			To 12/31/2016	Date/Time Pr 6/28/2017 3:	
PART I - COST	REPORT STATUS				
Provi der use only	<ol> <li>[ X ] Electronically filed cost report</li> <li>[ ] Manually submitted cost report</li> <li>[ 0 ] If this is an amended report enter the number of</li> </ol>		Date: 6/28/20 esubmitted this co		3:42 pm
Contractor use only	4. [F] Medicare Utilization. Enter "F" for full or "L"  5. [1] Cost Report Status	10. N 11. C r this Provider CCN 12. [	NPR Date: Contractor's Vendo [ O ]If line 5, co number of tim	lumn 1 is 4:	

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 FRANCISCAN HEALTH CRAWFORDSVILLE (15-0022) for the cost reporting period beginning 01/01/2016 and ending 12/31/2016 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

(Si gned)	
	Officer or Administrator of Provider(s)
Ti	tle

Date

			Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	HIT	Title XIX	
		1.00	2.00	3.00	4. 00	5. 00	
·	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	-23, 439	137, 314	-376, 608	0	1. 00
2.00	Subprovi der - IPF	0	0	0		0	2. 00
3.00	Subprovi der - IRF	0	0	0		0	3. 00
4.00	SUBPROVI DER I						4.00
5.00	Swing bed - SNF	0	0	0		0	5. 00
6.00	Swing bed - NF	0				0	6. 00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7. 00
8.00	NURSING FACILITY	0				0	8. 00
10.00	RURAL HEALTH CLINIC I	0		0		0	10.00
11. 00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11. 00
200.00	Total	0	-23, 439	137, 314	-376, 608	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.

							From 01/01 To 12/31	/2016	Part I Date/Ti		
	1.00	2.	. 00		3. 00			4. 00	6/28/20	1/ 3:4	1 pm
	Hospital and Hospital Health Care Co										
1.00	Street: 1710 LAFAYETTE RD.	PO Box:			47000		HONTOON	-DV			1.00
2.00	City: CRAWFORDSVILLE	State:     Component Na		CCN COde	2: 47933 CBSA	Provi der	ty: MONTGOM Date		nt Syst	om (P	2. 00
		oomponerte ne		umber	Number		Certi fi ed		0, or		
								V	XVIII		
	Hospital and Hospital-Based Componen	1.00		2.00	3. 00	4.00	5. 00	6. 00	7. 00	8. 00	
3.00	Hospi tal	FRANCI SCAN HEALT		50022	99915	1	01/01/196	5 N	Р	0	3. 00
		CRAWFORDSVI LLE								_	
4.00	Subprovi der - IPF	FRANCISCAN HEALT CRAWFORDSVILLE P		5S022	99915	4	01/01/199!	5 N	P	0	4. 00
5.00	Subprovider - IRF	CRAWI ORDSVILLE F	31								5. 00
6.00	Subprovider - (Other)										6. 00
7. 00 8. 00	Swing Beds - SNF										7. 00 8. 00
9. 00	Swing Beds - NF Hospital-Based SNF										9. 00
10.00	Hospi tal -Based NF										10. 00
10. 01	ICF/IID										10. 01
11. 00 12. 00	Hospi tal -Based OLTC Hospi tal -Based HHA										11. 00 12. 00
13. 00	Separately Certified ASC										13. 00
14.00	Hospi tal -Based Hospi ce										14.00
15. 00 16. 00	Hospital-Based Health Clinic - RHC Hospital-Based Health Clinic - FQHC										15. 00 16. 00
17. 00	Hospital-Based (CMHC) I										17. 00
17. 10	Hospital-Based (CORF) I										17. 10
18.00	Renal Dialysis										18.00
19. 00	Other						From	1.	To		19. 00
							1.00	)	2.0	00	
20.00	Cost Reporting Period (mm/dd/yyyy)						01/01/	2016	12/31/	2016	20.00
21. 00	Type of Control (see instructions) Inpatient PPS Information						2				21. 00
22. 00	Does this facility qualify and is it								N		22. 00
	share hospital adjustment, in accord										
	for yes or "N" for no. Is this facil amendment hospital?) In column 2, en				2. 106(C,	) (2) (PI CKI	е				
22. 01	Did this hospital receive interim un	compensated care	payments f	for thi			N		N		22. 01
	period? Enter in column 1, "Y" for y reporting period occurring prior to										
	for no for the portion of the cost r				_						
	(see instructions)		J								
22. 02	Is this a newly merged hospital that determined at cost report settlement						N N		N		22. 02
	or "N" for no, for the portion of th						:5				
	in column 2, "Y" for yes or "N" for	no, for the porti	on of the	cost r	eporti no	g period o	n				
22 02	or after October 1. Did this hospital receive a geograph	ic roclassificati	on from ur	chan to	rural d	ae a rocul	t N		N		22. 03
22. 03	of the OMB standards for delineating								14		22.03
	in column 1, "Y" for yes or "N" for	no for the portio	on of the c	cost re	porti ng	peri od					
	prior to October 1. Enter in column cost reporting period occurring on o						e				
	hospital contain at least 100 but no						h				
	42 CFR 412.105)? Enter in column 3,										
23. 00	Which method is used to determine Me 1, enter 1 if date of admission, 2 i							2	N		23. 00
	method of identifying the days in th	is cost reportino	g period di	fferen	t from <sup>.</sup>	the method					
	used in the prior cost reporting per	iod? In column 2	2, enter "Y In-State	/" for In-St		"N" for no Out-of		Medi cai	4 0	ther	
			Medi cai d	Medi		State		HMO day		i cai d	
			paid days	eligi	ble M	edi cai d	Medi cai d			ays	
				unpa day		aid days	el i gi bl e unpai d				
			1.00	2. 0		3. 00	4. 00	5. 00	6	. 00	
24. 00	If this provider is an IPPS hospital		(	_	0	0	0	2.00	0	0	24. 00
	in-state Medicaid paid days in colum										
	Medicaid eligible unpaid days in col out-of-state Medicaid paid days in c										
	out-of-state Medicaid eligible unpai	d days in column									
	4, Medicaid HMO paid and eligible bu										
	column 5, and other Medicaid days in	COT WHILE O.	I	I	I	1	l		I		

Health Financial Systems FRANCISCAN	HFALTH CRA	WFORDSVLLLE	F		In Lieu	ມ of For	m CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA		Provi der CC		Peri od:		Workshe		
				From 01/0 To 12/3	1/2016			
	In-State	In-State	Out-of	Out-of	Medi ca	6/28/20 i d 0	11/ 3:4 ther	I pm
	Medicaid paid days	Medicaid eligible	State Medicaid	State Medi cai d	HMO da	- I	di cai d days	
	paru uays	unpai d	paid days	el i gi bl e			iays	
	1.00	days	0.00	unpai d				
25.00 If this provider is an IRF, enter the in-state	1.00	2.00	3.00	4. 00	5. 00	0	5. 00	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.				Urban/R				
26.00 Enter your standard geographic classification (not wa	nge) status	at the bed	ainnina of t	1. (	2	2. (	00	26. 00
cost reporting period. Enter "1" for urban or "2" for	rural.	_						
27.00 Enter your standard geographic classification (not wa reporting period. Enter in column 1, "1" for urban or				sτ	2			27. 00
enter the effective date of the geographic reclassifi	cation in	column 2.						25.00
35.00 If this is a sole community hospital (SCH), enter the effect in the cost reporting period.	e number or	periods so	LH Status in	1	0			35. 00
				Begi nr		Endi 2. (		
36.00 Enter applicable beginning and ending dates of SCH st		cript line	36 for numb		50	2. (	<i>5</i> 0	36. 00
of periods in excess of one and enter subsequent date 37.00 If this is a Medicare dependent hospital (MDH), enter		r of period	ds MDH statu	IS	1			37. 00
is in effect in the cost reporting period.								27.01
37.01 Is this hospital a former MDH that is eligible for the accordance with FY 2016 OPPS final rule? Enter "Y" for				N				37. 01
instructions) 38.00 If line 37 is 1, enter the beginning and ending dates	of MDH st	atus Ifli	ne 37 is	01/01/	/2016	12/31,	/2016	38. 00
greater than 1, subscript this line for the number of				017017	2010	12/ 51/	2010	30.00
enter subsequent dates.				Y/	N	Y/	'N	
	<u> </u>		~	1. (	00	2. (	00	22.22
39.00 Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(ii						Y		39. 00
or "N" for no. Does the facility meet the mileage red CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes				.)				
40.00 Is this hospital subject to the HAC program reduction	n adjustmen	t? Enter "Y	" for yes o	or Y	,	N		40. 00
"N" for no in column 1, for discharges prior to Octob no in column 2, for discharges on or after October 1.			es or "N" f	for				
				'	V	XVIII	XIX	
Prospective Payment System (PPS)-Capital					1. 00	2. 00	3.00	
45.00 Does this facility qualify and receive Capital paymer with 42 CFR Section §412.320? (see instructions)	nt for disp	roporti onat	te share in	accordance	N	N	N	45. 00
46.00 Is this facility eligible for additional payment exce					N	N	N	46. 00
pursuant to 42 CFR §412.348(f)? If yes, complete Wkst Pt. III.	. L, Pt. I	II and Wkst	t. L-1, Pt.	I through				
47.00 Is this a new hospital under 42 CFR §412.300 PPS capi		,			N	N	N	47. 00
48.00 Is the facility electing full federal capital payment Teaching Hospitals	:? Enter "	Y" for yes	or "N" for	no.	N	N	N	48. 00
56.00 Is this a hospital involved in training residents in	approved G	ME programs	s? Enter "Y	" for yes	N			56. 00
or "N" for no. 57.00   If line 56 is yes, is this the first cost reporting p	eriod duri	ng which re	esidents in	approved				57. 00
GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mont	,				- 1			
for yes or "N" for no in column 2. If column 2 is "Y	", complet	e Worksheet						
"N", complete Wkst. D, Parts III & IV and D-2, Pt. II 58.00   If line 56 is yes, did this facility elect cost reimb			ans' service	s as	N			58. 00
defined in CMS Pub. 15-1, chapter 21, §2148? If yes,	complete W	kst. D-5.			N.			59.00
59.00 Are costs claimed on line 100 of Worksheet A? If yes 60.00 Are you claiming nursing school and/or allied health				he	N N			60.00
provider-operated criteria under §413.85? Enter "Y"	for yes or	"N" for no	o. (see inst Direct GM		F I	Di rec	t GMF	
61.00 Did your hospital receive FTE slots under ACA	1. 00 N	2. 00	3. 00	4. (	0.00	5. (		61.00
section 5503? Enter "Y" for yes or "N" for no in	"				5.00		5. 00	]
column 1. (see instructions) 61.01 Enter the average number of unweighted primary care		0. 00	c	0. 00				61. 01
FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see								
instructions)								

IOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	ΓΑ	Provi der CCI		Period: From 01/01/2016 To 12/31/2016	Worksheet S-2 Part I Date/Time Pre 6/28/2017 3:4	pared
	Y/N	IME	Direct GME	I ME	Direct GME	
	1. 00	2. 00	3. 00	4. 00	5. 00	
51.02 Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0. (	00		61. (
21.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0. (	od		61. (
51.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).		0.00	0. (	00		61. (
and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0. (	00		61.0
on 1.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0. (			61. (
	Pro	ogram Name	Program Code	FTE Count	Direct GME FTE Count	
4 40 00 11 575 1 11 14 05		1. 00	2. 00	3.00	4.00	
of the FTEs in line 61.05, specify each new program special ty, 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.  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 4, direct GME FTE unweighted count.				0. 00		61. 2
					1.00	
ACA Provisions Affecting the Health Resources and Ser				alad for while	0.00	(2.2.5
2.00 Enter the number of FTE residents that your hospital your hospital received HRSA PCRE funding (see instruction 2.01 Enter the number of FTE residents that rotated from a	ti ons) Teachi	ng Health Cent	er (THC) into			62. C
during in this cost reporting period of HRSA THC prog Teaching Hospitals that Claim Residents in Nonprovide			s)			
3.00 Has your facility trained residents in nonprovider se			st reporting	period? Enter	N	l 63. (
"Y" for yes or "N" for no in column 1. If yes, comple			<u>instructions</u>	<u>,                                      </u>		
			Unwei ghted	Unwei ghted	Ratio (col. 1/	

62.00	enter the number of FIE resident			reporting peri	od for which	0.00	62.00				
62 01	your hospital received HRSA PCRE Enter the number of FTE resident			tor (TUC) into	vour boenital	0.00	62. 01				
02.01	during in this cost reporting pe				your nospital	0.00	02.01				
	Teaching Hospitals that Claim Re			13)							
63 00	Has your facility trained reside		3	st renorting n	eriod? Enter	N	63. 00				
00.00	"Y" for yes or "N" for no in col				cirou. Eine		00.00				
	,	amir ii ii yee, sempie	(888)	Unwei ghted	Unweighted	Ratio (col. 1/					
				FTEs	FTEs in	(col. 1 + col.					
				Nonprovi der	Hospi tal	2))					
				Si te							
				1. 00	2.00	3.00					
	Section 5504 of the ACA Base Yea	ar FTE Residents in No	onprovider Settings	This base year	is your cost n	eporting					
	period that begins on or after J	July 1, 2009 and befor	re June 30, 2010.								
64.00	Enter in column 1, if line 63 is			0.00	0. 00	0. 000000	64. 00				
	in the base year period, the num										
	resident FTEs attributable to re										
	settings. Enter in column 2 the										
	resident FTEs that trained in yo										
	of (column 1 divided by (column		•			D 11 ( 1 0 (					
		Program Name	Program Code	Unweighted	Unwei ghted	Ratio (col. 3/					
				FTES	FTEs in	(col. 3 + col.					
				Nonprovi der Si te	Hospi tal	4))					
		1 00	2.00		4.00	F 00					
	1.00 2.00 3.00 4.00 5.00										

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0022 Peri od: Worksheet S-2 From 01/01/2016 Part I Date/Time Prepared: 12/31/2016 6/28/2017 3:41 pm Program Code Unwei ghted Unwei ghted Program Name Ratio (col. 3/ (col. 3 + col FTEs FTEs in Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3.00 4.00 5.00 0. 00 0. 00 0.000000 65.00 65.00 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code, enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) Unwei ghted Unwei ghted Ratio (col. 1/ FTEs FTEs in (col. 1 + col Nonprovi der Hospi tal 2)) Si te 1.00 2.00 3.00 Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010 Enter in column 1 the number of unweighted non-primary care resident 0.00 0. 00 0.000000 66.00 FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions) Program Name Unwei ghted Ratio (col. 3/ Program Code Unwei ahted FTES FTEs in (col. 3 + col Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3. 00 4.00 5.00 67.00 Enter in column 1, the program 0.000000 67.00 0.00 0.00 name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)) (see instructions) 1.00 2.00 3.00 Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? 70.00 Enter "Y" for yes or "N" for no. 71.00 If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most O Ν N 71.00 recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) Inpatient Rehabilitation Facility PPS 75.00 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF N 75.00 subprovider? Enter "Y" for yes and "N" for no. If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most 76.00 recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)

lealth Financial Systems FRANCISCAN HEALTH	CRAWFORDSVI LL	E		In Lie	u of Forr	n CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider Co	CN: 15-0022	Peri od: From 01/0 To 12/3	1/2016 1/2016		ne Pre	pared:
					6/28/20	17 3:4	I pm
Long Term Care Hospi tal PPS					1.0	0	
0.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes	s and "N" for	no.			N		80.00
1.00 Is this a LTCH co-located within another hospital for part on "Y" for yes and "N" for no.			ng period?	Enter	N		81.00
TEFRA Providers 5.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i)	) TFFRA? Ente	r "Y" for ve	s or "N" fo	r no	N		85. OC
6.00 Did this facility establish a new Other subprovider (exclude §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.	ed unit) under	42 CFR Sect	i on				86.00
7.00 Is this hospital a "subclause (II)" LTCH classified under se for yes or "N" for no.	ection 1886(d)	(1) (B) (i v) (I	I)? Enter "	Υ"	N		87. 00
TOT YES OF NOTION.			V		XIX	(	
T			1. 0	00	2. 0	0	1
Title V and XIX Services  0.00 Does this facility have title V and/or XIX inpatient hospita	al sarvicas? F	nter "V" for	· N		Y		90.00
yes or "N" for no in the applicable column.	ai seivices: L	inter i roi	14		'		70.00
1.00 Is this hospital reimbursed for title V and/or XIX through 1 full or in part? Enter "Y" for yes or "N" for no in the appl	licable column		N		Y		91.00
2.00 Are title XIX NF patients occupying title XVIII SNF beds (dulinstructions) Enter "Y" for yes or "N" for no in the application.		ion)? (see			N		92.00
3.00 Does this facility operate an ICF/IID facility for purposes "Y" for yes or "N" for no in the applicable column.		d XIX? Enter	N		N		93.00
4.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, applicable column.	and "N" for n	o in the	N		N		94.00
5.00 $ f $ line 94 is "Y", enter the reduction percentage in the app			0.0		0.0	0	95. 00
6.00 Does title V or XIX reduce operating cost? Enter "Y" for yes applicable column.	s or "N" for n	o in the	N		N		96.00
7.00 If line 96 is "Y", enter the reduction percentage in the app	plicable colum	n.	0.0	00	0.0	0	97. 00
Rural Providers  05.00 Does this hospital qualify as a critical access hospital (CA)	AH)?		N				105. 00
06.00 If this facility qualifies as a CAH, has it elected the all-		hod of payme	nt				106. 00
for outpatient services? (see instructions) 07.00 If this facility qualifies as a CAH, is it eligible for cost training programs? Enter "Y" for yes or "N" for no in column yes, the GME elimination is not made on Wkst. B, Pt. I, col.	n 1. (see inst	ructions) If					107. 00
reimbursed. If yes complete Wkst. D-2, Pt. II. 08.00 Is this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	·	-					108. 00
,	Physi cal	Occupati on			Respi ra		
09.00  f this hospital qualifies as a CAH or a cost provider, are	1.00 N	2.00 N	3. C		4. 0 N	0	109.00
therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	IN.	IV.	IV.		IN.		109.00
10.00Did this hospital participate in the Rural Community Hospita	al Demonstrati	on project (	410A Demo)f	or	1. O	0	110. 00
the current cost reporting period? Enter "Y" for yes or "N"	for no.						
				1. 00	2.00	3. 00	
Miscellaneous Cost Reporting Information	- "N" !	1 1	I &I 1	N.			115 0
15.00 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" percer	. If column 2 nt for long te	is "E", ente rm care (inc	r in column ludes			0	115. 0
psychiatric, rehabilitation and long term hospitals provider Pub. 15-1, chapter 22, §2208.1.	rs) based on t	he definitio	n in CMS				
16.00  s this facility classified as a referral center? Enter "Y" 17.00  s this facility legally-required to carry malpractice insur			r "N" for	N N			116. 0 117. 0
		•					118. 0
no. 18.00 s the malpractice insurance a claims-made or occurrence pol	licy? Enter 1	if the polic	y is	2			
	licy? Enter 1				Incure	nce	1
18.00 Is the malpractice insurance a claims-made or occurrence pol	licy? Enter 1	Premiums			Insura	ince	11010
18.00 Is the mal practice insurance a claims-made or occurrence pol	licy? Enter 1			ses	I nsura		

