI CES	12, 400, 313		12, 119, 1		90
	09100 EMERGENCY	27, 242, 238		27, 242, 2		91
00	09200 OBSERVATION BEDS (NON-DISTINCT PART		0			92
	OTHER REIMBURSABLE COST CENTERS				-	
	10100 HOME HEALTH AGENCY	0			0	101
. 00	10200 OPI OI D TREATMENT PROGRAM	0	0		0	102
00	SPECIAL PURPOSE COST CENTERS					110
	11300 I NTEREST EXPENSE 11600 HOSPI CE	9, 035, 262	0	9, 035, 2	62	113
3.00 3.00		9, 035, 262 553, 384, 381		9, 035, 2 549, 253, 1		118
	NONREIMBURSABLE COST CENTERS	555, 504, 581	-4, 131, 248	J47, 203, 1		
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1, 372, 858	0	1, 372, 8	58	190
	19200 PHYSI CLANS' PRI VATE OFFI CES	13, 451, 549		13, 329, 6		192
	07955 MARKETING & COMMUNITY RELATIONS	46, 604		46, 6		194
	07952 WOMEN' S CENTER	262, 487	0	262, 4		194
	07950 OTHER NONREIMBURSABLE COST CENTERS	574			74	194

Health Financial Systems F	RANCI SCAN HEALT	H INDIANAPOLIS	In Lieu of Form CMS-2552-10			
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC		Period: From 01/01/2022	Worksheet B Part I	
				To 12/31/2022	Date/Time Pre	
					5/29/2023 3:2	<u>22 pm</u>
Cost Center Description	Subtotal	Intern &	Total			
		Residents Cost				
		& Post				
		Stepdown				
		Adjustments				
	24.00	25.00	26.00			
194.04 07954 OTHER NRCC	106, 140, 926	0	106, 140, 92	6		194.04
194. 05 07956 FOUNDATI ON	10, 006	0	10, 00	6		194.05
200.00 Cross Foot Adjustments	0	0		0		200.00
201.00 Negative Cost Centers	0	0		0		201.00
202.00 TOTAL (sum lines 118 through 201)	674, 669, 385	-4, 253, 138	670, 416, 24	7		202.00

Health Financial Systems ALLOCATION OF CAPITAL RELATED COSTS	FRANCI SCAN HEALT	Provider C	CN: 15-0162 Pe Fi To	eriod: rom 01/01/2022	u of Form CMS-: Worksheet B Part II Date/Time Pre 5/29/2023 3:2	pared:
Cost Center Description	Di rectly Assigned New Capital Related Costs	BLDG & FIXT	LATED COSTS	Subtotal	EMPLOYEE BENEFI TS DEPARTMENT	
	0	1.00	2.00	2A	4.00	
GENERAL SERVI CE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FI XT 2.00 00200 CAP REL COSTS-BLDG & FI XT 2.00 00200 CAP REL COSTS-BLDG & FI XT 2.00 00200 CAP REL COSTS-MVBLE EQUIP 4.00 00400 EMPLOYEE BENEFI TS DEPARTMENT 5.01 00570 ADMI TTI NG 5 02 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 5.03 00590 OTHER ADMI N & GENERAL 6 6 7.00 00700 OPERATI ON OF PLANT 8 00 00800 LAUNDRY & LI NEN SERVI CE 9.00 00900 HOUSEKEEPI NG 0 <td></td> <td>120, 851 98, 951 131, 356 224, 573 0 420, 696</td> <td>10, 731 5, 606 1, 135, 855 89, 129 72, 978 96, 878 165, 626 0 310, 270</td> <td>0 60, 759 25, 282 13, 207 2, 675, 961 209, 980 171, 929 228, 234 390, 199 0 730, 966 283, 330</td> <td>0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0</td> <td>$\begin{array}{c} 5. \ 01 \\ 5. \ 02 \\ 5. \ 03 \\ 7. \ 00 \\ 8. \ 00 \\ 9. \ 00 \\ 10. \ 00 \\ 11. \ 00 \\ 13. \ 00 \end{array}$</td>		120, 851 98, 951 131, 356 224, 573 0 420, 696	10, 731 5, 606 1, 135, 855 89, 129 72, 978 96, 878 165, 626 0 310, 270	0 60, 759 25, 282 13, 207 2, 675, 961 209, 980 171, 929 228, 234 390, 199 0 730, 966 283, 330	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	$\begin{array}{c} 5. \ 01 \\ 5. \ 02 \\ 5. \ 03 \\ 7. \ 00 \\ 8. \ 00 \\ 9. \ 00 \\ 10. \ 00 \\ 11. \ 00 \\ 13. \ 00 \end{array}$
16.00 01600 MEDI CAL RECORDS & LI BRARY 21.00 02100 I & SERVI CES-SALARY & FRI NGES APPRV 22.00 02200 I & SERVI CES-OTHER PRGM COSTS APPRV 23.00 02300 MEDI CAL LABORATORY SCI ENTI ST PRGM 23.01 02302 PHARMACY PRGM 23.02 02301 EMERGENCY MEDI CAL SERVI CES 23.03 02303 PARAMEDI C PRGM 23.04 02305 SURGI CAL TECH PROGRAM INPATI ENT ROUTI NE SERVI CE COST CENTERS			0 0 0 0 0	0 23, 583 0 0 0 0 0 0	0 0 0 0 0 0 0 0	21. 00 22. 00 23. 00 23. 01 23. 02 23. 03
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT 31. 01 02060 NEONATAL INTENSIVE CARE UNIT 32. 00 03200 CORONARY CARE UNIT 34. 00 03400 SURGICAL INTENSIVE CARE UNIT 41. 00 04100 SUBPROVIDER - IRF 43. 00 04300 NURSERY		304, 379 217, 297 710, 376 357, 989 252, 296	224, 485 160, 260 523, 914 264, 023 186, 073	4, 442, 977 528, 864 377, 557 1, 234, 290 622, 012 438, 369 55, 894	0 0 0 0 0 0 0 0	31. 00 31. 01 32. 00 34. 00 41. 00
ANCI LLARY SERVICE COST CENTERS 50.00 OS000 OPERATING ROOM 52.00 O5200 DELIVERY ROOM & LABOR ROOM 54.00 O5400 RADI OLOGY-DI AGNOSTIC 55.00 O5500 RADI OLOGY-THERAPEUTIC 56.00 O5600 RADI OLOGY-THERAPEUTIC 56.00 O5600 RADI AC CATHETERIZATION 60.00 O6400 INTRAVENOUS THERAPY 61.00 O6600 LABORATORY 64.00 O6400 INTRAVENOUS THERAPY 65.00 O6500 RESPI RATORY THERAPY 66.00 O6600 PHYSI CAL THERAPY 67.00 O6700 OCCUPATI ONAL THERAPY 68.00 O6800 SPEECH PATHOLOGY 69.00 O6900 ELECTROCARDI OLOGY 70.00 O7000 ELECTROCEPHALOGRAPHY 71.00 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 73.00 O7300 DRUGS CHARGED TO PATI ENTS 73.00 O7400 RENAL DI ALYSI S 76.97 CARDI AC REHABI LI TATI ON 7700 ALLOGEN		406, 545 818, 825 56, 958 17, 336 348, 283 371, 472	299, 834 603, 897 42, 008 12, 786 256, 865 273, 967 119, 225 45, 450 80, 726 0 158, 577 0 0 41, 461 0 0	2, 257, 468 706, 379 1, 422, 722 98, 966 30, 122 605, 148 645, 439 280, 883 107, 076 190, 182 0 373, 592 0 0 97, 678 0 0		$\begin{array}{c} 52.\ 00\\ 54.\ 00\\ 55.\ 00\\ 55.\ 00\\ 60.\ 00\\ 64.\ 00\\ 65.\ 00\\ 65.\ 00\\ 66.\ 00\\ 67.\ 00\\ 68.\ 00\\ 69.\ 00\\ 70.\ 00\\ 71.\ 00\\ 72.\ 00\\ 73.\ 00\\ 74.\ 00\\ 76.\ 97\\ 77.\ 00\\ \end{array}$
90.01 09001 I BMT JOINT VENTURE 90.05 09005 CV DI AGNOSTI C SERVI CES 91.00 09100 EMERGENCY 92.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART OTHER REI MBURSABLE COST CENTERS	0	39, 399 0 698, 715	29, 058 0	68, 457 68, 457 0 1, 214, 029 0	000000000000000000000000000000000000000	90. 01 90. 05
101.00 10100 HOME HEALTH AGENCY 102.00 10200 OPI OI D TREATMENT PROGRAM SPECI AL PURPOSE COST CENTERS 113.00 11300 I NTEREST EXPENSE	0			0		101. 00 102. 00 113. 00
116.00 118.00 SUBTOTALS (SUM OF LINES 1 through 117 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN) 0	12, 143, 813		0 21, 100, 080 	0	116. 00 118. 00 190. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFICES 194. 00 07955 MARKETING & COMMUNITY RELATIONS 194. 01 07952 WOMEN'S CENTER	0	73, 450 73, 450 43, 637	54, 171 0	123, 276 127, 621 0 75, 820	0 0	192.00 194.00 194.01

Health Financial Systems	FRANCISCAN HEALT	H INDIANAPOLIS		In Lieu of Form CMS-2552-10			
ALLOCATION OF CAPITAL RELATED COSTS		Provider CO		Period: From 01/01/2022 To 12/31/2022			
		CAPI TAL REL	_ATED COSTS				
Cost Center Description	Di rectly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFI TS DEPARTMENT		
	0	1.00	2.00	2A	4.00		
194.02 07950 OTHER NONREIMBURSABLE COST CENTERS	0	0		0 0	0	194.02	
194.0407954OTHER NRCC	0	0		0 0	0	194.04	
194. 05 07956 FOUNDATI ON	0	0		0 0	0	194.05	
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	12, 333, 002	9, 095, 79	21, 428, 799	0	202.00	

ANCI LLARY SERVICE COST CENTERS 50.00 05000 OPERATI NG ROOM 6,502 853 645 324,043 22, 52.00 05200 DELI VERY ROOM & LABOR ROOM 1,972 189 143 101,396 11, 54.00 05400 RADI OLOGY-DI AGNOSTI C 3,812 647 490 204,222 15, 55.00 05500 RADI OLOGY-THERAPEUTI C 205 291 221 14, 206 56.00 05600 RADI OLOGY-THERAPEUTI C 205 10 8 4, 324 59.00 05900 CARDI AC CATHETERI ZATI ON 2, 804 150 113 86, 865 5, 60.00 06000 LABORATORY 5, 103 987 747 92, 648 64.00 04001 INTRAVENOUS THERAPY 2, 207 503 381 15, 370 66.00 066000 PHYSI CAL THERAPY 2, 207 503 381 15, 370 66.00 066000 PHYSI CAL THERAPY 836 250 189	E 1.00 2.00 4.00 5.01 5.02 5.03 7.00 51 8.00 0 9.00 0 10.00 0 13.00 0 14.00 0 14.00 0 16.00
ENERGY OF COST CENTERS 5.01 5.02 5.03 7.00 8.00 1.00 OTOLO CAP REL COSTS-BUDG & FLXT 0 <	1.00 2.00 4.00 5.01 5.02 5.03 7.00 51 8.00 0 9.00 0 10.00 0 11.00 0 13.00 0 14.00 0 15.00 0 16.00
CENERAL SERVICE COST CENTRES 1.00 OCIO CAP REL COSTS-BUDG & FIXT 0.00 CAP REL COSTS-BUDG & FIXT 0.01 OCOOD CAP REL COSTS-MUBLE EQUIP 5.01 OCOSTO AMITTIN O 5.01 OCOSTO AMITTINO 5.02 OSEO CASHI ERI ING/ACCOUNTS RECEI VABLE 5.03 OCOSTO OPERATION OF PLANT 0 7.00 OCOTO OPERATION OF PLANT 0 0.00 OPERATION OF PLANT 0 0.00 OCOSTO LAUNDRY & LINEN SERVICE 0 0.00 OCOSTO CENTRAL SERVICES & SUPPLY 0 0.1000 DI CARTERI A 0 114 87 56.010 1.00 OTIOC CENTRAL SERVICES & SUPPLY 0 1 1 0.01000 DI CARTERI A 0 144 0 0 1.00 OTIOC CENTRAL SERVICES A LIBRARY 0 339 256 40.670 1.00 OTIOC IRAS ESCRUCES SOLTHES TOPREV 0 8 0 0 2.00 OZOO IRAS ESCRUCES A LIBRARY 0 1 1 04.25 1.00	$\begin{array}{c} 2.00\\ 4.00\\ 5.01\\ 5.02\\ 5.03\\ 7.00\\ 0\\ 9.00\\ 0\\ 10.00\\ 0\\ 11.00\\ 0\\ 13.00\\ 0\\ 14.00\\ 0\\ 15.00\\ 0\\ 16.00 \end{array}$
1.00 00700 (AP REL COSTS -BULG & FLYT	$\begin{array}{c} 2.00\\ 4.00\\ 5.01\\ 5.02\\ 5.03\\ 7.00\\ 0\\ 9.00\\ 0\\ 10.00\\ 0\\ 11.00\\ 0\\ 13.00\\ 0\\ 14.00\\ 0\\ 15.00\\ 0\\ 16.00 \end{array}$
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 60 759 5. 01 00570 ADMITTING 60. 759 25. 38.	$ \begin{array}{c} 4.00\\ 5.01\\ 5.02\\ 5.03\\ 7.00\\ 0\\ 9.00\\ 0\\ 10.00\\ 0\\ 11.00\\ 0\\ 13.00\\ 0\\ 14.00\\ 0\\ 14.00\\ 0\\ 16.00\\ \end{array} $
5.01 00570 ADMITTING 60.759 5.02 00580 CASHI ERI NUCACCOUNTS RECEI VABLE 0 3.091 16.798 5.03 00590 OFFER ADMIN & GENERAL 0 3.091 16.798 7.00 00700 OPERATION OF PLANT 0 927 701 2.677,589 8.00 00800 LAURDRY & LI NED SERVICE 0 74 56 30.141 240. 9.00 00000 HOUSEKEEPING 0 302 229 24.679 10.00 01000 CETRAY 0 114 87 56.010 13.00 O1300 NUESING ADMINISTRATION 0 190 144 0 14.00 O1400 CETRAY SUPPLY 0 1 104.925 15.00 01500 PHARMACY 0 339 256 40.670 20 02200 IRSERVICES-SUPPRY 0 87 65 3.385 21.00 02300 IRSERVICES-SUPPRORV 0	$ \begin{array}{c} 5.01 \\ 5.02 \\ 5.03 \\ 7.00 \\ 51 \\ 8.00 \\ 0 \\ 9.00 \\ 0 \\ 10.00 \\ 0 \\ 11.00 \\ 0 \\ 13.00 \\ 0 \\ 14.00 \\ 0 \\ 15.00 \\ 0 \\ 16.00 \end{array} $
5.02 OOSBO CASH LERING/ACCOUNTS RECEI VABLE 0 25.28 5.03 OOSDO OTHER ANIN N & GENERAL 0 3.091 16.298 7.00 OOTOO OPERATION OF PLANT 0 3.091 16.298 8.00 OOSOO LAUNDRY & LINEN SERVICE 0 7.00 2.677, 589 9.00 OOSOO LAUNDRY & LINEN SERVICE 0 7.00 2.677, 589 9.00 OOSOO DIETARY 0 0.00 10.00 1.00 10.00 DITOO CAFETRIA 0 11.4 7.66, 070 0 13.00 DITOO PHARMACY 0 3.99 256 40, 670 16.00 TIGOO PHARAACY 0 3.99 256 40, 670 15.00 DITOO PHARAACY 0 3.99 256 40, 670 15.00 DISOO PHARAACY S.SERVI CES -SALARY & FRINCES APPRY 0 48 36 0 23.00 02300 LAS SERVI CES -SOTHER PRACU COSTS APPRY 0 12 9 0 23.00 02303 PHARAMEDY PRGM 0 <td< td=""><td>$\begin{array}{c} 5.02\\ 5.03\\ 7.00\\ 51\\ 8.00\\ 0\\ 9.00\\ 0\\ 10.00\\ 0\\ 11.00\\ 0\\ 13.00\\ 0\\ 14.00\\ 0\\ 15.00\\ 0\\ 16.00\\ \end{array}$</td></td<>	$\begin{array}{c} 5.02\\ 5.03\\ 7.00\\ 51\\ 8.00\\ 0\\ 9.00\\ 0\\ 10.00\\ 0\\ 11.00\\ 0\\ 13.00\\ 0\\ 14.00\\ 0\\ 15.00\\ 0\\ 16.00\\ \end{array}$
5.03 00590 OTHER ADMIN & GENERAL 0 3,001 16,298 7.00 00700 OPERATION OF FLANT 0 227 701 2,677,589 8.00 00800 LAUNDRY & LINEN SERVICE 0 74 56 30,141 240, 9.00 0900 HUBSEREPING 0 302 22,9 24,679 240,679 11.00 01000 LETARY 0 614 87,56,010 144 0 13.00 01300 NURSING ADMINISTRATION 0 190 144 0 14.00 OTAGO (ARCORD & LIBRARY 0 1 1 104,925 15.00 01500 (ARCORD FARLARY, FRINCES APPRY 0 87 65 3385 22.00 02300 (REDICAL LARCORDS & LIBRARY 0 12 9 0 23.00 02300 (REDICAL LARDORTORY SCIENT ST PRGM 0 12 9 0 23.00 02303 PRAMACY PRGM 0 12 9 0 23.00	5. 03 7. 00 51 8. 00 0 9. 00 0 10. 00 0 11. 00 0 13. 00 0 14. 00 0 15. 00 0 16. 00
B. 00 COBBOO LAUNDRY & LINEN SERVICE 0 74 56 30.141 240. 9.00 CORON HOUSEXEEPING 0 302 229 24.679 24.679 10.00 DIODO DIETARY 0 60 45 32.761 11.00 DIODO CAFETERIA 0 114 87 56.010 14.00 DIAGO CAFETERIA 0 11 14.925 14.4 0 15.00 DISOO PHARMACY 0 339 256 40.670 16.00 10.00 (AR ERCORDS & LIBRARY 0 6 5 0.0 10.00 DIOD (AR ERCORDS & LIBRARY 0 87 65 3.385 16.00 12.00 20.00 23.0	
9.00 00900 HOUSEKEEPING 0 302 229 24.679 10.00 01000 DIETAY 0 60 45 32.761 11.00 01300 NURSING ADMINISTRATION 0 114 87 56.010 13.00 01300 CENTRAL SERVICES & SUPPLY 0 1 1 104.925 15.00 01500 PHARMACY 0 339 256 40.670 16.00 01600 MEDICAL RECORDS & LIBRARY 0 87 65 3.385 22.00 02200 I AR SERVICES-SALARY & FRINGES APPRV 0 87 64 0 23.00 02300 IEAL CAL ABORATORY SCIENTIST PRGM 0 12 9 0 23.01 02302 PHARMACY PRGM 0 12 9 0 23.02 02300 ADULTAL LABORATORY SCIENTIST PRGM 0 12 9 0 23.01 02302 PHARMACY PRGM 0 12 9 0 23.01 02300 ADULTAL LABORATORY SCIENTIST PRGM 0 10 8 0 23.00 <td>$\begin{array}{c c} 0 & 9, 00 \\ 0 & 10, 00 \\ 0 & 11, 00 \\ 0 & 13, 00 \\ 0 & 14, 00 \\ 0 & 15, 00 \\ 0 & 16, 00 \end{array}$</td>	$\begin{array}{c c} 0 & 9, 00 \\ 0 & 10, 00 \\ 0 & 11, 00 \\ 0 & 13, 00 \\ 0 & 14, 00 \\ 0 & 15, 00 \\ 0 & 16, 00 \end{array}$
10:00 D1000 DIFTARY 0 60 45 32, 761 11:00 01100 CAFETERIA 0 114 87 56, 010 13:00 01300 NURSING ADMINISTRATION 0 190 144 0 14:00 01400 CENTRAL SERVICES & SUPPLY 0 1 1 104, 925 15:00 01500 HERORY 0 339 256 40, 670 16:00 01600 REDICAL RECORDS & LIBRARY 0 6 5 0 10:00 010 RS SERVICES-SALRY & FRINCES APPRV 0 48 36 0 23:00 02300 MEDICAL LABORATORY SCIENTIST PRGM 0 12 9 0 23:01 023031 PRAMEDIC PRGM 0 10 8 0 14:00 0100 RS 0 10 8 0 23:01 023031 PRAMEDIC PRGM 0 10 8 0 10:00 030	0 10.00 0 11.00 0 13.00 0 14.00 0 15.00 0 16.00
11.00 CAPETERIA 0 114 87 56.010 13.00 01300 NUESI NG ADMINISTRATION 0 190 144 0 14.00 01400 CENTRAL SERVICES & SUPPLY 0 1 104.925 15.00 01500 MEDICAL RECORDS & LIBRARY 0 339 256 40.670 16.00 01600 MEDICAL RECORDS & LIBRARY 0 6 5 0 20.00 02200 IAB SERVICES-SALARY & FRINGES APPRV 0 87 65 3.385 22.00 02200 IAB SERVICES-OTHER PROGLOSTS APPRV 0 12 9 0 23.01 02300 PARAMEDICAL LABORATORY SCIENTIST PRGM 0 12 9 0 23.01 02300 PARAMEDICAL SERVICES 0 10 8 0 23.01 02300 SUBGICAL TECH PROGRAM 0 5 4 0 23.01 03000 ADULTS & PEDIATRICS 6.619 1.959 1.482 637.756 91. 30.00 03000 ADULTS & PEDIATRICS 6.619 1.959 1.482 637.756 91. 31.01 02000 NEONATAL INTENSIVE CARE UNIT 1.459	0 11.00 0 13.00 0 14.00 0 15.00 0 16.00
14.00 CENTRAL SERVICES & SUPPLY 0 1 1 104.925 15.00 01500 PHARMACY 0 339 256 40,670 16.00 01600 MEDI CAL RECORDS & LI BRARY 0 65 3.385 20.00 0200 I&R SERVICES-SALARY & FRINGES APPRV 0 48 36 0 23.00 02300 IEX SERVICES-SOTHER PROM COSTS APPRV 0 48 36 0 23.01 02300 PHARMACY PROM 0 12 9 0 0 23.02 02301 EMERGENCY MEDI CAL SERVICES 0 3 2 0 0 23.03 02303 SURGI CAL TECH PROGRAM 0 10 8 0 0 30.00 03000 ADULTS & PEDI ATRICS 6,619 1,959 1,482 637,756 91, 31.00 03000 ADULTS & PEDI ATRICS 6,619 1,959 1,482 637,756 91, 32.00 03000 CORNARY CARE UNI T 1,459 476 360 75,915 12, 31.00 03400 SUBROI CAL INTENSIVE CARE UNI T 1,464 585 443 177, 174 <td>0 14.00 0 15.00 0 16.00</td>	0 14.00 0 15.00 0 16.00
15.00 PLARMACY 0 339 256 40, 670 16.00 01600 MEDICAL RECORDS & LIBRARY 0 65 0 21.00 02100 LAR SERVICES-SALARY & FRINGES APPRV 0 87 65 3, 385 22.00 02200 LAR SERVICES-OTHER PROM COSTS APPRV 0 48 36 0 23.01 02300 MEDICAL LABORATORY SCIENTIST PROM 0 12 9 0 23.02 02301 EMARMACY PROM 0 12 9 0 23.02 02303 PARAMEDIC PROM 0 10 8 0 23.01 02303 DARAMEDIC PROM 0 5 4 0 16.00 03000 ADULTS & PEDIATRICS 6,619 1,959 1,482 637,756 91, 31.00 03000 ADULTS & PEDIATRICS 6,619 1,959 1,482 637,756 91, 31.00 03000 CONNATAL INTENSI VE CARE UNIT 1,459 476 360 77,714 16, 34.00 03000 CONNATAL INTENSIVE CARE UNIT <td< td=""><td>0 15.00 0 16.00</td></td<>	0 15.00 0 16.00
16.00 IGO0 IAGO NEDICAL RECORDS & LIBRARY 0 6 5 0 21.00 02100 I&R SERVICES-SALARY & FRINGES APPRV 0 87 65 3, 385 22.00 02200 I&R SERVICES-OTHER PROM COSTS APPRV 0 48 36 0 23.01 02302 PHARMACY PRGM 0 12 9 0 23.02 02301 ENRGENCY MEDICAL SERVICES 0 3 2 0 23.03 02303 PARAMEDIC PRGM 0 10 8 0 23.04 02305 SURGICAL TECH PROGRAM 0 5 4 0 1.00 03100 INTENSI VE CARE UNI T 1, 459 1, 450 65 201 54, 196 1, 31.00 03000 ODAULTS & PEDIATRICS 6, 619 1, 959 1, 482 637, 756 91, 12. 31.00 03000 ADULTS & PEDIATRICS 6, 619 1, 959 1, 482 637, 756 91, 32.00 020RONARY CARE UNI T 1, 459 476 360 75, 915 12. 31.01	0 16.00
21.00 02100 Is R SERVICES-SALARY & FRINGES APPRV 0 87 65 3, 385 22.00 02200 I&B SERVICES-SALARY & FRINGES APPRV 0 48 36 0 23.00 02300 MEDICAL LABORATORY SCIENTIST PRGM 0 12 9 0 23.01 02303 PARAMEDIC PRGM 0 12 9 0 23.02 02303 PARAMEDIC PRGM 0 10 8 0 23.04 02305 SURGI CAL TECH PROGRAM 0 10 8 0 23.04 02305 SURGI CAL TECH PROGRAM 0 5 4 0 30.00 03001 NTENSI VE CARE UNI T 1,459 476 360 7.56 12. 31.01 03000 CORONARL INTENSI VE CARE UNI T 1,464 585 443 177.174 16. 32.00 03400 SURGI CAL INTENSI VE CARE UNI T 9.34 221 62.925 4.	
23.00 02300 MEDICAL LABORATORY SCIENTIST PRGM 0 5 4 0 23.01 02302 PHARMACY PRGM 0 12 9 0 23.02 02303 PRARMACY PRGM 0 10 8 0 23.02 02303 PRAMEDIC PRGM 0 10 8 0 23.04 02305 SURGICAL TECH PROGRAM 0 5 4 0 1000 03000 ADULTS & PEDIATRICS 6, 619 1, 959 1, 482 637, 756 91, 31.00 03100 INTENSI VE CARE UNIT 1, 459 476 360 75, 915 12, 31.01 02600 ROMARY CARE UNIT 1, 464 265 201 5, 4, 196 1, 32.00 03200 SURGICAL INTENSI VE CARE UNIT 934 275 208 89, 285 11, 41.00 O4100 SUBPROVI DER - 1 RF 635 164 124 62, 2, 925 4, 0.00 05200 DELI V	0 21.00
23. 01 023.02 PHARMACY PRGM 0 12 9 0 23. 02 02301 BERGERCY MEDICAL SERVICES 0 3 2 0 23. 03 02303 PARAMEDIC PRGM 0 10 8 0 23. 04 02305 SURGICAL TECH PROGRAM 0 5 4 0 30. 00 03000 ADULTS & PEDIATRICS 6,619 1,959 1,482 637,756 91, 31. 00 03200 CRONARY CARE UNIT 1,459 476 360 75,915 12, 30.00 O3200 CRONARY CARE UNIT 1,464 585 443 177,174 16, 34.00 03000 SURGICAL INTENSIVE CARE UNIT 934 275 208 89,285 111, 10.0 04100 SURGIVIDER - IRF 635 164 124 6,29,25 4, 43.00 JASON UBES EY 18 6,502 853 645 324,043 22, 50.00 05500 RDAD UGO	0 22.00
23 02 02301 ENERGENCY MEDI CAL SERVICES 0 3 2 0 23.03 02303 PARAMEDI C PRGM 0 10 8 0 23.04 02305 SURGI CAL TECH PROGRAM 0 5 4 0 10 03000 ADULTS & PEDI ATRI CS 6, 619 1, 959 1, 482 637, 756 91, 31.00 03100 INTENSI VE CARE UNI T 1, 459 476 360 75, 915 12, 31.01 02060 RORNATAL INTENSI VE CARE UNI T 1, 464 585 443 177, 174 16, 34.00 03400 SUBROVI DER - I RF 635 164 124 62, 925 4, 43.00 04300 SUBROVI DER - I RF 635 164 124 62, 925 4, 43.00 04300 SUBROVI DER - I RF 635 164 124, 042 62, 925 4, 43.00 04300 SUBROVI DER - I RF 189 143 101, 396 111,	0 23.00
23. 03 02303 PARAMEDIC PRGM 0 10 8 0 23. 04 02305 SURGI CAL TECH PROGRAM 0 5 4 0 1MPATI ENT ROUTINE SERVICE COST CENTERS	0 23.01 0 23.02
23.04 02305 SURGI CAL TECH PROGRAM 0 5 4 0 INPATI ENT ROUTINE SERVICE COST CENTERS	0 23.02
30.00 O3000 ADULTS & PEDIATRICS 6, 619 1, 959 1, 482 637, 756 91, 31.00 O3100 INTENSIVE CARE UNIT 1, 459 476 360 75, 915 12, 31.01 O2600 REONATAL INTENSIVE CARE UNIT 1, 581 265 201 54, 196 1, 32.00 O3200 CORONARY CARE UNIT 1, 464 585 443 177, 174 16, 34.00 O3400 SURGI CAL INTENSIVE CARE UNIT 934 275 208 89, 285 11, 11.00 O4100 SUBPRVI DER - IRF 635 164 124 62, 925 4, 43.00 O4300 NURSERY 413 81 61 8, 023 ANCI LLARY SERVICE COST CENTERS ANCI LLARY SERVICE COST CENTERS 50.00 O5400 PARTING ROOM 6, 502 853 645 324, 043 22, 52.00 05500 RADI DLOGY - HEARPEUTIC 205 291 221 14, 206 55.00 05500 RADI DLOGY - THERAPEUTIC 205 291 22	0 23.04
31.00 03100 INTENSIVE CARE UNIT 1,459 476 360 75,915 12, 31.00 02060 NEONATAL INTENSIVE CARE UNIT 1,581 265 201 54,196 1, 32.00 03200 CRONARY CARE UNIT 1,464 585 443 177,174 16, 34.00 03400 SURGI CAL INTENSIVE CARE UNIT 934 275 208 89,285 11, 41.00 04100 SUBPROVI DER - I FF 635 164 124 62,925 4, 43.00 OM300 NURSERY 413 81 61 8,023 22, 50.00 O5000 OPERATI NG ROOM 6,502 853 645 324,043 22, 51.00 05000 DELI VERY ROOM & LABOR ROOM 1,972 189 143 101,396 11, 52.00 05400 RADI OLOGY-THERAPEUTI C 205 291 221 14,206 14,206 14,206 14,206 11,3 86,865 5, 5,00 05500 RADI OLOGY-THERAPEUTI C 205 291 221 14,206 1	
31. 01 02060 NEONATAL INTENSIVE CARE UNIT 1,581 265 201 54,196 1, 32.00 03200 CORONARY CARE UNIT 1,464 585 443 177,174 16, 34.00 03400 SURGI CAL INTENSIVE CARE UNIT 934 275 208 89,285 11, 41.00 O4100 SUBPROVI DER - IRF 635 164 124 62,925 4, 43.00 04300 NURSERY 413 81 61 8,023 020 ANCI LLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 6,502 853 645 324,043 22, 52.00 05200 DELIVERY ROOM & LABOR ROOM 1,972 189 143 101,396 11, 54.00 05400 RADI OLGGY-DI AGNOSTI C 205 291 221 14,206 55.00 05500 RADI OLGGY-THERAPEUTI C 205 291 221 14,326 59.00 05900 CARDI AC CATHETERI ZATI ON 2,804 150 113 86,865 5,	
32.00 03200 CORONARY CARE UNI T 1,464 585 443 177,174 16, 34.00 03400 SURGI CAL INTENSIVE CARE UNI T 934 275 208 89,285 11, 41.00 O4100 SUBPROVI DER - I RF 635 164 124 62,925 4, 43.00 04300 NURSERY 413 81 61 8,023 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATI NG ROOM 6,502 853 6445 324,043 22, 52.00 05200 DELI VERY ROOM & LABOR ROOM 1,972 189 1413 101,396 11, 54.00 05400 RADI OLOGY-THERAPEUTI C 205 291 221 14,206 55.00 05500 RADI OLOGY-THERAPEUTI C 205 291 221 14,206 59.00 05900 CARDI AC CATHETERI ZATI ON 2,804 150 113 86,865 5, 60.00 06000 LABORATORY 5,103 987 747 92,648 64.00 06400 I	
41.00 04100 SUBPROVI DER - I RF 635 164 124 62,925 4, 43.00 O4300 NURSERY 4113 81 61 8,023 ANCI LLARY SERVICE COST CENTERS 50.00 O5000 OPERATI NG ROOM 6,502 853 645 324,043 22, 52.00 05200 DELI VERY ROOM & LABOR ROOM 1,972 189 143 101,396 11, 54.00 05400 RADI OLOGY-DI AGNOSTI C 3,812 647 490 204,222 15, 55.00 05500 RADI OLOGY-THERAPEUTI C 205 291 221 14,206 56.00 05600 RADI OLOGY-THERAPEUTI C 205 113 86,865 5, 60.00 05600 RADI OLOGY-THERAPEUTI C 2,804 150 113 86,865 5, 60.00 06000 LABORATORY 5,103 987 747 72,648 64.00 319 65.00 66.00 06400 INTRAVENOUS THERAPY 2,207 503 381 15,370 66.00 6600 PHYSI CAL THERAPY </td <td></td>	
43. 00 04300 NURSERY 413 81 61 8,023 ANCL LLARY SERVICE COST CENTERS 50. 00 05000 OPERATI NG ROOM 6,502 853 645 324,043 22, 52. 00 05200 DELI VERY ROOM & LABOR ROOM 1,972 189 143 101,396 11, 54. 00 05400 RADI OLOGY-DI AGNOSTI C 3,812 647 490 204, 222 15, 55. 00 05500 RADI OLOGY-THERAPEUTI C 205 291 221 14, 206 56. 00 05600 RADI OLOGY-THERAPEUTI C 205 291 221 14, 206 56. 00 05600 RADI OL CATHETERI ZATI ON 2, 804 150 113 86, 865 5, 60. 00 06000 LABORATORY 212 114 86 40, 319 65. 00 06500 RESPI RATORY THERAPY 2, 207 503 381 15, 370 66. 00 06600 PHYSI CAL THERAPY 2, 207 503 381 15, 370 67. 00 06700 CCUPATI ONAL THERAPY 836	
ANCI LLARY SERVICE COST CENTERS 50.00 05000 OPERATI NG ROOM 6,502 853 645 324,043 22, 52.00 05200 DELI VERY ROOM & LABOR ROOM 1,972 189 143 101,396 11, 54.00 05400 RADI OLOGY-DI AGNOSTI C 3,812 647 490 204,222 15, 55.00 05500 RADI OLOGY-THERAPEUTI C 205 291 221 14, 206 56.00 05600 RADI OLOGY-THERAPEUTI C 205 10 8 4, 324 59.00 05900 CARDI AC CATHETERI ZATI ON 2, 804 150 113 86, 865 5, 60.00 06400 INTRAVENOUS THERAPY 2,12 114 86 40, 319 65.00 06500 RESPI RATORY 2,207 503 381 15, 370 66.00 06600 PHYSI CAL THERAPY 2,207 503 381 15, 370 66.00 06600 SPEECH PATHOLOGY 2,205 43 32	45 41.00 13 43.00
50.00 05000 OPERATING ROOM 6, 502 853 645 324, 043 22, 52.00 05200 DELIVERY ROOM & LABOR ROOM 1, 972 189 143 101, 396 11, 54.00 05400 RADI OLOGY-DI AGNOSTI C 3, 812 647 490 204, 222 15, 55.00 05500 RADI OLOGY-THERAPEUTI C 205 291 221 14, 206 56.00 05600 RADI OLOGY-THERAPEUTI C 205 291 221 14, 206 59.00 05500 RADI OL CATHETERI ZATI ON 2, 804 150 113 86, 865 5, 60.00 06000 LABORATORY 5, 103 987 747 92, 648 64.00 06400 I NTRAVENOUS THERAPY 212 114 86 40, 319 65.00 06500 RESPI RATORY THERAPY 2, 207 503 381 15, 370 66.00 04500 INTRAVENOUS THERAPY 836 250 189 27, 299 2, 67.00 06700 0CCUPATI ONAL THERAPY 688 109 82 0	13 43.00
54.00 05400 RADI OLOGY - DI AGNOSTI C 3,812 647 490 204,222 15, 55.00 05500 RADI OLOGY - THERAPEUTI C 205 291 221 14,206 56.00 05600 RADI OL SOTOPE 95 10 8 4,324 59.00 05900 CARDI AC CATHETERI ZATI ON 2,804 150 113 86,865 5, 60.00 06000 LABORATORY 5,103 987 747 92,648 640,319 64.00 06400 INTRAVENOUS THERAPY 2,207 503 381 15,370 66.00 06600 PHYSI CAL THERAPY 2,207 503 381 55,370 66.00 06600 PHYSI CAL THERAPY 2,207 503 381 5,70 66.00 06600 PHYSI CAL THERAPY 836 250 189 27,299 2, 67.00 06700 0CUPATI ONAL THERAPY 688 109 82 0 68.00 SPECH PATHOLOGY 205 43 32 0 1 69.00 O6900<	37 50.00
55.00 05500 RADI OLOGY-THERAPEUTI C 205 291 221 14, 206 56.00 05600 RADI OLOGY-THERAPEUTI C 95 10 8 4, 324 59.00 05900 CARDI AC CATHETERI ZATI ON 2, 804 150 113 86, 865 5, 60.00 06000 LABORATORY 5, 103 987 747 92, 648 64.00 06400 INTRAVENOUS THERAPY 212 114 86 40, 319 65.00 06500 RESPI RATORY THERAPY 2, 207 503 381 15, 370 66.00 06600 PHYSI CAL THERAPY 836 250 189 27, 299 2, 67.00 06700 OCUPATI ONAL THERAPY 688 109 82 0 68.00 06800 SPECH PATHOLOGY 205 43 32 0 69.00 06900 ELECTROCARDI OLOGY 1,128 72 54 53, 627 1, 71.00 07000 ELECTROENCEPHALOGRAPHY	
56.00 05600 RADI OI SOTOPE 95 10 8 4, 324 59.00 05900 CARDI AC CATHETERI ZATI ON 2, 804 150 113 86, 865 5, 60.00 06000 LABORATORY 5, 103 987 747 92, 648 64.00 06400 INTRAVENOUS THERAPY 212 114 86 40, 319 65.00 06500 RESPI RATORY THERAPY 2, 207 503 381 15, 370 66.00 06600 PHYSI CAL THERAPY 836 250 189 27, 299 2, 67.00 06700 OCUPATI ONAL THERAPY 836 250 189 27, 299 2, 67.00 06700 OCUPATI ONAL THERAPY 836 250 43 32 0 68.00 06800 SPECH PATHOLOGY 1,128 72 54 53, 627 1, 70.00 07000 ELECTROENCEPHALOGRAPHY 321 78 59 0 71.00 07100	24 54.00 0 55.00
59.00 05900 CARDI AC CATHETERI ZATI ON 2,804 150 113 86,865 5, 60.00 06000 LABORATORY 5,103 987 747 92,648 64.00 06400 INTRAVENOUS THERAPY 212 114 86 40,319 65.00 06500 RESPI RATORY THERAPY 2,207 503 381 15,370 66.00 06600 PHYSI CAL THERAPY 836 250 189 27,299 2, 67.00 06700 OCCUPATI ONAL THERAPY 836 250 189 27,299 2, 67.00 06700 OCCUPATI ONAL THERAPY 836 250 189 27,299 2, 67.00 06700 OCCUPATI ONAL THERAPY 836 250 189 27,299 2, 68.00 06800 SPEECH PATHOLOGY 1,128 72 54 53,627 1, 70.00 07000 ELECTROCARDI OLOGY 1,128 75 0 71,00 0 0	70 56.00
64.00 06400 INTRAVENOUS THERAPY 212 114 86 40, 319 65.00 06500 RESPI RATORY THERAPY 2, 207 503 381 15, 370 66.00 06600 PHYSI CAL THERAPY 836 250 189 27, 299 2, 67.00 06700 OCUPATI ONAL THERAPY 688 109 82 0 68.00 06800 SPEECH PATHOLOGY 205 43 32 0 69.00 06900 ELECTROCARDI OLOGY 1, 128 72 54 53, 627 1, 70.00 07000 ELECTROENCEPHALOGRAPHY 321 78 59 0 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 4, 597 1, 383 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 4, 118 1, 271 962 0 73.00 07300 DRUGS CHARGED TO PATIENTS 6, 886 2, 428 1, 837 0	65 59.00
65.00 06500 RESPI RATORY THERAPY 2,207 503 381 15,370 66.00 06600 PHYSI CAL THERAPY 836 250 189 27,299 2, 67.00 06700 OCUPATI ONAL THERAPY 688 109 82 0 68.00 06800 SPEECH PATHOLOGY 205 43 32 0 69.00 06900 ELECTROCARDI OLOGY 1,128 72 54 53,627 1, 70.00 07000 ELECTROENCEPHALOGRAPHY 321 78 59 0 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 4,597 1, 383 0 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 4, 118 1,271 962 0 73.00 07300 DRUGS CHARGED TO PATI ENTS 6, 886 2, 428 1,837 0	10 60.00
66.00 06600 PHYSI CAL THERAPY 836 250 189 27, 299 2, 67.00 06700 OCUPATI ONAL THERAPY 688 109 82 0 68.00 06800 SPEECH PATHOLOGY 205 43 32 0 69.00 06900 ELECTROCARDI OLOGY 1, 128 72 54 53, 627 1, 70.00 07000 ELECTROENCEPHALOGRAPHY 321 78 59 0 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 4, 597 1, 827 1, 383 0 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 4, 118 1, 271 962 0 73.00 07300 DRUGS CHARGED TO PATI ENTS 6, 886 2, 428 1, 837 0	18 64.00 56 65.00
67.00 06700 OCCUPATI ONAL THERAPY 688 109 82 0 68.00 06800 SPEECH PATHOLOGY 205 43 32 0 69.00 06900 ELECTROCARDI OLOGY 1,128 72 54 53,627 1, 70.00 07000 ELECTROENCEPHALOGRAPHY 321 78 59 0 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 4,597 1,827 1,383 0 72.00 07300 DRUGS CHARGED TO PATI ENTS 4,118 1,271 962 0 73.00 07300 DRUGS CHARGED TO PATI ENTS 6,886 2,428 1,837 0	
69.00 06900 ELECTROCARDI OLOGY 1, 128 72 54 53, 627 1, 70.00 07000 ELECTROENCEPHALOGRAPHY 321 78 59 0 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 4, 597 1, 827 1, 383 0 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 4, 118 1, 271 962 0 73.00 07300 DRUGS CHARGED TO PATI ENTS 6, 886 2, 428 1, 837 0	0 67.00
70. 00 07000 ELECTROENCEPHALOGRAPHY 321 78 59 0 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 4, 597 1, 827 1, 383 0 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 4, 118 1, 271 962 0 73. 00 07300 DRUGS CHARGED TO PATI ENTS 6, 886 2, 428 1, 837 0	62 68.00
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 4, 597 1, 827 1, 383 0 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 4, 118 1, 271 962 0 73. 00 07300 DRUGS CHARGED TO PATI ENTS 6, 886 2, 428 1, 837 0	12 69.00 23 70.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 6, 886 2, 428 1, 837 0	0 71.00
	0 72.00
	0 73.00
74. 00 07400 RENAL DI ALYSI S 311 40 30 14, 021 76. 97 07697 CARDI AC REHABI LI TATI ON 6 23 17 0	50 74.00 0 76.97
77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION 1, 376 331 250 0	0 77.00
OUTPATIENT SERVICE COST CENTERS	
	95 90.00
90. 01 09001 I BMT JOI NT VENTURE 20 121 92 9, 827 90. 05 09005 CV DI AGNOSTI C SERVI CES 14 391 296 0	40 90.01 0 90.05
91. 00 09100 EMERGENCY 4, 200 768 581 174, 265 36,	
92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART	92.00
OTHER REI MBURSABLE COST CENTERS	0101.00
101.00 10100 HOME HEALTH AGENCY 0	0 101.00
SPECIAL PURPOSE COST CENTERS	0 102.00
113.00 11300 I NTEREST EXPENSE	113.00
116.00 11600 HOSPICE 3 289 219 0	0 116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) 60,759 21,064 13,599 2,630,404 237,1 NONREI MBURSABLE COST CENTERS NONREI MBURSABLE COST CENTERS NONREI MBURSABLE COST CENTERS NONREI MBURSABLE COST CENTERS	46 118.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 36 27 17, 983	
192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 419 317 18, 319	0 190.00
194. 00 07955 MARKETI NG & COMMUNI TY RELATI ONS 0 1 1 0	0 190. 00 50 192. 00
194.01 07952 WOMEN' S CENTER 0 3 2 10, 883 1, 194.02 07950 0THER NONREI MBURSABLE COST CENTERS 0 0 0 0	0 190. 00 50 192. 00 0 194. 00
194. 04 07954 OTHER NRCC 0 3, 759 2, 352 0	0 190.00 50 192.00 0 194.00 55 194.01
194. 05 07956 FOUNDATI ON 0 0 0	0 190. 00 50 192. 00 0 194. 00

Health Fin	ancial Systems	FRANCI SCAN HEALT	TH INDIANAPOLIS		In Lieu of Form CMS-2552-10			
ALLOCATI ON	N OF CAPITAL RELATED COSTS		Provider C		Period:	Worksheet B		
					rom 01/01/2022			
				1	To 12/31/2022	Date/Time Pre		
						5/29/2023 3:2	<u>2 pm</u>	
	Cost Center Description	ADMI TTI NG	CASHI ERI NG/ACC	OTHER ADMIN &	OPERATION OF	LAUNDRY &		
			OUNTS	GENERAL	PLANT	LINEN SERVICE		
			RECEI VABLE					
		5.01	5.02	5.03	7.00	8.00		
200.00	Cross Foot Adjustments						200.00	
201.00	Negative Cost Centers	0	0) (0 0	0	201.00	
202.00	TOTAL (sum lines 118 through 201)	60, 759	25, 282	16, 298	3 2, 677, 589	240, 251	202.00	

	Financial Systems FF TION OF CAPITAL RELATED COSTS	RANCI SCAN HEALTH	Provider CCN	F	eriod: rom 01/01/2022	J of Form CMS-2 Worksheet B Part II Date (Time Dree	
					o 12/31/2022	Date/Time Pre 5/29/2023 3:2	2 pm
	Cost Center Description	HOUSEKEEPING	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	
		9.00	10.00	11.00	13.00	14.00	
	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570 ADMI TTI NG						5.01
5.02 5.03	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 00590 OTHER ADMI N & GENERAL						5. 02 5. 03
7.00	00700 OPERATION OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00 10.00	00900 HOUSEKEEPI NG 01000 DI ETARY	197, 139 2, 462	263, 562				9.00 10.00
	01100 CAFETERI A	4, 210	203, 502	450, 620			11.00
13.00	01300 NURSING ADMINISTRATION	0	0	10, 053			13.00
	01400 CENTRAL SERVICES & SUPPLY	7,887	0	2,630		573, 970	1
	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	3, 057	0	16, 778 0	0	0	1
	02100 I &R SERVICES-SALARY & FRINGES APPRV	254	0	6, 683	0	125	1
	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	
	02300 MEDICAL LABORATORY SCIENTIST PRGM 02302 PHARMACY PRGM	0	0	547 1, 173	0	20 0	1
	02301 EMERGENCY MEDICAL SERVICES	0	0	755		0	1
	02303 PARAMEDI C PRGM	0	0	2, 108		0	1
23.04	02305 SURGI CAL TECH PROGRAM	0	0	478	0	0	23.04
30, 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	47, 935	134, 226	96, 194	5, 291	1, 180	30.00
	03100 I NTENSI VE CARE UNI T	5, 706	46, 810	19, 010		147	1
	02060 NEONATAL INTENSIVE CARE UNIT	4,074	17, 207	12, 086		94	1
	03200 CORONARY CARE UNIT 03400 SURGICAL INTENSIVE CARE UNIT	13, 317 6, 711	28, 758 15, 232	23, 812 13, 117		193 117	1
	04100 SUBPROVI DER – I RF	4, 730	12, 367	9, 392		53	1
	04300 NURSERY	603	8, 962	0		0	1
50.00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	24.257	0	21 010	0	2 71/	50.00
	05200 DELIVERY ROOM & LABOR ROOM	24, 357 7, 621	0	31, 818 9, 804		3, 716 116	1
	05400 RADI OLOGY-DI AGNOSTI C	15, 350	0	24, 375		551	54.00
	05500 RADI OLOGY-THERAPEUTI C	1,068	0	3, 841	0	39	1
56.00 59.00	05600 RADI OI SOTOPE 05900 CARDI AC CATHETERI ZATI ON	325 6, 529	0	565 7, 436		1 505	56.00 59.00
	06000 LABORATORY	6, 964	0	1, 248		58	1
	06400 I NTRAVENOUS THERAPY	3, 031	0	6, 651	0	158	
	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	1, 155 2, 052	0	22, 578 14, 602		102 76	
	06700 OCCUPATI ONAL THERAPY	2,032	0	7, 787			67.00
68.00	06800 SPEECH PATHOLOGY	0	0	2, 674	0	64	68.00
	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	4, 031	0	4, 888 5, 678		143 33	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	5, 678	0	342, 017	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	220, 131	
	07300 DRUGS CHARGED TO PATIENTS	0	0	6	0	446	
	07400 RENAL DI ALYSI S 07697 CARDI AC REHABI LI TATI ON	1,054	0	1, 750	0	6 19	
	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	
	OUTPATIENT SERVICE COST CENTERS	5 074	al				
	09000 CLINIC 09001 IBMT JOINT VENTURE	5, 271 739	0	20, 655 4, 213		47 49	90.00 90.01
	09005 CV DI AGNOSTI C SERVI CES	0	0	5, 675		287	90.01
	09100 EMERGENCY	13, 099	0	20, 150	0	304	
	09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS						92.00
	10100 HOME HEALTH AGENCY	0	0	0	0	0	101.00
	10200 OPI OI D TREATMENT PROGRAM	0	0	0	0		102.00
112 00	SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE	· · · · · ·					112 00
	11600 HOSPI CE	0	0	12, 352	0	110	113.00 116.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	193, 592	263, 562	423, 562		570, 940	
	NONREI MBURSABLE COST CENTERS			1.0:=			100.00
190 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	1, 352 1, 377	0	1, 947 12, 681	0		190.00 192.00
	THE THE THE THE THE THE	1, 577	5				
192.00	07955 MARKETING & COMMUNITY RELATIONS	0	0	240	0	0	194.00
192.00 194.00 194.01	07952 WOMEN'S CENTER	818	0 0	240 0	0	0	194.01
192.00 194.00 194.01 194.02		-	0 0 0	240 0 0 12, 190	0 0	0 212	

Health Fir	ancial Systems	FRANCI SCAN HEALT	H INDIANAPOLIS		In Lie	u of Form CMS-	2552-10
ALLOCATI O	N OF CAPITAL RELATED COSTS		Provider C		Period:	Worksheet B	
					From 01/01/2022 To 12/31/2022		nared
						5/29/2023 3:2	
	Cost Center Description	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	
					ADMI NI STRATI ON		
						SUPPLY	
		9.00	10.00	11.00	13.00	14.00	
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	(0 0	272, 440	201.00
202.00	TOTAL (sum lines 118 through 201)	197, 139	263, 562	450, 620	10, 387	846, 410	202.00

Heal th	Fina	nci	al S	Syste	ems		
			CAD		DEL	ATED	0

ALLOCA	ATION OF CAPITAL RELATED COSTS		Provider C	1	Period: From 01/01/2022 To 12/31/2022	Date/Time Pre	
				I NTERNS &	RESI DENTS	5/29/2023 3: 2	2 pm
	Cost Center Description	PHARMACY	MEDI CAL RECORDS & LI BRARY	Y & FRI NGES APPRV	RSERVI CES-OTHER PRGM COSTS APPRV	LABORATORY SCIENTIST PRGM	
	GENERAL SERVICE COST CENTERS	15.00	16.00	21.00	22.00	23.00	
1.00 2.00 4.00 5.01 5.02 5.03	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00570 ADMITTING 00580 CASHIERING/ACCOUNTS RECEIVABLE 00590 OTHER ADMIN & GENERAL						1. 0 2. 0 4. 0 5. 0 5. 0 5. 0
7.00 8.00 9.00 10.00 11.00 13.00 14.00	01300 NURSI NG ADMI NI STRATI ON						7.00 8.00 9.00 10.00 11.00 13.00 14.00
15.00 16.00 21.00 22.00 23.00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 02100 I &R SERVICES-SALARY & FRINGES APPRV 02200 I &R SERVICES-OTHER PRGM COSTS APPRV 02300 MEDICAL LABORATORY SCIENTIST PRGM	344, 430 0 0 0 0	14 C C C	34, 18.	2 84	576	15.00 16.00 21.00 22.00 23.00
23. 01 23. 02 23. 03 23. 04	02301 EMERGENCY MEDICAL SERVICES 02303 PARAMEDIC PRGM 02305 SURGICAL TECH PROGRAM INPATIENT ROUTINE SERVICE COST CENTERS	0 0 0					23.0 23.0 23.0 23.0
30.00 31.00 31.01 32.00 34.00 41.00	03100 INTENSIVE CARE UNIT 02060 NEONATAL INTENSIVE CARE UNIT 03200 CORONARY CARE UNIT 03400 SURGICAL INTENSIVE CARE UNIT	0 0 0 0 0					30.00 31.00 31.0 32.00 34.00 41.00
43.00		0	C				43.0
50.00	05000 OPERATI NG ROOM	0	C				50.0
52.00 54.00		0	C				52.0 54.0
54.00		0	(55.0
56.00	05600 RADI OI SOTOPE	0	C				56.0
59.00		0	0				59.0
50.00 54.00		0	C				60.0 64.0
54.00 55.00		0	0				65. C
6. 00		0	C				66.0
57.00		0	C				67. C
8.00 9.00		0	0				68. C
0.00		0	0				70.0
1. 00		0	C				71.0
2.00		0	0				72.0
73.00 74.00		344, 430	14 C				73.0
76.97		0	C				76.9
77.00		0)			77. C
90.00	OUTPATI ENT SERVI CE COST CENTERS	0					90. C
90.00 90.01		0	(90.0
90. 05	09005 CV DI AGNOSTI C SERVI CES	0	C				90.0
91.00		0	C	0			91.0
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS			I		1	92.0
	0 10100 HOME HEALTH AGENCY 0 10200 OPI OI D TREATMENT PROGRAM	0 0	((101. 0 102. 0
113 0	SPECIAL PURPOSE COST CENTERS			1		1	1112 0
	D 11600 HOSPICE D	0 344, 430	C 14		0 0	0	113. 0 116. 0 118. 0
100 5	NONREI MBURSABLE COST CENTERS	-1					100 5
	0 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0				190. 0 192. 0
	0 07955 MARKETING & COMMUNITY RELATIONS	0		Ď			192.0
194. O	1 07952 WOMEN' S CENTER	Ő	C	þ			194. 0
101 0	2 07950 OTHER NONREIMBURSABLE COST CENTERS	0	C				194.0

Health Financial Systems FF	FRANCI SCAN HEALTH I NDI ANAPOLI S			In Lieu of Form CMS-2552-10			
ALLOCATION OF CAPITAL RELATED COSTS				Period:	Worksheet B		
				rom 01/01/2022 o 12/31/2022			
			INTERNS &	RESI DENTS			
Cost Center Description	PHARMACY			SERVI CES-OTHER			
		RECORDS &	Y & FRINGES	PRGM COSTS	LABORATORY		
	15.00	LIBRARY	APPRV		SCIENTIST PRGM		
	15.00	16.00	21.00	22.00	23.00		
194.0407954OTHER NRCC	0	0				194.04	
194. 05 07956 FOUNDATI ON	0	0				194.05	
200.00 Cross Foot Adjustments			34, 182	84	576	200. 00	
201.00 Negative Cost Centers	0	0	(0 0	0	201.00	
202.00 TOTAL (sum lines 118 through 201)	344, 430	14	34, 182	84	576	202.00	

ALLOCA	TION OF CAPITAL RELATED COSTS		Provider C	F	eriod: rom 01/01/2022	Worksheet B Part II	
				Т	0 12/31/2022	Date/Time Pre 5/29/2023 3:2	pared: 2 pm
	Cost Center Description	PHARMACY PRGM	EMERGENCY MEDI CAL SERVI CES	PARAMEDI C PRGN	SURGI CAL TECH PROGRAM	Subtotal	
	r	23.01	23.02	23.03	23.04	24.00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT	1		1			1.00
2.00	00200 CAP REL COSTS-BLDG & FIXT						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570 ADMI TTI NG						5. 01
5.02	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5.02
5.03 7.00	00590 OTHER ADMIN & GENERAL 00700 OPERATION OF PLANT						5.03 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 CAFETERIA 01300 NURSING ADMINISTRATION						11.00
	01400 CENTRAL SERVICES & SUPPLY						14.00
	01500 PHARMACY						15.00
	01600 MEDICAL RECORDS & LIBRARY						16.00
21.00	02100 I &R SERVICES-SALARY & FRINGES APPRV						21.00
	02200 I & R SERVICES-OTHER PRGM COSTS APPRV 02300 MEDICAL LABORATORY SCIENTIST PRGM						22.00
	02302 PHARMACY PRGM	1, 194					23.01
23. 02	02301 EMERGENCY MEDICAL SERVICES		760				23. 02
	02303 PARAMEDI C PRGM			2, 126			23.03
23. 04	02305 SURGI CAL TECH PROGRAM I NPATI ENT ROUTI NE SERVI CE COST CENTERS				487		23.04
30.00	03000 ADULTS & PEDIATRICS					5, 467, 309	30.00
31.00	03100 I NTENSI VE CARE UNI T					693, 318	
	02060 NEONATAL INTENSIVE CARE UNIT					469, 410	•
32.00	03200 CORONARY CARE UNIT					1, 497, 303	
34.00 41.00	03400 SURGI CAL I NTENSI VE CARE UNI T 04100 SUBPROVI DER – I RF					759, 941 533, 891	•
43.00	04300 NURSERY					75, 103	1
	ANCILLARY SERVICE COST CENTERS				· · · · ·		
50.00	05000 OPERATI NG ROOM					2, 671, 939	
52.00	05200 DELIVERY ROOM & LABOR ROOM					838, 943	
54.00 55.00	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C					1, 688, 093 118, 837	•
56.00	05600 RADI OI SOTOPE					36, 020	
59.00	05900 CARDI AC CATHETERI ZATI ON					715, 115	1
60.00	06000 LABORATORY					753, 204	
64.00 65.00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY					331, 572 149, 428	
66.00	06600 PHYSI CAL THERAPY					237, 958	
67.00	06700 OCCUPATI ONAL THERAPY						67.00
	06800 SPEECH PATHOLOGY					3, 080	
						438, 647	
	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT					6, 692 349, 824	
	07200 I MPL. DEV. CHARGED TO PATIENTS					226, 482	
73.00	07300 DRUGS CHARGED TO PATIENTS					356, 047	73.00
	07400 RENAL DIALYSIS					113, 890	
	07697 CARDIAC REHABILITATION 07700 ALLOGENEIC STEM CELL ACQUISITION					1, 815 1, 957	
77.00	OUTPATIENT SERVICE COST CENTERS					1, 757	1 / /. 00
	09000 CLI NI C					585, 625	90.00
	09001 I BMT JOINT VENTURE					84, 258	90.01
	09005 CV DI AGNOSTI C SERVI CES					6, 663	•
	09100 EMERGENCY					1, 464, 156	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS	<u> </u>					92.00
101.00	10100 HOME HEALTH AGENCY					0	101.00
102.00	10200 OPI OI D TREATMENT PROGRAM						102.00
440.0-	SPECIAL PURPOSE COST CENTERS	1		1	I		440.07
	11300 I NTEREST EXPENSE					10 070	113.00
116.00	11600 HOSPICE SUBTOTALS (SUM OF LINES 1 through 117)	0	(o	12, 973 20, 698, 189	
0. 00	NONREI MBURSABLE COST CENTERS	0	C		<u> </u>	20,070,109	1.10.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN					147, 039	
192.00	19200 PHYSICIANS' PRIVATE OFFICES					163, 986	
	07955 MARKETING & COMMUNITY RELATIONS						194.00
	AZAFA WOMENU & GENTER						
194.01	07952 WOMEN'S CENTER					88, 981	
194. 01 194. 02	07952 WOMEN'S CENTER 07950 OTHER NONREIMBURSABLE COST CENTERS 07954 OTHER NRCC						194. 02

