Heal th Financi	al Systems FRANCISCAN	ST ANTHONY-M	ICHIGAN CITY		In Lie	u of Form	CMS-2552-10
This report is	required by law (42 USC 1395g; 42 CFR 413.2	20(b)). Failui	re to report can res	ultin	all interim	FORM APPE	ROVED
payments made	since the beginning of the cost reporting pe	eriod being de	eemed overpayments (42 USC	1395g).	OMB NO. C	0938-0050
HOSPITAL AND H AND SETTLEMENT	IOSPITAL HEALTH CARE COMPLEX COST REPORT CERT SUMMARY	ΓΙ FI CATI ON	Provider CCN: 150015	From	od: 01/01/2014 12/31/2014	Date/Time	
PART I - COST	REPORT STATUS					07 207 2010	7.00 diii
Provi der	1. [X] Electronically filed cost report			D	ate: 5/28/20	15 Tim	ne: 9:58 am
use only	2. [] Manually submitted cost report						
	3. [0] If this is an amended report enter 4. [F] Medicare Utilization. Enter "F" for			resubmi	tted this co	ost report	
Contractor use only	5. [1]Cost Report Status 6. Date Receive (1) As Submitted 7. Contractor N (2) Settled with Audit 9. [N] Final (3) Settled with Audit 9. [N] Final (2)	No. I Report for	11	. [0]	ctor's Vendo	lumn 1 is	

PART II - CERTIFICATION

(4) Reopened (5) Amended

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

CERTIFICATION BY 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 the Balance Sheet and Statement of Revenue and Expenses prepared by FRANCISCAN ST ANTHONY-MICHIGAN CITY (150015) for the cost reporting period beginning 01/01/2014 and ending 12/31/2014 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.

(Si gned)				
	Officer or	Admi ni strator	of Provider(s)	
			` ,	
Title				
ппе				
Date				

			Title XVIII				
	Cost Center Description	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	161, 487	185, 263	68, 467	0	1. 00
2.00	Subprovi der - I PF	0	17, 490	0		0	2. 00
3.00	Subprovider - IRF	0	-29, 385	0		0	3. 00
5.00	Swing bed - SNF	0	0	0		0	5. 00
6.00	Swing bed - NF	0				0	6. 00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7. 00
8.00	NURSING FACILITY	0				0	8. 00
200.00	Total	0	149, 592	185, 263	68, 467	0	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 valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 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.

Health Financial Systems FRANCISCAN ST ANTHONY-MICHIGAN CITY In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provi der CCN: 150015 Peri od: Worksheet S-2 From 01/01/2014 Part I Date/Time Prepared: 12/31/2014 5/28/2015 9:57 am 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 301 W. HOMER ST 1.00 PO Box: 1.00 State: IN 2.00 City: MICHIGAN CITY Zip Code: 46360 County: LAPORTE 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, 0, or N) Certi fi ed Number Number Type XVIII XIX 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 Hospi tal FRANCISCAN ST 150015 33140 07/01/1966 Ν Р 0 3.00 1 ANTHONY-MICHIGAN CITY Р 4.00 Subprovider - IPF FRANCISCAN ST 15S015 33140 01/01/1998 0 4 Ν 4.00 ANTHONY-MICHIGAN CITY 5.00 Subprovider - IRF FRANCISCAN ST 15T015 33140 5 01/01/1997 Ν Ρ 0 5.00 ANTHONY-MICHIGAN CITY 6.00 Subprovider - (Other) 6 00 Swing Beds - SNF 7.00 7.00 Swing Beds - NF 8.00 8.00 9.00 Hospital-Based SNF 9.00 10.00 Hospi tal -Based NF 10 00 11.00 Hospi tal -Based OLTC 11.00 Hospi tal -Based HHA 12.00 12.00 13.00 Separately Certified ASC 13.00 14.00 Hospi tal -Based Hospi ce 14 00 15.00 Hospital-Based Health Clinic - RHC 15.00 16.00 Hospital-Based Health Clinic - FQHC 16.00 17.00 Hospital-Based (CMHC) I 17.00 18.00 Renal Dialysis 18 00 19.00 Other 19.00 From: To: 1.00 2.00 20.00 Cost Reporting Period (mm/dd/yyyy) 12/31/2014 20.00 01/01/2014 Type of Control (see instructions) 21.00 Inpatient PPS Information 22.00 Does this facility qualify and is it currently receiving payments for disproportionate N 22.00 Υ share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim uncompensated care payments for this cost reporting 22.01 period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) 22. 02 Is this a newly merged hospital that requires final uncompensated care payments to be 22.02 Ν Ν determined at cost report settlement? (see instructions) Enter in column 1, "Y" or "N" for no, for the portion of the cost reporting period prior to October 1. Enter "Y" for yes or "N" for no, for the portion of the cost reporting period on in column 2 or after October 1. 22.03 Did this hospital receive a geographic reclassification from urban to rural as a result Ν 22.03 Ν of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. 23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column Ν 23.00 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2 enter "Y" "N" for no for yes or Other In-State In-State Out-of Out-of Medicai d Medi cai d Medi cai d State State HMO days Medi cai d el i gi bl e Medi cai d Medi cai d paid days days unpai d paid days el i gi bl e unpai d days 1.00 3. 00 4. 00 5.00 6.00 2.00 24.00 If this provider is an IPPS hospital, enter the 3, 521 183 68 437 70 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. 25.00 If this provider is an IRF, enter the in-state 75 27 0 0 25.00 4 Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.

0.00

0.00

0.00

0.00

0.00

61.04

61.05

61.06

instructions)

Enter the number of unweighted primary care/or

61.04 minus line 61.03). (see instructions)
61.06 Enter the amount of ACA §5503 award that is being

surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).
61.05 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

used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)

61.04

Health Financial Systems	FRANCISCAN S	T ANTHONY-M	CHIGAN CI	TY	In Lie	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMP	LEX IDENTIFICATION DA	TA	Provi der		eriod: rom 01/01/2014 o 12/31/2014	Worksheet S-2 Part I Date/Time Pre 5/28/2015 9:5	pared:
		Progran	n Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1. 0	00	2. 00	3. 00	4.00	
61.10 Of the FTEs in line 61.05, speci special ty, if any, and the number for each new program. (see instruction of the program code, enter in column 3, unweighted count and enter in compart of the FTE unweighted count. 61.20 Of the FTEs in line 61.05, speci program special ty, if any, and the special ty of the program special ty, if any, and the special ty of the FTE unweighted count. 3, the IME FTE unweighted count.	er of FTE residents ructions) Enter in re in column 2, the the IME FTE olumn 4, direct GME fy each expanded he number of FTE rram. (see the program name, code, enter in column and enter in column				0. 00		61. 10
				(11201)		1.00	
ACA Provisions Affecting the Hea 62.00 Enter the number of FTE resident					od for which	0.00	62. 00
your hospital received HRSA PCRE 62.01 Enter the number of FTE resident during in this cost reporting pe	funding (see instructs that rotated from a criod of HRSA THC prog	ctions) a Teaching H gram. (see i	ealth Cent	er (THC) into			62. 01
Teaching Hospitals that Claim Re 63.00 Has your facility trained reside	esidents in Nonprovide	er Settings	na +hio oo	ot sonostina s	aniad2 Entan	N	42.00
63.00 Has your facility trained reside				instructions)		Ratio (col. 1/	63. 00
				Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospital	(col. 1 + col. 2))	
				1. 00	2. 00	3.00	
Section 5504 of the ACA Base Yea				This base year	is your cost r	eporting	
period that begins on or after 3 64.00 Enter in column 1, if line 63 is in the base year period, the num resident FTEs attributable to rosettings. Enter in column 2 the resident FTEs that trained in you of (column 1 divided by (column	yes, or your facilit ber of unweighted nor tations occurring in number of unweighted our hospital. Enter ir	ty trained r n-primary ca all nonprov d non-primar n column 3 t	esidents re ider y care he ratio	0. 00	0. 00	0. 000000	64.00
	Program Name	Progran	ı Code	Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
	1.00	2.0	00	3. 00	4. 00	5.00	
65.00 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code, enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)				0.00	0.00	0. 000000	65.00

any subsequent academic year of the new teaching program in existence, enter 6 in column 3. (see instructions)		
	1.0	00
Long Term Care Hospital PPS	1.0	,,,
80.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N	80. 00
81.00 Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter	N	81. 00
"Y" for yes and "N" for no.		
TEFRA Provi ders		
85.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N	85. 00
86.00 Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section		86. 00
§413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.		

Health Financial Systems FRANCISCAN ST ANTHONY-				n Lie	u of Form		<u>552-10</u>
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der CC		Period: From 01/01/ To 12/31/		Workshee Part I Date/Tim 5/28/201	e Prepa 5 9:57	
			V 1.00		2. 00		
Title V and XIX Services 90.00 Does this facility have title V and/or XIX inpatient hospital	sarvi cas 2 Enta	r "V" for	l N		Y		90. 00
yes or "N" for no in the applicable column.							
91.00 Is this hospital reimbursed for title V and/or XIX through the full or in part? Enter "Y" for yes or "N" for no in the application.		either in	N		Y	'	91. 00
92.00 Are title XIX NF patients occupying title XVIII SNF beds (dual instructions) Enter "Y" for yes or "N" for no in the applicable		n)? (see			N		92. 00
93.00 Does this facility operate an ICF/MR facility for purposes of "Y" for yes or "N" for no in the applicable column.		X? Enter	N		N	(93. 00
94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and	d "N" for no i	n the	N		N		94. 00
applicable column. 95.00 If line 94 is "Y", enter the reduction percentage in the applic 96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes on		n the	N	0. 00	N	0.00	95. 00 96. 00
applicable column. 97.00 fline 96 is "Y", enter the reduction percentage in the applic	cable column.			0. 00		0.00	97. 00
Rural Providers 105.00 Does this hospital qualify as a Critical Access Hospital (CAH)'	?		N			10	05. 00
106.00 f this facility qualifies as a CAH, has it elected the all-inc for outpatient services? (see instructions)		d of payment					06. 00
107.00 Column 1: If this facility qualifies as a CAH, is it eligible for I &R training programs? Enter "Y" for yes or "N" for no in instructions) If yes, the GME elimination would not be on Wkst. the program would be cost reimbursed. If yes complete Wkst. D-2 this facility is a CAH, do I&Rs in an approved medical education CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N"	n column 1. (s B, Pt. I, co 2, Pt. II. Col on program tra	see bl. 25 and umn 2: If ain in the	N			10	07. 00
instructions) 108.00 s this a rural hospital qualifying for an exception to the CRI	NA fee schedul	e? See 42	N			10	08. 00
CFR Section §412.113(c). Enter "Y" for yes or "N" for no.		Occupati onal			Respi ra		
109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	1.00 N	2.00 N	3. 00 N	1	4. 00 N		09. 00
					1.00)	
110.00 Did this hospital participate in the Rural Community Hospital I the current cost reporting period? Enter "Y" for yes or "N" for		project (41	OA Demo)fo	r	N	1	10. 00
Miscellaneous Cost Reporting Information				1. 00	2.00	3. 00	
is yes, enter the method used (A, B, or E only) in column 2. It is yes, enter the method used (A, B, or E only) in column 2. It is yes, enter the method used (A, B, or E only) in column 2. It is yes, enter the method used (A, B, or E only) in column 2. It is yes, enter the method used (A, B, or E only) in column 2. It is yes, enter "98" percent to psychiatric, rehabilitation and long term hospitals providers) Pub. 15-1, §2208. 1. 116.00 Is this facility classified as a referral center? Enter "Y" for	f column 2 is for long term based on the	"E", enter care (inclu definition	in column udes	N			15. 00 16. 00
117.00 s this facility legally-required to carry malpractice insurand no.		,		Y			17. 00
118.00 s the malpractice insurance a claims-made or occurrence policy claim-made. Enter 2 if the policy is occurrence.	y? Enter 1 if	the policy	is	2		11′	18. 00
		Premi ums	Losse	S	Insura	nce	
	_	1. 00	2.00		3.00)	
118.01 List amounts of malpractice premiums and paid losses:		361, 70	_	0			18. 01
			1. 00		2.00		
118.02 Are malpractice premiums and paid losses reported in a cost cer Administrative and General? If yes, submit supporting schedule and amounts contained therein.			N				18. 02
119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Ha §3121 and applicable amendments? (see instructions) Enter in co "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.	olumn 1, "Y" f fies for the	for yes or Outpatient	N		N		19. 00 20. 00
121.00 Did this facility incur and report costs for high cost implanta patients? Enter "Y" for yes or "N" for no.	able devices o	charged to	Y			12	21. 00
Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" for y	yes and "N" fo	or no. If	N			12	25. 00
					i		
yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, enter in column 1 and termination date, if applicable, in column 2.	the certific	cation date				1:	26. 00

Ith Financial Systems FRANG SPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICA	CISCAN ST ANTHON ATION DATA		CCN: 150015	Peri From To			-2
					12/31/2014	5/28/2015 9:	
					1. 00	2. 00	
3.00 If this is a Medicare certified liver transpl in column 1 and termination date, if applicab			cation date	Э			128. 0
9.00 If this is a Medicare certified lung transpla	nt center, enter		ation date	in			129. 0
column 1 and termination date, if applicable, 0.00 f this is a Medicare certified pancreas tran		enter the certi	ification				130. 0
date in column 1 and termination date, if app	licable, in colu	umn 2.					
I.00 If this is a Medicare certified intestinal tr date in column 1 and termination date, if app			rti fi cati or	ר			131. 0
2.00 If this is a Medicare certified islet transpl	ant center, ente	er the certific	cation date	e			132. 0
in column 1 and termination date, if applicab 3.00 f this is a Medicare certified other transpl			cation date	е			133. (
in column 1 and termination date, if applicab							124 (
4.00 If this is an organ procurement organization and termination date, if applicable, in column		e OPO number II	n column 1				134. (
All Providers 0.00 Are there any related organization or home of	fice costs as de	efined in CMS I	Pub 15_1		Υ		140. 0
chapter 10? Enter "Y" for yes or "N" for no i	n column 1. If y	yes, and home of	office cost	ts	'		140. 0
are claimed, enter in column 2 the home offic	e chain number. 2.00		i ons)		3. 00		
If this facility is part of a chain organizat	ion, enter on li	ines 141 throu		name		of the	
home office and enter the home office contraction on Name: FRANCISCAN ALLAINCE, INC Contraction	<u>tor name and co</u> ctor's Name: WIS			ctor's	Number: 8001	1	 141. C
		VI CES					140.6
2.00 Street: 1515 DRAGOON TRAIL PO Box 3.00 City: MISHAWAKA State:			Zi p Coo	de:	4654	16	142. (143. (
						1.00	
1.00 Are provider based physicians' costs included	in Worksheet A?	?				1. 00 Y	144. (
5.00 If costs for renal services are claimed on Wo only? Enter "Y" for yes or "N" for no.	rksheet A, line	74, are the co	osts for in	npati er	nt services	N	145. (
IDIII V ETILET TOTO VES OF IN TOTO.							
	from the previous	sly filed cost	report?		1. 00	2. 00	146.0
5.00 Has the cost allocation methodology changed f Enter "Y" for yes or "N" for no in column 1.				er	1. 00 N	2.00	146. (
5.00 Has the cost allocation methodology changed f Enter "Y" for yes or "N" for no in column 1. the approval date (mm/dd/yyyy) in column 2.	(See CMS Pub. 15	5-2, § 4020) I	f yes, ente	er	N	2.00	
5.00 Has the cost allocation methodology changed f Enter "Y" for yes or "N" for no in column 1.	(See CMS Pub. 15 Enter "Y" for ye	5-2, § 4020) l [.] es or "N" for i	f yes, ente	er		2.00	147. (
5.00 Has the cost allocation methodology changed f Enter "Y" for yes or "N" for no in column 1. the approval date (mm/dd/yyyy) in column 2. 7.00 Was there a change in the statistical basis? 8.00 Was there a change in the order of allocation 9.00 Was there a change to the simplified cost fin	(See CMS Pub. 15 Enter "Y" for ye ? Enter "Y" for	5-2, § 4020) I [.] es or "N" for i yes or "N" foi	f yes, ente no. r no.		N N	2.00	147. (148. (
5.00 Has the cost allocation methodology changed f Enter "Y" for yes or "N" for no in column 1. the approval date (mm/dd/yyyy) in column 2. 7.00 Was there a change in the statistical basis? 8.00 Was there a change in the order of allocation	(See CMS Pub. 15 Enter "Y" for ye ? Enter "Y" for	5-2, § 4020) I es or "N" for I yes or "N" for ter "Y" for yes Part A	f yes, enterno. r no. s or "N" fo	or	N N N N	Ti tle XIX	147. (148. (
5.00 Has the cost allocation methodology changed f Enter "Y" for yes or "N" for no in column 1. the approval date (mm/dd/yyyy) in column 2. 7.00 Was there a change in the statistical basis? 8.00 Was there a change in the order of allocation 0.00 Was there a change to the simplified cost fin no.	(See CMS Pub. 15 Enter "Y" for ye ? Enter "Y" for ding method? Ent	5-2, § 4020) I- es or "N" for i yes or "N" foi ter "Y" for ye: Part A 1.00	f yes, enterno. r no. s or "N" for Part B 2.00	or	N N N N Title V 3.00	Title XIX 4.00	147. (148. (
5.00 Has the cost allocation methodology changed f Enter "Y" for yes or "N" for no in column 1. the approval date (mm/dd/yyyy) in column 2. 7.00 Was there a change in the statistical basis? 8.00 Was there a change in the order of allocation 9.00 Was there a change to the simplified cost fin no. Does this facility contain a provider that qu or charges? Enter "Y" for yes or "N" for no f	(See CMS Pub. 15 Enter "Y" for ye ? Enter "Y" for ding method? Ent	es or "N" for u yes or "N" for ter "Y" for yes Part A 1.00 exemption from nt for Part A	f yes, ento no. r no. s or "N" fo Part B 2.00 the appliand Part B	cation	N N N N Title V 3.00 of the lowe 42 CFR §413	Title XIX 4.00 er of costs 3.13)	147. (148. (149. (
Does this facility contain a provider that quor charges? Enter "Y" for yes or "N" for yes or "N" for no in column 1. Enter "Y" for yes or "N" for no in column 1. the approval date (mm/dd/yyyy) in column 2. OUWas there a change in the statistical basis? OUWas there a change in the order of allocation on the simplified cost fin no.	(See CMS Pub. 15 Enter "Y" for ye ? Enter "Y" for ding method? Ent	es or "N" for u yes or "N" for ter "Y" for yes Part A 1.00 exemption from nt for Part A	f yes, enterno. r no. s or "N" for Part B 2.00 the applicand Part B	cation	N N N N Title V 3.00 of the lowe 42 CFR §413 N	Title XIX 4.00 er of costs 3.13)	147. (148. (149. (
5.00 Has the cost allocation methodology changed f Enter "Y" for yes or "N" for no in column 1. the approval date (mm/dd/yyyy) in column 2. 7.00 Was there a change in the statistical basis? 8.00 Was there a change in the order of allocation 9.00 Was there a change to the simplified cost fin no. Does this facility contain a provider that qu or charges? Enter "Y" for yes or "N" for no f	(See CMS Pub. 15 Enter "Y" for ye ? Enter "Y" for ding method? Ent	es or "N" for u yes or "N" for ter "Y" for yes Part A 1.00 exemption from nt for Part A	f yes, ento no. r no. s or "N" fo Part B 2.00 the appliand Part B	cation	N N N N Title V 3.00 of the lowe 42 CFR §413	Title XIX 4.00 er of costs 3.13)	147. (148. (149. (155. (156. (
Does this facility contain a provider that quor charges? Enter "Y" for yes or "N" for yes or "N" for no in column 1. The approval date (mm/dd/yyyy) in column 2. Down there a change in the statistical basis? Down was there a change in the order of allocation on the simplified cost fin no. Does this facility contain a provider that quor charges? Enter "Y" for yes or "N" for no for the simplified cost fin no. Does this facility contain a provider that quor charges? Enter "Y" for yes or "N" for no for no for the subprovider - IPF Oom Subprovider - IRF Douglass the cost allocation methodology changed from the subject of the su	(See CMS Pub. 15 Enter "Y" for ye ? Enter "Y" for ding method? Ent	5-2, § 4020) Increase or "N" for a yes or "N" for the "Y" for yes or "N" for Part A N"	f yes, ento no. r no. s or "N" fo Part B 2.00 the appliand Part B N N	cation	N N N N Title V 3.00 of the lowe 42 CFR §413 N N	Title XIX 4.00 er of costs 3.13) N N N	147. (148. (149. (155. (156. (157. (158. (
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Does this facility contain a provider that quor charges? Enter "Y" for yes or "N" for no in column 1. Does this facility contain a provider that quor charges? Enter "Y" for yes or "N" for no	(See CMS Pub. 15 Enter "Y" for ye ? Enter "Y" for ding method? Enter allifies for an error each componer all that has one e	s-2, § 4020) In ses or "N" for in yes or "N" for it yes or "N" for ter "Y" for yes seemed in from the seemed in th	r yes, enterno. r no. r no. s or "N" for Part B 2.00 the appliand Part B N N N N N Ses in diff	cation. (See	N N N N N N Sittle V 3.00 of the lowe 42 CFR §413 N N N N N CBSAs?	Title XIX 4.00 er of costs 3.13) N N N N N N N S T.00 N FTE/Campus 5.00 0.0	146. C 147. C 148. C 149. C 155. C 156. C 157. C 160. C 161. C

Health Financial Systems	u of Form CMS-	2552-10			
HOSPITAL AND HOSPITAL HEALTH CARE COMP	LEX IDENTIFICATION DATA	Provi der CCN: 150015	Peri od:	Worksheet S-2	
			From 01/01/2014	Part I	
			To 12/31/2014	Date/Time Pre	pared:
				5/28/2015 9:5	7 am
			Begi nni ng	Endi ng	
			1. 00	2.00	
170.00 Enter in columns 1 and 2 the EHF period respectively (mm/dd/yyyy)		for the reporting	07/01/2014	09/30/2014	170. 00
				1.00	1
171.00 If line 167 is "Y", does this pr	rovider have any days for indivi	duals enrolled in secti	on 1876	N	171. 00
Medicare cost plans reported on	Wkst. S-3, Pt. I, line 2, col.	6? Enter "Y" for yes ar	nd "N" for no.		
(see instructions)					

	TAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE	STIONNAIRE Provider		Peri od:	worksheet S-2	
				From 01/01/2014		
				_	5/28/2015 9:5	57 am
				Y/N 1. 00	2. 00	
	General Instruction: Enter Y for all YES resp	onses. Enter N for all NO re	sponses. Enter			
	mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS					+
	Provider Organization and Operation				I	
. 00	Has the provider changed ownership immediatel reporting period? If yes, enter the date of t			N		1.00
	<u> </u>	3	Y/N	Date	V/I	
00	Has the provider terminated participation in	the Medicare Program? If	1.00 N	2. 00	3. 00	2.00
	yes, enter in column 2 the date of termination					2.00
00	voluntary or "I" for involuntary. Is the provider involved in business transact	ions including management	l N			3. 00
00	contracts, with individuals or entities (e.g.	, chain home offices, drug				0.00
	or medical supply companies) that are related officers, medical staff, management personnel					
	of directors through ownership, control, or f	family and other similar				
	relationships? (see instructions)		Y/N	Type	Date	
			1.00	2. 00	3. 00	
00	Financial Data and Reports Column 1: Were the financial statements prep	parad by a Cartified Dublic	Y	A	04/24/2015	4. 00
00	Accountant? Column 2: If yes, enter "A" for	Audited, "C" for Compiled,	'	A	04/24/2015	4.00
	or "R" for Reviewed. Submit complete copy or	enter date available in				
00	column 3. (see instructions) If no, see instr Are the cost report total expenses and total		N			5. 00
	those on the filed financial statements? If y	ves, submit reconciliation.		V (N)	1 1 - 0	
				Y/N 1. 00	Legal Oper. 2.00	
	Approved Educational Activities					
00	Column 1: Are costs claimed for nursing school the legal operator of the program?	ool? Column 2: IT yes, Is th	ne provider is	N		6. 00
00	Are costs claimed for Allied Health Programs?			N		7. 00
00	Were nursing school and/or allied health procost reporting period? If yes, see instruction	grams approved and/or renewed ons.	during the	N		8. 00
00	Are costs claimed for Intern-Resident program		st report? If	N		9. 00
. 00	yes, see instructions. Was an Intern-Resident program been initiated	or renewed in the current o	ost reportina	N		10.00
	period? If yes, see instructions.					44.00
. 00	Are GME cost directly assigned to cost center Teaching Program on Worksheet A? If yes, see		proved	N		11. 00
					Y/N	
	Bad Debts				1. 00	
	Is the provider seeking reimbursement for bac	3 .			Y	12. 00
. 00	If line 12 is yes, did the provider's bad deb period? If yes, submit copy.	ot collection policy change d	luring this cos	st reporting	N	13. 00
1. 00	If line 12 is yes, were patient deductibles a	nd/or co-payments waived? If	yes, see inst	tructi ons.	N	14. 00
. 00	Bed Complement Did total beds available change from the price	or cost reporting period? If	ves see instr	ructions	N	15. 00
<u> </u>	pra total beas avairable change from the price		Pai	rt A	Part B	10.00
		Description 0	Y/N 1.00	Date 2.00	Y/N 3. 00	
	PS&R Data	Ü	1.00	2.00	3.00	
00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes,		N		N	16. 00
	enter the paid-through date of the PS&R					
	Report used in columns 2 and 4 (see instructions)					
	Was the cost report prepared using the PS&R		Y	04/06/2015	Υ	17. 00
. 00	Report for totals and the provider's records					
. 00	for allocation? If oither column 1 or 2 is					
. 00	for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns					
	yes, enter the paid-through date in columns 2 and 4. (see instructions)		NI NI		NI NI	10 00
	yes, enter the paid-through date in columns		N		N	18. 00
	yes, enter the paid-through date in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not		N		N	18. 00
. 00	yes, enter the paid-through date in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		N		N	18. 00
. 00	yes, enter the paid-through date in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not		N N		N N	18. 00

20.00

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 $i\, nstructi\, ons.$

the other adjustments:

20.00 If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe

Health Financial Systems	FRANCISCAN ST ANTHONY-	MICHIGAN CITY		In Lieu of Form CMS-2552-10
LICCULTAL AND LICCULTAL LICALTIL A	CARE DELMBURGEMENT QUECTLONNALDE	Drawi dan CCN, 150015	Dorsi ad.	Washahaat C 2

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE Provider CCN: 150015 Peri od: From 01/01/2014 Part II 12/31/2014 Date/Time Prepared: 5/28/2015 9:57 am Part A Part B Description Y/N Date Y/N 0 1.00 2.00 3.00 21.00 Was the cost report prepared only using the N 21 00 Ν provider's records? If yes, see instructions 1.00 COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS) Capital Related Cost 22.00 Have assets been relifed for Medicare purposes? If yes, see instructions 22.00 Ν 23.00 Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost Ν 23.00 reporting period? If yes, see instructions. 24.00 Were new leases and/or amendments to existing leases entered into during this cost reporting period? 24.00 If ves. see instructions Have there been new capitalized leases entered into during the cost reporting period? If yes, see 25.00 25.00 instructions. 26.00 Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see Ν 26,00 instructions. 27 00 Has the provider's capitalization policy changed during the cost reporting period? If yes, submit Ν 27.00 copy Interest Expense 28.00 Were new loans, mortgage agreements or letters of credit entered into during the cost reporting N 28.00 period? If yes, see instructions. 29.00 Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) Ν 29.00 treated as a funded depreciation account? If yes, see instructions Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see Ν 30.00 instructions. 31.00 Ν Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see 31.00 instructions. Purchased Services 32.00 Have changes or new agreements occurred in patient care services furnished through contractual N 32.00 arrangements with suppliers of services? If yes, see instructions. If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If 33.00 33.00 no, see instructions. Provi der-Based Physi ci ans Are services furnished at the provider facility under an arrangement with provider-based physicians? Υ 34.00 If yes, see instructions. Iffine 34 is yes, were there new agreements or amended existing agreements with the provider-based Ν 35.00 physicians during the cost reporting period? If yes, see instructions. Y/N Date 1.00 2.00 Home Office Costs 36, 00 Were home office costs claimed on the cost report? 36, 00 37.00 If line 36 is yes, has a home office cost statement been prepared by the home office? 37.00 If yes, see instructions. If line 36 is yes, was the fiscal year end of the home office different from that of 38.00 N 38.00 the provider? If yes, enter in column 2 the fiscal year end of the home office. If line 36 is yes, did the provider render services to other chain components? If yes, 39.00 39.00 N see instructions. 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see Ν 40.00 instructions. 1.00 2.00 Cost Report Preparer Contact Information 41.00 Enter the first name, last name and the title/position HONG YANG 41.00 held by the cost report preparer in columns 1, 2, and 3, respecti vel v. 42.00 42.00 Enter the employer/company name of the cost report FRANCISCAN ALLIANCE INC preparer. 43.00 Enter the telephone number and email address of the cost (219) 932-2300 X33175 HONG. YANG@FRANCI SCANALLI ANCE 43.00 report preparer in columns 1 and 2, respectively. ORG

report preparer in columns 1 and 2, respectively.

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE Provider CCN: 150015 Peri od: Worksheet S-2 From 01/01/2014 To 12/31/2014 Part II Date/Time Prepared: 5/28/2015 9:57 am Part B Date 4.00 PS&R Data 16.00 Was the cost report prepared using the PS&R 16.00 Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 . (see instructions) 17.00 Was the cost report prepared using the PS&R 04/06/2015 17.00 Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) 18.00 | If line 16 or 17 is yes, were adjustments 18.00 made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.

19.00 If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of 19.00 other PS&R Report information? If yes, see i nstructi ons. If line 16 or 17 is yes, were adjustments 20.00 made to PS&R Report data for Other? Describe the other adjustments: Was the cost report prepared only using the provider's records? If yes, see 21.00 21.00 instructions. 3.00 Cost Report Preparer Contact Information Enter the first name, last name and the title/position REGIONAL DIRECTOR 41.00 held by the cost report preparer in columns 1, 2, and 3, REI MBURSEMENT respecti vel y. Enter the employer/company name of the cost report 42.00 42.00 preparer. 43.00 Enter the telephone number and email address of the cost 43.00 Heal th Financial Systems FRANCISCAN ST ANTHONY-MICHIGAN CITY
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CCN | Peri od: | Worksheet S-3 | From 01/01/2014 | Part I | To 12/31/2014 | Date/Time Prepared: Provider CCN: 150015

						7 12/31/2014	5/28/2015 9:5	
							I/P Days / 0/P	, cim
							Visits / Trips	
	Component	Worksheet A	No	of Beds	Bed Days	CAH Hours	Title V	
	55p5.115112	Line Number		0. 5000	Avai I abl e	57.11 T.15 G.1 S		
		1.00		2.00	3.00	4. 00	5. 00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	30, 00		135	49, 275	0.00	0	1. 00
	8 exclude Swing Bed, Observation Bed and				, =		_	
	Hospice days) (see instructions for col. 2							
	for the portion of LDP room available beds)							
2.00	HMO and other (see instructions)							2.00
3. 00	HMO IPF Subprovider							3. 00
4. 00	HMO IRF Subprovider							4. 00
5. 00	Hospital Adults & Peds. Swing Bed SNF						0	5. 00
6. 00	Hospital Adults & Peds. Swing Bed NF						Ö	6. 00
7. 00	Total Adults and Peds. (exclude observation			135	49, 275	0.00	0	7. 00
7.00	beds) (see instructions)			133	47, 275	0.00	J	7.00
8. 00	INTENSIVE CARE UNIT	31. 00		14	5, 110	0.00	0	8. 00
9. 00	CORONARY CARE UNIT	01.00			0, 110	0.00	Ŭ	9. 00
10. 00	BURN INTENSIVE CARE UNIT							10. 00
11. 00	SURGICAL INTENSIVE CARE UNIT							11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)							12. 00
13. 00	NURSERY	43. 00					0	13. 00
14. 00	Total (see instructions)	43.00		149	54, 385	0.00	0	14. 00
15. 00	CAH visits			147	54, 565	0.00	0	15. 00
16. 00	SUBPROVIDER - IPF	40. 00		18	6, 570		0	16. 00
17. 00	SUBPROVIDER - I RF	41. 00		16	5, 840		0	17. 00
18. 00	SUBPROVI DER	41.00		10	5, 640		U	18. 00
19. 00	SKILLED NURSING FACILITY	44. 00		0	o		0	19. 00
20. 00	NURSING FACILITY	44. 00 45. 00		0	0		0	20. 00
21. 00	OTHER LONG TERM CARE	43.00		U	U		U	21. 00
22. 00 23. 00	HOME HEALTH AGENCY							22. 00
	AMBULATORY SURGICAL CENTER (D. P.)							23. 00
24. 00	HOSPI CE	20.00						24. 00
24. 10	HOSPICE (non-distinct part)	30. 00						24. 10
25. 00	CMHC - CMHC							25. 00
26. 00	RURAL HEALTH CLINIC							26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER			400				26. 25
27. 00	Total (sum of lines 14-26)			183			_	27. 00
28. 00	Observation Bed Days						0	28. 00
29. 00	Ambul ance Tri ps							29. 00
30. 00	Employee discount days (see instruction)							30. 00
31. 00	Employee discount days - IRF							31. 00
32. 00	Labor & delivery days (see instructions)			0	0			32. 00
32. 01	Total ancillary labor & delivery room							32. 01
	outpatient days (see instructions)							
33. 00	LTCH non-covered days	l l						33. 00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 150015

Peri od: Worksheet S-3 From 01/01/2014 Part I To 12/31/2014 Date/Time Prepared:

5/28/2015 9:57 am Full Time Equivalents I/P Days / O/P Visits / Trips Title XVIII Component Title XIX Total All Total Interns Employees On Pati ents & Residents Payrol I 10.00 6.00 7.00 8.00 9.00 1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8, 924 3, 255 16, 512 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 1, 105 3.00 HMO IPF Subprovider 64 0 3.00 HMO IRF Subprovider 4.00 33 4.00 5.00 Hospital Adults & Peds. Swing Bed SNF 0 5.00 0 Hospital Adults & Peds. Swing Bed NF 6.00 0 6.00 7.00 Total Adults and Peds. (exclude observation 8,924 3, 255 16, 512 7.00 beds) (see instructions) INTENSIVE CARE UNIT 8.00 2,023 522 2,650 8.00 CORONARY CARE UNIT 9.00 9.00 BURN INTENSIVE CARE UNIT 10.00 10.00 11.00 SURGICAL INTENSIVE CARE UNIT 11.00 12.00 OTHER SPECIAL CARE (SPECIFY) 12.00 13.00 NURSERY 240 1.215 13.00 14.00 Total (see instructions) 10, 947 4,017 20, 377 0.00 728.13 14.00 CAH visits 15.00 15.00 SUBPROVIDER - IPF 811 1.077 2.876 17.19 16.00 0.00 16.00 SUBPROVIDER - IRF 17.99 17.00 1,898 106 2, 532 0.00 17.00 18.00 SUBPROVI DER 18.00 19.00 SKILLED NURSING FACILITY 0 0.00 0.00 19.00 0 20 00 NURSING FACILITY C 0 0 00 0.00 20 00 21.00 OTHER LONG TERM CARE 21.00 22.00 HOME HEALTH AGENCY 22.00 AMBULATORY SURGICAL CENTER (D. P.) 23.00 23.00 HOSPI CE 24 00 24 00 24. 10 HOSPICE (non-distinct part) 0 0 0 24.10 25.00 CMHC - CMHC 25.00 26.00 RURAL HEALTH CLINIC 26, 00 FEDERALLY QUALIFIED HEALTH CENTER 26.25 26.25 27.00 Total (sum of lines 14-26) 0.00 763.31 27.00 28.00 Observation Bed Days 509 2,602 28.00 29.00 29.00 Ambul ance Trips 0 30.00 Employee discount days (see instruction) 0 30.00 31.00 Employee discount days - IRF 31.00 Labor & delivery days (see instructions) 1, 329 32.00 32.00 262 0 Total ancillary labor & delivery room 32.01 32.01 outpatient days (see instructions)

33.00 LTCH non-covered days

| Peri od: | Worksheet S-3 | From 01/01/2014 | Part | To 12/31/2014 | Date/Time Prepared: | Part | P Heal th Financial Systems FRANCISCAN ST ANTHONY-MICHIGAN CITY
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CCN Provider CCN: 150015

				10) 12/31/2014	5/28/2015 9:5	
		Full Time		Di sch	arges	0, 20, 2010 ,10	, diii
		Equi val ents					
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Pati ents	
		11. 00	12.00	13. 00	14. 00	15. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and		C	2, 654	690	5, 399	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)			267	0		2. 00
3. 00	HMO IPF Subprovider						3. 00
4.00	HMO I RF Subprovi der						4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF						5. 00
6.00	Hospital Adults & Peds. Swing Bed NF						6. 00
7.00	Total Adults and Peds. (exclude observation						7. 00
	beds) (see instructions)						
8.00	I NTENSI VE CARE UNIT						8. 00
9.00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10. 00
11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12. 00
13. 00	NURSERY						13. 00
14. 00	Total (see instructions)	0. 00	C	2, 654	690	5, 399	
15. 00	CAH visits						15. 00
16. 00	SUBPROVIDER - IPF	0. 00	C		152	479	16. 00
17. 00	SUBPROVIDER - IRF	0. 00	C	143	6	194	17. 00
18. 00	SUBPROVI DER						18. 00
19. 00	SKILLED NURSING FACILITY	0. 00					19. 00
20. 00	NURSING FACILITY	0. 00					20. 00
21. 00	OTHER LONG TERM CARE						21. 00
22. 00	HOME HEALTH AGENCY						22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24. 00	HOSPI CE						24. 00
24. 10	HOSPICE (non-distinct part)						24. 10
25. 00	CMHC - CMHC						25. 00
26. 00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER						26. 25
27. 00	Total (sum of lines 14-26)	0. 00					27. 00
28. 00	Observation Bed Days						28. 00
29. 00	Ambul ance Tri ps						29. 00
30.00	Employee discount days (see instruction)						30.00
31. 00	Employee discount days - IRF						31. 00
32. 00	Labor & delivery days (see instructions)						32. 00
32. 01	Total ancillary labor & delivery room						32. 01
00.00	outpatient days (see instructions)						00.00
33.00	LTCH non-covered days				l		33. 00

Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 150015 | Period: From 01/0

Worksheet A Amount Reclassificati Adjusted Paid Hours Ave	5/28/2015 9: 57 verage Hourl y age (col . 4 ÷ col . 5) 6. 00 25. 68 0. 00 0. 00 0. 00	1. 00
Col. 2 ± col. Salaries in col. 4	6. 00 25. 68 0. 00 0. 00	
1.00 2.00 3.00 4.00 5.00	25. 68 0. 00 0. 00	
PART II - WAGE DATA SALARIES	25. 68 0. 00 0. 00	
1.00 Total salaries (see 200.00 40,770,835 0 40,770,835 1,587,892.00 instructions) 2.00 Non-physician anesthetist Part A 0 0 0 0 0.00 A 0.00 B 0 0 0 0.00	0. 00 0. 00	
instructions) 2.00 Non-physician anesthetist Part A 3.00 Non-physician anesthetist Part B 0 0 0 0 0.00 0 0.00	0. 00 0. 00	
3.00 A Non-physician anesthetist Part D O O O O O O O O O O O O O O O O O O	0. 00	2.00
3.00 Non-physician anesthetist Part 0 0 0 0.00		
	0. 00	3. 00
	0.00	4. 00
Admi ni strati ve		
4.01 Physicians - Part A - Teaching 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0. 00 0. 00	4. 01 5. 00
6.00 Non-physician-Part B 0 0 0 0 0.00	0. 00	6. 00
7.00 Interns & residents (in an 21.00 0 0 0.00 approved program)	0. 00	7. 00
7.01 Contracted interns and 0 0 0 0.00	0. 00	7. 01
resi dents (in an approved programs)		
8.00 Home office personnel 0 0 0 0.00	0. 00	8. 00
9.00 SNF 44.00 0 0 0 0.00 10.00 Excluded area salaries (see 3,594,751 0 3,594,751 130,718.00	0. 00 27. 50	9. 00 10. 00
instructions)	27. 30	10.00
OTHER WAGES & RELATED COSTS 11.00 Contract Labor: Direct Patient 1,295,294 0 1,295,294 28,944.00	44. 75	11. 00
Care		
12.00 Contract Labor: Top Level 0 0 0 0.00 management and other	0. 00	12. 00
management and administrative		
services	161. 43	13. 00
A - Administrative		
14.00 Home office salaries & 6,792,323 0 6,792,323 133,378.00 wage-related costs	50. 93	14. 00
15.00 Home office: Physician Part A 0 0 0 0.00 - Administrative	0. 00	15. 00
16.00 Home office and Contract 0 0 0 0	0. 00	16. 00
Physicians Part A - Teaching WAGE-RELATED COSTS		
17. 00 Wage-related costs (core) (see 9, 994, 632 0 9, 994, 632		17. 00
instructions) 18.00 Wage-related costs (other) 0 0 0		18. 00
(see instructions)		10.00
19. 00 Excl uded areas 922, 165 0 922, 165 20. 00 Non-physi ci an anestheti st Part 0 0 0		19. 00 20. 00
A		21. 00
21.00 Non-physician anesthetist Part 0 0 0		
22.00 Physician Part A - 0 0 0 0 Administrative		22. 00
22.01 Physician Part A - Teaching 0 0		22. 01
23.00 Physician Part B		23. 00 24. 00
25.00 Interns & residents (in an 0 0 0		25. 00
approved program)		
26.00 Employee Benefits Department 4.00 727,872 0 727,872 21,665.00		26. 00
27. 00 Administrative & General 5. 00 5, 791, 305 0 5, 791, 305 208, 515, 00 28. 00 Administrative & General under 134, 469 0 134, 469 386, 00		27. 00 28. 00
contract (see inst.)		
29. 00 Maintenance & Repairs 6. 00 0 0 0 0 0 0 0 0 0	0. 00 24. 86	29.00
31.00 Laundry & Linen Service 8.00 0 0 0 37,466.00	0. 00	31.00
32.00 Housekeeping 9.00 1,074,519 0 1,074,519 78,716.00 33.00 Housekeeping under contract 0 0 0 0 0 0.00		32. 00 33. 00
(see instructions)	0.00	33.00
34.00 Di etary		34. 00 35. 00
instructions)		
36. 00 Cafeteri a		36. 00 37. 00
38.00 Nursing Administration 13.00 1,535,467 0 1,535,467 41,971.00	36. 58	38. 00
39.00 Central Services and Supply 14.00 455, 113 0 455, 113 30, 486.00 40.00 Pharmacy 15.00 1, 386, 762 0 1, 386, 762 37, 095.00	1	39. 00 40. 00
10.00 1,000,702 0 1,000,702 57,073.00		

Heal th	Financial Systems	FRANC	CISCAN ST ANTH	ONY-MICHIGAN CI	TY	In Lieu of Form CMS-		
HOSPI T	AL WAGE INDEX INFORMATION			Provi der		Peri od:	Worksheet S-3	
						From 01/01/2014		
						To 12/31/2014		
							5/28/2015 9: 5	
		Worksheet A	Amount	Recl assi fi cati	Adj usted	Pai d Hours	Average Hourly	
		Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from	(col.2 ± col.	Salaries in	col . 5)	
				Worksheet A-6)	3)	col. 4		
		1. 00	2. 00	3. 00	4.00	5. 00	6. 00	
41.00	Medical Records & Medical	16. 00	658, 904	0	658, 90	4 34, 393. 00	19. 16	41.00
	Records Library							
42.00	Soci al Servi ce	17. 00	0	0		0.00	0.00	42.00
43.00	Other General Service	18. 00	0	0		0.00	0. 00	43. 00

HOSPITAL WAGE INDEX INFORMATION Worksheet S-3 Part III Date/Time Prepared: Provider CCN: 150015 Peri od: From 01/01/2014 To 12/31/2014 5/28/2015 9:57 am Worksheet A Amount Recl assi fi cati Adj usted Pai d Hours Average Hourly Line Number Reported on of Salaries Sal ari es Related to Wage (col. 4 ÷ (col.2 ± col. col. 5) (from Salaries in Works<u>heet A-6)</u> 3) col. 4 1.00 5.00 6.00 2.00 3.00 4.00 PART III - HOSPITAL WAGE INDEX SUMMARY 1.00 Net salaries (see 40, 905, 304 40, 905, 304 1, 588, 278. 00 25. 75 1.00 instructions) 2.00 Excluded area salaries (see 3, 594, 751 ol 3, 594, 751 130, 718. 00 27. 50 2.00 instructions) 3.00 Subtotal salaries (line 1 37, 310, 553 0 37, 310, 553 1, 457, 560. 00 25.60 3.00 minus line 2) 4.00 Subtotal other wages & related 8, 535, 431 0 8, 535, 431 165, 096. 00 51. 70 4.00 costs (see inst.) Subtotal wage-related costs 5.00 9, 994, 632 0 9, 994, 632 0.00 26. 79 5.00 (see inst.) Total (sum of lines 3 thru 5) 6.00 6.00 55, 840, 616 0 55, 840, 616 1, 622, 656. 00 34 41 7.00 Total overhead cost (see 14, 605, 717 14, 605, 717 628, 211. 00 23. 25 7.00 instructions)

HOSPITAL WAGE RELATED COSTS Provider CCN: 150015 Period: Worksheet	MS-2552-10
	S-3
From 01/01/2014 Part IV	