	Provider CCN: 15-0022	Period:	Worksheet	S-2
		From 01/01/2016 To 12/31/2016		
		1. 00	2.00	
18.02 Are malpractice premiums and paid losses reported in a cost of Administrative and General? If yes, submit supporting scheduland amounts contained therein.		N		118. (
19.00 DO NOT USE THIS LINE 20.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qua Hold Harmless provision in ACA §3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no.	column 1, "Y" for yes o alifies for the Outpatie	r	Y	119. ( 120. (
21.00 Did this facility incur and report costs for high cost implar patients? Enter "Y" for yes or "N" for no.	9			121. (
22.00 Does the cost report contain state health or similar taxes? If for no in column 1. If column 1 is "Y", enter in column 2 the where these taxes are included.  Transplant Center Information				122. (
25.00 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. (
26.00 If this is a Medicare certified kidney transplant center, enter in column 1 and termination date, if applicable, in column 2.				126. (
27.00 f this is a Medicare certified heart transplant center, ento in column 1 and termination date, if applicable, in column 2. 28.00 f this is a Medicare certified liver transplant center, ento				127. (
in column 1 and termination date, if applicable, in column 2. 29.00 f this is a Medicare certified lung transplant center, enter				129. (
column 1 and termination date, if applicable, in column 2.  30.00 If this is a Medicare certified pancreas transplant center, and termination date, if applicable, in column 1 and termination date, if applicable, in column 1.				130.
31.00 If this is a Medicare certified intestinal transplant center, date in column 1 and termination date, if applicable, in column	, enter the certificatio	n		131. (
32.00 If this is a Medicare certified islet transplant center, ento in column 1 and termination date, if applicable, in column 2.				132.
33.00   f this is a Medicare certified other transplant center, ento in column 1 and termination date, if applicable, in column 2. 34.00   f this is an organ procurement organization (OPO), enter the and termination date, if applicable, in column 2.				133. (
All Providers  40.00 Are there any related organization or home office costs as dechapter 10? Enter "Y" for yes or "N" for no in column 1. If yer are claimed, enter in column 2 the home office chain number.	yes, and home office cos		158014	140. (
1.00 2.00	)	3. 00		
If this facility is part of a chain organization, enter on I		e name and address	of the	
home office and enter the home office contractor name and col 1.00 Name: FRANCISCAN ALLIANCE, INC. Contractor's Name: WPS 2.00 Street: 1515 DRAGOON TRAIL PO Box: 129	Contra	ctor's Number: 0810	)1	141. 142.
3.00 City: MISHAWAKA   State: IN	Zi p Co	de: 465	16-1290	143.
4.00 Are provider based physicians' costs included in Worksheet A	?		1. 00 Y	144.
				_
		1.00	2.00	
5.00 If costs for renal services are claimed on Wkst. A, line 74, inpatient services only? Enter "Y" for yes or "N" for no in one, does the dialysis facility include Medicare utilization 1	are the costs for column 1. If column 1 is	1. 00 N	2.00 N	145.
5.00 If costs for renal services are claimed on Wkst. A, line 74, inpatient services only? Enter "Y" for yes or "N" for no in on, does the dialysis facility include Medicare utilization in period? Enter "Y" for yes or "N" for no in column 2.	are the costs for column 1. If column 1 is for this cost reporting sly filed cost report?	N N		145.
5.00 If costs for renal services are claimed on Wkst. A, line 74, inpatient services only? Enter "Y" for yes or "N" for no in on, does the dialysis facility include Medicare utilization in period? Enter "Y" for yes or "N" for no in column 2. 6.00 Has the cost allocation methodology changed from the previous Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 18 yes, enter the approval date (mm/dd/yyyy) in column 2.	are the costs for column 1. If column 1 is for this cost reporting sly filed cost report? 5-2, chapter 40, §4020)	N N	N 1. 00	146.
5.00 If costs for renal services are claimed on Wkst. A, line 74, inpatient services only? Enter "Y" for yes or "N" for no in one, does the dialysis facility include Medicare utilization in period? Enter "Y" for yes or "N" for no in column 2. 6.00 Has the cost allocation methodology changed from the previous Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15 yes, enter the approval date (mm/dd/yyyy) in column 2. 7.00 Was there a change in the statistical basis? Enter "Y" for yes 8.00 Was there a change in the order of allocation? Enter "Y" for	are the costs for column 1. If column 1 is for this cost reporting sly filed cost report? 5-2, chapter 40, §4020)  es or "N" for no. yes or "N" for no.	N N If	N	146. 147. 148. 149.
5.00 If costs for renal services are claimed on Wkst. A, line 74, inpatient services only? Enter "Y" for yes or "N" for no in on, does the dialysis facility include Medicare utilization in period? Enter "Y" for yes or "N" for no in column 2. 6.00 Has the cost allocation methodology changed from the previous Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 18 yes, enter the approval date (mm/dd/yyyy) in column 2. 7.00 Was there a change in the statistical basis? Enter "Y" for yes 8.00 Was there a change in the order of allocation? Enter "Y" for 9.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no for each componer.	are the costs for column 1. If column 1 is for this cost reporting sly filed cost report? 5-2, chapter 40, §4020)  es or "N" for no. yes or "N" for no. ter "Y" for yes or "N" for Part A Part B 1.00 2.00 exemption from the applient for Part A and Part E	N  N  N  Title V  3.00  cation of the low  3. (See 42 CFR §41:	1.00 N N Title XI 4.00 er of costs 3.13)	146. 147. 148. 149.
inpatient services are claimed on Wkst. A, line 74, inpatient services only? Enter "Y" for yes or "N" for no in one, does the dialysis facility include Medicare utilization of period? Enter "Y" for yes or "N" for no in column 2.  16.00 Has the cost allocation methodology changed from the previous Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15 yes, enter the approval date (mm/dd/yyyy) in column 2.  17.00 Was there a change in the statistical basis? Enter "Y" for yes.  18.00 Was there a change in the order of allocation? Enter "Y" for yes.  19.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no for each component or charges? Enter "Y" for yes or "N" for no for each component of the supprovider - IPF  16.00 Subprovider - IRF	are the costs for column 1. If column 1 is for this cost reporting sly filed cost report? 5-2, chapter 40, §4020)  es or "N" for no. yes or "N" for no. ter "Y" for yes or "N" for hart A Part B 1.00 2.00 exemption from the appli	N N N N N N N N N N N N N N N N N N N	1.00 N N N Title XI 4.00 er of costs	146. 147. 148. 149.
45.00 If costs for renal services are claimed on Wkst. A, line 74, inpatient services only? Enter "Y" for yes or "N" for no in on, does the dialysis facility include Medicare utilization in period? Enter "Y" for yes or "N" for no in column 2.  46.00 Has the cost allocation methodology changed from the previous Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15 yes, enter the approval date (mm/dd/yyyy) in column 2.  47.00 Was there a change in the statistical basis? Enter "Y" for yes on "N" for yes on "N" for no in column 1. (See CMS Pub. 15 yes on "N" for no in column 2.	are the costs for column 1. If column 1 is for this cost reporting sly filed cost report? 5-2, chapter 40, §4020)  es or "N" for no. yes or "N" for no. ter "Y" for yes or "N" f Part A Part B 1.00 2.00 exemption from the appliint for Part A and Part E N N	N  N  N  N  Title V  3.00  cation of the low  S. (See 42 CFR §41:  N  N	1.00 N N N Title XI 4.00 er of costs 3.13)	146. 147. 148. 149. X

Health Financial Systems		EALTH CRAWFORDSVIL	LE		In Lie	u of Form CMS	-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	Provi der (	CCN: 15-002	From O	1/01/2016	Worksheet S- Part I Date/Time Pr 6/28/2017 3:	epared:	
						1.00	
Mul ti campus							
165.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.	mpus hospital that ha	as one or more cam	ouses in di	fferent CE	SSAs?	N	165. 00
	Name	County	State		CBSA	FTE/Campus	
	0	1. 00	2. 00	3.00	4. 00	5. 00	
166.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)  Health Information Technology (HI 167.00 Is this provider a meaningful user 168.00 If this provider is a CAH (line 16	under §1886(n)? Ent	ter "Y" for yes or	"N" for no	D.	the	1. 00 Y	167. 00 0168. 00
reasonable cost incurred for the H 168.01 If this provider is a CAH and is r exception under §413.70(a)(6)(ii)? 169.00 If this provider is a meaningful u	not a meaningful user, P Enter "Y" for yes or	does this provider "N" for no. (see	instruction	ons)	•	0.3	168. 01 25169. 00
transition factor. (see instruction		and 13 not a can	(11110-100	13 11), 0	inter the	0.2	3107.00
	,			Be	gi nni ng	Endi ng	
					1. 00	2.00	
170.00 Enter in columns 1 and 2 the EHR k period respectively (mm/dd/yyyy)	oeginning date and end	ding date for the	reporti ng	01/	′01/2016	09/30/2016	170. 00
					1. 00	2.00	+
171.00 If line 167 is "Y", does this proving section 1876 Medicare cost plans re "Y" for yes and "N" for no in column 1876 Medicare days in column 2.	reported on Wkst. S-3, umn 1. If column 1 is	Pt. I, line 2, co	ol. 6? Ente		N N		0 171. 00

OSPI T	FINANCI SCAN HEALTH AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C	CN: 15-0022	Peri od: From 01/01/2016 To 12/31/2016		epared:
				Y/N	Date	
	General Instruction: Enter Y for all YES responses. Enter N	l for all NO re	esponses. Ent	1.00 er all dates in 1	2.00 the	
	mm/dd/yyyy format.					
	COMPLETED BY ALL HOSPITALS Provider Organization and Operation					
. 00	Has the provider changed ownership immediately prior to the	e beginning of	the cost	N		1.0
	reporting period? If yes, enter the date of the change in c	column 2. (see		<i>'</i>	\/ /I	
			1. 00	2.00	V/I 3. 00	
00	Has the provider terminated participation in the Medicare F yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary.		N			2. 0
.00	Is the provider involved in business transactions, includir contracts, with individuals or entities (e.g., chain home commedical supply companies) that are related to the provice officers, medical staff, management personnel, or members of directors through ownership, control, or family and other relationships? (see instructions)	offices, drug der or its of the board	N			3. 0
	relationships: (see Thisti detrons)		Y/N	Туре	Date	
			1.00	2. 00	3. 00	
00	Financial Data and Reports  Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" for "R" for Reviewed. Submit complete copy or enter date avacolumn 3. (see instructions) If no, see instructions.	or Compiled,	Y	A	05/03/2016	4.0
00	Are the cost report total expenses and total revenues diffe		N			5.0
	those on the filed financial statements? If yes, submit rec	conciliation.		Y/N 1.00	Legal Oper. 2.00	
00	Approved Educational Activities Column 1: Are costs claimed for nursing school? Column 2:	If you is th	no providor i	s N		6.0
. 00	the legal operator of the program?	ii yes, is ti	ie provider i	S IN		0.0
00 00	Are costs claimed for Allied Health Programs? If "Y" see in Were nursing school and/or allied health programs approved cost reporting period? If yes, see instructions.		d during the	N N		7. 0 8. 0
. 00	Are costs claimed for Interns and Residents in an approved		cal education	N		9. 0
0. 00	program in the current cost report? If yes, see instruction Was an approved Intern and Resident GME program initiated cost reporting period? If yes, see instructions.		the current	N		10.0
1. 00		& R in an App	proved	N	V (N	11.0
					Y/N 1. 00	
	Bad Debts					
	Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection period? If yes, submit copy.			ost reporting	Y N	12. C
4. 00	If line 12 is yes, were patient deductibles and/or co-payme	ents waived? If	yes, see in	structions.	N	14.0
5. 00	Bed Complement Did total beds available change from the prior cost reporti	na period? If	ves. see ins	tructions.	N	15. C
		Par	rt A	Par	t B	
		1. 00	2. 00	Y/N 3. 00	Date 4.00	
	PS&R Data	1.00	2.00	3.00	4.00	
6. 00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 (see instructions)	Y	05/25/2017	Y	05/25/2017	16. 0
7. 00		N		N		17. 0
8. 00	in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this	N		N		18.0
9. 00	cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report	N		N		19. 0

Heal th	Financial Systems FRANCISCAN HEALTH	CRAWFORDSVI LL	E	In Lie	u of Form CMS-	2552-10
	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C	CN: 15-0022	Peri od: From 01/01/2016 To 12/31/2016	Worksheet S-2 Part II Date/Time Pre 6/28/2017 3:4	pared:
			ipti on	Y/N	Y/N	
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R	(	0	1. 00 N	3. 00 N	20.00
20.00	Report data for Other? Describe the other adjustments:			IN IN	IN	20.00
		Y/N	Date	Y/N	Date	
		1. 00	2. 00	3. 00	4. 00	
21. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21. 00
					1. 00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCER	PT CHILDRENS H	IOSPI TALS)			
	Capital Related Cost					
22. 00	Have assets been relifed for Medicare purposes? If yes, see				N	22. 00
23. 00	Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.	due to apprais	sais made dur	ing the cost	N	23. 00
24. 00	Were new leases and/or amendments to existing leases entered if yes, see instructions	porting period?	N	24. 00		
25. 00	Have there been new capitalized leases entered into during instructions.	If yes, see	N	25. 00		
26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during the instructions.	e cost reporti	ng period? I	f yes, see	N	26. 00
27. 00	Has the provider's capitalization policy changed during the copy.	cost reportin	ng period? If	yes, submit	N	27. 00
28. 00	<pre>Interest Expense Were new Loans, mortgage agreements or Letters of credit en period? If yes, see instructions.</pre>	N	28. 00			
29. 00	Did the provider have a funded depreciation account and/or litreated as a funded depreciation account? If yes, see instri	Υ	29. 00			
30. 00	Has existing debt been replaced prior to its scheduled maturinstructions.	, see	N	30. 00		
31. 00	Has debt been recalled before scheduled maturity without is instructions.	suance of new	debt? If yes	, see	N	31. 00
32. 00	Purchased Services  Have changes or new agreements occurred in patient care servarrangements with suppliers of services? If yes, see instruc		ed through co	ntractual	N	32. 00
33. 00	If line 32 is yes, were the requirements of Sec. 2135.2 applino, see instructions.		ng to competi	tive bidding? If	N	33. 00
	Provi der-Based Physi ci ans					
	Are services furnished at the provider facility under an arilf yes, see instructions.	J	•	. ,	Y	34. 00
35. 00	If line 34 is yes, were there new agreements or amended eximply sicians during the cost reporting period? If yes, see in:		its with the		N	35. 00
				Y/N 1. 00	Date	
	Home Office Costs			1.00	2. 00	
36. 00	Were home office costs claimed on the cost report?			Υ		36. 00
37. 00	If line 36 is yes, has a home office cost statement been prolef yes, see instructions.	epared by the	home office?	Y		37. 00
	If line 36 is yes , was the fiscal year end of the home offithe provider? If yes, enter in column 2 the fiscal year end	of the home o	offi ce.			38. 00
39. 00	see instructions.	•	,			39. 00
40. 00	If line 36 is yes, did the provider render services to the linstructions.	N		40. 00		
		1	00	2.	00	
	Cost Report Preparer Contact Information	1.		2.		
41. 00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	PATRI CI A		GARREN		41. 00
42. 00		FRANCISCAN HEA	LTH			42. 00
43. 00	preparer. Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	765-428-5928		PATRI CI A. GARREI LI ANCE. O	N@FRANCI SCANAL	43. 00

Health Financial System	ns	FRANCI SCAN HEALTH	CRAWFORDSVI LLE		In Lie	u of Form CMS-:	2552-10
HOSPITAL AND HOSPITAL	HEALTH CARE REIMBURSEMENT	QUESTI ONNAI RE	Provi der CC	N: 15-0022	Peri od:	Worksheet S-2	
					From 01/01/2016 To 12/31/2016		
			3. (	00			
Cost Report Prep	arer Contact Information						
41.00 Enter the first	name, last name and the	ti tl e/posi ti on	ADMIN DIRECTOR	OF FINANCE			41.00
held by the cost	report preparer in colum	nns 1, 2, and 3,					
respecti vel y.							
42.00 Enter the employ	ver/company name of the co	ost report					42.00
preparer.							
43.00 Enter the teleph	none number and email addr	ress of the cost					43.00
report preparer	in columns 1 and 2, respe	ecti vel y.					