Health Fin	ancial Systems	FRANCI SCAN HEALT	H INDIANAPOLIS		In Lie	u of Form CMS-2	2552-10
ALLOCATI ON	N OF CAPITAL RELATED COSTS		Provider C		Period:	Worksheet B	
					rom 01/01/2022		
					To 12/31/2022	Date/Time Pre	
						5/29/2023 3:2	2 pm
	Cost Center Description	PHARMACY PRGM	EMERGENCY	PARAMEDI C PRGI	M SURGI CAL TECH	Subtotal	
			MEDI CAL		PROGRAM		
			SERVI CES				
		23.01	23.02	23.03	23.04	24.00	
200.00	Cross Foot Adjustments	1, 194	760	2, 12	6 487	39, 409	200.00
201.00	Negative Cost Centers	0	C) (0 0	272, 440	201.00
202.00	TOTAL (sum lines 118 through 201)	1, 194	760	2, 12	6 487	21, 428, 799	202.00

	Financial Systems Ff ION OF CAPITAL RELATED COSTS	RANCI SCAN HEALTH	I NDI ANAPOLI S Provi der CC	N: 15-0162	Period: From 01/01/2022	u of Form CMS-25 Worksheet B Part II	552-10
					To 12/31/2022	Date/Time Prepa	ared:
	Cost Center Description	Intern &	Total			5/29/2023 3: 22	pm
		Residents Cost					
		& Post Stepdown					
		Adjustments					
		25.00	26.00				
	GENERAL SERVICE COST CENTERS						1 00
	DO100 CAP REL COSTS-BLDG & FIXT DO200 CAP REL COSTS-MVBLE EQUIP						1.00 2.00
1	DO400 EMPLOYEE BENEFITS DEPARTMENT						4.00
	DO570 ADMI TTI NG						5.01
	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5.02
	00590 OTHER ADMIN & GENERAL						5.03
	DO700 OPERATION OF PLANT DO800 LAUNDRY & LINEN SERVICE						7.00 8.00
	DO900 HOUSEKEEPI NG						9.00
10.00	D1000 DI ETARY						10.00
	D1100 CAFETERIA						11.00
	01300 NURSI NG ADMI NI STRATI ON						13.00
	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY						14.00 15.00
	D1600 MEDICAL RECORDS & LIBRARY						16.00
	D2100 I&R SERVICES-SALARY & FRINGES APPRV						21.00
	D2200 I &R SERVICES-OTHER PRGM COSTS APPRV						22.00
	D2300 MEDICAL LABORATORY SCIENTIST PRGM						23.00
	D2302 PHARMACY PRGM D2301 EMERGENCY MEDICAL SERVICES						23. 01 23. 02
	D2303 PARAMEDIC PRGM						23.02
	02305 SURGI CAL TECH PROGRAM						23.04
	NPATIENT ROUTINE SERVICE COST CENTERS	1					
	03000 ADULTS & PEDIATRICS	0	5, 467, 309				30.00
	D3100 INTENSIVE CARE UNIT D2060 NEONATAL INTENSIVE CARE UNIT	0	693, 318 469, 410				31.00 31.01
	03200 CORONARY CARE UNIT	0	1, 497, 303				32.00
	03400 SURGI CAL I NTENSI VE CARE UNI T	0	759, 941				34.00
	04100 SUBPROVIDER - IRF	0	533, 891				41.00
	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	0	75, 103				43.00
	D5000 OPERATI NG ROOM	0	2, 671, 939				50.00
52.00 0	D5200 DELIVERY ROOM & LABOR ROOM	0	838, 943				52.00
	05400 RADI OLOGY-DI AGNOSTI C	0	1, 688, 093				54.00
	D5500 RADI OLOGY-THERAPEUTI C D5600 RADI OI SOTOPE	0	118, 837				55.00 56.00
	D5900 CARDI AC CATHETERI ZATI ON	0	36, 020 715, 115				59.00
	06000 LABORATORY	0	753, 204				60.00
	06400 I NTRAVENOUS THERAPY	0	331, 572				64.00
	06500 RESPI RATORY THERAPY	0	149, 428				65.00
	D6600 PHYSI CAL THERAPY D6700 OCCUPATI ONAL THERAPY	0	237, 958 8, 696				66.00 67.00
	06800 SPEECH PATHOLOGY	0	3, 080				68.00
	06900 ELECTROCARDI OLOGY	Ő	438, 647				69.00
	07000 ELECTROENCEPHALOGRAPHY	0	6, 692				70.00
	07100 MEDI CAL SUPPLIES CHARGED TO PATIENT	0	349, 824				71.00
	D7200 I MPL. DEV. CHARGED TO PATIENTS D7300 DRUGS CHARGED TO PATIENTS	0	226, 482 356, 047				72.00 73.00
	07400 RENAL DI ALYSI S	0	113, 890				74.00
76.97	07697 CARDI AC REHABI LI TATI ON	0	1, 815				76.97
	07700 ALLOGENEI C STEM CELL ACQUI SI TI ON	0	1, 957				77.00
	DUTPATIENT SERVICE COST CENTERS	0	585, 625				90.00
	09001 I BMT JOINT VENTURE	0	84, 258				90.00 90.01
90.05	D9005 CV DIAGNOSTIC SERVICES	0	6, 663				90.05
	09100 EMERGENCY	0	1, 464, 156				91.00
	D9200 OBSERVATION BEDS (NON-DISTINCT PART	0					92.00
	10100 HOME HEALTH AGENCY	0	0			1	101.00
	10200 OPI OI D TREATMENT PROGRAM	0	0				102.00
	SPECIAL PURPOSE COST CENTERS						
	11300 I NTEREST EXPENSE 11600 HOSPI CE	о	12 070				113.00 116.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	0	12, 973 20, 698, 189				116.00
-	IONREI MBURSABLE COST CENTERS						. 5. 50
190.001	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	147, 039				190. 00
	19200 PHYSICIANS' PRIVATE OFFICES 07955 MARKETING & COMMUNITY RELATIONS	0	163, 986				192.00 194.00
104 001		0	242			11	174 ())
	07952 WOMEN'S CENTER	0	88, 981				194.01

Health Financial Systems	FRANCISCAN HEALTH INDIANAPOLIS			In Lieu of Form CMS-2552-10			
ALLOCATION OF CAPITAL RELATED COSTS		Provider CC	CN: 15-0162	Period:	Worksheet B		
				From 01/01/2022 To 12/31/2022	Part II Date/Time Pre	nared	
					5/29/2023 3:2	2 pm	
Cost Center Description	Intern &	Total					
	Residents Cost						
	& Post						
	Stepdown						
	Adjustments						
	25.00	26.00					
194.04079540THER NRCC	0	18, 301				194.04	
194. 05 07956 FOUNDATI ON	0	0				194.05	
200.00 Cross Foot Adjustments	0	39, 409				200.00	
201.00 Negative Cost Centers	0	272, 440				201.00	
202.00 TOTAL (sum lines 118 through 201)	0	21, 428, 799				202.00	

FRANCI SCAN HEALTH I NDI ANAPOLI S Provi der CCN: 15-0162

 In Lieu of Form CMS-2552-10

 Period:
 Worksheet B-1

 From 01/01/2022
 Date/Time Prepared:

 To
 12/31/2022
 Date/Time Prepared:

					From 01/01/2022 To 12/31/2022	2 Date/Time Pre	
		CAPI TAL REI	ATED COSTS			5/29/2023 3: 2	2 pm
	Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS	ADMI TTI NG (I NPATI ENT CHARGES)	Reconciliation	
		1.00	2.00	SALARIES) 4.00	5. 01	5A. 02	
	GENERAL SERVICE COST CENTERS	1.00	2.00	4.00	5.01	5A. 02	
1.00	00100 CAP REL COSTS-BLDG & FIXT	832, 332					1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	0	832, 332		101		2.00
4.00 5.01	00400 EMPLOYEE BENEFITS DEPARTMENT 00570 ADMITTING	2, 360	0 2, 360		0 1, 565, 222, 86	1	4.00 5.01
5.02	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	982				-25, 282	5.02
5.03	00590 OTHER ADMIN & GENERAL	513				0 0	5.03
7.00 8.00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	103, 939 8, 156				0 0 0 0	7.00 8.00
9.00	00900 HOUSEKEEPING	6, 678				0 0	9.00
10.00	01000 DI ETARY	8, 865				0 0	10. 00
11.00 13.00	01100 CAFETERIA 01300 NURSING ADMINISTRATION	15, 156	15, 156 0			0 0 0 0	11.00 13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	28, 392	-			0 0	14.00
15.00	01500 PHARMACY	11,005			248	0 0	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	01/			0 0	16.00
21.00 22.00	02100 I & SERVICES-SALARY & FRINGES APPRV 02200 I & SERVICES-OTHER PRGM COSTS APPRV	916	916 0			0 0 0 0	21.00 22.00
23.00	02300 MEDICAL LABORATORY SCIENTIST PRGM	0	0	168, 8		0 0	23.00
23.01	02302 PHARMACY PRGM	0	0	312, 9		0 0	23.01
23. 02 23. 03	02301 EMERGENCY MEDICAL SERVICES 02303 PARAMEDIC PRGM	0	0	172, 0 480, 6			23. 02 23. 03
23.03	02305 SURGI CAL TECH PROGRAM	0	0			0 0	23.03
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS						
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	172, 573 20, 542					30. 00 31. 00
31.00	02060 NEONATAL INTENSIVE CARE UNIT	14, 665					31.00
32.00	03200 CORONARY CARE UNI T	47, 942					32.00
34.00 41.00	03400 SURGI CAL I NTENSI VE CARE UNI T 04100 SUBPROVI DER – I RF	24, 160					34.00 41.00
41.00	04300 NURSERY	17,027	17, 027 2, 171				41.00
	ANCI LLARY SERVI CE COST CENTERS					-	
50.00 52.00	05000 OPERATING ROOM 05200 DELIVERY ROOM & LABOR ROOM	87,684	87, 684 27, 437				50.00 52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	55, 261	55, 261				54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	3, 844					55.00
56.00 59.00	05600 RADI OI SOTOPE 05900 CARDI AC CATHETERI ZATI ON	1, 170 23, 505					56.00 59.00
60.00	06000 LABORATORY	25, 070					60.00
64.00	06400 I NTRAVENOUS THERAPY	10, 910					64.00
65.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	4, 159 7, 387					65.00 66.00
67.00	06700 OCCUPATI ONAL THERAPY	0					67.00
68.00	06800 SPEECH PATHOLOGY	0	0	1, 035, 1	107 5, 259, 91	1 0	68.00
69. 00 70. 00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	14, 511	14, 511				69. 00 70. 00
70.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	1, 765, 0	072 8, 223, 95 0 117, 859, 94	2 0	70.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 105, 584, 40	8 0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	0	0		0 176, 573, 75 0 7, 981, 75		73.00 74.00
74.00 76.97	07697 CARDI AC REHABI LI TATI ON	3, 794	3, 794				76.97
77.00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	3, 404, 9	905 35, 283, 60	7 0	77.00
90.00	OUTPATIENT SERVICE COST CENTERS	18, 976	18, 976	6, 754, 7	720 842, 82	4 0	90.00
90.01	09001 I BMT JOI NT VENTURE	2, 659					90.01
90.05	09005 CV DI AGNOSTI C SERVI CES	0	0				90. 05
91.00 92.00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	47, 155	47, 155	8, 733, 6	107, 686, 73	6 0	91.00 92.00
72.00	OTHER REIMBURSABLE COST CENTERS						72.00
	10100 HOME HEALTH AGENCY	0			-		101.00
102.00	10200 OPI OI D TREATMENT PROGRAM SPECIAL PURPOSE COST CENTERS	0	0		0	0 0	102.00
	11300 I NTEREST EXPENSE						113.00
	11600 HOSPICE	010 5 (1	0				116.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	819, 564	819, 564	192, 491, (026 1, 565, 222, 86	1 -25, 282	118.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	4, 866					190. 00
	19200 PHYSICIANS' PRIVATE OFFICES 07955 MARKETING & COMMUNITY RELATIONS	4, 957 0					192. 00 194. 00
174.00	UT 755 WARKETING & CONINUUNITY RELATIONS	0	0	40,3			174.00

alth Financial Systems	FRANCI SCAN HEALT	H INDIANAPOLIS		In Lie	u of Form CMS-2	2552-10
ST ALLOCATION - STATISTICAL BASIS		Provider C		Period:	Worksheet B-1	
				From 01/01/2022 To 12/31/2022		pared: 2 pm
	CAPI TAL REL	LATED COSTS				
Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	ADMI TTI NG (I NPATI ENT CHARGES)	Reconciliation	
	1.00	2.00	4.00	5. 01	5A. 02	
4.0107952 WOMEN'S CENTER	2, 945	2, 945	i	0 0	0	194.01
4.0207950 OTHER NONREIMBURSABLE COST CENTERS	0	0		0 0	0	194. 02
4.0407954 OTHER NRCC	0	0	1, 961, 14	7 0	0	194.04
4. 05 07956 FOUNDATI ON	0	0)	0 0	0	194. 05
0.00 Cross Foot Adjustments						200. 00
1.00 Negative Cost Centers						201.00
2.00 Cost to be allocated (per Wkst. B, Part I)	12, 333, 002	9, 095, 797	9, 566, 61	6 60, 759		202.00
3.00 Unit cost multiplier (Wkst. B, Part	I) 14.817407	10. 928088	0. 04709	0. 000039		203.00
4.00 Cost to be allocated (per Wkst. B, Part II)				0 60, 759		204.00
5.00 Unit cost multiplier (Wkst. B, Part			0.00000	0.000039		205.00
6.00 NAHE adjustment amount to be allocat (per Wkst. B-2)	ed					206.00
7.00 NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00

	Financial Systems FF LLOCATION - STATISTICAL BASIS	RANCISCAN HEALTH	I NDI ANAPOLI S Provi der CCI		eri od:	u of Form CMS-2 Worksheet B-1	
				T	rom 01/01/2022 b 12/31/2022	Date/Time Pre 5/29/2023 3:22	pared:
	Cost Center Description	CASHI ERI NG/ACC R OUNTS RECEI VABLE (ACCUM. COST)		GENERAL (ACCUM. COST)	PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	
	GENERAL SERVICE COST CENTERS	5.02	5A. 03	5.03	7.00	8.00	
$\begin{array}{c} 11.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 21.\ 00\\ 22.\ 00\\ 23.\ 00\\ 23.\ 01\\ 23.\ 02\\ 23.\ 03\\ \end{array}$	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00570 ADMITTING 00580 CASHI ERING/ACCOUNTS RECEIVABLE 00590 OTHER ADMIN & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 02100 I & SERVICES-SALARY & FRINGES APPRV 02200 I & SERVICES-OTHER PRGM COSTS APPRV 02300 EDICAL LABORATORY SCIENTIST PRGM 02301 EMERGENCY MEDICAL SERVICES 02303 PARAMEDIC PRGM 02305 SURGICAL TECH PROGRAM	674, 644, 103 83, 534, 495 25, 047, 469 1, 995, 851 8, 173, 737 1, 620, 693 3, 093, 009 5, 131, 341 22, 107 9, 159, 169 166, 491 2, 338, 660 1, 288, 603 134, 812 335, 598 84, 629 276, 191 140, 279	-83, 537, 586 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	591, 131, 799 25, 048, 396 1, 995, 925 8, 174, 039 1, 620, 753 3, 093, 123 5, 131, 531 22, 108 9, 159, 508 166, 497 2, 338, 747 1, 288, 651 134, 817 335, 610 84, 632 276, 201 140, 284	724, 538 8, 156 6, 678 8, 865 15, 156 0 28, 392 11, 005 0 916 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2, 770, 370 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 4.\ 00\\ 5.\ 01\\ 5.\ 02\\ 5.\ 03\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 21.\ 00\\ 22.\ 00\\ 23.\ 01\\ 23.\ 02\\ 23.\ 03\\ 23.\ 04 \end{array}$
31.00 31.01 32.00 34.00 41.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS 03100 I NTENSI VE CARE UNI T 02060 NEONATAL I NTENSI VE CARE UNI T 03200 CORONARY CARE UNI T 03400 SURGI CAL I NTENSI VE CARE UNI T 04100 SUBPROVI DER - I RF 04300 NURSERY	52, 935, 931 12, 868, 433 7, 170, 850 15, 818, 475 7, 438, 281 4, 437, 362 2, 189, 445	0 0 0 0 0 0 0	52, 937, 890 12, 868, 909 7, 171, 115 15, 819, 060 7, 438, 556 4, 437, 526 2, 189, 526	172, 573 20, 542 14, 665 47, 942 24, 160 17, 027 2, 171	1, 057, 280 146, 742 16, 963 186, 037 132, 029 53, 558 8, 218	31.00 31.01 32.00 34.00 41.00
$\begin{array}{c} 52.\ 00\\ 54.\ 00\\ 55.\ 00\\ 56.\ 00\\ 60.\ 00\\ 64.\ 00\\ 65.\ 00\\ 65.\ 00\\ 66.\ 00\\ 67.\ 00\\ 67.\ 00\\ 70.\ 00\\ 71.\ 00\\ 71.\ 00\\ 72.\ 00\\ 74.\ 00\\ 76.\ 97\\ 77.\ 00\\ \end{array}$	ANCI LLARY SERVI CE COST CENTERS 05000 OPERATI NG ROOM 05200 DELI VERY ROOM & LABOR ROOM 05400 RADI OLOGY-THERAPEUTI C 05500 RADI OLOGY-THERAPEUTI C 05600 RADI OLOGY-THERAPEUTI C 05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY 06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06600 PHYSI CAL THERAPY 06600 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY 06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 07200 IMPL. DEV. CHARGED TO PATI ENTS 07400 RENAL DI ALYSI S 07697 CARDI AC REHABI LI TATI ON 07700 ALLOGENEI C STEM CELL ACQUI SI TI ON 0UTPATI ENT SERVI CE COST CENTERS	$\begin{array}{c} 23,050,884\\ 5,120,136\\ 17,485,398\\ 7,877,445\\ 282,807\\ 4,050,905\\ 26,679,942\\ 3,080,711\\ 13,604,613\\ 6,747,262\\ 2,943,393\\ 1,155,559\\ 1,941,501\\ 2,096,350\\ 49,376,606\\ 34,364,555\\ 65,616,057\\ 1,085,351\\ 624,136\\ 8,942,211\\ \end{array}$		23, 051, 737 5, 120, 325 17, 486, 045 7, 877, 736 282, 817 4, 051, 055 26, 680, 929 3, 080, 825 13, 605, 116 6, 747, 512 2, 943, 502 1, 155, 602 1, 941, 573 2, 096, 428 49, 378, 433 34, 365, 826 65, 618, 485 1, 085, 391 624, 159 8, 942, 542	87, 684 27, 437 55, 261 3, 844 1, 170 23, 505 25, 070 10, 910 4, 159 7, 387 0 0 14, 511 0 0 0 14, 511 0 0 0 3, 794 0 0	28, 509 0 713 12, 828 6, 036 0 0 8, 651 0 0	$\begin{array}{c} 52.\ 00\\ 54.\ 00\\ 55.\ 00\\ 56.\ 00\\ 59.\ 00\\ 64.\ 00\\ 65.\ 00\\ 65.\ 00\\ 65.\ 00\\ 66.\ 00\\ 67.\ 00\\ 68.\ 00\\ 69.\ 00\\ 70.\ 00\\ 71.\ 00\\ 72.\ 00\\ 73.\ 00\\ 74.\ 00\\ 76.\ 97\\ 77.\ 00\\ \end{array}$
90. 01 90. 05 91. 00	09000 CLINIC 09001 IBMT JOINT VENTURE 09005 CV DIAGNOSTIC SERVICES 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS	5, 393, 050 3, 280, 591 10, 565, 256 20, 759, 533	0 0 0 0	5, 393, 250 3, 280, 712 10, 565, 647 20, 760, 301	18, 976 2, 659 0 47, 155	6, 864 8, 537 0 423, 885	90. 00 90. 01 90. 05 91. 00 92. 00
	10100 HOME HEALTH AGENCY 10200 OPI OLD TREATMENT PROGRAM SPECIAL PURPOSE COST CENTERS	0	0 0	0	0 0		101. 00 102. 00
	11300 I NTEREST EXPENSE 11600 HOSPI CE	7, 811, 113 569, 337, 276	0 -83, 537, 586	7, 811, 402 485, 820, 754	0 711, 770		113. 00 116. 00 118. 00
192.00 194.00 194.01 194.02	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICLANS' PRIVATE OFFICES 07955 MARKETING & COMMUNITY RELATIONS 07952 WOMEN'S CENTER 07950 OTHER NONREIMBURSABLE COST CENTERS 07954 OTHER NRCC	959, 595 11, 328, 086 38, 812 79, 494 0 92, 892, 073	0 0 0 0 0 0	959, 631 11, 328, 505 38, 813 79, 497 0 92, 895, 832	4, 866 4, 957 0 2, 945 0 0	9, 801 0 16, 782 0	190. 00 192. 00 194. 00 194. 01 194. 02 194. 04

Health F	Financial Systems FF	RANCI SCAN HEALT	H INDIANAPOLIS		In Lie	u of Form CMS-	2552-10
COST AL	COST ALLOCATION - STATISTICAL BASIS		Provider C		Period:	Worksheet B-1	
					rom 01/01/2022 To 12/31/2022	Date/Time Pre 5/29/2023 3:2	
	Cost Center Description	CASHI ERI NG/ACC	Reconciliation	OTHER ADMIN &	OPERATION OF	LAUNDRY &	
		OUNTS		GENERAL	PLANT	LINEN SERVICE	
		RECEI VABLE		(ACCUM. COST)	(SQUARE FEET)	(POUNDS OF	
		(ACCUM. COST)				LAUNDRY)	
		5.02	5A. 03	5.03	7.00	8.00	
194.050	7956 FOUNDATI ON	8, 767	0	8, 76	0	0	194.05
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	25, 282		83, 537, 586	28, 588, 185	2, 599, 797	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0. 000037		0. 141318	39. 457123	0. 938430	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	25, 282		16, 298	3 2, 677, 589	240, 251	204.00
205.00	Unit cost multiplier (Wkst. B, Part	0. 000037		0. 000028	3. 695581	0. 086722	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00

	Financial Systems Ff LLOCATION - STATISTICAL BASIS	RANCI SCAN HEALTI	H INDIANAPOLIS Provider CO	CN: 15-0162	In Lie Period:	u of Form CMS-2 Worksheet B-1	
				1	From 01/01/2022 To 12/31/2022	Date/Time Pre 5/29/2023 3:2	pared:
	Cost Center Description	HOUSEKEEPING (SQUARE FEET)	DI ETARY (TOTAL PATI	CAFETERI A (FTES)	NURSI NG ADMI NI STRATI ON	CENTRAL SERVICES &	
		(SECARE TEET)	ENT DAYS)	(1123)		SUPPLY	
					(TOTAL PATI ENT DAYS)	(COSTED REQUIS.)	
	GENERAL SERVI CE COST CENTERS	9.00	10.00	11.00	13.00	14.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00 4.00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT						2.00
5.01	00570 ADMI TTI NG						5.01
5.02 5.03	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 00590 OTHER ADMIN & GENERAL						5.02 5.03
7.00	00700 OPERATION OF PLANT						7.00
8.00 9.00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	709, 704					8.00 9.00
10.00	01000 DI ETARY	8, 865	111, 848				10.00
	01100 CAFETERIA 01300 NURSING ADMINISTRATION	15, 156 0	0	3, 908, 34 ⁻ 87, 190			11.00
14.00	01400 CENTRAL SERVICES & SUPPLY	28, 392	0	22, 80	7 0	92, 083, 730	14.00
15. 00 16. 00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	11, 005 0	0	145, 522		0 438	15.00 16.00
21.00	02100 I &R SERVICES-SALARY & FRINGES APPRV	916	0	57, 962		19, 997	21.00
	02200 I & R SERVICES-OTHER PRGM COSTS APPRV 02300 MEDICAL LABORATORY SCIENTIST PRGM	0	0	4, 748	-	0 3, 153	22.00 23.00
23.01	02302 PHARMACY PRGM	0	0	10, 170	0 0	20	23.01
	02301 EMERGENCY MEDICAL SERVICES 02303 PARAMEDIC PRGM	0	0	6, 540 18, 284		0	23.02
	02305 SURGI CAL TECH PROGRAM	0	0	4, 14		0	23.04
30.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	172, 573	56, 962	834, 328	3 56, 962	189, 306	30.00
31.00	03100 I NTENSI VE CARE UNI T	20, 542	19, 865	164, 882	2 19, 865	23, 649	31.00
	02060 NEONATAL INTENSIVE CARE UNIT 03200 CORONARY CARE UNIT	14, 665 47, 942	7, 302 12, 204	104, 82 ⁻ 206, 52 ⁻		15, 159 31, 029	
34.00	03400 SURGI CAL I NTENSI VE CARE UNI T	24, 160	6, 464	113, 770	6, 464	18, 701	34.00
41.00 43.00	04100 SUBPROVI DER – I RF 04300 NURSERY	17, 027 2, 171	5, 248 3, 803	81, 45!		8, 558 0	
	ANCILLARY SERVICE COST CENTERS						
50. 00 52. 00	05000 OPERATING ROOM 05200 DELIVERY ROOM & LABOR ROOM	87, 684 27, 437	0	275, 963 85, 036		596, 208 18, 668	
54.00	05400 RADI OLOGY-DI AGNOSTI C	55, 261	0	211, 410	0 0	88, 407	54.00
	05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE	3, 844 1, 170	0	33, 318 4, 902		6, 226 221	
59.00	05900 CARDI AC CATHETERI ZATI ON	23, 505	0	64, 49	4 O	81, 077	59.00
60.00 64.00	06000 LABORATORY 06400 I NTRAVENOUS THERAPY	25, 070 10, 910	0	10, 820 57, 68		9, 376 25, 336	
	06500 RESPI RATORY THERAPY	4, 159	0	195, 824		16, 390	65.00
66.00 67.00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	7, 387	0	126, 650 67, 535		12, 127 4, 781	
68.00	06800 SPEECH PATHOLOGY	0	0	23, 193	3 0	10, 342	68.00
	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	14, 511 0	0	42, 392 49, 245		22, 910 5, 233	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	(0 0	54, 869, 835	71.00
	07200 I MPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	0	50	5 0	35, 316, 972 71, 571	
	07400 RENAL DI ALYSI S	3, 794	0	(0	1, 022	
	07697 CARDIAC REHABILITATION 07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	15, 174 (3, 054 0	
00.00		10.07/	0	170 14		7 470	
	09000 CLINIC 09001 IBMT JOINT VENTURE	18, 976 2, 659	0 0	179, 145 36, 538		7, 479 7, 941	
90.05	09005 CV DI AGNOSTI C SERVI CES	0	0	49, 218		46, 121	90.05
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	47, 155	0	174, 76		48, 709	91.00 92.00
101 00							101 00
	10100 HOME HEALTH AGENCY 10200 OPI OI D TREATMENT PROGRAM	0	0 0		0 0 0 0		101.00 102.00
112 00	SPECIAL PURPOSE COST CENTERS	1					112 00
	11300 I NTEREST EXPENSE 11600 HOSPI CE	0	0	107, 133	3 0	17, 718	113.00 116.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	696, 936	111, 848	3, 673, 669		91, 597, 734	
190.00	NONREI MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	4, 866	0	16, 884	4 0	66, 715	190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	4, 957	0	109, 980		385, 298	192.00
	07955 MARKETING & COMMUNITY RELATIONS 07952 WOMEN'S CENTER	0 2, 945	0	2, 080			194. 00 194. 01
194.01							

Health Finar	ncial Systems Fl	RANCISCAN HEALT	H INDIANAPOLIS		In Lie	u of Form CMS-:	2552-10
COST ALLOCA	TION - STATISTICAL BASIS		Provider CO		Period: From 01/01/2022	Worksheet B-1	
					To 12/31/2022	Date/Time Pre 5/29/2023 3:2	
	Cost Center Description	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	
		(SQUARE FEET)	(TOTAL PATI	(FTES)	ADMI NI STRATI ON		
			ENT DAYS)		(7074) 5471	SUPPLY	
					(TOTAL PATI	(COSTED	
		9,00	10.00	11 00	ENT DAYS)	REQUIS.)	
194.0407954		9.00	10.00	11.00	13.00	14.00	194.04
194.0507956		0	0	105, 72	.8 0		194.04
200.00		0	0		0 0	0	200.00
	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0 500 (70	2 210 405	4 222 40		1 664 644	
202.00	Cost to be allocated (per Wkst. B, Part I)	9, 592, 673	2, 319, 405	4, 333, 10	5, 953, 375	1, 554, 544	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	13. 516442	20. 737116	1. 10867	9 53. 227371	0. 016882	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	197, 139	263, 562	450, 62	10, 387	846, 410	204.00
205.00	Unit cost multiplier (Wkst. B, Part	0. 277776	2. 356430	0. 11529	0. 092867	0. 006233	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

alth Financial Systems F ST ALLOCATION - STATISTICAL BASIS		Provider C	CN: 15-0162	Period: From 01/01/2022 To 12/31/2022	worksheet B-1	
			I NTERNS	& RESI DENTS	5/29/2023 3:2	
	500 500 500					
Cost Center Description	PHARMACY (COSTED REQUI S.)	MEDI CAL RECORDS & LI BRARY	Y & FRI NGES APPRV	RSERVICES-OTHER PRGMCOSTS APPRV	MEDI CAL LABORATORY SCI ENTI ST PRGM	
	15.00	(GROSS CHARGES)	(ASSI GNED TI ME)	(ASSI GNED TI ME)	(ASSI GNED TI ME)	
GENERAL SERVICE COST CENTERS	15.00	16.00	21.00	22.00	23.00	
ODIOI CAP COSTS-BLOG FIXT 00 00200 CAP REL COSTS-BLOG FIXT 00 00200 CAP REL COSTS-MVBLE EQUI P 00 00400 EMPLOYEE BENEFI TS DEPARTMENT 01 00570 ADMI TTI NG 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						1 2 4 5 5
00590 OTHER ADMIN & GENERAL 00 00590 00 00700 00 00800 LAUNDRY & LINEN SERVICE 00 00900 HOUSEKEEPING .00 01000 DI ETARY						5 7 8 9 10
. 00 01100 CAFETERIA . 00 01300 NURSING ADMINISTRATION . 00 01400 CENTRAL SERVICES & SUPPLY . 00 01500 PHARMACY . 00 01600 MEDICAL RECORDS & LIBRARY	100	3, 425, 940, 025				10 11 13 14 15 16
.00 02100 I &R SERVI CES-SALARY & FRINGES APPRV .00 02200 I &R SERVI CES-OTHER PRGM COSTS APPRV .00 02300 MEDI CAL LABORATORY .01 02302 PHARMACY PRGM .02 02301 EMERGENCY MEDI CAL		0, 420, 940, 020 C C C C	2, 61	7 2, 617	100	21 22
. 03 02303 PARAMEDI C PRGM . 04 02305 SURGI CAL TECH PROGRAM						23 23 23
. 00 03000 ADULTS & PEDI ATRI CS	0	225, 795, 089	1, 83	1, 839	0	30
. 00 03100 I NTENSI VE CARE UNI T	0	37, 398, 663	1	62 62		
. 01 02060 NEONATAL INTENSIVE CARE UNIT . 00 03200 CORONARY CARE UNIT	0	40, 535, 471 37, 541, 713		4 4 0 0	0	
. 00 03400 SURGICAL INTENSIVE CARE UNIT	0	23, 960, 012		0 0	0	
. 00 04100 SUBPROVIDER - IRF . 00 04300 NURSERY	0	16, 274, 834 10, 595, 988		0 0	0	
ANCI LLARY SERVI CE COST CENTERS		10, 070, 700		-		
. 00 05000 OPERATING ROOM . 00 05200 DELIVERY ROOM & LABOR ROOM	0	334, 384, 097 50, 798, 041		5 155 0 0		
00 05400 RADI OLOGY-DI AGNOSTI C	0	322, 124, 936		4 4	0	
. 00 05500 RADI OLOGY-THERAPEUTI C	0	89, 116, 059		0 0	0	55
00 05600 RADI OI SOTOPE	0	9, 295, 714		0 0	0	
00 05900 CARDI AC CATHETERI ZATI ON 00 06000 LABORATORY	0	175, 118, 428 286, 396, 860		0 0	0	
00 06400 I NTRAVENOUS THERAPY	0	45, 183, 984		0 0		
. 00 06500 RESPI RATORY THERAPY	0	66, 839, 341	1	5 15		
00 06600 PHYSI CAL THERAPY	0	47, 378, 809				
00 06700 OCCUPATI ONAL THERAPY 00 06800 SPEECH PATHOLOGY	0	27, 471, 907 10, 893, 693		0 0	0	
00 06900 ELECTROCARDI OLOGY	0	44, 604, 045		8 78		
00 07000 ELECTROENCEPHALOGRAPHY	0	26, 635, 915		8 18		70
00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	214, 687, 709		0 0	-	
00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	175, 944, 341		0 0	0	
00 07300 DRUGS CHARGED TO PATIENTS	100	585, 915, 408 8, 506, 754		0 0 7 47	0	
. 97 07697 CARDIAC REHABILITATION	0	4, 204, 988		0 0		
. 00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	35, 301, 310		0 0		
OUTPATIENT SERVICE COST CENTERS	-	47.000 617	•	-	-	
. 00 09000 CLINIC . 01 09001 IBMT JOINT VENTURE	0	17, 933, 145 11, 769, 455		0 0	0	
05 09005 CV DIAGNOSTIC SERVICES	0	91, 737, 503		-		
. 00 09100 EMERGENCY	0	335, 363, 795		0 0		
. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92
OTHER REIMBURSABLE COST CENTERS 1. 00 10100 HOME HEALTH AGENCY 2. 00 10200 OPI 0I D TREATMENT PROGRAM	0	C		0 0 0 0		101 102
SPECIAL PURPOSE COST CENTERS			1			1110
3. 00 11300 INTEREST_EXPENSE 6. 00 11600 H0SPICE	0	16, 232, 018	3		0	113 116
8.00 SUBTOTALS (SUM OF LINES 1 through 117)		3, 425, 940, 025		2 2, 542		118
NONREI MBURSABLE COST CENTERS	1		1		1	
	0	C		0 0		190

COST ALLOCA	TION - STATISTICAL BASIS		Provider C		Period:	Worksheet B-1	
					rom 01/01/2022 o 12/31/2022	Date/Time Pre 5/29/2023 3:2	
				INTERNS &	RESI DENTS		
	Cost Center Description	PHARMACY	MEDI CAL	SERVI CES-SALAR	SERVI CES-OTHER	MEDI CAL	
	•	(COSTED	RECORDS &	Y & FRINGES	PRGM COSTS	LABORATORY	
		REQUIS.)	LI BRARY	APPRV	APPRV	SCIENTIST PRGM	
			(GROSS	(ASSI GNED	(ASSI GNED		
			CHARGES)	TIME)	TIME)	(ASSI GNED	
						TIME)	
		15.00	16.00	21.00	22.00	23.00	
	MARKETING & COMMUNITY RELATIONS	0	0	C	0 0	-	194. (
	WOMEN' S CENTER	0	0	C	0 0		194. (
	OTHER NONREIMBURSABLE COST CENTERS	0	0	C	0 0		194. (
	OTHER NRCC	0	0	C	0		194. (
194.0507956		0	0	C	0 0		194. (
200.00	Cross Foot Adjustments						200. (
201.00	Negative Cost Centers						201. (
202.00	Cost to be allocated (per Wkst. B, Part I)	11, 198, 222	190, 033	2, 782, 377	1, 470, 761	159, 186	202. (
03.00	Unit cost multiplier (Wkst. B, Part I)	111, 982. 220000	0.000055	1, 063. 193351	562.002675	1, 591. 860000	203. (
204.00	Cost to be allocated (per Wkst. B, Part II)	344, 430	14	34, 182	84	576	204. 0
205.00	Unit cost multiplier (Wkst. B, Part	3, 444. 300000	0. 000000	13. 061521	0. 032098	5. 760000	205. (
06.00	NAHE adjustment amount to be allocated (per Wkst. B-2)					0	206. (
07.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)					0. 000000	207. (

	Financial Systems FF LLOCATION - STATISTICAL BASIS	RANCI SCAN HEALTI	H INDIANAPOLIS		In Lie Period:	u of Form CMS- Worksheet B-1	
COSTA				F	From 01/01/2022 To 12/31/2022	Date/Time Pre	pared:
	Cost Center Description	PHARMACY PRGM (ASSI GNED TI ME)	EMERGENCY MEDI CAL SERVI CES	PARAMEDI C PRGM (ASSI GNED	I SURGI CAL TECH PROGRAM (ASSI GNED	5/29/2023 3:2	2 pm
			(ASSI GNED TI ME)	TIME)	TI ME)		
	GENERAL SERVICE COST CENTERS	23.01	23.02	23.03	23.04		
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00 4.00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT						2.00
4.00 5.01	00570 ADMITTING						5.01
5.02	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5. 02
5.03	00590 OTHER ADMIN & GENERAL						5.03
7.00 8.00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE						7.00
9.00	00900 HOUSEKEEPI NG						9.00
	01000 DI ETARY						10.00
	01100 CAFETERIA 01300 NURSING ADMINISTRATION						11.00
	01400 CENTRAL SERVICES & SUPPLY						14.00
	01500 PHARMACY						15.00
	01600 MEDI CAL RECORDS & LI BRARY						16.00
	02100 I & SERVICES-SALARY & FRINGES APPRV 02200 I & SERVICES-OTHER PRGM COSTS APPRV						21.00 22.00
	02300 MEDICAL LABORATORY SCIENTIST PRGM						23.00
	02302 PHARMACY PRGM	100					23. 01
	02301 EMERGENCY MEDICAL SERVICES		100				23.02
	02303 PARAMEDIC PRGM 02305 SURGICAL TECH PROGRAM			100	100		23.03 23.04
	INPATIENT ROUTINE SERVICE COST CENTERS						
	03000 ADULTS & PEDIATRICS	0	0	(30.00
	03100 I NTENSI VE CARE UNI T 02060 NEONATAL I NTENSI VE CARE UNI T	0	0				31.00
	03200 CORONARY CARE UNI T	0	0				32.00
	03400 SURGICAL INTENSIVE CARE UNIT	0	0		-		34.00
	04100 SUBPROVIDER - IRF	0	0				41.00
43.00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	<u> </u>	0		<u>, 0</u>		43.00
	05000 OPERATI NG ROOM	0	0				50.00
	05200 DELIVERY ROOM & LABOR ROOM	0	0		-		52.00
	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	0	0				54.00 55.00
56.00	05600 RADI OI SOTOPE	0	0	(0 0		56.00
	05900 CARDI AC CATHETERI ZATI ON	0	0	(0		59.00
	06000 LABORATORY 06400 I NTRAVENOUS THERAPY	0	0				60.00 64.00
	06500 RESPIRATORY THERAPY	0	0		0 0		65.00
	06600 PHYSI CAL THERAPY	0	0		0 0		66.00
	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0	0				67.00 68.00
	06900 ELECTROCARDI OLOGY	0	0				69.00
	07000 ELECTROENCEPHALOGRAPHY	0	0		0 0		70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	(0		71.00
	07200 TMPL. DEV. CHARGED TO PATTENTS	100	0				73.00
	07400 RENAL DI ALYSI S	0	0	(0 0		74.00
	07697 CARDI AC REHABI LI TATI ON	0	0	(0		76.97
77.00	07700 ALLOGENEIC STEM CELL ACQUISITION OUTPATIENT SERVICE COST CENTERS	0	0	<u> </u>	0 0		77.00
	09000 CLI NI C	0	0	(0 0		90.00
	09001 I BMT JOI NT VENTURE	0	0	(0		90.01
	09005 CV DIAGNOSTIC SERVICES 09100 EMERGENCY	0	0 100	100			90.05 91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	100				92.00
	OTHER REIMBURSABLE COST CENTERS			1			
	10100 HOME HEALTH AGENCY	0	0				101.00
102.00	10200 OPIOLD TREATMENT PROGRAM SPECIAL PURPOSE COST CENTERS	0	0		0 0		102.00
	11300 INTEREST EXPENSE						113.00
	11600 HOSPICE	0	0	(-		116.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	100	100	100	0 100		118.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	(0 0		190. 00
192.00	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0				192.00
	07955 MARKETING & COMMUNITY RELATIONS 07952 WOMEN'S CENTER	0	0				194.00 194.01
	07952 WOMEN S CENTER 07950 OTHER NONREIMBURSABLE COST CENTERS	0	0				194.01
	· · ·	· · · · · · · · · · · · · · · · · · ·					<u>·</u>

Heal th	Fi nan	cial Systems FI	RANCI SCAN HEALTI	H INDIANAPOLIS	i	In Lie	u of Form CMS	-2552-10
COST A	LLOCAT	ION - STATISTICAL BASIS		Provider C		Peri od:	Worksheet B-	1
						From 01/01/2022 To 12/31/2022	Date/Time Pr 5/29/2023 3:	epared: 22 pm
		Cost Center Description	PHARMACY PRGM	EMERGENCY	PARAMEDIC PRG	M SURGICAL TECH		
		·	(ASSI GNED	MEDI CAL		PROGRAM		
			TIME)	SERVI CES	(ASSI GNED	(ASSI GNED		
				(ASSI GNED	TIME)	TIME)		
				TIME)				
			23.01	23.02	23.03	23.04		
194.04	07954	OTHER NRCC	0	C		0 0		194.04
194.05	07956	FOUNDATION	0	C		0 0		194.05
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	394, 313	103, 849	335, 50	4 164, 709		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	3, 943. 130000	1, 038. 490000	3, 355. 04000	0 1, 647. 090000		203.00
204.00		Cost to be allocated (per Wkst. B,	1, 194	760	2, 12	6 487		204.00
		Part II)						
205.00		Unit cost multiplier (Wkst. B, Part II)	11. 940000	7.60000	21.26000	4. 870000		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)	0	C		0 0		206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)	0. 000000	0. 000000	0.00000	0.000000		207. 00

FRANCISCAN HEALTH INDIANAPOLIS

In Lieu of Form CMS-2552-10

COMPUTATI	ON OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-0162	Period: From 01/01/2022 To 12/31/2022	Worksheet C Part I Date/Time Pre 5/29/2023 3:2	pared: 2 pm
			Title	XVIII	Hospi tal	PPS	
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs		Total Costs	
		(from Wkst. B,	Adj.		Di sal I owance		
		Part I, col.					
		26)	0.00	0.00	4.00	F 00	
LNI	PATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
	000 ADULTS & PEDIATRICS	75, 706, 748		75, 706, 74	48 0	75, 706, 748	30.00
	100 INTENSIVE CARE UNIT	17, 567, 969		17, 567, 9			
	060 NEONATAL INTENSIVE CARE UNIT	9, 636, 092		9, 636, 0			
	200 CORONARY CARE UNI T	21, 903, 043		21, 903, 04			
	400 SURGI CAL I NTENSI VE CARE UNI T	10, 499, 374		10, 499, 3			
	100 SUBPROVIDER - IRF	6, 496, 379		6, 496, 3			
	300 NURSERY	2, 903, 532		2, 903, 5			•
	CILLARY SERVICE COST CENTERS	2,903,532		2,903, 5.	52 0	2, 903, 332	43.00
	000 OPERATING ROOM	31, 697, 294		31, 697, 29	94 0	31, 697, 294	50.00
	200 DELIVERY ROOM & LABOR ROOM	7, 517, 275		7, 517, 2			
	400 RADI OLOGY-DI AGNOSTI C	23, 310, 422		23, 310, 42			•
	500 RADI OLOGY-THERAPEUTI C	9, 236, 577		9, 236, 5			
	600 RADI OL SOTOPE	396, 885		396, 8			
	900 CARDI AC CATHETERI ZATI ON	6, 011, 408		6, 011, 40			
	000 LABORATORY	31, 966, 681		31, 966, 68			•
	400 I NTRAVENOUS THERAPY	4, 162, 284		4, 162, 28			
	500 RESPI RATORY THERAPY	15, 969, 741	0				•
	600 PHYSI CAL THERAPY	8, 262, 352	0				
	700 OCCUPATIONAL THERAPY	3, 435, 939	0				
	800 SPEECH PATHOLOGY	1, 346, 066		1, 346, 0		1, 346, 066	•
	900 ELECTROCARDI OLOGY	3, 046, 528	0	3, 046, 5			
	000 ELECTROEARDI OLOGI 000 ELECTROENCEPHALOGRAPHY	2, 454, 505		2, 454, 5		2, 454, 505	
	100 MEDICAL SUPPLIES CHARGED TO PATIENT	57, 294, 601		57, 294, 60			
	200 IMPL. DEV. CHARGED TO PATIENTS	39, 828, 234		39, 828, 23			
	300 DRUGS CHARGED TO PATIENTS			86, 519, 19		86, 519, 194	
	400 RENAL DIALYSIS	86, 519, 194 1, 448, 360		1, 448, 30			
	697 CARDI AC REHABI LI TATI ON	729, 470		729, 4			
	700 ALLOGENEIC STEM CELL ACQUISITION	10, 208, 226		10, 208, 2			
	TPATIENT SERVICE COST CENTERS	10, 200, 220		10, 200, 2.	20 0	10, 200, 220	//.00
	000 CLINIC	7, 366, 806		7, 366, 80	0 0	7, 366, 806	90.00
	001 I BMT JOINT VENTURE	3, 934, 493		3, 934, 4			
	005 CV DI AGNOSTI C SERVI CES	12, 119, 155		12, 119, 1			
	100 EMERGENCY	27, 242, 238		27, 242, 2		27, 242, 238	•
	200 OBSERVATION BEDS (NON-DISTINCT PART	12, 588, 783		12, 588, 7		12, 588, 783	
	HER REIMBURSABLE COST CENTERS	12, 300, 703		12, 300, 70	55	12, 300, 703	72.00
	100 HOME HEALTH AGENCY	0			0	0	101.00
	200 OPI OI D TREATMENT PROGRAM	0			0		102.00
	ECIAL PURPOSE COST CENTERS		L		0		102.00
	300 INTEREST EXPENSE						113.00
	600 HOSPI CE	9,035,262		9, 035, 20	52	9, 035, 262	
200.00	Subtotal (see instructions)	561, 841, 916					
201.00	Less Observation Beds	12, 588, 783		12, 588, 78		12, 588, 783	
202.00	Total (see instructions)	549, 253, 133					
1			-				

Heal th	Fi nar	ici a	I Syst	ems			
COMPUT	ATLON	0F	RATIO	0F	COSTS	TO	CF

FRANCISCAN HEALTH INDIANAPOLIS

In Lieu of Form CMS-2552-10

COMPUTATION OF RATIO OF COSTS TO CHARGES			CN: 15-0162	Period: From 01/01/2022 To 12/31/2022	Worksheet C Part I Date/Time Pre 5/29/2023 3:2 PPS	
			XVIII	Hospi tal	PP5	
Cost Center Description	I npati ent	Charges Outpati ent	Total (col. + col. 7)	6 Cost or Other Ratio	TEFRA I npati ent Rati o	
	6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS			•			
30. 00 03000 ADULTS & PEDIATRICS	166, 535, 211		166, 535, 21	1		30.00
31. 00 03100 INTENSIVE CARE UNIT	37, 398, 663		37, 398, 66	53		31.00
31.01 02060 NEONATAL INTENSIVE CARE UNIT	40, 535, 471		40, 535, 47	/1		31.01
32. 00 03200 CORONARY CARE UNI T	37, 541, 713		37, 541, 71	3		32.00
34.00 03400 SURGICAL INTENSIVE CARE UNIT	23, 960, 012		23, 960, 01			34.00
41. 00 04100 SUBPROVIDER - IRF	16, 274, 834		16, 274, 83	34		41.00
43. 00 04300 NURSERY	10, 595, 988		10, 595, 98			43.00
ANCI LLARY SERVI CE COST CENTERS				· - I		1
50. 00 05000 OPERATI NG ROOM	166, 728, 545	167, 655, 552	334, 384, 09	0. 094793	0. 000000	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	50, 576, 736	221, 305		0. 147984	0.000000	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	97, 734, 796	224, 390, 140			0.000000	
55. 00 05500 RADI OLOGY-THERAPEUTI C	5, 243, 853				0.000000	
56. 00 05600 RADI OI SOTOPE	2, 445, 740	6, 849, 974			0. 000000	•
59. 00 05900 CARDI AC CATHETERI ZATI ON	71, 910, 140	103, 208, 288			0. 000000	•
50. 00 06000 LABORATORY	130, 844, 864	155, 551, 996			0. 000000	
54. 00 06400 I NTRAVENOUS THERAPY	5, 435, 890	39, 748, 094			0. 000000	
55. 00 06500 RESPIRATORY THERAPY	56, 579, 524	10, 259, 817			0. 000000	•
56. 00 06600 PHYSI CAL THERAPY	21, 448, 183	25, 930, 626			0. 000000	
57. 00 06700 OCCUPATI ONAL THERAPY	17, 640, 372	9, 831, 535			0. 000000	•
58. 00 06800 SPEECH PATHOLOGY	5, 259, 911	5, 633, 782			0. 000000	•
59. 00 06900 ELECTROCARDI OLOGY	28, 920, 215	15, 683, 830			0.000000	•
70. 00 07000 ELECTROENCEPHALOGRAPHY	8, 223, 958	18, 411, 957			0.000000	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	117, 859, 942	96, 827, 767			0.000000	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	105, 584, 408	70, 359, 933			0.000000	
73.00 07300 DRUGS CHARGED TO PATIENTS	176, 573, 759	409, 341, 649			0.000000	
74. 00 07400 RENAL DIALYSIS	7, 981, 755	409, 341, 849 524, 999			0.000000	
						•
76. 97 07697 CARDI AC REHABI LI TATI ON	142,960	4, 062, 028			0.000000	
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	35, 283, 607	17, 703	35, 301, 31	0 0. 289174	0. 000000	77.00
OUTPATIENT SERVICE COST CENTERS	0.42,024	17 000 001	17 000 1	0 410702	0,000000	
20. 00 09000 CLINIC	842, 824	17, 090, 321	17, 933, 14		0.00000	
PO. 01 09001 I BMT JOI NT VENTURE	517, 135	11, 252, 320			0.000000	
PO. 05 09005 CV DI AGNOSTI C SERVI CES	347,040	91, 390, 463			0.00000	
91.00 09100 EMERGENCY	107, 686, 736	227, 677, 059			0.00000	
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART	10, 497, 441	48, 762, 437	59, 259, 87	0. 212433	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS		0		2		101 00
101.00 10100 HOME HEALTH AGENCY	0	0		0		101.00
102.00 10200 OPI OLD TREATMENT PROGRAM	0	0	l	0		102.00
SPECIAL PURPOSE COST CENTERS	1					110 00
113.00 11300 INTEREST EXPENSE	70 / 05	4/ 4/4 000	44 000 00			113.00
116.00 11600 HOSPI CE	70, 635					116.00
200.00 Subtotal (see instructions)	1, 565, 222, 861	1, 860, 717, 164	3, 425, 940, 02	5		200.00
201.00 Less Observation Beds				-		201.00
202.00 Total (see instructions)	1, 565, 222, 861	1, 860, 717, 164	3, 425, 940, 02	25		202.00

Health Financial Systems	FRANCI SCAN HEALTH	I NDI ANAPOLI S	In Lieu	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0162	Period: From 01/01/2022 To 12/31/2022	Worksheet C Part I Date/Time Prep 5/29/2023 3:22	
		Title XVIII	Hospi tal	PPS	<u>z piii</u>
Cost Center Description	PPS Inpatient Ratio 11.00				
INPATIENT ROUTINE SERVICE COST CENTERS	11.00				
30. 00 03000 ADULTS & PEDI ATRI CS					30.00
31. 00 03100 I NTENSI VE CARE UNI T 31. 01 02060 NEONATAL I NTENSI VE CARE UNI T					31.00
32. 00 03200 CORONARY CARE UNIT					32.00
34. 00 03400 SURGICAL INTENSIVE CARE UNIT					34.00
41. 00 04100 SUBPROVI DER - I RF					41.00
43. 00 04300 NURSERY					41.00
ANCI LLARY SERVICE COST CENTERS					43.00
50. 00 05000 OPERATING ROOM	0. 094793				50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0. 147984				52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 072365				54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 103647				55.00
56. 00 05600 RADI 0I SOTOPE	0. 042695				56.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 034328				59.00
60. 00 06000 LABORATORY	0. 111617				60.00
64. 00 06400 I NTRAVENOUS THERAPY	0.092119				64.00
65. 00 06500 RESPI RATORY THERAPY	0. 238927				65.00
66. 00 06600 PHYSI CAL THERAPY	0. 174389				66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 125071				67.00
68.00 06800 SPEECH PATHOLOGY	0. 123564				68.00
69. 00 06900 ELECTROCARDI OLOGY	0.068302				69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0. 092150				70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 266874				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 226368				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 147665				73.00
74.00 07400 RENAL DIALYSIS	0. 170260				74.00
76. 97 07697 CARDIAC REHABILITATION	0. 173477				76.97
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0. 289174				77.00
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLINIC	0. 410793				90.00
90.01 09001 IBMT JOINT VENTURE	0. 334297				90.01
90. 05 09005 CV DI AGNOSTI C SERVI CES	0. 132107				90.05
91. 00 09100 EMERGENCY	0. 081232				91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART OTHER REI MBURSABLE COST CENTERS	0. 212433				92.00
101.00 10100 HOME HEALTH AGENCY					101.00
102.00 10200 OPI OI D TREATMENT PROGRAM					102.00
SPECIAL PURPOSE COST CENTERS	· ·				1
113.00 11300 INTEREST EXPENSE					113.00
116. 00 11600 HOSPI CE					116.00
200.00 Subtotal (see instructions)					200.00
	1				
201.00 Less Observation Beds					201.00

FRANCI SCAN HEALTH INDIANAPOLIS In Lieu of Form CMS-2552-10

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-0162	Period: From 01/01/2022 To 12/31/2022	Worksheet C Part I Date/Time Pre 5/29/2023 3:2	pared: 2 pm
	1	Titl	e XIX	Hospi tal	PPS	
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs		Total Costs	
	(from Wkst. B,	Adj.		Di sal I owance		
	Part I, col.					
	<u>26)</u> 1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
30. 00 03000 ADULTS & PEDIATRICS	75, 706, 748		75, 706, 7	48 0	75, 706, 748	30.00
31. 00 03100 I NTENSI VE CARE UNI T	17, 567, 969		17, 567, 9			
31. 01 02060 NEONATAL INTENSIVE CARE UNIT	9, 636, 092		9, 636, 0			
32.00 03200 CORONARY CARE UNIT	21, 903, 043		21, 903, 0			
34. 00 03400 SURGI CAL I NTENSI VE CARE UNI T	10, 499, 374		10, 499, 3			
41. 00 04100 SUBPROVIDER - IRF	6, 496, 379		6, 496, 3			
43. 00 04300 NURSERY	2, 903, 532		2, 903, 5			
ANCI LLARY SERVI CE COST CENTERS	2,700,002		2,700,0	52 0	2,700,002	10.00
50. 00 05000 OPERATING ROOM	31, 697, 294		31, 697, 2	94 0	31, 697, 294	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	7, 517, 275		7, 517, 2			
54.00 05400 RADI OLOGY-DI AGNOSTI C	23, 310, 422		23, 310, 4			
55. 00 05500 RADI OLOGY-THERAPEUTI C	9, 236, 577		9, 236, 5			
56. 00 05600 RADI OI SOTOPE	396, 885		396, 8			•
59. 00 05900 CARDI AC CATHETERI ZATI ON	6,011,408		6, 011, 4			
60. 00 06000 LABORATORY	31, 966, 681		31, 966, 6			
64. 00 06400 I NTRAVENOUS THERAPY	4, 162, 284		4, 162, 2			
65. 00 06500 RESPI RATORY THERAPY	15, 969, 741					
66. 00 06600 PHYSI CAL THERAPY	8, 262, 352					
67.00 06700 OCCUPATI ONAL THERAPY	3, 435, 939					•
68.00 06800 SPEECH PATHOLOGY	1, 346, 066					
69. 00 06900 ELECTROCARDI OLOGY	3, 046, 528		3, 046, 5			•
70.00 07000 ELECTROENCEPHALOGRAPHY	2, 454, 505		2, 454, 5			
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	57, 294, 601		57, 294, 6			
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	39, 828, 234		39, 828, 2			
73.00 07300 DRUGS CHARGED TO PATIENTS	86, 519, 194		86, 519, 1			
74.00 07400 RENAL DIALYSIS	1, 448, 360		1, 448, 3			
76. 97 07697 CARDI AC REHABI LI TATI ON	729, 470		729, 4	70 0	729, 470	76.97
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	10, 208, 226		10, 208, 2	26 0	10, 208, 226	77.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	7, 366, 806		7, 366, 8	0 0	7, 366, 806	90.00
90.01 09001 IBMT JOINT VENTURE	3, 934, 493		3, 934, 4	93 0	3, 934, 493	90. 01
90. 05 09005 CV DIAGNOSTIC SERVICES	12, 119, 155		12, 119, 1	55 0	12, 119, 155	90.05
91. 00 09100 EMERGENCY	27, 242, 238		27, 242, 2	38 0	27, 242, 238	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	12, 588, 783		12, 588, 7	33	12, 588, 783	92.00
OTHER REIMBURSABLE COST CENTERS			-			
101.00 10100 HOME HEALTH AGENCY	0			0	0	101.00
102.00 10200 OPI OI D TREATMENT PROGRAM	0			0	0	102.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300 INTEREST EXPENSE						113.00
116. 00 11600 HOSPI CE	9, 035, 262		9, 035, 2		9, 035, 262	
200.00 Subtotal (see instructions)	561, 841, 916					
201.00 Less Observation Beds	12, 588, 783		12, 588, 7		12, 588, 783	
202.00 Total (see instructions)	549, 253, 133	0	549, 253, 1	33 0	549, 253, 133	202.00

