Health Financi		ST. FRANCIS HOSPITAL &			u of Form CMS-2552-10
	required by law (42 USC 1395g; since the beginning of the cost				OMB NO. 0938-0050
HOSPITAL AND F AND SETTLEMENT	OSPITAL HEALTH CARE COMPLEX COST SUMMARY	REPORT CERTIFICATION	Provider CCN: 150162	Period: From 01/01/2014 To 12/31/2014	
PART I - COST	REPORT STATUS				
Provider use only	1.[ X ]Electronically filed cos 2.[ ]Manually submitted cost 3.[ 0 ]If this is an amended re 4.[ F ]Medicare Utilization. En	report mort enter the number o	f times the provider for low.	Date:5/26/20 resubmitted this o	·
Contractor use only	5.[1]Cost Report Status 6.E (1) As Submitted 7.C (2) Settled without Audit 8.[ (3) Settled with Audit 9.[ (4) Reopened (5) Amended	Contractor No.	111	.NPR Date: .Contractor's Vendo .[ O ]If line 5, co number of tim	or Code: 4 Jumn 1 is 4: Enter les reopened = 0-9.

PART II - CERTIFICATION

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 ST. FRANCIS HOSPITAL & HEALTH CENTER (150162) 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.

(Signed)

Encryption Information
ECR: Date: 5/26/2015 Time: 5:20 pm
5ar6EDmViKnNcClUMbZe3mVOJ18Tp0
NZQ600f6YZqoZBip1tiueZptu4P8rG
qceslnn8F508RidE
PI: Date: 5/26/2015 Time: 5:20 pm
UgWX44uqlU5ww9ZKpwSYXNL1T.AMG0
ZtYwSOprthIiglHOAaweX9GTGAFUPS

wvpDOP6NO.056JSF

Officer or Administrator of Provider(s)

Title Shole

Date

Title XVIII Part B Title V Part A Title XIX 1.00 2.00 3.00 4.00 5.00 PART III - SETTLEMENT SUMMARY 1.00 Hospital -415.823 368,223 -73.474 1.00 2.00 Subprovider - IPF n 2.00 Subprovider - IRF 3.00 0, 3.00 Swing bed - SNF 5.00 0 5.00 6.00 Swing bed - NF 6.00 9.00 HOME HEALTH AGENCY I 9.00 200.00 Total -422.198 368,223 -73,474 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.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provi der CCN: 150162 Peri od: Worksheet S-2 From 01/01/2014 Part I Date/Time Prepared: 12/31/2014 5/26/2015 12:47 pm 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 8111 S. EMERSON AVENUE 1.00 PO Box: 1.00 State: IN 2.00 City: INDIANAPOLIS Zi p Code: 46237 County: MARION 2.00 Component Name CCN CBSA Provi der Date Payment System (P, Certi fi ed T, 0, or N) 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 ST. FRANCIS HOSPITAL & 150162 26900 05/01/2006 Ν 3.00 1 HEALTH CENTER Subprovi der - IPF 4.00 4.00 5.00 Subprovi der - IRF REHAB UNIT 15T162 26900 5 01/01/2005 Ν Р Р 5.00 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 Hospi tal -Based NF 10.00 10.00 11.00 Hospital -Based OLTC 11.00 12.00 Hospital -Based HHA HOME HEALTH 157179 26900 01/01/2014 Ρ Ν 12.00 Separately Certified ASC 13.00 13.00 Hospi tal -Based Hospi ce HOSPI CE 14.00 151523 01/01/2014 14.00 26900 Hospital -Based Health Clinic - RHC 15 00 15 00 Hospital-Based Health Clinic - FQHC 16.00 Hospital -Based (CMHC) I 17.00 17.00 18.00 Renal Dialysis 18.00 19.00 Other 19.00 From 1.00 2.00 20.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2014 12/31/2014 20.00 Type of Control (see instructions) 21.00 Inpatient PPS Information Does this facility qualify and is it currently receiving payments for disproportionate 22.00 Υ Ν 22.00 share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter 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 γ 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 determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1. 22.03 Did this hospital receive a geographic reclassification from urban to rural as a result Ν 22.03 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 N 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" for yes or "N" for no. In-State In-State Out-of Out-of Medi cai d Other Medi cai d HMO days Medicai d State Medi cai d State Medi cai d Medi cai d paid days el i gi bl e days unpai d paid days el i gi bl e days unpai d 1.00 3.00 4.00 5.00 6.00 2.00 24.00 If this provider is an IPPS hospital, enter the 5, 187 1, 398 7, 984 339 24.00 in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6. If this provider is an IRF, enter the in-state 152 24 0 0 18 25.00 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.

	Financial Systems ST. FRANCIS H AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA		L & HEALTH CEN	CCN: 150162 P	lr eriod: rom 01/01/		u of Form Workshe Part I		
					o 12/31/	2014	Date/Ti		
					Urban/Rur	al S	5/26/20 Date of		
24 00	Enter your standard geographic classification (not wa	200) 6+	atus at the be	ginning of the	1. 00	1	2.0	00	26. 00
	cost reporting period. Enter "1" for urban or "2" for	rural		0		'			
27. 00	Enter your standard geographic classification (not wa reporting period. Enter in column 1, "1" for urban or enter the effective date of the geographic reclassifi	~ "2" f	or rural. If a			1			27.00
35. 00	If this is a sole community hospital (SCH), enter the effect in the cost reporting period.	e numbe	er of periods S	CH status in		0			35. 00
					Begi nni 1. 00		Endi ı 2. C		
36.00	Enter applicable beginning and ending dates of SCH st		Subscript line	36 for number			2.0	<i>.</i>	36.00
37 00	of periods in excess of one and enter subsequent date If this is a Medicare dependent hospital (MDH), enter		umber of perio	ds MDH status		0			37.00
	in effect in the cost reporting period.		·			Ü			
38.00	Enter applicable beginning and ending dates of MDH st of periods in excess of one and enter subsequent date		Subscript line	38 for number					38. 00
					Y/N 1.00		Y/I 2. C		
39. 00	Does this facility qualify for the inpatient hospital						2. C		39. 00
	hospitals in accordance with 42 CFR §412.101(b)(2)(ii or "N" for no. Does the facility meet the mileage rec								
40. 00	CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octob	or "N" adjus	for no. (see stment? Enter "	instructions) Y" for yes or	N		N		40.00
	no in column 2, for discharges on or after October 1.					V	XVIII	XIX	
	Prospective Payment System (PPS)-Capital					1.00	2.00	3. 00	
45. 00	Does this facility qualify and receive Capital paymer	nt for	di sproporti ona	te share in ac	cordance	N	Y	N	45. 00
46. 00	with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment excepursuant to 42 CFR §412.348(f)? If yes, complete Wkst					N	N	N	46. 00
	Pt. III. Is this a new hospital under 42 CFR §412.300 PPS capi Is the facility electing full federal capital payment					N N	N N	N N	47. 00 48. 00
56. 00	Teaching Hospitals Is this a hospital involved in training residents in	approv	ed GME program	s? Enter "Y"	for yes	Υ			56.00
57. 00	or "N" for no. If line 56 is yes, is this the first cost reporting p	peri od	durina which r	esidents in ap	proved	l N			57.00
	GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mont for yes or "N" for no in column 2. If column 2 is "N	yes o th of t (", com	or "N" for no i his cost repor plete Workshee	n column 1. If ting period?	column 1 Enter "Y"				
58. 00	"N", complete Wkst. D, Parts III & IV and D-2, Pt. II If line 56 is yes, did this facility elect cost reim	ourseme	ent for physici	ans' services	as	N			58. 00
59. 00	defined in CMS Pub. 15-1, § 2148? If yes, complete Wh Are costs claimed on line 100 of Worksheet A? If yes			, Pt. I.		N			59.00
	Are you claiming nursing school and/or allied health provider-operated criteria under §413.85? Enter "Y"	costs	for a program	that meets the		Y			60.00
	provider-operated criteria under 9413.80? ENTER Y	Y/N	I ME	Direct GME	IME		Di rect	t GME	
		1. 00	2. 00	3. 00	4. 00		5. C	00	
61. 00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N	2. 33	3. 33	1. 30	0. 00			61.00
61. 01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see		0.00	0.00					61.01
61. 02	instructions) Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of		0.00	0.00					61. 02
61. 03	ACA). (see instructions) Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see		0.00	0.00					61. 03
61. 04	instructions) Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the		0. 00	0.00					61.04
61. 05	current cost reporting period. (see instructions). 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		0.00	0.00					61. 05

0.00

0.00

61.06

primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)
61.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary

care or general surgery. (see instructions)

ealth Financial Systems ST. FRANCIS HO OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DAT		vider CCN: 15		Peri od:	u of Form CMS-2 Worksheet S-2	
				From 01/01/2014 To 12/31/2014	Part I Date/Time Pre 5/26/2015 12:	
	Program Na	ne Progra	am Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
	1. 00	2	. 00	3. 00	4. 00	
1.10 Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.  1.20 Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column				0. 00		61. 1
4, direct GME FTE unweighted count.						
ACA Provisions Affecting the Health Resources and Ser	vi cos Administ	ration (UDCA	`		1.00	
2.00 Enter the number of FTE residents that your hospital				riod for which	0.00	62.00
your hospital received HRSA PCRE funding (see instruction 2011) Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC programmer.	tions) Teaching Heal	th Center (Th	0.			62.0
Teaching Hospitals that Claim Residents in Nonprovide	r Settings					
3.00 Has your facility trained residents in nonprovider se "Y" for yes or "N" for no in column 1. If yes, comple:		. (see instru	uctions)	)	Y	63.0
			i ghted TEs	Unweighted FTEs in	Ratio (col. 1/ (col. 1 +	
			ovi der	Hospi tal	col. 2))	
			i te			
		1.	. 00	2. 00	3. 00	1
Section 5504 of the ACA Base Year FTE Residents in No			ase yea	r is your cost	reporti ng	
period that begins on or after July 1, 2009 and before			0. 0	0 00	0.000000	
4.00 Enter in column 1, if line 63 is yes, or your facility in the base year period, the number of unweighted non- resident FTEs attributable to rotations occurring in a settings. Enter in column 2 the number of unweighted resident FTEs that trained in your hospital. Enter in of (column 1 divided by (column 1 + column 2)). (see it	-primary care all nonprovide non-primary c column 3 the	r are	0.0	0.00	0. 000000	64.0
Program Name	Program Co	de Unwe	i ghted	Unwei ghted	Ratio (col.	
		Nonpr	TEs ovider ite	FTEs in Hospital	3/ (col. 3 + col. 4))	
1.00	2. 00		. 00	4. 00	5. 00	1
1.00				0 13. 91		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 3 divided by (column 3 + column 4)). (see instructions)

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.

86.00 Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section

85.00

86.00

N

'Y" for yes and "N" for no.

§413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.

TEFRA Providers

Ith Financial Systems ST. FRANCIS HOSPITAL SPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	& HEALTH CENT Provider (		Peri od:		Workshee		
			From 01/01, To 12/31,		5/26/201	5 12:	pared 47 pr
			1. 00		XI X 2. 00		
Title V and XIX Services	L comi coo? Er	ton "V" for	N.		Y		00
00 Does this facility have title V and/or XIX inpatient hospital yes or "N" for no in the applicable column.	i services? Er	iter i ror	N		Y		90.
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 Are title XIX NF patients occupying title XVIII SNF beds (dual	al certificati	on)? (see			N		92.
instructions) Enter "Y" for yes or "N" for no in the applical OO Does this facility operate an ICF/MR facility for purposes or		VIV2 Entor	N		N		93.
"Y" for yes or "N" for no in the applicable column.	i title v aliu	VIV. FIIIGI	IN IN		IN		93.
00 Does title V or XIX reduce capital cost? Enter "Y" for yes, a applicable column.	and "N" for no	in the	N		N		94.
00 lf'line 94 is "Y", enter the reduction percentage in the app 00 Does title V or XIX reduce operating cost? Enter "Y" for yes			N	0. 00	N	0. 00	95. 96.
applicable column.  On If line 96 is "Y", enter the reduction percentage in the applicable applicable column.	licable column	1		0. 00		0. 00	97
Rural Providers		•		0.00		0.00	1
5.00 Does this hospital qualify as a Critical Access Hospital (CAI 5.00 If this facility qualifies as a CAH, has it elected the all- for outpatient services? (see instructions)		od of payme	nt N				105. 106.
7.00 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			N				107
instructions) If yes, the GME elimination would not be on Wks	st. B, Pt. I,	col. 25 and					
the program would be cost reimbursed. If yes complete Wkst. I this facility is a CAH, do L&Rs in an approved medical educa							1
CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "I							1
instructions) 1.00 Is this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	CRNA fee sched	lul e? See 4	2 N				108
_	Physi cal	Occupati ona			Respi ra		
0.00  f this hospital qualifies as a CAH or a cost provider, are	1. 00 N	2. 00 N	3. OC N		4. 00 N		109
therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.							
					1.00		
0.00Did this hospital participate in the Rural Community Hospital the current cost reporting period? Enter "Y" for yes or "N"		n project (	410A Demo)f	or	N		110
				1 0			
Miscellaneous Cost Reporting Information				1.00	) 2.00	3. 00	
is this an all-inclusive rate provider? Enter "Y" for yes or is yes, enter the method used (A, B, or E only) in column 2.  3 either "93" percent for short term hospital or "98" percent psychiatric, rehabilitation and long term hospitals providers	If column 2 i t for long ter	s "E", ente m care (inc	r in column Iudes	N		0	115
Pub.15-1, §2208.1. b.00 Is this facility classified as a referral center? Enter "Y" :	for was or "N"	for no		N			116
.00 is this facility legally-required to carry malpractice insur			r "N" for	N			117
no. .00 Is the malpractice insurance a claims-made or occurrence poli	icy? Enter 1 i	f the polic	y is	2			118
claim-made. Enter 2 if the policy is occurrence.		Premi ums	Losse	 S	Insurar	nce	
		1. 00	2.00		3. 00		
.01List amounts of malpractice premiums and paid losses:		412, 6		3, 464		0, 774	118
			1.00		2. 00		
.02 Are mal practice premiums and paid losses reported in a cost of Administrative and General? If yes, submit supporting schedulers			N		2100		118
and amounts contained therein.  .00 DO NOT USE THIS LINE							119
0.00 Is this a SCH or EACH that qualifies for the Outpatient Hold					N		120
§3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that quality Hold Harmless provision in ACA §3121 and applicable amendmen	alifies for th	e Outpatien					
Enter in column 2, "Y" for yes or "N" for no.  .00 Did this facility incur and report costs for high cost implain patients? Enter "Y" for yes or "N" for no.	ntable devices	charged to	Y				121
Transplant Center Information		6					4.0-
.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below.	r yes and "N"	for no. If	N				125
gos, onto continuation date(s) (min/dat/yyyy) below.	tor the cortif	ication dat	e				126
							1
0.00 If this is a Medicare certified kidney transplant center, en in column 1 and termination date, if applicable, in column 2 1.00 If this is a Medicare certified heart transplant center, ento							127

nlth Financial Systems SPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DATA	Provi der	CCN: 150162	Per	i od:	Worksheet	S-2
STITIZE AND HOSTITIZE HEALTH GARE COM LE	TO TO THE TOTAL TON BATA	Trovider	0011. 130102	Fro	m 01/01/2014	Part I	
				То	12/31/2014	Date/Time 5/26/2015	Prepare
		<u> </u>					
8.00  f this is a Medicare certified	ver transplant center	enter the certif	ication dat	te	1. 00	2. 00	128.
in column 1 and termination date,	if applicable, in colum	ın 2.					
9.00 If this is a Medicare certified I			cation date	e in			129.
column 1 and termination date, if 0.00 f this is a Medicare certified pa	appircable, in column 2 ancreas transplant cente	 er, enter the cer	ti fi cati on				130.
date in column 1 and termination of	date, if applicable, in	column 2.					
1.00  f this is a Medicare certified in   date in column 1 and termination (			ertiticatio	on			131
2.00 If this is a Medicare certified is	slet transplant center,	enter the certif	ication dat	te			132.
in column 1 and termination date, 3.00  f this is a Medicare certified o			ication dat	to			133
in column 1 and termination date,			i cati on ua				133
4.00 If this is an organ procurement of		the OPO number	in columní	1			134.
and termination date, if applicable All Providers	le, in column 2.						
D. 00 Are there any related organization					Y	158014	140.
chapter 10? Enter "Y" for yes or				sts			
are claimed, enter in column 2 the		. 00	ti ons)		3. 00		
If this facility is part of a cha	in organization, enter c	on lines 141 thro	ugh 143 th	e name		s of the hom	ne
office and enter the home office 1.00Name: SISTERS OF ST. FRANCIS HEA			I ANS Contra	ctor's	Number 091	n1	141.
SERVI C		SERVICES	I ANSCOILL A	Ctor s	s Number . Oo N	01	141
2.00 Street: 1515 W DRAGOON TRL		1290	7: 0	1.	475		142
3.00 City: MISHAWAKA	State:	I N	Zi p Co	ae:	465	44	143
						1.00	
1.00 Are provider based physicians' co						Y	144
5.00  f costs for renal services are c	laimed on Worksheet A. I.	ine /4, are the	costs for i	ınpatı	ent services	S Y	145
				•			I
only? Enter "Y" for yes or "N" for							
only? Enter "Y" for yes or "N" for	r no.				1. 00	2.00	
only? Enter "Y" for yes or "N" for only? Enter "Y" for yes or "N"	r no. gy changed from the prev	riously filed cos	t report?	ter		2.00	146.
6.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no in the approval date (mm/dd/yyyy) in	r no.  gy changed from the prev n column 1. (See CMS Pub column 2.	). 15-2, § 4020)	If yes, ent	ter	1. 00	2.00	146.
only? Enter "Y" for yes or "N" for  5.00 Has the cost allocation methodologenter "Y" for yes or "N" for no in the approval date (mm/dd/yyyy) in 7.00 Was there a change in the statistic	r no.  gy changed from the prev n column 1. (See CMS Pub column 2. ical basis? Enter "Y" fo	o. 15-2, § 4020) or yes or "N" for	If yes, ent	ter	1. 00 N	2.00	147
6.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no in the approval date (mm/dd/yyyy) in	r no.  gy changed from the prev n column 1. (See CMS Pub column 2. cal basis? Enter "Y" fo f allocation? Enter "Y"	o. 15-2, § 4020) or yes or "N" for for yes or "N" f	If yes, entone no. for no.		1. 00 N	2.00	147 148
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Health Financial Systems	u of Form CMS-2	2552-10			
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX	( IDENTIFICATION DATA	Provi der CCN: 150162	Peri od:	Worksheet S-2	
			From 01/01/2014		
			To 12/31/2014	Date/Time Pre	
				5/26/2015 12:	47 pm
			Begi nni ng	Endi ng	
			1. 00	2.00	
170.00 Enter in columns 1 and 2 the EHR be period respectively (mm/dd/yyyy)	09/30/2014	170. 00			
				1.00	1
171.00 If line 167 is "Y", does this provi				N	171.00
Medicare cost plans reported on Wks	st. S-3, Pt. I, line 2, col.	6? Enter "Y" for yes a	and "N" for no.		
(see instructions)					

	Financial Systems ST. Fi TAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE:	RANCIS HOSPITAL & STIONNAIRE		CCN: 150162	Period:	u of Form CMS- Worksheet S-2	
					From 01/01/2014 To 12/31/2014		epared:
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	General Instruction: Enter Y for all YES resp mm/dd/yyyy format.	onses. Enter N foi	r all NO re	esponses. Ent	er all dates in	the	
	COMPLETED BY ALL HOSPITALS						
1. 00	Provider Organization and Operation Has the provider changed ownership immediatel	y prior to the he	ginning of	the cost	N		1.00
1.00	reporting period? If yes, enter the date of t						1.00
				Y/N	Date	V/I	
. 00	Has the provider terminated participation in	the Medicare Prod	ram? If	1.00 N	2. 00	3. 00	2.00
. 00	yes, enter in column 2 the date of termination voluntary or "I" for involuntary.						2.00
. 00	Is the provider involved in business transact	tions, including ma	anagement	Y			3.00
	contracts, with individuals or entities (e.g. or medical supply companies) that are related	, chain home offic	ces, drug				
	officers, medical staff, management personnel	, or members of t	he board				
	of directors through ownership, control, or f	family and other s	imilar				
	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 Cartifi	od Dublic	Υ	A		4 00
. 00	Accountant? Column 2: If yes, enter "A" for			l Y	A		4.00
	or "R" for Reviewed. Submit complete copy or	enter date availal					
. 00	column 3. (see instructions) If no, see instructions are the cost report total expenses and total		t from	l N			5.00
. 00	those on the filed financial statements? If y			14			3.00
					Y/N	Legal Oper.	
	Approved Educational Activities				1. 00	2. 00	
. 00	Column 1: Are costs claimed for nursing scho	ool? Column 2: If	yes, is t	he provider i	s N		6.00
. 00	the legal operator of the program? Are costs claimed for Allied Health Programs?	7 If "V" see instr	ucti ons		N		7.00
3. 00	Were nursing school and/or allied health prog	grams approved and.		d during the	Y		8.00
. 00	cost reporting period? If yes, see instruction  Are costs claimed for Intern-Resident program		ourrent oo	ot monomtalf	Y		9, 00
. 00	yes, see instructions.	is crarilled on the o	current co	st report? II	Y		9.00
0. 00	Was an Intern-Resident program been initiated	d or renewed in the	e current	cost reportin	ng N		10.00
1. 00	period? If yes, see instructions.  Are GME cost directly assigned to cost center	rs other than I &	R in an An	nroved	N		11.00
	Teaching Program on Worksheet A? If yes, see						
						Y/N 1. 00	
	Bad Debts					1.00	
	Is the provider seeking reimbursement for back					Y	12.00
3.00	If line 12 is yes, did the provider's bad deberiod? If yes, submit copy.	ot collection poli	cy change	during this c	cost reporting	N	13.00
4. 00	If line 12 is yes, were patient deductibles a	and/or co-payments	wai ved? I	fyes, see in	structi ons.	N	14.00
F 00	Bed Complement	or agat raparting	noriod2 lf	voc coo inc	tructions	Υ	15 00
5. 00	Did total beds available change from the price	or cost reporting	perrou? II		art A	Part B	15. 00
		Descriptio	on	Y/N	Date	Y/N	
	PS&R Data	0		1.00	2. 00	3. 00	
6. 00	Was the cost report prepared using the PS&R			N		N	16.00
	Report only? If either column 1 or 3 is yes,						
	lenter the paid-through date of the PS&R Report used in columns 2 and 4 (see						
	instructions)						
7. 00	Was the cost report prepared using the PS&R Report for totals and the provider's records			Y	04/02/2015	Y	17. 00
	for allocation? If either column 1 or 3 is						
	yes, enter the paid-through date in columns						
8. 00	2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments			l N		N	18.00
5. 00	made to PS&R Report data for additional			14		I.A.	10.00
	claims that have been billed but are not			1			1

Ν

Ν

19.00

20.00

instructions.

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 other PS&R Report information? If yes, see

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

other PS&R Report information? If yes, see

Health Financial Systems	ST. FRANCIS HOSPITAL & HE	ALTH CENTER	In Lieu	of Form CMS-2552-10

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE Provider CCN: 150162 Peri od: Worksheet S-2 From 01/01/2014 Part II Date/Time Prepared: 12/31/2014 5/26/2015 12:47 pm 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 Ν 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. Were new leases and/or amendments to existing leases entered into during this cost reporting period? Ν 24.00 If ves. see instructions 25.00 25 00 Have there been new capitalized leases entered into during the cost reporting period? If yes, see Ν instructions. 26.00 Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see Ν 26.00 i nstructi ons. 27 00 Has the provider's capitalization policy changed during the cost reporting period? If yes, submit Ν 27.00 сору. Interest Expense 28.00 Were new Loans, mortgage agreements or Letters of credit entered into during the cost reporting Ν 28.00 period? If ves. 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 30.00 Ν 30.00 instructions. Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see 31.00 Ν 31.00 instructions. Purchased Services 32.00 Have changes or new agreements occurred in patient care services furnished through contractual Ν 32.00 arrangements with suppliers of services? If yes, see instructions. 33.00 If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If 33.00 no, see instructions. Provi der-Based Physicians 34.00 Are services furnished at the provider facility under an arrangement with provider-based physicians? Υ 34.00 If yes, see instructions. If line 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 Were home office costs claimed on the cost report? 36, 00 36,00 If line 36 is yes, has a home office cost statement been prepared by the home office? 37.00 N 37.00 If yes, see instructions. If line 36 is yes, was the fiscal year end of the home office different from that of Ν 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 see instructions. 40 00 If line 36 is yes, did the provider render services to the home office? If yes, see Υ 40.00 instructions. 1.00 2.00 Cost Report Preparer Contact Information BKD 41.00 Enter the first name, last name and the title/position BKD 41.00 held by the cost report preparer in columns 1, 2, and 3, respectively. 42 00 BKD, LLP 42 00 Enter the employer/company name of the cost report preparer. 43.00 Enter the telephone number and email address of the cost 502-581-0435 \_VCOSTREPORTS@BKD. COM 43.00 report preparer in columns 1 and 2, respectively.

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE Provi der CCN: 150162 Peri od: Worksheet S-2 From 01/01/2014 To 12/31/2014 Part II Date/Time Prepared: 5/26/2015 12:47 pm 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 04/02/2015 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 19.00 made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions. 20.00 | If line 16 or 17 is yes, were adjustments 20.00 made to PS&R Report data for Other? Describe the other adjustments: 21.00 Was the cost report prepared only using the provider's records? If yes, see 21.00 instructions. 3.00 Cost Report Preparer Contact Information 41.00 Enter the first name, last name and the title/position BKD 41.00 held by the cost report preparer in columns 1, 2, and 3, respecti vel y. 42.00 Enter the employer/company name of the cost report 42.00 preparer. 43.00 Enter the telephone number and email address of the cost 43.00 report preparer in columns 1 and 2, respectively.

 
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 ST. FRANCIS HOSPITAL & HEALTH CENTER

 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA
 Provider CCN:
 In Lieu of Form CMS-2552-10 Peri od: Worksheet S-3
From 01/01/2014 Part I
To 12/31/2014 Date/Time Prepared: 5/26/2015 12: 47 pm Provi der CCN: 150162

							5/26/2015 12:	47 pm
							I/P Days /	
							0/P Visits /	
							Tri ps	
	Component	Worksheet A	No.	of Beds	Bed Days	CAH Hours	Title V	
		Line Number			Avai I abl e			
		1. 00		2.00	3.00	4. 00	5. 00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and			237	87, 597	0.00	0	1.00
1.00	8 exclude Swing Bed, Observation Bed and	00.00		207	07,077	0.00	Ŭ	1.00
	Hospice days) (see instructions for col. 2							
	for the portion of LDP room available beds)							
2.00	HMO and other (see instructions)							2.00
3. 00	HMO IPF Subprovi der							3.00
	•							
4. 00	HMO I RF Subprovi der						0	4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF			007	07.507		0	
7. 00	Total Adults and Peds. (exclude observation			237	87, 597	0. 00	0	7. 00
	beds) (see instructions)							
8.00	INTENSIVE CARE UNIT	31. 00		30		0. 00	0	8. 00
8. 01	NEONATAL INTENSIVE CARE UNIT	31. 01		24	· ·	0. 00	0	8. 01
9.00	CORONARY CARE UNIT	32.00		68	24, 820	0. 00	0	9.00
10.00	BURN INTENSIVE CARE UNIT							10.00
11. 00	SURGICAL INTENSIVE CARE UNIT	34.00		31	11, 315	0. 00	0	11.00
12.00	OTHER SPECIAL CARE (SPECIFY)							12.00
13.00	NURSERY	43.00					0	13.00
14.00	Total (see instructions)			390	143, 169	0. 00	0	14.00
15.00	CAH visits						0	15.00
16.00	SUBPROVI DER - I PF							16.00
17.00	SUBPROVI DER - I RF	41.00		22	8, 030		0	17.00
18.00	SUBPROVI DER							18. 00
19.00	SKILLED NURSING FACILITY							19.00
20.00	NURSING FACILITY							20.00
21.00	OTHER LONG TERM CARE							21.00
22.00	HOME HEALTH AGENCY	101.00					0	22.00
23.00	AMBULATORY SURGICAL CENTER (D. P.)							23. 00
24.00	HOSPI CE	116.00		0	o			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							26. 25
27. 00	Total (sum of lines 14-26)			412				27.00
28. 00	Observation Bed Days			112			0	
29. 00	Ambulance Trips						0	29.00
30.00	Employee discount days (see instruction)							30.00
31.00	Employee discount days (see l'istruction)							31.00
32.00	Labor & delivery days (see instructions)			0	0			32.00
32. 00	Total ancillary labor & delivery room			U	١			32.00
32.01	outpatient days (see instructions)							32.01
33 00	LTCH non-covered days							33.00
33.00	LIGHT HOTE COVER Ed days	I	I			l		1 33.00

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 ST. FRANCIS HOSPITAL
 & HEALTH CENTER

 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA
 Provider CCN:

Provider CCN: 150162 | Period: From 01/01/2014 | Part I | Date/Time Prepared: 5/26/2015 12: 47 pm

						5/26/2015 12:	47 pm
		I/P Days	/ O/P Visits	/ Trips	Full Time E	Equi val ents	
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
				Pati ents	& Residents	Payrol I	
		6. 00	7. 00	8. 00	9. 00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	19, 302	3, 130	49, 124			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)	10, 469	9, 064				2.00
3.00	HMO IPF Subprovider	o	o				3.00
4.00	HMO IRF Subprovider	507	42				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	ol	o	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		ol	0			6.00
7. 00	Total Adults and Peds. (exclude observation	19, 302	3, 130	49, 124			7.00
	beds) (see instructions)	,	-,	, .= .			
8.00	INTENSIVE CARE UNIT	5, 265	616	9, 739			8.00
8. 01	NEONATAL INTENSIVE CARE UNIT	0,230	294	4, 656			8. 01
9. 00	CORONARY CARE UNIT	6, 835	763	12, 067			9.00
10.00	BURN INTENSIVE CARE UNIT	0,000	, 00	12,007			10.00
11. 00	SURGICAL INTENSIVE CARE UNIT	3, 757	422	6, 673			11.00
12. 00	OTHER SPECIAL CARE (SPECIFY)	3, 737	422	0,073			12.00
13. 00	NURSERY		280	4, 419			13.00
14. 00	Total (see instructions)	35, 159	5, 505	86, 678		3, 453. 22	14.00
15. 00	CAH visits	35, 159	5, 505	00, 070	20.07	3, 433. 22	15.00
16. 00		٩	٩	U			
	SUBPROVIDER - I PF	2 251	150	4 104	0. 00	39. 41	16.00
17. 00	SUBPROVIDER - IRF	2, 251	152	4, 104	0.00	39. 41	17.00
18.00	SUBPROVI DER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20. 00	NURSING FACILITY						20.00
21. 00	OTHER LONG TERM CARE						21.00
22. 00	HOME HEALTH AGENCY	0	0	19, 414	0. 00	0. 00	•
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24. 00	HOSPI CE	0	0	0	0. 00	0.00	
24. 10	HOSPICE (non-distinct part)	0	0	0			24. 10
25.00	CMHC - CMHC						25. 00
26.00	RURAL HEALTH CLINIC						26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER						26. 25
27.00	Total (sum of lines 14-26)				20. 07	3, 492. 63	27.00
28. 00	Observation Bed Days		1, 271	7, 493			28. 00
29. 00	Ambul ance Trips	l ol		·			29.00
30.00	Employee discount days (see instruction)			0			30.00
31. 00	Employee discount days - IRF		ļ	0			31.00
32. 00	Labor & delivery days (see instructions)	0	339	699			32.00
32. 01	Total ancillary labor & delivery room		337	0			32. 01
02.01	outpatient days (see instructions)			O			52.01
33 00	LTCH non-covered days	o					33.00
55.00	121011 11011 00 voi cu uuyo	١	I				1 55. 55

Health Financial Systems ST. FRANCIS HOSPITAL & HEALTH CENTER

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CCN: 150162 | Peri od: | Worksheet S-3 | From 01/01/2014 | Part I | To 12/31/2014 | Date/Time Prepared:

				10	) 12/31/2014	Date/IIme Pre   5/26/2015 12:	
		Full Time	<u> </u>	Di sch	arges		
		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		0	7, 125	1, 325	17, 446	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, 018	O		2.00
3.00	HMO I PF Subprovi der						3.00
4.00	HMO IRF Subprovider						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
8. 00	beds) (see instructions) INTENSIVE CARE UNIT						8. 00
8. 01	NEONATAL INTENSIVE CARE UNIT						8. 01
9. 00							9. 00
10.00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						9. 00 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	0	7, 125	1, 325	17, 446	14. 00
15. 00	CAH visits	0.00	0	7, 123	1, 323	17, 440	15. 00
16. 00	SUBPROVIDER - IPF						16. 00
17. 00	SUBPROVIDER - IRF	0.00	0	200	9	364	17. 00
18. 00	SUBPROVI DER	0.00	O	200	1	001	18. 00
19. 00	SKILLED NURSING FACILITY						19.00
20. 00	NURSING FACILITY						20.00
21. 00	OTHER LONG TERM CARE						21.00
22. 00	HOME HEALTH AGENCY	0.00					22.00
23. 00	AMBULATORY SURGICAL CENTER (D. P. )	3.33					23. 00
24.00	HOSPI CE	0.00					24.00
24. 10	HOSPICE (non-distinct part)						24. 10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER						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 Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32. 01	Total ancillary labor & delivery room						32.01
	outpatient days (see instructions)						
33. 00	LTCH non-covered days						33.00

HOSPITAL WAGE INDEX INFORMATION Provider CCN: 150162 Peri od: Worksheet S-3 From 01/01/2014 Part II Date/Time Prepared: 12/31/2014 5/26/2015 12:47 pm Worksheet A Amount Recl assi fi cat Paid Hours Adj usted Average Hourly Wage (col. 4 ÷ col. 5) Line Number Reported ion of Sal ari es Related to Sal ari es (col. 2 ± col. Salaries in (from 3) col. 4 Worksheet A-6)1. 00 2.00 4.00 5.00 6.00 3.00 PART II - WAGE DATA SALARI ES 1.00 Total salaries (see 200.00 138, 998, 121 138, 998, 121 4, 725, 690. 86 29. 41 1.00 instructions) 2.00 Non-physician anesthetist Part 0 C 0 0.00 0.00 2.00 3.00 Non-physician anesthetist Part 0 0 0.00 0.00 3.00 Physician-Part A -3,004.71 4.00 287, 032 287, 032 95.53 4.00 Administrative 4.01 7, 822, 90 Physicians - Part A - Teaching 538.967 538.967 68.90 4.01 5.00 Physician-Part B 0.00 0.00 5.00 6.00 Non-physician-Part B 0.00 0.00 6.00 7.00 Interns & residents (in an 21.00 4, 177, 104 -2, 313, 127 1, 863, 977 54, 335. 89 34.30 7.00 approved program) 7 01 0.00 7.01 Contracted interns and 0 0.00 residents (in an approved programs) 8.00 Home office personnel 0.00 0.00 8.00 0 C 9.00 SNF 44.00 0.00 9.00 0 0.0010.00 Excluded area salaries (see 9, 288, 676 123, 105 9, 411, 781 159, 158. 71 59. 13 10.00 instructions) OTHER WAGES & RELATED COSTS 11 00 Contract labor: Direct Patient 4 751 685 0 4 751 685 131 635 07 36 10 11 00 Care 12.00 Contract Labor: Top Level 0 0.00 0.00 12.00 0 C management and other management and administrative servi ces Contract Labor: Physician-Part 0 5, 920. 94 112.85 13.00 668, 202 668, 202 13.00 A - Administrative 14.00 Home office salaries & 42, 842, 154 42, 842, 154 1, 017, 058. 28 42. 12 14.00 wage-related costs 15.00 Home office: Physician Part A 0 0 0.00 0.00 15.00 Administrative 16.00 Home office and Contract 0 0 0.00 0.00 16.00 Physicians Part A - Teaching WAGE-RELATED COSTS 17.00 Wage-related costs (core) (see 37, 820, 503 0 37, 820, 503 17.00 instructions) 18.00 Wage-related costs (other) 0 C 0 18.00 (see instructions) 2, 085, 688 19.00 19.00 Excluded areas 2, 085, 688 20.00 Non-physician anesthetist Part 20.00 0 21.00 Non-physician anesthetist Part 0 0 21.00 22.00 22.00 Physician Part A -Administrative 56, 026 22.01 Physician Part A - Teaching 56, 026 22.01 23.00 Physician Part B 115, 452 115, 452 23.00 24.00 Wage-related costs (RHC/FQHC) 24.00 Interns & residents (in an 506, 844 506, 844 25.00 25.00 approved program) OVERHEAD COSTS - DIRECT SALARIES Employee Benefits Department 4.00 0.00 0.00 26.00 27.00 Administrative & General 5.00 6, 194, 389 6, 194, 389 318, 298. 87 19.46 27.00 28.00 Administrative & General under 1, 572, 478 1, 572, 478 21, 669, 97 72. 56 28 00 contract (see inst.) 29.00 Maintenance & Repairs 6.00 0.00 0.00 29.00 Operation of Plant 4, 828, 186 4, 828, 186 186, 504. 52 30.00 7.00 25.89 30.00 15, 344. 01 31.00 Laundry & Linen Service 8.00 215, 747 215, 747 14.06 31.00 32.00 Housekeepi ng 9.00 3, 260, 052 3, 260, 052 245, 931. 21 13. 26 32 00 Housekeeping under contract 0.00 33.00 33.00 0.00 (see instructions) 10.00 1, 573, 860 9. 71 34.00 34.00 Dietary -949, 276 624, 584 64, 348, 45 35.00 Dietary under contract (see 130, 754 130, 754 3, 432. 00 38. 10 35.00 instructions) 126, 547. 04 36.00 Cafeteri a 11.00 775, 606 949, 276 1, 724, 882 13. 63 36.00 37.00 Maintenance of Personnel 12.00 0.00 0.00 37.00 13.00 138, 078. 39 34. 52 38. 00 38.00 Nursing Administration 4, 766, 372 4, 766, 372

Health Financial Systems	ST. F	RANCIS HOSPITA	AL & HEALTH CEN	HEALTH CENTER In Lieu			u of Form CMS-2552-10		
HOSPITAL WAGE INDEX INFORMATION			Provi der		Peri od:	Worksheet S-3			
					From 01/01/2014 To 12/31/2014	Part II   Date/Time Pre	narod:		
					10 12/31/2014	5/26/2015 12:			
	Worksheet A	Amount	Recl assi fi cat	Adj usted	Pai d Hours	Average			
	Line Number	Reported	ion of	Sal ari es	Related to	Hourly Wage			
			Sal ari es	(col.2 ± col.	Salaries in	(col. 4 ÷			
			(from	3)	col. 4	col. 5)			
			Worksheet						
			A-6)						
	1. 00	2. 00	3.00	4.00	5. 00	6. 00			
39.00 Central Services and Supply	14. 00	1, 976, 949	0	1, 976, 94	9 84, 796. 57	23. 31	39. 00		
40.00 Pharmacy	15. 00	4, 634, 001	0	4, 634, 00	1 141, 896. 14	32. 66	40.00		
41.00 Medical Records & Medical	16. 00	0	0		0.00	0. 00	41.00		
Records Library									
42.00 Social Service	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		

Health Financial Systems	ST. FRANCIS HOSPITAL & HEALTH CENTER	In Lieu of Form CMS-2552-10
HOCDITAL WACE INDEX INCODMATION	Described CON 1501(2) Described	WI+ C 2

near th	Financiai systems	31. F	KANCIS HUSPITA	AL & HEALTH CEN	IEK	in Lie	u of Form CMS-2	2552-10
HOSPI 1	FAL WAGE INDEX INFORMATION			Provi der		Period: From 01/01/2014 To 12/31/2014		pared:
		Worksheet A	Amount	Recl assi fi cat	Adj usted	Paid Hours	Average	
		Line Number	Reported	ion of	Sal ari es	Related to	Hourly Wage	
				Sal ari es	(col.2 ± col	Salaries in	(col. 4 ÷	
				(from	3)	col. 4	col. 5)	
				Worksheet				
				A-6)				
		1. 00	2. 00	3.00	4. 00	5. 00	6. 00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		135, 985, 282	2, 313, 127	138, 298, 40	9 4, 688, 634. 04	29. 50	1.00
	instructions)							
2.00	Excluded area salaries (see		9, 288, 676	123, 105	9, 411, 78	1 159, 158. 71	59. 13	2.00
	instructions)							
3.00	Subtotal salaries (line 1		126, 696, 606	2, 190, 022	128, 886, 62	8 4, 529, 475. 33	28. 46	3.00
	minus line 2)							
4.00	Subtotal other wages & related		48, 262, 041	0	48, 262, 04	1 1, 154, 614. 29	41. 80	4.00
	costs (see inst.)							
5.00	Subtotal wage-related costs		37, 820, 503	0	37, 820, 50	3 0.00	29. 34	5.00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		212, 779, 150	2, 190, 022	214, 969, 17	2 5, 684, 089. 62	37. 82	6.00
7.00	Total overhead cost (see		29, 928, 394	0	29, 928, 39	4 1, 346, 847. 17	22. 22	7.00
	instructions)							

Health Financial Systems	ST. FRANCIS HOSPITAL & HEALTH CENTER	In Lieu of Form CMS-2552-10
HOCDITAL WACE DELATED COCTO	D	(0 D : 1 1   W : 1 1   C 0

	01/01/2014   Part IV 12/31/2014   Date/Time Prepared: 5/26/2015 12:47 pm
	Amount
	Reported 1.00
PART IV - WAGE RELATED COSTS	1.00
Part A - Core List	
RETIREMENT COST	
1.00 401K Employer Contributions	0 1.00
2.00 Tax Sheltered Annuity (TSA) Employer Contribution	-36, 374 2.00
3.00   Nonqualified Defined Benefit Plan Cost (see instructions)	8, 824, 703 3. 00
4.00 Qualified Defined Benefit Plan Cost (see instructions)	0 4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)	
5.00 401K/TSA Plan Administration fees	0 5.00
6.00 Legal/Accounting/Management Fees-Pension Plan	0 6.00
7.00 Employee Managed Care Program Administration Fees	0 7.00
HEALTH AND INSURANCE COST	
8.00   Health Insurance (Purchased or Self Funded)	17, 449, 393 8. 00
9.00 Prescription Drug Plan	0 9.00
10.00 Dental, Hearing and Vision Plan	1, 014, 118 10.00
11.00 Life Insurance (If employee is owner or beneficiary)	0 11.00
12.00 Accident Insurance (If employee is owner or beneficiary)	0 12.00
13.00 Disability Insurance (If employee is owner or beneficiary)	480, 605 13. 00
14.00 Long-Term Care Insurance (If employee is owner or beneficiary)	0 14.00
15.00 'Workers' Compensation Insurance 16.00 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by F	1, 343, 790 15. 00 FASB 106. 0 16. 00
	ASB 106. 0 16.00
Non cumulative portion) TAXES	
17.00 FICA-Employers Portion Only	10, 322, 446 17. 00
18.00   Medicare Taxes - Employers Portion Only	0 18.00
19. 00   Unempl oyment Insurance	182, 171 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 a	above. (see 0 21.00
instructions))	
22.00 Day Care Cost and Allowances	0 22.00
23.00 Tuition Reimbursement	1, 003, 661 23. 00
24.00 Total Wage Related cost (Sum of lines 1 -23)	40, 584, 513 24. 00
Part B - Other than Core Related Cost	
25. 00 OTHER WAGE RELATED COSTS (SPECIFY)	0 25.00

Health Financial Systems	ST. FRANCIS HOSPITAL & HEALTH CENTER	In Lieu

u of Form CMS-2552-10 Worksheet S-3 Part V Date/Time Prepared: 5/26/2015 12:47 pm HOSPITAL CONTRACT LABOR AND BENEFIT COST Provi der CCN: 150162 Peri od: From 01/01/2014 To 12/31/2014 Cost Center Description Contract Benefit Cost Labor 1. 00 2. 00 PART V - Contract Labor and Benefit Cost Hospital and Hospital-Based Component Identification: 1.00 Total facility's contract labor and benefit cost 0 1.00 Hospi tal 0 2.00 0 2.00 Subprovi der - IPF
Subprovi der - IRF
Subprovi der - (Other)
Swing Beds - SNF
Swing Beds - NF 3.00 3.00 4.00 0 4.00 5.00 0 0 5.00 6.00 o 6.00 ol 0 7.00 0 7.00 8.00 Hospital -Based SNF 8.00 Hospi tal -Based NF Hospi tal -Based OLTC 9.00 9.00 10.00 10.00 Hospi tal -Based HHA 11.00 0 0 11.00 12.00 Separately Certified ASC 12.00 13.00 Hospi tal -Based Hospi ce 0 0 13.00 14.00 Hospital -Based Health Clinic RHC 14.00 15.00 Hospital-Based Health Clinic FQHC 15.00 16.00 Hospi tal -Based-CMHC 16.00 17.00 Renal Dialysis 17.00 0 18.00 Other 0 18.00

	Financial Systems ST. F	FRANCIS HOSPITAL	& HEALTH CEN	ITFR	In Lie	eu of Form CMS-2	2552-10
	HEALTH AGENCY STATISTICAL DATA	TO MADE TO THE OFFICE AND ADDRESS OF THE OFFICE ADDRESS OF THE OFFICE AND ADDRESS OF THE OFFICE	Provi der	CCN: 150162	Period: From 01/01/2014	Worksheet S-4	
			Componen	t CCN: 157179	To 12/31/2014	Date/Time Pre 5/26/2015 12:	
					Home Health Agency I	PPS	
			<u> </u>	<u> </u>		00	
0. 00	County				MARI ON		0.00
		Title V	Title XVIII	Title XIX	0ther	Total	
	HOME HEALTH ACENOV CTATICTICAL DATA	1. 00	2. 00	3. 00	4. 00	5. 00	
1. 00	HOME HEALTH AGENCY STATISTICAL DATA Home Health Aide Hours	O	3, 086	15	7 534	3, 777	1.00
2. 00	Unduplicated Census Count (see instructions)		0.00				
		5.55			oloyees (Full Ti		
		Enter the number	er of hours in	Staff	Contract	Total	
		your normal	work week				
		0		1.00	2.00	3.00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES						
3.00	Administrator and Assistant Administrator(s)		40. 00	1			
4.00	Director(s) and Assistant Director(s)			2. 6		l .	
5. 00 6. 00	Other Administrative Personnel Direct Nursing Service			5. 5 9. 0			
7. 00	Nursing Supervisor			0.0		l .	
8. 00	Physical Therapy Service			5. 2			
9.00	Physical Therapy Supervisor			0.0	0.00	0.00	9. 00
10.00	Occupational Therapy Service			2. 7			
11.00	Occupational Therapy Supervisor			0.0			
12.00	Speech Pathology Service			0. 4			
13. 00 14. 00	Speech Pathology Supervisor Medical Social Service			0.0			
15. 00	Medical Social Service Supervisor			0.0			
16. 00	Home Health Aide			1. 8			
17.00	Home Health Aide Supervisor			0.0			
18.00				0.0	0.00	0.00	18. 00
19. 00	HOME HEALTH AGENCY CBSA CODES  Enter in column 1 the number of CBSAs where	1		I	1		19.00
19.00	you provided services during the cost				1		19.00
	reporting period.						
20.00	List those CBSA code(s) in column 1 serviced			26900			20.00
	during this cost reporting period (line 20						
	contains the first code).	Full Ep	i sodes				
			With Outliers	LUPA Epi sodes	PEP Only	Total (cols.	
		Outliers		·	Epi sodes	1-4)	
	DDC ACTIVITY DATA	1. 00	2. 00	3. 00	4. 00	5. 00	
21. 00	PPS ACTIVITY DATA Skilled Nursing Visits	O	0		0 0	0	21.00
22. 00	3	o o	Ö	•	o o		
23. 00	3	O	0	•	0 0		
24.00	Physical Therapy Visit Charges	0	0		0 0	0	
25.00		0	0	1	0		
26.00		0	0	•	0		
27. 00 28. 00		0 0	0		0 0		
	Speech Pathology Visit Charges Medical Social Service Visits		0	1	0 0	0	
		. 9		1	-		
		0	0	)	0	0	00.00
29. 00 30. 00		0	0	1	0 0		31.00
29. 00 30. 00 31. 00 32. 00	Medical Social Service Visit Charges Home Health Aide Visits Home Health Aide Visit Charges	0	0		0 0	0	31. 00 32. 00
29. 00 30. 00 31. 00	Medical Social Service Visit Charges Home Health Aide Visits Home Health Aide Visit Charges Total visits (sum of lines 21, 23, 25, 27,	0	0		o o	0	31. 00 32. 00
29. 00 30. 00 31. 00 32. 00 33. 00	Medical Social Service Visit Charges Home Health Aide Visits Home Health Aide Visit Charges Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	0 0 0	0 0 0		0 0 0	0 0	31. 00 32. 00 33. 00
29. 00 30. 00 31. 00 32. 00 33. 00 34. 00	Medical Social Service Visit Charges Home Health Aide Visits Home Health Aide Visit Charges Total visits (sum of lines 21, 23, 25, 27, 29, and 31) Other Charges	0 0 0	0		0 0	0 0 0	31. 00 32. 00 33. 00 34. 00
29. 00 30. 00 31. 00 32. 00 33. 00	Medical Social Service Visit Charges Home Health Aide Visits Home Health Aide Visit Charges Total visits (sum of lines 21, 23, 25, 27, 29, and 31) Other Charges	0 0 0	000000000000000000000000000000000000000			0 0 0	31. 00 32. 00 33. 00 34. 00
29. 00 30. 00 31. 00 32. 00 33. 00 34. 00	Medical Social Service Visit Charges Home Health Aide Visits Home Health Aide Visit Charges Total visits (sum of lines 21, 23, 25, 27, 29, and 31) Other Charges Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34) Total Number of Episodes (standard/non	0 0 0	000000000000000000000000000000000000000			0 0 0	31.00 32.00 33.00 34.00 35.00
29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00	Medical Social Service Visit Charges Home Health Aide Visits Home Health Aide Visit Charges Total visits (sum of lines 21, 23, 25, 27, 29, and 31) Other Charges Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34) Total Number of Episodes (standard/non outlier)	0 0 0	000000000000000000000000000000000000000			0 0 0 0	31. 00 32. 00 33. 00 34. 00 35. 00
29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00	Medical Social Service Visit Charges Home Health Aide Visits Home Health Aide Visit Charges Total visits (sum of lines 21, 23, 25, 27, 29, and 31) Other Charges Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34) Total Number of Episodes (standard/non outlier)	0 0 0	000000000000000000000000000000000000000		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0	31. 00 32. 00 33. 00 34. 00 35. 00 36. 00

Health Financial Systems	ST. FRANCIS HOSPITAL & HE	EALTH CENTER	In Lieu of Form CMS-2553			
HOSPITAL IDENTIFICATION DATA		Provider CCN: 150162	Period: From 01/01/2014	Worksheet S-9 Parts I & II		
	1	Component CCN: 151523	To 12/31/2014	Date/Time Prepared:		

						Hospi ce I		
		Unduplicated Days						
		Title XVIII	Title XIX	Title XVIII	Title XIX	All Other	Total (sum of	
				Skilled	Nursi ng		cols. 1, 2 &	
				Nursi ng	Facility		5)	
				Facility				
		1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	
	PART I - ENROLLMENT DAYS							
1.00	Continuous Home Care	0	0	0	0	0	0	1.00
2.00	Routine Home Care	0	819	0	0	21, 490	22, 309	2.00
3.00	Inpatient Respite Care	0	0	0	0	23	23	3.00
4.00	General Inpatient Care	0	7	0	0	98	105	4.00
5.00	Total Hospi ce Days	0	826	0	0	21, 611	22, 437	5.00
	Part II - CENSUS DATA							
6.00	Number of Patients Receiving	0	24	0	0	655	679	6.00
	Hospi ce Care							
7.00	Total Number of Unduplicated	0.00		0. 00				7.00
	Continuous Care Hours Billable							
	to Medicare							
8.00	Average Length of Stay (line	0.00	34. 42	0. 00	0. 00	32. 99	33. 04	8.00
	5/line 6)							
9. 00	Unduplicated Census Count	ol	24	0	0	655	679	9.00

	Financial Systems ST. FRANCIS HOSPITAL & HEA AL UNCOMPENSATED AND INDIGENT CARE DATA P	rovi der C		Peri od:	u of Form CMS-2 Worksheet S-1				
				From 01/01/2014 To 12/31/2014	Date/Time Pre	nared:			
				10 12/31/2014	5/26/2015 12:				
					1. 00				
	Uncompensated and indigent care cost computation								
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divid	ded by lin	ie 202 colum	n 8)	0. 249318	1.00			
	Medicaid (see instructions for each line)								
2.00	Net revenue from Medicaid				52, 818, 955	2.00			
3.00	Did you receive DSH or supplemental payments from Medicaid?		S M P	10	N	3.00			
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental p		rom Medicai	a?		4.00			
5. 00 6. 00	If line 4 is "no", then enter DSH or supplemental payments from N $\!\!\!$ Medicaid charges	wedi cai d			0 211, 975, 528	5. 00 6. 00			
7. 00	Medicaid cost (line 1 times line 6)				52, 849, 315				
8. 00	Difference between net revenue and costs for Medicaid program (li	ne 7 minu	ıs sum of Li	nes 2 and 5: if	30, 360				
0.00	<pre>&lt; zero then enter zero)</pre>	7 III 110	13 34111 01 11	Tics 2 and 5, 11	30, 300	0.00			
	State Children's Health Insurance Program (SCHIP) (see instruction	ons for ea	ch line)			l			
9. 00	Net revenue from stand-alone SCHIP		ĺ		0	9.00			
10.00	Stand-alone SCHIP charges				0	10.00			
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)					1			
	Other state or local government indigent care program (see instru								
13.00	Net revenue from state or local indigent care program (Not includ				0				
14. 00	Charges for patients covered under state or local indigent care p	orogram (N	lot included	lin lines 6 or	0	14.00			
15. 00	10) 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	nent care	program (Li	no 15 minus line					
10.00	13; if < zero then enter zero)	gent care	program (11	TIE 13 IIITIUS TITIE		10.00			
	Uncompensated care (see instructions for each line)					l			
17. 00	Private grants, donations, or endowment income restricted to fund	ding chari	ty care		0	17.00			
18. 00	Government grants, appropriations or transfers for support of hos	spital ope	rati ons		0	18.00			
19.00	Total unreimbursed cost for Medicaid , SCHIP and state and local	i ndi gent	care progra	nms (sum of lines	30, 360	19.00			
	8, 12 and 16)								
			Uni nsured	Insured	Total (col. 1				
		-	patients 1.00	pati ents 2.00	+ col . 2) 3.00				
20. 00	Total initial obligation of patients approved for charity care (a	at full	78, 871, 20			20.00			
20.00	charges excluding non-reimbursable cost centers) for the entire f		70, 071, 20	30	76, 671, 200	20.00			
21. 00	Cost of initial obligation of patients approved for charity care		19, 664, 0	10 0	19, 664, 010	21 00			
21.00	times line 20)	(11110 1	17,001,0		17,001,010	21.00			
22. 00	Partial payment by patients approved for charity care		867, 58	83 0	867, 583	22.00			
23. 00									
0.4.00		1	1 . 1 . 22	.6.1.	1. 00	04.05			
24.00	Does the amount in line 20 column 2 include charges for patient d		ıd a Length	от stay limit	N	24.00			
25 00	imposed on patients covered by Medicaid or other indigent care pr		arom's land	th of ctou limit	0	25. 00			
	If line 24 is "yes," charges for patient days beyond an indigent		yıam s reng	jun or stay rimit	-				
	700 Total bad debt expense for the entire hospital complex (see instructions)  10. Medicare had debts for the entire hospital complex (see instructions)  11.78 931 2								

27.00 Medicare bad debts for the entire hospital complex (see instructions)

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

30.00 Cost of uncompensated care (line 23 column 3 plus line 29)

28.00 Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)

29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)

1, 178, 931

15, 236, 938

3, 798, 843 29. 00 22, 595, 270 30. 00

22, 625, 630 31.00

27.00

28.00

	02300 PARAMED ED PRGM	77, 808	27, 857	105, 665	144, 184	249, 849	23. 00
23. 01	02302 EMERGENCY MEDICAL SERVICES	0	0	0	0	0	23. 01
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS   03000   ADULTS & PEDIATRICS	19, 906, 824	5, 636, 163	25, 542, 987	-5, 402, 105	20, 140, 882	30.00
31.00	03100 I NTENSI VE CARE UNI T	6, 245, 166	2, 215, 640	8, 460, 806	-2, 053, 919	6, 406, 887	31.00
31. 01	02060 NEONATAL INTENSIVE CARE UNIT	2, 407, 045	1, 613, 050	4, 020, 095	-745, 690	3, 274, 405	
32.00	03200 CORONARY CARE UNIT	6, 970, 004	2, 070, 124	9, 040, 128	-1, 976, 997	7, 063, 131	32.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	3, 346, 837	1, 001, 366	4, 348, 203	-963, 542	3, 384, 661	
41.00	04100 SUBPROVI DER - I RF	1, 490, 309	473, 113	1, 963, 422	-388, 269	1, 575, 153	
43. 00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	637, 376	225, 110	862, 486	-214, 828	647, 658	43. 00
50. 00	05000 OPERATING ROOM	10, 456, 480	39, 763, 343	50, 219, 823	-27, 838, 631	22, 381, 192	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	2, 236, 877	1, 115, 537	3, 352, 414	-1, 058, 769	2, 293, 645	
54.00	05400 RADI OLOGY-DI AGNOSTI C	9, 494, 736	15, 579, 500	25, 074, 236	-4, 979, 545	20, 094, 691	
54.01	05402 CARDIAC NUCLEAR DIAGNOSTIC	11, 012	899, 675	910, 687	-34, 286	876, 401	54. 01
54. 02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0	0	0	0	0	54. 02
54. 03	03630 ULTRA SOUND	826, 852	217, 767	1, 044, 619	-212, 180	832, 439	
55. 00 56. 00	05500  RADI OLOGY - THERAPEUTI C   05600  RADI OI SOTOPE	27, 600	21, 960, 778	21, 988, 378	-19, 139, 804	2, 848, 574	•
59. 00	05900 CARDI AC CATHETERI ZATI ON	231, 811 1, 479, 570	931, 896 9, 744, 131	1, 163, 707 11, 223, 701	-64, 576 -9, 710, 281	1, 099, 131 1, 513, 420	•
60.00	06000 LABORATORY	876, 074	19, 460, 793	20, 336, 867	-1, 433, 998	18, 902, 869	
64. 00	06400 I NTRAVENOUS THERAPY	291, 337	351, 577	642, 914	-348, 485	294, 429	•
65.00	06500 RESPI RATORY THERAPY	5, 723, 107	2, 805, 618	8, 528, 725	-2, 533, 457	5, 995, 268	65.00
66.00	06600 PHYSI CAL THERAPY	3, 730, 218	1, 822, 691	5, 552, 909	-1, 300, 983	4, 251, 926	
66. 01	06601 SPORTS MEDICINE	0	0	0	0	0	66. 01
67.00	06700 OCCUPATIONAL THERAPY 06800 SPEECH PATHOLOGY	990, 315	401, 337	1, 391, 652	-137, 945	1, 253, 707	
68. 00 69. 00	06900 ELECTROCARDI OLOGY	605, 901 887, 624	157, 892 494, 602	763, 793 1, 382, 226	-55, 796 -447, 834	707, 997 934, 392	
69. 01	06901 CARDI AC CATH LAB	007,024	474, 002	1, 302, 220	-447, 034	754, 572	
70.00	07000 ELECTROENCEPHALOGRAPHY	1, 219, 209	1, 910, 575	3, 129, 784	-373, 709	2, 756, 075	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	27, 387, 810	27, 387, 810	
	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	18, 926, 330	18, 926, 330	
	07300 DRUGS CHARGED TO PATIENTS	0	0	0	35, 940, 101	35, 940, 101	
	07400 RENAL DI ALYSI S	507, 031	231, 216	738, 247	-216, 896	521, 351	
76. 97	07697 CARDI AC REHABI LI TATI ON OUTPATI ENT SERVI CE COST CENTERS	410, 926	183, 894	594, 820	-103, 855	490, 965	76. 97
90.00	09000 CLINIC	3, 755, 949	3, 766, 337	7, 522, 286	202, 360	7, 724, 646	90.00
90. 01	09001 I BMT JOINT VENTURE	914, 945	3, 213, 093	4, 128, 038	-259, 870	3, 868, 168	1
90. 02	09002 PSYCHIATRIC COUNCELING CENTER	1, 140, 261	544, 014	1, 684, 275	-273, 023	1, 411, 252	•
90. 03	09003 SOUTH INDY MRI & REHAB	252	86, 108	86, 360	-10, 151	76, 209	
90. 04	09004 BARI ATRI CS	0	0	0	0	0	90. 04
90.05	09005 CV DI AGNOSTI C SERVI CES	4, 571, 672	5, 936, 828	10, 508, 500	-1, 809, 441	8, 699, 059	
90. 06 91. 00	09006 CARDI AC REHAB 09100 EMERGENCY	7, 404, 168	3, 401, 112	10, 805, 280	-2, 659, 419	0 8, 145, 861	90. 06 91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	7, 404, 100	3, 401, 112	10, 603, 200	-2,037,417	0, 143, 001	92.00
,2.00	OTHER REIMBURSABLE COST CENTERS	L L	I	L			72.00
101.00	10100 HOME HEALTH AGENCY	2, 548, 808	2, 687, 603	5, 236, 411	-620, 669	4, 615, 742	101.00
	SPECIAL PURPOSE COST CENTERS						
	11300   NTEREST EXPENSE		-556, 139	-556, 139	556, 139		113. 00
	11600 HOSPI CE	2, 655, 259	2, 998, 286	5, 653, 545	-640, 263	5, 013, 282	
118. 00	SUBTOTALS (SUM OF LINES 1-117) NONREIMBURSABLE COST CENTERS	136, 481, 629	261, 360, 020	397, 841, 649	599, 436	398, 441, 085	118.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	119, 735	259, 004	378, 739	-28, 968	349, 771	190 00
	19001 MEDICAL OFFICE & PARKING	0	0	0	0		190. 01
	· · · · · · · · · · · · · · · · · · ·		-1		-1	- 1	· · · · · · · · · · · · · · · · · · ·
MCRI F3	2 - 7.2.157.2						

Health Financial Systems ST. I	FRANCIS HOSPITAL	& HEALTH CEN	TER	In Lie	u of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE (	OF EXPENSES	Provi der		Peri od:	Worksheet A	
				From 01/01/2014 To 12/31/2014		pared: 47 pm
Cost Center Description	Sal ari es	0ther	Total (col. 1	Recl assi fi cat	Recl assi fi ed	
			+ col. 2)	i ons (See	Trial Balance	
				A-6)	(col. 3 +-	
					col. 4)	
	1. 00	2. 00	3. 00	4. 00	5. 00	
192.00 19200 PHYSICIANS' PRIVATE OFFICES	1, 868, 258	10, 884, 995	12, 753, 25	3 -450, 025	12, 303, 228	192.00
194.00 07955 MARKETING & COMMUNITY RELATIONS	72, 619	33, 016	105, 63	5 -18, 088	87, 547	194.00
194. 01 07952 WOMEN' S CENTER	49, 415	2, 119, 204	2, 168, 61	9 -11, 875	2, 156, 744	194. 01
194.02 07950 SOUTH EMERSON SURGERY CENTER	o	201, 095	201, 09	5 0	201, 095	194. 02
194. 03 07951 SOUTHEAST SURGERY CENTER	o	409, 564	409, 56	4 0	409, 564	194. 03
194. 04 07954 OTHER NRCC	171, 649	49, 065	220, 71	4 -32, 992	187, 722	194. 04
194. 05 07956 FOUNDATI ON	176, 318	707, 528	883, 84	-43, 176	840, 670	194. 05
194.06 07953 FRANCISCAN SURGERY CENTER	58, 498	20, 221, 651	20, 280, 14	9 -14, 312	20, 265, 837	194.06
200.00 TOTAL (SUM OF LINES 118-199)	138, 998, 121	296, 245, 142	435, 243, 26	3 0	435, 243, 263	200. 00

Provi der CCN: 150162

Peri od: From 01/01/2014 To 12/31/2014 Date/Ti me Prepared: 5/26/2015 12:47 pm

			5/26/2015 12: 47 pm
Cost Center Description	Adjustments	Net Expenses	
	(See A-8)	For	
	4 00	Allocation 7.00	
GENERAL SERVICE COST CENTERS	6. 00	7.00	
1. 00 00100 NEW CAP REL COSTS-BLDG & FLXT	28, 034, 009	45, 377, 598	1.00
2. 00 00200 NEW CAP REL COSTS-MVBLE EQUIP	0	17, 078, 620	
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT	1, 565, 904	35, 526, 691	4.00
5. 01   00570 ADMITTING	2, 770, 802	4, 562, 406	1
5. 02 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	7, 114, 711	7, 114, 711	1
5. 03 00590 OTHER ADMIN & GENERAL	64, 517, 845	92, 470, 203	
7.00 00700 OPERATION OF PLANT	-318, 518	19, 009, 135	7.00
8.00 00800 LAUNDRY & LINEN SERVICE	0	1, 308, 646	8.00
9. 00 00900 HOUSEKEEPI NG	-70, 088	4, 130, 747	
10. 00   01000 DI ETARY	-325, 837	309, 711	10.00
11. 00  01100 CAFETERI A	-2, 317, 637	1, 845, 630	11.00
13.00 01300 NURSING ADMINISTRATION	-274, 324	5, 216, 867	13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	-105, 466	3, 047, 913	14.00
15. 00   01500   PHARMACY	-546, 744	5, 303, 265	15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	1, 333, 293	1, 333, 293	16.00
21.00   02100   1&R SERVICES-SALARY & FRINGES APPRVD	-34, 792	1, 826, 800	21.00
22.00   02200   1 &R SERVICES-OTHER PRGM COSTS APPRVD	-407, 575	1, 314, 874	22.00
23.00   02300   PARAMED ED PRGM	-43, 367	206, 482	23.00
23. 01 02302 EMERGENCY MEDICAL SERVICES	0	0	23. 01
INPATIENT ROUTINE SERVICE COST CENTERS			
30. 00   03000   ADULTS & PEDI ATRI CS	-5, 770	20, 135, 112	
31.00 03100 INTENSIVE CARE UNIT	0	6, 406, 887	1
31. 01 02060 NEONATAL INTENSIVE CARE UNIT	-183, 263	3, 091, 142	
32.00 03200 CORONARY CARE UNIT	0	7, 063, 131	
34.00 03400 SURGI CAL INTENSI VE CARE UNIT	-1, 031	3, 383, 630	1
41. 00   04100   SUBPROVI DER - I RF	-5, 000	1, 570, 153	
43. 00 04300 NURSERY	0	647, 658	43.00
ANCILLARY SERVICE COST CENTERS	0 504 050	40 700 004	50.00
50. 00   05000   OPERATING ROOM	-2, 581, 958	19, 799, 234	
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0 500 450	2, 293, 645	1
54. 00 05400 RADI OLOGY-DI AGNOSTI C	-3, 582, 458	16, 512, 233	
54. 01 05402 CARDI AC NUCLEAR DI AGNOSTI C	0	876, 401	
54. 02 03450 NUCLEAR MEDICINE - DIAGNOSTIC	0	0	
54. 03   03630   ULTRA SOUND	112 051	832, 439	1
55. 00   05500   RADI OLOGY - THERAPEUTI C	-112, 051	2, 736, 523	1
56. 00   05600   RADI OI SOTOPE	1 200	1, 099, 131	
59. 00 05900 CARDI AC CATHETERI ZATI ON	1, 300	1, 514, 720	
60. 00 06000 LABORATORY	-237, 087	18, 665, 782	1
64. 00   06400   I NTRAVENOUS THERAPY 65. 00   06500   RESPI RATORY THERAPY	52, 202	294, 429	
	-52, 302	5, 942, 966	1
66. 00   06600  PHYSI CAL THERAPY 66. 01   06601  SPORTS   MEDI CI NE	0	4, 251, 926 0	1
66. 01   06601   SPORTS   MEDI CI NE 67. 00   06700   OCCUPATI ONAL   THERAPY	-6, 740	_	1
68. 00 06800 SPEECH PATHOLOGY	-0, 740	1, 246, 967 707, 997	
69. 00   06900   ELECTROCARDI OLOGY	0	934, 392	1
69. 01   06901   CARDI AC   CATH   LAB		754, 572	1
70. 00 07000 ELECTROENCEPHALOGRAPHY	-24, 865	2, 731, 210	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	-334, 279	27, 053, 531	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT	0	18, 926, 330	1
73. 00 07300 DRUGS CHARGED TO PATIENTS	l o	35, 940, 101	
74. 00 07400 RENAL DI ALYSI S	-3, 654	517, 697	
76. 97 07697 CARDI AC REHABI LI TATI ON	-28, 043	462, 922	1
OUTPATIENT SERVICE COST CENTERS	23,310	.52, 722	70.77
90. 00 09000 CLINIC	-1, 413, 415	6, 311, 231	90.00
90. 01 09001 I BMT JOINT VENTURE	-64, 539	3, 803, 629	1
90. 02 09002 PSYCHI ATRI C COUNCELING CENTER	-46, 403	1, 364, 849	1
90. 03   09003   SOUTH   NDY MRI & REHAB	-4, 590	71, 619	1
90. 04   09004 BARI ATRI CS	0	0	1
90. 05 09005 CV DI AGNOSTI C SERVI CES	-209, 667	8, 489, 392	1
90. 06   09006 CARDI AC REHAB	0	0	90.06
91. 00 09100 EMERGENCY	-286, 130	7, 859, 731	1
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)			92.00
OTHER REIMBURSABLE COST CENTERS			
101.00 10100 HOME HEALTH AGENCY	0	4, 615, 742	101.00
SPECIAL PURPOSE COST CENTERS	. 9	.,,	
113. 00 11300   NTEREST EXPENSE	0	0	113.00
116. 00 11600 H0SPI CE	-154	5, 013, 128	1
118.00 SUBTOTALS (SUM OF LINES 1-117)	91, 710, 117	490, 151, 202	
NONREI MBURSABLE COST CENTERS			
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	349, 771	190.00
190.01 19001 MEDICAL OFFICE & PARKING	O	0	1
192.00 19200 PHYSICIANS' PRIVATE OFFICES	o	12, 303, 228	192.00
			·

Health Financial Systems	ST.	FRANCIS HOSPITAL &	HEALTH CENTER		In Lieu	u of Form CMS-2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL	BALANCE	OF EXPENSES	Provi der CCN:	150162	From 01/01/2014	Worksheet A  Date/Time Prepared:
					10 12/31/2014	5/26/2015 12:47 nm

			5/26/2015 12: 47 pm
Cost Center Description	Adjustments	Net Expenses	
	(See A-8)	For	
		Allocation	
	6. 00	7. 00	
194.00 07955 MARKETING & COMMUNITY RELATIONS	5, 034, 750	5, 122, 297	194. 00
194. 01 07952 WOMEN' S CENTER	0	2, 156, 744	194. 01
194. 02 07950 SOUTH EMERSON SURGERY CENTER	0	201, 095	194. 02
194. 03 07951 SOUTHEAST SURGERY CENTER	0	409, 564	194. 03
194. 04 07954 OTHER NRCC	1, 119, 930	1, 307, 652	194. 04
194. 05 07956 FOUNDATI ON	0	840, 670	194. 05
194. 06 07953 FRANCI SCAN SURGERY CENTER	0	20, 265, 837	194. 06
200.00 TOTAL (SUM OF LINES 118-199)	97, 864, 797	533, 108, 060	200.00

Health Financial Systems RECLASSIFICATIONS ST. FRANCIS HOSPITAL & HEALTH CENTER
Provider CCN: 150162 Peri od: Worksheet A-6
From 01/01/2014
To 12/31/2014 Date/Time Prepared: 5/26/2015 12:47 pm

					5/26/2015 12	2: 47 pm
		Increases	2.1	0.11		
	Cost Center	Li ne #	Sal ary	Other 5 00		
	2. 00 A - MEDI CAL SUPPLI ES	3. 00	4. 00	5. 00		
1. 00	OCCUPATIONAL THERAPY	67. 00	ol	130, 786		1.00
2. 00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	27, 387, 810		2.00
2.00	PATI ENTS	, 55		2,,00,,010		2.00
3.00	IMPL. DEV. CHARGED TO	72. 00	0	18, 926, 330		3.00
	PATI ENT					
4.00		0. 00	0	0		4. 00
5. 00		0. 00	0	0		5.00
6. 00		0. 00	0	0		6.00
7.00		0.00	0	0		7. 00
8. 00		0.00	0	0		8.00
9. 00 10. 00		0. 00 0. 00	0	0		9. 00 10. 00
11. 00		0.00	0	0		11.00
12. 00		0.00	o	O		12.00
13. 00		0. 00	o	Ö		13.00
14. 00		0.00	o	0		14.00
15.00		0.00	0	0		15. 00
16.00		0. 00	0	0		16.00
17.00		0. 00	0	0		17. 00
18.00		0. 00	0	0		18. 00
19. 00		0. 00	0	0		19. 00
20.00		0.00	0	0		20.00
21. 00		0.00	0	0		21.00
22. 00 23. 00		0. 00 0. 00	0	0		22. 00 23. 00
24. 00		0.00	0	0		24.00
25. 00		0.00	Ö	Ö		25. 00
26. 00		0.00	o	O		26.00
27. 00		0. 00	o	0		27. 00
28. 00		0.00	0	0		28. 00
29.00		0. 00	0	0		29. 00
30.00		0. 00	0	0		30.00
31.00		0. 00	0	0		31.00
32.00		0. 00	0	0		32.00
33.00		0.00	0	0		33.00
34. 00 35. 00		0. 00 0. 00	0	0		34. 00 35. 00
36. 00		0.00	O O	0		36.00
37. 00		0.00	o	o		37.00
38. 00		0.00	o	O		38.00
39. 00		0.00	Ö	0		39.00
	TOTALS			46, 444, 926		
	B - DRUG					
1.00	DRUGS CHARGED TO PATIENTS	73. 00	0	35, 940, 101		1. 00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5. 00 6. 00		0. 00 0. 00	0	0		5. 00 6. 00
7. 00		0.00	0	0		7. 00
8. 00		0.00	o	Ö		8.00
9. 00		0.00	0	0		9. 00
10.00		0.00	o	0		10.00
11.00		0. 00	О	0		11.00
12.00		0. 00	0	0		12.00
13.00		0. 00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16. 00 17. 00		0.00	0	0		16. 00 17. 00
17.00		0. 00 0. 00	0	0		18.00
19. 00		0.00	0	0		19.00
20. 00		0.00	0	0		20.00
21. 00		0.00	o	Ö		21.00
22. 00		0. 00	o	0		22. 00
23.00		0. 00	О	0		23. 00
24.00		0. 00	O	0		24. 00
25.00		0. 00	0	0		25.00
26.00		0.00	0	0		26.00
27. 00		0.00	0	0		27. 00
28.00		0.00	0	0		28.00
29. 00 30. 00		0. 00 0. 00	0	0		29. 00 30. 00
	1	0.00	9	O <sub>1</sub>		1 00.00

Health Financial Systems RECLASSIFICATIONS ST. FRANCIS HOSPITAL & HEALTH CENTER In Lieu of Form CMS-2552-10