 
 Heal th
 Financial
 Systems
 FRANCISCAN
 HEALTH
 CRAWFORDSVILLE

 HOSPITAL
 AND
 HOSPITAL
 HEALTH
 CARE
 COMPLEX
 STATISTICAL
 DATA
 Provider
 CCN
 Provider CCN: 15-0022 

Component   Worksheet A Line Number   No. of Beds   Red Days   Available   No. of Beds   Red Days   No. of Beds   No.						''	0 12/31/2010	6/28/2017 3:4	
No. of Beds   Red Days   CAH Hours   Title V   No. of Beds   Red Days   Available   No. of Beds   No. of Beds   Red Days   No. of Beds   No.									
Component									
1.00		Component	Worksheet A	No.	of Beds	Bed Days	CAH Hours		
No.						,			
1.00   Hospit al Adult s & Peds. (col umns 5, 6, 7 and 8   8 exclude Swing Bed, Observation Bed and Hospic ed days) (see instructions for col. 2   7 for the portion of LDP room available beds)   2.00   HM0 and other (see instructions)   2.00   HM0 lFF Subprovi der   2.00   Mol lFF Subprovi der   3.00   4.00   HM0 lFF Subprovi der   4.00   6.00   Hospit al Adult s & Peds. Swing Bed SNF   0.6.00   Hospit al Adult s & Peds. Swing Bed SNF   0.6.00   Hospit al Adult s & Peds. Swing Bed SNF   0.6.00   Nospit al Adult s & Peds. Swing Bed SNF   0.6.00   Nospit al Adult s & Peds. Swing Bed SNF   0.6.00   Nospit al Adult s & Peds. Swing Bed SNF   0.6.00   Nospit al Adult s & Peds. Swing Bed SNF   0.6.00   Nospit al Adult s & Peds. Swing Bed SNF   0.6.00   Nospit al Adult s & Peds. Swing Bed SNF   0.6.00   Nospit al Adult s & Peds. Swing Bed SNF   0.6.00   Nospit al Adult s & Peds. Swing Bed SNF   0.6.00   Nospit al Adult s & Peds. Swing Bed SNF   0.6.00   Nospit al Adult s & Peds. Swing Bed SNF   0.6.00   Nospit al Adult s & Peds. Swing Bed SNF   0.6.00   Nospit al Adult s & Peds. Swing Bed SNF   0.6.00   Nospit al Adult s & Peds. Swing Bed SNF   0.6.00   Nospit al Adult s & Peds. Swing Bed SNF   0.6.00   Nospit al Adult s and Peds. (exclude observation beds) (see instructions)   31.00   6   2,196   0.00					2. 00		4. 00	5. 00	
Hospice days) (see instructions for col. 2	1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00		25	9, 150	0.00	0	1. 00
For the portion of LDP room available beds)   2.00   Mo and other (see instructions)   2.00   3.00   Mol iPF Subprovider   3.00   4.00   Mol iPF Subprovider   4.00   5.00   Hospital Adults & Peds. Swing Bed SNF   0.5.00   0.5.00   Hospital Adults & Peds. Swing Bed NF   0.5.00   0		8 exclude Swing Bed, Observation Bed and							
2.00 HM0 and other (see instructions) 3.00 HM0 IPF Subprovider 4.00 5.00 Hospital Adults & Peds. Swing Bed NF 7.00 Hospital Adults & Peds. Swing Bed NF 8.00 Hospital Adults & Peds. Swing Bed NF 9.00 Coronary Care Unit 1		Hospice days) (see instructions for col. 2							
3. 00   HMC IPF Subprovi der		for the portion of LDP room available beds)							
4. 00   HMO IRF Subprovider	2.00	HMO and other (see instructions)							2. 00
5.00	3.00								3. 00
6.00   Hospital Adults & Peds. Swing Bed NF   25   9,150   0.00   0 7,00   10									
Total Adults and Peds. (exclude observation beds) (see instructions)   Substructions   Subst									
beds) (see instructions)	6.00	Hospital Adults & Peds. Swing Bed NF							6. 00
8. 00   INTENSIVE CARE UNIT   31. 00   6   2, 196   0. 00   0   8. 00   10. 00   SURN INTENSIVE CARE UNIT   32. 00   0   0   0. 00   0   9. 00   11. 00   SURN INTENSIVE CARE UNIT   33. 00   0   0   0. 00   11. 00   SURGICAL INTENSIVE CARE UNIT   11. 00   12. 00   OTHER SPECIAL CARE (SPECIFY)   12. 00   13. 00   NURSERY   43. 00   31   11, 346   0. 00   0   14. 00   15. 00   CAH visits   0   15. 00   16. 00   SUBPROVIDER - IPF   40. 00   11   4, 026   0   15. 00   17. 00   SUBPROVIDER - IFF   41. 00   0   0   0   0   18. 00   SUBPROVIDER SPECIALITY   44. 00   0   0   0   0   19. 00   SKILLED NURSING FACILITY   44. 00   0   0   0   20. 00   NURSING FACILITY   45. 00   0   0   0   20. 01   ICF/MR   45. 01   0   0   0   0   20. 01   ICF/MR   45. 01   0   0   0   21. 00   OTHER LONG TERM CARE   46. 00   0   22. 00   HOME HEALTH AGENCY   23. 00   AMBULATORY SURGICAL CENTER (D. P. )   115. 00   24. 01   HOSPICE (non-distinct part)   30. 00   24. 00   25. 00   CMHC - CORF   99. 10   25. 00   26. 25   FOEDRALLY QUALIFIED HEALTH CENTER   89. 00   29. 00   29. 00   Ambulance Trips   30. 00   30. 00   32. 01   Total anciliary labor & delivery room outpatient days (see instructions)   32. 01   32. 01   Total anciliary labor & delivery room outpatient days (see instructions)   32. 01   33. 00   30. 00   Total anciliary labor & delivery room outpatient days (see instructions)   32. 01   34. 00   Total anciliary labor & delivery room outpatient days (see instructions)   32. 01   34. 00   Total anciliary labor & delivery room outpatient days (see instructions)   32. 01   34. 00   Total anciliary labor & delivery room outpatient days (see instructions)   32. 01   34. 00   Total anciliary labor & delivery room outpatient days (see instructions)   32. 01   34. 00   Total anciliary labor & delivery room outpatient days (see instructions)   32. 01   34. 00   Total anciliary labor & delivery room outpatient days (see instructions)   32. 01   34. 00   Total control days (see instructions)   32. 01   35. 00   Total control days (see in	7.00	Total Adults and Peds. (exclude observation			25	9, 150	0.00	0	7. 00
9. 00 CORONARY CARE UNIT 32. 00 0 0 0. 00 0. 00 0 10. 00 11. 00 SURGICAL INTENSIVE CARE UNIT 11. 00 THER SPECIAL CARE (SPECIFY) 12. 00 11. 00 SUBGICAL INTENSIVE CARE UNIT 11. 00 11. 00 THER SPECIAL CARE (SPECIFY) 12. 00 11. 00 THER SPECIAL CARE (SPECIFY) 13. 00 NURSERY 43. 00 14. 00 Total (see instructions) 21. 00 14. 00 Total (see instructions) 21. 00 Total (see instructions) 22. 00 Total (subprovi DER - IPF 40. 00 11 4. 00 0 0 0 11. 00 0 0 15. 00 0 15. 00 0 16. 00 17. 00 SUBPROVI DER - IPF 41. 00 0 0 0 0 0 17. 00 18. 00 19. 00 0 0 0 17. 00 19. 00 0 0 19. 00 0 0 19. 00 19. 00 0 19. 00 0 19. 00 0 19. 00									
10.00   BURN INTENSIVE CARE UNIT   33.00   0   0   0   0   0   10.00   11.00   12.00   0   0   12.00   0   12.00   0   0   12.00   0   12.00   0   0   0   12.00   0   12.00   0   0   0   0   12.00   0   0   12.00   0   0   0   0   0   0   0   0   0					6	2, 196			
11. 00 12. 00 17. 00 17. 00 17. 00 17. 00 17. 00 18. 00 19	9.00	CORONARY CARE UNIT	32. 00		0	0			9. 00
12. 00 OTHER SPECIAL CARE (SPECIFY) 13. 00 NURSERY 143. 00 15. 00 CAH visits 0 CAH visits 0 15. 00 17. 00 SUBPROVIDER - IPF 18. 00 SUBPROVIDER - IRF 19. 00 SUBLILED NURSING FACILITY 19. 00 SUBLILED NURSING FACILITY 19. 00 SUBLILED NURSING FACILITY 19. 00 SUBRIGHT - IRF 19. 00 SUBPROVIDER - IRF 1			33. 00		0	0	0. 00	0	
13.00 NURSERY	11. 00	SURGICAL INTENSIVE CARE UNIT							
14. 00 Total (see instructions) 15. 00 CAH visits 16. 00 SUBPROVIDER - IPF 17. 00 SUBPROVIDER - IRF 18. 00 SUBPROVIDER - IRF 19. 00 SKILLED NURSING FACILITY 19. 00 SCILLED NURSING SCILLED NURSING SCILLED NURSING SCILLED NO		OTHER SPECIAL CARE (SPECIFY)							
15. 00 CAH visits  16. 00 SUBPROVIDER - IPF  40. 00 11 4,026 0 15. 00 16. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	13. 00		43. 00						13. 00
16. 00 SUBPROVIDER - IPF		Total (see instructions)			31	11, 346	0. 00		
17. 00   SUBPROVIDER - IRF   41. 00   0   0   0   17. 00   18. 00   SUBPROVIDER   42. 00   0   0   0   18. 00   19. 00   SKILLED NURSING FACILITY   44. 00   0   0   0   20. 00   NURSING FACILITY   45. 00   0   0   0   20. 01   ICF/MR   45. 01   0   0   0   0   21. 00   OTHER LONG TERM CARE   46. 00   0   0   22. 00   HOME HEALTH AGENCY   21. 00   23. 00   AMBULATORY SURGICAL CENTER (D. P. )   115. 00   24. 00   HOSPICE   116. 00   0   0   25. 00   CMHC - CMHC   25. 00   25. 10   CMHC - CORF   99. 10   26. 00   RURAL HEALTH CLINIC   88. 00   26. 00   CMRALLY QUALIFIED HEALTH CENTER   89. 00   27. 00   Observation Bed Days   29. 00   30. 00   Employee discount days (see instruction)   50. 00   31. 00   Employee discount days (see instructions)   30. 00   32. 01   Total ancillary labor & delivery room outpatient days (see instructions)   32. 01   32. 01   OUTPATE   A4. 00   0   0   0   34. 00   0   0   0   0   35. 00   0   0   0   36. 00   0   0   0   37. 00   0   0   0   38. 00   0   0   39. 00   0   0   30. 00									15. 00
18. 00   SUBPROVI DER   42. 00   0   0   0   0   18. 00   19. 00   NURSI NG FACILITY   44. 00   0   0   0   20. 00   NURSI NG FACILITY   45. 00   0   0   20. 01   ICF/MR   45. 01   0   0   0   21. 00   OTHER LONG TERM CARE   46. 00   0   22. 00   HOME HEALTH AGENCY   21. 00   23. 00   AMBULATORY SURGI CAL CENTER (D. P. )   115. 00   24. 00   HOSPI CE   116. 00   0   0   25. 00   CMHC - CMHC   24. 10   26. 20   FOERALLY QUALIFIED HEALTH CENTER   99. 10   26. 20   Total (sum of lines 14-26)   30. 00   27. 00   Observation Bed Days   42   28. 00   Observation Bed Days   42   30. 00   Employee di scount days (see instruction)   50. 00   31. 00   Employee di scount days - IRF   31. 00   32. 01   Total ancillary labor & delivery room outpatient days (see instructions)   32. 01   32. 01   Outpatient days (see instructions)   32. 01   34. 00   0   0   0   0   35. 01   0   0   0   36. 00   0   0   37. 00   0   0   38. 00   0   0   39. 00   0   0   30. 00   0   0   30. 00   0   30. 00   0   0   30. 00	16. 00	SUBPROVI DER - I PF	40. 00		11	4, 026			16. 00
19. 00					-	0			
20. 00   NURSING FACILITY   45. 00   0   0   0   20. 00   20. 01   1.CF/MR   45. 01   0   0   0   0   0   0   0   20. 01   21. 00   0   0   0   0   0   0   0   0   0						0			
20. 01   ICF/MR		SKILLED NURSING FACILITY	44. 00		0	0			19. 00
21. 00 OTHER LONG TERM CARE					-	_			
22. 00 HOME HEALTH AGENCY 23. 00 AMBULATORY SURGICAL CENTER (D. P.) 21. 00 HOSPICE 24. 00 HOSPICE (non-distinct part) 25. 00 CMHC - CMHC 25. 00 CMHC - CORF 25. 10 CMHC - CORF 26. 00 RURAL HEALTH CLINIC 27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambulance Trips 30. 00 Employee discount days (see instruction) 29. 00 Employee discount days - IRF 29. 00 Labor & delivery days (see instructions) 30. 00 Total ancillary labor & delivery room outpatient days (see instructions) 31. 00 Outpatient days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions)	20. 01				-	0	0. 00	0	
23. 00 AMBULATORY SURGICAL CENTER (D.P.)		OTHER LONG TERM CARE	46. 00		0	0			
24. 00 HOSPICE	22. 00	HOME HEALTH AGENCY							22. 00
24. 10 HOSPICE (non-distinct part) 25. 00 CMHC - CMHC 25. 10 CMHC - CORF 26. 00 RURAL HEALTH CLINIC 26. 05 FEDERALLY QUALIFIED HEALTH CENTER 27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambulance Trips 30. 00 Employee discount days (see instruction) 29. 00 Employee discount days (see instructions) 30. 00 Employee discount days (see instructions) 31. 00 Total ancillary labor & delivery room outpatient days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions)	23. 00		115. 00						
25. 00 CMHC - CMHC 25. 10 CMHC - CORF 26. 00 RURAL HEALTH CLINIC 26. 00 RURAL HEALTH CLINIC 27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambulance Trips 29. 00 Employee discount days (see instruction) 31. 00 Employee discount days - IRF 32. 00 Labor & delivery days (see instructions) 30. 01 Total ancillary labor & delivery room outpatient days (see instructions) 30. 01 Total ancillary labor & delivery room outpatient days (see instructions)	24. 00	HOSPI CE			0	0			
25. 10 CMHC - CORF 99. 10 26. 00 RURAL HEALTH CLINIC 88. 00 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 89. 00 27. 00 Total (sum of lines 14-26) 42 27. 00 28. 00 Observation Bed Days 29. 00 Ambulance Trips 29. 00 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days - IRF 32. 00 Labor & delivery days (see instructions) 32. 01 32. 01 Total ancillary labor & delivery room outpatient days (see instructions)	24. 10	HOSPICE (non-distinct part)	30. 00						
26. 00 RURAL HEALTH CLINIC 88. 00 26. 05 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 89. 00 26. 25 27. 00 Observation Bed Days 42 27. 00 28. 00 Observation Bed Days 42 29. 00 29. 00 Ambul ance Trips 29. 00 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days - IRF 32. 00 Labor & delivery days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 32. 01									
26. 25 FEDERALLY QUALIFIED HEALTH CENTER 89. 00 27. 00 Total (sum of lines 14-26) 42 27. 00 28. 00 Observation Bed Days 29. 00 Ambul ance Trips 29. 00 30. 00 Employee discount days (see instruction) Employee discount days - IRF 32. 00 Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions)	25. 10	CMHC - CORF							25. 10
27.00   Total (sum of lines 14-26)   27.00   28.00   29.00   28.00   29.00   2	26.00	RURAL HEALTH CLINIC	88. 00					0	26. 00
28.00 Observation Bed Days 29.00 Ambulance Trips 30.00 Employee discount days (see instruction) Employee discount days - IRF 31.00 Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions)  28.00 0 28.00 29.00 30.00 31.00 32.00 32.00	26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00					0	26. 25
29.00 Ambulance Trips 30.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions)  29.00 30.00 31.00 32.00					42				
30.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions)  30.00 31.00 32.00 32.01	28. 00	Observation Bed Days						0	28. 00
31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions)  31.00 0 0 0 32.00	29. 00								29. 00
32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions)  32.00	30.00	Employee discount days (see instruction)							30.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)	31.00	Employee discount days - IRF							31. 00
outpatient days (see instructions)	32.00				0	0			32. 00
	32. 01								32. 01
33.00  LTCH non-covered days                 33.00									
	33. 00	LTCH non-covered days							33. 00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-0022

Peri od: Worksheet S-3 From 01/01/2016 Part I To 12/31/2016 Date/Time Prepared:

6/28/2017 3:41 pm Full Time Equivalents I/P Days / O/P Visits / Trips Title XVIII Component Title XIX Total All Total Interns Employees On Pati ents & Residents Payrol I 6.00 7.00 8.00 9.00 10.00 1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 1, 766 279 2, 772 1.00 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) 2 00 HMO and other (see instructions) 2 00 569 3.00 HMO IPF Subprovider 0 3.00 HMO IRF Subprovider 4.00 0 4.00 5.00 Hospital Adults & Peds. Swing Bed SNF 0 0 5.00 Hospital Adults & Peds. Swing Bed NF 6.00 C 0 6.00 7.00 Total Adults and Peds. (exclude observation 1,766 279 2,772 7.00 beds) (see instructions) INTENSIVE CARE UNIT 8.00 300 64 561 8.00 CORONARY CARE UNIT 9.00 0 C C 9.00 10.00 BURN INTENSIVE CARE UNIT 0 C 0 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) 2,066 343 3, 333 0.00 143.89 14.00 CAH visits 15.00 0 15.00 SUBPROVIDER - IPF 1. 955 0.00 11.34 16.00 1.631 17 16.00 0 SUBPROVIDER - IRF 0.00 17.00 C 0 0.00 17.00 18.00 SUBPROVI DER 0 0 0.00 0.00 18.00 SKILLED NURSING FACILITY 19.00 0 0 0 0.00 0.00 19.00 20 00 NURSING FACILITY Ω 0 0 00 0.00 20 00 20.01 ICF/MR 0 C 0 0.00 0.00 20.01 21.00 OTHER LONG TERM CARE 0 0.00 0.00 21.00 HOME HEALTH AGENCY 22.00 22.00 AMBULATORY SURGICAL CENTER (D. P.) 0.00 23.00 0 00 23.00 24.00 HOSPI CE 0 0.00 0.00 24.00 HOSPICE (non-distinct part) 0 0 0 24. 10 24. 10 25.00 CMHC - CMHC 25.00 CMHC - CORF 0.00 0 Ω 0 0.00 25. 10 25.10 26.00 RURAL HEALTH CLINIC 0 0 0 0.00 0.00 26.00 0 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 0 0.00 0.00 26.25 Total (sum of lines 14-26) 27.00 0.00 155. 23 27.00 28 00 Observation Bed Days 17 1,095 28 00 29. 00 Ambul ance Trips 0 29.00 30.00 Employee discount days (see instruction) 30.00 0 Employee discount days - IRF 0 31.00 31.00 32.00 Labor & delivery days (see instructions) 0 0 32.00 Total ancillary labor & delivery room 0 32.01 32.01 outpatient days (see instructions) 33.00 LTCH non-covered days 33.00

 
 Heal th
 Financial
 Systems
 FRANCISCAN
 HEALTH
 CRAWFORDSVILLE

 HOSPITAL
 AND
 HOSPITAL
 HEALTH
 CARE
 COMPLEX
 STATISTICAL
 DATA
 Provider
 CCN
 Provider CCN: 15-0022 

				''	3 12/31/2010	6/28/2017 3:4	
		Full Time		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	661	133	1, 277	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)			164	0		2. 00
3. 00	HMO IPF Subprovider				0		3. 00
4.00	HMO IRF Subprovider				0		4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF						5. 00
6.00	Hospital Adults & Peds. Swing Bed NF						6. 00
7.00	Total Adults and Peds. (exclude observation						7. 00
	beds) (see instructions)						
8. 00	INTENSIVE CARE UNIT						8. 00
9.00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11.00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14. 00	Total (see instructions)	0. 00	0	661	133	1, 277	14. 00
15. 00	CAH visits						15. 00
16. 00	SUBPROVI DER - I PF	0. 00	0	1	0	142	16. 00
17. 00	SUBPROVI DER - I RF	0. 00	0	-	0	0	17. 00
18. 00	SUBPROVI DER	0. 00	0		0	0	18. 00
19. 00	SKILLED NURSING FACILITY	0. 00					19. 00
20.00	NURSING FACILITY	0. 00					20. 00
20. 01	I CF/MR	0. 00	0	0	0	0	20. 01
21. 00	OTHER LONG TERM CARE	0. 00				0	21. 00
22. 00	HOME HEALTH AGENCY						22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P. )	0. 00					23. 00
24. 00	HOSPI CE	0. 00					24. 00
24. 10	HOSPICE (non-distinct part)						24. 10
25. 00	CMHC - CMHC						25. 00
25. 10	CMHC - CORF	0. 00					25. 10
26. 00	RURAL HEALTH CLINIC	0. 00					26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0. 00					26. 25
27. 00	Total (sum of lines 14-26)	0. 00					27. 00
28. 00	Observation Bed Days						28. 00
29. 00	Ambul ance Tri ps						29. 00
30. 00	Employee discount days (see instruction)						30. 00
31. 00	Employee discount days - IRF						31.00
32. 00	Labor & delivery days (see instructions)						32. 00
32. 01	Total ancillary labor & delivery room						32. 01
22.00	outpatient days (see instructions)						22.00
33.00	LTCH non-covered days						33. 00

Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION

| Peri od: | Worksheet S-3 | From 01/01/2016 | Part II | To 12/31/2016 | Date/Time Prepared:

					To	o 12/31/2016	Date/Time Pre 6/28/2017 3:4	
		Worksheet A Line Number	Amount Reported	Reclassificati on of Salaries (from	(col.2 ± col.	Paid Hours Related to Salaries in	Average Hourly Wage (col. 4 ÷ col. 5)	
	+	1.00	2.00	<u>Worksheet A-6)</u> 3.00	3) 4.00	<u>col . 4</u> 5. 00	6. 00	
	PART II - WAGE DATA							
1. 00	SALARIES Total salaries (see	200. 00	10, 266, 124	606, 682	10, 872, 806	322, 881. 00	33. 67	1.00
2. 00	instructions) Non-physician anesthetist Part	200. 00	10, 200, 124		0	0.00		
3. 00	A Non-physician anesthetist Part		0	0	0	0.00		
4. 00	B Physician-Part A -		0	0	0	0. 00	0. 00	4.00
4. 01	Administrative Physicians - Part A - Teaching		0	0	0	0. 00	0. 00	4. 0´
5.00	Physician and Non Physician-Part B		0	0	0	0.00		5. 00
6. 00	Non-physician-Part B for hospital-based RHC and FQHC		0	0	0	0. 00	0.00	6. 0
7. 00	services Interns & residents (in an approved program)	21. 00	0	0	0	0. 00	0. 00	7.00
7. 01	Contracted interns and residents (in an approved programs)		0	0	О	0.00	0.00	7. 0
8. 00	Home office and/or related organization personnel		0	0	0	0.00	0. 00	8. 0
9. 00 10. 00	SNF Excluded area salaries (see	44. 00	0 1, 008, 429	0	- 1	0. 00 25, 393. 00	l .	
10.00	instructions)  OTHER WAGES & RELATED COSTS		1,000,127		1,000,127	20, 070. 00	07.71	
11. 00	Contract labor: Direct Patient Care		26, 239	0	26, 239	474.00	55. 36	11.0
12. 00	Contract labor: Top level management and other management and administrative		0	0	0	0.00	0.00	12.00
13. 00	services Contract Labor: Physician-Part A - Administrative		37, 253	0	37, 253	307.00	121. 35	13. 0
14. 00	Home office and/or related orgainzation salaries and wage-related costs		3, 075, 578	0	3, 075, 578	113, 962. 00	26. 99	14. 0
14. 01	Home office salaries		0	О	0	0.00		14. 0
14. 02 15. 00	Related organization salaries Home office: Physician Part A		0	0	0	0. 00 0. 00	l .	
16. 00	- Administrative Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16. 0
47.00	WAGE-RELATED COSTS		0.001.000				I	
17. 00	Wage-related costs (core) (see instructions)		3, 391, 900		2, 211, 133			17. 0
18. 00 19. 00	Wage-related costs (other) (see instructions) Excluded areas		0 314, 363	0	314, 363			18. 0
20. 00	Non-physician anesthetist Part		314, 303	o o	0			20. 0
21. 00	Non-physician anesthetist Part		0	0	0			21. 0
22. 00	Physician Part A - Administrative		0	0	0			22. 0
22. 01	Physician Part A - Teaching		0	0	0			22. 0
23. 00 24. 00	Physician Part B Wage-related costs (RHC/FQHC)		0	0	0			23. 0
25. 00 25. 50	Interns & residents (in an approved program) Home office wage-related		1, 033, 965	0	0 1, 033, 965			25. 0 25. 5
25. 50	Related orgainzation wage-related		1, 033, 965	0	0 0 0			25. 5
25. 52	Home office: Physician Part A - Administrative -		0	О	0			25. 5
25. 53	wage-related Home office & Contract Physicians Part A - Teaching -		О	О	О			25. 5
	wage-related  OVERHEAD COSTS - DIRECT SALARIE	S						
26. 00 27. 00	Employee Benefits Department	4. 00 5. 00	0 484, 119					
	,	3. 30	.51, 117	1 3.5,270	332, 377	5,515.00		,

Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0022

In Lieu of Form CMS-2552-10

Period: Worksheet S-3
From 01/01/2016 Part II
To 12/31/2016 Date/Time Prepared: 6/28/2017 3:41 pm