Heal th	Fi nan	ci a	I Syst	ems			
COMPLIE	TLON	0F	RATIO	0F	COSTS	TO	CF

FRANCISCAN HEALTH INDIANAPOLIS

In Lieu of Form CMS-2552-10

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-0162 Peroider CD: 15-0162 Worksheet C Transition		ATION OF RATIO OF COSTS TO CHARGES	RANCI SCAN HEALT			Peri od:	Worksheet C	2002-10
To To T2/31/202 Date/Time Progress/ Progrogress/ Progress/ Progress/ Progress/ Progress/ Pro	COMPUTA	ATTON OF RATIO OF COSTS TO CHARGES		Provider Co	JN. 15-0102	From 01/01/2022		
Cost Center Description Charges Unpatient Charges Outpatient Cost Of the Ratio Free Ratio TFERA Inpatient 0.00 0000001000001156 4 Pendanter CS 31.00 000000000000000000000000000000000000						To 12/31/2022	Date/Time Pre	pared:
Cost Center Description Charges Inpatient Total (col. 0utpatient Cost or Other science TEFRA Inpatient Ratio 10000 0.0000 ADULTS & PEDIATRICS 166, 535, 211 166, 535, 211 30.00 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>5/29/2023 3:2</td> <td>2 pm</td>							5/29/2023 3:2	2 pm
Cost Center Description Inpatient Outpatient Total (col. 6) (col. 7) Cost of the Ratio The FRA Inpatient 0 00000 00000 0.0000 0.000 0.0000 0.0000 0.0000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.000000 0.					e XIX	Hospi tal	PPS	
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31. 01 02060 NEONATAL INTENSIVE CARE UNIT 40, 535, 471 40, 535, 471 31. 01 31. 01 32. 00 34. 00 41. 00 41. 00 41. 00 41. 00 41. 00 41. 00 41. 00 41. 00 41. 00 41. 00 41. 00 41. 00 41. 00 41. 00 40. 000000 52. 00 50. 096. 001 01 14.7984 0. 000000 52. 00 50. 096. 011 0. 41.7984 0. 000000 52. 00 50. 00 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>								
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70.00 07000 ELECTROENCEPHALOGRAPHY 8, 223, 958 18, 411, 957 26, 635, 915 0.092150 0.000000 70.00 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 117, 859, 942 96, 827, 767 214, 687, 709 0.266874 0.000000 72.00 72.00 07300 DRUGS CHARGED TO PATI ENTS 105, 584, 408 70, 359, 933 175, 944, 341 0.226368 0.000000 73.00 73.00 07400 RENAL DI ALYSI S 7, 981, 755 524, 999 8, 506, 754 0.170665 0.000000 74.00 76.97 CARDI AC REHABI LI TATI ON 142, 960 4, 062, 028 4, 204, 988 0.173477 0.000000 77.00 007000 ALLOGENEI C STEM CELL ACQUI SI TI ON 35, 283, 607 17, 703 35, 301, 310 0.289174 0.000000 90.00 90.00 09000 CLI NI C 842, 824 17, 090, 321 17, 933, 145 0.410793 0.000000 90.00 90.00 90.01 99001 IBMT JOINT VENTURE 517, 135 11, 252, 320 11, 769, 455 0.334297 0.000000 90.00 90.05 90.00<								
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 117,859,942 96,827,767 214,687,709 0.266874 0.000000 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 105,584,408 70,359,933 175,944,341 0.226386 0.000000 72.00 73.00 07400 RENAL DI ALYSI S 176,573,759 409,341,649 585,915,408 0.147665 0.000000 74.00 74.00 07407 CARDI AC REHABILITATION 142,960 4,062,028 4,204,988 0.173477 0.000000 76.97 77.00 07700 ALLOGENEI C STEM CELL ACQUISITION 35,283,607 17,703 35,301,310 0.289174 0.000000 90.00 90.00 09000 CLINIC 842,824 17,090,321 17,793,145 0.410793 0.000000 90.01 90.01 09001 IBMT JOINT VENTURE 517,135 11,252,320 11,769,455 0.334297 0.000000 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00								
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 105,584,408 70,359,933 175,944,341 0.226368 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 176,573,759 409,341,649 585,915,408 0.147665 0.000000 73.00 74.00 07400 RENAL DIALYSIS 7,981,755 524,999 8,506,754 0.170260 0.000000 74.00 76.97 CARDIA CREHABILITATION 142,960 4,062,028 4,204,988 0.173477 0.000000 76.97 70.00 07700 ALLOGENEIC STEM CELL ACQUISITION 35,283,607 17,703 35,301,310 0.289174 0.000000 70.00 90.01 09000 CLINIC 842,824 17,090,321 17,933,145 0.410793 0.000000 90.01 90.05 09005 CV DI AGNOSTIC SERVICES 347,040 91,390,463 91,737,503 0.132107 0.000000 90.01 90.01 91.00 09100 EMERGENCY 107,686,736 227,677,059 335,363,795 0.081232 0.000000 92.00 92.00 09200 0BSERVATION BEDS (NON-DISTINCT P								
73.00 07300 DRUGS CHARGED TO PATIENTS 176, 573, 759 409, 341, 649 585, 915, 408 0. 147665 0. 000000 73.00 74.00 07400 RENAL DIALYSIS 7, 981, 755 524, 999 8, 506, 754 0. 170260 0.000000 74.00 76.97 07697 CARDIAC REHABILITATION 142, 960 4, 062, 028 4, 204, 988 0. 173477 0.000000 76.97 00TPATIENT SERVICE COST CENTERS 07700 ALLOGENEIC STEM CELL ACQUISITION 35, 283, 607 17, 703 35, 301, 310 0. 289174 0.000000 76.97 90.00 09000 CLINIC 842, 824 17, 090, 321 17, 933, 145 0. 410793 0.000000 90.00 90.01 09001 LBMT JOINT VENTURE 517, 135 11, 252, 320 11, 769, 455 0. 3132107 0.000000 90.05 91.00 09100 ERRERUCY 107, 686, 736 227, 677, 059 335, 363, 795 0. 212433 0.000000 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 10, 497, 441 48, 762, 437 59, 259, 878 0. 212433 0.000000 92.00 <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></t<>								
74.00 07400 RENAL DI ALYSI S 7,981,755 524,999 8,506,754 0.170260 0.000000 74.00 76.97 07697 CARDI AC REHABILI TATI ON 142,960 4,062,028 4,204,988 0.173477 0.000000 76.97 77.00 OT700 ALLOGENEI C STEM CELL ACQUI SI TI ON 35,283,607 17,703 35,301,310 0.289174 0.000000 76.97 90.00 OUTPATI ENT SERVI CE COST CENTERS 90.00 09000 CLI NI C 842,824 17,090,321 17,933,145 0.410793 0.000000 90.00								
76. 97 07697 CARDI AC REHABI LI TATI ON 142, 960 4, 062, 028 4, 204, 988 0. 173477 0. 000000 76. 97 77. 00 07700 ALLOGENEI C STEM CELL ACQUI SI TI ON 35, 283, 607 17, 703 35, 301, 310 0. 289174 0. 000000 77. 00 00.00 09000 CLI NI C 842, 824 17, 090, 321 17, 933, 145 0. 410793 0. 000000 90. 00 90.01 09001 IBMT JOINT VENTURE 517, 135 11, 252, 320 11, 769, 455 0. 334297 0. 000000 90. 05 90.05 OYOD ALGONOSTI C SERVI CES 347, 040 91, 390, 463 91, 737, 503 0. 132107 0. 000000 90. 05 91.00 09005 CV DI AGNOSTI C SERVI CES 107, 686, 736 227, 677, 059 335, 363, 795 0. 081232 0. 000000 91. 00 92.00 09200 DESERVATI ON BEDS (NON-DI STI NCT PART 10, 497, 441 48, 762, 437 59, 259, 878 0. 212433 0. 000000 92. 00 011.00 10100 HOME HEALTH AGENCY 0 0 0 0 102. 00 9ECI AL PURPOSE COST CENTERS 113.00								
77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION 35, 283, 607 17, 703 35, 301, 310 0.289174 0.000000 77. 00 00.00 09000 CLINIC 842, 824 17, 090, 321 17, 933, 145 0.410793 0.000000 90. 00 90.01 09001 IBMT JOINT VENTURE 517, 135 11, 252, 320 11, 769, 455 0.334297 0.000000 90. 05 90.05 09005 CV DI AGNOSTI C SERVICES 347, 040 91, 390, 463 91, 737, 503 0.132107 0.000000 90. 05 91.00 09100 EMERGENCY 107, 686, 736 227, 677, 059 335, 363, 795 0.081232 0.000000 91. 00 92.00 09200 0BSERVATION BEDS (NON-DI STINCT PART 10, 497, 441 48, 762, 437 59, 259, 878 0.212433 0.000000 92. 00 011.00 10100 HOME HEALTH AGENCY 0 0 0 0 101. 00 102.00 010200 010101 TREATMENT PROGRAM 0 0 0 102. 00 SPECI AL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 70, 635								1
OUTPATI ENT SERVICE COST CENTERS 90.00 09000 CLINIC 842,824 17,090,321 17,933,145 0.410793 0.000000 90.00 90.01 09001 IBMT JOINT VENTURE 517,135 11,252,320 11,769,455 0.334297 0.000000 90.05 90.05 09005 CV DIAGNOSTI C SERVICES 347,040 91,390,463 91,737,503 0.132107 0.000000 90.05 91.00 OPICO EMERGENCY 107,686,736 227,677,059 335,363,795 0.081232 0.000000 91.00 92.00 OBSERVATION BEDS (NON-DISTINCT PART 10,497,441 48,762,437 59,259,878 0.212433 0.000000 92.00 91.00 HOME HEALTH AGENCY 0 0 0 0 101.00 101.00 10100 HOME HEALTH AGENCY 0 0 0 102.00 913.00 11300 ITREATMENT PROGRAM 0 0 0 102.00 914.00 HOME HEALTH AGENCY 70,635 16,161,383 16,232,018 113.00								
90.00 09000 CLINIC 842,824 17,090,321 17,933,145 0.410793 0.000000 90.00 90.01 09001 IBMT JOINT VENTURE 517,135 11,252,320 11,769,455 0.334297 0.000000 90.01 90.05 09005 CV DIAGNOSTIC SERVICES 347,040 91,390,463 91,737,503 0.132107 0.000000 90.05 91.00 09100 EMERGENCY 107,686,736 227,677,059 335,363,795 0.081232 0.000000 91.00 92.00 OBSERVATION BEDS (NON-DISTINCT PART 10,497,441 48,762,437 59,259,878 0.212433 0.000000 92.00 92.00 OBSERVATION BEDS COST CENTERS 0 <t< td=""><td>+</td><td></td><td>35, 283, 607</td><td>17, 703</td><td>35, 301, 31</td><td>0 0.289174</td><td>0.000000</td><td>//.00</td></t<>	+		35, 283, 607	17, 703	35, 301, 31	0 0.289174	0.000000	//.00
90.01 09001 I BMT JOINT VENTURE 517,135 11,252,320 11,769,455 0.334297 0.000000 90.01 90.05 09005 CV DI AGNOSTI C SERVI CES 347,040 91,390,463 91,737,503 0.132107 0.000000 90.05 91.00 09100 EMERGENCY 107,686,736 227,677,059 335,363,795 0.081232 0.000000 91.00 92.00 09200 0BSERVATI ON BEDS (NON-DI STINCT PART 10,497,441 48,762,437 59,259,878 0.212433 0.000000 92.00 92.00 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 92.00 01.00 HOME HEALTH AGENCY 0 0 0 0 101.00 101.00 101.00 101.00 101.00 101.00 101.00 101.00 101.00 101.00 101.00 101.00 101.00 101.00 102.00 0 0 0 102.00 102.00 102.00 102.00 102.00 102.00 102.00				17 000 001	17.000.11		0.00000	
90.05 09005 CV DIAGNOSTIC SERVICES 347,040 91,390,463 91,737,503 0.132107 0.000000 90.05 91.00 09100 EMERGENCY 107,686,736 227,677,059 335,363,795 0.081232 0.000000 91.00 92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART 10,497,441 48,762,437 59,259,878 0.212433 0.000000 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 0 0 0 0 101.00 92.00 0.010200 0PI 0I D TREATMENT PROGRAM 0 0 0 102.00 0 10200 0 101.00 1020.00 10100 10100 1010.00 10200 10100 10100 1010.00 10200 10100 1010.00 102.00 102.00 10200 101.00 102.00								
91.00 09100 EMERGENCY 107, 686, 736 227, 677, 059 335, 363, 795 0.081232 0.000000 91.00 92.00 OBSERVATION BEDS (NON-DISTINCT PART 107, 686, 736 227, 677, 059 335, 363, 795 0.212433 0.000000 92.00 0THER REIMBURSABLE COST CENTERS 0 0 0 0 0 0 101.00 10100 1000 HOME HEALTH AGENCY 0 0 0 102.00 0 0 102.00 0 0 0 102.00 0 0 102.00 0 102.00 0 0 102.00 0 0 102.00 0 0 102.00 0 0 102.00 0 102.00 102.00 102.00 102.00 102.00 0 0 0 102.00 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>								
92. 00 OTHER REIMBURSABLE COST CENTERS 0. 212433 0. 000000 92. 00 101. 00 10100 HOME HEALTH AGENCY 0 0 0 101. 00 101. 00 10200 0P101D TREATMENT PROGRAM 0 0 0 102. 00 0 102.00 0 0 102.00 0 102.00 101. 00 102.00 102.00 0 0 0 102.00 0 102.00 0 102.00 102.00 102.00 0 0 0 0 102.00								
OTHER REI MBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 0 0 0 101.00 102.00 10200 OPI OI D TREATMENT PROGRAM 0 0 0 102.00 SPECI AL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 11300 11300 INTEREST 116.00 16.00 1600 HOSPI CE 116.00 200.00 201.00 200.00 201.00								
101.00 10100 HOME HEALTH AGENCY 0 0 0 101.00 102.00 0PIOLD TREATMENT PROGRAM 0 0 0 102.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 11300 INTEREST 113.00 11300 INTEREST 116.00 11600 HOSPICE 116.00 11600 100.00 200.00 200.00 200.00 200.00 201.00 200.00 201.00			10, 497, 441	48, 762, 437	59, 259, 87	8 0.212433	0.000000	92.00
102.00 10200 OPIOID TREATMENT PROGRAM 0 0 102.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 113.00 11300 INTEREST EXPENSE 113.00 116.00 116.00 1000 HOSPICE 113.00 116.00 116.00 200.00 201.00 Subtotal (see instructions) 1,565,222,861 1,860,717,164 3,425,940,025 200.00 201.00								101 00
SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 113. 00 116. 00 11600 HOSPICE 70, 635 16, 161, 383 16, 232, 018 116. 00 200. 00 Subtotal (see instructions) 1, 565, 222, 861 1, 860, 717, 164 3, 425, 940, 025 200. 00 201. 00 Less Observation Beds 201. 00 201. 00 201. 00 201. 00								
113.00 11300 INTEREST EXPENSE 113.00 116.00 11600 HOSPICE 70,635 16,161,383 16,232,018 116.00 200.00 Subtotal (see instructions) 1,565,222,861 1,860,717,164 3,425,940,025 200.00 201.00			0	0		U		102.00
116. 00 11600 HOSPICE 70,635 16,161,383 16,232,018 116. 00 200. 00 Subtotal (see instructions) 1,565,222,861 1,860,717,164 3,425,940,025 200. 00 201. 00			1					112 00
200.00 Subtotal (see instructions) 1,565,222,861 1,860,717,164 3,425,940,025 200.00 201.00 Less Observation Beds 1,565,222,861 1,860,717,164 3,425,940,025 201.00			70 (25	1/ 1/1 000	16 000 01	0		
201.00 Less Observation Beds 201.00								
		, , ,	1, 565, 222, 861	1,800,717,164	3, 425, 940, 02	S		
202. 00 [101a] (See Instructions) 1, 303, 222, 801 1, 800, 717, 164 3, 425, 940, 025 202. 00			1 646 000 0/1	1 040 717 1/4	2 425 040 02	E		
	202.00	Total (see instructions)	1, 202, 222, 861	1,000,717,104	3, 425, 940, 02	ol		1202.00

Health Financial Systems	FRANCI SCAN HEALTH	I NDI ANAPOLI S	In Lieu	u of Form CMS-2552-1
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0162	Peri od:	Worksheet C
			From 01/01/2022 To 12/31/2022	Part I Dato/Timo Proparod:
			10 12/31/2022	Date/Time Prepared: 5/29/2023 3:22 pm
		Title XIX	Hospi tal	PPS
Cost Center Description	PPS Inpatient		· · · · · · · · · · · · · · · · · ·	
	Ratio			
	11.00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDIATRICS				30.00
31.00 03100 INTENSIVE CARE UNIT				31.00
31.01 02060 NEONATAL INTENSIVE CARE UNIT				31.0
32.00 03200 CORONARY CARE UNIT				32.00
34.00 03400 SURGICAL INTENSIVE CARE UNIT				34.00
41.00 04100 SUBPROVIDER - IRF				41.00
43. 00 04300 NURSERY				43.00
ANCI LLARY SERVI CE COST CENTERS				
50. 00 05000 OPERATI NG ROOM	0. 094793			50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 147984			52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 072365			54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 103647			55.00
56. 00 05600 RADI OI SOTOPE	0. 042695			56.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 034328			59.00
60. 00 06000 LABORATORY	0. 111617			60.00
64.00 06400 INTRAVENOUS THERAPY	0. 092119			64.00
65. 00 06500 RESPI RATORY THERAPY	0. 238927			65.00
66. 00 06600 PHYSI CAL THERAPY	0. 174389			66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 125071			67.00
68.00 06800 SPEECH PATHOLOGY	0. 123564			68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 068302			69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0. 092150			70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 266874			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 226368			72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 147665			73.00
74.00 07400 RENAL DIALYSIS	0. 170260			74.00
76. 97 07697 CARDIAC REHABILITATION	0. 173477			76.9
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0. 289174			77.00
OUTPATIENT SERVICE COST CENTERS				
90. 00 09000 CLINIC	0. 410793			90.00
90. 01 09001 I BMT JOINT VENTURE	0. 334297			90.0
90. 05 09005 CV DIAGNOSTIC SERVICES	0. 132107			90.05
91.00 09100 EMERGENCY	0. 081232			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 212433			92.00
OTHER REIMBURSABLE COST CENTERS				
101.00 10100 HOME HEALTH AGENCY				101.00
102.00 10200 OPI OI D TREATMENT PROGRAM				102.00
SPECIAL PURPOSE COST CENTERS	1			
113.00 11300 INTEREST 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

		RANCI SCAN HEALT				u of Form CMS-	2002-1
	ION OF OUTPATIENT SERVICE COST TO CHARGE R	ATTUS NET OF	Provider CO	JN: 15-0162	Period: From 01/01/2022	Worksheet C Part II	
KEDUCITU	INS FOR MEDICAID ONLY				To 12/31/2022		pared:
						5/29/2023 3:2	2 pm
				e XIX	Hospi tal	PPS	
	Cost Center Description	Total Cost	Capital Cost			Operating Cost	
		(Wkst. B, Part				Reduction	
		I, col. 26)	II col. 26)	Cost (col. 1	-	Amount	
		1.00		col . 2)		5.00	
0.0		1.00	2.00	3.00	4.00	5.00	
	NCI LLARY SERVI CE COST CENTERS	21 (07 204	0 (71 000	20,025,21		0	50.0
		31, 697, 294				-	
	5200 DELIVERY ROOM & LABOR ROOM	7, 517, 275	838, 943				
	5400 RADI OLOGY-DI AGNOSTI C	23, 310, 422	1, 688, 093				
	5500 RADI OLOGY-THERAPEUTI C	9, 236, 577	118, 837			0	
	5600 RADI OI SOTOPE	396, 885	36, 020			0	
	5900 CARDI AC CATHETERI ZATI ON	6,011,408	715, 115			0	
	5000 LABORATORY	31, 966, 681	753, 204			0	
	5400 I NTRAVENOUS THERAPY	4, 162, 284	331, 572			0	1
	5500 RESPI RATORY THERAPY	15, 969, 741	149, 428			0	1 00.0
	6600 PHYSI CAL THERAPY	8, 262, 352	237, 958				
	5700 OCCUPATI ONAL THERAPY	3, 435, 939	8, 696			0	
	5800 SPEECH PATHOLOGY	1, 346, 066	3, 080				
	5900 ELECTROCARDI OLOGY	3, 046, 528	438, 647			0	
	7000 ELECTROENCEPHALOGRAPHY	2, 454, 505	6, 692		13 0	0	
	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	57, 294, 601	349, 824	56, 944, 7	77 0	0	1
	7200 IMPL. DEV. CHARGED TO PATIENTS	39, 828, 234	226, 482	39, 601, 7	52 0	0	1
	7300 DRUGS CHARGED TO PATIENTS	86, 519, 194	356, 047			0	73.0
4.00 07	7400 RENAL DIALYSIS	1, 448, 360	113, 890	1, 334, 4	70 0	0	74.0
6. 97 07	7697 CARDIAC REHABILITATION	729, 470	1, 815	727, 6	55 0	0	76.9
7.00 07	7700 ALLOGENEIC STEM CELL ACQUISITION	10, 208, 226	1, 957	10, 206, 20	69 0	0	77.0
OL	JTPATIENT SERVICE COST CENTERS						
0.00 09	9000 CLI NI C	7, 366, 806	585, 625	6, 781, 1	81 0	0	90.0
0.01 09	9001 IBMT JOINT VENTURE	3, 934, 493	84, 258	3, 850, 23	35 0	0	90.0
	9005 CV DIAGNOSTIC SERVICES	12, 119, 155	6, 663	12, 112, 4	92 0	0	90.0
1.00 09	9100 EMERGENCY	27, 242, 238	1, 464, 156	25, 778, 0	32 0	0	91.0
2.00 09	9200 OBSERVATION BEDS (NON-DISTINCT PART	12, 588, 783	909, 124		59 0	0	92.0
	THER REIMBURSABLE COST CENTERS	· · · · · · · · · · · · · · · · · · ·					1
01.0010	D100 HOME HEALTH AGENCY	0	0		0 0	0	1101. (
	0200 OPI OI D TREATMENT PROGRAM	0	0		0 0		102.0
	PECIAL PURPOSE COST CENTERS			L			1
	1300 I NTEREST EXPENSE						1113. (
	1600 HOSPI CE	9,035,262	12, 973	9, 022, 2	39 0	0	116. (
00.00	Subtotal (sum of lines 50 thru 199)	417, 128, 779	12, 111, 038				200. 0
201.00	Less Observation Beds	12, 588, 783	909, 124				200.0
-01.00	Total (line 200 minus line 201)	404, 539, 996					201.0

Health Financial Systems	FRANCI SCAN HEALTH	I INDIANAPOLIS		In Lie	u of Form CMS-	2552-10
CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE REDUCTIONS FOR MEDICAID ONLY	RATIOS NET OF	Provider C	CN: 15-0162	Period: From 01/01/2022 To 12/31/2022	Worksheet C Part II Date/Time Pro 5/29/2023 3:2	epared: 22 pm
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Cost Net of	Total Charges	Outpatient			
	Capital and	(Worksheet C,	Cost to Char			
	Operating Cost			6		
	Reduction	8)	/ col. 7)			
	6.00	7.00	8.00			
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	31, 697, 294	334, 384, 097				50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	7, 517, 275	50, 798, 041				52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	23, 310, 422	322, 124, 936				54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	9, 236, 577	89, 116, 059				55.00
56. 00 05600 RADI OI SOTOPE	396, 885	9, 295, 714				56.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	6, 011, 408	175, 118, 428	0. 0343	28		59.00
60. 00 06000 LABORATORY	31, 966, 681	286, 396, 860				60.00
64.00 06400 INTRAVENOUS THERAPY	4, 162, 284	45, 183, 984				64.00
65. 00 06500 RESPI RATORY THERAPY	15, 969, 741	66, 839, 341	0. 2389	27		65.00
66. 00 06600 PHYSI CAL THERAPY	8, 262, 352	47, 378, 809	0. 1743	39		66.00
67.00 06700 OCCUPATIONAL THERAPY	3, 435, 939	27, 471, 907	0. 1250	71		67.00
68.00 06800 SPEECH PATHOLOGY	1, 346, 066	10, 893, 693		64		68.00
69. 00 06900 ELECTROCARDI OLOGY	3, 046, 528	44, 604, 045	0. 0683	02		69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	2, 454, 505	26, 635, 915		50		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	57, 294, 601	214, 687, 709	0. 2668	74		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	39, 828, 234	175, 944, 341	0. 2263	68		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	86, 519, 194	585, 915, 408	0. 1476	65		73.00
74.00 07400 RENAL DIALYSIS	1, 448, 360	8, 506, 754				74.00
76. 97 07697 CARDI AC REHABI LI TATI ON	729, 470	4, 204, 988		77		76.97
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	10, 208, 226	35, 301, 310				77.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	7, 366, 806	17, 933, 145	0. 4107	93		90.00
90. 01 09001 I BMT JOI NT VENTURE	3, 934, 493	11, 769, 455				90.01
90. 05 09005 CV DI AGNOSTI C SERVI CES	12, 119, 155	91, 737, 503				90.05
91. 00 09100 EMERGENCY	27, 242, 238	335, 363, 795				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	12, 588, 783	59, 259, 878				92.00
OTHER REI MBURSABLE COST CENTERS	12/000//00	07/207/070	012121			- /2/00
101.00 10100 HOME HEALTH AGENCY	0	C	0.0000	20		101.00
102. 00 10200 OPI OI D TREATMENT PROGRAM	0	C				102.00
SPECIAL PURPOSE COST CENTERS	, V	0	0.0000			1.02.00
113. 00 11300 I NTEREST EXPENSE			1			113.00
116. 00 11600 HOSPI CE	9, 035, 262	16, 232, 018	0, 5566	32		116.00
200.00 Subtotal (sum of lines 50 thru 199)		3, 093, 098, 133				200.00
201.00 Less Observation Beds	12, 588, 783	3, 073, 070, 133				200.00
202.00 Total (line 200 minus line 201)		3, 093, 098, 133				201.00
	404, 537, 990	3, 073, 070, 133	1	1		1202. UU

Health Financial Systems	FRANCI SCAN HEALT	H INDIANAPOLIS		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPI	TAL COSTS	Provider C		Period: From 01/01/2022 To 12/31/2022	5/29/2023 3:2	
			XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,		Related Cost			
	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	5, 467, 309		5, 467, 30			
31.00 INTENSIVE CARE UNIT	693, 318		693, 31	8 19, 865	34.90	31.00
31.01 NEONATAL INTENSIVE CARE UNIT	469, 410		469, 41		64.29	31.01
32.00 CORONARY CARE UNIT	1, 497, 303		1, 497, 30	3 12, 204	122.69	32.00
34.00 SURGICAL INTENSIVE CARE UNIT	759, 941		759, 94	1 6, 464	117.57	34.00
41.00 SUBPROVIDER – IRF	533, 891	0	533, 89	1 5, 248	101.73	41.00
43.00 NURSERY	75, 103		75, 10	3 3, 803	19.75	43.00
200.00 Total (lines 30 through 199)	9, 496, 275		9, 496, 27	5 123, 209		200.00
Cost Center Description	I npati ent	Inpati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS			1			
30.00 ADULTS & PEDIATRICS	21, 019					30.00
31.00 INTENSIVE CARE UNIT	2,684	93, 672				31.00
31.01 NEONATAL INTENSIVE CARE UNIT	0	0				31.01
32.00 CORONARY CARE UNIT	4,050					32.00
34.00 SURGI CAL INTENSI VE CARE UNI T	2,019	237, 374				34.00
41.00 SUBPROVIDER – IRF	2, 795	284, 335				41.00
43.00 NURSERY	0	0				43.00
200.00 Total (lines 30 through 199)	32, 567	2, 794, 216				200.00

Health Financial Systems F	RANCI SCAN HEALT	H INDIANAPOLIS		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT.	AL COSTS	Provider C		Period: From 01/01/2022 To 12/31/2022	Worksheet D Part II	pared:
	_		XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,	Part I, col.		. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS		-	1	1	-	
50.00 05000 OPERATING ROOM	2, 671, 939					
52.00 05200 DELIVERY ROOM & LABOR ROOM	838, 943					
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 688, 093					
55. 00 05500 RADI OLOGY-THERAPEUTI C	118, 837				2, 094	•
56. 00 05600 RADI 0I SOTOPE	36, 020					
59. 00 05900 CARDI AC CATHETERI ZATI ON	715, 115				68, 507	•
60. 00 06000 LABORATORY	753, 204	286, 396, 860				
64.00 06400 INTRAVENOUS THERAPY	331, 572					•
65. 00 06500 RESPI RATORY THERAPY	149, 428		0.0022			•
66. 00 06600 PHYSI CAL THERAPY	237, 958					•
67.00 06700 OCCUPATI ONAL THERAPY	8, 696				1, 531	
68.00 06800 SPEECH PATHOLOGY	3, 080	10, 893, 693	0.0002	33 1, 249, 176	354	68.00
69. 00 06900 ELECTROCARDI OLOGY	438, 647	44, 604, 045	0.0098	8, 935, 021	87, 867	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	6, 692	26, 635, 915	0.0002	51 2, 345, 268	589	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	349, 824	214, 687, 709	0.0016	29 50, 207, 732	81, 788	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	226, 482	175, 944, 341	0.0012	37 28, 387, 114	36, 534	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	356, 047	585, 915, 408	0.0006	08 50, 057, 923	30, 435	73.00
74.00 07400 RENAL DIALYSIS	113, 890	8, 506, 754	0.0133	38 3, 198, 960	42, 828	74.00
76. 97 07697 CARDI AC REHABI LI TATI ON	1, 815	4, 204, 988	0.0004	32 567	0	76.97
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	1, 957	35, 301, 310	0.0000	55 0	0	77.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	585, 625	17, 933, 145	0. 0326	56 126, 485	4, 130	90.00
90.01 09001 IBMT JOINT VENTURE	84, 258	11, 769, 455	0.0071	59 95, 856	686	90.01
90. 05 09005 CV DIAGNOSTIC SERVICES	6, 663	91, 737, 503	0.0000	73 23, 571	2	90.05
91.00 09100 EMERGENCY	1, 464, 156	335, 363, 795	0.0043	35, 497, 525	154, 982	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	909, 124	59, 259, 878	0. 0153	5, 183, 753	79, 524	92.00
200.00 Total (lines 50 through 199)	12, 098, 065	3, 076, 866, 115		359, 151, 139	1, 376, 030	200.00

Health Financial Systems	FRANCI SCAN HEALTH				eu of Form CMS-	2552-1
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER	PASS THROUGH COST		CN: 15-0162	Period: From 01/01/2022 To 12/31/2022	Worksheet D Part III Date/Time Pre 5/29/2023 3:2	epared: 2 pm
		Titl€	e XVIII	Hospi tal	PPS	
Cost Center Description	Nursing Program Post-Stepdown Adjustments	Nursi ng Program			All Other Medical Education Cost	
	1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	20	2.00	0.00	
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT 31. 01 02060 NEONATAL INTENSIVE CARE UNIT	0 0	(((-	31.0
32. 00 03200 CORONARY CARE UNIT 34. 00 03400 SURGI CAL INTENSI VE CARE UNIT 41. 00 04100 SUBPROVI DER – IRF	0 0 0					34.0
43.00 04300 NURSERY 200.00 Total (lines 30 through 199)	0	0		0 0	0	43.0
Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patier Days	t Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	200.0
	4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS 31. 00 03100 I NTENSI VE CARE UNI T	0	C C	19, 8	65 0.00	2, 684	31.0
31. 01 02060 NEONATAL INTENSIVE CARE UNIT 32. 00 03200 CORONARY CARE UNIT 34. 00 03400 SURGI CAL INTENSIVE CARE UNIT			0 7, 3 0 12, 2 0 6, 4	0.00	4, 050	32.0
43. 00 04100 SUBPROVI DER - I RF 43. 00 04300 NURSERY	0	((5, 2 5, 2 0 3, 8	48 0.00	2, 795	41. C
200.00 Total (lines 30 through 199)			123, 2	09	32, 567	200. 0
Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x <u>col. 8)</u> 9.00					
I NPATI ENT ROUTI NE SERVI CE COST CENTERS						
30.00 O3000 ADULTS & PEDIATRICS 31.00 03100 INTENSIVE CARE UNIT 31.01 02060 NEONATAL INTENSIVE CARE UNIT 32.00 03200 CORONARY CARE UNIT 34.00 03400 SURGICAL INTENSIVE CARE UNIT						30. C 31. C 31. C 32. C 34. C
41.00 04100 SUBPROVIDER - IRF 43.00 04300 NURSERY 200.00 Total (lines 30 through 199)	0 0 0					41.0 43.0 200.0

Health Financial Systems F	RANCI SCAN HEALT	H INDIANAPOLIS			In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF THROUGH COSTS	RVICE OTHER PASS			To 12	/01/2022 /31/2022	Worksheet D Part IV Date/Time Pre 5/29/2023 3:22	
		Title	XVIII	Hosp	bi tal	PPS	
Cost Center Description	Non Physician	Nursi ng	Nursi ng			Allied Health	
	Anesthetist Cost	Program	Program		Stepdown		
	COST	Post-Stepdown Adjustments		Adjus	stments		
	1.00	2A	2.00		3A	3.00	
ANCI LLARY SERVI CE COST CENTERS							
50. 00 05000 OPERATI NG ROOM	0	0		0	0	164, 709	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0	0	0	52.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0	0	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0	1	0	0	0	55.00
56. 00 05600 RADI OI SOTOPE	0	0	1	0	0	0	56.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0	0	0	59.00
60. 00 06000 LABORATORY	0	0		0	0	159, 186	60.00
64.00 06400 I NTRAVENOUS THERAPY	0	0		0	0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0	0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0	0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0	0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0	0	0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	394, 313	73.00
74.00 07400 RENAL DIALYSIS	0	0		0	0	0	74.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		0	0	0	76.97
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	0		0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS		-		_	-	-	
90. 00 09000 CLINIC	0	0		0	0	0	90.00
90. 01 09001 I BMT JOI NT VENTURE	0	0		0	0	0	90.01
90. 05 09005 CV DI AGNOSTI C SERVI CES	0	0		U	0	0	90.05
91.00 09100 EMERGENCY	0	0		U	0	439, 353	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 200.00 Total (lines 50 through 199)	0	0		0	~	0 1 157 541	92.00
200.00 Total (lines 50 through 199)	I U	0	I	V	0	1, 157, 561	200.00

Health Financial Systems F	RANCISCAN HEALT	H INDIANAPOLIS		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PASS	S Provider C		Period:	Worksheet D	
THROUGH COSTS				From 01/01/2022 To 12/31/2022		narod
				10 12/31/2022	5/29/2023 3: 2	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,		
	Education Cost		Cost (sum of		(col. 5 ÷ col.	
		4)	col s. 2, 3,	8)	7)	
			and 4)		(see	
	4.00	5.00	6.00	7.00	instructions) 8.00	
ANCI LLARY SERVI CE COST CENTERS	4.00	5.00	0.00	7.00	8.00	
50. 00 05000 OPERATING ROOM	0	164, 709	164, 70	9 334, 384, 097	0. 000493	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	04,707		50, 798, 041	0.000000	•
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0			0 322, 124, 936		•
55. 00 05500 RADI OLOGY-THERAPEUTI C	0			0 89, 116, 059		•
56. 00 05600 RADI OI SOTOPE	0	0		0 9, 295, 714	0. 000000	•
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 175, 118, 428		•
60. 00 06000 LABORATORY	0	159, 186	159, 18			•
64. 00 06400 I NTRAVENOUS THERAPY	0	0		45, 183, 984		
65. 00 06500 RESPI RATORY THERAPY	0	0		66, 839, 341	0. 000000	
66. 00 06600 PHYSI CAL THERAPY	0	0		47, 378, 809		
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 27, 471, 907	0. 000000	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0 10, 893, 693	0. 000000	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 44, 604, 045	0. 000000	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 26, 635, 915	0. 000000	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 214, 687, 709	0. 000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 175, 944, 341	0. 000000	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	394, 313	394, 31			
74.00 07400 RENAL DIALYSIS	0	0		0 8, 506, 754	0. 000000	•
76. 97 07697 CARDI AC REHABI LI TATI ON	0	-		0 4, 204, 988		•
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	0		0 35, 301, 310	0.00000	77.00
OUTPATIENT SERVICE COST CENTERS			1			-
90. 00 09000 CLINIC	0	0		0 17, 933, 145		
90. 01 09001 I BMT JOI NT VENTURE	0	0		0 11, 769, 455		•
90. 05 09005 CV DI AGNOSTI C SERVI CES	0	0		0 91, 737, 503		
91.00 09100 EMERGENCY	0	439, 353				
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0			0 59, 259, 878		•
200.00 Total (lines 50 through 199)	0	1, 157, 561	1, 157, 56	1 3, 076, 866, 115		200. 00

Health Financial Systems F	RANCI SCAN HEALTH	I NDI ANAPOLI S		In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	VICE OTHER PASS	Provider C	CN: 15-0162	Peri od:	Worksheet D	
THROUGH COSTS				From 01/01/2022		
				To 12/31/2022	Date/Time Pre 5/29/2023 3:2	pared: 2 nm
		Title	XVIII	Hospi tal	PPS	<u>z piii</u>
Cost Center Description	Outpati ent	Inpatient	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through	n Charges	Pass-Through	
	(col. 6 ÷ col.		Costs (col.	8	Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCI LLARY SERVI CE COST CENTERS	1		1		I	
50. 00 05000 OPERATI NG ROOM	0. 000493	54, 265, 573				50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	58, 175		0 4, 731		52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	33, 057, 526		0 46, 788, 028		54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000	1, 569, 921		0 27, 097, 518		55.00
56. 00 05600 RADI OI SOTOPE	0. 000000	1, 053, 874		0 800, 212		56.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	16, 774, 391		0 30, 327, 128		59.00
60. 00 06000 LABORATORY	0. 000556	40, 970, 360				60.00
64.00 06400 INTRAVENOUS THERAPY	0. 000000	52, 390		0 9, 773, 093		64.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	15, 209, 165		0 2, 231, 818		65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	6, 000, 286		0 108, 541	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000	4, 830, 527		0 35, 918		67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	1, 249, 176		0 43, 768		68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	8, 935, 021		0 6, 261, 063		69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	2, 345, 268		0 2, 460, 439	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	50, 207, 732		0 36, 337, 660	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	28, 387, 114		0 13, 096, 660	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000673	50, 057, 923				73.00
74.00 07400 RENAL DIALYSIS	0. 000000	3, 198, 960		0 275, 134	0	74.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000	567		0 1, 269, 977	0	76.97
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0. 000000	0		0 0	0	77.00
OUTPATIENT SERVICE COST CENTERS					1	
90. 00 09000 CLINIC	0. 000000	126, 485		0 1, 258, 301	0	90.00
90.01 09001 IBMT JOINT VENTURE	0. 000000	95, 856		0 1, 960, 999	0	90. 01
90. 05 09005 CV DIAGNOSTIC SERVICES	0. 000000	23, 571		0 26, 890, 401		90.05
91. 00 09100 EMERGENCY	0. 001310	35, 497, 525				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	5, 183, 753		0 1, 539, 794		92.00
200.00 Total (lines 50 through 199)		359, 151, 139	129, 72	431, 792, 758	160, 297	200. 00

	RANCI SCAN HEALTI				u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	D VACCINE COST	Provider C	CN: 15-0162	Peri od:	Worksheet D Part V	
				From 01/01/2022 To 12/31/2022	Date/Time Pre	pared.
				10 12/01/2022	5/29/2023 3:2	
		Title	XVIII	Hospi tal	PPS	
			Charges		Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
		Services (see		Rei mbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins			
	1.00	2.00	(see inst.)	(see inst.)	5.00	
ANCI LLARY SERVI CE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
50. 00 05000 OPERATING ROOM	0. 094793	45, 189, 762	1	0 0	4, 283, 673	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0. 094793	43, 189, 782		0 0	4, 283, 873	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 072365	4, 731		1 0	3, 385, 816	
55. 00 05500 RADI OLOGY - DI AGNOSTI C	0. 072365	46, 788, 028 27, 097, 518			2, 808, 576	
56. 00 05600 RADIOLOGY-THERAPEOTIC	0. 042695	800, 212		0 0	2, 808, 576 34, 165	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 042895			0 0		
	0. 034328	30, 327, 128 10, 214, 020		0 0	1, 041, 070	
60. 00 06000 LABORATORY 64. 00 06400 I NTRAVENOUS THERAPY	0. 092119			0 0	1, 140, 058 900, 288	
	0. 238927	9, 773, 093		0 0		
		2, 231, 818		0 0	533, 242	
	0. 174389	108, 541		0 0	18, 928	
67. 00 06700 OCCUPATI ONAL THERAPY	0. 125071	35, 918		0 0	4, 492	
68. 00 06800 SPEECH PATHOLOGY	0. 123564	43, 768		0 0	5, 408	
69. 00 06900 ELECTROCARDI OLOGY	0.068302	6, 261, 063		0 0	427, 643	
70.00 07000 ELECTROENCEPHALOGRAPHY 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.092150	2, 460, 439		0 0	226, 729	
	0.266874	36, 337, 660			9, 697, 577	
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS 73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 226368 0. 147665	13, 096, 660		0 0 94 64, 893	2, 964, 665	
	0. 147865	137, 386, 527		04, 893	20, 287, 182	
		275, 134		0 0	46, 844	•
76. 97 07697 CARDIAC REHABILITATION 77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION	0. 173477 0. 289174	1, 269, 977 0		0 0	220, 312	
OUTPATIENT SERVICE COST CENTERS	0. 289174	0		0 0	0	17.00
90. 00 09000 CLINIC	0. 410793	1, 258, 301		0 0	516, 901	90.00
90. 01 09001 I BMT JOINT VENTURE	0. 334297	1, 960, 999		0 19, 336	655, 556	
90. 05 09005 CV DI AGNOSTI C SERVI CES	0. 132107	26, 890, 401		0 0	3, 552, 410	
91. 00 09100 EMERGENCY	0. 081232	30, 441, 266		0 0	2, 472, 805	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 212433	1, 539, 794		0 0	327, 103	
200.00 Subtotal (see instructions)		431, 792, 758		84, 229	55, 552, 143	
201.00 Less PBP Clinic Lab. Services-Program		,, ,		0 0	,, -10	201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)		431, 792, 758	96, 42	84, 229	55, 552, 143	202.00

Health Financial Systems Ff	RANCISCAN HEALT	H INDIANAPOLIS		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider CO		Peri od: From 01/01/2022 To 12/31/2022	Worksheet D Part V Date/Time Pre 5/29/2023 3:2	epared: 2 pm
		Title	XVIII	Hospi tal	PPS	
		sts				
Cost Center Description	Cost	Cost				
	Reimbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To Ded. & Coins.	Subject To Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7.00				
ANCI LLARY SERVI CE COST CENTERS	0.00	7.00				
50. 00 05000 OPERATING ROOM	0	0				50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0				52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0				54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0				55.00
56. 00 05600 RADI OI SOTOPE	0	0				56.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0				59.00
60. 00 06000 LABORATORY	0	0				60.00
64.00 06400 INTRAVENOUS THERAPY	0	0				64.00
65. 00 06500 RESPI RATORY THERAPY	0	0				65.00
66. 00 06600 PHYSI CAL THERAPY	0	0				66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0				67.00
68.00 06800 SPEECH PATHOLOGY	0	0				68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0				69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0				70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	194	0				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	14, 131	9, 582				73.00
74.00 07400 RENAL DIALYSIS	0	0				74.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0				76.97
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	0				77.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0	0				90.00
90. 01 09001 I BMT JOINT VENTURE	0	6, 464				90.01
90. 05 09005 CV DI AGNOSTI C SERVI CES	0	0				90.05
91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0				91.00 92.00
200.00 Subtotal (see instructions)	14, 325	16, 046				
200.00 Subtotal (see instructions) 201.00 Less PBP Clinic Lab. Services-Program	14, 325	10, 046				200.00
Only Charges						201.00
202.00 Net Charges (line 200 - line 201)	14, 325	16, 046				202.00

Health Financial Systems Fi	RANCI SCAN HEALT	H INDIANAPOLIS		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provider C	CN: 15-0162	Peri od:	Worksheet D	
		Component	CCN: 15-T162	From 01/01/2022 To 12/31/2022		narod
		Component	JUN. 13-1102	10 12/31/2022	5/29/2023 3:2	
		Title	XVIII	Subprovider -	PPS	
				I RF		
Cost Center Description	Capi tal	Total Charges			Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,		(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)			
	26)	2.00	2.00	4.00	F 00	
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	2, 671, 939	334, 384, 097	0.0079	69, 917	559	50.00
					559	
52. 00 05200 DELIVERY ROOM & LABOR ROOM	838, 943				-	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 688, 093					54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C 56. 00 05600 RADI OI SOTOPE	118, 837				0	55.00 56.00
	36, 020				29	56.00
	715, 115				-	60.00
60. 00 06000 LABORATORY 64. 00 06400 I NTRAVENOUS THERAPY	753, 204 331, 572				1, 838 55	
65. 00 06500 RESPIRATORY THERAPY						
66. 00 06600 PHYSI CAL THERAPY	149, 428 237, 958					66.00
67. 00 06700 OCCUPATI ONAL THERAPY	237, 958				610	•
68. 00 06800 SPEECH PATHOLOGY	3, 080				280	
69. 00 06900 ELECTROCARDI OLOGY	438, 647					69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	6, 692					70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	349, 824					71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	226, 482					72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	356, 047					73.00
74. 00 07400 RENAL DIALYSIS	113, 890					
76. 97 07697 CARDI AC REHABI LI TATI ON	1, 815				1,035	76.97
77. 00 07700 ALLOGENEI C STEM CELL ACQUI SI TI ON	1, 957				0	77.00
OUTPATIENT SERVICE COST CENTERS	1,757	35, 501, 510	0.0000	50 0	0	11.00
90. 00 09000 CLINIC	585, 625	17, 933, 145	0. 0326	56 0	0	90.00
90. 01 09001 I BMT JOINT VENTURE	84, 258				0	90.01
90. 05 09005 CV DI AGNOSTI C SERVI CES	6, 663				0	90.05
91. 00 09100 EMERGENCY	1, 464, 156					91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0				0	
200.00 Total (lines 50 through 199)	-	3, 076, 866, 115		7, 952, 794		

Health Financial Systems F	RANCI SCAN HEALT	H INDIANAPOLIS			In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEE	RVICE OTHER PAS	S Provider C	CN: 15-0162	Peri od:		Worksheet D	
THROUGH COSTS		Component	CCN: 15-T162		1/01/2022 2/31/2022		narod
		component	CCN. 15-1102	10 1.	2/ 31/ 2022	5/29/2023 3:2	2 pm
		Title	e XVIII	Subpro	ovider -	PPS	
					I RF		
Cost Center Description	Non Physician		Nursi ng			Allied Health	
	Anestheti st	Program	Program		Stepdown		
	Cost	Post-Stepdown		Adju	ustments		
	1.00	Adjustments 2A	2.00		3A	3, 00	
ANCI LLARY SERVI CE COST CENTERS	1.00	2A	2.00		SA	3.00	
50. 00 05000 OPERATING ROOM	0	0		0	0	164, 709	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0			0	0	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0	0	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0	0	0	55.00
56. 00 05600 RADI OI SOTOPE	0	0		0	0	0	56.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0)	0	0	0	59.00
60. 00 06000 LABORATORY	0	0		0	0	159, 186	60.00
64.00 06400 INTRAVENOUS THERAPY	0	0		0	0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0	0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0	0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0	0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0	0	0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0	0	0	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	394, 313	73.00
74.00 07400 RENAL DI ALYSI S	0	0		0	0	0	74.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		0	0	0	76.97
77. 00 07700 ALLOGENEI C STEM CELL ACQUI SI TI ON	0	0		0	0	0	77.00
0UTPATI ENT_SERVI CE_COST_CENTERS 90. 00 09000 CLI NI C	0	0		0	0	0	90.00
90. 00 09000 CLINIC 90. 01 09001 I BMT JOINT VENTURE	0			0	0	0	90.00
90. 05 09005 CV DI AGNOSTI C SERVI CES	0			0	0	0	90.01
91. 00 09100 EMERGENCY				0	0	439, 353	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0			0	0	437, 333	92.00
200.00 Total (lines 50 through 199)	0	0		0	0		
			1	-1	0	.,,	