PART IV - WAGE RELATED COSTS Township PART IV - WAGE RELATED COSTS PART IV - WA			01/01/2014 12/31/2014	Date/Time Pre	
PART IV - WAGE RELATED COSTS 1.00					7 am
PART I V - WAGE RELATED COSTS					
PART IV - WAGE RELATED COSTS Part A - Core List RETIREMENT OOST					
Part A - Core List RETIREMENT COST				1. 00	
RETIREMENT COST					
1.00					
2.00 Tax Sheltered Annuity (TSA) Employer Contribution 0 2.00					
3.00 Nonqualified Defined Benefit Plan Cost (see instructions) 0.00 0.0				376, 000	
4.00				-	
PLAN ADMINISTRATIVE COSTS (Paid to External Organization) 5.00					
5.00	4. 00			781, 360	4. 00
Legal / Accounting/Management Fees-Pension Plan 0 6.00					
The color of the				0	
HEALTH AND INSURANCE COST 8. 00 Heal th Insurance (Purchased or Self Funded) 5, 991, 515 8. 00 10.				0	
Resident Health Insurance (Purchased or Self Funded) 5, 991, 515 9.00	7. 00			0	7. 00
9.00 Prescription Drug Plan					
10.00 Dental, Hearing and Vision Plan 0 10.00				5, 991, 515	
11.00 Life Insurance (If employee is owner or beneficiary) 23, 232 11.00 12.00 Accident Insurance (If employee is owner or beneficiary) 0 12.00 13.00 Disability Insurance (If employee is owner or beneficiary) 141, 304 141, 304 13.00 140 Long-Term Care Insurance (If employee is owner or beneficiary) 0 14.00 15.00 Workers' Compensation Insurance 570, 220 16.00 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. 0 16.00 Non cumulative portion 2,856,937 17.00 TAXES 17.00 18.00 Medicare Taxes - Employers Portion Only 0 18.00 19.00 Unemployment Insurance 93,382 19.00 20.00 State or Federal Unemployment Taxes 0 20.00 20.00 OTHER Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see 0 21.00 10.00 10.01 10.01 10.01 11.00 12.00 13.00 12.00 13.00 14.00 14.00 14.00 15.00 16.00 16.00 16.00 16.00 16.00 17.00 18.00 18.00 18.00 19.00	9.00			0	
12.00				0	10.00
13.00 Disability Insurance (If employee is owner or beneficiary) 14.00 Long-Term Care Insurance (If employee is owner or beneficiary) 15.00 'Workers' Compensation Insurance 16.00 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion) TAXES 17.00 FICA-Employers Portion Only 18.00 Medicare Taxes - Employers Portion Only 19.00 Unemployment Insurance 20.00 State or Federal Unemployment Taxes 21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22.00 Day Care Cost and Allowances 23.00 Tuit ion Reimbursement 24.00 Total Wage Related cost (Sum of Lines 1 -23) Part B - Other than Core Related Cost	11. 00	Life Insurance (If employee is owner or beneficiary)		23, 232	11. 00
14. 00 Long-Term Care Insurance (If employee is owner or beneficiary) 15. 00 'Workers' Compensation Insurance Retirement Heal th Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumul ative portion) TAXES 17. 00 FI CA-Employers Portion Only Medicare Taxes - Employers Portion Only Unemployment Insurance State or Federal Unemployment Taxes OTHER 21. 00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22. 00 Day Care Cost and Allowances Tuition Reimbursement 24. 00 Part B - Other than Core Related Cost	12.00			0	12. 00
15.00 'Workers' Compensation Insurance				141, 304	
16.00 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion) TAXES 17.00 FI CA-Empl oyers Portion Only Medicare Taxes - Employers Portion Only Unemployment Insurance 20.00 State or Federal Unemployment Taxes ODITHER 21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22.00 Day Care Cost and Allowances Tuition Reimbursement 24.00 Total Wage Related cost (Sum of Lines 1 -23) Part B - Other than Core Related Cost				0	14. 00
Non cumulative portion TAXES	15. 00			570, 220	15. 00
TAXES 17. 00 FI CA-Employers Portion Only 2,856,937 17. 00 18. 00 Medicare Taxes - Employers Portion Only 0 18. 00 19. 00 Unemployment Insurance 93,382 19. 00 20. 00 OTHER 21. 00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see 0 21. 00 instructions)) 22. 00 Day Care Cost and Allowances 0 22. 00 23. 00 Tuition Reimbursement 24. 00 Total Wage Related cost (Sum of Lines 1 -23) 10,916,797 24. 00 Part B - Other than Core Related Cost 24. 00 Part B - Other than Core Related Cost 24. 00 Part B - Other than Core Related Cost 24. 00 Part B - Other than Core Related Cost 24. 00 Part B - Other than Core Related Cost 25. 00 26.	16. 00		ASB 106.	0	16. 00
17. 00 Fi CA-Employers Portion Only 2,856,937 17. 00 18. 00 18. 00 19.					
18.00 Medicare Taxes - Employers Portion Only 0 18.00 19.00 Unemployment Insurance 93, 382 19.00 20.00 State or Federal Unemployment Taxes 0 20.00 OTHER 21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 0 21.00 22.00 Day Care Cost and Allowances 0 22.00 23.00 Tuition Reimbursement 82,847 23.00 24.00 Total Wage Related cost (Sum of Lines 1 -23) 10,916,797 24.00 Part B - Other than Core Related Cost		1.0.1=4			
19. 00 Unempl oyment Insurance 93, 382 19. 00 20. 00 State or Federal Unempl oyment Taxes 0 20. 00 OTHER 21. 00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 0 21. 00 22. 00 Day Care Cost and Allowances 0 22. 00 23. 00 Tuit ion Reimbursement 82, 847 23. 00 24. 00 Total Wage Related cost (Sum of Lines 1 -23) 10, 916, 797 24. 00 Part B - Other than Core Related Cost				2, 856, 937	
20.00 State or Federal Unemployment Taxes 0 DTHER 21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22.00 Day Care Cost and Allowances 0 Day Care Cost and Milowances 0 Dittion Reimbursement 0 Security 10 Day Care Cost and Milowances 0 Da				-	
OTHER 21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22.00 Day Care Cost and Allowances 23.00 Tuition Reimbursement 24.00 Total Wage Related cost (Sum of Lines 1 -23) Part B - Other than Core Related Cost				93, 382	
21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22.00 Day Care Cost and Allowances Tuition Reimbursement 24.00 Total Wage Related cost (Sum of Lines 1 -23) Part B - Other than Core Related Cost	20. 00			0	20. 00
instructions) 22.00 Day Care Cost and Allowances 0 22.00 23.00 Tuition Reimbursement 82,847 23.00 24.00 24.00 24.00 Part B - Other than Core Related Cost 23.00 24.00 24.00 24.00 24.00 25.00		•			
22. 00 Day Care Cost and Allowances 0 22. 00 23. 00 Tuition Reimbursement 82, 847 23. 00 24. 00 Total Wage Related cost (Sum of lines 1 -23) 10, 916, 797 24. 00 Part B - Other than Core Related Cost 24. 00 24. 00	21. 00		bove. (see	0	21. 00
23.00 Tuition Reimbursement 24.00 Total Wage Related cost (Sum of lines 1 -23) Part B - Other than Core Related Cost 82, 847 23.00 10, 916, 797 24.00					
24.00 Total Wage Related cost (Sum of lines 1 -23) Part B - Other than Core Related Cost 10,916,797					
Part B - Other than Core Related Cost				· ·	
	24. 00			10, 916, 797	24. 00
25.00 OTHER WAGE RELATED COSTS (SPECIFY) 0 25.00					
	25. 00	OTHER WAGE RELATED COSTS (SPECIFY)		0	25. 00

Health Financial Systems	FRANCISCAN ST ANTHONY-MICHIGAN CITY	In Lie	u of Form CMS-2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provi der CCN:	150015 Peri od: From 01/01/2014 To 12/31/2014	Worksheet S-3 Part V Date/Time Prepared: 5/28/2015 9:57 am

			0 12/31/2014	Date/IIMe Pre 5/28/2015 9:5	
	Cost Center Description		Contract Labor	Benefit Cost	7 GIII
	'		1. 00	2. 00	
	PART V - Contract Labor and Benefit Cost				
	Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost		0	0	1. 00
2.00	Hospi tal		0	0	2. 00
3.00	Subprovi der – I PF		0	0	3. 00
4.00	Subprovi der – I RF		0	0	4. 00
5.00	Subprovider - (Other)		0	0	5. 00
6.00	Swing Beds - SNF		0	0	6. 00
7.00	Swing Beds - NF		0	0	7. 00
8.00	Hospi tal -Based SNF		0	0	8. 00
9.00	Hospi tal -Based NF		0	0	9. 00
10.00	Hospi tal -Based OLTC				10.00
11. 00	Hospi tal -Based HHA				11.00
12.00	Separately Certified ASC				12.00
13.00	Hospi tal -Based Hospi ce				13.00
14.00	Hospital-Based Health Clinic RHC				14.00
15.00	Hospital-Based Health Clinic FQHC				15.00
16.00	Hospi tal -Based-CMHC				16.00
17.00	Renal Dialysis				17.00
18. 00	Other		o	0	18. 00

	Financial Systems FRANCISCAN ST ANTHONY-MIC				u of Form CMS-2	
HOSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA	rovi der	CCN: 150015	Peri od: From 01/01/2014	Worksheet S-10	0
				To 12/31/2014	Date/Time Prep 5/28/2015 9:5	
	Uncomposited and indigent case cost computation				1. 00	
1.00	Uncompensated and indigent care cost computation Cost to charge ratio (Worksheet C, Part I line 202 column 3 divident	od by Lir	202 colum	, 0)	0. 242505	1. 00
1.00	Medicaid (see instructions for each line)	eu by iii	ie 202 Coi uiiii	1 0)	0. 242303	1.00
2.00	Net revenue from Medicaid				8, 135, 052	2. 00
3.00	Did you receive DSH or supplemental payments from Medicaid?				N	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental page 1	ayments 1	rom Medicai	d?	N	4. 00
5.00	If line 4 is "no", then enter DSH or supplemental payments from M				0	5. 00
6.00	Medi cai d charges				74, 810, 252	6. 00
7.00	Medicaid cost (line 1 times line 6)				18, 141, 860	7. 00
8.00	Difference between net revenue and costs for Medicaid program (li	ne 7 minu	us sum of lin	nes 2 and 5; if	10, 006, 808	8. 00
	<pre>< zero then enter zero) State Children's Health Insurance Program (SCHIP) (see instruction</pre>	ns for ea	nch Line)			
9. 00	Net revenue from stand-alone SCHIP	10 101 00			0	9. 00
10.00	Stand-alone SCHIP charges				0	
11. 00	Stand-alone SCHIP cost (line 1 times line 10)				0	11. 00
12.00	Difference between net revenue and costs for stand-alone SCHIP (I	ine 11 mi	nus line 9;	if < zero then	0	12.00
	enter zero)					
	Other state or local government indigent care program (see instru					
13.00	Net revenue from state or local indigent care program (Not include			,	-	13.00
14. 00	Charges for patients covered under state or local indigent care p	rogram (ľ	Not included	in lines 6 or	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 indig	ent care	program (Li	ne 15 minus line	Ö	
	13; if < zero then enter zero)	0	program (iii		Ü	10.00
	Uncompensated care (see instructions for each line)					
17. 00	Private grants, donations, or endowment income restricted to fund				0	
18. 00					0	
19. 00	Total unreimbursed cost for Medicaid , SCHIP and state and local 8, 12 and 16)	i ndi gent	care program	ns (sum of lines	10, 006, 808	19. 00
	10, 12 and 10)		Uni nsured	Insured	Total (col. 1	
			pati ents	pati ents	+ col . 2)	
			1. 00	2. 00	3. 00	
20. 00	Total initial obligation of patients approved for charity care (a		22, 284, 8	8, 505, 100	30, 789, 900	20. 00
21. 00	charges excluding non-reimbursable cost centers) for the entire for		E 404 1	75 2 042 520	7 4/4 704	21 00
21.00	Cost of initial obligation of patients approved for charity care times line 20)	(Tine I	5, 404, 1	75 2, 062, 529	7, 466, 704	21.00
22. 00	Partial payment by patients approved for charity care		490, 30	791, 000	1, 281, 300	22. 00
23. 00	Cost of charity care (line 21 minus line 22)		4, 913, 8		6, 185, 404	
20.00	poset of sharrey sars (fring 21 minutes fring 22)		., ,	1/2/1/02/	0/ 100/ 101	20.00
					1. 00	
24. 00	Does the amount in line 20 column 2 include charges for patient d		nd a Length o	of stay limit		24. 00
05 05	imposed on patients covered by Medicaid or other indigent care pr				_	05.00
25. 00	If line 24 is "yes," charges for patient days beyond an indigent		ogram's Leng	in of stay limit	0	
26. 00	Total bad debt expense for the entire hospital complex (see instru				6, 668, 435	
27. 00			alino 27)		627, 205	
28. 00 29. 00	Non-Medicare and non-reimbursable Medicare bad debt expense (line Cost of non-Medicare and non-reimbursable Medicare bad debt expens			28)	6, 041, 230 1, 465, 028	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	SC (11116	i times iine	20)	7, 650, 432	
	Total unreimbursed and uncompensated care cost (line 19 plus line	30)			17, 650, 432 17, 657, 240	
51.00	1.52a. a or mode occ and another sated care cost (True 17 prus True	50)			17,007,240	. 51.00

Health Financial Systems FRAN	CISCAN ST ANTHO	NY-MI CHI GAN CI	TY	In Lie	eu of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der		Peri od:	Worksheet A	
				From 01/01/2014 Fo 12/31/2014	Date/Time Pre 5/28/2015 9:5	
Cost Center Description	Sal ari es	0ther	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. 17 07967 ENT	0	0	(0	0	194. 17
194. 18 07968 SLEEP CLINIC	0	0		0	0	194. 18
194. 19 07969 HEALTH PARTNERS	o	1, 099	1, 09	9 0	1, 099	194. 19
194. 20 07970 CENTER OF HOPE	14, 589	1, 405	15, 99	4 0	15, 994	194. 20
200.00 TOTAL (SUM OF LINES 118-199)	40, 770, 835	108, 513, 910	149, 284, 74	5 0	149, 284, 745	200. 00

Heal th	Financial Systems FRAN	ICISCAN ST ANTH	ONY-MICHIGAN CI	TY	In Lie	eu of Form CMS-2552-10
	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE C			CCN: 150015	Peri od:	Worksheet A
					From 01/01/2014 To 12/31/2014	
						5/28/2015 9:57 am
	Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation			
		6. 00	7.00			
	GENERAL SERVICE COST CENTERS					
1.00	00100 CAP REL COSTS-BLDG & FLXT	-2, 508, 838				1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	1 00/ 133	-,,	1		2.00
4. 00 5. 00	OO4OO	1, 896, 132 -12, 646, 574		1		4. 00 5. 00
7. 00	00700 OPERATION OF PLANT	-74, 776		1		7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	71,770	1	1		8. 00
9.00	00900 HOUSEKEEPI NG	0	1	1		9. 00
10.00	01000 DI ETARY	-64, 220	479, 611			10. 00
	01100 CAFETERI A	-592, 336	1	1		11.00
	01300 NURSI NG ADMI NI STRATI ON	-9, 658	1	1		13.00
14. 00 15. 00	01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY	-135, 098 -175, 106		1		14. 00 15. 00
	01600 MEDICAL RECORDS & LIBRARY	-175, 100				16. 00
10.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0,,	,,,,,,,			10.00
30.00	03000 ADULTS & PEDIATRICS	-753	6, 141, 861			30.00
	03100 INTENSIVE CARE UNIT	-4, 732	1, 696, 657			31.00
	04000 SUBPROVI DER - I PF	0		1		40. 00
	04100 SUBPROVI DER - I RF	0	000,0.2			41.00
	04300 NURSERY 04400 SKILLED NURSING FACILITY		420, 827 0	1		43. 00 44. 00
	04500 NURSING FACILITY		1			45. 00
10.00	ANCI LLARY SERVI CE COST CENTERS			1		75.00
50.00	05000 OPERATI NG ROOM	-531, 845	5, 431, 527			50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	754, 596			52.00
	05300 ANESTHESI OLOGY	-2, 260	1	1		53.00
	05400 RADI OLOGY-DI AGNOSTI C	-55, 258	1	1		54.00
	05401 FSED RADI OLOGY - DI AGNOSTI C	07.100	007,02.	1		54. 01
	05500 RADI OLOGY-THERAPEUTI C 05501 WOODLAND CANCER CARE CENTER	-27, 186		1		55. 00 55. 01
	05700 CT SCAN	-21, 839	1	1		57. 00
	05800 MRI					58.00
	05900 CARDI AC CATHETERI ZATI ON	-36, 526	1			59. 00
	06000 LABORATORY	-40, 375		1		60.00
60. 01	06001 FSED LABORATORY	0	1, 096, 148	1		60. 01
65.00	06500 RESPI RATORY THERAPY	-5, 827	908, 678			65. 00
66. 00	06600 PHYSI CAL THERAPY	259		1		66. 00
69. 00	06900 ELECTROCARDI OLOGY	0	853, 150	1		69.00
	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	-102, 237	1 ' '	1		71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0		1		72. 00 73. 00
	03950 CV RESOURCE CENTER			1		76. 00
70.00	OUTPATIENT SERVICE COST CENTERS		0,020	1		70.00
90.00	09000 CLI NI C	0	0)		90.00
	09001 OB CLINIC	0	0			90. 01
	09002 PAIN MANAGEMENT	0	0	1		90. 02
	09003 I NFUSI ON OP SERVI CES	0	440, 996	1		90. 03
	09004 MATERNAL HEA	0	0 005 440	1		90.04
	09100 EMERGENCY 09101 FREE STANDING EMERGENCY DEPT	-532, 071	2, 985, 410 1, 490, 766	1		91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	-532,071	1,470,700			92.00
, 50	SPECIAL PURPOSE COST CENTERS	<u> </u>		1		/2.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	-15, 671, 823	123, 452, 786			118. 00
	NONREI MBURSABLE COST CENTERS					
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	1		190. 00
	07950 RETAIL PHARMACY	0	1			194. 00
	07951 WORKING WELL	0	3, 024, 505			194. 01
	07952 APS DUNELAND SURG ASSOC) 0			194. 02
	07953 MED WATCH 07954 OCCUPATIONAL MED CENTER		0			194. 03 194. 04
	07955 PHYSI CI AN PRACTI CE					194. 05
	07956 DENTAL SERVICES					194. 06
	07957 DUNELAND MED WATCH	0	ol o	,		194. 07
	07958 WESTVI LLE CLNI C		o o			194. 08
	07959 ORTHOPEDI CS	0	0			194. 09
	07960 WOMEN SERVICES	0	0			194. 10
	07961 DUNELAND FI TNESS CENTER	0	-1, 902	1		194. 11
	07962 CARDI OLOGY ASSOC	0	0	1		194. 12
	07963 DUNELAND FAMILY PRACTICE		0	1		194. 13
	07964 ORTHOPEDI CS 07965 OTHER NONREI MBURSABLE COST CENTERS					194. 14 194. 15
	07966 PHYSICIAN PRACTICE MD WISE		7, 120, 440			194. 15
	07960 PHISICIAN PRACTICE MD WISE		, , , , , , , , , , , , , , , , , , ,			194. 17
	07968 SLEEP CLINIC			ı		194. 18
194. 18	U/968 SLEEP CLI NI C	0	0	1		194.

Health Financial Systems	FRANCISCAN ST ANTHONY	Y-MICHIGAN CITY	In Lieu of Form CMS-2552-1		
RECLASSIFICATION AND ADJUSTMENTS OF	TRIAL BALANCE OF EXPENSES	Provi der CCN: 150015	Peri od: From 01/01/2014	Worksheet A	
			To 12/31/2014	Date/Time Prepared:	

			5/28/2015 9:5	/ alli
Cost Center Description	Adjustments	Net Expenses		
	(See A-8)	For Allocation		
	6. 00	7. 00		
194. 19 07969 HEALTH PARTNERS	0	1, 099		194. 19
194. 20 07970 CENTER OF HOPE	0	15, 994		194. 20
200.00 TOTAL (SUM OF LINES 118-199)	-15, 671, 823	133, 612, 922		200. 00

FRANCISCAN ST ANTHONY-MI CHI GAN CI TY
Provi der CCN: 150015 Health Financial Systems RECLASSIFICATIONS In Lieu of Form CMS-2552-10 Peri od: From 01/01/2014 To 12/31/2014 Worksheet A-6 Date/Time Prepared: 5/28/2015 9:57 am

	Cost Center 2.00	Increases Line #	6.1	0.11		
		line#				
	2 00		Sal ary	0ther		
		3. 00	4. 00	5. 00		
	A - CAPITAL	0.00		70.		4
1.00	CAP REL COSTS-MVBLE EQUIP		•	6, 499, 786		1. 00
	U CAFETEDIA		0	6, 499, 786		
	B - CAFETERIA	11 00	728, 158	E14 004		1 00
1. 00	CAFETERI A			<u>514, 0</u> 96 514, 096		1. 00
	C - WORKER'S COMPENSATION		720, 130	314, 090		
	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	6, 475		1.00
1.00	O DENCITED DELAKTIMENT		#	6, 475		1.00
-	D - MEDICAL SUPPLIES		<u> </u>	0, 473		
	MEDICAL SUPPLIES CHARGED TO	71. 00	ol	10, 550, 652		1.00
	PATI ENT	71.00	٩	10, 550, 652		1.00
2.00	7,111 E111	0.00	o	0		2. 00
3.00		0.00	ő	0		3. 00
4.00		0.00	o	0		4. 00
5.00		0.00	o	0		5. 00
6.00		0.00	o	0		6. 00
7. 00		0.00	ol	O		7. 00
8.00		0.00	o	0		8. 00
9.00		0.00	o	Ö		9. 00
10.00		0.00	ol	0		10.00
11. 00		0.00	ol	Ö		11. 00
12.00		0.00	ol	O		12. 00
13.00		0.00	o	0		13. 00
14. 00		0.00	ol	Ö		14. 00
15. 00		0.00	ol	O		15. 00
16. 00		0.00	o	Ö		16. 00
17. 00		0.00	o	0		17. 00
18. 00		0.00	ol	O		18. 00
19.00		0.00	o	0		19. 00
20. 00		0.00	o	O		20.00
21. 00		0.00	ol	O		21. 00
22. 00		0.00	o	O		22. 00
23. 00		0.00	ol	O		23. 00
24. 00		0.00	o	0		24. 00
25. 00		0.00	o	0		25. 00
26. 00		0.00	o	0		26. 00
27. 00		0.00	o	0		27. 00
28. 00		0.00	o	0		28. 00
	0			10, 550, 652		
İ	E - MEDICAL SUPPLIES - PACEMAK	ERS	<u>'</u>			
	IMPL. DEV. CHARGED TO	72.00	0	626, 693		1.00
	PATI ENTS					
2.00		0.00	0	0		2. 00
	0		0	626, 693		
	F - NURSERY AND LABOR/DELIVERY					
1.00	NURSERY	43.00	349, 594	71, 233		1. 00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	626, 866	127, 730		2. 00
	0		976, 460	198, 963		
	G - DEPRECIATION					
1.00	CAP REL COSTS-BLDG & FLXT	1.00	0_	457, 128		1. 00
	0		0	457, 128		
	H - INTEREST					
	CAP REL COSTS-BLDG & FIXT	1. 00	O	4, 579, 596		1. 00
2.00	<u> </u>	000	0	0		2. 00
Ī	0			4, 579, 596		
Ī	I - IMPLANTABLE DEVICES					
	IMPL. DEV. CHARGED TO	72. 00	0	5, 773, 857	·	1. 00
ļ	PATI ENTS					
	0		0	5, 773, 857		
500. 00	Grand Total: Increases		1, 704, 618	29, 207, 246		500.00

FRANCISCAN ST ANTHONY-MI CHI GAN CI TY
Provi der CCN: 150015 Health Financial Systems RECLASSIFICATIONS In Lieu of Form CMS-2552-10 Peri od: From 01/01/2014 To 12/31/2014 Worksheet A-6 Date/Time Prepared: 5/28/2015 9:57 am

						0 12/31/2014	5/28/2015 9:57 am
		Decreases					
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10. 00		
	A - CAPITAL						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	•	<u>6, 499, 7</u> 86			1.00
	0		0	6, 499, 786	5		
	B - CAFETERIA				1		
1. 00	DI ETARY	1000	72 <u>8, 1</u> 58	51 <u>4, 0</u> 96			1.00
	0		728, 158	514, 096	<u> </u>		
	C - WORKER' S COMPENSATION			, ,-,-	-1 -1		1.00
1. 00	ADMI NI STRATI VE & GENERAL			6, 475			1.00
	0 LIBBLIES		0	6, 475			
4 00	D - MEDICAL SUPPLIES	4 00		1 1/0			1.00
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1, 169			1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	28, 990			2.00
3.00	OPERATION OF PLANT	7. 00	0	749	1		3.00
4.00	HOUSEKEEPI NG	9.00	0	7, 764	1		4.00
5.00	DI ETARY	10.00	0	4, 212			5. 00
6. 00 7. 00	NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY	13. 00 14. 00	0	13 <i>6</i> 375, 015			6. 00 7. 00
8. 00	PHARMACY	15. 00	0	45, 169			8. 00
9. 00	ADULTS & PEDIATRICS	30. 00	0	453, 491			9. 00
10. 00	INTENSIVE CARE UNIT	31. 00	0	112, 426			10.00
11. 00	SUBPROVI DER - I PF	40. 00	0	6, 810			11.00
12. 00	SUBPROVIDER - I RF	41. 00	0	25, 213	1		12. 00
13. 00	OPERATING ROOM	50.00	0	7, 405, 471	1		13. 00
14. 00	ANESTHESI OLOGY	53. 00	0	1, 688			14. 00
15. 00	RADI OLOGY-DI AGNOSTI C	54.00	0	213, 166	1		15. 00
16. 00	FSED RADIOLOGY - DIAGNOSTIC	54. 01	0	30, 509			16. 00
17. 00	RADI OLOGY-THERAPEUTI C	55. 00	0	12, 047			17. 00
18. 00	WOODLAND CANCER CARE CENTER	55. 01	0	36, 576	1		18. 00
19. 00	CARDI AC CATHETERI ZATI ON	59. 00	0	1, 352, 200			19. 00
20. 00	LABORATORY	60.00	0	12, 522			20. 00
21. 00	FSED LABORATORY	60. 01	0	466			21. 00
22. 00	RESPIRATORY THERAPY	65. 00	0	71, 114	1		22. 00
23. 00	PHYSI CAL THERAPY	66.00	0	33, 497			23. 00
24. 00	ELECTROCARDI OLOGY	69.00	0	25, 514			24.00
25. 00	OB CLINIC	90. 01	0	882			25. 00
26. 00	INFUSION OP SERVICES	90. 03	o	13, 960	1		26. 00
27. 00	EMERGENCY	91.00	0	231, 722			27. 00
28. 00	FREE STANDING EMERGENCY DEPT	91. 01	o	48, 174			28. 00
20.00	0			10, 550, 652			25.55
	E - MEDICAL SUPPLIES - PACEMA	KFRS	<u> </u>	1070007002	-		
1.00	CENTRAL SERVICES & SUPPLY	14. 00	0	4, 612	2 0		1. 00
2.00	CARDIAC CATHETERIZATION	59.00	o	622, 081			2. 00
				626, 693			
	F - NURSERY AND LABOR/DELIVER	Υ			<u>'</u>		
1.00	ADULTS & PEDIATRICS	30.00	349, 594	71, 233	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	626, 866	127, 730	ol ol		2. 00
			976, 460	198, 963	3 1		
	G - DEPRECIATION	<u>'</u>			<u>'</u>		
1.00	OPERATING ROOM	50.00	0	457, 128	9		1.00
			0	457, 128	3 - 7		
	H - INTEREST						
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	4, 547, 210	11		1.00
2.00	OPERATING ROOM	5000	o	3 <u>2, 3</u> 86	511		2. 00
	0			4, 579, 596			
	I - IMPLANTABLE DEVICES						
1.00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	5, 773, 857	7 0		1. 00
	PATI ENT				L]		
	0		Ō	5, 773, 857	7		
500.00	Grand Total: Decreases		1, 704, 618	29, 207, 246			500. 00

10.00 Total (line 8 minus line 9)

10.00

RECONCILIATION OF CAPITAL COSTS CENTERS Provider CCN: 150015 Peri od: Worksheet A-7 From 01/01/2014 Part I Date/Time Prepared: 12/31/2014 5/28/2015 9:57 am Acqui si ti ons Begi nni ng Purchases Total Di sposal s and Donati on Bal ances Retirements 2.00 3.00 4. 00 5. 00 1 00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 6, 650, 028 0 1.00 3, 977, 433 0 35, 350 2.00 Land Improvements 35, 350 0 2.00 0 3. 00 3.00 Buildings and Fixtures 92, 240, 747 184, 753 184, 753 0 Building Improvements 0 4.00 0 0 4.00 5.00 Fixed Equipment 0 0 0 5.00 0 6.00 Movable Equipment 106, 433, 570 0 0 948, 182 6.00 0 7.00 HIT designated Assets 0 7.00 0 8.00 Subtotal (sum of lines 1-7) 209, 301, 778 220, 103 220, 103 948, 182 8.00 9.00 Reconciling Items 0 9.00 Total (line 8 minus line 9) <u>209, 301, 77</u>8 948, 182 220, 103 220, 103 10.00 0 10.00 Endi ng Bal ance Fully Depreci ated Assets 6.00 7.00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 Land 6, 650, 028 0 1.00 2.00 Land Improvements 4, 012, 783 0 2.00 3.00 Buildings and Fixtures 92, 425, 500 0 3.00 0 4.00 Building Improvements 4.00 5.00 Fi xed Equipment 0 0 5.00 Movable Equipment 0 6.00 105, 485, 388 6.00 7.00 HIT designated Assets 0 7.00 Subtotal (sum of lines 1-7) 8.00 208, 573, 699 0 8.00 9.00 Reconciling Items 9.00

208, 573, 699

0

Health Financ	ial Systems FRAI	NCISCAN ST ANTHO	ONY-MICHIGAN C	ΙΤΥ	In Lie	u of Form CMS-:	2552-10
RECONCI LI ATI O	ON OF CAPITAL COSTS CENTERS		Provi der		Period: From 01/01/2014	Worksheet A-7 Part II	
					To 12/31/2014	Date/Time Pre	pared:
						5/28/2015 9:5	7 am
SUMMARY OF CAPITAL							
(Cost Center Description	Depreciation	Lease	Interest	Insurance (see		
					instructions)	instructions)	
		9. 00	10.00	11.00	12. 00	13. 00	
PART I				and 2			
	L COSTS-BLDG & FLXT	9, 848, 733	(426, 50	668, 676		1. 00
2.00 CAP RE	L COSTS-MVBLE EQUIP	0	() (0	0	2. 00
3. 00 Total	(sum of lines 1-2)	9, 848, 733	(426, 50	4 668, 676	0	3. 00
		SUMMARY 0	F CAPITAL				
(Cost Center Description	0ther	Total (1) (sun	n			
		Capi tal -Rel ate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14.00	15.00				
PART I	I - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUM	N 2, LINES 1 a	and 2			
1.00 CAP RE	L COSTS-BLDG & FLXT	800, 386	11, 744, 299	9			1.00
2.00 CAP RE	L COSTS-MVBLE EQUIP	0	(2. 00
3.00 Total	(sum of lines 1-2)	800, 386	11, 744, 299	9			3. 00

Health Financial Systems FRAN	CISCAN ST ANTH	ONY-MICHIGAN CI	TY	In Lie	eu of Form CMS-:	2552-10	
RECONCILIATION OF CAPITAL COSTS CENTERS			<u> </u>	Period: From 01/01/2014 Fo 12/31/2014	Date/Time Pre 5/28/2015 9:5		
	COM	PUTATION OF RAT	TIOS	ALLOCATION OF	OTHER CAPITAL		
Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance		
	1. 00	2.00	3.00	4. 00	5. 00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00 CAP REL COSTS-BLDG & FLXT 2.00 CAP REL COSTS-MVBLE EQUIP	0	0		1.000000	•	1.00	
2.00 CAP REL COSTS-MVBLE EQUIP 3.00 Total (sum of lines 1-2)	0			0. 000000 1. 000000		2. 00 3. 00	
3.00 Total (Suiii of Titles 1-2)	ALLOCATION OF OTHER CAPITAL				DF CAPITAL	3.00	
	ALLOCA	TION OF OTHER C	DALLIAL	SOWWART	O CALLIAL		
Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease		
		Capi tal -Relate					
		d Costs	through 7)				
	6. 00	7.00	8. 00	9. 00	10. 00		
PART III - RECONCILIATION OF CAPITAL COSTS CI				F FF0 70F		4 00	
1.00 CAP REL COSTS-BLDG & FIXT 2.00 CAP REL COSTS-MVBLE EQUIP	0	_		5, 553, 735		1.00	
2.00 CAP REL COSTS-MVBLE EQUIP 3.00 Total (sum of lines 1-2)	0	_		6, 499, 786 12, 053, 521	0	2. 00 3. 00	
3.00 Total (Sulli of Times 1-2)	0	1 0	JMMARY OF CAPI		0	3.00	
		30	DIWINART OF CAFT	IAL			
Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum		
		instructions)	instructions)				
				d Costs (see	through 14)		
				instructions)			
DADT III DECONCILIATION OF CADITAL COSTS OF	11. 00	12.00	13. 00	14. 00	15. 00		

1, 549, 988

1, 549, 988

PART III - RECONCILIATION OF CAPITAL COSTS CENTERS
CAP REL COSTS-BLDG & FIXT 1

668, 676

668, 676

0 0 0

7, 772, 399 6, 499, 786 14, 272, 185

1.00

2. 00

0 0 0

1.00

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

In Lieu of Form CMS-2552-10 Health Financial Systems FRANCISCAN ST ANTHONY-MICHIGAN CITY Provi der CCN: 150015 ADJUSTMENTS TO EXPENSES Peri od: Worksheet A-8 From 01/01/2014 12/31/2014 Date/Time Prepared: 5/28/2015 9:57 am Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted Cost Center Description Basis/Code (2) Amount Cost Center Line # Wkst. A-7 Ref. 1.00 2.00 3.00 4.00 5.00 1.00 Investment income - CAP REL OCAP REL COSTS-BLDG & FIXT 1.00 COSTS-BLDG & FIXT (chapter 2) 2.00 Investment income - CAP REL OCAP REL COSTS-MVBLE EQUIP 2.00 COSTS-MVBLE EQUIP (chapter 2) 3.00 Investment income - other В -2,388 CAP REL COSTS-BLDG & FIXT 1.00 11 (chapter 2) Trade, quantity, and time 4 00 0 00 O discounts (chapter 8) 5.00 Refunds and rebates of В -8. 259 ADMINISTRATIVE & GENERAL 5.00 expenses (chapter 8) Rental of provider space by 6.00 0.00 suppliers (chapter 8) Tel ephone servi ces (pay 7.00 0.00 stations excluded) (chapter 8.00 Tel evi si on and radio servi ce 0.00 (chapter 21) Parking lot (chapter 21) 9.00 0.00 Provider-based physician -2, 399, 732 10.00 A-8-2 adj ustment 11.00 Sale of scrap, waste, etc. 0.00

Provi der CCN: 150015 ADJUSTMENTS TO EXPENSES Peri od: Worksheet A-8 From 01/01/2014 12/31/2014 Date/Time Prepared: 5/28/2015 9:57 am Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted Cost Center Description Basis/Code (2) Cost Center Line # Wkst. A-7 Ref. Amount 1.00 2.00 3.00 4.00 5.00 35. 00 STAFF EDUCATION COSTS -550 ADMINISTRATIVE & GENERAL 35. 00 В 5.00 OB PROGRAM FFFS -591 ADULTS & PEDIATRICS 36.00 В 30.00 0 36.00 37.00 DONATIONS EXPENSE -16, 145 ADMINI STRATI VE & GENERAL 5.00 37.00 Α 38.00 ADVERTISING EXPENSE -855, 064 ADMI NI STRATI VE & GENERAL 5.00 38.00 Α RENTAL INCOME -225, 762 ADMI NI STRATI VE & GENERAL 39 00 В 5 00 ol 39 00 -144, 377 ADMI NI STRATI VE & GENERAL A&G MISC REVENUE 40.00 В 5.00 40.00 41.00 LOBBYI NG Α -1,827 ADMINISTRATIVE & GENERAL 5.00 41.00 42.00 INTEREST INCOME В -30, 961 ADMINISTRATIVE & GENERAL 5.00 ol 42.00 -71, 847 OPERATION OF PLANT WOODLAND SURGERY BUILDING 43.00 В 7.00 43.00 RENTAL INC 44.00 GOODWI LL -800,386CAP REL COSTS-BLDG & FIXT 1.00 14 44.00 Α 45.00 OUTSIDE HOME HEALTH SUPPLIES Α -3, 390 ADMI NI STRATI VE & GENERAL 5.00 45.00 -387 FREE STANDING EMERGENCY DEPT 46, 00 FR MISC. INCOME 91.01 0 В 46.00 DI SCOUNTS/REBATES -64, 220 DI ETARY 47.00 В 10.00 0 47 00 DI SCOUNTS/REBATES -175, 986 PHARMACY 48.00 48.00 В 15.00 HAF PROVIDER TAX -9, 898, 544 ADMI NI STRATI VE & GENERAL 49.00 5.00 49.00 Α 1,896,132 EMPLOYEE BENEFITS DEPARTMENT 49.01 PENSI ON Α 4.00 49.01 MEDICAL RECORDS -8, 689 ADMINISTRATIVE & GENERAL 49.02 В 5.00 49.02 49.03 DI SCOUNTS EARNED/REBATES В -2, 929 OPERATION OF PLANT 7.00 10 49.03 DI SCOUNTS EARNED/REBATES -48, 299 OPERATING ROOM 49.04 50.00 49.04 В 49.05 DI SCOUNTS EARNED/REBATES -165, 547 OPERATING ROOM 50.00 ol 49.05 В 49.06 DI SCOUNTS EARNED/REBATES В -53, 135 RADI OLOGY-DI AGNOSTI C 54.00 49.06 -19, 922 WOODLAND CANCER CARE CENTER 49.07 RENTAL INCOME В 55.01 49.07 -5, 897 LABORATORY 49 08 DI SCOUNTS EARNED/REBATES 60.00 0 49.08 В -1, 724 RESPIRATORY THERAPY 49.09 DI SCOUNTS EARNED/REBATES В 65.00 49.09 MI SCELLANEOUS - OTHER 259 PHYSI CAL THERAPY 49. 10 49.10 В 66.00 OPERATI NG 49. 11 DI SCOUNTS EARNED/REBATES В -62, 625 MEDI CAL SUPPLI ES CHARGED TO 71.00 49. 11 PATI ENT -39, 612 MEDI CAL SUPPLI ES CHARGED TO DI SCOUNTS EARNED/REBATES 49.12 В 71.00 49.12 PATI ENT 49. 13 MI SCELLANEOUS - OTHER В -2, 500 PHARMACY 15.00 49. 13 OPERATI NG MI SCELLANEOUS - OTHER -162 ADULTS & PEDIATRICS 30.00 49. 14 49.14 В

-15, 671, 823

TOTAL (sum of lines 1 thru 49)

(Transfer to Worksheet A, column 6, line 200.)

OPERATI NG

50.00

⁽¹⁾ Description - all chapter references in this column pertain to CMS Pub. 15-1.

⁽²⁾ Basis for adjustment (see instructions)

A. Costs - if cost, including applicable overhead, can be determined.

B. Amount Received - if cost cannot be determined.

⁽³⁾ Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

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

					5/28/2015 9:5	7 am			
	Li ne No.	Cost Center	Expense Items	Amount of	Amount				
			·	Allowable Cost	Included in				
					Wks. A, column				
					5				
	1. 00	2. 00	3. 00	4. 00	5. 00				
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED								
	HOME OFFICE COSTS:								
1.00	1.00	CAP REL COSTS-BLDG & FIXT	I NTEREST	1, 093, 486	4, 547, 210	1.00			
2.00	1.00	CAP REL COSTS-BLDG & FIXT	ALLOWABLE NEW CAPITAL COSTS	1, 747, 660	0	2.00			
3.00	5. 00	ADMINISTRATIVE & GENERAL	ADMINISTRATIVE & GENERAL	10, 053, 933	10, 075, 914	3. 00			
4.00	14. 00	CENTRAL SERVICES & SUPPLY	CENTRAL SERVI CE	0	135, 098	4. 00			
4.01	15. 00	PHARMACY	COEP / PHARMACY	223, 121	219, 741	4. 01			
5.00	TOTALS (sum of lines 1-4).			13, 118, 200	14, 977, 963	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

 nde net been peeted to nornered in certains i and or 2, the amount arrenable enear a be manded in our anni. I 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.

	Comonit under the tro minimum		
6.00	В	100. 00 FRANCI SCAN ALLI 100. 00	6. 00
7.00		0.00	7. 00
8.00		0.00	8. 00
9.00		0.00	9. 00
10.00		0.00	10. 00
100.00	G. Other (financial or		100.00
	non-financial) specify:		

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

Heal th	Health Financial Systems			FRANCISCAN ST ANTHONY-MICHIGAN CITY					In Lieu of Form CMS-2552-1			2552-10			
STATEME	ENT OF COSTS OF	SERVICES FROM	RELATED ORG	ANI ZATI ONS	AND HOME		Provi der	CCN:	150015	Peri	od:		Worksheet	A-8	-1
OFFICE	COSTS									From	01/01				
										To	12/31	/2014			
													5/28/2015	9:5	7 am
	Net	Wkst. A-7 Ref.													
	Adjustments														
	(col. 4 minus														
	col. 5)*														
	6. 00	7. 00													
	A. COSTS INCUR	RED AND ADJUSTN	MENTS REQUIF	RED AS A RE	SULT OF T	FRANS	ACTIONS V	VITH F	RELATED (ORGANI	ZATI O	NS OR	CLAI MED		
	HOME OFFICE CO	STS:													
1.00	-3, 453, 724	11													1.00
2.00	1.747.660	1 9													2.00

5.00 -1, 859, 763 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

3.00

4.00

4.01

5 00

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

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

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

6.00	HEALTHCARE SERV	6. 00
7.00		7.00
8.00		8.00
9.00		9. 00
10.00		10.00
7. 00 8. 00 9. 00 10. 00 100. 00		100.00

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

Ó

0

3.00

4.00

4.01

-21, 981

3,380

-135, 098

- 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.
- 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
- 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

Provider CCN: 150015

Peri od:

PROVIDER BASED PHYSICIAN ADJUSTMENT

From 01/01/2014 12/31/2014 Date/Time Prepared: 5/28/2015 9:57 am Wkst. A Line # Cost Center/Physician Total Professi onal Provi der RCE Amount Physi ci an/Prov I denti fi er ider Component Remuneration Component Component Hours 1. 00 2.00 3. 00 4.00 5. 00 6. 00 7.00 5. 00 ADMI NI STRATI VE & GENERAL 14, 848 171, 400 1.00 1 00 14.848 0 119 2.00 5. 00 ADMINISTRATIVE & GENERAL 28, 375 0 28, 375 171, 400 227 2.00 3.00 5. 00 ADMINISTRATIVE & GENERAL 171, 400 1, 412, 355 1, 412, 355 3.00 13. 00 NURSI NG ADMI NI STRATI ON 4.00 6, 500 6,500 171, 400 62 4.00 0 5.00 13. 00 NURSING ADMINISTRATION 9, 750 0 2, 250 171, 400 18 5.00 6.00 31.00 INTENSIVE CARE UNIT 171, 400 70 10,500 0 10, 400 6.00 85, 050 7.00 50. 00 OPERATING ROOM 85, 050 0 204, 100 284 7.00 50. OOOPERATING ROOM 204, 100 17,000 8.00 17,000 0 124 8 00 9.00 50.00 OPERATING ROOM 279, 141 236, 141 43,000 204, 100 236 9.00 10.00 53. 00 ANESTHESI OLOGY 9,964 9,964 200, 300 80 10.00 54. 00 RADI OLOGY-DI AGNOSTI C 231, 100 11.00 2.123 2, 123 11.00 Ω 55. 00 RADI OLOGY-THERAPEUTI C 29, 519 12.00 29, 519 0 231, 100 21 12.00 13.00 55. 01 WOODLAND CANCER CARE CENTER 17, 250 0 17, 250 231, 100 138 13.00 14.00 59. 00 CARDI AC CATHETERI ZATI ON 71, 300 0 71, 300 171, 400 422 14.00 59, 045 59, 045 171, 400 60. 00 LABORATORY 15.00 393 15.00 0 60. 00 LABORATORY 16.00 23, 063 0 23,063 171, 400 185 16.00 17.00 65. 00 RESPIRATORY THERAPY 4, 350 250 171, 400 17.00 18.00 91. 00 EMERGENCY 30,000 30,000 171, 400 392 18.00 91. 01 FREE STANDING EMERGENCY DEPT 531, 684 531, 684 19 00 19.00 171, 400 0 200.00 2, 641, 817 2, 182, 303 447, 814 2,774 200.00 5 Percent of Cost of Provi der Physician Cost Wkst. A Line # Cost Center/Physician Unadjusted RCE Identi fi er Unadjusted RCE Memberships & Component of Mal practice Li mi t Conti nui ng Share of col Limit Insurance Educati on 12 1. 00 2.00 8.00 9.00 14. 00 12. 00 13.00 1.00 5. 00 ADMINISTRATIVE & GENERAL 9, 806 1. 00 5. 00 ADMINISTRATIVE & GENERAL 0 0 0 2.00 18, 706 935 2.00 0 0 3.00 5. 00 ADMINISTRATIVE & GENERAL 0 3.00 0 0 4.00 13.00 NURSING ADMINISTRATION 5, 109 255 0 4.00 0 13.00 NURSING ADMINISTRATION 5.00 1, 483 74 5.00 0 0 6.00 31.00 INTENSIVE CARE UNIT 5, 768 288 6.00 0 0 0 0 50. 00 OPERATING ROOM 0 0 7.00 27, 867 1, 393 7.00 8.00 50.00 OPERATING ROOM 12, 167 608 8.00 0 0 9.00 50. 00 OPERATING ROOM 23, 158 1, 158 9.00 0 0 10.00 53. 00 ANESTHESI OLOGY 10.00 7,704 385 0 11.00 54. 00 RADI OLOGY-DI AGNOSTI C 0 11.00 0 55. 00 RADI OLOGY-THERAPEUTI C 0 0 12.00 2, 333 117 12.00 55. 01 WOODLAND CANCER CARE CENTER 767 0 0 13.00 13.00 15, 333 0 0 0 59. 00 CARDI AC CATHETERI ZATI ON 34, 774 14.00 1,739 14.00 15.00 60. 00 LABORATORY 32, 385 1,619 0 0 15.00 0 16.00 60. 00 LABORATORY 15, 245 762 0 0 16.00 0 17.00 65. 00 RESPIRATORY THERAPY 0 247 12 17 00 0 18.00 91. OO EMERGENCY 32, 302 1, 615 0 0 18.00 19.00 91. 01 FREE STANDING EMERGENCY DEPT 0 19.00 244, 387 12, 217 200.00 200.00 Wkst. A Line # Cost Center/Physician Provi der RCE Adjusted RCE Adjustment Di sal I owance Identi fi er Component Limit Share of col 14 1.00 2.00 15. 00 16.00 17. 00 18.00 1.00 5. OO ADMINISTRATIVE & GENERAL 9. 806 5. 042 1. 00 0 5.042 5. 00 ADMINISTRATIVE & GENERAL 2.00 0 18, 706 9,669 9,669 2.00 3.00 5. 00 ADMINISTRATIVE & GENERAL o 1, 412, 355 3.00 (13.00 NURSING ADMINISTRATION 4.00 0 5, 109 1, 391 1, 391 4.00 13. 00 NURSING ADMINISTRATION 0 5 00 1, 483 767 8, 267 5 00 31.00 INTENSIVE CARE UNIT 6.00 0 5, 768 4,632 4, 732 6.00 7.00 50. 00 OPERATING ROOM o 27, 867 57, 183 57, 183 7.00 8.00 50. OOOPERATING ROOM 0 12 167 4.833 4 833 8.00 50.00 OPERATING ROOM 0 9.00 23, 158 19,842 255, 983 9.00 7, 704 10.00 53. 00 ANESTHESI OLOGY 0 2, 260 2, 260 10.00 54. 00 RADI OLOGY-DI AGNOSTI C 11.00 0 2, 123 11.00 55. 00 RADI OLOGY-THERAPEUTI C o 2, 333 27, 186 27. 186 12 00 12 00 55. 01 WOODLAND CANCER CARE CENTER 13.00 0 15, 333 1,917 1, 917 13.00 36, 526 14.00 59. 00 CARDI AC CATHETERI ZATI ON o 34, 774 36, 526 14.00 15.00 60. 00 LABORATORY 0 32, 385 26,660 15.00 26, 660 0 16.00 60. 00 LABORATORY 15, 245 7,818 16.00 7.818 17.00 65. 00 RESPIRATORY THERAPY 0 247 4, 103 17.00 18.00 91. 00 EMERGENCY 32, 302 18.00 91. 01 FREE STANDING EMERGENCY DEPT 531, 684 19.00 0 n 19.00 244, 387 205, 729 200.00 2, 399, 732 200.00

In Lieu of Form CMS-2552-10
Worksheet B
01/2014 Part I
01/2014 Date/Time Prepared: 5/28/2015 9:57 am Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS FRANCISCAN ST ANTHONY-MICHIGAN CITY Provi der CCN: 150015 Peri od: From 01/01/2014 To 12/31/2014 CAPITAL RELATED COSTS