							6/28/2017 3: 4	1 pm
		Worksheet A	Amount	Reclassi fi cati	Adj usted	Pai d Hours	Average Hourly	
		Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from	(col.2 ± col.	Salaries in	col . 5)	
				Worksheet A-6)		col. 4		
		1.00	2.00	3. 00	4.00	5. 00	6. 00	
28. 00	Administrative & General under		41, 264	0	41, 264	908.00	45. 44	28.00
	contract (see inst.)							
29. 00	Maintenance & Repairs	6. 00		0	[ C	0.00		29.00
30.00	Operation of Plant	7. 00	174, 040	0	174, 040	7, 454. 00	23. 35	30.00
31.00	Laundry & Linen Service	8. 00	121, 470	0	121, 470	8, 148. 00	14. 91	31.00
32.00	Housekeepi ng	9. 00	0	0	C	0.00	0.00	32.00
33.00	Housekeeping under contract		0	0	C	0.00	0.00	33.00
	(see instructions)							
34.00	Di etary	10. 00	338, 399	-152, 696	185, 703	11, 363. 00	16. 34	34.00
35.00	Di etary under contract (see		0	0	C	0.00	0.00	35.00
	instructions)							
36.00	Cafeteri a	11. 00	0	152, 696	152, 696	9, 343. 00	16. 34	36.00
37.00	Maintenance of Personnel	12. 00	0	0	C	0.00	0.00	37.00
38.00	Nursing Administration	13. 00	13, 549	163, 249	176, 798	377.00	468. 96	38.00
39.00	Central Services and Supply	14. 00	64, 870	0	64, 870	2, 312. 00	28. 06	39.00
40.00	Pharmacy	15. 00	414, 364	0	414, 364	9, 415. 00	44. 01	40.00
41.00	Medical Records & Medical	16. 00	0	0	C	0.00	0.00	41.00
	Records Library							
42.00	Soci al Servi ce	17. 00	0	0	[ C	0.00	0.00	42.00
43.00	Other General Service	18. 00	0	0	C	0.00	0.00	43.00

Provider CCN: 15-0022

							6/28/2017 3: 4	1 pm
		Worksheet A	Amount	Recl assi fi cati	Adj usted	Pai d Hours	Average Hourly	
		Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from	(col.2 ± col.	Salaries in	col . 5)	
				Worksheet A-6)	3)	col. 4		
		1.00	2. 00	3.00	4. 00	5. 00	6. 00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		10, 307, 388	606, 682	10, 914, 070	323, 789. 00	33. 71	1. 00
	instructions)							
2.00	Excluded area salaries (see		1, 008, 429	0	1, 008, 429	25, 393. 00	39. 71	2. 00
	instructions)							
3.00	Subtotal salaries (line 1		9, 298, 959	606, 682	9, 905, 641	298, 396. 00	33. 20	3. 00
	minus line 2)							
4.00	Subtotal other wages & related		3, 139, 070	0	3, 139, 070	114, 743. 00	27. 36	4.00
	costs (see inst.)							
5.00	Subtotal wage-related costs		4, 425, 865	0	4, 425, 865	0.00	44. 68	5. 00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		16, 863, 894	606, 682	17, 470, 576	413, 139. 00	42. 29	6. 00
7.00	Total overhead cost (see		1, 652, 075	606, 682	2, 258, 757	54, 865. 00	41. 17	7. 00
	instructions)							

Health Financial Systems	FRANCISCAN HEALTH CRAWFORDSVILLE	In Lie	u of Form CMS-2552-10
HOSPITAL WAGE RELATED COSTS	Provi der CCN: 15-0022	Peri od:	Worksheet S-3
		From 01/01/2016	
		T- 10/01/001/	D-+- /T! D

Annount Reported   1.00   1.		To 12/31/2016	Date/Time Prep 6/28/2017 3:4	
PART IV - WAGE RELATED COSTS   Part A - Core List				
PART IV - WAGE RELATED COSTS   Part A - Core   Ist   RETIREMENT COST   401K Employer Contributions   0   1.00   2.00   7.00			Reported	
Part A - Core List			1. 00	
RETIREMENT COST		PART IV - WAGE RELATED COSTS		
1.00		Part A - Core List		
2. 00		RETI REMENT COST		1
3.00   Nonqualified Defined Benefit Plan Cost (see instructions)   910, 178   4.00	1.00	401K Employer Contributions	0	1.00
4.00	2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)   401K/TSA Pl an Administration fees   0   0   5.00	3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
5.00	4.00		910, 178	4.00
Column   C		PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		1
Employee Managed Care Program Administration Fees   0   7.00	5.00	401K/TSA Plan Administration fees	0	5. 00
HEALTH AND INSURANCE COST	6.00	Legal/Accounting/Management Fees-Pension Plan	0	6. 00
Real th Insurance (Purchased or Self Funded)   1,501,870   8.00   Real th Insurance (Self Funded without a Third Party Administrator)   0 8.01   Real th Insurance (Self Funded without a Third Party Administrator)   0 8.02   8.03   Real th Insurance (Purchased)   0 8.03   9.00   Prescription Drug Plan   0 9.00   0.	7.00	Employee Managed Care Program Administration Fees	0	7. 00
Heal th Insurance (Self Funded without a Third Party Administrator)   0   8.01		HEALTH AND INSURANCE COST		
Real th Insurance (Self Funded with a Third Party Administrator)   0   8.02	8.00	Health Insurance (Purchased or Self Funded)	1, 501, 870	8. 00
8. 03   Heal th Insurance (Purchased)   9. 00   9. 00   9. 00   Prescription Drug Plan   0   9. 00   9. 00   10. 00   10. 00   10. 00   11. 00	8. 01	Health Insurance (Self Funded without a Third Party Administrator)	0	8. 01
9.00   Prescription Drug Plan	8.02	Health Insurance (Self Funded with a Third Party Administrator)	0	8. 02
10.00   Dental, Hearing and Vision Plan   129,906   10.00     11.00   Life Insurance (If employee is owner or beneficiary)   61   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)   29,561   13.00     14.00   Long-Term Care Insurance (If employee is owner or beneficiary)   0   14.00     15.00   Workers' Compensation Insurance   422,327   15.00     16.00   Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.   0     Non cumulative portion   712,360   17.00     18.00   Medicare Taxes - Employers Portion Only   0   18.00     19.00   Unemployment Insurance   0   19.00     20.00   State or Federal Unemployment Taxes   0   20.00     OTHER   21.00   Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see   0   21.00     10.00   10.00   10.00   10.00     10.00   10.00   10.00   10.00     10.00   10.00   10.00   10.00     10.00   10.00   10.00   10.00     10.00   10.00   10.00     10.00   10.00   10.00   10.00     10.00   10.00   10.00   10.00     10.00   10.00   10.00   10.00     10.00   10.00   10.00     10.00   10.00   10.00   10.00     10.00   10.00   10.00   10.00     10.00   10.00   10.00   10.00     10.00   10.00   10.00     10.00   10.00   10.00   10.00     10.00   10.00   10.00   10.00     10.00   10.00   10.00   10.00     10.00   10.00   10.00     10.00   10.00   10.00   10.00     10.00   10.00   10.0	8.03	Health Insurance (Purchased)	0	8. 03
11.00	9.00	Prescription Drug Plan	0	9. 00
12.00 Accident Insurance (If employee is owner or beneficiary)  13.00 Disability Insurance (If employee is owner or beneficiary)  14.00 Long-Term Care Insurance (If employee is owner or beneficiary)  15.00 'Workers' Compensation Insurance  Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.  Non cumulative portion)  TAXES  17.00 FICA-Employers Portion Only  18.00 Medicare Taxes - Employers Portion Only  19.00 Unemployment Insurance  20.00 State or Federal Unemployment Taxes  OTHER  21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions))  22.00 Day Care Cost and Allowances  Tuition Reimbursement  O 22.00 Total Wage Related cost (Sum of Lines 1 -23)  Part B - Other than Core Related Cost	10.00	Dental, Hearing and Vision Plan	129, 906	10.00
13.00 Disability Insurance (If employee is owner or beneficiary)  Long-Term Care Insurance (If employee is owner or beneficiary)  14.00 Vorkers' Compensation Insurance  Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.  Non cumulative portion)  TAXES  17.00 FICA-Employers Portion Only  Medicare Taxes - Employers Portion Only  Unemployment Insurance  State or Federal Unemployment Taxes  OTHER  21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions))  Day Care Cost and Allowances  Tuition Reimbursement  Total Wage Related cost (Sum of Lines 1 -23)  Part B - Other than Core Related Cost	11.00	Life Insurance (If employee is owner or beneficiary)	61	11. 00
14. 00 Long-Term Care Insurance (If employee is owner or beneficiary)  15. 00 'Workers' Compensation Insurance  Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.  Non cumulative portion)  TAXES  17. 00 FI CA-Employers Portion Only  Medicare Taxes - Employers Portion Only  Unemployment Insurance  State or Federal Unemployment Taxes  OTHER  21. 00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see  Instructions)  Day Care Cost and Allowances  Tuit ion Reimbursement  24. 00 Part B - Other than Core Related Cost	12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
15.00 'Workers' Compensation Insurance Retirement Heal th Care Cost (Only current year, not the extraordinary accrual required by FASB 106. 0 16.00 Non cumulative portion)  TAXES  17.00 FI CA-Empl oyers Portion Only 712, 360 17.00 Medicare Taxes - Employers Portion Only 0 18.00 Unemployment Insurance 0 19.00 State or Federal Unemployment Taxes 0 20.00 OTHER  21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions))  22.00 Day Care Cost and Allowances 0 23.00 Tuition Reimbursement 0 23.00 Total Wage Related cost (Sum of Lines 1 -23) 3, 706, 263 Part B - Other than Core Related Cost	13.00	Disability Insurance (If employee is owner or beneficiary)	29, 561	13.00
16.00 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)  TAXES  17.00 FI CA-Employers Portion Only Medicare Taxes - Employers Portion Only Unemployment Insurance 20.00 State or Federal Unemployment Taxes  21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22.00 Day Care Cost and Allowances 23.00 Tuit ion Reimbursement Total Wage Related cost (Sum of Lines 1 -23) Part B - Other than Core Related Cost	14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
Non cumulative portion   TAXES	15.00	'Workers' Compensation Insurance	422, 327	15. 00
TAXES	16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16.00
17. 00   FI CA-Employers Portion Only   17. 00   18. 00   18. 00   19. 00				l
18.00       Medicare Taxes - Employers Portion Only       0       18.00         19.00       Unemployment Insurance       0       19.00         20.00       State or Federal Unemployment Taxes       0       20.00         OTHER         21.00       Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions))       0       21.00         22.00       Day Care Cost and Allowances       0       22.00         23.00       Tuition Reimbursement       0       23.00         24.00       Total Wage Related cost (Sum of Lines 1 -23)       3,706,263       24.00         Part B - Other than Core Related Cost				
19.00   Unemployment Insurance   0   19.00			712, 360	17. 00
20.00 State or Federal Unemployment Taxes 0 0 OTHER 21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22.00 Day Care Cost and Allowances 0 22.00 23.00 Tuition Reimbursement 0 23.00 Total Wage Related cost (Sum of Lines 1 -23) 3,706,263 Part B - Other than Core Related Cost			0	18. 00
OTHER  21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))  22.00 Day Care Cost and Allowances  23.00 Tuition Reimbursement  24.00 Total Wage Related cost (Sum of lines 1 -23)  Part B - Other than Core Related Cost			0	19. 00
21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions))  22.00 Day Care Cost and Allowances  Tuition Reimbursement  Total Wage Related cost (Sum of Lines 1 -23)  Part B - Other than Core Related Cost  21.00  22.00  23.00  24.00  25.00  26.00  27.00  28.00  29.00  29.00  20.00	20.00		0	20.00
instructions))  22.00 Day Care Cost and Allowances  23.00 Tuition Reimbursement  24.00 Total Wage Related cost (Sum of lines 1 -23)  Part B - Other than Core Related Cost  24.00 Part B - Other than Core Related Cost				l
22. 00       Day Care Cost and Allowances       0       22. 00         23. 00       Tuition Reimbursement       0       23. 00         24. 00       Total Wage Related cost (Sum of lines 1 -23)       3, 706, 263       24. 00         Part B - Other than Core Related Cost	21. 00		0	21. 00
23.00 Tuition Reimbursement  24.00 Total Wage Related cost (Sum of lines 1 -23)  Part B - Other than Core Related Cost  23.00  24.00				1
24.00 Total Wage Related cost (Sum of lines 1 -23) Part B - Other than Core Related Cost  3,706,263 24.00			0	
Part B - Other than Core Related Cost			Ŭ	
	24. 00		3, 706, 263	24. 00
25.00   OTHER WAGE RELATED COSTS (SPECIFY)				
(2.25.3)	25. 00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25. 00

Health Financial Systems	FRANCISCAN HEALTH CRAWFORDSVILLE	In Lieu of Form CMS-2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provi der CCN: 15-0022	Peri od: Worksheet S-3 From 01/01/2016 Part V To 12/31/2016 Date/Time Prepared:

		То	12/31/2016	Date/Time Prep 6/28/2017 3:4	
	Cost Center Description	Cc	ontract Labor	Benefit Cost	ı piii
			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		26, 239	3, 706, 263	1.00
2.00	Hospi tal		26, 239	3, 706, 263	2.00
3.00	Subprovi der - IPF		0	0	3.00
4.00	Subprovi der - IRF		0	0	4.00
5.00	Subprovi der - (0ther)		0	0	5.00
6.00	Swing Beds - SNF		0	0	6.00
7.00	Swing Beds - NF		0	0	7.00
8.00	Hospi tal -Based SNF		0	0	8.00
9.00	Hospi tal -Based NF		0	0	9. 00
9. 01	Hospi tal -Based NF		0	0	9. 01
10.00	Hospi tal -Based OLTC				10.00
11.00	Hospi tal -Based HHA				11.00
12.00	Separately Certified ASC		0	0	12.00
13.00	Hospi tal -Based Hospi ce		0	0	13.00
14.00	Hospital-Based Health Clinic RHC		0	0	14.00
15.00	Hospital-Based Health Clinic FQHC		0	0	15.00
16.00	Hospi tal -Based-CMHC				16.00
16. 10	Hospi tal -Based-CMHC 10		0	0	16. 10
17.00	Renal Dialysis		0	0	17.00
18. 00	Other		o	0	18. 00

Heal th	n Financial Systems FRANCISCAN HEALTH C	RAWFORDSVI LLE	<u> </u>	In Lie	u of Form CMS-2	2552-10
	TAL UNCOMPENSATED AND INDIGENT CARE DATA	Provi der CC	N: 15-0022	Peri od:	Worksheet S-10	0
				From 01/01/2016	5	
				To 12/31/2016	Date/Time Prep 6/28/2017 3:4	
				L .	072072017 0. 1	) Dill
					1. 00	
	Uncompensated and indigent care cost computation					
1. 00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 d	ivided by lin	ne 202 colum	n 8)	0. 241505	1. 00
	Medicaid (see instructions for each line)				E 457 004	
2.00	Net revenue from Medicaid				5, 157, 394	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	al navmants	from Modicai	40	N	3. 00 4. 00
4. 00 5. 00	If line 3 is "yes", does line 2 include all DSH or supplement If line 4 is "no", then enter DSH or supplemental payments fr		irom medicai	ur	0	
6.00	Medicaid charges	on wearcard			25, 822, 603	
7. 00	Medicaid cost (line 1 times line 6)				6, 236, 288	
8. 00	Difference between net revenue and costs for Medicaid program	(line 7 minu	us sum of li	nes 2 and 5: if	1, 078, 894	
	< zero then enter zero)				, , , , , , , , , , , , , , , , , , , ,	
	Children's Health Insurance Program (CHIP) (see instructions	for each line	e)			
9.00	Net revenue from stand-alone CHIP				0	
10. 00	9				0	
11. 00	Stand-alone CHIP cost (line 1 times line 10)				0	11. 00
12. 00		'(line 11 mi	nus line 9;	if < zero then	0	12. 00
	enter zero) Other state or local government indigent care program (see in	etructions fo	or each line	١		
13. 00					0	13. 00
14. 00				,	0	
	10)	. o p. og. a (.			Ü	
15. 00	State or local indigent care program cost (line 1 times line	14)			0	15. 00
16.00	Difference between net revenue and costs for state or local i	ndigent care	program (li	ne 15 minus line	0	16. 00
	13; if < zero then enter zero)					
47.00	Uncompensated care (see instructions for each line)					47.00
	Private grants, donations, or endowment income restricted to				0	17. 00
18. 00 19. 00	9 . 11 1			c (cum of lines		
19.00	Total unreimbursed cost for Medicaid, CHIP and state and loc 8, 12 and 16)	ai indigent o	care program	s (sum or rines	1, 078, 894	19.00
	0, 12 did 10)		Uni nsured	Insured	Total (col. 1	
			patients	pati ents	+ col . 2)	
			1. 00	2. 00	3. 00	
20.00			7, 878, 6		7, 878, 608	
21. 00	Cost of patients approved for charity care (line 1 times line	20)	1, 902, 7		1, 902, 723	
22. 00	Partial payment by patients approved for charity care			0 0	0	
23. 00	Cost of charity care (line 21 minus line 22)		1, 902, 7	23 0	1, 902, 723	23. 00
					1 00	
24. 00	Does the amount in line 20 column 2 include charges for patie	nt days boyo	nd a Longth	of stay limit	1. 00 N	24. 00
24.00	imposed on patients covered by Medicaid or other indigent car		ilu a religiti	or stay irillit	IN	24.00
25. 00	If line 24 is "yes," charges for patient days beyond an indi	th of stav limit	0	25. 00		
26. 00			433, 096			
27. 00						
28. 00	Non-Medicare and non-reimbursable Medicare bad debt expense (	line 26 minus	s line 27)		243, 923	28. 00
29. 00		xpense (line	1 times lin	e 28)	58, 909	
30. 00					1, 961, 632	
31. 00	Total unreimbursed and uncompensated care cost (line 19 plus	line 30)			3, 040, 526	31.00

	Financial Systems FRA SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	ANCISCAN HEALTH F EXPENSES	Provi der Co		eri od:	u of Form CMS-: Worksheet A	2552-10
				F	rom 01/01/2016 o 12/31/2016	Date/Time Pre 6/28/2017 3:4	
	Cost Center Description	Sal ari es	Other		Recl assi fi cati	Recl assi fi ed	T pill
				+ col . 2)	ons (See A-6)	Trial Balance (col. 3 +-	
		1.00	2.00	2.00	4.00	col . 4)	
	GENERAL SERVICE COST CENTERS	1.00	2. 00	3. 00	4. 00	5. 00	
1.00	00100 CAP REL COSTS-BLDG & FIXT		3, 355, 207				1
2. 00 3. 00	00200 CAP REL COSTS-MVBLE EQUIP 00300 OTHER CAP REL COSTS		87, 293 0	87, 293 0	0	87, 293 0	1
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	3, 594, 398			3, 594, 398	1
5. 00 6. 00	00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS	484, 119	10, 177, 862 0	10, 661, 981	-1, 106, 964	9, 555, 017 0	1
7. 00	00700 OPERATION OF PLANT	174, 040	1, 341, 116	1, 515, 156	-1, 399	1, 513, 757	
8. 00 9. 00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING	121, 470	33, 586 524, 376	1		146, 849 506, 501	
10. 00	01000 DI ETARY	338, 399	230, 009	1		308, 569	
11.00	01100 CAFETERIA	0	0	C	255, 554	255, 554	1
12. 00 13. 00	01200 MAI NTENANCE OF PERSONNEL 01300 NURSI NG ADMI NI STRATI ON	13, 549	171, 688	185, 237	-365	0 184, 872	1
14. 00	01400 CENTRAL SERVICES & SUPPLY	64, 870	272, 500	337, 370	-70, 678	266, 692	14. 00
15. 00 16. 00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	414, 364	1, 150, 211	1, 564, 575		511, 025 0	1
10.00	INPATIENT ROUTINE SERVICE COST CENTERS						10.00
30.00	03000 ADULTS & PEDIATRICS	1, 382, 002	83, 322				1
31. 00 32. 00	03100 INTENSIVE CARE UNIT 03200 CORONARY CARE UNIT	694, 003	142, 772 0	836, 775 C	-16, 132 0	820, 643 0	1
33. 00	03300 BURN INTENSIVE CARE UNIT	0	0	C	0	0	33. 00
40. 00 41. 00	04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF	979, 927	14, 531 0	994, 458	-9, 965 0	984, 493 0	1
42. 00	04200 SUBPROVI DER	o	0	Č	o o	0	
43.00	04300 NURSERY	0	0	C	0	0	
44. 00 45. 00	04400 SKILLED NURSING FACILITY 04500 NURSING FACILITY	0	0			0	
45. 01	04510 I CF/MR	0	0	· c	0	0	
46. 00	04600 OTHER LONG TERM CARE ANCILLARY SERVICE COST CENTERS	0	0	<u>C</u>	) <u> </u>	0	46. 00
50. 00	05000 OPERATING ROOM	1, 325, 850	2, 049, 528	3, 375, 378	-1, 060, 060	2, 315, 318	1
51. 00 52. 00	O5100   RECOVERY ROOM   O5200   DELIVERY ROOM & LABOR ROOM	0	0	C	0	0	
53. 00	05300 ANESTHESI OLOGY		0	C	0	0	1
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 093, 372	662, 921			1, 672, 466	1
54. 01 55. 00	05401   ULTRASOUND   05500   RADI OLOGY-THERAPEUTI C	77, 533 456, 302	1, 850 6, 503, 412			79, 383 926, 307	1
56. 00	05600 RADI OI SOTOPE	79, 279	152, 533			133, 262	56. 00
57. 00 58. 00	05700   CT   SCAN     05800   MRI	0	0	C	0	0	
59. 00	05900 CARDI AC CATHETERI ZATI ON	o	0	Č	o o	0	59. 00
60.00	06000 LABORATORY	0	2, 184, 220	2, 184, 220	0	2, 184, 220 0	
60. 01 61. 00	06001   BLOOD LABORATORY   06100   PBP CLINICAL LAB SERVICES-PRGM ONLY		0	C	0	0	1
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	C	0	0	62. 00
63. 00 64. 00	06300 BLOOD STORING, PROCESSING & TRANS. 06400 INTRAVENOUS THERAPY	0	0			0	63. 00 64. 00
65. 00	06500 RESPI RATORY THERAPY	305, 397	44, 923			338, 170	65. 00
66. 00 67. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	479, 264	15, 676 0	494, 940	-4, 247	490, 693 0	1
68. 00	06800 SPEECH PATHOLOGY	0	0	C	o o	0	1
69.00	06900 ELECTROCARDI OLOGY	202, 588	15, 030	217, 618	-10, 894	206, 724	1
70. 00 71. 00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		1, 040, 390	0 1, 040, 390	
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	· c	454, 437	454, 437	72. 00
73. 00 74. 00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	0	0	C	7, 175, 584	7, 175, 584 0	1
75. 00	07500 ASC (NON-DISTINCT PART)	o	0	Č	o o	0	75. 00
76. 00	03020 ONCOLOGY	0	0	40.446	0	0	
76. 98	07698 HYPERBARI C OXYGEN THERAPY OUTPATIENT SERVICE COST CENTERS	l o	49, 648	49, 648	S <sub>I</sub> U <sub>I</sub>	49, 648	76. 98
88. 00	08800 RURAL HEALTH CLINIC	0	0	C	0	0	
89. 00 90. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC	139, 935	23, 750	163, 685	0 5 -3, 485	0 160, 200	89. 00 90. 00
91. 00	09100 EMERGENCY	1, 411, 359	511, 897			1, 785, 670	91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS						92. 00
99. 10		0	0	C	0	0	99. 10
100.00	SPECIAL PURPOSE COST CENTERS			1 .		^	109. 00
	) 10900 PANCREAS ACQUISITION  11000 INTESTINAL ACQUISITION	0	0				1109.00
	•	·					