Provider CCN: 150162 | Period: From 01/01/2014 | Worksheet A-6

RECLAS	STFICATIONS			Provi der	CCN: 150162	Period: From 01/01/201 To 12/31/201	<pre>14 Date/Time</pre>	Prepared:
		Increases					5/26/2015	12: 47 piii
	Cost Center 2.00	Li ne # 3.00	Sal ary 4.00	0ther 5.00				
31. 00	TOTAL C	0.00	0	0				31.00
	TOTALS  C - EQUI PMENT LEASE		UU	35, 940, 101				
1. 00	NEW CAP REL COSTS-MVBLE	2. 00	0	828, 310				1.00
2. 00	EQUI P	0.00	О	О				2.00
3. 00		0.00	0	0				3.00
4. 00 5. 00		0. 00 0. 00	0	0				4. 00 5. 00
6.00		0. 00	О	0				6. 00
7. 00 8. 00		0. 00 0. 00	0	0				7. 00 8. 00
9.00		0. 00	O	0				9. 00
10. 00 11. 00		0. 00 0. 00	0	0				10. 00 11. 00
12.00		0. 00	0	0				12.00
13. 00 14. 00		0. 00 0. 00	0	0				13. 00 14. 00
15.00		0. 00	О	Ö				15. 00
16. 00 17. 00		0. 00 0. 00	0	0				16. 00 17. 00
18. 00		0.00	ő	Ö				18. 00
19. 00	TOTALS — — — —		0	0 828, 310				19. 00
	D - DEPRECIATION		<u> </u>	828, 310				
1. 00	NEW CAP REL COSTS-BLDG & FLXT	1. 00	0	17, 898, 995				1. 00
2. 00		0. 00	О	0				2. 00
3. 00	TOTALS — — — —		0	00 17, 898, 995				3. 00
	E - CAFETERI A		U <sub>I</sub>	17, 696, 993				
1. 00	CAFETERI A	1100	94 <u>9, 2</u> 76 949, 276	1, 590, 261				1. 00
	F - THERAPY		949, 270	1, 590, 261				
1.00	OCCUPATIONAL THERAPY	67. 00	236, 390 98, 206	866				1.00
2. 00	SPEECH PATHOLOGY TOTALS		334, 596	<u>3</u> 60 1, 226				2.00
1 00	G - INTEREST	112.00		FF( 120				1.00
1. 00 2. 00	INTEREST EXPENSE	113. 00 0. 00	0	556, 139 0				1. 00 2. 00
	TOTALS		0	556, 139				
1. 00	H - PARAMEDICAL EDUCATION PARAMED ED PRGM	23. 00	123, 105	39, 914				1.00
	TOTALS		123, 105	39, 914				
1. 00	I - INTERN & RESIDENT I&R SERVICES-OTHER PRGM	22.00	1, 316, 758	405, 691				1.00
2.00	COSTS APPRVD	00.00	00/ 3/0	422 545				2.00
2. 00	TOTALS	90.00	99 <u>6, 3</u> 69 2, 313, 127	42 <u>2, 5</u> 45 828, 236				2. 00
1 00	J - EMPLOYEE BENEFITS	4 00		22.0/0.//4				1.00
1. 00 2. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00 0. 00	0	33, 960, 664 0				1. 00 2. 00
3.00		0. 00	O	0				3. 00
4. 00 5. 00		0. 00 0. 00	0	0				4. 00 5. 00
6.00		0. 00	0	0				6. 00
7. 00 8. 00		0. 00 0. 00	0	0				7. 00 8. 00
9.00		0. 00	0	0				9. 00
10. 00 11. 00		0. 00 0. 00	0	0				10. 00 11. 00
12.00		0. 00	O	0				12. 00
13. 00 14. 00		0. 00 0. 00	0	0				13. 00 14. 00
15.00		0. 00	0	0				15. 00
16. 00 17. 00		0. 00 0. 00	0	0				16. 00 17. 00
17.00		0.00	0	0				17.00
19.00		0.00	0	0				19.00
20. 00 21. 00		0. 00 0. 00	o	0				20. 00 21. 00
22.00		0. 00	0	0				22. 00
23. 00 24. 00		0. 00 0. 00	0	0				23. 00 24. 00
	<u>'</u>	·	•	<u> </u>				

In Lieu of Form CMS-2552-10

Health Financial Systems RECLASSIFICATIONS ST. FRANCIS HOSPITAL & HEALTH CENTER
Provider CCN: 150162 Period: Worksheet A-6 From 01/01/2014 To 12/31/2014 Date/Time Prepared: 5/26/2015 12:47 pm

					5/26/2015 12: 47 p	pm_
		Increases				
	Cost Center	Li ne #	Sal ary	0ther		
	2. 00	3.00	4. 00	5. 00		
25.00		0.00	0	0	25.	. 00
26.00		0.00	0	0	26.	. 00
27. 00		0.00	0	0	27.	. 00
28. 00		0.00	0	0	28.	. 00
29. 00		0.00	o	0	29.	. 00
30.00		0.00	o	0	30.	. 00
31. 00		0.00	o	0	31.	. 00
32. 00		0.00	o	0	32.	. 00
33.00		0.00	o	0	33.	. 00
34.00		0.00	o	0	34.	. 00
35.00		0.00	o	0	35.	. 00
36. 00		0.00	O	0	36.	. 00
37.00		0.00	O	0	37.	. 00
38. 00		0.00	o	0	38.	. 00
39. 00		0.00	o	0	39.	. 00
40.00		0.00	o	0		. 00
41.00		0.00	o	0	41.	. 00
42.00		0.00	O	0	42.	. 00
43.00		0.00	O	0	43.	. 00
44. 00		0.00	O	0	44.	. 00
45. 00		0.00	O	0	45.	. 00
46. 00		0.00	o	0	46.	. 00
47. 00		0.00	o	0	47.	. 00
48. 00		0.00	0	0	48.	. 00
49. 00		0.00	O	0	49.	. 00
50. 00		0.00	o	0		. 00
51.00		0.00	o	Ō		. 00
52.00		0.00	Ö	Ō	l l	. 00
	TOTALS		— — <del>-</del>	33, 960, 664		
	Grand Total: Increases		3, 720, 104	138, 088, 772		. 00

	Financial Systems	ST.	FRANCIS HOSPIT	AL &				of Form CMS	
RECLAS	SI FI CATI ONS				Provi der		Peri od: From 01/01/2014	Worksheet A-	-6
							To 12/31/2014		
		Decreases						5/26/2015 12	2: 47 pm
	Cost Center	Li ne #	Sal ary		0ther	Wkst. A-7 Ref.			
	6.00	7. 00	8. 00		9. 00	10. 00			
1. 00	A - MEDICAL SUPPLIES ADMITTING	5. 01	0		24, 895				1.00
2. 00	OTHER ADMIN & GENERAL	5. 03	Ö	1	53, 308				2.00
3.00	OPERATION OF PLANT	7. 00	0		28, 227	C			3.00
4.00	LAUNDRY & LINEN SERVICE	8. 00	0	1	273				4.00
5. 00 6. 00	HOUSEKEEPI NG DI ETARY	9. 00 10. 00	0	1	15, 198 28, 570				5. 00 6. 00
7. 00	NURSING ADMINISTRATION	13. 00	0	1	2, 968				7.00
8. 00	CENTRAL SERVICES & SUPPLY	14. 00	0	1	1, 293, 164		l .		8.00
9. 00	PHARMACY	15. 00	0		963, 780				9. 00
10. 00	I &R SERVI CES-SALARY &	21.00	0		21, 594	C	)		10.00
11. 00	FRINGES APPRVD ADULTS & PEDIATRICS	30.00	0		610, 347	C			11.00
12. 00	INTENSIVE CARE UNIT	31.00	0	1	501, 270		l .		12.00
13.00	NEONATAL INTENSIVE CARE UNIT	31. 01	0		162, 332		l .		13.00
14.00	CORONARY CARE UNIT	32.00	0	1	277, 275				14.00
15. 00 16. 00	SURGICAL INTENSIVE CARE UNIT SUBPROVIDER - IRF	34. 00 41. 00	0	1	152, 791 27, 686				15. 00 16. 00
17. 00	NURSERY	43.00	0	1	59, 214				17.00
18. 00	OPERATING ROOM	50.00	0	ł	25, 241, 364				18.00
19. 00	DELIVERY ROOM & LABOR ROOM	52.00	0	ł	516, 473				19. 00
20.00	RADI OLOGY-DI AGNOSTI C	54.00	0	ł	2, 714, 429		l .		20.00
21. 00 22. 00	CARDIAC NUCLEAR DIAGNOSTIC ULTRA SOUND	54. 01 54. 03	0	1	26, 040 11, 022	(			21. 00 22. 00
23. 00	RADI OLOGY - THERAPEUTI C	55. 00	0	1	341, 202		l .		23. 00
24.00	RADI OI SOTOPE	56.00	0		8, 464	C			24.00
25. 00	CARDI AC CATHETERI ZATI ON	59. 00	0	1	9, 339, 227	C			25. 00
26.00	LABORATORY	60.00	0	1	802, 926				26.00
27. 00 28. 00	I NTRAVENOUS THERAPY RESPI RATORY THERAPY	64. 00 65. 00	0	1	278, 074 1, 054, 694		1		27. 00 28. 00
29. 00	PHYSI CAL THERAPY	66.00	Ö	1	62, 646				29.00
30.00	SPEECH PATHOLOGY	68. 00	0		6, 459				30.00
31.00	ELECTROCARDI OLOGY	69. 00	0	1	234, 795		l .		31.00
32. 00 33. 00	ELECTROENCEPHALOGRAPHY	70.00	0	1	74, 253				32. 00 33. 00
34. 00	RENAL DIALYSIS CARDIAC REHABILITATION	74. 00 76. 97	0	1	83, 976 5, 287				34.00
35. 00	CLI NI C	90.00	0	1	243, 506				35.00
36.00	IBMT JOINT VENTURE	90. 01	0	1	39, 375		l .		36.00
37.00	SOUTH INDY MRI & REHAB	90. 03	0	ł	2, 872				37.00
38. 00 39. 00	CV DIAGNOSTIC SERVICES EMERGENCY	90. 05 91. 00	0	ł	265, 484 869, 466		1		38. 00 39. 00
07.00	TOTALS		<u> </u>		46, 444, 926		1		07.00
	B - DRUG								
1.00	OTHER ADMIN & GENERAL	5. 03	0	1	14, 154		1		1.00
2. 00 3. 00	DI ETARY NURSING ADMINISTRATION	10. 00 13. 00	0	1	34 157		l .		2. 00 3. 00
4. 00	CENTRAL SERVICES & SUPPLY	14. 00	Ö		1, 839				4.00
5.00	PHARMACY	15. 00	0	1	16, 636, 310				5.00
6.00	I&R SERVICES-SALARY &	21. 00	0		95, 026	C			6. 00
7. 00	FRI NGES APPRVD ADULTS & PEDI ATRI CS	30.00	0		5, 775				7. 00
8. 00	INTENSIVE CARE UNIT	31.00	0	ł	664		l .		8. 00
9. 00	NEONATAL INTENSIVE CARE UNIT	31. 01	0	ł	1, 976		l .		9.00
10.00	CORONARY CARE UNIT	32.00	0		720				10.00
11.00	SURGICAL INTENSIVE CARE UNIT	34.00	0		84	(			11.00
12. 00 13. 00	SUBPROVIDER - IRF OPERATING ROOM	41. 00 50. 00	0	1	24 42, 262		l .		12. 00 13. 00
14. 00	DELIVERY ROOM & LABOR ROOM	52. 00	0	1	79				14.00
15. 00	RADI OLOGY-DI AGNOSTI C	54. 00	0	1	5, 760	C			15. 00
16. 00	CARDIAC NUCLEAR DIAGNOSTIC	54. 01	0	1	467	C	l .		16. 00
17.00	RADI OLOGY - THERAPEUTI C	55.00	0	1	18, 785, 540		l .		17.00
18. 00 19. 00	RADI OI SOTOPE CARDI AC CATHETERI ZATI ON	56. 00 59. 00	0		212 823				18. 00 19. 00
20. 00	LABORATORY	60.00	0	1	823 5, 175		l .		20.00
21. 00	I NTRAVENOUS THERAPY	64. 00	Ö	1	25		l .		21. 00
22. 00	RESPI RATORY THERAPY	65. 00	0		1, 422	C			22. 00
23.00	PHYSI CAL THERAPY	66.00	0	1	1, 964				23. 00
24. 00 25. 00	OCCUPATIONAL THERAPY SPEECH PATHOLOGY	67. 00 68. 00	0	ł	265, 858 336		1		24. 00 25. 00
25. 00 26. 00	ELECTROCARDI OLOGY	69.00	0	ł	336 413				26.00
27. 00	RENAL DIALYSIS	74.00	0		4, 413		l .		27. 00
28. 00	CLINIC	90. 00	0	1	31, 027	C	l .		28. 00
29. 00	I BMT JOINT VENTURE	90. 01	0		1, 015		l .		29.00
30. 00	SOUTH INDY MRI & REHAB	90. 03	0	1	7, 222	(	ין		30.00

Health Financial Systems RECLASSIFICATIONS Period: Worksheet A-U From 01/01/2014 To 12/31/2014 Date/Time Prepared: 5/26/2015 12:47 pm Provi der CCN: 150162

						5/26/2015 1	2:47 pm
	Cook Cooker	Decreases	Calami	0+1	WI+ A 7 D-E		
	Cost Center 6.00	Li ne # 7.00	Sal ary 8. 00	0ther 9.00	Wkst. A-7 Ref. 10.00		
31. 00	CV DI AGNOSTI C SERVI CES	90. 05	0.00	29, 325	0		31.00
31.00	TOTALS			35, 940, 101			31.00
	C - EQUI PMENT LEASE		<u> </u>	00, 710, 101			
1.00	OTHER ADMIN & GENERAL	5. 03	0	720	10		1.00
2.00	OPERATION OF PLANT	7. 00	0	594	o		2. 00
3.00	DI ETARY	10. 00	0	13, 850	0		3.00
4.00	CENTRAL SERVICES & SUPPLY	14. 00	0	57, 970	0		4. 00
5.00	PHARMACY	15. 00	0	481, 989	0		5.00
6. 00	I &R SERVI CES-SALARY & FRI NGES APPRVD	21. 00	0	2, 325	U		6.00
7. 00	ADULTS & PEDIATRICS	30.00	0	17, 966	0		7. 00
8. 00	INTENSIVE CARE UNIT	31.00	o	56, 166	0		8.00
9. 00	CORONARY CARE UNIT	32. 00	o	23, 043	o		9.00
10.00	SURGICAL INTENSIVE CARE UNIT	34.00	O	24	o		10.00
11. 00	SUBPROVI DER - I RF	41. 00	0	2, 120	0		11.00
12.00	OPERATI NG ROOM	50. 00	0	37, 340	0		12. 00
13.00	DELIVERY ROOM & LABOR ROOM	52.00	0	784	0		13.00
14.00	RADI OLOGY - THERAPEUTI C	55.00	0	6, 135	0		14.00
15. 00 16. 00	CARDI AC CATHETERI ZATI ON RESPIRATORY THERAPY	59. 00 65. 00	0	13, 380 101, 374	0		15. 00 16. 00
17. 00	ELECTROENCEPHALOGRAPHY	70.00	0	5, 245	0		17.00
18. 00	RENAL DIALYSIS	74. 00	0	6, 750	0		18.00
19. 00	EMERGENCY	91. 00	o	535			19.00
	TOTALS			828, 310			
	D - DEPRECIATION						
1.00	NEW CAP REL COSTS-MVBLE	2. 00	0	17, 645, 206	9		1.00
0.00	EQUI P			050 (00			0.00
2.00	LABORATORY	60.00	0	252, 633	l 1		2.00
3. 00	CV_DI_AGNOSTI_C_SERVI_CES TOTALS	9005		<u>1, 1</u> 5 <u>6</u> 17, 898, 995	<u> </u>		3. 00
	E - CAFETERIA		U_	17, 070, 773			
1. 00	DI ETARY	10.00	949, 276	1, 590, 261	0		1.00
00	TOTALS — — —		949, 276	1, 590, 261			
	F - THERAPY						
1.00	PHYSI CAL THERAPY	66. 00	334, 596	1, 226			1.00
2. 00		0.00	•	0	0		2.00
	TOTALS		334, 596	1, 226			
1. 00	G - INTEREST NEW CAP REL COSTS-BLDG &	1. 00	ol	555, 406	11		1.00
1.00	FIXT	1.00	٥	333, 400	' '		1.00
2. 00	PHYSICIANS' PRIVATE OFFICES	192. 00	o	733	o		2.00
	TOTALS			556, 139			
	H - PARAMEDICAL EDUCATION						
1.00	LABORATORY	60.00	123, 105	3 <u>9, 9</u> 14			1.00
	TOTALS		123, 105	39, 914			_
1 00	I - INTERN & RESIDENT	21 00	2 212 127	020 227	O		1 00
1. 00	I &R SERVI CES-SALARY & FRI NGES APPRVD	21. 00	2, 313, 127	828, 236	۷		1.00
2. 00	I KINGLS AFFRYD	0.00	٥	0	٥		2.00
2.00	TOTALS — — — —		2, 313, 127		<u> </u>		2.00
	J - EMPLOYEE BENEFITS			•			
1.00	ADMI TTI NG	5. 01	0	421, 674	0		1.00
2.00	OTHER ADMIN & GENERAL	5. 03	0	1, 110, 893	l 1		2. 00
3.00	OPERATION OF PLANT	7. 00	0	1, 160, 880	0		3.00
4.00	LAUNDRY & LINEN SERVICE	8. 00	0	51, 484	0		4.00
5. 00 6. 00	HOUSEKEEPI NG DI ETARY	9. 00 10. 00	0	775, 088 442, 323	l		5. 00 6. 00
7. 00	CAFETERIA	11. 00	0	184, 660	l		7.00
8. 00	NURSING ADMINISTRATION	13. 00	0	1, 154, 399	· ·		8.00
9. 00	CENTRAL SERVICES & SUPPLY	14. 00	o	472, 853	l 1		9. 00
10.00	PHARMACY	15. 00	0	1, 112, 716			10.00
11. 00	I&R SERVICES-SALARY &	21. 00	0	992, 800	0		11.00
4	FRI NGES APPRVD						
12.00	PARAMED ED PRGM	23. 00	0	18, 835	0		12.00
13.00	ADULTS & PEDIATRICS	30.00	0	4, 768, 017	0		13.00
14. 00 15. 00	INTENSIVE CARE UNIT NEONATAL INTENSIVE CARE UNIT	31. 00 31. 01	0	1, 495, 819 581, 382	0		14. 00 15. 00
16. 00	CORONARY CARE UNIT	32.00	0	1, 675, 959	1		16.00
17. 00	SURGICAL INTENSIVE CARE UNIT	34. 00	0	810, 643	l 1		17.00
18. 00	SUBPROVI DER - I RF	41. 00	Ö	358, 439	o		18.00
19.00	NURSERY	43.00	0	155, 614	0		19.00
20.00	OPERATING ROOM	50.00	0	2, 517, 665	o		20.00
21.00	DELIVERY ROOM & LABOR ROOM	52.00	0	541, 433	l 1		21.00
22. 00	RADI OLOGY-DI AGNOSTI C	54. 00	0	2, 259, 356	0		22.00

Health Financial Systems RECLASSIFICATIONS Period: Worksheet A-6
From 01/01/2014
To 12/31/2014 Date/Time Prepared: 5/26/2015 12:47 pm Provi der CCN: 150162

						5/26/2015 12:	:4/pm
		Decreases				1	
	Cost Center	Li ne #	Sal ary		Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10. 00		
23.00	CARDIAC NUCLEAR DIAGNOSTIC	54. 01	0	7, 779		1	23. 00
24.00	ULTRA SOUND	54. 03	0	201, 158	0		24. 00
25.00	RADI OLOGY - THERAPEUTI C	55. 00	0	6, 927	0		25. 00
26.00	RADI OI SOTOPE	56. 00	0	55, 900	0		26. 00
27.00	CARDI AC CATHETERI ZATI ON	59. 00	0	356, 851	0		27.00
28.00	LABORATORY	60.00	0	210, 245	0		28. 00
29.00	INTRAVENOUS THERAPY	64.00	0	70, 386	0		29. 00
30.00	RESPI RATORY THERAPY	65. 00	0	1, 375, 967	0		30.00
31.00	PHYSI CAL THERAPY	66. 00	0	900, 551	0		31.00
32.00	OCCUPATI ONAL THERAPY	67.00	0	240, 129	0		32.00
33.00	SPEECH PATHOLOGY	68. 00	0	147, 567	0		33.00
34.00	ELECTROCARDI OLOGY	69. 00	0	212, 626	0		34.00
35.00	ELECTROENCEPHALOGRAPHY	70. 00	0	294, 211	0		35.00
36.00	RENAL DIALYSIS	74. 00	o	121, 757	0		36.00
37.00	CARDIAC REHABILITATION	76. 97	o	98, 568	0		37.00
38.00	CLINIC	90.00	O	942, 021	0		38.00
39.00	IBMT JOINT VENTURE	90. 01	O	219, 480	0		39.00
40.00	PSYCHIATRIC COUNCELING	90. 02	О	273, 023	0		40.00
	CENTER						
41.00	SOUTH INDY MRI & REHAB	90. 03	О	57	0		41.00
42.00	CV DIAGNOSTIC SERVICES	90. 05	О	1, 513, 476	0		42.00
43.00	EMERGENCY	91.00	О	1, 789, 418	0		43.00
44.00	HOME HEALTH AGENCY	101.00	o	620, 669	0		44.00
45.00	HOSPI CE	116. 00	o	640, 263	0		45.00
46.00	GIFT, FLOWER, COFFEE SHOP &	190. 00	o	28, 968			46.00
	CANTEEN						
47.00	PHYSICIANS' PRIVATE OFFICES	192. 00	o	449, 292	0		47.00
48.00	MARKETING & COMMUNITY	194. 00	o	18, 088	0		48.00
	RELATI ONS						
49.00	WOMEN'S CENTER	194. 01	О	11, 875	0		49.00
50.00	OTHER NRCC	194. 04	o	32, 992	0		50.00
51.00	FOUNDATI ON	194. 05	o	43, 176			51.00
52.00	FRANCISCAN SURGERY CENTER	194. 06	o	14, 312			52.00
	TOTALS			33, 960, 664		1	
500.00	Grand Total: Decreases		3, 720, 104	138, 088, 772		1	500.00

10.00 Total (line 8 minus line 9)

10.00

RECONCILIATION OF CAPITAL COSTS CENTERS Provi der CCN: 150162 Peri od: Worksheet A-7 From 01/01/2014 Part I Date/Time Prepared: 12/31/2014 5/26/2015 12:47 pm Acqui si ti ons Begi nni ng Purchases Disposals and Donati on Total Bal ances Retirements 3.00 4.00 5.00 1.00 2.00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 7, 221, 956 1.00 Land 0 2.00 Land Improvements 28, 053, 683 2, 771, 833 2, 771, 833 Ω 2.00 3.00 4, 314, 238 3.00 Buildings and Fixtures 4, 314, 238 247, 563, 663 0 0 4.00 Building Improvements 4, 374, 987 1, 188, 847 1, 188, 847 0 4.00 Fi xed Equi pment 292, 940, 044 7,808,803 0 7, 808, 803 5.00 0 5.00 0 6.00 Movable Equipment 139, 800, 777 4, 204, 810 4, 204, 810 0 6.00 0 7.00 HIT designated Assets 0 7.00 8.00 Subtotal (sum of lines 1-7) 719, 955, 110 20, 288, 531 20, 288, 531 0 8.00 9.00 Reconciling Items 0 0 9.00 719, 95<u>5, 110</u> Total (line 8 minus line 9) 20, 288, 531 20, 288, 531 10.00 10.00 0 0 Endi ng Ful I y Bal ance Depreciated Assets 6. 00 7.00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 Land 7, 221, 956 1.00 6, 008, 984 2.00 Land Improvements 30, 825, 516 2.00 251, 877, 901 3.00 Buildings and Fixtures 53, 968, 075 3.00 4.00 Building Improvements 5, 563, 834 1, 181, 620 4.00 5.00 Fixed Equipment 300, 748, 847 53, 568, 847 5.00 6.00 Movable Equipment 144, 005, 587 57, 691, 685 6.00 HIT designated Assets 7.00 Ω 7.00 8.00 Subtotal (sum of lines 1-7) 740, 243, 641 172, 419, 211 8.00 Reconciling Items 9.00 9.00

740, 243, 641

172, 419, 211

Heal t	n Financial Systems ST.	FRANCIS HOSPITA	L & HEALTH CEN	ITER	In Lie	eu of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der	CCN: 150162	Peri od:	Worksheet A-7	
					From 01/01/2014 To 12/31/2014	Part II   Date/Time Pre	nared:
					10 12/31/2014	5/26/2015 12:	47 pm
			Sl	JMMARY OF CAP	I TAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance	Taxes (see	
					(see	instructions)	
					instructions)		
		9. 00	10. 00	11. 00	12. 00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	RKSHEET A, COLU	MN 2, LINES 1	and 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	)	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	33, 895, 516	0	)	0	0	2.00
3.00	Total (sum of lines 1-2)	33, 895, 516	0		0 0	0	3.00
		SUMMARY 0	F CAPITAL				
	Cost Center Description	0ther	Total (1)				
	· ·	Capi tal -Rel at	(sum of cols.				
		ed Costs (see	9 through 14)				

Health Financial Systems ST. F	RANCIS HOSPITA	L & HEALTH CEN	TER	In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der		Period: From 01/01/2014	Worksheet A-7 Part III	
				o 12/31/2014	Date/Time Pre 5/26/2015 12:	
	COMF	PUTATION OF RAT	TI OS	ALLOCATION OF	OTHER CAPITAL	
Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets	Ratio (see	Insurance	
		Leases	for Ratio	instructions)		
			(col. 1 -			
			col. 2)			
	1. 00	2. 00	3. 00	4. 00	5. 00	
PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS					
1.00 NEW CAP REL COSTS-BLDG & FLXT	596, 238, 054	0	596, 238, 054	0. 805462	0	1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP	144, 005, 587	0	144, 005, 587	0. 194538	0	2.00
3.00 Total (sum of lines 1-2)	740, 243, 641	0	740, 243, 641	1. 000000	0	3.00
	ALLOCA <sup>-</sup>	TION OF OTHER (	CAPI TAL	SUMMARY O	F CAPITAL	
Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	

			Leases	l ioi katio	This tructions)		
				(col. 1 -			
				col . 2)			
		1. 00	2.00	3.00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS					
1.00	NEW CAP REL COSTS-BLDG & FIXT	596, 238, 054	0	596, 238, 054	0. 805462	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	144, 005, 587	0	144, 005, 587	0. 194538	ol	2.00
3.00	Total (sum of lines 1-2)	740, 243, 641	0	740, 243, 641	1. 000000	0	3.00
		ALLOCA <sup>-</sup>	TION OF OTHER (	CAPI TAL	SUMMARY 0	F CAPI TAL	
	Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
			Capi tal -Rel at	cols. 5			
			ed Costs	through 7)			
		6. 00	7. 00	8. 00	9. 00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS					
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	17, 898, 995	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	16, 250, 310	828, 310	2.00
3.00	Total (sum of lines 1-2)	0	0	0	34, 149, 305	828, 310	3.00
			SL	JMMARY OF CAPIT	AL		
	Cost Center Description	Interest	Insurance	Taxes (see	0ther	Total (2)	
			(see	instructions)	Capi tal -Rel at	(sum of cols.	
			instructions)		ed Costs (see	9 through 14)	
					instructions)		
		11. 00	12. 00	13. 00	14. 00	15. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS C		1				
1. 00	NEW CAP REL COSTS-BLDG & FLXT	27, 478, 603	0	0	0	45, 377, 598	
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	17, 078, 620	
3.00	Total (sum of lines 1-2)	27, 478, 603	0	0	0	62, 456, 218	3.00

ADJUSTMENTS TO EXPENSES Provider CCN: 150162 Peri od: Worksheet A-8 From 01/01/2014 12/31/2014 Date/Time Prepared: 5/26/2015 12:47 pm Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted Basis/Code Cost Center Line # Wkst. A-7 Cost Center Description Amount (2) Ref. 1.00 2.00 3.00 4.00 5. 00 1. 00 Investment income - NEW CAP -28,598 NEW CAP REL COSTS-BLDG & 1.00 11 1.00 REL COSTS-BLDG & FIXT (chapter lfi xt ONEW CAP REL COSTS-MVBLE 2.00 Investment income - NEW CAP 2.00 2.00 REL COSTS-MVBLE EQUIP (chapter EQUI P 3.00 Investment income - other 0.00 3.00 (chapter 2) 4.00 Trade, quantity, and time 0 0.00 4.00 discounts (chapter 8) Refunds and rebates of 5.00 0.00 5.00 expenses (chapter 8) 6 00 Rental of provider space by 0 00 6 00 suppliers (chapter 8) 7.00 Tel ephone services (pay 0.00 7.00 stations excluded) (chapter 21) 8.00 Television and radio service 8.00 0.00 0 (chapter 21) 9.00 Parking lot (chapter 21) 0.00 9.00 10.00 Provi der-based physi ci an A-8-2 -8, 811, 785 10.00 adjustment Sale of scrap, waste, etc. 11.00 0.00 11.00 0 (chapter 23) 12.00 Related organization A-8-1 118, 567, 902 12.00 transactions (chapter 10) Laundry and linen service 13.00 0.00 13.00 -2, 268, 512 CAFETERI A 14 00 Cafeteria-employees and guests В 11 00 14 00 Rental of quarters to employee 15.00 0.00 15.00 and others Sale of medical and surgical 16.00 16.00 0 0.00 supplies to other than pati ents 17.00 Sale of drugs to other than 17.00 0.00 pati ents 18.00 Sale of medical records and 0.00 18.00 abstracts Nursing school (tuition, fees, 19.00 19.00 0.00 books, etc.) -49, 125 CAFETERI A 20.00 Vending machines В 11.00 20.00 21.00 Income from imposition of 0.00 21.00 interest, finance or penalty charges (chapter 21) Interest expense on Medicare 22.00 22.00 0 0 00 overpayments and borrowings to repay Medicare overpayments Adjustment for respiratory ORESPIRATORY THERAPY 23.00 A-8-3 65.00 23.00 therapy costs in excess of limitation (chapter 14) OPHYSICAL THERAPY 24.00 Adjustment for physical A-8-3 66.00 24.00 therapy costs in excess of limitation (chapter 14) 25.00 Utilization review -0 \*\*\* Cost Center Deleted \*\*\* 114.00 25.00 physicians' compensation (chapter 21) 26.00 Depreciation - NEW CAP REL ONEW CAP REL COSTS-BLDG & 1.00 26.00 COSTS-BLDG & FLXT FLXT 27.00 Depreciation - NEW CAP REL ONEW CAP REL COSTS-MVBLE 2.00 27.00 COSTS-MVBLE EQUIP FOUI P 0 \*\*\* Cost Center Deleted \*\*\* 28.00 19 00 28 00 Non-physician Anesthetist 29.00 Physicians' assistant 0.00 29.00 Adjustment for occupational O OCCUPATIONAL THERAPY 30.00 A-8-3 67.00 30.00 therapy costs in excess of limitation (chapter 14) 30.99 Hospice (non-distinct) (see OADULTS & PEDIATRICS 30.00 30.99 instructions)

ADJUSTMENTS TO EXPENSES Provider CCN: 150162 Peri od: Worksheet A-8 From 01/01/2014 12/31/2014 Date/Time Prepared: 5/26/2015 12:47 pm Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted Basis/Code Cost Center Line # Wkst. A-7 Cost Center Description Amount (2) Ref. 1.00 2.00 3.00 4.00 5.00 31.00 Adjustment for speech A-8-3 OSPEECH PATHOLOGY 68.00 31.00 pathology costs in excess of limitation (chapter 14) CAH HIT Adjustment for 32.00 32.00 0 0.00 Depreciation and Interest 33.00 0.00 33.00 33. 01 MISCELLANEOUS INCOME В -1, 153, 996 OTHER ADMIN & GENERAL 5. 03 33.01 ol MISCELLANEOUS INCOME -318, 518 OPERATION OF PLANT 33.02 В 7.00 33.02 33.03 MISCELLANEOUS INCOME В -70, 088 HOUSEKEEPI NG 9.00 33.03 MISCELLANEOUS INCOME -325, 837 DI ETARY 33.04 В 10.00 33.04 -105, 466 CENTRAL SERVICES & SUPPLY 33 05 MISCELLANEOUS INCOME 33 05 В 14 00 MISCELLANEOUS INCOME -480, 972 PHARMACY 33.06 В 15.00 33.06 33.07 MISCELLANEOUS INCOME В -2, 359 I &R SERVI CES-SALARY & 21.00 33.07 FRINGES APPRVD MISCELLANEOUS INCOME В -43, 367 PARAMED ED PRGM 33.08 33.08 23.00 0 MISCELLANEOUS INCOME -770 ADULTS & PEDIATRICS 30.00 33.09 В 33.09 33. 10 MISCELLANEOUS INCOME -1, 031 SURGICAL INTENSIVE CARE UNIT 34.00 33.10 В MISCELLANEOUS INCOME -363,536 OPERATING ROOM 50.00 33.11 33. 11 В MISCELLANEOUS INCOME -2, 901, 957 RADI OLOGY-DI AGNOSTI C 54.00 33, 12 33. 12 В -112, 051 RADI OLOGY - THERAPEUTI C MISCELLANEOUS INCOME ol 33. 13 В 55.00 33 13 MISCELLANEOUS INCOME В 1, 300 CARDI AC CATHETERI ZATI ON 59.00 33.14 33.14 MISCELLANEOUS INCOME -29, 039 LABORATORY 33. 15 В 60.00 33.15 MISCELLANEOUS INCOME -27, 258 RESPI RATORY THERAPY 65.00 0 33.16 33. 16 В -6, 620 OCCUPATI ONAL THERAPY 33.17 MISCELLANEOUS INCOME В 67.00 33.17 33. 18 MISCELLANEOUS INCOME В -4, 500 ELECTROENCEPHALOGRAPHY 70.00 33.18 33. 19 MISCELLANEOUS INCOME В -334, 279 MEDI CAL SUPPLI ES CHARGED TO 71.00 33.19 PATI ENTS -28, 043 CARDI AC REHABI LI TATI ON MISCELLANEOUS INCOME 33.20 В 76.97 0 33.20 -693, 188 CLI NI C 33. 21 MISCELLANEOUS INCOME В 90.00 0 33. 21 -1, 087 BMT JOINT VENTURE 33. 22 MISCELLANEOUS INCOME В 90.01 33.22 MISCELLANEOUS INCOME -15, 259 PSYCHIATRIC COUNCELING 33 23 33.23 В 90.02 CENTER MISCELLANEOUS INCOME В -3, 790 SOUTH INDY MRI & REHAB 90.03 0 33.24 MISCELLANEOUS INCOME -209, 667 CV DIAGNOSTIC SERVICES 90.05 33. 25 33 25 В -248, 084 EMERGENCY MISCELLANEOUS INCOME 91.00 33. 26 0 33.26 В -21, 891 CLI NI C 33 27 ADVERTI SI NG Α 90.00 ol 33 27 33. 28 ADVERTI SI NG -120 OCCUPATI ONAL THERAPY 67.00 33. 28 Α MI SCELLANEOUS EXPENSE 33 29 -154 HOSPI CE 116.00 33. 29 Α NONALLOWABLE INTEREST 33.30 -2, 043, 458 NEW CAP REL COSTS-BLDG & 1.00 11 33.30 Α FLXT 97, 864, 797 50.00 TOTAL (sum of lines 1 thru 49) 50.00 (Transfer to Worksheet A,

column 6, line 200.)

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

<sup>(2)</sup> Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

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

Provider CCN: 150162
From 01/01/2014
To 12/31/2014
Peri od:
From 01/01/2014
To 12/31/2014
Date/Time Prepared:
5/26/2015 12: 47 pm

				_	5/26/2015 12:	47 pm
	Li ne No.	Cost Center	Expense Items	Amount of	Amount	
				Allowable Cost	Included in	
					Wks. A, column	
					5	
	1. 00	2. 00	3. 00	4. 00	5. 00	
	A. COSTS INCURRED AND ADJUST	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED (	ORGANI ZATI ONS OF	R CLAIMED HOME	
	OFFICE COSTS:					
1.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	SHARED SERVICE ALLOCATION	1, 565, 904	0	1.00
2.00	5. 01	ADMITTI NG	SHARED SERVICE ALLOCATION	2, 770, 802	0	2.00
3.00	5. 02	CASHI ERI NG/ACCOUNTS RECEI VAB	SHARED SERVICE ALLOCATION	7, 114, 711	0	3.00
4.00	5. 03	OTHER ADMIN & GENERAL	SHARED SERVICE ALLOCATION	30, 449, 464	0	4.00
4.01	16.00	MEDICAL RECORDS & LIBRARY	SHARED SERVICE ALLOCATION	1, 333, 293	0	4. 01
4.02	1.00	NEW CAP REL COSTS-BLDG & FIX	SHARED SERVICE ALLOCATION	19, 328, 129	0	4. 02
4.03	194.00	MARKETING & COMMUNITY RELATI	SHARED SERVICE ALLOCATION	5, 034, 750	0	4.03
4.04	194. 04	OTHER NRCC	SHARED SERVICE ALLOCATION	1, 119, 930	0	4.04
4.05	5. 03	OTHER ADMIN & GENERAL	FRANCISCAN HOME OFFICE	6, 123, 102	0	4.05
4.06	1.00	NEW CAP REL COSTS-BLDG & FIX	FRANCISCAN HOME OFFICE	11, 333, 342	555, 406	4.06
4.07	5. 03	OTHER ADMIN & GENERAL	FRANCISCAN HOME OFFICE	33, 151, 956	0	4. 07
4. 08	15. 00	PHARMACY	FRANCISCAN HOME OFFICE	894, 763	960, 535	4. 08
4.09	21.00	I&R SERVICES-SALARY & FRINGE	MOORESVILLE INTERN & RESIDEN	0	32, 433	4. 09
4. 10	22.00	I&R SERVICES-OTHER PRGM COST	MOORESVILLE INTERN & RESIDEN	ıl o	29, 971	4. 10
4. 11	60.00	LABORATORY	APHL - LAB SERVICES	15, 652, 781	15, 726, 680	4. 11
4. 12	0.00			0	0	4. 12
4. 13	0.00	ł		0	0	4. 13
5.00	0		0	135, 872, 927	17, 305, 025	1

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

			Related Organization(s) and/	or Home Office	
Symbol (1)	Name	Percentage of	Name	Percentage of	
		Ownershi p		Ownershi p	
1. 00	2. 00	3. 00	4. 00	5. 00	
B. INTERRELATIONSHIP TO RELAT	TED ORGANIZATION(S) AND/OR HO	ME OFFICE:			

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

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

	Comorre and the tro Attent				
6. 00	В	SISTERS OF STF	100.00	0.00	6. 00
7.00			0.00	0.00	7.00
8.00			0.00	0.00	8. 00
9.00			0.00	0.00	9. 00
10.00			0.00	0.00	10.00
	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 organization.
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

					To 12/31/2014	Date/Time Pre 5/26/2015 12:	epared: 47 nm
	Net	Wkst. A-7 Ref.				3/20/2013 12.	T7 DIII
	Adjustments						
	(col. 4 minus						
	col. 5)*						
	6. 00	7. 00					
		RED AND ADJUSTM	MENTS REQUIRED AS A RESULT OF TRA	ANSACTIONS WITH RELATED (	ORGANI ZATI ONS OR	CLAIMED HOME	
	OFFICE COSTS:						
1. 00	1, 565, 904	0					1.00
2. 00	2, 770, 802	0					2.00
3.00	7, 114, 711	0					3.00
4. 00	30, 449, 464	0					4. 00
4. 01	1, 333, 293	0					4. 01
4. 02	19, 328, 129						4. 02
4. 03	5, 034, 750						4.03
4. 04	1, 119, 930	0					4.04
4. 05	6, 123, 102	0					4. 05
4. 06	10, 777, 936						4.06
4. 07	33, 151, 956	0					4. 07
4. 08	-65, 772	0					4. 08
4. 09	-32, 433	0					4. 09
4. 10	-29, 971	0					4. 10
4. 11	-73, 899	0					4. 11
4. 12	0	0					4. 12
4. 13	0	0					4. 13
5. 00	118, 567, 902						5. 00

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

	Related Organization(s)		
	and/or Home Office		
	Type of Business		
	6. 00		
_	B. INTERRELATIONSHIP TO RELATE	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		6.00
7.00		7.00
7. 00 8. 00		8.00
9.00		9.00
10.00		10.00
9. 00 10. 00 100. 00	10	100.00

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

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT

In Lieu of Form CMS-2552-10
Worksheet A-8-2 Peri od: From 01/01/2014 To 12/31/2014 Worksheet A-8-2 Date/Time Prepared: 5/26/2015 12:47 pm

						0 12/31/2014	5/26/2015 12:	
	Wkst. A Line #		Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remuneration	Component	Component		ider Component Hours	
	1. 00	2.00	3. 00	4. 00	5. 00	6. 00	7. 00	
1. 00		OTHER ADMIN & GENERAL	4, 072, 537			177, 200		1.00
2.00		NURSING ADMINISTRATION	276, 880			177, 200	30	
3. 00	22. 00	I&R SERVICES-OTHER PRGM	1, 320, 342	C	1, 320, 342	177, 200	11, 066	3. 00
4. 00	30.00	COSTS APPRVD ADULTS & PEDIATRICS	5, 000	5, 000	0	0	0	4. 00
5. 00		NEONATAL INTENSIVE CARE UNIT	183, 263			0	0	5.00
6. 00		SUBPROVI DER - I RF	55, 000			177, 200	886	
7.00	50.00	OPERATING ROOM	2, 247, 922			208, 000	295	7. 00
8. 00		RADI OLOGY-DI AGNOSTI C	758, 706			225, 300	722	8.00
9. 00		RADI OLOGY - THERAPEUTI C	13, 313		,	225, 300	133	
10. 00 11. 00		LABORATORY RESPIRATORY THERAPY	176, 234 42, 338			177, 200 177, 200	494 203	10. 00 11. 00
12. 00		ELECTROENCEPHALOGRAPHY	33, 996			177, 200	160	12.00
13.00	74. 00	RENAL DIALYSIS	7, 658			177, 200	47	13.00
14. 00		CLINIC	954, 339			177, 200	3, 005	
15.00		I BMT JOINT VENTURE	167, 983		,	177, 200	1, 227	
16. 00	90.02	PSYCHIATRIC COUNCELING CENTER	31, 144	31, 144		U	0	16. 00
17. 00	90. 03	SOUTH INDY MRI & REHAB	800	800	0	0	0	17. 00
18.00	91. 00	EMERGENCY	73, 742		53, 250	177, 200	419	18. 00
200.00			10, 421, 197				19, 892	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit		Cost of	Provi der	Physician Cost of Malpractice	
		i denti i i ei	LIIIII	Limit	Memberships & Continuing	Component Share of col.	Insurance	
				21 1	Education	12	111041 41100	
	1. 00	2. 00	8. 00	9. 00	12. 00	13. 00	14. 00	
1.00		OTHER ADMIN & GENERAL	102, 657			0	0	
2. 00 3. 00		NURSING ADMINISTRATION I&R SERVICES-OTHER PRGM	2, 556 942, 738			0	0	
3.00	22.00	COSTS APPRVD	742, 730	47, 137		0		3.00
4.00	30. 00	ADULTS & PEDIATRICS	0	O	0	0	0	4.00
5. 00		NEONATAL INTENSIVE CARE UNIT	0	0	_	0	0	
6. 00		SUBPROVI DER - I RF	75, 480			0	0	
7. 00 8. 00		OPERATING ROOM RADIOLOGY-DIAGNOSTIC	29, 500 78, 205			0	0	
9. 00		RADI OLOGY - THERAPEUTI C	14, 406			0	0	
10.00		LABORATORY	42, 085			0	0	
11. 00		RESPIRATORY THERAPY	17, 294			0	0	
12.00		ELECTROENCEPHALOGRAPHY	13, 631	682		0	0	12.00
13. 00 14. 00		RENAL DIALYSIS CLINIC	4, 004 256, 003	200 12, 800		0	0	13. 00 14. 00
15. 00		I BMT JOINT VENTURE	104, 531	5, 227		0	0	15. 00
16.00		PSYCHIATRIC COUNCELING	0	o c		0	0	16.00
		CENTER						
17.00		SOUTH INDY MRI & REHAB	0	0 1. 785	_	0	0	
18. 00 200. 00	91.00	JEMERGENCY	35, 696 1, 718, 786		-	0	0	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment	J	200.00
		I denti fi er	Component	Limit	Di sal I owance			
			Share of col.					
	1. 00	2.00	14 15. 00	16. 00	17. 00	18. 00		
1. 00		OTHER ADMIN & GENERAL	0			4, 052, 681		1. 00
2.00		NURSING ADMINISTRATION	0		1, 984	274, 324		2.00
3.00	22. 00	I &R SERVICES-OTHER PRGM	0	942, 738	377, 604	377, 604		3. 00
4 00	30.00	COSTS APPRVD	0			E 000		4 00
4. 00 5. 00		ADULTS & PEDIATRICS NEONATAL INTENSIVE CARE UNIT				5, 000 183, 263		4. 00 5. 00
6. 00		SUBPROVI DER - I RF	Ö		_	5, 000		6. 00
7.00		OPERATING ROOM	0	29, 500	12, 700	2, 218, 422		7. 00
8. 00	•	RADI OLOGY-DI AGNOSTI C	0			680, 501		8.00
9. 00		RADI OLOGY - THERAPEUTI C	0			124 140		9.00
10. 00 11. 00		LABORATORY RESPIRATORY THERAPY	0 0			134, 149 25, 044		10. 00 11. 00
12. 00		ELECTROENCEPHALOGRAPHY	Ö			20, 365		12.00
13.00	74. 00	RENAL DIALYSIS	Ō	4, 004	3, 046	3, 654		13.00
14.00		CLINIC	0			698, 336		14.00
15.00		IBMT JOINT VENTURE	0			63, 452		15.00
16. 00	90.02	PSYCHIATRIC COUNCELING CENTER		C		31, 144		16. 00
17. 00	90. 03	SOUTH INDY MRI & REHAB	0	O	0	800		17. 00
18.00	91. 00	EMERGENCY	0	35, 696		38, 046		18. 00
200.00			0	1, 718, 786	691, 214	8, 811, 785		200. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS ST. FRANCIS HOSPITAL & HEALTH CENTER

Provider CCN: 150162

				To	12/31/2014	Date/Time Pre 5/26/2015 12:	
		CAPI TAL				372072013 12.	47 piii
	Coat Conton Decemintion	Not Evpopos	NEW DLDC 0	NEW MVDLE	EMPLOYEE	ADMITTI NO	
	Cost Center Description	Net Expenses for Cost	NEW BLDG & FIXT	NEW MVBLE EQUIP	BENEFI TS	ADMITTING	
		Allocation			DEPARTMENT		
		(from Wkst A					
		col. 7)	1. 00	2.00	4. 00	5. 01	
	GENERAL SERVICE COST CENTERS	Ü	11.00	2.00	55	0.01	
1. 00	00100 NEW CAP REL COSTS-BLDG & FIXT	45, 377, 598	45, 377, 598				1.00
2. 00 4. 00	OO200   NEW CAP REL COSTS-MVBLE EQUIP   OO400   EMPLOYEE BENEFITS DEPARTMENT	17, 078, 620 35, 526, 691	13, 011	17, 078, 620 4, 897	35, 544, 599		2.00 4.00
5. 01	00570 ADMITTING	4, 562, 406	223, 004		453, 966		5. 01
5. 02	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	7, 114, 711	172, 155		0		5. 02
5. 03	00590 OTHER ADMIN & GENERAL	92, 470, 203	1, 412, 629		1, 130, 063		5.03
7. 00 8. 00	OO7OO  OPERATION OF PLANT   OO8OO  LAUNDRY & LINEN SERVICE	19, 009, 135 1, 308, 646	4, 538, 200 333, 123		1, 234, 664 55, 171	0 0	7. 00 8. 00
9. 00	00900 HOUSEKEEPI NG	4, 130, 747	367, 126		833, 660		9.00
10.00	01000 DI ETARY	309, 711	681, 519		159, 719		10.00
11.00	01100 CAFETERI A	1, 845, 630	662, 977		441, 087 1, 218, 857	0	11.00
13. 00 14. 00	O1300   NURSI NG   ADMI NI STRATI ON   O1400   CENTRAL   SERVI CES & SUPPLY	5, 216, 867 3, 047, 913	1, 089, 186 536, 642		1, 218, 857 505, 545	0	13. 00 14. 00
15. 00	01500 PHARMACY	5, 303, 265	697, 546		1, 185, 007	Ö	15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	1, 333, 293	302, 136		0	-	16.00
21. 00 22. 00	02100   &R SERVI CES-SALARY & FRINGES APPRVD   02200   &R SERVI CES-OTHER PRGM COSTS APPRVD	1, 826, 800	0	1	476, 656	0	21. 00 22. 00
23. 00	02300 PARAMED ED PRGM	1, 314, 874 206, 482	0	1	336, 721 51, 377	0	23.00
23. 01	02302 EMERGENCY MEDICAL SERVICES	0	0		0		23. 01
	INPATIENT ROUTINE SERVICE COST CENTERS	00 405 440	5 040 744	0.010.047	5 000 570	- 10 100	
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	20, 135, 112 6, 406, 887	5, 340, 711 885, 101		5, 090, 572 1, 597, 014		30. 00 31. 00
31. 00	02060 NEONATAL INTENSIVE CARE UNIT	3, 091, 142	302, 827		615, 530	· ·	ı
32. 00	03200 CORONARY CARE UNIT	7, 063, 131	1, 950, 339	734, 043	1, 782, 369	140, 318	32.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	3, 383, 630	1, 078, 752		855, 853		1
41. 00 43. 00	O4100   SUBPROVI DER -   RF   O4300   NURSERY	1, 570, 153 647, 658			381, 102 162, 990		41.00 43.00
10.00	ANCILLARY SERVICE COST CENTERS	017,000	120, 002	10, 107	102, 770	07,100	10.00
50.00	05000 OPERATING ROOM	19, 799, 234	4, 319, 784		2, 673, 931		50.00
52. 00 54. 00	O5200   DELI VERY ROOM & LABOR ROOM   O5400   RADI OLOGY-DI AGNOSTI C	2, 293, 645 16, 512, 233	756, 943 3, 994, 896		572, 014 2, 427, 994		52.00 54.00
54. 01	05402 CARDI AC NUCLEAR DI AGNOSTI C	876, 401	3, 774, 670		2, 427, 774		1
54.02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0	0	0	0	0	54. 02
54. 03	03630 ULTRA SOUND	832, 439	131, 175		211, 443		54.03
55. 00 56. 00	O5500   RADI OLOGY - THERAPEUTI C   O5600   RADI OI SOTOPE	2, 736, 523 1, 099, 131	0 3, 143	-	7, 058 59, 279		55. 00 56. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	1, 514, 720	1, 229, 286		378, 356		59.00
60.00	06000 LABORATORY	18, 665, 782	1, 400, 624		192, 549		60.00
64. 00 65. 00	O6400   I NTRAVENOUS THERAPY   O6500   RESPI RATORY THERAPY	294, 429 5, 942, 966			74, 501 1, 463, 513	12, 537 295, 275	64. 00 65. 00
66. 00	06600 PHYSI CAL THERAPY	4, 251, 926					
66. 01	06601 SPORTS MEDICINE	0	0	0	0		66. 01
67.00	06700 OCCUPATI ONAL THERAPY	1, 246, 967	0		313, 693		1
68. 00 69. 00	06800  SPEECH PATHOLOGY   06900  ELECTROCARDI OLOGY	707, 997 934, 392	34, 129 663, 040		180, 054 226, 983		68. 00 69. 00
69. 01	06901 CARDI AC CATH LAB	0	003, 040	0	0	03,710	69. 01
70.00	07000 ELECTROENCEPHALOGRAPHY	2, 731, 210	0	0	311, 776	10, 030	70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT	27, 053, 531	0	0	0	405, 207	•
72. 00 73. 00	07300 DRUGS CHARGED TO PATIENTS	18, 926, 330 35, 940, 101	0	0	0	157, 818 812, 009	1
74.00	07400 RENAL DIALYSIS	517, 697	272, 846	102, 690	129, 658		74.00
76. 97	07697 CARDI AC REHABI LI TATI ON	462, 922	0	0	105, 082	12	76. 97
90. 00	OUTPATIENT SERVICE COST CENTERS  O9000 CLINIC	6, 311, 231	1, 643, 866	618, 697	1, 215, 263	1, 603	90.00
90. 01	09001 I BMT JOI NT VENTURE	3, 803, 629	126, 838		233, 970		90.00
90. 02	09002 PSYCHIATRIC COUNCELING CENTER	1, 364, 849	784, 535	295, 273	291, 588	6	90. 02
90. 03	09003 SOUTH INDY MRI & REHAB	71, 619	0	1	64	1	90.03
90. 04 90. 05	09004   BARI ATRI CS   09005   CV   DI AGNOSTI C   SERVI CES	8, 489, 392	0	0	0 1, 169, 068	0 1, 294	90. 04 90. 05
90.06	09006 CARDI AC REHAB	0	o	Ö	0	0	90.06
91.00	09100 EMERGENCY	7, 859, 731	2, 246, 190	845, 391	1, 893, 394	278, 673	
92. 00	O9200   OBSERVATION BEDS (NON-DISTINCT PART)   OTHER REIMBURSABLE COST CENTERS						92.00
101.00	10100 HOME HEALTH AGENCY	4, 615, 742	0	0	651, 781	0	101. 00
	SPECIAL PURPOSE COST CENTERS						
	11300 I NTEREST EXPENSE	E 010 100	250 054	07.4/0	470.000	_	113.00
116.00	11600 HOSPICE   SUBTOTALS (SUM OF LINES 1-117)	5, 013, 128 490, 151, 202			679, 003 34, 901, 082		116. 00 118. 00
	1 100.0	1 .75, 101, 202	.5,5,7,504		5., 751, 562	3,020,007	1

20, 265, 837

533, 108, 060

310, 815

17, 078, 620

825, 830

45, 377, 598

14, 959

35, 544, 599

0 194.06

0 201.00

5, 323, 307 202. 00

200.00

In Lieu of Form CMS-2552-10 Health Financial Systems ST. FRANCIS HOSPITAL & HEALTH CENTER COST ALLOCATION - GENERAL SERVICE COSTS Provi der CCN: 150162 Peri od: Worksheet B From 01/01/2014 Part I Date/Time Prepared: 12/31/2014 5/26/2015 12:47 pm CAPITAL RELATED COSTS NEW BLDG & NEW MVBLE **EMPLOYEE** ADMITTI NG Cost Center Description Net Expenses for Cost FLXT FOUL P BENEFITS DEPARTMENT Allocation (from Wkst A col. 7) 1.00 2.00 4. 00 0 5. 01 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190. 00 349, 771 190, 446 71,677 30, 619 190. 01 19001 MEDICAL OFFICE & PARKING 0 190.01 12, 303, 228 3, 441, 975 192.00 19200 PHYSICIANS' PRIVATE OFFICES 1, 295, 445 477, 751 0 192.00 194.00 07955 MARKETING & COMMUNITY RELATIONS 7, 996 18, 570 0 194.00 5, 122, 297 21, 244 194. 01 07952 WOMEN' S CENTER 0 194.01 2, 156, 744 395, 159 148, 725 12, 636 194. 02 07950 SOUTH EMERSON SURGERY CENTER 201, 095 0 0 194. 02 194. 03 07951 SOUTHEAST SURGERY CENTER 409, 564 0 194. 03 0 194. 04 07954 OTHER NRCC 0 194.04 1, 307, 652 43, 894 423, 380 159, 346 0 194. 05 194. 05 07956 FOUNDATI ON 840, 670 45, 088

194.06 07953 FRANCI SCAN SURGERY CENTER

200.00

201.00

202.00

Cross Foot Adjustments

TOTAL (sum lines 118-201)

Negative Cost Centers

Peri od: Worksheet B
From 01/01/2014 Part | Date/Time Prepared: 5/26/2015 12: 47 pm

OTHER ADMIN & OPERATION OF PLANT Heal th Financial Systems ST. FRANCIS HOSPITAL & HEALTH CENTER In Lieu of Form CMS-2552-10 COST ALLOCATION - GENERAL SERVICE COSTS Provi der CCN: 150162 Peri od: From 01/01/2014 To 12/31/2014 Cost Center Description CASHI ERI NG/AC Subtotal Subtotal COUNTS

			COUNTS RECEI VABLE		GENERAL	PLANT	
		5A. 01	5. 02	5A. 02	5. 03	7. 00	
1. 00	GENERAL SERVICE COST CENTERS OO100 NEW CAP REL COSTS-BLDG & FIXT						1 100
2. 00 4. 00 5. 01	00100 NEW CAP REL COSTS-BLDG & FIXT 00200 NEW CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00570 ADMITTING						1. 00 2. 00 4. 00 5. 01
5. 02 5. 03	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 00590 OTHER ADMI N & GENERAL	7, 351, 660 95, 544, 562	7, 351, 660 1, 336, 008	96, 880, 570	96, 880, 570		5. 02 5. 03
7. 00	00700 OPERATION OF PLANT	26, 490, 027	370, 410	26, 860, 437	5, 965, 354	32, 825, 791	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	1, 822, 316	25, 481	1, 847, 797	410, 372	280, 251	8.00
9. 00 10. 00	00900   HOUSEKEEPI NG   01000   DI ETARY	5, 469, 707 1, 407, 450	76, 483 19, 680	5, 546, 190 1, 427, 130	1, 231, 737 316, 947	308, 858 573, 352	9. 00 10. 00
11.00	01100 CAFETERI A	3, 199, 217	44, 735	3, 243, 952	720, 440	557, 753	11. 00
13. 00 14. 00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	7, 934, 843 4, 292, 074	110, 953 60, 016	8, 045, 796 4, 352, 090	1, 786, 867 966, 543	916, 316 451, 469	13. 00 14. 00
15. 00	01500 PHARMACY	7, 448, 351	104, 150	7, 552, 501	1, 677, 312	586, 836	15.00
16. 00 21. 00	01600 MEDICAL RECORDS & LIBRARY 02100 I&R SERVICES-SALARY & FRINGES APPRVD	1, 749, 143 2, 303, 456	24, 458 32, 209	1, 773, 601 2, 335, 665	393, 894 518, 721	254, 183 0	16. 00 21. 00
22. 00	02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	1, 651, 595	23, 094	2, 335, 665 1, 674, 689	371, 927	0	22.00
23.00	02300 PARAMED ED PRGM	257, 859	3, 606	261, 465	58, 068	0	23.00
23. 01	02302 EMERGENCY MEDICAL SERVICES INPATIENT ROUTINE SERVICE COST CENTERS	0	0	0	0	0	23. 01
30.00	03000 ADULTS & PEDIATRICS	33, 118, 942	463, 102	33, 582, 044	7, 458, 135	4, 493, 063	
31. 00 31. 01	03100   INTENSI VE CARE UNIT   02060   NEONATAL INTENSI VE CARE UNIT	9, 371, 545 4, 226, 272	131, 042 59, 096	9, 502, 587 4, 285, 368	2, 110, 401 951, 725	744, 623 254, 764	31. 00 31. 01
32.00	03200 CORONARY CARE UNIT	11, 670, 200	163, 184	11, 833, 384	2, 628, 041	1, 640, 792	32.00
34. 00 41. 00	03400 SURGICAL INTENSIVE CARE UNIT 04100 SUBPROVIDER - IRF	5, 821, 544 2, 927, 152	81, 403 40, 930	5, 902, 947 2, 968, 082	1, 310, 968 659, 172	907, 539 564, 469	34. 00 41. 00
43.00	04300 NURSERY	1, 023, 970		1, 038, 288	230, 590	107, 712	43.00
E0 00	ANCILLARY SERVICE COST CENTERS    O5000   OPERATING ROOM	20 002 755	40E 200	20, 200, 025	/ F2/ 022	2 /24 172	FO 00
50. 00 52. 00	05200 DELIVERY ROOM & LABOR ROOM	28, 983, 755 4, 073, 114	405, 280 56, 954	29, 389, 035 4, 130, 068	6, 526, 923 917, 234	3, 634, 173 636, 805	50. 00 52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	24, 871, 937	347, 784	25, 219, 721	5, 600, 972	3, 360, 849	54.00
54. 01 54. 02	05402 CARDI AC NUCLEAR DI AGNOSTI C   03450 NUCLEAR MEDI CI NE - DI AGNOSTI C	880, 730 0	12, 315 0	893, 045 0	198, 334 0	0	54. 01 54. 02
54.03	03630 ULTRA SOUND	1, 263, 700	17, 670	1, 281, 370	284, 576	110, 356	54.03
55. 00 56. 00	05500 RADI OLOGY - THERAPEUTI C 05600 RADI OI SOTOPE	2, 743, 864 1, 171, 223	38, 367 16, 377	2, 782, 231 1, 187, 600	617, 897 263, 751	0 2, 644	55. 00 56. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	3, 794, 260	53, 055	3, 847, 315	854, 439	1, 034, 180	
60.00	06000 LABORATORY	21, 318, 286	298, 094	21, 616, 380	4, 800, 717	1, 178, 325	60.00
64. 00 65. 00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	416, 070 8, 097, 966	5, 818 113, 234	421, 888 8, 211, 200	93, 696 1, 823, 601	21, 151 242, 179	64. 00 65. 00
66.00	06600 PHYSI CAL THERAPY	5, 928, 839	82, 903	6, 011, 742	1, 335, 130	432, 698	66.00
66. 01 67. 00	O6601   SPORTS   MEDICINE   O6700   OCCUPATIONAL   THERAPY	0 1, 595, 501	0 22, 310	0 1, 617, 811	0 359, 295	0	66. 01 67. 00
68.00	06800 SPEECH PATHOLOGY	951, 147	13, 300	964, 447	214, 191	28, 713	68. 00
69. 00 69. 01	O6900   ELECTROCARDI OLOGY   O6901   CARDI AC CATH LAB	2, 157, 677	30, 171 0	2, 187, 848 0	485, 893 0	557, 806 0	69. 00 69. 01
70.00	07000 ELECTROENCEPHALOGRAPHY	3, 053, 016	42, 690	3, 095, 706	687, 516	Ö	70. 00
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT	27, 458, 738 19, 084, 148	383, 956 266, 854	27, 842, 694 19, 351, 002	6, 183, 500 4, 297, 606	0	
	07300 DRUGS CHARGED TO PATIENTS	36, 752, 110	513, 905	37, 266, 015	8, 276, 408	0	
74. 00 76. 97	07400 RENAL DI ALYSI S 07697 CARDI AC REHABI LI TATI ON	1, 057, 848 568, 016	14, 792	1, 072, 640	238, 219 127, 913	229, 542	74.00
70. 97	OUTPATIENT SERVICE COST CENTERS	300,010	7, 943	575, 959	127, 913	0	76. 97
90.00	09000 CLINIC	9, 790, 660	136, 903	9, 927, 563	2, 204, 783	1, 382, 961	90.00
90. 01 90. 02	09001 IBMT JOINT VENTURE 09002 PSYCHIATRIC COUNCELING CENTER	4, 214, 017 2, 736, 251	58, 925 38, 261	4, 272, 942 2, 774, 512	948, 965 616, 183	106, 707 660, 018	90. 01 90. 02
90. 03	09003 SOUTH INDY MRI & REHAB	71, 684	1, 002	72, 686	16, 143	0	90. 03
90. 04 90. 05	09004   BARI ATRI CS   09005   CV   DI AGNOSTI C   SERVI CES	9, 659, 754	0 135, 072	0 9, 794, 826	0 2, 175, 304	0	90. 04 90. 05
90.06	09006 CARDI AC REHAB	0	0	0	2, 173, 304	Ö	90.06
91. 00 92. 00	O9100   EMERGENCY   O9200   OBSERVATION   BEDS (NON-DISTINCT PART)	13, 123, 379 0	183, 504	13, 306, 883 0	2, 955, 286	1, 889, 687	91. 00 92. 00
92.00	OTHER REIMBURSABLE COST CENTERS	0		0			92.00
101.00	10100 HOME HEALTH AGENCY	5, 267, 523	73, 656	5, 341, 179	1, 186, 206	0	101. 00
113.00	SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE						113. 00
116.00	11600 HOSPI CE	6, 048, 549		6, 133, 126	1, 362, 088	217, 856	116. 00
118. 00	SUBTOTALS (SUM OF LINES 1-117)   NONREIMBURSABLE COST CENTERS	482, 215, 647	6, 640, 030	481, 504, 017	85, 419, 983	28, 368, 630	118. 00 
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	642, 513	8, 984	651, 497	144, 689	160, 219	
	19001   MEDICAL OFFICE & PARKING   19200   PHYSICIANS' PRIVATE OFFICES	0 17, 518, 399	0 244, 960	0 17, 763, 359	0 3, 945, 011	0 2, 895, 684	190. 01
172.00	TITZOOTIIII SI CIANS FRI VATE UFFICES	17,010,399	244, 900	17, 703, 359	3, 743, 011	2, 090, 084	172.00

Health Financial Systems	ST. FRANCIS HOSPITAL &	HEALTH CENTER	In Lie	u of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der CCN: 150162	From 01/01/2014	Worksheet B Part I Date/Time Prepared:

			T	o 12/31/2014	Date/Time Pre 5/26/2015 12:	
Cost Center Description	Subtotal	CASHI ERI NG/AC	Subtotal	OTHER ADMIN &	OPERATION OF	
		COUNTS		GENERAL	PLANT	
		RECEI VABLE				
	5A. 01	5. 02	5A. 02	5. 03	7. 00	
194.00 07955 MARKETING & COMMUNITY RELATIONS	5, 170, 107	72, 294	5, 242, 401	1, 164, 269	17, 873	194. 00
194. 01 07952 WOMEN' S CENTER	2, 713, 264	37, 940	2, 751, 204	611, 007	332, 442	194. 01
194.02 07950 SOUTH EMERSON SURGERY CENTER	201, 095	2, 812	203, 907	45, 285	0	194. 02
194.03 07951 SOUTHEAST SURGERY CENTER	409, 564	5, 727	415, 291	92, 231	0	194. 03
194. 04 07954 OTHER NRCC	1, 934, 272	27, 047	1, 961, 319	435, 583	356, 184	194. 04
194. 05 07956 FOUNDATI ON	885, 758	12, 386	898, 144	199, 466	0	194. 05
194.06 07953 FRANCISCAN SURGERY CENTER	21, 417, 441	299, 480	21, 716, 921	4, 823, 046	694, 759	194.06
200.00 Cross Foot Adjustments	0		0			200.00
201.00 Negative Cost Centers	0	0	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	533, 108, 060	7, 351, 660	533, 108, 060	96, 880, 570	32, 825, 791	202.00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

		Cost Center Description	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	5/26/2015 12: NURSI NG	
		·	LINEN SERVICE				ADMI NI STRATI O N	
	GENED	AL SERVICE COST CENTERS	8. 00	9. 00	10. 00	11. 00	13. 00	
1.00		NEW CAP REL COSTS-BLDG & FIXT						1. 00
2.00		NEW CAP REL COSTS-MVBLE EQUIP						2. 00
4. 00		EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 01 5. 02	1	ADMITTING CASHIERING/ACCOUNTS RECEIVABLE						5. 01 5. 02
5. 03		OTHER ADMIN & GENERAL						5. 03
7. 00		OPERATION OF PLANT						7. 00
8. 00 9. 00	1	LAUNDRY & LINEN SERVICE HOUSEKEEPING	2, 538, 420	7, 086, 785				8. 00 9. 00
10.00	1	DI ETARY	0	126, 043				10.00
11.00		CAFETERI A	0	122, 614		4, 644, 759		11.00
13.00		NURSING ADMINISTRATION	516 9, 386	201, 439		168, 258	11, 119, 192	13.00
14. 00 15. 00	1	CENTRAL SERVICES & SUPPLY PHARMACY	9, 380	99, 249 129, 008		104, 481 174, 835	0	14. 00 15. 00
16. 00	1	MEDICAL RECORDS & LIBRARY	0	55, 879		0	0	16. 00
21. 00	1	I &R SERVICES-SALARY & FRINGES APPRVD	0	0		64, 386	0	21.00
22. 00 23. 00		I&R SERVICES-OTHER PRGM COSTS APPRVD   PARAMED ED PRGM	0	0	· ·	14, 073 7, 899	0	22. 00 23. 00
23. 00		EMERGENCY MEDICAL SERVICES	0	0		7, 899	0	23. 00
	I NPAT	ENT ROUTINE SERVICE COST CENTERS						
30. 00 31. 00		ADULTS & PEDIATRICS INTENSIVE CARE UNIT	634, 032	987, 736		860, 965 251, 779	6, 016, 822 1, 192, 856	30. 00 31. 00
31.00		NEONATAL INTENSIVE CARE UNIT	169, 759 15, 619			251, 778 79, 917	570, 278	31.00
32.00	1	CORONARY CARE UNIT	189, 933			289, 058	1, 477, 994	
34.00		SURGICAL INTENSIVE CARE UNIT	100, 226			146, 414	817, 325	34.00
41. 00 43. 00		SUBPROVI DER - I RF NURSERY	180, 255 11, 924	124, 091 23, 679		59, 340 26, 116	502, 668 541, 249	41. 00 43. 00
.0.00	ANCI L	LARY SERVICE COST CENTERS	, , , ,	20,0,7		20, 110	0117217	.0.00
50.00		OPERATING ROOM	246, 965			405, 973	0	50.00
52. 00 54. 00		DELIVERY ROOM & LABOR ROOM RADIOLOGY-DIAGNOSTIC	174, 038 86, 819			92, 236 344, 095	0	52. 00 54. 00
54. 01	1	CARDI AC NUCLEAR DI AGNOSTI C	0	0		0	0	54. 01
54. 02		NUCLEAR MEDICINE - DIAGNOSTIC	0	0	_	0	0	54. 02
54. 03 55. 00	1	ULTRA SOUND RADIOLOGY - THERAPEUTIC	76, 965	24, 260 0		29, 460 1, 312	0	54. 03 55. 00
56.00		RADI OI SOTOPE	6, 769	581	0	7, 548	0	56.00
59. 00		CARDI AC CATHETERI ZATI ON	73, 698	227, 350		54, 008	0	59. 00
60. 00 64. 00	4	LABORATORY I NTRAVENOUS THERAPY	477	259, 038 4, 650		25, 888 10, 586	0	60. 00 64. 00
65.00	1	RESPIRATORY THERAPY	0	53, 240		246, 270	0	65.00
66.00	06600	PHYSI CAL THERAPY	36, 297	95, 123	0	139, 431	0	66.00
66. 01		SPORTS MEDICINE OCCUPATIONAL THERAPY	0	0	· ·	0 E1 404	0	66. 01
67. 00 68. 00		SPEECH PATHOLOGY	0	6, 312		51, 486 26, 869	0	67. 00 68. 00
69. 00	06900	ELECTROCARDI OLOGY	8, 268		0	40, 972	0	69. 00
69. 01		CARDI AC CATH LAB	0	0	0	0	0	69. 01
70. 00 71. 00		ELECTROENCEPHALOGRAPHY MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 955	0	0	55, 001 35, 488	0	70. 00 71. 00
72. 00		IMPL. DEV. CHARGED TO PATIENT	0	0	Ö	0	0	72.00
73.00		DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74. 00 76. 97		RENAL DIALYSIS CARDIAC REHABILITATION	7, 617	50, 462 0		15, 701 21, 426	0	74. 00 76. 97
, 0, , ,	OUTPA	TIENT SERVICE COST CENTERS			, , , , , , , , , , , , , , , , , , ,	2.7.20	Ü	70.77
90.00		CLINIC	18, 049			202, 611	0	90.00
90. 01 90. 02		IBMT JOINT VENTURE PSYCHIATRIC COUNCELING CENTER	15, 577	23, 458 145, 096		81, 700 50, 697	0	90. 01 90. 02
90. 03	1	SOUTH INDY MRI & REHAB	0	0	0	9	0	90. 03
90.04		BARI ATRI CS	0	0	0	0	0	90.04
90. 05 90. 06		CV DI AGNOSTI C SERVI CES CARDI AC REHAB	0	0	0	3, 062 0	0	90. 05 90. 06
91.00	09100	EMERGENCY	450, 403	415, 421	Ö	338, 055	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
101.00		REIMBURSABLE COST CENTERS HOME HEALTH AGENCY	0	0	O	0	0	101. 00
	SPECI	AL PURPOSE COST CENTERS						
		I NTEREST EXPENSE HOSPI CE		47 000				113. 00 116. 00
118.00	1	SUBTOTALS (SUM OF LINES 1-117)	2, 515, 547	47, 893 6, 106, 940		4, 527, 404	11, 119, 192	
	NONRE	MBURSABLE COST CENTERS	, , , , , , , , , , , , , , , , , , , ,					
		GIFT, FLOWER, COFFEE SHOP & CANTEEN MEDICAL OFFICE & PARKING	0	35, 222 0		11, 631 0		190. 00 190. 01
		PHYSICIANS' PRIVATE OFFICES		636, 576		76, 998		190.01

Heal th Financial	Systems		ST. FRANCIS HOSPITAL & HEALTH CENTER					In L	ieu of F	orm (	CMS-2552-	-10
COST ALLOCATION -	- GENERAL S	SERVI CE COSTS			Provi der	CCN:	150162	Peri od:	Works	sheet	В	
								From 01/01/20				

				Т	o 12/31/2014	Date/Time Pre 5/26/2015 12:	
	Cost Center Description	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	
		LINEN SERVICE				ADMI NI STRATI O	
						N	
		8. 00	9. 00	10.00	11. 00	13.00	
194. 00 07955	MARKETING & COMMUNITY RELATIONS	0	3, 929	0	3, 866	0	194.00
194. 01 07952	WOMEN'S CENTER	15, 142	73, 083	0	3, 306	0	194. 01
194. 02 07950	SOUTH EMERSON SURGERY CENTER	0	0	0	0	0	194. 02
194. 03 07951	SOUTHEAST SURGERY CENTER	0	0	0	0	0	194. 03
194. 04 07954	OTHER NRCC	7, 727	78, 302	0	8, 774	0	194.04
194. 05 07956	FOUNDATI ON	4	0	0	10, 607	0	194.05
194. 06 07953	FRANCISCAN SURGERY CENTER	0	152, 733	0	2, 173	0	194.06
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, 538, 420	7, 086, 785	2, 443, 472	4, 644, 759	11, 119, 192	202.00

Health Financial Systems ST. FRANCIS HOSPITAL & HEALTH CENTER In Lieu of Form CMS-2552-10

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150162 | Period: From 01/01/2014 | To 12/31/2014 | Date/Time Prepared: 5/26/2015 12: 47 pm

							5/26/2015 12:	
							RESI DENTS	
		Cost Center Description	CENTRAL SERVICES &	PHARMACY	MEDICAL RECORDS &	SERVICES-SALA RY & FRINGES	SERVICES-OTHE R PRGM COSTS	
			SUPPLY		LI BRARY			
	GENER	AL SERVICE COST CENTERS	14. 00	15. 00	16. 00	21. 00	22. 00	
1. 00		NEW CAP REL COSTS-BLDG & FIXT						1. 00
2. 00 4. 00	1	NEW CAP REL COSTS-MVBLE EQUIP EMPLOYEE BENEFITS DEPARTMENT						2. 00 4. 00
5. 01	1	ADMITTING						5. 01
5. 02		CASHI ERI NG/ACCOUNTS RECEI VABLE						5. 02
5. 03 7. 00		OTHER ADMIN & GENERAL OPERATION OF PLANT						5. 03 7. 00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9. 00 10. 00		HOUSEKEEPI NG DI ETARY						9. 00 10. 00
11. 00		CAFETERI A						11. 00
13. 00 14. 00		NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY	5, 983, 218					13. 00 14. 00
15. 00		PHARMACY	11, 415	10, 131, 907				15. 00
16.00		MEDICAL RECORDS & LIBRARY	0	0	2, 477, 557			16.00
21. 00 22. 00		I&R SERVICES-SALARY & FRINGES APPRVD   I&R SERVICES-OTHER PRGM COSTS APPRVD	2, 737	0	0		2, 060, 689	21. 00 22. 00
23. 00	02300	PARAMED ED PRGM	48	0	0		0	23.00
23. 01		EMERGENCY MEDICAL SERVICES   ENT ROUTINE SERVICE COST CENTERS	0	0	0	0	0	23. 01
30.00	03000	ADULTS & PEDIATRICS	14, 817	0	124, 088	2, 027, 571	1, 430, 151	30.00
31. 00 31. 01		INTENSIVE CARE UNIT NEONATAL INTENSIVE CARE UNIT	5, 040	0			72, 601 52, 705	31.00
31.01		CORONARY CARE UNIT	1, 373 4, 356	0	20, 896 28, 522		53, 705 0	31. 01 32. 00
34.00		SURGICAL INTENSIVE CARE UNIT	2, 953	0			0	34.00
41. 00 43. 00	1	SUBPROVI DER - I RF NURSERY	1, 007 657	0	· ·		0	41. 00 43. 00
	ANCI L	LARY SERVICE COST CENTERS						
50. 00 52. 00		OPERATING ROOM DELIVERY ROOM & LABOR ROOM	37, 721 4, 496	0			161, 116 0	50. 00 52. 00
54. 00		RADI OLOGY-DI AGNOSTI C	10, 464	0			Ö	54.00
54. 01 54. 02		CARDIAC NUCLEAR DIAGNOSTIC NUCLEAR MEDICINE - DIAGNOSTIC	31, 265	0	28, 286 0		0	54. 01 54. 02
54. 02		ULTRA SOUND	179	0	27, 801	0	0	54. 02
55.00		RADI OLOGY - THERAPEUTI C	10, 986	0	30, 519		0	55.00
56. 00 59. 00	1	RADI OI SOTOPE CARDI AC CATHETERI ZATI ON	30 402	0	7, 472 91, 730		0	56. 00 59. 00
60.00	06000	LABORATORY	2, 761	0	260, 865	0	0	60.00
64. 00 65. 00		I NTRAVENOUS THERAPY RESPIRATORY THERAPY	51 12, 707	0	'		0 42, 765	64. 00 65. 00
66.00		PHYSI CAL THERAPY	2, 782	0			42, 765	66.00
66. 01 67. 00		SPORTS MEDICINE OCCUPATIONAL THERAPY	0 517	0	11 717	0	0	66. 01 67. 00
68. 00		SPEECH PATHOLOGY	132	0			0	68. 00
69.00		ELECTROCARDI OLOGY	395	0	25, 271	149, 459	105, 421	
69. 01 70. 00		CARDI AC CATH LAB ELECTROENCEPHALOGRAPHY	1, 702	0	0 26, 524	93, 060	0 65, 640	69. 01 70. 00
71.00		MEDICAL SUPPLIES CHARGED TO PATIENTS	3, 383, 802	0	122, 184		0	71.00
72. 00 73. 00	1	IMPL. DEV. CHARGED TO PATIENT DRUGS CHARGED TO PATIENTS	2, 338, 367	0 10, 131, 907	97, 006 441, 170		0	72. 00 73. 00
74.00	07400	RENAL DIALYSIS	218	0	7, 466	33, 840	23, 869	74.00
76. 97		CARDIAC REHABILITATION TIENT SERVICE COST CENTERS	577	0	2, 036	0	0	76. 97
90.00	09000	CLI NI C	3, 545	0	26, 395		0	90.00
90. 01 90. 02		IBMT JOINT VENTURE   PSYCHIATRIC COUNCELING CENTER	1, 320 3, 014	0	6, 860 8, 226		0	90. 01 90. 02
90. 03		SOUTH INDY MRI & REHAB	949	0	202		0	90. 02
90.04		BARI ATRI CS	0	0	0 24 701	0	0	90.04
90. 05 90. 06		CV DI AGNOSTI C SERVI CES CARDI AC REHAB	4, 325	0	36, 781 0	0	0	90. 05 90. 06
91.00	09100	EMERGENCY	8, 913	0	234, 435	88, 830	62, 656	91.00
92. 00		OBSERVATION BEDS (NON-DISTINCT PART) REIMBURSABLE COST CENTERS						92. 00
101.00	10100	HOME HEALTH AGENCY	14, 441	0	11, 834	0	0	101. 00
113 00		AL PURPOSE COST CENTERS INTEREST EXPENSE						113. 00
		HOSPI CE	6, 038	0				116. 00
118.00		SUBTOTALS (SUM OF LINES 1-117)	5, 926, 502	10, 131, 907	2, 477, 557	2, 921, 509	2, 060, 689	118. 00
190. 00		IMBURSABLE COST CENTERS GIFT, FLOWER, COFFEE SHOP & CANTEEN	285	0	0	0	0	190. 00
					•			