	Cost Center Description			BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			(from Wkst A col. 7) 0	1.00	2.00	4. 00	4A	
	GENERA	L SERVICE COST CENTERS	U	1.00	2.00	4.00	47.	
1.00	00100	CAP REL COSTS-BLDG & FLXT	7, 772, 399	7, 772, 399				1. 00
2.00		CAP REL COSTS-MVBLE EQUIP	6, 499, 786		6, 499, 786			2. 00
4.00		EMPLOYEE BENEFITS DEPARTMENT	13, 407, 194			13, 496, 700	0/ 070 /47	4. 00
5. 00 7. 00		ADMINISTRATIVE & GENERAL OPERATION OF PLANT	22, 827, 477 5, 648, 619	1, 248, 522 978, 079		1, 951, 988 603, 972	26, 972, 617 7, 295, 129	5. 00 7. 00
8. 00		LAUNDRY & LINEN SERVICE	388, 139			003, 472	474, 491	•
9. 00		HOUSEKEEPI NG	1, 381, 560			362, 172	1, 923, 524	•
10.00		DIETARY	479, 611	208, 597		108, 276	813, 510	1
11. 00		CAFETERI A	649, 918		· ·	245, 429	895, 347	
13.00		NURSI NG ADMI NI STRATI ON	1, 537, 422	35, 272		517, 537	2, 211, 325	1
14. 00 15. 00		CENTRAL SERVICES & SUPPLY PHARMACY	1, 142, 742 9, 066, 409	136, 420 55, 646	1	153, 398 467, 415	1, 530, 458 9, 591, 726	
16. 00		MEDICAL RECORDS & LIBRARY	999, 711	60, 420	1	222, 087	1, 287, 613	
		ENT ROUTINE SERVICE COST CENTERS	,		2, 2.2	===, ===,	., ==:, , =::	
30.00		ADULTS & PEDIATRICS	6, 141, 861	1, 240, 422		1, 957, 071	9, 454, 722	30. 00
31. 00		INTENSIVE CARE UNIT	1, 696, 657			569, 204	2, 528, 043	1
40.00		SUBPROVI DER – I PF SUBPROVI DER – I RF	1, 142, 189			322, 974	1, 596, 241	40.00
41. 00 43. 00		NURSERY	855, 612 420, 827	234, 116 18, 576		255, 323 117, 832	1, 375, 722 557, 543	1
44. 00		SKILLED NURSING FACILITY	420, 027	0,370	1	0	0	1
45.00	04500	NURSING FACILITY	0			o	0	•
		ARY SERVICE COST CENTERS						
50. 00 52. 00		OPERATING ROOM	5, 431, 527	390, 765		1, 374, 304	8, 460, 803	1
52.00		DELIVERY ROOM & LABOR ROOM ANESTHESIOLOGY	754, 596 80, 615			211, 288 14, 608	1, 114, 908 116, 153	1
54. 00		RADI OLOGY-DI AGNOSTI C	2, 876, 155	374, 193		754, 724	5, 899, 545	•
54. 01		FSED RADIOLOGY - DIAGNOSTIC	669, 021	59, 201		187, 777	915, 999	1
55.00	05500	RADI OLOGY-THERAPEUTI C	1, 498, 668	185, 061	60, 194	211, 098	1, 955, 021	55. 00
55. 01		WOODLAND CANCER CARE CENTER	820, 334	220, 809	1	181, 203	1, 222, 346	
57. 00		CT SCAN	0	0	-	0	0	
58. 00 59. 00	05800	MRI CARDIAC CATHETERIZATION	0 1, 001, 563	0 89, 493		0 240, 551	0 1, 762, 071	58. 00 59. 00
60.00		LABORATORY	6, 186, 456	185, 536		240, 331	6, 378, 900	1
60. 01		FSED LABORATORY	1, 096, 148			o	1, 123, 010	
65. 00		RESPI RATORY THERAPY	908, 678		1	276, 625	1, 242, 264	
66. 00		PHYSI CAL THERAPY	3, 219, 436		1	31, 933	3, 285, 666	
69. 00 71. 00		ELECTROCARDIOLOGY MEDICAL SUPPLIES CHARGED TO PATIENT	853, 150 4, 674, 558		1	230, 413	1, 250, 368 4, 674, 558	
72.00		IMPL. DEV. CHARGED TO PATIENTS	6, 400, 550		· ·	o o	6, 400, 550	•
73. 00		DRUGS CHARGED TO PATIENTS	0	0		o	0	73. 00
76. 00		CV RESOURCE CENTER	6, 026	0	0	2, 005	8, 031	76. 00
90. 00	09000	TENT SERVICE COST CENTERS	0	0	O	٥	0	90. 00
		OB CLINIC	0			0	3, 172	1
90. 02		PAIN MANAGEMENT	0	Ö		o	0, 1,2	1
90. 03	09003	INFUSION OP SERVICES	440, 996	28, 784	242	58, 482	528, 504	90. 03
90. 04		MATERNAL HEA	0	0	0	0	0	90. 04
91.00		EMERGENCY FREE STANDING EMERGENCY DEPT	2, 985, 410			896, 743	5, 192, 167	1
91. 01 92. 00		OBSERVATION BEDS (NON-DISTINCT PART	1, 490, 766	441, 803		336, 937	2, 269, 506 0	1
72.00		L PURPOSE COST CENTERS						72.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	123, 452, 786	7, 532, 539	6, 231, 744	12, 863, 369	122, 311, 553	118. 00
100.00		MBURSABLE COST CENTERS GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	20.252		ما	20. 252	100 00
		RETAIL PHARMACY	0	20, 353 0		0	20, 353	190.00
		WORKING WELL	3, 024, 505		1	609, 256	3, 856, 607	
		APS DUNELAND SURG ASSOC	0	0	0	O		194. 02
		MED WATCH	0	125, 633	0	0	125, 633	
	1 1	OCCUPATIONAL MED CENTER	0	0	0	0		194. 04
	1 1	PHYSI CI AN PRACTI CE DENTAL SERVI CES	0	0		0		194. 05 194. 06
		DUNELAND MED WATCH	0	Ö	l ol	ol		194. 07
194. 08	07958	WESTVILLE CLNIC	0	0	o	o	0	194. 08
		ORTHOPEDI CS	0	0	- T	0		194. 09
		WOMEN SERVICES	1 000	93, 874	1	0	93, 874	
		DUNELAND FITNESS CENTER CARDIOLOGY ASSOC	-1, 902 0	0	37, 646 0	0	35, 744 0	194. 11
		DUNELAND FAMILY PRACTICE	0	0	1	o		194. 13
			<u>'</u>		'	·		

COST ALLOCATION - GENERAL SERVICE COSTS		Provi der	CCN: 150015	Peri od:	Worksheet B	
				From 01/01/201	4 Part I	
				To 12/31/201	4 Date/Time Pre	epared:
					5/28/2015 9:5	57 am
		CAPI TAL RE	LATED COSTS			
0 1 0 1 0 1 11	– –	DIDO A FINE	10/01 5 501115		1	41

					5/28/2015 9:5	/ alli
		CAPI TAL REI	LATED COSTS			
Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
	0	1. 00	2.00	4. 00	4A	
194. 14 07964 ORTHOPEDI CS	0	0	0	0	0	194. 14
194. 15 07965 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194. 15
194.16 07966 PHYSICIAN PRACTICE MD WISE	7, 120, 440	0	0	19, 158	7, 139, 598	194. 16
194. 17 07967 ENT	0	0	0	0	0	194. 17
194. 18 07968 SLEEP CLINIC	0	0	0	0	0	194. 18
194. 19 07969 HEALTH PARTNERS	1, 099	0	7, 550	0	8, 649	194. 19
194. 20 07970 CENTER OF HOPE	15, 994	0	0	4, 917	20, 911	194. 20
200.00 Cross Foot Adjustments					0	200. 00
201.00 Negative Cost Centers		0	0	0	0	201. 00
202.00 TOTAL (sum lines 118-201)	133, 612, 922	7, 772, 399	6, 499, 786	13, 496, 700	133, 612, 922	202. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150015

| In Lieu of Form CMS-2552-10 | Period: Worksheet B | From 01/01/2014 Part | | To 12/31/2014 Date/Time Prepared: 5/28/2015 9:57 am

					5/28/2015 9:5	7 am
Cost Center Description	ADMI NI STRATI VE		LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	& GENERAL 5.00	PLANT 7. 00	LINEN SERVICE	9. 00	10.00	
GENERAL SERVICE COST CENTERS	5.00	7.00	8. 00	9.00	10.00	
1. 00 O0100 CAP REL COSTS-BLDG & FLXT						1.00
2. 00 00200 CAP REL COSTS-MVBLE EQUIP			•			2. 00
4. 00 O0400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 00 00500 ADMI NI STRATI VE & GENERAL	26, 972, 617					5. 00
7. 00 O0700 OPERATION OF PLANT	1, 845, 164	9, 140, 293				7. 00
8.00 00800 LAUNDRY & LINEN SERVICE	120, 013	144, 270				8. 00
9. 00 00900 HOUSEKEEPI NG	486, 519			2, 646, 902		9. 00
10. 00 01000 DI ETARY	205, 762	348, 505		81, 388	1, 449, 460	10.00
11. 00 01100 CAFETERI A	226, 461	0		62, 227	0	11. 00
13. 00 01300 NURSING ADMINISTRATION	559, 313	58, 930	o o	41, 155	0	13. 00
14. 00 01400 CENTRAL SERVICES & SUPPLY	387, 100			47, 769	0	14. 00
15. 00 01500 PHARMACY	2, 426, 023	92, 969		31, 868	0	15. 00
16. 00 01600 MEDICAL RECORDS & LIBRARY	325, 677	100, 944	1	65, 968	0	16. 00
INPATIENT ROUTINE SERVICE COST CENTERS				227.22		
30. 00 03000 ADULTS & PEDI ATRI CS	2, 391, 392	2, 072, 388	347, 224	744, 161	998, 713	30. 00
31.00 03100 INTENSIVE CARE UNIT	639, 420			107, 631	148, 660	31. 00
40. 00 04000 SUBPROVI DER - 1 PF	403, 739			113, 524	160, 678	40. 00
41. 00 04100 SUBPROVI DER - I RF	347, 963			111, 105	141, 409	41. 00
43. 00 04300 NURSERY	141, 020			12, 868	0	43.00
44.00 04400 SKILLED NURSING FACILITY	0	O		0	0	44. 00
45.00 04500 NURSING FACILITY	0	o	О	O	0	45. 00
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	2, 139, 999	652, 856	39, 155	427, 345	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	281, 995	248, 977	0	96, 367	0	52. 00
53. 00 05300 ANESTHESI OLOGY	29, 379	18, 849	0	6, 013	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 492, 178	625, 169	29, 698	176, 419	0	54.00
54. 01 05401 FSED RADIOLOGY - DIAGNOSTIC	231, 685	98, 907	0	0	0	54. 01
55. 00 05500 RADI OLOGY-THERAPEUTI C	494, 485	309, 184	369	27, 780	0	55. 00
55. 01 05501 WOODLAND CANCER CARE CENTER	309, 169	368, 908	7, 388	0	0	55. 01
57. 00 05700 CT SCAN	0	0	0	0	0	57. 00
58. 00 05800 MRI	0	0	0	0	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	445, 682	149, 517	222	33, 966	0	59. 00
60. 00 06000 LABORATORY	1, 613, 422	309, 978	0	108, 299	0	60.00
60. 01 06001 FSED LABORATORY	284, 044	44, 879	0	0	0	60. 01
65. 00 06500 RESPIRATORY THERAPY	314, 207	69, 149	0	17, 972	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	831, 047	47, 641	22, 163	34, 541	0	66. 00
69. 00 06900 ELECTROCARDI OLOGY	316, 257	191, 048	3, 694	43, 280	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 182, 341	0	0	0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	1, 618, 898	0	0	0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73. 00
76.00 03950 CV RESOURCE CENTER	2, 031	0	0	0	0	76. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	0	0	0	0	90. 00
90. 01 09001 0B CLINIC	802	0	0	0	0	90. 01
90. 02 09002 PAI N MANAGEMENT	0	0	0	0	0	90. 02
90. 03 09003 I NFUSI ON OP SERVI CES	133, 675	48, 090	222	13, 135	0	90. 03
90.04 09004 MATERNAL HEA	0	0		0	0	90. 04
91. 00 09100 EMERGENCY	1, 313, 260	693, 627		228, 959	0	91. 00
91.01 09101 FREE STANDING EMERGENCY DEPT	574, 028	738, 127	29, 551	0	0	91. 01
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
SPECIAL PURPOSE COST CENTERS	_					
118.00 SUBTOTALS (SUM OF LINES 1-117)	24, 114, 150	8, 739, 555	701, 835	2, 633, 740	1, 449, 460	118. 00
NONREI MBURSABLE COST CENTERS	_					
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	5, 148	34, 005	0	13, 162		190. 00
194. 00 07950 RETAIL PHARMACY	0	0	0	0		194. 00
194. 01 07951 WORKI NG WELL	975, 455	0	0	0	_	194. 01
194.02 07952 APS DUNELAND SURG ASSOC	0	0	0	0		194. 02
194.03 07953 MED WATCH	31, 776	209, 897	0	0		194. 03
194.04 07954 OCCUPATIONAL MED CENTER	0	0	0	0		194. 04
194. 05 07955 PHYSI CI AN PRACTI CE	0	0	0	0		194. 05
194. 06 07956 DENTAL SERVICES	0	0	0	0		194. 06
194.07 07957 DUNELAND MED WATCH	0	0	0	0		194. 07
194. 08 07958 WESTVI LLE CLNI C	0	0	0	0		194. 08
194. 09 07959 ORTHOPEDI CS	0	0	0	0		194. 09
194. 10 07960 WOMEN SERVICES	23, 744	156, 836	0	0		194. 10
194. 11 07961 DUNELAND FITNESS CENTER	9, 041	0	0	0		194. 11
194. 12 07962 CARDI OLOGY ASSOC	0	0	0	0		194. 12
194. 13 07963 DUNELAND FAMILY PRACTICE	0	0	0	0		194. 13
194. 14 07964 ORTHOPEDI CS	0	0	9	0		194. 14
194. 15 07965 OTHER NONREI MBURSABLE COST CENTERS	0	0	9	0		194. 15
194. 16 07966 PHYSICIAN PRACTICE MD WISE	1, 805, 826	0) O	0		194. 16
194. 17 07967 ENT	0	0	0	0		194. 17
194. 18 07968 SLEEP CLINIC	0	<u> </u>	il 0	0	0	194. 18

Health Financial Systems	FRANCISCAN ST ANTHONY-MICHIGAN CITY			In Lieu of Form CMS-2552-1		
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 15		From 01/01/2014 To 12/31/2014	Worksheet B Part I Date/Time Prepared:	

						5/28/2015 9:5	7 am
	Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		& GENERAL	PLANT	LINEN SERVICE			
		5. 00	7. 00	8. 00	9. 00	10.00	
194. 19 07969	HEALTH PARTNERS	2, 188	0	36, 939	0	0	194. 19
194. 20 07970	CENTER OF HOPE	5, 289	0	0	0	0	194. 20
200.00	Cross Foot Adjustments						200.00
201. 00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	26, 972, 617	9, 140, 293	738, 774	2, 646, 902	1, 449, 460	202.00

In Lieu of Form CMS-2552-10 Health Financial Systems FRANCISCAN ST ANTHONY-MICHIGAN CITY COST ALLOCATION - GENERAL SERVICE COSTS Provi der CCN: 150015 Peri od: Worksheet B From 01/01/2014 Part I Date/Time Prepared: 12/31/2014 5/28/2015 9:57 am Cost Center Description CAFETERI A NURSI NG CENTRAL **PHARMACY** MEDI CAL RECORDS & SERVICES & ADMI NI STRATI ON SUPPLY LI BRARY 11. 00 13.00 15.00 14.00 16,00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 00700 OPERATION OF PLANT 7.00 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 00900 HOUSEKEEPI NG 9.00 9 00 10.00 01000 DI ETARY 10.00 11.00 01100 CAFETERI A 1, 184, 035 11.00 01300 NURSING ADMINISTRATION 45.228 2, 915, 951 13.00 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 32.856 r 2, 226, 101 14 00 15.00 01500 PHARMACY 39, 961 12, 182, 547 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 37,070 1, 817, 272 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 267, 557 1,009,383 0 106, 261 30.00 03100 INTENSIVE CARE UNIT 283, 435 0 0 18, 915 31.00 31.00 52,870 0 40.00 04000 SUBPROVI DER - I PF 38, 527 105, 332 0 12, 741 40.00 04100 SUBPROVI DER - I RF 0 41 00 40, 319 110, 824 21, 310 41 00 43.00 04300 NURSERY 4, 433 43.00 04400 SKILLED NURSING FACILITY 0 0 44.00 44.00 0 0 04500 NURSING FACILITY 45.00 0 45.00 0 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 168, 988 536, 075 0 0 372, 538 50.00 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 0 7, 950 52.00 0 0 53 00 05300 ANESTHESI OLOGY 2 241 15, 437 53 00 |05400| RADI OLOGY-DI AGNOSTI C 0 54.00 81, 311 42, 957 239, 185 54.00 05401 FSED RADIOLOGY - DIAGNOSTIC 19, 723 0 45,020 54.01 54.01 55.00 05500 RADI OLOGY-THERAPEUTI C 16,652 0 0 0 45, 459 55.00 05501 WOODLAND CANCER CARE CENTER 0 55.01 17, 616 C 8, 305 55.01 57.00 05700 CT SCAN 0 57.00 58.00 05800 MRI 0 0 58.00 0 59 00 05900 CARDIAC CATHETERIZATION 20 350 58,060 0 55, 250 59 00 06000 LABORATORY 60.00 165, 371 60.00 06001 FSED LABORATORY 0 17, 539 60.01 0 60.01 0 06500 RESPIRATORY THERAPY 65.00 32, 475 33, 560 65.00 06600 PHYSI CAL THERAPY 54, 081 1, 177 O 49, 519 66 00 66 00 69.00 06900 ELECTROCARDI OLOGY 23, 712 40, 799 0 0 45, 867 69.00 57, 870 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 951, 357 0 71.00 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 1, 274, 744 48, 893 72.00 07300 DRUGS CHARGED TO PATIENTS 12, 182, 547 262, 267 73.00 0 Ω 0 73.00 76.00 03950 CV RESOURCE CENTER 76.00 0 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 90.00 С 0 0 90.01 09001 OB CLINIC 0 0 0 90.01 90.02 09002 PAIN MANAGEMENT 0 0 0 0 90.02 90 03 09003 INFUSION OP SERVICES 6, 141 56, 099 0 0 9, 388 90 03 0 0 09004 MATERNAL HEA 90.04 90.04 0 09100 EMERGENCY 0 140, 358 91.00 92.876 551, 963 0 91.00 09101 FREE STANDING EMERGENCY DEPT 0 91.01 91.01 31, 377 33, 836 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1-117) 1, 122, 065 2, 796, 104 2, 226, 101 12, 182, 547 1, 817, 272 118. 00 NONREIMBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190, 00 0 0 194.00 194. 00 07950 RETAIL PHARMACY 0 194. 01 07951 WORKING WELL 0 0 194. 01 59, 437 111, 413 0 0 0 0 0 0 0 0 0 0 0 0 0 194. 02 07952 APS DUNELAND SURG ASSOC 0 0 194. 02 194.03 07953 MED WATCH 0 0 194, 03 0 0 194. 04 07954 OCCUPATIONAL MED CENTER 0 0 C 0 194. 04 194. 05 07955 PHYSICIAN PRACTICE 0 194. 05 0000000000 194.06 07956 DENTAL SERVICES 0 0 0 194. 06 194. 07 07957 DUNELAND MED WATCH 0 0 194 07 194. 08 07958 WESTVILLE CLNIC 0 194. 08 194. 09 07959 ORTHOPEDI CS 0 194. 09 194. 10 07960 WOMEN SERVICES 0 0 194, 10 194. 11 07961 DUNELAND FITNESS CENTER 0 194. 11 0 0 194. 12 07962 CARDI OLOGY ASSOC 0 0 0 194. 12 194. 13 07963 DUNELAND FAMILY PRACTICE 0 0 194. 13 194. 14 07964 ORTHOPEDI CS Ω 0 0 194, 14

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0 194. 15

0 194. 16

0 194. 17

194. 17 07967 ENT

194. 15 07965 OTHER NONREIMBURSABLE COST CENTERS

194. 16 07966 PHYSICIAN PRACTICE MD WISE

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS FRANCISCAN ST ANTHONY-MICHIGAN CITY Provider CCN: 150015

						5/28/2015 9:5	/ am
	Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
			ADMI NI STRATI ON	SERVICES &		RECORDS &	
				SUPPLY		LI BRARY	
		11.00	13. 00	14.00	15. 00	16.00	
194. 18 07968	SLEEP CLINIC	0	0	0	0	0	194. 18
194. 19 07969	HEALTH PARTNERS	0	8, 238	0	0	0	194. 19
194. 20 07970	CENTER OF HOPE	471	196	0	0	0	194. 20
200. 00	Cross Foot Adjustments						200. 00
201. 00	Negative Cost Centers	0	o	0	0	0	201. 00
202. 00	TOTAL (sum lines 118-201)	1, 184, 035	2, 915, 951	2, 226, 101	12, 182, 547	1, 817, 272	202. 00

Health Financial Systems FRANCISCAN ST ANTHONY-MICHIGAN CITY In Lieu of Form CMS-2552-10

COST ALLOCATION - GENERAL SERVICE COSTS
Provider CCN: 150015
From 01/01/2014
To 12/31/2014
Date/Time Prepared:

				o 12/31/2014 Date/lime Pr 5/28/2015 9:	
Cost Center Description	Subtotal	Intern &	Total		
		Residents Cost			
		& Post Stepdown			
		Adjustments			
	24. 00	25. 00	26. 00		
GENERAL SERVI CE COST CENTERS	T	Г			
1.00 O0100 CAP REL COSTS-BLDG & FLXT					1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT					2. 00 4. 00
5. 00 00500 ADMINISTRATIVE & GENERAL					5. 00
7. 00 00700 OPERATION OF PLANT					7. 00
8.00 00800 LAUNDRY & LINEN SERVICE					8. 00
9. 00 00900 HOUSEKEEPI NG					9. 00
10. 00 01000 DI ETARY					10.00
11. 00 01100 CAFETERI A					11.00
13. 00 O1300 NURSI NG ADMI NI STRATI ON 14. 00 O1400 CENTRAL SERVI CES & SUPPLY					13. 00 14. 00
15. 00 01500 PHARMACY					15. 00
16.00 01600 MEDICAL RECORDS & LIBRARY					16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS	17, 391, 801	0	17, 391, 801		30.00
31. 00 03100 I NTENSI VE CARE UNI T	4, 019, 492	1	4, 019, 492		31.00
40. 00 04000 SUBPROVI DER - PF 41. 00 04100 SUBPROVI DER - RF	2, 728, 158 2, 569, 343	1	2, 728, 158		40. 00 41. 00
43. 00 04300 NURSERY	747, 122		2, 569, 343 747, 122		43. 00
44. 00 04400 SKILLED NURSING FACILITY	0	1 1	, , , , , , , , ,		44. 00
45.00 04500 NURSING FACILITY	0	0	C		45. 00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	12, 797, 759		12, 797, 759		50.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM	1, 750, 197	i i	1, 750, 197		52. 00
53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY - DI AGNOSTI C	188, 072 8, 586, 462	0	188, 072 8, 586, 462		53. 00 54. 00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	1, 311, 334		1, 311, 334		54. 00
55. 00 05500 RADI OLOGY-THERAPEUTI C	2, 848, 950	1	2, 848, 950		55. 00
55. 01 05501 WOODLAND CANCER CARE CENTER	1, 933, 732	O	1, 933, 732		55. 01
57.00 05700 CT SCAN	0	0	C		57. 00
58. 00 05800 MRI	0	0	0		58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON 060. 00 06000 LABORATORY	2, 525, 118	l I	2, 525, 118		59.00
60. 00 06000 LABORATORY 60. 01 06001 FSED LABORATORY	8, 575, 970 1, 469, 472	1	8, 575, 970 1, 469, 472		60. 00 60. 01
65. 00 06500 RESPIRATORY THERAPY	1, 709, 627		1, 709, 627		65. 00
66. 00 06600 PHYSI CAL THERAPY	4, 325, 835	O	4, 325, 835		66.00
69. 00 06900 ELECTROCARDI OLOGY	1, 915, 025	0	1, 915, 025		69. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	6, 866, 126	0	6, 866, 126		71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	9, 343, 085	1	9, 343, 085		72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS 76. 00 03950 CV RESOURCE CENTER	12, 444, 814 10, 196	1	12, 444, 814 10, 196		73. 00 76. 00
OUTPATIENT SERVICE COST CENTERS	10, 170	<u> </u>	10, 170		70.00
90. 00 09000 CLI NI C	0		C		90. 00
90. 01 09001 0B CLINIC	3, 974	0	3, 974		90. 01
90. 02 09002 PAIN MANAGEMENT	705 054	0	705.054		90. 02
90. 03 09003 INFUSION OP SERVICES 90. 04 09004 MATERNAL HEA	795, 254	0	795, 254		90. 03 90. 04
91. 00 09100 EMERGENCY	8, 287, 087		8, 287, 087		91. 00
91. 01 09101 FREE STANDING EMERGENCY DEPT	3, 676, 425	o	3, 676, 425		91. 01
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0			92. 00
SPECIAL PURPOSE COST CENTERS					
118. 00 SUBTOTALS (SUM OF LINES 1-117)	118, 820, 430	0	118, 820, 430		118. 00
NONREIMBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	72, 668	ا ا	72, 668		190. 00
194. 00 07950 RETAIL PHARMACY	72,000		72,000		194. 00
194. 01 07951 WORKI NG WELL	5, 002, 912	o	5, 002, 912		194. 01
194.02 07952 APS DUNELAND SURG ASSOC	0	0	C		194. 02
194. 03 07953 MED WATCH	367, 306	0	367, 306		194. 03
194. 04 07954 OCCUPATIONAL MED CENTER	0	0	C		194. 04
194. 05 07955 PHYSI CI AN PRACTI CE 194. 06 07956 DENTAL SERVI CES	0		0		194. 05 194. 06
194. 07 07957 DUNELAND MED WATCH	0		0		194. 00
194. 08 07958 WESTVI LLE CLNI C			O.		194. 07
194. 09 07959 ORTHOPEDI CS	0		Ö		194. 09
194. 10 07960 WOMEN SERVICES	274, 454	1	274, 454		194. 10
194. 11 07961 DUNELAND FI TNESS CENTER	44, 785		44, 785		194. 11
194. 12 07962 CARDI OLOGY ASSOC	0	٥	O		194. 12
194. 13 07963 DUNELAND FAMILY PRACTICE 194. 14 07964 ORTHOPEDICS	0	1	C		194. 13 194. 14
194. 14 07964 ORTHOPEDICS 194. 15 07965 OTHER NONREIMBURSABLE COST CENTERS	0	l	C		194. 14
	, ,	<u>, </u>		ı	

COST ALLOCATION - GENERAL SERVICE COSTS	Provider CCN: 150015	Peri od:	Worksheet B
		From 01/01/2014	Part I
		To 12/31/2014	Date/Time Prepared:
			5/20/2015 0:57 am

					5/28/2015 9:	
	Cost Center Description	Subtotal	Intern &	Total		
			Residents Cost			
			& Post			
			Stepdown			
			Adjustments			
		24. 00	25. 00	26. 00		
194. 16 07966	PHYSICIAN PRACTICE MD WISE	8, 947, 486	0	8, 947, 486		194. 16
194. 17 07967	ENT	0	0	0		194. 17
194. 18 07968	SLEEP CLINIC	0	0	0		194. 18
194. 19 07969	HEALTH PARTNERS	56, 014	0	56, 014		194. 19
194. 20 07970	CENTER OF HOPE	26, 867	0	26, 867		194. 20
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 118-201)	133, 612, 922	0	133, 612, 922		202. 00

Provi der CCN: 150015

Peri od:

From 01/01/2014

ALLOCATION OF CAPITAL RELATED COSTS

Part II

Date/Time Prepared: 12/31/2014 5/28/2015 9:57 am CAPITAL RELATED COSTS Cost Center Description Directly BLDG & FIXT MVBLE EQUIP Subtotal **EMPLOYEE** Assigned New **BENEFITS** DEPARTMENT Capi tal Related Costs 1.00 2.00 2A 4.00 0 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 74, 905 14, 601 89, 506 89, 506 4 00 5.00 00500 ADMINISTRATIVE & GENERAL 0 0 0 1, 248, 522 944, 630 2, 193, 152 12, 944 5.00 00700 OPERATION OF PLANT 978, 079 64, 459 1, 042, 538 4, 005 7 00 7 00 00800 LAUNDRY & LINEN SERVICE 8.00 86, 352 86, 352 n 8.00 9.00 00900 HOUSEKEEPI NG 141, 771 38, 021 179, 792 2, 402 9.00 208, 597 17, 026 225, 623 01000 DI ETARY 0 0 718 10.00 10 00 01100 CAFETERI A 11.00 1,627 11.00 13.00 01300 NURSING ADMINISTRATION 35, 272 121, 094 156, 366 3, 432 13.00 01400 CENTRAL SERVICES & SUPPLY 0 14.00 136, 420 97, 898 234, 318 1,017 14.00 01500 PHARMACY 57, 902 2 256 3, 099 15 00 15 00 55, 646 16.00 01600 MEDICAL RECORDS & LIBRARY 60, 420 5, 395 65, 815 1, 473 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 0 30.00 03000 ADULTS & PEDIATRICS 1, 240, 422 1, 355, 790 12, 986 30.00 115, 368 3, 774 03100 INTENSIVE CARE UNIT 31 00 121, 852 140, 330 262, 182 31 00 40.00 04000 SUBPROVIDER - IPF 0 129, 353 1,725 131, 078 2, 142 40.00 1, 693 04100 SUBPROVI DER - I RF 264, 787 41.00 234, 116 30, 671 41.00 0 43.00 04300 NURSERY 308 18, 884 781 43.00 18, 576 04400 SKILLED NURSING FACILITY 44.00 0 0 44.00 45.00 04500 NURSING FACILITY 45.00 0 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 0 50.00 390, 765 1, 264, 207 1, 654, 972 9. 113 50.00 0 05200 DELIVERY ROOM & LABOR ROOM 52.00 149, 024 149, 024 1, 401 52 00 05300 ANESTHESI OLOGY 11, 282 9,648 20, 930 97 53.00 53.00 0000000000000000 05400 RADI OLOGY-DI AGNOSTI C 54.00 374, 193 1, 894, 473 2, 268, 666 5,005 54.00 05401 FSED RADIOLOGY - DIAGNOSTIC 59, 201 59, 201 1, 245 54.01 54.01 C 05500 RADI OLOGY-THERAPEUTI C 55.00 185, 061 60, 194 245, 255 1, 400 55.00 220, 809 05501 WOODLAND CANCER CARE CENTER 55.01 220, 809 1, 202 55.01 57.00 05700 CT SCAN 0 57.00 05800 MRI 58 00 Λ 58 00 05900 CARDIAC CATHETERIZATION 59.00 89, 493 430, 464 519, 957 1, 595 59.00 06000 LABORATORY 192, 444 60.00 185, 536 6, 908 Ω 60.00 06001 FSED LABORATORY 26, 862 60.01 26, 862 60.01 C 0 06500 RESPIRATORY THERAPY 41, 389 65.00 15, 572 56, 961 1,834 65.00 28, 515 66,00 06600 PHYSI CAL THERAPY 5, 782 34, 297 212 66.00 06900 ELECTROCARDI OLOGY 114, 351 52, 454 166, 805 1,528 69.00 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71 00 n 71.00 0 Ω 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS C 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 73.00 03950 CV RESOURCE CENTER 0 76.00 76.00 13 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 0 0 90.00 09001 OB CLINIC 90. 01 0 0 3, 172 3, 172 0 90.01 90 02 09002 PAIN MANAGEMENT 90 02 C 0 09003 INFUSION OP SERVICES 90.03 28, 784 242 29, 026 388 90.03 90.04 09004 MATERNAL HEA 0 90.04 0 0 91.00 09100 EMERGENCY 415, 168 894, 846 1, 310, 014 5, 946 91.00 0 09101 FREE STANDING EMERGENCY DEPT 2, 234 91 01 91 01 441, 803 441, 803 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1-117)
NONREIMBURSABLE COST CENTERS 118.00 0 7, 532, 539 6, 231, 744 13, 764, 283 85, 306 118. 00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 20, 353 20, 353 0 190, 00 194.00 07950 RETAIL PHARMACY 0 0 194.00 0 0 194. 01 07951 WORKING WELL 4, 040 194. 01 222, 846 222, 846 0 194. 02 07952 APS DUNELAND SURG ASSOC 0 194, 02 C 194.03 07953 MED WATCH 00000000000 125, 633 0 125, 633 0 194. 03 194. 04 07954 OCCUPATIONAL MED CENTER 0 0 194. 04 194. 05 07955 PHYSICIAN PRACTICE 0 0 194. 05 0 C 194. 06 07956 DENTAL SERVICES 0 0 0 0 194.06 194. 07 07957 DUNELAND MED WATCH 0 0 194. 07 194. 08 07958 WESTVILLE CLNIC 0 0 0 0 194. 08 194. 09 07959 ORTHOPEDI CS 0 0 0 194. 09 194. 10 07960 WOMEN SERVICES 93, 874 93, 874 0 194. 10 194. 11 07961 DUNELAND FITNESS CENTER C 37, 646 37, 646 0 194. 11 194. 12 07962 CARDI OLOGY ASSOC 0 194, 12 0 0 194. 13 07963 DUNELAND FAMILY PRACTICE 0 0 194. 13 Ω 0 194. 14 07964 ORTHOPEDI CS 0 0 0 194. 14

				To 12/31/2014	Date/Time Pre 5/28/2015 9:5	
		CAPI TAL REL	LATED COSTS			
Cost Center Description	Directly	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
	Assigned New				BENEFITS	
	Capi tal				DEPARTMENT	
	Related Costs					
	0	1. 00	2. 00	2A	4. 00	
194.15 07965 OTHER NONREIMBURSABLE COST CENTERS	0	0		0	0	194. 15
194.16 07966 PHYSICIAN PRACTICE MD WISE	0	0	(0	127	194. 16
194. 17 07967 ENT	0	0	(0	0	194. 17
194. 18 07968 SLEEP CLINIC	0	0		0	0	194. 18
194. 19 07969 HEALTH PARTNERS	0	0	7, 55	0 7, 550	0	194. 19
194. 20 07970 CENTER OF HOPE	0	0		0	33	194. 20
200.00 Cross Foot Adjustments				0		200.00
201.00 Negative Cost Centers		0		0	0	201. 00
202.00 TOTAL (sum lines 118-201)	o	7, 772, 399	6, 499, 78	6 14, 272, 185	89, 506	202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150015

| Period: | Worksheet B | From 01/01/2014 | Part II | To | 12/31/2014 | Date/Time Prepared: | 5/28/2015 9:57 am

				'	0 12/31/2014	5/28/2015 9:5	
	Cost Center Description	ADMI NI STRATI VE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	
		5. 00	7.00	8.00	9. 00	10. 00	
	GENERAL SERVICE COST CENTERS	T	I				
1. 00 2. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP					1	1. 00 2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT					l	4.00
5. 00	00500 ADMI NI STRATI VE & GENERAL	2, 206, 096				l	5.00
7. 00	00700 OPERATION OF PLANT	150, 914	l e	,		l	7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	9, 816	1	1		l	8. 00
9.00	00900 HOUSEKEEPI NG	39, 792		1	l .	l	9. 00
10.00	01000 DI ETARY	16, 829	45, 657	46	7, 780	296, 653	10.00
11. 00	01100 CAFETERI A	18, 522	C	1	5, 948	0	11. 00
13. 00	01300 NURSI NG ADMI NI STRATI ON	45, 746		1	3, 934	0	13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	31, 661	29, 859		4, 566	0	14. 00
15. 00	01500 PHARMACY	198, 449		1		0	15.00
16. 00	01600 MEDICAL RECORDS & LIBRARY	26, 637	13, 225	5 0	6, 306	0	16. 00
30. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	195, 590	271, 500	54, 078	71, 134	204, 402	30.00
31. 00	03100 I NTENSI VE CARE UNI T	52, 298		1	· · ·	· ·	31.00
40. 00	04000 SUBPROVI DER - I PF	33, 021	28, 312	1	· · ·	32, 885	•
41. 00	04100 SUBPROVIDER - I RF	28, 460	l	1		28, 941	1
43. 00	04300 NURSERY	11, 534	4, 066	1	l		43. 00
44.00	04400 SKILLED NURSING FACILITY	0	C		0	0	44.00
45. 00	04500 NURSING FACILITY	0	c	0	o	0	45. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	175, 029			· · ·	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	23, 064		1		0	52.00
53. 00	05300 ANESTHESI OLOGY	2, 403	l	1	575	0	53. 00
54.00	05400 RADI OLOGY - DI AGNOSTI C	122, 044	81, 902	1	16, 864	0	54.00
54. 01	05401 FSED RADI OLOGY - DI AGNOSTI C	18, 949			0	0	54. 01
55. 00	05500 RADI OLOGY-THERAPEUTI C	40, 444			2, 655	0	55. 00
55. 01 57. 00	05501 WOODLAND CANCER CARE CENTER 05700 CT SCAN	25, 287	48, 330	1, 151	0	0	55. 01 57. 00
58. 00	05800 MRI	0				0	58.00
59. 00	05900 CARDI AC CATHETERI ZATI ON	36, 452	19, 588	1	·	0	59.00
60. 00	06000 LABORATORY	131, 960			· · ·	o o	60.00
60. 01	06001 FSED LABORATORY	23, 232	5, 880	1	0	Ö	60. 01
65. 00	06500 RESPI RATORY THERAPY	25, 699			1, 718	Ö	65. 00
66. 00	06600 PHYSI CAL THERAPY	67, 971	6, 241			0	66. 00
69. 00	06900 ELECTROCARDI OLOGY	25, 866	1			0	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	96, 703	C	0	O	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	132, 408	C	0	0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	C	0	0	0	73. 00
76. 00	03950 CV RESOURCE CENTER	166	C	0	0	0	76. 00
	OUTPATIENT SERVICE COST CENTERS	_	-				
90.00	09000 CLINIC	0		0	0	0	90.00
90. 01 90. 02	09001 OB CLINIC 09002 PAIN MANAGEMENT	66		0	0	0	90. 01 90. 02
90. 02	09003 I NFUSI ON OP SERVI CES	10, 933	6, 300	35	1, 256		90.02
	09004 MATERNAL HEA	10, 733			l	0	90. 04
	09100 EMERGENCY	107, 410		1		-	1
91. 01	09101 FREE STANDING EMERGENCY DEPT	46, 949				0	91. 01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART					I	92.00
	SPECIAL PURPOSE COST CENTERS						
118.00	<u> </u>	1, 972, 304	1, 144, 957	109, 315	251, 759	296, 653	118. 00
	NONREI MBURSABLE COST CENTERS	1					
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	421	4, 455	0	1, 258		190. 00
	07950 RETAIL PHARMACY	0		0	0		194. 00
	07951 WORKI NG WELL	79, 782		0	0		194. 01 194. 02
	07952 APS DUNELAND SURG ASSOC 07953 MED WATCH	2, 599	27 400	3 0	0		194. 02
	107954 OCCUPATIONAL MED CENTER	2, 399	27, 498		0		194. 03
	07955 PHYSI CI AN PRACTI CE	0	7				194. 05
	07956 DENTAL SERVICES	0					194. 06
	07957 DUNELAND MED WATCH	0	ĺ		0		194. 07
	07958 WESTVILLE CLNIC			ol o			194. 08
	07959 ORTHOPEDI CS	0	l c	0	О	0	194. 09
	07960 WOMEN SERVICES	1, 942	20, 547	' O	0	0	194. 10
	07961 DUNELAND FITNESS CENTER	739) o	0	0	194. 11
	07962 CARDI OLOGY ASSOC	0	[c	0	0		194. 12
	07963 DUNELAND FAMILY PRACTICE	0	[C	0	0		194. 13
	07964 ORTHOPEDI CS	0	C	0	0		194. 14
	07965 OTHER NONREIMBURSABLE COST CENTERS	0	C	0	0		194. 15
	07966 PHYSICIAN PRACTICE MD WISE	147, 697	C	0	이		194. 16
	(07967 ENT	0	2	0	0		194. 17
194. 18	07968 SLEEP CLINIC	0	l C	0	<u> </u> 0	0	194. 18

Health Financial Systems	FRANCISCAN ST ANTHONY-M	ICHIGAN CITY	In Lie	u of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 150015	From 01/01/2014	Worksheet B Part II Date/Time Prepared: 5/28/2015 9:57 am

				1		5/28/2015 9:5	7 am
							7 alli
	Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		& GENERAL	PLANT	LINEN SERVICE			
		5. 00	7. 00	8. 00	9. 00	10.00	
194. 19 07969	HEALTH PARTNERS	179	0	5, 754	0	0	194. 19
194. 20 07970	CENTER OF HOPE	433	0	0	0	0	194. 20
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201. 00
202.00	TOTAL (sum lines 118-201)	2, 206, 096	1, 197, 457	115, 069	253, 017	296, 653	202. 00

Health Financial Systems In Lieu of Form CMS-2552-10 FRANCISCAN ST ANTHONY-MICHIGAN CITY ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 150015 Peri od: Worksheet B From 01/01/2014 Part II Date/Time Prepared: 12/31/2014 5/28/2015 9:57 am Cost Center Description CAFETERI A NURSI NG CENTRAL **PHARMACY** MEDI CAL RECORDS & SERVICES & ADMI NI STRATI ON SUPPLY LI BRARY 11. 00 13.00 15.00 14.00 16,00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 00700 OPERATION OF PLANT 7.00 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 00900 HOUSEKEEPI NG 9.00 9 00 10.00 01000 DI ETARY 10.00 11.00 01100 CAFETERI A 26,097 11.00 01300 NURSING ADMINISTRATION 997 218, 195 13.00 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 724 302, 145 14 00 15.00 01500 PHARMACY 881 275, 557 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 0 114, 273 16.00 817 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 5.897 75, 530 0 6,675 30.00 03100 INTENSIVE CARE UNIT 0 0 31.00 1, 165 21, 209 1, 188 31.00 04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF 0 0 40.00 849 7, 882 800 40.00 0 41.00 889 8, 293 1, 339 41 00 43.00 04300 NURSERY 0 0 279 43.00 04400 SKILLED NURSING FACILITY 0 0 44.00 44.00 0 0 04500 NURSING FACILITY 0 45.00 0 45.00 0 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 3,725 40, 113 0 0 23, 514 50.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 0 0 499 52.00 0 53 00 05300 ANESTHESI OLOGY 49 970 53 00 |05400| RADI OLOGY-DI AGNOSTI C 1, 792 0 54.00 3, 214 15,026 54.00 0 05401 FSED RADIOLOGY - DIAGNOSTIC 435 2,828 54.01 54.01 0 55.00 05500 RADI OLOGY-THERAPEUTI C 367 0 0 2,856 55.00 05501 WOODLAND CANCER CARE CENTER 0 55.01 388 C 522 55.01 57.00 05700 CT SCAN 0 0 57.00 0 58.00 05800 MRI 0 0 0 58.00 59 00 05900 CARDIAC CATHETERIZATION 449 4.345 0 3 471 59 00 06000 LABORATORY 0 60.00 0 10, 389 60.00 0 06001 FSED LABORATORY 0 0 1, 102 60.01 C 60.01 0 06500 RESPIRATORY THERAPY 65.00 716 0 2, 108 65.00 06600 PHYSI CAL THERAPY O 3, 111 66 00 1 192 88 66 00 69.00 06900 ELECTROCARDI OLOGY 523 3,053 0 0 2,881 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 129, 126 0 3, 635 71.00 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 173, 019 0 3, 071 72.00 07300 DRUGS CHARGED TO PATIENTS 0 275, 557 73.00 Ω 0 16, 476 73.00 76.00 03950 CV RESOURCE CENTER 0 0 76.00 0 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 90.00 С 0 0 90.01 09001 OB CLINIC 0 C 0 0 90.01 90.02 09002 PAIN MANAGEMENT 0 0 0 0 90.02 90 03 09003 INFUSION OP SERVICES 135 4, 198 0 0 590 90 03 0 0 09004 MATERNAL HEA 90.04 90.04 0 09100 EMERGENCY 0 91.00 2.047 41, 302 0 8.817 91.00 09101 FREE STANDING EMERGENCY DEPT 0 91.01 91.01 692 2, 126 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1-117) 24, 732 209, 227 302, 145 275, 557 114, 273 118. 00 NONREIMBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190, 00 0 0 0 194.00 194. 00 07950 RETAIL PHARMACY 0 194. 01 07951 WORKING WELL 0 0 194. 01 1,310 8, 337 0 0 0 0 0 0 0 0 0 0 0 0 0 194. 02 07952 APS DUNELAND SURG ASSOC 0 0 194. 02 194. 03 07953 MED WATCH 0 0 194, 03 0 0 194. 04 07954 OCCUPATIONAL MED CENTER 0 0 C 0 194. 04 194. 05 07955 PHYSICIAN PRACTICE 0 194. 05 000000000000 194.06 07956 DENTAL SERVICES 0 0 0 194.06 194. 07 07957 DUNELAND MED WATCH 0 nl194.07 C 194. 08 07958 WESTVILLE CLNIC 0 194. 08 194. 09 07959 ORTHOPEDI CS 0 0 194. 09 194. 10 07960 WOMEN SERVICES 0 0 0 194, 10 194. 11 07961 DUNELAND FITNESS CENTER 0 194. 11 0 0 194. 12 07962 CARDI OLOGY ASSOC 0 0 0 194. 12

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0 194. 16

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194. 17 07967 ENT

194. 14 07964 ORTHOPEDI CS

194. 13 07963 DUNELAND FAMILY PRACTICE

194. 16 07966 PHYSICIAN PRACTICE MD WISE

194. 15 07965 OTHER NONREIMBURSABLE COST CENTERS

Heal th Financ	al Systems	FRANCISCAN ST ANTHONY-M	ICHIGAN CITY		In Lie	u of Form CMS-2552-10
ALLOCATION OF	CAPITAL RELATED COSTS		Provi der CCN:	150015		Worksheet B
					From 01/01/2014	Part II Date/Time Prepared

					To 12/31/2014	Date/Time Pre 5/28/2015 9:5	
	Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
			ADMI NI STRATI ON	SERVICES &		RECORDS &	
				SUPPLY		LI BRARY	
		11. 00	13. 00	14. 00	15. 00	16.00	
194. 18 07968	SLEEP CLINIC	0	0	(0	0	194. 18
194. 19 07969	HEALTH PARTNERS	0	616	(0	0	194. 19
194. 20 07970	CENTER OF HOPE	10	15	(0	0	194. 20
200.00	Cross Foot Adjustments						200.00
201. 00	Negative Cost Centers	0	0	(0	0	201.00
202.00	TOTAL (sum lines 118-201)	26, 097	218, 195	302, 145	275, 557	114, 273	202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2014 | Part II | To 12/31/2014 | Date/Time Prepared: | Peri od:
				'	o 12/31/2014 Date/lime Pr 5/28/2015 9:	
	Cost Center Description	Subtotal	Intern &	Total		
			Residents Cost			
			& Post Stepdown			
			Adjustments			
		24. 00	25. 00	26. 00		
	ERAL SERVICE COST CENTERS					4 00
	00 CAP REL COSTS-BLDG & FLXT 00 CAP REL COSTS-MVBLE EQUIP					1.00
	OO EMPLOYEE BENEFITS DEPARTMENT					4. 00
	OO ADMINISTRATIVE & GENERAL					5. 00
	OO OPERATION OF PLANT					7. 00
8.00 008	OO LAUNDRY & LINEN SERVICE					8. 00
	00 HOUSEKEEPI NG					9. 00
1	OO DI ETARY					10. 00
	OO CAFETERI A					11.00
	00 NURSING ADMINISTRATION 00 CENTRAL SERVICES & SUPPLY					13. 00
	OO PHARMACY					15. 00
	00 MEDICAL RECORDS & LIBRARY					16. 00
	ATIENT ROUTINE SERVICE COST CENTERS		l			
30. 00 030	00 ADULTS & PEDIATRICS	2, 253, 582	0	2, 253, 582		30. 00
	00 INTENSIVE CARE UNIT	414, 954	0	414, 954		31. 00
	00 SUBPROVI DER - I PF	260, 479	0	260, 479		40. 00
	00 SUBPROVI DER – I RF	400, 869	0	400, 869		41. 00
	00 NURSERY 00 SKILLED NURSING FACILITY	36, 809 0	0 0	36, 809 (43. 00 44. 00
	OO NURSING FACILITY	0	0	(45. 00
	I LLARY SERVI CE COST CENTERS	<u> </u>	<u> </u>		/	45.00
	OO OPERATING ROOM	2, 038, 945	0	2, 038, 945	5	50.00
52. 00 052	OO DELIVERY ROOM & LABOR ROOM	215, 818	o	215, 818	3	52. 00
	00 ANESTHESI OLOGY	27, 493	0	27, 493		53. 00
	00 RADI OLOGY-DI AGNOSTI C	2, 519, 139	0	2, 519, 139		54.00
	01 FSED RADI OLOGY - DI AGNOSTI C	95, 616	0	95, 616		54. 01
	00 RADI OLOGY-THERAPEUTI C 01 WOODLAND CANCER CARE CENTER	333, 541 297, 689	0	333, 541 297, 689		55. 00 55. 01
	00 CT SCAN	247,009	o	297,009		57. 00
	00 MRI	0	o	(58. 00
	OO CARDI AC CATHETERI ZATI ON	589, 139	o	589, 139		59. 00
60.00 060	00 LABORATORY	385, 755	O	385, 755	5	60.00
	01 FSED LABORATORY	57, 076	0	57, 076		60. 01
	00 RESPI RATORY THERAPY	98, 095	0	98, 095		65. 00
	00 PHYSI CAL THERAPY 00 ELECTROCARDI OLOGY	119, 866	0	119, 866		66. 00 69. 00
	OO MEDICAL SUPPLIES CHARGED TO PATIENT	230, 397 229, 464	0	230, 397 229, 464		71. 00
	OO IMPL. DEV. CHARGED TO PATIENTS	308, 498	o	308, 498		72.00
1	OO DRUGS CHARGED TO PATIENTS	292, 033	o	292, 033		73. 00
	50 CV RESOURCE CENTER	182	0	182		76. 00
	PATIENT SERVICE COST CENTERS				1	
	OO CLINIC	0	0	(90.00
1	O1 OB CLINIC	3, 238	0			90. 01
1	02 PAIN MANAGEMENT 03 INFUSION OP SERVICES	0 52, 861	0	52, 861		90. 02
	04 MATERNAL HEA	52, 601 N	0	52, 60 1		90. 03
	OO EMERGENCY	1, 599, 800	o	1, 599, 800		91.00
	01 FREE STANDING EMERGENCY DEPT	595, 108	o	595, 108		91. 01
92. 00 092	OO OBSERVATION BEDS (NON-DISTINCT PART		0			92. 00
	CIAL PURPOSE COST CENTERS					
118. 00	SUBTOTALS (SUM OF LINES 1-117)	13, 456, 446	0	13, 456, 446	o l	118. 00
	REIMBURSABLE COST CENTERS OO GIFT, FLOWER, COFFEE SHOP & CANTEEN	26, 487	٥	24 497	7	190. 00
	50 RETAIL PHARMACY	20, 467	0	26, 487		194. 00
	51 WORKI NG WELL	316, 315	Ö	316, 315		194. 01
1	52 APS DUNELAND SURG ASSOC	0	Ö	(194. 02
	53 MED WATCH	155, 730	О	155, 730		194. 03
	54 OCCUPATIONAL MED CENTER	0	0	C		194. 04
	55 PHYSI CI AN PRACTI CE	0	0	C		194. 05
	56 DENTAL SERVICES	0	0	(194. 06
	157 DUNELAND MED WATCH 158 WESTVILLE CLNIC	0	0	(194. 07 194. 08
	58 WESTVILLE CLINIC 59 ORTHOPEDICS	0	0	(á	194. 08
	60 WOMEN SERVICES	116, 363	0	116, 363	3	194. 10
1	61 DUNELAND FITNESS CENTER	38, 385	o	38, 385		194. 11
1	62 CARDI OLOGY ASSOC	0	o	(194. 12
	63 DUNELAND FAMILY PRACTICE	0	0	C		194. 13
	64 ORTHOPEDICS	0	0	(194. 14
194. 15 079	65 OTHER NONREIMBURSABLE COST CENTERS	0	0	C	/	194. 15