Health Financial Systems FRA	ANCISCAN HEALTH	CDAWEODDSVILL	_	In Lie	eu of Form CMS-:	2552 10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O		Provi der CO		Peri od:	Worksheet A	2552-10
				From 01/01/2016		narad.
				Го 12/31/2016	Date/Time Pre 6/28/2017 3:4	
Cost Center Description	Sal ari es	0ther	Total (col. 1	Recl assi fi cati		
			+ col. 2)	ons (See A-6)	Trial Balance	
					(col. 3 +-	
	1.00			4 00	col . 4)	
444 00 44400 LOLET ACCURCITION	1.00	2. 00	3. 00	4. 00	5. 00	111 00
111. 00 11100   SLET ACQUI SI TI ON	0	0	(	0		111.00
113. 00 11300   I NTEREST EXPENSE		0	(	0		113.00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF	0	0	(	0		114. 00
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	,	0		115. 00
116. 00 11600 HOSPI CE	10 227 (22	22 204 250	42 (24 00)	1 (02		116. 00
118. 00 SUBTOTALS (SUM OF LINES 1-117)  NONREI MBURSABLE COST CENTERS	10, 237, 622	33, 394, 259	43, 631, 88	1 693	43, 632, 574	1118.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN		0	,		1 0	190. 00
191. 00 19100 RESEARCH		0	)	0		191. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	28, 502	1, 946, 162	1, 974, 664	4 -693		
193. 00 19300 NONPALD WORKERS	20, 302	1, 740, 102	1, 774, 00	1 -073		193. 00
194. 00 07950 OTHER NONREIMBURSABLE COST CENTERS		0	ì		l .	194. 00
194. 01 07951 SPORTS MEDICINE		0	ì	0		194. 01
194. 02 07952 COMMUNITY IND HEALTH		0				194. 02
200. 00 TOTAL (SUM OF LINES 118-199)	10, 266, 124	35, 340, 421	45, 606, 54!	0	45, 606, 545	
	1 .,,		, , , , , , , , , , , , , , , , , , , ,	- 1	1	

In Lieu of Form CMS-2552-10
Worksheet A Peri od: From 01/01/2016 To 12/31/2016 Date/Time Prepared: 6/28/2017 3:41 pm

				6/28/2017 3: 41	1 pm
	Cost Center Description	Adjustments	Net Expenses		
		(See A-8) 6.00	For Allocation 7.00		
	GENERAL SERVICE COST CENTERS	0.00	7.00		
1.00	00100 CAP REL COSTS-BLDG & FIXT	2, 356, 430	6, 837, 195		1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	0	87, 293		2. 00
3.00	00300 OTHER CAP REL COSTS	0	0		3. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	-3, 184			4. 00
5.00	00500 ADMI NI STRATI VE & GENERAL	-3, 745, 226	1		5. 00
6.00	00600 MAI NTENANCE & REPAI RS	0	0		6. 00
7. 00 8. 00	OO7OO   OPERATION OF PLANT   OO8OO   LAUNDRY & LINEN SERVICE	-17, 022	1, 513, 757 129, 827		7. 00 8. 00
9. 00	00900 HOUSEKEEPI NG	-17,022	506, 501		9. 00
10. 00	01000 DI ETARY	-65, 213			10. 00
11. 00	01100 CAFETERI A	-73, 767	181, 787		11. 00
12. 00	01200 MAINTENANCE OF PERSONNEL	0	0		12. 00
	01300 NURSI NG ADMI NI STRATI ON	176, 387	361, 259		13. 00
	01400 CENTRAL SERVICES & SUPPLY	0	266, 692		14.00
	01500 PHARMACY	2, 493	513, 518		15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	479, 665	479, 665		16.00
	INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00	03000 ADULTS & PEDIATRICS	0			30. 00
31. 00	03100   NTENSI VE CARE UNI T	0	820, 643		31. 00
	03200 CORONARY CARE UNIT	0	0		32. 00
33. 00	03300 BURN INTENSIVE CARE UNIT	0	004 403		33. 00
40.00	04000   SUBPROVI DER -   PF   04100   SUBPROVI DER -   RF	0	984, 493 0		40. 00 41. 00
	04200 SUBPROVI DER	0			42.00
	04300 NURSERY	0			43.00
44. 00	04400 SKILLED NURSING FACILITY	0			44. 00
	04500 NURSING FACILITY	0			45. 00
45. 01	04510 I CF/MR	0	l ol		45. 01
46. 00	04600 OTHER LONG TERM CARE	0	1		46. 00
	ANCILLARY SERVICE COST CENTERS		· · · · · · · · · · · · · · · · · · ·		
50.00	05000 OPERATI NG ROOM	-797, 092	1, 518, 226		50.00
51.00	05100 RECOVERY ROOM	0	o		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	O		52.00
53.00	05300 ANESTHESI OLOGY	0	0		53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	-10, 905			54.00
54. 01	05401 ULTRASOUND	0	79, 383		54.01
55. 00	05500 RADI OLOGY-THERAPEUTI C	-207, 790			55.00
56. 00	05600 RADI OI SOTOPE	0	133, 262		56.00
57. 00	05700 CT SCAN	0	0		57. 00
58. 00	05800   MRI	0	0		58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0		59. 00
60.00	06000 LABORATORY	-4, 722	2, 179, 498		60.00
60. 01 61. 00	06001 BLOOD LABORATORY	0	0		60. 01 61. 00
	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0		62.00
62. 00 63. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06300 BLOOD STORING, PROCESSING & TRANS.	0			63.00
64. 00	06400 I NTRAVENOUS THERAPY		1		64. 00
	06500 RESPIRATORY THERAPY	0	338, 170		65. 00
	06600 PHYSI CAL THERAPY	-19, 641	471, 052		66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	17,011	0		67. 00
	06800 SPEECH PATHOLOGY	0	l ol		68. 00
	06900 ELECTROCARDI OLOGY	-630	206, 094		69.00
	07000 ELECTROENCEPHALOGRAPHY	0	o		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	1, 040, 390		71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	454, 437		72.00
	07300 DRUGS CHARGED TO PATIENTS	0	7, 175, 584		73.00
	07400 RENAL DI ALYSI S	0	0		74.00
	07500 ASC (NON-DISTINCT PART)	0	0		75. 00
76. 00	03020 ONCOLOGY	0	0		76. 00
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	49, 648		76. 98
05 -:	OUTPATIENT SERVICE COST CENTERS				
88. 00	08800 RURAL HEALTH CLINIC	0	0		88. 00
	1 1	0	0		89. 00
90.00	09000 CLINIC	-6, 790			90.00
	09100 EMERGENCY	-1, 680	1, 783, 990		91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART				92. 00
00 10	OTHER REIMBURSABLE COST CENTERS  09910 CORF	0	o		99. 10
77. IU	SPECIAL PURPOSE COST CENTERS		ı U		77. IU
109 00	10900 PANCREAS ACQUISITION	0	O		109. 00
	11000 INTESTINAL ACQUISITION	0	1		110.00
	11100 I SLET ACQUI SI TI ON	0	1		111. 00
	11300   NTEREST EXPENSE	0			113. 00

Health FinancialSystemsFRANCISCAN HEADRECLASSIFICATIONAND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES In Lieu of Form CMS-2552-10 FRANCISCAN HEALTH CRAWFORDSVILLE Provi der CCN: 15-0022 Peri od: Worksheet A 

			6/28/2017 3:	
Cost Center Description	Adjustments	Net Expenses		
	(See A-8)	For Allocation		
	6. 00	7.00		
114.00 11400 UTI LI ZATI ON REVI EW-SNF	0	0		114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0		115. 00
116. 00 11600 HOSPI CE	0	0		116. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	-1, 938, 687	41, 693, 887		118. 00
NONREI MBURSABLE COST CENTERS				
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190. 00
191. 00 19100 RESEARCH	0	0		191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	1, 973, 971		192. 00
193. 00 19300 NONPALD WORKERS	0	0		193. 00
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	0	0		194. 00
194. 01 07951 SPORTS MEDICINE	0	0		194. 01
194.02 07952 COMMUNITY IND HEALTH	0	o		194. 02
200.00 TOTAL (SUM OF LINES 118-199)	-1, 938, 687	43, 667, 858		200. 00

Health Financial Systems RECLASSIFICATIONS | Peri od: | From 01/01/2016 | To 12/31/2016 | Worksheet A-6 | Date/Time Prepared: | 6/28/2017 3:41 pm Provider CCN: 15-0022

					6/28/2017 3:41 pr
		Increases	0.1	0.11	
	Cost Center 2.00	Li ne # 3.00	Sal ary 4.00	0ther 5.00	
	A - CAPITAL	3.00	4.00	3.00	
	CAP REL COSTS-BLDG & FIXT	1.00	0	47, 250	1
0		0.00	O	0	2
0		0.00	0	0	3
0		0.00	0	0	4
0		0.00	0	0	5
)		0.00	0	0	6
)		0. 00 0. 00	0	0	7
)		0.00	ol Ol	0	9
00		0.00	o	Ö	10
00		0.00	o	O	11
00		0.00	0	0	12
00		0.00	0	0	13
00		0. 00	0	0	14
00		0.00		0	15
	TOTALS		0	47, 250	
)	B - INTEREST EXPENSE CAP REL COSTS-BLDG & FIXT	1.00	0	1, 078, 308	1
	TOTALS		<del> </del> _	1, 078, 308	'
	C - DIETARY		٩	1,070,000	
	CAFETERI A	11. 00	152, 696	102, 858	1
	TOTALS		152, 696	102, 858	
	D - CHARGEABLE SUPPLIES				
)	MEDICAL SUPPLIES CHARGED TO	71. 00	0	1, 040, 390	1
,	PATI ENT	0.00			
) )		0. 00 0. 00	0	0	2
)		0.00	Ö	Ö	
)		0.00	Ö	O	5
)		0.00	O	0	6
)		0. 00	O	0	7
)		0.00	0	0	8
)		0. 00	0	0	9
00		0.00	0	0	10
00		0.00	0	0	11
00		0. 00 0. 00	0	0	12
00		0.00	0	0	14
00		0.00	Ö	Ö	15
00		0.00	o	0	16
00		0.00	O	0	17
00		0.00	0	0	18
00		0.00	•	0	19
	TOTALS	ITC	0	1, 040, 390	
	E - DRUGS CHARGEABLE TO PATIENTS  DRUGS CHARGED TO PATIENTS	73.00	0	7, 175, 584	
)	DROGS CHARGED TO FATTENTS	0.00	o	7, 173, 304	2
)		0.00	o	0	3
)		0.00	Ö	Ö	4
)		0.00	О	0	5
)		0.00	0	0	6
)		0.00	0	0	7
)		0.00	0	0	3
00		0. 00 0. 00	0	0	10
0		0.00	0	0	11
0		0.00	ő	Ö	12
0		0.00	ō	0	13
0		0.00	О	0	14
0		0.00	•	0	15
	TOTALS		0	7, 175, 584	
	F - IMPLANTABLE DEVICES IMPL. DEV. CHARGED TO	72.00	0	4E 4 427	-
1	PATIENTS	72. 00	٥	454, 437	1
)	I ALLENIS	0.00	0	0	2
	TOTALS — — — —		<del> </del>	454, 437	
	G - FSEH SHARED SERVICES		<u> </u>		
	EMPLOYEE BENEFITS DEPARTMENT	4.00	148, 518	23, 363	1
)	1	5.00	318, 278	0	
)	ADMINISTRATIVE & GENERAL				
)	ADMINISTRATIVE & GENERAL NURSING ADMINISTRATION TOTALS	13.00	163, 249 630, 045		3

Health Financial Systems RECLASSIFICATIONS In Lieu of Form CMS-2552-10
Worksheet A-6 Peri od: From 01/01/2016 To 12/31/2016 Date/Time Prepared: 6/28/2017 3: 41 pm Provi der CCN: 15-0022

						6/28/2017 3	s: 41 pm
		Decreases					
	Cost Center	Li ne #	Sal ary	Other	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10.00		
	A - CAPITAL						
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	17, 390	9		1. 00
2.00	LAUNDRY & LINEN SERVICE	8. 00	0	6, 168	0		2. 00
3.00	DI ETARY	10.00	0	2, 057	0		3. 00
4.00	PHARMACY	15. 00	o	251	0		4. 00
5.00	ADULTS & PEDIATRICS	30.00	o	891	0		5. 00
6.00	INTENSIVE CARE UNIT	31.00	o	1, 257	0		6. 00
7.00	SUBPROVI DER - I PF	40.00	O	111			7. 00
8.00	OPERATING ROOM	50.00	o	7, 776	0		8. 00
9.00	RADI OLOGY-DI AGNOSTI C	54.00	o	5, 976			9. 00
10.00	RADI OLOGY-THERAPEUTI C	55.00	0	55		l e	10. 00
11. 00	RESPIRATORY THERAPY	65. 00	o	20			11. 00
12. 00	PHYSI CAL THERAPY	66.00	o	115			12. 00
13. 00	ELECTROCARDI OLOGY	69.00	0	1, 114			13. 00
14. 00	EMERGENCY	91.00	o	3, 644		l I	14. 00
15. 00	PHYSICIANS' PRIVATE OFFICES	192. 00	o o	425		l e	15. 00
.0.00	TOTALS		— — <del> </del>	47, 250			10.00
	B - INTEREST EXPENSE		<u> </u>	17, 200	1	l .	
1.00	ADMI NI STRATI VE & GENERAL	5. 00	0	1, 078, 308	11		1.00
1.00	TOTALS		— — <del>"</del>	1, 078, 308		•	1.00
	C - DI ETARY		9	1,070,300			
1.00	DI ETARY	10.00	152, 696	102, 858	0		1.00
1.00	TOTALS — — — — —		152, 696	102, 858			1.00
	D - CHARGEABLE SUPPLIES		132, 090	102, 636			
1. 00	OPERATION OF PLANT	7.00	o	779	0		1.00
	LAUNDRY & LINEN SERVICE	8. 00	-	2, 039	1		1
2.00			0				2.00
3.00	HOUSEKEEPI NG	9. 00	0	17, 870		l I	3. 00
4.00	DI ETARY	10.00	0	2, 228		l e e e e e e e e e e e e e e e e e e e	4. 00
5.00	NURSING ADMINISTRATION	13. 00	0	365		l I	5. 00
6.00	CENTRAL SERVICES & SUPPLY	14. 00	0	70, 678			6. 00
7.00	PHARMACY	15. 00	0	30, 445			7. 00
8. 00	ADULTS & PEDIATRICS	30.00	0	60, 021		l.	8. 00
9. 00	INTENSIVE CARE UNIT	31. 00	0	14, 650			9. 00
10. 00	SUBPROVI DER - I PF	40. 00	0	9, 841		l	10. 00
11. 00	OPERATING ROOM	50. 00	0	594, 188			11. 00
12.00	RADI OLOGY-DI AGNOSTI C	54.00	0	69, 781		l	12. 00
13.00	RADI OLOGY-THERAPEUTI C	55. 00	0	5, 560		l e	13. 00
14. 00	RESPI RATORY THERAPY	65. 00	0	12, 129		l	14. 00
15. 00	PHYSI CAL THERAPY	66. 00	0	4, 128	0		15. 00
16. 00	ELECTROCARDI OLOGY	69. 00	0	9, 772	. 0		16. 00
17.00	CLINIC	90.00	0	3, 473	0		17. 00
18.00	EMERGENCY	91. 00	0	132, 175	0		18. 00
19.00	PHYSICIANS' PRIVATE OFFICES	192. 00	0	268	0		19. 00
	TOTALS			1, 040, 390			
	E - DRUGS CHARGEABLE TO PATIE	ENTS					
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	11, 266			1. 00
2.00	HOUSEKEEPI NG	9. 00	0	5	0		2. 00
3.00	PHARMACY	15. 00	0	1, 022, 854	0		3. 00
4.00	ADULTS & PEDIATRICS	30.00	0	738	0		4. 00
5.00	INTENSIVE CARE UNIT	31.00	O	225	0		5. 00
6.00	SUBPROVI DER - I PF	40. 00	O	13	0		6. 00
7.00	OPERATING ROOM	50.00	O	4, 279	0		7. 00
8.00	RADI OLOGY-DI AGNOSTI C	54.00	O	8, 070	0		8. 00
9.00	RADI OLOGY-THERAPEUTI C	55. 00	o	6, 027, 792			9. 00
10.00	RADI OI SOTOPE	56.00	o	98, 550			10. 00
11. 00	RESPIRATORY THERAPY	65. 00	o	1	0	l I	11.00
12. 00	PHYSI CAL THERAPY	66.00	ol	4		l	12. 00
13. 00	ELECTROCARDI OLOGY	69. 00	ol		0	l	13. 00
14. 00	CLINIC	90.00	0	12		l l	14. 00
15. 00	EMERGENCY	91.00	Ŏ	1, 767	1		15. 00
13.00	TOTALS		— — —	7, 175, 584			13.00
	F - IMPLANTABLE DEVICES		U <sub>I</sub>	7, 175, 304			
1.00	OPERATION OF PLANT	7. 00	o	620	0		1.00
2.00	OPERATION OF PLANT	50. 00	0	453, 817			2.00
∠. ∪∪	TOTALS		— — — <del>}</del>			1	2.00
			U	454, 437			_
1 00	G - FSEH SHARED SERVICES	4 00	22.242	140 540			1 00
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	23, 363	148, 518		l .	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	318, 278			2.00
3. 00	NURSI NG ADMI NI STRATI ON	1300		163, 249			3. 00
F00 0-	TOTALS		23, 363	630, 045			F06 33
500.00	Grand Total: Decreases	1	176, 059	10, 528, 872	1		500.00