APPORTIONMENT OF INPATIENT/AUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS Provider CCN: 15-0162 Component CCN: 15-1162 Poriot From 01/01/2022 To 12/31/2023 Worksheet D Part IV To 12/31/2023 Part IV To 12/31/2023	Health Financial Systems F	RANCI SCAN HEALT	H INDIANAPOLIS		In Lie	eu of Form CMS-:	2552-10
Annoolan Cost of a cost	APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEI	RVICE OTHER PASS	S Provider C				
ANCI LLARY SERVICE COST CENTERS Total Cost Total Cost Cost (Sum of Cost (S	THROUGH COSTS		Component				narod
Cost Center Description All Other (sum of cols. Education Cost) Total Cost (sum of cols. 1, 2, 3, and 4) Total Cost (sum of cols. 1, 2, 3, and 4) Total Charges (col. 5 + col. 8) Total Charges (col. 5 + col. 8) ANCILLARY SERVICE COST CENTERS 4.00 5.00 6.00 7.00 8.00 MACILLARY SERVICE COST CENTERS 0 <td></td> <td></td> <td>component</td> <td>JON. 15-1102</td> <td>10 12/31/2022</td> <td></td> <td></td>			component	JON. 15-1102	10 12/31/2022		
Cost Center Description All Other Medical Education Cost (sum of cols. 4) Total (sum of cols. 4) Total (sum of cols. cols. 4) Total (sum of cols. cols. and 4) Total (sum of cols. cols. and 4) Total (sum of cols. cols. and 4) Total (sum of cols. cols. and 4) Total (sum of cols. and 4) 50.00 65000 (socol PERATING ROOM 52.00 6.00 7.00 8.00 50.00 05000 (PERATING ROOM 600 RADIOLOGY-DIAGNOSTIC 0 0 164,709 164,709 334,384,097 0.000493 50.00 50.00 05200 DELIVERY ROM & LABOR ROOM 0 0 0 0 322,214,936 0.00000054.00 50.00 50.00 05500 RADIOLOGY-THERAPEUTIC 0 0 0 322,214,936 0.000000 55.00 60.00 05600 RADIOLOGY-THERAPEUTIC 0 0 0 9,295,714 0.000000 55.00 60.00 06000 LABORATORY 0 159,186 159,186 286,396,860 0.000000 54.00 60.00 06000 OHINTAVENDUS THERAPY 0 0 0 45,813,984 0.000000 64.00 64.00 0.000000			Title XVIII		Subprovider -		
ANCILLARY SERVICE COST CENTERS A.00 5.00 6.00 7.00 8.00 20.00 05000 0PERATI NG ROM 0 164,709 164,709 334,384,097 0.00000 5.00 5.00 5.00 5.000 5.00							
Education Cost 1, 2, 3, and Cost (sum of and 4) Part 1, col. (col. 5, -col. 8) (col. 5, -col. 7) (sum of instructions) 4.00 5.00 6.00 7.00 8.00 1 50.00 05000 0PERATI NG ROOM 0 164,709 164,709 334,384,097 0.000004 52.00 52.00 05200 DELI VERY ROOM & LABOR ROOM 0 0 0 322,124,936 0.000000 52.00 55.00 05000 RADI OLOCY-DI AGNOSTI C 0 0 0 322,124,936 0.000000 52.00 56.00 05000 RADI OLOCY-THERAPEUTI C 0 0 0 9,295,714 0.000000 56.00 59.00 05000 CARDI AC CATHETER IZATI ON 0 0 0 17,18,428 0.000000 56.00 64.00 06400 INTRAVENOUS THERAPY 0 159,186 159,186 286,339,693 0.000000 66.00 65.00 06600 PHYSI CAL THERAPY 0 0 0 17,378,809 0.000000 67.00 66.00 06	Cost Center Description						
ANCILLARY SERVICE COST CENTERS 4.00 5.00 6.00 7.00 8.00 50.00 05000 0PERATING ROOM 0 164,709 164,709 334,384,097 0.000493 50.00 52.00 052000 DELVERY ROM & LABOR ROOM 0 0 0 50.786,011 0.000000 54.00 52.00 05500 RADIOLOGY-THERAPEUTIC 0 0 0 322,124,936 0.000000 54.00 55.00 05500 RADIOLOGY-THERAPEUTIC 0 0 0 92,95,714 0.000000 55.00 50.00 05600 RADIOLOGY-THERAPEUTIC 0 0 0 175,118,428 0.000000 56.00 50.00 05600 RADIOLOGY-THERAPY 0 159,186 159,186 159,186 159,186,493,684 0.000000 56.00 60.00 06000 LABDARORY 0 159,186 159,186 159,186,393,684 0.000000 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>							
ANCILLARY SERVICE COST CENTERS 4.00 5.00 6.00 7.00 8.00 ANCILLARY SERVICE COST CENTERS 0 164,709 334,384,097 0.000493 50.00 52.00 05200 [DELIVERY ROM & LABOR ROM 0 164,709 334,384,097 0.000493 50.00 52.00 05200 [DELIVERY ROM & LABOR ROM 0 0 52,2124,936 0.000000 52.00 54.00 05500 RADI OLOGY-DI AGNOSTI C 0 0 0 32,2124,936 0.000000 55.00 55.00 05500 CARDI AC CATHETERI ZATI ON 0 0 175,118,428 0.000000 56.00 50.00 06000 LABORATORY 0 159,186 159,186 159,186 286,396,860 0.00056 60.00 66.00 0 0 27,471,907 0.000000 66.00 66,839,341 0.000000 66.00 66.00 66.000 66.00 66.00 66.00 66.00 66.00 66.000 66.00 66.00 66.00 66.00 66.00 66.00 66.00		Education Cost					
ANCI LLARY SERVICE COST CENTERS 6.00 7.00 8.00 50.00 05000 DPERATI NG ROOM 0 164,709 334,384,097 0.000493 50.00 52.00 052000 DELVERY ROOM & LABOR ROOM 0 0 50.796,841 0.000000 54.00 55.00,841 0.000000 54.00 55.00,841 0.000000 54.00 55.00 60.00 7.00 89,116,059 0.000000 54.00 55.00 60.00 0 0 0 0 0 0.000000 54.00 55.00 55.00 55.00 55.00 0.000000 54.00 0 0 0 0 0 0 0 0.000000 55.00 55.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 0 0 0 0 0 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 </td <td></td> <td></td> <td>4)</td> <td></td> <td>8)</td> <td></td> <td></td>			4)		8)		
ANCILLARY SERVICE COST CENTERS 0.00 05000 OPERATING ROM 0 164,709 134,384,097 0.000493 50.00 52.00 05200 DELIVERY ROOM & LABOR ROM 0 164,709 164,709 334,384,097 0.000493 50.00 54.00 05400 RADIOLOGY-DIAGNOSTIC 0 0 0 322,124,936 0.000000 54.00 55.00 05500 RADIOLOGY-THERAPEUTIC 0 0 0 89,116,059 0.000000 55.00 56.00 05500 CABTIAC CATHETER ZATION 0 0 0 175,118,428 0.000000 59,00 60.00 06000 LABORATORY 0 0 0 45,183,984 0.000000 66,00 64.00 OAGOO RESPI RATORY THERAPY 0 0 0 47,378,809 0.000000 66,00 66,00 66,00 66,00 66,00 66,00 66,00 66,00 66,00 66,00 66,00 66,00 66,00 66,00 66,00 66,00				and 4)			
ANCLILLARY SERVICE COST CENTERS 0 0 50.00 05000 [DERATING ROOM 0 164,709 164,709 334,384,097 0.000493 50.00 52.00 05200 [DELIVERY ROM & LABOR ROOM 0 0 0 0.000000 52.00 55.00 05500 [ADD IOCGY-THERAPEUTI C 0 0 0 0.000000 55.00 56.00 05600 [RADI IOGY-THERAPEUTI C 0 0 0 9,295,714 0.000000 56.00 59.00 05500 [CADI AC CATHETERI ZATI ON 0 0 0 175,118,428 0.000000 56.00 60.00 06000 [LABORATORY 0 159,186 159,186,286,96,860 0.000000 64.00 64.00 06400 [NTRAVENOUS THERAPY 0 0 0 45,183,984 0.000000 65.00 65.00 06500 [RSPI RATORY THERAPY 0 0 0 47,378,809 0.000000 66.00 64.00 06900 [ELECTROCARDI OLOGY 0 0 17,471,907 0.000000 68.00 65.		4.00	F 00	(00	7.00		
50.00 05000 0PERATI NC ROOM 0 164, 709 334, 384, 097 0.000493 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0 50.07 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 0 0 0 0 0 0 0.000000 51.00 52.00 55.00 05500 RADI OLOGY-THERAPEUTI C 0 0 0 9.295,714 0.000000 55.00 56.00 05600 CARDI AC CATHETERI ZATI ON 0 0 0 175,118,428 0.000000 59.00 60.00 06000 LABORATORY 0 159,186 159,186 286,396,860 0.000006 64.00 64.00 06400 INTRAVENOUS THERAPY 0 0 0 45,183,984 0.000000 65.00 66.00 06600 PHYSI CAL THERAPY 0 0 0 0 64.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00	ANCILLARY SERVICE COST CENTERS	4.00	5.00	6.00	7.00	8.00	
52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 50, 798, 041 0.000000 52.00 54.00 05400 RADI OLOGY - DI AGNOSTI C 0 0 322, 124, 936 0.000000 55.00 55.00 ROSON CADI OLOGY - THERAPEUTI C 0 0 0 99, 116, 059 0.000000 56.00 59.00 OSOOC RADI OLOGY - THERAPEUTI C 0 0 0 92, 95, 714 0.000000 56.00 59.00 OSOOC ARDI AC CATHETERI ZATI ON 0 0 175, 118, 428 0.000000 56.00 64.00 O6400 INTRAVENOUS THERAPY 0 0 0 45, 183, 984 0.000000 66.00 65.00 DESOU ESPI RATORY THERAPY 0 0 0 47, 378, 809 0.000000 66.00 66.00 OESOU OCULATI ONAL THERAPY 0 0 0 17, 378, 809 0.000000 66.00 67.00 O6700 OCULATI THERAPY 0 0 0 17, 378, 809 0.000000 67.00 68.00 OBSOU ESPI RATORY THERAPY 0 0 0		0	164 709	164 70	0 33/ 38/ 007	0.000493	50 00
54.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 322, 124, 936 0.000000 54.00 55.00 OS500 RADI OLOGY-THERAPEUTI C 0 0 0 89, 116, 059 0.000000 55.00 56.00 OS500 RADI OLOGY-THERAPEUTI C 0 0 0 9, 295, 714 0.000000 56.00 59.00 OS500 CARDI AC CATHETERI ZATI ON 0 0 0 9, 295, 714 0.000000 56.00 60.00 D6400 LABORATORY 0 159, 186 159, 186 286, 396, 860 0.00055 60.00 64.00 D6400 INTRAVENOUS THERAPY 0 0 0 45, 183, 984 0.000000 64.00 65.00 06500 RESPI RATORY THERAPY 0 0 0 47, 378, 809 0.000000 65.00 67.00 06700 0CCUPATI ONAL THERAPY 0 0 0 27, 471, 907 0.000000 67.00 69.00 D6900 ELECTROCARDI OLOGY 0 0 24, 682, 915 0.000000 71.00 70.00 07100 EL		0					
55.00 05500 RADI OLOGY-THERAPEUTI C 0 0 0 89, 116, 059 0.000000 55.00 56.00 05600 RADI OL SOTOPE 0 0 9, 295, 714 0.000000 56.00 59.00 05000 RADI AC CATHETERI ZATI ON 0 0 175, 118, 428 0.000000 59.00 60.00 06000 LABORATORY 0 159, 186 159, 186 286, 396, 860 0.00005 60.00 64.00 06400 INTRAVENOUS THERAPY 0 0 45, 183, 984 0.000000 65.00 65.00 06500 RESPI RATORY THERAPY 0 0 0 47, 378, 809 0.000000 66.00 66.00 06400 PHYSI CAL THERAPY 0 0 0 10, 893, 693 0.000000 68.00 67.00 06700 0CUPATI ONAL THERAPY 0 0 0 10, 893, 693 0.000000 68.00 69.00 06900 LECTROCARDI OLOGY 0 0 0 10, 893, 693 0.000000 69.00 70.00 07000 LECTROCARDI OLOGY 0 </td <td></td> <td>0</td> <td></td> <td></td> <td></td> <td></td> <td></td>		0					
56.00 05600 RADI 0I SOTOPE 0 0 9, 295, 714 0.000000 56.00 59.00 05900 CARDI AC CATHETERI ZATI 0N 0 0 0 175, 118, 428 0.000000 59.00 60.00 LABORATORY 0 159, 186 159, 186 286, 396, 860 0.000556 60.00 64.00 0.6400 INTRAVENOUS THERAPY 0 0 45, 183, 984 0.000000 64.00 65.00 06500 RESPI RATORY THERAPY 0 0 0 47, 378, 809 0.000000 65.00 66.00 06700 0CUPATI ONAL THERAPY 0 0 0 27, 71, 90 0.000000 66.00 67.00 06700 0CUPATI ONAL THERAPY 0 0 0 27, 71, 90 0.000000 68.00 69.00 06900 ELECTROCARDI OLOGY 0 0 0 26, 635, 915 0.000000 69.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 175, 944, 341 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS		0					
59.00 05900 CARDI AC CATHETERI ZATI ON 0 0 175, 118, 428 0.000000 59.00 60.00 06000 LABORATORY 0 159, 186 159, 186 286, 396, 860 0.000556 60.00 64.00 06000 INTRAVENOUS THERAPY 0 0 45, 183, 984 0.000000 64.00 65.00 06500 RESPI RATORY THERAPY 0 0 66, 839, 341 0.000000 66.00 66.00 06600 PHYSI CAL THERAPY 0 0 0 47, 378, 809 0.000000 66.00 67.00 0CCUPATI ONAL THERAPY 0 0 0 17, 471, 907 0.000000 67.00 68.00 06800 SPECTROCARDI OLOGY 0 0 0 10, 893, 693 0.000000 68.00 69.00 06900 ELECTROCARDI OLOGY 0 0 0 26, 635, 915 0.000000 71.00 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 0 26, 635, 915 0.000000 72.00 73.00 07300 RENAL DI ALYSIS 0		0					
60.00 LABORATORY 0 159, 186 159, 186 286, 396, 860 0.000556 60.00 64.00 06400 INTRAVENOUS THERAPY 0 0 45, 183, 984 0.00000 64.00 65.00 06500 RESPI RATORY THERAPY 0 0 0 66, 839, 341 0.000000 65.00 66.00 06600 PHYSI CAL THERAPY 0 0 0 47, 378, 809 0.000000 66.00 67.00 06700 OCUPATI ONAL THERAPY 0 0 0 47, 378, 809 0.000000 67.00 68.00 06800 SPECH PATHOLOGY 0 0 0 10, 893, 693 0.000000 69.00 69.00 06900 ELECTROCARDI OLOGY 0 0 0 26, 635, 915 0.000000 70.00 70.00 07200 I MEL. DEV. CHARGED TO PATI ENTS 0 0 175, 944, 341 0.000000 74.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 85, 915, 408 0.000007 74.00 74.00 07400 RENAL DI ALYSI S		0	0				
64.00 06400 INTRAVENOUS THERAPY 0 0 45, 183, 984 0.000000 64.00 65.00 06500 RESPI RATORY THERAPY 0 0 0 66, 839, 341 0.000000 65.00 66.00 06600 PHYSI CAL THERAPY 0 0 0 47, 378, 809 0.000000 66.00 67.00 0CCUPATI ONAL THERAPY 0 0 0 27, 471, 907 0.000000 66.00 68.00 06800 SPEECH PATHOLOGY 0 0 0 10, 933, 693 0.000000 68.00 69.00 06900 ELECTROCARDI OLOGY 0 0 0 26, 635, 915 0.000000 69.00 70.00 07000 ELECTROCARDI OLOGY 0 0 214, 687, 709 0.000000 71.00 71.00 O7100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 175, 94, 341 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 394, 313 394, 313 585, 915, 408 0.000007 73.00 74.00 07400 RENAL DI ALYSIS		0	159 186				
65.00 06500 RESPI RATORY THERAPY 0 0 66, 839, 341 0.000000 65.00 66.00 06600 PHYSI CAL THERAPY 0 0 0 47, 378, 809 0.000000 66.00 67.00 06700 0CCUPATI ONAL THERAPY 0 0 0 27, 471, 907 0.000000 67.00 68.00 06800 SPECH PATHOLOGY 0 0 0 10, 893, 693 0.000000 68.00 69.00 06900 ELECTROCARDI OLOGY 0 0 0 24, 643, 045 0.000000 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 24, 637, 709 0.000000 71.00 72.00 J7200 IMPL DEV. CHARGED TO PATI ENTS 0 0 175, 59, 915, 408 0.000007 73.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 394, 313 394, 313 594, 344 0.000000 74.00 74.00 07400 RENAL DI ALYSI S 0 0 0 35, 301, 310 0.000000 76.97 77.00 ACTO		0	-				
66.00 06600 PHYSI CAL THERAPY 0 0 47, 378, 809 0.000000 66.00 67.00 06700 0CCUPATI ONAL THERAPY 0 0 0 27, 471, 907 0.000000 67.00 68.00 06800 SPEECH PATHOLOGY 0 0 0 10, 893, 693 0.000000 68.00 69.00 06900 ELECTROCARDI OLOGY 0 0 0 44, 604, 045 0.000000 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 26, 635, 915 0.000000 70.00 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 0 175, 944, 341 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 394, 313 394, 313 585, 915, 408 0.000673 73.00 74.00 07400 RENAL DI ALYSI S 0 0 0 4, 204, 988 0.000000 74.00 75.970 CARDI AC REHABI LI TATI ON 0 0 0 35, 301, 310 0.000000 77.00 00.00 07400<		0	0				
67.00 06700 0CCUPATI ONAL THERAPY 0 0 0 27, 471, 907 0.000000 67.00 68.00 06800 SPEECH PATHOLOGY 0 0 0 10, 893, 693 0.000000 68.00 69.00 06900 ELECTROCARDI OLOGY 0 0 0 44, 604, 045 0.000000 69.00 70.00 07000 ELECTROCENCEPHALOGRAPHY 0 0 26, 635, 915 0.000000 70.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0 0 214, 687, 709 0.000000 72.00 73.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 394, 313 394, 313 585, 915, 408 0.000673 73.00 74.00 07400 RENAL DI ALYSIS 0 0 0 8, 506, 754 0.000000 74.00 76.97 CARDI AC REHABI LI TATI ON 0 0 0 35, 301, 310 0.000000 74.00 77.00 OLOGENT 0 0 0 17, 933, 145 0.000000 76.97 77.00 OLOGENT CE STEM CELL ACQUI SI TI ON 0		0	0				
68.00 06800 SPEECH PATHOLOGY 0 0 10, 893, 693 0.000000 68.00 69.00 06900 ELECTROCARDIOLOGY 0 0 0 44, 604, 045 0.000000 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 26, 635, 915 0.000000 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 214, 687, 709 0.000000 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 175, 944, 341 0.000007 72.00 73.00 07300 RENAL DIALYSIS 0 394, 313 394, 313 585, 915, 408 0.000007 74.00 74.00 07400 RENAL DIALYSIS 0 0 0 0 4, 204, 988 0.000000 74.00 76.97 07697 CARDIAC REHABILITATION 0 0 0 35, 301, 310 0.000000 77.00 000 09000 CLINIC 0 0 0 17, 933, 145 0.000000 90.01 90.01 090001 IBMT JO		0	0				
69.00 06900 ELECTROCARDIOLOGY 0 0 0 44,604,045 0.000000 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 26,635,915 0.000000 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 0 214,687,709 0.000000 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 175,944,341 0.000000 72.00 73.00 07300 RENAL DIALYSIS 0 394,313 394,313 585,915,408 0.000000 74.00 74.00 07400 RENAL DIALYSIS 0 0 0 8,506,754 0.000000 74.00 76.97 07697 CARDIAC REHABILITATION 0 0 0 4,204,988 0.000000 76.97 77.00 07700 ALLOGENEIC STEM CELL ACQUISITION 0 0 0 17,933,145 0.000000 90.00 90.01 09001 IBMT JOINT VENTURE 0 0 0 11,769,455 0.000000 90.01 90.05 090		0	0				
71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0 0 214, 687, 709 0.000000 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 175, 944, 341 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 394, 313 394, 313 585, 915, 408 0.000673 73.00 74.00 07400 RENAL DI ALYSI S 0 0 0 8, 506, 754 0.000000 74.00 76.97 07697 CARDI AC REHABI LI TATI ON 0 0 0 4, 204, 988 0.000000 76.97 77.00 0700 ALLOGENEIC STEM CELL ACQUI SI TI ON 0 0 0 35, 301, 310 0.000000 77.00 00 09000 CLI NI C 0 0 0 17, 933, 145 0.000000 90.01 90.00 09000 CLI NI C 0 0 0 17, 793, 145 0.000000 90.01 90.01 09001 IBMT JOI NT VENTURE 0 0 0 11, 769, 455 0.000000 90.05 91.00 <td< td=""><td></td><td>0</td><td>0</td><td></td><td></td><td></td><td></td></td<>		0	0				
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0 0 214, 687, 709 0.000000 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 175, 944, 341 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 394, 313 394, 313 585, 915, 408 0.000673 73.00 74.00 07400 RENAL DIALYSIS 0 0 0 8, 506, 754 0.000000 74.00 76.97 07607 CARDIA C REHABILITATION 0 0 0 4, 204, 988 0.000000 76.97 77.00 0700 ALLOGENEIC STEM CELL ACQUISITION 0 0 0 35, 301, 310 0.000000 77.00 00 09000 CLINIC 0 0 0 17, 933, 145 0.000000 90.01 90.01 09001 IBMT JOINT VENTURE 0 0 0 11, 769, 455 0.000000 90.01 90.05 09005 CV DI AGNOSTIC SERVICES 0 0 91, 737, 503 0.000000 90.05 91.00 0	70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 26, 635, 915	0. 000000	70.00
73.00 07300 DRUGS CHARGED TO PATIENTS 0 394, 313 394, 313 585, 915, 408 0.000673 73.00 74.00 07400 RENAL DI ALYSIS 0 0 0 8, 506, 754 0.000000 74.00 76.97 07697 CARDI AC REHABILITATION 0 0 0 4, 204, 988 0.000000 76.97 77.00 0700 ALLOGENEIC STEM CELL ACQUISITION 0 0 0 35, 301, 310 0.000000 77.00 0UTPATIENT SERVICE COST CENTERS 0 0 0 17, 933, 145 0.000000 90.00 90.00 09000 CLINIC 0 0 0 17, 933, 145 0.000000 90.00 90.01 09001 IBMT JOINT VENTURE 0 0 0 11, 769, 455 0.000000 90.05 90.02 09005 CV DI AGNOSTIC SERVICES 0 0 91, 737, 503 0.000000 90.05 91.00 09100 EMERGENCY 0 439, 353 439, 353 335, 363, 795 0.001310 91.00 92.00 09200 OBSERVATI ON B	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0				71.00
74. 00 07400 RENAL DI ALYSI S 0 0 0 8, 506, 754 0.000000 74. 00 76. 97 07697 CARDI AC REHABI LI TATI ON 0 0 0 4, 204, 988 0.000000 76. 97 77. 00 07700 ALLOGENEI C STEM CELL ACQUI SI TI ON 0 0 0 35, 301, 310 0.000000 77. 00 OUTPATI ENT SERVICE COST CENTERS 90. 00 09000 CLI NI C 0 0 0 17, 933, 145 0.000000 90. 00 90. 01 09001 I BMT JOI NT VENTURE 0 0 0 11, 769, 455 0.000000 90. 01 90. 05 09005 CV DI AGNOSTI C SERVI CES 0 0 91, 737, 503 0.000000 90. 05 91. 00 09100 EMERGENCY 0 439, 353 439, 353 335, 363, 795 0.001310 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0 0 59, 259, 878 0.000000 92. 00	72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 175, 944, 341	0. 000000	72.00
76. 97 07697 CARDI AC REHABILITATION 0 0 4, 204, 988 0.000000 76. 97 77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION 0 0 0 35, 301, 310 0.000000 77. 00 0UTPATI ENT SERVICE COST CENTERS 0 0 0 0 0 0 90. 00 90. 00 90. 00 90. 00 90. 00 90. 00 90. 00 90. 00 0 0 90. 00 90. 00 90. 00 90. 00 90. 00 90. 00 90. 01 90. 01 90. 01 90. 01 90. 01 90. 01 90. 02 0 90. 01 90. 01 90. 01 90. 01 90. 01 90. 01 90. 01 90. 01 90. 02 90. 01 90. 01 90. 01 90. 01 90. 01 90. 01 90. 01 90. 01 90. 01 90. 01 90. 01 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 92. 00 92. 00 0 0 0 92.	73.00 07300 DRUGS CHARGED TO PATIENTS	0	394, 313	394, 31	3 585, 915, 408	0. 000673	73.00
77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION 0 0 35, 301, 310 0.000000 77. 00 0UTPATI ENT SERVICE COST CENTERS 0 0 0 0 0, 00000 0 17, 933, 145 0.000000 90. 00 90. 00 90. 00 11, 769, 455 0.000000 90. 01 90. 01 9000 CLINIC 0 0 0 11, 769, 455 0.000000 90. 01 90. 05 9005 CV DI AGNOSTI C SERVICES 0 0 91, 737, 503 0.000000 90. 01 91. 00 91.00 9100 EMERGENCY 0 439, 353 439, 353 335, 363, 795 0.001310 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART 0 0 0 59, 259, 878 0.000000 92. 00	74.00 07400 RENAL DIALYSIS	0	0		0 8, 506, 754	0. 000000	74.00
OUTPATI ENT SERVICE COST CENTERS 90.00 09000 CLINIC 0 0 17, 933, 145 0.000000 90.00 90.01 09001 I BMT JOINT VENTURE 0 0 011, 769, 455 0.000000 90.01 90.05 09005 CV DI AGNOSTI C SERVICES 0 0 0 91, 737, 503 0.000000 90.05 91.00 09100 EMERGENCY 0 439, 353 439, 353 335, 363, 795 0.001310 91.00 92.00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART 0 0 0 59, 259, 878 0.000000 92.00	76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		0 4, 204, 988	0. 000000	76.97
90. 00 09000 CLINIC 0 0 0 17, 933, 145 0.00000 90. 00 90. 01 09001 I BMT JOINT VENTURE 0 0 0 11, 769, 455 0.000000 90. 01 90. 05 09005 CV DI AGNOSTI C SERVICES 0 0 0 91, 737, 503 0.000000 90. 05 91. 00 09100 EMERGENCY 0 439, 353 439, 353 335, 363, 795 0.001310 91. 00 92. 00 09200 DBSERVATI ON BEDS (NON-DI STINCT PART 0 0 0 59, 259, 878 0.000000 92. 00	77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	0		0 35, 301, 310	0. 000000	77.00
90. 01 09001 I BMT_JOINT_VENTURE 0 0 11, 769, 455 0.000000 90. 01 90. 05 09005 CV_DIAGNOSTIC_SERVICES 0 0 0 91, 737, 503 0.000000 90. 05 91. 00 09100 EMERGENCY 0 439, 353 439, 353 335, 363, 795 0.001310 91. 00 92. 00 09200 OBSERVATION_BEDS_(NON-DISTINCT_PART) 0 0 0 59, 259, 878 0.000000 92. 00	OUTPATIENT SERVICE COST CENTERS						
90. 05 09005 CV_DIAGNOSTIC_SERVICES 0 0 91, 737, 503 0. 00000 90. 05 91. 00 09100 EMERGENCY 0 439, 353 439, 353 335, 363, 795 0. 001310 91. 00 92. 00 09200 OBSERVATION_BEDS_(NON-DISTINCT_PART) 0 0 0 59, 259, 878 0. 000000 92. 00	90. 00 09000 CLINIC	0	0		0 17, 933, 145	0.000000	90.00
91.00 09100 EMERGENCY 0 439,353 439,353 335,363,795 0.001310 91.00 92.00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART 0 0 0 59,259,878 0.000000 92.00		0	0		0 11, 769, 455	0.000000	
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0 0 0 59, 259, 878 0. 000000 92. 00		0	0				
		0	439, 353	439, 35			
200.00 Total (Lines 50 through 199) 0 1, 157, 561 1, 157, 561 3, 076, 866, 115 200, 00		0	0				
	200.00 Total (lines 50 through 199)	0	1, 157, 561	1, 157, 56	1 3, 076, 866, 115		200. 00

Health Financial Systems F	RANCI SCAN HEALTH	I NDI ANAPOLI S		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEP	RVICE OTHER PASS	Provider CO	CN: 15-0162	Peri od:	Worksheet D	
THROUGH COSTS				From 01/01/2022		
		Component (CCN: 15-T162	To 12/31/2022	Date/Time Pre 5/29/2023 3:22	pared: 2 pm
		Title	XVIII	Subprovider -	PPS	
				I RF		
Cost Center Description	Outpati ent	Inpati ent	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through		Pass-Through	
	(col. 6 ÷ col.		Costs (col.	8	Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCI LLARY SERVI CE COST CENTERS						
50.00 ODERATING ROOM	0. 000493	69, 917	3	34 0		50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0 0	-	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	206, 535		0 0	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000	0		0 0	0	55.00
56. 00 05600 RADI OI SOTOPE	0. 000000	7, 552		0 0	0	56.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	0		0 0	0	59.00
60. 00 06000 LABORATORY	0. 000556	698, 987	38	39 0	0	60.00
64.00 06400 INTRAVENOUS THERAPY	0. 000000	7, 496		0 0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	353, 213		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	2,067,068		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000	1, 925, 186		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	989, 004		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	45, 843		0 0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	4, 280		0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	800, 530		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	5, 839		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000673	643, 510	43	33 0	0	73.00
74.00 07400 RENAL DIALYSIS	0. 000000	122, 148		0 0	0	74.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000	0		0 0	0	76.97
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0. 000000	0		0 0	0	77.00
OUTPATIENT SERVICE COST CENTERS	· · · ·					
90. 00 09000 CLINIC	0.000000	0		0 1, 128	0	90.00
90.01 09001 IBMT JOINT VENTURE	0. 000000	0		0 0	0	90.01
90. 05 09005 CV DI AGNOSTI C SERVI CES	0. 000000	0		0 0	0	90.05
91.00 09100 EMERGENCY	0.001310	5, 686		7 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	0		0 0	0	92.00
200.00 Total (lines 50 through 199)		7,952,794	86	1, 128	0	200. 00

	ncial Systems F TT OF MEDICAL, OTHER HEALTH SERVICES AND		H INDIANAPOLIS		Peri od:	u of Form CMS- Worksheet D	2002-10
	INT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST		511. 13-0102	From 01/01/2022	Part V	
			Component (CCN: 15-T162	To 12/31/2022	Date/Time Pre	epared:
						5/29/2023 3:2	22 pm
			Title	XVIII	Subprovider - IRF	PPS	
				Charges		Costs	
	Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
	·		Services (see	Reimbursed	Reimbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins			
				(see inst.)	(see inst.)		
		1.00	2.00	3.00	4.00	5.00	
	LLARY SERVICE COST CENTERS						
	O OPERATING ROOM	0. 094793	0		0 0	0	
	O DELIVERY ROOM & LABOR ROOM	0. 147984	0		0 0	0	52.00
54.00 05400	0 RADI OLOGY-DI AGNOSTI C	0. 072365	0		0 0	0	54.00
55.00 05500	0 RADI OLOGY-THERAPEUTI C	0. 103647	0		0 0	0	55.00
56.00 05600	0 RADI OI SOTOPE	0. 042695	0		0 0	0	56.00
59.00 05900	O CARDI AC CATHETERI ZATI ON	0. 034328	0		0 0	0	59.00
60.00 06000	0 LABORATORY	0. 111617	0		0 0	0	60.00
64.00 06400	O INTRAVENOUS THERAPY	0. 092119	0		0 0	0	64.00
65.00 06500	RESPI RATORY THERAPY	0. 238927	0		0 0	0	65.00
66.00 06600	O PHYSI CAL THERAPY	0. 174389	0		0 0	0	66.00
67.00 06700	O OCCUPATIONAL THERAPY	0. 125071	0		0 0	0	67.00
68.00 06800	SPEECH PATHOLOGY	0. 123564	0		0 0	0	68.00
69.00 06900	ELECTROCARDI OLOGY	0.068302	0		0 0	0	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0.092150	0		0 0	0	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0. 266874	0		0 0	0	71.00
	O IMPL. DEV. CHARGED TO PATIENTS	0. 226368	0		0 0	0	72.00
	O DRUGS CHARGED TO PATIENTS	0. 147665	0		0 625	0	73.00
	O RENAL DIALYSIS	0. 170260	0		0 0	0	
	7 CARDI AC REHABI LI TATI ON	0. 173477	0		0 0	0	
	O ALLOGENEI C STEM CELL ACQUI SI TI ON	0. 289174	0		0 0	0	
	ATIENT SERVICE COST CENTERS	01207171					
		0. 410793	1, 128		0 0	463	90.00
	1 I BMT JOINT VENTURE	0. 334297	0		0 0	0	
	5 CV DI AGNOSTI C SERVI CES	0. 132107	0		0 0	0	
	0 EMERGENCY	0. 081232	0		0 0	0	
	O OBSERVATION BEDS (NON-DISTINCT PART	0. 212433	0		0 0	0	
200.00	Subtotal (see instructions)	0.212400	1, 128		0 625		200.00
200.00	Less PBP Clinic Lab. Services-Program		1, 120		0 025	403	201.00
201 00							
201.00	Only Charges				0		201.00

Health Financial Systems F	RANCI SCAN HEALTI	H INDIANAPOLIS		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	O VACCINE COST	Provider CO	CN: 15-0162 CCN: 15-T162	Period: From 01/01/2022 To 12/31/2022	Worksheet D Part V Date/Time Pre 5/29/2023 3:2	
		Title	XVIII	Subprovider - IRF	PPS	
	Cos				·	
Cost Center Description	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.) 6.00	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.) 7.00				
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATI NG ROOM 52.00 05200 DELI VERY ROOM & LABOR ROOM 54.00 05400 RADI OLOGY-DI AGNOSTI C 55.00 05500 RADI OLOGY-THERAPEUTI C 56.00 05600 RADI OLOGY-THERAPEUTI C 56.00 05600 RADI OLOGY-THERAPEUTI C 50.00 05900 CARDI AC CATHETERI ZATI ON 60.00 06000 LABORATORY 64.00 06400 I NTRAVENOUS THERAPY 65.00 06500 RESPI RATORY THERAPY 66.00 06600 PHYSI CAL THERAPY 66.00 06700 OCCUPATI ONAL THERAPY 68.00 06800 SPEECH PATHOLOGY 69.00 06900 ELECTROCARDI OLOGY 70.00 07000 ELECTROCARDI OLOGY 70.00 07000 ELECTROCARDI OLOGY 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 73.00 07300 DRUGS CHARGED TO PATI ENTS 74.00		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				$\begin{array}{c} 50.\ 00\\ 52.\ 00\\ 54.\ 00\\ 55.\ 00\\ 59.\ 00\\ 60.\ 00\\ 64.\ 00\\ 65.\ 00\\ 65.\ 00\\ 66.\ 00\\ 67.\ 00\\ 68.\ 00\\ 69.\ 00\\ 70.\ 00\\ 71.\ 00\\ 72.\ 00\\ 71.\ 00\\ 74.\ 00\\ 74.\ 00\\ 76.\ 97\\ \end{array}$
77. 00 07700 ALLOGENEI C STEM CELL ACQUI SI TI ON	0	0				77.00
OUTPATIENT SERVICE COST CENTERS 90.00 O9000 CLINIC 90.01 09001 IBMT JOINT VENTURE 90.05 09005 CV DIAGNOSTIC SERVICES 91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 200.00 Subtotal (see instructions) 201.00 Less PBP Clinic Lab. Services-Program Only Charges 202.00 Net Charges (line 200 - line 201)		0 0 0 0 92 92				90.00 90.01 90.05 91.00 92.00 200.00 201.00

Health Financial Systems	FRANCISCAN HEALT	H INDIANAPOLIS	i	In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPIT	AL COSTS	Provider C	-	Period: From 01/01/2022 To 12/31/2022	Date/Time Pre 5/29/2023 3:2	
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,	-	Related Cost			
	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	5, 467, 309	0	5, 467, 30	9 68, 323	80.02	30.00
31.00 INTENSIVE CARE UNIT	693, 318		693, 31	8 19, 865	34.90	31.00
31.01 NEONATAL INTENSIVE CARE UNIT	469, 410		469, 41	7, 302	64.29	31.01
32.00 CORONARY CARE UNI T	1, 497, 303		1, 497, 30	3 12, 204	122.69	32.00
34.00 SURGI CAL I NTENSI VE CARE UNI T	759, 941		759, 94	1 6, 464	117.57	34.00
41.00 SUBPROVIDER - IRF	533, 891	0	533, 89	1 5, 248	101.73	41.00
43.00 NURSERY	75, 103		75, 10	3 3, 803	19.75	43.00
200.00 Total (lines 30 through 199)	9, 496, 275		9, 496, 27	5 123, 209		200.00
Cost Center Description	I npati ent	Inpatient				
	Program days	Program				
	0 9	Capital Cost				
		(col. 5 x col.				
		6)				
	6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	604	48, 332				30.00
31.00 INTENSIVE CARE UNIT	337	11, 761				31.00
31.01 NEONATAL INTENSIVE CARE UNIT	49	3, 150				31.01
32.00 CORONARY CARE UNI T	84	10, 306	,			32.00
34.00 SURGICAL INTENSIVE CARE UNIT	47	5, 526	,			34.00
41.00 SUBPROVIDER - IRF	0	0				41.00
43.00 NURSERY	189					43.00
200.00 Total (lines 30 through 199)	1, 310	82, 808	1			200. 00

Health Financial Systems F	RANCI SCAN HEALT	H INDIANAPOLIS		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT	AL COSTS	Provider C		Period: From 01/01/2022 To 12/31/2022	Date/Time Pre 5/29/2023 3:2	
			e XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,	Part I, col.	(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATING ROOM	2, 671, 939					
52.00 05200 DELIVERY ROOM & LABOR ROOM	838, 943	50, 798, 041	0. 0165	15 2, 710, 220	44, 759	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 688, 093	322, 124, 936	0.0052	40 2, 557, 182	13, 400	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	118, 837	89, 116, 059	0.0013	34 22, 921	31	55.00
56. 00 05600 RADI OI SOTOPE	36, 020	9, 295, 714	0.0038	75 33, 289	129	56.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	715, 115	175, 118, 428	0.0040	913, 705	3, 732	59.00
60. 00 06000 LABORATORY	753, 204	286, 396, 860	0.0026	30 3, 918, 538	10, 306	60.00
64.00 06400 I NTRAVENOUS THERAPY	331, 572	45, 183, 984	0.0073	38 151, 066	1, 109	64.00
65. 00 06500 RESPI RATORY THERAPY	149, 428	66, 839, 341	0.0022	36 1, 470, 114	3, 287	65.00
66. 00 06600 PHYSI CAL THERAPY	237, 958	47, 378, 809	0.0050	22 373, 410	1, 875	66.00
67.00 06700 OCCUPATI ONAL THERAPY	8, 696	27, 471, 907	0.0003	17 294, 387	93	67.00
68.00 06800 SPEECH PATHOLOGY	3, 080	10, 893, 693	0.0002	33 70, 867	20	68.00
69. 00 06900 ELECTROCARDI OLOGY	438, 647	44, 604, 045	0.0098	658, 572	6, 476	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	6, 692	26, 635, 915	0.0002	51 156, 372	39	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	349, 824	214, 687, 709	0.0016	5, 348, 719	8, 713	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	226, 482	175, 944, 341	0.0012	37 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	356, 047	585, 915, 408	0.0006	3, 916, 029	2, 381	73.00
74.00 07400 RENAL DIALYSIS	113, 890	8, 506, 754	0. 0133	38 121, 814	1, 631	74.00
76. 97 07697 CARDI AC REHABI LI TATI ON	1, 815	4, 204, 988	0.00043	32 2, 273	1	76.97
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	1, 957	35, 301, 310	0.0000	55 0	0	77.00
OUTPATIENT SERVICE COST CENTERS		•	•			
90. 00 09000 CLINIC	585, 625	17, 933, 145	0. 0326	56 51, 695	1, 688	90.00
90. 01 09001 I BMT JOINT VENTURE	84, 258	11, 769, 455	0.0071	59 0	0	90.01
90. 05 09005 CV DI AGNOSTI C SERVI CES	6, 663	91, 737, 503	0.0000	73 8, 077	1	90.05
91.00 09100 EMERGENCY	1, 464, 156				10, 310	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	909, 124					
200.00 Total (lines 50 through 199)	12, 098, 065	3, 076, 866, 115		28, 498, 690	136, 944	200. 00

ealth Financial Systems	FRANCI SCAN HEALTH				eu of Form CMS-	2552-
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER	PASS THROUGH COST:	S Provider C	CN: 15-0162	Period: From 01/01/2022 To 12/31/2022	Worksheet D Part III Date/Time Pre 5/29/2023 3:2	pared 2 pm
			e XIX	Hospi tal	PPS	
Cost Center Description	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Healt Post-Stepdow Adjustments		All Other Medical Education Cost	
	1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS			2.11	2100	0.00	
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT 31. 01 02060 NEONATAL INTENSIVE CARE UNIT	0 0 0	(((0 0 0 0 0 0	, °	31.0
32. 00 03200 CORONARY CARE UNIT 34. 00 03400 SURGICAL INTENSIVE CARE UNIT 11. 00 04100 SUBPROVIDER - IRF	0 0 0	(((0 0 0 0 0 0	0 0 0	34.0
13.00 04300 NURSERY 200.00 Total (lines 30 through 199)	0	(0 0	0	43. 0 200. 0
Cost Center Description	Amount (see	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patien Days	t Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	200.0
	4.00	5.00	6.00	7.00	8.00	
INPATI ENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 31.00 03100 INTENSIVE CARE UNIT 31.01 02060 NEONATAL INTENSIVE CARE UNIT 32.00 03200 CORONARY CARE UNIT 34.00 03400 SURGICAL INTENSIVE CARE UNIT 31.01 04000 SUBPROVIDER - IRF 33.00 04300 NURSERY 200.00 Total (lines 30 through 199)	0		19, 80 7, 30 12, 20 6, 40 5, 20 3, 80	55 0.00 02 0.00 04 0.00 64 0.00 18 0.00 03 0.00	337 49 84 47 0	31.0 31.0 32.0 34.0 41.0 43.0
Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x <u>col. 8)</u> 9.00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS 31.00 03100 INTENSIVE CARE UNIT 32.00 02060 NEONATAL INTENSIVE CARE UNIT 32.00 03200 CORONARY CARE UNIT 34.00 03400 SURGICAL INTENSIVE CARE UNIT 34.00 04100 SUBPROVIDER - IRF 30.00 04300 NURSERY						30. (31. (31. (32. (34. (41. (43. (
200.00 Total (lines 30 through 199)	0					200.

Health Financial Systems F	RANCI SCAN HEALTH	I NDI ANAPOLI S			In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SET THROUGH COSTS	RVICE OTHER PASS	Provider CO		To 1	1/01/2022 2/31/2022	5/29/2023 3:2	pared: 2 pm
		Titl	e XIX		spi tal	PPS	
Cost Center Description		Nursing Program Post-Stepdown Adjustments	Nursing Program	Post	-Stepdown ustments	Allied Health	
	1.00	2A	2.00		3A	3.00	
ANCILLARY SERVICE COST CENTERS			·				
50.00 05000 0PERATING ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM 54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0 0		0 0	0 0	164, 709 0 0	50.00 52.00 54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0	0	0	55.00
56. 00 05600 RADI OI SOTOPE	0	0		0	0	0	56.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0	0	0	59.00
60. 00 06000 LABORATORY	0	0		0	0	159, 186	60.00
64. 00 06400 I NTRAVENOUS THERAPY	0	0		0	0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0	0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0	0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0	0	0	68,00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0	0	0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	394, 313	73.00
74.00 07400 RENAL DIALYSIS	0	0		0	0	0	74.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		0	0	0	76.97
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	0		0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS							
90. 00 09000 CLI NI C	0	0		0	0	0	90.00
90.01 09001 I BMT JOINT VENTURE	0	0		0	0	0	90.01
90. 05 09005 CV DI AGNOSTI C SERVI CES	0	0		0	0	0	90.05
91. 00 09100 EMERGENCY	0	0		0	0	439, 353	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	-		0	-	0	92.00
200.00 Total (lines 50 through 199)	0	0		0	0	1, 157, 561	

Health Financial Systems F	RANCI SCAN HEALT	H INDIANAPOLIS		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PASS	S Provider C		Period:	Worksheet D	
THROUGH COSTS				From 01/01/2022 To 12/31/2022	Part IV Date/Time Pre	narad
				10 12/31/2022	5/29/2023 3:2	2 pm
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,		
	Education Cost		Cost (sum of		(col. 5 ÷ col.	
		4)	cols. 2, 3,	8)	7)	
			and 4)		(see	
	1.00	F 00	(00	7.00	instructions)	
	4.00	5.00	6.00	7.00	8.00	
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM	0	1(4, 700	164, 70	334, 384, 097	0. 000493	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	164, 709			0. 000493	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0			50, 798, 041 322, 124, 936		
55. 00 05500 RADI OLOGY-THERAPEUTI C	0			89, 116, 059		
56. 00 05600 RADI OLOGI - MERAPEUTI C	0			9, 295, 714	0. 000000	•
59. 00 05900 CARDI AC CATHETERI ZATI ON	0			175, 118, 428	0. 000000	
60. 00 06000 LABORATORY	0	159, 186			0. 000556	
64. 00 06400 INTRAVENOUS THERAPY	0	0		45, 183, 984	0.000000	
65. 00 06500 RESPIRATORY THERAPY	0			66, 839, 341	0. 000000	
66. 00 06600 PHYSI CAL THERAPY	0			47, 378, 809	0. 000000	
67. 00 06700 OCCUPATI ONAL THERAPY	0	0		27, 471, 907	0. 000000	•
68. 00 06800 SPEECH PATHOLOGY	0	0		10, 893, 693	0. 000000	
69. 00 06900 ELECTROCARDI OLOGY	0	0		44, 604, 045	0. 000000	
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		26, 635, 915	0.000000	•
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		214, 687, 709	0.000000	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 175, 944, 341	0. 000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	394, 313	394, 31	3 585, 915, 408	0. 000673	73.00
74.00 07400 RENAL DIALYSIS	0	0		8, 506, 754	0. 000000	74.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		4, 204, 988	0.00000	76.97
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	0		35, 301, 310	0.00000	77.00
OUTPATIENT SERVICE COST CENTERS	-			-		
90. 00 09000 CLI NI C	0	0		0 17, 933, 145	0.00000	
90. 01 09001 IBMT JOINT VENTURE	0	0		0 11, 769, 455	0. 000000	•
90. 05 09005 CV DI AGNOSTI C SERVI CES	0	0		91, 737, 503	0. 000000	
91.00 09100 EMERGENCY	0	439, 353				
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		59, 259, 878	0.00000	•
200.00 Total (lines 50 through 199)	0	1, 157, 561	1, 157, 56	1 3, 076, 866, 115		200.00

Health Financial Systems F	RANCI SCAN HEALTH	I NDI ANAPOLI S		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PASS	Provider C	CN: 15-0162	Peri od:	Worksheet D	
THROUGH COSTS				From 01/01/2022 To 12/31/2022		narodi
				10 12/31/2022	5/29/2023 3:2	
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Outpati ent	Inpati ent	I npati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Throug		Pass-Through	
	(col. 6 ÷ col.		Costs (col.	8	Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCI LLARY SERVI CE COST CENTERS			1	- 1		
50.00 O5000 OPERATING ROOM	0. 000493	3, 340, 592			0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	2, 710, 220		0 0	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	2, 557, 182		0 0	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000	22, 921		0 0	0	55.00
56. 00 05600 RADI OI SOTOPE	0.000000	33, 289		0 0	0	56.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	913, 705		0 0	0	59.00
60. 00 06000 LABORATORY	0. 000556	3, 918, 538	2, 1	79 0	0	60.00
64.00 06400 INTRAVENOUS THERAPY	0. 000000	151, 066		0 0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	1, 470, 114		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	373, 410		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000	294, 387		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	70, 867		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	658, 572		0 0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0.000000	156, 372		0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	5, 348, 719		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.000673	3, 916, 029	2,6	35 0	0	73.00
74.00 07400 RENAL DI ALYSI S	0.000000	121, 814		0 0	0	74.00
76. 97 07697 CARDI AC REHABILI TATI ON	0.000000	2, 273		0 0	0	76.97
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0.000000	0		0 0	0	77.00
OUTPATIENT SERVICE COST CENTERS			1			
90. 00 09000 CLI NI C	0.000000	51, 695		0 0	0	90.00
90. 01 09001 I BMT JOINT VENTURE	0.000000	0		0 0	0	90.01
90. 05 09005 CV DI AGNOSTI C SERVI CES	0.000000	8,077		0 0	0	90.05
91. 00 09100 EMERGENCY	0.001310	2, 361, 382		93 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000	17, 466		0 0	0	92.00
200.00 Total (lines 50 through 199)		28, 498, 690				200.00
				1		

Health Financial Systems Fi	RANCI SCAN HEALT	H INDIANAPOLIS		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provider C	CN: 15-0162	Peri od:	Worksheet D	
		Component	CCN: 15-T162	From 01/01/2022 To 12/31/2022		narod
		Component	CCN. 15-1102	10 12/31/2022	5/29/2023 3:2	
		Titl	e XIX	Subprovider -	PPS	
	T	-		IRF		
Cost Center Description	Capi tal	Total Charges			Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,		(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)			
	26)	0.00	0.00	4.00	F 00	
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	2 (71 020	224 204 007	0.0079	91 0	0	50.00
	2, 671, 939				-	
52. 00 05200 DELIVERY ROOM & LABOR ROOM	838, 943					52.00 54.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 688, 093				0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C 56. 00 05600 RADI OI SOTOPE	118, 837				0	55.00
	36,020				0	56.00
	715, 115				0	60.00
60. 00 06000 LABORATORY 64. 00 06400 I NTRAVENOUS THERAPY	753, 204				0	64.00
65. 00 06500 RESPIRATORY THERAPY	331, 572				0	65.00
66. 00 06600 PHYSI CAL THERAPY	149, 428 237, 958				-	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	237, 958					67.00
68. 00 06800 SPEECH PATHOLOGY	3, 080					68.00
69. 00 06900 ELECTROCARDI OLOGY	438, 647				40	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	438, 847				0	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	349, 824				-	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	226, 482				0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	356, 047				0	73.00
74. 00 07400 RENAL DIALYSIS	113, 890				0	74.00
76. 97 07697 CARDI AC REHABI LI TATI ON	1, 815				0	76.97
77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION	1, 957				0	77.00
OUTPATIENT SERVICE COST CENTERS	1,737	35, 501, 510	0.0000	55 0	0	11.00
90. 00 09000 CLINIC	585, 625	17, 933, 145	0.0326	56 0	0	90.00
90. 01 09001 I BMT JOINT VENTURE	84, 258				0	90.01
90. 05 09005 CV DI AGNOSTI C SERVI CES	6, 663				0	90.05
91. 00 09100 EMERGENCY	1, 464, 156				0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0				0	92.00
200.00 Total (lines 50 through 199)	-	3, 076, 866, 115		820, 070		200.00
					,	

Health Financial Systems F	RANCISCAN HEALTH INDIANAPOLIS				In Lieu of Form CMS-2552-10			
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	RVICE OTHER PASS Provider CCN: 15-0162				Worksheet D			
THROUGH COSTS	Component CCN: 15-T162			om 01/01/2022 Part IV 12/31/2022 Date/Time Prepared:		narod		
	component con. 15-1162			10	12/31/2022	5/29/2023 3:2	2 pm	
		Titl	Title XIX		rovider -	PPS		
· · · · · · · · · · · · · · · · · · ·					I RF			
Cost Center Description	Non Physician		Nursi ng			Allied Health		
	Anestheti st	Program	Program		-Stepdown			
	Cost	Post-Stepdown Adjustments		Adj	ustments			
	1.00	2A	2.00		3A	3.00		
ANCI LLARY SERVI CE COST CENTERS	1.00	2/1	2.00		5/1	3.00		
50. 00 05000 OPERATING ROOM	0	0		0	0	164, 709	50.00	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0	0	0	52.00	
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0	0	0	54.00	
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0	0	0	55.00	
56. 00 05600 RADI 0I SOTOPE	0	0		0	0	0	56.00	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0	0	0	59.00	
60. 00 06000 LABORATORY	0	0		0	0	159, 186	60.00	
64.00 06400 I NTRAVENOUS THERAPY	0	0		0	0	0	64.00	
65. 00 06500 RESPI RATORY THERAPY	0	0		0	0	0	65.00	
66. 00 06600 PHYSI CAL THERAPY	0	0		0	0	0	66.00	
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0	0	0	67.00	
68.00 06800 SPEECH PATHOLOGY	0	0		0	0	0	68.00	
69.00 06900 ELECTROCARDI OLOGY	0	0		0	0	0	69.00	
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0	0	0	70.00	
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT	0	0		0	0	0	71.00	
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0	0	0	72.00	
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	394, 313	73.00	
74. 00 07400 RENAL DIALYSIS 76. 97 07697 CARDIAC REHABILITATION	0	0		0	0	0	74.00	
76. 97 07897 CARDIAC REHABILITATION 77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION	0			0	0		76.97 77.00	
OUTPATIENT SERVICE COST CENTERS	0	0		0	0	0	//.00	
90. 00 09000 CLINIC	0	0		0	0	0	90.00	
90. 01 09001 I BMT JOINT VENTURE	0			0	0	0	90.01	
90. 05 09005 CV DI AGNOSTI C SERVICES	0	0		0	0	l o	90.05	
91. 00 09100 EMERGENCY	0	0		0	0	439, 353		
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0			0	0	0	92.00	
200.00 Total (lines 50 through 199)	0	0		0	0	1, 157, 561		
		,	•				•	

Health Financial Systems F	RANCI SCAN HEALT	H INDIANAPOLIS		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER		S Provider C	Provider CCN: 15-0162		Worksheet D	
THROUGH COSTS		Component CCN: 15-T162		From 01/01/2022 To 12/31/2022		narod
			10 12/31/2022	5/29/2023 3:2		
		Title XIX		Subprovider -	PPS	
				I RF		
Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
	Medi cal	(sum of cols.	Outpatient	(from Wkst. C,		
	Education Cost		Cost (sum of		(col. 5 ÷ col.	
		4)	col s. 2, 3,	8)	7)	
			and 4)		(see instructions)	
	4.00	5.00	6.00	7.00	8.00	
ANCI LLARY SERVI CE COST CENTERS	4.00	3.00	0.00	7.00	0.00	
50. 00 05000 OPERATING ROOM	0	164, 709	164, 70	9 334, 384, 097	0.000493	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 50, 798, 041	0.000000	•
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 322, 124, 936	0.000000	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0 89, 116, 059	0. 000000	55.00
56. 00 05600 RADI OI SOTOPE	0	0		0 9, 295, 714		56.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 175, 118, 428	0. 000000	59.00
60. 00 06000 LABORATORY	0	159, 186	159, 18	6 286, 396, 860	0. 000556	60.00
64.00 06400 INTRAVENOUS THERAPY	0	0		0 45, 183, 984	0.000000	64.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0 66, 839, 341	0.000000	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 47, 378, 809		
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 27, 471, 907		
68.00 06800 SPEECH PATHOLOGY	0	0		0 10, 893, 693		
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 44, 604, 045		
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 26, 635, 915		
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 214, 687, 709		
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 175, 944, 341	0. 000000	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	394, 313				
74.00 07400 RENAL DIALYSIS	0	0		0 8, 506, 754		
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		0 4, 204, 988		
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	0		0 35, 301, 310	0.000000	77.00
OUTPATIENT SERVICE COST CENTERS				0 47 000 445	0.00000	
90. 00 09000 CLINIC	0	0		0 17, 933, 145		
90. 01 09001 I BMT JOI NT VENTURE	0	0		0 11, 769, 455		
90. 05 09005 CV DI AGNOSTI C SERVI CES	0	420.252		0 91, 737, 503		
91.00 09100 EMERGENCY	0	439, 353				
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 200.00 Total (lines 50 through 199)	0	1 157 571		0 59, 259, 878 1 3, 076, 866, 115		92.00 200.00
200.00 Total (lines 50 through 199)	0	1, 157, 561	1, 157, 50	1 3, 070, 000, 115	I	1200. OU

Health Financial Systems F	RANCI SCAN HEALTH	I NDI ANAPOLI S		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SET	RVICE OTHER PASS	Provider C	CN: 15-0162	Period: From 01/01/2022	Worksheet D Part IV	
THROUGH COSTS		Component (CCN: 15-T162	To 12/31/2022		
		Titl	e XIX	Subprovider -	PPS	<u>z pili</u>
				IRF		
Cost Center Description	Outpati ent	Inpati ent	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Throug		Pass-Through	
	(col. 6 ÷ col.		Costs (col.	8	Costs (col. 9	
	7)	10.00	x col. 10)	12.00	x col. 12)	
ANCI LLARY SERVI CE COST CENTERS	9.00	10.00	11.00	12.00	13.00	
50.00 05000 OPERATING ROOM	0. 000493	0	1	0 0	0	50.00
		0		0	-	
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0.000000	0		0 0	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 55. 00 05500 RADI OLOGY-THERAPEUTI C		0		0 0	0	54.00 55.00
55. 00 05500 RADI OLOGY-THERAPEUTI C 56. 00 05600 RADI OI SOTOPE	0. 000000 0. 000000	0		0 0	0	56.00
59. 00 05900 CARDI OF SOTOPE 59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	0		0 0	-	56.00
60. 00 06000 LABORATORY	0.000556	0		0 0	0	60.00
64. 00 06400 INTRAVENOUS THERAPY	0. 000558	0			0	64.00
		0				
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL_THERAPY	0. 000000 0. 000000	0 341, 819		0 0	U U	65.00 66.00
67. 00 06700 OCCUPATIONAL THERAPY	0. 000000	341, 819		0 0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0. 000000	162, 453		0 0	0	67.00
	0. 000000				0	69.00
		0				
70. 00 07000 ELECTROENCEPHALOGRAPHY 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT	0. 000000 0. 000000	788			0	70.00 71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000	/88		0 0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0.000673	0		0 0	0	72.00
74. 00 07400 RENAL DIALYSIS	0. 000073	0		0 0	0	74.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000	0		0 0	0	76.97
77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION	0. 000000	0		0 0	0	77.00
OUTPATIENT SERVICE COST CENTERS	0.000000	0		0 0	0	//.00
90. 00 09000 CLINIC	0.000000	0		0 0	0	90.00
90. 01 09001 I BMT JOINT VENTURE	0. 000000	0		0 0	0	90.01
90. 05 09005 CV DI AGNOSTI C SERVICES	0. 000000	0		0 0	0	90.05
91. 00 09100 EMERGENCY	0.001310	0		0 0	0	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	0		0 0	0	
200.00 Total (lines 50 through 199)		820, 070		0 0		200.00
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FRANCI SCAN	HEALTH	I NDI ANAPOLI S

In Lieu of Form CMS-2552-10

COMPUT	Financial Systems FRANCI SCAN HEALTH		In Lie	u of Form CMS-2	2552-
	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0162	Period: From 01/01/2022 To 12/31/2022	Worksheet D-1 Date/Time Pre 5/29/2023 3:22	
		Title XVIII	Hospi tal	PPS	z pili
	Cost Center Description		noopritai	110	
				1.00	
l	PART I – ALL PROVIDER COMPONENTS INPATIENT DAYS				
. 00	Inpatient days (including private room days and swing-bed da	uvs. excluding newborn)		68, 323	1.0
. 00	Inpatient days (including private room days, excluding swing			68, 323	2.0
. 00	Private room days (excluding swing-bed and observation bed d		rivate room days,	0	3.
	do not complete this line.				
. 00 . 00	Semi-private room days (excluding swing-bed and observation		n 21 of the east	56, 962 0	4.
. 00	Total swing-bed SNF type inpatient days (including private r reporting period	com days) through becembe	er 31 of the cost	0	5.
. 00	Total swing-bed SNF type inpatient days (including private r	oom days) after December	31 of the cost	0	6.
1	reporting period (if calendar year, enter 0 on this line)				
. 00	Total swing-bed NF type inpatient days (including private ro	oom days) through Decembe	⁻ 31 of the cost	0	7.
. 00	reporting period Total swing-bed NF type inpatient days (including private ro	om dave) after December (1 of the cost	0	8.
. 00	reporting period (if calendar year, enter 0 on this line)	on days) after becenber .	of the cost	0	0.
9.00	Total inpatient days including private room days applicable	to the Program (excluding	g swing-bed and	21, 019	9.1
I	newborn days) (see instructions)				
0.00	Swing-bed SNF type inpatient days applicable to title XVIII		room days)	0	10.
1.00	through December 31 of the cost reporting period (see instru Swing-bed SNF type inpatient days applicable to title XVIII		coom days) after	0	11.
1.00	December 31 of the cost reporting period (if calendar year,		com days) arter	0	
2.00	Swing-bed NF type inpatient days applicable to titles V or X	(IX only (including priva	te room days)	0	12.
2 00	through December 31 of the cost reporting period			0	10
3.00	Swing-bed NF type inpatient days applicable to titles V or X after December 31 of the cost reporting period (if calendar			0	13.
4.00	Medically necessary private room days applicable to the Prog			0	14.
	Total nursery days (title V or XIX only)			0	15.
6.00	Nursery days (title V or XIX only)			0	16.
7 00	SWING BED ADJUSTMENT	through December 21	6 the east	0.00	17
7.00	Medicare rate for swing-bed SNF services applicable to servi reporting period	ces through December 31 (or the cost	0.00	17.
8.00	Medicare rate for swing-bed SNF services applicable to servi	ces after December 31 of	the cost	0.00	18.
	reporting period				
9.00	Medicaid rate for swing-bed NF services applicable to servic	es through December 31 of	f the cost	0.00	19.
0.00	reporting period Medicaid rate for swing-bed NF services applicable to servic	es after December 31 of .	the cost	0.00	20.
0.00	reporting period			0.00	20.
	Total general inpatient routine service cost (see instructio			75, 706, 748	21.
2.00	Swing-bed cost applicable to SNF type services through Decem	ber 31 of the cost repor	ting period (line	0	22.
3. 00	5 x line 17) Swing-bed cost applicable to SNF type services after Decembe	or 21 of the cost reportio	na poriod (lino 6	0	23.
3.00	x line 18)		ig period (The o	0	23.
4.00	Swing-bed cost applicable to NF type services through Decemb	er 31 of the cost reporti	ng period (line	0	24.
	7 x line 19)				
			period (line 8	0	
5. 00	Swing-bed cost applicable to NF type services after December	SI OI THE COST TEPOITIN	j por ou (rino o	0	25.
	x line 20)			-	25. 26
6. 00	x line 20) Total swing-bed cost (see instructions)		, , , , , , , , , , , , , , , , , , , ,	0	25. 26. 27.
6. 00	x line 20)			-	26.
6. 00 7. 00 8. 00	x line 20) Total swing-bed cost (see instructions) <u>General inpatient routine service cost net of swing-bed cost</u> <u>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</u> General inpatient routine service charges (excluding swing-b	: (line 21 minus line 26)		0 75, 706, 748 0	26. 27. 28.
6. 00 7. 00 8. 00 9. 00	x line 20) Total swing-bed cost (see instructions) <u>General inpatient routine service cost net of swing-bed cost</u> <u>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</u> General inpatient routine service charges (excluding swing-be Private room charges (excluding swing-bed charges)	: (line 21 minus line 26)		0 75, 706, 748 0 0	26. 27. 28. 29.
6. 00 7. 00 8. 00 9. 00 0. 00	x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-b Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)	(line 21 minus line 26) Wed and observation bed cl		0 75, 706, 748 0 0 0	26. 27. 28. 29. 30.
6. 00 7. 00 8. 00 9. 00 0. 00 1. 00	x line 20) Total swing-bed cost (see instructions) <u>General inpatient routine service cost net of swing-bed cost</u> <u>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</u> General inpatient routine service charges (excluding swing-b 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 21 minus line 26) Wed and observation bed cl		0 75, 706, 748 0 0	26. 27. 28. 29. 30. 31.
6. 00 7. 00 8. 00 9. 00 0. 00 1. 00 2. 00 3. 00	x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-b Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)	(line 21 minus line 26) wed and observation bed cl	narges)	0 75, 706, 748 0 0 0 0 0 0. 000000	26. 27. 28. 29. 30. 31. 32. 33.
6.00 7.00 8.00 9.00 0.00 1.00 2.00 3.00 4.00	x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-b Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 m	: (line 21 minus line 26) wed and observation bed cl y ÷ line 28) ninus line 33)(see instruc	narges)	0 75, 706, 748 0 0 0 0. 000000 0. 000000 0. 00 0. 00 0. 00 0. 00	26. 27. 28. 29. 30. 31. 32. 33. 34.
6.00 7.00 8.00 9.00 0.00 1.00 2.00 3.00 4.00 5.00	x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-b Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge differential (line 32 m Average per diem private room cost differential (line 34 x l	inus line 33)(see instruction in the interval interval in the interval interval interval in the interval in	narges)	0 75, 706, 748 0 0 0 0. 000000 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00	26. 27. 28. 29. 30. 31. 32. 33. 34. 35.
6. 00 7. 00 8. 00 9. 00 0. 00 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00	x line 20) Total swing-bed cost (see instructions) <u>General inpatient routine service cost net of swing-bed cost</u> <u>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</u> <u>General inpatient routine service charges (excluding swing-bed charges)</u> <u>Semi-private room charges (excluding swing-bed charges)</u> <u>General inpatient routine service cost/charge ratio (line 27</u> <u>Average private room per diem charge (line 29 ÷ line 3)</u> <u>Average semi-private room per diem charge (line 30 ÷ line 4)</u> <u>Average per diem private room cost differential (line 32 m</u> <u>Average per diem private room cost differential (line 34 x line 35)</u>	(line 21 minus line 26) wed and observation bed cl + line 28) ninus line 33)(see instruction ine 31)	narges)	0 75, 706, 748 0 0 0.000000 0.00 0.00 0.00 0.00 0.00	26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36.
6. 00 7. 00 8. 00 9. 00 0. 00 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00	x line 20) Total swing-bed cost (see instructions) <u>General inpatient routine service cost net of swing-bed cost</u> <u>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</u> <u>General inpatient routine service charges (excluding swing-bed</u> Private room charges (excluding swing-bed charges) <u>Semi-private room charges (excluding swing-bed charges)</u> <u>General inpatient routine service cost/charge ratio (line 27</u> <u>Average private room per diem charge (line 29 ÷ line 3)</u> <u>Average semi-private room per diem charge (line 30 ÷ line 4)</u> <u>Average per diem private room cost differential (line 34 × l Private room cost differential adjustment (line 3 × line 35)</u> <u>General inpatient routine service cost net of swing-bed cost</u>	(line 21 minus line 26) wed and observation bed cl + line 28) ninus line 33)(see instruction ine 31)	narges)	0 75, 706, 748 0 0 0 0. 000000 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00	26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36.
6. 00 7. 00 9. 00 9. 00 0. 00 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00	x line 20) Total swing-bed cost (see instructions) <u>General inpatient routine service cost net of swing-bed cost</u> <u>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</u> <u>General inpatient routine service charges (excluding swing-bed charges)</u> <u>Semi-private room charges (excluding swing-bed charges)</u> <u>General inpatient routine service cost/charge ratio (line 27</u> <u>Average private room per diem charge (line 29 ÷ line 3)</u> <u>Average semi-private room per diem charge (line 30 ÷ line 4)</u> <u>Average per diem private room cost differential (line 32 m</u> <u>Average per diem private room cost differential (line 34 x line 35)</u>	(line 21 minus line 26) wed and observation bed cl + line 28) ninus line 33)(see instruction ine 31)	narges)	0 75, 706, 748 0 0 0.000000 0.00 0.00 0.00 0.00 0.00	26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36.
6. 00 7. 00 8. 00 9. 00 0. 00 1. 00 2. 00 3. 00 5. 00 6. 00 7. 00	x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-b Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room cost differential (line 32 m Average per diem private room cost differential (line 34 x l Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost 27 minus line 36) PART 11 - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AD	(line 21 minus line 26) wed and observation bed cl ' ÷ line 28) minus line 33)(see instruct ine 31) and private room cost di UUSTMENTS	narges)	0 75, 706, 748 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37.
6. 00 7. 00 8. 00 9. 00 0. 00 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00	x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-b Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room cost differential (line 34 × l Private room cost differential adjustment (line 3 × line 35) General inpatient routine service cost net of swing-bed cost 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AD Adjusted general inpatient routine service cost per diem (se	<pre>: (line 21 minus line 26) ved and observation bed cl ' + line 28) ninus line 33)(see instruction 31) : and private room cost di UUSTMENTS ve instructions)</pre>	narges)	0 75, 706, 748 0 0 0 0.00000 0.00 0.00 0.00 0.00 0.0	26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38.
6. 00 7. 00 8. 00 9. 00 0. 00 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-b Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room cost differential (line 32 m Average per diem private room cost differential (line 34 x l Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost 27 minus line 36) PART 11 - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AD	(line 21 minus line 26) yed and observation bed cl y + line 28) ninus line 33)(see instructione 31) and private room cost di <u>JUSTMENTS</u> ye instructions) ne 38)	narges)	0 75, 706, 748 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37.