Health Financial Systems	FRANCISCAN ST ANTHONY-MICHIGAN CITY	In Lie	n Lieu of Form CMS-2552-10	
ALLOCATION OF CAPITAL RELATED COSTS	Provi der CCN: 150015	Peri od: From 01/01/2014	Worksheet B	

			-	To 12/31/2014	Date/Time Prepared: 5/28/2015 9:57 am
Cost Center Description	Subtotal	Intern &	Total		
		Residents Cost			
		& Post			
		Stepdown			
		Adjustments			
	24. 00	25. 00	26.00		
194.16 07966 PHYSICIAN PRACTICE MD WISE	147, 869	0	147, 869	9	194. 16
194. 17 07967 ENT	0	0	(O	194. 17
194. 18 07968 SLEEP CLINIC	0	0	(O	194. 18
194. 19 07969 HEALTH PARTNERS	14, 099	0	14, 09	9	194. 19
194. 20 07970 CENTER OF HOPE	491	0	49	1	194. 20
200.00 Cross Foot Adjustments	0	0	(O	200. 00
201.00 Negative Cost Centers	0	0	(0	201. 00
202.00 TOTAL (sum lines 118-201)	14, 272, 185	O	14, 272, 18	5	202. 00

	ALLOCATION - STATISTICAL BASIS	ICI SCAN SI ANTI		CCN: 150015 F	Peri od:	Worksheet B-1	
				F	From 01/01/2014 o 12/31/2014	. Date/Time Pre	pared:
		OADLTAL DE	ATER COSTS			5/28/2015 9:5	
		CAPITAL RE	LATED COSTS				
	Cost Center Description	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Reconciliation	ADMI NI STRATI VE	
	·	(SQUARE FEET)	(DOLLAR VALUE)			& GENERAL	
				DEPARTMENT		(ACCUM. COST)	
				(GROSS SALARI ES)			
		1. 00	2.00	4. 00	5A	5. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT	376, 144					1.00
2. 00 4. 00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT	3, 625	6, 464, 606 14, 522				2. 00 4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	60, 422	· ·			106, 640, 305	5. 00
7. 00	00700 OPERATION OF PLANT	47, 334				7, 295, 129	1
8.00	00800 LAUNDRY & LINEN SERVICE	4, 179	l e	· ·	-	474, 491	
9.00	00900 HOUSEKEEPI NG	6, 861				1, 923, 524	
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	10, 095	16, 934	321, 240 728, 158		813, 510 895, 347	
13. 00	01300 NURSING ADMINISTRATION	1, 707	120, 439			2, 211, 325	
14. 00	01400 CENTRAL SERVICES & SUPPLY	6, 602				1, 530, 458	
15.00	01500 PHARMACY	2, 693	2, 244	1, 386, 762	2 0	9, 591, 726	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	2, 924	5, 366	658, 904	l 0	1, 287, 613	16. 00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	60, 030	114 744	5, 806, 321	1 0	0 454 722	20 00
30. 00 31. 00	03100 I NTENSI VE CARE UNI T	5, 897				9, 454, 722 2, 528, 043	
40. 00	04000 SUBPROVI DER - I PF	6, 260				1, 596, 241	
41.00	04100 SUBPROVI DER - I RF	11, 330				1, 375, 722	1
43.00	04300 NURSERY	899		349, 594	0	557, 543	1
44. 00	04400 SKILLED NURSING FACILITY	0		C	-	0	
45. 00	04500 NURSING FACILITY ANCILLARY SERVICE COST CENTERS	0	0	<u> </u>) 0	0	45. 00
50. 00	05000 OPERATI NG ROOM	18, 911	1, 257, 364	4, 077, 388	3 0	8, 460, 803	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	7, 212		1		1, 114, 908	1
53.00	05300 ANESTHESI OLOGY	546				116, 153	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	18, 109		1		5, 899, 545	
54. 01 55. 00	05401 FSED RADI OLOGY - DI AGNOSTI C 05500 RADI OLOGY - THERAPEUTI C	2, 865	l .	557, 110		915, 999	
55. 00	05501 WOODLAND CANCER CARE CENTER	8, 956 10, 686				1, 955, 021 1, 222, 346	1
57. 00	05700 CT SCAN	0,000	l .	337,000		0	
58. 00	05800 MRI	0	0	c	0	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	4, 331		1	0	1, 762, 071	
60.00	06000 LABORATORY 06001 FSED LABORATORY	8, 979		1		6, 378, 900	
60. 01 65. 00	06500 RESPIRATORY THERAPY	1, 300 2, 003	l e	_		1, 123, 010 1, 242, 264	
66. 00	06600 PHYSI CAL THERAPY	1, 380		1		3, 285, 666	
69.00	06900 ELECTROCARDI OLOGY	5, 534		1		1, 250, 368	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0		C	0	4, 674, 558	
72.00		0	0	C	0	6, 400, 550	
	07300 DRUGS CHARGED TO PATIENTS 03950 CV RESOURCE CENTER		0	5, 949		0 8, 031	1
70.00	OUTPATIENT SERVICE COST CENTERS		0	J, 747	,	0,031	70.00
90. 00	09000 CLI NI C	0	0	C	0	0	90.00
90. 01	1	0	3, 155	C	0	3, 172	
90. 02		1 202	0	170 510	0	0	90. 02
90. 03 90. 04	09003 INFUSION OP SERVICES 09004 MATERNAL HEA	1, 393		173, 510		528, 504 0	90.03
91. 00	09100 EMERGENCY	20, 092	_	2, 660, 524	í	5, 192, 167	
91. 01	09101 FREE STANDING EMERGENCY DEPT	21, 381		999, 649		2, 269, 506	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
110 0	SPECIAL PURPOSE COST CENTERS	2/4 50/	/ 100 015	20 1/2 047	2/ 072 /47	0E 220 021	110 00
118. 00	SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS	364, 536	6, 198, 015	38, 163, 947	-26, 972, 617	95, 338, 936	1118.00
190. 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	985	0	C	0	20, 353	190. 00
	07950 RETAIL PHARMACY	0	0	c	-	l .	194. 00
	1 07951 WORKI NG WELL	0		1, 807, 587	' O	3, 856, 607	
	2 07952 APS DUNELAND SURG ASSOC	0 000	_	C	0		194. 02
	3 07953 MED WATCH 4 07954 0CCUPATIONAL MED CENTER	6, 080				125, 633	194. 03
	5 07955 PHYSICIAN PRACTICE		n n			l .	194. 04
	07755 THISTOTAL TRACTICES		Ö	ıl c		l .	194. 06
194. 0	7 07957 DUNELAND MED WATCH	0	0	C) 0	0	194. 07
	3 07958 WESTVILLE CLNIC	0	0	C	0	1	194. 08
	9 07959 0RTHOPEDICS 07960 WOMEN_SERVICES	0	_		0	0 02 974	
	0/0/960 WOMEN SERVICES 1/07961 DUNELAND FITNESS CENTER	4, 543	l .				194. 10 194. 11
	2 07962 CARDI OLOGY ASSOC						194. 11
	3 07963 DUNELAND FAMILY PRACTICE	0	1	d			194. 13

COST ALLOCATION - STATISTICAL BASIS	0100/11 01 /111111		CCN: 150015	Period: From 01/01/2014	Worksheet B-1	
				To 12/31/2014	Date/Time Pre 5/28/2015 9:5	pared: 7 am
	CAPITAL REL	LATED COSTS				
Cost Center Description	,	MVBLE EQUIP (DOLLAR VALUE)	DEPARTMENT (GROSS SALARI ES)		ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	1. 00	2. 00	4. 00	5A	5. 00	
194. 14 07964 ORTHOPEDI CS	0	0		0		194. 14
194. 15 07965 OTHER NONREIMBURSABLE COST CENTERS	0	0		0		194. 15
194.16 07966 PHYSICIAN PRACTICE MD WISE	0	0	56, 84	0	7, 139, 598	1
194. 17 07967 ENT	0	0		0		194. 17
194. 18 07968 SLEEP CLINIC	0	0		0		194. 18
194. 19 07969 HEALTH PARTNERS	0	7, 509		0		194. 19
194. 20 07970 CENTER OF HOPE	0	0	14, 58	9 0		194. 20
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)	7, 772, 399	6, 499, 786	13, 496, 70	0	26, 972, 617	202. 00
203.00 Unit cost multiplier (Wkst. B, Part I)	20. 663360	1. 005442	0. 33705	5	0. 252931	203. 00
204.00 Cost to be allocated (per Wkst. B, Part II)			89, 50	6	2, 206, 096	204. 00
205.00 Unit cost multiplier (Wkst. B, Part			0. 00223	5	0. 020687	205. 00

COST A	LLOCATION - STATISTICAL BASIS		Provi der	CCN: 150015 F	Peri od:	Worksheet B-1	2332-10
					From 01/01/2014 o 12/31/2014	Date/Time Pre	pared:
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	5/28/2015 9: 5 CAFETERI A	7 am
		PLANT	LINEN SERVICE		(MEALS SERVED)	(FTE'S)	
		(SQUARE FEET)	(POUNDS OF LAUNDRY)				
		7. 00	8.00	9. 00	10.00	11. 00	
1. 00	GENERAL SERVICE COST CENTERS OO100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-BUBB & TTXT						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMI NI STRATI VE & GENERAL	2/4 7/2					5.00
7. 00 8. 00	OO7OO OPERATION OF PLANT OO8OO LAUNDRY & LINEN SERVICE	264, 763 4, 179					7. 00 8. 00
9. 00	00900 HOUSEKEEPI NG	6, 861					9. 00
10.00	01000 DI ETARY	10, 095	292			F2 020	10.00
11. 00 13. 00	01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON	1, 707	0	4, 657 3, 080		52, 830 2, 018	11. 00 13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	6, 602	l .	3, 575		1, 466	ı
15.00	01500 PHARMACY	2, 693		2, 385		1, 783	
16. 00	01600 MEDICAL RECORDS & LIBRARY NPATIENT ROUTINE SERVICE COST CENTERS	2, 924	0	4, 937	/ O	1, 654	16. 00
	03000 ADULTS & PEDIATRICS	60, 030				11, 938	30.00
31.00	03100 NTENSI VE CARE UNI T	5, 897				2, 359	
40.00	04000 SUBPROVI DER - PF 04100 SUBPROVI DER - RF	6, 260 11, 330				1, 719 1, 799	
43. 00	04300 NURSERY	899				0	1
44. 00		0	_	C	1	0	44.00
45. 00	04500 NURSING FACILITY ANCILLARY SERVICE COST CENTERS	0	0		0	0	45. 00
50. 00	05000 OPERATING ROOM	18, 911	38, 696	31, 982	2 0	7, 540	50.00
	05200 DELIVERY ROOM & LABOR ROOM	7, 212				0	
53.00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	546 18, 109	l .	450 13, 203		100 3, 628	•
54. 00	05400 RADI OLOGY - DI AGNOSTI C	2, 865	1	13, 203		3, 028 880	•
55. 00	05500 RADI OLOGY-THERAPEUTI C	8, 956	365		o	743	55.00
55. 01 57. 00	05501 WOODLAND CANCER CARE CENTER	10, 686	7, 301			786	•
57.00	05700 CT SCAN 05800 MRI		0			0	
59. 00	05900 CARDI AC CATHETERI ZATI ON	4, 331				908	59. 00
60.00	06000 LABORATORY	8, 979	l .	8, 105		0	
60. 01 65. 00	06001 FSED LABORATORY 06500 RESPI RATORY THERAPY	1, 300 2, 003	l .	1, 345	1	0 1, 449	60. 01 65. 00
66. 00	06600 PHYSI CAL THERAPY	1, 380		2, 585	0	2, 413	•
69. 00	06900 ELECTROCARDI OLOGY	5, 534	3, 651	3, 239	0	1, 058	•
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS		0			0	71. 00 72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	Ō	d	o	0	
76. 00	03950 CV RESOURCE CENTER OUTPATIENT SERVICE COST CENTERS	0	0) 0	6	76. 00
90. 00	09000 CLINIC	1 0	0		ol	0	90.00
90. 01	09001 OB CLINIC	0	0	C	o	0	90. 01
90. 02	09002 PALN MANAGEMENT	1 202	0	003	0	0	
90. 03 90. 04	09003 INFUSION OP SERVICES 09004 MATERNAL HEA	1, 393	219	983		274 0	
91. 00	09100 EMERGENCY	20, 092	73, 011	17, 135	5 0	4, 144	91.00
	09101 FREE STANDING EMERGENCY DEPT	21, 381	29, 204	C	0	1, 400	91. 01
92.00	O9200 OBSERVATION BEDS (NON-DISTINCT PART SPECIAL PURPOSE COST CENTERS						92.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	253, 155	693, 604	197, 106	107, 944	50, 065	118. 00
100.00	NONREI MBURSABLE COST CENTERS	0.00	1 0	1 005	- 0		100.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 07950 RETAIL PHARMACY	985	0	985			190. 00 194. 00
	07951 WORKI NG WELL		Ö				194. 01
	07952 APS DUNELAND SURG ASSOC	0 0	0	(194. 02
	07953 MED WATCH 07954 OCCUPATIONAL MED CENTER	6, 080	0		1		194. 03 194. 04
	07955 PHYSI CI AN PRACTI CE		Ö		o o		194. 05
	07956 DENTAL SERVICES	0	0	C			194. 06
	07957 DUNELAND MED WATCH 07958 WESTVI LLE CLNI C		0				194. 07 194. 08
	07959 ORTHOPEDI CS		Ö		o o		194. 09
	07960 WOMEN SERVICES	4, 543	0	(194. 10
	07961 DUNELAND FITNESS CENTER 07962 CARDI OLOGY ASSOC		0				194. 11 194. 12
	07963 DUNELAND FAMILY PRACTICE		Ö				194. 12
	07964 ORTHOPEDICS	0	0	C			194. 14
	07965 OTHER NONREIMBURSABLE COST CENTERS 07966 PHYSICIAN PRACTICE MD WISE	0	0				194. 15 194. 16
. , , , , ,		1		1	·,	72	1 10

Heal th Financial	Systems FR	ANCISCAN ST ANTHONY	-MICHIGAN CI	ΙΤΥ	In Lie	u of Form CMS-	2552-10
COST ALLOCATION	- STATISTICAL BASIS		Provi der		Peri od:	Worksheet B-1	
					From 01/01/2014 To 12/31/2014	Date/Time Pre	nared·
					10 12/01/2011	5/28/2015 9:5	
Cost	Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI N	G DIFTARY	CAFETERIA	

				'	0 12/31/2014	5/28/2015 9:5	
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
	·	PLANT	LINEN SERVICE	(SQUARE FEET)	(MEALS SERVED)	(FTE' S)	
		(SQUARE FEET)	(POUNDS OF				
			LAUNDRY)				
		7. 00	8. 00	9. 00	10.00	11. 00	
194. 17	07967 ENT	0	0	0	0	0	194. 17
194. 18	07968 SLEEP CLINIC	0	0	0	0	0	194. 18
194. 19	07969 HEALTH PARTNERS	0	36, 506	0	0	0	194. 19
194. 20	07970 CENTER OF HOPE	0	0	0	0	21	194. 20
200.00	Cross Foot Adjustments						200. 00
201.00	Negative Cost Centers						201. 00
202.00	Cost to be allocated (per Wkst. B,	9, 140, 293	738, 774	2, 646, 902	1, 449, 460	1, 184, 035	202. 00
	Part I)						
203.00	Unit cost multiplier (Wkst. B, Part I)	34. 522547	1. 011867	13. 362051	13. 427889	22. 412171	203. 00
204.00	Cost to be allocated (per Wkst. B,	1, 197, 457	115, 069	253, 017	296, 653	26, 097	204. 00
	Part II)						
205.00	Unit cost multiplier (Wkst. B, Part	4. 522751	0. 157605	1. 277277	2. 748212	0. 493981	205. 00
	11)						

		NCISCAN ST ANTHO				u of Form CMS-2552-10
COST	ALLOCATION - STATISTICAL BASIS		Provi der	CCN: 150015	Period: From 01/01/2014	Worksheet B-1
					To 12/31/2014	Date/Time Prepared: 5/28/2015 9:57 am
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	372072013 9.37 dill
		ADMI NI STRATI ON	SERVICES &	(COSTED	RECORDS &	
		(DI DECT NDC	SUPPLY	REQUI S.)	LI BRARY	
		(DI RECT NRS I NG)	(COSTED REQUIS.)		(GROSS CHAR GES)	
		13.00	14. 00	15. 00	16.00	
	GENERAL SERVICE COST CENTERS					
1. 00 2. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP					1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500 ADMINISTRATIVE & GENERAL					5. 00
7. 00	00700 OPERATION OF PLANT					7. 00
8. 00 9. 00	00800 LAUNDRY & LINEN SERVICE					8. 00 9. 00
10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY					10.00
11. 00	01100 CAFETERI A					11. 00
13. 00	01300 NURSING ADMINISTRATION	14, 866				13. 00
14. 00 15. 00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	0	11, 177, 347	10	0	14.00
16. 00	01600 MEDI CAL RECORDS & LI BRARY	0	ol Ol	10	0 489, 971, 391	15. 00 16. 00
10.00	INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>	<u> </u>		0 107, 771, 071	10.00
30. 00	03000 ADULTS & PEDIATRICS	5, 146	0	1	0 28, 649, 589	30.00
31.00	03100 NTENSI VE CARE UNI T	1, 445	0		5, 099, 700	
40. 00 41. 00	04000 SUBPROVI DER	537 565	0		0 3, 435, 072 0 5, 745, 384	40.00
43. 00	04300 NURSERY	0	o		0 1, 195, 306	43.00
44.00	04400 SKILLED NURSING FACILITY	0	o		0	44. 00
45. 00	04500 NURSING FACILITY	0	0		0 0	45. 00
50. 00	ANCILLARY SERVICE COST CENTERS O5000 OPERATING ROOM	2, 733	ol		0 100, 450, 321	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	2, 733	ol		0 2, 143, 335	52.00
53. 00	05300 ANESTHESI OLOGY	0	ō		0 4, 162, 036	
54.00	05400 RADI OLOGY-DI AGNOSTI C	219	0		0 64, 487, 813	54. 00
54. 01	05401 FSED RADI OLOGY - DI AGNOSTI C	0	0		0 12, 137, 966	54. 01
55. 00 55. 01	O5500 RADI OLOGY-THERAPEUTI C O5501 WOODLAND CANCER CARE CENTER	0	0		0 12, 256, 499 0 2, 239, 047	55. 00 55. 01
57. 00	05700 CT SCAN	0	o		0 0	57. 00
58. 00	05800 MRI	0	О		0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	296	0		0 14, 896, 125	59.00
60. 00 60. 01	O6000 LABORATORY O6001 FSED LABORATORY	0	0		0 44, 586, 430 0 4, 728, 706	
65. 00	06500 RESPIRATORY THERAPY		0		9, 048, 219	
66. 00	06600 PHYSI CAL THERAPY	6	ō		0 13, 351, 095	
69. 00	06900 ELECTROCARDI OLOGY	208	0		0 12, 366, 420	
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	0	4, 776, 798		0 15, 602, 638 0 13 182 196	
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	6, 400, 549 0	10	.0, .02, .70	
	03950 CV RESOURCE CENTER	0	o		0 0	
	OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0	0		0	90.00
90. 01 90. 02	09001 OB CLINIC 09002 PAIN MANAGEMENT	0	0		0	90. 01
90. 02	09003 I NFUSI ON OP SERVI CES	286	o		0 2, 531, 174	90. 02
90. 04	09004 MATERNAL HEA	0	o		0	90. 04
91.00	09100 EMERGENCY	2, 814	0		0 37, 842, 576	
91. 01	09101 FREE STANDING EMERGENCY DEPT 09200 OBSERVATION BEDS (NON-DISTINCT PART	O	0		9, 122, 668	91. 01
92.00	SPECIAL PURPOSE COST CENTERS					72.00
118.00		14, 255	11, 177, 347	10	0 489, 971, 391	118. 00
400.00	NONREI MBURSABLE COST CENTERS	1	al			400.00
	1900 GIFT, FLOWER, COFFEE SHOP & CANTEEN 07950 RETAIL PHARMACY	0	0		0 0	
	07950 RETAIL PHARMACT	568	0		0 0	194. 00
	07952 APS DUNELAND SURG ASSOC	0	Ö		0 0	194. 02
	07953 MED WATCH	0	O		0	194. 03
	07954 OCCUPATIONAL MED CENTER	0	0		0	194. 04
	07955 PHYSI CI AN PRACTI CE 07956 DENTAL SERVI CES	0	0		0	194. 05 194. 06
	07957 DUNELAND MED WATCH		o		0 0	194. 07
194. 08	07958 WESTVILLE CLNIC		Ö		0 0	194. 08
	07959 ORTHOPEDI CS	0	0		0	194. 09
	07960 WOMEN SERVICES	0	0		0 0	194. 10
	07961 DUNELAND FITNESS CENTER 207962 CARDIOLOGY ASSOC		0		0	194. 11 194. 12
	07963 DUNELAND FAMILY PRACTICE		ol		o o	194. 12
194. 14	07964 ORTHOPEDI CS	0	ō		0	194. 14
194. 15	07965 OTHER NONREIMBURSABLE COST CENTERS	0	O		0 0	194. 15

a. tii i i iia	nciai systems - Fran	NCISCAN SI ANTHU	NI WII CITI OAN CI		III LIC	u oi foriii civis-2	2332-10
COST ALLOCA	TION - STATISTICAL BASIS		Provi der		Peri od: From 01/01/2014	Worksheet B-1	
					To 12/31/2014	Date/Time Prep	pared:
						5/28/2015 9:57	7 am
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL		
		ADMI NI STRATI ON	SERVICES &	(COSTED	RECORDS &		
			SUPPLY	REQUI S.)	LI BRARY		
		(DI RECT NRS	(COSTED		(GROSS CHAR		
		I NG)	REQUIS.)		GES)		
		13.00	14.00	15.00	16.00		
194. 16 0796	PHYSICIAN PRACTICE MD WISE	0	0		0 0		194. 16
194. 17 0796	7 ENT	0	0		0 0	-	194. 17
194. 18 0796	SLEEP CLINIC	0	0		0 0		194. 18
194. 19 0796	HEALTH PARTNERS	42	0		o o	-	194. 19
194. 20 0797	CENTER OF HOPE	1	0		o o	-	194. 20
200. 00	Cross Foot Adjustments						200. 00
201. 00	Negative Cost Centers						201. 00
202. 00	Cost to be allocated (per Wkst. B,	2, 915, 951	2, 226, 101	12, 182, 54	7 1, 817, 272		202. 00
	Part I)						
203. 00	Unit cost multiplier (Wkst. B, Part I)	196. 148998	0. 199162	121, 825. 47000	0. 003709		203. 00
204. 00	Cost to be allocated (per Wkst. B,	218, 195	302, 145		1	1:	204. 00
	Part II)			.,			
205. 00	Unit cost multiplier (Wkst. B, Part	14. 677452	0. 027032	2, 755. 57000	0. 000233	1:	205. 00
	[1]						

COMI	ATTON OF NATIO OF COSTS TO CHANGES		1 Tovi dei		From 01/01/2014 From 12/31/2014	Part I Date/Time Pre 5/28/2015 9:5	pared: 7 am
			Ti tl	e XVIII	Hospi tal	PPS	
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst. B,	Adj .		Di sal I owance		
		Part I, col.					
		26)					
	LABOT ENT BOUTLAG OFFICE	1.00	2.00	3. 00	4. 00	5. 00	
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	17 201 001	I	17 201 00:	1	17 201 001	20.00
30.00	03000 ADULTS & PEDIATRICS	17, 391, 801		17, 391, 80		17, 391, 801	30.00
31.00	03100 I NTENSI VE CARE UNI T	4, 019, 492		4, 019, 492		4, 024, 124	
40.00	04000 SUBPROVI DER - I PF	2, 728, 158		2, 728, 158		2, 728, 158	1
41.00	04100 SUBPROVI DER - I RF 04300 NURSERY	2, 569, 343		2, 569, 343		2, 569, 343	
43.00		747, 122		747, 122		747, 122	1
44. 00	04400 SKILLED NURSING FACILITY 04500 NURSING FACILITY	0			-	0	
45. 00	ANCI LLARY SERVICE COST CENTERS] 0) 0	0	45. 00
50. 00	05000 OPERATING ROOM	12, 797, 759	I	12, 797, 759	81, 858	12, 879, 617	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	1, 750, 197		1, 750, 19			52. 00
53. 00	05300 ANESTHESI OLOGY	188, 072		188, 072			
54. 00	05400 RADI OLOGY-DI AGNOSTI C	8, 586, 462		8, 586, 462		8, 586, 462	
54. 00	05401 FSED RADIOLOGY - DI AGNOSTI C	1, 311, 334		1, 311, 33		1, 311, 334	
55. 00	05500 RADI OLOGY - THERAPEUTI C	2, 848, 950		2, 848, 950			1
55. 01	05501 WOODLAND CANCER CARE CENTER	1, 933, 732		1, 933, 732		1, 935, 649	
57. 00	05700 CT SCAN	1, 755, 752		1, 755, 752		1, 755, 047	1
58. 00	05800 MRI	0				0	58.00
59. 00	05900 CARDI AC CATHETERI ZATI ON	2, 525, 118		2, 525, 118	ار	ľ	
60. 00	06000 LABORATORY	8, 575, 970		8, 575, 970			
60. 01	06001 FSED LABORATORY	1, 469, 472		1, 469, 472		1, 469, 472	1
65. 00	06500 RESPI RATORY THERAPY	1, 709, 627				1, 709, 630	
66. 00	06600 PHYSI CAL THERAPY	4, 325, 835				4, 325, 835	1
69. 00	06900 ELECTROCARDI OLOGY	1, 915, 025		1, 915, 025		1, 915, 025	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	6, 866, 126		6, 866, 126		6, 866, 126	1
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	9, 343, 085		9, 343, 08!		9, 343, 085	1
73. 00	07300 DRUGS CHARGED TO PATIENTS	12, 444, 814		12, 444, 814			
76. 00	03950 CV RESOURCE CENTER	10, 196		10, 196			1
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0		(0	0	90.00
90. 01	09001 OB CLINIC	3, 974		3, 97	1 0	3, 974	90. 01
90. 02	09002 PAIN MANAGEMENT	0			o	0	90. 02
90. 03	09003 INFUSION OP SERVICES	795, 254		795, 254	1 0	795, 254	90. 03
90. 04	09004 MATERNAL HEA	0			0	0	90. 04
91. 00	09100 EMERGENCY	8, 287, 087		8, 287, 08	7 0	8, 287, 087	91.00
91. 01	09101 FREE STANDING EMERGENCY DEPT	3, 676, 425		3, 676, 42!	5 0	3, 676, 425	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	2, 367, 560		2, 367, 560		2, 367, 560	
200.00		121, 187, 990	0	121, 187, 990	188, 860		
201.00	Less Observation Beds	2, 367, 560		2, 367, 560		2, 367, 560	
202.00	Total (see instructions)	118, 820, 430	0	118, 820, 430	188, 860	119, 009, 290	202. 00

COMPUTATION OF RATIO OF COSTS TO CHARGES Provi der CCN: 150015 Peri od: Worksheet C From 01/01/2014 Part I Date/Time Prepared: 12/31/2014 5/28/2015 9:57 am Title XVIII Hospi tal PPS Charges Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other TFFRA I npati ent + col . 7) Ratio Ratio 6.00 7.00 8.00 9. 00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 25, 345, 576 03000 ADULTS & PEDIATRICS 25, 345, 576 30.00 30.00 31.00 03100 INTENSIVE CARE UNIT 5, 099, 700 5, 099, 700 31.00 04000 SUBPROVIDER - IPF 3, 435, 072 3, 435, 072 40.00 40.00 41.00 04100 SUBPROVI DER - I RF 5, 745, 384 5, 745, 384 41.00 04300 NURSERY 43.00 1, 195, 306 1, 195, 306 43.00 44.00 04400 SKILLED NURSING FACILITY 44.00 45.00 04500 NURSING FACILITY 0 45 00 ANCILLARY SERVICE COST CENTERS 50 00 50 00 05000 OPERATING ROOM 25, 817, 028 74, 633, 293 100, 450, 321 0.127404 0.000000 2, 000, 681 52.00 05200 DELIVERY ROOM & LABOR ROOM 142, 654 2, 143, 335 0.816577 0.000000 52.00 53.00 05300 ANESTHESI OLOGY 1, 717, 985 2, 444, 051 4, 162, 036 0.045187 0.000000 53.00 14, 858, 184 49, 629, 629 05400 RADI OLOGY-DI AGNOSTI C 64, 487, 813 0.000000 54.00 0.133149 54.00 54.01 05401 FSED RADIOLOGY - DIAGNOSTIC 815, 479 11, 322, 487 12, 137, 966 0.108036 0.000000 54.01 55.00 05500 RADI OLOGY-THERAPEUTI C 1,076,097 11, 180, 402 12, 256, 499 0. 232444 0.000000 55.00 55.01 05501 WOODLAND CANCER CARE CENTER 26, 087 2, 212, 960 2, 239, 047 0.863641 0.000000 55.01 57 00 05700 CT SCAN 0.000000 0.000000 57 00 58.00 05800 MRI 0.000000 0.000000 58.00 05900 CARDIAC CATHETERIZATION 5, 817, 998 9, 078, 127 14, 896, 125 0.169515 0.000000 59.00 59.00 06000 LABORATORY 16, 529, 321 28, 057, 109 44, 586, 430 0.192345 0.000000 60.00 60.00 06001 FSED LABORATORY 60.01 55, 027 4, 673, 679 4, 728, 706 0. 310756 0.000000 60.01 65.00 06500 RESPIRATORY THERAPY 8,051,296 996, 923 9, 048, 219 0.188946 0.000000 65.00 06600 PHYSI CAL THERAPY 66.00 2, 267, 992 11, 083, 103 13, 351, 095 0. 324006 0.000000 66.00 69 00 06900 ELECTROCARDI OLOGY 4.844.017 7, 522, 403 12 366 420 0 154857 0.000000 69 00 |07100|MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 7,011,910 8, 590, 728 15, 602, 638 0.440062 0.000000 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 8, 479, 779 4, 702, 417 13, 182, 196 0.708765 0.000000 72.00 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 26, 428, 291 44, 282, 785 70, 711, 076 0.175995 0.000000 73.00 03950 CV RESOURCE CENTER 76.00 0.000000 0.000000 76.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 0 0.000000 0.000000 90.00 90 01 09001 OB CLINIC 0 Ω 0 0.000000 0.000000 90 01 09002 PAIN MANAGEMENT 90.02 Ω 0.000000 0.000000 90.02 90.03 09003 INFUSION OP SERVICES 1,004,225 1, 526, 949 2, 531, 174 0.314184 0.000000 90.03 90.04 09004 MATERNAL HEA 0.000000 0.000000 90.04 91 00 09100 EMERGENCY 8, 313, 096 29, 529, 480 37, 842, 576 0 218988 0.000000 91 00 1,000,768 91.01 09101 FREE STANDING EMERGENCY DEPT 8, 121, 900 9, 122, 668 0.402999 0.000000 91.01 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 455, 043 2, 848, 970 3, 304, 013 0.716571 0.000000 92.00 200.00 Subtotal (see instructions) 177, 391, 342 312, 580, 049 489, 971, 391 200.00 201 00 201.00 Less Observation Beds 202.00 Total (see instructions) 177, 391, 342 312, 580, 049 489, 971, 391 202.00

		Title XVIII	Hospi tal	PPS	<i>7</i> aiii
Cost Center Description	PPS Inpatient	THE SAVIET	nospi tui	110	
5551 551151 55551 Ft 1511	Ratio				
	11. 00				
INPATIENT ROUTINE SERVICE COST CENTERS	1				
30. 00 03000 ADULTS & PEDI ATRI CS					30.00
31.00 03100 INTENSIVE CARE UNIT					31.00
40. 00 04000 SUBPROVI DER - 1 PF					40.00
41. 00 04100 SUBPROVI DER - RF					41.00
43. 00 04300 NURSERY					43.00
44.00 04400 SKILLED NURSING FACILITY					44. 00
45.00 04500 NURSING FACILITY					45. 00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	0. 128219				50. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 816577				52.00
53. 00 05300 ANESTHESI OLOGY	0. 045731				53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 133149				54.00
54. 01 05401 FSED RADI OLOGY - DI AGNOSTI C	0. 108036				54. 01
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 234662				55. 00
55. O1 05501 WOODLAND CANCER CARE CENTER	0. 864497				55. 01
57. 00 05700 CT SCAN	0. 000000				57.00
58. 00 05800 MRI	0. 000000				58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 171967				59. 00
60. 00 06000 LABORATORY	0. 193118				60.00
60. 01 06001 FSED_LABORATORY	0. 310756				60. 01
65. 00 06500 RESPIRATORY THERAPY	0. 188947				65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 324006				66. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 154857				69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 440062				71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 708765				72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 175995				73. 00
76. 00 03950 CV RESOURCE CENTER	0. 000000				76. 00
OUTPATIENT SERVICE COST CENTERS	, , , , , , , , , , , , , , , , , , , ,				
90. 00 09000 CLI NI C	0. 000000				90.00
90. 01 09001 0B CLINIC	0. 000000				90. 01
90. 02 09002 PAIN MANAGEMENT	0. 000000				90. 02
90. 03 09003 I NFUSI ON OP SERVI CES	0. 314184				90. 03
90. 04 09004 MATERNAL HEA	0. 000000				90. 04
91. 00 09100 EMERGENCY	0. 218988				91.00
91.01 09101 FREE STANDING EMERGENCY DEPT	0. 402999				91. 01
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 716571				92. 00
200.00 Subtotal (see instructions)					200. 00
201.00 Less Observation Beds					201. 00
202.00 Total (see instructions)					202. 00

Provi der CCN: 150015

Peri od:

COMPUTATION OF RATIO OF COSTS TO CHARGES

From 01/01/2014 Part I Date/Time Prepared: 12/31/2014 5/28/2015 9:57 am Title XIX Hospi tal Cost Costs Cost Center Description Total Cost Therapy Limit Total Costs RCF Total Costs from Wkst. B, Adj Di sal I owance Part I, col. 26) 4. 00 1.00 2.00 3.00 5.00 INPATIENT ROUTINE SERVICE COST CENTERS 30 00 17, 391, 801 30 00 03000 ADULTS & PEDIATRICS 17.391.801 17, 391, 801 03100 INTENSIVE CARE UNIT 4, 019, 492 4, 019, 492 4, 632 4, 024, 124 31.00 31.00 04000 SUBPROVIDER - IPF 40.00 2, 728, 158 2, 728, 158 0 2, 728, 158 40.00 04100 SUBPROVIDER - IRF 2, 569, 343 41.00 2, 569, 343 0 2, 569, 343 41.00 04300 NURSERY 43.00 747, 122 747, 122 0 747, 122 43.00 44.00 04400 SKILLED NURSING FACILITY 0 0 0 44.00 45.00 04500 NURSING FACILITY 45.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 12, 797, 759 12, 797, 759 81, 858 12, 879, 617 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 1, 750, 197 1, 750, 197 1, 750, 197 52.00 53.00 05300 ANESTHESI OLOGY 188, 072 188, 072 2, 260 190, 332 53.00 8, 586, 462 05400 RADI OLOGY-DI AGNOSTI C 54.00 8, 586, 462 8, 586, 462 0 54.00 54.01 05401 FSED RADIOLOGY - DIAGNOSTIC 1, 311, 334 1, 311, 334 1, 311, 334 54.01 05500 RADI OLOGY-THERAPEUTI C 55.00 2, 848, 950 2, 848, 950 27, 186 2, 876, 136 55.00 05501 WOODLAND CANCER CARE CENTER 1, 933, 732 1, 917 55 01 1, 933, 732 1, 935, 649 55 01 57.00 05700 CT SCAN 0 \cap Ω 57.00 58.00 05800 MRI 0 58.00 0 0 0 05900 CARDIAC CATHETERIZATION 59.00 2, 525, 118 2, 525, 118 36, 526 2, 561, 644 59.00 06000 LABORATORY 8, 575, 970 8, 575, 970 34, 478 8, 610, 448 60 00 60 00 60.01 06001 FSED LABORATORY 1, 469, 472 1, 469, 472 1, 469, 472 60.01 06500 RESPIRATORY THERAPY 1, 709, 627 65.00 1, 709, 627 3 1, 709, 630 65.00 4, 325, 835 66 00 06600 PHYSI CAL THERAPY 4, 325, 835 0 4, 325, 835 66 00 0 69.00 06900 ELECTROCARDI OLOGY 1, 915, 025 1, 915, 025 1, 915, 025 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 6, 866, 126 6, 866, 126 6, 866, 126 71.00 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 9, 343, 085 9, 343, 085 9, 343, 085 72.00 07300 DRUGS CHARGED TO PATIENTS 73 00 12.444.814 12, 444, 814 12, 444, 814 73 00 03950 CV RESOURCE CENTER 76.00 10, 196 10, 196 10, 196 76.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 90.00 09001 OB CLINIC 0 3.974 3.974 3, 974 90 01 90.01 90.02 09002 PAIN MANAGEMENT 0 0 0 90.02 09003 INFUSION OP SERVICES 795, 254 795, 254 0 795, 254 90.03 90.03 0 90.04 09004 MATERNAL HEA 0 90.04 09100 EMERGENCY 8, 287, 087 8, 287, 087 0 8, 287, 087 91.00 91.00 91.01 09101 FREE STANDING EMERGENCY DEPT 3, 676, 425 3, 676, 425 3, 676, 425 91.01 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 2, 367, 560 2, 367, 560 2, 367, 560 92.00 Subtotal (see instructions) 121, 187, 990 121, 187, 990 200.00 121, 376, 850 200. 00 188, 860 201.00 Less Observation Beds 2, 367, 560 2, 367, 560 2, 367, 560 201. 00 202.00 Total (see instructions) 118, 820, 430 118, 820, 430 188, 860 119, 009, 290 202. 00

COMPUTATION OF RATIO OF COSTS TO CHARGES Provi der CCN: 150015 Peri od: Worksheet C From 01/01/2014 Part I Date/Time Prepared: 12/31/2014 5/28/2015 9:57 am Title XIX Hospi tal Cost Charges Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other **TFFRA** I npati ent + col . 7) Ratio Ratio 6.00 7.00 8.00 9. 00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 25, 345, 576 03000 ADULTS & PEDIATRICS 25, 345, 576 30.00 30.00 31.00 03100 INTENSIVE CARE UNIT 5, 099, 700 5, 099, 700 31.00 04000 SUBPROVIDER - IPF 3, 435, 072 3, 435, 072 40.00 40.00 41.00 04100 SUBPROVI DER - I RF 5, 745, 384 5, 745, 384 41.00 04300 NURSERY 43.00 1, 195, 306 1, 195, 306 43.00 44.00 04400 SKILLED NURSING FACILITY 44.00 45.00 04500 NURSING FACILITY 0 45 00 ANCILLARY SERVICE COST CENTERS 50 00 50 00 05000 OPERATING ROOM 25, 817, 028 74, 633, 293 100, 450, 321 0.127404 0.000000 52.00 05200 DELIVERY ROOM & LABOR ROOM 2,000,681 142, 654 2, 143, 335 0.816577 0.000000 52.00 53.00 05300 ANESTHESI OLOGY 1, 717, 985 2, 444, 051 4, 162, 036 0.045187 0.000000 53.00 14, 858, 184 49, 629, 629 05400 RADI OLOGY-DI AGNOSTI C 64, 487, 813 0.000000 54.00 0.133149 54.00 54.01 05401 FSED RADIOLOGY - DIAGNOSTIC 815, 479 11, 322, 487 12, 137, 966 0.108036 0.000000 54.01 55.00 05500 RADI OLOGY-THERAPEUTI C 1,076,097 11, 180, 402 12, 256, 499 0. 232444 0.000000 55.00 55.01 05501 WOODLAND CANCER CARE CENTER 26, 087 2, 212, 960 2, 239, 047 0.863641 0.000000 55.01 57 00 05700 CT SCAN 0.000000 0.000000 57 00 58.00 05800 MRI 0.000000 0.000000 58.00 05900 CARDIAC CATHETERIZATION 5, 817, 998 9, 078, 127 14, 896, 125 0.169515 0.000000 59.00 59.00 06000 LABORATORY 16, 529, 321 28, 057, 109 44, 586, 430 0.192345 0.000000 60.00 60.00 06001 FSED LABORATORY 60.01 55, 027 4, 673, 679 4, 728, 706 0.310756 0.000000 60.01 65.00 06500 RESPIRATORY THERAPY 8,051,296 996, 923 9, 048, 219 0.188946 0.000000 65.00 06600 PHYSI CAL THERAPY 66.00 2, 267, 992 11, 083, 103 13, 351, 095 0. 324006 0.000000 66.00 69 00 06900 ELECTROCARDI OLOGY 4.844.017 7, 522, 403 12 366 420 0 154857 0.000000 69 00 |07100|MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 7,011,910 8, 590, 728 15, 602, 638 0.440062 0.000000 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 8, 479, 779 4, 702, 417 13, 182, 196 0.708765 0.000000 72.00 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 26, 428, 291 44, 282, 785 70, 711, 076 0.175995 0.000000 73.00 03950 CV RESOURCE CENTER 76.00 0.000000 0.000000 76.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 0 0.000000 0.000000 90.00 90 01 09001 OB CLINIC 0 Ω 0 0.000000 0.000000 90 01 09002 PAIN MANAGEMENT 90.02 Ω 0.000000 0.000000 90.02 90.03 09003 INFUSION OP SERVICES 1,004,225 1, 526, 949 2, 531, 174 0.314184 0.000000 90.03 90.04 09004 MATERNAL HEA 0.000000 0.000000 90.04 91 00 09100 EMERGENCY 8, 313, 096 29, 529, 480 37, 842, 576 0 218988 0.000000 91 00 1,000,768 91.01 09101 FREE STANDING EMERGENCY DEPT 8, 121, 900 9, 122, 668 0.402999 0.000000 91.01 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 455, 043 2, 848, 970 3, 304, 013 0.716571 0.000000 92.00 200.00 Subtotal (see instructions) 177, 391, 342 312, 580, 049 489, 971, 391 200.00 201 00 201.00 Less Observation Beds 202.00 Total (see instructions) 177, 391, 342 312, 580, 049 489, 971, 391 202.00

					5/28/2015 9:5/ ai	<u>am</u>
			Title XIX	Hospi tal	Cost	
	Cost Center Description	PPS Inpatient				
		Ratio				
		11. 00				
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30	0. 00
31.00	03100 INTENSIVE CARE UNIT				31	1.00
40.00	04000 SUBPROVI DER - I PF				40	0. 00
41.00	04100 SUBPROVI DER - I RF				41	1. 00
43.00	04300 NURSERY				43	3. 00
44.00	04400 SKILLED NURSING FACILITY				44	4. 00
45.00	04500 NURSING FACILITY				45	5. 00
	ANCILLARY SERVICE COST CENTERS	<u> </u>				
50.00	05000 OPERATING ROOM	0. 000000			50	0. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000			52	2. 00
53.00	05300 ANESTHESI OLOGY	0. 000000				3. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000			l	4. 00
54. 01	05401 FSED RADIOLOGY - DIAGNOSTIC	0. 000000				4. 01
55. 00		0. 000000				5. 00
55. 01	05501 WOODLAND CANCER CARE CENTER	0. 000000				5. 01
57. 00	05700 CT SCAN	0. 000000				7. 00
58. 00	05800 MRI	0. 000000				8. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0. 000000				9. 00
60.00	06000 LABORATORY	0. 000000				0. 00
60. 01	06001 FSED LABORATORY	0. 000000				0. 01
65. 00	06500 RESPIRATORY THERAPY	0. 000000				5. 00
66. 00	06600 PHYSI CAL THERAPY	0. 000000			l l	6. 00
69. 00	06900 ELECTROCARDI OLOGY	0. 000000				9. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000				1. 00
72. 00		0. 000000				2. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0. 000000				3. 00
76. 00		0. 000000				6. 00
	OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLI NI C	0. 000000			90	0. 00
90. 01	09001 OB CLINIC	0. 000000			90	0. 01
	09002 PAIN MANAGEMENT	0. 000000				0. 02
90. 03	09003 I NFUSI ON OP SERVI CES	0. 000000				0. 03
90. 04	09004 MATERNAL HEA	0. 000000				0. 04
91. 00	09100 EMERGENCY	0. 000000				1. 00
91. 01	09101 FREE STANDING EMERGENCY DEPT	0. 000000				1. 01
		0. 000000				2. 00
200.00						0. 00
201.00	, ,					1. 00
202.00						2. 00
	1 (, ,	1			1202	

Health Financial Systems	FRANCISCAN ST ANTH	ONY-MICHIGAN CI	ΙΤΥ	In Li∈	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAP	PLITAL COSTS	Provi der		Period: From 01/01/2014 To 12/31/2014		
			e XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced		Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col . 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col . 1 - col			
	26)		2)			
	1.00	2.00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS		,				
30. 00 ADULTS & PEDIATRICS	2, 253, 582		2, 253, 58		l .	
31.00 INTENSIVE CARE UNIT	414, 954		414, 95			
40. 00 SUBPROVI DER - I PF	260, 479		260, 47			
41. 00 SUBPROVI DER - I RF	400, 869		400, 86			
43. 00 NURSERY	36, 809		36, 80	9 1, 215	30. 30	43. 00
44.00 SKILLED NURSING FACILITY	0			0	0.00	
45.00 NURSING FACILITY	0			0 0	0.00	45. 00
200.00 Total (lines 30-199)	3, 366, 693		3, 366, 69	3 28, 387		200. 00
Cost Center Description	Inpatient	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDI ATRI CS	8, 924					30.00
31.00 INTENSIVE CARE UNIT	2, 023		•			31.00
40. 00 SUBPROVI DER - I PF	811		•			40. 00
41. 00 SUBPROVI DER - I RF	1, 898		•			41. 00
42 OO NUDCEDY			d.			1 12 00

0 0

13, 656

1, 742, 865

0

43.00

44. 00 45. 00 200. 00

43. 00 NURSERY

44.00 SKILLED NURSING FACILITY
45.00 NURSING FACILITY
200.00 Total (lines 30-199)

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der	CCN: 150015	Peri od: From 01/01/2014 To 12/31/2014	Worksheet D Part II Date/Time Pre 5/28/2015 9:5	pared: 7 am
		Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges		t Inpatient	Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,			. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	2, 038, 945				234, 374	
52.00 05200 DELIVERY ROOM & LABOR ROOM	215, 818				1, 048	
53. 00 05300 ANESTHESI OLOGY	27, 493				•	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 519, 139				334, 434	
54. 01 05401 FSED RADI OLOGY - DI AGNOSTI C	95, 616				0	
55. 00 05500 RADI OLOGY-THERAPEUTI C	333, 541				18, 866	
55.01 05501 WOODLAND CANCER CARE CENTER	297, 689	2, 239, 047			0	55. 01
57.00 05700 CT SCAN	0	0	0.0000		0	57.00
58. 00 05800 MRI	0	0	0.00000		0	
59. 00 05900 CARDI AC CATHETERI ZATI ON	589, 139				139, 046	
60. 00 06000 LABORATORY	385, 755				73, 176	
60. 01 06001 FSED LABORATORY	57, 076				0	60. 01
65. 00 06500 RESPIRATORY THERAPY	98, 095				48, 791	
66. 00 06600 PHYSI CAL THERAPY	119, 866				13, 379	
69. 00 06900 ELECTROCARDI OLOGY	230, 397		1		52, 994	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	229, 464				39, 019	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	308, 498					
73.00 07300 DRUGS CHARGED TO PATIENTS	292, 033				59, 410	
76. 00 03950 CV RESOURCE CENTER	182	0	0.0000	00 0	0	76. 00
OUTPATIENT SERVICE COST CENTERS			,			
90. 00 09000 CLI NI C	0		0.00000		0	
90. 01 09001 0B CLINIC	3, 238	0	0. 00000		0	90. 01
90. 02 09002 PAI N MANAGEMENT	0	0	0.00000		0	90. 02
90. 03 09003 I NFUSI ON OP SERVI CES	52, 861				11, 563	
90. 04 09004 MATERNAL HEA	0		0.00000		0	
91. 00 09100 EMERGENCY	1, 599, 800				162, 882	
91. 01 09101 FREE STANDING EMERGENCY DEPT	595, 108				0	91. 01
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	306, 781		1		24, 689	
200.00 Total (lines 50-199)	10, 396, 534	449, 150, 353		68, 337, 695	1, 317, 762	200.00