Provider CCN: 15-0022

					To 12/31/2016	Date/Time Pre	pared:
				Acqui si ti ons		6/28/2017 3: 4	I pm
		Begi nni ng	Purchases	Donati on	Total	Di sposal s and	
		Bal ances	i di chases	Donation	Total	Retirements	
		1.00	2.00	3. 00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET		2.00	0.00		0.00	
1.00	Land	970, 120	0		0 0	0	1.00
2.00	Land Improvements	3, 186, 248	O	(	0	0	2. 00
3.00	Buildings and Fixtures	29, 879, 508	1, 411, 910	(	1, 411, 910	0	3. 00
4.00	Building Improvements	507, 274	0	(	0	0	4. 00
5.00	Fi xed Equipment	19, 623	0	(	0	0	5. 00
6.00	Movable Equipment	18, 097, 650	2, 003, 972	(	2, 003, 972	0	6. 00
7.00	HIT designated Assets	0	0	(	0 0	0	7. 00
8.00	Subtotal (sum of lines 1-7)	52, 660, 423	3, 415, 882	(	3, 415, 882	0	8. 00
9.00	Reconciling Items	0	0	(	0	0	9. 00
10.00	Total (line 8 minus line 9)	52, 660, 423	3, 415, 882	(	3, 415, 882	0	10.00
		Endi ng Bal ance	Fully				
			Depreci ated				
			Assets				
		6.00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET						
1.00	Land	970, 120	0				1. 00
2.00	Land Improvements	3, 186, 248	0				2. 00
3.00	Buildings and Fixtures	31, 291, 418	0				3. 00
4.00	Building Improvements	507, 274	0				4. 00
5.00	Fixed Equipment	19, 623	0				5. 00
6.00	Movable Equipment	20, 101, 622	0				6. 00
7. 00	HIT designated Assets	0	0				7. 00
8.00	Subtotal (sum of lines 1-7)	56, 076, 305	0				8. 00
9.00	Reconciling Items	0	0				9. 00
10. 00	Total (line 8 minus line 9)	56, 076, 305	0				10. 00

Hool +k	Financial Cyatama	ANCISCAN HEALTH	I CDAWEODDCVIII	г	مالعا	u of Form CMC	2552 10
		ANCI SCAN HEALIF				eu of Form CMS-1	
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der Co	UN: 15-0022	Peri od: From 01/01/2016	Worksheet A-7	
					To 12/31/2016		nared:
					10 12/01/2010	6/28/2017 3:4	
			Sl	JMMARY OF CAP	I TAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see	Taxes (see	
	·				instructions)	instructions)	
		9. 00	10.00	11. 00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUM	MN 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FLXT	3, 355, 207	0		0 0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	87, 293	0		0 0	0	2. 00
3.00	Total (sum of lines 1-2)	3, 442, 500	0		0 0	0	3. 00
		SUMMARY O	F CAPITAL				
	Cost Center Description	Other	Total (1) (sum				
		Capi tal -Rel ate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14.00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUM	NN 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	3, 355, 207				1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	0	87, 293				2. 00
0 00	T 1 1 ( C1: 4 O)	1	0 440 500	I			

0 0

3, 355, 207 87, 293 3, 442, 500

1. 00 2. 00 3. 00

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

Heal th	n Financial Systems FRA	ANCISCAN HEALTH	I CRAWFORDSVILL	E	In Lie	u of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der Co		Period: From 01/01/2016 To 12/31/2016	Worksheet A-7 Part III Date/Time Pre 6/28/2017 3:4	pared:
		COMI	PUTATION OF RAT	TIOS	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets		Insurance	
			Leases	for Ratio (col. 1 - col	instructions)		
				2)	•		
		1.00	2.00	3.00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS CI						
1.00	CAP REL COSTS-BLDG & FLXT	3, 562, 856		3, 562, 85			1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	90, 384		90, 38			2. 00
3.00	Total (sum of lines 1-2)	3, 653, 240		3, 653, 24			3. 00
		ALLOCA	TION OF OTHER (	CAPITAL	SUMMARY C	F CAPITAL	
	Cost Center Description	Taxes	0ther	Total (sum o	f Depreciation	Lease	
			Capi tal -Relate				
			d Costs	through 7)			
	DART III DECONOLITATION OF CARLTAL COCTO OF	6. 00	7. 00	8. 00	9. 00	10. 00	
1 00	PART III - RECONCILIATION OF CAPITAL COSTS CI	ENTERS O	1 0	ı	0 3, 891, 909	1, 875, 141	1. 00
1. 00 2. 00	CAP REL COSTS-BLDG & FIXT	0	0		0 3, 891, 909		2.00
3.00	Total (sum of lines 1-2)	0			0 3, 979, 202		3.00
3.00	Total (Sull of Titles 1-2)	0	SI	'L JMMARY OF CAPI		1,075,141	3.00
			50	5WWW.444.1 O1 O741.1	1712		
	Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
			instructions)	instructions	) Capi tal -Rel ate		
					d Costs (see	through 14)	
		11.00	10.00	10.00	instructions)	45.00	
	DART III DECONCILIATION OF CARLTAL COCTO OF	11. 00	12.00	13. 00	14.00	15. 00	
1. 00	PART III - RECONCILIATION OF CAPITAL COSTS CI	1, 070, 145	0	ı	0 0	6, 837, 195	1. 00
2.00	CAP REL COSTS-BLDG & FIXT	1,070,143			0	87, 293	2.00
3.00	Total (sum of lines 1-2)	1, 070, 145	-		0 0	6, 924, 488	
5.00	1.010. (00 01.1.1.00 1.2)	1 .,070,110	1	1	٥,	5, 72 1, 100	0.00

					To 12/31/2016	Date/Time Prep 6/28/2017 3:4	
				Expense Classification o	n Worksheet A	0/20/2017 3.4	ı piii
				To/From Which the Amount is	s to be Adjusted		
	Cost Center Description	Basi s/Code (2)	Amount	Cost Center		Wkst. A-7 Ref.	
1. 00	Investment income - CAP REL	1. 00 B	2. 00	3.00 CAP REL COSTS-BLDG & FLXT	4. 00	5. 00 11	1. 00
1.00	COSTS-BLDG & FIXT (chapter 2)		0, 100	SAL REE GOSTO BEBG & TTAT	1.00	' '	1.00
2.00	Investment income - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2. 00
3. 00	COSTS-MVBLE EQUIP (chapter 2) Investment income - other		0		0.00	0	3. 00
3.00	(chapter 2)		0		0.00	Ĭ	3.00
4.00	Trade, quantity, and time		0		0.00	0	4. 00
5. 00	di scounts (chapter 8) Refunds and rebates of	В	152 210	ADMINISTRATIVE & GENERAL	5. 00	0	5. 00
5.00	expenses (chapter 8)	В .	-155, 510	ADMINISTRATIVE & GENERAL	5.00		3.00
6.00	Rental of provider space by		0		0.00	О	6. 00
7.00	suppliers (chapter 8)		0		0.00		7 00
7. 00	Tel ephone servi ces (pay stations excluded) (chapter		Ü		0.00	0	7. 00
	21)						
8.00	Television and radio service		0		0. 00	0	8. 00
9. 00	(chapter 21) Parking Lot (chapter 21)		0		0.00	0	9. 00
10. 00	Provi der-based physician	A-8-2	-1, 017, 260		0.00	0	10.00
	adjustment				_		
11. 00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11. 00
12. 00	Related organization	A-8-1	2, 203, 120			o	12. 00
	transactions (chapter 10)						
13.00	Laundry and linen service	В		LAUNDRY & LINEN SERVICE	8.00		13.00
14. 00 15. 00	Cafeteria-employees and guests Rental of quarters to employee			CAFETERI A ADMI NI STRATI VE & GENERAL	11. 00 5. 00		14. 00 15. 00
10.00	and others		07, 102	ADMINISTRATIVE & SENERALE	0.00	Ĭ	10.00
16.00	Sale of medical and surgical		0		0.00	0	16. 00
	supplies to other than patients						
17. 00	Sale of drugs to other than		0		0.00	0	17. 00
	pati ents						
18. 00	Sale of medical records and abstracts	В	-1, 580	ADMINISTRATIVE & GENERAL	5. 00	0	18. 00
19. 00	Nursing school (tuition, fees,		0		0.00	o	19. 00
	books, etc.)						
20.00	Vending machines	В	-7, 651	DI ETARY	10.00		20.00
21. 00	Income from imposition of interest, finance or penalty		0		0.00	0	21. 00
	charges (chapter 21)						
22. 00	Interest expense on Medicare		0		0. 00	0	22. 00
	overpayments and borrowings to repay Medicare overpayments						
23. 00	Adjustment for respiratory	A-8-3	0	RESPI RATORY THERAPY	65.00		23. 00
	therapy costs in excess of						
24 00	limitation (chapter 14) Adjustment for physical	A-8-3	^	PHYSI CAL THERAPY	66.00		24. 00
∠4. UU	therapy costs in excess of	N-0-3	U	HINDIOAL HILAAFI	66.00		∠4.00
	limitation (chapter 14)						
25. 00	Utilization review -		0	UTILIZATION REVIEW-SNF	114.00		25. 00
	physicians' compensation (chapter 21)						
26. 00	Depreciation - CAP REL		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26. 00
27 00	COSTS-BLDG & FLXT		^	CAD DEL COSTS MUDIE FOURD	2.00		27 00
27. 00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	27. 00
28. 00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28. 00
29.00	Physicians' assistant		0	OCCUPATIONAL TUESCO'	0.00		29. 00
30. 00	Adjustment for occupational therapy costs in excess of	A-8-3	0	OCCUPATI ONAL THERAPY	67. 00		30. 00
	limitation (chapter 14)						
30. 99	Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30.00		30. 99
31. 00	instructions) Adjustment for speech	A-8-3	^	SPEECH PATHOLOGY	68. 00		31. 00
31.00	pathology costs in excess of	A-0-3	Ü	SI EEGII I AIIIOEGGI	00.00		31.00
	limitation (chapter 14)						
32. 00	CAH HIT Adjustment for		0		0.00	0	32. 00
33. 00	Depreciation and Interest MISC INCOME	В	-13. 100	ADMINISTRATIVE & GENERAL	5. 00	0	33. 00
	MI SC I NCOME	В		DI ETARY	10.00		33. 01
		<u>'</u>					

Health Financial Systems	FRANCI SCAN HEALTH CRAWFORDSVILLE	In Lieu	of Form CMS-2552-10
ADJUSTMENTS TO EXPENSES		Period: From 01/01/2016	Worksheet A-8
		To 12/31/2016	Date/Time Prepared: 6/28/2017 3:41 pm
	Expense Classification o	n Worksheet A	

						6/28/2017 3:4	1 pm
				Expense Classification on	Worksheet A		
				To/From Which the Amount is	to be Adjusted		
					·		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4. 00	5. 00	
33. 02	MISC INCOME	В	-630	ELECTROCARDI OLOGY	69. 00	0	33. 02
33. 03	MISC INCOME	В	-19, 641	PHYSI CAL THERAPY	66.00	0	33. 03
33.04	MISC INCOME	В	-3, 176	RADI OLOGY-THERAPEUTI C	55.00	0	33. 04
33.05	MISC INCOME	В	-1, 572	ADMINISTRATIVE & GENERAL	5. 00	0	33. 05
33.06	MISC INCOME	В	-3, 800	DI ETARY	10.00	0	33. 06
33.07	ADVERTISING EXPENSE	A	-73	RADI OLOGY-THERAPEUTI C	55. 00	0	33. 07
33. 08	HAF ASSESSMENT	A	-1, 128, 319	ADMINISTRATIVE & GENERAL	5. 00	0	33. 08
33.09	PENSION ADJ	A	106, 247	ADMINISTRATIVE & GENERAL	5. 00	0	33. 09
33. 10	INTEREST EXPENSE	A	-1, 705, 746	ADMINISTRATIVE & GENERAL	5. 00	11	33. 10
50.00	TOTAL (sum of lines 1 thru 49)		-1, 938, 687				50.00
	(Transfer to Worksheet A,						
	column 6, line 200.)						
				0110 B L 45 4			

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

- (2) Basis for adjustment (see instructions).

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

  B. Amount Received if cost cannot be determined.

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

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

Peri od: Worksheet A-8-1 From 01/01/2016 OFFICE COSTS 12/31/2016 Date/Time Prepared:

					6/28/2017 3:4	1 pm					
	Li ne No.	Cost Center	Expense I tems	Amount of	Amount						
				Allowable Cost	Included in						
					Wks. A, column						
					5						
	1. 00	2. 00	3. 00	4. 00	5. 00						
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED										
	HOME OFFICE COSTS:										
1.00	1. 00	CAP REL COSTS-BLDG & FIXT	FA-INT	2, 967, 419	1, 092, 278	1.00					
2.00	1.00	CAP REL COSTS-BLDG & FIXT	FA-NEW CAP	489, 452	0	2.00					
3.00	5. 00	ADMINISTRATIVE & GENERAL	FA-A&G	4, 942, 051	6, 409, 363	3.00					
4.00	15. 00	PHARMACY	FA-COEP	65, 961	63, 468	4.00					
4.01	90.00	CLINIC	FA-AIS	0	6, 790	4. 01					
4.02	91. 00	EMERGENCY	FA-AIS	0	1, 680	4. 02					
4.03	16. 00	MEDICAL RECORDS & LIBRARY	FA-HIM	644, 929	165, 264	4.03					
4.04	4.00	EMPLOYEE BENEFITS DEPARTMENT	FSEH SHARED SERVICE	0	3, 184	4.04					
4.05	5. 00	ADMINISTRATIVE & GENERAL	FSEH SHARED SERVICE	658, 948	0	4. 05					
4.06	13.00	NURSING ADMINISTRATION	FSEH SHARED SERVICE	176, 387	0	4.06					
5.00	TOTALS (sum of lines 1-4).			9, 945, 147	7, 742, 027	5.00					
	Transfer column 6, line 5 to				, , , ,						
	Worksheet A-8, column 2,										
	line 12.										

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

	The been posted to worksheet N, cordinas I did of 2, the amount arrowable should be that eated in cordinar I 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 RELATED ORGANIZATION(S) AND/OR HOME OFFICE:									

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

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

6.00	В	FRANCISCAN ALLI	100.00 FRANCI SCAN ALLI	100.00	6. 00
7.00	G	FSEH	100. 00 FSEH	100.00	7. 00
8.00			0. 00	0.00	8. 00
9.00			0. 00	0.00	9. 00
10.00			0. 00	0.00	10.00
100.00	G. Other (financial or	SHARED SERVICES			100.00
	non-financial) specify:				

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

5.00 2, 203, 120 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

4 02

4.03

4.04

4.05

4.06

nas n	t been posted to worksheet A,	cordinas i and/or 2, the amount arrowable should be marcated in cordina 4 or this part.	
	Related Organization(s)		
	and/or Home Office		
	Type of Business		
	6. 00		
	B. INTERRELATIONSHIP TO RELA	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

	. Comont under the contract	
6.00	HOME OFFICE	6.00
7.00	SISTER FACILITY	7.00
8.00		8.00
9. 00 10. 00		9.00
10.00		10.00
100.00		100.00

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

0

0

0

0

4 02

4.03

4.04

4.05

4.06

-1, 680

-3, 184

479,665

658.948

176, 387

- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- B. Corporation, partnership, or other organization has financial interest in provider.
- C. Provider has financial interest in corporation, partnership, or other organization.
- D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organi zati on.
- E. Individual is director, officer, administrator, or key person of provider and related organization.
  F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provi der

| Period: | Worksheet A-8-2 | From 01/01/2016 | To 12/31/2016 | Date/Time Prepared: Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT Provi der CCN: 15-0022

					-	Γο 12/31/2016	Date/Time Pre 6/28/2017 3:4	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	, p
		l denti fi er	Remuneration	Component	Component		ider Component	
							Hours	
	1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	7. 00	
1. 00		OPERATING ROOM	761, 563		· ·	182, 900		
2.00		OPERATING ROOM	35, 619					
3. 00		OPERATING ROOM	8, 000			182, 900		
4. 00	54. 00 RADI OLOGY-DI AGNOSTI C		6, 350			217, 600		
5.00		RADI OLOGY-DI AGNOSTI C	3, 975			217, 600		5. 00
6.00		RADI OLOGY-DI AGNOSTI C	580			217, 600		
7. 00		RADI OLOGY-THERAPEUTI C	204, 541	204, 541		217, 600		7. 00
8. 00		LABORATORY	21, 240	0	21, 240	159, 800		8. 00
9. 00	0.00		0	0	0	0	0	9. 00
10. 00	0. 00		0	0	0	0	0	10. 00
200.00		0 1 0 1 (0)	1, 041, 868				307	
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of		Physician Cost	
		l denti fi er	Limit	Unadjusted RCE Limit	Continuing	Component Share of col.	of Malpractice Insurance	
				LIIIII	Education	12	i risurance	
	1. 00	2.00	8.00	9. 00	12. 00	13. 00	14.00	
1. 00		OPERATING ROOM	8, 090					1. 00
2. 00		OPERATING ROOM	0,070			0	_	2. 00
3. 00		OPERATING ROOM	0	0	-	0	Ö	3. 00
4. 00		RADI OLOGY-DI AGNOSTI C	l o	Ö	0	Ö	0	4. 00
5. 00	54.00	RADI OLOGY-DI AGNOSTI C	0	0	0	0	0	5. 00
6.00	54. 00	RADI OLOGY-DI AGNOSTI C	0	0	0	0	0	6. 00
7.00		RADI OLOGY-THERAPEUTI C	0	0	0	0	0	7. 00
8.00	60.00	LABORATORY	16, 518	826	0	0	0	8. 00
9.00	0.00		0	0	0	0	0	9. 00
10.00	0.00		0	0	0	0	0	10.00
200.00			24, 608			0	0	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		ldenti 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		OPERATING ROOM	15.00					1 00
1. 00 2. 00		OPERATING ROOM OPERATING ROOM		-,		753, 473 35, 619	•	1. 00 2. 00
2. 00 3. 00		OPERATING ROOM OPERATING ROOM	0	0	0	8,000		3.00
4. 00		RADI OLOGY-DI AGNOSTI C		0	0	6, 350	•	4. 00
4. 00 5. 00		RADI OLOGY - DI AGNOSTI C RADI OLOGY - DI AGNOSTI C				3, 975		5.00
6. 00	54. OO RADI OLOGY-DI AGNOSTI C			0	0	580		6.00
7. 00	54. OO RADI OLOGY - DI AGNOSTI C 55. OO RADI OLOGY - THERAPEUTI C					204, 541	1	7. 00
8. 00	60. 00 LABORATORY			16, 518	4, 722	4, 722		8. 00
9. 00	0.00	LADONATONT		10,516	4, 722	4,722		9. 00
10. 00	0.00							10.00
200.00	3.00		0	24, 608	12, 645	1, 017, 260		200.00
	1		1	, 000	/ 0 10	., , 200	I .	,