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Peri od: Worksheet B From 01/01/2014 Part I To 12/31/2014 Date/Time Prepared: 5/26/2015 12: 47 pm Provi der CCN: 150162

					5/26/2015 12:	4/ pm_
				INTERNS &	RESI DENTS	
Cost Center Description	CENTRAL	PHARMACY	MEDI CAL	SERVI CES-SALA	SERVI CES-OTHE	
	SERVICES &		RECORDS &	RY & FRINGES	R PRGM COSTS	
	SUPPLY		LI BRARY			
	14. 00	15. 00	16.00	21.00	22. 00	
190.01 19001 MEDICAL OFFICE & PARKING	0	0	0	0	0	190. 01
192.00 19200 PHYSICIANS' PRIVATE OFFICES	10, 204	0	0	0	0	192.00
194.00 07955 MARKETING & COMMUNITY RELATIONS	62	0	0	0	0	194.00
194. 01 07952 WOMEN' S CENTER	1, 362	0	0	0	0	194. 01
194.02 07950 SOUTH EMERSON SURGERY CENTER	61	0	0	0	0	194. 02
194. 03 07951 SOUTHEAST SURGERY CENTER	0	0	0	0	0	194. 03
194. 04 07954 OTHER NRCC	265	0	0	0	0	194. 04
194. 05 07956 FOUNDATI ON	44, 477	0	0	0	0	194. 05
194.06 07953 FRANCI SCAN SURGERY CENTER	0	0	0	0	0	194. 06
200.00 Cross Foot Adjustments				0	0	200. 00
201.00 Negative Cost Centers	0	0	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	5, 983, 218	10, 131, 907	2, 477, 557	2, 921, 509	2, 060, 689	202. 00

COST ALLOCATION - GENERAL SERVICE COSTS		Provi der		eriod: rom 01/01/2014 o 12/31/2014	Worksheet B Part I Date/Time Pre	
Cost Center Description	PARAMED ED PRGM	EMERGENCY MEDI CAL SERVI CES	Subtotal	Intern & Residents Cost & Post Stepdown	5/26/2015 12: Total	47 pm
	23. 00	23. 01	24. 00	Adjustments 25.00	26. 00	
GENERAL SERVI CE COST CENTERS  1. 00	327, 480 0	0				1. 00 2. 00 4. 00 5. 01 5. 02 5. 03 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00 16. 00 21. 00 22. 00 23. 00
30. 00   03000   ADULTS & PEDIATRICS   31. 00   03100   INTENSIVE CARE UNIT   32. 00   03200   CORONARY CARE UNIT   34. 00   03400   SURGICAL INTENSIVE CARE UNIT   41. 00   04100   SUBPROVIDER - IRF   43. 00   04300   NURSERY	0 0 0 0 0 0	0 0 0 0 0 0	58, 951, 637 14, 608, 775 6, 491, 111 18, 777, 578 9, 587, 270 5, 180, 200 2, 106, 698	-175, 531 -129, 845 0 0	55, 493, 915 14, 433, 244 6, 361, 266 18, 777, 578 9, 587, 270 5, 180, 200 2, 106, 698	31. 00 31. 01
ANCI LLARY SERVI CE COST CENTERS  50. 00	0 0 0 0 0 0 0 0 0 0 327, 480 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	41, 641, 612 6, 128, 626 35, 719, 479 1, 150, 930 0 1, 834, 967 3, 442, 945 1, 476, 395 6, 183, 122 28, 471, 931 554, 821 10, 759, 645 8, 196, 556 0 2, 040, 826 1, 248, 123 3, 683, 959 0 4, 027, 104 37, 567, 668 26, 083, 981 56, 115, 500 1, 679, 574 727, 911	0 0 0 0 0 0 0 0 0 -103, 395 -103, 395 -103, 395 0 0 0 -254, 880 0 0 -158, 700 0 0	41, 252, 077 6, 128, 626 35, 719, 479 1, 150, 930 0 1, 834, 967 3, 442, 945 1, 476, 395 6, 183, 122 28, 471, 931 554, 821 10, 656, 250 8, 093, 161 0 2, 040, 826 1, 248, 123 3, 429, 079 0 3, 868, 404 37, 567, 668 26, 083, 981 56, 115, 500 1, 621, 865 727, 911	54. 00 54. 01 54. 02 54. 03 55. 00 56. 00 60. 00 64. 00 66. 00 66. 01 67. 00 68. 00 69. 01 70. 00 71. 00 72. 00 73. 00
90. 01   09001   IBMT JOINT VENTURE   90. 02   09002   PSYCHI ATRI C COUNCELING CENTER   90. 03   09003   SOUTH I NDY MRI & REHAB   90. 04   09004   BARI ATRI CS   90. 05   09005   CV DI AGNOSTI C SERVI CES   90. 06   09006   CARDI AC REHAB   91. 00   09100   EMERGENCY   92. 00   09200   0BSERVATI ON BEDS (NON-DI STI NCT PART)   OTHER REI MBURSABLE COST CENTERS   101. 00   10100   HOME HEALTH AGENCY   SPECI AL PURPOSE COST CENTERS	0 0 0 0 0 0	0 0 0 0 0	5, 457, 529 4, 257, 746 89, 989 0 12, 014, 298 0 19, 750, 569	0 0 0 0 0 0 -151, 486	5, 457, 529 4, 257, 746 89, 989 0 12, 014, 298 0 19, 599, 083	90. 01 90. 02 90. 03 90. 04 90. 05 90. 06 91. 00 92. 00
113. 00 11300 INTEREST EXPENSE 116. 00 11600 HOSPI CE 118. 00 SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS	0 327, 480	0 0	7, 776, 813 464, 409, 480	-4, 982, 198	7, 776, 813 459, 427, 282	118. 00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	1, 003, 543	0	1, 003, 543	1190.00

TOTAL (sum lines 118-201)

528, 125, 862 202. 00

COST ALLOCATION - GENERAL SERVICE COSTS Provi der CCN: 150162 Peri od: Worksheet B From 01/01/2014 Part I 12/31/2014 Date/Time Prepared: 5/26/2015 12: 47 pm **EMERGENCY** Cost Center Description PARAMED ED Subtotal Intern & Total PRGM MEDI CAL Resi dents SERVI CES Cost & Post Stepdown Adjustments 23. 01 23.00 24.00 25.00 26.00 190. 01 19001 MEDICAL OFFICE & PARKING 0 0 190. 01 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 0 0 0 0 0 0 0 0 0 25, 327, 832 25, 327, 832 192. 00 6, 432, 400 6, 432, 400 194. 00 194.00 07955 MARKETING & COMMUNITY RELATIONS 0 194. 01 07952 WOMEN' S CENTER 3, 787, 546 3, 787, 546 194. 01 194. 02 07950 SOUTH EMERSON SURGERY CENTER 0 249, 253 249, 253 194. 02 0 0 194. 03 07951 SOUTHEAST SURGERY CENTER 0 507, 522 507, 522 194. 03 194. 04 07954 OTHER NRCC 2, 848, 154 194. 04 2, 848, 154 0 194. 05 07956 FOUNDATI ON 0 1, 152, 698 1, 152, 698 194. 05 194.06 07953 FRANCI SCAN SURGERY CENTER 0 27, 389, 632 27, 389, 632 194. 06 0 200.00 Cross Foot Adjustments 0 200.00 0 0 0 201.00 201.00 Negative Cost Centers 0 0 0 0

327, 480

533, 108, 060

-4, 982, 198

202.00

| Peri od: | Worksheet B | From 01/01/2014 | Part | I | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | To 12/31 Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS ST. FRANCIS HOSPITAL & HEALTH CENTER
Provider CCN: 150162

				To	12/31/2014	Date/Time Pre 5/26/2015 12:	
			CAPI TAL REI	LATED COSTS		0/20/2013 12.	T7 DIII
	Overland Branch all an	D:	NEW DIDO A	NEW MADE		EMPL OVEE	
	Cost Center Description	Directly Assigned New	NEW BLDG & FLXT	NEW MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS	
		Capi tal	1171	Edoli		DEPARTMENT	
		Related Costs					
	GENERAL SERVICE COST CENTERS	0	1. 00	2. 00	2A	4. 00	
1. 00	00100 NEW CAP REL COSTS-BLDG & FLXT						1. 00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	13, 011		17, 908	17, 908	4. 00
5. 01 5. 02	OO570   ADMI TTI NG   OO580   CASHI ERI NG/ACCOUNTS   RECEI VABLE	0	223, 004 172, 155		306, 935 236, 949	229 0	5. 01 5. 02
5. 02	00590 OTHER ADMIN & GENERAL	6, 123, 102	1, 412, 629		8, 067, 398	570	5. 02
7.00	00700 OPERATION OF PLANT	0	4, 538, 200		6, 246, 228	623	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	333, 123		458, 499	28	8.00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	0	367, 126 681, 519		505, 300 938, 020	421 81	9. 00 10. 00
11. 00	01100 CAFETERI A	0	662, 977		912, 500	223	11.00
13.00	01300 NURSING ADMINISTRATION	0	1, 089, 186		1, 499, 119	615	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	0	536, 642		738, 616	255	
15. 00 16. 00	01600 MEDI CAL RECORDS & LI BRARY	0	697, 546 302, 136		960, 079 415, 850	598 0	15. 00 16. 00
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRVD	Ö	0		0	240	21. 00
22. 00	02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0		0	170	22. 00
23. 00	02300 PARAMED ED PRGM	0	0	0	0	26 0	23. 00
23. 01	02302   EMERGENCY MEDICAL SERVICES   INPATIENT ROUTINE SERVICE COST CENTERS	J O	0	l O	<u>U</u>	0	23. 01
30.00	03000 ADULTS & PEDIATRICS	0	5, 340, 711	2, 010, 067	7, 350, 778	2, 542	30. 00
31.00	03100   NTENSI VE CARE UNI T	0	885, 101		1, 218, 224	806	31.00
31. 01 32. 00	02060 NEONATAL INTENSIVE CARE UNIT   03200 CORONARY CARE UNIT	0	302, 827 1, 950, 339		416, 801 2, 684, 382	311 899	31. 01 32. 00
34.00	03400 SURGI CAL I NTENSI VE CARE UNI T	0	1, 950, 339		1, 484, 758	432	
41.00	04100 SUBPROVI DER - I RF	0	670, 959		923, 486	192	41.00
43. 00	04300 NURSERY	0	128, 032	48, 187	176, 219	82	43.00
50. 00	ANCILLARY SERVICE COST CENTERS    O5000   OPERATING ROOM	0	4, 319, 784	1, 625, 823	5, 945, 607	1, 349	50. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	756, 943		1, 041, 831	289	
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	3, 994, 896		5, 498, 442	1, 225	54.00
54. 01	05402 CARDI AC NUCLEAR DI AGNOSTI C	0	0		0	1	54. 01
54. 02 54. 03	03450   NUCLEAR MEDICINE - DIAGNOSTIC   03630   ULTRA SOUND	0	0 131, 175	-	180, 545	0 107	54. 02 54. 03
55. 00	05500 RADI OLOGY - THERAPEUTI C	Ö	0	0	0	4	55. 00
56.00	05600 RADI OI SOTOPE	0	3, 143		4, 326	30	56.00
59. 00 60. 00	05900   CARDI AC   CATHETERI ZATI ON   06000   LABORATORY	0	1, 229, 286 1, 400, 624		1, 691, 948 1, 927, 772	191 97	59. 00 60. 00
64. 00	06400 I NTRAVENOUS THERAPY	0	25, 141		34, 603	38	64. 00
65.00	06500 RESPIRATORY THERAPY	0	287, 868		396, 212	738	65.00
66.00	06600 PHYSI CAL THERAPY	0	514, 329		707, 905	438	66.00
66. 01 67. 00	O6601   SPORTS   MEDICINE   O6700   OCCUPATIONAL   THERAPY	0	0		0	0 158	66. 01 67. 00
68. 00	06800 SPEECH PATHOLOGY	0	34, 129		46, 974	91	
69. 00	06900 ELECTROCARDI OLOGY	0	663, 040	249, 546	912, 586	115	
69. 01 70. 00	O6901   CARDI AC CATH LAB   O7000   ELECTROENCEPHALOGRAPHY	0	0	0	0	0 157	69. 01 70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	o	0	70.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	O	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74. 00 76. 97	07400  RENAL DI ALYSI S   07697  CARDI AC REHABI LI TATI ON	0	272, 846 0	1	375, 536 0	65 53	74. 00 76. 97
70. 77	OUTPATIENT SERVICE COST CENTERS	<u> </u>	U	0		33	70. 77
90.00	09000 CLI NI C	0	1, 643, 866		2, 262, 563	613	90. 00
90. 01 90. 02	09001   BMT JOINT VENTURE   09002   PSYCHIATRIC COUNCELING CENTER	0	126, 838 784, 535		174, 576 1, 079, 808	118 147	
90. 02	09003 SOUTH INDY MRI & REHAB	0	784, 535	_	1, 079, 808	0	
90. 04	09004 BARI ATRI CS	0	0		ő	0	90. 04
90.05	09005 CV DI AGNOSTI C SERVI CES	0	0	0	0	590	
90. 06 91. 00	09006 CARDI AC REHAB 09100 EMERGENCY	0	0 2, 246, 190	0 845, 391	0 3, 091, 581	0 955	90. 06 91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)		2, 240, 190	040, 391	3, 091, 361	700	91.00
	OTHER REIMBURSABLE COST CENTERS						
101.00	10100 HOME HEALTH AGENCY	0	0	0	0	329	101. 00
113 00	SPECIAL PURPOSE COST CENTERS   11300   NTEREST EXPENSE						113. 00
	11600 HOSPI CE	0	258, 956	97, 462	356, 418		116. 00
118. 00	SUBTOTALS (SUM OF LINES 1-117)	6, 123, 102	40, 079, 564	15, 084, 616	61, 287, 282	17, 584	118. 00

17, 908 202. 00

ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 150162 Peri od: Worksheet B From 01/01/2014 Part II Date/Time Prepared: 5/26/2015 12:47 pm 12/31/2014 CAPITAL RELATED COSTS Di rectly NEW BLDG & NEW MVBLE **EMPLOYEE** Cost Center Description Subtotal Assi gned New **BENEFITS** FIXT FOUL P DEPARTMENT Capi tal Related Costs 1.00 2.00 2A 4.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 190, 446 15 190. 00 71, 677 262, 123 0 0 0 0 0 0 0 0 190. 01 190.01 19001 MEDICAL OFFICE & PARKING 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 3, 441, 975 1, 295, 445 4, 737, 420 241 192. 00 194.00 07955 MARKETING & COMMUNITY RELATIONS 9 194.00 7, 996 29, 240 21, 244 194. 01 07952 WOMEN' S CENTER 6 194.01 543, 884 395, 159 148, 725 194. 02 07950 SOUTH EMERSON SURGERY CENTER 0 194. 02 194. 03 07951 SOUTHEAST SURGERY CENTER 0 194. 03 194. 04 07954 OTHER NRCC 194. 05 07956 FOUNDATION 22 194. 04 423, 380 159, 346 582, 726 23 194. 05 194.06 07953 FRANCI SCAN SURGERY CENTER 825, 830 310, 815 1, 136, 645 8 194.06 200.00 Cross Foot Adjustments 200.00 201.00 0 201.00 Negative Cost Centers

6, 123, 102

45, 377, 598

17, 078, 620

68, 579, 320

202.00

TOTAL (sum lines 118-201)

Health Financial Systems In Lieu of Form CMS-2552-10 ST. FRANCIS HOSPITAL & HEALTH CENTER ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 150162 Peri od: Worksheet B From 01/01/2014 Part II Date/Time Prepared: 12/31/2014 5/26/2015 12:47 pm Cost Center Description ADMITTI NG CASHIERING/AC OTHER ADMIN & OPERATION OF LAUNDRY & LINEN SERVICE COUNTS **GENERAL PLANT** RECEI VABLE 5.03 7. 00 8. 00 5 01 5 02 GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 00200 NEW CAP REL COSTS-MVBLE EQUIP 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4 00 5.01 00570 ADMITTING 307, 164 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 236, 949 5.02 5.03 00590 OTHER ADMIN & GENERAL 0 42, 919 8, 110, 887 00700 OPERATION OF PLANT 7.00 11, 947 0 499, 416 6, 758, 214 8.00 00800 LAUNDRY & LINEN SERVICE 0 822 34, 356 57, 698 551, 403 9 00 00900 HOUSEKEEPI NG 0 0 2, 467 103, 120 63, 588 0 01000 DI ETARY 118, 042 26, 535 10.00 635 0 01100 CAFETERI A 11.00 1, 443 60.315 114, 831 Λ 0 13.00 01300 NURSING ADMINISTRATION 3, 579 149, 595 188, 652 112 14.00 01400 CENTRAL SERVICES & SUPPLY 1, 936 80, 918 92, 949 2,039 0 15.00 01500 PHARMACY 3, 359 140, 424 120, 818 0 0 16.00 01600 MEDICAL RECORDS & LIBRARY 789 32, 977 52, 331 0 02100 I &R SERVICES-SALARY & FRINGES APPRVD 21.00 1,039 43, 427 0 0 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD 31, 137 22.00 745 0 0 02300 PARAMED ED PRGM 0 23 00 116 4,861 0 0 02302 EMERGENCY MEDICAL SERVICES 23.01 0 23.01 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 30.00 31, 341 14, 937 624, 391 925, 042 137, 725 31.00 03100 INTENSIVE CARE UNIT 8,633 4, 227 176, 682 153, 304 36, 876 5, 939 1, 906 31.01 02060 NEONATAL INTENSIVE CARE UNIT 79,678 52, 451 3, 393 03200 CORONARY CARE UNIT 8, 107 5, 263 220, 018 337, 808 41, 258 32.00 03400 SURGICAL INTENSIVE CARE UNIT 34.00 5,622 2,626 109, 753 186, 845 21, 771 41.00 04100 SUBPROVI DER - I RF 3,028 1, 320 55, 186 116, 213 39, 155 04300 NURSERY 43.00 2, 144 462 19, 305 22, 176 2,590 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 748, 208 32, 641 13,072 546, 430 53, 646 52.00 05200 DELIVERY ROOM & LABOR ROOM 9,569 1,837 76, 790 131, 106 37,805 05400 RADI OLOGY-DI AGNOSTI C 468, 910 54.00 25, 031 11, 217 691, 936 18, 859 54 01 05402 CARDIAC NUCLEAR DIAGNOSTIC 87 397 16,604 0 0 03450 NUCLEAR MEDICINE - DIAGNOSTIC 54.02 0 Λ 16, 719 54.03 03630 ULTRA SOUND 2, 269 570 23, 825 22, 720 05500 RADI OLOGY - THERAPEUTI C 55.00 16 1, 237 51, 730 0 05600 RADI OI SOTOPE 490 22, 081 1 470 56 00 528 544 05900 CARDI AC CATHETERI ZATI ON 212, 918 59.00 12,088 1,711 71, 533 16,009 30, 746 06000 LABORATORY 401, 913 242, 595 104 60.00 9, 615 64 00 06400 INTRAVENOUS THERAPY 724 188 7.844 4.355 Ω 06500 RESPIRATORY THERAPY 65.00 17,059 3, 652 152, 671 49,860 0 06600 PHYSI CAL THERAPY 89, 084 7,885 66.00 5,817 2,674 111, 776 66.01 06601 SPORTS MEDICINE 0 0 0 0 06700 OCCUPATI ONAL THERAPY 2, 013 720 30, 080 67 00 0 0 68.00 06800 SPEECH PATHOLOGY 931 429 17, 932 5, 911 0 69.00 06900 ELECTROCARDI OLOGY 4.837 973 40,679 114, 842 1, 796 06901 CARDI AC CATH LAB 69.01 0 70.00 07000 ELECTROENCEPHALOGRAPHY 579 1.377 57.558 425 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 23, 410 12, 384 517, 679 0 0 07200 I MPL. DEV. CHARGED TO PATIENT 359, 793 72.00 9, 118 8,607 0 0 07300 DRUGS CHARGED TO PATIENTS 16, 575 692, 998 73.00 46.530 0 0 07400 RENAL DIALYSIS 74 00 2.020 477 19 944 47, 258 1,654 76. 97 07697 CARDIAC REHABILITATION 10, 709 256 0 OUTPATIENT SERVICE COST CENTERS 3, 921 90.00 93 4. 416 184, 583 284, 726 09000 CLI NI C 09001 IBMT JOINT VENTURE 90.01 106 1, 901 79, 447 21, 969 3, 384 09002 PSYCHIATRIC COUNCELING CENTER 51, 587 135, 885 90.02 0 1, 234 0 90.03 09003 SOUTH INDY MRI & REHAB 0 32 1.351 0 0 90.04 09004 BARI ATRI CS 0 C 0 0 0 09005 CV DIAGNOSTIC SERVICES 90.05 75 4, 357 182, 115 0 0 90.06 09006 CARDI AC REHAB 0 91.00 09100 EMERGENCY 16, 100 5, 919 247, 415 389, 051 97,838 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 OTHER REIMBURSABLE COST CENTERS

MCRI F32 - 7. 2. 157. 2

Health Financial Systems	ST. FRANCIS HOSPITAL & HI	EALTH CENTER	In Lieu	of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 150162	From 01/01/2014	Worksheet B Part II Date/Time Prepared:

				11	0 12/31/2014	5/26/2015 12:	
	Cost Center Description	ADMI TTI NG	CASHI ERI NG/AC	OTHER ADMIN &	OPERATION OF	LAUNDRY &	
			COUNTS	GENERAL	PLANT	LINEN SERVICE	
			RECEI VABLE				
		5. 01	5. 02	5. 03	7. 00	8. 00	
194.00 07955	MARKETING & COMMUNITY RELATIONS	0	2, 332	97, 472	3, 680	0	194. 00
194. 01 07952	WOMEN'S CENTER	0	1, 224	51, 153	68, 443	3, 289	194. 01
194. 02 07950	SOUTH EMERSON SURGERY CENTER	0	91	3, 791	0	0	194. 02
194. 03 07951	SOUTHEAST SURGERY CENTER	0	185	7, 722	0	0	194. 03
194. 04 07954	OTHER NRCC	0	872	36, 467	73, 332	1, 679	194. 04
194.05 07956	FOUNDATI ON	0	399	16, 699	0	1	194. 05
194.06 07953	FRANCISCAN SURGERY CENTER	0	9, 659	403, 783	143, 038	0	194.06
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)	307, 164	236, 949	8, 110, 887	6, 758, 214	551, 403	202. 00

Health Financial Systems ST. FR ALLOCATION OF CAPITAL RELATED COSTS

Provi der CCN: 150162 | Peri od: From 01/01/2014

					5/26/2015 12:	47 pm
Cost Center Description	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI O	CENTRAL SERVICES &	
	9. 00	10. 00	11. 00	N 13. 00	SUPPLY 14. 00	
GENERAL SERVICE COST CENTERS						
1. 00    00100    NEW CAP REL COSTS-BLDG & FIXT   2. 00    00200    NEW CAP REL COSTS-MVBLE EQUIP   4. 00    00400    EMPLOYEE BENEFITS DEPARTMENT   5. 01    00570    ADMITTING   5. 02    00580    CASHIERING/ACCOUNTS RECEIVABLE   5. 03    00590    OTHER ADMIN & GENERAL   7. 00    00700    OPERATION OF PLANT   8. 00    00800    LAUNDRY & LINEN SERVICE   9. 00    00900    HOUSEKEEPING   10. 00    01000    DIETARY   11. 00    01100    CAFETERIA   13. 00    01300    NURSING ADMINISTRATION   14. 00    01400    CENTRAL SERVICES & SUPPLY   15. 00    01500    PHARMACY   16. 00    01600    MEDICAL RECORDS & LIBRARY   21. 00    02100    L&R SERVICES-SALARY & FRINGES APPRVD   22. 00    02200    L&R SERVICES-OTHER PRGM COSTS APPRVD   23. 01    02302    EMERGENCY MEDICAL SERVICES   INPATIENT ROUTINE SERVICE COST CENTERS	674, 896 12, 004 11, 677 19, 184 9, 452 12, 286 5, 321 0 0	1, 095, 317 0 0 0 0 0 0 0 0	1, 100, 989 39, 884 24, 766 41, 443 0 15, 262 3, 336 1, 872	1, 900, 740 0 0 0 0 0 0 0	950, 931 1, 814 0 435 0 8	1. 00 2. 00 4. 00 5. 01 5. 02 5. 03 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00 16. 00 21. 00 22. 00 23. 00
30. 00 03000 ADULTS & PEDIATRICS	94, 064	592, 699	204, 079	1, 028, 530	2, 355	30.00
31. 00 03100 I NTENSI VE CARE UNI T	15, 589	117, 504	59, 681	203, 909	801	31.00
31.01   02060   NEONATAL INTENSIVE CARE UNIT 32.00   03200   CORONARY CARE UNIT	5, 334 34, 351	56, 176 145, 593	18, 944 68, 518	· ·	218 692	31. 01 32. 00
34. 00   03400 SURGI CAL INTENSI VE CARE UNIT	19, 000	80, 512	34, 706		469	34.00
41. 00   04100   SUBPROVI DER -   I RF	11, 818	49, 516	14, 066		160	41.00
43. 00 04300 NURSERY	2, 255	53, 317	6, 191	92, 522	104	43.00
ANCILLARY SERVICE COST CENTERS 50. 00 05000 OPERATING ROOM	76, 084	ol	96, 232	0	5, 995	50.00
52. 00   05200   DELIVERY ROOM & LABOR ROOM	13, 332	0	21, 864			52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	70, 362	Ö	81, 564		1, 663	54.00
54. 01 05402 CARDIAC NUCLEAR DIAGNOSTIC	0	0	0	0	4, 969	54. 01
54. 02   03450   NUCLEAR MEDICINE - DIAGNOSTIC	0	0	0	0	0	54.02
54. 03   03630   ULTRA SOUND 55. 00   05500   RADI OLOGY - THERAPEUTI C	2, 310 0	0	6, 983 311	0	28 1, 746	54. 03 55. 00
56. 00   05600   RADI 01 SOTOPE	55	0	1, 789		1,740	56.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	21, 651	Ö	12, 802		64	59.00
60. 00   06000   LABORATORY	24, 669	0	6, 137	0	439	60.00
64. 00 06400 I NTRAVENOUS THERAPY	443	0	2, 509		8	64.00
65. 00   06500   RESPI RATORY   THERAPY 66. 00   06600   PHYSI CAL   THERAPY	5, 070 9, 059	0	58, 376 33, 051	0	2, 020 442	65. 00 66. 00
66. 01   06601   SPORTS   MEDI CI NE	9,039	0	33, 031	0	0	66. 01
67. 00 06700 OCCUPATI ONAL THERAPY	o	Ō	12, 204	0	82	67.00
68.00 06800 SPEECH PATHOLOGY	601	0	6, 369	0	21	68. 00
69. 00 06900 ELECTROCARDI OLOGY	11, 678	0	9, 712	0	63	69.00
69. 01   06901   CARDI AC   CATH   LAB 70. 00   07000   ELECTROENCEPHALOGRAPHY	0	0	0 13, 037		0 271	69. 01 70. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		ő	8, 412		537, 805	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	O	0	0	371, 637	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74. 00   07400   RENAL DI ALYSI S 76. 97   07697   CARDI AC   REHABI LI TATI ON	4, 806	0	3, 722 5, 079			74. 00 76. 97
OUTPATIENT SERVICE COST CENTERS	٩	<u> </u>	3,017	<u> </u>	72	70.77
90. 00 09000 CLI NI C	28, 953	0	48, 027	0	563	90.00
90. 01   09001   I BMT JOI NT VENTURE	2, 234	0	19, 366			90. 01
90. 02   09002   PSYCHIATRIC COUNCELING CENTER 90. 03   09003   SOUTH   NDY MRI & REHAB	13, 818	0	12, 017	0	479 151	90. 02 90. 03
90. 04   09004   BARI ATRI CS		0	0	0	0	90.03
90. 05 09005 CV DI AGNOSTI C SERVI CES	o o	Ö	726	0	687	90.05
90. 06   09006   CARDI AC REHAB	0	0	0		0	90. 06
91. 00 09100 EMERGENCY	39, 562	0	80, 132	0	1, 417	
92. 00   O9200   OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS						92.00
101. 00 10100 HOME HEALTH AGENCY	0	0	0	0	2, 295	101.00
SPECIAL PURPOSE COST CENTERS	,				_,_,	
113. 00 11300 INTEREST EXPENSE						113.00
116. 00 11600 HOSPI CE 118. 00  SUBTOTALS (SUM OF LINES 1-117)	4, 561	1 005 247	1 072 171	1 000 740		116.00
118.00 SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS	581, 583	1, 095, 317	1, 073, 171	1, 900, 740	941, 917	1118.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	3, 354	0	2, 757	0	45	190. 00
190.01 19001 MEDICAL OFFICE & PARKING	0	О	0	0		190. 01
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	60, 623	0	18, 252	0	1, 622	192. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS ST. FRANCIS HOSPITAL & HEALTH CENTER
Provider CCN: 150162

					5/26/2015 12:	4/ pm_
Cost Center Description	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	
				ADMI NI STRATI O	SERVICES &	
				N	SUPPLY	
	9. 00	10. 00	11. 00	13.00	14.00	
194.00 07955 MARKETING & COMMUNITY RELATIONS	374	0	916	0	10	194. 00
194. 01 07952 WOMEN' S CENTER	6, 960	0	784	0	216	194. 01
194.02 07950 SOUTH EMERSON SURGERY CENTER	0	0	0	0	10	194. 02
194. 03 07951 SOUTHEAST SURGERY CENTER	0	0	0	0	0	194. 03
194. 04 07954 OTHER NRCC	7, 457	0	2, 080	0	42	194. 04
194. 05 07956 FOUNDATI ON	0	0	2, 514	0	7, 069	194. 05
194.06 07953 FRANCISCAN SURGERY CENTER	14, 545	0	515	0	0	194. 06
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)	674, 896	1, 095, 317	1, 100, 989	1, 900, 740	950, 931	202. 00

| Peri od: | Worksheet B | From 01/01/2014 | Part | I | To | 12/31/2014 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS ST. FRANCIS HOSPITAL & HEALTH CENTER
Provider CCN: 150162

					Т	o 12/31/2014	Date/Time Pre 5/26/2015 12:	
				<u> </u>	INTERNS &	RESI DENTS	0, 20, 20.0	, p
		Cost Center Description	PHARMACY	MEDI CAL		SERVI CES-OTHE	PARAMED ED	
				RECORDS & LI BRARY	RY & FRINGES	R PRGM COSTS	PRGM	
	OFNED	AL CERVICE COST CENTERS	15. 00	16. 00	21. 00	22. 00	23. 00	
1. 00		AL SERVICE COST CENTERS NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4. 00 5. 01		EMPLOYEE BENEFITS DEPARTMENT ADMITTING						4. 00 5. 01
5. 01	1	CASHI ERI NG/ACCOUNTS RECEI VABLE						5.01
5. 03		OTHER ADMIN & GENERAL						5.03
7. 00 8. 00	1	OPERATION OF PLANT LAUNDRY & LINEN SERVICE						7. 00 8. 00
9. 00	1	HOUSEKEEPI NG						9. 00
10.00	1	DIETARY						10.00
11. 00 13. 00		CAFETERIA   NURSI NG ADMINI STRATI ON						11. 00 13. 00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15. 00 16. 00	1	PHARMACY MEDICAL RECORDS & LIBRARY	1, 280, 821	507, 268				15. 00 16. 00
21. 00		I &R SERVICES-SALARY & FRINGES APPRVD	0	0 307, 208				21.00
22. 00	1	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0		35, 388	,	22.00
23. 00 23. 01	1	PARAMED ED PRGM   EMERGENCY MEDICAL SERVICES	0	0			6, 883	23. 00 23. 01
20.01	I NPAT	IENT ROUTINE SERVICE COST CENTERS	5	<u>_</u>				20.01
30. 00 31. 00	1	ADULTS & PEDIATRICS INTENSIVE CARE UNIT	0	25, 390 6, 215				30. 00 31. 00
31. 00		NEONATAL INTENSIVE CARE UNIT	0	4, 276				31.00
32. 00	1	CORONARY CARE UNIT	o	5, 836				32.00
34. 00 41. 00	1	SURGICAL INTENSIVE CARE UNIT SUBPROVIDER - IRF	0	4, 047 2, 180				34. 00 41. 00
43. 00	1	NURSERY	o	1, 543				43.00
50. 00		LARY SERVICE COST CENTERS OPERATING ROOM	ol	43, 453	I			50.00
52. 00	1	DELIVERY ROOM & LABOR ROOM	0	6, 907				52.00
54.00	1	RADI OLOGY-DI AGNOSTI C	0	73, 195				54.00
54. 01 54. 02	1	CARDIAC NUCLEAR DIAGNOSTIC	0	5, 788 0				54. 01 54. 02
54. 03	1	ULTRA SOUND	Ö	5, 688				54. 03
55. 00 56. 00		RADI OLOGY - THERAPEUTI C RADI OI SOTOPE	0	6, 245				55. 00 56. 00
59.00		CARDI AC CATHETERI ZATI ON	0	1, 529 18, 769				59.00
60.00		LABORATORY	o	53, 376				60.00
64. 00 65. 00		I NTRAVENOUS THERAPY   RESPI RATORY THERAPY	0	573 13, 720				64. 00 65. 00
66. 00		PHYSI CAL THERAPY	0	8, 176				66.00
66. 01	1	SPORTS MEDICINE	0	0				66. 01
67. 00 68. 00		OCCUPATIONAL THERAPY SPEECH PATHOLOGY	0	2, 398 1, 526	1			67. 00 68. 00
69. 00	06900	ELECTROCARDI OLOGY	Ö	5, 171				69.00
69. 01 70. 00		CARDI AC CATH LAB ELECTROENCEPHALOGRAPHY	0	0 5, 427				69. 01 70. 00
71.00		MEDICAL SUPPLIES CHARGED TO PATIENTS	0	25, 000				71.00
72.00		IMPL. DEV. CHARGED TO PATIENT	0	19, 849	•			72.00
73. 00 74. 00		DRUGS CHARGED TO PATIENTS RENAL DIALYSIS	1, 280, 821 0	90, 594 1, 528	•			73. 00 74. 00
76. 97	07697	CARDIAC REHABILITATION	ō	417				76. 97
90. 00		TIENT SERVICE COST CENTERS	O	5, 401	I			90.00
90. 00	09001	IBMT JOINT VENTURE		1, 404	•			90.00
90. 02		PSYCHIATRIC COUNCELING CENTER	0	1, 683				90.02
90. 03 90. 04		SOUTH INDY MRI & REHAB BARIATRICS	0	41 0				90. 03 90. 04
90. 05	09005	CV DI AGNOSTI C SERVI CES	ō	7, 526				90. 05
90.06		CARDIAC REHAB EMERGENCY	0	47.049				90. 06 91. 00
		OBSERVATION BEDS (NON-DISTINCT PART)		47, 968				91.00
	OTHER	REIMBURSABLE COST CENTERS	51	0 101	I			
101.00		HOME HEALTH AGENCY AL PURPOSE COST CENTERS	0	2, 421				101. 00
	11300	INTEREST EXPENSE						113. 00
116. 00 118. 00	1	HOSPICE SUBTOTALS (SUM OF LINES 1-117)	0 1, 280, 821	2, 008 507, 268		0	0	116. 00 118. 00
	NONRE	IMBURSABLE COST CENTERS				<u> </u>	0	
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0				190. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 150162

					3/20/2013 12.	47 PIII
			INTERNS &	RESI DENTS		
Cost Center Description	PHARMACY	MEDI CAL	SERVI CES-SALA	SERVI CES-OTHE	PARAMED ED	
		RECORDS &	RY & FRINGES	R PRGM COSTS	PRGM	
		LI BRARY				
	15. 00	16. 00	21.00	22. 00	23. 00	
190.01 19001 MEDICAL OFFICE & PARKING	0	0				190. 01
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0				192.00
194.00 07955 MARKETING & COMMUNITY RELATIONS	0	0				194. 00
194. 01 07952 WOMEN' S CENTER	0	0				194. 01
194.02 07950 SOUTH EMERSON SURGERY CENTER	0	0				194. 02
194. 03 07951 SOUTHEAST SURGERY CENTER	0	0				194. 03
194. 04 07954 OTHER NRCC	0	0				194. 04
194. 05 07956 FOUNDATI ON	0	0				194. 05
194.06 07953 FRANCISCAN SURGERY CENTER	0	0				194.06
200.00 Cross Foot Adjustments			60, 403	35, 388	6, 883	200.00
201.00 Negative Cost Centers	0	0	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	1, 280, 821	507, 268	60, 403	35, 388	6, 883	202. 00

ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 150162 Peri od: Worksheet B From 01/01/2014 Part II Date/Time Prepared: 12/31/2014 5/26/2015 12:47 pm Cost Center Description **EMERGENCY** Subtotal Intern & Total MEDI CAL Resi dents SERVI CES Cost & Post Stepdown Adjustments 23. 01 24.00 25. 00 26.00 GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT 00200 NEW CAP REL COSTS-MVBLE EQUIP 1.00 1.00 2.00 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00570 ADMITTING 5.01 5.01 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 5.02 5.02 00590 OTHER ADMIN & GENERAL 5.03 5.03 7.00 00700 OPERATION OF PLANT 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 11.00 01300 NURSING ADMINISTRATION 13.00 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 14.00 15. 00 | 01500 PHARMACY 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 16.00 02100 I &R SERVICES-SALARY & FRINGES APPRVD 21 00 21 00 22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD 22.00 02300 PARAMED ED PRGM 23.00 23.00 02302 EMERGENCY MEDICAL SERVICES 23.01 23.01 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 11, 033, 873 0 11, 033, 873 30.00 03100 INTENSIVE CARE UNIT 31.00 2,002,451 0 2, 002, 451 31.00 31 01 02060 NEONATAL INTENSIVE CARE UNIT 742, 912 0 742, 912 31 01 03200 CORONARY CARE UNIT 0 32.00 3, 805, 377 3, 805, 377 32.00 34.00 03400 SURGICAL INTENSIVE CARE UNIT 2,090,256 2, 090, 256 34.00 04100 SUBPROVI DER - I RF 41.00 1, 302, 247 0 1, 302, 247 41.00 04300 NURSERY 378<u>,</u> 910 43.00 0 378, 910 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 7, 562, 717 0 7, 562, 717 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 1, 342, 044 0 1, 342, 044 52.00 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 6, 942, 404 6.942.404 54 00 0 54.01 05402 CARDIAC NUCLEAR DIAGNOSTIC 27, 846 27, 846 54.01 03450 NUCLEAR MEDICINE - DIAGNOSTIC 54.02 54.02 54.03 03630 ULTRA SOUND 261, 764 0 261, 764 54.03 0 05500 RADI OLOGY - THERAPEUTI C 55.00 61, 289 61, 289 55.00 56.00 05600 RADI OI SOTOPE 32, 847 32, 847 56.00 59 00 05900 CARDIAC CATHETERIZATION 2,059,684 0 2, 059, 684 59.00 06000 LABORATORY 2, 697, 463 0 2, 697, 463 60.00 60.00 0 06400 I NTRAVENOUS THERAPY 64.00 51, 285 51, 285 64.00 65.00 06500 RESPIRATORY THERAPY 699, 378 0 699, 378 65.00 06600 PHYSI CAL THERAPY 66.00 976, 307 976, 307 66.00 0 06601 SPORTS MEDICINE 66.01 C 0 66.01 67.00 06700 OCCUPATI ONAL THERAPY 47, 655 0 47,655 67.00 68 00 06800 SPEECH PATHOLOGY 80, 785 80, 785 68.00 06900 ELECTROCARDI OLOGY 0 1, 102, 452 1, 102, 452 69.00 69.00 0 06901 CARDI AC CATH LAB 69.01 69 01 07000 ELECTROENCEPHALOGRAPHY 78, 831 78, 831 70.00 70.00 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 1, 124, 690 1, 124, 690 71.00 07200 I MPL. DEV. CHARGED TO PATIENT 0 72.00 769,004 769, 004 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 2, 127, 518 2, 127, 518 73.00 07400 RENAL DIALYSIS 457, 045 0 457, 045 74.00 07697 CARDIAC REHABILITATION 16, 607 76.97 76.97 0 16,607 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 2, 823, 859 0 2, 823, 859 90.00 09001 I BMT JOINT VENTURE 90.01 304, 715 0 304, 715 90.01 09002 PSYCHIATRIC COUNCELING CENTER 0 90.02 90.02 1, 296, 658 1, 296, 658 09003 SOUTH INDY MRI & REHAB 0 90.03 1, 577 1, 577 90.03 90.04 09004 BARI ATRI CS 0 90.04 09005 CV DIAGNOSTIC SERVICES 90.05 196,076 0 196, 076 90.05 90 06 09006 CARDI AC REHAB 0 90 06 0 09100 EMERGENCY 91.00 4,017,938 4, 017, 938 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 0 101.00 106, 730 106, 730 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | NTEREST EXPENSE 113.00 116. 00 11600 HOSPI CE 525 903 O 525 903 116 00 SUBTOTALS (SUM OF LINES 1-117) 118.00 59, 149, 097 0 59, 149, 097 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 313, 683 0 313, 683 190.00

Health Financial Systems	ST. FRANCIS HOSPITA	L & HEALTH CEN	TER	In Lie	u of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der		Period: From 01/01/2014	Worksheet B Part II
				To 12/31/2014	
Cost Center Description	EMERGENCY	Subtotal	Intern &	Total	
	MEDI CAL		Residents		
	SERVI CES		Cost & Post		
			Stepdown		
			Adjustments		
	23. 01	24. 00	25. 00	26. 00	
190.01 19001 MEDICAL OFFICE & PARKING		0	(	0	190. 01
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES		5, 752, 500	(	5, 752, 500	192. 00
194.00 07955 MARKETING & COMMUNITY RELATIONS		134, 033	(	134, 033	194. 00
194. 01 07952 WOMEN' S CENTER		675, 959	(	675, 959	194. 01
194.02 07950 SOUTH EMERSON SURGERY CENTER		3, 892	(	3, 892	194. 02
194.03 07951 SOUTHEAST SURGERY CENTER		7, 907	(	7, 907	194. 03
194. 04 07954 OTHER NRCC		704, 677	(	704, 677	194. 04
194. 05 07956 FOUNDATI ON		26, 705	(	26, 705	194. 05
194.06 07953 FRANCI SCAN SURGERY CENTER		1, 708, 193	(	1, 708, 193	194. 06
200.00 Cross Foot Adjustments	О	102, 674	(	102, 674	200. 00
201.00 Negative Cost Centers	0	0		ol	201.00
202.00 TOTAL (sum lines 118-201)	0	68, 579, 320	(	68, 579, 320	202. 00

	TIMANCIAL SYSTEMS SI. F	-KANCIS HUSPITAL			eri od:	Worksheet B-1	
C031 F	RELOCATION - STATISTICAL BASIS		litovidei	F	rom 01/01/2014		
				T	o 12/31/2014	Date/Time Pre 5/26/2015 12:	
		CAPITAL REL	ATED COSTS			37 207 2013 12.	47 piii
	Cost Center Description	NEW BLDG &	NEW MVBLE	EMPLOYEE	ADMITTING	Reconciliatio	
		FIXT (SQUARE	EQUI P (SQUARE	BENEFITS DEPARTMENT	(I NPATI ENT CHARGES)	n	
		FEET)	FEET)	(GROSS	CHARGES)		
			,	SALARI ES)			
		1. 00	2. 00	4. 00	5. 01	5A. 02	
	GENERAL SERVICE COST CENTERS	704.040				T	
1. 00 2. 00	00100 NEW CAP REL COSTS-BLDG & FIXT 00200 NEW CAP REL COSTS-MVBLE EQUIP	721, 960	721, 960				1. 00 2. 00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	207	721, 900 207	138, 998, 121			4.00
5. 01	00570 ADMI TTI NG	3, 548	3, 548	1, 775, 247	805, 129, 492		5. 01
5.02	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	2, 739	2, 739		0		
5. 03	00590 OTHER ADMIN & GENERAL	22, 475	22, 475	4, 419, 142	0	-	5. 03
7.00	00700 OPERATION OF PLANT	72, 203	72, 203			•	7.00
8. 00 9. 00	O0800   LAUNDRY & LI NEN SERVI CE   O0900   HOUSEKEEPI NG	5, 300 5, 841	5, 300 5, 841	215, 747 3, 260, 052	0		8. 00 9. 00
10.00	01000 DI ETARY	10, 843	10, 843				10.00
11. 00	01100 CAFETERI A	10, 548	10, 548		0		11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	17, 329	17, 329	4, 766, 372	0	0	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	8, 538	8, 538				14.00
15.00	01500 PHARMACY	11, 098	11, 098	4, 634, 001	0	_	15.00
16. 00 21. 00	01600   MEDICAL RECORDS & LIBRARY   02100   I&R SERVICES-SALARY & FRINGES APPRVD	4, 807	4, 807 0	1, 863, 977	0	0	16. 00 21. 00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD		0	1, 316, 758	0	1	22.00
23. 00	02300 PARAMED ED PRGM	O	0	200, 913			23. 00
23. 01	02302 EMERGENCY MEDICAL SERVICES	0	0	0	0	0	23. 01
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	84, 971	84, 971				
31. 00 31. 01	03100   INTENSI VE CARE UNIT   02060   NEONATAL   INTENSI VE CARE UNIT	14, 082 4, 818	14, 082 4, 818	6, 245, 166 2, 407, 045			31. 00 31. 01
32. 00	03200 CORONARY CARE UNIT	31, 030	31, 030				32.00
34. 00	03400 SURGICAL INTENSIVE CARE UNIT	17, 163	17, 163				1
41.00	04100 SUBPROVI DER - I RF	10, 675	10, 675				1
43.00	04300 NURSERY	2, 037	2, 037	637, 376	5, 611, 391	0	43.00
	ANCILLARY SERVICE COST CENTERS	(0.700	(0.700	10 15/ 100	05 440 475	1	
50. 00 52. 00	O5000   OPERATING ROOM   O5200   DELIVERY ROOM & LABOR ROOM	68, 728 12, 043	68, 728 12, 043				50. 00 52. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	63, 559	63, 559	9, 494, 736			54.00
54. 01	05402 CARDI AC NUCLEAR DI AGNOSTI C	0	0	11, 012			54. 01
54.02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0	0	0	0	0	54.02
54. 03	03630 ULTRA SOUND	2, 087	2, 087	826, 852			54.03
55.00	05500 RADI OLOGY - THERAPEUTI C	0	0	27, 600			55.00
56. 00 59. 00	05600   RADI OI SOTOPE   05900   CARDI AC   CATHETERI ZATI ON	50 19, 558	50 19, 558	231, 811 1, 479, 570	1, 283, 550 31, 644, 912		56. 00 59. 00
60.00	06000 LABORATORY	22, 284	22, 284	752, 969			60.00
64.00	06400 I NTRAVENOUS THERAPY	400	400				1
65.00	06500 RESPI RATORY THERAPY	4, 580	4, 580	5, 723, 107	44, 657, 475	0	65.00
66.00	06600 PHYSI CAL THERAPY	8, 183	8, 183		15, 226, 886		
66. 01	06601 SPORTS MEDICINE	0	0	0	0	0	66. 01
67. 00 68. 00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	543	543	1, 226, 705 704, 107	5, 269, 354 2, 438, 277		67. 00 68. 00
69.00	06900 ELECTROCARDI OLOGY	10, 549	10, 549		12, 661, 174		69.00
69. 01	06901 CARDI AC CATH LAB	0	0	0	0	0	69. 01
70.00	07000 ELECTROENCEPHALOGRAPHY	O	0	1, 219, 209	1, 516, 926		70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	61, 283, 556		71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	0	0	0	23, 868, 371	0	72.00
73. 00 74. 00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	0 4, 341	4, 341	507, 031	122, 839, 990 5, 286, 911		73. 00 74. 00
76. 97	07697 CARDI AC REHABILI TATI ON	4, 341	4, 341	410, 926			
	OUTPATIENT SERVICE COST CENTERS	-1			.,,,,,,,		
90.00	09000 CLI NI C	26, 154	26, 154		242, 486	0	
90. 01	09001 I BMT JOINT VENTURE	2, 018	2, 018				
90. 02	09002 PSYCHI ATRI C COUNCELI NG CENTER	12, 482	12, 482	1, 140, 261	969		90.02
90. 03 90. 04	09003 SOUTH INDY MRI & REHAB 09004 BARIATRICS	0	0	252	108	0	90. 03 90. 04
	09005 CV DI AGNOSTI C SERVI CES		0	4, 571, 672	195, 749		90.05
90.06	09006 CARDI AC REHAB	0	0	0	0	0	90.06
91.00	09100 EMERGENCY	35, 737	35, 737	7, 404, 168	42, 146, 576	0	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
101 00	OTHER REIMBURSABLE COST CENTERS 10100 HOME HEALTH AGENCY	0	0	2, 548, 808	0		101.00
101.00	SPECIAL PURPOSE COST CENTERS	<u> </u>	0	2, 348, 808	0	1 0	1101.00
113. 00	11300 I NTEREST EXPENSE						113.00
116.00	11600 H0SPI CE	4, 120	4, 120				116. 00
118.00	SUBTOTALS (SUM OF LINES 1-117)	637, 668	637, 668	136, 481, 629	805, 129, 492	-7, 351, 660	118. 00

Health Financial Systems ST.	FRANCIS HOSPITA	L & HEALTH CEN	TER	In Lie	eu of Form CMS-	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der		Peri od:	Worksheet B-1	
				From 01/01/2014 To 12/31/2014		nared:
				12/31/2014	5/26/2015 12:	
	CAPI TAL REL	ATED COSTS				
	NEW BLBC &	115111 111/01 5		15111 771 110		
Cost Center Description	NEW BLDG & FLXT	NEW MVBLE	EMPLOYEE	ADMITTING	Reconciliatio	
	(SQUARE	EQUI P (SQUARE	BENEFITS DEPARTMENT	(I NPATI ENT CHARGES)	n	
	FEET)	FEET)	(GROSS	CHARGES)		
	1 1 1 1	ILLI)	SALARI ES)			
	1. 00	2. 00	4.00	5. 01	5A. 02	
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	3, 030	3, 030	119, 73	5 0		190. 00
190.01 19001 MEDICAL OFFICE & PARKING	0	0	(	0		190. 01
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	54, 762	54, 762				192. 00
194.00 07955 MARKETING & COMMUNITY RELATIONS	338	338				194. 00
194. 01 07952 WOMEN' S CENTER	6, 287	6, 287	49, 415	5 0		194. 01
194.02 07950 SOUTH EMERSON SURGERY CENTER	0	0	(	0		194. 02
194. 03 07951 SOUTHEAST SURGERY CENTER	0	0	(	0		194. 03
194. 04 07954 OTHER NRCC	6, 736	6, 736				194. 04
194. 05 07956 FOUNDATI ON	0	0	176, 318			194. 05
194.06 07953 FRANCISCAN SURGERY CENTER	13, 139	13, 139	58, 498	3 0	0	194. 06
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers						201.00
202.00 Cost to be allocated (per Wkst. B,	45, 377, 598	17, 078, 620	35, 544, 599	5, 323, 307		202. 00
Part I) 203.00 Unit cost multiplier (Wkst. B, Part I)	62. 853341	23. 655909	0. 255720	0. 006612		203. 00
204.00 Cost to be allocated (per Wkst. B,	02. 003341	23. 000909	17, 908			203.00
Part II)			17, 900	307, 104		204.00
205.00 Unit cost multiplier (Wkst. B, Part			0. 000129	0. 000382		205. 00
			3.00012	3,00002		
			•	•	•	•

Heal th	Financial Systems ST.	FRANCIS HOSPITAL	& HEALTH CEN	ΓER	In Lie	u of Form CMS-2	2552-10
COST A	ALLOCATION - STATISTICAL BASIS		Provi der	CCN: 150162 P	eriod: rom 01/01/2014	Worksheet B-1	
					o 12/31/2014	Date/Time Pre	pared:
	Cost Center Description	CASHI ERI NG/AC	Posopoi Li ati o	OTHER ADMIN ®	OPERATION OF	5/26/2015 12: LAUNDRY &	47 pm
	cost center bescription	COUNTS	n	GENERAL	PLANT	LINEN SERVICE	
		RECEI VABLE		(ACCUM. COST)	(SQUARE	(POUNDS OF	
		(ACCUM. COST)			FEET)	LAUNDRY)	
	GENERAL SERVICE COST CENTERS	5. 02	5A. 03	5. 03	7. 00	8. 00	
1. 00	00100 NEW CAP REL COSTS-BLDG & FLXT						1.00
2. 00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 01	00570 ADMITTING						5. 01
5. 02 5. 03	OO580   CASHI ERI NG/ACCOUNTS RECEI VABLE   OO590   OTHER ADMI N & GENERAL	525, 756, 400	04 000 570	436, 227, 490			5. 02 5. 03
7. 00	00700 OPERATION OF PLANT	95, 544, 562 26, 490, 027	-96, 880, 570 0	26, 860, 437			7.00
8. 00	00800 LAUNDRY & LINEN SERVICE	1, 822, 316	o	1, 847, 797		•	
9. 00	00900 HOUSEKEEPI NG	5, 469, 707	o	5, 546, 190	5, 841	0	9. 00
10.00	01000 DI ETARY	1, 407, 450	0	1, 427, 130			
11. 00 13. 00	O1100   CAFETERI A   O1300   NURSI NG   ADMI NI STRATI ON	3, 199, 217	0	3, 243, 952			
14. 00	01400 CENTRAL SERVICES & SUPPLY	7, 934, 843 4, 292, 074	0	8, 045, 796 4, 352, 090			
15. 00	01500 PHARMACY	7, 448, 351	o	7, 552, 501			
	01600 MEDICAL RECORDS & LIBRARY	1, 749, 143	o	1, 773, 601	4, 807	0	16. 00
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRVD	2, 303, 456	0	2, 335, 665		•	21.00
22. 00	O2200   1 & R SERVICES-OTHER PRGM COSTS APPRVD   O2300   PARAMED ED PRGM	1, 651, 595	0	1, 674, 689 261, 465		•	
23. 00 23. 01	02302 EMERGENCY MEDICAL SERVICES	257, 859 0	0	201, 403			1
20.0.	INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>	<u> </u>				20.0.
30. 00	03000 ADULTS & PEDIATRICS	33, 118, 942	0	33, 582, 044			1
31.00	03100   INTENSIVE CARE UNIT   02060   NEONATAL   INTENSIVE CARE UNIT	9, 371, 545	0	9, 502, 587			1
31. 01	03200 CORONARY CARE UNIT	4, 226, 272 11, 670, 200	0	4, 285, 368 11, 833, 384			1
34. 00	03400 SURGICAL INTENSIVE CARE UNIT	5, 821, 544	ő	5, 902, 947			
41.00	04100 SUBPROVI DER - I RF	2, 927, 152	0	2, 968, 082			1
43.00	04300 NURSERY	1, 023, 970	0	1, 038, 288	2, 037	9, 705	43.00
50. 00	ANCILLARY SERVICE COST CENTERS    O5000   OPERATING ROOM	28, 983, 755	ol	29, 389, 035	68, 728	201, 002	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	4, 073, 114	0	4, 130, 068			
54. 00	05400 RADI OLOGY-DI AGNOSTI C	24, 871, 937	Ō	25, 219, 721			1
54. 01	05402 CARDIAC NUCLEAR DIAGNOSTIC	880, 730	0	893, 045		-	
	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0	0	1 201 270	_	0	
54. 03 55. 00	03630  ULTRA SOUND   05500  RADI OLOGY - THERAPEUTI C	1, 263, 700 2, 743, 864	0	1, 281, 370 2, 782, 231			
56. 00	05600 RADI OI SOTOPE	1, 171, 223	o	1, 187, 600		_	
59. 00	05900 CARDI AC CATHETERI ZATI ON	3, 794, 260	0	3, 847, 315			
60.00	06000 LABORATORY	21, 318, 286	0	21, 616, 380			
64. 00 65. 00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	416, 070 8, 097, 966	0	421, 888 8, 211, 200			
	06600 PHYSI CAL THERAPY	5, 928, 839	0	6, 011, 742			66.00
	06601 SPORTS MEDICINE	0	Ō	0			66. 01
	06700 OCCUPATI ONAL THERAPY	1, 595, 501	0	1, 617, 811		0	
68. 00 69. 00	06800 SPEECH PATHOLOGY	951, 147	0	964, 447			
69. 00	O6900  ELECTROCARDI OLOGY   O6901  CARDI AC CATH LAB	2, 157, 677	0	2, 187, 848 0			1
70. 00	07000 ELECTROENCEPHALOGRAPHY	3, 053, 016	Ö	3, 095, 706			70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	27, 458, 738	0	27, 842, 694	0	0	
	07200 I MPL. DEV. CHARGED TO PATIENT	19, 084, 148	0	19, 351, 002		0	
73.00	O7300   DRUGS CHARGED TO PATIENTS   O7400   RENAL DIALYSIS	36, 752, 110 1, 057, 848	0	37, 266, 015 1, 072, 640		6 100	73. 00 74. 00
	07697 CARDI AC REHABI LI TATI ON	568, 016	0	575, 959			1
	OUTPATIENT SERVICE COST CENTERS		-	2.2,.2.	_		
90.00	09000 CLI NI C	9, 790, 660	0	9, 927, 563			
90. 01	09001 I BMT JOINT VENTURE 09002 PSYCHIATRIC COUNCELING CENTER	4, 214, 017 2, 736, 251	0	4, 272, 942			1
90. 02	09003 SOUTH INDY MRI & REHAB	71, 684	0	2, 774, 512 72, 686		0	
	09004 BARI ATRI CS	0	o	72,000	0	Ö	1
90. 05	09005 CV DI AGNOSTI C SERVI CES	9, 659, 754	0	9, 794, 826	0	0	
	09006 CARDI AC REHAB	0	0	12 20/ 002	0	0	
91. 00 92. 00	O9100   EMERGENCY   O9200   OBSERVATION   BEDS (NON-DISTINCT PART)	13, 123, 379	U U	13, 306, 883	35, 737	366, 577	91. 00 92. 00
,2.00	OTHER REIMBURSABLE COST CENTERS				I.		72.00
101.00	10100 HOME HEALTH AGENCY	5, 267, 523	0	5, 341, 179	0	0	101.00
113 00	SPECIAL PURPOSE COST CENTERS   11300 INTEREST EXPENSE						113. 00
	11600 HOSPI CE	6, 048, 549	О	6, 133, 126	4, 120	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	474, 863, 987	-96, 880, 570	384, 623, 447			118.00
190 00	NONREIMBURSABLE COST CENTERS   19000   GIFT, FLOWER, COFFEE SHOP & CANTEEN	642, 513	0	651, 497	3, 030	0	190. 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	042, 513	o	051, 497			190.00
		. 1	-1				

Health Financial Systems	ST. FRANCIS HOSPITAL & HEALTH CENTER	In Lieu of Form CMS-2552-10	
COST ALLOCATION STATISTICAL DASIS	Provider CCN: 150163 Period:	Workshoot P 1	

Period: From 01/01/2014 To 12/31/2014 Date/Time Prepared: 5/26/2015 12:47 pm Cost Center Description CASHIERING/AC Reconciliatio OTHER ADMIN & OPERATION OF LAUNDRY & COUNTS GENERAL PLANT LINEN SERVICE n RECEI VABLE (ACCUM. COST) (SQUARE (POUNDS OF (ACCUM. COST) LAUNDRY) FEET) 5A. 03 5.03 5.02 7.00 8.00 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 17, 763, 359 17, 518, 399 54, 762 0 192.00 194.00 07955 MARKETING & COMMUNITY RELATIONS 5, 170, 107 5, 242, 401 338 0 194.00 12, 324 194. 01 194. 01 07952 WOMEN' S CENTER 2, 713, 264 2, 751, 204 6, 287 0 194.02 194. 02 07950 SOUTH EMERSON SURGERY CENTER 201, 095 0 203, 907 0 194. 03 07951 SOUTHEAST SURGERY CENTER 409, 564 415, 291 0 194. 03 6, 289 194. 04 3 194. 05 194. 04 07954 OTHER NRCC 1, 934, 272 0 1, 961, 319 6, 736 194. 05 07956 FOUNDATI ON 885, 758 0 898, 144 194.06 07953 FRANCI SCAN SURGERY CENTER 21, 417, 441 21, 716, 921 13, 139 0 194.06 200.00 Cross Foot Adjustments 200.00 201.00 201.00 Negative Cost Centers 202.00 Cost to be allocated (per Wkst. B, 7, 351, 660 96, 880, 570 32, 825, 791 2, 538, 420 202. 00 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 0.013983 0. 222087 52. 877618 1. 228671 203. 00 204.00 Cost to be allocated (per Wkst. B, 236, 949 8, 110, 887 551, 403 204. 00 6, 758, 214 Part II) 205.00 Unit cost multiplier (Wkst. B, Part 0.000451 0.018593 10.886509 0. 266895 205. 00 11)

Health Financ	ial Systems ST. I ION - STATISTICAL BASIS	FRANCIS HOSPITA			<u>In Lie</u> Period:	u of Form CMS-2 Worksheet B-1	
COST ALLOCATI	TON - STATISTICAL BASIS		Trovider	F	rom 01/01/2014 o 12/31/2014		
	Cost Center Description	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	5/26/2015 12: CENTRAL	47 pm
	·	(SQUARE FEET)	(TOTAL PATIENT DAYS)	(FTES)	ADMI NI STRATI O N	SERVICES & SUPPLY	
		TLL1)	TATIENT DATS)		(TOTAL	(COSTED	
		9. 00	10. 00	11. 00	PATIENT DAYS) 13.00	REQUIS.) 14.00	
	L SERVICE COST CENTERS						1.00
	NEW CAP REL COSTS-BLDG & FIXT NEW CAP REL COSTS-MVBLE EQUIP						1. 00 2. 00
	EMPLOYEE BENEFITS DEPARTMENT ADMITTING						4. 00 5. 01
5. 02 00580	CASHI ERI NG/ACCOUNTS RECEI VABLE						5. 02
1 1	OTHER ADMIN & GENERAL OPERATION OF PLANT						5. 03 7. 00
8. 00   00800	LAUNDRY & LINEN SERVICE						8.00
	HOUSEKEEPI NG DI ETARY	609, 647 10, 843	l .				9.00
	CAFETERI A	10, 548	O	3, 769, 689			11.00
	NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY	17, 329 8, 538		136, 558 84, 797		48, 427, 039	13. 00 14. 00
	PHARMACY MEDICAL RECORDS & LIBRARY	11, 098		141, 896	1	92, 393	1
	I&R SERVICES-SALARY & FRINGES APPRVD	4, 807 0	0	52, 256	1	0 22, 154	
	I&R SERVICES-OTHER PRGM COSTS APPRVD PARAMED ED PRGM	0	0	11, 422 6, 411		0 386	
23. 01 02302	EMERGENCY MEDICAL SERVICES	0		0, 411		0	1
	ENT ROUTINE SERVICE COST CENTERS  ADULTS & PEDIATRICS	84, 971	49, 124	698, 755	49, 124	119, 925	30.00
31. 00   03100	INTENSIVE CARE UNIT	14, 082	9, 739	204, 343	9, 739	40, 795	31.00
1 1	NEONATAL INTENSIVE CARE UNIT CORONARY CARE UNIT	4, 818 31, 030		64, 861 234, 600		11, 116 35, 260	31.01
34. 00 03400	SURGICAL INTENSIVE CARE UNIT	17, 163	6, 673	118, 830	6, 673	23, 901	34.00
	SUBPROVI DER – I RF NURSERY	10, 675 2, 037				8, 153 5, 320	1
ANCI LL	ARY SERVICE COST CENTERS	·					1
	OPERATING ROOM DELIVERY ROOM & LABOR ROOM	68, 728 12, 043	1	329, 488 74, 859		305, 311 36, 386	1
1 1	RADIOLOGY-DIAGNOSTIC CARDIAC NUCLEAR DIAGNOSTIC	63, 559 0	0	279, 268 0	1	84, 690 253, 053	1
1 1	NUCLEAR MEDICINE - DIAGNOSTIC	0	0	O		253, 053	1
	ULTRA SOUND RADIOLOGY - THERAPEUTIC	2, 087	0	23, 910 1, 065		1, 448 88, 918	1
56. 00 05600 1	RADI OI SOTOPE	50	O	6, 126	O	246	56.00
	CARDI AC CATHETERI ZATI ON LABORATORY	19, 558 22, 284	0	43, 833 21, 011		3, 256 22, 346	
64.00 06400	INTRAVENOUS THERAPY	400	0	8, 592	. 0	412	64.00
	RESPI RATORY THERAPY PHYSI CAL THERAPY	4, 580 8, 183	1	199, 873 113, 162		102, 848 22, 515	65.00
	SPORTS MEDICINE	0	o	O	O	0	66. 01
	OCCUPATIONAL THERAPY SPEECH PATHOLOGY	0 543	0	41, 786 21, 807		4, 187 1, 072	1
	ELECTROCARDI OLOGY	10, 549	0	33, 253 0	0	3, 201	1
	CARDI AC CATH LAB ELECTROENCEPHALOGRAPHY	0	0	44, 639	-	0 13, 777	
	MEDICAL SUPPLIES CHARGED TO PATIENTS IMPL. DEV. CHARGED TO PATIENT	0	0	28, 802 0	1	27, 387, 810 18, 926, 330	1
73. 00 07300 1	DRUGS CHARGED TO PATIENTS	0	o o	0	O	0	73.00
	RENAL DIALYSIS CARDIAC REHABILITATION	4, 341	0	12, 743 17, 389		1, 761 4, 670	74. 00 76. 97
OUTPAT	LENT SERVICE COST CENTERS		, s			·	1
90. 00   09000   90. 01   09001	CLINIC IBMT JOINT VENTURE	26, 154 2, 018	0	164, 439 66, 308		28, 694 10, 681	1
90. 02   09002   1	PSYCHIATRIC COUNCELING CENTER	12, 482	o	41, 146		24, 398	90.02
	SOUTH INDY MRI & REHAB BARIATRICS	0	0	0	0	7, 677 0	1
	CV DIAGNOSTIC SERVICES CARDIAC REHAB	0	0	2, 485	0	35, 005 0	90. 05 90. 06
91. 00 09100	EMERGENCY	35, 737	o o	274, 366	ő	72, 138	1
	OBSERVATION BEDS (NON-DISTINCT PART) REIMBURSABLE COST CENTERS						92.00
101. 00 10100 I	HOME HEALTH AGENCY	0	0	C	0	116, 884	101. 00
	L PURPOSE COST CENTERS INTEREST EXPENSE						113.00
116. 00 11600 1	HOSPI CE	4, 120		0	0		116.00
	SUBTOTALS (SUM OF LINES 1-117) MBURSABLE COST CENTERS	525, 355	90, 782	3, 674, 442	90, 782	47, 967, 991	J118. 00
	GIFT, FLOWER, COFFEE SHOP & CANTEEN	3, 030	0	9, 440	0	2, 308	190. 00

COST ALLOCATION - STATISTICAL BASIS Provi der CCN: 150162 Peri od: Worksheet B-1 From 01/01/2014 12/31/2014 Date/Time Prepared: 5/26/2015 12:47 pm Cost Center Description HOUSEKEEPI NG DI ETARY CAFETERI A NURSI NG CENTRAL (SQUARE (TOTAL (FTES) ADMI NI STRATI O SERVICES & FEET) PATIENT DAYS) SUPPLY Ν (TOTAL (COSTED PATIENT DAYS) REQUIS. ) 9. 00 10.00 11.00 13.00 14.00 190. 01 19001 MEDICAL OFFICE & PARKING 0 190. 01 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 62, 492 0 82, 589 192. 00 54, 762 0 194.00 07955 MARKETING & COMMUNITY RELATIONS 0 500 194.00 338 3, 138 0 194. 01 07952 WOMEN' S CENTER 6, 287 2,683 11, 024 194. 01 194. 02 07950 SOUTH EMERSON SURGERY CENTER 0 497 194. 02 0 0 0 0 194. 03 07951 SOUTHEAST SURGERY CENTER 0 194.03 0 0 0 194. 04 07954 OTHER NRCC 0 2, 143 194. 04 6,736 7, 121 194. 05 07956 FOUNDATI ON 0 8,609 0 359, 987 194. 05 194.06 07953 FRANCI SCAN SURGERY CENTER 13, 139 1,764 0 194.06 200.00 200.00 Cross Foot Adjustments 201.00 Negative Cost Centers 201.00 202.00 Cost to be allocated (per Wkst. B, 7, 086, 785 2, 443, 472 4, 644, 759 11, 119, 192 5, 983, 218 202. 00 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 11. 624407 26. 915820 122. 482342 0. 123551 203. 00 1.232133 204.00 Cost to be allocated (per Wkst. B, 674, 896 1, 095, 317 1, 100, 989 1, 900, 740 950, 931 204. 00 Part II)

1. 107028

12.065354

0.292064

20. 937410

In Lieu of Form CMS-2552-10

0. 019636 205. 00

205.00

11)

Unit cost multiplier (Wkst. B, Part

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS ST. FRANCIS HOSPITAL & HEALTH CENTER In Lieu of Form CMS-2552-10 Provi der CCN: 150162 Peri od: From 01/01/2014 To 12/31/2014 Worksheet B-1 Date/Time Prepared: 5/26/2015 12:47 pm INTERNS & RESIDENTS

Cost Center Description	PHARMACY (COSTED REQUIS.)	MEDI CAL RECORDS & LI BRARY (GROSS CHARGES) 16.00	SERVI CES-SALA RY & FRI NGES (ASSI GNED TI ME)	SERVI CES-OTHE R PRGM COSTS (ASSI GNED TI ME)	PARAMED ED PRGM (ASSI GNED TI ME)	
GENERAL SERVICE COST CENTERS	13.00	10.00	21.00	22.00	25.00	
1. 00	100 0 0 0 0	1, 842, 736, 340 0 0 0 0 0	2, 072	2, 072	100 0	1.00 2.00 4.00 5.01 5.02 5.03 7.00 8.00 9.00 10.00 11.00 13.00 14.00 15.00 16.00 21.00 22.00 23.00
INPATIENT ROUTINE SERVICE COST CENTERS  30. 00 03000 ADULTS & PEDIATRICS	0	92, 327, 389	1, 438	1, 438	0	30. 00
31.00   03100   INTENSI VE CARE UNI T 31.01   02060   NEONATAL   INTENSI VE CARE UNI T 32.00   03200   CORONARY CARE UNI T 34.00   03400   SURGI CAL   INTENSI VE CARE UNI T 41.00   04100   SUBPROVI DER -   I RF	0 0 0	22, 598, 300 15, 547, 341 21, 221, 676 14, 716, 168 7, 926, 619	73 54 0 0	73 54 0 0	0 0 0 0	31. 00 31. 01 32. 00 34. 00 41. 00
43. 00 O4300 NURSERY	0	5, 611, 391	0	0	0	43.00
ANCI LLARY SERVI CE COST CENTERS  50. 00   05000   OPERATI NG ROOM  52. 00   05200   DELI VERY ROOM & LABOR ROOM  54. 00   05400   RADI OLOGY-DI AGNOSTI C  54. 01   05402   CARDI AC NUCLEAR DI AGNOSTI C  54. 02   03450   NUCLEAR MEDI CI NE - DI AGNOSTI C  54. 03   03630   ULTRA SOUND  55. 00   05500   RADI OLOGY - THERAPEUTI C  56. 00   05600   RADI OLOGY - THERAPEUTI C  56. 00   05600   RADI OLOGY - THERAPEUTI C  56. 00   05900   CARDI AC CATHETERI ZATI ON  60. 00   06400   LABORATORY  64. 00   06400   INTRAVENOUS THERAPY  65. 00   06500   RESPI RATORY THERAPY  66. 01   06601   SPORTS MEDI CI NE  67. 00   06700   OCCUPATI ONAL THERAPY  68. 00   06800   SPEECH PATHOLOGY  69. 01   06901   CARDI AC CATH LAB  70. 00   07000   ELECTROCARDI OLOGY  69. 01   06901   CARDI AC CATH LAB  70. 00   07000   ELECTROENCEPHALOGRAPHY  71. 00   07100   MEDI CAL SUPPLI ES CHARGED TO PATI ENTS  72. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS  74. 00   07697   CARDI AC REHABI LI TATI ON  OUTPATI ENT SERVI CE COST CENTERS	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	25, 115, 804 266, 162, 844 21, 045, 898 0 20, 685, 446 22, 707, 647 5, 559, 787 68, 251, 478 194, 096, 047 2, 082, 896 49, 890, 678 29, 730, 769 0 8, 718, 361 5, 550, 146 18, 802, 925 0 19, 734, 764 90, 910, 450 72, 177, 363 327, 568, 031 5, 555, 055	0 0 0 0 0 0 0 0 0 43 43 43 0 0 0 0 0 66 0	162 0 0 0 0 0 0 0 0 0 0 43 43 43 0 0 0 0 0	0 0 0 0 0 0 0 0 1000 0 0 0 0 0 0 0 0 0	50. 00 52. 00 54. 01 54. 02 54. 03 55. 00 56. 00 59. 00 60. 00 64. 00 66. 01 67. 00 68. 00 69. 01 70. 00 71. 00 72. 00 73. 00 74. 00 76. 97
90. 00   09000   CLINIC   90. 01   09001   IBMT JOINT VENTURE   90. 02   09002   PSYCHIATRIC COUNCELING CENTER   90. 03   09003   SOUTH INDY MRI & REHAB   90. 04   09004   BARIATRICS   90. 05   09005   CV DIAGNOSTIC SERVICES   90. 06   09006   CARDIAC REHAB   91. 00   09100   EMERGENCY   92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART)   OTHER REIMBURSABLE COST CENTERS	0 0 0 0 0 0 0	19, 639, 045 5, 104, 463 6, 120, 329 149, 986 0 27, 366, 690 0 174, 430, 576	0 0 0 0 0 0 63	0 0 0 0 0 0 0 0 63	0 0 0 0 0 0 0	90. 00 90. 01 90. 02 90. 03 90. 04 90. 05 90. 06 91. 00 92. 00
101. 00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0	8, 805, 179	0	0	0	101. 00
113.00   11300   INTEREST EXPENSE 116.00   11600   HOSPI CE 118.00   SUBTOTALS (SUM OF LINES 1-117)	0 100	7, 300, 668 1, 842, 736, 340		0 2, 072	0	113. 00 116. 00 118. 00