Health Financial Systems FRAN	CISCAN ST ANTHO	ONY-MICHIGAN C	ΙΤΥ	In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	SS THROUGH COS		<u> </u>	Period: From 01/01/2014 To 12/31/2014	Date/Time Pre 5/28/2015 9:5	
		Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	Nursing School	Allied Health	All Other	Swi ng-Bed	Total Costs	
		Cost	Medi cal	Adjustment	(sum of cols.	
			Education Cos		1 through 3,	
				instructions)	minus col. 4)	
	1. 00	2. 00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	0	(0	0	30. 00
31.00 03100 INTENSIVE CARE UNIT	0	(O	0	31.00
40. 00 04000 SUBPROVI DER - 1 PF	0	(0	0	40.00
41. 00 04100 SUBPROVI DER - I RF	0	(0	0	41.00
43. 00 04300 NURSERY	0	(O	0	43.00
44.00 04400 SKILLED NURSING FACILITY	0	(O	0	44.00
45.00 04500 NURSING FACILITY	0	(O	0	45. 00
200.00 Total (lines 30-199)	0)	0	200. 00
Cost Center Description	Total Patient	Per Diem (col.	Inpati ent	Inpati ent		
	Days	5 ÷ col . 6)	Program Days	Program		
				Pass-Through		
				Cost (col. 7 x		
				col . 8)		
	6. 00	7. 00	8. 00	9. 00		
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	19, 114	0.00	8, 92	4 O		30. 00
31.00 03100 INTENSIVE CARE UNIT	2, 650	0.00	2, 02	3 0		31.00
40. 00 04000 SUBPROVI DER - I PF	2, 876	0.00	81	1 0		40.00
41. 00 04100 SUBPROVI DER - I RF	2, 532	0.00	1, 89	3 0		41.00
43. 00 04300 NURSERY	1, 215	0.00		0		43.00
44.00 04400 SKILLED NURSING FACILITY	0	0.00		0		44.00
45.00 04500 NURSING FACILITY	0	0.00		0		45. 00
200.00 Total (lines 30-199)	28, 387		13, 65	6 0		200. 00

Health Financial Systems	FRANCISCAN ST ANTHONY-M	IICHIGAN CITY	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIEN	T ANCILLARY SERVICE OTHER PASS	Provi der CCN: 150015	Peri od:	Worksheet D

From 01/01/2014 Part IV To 12/31/2014 Date/Time Prepared: THROUGH COSTS 5/28/2015 9:57 am Title XVIII Hospi tal Cost Center Description Non Physician Nursing School Allied Health All Other Total Cost Anestheti st Medi cal (sum of col 1 through col . Cost Education Cost 1.00 2.00 3.00 4.00 5.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 50.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 05200 DELIVERY ROOM & LABOR ROOM 52.00 52.00 0 0 53.00 05300 ANESTHESI OLOGY 53.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 54.00 54.00 0 05401 FSED RADIOLOGY - DIAGNOSTIC 0 54.01 0 54.01 0 05500 RADI OLOGY-THERAPEUTI C 0 55.00 0 55.00 55.01 05501 WOODLAND CANCER CARE CENTER 0 0 55.01 57.00 05700 CT SCAN 0 57.00 58.00 05800 MRI 0 58.00 0 0 05900 CARDI AC CATHETERI ZATI ON 59.00 0 59.00 60.00 06000 LABORATORY 60.00 06001 FSED LABORATORY 0 60.01 60.01 06500 RESPIRATORY THERAPY 0 65.00 65.00 0 66.00 06600 PHYSI CAL THERAPY 0 66.00 06900 ELECTROCARDI OLOGY 0 69.00 69.00 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 0 0 71.00 71 00 0 07200 I MPL. DEV. CHARGED TO PATIENTS 72.00 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 73.00 03950 CV RESOURCE CENTER 0 0 0 76.00 0 0 76.00 OUTPATIENT SERVICE COST CENTERS 90.00 90.00 09000 CLI NI C 0 0 0 0 0 0 0 0 0 0 0 0 09001 OB CLINIC 0 90. 01 90.01 0 0 0 0 0 0 09002 PAIN MANAGEMENT 0 90.02 0 Ω 90.02 09003 INFUSION OP SERVICES 0 0 90.03 90.03 0 90. 04 09004 MATERNAL HEA 0 90.04 09100 EMERGENCY 0 0 91.00 91.00 0 0 91. 01 | 09101 | FREE STANDING EMERGENCY DEPT 91. 01 0 Ω 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 0 0 200.00 Total (lines 50-199) 0 200. 00

Health Financial Systems	FRANCISCAN ST ANTHONY-	MICHIGAN CITY	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIE	NT ANCILLARY SERVICE OTHER PASS	Provi der CCN: 150015	Peri od:	Worksheet D
THROUGH COSTS			From 01/01/2014	Part IV

APPORTI ON THROUGH (NMENT OF INPATIENT/OUTPATIENT ANCILLARY SER COSTS	VICE OTHER PASS	S	Provi der		Period: From 01/01/2014 To 12/31/2014		
				Ti +I	e XVIII	Hospi tal	5/28/2015 9: 5 PPS	7 am
	Cost Center Description	Total	Total		Ratio of Cos		Inpatient	
	oust deliter beschiptron	Outpatient		Wkst. C,		Ratio of Cost	Program	
		Cost (sum of			(col. 5 ÷ col		Charges	
		col. 2, 3 and		8)	7)	(col . 6 ÷ col .	onal goo	
		4)		-,	',	7)		
		6.00		7. 00	8. 00	9. 00	10.00	
AN	CILLARY SERVICE COST CENTERS		•					
	OOO OPERATING ROOM	0	10	0, 450, 321	0.00000	0. 000000	11, 546, 640	50.00
52.00 05	200 DELIVERY ROOM & LABOR ROOM	0		2, 143, 335	0.00000	0. 000000	10, 408	52. 00
53.00 05	300 ANESTHESI OLOGY	0		4, 162, 036	0.00000	0. 000000	779, 173	53. 00
54.00 05	400 RADI OLOGY-DI AGNOSTI C	0	6	4, 487, 813	0.00000	0. 000000	8, 561, 188	54.00
54. 01 05	401 FSED RADIOLOGY - DIAGNOSTIC	0	1	2, 137, 966	0.00000	0. 000000	0	54. 01
55.00 05	500 RADI OLOGY-THERAPEUTI C	0	1	2, 256, 499	0.00000	0. 000000	693, 276	55. 00
55. 01 05	501 WOODLAND CANCER CARE CENTER	0		2, 239, 047	0.00000	0. 000000	0	55. 01
57.00 05	700 CT SCAN	0		0	0.00000	0. 000000	0	57.00
58. 00 05	800 MRI	0		0	0.00000	0. 000000	0	58. 00
59.00 05	900 CARDI AC CATHETERI ZATI ON	0	1	4, 896, 125	0.00000	0. 000000	3, 515, 692	59. 00
60.00 06	000 LABORATORY	0	4	4, 586, 430	0.00000	0. 000000	8, 457, 697	60.00
60. 01 06	001 FSED LABORATORY	0		4, 728, 706	0.00000	0. 000000	0	60. 01
65.00 06	500 RESPI RATORY THERAPY	0		9, 048, 219	0.00000	0. 000000	4, 500, 556	65.00
66. 00 06	600 PHYSI CAL THERAPY	0	1	3, 351, 095	0.00000	0. 000000	1, 490, 177	66. 00
69. 00 06	900 ELECTROCARDI OLOGY	0	1	2, 366, 420	0. 00000	0. 000000	2, 844, 415	69. 00
71. 00 07	100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	1	5, 602, 638	0.00000	0. 000000	2, 653, 113	71. 00
72. 00 07.	200 IMPL. DEV. CHARGED TO PATIENTS	0	1	3, 182, 196	0.00000	0. 000000	4, 227, 848	72. 00
73. 00 07	300 DRUGS CHARGED TO PATIENTS	0	7	0, 711, 076	0.00000	0. 000000	14, 384, 995	73. 00
76.00 03	950 CV RESOURCE CENTER	0		0	0.00000	0. 000000	0	76. 00
	TPATIENT SERVICE COST CENTERS							
	000 CLI NI C	0		0	0.00000		0	, , , , , ,
90. 01 09	OO1 OB CLINIC	0		0	0.00000	0. 000000	0	90. 01
90. 02 09	OO2 PAIN MANAGEMENT	0		0	0.00000	0. 000000	0	90. 02
90. 03 09	003 INFUSION OP SERVICES	0		2, 531, 174	0.00000	0. 000000	553, 696	90. 03
90. 04 09	004 MATERNAL HEA	0		0	0.00000	0. 000000	0	90. 04
91. 00 09	100 EMERGENCY	0	3	7, 842, 576	0.00000	0. 000000	3, 852, 927	91.00
91. 01 09	101 FREE STANDING EMERGENCY DEPT	0		9, 122, 668	0.00000	0. 000000	0	91. 01
92. 00 09	200 OBSERVATION BEDS (NON-DISTINCT PART	0		3, 304, 013	0.00000	0. 000000	265, 894	92. 00
200.00	Total (lines 50-199)	0	44	9, 150, 353			68, 337, 695	200. 00

THROUGH COSTS

Title XVIII Hospital PPS
Program Program Program Program Pass-Through Costs (col. 8 x col. 10) x col. 12) x col. 12)
Pass-Through Costs (col. 8 x col. 10) x col. 12) x col. 12)
Costs (col. 8 x col. 10) x col. 12)
X COI. 10) X COI. 12)
11.00 12.00 13.00
ANCI LLARY SERVI CE COST CENTERS
50. 00 05000 OPERATI NG ROOM 0 27, 335, 709 0 50. 00 52. 00 05200 DELI VERY ROOM & LABOR ROOM 0 0 0 52. 00 53. 00 05300 ANESTHESI OLOGY 0 731, 973 0 53. 00 54. 00 05400 RADI OLOGY - DI AGNOSTI C 0 20, 972, 616 0 54. 00 54. 01 05401 FSED RADI OLOGY - DI AGNOSTI C 0 0 0 54. 01 55. 00 05500 RADI OLOGY - THERAPEUTI C 0 2, 342, 700 0 55. 00 55. 01 05501 WOODLAND CANCER CARE CENTER 0 0 0 55. 01 57. 00 O5700 CT SCAN 0 0 0 0 57. 00 58. 00 O5800 MRI 0 0 0 58. 00 59. 00 CARDI AC CATHETERI ZATI ON 0 6, 135, 017 0 59. 00 60. 01 O6001 FSED LABORATORY 0 0 60. 00 60. 01
52. 00 05200 DELI VERY ROOM & LABOR ROOM 0 0 52. 00 53. 00 05300 ANESTHESI OLOGY 0 731, 973 0 53. 00 54. 00 05400 RADI OLOGY - DI AGNOSTI C 0 20, 972, 616 0 54. 00 54. 01 05401 FSED RADI OLOGY - DI AGNOSTI C 0 0 0 54. 01 55. 00 05500 RADI OLOGY - THERAPEUTI C 0 2, 342, 700 0 0 55. 00 55. 01 05501 WODLAND CANCER CARE CENTER 0 0 0 55. 01 57. 00 05700 CT SCAN 0 0 0 57. 00 58. 00 05800 MRI 0 0 0 58. 00 59. 00 05900 CARDI AC CATHETERI ZATI ON 0 6, 135, 017 0 60. 00 60. 01 06001 FSED LABORATORY 0 5, 156, 764 0 60. 00
53. 00 05300 ANESTHESI OLOGY 0 731, 973 0 53. 00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 20, 972, 616 0 0 54. 01 05401 FSED RADI OLOGY - DI AGNOSTI C 0 0 0 54. 01 55. 00 05500 RADI OLOGY-THERAPEUTI C 0 2, 342, 700 0 0 55. 00 55. 01 05501 WODLAND CANCER CARE CENTER 0 0 0 0 55. 01 57. 00 05700 CT SCAN 0 0 0 0 57. 00 58. 00 05800 MRI 0 0 0 0 58. 00 59. 00 05900 CARDI AC CATHETERI ZATI ON 0 6, 135, 017 0 59. 00 60. 00 06001 LABORATORY 0 5, 156, 764 0 60. 00 60. 01 06001 FSED LABORATORY 0 0 0 60. 01
54. 00 05400 RADI OLOGY - DI AGNOSTI C 0 20, 972, 616 0 0 54. 01 05401 FSED RADI OLOGY - DI AGNOSTI C 0 0 0 54. 01 55. 00 05500 RADI OLOGY - THERAPEUTI C 0 2, 342, 700 0 0 55. 00 55. 01 05501 WOODLAND CANCER CARE CENTER 0 0 0 0 55. 01 57. 00 05700 CT SCAN 0 0 0 57. 00 58. 00 05800 MRI 0 0 0 58. 00 59. 00 05900 CARDI AC CATHETERI ZATI ON 0 6. 135, 017 0 59. 00 60. 00 06001 LABORATORY 0 5, 156, 764 0 60. 00 60. 01 06001 FSED LABORATORY 0 0 60. 01
54. 01 05401 FSED RADI OLOGY - DI AGNOSTI C 0 0 54. 01 55. 00 05500 RADI OLOGY-THERAPEUTI C 0 2, 342, 700 0 0 55. 01 05501 WODDLAND CANCER CARE CENTER 0 0 0 55. 01 57. 00 05700 CT SCAN 0 0 0 57. 00 58. 00 05800 MRI 0 0 0 58. 00 59. 00 05900 CARDI AC CATHETERI ZATI ON 0 6, 135, 017 0 59. 00 60. 00 06001 LABORATORY 0 5, 156, 764 0 60. 00 60. 01 06001 FSED LABORATORY 0 0 60. 01
55. 00 05500 RADI OLOGY-THERAPEUTI C 0 2, 342, 700 0 55. 00 55. 01 05501 WOODLAND CANCER CARE CENTER 0 0 0 55. 01 57. 00 05700 CT SCAN 0 0 0 57. 00 58. 00 05800 MRI 0 0 0 58. 00 59. 00 05900 CARDI AC CATHETERI ZATI ON 0 6, 135, 017 0 59. 00 60. 00 06000 LABORATORY 0 5, 156, 764 0 60. 00 60. 01 06001 FSED LABORATORY 0 0 60. 01
55. 01 05501 WOODLAND CANCER CARE CENTER 0 0 0 57. 00 05700 CT SCAN 0 0 0 58. 00 05800 MRI 0 0 0 0 59. 00 05900 CARDI AC CATHETERI ZATI ON 0 6, 135, 017 0 0 60. 00 06000 LABORATORY 0 5, 156, 764 0 60. 00 60. 01 06001 FSED LABORATORY 0 0 0 60. 01
57. 00 05700 CT SCAN 0 0 0 58. 00 05800 MRI 0 0 0 59. 00 05900 CARDI AC CATHETERI ZATI ON 0 6, 135, 017 0 59. 00 60. 00 06000 LABORATORY 0 5, 156, 764 0 60. 00 60. 01 06001 FSED LABORATORY 0 0 0 60. 01
58. 00 05800 MRI 0 0 0 58. 00 59. 00 05900 CARDI AC CATHETERI ZATI ON 0 6, 135, 017 0 59. 00 60. 00 06000 LABORATORY 0 5, 156, 764 0 60. 00 60. 01 06001 FSED LABORATORY 0 0 0 60. 01
59. 00 05900 CARDI AC CATHETERI ZATI ON 0 6, 135, 017 0 59. 00 60. 00 06000 LABORATORY 0 5, 156, 764 0 60. 00 60. 01 06001 FSED LABORATORY 0 0 60. 01
60. 00 06000 LABORATORY
60. 01 06001 FSED LABORATORY 0 0 0 60. 01
65. 00 06500 RESPI RATORY THERAPY 0 357, 180 0 65. 00
66. 00 06600 PHYSI CAL THERAPY 0 6, 159 0 66. 00
69. 00 06900 ELECTROCARDI OLOGY 0 2, 966, 746 0 69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 1,743,493 0 71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 2, 412, 988 0 72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS 0 23,058,854 0 73. 00
76. 00 03950 CV RESOURCE CENTER 0 0 0 76. 00
OUTPATIENT SERVICE COST CENTERS
90. 00 09000 CLINIC 0 0 0 90. 00
90. 01 09001 0B CLINIC 0 0 0 90. 01
90. 02 09002 PALN MANAGEMENT 0 0 0 90. 02
90. 03 09003 INFUSION OP SERVICES 0 848, 410 0 90. 03
90. 04 09004 MATERNAL HEA 0 0 0 90. 04
91. 00 O9100 EMERGENCY O 5, 765, 383 O 91. 00
91. 01 09101 FREE STANDI NG EMERGENCY DEPT 0 0 0 91. 01
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 1,001,092 0 92. 00
200.00 Total (lines 50-199) 0 100, 835, 084 0 200.00

	ICISCAN ST ANTHO				u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der		Peri od:	Worksheet D	
				From 01/01/2014 To 12/31/2014	Part V Date/Time Pre	narod:
				10 12/31/2014	5/28/2015 9:5	pareu. 7 am
-		Ti tl	e XVIII	Hospi tal	PPS	, diii
			Charges		Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
	Ratio From	Services (see	Reimbursed	Rei mbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins.	Ded. & Coins.		
			(see inst.)	(see inst.)		
	1.00	2. 00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0. 127404	27, 335, 709		0 0	3, 482, 679	50. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 816577	0		0 0	0	52. 00
53. 00 05300 ANESTHESI OLOGY	0. 045187	731, 973		0	33, 076	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 133149	20, 972, 616		0	2, 792, 483	54.00
54.01 05401 FSED RADIOLOGY - DIAGNOSTIC	0. 108036	0		0	0	54. 01
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 232444	2, 342, 700		0 0	544, 547	55. 00
55. 01 05501 WOODLAND CANCER CARE CENTER	0. 863641	0		0 0	0	55. 01
57. 00 05700 CT SCAN	0. 000000	0		0 0	0	57. 00
58. 00 05800 MRI	0. 000000	0		0 0	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 169515	6, 135, 017		0 0	1, 039, 977	59.00
60. 00 06000 LABORATORY	0. 192345			0 0	991, 878	60.00
60. 01 06001 FSED LABORATORY	0. 310756			0 0	0	60. 01
65. 00 06500 RESPIRATORY THERAPY	0. 188946	357, 180		0 0	67, 488	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 324006			0	1, 996	66.00
69. 00 06900 ELECTROCARDI OLOGY	0. 154857	2, 966, 746		0	459, 421	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 440062			0	767, 245	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 708765			0	1, 710, 241	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 175995			0 62, 293	4, 058, 243	73. 00
76. 00 03950 CV RESOURCE CENTER	0. 000000		i	0	0	76.00
OUTPATIENT SERVICE COST CENTERS				-	-	
90. 00 09000 CLI NI C	0. 000000	0		0 0	0	90.00
90. 01 09001 OB CLINIC	0. 000000			0	0	90. 01
90. 02 09002 PAIN MANAGEMENT	0. 000000			0	0	90. 02
90. 03 09003 INFUSION OP SERVICES	0. 314184	ŀ		0	266, 557	90. 03
90. 04 09004 MATERNAL HEA	0. 000000			0	0	90. 04
91. 00 09100 EMERGENCY	0. 218988			0	1, 262, 550	91.00
91. 01 09101 FREE STANDING EMERGENCY DEPT	0. 402999			0	0	91. 01
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 716571	1, 001, 092		0	717, 353	
200.00 Subtotal (see instructions)		100, 835, 084		0 62, 293	18, 195, 734	
201.00 Less PBP Clinic Lab. Services-Program				0 0		201.00
Only Charges]		
202.00 Net Charges (line 200 +/- line 201)	1	100, 835, 084		0 62, 293	18, 195, 734	202. 00

Heal th Fi	nancial Systems FRAN	ICISCAN ST ANTH	ONY-MICHIGAN CI	TY	In Lie	u of Form CMS-	2552-10
APPORTI ON	WENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST		CCN: 150015	Peri od: From 01/01/2014 To 12/31/2014	Worksheet D Part V Date/Time Pre 5/28/2015 9:5	
				e XVIII	Hospi tal	PPS	
		Cos	șts				
	Cost Center Description	Cost	Cost				
		Rei mbursed	Rei mbursed				
		Servi ces	Services Not				
		Subject To	Subject To				
		Ded. & Coins.	Ded. & Coins.				
		(see inst.)	(see inst.)				
		6.00	7.00				
	CILLARY SERVICE COST CENTERS						
	OOO OPERATING ROOM	0	0)			50. 00
52.00 05	200 DELIVERY ROOM & LABOR ROOM	0	0				52. 00
53.00 05	300 ANESTHESI OLOGY	0	0				53.00
54.00 05	400 RADI OLOGY-DI AGNOSTI C	0	0				54.00
54. 01 05	401 FSED RADIOLOGY - DIAGNOSTIC	0	0				54. 01
55. 00 05	500 RADI OLOGY-THERAPEUTI C	0	0)			55. 00
	501 WOODLAND CANCER CARE CENTER	0	0				55. 01
57. 00 05	700 CT SCAN	0					57. 00
	800 MRI	0					58.00
	900 CARDI AC CATHETERI ZATI ON	0)			59. 00
	000 LABORATORY	0)			60.00
	001 FSED LABORATORY	0		,			60. 01
	500 RESPI RATORY THERAPY	0		,			65. 00
	600 PHYSI CAL THERAPY	0		,			66. 00
1	900 ELECTROCARDI OLOGY	0					69. 00
	100 MEDICAL SUPPLIES CHARGED TO PATIENT	0					71.00
	200 IMPL. DEV. CHARGED TO PATIENTS	0		1			72.00
	300 DRUGS CHARGED TO PATIENTS	0	_	1			73. 00
	950 CV RESOURCE CENTER	Ö	1	1			76.00
	TPATIENT SERVICE COST CENTERS		,	1			70.00
	000 CLINIC	T 0	0	1			90.00
	001 OB CLINIC	0	1	1			90. 01
	002 PAIN MANAGEMENT	0					90. 02
	003 I NFUSI ON OP SERVI CES	0					90. 03
	004 MATERNAL HEA						90. 04
	100 EMERGENCY						91. 00
1	101 FREE STANDING EMERGENCY DEPT						91. 01
	200 OBSERVATION BEDS (NON-DISTINCT PART			1			91.01
200.00		0	10, 963				200. 00
200.00	Subtotal (see instructions)		10, 903				200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges		1				201.00
202. 00	Net Charges (line 200 +/- line 201)	0	10, 963				202. 00
202.00	iner charges (Title 200 +/- Title 201)	1	10, 903	'I			1202.00

Health Financial Systems FRAN	ICISCAN ST ANTH	ONY-MICHIGAN CI	TY	In lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA			CCN: 150015	Peri od:	Worksheet D	1002 10
	000.0		t CCN: 15S015	From 01/01/2014 To 12/31/2014	Part II	pared: 7 am
		Ti tl	e XVIII	Subprovi der - I PF	PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos		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)	3	ĺ	
	26)	,				
	1.00	2.00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	2, 038, 945	100, 450, 321	0. 02029	98 2, 715	55	50. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	215, 818	2, 143, 335	0. 10069	93 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	27, 493	4, 162, 036	0. 00660	06	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 519, 139	64, 487, 813	0. 0390	54 51, 675	2, 019	54. 00
54. 01 05401 FSED RADI OLOGY - DI AGNOSTI C	95, 616	12, 137, 966	0. 00787	77 0	0	54. 01
55. 00 05500 RADI OLOGY-THERAPEUTI C	333, 541				179	55. 00
55. 01 05501 WOODLAND CANCER CARE CENTER	297, 689	2, 239, 047			0	55. 01
57. 00 05700 CT SCAN	0	0	0.0000		0	57. 00
58. 00 05800 MRI	0		0.00000		0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	589, 139				0	59. 00
60. 00 06000 LABORATORY	385, 755				1, 069	60.00
60. 01 06001 FSED LABORATORY	57, 076				0	60. 01
65. 00 06500 RESPIRATORY THERAPY	98, 095					65. 00
66. 00 06600 PHYSI CAL THERAPY	119, 866					66. 00
69. 00 06900 ELECTROCARDI OLOGY	230, 397					69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	229, 464				l	71. 00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	308, 498				0	72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	292, 033					
76. 00 03950 CV RESOURCE CENTER	182	0	0.0000	00 0	0	76. 00
OUTPATIENT SERVICE COST CENTERS		1				
90. 00 09000 CLI NI C	0	_				
90. 01 09001 0B CLINIC	3, 238				0	90. 01
90. 02 09002 PAI N MANAGEMENT	0		0.00000		0	90. 02
90. 03 09003 I NFUSI ON OP SERVI CES	52, 861				0	90. 03
90. 04 09004 MATERNAL HEA	1 500 000	-	1 0.0000		0	90. 04
91. 00 09100 EMERGENCY	1, 599, 800				l	91.00
91. 01 09101 FREE STANDING EMERGENCY DEPT	595, 108				0	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	10,000,753	-,,	1		0 (05	
200.00 Total (lines 50-199)	10, 089, 753	449, 150, 353	·I	557, 160	8, 685	200. 00

Health Financial Systems FRANCISCAN ST ANTHONY-MICHIGAN CITY In Lieu of Form CMS-2552-10						
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			CCN: 150015 CCN: 15S015	Peri od: From 01/01/2014	Worksheet D Part IV	pared:
			e XVIII	Subprovi der -	PPS	
Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Healt		4)	
	1. 00	2.00	3.00	4. 00	5. 00	
ANCI LLARY SERVI CE COST CENTERS						
50. 00 05000 OPERATING ROOM	C	1		0	0	
52.00 05200 DELIVERY ROOM & LABOR ROOM		0		0	0	52. 00
53. 00 05300 ANESTHESI OLOGY		0		0	0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0		0	0	54. 00
54. 01 05401 FSED RADI OLOGY - DI AGNOSTI C		0		0 0	0	54. 01
55. 00 05500 RADI OLOGY-THERAPEUTI C	(0		0	0	55.00
55. 01 05501 WOODLAND CANCER CARE CENTER	()	0		0	0	
57. 00 05700 CT SCAN	(0		0	0	57.00
58. 00 05800 MRI		0		0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON		0		0	0	59.00
60. 00 06000 LABORATORY				0	0	60.00
60. 01 06001 FSED LABORATORY				0	0	60. 01
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY				0		65. 00 66. 00
69. 00 06900 ELECTROCARDI OLOGY				0	0	69.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO	DATI ENT			0	0	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIEN				0	0	
73. 00 07300 DRUGS CHARGED TO PATIENTS	15			0 0	0	
76. 00 03950 CV RESOURCE CENTER				0 0	0	
OUTPATIENT SERVICE COST CENTERS		,		<u> </u>		70.00
90. 00 09000 CLINIC		0		0 0	0	90.00
90. 01 09001 0B CLINIC		ol o		0 0	0	90. 01
90. 02 09002 PAIN MANAGEMENT		o		0 0	0	90. 02
90. 03 09003 INFUSION OP SERVICES		0		0 0	0	90. 03
90.04 09004 MATERNAL HEA		0		0 0	0	90. 04
91. 00 09100 EMERGENCY		0		0 0	0	91.00
91.01 09101 FREE STANDING EMERGENCY DEPT		0		0 0	0	91. 01
92.00 09200 OBSERVATION BEDS (NON-DISTIN	CT PART C	0		0 0	0	92. 00
200.00 Total (lines 50-199)		0		0 0	0	200. 00

	nncial Systems FRAM ENT OF INPATIENT/OUTPATIENT ANCILLARY SER	NCISCAN ST ANTHO		CCN: 150015	Peri od:	u of Form CMS-2 Worksheet D	2332-10
THROUGH COS		WI OL OTHER TAO			From 01/01/2014	Part IV	
			Component	t CCN: 15S015	To 12/31/2014	Date/Time Pre 5/28/2015 9:5	pared: 7 am
			Ti tl	e XVIII	Subprovi der – I PF	PPS	
	Cost Center Description	Total	Total Charges	Patio of Cos		I npati ent	
	cost center bescription	Outpati ent	(from Wkst. C,		Ratio of Cost	Program	
		Cost (sum of		(col. 5 ÷ col		Charges	
		col. 2, 3 and	8)	7)	(col . 6 ÷ col .	char ges	
		4)	0)	'/	7)		
		6.00	7. 00	8, 00	9, 00	10. 00	
ANCI	LLARY SERVICE COST CENTERS						
50.00 0500	O OPERATING ROOM	0	100, 450, 321	0.00000	0. 000000	2, 715	50.00
52.00 0520	DO DELIVERY ROOM & LABOR ROOM	0	2, 143, 335	0.00000	0. 000000	0	52.00
53.00 0530	OO ANESTHESI OLOGY	0	4, 162, 036	0.00000	0. 000000	0	53.00
54.00 0540	OO RADI OLOGY-DI AGNOSTI C	0	64, 487, 813	0.00000	0. 000000	51, 675	54.00
54. 01 0540	1 FSED RADIOLOGY - DIAGNOSTIC	0	12, 137, 966	0. 00000	0. 000000	0	54. 01
55. 00 0550	00 RADI OLOGY-THERAPEUTI C	0	12, 256, 499	0.00000	0. 000000	6, 582	55.00
55. 01 0550	1 WOODLAND CANCER CARE CENTER	0	2, 239, 047	0.00000	0. 000000	0	
	OO CT SCAN	0	0			0	57.00
	OO MRI	0	0			0	
	OO CARDI AC CATHETERI ZATI ON	0	,			0	
	OO LABORATORY	0	1 ,			123, 570	
	1 FSED LABORATORY	0				0	
	O RESPIRATORY THERAPY	0	.,			17, 655	
	OO PHYSI CAL THERAPY	0		1		11, 062	
	OO ELECTROCARDI OLOGY	0	,			11, 865	
	MEDICAL SUPPLIES CHARGED TO PATIENT	0	,			630	
	ON IMPL. DEV. CHARGED TO PATIENTS	0	1,,	1		0	1
	DO DRUGS CHARGED TO PATIENTS	0				240, 309	
	O CV RESOURCE CENTER	0	0	0.00000	0. 000000	0	76. 00
	ATIENT SERVICE COST CENTERS	1					
	OO CLINIC	0				0	
	01 OB CLINIC	0	_			0	
	22 PAIN MANAGEMENT	0	l ~	0.0000		0	90.02
	NFUSION OP SERVICES	0	_, -,,			0	
	04 MATERNAL HEA	0		0.00000		01 007	
	OO EMERGENCY	0	,,			91, 097	1
	PREE STANDING EMERGENCY DEPT	0	1, .==,			0	
	OO OBSERVATION BEDS (NON-DISTINCT PART	0		1	0. 000000	0	
200. 00	Total (lines 50-199)	0	449, 150, 353	1	_ I	557, 160	J∠00. 00

Health Financial Systems	FRANCISCAN ST ANTHONY-N	MICHIGAN CITY	In Lieu of Form CMS-2552-10		
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provi der CCN: 150015	Peri od: From 01/01/2014	Worksheet D Part IV	
1111100011 00313		Component CCN: 15S015	To 12/31/2014	Date/Time Prepared: 5/28/2015 9:57 am	
		Title XVIII	Subprovi der -	PPS	

			Ti tl	e XVIII	Subprovi der - I PF	PPS	
	Cost Center Description	Inpatient	Outpati ent	Outpati ent	IPF		
	cost center bescription	Program	Program	Program			
		Pass-Through	Charges	Pass-Through			
		Costs (col. 8	onal ges	Costs (col. 9			
		x col. 10)		x col. 12)			
		11.00	12.00	13.00			
	ANCILLARY SERVICE COST CENTERS			•			
50.00	05000 OPERATING ROOM	0	C		0		50. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	C		0		52. 00
53.00	05300 ANESTHESI OLOGY	0	C		0		53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	C		0		54.00
54. 01	05401 FSED RADIOLOGY - DIAGNOSTIC	0	C		0		54. 01
55.00	05500 RADI OLOGY-THERAPEUTI C	0	C		0		55. 00
55. 01	05501 WOODLAND CANCER CARE CENTER	0	C		0		55. 01
57.00	05700 CT SCAN	0	C		0		57. 00
58. 00	05800 MRI	0	C		0		58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	C		0		59. 00
60.00	06000 LABORATORY	0	C		0		60.00
60. 01	06001 FSED LABORATORY	0	C		0		60. 01
65.00	06500 RESPI RATORY THERAPY	0	C		0		65. 00
66.00	06600 PHYSI CAL THERAPY	0	C		0		66. 00
69. 00	06900 ELECTROCARDI OLOGY	0	C		0		69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	C		0		71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	C		0		72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	C		0		73. 00
76.00	03950 CV RESOURCE CENTER	0	C		0		76. 00
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLI NI C	0	C)	0		90. 00
	09001 OB CLINIC	0	C		0		90. 01
90. 02	09002 PAIN MANAGEMENT	0	C		0		90. 02
90. 03	09003 INFUSION OP SERVICES	0	C		0		90. 03
	09004 MATERNAL HEA	0	C		0		90. 04
	09100 EMERGENCY	0	C		0		91. 00
	09101 FREE STANDING EMERGENCY DEPT	0	C		0		91. 01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	C		0		92. 00
200.00	Total (lines 50-199)	0	C		0		200. 00

Health Financial Systems	FRANCISCAN ST ANTHO	In Lieu of Form CMS-2552-10			
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICE	CES AND VACCINE COST	Provi der CCN: 150015	Peri od:	Worksheet D	
			From 01/01/2014		
		Component CCN: 15SO15	To 12/31/2014	Date/Time Pre	pared:
				5/28/2015 9:5	7 am
		Title XVIII	Subprovi der -	PPS	
			I PF		
		Charges		Costs	

			1111	e xviii	Subprovider -	PPS	
				Charges		Costs	
	Cost Center Description	Cost to Charge	PPS Reimbursed		Cost	PPS Services	
	occi contor boson per on		Services (see	Rei mbursed	Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not	(000 111011)	
		Part I, col. 9		Subject To	Subject To		
		,		Ded. & Coins.	Ded. & Coins.		
				(see inst.)	(see inst.)		
		1.00	2. 00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	0. 127404	0		0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 816577	0		0	0	52. 00
53.00	05300 ANESTHESI OLOGY	0. 045187	0		0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 133149	0		0	0	54.00
54.01	05401 FSED RADIOLOGY - DIAGNOSTIC	0. 108036	0		0	0	54. 01
55.00	05500 RADI OLOGY-THERAPEUTI C	0. 232444	0		0	0	55. 00
55. 01	05501 WOODLAND CANCER CARE CENTER	0. 863641	0		0	0	55. 01
57.00	05700 CT SCAN	0. 000000	0		0	0	57. 00
58.00	05800 MRI	0. 000000	0		0	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0. 169515	0		0	0	59. 00
60.00	06000 LABORATORY	0. 192345	0		0	0	60.00
60. 01	06001 FSED LABORATORY	0. 310756	0		0	0	60. 01
65.00	06500 RESPIRATORY THERAPY	0. 188946	0		0	0	65. 00
66.00	06600 PHYSI CAL THERAPY	0. 324006	0		0	0	66. 00
69.00	06900 ELECTROCARDI OLOGY	0. 154857	0		0	0	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 440062	0		0	0	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 708765	0		0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 175995	0		0	0	73. 00
76.00	03950 CV RESOURCE CENTER	0. 000000	0		0	0	76. 00
	OUTPATIENT SERVICE COST CENTERS						1
90.00	09000 CLI NI C	0. 000000	0		0	0	90. 00
90. 01	09001 OB CLINIC	0. 000000	0		0	0	90. 01
90. 02	09002 PAIN MANAGEMENT	0. 000000	0		0	0	90. 02
90. 03	09003 INFUSION OP SERVICES	0. 314184	0		0	0	90. 03
90.04	09004 MATERNAL HEA	0. 000000			0	0	90. 04
91.00	09100 EMERGENCY	0. 218988	0		0	0	91.00
91. 01	09101 FREE STANDING EMERGENCY DEPT	0. 402999	0		0	0	91. 01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 716571	0		0	0	92.00
200.00			0		0	0	200.00
201.00		1			0		201.00
	Only Charges						
202.00	Net Charges (line 200 +/- line 201)		0		0 0	0	202. 00

APPORTI ON	PORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND			CCN: 150015 CCN: 15S015	Peri od: From 01/01/2014 To 12/31/2014	Worksheet D Part V Date/Time Pre 5/28/2015 9:5	epared
			Ti tl	e XVIII	Subprovi der - I PF	PPS	
		Cos	sts		111		
	Cost Center Description	Cost	Cost				
		Rei mbursed	Rei mbursed				
		Servi ces	Services Not				
		Subject To	Subject To				
			Ded. & Coins.				
		(see inst.)	(see inst.)				
ANC	CILLARY SERVICE COST CENTERS	6. 00	7. 00				-
	OOO OPERATING ROOM	0	0				50.
	200 DELIVERY ROOM & LABOR ROOM	0					52.
	300 ANESTHESI OLOGY	0	0				53.
	400 RADI OLOGY-DI AGNOSTI C	0	0				54.
	401 FSED RADIOLOGY - DIAGNOSTIC	0	0				54.
	500 RADI OLOGY-THERAPEUTI C	0	Ö				55.
1	501 WOODLAND CANCER CARE CENTER	0	0				55.
	700 CT SCAN	0	0				57.
	800 MRI	0	0				58.
	900 CARDI AC CATHETERI ZATI ON	0	Ö				59.
	OOO LABORATORY	0	o o				60.
	001 FSED LABORATORY	0	o o				60.
	500 RESPI RATORY THERAPY	0	0				65.
	600 PHYSI CAL THERAPY	0	0				66.
	900 ELECTROCARDI OLOGY	0	0				69.
- 1	100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0				71.
	200 IMPL. DEV. CHARGED TO PATIENTS	0	0				72.
	300 DRUGS CHARGED TO PATIENTS	0	0				73.
	950 CV RESOURCE CENTER	0	0				76.
	TPATIENT SERVICE COST CENTERS						1
0.00	000 CLI NI C	0	0				90.
0. 01 090	001 OB CLINIC	0	0				90.
0. 02 090	DO2 PAIN MANAGEMENT	0	0				90.
0. 03 090	003 INFUSION OP SERVICES	0	0				90.
090 090	004 MATERNAL HEA	0	0				90.
	100 EMERGENCY	0	0				91.
	101 FREE STANDING EMERGENCY DEPT	0	0				91.
	200 OBSERVATION BEDS (NON-DISTINCT PART	0	0				92.
00.00	Subtotal (see instructions)	0	0				200.
01.00	Less PBP Clinic Lab. Services-Program	0					201.
	Only Charges	1	l				1

202. 00

Only Charges Net Charges (line 200 +/- line 201)

202.00

Health Financial Systems FRANCISCAN ST ANTHONY-MICHIGAN CITY In Lieu of Form CMS-2552-10							
Health Financial Systems FRAN APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA			CCN: 150015	Period:	eu of Form CMS-2 Worksheet D	2552-10	
AFFORTIONNENT OF INFATTENT ANGIELARY SERVICE CAPITA	AL 00313		t CCN: 15T015	From 01/01/2014 To 12/31/2014	Part II	pared: 7 am	
		Ti tl	e XVIII	Subprovider - IRF	PPS		
Cost Center Description	Capi tal	Total Charges			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		
ANCILLARY SERVICE COST CENTERS							
50. 00 05000 OPERATI NG ROOM	2, 038, 945		•		5, 883		
52.00 05200 DELIVERY ROOM & LABOR ROOM	215, 818	2, 143, 335			0	52. 00	
53. 00 05300 ANESTHESI OLOGY	27, 493				13	53. 00	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 519, 139				12, 969		
54. 01 05401 FSED RADI OLOGY - DI AGNOSTI C	95, 616	12, 137, 966	0. 00787		0	54. 01	
55. 00 05500 RADI OLOGY-THERAPEUTI C	333, 541	12, 256, 499	0. 02721	10, 309	281	55. 00	
55. 01 05501 WOODLAND CANCER CARE CENTER	297, 689	2, 239, 047	0. 13295	53 0	0	55. 01	
57. 00 05700 CT SCAN	0	0	0.00000	00	0	57. 00	
58. 00 05800 MRI	0	0	0.00000		0	58. 00	
59. 00 05900 CARDI AC CATHETERI ZATI ON	589, 139	14, 896, 125	0. 03955	0 0	0	59. 00	
60. 00 06000 LABORATORY	385, 755	44, 586, 430	0.00865	52 464, 576	4, 020	60.00	
60. 01 06001 FSED LABORATORY	57, 076	4, 728, 706	0. 01207	0 0	0	60. 01	
65. 00 06500 RESPIRATORY THERAPY	98, 095	9, 048, 219	0. 01084	310, 122	3, 362	65.00	
66. 00 06600 PHYSI CAL THERAPY	119, 866	13, 351, 095	0. 00897	138, 246	1, 241	66. 00	
69. 00 06900 ELECTROCARDI OLOGY	230, 397	12, 366, 420	0. 01863	41, 335	770	69. 00	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	229, 464	15, 602, 638	0. 01470	58, 202	856	71. 00	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	308, 498	13, 182, 196	0. 02340	0	0	72. 00	
73.00 07300 DRUGS CHARGED TO PATIENTS	292, 033	70, 711, 076	0. 00413	1, 802, 729	7, 445	73. 00	
76.00 03950 CV RESOURCE CENTER	182			00	0	76. 00	
OUTPATIENT SERVICE COST CENTERS							
90. 00 09000 CLI NI C	0	0	0.00000	0 0	0	90.00	
90. 01 09001 0B CLINIC	3, 238	0	0.00000	00	0	90. 01	
90. 02 09002 PAI N MANAGEMENT	0	0	0.00000	0 0	0	90. 02	
90. 03 09003 INFUSION OP SERVICES	52, 861	2, 531, 174	0. 02088	84 0	0	90. 03	
90.04 09004 MATERNAL HEA	0	0	0.00000	00	0	90. 04	
91. 00 09100 EMERGENCY	1, 599, 800	37, 842, 576	0. 04227	20, 016	846	91. 00	
91.01 09101 FREE STANDING EMERGENCY DEPT	595, 108	9, 122, 668	0. 06523	34 0	0	91. 01	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	3, 304, 013	0. 00000	00 0	0	92. 00	
200.00 Total (lines 50-199)	10, 089, 753	449, 150, 353		3, 469, 363	37, 686	200. 00	

Health Financial Systems FRAI	NCISCAN ST ANTHO	ONY_MICHIGAN CI	TV	In lie	u of Form CMS-:	2552_10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEE			CCN: 150015	Peri od:	Worksheet D	2332-10
THROUGH COSTS			CCN: 15T015	From 01/01/2014 To 12/31/2014	Part IV Date/Time Pre 5/28/2015 9:5	pared: 7 am
		Ti tl	e XVIII	Subprovi der - I RF	PPS	
Cost Center Description	Non Physician	Nursing School	Allied Healt		Total Cost	
	Anesthetist			Medi cal	(sum of col 1	
	Cost			Education Cost		
	1.00	2. 00	3.00	4. 00	4) 5. 00	
ANCILLARY SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
50. 00 05000 OPERATING ROOM	O	0		0 0	0	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	_		0 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0	Ö		0 0	Ö	53.00
54, 00 05400 RADI OLOGY-DI AGNOSTI C	o	Ö		0 0	0	54.00
54. 01 05401 FSED RADI OLOGY - DI AGNOSTI C	0	O		0 0	0	54. 01
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0 0	0	55. 00
55. 01 05501 WOODLAND CANCER CARE CENTER	0	0		0 0	0	55. 01
57. 00 05700 CT SCAN	0	0		0 0	0	57.00
58. 00 05800 MRI	0	0		0 0	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0	0	59. 00
60. 00 06000 LABORATORY	0	0		0	0	60.00
60. 01 06001 FSED LABORATORY	0	0		0	0	60. 01
65. 00 06500 RESPI RATORY THERAPY	0	0		0 0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0	0		0	0	66.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 72.00 07200 MPL. DEV. CHARGED TO PATIENTS	0			0	0	71. 00 72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0			0	0	73.00
76. 00 03950 CV RESOURCE CENTER	0	0		0 0	0	
OUTPATIENT SERVICE COST CENTERS	<u> </u>			0 0	0	70.00
90. 00 09000 CLINIC	O	O		0 0	0	90. 00
90. 01 09001 OB CLINIC	0	O		0 0	0	90. 01
90. 02 09002 PAIN MANAGEMENT	o	o		0 0	0	90. 02
90. 03 09003 INFUSION OP SERVICES	o	0		0 0	0	90. 03
90. 04 09004 MATERNAL HEA	0	0		0 0	0	90. 04
91. 00 09100 EMERGENCY	0	0		0	0	91. 00
91. 01 09101 FREE STANDING EMERGENCY DEPT	0	0		0	0	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		0	0	
200.00 Total (lines 50-199)	0	0	1	0 0	0	200. 00

Heal th	Financial Systems FRAN	ICISCAN ST ANTH	ONY-MICHIGAN C	ΙΤΥ	In Lie	u of Form CMS-:	2552-10
	TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	RVICE OTHER PAS	S Provi der	CCN: 150015	Peri od:	Worksheet D	
THROUG	H COSTS		Componen	t CCN: 15T015	From 01/01/2014 To 12/31/2014	Part IV Date/Time Pre 5/28/2015 9:5	pared: 7 am
			Ti tl	e XVIII	Subprovi der -	PPS	
					I RF		
	Cost Center Description	Total	Total Charges			Inpati ent	
		Outpati ent	(from Wkst. C,		Ratio of Cost	Program	
		Cost (sum of				Charges	
		col. 2, 3 and	8)	7)	(col . 6 ÷ col .		
		4) 6. 00	7.00	8. 00	7) 9. 00	10.00	
	ANCILLARY SERVICE COST CENTERS	6.00	7.00	8.00	9.00	10.00	
50. 00	05000 OPERATING ROOM	0	100, 450, 321	0.0000	0. 000000	289, 813	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM			•		209, 013	1
53. 00	05300 ANESTHESI OLOGY					2, 011	
54. 00	05400 RADI OLOGY-DI AGNOSTI C		.,			332, 004	
54. 00	05401 FSED RADIOLOGY - DIAGNOSTIC			•		332,004	1
55. 00	05500 RADI OLOGY-THERAPEUTI C			•		10, 309	
55. 01	05501 WOODLAND CANCER CARE CENTER					10, 307	
57. 00	05700 CT SCAN		2, 237, 047	1		0	57. 00
58. 00	05800 MRI		_	1		0	
59.00	05900 CARDI AC CATHETERI ZATI ON		_			0	
60.00	06000 LABORATORY			•		464, 576	
60. 01	06001 FSED LABORATORY	0		•		0	1
65. 00	06500 RESPI RATORY THERAPY	0				310, 122	
66. 00	06600 PHYSI CAL THERAPY	0				138, 246	
69.00	06900 ELECTROCARDI OLOGY	0				41, 335	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0				58, 202	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0			0. 000000	0	
73.00	07300 DRUGS CHARGED TO PATIENTS	0			0. 000000	1, 802, 729	73. 00
76.00	03950 CV RESOURCE CENTER	0	l c	0. 00000	0. 000000	0	76.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	C	0.0000	0. 000000	0	90. 00
90. 01	09001 OB CLINIC	0	C	0.0000	0. 000000	0	90. 01
90. 02	09002 PAIN MANAGEMENT	0	C	0. 00000	0. 000000	0	90. 02
90. 03	09003 INFUSION OP SERVICES	0	2, 531, 174	0. 00000	0. 000000	0	90. 03
90. 04	09004 MATERNAL HEA	0				0	
91. 00	09100 EMERGENCY	0		•		20, 016	
91. 01	09101 FREE STANDING EMERGENCY DEPT	0	., .==,			0	
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	-,,	•	0. 000000	0	
200.00	Total (lines 50-199)	0	449, 150, 353	s		3, 469, 363	200. 00

Health Financial Systems	FRANCISCAN ST ANTHONY-N	MICHIGAN CITY	In Lieu of Form CMS-2552-10		
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provi der CCN: 150015	Peri od: From 01/01/2014	Worksheet D Part IV	
1111100011 00313		Component CCN: 15T015	To 12/31/2014	Date/Time Prepared: 5/28/2015 9:57 am	
		Title XVIII	Subprovi der -	PPS	

		Ti tI	e XVIII	Subprovider -	PPS	
		0 1 1: 1		I RF		
Cost Center Description	Inpati ent	Outpati ent	Outpati ent			
	Program	Program	Program			
	Pass-Through	Charges	Pass-Through			
	Costs (col. 8 x col. 10)		Costs (col. v col. 12)	9		
	11.00	12.00	13.00			
ANCILLARY SERVICE COST CENTERS	11.00	12.00	13.00			_
50. 00 05000 OPERATING ROOM	0		٦	0		50.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM	0	(0		52. 00
53. 00 05300 ANESTHESI OLOGY				0		53. 00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	0			0		54.00
54. 01 05401 FSED RADI OLOGY - DI AGNOSTI C	0			0		54. 01
55. 00 05500 RADI OLOGY-THERAPEUTI C				0		55. 00
55. 01 05501 WOODLAND CANCER CARE CENTER				0		55. 01
57. 00 05700 CT SCAN				0		57. 00
58. 00 05800 MRI				0		58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON				0		59.00
60. 00 06000 LABORATORY		(0		60.00
60. 01 06001 FSED LABORATORY				0		60. 01
65. 00 06500 RESPIRATORY THERAPY				0		65. 00
66. 00 06600 PHYSI CAL THERAPY	o o			0		66. 00
69. 00 06900 ELECTROCARDI OLOGY	o o			0		69. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	Č		0		71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	Č		0		72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	Ć		0		73. 00
76. 00 03950 CV RESOURCE CENTER	0	(0		76. 00
OUTPATIENT SERVICE COST CENTERS	-1	-	-1	-,		1
90. 00 09000 CLI NI C	0	C		0		90.00
90. 01 09001 0B CLINIC	0	C		0		90. 01
90. 02 09002 PAIN MANAGEMENT	0	C		0		90. 02
90. 03 09003 INFUSION OP SERVICES	0	C		0		90. 03
90. 04 09004 MATERNAL HEA	0	C		0		90. 04
91. 00 09100 EMERGENCY	0	C		0		91. 00
91.01 09101 FREE STANDING EMERGENCY DEPT	0	C		0		91. 01
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	C		0		92.00
200.00 Total (lines 50-199)	0	C		0		200. 00

Health Financial Systems FRA	Ith Financial Systems FRANCISCAN ST ANTHONY-N			In Lie	eu of Form CMS-2552-10	
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST			Peri od: From 01/01/2014	Worksheet D Part V	
		Component		To 12/31/2014		
		Ti tl	e XVIII	Subprovi der -	PPS	
				I RF		
			Charges		Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
	Ratio From	Services (see	Reimbursed	Rei mbursed	(see inst.)	