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

					To	12/31/2016	Date/Time Pre	
				CAPITAL RELATED COSTS			6/28/2017 3: 4	ı pili
				DI DO A FLAT	10/01 5 50/11 0	511D1 01/55		
		Cost Center Description	Net Expenses for Cost	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS	Subtotal	
			Allocation			DEPARTMENT		
			(from Wkst A					
			col. 7) 0	1. 00	2.00	4. 00	4A	
	GENER	AL SERVICE COST CENTERS	0	1.00	2.00	4.00	44	
1.00		CAP REL COSTS-BLDG & FIXT	6, 837, 195	6, 837, 195				1. 00
2.00		CAP REL COSTS-MVBLE EQUIP	87, 293		87, 293			2. 00
4. 00 5. 00	1	EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL	3, 591, 214 5, 809, 791	46, 812 1, 039, 652		3, 638, 624 271, 652	7, 134, 368	4. 00 5. 00
6. 00	1	MAINTENANCE & REPAIRS	0, 809, 791	1,039,032	13, 2/3	271,032	7, 134, 308	6. 00
7. 00	00700	OPERATION OF PLANT	1, 513, 757	514, 353	6, 567	58, 921	2, 093, 598	7. 00
8.00		LAUNDRY & LINEN SERVICE	129, 827	200, 328		41, 124	373, 837	8. 00
9. 00 10. 00	1	HOUSEKEEPI NG DI ETARY	506, 501 243, 356	15, 993 199, 487		0 62, 870	522, 698 508, 260	9. 00 10. 00
11. 00		CAFETERIA	181, 787	109, 423		51, 695	344, 302	11. 00
12. 00	01200	MAINTENANCE OF PERSONNEL	0	0		0	0	12. 00
13.00	1	NURSI NG ADMI NI STRATI ON	361, 259			59, 855	487, 540	13.00
14. 00 15. 00		CENTRAL SERVICES & SUPPLY   PHARMACY	266, 692 513, 518	366, 535 19, 424		21, 962 140, 283	659, 869 673, 473	14. 00 15. 00
16. 00		MEDICAL RECORDS & LIBRARY	479, 665	125, 286		0	606, 551	16. 00
		IENT ROUTINE SERVICE COST CENTERS						
30.00		ADULTS & PEDIATRICS INTENSIVE CARE UNIT	1, 403, 674			467, 878	2, 902, 901	30.00
31. 00 32. 00		CORONARY CARE UNIT	820, 643	121, 660 0	1, 553 0	234, 955 0	1, 178, 811 0	31. 00 32. 00
33. 00		BURN INTENSIVE CARE UNIT	0	0	Ö	Ö	0	33. 00
40.00		SUBPROVIDER - IPF	984, 493	279, 061	3, 563	331, 755	1, 598, 872	40. 00
41.00		SUBPROVIDER - IRF	0	0	0	0	0	41. 00
42. 00 43. 00		SUBPROVI DER NURSERY	0	0	0	0	0	42. 00 43. 00
44. 00		SKILLED NURSING FACILITY	0	0	Ö	o	0	44. 00
45. 00		NURSING FACILITY	0	0	0	0	0	45. 00
45. 01		I CF/MR	0	0	· -	0	0	45. 01
46. 00		OTHER LONG TERM CARE  LARY SERVICE COST CENTERS	0	0	0	0	0	46. 00
50.00		OPERATI NG ROOM	1, 518, 226	406, 160	5, 186	448, 868	2, 378, 440	50. 00
51. 00		RECOVERY ROOM	0	0	·	0	0	51. 00
52. 00 53. 00		DELIVERY ROOM & LABOR ROOM   ANESTHESIOLOGY	0	0	0	0	0	52. 00 53. 00
54. 00		RADI OLOGY-DI AGNOSTI C	1, 661, 561	1, 002, 160	12, 795	370, 162	3, 046, 678	
54. 01		ULTRASOUND	79, 383	18, 194		26, 249	124, 058	54. 01
55. 00		RADI OLOGY-THERAPEUTI C	718, 517	0	I -	154, 481	872, 998	55. 00
56. 00 57. 00	1	RADI OI SOTOPE CT SCAN	133, 262	17, 288	221	26, 840	177, 611 0	56. 00 57. 00
58. 00	05800		0	0	0	0	0	58. 00
59. 00	05900	CARDI AC CATHETERI ZATI ON	0	0	0	0	0	59. 00
60.00		LABORATORY	2, 179, 498	348, 729	4, 452	0	2, 532, 679	
60. 01 61. 00	1	BLOOD LABORATORY PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0	60. 01 61. 00
62. 00		WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
63.00		BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63. 00
64.00		I NTRAVENOUS THERAPY	0	0	0	0	0	64. 00
65. 00 66. 00		RESPI RATORY THERAPY PHYSI CAL THERAPY	338, 170 471, 052	26, 287 150, 797		103, 392 162, 255	468, 185 786, 029	65. 00 66. 00
67. 00		OCCUPATIONAL THERAPY	0	130, 777	1, 723	102, 233	700, 027	67. 00
68. 00		SPEECH PATHOLOGY	0	0	0	0	0	68. 00
69. 00	1	ELECTROCARDI OLOGY	206, 094	20, 913	267	68, 586	295, 860	69. 00
70. 00 71. 00		ELECTROENCEPHALOGRAPHY   MEDICAL SUPPLIES CHARGED TO PATIENT	1, 040, 390	0 91, 423	0 1, 167	0	0 1, 132, 980	70. 00 71. 00
72.00	1	IMPL. DEV. CHARGED TO PATIENTS	454, 437	0	0	0	454, 437	71.00
73. 00		DRUGS CHARGED TO PATIENTS	7, 175, 584	276, 536	3, 531	0	7, 455, 651	
74.00		RENAL DIALYSIS	0	0	0	0	0	74. 00
75. 00 76. 00		ASC (NON-DISTINCT PART) ONCOLOGY	0	0	0	0	0	75. 00 76. 00
76. 98	1	HYPERBARI C OXYGEN THERAPY	49, 648	0	1	o	49, 648	
	OUTPA	TIENT SERVICE COST CENTERS		-	-			
88. 00	1	RURAL HEALTH CLINIC	0	0	0	0	0	88. 00
89. 00 90. 00		FEDERALLY QUALIFIED HEALTH CENTER   CLINIC	153, 410	55, 100	703	0 47, 375	0 256, 588	89. 00 90. 00
91. 00	1	EMERGENCY	1, 783, 990			477, 817	2, 437, 808	91. 00
92. 00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92. 00
99. 10		REIMBURSABLE COST CENTERS	0	0	0	0	0	99. 10
77. IU	107710		ı O	0	١	ΟĮ	O <sub>1</sub>	//. 10

Health Financial Cyctems FD	ANCISCAN HEALTH	CDAWEODDCVIIII	r	منا ما	u of Form CMS-2552	2 10
Health Financial Systems FRA	ANCISCAN HEALIH	Provi der CC	CN: 15-0022	Period: From 01/01/2016 To 12/31/2016	Worksheet B Part I	ed:
		CAPI TAL REL	LATED COSTS			
Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
	0	1.00	2.00	4. 00	4A	
SPECIAL PURPOSE COST CENTERS		_		_1		
109. 00 10900 PANCREAS ACQUISITION	0	0		0	0 109	
110.00 11000 INTESTINAL ACQUISITION 111.00 11100 ISLET ACQUISITION	0	0		0	0 110 0 111	
113. 00 11300   NTEREST EXPENSE	۷	U		U U		1. 00 3. 00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF						4. 00
115. OO 11500 AMBULATORY SURGICAL CENTER (D. P. )	0	0		0	0 115	
116. 00 11600 HOSPI CE		0		0 0	0 116	
118.00 SUBTOTALS (SUM OF LINES 1-117)	41, 693, 887	6, 709, 319	85, 66	1 3, 628, 975	41, 554, 730 118	
NONREI MBURSABLE COST CENTERS		97.19.7		., ., ., .,	11,001,100	
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	22, 726	29	0 0	23, 016 190	). 00
191. 00 19100 RESEARCH	0	0		0	0 191	1.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	1, 973, 971	0		0 9, 649	1, 983, 620 192	
193.00 19300 NONPALD WORKERS	0	0		0	0 193	
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	0	0		0	0 194	
194. 01 07951 SPORTS MEDICINE	0	0		0	0 194	
194. 02 07952 COMMUNITY IND HEALTH	0	105, 150	1, 34	2 0	106, 492 194	
200.00 Cross Foot Adjustments					0 200	
201.00   Negative Cost Centers 202.00   TOTAL (sum lines 118-201)	12 447 050	U 4 027 105	87, 29	2 420 424	0 201 43, 667, 858 202	
ZUZ. UU    TUTAL (SUIII TITIES TT8-ZUT)	43, 667, 858	6, 837, 195	87, 29	3, 638, 624	43, 007, 838 202	<u>.</u> . UU

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2016 Part I
To 12/31/2016 Date/Time Prepared:
6/28/2017 3:41 pm

					72/31/2010	6/28/2017 3:4	
	Cost Center Description	ADMI NI STRATI VE		OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
		& GENERAL 5.00	REPAI RS 6. 00	PLANT 7. 00	LINEN SERVICE 8.00	9. 00	
	GENERAL SERVICE COST CENTERS	5.00	0.00	7.00	8.00	9.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	7, 134, 368					5. 00
6.00	OO6OO   MAINTENANCE & REPAIRS   OO7OO   OPERATION OF PLANT	400 044	0	2 502 442			6.00
7. 00 8. 00	00800 LAUNDRY & LINEN SERVICE	408, 844 73, 004	0	2, 502, 442 95, 736	542, 577		7. 00 8. 00
9. 00	00900 HOUSEKEEPI NG	102, 074	0	7, 643	60, 152	692, 567	9. 00
10. 00	01000 DI ETARY	99, 255	o	95, 334	3, 646	27, 521	1
11. 00	01100 CAFETERI A	67, 236	0	52, 293	0	15, 096	1
12.00	01200 MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13. 00	01300 NURSI NG ADMI NI STRATI ON	95, 208	0	31, 345	0	9, 049	•
14. 00	01400 CENTRAL SERVICES & SUPPLY	128, 861	0	175, 165	2, 003	50, 567	14.00
15.00	01500 PHARMACY	131, 518	0	9, 283	0	2, 680	1
16. 00	01600 MEDICAL RECORDS & LIBRARY I NPATIENT ROUTINE SERVICE COST CENTERS	118, 449	0	59, 874	0	17, 284	16. 00
30. 00	03000 ADULTS & PEDIATRICS	566, 887	0	486, 661	164, 537	140, 491	30.00
31. 00	03100   NTENSI VE CARE UNI T	230, 202	o	58, 141	15, 432	16, 784	31. 00
32.00	03200 CORONARY CARE UNIT	0	0	0	0	0	32. 00
33. 00	03300 BURN INTENSIVE CARE UNIT	0	0	0	0	0	33. 00
40. 00	04000 SUBPROVI DER - I PF	312, 233	0	133, 362	50, 612	38, 499	1
41. 00	04100 SUBPROVI DER – I RF	0	0	0	0	0	41.00
42. 00	04200 SUBPROVI DER	0	0	0	0	0	42.00
43. 00 44. 00	04300 NURSERY 04400 SKILLED NURSING FACILITY	0	0	0	0	0	43. 00 44. 00
45. 00	04500 NURSING FACILITY	0	0	0	0	0	45. 00
45. 01	04510 I CF/MR	ő	ő	0	0	0	45. 01
46.00	04600 OTHER LONG TERM CARE	0	0	0	0	0	46. 00
	ANCILLARY SERVICE COST CENTERS						
50. 00	05000 OPERATI NG ROOM	464, 469	0	194, 102	72, 487	56, 034	50. 00
51. 00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
52. 00 53. 00	O5200   DELI VERY ROOM & LABOR ROOM	0	0	0	0	0	52. 00 53. 00
54. 00	05300   ANESTHESI OLOGY   05400   RADI OLOGY-DI AGNOSTI C	594, 964	0	478, 928	20, 170	138, 258	ı
54. 00	05401 ULTRASOUND	24, 226	0	8, 695	20, 170	2, 510	1
55. 00	05500 RADI OLOGY-THERAPEUTI C	170, 482	0	0, 0,0	0	0	55. 00
56.00	05600 RADI OI SOTOPE	34, 684	0	8, 262	0	2, 385	•
57.00	05700 CT SCAN	0	0	0	0	0	57. 00
58. 00	05800 MRI	0	0	0	0	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0	59.00
60.00	06000   LABORATORY   06001   BLOOD   LABORATORY	494, 589	0	166, 656	0	48, 111	60.00
60. 01 61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	U	U	U	0	60. 01 61. 00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	o	o	0	0	0	63. 00
64.00	06400 I NTRAVENOUS THERAPY	0	0	0	0	0	64. 00
65.00		91, 429	0	12, 563		3, 627	65. 00
66. 00	06600 PHYSI CAL THERAPY	153, 498	0	72, 065	14, 097	20, 804	
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	0	0	0	67. 00
68. 00	06800  SPEECH PATHOLOGY   06900  ELECTROCARDI OLOGY	E7 774	0	0.004	0	0	68.00
69. 00 70. 00	07000 ELECTROCARDI OLOGI 07000 ELECTROENCEPHALOGRAPHY	57, 776	0	9, 994	0	2, 885 0	69. 00 70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	221, 252	0	43, 691	0	12, 613	1
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	88, 744	Ö	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1, 455, 962	0	132, 155	0	38, 151	1
74.00	07400 RENAL DI ALYSI S	0	0	0	0	0	74. 00
75. 00	07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	75. 00
76. 00	03020 ONCOLOGY	0	0	0	0	0	76. 00
76. 98	07698 HYPERBARI C OXYGEN THERAPY	9, 695	0	0	U	0	76. 98
88. 00	OUTPATIENT SERVICE COST CENTERS  08800 RURAL HEALTH CLINIC	0	0	0	0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89. 00
90.00	09000 CLINIC	50, 107	Ö	26, 332	0	7, 602	90.00
91.00	09100 EMERGENCY	476, 062	0	83, 050	136, 647	23, 975	1
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
	OTHER REIMBURSABLE COST CENTERS						
99. 10	09910 CORF	0	0	0	0	0	99. 10
100.00	SPECIAL PURPOSE COST CENTERS 10900 PANCREAS ACQUISITION		ما	^		^	100 00
	10900  PANCREAS ACQUISITION   11000  INTESTINAL ACQUISITION	0	0	0	0		109. 00 110. 00
	11100 I SLET ACQUISITION		0	0	0		111.00
	11300   NTEREST EXPENSE		Ĭ	J	J		113. 00
	11400 UTI LI ZATI ON REVI EW-SNF						114. 00

Health Financial Systems	FRANCISCAN HEALTH CRAWFORDSVILLE	In Lieu of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS	Provi der CCN: 15-0022	Period: Worksheet B

			T	o 12/31/2016	Date/Time Pre 6/28/2017 3:4	
Cost Center Description	ADMI NI STRATI VE	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
	& GENERAL	REPAI RS	PLANT	LINEN SERVICE		
	5. 00	6. 00	7.00	8. 00	9. 00	
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	0	0	0	115. 00
116. 00 11600 HOSPI CE	0	0	0	0	0	116. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	6, 721, 710	0	2, 441, 330	542, 577	674, 926	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	4, 495	0	10, 861	0	3, 135	190. 00
191. 00 19100 RESEARCH	0	0	0	0	0	191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	387, 367	0	0	0	0	192. 00
193.00 19300 NONPALD WORKERS	0	0	0	0	0	193. 00
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194. 00
194. 01 07951 SPORTS MEDICINE	0	0	0	0	0	194. 01
194.02 07952 COMMUNITY IND HEALTH	20, 796	0	50, 251	0	14, 506	194. 02
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)	7, 134, 368	0	2, 502, 442	542, 577	692, 567	202.00

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2016 Part I
To 12/31/2016 Date/Time Prepared:
6/28/2017 3:41 pm

						6/28/2017 3:4	
	Cost Center Description	DI ETARY	CAFETERI A	MAINTENANCE OF		CENTRAL	
				PERSONNEL	ADMI NI STRATI ON	SERVI CES & SUPPLY	
		10.00	11. 00	12.00	13. 00	14. 00	
1. 00	GENERAL SERVICE COST CENTERS    OO100   CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-BLDG & FIXT						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMINISTRATIVE & GENERAL						5. 00
6.00	00600 MAINTENANCE & REPAIRS						6. 00
7.00	00700 OPERATION OF PLANT						7. 00
8.00	00800 LAUNDRY & LINEN SERVICE						8. 00
9.00	00900 HOUSEKEEPI NG	704.044					9.00
10. 00 11. 00	01000  DI ETARY  01100  CAFETERI A	734, 016	479 027	,			10.00
12. 00	01200 MAINTENANCE OF PERSONNEL	0	478, 927 (	1			11. 00 12. 00
13. 00	01300 NURSI NG ADMI NI STRATI ON	0	642	1	623, 784		13. 00
14. 00	01400 CENTRAL SERVI CES & SUPPLY	l ol	3, 960		5, 172	1, 025, 597	14. 00
15. 00	01500 PHARMACY	O	16, 160	o	21, 062	0	15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	C	0	0	0	16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	1					
30. 00	03000 ADULTS & PEDI ATRI CS	384, 775	71, 384	1	93, 112	0	
31. 00	03100 I NTENSI VE CARE UNI T	77, 866	30, 609		39, 940	0	
32. 00 33. 00	03200   CORONARY CARE UNIT   03300   BURN INTENSIVE CARE UNIT	0	(		0	0	32. 00 33. 00
40. 00	04000 SUBPROVI DER – I PF	271, 375	40, 455		52, 767	0	40.00
41. 00	04100 SUBPROVI DER - I RF	271,375	40, 430		0.0	0	41. 00
42. 00	04200 SUBPROVI DER	0	C	o o	0	0	42. 00
43.00	04300 NURSERY	0	C	o	0	0	43. 00
44.00	04400 SKILLED NURSING FACILITY	0	C	0	0	0	44. 00
45.00	04500 NURSING FACILITY	0	C	0	0	0	45. 00
45. 01	04510   I CF/MR	0	C	0	0	0	45. 01
46. 00	04600 OTHER LONG TERM CARE	0		) 0	0	0	46. 00
EO 00	ANCILLARY SERVICE COST CENTERS    O5000   OPERATING ROOM	O	74.02/	il 0	04 520	0	E0 00
50. 00 51. 00	05100 RECOVERY ROOM	0	74, 024	1 0	96, 530 0	0	50. 00 51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM				0	0	52.00
53. 00	05300 ANESTHESI OLOGY	l o	C	ol o	0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	57, 436	0	74, 911	0	54.00
54. 01	05401 ULTRASOUND	0	3, 746	o 0	4, 892	0	54. 01
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	34, 604	<b>!</b> 0	45, 123	0	55. 00
56. 00	05600 RADI OI SOTOPE	0	3, 639	0	4, 731	0	56. 00
57. 00	05700 CT SCAN	0	C	0	0	0	57. 00
58. 00	05800   MRI   05900   CARDI AC   CATHETERI ZATI ON	0	(	0	0	0	58.00
59. 00 60. 00	06000 LABORATORY	0	(		0	0	59. 00 60. 00
60. 01	06001 BLOOD LABORATORY	0			0	0	60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY			1	ŭ	· ·	61. 00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	O	C	o	0	0	62. 00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	C	0	0	0	63. 00
64.00	06400 I NTRAVENOUS THERAPY	0	C	0	0	0	
65. 00	06500 RESPI RATORY THERAPY	0	19, 228		25, 061	0	
66. 00	06600 PHYSI CAL THERAPY	0	25, 685	0	33, 493	0	66.00
67. 00 68. 00	06700 OCCUPATI ONAL THERAPY	0	(		0	0	67. 00 68. 00
	O6800   SPEECH   PATHOLOGY   O6900   ELECTROCARDI OLOGY	0	13, 378	3	17, 431	0	69.00
	l l	0	13, 376		0	0	70. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	C	o o	0	717, 918	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	C	o o	0	307, 679	
73.00	07300 DRUGS CHARGED TO PATIENTS	0	C	0	0	0	73. 00
74.00	07400 RENAL DIALYSIS	0	C	0	0	0	74. 00
75. 00	07500 ASC (NON-DISTINCT PART)	0	C	0	0	0	75. 00
76. 00	03020 ONCOLOGY	0	C	0	0	0	
76. 98	07698 HYPERBARIC OXYGEN THERAPY OUTPATIENT SERVICE COST CENTERS	0		) 0	0	0	76. 98
88. 00	08800 RURAL HEALTH CLINIC	0	(		0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0			0	0	89. 00
	09000 CLINIC	l ol	7, 064	il o	9, 234	0	90.00
91.00	09100 EMERGENCY	0	76, 913	1	100, 325	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
	OTHER REIMBURSABLE COST CENTERS						
99. 10	09910 CORF	0		0	0	0	99. 10
100.00	SPECIAL PURPOSE COST CENTERS			\		^	100.00
	10900 PANCREAS ACQUISITION  11000 INTESTINAL ACQUISITION	0	(	1	0		109. 00 110. 00
	11100   I SLET ACQUI SI TI ON		(		0		111.00
	11300 I NTEREST EXPENSE			]	0	O	113. 00
	t t	<u> </u>					

					6/28/2017 3: 4	
Cost Center Description	DI ETARY	CAFETERI A	MAINTENANCE OF	NURSI NG	CENTRAL	
			PERSONNEL	ADMI NI STRATI ON	SERVICES &	
					SUPPLY	
	10.00	11. 00	12. 00	13. 00	14. 00	
114.00 11400 UTI LI ZATI ON REVI EW-SNF						114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	0	0	0	115. 00
116. 00 11600 HOSPI CE	0	0	0	0	0	116. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	734, 016	478, 927	0	623, 784	1, 025, 597	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
191. 00 19100 RESEARCH	0	0	0	0	0	191. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	0	0	192. 00
193. 00 19300 NONPALD WORKERS	0	0	0	0	0	193. 00
194.00 07950 OTHER NONREI MBURSABLE COST CENTERS	0	0	0	0	0	194. 00
194. 01 07951 SPORTS MEDICINE	0	0	0	0	0	194. 01
194. 02 07952 COMMUNITY IND HEALTH	0	0	0	0	0	194. 02
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)	734, 016	478, 927	0	623, 784	1, 025, 597	202. 00