Health Financial Systems ST. F	RANCIS HOSPITA	L & HEALTH CEN	TER	In Lie	u of Form CMS-	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der		Period: From 01/01/2014	Worksheet B-1	
				o 12/31/2014	Date/Time Pre	pared:
					5/26/2015 12:	47 pm
			INTERNS &	RESI DENTS		
Cost Center Description	PHARMACY	MEDI CAL	CEDVICES SALA	SERVI CES-OTHE	PARAMED ED	
cost center bescription	(COSTED	RECORDS &	RY & FRINGES	R PRGM COSTS	PRGM	
	REQUIS.)	LI BRARY	(ASSI GNED	(ASSI GNED	(ASSI GNED	
	KLQUI 3. )	(GROSS	TIME)	TIME)	TIME)	
		CHARGES)	I I IVIL)	TTWL)	I I WIL)	
	15. 00	16. 00	21.00	22. 00	23. 00	
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	C	0		190. 00
190.01 19001 MEDICAL OFFICE & PARKING	0	0	C	0		190. 01
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	0	0	C	0		192. 00
194.00 07955 MARKETING & COMMUNITY RELATIONS	0	0	C	0		194.00
194. 01 07952 WOMEN' S CENTER	0	0	[ C	0		194. 01
194.02 07950 SOUTH EMERSON SURGERY CENTER	0	0	[ C	0		194. 02
194. 03 07951 SOUTHEAST SURGERY CENTER	0	0	C	0		194. 03
194. 04 07954 OTHER NRCC	0	0	C	0		194. 04
194. 05 07956 FOUNDATI ON	0	0	C	0		194. 05
194.06 07953 FRANCI SCAN SURGERY CENTER	0	0	C	0	0	194. 06
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers						201.00
202.00 Cost to be allocated (per Wkst. B,	10, 131, 907	2, 477, 557	2, 921, 509	2, 060, 689	327, 480	202.00
Part I) 203.00 Unit cost multiplier (Wkst. B, Part I)	101, 319. 07000	0. 001344	1, 409. 994691	994. 541023	3, 274. 800000	203 00
203.00 Unit cost martipires (wkst. b, rait 1)	0	0.001344	1, 407. 774071	774. 541025	3, 274. 000000	203.00
204.00 Cost to be allocated (per Wkst. B,	1, 280, 821	507, 268	60, 403	35, 388	6, 883	204.00
Part II)			, , , , ,			
205.00 Unit cost multiplier (Wkst. B, Part	12, 808. 210000	0. 000275	29. 152027	17. 079151	68. 830000	205.00

Health FinancialSystemsST. FRANCIS HOSPITAL & HEALTH CENTERIn Lieu of Form CMS-2552-10COST ALLOCATION - STATISTICAL BASISProvider CCN: 150162Period: Worksheet B-1

From 01/01/2014 12/31/2014 Date/Time Prepared: 5/26/2015 12:47 pm Cost Center Description **EMERGENCY** MEDI CAL SERVI CES (ASSLGNED TIME) 23. 01 GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 1.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 2.00 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00570 ADMITTING 5.01 5.01 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 5.02 5.02 00590 OTHER ADMIN & GENERAL 5.03 5.03 7.00 00700 OPERATION OF PLANT 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 11.00 13.00 01300 NURSING ADMINISTRATION 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 14.00 15. 00 | 01500 PHARMACY 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 16.00 02100 I &R SERVICES-SALARY & FRINGES APPRVD 21 00 21 00 22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD 22.00 02300 PARAMED ED PRGM 23.00 23.00 02302 EMERGENCY MEDICAL SERVICES 23.01 23.01 INPATIENT ROUTINE SERVICE COST CENTERS 30. 00 | 03000 | ADULTS & PEDI ATRI CS 0 30.00 31.00 03100 INTENSIVE CARE UNIT 0 0 0 31.00 31 01 02060 NEONATAL INTENSIVE CARE UNIT 31 01 03200 CORONARY CARE UNIT 32.00 32.00 34.00 03400 SURGICAL INTENSIVE CARE UNIT 34.00 04100 SUBPROVI DER - I RF 0 41.00 41.00 0 04300 NURSERY 43.00 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0000000000000000000000 52.00 05400 RADI OLOGY-DI AGNOSTI C 54 00 54 00 54.01 05402 CARDIAC NUCLEAR DIAGNOSTIC 54.01 03450 NUCLEAR MEDICINE - DIAGNOSTIC 54.02 54.02 54.03 03630 ULTRA SOUND 54.03 05500 RADI OLOGY - THERAPEUTI C 55.00 55.00 56.00 05600 RADI OI SOTOPE 56.00 59.00 05900 CARDIAC CATHETERIZATION 59.00 06000 LABORATORY 60.00 60.00 06400 I NTRAVENOUS THERAPY 64.00 64.00 65.00 06500 RESPIRATORY THERAPY 65.00 06600 PHYSI CAL THERAPY 66.00 66.00 06601 SPORTS MEDICINE 66.01 66.01 67.00 06700 OCCUPATIONAL THERAPY 67.00 68 00 06800 SPEECH PATHOLOGY 68.00 06900 ELECTROCARDI OLOGY 69.00 69.00 69.01 06901 CARDI AC CATH LAB 69 01 07000 ELECTROENCEPHALOGRAPHY 70.00 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 07200 IMPL. DEV. CHARGED TO PATIENT 72.00 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 73.00 74.00 07400 RENAL DIALYSIS 0 74.00 0 07697 CARDIAC REHABILITATION 76.97 76.97 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 90.00 09001 I BMT JOINT VENTURE 90.01 0 0 0 90.01 09002 PSYCHIATRIC COUNCELING CENTER 90.02 90.02 09003 SOUTH INDY MRI & REHAB 90.03 90.03 90. 04 | 09004 BARI ATRI CS 90.04 09005 CV DIAGNOSTIC SERVICES 90.05 0 90.05 90 06 09006 CARDI AC REHAB 90 06 09100 EMERGENCY 91.00 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 101.00 0 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | NTEREST EXPENSE 113.00 116. 00 11600 HOSPI CE 0 116 00 118.00 SUBTOTALS (SUM OF LINES 1-117) 0 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190.00

Health Financial Systems	ST. FRANCIS HOSPITAL & HEALTH CENTER	In Lieu of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS	Provi der CCN: 150162 Peri From To	m 01/01/2014 12/31/2014 Date/Time Prepared:
		E/2//201E 12.47 nm

			To	0 12/31/2014   Date/Time Prepared:   5/26/2015 12:47 pm
	Cost Center Description	EMERGENCY MEDI CAL SERVI CES (ASSI GNED TI ME) 23. 01		3/20/2013 12. 47 piii
190. 01 190	O1 MEDICAL OFFICE & PARKING	0		190. 01
192. 00 192	OO PHYSICIANS' PRIVATE OFFICES	0		192. 00
194. 00 079	55 MARKETING & COMMUNITY RELATIONS	0		194. 00
194. 01 079	52 WOMEN'S CENTER	0		194. 01
194. 02 079	50 SOUTH EMERSON SURGERY CENTER	0		194. 02
194. 03 079	51 SOUTHEAST SURGERY CENTER	0		194. 03
194. 04 079	54 OTHER NRCC	0		194. 04
194. 05 079	56 FOUNDATI ON	0		194. 05
194. 06 079	53 FRANCISCAN SURGERY CENTER	0		194. 06
200. 00	Cross Foot Adjustments			200.00
201.00	Negative Cost Centers			201.00
202. 00	Cost to be allocated (per Wkst. B,	0		202.00
	Part I)			
203.00	Unit cost multiplier (Wkst. B, Part I)	0. 000000		203.00
204. 00	Cost to be allocated (per Wkst. B,	0		204.00
	Part II)			
205. 00	Unit cost multiplier (Wkst. B, Part	0. 000000		205. 00
	11)			

Part I

Peri od:

From 01/01/2014 Date/Time Prepared: 12/31/2014 5/26/2015 12:47 pm Title XVIII Hospi tal PPS Costs Cost Center Description Total Cost Therapy Limit Total Costs RCF Total Costs (from Wkst. Adj Di sal I owance B, Part I, col. 26) 1. 00 2.00 3.00 4.00 5.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 55, 493, 915 55, 493, 915 55, 493, 915 30.00 03100 INTENSIVE CARE UNIT 14, 433, 244 0 14, 433, 244 31.00 14, 433, 244 31.00 31.01 02060 NEONATAL INTENSIVE CARE UNIT 6, 361, 266 6, 361, 266 0 6, 361, 266 31.01 03200 CORONARY CARE UNIT 18, 777, 578 0 18, 777, 578 32 00 18, 777, 578 32 00 34.00 03400 SURGICAL INTENSIVE CARE UNIT 9, 587, 270 9, 587, 270 0 9, 587, 270 34.00 04100 SUBPROVI DER - I RF 41 00 5, 180, 200 5, 180, 200 0 5, 180, 200 41 00 04300 NURSERY 43.00 2, 106, 698 2, 106, 698 2, 106, 698 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 41, 252, 077 41, 252, 077 12,700 41, 264, 777 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 6, 128, 626 6, 128, 626 6, 128, 626 52.00 35, 719, 479 35, 719, 479 05400 RADI OLOGY-DI AGNOSTI C 35, 800, 521 54.00 81,042 54.00 54.01 05402 CARDIAC NUCLEAR DIAGNOSTIC 1, 150, 930 1, 150, 930 0 1, 150, 930 54.01 54.02 03450 NUCLEAR MEDICINE - DIAGNOSTIC 54.02 54.03 03630 ULTRA SOUND 1, 834, 967 1, 834, 967 0 1, 834, 967 54.03 05500 RADI OLOGY - THERAPEUTI C 3, 442, 945 3, 442, 945 3, 442, 945 55 00 0 55.00 56.00 05600 RADI 0I SOTOPE 1, 476, 395 1, 476, 395 0 1, 476, 395 56.00 05900 CARDIAC CATHETERIZATION 59.00 6, 183, 122 6, 183, 122 6, 183, 122 59.00 28, 471, 931 06000 LABORATORY 28, 471, 931 60.00 29.734 28, 501, 665 60.00 06400 I NTRAVENOUS THERAPY 64.00 554, 821 554, 821 0 554, 821 64.00 65.00 06500 RESPIRATORY THERAPY 10, 656, 250 0 10, 656, 250 12, 481 10, 668, 731 65.00 66.00 06600 PHYSI CAL THERAPY 8, 093, 161 8, 093, 161 8, 093, 161 66.00 0 06601 SPORTS MEDICINE 0 0 66 01 66 01 Ω 0 67.00 06700 OCCUPATI ONAL THERAPY 2,040,826 C 2,040,826 0 2,040,826 67.00 06800 SPEECH PATHOLOGY 1, 248, 123 1, 248, 123 0 1, 248, 123 68.00 68.00 69.00 06900 ELECTROCARDI OLOGY 3, 429, 079 3, 429, 079 ol 3, 429, 079 69.00 06901 CARDI AC CATH LAB 69.01 0 69.01 70.00 07000 ELECTROENCEPHALOGRAPHY 3, 868, 404 3, 868, 404 15, 524 3, 883, 928 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 37, 567, 668 37, 567, 668 0 37, 567, 668 71.00 72 00 07200 IMPL. DEV. CHARGED TO PATIENT 26, 083, 981 26 083 981 0 26, 083, 981 72 00 07300 DRUGS CHARGED TO PATIENTS 73.00 56, 115, 500 56, 115, 500 56, 115, 500 73.00 07400 RENAL DIALYSIS 1, 621, 865 1, 621, 865 3,046 1, 624, 911 74.00 74.00 76.97 07697 CARDIAC REHABILITATION 727, 911 727, 911 727, 911 76.97 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 14, 069, 932 14, 069, 932 76.093 14, 146, 025 90.00 09001 I BMT JOINT VENTURE 5, 457, 529 5, 520, 981 90.01 5, 457, 529 63, 452 90.01 90.02 09002 PSYCHIATRIC COUNCELING CENTER 4, 257, 746 4, 257, 746 0 4, 257, 746 90.02 09003 SOUTH INDY MRI & REHAB 90.03 90.03 89, 989 89, 989 0 89, 989 90.04 09004 BARI ATRI CS 0 90.04 0 90.05 09005 CV DIAGNOSTIC SERVICES 12, 014, 298 12, 014, 298 0 12, 014, 298 90.05 09006 CARDI AC REHAB 90.06 90.06 0 0 19, 599, 083 91.00 09100 EMERGENCY 19 599 083 17.554 19, 616, 637 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 7, 344, 339 7, 344, 339 7, 344, 339 92.00 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 6, 553, 660 101. 00 6, 553, 660 6, 553, 660 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 116. 00 11600 HOSPI CE 7, 776, 813 7, 776, 813 7, 776, 813 116. 00 467, 083, 247 200. 00 200.00 Subtotal (see instructions) 466, 771, 621 0 466, 771, 621 311, 626 201.00 Less Observation Beds 7, 344, 339 7, 344, 339 7, 344, 339 201. 00 202.00 Total (see instructions) 459, 427, 282 459, 427, 282 311, 626 459, 738, 908 202. 00

COMPUTATION OF RATIO OF COSTS TO CHARGES

202.00

From 01/01/2014 Part I Date/Time Prepared: 12/31/2014 5/26/2015 12:47 pm Title XVIII Hospi tal PPS Charges Total (col. 6 Cost or Other Cost Center Description Inpati ent Outpati ent TEFRA + col. 7) Ratio Inpati ent Ratio 6. 00 7.00 8.00 9.00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 79 112 009 79, 112, 009 30.00 31.00 03100 INTENSIVE CARE UNIT 22, 598, 300 22, 598, 300 31.00 15, 547, 341 02060 NEONATAL INTENSIVE CARE UNIT 15, 547, 341 31.01 31.01 32.00 03200 CORONARY CARE UNIT 21, 221, 676 21, 221, 676 32.00 03400 SURGICAL INTENSIVE CARE UNIT 14, 716, 168 34.00 14, 716, 168 34 00 41.00 04100 SUBPROVI DER - I RF 7, 926, 619 7, 926, 619 41.00 43.00 04300 NURSERY 5, 611, 391 5, 611, 391 43 00 ANCILLARY SERVICE COST CENTERS 50 00 158, 009, 384 0.000000 50.00 05000 OPERATING ROOM 85 448 175 72, 561, 209 0 261074 52.00 05200 DELIVERY ROOM & LABOR ROOM 25, 049, 062 66, 742 25, 115, 804 0. 244015 0.000000 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 65, 527, 468 200, 635, 376 266, 162, 844 0.134202 0.000000 54.00 21, 045, 898 0.000000 54.01 05402 CARDIAC NUCLEAR DIAGNOSTIC 0.054687 228, 884 20, 817, 014 54 01 54.02 03450 NUCLEAR MEDICINE - DIAGNOSTIC 0.000000 0.000000 54.02 03630 ULTRA SOUND 5, 939, 588 14, 745, 858 20, 685, 446 0. 088708 54.03 0.000000 54.03 42, 790 22, 707, 647 05500 RADI OLOGY - THERAPEUTI C 22, 664, 857 0. 151621 0.000000 55.00 55.00 05600 RADI 0I SOTOPE 5, 559, 787 56 00 1, 283, 550 4, 276, 237 0.265549 0.000000 56 00 05900 CARDI AC CATHETERI ZATI ON 31, 644, 912 36, 606, 566 68, 251, 478 0.090593 0.000000 59.00 59.00 60.00 06000 LABORATORY 80, 487, 459 113, 608, 588 194, 096, 047 0.146690 0.000000 60.00 06400 INTRAVENOUS THERAPY 64.00 1, 896, 035 186, 861 2, 082, 896 0.266370 0.000000 64.00 65.00 06500 RESPIRATORY THERAPY 44, 657, 475 5, 233, 203 49, 890, 678 0. 213592 0.000000 65.00 66, 00 06600 PHYSI CAL THERAPY 15, 226, 886 14, 503, 883 29, 730, 769 0.272215 0.000000 66,00 06601 SPORTS MEDICINE 0.000000 0.000000 66.01 66.01 06700 OCCUPATI ONAL THERAPY 3, 449, 007 67.00 5, 269, 354 8, 718, 361 0.234084 0.000000 67 00 68.00 06800 SPEECH PATHOLOGY 2, 438, 277 3, 111, 869 5, 550, 146 0. 224881 0.000000 68.00 06900 ELECTROCARDI OLOGY 0. 182369 69.00 12, 661, 174 6, 141, 751 18, 802, 925 0.000000 69.00 06901 CARDI AC CATH LAB 0.000000 0.000000 69.01 0 69.01 07000 ELECTROENCEPHALOGRAPHY 1, 516, 926 18, 217, 838 19, 734, 764 0.196020 70.00 0.000000 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 61, 283, 556 29, 626, 894 90, 910, 450 0.413238 0.000000 71.00 07200 IMPL. DEV. CHARGED TO PATIENT 72.00 23, 868, 371 48, 308, 992 72, 177, 363 0.361387 0.000000 72.00 73 00 07300 DRUGS CHARGED TO PATIENTS 122 839 990 204, 728, 041 327 568 031 0 171309 0.000000 73 00 07400 RENAL DIALYSIS 74.00 5, 286, 911 268, 144 5, 555, 055 0.291962 0.000000 74.00 07697 CARDIAC REHABILITATION 1,806 1, 512, 941 1, 514, 747 0.480550 0.000000 76.97 76.97 OUTPATIENT SERVICE COST CENTERS 90 00 19 639 045 90 00 09000 CL LNLC 242 486 19, 396, 559 0 716426 0.000000 09001 IBMT JOINT VENTURE 90.01 278, 636 4, 825, 827 5, 104, 463 1.069168 0.000000 90.01 09002 PSYCHIATRIC COUNCELING CENTER 969 6, 119, 360 6, 120, 329 0. 695673 0.000000 90.02 90.02 90 03 09003 SOUTH INDY MRI & REHAB 108 149, 878 149, 986 0.599983 0.000000 90 03 90.04 09004 BARI ATRI CS 0 0.000000 0.000000 90.04 90.05 09005 CV DIAGNOSTIC SERVICES 195, 749 27, 170, 941 0.439012 0.000000 90.05 27, 366, 690 90.06 09006 CARDI AC REHAB 0.000000 0.000000 90.06 0 09100 EMERGENCY 42, 146, 576 174 430 576 91 00 91 00 132, 284, 000 0 112360 0.000000 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 2, 932, 815 10, 282, 565 13, 215, 380 0.555742 0.000000 92.00 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 8, 805, 179 101.00 Э 8, 805, 179 SPECIAL PURPOSE COST CENTERS 113. 00 11300 I NTEREST EXPENSE 113.00 116. 00 11600 HOSPI CE 7, 300, 668 7, 300, 668 116.00 200.00 Subtotal (see instructions) 200.00 805, 129, 492 1, 037, 606, 848 1, 842, 736, 340 201 00 Less Observation Beds 201 00

805, 129, 492 1, 037, 606, 848 1, 842, 736, 340

Provider CCN: 150162

Peri od:

202.00

Total (see instructions)

Health Financial Systems

COMPUTATION OF RATIO OF COSTS TO CHARGES ST. FRANCIS HOSPITAL & HEALTH CENTER In Lieu of Form CMS-2552-10 Provi der CCN: 150162

| Peri od: | Worksheet C | From 01/01/2014 | Part | To | 12/31/2014 | Date/Time Prepared: 5/26/2015 12:47 pm

INPATIENT ROUTINE SERVICE COST CENTERS   11.00   30.						5/26/2015 12:	47 pm
INPATIENT ROUTINE SERVICE COST CENTERS   11.00				Title XVIII	Hospi tal	PPS	
INPATI ENT ROUTINE SERVICE COST CENTERS   30.00   300.00   ADULTS & PEDI ATRI CS   31.00   31.00   310.00   310.00   THENSI VE CARE UNIT   31.00   31.00   310.00   THENSI VE CARE UNIT   31.00   31		Cost Center Description	PPS Inpatient				
INPATI ENT ROUTINE SERVICE COST CENTERS   30.00   300.00   ADULTS & PEDI ATRI CS   31.00   31.00   310.00   310.00   THENSI VE CARE UNIT   31.00   31.00   310.00   THENSI VE CARE UNIT   31.00   31		· ·					
IMPATI ENT ROUTINE SERVICE COST CENTERS   30 .00							
30.00		INPATIENT ROUTINE SERVICE COST CENTERS					
31.00   03100   INTENSI VE CARE UNIT	30 00						30.00
31. 01   02060 NEONATAL INTENSIVE CARE UNIT   32. 00   03200 CROMARY CARE UNIT   34. 00   41. 00   03400 CROMARY CARE UNIT   34. 00   41. 00   03400 SURGICAL INTENSIVE CARE UNIT   41. 00   4							1
32.00   33200   COROMARY CARE UNIT							
34. 00   03400   SURGICAL INTENSIVE CARE UNIT		1 1					
1.1 00   0.4100   SUBPROVI DER - I RF		1 1					1
43. 00   04300   NURSERY							
ANCIL LARY SERVICE COST CENTERS   50.00							
50.00	43.00						<u> </u>
S2.00   OSCOV   DELIVERY ROOM & LABOR ROOM   0. 244015   52.00							1
S4. 00   05400   RADIO LOGY-DI AGNOSTIC   0. 134506   54. 00		05000  OPERATI NG ROOM	0. 261154				50.00
54. 01   05402   CARDIAC NUCLEAR DIAGNOSTIC   0. 054687   54. 02   54.00   54.00   54.00   54.00   54.00   54.00   54.00   55.00   5	52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 244015				52.00
54. 02   03450   NUCLEAR MEDICINE - DI AGNOSTI C   0. 0000000   54. 02   54. 03   63.03   01.TAR SOUND   54. 03   55. 00   05500   RADI OLOGY - THERAPEUTI C   0. 151621   55. 00   05600   RADI OLOGY - THERAPEUTI C   0. 265549   56. 00   05600   RADI OLOGY - THERAPEUTI C   0. 265549   56. 00   05600   RADI OLOGY - THERAPEUTI C   0. 265549   56. 00   05000   CARDI AC CATHETER IZATI ON   0. 090593   59. 00   05000   CARDI AC CATHETER IZATI ON   0. 090593   59. 00   05000   CARDI AC CATHETER IZATI ON   0. 146643   60. 00   06000   INTRAVENOUS THERAPY   0. 266370   64. 00   06400   INTRAVENOUS THERAPY   0. 213842   65. 00   06500   PKPS ICAL THERAPY   0. 272215   66. 00   06600   PKPS ICAL THERAPY   0. 272215   66. 00   06600   PKPS ICAL THERAPY   0. 234084   67. 00   06700   0CCUPATI ONAL THERAPY   0. 234084   67. 00   06700   0CCUPATI ONAL THERAPY   0. 234084   67. 00   06900   ELECTROCARDI OLOGY   0. 182369   69. 00   06901   CARDI AC CATH LAB   0. 000000   06901   CARDI AC CATH LAB   0. 000000   06901   CARDI AC CATH LAB   0. 000000   0. 00000   0. 00000   0. 00000   0. 00000   0. 00000   0. 00000   0. 00000   0. 00000   0. 00000   0. 00000   0. 00000   0. 00000   0. 00000   0. 00000   0. 000000   0. 00000   0. 00000   0. 00000   0. 00000   0. 00000   0. 00000   0. 00000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 00000000	54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 134506				54.00
54. 03   03630   ILITRA SOUND	54.01	05402 CARDIAC NUCLEAR DIAGNOSTIC	0. 054687				54. 01
55.00   05500   RADIOLOGY - THERAPEUTIC   0. 15162T   55.00   56.00   65.00   65.00   65.00   65.00   65.00   65.00   65.00   65.00   65.00   65.00   65.00   65.00   65.00   65.00   65.00   65.00   65.00   65.00   66.00	54.02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0. 000000				54.02
55.00   05500   RADIOLOGY - THERAPEUTIC   0.151621   55.00   56.00   56.00   56.00   56.00   65.00   65.00   65.00   65.00   65.00   65.00   65.00   65.00   65.00   65.00   65.00   65.00   65.00   65.00   65.00   65.00   66.00	54.03	03630 ULTRA SOUND	0. 088708				54.03
56.00   05000   05000   CADDIAC CATHETER ZATION   0.090593   0.0900   0.00000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.000000   0.000000   0.000000   0.000000   0.000000   0.00000000	55.00						
59.00   05900   CARDIAC CATHETERIZATION   0.090593   59.00	56 00		1				1
60.00   06000   LABORATORY   0.146843   66.00   06400   NTRAVENOUS THERAPY   0.266370   66.00   06500   RESPI RATORY THERAPY   0.273842   65.00   06500   RESPI RATORY THERAPY   0.273842   66.00   06600   PAYSI CAL THERAPY   0.272215   66.00   06600   SPORTS REDI CINE   0.000000   66.01   06601   SPORTS REDI CINE   0.000000   66.01   06601   SPORTS REDI CINE   0.000000   66.01   06601   SPORTS REDI CINE   0.000000   66.00   06900   CELECTROCARDI OLOGY   0.224881   68.00   08900   ELECTROCARDI OLOGY   0.82369   69.00   06900   ELECTROCARDI OLOGY   0.82369   69.01   06901   CARDI AC CATH LAB   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.00000000			1				1
64. 00 65. 00 66.00 65. 00 66.							
65.00   06500   RESPIRATORY THERAPY   0. 213842   66.00   06600   PHYSI CAL THERAPY   0. 272215   66.00   66.01   06601   SPORTS MEDI CI NE   0. 000000   66.01   06601   SPORTS MEDI CI NE   0. 000000   67.00   06700   0CCUPATI ONAL THERAPY   0. 234084   67.00   68.00   06800   SPEECH PATHOLOGY   0. 224881   68.00   06800   SPEECH PATHOLOGY   0. 224881   68.00   06900   ELECTROCARDI OLOGY   0. 182369   69.01   06901   CARDI AC CATH LAB   0. 0000000   0. 000000   0. 000000   0. 0000000   0. 0000000   0. 00000000			1				
66. 00   06600   PHYSICAL THERAPY   0. 272215   66. 00   06601   SPORTS MEDICINE   0. 0000000   66. 01   67. 00   06600   SPORTS MEDICINE   0. 234084   67. 00   68. 00   06800   SPECH PATHOLOGY   0. 224881   68. 00   06900   ELECTROCARDIOLOGY   0. 182369   69. 01   06901   CARDIAC CATH LAB   0. 000000   69. 01   06901   CARDIAC CATH LAB   0. 000000   69. 01   07.00   07.0			1				1
66. 01   06601   SPORTS MEDI CI NE   0. 000000   67. 00   06700   0CCUPATI ONAL THERAPY   0. 234084   67. 00   06800   SPEECH PATHOLOGY   0. 224881   68. 00   06900   06900   06900   06901							
67. 00   06700   06700   0CCUPATI ONAL THERAPY   0.234084   68. 00   6800   06800   SPEECH PATHOLOGY   0.224881   68. 00   69. 00   06900   ELECTROCARDI OLOGY   0.182369   69. 00   69. 01   06901   CARDI AC CATH LAB   0.000000   0.000000   0.000000   0.000000   0.0000000   0.0000000   0.0000000   0.0000000   0.00000000			1				
68. 00   06800   SPECH PATHOLOGY   0. 224881   68. 00   69. 00   06900   ELECTROCARDI OLOGY   0. 182369   69. 00   69. 00   06901 CARDI AC CATH LAB   0. 000000   69. 01   06901 CARDI AC CATH LAB   0. 000000   69. 01   07000   ELECTROENCEPHALOGRAPHY   0. 196806   70. 00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   0. 413238   71. 00   07200   MEDI CAL SUPPLIES CHARGED TO PATIENTS   0. 413238   72. 00   07300   DRUGS CHARGED TO PATIENTS   0. 171309   73. 00   73. 00   07300   DRUGS CHARGED TO PATIENTS   0. 171309   73. 00   74. 00   07400   RENAL DIALYSIS   0. 292510   74. 00   07400   RENAL DIALYSIS   0. 292510   74. 00   07597   CARDIA C REHABI LITATI ON   0. 480550   76. 97   07597   CARDIA C REHABI LITATI ON   0. 480550   76. 97   00000   0000   CLI NI C   0. 720301   90. 00   09000   CLI NI C   0. 720301   90. 01   90001   BMT JOINT VENTURE   1. 081599   90. 01   90. 01   90000   90. 04   90. 01   90. 02   90. 02   90002   PSYCHI ATRI C COUNCELING CENTER   0. 695673   90. 03   90003   SOUTH I NDY MRI & REHAB   0. 599983   90. 03   90. 04   90004   BARI TARI CS   0. 000000   90. 04   90. 05   90. 00   90			1				
69. 00		1	1				•
69. 01   06901   CARDIAC CATH LAB			1				1
70. 00   07000   ELECTROENCEPHALOGRAPHY   0. 196806   70. 00   7		1					
71. 00		1 1	1				
72. 00 07200 I MPL. DEV. CHARGED TO PATIENT 0. 361387 73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 171309 74. 00 07400 RENAL DI ALYSIS 0. 292510 76. 97 07697 CARDI AC REHABILITATION 0. 480550  90. 00 09000 CLI NI C 0. 720301 90. 01 09001 I BMT JOI NT VENTURE 1. 081599 90. 02 09002 PSYCHIATRI C COUNCELING CENTER 0. 695673 90. 03 09003 SOUTH INDY MRI & REHAB 0. 599983 90. 04 09004 BARIATRI CS 0. 0. 000000 90. 05 09005 C DI AGNOSTIC SERVICES 0. 439012 90. 06 09006 CARDI AC REHAB 0. 0. 000000 91. 00 09100 EMERGENCY 0. 112461 92. 00 09200 DSSERVATI ON BEDS (NON-DI STI NCT PART) 0. 555742 0THER REI MBURSABLE COST CENTERS  101. 00 10100 HOME HEALTH AGENCY 9. 0. 113.00 11300 I NTEREST EXPENSE 113.00 11600 HOSPI CE 200.00 200.00 Subtotal (see instructions)		1	1				1
73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 171309 74. 00 07400 RENAL DIALYSIS 0. 292510 76. 97 07697 CARDIAC REHABILITATION 0. 480550  90. 00 0UTPATIENT SERVICE COST CENTERS  90. 00 09000 CLINIC 0. 70. 70. 70. 70. 70. 70. 70. 70. 70.							
74. 00							
76. 97 O7697 CARDIAC REHABILITATION 0. 480550  90. 00 O9000 CLINIC 0. 0. 720301  90. 01 O9001 IBMT JOINT VENTURE 1. 081599  90. 02 O9002 PSYCHIATRIC COUNCELING CENTER 0. 695673  90. 03 O9003 SOUTH INDY MRI & REHAB 0. 599983  90. 04 O9004 BARIATRICS 0. 0. 000000  90. 05 O9005 CV DI AGNOSTIC SERVICES 0. 439012  90. 06 O9006 CARDIAC REHAB 0. 0. 000000  91. 00 O9100 EMERGENCY 0. 112461  92. 00 O9200 OBSERVATION BEDS (NON-DISTINCT PART) 0. 555742  101. 00 OTHER REIMBURSABLE COST CENTERS  113. 00 11300 INTEREST EXPENSE 113. 00  116. 00 11600 HOSPI CE SUSTINCTIONS 200. 000  200. 00 Subtotal (see instructions)		1 1	0. 171309				
OUTPATI ENT SERVI CE COST CENTERS   O. 720301   90. 00	74.00	07400 RENAL DI ALYSI S	0. 292510				74.00
90. 00   09000   CLINIC   0.720301   90. 00   90. 01   09001   IBMT JOINT VENTURE   1. 081599   90. 01   90. 02   09002   PSYCHIATRI C COUNCELING CENTER   0. 695673   90. 02   90. 03   09003   SOUTH INDY MRI & REHAB   0. 599983   90. 03   90. 04   09004   BARI ATRI CS   0. 000000   90. 05   09005   CV DI AGNOSTI C SERVI CES   0. 439012   90. 05   90. 05   09005   CV DI AGNOSTI C SERVI CES   0. 439012   90. 06   91. 00   09100   EMERGENCY   0. 112461   91. 00   09200   0BSERVATI ON BEDS (NON-DI STI NCT PART)   0. 555742   92. 00   0THER REI MBURSABLE COST CENTERS   101. 00   SPECI AL PURPOSE COST CENTERS   113. 00   11300   INTEREST EXPENSE   113. 00   116. 00   11600   Subtotal (see instructions)   200. 00	76. 97	07697 CARDI AC REHABI LI TATI ON	0. 480550				76. 97
90. 01		OUTPATIENT SERVICE COST CENTERS					
90. 02	90.00	09000 CLI NI C	0. 720301				90.00
90. 03   09003   SOUTH INDY MRI & REHAB   0. 599983   90. 03   90. 04   90. 04   90. 04   90. 05   90. 05   90. 05   90. 05   90. 06   90.	90. 01	09001 I BMT JOINT VENTURE	1. 081599				90. 01
90. 04	90. 02	09002 PSYCHIATRIC COUNCELING CENTER	0. 695673				90. 02
90. 04   09004   BARI ATRI CS   0. 000000   90. 04   90. 05   09005   CV DI AGNOSTI C SERVI CES   0. 439012   90. 05   90. 06   09006   CARDI AC REHAB   0. 000000   90. 06   91. 00   09100   EMERGENCY   0. 112461   91. 00   09200   0BSERVATI ON BEDS (NON-DI STI NCT PART)   0. 555742   92. 00   09100   HEALTH AGENCY   92. 00   09100   HEALTH AGENCY   92. 00   09100   HEALTH AGENCY   101. 00   10100   HOME HEALTH AGENCY   101. 00   11300   INTEREST EXPENSE   113. 00   116. 00   11600   HOSPI CE   116. 00   200. 00   Subtotal (see instructions)   200. 00   200. 00	90. 03	09003 SOUTH INDY MRI & REHAB	0. 599983				90. 03
90. 05	90. 04		1 1				90.04
90. 06	90. 05	1					
91. 00			1 1				1
92. 00			1				
OTHER REIMBURSABLE COST CENTERS   101.00   10100   HOME   HEALTH   AGENCY   101.00   SPECIAL   PURPOSE   COST   CENTERS   113.00   11300   INTEREST   EXPENSE   113.00   116.00   11600   HOSPICE   116.00   200.00   Subtotal   (see instructions)   200.00							
101. 00   10100   HOME   HEALTH   AGENCY	72.00		0. 333742				72.00
SPECIAL PURPOSE COST CENTERS   113.00   11300   I NTEREST EXPENSE   113.00   116.00   11600	101 00						101 00
113. 00	101.00						1101.00
116. 00   11600   HOSPI CE     116. 00   200. 00   Subtotal (see instructions)   200. 00	112 00						112 00
200.00 Subtotal (see instructions) 200.00							
201.00   Less Observation Beds		,					1
202.00   Total (see instructions)	202. 00						202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 150162 Peri od: Worksheet C From 01/01/2014 Part I Date/Time Prepared: 12/31/2014 5/26/2015 12:47 pm Title XIX Hospi tal PPS Costs Cost Center Description Total Cost Therapy Limit Total Costs RCF Total Costs (from Wkst. Adj Di sal I owance B, Part I, col. 26) 1. 00 2.00 3.00 4.00 5.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 55, 493, 915 55, 493, 915 55, 493, 915 30.00 03100 INTENSIVE CARE UNIT 14, 433, 244 0 14, 433, 244 31.00 14, 433, 244 31.00 31.01 02060 NEONATAL INTENSIVE CARE UNIT 6, 361, 266 6, 361, 266 0 6, 361, 266 31.01 03200 CORONARY CARE UNIT 18, 777, 578 0 18, 777, 578 32 00 18, 777, 578 32 00 34.00 03400 SURGICAL INTENSIVE CARE UNIT 9, 587, 270 9, 587, 270 0 9, 587, 270 34.00 04100 SUBPROVI DER - I RF 41 00 5, 180, 200 5, 180, 200 0 5, 180, 200 41 00 04300 NURSERY 43.00 2, 106, 698 2, 106, 698 2, 106, 698 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 41, 252, 077 41, 252, 077 12,700 41, 264, 777 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 6, 128, 626 6, 128, 626 6, 128, 626 52.00 35, 719, 479 35, 719, 479 05400 RADI OLOGY-DI AGNOSTI C 35, 800, 521 54.00 81,042 54.00 54.01 05402 CARDIAC NUCLEAR DIAGNOSTIC 1, 150, 930 1, 150, 930 0 1, 150, 930 54.01 54.02 03450 NUCLEAR MEDICINE - DIAGNOSTIC 54.02 54.03 03630 ULTRA SOUND 1, 834, 967 1, 834, 967 0 1, 834, 967 54.03 05500 RADI OLOGY - THERAPEUTI C 3, 442, 945 3, 442, 945 3, 442, 945 55 00 0 55.00 56.00 05600 RADI OI SOTOPE 1, 476, 395 1, 476, 395 0 1, 476, 395 56.00 05900 CARDIAC CATHETERIZATION 59.00 6, 183, 122 6, 183, 122 6, 183, 122 59.00 28, 471, 931 06000 LABORATORY 28, 471, 931 60.00 29.734 28, 501, 665 60.00 06400 I NTRAVENOUS THERAPY 64.00 554, 821 554, 821 0 554, 821 64.00 65.00 06500 RESPIRATORY THERAPY 10, 656, 250 0 10, 656, 250 12, 481 10, 668, 731 65.00 66.00 06600 PHYSI CAL THERAPY 8, 093, 161 8, 093, 161 8, 093, 161 66.00 0 06601 SPORTS MEDICINE 0 0 66 01 66 01 Ω 0 67.00 06700 OCCUPATI ONAL THERAPY 2,040,826 C 2,040,826 0 2,040,826 67.00 06800 SPEECH PATHOLOGY 1, 248, 123 1, 248, 123 0 1, 248, 123 68.00 68.00 69.00 06900 ELECTROCARDI OLOGY 3, 429, 079 3, 429, 079 ol 3, 429, 079 69.00 06901 CARDI AC CATH LAB 69.01 0 69.01 70.00 07000 ELECTROENCEPHALOGRAPHY 3, 868, 404 3, 868, 404 15, 524 3, 883, 928 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 37, 567, 668 37, 567, 668 0 37, 567, 668 71.00 72 00 07200 IMPL. DEV. CHARGED TO PATIENT 26, 083, 981 26 083 981 0 26, 083, 981 72 00 07300 DRUGS CHARGED TO PATIENTS 73.00 56, 115, 500 56, 115, 500 56, 115, 500 73.00 07400 RENAL DIALYSIS 1, 621, 865 1, 621, 865 3,046 1, 624, 911 74.00 74.00 76.97 07697 CARDIAC REHABILITATION 727, 911 727, 911 727, 911 76.97 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 14, 069, 932 14, 069, 932 76.093 14, 146, 025 90.00 09001 I BMT JOINT VENTURE 5, 457, 529 5, 520, 981 90.01 5, 457, 529 63, 452 90.01 90.02 09002 PSYCHIATRIC COUNCELING CENTER 4, 257, 746 4, 257, 746 0 4, 257, 746 90.02 09003 SOUTH INDY MRI & REHAB 90.03 90.03 89, 989 89, 989 0 89, 989 90.04 09004 BARI ATRI CS 0 90.04 0 90.05 09005 CV DIAGNOSTIC SERVICES 12, 014, 298 12, 014, 298 0 12, 014, 298 90.05 09006 CARDI AC REHAB 90.06 90.06 0 0 19, 599, 083 91.00 09100 EMERGENCY 19 599 083 17.554 19, 616, 637 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 7, 344, 339 7, 344, 339 7, 344, 339 92.00 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 6, 553, 660 101. 00 6, 553, 660 6, 553, 660 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 116. 00 11600 HOSPI CE 7, 776, 813 7, 776, 813 7, 776, 813 116. 00

466, 771, 621

459, 427, 282

7, 344, 339

0

466, 771, 621

459, 427, 282

7, 344, 339

467, 083, 247 200. 00

459, 738, 908 202. 00

7, 344, 339 201. 00

311, 626

311, 626

200.00

201.00

202.00

Subtotal (see instructions)

Less Observation Beds

Total (see instructions)

COMPUTATION OF RATIO OF COSTS TO CHARGES

202.00

Worksheet C From 01/01/2014 Part I Date/Time Prepared: 12/31/2014 5/26/2015 12:47 pm Title XIX Hospi tal PPS Charges Total (col. 6 Cost or Other Cost Center Description Inpati ent Outpati ent TEFRA + col. 7) Ratio Inpati ent Ratio 6. 00 7.00 8.00 9.00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 79 112 009 79, 112, 009 30.00 31.00 03100 INTENSIVE CARE UNIT 22, 598, 300 22, 598, 300 31.00 15, 547, 341 02060 NEONATAL INTENSIVE CARE UNIT 15, 547, 341 31.01 31.01 32.00 03200 CORONARY CARE UNIT 21, 221, 676 21, 221, 676 32.00 03400 SURGICAL INTENSIVE CARE UNIT 14, 716, 168 34.00 14, 716, 168 34 00 41.00 04100 SUBPROVI DER - I RF 7, 926, 619 7, 926, 619 41.00 43.00 04300 NURSERY 5, 611, 391 5, 611, 391 43 00 ANCILLARY SERVICE COST CENTERS 50 00 158, 009, 384 0.000000 50.00 05000 OPERATING ROOM 85 448 175 72, 561, 209 0 261074 52.00 05200 DELIVERY ROOM & LABOR ROOM 25, 049, 062 66, 742 25, 115, 804 0. 244015 0.000000 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 65, 527, 468 200, 635, 376 266, 162, 844 0.134202 0.000000 54.00 21, 045, 898 0.000000 54.01 05402 CARDIAC NUCLEAR DIAGNOSTIC 0.054687 228, 884 20, 817, 014 54 01 54.02 03450 NUCLEAR MEDICINE - DIAGNOSTIC 0.000000 0.000000 54.02 03630 ULTRA SOUND 5, 939, 588 14, 745, 858 20, 685, 446 0. 088708 54.03 0.000000 54.03 42, 790 22, 707, 647 05500 RADI OLOGY - THERAPEUTI C 22, 664, 857 0. 151621 0.000000 55.00 55.00 05600 RADI 0I SOTOPE 5, 559, 787 56 00 1, 283, 550 4, 276, 237 0.265549 0.000000 56 00 05900 CARDI AC CATHETERI ZATI ON 31, 644, 912 36, 606, 566 68, 251, 478 0.090593 0.000000 59.00 59.00 60.00 06000 LABORATORY 80, 487, 459 113, 608, 588 194, 096, 047 0.146690 0.000000 60.00 06400 INTRAVENOUS THERAPY 64.00 1, 896, 035 186, 861 2, 082, 896 0.266370 0.000000 64.00 65.00 06500 RESPIRATORY THERAPY 44, 657, 475 5, 233, 203 49, 890, 678 0. 213592 0.000000 65.00 66, 00 06600 PHYSI CAL THERAPY 15, 226, 886 14, 503, 883 29, 730, 769 0.272215 0.000000 66,00 06601 SPORTS MEDICINE 0.000000 0.000000 66.01 66.01 06700 OCCUPATI ONAL THERAPY 3, 449, 007 67.00 5, 269, 354 8, 718, 361 0.234084 0.000000 67 00 68.00 06800 SPEECH PATHOLOGY 2, 438, 277 3, 111, 869 5, 550, 146 0. 224881 0.000000 68.00 06900 ELECTROCARDI OLOGY 0. 182369 69.00 12, 661, 174 6, 141, 751 18, 802, 925 0.000000 69.00 06901 CARDI AC CATH LAB 0.000000 0.000000 69.01 0 69.01 07000 ELECTROENCEPHALOGRAPHY 1, 516, 926 18, 217, 838 19, 734, 764 0.196020 70.00 0.000000 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 61, 283, 556 29, 626, 894 90, 910, 450 0.413238 0.000000 71.00 07200 IMPL. DEV. CHARGED TO PATIENT 72.00 23, 868, 371 48, 308, 992 72, 177, 363 0.361387 0.000000 72.00 73 00 07300 DRUGS CHARGED TO PATIENTS 122 839 990 204, 728, 041 327 568 031 0 171309 0.000000 73 00 07400 RENAL DIALYSIS 74.00 5, 286, 911 268, 144 5, 555, 055 0.291962 0.000000 74.00 07697 CARDIAC REHABILITATION 1,806 1, 512, 941 1, 514, 747 0.480550 0.000000 76.97 76.97 OUTPATIENT SERVICE COST CENTERS 90 00 19 639 045 90 00 09000 CL LNLC 242 486 19, 396, 559 0 716426 0.000000 09001 IBMT JOINT VENTURE 90.01 278, 636 4, 825, 827 5, 104, 463 1.069168 0.000000 90.01 09002 PSYCHIATRIC COUNCELING CENTER 969 6, 119, 360 6, 120, 329 0. 695673 0.000000 90.02 90.02 90 03 09003 SOUTH INDY MRI & REHAB 108 149, 878 149, 986 0.599983 0.000000 90 03 90.04 09004 BARI ATRI CS 0 0.000000 0.000000 90.04 90.05 09005 CV DIAGNOSTIC SERVICES 195, 749 27, 170, 941 0.439012 0.000000 90.05 27, 366, 690 90.06 09006 CARDI AC REHAB 0.000000 0.000000 90.06 0 09100 EMERGENCY 42, 146, 576 174 430 576 91 00 91 00 132, 284, 000 0 112360 0.000000 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 2, 932, 815 10, 282, 565 13, 215, 380 0.555742 0.000000 92.00 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 8, 805, 179 101.00 Э 8, 805, 179 SPECIAL PURPOSE COST CENTERS 113. 00 11300 I NTEREST EXPENSE 113.00 116. 00 11600 HOSPI CE 7, 300, 668 7, 300, 668 116.00 200.00 Subtotal (see instructions) 200.00 805, 129, 492 1, 037, 606, 848 1, 842, 736, 340 201 00 Less Observation Beds 201 00

805, 129, 492 1, 037, 606, 848 1, 842, 736, 340

Provider CCN: 150162

Peri od:

202.00

Total (see instructions)

Health Financial Systems

COMPUTATION OF RATIO OF COSTS TO CHARGES ST. FRANCIS HOSPITAL & HEALTH CENTER In Lieu of Form CMS-2552-10 Provi der CCN: 150162

				5/26/2015 12:	4/ pm_
		Title XIX	Hospi tal	PPS	
Cost Center Description	PPS Inpatient				
	Ratio				
	11. 00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS					30.00
31. 00   03100   NTENSI VE CARE UNIT					31.00
					1
31. 01   02060   NEONATAL   INTENSIVE CARE UNIT					31.01
32. 00  03200 CORONARY CARE UNIT					32.00
34.00  03400   SURGICAL INTENSIVE CARE UNIT					34.00
41. 00   04100   SUBPROVI DER - I RF					41.00
43. 00   04300   NURSERY					43.00
ANCILLARY SERVICE COST CENTERS					
50. 00 05000 OPERATING ROOM	0. 261154				50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 244015				52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 134506				54.00
54. 01 05402 CARDI AC NUCLEAR DI AGNOSTI C	0. 054687				54. 01
					1
54. 02   03450   NUCLEAR MEDICINE - DIAGNOSTIC	0.000000				54.02
54. 03   03630   ULTRA SOUND	0. 088708				54. 03
55. 00   05500   RADI OLOGY - THERAPEUTI C	0. 151621				55.00
56. 00   05600 RADI 0I SOTOPE	0. 265549				56.00
59. 00   05900   CARDI AC   CATHETERI ZATI ON	0. 090593				59.00
60. 00   06000   LABORATORY	0. 146843				60.00
64.00 06400 INTRAVENOUS THERAPY	0. 266370				64.00
65. 00 06500 RESPIRATORY THERAPY	0. 213842				65.00
66. 00   06600   PHYSI CAL THERAPY	0. 272215				66.00
66. 01   06601   SPORTS   MEDI CI NE	0. 000000				66. 01
	1				1
	0. 234084				67.00
68. 00 06800 SPEECH PATHOLOGY	0. 224881				68. 00
69. 00   06900   ELECTROCARDI OLOGY	0. 182369				69. 00
69. 01  06901 CARDI AC CATH LAB	0. 000000				69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 196806				70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 413238				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 361387				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 171309				73.00
74. 00   07400   RENAL DI ALYSI S	0. 292510				74.00
76. 97 O7697 CARDI AC REHABI LI TATI ON	0. 480550				76. 97
OUTPATIENT SERVICE COST CENTERS	0. 400330				1 70. 77
90. 00 09000 CLINIC	0.720201				1 00 00
	0. 720301				90.00
90. 01   09001   I BMT JOI NT VENTURE	1. 081599				90. 01
90. 02 09002 PSYCHI ATRI C COUNCELING CENTER	0. 695673				90. 02
90.03 O9003 SOUTH INDY MRI & REHAB	0. 599983				90. 03
90. 04  09004 BARI ATRI CS	0. 000000				90. 04
90. 05   09005   CV DI AGNOSTI C SERVI CES	0. 439012				90.05
90. 06   09006 CARDI AC REHAB	0. 000000				90.06
91. 00 09100 EMERGENCY	0. 112461				91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 555742				92.00
OTHER REIMBURSABLE COST CENTERS	3. 3007 12				1 /2:00
101. 00 10100 HOME HEALTH AGENCY					101.00
	<u> </u>				1101.00
SPECIAL PURPOSE COST CENTERS					112 00
113. 00 11300   NTEREST EXPENSE					113.00
116. 00 11600 HOSPI CE					116. 00
200.00 Subtotal (see instructions)					200.00
201.00 Less Observation Beds					201.00
202.00 Total (see instructions)					202.00
	•				

Health Financial Systems ST. FRANCIS HOSPI CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICALD ONLY Peri od: Worksheet C From 01/01/2014 Part II To 12/31/2014 Date/Time Prepared: Provi der CCN: 150162

					10 12/31/2014	5/26/2015 12:	
			Ti 1	le XIX	Hospi tal	PPS	
	Cost Center Description	Total Cost	Capital Cost	Operating	Capi tal	Operating	
	•	(Wkst. B,	(Wkst. B,	Cost Net of	Reducti on	Cost	
		Part I, col.	Part II col.	Capital Cost		Reduction	
		26)	26)	(col. 1 -		Amount	
			,	col . 2)			
		1. 00	2.00	3.00	4.00	5. 00	
	ANCILLARY SERVICE COST CENTERS			•	*		
50.00	05000 OPERATI NG ROOM	41, 252, 077	7, 562, 717	33, 689, 36	0 0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	6, 128, 626	l '			0	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	35, 719, 479	6, 942, 404	28, 777, 07	5 0	O	54.00
54. 01	05402 CARDI AC NUCLEAR DI AGNOSTI C	1, 150, 930				0	54. 01
54. 02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0	(		0 0	0	54. 02
54. 03	03630 ULTRA SOUND	1, 834, 967	261, 764	1, 573, 20	3 0	0	54. 03
55. 00	05500 RADI OLOGY - THERAPEUTI C	3, 442, 945					55.00
56. 00	05600 RADI OI SOTOPE	1, 476, 395			-	_	56.00
59.00	05900 CARDI AC CATHETERI ZATI ON	6, 183, 122			-	_	59.00
60.00	06000 LABORATORY	28, 471, 931	1				60.00
64. 00	06400 I NTRAVENOUS THERAPY	554, 821	51, 285				64.00
65.00	06500 RESPI RATORY THERAPY	10, 656, 250	1				65.00
66.00	06600 PHYSI CAL THERAPY	8, 093, 161	1			ľ	66.00
	06601 SPORTS MEDICINE		976, 307	1		_	
66. 01		0	1	1	-1	-	66. 01
67.00	06700 OCCUPATI ONAL THERAPY	2, 040, 826				_	67.00
68. 00	06800 SPEECH PATHOLOGY	1, 248, 123	1			_	68. 00
69. 00	06900 ELECTROCARDI OLOGY	3, 429, 079	1, 102, 452				69.00
69. 01	06901 CARDI AC CATH LAB	0	(	1	0	_	69. 01
70.00	07000 ELECTROENCEPHALOGRAPHY	3, 868, 404	1			_	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	37, 567, 668	1			-	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	26, 083, 981	769, 004			0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	56, 115, 500				_	73. 00
74.00	07400 RENAL DI ALYSI S	1, 621, 865	457, 045			_	74.00
76. 97	07697 CARDI AC REHABI LI TATI ON	727, 911	16, 607	711, 30	0	0	76. 97
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	14, 069, 932	2, 823, 859	11, 246, 07			90.00
90. 01	09001 I BMT JOINT VENTURE	5, 457, 529	304, 715	5, 152, 81	4 0	0	90. 01
90.02	09002 PSYCHIATRIC COUNCELING CENTER	4, 257, 746	1, 296, 658	2, 961, 08	8 0	0	90. 02
90.03	09003 SOUTH INDY MRI & REHAB	89, 989	1, 577	88, 41	2 0	0	90. 03
90.04	09004 BARI ATRI CS	0	(		0 0	0	90. 04
90.05	09005 CV DIAGNOSTIC SERVICES	12, 014, 298	196, 076	11, 818, 22	2 0	0	90. 05
90.06	09006 CARDI AC REHAB	0	(		0 0	0	90.06
91.00	09100 EMERGENCY	19, 599, 083	4, 017, 938	15, 581, 14	5 0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	7, 344, 339	1, 460, 275	5, 884, 06	4 0	0	92.00
	OTHER REIMBURSABLE COST CENTERS				•		1
101.00	10100 HOME HEALTH AGENCY	6, 553, 660	106, 730	6, 446, 93	0 0	0	101.00
	SPECIAL PURPOSE COST CENTERS						
113. 00	11300   INTEREST EXPENSE						113. 00
	11600 H0SPI CE	7, 776, 813	525, 903	7, 250, 91	0 0	n	116.00
200.00		354, 831, 450					200.00
201.00	,	7, 344, 339	1				201.00
201.00	1	347, 487, 111	1				202.00
202.00	Total (Title 200 millias Title 201)	] 347,407,111	31, 173, 07	307, 074, 04	0	0	1202.00

Heal th Financial Systems ST. FRANCIS HOSPITAL & HEALTH CENTER

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF Provider CCN: 150162

REDUCTIONS FOR MEDICALD ONLY

Cost Center Description  Cost Net of Capital and Operating Part I, Charge Ratio	
Capital and (Worksheet C, Cost to	
Cost column 8) (col. 6 /	
Reduction col. 7)	
6.00 7.00 8.00	
ANCI LLARY SERVI CE COST CENTERS	
	50. 00
	52. 00
	54. 00
	54. 01
	54. 02
	54. 03
	55. 00
	56.00
	59. 00
	60.00
	64. 00
	65. 00
	66.00
	66. 01
	67. 00
	68. 00
	69. 00
	69. 01
	70. 00
	71. 00
	72.00
	73.00
	74.00
76. 97 O7697 CARDI AC REHABI LI TATI ON 727, 911 1, 514, 747 0. 480550	76. 97
OUTPATIENT SERVICE COST CENTERS	
90. 00   09000   CLI NI C   14, 069, 932   19, 639, 045   0. 716426	90.00
90. 01   09001   I BMT JOI NT VENTURE 5, 457, 529 5, 104, 463 1. 069168	90. 01
90. 02   09002   PSYCHI ATRI C COUNCELI NG CENTER 4, 257, 746 6, 120, 329 0. 695673	90. 02
90. 03 09003 SOUTH INDY MRI & REHAB 89, 989 149, 986 0. 599983	90. 03
90. 04   09004   BARI ATRI CS   0   0, 000000	90. 04
90. 05   09005   CV   DI AGNOSTI C   SERVI CES   12, 014, 298   27, 366, 690   0. 439012	90. 05
90. 06   09006   CARDI AC REHAB   0   0, 000000	90. 06
	91. 00
92. 00   09200   OBSERVATI ON BEDS (NON-DISTINCT PART)   7, 344, 339   13, 215, 380   0.555742	92.00
OTHER REIMBURSABLE COST CENTERS	
	01.00
SPECIAL PURPOSE COST CENTERS	
	13.00
	16. 00
	00.00
	01.00
202.00   Total (line 200 minus line 201)   347,487,111  1,676,002,836    2	02.00

Health Financial Systems		ST.	FRANCIS	HOSPITAL & F	IEALTH CEN	ITER		In Lieu	of Form (	MS-2552-10
APPORTIONMENT OF INPATIEN	T ROUTINE SERVICE	CAPI TA	L COSTS		Provi der	CCN: 150162	From	01/01/2014 12/31/2014		Prepared:

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS				Period: From 01/01/2014 To 12/31/2014		
		Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem	
	Related Cost	Adjustment	Capi tal	Days	(col. 3 /	
	(from Wkst.		Related Cost		col. 4)	
	B, Part II,		(col. 1 -			
	col. 26)		col. 2)			
	1. 00	2. 00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	11, 033, 873	0	11, 033, 87	·	194. 89	
31.00   INTENSIVE CARE UNIT	2, 002, 451		2, 002, 45	·		31.00
31. 01 NEONATAL INTENSIVE CARE UNIT	742, 912		742, 91			
32.00 CORONARY CARE UNIT	3, 805, 377		3, 805, 37	7 12, 067		
34.00 SURGICAL INTENSIVE CARE UNIT	2, 090, 256		2, 090, 25	6, 673		
41. 00   SUBPROVI DER - I RF	1, 302, 247	0	1, 302, 24	7 4, 104		
43. 00 NURSERY	378, 910		378, 91	0 4, 419	85. 75	43.00
200.00 Total (lines 30-199)	21, 356, 026		21, 356, 02	6 98, 275		200.00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x				
		col. 6)				
	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS			1			
30. 00 ADULTS & PEDIATRICS	19, 302	3, 761, 767	•			30.00
31.00 INTENSIVE CARE UNIT	5, 265	1, 082, 537	1			31.00
31.01 NEONATAL INTENSIVE CARE UNIT	0	0	I .			31.01
32.00 CORONARY CARE UNIT	6, 835	2, 155, 417				32.00
34.00 SURGICAL INTENSIVE CARE UNIT	3, 757	1, 176, 843	•			34.00
41. 00   SUBPROVI DER - I RF	2, 251	714, 265				41.00
43. 00 NURSERY	0	0				43.00
200.00 Total (lines 30-199)	37, 410	8, 890, 829				200. 00

			Ti tl	e XVIII	Hospi tal	PPS	
	Cost Center Description	Capi tal	Total Charges	Ratio of Cost	I npati ent	Capital Costs	
		Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
		(from Wkst.	C, Part I,	(col. 1 ÷	Charges	column 4)	
		B, Part II,	col. 8)	col . 2)	-		
		col. 26)					
		1. 00	2.00	3. 00	4. 00	5. 00	
	CILLARY SERVICE COST CENTERS						
50.00 05	000 OPERATING ROOM	7, 562, 717	158, 009, 384	0. 047862	25, 665, 567	1, 228, 405	50.00
52.00 05	200 DELIVERY ROOM & LABOR ROOM	1, 342, 044	25, 115, 804	0. 053434	70, 747	3, 780	52.00
54.00 05	400 RADI OLOGY-DI AGNOSTI C	6, 942, 404	266, 162, 844	0. 026083	29, 688, 713	774, 371	54.00
54. 01 05	402 CARDIAC NUCLEAR DIAGNOSTIC	27, 846	21, 045, 898	0. 001323	134, 514	178	54.01
54. 02   03	450 NUCLEAR MEDICINE - DIAGNOSTIC	0	0	0.000000	0	0	54.02
54. 03   03	630 ULTRA SOUND	261, 764	20, 685, 446	0. 012655	2, 776, 594	35, 138	54.03
55.00 05	500 RADI OLOGY - THERAPEUTI C	61, 289	22, 707, 647	0. 002699	40, 184	108	55.00
56.00 05	600 RADI OI SOTOPE	32, 847	5, 559, 787	0. 005908	617, 582	3, 649	56.00
59.00 05	900 CARDI AC CATHETERI ZATI ON	2, 059, 684	68, 251, 478	0. 030178	10, 663, 188	321, 794	59.00
60.00 06	000 LABORATORY	2, 697, 463	194, 096, 047	0. 013898	33, 922, 467	471, 454	60.00
64. 00 06	400 I NTRAVENOUS THERAPY	51, 285	2, 082, 896	0. 024622	786, 316	19, 361	64.00
65. 00 06	500 RESPI RATORY THERAPY	699, 378	49, 890, 678	0. 014018	18, 109, 533	253, 859	65.00
66. 00 06	600 PHYSI CAL THERAPY	976, 307	29, 730, 769	0. 032838	6, 421, 819	210, 880	66. 00
66. 01 06	601 SPORTS MEDICINE	0	0	0.000000	0	0	66. 01
67. 00 06	700 OCCUPATI ONAL THERAPY	47, 655	8, 718, 361	0.005466	1, 988, 727	10, 870	67.00
68. 00 06	800 SPEECH PATHOLOGY	80, 785	5, 550, 146	0. 014555	704, 327	10, 251	68. 00
69. 00 06	900 ELECTROCARDI OLOGY	1, 102, 452	18, 802, 925	0. 058632	6, 647, 137		69. 00
69. 01 06	901 CARDI AC CATH LAB	0	0	0.000000	0	0	69. 01
70.00 07	000 ELECTROENCEPHALOGRAPHY	78, 831	19, 734, 764		588, 347	2, 350	70.00
71.00 07	100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 124, 690			40, 909, 341	506, 089	71.00
72. 00 07.	200 IMPL. DEV. CHARGED TO PATIENT	769, 004		0. 010654	17, 944, 918	191, 185	72.00
	300 DRUGS CHARGED TO PATIENTS	2, 127, 518			50, 774, 961	329, 783	73.00
	400 RENAL DIALYSIS	457, 045			3, 057, 323	251, 544	74.00
	697 CARDI AC REHABI LI TATI ON	16, 607			258		76. 97
	TPATIENT SERVICE COST CENTERS			'		<u> </u>	
	000 CLI NI C	2, 823, 859	19, 639, 045	0. 143788	80, 347	11, 553	90.00
90. 01 09	001 BMT JOINT VENTURE	304, 715	5, 104, 463	0. 059696	49, 766	2, 971	90. 01
90. 02 09	002 PSYCHIATRIC COUNCELING CENTER	1, 296, 658			0	0	90. 02
	003 SOUTH INDY MRI & REHAB	1, 577			0	0	90. 03
	004 BARI ATRI CS	0	0	0.000000	0	0	90. 04
	005 CV DIAGNOSTIC SERVICES	196, 076	27, 366, 690		25, 525	183	
	006 CARDI AC REHAB	0	0	0. 000000	0	0	90.06
	100 EMERGENCY	4, 017, 938	174, 430, 576		19, 818, 112	1	
	200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 460, 275			1, 499, 382		
200.00	Total (lines 50-199)		1, 659, 896, 989		272, 985, 695		
	1	,,	, , , ,	1	, , 0,0	1 2, 22 1, 000	

Health Financial Systems ST. F	RANCIS HOSPITA	L & HEALTH CEN	TER	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	ASS THROUGH COS			Period: From 01/01/2014 To 12/31/2014	Date/Time Pre 5/26/2015 12:	
		Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	Nursi ng	Allied Health	All Other	Swi ng-Bed	Total Costs	
	School	Cost	Medi cal	Adjustment	(sum of cols.	
			Educati on	Amount (see	1 through 3,	
			Cost	instructions)	minus col. 4)	
	1. 00	2.00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00   03000   ADULTS & PEDI ATRI CS	0	0		0 0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	0	0		0	0	31.00
31.01 02060 NEONATAL INTENSIVE CARE UNIT	0	0		0	0	31. 01
32. 00 03200 CORONARY CARE UNIT	0	0		O	0	32.00
34.00 03400 SURGICAL INTENSIVE CARE UNIT	0	0		O	0	34.00
41. 00   04100   SUBPROVI DER -   RF	0	0		0 0	0	41.00
43. 00 04300 NURSERY	0	0		o	0	43.00
200.00 Total (lines 30-199)	0	0		o	0	200.00
Cost Center Description	Total Patient	Per Diem	I npati ent	I npati ent		
	Days	(col. 5 ÷	Program Days	Program		
	·	col. 6)		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	56, 617		,			30.00
31.00  03100 INTENSIVE CARE UNIT	9, 739	0.00	5, 26	5 0		31.00
31.01  02060 NEONATAL INTENSIVE CARE UNIT	4, 656			0		31.01
32.00   03200   CORONARY CARE UNIT	12, 067	0.00	6, 83	5 0		32.00
34.00   03400   SURGICAL INTENSIVE CARE UNIT	6, 673	0.00	3, 75	7 0		34.00
41. 00   04100   SUBPROVI DER - I RF	4, 104	0.00	2, 25	1 0		41.00
43. 00   04300   NURSERY	4, 419	0.00		0 0		43.00
200.00   Total (lines 30-199)	98, 275		37, 41	0 0		200.00

Health Financial Systems ST. FRANCIS HOSPITAL & APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS | Peri od: | Worksheet D | From 01/01/2014 | Part IV | To 12/31/2014 | Date/Time Prepared: | 12/47/2015 | Part IV | Provi der CCN: 150162 THROUGH COSTS

				10	12/31/2014	5/26/2015 12:	
			Titl	e XVIII	Hospi tal	PPS	
	Cost Center Description	Non Physician	Nursi ng	Allied Health	All Other	Total Cost	
		Anesthetist	School		Medi cal	(sum of col 1	
		Cost			Educati on	through col.	
					Cost	4)	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0	0	0	0	54.00
54. 01	05402 CARDIAC NUCLEAR DIAGNOSTIC	0	0	0	0	0	54. 01
54. 02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0	0	0	0	0	54. 02
54. 03	03630 ULTRA SOUND	0	0	0	0	0	54.03
55. 00	05500 RADI OLOGY - THERAPEUTI C	0	0	0	0	0	55.00
56. 00	05600 RADI OI SOTOPE	0	0	0	0	0	56.00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0	59. 00
60.00	06000 LABORATORY	0	0	327, 480	0	327, 480	60.00
64. 00	06400 I NTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500 RESPI RATORY THERAPY	0	0	0	0	0	65.00
66. 00	06600 PHYSI CAL THERAPY	0	0	0	0	0	66. 00
66. 01	06601 SPORTS MEDICINE	0	0	0	0	0	66. 01
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	0	0	0	67.00
68. 00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0	0	0	0	69. 00
69. 01	06901 CARDI AC CATH LAB	0	0	0	0	0	69. 01
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	74.00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0	0	0	0	76. 97
	OUTPATIENT SERVICE COST CENTERS		_		_	_	
90.00	09000 CLINIC	0	0	0	0	0	90.00
90. 01	09001 I BMT JOINT VENTURE	0	0	0	0	0	90. 01
90. 02	09002 PSYCHI ATRI C COUNCELI NG CENTER	0	0	0	0	0	90. 02
90. 03	09003 SOUTH INDY MRI & REHAB	0	0	0	0	0	90. 03
90.04	09004 BARI ATRI CS	0	0	0	0	0	90.04
90. 05	09005 CV DI AGNOSTI C SERVI CES	0	0	0	0	0	90.05
90.06	09006 CARDI AC REHAB	0	0	0	0	0	90.06
	09100 EMERGENCY	0	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	227 420	0	0	92.00
200.00	Total (lines 50-199)	0	0	327, 480	0	327, 480	200.00

Health Financial Systems ST. FRANCIS HOSPITAL & APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS | Peri od: | Worksheet D | From 01/01/2014 | Part IV | To 12/31/2014 | Date/Time Prepared: | 12/47/2015 | Part IV | Provi der CCN: 150162 THROUGH COSTS

					0 12/31/2014	5/26/2015 12:	
			Ti tl	e XVIII	Hospi tal	PPS	., p
	Cost Center Description	Total		Ratio of Cost		I npati ent	
	•	Outpati ent	(from Wkst.	to Charges	Ratio of Cost	Program	
		Cost (sum of	C, Part I,	(col. 5 ÷	to Charges	Charges	
		col . 2, 3 and	col. 8)	col. 7)	(col. 6 ÷	Ü	
		4)			col. 7)		
		6. 00	7. 00	8. 00	9. 00	10.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	158, 009, 384	0.000000	0. 000000	25, 665, 567	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	25, 115, 804			70, 747	52.00
54.00	05400   RADI OLOGY-DI AGNOSTI C	0	266, 162, 844	0.000000	0. 000000	29, 688, 713	54.00
54.01	05402 CARDIAC NUCLEAR DIAGNOSTIC	0	21, 045, 898	0.000000	0. 000000	134, 514	54. 01
54.02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0	0	0.000000	0. 000000	0	54.02
54.03	03630 ULTRA SOUND	0	20, 685, 446	0.000000	0. 000000	2, 776, 594	54.03
55.00	05500   RADI OLOGY - THERAPEUTI C	0	22, 707, 647	0.000000	0. 000000	40, 184	55.00
56.00	05600 RADI OI SOTOPE	0	5, 559, 787	0.000000	0. 000000	617, 582	56.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	68, 251, 478	0.000000	0. 000000	10, 663, 188	59.00
60.00	06000 LABORATORY	327, 480	194, 096, 047	0. 001687	0. 001687	33, 922, 467	60.00
64.00	06400 I NTRAVENOUS THERAPY	0	2, 082, 896	0.000000	0. 000000	786, 316	64.00
65.00	06500 RESPIRATORY THERAPY	0	49, 890, 678	0.000000	0. 000000	18, 109, 533	65.00
66.00	06600 PHYSI CAL THERAPY	0	29, 730, 769	0.000000	0. 000000	6, 421, 819	66.00
66. 01	06601 SPORTS MEDICINE	0	0	0.000000	0. 000000	0	66. 01
67.00	06700 OCCUPATI ONAL THERAPY	0	8, 718, 361	0.000000	0. 000000	1, 988, 727	67.00
68.00	06800 SPEECH PATHOLOGY	0	5, 550, 146	0.000000	0. 000000	704, 327	68.00
69.00	06900 ELECTROCARDI OLOGY	0	18, 802, 925	0.000000	0. 000000	6, 647, 137	69.00
69. 01	06901 CARDI AC CATH LAB	0	0	0.000000	0. 000000	0	69. 01
70.00	07000 ELECTROENCEPHALOGRAPHY	0	19, 734, 764	0.000000	0. 000000	588, 347	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	90, 910, 450	0.000000	0. 000000	40, 909, 341	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	72, 177, 363	0.000000	0. 000000	17, 944, 918	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	327, 568, 031	0.000000	0. 000000	50, 774, 961	73.00
74.00	07400 RENAL DIALYSIS	0	5, 555, 055	0.000000	0. 000000	3, 057, 323	74.00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	1, 514, 747	0.000000	0. 000000	258	76. 97
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000  CLI NI C	0				80, 347	90.00
90. 01	09001 I BMT JOINT VENTURE	0	5, 104, 463	0.000000	0. 000000	49, 766	90. 01
90. 02	09002 PSYCHIATRIC COUNCELING CENTER	0	6, 120, 329			0	90. 02
90. 03	09003 SOUTH INDY MRI & REHAB	0	149, 986	0.000000		0	90. 03
90.04	09004 BARI ATRI CS	0	0	0.000000		0	90. 04
90.05	09005 CV DIAGNOSTIC SERVICES	0	27, 366, 690			25, 525	90. 05
90.06	09006 CARDI AC REHAB	0	0	0.000000		0	90.06
91.00	09100 EMERGENCY	0	174, 430, 576				91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	13, 215, 380		0. 000000	1, 499, 382	92.00
200.00	Total (lines 50-199)	327, 480	1, 659, 896, 989			272, 985, 695	200. 00

Peri od: Worksheet D From 01/01/2014 Part IV To 12/31/2014 Date/Time Prepared: 5/26/2015 12:47 pm THROUGH COSTS

				5/26/2015 12		47 pm	
			Ti tl	e XVIII	Hospi tal	PPS	
	Cost Center Description	Inpatient	Outpati ent	Outpati ent			
		Program	Program	Program			
		Pass-Through	Charges	Pass-Through	1		
		Costs (col. 8	Ü	Costs (col.	9		
		x col. 10)		x col. 12)			
		11. 00	12. 00	13. 00			
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	0	15, 889, 247		0		1 50. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0		52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	65, 869, 023		0		54.00
54. 01	05402 CARDI AC NUCLEAR DI AGNOSTI C		8, 819, 565		0		54. 01
54. 02	03450 NUCLEAR MEDICINE - DIAGNOSTIC		0		0		54. 02
54. 03	03630 ULTRA SOUND		2, 843, 278		0		54. 03
55. 00	05500 RADI OLOGY - THERAPEUTI C		2, 814, 409		0		55.00
56. 00	05600 RADI OI SOTOPE		1, 193, 881		0		56.00
59. 00	05900 CARDI AC CATHETERI ZATI ON		15, 088, 032		0		59.00
60.00	06000 LABORATORY	57, 227	13, 523, 398		-		60.00
64. 00	06400 I NTRAVENOUS THERAPY	37, 227					64.00
65. 00		0	87, 530		0		65.00
	06500 RESPI RATORY THERAPY	0	1, 495, 708		0		
66. 00	06600 PHYSI CAL THERAPY	0	7, 774		0		66.00
66. 01	06601 SPORTS MEDICINE	0	0		0		66. 01
67. 00	06700 OCCUPATI ONAL THERAPY	0	0		0		67.00
68. 00	06800 SPEECH PATHOLOGY	0	20, 005		0		68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	1, 798, 432		0		69. 00
69. 01	06901 CARDI AC CATH LAB	0	0		0		69. 01
70.00	07000 ELECTROENCEPHALOGRAPHY	0	3, 972, 211		0		70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	15, 065, 175		0		71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	0	11, 889, 499		0		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	69, 653, 929		0		73.00
74.00	07400 RENAL DIALYSIS	0	117, 381		0		74.00
76. 97	07697 CARDI AC REHABI LI TATI ON	O	622, 828		0		76. 97
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	5, 113, 308		0		90.00
90. 01	09001 I BMT JOINT VENTURE	o	238, 618		0		90. 01
90. 02	09002 PSYCHIATRIC COUNCELING CENTER	o	1, 420, 994		0		90.02
90. 03	09003 SOUTH INDY MRI & REHAB	0	0		0		90. 03
90. 04	09004 BARI ATRI CS		0		0		90.04
90. 05	09005 CV DI AGNOSTI C SERVI CES		11, 850, 208		0		90.05
90. 06	09006 CARDI AC REHAB		, 555, <u>2</u> 66		0		90.06
91. 00	09100 EMERGENCY		25, 153, 878		0		91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)		2, 169, 082		0		92.00
200.00		57, 227	276, 717, 393		-		200.00
200.00	110101 (111103 30 177)	37,227	210, 111, 373	22,01	'1		1200.00

APPORT	TIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der	CCN: 150162	Period: From 01/01/2014	Worksheet D Part V	
					To 12/31/2014	Date/Time Pre	pared:
			T: ±1	- ////	Hanni Ani	5/26/2015 12:	47 pm
			1111	e XVIII Charges	Hospi tal	PPS Costs	
	Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
	cost center bescription	Charge Ratio	Reimbursed	Rei mbursed	Rei mbursed	(see inst.)	
		From	Services (see		Servi ces Not	(366 11131.)	
		Worksheet C,	inst.)	Subject To	Subject To		
		Part I, col.	11131.)	Ded. & Coins			
		9		(see inst.)	(see inst.)		
		1.00	2.00	3.00	4.00	5. 00	
	ANCILLARY SERVICE COST CENTERS	1.00	2.00	0.00		0.00	
50.00	05000 OPERATING ROOM	0. 261074	15, 889, 247	1	0 0	4, 148, 269	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 244015			0 0	0	1
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0. 134202			o o	8, 839, 755	
54. 01	05402 CARDI AC NUCLEAR DI AGNOSTI C	0. 054687	8, 819, 565	1	0 0	482, 316	
54. 02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0. 000000			0 0	0	1
54. 03	03630 ULTRA SOUND	0. 088708			0 0	252, 222	
55. 00	05500 RADI OLOGY - THERAPEUTI C	0. 151621	2, 814, 409	1	0 0	426, 724	
56. 00	05600 RADI OI SOTOPE	0. 265549			0 0	317, 034	
59.00	05900 CARDI AC CATHETERI ZATI ON	0. 090593				1, 366, 870	
60.00	06000 LABORATORY	0. 146690				1, 983, 747	
64. 00	06400 I NTRAVENOUS THERAPY	0. 266370			0 0	23, 315	
65. 00	06500 RESPIRATORY THERAPY	0. 213592		1		319, 471	
66. 00	06600 PHYSI CAL THERAPY	0. 272215		1	0 0	2, 116	
66. 01	06601 SPORTS MEDICINE	0. 000000				2,110	1
67. 00	06700 OCCUPATI ONAL THERAPY	0. 234084			0 0	0	
68. 00	06800 SPEECH PATHOLOGY	0. 234084	20, 005	<u>'</u>	0 0	4, 499	
69. 00	06900 ELECTROCARDI OLOGY	0. 182369		1	0 0	327, 978	
69. 01	06901 CARDI AC CATH LAB	0. 000000			0 0	327, 478	1
70. 00	07000 ELECTROENCEPHALOGRAPHY	0. 196020		ή	0 0	778, 633	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 140020	· · ·	1	-1	6, 225, 503	
71.00	07200 I MPL. DEV. CHARGED TO PATIENT	0. 413236	11, 889, 499		0 0	4, 296, 710	
72.00	07300 DRUGS CHARGED TO PATIENTS			1			1
74.00	07400 RENAL DIALYSIS	0. 171309 0. 291962			0 0	11, 932, 345	
76. 97	07400 RENAL DI ALTSI S 07697 CARDI AC REHABI LI TATI ON	0. 480550			0 0		
70. 97	OUTPATIENT SERVICE COST CENTERS	0. 460330	022, 020	9	0 0	299, 300	70.97
90.00	09000 CLINIC	0. 716426	5, 113, 308		0 0	3, 663, 307	90.00
90.00	09001 I BMT JOINT VENTURE	1. 069168		1	0 0	255, 123	1
	1 1			1	0 0	· ·	
90. 02	09002 PSYCHI ATRI C COUNCELI NG CENTER	0. 695673				988, 547	
90. 03	09003 SOUTH INDY MRI & REHAB	0. 599983			0 0	0	
90. 04	09004 BARI ATRI CS	0.000000			0 0	0	
90. 05	09005 CV DI AGNOSTI C SERVI CES	0. 439012		3	0 0	5, 202, 384	
90.06	09006 CARDI AC REHAB	0.000000		1	0 0	0	90.06
91.00	09100 EMERGENCY	0. 112360		1		2, 826, 290	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 555742			0 0	1, 205, 450	
200.00	, ,		276, 717, 393	199, 89		56, 202, 179	
201.00					0 0		201.00
202.00	Only Charges (Line 200 // Line 201)		274 717 202	100.00	01	E4 202 170	202 00
202.00	Net Charges (line 200 +/- line 201)	l	276, 717, 393	199, 89	91  0	56, 202, 179	1202. UU