					I RF		
				Charges		Costs	
	Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
		Ratio From	Services (see	Reimbursed	Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins.	Ded. & Coins.		
				(see inst.)	(see inst.)		
		1.00	2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0. 127404	0	0	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 816577	0	0	0	0	52. 00
53.00	05300 ANESTHESI OLOGY	0. 045187	0	0	0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 133149	0	0	0	0	54. 00
54. 01	05401 FSED RADIOLOGY - DIAGNOSTIC	0. 108036	0	0	0	0	54. 01
55.00	05500 RADI OLOGY-THERAPEUTI C	0. 232444	0	0	0	0	55. 00
55. 01	05501 WOODLAND CANCER CARE CENTER	0. 863641	0	0	0	0	55. 01
57.00	05700 CT SCAN	0. 000000	0	0	0	0	57.00
58. 00	05800 MRI	0. 000000	0	l o	0	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0. 169515		0	0	0	59.00
60.00	06000 LABORATORY	0. 192345	l e	0	0	0	60.00
60. 01	06001 FSED LABORATORY	0. 310756	l e	0	0	0	60. 01
65. 00	06500 RESPIRATORY THERAPY	0. 188946		0	0	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	0. 324006		0	0	0	66. 00
69. 00	06900 ELECTROCARDI OLOGY	0. 154857	0	0	0	0	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 440062	0		0	0	71.00
72. 00		0. 708765	0	0	0	0	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0. 175995		0	_	0	73. 00
76. 00	03950 CV RESOURCE CENTER	0. 000000	l .	· -		0	76. 00
70.00	OUTPATIENT SERVICE COST CENTERS	0.00000			0	0	70.00
90. 00	09000 CLINIC	0. 000000	0	0	0	0	90.00
90. 01	09001 OB CLINIC	0. 000000				0	90. 01
90. 02	09002 PALN MANAGEMENT	0. 000000	l e		_	0	90. 02
90. 03	09003 I NFUSI ON OP SERVI CES	0. 314184	l e			0	90. 03
90. 04	09004 MATERNAL HEA	0. 000000	l e			0	90.03
91. 00	09100 EMERGENCY	0. 218988				0	91.00
91. 00	09101 FREE STANDING EMERGENCY DEPT	0. 402999			0	0	91.00
91.01	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 716571		1 0	0	0	
200.00		0.710371	0		0	_	200.00
200.00			١		0		200.00
201.00	Only Charges			١	U		201.00
202.00			0	0	0	0	202. 00
202.00	INCLUDIAL GES (TITLE 200 +7 - TITLE 201)	I	ı	٠	١	0	1202.00

APP0RT	Financial Systems FRAN TONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST		CCN: 150015 CCN: 15T015	In Lie Period: From 01/01/2014 To 12/31/2014	Worksheet D Part V Date/Time Pre	epared:
			Ti tl	e XVIII	Subprovi der -	5/28/2015 9:5 PPS	57 am
		Cos	sts		I RF		
	Cost Center Description	Cost Reimbursed Services Subject To	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)				
	ANOTHER SERVICES OF SERVICES	6. 00	7. 00				
	ANCILLARY SERVICE COST CENTERS O5000 OPERATING ROOM	0	0				50.00
	05200 DELIVERY ROOM & LABOR ROOM	0		1			52.00
	05300 ANESTHESI OLOGY	0	0				53.00
	05400 RADI OLOGY-DI AGNOSTI C	Ö	Ö	1			54.00
	05401 FSED RADIOLOGY - DIAGNOSTIC	0	O				54. 01
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0				55.00
	05501 WOODLAND CANCER CARE CENTER	0	0				55. 01
	05700 CT SCAN	0	0				57.00
	05800 MRI	0	0				58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0	•			59.00
60.00	06000 LABORATORY	0	0	•			60.00
60. 01 65. 00	06001 FSED LABORATORY 06500 RESPI RATORY THERAPY	0					60. 01 65. 00
	06600 PHYSI CAL THERAPY						66.00
	06900 ELECTROCARDI OLOGY	0	0				69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	Ö	Ö				71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	O				72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0				73.00
76. 00	03950 CV RESOURCE CENTER	0	0				76. 00
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLI NI C	0					90.00
	09001 OB CLINIC	0	ľ	•			90. 01
90. 02 90. 03	09002 PAIN MANAGEMENT		0	•			90. 02
	09003 INFUSION OP SERVICES 09004 MATERNAL HEA			I			90.03
	09100 EMERGENCY						91.00
91. 00	09101 FREE STANDING EMERGENCY DEPT	1 0	0				91.00
			Ö				92.00
200.00		0	Ö				200.00
201.00		0					201. 00

202. 00

Only Charges Net Charges (line 200 +/- line 201)

202.00

Heal th	Financial Systems FR	ANCISCAN ST ANTHONY-MIC	HIGAN CITY	In Lie	u of Form CMS-2	2552-10
	FATION OF INPATIENT OPERATING COST	P	rovi der CCN: 150015	Period: From 01/01/2014 To 12/31/2014	Worksheet D-1 Date/Time Preps/28/2015 9:5	pared:
			Title XVIII	Hospi tal	PPS	
	Cost Center Description					
					1. 00	
	PART I - ALL PROVIDER COMPONENTS					
	I NPATI ENT DAYS					
1.00	Inpatient days (including private room days				19, 114	1. 00
2.00	Inpatient days (including private room days				19, 114	2.00
3.00	Pri vate room days (excluding swing-bed and	observation bed days).	If you have only pr	ivate room days,	0	3. 00
4. 00	do not complete this line. Semi-private room days (excluding swing-bed	d and observation had do	ave)		16, 512	4. 00
5.00	Total swing-bed SNF type inpatient days (in			r 31 of the cost	10, 512	5. 00
3.00	reporting period	nerduring private room de	ays) thi ough becembe	1 31 01 the cost	O	3.00
6. 00	Total swing-bed SNF type inpatient days (in	ncluding private room da	avs) after December	31 of the cost	0	6. 00
	reporting period (if calendar year, enter (
7.00	Total swing-bed NF type inpatient days (inc	cluding private room day	ys) through December	31 of the cost	0	7. 00
	reporting period					
8.00	Total swing-bed NF type inpatient days (inc		ys) after December 3	1 of the cost	0	8. 00
	reporting period (if calendar year, enter (
9. 00	Total inpatient days including private roor	m days applicable to the	e Program (excluding	swing-bed and	8, 924	9. 00
40.00	newborn days)		<i>.</i>			40.00
10.00	Swing-bed SNF type inpatient days applicable through December 31 of the cost reporting processing states.			oom days)	Ü	10. 00
11 00	Swing-bed SNF type inpatient days applicable			oom days) after	0	11. 00
11.00	December 31 of the cost reporting period (i			dom days) arter	U	11.00
12. 00	Swing-bed NF type inpatient days applicable			e room davs)	0	12. 00
	through December 31 of the cost reporting p		5 (· · · · · · · · · · · · · · · · · ·	,	-	
	1 9 1	•				1

	Cost Center Description	1. 00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	19, 114	1. 00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	19, 114	2. 00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days,	0	3. 00
	do not complete this line.	4. 540	
4.00	Semi-private room days (excluding swing-bed and observation bed days)	16, 512	4. 00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost	0	5. 00
6. 00	reporting period Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	0	6. 00
0.00	reporting period (if calendar year, enter 0 on this line)	O	0.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost	0	7. 00
	reporting period		
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	0	8. 00
	reporting period (if calendar year, enter 0 on this line)		
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and	8, 924	9. 00
	newborn days)	_	
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	0	10. 00
11 00	through December 31 of the cost reporting period (see instructions)	0	11 00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	U	11. 00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	12. 00
12.00	through December 31 of the cost reporting period	o .	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	13.00
	after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15. 00	Total nursery days (title V or XIX only)	0	15. 00
16. 00	Nursery days (title V or XIX only)	0	16. 00
47.00	SWING BED ADJUSTMENT		47.00
17. 00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost	0.00	17. 00
18. 00	reporting period	0.00	18. 00
16.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	10.00
19. 00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost	0.00	19. 00
17.00	report in a peri od	0.00	17.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost	0.00	20. 00
	reporting period		
21. 00	Total general inpatient routine service cost (see instructions)	17, 391, 801	21.00
22. 00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line	0	22. 00
00.00	5 x line 17)		00.00
23. 00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6	0	23. 00
24. 00	x line 18) Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	0	24. 00
24.00	7 x line 19)	U	24.00
25. 00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	0	25. 00
20.00	x line 20)	· ·	20.00
26.00	Total swing-bed cost (see instructions)	0	26. 00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	17, 391, 801	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28. 00		0	
29. 00	Private room charges (excluding swing-bed charges)	0	
	Semi -pri vate room charges (excluding swing-bed charges)	0	00.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0. 000000	
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	
33. 00 34. 00	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	
35. 00	Average per diem private room cost differential (line 34 x line 31)	0. 00 0. 00	
36. 00	Private room cost differential adjustment (line 3 x line 35)	0.00	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line	17, 391, 801	37. 00
	27 minus line 36)	, 5, ., 501	
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38. 00	Adjusted general inpatient routine service cost per diem (see instructions)	909. 90	
39. 00	Program general inpatient routine service cost (line 9 x line 38)	8, 119, 948	
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0 110 040	40.00

A2.00 NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT 45.00 BURN INTENSIVE CARE UNIT 46.00 SURGICAL INTENSIVE CARE UNIT 47.00 OTHER SPECIAL CARE (SPECIFY) Cost Center Description	NCISCAN ST ANTHONY-M		CCN: 150015	Peri od: From 01/01/2014	worksheet D-1	
NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units				To 12/31/2014	Date/Time Pre 5/28/2015 9:5	
NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units		Ti tl	e XVIII	Hospi tal	PPS	, am
Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT 3.00 CORONARY CARE UNIT 5.00 BURN INTENSIVE CARE UNIT 5.00 SURGICAL INTENSIVE CARE UNIT 7.00 OTHER SPECIAL CARE (SPECIFY) Cost Center Description 3.00 Program inpatient ancillary service cost (William of the cost of Cost Center Description 3.00 Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inpatient operating cost exclumedical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION 4.00 Program discharges Target amount per discharge Target amount per discharge Target amount (line 54 x line 55) To Difference between adjusted inpatient operating cost excluments because the cost of lines 53/54 or 55 from the cost of market basket Lesser of lines 53/54 or 55 from prior year lesser of lines 53/54 is less than the lower of line which operating costs (line 53) are less than amount (line 56), otherwise enter zero (see Relief payment (see instructions) 3.00 Allowable Inpatient cost plus incentive payr PROGRAM INPATIENT ROUTINE SWING BED COST 4.00 Medicare swing-bed SNF inpatient routine cost instructions) (title XVIII only) 5.00 Medicare swing-bed SNF inpatient routine cost instructions) (title XVIII only) 7.00 Total Medicare swing-bed NF inpatient routine cost instructions) (title XVIII only) 7.00 Total Medicare swing-bed NF inpatient routine cost instructions) (title XVIII only) 7.00 Total Medicare swing-bed NF inpatient routine cost instructions) (title XVIII only) 7.00 Total Medicare swing-bed NF inpatient routine cost instructions) (title XVIII only) 7.00 Total Medicare swing-bed NF inpatient routine cost instructions) 7.00 Total Medicare swing-bed NF inpatient routine cost instructions (line 12 x line 19) 7.00 Total Program general inpatient routine service cost (line 9 x line line 12 x line 19) 7.00 Total Troutine service cost (line 9 x line line 12 x line 19) 7.00 Total Troutine service cost (line 9 x line line 14 x line 15)	Total Inpatient CostInpat	Total tient Days	Average Per Diem (col. 1 col. 2)	3	Program Cost (col. 3 x col. 4)	
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OD Lesser of lines 53/54 or 55 from prior year OD If line 53/54 is less than the lower of line which operating costs (line 53) are less the amount (line 56), otherwise enter zero (see OD Relief payment (see instructions) OD Allowable Inpatient cost plus incentive payr PROGRAM INPATIENT ROUTINE SWING BED COST OD Medicare swing-bed SNF inpatient routine cost instructions)(title XVIII only) OD Medicare swing-bed SNF inpatient routine cost instructions)(title XVIII only) OD Total Medicare swing-bed SNF inpatient routine CAH (see instructions) OD Title V or XIX swing-bed NF inpatient routine (line 12 x line 19) OD Title V or XIX swing-bed NF inpatient routine (line 13 x line 20) OD Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER NO OD Skilled nursing facility/other nursing facil OD Adjusted general inpatient routine service co OD Program routine service cost (line 9 x line OD Medically necessary private room cost applic OD Total Program general inpatient routine service OD Capital-related costs (line 9 x line OD Capital-related costs (line 75 ÷ li OD Program capital-related costs (line 9 x line OD Inpatient routine service cost (line 74 minu Aggregate charges to beneficiaries for excest OD Total Program routine service cost per diem limi OD Inpatient routine service cost per diem limi OD Reasonable inpatient routine services (see in OD Utilization review - physician compensation OD Total Program inpatient operating costs (sur	eporting period endir	ng 1996, u	paatea ana co	ompounded by the	0.00	55
If line 53/54 is less than the lower of line which operating costs (line 53) are less that amount (line 56), otherwise enter zero (see Relief payment (see instructions) Allowable Inpatient cost plus incentive paymerogram Inpatient routine service cost instructions) (title XVIII only) Medicare swing-bed SNF inpatient routine cost instructions) (title XVIII only) Medicare swing-bed SNF inpatient routine cost instructions) (title XVIII only) Total Medicare swing-bed SNF inpatient routine CAH (see instructions) Title V or XIX swing-bed NF inpatient routine (line 12 x line 19) Title V or XIX swing-bed NF inpatient routine (line 13 x line 20) Total title V or XIX swing-bed NF inpatient routine Skilled nursing facility/other nursing facil Adjusted general inpatient routine service Program routine service cost (line 9 x line Companies) Medically necessary private room cost applicated to inpatient routine service cost (line 45) Per diem capital-related costs (line 75 ÷ line 100 program capital-related costs (line 74 minus) Aggregate charges to beneficiaries for excess total program routine service cost per diem limitent routine service cost service (see in Utilization review - physician compensation Total Program inpatient operating costs (sur	cost report, updated	d by the m	arket basket		0.00	60
amount (line 56), otherwise enter zero (see Relief payment (see instructions) Allowable Inpatient cost plus incentive payment (see instructions) Allowable Inpatient cost plus incentive payment (see instructions) Medicare swing-bed SNF inpatient routine cost instructions) (title XVIII only) Medicare swing-bed SNF inpatient routine cost instructions) (title XVIII only) Total Medicare swing-bed SNF inpatient routine (CAH (see instructions) Title V or XIX swing-bed NF inpatient routine (line 12 x line 19) Title V or XIX swing-bed NF inpatient routine (line 13 x line 20) Total title V or XIX swing-bed NF inpatient routine (line 13 x line 20) Skilled nursing facility/other nursing facil Adjusted general inpatient routine service of Program routine service cost (line 9 x line Medically necessary private room cost application (application) Medically necessary private room cost (application) Medical				the amount by	0	
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Allowable Inpatient cost plus incentive payr PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cost instructions) (title XVIII only) Medicare swing-bed SNF inpatient routine cost instructions) (title XVIII only) Total Medicare swing-bed SNF inpatient routine CAH (see instructions) Title V or XIX swing-bed NF inpatient routine (line 12 x line 19) Total title V or XIX swing-bed NF inpatient routine (line 13 x line 20) Total title V or XIX swing-bed NF inpatient routine (line 13 x line 20) Total title V or XIX swing-bed NF inpatient routine Skilled nursing facility/other nursin	instructions)					
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instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cost instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routine CAH (see instructions) Title V or XIX swing-bed NF inpatient routine (line 12 x line 19) Title V or XIX swing-bed NF inpatient routine (line 13 x line 20) Total title V or XIX swing-bed NF inpatient routine (line 13 x line 20) Total title V or XIX swing-bed NF inpatient routine SKILLED NURSING FACILITY, OTHER NOW Skilled nursing facility/other nursing facility Adjusted general inpatient routine service cost (line 9 x line program routine service cost (line 9 x line service) Medically necessary private room cost application (application of the cost of the cost of the cost (line 75 ± line program capital-related costs (line 75 ± line program capital-related costs (line 74 mine program capital-related costs (line 74 mine program routine service cost (line 74 mine program routine service cost per diem limited in line program routine service cost per diem limited in patient routine service cost per diem limited in patient routine service cost per diem limited in program inpatient routine service (see in limitization review - physician compensation total Program inpatient operating costs (sur	sts through December	31 of the	cost reporti	na period (See	0	64
instructions) (title XVIII only) Total Medicare swing-bed SNF inpatient routing CAH (see instructions) Title V or XIX swing-bed NF inpatient routing (line 12 x line 19) Title V or XIX swing-bed NF inpatient routing (line 13 x line 20) Total title V or XIX swing-bed NF inpatient routing (line 13 x line 20) Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER NOTES Adjusted general inpatient routine service of Program routine service cost (line 9 x line Medically necessary private room cost applicated to Inpatient 26, line 45) Per diem capital-related costs (line 75 ÷ line 100 Program capital-related costs (line 74 minus Aggregate charges to beneficiaries for excession Total Program routine service cost (line 74 minus Aggregate charges to beneficiaries for excession Inpatient routine service cost per diem limit Inpatient routine service cost per	<u>-</u>			9		
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CAH (see instructions) Title V or XIX swing-bed NF inpatient routing (line 12 x line 19) Title V or XIX swing-bed NF inpatient routing (line 13 x line 20) Total title V or XIX swing-bed NF inpatient routing (line 13 x line 20) Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER NOTES Skilled nursing facility/other nursing facility			=> <			١.,
Title V or XIX swing-bed NF inpatient routing (line 12 x line 19) Title V or XIX swing-bed NF inpatient routing (line 13 x line 20) Total title V or XIX swing-bed NF inpatient routing (line 13 x line 20) Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER NOTES (Skilled nursing facility/other nursing faci	ne costs (line 64 pl	lus line 6	5)(title XVII	I only). For	0	66
(line 12 x line 19) Title V or XIX swing-bed NF inpatient routin (line 13 x line 20) Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER NOTES Adjusted general inpatient routine service of Program routine service cost (line 9 x line 00) Medically necessary private room cost applic OTOTAL Program general inpatient routine service (apital-related cost allocated to inpatient 26, line 45) Per diem capital-related costs (line 75 ÷ line 00) Program capital-related costs (line 74 minu 00) Aggregate charges to beneficiaries for excession of the program routine service cost per diem liming linpatient routine service cost per diem liming linpatient routine service cost limitation (line 00) Reasonable inpatient routine services (see in 00) Utilization review - physician compensation Total Program inpatient operating costs (sur	ne costs through Dece	ember 31 o	f the cost re	enorting period	0	67
Title V or XIX swing-bed NF inpatient routing (line 13 x line 20) Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER NOT Skilled nursing facility/other nursing facility/	3					"
Total title V or XÍX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N Skilled nursing facility/other nursing facil OO Adjusted general inpatient routine service o OProgram routine service cost (line 9 x line OO Medically necessary private room cost applic Total Program general inpatient routine service Capital-related cost allocated to inpatient 26, line 45) Per diem capital-related costs (line 75 ÷ li OO OPROGRAM CAPICAL COST (line 74 minus) OO Aggregate charges to beneficiaries for excess Total Program routine service cost per diem limit Inpatient routine service cost per diem limit Inpatient routine service cost limitation (li OPROGRAM COST (III) OPROGRAM	ne costs after Decemb	ber 31 of	the cost repo	orting period	0	68
PART III - SKILLED NURSING FACILITY, OTHER NO.00 Skilled nursing facility/other nursing fac						
Skilled nursing facility/other nursing facil Adjusted general inpatient routine service of Program routine service cost (line 9 x line Medically necessary private room cost applic Total Program general inpatient routine service Capital-related cost allocated to inpatient 26, line 45) Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minu Aggregate charges to beneficiaries for exces Total Program routine service costs for comp Inpatient routine service cost per diem limi Inpatient routine service cost limitation (line Reasonable inpatient routine services (see in Utilization review - physician compensation Total Program inpatient operating costs (sur					0	69
Adjusted general inpatient routine service of Program routine service cost (line 9 x line 00 Medically necessary private room cost application of Total Program general inpatient routine service (apital-related cost allocated to inpatient 26, line 45) Der diem capital-related costs (line 75 ÷ line 100 Program capital-related costs (line 9 x line 100 Inpatient routine service cost (line 74 minus 100 Aggregate charges to beneficiaries for excess 100 Total Program routine service cost per diem limit 100 Inpatient routine service cost per diem limit 100 Reasonable inpatient routine service cost program inpatient routine services (see in 100 Utilization review - physician compensation 101 Total Program inpatient operating costs (sur						70
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Total Program general inpatient routine service Capital-related cost allocated to inpatient 26, line 45) Per diem capital-related costs (line 75 ÷ line 45) Program capital-related costs (line 74 minus 40) Aggregate charges to beneficiaries for excession of the cost o			,			72
Capital-related cost allocated to inpatient 26, line 45) Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line 10 linpatient routine service cost (line 74 minu Aggregate charges to beneficiaries for excess Total Program routine service costs for composition linpatient routine service cost per diem limi linpatient routine service cost limitation (linpatient routine service cost (see in linitation review - physician compensation linpatient program inpatient operating costs (sur	cable to Program (lir	ne 14 x li	ne 35)			73
26, line 45) Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minu Aggregate charges to beneficiaries for exces Inpatient routine service costs for come Inpatient routine service cost per diem limi Inpatient routine service cost limitation (language) Reasonable inpatient routine service costs Program inpatient ancillary services (see in Utilization review - physician compensation Total Program inpatient operating costs (sur	-					74
OD Per diem capital-related costs (line 75 ÷ line 100 program capital-related costs (line 9 x line 100 linpatient routine service cost (line 74 minus 100 program capital program routine service costs for excess 100 linpatient routine service costs for compusition of 100 linpatient routine service cost per diem limis 100 linpatient routine service cost limitation (line 100 program inpatient routine service costs 100 program inpatient ancillary services (see in 100 litization review - physician compensation 100 Total program inpatient operating costs (sur	routine service cost	ts (from W	orksheet B, F	Part II, column		75
Program capital-related costs (line 9 x line of the cost of the co	ne 2)					76
On Inpatient routine service cost (line 74 minum Aggregate charges to beneficiaries for excess Total Program routine service costs for computational Inpatient routine service cost per diem limical Inpatient routine service cost limitation (Inpatient routine service cost limitation (Inpatient routine service cost of Program inpatient routine services (see in Utilization review - physician compensation Total Program inpatient operating costs (sur	•					77
Aggregate charges to beneficiaries for excession of the program routine service costs for composition of the program routine service cost per diem limit Inpatient routine service cost limitation (Inpatient routine service cost limitation (Inpatient routine service costs) of Program inpatient ancillary services (see in Utilization review - physician compensation of Total Program inpatient operating costs (sur	-					78
On Inpatient routine service cost per diem limit on Inpatient routine service cost limitation (Inpatient routine service cost limitation (Inpatient routine service costs on Program inpatient ancillary services (see in Utilization review - physician compensation Total Program inpatient operating costs (sur	,	der record	s)			79
On Inpatient routine service cost limitation (I) Reasonable inpatient routine service costs (I) Program inpatient ancillary services (see in Utilization review - physician compensation Total Program inpatient operating costs (sur		limitation	(line 78 mir	nus line 79)		80
On Reasonable inpatient routine service costs of Program inpatient ancillary services (see in Utilization review - physician compensation Total Program inpatient operating costs (sur						81
On Program inpatient ancillary services (see in Utilization review - physician compensation Total Program inpatient operating costs (sur						82
00 Utilization review - physician compensation 00 Total Program inpatient operating costs (sur						83
.00 Total Program inpatient operating costs (sur						84
		h 85)				86
PART IV - COMPUTATION OF OBSERVATION BED PAS]
.00 Total observation bed days (see instructions	•			<u> </u>	2, 602	
0.00 Adjusted general inpatient routine cost per 0.00 Observation bed cost (line 87 x line 88) (se		e 2)			909. 90 2, 367, 560	

Health Financial Systems FRA	NCISCAN ST ANTH	ONY-MICHIGAN CI	TY	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Peri od:	Worksheet D-1	
				From 01/01/2014 To 12/31/2014	Date/Time Prep 5/28/2015 9:5	
		Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 27)	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	2, 253, 582	17, 391, 801	0. 12957	7 2, 367, 560	306, 781	90.00
91.00 Nursing School cost	0	17, 391, 801	0.00000	2, 367, 560	0	91.00
92.00 Allied health cost	0	17, 391, 801	0.00000	2, 367, 560	0	92.00
93.00 All other Medical Education	0	17, 391, 801	0. 00000	2, 367, 560	0	93. 00

Health Financial Systems	FRANCISCAN ST ANTHONY-MICHIGAN CITY	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 1	150015 Peri od: From 01/01/2014	Worksheet D-1
	Component CCN:	15S015 To 12/31/2014	
	Ti tle XVI	II Subprovider -	PPS

		II LIE AVIII	I PF	FF3	
	Cost Center Description			4.00	
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days,			2, 876	1.00
2.00	Inpatient days (including private room days, excluding swing-bed			2, 876	2.00
3. 00	Private room days (excluding swing-bed and observation bed days do not complete this line.	. If you have only pri	vate room days,	0	3. 00
4. 00	Semi-private room days (excluding swing-bed and observation bed	days)		2, 876	4. 00
5.00	Total swing-bed SNF type inpatient days (including private room		31 of the cost	0	5. 00
	reporting period				
6. 00	Total swing-bed SNF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	days) after December 3	31 of the cost	0	6. 00
7. 00	Total swing-bed NF type inpatient days (including private room o	days) through December	31 of the cost	0	7. 00
	reporting period	.,			
8.00	Total swing-bed NF type inpatient days (including private room	days) after December 3°	1 of the cost	0	8. 00
9. 00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to	he Program (evoluding	swing-hed and	811	9. 00
7.00	newborn days)	the frogram (excruding	swillig-bed and	011	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only		oom days)	0	10. 00
	through December 31 of the cost reporting period (see instruction				
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only December 31 of the cost reporting period (if calendar year, ent		oom days) arter	0	11. 00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX of		e room davs)	0	12. 00
	through December 31 of the cost reporting period	3 .	,		
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX			0	13. 00
14. 00	after December 31 of the cost reporting period (if calendar year Medically necessary private room days applicable to the Program			0	14. 00
15. 00	Total nursery days (title V or XIX only)	(exertaining suring bear	ady 3)	0	15. 00
16.00	Nursery days (title V or XIX only)			0	16. 00
47.00	SWING BED ADJUSTMENT	11 1 0 1 01	s	0.00	47.00
17. 00	Medicare rate for swing-bed SNF services applicable to services reporting period	through December 31 of	r the cost	0.00	17. 00
18. 00	Medicare rate for swing-bed SNF services applicable to services	after December 31 of	the cost	0.00	18. 00
	reporting period				
19. 00	Medicald rate for swing-bed NF services applicable to services reporting period	through December 31 of	the cost	0.00	19. 00
20. 00	Medicald rate for swing-bed NF services applicable to services a	after December 31 of th	ne cost	0.00	20. 00
	reporting period				
21. 00	Total general inpatient routine service cost (see instructions)	24 -6		2, 728, 158	
22. 00	Swing-bed cost applicable to SNF type services through December 5×1 ine 17)	31 of the cost reporti	ng period (iine	0	22. 00
23. 00	Swing-bed cost applicable to SNF type services after December 3	of the cost reporting	g period (line 6	0	23. 00
	x line 18)			_	
24. 00	Swing-bed cost applicable to NF type services through December $7 \times 1 = 19$	31 of the cost reportion	ng period (line	0	24. 00
25. 00	Swing-bed cost applicable to NF type services after December 31	of the cost reporting	period (line 8	0	25. 00
	x line 20)	, ,			
26. 00	Total swing-bed cost (see instructions)	21 1: 2()		0 720 150	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost (I) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	ne 21 minus iine 26)		2, 728, 158	27.00
28. 00	General inpatient routine service charges (excluding swing-bed	and observation bed cha	arges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)		3 /	0	29. 00
30. 00	Semi-private room charges (excluding swing-bed charges)			0	30. 00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷	i ne 28)		0. 000000	
32. 00 33. 00	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)			0. 00 0. 00	
34. 00	Average per diem private room charge differential (line 32 minus	s line 33)(see instruc	tions)	0.00	
35. 00	Average per diem private room cost differential (line 34 x line		,	0.00	1
36. 00	Private room cost differential adjustment (line 3 x line 35)			0	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost and	d private room cost di	fferential (line	2, 728, 158	37. 00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUST	MENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see i	nstructions)		948. 59	
39. 00	Program general inpatient routine service cost (line 9 x line 3			769, 306	
40. 00 41. 00	Medically necessary private room cost applicable to the Program Total Program general inpatient routine service cost (line 39 +	•		769, 306	40.00
41.00	Trotal Trogram general impatrent routine service cost (ITHE 39 +	11116 40)	ı	707, 300	41.00

	Financial Systems FRAN ATION OF INPATIENT OPERATING COST	CISCAN SI ANIHO	Provi der	CCN: 150015	Peri od:	worksheet D-1	
			Componen	t CCN: 15S015	From 01/01/2014 To 12/31/2014	Date/Time Pre	
			Ti tl	e XVIII	Subprovider -	5/28/2015 9: 5 PPS	/ alli
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1		Program Cost (col. 3 x col.	
		1.00	2. 00	col . 2) 3.00	4. 00	4) 5. 00	
42. 00	NURSERY (title V & XIX only)	0	2.00				42.00
42.00	Intensive Care Type Inpatient Hospital Units	0	(00	1 0	1 42 00
43. 00 44. 00	INTENSIVE CARE UNIT CORONARY CARE UNIT	O I	C	0.	00 0	0	43. 00 44. 00
45. 00	BURN INTENSIVE CARE UNIT						45. 00
46. 00 47. 00	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)			•			46. 00 47. 00
	Cost Center Description			•		1.00	
48. 00	Program inpatient ancillary service cost (Wks	st. D-3. col. 3	. line 200)			1. 00 103, 913	48. 00
	Total Program inpatient costs (sum of lines			ons)		873, 219	
50. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inpa	atient routine	services (from	n Wkst. D. sui	m of Parts I and	73, 452	50. OC
	111)		•				
51. 00	Pass through costs applicable to Program inpa and IV)	atrent ancillar	y services (fr	om Wkst. D,	sum of Parts II	8, 685	51.00
52.00	Total Program excludable cost (sum of lines 5					82, 137	
53. 00	Total Program inpatient operating cost exclude medical education costs (line 49 minus line 5		rated, non-phy	sician anestl	hetist, and	791, 082	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION						1
	Program discharges Target amount per discharge					0.00	54.00
56. 00	Target amount (line 54 x line 55)					0	56.00
57. 00 58. 00	Difference between adjusted inpatient operati Bonus payment (see instructions)	ng cost and ta	rget amount (I	ine 56 minus	line 53)	0 0	
59. 00	Lesser of lines 53/54 or 55 from the cost rep	oorting period	endi ng 1996, ເ	pdated and c	ompounded by the		59.00
60. 00	market basket Lesser of lines 53/54 or 55 from prior year of	cost roport un	dated by the m	arkot baskot		0.00	60.00
	If line 53/54 is less than the lower of lines					0.00	
	which operating costs (line 53) are less than amount (line 56), otherwise enter zero (see i		s (lines 54 x	60), or 1% o	f the target		
62. 00	Relief payment (see instructions)	ristructrons)				0	62.00
63. 00	Allowable Inpatient cost plus incentive payme PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instru	ctions)			0	63.00
64. 00	Medicare swing-bed SNF inpatient routine cost	ts through Dece	mber 31 of the	cost report	ing period (See	0	64.00
65. 00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cost</pre>	ts after Decemb	er 31 of the d	ost renortin	n neriod (See	0	65.00
00.00	instructions)(title XVIII only)						
66. 00	Total Medicare swing-bed SNF inpatient routing CAH (see instructions)	ne costs (line	64 plus line 6	5)(title XVI	II only). For	0	66.00
67. 00	Title V or XIX swing-bed NF inpatient routine	e costs through	December 31 d	of the cost r	eporting period	0	67. 00
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routine	e costs after D	ecember 31 of	the cost rep	orting period	0	68.00
, o oo	(line 13 x line 20)			·	3 1		
U7. UU	Total title V or XIX swing-bed NF inpatient marked FACILITY, OTHER NU	•				0	69.00
70.00	Skilled nursing facility/other nursing facili	-					70.00
71. 00 72. 00	Adjusted general inpatient routine service co Program routine service cost (line 9 x line 7		ine /U ÷ line	۷)			71.00
73. 00	Medically necessary private room cost applica	abĺe to Program					73.00
74. 00 75. 00	Total Program general inpatient routine servi Capital-related cost allocated to inpatient r				Part II, column		74. 00 75. 00
76. 00	26, line 45) Per diem capital-related costs (line 75 ÷ lir	ne 2)					76.00
77. 00	Program capital-related costs (line 9 x line	76)					77. 00
78. 00 79. 00	Inpatient routine service cost (line 74 minus Aggregate charges to beneficiaries for excess		rovi den record	ls)			78. 00 79. 00
80.00	Total Program routine service costs for compa	arison to the c			nus line 79)		80.00
81. 00 82. 00	Inpatient routine service cost per diem limit Inpatient routine service cost limitation (li)				81. 00 82. 00
82.00	Reasonable inpatient routine service cost ilmitation (ii		* .				83.00
84. 00	Program inpatient ancillary services (see ins	structions)	,				84.00
85. 00 86. 00	Utilization review - physician compensation (Total Program inpatient operating costs (sum						85. 00 86. 00
	PART IV - COMPUTATION OF OBSERVATION BED PASS	THROUGH COST	J/			T	1
87.00	Total observation bed days (see instructions) Adjusted general inpatient routine cost per of		line 2)			0.00	87.00
	Observation bed cost (line 87 x line 88) (see	•					89.00

Health Financial Systems FRAM	NCISCAN ST ANTHO	ONY-MICHIGAN CI	TY	In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Peri od:	Worksheet D-1	
		Component	CCN: 15S015	From 01/01/2014 To 12/31/2014		
		Ti tl	e XVIII	Subprovi der - I PF	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 27)	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	260, 479	2, 728, 158	0. 09547	8 0	0	90.00
91.00 Nursing School cost	0	2, 728, 158	0.00000	0	0	91.00
92.00 Allied health cost	0	2, 728, 158	0.00000	0 0	0	92. 00
93.00 All other Medical Education	0	2, 728, 158	0.00000	0	0	93. 00

Health Financial Systems	FRANCISCAN ST ANTHONY-MICHI	IGAN CITY	In Lieu	of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Pro	ovider CCN: 150015	Peri od: From 01/01/2014	Worksheet D-1
	Com		To 12/31/2014	Date/Time Prepared: 5/28/2015 9:57 am
		Title XVIII	Subprovi der -	PPS

		II the Aviii	I RF	FF3	
	Cost Center Description			4.00	
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days,			2, 532	1. 00
2.00	Inpatient days (including private room days, excluding swing-bed Private room days (excluding swing-bed and observation bed days)			2, 532	2.00
3. 00	do not complete this line.	i. II you have only pri	vate room days,	0	3. 00
4.00	Semi-private room days (excluding swing-bed and observation bed	days)		2, 532	4. 00
5.00	Total swing-bed SNF type inpatient days (including private room	days) through December	31 of the cost	0	5.00
6. 00	reporting period Total swing-bed SNF type inpatient days (including private room	days) after December 3	21 of the cost	0	6. 00
0.00	reporting period (if calendar year, enter 0 on this line)	days) arter becember t	or or the cost	Ö	0.00
7. 00	Total swing-bed NF type inpatient days (including private room	days) through December	31 of the cost	0	7. 00
8. 00	reporting period Total swing-bed NF type inpatient days (including private room)	Mays) after December 21	l of the cost	0	8. 00
0.00	reporting period (if calendar year, enter 0 on this line)	lays) at ter becember 3	i or the cost	U	8.00
9. 00	Total inpatient days including private room days applicable to	the Program (excluding	swi ng-bed and	1, 898	9. 00
10. 00	newborn days) Swing-bed SNF type inpatient days applicable to title XVIII only	, (i noludi na privoto re	nom days)	0	10. 00
10.00	through December 31 of the cost reporting period (see instruction		Joili days)	U	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only	(including private ro	oom days) after	0	11. 00
12.00	December 31 of the cost reporting period (if calendar year, enti-		s seem dove)	0	12.00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX through December 31 of the cost reporting period	only (including private	e room days)	0	12. 00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX			0	13. 00
14.00	after December 31 of the cost reporting period (if calendar yea	-	, I	0	14.00
14. 00 15. 00	Medically necessary private room days applicable to the Program Total nursery days (title V or XIX only)	(excluding swing-bed of	lays)	0	14. 00 15. 00
16. 00	Nursery days (title V or XIX only)			0	16. 00
	SWING BED ADJUSTMENT				
17. 00	Medicare rate for swing-bed SNF services applicable to services reporting period	through December 31 of	the cost	0. 00	17. 00
18. 00	Medicare rate for swing-bed SNF services applicable to services	after December 31 of 1	the cost	0. 00	18. 00
	reporting period				
19. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	through December 31 of	the cost	0.00	19. 00
20. 00	Medicaid rate for swing-bed NF services applicable to services	after December 31 of th	ne cost	0. 00	20.00
21 00	reporting period			2 5/0 242	21 00
21. 00 22. 00	Total general inpatient routine service cost (see instructions) Swing-bed cost applicable to SNF type services through December	31 of the cost reporti	ng period (line	2, 569, 343 0	21. 00 22. 00
	5 x line 17)				
23. 00	Swing-bed cost applicable to SNF type services after December 3	l of the cost reportino	g period (line 6	0	23. 00
24. 00	x line 18) Swing-bed cost applicable to NF type services through December:	31 of the cost reportir	na period (line	0	24. 00
	7 x line 19)	·			
25. 00	Swing-bed cost applicable to NF type services after December 31	of the cost reporting	period (line 8	0	25. 00
26. 00	x line 20) Total swing-bed cost (see instructions)			0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost (ne 21 minus line 26)		2, 569, 343	27. 00
20.00	PRI VATE ROOM DI FFERENTI AL ADJUSTMENT	and abasemention had abo	15000)	0	28. 00
28. 00 29. 00	General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges)	and observation bed cha	ii ges)	0	
30. 00	Semi -pri vate room charges (excluding swing-bed charges)			0	30.00
31. 00	General inpatient routine service cost/charge ratio (line 27 ÷	i ne 28)		0. 000000	
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	
33. 00 34. 00	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 minu:	Line 33)(see instruct	tions)	0. 00 0. 00	
35. 00	Average per diem private room cost differential (line 34 x line		11 0113)	0.00	
36. 00	Private room cost differential adjustment (line 3 x line 35)			0	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost and	d private room cost dif	ferential (line	2, 569, 343	37. 00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUST	MENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see i	nstructi ons)		1, 014. 75	
39. 00	Program general inpatient routine service cost (line 9 x line 3			1, 925, 996	
40. 00 41. 00	Medically necessary private room cost applicable to the Program Total Program general inpatient routine service cost (line 39 +	•		0 1, 925, 996	40. 00 41. 00
71.00	Trotal Trogram general impatrent routine service cost (Tille 37 +	11110 40)	I	1, 723, 770	- 1.00

	Financial Systems FRANCATION OF INPATIENT OPERATING COST	CISCAN ST ANTHO			TY CCN: 150015	Peri od:	ieu of Form CMS- Worksheet D-1	
			Comp	onent	CCN: 15T015	From 01/01/201 To 12/31/201	4 Date/Time Pre	
				Titl	e XVIII	Subprovi der -	5/28/2015 9: 5 PPS	7 am
	Cost Center Description	Total	Total		Average Per	IRF Program Days	s Program Cost	
		Inpatient Cost	I npati ent	Days	Diem (col. 1		(col. 3 x col.	
		1. 00	2.00		col . 2) 3.00	4. 00	4) 5. 00	
42. 00	NURSERY (title V & XIX only)	0		0	0.	00	0 0	42. 00
43. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	0		0	0.	00	0 0	43.00
44.00	CORONARY CARE UNIT							44.00
45. 00 46. 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT							45. 00 46. 00
47. 00	OTHER SPECIAL CARE (SPECIFY)							47. 00
	Cost Center Description						1. 00	
48. 00	Program inpatient ancillary service cost (Wks				`		630, 652	
49. 00	Total Program inpatient costs (sum of lines 4 PASS THROUGH COST ADJUSTMENTS	1 through 48)(see instr	uctio	ns)		2, 556, 648	49.00
50. 00	Pass through costs applicable to Program inpa	tient routine	servi ces	(from	Wkst. D, su	m of Parts I an	d 300, 491	50. 00
51. 00	<pre>III) Pass through costs applicable to Program inpa</pre>	itient ancillar	y service	s (fr	om Wkst. D,	sum of Parts II	37, 686	51.00
	and IV)		,		1			
52. 00 53. 00	Total Program excludable cost (sum of lines 5 Total Program inpatient operating cost exclud		elated. no	n-phv	sician anest	hetist, and	338, 177 2, 218, 471	1
	medical education costs (line 49 minus line 5			. ,				
54. 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges						0	54.00
	Target amount per discharge						1	55. 00
56. 00 57. 00	Target amount (line 54 x line 55) Difference between adjusted inpatient operati	ng cost and ta	arget amou	nt (I	ine 56 minus	line 53)	0	
58. 00	Bonus payment (see instructions)	9	Ü			•	0	58.00
59. 00	Lesser of lines 53/54 or 55 from the cost rep market basket	orting period	endi ng 19	96, u	pdated and c	ompounded by th	e 0.00	59.00
60. 00							0.00	•
61. 00	If line 53/54 is less than the lower of lines which operating costs (line 53) are less than						0	61.00
	amount (line 56), otherwise enter zero (see i		(0 . X	00), 0. 1% 0	. the target		
62. 00 63. 00	Relief payment (see instructions) Allowable Inpatient cost plus incentive payme	ent (see instru	ıctions)				1	62.00
	PROGRAM INPATIENT ROUTINE SWING BED COST							
64. 00	Medicare swing-bed SNF inpatient routine cost instructions)(title XVIII only)	s through Dece	ember 31 o	f the	cost report	ing period (See	0	64. 00
65. 00	Medicare swing-bed SNF inpatient routine cost	s after Decemb	per 31 of	the c	ost reportin	g period (See	0	65. 00
66. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routir	e costs (line	64 plus l	ine 6	5)(title XVI	II only). For	0	66. 00
<i>(</i> 7 00	CAH (see instructions)		Dogombou	21.5	f the cost is	anamting namiad		67. 00
67. 00	Title V or XIX swing-bed NF inpatient routine (line 12 x line 19)	costs through	December	31 0	i the cost i	eporting period		67.00
68. 00	Title V or XIX swing-bed NF inpatient routine (line 13 x line 20)	costs after D	December 3	1 of	the cost rep	orting period	0	68. 00
69. 00	Total title V or XIX swing-bed NF inpatient r	outine costs ((line 67 +	line	68)		0	69. 00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER NU Skilled nursing facility/other nursing facili							70.00
71. 00	Adjusted general inpatient routine service co	st per diem (I						71.00
72. 00 73. 00	Program routine service cost (line 9 x line 7 Medically necessary private room cost applica		ı (lino 14	v li	no 25)			72. 00 73. 00
74. 00	Total Program general inpatient routine servi				ne 33)			74. 00
75. 00	Capital-related cost allocated to inpatient r 26, line 45)	outine service	costs (f	rom W	orksheet B,	Part II, column		75. 00
76. 00	Per diem capital-related costs (line 75 ÷ lir	ne 2)						76. 00
77. 00 78. 00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minus	•						77. 00 78. 00
79. 00	Aggregate charges to beneficiaries for excess	.*	orovi der ir	ecord	s)			79.00
80.00	Total Program routine service costs for compa		cost limit	ati on	(line 78 mi	nus line 79)		80.00
81. 00 82. 00	Inpatient routine service cost per diem limit Inpatient routine service cost limitation (li		1)					81. 00 82. 00
83. 00	Reasonable inpatient routine service costs (s	ee instruction	* .					83.00
84. 00 85. 00	Program inpatient ancillary services (see ins Utilization review - physician compensation (ons)					84. 00 85. 00
86. 00	Total Program inpatient operating costs (sum	of lines 83 th						86. 00
87. 00	PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions)						1 0	87. 00
88. 00	Adjusted general inpatient routine cost per o	liem (line 27 ÷					0.00	88. 00
89 NN	Observation bed cost (line 87 x line 88) (see	instructions))				0	89. 00

Health Financial Systems FRAM	NCISCAN ST ANTHO	ONY-MICHIGAN CI	TY	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Peri od:	Worksheet D-1	
		Component	CCN: 15T015	From 01/01/2014 To 12/31/2014		
		Ti tl	e XVIII	Subprovi der - I RF	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 27)	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	400, 869	2, 569, 343	0. 15602	0 0	0	90.00
91.00 Nursing School cost	0	2, 569, 343	0.00000	0	0	91.00
92.00 Allied health cost	0	2, 569, 343	0.00000	0 0	0	92. 00
93.00 All other Medical Education	0	2, 569, 343	0.00000	0	0	93. 00