	ATION OF INPATIENT OPERATING COST		Provider CC		eriod: rom 01/01/2022	Worksheet D-1	
				Т	o 12/31/2022	Date/Time Pre 5/29/2023 3:2	
				XVIII	Hospi tal	PPS	
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
2.00		0	0	0.00	0	0	42. (
3.00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	17, 567, 969	19, 865	884.37	2, 684	2, 373, 649	43.
3. 01	NEONATAL INTENSIVE CARE UNIT	9, 636, 092		1, 319. 65			
4.00	CORONARY CARE UNI T	21, 903, 043		1, 794. 74		-	
5.00	BURN INTENSIVE CARE UNIT						45.
5.00 7.00	SURGI CAL I NTENSI VE CARE UNI T OTHER SPECI AL CARE (SPECI FY)	10, 499, 374	6, 464	1, 624. 28	2, 019	3, 279, 421	46. 47.
7.00	Cost Center Description						47.
	-					1.00	
3.00 3.01	Program inpatient ancillary service cost (We Program inpatient cellular therapy acquisiti			III line 10	column 1)	51, 004, 824	1
9.00						87, 217, 114	
	PASS THROUGH COST ADJUSTMENTS	in through for o				072177111	
0. 00	Pass through costs applicable to Program inp	patient routine	services (from	Wkst. D, sum	of Parts I and	2, 509, 881	50.
1.00	III) Pass through costs applicable to Program ing	atient ancillar	y services (fr	om Wkst D su	m of Parts II	1, 505, 754	51.
1.00	and IV)		y 301 11 003 (11	om wikst. D, Su		1, 303, 734	31.
2.00	Total Program excludable cost (sum of lines	,				4, 015, 635	
3. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION		elated, non-phy	sician anesthe	tist, and	83, 201, 479	53.
4. 00	Program di scharges					0	54.
5.00	Target amount per discharge					0.00	
5.01	Permanent adjustment amount per discharge					0.00	
5. 02 5. 00	Adjustment amount per discharge (contractor Target amount (line 54 x sum of lines 55, 55					0.00	
. 00	Difference between adjusted inpatient operation			ine 56 minus l	ine 53)	0	
8. 00	Bonus payment (see instructions)	0	0			0	
9.00	Trended costs (lesser of line 53 ÷ line 54,		the cost repo	rting period e	ndi ng 1996,	0.00	59.
). 00	updated and compounded by the market basket) Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the						
. 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 enter zero. (see instructions)						
2.00	Relief payment (see instructions)					0	
8. 00	Allowable Inpatient cost plus incentive payr PROGRAM INPATIENT ROUTINE SWING BED COST	nent (see Instru	ictions)			0	63.
. 00	Medicare swing-bed SNF inpatient routine cos	sts through Dece	ember 31 of the	cost reportin	g period (See	0	64.
	instructions) (title XVIII only)	Ū					
5.00	Medicare swing-bed SNF inpatient routine cos	sts after Decemb	er 31 of the c	ost reporting	period (See	0	65.
5.00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line 6	5)(title XVIII	only); for	0	66.
	CAH, see instructions	·			5.		
7.00	Title V or XIX swing-bed NF inpatient routir (line 12 x line 19)	ne costs through	December 31 o	f the cost rep	orting period	0	67.
3. 00	Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)	ne costs after D	ecember 31 of	the cost repor	ting period	0	68.
9.00	Total title V or XIX swing-bed NF inpatient					0	69.
). 00	PART III - SKILLED NURSING FACILITY, OTHER N Skilled nursing facility/other nursing facil		•				70.
. 00	Adjusted general inpatient routine service of					1	71.
. 00	Program routine service cost (line 9 x line	71)					72.
. 00	Medically necessary private room cost applic			ne 35)			73.
. 00 . 00	Total Program general inpatient routine serv Capital-related cost allocated to inpatient 26, line 45)			orksheet B, Pa	rt II, column		74.
. 00	Per diem capital-related costs (line 75 ÷ li						76.
. 00	Program capital -related costs (line 9 x line	· · · · · · · · · · · · · · · · · · ·					77.
. 00 . 00	Inpatient routine service cost (line 74 minu Aggregate charges to beneficiaries for exces		rovi der record	s)			78.
. 00	Total Program routine service costs for com				s line 79)	1	80.
. 00	Inpatient routine service cost per diem limi	tati on			<i>,</i>		81.
. 00	Inpatient routine service cost limitation (I		· .				82.
. 00 . 00	Reasonable inpatient routine service costs Program inpatient ancillary services (see in	•	15)				83.
. 00	Utilization review - physician compensation		ons)				85.
-	Total Program inpatient operating costs (sur	•					86.
. 00							
. 00	PART IV - COMPUTATION OF OBSERVATION BED PAS Total observation bed days (see instructions					11, 361	87.

Health Financial Systems FF	RANCISCAN HEALTI	H INDIANAPOLIS		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period: From 01/01/2022	Worksheet D-1	
				To 12/31/2022	Date/Time Pre 5/29/2023 3:2:	pared: 2 pm
		Title	XVIII	Hospi tal	PPS	
Cost Center Description						
					1.00	
89.00 Observation bed cost (line 87 x line 88) (see	e instructions)				12, 588, 783	89.00
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH C	COST					
90.00 Capital-related cost	5, 467, 309	75, 706, 748	0. 07221	7 12, 588, 783	909, 124	90.00
91.00 Nursing Program cost	0	75, 706, 748	0.00000	0 12, 588, 783	0	91.00
92.00 Allied health cost	0	75, 706, 748	0.00000	0 12, 588, 783	0	92.00
93.00 All other Medical Education	0	75, 706, 748	0.00000	0 12, 588, 783	0	93.00

MPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0162 Component CCN: 15-T162	Peri od: From 01/01/2022 To 12/31/2022	Worksheet D-1 Date/Time Pre 5/29/2023 3:2	pare
		Title XVIII	Subprovider -	PPS	
	Cost Center Description		-	1.00	
	PART I - ALL PROVIDER COMPONENTS				-
	INPATIENT DAYS Inpatient days (including private room days and swing-bed day	vs. excluding newborn)		5, 248	1 1
00	Inpatient days (including private room days, excluding swing-			5, 248	2
00	Private room days (excluding swing-bed and observation bed da	ays). If you have only pr	ivate room days,	0	3
00	do not complete this line. Semi-private room days (excluding swing-bed and observation b	and dave)		5, 248	4
00	Total swing-bed SNF type inpatient days (including private ro		r 31 of the cost	3, 240	5
	reporting period			-	
00	Total swing-bed SNF type inpatient days (including private ro	oom days) after December	31 of the cost	0	6
00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private roo	om davs) through December	31 of the cost	0	7
00	reporting period			0	ĺ '
00	Total swing-bed NF type inpatient days (including private roo	om days) after December 3	1 of the cost	0	8
00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable t	to the Program (excluding	swing_bed and	2, 795	9
00	newborn days) (see instructions)		Swirig-bed and	2,175	
. 00	Swing-bed SNF type inpatient days applicable to title XVIII of		oom days)	0	10
00	through December 31 of the cost reporting period (see instruction of the cost reporting back set in the VIII of the cost of th		and days) often	0	11
. 00	Swing-bed SNF type inpatient days applicable to title XVIII of December 31 of the cost reporting period (if calendar year, e		oom days) arter	0	11
. 00	Swing-bed NF type inpatient days applicable to titles V or XI		e room days)	0	12
	through December 31 of the cost reporting period				
	Swing-bed NF type inpatient days applicable to titles V or XI after December 31 of the cost reporting period (if calendar y			0	13
	Medically necessary private room days applicable to the Progr			0	14
	Total nursery days (title V or XIX only)	× 5 5	3 /	0	
	Nursery days (title V or XIX only)			0	16
	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to servic	ces through December 31 c	of the cost	0.00	17
	reporting period				
. 00	Medicare rate for swing-bed SNF services applicable to servic	ces after December 31 of	the cost	0.00	18
. 00	reporting period Medicaid rate for swing-bed NF services applicable to service	es through December 31 of	the cost	0.00	19
	reporting period	-			
. 00	Medicaid rate for swing-bed NF services applicable to service	es after December 31 of t	he cost	0.00	20
00	reporting period Total general inpatient routine service cost (see instruction	ns)		6, 496, 379	21
	Swing-bed cost applicable to SNF type services through Decemb		ing period (line	0, 170, 077	
	5 x line 17)				
. 00	Swing-bed cost applicable to SNF type services after December x line 18)	r 31 of the cost reportin	g period (line 6	0	23
. 00	Swing-bed cost applicable to NF type services through December	er 31 of the cost reporti	ng period (line	0	24
	7 x line 19)				
. 00	Swing-bed cost applicable to NF type services after December x line 20)	31 of the cost reporting	period (line 8	0	25
. 00	Total swing-bed cost (see instructions)			0	26
. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		6, 496, 379	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	ad and abcomuction had a	00000	0	1 20
	General inpatient routine service charges (excluding swing-be Private room charges (excluding swing-bed charges)	ed and observation bed ch	lar ges)	0	28
	Semi -private room charges (excluding swing-bed charges)			0	30
	General inpatient routine service cost/charge ratio (line 27	÷line 28)		0.000000	
	Average private room per diem charge (line 29 ÷ line 3)			0.00	
-	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 mi	nus line 33)(see instruc	tions)	0.00 0.00	
-	Average per diem private room cost differential (line 34 x li	, ,		0.00	
. 00	Private room cost differential adjustment (line 3 x line 35)			0	36
. 00	General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line	6, 496, 379	37
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				1
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ				1
	Adjusted general inpatient routine service cost per diem (see			1,237.88	
	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Progr			3, 459, 875 0	
. 00	Total Program general inpatient routine service cost (line 39	. ,		3, 459, 875	

ealth Financial Systems FF DMPUTATION OF INPATIENT OPERATING COST	ANCI SCAN HEALTH	Provider CC		Period: From 01/01/202		1
		Component C Title		To 12/31/202 Subprovi der	5/29/2023 3:	
Cost Center Description	Total	Total	Average Per	IRF Program Days	s Program Cost	
	Inpatient Costlr	patient Days	Diem (col. 1 <u>col. 2)</u> 3.00	÷ 4.00	(col. 3 x col. 4) 5.00	
2.00 NURSERY (title V & XIX only)	0	2.00	<u> </u>			2 42.00
Intensive Care Type Inpatient Hospital Units 3.00 INTENSIVE CARE UNIT	0	0	0.	00	0	0 43.00
3. 01 NEONATAL INTENSIVE CARE UNIT	0	0	0.			0 43.01
4. 00 CORONARY CARE UNIT	0	0	0.	00	0 (0 44.00
5. 00 BURN INTENSIVE CARE UNIT 6. 00 SURGICAL INTENSIVE CARE UNIT	0	о	0.	00	0	45.00 46.00
7.00 OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description					1.00	
3.00 Program inpatient ancillary service cost (Wks	st. D-3, col. 3,	line 200)			1, 243, 23	3 48.00
8.01 Program inpatient cellular therapy acquisition				, column 1)		0 48.01
P. 00 Total Program inpatient costs (sum of lines / PASS THROUGH COST ADJUSTMENTS	41 through 48.01	(see Instruct	tions)		4, 703, 10	<u>3</u> 49.00
0.00 Pass through costs applicable to Program inpa	atient routine s	ervices (from	Wkst. D, su	m of Parts I ar	nd 284, 33	5 50.00
) 1.00 Dass through costs applicable to Drogram input	ationt ancillary	convigos (fr	om Wkct D	sum of Dorte II	20.20	2 51.00
 Pass through costs applicable to Program inpa and IV) 	attent and italy	Services (III	JIII WKSL. D,	Juni VI Palits II	20, 30	2 01.00
2.00 Total Program excludable cost (sum of lines !					304, 63	
3.00 Total Program inpatient operating cost excluding medical education costs (line 49 minus line 9		atea, non-phys	sıcıan anest	netist, and	4, 398, 47	1 53.00
TARGET AMOUNT AND LIMIT COMPUTATION	()					
4.00 Program discharges					0.00	0 54.00 0 55.00
5.00 Target amount per discharge 5.01 Permanent adjustment amount per discharge					0.00	
5.02 Adjustment amount per discharge (contractor u					0.00	
5.00 Target amount (line 54 x sum of lines 55, 55. 7.00 Difference between adjusted inpatient operati		not amount (Li	no 56 minus	Lino 52)		0 56.0 0 57.0
3.00 Bonus payment (see instructions)	ng cost and targ	get aniount (n	The so millings	TTHE 55)		57.0
9.00 Trended costs (lesser of line 53 ÷ line 54, o	or line 55 from ⁻	the cost repo	rting period	endi ng 1996,	0.00	59.00
updated and compounded by the market basket) D.00 Expected costs (lesser of line 53 ÷ line 54, market basket)	or line 55 from	prior year co	ost report,	updated by the	0.00	60.00
 1.00 Continuous improvement bonus payment (if line 55.01, or line 59, or line 60, enter the less 53) are less than expected costs (lines 54 x enter zero. (see instructions) 	ser of 50% of the	e amount by wh	nich operati	ng costs (line	(61.00
2.00 Relief payment (see instructions)						62.00
3.00 Allowable Inpatient cost plus incentive payme	ent (see instruc	tions)			(0 63.00
PROGRAM INPATIENT ROUTINE SWING BED COST 4.00 Medicare swing-bed SNF inpatient routine cost	ts through Decem	per 31 of the	cost report	ing period (See	e (0 64.00
instructions)(title XVIII only)	Ū			0.		
5.00 Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts after Decembe	r 31 of the co	ost reportin	g period (See		0 65.0
5.00 Total Medicare swing-bed SNF inpatient routin CAH, see instructions	•			37		0 66.0
7.00 Title V or XIX swing-bed NF inpatient routine (line 12 x line 19)	e costs through I	December 31 of	f the cost r	eporting period		0 67.00
3.00 Title V or XIX swing-bed NF inpatient routine (line 13 x line 20)				orting period		0 68.00
P. 00 Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER NU						0 69.0
D. 00 Skilled nursing facility/other nursing facili)		70.00
1.00 Adjusted general inpatient routine service co	ost per diem (li					71.00
2.00 Program routine service cost (line 9 x line 3.00 Medically necessary private room cost applica		(line 14 x lir	ne 35)			72.0
4.00 Total Program general inpatient routine servi	ce costs (line	72 + line 73)				74.00
5.00 Capital-related cost allocated to inpatient i 26, line 45)		costs (from Wo	orksheet B,	Part II, columr	ו ו	75.0
6.00 Per diem capital-related costs (line 75 ÷ lin 7.00 Program capital-related costs (line 9 x line						76.0
3.00 Inpatient routine service cost (line 74 minus	s line 77)					78.00
9.00 Aggregate charges to beneficiaries for excess0.00 Total Program routine service costs for comparent				nus ling 70)		79.0
1.00 Inpatient routine service costs for compa- 1.00 Inpatient routine service cost per diem limi:				143 ITHE /9)		80.0
2.00 Inpatient routine service cost limitation (li	ne 9 x line 81)					82.0
 Reasonable inpatient routine service costs (Program inpatient ancillary services (see instance))				83. 0 84. 0
5.00 Utilization review - physician compensation		5)				84.00
6.00 Total Program inpatient operating costs (sum	•				1	86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS		bugn 85)				- 00.0

lealth Financial Systems FR	ANCISCAN HEALT	H INDIANAPOLIS		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period: From 01/01/2022	Worksheet D-1	
		Component C	CCN: 15-T162	To 12/31/2022	Date/Time Prep 5/29/2023 3:22	
		Title	XVIII	Subprovider - IRF	PPS	
Cost Center Description						
					1.00	
38.00 Adjusted general inpatient routine cost per d	liem (line 27 ÷	line 2)			0.00	88.00
39.00 Observation bed cost (line 87 x line 88) (see	e instructions)				0	89.00
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH C	OST					
90.00 Capital-related cost	533, 891	6, 496, 379	0.08218	3 0	0	90.00
91.00 Nursing Program cost	0	6, 496, 379	0.00000	0 0	0	91.00
92.00 Allied health cost	0	6, 496, 379	0.00000	0 0	0	92.00
93.00 All other Medical Education	ol	6, 496, 379	0.00000		0	93.00

Health Financial Systems

FRANCI SCAN	HEALTH	I NDI ANAPOLI S

In Lieu of Form CMS-2552-10

lealth Financial Systems	FRANCI SCAN	HEALTH INDIANAPOLIS	In Lie	u of Form CMS-2	2552-1
COMPUTATION OF INPATIEN	OPERATI NG COST	Provider CCN: 15-0162	Period: From 01/01/2022 To 12/31/2022	Worksheet D-1 Date/Time Pre 5/29/2023 3:2	pared
		Title XIX	Hospi tal	PPS	2 pm
Cost Center	Description			·	
PART I - ALL PROV	DED COMPONENTS			1.00	
I NPATI ENT DAYS	IDER COMPONENTS				1
	ncluding private room days and swing-	bed days, excluding newborn)		68, 323	1.0
	ncluding private room days, excluding			68, 323	2.0
	(excluding swing-bed and observation	n bed days). If you have only pr	ivate room days,	0	3.0
do not complete t				54 949	
	days (excluding swing-bed and observ		r 21 of the east	56, 962	4.0
5.00 Total swing-bed S reporting period	NF type inpatient days (including pri	vate room days) through Decembe	r 31 of the cost	0	5.0
	NF type inpatient days (including pri	vate room days) after December	31 of the cost	0	6.0
	(if calendar year, enter 0 on this li			-	
	F type inpatient days (including priv	ate room days) through December	31 of the cost	0	7.0
reporting period				_	
	F type inpatient days (including priv		1 of the cost	0	8.0
	(if calendar year, enter 0 on this li ays including private room days appli		swing bod and	604	9.0
newborn days) (se	5 51 5 11	cable to the riogram (excluding	Swillig-bed and	004	7.0
	e inpatient days applicable to title	XVIII only (including private r	oom days)	0	10. (
5	31 of the cost reporting period (see	,	•		
	e inpatient days applicable to title		oom days) after	0	11. (
	e cost reporting period (if calendar inpatient days applicable to titles		a room day(c)	0	12. (
	31 of the cost reporting period	v or xix only (including privat	e room days)	0	12.0
	inpatient days applicable to titles	V or XIX only (including privat	e room davs)	0	13.0
	of the cost reporting period (if cal				
	ry private room days applicable to th	e Program (excluding swing-bed	days)	0	1
	s (title V or XIX only)			3, 803	
16.00 Nursery days (tit SWING BED ADJUSTM				189	16. (
	swing-bed SNF services applicable to	services through December 31 o	f the cost	0.00	17.0
reporting period				0.00	
	swing-bed SNF services applicable to	services after December 31 of	the cost	0.00	18.0
reporting period				0.00	10.0
19.00 Medicaid rate for reporting period	swing-bed NF services applicable to	services through December 31 of	the cost	0.00	19.0
	swing-bed NF services applicable to	services after December 31 of t	he cost	0.00	20.0
reporting period	0				
	atient routine service cost (see inst			75, 706, 748	
22.00 Swing-bed cost ap 5 x line 17)	plicable to SNF type services through	December 31 of the cost report	ing period (line	0	22.0
	plicable to SNF type services after D	ecember 31 of the cost reportin	a period (line 6	0	23.0
x line 18)			g por lou (i no o	Ũ	20.0
	plicable to NF type services through	December 31 of the cost reporti	ng period (line	0	24.0
7 x line 19)					
5	plicable to NF type services after De	ecember 31 of the cost reporting	period (line 8	0	25.0
x line 20) 26.00 Total swing-bed c	ost (see instructions)			0	26.0
	routine service cost net of swing-be	ed cost (line 21 minus line 26)		75, 706, 748	
	ERENTIAL ADJUSTMENT	· · · ·			
	routine service charges (excluding s	wing-bed and observation bed ch	arges)	0	
	ges (excluding swing-bed charges)	、		0	
	charges (excluding swing-bed charges routine service cost/charge ratio (I			0.000000	
	oom per diem charge (line 29 ÷ line 3			0.000000	
	ate room per diem charge (line 30 ÷ l			0.00	
5 1	private room charge differential (lin		tions)	0.00	
35.00 Average per diem	private room cost differential (line			0.00	
1	differential adjustment (line 3 x li		cc	0	36.0
	routine service cost net of swing-be	ed cost and private room cost di	fferential (line	75, 706, 748	37.0
27 minus line 36) PART II - HOSPITA	L AND SUBPROVI DERS ONLY				1
	OPERATING COST BEFORE PASS THROUGH C	OST ADJUSTMENTS			1
	inpatient routine service cost per di			1, 108. 07	38. 0
5 5	npatient routine service cost (line 9			669, 274	
	ry private room cost applicable to th			0	•
41 UU LIOTAL Prodram der	eral inpatient routine service cost (iine 39 + line 40)		669, 274	41. (

	Financial Systems FF ATION OF INPATIENT OPERATING COST	RANCISCAN HEALT	H INDIANAPOLIS	CN: 15-0162 F	Period:	worksheet D-1	
					rom 01/01/2022 o 12/31/2022		
				e XIX	Hospi tal	PPS	
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	2, 903, 532	3, 803	763.48	189	144, 298	42.00
43.00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	17, 567, 969	19, 865	884.37	337	298, 033	43.00
43.00	NEONATAL INTENSIVE CARE UNIT	9, 636, 092					
44.00	CORONARY CARE UNIT	21, 903, 043					
45.00	BURN INTENSIVE CARE UNIT	10, 100, 07,					45.00
46.00	SURGI CAL I NTENSI VE CARE UNI T OTHER SPECI AL CARE (SPECI FY)	10, 499, 374	6, 464	1, 624. 28	47	76, 341	46.00 47.00
47.00	Cost Center Description						47.00
	·					1.00	
48.00	Program inpatient ancillary service cost (Wks					4, 155, 236	
48. 01 49. 00	Program inpatient cellular therapy acquisition Total Program inpatient costs (sum of lines a				column I)	0 5, 558, 603	48.01 49.00
47.00	PASS THROUGH COST ADJUSTMENTS					3, 330, 003	47.00
50.00	Pass through costs applicable to Program inpa	atient routine	services (from	Wkst. D, sum	of Parts I and	82, 808	50.00
F1 00)	ationt anaillar	w convious (fr		m of Dorto II	144 400	E1 00
51.00	Pass through costs applicable to Program inpa and IV)		y services (II	UNI WKSL. D, SU	III UI PALLS II	146, 498	51.00
52.00	Total Program excludable cost (sum of lines !	50 and 51)				229, 306	52.00
53.00	Total Program inpatient operating cost exclud		elated, non-phy	sician anesthe	tist, and	5, 329, 297	53.00
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)					
54.00	Program di scharges					0	54.00
55.00	Target amount per discharge					0.00	
55.01	Permanent adjustment amount per discharge					0.00	
55. 02 56. 00	Adjustment amount per discharge (contractor u Target amount (line 54 x sum of lines 55, 55.					0.00	55.02 56.00
57.00	Difference between adjusted inpatient operati			ine 56 minus l	ine 53)	0	
58.00	Bonus payment (see instructions)					0	
59.00	Trended costs (lesser of line 53 ÷ line 54, or updated and compounded by the market basket)	or line 55 from	n the cost repo	rting period e	ndi ng 1996,	0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54,	or line 55 fro	m prior year c	ost report, up	dated by the	0.00	60.00
	market basket)	50 11 54				0	61.00
61.00	00 Continuous improvement bonus payment (if line $53 \div$ 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 54×60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)						
62.00	Relief payment (see instructions)					0	
63.00	Allowable Inpatient cost plus incentive payme PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instru	ictions)			0	63.00
64.00	Medicare swing-bed SNF inpatient routine cost	ts through Dece	mber 31 of the	cost reportin	a period (See	0	64.00
	instructions) (title XVIII only)				9 poi te (tete		
65.00	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	er 31 of the c	ost reporting	period (See	0	65.00
66.00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routin	ne costs (line	64 plus line 6	5)(title XVIII	only) for	0	66.00
00.00	CAH, see instructions				5 J)// 101		
67.00	Title V or XIX swing-bed NF inpatient routine	e costs through	December 31 o	f the cost rep	orting period	0	67.00
68.00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routine (line 12 x line 20)	e costs after D	ecember 31 of	the cost repor	ting period	0	68.00
69.00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient n	routine costs (line 67 + line	68)		0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NU	JRSING FACILITY	, AND ICF/IID	ONLY		· · · · · · · · · · · · · · · · · · ·	
70.00	Skilled nursing facility/other nursing facili						70.00
71.00 72.00	Adjusted general inpatient routine service of Program routine service cost (line 9 x line		ine /0 ÷ line	2)			71.00
73.00	Medically necessary private room cost application	,	n (line 14 x li	ne 35)			73.00
74.00	Total Program general inpatient routine servi	ice costs (line	e 72 + line 73)				74.00
75.00	Capital-related cost allocated to inpatient 1 26, line 45)	routine service	e costs (from W	orksheet B, Pa	rt II, column		75.00
76.00	Per diem capital-related costs (line 75 ÷ lin						76.00
77.00 78.00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minus						77.00
79.00	Aggregate charges to beneficiaries for excess		orovi der record	s)			79.00
80.00	Total Program routine service costs for compa		ost limitation	(line 78 minu	is line 79)		80.00
81.00 82.00	Inpatient routine service cost per diem limi)				81.00
82.00	Inpatient routine service cost limitation (li Reasonable inpatient routine service costs (82.00 83.00
84.00	Program inpatient ancillary services (see ins						84.00
85.00	Utilization review - physician compensation						85.00
86.00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS		rough 85)				86.00
87.00	Total observation bed days (see instructions)					11, 361	87.00
88.00	Adjusted general inpatient routine cost per o		line 2)			1, 108. 07	

Health Financial Systems Fi	RANCI SCAN HEALT	H INDIANAPOLIS		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period:	Worksheet D-1	
				From 01/01/2022 To 12/31/2022	Date/Time Pre 5/29/2023 3:2:	pared: 2 pm
		Title	e XIX	Hospi tal	PPS	
Cost Center Description						
					1.00	
89.00 Observation bed cost (line 87 x line 88) (see	e instructions)				12, 588, 783	89.00
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST					
90.00 Capital-related cost	5, 467, 309	75, 706, 748	0. 07221	7 12, 588, 783	909, 124	90.00
91.00 Nursing Program cost	0	75, 706, 748	0.00000	0 12, 588, 783	0	91.00
92.00 Allied health cost	0	75, 706, 748	0.00000	0 12, 588, 783	0	92.00
93.00 All other Medical Education	0	75, 706, 748	0.00000	0 12, 588, 783	0	93.00

		Component CCN: 15-T162	From 01/01/2022 To 12/31/2022		
		Title XIX	Subprovider -	5/29/2023 3: 22 PPS	<u>2 p</u>
	Cost Center Description		-	1.00	
	PART I - ALL PROVIDER COMPONENTS		1		
	INPATIENT DAYS Inpatient days (including private room days and swing-bed da	ve oveluding nowhorn)		5, 248	1 1
	Inpatient days (including private room days, excluding swing-bed da			5, 248	
	Private room days (excluding swing-bed and observation bed d		ivate room days,	0	
	do not complete this line.	5, 5, 5,			
	Semi-private room days (excluding swing-bed and observation			5, 248	
00	Total swing-bed SNF type inpatient days (including private r	oom days) through Decembe	r 31 of the cost	0	5
00	reporting period Total swing-bed SNF type inpatient days (including private r	oom days) after December	31 of the cost	0	6
	reporting period (if calendar year, enter 0 on this line)			°,	
00	Total swing-bed NF type inpatient days (including private ro	om days) through December	31 of the cost	0	7
	reporting period			_	
00	Total swing-bed NF type inpatient days (including private ro reporting period (if calendar year, enter 0 on this line)	om days) after December 3	1 of the cost	0	8
00	Total inpatient days including private room days applicable	to the Program (excluding	swing-bed and	0	0
	newborn days) (see instructions)			Ű	'
. 00	Swing-bed SNF type inpatient days applicable to title XVIII		oom days)	0	10
00	through December 31 of the cost reporting period (see instru				1 1 1
	Swing-bed SNF type inpatient days applicable to title XVIII December 31 of the cost reporting period (if calendar year,		oom days) arter	0	1
	Swing-bed NF type inpatient days applicable to titles V or X		e room days)	0	12
	through December 31 of the cost reporting period	<u> </u>	3 /		
	Swing-bed NF type inpatient days applicable to titles V or X			0	13
	after December 31 of the cost reporting period (if calendar			0	1
	Medically necessary private room days applicable to the Prog Total nursery days (title V or XIX only)	ram (excluding swing-bed	uays)	0 3, 803	
	Nursery days (title V or XIX only)			189	
	SWING BED ADJUSTMENT				
. 00	Medicare rate for swing-bed SNF services applicable to servi	ces through December 31 o	f the cost	0.00	17
2 00	reporting period Medicare rate for swing-bed SNF services applicable to servi	cas after December 31 of	the cost	0.00	1
	reporting period	ces arter becember 51 01	the cost	0.00	
	Medicaid rate for swing-bed NF services applicable to servic	es through December 31 of	the cost	0.00	19
	reporting period				
	Medicaid rate for swing-bed NF services applicable to servic	es after December 31 of t	he cost	0.00	20
	reporting period Total general inpatient routine service cost (see instructio	ns)		6, 496, 379	21
	Swing-bed cost applicable to SNF type services through Decem		ing period (line	0	
	5 x line 17)	·			
	Swing-bed cost applicable to SNF type services after Decembe	r 31 of the cost reportin	g period (line 6	0	23
	x line 18) Swing-bed cost applicable to NF type services through Decemb	er 31 of the cost reporti	na period (line	0	24
. 00	7 x line 19)	er si or the cost reporti	ng period (rine	0	2.
5.00	Swing-bed cost applicable to NF type services after December	31 of the cost reporting	period (line 8	0	25
	x line 20)			_	
	Total swing-bed cost (see instructions)	(line 21 minus line 2()		0	
i i i i i i i i i i i i i i i i i i i	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(TTTTE 21 IIITTTUS TTTTE 20)		6, 496, 379	27
	General inpatient routine service charges (excluding swing-b	ed and observation bed ch	arges)	0	28
0. 00	Private room charges (excluding swing-bed charges)		-	0	20
	Semi-private room charges (excluding swing-bed charges)			0	
	General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 ÷ line 3)	÷ line 28)		0.00000	
	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)			0.00 0.00	
	Average per diem private room charge differential (line 32 m		tions)	0.00	
	Average per diem private room cost differential (line 34 x l	, (·	0.00	
. 00	Private room cost differential adjustment (line 3 x line 35)			0	
	General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line	6, 496, 379	37
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AD.	JUSTMENTS			
	Adjusted general inpatient routine service cost per diem (se			1, 237. 88	38
				0	1 20
	Program general inpatient routine service cost (line 9 x lin Medically necessary private room cost applicable to the Proq			0	

 43. 00 INTENSIVE CARE UNI 43. 01 NEONATAL INTENSIVE 44. 00 CORONARY CARE UNI 45. 00 BURN INTENSIVE CARE 46. 00 SURGICAL INTENSIVE 47. 00 OTHER SPECIAL CARE 48. 01 Program inpatient 49. 00 Total Program excl 50. 00 Total Program inpatient 51. 00 Pass through costs 111) 51. 00 Pass through costs and IV) 52. 00 Total Program excl 53. 00 Total Program inpatient 44. 00 Program discharges 50. 01 Target amount per 55. 02 Adjustment amount 56. 00 Target amount (Iir 57. 00 Difference betweer 58. 00 Bonus payment (see 59. 00 Trended costs (Ies updated and compou 60. 00 Expected costs (Ies updated and compou 61. 00 Continuous improve 55. 01, or Line 59, 53) are less than enter zero. (see i 62. 00 Relief payment (see 63. 00 Al lowable Inpatient 64. 00 Medicare swing-bec instructions) (titl 65. 00 Title V or XIX swi (line 13 x line 20 69. 00 Total Medicare swi (24H, see instructi 67. 00 Title V or XIX swi (line 13 x line 20 69. 00 Total Program gene 71. 00 Adjusted general i 72. 00 Program routine se 73. 00 Medically necessar 74. 00 Total Program gene 75. 00 Adjusted general i 76. 00 Program copital -re 77. 00 Program copital -re 78. 00 Inpatient routine 79. 00 Aggregate charges 					From 01/01/2022		1
42. 00 NURSERY (title V & Intensive Care Typ 43. 00 INTENSIVE CARE UNI 43. 01 NEONATAL INTENSIVE CARE UNI 43. 00 ORONARY CARE UNI 45. 00 BURN INTENSIVE CARE 46. 00 SURGICAL INTENSIVE CARE 47. 00 OTHER SPECIAL CARE 7. 00 OTHER SPECIAL CARE 7. 00 OTHER SPECIAL CARE 7. 00 Total Program inpatient 48. 01 Program inpatient 7. 00 Total Program excl 7. 00 Total Program inpatient 7. 00 Total Program excl 7. 00 Total Program excl 7. 00 Total Program inpatient 7. 00 Total Program inpatient 7. 00 Total Program inpatient 7. 00 Total Program excl 7. 00 Total Program excl 7. 00 Total Program inpatient 7. 00 Target amount per 7. 00 Target amount (Iir 7. 00 Target amount (Iir 7. 00 Target amount (See 7. 00 Trended costs (Ies 8. 00 Do			Component	CCN: 15-T162	To 12/31/2022		
42. 00 NURSERY (title V & Intensive Care Typ 43. 00 INTENSIVE CARE UNI 43. 01 NEONATAL INTENSIVE CARE UNI AS 43. 00 ORONARY CARE UNI AS 46. 00 SURGICAL INTENSIVE CARE Cost Center D 48. 00 Program inpatient AS 49. 00 OTHER SPECIAL CARE Cost Center D 48. 01 Program inpatient Program inpatient AS 49. 00 Total Program inpatient AS 50. 00 Pass through costs and IV 51. 00 Pass through costs and IV 52. 01 Total Program inpatient ARGET AMOUNT AND 54. 00 Program discharges 55. 01 Permanent adjustme Adjustment amount per 55. 02 Adjustment amount (Iir Adjustment amount (See Seg) 00 55. 01 Target amount (Iir ATGET AMOUNT AND 56. 00 Target amount (See Seg) 00 57. 00 Difference betweer 58. 00 Bonus payment (see Seg) 00 59. 00 Trended costs (Ies updated and compou (see Seg) 00 50. 01, or Line 59, 53) are less than enter zero. (see i instructions) (titl 54. 00 Medicare swing-bec instructions) (titl 56. 00 Relief payment (se Se Al Iowable I			Titl	le XIX	Subprovider -	PPS	<u>.z pm</u>
Intensive Care Typ43.00INTENSIVE CARE UNI43.01NEONATAL INTENSIVE CARE44.00CORONARY CARE UNIT45.00BURN INTENSIVE CARE46.00SURGICAL INTENSIVE47.00OTHER SPECIAL CARE48.01Program inpatient48.01Program inpatient48.01Program inpatient48.01Program inpatient48.01Program inpatient48.02Total Program inpatient48.03Pass through costs50.04Pass through costs51.05Total Program excl53.00Total Program inpatient54.00Program di scharges55.00Target amount per55.01Permanent adj ustme55.02Adj ustment amount56.03Target amount (lir57.00Target amount (see58.00Target costs (legupdated and compout55.01or Tended costs (legupdated and compout55.03are less than64.00Relief payment (see55.01or Line 5953) are less thanenter zero. (see i64.00Medicare swing-bec65.00Relief payment (see64.00Medicare swing-bec65.00Relief payment (see63.00Allowable Inpatient64.00Medicare swing-bec65.00Relief payment (see63.00Allowable Inpatient64.00Medicare swing-bec65.00Relief payment (see	Description	Total Inpatient CostIn	Total patient Days	Average Per Diem (col. 1 col. 2)		Program Cost (col. 3 x col. 4)	
Intensive Care Typ13.00INTENSIVE CARE UNI13.01NEONATAL INTENSIVE CARE14.00CORONARY CARE UNIT15.00BURN INTENSIVE CARE16.00SURGICAL INTENSIVE17.00OTHER SPECIAL CARE18.00Program inpatient18.01Program inpatient18.00Program inpatient18.01Program inpatient19.00Total Program inpatient19.00Total Program inpatient19.00Total Program excl50.00Pass through costs51.00Pass through costs53.00Total Program inpatient54.00Program di scharges55.01Permanent adj ustme55.02Adj ustment amount56.03Target amount (lin57.00Difference betweer58.00Target amount (see59.00Trended costs (les59.00Urended costs (les50.01or lineus improve55.02Adj ustment amount56.03O57.00Expected costs (les58.00Relief payment (see59.00Trended costs (les51.00Medi care swing-bec53.01or line 2x line 1954.00Medi care swing-bec55.01or lite V or XIX swi64.00Medi care swing-bec57.00Title V or XIX swi65.00Total Medicare swi66.00Total Medi care swi67.00Skilled nursing fa68.00Nedi cally necessar </td <td></td> <td>1.00</td> <td>2.00</td> <td>3.00</td> <td>4.00</td> <td>5.00</td> <td></td>		1.00	2.00	3.00	4.00	5.00	
13.00 INTENSIVE CARE UNI 13.00 INTENSIVE CARE UNI 13.01 NEONATAL INTENSIVE 14.00 CORONARY CARE UNI 15.00 BURN INTENSIVE CARE 15.00 SURGICAL INTENSIVE 15.00 OTHER SPECIAL CARE 15.00 OTHER SPECIAL CARE 17.00 OTHER SPECIAL CARE 18.00 Program inpatient 18.01 Program inpatient 18.01 Program inpatient 19.00 Total Program inpatient 19.00 Total Program excl 50.00 Pass through costs 111) Sthrough costs 51.00 Pass through costs 52.00 Total Program excl 53.00 Total Program inpatient 54.00 Program discharges 55.01 Permanent adjustme 65.02 Adjustment amount 66.00 Target amount (Iir 67.00 Ifference betweer 68.00 Bonus payment (see 69.00 Trended costs (Ies 18.00 Continuous improve 52.01, or Line 59	e Inpatient Hospital Units	0	(0.0	00 0	0	42.0
14.00 CORONARY CARE UNIT 15.00 BURN INTENSIVE CAR 16.00 SURGICAL INTENSIVE CAR 16.00 OTHER SPECIAL CARE 17.00 OTHER SPECIAL CARE 18.00 Program inpatient 18.01 Program inpatient 18.01 Program inpatient 18.01 Program inpatient 18.01 Program inpatient 19.00 Pass through costs 1111 Strongh costs 50.00 Total Program inpatient 10.01 Pass through costs 1111 Strongh costs 51.00 Target amount per 55.01 Target amount per 55.02 Adjustment amount 56.03 Difference between 57.00 Difference between 58.00 Bonus payment (see 59.01, or Line 59, S3) are less than 51.00 Continuous improve 52.01, or Line 59, S3) are less than 53.00 Allowable Inpatien PROGRAM INPATIENT 54.00 Medicare swing-bec 55.01, or Line 59,	T	0	C				
15.00 BURN INTENSIVE CARE 16.00 SURGICAL INTENSIVE 17.00 OTHER SPECIAL CARE Cost Center I 18.00 Program inpatient 19.00 Total Program inpatient 19.00 Pass through costs 111) Sthrough costs 31.00 Pass through costs and IV Stand IV 52.00 Total Program inpatient 7.00 Total Program inpatient 7.00 Total Program inpatient 7.00 Total Program inpatient 7.00 Total Program adjustme 64.00 Program discharges 7.00 Bonus payment (see 65.01 rended costs (les updated and compou Stoll or singrows 65.01 or line 59, 63.00 Relief payment (see 63.00 Relief payment (see 64.10 <td< td=""><td></td><td>0</td><td>0</td><td></td><td></td><td></td><td></td></td<>		0	0				
17.00 OTHER SPECIAL CARE Cost Center I Cost Center I 18.00 Program inpatient 18.01 Program inpatient 19.00 Total Program inpatient 19.00 Total Program inpatient 19.00 Pass through costs 10.01 Pass through costs 111) Strong main par 10.02 Total Program excl 13.00 Total Program inpar medical education Target amount per 14.00 Program di scharges 15.00 Target amount per 16.00 Target amount (lir 17.00 Difference betweer 18.00 Continuous improve 18.00 Continuous improve 19.00 Continuous improve 19.00 Continuous improve 19.00 Continuous improve 19.00 Relief payment (see 10 Total		Ŭ					45.0
Cost Center I 8. 00 Program inpatient 9. 00 Total Program inpatient 9. 00 Pass through costs 111) 1. 00 Pass through costs 1. 00 Total Program excl 1. 00 Program discharges 1. 00 Difference between 1. 00 Difference between 1. 00 Difference between 1. 00 Expected costs (les 1. 00 Urended costs (les 1. 00 Continuous improve 55. 01, or line 59, 53) are less than 1. 00 Continuous improve 55. 01, or line 59, 53) are less than 1. 00 Medicare swing-bec 1. 01 Instructions) (titlet 1. 00 Medicare swing-bec 1. 01 Total Medicare swi 1. 01 Contal Medicare swi 1. 01 Contal Medicare swi 1. 02 Contal title V or XIX swi (line 13 x line 20 1. 00 Skilled nursing fat 1. 00 Adj usted general i 1. 00 Program routine se 1. 00 Program copital -ref 1. 00 Program capital -ref 1. 00 Program capital -ref 1. 00 Aggregate charges		0	C	0.0	00 00	0	
 18. 01 Program inpatient Total Program inpatient PASS THROUGH COST 10. 00 Pass through costs and IV) 11. 00 Pass through costs and IV) 12. 00 Total Program excl Total Program inpa medical education TARGET AMOUNT AND 14. 00 Program discharges 15. 01 Permanent adjustme 16. 00 Program discharges 17. 00 Difference between 18. 00 Bonus payment (see updated and compou 55. 01, or Line 59, 53) are less than enter zero. (see instructions) (titl Total Medicare swing-bec instructions) (titl Total Medicare swing-bec instructions) (titl Total Medicare swing-bec instructions) (titl Total Medicare swing-bec instructions) (titl O Medicare swing-bec instructions) (titl Total Medicare swi CAH, see instructi Total X Line 12 X Line 12 X Line 19 X Title V or XIX swi (line 13 X Line 20 Total title V or X PART III - SKILLED 10. 00 Skilled nursing fa X 00 Adjusted general i Z 00 Relical program general Capital -related co Z 00 Forgram copital -re 10. 01 Total Medicare swi CAH, see instructi Total Title V or X PART III - SKILLED 11. 00 Adjusted general i Z 00 Program copital -re 12. 00 Program copital -re 13. 00 Adjusted general i X 00 Total Trelated co Z 00 Per diem capital -re 14. 00 Program copital -re 15. 00 Per diem capital -re 16. 00 Per diem capital -re 17. 00 Per diem capital -re 18. 00 Per diem capital -re 19. 00 Aggregate charges 	• •						47. C
 18. 01 Program inpatient Total Program inpatient PASS THROUGH COST 10. 00 Pass through costs and IV) 11. 00 Pass through costs and IV) 12. 00 Total Program excl Total Program inpa medical education TARGET AMOUNT AND 14. 00 Program discharges 15. 01 Permanent adjustme 16. 00 Program discharges 17. 00 Difference between 18. 00 Bonus payment (see updated and compou 55. 01, or Line 59, 53) are less than enter zero. (see instructions) (titl Total Medicare swing-bec instructions) (titl Total Medicare swing-bec instructions) (titl Total Medicare swing-bec instructions) (titl Total Medicare swing-bec instructions) (titl O Medicare swing-bec instructions) (titl Total Medicare swi CAH, see instructi Total X Line 12 X Line 12 X Line 19 X Title V or XIX swi (line 13 X Line 20 Total title V or X PART III - SKILLED 10. 00 Skilled nursing fa X 00 Adjusted general i Z 00 Relical program general Capital -related co Z 00 Forgram copital -re 10. 01 Total Medicare swi CAH, see instructi Total Title V or X PART III - SKILLED 11. 00 Adjusted general i Z 00 Program copital -re 12. 00 Program copital -re 13. 00 Adjusted general i X 00 Total Trelated co Z 00 Per diem capital -re 14. 00 Program copital -re 15. 00 Per diem capital -re 16. 00 Per diem capital -re 17. 00 Per diem capital -re 18. 00 Per diem capital -re 19. 00 Aggregate charges 	•					1.00	
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 III) III) Pass through costs and IV) Total Program excl Total Program inpamedical education TARGET AMOUNT AND TARGET AMOUNT AND TARGET AMOUNT AND Program discharges Target amount per 3 Permanent adjustme Adjustment amount (Fright amount for a second costs (Fright amount (Fright amount for a second costs (Fright amount for a second costs) (Fright amount fo]
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medical education TARGET AMOUNT AND TARGET AMOUNT AND 7ARGET AMOUNT AND 7ARGET AMOUNT AND 7Fogram discharges 75:00 Permanent adjustme 76:00 77:00 Difference betweer 78:00 79:00 Difference betweer 70:00 Expected costs (Les 10:00 Continuous improve 55:01, or line 59, 53) are less than enter zero. (see i 70:00 Relief payment (see 71:00 Medicare swing-bec instructions)(titl 75:00 Medicare swing-bec instructions)(titl 76:00 Title V or XIX swi (line 12 x line 19 7	itient operating cost exclu		ted, non-phy	ysician anest!	netist, and	1, 864	
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PROGRAM INPATIENT 4.00 Medicare swing-becinstructions)(titl 5.00 Medicare swing-becinstructions)(titl 6.00 Total Medicare swing-becinstructions)(titl 6.00 Total Medicare swing-becinstructions)(titl 7.00 Title V or XIX swing (line 12 x line 19 8.00 Title V or XIX swing (line 13 x line 20 9.00 Total title V or X PART 111 - SKILLED 0.00 Skilled nursing fa 1.00 Adjusted general i 2.00 Porgram routine se 3.00 Medically necessar 4.00 Total Program gene 5.00 Capital-related co 26, line 45) Porgram capital-re 8.00 Pergram capital-re 9.00 Aggregate charges	<i>,</i>					0	
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CAH, see instructi 7.00 (line 12 x line 19 Title V or XIX swi (line 12 x line 19 Title V or XIX swi (line 13 x line 20 Total title V or X PART 111 - SKILLED 0.00 Skilled nursing fa 1.00 Adjusted general i Program routine se 3.00 Medically necessar 4.00 Total Program gene 5.00 Capital -related co 26, line 45) 6.00 Per diem capital -re 8.00 Inpatient routine 9.00 Aggregate charges				soor roporting	g poi i ou (000		
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9.00 Total title V or X PART III - SKILLED 0.00 Skilled nursing fa 1.00 Adjusted general i 2.00 Program routine se 3.00 Medically necessar 4.00 Total Program gene 5.00 Capital-related cc 26, line 45) Per diem capital-re 6.00 Per diem capital-re 7.00 Program capital-re 9.00 Aggregate charges	ng-bed NF inpatient routin	e costs after Dec	ember 31 of	the cost repo	orting period	0	68. (
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5.00 Capital-related cc 26, line 45) 6.00 Per diem capital-r 7.00 Program capital-re 8.00 Inpatient routine 9.00 Aggregate charges	ry private room cost applic eral inpatient routine servi						73.0
5.00 Per diem capital-r 7.00 Program capital-re 3.00 Inpatient routine 9.00 Aggregate charges	ost allocated to inpatient	routine service c	osts (from V	Vorksheet B, F	Part II, column		75. (
3.00 Inpatient routine 9.00 Aggregate charges	elated costs (line 75 ÷ li						76.
9.00 Aggregate charges	elated costs (line 9 x line service cost (line 74 minus						77.
00 Total Drogram rout	to beneficiaries for excess	s costs (from pro					79.
-	ine service costs for comp	arison to the cos			nus line 79)		80.
	service cost per diem limit service cost limitation (1						81. 82.
	ent routine service costs (82. 83.
4.00 Program inpatient	ancillary services (see in	structions)					84.
	/ - physician compensation tient operating costs (sum						85. 0 86. 0
PART IV - COMPUTAT			agri 00)			1	_ 00.0

lealth Financial Systems FR	RANCISCAN HEALT	H INDIANAPOLIS		In Lie	u of Form CMS-2	2552-1
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period: From 01/01/2022	Worksheet D-1	
		Component C	CCN: 15-T162	To 12/31/2022	Date/Time Prep 5/29/2023 3:22	
		Title	e XIX	Subprovider - IRF	PPS	
Cost Center Description		· ·				
					1.00	
38.00 Adjusted general inpatient routine cost per o	diem (line 27 ÷	line 2)			0.00	88.00
39.00 Observation bed cost (line 87 x line 88) (see	e instructions)				0	89.00
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH C	COST					
90.00 Capital-related cost	533, 891	6, 496, 379	0. 08218	3 0	0	90.0
91.00 Nursing Program cost	0	6, 496, 379	0.00000	0 0	0	91.00
92.00 Allied health cost	0	6, 496, 379	0.00000	0 0	0	92.00
93.00 All other Medical Education		6, 496, 379	0.00000		0	93.0

31.00 03100 INTENSIVE CARE UNIT 13,553,008 3 31.01 02060 NEONATAL INTENSIVE CARE UNIT 4,719,020 3 32.00 03200 CORONARY CARE UNIT 6,304,265 3 31.00 0400 SURGI CAL INTENSIVE CARE UNIT 6,304,265 3 31.00 04100 SUBRICAL INTENSIVE CARE UNIT 6,304,265 3 50.00 05000 OPERATING ROM 0.04793 54,265,573 5,143,996 5 51.00 05000 OPERATING ROM 0.147984 58,175 8,609 5 52.00 05000 RADI 0LOGY - DI AGNOSTIC 0.072365 33,057,526 2,392,208 5 54.00 05000 CARDI AC CATHETERI ZATI 0N 0.034328 16,774,391 575,831 5 59.00 05900 CARDI AC CATHETERI ZATI 0N 0.034328 16,774,3	Heal th	Financial Systems	FRANCI SCAN HEALTH INDI ANAPOLI	S	In Lie	eu of Form CMS-	2552-10
Title XVIII Hospital PPS Cost Center Description Ratio of Cost To Charges Inpatient Program Charges Inpatient Program Charges	INPATI	ENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der	CCN: 15-0162	From 01/01/2022	2	
Cost Center Description Ratio of Cost To Charges Inpatient Program Inpatient Program Inpatient Program 30.00 03000 ADULTS & PEDIATRICS 1.00 2.00 3.00 31.00 03000 NEDWATAL INTENSI VE CARE UNIT 13,553,000 3 3 10 2000 NEDWATAL INTENSI VE CARE UNIT 13,553,000 3 3 10 2000 SURGICATAL INTENSI VE CARE UNIT 4,719,020 3 3 3 10 2000 OSURGICATAL INTENSI VE CARE UNIT 4,719,020 3 3 4 3 5,304,265 3 3 4 1,032 4						5/29/2023 3:2	
INPATI ENT ROUTINE SERVICE COST CENTERS To Charges Program (Charges) Program (Col 1 x col 2) 30.00 03000 ADULTS & FEDI ATR CS 65, 269, 282 3 3 31.00 03000 INTENSIVE CARE UNIT 1, 3, 553, 008 3 3 30.00 03000 OLITS & FEDI ATR CS 65, 269, 282 3 3 3 3 3 3, 553, 008 3 3 31.00 03000 CORONARY CARE UNIT 0 3 3, 553, 008 3 3 3 3 0 3, 000 <t< td=""><td></td><td></td><td>Tit</td><td></td><td></td><td></td><td></td></t<>			Tit				
Image: Control of the service cost centers Control of the service cost centers 30.00 03000 ADULTS & PEDIATRICS 65, 269, 282 3 31.00 03000 ADULTS & PEDIATRICS 13, 553, 008 3 31.01 02006 NEONARY CARE UNIT 13, 553, 008 3 32.00 03200 CROWARY CARE UNIT 4, 719, 020 3 34.00 03400 SURG CAL INTENSIVE CARE UNIT 6, 304, 265 3 43.00 04300 SURG CAL INTENSIVE CARE UNIT 6, 304, 265 3 43.00 04300 UBPROVIDER - LIFE 1, 032 4 43.00 04300 UBPROVIDER - LIFE 1, 032 4 50.00 05000 DELIVERY POOM & LABOR ROOM 0.14794 58, 175 8, 609 50.00 05000 DELIVERY POOM & LABOR ROOM 0.14794 58, 175 8, 609 50.00 05000 RADIOLOS - THERAPEUTIC 0.03424 1, 50, 99, 21 16, 714, 59 50.00 05000 CADIATORY THERAPY 0.0342921 15, 209, 165 33, 388, 74 <td< td=""><td></td><td>Cost Center Description</td><td></td><td></td><td></td><td></td><td></td></td<>		Cost Center Description					
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69.00 06900 ELECTROCARDI OLOGY 0.068302 8,935,021 610,280 6 70.00 07000 ELECTROENCEPHALOGRAPHY 0.092150 2,345,268 216,116 7 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0.266874 50,207,732 13,399,138 7 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 0.266874 50,057,923 7,391,803 7 73.00 07300 DRUGS CHARGED TO PATIENTS 0.147665 50,057,923 7,391,803 7 74.00 07400 RENAL DI ALYSIS 0.170260 3,198,960 544,655 7 76.97 07697 CARDI AC REHABILITATION 0.173477 567 98 7 77.00 07700 ALLOGENEI C STEM CELL ACQUISITION 0.289174 0 0 7 00100 UPATI ENT SERVICE COST CENTERS 0.34297 95,856 32,044 9 9 90.01 09000 CLI NI C 0.334297 95,856 32,044 9 90.05 090005 CV DI AGNOSTIC SERVICES <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>							
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71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0.266874 50,207,732 13,399,138 7 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.226368 28,387,114 6,425,934 7 73.00 07300 DRUGS CHARGED TO PATIENTS 0.147665 50,057,923 7,391,803 7 74.00 07400 RENAL DI ALYSIS 0.147665 50,057,923 7,391,803 7 76.97 07697 CARDI AC REHABILITATION 0.170260 3,198,960 544,655 7 77.00 07700 ALLOGENEI C STEM CELL ACQUI SI TI ON 0.289174 0 0 7 00.017024 09000 CLI NI C 0.410793 126,485 51,959 9 90.01 09001 I BMT JOI NT VENTURE 0.334297 95,856 32,044 9 90.05 09005 CV DI AGNOSTI C SERVI CES 0.132107 23,571 3,114 9 91.00 09100 EMERGENCY 0.081232 35,497,525 2,883,535 9							
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.226368 28,387,114 6,425,934 7 73.00 07300 DRUGS CHARGED TO PATIENTS 0.147665 50,057,923 7,391,803 7 74.00 07400 RENAL DI ALYSI S 0.170260 3,198,960 544,655 7 76.97 07697 CARDI AC REHABILI TATI ON 0.173477 567 98 7 77.00 0700 ALLOGENEI C STEM CELL ACQUI SI TI ON 0.289174 0 0 7 90.00 09000 CLI NI C 0.410793 126,485 51,959 9 9 9 0.334297 95,856 32,044 9 90.05 09005 CV DI AGNOSTI C SERVI CES 0.132107 23,571 3,114 9 91.00 09100 EMERGENCY 0.081232 35,497,525 2,883,535 9			т				
73.00 07300 DRUGS CHARGED TO PATIENTS 0.147665 50,057,923 7,391,803 7 74.00 07400 RENAL DI ALYSI S 0.170260 3,198,960 544,655 7 76.97 07697 CARDI AC REHABILI TATI ON 0.173477 567 98 7 77.00 0700 ALLOGENEI C STEM CELL ACQUI SI TI ON 0.289174 0 0 7 0000 0000 CLI NI C 0.410793 126,485 51,959 9 9 90.01 09000 I I BMT JOI NT VENTURE 0.334297 95,856 32,044 9 9 90.05 09100 EMERGENCY 0.132107 23,571 3,114 9 91.00 09100 EMERGENCY 0.081232 35,497,525 2,883,535 9							
74. 00 07400 RENAL DI ALYSI S 0. 170260 3, 198, 960 544, 655 7 76. 97 07697 CARDI AC REHABI LI TATI ON 0. 173477 567 98 7 07.00 ALLOGENEI C STEM CELL ACQUI SI TI ON 0. 289174 0 0 7 00 09000 CLI NI C 0. 410793 126, 485 51, 959 9 90. 01 09001 IBMT JOI NT VENTURE 0. 334297 95, 856 32, 044 9 90. 05 09005 CV DI AGNOSTI C SERVI CES 0. 132107 23, 571 3, 114 9 91. 00 09100 EMERGENCY 0. 081232 35, 497, 525 2, 883, 535 9							
76. 97 07697 CARDIAC REHABILITATION 0.173477 567 98 7 77.00 07700 ALLOGENEIC STEM CELL ACQUISITION 0.289174 0 7 00 09000 CLINIC 0.410793 126,485 51,959 9 90.01 09000 IBMT JOINT VENTURE 0.334297 95,856 32,044 9 90.05 09005 CV DI AGNOSTIC SERVICES 0.132107 23,571 3,114 9 91.00 09100 EMERGENCY 0.081232 35,497,525 2,883,535 9							
77. 00 07700 ALLOGENEI C STEM CELL ACQUISITION 0.289174 0 0 7 0UTPATI ENT SERVICE COST CENTERS 0 0.289174 0 0 7 7 0 0 7 0 0 7 7 0 0 7 7 0 0 7 7 0 0 7 <td< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td></td<>							
OUTPATI ENT SERVICE COST CENTERS 90.00 09000 CLINIC 0.410793 126,485 51,959 9 90.01 09001 IBMT JOINT VENTURE 0.334297 95,856 32,044 9 90.05 09005 CV DI AGNOSTI C SERVICES 0.132107 23,571 3,114 9 91.00 09100 EMERGENCY 0.081232 35,497,525 2,883,535 9							77.00
90. 01 09001 I BMT_JOLNT_VENTURE 0. 334297 95, 856 32, 044 9 90. 05 09005 CV_DIAGNOSTIC_SERVICES 0. 132107 23, 571 3, 114 9 91. 00 09100 EMERGENCY 0. 081232 35, 497, 525 2, 883, 535 9						1	
90. 05 09005 CV DI AGNOSTI C SERVI CES 0. 132107 23, 571 3, 114 9 91. 00 09100 EMERGENCY 0. 081232 35, 497, 525 2, 883, 535 9				0. 4107	93 126, 485	5 51, 959	90.00
91. 00 09100 EMERGENCY 0. 081232 35, 497, 525 2, 883, 535 9	90.01	09001 IBMT JOINT VENTURE		0. 3342	97 95, 856	32, 044	90.01
	90.05	09005 CV DIAGNOSTIC SERVICES		0. 1321	07 23, 571	3, 114	90.05
92 00 09200 0BSERVATION BEDS (NON-DISTINCT PART 0 212433 5 183 753 1 101 200 0	91.00	09100 EMERGENCY		0.0812	32 35, 497, 525	2, 883, 535	5 91.00
	92.00	09200 OBSERVATION BEDS (NON-DISTINCT PAR	т	0. 2124	33 5, 183, 753	1, 101, 200	92.00
200.00 Total (sum of lines 50 through 94 and 96 through 98) 359, 151, 139 51, 004, 824 20	200.00	Total (sum of lines 50 through 94	and 96 through 98)				
							201.00
202.00 Net charges (line 200 minus line 201) 359, 151, 139 20	202.00	Net charges (line 200 minus line 2	01)		359, 151, 139	2	202.00

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		ANCLLL			COCT

FRANCISCAN HEALTH INDIANAPOLIS

In Lieu of Form CMS-2552-10

Health Financial Systems FRANCISCAN HEALTH I	NUT ANAPULTS)	In Lie	U OT FORM CMS-	2002-
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0162	Peri od:	Worksheet D-3	3
	Component	CCN: 15-T162	From 01/01/2022 To 12/31/2022	Date/Time Pre	parod
	component	CCN. 15-1102	10 12/31/2022	5/29/2023 3:2	
	Titl€	e XVIII	Subprovider -	PPS	
			I RF		
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					1
30. 00 03000 ADULTS & PEDIATRICS					30.0
31. 00 03100 I NTENSI VE CARE UNI T					31.0
31. 01 02060 NEONATAL INTENSIVE CARE UNIT					31.0
32.00 03200 CORONARY CARE UNIT					32.0
34. 00 03400 SURGI CAL I NTENSI VE CARE UNI T					34.0
41.00 04100 SUBPROVIDER - IRF			8, 668, 642		41.0
43. 00 04300 NURSERY					43.0
ANCI LLARY SERVI CE COST CENTERS					
50. 00 05000 OPERATING ROOM		0.0947		6, 628	50.0
52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 14798	34 0	C	52.0
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 0723	55 206, 535	14, 946	54.0
55. 00 05500 RADI OLOGY-THERAPEUTI C		0. 1036	47 0	C	55.0
56. 00 05600 RADI OI SOTOPE		0.0426	95 7, 552	322	56.0
59. 00 05900 CARDI AC CATHETERI ZATI ON		0.0343	28 0	C	59.0
60. 00 06000 LABORATORY		0. 1116	17 698, 987	78, 019	60.0
54.00 06400 INTRAVENOUS THERAPY		0. 0921	19 7, 496	691	64.0
65. 00 06500 RESPI RATORY THERAPY		0. 2389	27 353, 213	84, 392	65.0
56. 00 06600 PHYSI CAL THERAPY		0. 1743	2, 067, 068	360, 474	66. C
57.00 06700 OCCUPATIONAL THERAPY		0. 1250	71 1, 925, 186	240, 785	67.0
58.00 06800 SPEECH PATHOLOGY		0. 1235	989, 004	122, 205	68.0
59. 00 06900 ELECTROCARDI OLOGY		0.06830	45, 843	3, 131	69.0
70.00 07000 ELECTROENCEPHALOGRAPHY		0. 0921	50 4, 280	394	70.0
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 2668	74 800, 530	213, 641	71.0
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 2263	58 5, 839	1, 322	72.0
3.00 07300 DRUGS CHARGED TO PATIENTS		0. 1476	643, 510	95, 024	73.0
4.00 07400 RENAL DIALYSIS		0. 1702	50 122, 148	20, 797	74.0
6. 97 07697 CARDI AC REHABI LI TATI ON		0. 1734		C	76.9
7.00 07700 ALLOGENEIC STEM CELL ACQUISITION		0. 2891	74 0	C	77.0
OUTPATIENT SERVICE COST CENTERS					
0. 00 09000 CLI NI C		0. 4107	93 0	C	90.0
0. 01 09001 I BMT JOINT VENTURE		0. 3342		C	90.0
00. 05 09005 CV DI AGNOSTI C SERVI CES		0. 1321		C	90. C
91. 00 09100 EMERGENCY		0.0812		462	91.0
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 2124		C	
200.00 Total (sum of lines 50 through 94 and 96 through 98)			7, 952, 794	1, 243, 233	1
201.00 Less PBP Clinic Laboratory Services-Program only charges	(line 61)		0	., 210, 200	201.0
202.00 Net charges (line 200 minus line 201)	(7, 952, 794		202.0
		1	1,,,02,774	I	1-02.0