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provi der CCN: 150162 Peri od: Worksheet D From 01/01/2014 Part V 12/31/2014 Date/Time Prepared: 5/26/2015 12:47 pm Titl<u>e XVIII</u> Hospi tal PPS Costs Cost Center Description Cost Cost Rei mbursed Rei mbursed Servi ces Services Not Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 6.00 7.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 50.00 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 52.00 0 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 05402 CARDIAC NUCLEAR DIAGNOSTIC 0 0 0 54.01 54.02 03450 NUCLEAR MEDICINE - DIAGNOSTIC 0 54.02 03630 ULTRA SOUND 54.03 0 54.03 05500 RADIOLOGY - THERAPEUTIC 0 55.00 0 55.00 56.00 05600 RADI OI SOTOPE 0 56.00 0 0 59.00 05900 CARDI AC CATHETERI ZATI ON 59.00 06000 LABORATORY 3, 625 0 60.00 60.00 64.00 06400 I NTRAVENOUS THERAPY 0 0 64.00 06500 RESPIRATORY THERAPY 0 65.00 0 0 65.00 06600 PHYSI CAL THERAPY 0 66 00 66 00 66.01 06601 SPORTS MEDICINE 0 66.01 67.00 06700 OCCUPATI ONAL THERAPY 0 67.00 0 06800 SPEECH PATHOLOGY 68.00 68.00 06900 ELECTROCARDI OLOGY 0 69 00 69 00 06901 CARDI AC CATH LAB 0 69.01 0 69.01 70.00 07000 ELECTROENCEPHALOGRAPHY 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71.00 1, 781 71.00 07200 IMPL. DEV. CHARGED TO PATIENT 72 00 0 72.00 0 07300 DRUGS CHARGED TO PATIENTS 73.00 29, 062 0 73.00 07400 RENAL DIALYSIS 0 74.00 74.00 0 07697 CARDIAC REHABILITATION 0 76.97 0 76.97 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 0 90.00 09001 I BMT JOINT VENTURE 90.01 0 0 0 0 90.01 09002 PSYCHIATRIC COUNCELING CENTER 0 90.02 90 02 09003 SOUTH INDY MRI & REHAB 90.03 0 90.03 09004 BARI ATRI CS 90.04 90.04 0 90.05 09005 CV DIAGNOSTIC SERVICES 0 90.05 09006 CARDI AC REHAB 90.06 0 90.06 91.00 09100 EMERGENCY 138 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 92.00 Subtotal (see instructions) 200.00 200.00 34,606 0 Less PBP Clinic Lab. Services-Program 201.00 201.00 Only Charges

34,606

202.00

202.00

Net Charges (line 200 +/- line 201)

	Financial Systems ST. I TONMENT OF INPATIENT ANCILLARY SERVICE CAPIT.	FRANCIS HOSPITA		ENTER er CCN: 150162	In Lie	eu of Form CMS-2 Worksheet D	2552-10
APPURI	TONMENT OF INPATTENT ANCILLARY SERVICE CAPITA	AL CUSTS	Provide	er CCN: 150162	From 01/01/2014		
			Compone	ent CCN: 15T162	To 12/31/2014	Date/Time Pre	pared:
			Ti	tle XVIII	Subprovi der -	5/26/2015 12:47 pm PPS	
				LIE AVIII	I RF	PPS	
	Cost Center Description	Capi tal	Total Charge	es Ratio of Cos		Capital Costs	
	·	Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
		(from Wkst.	C, Part I,	(col . 1 ÷	Charges	column 4)	
		B, Part II,	col. 8)	col . 2)			
		col. 26)					
		1. 00	2. 00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						1
50.00	05000 OPERATING ROOM	7, 562, 717				1, 399	1
52.00	05200 DELIVERY ROOM & LABOR ROOM	1, 342, 044					52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	6, 942, 404				5, 841	54.00
54. 01	05402 CARDI AC NUCLEAR DI AGNOSTI C	27, 846				0	0 0 .
54. 02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0		0.0000		0	54. 02
54. 03	03630 ULTRA SOUND	261, 764					
55.00	05500 RADI OLOGY - THERAPEUTI C	61, 289					55. 00
56.00	05600 RADI OI SOTOPE	32, 847				_	56.00
59. 00	05900 CARDI AC CATHETERI ZATI ON	2, 059, 684				0	59.00
60.00	06000 LABORATORY	2, 697, 463					60.00
64. 00	06400 I NTRAVENOUS THERAPY	51, 285				_	
65.00	06500 RESPI RATORY THERAPY	699, 378					1
66.00	06600 PHYSI CAL THERAPY	976, 307					66.00
66. 01	06601 SPORTS MEDICINE	0		0.0000			
67.00	06700 OCCUPATI ONAL THERAPY	47, 655					1
68. 00	06800 SPEECH PATHOLOGY	80, 785					1
69. 00	06900 ELECTROCARDI OLOGY	1, 102, 452					1
69. 01	06901 CARDI AC CATH LAB	0		0.0000		_	
70.00	07000 ELECTROENCEPHALOGRAPHY	78, 831					70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 124, 690					1
72.00	07200 I MPL. DEV. CHARGED TO PATI ENT	769, 004					72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	2, 127, 518					
74.00	07400 RENAL DI ALYSI S	457, 045					
76. 97	07697 CARDI AC REHABI LI TATI ON	16, 607	1, 514, 7	47 0. 0109	64 0	0	76. 97
00 00	OUTPATIENT SERVICE COST CENTERS	2 022 050	10 (20 0	45 0 1407	00 0		00 00
90.00	09000 CLINIC	2, 823, 859				_	1 /0.00
90. 01	09001 I BMT JOI NT VENTURE	304, 715				_	
90. 02 90. 03	09002 PSYCHI ATRI C COUNCELI NG CENTER	1, 296, 658				0	90. 02 90. 03
	09003 SOUTH INDY MRI & REHAB 09004 BARIATRICS	1, 577		0. 0105 0 0. 0000			1
	109004 BARTATRICS	196 076				_	

0

93, 319 200. 00

90.05

90.06

91.00 0

92.00 0

0.007165

0.000000

0. 023035 0. 000000

5, 178, 159

174, 430, 576 13, 215, 380

37, 160, 438 1, 659, 896, 989

90. 05 09005 CV DI AGNOSTI C SERVI CES

91. 00 | 09100 | EMERGENCY | 92. 00 | 09200 | OBSERVATION | BEDS (NON-DISTINCT PART)

Total (lines 50-199)

90. 06 09006 CARDI AC REHAB

Health Financial Systems	ST. FRANCIS HOSPITAL &	HEALTH CENTER	In Lieu	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIEN	T ANCILLARY SERVICE OTHER PASS	Provi der CCN: 150162		Worksheet D
TUDOLICU COCTO			From 01/01/2014	Part IV

THROUGH COSTS Component CCN: 15T162 To 12/31/2014 Date/Time Prepared: 5/26/2015 12:47 pm Title XVIII Subprovi der PPS **IRF** Non Physician Total Cost Cost Center Description Nursi ng Allied Health All Other Anestheti st Medi cal (sum of col 1 School Educati on Cost through col. 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 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 0 0 52.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 54.00 000000000000000000000000 0 05402 CARDIAC NUCLEAR DIAGNOSTIC 0 0 54.01 54.01 0 03450 NUCLEAR MEDICINE - DIAGNOSTIC 0 54.02 0 54.02 54.03 03630 ULTRA SOUND 0 0 54.03 55.00 05500 RADI OLOGY - THERAPEUTI C 0 55.00 05600 RADI OI SOTOPE 0 56.00 0 56, 00 0 05900 CARDIAC CATHETERIZATION 59.00 0 0 0 59.00 60.00 06000 LABORATORY 327, 480 327, 480 60.00 64.00 06400 I NTRAVENOUS THERAPY 0 0 0 64.00 06500 RESPIRATORY THERAPY 0 0 65.00 65.00 0 66.00 06600 PHYSI CAL THERAPY 0 66.00 06601 SPORTS MEDICINE 0 66.01 0 66.01 06700 OCCUPATIONAL THERAPY 0 0 67 00 0 67 00 0 68.00 06800 SPEECH PATHOLOGY 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0 0 0 69.00 06901 CARDI AC CATH LAB 0 69.01 0 69.01 07000 ELECTROENCEPHALOGRAPHY 0 0 70 00 70 00 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71.00 0 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENT 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 0 0 73.00 0 07400 RENAL DIALYSIS 74 00 0 74 00 0 07697 CARDIAC REHABILITATION 76.97 0 0 76.97 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 0 90.00 00000000000 09001 I BMT JOINT VENTURE 0 0 90.01 0 0 90.01 09002 PSYCHIATRIC COUNCELING CENTER 0 90.02 0 0 0 0 0 0 90.02 09003 SOUTH INDY MRI & REHAB 0 90.03 0 0 90.03 0 09004 BARI ATRI CS 0 90 04 90 04 0 09005 CV DIAGNOSTIC SERVICES 0 90.05 0 0 90.05 09006 CARDI AC REHAB 0 90.06 0 91.00 09100 EMERGENCY 0 0 0 91.00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 92.00

0

327, 480

Ω

327, 480 200. 00

200.00

Total (lines 50-199)

Health Financial Systems ST. FRANCIS HOSPITAL & HEALTH CENTER In Lieu of Form CMS-2552-10							
	TIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE				Period:	Worksheet D	2552-10
	THROUGH COSTS				From 01/01/2014		
	Com				To 12/31/2014	Date/Time Pre 5/26/2015 12:	pared: 47 pm
				e XVIII	Subprovi der - I RF	PPS	
	Cost Center Description	Total	Total Charges	Ratio of Cos		I npati ent	
		Outpati ent	(from Wkst.	to Charges	Ratio of Cost	Program	
		Cost (sum of	C, Part I,	(col. 5 ÷	to Charges	Charges	
		col . 2, 3 and	col. 8)	col. 7)	(col. 6 ÷		
		4)			col. 7)		
		6. 00	7. 00	8. 00	9. 00	10.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000  OPERATI NG ROOM	0	158, 009, 384			29, 225	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	25, 115, 804			0	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	266, 162, 844	0.00000	0. 000000	223, 945	54.00
54.01	05402 CARDIAC NUCLEAR DIAGNOSTIC	0	21, 045, 898	0.00000	0. 000000	0	54.01
54.02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0	0	0.00000	0. 000000	0	54.02
54.03	03630 ULTRA SOUND	0	20, 685, 446	0.00000	0. 000000	48, 381	54.03
55.00	05500 RADI OLOGY - THERAPEUTI C	0	22, 707, 647	0.00000	0. 000000	2, 156	55.00
56.00	05600 RADI OI SOTOPE	0	5, 559, 787	0.00000	0. 000000	0	56.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	68, 251, 478	0. 00000	0. 000000	0	59.00
60.00	06000 LABORATORY	327, 480	194, 096, 047	0. 00168	7 0. 001687	426, 726	60.00
64.00	06400 I NTRAVENOUS THERAPY	0			0. 000000	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	49, 890, 678	0.00000	0. 000000	271, 366	65.00
66.00	06600 PHYSI CAL THERAPY	0	29, 730, 769			1, 348, 853	
66. 01	06601 SPORTS MEDICINE	0		0.00000		0	66. 01
67. 00	06700 OCCUPATI ONAL THERAPY	0	8, 718, 361			1, 120, 606	1
68. 00	06800 SPEECH PATHOLOGY	0				425, 128	68. 00
69. 00	06900 ELECTROCARDI OLOGY	Ö				22, 814	
69. 01	06901 CARDI AC CATH LAB	Ö		0. 00000		0	69. 01
70.00	07000 ELECTROENCEPHALOGRAPHY	Ö				747	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0				521, 363	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	Ö	, ,			1, 184	
73.00	07300 DRUGS CHARGED TO PATIENTS	Ö				638, 382	73.00
74.00	07400 RENAL DIALYSIS	Ö				86, 159	1
76. 97	07697 CARDI AC REHABI LI TATI ON	Ö					1
10. 71	OUTPATIENT SERVICE COST CENTERS		1, 314, 747	0.00000	0.00000	0	70.77
90.00	09000 CLINIC	0	19, 639, 045	0.00000	0. 000000	0	90.00
90. 00	09001 I BMT JOI NT VENTURE	0				0	90.00
90. 01	09002 PSYCHIATRIC COUNCELING CENTER					1 0	90.01
90. 02	09003 SOUTH INDY MRI & REHAB					0	90.02
90. 03	09004 BARI ATRI CS			0.00000		0	90.03
90.04	09005 CV DI AGNOSTI C SERVI CES		-	•		_	90.04
	I I		,	•		11, 124	1
90.06	09006 CARDI AC REHAB	1	-	0.00000		Ŭ	90.06
91.00	09100 EMERGENCY	0	.,			0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	13, 215, 380	0. 00000	0. 000000	0	92.00

327, 480 1, 659, 896, 989

5, 178, 159 200. 00

Total (lines 50-199)

Health Financial Systems	ST. FRANCIS HOSPITAL & F	u of Form CMS-2552-10		
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provi der CCN: 150162		Worksheet D
THROUGH COSTS			From 01/01/2014	
		Component CCN: 15T162	To 12/31/2014	Date/Time Prepared:
				5/26/2015 12:47 pm
•		T \0.0.1.1	0 1 1 1	550

			Ti tl	e XVIII	Subprovi der -	PPS
	Cook Cooks Doors at an	1	0	0	I RF	
	Cost Center Description	Inpatient Program	Outpatient Program	Outpatient Program		
		Pass-Through	Charges	Pass-Through		
		Costs (col. 8	chai ges	Costs (col.		
		x col . 10)		x col . 12)	7	
		11.00	12. 00	13.00		
	ANCILLARY SERVICE COST CENTERS	11.00	12.00	13.00		
50.00	05000 OPERATING ROOM	0	C	)	0	50.00
	05200 DELIVERY ROOM & LABOR ROOM	ol	C	•	0	52.00
	05400 RADI OLOGY-DI AGNOSTI C	ol	C		0	54.00
	05402 CARDI AC NUCLEAR DI AGNOSTI C	ol	C		0	54. 01
	03450 NUCLEAR MEDICINE - DIAGNOSTIC	ol	C		0	54. 02
	03630 ULTRA SOUND	o	C		0	54. 03
	05500 RADI OLOGY - THERAPEUTI C	o	C		0	55. 00
56.00	05600 RADI OI SOTOPE	ol	C		0	56.00
59.00	05900 CARDI AC CATHETERI ZATI ON	ol	C		0	59.00
60.00	06000 LABORATORY	720	C		0	60.00
64.00	06400 I NTRAVENOUS THERAPY	ol	C		0	64.00
65.00	06500 RESPIRATORY THERAPY	ol	C		0	65. 00
66.00	06600 PHYSI CAL THERAPY	o	C		0	66.00
66. 01	06601 SPORTS MEDICINE	o	C		0	66. 01
67.00	06700 OCCUPATI ONAL THERAPY	o	C		0	67.00
68.00	06800 SPEECH PATHOLOGY	o	C		0	68.00
69.00	06900 ELECTROCARDI OLOGY	o	C		0	69.00
69. 01	06901 CARDI AC CATH LAB	o	C		0	69. 01
70.00	07000 ELECTROENCEPHALOGRAPHY	o	C		0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	o	C		0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	C		0	72.00
	07300 DRUGS CHARGED TO PATIENTS	0	C		0	73.00
74.00	07400 RENAL DIALYSIS	0	C	)	0	74.00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	C	)	0	76. 97
	OUTPATIENT SERVICE COST CENTERS					
	09000 CLI NI C	0	C	•	0	90.00
	09001 I BMT JOINT VENTURE	0	C	)	0	90. 01
	09002 PSYCHIATRIC COUNCELING CENTER	0	C	)	0	90. 02
	09003 SOUTH INDY MRI & REHAB	0	C	)	0	90. 03
	09004 BARI ATRI CS	0	C	)	0	90.04
	09005 CV DI AGNOSTI C SERVI CES	0	C	)	0	90. 05
	09006 CARDI AC REHAB	0	C		0	90.06
	09100 EMERGENCY	0	C		0	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	C	l .	0	92. 00
200.00	Total (lines 50-199)	720	C	PJ	0	200.00

Health Financial Systems		ST. F	FRANCIS HOSPITAL & H	IEALTH CENTER		In Lieu	u of Form CMS-2552-10	J
APPORTIONMENT OF INPATIENT ROUT	INE SERVICE	CAPI TAL	COSTS	Provider CCN: 15016	2 Peri od:		Worksheet D	_

Health Financial Systems 51. Francis Hospital & Health Center In Lieu of Form CMS-2552-							
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der	CCN: 150162	Peri od:	Worksheet D		
				From 01/01/2014			
				To 12/31/2014			
				5/26/2015 12:	47 pm		
			le XIX	Hospi tal	PPS		
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem		
	Related Cost	Adjustment	Capi tal	Days	(col. 3 /		
	(from Wkst.		Related Cost		col. 4)		
	B, Part II,		(col. 1 -				
	col. 26)		col. 2)				
	1. 00	2.00	3. 00	4. 00	5. 00		
INPATIENT ROUTINE SERVICE COST CENTERS			•				
30.00 ADULTS & PEDIATRICS	11, 033, 873	0	11, 033, 87	73 56, 617	194. 89	30.00	
31.00 INTENSIVE CARE UNIT	2, 002, 451		2, 002, 45	9, 739	205. 61	31.00	
31. 01 NEONATAL INTENSIVE CARE UNIT	742, 912		742, 91		159, 56	31. 01	
32.00 CORONARY CARE UNIT	3, 805, 377		3, 805, 37	7 12, 067	315. 35	32.00	
34.00 SURGICAL INTENSIVE CARE UNIT	2, 090, 256	l e	2, 090, 25		<b>l</b>		
41. 00 SUBPROVIDER - I RF	1, 302, 247	l e			<b>l</b>		
43. 00 NURSERY	378, 910		378, 91				
200.00 Total (lines 30-199)	21, 356, 026	l e	21, 356, 02		l	200.00	
Cost Center Description	I npati ent	Inpati ent					
	Program days	Program					
	i i ogi am dajo	Capital Cost					
		(col. 5 x					
		col. 6)					
	6. 00	7.00	1				
INPATIENT ROUTINE SERVICE COST CENTERS	0.00	7.00					
30. 00 ADULTS & PEDIATRICS	3, 130	610, 006				30.00	
31. 00   INTENSIVE CARE UNIT	616					31.00	
31. 01 NEONATAL INTENSIVE CARE UNIT	294					31.00	
32. 00   CORONARY CARE UNIT	763					32.00	
34. 00   SURGI CAL   INTENSI VE CARE UNI T	422					34.00	
	152					41.00	
41. 00   SUBPROVIDER - IRF 43. 00   NURSERY	280					41.00	
200.00 Total (lines 30-199)	5, 657	1, 228, 613	1			200. 00	

Health Financial Systems ST. FRANCIS HOSPITAL & HEALTH CENTER In Lieu of Form CMS-2552-							
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provi der		Period: From 01/01/2014 To 12/31/2014	Date/Time Pre	pared:	
						5/26/2015 12:	47 pm
	0	0		le XIX	Hospi tal	PPS	
	Cost Center Description	Capi tal	Total Charges			Capital Costs	
		Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
		(from Wkst.	C, Part I,	(col . 1 ÷	Charges	column 4)	
		B, Part II,	col. 8)	col . 2)			
		col. 26)	0.00	2.00	4.00	F 00	
	ANCILLARY CERVICE COCT CENTERS	1. 00	2. 00	3. 00	4. 00	5. 00	
FO 00	ANCILLARY SERVICE COST CENTERS	7 5/0 717	150,000,004	0.0470/	2 720 245	170 445	
50.00	05000 OPERATING ROOM	7, 562, 717					
52.00	05200 DELIVERY ROOM & LABOR ROOM	1, 342, 044					
54.00	05400 RADI OLOGY-DI AGNOSTI C	6, 942, 404		•			
54. 01	05402 CARDI AC NUCLEAR DI AGNOSTI C	27, 846					
54. 02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0	_	0. 00000		1	
54. 03	03630 ULTRA SOUND	261, 764					
55.00	05500 RADI OLOGY - THERAPEUTI C	61, 289					55.00
56.00	05600 RADI OI SOTOPE	32, 847					56.00
59.00	05900 CARDI AC CATHETERI ZATI ON	2, 059, 684					
60.00	06000 LABORATORY	2, 697, 463	194, 096, 047	0. 01389	8 7, 929, 960	110, 211	60.00
64.00	06400 I NTRAVENOUS THERAPY	51, 285	2, 082, 896	0. 02462	2 128, 269	3, 158	64.00
65.00	06500 RESPIRATORY THERAPY	699, 378	49, 890, 678	0. 01401	8 4, 505, 954	63, 164	65.00
66.00	06600 PHYSI CAL THERAPY	976, 307	29, 730, 769	0. 03283	8 731, 934	24, 035	66.00
66. 01	06601 SPORTS MEDICINE	0	0	0. 00000	0	0	66. 01
67.00	06700 OCCUPATI ONAL THERAPY	47, 655	8, 718, 361	0. 00546	6 535, 418	2, 927	67.00
68.00	06800 SPEECH PATHOLOGY	80, 785					
69. 00	06900 ELECTROCARDI OLOGY	1, 102, 452					
69. 01	06901 CARDI AC CATH LAB	0		1			1
70.00	07000 ELECTROENCEPHALOGRAPHY	78, 831	_			-	1
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 124, 690					
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	769, 004					1
73. 00	07300 DRUGS CHARGED TO PATIENTS	2, 127, 518					1
74.00	07400 RENAL DIALYSIS	457, 045					
76. 97	07697 CARDI AC REHABI LI TATI ON	16, 607		•			1
10. 71	OUTPATIENT SERVICE COST CENTERS	10,007	1, 314, 747	0.01090	4 0		70. 77
90.00	09000 CLINIC	2, 823, 859	19, 639, 045	0. 14378	8 7, 419	1, 067	90.00
90. 01	09001 I BMT JOI NT VENTURE	304, 715		1			1
90. 01	09002 PSYCHIATRIC COUNCELING CENTER	1, 296, 658		•			1
90. 02	09003 SOUTH INDY MRI & REHAB	1, 290, 038				1	
90. 03		1,5//		0.00000		1	
	09004 BARI ATRI CS	_	·			0	
90.05	09005 CV DI AGNOSTI C SERVI CES	196, 076				•	90.05
90.06	09006 CARDI AC REHAB	0	· · · · · · · · · · · · · · · · · · ·	0.00000			
91.00	09100 EMERGENCY	4, 017, 938					
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 460, 275					
200.00	Total (lines 50-199)	38, 620, 713	1, 659, 896, 989		59, 065, 040	1, 407, 118	1200.00

Health Financial Systems	ST.	FRANCIS HOSPITAL &	HEALTH CENTER	In Li

ieu of Form CMS-2552-10 APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS Provider CCN: 150162 Peri od: Worksheet D From 01/01/2014 To 12/31/2014 Part III Date/Time Prepared: 5/26/2015 12:47 pm Title XIX Hospi tal PPS Cost Center Description Nursi ng Allied Health All Other Total Costs Swi ng-Bed (sum of cols. Medi cal Adjustment School Cost Educati on Amount (see 1 through 3, Cost nstructions) minus col. 1. 00 2.00 3.00 4. 00 5.00 INPATIENT ROUTINE SERVICE COST CENTERS 30. 00 03000 ADULTS & PEDIATRICS 30.00 0 0 0 0 0 0 0 0 31.00 03100 INTENSIVE CARE UNIT 0 0 31.00 31. 01 02060 NEONATAL INTENSIVE CARE UNIT 0 31.01 32.00 03200 CORONARY CARE UNIT 0 0 0 0 0 32.00 34. 00 03400 SURGI CAL INTENSI VE CARE UNIT 0 0 34.00 41. 00 | 04100 | SUBPROVI DER - I RF 0 0 41.00 43. 00 04300 NURSERY 0 0 0 43.00 Total (lines 30-199) 0 200. 00 200.00 Total Patient Per Diem I npati ent Cost Center Description I npati ent Days (col. 5 ÷ Program Days Program Pass-Through col. 6) Cost (col. x col. 8) 9. 00 6. 00 7.00 8.00 INPATIENT ROUTINE SERVICE COST CENTERS 30. 00 03000 ADULTS & PEDIATRICS 56, 617 0.00 3, 130 30.00 0 31.00 03100 INTENSIVE CARE UNIT 9, 739 0.00 31.00 616 0.00 31. 01 | 02060 | NEONATAL INTENSIVE CARE UNIT 4,656 294 31.01 32.00 03200 CORONARY CARE UNIT 12, 067 0.00 763 0 0 0 32.00 34.00 03400 SURGICAL INTENSIVE CARE UNIT 6,673 0.00 422 34.00 41. 00 | 04100 | SUBPROVI DER - I RF 4, 104 0.00 152 41.00 43. 00 | 04300 NURSERY 4, 419 0.00 280 43.00 200.00 Total (lines 30-199) 98, 275 5, 657 200.00

Health Financial Systems ST. FRANCIS HOSPITAL & APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provi der CCN: 150162 THROUGH COSTS

				10	12/31/2014	Date/Time Pre 5/26/2015 12:	
			Ti t	le XIX	Hospi tal	PPS	тт рііі
	Cost Center Description	Non Physician	Nursi ng	Allied Health	All Other	Total Cost	
	·	Anestheti st	School		Medi cal	(sum of col 1	
		Cost			Educati on	through col.	
					Cost	4)	
		1. 00	2. 00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0	0	0	0	54.00
54. 01	05402 CARDI AC NUCLEAR DI AGNOSTI C	0	0	0	0	0	54. 01
54.02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0	0	0	0	0	54.02
54.03	03630 ULTRA SOUND	0	0	0	0	0	54.03
55.00	05500 RADI OLOGY - THERAPEUTI C	0	0	0	0	0	55.00
56.00	05600 RADI OI SOTOPE	0	0	0	0	0	56.00
59. 00	05900  CARDI AC CATHETERI ZATI ON	0	0	0	0	0	59.00
60.00	06000 LABORATORY	0	0	327, 480	0	327, 480	60.00
64. 00	06400 I NTRAVENOUS THERAPY	0	0	0	0	0	64.00
65. 00	06500 RESPI RATORY THERAPY	0	0	0	0	0	65.00
66.00	06600 PHYSI CAL THERAPY	0	0	0	0	0	66.00
66. 01	06601 SPORTS MEDICINE	0	0	0	0	0	66. 01
67.00	06700 OCCUPATI ONAL THERAPY	0	0	0	0	0	67.00
68. 00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0	0	0	0	69. 00
69. 01	06901 CARDI AC CATH LAB	0	0	0	0	0	69. 01
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	74.00
76. 97	O7697   CARDI AC REHABI LI TATI ON	0	0	0	0	0	76. 97
	OUTPATIENT SERVICE COST CENTERS				ام		
90.00	09000 CLINIC	0	0	0	0	0	90.00
90. 01	09001 I BMT JOINT VENTURE	0	0	0	0	0	90. 01
90. 02	09002 PSYCHI ATRI C COUNCELI NG CENTER	0	0	0	0	0	90. 02
90.03	09003 SOUTH INDY MRI & REHAB	0	0	0	0	0	90.03
90.04	09004 BARI ATRI CS	0	0	0	0	0	90.04
90.05	09005 CV DI AGNOSTI C SERVI CES	0	0	0	0	0	90.05
90.06	09006 CARDI AC REHAB	0	0	0	0	0	90.06
91.00	09100 EMERGENCY	0	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0	227 400	0	227 480	92.00
200.00	Total (lines 50-199)	ı oj	0	327, 480	0	327, 480	200.00

In Lieu of Form CMS-2552-10 Health Financial Systems ST. FRANCIS HOSPITAL & HEALTH CENTER APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provi der CCN: 150162 Peri od: Worksheet D From 01/01/2014 THROUGH COSTS Part IV Date/Time Prepared: 12/31/2014 5/26/2015 12:47 pm Title XIX Hospi tal PPS Total Charges Ratio of Cost I npati ent Cost Center Description Total Outpati ent to Charges Outpati ent (from Wkst. Ratio of Cost Program Cost (sum of C, Part I, (col. 5 ÷ to Charges Charges (col. 6 ÷ col. 7) col. 2, 3 and col. 8) col. 7) 4) 9. 00 10.00 6.00 7.00 8.00 ANCILLARY SERVICE COST CENTERS 50 00 0.000000 50.00 05000 OPERATING ROOM 158, 009, 384 0.000000 3, 728, 315 05200 DELIVERY ROOM & LABOR ROOM 25, 115, 804 0.000000 0.000000 8, 511, 777 52.00 52.00 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 266, 162, 844 0.000000 0.000000 4, 692, 924 54.00 05402 CARDIAC NUCLEAR DIAGNOSTIC 0 0.000000 15, 200 54.01 21, 045, 898 0.00000054.01 54.02 03450 NUCLEAR MEDICINE - DIAGNOSTIC 0.000000 0.000000 0 54.02 607, 868 03630 ULTRA SOUND 0 20, 685, 446 0.000000 0.000000 54.03 55.00 05500 RADI OLOGY - THERAPEUTI C 0 22, 707, 647 0.000000 0.000000 450 55.00 0 0.000000 95, 099 56.00 05600 RADI OI SOTOPE 5, 559, 787 0.000000 56.00 59.00 05900 CARDIAC CATHETERIZATION 0 68, 251, 478 0.000000 0.000000 1, 072, 462 59.00 60.00 06000 LABORATORY 327, 480 194, 096, 047 0.001687 0.001687 7, 929, 960 60.00 06400 I NTRAVENOUS THERAPY 2, 082, 896 0.000000 0.000000 128, 269 64.00 0 64.00 65.00

Peri od: Worksheet D
From 01/01/2014 Part IV
To 12/31/2014 Date/Time Prepared: 5/26/2015 12:47 pm THROUGH COSTS

						5/26/2015 12:	47 pm
			Ti t	le XIX	Hospi tal	PPS	
	Cost Center Description	Inpati ent	Outpati ent	Outpati ent			
	•	Program	Program	Program			
		Pass-Through	Charges	Pass-Through	n l		
		Costs (col. 8	3.1	Costs (col.			
		x col. 10)		x col. 12)			
		11. 00	12. 00	13.00			
	ANCILLARY SERVICE COST CENTERS	1 11122					
50.00	05000 OPERATING ROOM	0	0		0		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0		52.00
	05400 RADI OLOGY-DI AGNOSTI C	0	0		0		54.00
	05402 CARDI AC NUCLEAR DI AGNOSTI C	0	0		0		54. 01
	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0	0		0		54. 02
54. 03	03630 ULTRA SOUND	0	0		0		54. 03
	05500 RADI OLOGY - THERAPEUTI C	0	0		0		55.00
56. 00	05600 RADI OI SOTOPE	0	0		0		56.00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0		0		59.00
60.00	06000 LABORATORY	13, 378	0		0		60.00
64. 00	06400 I NTRAVENOUS THERAPY	0	0		0		64.00
65. 00	06500 RESPIRATORY THERAPY	0	0		0		65. 00
66.00	06600 PHYSI CAL THERAPY	o o	0		0		66.00
	06601 SPORTS MEDICINE	0	0		0		66. 01
67. 00	06700 OCCUPATI ONAL THERAPY		0		0		67. 00
68. 00	06800 SPEECH PATHOLOGY		0		0		68.00
	06900 ELECTROCARDI OLOGY		0		0		69.00
	06901 CARDI AC CATH LAB		0		0		69. 01
	07000 ELECTROENCEPHALOGRAPHY		0		0		70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0		0		71.00
	07200 I MPL. DEV. CHARGED TO PATIENT		0		0		72.00
	07300 DRUGS CHARGED TO PATIENTS		0		0		73.00
	07400 RENAL DIALYSIS		0		o		74.00
	07697 CARDI AC REHABI LI TATI ON	o o	0		0		76. 97
70.77	OUTPATIENT SERVICE COST CENTERS	<u> </u>			<u> </u>		1 /0: //
90.00	09000 CLINIC	0	0		0		90.00
	09001 I BMT JOINT VENTURE	Ö	0		0		90.01
	09002 PSYCHI ATRI C COUNCELING CENTER	o o	0		0		90. 02
90. 03	09003 SOUTH INDY MRI & REHAB	o o	0		0		90. 03
	09004 BARI ATRI CS		0		0		90.04
	09005 CV DI AGNOSTI C SERVI CES	o o	0		0		90.05
	09006 CARDI AC REHAB		0		o l		90.06
91.00	09100 EMERGENCY		0		0		91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0		0		92.00
200.00		13, 378	0		0		200.00
200.00	1 10tal (11163 30-177)	13,370	U	I	9		1200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provi der CCN: 150162 Peri od: Worksheet D From 01/01/2014 Part V Date/Time Prepared: 12/31/2014 5/26/2015 12:47 pm Title XIX Hospi tal PPS Charges Costs PPS Services Cost Center Description Cost to PPS Cost Cost Charge Ratio Rei mbursed Rei mbursed Rei mbursed (see inst.) From Services (see Servi ces Services Not Worksheet C, Subject To inst.) Subject To Part I, col. Ded. & Coins. Ded. & Coins. 9 (see inst.) (see inst.) 1. 00 2.00 5.00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 5, 779, 242 0. 261074 50.00 05200 DELIVERY ROOM & LABOR ROOM 0 0.244015 52.00 0 24, 242 52.00 0 05400 RADI OLOGY-DI AGNOSTI C 22, 490, 324 54.00 0. 134202 0 0 54.00 05402 CARDIAC NUCLEAR DIAGNOSTIC 0.054687 788,030 0 54.01 54.02 03450 NUCLEAR MEDICINE - DIAGNOSTIC 0.000000 0 54.02 03630 ULTRA SOUND 0.088708 54 03 3, 341, 171 0 54.03 05500 RADIOLOGY - THERAPEUTIC 55.00 0.151621 0 713, 889 0 55.00 56.00 05600 RADI OI SOTOPE 0. 265549 351, 795 0 56.00 59.00 05900 CARDI AC CATHETERI ZATI ON 0.090593 1, 884, 551 0 59.00 06000 LABORATORY 0.146690 60.00 15, 604, 316 0 60.00 64.00 06400 I NTRAVENOUS THERAPY 0.266370 7,838 0 64.00 06500 RESPIRATORY THERAPY 65.00 0. 213592 783, 617 0 65.00 06600 PHYSI CAL THERAPY 66 00 0 272215 2, 253, 851 0 66 00 66.01 06601 SPORTS MEDICINE 0.000000 0 66.01 67.00 06700 OCCUPATI ONAL THERAPY 0. 234084 1, 301, 025 0 67.00 06800 SPEECH PATHOLOGY 68.00 0. 224881 1, 547, 144 0 68.00 06900 ELECTROCARDI OLOGY 69 00 0 182369 0 771, 206 69 00 0 69.01 06901 CARDI AC CATH LAB 0.000000 0 0 69.01 07000 ELECTROENCEPHALOGRAPHY 0. 196020 2, 700, 481 0 70.00 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 0.413238 0 4, 698, 420 0 71.00 07200 I MPL. DEV. CHARGED TO PATIENT 0.361387 0 1, 779, 512 72.00 72 00 0 07300 DRUGS CHARGED TO PATIENTS 73.00 0.171309 0 17, 253, 973 0 73.00 0. 291962 59, 890 07400 RENAL DIALYSIS 0 0 0 74.00 74.00 07697 CARDIAC REHABILITATION 0. 480550 0 0 76. 97 42, 621 0 76.97 OUTPATIENT SERVICE COST CENTERS 0 90.00 09000 CLI NI C 0.716426 1, 788, 129 0 90.00 09001 I BMT JOINT VENTURE 90. 01 1.069168 0 125, 665 0 0 0 0 0 0 0 0 0 0 90.01 09002 PSYCHIATRIC COUNCELING CENTER 0.695673 90 02 90 02 0 1, 907, 270 0 90.03 09003 SOUTH INDY MRI & REHAB 0.599983 0 0 0 90.03 09004 BARI ATRI CS 0.000000 90.04 90.04 90.05 09005 CV DIAGNOSTIC SERVICES 0. 439012 0 1, 191, 551 0 90.05 09006 CARDI AC REHAB 0.000000 0 90.06 90.06 0 91.00 09100 EMERGENCY 0.112360 31, 621, 792 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.555742 0 2, 238, 487 0 92.00 Subtotal (see instructions) 200.00 200.00 123, 050, 032 0 Less PBP Clinic Lab. Services-Program 201.00 0 201.00 Only Charges

123, 050, 032

0 202.00

202.00

Net Charges (line 200 +/- line 201)

Health Financial Systems	ST. FRANCIS HOSPITAL &	HEALTH CENTER	In Lieu of Form CMS-2552-10

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 150162 Peri od: Worksheet D From 01/01/2014 To 12/31/2014 Part V Date/Time Prepared: 5/26/2015 12:47 pm Title XIX Hospi tal PPS Costs Cost Center Description Cost Cost Rei mbursed Rei mbursed Servi ces Services Not Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 6.00 7.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 1, 508, 810 50.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 5, 915 0 52.00 3, 018, 246 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 54.01 05402 CARDIAC NUCLEAR DIAGNOSTIC 43,095 0 54.01 54.02 03450 NUCLEAR MEDICINE - DIAGNOSTIC 0 54.02 54.03 03630 ULTRA SOUND 296, 389 0 54.03 55.00 05500 RADI OLOGY - THERAPEUTI C 108, 241 0 55.00 56.00 05600 RADI OI SOTOPE 93, 419 56.00 0 59.00 05900 CARDIAC CATHETERIZATION 170, 727 59.00 06000 LABORATORY 2, 288, 997 0 60.00 60.00 64.00 06400 I NTRAVENOUS THERAPY 2,088 0 64.00 06500 RESPIRATORY THERAPY 0 65.00 167, 374 65.00 06600 PHYSI CAL THERAPY 0 66 00 613, 532 66 00 66.01 06601 SPORTS MEDICINE 0 66.01 67.00 06700 OCCUPATI ONAL THERAPY 304, 549 0 67.00 06800 SPEECH PATHOLOGY 68.00 347, 923 68.00 0 69 00 06900 ELECTROCARDI OLOGY 69 00 140, 644 69.01 06901 CARDI AC CATH LAB 0 69.01 70.00 07000 ELECTROENCEPHALOGRAPHY 529, 348 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 1, 941, 566 0 71.00 07200 I MPL. DEV. CHARGED TO PATIENT 0 72.00 72 00 643.093 73.00 07300 DRUGS CHARGED TO PATIENTS 2, 955, 761 0 73.00 07400 RENAL DIALYSIS 0 74.00 74.00 17, 486 07697 CARDIAC REHABILITATION 20, 482 0 76. 97 76.97 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 1, 281, 062 0 90.00 09001 I BMT JOINT VENTURE 90.01 134, 357 0 90.01 09002 PSYCHIATRIC COUNCELING CENTER 1, 326, 836 90 02 0 90 02 90.03 09003 SOUTH INDY MRI & REHAB 0 0 90.03 09004 BARI ATRI CS 90.04 90.04 90.05 09005 CV DIAGNOSTIC SERVICES 523, 105 0 90.05 09006 CARDI AC REHAB 90.06 Ω 0 90.06 91.00 09100 EMERGENCY 3, 553, 025 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 1, 244, 021 0 92.00 Subtotal (see instructions) 200.00 200.00 23, 280, 091 0 Less PBP Clinic Lab. Services-Program 201.00 0 201.00 Only Charges 202.00 Net Charges (line 200 +/- line 201) 23, 280, 091 202.00

		FRANCIS HOSPITA				u of Form CMS-2	2552-10
APPORT	TIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der	CCN: 150162	Peri od:	Worksheet D Part II	
			Component	t CCN: 15T162	From 01/01/2014 To 12/31/2014	Date/Time Pre	pared:
						5/26/2015 12:	47 pm
			lit	le XIX	Subprovi der -	PPS	
	Cost Center Description	Capi tal	Total Charges	Patio of Cos	I RF st   I npati ent	Capital Costs	
	cost center bescription	Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
		(from Wkst.	C, Part I,	(col. 1 ÷	Charges	column 4)	
		B, Part II,	col. 8)	col . 2)	onal ges	corumir 4)	
		col . 26)	(01. 0)	COI. 2)			
		1. 00	2.00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS	1.00	2.00	0.00	1. 00	0.00	
50.00	05000 OPERATING ROOM	7, 562, 717	158, 009, 384	0. 04786	62 47, 513	2, 274	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1, 342, 044	25, 115, 804	0.05343	34 0	0	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	6, 942, 404		0. 02608	30, 327	791	54.00
54.01	05402 CARDI AC NUCLEAR DI AGNOSTI C	27, 846	21, 045, 898	0. 00132		0	54. 01
54.02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0	0	0. 00000	00	0	54.02
54.03	03630 ULTRA SOUND	261, 764	20, 685, 446	0. 0126	55 0	0	54.03
55.00	05500 RADI OLOGY - THERAPEUTI C	61, 289	22, 707, 647	0. 00269	99 0	0	55.00
56.00	05600 RADI 0I SOTOPE	32, 847	5, 559, 787	0. 00590	3, 807	22	56.00
59.00	05900 CARDI AC CATHETERI ZATI ON	2, 059, 684			78 0	0	59.00
60.00	06000 LABORATORY	2, 697, 463	194, 096, 047	0. 01389	98 67, 446	937	60.00
64.00	06400 I NTRAVENOUS THERAPY	51, 285	2, 082, 896			117	64.00
65.00	06500 RESPI RATORY THERAPY	699, 378				246	
66.00	06600 PHYSI CAL THERAPY	976, 307	29, 730, 769			7, 596	
66. 01	06601 SPORTS MEDICINE	0	ı	0.0000		0	66. 01
67. 00	06700 OCCUPATI ONAL THERAPY	47, 655		0. 00546		16	67.00
68. 00	06800 SPEECH PATHOLOGY	80, 785		l .		43	
69. 00	06900 ELECTROCARDI OLOGY	1, 102, 452				280	
69. 01	06901 CARDI AC CATH LAB	0		0.0000		0	69. 01
70. 00	07000 ELECTROENCEPHALOGRAPHY	78, 831	19, 734, 764			41	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 124, 690				203	
72. 00	07200 I MPL. DEV. CHARGED TO PATIENT	769, 004			· ·	638	
73. 00	07300 DRUGS CHARGED TO PATIENTS	2, 127, 518				636	
74.00	07400 RENAL DIALYSIS	457, 045				0	74.00
76. 97	07697 CARDI AC REHABILITATION	16, 607	1, 514, 747	0. 01096	64 0	0	76. 97
00.00	OUTPATIENT SERVICE COST CENTERS  O9000 CLINIC	2 022 050	10 (20 045	0.1407/	20 4 447	400	00.00
		2, 823, 859				639	
90. 01 90. 02	O9001   IBMT JOINT VENTURE   O9002   PSYCHIATRIC COUNCELING CENTER	304, 715		l .		0	90. 01 90. 02
90.02	109002 PSYCHIATRIC COUNCELING CENTER	1, 296, 658	6, 120, 329	0.21180		0	90.02

1, 577

196, 076

4, 017, 938

149, 986

27, 366, 690

174, 430, 576 13, 215, 380

37, 160, 438 1, 659, 896, 989

0.010514

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0. 023035 0. 000000

602, 361

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92.00 0

0 90.03 90.04

0

0 90.05

0

0

14, 479 200. 00

90. 03 | 09003 | SOUTH | NDY MRI & REHAB

90. 05 09005 CV DIAGNOSTIC SERVICES

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)

Total (lines 50-199)

09004 BARI ATRI CS

90. 06 09006 CARDI AC REHAB

91. 00 | 09100 | EMERGENCY

90.04

Health Financial Systems	ST. FRANCIS HOSPITAL & I	HEALTH CENTER	In Lieu	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provi der CCN: 150162	Peri od:	Worksheet D
THROUGH COSTS			From 01/01/2014	Part IV

THROUGH COSTS Component CCN: 15T162 To 12/31/2014 Date/Time Prepared: 5/26/2015 12:47 pm PPS Title XIX Subprovi der **IRF** Non Physician Cost Center Description Nursi ng Allied Health All Other Total Cost Anestheti st Medi cal (sum of col 1 School Cost Educati on through col. 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 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 0 0 52.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 54.00 000000000000000000000000 0 05402 CARDIAC NUCLEAR DIAGNOSTIC 0 0 54.01 54.01 0 03450 NUCLEAR MEDICINE - DIAGNOSTIC 0 54.02 0 54.02 54.03 03630 ULTRA SOUND 0 0 54.03 55.00 05500 RADI OLOGY - THERAPEUTI C 0 55.00 05600 RADI OI SOTOPE 0 56.00 0 56, 00 0 05900 CARDIAC CATHETERIZATION 59.00 0 0 0 59.00 60.00 06000 LABORATORY 327, 480 327, 480 60.00 64.00 06400 I NTRAVENOUS THERAPY 0 0 0 64.00 06500 RESPIRATORY THERAPY 0 0 65.00 65.00 0 66.00 06600 PHYSI CAL THERAPY 0 0 66.00 06601 SPORTS MEDICINE 0 66.01 0 66.01 06700 OCCUPATIONAL THERAPY 0 0 67 00 0 67 00 0 68.00 06800 SPEECH PATHOLOGY 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0 0 0 69.00 06901 CARDI AC CATH LAB 0 69.01 0 69.01 07000 ELECTROENCEPHALOGRAPHY 0 0 70 00 70 00 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71.00 0 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENT 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 0 0 73.00 0 07400 RENAL DIALYSIS 74 00 0 74 00 0 07697 CARDIAC REHABILITATION 76.97 0 0 76.97 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 0 0 90.00 00000000000 09001 I BMT JOINT VENTURE 0 0 90.01 0 90.01 0 09002 PSYCHIATRIC COUNCELING CENTER 0 90.02 0 0 0 0 0 0 90.02 09003 SOUTH INDY MRI & REHAB 0 90.03 0 0 90.03 οl 09004 BARI ATRI CS 0 90 04 90 04 0

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09005 CV DIAGNOSTIC SERVICES

92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)

Total (lines 50-199)

09006 CARDI AC REHAB

09100 EMERGENCY

90.05

91.00

	Figure 1 of Control	-DANOLC HOCDLTA		ITED	111	C. F OMC (	2550 40
APP0R1	Financial Systems ST. I TIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEI SH COSTS	FRANCIS HOSPITA RVICE OTHER PAS	S Provi der	CCN: 150162	Period: From 01/01/2014 To 12/31/2014		pared:
			Ti t	le XIX	Subprovi der - I RF	PPS	
	Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cos to Charges (col. 5 ÷ col. 7)	t Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	I npati ent Program Charges	
		6. 00	7. 00	8. 00	9.00	10.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	100/00//00/				
52.00	05200 DELIVERY ROOM & LABOR ROOM	0					
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	266, 162, 844				54.00
54. 01	05402 CARDI AC NUCLEAR DI AGNOSTI C	0	21, 045, 898			0	54. 01
54. 02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0				0	
54. 03	03630 ULTRA SOUND	0	20, 685, 446			0	54.03
55.00	05500 RADI OLOGY - THERAPEUTI C	0	22, 707, 647			0	55.00
56.00	05600 RADI OI SOTOPE	0	5, 559, 787			3, 807	
59.00	05900 CARDI AC CATHETERI ZATI ON	0	68, 251, 478			0	
60.00	06000 LABORATORY	327, 480				67, 446	
64.00	06400 I NTRAVENOUS THERAPY	0	2, 082, 896			4, 749	
65.00	06500 RESPIRATORY THERAPY	0	49, 890, 678				
66.00	06600 PHYSI CAL THERAPY	0	29, 730, 769				
66. 01	06601 SPORTS MEDICINE	0	0.710.2/1	0.0000			
67. 00 68. 00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0	8, 718, 361	0.00000			1
	l l	0	5, 550, 146				l
69. 00 69. 01	O6900  ELECTROCARDI OLOGY   O6901  CARDI AC CATH LAB	0	18, 802, 925	1			69. 00 69. 01
	07000 ELECTROENCEPHALOGRAPHY	0	10 724 744			10, 202	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	19, 734, 764 90, 910, 450				1
71.00	07200 I MPL. DEV. CHARGED TO PATIENT	0	72, 177, 363			59, 901	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	327, 568, 031	1			
	07400 RENAL DIALYSIS	0	5, 555, 055				1
76. 97	07697 CARDI AC REHABI LI TATI ON	0					76. 97
70.97	OUTPATIENT SERVICE COST CENTERS		1,314,747	0.00000	0.00000	U	10.91
90 00	09000 CLINIC	0	19, 639, 045	0.00000	0. 000000	4, 447	90.00
90. 01	09001 I BMT JOINT VENTURE	0	5, 104, 463	1			1
90. 02	09002 PSYCHI ATRI C COUNCELING CENTER	0	6, 120, 329	1		0	
00.02	COCCO COUTH LANDY MIN A DELIAR	1	0,120,027	0.00000		0	

149, 986

27, 366, 690

174, 430, 576 13, 215, 380

327, 480 1, 659, 896, 989

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90.04

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90.06

91.00 0

92.00 0

0 90.03

0

0

0

602, 361 200. 00

91. 00 | 09100 | EMERGENCY | 92. 00 | 09200 | OBSERVATION | BEDS (NON-DISTINCT PART)

Total (lines 50-199)

90. 03 | 09003 | SOUTH | NDY MRI & REHAB 90. 04 | 09004 | BARI ATRI CS

90. 05 09005 CV DIAGNOSTIC SERVICES

90. 06 09006 CARDI AC REHAB

Health Financial Systems	ST. FRANCIS HOSPITAL & H	HEALTH CENTER	In Lieu	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 150162 Component CCN: 15T162	From 01/01/2014	
		Ti +I o VI V	Cubasavidas	DDC

			Ti t	Te XIX	Subprovi der -	PPS	. <del>4</del> 7 piii
	Coot Contar Decerintian	I nnoti ont	Outpati ent	Outpotiont	I RF		
	Cost Center Description	Inpatient Program	Program	Outpatient Program			
		Pass-Through	Charges	Pass-Through			
		Costs (col. 8	chai ges	Costs (col.			
		x col . 10)		x col . 12)	7		
		11.00	12. 00	13.00			
	ANCILLARY SERVICE COST CENTERS	11.00	12.00	13.00			
	05000 OPERATING ROOM	0	C		0		50.00
	05200 DELIVERY ROOM & LABOR ROOM	0	C		0		52.00
	05400 RADI OLOGY-DI AGNOSTI C	0	C		0		54.00
	05402 CARDIAC NUCLEAR DIAGNOSTIC	0	C		0		54. 01
	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0	C		0		54. 02
	03630 ULTRA SOUND	0	C		0		54. 03
	05500 RADI OLOGY - THERAPEUTI C	0	C		0		55. 00
	05600 RADI OI SOTOPE	0	C		0		56.00
	05900 CARDI AC CATHETERI ZATI ON	0	C		0		59.00
	06000 LABORATORY	114	C		0		60.00
	06400 I NTRAVENOUS THERAPY	0	C	•	0		64.00
	06500 RESPI RATORY THERAPY	0	C		0		65. 00
	06600 PHYSI CAL THERAPY	0	C		0		66.00
	06601 SPORTS MEDICINE	0	C		0		66. 01
	06700 OCCUPATI ONAL THERAPY	0	C		0		67. 00
68. 00	06800 SPEECH PATHOLOGY	0	C		0		68. 00
69. 00	06900 ELECTROCARDI OLOGY	O	C		0		69. 00
	06901 CARDI AC CATH LAB	0	C		0		69. 01
	07000 ELECTROENCEPHALOGRAPHY	0	C		0		70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	C		0		71.00
	07200 IMPL. DEV. CHARGED TO PATIENT	0	C		0		72. 00
	07300 DRUGS CHARGED TO PATIENTS	0	C		0		73. 00
	07400 RENAL DI ALYSI S	0	C		0		74.00
76. 97	07697 CARDIAC REHABILITATION	O	C		0		76. 97
	OUTPATIENT SERVICE COST CENTERS	· · · · · ·		1			
90.00	09000 CLI NI C	0	C	)	0		90.00
90. 01	09001 IBMT JOINT VENTURE	0	C		0		90. 01
90. 02	09002 PSYCHIATRIC COUNCELING CENTER	0	C		0		90. 02
90. 03	09003 SOUTH INDY MRI & REHAB	0	C		0		90. 03
90. 04	D9004 BARI ATRI CS	0	C		0		90.04
90. 05	09005 CV DIAGNOSTIC SERVICES	0	C		0		90.05
90. 06	09006 CARDI AC REHAB	0	C		0		90.06
	D9100 EMERGENCY	0	C		0		91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	C		0		92.00
200.00	Total (lines 50-199)	114	C	)	0		200. 00

Heal th	Financial Systems ST. FRANCIS HOSPITAL &	HEALTH CENTER	In lie	u of Form CMS-2	2552-10
	ATION OF INPATIENT OPERATING COST	Provi der CCN: 150162	Peri od:	Worksheet D-1	
			From 01/01/2014	5 . (7) 5	
			To 12/31/2014	Date/Time Pre 5/26/2015 12:	
		Title XVIII	Hospi tal	PPS	77 PIII
	Cost Center Description				
	·			1. 00	
	PART I - ALL PROVIDER COMPONENTS				
	I NPATI ENT DAYS				
1. 00	Inpatient days (including private room days and swing-bed days			56, 617	
2.00	Inpatient days (including private room days, excluding swing-b			56, 617	2.00
3. 00	Private room days (excluding swing-bed and observation bed day	/s). If you have only p	rivate room days,	0	3.00
	do not complete this line.			40.404	
4.00	Semi-private room days (excluding swing-bed and observation be		04 6 11	49, 124	4.00
5. 00	Total swing-bed SNF type inpatient days (including private roo	om days) through Decemb	er 31 of the cost	0	5.00
6. 00	reporting period Total swing-bed SNF type inpatient days (including private roc	om days) after December	21 of the cost	0	6.00
0.00	reporting period (if calendar year, enter 0 on this line)	on days) arter becember	31 Of the Cost	U	0.00
7. 00	Total swing-bed NF type inpatient days (including private room	n days) through Decembe	r 31 of the cost	0	7.00
	reporting period	, .,g			
8.00	Total swing-bed NF type inpatient days (including private room	n 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	g swing-bed and	19, 302	9. 00
40.00	newborn days)				10.00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII on through December 31 of the cost reporting period (see instruct		room days)	0	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII on		room days) after	0	11.00
11.00	December 31 of the cost reporting period (if calendar year, en		days) arter	U	11.00
12. 00			te room days)	0	12.00
	through December 31 of the cost reporting period	· ···· y (· · · · · · · · · · · · · · ·			
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX	only (including priva	te room days)	0	13.00
	after December 31 of the cost reporting period (if calendar ye	ear, enter O on this li	ne)		
14.00	Medically necessary private room days applicable to the Progra	nm (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
	SWING BED ADJUSTMENT				
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31	of the cost	0. 00	17. 00
40.00	reporting period	6. 5			40.00
18. 00	Medicare rate for swing-bed SNF services applicable to service	es arter becember 31 of	ine cost	0.00	18. 00
10 00	reporting period Medicaid rate for swing-bed NF services applicable to services	through December 21 o	f the cost	0.00	19.00
17.00	reporting period	s through becember 31 0	i the cost	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			3.00	
21.00	1 91	s)		55, 493, 915	21.00

	Cost Center Description		
	PART I - ALL PROVIDER COMPONENTS	1. 00	
	INPATIENT DAYS		
1. 00	Inpatient days (including private room days and swing-bed days, excluding newborn)	56, 617	1.00
2. 00	Inpatient days (including private room days, excluding swing-bed and newborn days)	56, 617	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.		
4.00	Semi-private room days (excluding swing-bed and observation bed days)	49, 124	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost	0	5.00
	reporting period		
6. 00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	0	6. 00
7 00	reporting period (if calendar year, enter 0 on this line)	0	7 00
7. 00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7. 00
8. 00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	0	8.00
0.00	reporting period (if calendar year, enter 0 on this line)	o l	0.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and	19, 302	9.00
	newborn days)		
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	0	10.00
	through December 31 of the cost reporting period (see instructions)		
11. 00		0	11.00
12 00	December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	12.00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	13.00
13.00	after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	O	13.00
14.00		0	14.00
15. 00		0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17. 00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost	0. 00	17. 00
	reporting period		
18. 00		0. 00	18. 00
10 00	reporting period	0.00	10.00
19. 00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19. 00
20. 00		0.00	20.00
20.00	report in giperiod	0.00	20.00
21.00		55, 493, 915	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line	0	22.00
	5 x line 17)		
23. 00		0	23. 00
	x line 18)		
24. 00		0	24.00
25 00	7 x line 19)	0	25. 00
25. 00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	U	25.00
26. 00		0	26.00
27. 00	, ,	55, 493, 915	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28. 00
29.00	Private room charges (excluding swing-bed charges)	0	29. 00
30.00	Semi -pri vate room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0. 000000	1
32.00	Average private room per diem charge (line 29 ÷ line 3)	0. 00	1
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)	0. 00	1
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	1
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	1
36.00	Private room cost differential adjustment (line 3 x line 35)	0 55 402 015	36.00
37. 00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	55, 493, 915	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		1
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38. 00		980. 16	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line 38)	18, 919, 048	1
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	18, 919, 048	41.00
		,	

	Financial Systems ST. F	RANCIS HOSPITAL			In Lie	u of Form CMS-2 Worksheet D-1	
				F	rom 01/01/2014 o 12/31/2014	Date/Time Pre 5/26/2015 12:	pared:
	Cost Center Description	Total I npati ent Cost 1.00	Titl Total Inpatient Days 2.00	e XVIII  Average Per Diem (col. 1  ÷ col. 2)  3.00	Hospi tal Program Days 4.00	PPS Program Cost (col. 3 x col. 4) 5.00	
42. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	0				42.00
43.00	INTENSIVE CARE UNIT	14, 433, 244	9, 739			7, 802, 730	43. 00 43. 01
43. 01 44. 00	CORONARY CARE UNIT	6, 361, 266 18, 777, 578	4, 656 12, 067	,	-	0 10, 636, 012	44. 00
46.00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)	9, 587, 270	6, 673	1, 436. 73	3, 757	5, 397, 795	45.00 46.00 47.00
777.00	Cost Center Description	<u> </u>				1. 00	171.00
48. 00 49. 00	Program inpatient ancillary service cost (Wk Total Program inpatient costs (sum of lines			ons)		61, 034, 290 103, 789, 875	
50. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inp	g , ,			of Parts I and		
51. 00	Pass through costs applicable to Program inp		•			5, 708, 910	
52. 00	and IV) Total Program excludable cost (sum of lines		y 30. 1. 300 (	. cc 2, c	u 01 1 a1 t0 11	13, 885, 474	
53. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line	ding capital re	elated, non-phy	ysician anesth	etist, and	89, 904, 401	1
	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54.00
55. 00 56. 00	Target amount (line 54 x line 55)					0.00	56. 00
57. 00 58. 00	Difference between adjusted inpatient operat Bonus payment (see instructions)	ing cost and ta	nrget amount (I	line 56 minus	line 53)	0	57. 00 58. 00
59. 00	Lesser of lines 53/54 or 55 from the cost re market basket	porting period	endi ng 1996, เ	updated and co	mpounded by the	0.00	59. 00
60. 00 61. 00	Lesser of lines 53/54 or 55 from prior year	s 55, 59 or 60	enter the less	ser of 50% of		0. 00 0	60. 00 61. 00
62. 00	amount (line 56), otherwise enter zero (see Relief payment (see instructions)	instructions)				0	62.00
63. 00	Allowable Inpatient cost plus incentive paym PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instru	ıcti ons)			0	63. 00
64. 00		ts through Dece	ember 31 of the	e cost reporti	ng period (See	0	64. 00
65. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts after Decemb	er 31 of the o	cost reporting	period (See	0	65. 00
66. 00	1	ne costs (line	64 plus line 6	65)(title XVII	l only). For	0	66. 00
67. 00	Title V or XIX swing-bed NF inpatient routin (line 12 x line 19)	e costs through	December 31 o	of the cost re	porting period	0	67. 00
68. 00	Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)	e costs after D	ecember 31 of	the cost repo	rting period	0	68. 00
69. 00	1 7					0	69. 00
70. 00 71. 00	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service c	ity/ICF/MR rout	ine service co	ost (line 37)			70.00 71.00
72.00	Program routine service cost (line 9 x line	71)		•			72.00
74.00	Medically necessary private room cost applic Total Program general inpatient routine serv	ice costs (line	2 72 + line 73	)			73.00
75. 00 76. 00	Capital-related cost allocated to inpatient 26, line 45) Per diem capital-related costs (line 75 ÷ li		e costs (from N	Worksheet B, P	art II, column		75. 00 76. 00
77. 00 78. 00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minu	•					77. 00 78. 00
	Aggregate charges to beneficiaries for exces Total Program routine service costs for comp	s costs (from p			us line 79)		79. 00 80. 00
81. 00 82. 00	Inpatient routine service cost per diem limi	tati on		. (11110 70 111111	GO 11110 17)		81. 00 82. 00
83.00	Inpatient routine service cost limitation (I Reasonable inpatient routine service costs (	see instruction	* .				83.00
84. 00 85. 00	Program inpatient ancillary services (see in Utilization review - physician compensation		ons)				84. 00 85. 00
86. 00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS		rough 85)				86. 00
87. 00 88. 00	Total observation bed days (see instructions Adjusted general inpatient routine cost per	)	· line 2)			7, 493 980. 16	1
	Observation bed cost (line 87 x line 88) (se	•				7, 344, 339	1

Health Financial Systems ST.	FRANCIS HOSPITA	L & HEALTH CEN	TER	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Peri od: From 01/01/2014	Worksheet D-1	
				To 12/31/2014	Date/Time Pre 5/26/2015 12:	pared: 47 pm
		Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		27)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	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	11, 033, 873	55, 493, 915	0. 19883	0 7, 344, 339	1, 460, 275	90.00
91.00 Nursing School cost	0	55, 493, 915	0.00000	0 7, 344, 339	0	91.00
92.00 Allied health cost	0	55, 493, 915	0. 00000	0 7, 344, 339	0	92.00
93.00 All other Medical Education	0	55, 493, 915	0. 00000	0 7, 344, 339	0	93. 00

Health Financial Systems	ST. FRANCIS HOSPITAL & I	HEALTH CENTER	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CCN: 150162	Peri od: From 01/01/2014	Worksheet D-1
		Component CCN: 15T162		
		Title XVIII	Subprovi der -	PPS
			IRF	

Description   1.00			IITIE XVIII	I RF	PPS	
HAPATLE AIL PROVIDER COMPONENTS   HAPATLE AIL PROVIDER COMPONENTS		Cost Center Description			1 00	
INVALESTED BAYS		PART I - ALL PROVIDER COMPONENTS			1.00	
Impatient days (including private room days, excluding saying-bed and newborn days)   4,104   2.00   3.00   7.00						
Private room days (excluding swing-bed and observation bed days). If you have only private room days.   4,104   4,00			9 ,		·	
do not complete *his line.						1
Semi-private room days (excluding swing-bed and observation bed days)   Semi-private room days (including private room days) through December 31 of the cost	3.00		). If you have only p	rivate room days,	0	3.00
Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if callendary sear, enter 0 on this line)  7. 00 Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period (if callendary sear, enter 0 on this line)  7. 00 Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period (if callendary sear, enter 0 on this line)  7. 00 Total inpatient days including private room days) after December 31 of the cost reporting period (if callendary sear, enter 0 on this line)  7. 00 Total inpatient days including private room days after December 31 of the cost reporting period (if callendary sear, enter 0 on this line)  7. 00 Swing-bed SNF type inpatient days applicable to the Program (excluding swing-bed and period SNF type inpatient days applicable to the Program (excluding private room days)  8. 10 Swing-bed SNF type inpatient days applicable to the Interval on this line)  8. 10 Swing-bed SNF type inpatient days applicable to the Interval on this line)  8. 10 Swing-bed SNF type inpatient days applicable to the Interval on this line)  9. 10 Swing-bed SNF type inpatient days applicable to the Interval on this line)  10 Swing-bed SNF type inpatient days applicable to the Interval on this line)  11 Swing-bed SNF type inpatient days applicable to the Interval on this line)  12 Swing-bed SNF type inpatient days applicable to the Interval on this line)  13 Swing-bed SNF type inpatient days applicable to the Interval on this line)  14 Swing-bed SNF type inpatient days applicable to the Program (excluding private room days)  15 Swing-bed SNF type inpatient days applicable to the Program (excluding private room days)  16 Swing-bed SNF swing-bed SNF services applicable to SNF type services through December 31 of the cost reporting period (in the Callendary sear, enter 0 on this line)  16 Swing-bed Cost applicable to SNF type services after December 31 of the	4.00		davs)		4. 104	4.00
10   10   10   10   10   10   10   10				er 31 of the cost		1
reporting period (if calendar year, enter 0 on this line)  7. 00 Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost of total swing-bed in the case of the cost o						
Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost of Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost of Total inpatient days (including private room days applicable to the Program (excluding swing-bed and 2, 251 0, 00	6. 00		days) after December	31 of the cost	0	6.00
reporting period  8. 00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  9. 00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and 2, 251 9, 00 on whorn days)  10. 00 Swing-bed SMbr 13 of the cost reporting period (see instructions)  11. 00 Swing-bed SMbr 13 of the cost reporting period (see instructions)  12. 00 Swing-bed SMbr 13 of the cost reporting period (if calendar year, enter 0 on this line)  12. 00 Swing-bed SMbr 13 of the cost reporting period (if calendar year, enter 0 on this line)  13. 00 Swing-bed NF type inpatient days applicable to titles Vior XIX only (including private room days) after 0 through December 31 of the cost reporting period (if calendar year, enter 0 on this line)  13. 00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 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 titles V or XIX only (including private room days) 0 14. 00 on Total runsers days (if it even the period of the cost reporting period (if calendar year, enter 0 on this line)  15. 00 Total runsers days (if it is V or XIX only V or XIX on	7 00		days) through December	r 31 of the cost	0	7 00
Total swing-bed NF type inpatient days (including private room days) after becember 31 of the cost reporting period (if calendar year, enter 0 on this line)	7.00		days) thi odgir becombe	01 01 116 6031	O	7.00
10.00   Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days)   0.00   10.00	8.00		days) after December :	31 of the cost	0	8.00
newborn days)  10. Os Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)  11. Os Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  12. Os Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) on through December 31 of the cost reporting period (if calendar year, enter 0 on this line)  13. Os Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) on through December 31 of the cost reporting period (if calendar year, enter 0 on this line)  14. On Total nursery days (title V or XIX only) on the Program (excluding swing-bed days) on 15. On Total nursery days (title V or XIX only) on 15. On 15			5 (		0.054	
10.00 Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days) after through December 31 of the cost reporting period (see instructions)  11.00 Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days) after the cost reporting period (if calendar year, enter 0 on this line)  12.00 Swing-bed SMF type inpatient days applicable to titles V or XIX only (including private room days)  13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  14.00 Medically necessary private room days applicable to titles V or XIX only (including private room days)  15.00 Total nursery days (title V or XIX only)  16.00 Nestery days (title V or XIX only)  17.00 Medically necessary private room days applicable to the Program (excluding swing-bed days)  18.00 Set Nestery days (title V or XIX only)  19.00 Nestery days (title V or XIX only)  19.00 Set Nestery days (title V or XIX only)  19.00 Medical care rate for swing-bed SMF services applicable to services through December 31 of the cost reporting period (including private room days)  19.00 Medical care for responsible to services after December 31 of the cost reporting period (including private room days)  19.00 Medical care for swing-bed SMF services applicable to services after December 31 of the cost of the cost reporting period (including swing-bed cost applicable to SMF type services after December 31 of the cost reporting period (line of X X III only)  20.00 Medical d rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (line of X X III only)  21.00 Total general inpatient routine service cost (see Instructions)  22.00 Swing-bed cost applicable to SMF type services after December 31 of the cost reporting period (line of X X III only)  23.00 Swing-bed cost applicable to SMF type services after December 31 of the cost reporting period (line of X X III only)  24.00 General inpatient routine service cost (see Instru	9.00		the Program (excluding	g swing-bed and	2, 251	9.00
through December 31 of the cost reporting period (see instructions)  1.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after 0 11.00 December 31 of the cost reporting period (if calendar year, enter 0 on this line)  12.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 0 12.00 through December 31 of the cost reporting period (if calendar year, enter 0 on this line)  14.00 Medically inecessary private room days applicable to titles V or XIX only (including private room days) 1 13.00 after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  15.00 Total nursery days (title V or XIX only) 1 15.00 Total nursery days (title V or XIX only) 1 15.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost 0.00 reporting period (incare rate for swing-bed SNF services applicable to services after December 31 of the cost 0.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost 0.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost 0.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost 0.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost 0.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost 0.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost 0.00 Medicaid rate for swing-bed NF services after December 31 of the cost reporting period (line 0.00 Medicaid rate for swing-bed NF services after December 31 of the cost reporting period (line 0.00 Medicaid rate for swing-bed NF services after December 31 of the cost reporting period (line 0.00 Medicaid rate for swing-bed sort applicable to SNF type services after December 31 of the cost reporting period (line 0.00 Medicaid rate for swing-bed cost (see instruc	10.00		v (including private	room davs)	0	10.00
December 31 of the cost reporting period (if calendar year, enter 0 on this line)  12.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  14.00 Medical line provided in the cost reporting period (if calendar year, enter 0 on this line)  15.00 Total nursery days (title V or XIX only)  16.00 Nursery days (title V or XIX only)  17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period (including private room cost differential (line 20 on the cost reporting period (including private room cost differential (line 27 on the cost reporting period (including private room cost differential (line 32 minus line 33) (see instructions)  18.00 Medical drate for swing-bed SNF services applicable to services after December 31 of the cost on the cost reporting period (including private room cost differential (line 20 on the cost reporting period (including private room cost differential (including private room days)  19.00 Medical drate for swing-bed SNF services applicable to services after December 31 of the cost on the cost reporting period (including private room cost applicable to services applicable to services after December 31 of the cost on the cost reporting period (including private room cost applicable to SNF type services after December 31 of the cost reporting period (line on the cost reporting period (line on the cost on the cost reporting period (line on the cost reporting period (line on the cost applicable to SNF type services after December 31 of the cost reporting period (line on the cost applicable to SNF type services after December 31 of the cost reporting period (line on the cost on the cost applicable to SNF type services after December 31 of the cost reporting period (line on the cost on the cost on the cost on the cost reporting period (line on the cost on the cost reporting period (line on					_	
12.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period  13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if called and ryear, enter 0 on this line)  14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days)  15.00 Nursery days (title V or XIX only)  17.00 Nursery days (title V or XIX only)  18.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period  18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period  19.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period  19.00 Medicald rate for swing-bed NF services applicable to services after December 31 of the cost reporting period  19.00 Medicald rate for swing-bed NF services applicable to services after December 31 of the cost reporting period  19.00 Medicald rate for swing-bed NF services applicable to services after December 31 of the cost reporting period  19.00 Medicald rate for swing-bed NF services applicable to services after December 31 of the cost reporting period  20.00 Medicald rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (line 6 x 1 line 17)  21.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 6 x 1 line 18)  22.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x 1 line 18)  23.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x 1 line 18)  24.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x 1 line 18)  25.00 Swing-bed cost applicable to NF type services after Decem	11. 00			room days) after	0	11.00
through December 31 of the cost reporting period 31.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 31.00 Swing-bed NF type inpatient days applicable to the Program (excluding swing-bed days) 31.00 Total nursery days (title V or XIX only) 31.00 Nergory days (title Vor XIX only) 31.00 Nergory days (title Vor XIX only) 31.00 Nergory days (title Vor XIX	12 00			to room dovo)	0	12 00
13.00   Swing-bed NF type inpatient days applicable to titles V or XIX only (Including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)   14.00   15.00	12.00		only (Theruarny priva	te room days)	U	12.00
14.00   Medically necessary private room days applicable to the Program (excluding swing-bed days)   0   14.00   0   15.00   15.00   16.00   Nursery days (title V or XIX only)   0   15.00   15.00   15.00   16.00   Nursery days (title V or XIX only)   0   15.00	13.00		only (including priva	te room days)	0	13.00
15.00   Total nursery days (title V or XIX only)						
16.00   Nursery days (title V or XIX only)   0   16.00   SWING BED ADJUSTMENT   17.00   Modi care rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period   17.00   17.00   18.00   19.00   Modi care rate for swing-bed SNF services applicable to services after December 31 of the cost   0.00   18.00   19.00			(excluding swing-bed	days)	-	
SWING BED ADJUSTMENT						
17.00   Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost   0.00   17.00	10.00				0	10.00
Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost   0.00   18.00   19.00   19.00   Medicald rate for swing-bed NF services applicable to services through December 31 of the cost   0.00   19.00   20.00   Medicald rate for swing-bed NF services applicable to services after December 31 of the cost   0.00   20.00	17. 00		through December 31	of the cost	0. 00	17.00
reporting period  Medicald rate for swing-bed NF services applicable to services after December 31 of the cost reporting period reporting period reporting period  1.00 Medicald rate for swing-bed NF services applicable to services after December 31 of the cost 0.00 20.00 reporting period  1.00 Total general inpatient routine service cost (see instructions)  2.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)  2.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 0 23.00 x line 18)  2.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 0 23.00 x line 19)  2.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 19)  2.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 19)  2.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  2.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  2.00 Total swing-bed cost (see instructions)  2.00 Semi-private room charges (excluding swing-bed charges)  2.00 Semi-private room charges (excluding swing-bed charges)  2.00 Semi-private room charges (excluding swing-bed charges)  2.00 Average per internal service cost/charge ratio (line 27 + line 28)  2.00 Average per diem private room charge (line 29 + line 3)  2.00 Average semi-private room per diem charge (line 30 + l		1 91	•			
19.00   Medical d Tate for swing-bed NF services applicable to services through December 31 of the cost reporting period   20.00   2	18. 00		after December 31 of	the cost	0. 00	18. 00
reporting period Medicald rate for swing-bed NF services applicable to services after December 31 of the cost reporting period  1.00 Total general inpatient routine service cost (see instructions)  2.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)  3.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  4.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 18)  5.10 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 19)  5.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  5.10 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  6.00 Total swing-bed cost (see instructions)  6.00 Concernal inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  7.10 Private ROMD Differential ADJUSTMENT  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  9.00 Private room charges (excluding swing-bed charges)  9.00 Private room charges (excluding swing-bed charges)  9.00 Concernal inpatient routine service cost/charge ratio (line 27 + line 28)  9.00 Concernal inpatient routine service cost/charge ratio (line 27 + line 28)  9.00 Concernal inpatient routine service cost/charge ratio (line 27 + line 28)  9.00 Concernal inpatient routine service cost (line 30 + line 3)  9.00 Concernal inpatient routine service cost (line 30 + line 3)  9.00 Concernal inpatient routine service cost of differential (line 32 minus line 33)(see instructions)  1.00 Concernal inpatient routine service cost net of swing-bed cost and private room cost differential (line 5, 180, 200 Concernal inpatient routine service cost net of swing-bed cost and private room cost differential (line 5, 180, 200 Concernal inpatient routine	19 00		through December 31 o	f the cost	0.00	19 00
20.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost reporting period  21.00 Total general inpatient routine service cost (see instructions)  22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)  23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 6 x line 18)  25.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)  26.00 Total swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 General inpatient routine service cost/charge ratio (line 27 ± line 28)  30.00 Average private room per diem charge (line 29 + line 3)  30.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions)  30.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions)  30.00 Average per diem private room charge differential (line 32 minus line 33)  30.00 Average per diem private room charge differential (line 32 minus line 33)  30.00 Average per diem private room charge differential (line 32 minus line 33)  30.00 Average per diem private room charge differential (line 32 minus line 33)  30.00 Average per diem private room cost differential (line 35 minus line 36)  30.00 Average per diem private room cost differential (line 30 minus line 31)  30.00 Average per diem private room cost differential (line 30 minus line 31)  30.00 Average per diem private room	17.00		thi ough becember 51 0	the cost	0.00	17.00
21.00   Total general inpatient routine service cost (see instructions)   5, 180, 200   21.00   22.00   5 x line 17)   23.00   23.00   24.00   24.00   25.00   24.00   25.00	20.00		after December 31 of	the cost	0.00	20.00
22.00   Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)   23.00   Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)   24.00   Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)   25.00   Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)   26.00   Total swing-bed cost (see instructions)   0 26.00   27.00   Coeneral inpatient routine service cost net of swing-bed cost (line 21 minus line 26)   5, 180, 200   27.00   PRIVATE ROOM DIFFERENTIAL ADJUSTMENT   0 29.00   28.00   Semi-private room charges (excluding swing-bed charges)   0 29.00   30.00   Semi-private room charges (excluding swing-bed charges)   0 29.00   31.00   General inpatient routine service cost/charge ratio (line 27 + line 28)   0.000   32.00   Average private room per diem charge (line 29 + line 3)   0.00   33.00   Average per diem private room cost differential (line 30 + line 4)   0.00   34.00   Average per diem private room cost differential (line 34 x line 35)   0.00   35.00   Average per diem private room cost differential (line 34 x line 35)   0.00   37.00   PRIVATE ROOM DIFFERENTIAL ADJUSTMENT   0.00   37.00   O Private room cost differential dijustment (line 34 x line 35)   0.00   37.00   O Private room cost differential dijustment (line 34 x line 35)   0.00   37.00   O Private room cost differential dijustment (line 34 x line 35)   0.00   37.00   O Private room cost differential dijustment (line 30 x line 30)   0.00   37.00   O Private room cost differential (line 30 x line 35)   0.00   37.00   O Private room cost differential dijustment (line 30 x line 36)   0.00   37.00   O Private room cost differential dijustment (line 30 x line 36)   0.00   38.00   O Private general inpatient routine service cost per diem (see instructions)   0.00   38.00   O Provent general inpatient routine service	04 00	, , , , , , , , , , , , , , , , , , , ,			F 400 000	04 00
5 x line 17)  Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  24.00  Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)  25.00  Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  26.00  Total swing-bed cost (see instructions)  Concral inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  Concral inpatient routine service charges (excluding swing-bed and observation bed charges)  Defenral inpatient routine service cost-parts (line 27 + line 28)  Average perivate room charges (excluding swing-bed charges)  Average per diem private room charge differential (line 30 + line 4)  Average per diem private room cost differential (line 30 + line 31)  Average per diem private room cost differential (line 34 x line 31)  One of oneral inpatient routine service cost-patine (line 30 + line 31)  Average per diem private room cost differential (line 34 x line 31)  One of oneral inpatient routine service cost-patine (line 30 + line 31)  One of oneral inpatient routine service cost per diem charge (line 30 + line 31)  One of oneral inpatient routine service cost per diem (see instructions)  Average per diem private room cost differential (line 34 x line 31)  One of oneral inpatient routine service cost per diem (see instructions)  Adjusted general inpatient routine service cost per diem (see instructions)  Adjusted general inpatient routine service cost per diem (see instructions)  Adjusted general inpatient routine service cost per diem (see instructions)  Adjusted general inpatient routine service cost per diem (see instructions)  Adjusted general inpatient routine service cost per diem (see instructions)  Adjusted general inpatient routine service cost per diem (see instructions)  Adjusted general inpatient routine service cost per diem (see instructions)  Adjusted general inpat				ting period (line		
x line 18)  24.00  24.00  25.00  26.00  27.00  28.00  27.00  29.00  29.00  29.00  20.0	22.00		31 of the cost repor	tring period (Trine	O	22.00
24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28.00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 + line 28) 32.00 Average perion the private room perion (line 29 + line 3) 33.00 Average semi-private room perion (line 29 + line 3) 34.00 Average perion diem private room charge (line 30 + line 4) 35.00 Average perion diem private room cost differential (line 34 x line 31) 35.00 Average perion cost differential (line 34 x line 31) 35.00 Average perion cost differential (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 5, 180, 200) 37.00 PRATI 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) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 42.40 Average per diem private room cost applicable to the Program (line 14 x line 35) 42.80 Adjusted general inpatient routine service cost per diem (see instructions) 43.00 Average per diem private room cost applicable to the Program (line 14 x line 35) 43.00 Average per diem private room cost applicable to the Program (line 14 x line 35) 43.00 Average per diem private room cost applicable to the Program (line 14 x line 35)	23.00	Swing-bed cost applicable to SNF type services after December 3	1 of the cost reporti	ng period (line 6	0	23. 00
7 x line 19)  Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 vine 20)  26.00 Total swing-bed cost (see instructions)  General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  8.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  Private room charges (excluding swing-bed charges)  Semi-private room charges (excluding swing-bed charges)  Semi-private room charges (excluding swing-bed charges)  Average private room per diem charge (line 29 + line 3)  Average per diem private room charge differential (line 32 minus line 33) (see instructions)  Average per diem private room cost differential (line 34 x line 31)  Private room cost differential adjustment (line 3 x line 35)  Program general inpatient routine service cost per diem (see instructions)  Average per diem private room cost differential (line 32 x line 35)  Average per diem private room cost differential (line 32 x line 35)  Average per diem private room cost differential (line 32 x line 35)  Program general inpatient routine service cost per diem (see instructions)  Average per diem private room cost differential (line 32 x line 35)  Adjusted general inpatient routine service cost per diem (see instructions)  Program general inpatient routine service cost per diem (see instructions)  1, 262.23  38.00  Average per diem private room cost differential (line 38)  Adjusted general inpatient routine service cost per diem (see instructions)  Program general inpatient routine service cost per diem (see instructions)  Average per diem private room cost differential (line 38)  Average per diem private room cost differential (line 38)  Average per diem private room cost differential (line 32 x line 35)  Adjusted general inpatient routine service cost per diem (see instructions)  Average per diem private room cost diem charge (line 14 x line 35)  Average per diem private room cost diem charge (line 14 x lin		l			_	
25.00   Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)   25.00 x line 20   26.00   26.00   27.00   27.00   27.00   28.00   27.00   28.00   27.00   28.00   28.00   29	24.00		31 of the cost report	ing period (line	0	24.00
X   line 20)   Total swing-bed cost (see instructions)   0   26. 00   27. 00   Ceneral inpatient routine service cost net of swing-bed cost (line 21 minus line 26)   5, 180, 200   PRI VATE ROOM DIFFERENTIAL ADJUSTMENT   7.00   PRI VATE ROOM DIFFERENTIAL PROOF DIFFERENTI	25. 00	l	of the cost reporting	a period (line 8	0	25. 00
27. 00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28. 00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  Private room charges (excluding swing-bed charges)  Semi-private room charges (excluding swing-bed charges)  Semi-private room charges (excluding swing-bed charges)  Semi-private room charges (excluding swing-bed charges)  General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  Average private room per diem charge (line 29 + line 3)  Average semi-private room per diem charge (line 30 ÷ line 4)  Average per diem private room charge differential (line 32 minus line 33)(see instructions)  Average per diem private room cost differential (line 34 x line 31)  Average per diem private room cost differential (line 34 x line 31)  Average per diem private room cost differential (line 34 x line 35)  Orageneral inpatient routine service cost net of swing-bed cost and private room cost differential (line 5, 180, 200)  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  Adjusted general inpatient routine service cost per diem (see instructions)  Program general inpatient routine service cost per diem (see instructions)  Medically necessary private room cost applicable to the Program (line 14 x line 35)  Orageneral inpatient routine service cost per diem (see instructions)  Orageneral inpatient routine service cost (line 9 x line 38)  Orageneral inpatient routine service cost (line 9 x line 38)  Orageneral inpatient routine service cost per diem (see instructions)  Orageneral inpatient routine service cost per diem (see instructions)  Orageneral inpatient routine service cost per diem (see instructions)  Orageneral inpatient routine service cost per diem (see instructions)  Orageneral inpatient routine service cost (line 9 x line 38)  Orageneral inpatient routine service cost (line 9 x line 38)  Orageneral inpatient routine service cost (line 9 x line 38)  Oragene				9	_	
PRI VATE ROOM DIFFERENTIAL ADJUSTMENT  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  9.00 Pri vate room charges (excluding swing-bed charges)  30.00 Semi-pri vate room charges (excluding swing-bed charges)  31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  32.00 Average pri vate room per diem charge (line 29 ÷ line 3)  32.00 Average semi-pri vate room per diem charge (line 30 ÷ line 4)  32.00 Average per diem pri vate room charge differential (line 32 minus line 33) (see instructions)  33.00 Average per diem pri vate room cost differential (line 34 x line 31)  35.00 Pri vate room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 5, 180, 200 27 minus line 36)  PART II - HOSPITAL AND SUBPROVI DERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost (line 9 x line 38)  9.00 Program general inpatient routine service cost (line 9 x line 38)  2,841,280 39.00  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)					-	1
28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  30.00 Average private room per diem charge (line 29 ÷ line 3)  30.00 Average semi-private room per diem charge (line 30 ÷ line 4)  30.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions)  30.00 Average per diem private room cost differential (line 34 x line 31)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Private room cost differential adjustment (line 3 x line 35)  30.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 5, 180, 200 and 27 minus line 36)  30.00 PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  30.00 Adjusted general inpatient routine service cost per diem (see instructions)  30.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  30.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)	27. 00		ine 21 minus line 26)		5, 180, 200	27.00
29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Average private room per diem charge (line 29 ÷ line 3) 30.00 Average semi-private room per diem charge (line 30 ÷ line 4) 30.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 30.00 Average per diem private room cost differential (line 34 x line 31) 30.00 Average per diem private room cost differential (line 34 x line 31) 30.00 Private room cost differential adjustment (line 3 x line 35) 30.00 Private room cost differential adjustment (line 3 x line 35) 30.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 5, 180, 200 and 19, 200 and	28 00		and observation hed c	harges)	0	28 00
31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  32.00 Average private room per diem charge (line 29 ÷ line 3)  32.00 Average semi-private room per diem charge (line 30 ÷ line 4)  32.00 Average semi-private room per diem charge (line 30 ÷ line 4)  32.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions)  32.00 Average per diem private room cost differential (line 34 x line 31)  33.00 Average per diem private room cost differential (line 34 x line 31)  34.00 Private room cost differential adjustment (line 3 x line 35)  35.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 5, 180, 200 27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  Adjusted general inpatient routine service cost per diem (see instructions)  38.00 Program general inpatient routine service cost (line 9 x line 38)  2, 841, 280 39.00  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 0.00 000 000 000 000 000 000 000 000			and observation bed of	nar ges)		1
32.00 Average private room per diem charge (line 29 ÷ line 3)  32.00 Average semi-private room per diem charge (line 30 ÷ line 4)  33.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions)  34.00 Average per diem private room cost differential (line 34 x line 31)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  36.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 5, 180, 200 27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	30.00					30.00
33.00 Average semi-private room per diem charge (line 30 ÷ line 4)  34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 5, 180, 200 27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost (line 9 x line 38)  Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		, ,	line 28)			1
34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions)  34.00 Average per diem private room cost differential (line 34 x line 31)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 5, 180, 200 27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  39.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 0 34.00  37.00 35.00  37.00 36.00  37.00 37.00  37.00 37.00		, , , , , , , , , , , , , , , , , , , ,				1
35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 5, 180, 200 27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		, , , , , , , , , , , , , , , , , , , ,	s lina 33)/saa instru	ctions)		1
36.00 Private room cost differential adjustment (line 3 x line 35)  36.00 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 5, 180, 200 27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  36.00 37.00 37.00 37.00 37.00				- C C O O O O		1
27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  1, 262.23 38.00  39.00 Program general inpatient routine service cost (line 9 x line 38)  2, 841, 280 39.00  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00		9   ' '	,			1
PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  1, 262.23 38.00  39.00 Program general inpatient routine service cost (line 9 x line 38)  2, 841, 280 39.00  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00	37. 00		d private room cost d	ifferential (line	5, 180, 200	37.00
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  1, 262.23 38.00  39.00 Program general inpatient routine service cost (line 9 x line 38)  2, 841, 280 39.00  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00		27 minus line 36)				
38.00 Adjusted general inpatient routine service cost per diem (see instructions)  1, 262.23 38.00  39.00 Program general inpatient routine service cost (line 9 x line 38)  2, 841, 280 39.00  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00			TMENTS			
39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  2,841,280 39.00 40.00	38. 00			T	1, 262, 23	38.00
41.00   Total Program general inpatient routine service cost (line 39 + line 40) 2,841,280   41.00		, , , , , , , , , , , , , , , , , , , ,				1
	41. 00	lotal Program general inpatient routine service cost (line 39 +	line 40)		2, 841, 280	41.00