INPATI	ENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der	CCN: 150015	Peri od:	Worksheet D-3	
				From 01/01/2014 To 12/31/2014	Date/Time Pre 5/28/2015 9:5	pared: 7 am
		Ti tl	e XVIII	Hospi tal	PPS	
	Cost Center Description		Ratio of Cos		I npati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
			1.00	2. 00	2) 3. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
30. 00	03000 ADULTS & PEDIATRICS			12, 881, 311		30.00
31.00	03100 I NTENSI VE CARE UNI T			2, 787, 876		31.00
40.00	04000 SUBPROVI DER – I PF			2,707,070		40.00
41. 00	04100 SUBPROVI DER – I RF			0		41.00
43. 00	04300 NURSERY					43.00
10.00	ANCILLARY SERVICE COST CENTERS					10.00
50.00	05000 OPERATING ROOM		0. 12821	9 11, 546, 640	1, 480, 499	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM		0. 81657			
53.00	05300 ANESTHESI OLOGY		0.04573	•		
54.00	05400 RADI OLOGY-DI AGNOSTI C		0. 13314	8, 561, 188	1, 139, 914	54.00
54.01	05401 FSED RADIOLOGY - DIAGNOSTIC		0. 10803	36 0	0	
55.00	05500 RADI OLOGY-THERAPEUTI C		0. 23466	693, 276	162, 686	55.00
55. 01	05501 WOODLAND CANCER CARE CENTER		0. 86449	07	0	55. 01
57.00	05700 CT SCAN		0.00000	00	0	57.00
58.00	05800 MRI		0.00000	00	0	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON		0. 17196	3, 515, 692	604, 583	59.00
60.00	06000 LABORATORY		0. 19311	8, 457, 697	1, 633, 334	60.00
60.01	06001 FSED LABORATORY		0. 31075	66 0	0	60.01
65.00	06500 RESPIRATORY THERAPY		0. 18894	4, 500, 556	850, 367	65.00
66.00	06600 PHYSI CAL THERAPY		0. 32400	1, 490, 177	482, 826	66.00
69.00	06900 ELECTROCARDI OLOGY		0. 15485	2, 844, 415	440, 478	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 44006	2, 653, 113	1, 167, 534	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		0. 70876	5 4, 227, 848	2, 996, 551	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		0. 17599	14, 384, 995	2, 531, 687	73.00
76.00	03950 CV RESOURCE CENTER		0.00000	00	0	76.00
	OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLI NI C		0.00000	00 0	0	
90. 01	09001 OB CLINIC		0.00000	0 0	0	90. 01
90.02	09002 PAIN MANAGEMENT		0.00000	0 0	0	90. 02
90. 03	09003 INFUSION OP SERVICES		0. 31418	553, 696	173, 962	
	09004 MATERNAL HEA		0.00000		0	
01 00	109100 EMERGENCY		0 21898	88 3 852 927	843 745	91 00

0. 218988

0. 402999

0. 716571

91.00

91.01

201. 00 202. 00

190, 532 92. 00 14, 742, 829 200. 00

265, 894 68, 337, 695

3, 852, 927

68, 337, 695

09100 EMERGENCY

91. 01 09101 FREE STANDING EMERGENCY DEPT

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 200.00 Total (sum of lines 50-94 and 96-98)

Net Charges (line 200 minus line 201)

Less PBP Clinic Laboratory Services-Program only charges (line 61)

91.00

201.00 202.00

ealth Financial Systems FRANCISCAN NPATIENT ANCILLARY SERVICE COST APPORTIONMENT	ST ANTHONY-MI CHI GAN CI TY Provi der CCN: 15	0015	Peri od:	worksheet D-3	
THE PROPERTY OF SERVICE GOOD AND ONLY ON WHEN			From 01/01/2014		
	Component CCN: 1	5S015	To 12/31/2014	Date/Time Pre 5/28/2015 9:5	
	Title XVIII		Subprovi der -	PPS	
Cost Center Description	Ratio	of Cost		Inpati ent	
	To Ch	narges	Program	Program Costs	
			Charges	(col. 1 x col.	
	1	00	2. 00	2) 3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS		00	2.00	3.00	
30. 00 03000 ADULTS & PEDI ATRI CS			0		30. (
31.00 03100 INTENSIVE CARE UNIT			0		31.
10. 00 04000 SUBPROVI DER - 1 PF			966, 362		40.
I1. 00 04100 SUBPROVI DER - I RF			0		41. (
13. 00 04300 NURSERY					43.
ANCI LLARY SERVI CE COST CENTERS		12021	0 2.715	240	-
0.00 05000 OPERATING ROOM 2.00 05200 DELIVERY ROOM & LABOR ROOM). 12821 [.]). 81657 [.]		348	1
2.00 05200 DELIVERY ROOM & LABOR ROOM 3.00 05300 ANESTHESI OLOGY	I). 81657). 04573		0	
4. 00 05400 RADI OLOGY-DI AGNOSTI C	I). 13314 [,]		6, 880	
4. 01 05401 FSED RADI OLOGY - DI AGNOSTI C). 10803		0,000	1
5. 00 05500 RADI OLOGY-THERAPEUTI C		0. 23466		1, 545	
5. 01 05501 WOODLAND CANCER CARE CENTER		0. 86449		0	1
7. 00 05700 CT SCAN		0.00000	0	0	57.
8. 00 05800 MRI		0.00000	0	0	58.
9. 00 05900 CARDI AC CATHETERI ZATI ON). 17196		0	1
0. 00 06000 LABORATORY). 19311			1
0. 01 06001 FSED LABORATORY	•	0. 31075		0	1
55. 00 06500 RESPIRATORY THERAPY	•). 18894		3, 336	•
6. 00 06600 PHYSI CAL THERAPY 9. 00 06900 ELECTROCARDI OLOGY). 32400). 15485		3, 584 1, 837	
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT). 13465). 44006:		277	1
2. 00 07100 IMPL. DEV. CHARGED TO PATIENTS	•). 70876!		0	1
3. 00 07300 DRUGS CHARGED TO PATIENTS	ı). 17599!		42, 293	1
6.00 03950 CV RESOURCE CENTER		0. 000000		0	1
OUTPATIENT SERVICE COST CENTERS					
0. 00 09000 CLI NI C	(0.00000	0 0	0	90.
0. 01 09001 0B CLINIC		0.00000		0	1
0. 02 09002 PAI N MANAGEMENT		0. 000000		0	1
00. 03 09003 NFUSION OP SERVICES		0. 31418		0	
0. 04 09004 MATERNAL HEA		0.00000		0	1
01. 00 09100 EMERGENCY). 21898		19, 949	1
01.01 09101 FREE STANDING EMERGENCY DEPT 02.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	I). 40299¹). 71657˚		0	
70.00 Total (sum of lines 50-94 and 96-98)		. / 100/	557 160		

0 91.01 0 92.00 103,913 200.00

201. 00 202. 00

557, 160

200.00

201.00 202.00 Total (sum of lines 50-94 and 96-98)

Less PBP Clinic Laboratory Services-Program only charges (line 61) Net Charges (line 200 minus line 201)

I NPATI	ENT ANCILLARY SERVICE COST APPORTIONMENT	Componen	CCN: 150015 t CCN: 15T015	Peri od: From 01/01/2014 To 12/31/2014		pared:
		Ti tI	e XVIII	Subprovi der – I RF	PPS	
	Cost Center Description		Ratio of Cos To Charges	t Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
	T		1.00	2. 00	3. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS				T	
30. 00 31. 00	03000 ADULTS & PEDI ATRI CS 03100 I NTENSI VE CARE UNI T			0	•	30.00
40. 00	04000 SUBPROVI DER - I PF			0		40.0
41. 00	04100 SUBPROVI DER – I RF			2, 064, 814		41. 0
43. 00	04300 NURSERY			_,,,		43. 0
	ANCILLARY SERVICE COST CENTERS		•	•	•	1
50.00	05000 OPERATING ROOM		0. 1282	19 289, 813	37, 160	50.0
52. 00	05200 DELIVERY ROOM & LABOR ROOM		0. 8165		0	
53. 00	05300 ANESTHESI OLOGY		0. 04573		92	
54.00	05400 RADI OLOGY-DI AGNOSTI C		0. 13314			1
54. 01	05401 FSED RADI OLOGY - DI AGNOSTI C		0. 10803		0	
55. 00 55. 01	05500 RADI OLOGY-THERAPEUTI C 05501 WOODLAND CANCER CARE CENTER		0. 23460 0. 86449		2, 419 0	1
57. 00	05700 CT SCAN		0. 00000		0	1
8. 00	05800 MRI		0.00000		0	58.0
59. 00	05900 CARDI AC CATHETERI ZATI ON		0. 17196		l o	59.0
60.00	06000 LABORATORY		0. 1931		89, 718	60.0
50. 01	06001 FSED LABORATORY		0. 3107	56 0	0	60.0
55.00	06500 RESPI RATORY THERAPY		0. 18894		58, 597	
66. 00	06600 PHYSI CAL THERAPY		0. 32400			1
59. 00	06900 ELECTROCARDI OLOGY		0. 1548			ı
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 4400		25, 612	
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENTS		0. 70870		0	
	07300 DRUGS CHARGED TO PATIENTS 03950 CV RESOURCE CENTER		0. 1759 0. 00000			ı
0.00	OUTPATIENT SERVICE COST CENTERS		0.00000	50 0	0	70.0
90. 00	09000 CLINIC		0.0000	00 0	0	90.0
0. 01	09001 0B CLINIC		0. 00000		Ö	90.0
	09002 PAIN MANAGEMENT		0.00000		0	90.0
90. 03	09003 I NFUSI ON OP SERVI CES		0. 31418		0	90.0
90. 04	09004 MATERNAL HEA		0.00000		0	
91. 00	09100 EMERGENCY		0. 21898			1
	09101 FREE STANDING EMERGENCY DEPT		0. 40299			
വാ നവ	OOOOO ORSEDVATION REDS (NON_DISTINCT DART		0 7165	71	l 0	loor

0. 402999 0. 716571

0 91.01 0 92.00 630,652 200.00

201. 00

92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 200. 00 Total (sum of lines 50-94 and 96-98)

201.00 202.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) Net Charges (line 200 minus line 201)

Hoal th	Financial Systems FRANCISCAN ST ANTHONY-	MICHICAN CI	TV	In Lie	eu of Form CMS-:	2552 10
	ENT ANCILLARY SERVICE COST APPORTIONMENT	_		Peri od: From 01/01/2014 To 12/31/2014	Worksheet D-3	pared:
		Ti t	le XIX	Hospi tal	Cost	
	Cost Center Description		Ratio of Cos To Charges	t Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1. 00	2. 00	3. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS		1		1	
	03000 ADULTS & PEDI ATRI CS			4, 554, 714		30.00
	03100 I NTENSI VE CARE UNI T			713, 385		31.00
	04000 SUBPROVI DER - I PF			0		40.00
	04100 SUBPROVI DER - I RF			7/7 420		41.00
	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS			767, 420		43. 00
	05000 OPERATING ROOM		0. 12740	3, 342, 096	425, 796	50.00
	05200 DELIVERY ROOM & LABOR ROOM		0. 12740		425, 790	52.00
	05300 ANESTHESI OLOGY		0. 04518			53.00
	05400 RADI OLOGY-DI AGNOSTI C		0. 13314			
	05401 FSED RADIOLOGY - DIAGNOSTIC		0. 10803			
	05500 RADI OLOGY-THERAPEUTI C		0. 2324		0	
	05501 WOODLAND CANCER CARE CENTER		0. 86364		0	55. 01
	05700 CT SCAN		0. 00000		0	57. 00
	05800 MRI		0. 00000		0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON		0. 1695°	15 298, 338	50, 573	59. 00
60.00	06000 LABORATORY		0. 1923	15 2, 743, 710	527, 739	60.00
60. 01	06001 FSED LABORATORY		0. 3107	56 0	0	60. 01
65.00	06500 RESPI RATORY THERAPY		0. 18894	1, 154, 595	218, 156	65. 00
66.00	06600 PHYSI CAL THERAPY		0. 32400	06 176, 582	57, 214	66. 00
69.00	06900 ELECTROCARDI OLOGY		0. 1548	57 489, 179	75, 753	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 4400	493, 569	217, 201	71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS		0. 70876	814, 466	577, 265	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS		0. 17599	95 4, 432, 038	780, 017	73. 00
	03950 CV RESOURCE CENTER		0.00000	00	0	76. 00
	OUTPAȚIENT SERVICE COST CENTERS			_		
	09000 CLI NI C		0.00000		0	
	09001 OB CLINIC		0.00000		0	90. 01
	09002 PALN MANAGEMENT		0.00000		0	
00 02 0	NONDELL METICIONE OD CEDVITCEC		0 21/10	2/1 1/6 276	15 000	00 02

0. 314184

0. 000000

0. 218988

0.402999

0. 716571

17, 368, 687

17, 368, 687

90.03

90. 04

91.00

91.01

92.00 0 3, 471, 198 200. 00

201. 00 202. 00

45, 989

09003 I NFUSI ON OP SERVI CES 09004 MATERNAL HEA

91. 01 09101 FREE STANDING EMERGENCY DEPT

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 200.00 Total (sum of lines 50-94 and 96-98)

Net Charges (line 200 minus line 201)

Less PBP Clinic Laboratory Services-Program only charges (line 61)

09100 EMERGENCY

90.03

90.04

91.00

201.00

202.00

	ial Systems FRANCISCAN ST ANTHON		CCN: 150015	Pei	ri od:	u of Form CMS-2 Worksheet D-3	
			t CCN: 15S015	Fro	om 01/01/2014		
		·				5/28/2015 9:5	
		Ti t	le XIX	S	ubprovi der – I PF	Cost	
(Cost Center Description		Ratio of Cos		Inpati ent	Inpati ent	
			To Charges		Program	Program Costs (col. 1 x col.	
					Charges	2)	
			1.00		2. 00	3. 00	
I NPATI E	ENT ROUTINE SERVICE COST CENTERS		1				
	ADULTS & PEDIATRICS				3, 381		30.00
	NTENSI VE CARE UNI T				0	I	31.00
	SUBPROVI DER - I PF				1, 283, 058	I	40.00
	SUBPROVI DER - I RF				0	I	41.00
43. 00 04300 N					0		43.00
	ARY SERVICE COST CENTERS PERATING ROOM		0. 1274	04	0	0	50.00
	DELIVERY ROOM & LABOR ROOM		0. 1274		0	0	52. 0
	NESTHESI OLOGY		0. 0451		0	0	
1 1	RADI OLOGY-DI AGNOSTI C		0. 0431		0	0	
1 1	SED RADIOLOGY - DIAGNOSTIC		0. 1080		0	0	
	RADI OLOGY-THERAPEUTI C		0. 2324		0	Ö	
	VOODLAND CANCER CARE CENTER		0. 8636		0	Ō	
57. 00 05700 C	CT SCAN		0.0000	00	0	0	
58. 00 05800 N	MRI .		0.0000	00	0	0	58. 0
59.00 05900 0	CARDI AC CATHETERI ZATI ON		0. 1695	15	0	0	59. 0
	ABORATORY		0. 1923		0	0	
1 1	SED LABORATORY		0. 3107		0	0	
	RESPI RATORY THERAPY		0. 1889		0	0	
1 1	PHYSI CAL THERAPY		0. 3240		0	0	
	ELECTROCARDI OLOGY		0. 1548		2, 530	392	
	MEDICAL SUPPLIES CHARGED TO PATIENT		0. 4400		184 0	81 0	
	MPL. DEV. CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS		0. 7087 0. 1759		0	0	
	CV RESOURCE CENTER		0. 1739		0	0	
	ENT SERVICE COST CENTERS		0.0000	00	<u> </u>		70.0
90. 00 09000 0			0.0000	00	0	0	90.0
90. 01 09001 0	OB CLINIC		0.0000	00	0	0	90.0
0. 02 09002 F	PALN MANAGEMENT		0.0000	00	0	0	90.0
0. 03 09003 1	NFUSION OP SERVICES		0. 3141	84	0	0	90.0
	MATERNAL HEA		0.0000	00	0	0	
	MERGENCY		0. 2189		0	0	
	REE STANDING EMERGENCY DEPT		0. 4029		0	0	
	DBSERVATION BEDS (NON-DISTINCT PART		0. 7165	71	0	0	
	otal (sum of lines 50-94 and 96-98)				2, 714	473	200. 0
	Less PBP Clinic Laboratory Services-Program only charge	s (line 61)			0	I	201. 0
202.00 N	let Charges (line 200 minus line 201)				2, 714	ı	202.00

ealth Financial Systems FRANCISCAN ST ANTHO NPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der	CCN: 150015	Peri od:	Worksheet D-3	}
			From 01/01/2014		
		CCN: 15T015	To 12/31/2014	Date/Time Pre 5/28/2015 9:5	
	Ti t	le XIX	Subprovi der - I RF	Cost	
Cost Center Description		Ratio of Cos		I npati ent	
		To Charges	3	Program Costs	
			Charges	(col. 1 x col.	
		1.00	2. 00	2) 3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	-
D. 00 03000 ADULTS & PEDIATRICS			0		30.
1. 00 03100 NTENSI VE CARE UNIT			0		31.
0. 00 04000 SUBPROVI DER - I PF			0		40.
1. 00 04100 SUBPROVI DER - RF			186, 543		41.
3. 00 04300 NURSERY			0		43.
ANCILLARY SERVICE COST CENTERS		•	<u> </u>		
D. 00 05000 OPERATING ROOM		0. 1274	04 0	0	50.
2.00 05200 DELIVERY ROOM & LABOR ROOM		0. 8165	77 0	0	52.
3. 00 05300 ANESTHESI OLOGY		0. 0451	87 0	0	53.
P. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 1331		0	
P. 01 05401 FSED RADIOLOGY - DIAGNOSTIC		0. 1080		0	
5. 00 05500 RADI OLOGY-THERAPEUTI C		0. 2324		0	
5. 01 05501 WOODLAND CANCER CARE CENTER		0. 8636		0	
7. 00 05700 CT SCAN		0.0000		0	1
3. 00 05800 MRI		0.0000		0	
P. 00 05900 CARDI AC CATHETERI ZATI ON		0. 1695		0	
0. 00 06000 LABORATORY		0. 1923		0	
0. 01 06001 FSED LABORATORY 5. 00 06500 RESPI RATORY THERAPY		0. 3107		0 0	1
5. 00 06500 RESPI RATORY THERAPY 5. 00 06600 PHYSI CAL THERAPY		0. 1889 0. 3240		0	
D. 00 06000 PHYSICAL THERAPY D. 00 06900 ELECTROCARDI OLOGY		0. 3240		39	
. 00 00700 ELECTROCARD OLOGI . 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 1348		195	
00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 7087		0	
00 07300 DRUGS CHARGED TO PATIENTS		0. 1759		0	1
. 00 03950 CV RESOURCE CENTER		0.0000		0	
OUTPATIENT SERVICE COST CENTERS		0.0000	00 0	<u> </u>	1 ′ °
. 00 09000 CLI NI C		0.0000	00 0	0	90
. 01 09001 0B CLINIC		0.0000	00 0	0	90
. 02 09002 PAI N MANAGEMENT		0.0000	00 0	0	90
. 03 09003 I NFUSI ON OP SERVI CES		0. 3141	84 0	0	90
.04 09004 MATERNAL HEA		0.0000	00 0	0	90
. 00 09100 EMERGENCY		0. 2189	88 0	0	91
. 01 09101 FREE STANDING EMERGENCY DEPT		0. 4029	99 0	0	91
.00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 7165	71 0	0	92
0.00 Total (sum of lines 50-94 and 96-98)			695	234	200
O1.00 Less PBP Clinic Laboratory Services-Program only charg	ges (line 61)		0		201
02.00 Net Charges (line 200 minus line 201)			695		202

Title 2011 Description D		ATION OF REIMBURSEMENT SETTLEMENT		CCN: 150015	Peri od: From 01/01/2014	Worksheet E Part A	1002 10
DRG Amounts Other than Outlier Poyments 0					To 12/31/2014	Date/Time Pre	pared: 7 am
No. PARE A INVALIBINITY IAL SERVICES MOBER 1975 1.00 1			Ti tl	e XVIII	Hospi tal	PPS	
1.00 Nick amounts other than outil ser payments for discharges occurring prior to October 1 (see instructions) 1.00		DADT A INDATIENT HOSDITAL SERVICES LINDED LDDS		0	1. 00	2. 00	
1. 02 GR. dismostration than that not if an apprents for discharges occurring on or 1.02 GR. dismostration than that not if an apprents for discharges occurring from the 1.03 GR. for Federal specific operating payment for Model 4 BRCI for 0.0 discharges occurring prior to October 1.03 discharges occurring prior to October 1.03 GR. for Federal specific operating payment for Model 4 BRCI for 0.0 discharges for Robert 1.03 GR. for Federal specific operating payment for Model 4 BRCI for 0.0 discharges for Robert 1.03 GR. for Federal specific operating payment for discharges for Model 4 BRCI for 0.0 discharges for Robert 1.03 GR. for Federal specific operating payment for discharges for Model 4 BRCI for 0.0 discharges for Robert 1.03 GR. for for for for payment for discharges for Robert 1.03 GR. for for for for payment for discharges for Robert 1.03 GR. for for for for for for payment for discharges for Robert 1.03 GR. for	1.00				O		1.00
1.02 BRG amounts other than outlier payments for discharges occurring on or 5,294,810 1.02	1.01	DRG amounts other than outlier payments for discharges occurrin	g prior		15, 884, 429		1. 01
after October 1 (see instructions)	1. 02		a on or		5, 294, 810		1. 02
discharges occurring prior for October 1 (see instructions) 0 1.04		after October 1 (see instructions)	9		, , , , , , ,		
1.04 DRG For Toderer's specific operating payment for Model 4 BRCI for decisional specified in control or affer October 1 (see instructions) 308,662 2.00 0.11 in payments for discharges (see instructions) 308,662 2.00 0.11 in payments for discharges for Model 4 BRCI (see instructions) 0 2.02 0.01 0.00 0.	1. 03				0		1. 03
2.00 Dutil eir payments for di schariges. (see instructions) 0.01 1 1 2.01 1 2.01 1 2.0	1.04				0		1. 04
2.01 Outlier reconciliation amount 0 2.01	2 00				200 602		2 00
Managed Care Simulated Payments					0		2.00
Bed days available divided by number of days in the cost reporting 141.87 4.00 period (see instructions)			ns)		0		2. 02
period Gene Instructions			i na				ı
File count for all opathic and osteopathic programs for the most recent constructions 5.00 5.00 6.0	00	period (see instructions)					
Cost reporting period ending on or before 12/31/1996. (see instructions) Cost	F 00		rocont	I	0.00		5 00
Criteria for an add-on to the cap for new programs in accordance with 42 CFR 413,79(e) 7.00 MBA Section 422 reduction amount to the IME cap as specified under 42 0.00 7.00 CFR 9412,105(f)(1)(1)(1)(8)(2) Tribe cost report straddles July 1, 2011 Then see Instructions CFR 9412,105(f)(1)(1)(1)(8)(2) Tribe cost report straddles July 1, 2011 Then see Instructions CFR 9412,105(f)(1)(1)(1)(8)(2) Tribe cost report straddles July 1, 2011 Then see Instructions CFR 9412,05(f)(1)(1)(1)(8)(2) Tribe cost report straddles July 1, 2011 Then see Instructions CFR 9413,79(b), 413,79(c),21(1), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002). Respectively and for the first cost report straddles July 1, 2011, see Instructions. CFR 9413,79(b), 413,79(c),21(1), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002). Respectively and for section 5503 of the ACA. If the cost report straddles July 1, 2011, see Instructions. CFR 9413,79(b), 413,79(c),21(1), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002). Respectively and for section 5503 of the ACA. If the cost report straddles July 1, 2011, see Instructions. CFR 9413,79(c),21(1), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002). Respectively and form seed to a first form a closed teaching hospital under section 5506 of ACA. (see Instructions) CFR 9413, 64 FFR 9413, 6	5.00				0.00		3.00
CRR 413.79(e) CRR 413.79(e) CRR 413.79(e) CRR 5412.105(f)(1)(iv)(6)(1) CRR 5412.105(f)(1)(iv)(6)(1) CRR 5412.105(f)(1)(iv)(6)(1) CRR 5412.105(f)(1)(iv)(6)(2) If the cost report straddles July 1, 2011 CRR 5412.105(f)(1)(iv)(6)(2) If the cost report straddles July 1, 2011 CRR 5412.105(f)(1)(iv)(6)(2) If the cost report straddles July 1, 2011 CRR 5412.105(f)(1)(iv)(6)(2) CRR 5412.105(f)(1)(iv)(6)(2) CRR 5412.105(f)(1)(iv)(6)(2) CRR 5412.105(f)(1)(iv)(6)(2) CRR 5412.105(f)(1)(iv)(6)(2) CRR 5412.105(f)(1)(iv)(6)(1)(1)(1)(6)(1)(1)(1)(1)(1)(6)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)	6.00				0.00		6. 00
7.00 MAA Section 422 reduction amount to the IME cap as specified under 42 0.00 7.00 7.00 7.00 7.01			e with 42				
ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR \$412.105(f7(1)(1)(w)(8)(2) if the cost report straddles July 1, 2011 then see instructions.	7.00	MMA Section 422 reduction amount to the IME cap as specified un	der 42		0.00		7. 00
CFR \$412.105(fr)(1)(1)(8)(2) If the cost report straddles July 1, 2011 then see instructions.	7 01		nder 12		0.00		7 01
Adjustment (Increase or decrease) to the FTE count for all lopathic and osteopathic programs for affill listed programs in accordance with 12 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	7.01				0.00		7.01
osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.76(b), 413.76(c) (2)(iv), 64 FR 20340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	9 00		ic and		0.00		0 00
August 1, 2002).	8.00				0.00		8.00
8.01 The amount of Increase If the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see Instructions.		413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67					
section 5503 of the ACA If the cost report straddles July 1, 2011, see	8 01		s under		0.00		8 01
Second S	0.01				0.00		0.01
closed teaching hospital under section 5506 of ACA. (see instructions) 0.00 9.00 and 8.02) (see instructions) 0.00 9.00 and 8.02) (see instructions) 0.00 10	0 02		s from a		0.00		0 02
and 8,02) (see instructions) 10.00	0. 02				0.00		0.02
10.00 FTE count for all opathic and osteopathic programs in the current year from your records 11.00 FTE count for residents in dental and podiatric programs. 0.00 11.00 12.00 12.00 12.00 12.00 12.00 13.00 14.00 14.00 15.00 14.00 15.00 14.00 15.00 15.00 14.00 15.00	9. 00		(8, 8, 01		0.00		9. 00
From your records FTE count for residents in dental and podiatric programs. 0.00 11.00 12.00 12.00 12.00 12.00 12.00 12.00 13.00 12.00 13.00 16.00 12.00 13.00 16.00 13.00 16.00 13.00 16.00 13.00 16.00 16.00 17.00 16.00 17.00 17.00 18.00 17.00 18.00 18.00 19.00 18.00 19.00 18.00 19.00 18.00 19.00 18.00 19.00 18.00 19.00 18.00 19.00 18.00 19.00 18.00 19.00 18.00 19.00 19.00 18.00 19.00 19.00 18.00 19.00	10. 00		t vear		0.00		10.00
12.00 Current year allowable FTE (see instructions) 12.00 12.00 13.00 14.00 14.00 14.00 14.00 14.00 14.00 15.00 15.00 15.00 15.00 15.00 16.00 15.00 16.00 16.00 16.00 16.00 17.0		from your records					
13.00 Total allowable FTE count for the prior year.							
or after September 30, 1997, otherwise enter zero. Sum of lines 12 through 14 divided by 3. 15.00 Sum of lines 12 through 14 divided by 3. 16.00 Adjustment for residents in initial years of the program 0.00 17.00 Adjustment for residents displaced by program or hospital closure 0.00 18.00 Adjusted rolling average FTE count 0.00 18.00 Current year resident to bed ratio (line 18 divided by line 4). 0.000000 Prior year resident to bed ratio (see instructions) 0.000000 19.00 20.00 Prior year resident to bed ratio (see instructions) 10.00							13. 00
15.00 Sum of lines 12 through 14 divided by 3. 0.00 15.00 16.00 16.00 16.00 16.00 17.00 16.00 17.00 18.00 17.00 18	14. 00		ended on		0.00		14. 00
16.00	15. 00				0.00		15. 00
18.00	16. 00	Adjustment for residents in initial years of the program			0.00		16. 00
19.00 Current year resident to bed ratio (line 18 divided by line 4). 0.000000 19.00 20.00		, , , , , , , , , , , , , , , , , , , ,	е				
21.00 Enter the lesser of lines 19 or 20 (see instructions) 0.000000 21.00 22.00 IME payment adjustment (see instructions) 0 22.00 IME payment adjustment - Managed Care (see instructions) 0 22.01 Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA 23.00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C). 24.00 IME FTE Resident Count Over Cap (see instructions) 0.00 24.00 25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions) 0.000000 26.00 27.00 IME payments adjustment factor. (see instructions) 0.000000 27.00 28.00 IME add-on adjustment amount (see instructions) 0.000000 28.00 IME add-on adjustment amount - Managed Care (see instructions) 0.000000 28.00 29.00 Total IME payment (sum of lines 22 and 28) 0.00 29.00 29.00 29.01 29.0		, ,					19.00
22.00 IME payment adjustment (see instructions) 22.00 IME payment adjustment - Managed Care (see instructions) 22.01 Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA 23.00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C). 24.00 IME FTE Resident Count Over Cap (see instructions) 0.00 24.00 25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions) 0.000 25.00 26.00 27.00 IME payments adjustment factor. (see instructions) 0.000000 27.00 IME payments adjustment amount (see instructions) 0.000000 27.00 28.00 IME add-on adjustment amount - Managed Care (see instructions) 0.000000 28.01 IME add-on adjustment amount - Managed Care (see instructions) 0.000000 28.01 29.00		, , , , , , , , , , , , , , , , , , , ,					20.00
22. 01 IME payment adjustment - Managed Care (see instructions) Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA 23. 00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412. 105 (f)(1)(iv)(C). 24. 00 IME FTE Resident Count Over Cap (see instructions) 25. 00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions) 26. 00 Resident to bed ratio (divide line 25 by line 4) 27. 00 IME payments adjustment factor. (see instructions) 28. 00 IME add-on adjustment amount (see instructions) 28. 01 IME add-on adjustment amount - Managed Care (see instructions) 29. 00 Total IME payment (sum of lines 22 and 28) 29. 01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) Disproportionate Share Adjustment 30. 00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 31. 00 Percentage of Medicaid patient days (see instructions) 32. 00 Sum of lines 30 and 31 33. 00 Allowable disproportionate share percentage (see instructions) 30. 01 Allowable disproportionate share percentage (see instructions) 33. 00 Allowable disproportionate share percentage (see instructions) 30. 01 Managed Care (see instructions) 30. 02 Sum of lines 30 and 31 31. 00 Sum of lines 30 and 31 32. 39. 33. 30.					0.000000		1
23. 00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C). 24. 00 IME FTE Resident Count Over Cap (see instructions) 25. 00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions) 26. 00 Resident to bed ratio (divide line 25 by line 4) 27. 00 IME payments adjustment factor. (see instructions) 28. 01 IME add-on adjustment amount (see instructions) 29. 00 Total IME payment (sum of lines 22 and 28) 29. 01 Total IME payment (sum of lines 22 and 28) 29. 01 Total IME payment - Managed Care (sem of lines 22.01 and 28.01) Disproportionate Share Adjustment 30. 00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 31. 00 Percentage of Medicaid patient days (see instructions) 32. 00 Sum of lines 30 and 31 33. 00 Allowable disproportionate share percentage (see instructions) 8. 96 23. 00 24. 00 24. 00 24. 00 26. 00 27. 00 28. 00 29. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 21. 00 22. 00 23. 00 24. 00 25. 00 26. 00 26. 00 27. 00 28. 00 29. 00 29. 01 20. 01 20. 02 20. 02 20. 02 20. 03 20. 03 20. 03 20. 03 20. 03 20. 03 20. 04 20. 05 20. 06 20. 00 20. 00 20. 00 20. 00 20. 00 20		IME payment adjustment - Managed Care (see instructions)			0		22. 01
Slots under 42 Sec. 412.105 (f)(1)(iv)(C). 24.00 IME FTE Resident Count Over Cap (see instructions) 0.00 24.00 25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions) 0.00 25.00 26.00 Resident to bed ratio (divide line 25 by line 4) 0.000000 27.00 28.00 IME payments adjustment factor. (see instructions) 0.000000 27.00 28.01 IME add-on adjustment amount (see instructions) 0 28.01 29.00 Total IME payment (sum of lines 22 and 28) 0 29.00 29.01 Total IME payment - Managed Care (see instructions) 0 29.00 29.01 Disproportionate Share Adjustment 29.01 30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 19.71 31.00 31.00 Sum of lines 30 and 31 23.93 32.00 33.00 Allowable disproportionate share percentage (see instructions) 8.96 33.00	22.00			he MMA	0.00		22.00
25. 00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions) 26. 00 Resident to bed ratio (divide line 25 by line 4) 27. 00 IME payments adjustment factor. (see instructions) 28. 00 IME add-on adjustment amount (see instructions) 28. 01 IME add-on adjustment amount - Managed Care (see instructions) 29. 00 Total IME payment (sum of lines 22 and 28) 29. 01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) Disproportionate Share Adjustment 30. 00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 31. 00 Percentage of Medicaid patient days (see instructions) 32. 00 Sum of lines 30 and 31 33. 00 Allowable disproportionate share percentage (see instructions) 8. 96 25. 00 0. 000000 26. 00 27. 00 28. 01 28. 01 29. 00 29. 01 29. 01 30. 00 30. 00 31. 00 32. 00 33. 00 34. lowable disproportionate share percentage (see instructions) 35. 00	23.00		ι сар		0.00		23.00
Iine 23 or line 24 (see instructions)							24. 00
26. 00 Resident to bed ratio (divide line 25 by line 4) 0.000000 26. 00 27. 00 IME payments adjustment factor. (see instructions) 0.000000 27. 00 28. 00 IME add-on adjustment amount (see instructions) 0 28. 00 28. 01 IME add-on adjustment amount - Managed Care (see instructions) 0 28. 01 29. 00 Total IME payment (sum of lines 22 and 28) 0 29. 00 29. 01 Disproportionate Share Adjustment 0 29. 01 30. 00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 4. 22 30. 00 31. 00 Percentage of Medicaid patient days (see instructions) 19. 71 31. 00 32. 00 Sum of lines 30 and 31 23. 93 32. 00 33. 00 Allowable disproportionate share percentage (see instructions) 8. 96 33. 00	25. 00		wer of		0.00		25. 00
28. 00 IME add-on adjustment amount (see instructions) 28. 01 IME add-on adjustment amount - Managed Care (see instructions) 29. 00 Total IME payment (sum of lines 22 and 28) 29. 01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) Disproportionate Share Adjustment 30. 00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 31. 00 Percentage of Medicaid patient days (see instructions) 31. 00 Sum of lines 30 and 31 32. 00 Allowable disproportionate share percentage (see instructions) 32. 00 Allowable disproportionate share percentage (see instructions) 33. 00 Allowable disproportionate share percentage (see instructions) 38. 96 28. 00 28. 00 28. 00 29. 00 29. 00 29. 01 29. 01 29. 01 30. 00 30. 00 30. 00 31. 00 32. 00 33. 00 34. 22 35. 00		Resident to bed ratio (divide line 25 by line 4)					26. 00
28. 01 IME add-on adjustment amount - Managed Care (see instructions) 29. 00 Total IME payment (sum of lines 22 and 28) 29. 01 Disproportionate Share Adjustment 30. 00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 31. 00 Percentage of Medicaid patient days (see instructions) 32. 00 Sum of lines 30 and 31 33. 00 Allowable disproportionate share percentage (see instructions) 28. 01 29. 00 29. 01 29. 00 29. 01 2					0.000000		27. 00
29. 00 Total IME payment (sum of lines 22 and 28) 29. 01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) Disproportionate Share Adjustment 30. 00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 31. 00 Percentage of Medicaid patient days (see instructions) 32. 00 Sum of lines 30 and 31 33. 00 Allowable disproportionate share percentage (see instructions) 29. 00 29. 00 29. 00 29. 01 30. 00 30. 00 30. 00 30. 00 30. 00 31. 00 32. 00 33. 00 33. 00 34. lowable disproportionate share percentage (see instructions) 35. 00 36. 00 37. 00 38. 96 38. 96 38. 96		, , , , , , , , , , , , , , , , , , , ,			0		28. 00
Disproportionate Share Adjustment 30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 31.00 Percentage of Medicaid patient days (see instructions) 32.00 Sum of lines 30 and 31 33.00 Allowable disproportionate share percentage (see instructions) 8.96 33.00		, , ,			_		29. 00
30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 31.00 Percentage of Medicaid patient days (see instructions) 31.00 Sum of lines 30 and 31 32.00 Allowable disproportionate share percentage (see instructions) 30.00 4.22 30.00 31.00 32.00 33.00	29. 01				0		29. 01
31.00 Percentage of Medicaid patient days (see instructions) 19.71 31.00 Sum of lines 30 and 31 32.00 Allowable disproportionate share percentage (see instructions) 8.96 33.00	30. 00		i ent days		4. 22		30.00
32. 00 Sum of lines 30 and 31 23. 93 32. 00 33. 00 Allowable disproportionate share percentage (see instructions) 8. 96 33. 00	31 00				10 71		31 00
33.00 Allowable disproportionate share percentage (see instructions) 8.96 33.00							31.00
34. UU UI sproporti onate share adjustment (see instructions) 474, 415 34. 00	33. 00	Allowable disproportionate share percentage (see instructions)			8. 96		33. 00
	34.00	ןטן sproportionate share adjustment (see instructions)		l	474, 415		34.00

CALCUL	ATION OF REIMBURSEMENT SETTLEMENT		Period: From 01/01/2014	Worksheet E Part A	
			To 12/31/2014	Date/Time Pre 5/28/2015 9:5	
		Title XVIII	Hospi tal	PPS	
			Prior to October 1	On/After October 1	
		0	1.00	2. 00	
0- 00	Uncompensated Care Adjustment		T al		
35. 00 35. 01	Total uncompensated care amount (see instructions) Factor 3 (see instructions)		0. 000000000	0 0. 000157052	
35. 02	Hospital uncompensated care payment (If line 34 is zero,		1, 409, 487	1, 201, 082	
	enter zero on this line) (see instructions)				
35. 03	Pro rata share of the hospital uncompensated care payment		1, 054, 219	302, 739	35. 03
36. 00	amount (see instructions) Total uncompensated care (sum of columns 1 and 2 on line		1, 356, 958		36.00
	35. 03)				
40. 00	Additional payment for high percentage of ESRD beneficiary dis Total Medicare discharges on Worksheet S-3, Part I	scharges (lines 40 throug	h 46) 		40.00
40.00	excluding discharges for MS-DRGs 652, 682, 683, 684 and				40.00
	685 (see instructions)				
41. 00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0		41.00
41. 01	Total ESRD Medicare covered and paid discharges excluding		0		41. 01
	MS-DRGs 652, 682, 683, 684 an 685. (see instructions)				
42. 00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00		42.00
43. 00	Total Medicare ESRD inpatient days excluding MS-DRGs 652,		0		43.00
	682, 683, 684 an 685. (see instructions)				
44. 00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0. 000000		44.00
45. 00	Average weekly cost for dialysis treatments (see		0.00		45. 00
	instructions)				
46. 00	Total additional payment (line 45 times line 44 times line 41.01)		0		46.00
47. 00	Subtotal (see instructions)		23, 319, 294		47.00
48. 00	Hospital specific payments (to be completed by SCH and		0		48. 00
49. 00	MDH, small rural hospitals only. (see instructions) Total payment for inpatient operating costs (see		23, 319, 294		49.00
17.00	instructions)		20,017,271		17.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I		1, 810, 853		50.00
51. 00	and Pt. II, as applicable) Exception payment for inpatient program capital (Wkst. L,		0		51.00
	Pt. III, see instructions)				
52. 00	Direct graduate medical education payment (from Wkst. E-4,		0		52.00
53. 00	line 49 see instructions). Nursing and Allied Health Managed Care payment		0		53.00
54.00	Special add-on payments for new technologies		0		54.00
55. 00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1,		0		55.00
56. 00	line 69) Cost of physicians' services in a teaching hospital (see		0		56.00
	intructions)				
57. 00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0		57.00
58. 00	Ancillary service other pass through costs from Wkst. D,		0		58.00
	Pt. IV, col. 11 line 200)				
59. 00 60. 00	Total (sum of amounts on lines 49 through 58) Primary payer payments		25, 130, 147 11, 846		59. 00 60. 00
61. 00	Total amount payable for program beneficiaries (line 59		25, 118, 301		61.00
	minus line 60)				
62. 00 63. 00	Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries		2, 303, 808 53, 488		62.00
64. 00	Allowable bad debts (see instructions)		348, 897		64. 00
65.00	Adjusted reimbursable bad debts (see instructions)		226, 783		65.00
66. 00	Allowable bad debts for dual eligible beneficiaries (see instructions)		41, 373		66. 00
67. 00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		22, 987, 788		67.00
68. 00	Credits received from manufacturers for replaced devices		0		68.00
69. 00	for applicable to MS-DRGs (see instructions) Outlier payments reconciliation (sum of lines 93, 95 and		0		69.00
37.00	96). (For SCH see instructions)				57.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		70.00
70. 50 70. 89	RURAL DEMONSTRATION PROJECT Pioneer ACO demonstration payment adjustment amount (see		0		70. 50
70.07	instructions)				, 0. 0
70. 90	HSP bonus payment HVBP adjustment amount (see		0		70. 90
70. 91	instructions) HSP bonus payment HRR adjustment amount (see instructions)				70. 9
70. 91	Bundled Model 1 discount amount (see instructions)				70. 92
70. 93	1		60, 935		70. 93
	HVBP payment adjustment amount (see instructions)				
70. 94 70. 95	HVBP payment adjustment amount (see instructions) HRR adjustment amount (see instructions) Recovery of accelerated depreciation		-54, 704 0		70. 94 70. 95

	Financial Systems FRANCISCAN ST ANTHO			eu of Form CMS-:	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 150015	Peri od: From 01/01/2014	Worksheet E Part A	
			To 12/31/2014		pared:
			12, 01, 2011	5/28/2015 9:5	7 am
		Title XVIII	Hospi tal	PPS	
			Prior to	On/After	
			October 1	October 1	
		0	1. 00	2. 00	
70. 96	Low volume adjustment for federal fiscal year (yyyy)		0		70. 96
	(Enter in column 0 the corresponding federal year for the				
70 07	period prior to 10/1)				70.07
70. 97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the		0		70. 97
	period ending on or after 10/1)				
70. 98	, ,		0		70. 98
70. 99	HAC adjustment amount (see instructions)				70. 99
71. 00	Amount due provider (line 67 minus lines 68 plus/minus		22, 994, 019		71.00
71.00	lines 69 & 70)		22, 774, 017		/ 1.00
71. 01	Sequestration adjustment (see instructions)		459, 880		71. 01
72. 00	Interim payments		22, 372, 652		72. 00
73. 00	Tentative settlement (for contractor use only)		0		73.00
74.00	Balance due provider (Program) (line 71 minus lines 71.01,		161, 487		74.00
	72, and 73)				
75.00	Protested amounts (nonallowable cost report items) in		1, 118, 043		75.00
	accordance with CMS Pub. 15-2, chapter 1, §115.2				
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)				
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see		0		90.00
	instructions)				
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0		91.00
92. 00	Operating outlier reconciliation adjustment amount (see		0		92.00
02.00	instructions)				02.00
93. 00	Capital outlier reconciliation adjustment amount (see instructions)		0		93.00
94. 00	The rate used to calculate the time value of money (see		0.00		94.00
74.00	instructions)		0.00		74.00
95. 00	Time value of money for operating expenses (see		0		95. 00
, 0. 00	instructions)				75.00
96. 00			0		96. 00
	instructions)				
			Prior to 10/1	05 /After 10/1	

	1.00	2.00	
HSP Bonus Payment Amount			
100.00 HSP bonus amount (see instructions)	0	0	100. 00
HVBP Adjustment for HSP Bonus Payment			
101.00 HVBP adjustment factor (see instructions)	0	0	101. 00
102.00 HVBP adjustment amount for HSP bonus payment (see instructions)	0	0	102. 00
HRR Adjustment for HSP Bonus Payment			
103.00 HRR adjustment factor (see instructions)	0.0000	0.0000	103. 00
104.00 HRR adjustment amount for HSP bonus payment (see instructions)	O	0	104. 00

Prior to 10/1 On/After 10/1

Health Financial Systems	FRANCISCAN ST ANTHONY-MICHI	In Lieu	of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT	Pro	ovider CCN: 150015		Worksheet E
			From 01/01/2014	Part B
			To 12/31/2014	Date/Time Prepared:

			To 12/31/2014		
		Title XVIII	Hospi tal	5/28/2015 9:5 PPS	/ alli
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1. 00	
1. 00	Medical and other services (see instructions)			10, 963	1.00
2.00	Medical and other services reimbursed under OPPS (see instructi	ons)		18, 195, 734	2. 00
3.00	PPS payments			18, 000, 837	3. 00
4.00	Outlier payment (see instructions)			28, 021	4. 00
5.00	Enter the hospital specific payment to cost ratio (see instruct	i ons)		0.000	5. 00
6. 00 7. 00	Line 2 times line 5			0 0. 00	6. 00 7. 00
8. 00	Sum of line 3 plus line 4 divided by line 6 Transitional corridor payment (see instructions)			0.00	8.00
9. 00	Ancillary service other pass through costs from Wkst. D, Pt. IV	. col. 13. line 200		Ö	9.00
10.00	Organ acqui si ti ons			0	10.00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			10, 963	11. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
12 00	Reasonable charges			62, 293	12. 00
12. 00 13. 00	Ancillary service charges Organ acquisition charges (from Wkst. D-4, Pt. III, line 69, co	1 4)		02, 293	13.00
14. 00	Total reasonable charges (sum of lines 12 and 13)			62, 293	•
	Customary charges				
15. 00	Aggregate amount actually collected from patients liable for pa	yment for services on	a charge basis	0	15. 00
16. 00	Amounts that would have been realized from patients liable for	payment for services o	n a chargebasis	0	16. 00
17 00	had such payment been made in accordance with 42 CFR §413.13(e)			0. 000000	17. 00
17. 00 18. 00	Ratio of line 15 to line 16 (not to exceed 1.000000) Total customary charges (see instructions)			62, 293	18.00
19. 00	Excess of customary charges over reasonable cost (complete only	if line 18 exceeds li	ne 11) (see	51, 330	1
	instructions)		, (***	,	
20. 00	Excess of reasonable cost over customary charges (complete only	if line 11 exceeds li	ne 18) (see	0	20. 00
21. 00	<pre>instructions) Lesser of cost or charges (line 11 minus line 20) (for CAH see</pre>	instructions)		10, 963	21. 00
22. 00	Interns and residents (see instructions)	riisti ucti olis)		10, 703	22.00
23. 00	· · · · · · · · · · · · · · · · · · ·			0	23. 00
24.00					24. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25. 00	Deductibles and coinsurance (for CAH, see instructions) Deductibles and Coinsurance relating to amount on line 24 (for	CALL and imptruptions)		2 020 000	25. 00 26. 00
26. 00 27. 00	Subtotal {(lines 21 and 24 minus the sum of lines 25 and 26) pl		and 23) (for	3, 820, 080 14, 219, 741	
27.00	CAH, see instructions)	us the sum of filles 22	and 23) (10)	17, 217, 771	27.00
28. 00	Direct graduate medical education payments (from Wkst. E-4, lin	e 50)		0	28. 00
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	29. 00
30.00	Subtotal (sum of lines 27 through 29)			14, 219, 741	30.00
31. 00 32. 00	Primary payer payments Subtotal (line 30 minus line 31)			9, 953 14, 209, 788	1
32.00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE:	S)		14, 209, 700	32.00
33. 00	Composite rate ESRD (from Wkst. I-5, line 11)	5)		0	33. 00
34.00	Allowable bad debts (see instructions)			588, 613	34. 00
35.00	Adjusted reimbursable bad debts (see instructions)			382, 598	
36. 00	Allowable bad debts for dual eligible beneficiaries (see instru	ctions)		282, 872	
37. 00	Subtotal (see instructions)			14, 592, 386	
38. 00 39. 00	MSP-LCC reconciliation amount from PS&R OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	38. 00 39. 00
39. 50	Pioneer ACO demonstration payment adjustment (see instructions)			0	39. 50
39. 98	Partial or full credits received from manufacturers for replace	d devices (see instruc	tions)	Ö	39. 98
39. 99	RECOVERY OF ACCELERATED DEPRECIATION	,	ŕ	0	39. 99
40.00	Subtotal (see instructions)			14, 592, 386	40. 00
40. 01	, , , , , , , , , , , , , , , , , , ,			291, 848	1
41. 00	· ·			14, 115, 275	1
42. 00 43. 00	,			0 185, 263	42. 00 43. 00
44. 00	Protested amounts (nonallowable cost report items) in accordance	e with CMS Pub 15-2	chapter 1	165, 203	44. 00
1 1. 00	§115. 2		5aptor 1,		11.00
	TO BE COMPLETED BY CONTRACTOR				
90.00	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 0. 00	91. 00 92. 00
93.00	Time Value of Money (see instructions)			0.00	93.00
	Total (sum of lines 91 and 93)			Ö	
				•	

Health Financial Systems	FRANCISCAN ST ANTHONY-M	ICHIGAN CITY	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der CCN: 150015	From 01/01/2014	
		Component CCN: 15S015	10 12/31/2014	5/28/2015 9:57 am
		Title XVIII	Subprovi der -	PPS