I NPATI	ENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0162	Period: From 01/01/2022 To 12/31/2022	Worksheet D-3 Date/Time Pre 5/29/2023 3:2	epared:
		Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description		Ratio of Cos		Inpati ent	
	·		To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
				0	2)	
			1.00	2.00	3.00	
	INPATIENT ROUTINE SERVICE COST CENTERS					
	03000 ADULTS & PEDI ATRI CS			4, 629, 714		30.00
31.00	03100 I NTENSI VE CARE UNI T			1, 233, 024		31.00
31.01	02060 NEONATAL INTENSIVE CARE UNIT			2, 591, 610		31.0
	03200 CORONARY CARE UNI T			723, 287		32.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT			513, 743		34.00
41.00	04100 SUBPROVI DER – I RF			0		41.00
43.00	04300 NURSERY			628, 552		43.00
	ANCI LLARY SERVI CE COST CENTERS					
50.00	05000 OPERATI NG ROOM		0. 0947		316, 665	
52.00	05200 DELIVERY ROOM & LABOR ROOM		0. 14798		401, 069	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C		0.0723	65 2, 557, 182	185, 050	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C		0. 1036	47 22, 921	2, 376	55.00
56.00	05600 RADI OI SOTOPE		0.0426	95 33, 289	1, 421	56.00
59.00	05900 CARDI AC CATHETERI ZATI ON		0.0343	28 913, 705	31, 366	59.00
60.00	06000 LABORATORY		0. 1116	17 3, 918, 538	437, 375	60.00
64.00	06400 I NTRAVENOUS THERAPY		0. 0921	19 151, 066	13, 916	64.00
65.00	06500 RESPI RATORY THERAPY		0. 23892	27 1, 470, 114	351, 250	65.00
66.00	06600 PHYSI CAL THERAPY		0. 1743	373, 410	65, 119	66.00
67.00	06700 OCCUPATI ONAL THERAPY		0. 1250	71 294, 387	36, 819	67.0
68.00	06800 SPEECH PATHOLOGY		0. 1235	64 70, 867	8, 757	68.00
69.00	06900 ELECTROCARDI OLOGY		0.06830	02 658, 572	44, 982	69.0
70.00	07000 ELECTROENCEPHALOGRAPHY		0.0921		14, 410	70.0
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 2668	74 5, 348, 719	1, 427, 434	71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS		0. 2263	68 0	0	72.0
73.00	07300 DRUGS CHARGED TO PATIENTS		0. 1476		578, 260	73.00
	07400 RENAL DI ALYSI S		0. 1702		20, 740	
76.97	07697 CARDI AC REHABI LI TATI ON		0. 1734		394	76.9
77.00	07700 ALLOGENEIC STEM CELL ACQUISITION		0. 2891	74 0	0	77.00
	OUTPATIENT SERVICE COST CENTERS		•			
90.00	09000 CLI NI C		0. 4107	93 51, 695	21, 236	90.00
90. 01	09001 I BMT JOI NT VENTURE		0. 3342		0	
	09005 CV DI AGNOSTI C SERVI CES		0. 1321		1, 067	
	09100 EMERGENCY		0.0812		191, 820	
	09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 2124		3, 710	
200.00		8)		28, 498, 690	4, 155, 236	
201.00				20, 170, 070	.,, 200	201.00
202.00	, , , , , , , , , , , , , , , , , , ,	g (28, 498, 690		202.00

	EALTH INDIANAPOLIS			u of Form CMS-	
NPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0162	Period: From 01/01/2022	Worksheet D-3	
	Component	CCN: 15-T162	To 12/31/2022	Date/Time Pre 5/29/2023 3:2	
	Titl	e XIX	Subprovider - IRF	PPS	!
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1.00	2.00	3.00	<u> </u>
INPATIENT ROUTINE SERVICE COST CENTERS		1			4
30. 00 03000 ADULTS & PEDIATRICS					30.0
31.00 03100 INTENSIVE CARE UNIT					31. (
31. 01 02060 NEONATAL INTENSIVE CARE UNIT					31.0
32.00 03200 CORONARY CARE UNIT					32.0
34.00 03400 SURGI CAL INTENSIVE CARE UNIT			1 0 40 005		34.0
11.00 04100 SUBPROVIDER - IRF			1, 349, 395		41.0
13. 00 04300 NURSERY					43. (
ANCI LLARY SERVI CE COST CENTERS		0.0047	0.0	0	1 50
0.00 05000 OPERATING ROOM		0.0947		0	
22.00 05200 DELIVERY ROOM & LABOR ROOM		0. 1479		0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C 55. 00 05500 RADI OLOGY-THERAPEUTI C		0.0723		0	
56. 00 05500 RADIOLOGY-THERAPEUTIC		0. 1036 0. 0426		0	
59. 00 05900 CARDI AC CATHETERI ZATI ON		0.0428		0	
50. 00 06000 LABORATORY		0. 0343		0	
04.00 06400 INTRAVENOUS THERAPY		0.0921		0	
5. 00 06500 RESPIRATORY THERAPY		0. 2389		0	
6. 00 06600 PHYSI CAL THERAPY		0. 1743		59,609	
57. 00 06700 OCCUPATIONAL THERAPY		0. 1250		39, 309	
58. 00 06800 SPEECH PATHOLOGY		0. 1235		20, 073	
99. 00 06900 ELECTROCARDI OLOGY		0. 0683		0	
70. 00 07000 ELECTROENCEPHALOGRAPHY		0.0921		0	
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 2668		210	
2.00 07200 I MPL. DEV. CHARGED TO PATIENTS		0. 2263		0	
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 1476		0	
74.00 07400 RENAL DIALYSIS		0. 1702		0	74.
6. 97 07697 CARDI AC REHABI LI TATI ON		0. 1734		0	76.
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION		0. 2891		0	77.
OUTPATIENT SERVICE COST CENTERS					1
00. 00 09000 CLI NI C		0. 4107	93 0	0	90.
0.01 09001 IBMT JOINT VENTURE		0. 3342	97 0	0	90.
0. 05 09005 CV DI AGNOSTI C SERVI CES		0. 1321	07 0	0	90.
01.00 09100 EMERGENCY		0. 0812	32 0	0	91.
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 2124		0	92.
200.00 Total (sum of lines 50 through 94 and 96 through	98)		820, 070	119, 291	200.
201.00 Less PBP Clinic Laboratory Services-Program only	charges (line 61)		0		201.
Net charges (line 200 minus line 201)	-		820, 070		202. (

	Financial Systems FF ATION OF CELLULAR THERAPY ACQUISITION COSTS	RANCI SCAN HEALT	Provi der C	CN: 15-0162 Pe	eriod: rom 01/01/2022	Date/Time Pre	pared:
	Inpatient Routine Services Acquisition Costs	D-1	Routi ne Servi ces Acqui si ti on Charges	Per Diem Costs (see instructions)	Inpatient Acquisition Days	5/29/2023 3:2 Acquisition Costs (col. 2 x col. 3)	
		0	1.00	2.00	3.00	4.00	
1 00	PART I - INPATIENT ROUTINE AND ANCILLARY SERV				0	0	1 1 00
1.00 2.00	ADULTS & PEDIATRICS INTENSIVE CARE UNIT	38.00 43.00			0 0		
2.00	NEONATAL INTENSIVE CARE UNIT	43.00			0	0	
3.00	CORONARY CARE UNIT	44.00	_	.,			3.00
4.00	BURN INTENSIVE CARE UNIT	45.00					4.00
5.00	SURGICAL INTENSIVE CARE UNIT	46.00	0		0	0	
6.00	OTHER SPECIAL CARE (SPECIFY)	47.00	0	0.00	0	0	
7.00	TOTAL (sum of lines 1 through 6) Ancillary Services Acquisition Costs	С	Ratio of Cost	Inpatient	0 Outpatient	0 Inpatient	7.00
	And Finally Services Acquisition costs	C	to Charges (from Wkst. C, Pt. I, col. 9)	Anci I I ary Servi ces Acqui sti on Charges	Ancillary Services Acquistion Charges	Anci I I ary Servi ces Acqui sti on Cost	
		0	1.00	2.00	3.00	4.00	
8.00	OPERATING ROOM	50.00	0. 094793	1, 454	0	138	8.00
9.00	RECOVERY ROOM	51.00	0. 000000	0	0	0	9.00
10.00	DELIVERY ROOM & LABOR ROOM	52.00	0.0000		-	-	10.00
11. 00 12. 00	ANESTHESI OLOGY RADI OLOGY-DI AGNOSTI C	53.00 54.00	0. 000000		0	0	
12.00	RADI OLOGY-THERAPEUTI C	55.00	0. 103647	1, 585, 015 11, 330	0	114, 700	
14.00	RADI OI SOTOPE	56.00	0. 042695	0	0	0	•
15.00	CT SCAN	57.00	0. 000000	0	0	0	•
16.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0. 000000	0	0	0	
17.00	CARDI AC CATHETERI ZATI ON	59.00	0. 034328		0	0	
18.00		60.00	0. 111617	795, 943	0	88, 841	18.00
19.00 20.00	PBP CLINICAL LAB SERVICES-PRGM ONLY WHOLE BLOOD & PACKED RED BLOOD CELLS	61.00 62.00	0.000000	0	0	0	19.00 20.00
20.00	BLOOD STORING, PROCESSING & TRANS.	63.00	0.000000		0		•
22.00	INTRAVENOUS THERAPY	64.00	0. 092119		0	1, 381	22.00
23.00	ELECTROCARDI OLOGY	69.00	0. 068302	0	0	0	
24.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0. 266874	2, 656	0	709	•
25.00	DRUGS CHARGED TO PATIENTS	73.00	0. 147665		0	15, 785	
26.00 27.00	ASC (NON-DISTINCT PART) OTHER ANCILLARY SERVICE COST CENTERS	75.00 76.00	0. 000000	0	0	0	26.00 27.00
27.97	CARDI AC REHABI LI TATI ON	76.97	0. 173477	0	0	0	•
28.00	CLINIC	90.00	0. 410793	0	0	0	•
28. 01	IBMT JOINT VENTURE	90.01	0. 334297	30, 956	0	10, 348	
28.05	CV DI AGNOSTI C SERVI CES	90.05	0. 132107	34, 801	0	4, 597	
30.00	TOTAL (sum of lines 8 through 28) Ancillary Services Acquisition Costs	Outpati ent		2, 584, 047	0	237, 673	30.00
	Alici I al y Services Acqui si troli costs	Ancillary					
		Servi ces					
		Acquistion					
		Cost	-				
8.00	OPERATING ROOM	5.00)				8.00
9.00	RECOVERY ROOM	C					9.00
10.00	DELIVERY ROOM & LABOR ROOM						10.00
11.00	ANESTHESI OLOGY	C					11.00
12.00	RADI OLOGY-DI AGNOSTI C RADI OLOGY-THERAPEUTI C	C					12.00
13.00 14.00	RADI OLOGY - THERAPEOTIC RADI OI SOTOPE						13.00 14.00
15.00	CT SCAN	C					15.00
16.00	MAGNETIC RESONANCE IMAGING (MRI)	C					16.00
17.00	CARDI AC CATHETERI ZATI ON	C					17.00
18.00	LABORATORY	C					18.00
19.00 20.00	PBP CLINICAL LAB SERVICES-PRGM ONLY WHOLE BLOOD & PACKED RED BLOOD CELLS						19.00 20.00
20.00	BLOOD STORING, PROCESSING & TRANS.						21.00
22.00	I NTRAVENOUS THERAPY	C					22.00
23.00	ELECTROCARDI OLOGY	C					23.00
24.00	MEDI CAL SUPPLIES CHARGED TO PATI ENT	C					24.00
25.00	DRUGS CHARGED TO PATIENTS	C					25.00
26.00 27.00	ASC (NON-DISTINCT PART) OTHER ANCILLARY SERVICE COST CENTERS						26.00 27.00
	CARDIAC REHABILITATION						27.00
)/ 4/		-	1				
27. 97 28. 00	CLINIC	C					28.00
	CLINIC IBMT JOINT VENTURE	C					28.00 28.01
28. 00 28. 01 28. 05		-					•

Heal th	Financial Systems FRANCISCAN HEALT	H INDIANAPOLIS		In Lie	eu of Form CM	S-2	552-10
COMPUT	ATI ON OF CELLULAR THERAPY ACQUISITION COSTS	Provider C		Period: From 01/01/2022 To 12/31/2022	Date/Time P 5/29/2023 3	V rep : 22	
	Interns and Residents Not in Approved Teaching Program Acquisition Costs	D-2	Average Cos Per Day (fro Wkst. D-2, P [.] I, col. 4)	m Acquisition	Inpatient Pa B Acquisitic Costs (col. x col. 2)	n	
		0	1.00	2.00	3.00	-	
	PART II - INTERNS AND RESIDENTS NOT IN AN APPROVED TEACHING	PROGRAM CELLU					
1.00	ADULTS & PEDI ATRI CS	2.00	0.0	0 00		0	1.00
2.00	INTENSIVE CARE UNIT	3.00	0.0	0 0		0	2.00
2.01	NEONATAL INTENSIVE CARE UNIT	3.01	0.0	0 0		0	2.01
3.00	CORONARY CARE UNIT	4.00					3.00
4.00	BURN INTENSIVE CARE UNIT						4.00
5.00	SURGI CAL I NTENSI VE CARE UNI T	6.00	0.0	0 0		0	5.00
6.00	OTHER SPECIAL CARE (SPECIFY)						6.00
7.00	TOTAL (sum of lines 1 through 6)			0		0	7.00
					Amount	_	
					1.00	_	
1.00	PART III - SUMMARY OF CELLULAR THERAPY ACQUISITION COSTS Acquisition cost from Worksheet B, col. 26 (see instruction))			10, 208, 2	26	1.00
1.00	Acquisition Services Total Costs	15)		I npati ent	Outpati ent		1.00
	Acquisition services total costs			1.00	2.00	-	
2.00	Routine and ancillary		-	237, 673		0	2.00
3.00	Interns and residents			0			3.00
4.00	Apportionment of acquisition cost from line 1			10, 208, 226		ol	4.00
5.00	Cost of physicians' services in a teaching hospital (see ir	nstructions)		0		0	5.00
6.00	Total acquisition cost (sum of lines 2 through 5)			10, 445, 899		0	6.00
	Determine Ratio of Medicare Transplants to Total Tran	spl ants	Inpati ent	Outpati ent	Total		
			1.00	2.00	3.00		
7.00	Total transplants (see instructions)			37 0		37	7.00
8.00	Medicare transplants (see instructions)			7 0			8.00
9.00	Medicare ratio (line 8 ÷ line 7)		0. 18918				9.00
10.00	Medicare cost (see instructions)		1, 976, 24	19 0		_	10.00
					Amount	_	
					1.00		
1.00	PART IV - STATISTICS Number of recipients intended for allogeneic HSCT where the transplant did not occur (see instructions)	e acquisition o	cost was incur	red but the		0	1.00

	Financial Systems FRANCISCAN HEALTH	Provider CCN: 15-0162	Peri od: From 01/01/2022 To 12/31/2022	Date/Time Pre 5/29/2023 3:2	pared:
		Title XVIII	Hospi tal	PPS	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS			1.00	
1.00	DRG Amounts Other than Outlier Payments			0	1.00
1.01	DRG amounts other than outlier payments for discharges occurr instructions)	ing prior to October 1	(see	52, 855, 306	1.01
1.02	DRG amounts other than outlier payments for discharges occurr instructions)	ing on or after October	1 (see	19, 360, 784	1. 02
1.03	DRG for federal specific operating payment for Model 4 BPCI for	or discharges occurring	prior to October	0	1.03
1.04	1 (see instructions) DRG for federal specific operating payment for Model 4 BPCI for October 1 (see instructions)	or discharges occurring	on or after	0	1.04
2. 00 2. 01	Outlier payments for discharges. (see instructions) Outlier reconciliation amount			0	2.00 2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instruct	i ons)		0	2.02
2.03 2.04	Outlier payments for discharges occurring prior to October 1 Outlier payments for discharges occurring on or after October			4, 381, 233 1, 371, 720	
2.04 3.00	Managed Care Simulated Payments	(see mistructions)		59, 968, 346	1
4.00	Bed days available divided by number of days in the cost repo	rting period (see instru	uctions)	467.87	4.00
5.00	Indirect Medical Education Adjustment FTE count for allopathic and osteopathic programs for the mos or before 12/31/1996. (see instructions)	t recent cost reporting	period ending on	21. 78	5.00
5.01	FTE cap adjustment for qualifing hospitals under §131 of the	CAA 2021 (see instructio	ons)	0.00	5. 01
6.00	FTE count for allopathic and osteopathic programs that meet t new programs in accordance with 42 CFR 413.79(e)			0.00	
6.26	Rural track program FTE cap limitation adjustment after the c the CAA 2021 (see instructions)	ap-building window close	ed under \$127 of	0.00	6. 26
7.00	MMA Section 422 reduction amount to the IME cap as specified			0.32	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under cost report straddles July 1, 2011 then see instructions.	42 CFR §412.105(†)(1)(1	v)(B)(2) If the	0.00	7.01
7.02	Adjustment (increase or decrease) to the hospital's rural track programs with a rural track for Medicare GME affiliated			0.00	7. 02
8.00	and 87 FR 49075 (August 10, 2022) (see instructions) Adjustment (increase or decrease) to the FTE count for allopa affiliated programs in accordance with 42 CFR 413.75(b), 413.			0.00	8.00
8. 01	1998), and 67 FR 50069 (August 1, 2002). The amount of increase if the hospital was awarded FTE cap sl			0. 81	8. 01
8.02	report straddles July 1, 2011, see instructions. The amount of increase if the hospital was awarded FTE cap sl	ots from a closed teachi	ng hospital	0.00	8. 02
8. 21	under § 5506 of ACA. (see instructions) The amount of increase if the hospital was awarded FTE cap sl	ots under §126 of the CA	AA 2021 (see	0.00	8. 21
9.00	instructions) Sum of lines 5 and 5.01, plus line 6, plus lines 6.26 through	6.49, minus lines 7 and	d 7.01, plus or	22. 27	9.00
10. 00	minus line 7.02, plus/minus line 8, plus lines 8.01 through 8		cde	22. 92	10.00
	FTE count for allopathic and osteopathic programs in the curre FTE count for residents in dental and podiatric programs.	ent year from your recor	us		11.00
	Current year allowable FTE (see instructions)				12.00
13.00 14.00	Total allowable FTE count for the prior year.	ar and an ar after So	atombor 20 1007	22. 27 17. 87	
14.00	Total allowable FTE count for the penultimate year if that ye otherwise enter zero.		Stember 30, 1997,	17.07	14.00
	Sum of lines 12 through 14 divided by 3.				15.00
16. 00 17. 00	Adjustment for residents in initial years of the program (see Adjustment for residents displaced by program or hospital clo			0.00 0.00	
18.00	Adjusted rolling average FTE count	3410		20.80	1
	Current year resident to bed ratio (line 18 divided by line 4).		0. 044457	
20. 00 21. 00	Prior year resident to bed ratio (see instructions) Enter the lesser of lines 19 or 20 (see instructions)			0. 047676 0. 044457	
21.00	IME payment adjustment (see instructions)			1, 732, 608	1
22. 01	IME payment adjustment - Managed Care (see instructions)			1, 438, 761	
23.00	Indirect Medical Education Adjustment for the Add-on for § 42: Number of additional allopathic and osteopathic IME FTE resid		CFR 412.105	0.00	23.00
24.00	(f)(1)(iv)(C). IME FTE Resident Count Over Cap (see instructions)			0.65	24.00
25.00	If the amount on line 24 is greater than -O-, then enter the instructions)	lower of line 23 or line	e 24 (see	0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)			0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)			0. 000000	27.00
	IME add-on adjustment amount (see instructions)	`		0	28.00
28. 01 29. 00	IME add-on adjustment amount - Managed Care (see instructions Total IME payment (sum of lines 22 and 28)	J		0 1, 732, 608	28.01 29.00
29.00	Total IME payment - Managed Care (sum of lines 22.01 and 28.0	1)		1, 438, 761	
00.55	Disproportionate Share Adjustment				
30. 00 31. 00	Percentage of SSI recipient patient days to Medicare Part A p. Percentage of Medicaid patient days (see instructions)	atient days (see instruc	CTIONS)	3. 04 23. 58	
32.00	Sum of Lines 30 and 31			26.62	
33.00	Allowable disproportionate share percentage (see instructions)		11.18	33.00
34.00	Disproportionate share adjustment (see instructions)			2, 018, 440	34.00

	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0162	Peri od:	Worksheet E	
			From 01/01/2022 To 12/31/2022	Part A Date/Time Pre	
		Title XVIII	Hospi tal	5/29/2023 3: 2: PPS	2 pr
			Prior to 10/1		
			1.00	2.00	
	Uncompensated Care Payment Adjustment				
	Total uncompensated care amount (see instructions)		0	0	
	Factor 3 (see instructions) Hospital UCP, including supplemental UCP (If line 34 is ze	ro enter zero on this line	e) 0. 00000000 8, 843, 657	0. 000000000 7, 673, 313	
. 02	(see instructions)		5) 0, 043, 037	7,075,515	35
. 03	Pro rata share of the hospital UCP, including supplemental	UCP (see instructions)	6, 614, 569	1, 934, 097	35
	Total UCP adjustment (sum of columns 1 and 2 on line 35.03)		8, 548, 666		36
	Additional payment for high percentage of ESRD beneficiary	discharges (lines 40 throu			
	Total Medicare discharges (see instructions)		0		40
	Total ESRD Medicare discharges (see instructions)	usti spo)	0		41
	Total ESRD Medicare covered and paid discharges (see instru- Divide line 41 by line 40 (if less than 10%, you do not qu		0.00		41
	Total Medicare ESRD inpatient days (see instructions)	arry for adjustment)	0.00		42
	Ratio of average length of stay to one week (line 43 divide	ed by line 41 divided by 7	0.000000		44
-	days)	<u> </u>			
	Average weekly cost for dialysis treatments (see instruction	-	0.00		45
	Total additional payment (line 45 times line 44 times line	41.01)	0		46
	Subtotal (see instructions)	amall susal bassitals	90, 268, 757		47
. 00	Hospital specific payments (to be completed by SCH and MDH only. (see instructions)	, smart rurar nospitars	0		48
				Amount	
				1.00	
	Total payment for inpatient operating costs (see instruction			91, 707, 518	
	Payment for inpatient program capital (from Wkst. L, Pt. I			6, 470, 439	
	Exception payment for inpatient program capital (Wkst. L, Direct graduate medical education payment (from Wkst. E-4,			0 872, 077	51
	Nursing and Allied Health Managed Care payment	Time 49 see flistidetions).		228, 558	
	Special add-on payments for new technologies			431, 891	
	Islet isolation add-on payment			0	54
. 00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line	e 69)		0	55
	Cellular therapy acquisition cost (see instructions)			1, 976, 249	
	Cost of physicians' services in a teaching hospital (see in			0	56
	Routine service other pass through costs (from Wkst. D, Pt Ancillary service other pass through costs from Wkst. D, P		through 35).	0 129, 724	57 58
	Total (sum of amounts on lines 49 through 58)	t. 10, col. 11 111e 200)		101, 816, 456	
	Primary payer payments			23, 425	
	Total amount payable for program beneficiaries (line 59 mil	nus line 60)		101, 793, 031	
	Deductibles billed to program beneficiaries			6, 138, 336	
	Coinsurance billed to program beneficiaries			433, 098	
	Allowable bad debts (see instructions)			258, 900	
	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see in	nstructions)		168, 285 86, 638	
	Subtotal (line 61 plus line 65 minus lines 62 and 63)			86, 638 95, 389, 882	
	Credi ts received from manufacturers for replaced devices for	or applicable to MS-DRGs (s	see instructions)	⁷⁵ , 307, 882	
	Outlier payments reconciliation (sum of lines 93, 95 and 9			0	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	70
	Rural Community Hospital Demonstration Project (§410A Demo		instructions)	0	70
	N95 respirator payment adjustment amount (see instructions)	e		0	70
	Demonstration payment adjustment amount before sequestration			0	70 70
	SCH or MDH volume decrease adjustment (contractor use only Pioneer ACO demonstration payment adjustment amount (see i			0	70
	HSP bonus payment HVBP adjustment amount (see instructions)			0	
	HSP bonus payment HRR adjustment amount (see instructions)	<i>,</i>		0	
. 91. i				0	70
	Bundled Model 1 discount amount (see instructions)			0	
). 92). 93	Bundled Model 1 discount amount (see instructions) HVBP payment adjustment amount (see instructions) HRR adjustment amount (see instructions)			0 - 102, 131	70

	nancial Systems FRANCISCAN HEALTH ON OF REIMBURSEMENT SETTLEMENT	Provider C	CN: 15-0162	Period: From 01/01/2022	Worksheet E Part A	
				To 12/31/2022		
		Titl∈	e XVIII	Hospi tal	PPS	
			FFY	(уууу)	Amount	<u> </u>
), 96 Lov	w volume adjustment for federal fiscal year (yyyy) (Enter	in column 0		0	1.00	70
	e corresponding federal year for the period prior to 10/1)			0	0	1 /0
	w volume adjustment for federal fiscal year (yyyy) (Enter			0	0	70
	e corresponding federal year for the period ending on or a	after 10/1)				
	w Volume Payment-3				0	70
	C adjustment amount (see instructions) ount due provider (line 67 minus lines 68 plus/minus lines				05 207 751	70
	questration adjustment (see instructions)	5 09 & 70)			95, 287, 751 1, 200, 625	
1	nonstration payment adjustment amount after sequestration				1, 200, 025	
	questration adjustment-PARHM or CHART pass-throughs					7
.00 Int	terim payments				89, 135, 416	72
1	terim payments-PARHM or CHART					72
	ntative settlement (for contractor use only)	``			0	
	ntative settlement-PARHM or CHART (for contractor use onl				4 OE1 710	73
. 00 Bal (73)	lance due provider/program (line 71 minus lines 71.01, 71.)	oz, /z, and			4, 951, 710	'
	, lance due provider/program-PARHM or CHART (see instructior	ns)				74
	otested amounts (nonallowable cost report items) in accord				88, 335	
CMS	S Pub. 15-2, chapter 1, §115.2					
	BE COMPLETED BY CONTRACTOR (lines 90 through 96)		1			
	erating outlier amount from Wkst. E, Pt. A, line 2, or sum	n of 2.03			0	90
	us 2.04 (see instructions) pital outlier from Wkst. L, Pt. I, line 2				0	9.
	erating outlier reconciliation adjustment amount (see inst	tructions)			0	
	pital outlier reconciliation adjustment amount (see instru				0	9
	e rate used to calculate the time value of money (see inst				0.00	
	me value of money for operating expenses (see instructions				0	
.00 Tin	me value of money for capital related expenses (see instru	uctions)		Prior to 10/1	0 0p/After 10/1	96
				1.00	2.00	-
HSP	P Bonus Payment Amount					
	P bonus amount (see instructions)			0	0	100
	3P Adjustment for HSP Bonus Payment					
	BP adjustment factor (see instructions)	202)		0.000000000	0.000000000	
	BP adjustment amount for HSP bonus payment (see instructic R Adjustment for HSP Bonus Payment	JIIS)		0	0	10:
	R adjustment factor (see instructions)			0,0000	0.0000	110
	R adjustment amount for HSP bonus payment (see instruction	ıs)		0		10
	al Community Hospital Demonstration Project (§410A Demons		ustment			
	this the first year of the current 5-year demonstration p	period under t	the 21st			20
	ntury Cures Act? Enter "Y" for yes or "N" for no.					
	st Reimbursement dicare inpatient service costs (from Wkst. D-1, Pt. II, li	po (0)				20'
	di care di scharges (see instructions)	ne 49)				20
	se-mix adjustment factor (see instructions)					20
	nputation of Demonstration Target Amount Limitation (N/A i	n first year	of the curren	t 5-year demonst		
	ri od)			-		
	dicare target amount					204
1	se-mix adjusted target amount (line 203 times line 204)	-)				205
	dicare inpatient routine cost cap (line 202 times line 205 ustment to Medicare Part A Inpatient Reimbursement)				200
	ogram reimbursement under the §410A Demonstration (see ins	structions)				207
	dicare Part A inpatient service costs (from Wkst. E, Pt. A					208
	justment to Medicare IPPS payments (see instructions)	,				209
	served for future use					210
	tal adjustment to Medicare IPPS payments (see instructions	5)				21
1.00 <u>Tot</u>						
1.00 Tot Com	nparision of PPS versus Cost Reimbursement			1		1011
1.00 Tot Com 2.00 Tot	tal adjustment to Medicare Part A IPPS payments (from line	e 211)				212
1.00 <u>Tot</u> <u>Com</u> 2.00 Tot 3.00 Lov			nbursement)			212 213 218

	Financial Systems LUME CALCULATION EXHIBIT 4	FF	RANCI SCAN HEALT	H INDIANAPOLIS Provider CC		eriod: com 01/01/2022	u of Form CMS-2 Worksheet E Part A Exhibit Date/Time Prep	t 4 pared
			Amounts (from	Pre/Post	XVIII Period Prior	Hospi tal Peri od	5/29/2023 3: 22 PPS Total (Col 2	<u>2 pm</u>
		line 0	E, Part A) 1.00	Entitlement 2.00	<u>to 10/01</u> 3.00	0n/After 10/01 4.00	through 4) 5.00	
00	DRG amounts other than outlier		0	0	0	0	0	1.
01	payments DRG amounts other than outlier payments for discharges	1.01	52, 855, 306	О	52, 855, 306		52, 855, 306	1.
02	occurring prior to October 1 DRG amounts other than outlier payments for discharges occurring on or after October	1. 02	19, 360, 784	0		19, 360, 784	19, 360, 784	1.
03	1 DRG for Federal specific operating payment for Model 4 BPCl occurring prior to	1. 03	0	O	0		0	1.
04	October 1 DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1. 04	0	0		0	0	1.
00	Outlier payments for	2.00						2.
01	discharges (see instructions) Outlier payments for	2. 02	0	0	0	0	0	2.
02	discharges for Model 4 BPCI Outlier payments for discharges occurring prior to	2. 03	4, 381, 233	0	4, 381, 233		4, 381, 233	2.
03	October 1 (see instructions) Outlier payments for discharges occurring on or after October 1 (see	2.04	1, 371, 720	0		1, 371, 720	1, 371, 720	2
	instructions)	0.01						
00	Operating outlier reconciliation	2.01	0	0	0	0	0	3
00	Managed care simulated payments	3.00	59, 968, 346	0	43, 262, 953	16, 705, 393	59, 968, 346	4
00	Indirect Medical Education Adju Amount from Worksheet E, Part	ustment 21.00	0. 044457	0.044457	0. 044457	0. 044457		5
00	A, line 21 (see instructions) IME payment adjustment (see	21.00	1, 732, 608	0. 044437	1, 268, 104	464, 504	1, 732, 608	
1	instructions) IME payment adjustment for managed care (see instructions)	22. 01	1, 438, 761	0	1, 037, 965	400, 796	1, 438, 761	6
	Indirect Medical Education Adju	L LISTMENT FOR THE	e Add-on for Se	ction 422 of th	ne MMA	I		
0	IME payment adjustment factor (see instructions)	27.00	0. 000000	0. 000000	0. 000000	0. 000000		7
)0)1	IME adjustment (see instructions) IME payment adjustment add on	28. 00 28. 01	0	0	0	0	0	
	for managed care (see instructions)			Ĵ	Ū			
)0)1	Total IME payment (sum of lines 6 and 8) Total IME payment for managed	29.00 29.01	1, 732, 608 1, 438, 761	0	1, 268, 104 1, 037, 965	464, 504 400, 796	1, 732, 608 1, 438, 761	
	care (sum of lines 6.01 and 8.01)		.,		.,, ,		.,	
00	Disproportionate Share Adjustmo Allowable disproportionate share percentage (see	ant 33.00	0. 1118	0. 1118	0. 1118	0. 1118		10
00	instructions) Disproportionate share	34.00	2, 018, 440	0	1, 477, 306	541, 134	2, 018, 440	11
01	adjustment (see instructions) Uncompensated care payments Additional payment for high per	36.00 centage of ESF	8, 548, 666 D benefi ci ary	0 di scharges	6, 614, 569	1, 934, 097	8, 548, 666	11
00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	
00 00	Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	47.00 48.00	90, 268, 757 0	0 0	66, 596, 518 0	23, 672, 239 0	90, 268, 757 0	13
00	Total payment for inpatient operating costs (see instructions)	49.00	91, 707, 518	0	67, 634, 483	24, 073, 035	91, 707, 518	15
00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	6, 470, 439	0	4, 772, 857	1, 697, 582	6, 470, 439	16

	Financial Systems	Fr	RANCISCAN HEALT	Provider C		Period:	u of Form CMS-2 Worksheet E	2552-1
LOW VO	LUME CALCULATION EXHIBIT 4					From 01/01/2022 To 12/31/2022	Part A Exhibi Date/Time Pre 5/29/2023 3:2	pared:
					XVIII	Hospi tal	PPS	
		line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prion to 10/01	On/After 10/01		
		0	1.00	2.00	3.00	4.00	5.00	
17.00	Special add-on payments for new technologies	54.00	431, 891	0	326, 0 ⁻	105, 875	431, 890	
17.01	Net organ aquisition cost							17.0
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0		0 0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see		0	0		0 0	0	18.00
19.00	instructions) SUBTOTAL			0	72, 733, 3	25, 876, 492	98, 609, 847	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20. 00 20. 01	Capital DRG other than outlier Model 4 BPCI Capital DRG other than outlier	1. 00 1. 01	5, 481, 064 0	0 0		04 1, 452, 760 0 0	5, 481, 064 0	1
21. 00 21. 01	Capital DRG outlier payments Model 4 BPCI Capital DRG	2. 00 2. 01	874, 821 0	0 0	000,00	52 214, 459 0 0	874, 821 0	
22.00	outlier payments Indirect medical education percentage (see instructions)	5.00	0. 0209	0. 0209	0. 020	0. 0209		22. 0
23.00	Indirect medical education adjustment (see instructions)	6.00	114, 554	0	84, 19	30, 363	114, 554	23.0
24.00	Allowable disproportionate share percentage (see instructions)	10. 00	0. 0000	0.0000	0.000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0		0 0	0	25.0
26.00	Total prospective capital payments (see instructions)	12.00	6, 470, 439	0	4, 772, 8	57 1, 697, 582	6, 470, 439	26.00
			(Amounts to E,					
		line	Part A)	0.00	0.00	1.00	F 00	
27.00	Low volume adjustment factor	0	1.00	2.00	3.00	<u>4.00</u> 0.000000	5.00	27.00
28.00	Low volume adjustment factor Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70. 96			0.0000	0	0	
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70. 97				0	0	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100. 00

			H INDIANAPOLIS		In Lie	u of Form CMS-2	2552-10
HOSPI 1	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	TION EXHIBIT 5	Provider CC	F	eriod: rom 01/01/2022		
					o 12/31/2022	5/29/2023 3:2	
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt.	XVIII Period to 10/01	Hospital Period on after 10/01	PPS Total (cols. 2 and 3)	
		0	A) 1.00	2.00	3.00	4.00	
1.00 1.01	DRG amounts other than outlier payments DRG amounts other than outlier payments for	1.00 1.01	52, 855, 306			52, 855, 306	1. 00 1. 01
1.02	discharges occurring prior to October 1 DRG amounts other than outlier payments for	1.02	19, 360, 784		19, 360, 784	19, 360, 784	1. 02
1.03	discharges occurring on or after October 1 DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October	1.03	0	C		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1. 04
2.00	Outlier payments for discharges (see instructions)	2.00					2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	C	0	0	2. 01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	4, 381, 233	4, 381, 233		4, 381, 233	2. 02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	1, 371, 720		1, 371, 720	1, 371, 720	2. 03
3.00 4.00	Operating outlier reconciliation Managed care simulated payments	2.01 3.00	0 59, 968, 346	C 43, 262, 953	0 16, 705, 393	0 59, 968, 346	3.00 4.00
5.00	Indirect Medical Education Adjustment Amount from Worksheet E, Part A, Line 21	21.00	0. 044457				5.00
6.00	(see instructions) IME payment adjustment (see instructions)	22.00	1, 732, 608				6. 00
6.01	IME payment adjustment for managed care (see instructions)	22.00	1, 438, 761				6. 01
	Indirect Medical Education Adjustment for the				1		
7.00	IME payment adjustment factor (see instructions)	27.00	0. 000000	0. 000000	0. 000000		7.00
8.00 8.01	IME adjustment (see instructions) IME payment adjustment add on for managed care (see instructions)	28.00 28.01	0	C		0 0	8. 00 8. 01
9.00 9.01	Total IME payment (sum of lines 6 and 8) Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.00 29.01	1, 732, 608 1, 438, 761				9. 00 9. 01
	Di sproporti onate Share Adjustment			<u> </u>			
10.00		33.00	0. 1118	0. 1118	0. 1118		10. 00
11.00	Disproportionate share adjustment (see instructions)	34.00	2, 018, 440	1, 477, 306	541, 134	2, 018, 440	11. 00
11.01	Uncompensated care payments Additional payment for high percentage of ESR	36.00	8, 548, 666 di scharges	6, 614, 569	1, 934, 097	8, 548, 666	11. 01
12.00	Total ESRD additional payment (see instructions)	46.00	0	C	0	0	12.00
13. 00 14. 00	Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see	47.00 48.00	90, 268, 757 0	66, 596, 518 C	23, 672, 239 0	90, 268, 757 0	13. 00 14. 00
15.00	instructions) Total payment for inpatient operating costs	49.00	91, 707, 518	67, 634, 483	24, 073, 035	91, 707, 518	15.00
16.00	(see instructions) Payment for inpatient program capital (from	50.00	6, 470, 439	4, 772, 857	1, 697, 582	6, 470, 439	16. 00
17.00	Wkst. L, Pt. I, if applicable) Special add-on payments for new technologies	54.00	431, 891	326, 016	105, 875	431, 891	
17. 01 17. 02		68.00	0	C	0	0	17. 01 17. 02
18.00	replaced devices for applicable MS-DRGs Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	C	0	0	18.00
19. 00	amount (see instructions) SUBTOTAL			72, 733, 356	25, 876, 492	98, 609, 848	19.00

HOSPI T	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	TION EXHIBIT 5	Provider CO		Period: From 01/01/2022 To 12/31/2022		pared:
			Title	XVIII	Hospi tal	PPS	
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	5, 481, 064	4, 028, 30	1, 452, 760	5, 481, 064	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	874, 821	660, 36	214, 459	874, 821	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. 0209	0. 020	09 0. 0209		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	114, 554	84, 19	30, 363	114, 554	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0		0 0	0	25.00
26. 00	Total prospective capital payments (see instructions)	12.00	6, 470, 439	4, 772, 85	57 1, 697, 582	6, 470, 439	26.00
		Wkst. E, Pt.	(Amt. from				
		A, line	Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70. 96	0		0	0	28.00
29.00	Low volume adjustment on or after October 1	70. 97	0		0	0	29.00
30. 00	HVBP payment adjustment (see instructions)	70. 93	0		0 0	0	30.00
30. 01	HVBP payment adjustment for HSP bonus payment (see instructions)	70. 90	0		0 0	0	30. 01
31.00	HRR adjustment (see instructions)	70.94	-102, 131	-10, 63	-91, 493	-102, 131	31.00
31. 01	HRR adjustment for HSP bonus payment (see instructions)	70. 91	0		0 0	0	31.01
						(Amt. to Wkst.	
						E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
	HAC Reduction Program adjustment (see instructions)	70. 99			0 0	0	02.00
	Transfer HAC Reduction Program adjustment to	1	N				100.00

	Financial Systems FRANCISCAN HEALTH IND ATION OF REIMBURSEMENT SETTLEMENT P	rovider CCN: 15-0162	Peri od:	u of Form CMS-2 Worksheet E	2002-10
			From 01/01/2022 To 12/31/2022	Part B Date/Time Pre	
		Title XVIII	Hospi tal	5/29/2023 3: 2 PPS	2 piii
				1 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
1.00	Medical and other services (see instructions)			30, 371	1.00
2.00	Medical and other services reimbursed under OPPS (see instruction	ns)		55, 391, 846	
3.00 4.00	OPPS payments Outlier payment (see instructions)			52, 680, 399 315, 310	
4.01	Outlier reconciliation amount (see instructions)			0	
5.00	Enter the hospital specific payment to cost ratio (see instructi	ons)		0.000	
6.00 7.00	Line 2 times line 5 Sum of lines 3, 4, and 4.01, divided by line 6			0 0.00	
8.00	Transitional corridor payment (see instructions)			0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV,	col. 13, line 200		160, 297	
10. 00 11. 00	Organ acquisitions Total cost (sum of lines 1 and 10) (see instructions)		0 30, 371		
	COMPUTATION OF LESSER OF COST OR CHARGES				
40.00	Reasonable charges			400 (50	10.00
	Ancillary service charges Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line	69)		180, 652 0	
14.00	Total reasonable charges (sum of lines 12 and 13)	())		180, 652	1
	Customary charges		· · · ·		
15.00 16.00	Aggregate amount actually collected from patients liable for pay Amounts that would have been realized from patients liable for p			0	
10.00	had such payment been made in accordance with 42 CFR §413.13(e)	ayment for services c	a chargebasi s	0	10.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000	1
18.00 19.00	Total customary charges (see instructions) Excess of customary charges over reasonable cost (complete only	ifling 18 exceeds li	ng 11) (soo	180, 652 150, 281	
19.00	instructions)	IT THE TO EXCEEDS IT	lie II) (See	150, 201	19.00
20.00	Excess of reasonable cost over customary charges (complete only	ifline 11 exceeds li	ne 18) (see	0	20.00
21.00	instructions) Lesser of cost or charges (see instructions)			30, 371	21.00
22.00	Interns and residents (see instructions)			00,071	
	Cost of physicians' services in a teaching hospital (see instruc	tions)		0	
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) COMPUTATION OF REIMBURSEMENT SETTLEMENT			53, 156, 006	24.00
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)			146	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 2			8, 878, 000	
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plu instructions)	s the sum of lines 22	and 23] (see	44, 308, 231	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line	50)		516, 329	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	
30. 00 31. 00	Subtotal (sum of lines 27 through 29) Primary payer payments			44, 824, 560 3, 956	
	Subtotal (line 30 minus line 31)			44, 820, 604	
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		_	
33.00 34.00	Composite rate ESRD (from Wkst. 1-5, line 11) Allowable bad debts (see instructions)			0 441, 051	
35.00	Adjusted reimbursable bad debts (see instructions)			286, 683	
36.00	Allowable bad debts for dual eligible beneficiaries (see instruc	tions)		231, 507	
37.00 38.00	Subtotal (see instructions) MSP-LCC reconciliation amount from PS&R			45, 107, 287 281	
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			201	
39.50	Pioneer ACO demonstration payment adjustment (see instructions)				39.50
39.75	N95 respirator payment adjustment amount (see instructions)			0	
39. 97 39. 98	Demonstration payment adjustment amount before sequestration Partial or full credits received from manufacturers for replaced	devices (see instruc	tions)	0 3, 460	
39.99	RECOVERY OF ACCELERATED DEPRECIATION		,	0	
40.00	Subtotal (see instructions)			45, 107, 006	
40. 01 40. 02	Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration			568, 349 0	
40.02	Sequestration adjustment-PARHM or CHART pass-throughs			0	40.02
41.00	Interim payments			45, 018, 327	
41.01 42.00	Interim payments-PARHM or CHART Tentative settlement (for contractors use only)			0	41.01 42.00
42.00 42.01	Tentative settlement-PARHM or CHART (for contractor use only)			0	42.00
43.00	Balance due provider/program (see instructions)			-479, 670	
43.01	Balance due provider/program-PARHM (see instructions)	with CMS Dub 15 0	chaptor 1	^	43.01
44.00	Protested amounts (nonallowable cost report items) in accordance §115.2	with GWS PUD. 15-2,	chapter I,	0	44.00
	TO BE COMPLETED BY CONTRACTOR				
	Original outlier amount (see instructions)			0	
91.00 92.00	Outlier reconciliation adjustment amount (see instructions) The rate used to calculate the Time Value of Money			0.00	
93.00	Time Value of Money (see instructions)			0	93.00
94.00	Total (sum of lines 91 and 93)			0	94.00

Health Financial Systems	u of Form CMS-:	2552-10		
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0162 Peri od:		Worksheet E	
		From 01/01/2022 To 12/31/2022	Date/Time Pre	
			5/29/2023 3:2	2 pm
	Title XVIII	Hospi tal	PPS	
			1.00	
MEDICARE PART B ANCILLARY COSTS				
200.00 Part B Combined Billed Days			0	200. 00

PA 1.00 Me 2.00 Me 3.00 OF 4.00 Ou 5.00 Li 7.00 St 8.00 Tr 9.00 Ar 10.00 Or 11.00 Tc CC CC 12.00 Ar 13.00 Or 14.00 Tc CL To 15.00 Ar 16.00 Ar	ART B - MEDICAL AND OTHER HEALTH SERVICES edical and other services (see instructions) edical and other services reimbursed under OPPS (see instruc PPS payments utlier payment (see instructions) utlier reconciliation amount (see instructions) nter the hospital specific payment to cost ratio (see instru ine 2 times line 5 um of lines 3, 4, and 4.01, divided by line 6 ransitional corridor payment (see instructions) ncillary service other pass through costs from Wkst. D, Pt. rgan acquisitions otal cost (sum of lines 1 and 10) (see instructions) MMPUTATION OF LESSER OF COST OR CHARGES easonable charges ncillary service charges (from Wkst. D-4, Pt. III, col. 4, I otal reasonable charges (sum of lines 12 and 13) Jstomary charges	Component CCN: 15-T162 Title XVIII tions) ctions)	Peri od: From 01/01/2022 To 12/31/2022 Subprovi der - IRF	Date/Ti me Pre 5/29/2023 3: 2: PPS 1.00 92 463 321 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1. 00 2. 00 3. 00 4. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00
1.00 Me 2.00 Me 3.00 OF 4.00 Ou 4.01 Ou 5.00 Er 6.00 Li 7.00 Su 8.00 Tr 9.00 Ar 10.00 Or 11.00 Tc CC Re 12.00 Ar 13.00 Or 14.00 Tc CL 15.00 Ar 16.00 Ar	edical and other services (see instructions) edical and other services reimbursed under OPPS (see instruc PPS payments utlier payment (see instructions) utlier reconciliation amount (see instructions) nter the hospital specific payment to cost ratio (see instru ine 2 times line 5 um of lines 3, 4, and 4.01, divided by line 6 ransitional corridor payment (see instructions) ncillary service other pass through costs from Wkst. D, Pt. rgan acquisitions otal cost (sum of lines 1 and 10) (see instructions) DMPUTATION OF LESSER OF COST OR CHARGES easonable charges rgan acquisition charges (from Wkst. D-4, Pt. III, col. 4, I otal reasonable charges (sum of lines 12 and 13) ustomary charges	Title XVIII tions) ctions)	Subprovider -	5/29/2023 3: 2: PPS 1. 00 92 463 321 0 0 0 0 0. 000 0 0 0. 000 0 0 0 92	1. 00 2. 00 3. 00 4. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00
1.00 Me 2.00 Me 3.00 OF 4.01 Ou 5.00 Er 6.00 Li 7.00 Su 8.00 Tr 9.00 Ar 10.00 Gr 11.00 Tr 02.00 Ar 13.00 Or 14.00 Tr 15.00 Ar 16.00 Ar 16.00 Ar	edical and other services (see instructions) edical and other services reimbursed under OPPS (see instruc PPS payments utlier payment (see instructions) utlier reconciliation amount (see instructions) nter the hospital specific payment to cost ratio (see instru ine 2 times line 5 um of lines 3, 4, and 4.01, divided by line 6 ransitional corridor payment (see instructions) ncillary service other pass through costs from Wkst. D, Pt. rgan acquisitions otal cost (sum of lines 1 and 10) (see instructions) DMPUTATION OF LESSER OF COST OR CHARGES easonable charges rgan acquisition charges (from Wkst. D-4, Pt. III, col. 4, I otal reasonable charges (sum of lines 12 and 13) ustomary charges	tions) ctions) IV, col. 13, line 200		1.00 92 463 321 0 0 0 0 0 0 0 0 0 0 0 92	2. 00 3. 00 4. 00 4. 01 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00
1.00 Me 2.00 Me 3.00 OF 4.00 Ou 4.01 Ou 5.00 Er 6.00 Li 7.00 Su 8.00 Tr 9.00 Ar 10.00 Or 11.00 Tc CC Re 12.00 Ar 13.00 Or 14.00 Tc CL 15.00 Ar 16.00 Ar	edical and other services (see instructions) edical and other services reimbursed under OPPS (see instruc PPS payments utlier payment (see instructions) utlier reconciliation amount (see instructions) nter the hospital specific payment to cost ratio (see instru ine 2 times line 5 um of lines 3, 4, and 4.01, divided by line 6 ransitional corridor payment (see instructions) ncillary service other pass through costs from Wkst. D, Pt. rgan acquisitions otal cost (sum of lines 1 and 10) (see instructions) DMPUTATION OF LESSER OF COST OR CHARGES easonable charges rgan acquisition charges (from Wkst. D-4, Pt. III, col. 4, I otal reasonable charges (sum of lines 12 and 13) ustomary charges	ctions) IV, col. 13, line 200		92 463 321 0 0 0.000 0 0.000 0 0 0 92	2. 00 3. 00 4. 00 4. 01 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00
1.00 Me 2.00 Me 3.00 OF 4.01 Ou 5.00 Er 6.00 Li 7.00 Su 8.00 Tr 9.00 Ar 10.00 Gr 11.00 Tr 02.00 Ar 13.00 Or 14.00 Tr 15.00 Ar 16.00 Ar 16.00 Ar	edical and other services (see instructions) edical and other services reimbursed under OPPS (see instruc PPS payments utlier payment (see instructions) utlier reconciliation amount (see instructions) nter the hospital specific payment to cost ratio (see instru ine 2 times line 5 um of lines 3, 4, and 4.01, divided by line 6 ransitional corridor payment (see instructions) ncillary service other pass through costs from Wkst. D, Pt. rgan acquisitions otal cost (sum of lines 1 and 10) (see instructions) DMPUTATION OF LESSER OF COST OR CHARGES easonable charges rgan acquisition charges (from Wkst. D-4, Pt. III, col. 4, I otal reasonable charges (sum of lines 12 and 13) ustomary charges	ctions) IV, col. 13, line 200		92 463 321 0 0 0.000 0 0.000 0 0 0 92	2. 00 3. 00 4. 00 4. 01 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00
2.00 Me 3.00 OF 4.00 Ou 4.01 Ou 5.00 Er 6.00 Er 7.00 Su 8.00 Tr 9.00 Ar 10.00 Or 11.00 C CC Re 12.00 Ar 13.00 Or 14.00 C Cu 15.00 Ag 16.00 Ar	edical and other services reimbursed under OPPS (see instruc PPS payments utlier payment (see instructions) utlier reconciliation amount (see instructions) nter the hospital specific payment to cost ratio (see instru- ine 2 times line 5 um of lines 3, 4, and 4.01, divided by line 6 ransitional corridor payment (see instructions) ncillary service other pass through costs from Wkst. D, Pt. rgan acquisitions otal cost (sum of lines 1 and 10) (see instructions) MPUTATION OF LESSER OF COST OR CHARGES passonable charges ncillary service charges rgan acquisition charges (from Wkst. D-4, Pt. III, col. 4, I otal reasonable charges (sum of lines 12 and 13) ustomary charges	ctions) IV, col. 13, line 200		463 321 0 0.000 0.000 0 0 0 92	2. 00 3. 00 4. 00 4. 01 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00
3.00 0F 4.00 0u 4.01 0u 5.00 Er 6.00 Li 7.00 Su 8.00 Tr 9.00 Ar 10.00 0r 11.00 Tc CC Re 12.00 Ar 13.00 0r 14.00 Tc Cu 15.00 Ar 15.00 Ar	PPS payments utlier payment (see instructions) utlier reconciliation amount (see instructions) nter the hospital specific payment to cost ratio (see instru- ine 2 times line 5 um of lines 3, 4, and 4.01, divided by line 6 ransitional corridor payment (see instructions) ncillary service other pass through costs from Wkst. D, Pt. rgan acquisitions otal cost (sum of lines 1 and 10) (see instructions) DMPUTATION OF LESSER OF COST OR CHARGES pasonable charges ncillary service charges rgan acquisition charges (from Wkst. D-4, Pt. III, col. 4, I otal reasonable charges (sum of lines 12 and 13) ustomary charges	ctions) IV, col. 13, line 200		321 0 0.000 0.000 0.00 0 0 92	3. 00 4. 00 4. 01 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00
4.01 00 5.00 Er 6.00 Li 7.00 St 8.00 Tr 9.00 Ar 10.00 Tr 11.00 Tr 12.00 Ar 13.00 Or 14.00 Tr 22.00 Ar 13.00 Or 14.00 Tr 24.00 Ar 15.00 Ar	utlier reconciliation amount (see instructions) nter the hospital specific payment to cost ratio (see instru- ine 2 times line 5 um of lines 3, 4, and 4.01, divided by line 6 ransitional corridor payment (see instructions) ncillary service other pass through costs from Wkst. D, Pt. rgan acquisitions otal cost (sum of lines 1 and 10) (see instructions) OMPUTATION OF LESSER OF COST OR CHARGES aasonable charges ncillary service charges rgan acquisition charges (from Wkst. D-4, Pt. III, col. 4, I otal reasonable charges ustomary charges	IV, col. 13, line 200		0 0.000 0.00 0 0 0 92	4. 0 ⁻ 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00
5.00 Er 6.00 Li 7.00 St 8.00 Tr 9.00 Ar 10.00 Tr 11.00 Tr 11.00 Tr 12.00 Ar 13.00 Or 14.00 Tr 14.00 Tr 14.00 Tr 14.00 Tr 14.00 Ar 15.00 Ar	nter the hospital specific payment to cost ratio (see instru- ine 2 times line 5 um of lines 3, 4, and 4.01, divided by line 6 ransitional corridor payment (see instructions) ncillary service other pass through costs from Wkst. D, Pt. rgan acquisitions otal cost (sum of lines 1 and 10) (see instructions) DMPUTATION OF LESSER OF COST OR CHARGES easonable charges ncillary service charges rgan acquisition charges (from Wkst. D-4, Pt. III, col. 4, I otal reasonable charges ustomary charges	IV, col. 13, line 200		0.000 0 0.00 0 0 92	5. 00 6. 00 7. 00 8. 00 9. 00 10. 00
6.00 Li 7.00 St 8.00 Tr 9.00 Ar 10.00 Or 11.00 Tc CC Re 12.00 Ar 13.00 Or 14.00 Cu 15.00 Ar 16.00 Ar	ine 2 times line 5 um of lines 3, 4, and 4.01, divided by line 6 ransitional corridor payment (see instructions) ncillary service other pass through costs from Wkst. D, Pt. rgan acquisitions otal cost (sum of lines 1 and 10) (see instructions) DMPUTATION OF LESSER OF COST OR CHARGES easonable charges ncillary service charges rgan acquisition charges (from Wkst. D-4, Pt. III, col. 4, I otal reasonable charges (sum of lines 12 and 13) ustomary charges	IV, col. 13, line 200		0.00 0 0 92	7.00 8.00 9.00 10.00
8.00 Tr 9.00 Ar 10.00 Or 11.00 CC Re 12.00 Ar 13.00 Or 14.00 Tr CU 15.00 Ar 16.00 Ar	ransitional corridor payment (see instructions) ncillary service other pass through costs from Wkst. D, Pt. rgan acquisitions otal cost (sum of lines 1 and 10) (see instructions) DMPUTATION OF LESSER OF COST OR CHARGES easonable charges ncillary service charges rgan acquisition charges (from Wkst. D-4, Pt. III, col. 4, I otal reasonable charges (sum of lines 12 and 13) ustomary charges			0 0 92	8.00 9.00 10.00
9.00 Ar 10.00 0r 11.00 Tc CC Re 12.00 Ar 13.00 0r 14.00 Tc CU 15.00 Ac 16.00 Ar	ncillary service other pass through costs from Wkst. D, Pt. rgan acquisitions otal cost (sum of lines 1 and 10) (see instructions) MMPUTATION OF LESSER OF COST OR CHARGES easonable charges ncillary service charges rgan acquisition charges (from Wkst. D-4, Pt. III, col. 4, I otal reasonable charges (sum of lines 12 and 13) istomary charges			0 0 92	9.00 10.00
10.00 0r 11.00 <u>rc</u> <u>CC</u> <u>Re</u> 12.00 Ar 13.00 0r 14.00 <u>rc</u> <u>CU</u> 15.00 Ar 16.00 Ar	rgan acquisitions otal cost (sum of lines 1 and 10) (see instructions) DMPUTATION OF LESSER OF COST OR CHARGES aasonable charges ncillary service charges rgan acquisition charges (from Wkst. D-4, Pt. III, col. 4, I otal reasonable charges (sum of lines 12 and 13) ustomary charges			0 92	10.00
12. 00 Ar 13. 00 Or 14. 00 Tc 15. 00 Ac 16. 00 Ar ha	DMPUTATION OF LESSER OF COST OR CHARGES aasonable charges ncillary service charges rgan acquisition charges (from Wkst. D-4, Pt. III, col. 4, I otal reasonable charges (sum of lines 12 and 13) ustomary charges	i ne 69)			11.00
Re 12.00 Ar 13.00 Or 14.00 Tc 15.00 Ag 16.00 Ar	easonable charges ncillary service charges rgan acquisition charges (from Wkst. D-4, Pt. III, col. 4, I otal reasonable charges (sum of lines 12 and 13) ustomary charges	i ne 69)			
12. 00 Ar 13. 00 Or 14. 00 Tc 15. 00 Ac 16. 00 Ar ha	ncillary service charges rgan acquisition charges (from Wkst. D-4, Pt. III, col. 4, I otal reasonable charges (sum of lines 12 and 13) ustomary charges	ine 69)		10-	1
14.00 To Cu 15.00 Ag 16.00 Ar ha	otal reasonable charges (sum of lines 12 and 13) ustomary charges	ine 69)		625	12.00
15.00 Ag 16.00 Ar ha	ustomary charges			0	
15.00 Aç 16.00 Ar ha				625	14.00
ha	ggregate amount actually collected from patients liable for	payment for services on a	charge basis	0	15.00
	mounts that would have been realized from patients liable fo ad such payment been made in accordance with 42 CFR §413.13(i a chargebasis	0	16.00
	atio of line 15 to line 16 (not to exceed 1.000000)	θ)		0. 000000	17.00
	otal customary charges (see instructions)			625	
	xcess of customary charges over reasonable cost (complete on nstructions)	lyifline 18 exceeds lin	ie 11) (see	533	19.00
	xcess of reasonable cost over customary charges (complete on	lyifline 11 exceeds lin	ie 18) (see	0	20.00
	nstructions)				
	esser of cost or charges (see instructions) nterns and residents (see instructions)			92 0	
	ost of physicians' services in a teaching hospital (see inst	ructions)		0	
	otal prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			321	24.00
	DMPUTATION OF REIMBURSEMENT SETTLEMENT eductibles and coinsurance amounts (for CAH, see instruction	5)		0	25.00
1	eductibles and Coinsurance amounts relating to amount on lin	-	icti ons)	0	
	ubtotal [(lines 21 and 24 minus the sum of lines 25 and 26)	plus the sum of lines 22	and 23] (see	413	27.00
	nstructions) irect graduate medical education payments (from Wkst. E-4, I	ine 50)		0	28.00
29.00 ES	SRD direct medical education costs (from Wkst. E-4, line 36)	,		0	
	ubtotal (sum of lines 27 through 29)			413 0	
	rimary payer payments ubtotal (line 30 minus line 31)			413	
AL	LOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVIO	CES)			
	omposite rate ESRD (from Wkst. I-5, line 11) Ilowable bad debts (see instructions)			0	
1	djusted reimbursable bad debts (see instructions)			0	
1	llowable bad debts for dual eligible beneficiaries (see inst	ructions)		0	
1	ubtotal (see instructions) SP-LCC reconciliation amount from PS&R			413 0	
1	THER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
	ioneer ACO demonstration payment adjustment (see instruction	s)			39.50
1	95 respirator payment adjustment amount (see instructions) emonstration payment adjustment amount before sequestration			0	
	artial or full credits received from manufacturers for repla	ced devices (see instruct	i ons)	0	
	ECOVERY OF ACCELERATED DEPRECIATION			0	
	ubtotal (see instructions) equestration adjustment (see instructions)			413 5	
	emonstration adjustment (see first detrois) emonstration payment adjustment amount after sequestration			0	
	equestration adjustment-PARHM or CHART pass-throughs				40. 03
	nterim payments nterim payments-PARHM or CHART			440	41.00 41.01
	entative settlement (for contractors use only)			0	
	2.01 Tentative settlement-PARHM or CHART (for contractor use only)				
	43.00 Balance due provider/program (see instructions)43.01 Balance due provider/program-PARHM (see instructions)				
1	rotested amounts (nonallowable cost report items) in accorda	nce with CMS Pub. 15-2, c	hapter 1,	0	43.0
§	115. 2		•		
) BE COMPLETED BY CONTRACTOR riginal outlier amount (see instructions)			0	90.00
	utlier reconciliation adjustment amount (see instructions)			0	
	he rate used to calculate the Time Value of Money			0.00	
	ime Value of Money (see instructions) otal (sum of lines 91 and 93)			0	93.00 94.00