		RANCIS HOSPITA				u of Form CMS-2	
COMPUT	ATION OF INPATIENT OPERATING COST			F	eriod: rom 01/01/2014	Worksheet D-1	
			Componen	t CCN: 15T162 T	o 12/31/2014	Date/Time Pre 5/26/2015 12:	
-			Ti tl	e XVIII	Subprovi der -	PPS	., р
	Cost Center Description	Total	Total	Average Per	IRF Program Days	Program Cost	
	cost center bescription	Inpatient	Inpatient	Di em (col. 1	Frogram bays	(col. 3 x	
		Cost	Days	÷ col. 2)	4.00	col . 4)	
42. 00	NURSERY (title V & XIX only)	1. 00 0	2.00	3.00	4.00	5. 00	42.00
42.00	Intensive Care Type Inpatient Hospital Units	0		0.00	U		42.00
43.00	INTENSIVE CARE UNIT	0				0	
43. 01 44. 00	NEONATAL INTENSIVE CARE UNIT CORONARY CARE UNIT	0			0	0 0	
	BURN INTENSIVE CARE UNIT	O		0.00	J		45.00
46.00	SURGICAL INTENSIVE CARE UNIT	0	(	0.00	0	0	
47. 00	OTHER SPECIAL CARE (SPECIFY)						47.00
	Cost Center Description					1. 00	
48. 00	Program inpatient ancillary service cost (Wk	st. D-3, col.	3, line 200)			1, 247, 791	48.00
49. 00	Total Program inpatient costs (sum of lines	41 through 48)	(see instructi	ons)		4, 089, 071	49. 00
50. 00	PASS THROUGH COST ADJUSTMENTS  Pass through costs applicable to Program inp	ationt routino	sorvi cos (fro	m Wket D sum	of Parts I and	714, 265	50.00
30.00		attent routine	services (iii	III WKSt. D, Suiii	OI Faits I allo	714, 203	30.00
51.00	Pass through costs applicable to Program inp	atient ancilla	ry services (f	rom Wkst. D, su	um of Parts II	94, 039	51.00
52. 00	and IV) Total Program excludable cost (sum of lines	50 and 51\				808, 304	52.00
53. 00	Total Program inpatient operating cost exclu		elated, non-ph	vsician anesth	etist, and	3, 280, 767	1
	medical education costs (line 49 minus line						
E4 00	TARGET AMOUNT AND LIMIT COMPUTATION					0	F4 00
	Program discharges Target amount per discharge					0 0. 00	
56.00	Target amount (line 54 x line 55)					0	56.00
	Difference between adjusted inpatient operat	ing cost and t	arget amount (	line 56 minus I	ine 53)	0	
58. 00 59. 00	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost re	norting period	endina 1996	undated and cor	mnounded by the	0.00	
37.00	market basket	por tring period	charing 1770,	apaatea ana eo	iipodriaca by the	0.00	37.00
60.00	Lesser of lines 53/54 or 55 from prior year					0.00	
61. 00	If line 53/54 is less than the lower of line which operating costs (line 53) are less tha					0	61.00
	amount (line 56), otherwise enter zero (see		13 (11103 54 )	00), 01 1% 01	the target		
62.00	Relief payment (see instructions)					0	
63. 00	Allowable Inpatient cost plus incentive paym PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instr	uctions)			0	63.00
64. 00		ts through Dec	ember 31 of th	e cost reportin	ng period (See	0	64.00
	instructions)(title XVIII only)					_	
65. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts after Decem	ber 31 of the	cost reporting	period (See	0	65.00
66. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line	65)(title XVIII	only). For	0	66.00
	CAH (see instructions)			6.11			,,,,,,
67.00	Title V or XIX swing-bed NF inpatient routin (line 12 x line 19)	e costs throug	n December 31	of the cost rep	porting period	0	67.00
68. 00	Title V or XIX swing-bed NF inpatient routin	e costs after	December 31 of	the cost repor	rting period	0	68.00
	(line 13 x line 20)		<i>(</i> 1)	(0)			
69.00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N					0	69.00
70. 00	Skilled nursing facility/other nursing facil		•				70.00
	Adjusted general inpatient routine service c	ost per diem (					71.00
72. 00 73. 00	Program routine service cost (line 9 x line Medically necessary private room cost applic	,	m (line 14 y l	ine 35)			72.00
74. 00	Total Program general inpatient routine serv	9	•				74.00
75.00	Capital-related cost allocated to inpatient	routine servic	e costs (from	Worksheet B, Pa	art II, column		75.00
76. 00	26, line 45) Per diem capital-related costs (line 75 ÷ li	ne 2)					76.00
							77.00
78.00	Inpatient routine service cost (line 74 minu	s line 77)					78.00
79. 00 80. 00	Aggregate charges to beneficiaries for exces Total Program routine service costs for comp	-		· .	ıs lina 70)		79. 00 80. 00
81.00	Inpatient routine service costs for comp		COSt Timitatio	(11110 /0 1111111	25 TTHE 77)		81.00
82.00	Inpatient routine service cost limitation (	ine 9 x line 8					82.00
83. 00 84. 00	Reasonable inpatient routine service costs (		ns)				83.00
85.00	Program inpatient ancillary services (see in Utilization review - physician compensation		ons)				85.00
	Total Program inpatient operating costs (sum	of lines 83 t					86.00
07 00	PART IV - COMPUTATION OF OBSERVATION BED PASS					^	07 00
87. 00 88. 00	Total observation bed days (see instructions Adjusted general inpatient routine cost per		÷ line 2)			0 0. 00	87. 00 88. 00
	Observation bed cost (line 87 x line 88) (se						89.00

Health Financial Systems ST.	FRANCIS HOSPITAL & HEALTH CENTER			In Lieu of Form CMS-2552-10		
COMPUTATION OF INPATIENT OPERATING COST	OPERATING COST			Peri od:	Worksheet D-1	
		Component		From 01/01/2014 To 12/31/2014	Date/Time Pre	nared·
			. 0014. 101102	12/01/2011	5/26/2015 12:	
			e XVIII	Subprovi der -	PPS	
			I RF			
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		27)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	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	1, 302, 247	5, 180, 200	0. 25138	9 0	0	90.00
91.00 Nursing School cost	0	5, 180, 200	0. 00000	0 0	0	91.00
92.00 Allied health cost	0	5, 180, 200	0. 00000	0 0	0	92.00
93.00 All other Medical Education	0	5, 180, 200	0. 00000	0 0	0	93. 00

		ST. FRANCIS HOSPITAL &			u of Form CMS-:	
COMPUT	ATION OF INPATIENT OPERATING COST		Provi der CCN: 150162	Peri od: From 01/01/2014	Worksheet D-1	
				To 12/31/2014	Date/Time Pre 5/26/2015 12:	
			Title XIX	Hospi tal	PPS	
	Cost Center Description				4.00	
	PART I - ALL PROVIDER COMPONENTS				1. 00	
	INPATIENT DAYS					1
1. 00	Inpatient days (including private room o	lavs and swing-bed days	excluding newborn)		56, 617	1.00
2. 00	Inpatient days (including private room of				56, 617	2.00
3. 00	Private room days (excluding swing-bed a			rivate room davs.	0	
	do not complete this line.		3			
4.00	Semi-private room days (excluding swing-	bed and observation bed	d days)		49, 124	4.00
5.00	Total swing-bed SNF type inpatient days			er 31 of the cost		
	reporting period					
6.00	Total swing-bed SNF type inpatient days		m days) after December	31 of the cost	0	6.00
	reporting period (if calendar year, ente					
7. 00	Total swing-bed NF type inpatient days (	including private room	days) through December	r 31 of the cost	0	7.00
0.00	reporting period		da) -6t D	21 -6 -1		0.00
8. 00	Total swing-bed NF type inpatient days (		days) after becember	31 of the cost	0	8.00
9. 00	reporting period (if calendar year, ente Total inpatient days including private r		the Program (evoluding	a swing-bod and	3, 130	9.00
7. 00	newborn days)	dom days appricable to	the rrogram (excruding	g swifig-bed and	3, 130	7.00
10.00	Swing-bed SNF type inpatient days applic	cable to title XVIII onl	v (including private	room davs)	0	10.00
	through December 31 of the cost reporting			<i>,</i>		
11.00	Swing-bed SNF type inpatient days applic	cable to title XVIII onl	y (including private	room days) after	0	11.00
	December 31 of the cost reporting period					
12.00	Swing-bed NF type inpatient days applica	able to titles V or XIX	only (including priva	te room days)	0	12.00
40.00	through December 31 of the cost reporting					40.00
13. 00	Swing-bed NF type inpatient days applica				0	13.00
14. 00	after December 31 of the cost reporting Medically necessary private room days as				0	14.00
	Total nursery days (title V or XIX only)		ii (excruding swing-bed	uays)	_	15.00
16. 00	Nursery days (title V or XIX only)					16.00
10.00	SWING BED ADJUSTMENT				200	10.00
17. 00	Medicare rate for swing-bed SNF services	applicable to services	s through December 31	of the cost	0.00	17.00
	reporting period		3			
18.00	Medicare rate for swing-bed SNF services	applicable to services	s after December 31 of	the cost	0.00	18.00
	reporting period					
19. 00	Medicaid rate for swing-bed NF services	applicable to services	through December 31 o	f the cost	0. 00	19.00
	reporting period					
20. 00	Medicaid rate for swing-bed NF services	applicable to services	after December 31 of	the cost	0. 00	20.00
21 00	reporting period				FF 400 01F	21 00
21. 00 22. 00	Total general inpatient routine service Swing-bed cost applicable to SNF type se			ting ported (line	55, 493, 915 0	1
22.00	5 x line 17)	er vi ces tili ougii becember	31 of the cost repor	ting period (inte	U	22.00
23. 00	Swing-bed cost applicable to SNF type se	ervices after December 1	31 of the cost reportion	na period (line A	0	23.00
23.00	x line 18)	or vi ded at ter becomber t	or or the cost reporting	ig porrou (rifle d		25.00
24.00	Swing-bed cost applicable to NF type ser	rvices through December	31 of the cost report	ing period (line	0	24.00
	7 x line 19)	3		- ' '		
25.00	Swing-bed cost applicable to NF type ser	vices after December 3	1 of the cost reporting	period (line 8	0	25.00

		FRANCIS HOSPITA				u of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST		Provider	F	eriod: rom 01/01/2014 o 12/31/2014	Worksheet D-1 Date/Time Pre 5/26/2015 12:	
			Ti t	le XIX	Hospi tal	PPS	47 pili
	Cost Center Description	Cost Center Description  Total Inpatient Inpatient Cost Days  Total Average Per Di em (col. 1  ÷ col. 2)					
		1. 00	2.00	3.00	4. 00	col . 4) 5.00	
42.00	NURSERY (title V & XIX only)	2, 106, 698	4, 419	476. 74	280	133, 487	42.00
42.00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT		0.720	1 400 00	/1/	012 012	42.00
43. 00 43. 01	NEONATAL INTENSIVE CARE UNIT	14, 433, 244 6, 361, 266				912, 912 401, 678	43. 00 43. 01
44. 00	CORONARY CARE UNIT	18, 777, 578				1, 187, 312	44. 00
45.00	BURN INTENSIVE CARE UNIT	, , , , ,	,	,			45.00
46.00	SURGICAL INTENSIVE CARE UNIT	9, 587, 270	6, 673	1, 436. 73	422	606, 300	46.00
47.00	OTHER SPECIAL CARE (SPECIFY)  Cost Center Description						47. 00
	cost center bescription					1. 00	
48. 00	Program inpatient ancillary service cost (Wk	st. D-3, col.	3, line 200)	-		13, 126, 154	48. 00
49. 00	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS	41 through 48)	(see instructi	,		19, 435, 744	49. 00
50. 00	Pass through costs applicable to Program inp		•	·		1, 180, 382	50.00
51. 00	Pass through costs applicable to Program inp and IV)	atient ancilla	ry services (f	rom Wkst. D, s	um of Parts II	1, 420, 496	51.00
52. 00 53. 00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu	ding capital re	elated, non-ph	ysician anesth	etist, and	2, 600, 878 16, 834, 866	
	medical education costs (line 49 minus line	52)					
E4 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	E4 00
55.00	Target amount per discharge					0. 00	54. 00 55. 00
56. 00						0.00	56.00
57.00	Difference between adjusted inpatient operat	ing cost and ta	arget amount (	line 56 minus	line 53)	0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59. 00	Lesser of lines 53/54 or 55 from the cost re market basket	porting period	ending 1996, i	updated and co	mpounded by the	0.00	59. 00
60.00	Lesser of lines 53/54 or 55 from prior year	cost report, u	pdated by the i	market basket		0. 00	60.00
	If line 53/54 is less than the lower of line				the amount by	0	61.00
	which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target						
62. 00	amount (line 56), otherwise enter zero (see instructions)						62. 00
	Relief payment (see instructions) Allowable Inpatient cost plus incentive paym	ent (see instr	uctions)			0	
	PROGRAM INPATIENT ROUTINE SWING BED COST						
64. 00	Medicare swing-bed SNF inpatient routine cos	ts through Dec	ember 31 of the	e cost reporti	ng period (See	0	64.00
65. 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	ts after Decemb	ber 31 of the	cost reporting	period (See	0	65. 00
66. 00	<pre>instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi</pre>	ne costs (line	64 nlus line	45)(title XVII	l only) For	0	66. 00
	CAH (see instructions)		·			0	
68. 00	Title V or XIX swing-bed NF inpatient routin (line 12 x line 19) Title V or XIX swing-bed NF inpatient routin					0	68. 00
	(line 13 x line 20)			•	iting perrou		
U7. UU	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N					0	69. 00
70.00	Skilled nursing facility/other nursing facil	ity/ICF/MR rou	tine service c	ost (line 37)			70. 00
71.00	Adjusted general inpatient routine service c		line 70 ÷ line	2)			71.00
72. 00 73. 00	Program routine service cost (line 9 x line Medically necessary private room cost applic	,	m (line 14 v li	ine 35)			72. 00 73. 00
74. 00	Total Program general inpatient routine serv		•	•			74.00
75. 00	Capital-related cost allocated to inpatient 26, line 45)	•			art II, column		75. 00
76.00	Per diem capital-related costs (line 75 ÷ li	ne 2)					76. 00
77. 00	Program capital -related costs (line 9 x line						77. 00
78. 00 79. 00	Inpatient routine service cost (line 74 minu	,	nrovi don rocon	de)			78. 00 79. 00
80.00	Aggregate charges to beneficiaries for exces Total Program routine service costs for comp			,	us line 79)		80. 00
81. 00	Inpatient routine service cost per diem limi				,		81.00
82.00	Inpatient routine service cost limitation (I		•				82.00
83.00	Reasonable inpatient routine service costs ( Program inpatient ancillary services (see in		ns)				83. 00 84. 00
84. 00 85. 00	Utilization review - physician compensation		ons)				84. 00 85. 00
	Total Program inpatient operating costs (sum						86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS	S THROUGH COST					
87. 00 88. 00	Total observation bed days (see instructions Adjusted general inpatient routine cost per	•	· line 2)			7, 493 980. 16	87. 00 88. 00
	Observation bed cost (line 87 x line 88) (se					7, 344, 339	
	(30)		•			, , , ,	

Health Financial Systems ST.	FRANCIS HOSPITA	L & HEALTH CEN	TER	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Peri od: From 01/01/2014	Worksheet D-1	
				To 12/31/2014	Date/Time Pre 5/26/2015 12:	pared: 47 pm
		Ti t	le XIX	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		27)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	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	11, 033, 873	55, 493, 915	0. 19883	0 7, 344, 339	1, 460, 275	90.00
91.00 Nursing School cost	0	55, 493, 915	0.00000	0 7, 344, 339	0	91.00
92.00 Allied health cost	0	55, 493, 915	0. 00000	0 7, 344, 339	0	92.00
93.00 All other Medical Education	0	55, 493, 915	0. 00000	0 7, 344, 339	0	93.00

Health Financial Systems	ST. FRANCIS HOSPITAL &	u of Form CMS-2552-10		
COMPUTATION OF INPATIENT OPERATING COST		Provi der CCN: 150162	Peri od: From 01/01/2014	Worksheet D-1
		Component CCN: 15T162		
		Title XIX	Subprovi der -	PPS
			I RF	

		I RF		
	Cost Center Description		1. 00	
	PART I - ALL PROVIDER COMPONENTS		1.00	
	INPATIENT DAYS			
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		4, 104	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		4, 104	2.00
3. 00	Private room days (excluding swing-bed and observation bed days). If you have only pri	vate room days,	0	3. 00
4. 00	do not complete this line.  Semi-private room days (excluding swing-bed and observation bed days)		4, 104	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private room days) through December	31 of the cost		5. 00
	reporting period			
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 3	11 of the cost	0	6. 00
7. 00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room days) through December	21 of the cost	0	7. 00
7.00	reporting period	31 OF THE COST	U	7.00
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	152	9. 00
10.00	newborn days) Swing-bed SNF type inpatient days applicable to title XVIII only (including private ro	nom days)	0	10. 00
10.00	through December 31 of the cost reporting period (see instructions)	om days)	· ·	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private ro	oom days) after	0	11. 00
40.00	December 31 of the cost reporting period (if calendar year, enter 0 on this line)			40.00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private through December 31 of the cost reporting period	e room days)	0	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 of	lays)	0	14.00
15.00	Total nursery days (title V or XIX only)			15.00
16.00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT		280	16. 00
17. 00		the cost	0.00	17. 00
	reporting period			
18. 00	Medicare rate for swing-bed SNF services applicable to services after December 31 of t	he cost	0. 00	18. 00
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to services through December 31 of	the cost	0.00	19. 00
19.00	reporting period	the cost	0.00	17.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the	ne cost	0.00	20.00
21 00	reporting period		E 100 200	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	5, 180, 200	21.00
22.00	5 x line 17)	ng perrou (irin	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting	period (line 6	0	23.00
24.00	x line 18)		0	24.00
24. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting $7 \times 1$ line 19)	ig period (iine	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			0 F 100 200	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	l	5, 180, 200	27.00
28. 00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	irges)	0	28. 00
	Private room charges (excluding swing-bed charges)		0	29. 00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31. 00 32. 00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  Average private room per diem charge (line 29 ÷ line 3)		0. 000000 0. 00	31. 00 32. 00
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33. 00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instruct	i ons)	0.00	34.00
35. 00	Average per diem private room cost differential (line 34 x line 31)		0.00	35. 00
36.00	Private room cost differential adjustment (line 3 x line 35)	forential (1:-	0 E 190 200	36.00
37. 00	General inpatient routine service cost net of swing-bed cost and private room cost dif 27 minus line 36)	recential (IIne	5, 180, 200	37. 00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY			
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS			
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1, 262. 23	
39.00	Program general inpatient routine service cost (line 9 x line 38)		191, 859	39.00
	Medically necessary private room cost applicable to the Program (line 14 x line 35)  Total Program general inpatient routine service cost (line 39 + line 40)		0 191, 859	40. 00 41. 00
55	1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.	l	171,007	

		RANCIS HOSPITA				u of Form CMS-2	
COMPUT	ATION OF INPATIENT OPERATING COST			F	eriod: rom 01/01/2014	Worksheet D-1	
			Componen	t CCN: 15T162 T	o 12/31/2014	Date/Time Pre 5/26/2015 12:	
			Ti t	Te XIX	Subprovi der -	PPS	
	Cost Center Description	Total	Total	Average Per	IRF Program Days	Program Cost	
		Inpatient Cost	Inpatient Days	Diem (col. 1 ÷ col. 2)		(col. 3 x col. 4)	
		1. 00	2. 00	3.00	4. 00	5. 00	
42.00	NURSERY (title V & XIX only)	0	C	0.00	0	0	42.00
43.00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	0		0.00	0	0	43.00
43. 01	NEONATAL INTENSIVE CARE UNIT	0			l .	0	
44. 00 45. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT	0	C	0.00	0	0	44. 00 45. 00
46.00	SURGICAL INTENSIVE CARE UNIT	0	c	0.00	0	0	46.00
47. 00	OTHER SPECIAL CARE (SPECIFY)  Cost Center Description						47.00
						1. 00	
	Program inpatient ancillary service cost (Wk Total Program inpatient costs (sum of lines			one)		148, 040	
49.00	PASS THROUGH COST ADJUSTMENTS	41 (111 ough 46)	(See Tristructi	uris)		339, 899	49.00
50.00	Pass through costs applicable to Program inp	atient routine	services (fro	m Wkst. D, sum	of Parts I and	48, 231	50.00
51. 00	<pre>III) Pass through costs applicable to Program inp</pre>	atient ancilla	ry services (f	rom Wkst. D, sı	um of Parts II	14, 593	51.00
<b>50.00</b>	and IV)			•			
52. 00 53. 00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu		elated non-ph	vsician anesth	etist and	62, 824 277, 075	
00.00	medical education costs (line 49 minus line				orror, and		]
54 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54.00
	Target amount per discharge					0.00	
56. 00 57. 00	Target amount (line 54 x line 55) Difference between adjusted inpatient operat	ing cost and t	arget amount (	ling 56 minus l	ine 53)	0	56. 00 57. 00
58. 00	Bonus payment (see instructions)	ring cost and to	arget amount (	Title 30 millias i	1116 33)	0	1
59. 00	Lesser of lines 53/54 or 55 from the cost re	porting period	endi ng 1996,	updated and cor	npounded by the	0.00	59.00
60.00	market basket 00 Lesser of Lines 53/54 or 55 from prior year cost report, updated by the market basket						60.00
61. 00							61.00
	which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						
62.00	Relief payment (see instructions)	ont (oog i notn	unti ana)			0	
63. 00	Allowable Inpatient cost plus incentive paym PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see mstr	uctions)			0	63.00
64. 00	Medicare swing-bed SNF inpatient routine cos	ts through Dec	ember 31 of th	e cost reporti	ng period (See	0	64.00
65. 00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos</pre>	ts after Decemb	ber 31 of the	cost reporting	period (See	0	65.00
// 00	instructions)(title XVIII only)	(III	(4 -1 1:			0	// 00
66. 00	Total Medicare swing-bed SNF inpatient routi CAH (see instructions)	ne costs (line	64 plus line	65)(TITIE XVIII	only). For	0	66.00
67. 00	Title V or XIX swing-bed NF inpatient routin	e costs through	h December 31	of the cost rep	porting period	0	67. 00
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routin	e costs after	December 31 of	the cost repo	rting period	0	68.00
(0.00	(line 13 x line 20)			·	3 1	0	
69.00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N					0	69.00
70.00	Skilled nursing facility/other nursing facil	ity/ICF/MR rou	tine service c	ost (line 37)			70.00
71. 00 72. 00	Adjusted general inpatient routine service c Program routine service cost (line 9 x line		line /0 ÷ line	2)			71. 00 72. 00
73.00	Medically necessary private room cost applic	abĺe to Progra	•	,			73.00
74. 00 75. 00	Total Program general inpatient routine serv Capital-related cost allocated to inpatient			•	art II column		74. 00 75. 00
	26, line 45)		0 00313 (110111	WOT KSTICCT B, TO	art II, corumi		
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line						76. 00 77. 00
78. 00	Inpatient routine service cost (line 74 minu						78.00
79. 00 80. 00	Aggregate charges to beneficiaries for exces Total Program routine service costs for comp			*.	ıs line 701		79. 00 80. 00
81. 00	Inpatient routine service costs for comp			(1116 70 111111	20 11110 17)		81.00
82. 00 83. 00	Inpatient routine service cost limitation (I						82. 00 83. 00
84.00	Reasonable inpatient routine service costs ( Program inpatient ancillary services (see in		113)				84.00
85.00	Utilization review - physician compensation	(see instructi					85.00
86. 00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PAS:		nrougn 85)				86.00
87.00	Total observation bed days (see instructions	)				0	
88. 00 89. 00	Adjusted general inpatient routine cost per Observation bed cost (line 87 x line 88) (se	•					88. 00 89. 00
	(30)		•		'	O	

Health Financial Systems	ST. FRANCIS HOSPITA	L & HEALTH CEN	In Lie	2552-10		
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Peri od:	Worksheet D-1	
		Component	CCN: 15T162	From 01/01/2014 To 12/31/2014		
		Ti t	le XIX	Subprovi der -	PPS	
				I RF		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		27)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
				ŕ	instructions)	
	1. 00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THRO	UGH COST					
90.00 Capital -related cost	1, 302, 247	5, 180, 200	0. 25138	9 0	0	90.00
91.00 Nursing School cost	0	5, 180, 200	0. 00000	0 0	0	91.00
92.00 Allied health cost	0	5, 180, 200	0. 00000	0 0	0	92.00
93.00 All other Medical Education	0	5, 180, 200	0. 00000	0 0	0	93.00

Health Financial Systems	ST. FRANCIS HOSPITAL &	HEALTH CENTER	In Lie	u of Form CMS-2552-10
INDATIENT ANGLILADY CEDVICE COC	T ADDODTI ONMENT	D CON 1501/0	D =! = -I	Waskahaat D 2

Health Financial Systems ST. FRANCIS HOSPITAL &	HEALTH CENTI	ER	In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 150162	Peri od:	Worksheet D-3	
			From 01/01/2014	D-+- /T: D	
			To 12/31/2014	Date/Time Pre 5/26/2015 12:	
	Title	XVIII	Hospi tal	PPS	тл рііі
Cost Center Description		Ratio of Cos		I npati ent	
		To Charges	Program	Program Costs	
		3	Charges	(col. 1 x	
			Ü	col . 2)	
		1. 00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS			32, 312, 855		30.00
31. 00   03100   I NTENSI VE CARE UNI T			12, 300, 087		31.00
31. 01   02060   NEONATAL   NTENSI VE CARE UNI T			0		31. 01
32. 00   03200   CORONARY CARE UNIT			11, 356, 214		32.00
34. 00   03400   SURGI CAL   INTENSI VE CARE UNI T			6, 706, 947		34.00
41. 00   04100   SUBPROVI DER - I RF			0		41.00
43. 00 04300 NURSERY					43.00
ANCILLARY SERVICE COST CENTERS  50. 00   05000   OPERATING ROOM		0. 26115	4 25, 665, 567	6, 702, 665	50. 00
52. 00   05200   DELI VERY ROOM & LABOR ROOM		0. 24401		17, 263	52. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C		0. 13450		3, 993, 310	54.00
54. 01   05400  CARDI AC NUCLEAR DI AGNOSTI C		0. 05468		7, 356	54. 00
54. 02   03450  NUCLEAR MEDICINE - DIAGNOSTIC		0. 00000		7, 330	54. 02
54. 03   03630   ULTRA SOUND		0. 08870		246, 306	54. 03
55. 00   05500   RADI OLOGY - THERAPEUTI C		0. 15162		6, 093	55.00
56. 00   05600   RADI OI SOTOPE		0. 26554		163, 998	56. 00
59. 00 O5900 CARDI AC CATHETERI ZATI ON		0. 09059		966, 010	59. 00
60. 00   06000   LABORATORY		0. 14684		4, 981, 277	60.00
64. 00 06400 I NTRAVENOUS THERAPY		0. 26637		209, 451	64.00
65. 00 06500 RESPIRATORY THERAPY		0. 21384		3, 872, 579	65.00
66. 00 06600 PHYSI CAL THERAPY		0. 27221		1, 748, 115	66.00
66. 01   06601   SPORTS   MEDI CI NE		0. 00000		0	66. 01
67. 00 06700 OCCUPATI ONAL THERAPY		0. 23408		465, 529	67.00
68. 00 06800 SPEECH PATHOLOGY		0. 22488		158, 390	68.00
69. 00 06900 ELECTROCARDI OLOGY		0. 18236	9 6, 647, 137	1, 212, 232	69.00
69. 01   06901   CARDI AC   CATH   LAB		0.00000	o o	0	69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 19680	6 588, 347	115, 790	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 41323	8 40, 909, 341	16, 905, 294	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT		0. 36138	7 17, 944, 918	6, 485, 060	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 17130	9 50, 774, 961	8, 698, 208	73.00
74. 00   07400   RENAL DI ALYSI S		0. 29251	0 3, 057, 323	894, 298	74.00
76. 97 O7697 CARDI AC REHABI LI TATI ON		0. 48055	0 258	124	76. 97
OUTPATIENT SERVICE COST CENTERS					
90. 00   09000   CLINIC		0. 72030		57, 874	90.00
90. 01   09001   I BMT JOI NT VENTURE		1. 08159		53, 827	90. 01
90. 02   09002   PSYCHI ATRI C COUNCELI NG CENTER		0. 69567		0	90.02
90. 03   09003   SOUTH   NDY MRI & REHAB		0. 59998		0	90.03
90. 04   09004   BARI ATRI CS		0.00000		11 204	90.04
90. 05   09005   CV DI AGNOSTI C SERVI CES		0. 43901		11, 206	90.05
90. 06   09006   CARDI AC REHAB		0.00000		2 220 745	90.06
91. 00   09100   EMERGENCY 92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART)		0. 11246		2, 228, 765	91. 00 92. 00
200.00 Total (sum of lines 50-94 and 96-98)		0. 55574	2 1, 499, 382 272, 985, 695	833, 270 61, 034, 290	
201.00 Less PBP Clinic Laboratory Services-Program only charges	(Line 61)		212, 700, 090	01,034,290	200.00
202.00 Net Charges (line 200 minus line 201)	(TITIE OI)		272, 985, 695		201.00
202. 00     met ondriges (Trice 200 millios Trice 201)			2,2, 303, 093		202.00

Health Financial Systems ST. FRANCIS HINPATIENT ANCILLARY SERVICE COST APPORTIONMENT	OSPITAL & HEALTH CEN Provider	CCN: 150162	Peri od:	Worksheet D-3	3
	Component	t CCN: 15T162	From 01/01/2014 To 12/31/2014	Date/Time Pre 5/26/2015 12:	epared:
	Ti tl	e XVIII	Subprovi der - I RF	PPS	., p
Cost Center Description	,	Ratio of Cos To Charges	_	Inpatient Program Costs (col. 1 x col. 2)	
		1. 00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS		,			
30. 00   03000   ADULTS & PEDI ATRI CS			0		30.00
31. 00   03100   INTENSIVE CARE UNIT			0		31.00
31. 01   02060   NEONATAL INTENSIVE CARE UNIT			0		31.01
32. 00   03200   CORONARY CARE UNIT 34. 00   03400   SURGI CAL I NTENSI VE CARE UNIT			0		32. 00 34. 00
41. 00   04100   SUBPROVI DER -   RF			4, 346, 182		41.00
43. 00   04300   NURSERY			1,010,102		43.00
ANCILLARY SERVICE COST CENTERS					
50. 00 05000 OPERATING ROOM		0. 2611!	54 29, 225	7, 632	
52. 00   05200   DELI VERY ROOM & LABOR ROOM		0. 2440		0	
54. 00   05400   RADI OLOGY - DI AGNOSTI C		0. 13450		30, 122	1
54. 01   05402   CARDI AC NUCLEAR DI AGNOSTI C		0.05468		0	
54. 02   03450   NUCLEAR MEDICINE - DIAGNOSTIC 54. 03   03630   ULTRA SOUND		0. 00000 0. 08870		0 4, 292	
55. 00   05500   RADI OLOGY - THERAPEUTI C		0. 1516		327	
56. 00   05600   RADI OI SOTOPE		0. 2655	·	0	1
59. 00   05900 CARDI AC CATHETERI ZATI ON		0. 09059		0	
60. 00   06000   LABORATORY		0. 1468	43 426, 726	62, 662	60.00
64. 00 06400 I NTRAVENOUS THERAPY		0. 2663	70 0	0	
65. 00 06500 RESPI RATORY THERAPY		0. 2138		58, 029	
66. 00   06600   PHYSI CAL THERAPY		0. 2722		367, 178	
66. 01   06601   SPORTS   MEDI CI NE		0.00000		0	
67. 00   06700   0CCUPATI ONAL THERAPY 68. 00   06800   SPEECH PATHOLOGY		0. 23408 0. 22488		262, 316 95, 603	
69. 00   06900   ELECTROCARDI OLOGY		0. 2246		4, 161	
69. 01 06901 CARDI AC CATH LAB		0. 00000		0	
70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 19680		147	1
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 4132	38 521, 363	215, 447	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT		0. 3613	1, 184	428	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 17130	·	109, 361	
74. 00   07400   RENAL DI ALYSI S		0. 2925		25, 202	
76. 97 O7697 CARDI AC REHABI LI TATI ON		0. 4805	50 0	0	76. 97
90. 00 OUTPATIENT SERVICE COST CENTERS 90. 00 OP000 CLINIC		0.7202	01	0	00 00
90. 00   09000  CLI NI C 90. 01   09001  I BMT JOI NT VENTURE		0. 72030 1. 08150		0	
90. 02 09002 PSYCHI ATRI C COUNCELI NG CENTER		0. 6956		0	
90. 03   09003   SOUTH   NDY MRI & REHAB		0. 59998		0	
90. 04   09004   BARI ATRI CS		0.0000		0	
90. 05 09005 CV DI AGNOSTI C SERVI CES		0. 4390°		4, 884	90.05
90. 06 09006 CARDI AC REHAB		0. 00000		0	
91. 00   09100   EMERGENCY		0. 1124		0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 5557		0	
200.00 Total (sum of lines 50-94 and 96-98)		1	5, 178, 159	1, 247, 791	1200. OO

4, 884 90. 05 0 90. 06 0 91. 00 0 92. 00 1, 247, 791 200. 00

5, 178, 159

201.00

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)

Health Financial Systems	ST. FRANCIS HOSPITAI	. & HEALTH CENTER	In Lie	u of Form CMS-2552-10
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Health Financial Systems ST. FRANCIS HOSPITAL & I	HEALTH CEN	ITER	In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der	CCN: 150162	Peri od:	Worksheet D-3	
			From 01/01/2014		
			To 12/31/2014		
				5/26/2015 12:	47 pm
	Ti t	le XIX	Hospi tal	PPS	
Cost Center Description		Ratio of Cos	t Inpatient	I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col . 1 x	
				col . 2)	
		1.00	2.00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
30. 00 03000 ADULTS & PEDI ATRI CS			9, 395, 332		30.00
31. 00   03100   INTENSIVE CARE UNIT			2, 318, 212		31.00
31.01 O2060 NEONATAL INTENSIVE CARE UNIT			8, 798, 663		31. 01
32. 00  03200  CORONARY CARE UNIT			1, 252, 430		32.00
34.00 03400 SURGICAL INTENSIVE CARE UNIT			979, 190		34.00
41. 00   04100   SUBPROVI DER - I RF			0		41.00
43. 00   04300   NURSERY			3, 388, 833		43.00
ANCI LLARY SERVI CE COST CENTERS			0,000,000		10.00
50. 00 05000 OPERATI NG ROOM		0. 26115	3, 728, 315	973, 664	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM		0. 24401		2, 077, 001	52.00
		1			1
54. 00   05400   RADI OLOGY-DI AGNOSTI C		0. 13450		631, 226	
54. 01   05402   CARDI AC NUCLEAR DI AGNOSTI C		0. 05468		831	
54. 02   03450   NUCLEAR MEDICINE - DIAGNOSTIC		0.00000	0 0	0	54.02
54. 03  03630  ULTRA SOUND		0. 08870	08 607, 868	53, 923	54.03
55. 00 05500 RADI OLOGY - THERAPEUTI C		0. 15162	1 450	68	55.00
56. 00   05600   RADI OI SOTOPE		0. 26554		25, 253	56.00
59. 00   05900   CARDI AC   CATHETERI ZATI ON		0. 09059		97, 158	1
60. 00   06000   LABORATORY		0. 14684		1, 164, 459	1
64. 00   06400   NTRAVENOUS THERAPY		0. 26637		34, 167	
65. 00 06500 RESPI RATORY THERAPY		0. 21384		963, 562	
66. 00 O6600 PHYSI CAL THERAPY		0. 27221	·	199, 243	
66. 01  06601 SPORTS MEDICINE		0.00000	0 0	0	66. 01
67. 00  06700 0CCUPATI ONAL THERAPY		0. 23408	535, 418	125, 333	67.00
68. 00   06800   SPEECH PATHOLOGY		0. 22488	126, 100	28, 357	68. 00
69. 00 06900 ELECTROCARDI OLOGY		0. 18236	783, 094	142, 812	69.00
69. 01   06901   CARDI AC   CATH   LAB		0.00000		0	69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 19680		28, 829	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		1		3, 084, 799	
		0. 41323			
72. 00 O7200 I MPL. DEV. CHARGED TO PATIENT		0. 36138		656, 883	
73.00 O7300 DRUGS CHARGED TO PATIENTS		0. 17130		1, 972, 730	
74. 00   07400   RENAL DI ALYSI S		0. 29251		134, 832	
76. 97 O7697 CARDI AC REHABI LI TATI ON		0. 48055	0	0	76. 97
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLI NI C		0. 72030	7, 419	5, 344	90.00
90. 01   09001   I BMT JOI NT VENTURE		1. 08159	9 85, 640	92, 628	90. 01
90. 02 09002 PSYCHI ATRI C COUNCELI NG CENTER		0. 69567		0	90.02
90. 03   09003   SOUTH   NDY MRI & REHAB		0. 59998		ő	90.03
90. 04   09004   BARI ATRI CS				0	
		0.00000			90.04
90. 05   09005   CV   DI AGNOSTI C   SERVI CES		0. 43901		43	90.05
90. 06   09006   CARDI AC REHAB		0.00000		0	90.06
91. 00   09100   EMERGENCY		0. 11246	3, 713, 900	417, 669	
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 55574	2 387, 482	215, 340	92.00
200.00 Total (sum of lines 50-94 and 96-98)			59, 065, 040	13, 126, 154	200.00
201.00 Less PBP Clinic Laboratory Services-Program only charges	(line 61)		0		201.00
202.00 Net Charges (line 200 minus line 201)	,		59, 065, 040		202.00
202. 00 The charges (True 200 million 11th 201)		I	37, 003, 040	1	1202.00

Health Financial Systems ST. FRANCIS HOSE INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	PITAL & HEALTH CEN Provider	CCN: 150162	Peri od:	u of Form CMS-2 Worksheet D-3	
	Componen <sup>-</sup>	t CCN: 15T162	From 01/01/2014 To 12/31/2014	Date/Time Pre 5/26/2015 12:	pared:
	Ti t	le XIX	Subprovi der -	PPS	47 pili
Cost Center Description		Ratio of Cos		I npati ent	
		To Charges	Program Charges	Program Costs (col. 1 x col. 2)	
		1. 00	2. 00	3. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS					
30. 00   03000   ADULTS & PEDI ATRI CS			0		30.00
31. 00   03100   INTENSI VE CARE UNI T			0		31.00
31. 01   02060   NEONATAL I NTENSI VE CARE UNI T 32. 00   03200   CORONARY CARE UNI T			0		31.01
32. 00   03200   CORONARY CARE UNIT 34. 00   03400   SURGICAL INTENSIVE CARE UNIT			0		34.00
41. 00   04100   SUBPROVI DER -   RF			342, 097		41.00
43. 00   04300   NURSERY			0 12, 0 77		43.00
ANCILLARY SERVICE COST CENTERS		•			
50. 00 05000 OPERATING ROOM		0. 2611	54 47, 513	12, 408	50.00
52.00   05200   DELIVERY ROOM & LABOR ROOM		0. 2440	15 0	0	
54. 00   05400   RADI OLOGY-DI AGNOSTI C		0. 13450	30, 327	4, 079	
54. 01   05402   CARDI AC NUCLEAR DI AGNOSTI C		0. 05468		0	
54. 02   03450   NUCLEAR MEDICINE - DIAGNOSTIC		0.00000		0	
54. 03   03630   ULTRA SOUND 55. 00   05500   RADI OLOGY - THERAPEUTI C		0.08870		0	
56. 00   05600   RADI 0L0GY - THERAPEUTI C		0. 15162 0. 26554		1, 011	
59. 00   05900   CARDI AC   CATHETERI ZATI ON		0. 09059	· ·	0	1
60. 00   06000   LABORATORY		0. 14684		9, 904	
64. 00 06400 I NTRAVENOUS THERAPY		0. 2663		1, 265	1
65. 00 06500 RESPI RATORY THERAPY		0. 21384		3, 756	1
66. 00 06600 PHYSI CAL THERAPY		0. 2722		62, 966	66.00
66. 01   06601   SPORTS   MEDI CI NE		0.00000	00 0	0	66. 01
67. 00 06700 OCCUPATI ONAL THERAPY		0. 23408	·	676	
68. 00 O6800 SPEECH PATHOLOGY		0. 22488		665	
69. 00   06900   ELECTROCARDI OLOGY		0. 18236		872	
69. 01  06901 CARDI AC CATH LAB 70. 00  07000 ELECTROENCEPHALOGRAPHY		0.00000		0 2, 028	
71. 00   07100   MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 19680 0. 41323	· ·	2, 028 6, 779	
72. 00   07200   MPL. DEV. CHARGED TO PATIENT		0. 36138		21, 647	1
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 17130	· ·	16, 781	
74. 00 07400 RENAL DI ALYSI S		0. 2925	·	0,701	
76. 97 O7697 CARDI AC REHABI LI TATI ON		0. 4805!		0	
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLI NI C		0. 72030	01 4, 447	3, 203	90.00
90. 01   09001   I BMT JOINT VENTURE		1. 08159		0	
90. 02   09002   PSYCHI ATRI C COUNCELI NG CENTER		0. 6956		0	
90. 03   09003   SOUTH   NDY MRI & REHAB		0. 59998		0	
90. 04   09004   BARI ATRI CS 90. 05   09005   CV   DI AGNOSTI C   SERVI CES		0.00000		0	
90. 05   09005   CV   DI AGNOSTI C   SERVI CES 90. 06   09006   CARDI AC   REHAB		0. 4390		0	
91. 00   09100   EMERGENCY		0. 00000		0	
92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART)		0. 55574		0	
200.00 Total (sum of lines 50-94 and 96-98)			602, 361	148, 040	

201. 00 202. 00

602, 361

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)

Health Financial Systems	ST. FRANCIS HOSPITAL & HEALTH CENTER		In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der CCN: 150162	Peri od:	Worksheet F

CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provi der	CCN: 150162	Peri od: From 01/01/2014 To 12/31/2014	Worksheet E Part A Date/Time Pre	pared:
		Ti tl	e XVIII	Hospi tal	5/26/2015 12: PPS	47 pm
			0	1.00	2. 00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS			1.00	2.00	
1. 00 1. 01	DRG Amounts Other than Outlier Payments DRG amounts other than outlier payments for discharges occurring	ng prior		0 52, 464, 473		1. 00 1. 01
1. 02	to October 1 (see instructions) DRG amounts other than outlier payments for discharges occurring after October 1 (see instructions)	ng on or		17, 867, 737		1. 02
1. 03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)			0		1.03
1. 04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)	-		0		1.04
2. 00 2. 01	Outlier payments for discharges. (see instructions) Outlier reconciliation amount			6, 340, 215 0		2. 00 2. 01
2. 02	Outlier payment for discharges for Model 4 BPCI (see instruction	ons)		0		2.02
3.00	Managed Care Simulated Payments			20, 195, 844		3.00
4. 00	Bed days available divided by number of days in the cost report period (see instructions)	. i rig		371. 72		4.00
5. 00	Indirect Medical Education Adjustment FTE count for allopathic and osteopathic programs for the most			15. 30		5. 00
6. 00	cost reporting period ending on or before 12/31/1996. (see instr FTE count for allopathic and osteopathic programs which meet the	ne		2. 22		6. 00
7.00	criteria for an add-on to the cap for new programs in accordanc CFR 413.79(e)			0.00		7.00
7. 00	MMA Section 422 reduction amount to the IME cap as specified ur CFR $\S412.105(f)(1)(iv)(B)(1)$			0.00		7.00
7. 01	ACA Section 5503 reduction amount to the IME cap as specified $\iota$ CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July then see instructions.			0.00		7.01
8. 00	Adjustment (increase or decrease) to the FTE count for allopath osteopathic programs for affiliated programs in accordance with 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67	1 42 CFR		-0. 63		8. 00
8. 01	(August 1, 2002). The amount of increase if the hospital was awarded FTE cap slot section 5503 of the ACA. If the cost report straddles July 1, 2			0.00		8. 01
8. 02	Instructions. The amount of increase if the hospital was awarded FTE cap slot			0.00		8. 02
9. 00	closed teaching hospital under section 5506 of ACA. (see instru Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines and 8,02) (see instructions)			16. 89		9. 00
10. 00	FTE count for allopathic and osteopathic programs in the currer from your records	nt year		20. 31		10.00
11. 00 12. 00	FTE count for residents in dental and podiatric programs.  Current year allowable FTE (see instructions)			0. 26 17. 15		11. 00 12. 00
13. 00	Total allowable FTE count for the prior year.			17. 15		13.00
14. 00	Total allowable FTE count for the penultimate year if that year or after September 30, 1997, otherwise enter zero.	ended on		18. 15		14.00
15. 00	Sum of lines 12 through 14 divided by 3.			17. 46		15.00
16. 00 17. 00	Adjustment for residents in initial years of the program Adjusment for residents displaced by program or hospital closur	·		0. 00 0. 00		16. 00 17. 00
18. 00	Adjusted rolling average FTE count	C		17. 46		18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).			0. 046971		19.00
20.00	Prior year resident to bed ratio (see instructions)			0. 042889		20.00
21. 00	Enter the lesser of lines 19 or 20 (see instructions)			0. 042889		21.00
22. 00	IME payment adjustment (see instructions)			2, 096, 358		22.00
22. 01	IME payment adjustment - Managed Care (see instructions) Indirect Medical Education Adjustment for the Add-on for Section		the MMA	0		22.01
23. 00	Number of additional allopathic and osteopathic IME FTE resider slots under 42 Sec. 412.105 $(f)(1)(iv)(C)$ .	ії сар		0.00		23. 00
24. 00 25. 00	IME FTE Resident Count Over Cap (see instructions) If the amount on line 24 is greater than -0-, then enter the lo	ower of		3. 42 0. 00		24. 00 25. 00
26. 00	line 23 or line 24 (see instructions) 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)			2 004 259		28. 01
29. 00 29. 01	Total IME payment ( sum of lines 22 and 28) Total IME payment - Managed Care (sum of lines 22.01 and 28.01)			2, 096, 358 0		29. 00 29. 01
30. 00	Disproportionate Share Adjustment  Percentage of SSI recipient patient days to Medicare Part A pat (see instructions)	ient days		3. 33		30.00
31.00	Percentage of Medicaid patient days (see instructions)			17. 06		31.00
32.00	Sum of lines 30 and 31			20. 39		32.00
33. 00 34. 00	Allowable disproportionate share percentage (see instructions) Disproportionate share adjustment (see instructions)			6. 04 1, 062, 017		33. 00 34. 00
			•			-

CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 150162	Peri od: From 01/01/2014 To 12/31/2014		pared:
		Title XVIII	Hospi tal	PPS	., р
			Prior to	On/After	
			October 1	October 1	
		0	1. 00	2. 00	
	Uncompensated Care Adjustment		1		
35.00	Total uncompensated care amount (see instructions)			7, 647, 644, 855	35.00
35. 01	Factor 3 (see instructions)		0. 000452432	0. 000451752	35. 01
35. 02	Hospital uncompensated care payment (If line 34 is zero,		4, 092, 872	3, 454, 839	35. 02
	enter zero on this line) (see instructions)				
35. 03	Pro rata share of the hospital uncompensated care payment		3, 061, 243	870, 809	35. 03
	amount (see instructions)				
36. 00	Total uncompensated care (sum of columns 1 and 2 on line		3, 932, 052		36.00
	35. 03)	(11, 10, 11			
	Additional payment for high percentage of ESRD beneficiary di	scharges (lines 40 throu	•		
40. 00	Total Medicare discharges on Worksheet S-3, Part I		0		40.00
	excluding discharges for MS-DRGs 652, 682, 683, 684 and				
41 00	685 (see instructions)				41 00
41. 00	Total ESRD Medicare discharges excluding MS-DRGs 652,		U		41. 00
41 01	682, 683, 684 an 685. (see instructions)				41 01
41. 01	Total ESRD Medicare covered and paid discharges excluding		U		41. 01
42. 00	MS-DRGs 652, 682, 683, 684 an 685. (see instructions) Divide line 41 by line 40 (if less than 10%, you do not		0.00		42. 00
42.00	qualify for adjustment)		0.00		42.00
43. 00	Total Medicare ESRD inpatient days excluding MS-DRGs 652,		0		43. 00
43.00	682, 683, 684 an 685. (see instructions)		ď		43.00
44. 00	Ratio of average length of stay to one week (line 43		0. 000000		44. 00
44.00	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
10.00	instructions)		0.00		10.00
46.00	Total additional payment (line 45 times line 44 times line		0		46. 00
	41.01)				
47.00	Subtotal (see instructions)		83, 762, 852		47.00
48.00	Hospital specific payments (to be completed by SCH and		0		48. 00
	MDH, small rural hospitals only. (see instructions)				
49.00	Total payment for inpatient operating costs (see		83, 762, 852		49.00
	instructions)				
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I		6, 871, 111		50.00
	and Pt. II, as applicable)				
51.00	Exception payment for inpatient program capital (Wkst. L,		o		51.00
	Pt. III, see instructions)				
52.00	Direct graduate medical education payment (from Wkst. E-4,		679, 703		52.00
	line 49 see instructions).				
53.00	Nursing and Allied Health Managed Care payment		41, 162		53.00
54.00	Special add-on payments for new technologies		16, 174		54.00
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1,		0		55.00
	line 69)				
56.00	Cost of physicians' services in a teaching hospital (see		0		56.00
	intructions)				
57.00	Routine service other pass through costs (from Wkst. D,		0		57.00
	Pt. III, column 9, lines 30 through 35).				
58. 00	Ancillary service other pass through costs from Wkst. D,		57, 227		58. 00
	Pt. IV, col. 11 line 200)				
59. 00	Total (sum of amounts on lines 49 through 58)		91, 428, 229		59.00
60.00	Primary payer payments		34, 742		60.00
61. 00	Total amount payable for program beneficiaries (line 59		91, 393, 487		61.00
40.00	minus line 60)		/ 477 040		40.00
62.00	Deductibles billed to program beneficiaries		6, 177, 312		62.00
63.00	Coinsurance billed to program beneficiaries		269, 344		63.00
64.00	Allowable bad debts (see instructions)		618, 764		64.00
65.00	Adjusted reimbursable bad debts (see instructions)		402, 197		65.00
66. 00	Allowable bad debts for dual eligible beneficiaries (see		92, 278		66. 00
67. 00	instructions)		05 240 020		/7 00
	Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices		85, 349, 028		67.00
68. 00	· · · · · · · · · · · · · · · · · · ·		7, 000		68. 00
69. 00	for applicable to MS-DRGs (see instructions) Outlier payments reconciliation (sum of lines 93, 95 and		0		69. 00
U7. UU	96). (For SCH see instructions)		۱		U7. UU
70. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)				70. 00
70. 50	RURAL DEMONSTRATION PROJECT		0		70. 50
70. 30	Pioneer ACO demonstration payment adjustment amount (see				70. 30
70.07	instructions)		۱		10.09
70. 90	HSP bonus payment HVBP adjustment amount (see				70. 90
70.70	instructions)		"		70.70
70. 91	HSP bonus payment HRR adjustment amount (see instructions)		0		70. 91
70. 91	Bundled Model 1 discount amount (see instructions)				70. 91
70. 92	HVBP payment adjustment amount (see instructions)		139, 527		70. 92
	HRR adjustment amount (see instructions)		-25, 015		70. 73
70. 95	,		25,015		70. 95
			1	<u> </u>	

leal th	Financial Systems ST. FRANCIS HOSPITAL	& HEALTH CENTER		u of Form CMS-	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 150162	Peri od: From 01/01/2014 To 12/31/2014	Worksheet E Part A Date/Time Pre 5/26/2015 12:	epared:
		Title XVIII	Hospi tal	PPS	47 pili
			Prior to October 1	On/After October 1	
		0	1. 00	2. 00	
70. 96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)		0 0		70. 96
70. 97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)		0 0		70. 97
70. 98	Low Volume Payment-3		0		70. 98
70. 99	HAC adjustment amount (see instructions)		0		70. 99
71. 00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		85, 456, 540		71.00
71.01	Sequestration adjustment (see instructions)		1, 709, 131		71.01
72.00	Interim payments		84, 163, 232		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, 72, and 73)		-415, 823		74.00
75.00	Protested amounts (nonallowable cost report items) in		326, 341		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 instructions)		0		90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0		91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0		92.00
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 instructions)		0. 00		94.00
95. 00	Time value of money for operating expenses (see instructions)		0		95.00
96. 00	Time value of money for capital related expenses (see instructions)		0		96.00
			Prior to 10/1	05/After 10/1	

Tisti deti dis)			1
	Prior to 10/1	On/After 10/1	
	1. 00	2. 00	
HSP Bonus Payment Amount			
100.00 HSP bonus amount (see instructions)	C	0	100. 00
HVBP Adjustment for HSP Bonus Payment			
101.00 HVBP adjustment factor (see instructions)	C	0	101.00
102.00 HVBP adjustment amount for HSP bonus payment (see instructions)	C	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)	C	0	104.00
		,	

Health Financial Systems	ST. FRANCIS HOSPITAL & I	HEALTH CENTER	In Lieu	of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der CCN: 150162	From 01/01/2014 To 12/31/2014	Worksheet E Part B Date/Time Prepared: 5/26/2015 12:47 pm

			To 12/31/2014	Date/Time Pre 5/26/2015 12:	
		Title XVIII	Hospi tal	PPS	47 piii
				1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1. 00	
1.00	Medical and other services (see instructions)			34, 606	1.00
2.00	Medical and other services reimbursed under OPPS (see instructi	ons)		56, 179, 365	1
3.00	PPS payments			44, 732, 601	3.00
4.00	Outlier payment (see instructions)			474, 185	•
5. 00	Enter the hospital specific payment to cost ratio (see instruc-	tions)		0. 000	•
6.00	Line 2 times line 5			0	6.00
7. 00 8. 00	Sum of line 3 plus line 4 divided by line 6 Transitional corridor payment (see instructions)			0. 00 0	ı
9. 00	Ancillary service other pass through costs from Wkst. D, Pt. IV	/ col 13 line 200		22, 814	•
10. 00	Organ acqui si ti ons	7, 661. 16, 11116 266		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			34, 606	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonable charges				
12.00	Ancillary service charges	1 4		199, 891	•
13. 00 14. 00	Organ acquisition charges (from Wkst. D-4, Pt. III, line 69, co Total reasonable charges (sum of lines 12 and 13)	01. 4)		0 199, 891	
14.00	Customary charges			177, 071	14.00
15. 00	Aggregate amount actually collected from patients liable for pa	ayment for services on	a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for			0	16.00
	had such payment been made in accordance with 42 CFR §413.13(e)				
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000	•
18.00	Total customary charges (see instructions)	if line 10 eyesede l	ino 11) (000	199, 891	
19. 00	Excess of customary charges over reasonable cost (complete only instructions)	/ IT TIME 18 exceeds I	rne II) (see	165, 285	19. 00
20. 00	Excess of reasonable cost over customary charges (complete only	/if line 11 exceeds L	ine 18) (see	0	20.00
	instructions)		, (	-	
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see	i nstructi ons)		34, 606	
22. 00	Interns and residents (see instructions)			0	
23. 00	Cost of physicians' services in a teaching hospital (see instru	uctions)		0	
24. 00	Total prospective payment (sum of lines 3, 4, 8 and 9)  COMPUTATION OF REIMBURSEMENT SETTLEMENT			45, 229, 600	24.00
25. 00	Deductibles and coinsurance (for CAH, see instructions)			862	25. 00
26. 00	Deductibles and Coinsurance relating to amount on line 24 (for	CAH, see instructions	()	9, 074, 333	•
27. 00	Subtotal {(lines 21 and 24 minus the sum of lines 25 and 26) pl			36, 189, 011	1
	CAH, see instructions)	,			
28. 00	Direct graduate medical education payments (from Wkst. E-4, line 20)	ne 50)		354, 392	1
29. 00 30. 00	ESRD direct medical education costs (from Wkst. E-4, line 36) Subtotal (sum of lines 27 through 29)			0 36, 543, 403	
31. 00	Primary payer payments			7, 730	1
32. 00	Subtotal (line 30 minus line 31)			36, 535, 673	•
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE	(S)			
33. 00	Composite rate ESRD (from Wkst. I-5, line 11)			0	
34.00	Allowable bad debts (see instructions)			1, 194, 976	1
35. 00 36. 00	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instru	ictions)		776, 734 620, 723	
37. 00	Subtotal (see instructions)	2011 0113)		37, 312, 407	
38. 00	MSP-LCC reconciliation amount from PS&R				38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
39. 50	Pioneer ACO demonstration payment adjustment (see instructions)			0	
39. 98	Partial or full credits received from manufacturers for replace	ed devices (see instru	icti ons)	0	39. 98
39. 99	RECOVERY OF ACCELERATED DEPRECIATION			0	39. 99 40. 00
40. 00 40. 01	Subtotal (see instructions) Sequestration adjustment (see instructions)			37, 312, 444 746, 249	•
41. 00					1
42.00	Tentative settlement (for contractors use only)			36, 197, 972 0	l
43.00	Balance due provider/program (see instructions)			368, 223	
44. 00	Protested amounts (nonallowable cost report items) in accordance	ce with CMS Pub. 15-2,	chapter 1,	0	44.00
	§115. 2				
90 00	TO BE COMPLETED BY CONTRACTOR  Original outlier amount (see instructions)			0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			0	1
92.00	The rate used to calculate the Time Value of Money				92.00
93.00	Time Value of Money (see instructions)			0	1
94.00	Total (sum of lines 91 and 93)			0	94.00

Heal th Financial Systems

ST. FRANCIS HOSPITAL & HEALTH CENTER

In Lieu of Form CMS-2552-10

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 150162

Period:
From 01/01/2014
To 12/31/2014

Part I
Date/Time Prepared:
5/26/2015 12: 47 pm

In Lieu of Form CMS-2552-10

From 01/01/2014
To 12/31/2014

Part I
Date/Time Prepared:
5/26/2015 12: 47 pm

					5/26/2015 12:4	47 pm
		Ti tl	e XVIII	Hospi tal	PPS	
		I npati en	t Part A	Pai	rt 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		83, 772, 33	2	35, 929, 472	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	08/22/2014	390, 90	0 08/22/2014	268, 500	3. 01
3.02				0	0	3. 02
3.03				0	o	3. 03
3.04				0	o	3.04
3.05				0	o	3. 05
	Provider to Program		•		•	
3.50	ADJUSTMENTS TO PROGRAM			0	0	3. 50
3. 51				0	o	3. 51
3. 52				0	o	3. 52
3. 53				0	o	3. 53
3. 54				0	o	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		390, 90	0	268, 500	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		84, 163, 23	2	36, 197, 972	4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5.00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5.01	TENTATI VE TO PROVI DER			0	0	5. 01
5.02				0	0	5. 02
5.03				0	0	5. 03
	Provider to Program					
5.50	TENTATI VE TO PROGRAM			0	0	5. 50
5. 51				0	0	5. 51
5. 52				0	0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	5. 99
	5. 50-5. 98)					
6.00	Determined net settlement amount (balance due) based on					6.00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVIDER			0	368, 223	6. 01
6. 02	SETTLEMENT TO PROGRAM		415, 82		0	6. 02
7. 00	Total Medicare program liability (see instructions)		83, 747, 40		36, 566, 195	7. 00
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
		(	)	1. 00	2. 00	
8.00	Name of Contractor				1	8.00

		Ti tl	e XVIII	Subprovi der - I RF	PPS	
		I npati en	t Part A		rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3. 00	4.00	
1. 00	Total interim payments paid to provider		4, 008, 638		0	1.00
2. 00	Interim payments payable on individual bills, either		C	)	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)					
3. 01	Program to Provider ADJUSTMENTS TO PROVIDER		Г	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	1 0	3.01
3. 01	ADJUSTMENTS TO PROVIDER				0	
3. 02					0	
3. 04					0	3. 04
3. 05			C	)	0	3. 05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		C		0	
3. 51			C		0	3. 51
3.52			C I		0	3.52
3. 53 3. 54					0	
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines				0	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		4, 008, 638	3	0	4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropriate) TO BE COMPLETED BY CONTRACTOR					
5. 00	List separately each tentative settlement payment after					5.00
0.00	desk review. Also show date of each payment. If none,					0.00
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER		C		0	5. 01
5. 02 5. 03			C		0	
5.03	Provider to Program			/		3.03
5. 50	TENTATI VE TO PROGRAM		C		0	5.50
5. 51			C		0	
5. 52			C	)	0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		C	)	0	5. 99
,	5. 50-5. 98)					
6. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6. 01	SETTLEMENT TO PROVIDER		_		0	6. 01
6. 02	SETTLEMENT TO PROGRAM		6, 375			
7. 00	Total Medicare program liability (see instructions)		4, 002, 263		0	
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
0.00	Nome of Contractor		)	1. 00	2. 00	0.00
8. 00	Name of Contractor			I	I	8. 00

Heal th	Financial Systems ST. FRANCIS HOSPITAL &	HEALTH CENTER	In Lie	u of Form CMS-2	2552-10
	CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 150162 Period: From 01/01/2014				pared:
			10 12/01/2011	5/26/2015 12:	
		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.		e 14	17, 446 35, 159	1. 00 2. 00
2.00					
3. 00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			10, 469	3.00
4. 00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-	12		82, 259	4.00
5. 00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			1, 842, 736, 340	5.00
6. 00	Total hospital charity care charges from Wkst. S-10, col. 3 li		WI	78, 871, 200	6.00
7. 00	CAH only - The reasonable cost incurred for the purchase of celline 168	rtified Hil technology	WKST. S-2, PT. I	0	7. 00
8.00	Calculation of the HIT incentive payment (see instructions)			1, 523, 911	8.00
9.00	Sequestration adjustment amount (see instructions)			30, 478	9.00
10.00	Calculation of the HIT incentive payment after sequestration (	see instructions)		1, 493, 433	10.00
	INPATIENT HOSPITAL SERVICES UNDER PPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			1, 566, 907	30.00
31.00	Other Adjustment (specify)			0	31.00
32. 00	Balance due provider (line 8 (or line 10) minus line 30 and li	ne 31) (see instruction	ns)	-73, 474	32.00

	Financial Systems ST. FRANCIS HOSPITAL &			u of Form CMS-2	
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150162	Period: From 01/01/2014	Worksheet E-3 Part III	
		Component CCN: 15T162			
		Title XVIII	Subprovi der -	PPS	
			I RF		
			-	1. 00	
	PART III - MEDICARE PART A SERVICES - IRF PPS			1.00	
1. 00	Net Federal PPS Payment (see instructions)			3, 473, 157	1.00
2. 00	Medicare SSI ratio (IRF PPS only) (see instructions)			0. 0019	•
3.00	Inpatient Rehabilitation LIP Payments (see instructions)			53, 487	3.00
4. 00	Outlier Payments			573, 266	
5. 00	Unweighted intern and resident FTE count in the most recent co	st reporting period e	nding on or prior		
3.00	to November 15, 2004 (see instructions)	st reporting perrod er	iding on or prior	0.00	3.00
5. 01	Cap increases for the unweighted intern and resident FTE count	for residents that we	re displaced by	0.00	5. 01
5. 01	program or hospital closure, that would not be counted without			0.00	3.01
	CFR §412. 424(d)(1)(iii)(F)(1) or (2) (see instructions)	a temperary cap aajus	tillorre dilaci 12		
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 t	he new program growth w	period of a "new	0.00	
. 00	teaching program" (see instructions)	ne new program growth p		0.00	7.00
3. 00	Current year's unweighted I&R FTE count for residents within t	he new program growth w	period of a "new	0.00	8.00
	teaching program" (see instructions)	pg g l			
9. 00	Intern and resident count for IRF PPS medical education adjust	ment (see instructions	)	0.00	9.00
10. 00	Average Daily Census (see instructions)			11. 243836	1
11. 00	Teaching Adjustment Factor (see instructions)			0.000000	1
12.00	Teaching Adjustment (see instructions)			0	12.00
13. 00	Total PPS Payment (see instructions)			4, 099, 910	13.00
14. 00	Nursing and Allied Health Managed Care payments (see instructi	on)		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 instr	uctions)		0	16.00
17. 00	Subtotal (see instructions)	,		4, 099, 910	17.00
18. 00	Primary payer payments			0	18.00
19. 00	Subtotal (line 17 less line 18).			4, 099, 910	19.00
20.00	Deducti bl es			12, 128	20.00
21. 00	Subtotal (line 19 minus line 20)			4, 087, 782	
22. 00	Coinsurance			4, 560	1
23. 00	Subtotal (line 21 minus line 22)			4, 083, 222	•
24. 00	Allowable bad debts (exclude bad debts for professional servic	es) (see instructions)		0	1
25. 00	Adjusted reimbursable bad debts (see instructions)	00) (000 111011 4011 0110)		0	25.00
26. 00	Allowable bad debts for dual eligible beneficiaries (see instr	uctions)		0	26.00
27. 00	Subtotal (sum of lines 23 and 25)	401.01.0)		4, 083, 222	
28. 00	Direct graduate medical education payments (from Wkst. E-4, li	ne 49)		0	1
29. 00	Other pass through costs (see instructions)			720	
30.00	Outlier payments reconciliation			0	
31. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
31. 50	Pioneer ACO demonstration payment adjustment (see instructions	)		0	
31. 99	Recovery of Accelerated Depreciation	,		0	
22 00	Total amount navable to the provider (coe instructions)			4 002 042	