		Title XVIII	Subprovi der - I PF	PPS	
				1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
1.00	Medical and other services (see instructions)			0	1. 00
2. 00 3. 00	Medical and other services reimbursed under OPPS (see instruction	ons)		0	2. 00 3. 00
4.00	PPS payments Outlier payment (see instructions)			0	4. 00
5.00	Enter the hospital specific payment to cost ratio (see instruct	i ons)		0. 000	5. 00
6.00	Line 2 times line 5			0	6. 00
7.00	Sum of line 3 plus line 4 divided by line 6			0.00	7. 00
8. 00 9. 00	Transitional corridor payment (see instructions) Ancillary service other pass through costs from Wkst. D, Pt. IV	col 13 line 200		0	8. 00 9. 00
10.00	Organ acquisitions	, 601. 10, 11110 200		o o	10. 00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			0	11. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
12. 00	Reasonable charges Ancillary service charges			0	12. 00
13. 00	Organ acquisition charges (from Wkst. D-4, Pt. III, line 69, co	1. 4)		Ö	13. 00
14. 00	Total reasonable charges (sum of lines 12 and 13)			0	14. 00
45.00	Customary charges				45.00
15. 00 16. 00	Aggregate amount actually collected from patients liable for pa Amounts that would have been realized from patients liable for			0	15. 00 16. 00
10.00	had such payment been made in accordance with 42 CFR §413.13(e)	payment for services of	ii a ciiai yebasi s	١	10.00
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0. 000000	17. 00
18.00	Total customary charges (see instructions)	1011 40 1 11	44) (0	18. 00
19. 00	Excess of customary charges over reasonable cost (complete only instructions)	if line 18 exceeds li	ne 11) (see	0	19. 00
20. 00	Excess of reasonable cost over customary charges (complete only	if line 11 exceeds li	ne 18) (see	0	20. 00
	instructions)		, ,	0	
21. 00	, , ,				21. 00
22. 00 23. 00	· · · · · · · · · · · · · · · · · · ·				22. 00 23. 00
24. 00					24. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25. 00	Deductibles and coinsurance (for CAH, see instructions)	CALL !+!)		0	25. 00
26. 00 27. 00	Deductibles and Coinsurance relating to amount on line 24 (for Subtotal {(lines 21 and 24 minus the sum of lines 25 and 26) pl		and 23) (for	0	26. 00 27. 00
27.00	CAH, see instructions)	us the sum of 111165 22	una 20) (101	ĭ	27.00
28. 00	Direct graduate medical education payments (from Wkst. E-4, lin	e 50)		0	28. 00
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	29. 00 30. 00
30. 00 31. 00	Subtotal (sum of lines 27 through 29) Primary payer payments			0	30.00
32. 00	Subtotal (line 30 minus line 31)			Ö	32. 00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE:	S)			
33.00				0	33.00
35.00	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			0	34. 00 35. 00
36. 00	, , , , , , , , , , , , , , , , , , , ,	ctions)		Ö	36. 00
37. 00	Subtotal (see instructions)			0	37. 00
38. 00	MSP-LCC reconciliation amount from PS&R			0	38. 00
39. 00 39. 50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions)			0	39. 00 39. 50
39. 98	Partial or full credits received from manufacturers for replace	d devices (see instruc	tions)	Ö	39. 98
39. 99	RECOVERY OF ACCELERATED DEPRECIATION	•	,	0	39. 99
40.00	O Subtotal (see instructions)			0	40.00
40. 01 41. 00				0	40. 01 41. 00
42.00					42.00
43.00	,			0	43.00
44. 00	Protested amounts (nonallowable cost report items) in accordance	e with CMS Pub. 15-2,	chapter 1,	0	44. 00
	§115. 2 TO BE COMPLETED BY CONTRACTOR				
90. 00	Original outlier amount (see instructions)			0	90. 00
91. 00	, ,			Ö	91. 00
92. 00	The rate used to calculate the Time Value of Money				92. 00
93.00	Time Value of Money (see instructions) Total (sum of lines 91 and 93)			0	93. 00 94. 00
74. UU	Total (Suii of 111163 71 and 73)		I	υĮ	74.00

Health Financial Systems	FRANCISCAN ST ANTHONY-M	ICHIGAN CITY	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der CCN: 150015	Peri od: From 01/01/2014	Worksheet E Part B
		Component CCN: 15T015		
		Title XVIII	Subprovi der -	PPS

		Title XVIII	Subprovi der - I RF	PPS	
				1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1. 00	
1.00	Medical and other services (see instructions)			0	1. 00
2.00	Medical and other services reimbursed under OPPS (see instructi	ons)		0	2.00
3. 00 4. 00	PPS payments Outlier payment (see instructions)			0	3. 00 4. 00
5.00	Enter the hospital specific payment to cost ratio (see instruct	i ons)		0. 000	
6.00	Line 2 times line 5	,		0	6. 00
7.00	Sum of line 3 plus line 4 divided by line 6			0.00	
8. 00 9. 00	Transitional corridor payment (see instructions) Ancillary service other pass through costs from Wkst. D, Pt. IV	col 13 line 200		0	8. 00 9. 00
10.00	Organ acquisitions	, cor. 13, frile 200		0	10. 00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			0	11. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
12. 00	Reasonable charges Ancillary service charges			0	12. 00
13. 00	Organ acquisition charges (from Wkst. D-4, Pt. III, line 69, co	1. 4)		0	
14. 00	Total reasonable charges (sum of lines 12 and 13)			0	14. 00
15 00	Customary charges	ment for comitoes on	a abanga basi s	0	15 00
15. 00 16. 00	Aggregate amount actually collected from patients liable for pa Amounts that would have been realized from patients liable for			0	15. 00 16. 00
10.00	had such payment been made in accordance with 42 CFR §413.13(e)	payment for services (on a chargebasis	G	10.00
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0. 000000	
18. 00 19. 00	Total customary charges (see instructions) Excess of customary charges over reasonable cost (complete only	if line 10 exceeds li	no 11) (soo	0	18. 00 19. 00
19.00	instructions)	II IIIle to exceeds II	ile II) (see	U	19.00
20. 00	Excess of reasonable cost over customary charges (complete only	if line 11 exceeds li	ne 18) (see	0	20. 00
21. 00	instructions)	instructions)		0	21. 00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see Interns and residents (see instructions)	i iisti ucti olis)		0	22. 00
23. 00	Cost of physicians' services in a teaching hospital (see instru	ctions)		0	23. 00
24. 00	Total prospective payment (sum of lines 3, 4, 8 and 9)			0	24. 00
25. 00	COMPUTATION OF REIMBURSEMENT SETTLEMENT Deductibles and coinsurance (for CAH, see instructions)			0	25. 00
26. 00	Deductibles and Coinsurance relating to amount on line 24 (for	CAH, see instructions)	0	26. 00
27. 00	Subtotal {(lines 21 and 24 minus the sum of lines 25 and 26) pl	us the sum of lines 22	2 and 23} (for	0	27. 00
28. 00	CAH, see instructions) Direct graduate medical education payments (from Wkst. E-4, lin	o 50)		0	28. 00
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)	e 30)		0	29. 00
30.00	Subtotal (sum of lines 27 through 29)			0	30. 00
31.00	Primary payer payments			0	31.00
32. 00	Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE)	3)		0	32. 00
33. 00	Composite rate ESRD (from Wkst. I-5, line 11)	<i>5)</i>		0	33. 00
34.00	Allowable bad debts (see instructions)			0	
35. 00	Adjusted reimbursable bad debts (see instructions)	-+!>		0	35. 00
36. 00 37. 00	Allowable bad debts for dual eligible beneficiaries (see instru Subtotal (see instructions)	Ctrons)		0	36. 00 37. 00
38. 00	MSP-LCC reconciliation amount from PS&R			0	38. 00
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
39. 50 39. 98	Prioneer ACO demonstration payment adjustment (see instructions)	d dovisos (soo instru	ations)	0	
39. 99	Partial or full credits received from manufacturers for replace RECOVERY OF ACCELERATED DEPRECIATION	u devices (see ilistiud	Zti olis)	0	39. 96 39. 99
40. 00				0	40. 00
40. 01	Ol Sequestration adjustment (see instructions)				40. 01
41. 00 42. 00					41. 00 42. 00
43. 00	· · · · · · · · · · · · · · · · · · ·				43. 00
44. 00					44. 00
	§115. 2				
90. 00	TO BE COMPLETED BY CONTRACTOR Original outlier amount (see instructions)			0	90. 00
	Outlier reconciliation adjustment amount (see instructions)			0	91. 00
92. 00	The rate used to calculate the Time Value of Money			0. 00	
	Time Value of Money (see instructions) Total (sum of lines 91 and 93)			0	
, 00	1.2.2. (2.2 3. 1.1.03 // 3.0/		'	٥١	700

Part I

From 01/01/2014 12/31/2014 Date/Time Prepared: 5/28/2015 9:57 am Title XVIII Hospi tal PPS Inpatient Part A Part B mm/dd/yyyy mm/dd/yyyy Amount Amount 1.00 2.00 3.00 4.00 1.00 Total interim payments paid to provider 22, 305, 652 14, 063, 975 1. 00 2.00 Interim payments payable on individual bills, either 2.00 submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero 3.00 List separately each retroactive lump sum adjustment 3.00 amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 3.01 ADJUSTMENTS TO PROVIDER 07/17/2014 67,000 07/17/2014 51, 300 3.01 3.02 3.02 3.03 0 3.03 0 3.04 0 0 3.04 3.05 0 0 3.05 Provider to Program 3.50 ADJUSTMENTS TO PROGRAM 0 0 3.50 0 3.51 0 3.51 0 0 3.52 3.52 0 3.53 3.53 0 3.54 \cap Λ 3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 67,000 51, 300 3.99 3.50-3.98) 22, 372, 652 14, 115, 275 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 4.00 (transfer to Wkst. E or Wkst. E-3, line and column as appropri ate) TO BE COMPLETED BY CONTRACTOR 5.00 List separately each tentative settlement payment after 5.00 desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 5.01 TENTATIVE TO PROVIDER 0 0 5.01 5.02 0 0 5.02 0 5.03 0 5.03 Provider to Program 5.50 TENTATI VE TO PROGRAM 0 0 5.50 5.51 0 0 5. 51 0 5.52 0 5.52 0 5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 0 5.99 5.50-5.98) 6.00 Determined net settlement amount (balance due) based on 6.00 the cost report. (1) SETTLEMENT TO PROVIDER 6.01 161, 487 185, 263 6.01 6 02 SETTLEMENT TO PROGRAM 6.02 7.00 Total Medicare program liability (see instructions) 22, 534, 139 14, 300, 538 7.00 Contractor NPR Date (Mo/Day/Yr) Number

Provi der CCN: 150015

0

1 00

2 00

8.00

Peri od:

8.00 Name of Contractor

 Heal th
 Financial
 Systems
 FRANCISCAN ST
 ANTHONY-MI CHIGAN CITY

 ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED
 Provider CCN

		Ti tl	e XVIII	Subprovider - IPF	PPS	
		Inpatien	t Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3. 00	4. 00	
1. 00 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		521, 17	7 0	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			0	0	3. 01
3.02				0	0	3. 02
3.03				0	0	3. 03
3.04				0	0	3. 04
3. 05	Durand days to Duranges			0	0	3. 05
3. 50	Provider to Program ADJUSTMENTS TO PROGRAM		I	ol	0	3. 50
3. 50	ADJUSTIVIENTS TO FROGRAM			o		3. 50
3. 52				0	l ől	3. 52
3. 53				Ö	0	3. 53
3. 54				o	l ol	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			o	o o	3. 99
	3. 50-3. 98)					
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)		521, 17	7	0	4. 00
	TO BE COMPLETED BY CONTRACTOR					
5. 00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5. 00
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER			0	0	5. 01
5. 02				0	0	5. 02
5. 03	Durand days to Duranges			0	0	5. 03
5. 50	Provider to Program TENTATIVE TO PROGRAM			ol	0	5. 50
5. 50	I LINIALI VE TO FROGRAM			0		5. 50
5. 52				o		5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	0	5. 99
6. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6. 00
6. 01	SETTLEMENT TO PROVIDER		17, 49	0	ol	6. 01
6. 02	SETTLEMENT TO PROGRAM		.,, ,,	ō	l o	6. 02
7. 00	Total Medicare program liability (see instructions)		538, 66	7	Ö	7. 00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		()	1. 00	2. 00	
8.00	Name of Contractor					8. 00

Heal th Financial Systems FRANCISCAN ST ANTHONY-MICHIGAN CITY
ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provider CCN

		Ti tl	e XVIII	Subprovi der - I RF	PPS	<u>/ am</u>
		Inpatier	it Part A		t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2.00	3. 00	4. 00	
1.00	Total interim payments paid to provider		2, 360, 30	6	0	1. 00
2.00	Interim payments payable on individual bills, either			0	0	2. 00
	submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3. 00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER			0	0	3. 01
3. 02				0	0	3. 02
3.03				0	0	3. 03
3. 04				0	0	3. 04
3. 05	Provider to Program			0	0	3. 05
3. 50	ADJUSTMENTS TO PROGRAM		I	0	0	3. 50
3. 51	AUSCOTINE TO TROOTS WIN			0	Ö	3. 51
3.52				0	0	3. 52
3.53				0	0	3. 53
3.54				0	0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			0	0	3. 99
4. 00	Total interim payments (sum of lines 1, 2, and 3.99)		2, 360, 30	16	0	4. 00
00	(transfer to Wkst. E or Wkst. E-3, line and column as		2,000,00			
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR		1		l .	
5. 00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none,					5. 00
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER			0	0	5. 01
5. 02				0	0	5. 02
5. 03	Provider to Program			0	0	5. 03
5. 50	TENTATI VE TO PROGRAM			0	0	5. 50
5. 51	TENTATI VE TO TROOM WIII			0	Ö	5. 51
5.52				0	0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	0	5. 99
6. 00	Determined net settlement amount (balance due) based on					6. 00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVIDER		20.20	U	0	6. 01
6. 02 7. 00	SETTLEMENT TO PROGRAM Total Medicare program liability (see instructions)		29, 38 2, 330, 92		0	6. 02 7. 00
7.00	Total modificate program frability (See Histractions)		2, 330, 92	Contractor	NPR Date	7.00
				Number	(Mo/Day/Yr)	
8. 00	Name of Contractor		0	1. 00	2. 00	8. 00
0.00	INAILE OF COTTE ACTO			T	I	0.00

Hool +h	Financial Systems FDANCISCAN ST ANTHONY	MICHICAN CITY	In Lie	u of Form CMS-2	DEE2 10
	CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 150015 Period: From 01/01/2014 To 12/31/2014			Worksheet E-1 Part II	pared:
		Title XVIII	Hospi tal	PPS	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS				
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst.		14	5, 399 10, 947	1. 00
2.00	2.00 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12				
3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2					3. 00
4.00	4.00 Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12				
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			489, 971, 391	5. 00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 li	ne 20		30, 789, 900	6. 00
7.00	CAH only - The reasonable cost incurred for the purchase of ce	rtified HIT technology	Wkst. S-2, Pt. I	0	7. 00
	line 168				
8.00	Calculation of the HIT incentive payment (see instructions)			1, 434, 476	8. 00
9.00	Sequestration adjustment amount (see instructions)			28, 690	9. 00
10.00	10.00 Calculation of the HIT incentive payment after sequestration (see instructions)				10. 00
	INPATIENT HOSPITAL SERVICES UNDER PPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			1, 337, 319	30. 00
31.00	Other Adjustment (specify)			0	31. 00
32 00	2.00 Ralance due provider (Line 8 (or Line 10) minus line 30 and Line 31) (see instructions) 68 467 3				

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

1, 337, 319 30. 00 0 31. 00 68, 467 32. 00

Health Financial Systems	FRANCISCAN ST ANTHONY-MIC	CHIGAN CITY	In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	P	Provider CCN: 150015	Peri od: From 01/01/2014	Worksheet E-3
	C	Component CCN: 15SO15	To 12/31/2014	
		Title XVIII	Subprovi der -	PPS

			I PF		
				1. 00	
P	ART II - MEDICARE PART A SERVICES - IPF PPS			1.00	
	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical	al education payments)		612, 600	1 1.
	Net IPF PPS Outlier Payments	,		16, 452	
	Net IPF PPS ECT Payments			0	1
1	Jnweighted intern and resident FTE count in the most recent cos	t report filed on or b	efore November	0.00	4.
	15, 2004. (see instructions)	•			
1. 01 C	Cap increases for the unweighted intern and resident FTE count or congram or hospital closure, that would not be counted without a CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00	4.
. 00	New Teaching program adjustment. (see instructions)			0.00	5.
. 00	Current year's unweighted FTE count of I&R excluding FTEs in the	e new program growth p	eriod of a "new	0.00	6.
	teaching program" (see instuctions)				
t	Current year's unweighted I&R FTE count for residents within the teaching program" (see instuctions)			0.00	7.
1	ntern and resident count for IPF PPS medical education adjustme	ent (see instructions)		0.00	
	Average Daily Census (see instructions)	0 5150 1)		7. 879452	
- 1	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to the	e power of .5150 -1}.		0. 000000	
- 1	Feaching Adjustment (line 1 multiplied by line 10).			0	
	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)			629, 052	
	Nursing and Allied Health Managed Care payment (see instruction))		0	
	Organ acquisition (DO NOT USE THIS LINE)	-+:>		0	14
	Cost of physicians' services in a teaching hospital (see instruc	ctions)		(20, 252	
1	Subtotal (see instructions)			629, 052	
1	Primary payer payments			0 629, 052	
	Subtotal (line 16 less line 17). Deductibles			97, 216	
	Subtotal (line 18 minus line 19)			531, 836	
	Coi nsurance			0.00	
	Subtotal (line 20 minus line 21)			531, 836	
	Allowable bad debts (exclude bad debts for professional service:	s) (see instructions)		27, 421	
	Adjusted reimbursable bad debts (see instructions)	3) (See Thisti detrons)		17, 824	
	Allowable bad debts for dual eligible beneficiaries (see instruc	rtions)		1, 659	
1	Subtotal (sum of lines 22 and 24)	311 3113)		549, 660	
	Direct graduate medical education payments (from Wkst. E-4, line	9 49)		0	
	Other pass through costs (see instructions)	,		0	
	Outlier payments reconciliation			0	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
1	Pioneer ACO demonstration payment adjustment (see instructions)			0	30
	Recovery of Accelerated Depreciation			0	
1	Total amount payable to the provider (see instructions)			549, 660	3
1	Sequestration adjustment (see instructions)			10, 993	3
	nterim payments			521, 177	32
	Tentative settlement (for contractor use only)			0	33
. 00 E	Balance due provider/program (line 31 minus lines 31.01, 32 and	33)		17, 490	34
٤	Protested amounts (nonallowable cost report items) in accordance §115.2	e with CMS Pub. 15-2,	chapter 1,	0	35
	O BE COMPLETED BY CONTRACTOR		1		_
1	Original outlier amount from Worksheet E-3, Part II, line 2			16, 452	
	Outlier reconciliation adjustment amount (see instructions)			0	
1	The rate used to calculate the Time Value of Money			0. 00	
3. UU I	Time Value of Money (see instructions)			0	53

Health Financial Systems	FRANCISCAN ST ANTHONY-MICHIGAN CIT	TY	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der (CCN: 150015		Worksheet E-3
	Component	CCN: 15T015	From 01/01/2014 To 12/31/2014	Date/Time Prepared:
				5/28/2015 9:57 am
	Title	e XVIII	Subprovi der -	PPS

	IRF	1.0	
	PART III - MEDICARE PART A SERVICES - IRF PPS	1.00	
1.00	Net Federal PPS Payment (see instructions)	2, 310, 097	1. 00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)	0.0101	2. 00
3. 00	Inpatient Rehabilitation LIP Payments (see instructions)	37, 424	3. 00
4. 00	Outlier Payments	49, 482	4. 00
5. 00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior		5. 00
	to November 15, 2004 (see instructions)		
5. 01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by	0.00	5. 01
	program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)		
6. 00	New Teaching program adjustment. (see instructions)	0.00	6. 00
7. 00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new	0.00	7. 00
7.00	teaching program" (see instructions)	0.00	7.00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new	0.00	8.00
	teaching program" (see instructions)		
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)	0.00	9. 00
10.00	Average Daily Census (see instructions)	6. 936986	
11. 00	Teaching Adjustment Factor (see instructions)	0.000000	11. 00
12. 00	Teaching Adjustment (see instructions)	0	12. 00
13.00	Total PPS Payment (see instructions)	2, 397, 003	13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)	0	14.00
15. 00	Organ acquisition (DO NOT USE THIS LINE)		15. 00
16. 00	Cost of physicians' services in a teaching hospital (see instructions)	0	16. 00
17. 00	Subtotal (see instructions)	2, 397, 003	
18. 00	Primary payer payments	8, 784	
19. 00	Subtotal (line 17 less line 18).	2, 388, 219	
20. 00	Deducti bl es	7, 296	
21. 00	Subtotal (line 19 minus line 20)	2, 380, 923	
22. 00	Coi nsurance	2, 432	22. 00
23. 00	Subtotal (line 21 minus line 22)	2, 378, 491	
24. 00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	0	24. 00
25. 00	Adjusted reimbursable bad debts (see instructions)	0	25. 00
26. 00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	26. 00
27. 00	Subtotal (sum of lines 23 and 25)	2, 378, 491	
28. 00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	28. 00
29. 00	Other pass through costs (see instructions)	0	29. 00
30.00	Outlier payments reconciliation	0	30.00
31. 00	OTHER	0	31. 00
31. 50	Pioneer ACO demonstration payment adjustment (see instructions)	0	31. 50
31. 99	Recovery of Accelerated Depreciation	0	31. 99
32. 00	Total amount payable to the provider (see instructions)	2, 378, 491	
32. 01	Sequestration adjustment (see instructions)	47, 570	
33. 00	Interim payments	2, 360, 306	33. 00
34.00	Tentative settlement (for contractor use only)	0	34.00
35. 00	Balance due provider/program line 32 minus lines 32.01, 33 and 34	-29, 385	35. 00
36. 00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	36. 00
	TO BE COMPLETED BY CONTRACTOR		
50. 00	Original outlier amount from Wkst. E-3, Pt. III, line 4	49, 482	50. 00
51. 00	Outlier reconciliation adjustment amount (see instructions)	0	51. 00
52.00	The rate used to calculate the Time Value of Money	0.00	52. 00
	Time Value of Money (see instructions)	0.00	
		, "	

Health Financial Systems	FRANCISCAN ST ANTHONY-MICHIGAN CITY	In Lieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 150015	Peri od: Worksheet E-3

From 01/01/2014 To 12/31/2014 Part VII Date/Time Prepared: 5/28/2015 9:57 am Title XIX Hospi tal Cost Inpati ent Outpati ent 1.00 2.00 PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES COMPUTATION OF NET COST OF COVERED SERVICES 1.00 Inpatient hospital/SNF/NF services 1.00 2.00 Medical and other services Ω 2.00 3.00 Organ acquisition (certified transplant centers only) 0 3.00 Subtotal (sum of lines 1, 2 and 3) 0 4.00 4.00 Inpatient primary payer payments 5.00 5.00 Outpatient primary payer payments 6.00 Ω 6.00 7.00 Subtotal (line 4 less sum of lines 5 and 6) 0 7.00 COMPUTATION OF LESSER OF COST OR CHARGES Reasonable Charges 8.00 Routine service charges 8.00 9.00 Ancillary service charges 17, 368, 687 0 9.00 10.00 Organ acquisition charges, net of revenue 10.00 0 Incentive from target amount computation 11 00 11 00 12.00 Total reasonable charges (sum of lines 8 through 11) 17, 368, 687 0 12.00 CUSTOMARY CHARGES 13.00 Amount actually collected from patients liable for payment for services on a charge 0 13.00 basi s Amounts that would have been realized from patients liable for payment for services on 14.00 0 0 14.00 a charge basis had such payment been made in accordance with 42 CFR §413.13(e) 15.00 Ratio of line 13 to line 14 (not to exceed 1.000000) 0.000000 0.000000 15.00 16.00 Total customary charges (see instructions) 17, 368, 687 16.00 17, 368, 687 17.00 17.00 Excess of customary charges over reasonable cost (complete only if line 16 exceeds 0 line 4) (see instructions) 18.00 Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 0 18.00 0 (see instructions) 19.00 Interns and Residents (see instructions) 0 0 19.00 20.00 Cost of physicians' services in a teaching hospital (see instructions) 0 0 20.00 21.00 Cost of covered services (enter the lesser of line 4 or line 16) 0 0 21.00 PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers 22.00 Other than outlier payments 0 0 22.00 0 23.00 Outlier payments 23.00 Λ 24.00 Program capital payments 24.00 25.00 Capital exception payments (see instructions) 0 25.00 Routine and Ancillary service other pass through costs 26.00 26 00 0 Subtotal (sum of lines 22 through 26) 27.00 0 27.00 28. 00 Customary charges (title V or XIX PPS covered services only) 0 0 28.00 29.00 Titles V or XIX (sum of lines 21 and 27) 0 0 29.00 COMPUTATION OF REIMBURSEMENT SETTLEMENT 30.00 Excess of reasonable cost (from line 18) 0 0 30.00 31.00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 0 0 0 0 0 0 0 0 0 0 0 31.00 32.00 Deducti bl es 32.00 0 33 00 Coi nsurance 33 00 0 34.00 Allowable bad debts (see instructions) Ω 34.00 Utilization review 35.00 35.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 36.00 36, 00 0 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 37.00 0 37.00 38.00 Subtotal (line 36 ± line 37) 0 38.00 Direct graduate medical education payments (from Wkst. E-4) 39.00 39.00 40.00 40.00 Total amount payable to the provider (sum of lines 38 and 39) 0 41.00 Interim payments 0 41.00 Balance due provider/program (line 40 minus line 41) 42.00 0 42.00

0 43.00

Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,

43.00

chapter 1, §115.2

Health Financial Systems	FRANCISCAN ST ANTHONY-MICH	IIGAN CITY	In Lie	u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT			From 01/01/2014		
	Col	iliporierri cciv. 153015	10 12/31/2014	5/28/2015 9:57	
		Title XIX	Subprovi der -	Cost	
			IPF		
			I npati ent	Outpati ent	
			1. 00	2. 00	
DART VIII CALCIII ATLON OF DELMBURGEMENT	ALL OTHER HEALTH CERVICES	C EOD TITLES V OD VI	V CEDVICEC		

		I PF		
		I npati ent	Outpati ent	
		1. 00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX	SERVI CES		
	COMPUTATION OF NET COST OF COVERED SERVICES			
1. 00	Inpatient hospital/SNF/NF services	0		1. 00
2.00	Medical and other services		0	2. 00
3.00	Organ acquisition (certified transplant centers only)	0		3. 00
4.00	Subtotal (sum of lines 1, 2 and 3)	0	0	4. 00
5.00	Inpatient primary payer payments	0		5. 00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	0	0	7. 00
	COMPUTATION OF LESSER OF COST OR CHARGES			
0.00	Reasonabl e Charges			0.00
8.00	Routine service charges	0 714		8. 00
9.00	Ancillary service charges	2, 714	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11. 00	Incentive from target amount computation	0 714	0	11.00
12. 00	Total reasonable charges (sum of lines 8 through 11)	2, 714	0	12. 00
12 00	CUSTOMARY CHARGES	ol	0	13. 00
13. 00	Amount actually collected from patients liable for payment for services on a charge basis	٩	U	13.00
14. 00	Amounts that would have been realized from patients liable for payment for services on	0	0	14. 00
14.00	a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	٥	O	14.00
15. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0. 000000	0. 000000	15. 00
16. 00	Total customary charges (see instructions)	2, 714	0.000000	16.00
17. 00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds	2, 714	0	17. 00
17.00	lline 4) (see instructions)	2, 714	O	17.00
18. 00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line	o	0	18. 00
10.00	16) (see instructions)	٩	O	10.00
19. 00	Interns and Residents (see instructions)	o	0	19. 00
20. 00	Cost of physicians' services in a teaching hospital (see instructions)	o	0	20.00
21. 00	Cost of covered services (enter the lesser of line 4 or line 16)	o	0	21. 00
21.00	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS provide			21.00
22. 00	Other than outlier payments	0	0	22. 00
23. 00	Outlier payments	o	0	23. 00
24. 00	Program capital payments	o		24. 00
25. 00	Capital exception payments (see instructions)	0		25. 00
26. 00	Routine and Ancillary service other pass through costs	o	0	1
27. 00	Subtotal (sum of lines 22 through 26)	0	0	27. 00
28. 00	Customary charges (title V or XIX PPS covered services only)	o	0	28. 00
29. 00	Titles V or XIX (sum of lines 21 and 27)	0	0	l
27.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT	<u> </u>		27.00
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31. 00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	0	0	31.00
32. 00	Deducti bl es	0	0	32. 00
33. 00	Coinsurance	o	0	33. 00
34. 00	Allowable bad debts (see instructions)	o	0	34. 00
35. 00	Utilization review	o		35. 00
36. 00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	o	0	36. 00
37. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37. 00
38. 00	Subtotal (line 36 ± line 37)	o	0	38. 00
39. 00	Direct graduate medical education payments (from Wkst. E-4)	o	· ·	39. 00
40. 00	Total amount payable to the provider (sum of lines 38 and 39)	0	0	40. 00
41. 00	Interim payments	o	0	41. 00
42. 00	Balance due provider/program (line 40 minus line 41)	o	0	1
43. 00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,	o	0	43. 00
	chapter 1, §115.2		Ŭ	
		1		'

Health Financial Systems	FRANCISCAN ST ANTHONY-MICHIGAN CITY	In Lie	u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 150015 Component CCN: 15T015	From 01/01/2014		nared·
	Title XIX	Subprovi der - I RF	Cost	
		I npati ent	Outpati ent	
		1. 00	2. 00	
PART VII - CALCULATION OF REIMBURSEMENT	- ALL OTHER HEALTH SERVICES FOR TITLES V OR 3	(IX SERVICES		

			I RF		
			Inpati ent	Outpati ent	
			1.00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR	R TITLES V OR XIX	SERVI CES		
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services		0		1.00
2. 00	Medical and other services		Ĭ	0	
3.00	Organ acquisition (certified transplant centers only)		o	O	3. 00
4.00	Subtotal (sum of lines 1, 2 and 3)			0	4. 00
				U	•
5.00	Inpatient primary payer payments		0	0	5. 00
6.00	Outpatient primary payer payments			0	
7.00	Subtotal (line 4 less sum of lines 5 and 6)		0	0	7. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonable Charges				
8. 00	Routine service charges		0		8. 00
9.00	Ancillary service charges		695	0	9. 00
10.00	Organ acquisition charges, net of revenue		0		10.00
11. 00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		695	0	12.00
	CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for services	s on a charge	0	0	13. 00
	basis	· ·			
14.00	Amounts that would have been realized from patients liable for payment	for services on	o	0	14. 00
	a charge basis had such payment been made in accordance with 42 CFR §41	13. 13(e)			
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0. 000000	0.000000	15. 00
	Total customary charges (see instructions)		695	0	16. 00
17. 00	Excess of customary charges over reasonable cost (complete only if line	e 16 exceeds	695	0	17. 00
00	line 4) (see instructions)	3 10 0100000	0,0	ŭ	
18. 00	Excess of reasonable cost over customary charges (complete only if line	4 exceeds line	0	0	18. 00
10.00	16) (see instructions)	o i caccedo iine	Ĭ	Ŭ	10.00
19. 00	Interns and Residents (see instructions)		o	0	19. 00
20. 00	Cost of physicians' services in a teaching hospital (see instructions)		o	0	
21. 00	Cost of covered services (enter the lesser of line 4 or line 16)			0	21.00
21.00	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed	1 for DDC provide		0	21.00
22. 00	Other than outlier payments	i ioi rra piovide	0	0	22. 00
23. 00	Outlier payments			0	23. 00
	1 ' 3		· ·	U	•
	Program capital payments		0		24. 00
25. 00	Capital exception payments (see instructions)		0		25. 00
26. 00	Routine and Ancillary service other pass through costs		0	0	
27. 00			0	0	
28. 00	Customary charges (title V or XIX PPS covered services only)		0	0	
29. 00	Titles V or XIX (sum of lines 21 and 27)		0	0	29. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30. 00	Excess of reasonable cost (from line 18)		0	0	
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		0	0	31.00
32.00	Deducti bl es		0	0	32. 00
33.00	Coi nsurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		o	0	34.00
35.00	Utilization review		o		35. 00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		ol	0	36. 00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		ol	0	37. 00
38. 00	Subtotal (line 36 ± line 37)		0	0	38. 00
39. 00	Direct graduate medical education payments (from Wkst. E-4)		o	Ü	39.00
	Total amount payable to the provider (sum of lines 38 and 39)		0	0	
41. 00	Interim payments			0	
41.00	Balance due provider/program (line 40 minus line 41)			0	1
42.00		CMC Dub 15 2		0	1
43.00	Protested amounts (nonallowable cost report items) in accordance with C	JWIJ FUD 13-Z,	١	U	43.00
	chapter 1, §115.2		l l		l

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

Provider CCN: 150015

Peri od: From 01/01/2014 To 12/31/2014 Worksheet G Date/Time Prepared: 5/28/2015 9:57 am

					5/28/2015 9:5	7 am
		General Fund	Speci fi c	Endowment Fund	Plant Fund	
			Purpose Fund			
		1.00	2.00	3. 00	4. 00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	66, 612, 925	0	0	_	1. 00
2.00	Temporary investments	10, 419, 258	0	0		2. 00
3.00	Notes receivable	0	0	0	0	3. 00
4.00	Accounts receivable	29, 581, 321	0	0	0	4. 00
5.00	Other recei vable	0	0	0	0	5. 00
6.00	Allowances for uncollectible notes and accounts receivable	-10, 423, 804	0	0	0	6.00
7.00	Inventory	3, 423, 699	0	0	0	7. 00
8. 00	Prepai d expenses	631, 726		0	0	8. 00
9. 00	Other current assets	1, 935, 709		0	0	9. 00
10. 00	Due from other funds	1,700,707	o o	_	Ö	10.00
11. 00	Total current assets (sum of lines 1-10)	102, 180, 834		_	•	11. 00
11.00	FIXED ASSETS	102, 100, 034	·			11.00
12. 00	Land	6, 650, 028	0	0	0	12. 00
13. 00	Land improvements	4, 012, 783		_	1	13. 00
14. 00	Accumulated depreciation		1	_		14. 00
		-106, 850, 219	1	_		•
15.00	Buildings	92, 425, 500		0		15.00
16.00	Accumulated depreciation	0 000 040		0	0	16.00
17. 00	Leasehold improvements	3, 938, 248		_	0	17. 00
18. 00	Accumulated depreciation	0	0	_	0	18. 00
19. 00	Fi xed equipment	105, 485, 388	0	0	0	19. 00
20. 00	Accumulated depreciation	0) 0	0	0	20. 00
21. 00	Automobiles and trucks	0) 0	0	0	21. 00
22. 00	Accumulated depreciation	0	0	0	0	22. 00
23. 00	Major movable equipment	0	0	0	0	23. 00
24.00	Accumul ated depreciation	0	0	0	0	24. 00
25. 00	Mi nor equipment depreciable	0	0	0	0	25. 00
26. 00	Accumulated depreciation	0	0	0	0	26. 00
27.00	HIT designated Assets	0	0	0	0	27. 00
28. 00	Accumul ated depreciation	0	0	0	0	28. 00
29. 00	Mi nor equi pment-nondepreci abl e	0	0	0		29. 00
30. 00	Total fixed assets (sum of lines 12-29)	105, 661, 728	1	_	1	30.00
30.00	OTHER ASSETS	103,001,720	,,			30.00
31. 00	Investments	1	0	0	0	31. 00
32. 00	Deposits on Leases			_		32. 00
33. 00	· ·			_	0	33. 00
	Due from owners/officers	0 000 (4)	1	_		•
34.00	Other assets	3, 208, 646			0	34.00
35. 00	Total other assets (sum of lines 31-34)	3, 208, 646	1	_	1	35. 00
36. 00	Total assets (sum of lines 11, 30, and 35)	211, 051, 208	8 0	0	0	36. 00
	CURRENT LI ABI LI TI ES		_	_	_	
37. 00	Accounts payable	11, 394, 389	1	_		37. 00
38. 00	Salaries, wages, and fees payable	3, 603, 401	0	0	_	38. 00
39. 00	Payroll taxes payable	0) 0	0	0	39. 00
40. 00	Notes and Loans payable (short term)	1, 274, 190) 0	0	0	40. 00
41. 00	Deferred income	0	0	0	0	41. 00
42.00	Accel erated payments	0)			42. 00
43.00	Due to other funds	1, 024, 146	0	0	0	43.00
44. 00	Other current liabilities	1, 987, 912	2	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	19, 284, 038	0	0	0	45. 00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46. 00
47.00	Notes payable	3, 857, 239	0	0		47. 00
48. 00	Unsecured Loans	0	0	0		48. 00
49. 00	Other long term liabilities	2, 103, 906		_		49. 00
50. 00	Total long term liabilities (sum of lines 46 thru 49	5, 961, 145	1	_		50.00
51. 00	Total liabilites (sum of lines 45 and 50)	25, 245, 183				51.00
51.00	CAPITAL ACCOUNTS	25, 245, 165	0		0	31.00
E2 00		105 007 025			I	F2 00
52.00	General fund balance	185, 806, 025				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0	•	54.00
55. 00	Donor created - endowment fund balance - unrestricted			0		55. 00
56. 00	Governing body created - endowment fund balance			0		56. 00
57. 00	Plant fund balance - invested in plant				0	57. 00
58. 00	Plant fund balance - reserve for plant improvement,				0	58. 00
	repl acement, and expansi on]			l
59. 00	Total fund balances (sum of lines 52 thru 58)	185, 806, 025		0	0	59. 00
60.00	Total liabilities and fund balances (sum of lines 51 and	211, 051, 208	0	0	0	60. 00
	[59]		[

STATEMENT OF CHANGES IN FUND BALANCES Provider CCN: 150015 Peri od: Worksheet G-1 From 01/01/2014 12/31/2014 Date/Time Prepared: 5/28/2015 9:57 am General Fund Special Purpose Fund Endowment Fund 1.00 2.00 3.00 4. 00 5. 00 1.00 Fund balances at beginning of period 172, 583, 740 0 1.00 2.00 Net income (loss) (from Wkst. G-3, line 29) 25, 292, 953 2.00 3.00 Total (sum of line 1 and line 2) 197, 876, 693 0 3.00 4.00 0 0 4.00 0 0 0 0 0 5.00 0 5.00 6.00 6.00 0 7.00 0 7.00 0 8.00 0 8.00 0 9.00 0 9. 00 10.00 Total additions (sum of line 4-9) 10.00 Subtotal (line 3 plus line 10) 197, 876, 693 11.00 0 11.00 FUND BALANCE ADJUSTMENT 1, 986, 888 12.00 0 12.00 13.00 13.00 14.00 0 0 0 0 14.00 0 15.00 15.00 0 16.00 0 16.00 17.00 17.00 1, 986, 888 18.00 Total deductions (sum of lines 12-17) 18.00 Fund balance at end of period per balance 19.00 195, 889, 805 19.00 sheet (line 11 minus line 18) Endowment Fund Plant Fund 7. 00 8.00 6. 00 1.00 Fund balances at beginning of period 0 0 1.00 Net income (loss) (from Wkst. G-3, line 29) 2.00 2.00 3.00 Total (sum of line 1 and line 2) 0 0 3.00 4.00 4.00 5.00 0 5.00 0 6.00 6.00 7.00 0 7 00 8.00 0 8.00 9.00 9.00 10.00 Total additions (sum of line 4-9) 0 0 10.00 11.00 Subtotal (line 3 plus line 10) 0 0 11.00 12.00 FUND BALANCE ADJUSTMENT 12.00 13.00 13.00 14.00 0 14.00 0 15.00 15.00 16.00 16.00 17.00 17.00 Total deductions (sum of lines 12-17) 18.00

0

0

0

18.00

19.00

Fund balance at end of period per balance

sheet (line 11 minus line 18)

Health Financial Systems FRANCI STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES FRANCISCAN ST ANTHONY-MICHIGAN CITY Provi der CCN: 150015 Cost Center Description Inpatient Outpatient Total

	cost center bescription	1 npatrent	outpatrent	2 00	
		1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospi tal	26, 540, 881		26, 540, 881	1. 00
2.00	SUBPROVI DER - I PF	5, 745, 384		5, 745, 384	2. 00
3.00	SUBPROVI DER - I RF	3, 435, 072		3, 435, 072	3. 00
4.00	SUBPROVI DER				4. 00
5. 00	Swing bed - SNF	0		0	5. 00
6.00	Swing bed - NF	0		0	
7. 00	SKILLED NURSING FACILITY	0		0	7. 00
8.00	NURSING FACILITY	0		0	1 0.00
9.00	OTHER LONG TERM CARE				9. 00
10. 00	Total general inpatient care services (sum of lines 1-9)	35, 721, 337		35, 721, 337	10.00
	Intensive Care Type Inpatient Hospital Services				
11. 00	INTENSIVE CARE UNIT	5, 099, 700		5, 099, 700	11. 00
12.00	CORONARY CARE UNIT				12. 00
13.00	BURN INTENSIVE CARE UNIT				13. 00
14.00	SURGI CAL INTENSIVE CARE UNIT				14. 00
15.00	OTHER SPECIAL CARE (SPECIFY)				15. 00
16.00	Total intensive care type inpatient hospital services (sum of lines	5, 099, 700		5, 099, 700	16. 00
	11-15)				
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	40, 821, 037		40, 821, 037	17. 00
18.00	Ancillary services	125, 797, 173	270, 552, 749	396, 349, 922	18. 00
19. 00	Outpati ent servi ces	10, 773, 132	42, 027, 299	52, 800, 431	19. 00
20.00	RURAL HEALTH CLINIC	0	0	0	20. 00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21. 00
22.00	HOME HEALTH AGENCY				22. 00
23.00	AMBULANCE SERVICES				23. 00
24.00	CMHC				24. 00
25.00	AMBULATORY SURGICAL CENTER (D. P.)				25. 00
26.00	HOSPI CE				26. 00
27.00	NON-REI MBURSABLE	0	2, 831, 073	2, 831, 073	27. 00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst.	177, 391, 342	315, 411, 121	492, 802, 463	28. 00
	G-3, line 1)				
	PART II - OPERATING EXPENSES		·		
29.00	Operating expenses (per Wkst. A, column 3, line 200)		149, 284, 745		29. 00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31. 00
32.00		l o			32. 00
33.00		l o			33.00
34.00		l o			34.00
35. 00		l o			35. 00
36, 00	Total additions (sum of lines 30-35)		o		36, 00
37. 00	DEDUCT (SPECIFY)	0			37. 00
38. 00	()	l o			38. 00
39. 00		l o			39. 00
40. 00					40.00
41. 00					41. 00
42. 00	Total deductions (sum of lines 37-41)		n		42. 00
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer		149, 284, 745		43. 00
.5. 55	to Wkst. G-3, line 4)		, 20 1, 7 40		.5. 55
	1	1	'		'

	Financial Systems FRANCISCAN ST ANTHONY-			u of Form CMS-	
STATE	ENT OF REVENUES AND EXPENSES	Provi der CCN: 150015	Peri od: From 01/01/2014	Worksheet G-3	
				Date/Time Pre 5/28/2015 9:5	
				0, 20, 2010 710	, d
				1. 00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line	28)		492, 802, 463	1. 00
2.00	Less contractual allowances and discounts on patients' accounts	S		321, 377, 118	2. 00
3.00	Net patient revenues (line 1 minus line 2)			171, 425, 345	3. 00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43	3)		149, 284, 745	4. 00
5.00	Net income from service to patients (line 3 minus line 4)			22, 140, 600	5. 00
	OTHER INCOME				
6.00	Contributions, donations, bequests, etc			0	6. 00
7.00	Income from investments			0	7. 00
8.00	Revenues from telephone and other miscellaneous communication s	servi ces		0	8. 00
9.00	Revenue from television and radio service			0	9. 00
10.00	Purchase di scounts			0	10.00
	Rebates and refunds of expenses			0	11. 00
	Parking lot receipts			0	1 . 2 . 00
	Revenue from Laundry and Linen service			0	13. 00
	Revenue from meals sold to employees and guests			0	14. 00
	Revenue from rental of living quarters			0	15. 00
16.00	Revenue from sale of medical and surgical supplies to other that	an patients		0	16. 00

18.00

21.00

0 22.00

24.00

24. 01

24.04

25.00

26.00

27.00

27.01

27.02

28.00

0 19.00

0 20.00

0 23.00

0 24.02

0 24.03

3, 118, 530

6, 750, 418

9, 868, 948

32, 009, 548

6, 668, 435

6, 716, 595

48, 160

25, 292, 953 29. 00

17.00 Revenue from sale of drugs to other than patients

19.00 Tuition (fees, sale of textbooks, uniforms, etc.)

21.00 Rental of vending machines

26.00 Total (line 5 plus line 25)

27. 02 TOTAL NON OPERATING REVENUE

24. 00 OTHER OPERATING REVENUE

PREMIUM REVENUE

BAD DEBTS

BAD DEBTS

27. 01 EQUITY TRANSFERS

Rental of hospital space

Governmental appropriations

24.03 NET ASSETS RELEASED FROM OPERATIONS

Total other income (sum of lines 6-24)

TOTAL NON-OPERATING REVENUE

20.00

22. 00

23.00

24. 01

24. 02

25.00

27.00

28.00

18.00 Revenue from sale of medical records and abstracts

Revenue from gifts, flowers, coffee shops, and canteen

Total other expenses (sum of line 27 and subscripts)

29.00 Net income (or loss) for the period (line 26 minus line 28)

CALCUL	ATION OF CAPITAL PAYMENT	Provider CCN: 150015	Peri od:	u of Form CMS-2 Worksheet L	
			From 01/01/2014 To 12/31/2014	Date/Time Pre	
		Title XVIII	Hospi tal	5/28/2015 9: 5 PPS	/ am
		11 21 3 77711	noopi tai	10	
				1. 00	
	PART I - FULLY PROSPECTIVE METHOD				ļ
	CAPITAL FEDERAL AMOUNT			1 (01 (0)	
1.00	Capital DRG other than outlier			1, 681, 696	
1. 01 2. 00	Model 4 BPCI Capital DRG other than outlier Capital DRG outlier payments			0 45, 577	1. 0° 2. 00
2. 00 2. 01	Model 4 BPCI Capital DRG outlier payments			45, 577	
3. 00	Total inpatient days divided by number of days in the cost re	norting period (see inst	ructions)	56. 14	
4. 00	Number of interns & residents (see instructions)	portring period (see That	r de trons)	0.00	
5. 00	Indirect medical education percentage (see instructions)			0.00	
6.00	Indirect medical education adjustment (multiply line 5 by the	sum of lines 1 and 1.01)	0	6.00
7. 00	Percentage of SSI recipient patient days to Medicare Part A p 30) (see instructions)			4. 22	7.00
8. 00	Percentage of Medicaid patient days to total days (see instru	ctions)		19. 71	8.00
9. 00	Sum of lines 7 and 8	o : · o		23. 93	
10.00	Allowable disproportionate share percentage (see instructions)		4. 97	
11. 00	Disproportionate share adjustment (line 10 times the sum of I			83, 580	11.00
12. 00	Total prospective capital payments (sum of lines 1, 1.01, 2,	2.01, 6 and 11)		1, 810, 853	12.00
				1. 00	
1 00	PART II - PAYMENT UNDER REASONABLE COST Program inpatient routine capital cost (see instructions)			0	1 00
1. 00 2. 00	Program inpatient routine capital cost (see instructions)			0	1. 00 2. 00
2. 00 3. 00	Total inpatient program capital cost (see instructions)			0	
4. 00	Capital cost payment factor (see instructions)			0	
5. 00	Total inpatient program capital cost (line 3 x line 4)			0	
				1. 00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS			1.00	
1. 00	Program inpatient capital costs (see instructions)			0	1.00
2. 00	Program inpatient capital costs for extraordinary circumstanc	es (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	
5.00	Capital cost for comparison to payments (line 3 x line 4)			0	0.00
6. 00	Percentage adjustment for extraordinary circumstances (see in			0. 00	
7.00	Adjustment to capital minimum payment level for extraordinary	circumstances (line 2 x	line 6)	0	
8.00	Capital minimum payment level (line 5 plus line 7)			0	
9.00	Current year capital payments (from Part I, line 12, as appli	,	l ! O)	0	
10. 00 11. 00	Current year comparison of capital minimum payment level to c Carryover of accumulated capital minimum payment level over c		,	0	10. 00 11. 00
11.00	Worksheet L, Part III, line 14)	apitai payillerit (110111 pii	oi yeai	U	11.00
12. 00	Net comparison of capital minimum payment level to capital pa	yments (line 10 plus lin	e 11)	0	12.00
13. 00	Current year exception payment (if line 12 is positive, enter			0	13.00
14. 00	Carryover of accumulated capital minimum payment level over c			0	14.00
	(if line 12 is negative, enter the amount on this line)	· •	- '		
				_	1 45 00
15. 00	Current year allowable operating and capital payment (see ins	tructions)		0	
16. 00	Current year allowable operating and capital payment (see ins Current year operating and capital costs (see instructions) Current year exception offset amount (see instructions)	tructions)		0	16. 00