Health Financial Systems	FRANCISCAN HEALTH INDIANAPOLIS	In Lieu of Form CMS-2552-10			
CALCULATION OF REIMBURSEMENT SETTLEMENT					
		From 01/01/2022			
	Component CCN: 15-T162	To 12/31/2022	5/29/2023 3:2	epared: 22 pm	
	Title XVIII	Subprovider -	PPS		
		I RF			
			1.00		
MEDICARE PART B ANCILLARY COSTS					
200.00 Part B Combined Billed Days				200.00	

	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	FI		Period: From 01/01/2022 To 12/31/2022		pared: 2 pm
		Title	XVIII	Hospi tal	PPS	- 1
		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 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		87, 450, 74	42 0	43, 575, 316 0	1.00 2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					3.00
3. 01	ADJUSTMENTS TO PROVIDER	12/31/2022	1, 568, 67	74 12/31/2022	1, 443, 011	3. 01
3.02		12/31/2022	116, 00		0	3. 02
3.03				0	0	3.03
3.04				0	0	3.04
3.05				0	0	3.05
3.50	Provider to Program ADJUSTMENTS TO PROGRAM			0	0	3.50
3.50 3.51	ADJUSTMENTS TO PROGRAM			0	0	3.50
3.52				0	0	3. 52
3.53				0	0	3. 53
3.54				0	0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		1, 684, 67		1, 443, 011	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		89, 135, 41	16	45, 018, 327	4.00
5.00	TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after					5.00
5.00	desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
F 04	Program to Provider					F 04
5.01 5.02	TENTATI VE TO PROVI DER			0	0	5. 01 5. 02
5.02				0	0	5.02
2.00	Provider to Program			-1	0	0.00
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 5.50-5.98)			0	0	5.99
5.00	Determined net settlement amount (balance due) based on the cost report. (1)		4 05 1 7	10		6.00
6.01	SETTLEMENT TO PROVIDER		4, 951, 71		0 479, 670	6.0
6.02 7.00	SETTLEMENT TO PROGRAM Total Medicare program liability (see instructions)		94, 087, 12	26	479, 670 44, 538, 657	6.02 7.00
7.00			74,007,12	Contractor	NPR Date	7.00
				Number	(Mo/Day/Yr)	
		()	1,00	2.00	

IALYS	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CO	CN: 15-0162 CCN: 15-T162		/01/2022 /31/2022		pare
		Title	XVIII		vider – RF	PPS	
		Inpatien	t Part A			t B	
		mm/dd/yyyy	Amount	mm/d	d/yyyy	Amount	
		1.00	2.00		. 00	4.00	
00 00 00 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 List separately each retroactive lump sum adjustment		5, 548, 8	34 0		440 0	1. 2. 3.
	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						
01	ADJUSTMENTS TO PROVIDER		[0		0	3
02				0		0	3
03				0		0	
)4)5				0		0	3
5	Provider to Program			0		0	3
0	ADJUSTMENTS TO PROGRAM			0		0	3
51				0		0	3
52				0		0	
53				0		0	3
54 99	Subtotal (sum of lines 3.01–3.49 minus sum of lines 3.50–3.98)			0		0	3
00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		5, 548, 8	34		440	4
	TO BE COMPLETED BY CONTRACTOR						
00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						5
)1	Program to Provider TENTATIVE TO PROVIDER			0		0	5
)2				0		0	5
03				0		0	
	Provider to Program			-			
50 51	TENTATI VE TO PROGRAM			0		0	5
52				0		0	
9	Subtotal (sum of lines 5.01–5.49 minus sum of lines 5.50–5.98)			0		0	5
00	Determined net settlement amount (balance due) based on the cost report. (1)						6
)1)2	SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM		10, 2	0		0 32	6
)2)0	Total Medicare program liability (see instructions)		5, 538, 6			32 408	
			0,000,0	Cont	ractor mber	NPR Date (Mo/Day/Yr)	, ,
)		. 00	2.00	

Heal th	Financial Systems FRANCISCAN HEALTI	H INDIANAPOLIS	In Lie	u of Form CMS-	2552-10	
CALCUL	CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 15-0162 Period: From 01/01/2022 To 12/31/2022					
		Title XVIII	Hospi tal	PPS		
				1.00		
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS	01			-	
1 00	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATIO		14		1.00	
1.00 2.00	Total hospital discharges as defined in AARA §4102 from Wks Medicare days (see instructions)	St. 5-3, Pt. 1 COL. 15 TIME	2 14		2.00	
	3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. Line 2					
4.00	Total inpatient days (see instructions)				3.00 4.00	
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5.00	
6.00	Total hospital charity care charges from Wkst. S-10, col. 3	line 20			6.00	
7.00	CAH only - The reasonable cost incurred for the purchase of		Wkst. S-2, Pt. I		7.00	
	line 168					
8.00	Calculation of the HIT incentive payment (see instructions)				8.00	
9.00	Sequestration adjustment amount (see instructions)				9.00	
10.00	Calculation of the HIT incentive payment after sequestratio	n (see instructions)			10.00	
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH					
	Initial/interim HIT payment adjustment (see instructions)				30.00	
	Other Adjustment (specify)				31.00	
32.00	Balance due provider (line 8 (or line 10) minus line 30 and	line 31) (see instruction	ns)		32.00	

ALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0162 Component CCN: 15-T162	Peri od: From 01/01/2022 To 12/31/2022	Worksheet E-3 Part III	
				Date/Time Pre 5/29/2023 3:2:	parec 2 pm
		Title XVIII	Subprovider - IRF	PPS	
				1.00	
	PART III - MEDICARE PART A SERVICES - IRF PPS				
00	Net Federal PPS Payment (see instructions)			5, 193, 628	1.0
00	Medicare SSI ratio (IRF PPS only) (see instructions)			0.0097	2.
00	Inpatient Rehabilitation LIP Payments (see instructions)			213, 977	3.
00	Outlier Payments			241, 614	4.
00	Unweighted intern and resident FTE count in the most recent of to November 15, 2004 (see instructions)	cost reporting period en	ding on or prior	0.00	5.
01	Cap increases for the unweighted intern and resident FTE cour	nt for residents that wer	e displaced by	0.00	5.
0.	program or hospital closure, that would not be counted without			0100	
	CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)				
00	New Teaching program adjustment. (see instructions)			0.00	6.
00	Current year's unweighted FTE count of I&R excluding FTEs in	the new program growth p	eriod of a "new	0.00	7.
	teaching program" (see instructions)				
00	Current year's unweighted I&R FTE count for residents within	the new program growth p	eriod of a "new	0.00	8.
~~	teaching program" (see instructions)			0.00	
00 . 00	Intern and resident count for IRF PPS medical education adjus Average Daily Census (see instructions)	stment (see instructions)		0. 00 14. 378082	
. 00	Teaching Adjustment Factor (see instructions)			0.000000	
. 00	Teaching Adjustment (see instructions)			0.000000	
. 00	Total PPS Payment (see instructions)			5, 649, 219	
. 00	Nursing and Allied Health Managed Care payments (see instruct	tion)		0,047,217	
. 00	Organ acqui si ti on (DO NOT USE THIS LINE)				15.
. 00	Cost of physicians' services in a teaching hospital (see inst	tructions)		0	16.
. 00	Subtotal (see instructions)	,		5, 649, 219	17.
. 00	Primary payer payments			0	18
. 00	Subtotal (line 17 less line 18).			5, 649, 219	19.
. 00	Deducti bl es			35, 716	20.
. 00	Subtotal (line 19 minus line 20)			5, 613, 503	
. 00	Coinsurance			5, 057	
. 00	Subtotal (line 21 minus line 22)			5, 608, 446	
. 00	Allowable bad debts (exclude bad debts for professional servi	ices) (see instructions)		0	24
. 00	Adjusted reimbursable bad debts (see instructions)	•		0	25
. 00	Allowable bad debts for dual eligible beneficiaries (see inst	tructions)		0	26
. 00 . 00	Subtotal (sum of lines 23 and 25) Direct graduate medical education payments (from Wkst. E-4, I	line (0)		5, 608, 446 0	27.
. 00	Other pass through costs (see instructions)	111e 49)		863	
. 00	Outlier payments reconciliation			005	30
. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	31
. 50	Pioneer ACO demonstration payment adjustment (see instruction	ns)		0	31
. 98	Recovery of accelerated depreciation.			0	31
. 99	Demonstration payment adjustment amount before sequestration			0	31
. 00	Total amount payable to the provider (see instructions)			5, 609, 309	32
. 01				70, 677	
. 02	Demonstration payment adjustment amount after sequestration				32.
. 00	Interim payments			5, 548, 834	
. 00	Tentative settlement (for contractor use only)			0	
. 00	Balance due provider/program (line 32 minus lines 32.01, 32.0		abortor 1	-10, 202	
. 00	Protested amounts (nonallowable cost report items) in accorda §115.2	ance with two Pub. 15-2,	chapter I,	0	36.
	TO BE COMPLETED BY CONTRACTOR				
. 00	Original outlier amount from Wkst. E-3, Pt. III, line 4			241, 614	
. 00	Outlier reconciliation adjustment amount (see instructions)			0	51.
. 00	The rate used to calculate the Time Value of Money			0.00	
. 00	Time Value of Money (see instructions)			0	53.
. 00	FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND				00
1 11 1	Teaching Adjustment Factor for the cost reporting period imme	euratery preceding Februa	i y 29, 2020.	0.000000	99.

	Financial Systems FRANCISCAN HEALTH ATION OF REIMBURSEMENT SETTLEMENT	I NDI ANAPOLI S Provi der CCN: 15-0162	Peri od:	u of Form CMS-2 Worksheet E-3	
.2002			From 01/01/2022 To 12/31/2022	Part VII	pare
		Title XIX	Hospi tal	PPS	2 pi
			I npati ent	Outpati ent	
			1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH S	ERVICES FOR TITLES V OR >	(IX SERVICES		
~~	COMPUTATION OF NET COST OF COVERED SERVICES				
00 00	Inpatient hospital/SNF/NF services		0	0	1
00	Medical and other services Organ acquisition (certified transplant programs only)		0	0	
00	Subtotal (sum of lines 1, 2 and 3)		0	0	
00	Inpatient primary payer payments		0	Ū	5
00	Outpatient primary payer payments			0	6
00	Subtotal (line 4 less sum of lines 5 and 6)		0	0	7
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonabl e Charges				
00	Routine service charges		0	0	8
00	Ancillary service charges		28, 498, 690	0	
	Organ acquisition charges, net of revenue Incentive from target amount computation		0		10
	Total reasonable charges (sum of lines 8 through 11)		28, 498, 690	0	
. 00	CUSTOMARY CHARGES		20, 470, 070	0	1 12
8. 00	Amount actually collected from patients liable for payment f	or services on a charge	0	0	113
	basi s	C			
. 00	Amounts that would have been realized from patients liable f		on O	0	14
	a charge basis had such payment been made in accordance with	42 CFR §413.13(e)			
5.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.00000	0.000000	
	Total customary charges (see instructions) Excess of customary charges over reasonable cost (complete o	nly if line 14 exceeds	28, 498, 690 28, 498, 690	0	16
. 00	line 4) (see instructions)	III y II IIIe To exceeds	20, 490, 090	0	
3. 00	Excess of reasonable cost over customary charges (complete o	nlvifline 4 exceeds li	ne O	0	18
	16) (see instructions)	j			
9.00	Interns and Residents (see instructions)		0	0	19
	Cost of physicians' services in a teaching hospital (see ins		0	0	20
. 00	Cost of covered services (enter the lesser of line 4 or line		0	0	21
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be	e completed for PPS provi		0	
	Other than outlier payments		10, 962, 933	0	22
	Outlier payments Program capital payments		0	0	23
	Capital exception payments (see instructions)		0		25
	Routine and Ancillary service other pass through costs		9, 554	0	26
	Subtotal (sum of lines 22 through 26)		10, 972, 487	0	27
3. 00	Customary charges (title V or XIX PPS covered services only)		0	0	28
00 .	Titles V or XIX (sum of lines 21 and 27)		10, 972, 487	0	29
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
	Excess of reasonable cost (from line 18)		0	0	30
. 00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and	6)	10, 972, 487	0	
. 00	Deducti bl es Coi nsurance		38, 859	0	32
	Allowable bad debts (see instructions)		237, 038	0	
	Utilization review		0	0	35
	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 a	nd 33)	10, 696, 590	0	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	- /	0	0	37
	Subtotal (line 36 ± line 37)		10, 696, 590	0	
9.00	Direct graduate medical education payments (from Wkst. E-4)		0		39
	Total amount payable to the provider (sum of lines 38 and 39)	10, 696, 590	0	
	Interim payments		10, 696, 504	0	41
2.00	Balance due provider/program (line 40 minus line 41)		86	0	
3.00	Protested amounts (nonallowable cost report items) in accord	ance with CMS Pub 15-2,	0	0	43

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0162	Peri od:	Worksheet E-3	
		Component CCN: 15-T162	From 01/01/2022 To 12/31/2022		
		Title XIX	Subprovider -	PPS	- P
			I npati ent	Outpati ent	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH	SERVICES FOR TITLES V OR X	1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES				1
00	Inpatient hospital/SNF/NF services	0		1 1	
00	edical and other services			0	2
00	Organ acquisition (certified transplant programs only)		0		3
00	Subtotal (sum of lines 1, 2 and 3)		0	0	
00	Inpatient primary payer payments		0	_	5
00	Outpatient primary payer payments			0	
00	Subtotal (line 4 less sum of lines 5 and 6)		0	0	7
	COMPUTATION OF LESSER OF COST OR CHARGES				
00	Reasonable Charges Routine service charges		1 240 205		6
00	Ancillary service charges		1, 349, 395 820, 070	0	
0.00	Organ acquisition charges, net of revenue		020, 070	0	10
. 00	Incentive from target amount computation		0		1
. 00	Total reasonable charges (sum of lines 8 through 11)		2, 169, 465	0	
	CUSTOMARY CHARGES				
. 00	Amount actually collected from patients liable for payment	for services on a charge	0	0	1:
	basi s				
. 00	Amounts that would have been realized from patients liable		n 0	0	14
	a charge basis had such payment been made in accordance wit	h 42 CFR §413.13(e)			
. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0. 000000	0.000000	
. 00	Total customary charges (see instructions)		2, 169, 465	0	
. 00	Excess of customary charges over reasonable cost (complete	only if line 16 exceeds	2, 169, 465	0	1
. 00	line 4) (see instructions) Excess of reasonable cost over customary charges (complete	only if line 4 exceeds lin		0	18
. 00	16) (see instructions)	only if the 4 exceeds if h	e 0	0	
. 00	Interns and Residents (see instructions)		0	0	19
. 00	Cost of physicians' services in a teaching hospital (see in	structions)	0	0	
. 00	Cost of covered services (enter the lesser of line 4 or lin		0	0	2
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only		ders.		1
. 00	Other than outlier payments		0	0	22
. 00	Outlier payments		0	0	23
. 00	Program capital payments		0		24
. 00	Capital exception payments (see instructions)		0		2
. 00	Routine and Ancillary service other pass through costs		0	0	
. 00	Subtotal (sum of lines 22 through 26)		0	0	
. 00	Customary charges (title V or XIX PPS covered services only	')	0	0	
. 00	Titles V or XIX (sum of lines 21 and 27) COMPUTATION OF REIMBURSEMENT SETTLEMENT		0	0	20
. 00	Excess of reasonable cost (from line 18)		0	0	30
. 00	· · · · · · · · · · · · · · · · · · ·	6)	0	0	
	Deductibles		0	0	
. 00	Coi nsurance		0	0	
. 00	Allowable bad debts (see instructions)		0	0	
. 00	Utilization review		0		3!
. 00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32	and 33)	0	0	30
. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	3
. 00	Subtotal (line 36 ± line 37)		0	0	
. 00	Direct graduate medical education payments (from Wkst. E-4)		0		30
. 00	Total amount payable to the provider (sum of lines 38 and 3	9)	0	0	
. 00	Interim payments		0	0	
. 00	Balance due provider/program (line 40 minus line 41)		0	0	
. (1()	Protested amounts (nonallowable cost report items) in accor	dance with UMS Pub 15-2,	0	0	43

DI RECT	Financial Systems FRANCISCAN HEALTH I GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DI RECT	Provider CCN: 15-		ri od:	u of Form CMS-2 Worksheet E-4	2552-10
MEDI CA	L EDUCATION COSTS		Fr To	om 01/01/2022 12/31/2022	Date/Time Pre 5/29/2023 3:22	
		Title XVIII	I	Hospi tal	PPS	
					1.00	
1.00	COMPUTATION OF TOTAL DIRECT GME AMOUNT Unweighted resident FTE count for allopathic and osteopathic p	rograms for cost	reporting	periods	19. 50	1.00
	ending on or before December 31, 1996.	0	i opor ti ng	porrodo		
1.01	FTE cap adjustment under §131 of the CAA 2021 (see instruction Unweighted FTE resident cap add-on for new programs per 42 CFR	,	oo instruc	ti onc)	0. 00 0. 00	
2.00 2.26	Rural track program FTE cap limitation adjustment after the ca				0.00	2.00
3.00	the CAA 2021 (see instructions) Amount of reduction to Direct GME cap under section 422 of MMA		0. 94	3.00		
3.00	Direct GME cap reduction amount under ACA §5503 in accordance	0.00				
	instructions for cost reporting periods straddling 7/1/2011)					
3. 02	Adjustment (increase or decrease) to the hospital's rural trac programs with a rural track Medicare GME affiliation agreement					3. 02
4.00	49075 (August 10, 2022) (see instructions) Adjustment (plus or minus) to the FTE cap for allopathic and o	steopathic progra	ams due to	a Medicare	0.00	4.00
	GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))				0.00	
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instr straddling 7/1/2011)	uctions for cost	reporting	peri ods	0.00	4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots periods straddling 7/1/2011)	(see instructio	ons for co	st reporting	0.00	4. 02
4. 21	The amount of increase if the hospital was awarded FTE cap slo instructions)	ts under §126 of	the CAA 2	021 (see		4. 21
5.00	FTE adjusted cap (line 1 plus and 1.01, plus line 2, plus line	lines 3 and	18. 56	5.00		
6.00	3.01, plus or minus line 3.02, plus or minus line 4, plus line Unweighted resident FTE count for allopathic and osteopathic p	ar from your	22. 92	6.00		
7.00	records (see instructions) 00 Enter the lesser of line 5 or line 6					
			ary Care	Other	Total	
8.00	Weighted FTE count for physicians in an allopathic and osteopa		1.00 22.92	2.00	3.00	8.00
9.00	program for the current year. If line 6 is less than 5 enter the amount from line 8, otherwi	se	18. 56	0.00	18. 56	9.00
,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Multiply line 8 times the result of line 5 divided by the amou 6. For cost reporting periods beginning on or after October 1, if Worksheet S-2, Part I, line 68, is "Y", see instructions.	nt on line		0.00	101.00	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
10.00	Weighted dental and podiatric resident FTE count for the curre	nt year		0.00		10.00
10. 01	Unweighted dental and podiatric resident FTE count for the cur			0.00		10. 01
11.00 12.00	Total weighted FTE count Total weighted resident FTE count for the prior cost reporting	Noar (coo	18. 56 18. 56	0.00 0.00		11.00 12.00
12.00	instructions)	year (see	16.00	0.00		12.00
13.00	Total weighted resident FTE count for the penultimate cost rep year (see instructions)	orting	18. 51	0.00		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided	by 3).	18.54	0.00		14.00
15.00	Adjustment for residents in initial years of new programs		0.00	0.00		15.00
15.01	Unweighted adjustment for residents in initial years of new pr		0.00	0.00		15.01
16. 00 16. 01	Adjustment for residents displaced by program or hospital clos Unweighted adjustment for residents displaced by program or ho		0.00 0.00	0.00 0.00		16. 00 16. 01
	closure Adjusted rolling average FTE count		18.54	0.00		17.00
17 00		1	35, 823. 72	135, 823. 72		18.00
	Per resident amount	I	33,023.72			
18. 00 18. 01	Per resident amount Per resident amount under §131 of the CAA 2021					
17.00 18.00 18.01 19.00	Per resident amount		2, 518, 172	0	2, 518, 172	
18. 00 18. 01	Per resident amount Per resident amount under §131 of the CAA 2021				2, 518, 172	
18. 00 18. 01	Per resident amount Per resident amount under §131 of the CAA 2021 Approved amount for resident costs Additional unweighted allopathic and osteopathic direct GME FT	:	2, 518, 172	0	1.00	19.00
18. 00 18. 01 19. 00	Per resident amount Per resident amount under §131 of the CAA 2021 Approved amount for resident costs	E resident cap sl	2, 518, 172	0	1.00 0.00	19.00 20.00
18. 00 18. 01 19. 00 20. 00 21. 00 22. 00	Per resident amount Per resident amount under §131 of the CAA 2021 Approved amount for resident costs Additional unweighted allopathic and osteopathic direct GME FT Sec. 413.79(c)(4) Direct GME FTE unweighted resident count over cap (see instruc Allowable additional direct GME FTE Resident Count (see instru	E resident cap sl tions) ctions)	2, 518, 172	0	1.00 0.00 4.36 0.00	20.00 21.00 22.00
18. 00 18. 01 19. 00 20. 00 21. 00 22. 00 23. 00	Per resident amount Per resident amount under §131 of the CAA 2021 Approved amount for resident costs Additional unweighted allopathic and osteopathic direct GME FT Sec. 413.79(c)(4) Direct GME FTE unweighted resident count over cap (see instruc Allowable additional direct GME FTE Resident Count (see instru Enter the locality adjustment national average per resident am	E resident cap sl tions) ctions)	2, 518, 172	0	1.00 0.00 4.36 0.00 0.00	19.00 20.00 21.00 22.00 23.00
18. 00 18. 01 19. 00 20. 00 21. 00 22. 00 23. 00 24. 00	Per resident amount Per resident amount under §131 of the CAA 2021 Approved amount for resident costs Additional unweighted allopathic and osteopathic direct GME FT Sec. 413.79(c)(4) Direct GME FTE unweighted resident count over cap (see instruc Allowable additional direct GME FTE Resident Count (see instru	E resident cap sl tions) ctions)	2, 518, 172	0	1.00 0.00 4.36 0.00	19. 20. 21. 22. 23. 24.

Health Financial Systems FRANCISCAN HEALT DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT	Provider C	CN: 15-0162	Peri od:	u of Form CMS-2 Worksheet E-4		
MEDICAL EDUCATION COSTS			From 01/01/2022 To 12/31/2022	Date/Time Pre 5/29/2023 3:23		
	Titl	e XVIII	Hospi tal	PPS		
			rt Managed Care	Total		
		A 1.00	2.00	3.00		
COMPUTATION OF PROGRAM PATIENT LOAD		1.00	2.00	0.00		
26.00 Inpatient Days (see instructions) (Title XIX - see S-2 Part 3.02, column 2)	IX, line	32, 5	67 28, 426		26. 00	
27.00 Total Inpatient Days (see instructions)		108, 9	43 108, 943		27.00	
28.00 Ratio of inpatient days to total inpatient days		0. 2989			28.00	
29.00 Program direct GME amount		752, 7		1, 409, 826	29.00	
29.01 Percent reduction for MA DGME			3.26		29.01	
30.00 Reduction for direct GME payments for Medicare Advantage			21, 420	21, 420		
31.00 Net Program direct GME amount				1, 388, 406	31.00	
				1.00		
DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TI	TLE XVIII ONL'	Y (NURSING PRO	OGRAM AND PARAMED			
EDUCATION COSTS)		X				
32.00 Renal dialysis direct medical education costs (from Wkst. E and 94)	d 23, lines 74	0	32.00			
	00 Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)					
34.00 Ratio of direct medical education costs to total charges (I	ine 32 ÷ line	33)		0.00000		
35.00 Medicare outpatient ESRD charges (see instructions)				0	35.00	
36.00 Medicare outpatient ESRD direct medical education costs (li		35)		0	36.00	
APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVI Part A Reasonable Cost	II ONLY					
37.00 Reasonable cost (see instructions)				91, 920, 222	37.00	
38.00 Organ acquisition and HSCT acquisition costs (see instructi	ons)			1, 976, 249		
39.00 Cost of physicians' services in a teaching hospital (see in				0	39.00	
40.00 Primary payer payments (see instructions)	lotr dotrono)			23, 425		
41.00 Total Part A reasonable cost (sum of lines 37 through 39 mi	nus line 40)			93, 873, 046		
Part B Reasonable Cost						
42.00 Reasonable cost (see instructions)				55, 583, 069	42.00	
43.00 Primary payer payments (see instructions)				3, 956	43.00	
44.00 Total Part B reasonable cost (line 42 minus line 43)				55, 579, 113	44.00	
45.00 Total reasonable cost (sum of lines 41 and 44)				149, 452, 159	45.00	
46.00 Ratio of Part A reasonable cost to total reasonable cost (I				0.628114		
47.00 Ratio of Part B reasonable cost to total reasonable cost (I		45)		0. 371886	47.00	
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND	PARIB			1 200 404	40.00	
48.00 Total program GME payment (line 31)	W) (000 in-t	unti ana)		1, 388, 406		
49.00 Part A Medicare GME payment (line 46 x 48) (title XVIII onl 50.00 Part B Medicare GME payment (line 47 x 48) (title XVIII onl				872, 077 516, 329		

Health Financial Systems FRANCISCA	u of Form CMS-2	552-10		
OUTLIER RECONCILIATION AT TENTATIVE SETTLEMENT	Provider CCN: 15-0162	Period: From 01/01/2022	Worksheet E-5	
	Date/Time Prepared: 5/29/2023 3:22 pm			
	PPS			
			1.00	
TO BE COMPLETED BY CONTRACTOR				
1.00 Operating outlier amount from Wkst. E, Pt. A, line 2	, or sum of 2.03 plus 2.04 (see i	nstructions)	0	1.00
2.00 Capital outlier from Wkst. L, Pt. I, line 2			0	2.00
3.00 Operating outlier reconciliation adjustment amount (see instructions)		0	3.00
4.00 Capital outlier reconciliation adjustment amount (se	e instructions)		0	4.00
5.00 The rate used to calculate the time value of money (see instructions)		0.00	5.00
6.00 Time value of money for operating expenses (see inst		0	6.00	
7.00 Time value of money for capital related expenses (se	e instructions)		0	7.00
		,		

LANC	Financial Systems FRANCISCAN HEALT E SHEET (If you are nonproprietary and do not maintain yop accounting records, complete the Constal Fund column	Provi der C	CN: 15-0162 P	eriod: rom 01/01/2022	u of Form CMS-2 Worksheet G	
na-t Iy)	ype accounting records, complete the General Fund column			o 12/31/2022	Date/Time Pre 5/29/2023 3:2	pare 2 pm
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	pm
	CURRENT ASSETS	1.00	2.00	3.00	4.00	
00	Cash on hand in banks	354, 315, 758	0	0	0	1 1.
00	Temporary investments	0	0	0	0	2
00	Notes receivable	0	0	0	0	
00	Accounts receivable	509, 834, 527	0	0	0	
00	Other receivable	3, 616, 172	0	0	0	
00	Allowances for uncollectible notes and accounts receivable	-387, 444, 487	0	0	0	
00 00	Inventory Prepaid expenses	13, 405, 795 1, 610, 206		0	0	
00 00	Other current assets	1, 010, 200		0	0	-
00	Due from other funds	2, 902, 072		0	0	
	Total current assets (sum of lines 1-10)	498, 240, 043		0	0	
	FIXED ASSETS		-	1		1
00	Land	21, 196, 680	0	0	0] 12
. 00	Land improvements	35, 234, 568	0	0	0	13
	Accumul ated depreciation	-32, 582, 349		0	0	
	Bui I di ngs	251, 062, 099		0	0	
	Accumulated depreciation	-139, 224, 802	0	0	0	
	Leasehold improvements	18, 931, 604	0	0	0	
	Accumulated depreciation		0	0	0	
	Fixed equipment Accumulated depreciation	283, 651, 816 -168, 940, 976		0	0	1
	Automobiles and trucks	-100, 940, 970		0	0	
	Accumulated depreciation			0	0	
	Major movable equipment	210, 851, 342	l o	0	0	
	Accumulated depreciation	-125, 285, 289		0	0	
. 00	Minor equipment depreciable	0	0	0	0	25
. 00	Accumulated depreciation	0	0	0	0	26
	HIT designated Assets	0	0	0	0	
	Accumulated depreciation	0	0	0	0	1
	Minor equipment-nondepreciable	0	0	0	0	
. 00	Total fixed assets (sum of lines 12-29)	354, 894, 693	0	0	0	30
. 00	OTHER ASSETS Investments	30, 815, 135	0	0	0	31
	Deposits on Leases	0	0	0	0	
	Due from owners/officers	0	0	0	0	
	Other assets	124, 466, 821	0	0	0	
. 00	Total other assets (sum of lines 31-34)	155, 281, 956	0	0	0	35
. 00	Total assets (sum of lines 11, 30, and 35)	1, 008, 416, 692	0	0	0	36
	CURRENT LI ABI LI TI ES			· · · · · · · · ·		
	Accounts payable	85, 739, 807	0	0	0	
. 00	Salaries, wages, and fees payable	18, 048, 284		0	0	
. 00	Payroll taxes payable	3, 101, 976	0	0	0	
	Notes and Loans payable (short term)	0	0	0	0	
	Deferred income Accelerated payments		0	0	0	41
	Due to other funds			0	0	
	Other current liabilities	11, 853, 387		0	0	
	Total current liabilities (sum of lines 37 thru 44)	118, 743, 454			0	
	LONG TERM LIABILITIES	[,,	-	-1		1
. 00	Mortgage payable	0	0	0	0	1 46
. 00	Notes payable	0	0	0	0	47
. 00	Unsecured Loans	2, 383, 251	0	0	0	48
	Other long term liabilities	32, 194, 684		0	0	
	Total long term liabilities (sum of lines 46 thru 49)	34, 577, 935		0	0	
00	Total liabilities (sum of lines 45 and 50)	153, 321, 389	0	0	0	51
~~	CAPITAL ACCOUNTS	055 005 202				1
	General fund balance	855, 095, 303				52
00	Specific purpose fund Donor created - endowment fund balance - restricted		0	_		53
00	Donor created - endowment fund balance - restricted			0		54
	Governing body created - endowment fund balance			0		56
	Plant fund balance - invested in plant			0	0	
	Plant fund balance - reserve for plant improvement,				0	
. 00		1	1		0	1
. 00	replacement, and expansion					1
. 00	replacement, and expansion Total fund balances (sum of lines 52 thru 58)	855, 095, 303	0	о	0	59

	2	RANCI SCAN HEALTH					u of Form CMS	
STATEM	ENT OF CHANGES IN FUND BALANCES	DF CHANGES IN FUND BALANCES		Provider CCN: 15-0162		l: 01/01/2022 12/31/2022	Worksheet G- Date/Time Pr 5/29/2023 3:	epared:
		General	Fund	Speci al	Purpose	e Fund	Endowment Fund	
		1.00	2.00	3.00		4.00	5.00	
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ \end{array}$	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)		928, 236, 820 327, 057, 913 1, 255, 294, 733 0 1, 255, 294, 733 0 1, 255, 294, 733 0 1, 255, 294, 733		0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0		$ \begin{array}{c} 1.00\\ 2.00\\ 3.00\\ 4.00\\ 5.00\\ 0.6.00\\ 0.6.00\\ 0.6.00\\ 0.7.00\\ 8.00\\ 0.9.00\\ 10.00\\ 11.00\\ 112.00\\ 0.12.00\\ 0.13.00\\ 0.13.00\\ 0.15.00\\ 0.15.00\\ 0.16.00\\ 0.17.00\\ 18.00\\ 19.00\\ \end{array} $
		Endowment Fund	Pl ant		_			
1.00	Fund balances at beginning of period	6.00 0	7.00	8.00	0			1.00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	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 13.00 14.00 15.00 16.00 17.00 18.00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Total deductions (sum of lines 12-17)	000	0 0 0 0 0		0			10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0			0			19.00

	Financial Systems FRANCI SCAN HEALTH I IENT OF PATI ENT REVENUES AND OPERATI NG EXPENSES	Provider C		Per	In Lie	u of Form CMS- Worksheet G-2	
STATES			5N. 10 0102		om 01/01/2022	Parts I & II	epared:
	Cost Center Description		I npati ent		Outpati ent	Total	
			1.00		2.00	3.00	
	PART I - PATIENT REVENUES						_
4 00	General Inpatient Routine Services			ee!		0/0 0/4 055	1 1 00
1.00			268, 244, 9	55		268, 244, 955	
2.00 3.00	SUBPROVI DER – I PF SUBPROVI DER – I RF		25 (24 0	15		25 (24 015	2.00
3.00 4.00	SUBPROVIDER - TRF		25, 624, 0	15		25, 624, 015	4.00
4.00 5.00	Swing bed - SNF			0		C	
6.00	Swing bed - NF			0			
7.00	SKILLED NURSING FACILITY			Ŭ			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)		293, 868, 9	70		293, 868, 970	
	Intensive Care Type Inpatient Hospital Services			1			
11.00	INTENSIVE CARE UNIT		39, 407, 2	86		39, 407, 286	11.00
11.01	NEONATAL INTENSIVE CARE UNIT		41, 119, 5			41, 119, 554	
12.00	CORONARY CARE UNI T		52,044,4			52, 044, 464	
13.00	BURN INTENSIVE CARE UNIT						13.00
14.00	SURGICAL INTENSIVE CARE UNIT		26, 178, 1	93		26, 178, 193	14.00
15.00	OTHER SPECIAL CARE (SPECIFY)						15.00
16.00	Total intensive care type inpatient hospital services (sum of	lines	158, 749, 4	97		158, 749, 497	16.00
	11-15)						
17.00	Total inpatient routine care services (sum of lines 10 and 16))	452, 618, 4	67		452, 618, 467	
18.00	Ancillary services		1, 057, 556, 8	82	1, 438, 860, 247	2, 496, 417, 129	18.00
19.00	Outpatient services		109, 416, 5	16	353, 185, 808	462, 602, 324	19.00
20.00	RURAL HEALTH CLINIC			0	0	C	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER			0	0		
22.00	HOME HEALTH AGENCY				0	C	
23.00	AMBULANCE SERVI CES						23.00
24.00	СМНС						24.00
25.00	AMBULATORY SURGICAL CENTER (D. P.)						25.00
26.00	HOSPI CE		70, 6		16, 161, 383		
27.00	OTHER REVENUE		162, 4		145, 226, 410		
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3	to Wkst.	1, 619, 824, 9	49	1, 953, 433, 848	3, 573, 258, 797	28.00
	G-3, line 1)						
29.00	PART II - OPERATING EXPENSES				602, 389, 890		29.00
29.00	Operating expenses (per Wkst. A, column 3, line 200)			0	002, 389, 890		30.00
30.00	ADD (SPECI FY)			0			30.00
32.00				0			32.00
33.00				0			33.00
34.00				0			34.00
35.00				0			35.00
36.00	Total additions (sum of lines 30-35)			0	0		36.00
37.00	DEDUCT (SPECIFY)			0	0		37.00
37.00				0			37.00
38.00				0			38.00
40.00				0			40.00
40.00				0			40.00
	Total deductions (sum of lines 37-41)			U	0		41.00
)(transfor			0		42.00
45.00					002, 307, 890		43.00
42.00 43.00	Total deductions (sum of lines 37–41) Total operating expenses (sum of lines 29 and 36 minus line 4 to Wkst. G-3, line 4)	2)(transfer			0 602, 389, 890		

	Financial Systems FRANCISCAN HEALTH I			u of Form CMS-2	
STATEN	IENT OF REVENUES AND EXPENSES	Provider CCN: 15-0162	Period: From 01/01/2022	Worksheet G-3	
			To 12/31/2022	Date/Time Pre	pared:
			10 12/01/2022	5/29/2023 3:2	2 pm
				1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line			3, 573, 258, 797	1.00
2.00	Less contractual allowances and discounts on patients' account	ts		2, 681, 941, 947	
3.00	Net patient revenues (line 1 minus line 2)			891, 316, 850	
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 4	43)		602, 389, 890	
5.00	Net income from service to patients (line 3 minus line 4)			288, 926, 960	5.00
(00	OTHER INCOME			252, 102	
6.00 7.00	Contributions, donations, bequests, etc Income from investments			253, 103 18, 001, 958	
7.00 8.00	Revenues from telephone and other miscellaneous communication			18,001,958	
8.00 9.00	Revenue from television and radio service	Ser vi ces		0	
9.00 10.00	Purchase di scounts			0	9.0
10.00	Rebates and refunds of expenses			5, 041, 449	
12.00	Parking lot receipts			5, 041, 449	
12.00	Revenue from Laundry and Linen service			0	
14.00	Revenue from meals sold to employees and guests			2, 411, 057	
15.00	Revenue from rental of living quarters				15.0
16.00	Revenue from sale of medical and surgical supplies to other th	nan natients		-	16.0
17.00	Revenue from sale of drugs to other than patients	ian pari cires			17.0
	Revenue from sale of medical records and abstracts			0	
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)			784, 868	
20.00	Revenue from gifts, flowers, coffee shops, and canteen			496, 214	
21.00	Rental of vending machines			43, 938	
22.00	Rental of hospital space			5, 839, 460	22.0
23.00	Governmental appropriations			0	
24.00	OTHER REVENUE			5, 258, 906	24.0
24.50	COVI D-19 PHE Funding			0	
25.00	Total other income (sum of lines 6-24)			38, 130, 953	25.0
26.00	Total (line 5 plus line 25)			327, 057, 913	26.0
27.00	OTHER EXPENSES (SPECIFY)			0	27.0
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)			327,057,913	29 0

	I Financial Systems SIS OF HOSPITAL-BASED HOSPICE COSTS	FRANCI SCAN HEALTH		S CN: 15-0162	Period:	worksheet 0	2552-1
			Hospice CC		From 01/01/2022 To 12/31/2022	Date/Time Pre	pared:
					Hospi ce I	5/29/2023 3:2	2 pm
		SALARI ES	OTHER	SUBTOTAL (co 1 plus col.	I. RECLASSI FI -	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT*		(D	0 0		
2.00	CAP REL COSTS-MVBLE EQUIP*		(D	0 0	0	
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	1	1	1 0	1	3.00
4.00	ADMINISTRATIVE & GENERAL*	0	258, 397	7 258, 3	97 10, 584	268, 981	4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	1	1	1 0	1	5.00
6.00	LAUNDRY & LINEN SERVICE*	0	18, 888	3 18, 8	88 0	18, 888	
7.00	HOUSEKEEPI NG*	0	(D	0 0	0	
8.00	DI ETARY*	0	23, 411	1 23, 4	11 0	23, 411	
9.00	NURSING ADMINISTRATION*	0	(0 0	0	
10.00	ROUTINE MEDICAL SUPPLIES*	0	()	0 0	0	
11.00	MEDI CAL RECORDS*	0	(D	0 0	0	
12.00	STAFF TRANSPORTATION*	0	80, 970			80, 970	
13.00	VOLUNTEER SERVICE COORDINATION*	63, 697	(63, 6		63, 697	
14.00	PHARMACY*	0	347, 876	5 347,8		347, 876	
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	()	0 0	0	
16.00	OTHER GENERAL SERVICE*	0	(2	0 0	0	
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
	DI RECT PATI ENT CARE SERVICE COST CENTERS			-1		-	
25.00	INPATIENT CARE-CONTRACTED**		()	0 0		
26.00	PHYSICIAN SERVICES**	0	()	0 0	-	
27.00	NURSE PRACTITIONER**	0	()	0 0	0	
28.00	REGI STERED NURSE**	2, 362, 416	30, 464	1 2, 392, 8	80 0	2, 392, 880	
29.00	LPN/LVN**	0	()	0 0	0	
30.00	PHYSICAL THERAPY**	0	(0 0	0	
31.00	OCCUPATIONAL THERAPY**	0	(0 0	0	
32.00	SPEECH/LANGUAGE PATHOLOGY**	407 100	(107.1	0 0	0	
33.00	MEDICAL SOCIAL SERVICES**	427, 130	(427, 1		427, 130	
34.00	SPIRITUAL COUNSELING**	195, 139	(195, 1		195, 139	
35.00	DI ETARY COUNSELING**	0	(0 0	-	
36.00	COUNSELING - OTHER**	517 010	(517.0	0 0	0 517 010	
37.00	HOSPICE AIDE & HOMEMAKER SERVICES**	517, 018		017,0			
38.00 39.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	238, 810	238,8		200,010	
40.00	PATIENT TRANSPORTATION** IMAGING SERVICES**	0	(0	
40.00	LABS & DI AGNOSTI CS**	0	1		1 0	1	40.00
41.00	MEDI CAL SUPPLI ES-NON-ROUTI NE**	0	145, 398	145,3		145, 398	
42.50	DRUGS CHARGED TO PATIENTS**	0	410, 319			410, 319	
42.00	OUTPATIENT SERVICES**	0	1, 105			1, 105	
44.00	PALLIATIVE RADIATION THERAPY**	0	1, 100			1, 105	
45.00	PALLIATIVE CHEMOTHERAPY**	0	(0 0		
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	(0 0		
40.00	NONREI MBURSABLE COST CENTERS	<u>Ч</u>	(7	0 0	0	40.00
60. 00		82, 950	(82, 9	50 0	82, 950	60.00
61.00	VOLUNTEER PROGRAM *	02, 930	(1			
62.00	FUNDRAL SI NG*	0	(0 0	0	
63.00		0	(0 0	0	
64.00		2, 245, 739	73, 196	2, 318, 9	35 0		
65.00		_, , , , 0	, . , . , . , . , . , . , . , . , .) _, <u>, , , ,</u>	0 0	2,010,700	
56. 00		0	(0 0	0	
67.00		0	(0 0	0	
68.00		0	(0 0	0	
59.00		0	(0 0	0	
	NURSING FACILITY ROOM & BOARD*	0	(0 0	0	
71.00		0	(0 0	0	
	TOTAL	5, 894, 089	1, 628, 837	7, 522, 9	26 10, 584		
	-	., , , ,	, ====, 50,	, -==, ,	,,	, ,	

** See instructions. Do not transfer the amounts in column 7 to Wkst. 0-5.

IALYS	SIS OF HOSPITAL-BASED HOSPICE COSTS		Provider CCN: Hospice CCN:	15-0162 15-1523	Period: From 01/01/2022 To 12/31/2022	Worksheet 0 Date/Time Pi 5/29/2023 3	repared
					Hospi ce I		
		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)				
		6.00	7.00				
00	GENERAL SERVICE COST CENTERS	0	0				1 1
00 00	CAP REL COSTS-BLDG & FIXT* CAP REL COSTS-MVBLE EQUIP*	0	0				1. (
00	EMPLOYEE BENEFITS DEPARTMENT*	0	1				3. (
00	ADMI NI STRATI VE & GENERAL*	0	268, 981				4. (
00	PLANT OPERATION & MAINTENANCE*	0	1				5.0
00	LAUNDRY & LINEN SERVICE*	0	18, 888				6. (
00	HOUSEKEEPI NG*	0	0				7.0
00	DI ETARY*	0	23, 411				8. (
00	NURSING ADMINISTRATION*	0	0				9.0
. 00	ROUTINE MEDICAL SUPPLIES*	0	0				10.0
. 00	MEDI CAL RECORDS*	0	0				11.
. 00	STAFF TRANSPORTATION*	0	80, 970				12.
. 00	VOLUNTEER SERVICE COORDINATION*	0	63, 697				13.
. 00		0	347, 876				14.
. 00	PHYSI CI AN ADMI NI STRATI VE SERVI CES*	0	0				15.
. 00	OTHER GENERAL SERVICE* PATIENT/RESIDENTIAL CARE SERVICES	0	0				16.
. 00	DI RECT PATIENT CARE SERVICE COST CENTERS						17.
. 00	INPATIENT CARE-CONTRACTED**	0	0				25.
. 00	PHYSI CI AN SERVI CES**	0	0				26.
. 00	NURSE PRACTITIONER**	0	0				27.
. 00	REGI STERED NURSE**	0	2, 392, 880				28.
. 00	LPN/LVN**	0	0				29.
. 00	PHYSI CAL THERAPY**	0	0				30.
. 00	OCCUPATIONAL THERAPY**	0	0				31.
. 00	SPEECH/LANGUAGE PATHOLOGY**	0	0				32.
. 00	MEDICAL SOCIAL SERVICES**	0	427, 130				33.
. 00	SPIRITUAL COUNSELING**	0	195, 139				34.
. 00	DI ETARY COUNSELI NG**	0	0				35.
. 00	COUNSELING - OTHER**	0	0				36.
. 00	HOSPICE AIDE & HOMEMAKER SERVICES**	0	517, 018				37.
. 00 . 00	DURABLE MEDI CAL EQUI PMENT/OXYGEN** PATI ENT TRANSPORTATI ON**	0	238, 810 0				38. 39.
. 00	I MAGI NG SERVI CES**	0	0				40.
. 00	LABS & DI AGNOSTI CS**	0	1				40.
. 00	MEDI CAL SUPPLI ES-NON-ROUTI NE**	0	145, 398				42.
. 50	DRUGS CHARGED TO PATI ENTS**	0	410, 319				42.
. 00	OUTPATI ENT SERVICES**	0	1, 105				43.
. 00	PALLIATIVE RADIATION THERAPY**	0	0				44.
. 00	PALLIATIVE CHEMOTHERAPY**	0	0				45.
. 00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	0				46.
	NONREIMBURSABLE COST CENTERS						
. 00	BEREAVEMENT PROGRAM *	0	82, 950				60.
. 00	VOLUNTEER PROGRAM *	0	0				61.
. 00	FUNDRAI SI NG*	0	0				62.
. 00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0				63.
. 00	PALLIATIVE CARE PROGRAM*	0	2, 318, 935				64.
. 00	OTHER PHYSICIAN SERVICES*	0	0				65.
. 00	RESIDENTIAL CARE* ADVERTISING*	0	U				66.
. 00 . 00		0	U				67. 68.
. 00	TELEHEALTH/TELEMONI TORI NG* THRI FT STORE*	0	U				68.
. 00	NURSING FACILITY ROOM & BOARD*	0	0				70.
. 00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0				70.
	TOTAL	0	7, 533, 510				100.

** See instructions. Do not transfer the amounts in column 7 to Wkst. 0-5.

Health Financial Systems	FRANCI SCAN HEALTH				u of Form CMS-2	
ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOS	PICE ROUTINE HOME	Provider C	CN: 15-0162	Peri od:	Worksheet 0-2	
CARE		Hospi ce CCI	N: 15-1523	From 01/01/2022 To 12/31/2022	Date/Time Pre 5/29/2023 3:2	
				Hospi ce I		
	SALARI ES	OTHER	SUBTOTAL (CO		SUBTOTAL	
			$1 + col \cdot 2$			
	1.00	2.00	3.00	4.00	5.00	
DI RECT PATI ENT CARE SERVICE COST CENTERS						05 00
25. 00 INPATIENT CARE-CONTRACTED					0	25.00
26. 00 PHYSI CI AN SERVI CES	0	0		0 0	0	26.00
27. 00 NURSE PRACTITIONER 28. 00 REGISTERED NURSE	104, 581	0	124 2		124 220	27.00
28. 00 REGI STERED NURSE 29. 00 LPN/LVN	104, 581	29, 748	134, 3	29 0	134, 329 0	28.00
30. 00 PHYSI CAL THERAPY	0	0		0 0	0	30.00
31. 00 OCCUPATIONAL THERAPY	0	0		0 0	0	31.00
32. 00 SPEECH/LANGUAGE PATHOLOGY	0	0		0 0	0	32.00
33. 00 MEDI CAL SOCI AL SERVI CES	427, 130	0	427, 1	30 0	427, 130	
34. 00 SPIRI TUAL COUNSELING	195, 139	0	195, 1		195, 139	
35. 00 DI ETARY COUNSELING	175, 157	0	175, 1	0 0	193, 139	35.00
36.00 COUNSELING - OTHER	0	0		0 0	0	36.00
37. 00 HOSPICE AIDE & HOMEMAKER SERVICES	488, 477	0	488, 4	77 0	488, 477	37.00
38. 00 DURABLE MEDICAL EQUI PMENT/OXYGEN	0	233, 595	233, 5		233, 595	
39.00 PATIENT TRANSPORTATION	0	0		0 0	0	39.00
40.00 I MAGI NG SERVI CES	0	0		0 0	0	40.00
41.00 LABS & DIAGNOSTICS	0	1		1 0	1	41.00
42.00 MEDI CAL SUPPLI ES-NON-ROUTI NE	0	141, 981	141, 9	81 0	141, 981	42.00
42.50 DRUGS CHARGED TO PATIENTS	0	401, 359	401, 3	59 0	401, 359	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	0		0 0	0	46.00
100 00 TOTAL *	1 015 007	00/ /04	2 0 0 0 0	11 0	0 000 011	100 00

43. 00 DOTPATIENT SERVICES
44. 00 PALLIATIVE RADIATION THERAPY
45. 00 PALLIATIVE CHEMOTHERAPY
46. 00 OTHER PATIENT CARE SERVICES (SPECIFY)
100. 00 TOTAL * * Transfer the amount in column 7 to Wkst. 0-5, column 1, line 51.

		ADJUSTMENTS	TOTAL (col. 5	
			± col. 6)	
		6.00	7.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS		1	
25.00	INPATIENT CARE-CONTRACTED			25.00
26.00	PHYSI CI AN SERVI CES	0	0	26.00
27.00	NURSE PRACTITIONER	0	0	27.00
28.00	REGI STERED NURSE	0	134, 329	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	427, 130	33.00
34.00	SPI RI TUAL COUNSELI NG	0	195, 139	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	488, 477	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	233, 595	38.00
39.00	PATI ENT TRANSPORTATI ON	0	0	39.00
40.00	I MAGI NG SERVI CES	0	0	40.00
41.00	LABS & DI AGNOSTI CS	0	1	41.00
42.00	MEDI CAL SUPPLI ES-NON-ROUTI NE	0	141, 981	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	401, 359	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
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	46.00
100.00	D TOTAL *	0	2, 022, 011	100.00

1, 215, 327

2,022,011

806, 684

0 0 0

2, 022, 011 100. 00

Health Financial Systems FF	RANCISCAN HEALTH	I NDI ANAPOLI S		In Lie	u of Form CMS-2	2552-10
ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPIC	E INPATIENT	Provider CC		Peri od:	Worksheet 0-3	
RESPITE CARE		Hospice CCN		From 01/01/2022 To 12/31/2022	Date/Time Pre	nared
			1. 10 1020	10 12/31/2022	5/29/2023 3:2	
				Hospi ce I		
	SALARI ES	OTHER	SUBTOTAL (col	. RECLASSI FI -	SUBTOTAL	
			1 + col. 2)	CATIONS		
	1.00	2.00	3.00	4.00	5.00	
DIRECT PATIENT CARE SERVICE COST CENTERS	I			-		
25.00 INPATIENT CARE-CONTRACTED		0		0 0	0	25.00
26. 00 PHYSI CLAN SERVI CES	0	0		0 0	0	26.00
27.00 NURSE PRACTITIONER	0	0		0 0	0	27.00
28.00 REGI STERED NURSE	226, 038	664	226, 70	2 0	226, 702	
29.00 LPN/LVN	0	0		0 0	0	27.00
30. 00 PHYSI CAL THERAPY	0	0		0 0	0	30.00
31.00 OCCUPATIONAL 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	0	0		0 0	0	33.00
34. 00 SPI RI TUAL COUNSELI NG	0	0		0 0	0	34.00
35. 00 DI ETARY COUNSELI NG	0	0		0 0	0	35.00
36.00 COUNSELING - OTHER	0	0		0 0	0	36.00
37.00 HOSPICE AIDE & HOMEMAKER SERVICES	2, 857	0	2, 85		2, 857	37.00
38.00 DURABLE MEDICAL EQUIPMENT/OXYGEN	0	5, 215	5, 21	5 0	5, 215	
39.00 PATIENT TRANSPORTATION	0	0		0 0	0	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 MEDI CAL SUPPLI ES-NON-ROUTI NE	0	3, 170	3, 17		3, 170	
42.50 DRUGS CHARGED TO PATIENTS	0	8, 960	8, 96	0 0	8, 960	
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	0		0 0	0	46.00
100.00 TOTAL *	228, 895	18, 009	246, 90	4 0	246, 904	100.00

 100.00
 Total *
 228,895

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

		ADJUSTMENTS	TOTAL (col. 5	
		6,00	<u>± col. 6)</u> 7.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS	0.00	7.00	
25.00	INPATIENT CARE-CONTRACTED	0	0	25.00
26.00	PHYSI CLAN SERVI CES	0	0	26.00
27.00	NURSE PRACTITIONER	0	0	27.00
28.00	REGI STERED NURSE	0	226, 702	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	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	0	33.00
34.00	SPI RI TUAL COUNSELI NG	0	0	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	2, 857	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	5, 215	38.00
39.00	PATI ENT TRANSPORTATI ON	0	0	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	3, 170	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	8, 960	42.50
43.00	OUTPATI ENT 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
100.00	TOTAL *	0	246, 904	100.00
* Trar	sfer the amount in column 7 to Wkst. 0-5, col	umn 1, line 52.		

Heal th	Financial Systems F	RANCI SCAN HEALTH	I NDI ANAPOLI S		In Lie	u of Form CMS-2	2552-10
	IS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPIC	CE GENERAL	Provider C	CN: 15-0162	Peri od:	Worksheet 0-4	
I NPATI	ENT CARE		Hospi ce CCI	N: 15-1523	From 01/01/2022 To 12/31/2022	Date/Time Pre 5/29/2023 3:2	
					Hospi ce I		
		SALARI ES	OTHER	SUBTOTAL (col 1 + col. 2)	. RECLASSI FI - CATI ONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS	I					
25.00	INPATIENT CARE-CONTRACTED		0		0 0	0	25.00
26.00	PHYSI CI AN SERVI CES	0	0		0 0	0	26.00
27.00	NURSE PRACTITIONER	0	0		0 0	0	27.00
28.00	REGI STERED NURSE	2, 031, 797	52	2, 031, 84	19 0	2, 031, 849	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	OCCUPATIONAL 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	0	0		0 0	0	33.00
34.00	SPI RI TUAL COUNSELI NG	0	0		0 0	0	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	25, 684	0	25, 68	34 0	25, 684	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0		0 0	0	38.00
39.00	PATI ENT TRANSPORTATI ON	0	0		0 0	0	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	MEDI CAL SUPPLI ES-NON-ROUTI NE	0	247	24	17 0	247	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0		0 0	0	42.50
43.00	OUTPATI ENT SERVI CES	0	1, 105	1, 10	05 0	1, 105	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	0		0 0	0	46.00
100.00	TOTAL *	2, 057, 481	1, 404	2, 058, 88	35 0	2, 058, 885	100.00

 46.00
 OTHER PATIENT CARE SERVICES (SPECIFY)
 0

 100.00
 TOTAL *
 2,057,481

 * 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	INPATIENT CARE-CONTRACTED	0	0		25.00
26.00	PHYSI CI AN SERVI CES	0	0		26.00
27.00	NURSE PRACTITIONER	0	0		27.00
28.00	REGI STERED NURSE	0	2, 031, 849		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	0		33.00
34.00	SPI RI TUAL COUNSELI NG	0	0		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	25, 684		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0		38.00
39.00	PATIENT TRANSPORTATION	0	0		39.00
40.00	I MAGI NG SERVI CES	0	0		40.00
41.00	LABS & DIAGNOSTICS	0	0		41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	247		42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0		42.50
43.00	OUTPATI ENT SERVICES	0	1, 105		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
100.00	TOTAL *	0	2, 058, 885	10	00.00
* Trar	sfer the amount in column 7 to Wkst. 0-5, col	umn 1, line 53.			