4, 083, 942

4, 008, 638

81, 679

-6, 375

573, 266

0.00

32.01

33.00

34.00

35.00

36.00

51.00 0

52.00

0 53.00

32.01

35.00

36.00

33.00 Interim payments

32.00 Total amount payable to the provider (see instructions) Sequestration adjustment (see instructions)

50.00 Original outlier amount from Wkst. E-3, Pt. III, line 4

52.00 | The rate used to calculate the Time Value of Money

51.00 Outlier reconciliation adjustment amount (see instructions)

Balance due provider/program line 32 minus lines 32.01, 33 and 34

Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,

34.00 Tentative settlement (for contractor use only)

§115. 2
TO BE COMPLETED BY CONTRACTOR

53.00 Time Value of Money (see instructions)

Health Financial Systems	ST. FRANCIS HOSPITAL & F	HEALTH CENTER	In Lieu of Form CMS-255		
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der CCN: 150162	Peri od: From 01/01/2014	Worksheet E-3 Part VII	

To 12/31/2014 Date/Time Prepared: 5/26/2015 12:47 pm Title XIX Hospi tal PPS I npati 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 Medical and other services 2.00 23, 280, 091 2 00 3.00 Organ acquisition (certified transplant centers only) 0 3.00 Subtotal (sum of lines 1, 2 and 3) 0 4.00 23, 280, 091 4.00 0 5.00 Inpatient primary payer payments 5.00 Outpatient primary payer payments 6.00 6.00 7.00 Subtotal (line 4 less sum of lines 5 and 6) 23, 280, 091 7.00 COMPUTATION OF LESSER OF COST OR CHARGES Reasonable Charges 8.00 Routine service charges 8.00 Ancillary service charges 59, 065, 040 123, 050, 032 9.00 9.00 10.00 Organ acquisition charges, net of revenue 10.00 Incentive from target amount computation 11 00 11 00 Total reasonable charges (sum of lines 8 through 11) 123, 050, 032 12.00 59, 065, 040 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) 0.000000 Ratio of line 13 to line 14 (not to exceed 1.000000) 0.000000 15.00 Total customary charges (see instructions) 59, 065, 040 123, 050, 032 16.00 16.00 59, 065, 040 99, 769, 941 17.00 Excess of customary charges over reasonable cost (complete only if line 16 exceeds 17.00 line 4) (see instructions) Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 18.00 18.00 16) (see instructions) 19.00 Interns and Residents (see instructions) 0 0 19.00 20.00 Cost of physicians' services in a teaching hospital (see instructions) 0 0 20.00 Cost of covered services (enter the lesser of line 4 or line 16) 23, 280, 091 21.00 21.00 PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers. 22.00 Other than outlier payments 22.00 0 0 23.00 Outlier payments 0 0 23.00 Program capital payments 0 24.00 24.00 25.00 Capital exception payments (see instructions) 0 25.00 13, 378 Routine and Ancillary service other pass through costs 26,00 Ω 26 00 27.00 Subtotal (sum of lines 22 through 26) 13, 378 0 27.00 Customary charges (title V or XIX PPS covered services only) 28.00 O 28.00 Titles V or XIX (sum of lines 21 and 27) 13, 378 23, 280, 091 29.00 29.00 COMPUTATION OF REIMBURSEMENT SETTLEMENT 30.00 Excess of reasonable cost (from line 18) 30.00 31.00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 13, 378 23, 280, 091 31.00 32.00 Deductibles 0 Λ 32.00 33.00 Coi nsurance 0 0 33.00 34.00 Allowable bad debts (see instructions) 0 34.00 35.00 Utilization review 35.00 0 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 13, 378 23, 280, 091 36,00 36,00 37.00 OTHER ADJ - TO ZERO OUT MEDICAID PMT -13, 378 -23, 280, 091 37.00 38.00 Subtotal (line 36  $\pm$  line 37) 0 38.00 39 00 Direct graduate medical education payments (from Wkst. E-4) 0 39.00 40.00 Total amount payable to the provider (sum of lines 38 and 39) 0 40.00 0 0 41.00 41.00 Interim payments 42.00 Balance due provider/program (line 40 minus line 41) 0 42.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 43.00 43 00 0

chapter 1, §115.2

Heal th	ı Financial Systems ST. FRANCIS HOSPITAL & HEA	ALTH CENTER	In Lie	ı of Form CMS-2	2552-10
CALCUL	_ATION OF REIMBURSEMENT SETTLEMENT PI	rovider CCN: 150162	Peri od:	Worksheet E-3	
	Cr	omponent CCN: 15T162	From 01/01/2014 To 12/31/2014	Part VII Date/Time Pre 5/26/2015 12:	pared: 47 pm
		Title XIX	Subprovi der - I RF	PPS	
			I npati ent	Outpati ent	
			1.00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICE	ES FOR TITLES V OR X	IX SERVICES		
	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		8.00
9.00	Ancillary service charges		602, 361	0	
10.00	Organ acquisition charges, net of revenue		0		10.00
11. 00 12. 00	Incentive from target amount computation Total reasonable charges (sum of lines 8 through 11)		402 241	0	11. 00 12. 00
12.00	CUSTOMARY CHARGES		602, 361	U	12.00
13. 00	Amount actually collected from patients liable for payment for se	arvices on a charge	0	0	13.00
13.00	basis	i vi ces on a charge	٩	O	13.00
14. 00	Amounts that would have been realized from patients liable for pa	yment for services o	n o	0	14.00
	a charge basis had such payment been made in accordance with 42 C			_	
15. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)	3112112(2)	0. 000000	0.000000	15. 00
16.00	Total customary charges (see instructions)		602, 361	0	
17.00	Excess of customary charges over reasonable cost (complete only i	f line 16 exceeds	602, 361	0	17.00
	line 4) (see instructions)				
18. 00	Excess of reasonable cost over customary charges (complete only i	fline 4 exceeds lin	e 0	0	18. 00
	16) (see instructions)				
19. 00	Interns and Residents (see instructions)		0	0	
20. 00	Cost of physicians' services in a teaching hospital (see instruct	i ons)	0	0	20.00
21. 00	Cost of covered services (enter the lesser of line 4 or line 16)	1 1 1 6 222	. 0	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be com	ipleted for PPS provi			
22. 00	Other than outlier payments		0	0	
23. 00	Outlier payments		0	0	23.00
24. 00	Program capital payments		0		24.00
25. 00	Capital exception payments (see instructions)		114	0	25.00
26. 00 27. 00	Routine and Ancillary service other pass through costs Subtotal (sum of lines 22 through 26)		114 114	0	
28. 00	Customary charges (title V or XIX PPS covered services only)		114	0	28.00
29. 00	Titles V or XIX (sum of lines 21 and 27)		114	0	
27.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT		114	0	27.00
30. 00	Excess of reasonable cost (from line 18)		O	0	30.00
31. 00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		114	0	
32.00			114	0	

0 32.00

0 34.00

0 36.00

0 37.00

0 40.00

0 42.00

0 43.00

33.00

35.00

38.00

39.00

41.00

32.00 Deductibles

33. 00 Coi nsurance

35.00 Utilization review

41.00 Interim payments

38.00 | Subtotal (line 36 ± line 37)

Allowable bad debts (see instructions)

OTHER ADJ - TO ZERO OUT MEDICALD PMT

36.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)

Total amount payable to the provider (sum of lines 38 and 39)

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

39.00 Direct graduate medical education payments (from Wkst. E-4)

Balance due provider/program (line 40 minus line 41)

34.00

37.00

40.00

42.00

	Financial Systems ST. FRANCIS HOSPITAL &	HEALTH CEN	TER	In Lie	u of Form CMS-2	2552-10				
	GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT L EDUCATION COSTS	Provi der		Period: From 01/01/2014 To 12/31/2014						
		Ti +L	e XVIII	Hospi tal	5/26/2015 12: PPS	47 pm				
		11 (1)	e XVIII	позрі таї	FF3					
	COMPUTATION OF TOTAL PUREAT ONE AMOUNT				1. 00					
1. 00	COMPUTATION OF TOTAL DIRECT GME AMOUNT Unweighted resident FTE count for allopathic and osteopathic pending on or before December 31, 1996.	programs for	r cost reporti	ing periods	18. 00	1.00				
2. 00 3. 00 3. 01	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)  Amount of reduction to Direct GME cap under section 422 of MMA									
4. 00	Direct GME cap reduction amount under ACA §5503 in accordance instructions for cost reporting periods straddling 7/1/2011) Adjustment (plus or minus) to the FTE cap for allopathic and o		, ,	•	0. 00 -0. 63	3. 01 4. 00				
4. 01	GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f)) ACA Section 5503 increase to the Direct GME FTE Cap (see instr	·	. 0		0. 00	4. 01				
4. 02	straddling 7/1/2011) ACA Section 5506 number of additional direct GME FTE cap slots periods straddling 7/1/2011)	s (see inst	tructions for	cost reporting	0. 00	4. 02				
5. 00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plu 4.02 plus applicable subscripts	ıs or minus	line 4 plus l	ines 4.01 and	15. 97	5. 00				
6. 00	Unweighted resident FTE count for allopathic and osteopathic precords (see instructions)	rograms for	r the current	year from your	19. 81	6. 00				
7. 00	Enter the lesser of line 5 or line 6		Primary Care	Other	15. 97 Total	7. 00				
			1. 00	2.00	3. 00					
8. 00	Weighted FTE count for physicians in an allopathic and osteopa	ıthi c	6. 9	7 13. 33	20. 30	8. 00				
9. 00	program for the current year.  If line 6 is less than 5 enter the amount from line 8, otherwind multiply line 8 times the result of line 5 divided by the amount from line 8 times the result of line 5 divided by the amount from line 8 times the result of line 5 divided by the amount from line 8 times the result of line 5 divided by the amount from line 8.		5. 6	2 10. 75	16. 37	9. 00				
10. 00 11. 00 12. 00	6. Weighted dental and podiatric resident FTE count for the curre Total weighted FTE count Total weighted resident FTE count for the prior cost reporting instructions)	3	5. 6 6. 5			10. 00 11. 00 12. 00				
13. 00	Total weighted resident FTE count for the penultimate cost rep year (see instructions)	orti ng	16. 6	0.00		13. 00				
14. 00 15. 00 16. 00 17. 00 18. 00 19. 00	Rolling average FTE count (sum of lines 11 through 13 divided Adjustment for residents in initial years of new programs Adjustment for residents displaced by program or hospital clos Adjusted rolling average FTE count Per resident amount Approved amount for resident costs	,	9. 5 0. 0 0. 0 9. 5 116, 785. 2 1, 117, 63	0 0. 00 0 0. 00 7 6. 89 4 116, 785. 24	1, 922, 285	14. 00 15. 00 16. 00 17. 00 18. 00 19. 00				
					1. 00					
20. 00	Additional unweighted allopathic and osteopathic direct GME FT Sec. 413.79(c)(4)	E resident	cap slots red	cei ved under 42		20.00				
	Direct GME FTE unweighted resident count over cap (see instructional direct GME FTE Resident Count (see instructional direct GME FTE Resident Count (see instructional locally adjustment national average per resident amount of the country of the c	ıcti ons)	nstructions)		0. 00 0. 00	23. 00				
	Multiply line 22 time line 23 Total direct GME amount (sum of lines 19 and 24)				0 1, 922, 285					
			Inpatient Part A	Managed care						
			1.00	2. 00	3. 00					
27. 00 28. 00 29. 00 30. 00	COMPUTATION OF PROGRAM PATIENT LOAD Inpatient Days (see instructions) Total Inpatient Days (see instructions) Ratio of inpatient days to total inpatient days Program direct GME amount Reduction for direct GME payments for Medicare Advantage		37, 41 87, 06 0. 42969 825, 99	2 87, 062 4 0. 126071		26. 00 27. 00 28. 00 29. 00 30. 00				
31. 00	Net Program direct GME amount				1, 034, 095	31.00				

Heal th	Financial Systems ST. FRANCIS HOSPITAL &	HFALTH CENTER	In Lie	u of Form CMS-2	2552-10			
	GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT	Provider CCN: 150162	Peri od:	Worksheet E-4				
MEDI CA	L EDUCATION COSTS		From 01/01/2014 To 12/31/2014	Date/Time Pre 5/26/2015 12:				
		Title XVIII	Hospi tal	PPS				
				1. 00				
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE EDUCATION COSTS)	`		I CAL				
32. 00	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)							
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I,	col. 8, sum of lines	74 and 94)	5, 555, 055	33.00			
34.00	Ratio of direct medical education costs to total charges (line	32 ÷ line 33)		0.000000	34.00			
35.00	Medicare outpatient ESRD charges (see instructions)			0	35.00			
36.00	Medicare outpatient ESRD direct medical education costs (line 3			0	36.00			
	APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII C	NLY						
	Part A Reasonable Cost							
	Reasonable cost (see instructions)			107, 878, 946				
	Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69)			0				
	Cost of physicians' services in a teaching hospital (see instru	uctions)		0				
40.00	Primary payer payments (see instructions)			34, 742				
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus	line 40)		107, 844, 204	41.00			
40.00	Part B Reasonable Cost			F/ 22/ 70F	40.00			
	Reasonable cost (see instructions) Primary payer payments (see instructions)			56, 236, 785	42.00			
	Total Part B reasonable cost (line 42 minus line 43)			56, 229, 055				
	Total reasonable cost (sum of lines 41 and 44)			164, 073, 259				
	Ratio of Part A reasonable cost to total reasonable cost (line	41 ÷ line 45)		0. 657293				
	Ratio of Part B reasonable cost to total reasonable cost (line	,		0. 342707				
47.00	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART	,		0. 342707	47.00			
48 00	Total program GME payment (line 31)			1, 034, 095	48 00			
	Part A Medicare GME payment (line 46 x 48) (title XVIII only)	(see instructions)		679, 703				
	Part B Medicare GME payment (line 47 x 48) (title XVIII only)			354, 392				
	, , , , , , , , , , , , , , , , , , , ,	(	'					

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

Provi der CCN: 150162

Period: Worksheet G From 01/01/2014 To 12/31/2014 Date/Time Prepared: 5/26/2015 12: 47 pm

				12/01/2011	5/26/2015 12:	47 pm
		General Fund	Speci fi c	Endowment	Pl ant Fund	
			Purpose Fund	Fund		
		1.00	2.00	3. 00	4. 00	
1 00	CURRENT ASSETS	F 227 F04		ما		1 00
1. 00 2. 00	Cash on hand in banks Temporary investments	5, 327, 594	0	0	0	1.00 2.00
3.00	Notes receivable		0	0	0	3.00
4. 00	Accounts recei vable	285, 248, 433		0	0	4.00
5. 00	Other recei vabl e	8, 919, 329	1	0	0	5.00
6. 00	Allowances for uncollectible notes and accounts receivable		1	Ō	0	6. 00
7.00	Inventory	8, 423, 474	1	0	0	7. 00
8.00	Prepai d expenses	2, 456, 081	0	0	0	8. 00
9.00	Other current assets	0	0	0	0	9. 00
10.00	Due from other funds	3, 321, 668		0	0	10.00
11. 00	Total current assets (sum of lines 1-10)	115, 582, 244	0	0	0	11. 00
40.00	FI XED ASSETS			ما		10.00
12.00	Land	0		0	0	
13. 00 14. 00	Land improvements	42, 119, 833 -15, 459, 663	- 1	0	0	13. 00 14. 00
15. 00	Accumulated depreciation Buildings	437, 630, 482		0	0	15.00
16. 00	Accumulated depreciation	-160, 627, 886	I	0	o o	16.00
17. 00	Leasehold improvements	4, 514, 255		Ö	0	17. 00
18. 00	Accumul ated depreciation	-1, 656, 912		0	0	18.00
19.00	Fi xed equipment	0	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	145, 549, 389		0	0	23. 00
24. 00	Accumulated depreciation	-53, 422, 446		0	0	24.00
25. 00	Mi nor equi pment depreci abl e	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 29. 00	Accumulated depreciation Minor equipment-nondepreciable	0	0	0	0	28. 00 29. 00
30.00	Total fixed assets (sum of lines 12-29)	398, 647, 052		0	0	30.00
30.00	OTHER ASSETS	370,047,032	0	<u> </u>	0	30.00
31.00	Investments	28, 880, 811	0	0	0	31. 00
32.00	Deposits on leases	0		0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33. 00
34.00	Other assets	36, 009, 352	0	0	0	34.00
35. 00	Total other assets (sum of lines 31-34)	64, 890, 163	1	0	0	35. 00
36. 00	Total assets (sum of lines 11, 30, and 35)	579, 119, 459	0	0	0	36. 00
	CURRENT LI ABI LI TI ES	00 450 450				
37.00	Accounts payable	28, 152, 152	I	0	0	
38. 00 39. 00	Salaries, wages, and fees payable Payroll taxes payable	0 17, 668, 487		0	0	38. 00 39. 00
40. 00	Notes and Loans payable (short term)	940, 000		0	0	40.00
41. 00	Deferred income	740,000	0	0	0	41.00
42. 00	Accel erated payments			Ŭ.	Ĭ	42.00
43. 00	Due to other funds	0	0	0	0	43.00
	Other current liabilities	21, 435, 519		0	0	
45.00	Total current liabilities (sum of lines 37 thru 44)	68, 196, 158	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0		0	0	46. 00
47. 00	Notes payable	0		0	0	47. 00
48. 00	Unsecured Loans	0	0	0	0	48. 00
49. 00	Other long term liabilities	-11, 880, 702	1	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	-11, 880, 702	1	0	0	50.00
51. 00	Total liabilites (sum of lines 45 and 50)  CAPITAL ACCOUNTS	56, 315, 456	0	0	0	51.00
52. 00	General fund balance	522, 804, 003				52. 00
53. 00	Specific purpose fund	322,004,003	0			53.00
54. 00	Donor created - endowment fund balance - restricted			0		54.00
55. 00	Donor created - endowment fund balance - unrestricted			Ö		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
	replacement, and expansion					
59.00	Total fund balances (sum of lines 52 thru 58)	522, 804, 003	1	0	0	
60. 00	Total liabilities and fund balances (sum of lines 51 and	579, 119, 459	0	이	0	60.00
	[59]	I	ı l	ı	·	I

19.00

STATEMENT OF CHANGES IN FUND BALANCES Provi der CCN: 150162 Peri od: Worksheet G-1 From 01/01/2014 12/31/2014 Date/Time Prepared: 5/26/2015 12:47 pm General Fund Special Purpose Fund Endowment Fund 1. 00 3.00 4.00 5.00 2.00 1.00 Fund balances at beginning of period 558, 105, 512 0 1.00 Net income (loss) (from Wkst. G-3, line 29) 269, 344, 701 2.00 2.00 827, 450, 213 3.00 Total (sum of line 1 and line 2) ol 3.00 4.00 4.00 0 5.00 0 0 0 0 0 5.00 0 6.00 0 6.00 0 7.00 0 7.00 0 8.00 0 8.00 9.00 0 9.00 10.00 Total additions (sum of line 4-9) 0 10.00 827, 450, 213 Subtotal (line 3 plus line 10) 0 11.00 11.00 FUND EQUITY CHANGES 12.00 159, 276, 141 0 12.00 13.00 SHARED SERVICES 129, 477, 412 0 13.00 14.00 HHA & HOSPICE IMPACT 15, 892, 657 0 0 14.00 15.00 0 15.00 0 16.00 0 0 16.00 17.00 0 17.00 304, 646, 210 18.00 18.00 Total deductions (sum of lines 12-17) Fund balance at end of period per balance 19.00 522, 804, 003 19.00 sheet (line 11 minus line 18) Endowment Plant Fund Fund 6.00 8.00 7.00 1.00 Fund balances at beginning of period 0 0 Net income (loss) (from Wkst. G-3, line 29) 2.00 2.00 0 0 3.00 Total (sum of line 1 and line 2) 3.00 4.00 4.00 5.00 5.00 6.00 0 6.00 7.00 0 7.00 8.00 0 8.00 9.00 0 9.00 Total additions (sum of line 4-9) 0 10.00 10.00 11.00 Subtotal (line 3 plus line 10) 0 11.00 FUND EQUITY CHANGES 12.00 12.00 13.00 SHARED SERVICES 0 13.00 HHA & HOSPICE IMPACT 0 14.00 14.00 15.00 15.00 16.00 0 16.00 17.00 17.00 Total deductions (sum of lines 12-17) 18.00 0 18.00

0

0

Fund balance at end of period per balance

sheet (line 11 minus line 18)

Health Financial Systems ST. FRANCIS HOSPITAL & HEALTH CENTER In Lieu of Form CMS-2552-10 STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider CCN: 150162 Peri od: Worksheet G-2 From 01/01/2014 Parts I & II Date/Time Prepared: 12/31/2014 5/26/2015 12:47 pm Cost Center Description Inpati ent Outpati ent Total 1.00 2.00 3.00 PART I - PATIENT REVENUES General Inpatient Routine Services 1.00 Hospi tal 98, 744, 920 98, 744, 920 1.00 2.00 SUBPROVIDER - IPF 2.00 SUBPROVIDER - IRF 7, 927, 709 3.00 7, 927, 709 3.00 4.00 SUBPROVI DER 4.00 5.00 Swing bed - SNF 0 0 5.00 Swing bed - NF 6.00 0 6.00 0 SKILLED NURSING FACILITY 7.00 7.00 8.00 NURSING FACILITY 8.00 9.00 OTHER LONG TERM CARE 9.00 10.00 Total general inpatient care services (sum of lines 1-9) 106, 672, 629 106, 672, 629 10 00 Intensive Care Type Inpatient Hospital Services 11.00 INTENSIVE CARE UNIT 39, 334, 771 39, 334, 771 11.00 11.01 NEONATAL INTENSIVE CARE UNIT 11.01 0 CORONARY CARE UNIT 12 00 25, 843, 583 25, 843, 583 12 00 BURN INTENSIVE CARE UNIT 13.00 13.00 14.00 SURGICAL INTENSIVE CARE UNIT 15, 900, 612 15, 900, 612 14.00 15.00 OTHER SPECIAL CARE (SPECIFY) 15.00 81, 078, 966 Total intensive care type inpatient hospital services (sum of lines 81, 078, 966 16.00 16.00 17.00 Total inpatient routine care services (sum of lines 10 and 16) 187, 751, 595 187, 751, 595 17.00 18.00 Ancillary services 579, 768, 257 795, 243, 494 1, 375, 011, 751 18.00 Outpatient services 19.00 46, 821, 325 206, 391, 346 253, 212, 671 19.00 20.00 RURAL HEALTH CLINIC 0 20.00 21.00 FEDERALLY QUALIFIED HEALTH CENTER 0 21.00 HOME HEALTH AGENCY 8, 805, 179 22.00 8, 805, 179 22.00 23.00 AMBULANCE SERVICES 23.00 24.00 CMHC 24.00 AMBULATORY SURGICAL CENTER (D. P.) 25.00 25.00 7, 300, 668 26.00 HOSPI CE 7, 300, 668 26,00 27.00 OTHER 11, 785, 754 90, 575, 266 102, 361, 020 27.00 28.00 Total patient revenues (sum of lines 17-27) (transfer column 3 to Wkst. 826, 126, 931 1, 108, 315, 953 1, 934, 442, 884 28.00 line 1) PART II - OPERATING EXPENSES 29.00 Operating expenses (per Wkst. A, column 3, line 200) 435, 243, 263 29.00 30.00 ADD (SPECIFY) 0 30.00 31.00 0 31.00 32 00 0 32 00 0 33.00 33.00 34.00 34.00 35.00 0 35.00 Total additions (sum of lines 30-35) 36.00 0 36.00 37.00 DEDUCT (SPECIFY) 37.00 38.00 0 38.00

0

0

0

435, 243, 263

39.00

40.00

41.00

42.00

43.00

39.00

40.00

41.00

42.00

43.00

Total deductions (sum of lines 37-41)

to Wkst. G-3, line 4)

Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer

	Financial Systems ST. FRANCIS HOSPITAL &			u of Form CMS-2	
STATEM	ENT OF REVENUES AND EXPENSES	Provi der CCN: 150162	Peri od:	Worksheet G-3	
			From 01/01/2014		narad.
			To 12/31/2014	5/26/2015 12:	
				37 207 2013 12.	T/ pill
				1. 00	
1. 00	Total patient revenues (from Wkst. G-2, Part I, column 3, line	28)		1, 934, 442, 884	1. 00
2. 00	Less contractual allowances and discounts on patients' account	•		1, 261, 657, 286	
3. 00	Net patient revenues (line 1 minus line 2)	13		672, 785, 598	
4. 00	Less total operating expenses (from Wkst. G-2, Part II, line	43)		435, 243, 263	
5. 00	Net income from service to patients (line 3 minus line 4)	43)		237, 542, 335	
5.00	OTHER I NCOME			231, 342, 333	3.00
6. 00	Contributions, donations, bequests, etc			76, 890	6. 00
7. 00	Income from investments			8	7. 00
8. 00	Revenues from telephone and other miscellaneous communication	servi ces		966, 614	
9. 00	Revenue from television and radio service	301 11 003		700,011	9. 00
10. 00	Purchase di scounts			2, 219, 094	
11. 00	Rebates and refunds of expenses			2,217,074	11.00
12. 00	Parking lot receipts			300	12.00
13. 00	Revenue from Laundry and Linen service			0	13.00
14. 00	Revenue from meals sold to employees and guests			2, 305, 969	
15. 00	Revenue from rental of living quarters			2, 303, 404	15. 00
	Revenue from sale of medical and surgical supplies to other t	han nationts		1	16.00
17. 00	, , , , , , , , , , , , , , , , , , , ,	iaii pati eiits		0	17.00
17.00	Revenue II om sale of drugs to other than patrefits			1	17.00

-25

0 448, 385

0

0 27.00

0 28.00

269, 344, 701 29. 00

49, 125

2, 368, 066

23, 367, 940

31, 802, 366

269, 344, 701

18. 00 19. 00

20.00

21.00

22.00

23.00

25.00

26.00

18.00 Revenue from sale of medical records and abstracts
19.00 Tuition (fees, sale of textbooks, uniforms, etc.)

28.00 Total other expenses (sum of line 27 and subscripts)

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

Total other income (sum of lines 6-24)
Total (line 5 plus line 25)

21.00 Rental of vending machines

24. 00 | I DENTIFIED ON TRIAL BALANCE

Governmental appropriations

22.00 Rental of hospital space

27.00 OTHER EXPENSES (SPECIFY)

Revenue from gifts, flowers, coffee shops, and canteen

20.00

23.00

25.00

26.00

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS Provider CCN: 150162 Peri od: Worksheet H From 01/01/2014 157179 HHA CCN: To 12/31/2014 Date/Time Prepared: 5/26/2015 12:47 pm Home Health PPS Agency I Sal ari es Empl oyee Transportatio Contracted/Pu Other Costs Total (sum of col s. Benefits n (see rchased 1 thru 5) instructions) Servi ces 1.00 2.00 3.00 4.00 5.00 6.00 GENERAL SERVICE COST CENTERS 1.00 0 1.00 Capital Related - Bldg. & Fi xtures 2.00 Capital Related - Movable 0 2.00 Eaui pment 3.00 Plant Operation & Maintenance 3.00 13 13 209, 438 209, 438 4 00 4 00 0 0 0 Transportati on 5.00 Administrative and General 465, 571 109, 346 0 1,053,341 29, 182 1,657,440 5.00 HHA REIMBURSABLE SERVICES Skilled Nursing Care 6.00 760, 010 188, 105 0 1, 543, 310 6.00 595, 195 0 Physical Therapy 7 00 793.026 194, 385 0 987.411 7 00 0 8.00 Occupational Therapy 367, 549 89, 623 0 0 0 457, 172 8.00 Speech Pathology 52, 239 0 9.00 12,657 0 64, 896 9.00 Medical Social Services 54, 987 13, 240 68, 227 10.00 0 0 10.00 0 140, 004 11.00 11.00 Home Heal th Aide 55, 426 13, 313 0 71, 265 0 12.00 Supplies (see instructions) 0 0 108, 500 108, 500 12.00 0 0 13.00 Drugs 0 0 0 13.00 0 0 14.00 DMF 0 0 14.00 0 0 HHA NONREIMBURSABLE SERVICES 15.00 Home Dialysis Aide Services 0 0 15.00 0 16.00 Respiratory Therapy 0 0 0 0 0 16.00 0 Private Duty Nursing 0 0 0 0 17.00 17.00 0 0 0 18.00 Clinic 18.00 0 0 0 0 19.00 19.00 Health Promotion Activities Day Care Program 0 0 20.00 0 0 20.00 Home Delivered Meals Program 0 0 O 21.00 0 21.00 Homemaker Service 0 0 0 22.00 22.00 23.00 All Others (specify) 23.00 209, 438 137, 695 24.00 24.00 Total (sum of lines 1-23) 2, 548, 808 620, 669 1, 719, 801 5, 236, 411 Reclassi fi cat Recl assi fi ed Adjustments Net Expenses Trial Balance for i on (col. 6 +Allocation col. 7) (col. 8 +9) col. 7. 00 8.00 9.00 10.00 GENERAL SERVICE COST CENTERS 1.00 Capital Related - Bldg. & 0 n 1.00 Fi xtures Capital Related - Movable 0 2.00 0 0 2.00 Equi pment 3.00 Plant Operation & Maintenance 3.00 13 4.00 Transportation 0 209, 438 209, 438 4.00 Administrative and General -109, 346 5.00 0 1,657,440 1, 548, 094 5.00 HHA REIMBURSABLE SERVICES 1, 543, 310 6.00 0 -188, 105 1, 355, 205 6.00 Skilled Nursing Care Physical Therapy 7.00 0 987, 411 -194, 385 793, 026 7.00 0 Occupational Therapy 457, 172 -89, 623 367, 549 8 00 8.00 Speech Pathology 0 9.00 64, 896 -12, 657 52, 239 9.00 54, 987 Medical Social Services 0 10.00 68, 227 -13,24010.00 0 140,004 -13, 313 126, 691 11.00 Home Heal th Aide 11.00 12.00 Supplies (see instructions) 0 108, 500 108, 500 12.00 13.00 0 13.00 Drugs 14.00 DMF 0 0 0 0 14.00 HHA NONREI MBURSABLE SERVI CES 15.00 Home Dialysis Aide Services 0 15.00 Respiratory Therapy 0 0 0 16.00 16.00 0 0 Private Duty Nursing 0 17.00 17.00 0 18.00 Clinic C 0 18.00 0 19.00 Health Promotion Activities 0 0 19.00 20.00 Day Care Program 0 0 0 20.00

0

0

0

0

5, 236, 411

0

r

-620, 669

0

0

4, 615, 742

21.00

22.00

23.00

24.00

Home Delivered Meals Program

Homemaker Service

24.00 Total (sum of lines 1-23)

23.00 All Others (specify)

21.00

22.00

COST ALLOCATION - HHA GENERAL SERVICE COST Provider CCN: 150162 Peri od: Worksheet H-1 From 01/01/2014 Part I 157179 Date/Time Prepared: HHA CCN: 12/31/2014 5/26/2015 12:47 pm PPS Home Health Agency I Capital Related Costs Transportati o Bldgs & Subtotal Net Expenses Movabl e PI ant for Cost Fi xtures Equi pment Operation & (cols. 0-4)n Allocation Mai ntenance (from Wkst. col . 10) 1.00 4A. 00 0 2.00 3.00 4.00 GENERAL SERVICE COST CENTERS 1.00 Capital Related - Bldg. & 0 0 1.00 Fixtures 0 2.00 Capital Related - Movable Ω 2.00 Equi pment 3.00 Plant Operation & Maintenance 3.00 13 0 13 209, 438 0 4.00 Transportati on 0 0 209, 438 4.00 5.00 Administrative and General 1,548,094 0 0 13 209, 438 1, 757, 545 5.00 HHA REIMBURSABLE SERVICES 6.00 Skilled Nursing Care 1, 355, 205 0 1, 355, 205 6.00 Physical Therapy 0 7.00 793, 026 0 0 0 0 793, 026 7.00 367, 549 0 8.00 Occupational Therapy 0 0 367, 549 8.00 9.00 Speech Pathology 52, 239 0 0 52, 239 9.00 Medical Social Services 54, 987 0 0 0 54, 987 10.00 0 0 10.00 Home Health Aide 126, 691 0 0 0 126, 691 11.00 11.00 0 0 0 108, 500 12.00 Supplies (see instructions) 108, 500 12.00 Drugs 13.00 0 0 0 0 13.00 14.00 0 0 0 0 0 14.00 HHA NONREIMBURSABLE SERVICES 15.00 Home Dialysis Aide Services 0 0 0 0 0 15.00 Respiratory Therapy 0 0 0 0 0 16.00 16.00 0 0 0 17.00 Private Duty Nursing 00000 0 17.00 0 0 0 18 00 Clinic 0 18 00 19.00 Health Promotion Activities 0 19.00 Day Care Program 0 0 0 0 20.00 20.00 21.00 Home Delivered Meals Program 0 0 0 0 21.00 0 0 Ω 0 22.00 22.00 Homemaker Service 23.00 All Others (specify) 0 C 0 0 23.00 24.00 Total (sum of lines 1-23) 4, 615, 742 209, 438 4, 615, 742 13 24.00 Total (cols. Administrativ e & General 4A + 5)5.00 6.00 GENERAL SERVICE COST CENTERS Capital Related - Bldg. & 1.00 1.00 Fi xtures 2.00 Capital Related - Movable 2.00 Equi pment 3.00 Plant Operation & Maintenance 3.00 4 00 Transportati on 4 00 5.00 Administrative and General 1, 757, 545 5.00 HHA REIMBURSABLE SERVICES Skilled Nursing Care 6.00 833, 335 2, 188, 540 6.00 Physical Therapy 1, 280, 669 7.00 7.00 487, 643 8.00 Occupational Therapy 226, 011 593, 560 8.00 Speech Pathology 32, 122 84, 361 9.00 9.00 33, 812 88, 799 10.00 Medical Social Services 10.00 11.00 Home Health Aide 77.904 204, 595 11.00 66, 718 12.00 Supplies (see instructions) 175, 218 12.00 13.00 Drugs 0 0 13.00 DMF 14.00 0 14.00 0 HHA NONREIMBURSABLE SERVICES 15.00 Home Dialysis Aide Services 15.00 0 0 16.00 Respiratory Therapy 16.00 0 Private Duty Nursing 0 17.00 17.00 0 18.00 Clinic 18.00 19.00 19.00 Health Promotion Activities 0 0 Day Care Program 0 0 20.00 20.00 0 0 Home Delivered Meals Program 21 00 21.00 22.00 Homemaker Service 0 22.00 23.00 All Others (specify) 0 0 23.00 24.00 Total (sum of lines 1-23) 4, 615, 742 24.00

Provider CCN: 150162 | Period: From 01/01/2014 | Worksheet H-1 Part II

				HHA CCN:		To 12/31/2014		
						Home Health	PPS	
						Agency I		
		Capital Rel	ated Costs					
		BI dgs &	Movabl e	PI ant	Transportatio	Reconciliatio	Administrativ	
		Fi xtures	Equi pment	Operation &	n (MI LEAGE)	n	e & General	
		(SQUARE FEET)	(DOLLAR	Mai ntenance			(ACCUM. COST)	
			VALUE)	(SQUARE FEET)				
		1. 00	2. 00	3. 00	4.00	5A. 00	5. 00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. &	4, 120				0		1.00
	Fixtures							
2. 00	Capital Related - Movable		0			0		2.00
	Equi pment							
3. 00	Plant Operation & Maintenance	0	0	4, 120		0		3.00
4.00	Transportation (see	0	0	0	1			4.00
F 00	instructions)	4 400	•	4 400		4 757 545	0 050 407	F 00
5. 00	Administrative and General	4, 120	0	4, 120	1	-1, 757, 545	2, 858, 197	5.00
	HHA REIMBURSABLE SERVICES		0				1 255 205	/ 00
6.00	Skilled Nursing Care	0	0	0	`	-	1, 355, 205	
7. 00 8. 00	Physical Therapy Occupational Therapy	0	0	0		0	793, 026 367, 549	
9. 00	Speech Pathology	0	0	0			52, 239	
10.00	Medical Social Services	0	0	0			52, 239 54, 987	
11. 00	Home Health Aide		0	0			126, 691	
12. 00	Supplies (see instructions)	0	0	0			108, 500	
13. 00	Drugs	0	0	0			108, 300	13.00
14. 00	DME		0			0	0	
14.00	HHA NONREI MBURSABLE SERVI CES	<u> </u>		0		<u> </u>	0	14.00
15. 00	Home Dialysis Aide Services		0	0		0	0	15.00
16. 00	Respiratory Therapy		0	١		-	0	
17. 00	Pri vate Duty Nursing		0	0			0	17.00
18. 00	Clinic		0	0	1		0	18.00
19. 00	Health Promotion Activities	l o	0	0	1	0	0	
20.00	Day Care Program	l o	0	0	1	0	0	20.00
21. 00	Home Delivered Meals Program	l ol	0	Ö	1	0	0	21.00
22. 00	Homemaker Service	l ol	0	Ö	1	0	0	22. 00
23. 00	All Others (specify)	l	0	ĺ	1 6	o o	0	23. 00
24. 00	Total (sum of lines 1-23)	4, 120	0	4, 120	1	-1, 757, 545	2, 858, 197	
25. 00	Cost To Be Allocated (per	0	0	13			1, 757, 545	
	Worksheet H-1, Part I)				,			
26.00	Unit Cost Multiplier	0. 000000	0. 000000	0. 003155	209, 438. 00000		0. 614914	26.00
					(	)		

Health Financial Systems ST. FRANCIALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS Peri od: Worksheet H-2
From 01/01/2014 Part I
To 12/31/2014 Date/Time Prepared: 5/26/2015 12: 47 pm Provi der CCN: 150162 Peri od: HHA CCN: 157179 Home Health PPS

						Agency I	PPS	
			CAPI TAL REL	ATED COSTS				
	Cost Center Description	HHA Trial Balance (1)	NEW BLDG & FIXT	NEW MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	ADMI TTI NG	Subtotal	
		0	1. 00	2. 00	4. 00	5. 01	5A. 01	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 000 14. 00 15. 00 16. 00 17. 00 18. 00 20. 00 21. 00	Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Total (sum of lines 1-19) (2)	0 2, 188, 540 1, 280, 669 593, 560 84, 361 88, 799 204, 595 175, 218 0 0 0 0 0 0 0 0 0 0 4, 615, 742	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	119, 056 194, 350 202, 791 93, 990 13, 359 14, 061 14, 174 0 0 0 0	0 0 0 0 0 0 0 0 0	119, 056 2, 382, 890 1, 483, 460 687, 550 97, 720 102, 860 218, 769 175, 218 0 0 0 0 0 0 0 0 0 5, 267, 523 0. 0000000	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 112. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00
	6 decimal places.  Cost Center Description	CASHI ERI NG/AC COUNTS	Subtotal	OTHER ADMIN & GENERAL	OPERATION OF PLANT	LAUNDRY &	HOUSEKEEPI NG	
		RECEI VABLE	FA 00				0.00	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 17. 00 18. 00 20. 00 21. 00	Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Total (sum of lines 1-19) (2)	5. 02 1, 665 33, 321 20, 743 9, 614 1, 366 1, 438 3, 059 2, 450 0 0 0 0 0 0 0 73, 656	5A. 02 120, 721 2, 416, 211 1, 504, 203 697, 164 99, 086 104, 298 221, 828 177, 668 0 0 0 0 0 0 0 0 0 5, 341, 179 0. 000000	49, 265 39, 458 0 0 0 0 0 0 0 0 0 0 0 1, 186, 206	0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0	9.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 19. 00 20. 00 21. 00

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

Part I

Peri od:

From 01/01/2014 157179 12/31/2014 Date/Time Prepared: HHA CCN: To 5/26/2015 12:47 pm Home Health PPS Agency I NURSI NG CENTRAL PHARMACY MEDI CAL Cost Center Description DI ETARY CAFETERI A ADMI NI STRATI O SERVICES & RECORDS & SUPPLY LI BRARY N 10.00 11. 00 13. 00 14.00 15.00 16.00 14, 441 11, 834 1.00 Administrative and General 0 1.00 2.00 Skilled Nursing Care 0 000000000000000000 0 0 2.00 C Physical Therapy 0 3.00 C 3.00 4.00 Occupational Therapy 4.00 Speech Pathology 0 0 5.00 0 0 0 0 0 0 0 0 0 0 0 0 5.00 Medical Social Services 6.00 0 0 6.00 0 οĺ 0 7.00 Home Health Aide 7.00 8.00 Supplies (see instructions) 0 0 0 8.00 9.00 0 0 0 0 9.00 Drugs 0 10.00 DMF 0 0 10.00 0 11.00 Home Dialysis Aide Services 0 11.00 12.00 Respiratory Therapy 12.00 0 13.00 Private Duty Nursing 0 0 13.00 0 0 0 14.00 14.00 Clinic 15.00 Health Promotion Activities 0 15.00 0 16.00 Day Care Program 0 0 0 16.00 0 Home Delivered Meals Program 0 0 17 00 17 00 18.00 Homemaker Service 0 18.00 All Others (specify) 0 19.00 19.00 0 Total (sum of lines 1-19) (2) 11, 834 20.00 20.00 14, 441 Unit Cost Multiplier: column 21.00 21.00 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places. INTERNS & RESIDENTS Cost Center Description SERVI CES-SALA SERVI CES-OTHE PARAMED ED **EMERGENCY** Subtotal Intern & RY & FRINGES R PRGM COSTS **PRGM** MEDI CAL Resi dents SERVI CES Cost & Post Stepdown Adjustments 21.00 22.00 23.00 23.01 24.00 25.00 1.00 Administrative and General 173, 807 1.00 Skilled Nursing Care 0 0 0 0 000000000000000000 2, 952, 819 2.00 2.00 C 3.00 0 0 1, 838, 267 3.00 Physical Therapy 4.00 Occupational Therapy 0 0 851, 995 4.00 Speech Pathology 0 121, 092 5.00 0 0 5.00 0 6.00 0 Medical Social Services 0 127, 461 6.00 7.00 Home Heal th Aide 0 0 271, 093 7.00 0 217, 126 8.00 Supplies (see instructions) 0 0 0 8.00 0 Drugs 0 9.00 9.00 0 0 10.00 DMF 0 0 10.00 Home Dialysis Aide Services 11.00 0 0 11.00 0 12.00 Respiratory Therapy 0 0 0 0 0 0 12.00 0 Private Duty Nursing 0 13 00 13 00 0 0 14.00 Clinic 14.00 15.00 Health Promotion Activities 0 0 0 15.00 0 ol 16.00 Day Care Program 0 0 16.00 0 Home Delivered Meals Program 0 o 17.00 0 O 17.00 18.00 Homemaker Service 0 C 0 0 18.00 All Others (specify) 19.00 19.00 Total (sum of lines 1-19) (2) 6, 553, 660 20.00 20.00 0 Unit Cost Multiplier: column 21.00 21.00 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.

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

Health Financial Systems ST. FRANCIALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS ST. FRANCIS HOSPITAL & HEALTH CENTER In Lieu of Form CMS-2552-10 Worksheet H-2 Part I Date/Time Prepared: 5/26/2015 12:47 pm Provi der CCN: 150162 Peri od: From 01/01/2014 To 12/31/2014

HHA CCN: 157179

						Home Health	PPS	
						Agency I		
	Cost Center Description	Subtotal	Allocated HHA	Total HHA	١			
			A&G (see Part	Costs				
			11)					
		26. 00	27. 00	28. 00				
1. 00	Administrative and General	173, 807						1.00
2.00	Skilled Nursing Care	2, 952, 819	80, 445	3, 033, 3				2.00
3.00	Physi cal Therapy	1, 838, 267	50, 080	1, 888,	347			3.00
4.00	Occupational Therapy	851, 995	23, 211	875, 3				4.00
5.00	Speech Pathology	121, 092	3, 299	124,				5.00
6.00	Medical Social Services	127, 461	3, 472	130,	933			6.00
7.00	Home Health Aide	271, 093	7, 385	278,	478			7.00
8.00	Supplies (see instructions)	217, 126	5, 915	223, (	041			8.00
9.00	Drugs	0	0		0			9. 00
10.00	DME	0	0		0			10.00
11. 00	Home Dialysis Aide Services	0	0		0			11.00
12.00	Respiratory Therapy	0	0		0			12.00
13.00	Private Duty Nursing	0	0		0			13.00
14.00	Clinic	0	0		0			14.00
15.00	Health Promotion Activities	0	0		0			15. 00
16.00	Day Care Program	0	0		0			16.00
17.00	Home Delivered Meals Program	0	0		0			17.00
18.00	Homemaker Service	0	0		0			18.00
19.00	All Others (specify)	0	0		0			19.00
20.00	Total (sum of lines 1-19) (2)	6, 553, 660	173, 807	6, 553,	660			20.00
21.00	Unit Cost Multiplier: column		0. 027243					21.00
	26, line 1 divided by the sum							
	of column 26, line 20 minus							
	column 26, line 1, rounded to							
	6 decimal places.							

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

Health Financial Systems ST. FRANCIS HOSPITAL & HEALTH CENTER ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL Provider CCN: BASIS

Cost Center Description							Home Health	PPS	
Cost Center Description			CAPITAL REI	ATED COSTS			Agency I		
FIXT   CSOLARE   FEET)   SOLARE   FEET   SOL			CALLIAL KEE	LATED COSTS					
FIXT   CSOLARE   FEET)   SOLARE   FEET   SOL		Cost Center Description	NEW BLDG &	NEW MVBLE	EMPLOYEE	ADMITTING	Reconciliatio	CASHLERI NG/AC	
CSOLARE   FEET)   FEET)   CHARGES   CACCUM COST)									
1.00			(SQUARE	(SQUARE	DEPARTMENT			RECEI VABLE	
1.00			FEET)	FEET)	(GROSS			(ACCUM. COST)	
1.00   Administrative and General   0   0   465.571   0   0   119,056   1.00									
2 00   Skilled Nursing Care   0   0   760,010   0   2,382,890   2,00   4.00   Occupational Therapy   0   0   0   793,026   0   0   0   1,483,460   3,00   4.00   Occupational Therapy   0   0   0   367,549   0   0   0   687,550   4,00   5.00   Speech Pathology   0   0   52,239   0   0   0   97,720   5,00   6.00   Medical Social Services   0   0   0   54,987   0   0   1102,860   6,00   8.00   Supplies (see instructions)   0   0   0   0   0   0   175,218   8,00   9.00   Drugs   0   0   0   0   0   0   0   0   175,218   8,00   11.00   DME   0   0   0   0   0   0   0   0   0									
3.00						ľ	· ·	1 , , 000	
4.00		9		-1			_		
5.00   Speech Pathology			0				-	.,,	
6.00   Medical Social Services   0   0   54,987   0   0   102,880   6.00			0				· ·		
No.   Home Health Aide			0				_		
8.00 Supplies (see instructions) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0						
9.00   Drúgs   0   0   0   0   0   0   0   0   0					33, 420		_		
10,0   DME   DME   10,0   DME   10,0   DME   DME   10					0		-		
11.00   Home Dial ysis Aide Services   0   0   0   0   0   0   0   11.00			0		-			-1	
12.00   Respiratory Therapy   0   0   0   0   0   0   0   13.00     13.00   Private Duty Nursing   0   0   0   0   0   0   0   0     15.00   Health Promotion Activities   0   0   0   0   0   0   0   0     15.00   Health Promotion Activities   0   0   0   0   0   0   0   0     15.00   Health Promotion Activities   0   0   0   0   0   0   0     17.00   Home Bell vered Meals Program   0   0   0   0   0   0   0   0     17.00   Home Bell vered Meals Program   0   0   0   0   0   0   0     17.00   Home Bell vered Meals Program   0   0   0   0   0   0   0     18.00   Homemaker Service   0   0   0   0   0   0   0   0     18.00   Homemaker Service   0   0   0   0   0   0   0     18.00   Homemaker Service   0   0   0   0   0   0   0     18.00   Homemaker Service   0   0   0   0   0   0   0     18.00   Homemaker Service   0   0   0   0   0   0   0     18.00   Homemaker Service   0   0   0   0   0   0   0     18.00   Homemaker Service   0   0   0   0   0   0   0     18.00   Homemaker Service   0   0   0   0   0   0   0     18.00   Homemaker Service   0   0   0   0   0   0   0     18.00   Homemaker Service   0   0   0   0   0   0   0     18.00   Homemaker Service   0   0   0   0   0   0     18.00   Homemaker Service   0   0   0   0   0   0   0     18.00   Homemaker Service   0   0   0   0   0   0   0   0     18.00   Homemaker Service   0   0   0   0   0   0   0   0     18.00   Homemaker Service   0   0   0   0   0   0   0   0     18.00   Homemaker Service   0   0   0   0   0   0   0   0   0     18.00   Homemaker Service   0   0   0   0   0   0   0   0   0		1	0	-1	Ö		-	1	
13.00			0		ol	· ·	_		
14.00   Clinic			0		ol	0	0	l ol	
16.00   Day Care Program   0	14.00	3	0	O	o	0	0	l o	14.00
17. 00   Home Delivered Meals Program   18. 00   Homemaker Service   0   0   0   0   0   0   0   18. 00     18. 00   Homemaker Service   0   0   0   0   0   0   0   0   0     19. 00   All Others (specify)   0   0   0   0   0   0   0   0     20. 00   Total (sum of lines 1-19)   0   0   0   0   0   0   5, 267, 523   20. 00     21. 00   Total (sum of lines 1-19)   0   0   0   0   0   0   0   0     22. 00   Unit cost multiplier   0   0   0   0   0   0   0   0   0     Cost Center Description   Reconciliation   N   CHER ADMIN & GENERAL (ACCUM. COST)   CST   CRUMARE   FEET)   CST   CST	15.00	Health Promotion Activities	0	0	ol	0	0	l o	15.00
18.00	16.00	Day Care Program	0	0	ol	0	0	o	16.00
19,00   All Others (specify)   0   0   0   0   0   0   0   0   5,267,523   20.00   20.00   Total (cust of be allocated 20.000000   0.000000   0.000000   0.255720   0.000000   0.255720   0.000000   0.000000   0.255720   0.000000   0.000000   0.255720   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.00000000	17.00	Home Delivered Meals Program	0	0	O	0	0	0	17.00
20. 0			0	0	O	0	0	0	
21.00   Total cost to be all ocated   20.00   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.00000000			0	-1	0	0	0	١	
22.00   Unit cost multiplier   0.000000   0.000000   0.255720   0.000000   0.013983   22.00			0	0		0			
Cost Center Description   Reconciliatio   OTHER ADMIN & GENERAL (ACCUM. COST)   PLANT (SQUARE (FEET)   COUNTS OF LAUNDRY)			0	0		0			
Note	22. 00								22.00
CACCUM. COST)   CSQUARE   CPOUNDS OF LAUNDRYY   FEET)   PATI ENT DAYS   FEET)   FEET)   DAYS   FEET)   FEET)   DAYS   FEET)   FEET)   DAYS   DAYS		cost center bescription							
SA.03   S.03   TEET			"				,	,	
1.00   Administrative and General   2.00   Skilled Nursing Care   0   120,721   0   0   0   0   0   0   0   0   0				(ACCOM. COST)			1	TATIENT DATS)	
2.00   Skilled Nursing Care   0   2,416,211   0   0   0   0   2.00   3.00   Physical Therapy   0   1,504,203   0   0   0   0   3.00   4.00   Occupational Therapy   0   697,164   0   0   0   0   0   0   5.00   Speech Pathology   0   699,086   0   0   0   0   0   6.00   Medical Social Services   0   104,298   0   0   0   0   0   7.00   Home Health Aide   0   221,828   0   0   0   0   0   8.00   Supplies (see instructions)   0   177,668   0   0   0   0   9.00   Drugs   0   0   0   0   0   10.00   DME   0   0   0   0   0   11.00   Home Dialysis Aide Services   0   0   0   0   12.00   Respiratory Therapy   0   0   0   0   13.00   Private Duty Nursing   0   0   0   0   14.00   Clinic   0   0   0   0   15.00   Health Promotion Activities   0   0   0   0   17.00   Home Delivered Meals Program   0   0   0   0   17.00   Home Delivered Meals Program   0   0   0   0   18.00   Homemaker Service   0   0   0   0   19.00   All Others (specify)   0   0   0   0   2.00   Total (sum of lines 1-19)   5,341,179   0   0   0   2.00   Total cost to be allocated   1,186,206   0   0   0    2.00   Total cost to be allocated   1,186,206   0   0   0    3.00   0   0   0   0   0   0   0   0   0			5A. 03	5. 03			9. 00	10.00	
2.00   Skilled Nursing Care   0   2,416,211   0   0   0   0   2.00   3.00   Physical Therapy   0   1,504,203   0   0   0   0   3.00   4.00   Occupational Therapy   0   697,164   0   0   0   0   0   0   5.00   Speech Pathology   0   699,086   0   0   0   0   0   6.00   Medical Social Services   0   104,298   0   0   0   0   0   7.00   Home Health Aide   0   221,828   0   0   0   0   0   8.00   Supplies (see instructions)   0   177,668   0   0   0   0   9.00   Drugs   0   0   0   0   0   10.00   DME   0   0   0   0   0   11.00   Home Dialysis Aide Services   0   0   0   0   12.00   Respiratory Therapy   0   0   0   0   13.00   Private Duty Nursing   0   0   0   0   14.00   Clinic   0   0   0   0   15.00   Health Promotion Activities   0   0   0   0   17.00   Home Delivered Meals Program   0   0   0   0   17.00   Home Delivered Meals Program   0   0   0   0   18.00   Homemaker Service   0   0   0   0   19.00   All Others (specify)   0   0   0   0   2.00   Total (sum of lines 1-19)   5,341,179   0   0   0   2.00   Total cost to be allocated   1,186,206   0   0   0    2.00   Total cost to be allocated   1,186,206   0   0   0    3.00   0   0   0   0   0   0   0   0   0	1. 00	Administrative and General							
3.00 Physical Therapy	2.00				Ui	1 0	0	0	1.00
5.00         Speech Pathology         0         99,086         0         0         0         5.00           6.00         Medical Social Services         0         104,298         0         0         0         0         6.00           7.00         Home Heal th Aide         0         221,828         0         0         0         0         0         7.00           8.00         Supplies (see instructions)         0         177,668         0         0         0         0         0         0         9.00         0         0         0         0         9.00         0	3.00		0						
6.00 Medical Social Services 0 104,298 0 0 0 0 0 0 6.00 7.00 Home Health Aide 0 221,828 0 0 0 0 0 0 7.00 8.00 Supplies (see instructions) 0 177,668 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		Physi cal Therapy		2, 416, 211	0	0	0	o	2.00
7.00 Home Heal th Aide			0	2, 416, 211 1, 504, 203	0	0	0	0	2. 00 3. 00
8.00 Supplies (see instructions) 9.00 Drugs 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	4. 00 5. 00	Occupational Therapy Speech Pathology	0 0	2, 416, 211 1, 504, 203 697, 164 99, 086	0	0 0 0 0	0 0 0 0	0 0 0 0	2. 00 3. 00 4. 00 5. 00
9.00 Drugs 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	4. 00 5. 00 6. 00	Occupational Therapy Speech Pathology Medical Social Services	0 0 0 0	2, 416, 211 1, 504, 203 697, 164 99, 086 104, 298	0 0 0 0	0 0 0 0	0 0 0 0	0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00
10.00       DME       0       0       0       0       0       0       10.00         11.00       Home Dialysis Aide Services       0       0       0       0       0       0       0       0       0       11.00         12.00       Respiratory Therapy       0       0       0       0       0       0       0       0       0       0       0       12.00         13.00       Private Duty Nursing       0	4. 00 5. 00 6. 00 7. 00	Occupational Therapy Speech Pathology Medical Social Services Home Health Aide	0 0 0 0	2, 416, 211 1, 504, 203 697, 164 99, 086 104, 298 221, 828	0 0 0 0 0	0 0 0 0 0	0 0 0 0 0	0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00
11.00       Home Dialysis Aide Services       0       0       0       0       0       0       11.00         12.00       Respiratory Therapy       0       0       0       0       0       0       0       0       12.00         13.00       Private Duty Nursing       0       0       0       0       0       0       0       0       0       0       0       13.00         14.00       Clinic       0       0       0       0       0       0       0       0       0       14.00         15.00       Heal th Promotion Activities       0       0       0       0       0       0       0       0       0       0       0       0       15.00         16.00       Day Care Program       0 <t< td=""><td>4. 00 5. 00 6. 00 7. 00 8. 00</td><td>Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions)</td><td>0 0 0 0 0</td><td>2, 416, 211 1, 504, 203 697, 164 99, 086 104, 298 221, 828 177, 668</td><td>0 0 0 0 0</td><td>0 0 0 0 0 0</td><td>0 0 0 0 0 0</td><td>0 0 0 0 0 0 0 0 0 0 0</td><td>2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00</td></t<>	4. 00 5. 00 6. 00 7. 00 8. 00	Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions)	0 0 0 0 0	2, 416, 211 1, 504, 203 697, 164 99, 086 104, 298 221, 828 177, 668	0 0 0 0 0	0 0 0 0 0 0	0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00
12.00       Respiratory Therapy       0       0       0       0       0       12.00         13.00       Private Duty Nursing       0       0       0       0       0       0       0       0       0       13.00         14.00       Clinic       0       0       0       0       0       0       0       0       14.00         15.00       Heal th Promotion Activities       0       0       0       0       0       0       0       0       0       0       0       15.00         16.00       Day Care Program       0	4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs	0 0 0 0 0	2, 416, 211 1, 504, 203 697, 164 99, 086 104, 298 221, 828 177, 668	0 0 0 0 0 0	0 0 0 0 0 0	0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
13.00     Private Duty Nursing     0     0     0     0     0     0     13.00       14.00     Clinic     0     0     0     0     0     0     0     14.00       15.00     Heal th Promotion Activities     0     0     0     0     0     0     0     0     15.00       16.00     Day Care Program     0     0     0     0     0     0     0     0     0     0     0     0     0     16.00       17.00     Home Delivered Meals Program     0	4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00	Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME	0 0 0 0 0 0	2, 416, 211 1, 504, 203 697, 164 99, 086 104, 298 221, 828 177, 668 0	0 0 0 0 0 0	0 0 0 0 0 0 0	0 0 0 0 0 0 0	0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00
14.00     Clinic     0     0     0     0     0     0     14.00       15.00     Health Promotion Activities     0     0     0     0     0     0     0     0     0     15.00       16.00     Day Care Program     0     0     0     0     0     0     0     0     0     16.00       17.00     Home Delivered Meals Program     0     0     0     0     0     0     0     0     0     17.00       18.00     Homemaker Service     0     0     0     0     0     0     0     0     0     0     0     0     19.00       20.00     All Others (specify)     0<	4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00	Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services	0 0 0 0 0 0 0	2, 416, 211 1, 504, 203 697, 164 99, 086 104, 298 221, 828 177, 668 0 0	0 0 0 0 0 0 0	0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00
15.00     Health Promotion Activities     0     0     0     0     0     0     15.00       16.00     Day Care Program     0     0     0     0     0     0     0     0     16.00       17.00     Home Delivered Meals Program     0     0     0     0     0     0     0     0     17.00       18.00     Homemaker Service     0     0     0     0     0     0     0     0     0     0     19.00       20.00     Total (sum of lines 1-19)     5, 341, 179     0     0     0     0     0     0     20.00       21.00     Total cost to be allocated     1, 186, 206     0     0     0     0     0     0     0	4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00	Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy	0 0 0 0 0 0 0	2, 416, 211 1, 504, 203 697, 164 99, 086 104, 298 221, 828 177, 668 0 0	0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00
16.00     Day Care Program     0     0     0     0     0     0     16.00       17.00     Home Delivered Meals Program     0     0     0     0     0     0     0     17.00       18.00     Homemaker Service     0     0     0     0     0     0     0     18.00       19.00     All Others (specify)     0     0     0     0     0     0     19.00       20.00     Total (sum of lines 1-19)     5,341,179     0     0     0     0     0     20.00       21.00     Total cost to be allocated     1,186,206     0     0     0     0     0     21.00	4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00	Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing	0 0 0 0 0 0 0	2, 416, 211 1, 504, 203 697, 164 99, 086 104, 298 221, 828 177, 668 0 0	0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00
17. 00     Home Delivered Meals Program     0     0     0     0     0     17. 00       18. 00     Homemaker Service     0     0     0     0     0     0     18. 00       19. 00     All Others (specify)     0     0     0     0     0     0     0     19. 00       20. 00     Total (sum of lines 1-19)     5, 341, 179     0     0     0     0     0     20. 00       21. 00     Total cost to be allocated     1, 186, 206     0     0     0     0     0     21. 00	4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00	Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic	0 0 0 0 0 0 0	2, 416, 211 1, 504, 203 697, 164 99, 086 104, 298 221, 828 177, 668 0 0	0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00
18.00     Homemaker Service     0     0     0     0     0     18.00       19.00     All Others (specify)     0     0     0     0     0     0     19.00       20.00     Total (sum of lines 1-19)     5,341,179     0     0     0     0     0     0     20.00       21.00     Total cost to be allocated     1,186,206     0     0     0     0     0     21.00	4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00	Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities	0 0 0 0 0 0 0	2, 416, 211 1, 504, 203 697, 164 99, 086 104, 298 221, 828 177, 668 0 0	0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00
19.00     All Others (specify)     0     0     0     0     0     19.00       20.00     Total (sum of lines 1-19)     5,341,179     0     0     0     0     0     0     20.00       21.00     Total cost to be allocated     1,186,206     0     0     0     0     0     21.00	4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00	Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program	0 0 0 0 0 0 0	2, 416, 211 1, 504, 203 697, 164 99, 086 104, 298 221, 828 177, 668 0 0 0	0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0	000000000000000000000000000000000000000	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00
20. 00     Total (sum of lines 1-19)     5,341,179     0     0     0     0     20.00       21. 00     Total cost to be allocated     1,186,206     0     0     0     0     21.00	4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00	Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program	0 0 0 0 0 0 0	2, 416, 211 1, 504, 203 697, 164 99, 086 104, 298 221, 828 177, 668 0 0 0 0	0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00
21.00 Total cost to be allocated 1,186,206 0 0 0 0 21.00	4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00	Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service	0 0 0 0 0 0 0	2, 416, 211 1, 504, 203 697, 164 99, 086 104, 298 221, 828 177, 668 0 0 0 0	0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00
22.00   Unit cost multiplier   0.222087   0.000000   0.000000   0.000000   22.00	4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00	Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify)	0 0 0 0 0 0 0	2, 416, 211 1, 504, 203 697, 164 99, 086 104, 298 221, 828 177, 668 0 0 0 0 0	0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00
	4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 13.00 14.00 15.00 17.00 18.00 19.00 20.00	Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Total (sum of lines 1-19)	0 0 0 0 0 0 0	2, 416, 211 1, 504, 203 697, 164 99, 086 104, 298 221, 828 177, 668 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 20. 00

Health Financial Systems ST. FRANCIS HOSPITAL & HEALTH CENTER ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL Provider CCN: Provi der CCN: 150162 BASIS HHA CCN: 157179

					Home Health Agency I	PPS	
Cost Center Description	CAFETERI A (FTES)	NURSING ADMINISTRATIO N (TOTAL PATIENT DAYS)	CENTRAL SERVI CES & SUPPLY (COSTED REQUI S. )	PHARMACY (COSTED REQUIS.)	MEDI CAL RECORDS & LI BRARY (GROSS CHARGES)	I NTERNS & RESI DENTS SERVI CES-SALA RY & FRI NGES (ASSI GNED TI ME)	
	11. 00	13. 00	14. 00	15. 00	16.00	21.00	
1.00 Administrative and General 2.00 Skilled Nursing Care 3.00 Physical Therapy 4.00 Occupational Therapy 5.00 Speech Pathology 6.00 Medical Social Services 7.00 Home Health Aide 8.00 Supplies (see instructions) 9.00 DTUGS 10.00 DME 11.00 Home Dialysis Aide Services 12.00 Respiratory Therapy 13.00 Private Duty Nursing 14.00 Clinic 15.00 Health Promotion Activities 16.00 Day Care Program 17.00 Home Delivered Meals Program 18.00 Homemaker Service 19.00 All Others (specify) 20.00 Total (sum of lines 1-19) 21.00 Total cost to be allocated		0 0 0 0 0 0	116, 884 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		8, 805, 179 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00
22.00 Unit cost multiplier	0. 000000	0. 000000	0. 123550	0. 00000	0. 001344	0. 000000	22. 00
Cost Center Description	INTERNS & RESI DENTS SERVI CES-OTHE R PRGM COSTS (ASSI GNED TIME)	PARAMED ED PRGM (ASSI GNED TI ME)	EMERGENCY MEDI CAL SERVI CES (ASSI GNED TI ME) 23. 01				
1.00 Administrative and General	22.00		23.01				1.00
2.00 Skilled Nursing Care 3.00 Physical Therapy 4.00 Occupational Therapy 5.00 Speech Pathology 6.00 Medical Social Services 7.00 Home Health Aide 8.00 Supplies (see instructions) 9.00 Drugs 10.00 DME 11.00 Home Dialysis Aide Services 12.00 Respiratory Therapy 13.00 Private Duty Nursing 14.00 Clinic 15.00 Health Promotion Activities 16.00 Day Care Program 17.00 Home Delivered Meals Program 18.00 Homemaker Service 19.00 All Others (specify) 20.00 Total (sum of lines 1-19) 21.00 Total cost to be allocated 22.00 Unit cost multiplier	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00 22. 00

Heal th	Financial Systems	ST. F	RANCIS HOSPITA	AL & H	EALTH CEN	ITER	In Lie	u of Form CMS-2	2552-10
	TONMENT OF PATIENT SERVICE COST	TS				CCN: 150162	Peri od: From 01/01/2014	Worksheet H-3 Part I	
					HHA CCN:	157179	To 12/31/2014	Date/Time Pre 5/26/2015 12:	
					Ti tl	e XVIII	Home Health Agency I	PPS	
	Cost Center Description	From, Wkst.	Facility		hared	Total HHA	Total Visits	Average Cost	
		H-2, Part I,	Costs (from		cillary	Costs (cols.		Per Visit	
		col. 28, line			ts (from	1 + 2)		(col. 3 ÷	
		0	Part I)		rt II)	2.00	4.00	col . 4)	
	DART I COMPUTATION OF LECCED	0	1.00		2.00	3.00	4.00	5. 00	
	PART I - COMPUTATION OF LESSER COST LIMITATION	OF AGGREGATE	PROGRAM COST, A	AGGRE	JAIE OF I	HE PROGRAM LI	MITATION COST, C	JR BENEFICIARY	
	Cost Per Visit Computation								
1. 00	Skilled Nursing Care	2. 00				3, 033, 26			
2. 00	Physi cal Therapy	3.00			C				
3. 00	Occupational Therapy	4.00	,		C				
4. 00	Speech Pathology	5. 00			C				
5. 00	Medical Social Services	6. 00	,			130, 93			
6. 00	Home Heal th Ai de	7. 00			_	278, 47		1	
7. 00	Total (sum of lines 1-6)		6, 330, 619	1	C				7.00
						Program Visi	īs		
						D:	art B		
	Cost Center Description	Cost Limits	CBSA No. (1)		art A	Not Subject			
	cost center bescription	COST LIMITS	CDSA NO. (1)	· '	ait A	to	Deductibles		
						Deducti bl es			
						Coi nsurance			
		0	1. 00		2. 00	3.00	4. 00	5. 00	
	Limitation Cost Computation								
8.00	Skilled Nursing Care		26900		C	)	0		8. 00
9.00	Physi cal Therapy		26900		C	)	0		9.00
10. 00	Occupational Therapy		26900		C	)	0		10.00
11. 00	Speech Pathology		26900		C	•	0		11. 00
12. 00	Medical Social Services		26900		C	•	0		12.00
13.00	Home Health Aide		26900		C	)	0		13.00
14.00	Total (sum of lines 8-13)				C		0		14.00
	Cost Center Description	From Wkst.	Facility		hared	Total HHA		Ratio (col. 3	
		H-2 Part I,	Costs (from		cillary	Costs (cols.	7	÷ col . 4)	
		col. 28, line	·		ts (from	1 + 2)	Record)		
		0	Part I) 1.00		<u>rt II)</u> 2.00	3. 00	4.00	5. 00	
	Supplies and Drugs Cost Comput		1.00	l	2.00	3.00	4.00	5.00	
15 00	Cost of Medical Supplies	8.00	223, 041		C	223, 04	11 0	0. 000000	15 00
	Cost of Drugs	9. 00		1	C		o o		
	,		Program Visits	;		Cost of			
						Servi ces			
				t B			Part B		
	Cost Center Description	Part A	Not Subject		ject to	Part A	Not Subject	Subject to	
			to		ctibles &		to	Deductibles &	
			Deductibles &	Coi	nsurance		Deductibles &	Coi nsurance	
		/ 00	Coi nsurance		0.00	0.00	Coi nsurance	11.00	
	DART I COMPUTATION OF LECCED	6. 00	7. 00		8.00	9.00	10.00	11.00	
	PART I - COMPUTATION OF LESSER COST LIMITATION	OF AGGREGATE	PRUGRAW CUST, I	AGGRE	JAIL UF I	HE PRUGRAW LI	MITATION COST, C	JR BENEFICIARY	
	Cost Per Visit Computation								
1. 00	Skilled Nursing Care	0	0	1			0 0		1.00
2. 00	Physical Therapy			1					2.00
3. 00	Occupational Therapy								3.00
4. 00	Speech Pathology			1					4.00
5.00	Medical Social Services								5.00
6. 00	Home Heal th Ai de							1	6.00
7. 00	Total (sum of lines 1-6)	l ő				1			7.00
		,	,	1		•	,		

Heal th	Financial Systems	ST. F	RANCIS HOSPITA	AL & HEALTH CE	NTER	In Lie	u of Form CMS-2	2552-10
APPORT	TIONMENT OF PATIENT SERVICE COST	TS .		Provi der	CCN: 150162 157179	Peri od: From 01/01/2014 To 12/31/2014		pared:
					le XVIII	Home Health Agency I	PPS	
	Cost Center Description			·				
		6. 00	7. 00	8. 00	9. 00	10. 00	11. 00	
8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00	Limitation Cost Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 8-13)							8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00
	Program Covered Charges Cost of Services							
	Cost Center Description	Part A	Par Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	Part B Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		6. 00	7. 00	8.00	9. 00	10. 00	11. 00	
	Supplies and Drugs Cost Comput		<u> </u>					
15. 00 16. 00	Cost of Medical Supplies Cost of Drugs	0	0		) )	0	0	15. 00 16. 00
	Cost Center Description	Total Program Cost (sum of cols. 9-10) 12.00						
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION  Cost Per Visit Computation								
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6)	0 0 0 0 0 0						1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00
	Cost Center Description	12. 00						
8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00	Limitation Cost Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 8-13)							8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00

Health Financial Systems ST. FRANCIS HOSPITAL & HEALTH CENTER In Lieu of Form CMS-25							2552-10	
APPORTIONMENT OF PATIENT SERVICE COSTS				Provi der	CCN: 150162	Peri od:	Worksheet H-3	
					157179	From 01/01/2014 To 12/31/2014	Part II Date/Time Pre 5/26/2015 12:	
				Ti tl	e XVIII	Home Health	PPS	
						Agency I		
	Cost Center Description	From Wkst. C,	Cost to	Total HHA	HHA Shared	Transfer to		
		Part I, col.	Charge Ratio	Charge (from	Ancillary	Part I as		
9, line		provi der	Costs (col.	1 Indicated				
				records)	x col. 2)			
		0	1. 00	2.00	3.00	4. 00		
	PART II - APPORTIONMENT OF COS	T OF HHA SERVI	CES FURNISHED E	BY SHARED HOSP	ITAL DEPARTME	NTS		
1.00	Physi cal Therapy	66.00	0. 272215	C	)	0 col. 2, line 2	. 00	1.00
1.01	Physical Therapy 1	66. 01	0. 000000	C		0 col. 2, line 2	. 01	1.01
2.00	Occupational Therapy	67.00	0. 234084	C		0 col. 2, line 3	. 00	2.00
3.00	Speech Pathology	68.00	0. 224881	l c		Ocol. 2, line 4	. 00	3.00
4.00	Cost of Medical Supplies	71.00	0. 413238	l c		0 col. 2, line 1	5. 00	4.00
5.00	Cost of Drugs	73. 00	0. 171309	[ c	o	0 col. 2, line 1	6. 00	5. 00

	ATION OF HHA REIMBURSEMENT SETTLEMENT	Provi der	CCN: 150162	Peri od:	Worksheet H-4	<u>2552-1</u> I
		HHA CCN:	157179	From 01/01/2014	Part I-II	epared:
		Ti tl e	e XVIII	Home Health Agency I	PPS	47 piii
			Part A	Par Not Subject	t B Subject to	
			Tarta	to Deductibles &	Deductibles & Coinsurance	
			1. 00	Coi nsurance 2.00	3. 00	
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOM	ARY CHARGE	ES			
. 00	Reasonable Cost of Part A & Part B Services Reasonable cost of services (see instructions)			0 0	0	1.0
. 00	Total charges			0 0	0	
	Customary Charges					
. 00	Amount actually collected from patients liable for payment for on a charge basis (from your records)	servi ces		0 0	0	3.00
. 00	Amount that would have been realized from patients liable for p for services on a charge basis had such payment been made in ac	ayment cordance		0 0	0	4.00
. 00	with 42 CFR §413.13(b) Ratio of line 3 to line 4 (not to exceed 1.000000)		0. 00000	0. 000000	0. 000000	5.0
. 00	Total customary charges (see instructions)			0 0	0	6.0
. 00	Excess of total customary charges over total reasonable cost (c only if line 6 exceeds line 1)			0 0	0	
. 00	Excess of reasonable cost over customary charges (complete only 1 exceeds line $6$ )	if line		0 0	0	
. 00	Primary payer amounts			0 0 Part A	Part B	9.0
				Servi ces	Servi ces	
				1.00	2. 00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT Total reasonable cost (see instructions)			0	0	10.00
1. 00	Total PPS Reimbursement - Full Episodes without Outliers			Ö	0	
2. 00	Total PPS Reimbursement - Full Episodes with Outliers			0	0	
3. 00 4. 00	Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes			0	0	1
	Total PPS Outlier Reimbursement - Full Episodes with Outliers			0	0	1
	Total PPS Outlier Reimbursement - PEP Episodes			Ö	0	
	Total Other Payments			0	0	1
	DME Payments			0	0	1
	Oxygen Payments Prosthetic and Orthotic Payments			0	0	
	Part B deductibles billed to Medicare patients (exclude coinsur	ance)			0	1
2. 00	Subtotal (sum of lines 10 thru 20 minus line 21)	,		0	0	1
	Excess reasonable cost (from line 8)			0	0	
	Subtotal (line 22 minus line 23)			0	0	1
5.00 6.00	Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25)			0	0	
	Reimbursable bad debts (from your records)				Ü	27. 0
3. 00	Reimbursable bad debts for dual eligible beneficiaries (see ins	,	)			28.0
9. 00	Total costs - current cost reporting period (line 26 plus line	27)		0	0	1
0. 00 0. 50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions)			0	0	
	Subtotal (see instructions)			ő	0	1
	Sequestration adjustment (see instructions)			O	0	31. (
	Interim normante (coe instructions)			1 0	0	32.0
1. 01 2. 00	Interim payments (see instructions)			٦		
31. 01 32. 00	Tentative settlement (for contractor use only) Balance due provider/program (line 31 minus lines 31.01, 32, an	4 33)		0	0	33.0

In Lieu of Form CMS-2552-10

Heal th Financial Systems

ST. FRANCIS HOSPITAL & HEALTH CENTER

ANALYSIS OF PAYMENTS TO PROVIDER-BASED HHAS FOR SERVICES RENDERED TO Provider CCN: 150162

HHA CCN: 157179

HHA CCN: 157179

Date/Time Prepared: 5/26/2015 12: 47 pm

PPS

				Home Health Agency I	PPS	<u> </u>
		I npati en	t Part A		t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2. 00	3. 00	4. 00	
1. 00 2. 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero			0	0	1. 00 2. 00
3. 00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)  Program to Provider					3. 00
3. 01				0	0	3. 01
3. 02				0	0	3. 02 3. 03
3. 03 3. 04				0		3.03
3. 05				0		3. 05
	Provi der to Program			-		
3.50				0	0	3. 50
3. 51				0	0	3. 51
3. 52				0	0	3. 52
3. 53 3. 54				0	0	3. 53 3. 54
3. 54 3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0		3. 54
	3. 50-3. 98)					
4. 00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)			0	0	4. 00
	TO BE COMPLETED BY CONTRACTOR			1		
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				0	0	5. 01 5. 02
5. 02 5. 03				0		5. 02
3.03	Provider to Program			0		3.03
5.50				0	0	5. 50
5. 51				0	0	5. 51
5. 52				0	0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	0	5. 99
6. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6. 00
6. 01	SETTLEMENT TO PROVIDER			0	0	6. 01
6. 02	SETTLEMENT TO PROGRAM			0	0	6. 02
7. 00	Total Medicare program liability (see instructions)			0	0	7. 00
				Contractor Number	NPR Date (Mo/Day/Yr)	
8. 00	Name of Contractor		)	1.00	2. 00	8. 00
0.00	INAMIC OF CONTRACTOR			1	1	0.00