Heal th	Financial Systems FRANCI SCAN HEALTH	I NDI ANAPOLI S	5	In Lie	eu of Form CMS-:	2552-10
	LLOCATION - DETERMINATION OF HOSPITAL-BASED HOSPICE NET		CN: 15-0162	Peri od:	Worksheet 0-5	
EXPENS	ES FOR ALLOCATION			From 01/01/2022		
		Hospi ce CC	N: 15-1523	To 12/31/2022		
				Hospi ce I	5/29/2023 3:2	z pili
	Descriptions		HOSPICE DIRE		TOTAL EXPENSES	
			EXPENSES (se		(sum of cols.	
) EXPENSES FROM	1 + 2)	
				WKST B PART I	,	
				(see		
				instructions)		
			1.00	2.00	3.00	
	GENERAL SERVICE COST CENTERS		_			
1.00	CAP REL COSTS-BLDG & FIXT			0 0		
2.00	CAP REL COSTS-MVBLE EQUIP			0 0	-	
3.00	EMPLOYEE BENEFITS DEPARTMENT			1 277, 600		3.00
4.00	ADMINISTRATIVE & GENERAL		268, 9	31 1, 222, 960	1, 491, 941	4.00
5.00	PLANT OPERATION & MAINTENANCE			1 0		5.00
6.00	LAUNDRY & LINEN SERVICE		18, 8	38 0	18, 888	
7.00	HOUSEKEEPING			0 0	-	
8.00	DI ETARY		23, 4			8.00
9.00	NURSING ADMINISTRATION			0 0	-	
10.00	ROUTINE MEDICAL SUPPLIES			0 299		
11.00	MEDI CAL RECORDS			0 893		
12.00	STAFF TRANSPORTATION		80, 9		80, 970	
13.00	VOLUNTEER SERVICE COORDINATION		63, 69		63, 697	•
14.00	PHARMACY		347, 8			•
15.00	PHYSI CI AN ADMI NI STRATI VE SERVI CES			0	0	
16.00	OTHER GENERAL SERVICE			0 0		
17.00	PATI ENT/RESI DENTI AL CARE SERVI CES			0	0	17.00
	LEVEL OF CARE HOSPI CE CONTI NUOUS HOME CARE			0	0	50.00
50.00 51.00			2 022 0			
51.00	HOSPICE ROUTINE HOME CARE HOSPICE INPATIENT RESPITE CARE		2, 022, 0 246, 9		2, 022, 011 246, 904	•
53.00	HOSPICE GENERAL INPATIENT CARE		2,058,8		2, 058, 885	
55.00	NONREI MBURSABLE COST CENTERS		2,030,00	55	2,030,003	33.00
60, 00	BEREAVEMENT PROGRAM		82, 9	50	82, 950	60.00
61.00	VOLUNTEER PROGRAM		02, 7	0	02, 700	
62.00	FUNDRAI SI NG			0	0	
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS			0	0	
64.00	PALLIATIVE CARE PROGRAM		2, 318, 93	35	2, 318, 935	
65.00	OTHER PHYSICIAN SERVICES			0	0	
66,00	RESI DENTI AL CARE			0	0	
67.00	ADVERTI SI NG			0	0	67.00
68.00	TELEHEALTH/TELEMONI TORI NG			0	0	
69.00	THRI FT STORE			0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD			0	0	
71.00	OTHER NONREIMBURSABLE (SPECIFY)		1	0	0	
99.00	NEGATI VE COST CENTER			0	0	99.00
100.00	TOTAL		7, 533, 5	1, 501, 752	9, 035, 262	100.00

COST A	Financial Systems LLOCATION - HOSPITAL-BASED HOSPICE GENERAL	SERVICE COSTS	Provider CC				Worksheet 0-6 Part I Date/Time Pre 5/29/2023 3:2:	pared: 2 pm
						Hospi ce I	CURTOTAL	
	Descriptions	TOTAL EXPENSES C/	FIX	EQUI P	LE	EMPLOYEE BENEFI TS DEPARTMENT	SUBTOTAL	
		0	1.00	2.00		3.00	3A	
	GENERAL SERVICE COST CENTERS							
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	277, 601	0		0	277, 601		3.00
4.00	ADMI NI STRATI VE & GENERAL	1, 491, 941	0		0	27, 927	1, 519, 868	4.00
5.00	PLANT OPERATION & MAINTENANCE	1	0		0	0	1	5.00
6.00	LAUNDRY & LINEN SERVICE	18, 888	0		0	0	18, 888	6.00
7.00	HOUSEKEEPING	0	0		0	0	0	7.00
8.00	DI ETARY	23, 411	0		0	0	23, 411	8.00
9.00	NURSI NG ADMI NI STRATI ON	0	0		0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	299	0		0	0	299	10.00
11.00	MEDI CAL RECORDS	893	0		0	0	893	
12.00	STAFF TRANSPORTATION	80, 970	0		0	0	80, 970	12.00
13.00	VOLUNTEER SERVICE COORDINATION	63, 697	0		0	2, 291	65, 988	13.00
14.00	PHARMACY	347, 876	0		0	0	347, 876	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0		0	0	0	15.00
16.00	OTHER GENERAL SERVICE	0	0		0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES		0		0		0	17.00
	LEVEL OF CARE							
50.00	HOSPI CE CONTI NUOUS HOME CARE	0				0	0	
51.00	HOSPICE ROUTINE HOME CARE	2, 022, 011				43, 706	2, 065, 717	
52.00	HOSPICE INPATIENT RESPITE CARE	246, 904	0		0	8, 232	255, 136	
53.00	HOSPICE GENERAL INPATIENT CARE	2, 058, 885	0		0	73, 992	2, 132, 877	53.00
	NONREI MBURSABLE COST CENTERS	00.050				a	00.050	
	BEREAVEMENT PROGRAM	82, 950	0		0	0	82, 950	
61.00	VOLUNTEER PROGRAM	0	0		0	0	0	61.00
62.00	FUNDRAI 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	2, 318, 935	0		0	121, 453	2, 440, 388	
65.00	OTHER PHYSI CI AN SERVI CES	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		U	0	0	67.00
68.00	TELEHEALTH/TELEMONI TORI NG	0	0		U	0	0	68.00
69.00	THRIFT STORE	0	0		U	0	0	69.00
	NURSING FACILITY ROOM & BOARD	0	~			~	0	70.00
	OTHER NONREI MBURSABLE (SPECIFY)	0	0		U	0	0	71.00
	NEGATIVE COST CENTER		0		U			99.00
100.00	TOTAL	9, 035, 262	0	1	0	277, 601	9, 035, 262	1100.00

	Financial Systems		H INDIANAPOLIS		1	u of Form CMS-2	
COST A	LLOCATI ON - HOSPI TAL-BASED HOSPI CE GENERAL	SERVICE COSTS	Provider C Hospice CC	CN: 15-0162 N: 15-1523	Period: From 01/01/2022 To 12/31/2022	Worksheet 0-6 Part I Date/Time Pre 5/29/2023 3:2	pared:
					Hospi ce I	0/2//2020 0.2	<u> </u>
	Descriptions	ADMI NI STRATI VE & GENERAL	PLANT OPERATI ON & MAI NTENANCE	LAUNDRY & LINEN SERVIO	HOUSEKEEPI NG	DI ETARY	
		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	1, 519, 868					4.00
5.00	PLANT OPERATION & MAINTENANCE	0	1				5.00
6.00	LAUNDRY & LINEN SERVICE	3, 820	0	22, 7	08		6.00
7.00	HOUSEKEEPING	0	0		0		7.00
8.00	DI ETARY	4, 735	0		0	28, 146	
9.00	NURSING ADMINISTRATION	0	0		0		9.00
10.00	ROUTINE MEDICAL SUPPLIES	60	0		0		10.00
11.00	MEDI CAL RECORDS	181	0		0		11.00
12.00	STAFF TRANSPORTATION	16, 375	0		0		12.00
13.00	VOLUNTEER SERVICE COORDINATION	13, 345	0		0		13.00
14.00	PHARMACY	70, 352	0		0		14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0		0		15.00
16.00	OTHER GENERAL SERVICE	0	C		0		16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0		0		17.00
	LEVEL OF CARE			1			
50.00	HOSPICE CONTINUOUS HOME CARE	0					50.00
51.00	HOSPICE ROUTINE HOME CARE	417, 758					51.00
52.00	HOSPICE INPATIENT RESPITE CARE	51, 597	1	21, 4		26, 606	
53.00	HOSPICE GENERAL INPATIENT CARE	431, 340	0	1, 2	42 0	1, 540	53.00
(0.00	NONREI MBURSABLE COST CENTERS	1/ 775	0		0		
	BEREAVEMENT PROGRAM	16, 775	-		-		60.00
61.00	VOLUNTEER PROGRAM	0	0		0		61.00
62.00	FUNDRALSING	0	U		0		62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	400 500	U		0		63.00
64.00	PALLIATIVE CARE PROGRAM	493, 530	0		0		64.00
65.00	OTHER PHYSI CI AN SERVI CES	0	0		0		65.00
66.00	RESIDENTIAL CARE	0	0		0 0	0	00.00
67.00	ADVERTI SI NG	0	0		0		67.00
68.00	TELEHEALTH/TELEMONI TORI NG	0	0	1	0		68.00
69.00	THRIFT STORE	0	Ŭ		0		69.00
	NURSING FACILITY ROOM & BOARD		~			0	70.00
	OTHER NONREIMBURSABLE (SPECIFY)	0	0	1	0 0		
	NEGATIVE COST CENTER	1 510 040	1		0 0		/// 00
100.00	IUTAL	1, 519, 868	I	22, 7	00 0	28, 146	100.00

Heal th	Financial Systems	RANCI SCAN HEALTH	I NDI ANAPOLI S		In Lie	u of Form CMS-2	2552-10
	ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL S	ERVICE COSTS	Provider CC Hospice CC		Period: From 01/01/2022 To 12/31/2022	Worksheet 0-6 Part I Date/Time Pre 5/29/2023 3:2	pared:
					Hospi ce I		
	Descriptions	NURSI NG ADMI NI STRATI ON	ROUTI NE MEDI CAL SUPPLI ES	MEDI CAL RECORDS	STAFF TRANSPORTATI ON	VOLUNTEER SERVI CE COORDI NATI ON	
		9.00	10.00	11.00	12.00	13.00	
	GENERAL SERVICE COST CENTERS	<u> </u>		•			
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	ADMI NI STRATI VE & 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	NURSI NG ADMI NI STRATI ON	0					9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	359				10.00
11.00	MEDICAL RECORDS	0		1,0	74		11.00
12.00	STAFF TRANSPORTATION	0		., 0	97, 345		12.00
13.00	VOLUNTEER SERVICE COORDINATION	0			0	79, 333	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	0	17.00
17.00	LEVEL OF CARE			1			17.00
50,00	HOSPICE CONTINUOUS HOME CARE	0	0		0 0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	0	352	1,0	0	77, 790	
52.00	HOSPICE INPATIENT RESPITE CARE	0	7		20 0	1, 413	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	, 0		1 0	130	53.00
00.00	NONREI MBURSABLE COST CENTERS		0	1		100	00.00
60,00	BEREAVEMENT PROGRAM	0			0	0	60.00
61.00	VOLUNTEER PROGRAM	0			0	0	61.00
62.00	FUNDRALSING	0			0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0			0	0	63.00
64.00	PALLIATI VE 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	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				0	0	70.00
70.00	OTHER NONREIMBURSABLE (SPECIFY)	0			0	0	71.00
99.00	NEGATI VE COST CENTER	0	0		0 0	0	99.00
	TOTAL	0	359	1,0	74 97, 345	-	
100.00	1.0		557	1,0	, , , , , , , , , , , , , , , , , , ,	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	1.00.00

2.00 CAP REL COSTS-MVBLE EQUIP 2 3.00 EMPLOYEE BENEFITS DEPARTMENT 3 4.00 ADMI NI STRATIVE & GENERAL 4 5.00 PLANT OPERATION & MAI NTENANCE 6 6.00 LAUNDRY & LINEN SERVICE 6 7.00 HOUSSEKEEPI NG 7 8.00 NURSING ADMI NI STRATION 8 9.00 NURSING ADMI NI STRATION 7 11.00 MEDI CAL SUPPLI ES 11 12.00 STAFF TRANSPORTATION 12 13.00 VOLUNTEER SERVICE COORDINATION 12 14.00 PHARMACY 418, 228 14 14.00 PHARMACY 418, 228 14 14.00 PHARMACY 418, 228 14 15.00 PHYSICLAN ADMI NI STRATI VE SERVI CES 0 0 17 16.00 OTHER GENERAL SERVI CE CORDI NATI ON 12 14 14 16.00 OTHER GENERAL SERVI CE CORDI NATI ON 16 17 17 17 DO O 0 16	COST A	LLOCATION - HOSPITAL-BASED HOSPICE GENERAL S	ERVICE COSTS	Provider C Hospice CC		Period: From 01/01/2022 To 12/31/2022		epared:
ADMI NI STRATI VE SERVI CES RESI DENTI AL CARE SERVI CE CRESI DENTI AL CARE SERVI CE CRESI DENTI AL CARE SERVI CE Notest CRESI DENTI AL CARE SERVI CE Notest CRESI DENTI AL CARE SERVI CE Notest CARE SERVI CE Notest CRESI DENTI AL CARE SERVI CE Notest CRESI DENTI AL CRESI DENTI A								
Image: Constraint of the cost of centers 14.00 15.00 16.00 17.00 18.00 1.00 CAP REL COSTS - MUG & FIXT 20 CAP REL COSTS - MUG & FIXT 21 2.00 CAP REL COSTS - MUG & FIXT 21 23 3.00 DENLOYCE BENETI'S DEPARTMENT 21 33 4.00 ADMINISTRATIVE & GENERAL 55 5.00 PLANT OPERATION & MAINTENANCE 6 6.00 LAUNDRY & LINEN SERVICE 6 7 78.00 DIETARY 8 9.00 NRSI MG ADMINISTRATION 9 9 10.00 KOLCAL RECORDS 11 12 11.00 MEDICAL SUPPLIES 10 12 13.00 VOLUNTERS SERVICE COORDINATION 12 13 14.00 PHARMACY 418,228 0 0 0 0 0 0 3 13 15.00 PHELOYCE CORD 418,228 0 0 14 16.00 OTHECE GONTI NUCE CONDI NATI ON 12 14		Descriptions		ADMI NI STRATI VE		RESI DENTI AL	TOTAL	
1.00 CAP REL COSTS-BLOG & FIXT 1 2.00 CAP REL COSTS-PLOG & FIXT 3 3.00 EMPLOYEE BENEFITS DEPARTMENT 3 4.00 ADMI NI STRATI VE & GENERAL 3 5.00 PLANT OPERATI NO & MAIN TENANCE 5 6.00 LAUNDRY & LINEN SERVICE 6 7.00 HOUSEKEPI NG 7 8.00 DI ETARY 8 9.00 NORSING ADMINISTRATION 9 9.00 NORSING ADMINISTRATION 9 11.00 MEDI CAL, RECORDS 11 12.00 STAFF TRANSPORTATION 12 13.00 VOLUNTEER SERVICE COORDINATION 12 14.00 PHARMACY 418, 228 0 17.00 HOUSE SERVICE CORDINATION 12 17.00 PATI ENT RESIDENTIAL CARE SERVICES 0 0 17.00 PATI ENT RESIDENTIAL CARE SERVICES 0 0 17.00 POLE OF CARE 0 0 3,070,316 15.00 HOSPI CE CONTI NUOUS HOME CARE 0 0 3,070,316 15.00 HOSPI CE CONTI NUOUS HOME CARE			14.00	15.00	16.00	17.00	18.00	
2.00 CAP REL COSTS-MVBLE EQUIP 3.00 EMPLOYEE BENEFITS DEPARTMENT 4.00 ADMINISTRATIVE & GENERAL 5.00 PLANT OPERATION & MAINTENANCE 6.00 LAUNDRY & LINEN SERVICE 7.00 HOUSEKEEPINO 8.00 DI USEKEEPINO 8.00 DI USEKEEPINO 9.00 ROUTINE MEDICAL SUPPLIES 1.11 1.20 VOLUMTEER SERVICE COORDINATION 1.20 VOLUMTEER SERVICE COORDINATION 1.20 VOLUMTEER SERVICE COORDINATION 1.20 VOLUMTEER SERVICE COORDINATION 1.20 VOLUMTEER SERVICE 5.00 OI HOUSEKEEPINO 5.00 DI COUNTER SERVICE 5.00 OI COUNTER SERVICE 5.00 HOSPICE COUNTINUOUS HOME CARE 5.00 HOSPICE COUNTINE HOME CARE 5.00 HOSPICE COUNT HOUS HOME HOME CARE 5.00 HOSPICE COUNT HOUS HOME HOME CARE 5.00 HOSPICE COUNT HOUS HOME CARE 5.00 HOSPICE FOR COUNT HOUS HOME HOME CARE 5.00 HOSPICE FOR C		GENERAL SERVICE COST CENTERS						
3.00 EMPLOYEE BENEFITS DEPARTMENT 3 4.00 ADMINISTRATIVE & GENERAL 4 5.00 PLAYT OPERATION & MAINTENANCE 4 6.00 LAUNDRY & LINEN SERVICE 5 6.00 LAUNDRY & LINEN SERVICE 7 7.00 HOUSEKEEPI NG 8 9.00 NURSING ADMINISTRATION 8 9.00 NURSING ADMINISTRATION 9 11.00 MEDICAL SUPPLIES 10 12.00 STAFF TRANSPORTATION 12 13.00 VOLUNTEER SERVICE CORDINATION 12 13.00 OULWATERS SERVICE CORDINATION 14 15.00 PHYSICIAN ADMINISTRATIVE SERVICES 0 0 16.00 OTHER GENERAL SERVICE 0 0 15 16.00 OHER GENERAL SERVICE 0 0 16 15.00 PHYSICIAN ADMINISTRATIVE SERVICES 0 0 17 HORARACY 418, 228 0 0 3, 070, 316 51 16.00 OHER GENERAL SERVICE	1.00	CAP REL COSTS-BLDG & FIXT						1.00
4.00 ADMIN IN STRATI VE & GENERAL 4 5.00 PLANT OPERATION & MAINTENANCE 5 6.00 LAUNDRY & LINEN SERVICE 7 7.00 HOUSEKEEPI NG 7 8.00 NURSI NG ADMI NI STRATI ON 7 9.00 NURSI NG ADMI NI STRATI ON 7 9.00 NURSI NG ADMI NI STRATI ON 7 9.00 NURSI NG ADMI NI STRATI ON 7 11.00 MEDI CAL RECORDS 11 12.00 STAFF TRANSPORTATI ON 12 13.00 VOLUNTEER SERVI CE COORDI NATI ON 12 14.00 PHARMACY 418, 228 14 14.00 PHARMACY 418, 228 0 17 15 0 0 17 15 16.00 OHER GENERAL SERVI CE S 0 0 17 16.00 OHER GENERAL SERVI CE S 0 0 3,070,316 51 16.00 OHER GENERAL SERVI CE S 0 0 0 3,070,316 51 17 DEVEL OF CAR	2.00	CAP REL COSTS-MVBLE EQUIP						2.00
5.00 PLANT OPERATION & MAINTENANCE 5 6.00 LAUNDRY & LINEN SERVICE 5 6.00 HOUSEKEEPING 7 8.00 DIETARY 8 9.00 NURSING ADMINISTRATION 9 10.00 ROUTINE MEDICAL SUPPLIES 10 11 12 STAFF TRANSPORTATION 12 13.00 VOLUNTEER SERVICE COORDINATION 12 13.00 VOLUNTEER SERVICE SERVICES 0 0 PHYSICIAN ADMINISTRATIVE SERVICES 0 0 PATIENT/RESIDENTIAL CARE SERVICES 0 0 PATIENT/RESIDENTIAL CARE SERVICES 0 0 HOSPICE CONTINUOUS HOME CARE 0 0 12.00 HOSPICE CONTINUOUS HOME CARE 0 0 3,070,316 13.00 HOSPICE CONTINUOUS HOME CARE 0 0 3,070,316 50 14.00 HARMACY 418,228 0 0 3,070,316 51 0 PATIENT/RESIDENTIAL CARE SERVICES 0 0 3,070,316 51								3.00
6.00 LAUNDRY & LI NEN SERVI CE 6 7.00 HOUSEKEEPI NG 7 8.00 DI ETARY 7 9.00 NURSI NG ADMI NI STRATI ON 9 9.00 NURSI NG ADMI NI STRATI ON 9 11.00 MEDI CAL SUPPLIES 11 12.00 VOLUTI NE MEDI CAL SUPPLIES 11 12.00 VOLUTEER SERVI CE COORDINATI ON 12 13.00 VOLUTEER SERVI CE COORDINATI VE SERVI CES 0 11 14.00 PHARMACY 418, 228 14 15.00 PHYSI CI AN ADMI NI STRATI VE SERVI CES 0 0 13 16.00 OTHER GENERAL SERVI CE 0 0 16 17.00 PATI ENT/RESI DENTI AL CARE SERVI CES 0 0 3,070,316 15.00 HOSPI CE CONTI NUOUS HOME CARE 10,482 0 0 3,070,316 15.20 HOSPI CE CONTI NUOUS HOME CARE 1,445 0 0 2,568,57 53 16.00 OTHER MURDABLE COST CENTERS 0 0 2,93,918 <td< td=""><td>4.00</td><td></td><td></td><td></td><td></td><td></td><td></td><td>4.00</td></td<>	4.00							4.00
7.00 HOUSEKEEPING 7 8.00 DIETARY 8 9.00 NURSI NG ADMINISTRATI ON 9 11.00 REDICAL SEPPLIES 10 11.00 MEDICAL SEPPLIES 10 11.00 MEDICAL SECORDS 11 12.00 STAFF TRANSPORTATI ON 12 13.00 VOLUNTEER SERVICE COORDINATION 13 14.00 PHARMACY 418, 228 14 15.00 OTHER GENERAL SERVICE 0 0 15 16.00 OTHER GENERAL SERVICE 0 0 16 15.00 HOSPICE CONTINUOUS HOME CARE 0 0 3, 070, 316 15.00 HOSPICE CONTINUOUS HOME CARE 410, 301 0 0 3, 070, 316 51 15.00 HOSPICE CONTINUOUS HOME CARE 410, 301 0 0 3, 070, 316 51 15.00 HOSPICE CONTINUOS HOME CARE 1, 445 0 0 2, 568, 575 53 10.00 UNTRET MEDICAL INPATIENT CARE 1, 445 0								5.00
8.00 DIETARY 8.00 NURSING ADMINISTRATION 9.00 0.00 ROUTINE MEDICAL SUPPLIES 10 10 11.00 MEDICAL RECORDS 11 12 12.00 STAFF TRANSPORTATION 12 13.00 VOLUNTEER SERVICE COORDINATION 13 14.00 PHARMACY 418,228 14 15.00 PHYSICIAN ADMINISTRATIVE SERVICES 0 0 15 16.00 OTHER GENERAL SERVICE 0 0 16 17.00 PATIENT/RESIDENTIAL CARE SERVICES 0 0 16 17.00 PATIENT/RESIDENTIAL CARE SERVICES 0 0 3.070,316 15 10.00 HOSPICE CONTINUOUS HOME CARE 0 0 3.070,316 15 51.00 HOSPICE ROLTINE HOME CARE 1,445 0 0 2,568,575 53 10.01 DO 3.070,316 0 0 2,568,575 53 53 0 10 0 2,568,575 53 53 64 0								6.00
9.00 NURSI NG ADMI NI STRATION 9 10.00 ROUTI NE MEDI CAL SUPPLIES 11 11.00 MEDI CAL RECORDS 11 12.00 STAFF TRANSPORTATI ON 12 13.00 VOLUNTEER SERVI CE COORDI NATI ON 12 14.00 PHARMACY 418, 228 14 15.00 PHARE SERVI CE SERVI CES 0 0 15 16.00 OTHER GENERAL SERVI CE 0 0 16 17.00 PATI ENT/RESIDENTI AL CARE SERVI CES 0 0 17 LEVEL OF CARE 0 0 0 3,070,316 51 18.00 HOSPI CE CONTI NUOUS HOME CARE 410,301 0 0 3,070,316 51 19.00 HOSPI CE CONTI NUOUS HOME CARE 1,445 0 0 0 3,070,316 51 20.00 HOSPI CE CONTERAL INPATI ENT CARE 1,445 0 0 0 2,565,55 53 NOREI MBURSABLE COST CENTERS 0 0 0 0 0 60 60<								7.00
10.00 ROUTI NE MEDI CAL SUPPLIES 10 11.00 MEDI CAL RECORDS 11 12.00 STAFF TRANSPORTATI ON 12 13.00 VOLUNTEER SERVI CE COORDI NATI ON 13 14.00 PHARMACY 418, 228 14 15.00 PHYSI CI AN ADMI NI STRATI VE SERVI CES 0 0 15 16.00 OTHER GENERAL SERVI CE 0 0 16 17.00 PATI ENT/RESI DENTI AL CARE SERVI CES 0 0 16 17.00 PATI ENT/RESI DENTI AL CARE SERVI CES 0 0 16 17.00 HOSPI CE CONTI NUOUS HOME CARE 0 0 3,070,316 50 51.00 HOSPI CE CONTI NUOUS HOME CARE 6,482 0 0 3,070,316 51 53.00 HOSPI CE ENPATI ENT RESPITE CARE 1,445 0 0 2,568,575 53 60.00 ERRAVEMENT PROGRAM 0 0 0 0 61 61.00 VULUNTEER PROGRAM 0 0 0 0 64 62.00 FUNARLI MSURSABLE COST CENTERS 0 0 <								8.00
11.00 MEDI CAL RECORDS 11 12.00 STAFF TRANSPORTATION 12 30.00 VOLUNTEER SERVI CE COORDINATION 13 14.00 PHARMACY 418,228 14 15.00 PHARMACY 418,228 14 16.00 OTHER GENERAL SERVI CE 0 0 15 17.00 PATI ENT/RESI DENTI AL CARE SERVI CE 0 0 16 17.00 PATI ENT/RESI DENTI AL CARE SERVI CES 0 0 17 50.00 HOSPI CE ROUTI NE HOME CARE 0 0 3,070,316 51 51.00 HOSPI CE ROUTI NE HOME CARE 410,301 0 0 3,070,316 51 52.00 HOSPI CE ROUTI NE HOME CARE 1,445 0 0 0,2,568,575 53 NORREI MBURSABLE COST CENTERS 0 0 0 62 64								9.00
12.00 STAFF TRANSPORTATION 12 13.00 VOLUNTEER SERVI CE COORDINATION 13 14.00 PHARMACY 418,228 15.00 PHYSI CI AN ADMI NI STRATI VE SERVI CES 0 16 16.00 OTHER GENERAL SERVI CE 0 0 16 17.00 PATI IENT/REST DENTI AL CARE SERVI CES 0 0 17 17.00 PATI IENT/REST DENTI AL CARE SERVI CES 0 0 17 17.00 PATI IENT/REST DENTI AL CARE SERVI CES 0 0 17 17.00 PATI IENT/REST DENTI AL CARE SERVI CES 0 0 17 17.00 PATI ENT/REST DENTI AL CARE 410, 301 0 3, 070, 316 51 10.00 HOSPI CE CONTI NUOUS HOME CARE 6, 482 0 0 3, 070, 316 51 52.00 HOSPI CE GENERAL INPATI ENT CARE 1, 445 0 0 2, 568, 57 53 60.00 BEREAVEMENT PROGRAM 0 0 0 63 64 63 64 63 64 63 64 63 64 63 64 64								10.00
13.00 VOLUNTEER SERVI CE COORDINATI ON 13 14.00 PHARMACY 418,228 14 15.00 PHYSI CI AN ADMINI NI STRATI VE SERVI CES 0 0 16.00 OTHER GENERAL SERVI CE 0 0 16 17.00 PATI ENT/RESI DENTI AL CARE SERVI CES 0 0 16 17.00 PATI ENT/RESI DENTI AL CARE SERVI CES 0 0 16 17.00 HOSPI CE CONTI NUOUS HOME CARE 0 0 3,070,316 51 51.00 HOSPI CE CONTI NUOUS HOME CARE 1,445 0 0 3,070,316 51 52.00 HOSPI CE INPATI ENT RESPI TE CARE 1,445 0 0 2,568,575 53 NONREI MBURSABLE COST CENTERS 0 0 99,725 60 61 61.00 VOLUNTEER PROGRAM 0 0 62 64 64 64 64 62 64 62 64 62 64 64 62 64 64 64 64 64 64 64 64 64 64 64 64 64 64								11.00
14.00 PHARMACY 418,228 14 15.00 PHYSI CLAN ADMINI STRATI VE SERVI CES 0 0 15 16.00 OTHER GENERAL SERVI CE 0 0 16 17.00 PATI ENT/RESI DENTI AL CARE SERVI CES 0 0 17 LEVEL OF CARE EVEVEL OF CARE 0 0 0 50 LEVEL OF CARE 0 0 0 3,070,316 51 So 00 HOSPI CE CONTI NUOUS HOME CARE 410,301 0 0 3,070,316 51 52.00 HOSPI CE GENERAL INPATI ENT RESPI TE CARE 6,482 0 0 0 2,568,575 53 MONREI MBURSABLE COST CENTERS 0 0 0 2,568,575 53 60.00 BERAVENT PROGRAM 0 0 0 62 61.00 VOLUNTEER PROGRAM 0 0 0 62 62.00 FUNDRAI SI NG 0 0 0 63 63.00 HOSPI CE ZPALLI ATI VE MEDI CI NE FELLOWS 0 0 63 64.00 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>12.00</td>								12.00
15.00 PHYSICIAN ADMINISTRATIVE SERVICES 0 0 15 16.00 OTHER GENERAL SERVICE 0 0 16 17.00 PATIENT/RESIDENTIAL CARE SERVICES 0 0 16 17.00 PATIENT/RESIDENTIAL CARE SERVICES 0 0 17 17.00 PATIENT/RESIDENTIAL CARE SERVICES 0 0 0 17 16.00 HOSPICE CONTINUOUS HOME CARE 410,301 0 0 3,070,316 51 52.00 HOSPICE ROUTINE HOME CARE 6,482 0 0 3,2728 52 53.00 HOSPICE GENERAL INPATIENT CARE 1,445 0 0 2,568,575 53 NONREI MBURSABLE COST CENTERS 0 0 0 2,568,575 53 NONREI MBURSABLE COST CENTERS 0 0 0 62 64<			110 220					14.00
16.00 OTHER GENERAL SERVICE 0 16 17.00 PATIENT/RESIDENTIAL CARE SERVICES 0 17 LEVEL OF CARE 0 0 0 50 100 HOSPICE CONTINUOUS HOME CARE 0 0 0 50 50.00 HOSPICE ROUTINE HOME CARE 410,301 0 0 3,070,316 51 52.00 HOSPICE INPATIENT RESPITE CARE 6.482 0 0 362,728 52 53.00 HOSPICE GENERAL INPATIENT CARE 1,445 0 0 2,568,575 53 60.00 BEREAVEMENT PROGRAM 0 0 99,725 60 61.00 VOLUNTEER PROGRAM 0 0 0 62 62.00 FUNDRAI SI NG 0 0 62 64 62 0 0 62 64.00 PALLIATI VE MEDI CI NE FELLOWS 0 0 0 62 64 65 66 65 66 65 66 65 66 65 66 66 67 68 67 69 67 68 69 </td <td></td> <td></td> <td></td> <td>0</td> <td></td> <td></td> <td></td> <td>15.00</td>				0				15.00
17.00 PATI ENT/RESI DENTI AL CARE SERVICES 0 17 LEVEL OF CARE 0 0 0 50 0 00 0 0 50 50 50.00 HOSPI CE CONTI NUOUS HOME CARE 410, 301 0 0 3, 070, 316 51 51.00 HOSPI CE ROUTI NE HOME CARE 410, 301 0 0 362, 728 52 52.00 HOSPI CE GENERAL I NPATI ENT CARE 1, 445 0 0 2, 568, 575 53 60.00 BEREAVEMENT PROGRAM 0 0 99, 725 60 61.00 VOLUNTEER PROGRAM 0 0 99, 725 60 61.00 VOLUNTEER PROGRAM 0 0 0 61 62.00 FUNDRAI SI NG 0 0 0 63 64.00 PALLI ATI VE MEDI CINE FELLOWS 0 0 63 64 65 65.00 OTHER PHYSI CI AN SERVI CES 0 0 0 65 66 65 66 67 0 0 65 66.00 RESI DENTI AL CARE 0 0 0<			-	0		0		16.00
LEVEL OF CARE O O O O So. 00 50.00 HOSPI CE CONTI NUOUS HOME CARE 0 0 0 0 50 50 51.00 HOSPI CE ROUTI NE HOME CARE 410, 301 0 0 3, 070, 316 51 52.00 HOSPI CE GENERAL INPATI ENT CARE 6, 482 0 0 0 3, 62, 728 52 NONREI MBURSABLE COST CENTERS 1, 445 0 0 0 2, 568, 575 53 NONREI MBURSABLE COST CENTERS 0 0 0 2, 568, 575 53 60.00 BEREAVEMENT PROGRAM 0 0 0 0 61 62 00 0 0 61 62 0 0 0 0 63 64 0 0 0 0 63 64 0 0 0 63 64 0 0 0 63 64 0 0 0 0 64 65 66 0			0			-		17.00
50.00 HOSPI CE CONTI NUOUS HOME CARE 0 0 0 0 50.00 HOSPI CE ROUTI NE HOME CARE 410, 301 0 0 3, 070, 316 51 51 52.00 HOSPI CE INPATI ENT RESPI TE CARE 6, 482 0 0 0 362, 728 52 53.00 HOSPI CE GENERAL INPATI ENT CARE 1, 445 0 0 2, 568, 575 53 NONREI MBURSABLE COST CENTERS 0 0 99, 725 60 60.00 BEREAVEMENT PROGRAM 0 0 99, 725 60 61.00 VOLUNTEER PROGRAM 0 0 99, 725 60 62.00 FUNDRAI SI NG 0 0 0 62 63.00 HOSPI CE /PALLI ATI VE MEDI CI NE FELLOWS 0 0 62 63 64.00 PALLI ATI VE CARE PROGRAM 0 0 0 63 64 65 66 67 60 0 65 66 66 67 60 0 67 68 67								
51.00 HOSPI CE ROUTI NE HOME CARE 410, 301 0 0 3, 070, 316 51 52.00 HOSPI CE INPATI ENT RESPI TE CARE 6, 482 0 0 362, 728 52 53.00 HOSPI CE GENERAL INPATI ENT CARE 1, 445 0 0 2, 568, 575 52 NOREI MBURSABLE COST CENTERS 0 0 99, 725 60 61.00 VOLUNTEER PROGRAM 0 0 0 61 62.00 FUNDRAI SI NG 0 0 0 62 63.00 HOSPI CE /PALLI ATI VE MEDI CI NE FELLOWS 0 0 63 64.00 PALLI ATI VE CARE PROGRAM 0 0 0 63 65.00 OTHER PHYSI CI AN SERVI CES 0 0 0 63 64.00 PALLI ATI VE CARE PROGRAM 0 0 0 65 65.00 RESI DENTI AL CARE 0 0 0 66 67.00 ADVERTI SI NG 0 0 0 67 68.00	50.00		0	C		0	C	50.00
53.00 HOSPICE GENERAL INPATIENT CARE 1,445 0 0 2,568,575 53.00 NORREI MBURSABLE COST CENTERS	51.00		410, 301	C		0	3, 070, 316	51.00
NONREI MBURSABLE COST CENTERS 60.00 BEREAVEMENT PROGRAM 0 0 99, 725 60 61.00 VOLUNTEER PROGRAM 0 0 0 61 62.00 FUNDRAI SI NG 0 0 0 61 63.00 HOSPI CE/PALLI ATI VE MEDI CI NE FELLOWS 0 0 63 0 63 64.00 PALLI ATI VE CARE PROGRAM 0 0 0 63 64 0 0 63 64 0 0 63 64 0 0 63 64 0 0 64 0 0 63 64 0 0 64 0 0 64 0 0 0 65 66 0 18 64 65 0 0 0 0 65 66 0 0 0 0 65 66 67 0 0 0 67 68 69 0 0 0 67 68 69<	52.00	HOSPICE INPATIENT RESPITE CARE	6, 482	0		0 0	362, 728	52.00
60.00 BEREAVEMENT PROGRAM 0 0 99,725 60 61.00 VOLUNTEER PROGRAM 0 0 0 61 62.00 FUNDRAI SI NG 0 0 0 61 62.00 FUNDRAI SI NG 0 0 0 62 63.00 HOSPI CE/PALLI ATI VE MEDI CI NE FELLOWS 0 0 0 63 64.00 PALLI ATI VE CARE PROGRAM 0 0 0 63 65.00 OTHER PHYSI CI AN SERVI CES 0 0 0 65 66.00 RESI DENTI AL CARE 0 0 0 0 66 67.00 ADVERTI SI NG 0 0 0 0 67 68.00 TELEHEALTH/TELEMONI TORI NG 0 0 0 0 68 69.00 THRI FT STORE 0 0 0 0 68 69.00 THRI FT STORE 0 0 0 0 0 0 71.00	53.00	HOSPICE GENERAL INPATIENT CARE	1, 445	0		0 0	2, 568, 575	53.00
61.00 VOLUNTEER PROGRAM 0 0 61 62.00 FUNDRAI SI NG 0 0 62 63.00 HOSPI CE/PALLI ATI VE MEDI CI NE FELLOWS 0 0 63 64.00 PALLI ATI VE CARE PROGRAM 0 0 2, 933, 918 64 65.00 OTHER PHYSI CI AN SERVI CES 0 0 0 65 66.00 RESI DENTI AL CARE 0 0 0 65 66.00 RESI DENTI AL CARE 0 0 0 66 67.00 ADVERTI SI NG 0 0 0 66 68.00 TELEHEALTH/TELEMONI TORI NG 0 0 68 69 68 69 69 69 69 69 69 69 70 0 0 69 69 70 71 0 0 0 0 71 71 0 0 0 0 0 71 99.00 NEGATI VE COST CENTER 0 0 0 0 0 0 0 99		NONREIMBURSABLE COST CENTERS						
62.00 FUNDRAI SI NG 0 0 62 63.00 HOSPI CE/PALLI ATI VE MEDI CI NE FELLOWS 0 0 63 64.00 PALLI ATI VE CARE PROGRAM 0 0 2,933,918 64 65.00 OTHER PHYSI CI AN SERVI CES 0 0 0 65 66 67 0 0 0 66 66 66 67 0 0 0 66 66 67 0 0 0 0 66 66 67 0 0 0 0 66 66 67 0 0 0 0 66 66 67 0 0 0 0 66 66 67 0 0 0 67 68 69 0 10 67 68 69 0 10 68 69 69 69 0 10 69 69 69 69 69 69 70 0 0 69 70 71 00 10 70 71 00 0 0 0 71	60.00	BEREAVEMENT PROGRAM	0			0	99, 725	60.00
63.00 HOSPICE/PALLIATIVE MEDICINE FELLOWS 0 0 63 64.00 PALLIATIVE CARE PROGRAM 0 0 2,933,918 64 65.00 OTHER PHYSICIAN SERVICES 0 0 0 65 65 66.00 RESIDENTIAL CARE 0 0 0 0 66 67.00 ADVERTISING 0 0 0 67 67 68.00 TELEHEALTH/TELEMONITORING 0 0 0 67 67 69.00 THRI FT STORE 0 0 0 69 69 70 0 0 69 70 0 70 71 0 0 0 0 71 99 0 0 0 0 0 0 99 99 NEGATIVE COST CENTER 0 0 0 0 0 0 99			0			0		
64.00 PALLIATIVE CARE PROGRAM 0 2,933,918 64 65.00 OTHER PHYSICIAN SERVICES 0 0 0 65 66.00 RESIDENTIAL CARE 0 0 0 66 67.00 ADVERTISING 0 0 0 66 67.00 ADVERTISING 0 0 67 68 68.00 TELEHEALTH/TELEMONITORING 0 0 67 68 69.00 THRIFT STORE 0 0 69 0 70 0 70 0 70 0 70 70 0 70 71 0 0 0 0 71 71 0 0 0 0 0 71 71 99 0 0 0 0 0 99 99			0			0		
65.00 OTHER PHYSICIAN SERVICES 0 0 65 66.00 RESIDENTIAL CARE 0 0 0 66 67.00 ADVERTISING 0 0 0 67 68.00 TELEHEALTH/TELEMONITORING 0 0 0 67 69.00 THRIFT STORE 0 0 0 68 70.00 NURSING FACILITY ROOM & BOARD 0 0 0 70 71.00 OTHER NONREI MBURSABLE (SPECIFY) 0 0 0 0 71 99.00 NEGATIVE COST CENTER 0 0 0 0 0 99			0			0		
66.00 RESIDENTIAL CARE 0 0 0 0 66 67.00 ADVERTISING 0 0 0 67 68 0 0 67 68 0 0 67 68 0 10 67 68 0 10 67 68 0 10 68 67 0 10 68 67 0 10 68 69 0 10 68 69 0 10 68 69 0 10 68 69 0 10 68 69 0 10 68 69 0 10 68 69 0 10 69 69 0 10 69 70 0 70			0			0		
67.00 ADVERTISING 0 0 67 68.00 TELEHEALTH/TELEMONITORING 0 0 0 68 69.00 THRIFT STORE 0 0 0 69 70.00 NURSING FACILITY ROOM & BOARD 0 0 0 70 71.00 OTHER NONREI MBURSABLE (SPECI FY) 0 0 0 0 71 99.00 NEGATI VE COST CENTER 0 0 0 0 99			0			0		
68.00 TELEHEALTH/TELEMONITORING 0 0 68 0 68 0 0 68 0 68 0 68 0 100 68 69 00 100 68 00 69 00 00 69 00 69 00 69 00 69 00 69 00<			0	C		0 0	-	
69.00 THRIFT STORE 0 0 69 70.00 NURSING FACILITY ROOM & BOARD 0 0 70 70 71.00 OTHER NONREI MBURSABLE (SPECI FY) 0 0 0 0 71 99.00 NEGATI VE COST CENTER 0 0 0 0 99			0			0		
70.00 NURSING FACILITY ROOM & BOARD 0 70 70 71.00 OTHER NONREI MBURSABLE (SPECI FY) 0 0 0 0 71 99.00 NEGATI VE COST CENTER 0 0 0 0 99			0			0	-	
71.00 OTHER NONREI MBURSABLE (SPECI FY) 0 0 0 0 71 99.00 NEGATI VE COST CENTER 0 0 0 0 99			0			U		1
99. 00 NEGATI VE COST CENTER 0 0 0 0 99				0		0	-	
			0	0		-		
			418, 228	0		0 0	-	

	Financial Systems	FRANCI SCAN HEALT				u of Form CMS-2	
	LLOCATION - HOSPITAL-BASED HOSPICE GEN	ERAL SERVICE COSTS	Provider C	CN: 15-0162	Period:	Worksheet 0-6	
STATI S	TICAL BASIS		Hospi ce CCI	N: 15-1523	From 01/01/2022 To 12/31/2022	Part II Date/Time Pre	narod
			nospi ce co	1. 15-1525	10 12/31/2022	5/29/2023 3:2	
					Hospi ce I		
	Cost Center Descriptions	CAP REL BLDG &	CAP REL MVBLE	EMPLOYEE	RECONCI LI ATI ON	ADMI NI STRATI VE	
		FLX	EQUI P	BENEFITS		& GENERAL	
		(SQUARE FEET)	(DOLLAR VALUE)	DEPARTMENT		(ACCUMULATED	
				(GROSS		COSTS)	
				SALARI ES)			
		1.00	2.00	3.00	4A	4.00	
	GENERAL SERVICE COST CENTERS		-				
1.00	CAP REL COSTS-BLDG & FIXT	0					1.00
2.00	CAP REL COSTS-MVBLE EQUIP		0				2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	5, 295, 9			3.00
4.00	ADMINISTRATIVE & GENERAL	0	0	532, 70	66 -1, 519, 868	7, 515, 394	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0		0 0	1	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0		0 0	18, 888	6.00
7.00	HOUSEKEEPING	0	0 0		0 0	0	7.00
8.00	DI ETARY	0	0		0 0	23, 411	8.00
9.00	NURSING ADMINISTRATION	0	0		0 0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0		0 0	299	10.00
11.00	MEDI CAL RECORDS	0	0		0 0	893	11.00
12.00	STAFF TRANSPORTATION	0	0		0 0	80, 970	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	43, 70	0 0	65, 988	13.00
14.00	PHARMACY	0	0 0		0 0	347, 876	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0		0 0	0	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	· ·					1
50.00	HOSPICE CONTINUOUS HOME CARE				0 0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE			833, 80	02 0	2, 065, 717	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	157, 0	39 0	255, 136	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	1, 411, 5	80 0	2, 132, 877	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	0		0 0	82, 950	60.00
61.00	VOLUNTEER PROGRAM	0	0		0 0	0	61.00
62.00	FUNDRAI 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	2, 317, 0	62 0	2, 440, 388	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	66.0
67.00	ADVERTI SI NG	0	0		0 0	0	67.00
68.00	TELEHEALTH/TELEMONI TORI NG	0	0		0 0	0	68.0
69.00	THRI FT STORE	0	0		0 0	0	69.0
70.00	NURSING FACILITY ROOM & BOARD				0		70.0
	OTHER NONREIMBURSABLE (SPECIFY)	0	0		0 0	0	71.0
	NEGATIVE COST CENTER						99.0
100 00	COST TO BE ALLOCATED (per Wkst. 0-6, F	Part I) 0	0	277, 60	01	1, 519, 868	100.0
	UNIT COST MULTIPLIER					0. 202234	

Heal th	Financial Systems Fi	RANCISCAN HEALT	H INDIANAPOLIS		In Lie	eu of Form CMS-2	2552-10
	LLOCATION - HOSPITAL-BASED HOSPICE GENERAL SE		Provider C		Peri od:	Worksheet 0-6	
	TICAL BASIS				From 01/01/2022		
011110			Hospi ce CC	N: 15-1523	To 12/31/2022		
						5/29/2023 3:2	2 pm
					Hospi ce I		
	Cost Center Descriptions	PLANT	LAUNDRY &	HOUSEKEEPI N	G DI ETARY	NURSI NG	
		OPERATION &	LINEN SERVICE	(SQUARE FEET) (IN-FACILITY	ADMI NI STRATI ON	
		MAI NTENANCE	(IN-FACILITY		DAYS)		
		(SQUARE FEET)	DAYS)			(DI RECT NURS.	
						HRS.)	
		5.00	6.00	7.00	8.00	9.00	
	GENERAL SERVICE COST CENTERS			1		I	
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	329					5.00
6.00	LAUNDRY & LINEN SERVICE	0	329				6.00
7.00	HOUSEKEEPING	0			0		7.00
8.00	DI ETARY	0			0 329		8.00
9.00	NURSI NG ADMI NI STRATI ON	0			0	0	9.00
10.00	ROUTI NE MEDI CAL SUPPLI ES	0			0	0	10.00
11.00	MEDICAL RECORDS	0			0	0	11.00
12.00	STAFF TRANSPORTATION	0			0	0	12.00
		0			0	-	
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	PATI ENT/RESI DENTI AL CARE SERVI CES	0			0		17.00
	LEVEL OF CARE				-		
50.00	HOSPICE CONTINUOUS HOME CARE					0	50.00
51.00	HOSPICE ROUTINE HOME CARE					0	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	311	311		0 311	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	18	18		0 18	0	53.00
	NONREIMBURSABLE COST CENTERS			•		•	1
60.00	BEREAVEMENT PROGRAM	0			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 0		66.00
67.00	ADVERTI SI NG	0	0		0	0	67.00
		0			0	-	
68.00	TELEHEALTH/TELEMONI TORI NG	0			0	0	68.00
69.00	THRIFT STORE	0			U	0	69.00
70.00	NURSING FACILITY ROOM & BOARD		_				70.00
71.00	OTHER NONREI MBURSABLE (SPECI FY)	0	0		0 0	0	
	NEGATI VE COST CENTER						99.00
	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	1	22, 708		0 28, 146	-	100.00
101.00	UNIT COST MULTIPLIER	0. 003040	69. 021277	0.0000	85. 550152	0.000000	101. 00

COST A	Financial Systems F NLLOCATION - HOSPITAL-BASED HOSPICE GENERAL S STICAL BASIS	FRANCISCAN HEALTH ERVICE COSTS		CN: 15-0162	Period: From 01/01/2022 To 12/31/2022	w of Form CMS- Worksheet 0-6 Part II Date/Time Pre	pared:
						5/29/2023 3:2	2 pm
	Cost Center Descriptions	ROUTI NE MEDI CAL SUPPLI ES (PATI ENT DAYS)	MEDI CAL RECORDS (PATI ENT DAYS)	STAFF TRANSPORTATI ((MI LEAGE)	Hospi ce I VOLUNTEER N 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	11.00	
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00 \end{array}$	CAP REL COSTS-BLOG & FIXT CAP REL COSTS-BLOG & FIXT CAP REL COSTS-MVBLE EQUIP EMPLOYEE BENEFITS DEPARTMENT ADMINI STRATI VE & GENERAL PLANT OPERATION & MAINTENANCE LAUNDRY & LINEN SERVICE HOUSEKEEPING DI ETARY NURSING ADMINI STRATION ROUTINE MEDICAL SUPPLIES MEDICAL RECORDS STAFF TRANSPORTATION VOLUNTEER SERVICE COORDINATION PHARMACY PHYSICIAN ADMINI STRATIVE SERVICES OTHER GENERAL SERVICE PATIENT/RESIDENTIAL CARE SERVICES LEVEL OF CARE	16, 517	16, 517	. 10	0 0 31, 056 0 0 0 0 0 0	23, 162 0 0	15.00
50.00 51.00 52.00 53.00	HOSPI CE CONTI NUOUS HOME CARE HOSPI CE ROUTI NE HOME CARE HOSPI CE I NPATI ENT RESPI TE CARE HOSPI CE GENERAL I NPATI ENT CARE	0 16, 188 311 18	0 16, 188 311 18	10	0 0 0 30, 452 0 553 0 51	0 22, 723 359 80	51.00 52.00
	NONREIMBURSABLE COST CENTERS BEREAVEMENT PROGRAM VOLUNTEER PROGRAM FUNDRAISING HOSPICE/PALLIATIVE MEDICINE FELLOWS PALLIATIVE CARE PROGRAM OTHER PHYSICIAN SERVICES RESIDENTIAL CARE ADVERTISING TELEHEALTH/TELEMONITORING THRIFT STORE NURSING FACILITY ROOM & BOARD OTHER NONREIMBURSABLE (SPECIFY) NEGATIVE COST CENTER OCOST TO BE ALLOCATED (per Wkst. 0-6, Part 1) UNIT COST MULTIPLIER) <u>359</u> 0. 021735	1, 074 0. 065024			0 0 0 0 0 0 0 0 0 418, 228 18. 056645	61.00 62.00 63.00 64.00 65.00 66.00 67.00 68.00 69.00 70.00 71.00 99.00

	LLOCATION - HOSPITAL-BASED HOSPICE GENE TICAL BASIS	RAL SERVICE COSTS		CN: 15-0162	Period: From 01/01/2022	Worksheet O- Part II	
			Hospi ce CC	N: 15-1523	To 12/31/2022	Date/Time Pr 5/29/2023 3:	
					Hospi ce I		, F
	Cost Center Descriptions	PHYSI CI AN	OTHER GENERAL	PATI ENT/			
		ADMI NI STRATI VE		RESI DENTI AL			
		SERVI CES	(SPECI FY	CARE SERVICE			
		(PATIENT DAYS)	BASI S)	(IN-FACILIT	Y		
		15.00	16.00	DAYS)			
	GENERAL SERVICE COST CENTERS	15.00	16.00	17.00			_
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	ADMI NI STRATI VE & 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 ADMINI STRATION						9.00
10.00	ROUTINE MEDICAL SUPPLIES						10.00
11.00	MEDICAL 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	0					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					50.00
51.00	HOSPICE ROUTINE HOME CARE	0					51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0			0		52.00
53.00	HOSPICE GENERAL INPATIENT CARE) ()	0		53.00
	NONREI MBURSABLE COST CENTERS		1				
60.00	BEREAVEMENT PROGRAM		(60.00
61.00	VOLUNTEER PROGRAM		(61.00
62.00	FUNDRALSING		0				62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS						63.00
64.00	PALLIATIVE CARE PROGRAM						64.00
65.00	OTHER PHYSICIAN SERVICES	(0		65.00
66.00 67.00	RESI DENTI AL CARE ADVERTI SI NG			Ś	0		66.00 67.00
67.00	TELEHEALTH/TELEMONI TORI NG			()			68.00
69.00	THRIFT STORE			Ś.			69.00
70.00	NURSING FACILITY ROOM & BOARD			Ί			70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	(0		71.00
	NEGATI VE COST CENTER				Ŭ		99.00
	COST TO BE ALLOCATED (per Wkst. 0-6, Pa	art I)			0		100.00
100.00							

Heal th	Financial Systems	RANCI SCAN HEALT	H INDIANAPOLIS		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF HOSPITAL-BASED HOSPICE SHARED SERVICE CO			Provider CCN: 15-0162		Peri od:	Worksheet 0-7	
LEVEL	OF CARE		lloopi og CCI	. 15 1500	From 01/01/2022	Data /Tima Dra	norod.
			Hospi ce cui	N: 15-1523	To 12/31/2022	Date/Time Pre 5/29/2023 3:2	
					Hospi ce I	5/21/2025 5.2	<u>z piii</u>
				Charges by	LOC (from Provi	der Records)	
	Cost Center Descriptions	From Wkst. C,	Cost to Charge	НСНС	HRHC	HI RC	
		Part I, Col. 9					
		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. 125071		0 0	0	2.00
3.00	SPEECH PATHOLOGY	68.00	0. 123564		0 0	0	3.00
4.00	DRUGS CHARGED TO PATIENTS	73.00	0. 147665		0 0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00					5.00
6.00	LABORATORY	60.00	0. 111617		0 0	0	6.00
7.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0. 266874		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. 103647		0 0	0	9.00
10.97	CARDI AC REHABI LI TATI ON	76.97	0. 173477		0 0	0	10.97
11.00	Totals (sum of lines 1-11)						11.00
		Charges by LOC		Shared Serv	ce Costs by LOC		
		(from Provider			, in the second s		
		Records)					
	Cost Center Descriptions	HGI P	HCHC (col. 1 x	HRHC (col. 1	xHIRC (col. 1 x	HGIP (col. 1 x	
			col. 2)	col. 3)	col. 4)	col. 5)	
		5.00	6.00	7.00	8.00	9.00	
	ANCI LLARY SERVICE COST CENTERS	- T			1		
1.00	PHYSI CAL THERAPY	0	0		0 0	0	
2.00	OCCUPATI ONAL THERAPY	0	0		0 0	0	
3.00	SPEECH PATHOLOGY	0	0		0 0	0	3.00
4.00	DRUGS CHARGED TO PATIENTS	0	0		0 0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED						5.00
6.00	LABORATORY	0	0		0 0	0	
7.00	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 0	0	1.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER						8.00
9.00	RADI OLOGY-THERAPEUTI C	0	0		0 0	0	
10. 97	CARDI AC REHABI LI TATI ON	0	0		0 0	0	
11 00	Totals (sum of lines 1-11)		0		0 0	0	11.00

Heal th Financial Systems FRANCISCAN HEA CALCULATION OF HOSPITAL-BASED HOSPICE PER DIEM COST		Provi der CCN: 15-0162		Peri od:	u of Form CMS-2552- Worksheet 0-8	
		Hospi ce CCI	N: 15-1523	From 01/01/2022 To 12/31/2022	Date/Time Pre	
				lleeni ee l	5/29/2023 3:23	2 pm
	· · · · · · · · · · · · · · · · · · ·		TITLE XVIII	Hospice I TITLE XIX	TOTAL	
			MEDICARE	MEDICALD	TUTAL	
			1.00	2.00	3.00	
	HOSPICE CONTINUOUS HOME CARE		1.00	2.00	5.00	
	Total cost (Wkst. 0-6, Part I, col. 18, line 50 plus Wkst. 0-	-7 col 6			0	1.0
	line 11)	7, 001. 0,			0	1.0
	Total unduplicated days (Wkst. S-9, col. 4, line 10)				0	2.0
	Total average cost per diem (line 1 divided by line 2)				0.00	
	Unduplicated program days (Wkst. S-9 col. as appropriate, lin	ne 10)		0 0		4.0
	Program cost (line 3 times line 4)	10 10)		0 0		5.0
	HOSPICE ROUTINE HOME CARE				1	
	Total cost (Wkst. 0-6, Part I, col. 18, line 51 plus Wkst. 0-	-7. col. 7.			3, 070, 316	6.0
	line 11)	.,			-,,	
00	Total unduplicated days (Wkst. S-9, col. 4, line 11)				16, 188	7.0
	Total average cost per diem (line 6 divided by line 7)				189.67	8. (
	Unduplicated program days (Wkst. S-9, col. as appropriate, li	ne 11)	14, 1	09 739		9.0
	Program cost (line 8 times line 9)		2, 676, 0			10.0
	HOSPICE INPATIENT RESPITE CARE					
1.00	Total cost (Wkst. 0-6, Part I, col. 18, line 52 plus Wkst. 0-	-7, col. 8,			362, 728	11. (
	line 11)					
2.00	Total unduplicated days (Wkst. S-9, col. 4, line 12)				311	12. (
3.00	Total average cost per diem (line 11 divided by line 12)				1, 166. 33	13.
4.00	Unduplicated program days (Wkst. S-9, col. as appropriate, li	ne 12)	2	75 18		14. (
5.00	Program cost (line 13 times line 14)		320, 7	41 20, 994		15.0
	HOSPICE GENERAL INPATIENT CARE		_			
5.00	Total cost (Wkst. 0-6, Part I, col. 18, line 53 plus Wkst. 0-	-7, col. 9,			2, 568, 575	16. (
	line 11)					
	Total unduplicated days (Wkst. S-9, col. 4, line 13)					17.0
	Total average cost per diem (line 16 divided by line 17)				142, 698. 61	
	Unduplicated program days (Wkst. S-9, col. as appropriate, li	ne 13)		15 2		19. (
	Program cost (line 18 times line 19)		2, 140, 4	79 285, 397		20. (
	TOTAL HOSPICE CARE					
	Total cost (sum of line 1 + line 6 + line 11 + line 16)				6, 001, 619	
	Total unduplicated days (Wkst. S-9, col. 4, line 14)				16, 517	
3.00	Average cost per diem (line 21 divided by line 22)				363.36	23.0

Health Financial Systems	FRANCI SCAN HEALTH I	NDI ANAPOLI S	In Lieu of Form CMS-2552-10			
CALCULATION OF CAPITAL PAYMENT		Provider CCN: 15-0162	Period: From 01/01/2022 To 12/31/2022	Worksheet L Parts I-III Date/Time Pre 5/29/2023 3:2		
		Title XVIII	Hospi tal	PPS		

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	5, 481, 064	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	874, 821	2.00
2.01	Model 4 BPCI Capital DRG outlier payments	0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)	284.10	3.00
4.00	Number of interns & residents (see instructions)	20.80	4.00
5.00	Indirect medical education percentage (see instructions)	2.09	5.00
5.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01) (see instructions)	114, 554	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	0.00	8.00
9.00	Sum of Lines 7 and 8	0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)	0.00	10.00
11.00		0	11.00
12.00	Total prospective capital payments (see instructions)	6, 470, 439	12.00
		1.00	
	PART II - PAYMENT UNDER REASONABLE COST		
1.00	Program inpatient routine capital cost (see instructions)	0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)	0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)	0	3.00
4.00	Capital cost payment factor (see instructions)	0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)	0	5.00
		1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS		
1.00	Program inpatient capital costs (see instructions)	0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)	0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)	0	3.00
4.00	Applicable exception percentage (see instructions)	0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)	0	5.00
5.00	Percentage adjustment for extraordinary circumstances (see instructions)	0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)	0	7.00
3.00	Capital minimum payment level (line 5 plus line 7)	0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)	0	9.00
0.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)	0	10.00
1. 00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)	0	11.00
12.00		0	12.00
13.00		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)	0	14.00
15.00	Current year allowable operating and capital payment (see instructions)	0	15.00
16.00	Current year operating and capital costs (see instructions)	0	16.00
		0	17.00