Heal th	Financial Systems ST. FRANCIS HOSPITAL & HE	EALTH CENTER	In Lie	u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSABLE BAD DEBTS - TITLE XVIII - PART B	Provi der CCN: 150162	Peri od:	Worksheet I-5	
			From 01/01/2014	5 . /=! 5	
			To 12/31/2014	Date/Time Pre 5/26/2015 12:	
				3/20/2013 12.	47 pili
			1. 00	2. 00	
	PART I - CALCULATION OF REIMBURSABLE BAD DEBTS - TITLE XVIII - P	PART B			
1.00	Total expenses related to care of program beneficiaries (see ins	structions)	0		1.00
2.00	Total payment due (from Wkst. I-4, col. 6, line 11) (see instruc	ctions)	0	0	2.00
2.01	Total payment due (from Wkst. I-4, col. 6.01, line 11) (see inst	ructions)			2. 01
2.02	Total payment due(from Wkst. I-4, col. 6.02, line 11) (see instr	ructions)			2. 02
2.03	Total payment due (see instructions)				2. 03
2.04	Outlier payments		0		2. 04
3.00	Deductibles billed to Medicare (Part B) patients (see instruction	ons)	0	0	3.00
3. 01	Deductibles billed to Medicare (Part B) patients (see instruction				3. 01
3. 02	Deductibles billed to Medicare (Part B) patients (see instruction				3. 02
3.03	Total deductibles billed to Medicare (Part B) patients (see inst	ructions)			3. 03
4.00	Coinsurance billed to Medicare (Part B) patients		0	0	4. 00
4. 01	Coinsurance billed to Medicare (Part B) patients (see instruction				4. 01
4.02	Coinsurance billed to Medicare (Part B) patients (see instruction	,			4. 02
4.03	Total coinsurance billed to Medicare (Part B) patients (see inst		0	0	
5.00	Bad debts for deductibles and coinsurance, net of bad debt recov		0	0	5.00
5. 01	Transition period 1 (75-25%) bad debts for deductibles and coins		t 0	0	5. 01
	recoveries for services rendered on or after 1/1/2011 but before				
5. 02	Transition period 2 (50-50%) bad debts for deductibles and coins		t 0	0	5. 02
	recoveries for services rendered on or after 1/1/2012 but before			_	
5. 03	Transition period 3 (25-75%) bad debts for deductibles and coins		t 0	0	5. 03
F 04	recoveries for services rendered on or after 1/1/2013 but before				F 04
5. 04	100% PPS bad debts for deductibles and coinsurance net of bad de	ebt recoveries for	0	0	5. 04
F 0F	services rendered on or after 1/1/2014			0	F 0F
5. 05	Total bad debts (sum of line 5 through line 5.04)		0	U	
6. 00 7. 00	Allowable bad debts (see instructions) Reimbursable bad debts for dual eligible beneficiaries (see inst	rusti spa)	0		6. 00 7. 00
7. 00 8. 00	Net deductibles and coinsurance billed to Medicare (Part B) pati		0	0	
8.00	instructions)	ents (see	0	0	8.00
9. 00	Program payment (see instructions)		0	0	9.00
10.00	Unrecovered from Medicare (Part B) patients (see instructions)		0	0	10.00
11. 00	, , , , , , , , , , , , , , , , , , , ,	E Part P line 22)	0		11.00
11.00	PART II - CALCULATION OF FACILITY SPECIFIC COMPOSITE COST PERCEN				11.00
12. 00		TITIOL	0		12.00
13. 00	Total composite costs (from Wkst. I-4, col. 2, line 11)		0		13.00
	Facility specific composite cost percentage (line 13 divided by	line 12)	0. 000000		14.00
20	The state of the s	,	1 2:22000	1	

Health Financial Systems	ST. FRANCIS HOSPITAL & HEALTH CENTER	In Lieu of Form CMS-2552-10
ANALYSIS OF DROWLDED DASED HOSDICE COSTS	Drayi day CCN, 1E01/2 Dayi ad	Workshoot V

Peri od: From 01/01/2014 To 12/31/2014 ANALYSIS OF PROVIDER-BASED HOSPICE COSTS Provi der CCN: 150162 Worksheet K Hospi ce CCN: 151523 Date/Time Prepared: 5/26/2015 12:47 pm Hospi ce I Sal ari es Employee Transportati o Contracted 0ther (from Wkst. Benefi ts n (see inst.) Servi ces (from Wkst. K-1) (from Wkst K-2) K-3) 1. 00 2.00 3.00 4.00 5.00 GENERAL SERVICE COST CENTERS 1 00 Capital Related Costs-Bldg and Fixt. 0 1 00 0 0 2.00 Capital Related Costs-Movable Equip. 0 2.00 3.00 Plant Operation and Maintenance 0 3.00 4.00 Transportation - Staff 0 0 0 0 0 4.00 Volunteer Service Coordination 0 5.00 0 0 0 5.00 6.00 Administrative and General 775, 247 186, 935 29, 267 1, 997, 411 6.00 INPATIENT CARE SERVICE 7.00 0 7.00 Inpatient - General Care 0 0 Inpatient - Respite Care 8.00 0 0 0 8.00 VISITING SERVICES 9.00 Physician Services 9.00 0 10.00 1, 332, 032 Nursing Care 321, 193 24, 561 0 10.00 0 11.00 Nursing Care-Continuous Home Care 0 0 11.00 12.00 Physical Therapy 0 0 12.00 0 0 13.00 Occupational Therapy 0 13.00 0 Speech/ Language Pathology 108, 824 0 14 00 451, 308 0 14 00 15.00 Medical Social Services 0 0 0 15.00 Spiritual Counseling 0 16.00 0 0 0 0 16.00 Dietary Counseling 0 0 17.00 17.00 0 0 18.00 Counseling - Other 0 0 18.00 0 19.00 Home Health Aide and Homemaker 96, 673 23, 311 0 0 19.00 0 0 20.00 HH Aide & Homemaker - Cont. Home Care 261, 777 20.00 21 00 Other 0 0 0 0 21 00 0 OTHER HOSPICE SERVICE COSTS 22.00 Drugs, Biological and Infusion Therapy 0 0 0 22.00 0 o 23.00 0 0 0 23.00 Anal gesi cs 0 Sedatives / Hypnotics 0 0 24.00 0 Ω 24.00 0 25.00 Other - Specify 0 39, 460 25.00 Durable Medical Equipment/Oxygen 0 26.00 0000000 0 0 0 26.00 Patient Transportation 27 00 0 0 5.547 27 00 0 28.00 Imaging Services 0 0 28.00 29.00 Labs and Diagnostics 0 0 0 29.00 0 30.00 Medical Supplies 0 0 0 30.00 0 Outpatient Services (including E/R Dept.) 0 0 31 00 31.00 0 0 32.00 32.00 Radiation Therapy 0 0 33.00 0 0 0 0 33.00 Chemotherapy 34.00 0ther 0 0 0 34.00 HOSPICE NONREIMBURSABLE SERVICE 35.00 Bereavement Program Costs 0 0 0 0 35.00 36.00 Volunteer Program Costs 0 0 0 0 0 36.00 0 0 37.00 37.00 Fundrai si ng 0 0 0 0 38.00 Other Program Costs 0 C 0 Ω 38.00 0 39.00 Total (sum of lines 1 thru 38) 2, 655, 260 640, 263 53, 828 2, 304, 195 39. 00

Health Financial Systems	ST. FRANCIS HOSPITAL &	HEALTH CENTER	In Lieu	u of Form CMS-2552-10
ANALYSIS OF PROVIDER-BASED HOSPICE COSTS		Provi der CCN: 150162	Peri od: From 01/01/2014	Worksheet K
		Hospi ce CCN: 151523		Date/Time Prepared: 5/26/2015 12:47 pm
			Hospi ce I	

			Hospi ce C	CN: 151523	To 12/31/2014		
-					Hospi ce I	5/26/2015 12:	47 pm
		Total (col s.	Reclassi fi cat	Subtotal	Adjustments	Total (col. 8	
		1-5)	ion	(col. 6 ±	Auj ustilicitis	± col. 9)	
		. 57		col. 7)			
		6. 00	7. 00	8.00	9. 00	10.00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.	0	0		0	0	1.00
2.00	Capital Related Costs-Movable Equip.	0	0		0 0	0	2.00
3.00	Plant Operation and Maintenance	0	0		0 0	0	3.00
4.00	Transportation - Staff	0	0		0	0	4.00
5.00	Volunteer Service Coordination	0	0		0	0	5.00
6.00	Administrative and General	2, 988, 860	-585, 332	2, 403, 52	8 -154	2, 403, 374	6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	0		-54, 93	2 0	-54, 932	7. 00
8.00	Inpatient - Respite Care	0	0		0 0	0	8. 00
	VISITING SERVICES						
9.00	Physician Services	0			0	0	9. 00
10.00	Nursing Care	1, 677, 786	0	1, 677, 78	6 0	1, 677, 786	10.00
11. 00	Nursing Care-Continuous Home Care	0	0		0	0	11. 00
12.00	Physi cal Therapy	0	0		0	0	12.00
13.00	Occupational Therapy	0	0		0	0	13.00
14.00	Speech/ Language Pathology	560, 132	0	560, 13	2 0	560, 132	14.00
15.00	Medical Social Services	0	0		0 0	0	15. 00
16.00	Spiritual Counseling	0	0		0 0	0	16. 00
17.00	Di etary Counsel i ng	0	0		0 0	0	17. 00
18.00	Counseling - Other	0	0		0 0	0	18. 00
19.00	Home Health Aide and Homemaker	119, 984	0	119, 98	4 0	119, 984	19. 00
20.00	HH Aide & Homemaker - Cont. Home Care	261, 777	0	261, 77	7 0	261, 777	20.00
21.00		0	0		0 0	0	21. 00
	OTHER HOSPICE SERVICE COSTS				_		
	Drugs, Biological and Infusion Therapy	0	1		0	0	
	Anal gesi cs	0	1 1		0	0	23. 00
	Sedatives / Hypnotics	0	0		0	0	24. 00
25. 00	Other - Specify	39, 460	0	39, 46	0	39, 460	
26. 00	Durable Medical Equipment/Oxygen	0	0		0	0	26. 00
27. 00	Pati ent Transportati on	5, 547	0	5, 54	7 0	5, 547	27. 00
	I maging Services	0	0		0	0	28. 00
	Labs and Diagnostics	0	0		0	0	29. 00
	Medical Supplies	0	0		0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0		0	0	31.00
32.00	Radiation Therapy	0	0		0	0	32. 00
33. 00	Chemotherapy	0	-1		0	0	
34.00	Other	0	0		0 0	0	34.00
	HOSPI CE NONREI MBURSABLE SERVI CE				-		
35. 00	Bereavement Program Costs	0	0		0	_	
36. 00	Volunteer Program Costs	0	0		0	0	36.00
37. 00	Fundrai si ng	0	0		0	0	37.00
38. 00	Other Program Costs	0	0	F 040	0	0	38. 00
39.00	Total (sum of lines 1 thru 38)	5, 653, 546	-640, 264	5, 013, 28	2 -154	5, 013, 128	39.00

Health Financial Systems	ST. FRANCIS HOSPITA	AL & HEALTH CENTER	In Lieu of Form CMS-2552-10
HOCDLOE COMPENSATION ANALYSIS SALAR	EC AND WACEC	D 1 L . OON 450440	Desired Westsheld 4

		TRANCIS HOSFITAL				III LIE	1 01 1 01 III CIVIS	
HOSPI (	CE COMPENSATION ANALYSIS SALARIES AND WAGES		Provi der	CCN: 150162	Peri od:	1 /201 4	Worksheet K-1	
			Hospi ca (	CCN: 151523	From 01/0	1/2014	Date/Time Pre	nared:
			nospi ce v	JCIN. 131323	10 12/3	1/2014	5/26/2015 12:	
					Hospi c	e I	0, 20, 2010 121	.,
		Admi ni strator	Di rector	Soci al	Supervi		Nurses	
		/ dilli ill strator	DIT CC COI	Servi ces	Supervi	3013	1441 303	
		1.00	2.00	3. 00	4. C	10	5. 00	
	GENERAL SERVICE COST CENTERS	1.00	2.00	0.00	1. 0	,0 1	0.00	
1. 00	Capital Related Costs-Bldg and Fixt.							1.00
2. 00	Capital Related Costs-Movable Equip.							2.00
3. 00	Plant Operation and Maintenance	0	0		0	0	0	
4. 00	Transportation - Staff		0		0		0	
5. 00	Volunteer Service Coordination		0		0		0	
6. 00	Administrative and General	775 247	0		0	0	0	
0.00		775, 247	U	′!	U	U	U	0.00
7 00	INPATIENT CARE SERVICE Inpatient - General Care				0	o	0	7 00
7.00		0	0		0	0	0	
8. 00	Inpati ent - Respi te Care	J U	U	1	U	UĮ	U	8.00
0.00	VI SI TI NG SERVI CES		0		0	0	0	9.00
9.00	Physician Services	0	0	1	0	0	-	
10.00	Nursing Care	0	0	<u>'</u>	-	- 1	1, 332, 032	
11.00	Nursing Care-Continuous Home Care	0	U	<u>'</u>	0	0	0	
12.00	Physi cal Therapy	0	U	]	0	U	0	1
13.00	Occupational Therapy	0	Ü	154.0	0	0	0	
14.00	Speech/ Language Pathology	0	0	451, 3	08	0	0	1
15. 00	Medical Social Services	0	0	]	0	0	0	1
16. 00	Spiritual Counseling	0	0	)	0	0	0	
17. 00	Di etary Counsel i ng	0	0	)	0	0	0	1
18. 00	Counseling - Other	0	0	)	0	0	0	1
19. 00	Home Health Aide and Homemaker	0	0	)	0	0	0	
20.00	HH Aide & Homemaker - Cont. Home Care	0	0		0	0	0	
21. 00	Other	0	0		0	0	0	21.00
	OTHER HOSPICE SERVICE COSTS							
22. 00	Drugs, Biological and Infusion Therapy							22. 00
23. 00	Anal gesi cs							23. 00
24. 00	Sedatives / Hypnotics							24.00
25. 00	Other - Specify							25. 00
26. 00	Durable Medical Equipment/Oxygen							26.00
27. 00	Patient Transportation	0	0	)	0	0	0	
28. 00	I maging Services	0	0	)	0	0	0	
29. 00	Labs and Diagnostics	0	0	)	0	0	0	
30.00	Medical Supplies	0	0	)	0	0	0	
31.00	Outpatient Services (including E/R Dept.)	0	0	)	0	0	0	
32.00	Radi ati on Therapy	0	0	)	0	0	0	
33.00	Chemotherapy	0	0	)	0	0	0	33.00
34.00	Other	0	0	)	0	0	0	34.00
	HOSPI CE NONREI MBURSABLE SERVI CE							
35.00	Bereavement Program Costs	0	0	1	0	0	0	
36.00	Volunteer Program Costs	0	0	)	0	0	0	
37.00	Fundrai si ng	0	0	)	0	0	0	37.00
38.00	Other Program Costs	0	0	)	0	0	0	38.00
39. 00	Total (sum of lines 1 thru 38)	775, 247	0	451, 3	08	0	1, 332, 032	39.00
		,				·		

Health Financial Systems	ST.	FRANCIS HOSPITAL & H	HEALTH CENT	TER		In Lieu	of Form CM	MS-2552-10
HOSPICE COMPENSATION ANALYSIS SALARIES	AND WAGES		Provi der (	CCN:	150162		Worksheet	K-1
			Hospice C	CN.	151523	01/01/2014 12/31/2014	Date/Time	Prepared:

	5/26/2015 12:47 pm
	Hospi ce I
Total Aides All-0	other Total (1)
Therapi sts	
6.00 7.00 8.0	00 9.00
GENERAL SERVICE COST CENTERS	
1.00 Capital Related Costs-Bldg and Fixt.	1.0
2.00 Capital Related Costs-Movable Equip.	2.0
3.00 Plant Operation and Maintenance	0 0 3.0
4.00 Transportation - Staff 0	0 0 4.0
5.00 Volunteer Service Coordination	0 0 5.0
6.00 Administrative and General 0	0 775, 247 6. 0
INPATIENT CARE SERVICE	
7.00   Inpatient - General Care   0	0 0 7.0
8.00 Inpatient - Respite Care 0	0 0 8.0
VISITING SERVICES	
9. 00 Physician Services 0	0 9.0
10.00 Nursing Care	0 1, 332, 032 10. (
11.00 Nursing Care-Continuous Home Care	0 0 11.0
12.00 Physical Therapy 0 0	0 0 12.0
13.00 Occupational Therapy 0 0	0 0 13.0
14. 00   Speech / Language Pathol ogy 0 0	0 451, 308 14. (
15.00 Medical Social Services	0 0 15.0
16.00 Spiritual Counseling	0 0 16.0
17. 00 Di etary Counsel i ng	0 0 17.0
18.00 Counseling - Other 0	0 0 18.0
19.00 Home Heal th Ai de and Homemaker 96,673	0 96, 673 19. (
20.00 HH Aide & Homemaker - Cont. Home Care	0 0 20.0
21. 00 Other 0	0 0 21.0
OTHER HOSPI CE SERVI CE COSTS	
22.00 Drugs, Biological and Infusion Therapy	22. (
23. 00 Anal gesi cs	23. (
24.00 Sedatives / Hypnotics	24. 0
25. 00 Other - Specify	25. (
26.00 Durable Medical Equipment/Oxygen	26. 0
27.00 Patient Transportation	0 0 27.0
28. 00   Imaging Services 0	0 0 28.0
29.00 Labs and Diagnostics	0 0 29.0
30.00 Medical Supplies 0	0 0 30.0
31.00 Outpatient Services (including E/R Dept.)	0 31.0
32.00 Radi ati on Therapy	0 0 32.0
33.00 Chemotherapy	0 0 33.0
34. 00 Other 0	0 0 34.0
HOSPI CE NONREI MBURSABLE SERVI CE	0 0 25 (
35.00 Bereavement Program Costs	0 0 35.0
36.00 Volunteer Program Costs	0 0 36.0
37.00 Fundraising 0	0 0 37.0
38.00 Other Program Costs 39.00 Total (sum of lines 1 thru 38) 0 96,673	0 0 38.0
39.00  Total (sum of lines 1 thru 38)   0   96,673	0 2, 655, 260 39.0

HOSPICE COMPENSATION ANALYSIS EMPLOYEE BENEFITS (PAYROLL RELATED) Provider CCN: 150162 Peri od: Worksheet K-2 From 01/01/2014 Hospi ce CCN: 151523 To 12/31/2014 Date/Time Prepared: 5/26/2015 12:47 pm Hospi ce I Admi ni strator Di rector Soci al Nurses Supervi sors Servi ces 1.00 2.00 4.00 5.00 3.00 GENERAL SERVICE COST CENTERS 1.00 Capital Related Costs-Bldg and Fixt. 1.00 2 00 Capital Related Costs-Movable Equip. 2 00 3.00 Plant Operation and Maintenance 0 0 0 3.00 0 4.00 Transportation - Staff 0 0 0 0 4.00 Volunteer Service Coordination 0 ol 5.00 0 0 0 5.00 Administrative and General 186, 935 0 0 0 Ω 6.00 6.00 INPATIENT CARE SERVICE Inpatient - General Care Inpatient - Respite Care 7.00 0 0 0 0 0 7.00 8.00 0 0 0 ol 0 8.00 VISITING SERVICES 9.00 Physician Services 0 0 0 0 9.00 10.00 Nursing Care 0 0 0 0 321, 193 10.00 Nursing Care-Continuous Home Care 0000000000 0 0 0 0 0 0 0 0 0 11.00 0 0 11.00 0 0 12.00 Physical Therapy 0 12.00 0 13.00 Occupational Therapy 0 0 0 13.00 Speech/ Language Pathology 108, 824 14.00 0 14.00 Medical Social Services 0 15.00 15.00 0 0 Spiritual Counseling 0 0 16.00 0 16.00 17.00 Dietary Counseling 0 0 17.00 0 0 18.00 Counseling - Other 0 18.00 Home Health Aide and Homemaker 0 19.00 19.00 0 0 20.00 HH Aide & Homemaker - Cont. Home Care C 0 20.00 21.00 0 0 21.00 OTHER HOSPICE SERVICE COSTS 22.00 Drugs, Biological and Infusion Therapy 22 00 23.00 Anal gesi cs 23.00 24.00 Sedatives / Hypnotics 24.00 Other - Specify 25.00 25.00 Durable Medical Equipment/Oxygen 26.00 26.00 27.00 Patient Transportation 27.00 000000 0 28.00 Imaging Services 0 0 28.00 0 Labs and Diagnostics 0 29.00 29.00 0 30.00 Medical Supplies 0 0 30.00 Outpatient Services (including E/R Dept.) 0 0 0 0 31.00 0 31.00 Radiation Therapy 0 32.00 0 0 32.00 0 0 0 33.00 Chemotherapy 33.00 34.00 0ther 0 0 0 0 0 34.00 HOSPICE NONREIMBURSABLE SERVICE 35 00 0 0 0 0 n 35.00 Bereavement Program Costs Volunteer Program Costs 0 0 36.00 0 0 36.00 0 37.00 Fundrai si ng 0 0 0 0 37.00 0 38.00 Other Program Costs 0 0 0 0 38.00 108, 824 39.00 Total (sum of lines 1 thru 38) 186, 935 0 321, 193 39. 00

In Lieu of Form CMS-2552-10 HOSPICE COMPENSATION ANALYSIS EMPLOYEE BENEFITS (PAYROLL RELATED) Provider CCN: 150162 Peri od: Worksheet K-2 From 01/01/2014 Hospi ce CCN: 151523 12/31/2014 Date/Time Prepared: 5/26/2015 12:47 pm Hospi ce I Total Ai des All-Other Total (1) Therapi sts 7.00 8.00 9. 00 6.00 GENERAL SERVICE COST CENTERS 1.00 Capital Related Costs-Bldg and Fixt. 1.00 2 00 Capital Related Costs-Movable Equip. 2 00 3.00 Plant Operation and Maintenance 0 0 3.00 0 4.00 Transportation - Staff 0 0 4.00 Volunteer Service Coordination 5.00 0 0 0 5.00 Administrative and General 0 0 186, 935 6.00 6.00 INPATIENT CARE SERVICE Inpatient - General Care Inpatient - Respite Care 7.00 0 0 0 7.00 8.00 0 0 0 8.00 VISITING SERVICES 9.00 Physician Services 0 0 9.00 10.00 Nursing Care 0 0 321, 193 10.00 Nursing Care-Continuous Home Care 0 11.00 0 11.00 0 0 12.00 Physical Therapy 0 0 12.00 13.00 Occupational Therapy 0 0 0 0 13.00 14.00 Speech/ Language Pathology 0 108, 824 14.00 Medical Social Services 0 0 15.00 15.00 0 0 16.00 Spiritual Counseling C 0 16.00 17.00 Dietary Counseling 0 17.00 0 18.00 Counseling - Other 0 18.00 Home Health Aide and Homemaker 0 19.00 19.00 23, 311 23, 311 20.00 HH Aide & Homemaker - Cont. Home Care 0 20.00 21.00 0 21.00 OTHER HOSPICE SERVICE COSTS 22.00 Drugs, Biological and Infusion Therapy 22 00 23.00 Anal gesi cs 23.00 24.00 Sedatives / Hypnotics 24.00 Other - Specify 25.00 25.00 Durable Medical Equipment/Oxygen 26.00 26.00 27.00 Patient Transportation 27.00 0 28.00 Imaging Services 0 0 28.00 0 Labs and Diagnostics 0 29 00 29.00 30.00 Medical Supplies 0 30.00 0 Outpatient Services (including E/R Dept.) 0 0 31.00 31.00 Radiation Therapy 0 32.00 0 32.00 0 0 0 33.00 Chemotherapy 33.00 34.00 0ther 0 0 0 34.00 HOSPICE NONREIMBURSABLE SERVICE 35 00 0 0 O 35.00 Bereavement Program Costs 0 36.00 Volunteer Program Costs 0 0 36.00 37.00 Fundrai si ng 0 0 37.00 38.00 Other Program Costs 0 0 0 38.00 0 39.00 Total (sum of lines 1 thru 38) 0 23, 311 640, 263 39.00

0 37.00

0 38.00

39.00 0

HOSPICE COMPENSATION ANALYSIS CONTRACTED SERVICES/PURCHASED SERVICES Provi der CCN: 150162 Peri od: Worksheet K-3 From 01/01/2014 Hospi ce CCN: 151523 12/31/2014 Date/Time Prepared: 5/26/2015 12:47 pm Hospi ce I Admi ni strator Di rector Soci al Nurses Supervi sors Servi ces 1.00 2.00 4.00 5.00 3.00 GENERAL SERVICE COST CENTERS 1.00 Capital Related Costs-Bldg and Fixt. 1.00 2 00 Capital Related Costs-Movable Equip. 2 00 3.00 Plant Operation and Maintenance 0 0 0 3.00 0 4.00 Transportation - Staff 0 0 0 0 4.00 Volunteer Service Coordination 0 0 ol 5.00 0 0 5.00 Administrative and General 0 0 0 0 Ω 6.00 6.00 INPATIENT CARE SERVICE Inpatient - General Care Inpatient - Respite Care 7.00 0 0 0 0 0 7.00 8.00 0 0 0 ol 0 8.00 VISITING SERVICES 9.00 Physician Services 0 0 0 0 0 9.00 10.00 Nursing Care 0 0 0 0 0 10.00 Nursing Care-Continuous Home Care 0000000000 0 0 0 0 0 0 0 0 0 0 11.00 0 0 11.00 0 12.00 Physical Therapy 0 12.00 0 0 13.00 Occupational Therapy 0 0 13.00 Speech/ Language Pathology 0 14.00 14.00 Medical Social Services 0 0 15.00 0 15.00 0 16.00 Spiritual Counseling 0 16.00 17.00 Dietary Counseling 0 0 17.00 0 0 18.00 Counseling - Other 0 18.00 Home Health Aide and Homemaker 0 19.00 19.00 0 0 20.00 HH Aide & Homemaker - Cont. Home Care C 0 20.00 21.00 0 0 21.00 OTHER HOSPICE SERVICE COSTS 22.00 Drugs, Biological and Infusion Therapy 22 00 23.00 Anal gesi cs 23.00 24.00 Sedatives / Hypnotics 24.00 Other - Specify 25.00 25.00 Durable Medical Equipment/Oxygen 26.00 26.00 27.00 Patient Transportation 27.00 000000 0 28.00 Imaging Services 0 0 0 0 0 28.00 0 Labs and Diagnostics 0 29.00 29.00 0 30.00 Medical Supplies 0 0 30.00 Outpatient Services (including E/R Dept.) 0 0 31.00 31.00 0 Radiation Therapy 0 32.00 0 0 32.00 0 0 0 33.00 Chemotherapy 33.00 34.00 0ther 0 0 0 0 0 34.00 HOSPICE NONREIMBURSABLE SERVICE 35 00 0 0 0 35.00 Bereavement Program Costs 0 0 0 0 0 0 0 0 0 0 36.00 Volunteer Program Costs 0 36.00

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37.00

38.00

Fundrai si ng

Other Program Costs

39.00 Total (sum of lines 1 thru 38)

23.00

24.00

25.00

26.00

27.00

28.00

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31.00

32.00

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29. 00 30. 00

31.00

32.00

33.00

34.00

35 00

36.00

37.00

38.00

Anal gesi cs

Other - Specify

Imaging Services

Medical Supplies

Radiation Therapy

Chemotherapy

Fundrai si ng

0ther

Sedatives / Hypnotics

Patient Transportation

Labs and Diagnostics

Durable Medical Equipment/Oxygen

HOSPICE NONREIMBURSABLE SERVICE

Bereavement Program Costs

Volunteer Program Costs

39.00 Total (sum of lines 1 thru 38)

Other Program Costs

Outpatient Services (including E/R Dept.)

| Provider CCN: 150162 | Period: | Worksheet K-4 | From 01/01/2014 | Part I | To 12/31/2014 | Date/Time Prepared: | 5/26/2015 12: 47 pm Health Financial Systems SCOST ALLOCATION - HOSPICE GENERAL SERVICE COST

			·			5/26/2015 12:	47 pm
					Hospi ce I		
			CAPI TAL RE	LATED COST			
		NET EXPENSES FOR COST ALLOCATION	BUI LDI NGS & FI XTURES	MOVABLE EQUI PMENT	PLANT OPERATION & MAINT.	TRANSPORTATIO N	
		0	1. 00	2. 00	3. 00	4. 00	
	GENERAL SERVICE COST CENTERS			T		T	
1. 00	Capital Related Costs-Bldg and Fixt.	0	0				1.00
2.00	Capital Related Costs-Movable Equip.	0			0		2.00
3. 00	Plant Operation and Maintenance	0	0		0		3. 00
4. 00	Transportation - Staff	0	0		0 0		4.00
5.00	Volunteer Service Coordination	0	0		0		5. 00
6. 00	Administrative and General	2, 403, 374	0		0 0	0	6. 00
	INPATIENT CARE SERVICE			T		1	
7.00	Inpatient - General Care	-54, 932	0		0 0		7.00
8. 00	Inpatient - Respite Care	0	0		0 0	0	8. 00
0.00	VI SI TI NG SERVI CES			ı			0.00
9.00	Physi ci an Servi ces	0	0		0		9.00
10.00	Nursing Care	1, 677, 786	0		0		10.00
11. 00	Nursing Care-Continuous Home Care	0	0		0		11.00
12.00	Physical Therapy	0	0		0	0	12.00
13.00	Occupational Therapy	5(0.122	0		0	_	13.00
14.00	Speech/ Language Pathology	560, 132	0		0 0	_	14.00
15.00	Medical Social Services	0	0		0 0		15.00
16.00	Spiritual Counseling	0	0		-	_	16.00
17.00		0	0		0 0	0	17. 00 18. 00
18. 00 19. 00	Counseling - Other Home Health Aide and Homemaker	119, 984	0		0 0		19.00
20.00	HH Aide & Homemaker - Cont. Home Care	261, 777	0		0 0		20.00
21.00	Other	201, 777	0	1	0 0		21.00
21.00	OTHER HOSPICE SERVICE COSTS	l o			0 0	0	21.00
22. 00	Drugs, Biological and Infusion Therapy	0	0		0 0	0	22.00
	Anal gesi cs		0	•	0 0		23.00
24. 00	Sedatives / Hypnotics	0	0		0 0		24.00
25. 00	Other - Specify	39, 460	0				25. 00
26. 00	Durable Medical Equipment/Oxygen	07, 100	0			_	26.00
27. 00	Pati ent Transportati on	5, 547	0		0 0	_	27. 00
28. 00	Imaging Services	0,017	0			_	28. 00
29. 00	Labs and Diagnostics	0	0				29. 00
	Medical Supplies	0	0		0		30.00
31. 00	Outpatient Services (including E/R Dept.)	0	0		0		31.00
32.00	Radiation Therapy	0	0		0 0	0	32.00
33.00	Chemotherapy	0	0		0 0	0	33. 00
34.00	Other	0	0		0 0		34.00
	HOSPI CE NONREI MBURSABLE SERVI CE	- 1					
35.00	Bereavement Program Costs	0	0		0 0	0	35. 00
	Volunteer Program Costs	o	0		0 0	0	36.00
37.00	Fundrai si ng	o	0		0 0	0	37.00
38.00	Other Program Costs	0	0		0 0	0	38. 00
39.00	Total (sum of lines 1 thru 38)	5, 013, 128	0		0 0	0	39. 00
		·					

Health Financial S	Systems	ST.	FRANCIS HOSPITAL &	HEALT	H CEI	NTER		In Lie	u of	Form	CMS-255	2-10
				_			 					

Heal th	Financial Systems SI.	FRANCIS HOSPITA	L & HEALIH CEN	HER	in Lie	u of Form CMS-2552-1
COST A	ALLOCATION - HOSPICE GENERAL SERVICE COST		Provi der	CCN: 150162	Peri od:	Worksheet K-4
					From 01/01/2014	Part I
			Hospi ce	CCN: 151523	To 12/31/2014	
						5/26/2015 12:47 pm
		VOLUNTEED	CUDTOTAL	ADMINI CTDATI	Hospi ce I	
		VOLUNTEER	SUBTOTAL	ADMI NI STRATI		
		SERVI CES	(cols. 0 - 5)	E & GENERAL	5A ± col. 6)	
		COORDI NATOR	Ε.Δ	/ 00	7.00	
	OFFICE ALL OFFICE OF COOT OFFITEEN	5. 00	5A	6. 00	7. 00	
	GENERAL SERVICE COST CENTERS					
1.00	Capital Related Costs-Bldg and Fixt.					1.0
2. 00	Capital Related Costs-Movable Equip.					2.0
3.00	Plant Operation and Maintenance					3.0
4.00	Transportation - Staff					4.0
5.00	Volunteer Service Coordination	0				5.0
6.00	Administrative and General	0	2, 403, 374	2, 403, 3	74	6.0
	INPATIENT CARE SERVICE					
7.00	Inpatient - General Care	0	-54, 932	-50, 58	38 -105, 520	7.0
8.00	Inpatient - Respite Care	0	C		0 0	8.0
	VISITING SERVICES					
9.00	Physi ci an Servi ces	0	C		0 0	9. 0
10.00	Nursi ng Care	0	1, 677, 786	1, 545, 10	3, 222, 891	10.0
11.00	Nursing Care-Continuous Home Care	0	C		0 0	11.0
12.00	Physi cal Therapy	0	C		0	12.0
13. 00	Occupational Therapy	0	Ċ		0	13. 0
14. 00	Speech/ Language Pathology	0	560, 132	515, 83	1, 075, 969	14.0
15. 00	Medical Social Services	0	000,102	3.575	0 1,0,0,,0,	15. 0
16. 00	Spiritual Counseling	Ŏ	Č			16. 0
17. 00	Di etary Counsel i ng	Ŏ	ì			17. 0
18. 00	Counseling - Other	0			0	18. 0
19. 00	Home Health Aide and Homemaker	0	119, 984	110, 49	230, 480	19. 0
20. 00	HH Aide & Homemaker - Cont. Home Care	0	261, 777	•		20.0
21. 00	Other	0	201,777	241,0	0 502, 833	21. 0
21.00	OTHER HOSPICE SERVICE COSTS	U		1	U U	21.0
22.00		0			0 0	22. 0
22. 00 23. 00	Drugs, Biological and Infusion Therapy	0		(		22. 0
	Anal gesi cs			<u>'</u>	0	
24.00	Sedatives / Hypnotics	0	00.446	, ,	10 75 000	24. 0
25. 00	Other - Specify	0	39, 460	36, 34	75, 800	25. 0
26.00	Durable Medical Equipment/Oxygen	0			0 10 (55	26.0
27. 00	Patient Transportation	0	5, 547	5, 10	08 10, 655	27.0
28. 00	I maging Services	0	C	)	0	28. 0
29. 00	Labs and Diagnostics	0	C	)	0	29. 0
30.00	Medical Supplies	0	C	)	0 0	30.0
31.00	Outpatient Services (including E/R Dept.)	0	C	)	0 0	31.0
32.00	Radiation Therapy	0	C	)	0	32.0
33.00	Chemotherapy	0	C	)	0	33.0
34.00	Other	0	C	)	0 0	34.0
	HOSPICE NONREIMBURSABLE SERVICE					
35.00	Bereavement Program Costs	0	C		0 0	35.0
36.00	Volunteer Program Costs	0	C		0 0	36.0
37.00	Fundrai si ng	0	C	)	0 0	37.0
38.00	Other Program Costs	0	C	)	0 0	38.0
39.00	Total (sum of lines 1 thru 38)	0	5, 013, 128	8	5, 013, 128	39. 0
				•		•

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS

			·			5/26/2015 12:	47 pm_
					Hospi ce I		
		CAPITAL RE	LATED COST				
		BUILDINGS &	MOVABLE	PLANT	TRANSPORTATI 0	VOLUNTEER	
		FIXTURES (SQ.	EQUIPMENT (\$	OPERATION &	N (MILEAGE)	SERVI CES	
		FT.)	VALUE)	MAINT. (SQ.		COORDI NATOR	
				FT.)		(HOURS)	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.	0					1.00
2.00	Capital Related Costs-Movable Equip.	0	0				2.00
3.00	Plant Operation and Maintenance	0	0		0		3.00
4.00	Transportation - Staff	0	0		0		4.00
5.00	Volunteer Service Coordination	0	0		0	0	5.00
6.00	Administrative and General	0	0		0	0	6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	0	0		0	0	7.00
8. 00	Inpatient - Respite Care	0			0		8.00
0.00	VI SI TI NG SERVI CES				<u> </u>		0.00
9. 00	Physician Services	0	0		0 0	0	9.00
10.00	Nursing Care	0	0		0		10.00
11. 00	Nursing Care-Continuous Home Care	0	0		0		11.00
12. 00	Physical Therapy	0	0		0	-	12.00
13. 00	Occupational Therapy	0	0		0		13.00
14. 00	Speech/ Language Pathology	0	0		0	_	14.00
15. 00	Medical Social Services					_	15.00
16. 00	Spiritual Counseling		0				16.00
17. 00	Dietary Counseling		0			0	17.00
18.00	Counseling - Other	0	0		0		18.00
19. 00	Home Health Aide and Homemaker	0	0			0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0			-		20.00
21. 00	Other				0 0		20.00
21.00	OTHER HOSPICE SERVICE COSTS	1 0	l 0	<u> </u>	J <sub>1</sub> 0	0	21.00
22. 00	Drugs, Biological and Infusion Therapy	0	0		0 (	0	22.00
23. 00		0			0		23.00
	Anal gesi cs	0	0		0		24.00
24. 00	31	0	-				
25. 00	Other - Specify	0	0		0		25. 00
26.00	Durable Medical Equipment/Oxygen	0	0		0	0	26.00
27. 00	Pati ent Transportati on	0	0		0		27. 00
28. 00	I maging Services	0	0		0	_	28. 00
29. 00	Labs and Diagnostics	0	0		0	0	29. 00
30.00	Medi cal Supplies	0	0		0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0		0	0	31. 00
32.00	Radiation Therapy	0	0		0	0	32.00
33.00	Chemotherapy	0	0		0		33.00
34.00	Other	0	0		0	0	34.00
	HOSPI CE NONREI MBURSABLE SERVI CE						
35. 00	9	0	1		0		35.00
	Volunteer Program Costs	0	0	•	0	_	36.00
37. 00	Fundraising	0	0		0	0	37.00
38. 00	Other Program Costs	0	0		0	0	38. 00
39. 00	Cost to be Allocated (per Wkst. K-4, Part I)		0		0	0	39. 00
40. 00	Unit Cost Multiplier	0. 000000	0. 000000	0.00000	0.000000	0. 000000	40.00

					5/26/2015 12:47 pm
		1		Hospi ce I	
			ADMI NI STRATI V		
		N	E & GENERAL		
			(ACC. COST)		
	Tanana	6A	6. 00		
	GENERAL SERVICE COST CENTERS	T	Г		
1. 00	Capital Related Costs-Bldg and Fixt.	0			1.00
2.00	Capital Related Costs-Movable Equip.	0			2. 00
3.00	Plant Operation and Maintenance	0			3.00
4. 00	Transportation - Staff	0			4.00
5. 00	Volunteer Service Coordination				5. 00
6. 00	Administrative and General	-2, 403, 374	2, 609, 754		6. 00
	I NPATI ENT CARE SERVI CE				
7. 00	Inpatient - General Care	0			7.00
8.00	Inpatient - Respite Care	0	0		8. 00
	VISITING SERVICES				
9. 00	Physician Services	0			9. 00
10. 00	Nursing Care	0	1, 677, 786		10.00
11. 00	Nursing Care-Continuous Home Care	0	0		11.00
12. 00	Physi cal Therapy	0	0		12. 00
	Occupational Therapy	0	0		13.00
14.00	Speech/ Language Pathology	0	560, 132		14.00
	Medical Social Services	0	0		15. 00
16. 00		0	0		16.00
17. 00		0	0		17. 00
18. 00		0	0		18. 00
19. 00	Home Health Aide and Homemaker	0	119, 984		19. 00
20.00	HH Aide & Homemaker - Cont. Home Care	0	261, 777		20.00
21. 00	Other	0	0		21. 00
	OTHER HOSPICE SERVICE COSTS	1			
22. 00		0	0		22. 00
	Anal gesi cs	0	0		23. 00
24. 00	1	0	0		24. 00
	Other - Specify	0	39, 460		25. 00
26.00		0	0		26. 00
27. 00	Patient Transportation	0	5, 547		27. 00
28. 00	I maging Services	0	0		28. 00
29. 00	9	0	0		29. 00
30. 00	Medical Supplies	0	0		30.00
31. 00	Outpatient Services (including E/R Dept.)	0	0		31.00
32.00	1 113	0	0		32. 00
33.00	Chemotherapy	0	0		33.00
34.00	Other	0	0		34.00
	HOSPI CE NONREI MBURSABLE SERVI CE				
	Bereavement Program Costs	0	ı		35. 00
36. 00		0	1		36.00
	Fundrai si ng	0	0		37.00
38. 00	3	0	0		38. 00
39. 00	Cost to be Allocated (per Wkst. K-4, Part I)		2, 403, 374		39.00
40. 00	Unit Cost Multiplier		0. 920920		40.00

Health Financial Systems ST. FRANCIS HOALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS 

						3/20/2013 12.	47 pili
					Hospi ce I		
			CAPI TAL REI	LATED COSTS			
	Cost Center Description	Hospice Trial	NEW BLDG &	NEW MVBLE	EMPLOYEE	ADMITTI NG	
		Bal ance (1)	FIXT	EQUI P	BENEFITS		
					DEPARTMENT		
		0	1.00	2.00	4. 00	5. 01	
1.00	Administrative and General		258, 956	97, 462	198, 246	0	
2.00	Inpatient - General Care	-105, 520	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	0	4.00
5.00	Nursi ng Care	3, 222, 891	0	0	340, 628	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6. 00
7.00	Physi cal Therapy	O	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8. 00
9.00	Speech/ Language Pathology	1, 075, 969	0	0	0	0	9.00
10.00	Medi cal Soci al Servi ces	0	0	0	115, 408	0	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Di etary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	230, 480	0	0	24, 721	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	502, 853	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17. 00
18. 00	Anal gesi cs	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	75, 800	0	0	0	0	1
21. 00	Durable Medical Equipment/Oxygen	0	0	0	0	0	
22. 00	Patient Transportation	10, 655	0	0	0	0	22.00
23. 00	I maging Services	0	0	0	0	0	23. 00
24. 00	Labs and Diagnostics	0	0	0	0	0	
25. 00	Medical Supplies	0	0	0	0	0	
26. 00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27. 00	Radi ati on Therapy	0	0	0	0	0	27. 00
28. 00	Chemotherapy	0	0	0	0	0	
29. 00	Other	0	0	0	0	0	1
30.00	Bereavement Program Costs	0	n	l ő	0	0	30.00
31. 00	Volunteer Program Costs	0	n	l ő	0	Ö	31.00
32. 00	Fundrai si ng	0	n	,	n	Ö	1
33. 00	Other Program Costs		n	٥	0	0	1
34. 00	Total (sum of lines 1 thru 33) (2)	5, 013, 128	258, 956	97, 462	679, 003	0	34.00
	Unit Cost Multiplier (see instructions)	3, 313, 120	200, 700	,,, 402	377,003		35.00
33. 00	John C 3032 Mar Crpi (300 This Clauditions)	1 1					1 33.00

Health Financial Systems ST. FRANCIS HOALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS In Lieu of Form CMS-2552-10 Provi der CCN: 150162 | Peri od: From 01/01/2014 | Peri od: From 01/01/2014 | Peri od: From 01/01/2014 | Part I | Date/Time Prepared: 5/26/2015 12: 47 pm

						3/20/2013 12.	+/ piii
					Hospi ce I		
	Cost Center Description	Subtotal	CASHI ERI NG/AC	Subtotal	OTHER ADMIN &	OPERATION OF	
			COUNTS		GENERAL	PLANT	
			RECEI VABLE				
	Tarana arang ar	5A. 01	5. 02	5A. 02	5. 03	7. 00	
1. 00	Administrative and General	554, 664			· ·	217, 856	1.00
2.00	Inpatient - General Care	-105, 520	-1, 475	-106, 995	-23, 762	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	0	4.00
5.00	Nursing Care	3, 563, 519	49, 829	3, 613, 348	802, 478	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6. 00
7.00	Physi cal Therapy	0	0	0	0	0	7. 00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	1, 075, 969			· ·	0	9. 00
10.00	Medical Social Services	115, 408	1, 614	117, 022	25, 989	0	10.00
11. 00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Di etary Counsel i ng	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	255, 201	3, 568	258, 769	57, 469	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	502, 853	7, 031	509, 884	113, 239	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00	Anal gesi cs	0	0	0	0	0	18. 00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	75, 800	1, 060	76, 860	17, 070	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	10, 655	149	10, 804	2, 399	0	22.00
23.00	I maging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundrai si ng	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	6, 048, 549	84, 577	6, 133, 126	1, 362, 088	217, 856	34.00
35.00	Unit Cost Multiplier (see instructions)	0. 000000		0. 000000			35.00

Heal th FinancialSystemsST. FRANCIS HOALLOCATION OF GENERALSERVICE COSTS TO HOSPICE COST CENTERS 

						5/26/2015 12:	47 pili
					Hospi ce I		
	Cost Center Description	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	
		LINEN SERVICE				ADMI NI STRATI O	
						N	
		8. 00	9. 00	10.00	11. 00	13.00	
1.00	Administrative and General	0	47, 893		0	0 0	1.00
2.00	Inpatient - General Care	0	0		0	0 0	2.00
3.00	Inpatient - Respite Care	0	0		0	0 0	3.00
4.00	Physician Services	0	0		0	0 0	4.00
5.00	Nursi ng Care	0	0		0	0 0	5. 00
6.00	Nursing Care-Continuous Home Care	0	0		0	0 0	6. 00
7.00	Physi cal Therapy	0	0		0	0 0	7. 00
8.00	Occupational Therapy	0	0		0	0 0	8. 00
9.00	Speech/ Language Pathology	0	0		0	0 0	9. 00
10.00	Medical Social Services	0	0		0	0 0	10.00
11.00	Spiritual Counseling	0	0		0	0 0	11.00
12.00	Di etary Counseling	0	0		0	o o	12.00
13.00	Counseling - Other	0	0		0	o o	13.00
14.00	Home Health Aide and Homemaker	0	0		0	ol o	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0		0	ol o	15. 00
16.00	Other	0	0		0	ol o	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0		0	o o	17. 00
18.00	Anal gesi cs	0	0		0	o o	18. 00
19.00	Sedatives / Hypnotics	0	0		0	o o	19. 00
20.00	Other - Specify	0	0		0	o o	20.00
21.00	Durable Medical Equipment/Oxygen	0	0		0	o o	21.00
22.00	Patient Transportation	0	0		0	o o	22. 00
23.00	I maging Services	0	0		0	o o	23. 00
24.00	Labs and Diagnostics	0	0		0	o o	24.00
25.00	Medical Supplies	0	0		0	o o	25. 00
26.00	Outpatient Services (including E/R Dept.)	0	0		0	o o	26. 00
27.00	Radi ati on Therapy	0	0		0	ol o	27. 00
28.00	Chemotherapy	0	0		0	0 0	28. 00
29.00	Other	0	0		0	o o	29. 00
30.00	Bereavement Program Costs	0	0		0	o o	30.00
31.00	Volunteer Program Costs	0	0		0	0 0	31.00
32.00	Fundrai si ng	0	0		0	o o	32.00
33.00	Other Program Costs	0	0		0	0 0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	0	47, 893		0	0 0	34.00
	Unit Cost Multiplier (see instructions)						35.00
		1	1	'	•	•	

Health Financial Systems ST. FRANCIS HOALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS 

						3/20/2013 12.	47 pili
					Hospi ce I		
					INTERNS &	RESI DENTS	
	Cost Center Description	CENTRAL	PHARMACY	MEDI CAL	SERVI CES-SALA	SERVI CES-OTHE	
		SERVICES &		RECORDS &	RY & FRINGES	R PRGM COSTS	
		SUPPLY		LI BRARY			
		14. 00	15. 00	16. 00	21.00	22. 00	
1.00	Administrative and General	6, 038	0	9, 812	. 0	0	1.00
2.00	Inpatient - General Care	0	0	C	0	0	2.00
3.00	Inpatient - Respite Care	0	0	C	0	0	3.00
4.00	Physi ci an Servi ces	0	0	0	0	0	4.00
5.00	Nursi ng Care	0	0	0	0	0	5. 00
6.00	Nursing Care-Continuous Home Care	o	0	0	0	0	6.00
7.00	Physical Therapy	o	0	0	0	0	7.00
8.00	Occupational Therapy	o	0	0	0	0	8. 00
9.00	Speech/ Language Pathology	O	0	0	0	0	9. 00
10.00	Medical Social Services	O	0		0	0	10.00
11.00	Spiritual Counseling	o	0		0	0	11.00
12.00	Di etary Counseling	o	0	l c	0	0	12.00
13.00	Counseling - Other	o	0	l c	0	0	13.00
14. 00	Home Health Aide and Homemaker	o	0		0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	ol	0		0	0	15.00
16. 00	Other	0	0	0	0	Ō	1
17.00	Drugs, Biological and Infusion Therapy	ol	0		0	0	1
18. 00	Anal gesi cs	ol	0		0	0	18.00
19.00	Sedatives / Hypnotics	o	0		0	0	19.00
20.00	Other - Specify	o	0		0	0	1
21. 00	Durable Medical Equipment/Oxygen	0	0	i o	0	Ō	
22. 00	Patient Transportation	0	0	i o	0	0	22.00
23. 00	I maging Services	0	0	i o	0	Ō	23. 00
24. 00	Labs and Diagnostics	0	0	i o	0	Ō	
25. 00	Medical Supplies	0	0	i o	0	Ō	
26. 00	Outpatient Services (including E/R Dept.)	0	0	i o	0	Ō	26.00
27. 00	Radiation Therapy		0	0	0	Ō	27. 00
28. 00	Chemotherapy		0	0	0	ō	
29. 00	Other		0	0	0	Ō	
30.00	Bereavement Program Costs		0	l o	i o	o o	30.00
31. 00	Volunteer Program Costs		0	l o	i o	ő	31.00
32. 00	Fundrai si ng		0	l o	0	ő	1
33. 00	Other Program Costs		0		0	o o	1
34. 00	Total (sum of lines 1 thru 33) (2)	6, 038	0	9, 812	0	0	34.00
	Unit Cost Multiplier (see instructions)	3,030	O	,,012			35.00
55. 66	John Coose man erpiror (see Tristi detroils)	1 1		l	T	I	1 55.00

Health Financial Systems ST. FRANCIS HOSPITAL & HEALTH CENTER ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS Provider CCN: In Lieu of Form CMS-2552-10 

			nospi ce c	JON. 131323 11	3 12/31/2014	5/26/2015 12:	
					Hospi ce I		
	Cost Center Description	PARAMED ED	EMERGENCY	Subtotal	Intern &	Subtotal	
		PRGM	MEDI CAL	(cols. 4A-23)	Resi dents	(cols. 24 ±	
			SERVI CES		Cost & Post	25)	
					Stepdown		
					Adjustments		
		23. 00	23. 01	24. 00	25. 00	26. 00	
1.00	Administrative and General	0	0	7007720			1.00
2.00	Inpatient - General Care	0	0	-130, 757	0	-130, 757	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physi ci an Servi ces	0	0	0	0	0	4. 00
5.00	Nursing Care	0	0	4, 415, 826	0	4, 415, 826	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6. 00
7.00	Physi cal Therapy	0	0	0	0	0	7. 00
8.00	Occupational Therapy	0	0	0	0	0	8. 00
9. 00	Speech/ Language Pathology	0	0	1, 333, 314	0	1, 333, 314	9. 00
10.00	Medical Social Services	0	0	143, 011	0	143, 011	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Di etary Counsel i ng	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14. 00	Home Health Aide and Homemaker	0	0	316, 238	0	316, 238	
15. 00	HH Aide & Homemaker - Cont. Home Care	0	0	623, 123	0	623, 123	
16.00	Other	0	0	0	0	0	16.00
17. 00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18. 00	Anal gesi cs	0	0	0	0	0	18.00
19. 00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	93, 930	0	93, 930	20.00
21. 00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	13, 203	0	13, 203	
23.00	I maging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26. 00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29. 00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31. 00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundrai si ng	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	0	0	7, 776, 813	0	7, 776, 813	34.00
35. 00	Unit Cost Multiplier (see instructions)						35. 00

Hospi ce CCN: 151523

				Hospi ce	I	
	Cost Center Description	Allocated	Total Hospice			
		Hospi ce A&G	Costs (cols.			
		(See Part II)	26 ± 27)			
		27. 00	28. 00			
1.00	Administrative and General					1.00
2.00	Inpatient - General Care	-18, 610	-149, 367	'		2.00
3.00	Inpatient - Respite Care	0	0	)		3.00
4.00	Physi ci an Servi ces	0	0	)		4. 00
5.00	Nursi ng Care	628, 478	5, 044, 304	<u> </u>		5.00
6.00	Nursing Care-Continuous Home Care	0	0	)		6. 00
7.00	Physi cal Therapy	0	0	)		7. 00
8.00	Occupational Therapy	0	0	)		8. 00
9.00	Speech/ Language Pathology	189, 763		'		9. 00
10.00	Medical Social Services	20, 354	163, 365	از		10.00
11. 00	Spiritual Counseling	0	0	)		11.00
12.00	Di etary Counsel i ng	0	0	)		12.00
13.00	Counseling - Other	0	0	)		13.00
14.00	Home Health Aide and Homemaker	45, 008	361, 246			14.00
15.00	HH Aide & Homemaker - Cont. Home Care	88, 685	711, 808	3		15.00
16.00	Other	0	0	)		16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	)		17.00
18.00	Anal gesi cs	0	0	)		18. 00
19. 00	Sedatives / Hypnotics	0	0	)		19. 00
20.00	Other - Specify	13, 368	107, 298	<u></u>		20.00
21.00	Durable Medical Equipment/Oxygen	0	0	)		21.00
22.00	Patient Transportation	1, 879	15, 082	2		22. 00
23.00	I maging Services	0	0	)		23.00
24.00	Labs and Diagnostics	0	0	)		24.00
25.00	Medical Supplies	0	0	)		25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	)		26.00
27. 00	Radiation Therapy	0	0	)		27. 00
28.00	Chemotherapy	0	0	)		28. 00
29.00	Other	0	0	)		29. 00
30.00	Bereavement Program Costs	0	0	)		30.00
31.00	Volunteer Program Costs	0	0	)		31.00
32.00	Fundrai si ng	0	0	)		32.00
33.00	Other Program Costs	0	0	)		33.00
34.00	Total (sum of lines 1 thru 33) (2)		7, 776, 813	;		34.00
35.00	Unit Cost Multiplier (see instructions)	0. 142324				35.00

STATI STI CAL BASI S

					5/26/2015 12:	47 pm_
				Hospi ce I		
	CAPI TAL REL	ATED COSTS				
Cost Center Description	NEW BLDG &	NEW MVBLE	EMPLOYEE	ADMITTI NG	Reconciliatio	
	FLXT	EQUI P	BENEFITS	(I NPATI ENT	n	
	(SQUARE	(SQUARE	DEPARTMENT	CHARGES)		
	FEET)	FEET)	(GROSS	0.1.1.1020)		
	1	1 221)	SALARI ES)			
	1. 00	2. 00	4.00	5. 01	5A. 02	
1.00 Administrative and General	4, 120	4, 120		3.01		1.00
2.00 Inpatient - General Care	4, 120	4, 120	1	0	Ĭ	2.00
3.00 Inpatient - Respite Care		0	0	0		3.00
4.00 Physician Services		0	0	0		4.00
		0	1 222 021	0	-	
9	0	0	1, 332, 031	0	0	5.00
6.00 Nursing Care-Continuous Home Care	0	0	0	Ü	0	6.00
7.00 Physical Therapy	0	0	0	0	0	7.00
8.00 Occupational Therapy	0	0	0	0	0	8.00
9.00 Speech/ Language Pathology	0	0		0	0	9.00
10.00 Medical Social Services	0	0	451, 308	0	0	10.00
11.00 Spiritual Counseling	0	0	0	0	0	11. 00
12.00 Di etary Counseling	0	0	0	0	0	12.00
13.00 Counseling - Other	0	0	_	0	0	13.00
14.00 Home Health Aide and Homemaker	0	0	96, 673	0	0	14.00
15.00 HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00 Other	0	0	0	0	0	16.00
17.00 Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00 Anal gesi cs	o	0	0	0	0	18.00
19.00 Sedatives / Hypnotics	ol	0	0	0	0	19.00
20.00 Other - Specify	0	0	0	0	0	20.00
21.00 Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00 Patient Transportation		0	0	0	Ō	22.00
23.00   I maging Services		0		0	0	23. 00
24.00 Labs and Diagnostics		0		0	0	24.00
25.00 Medical Supplies		0		0	o o	25.00
26.00 Outpatient Services (including E/R Dept.)		0	ľ	0	o o	26.00
27. 00 Radi ati on Therapy		0	ľ	0	ő	27. 00
28.00 Chemotherapy		0	·	0		28.00
29. 00 Other		0	· ·	0		29.00
		0	0	0	-	
30.00 Bereavement Program Costs		0		0	0	30.00
31.00 Volunteer Program Costs	0	0		0	0	31.00
32. 00 Fundrai si ng	0	0	0	0	0	32.00
33.00 Other Program Costs	0	0	_	0	0	33.00
34.00 Total (sum of lines 1 thru 33) (2)	4, 120	4, 120			'	34.00
35.00 Total cost to be allocated	258, 956	97, 462			'	35.00
36.00  Unit Cost Multiplier (see instructions)	62. 853398	23. 655825	0. 255720	0. 000000	1	36. 00

Provi der CCN: 150162 | Peri od: | Worksheet K-5 | Prom 01/01/2014 | Part II STATISTICAL BASIS

						3/20/2013 12.	47 PIII
					Hospi ce I		
	Cost Center Description		Reconciliatio		OPERATION OF	LAUNDRY &	
		COUNTS	n	GENERAL	PLANT	LINEN SERVICE	
		RECEI VABLE		(ACCUM. COST)	(SQUARE	(POUNDS OF	
		(ACCUM. COST)			FEET)	LAUNDRY)	
		5. 02	5A. 03	5. 03	7. 00	8. 00	
1.00	Administrative and General	554, 664	<b>1</b>	562, 420	4, 120		1.00
2.00	Inpatient - General Care	-105, 520	0	-106, 995	0	0	2.00
3.00	Inpatient - Respite Care	C	0	0	0	0	3.00
4.00	Physi ci an Servi ces	C	0	0	0	0	4.00
5.00	Nursing Care	3, 563, 519	0	3, 613, 348	0	0	5.00
6.00	Nursing Care-Continuous Home Care	C	0	0	0	0	6.00
7.00	Physi cal Therapy	C	0	0	0	0	7.00
8.00	Occupational Therapy	C	0	0	0	0	8.00
9.00	Speech/ Language Pathology	1, 075, 969	0	1, 091, 014	0	0	9.00
10.00	Medical Social Services	115, 408	0	117, 022	0	0	10.00
11.00	Spiritual Counseling	C	0	0	0	0	11.00
12.00	Di etary Counseling	C	0	0	0	0	12.00
13.00	Counseling - Other	C	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	255, 201	0	258, 769	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	502, 853	0	509, 884	0	0	15.00
16.00	0ther	C	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	C	0	0	0	0	17.00
18.00	Anal gesi cs	C	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	C	0	0	0	0	19.00
20.00	Other - Specify	75, 800	0	76, 860	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	C	0	0	0	0	21.00
22.00	Pati ent Transportation	10, 655	0	10, 804	0	0	22.00
23.00	I maging Services	C	0	0	0	0	23. 00
24.00	Labs and Diagnostics	C	0	0	0	0	24.00
25.00	Medi cal Supplies	C	0	0	0	0	25. 00
26.00	Outpatient Services (including E/R Dept.)	C	0	0	0	0	26.00
27.00	Radi ati on Therapy	C	0	0	0	0	27.00
28.00	Chemotherapy	C	0	0	0	0	28. 00
29.00	Other	C	0	0	0	0	29.00
30.00	Bereavement Program Costs	C	0	0	0	0	30.00
31.00	Volunteer Program Costs	C	0	0	0	0	31.00
32.00	Fundrai si ng	C	0	0	0	0	32.00
33.00	Other Program Costs	C	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	6, 048, 549	)	6, 133, 126	4, 120	0	34.00
35.00	Total cost to be allocated	84, 577	1	1, 362, 088		0	35.00
36.00	Unit Cost Multiplier (see instructions)	0. 013983	1	0. 222087			36.00
		•	•	•			•

STATI STI CAL BASI S

						5/26/2015 12:	4/ pm
					Hospi ce I		
	Cost Center Description	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	
		(SQUARE	(TOTAL	(FTES)	ADMI NI STRATI O	SERVICES &	
		FEET)	PATIENT DAYS)		N	SUPPLY	
					(TOTAL	(COSTED	
					PATIENT DAYS)	REQUIS.)	
		9. 00	10. 00	11.00	13. 00	14.00	
1.00	Administrative and General	4, 120	0	1	0	48, 874	1.00
2.00	Inpatient - General Care	0	0	1	0	0	
3.00	Inpatient - Respite Care	0	0	1	0	0	
4.00	Physician Services	0	0	1	0	0	
5.00	Nursi ng Care	0	0	1	0	0	
6.00	Nursing Care-Continuous Home Care	0	0	1	0	0	6.00
7.00	Physi cal Therapy	0	0	1	0	0	7.00
8.00	Occupational Therapy	0	0	1	0	0	8.00
9.00	Speech/ Language Pathology	0	0	1	0	0	9. 00
10.00	Medical Social Services	0	0	1	0	0	10.00
11. 00	Spiritual Counseling	0	0	1	0	0	11.00
12.00	Di etary Counseling	0	0	1	0	0	12.00
13.00	Counseling - Other	0	0	)	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0		0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0		0	0	15.00
16.00	Other	0	0		0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0		0	0	17.00
18.00	Anal gesi cs	0	0		0	0	18.00
19.00	Sedatives / Hypnotics	0	0		0	0	19.00
20.00	Other - Specify	0	0		0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0		0	0	21.00
22.00	Patient Transportation	0	0		0	0	22.00
23.00	I maging Services	0	0		0	0	23.00
24.00	Labs and Diagnostics	0	0		0	0	24.00
25.00	Medical Supplies	0	0		0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0		0	0	26.00
27.00	Radi ati on Therapy	0	0		0	0	27.00
28.00	Chemotherapy	0	0		0	0	28. 00
29.00	Other	0	0		0	0	29.00
30.00	Bereavement Program Costs	0	0		0	0	30.00
31.00	Volunteer Program Costs	0	0		0	0	31.00
32.00	Fundrai si ng	0	0		0	0	32.00
33.00	Other Program Costs	0	0	)	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	4, 120	0	)	0	48, 874	34.00
35.00	Total cost to be allocated	47, 893	0	1	0	6, 038	35.00
36. 00	Unit Cost Multiplier (see instructions)	11. 624515	0. 000000	0.0000	0. 000000	0. 123542	36.00

STATI STI CAL BASI S

					5/26/2015 12:	47 pm_
				Hospi ce I		
			INTERNS &	RESI DENTS		
Cost Center Description	PHARMACY	MEDI CAL	SERVI CES-SALA	SERVI CES-OTHE	PARAMED ED	
	(COSTED	RECORDS &	RY & FRINGES	R PRGM COSTS	PRGM	
	REQUIS.)	LI BRARY	(ASSI GNED	(ASSI GNED	(ASSI GNED	
	1,220,0,7	(GROSS	TIME)	TIME)	TIME)	
		CHARGES)	'''''''	I I WL	II WL)	
	15. 00	16. 00	21. 00	22.00	23. 00	
1 00   Administrative and Conseque		7, 300, 668		22.00		1 00
1.00 Administrative and General	0	7, 300, 668		0	0	1.00
2.00 Inpatient - General Care	0	0	0	0	0	2.00
3.00 Inpatient - Respite Care	0	0	0	0	0	3. 00
4.00 Physician Services	0	0	0	0	0	4. 00
5.00 Nursing Care	0	0	0	0	0	5.00
6.00 Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00 Physical Therapy	0	0	0	0	0	7.00
8.00 Occupational Therapy	0	0	0	0	0	8.00
9.00 Speech/ Language Pathology		0	0	o	0	9.00
10.00 Medical Social Services	o	0	l o	o	0	10.00
11.00 Spiritual Counseling	0	0	0	0	0	11.00
12.00 Di etary Counsel i ng		0	1	0	0	12.00
13. 00   Counsel i ng - Other		0	١	0	0	13. 00
14.00 Home Health Aide and Homemaker		0		0	Ö	14. 00
15.00 HH Aide & Homemaker - Cont. Home Care		0		0	0	15. 00
16.00 Other		0		0	0	16. 00
		0	0	0	0	17. 00
1 3 . 3	0	ū		0	_	
18.00 Anal gesi cs	0	0		0	0	18.00
19.00   Sedatives / Hypnotics	0	0	0	0	0	19. 00
20.00 Other - Specify	0	0	· -	_	0	20.00
21.00 Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00 Patient Transportation	0	0	0	0	0	22.00
23.00   I maging Services	0	0	0	0	0	23.00
24.00 Labs and Diagnostics	0	0	0	0	0	24.00
25.00 Medical Supplies	0	0	0	0	0	25.00
26.00 Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00 Radiation Therapy	0	0	0	0	0	27.00
28.00 Chemotherapy	o	0	0	o	0	28.00
29. 00 Other	0	0	0	o	0	29. 00
30.00 Bereavement Program Costs	o	0	l o	o	0	30.00
31.00 Volunteer Program Costs	ا	0	l o	n	0	31.00
32.00 Fundrai si ng		n	l	n	Ö	32.00
33.00 Other Program Costs		0		0	Ö	33. 00
34.00 Total (sum of lines 1 thru 33) (2)		7, 300, 668			0	34.00
35.00 Total cost to be allocated		7, 300, 668 9, 812			0	35. 00
	9	· ·		0 000000	_	
36.00   Unit Cost Multiplier (see instructions)	0. 000000	0. 001344	0. 000000	0. 000000	0. 000000	36. 00

Health Financial Systems	ST. FRANCIS HOSPITAL &	HEALTH CENTER	In Lieu	of Form CMS-2552-10
ALLOCATION OF GENERAL SERVICE COSTS T STATISTICAL BASIS	TO HOSPICE COST CENTERS	Provi der CCN: Hospi ce CCN:	From 01/01/2014	Worksheet K-5 Part II Date/Time Prepared:
				5/26/2015 12:47 pm
			l Hospice I	

			3/20/2013 12.4	47 pili
		Hospi ce I		
Cost Center Description	EMERGENCY			
	MEDI CAL			
	SERVI CES			
	(ASSI GNED			
	TIME)			
	23. 01			
1.00 Administrative and General	0			1. 00
2.00 Inpatient - General Care	o o			2.00
3.00 Inpatient - Respite Care				3. 00
4. 00 Physi ci an Servi ces	0			4.00
5. 00 Nursing Care	0			5.00
6.00 Nursing Care-Continuous Home Care	0			6.00
7. 00 Physi cal Therapy	0			7.00
8.00 Occupational Therapy	0			8.00
9.00 Speech/ Language Pathology	0			9.00
10.00 Medical Social Services	0			10.00
11.00  Spiritual Counseling	0			11.00
12.00 Dietary Counseling	0			12.00
13.00 Counseling - Other	O			13.00
14.00 Home Health Aide and Homemaker	o			14.00
15.00 HH Aide & Homemaker - Cont. Home Care	o			15.00
16.00 Other	O			16.00
17.00 Drugs, Biological and Infusion Therapy	o			17. 00
18. 00 Anal gesi cs	l ol			18. 00
19.00   Sedatives / Hypnotics	o o			19. 00
20.00 Other - Specify	0			20.00
21.00 Durable Medical Equipment/Oxygen				21.00
22.00 Patient Transportation	0			22.00
23. 00   I maging Services	0			23.00
24.00 Labs and Diagnostics	0			24.00
25. 00 Medical Supplies				25. 00
26.00 Outpatient Services (including E/R Dept.)				26.00
	1			27.00
27.00 Radiation Therapy	0			
28.00 Chemotherapy	0			28.00
29.00 Other	0			29.00
30.00 Bereavement Program Costs	0			30.00
31.00 Volunteer Program Costs	0			31.00
32.00 Fundrai si ng	0			32.00
33.00 Other Program Costs	0			33.00
34.00 Total (sum of lines 1 thru 33) (2)	0			34.00
35.00 Total cost to be allocated	0			35.00
36.00 Unit Cost Multiplier (see instructions)	0. 000000			36.00

Heal th	Financial Systems ST. FRANCIS HOSPIT	AL & HEALTH CEN	ITER	In Lie	u of Form CMS-:	2552-10
COMPUT	ATION OF TOTAL HOSPICE SHARED COSTS	Provi der		Peri od:	Worksheet K-5	
				From 01/01/2014		
		Hospi ce (	CCN: 151523	To 12/31/2014		pared:
				Hospi ce I	5/26/2015 12:	47 piii
	Cost Center Description	Wkst. C, Part	Cost to	Total Hospice	Hospi ce	
	COST CERTER DESCRIPTION	I, col. 11	Charge Ratio		Shared	
		line	Charge Ratic	(Provi der	Ancillary	
		Title		Records)	Costs (cols.	
				Records)	1 x 2)	
		0	1.00	2.00	3.00	
	ANCILLARY SERVICE COST CENTERS		1.00	2.00	3.00	
1. 00	PHYSI CAL THERAPY	66.00	0. 27221	5 0	0	1.00
1. 01	SPORTS MEDICINE	66. 01	•		0	
2. 00	OCCUPATIONAL THERAPY	67.00	•		0	2.00
3. 00	SPEECH PATHOLOGY	68.00	•		0	
4. 00	DRUGS CHARGED TO PATIENTS	73.00	•		0	ı
5. 00	DURABLE MEDI CAL EQUI P-RENTED	96.00	•	0	0	5.00
6. 00	LABORATORY	60.00	1	.3	0	
6. 01	BLOOD LABORATORY	60. 01	l	0	Ŭ	6. 01
7. 00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	l	.8	0	7.00
8. 00	OTHER OUTPATIENT SERVICE COST CENTER	93.00		0	Ŭ	8.00
9. 00	RADI OLOGY - THERAPEUTI C	55. 00		1 0	0	1
10.00	OTHER ANCILLARY SERVICE COST CENTERS	76.00			Ŭ	10.00
10. 97	CARDI AC REHABI LI TATI ON	76. 97	l	0	0	
11. 00	Totals (sum of lines 1-10)	70.77	3. 40033		0	1
11.00	Total's (sum of filles 1 to)	I	I	Ţ	0	1 11.00

Heal th	Financial Systems ST. FRANCIS HOSPITA	L & F	HEALTH CEN	TER		In Lie	u of Form CMS-2	2552-10
CALCUL	ATION OF HOSPICE PER DIEM COST		Provi der	CCN: 15		Peri od:	Worksheet K-6	
			Hospi ce (	CCN: 1		From 01/01/2014 To 12/31/2014	Date/Time Pre 5/26/2015 12:	
						Hospi ce I		
		Ti t	le XVIII	Ti tl	e XIX	Other	Total	
			1.00	2	. 00	3. 00	4.00	
1.00	Total cost (see instructions)						7, 776, 813	1.00
2.00	Total Unduplicated Days (Worksheet S-9, column 6, line 5)						22, 437	2.00
3.00	Average cost per diem (line 1 divided by line 2)						346. 61	3.00
4. 00	Upduplicated Medicare Days (Worksheet S-9, column 1, line 5)		0					4. 00
5.00	Aggregate Medicare cost (line 3 time line 4)	İ	0					5.00
6. 00	Unduplicated Medicaid Days (Worksheet S-9, column 2, line 5)				82	6		6. 00
7.00	Aggregate Medicaid cost (line 3 time line 60)				286, 30	0		7.00
8.00	Upduplicated SNF Days (Worksheet S-9, column 3, line 5)		0					8. 00
9.00	Aggregate SNF cost (line 3 time line 8)		0					9. 00
10.00	Unduplicated NF Days (Worksheet S-9, column 4, line 5)					0		10.00
11.00	Aggregate NF cost (line 3 times line 10)					0		11.00
12.00	Other Unduplicated days (Worksheet S-9, column 5, line 5)					21, 611		12.00
13.00	Aggregate cost for other days (line 3 times line 12)					7, 490, 589		13.00

	Financial Systems ST. FRANCIS HOSPITAL & ATION OF CAPITAL PAYMENT	Provi der CCN: 150162	Peri od:	u of Form CMS-2 Worksheet L	
ONLOGE	ATTOM OF ONLINE TAIMENT	17.001 001. 130102	From 01/01/2014 To 12/31/2014	Parts I-III	pared: 47 pm
		Title XVIII	Hospi tal	PPS	
				1. 00	
	PART I - FULLY PROSPECTIVE METHOD				
4 00	CAPITAL FEDERAL AMOUNT			F (00 7/F	4 00
1.00	Capital DRG other than outlier			5, 622, 765	1.00
1. 01	Model 4 BPCI Capital DRG other than outlier			007.034	1. 0° 2. 00
2. 00 2. 01	Capital DRG outlier payments			887, 926 0	2.00
3. 00	Model 4 BPCI Capital DRG outlier payments  Total inpatient days divided by number of days in the cost rep	porting ported (see ins	tructions)	227. 28	3.00
4. 00	Number of interns & residents (see instructions)	of triig perrod (see riis	tructrons)	17. 46	4.0
5. 00	Indirect medical education percentage (see instructions)			2. 19	5. 0
6. 00	Indirect medical education adjustment (multiply line 5 by the	sum of lines 1 and 1 0	1)	123, 139	6. 0
7. 00	Percentage of SSI recipient patient days to Medicare Part A pa			3. 33	7. 0
	30) (see instructions)		_,		
8. 00	Percentage of Medicaid patient days to total days (see instruc	ctions)		17. 06	8. 0
9. 00	Sum of lines 7 and 8			20. 39	9. 0
10.00	Allowable disproportionate share percentage (see instructions)	4. 22	10.0		
11.00	Disproportionate share adjustment (line 10 times the sum of li	nes 1 and 1.01)		237, 281	11.00
12. 00	Total prospective capital payments (sum of lines 1, 1.01, 2, 2	2.01, 6 and 11)		6, 871, 111	12.0
				1. 00	
	PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)			0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)			0	2.0
3.00	Total inpatient program capital cost (line 1 plus line 2)			0	3. 0
4.00	Capital cost payment factor (see instructions)			0	4.0
5.00	Total inpatient program capital cost (line 3 x line 4)			0	5. 0
				1. 00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1. 00	Program inpatient capital costs (see instructions)			0	1.00
2. 00	Program inpatient capital costs for extraordinary circumstance	es (see instructions)		0	2. 0
3.00	Net program inpatient capital costs (line 1 minus line 2)			0	3. 0
4. 00	Applicable exception percentage (see instructions)			0. 00	4. 0
5. 00	Capital cost for comparison to payments (line 3 x line 4)			0	5.0
6. 00	Percentage adjustment for extraordinary circumstances (see ins			0. 00	6.0
7.00	Adjustment to capital minimum payment level for extraordinary	circumstances (line 2	x line 6)	0	7.0
8.00	Capital minimum payment level (line 5 plus line 7)			0	8.0
9.00	Current year capital payments (from Part I, line 12, as applic		1000 line ()	0	9.0
10. 00 11. 00	Current year comparison of capital minimum payment level to ca			0	10. 0 11. 0
11.00	Carryover of accumulated capital minimum payment level over ca Worksheet L, Part III, line 14)	ipi tai payillerit (Trolli pi	i or year	U	11.0
12 00		ments (line 10 nlus li		0	

Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)

Current year exception payment (if line 12 is positive, enter the amount on this line)

Carryover of accumulated capital minimum payment level over capital payment for the following period

(if line 10 is prosective, enter the amount on this line)

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

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

16.00 Current year operating and capital costs (see instructions)

17.00 | Current year exception offset amount (see instructions)

0

0 14.00

0 15.00

0 16.00 0 17.00

12.00

0 13.00

12.00

13.00

14.00