In Lieu of Form CMS-2552-10 Health Financial Systems FRANCISCAN HEALTH CRAWFORDSVILLE COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0022 Peri od: Worksheet B From 01/01/2016 Part I Date/Time Prepared: 12/31/2016 6/28/2017 3:41 pm Cost Center Description **PHARMACY** MEDI CAL Subtotal Intern & Total RECORDS & Residents Cost LI BRARY & Post Stendown Adjustments 15.00 16.00 24.00 25.00 26.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 00600 MAINTENANCE & REPAIRS 6.00 6.00 00700 OPERATION OF PLANT 7.00 7 00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10 00 10 00 11.00 01100 CAFETERI A 11.00 12.00 01200 MAINTENANCE OF PERSONNEL 12.00 13.00 01300 NURSING ADMINISTRATION 13.00 01400 CENTRAL SERVICES & SUPPLY 14 00 14 00 15.00 01500 PHARMACY 854, 176 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 802, 158 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 28, 401 4, 839, 149 4, 839, 149 30.00 03100 INTENSIVE CARE UNIT 0 9, 382 1, 657, 167 0 1, 657, 167 31.00 31.00 03200 CORONARY CARE UNIT 0 32.00 0 0 0 32.00 03300 BURN INTENSIVE CARE UNIT 0 33 00 0 33 00 0 40.00 04000 SUBPROVIDER - IPF 16, 984 2, 515, 159 2, 515, 159 40.00 04100 SUBPROVI DER - I RF o 41.00 41.00 0 42.00 04200 SUBPROVI DER 0 0 0 42.00 0 04300 NURSERY 0 43 00 C 0 43 00 0 44.00 04400 SKILLED NURSING FACILITY 0 0 44.00 04500 NURSING FACILITY 0 0 ol 45.00 0 45.00 0 04510 I CF/MR 0 45.01 0 0 45.01 04600 OTHER LONG TERM CARE O 46.00 0 46.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 50 00 46, 877 3, 382, 963 3, 382, 963 50 00 0 0 05100 RECOVERY ROOM 51.00 0 51.00 0 05200 DELIVERY ROOM & LABOR ROOM 52 00 r 0 Λ 52 00 0 05300 ANESTHESI OLOGY 0 53.00 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 164, 182 4, 575, 527 0 4, 575, 527 54.00 05401 ULTRASOUND 13, 725 54.01 181, 852 181, 852 54.01 05500 RADI OLOGY-THERAPEUTI C 55.00 18,066 1, 141, 273 1, 141, 273 55.00 56, 00 05600 RADI OI SOTOPE 0 0 14, 282 245, 594 0 245, 594 56,00 05700 CT SCAN 57.00 57.00 05800 MRI 58.00 0 Λ 58 00 0 0 59.00 05900 CARDIAC CATHETERIZATION 59.00 60.00 06000 LABORATORY 89, 804 3, 331, 839 3, 331, 839 60.00 0 06001 BLOOD LABORATORY 60.01 0 0 60.01 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 0 0 61.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 62.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 0 0 63.00 63.00 06400 I NTRAVENOUS THERAPY 64.00 Ω Ω 64.00 65.00 06500 RESPIRATORY THERAPY 8, 757 631, 644 631, 644 65.00 06600 PHYSI CAL THERAPY 0 66.00 10, 999 1, 116, 670 0 0 1, 116, 670 66.00 06700 OCCUPATIONAL THERAPY 67.00 0 67.00 68.00 06800 SPEECH PATHOLOGY Λ 68.00 69.00 06900 ELECTROCARDI OLOGY 0 23, 620 420, 944 0 420, 944 69.00 0 70.00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 70.00 2, 187, 907 71 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 59 453 2 187 907 71 00 07200 I MPL. DEV. CHARGED TO PATIENTS 72.00 0 15, 939 866, 799 866, 799 72.00 07300 DRUGS CHARGED TO PATIENTS 854, 176 10, 114, 826 73.00 73.00 178, 731 10, 114, 826 0 74.00 07400 RENAL DIALYSIS 74.00 0 C C 0 07500 ASC (NON-DISTINCT PART) 75 00 0 75 00 0 0 03020 ONCOLOGY 76.00 0 0 0 76.00 07698 HYPERBARIC OXYGEN THERAPY 76.98 1,805 61, 148 61, 148 76.98 OUTPATIENT SERVICE COST CENTERS 88 00 08800 RURAL HEALTH CLINIC 88 00 0 0 0 0 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 89.00 C 09000 CLI NI C 0 2, 913 359, 840 0 359, 840 90.00 90.00 91.00 09100 EMERGENCY 0 98, 238 3, 433, 018 0 3, 433, 018 91.00

0

0

0

0

0

0

0

0

0

0

92.00

0 109. 00

0 110.00

0 99. 10

09910 CORF

09200 OBSERVATION BEDS (NON-DISTINCT PART

OTHER REIMBURSABLE COST CENTERS

SPECIAL PURPOSE COST CENTERS 109.00 10900 PANCREAS ACQUISITION

110.00 11000 INTESTINAL ACQUISITION

92.00

99.10

Health Financial Systems	FRANCISCAN HEALTH CRAWFORDSVILLE	In Lie	u of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS	Provi der CCN: 15-0022	Peri od:	Worksheet B

COST ALLOCATION - GENERAL SERVICE COSTS		Frovider CC	F	From 01/01/2016 o 12/31/2016	Part I Date/Time Pre 6/28/2017 3:4	
Cost Center Description	PHARMACY	MEDI CAL	Subtotal	Intern &	Total	
		RECORDS &		Residents Cost		
		LI BRARY		& Post		
				Stepdown		
	15.00	1/ 00	04.00	Adjustments	04.00	
444 00 44400 1 CLET 400 11 CLET 011	15. 00	16.00	24.00	25. 00	26.00	111 00
111. 00 11100   SLET ACQUI SI TI ON	O O	O <sub>1</sub>	C		U	111.00
113. 00 11300 I NTEREST EXPENSE						113.00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF	`					114. 00
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P	.)	0	(			115.00
116. 00 11600 HOSPI CE	0	0	(			116.00
118. 00 SUBTOTALS (SUM OF LINES 1-117)	854, 176	802, 158	41, 063, 319	에 이	41, 063, 319	1118.00
NONREI MBURSABLE COST CENTERS		-			11 507	
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CAN	IEEN O	0	41, 507	(	· ·	190.00
191. 00 19100 RESEARCH	ا	0	(	0		191. 00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	0	0	2, 370, 987	<u> </u>   0	2, 370, 987	
193. 00 19300 NONPALD WORKERS	0	0	(	이		193. 00
194. 00 07950 OTHER NONREI MBURSABLE COST CENT	ERS 0	0	C	이		194. 00
194. 01 07951 SPORTS MEDICINE	0	0	C	0		194. 01
194.02 07952 COMMUNITY IND HEALTH	0	0	192, 045	5 0	192, 045	1
200.00 Cross Foot Adjustments			C	이	0	200. 00
201.00 Negative Cost Centers	0	0	C	0	0	201. 00
202.00 TOTAL (sum lines 118-201)	854, 176	802. 158	43, 667, 858	sl ol	43, 667, 858	202.00

| Peri od: | Worksheet B | From 01/01/2016 | Part | I | To | 12/31/2016 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0022

					To	12/31/2016	Date/Time Prep 6/28/2017 3:4	
				CAPI TAL REI	LATED COSTS		0/20/2017 3.4	) piii
		Cost Center Description	Directly	BLDG & FLXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
		oost denter bescription	Assigned New	DEDO & TIXI	WVDEE EQUIT	Subtotal	BENEFITS	
			Capital Related Costs				DEPARTMENT	
			0	1.00	2. 00	2A	4. 00	
1. 00		AL SERVICE COST CENTERS  CAP REL COSTS-BLDG & FIXT						1. 00
2.00	1	CAP REL COSTS-BUDG & TTAT						2. 00
4.00		EMPLOYEE BENEFITS DEPARTMENT	0	46, 812		47, 410	47, 410	
5. 00 6. 00		ADMINISTRATIVE & GENERAL MAINTENANCE & REPAIRS	0	1, 039, 652 0		1, 052, 925 0	3, 539 0	5. 00 6. 00
7.00	00700	OPERATION OF PLANT	0	514, 353	6, 567	520, 920	768	7. 00
8. 00 9. 00	1	LAUNDRY & LINEN SERVICE HOUSEKEEPING	0	200, 328 15, 993		202, 886 16, 197	536 0	8. 00 9. 00
10.00	1	DIETARY	0	199, 487		202, 034	819	
11.00	1	CAFETERI A	0	109, 423		110, 820	674	11.00
12. 00 13. 00	1	MAI NTENANCE OF PERSONNEL NURSI NG ADMI NI STRATI ON	0	0 65, 589	_	0 66, 426	0 780	12. 00 13. 00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	366, 535		371, 215	286	
15. 00 16. 00		PHARMACY MEDICAL RECORDS & LIBRARY	0	19, 424 125, 286		19, 672 126, 886	1, 828 0	15. 00 16. 00
10.00	I NPAT	IENT ROUTINE SERVICE COST CENTERS	0	125, 200	1, 000	120, 000	0	10.00
30.00	03000	ADULTS & PEDIATRICS	0	1, 018, 347		1, 031, 349	6, 096	30.00
31. 00 32. 00		INTENSIVE CARE UNIT CORONARY CARE UNIT	0	121, 660 0		123, 213 0	3, 061 0	31. 00 32. 00
33. 00	03300	BURN INTENSIVE CARE UNIT	0	0	0	o	0	33. 00
40. 00 41. 00		SUBPROVI DER - I PF SUBPROVI DER - I RF	0	279, 061	3, 563	282, 624	4, 322 0	40. 00 41. 00
41.00	1	SUBPROVIDER - TRE	0	0	0	0	0	41.00
43.00	1	NURSERY	0	0	0	0	0	43.00
44. 00 45. 00		SKILLED NURSING FACILITY NURSING FACILITY	0	0	0	0	0	44. 00 45. 00
45. 01	04510	I CF/MR	0	0		O	0	45. 01
46. 00		OTHER LONG TERM CARE LARY SERVICE COST CENTERS	0	0	0	0	0	46. 00
50. 00		OPERATING ROOM	0	406, 160	5, 186	411, 346	5, 848	50. 00
51.00	1	RECOVERY ROOM	0	0		0	0	51.00
52. 00 53. 00		DELIVERY ROOM & LABOR ROOM ANESTHESIOLOGY	0	0	0	0	0	52. 00 53. 00
54.00	05400	RADI OLOGY-DI AGNOSTI C	0	1, 002, 160		1, 014, 955	4, 823	54. 00
54. 01 55. 00	1	ULTRASOUND RADI OLOGY-THERAPEUTI C	0	18, 194 0		18, 426	342 2, 013	54. 01 55. 00
56. 00		RADI OI SOTOPE	0	17, 288	_	17, 509	350	
57. 00		CT SCAN	0	0	0	0	0	57. 00
58. 00 59. 00	05800 05900	CARDI AC CATHETERI ZATI ON	0		0	0	0	58. 00 59. 00
60.00	06000	LABORATORY	0	348, 729	1	353, 181	0	60. 00
60. 01 61. 00	1	BLOOD LABORATORY PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0	60. 01 61. 00
62. 00		WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	О	Ö	0	
63.00		BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64. 00 65. 00		I NTRAVENOUS THERAPY RESPI RATORY THERAPY	0	26, 287	336	26, 623	0 1, 347	64. 00 65. 00
66.00	06600	PHYSI CAL THERAPY	0	150, 797	1, 925	152, 722	2, 114	66. 00
67. 00 68. 00		OCCUPATIONAL THERAPY SPEECH PATHOLOGY	0	0	0	0	0	67. 00 68. 00
69. 00		ELECTROCARDI OLOGY	0	20, 913	267	21, 180	894	69. 00
70.00		ELECTROENCEPHALOGRAPHY	0	01 422	0	02 500	0	70.00
71. 00 72. 00	1	MEDICAL SUPPLIES CHARGED TO PATIENT IMPL. DEV. CHARGED TO PATIENTS	0	91, 423 0	1, 167 0	92, 590 0	0	71. 00 72. 00
73. 00	07300	DRUGS CHARGED TO PATIENTS	0	276, 536	3, 531	280, 067	0	73. 00
74. 00 75. 00	1	RENAL DIALYSIS ASC (NON-DISTINCT PART)	0	0	0	0	0	74. 00 75. 00
76. 00		ONCOLOGY	0	0	o	0	0	76. 00
76. 98		HYPERBARI C OXYGEN THERAPY	0	0	o	o	0	76. 98
88. 00		TIENT SERVICE COST CENTERS RURAL HEALTH CLINIC	0	0	0	0	0	88. 00
89. 00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89. 00
90. 00 91. 00		CLI NI C EMERGENCY	0	55, 100 173, 782		55, 803 176, 001	617 6, 227	90. 00 91. 00
92. 00	1	OBSERVATION BEDS (NON-DISTINCT PART		175, 702	2,217	170,001	0, 221	92.00
99. 10		REIMBURSABLE COST CENTERS	0	^	0	0	0	99. 10
99. 10		AL PURPOSE COST CENTERS	0	0	0	U <sub>I</sub>	0	77. 10
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109. 00

Fr	rom 01/01/2016	
To	o 12/31/2016	Date/Time Prepared:
		6/28/2017 3:41 pm

			'`	12/01/2010	6/28/2017 3: 4	
		CAPI TAL REI	ATED COSTS			
Cost Center Description	Di rectly	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
	Assigned New				BENEFITS	
	Capi tal				DEPARTMENT	
	Related Costs	1. 00	2.00	2A	4. 00	
110. 00 11000 I NTESTI NAL ACQUI SI TI ON	0	1.00	2.00	2A 0		110. 00
111. 00 11100   SLET ACQUISITION	0	0	0	0		111. 00
113. 00 11300   NTEREST EXPENSE		O	o o	ĭ		113. 00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF						114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P. )	0	0	0	ol		115. 00
116. 00 11600 HOSPI CE	0	0	0	o	0	116. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	0	6, 709, 319	85, 661	6, 794, 980	47, 284	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	22, 726	290	23, 016	0	190. 00
191. 00 19100 RESEARCH	0	0	0	0	0	191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	126	192. 00
193.00 19300 NONPALD WORKERS	0	0	0	0		193. 00
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0		194. 00
194. 01 07951 SPORTS MEDICINE	0	0	0	0		194. 01
194. 02 07952 COMMUNITY IND HEALTH	0	105, 150	1, 342	106, 492		194. 02
200.00 Cross Foot Adjustments		_	_	0		200. 00
201.00 Negative Cost Centers		0	0	0		201. 00
202.00   TOTAL (sum lines 118-201)	0	6, 837, 195	87, 293	6, 924, 488	47, 410	202. 00

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2016 Part II
To 12/31/2016 Date/Time Prepared:
6/28/2017 3:41 pm

		1				6/28/2017 3:4	
	Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	
		5. 00	6.00	7. 00	8. 00	9. 00	
•	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS MARIE FOLLO						1.00
2. 00 4. 00	OO200   CAP REL COSTS-MVBLE EQUIP   OO400   EMPLOYEE BENEFITS DEPARTMENT						2. 00 4. 00
5. 00	00500 ADMI NI STRATI VE & GENERAL	1, 056, 464					5. 00
6. 00	00600 MAINTENANCE & REPAIRS	0	0				6. 00
7.00	00700 OPERATION OF PLANT	60, 543	0	582, 231			7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	10, 811	0	22, 274	236, 507		8. 00
9.00	00900 HOUSEKEEPI NG	15, 115	0	1, 778			1
10. 00 11. 00	01000  DI ETARY  01100  CAFETERI A	14, 698 9, 957	0	22, 181 12, 167	1, 589 0	2, 357 1, 293	
12. 00	01200 MAINTENANCE OF PERSONNEL	9, 437	0	12, 107	0	1, 293	1
13. 00	01300 NURSI NG ADMI NI STRATI ON	14, 099	Ö	7, 293	0	775	
14. 00	01400 CENTRAL SERVICES & SUPPLY	19, 082	0	40, 755	873	4, 330	1
15.00	01500 PHARMACY	19, 475	0	2, 160	0	229	15. 00
16. 00	01600 MEDI CAL RECORDS & LI BRARY	17, 540	0	13, 931	0	1, 480	16. 00
00.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	00.04/	٥	440.000	74 704	40.000	00.00
30. 00 31. 00	03000   ADULTS & PEDIATRICS   03100   INTENSIVE CARE UNIT	83, 946 34, 089	0	113, 228 13, 527	71, 721 6, 727	12, 032 1, 437	30. 00 31. 00
32. 00	03200 CORONARY CARE UNIT	34,009	0	13, 527	0, 727	1, 437	1
33. 00	03300 BURN INTENSIVE CARE UNIT	ő	ő	0	0	ő	33. 00
40. 00	04000 SUBPROVI DER - I PF	46, 236	0	31, 029	22, 061	3, 297	40.00
41.00	04100 SUBPROVI DER - I RF	0	0	0	0	0	41. 00
42.00	04200 SUBPROVI DER	0	0	0	0	0	42. 00
43.00	04300 NURSERY	0	0	0	0	0	43. 00
44.00	04400 SKI LLED NURSING FACILITY	0	0	0	0	0	44.00
45. 00 45. 01	04500  NURSING FACILITY  04510  ICF/MR	0	0	0	0	0 0	45. 00 45. 01
46. 00	04600 OTHER LONG TERM CARE	0	0	0	0	0	1
10.00	ANCI LLARY SERVI CE COST CENTERS	J	<u> </u>	<u> </u>	<u> </u>		10.00
50.00	05000 OPERATING ROOM	68, 780	0	45, 161	31, 597	4, 799	50. 00
51. 00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300 ANESTHESI OLOGY	00 104	0	111 420	0 703	11 040	53.00
54. 00 54. 01	05400   RADI OLOGY-DI AGNOSTI C   05401   ULTRASOUND	88, 104 3, 588	0	111, 430 2, 023	8, 792	11, 840 215	1
55. 00	05500 RADI OLOGY-THERAPEUTI C	25, 245	0	2, 023	0	0	1
56. 00	05600 RADI OI SOTOPE	5, 136	ő	1, 922	0	204	56.00
57. 00	05700 CT SCAN	0	0	. 0	0	0	57. 00
58. 00	05800 MRI	0	0	0	0	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0	59. 00
60.00	06000 LABORATORY	73, 240	0	38, 775	0	4, 120	1
60. 01	06001   BLOOD LABORATORY   06100   PBP CLINICAL LAB SERVICES-PRGM ONLY	O	O	0	0	0	60. 01
61. 00 62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	61. 00 62. 00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	o o	0	0	0	0	63.00
64. 00	06400 I NTRAVENOUS THERAPY	o	0	0	0	0	1
65.00	06500 RESPIRATORY THERAPY	13, 539	0	2, 923	1, 218	311	65. 00
66. 00	06600 PHYSI CAL THERAPY	22, 730	0	16, 767	6, 145	1, 782	
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	0	0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0	0	0	0	
69.00	06900  ELECTROCARDI OLOGY   07000  ELECTROENCEPHALOGRAPHY	8, 556	0	2, 325	0	247 0	69. 00 70. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	32, 764	0	10, 165	0	1, 080	
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	13, 141	0	10, 103	0	0	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	215, 589	o	30, 748	0	3, 267	73. 00
74.00	07400 RENAL DIALYSIS	0	o	0	0	0	74. 00
75. 00	07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	
76. 00	03020 ONCOLOGY	0	0	0	0	0	
76. 98	07698 HYPERBARI C OXYGEN THERAPY	1, 436	0	0	0	0	76. 98
88. 00	OUTPATIENT SERVICE COST CENTERS  08800 RURAL HEALTH CLINIC	0	0	^	^	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	
90. 00	09000 CLINIC	7, 420	ő	6, 127	0	651	90.00
91. 00	09100 EMERGENCY	70, 497	0	19, 323	59, 564	2, 053	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
	OTHER REIMBURSABLE COST CENTERS						
99. 10	09910 CORF	0	0	0	0	0	99. 10
100 00	SPECIAL PURPOSE COST CENTERS 10900 PANCREAS ACQUISITION	0	O	0	^	0	109. 00
	11000   NTESTINAL ACQUISITION	0	0	0	0		1109.00
	11100 I SLET ACQUI SI TI ON	Ö	0	0	0		111.00
113.00	11300 INTEREST EXPENSE						113. 00
114.00	11400 UTILIZATION REVIEW-SNF		<u> </u>		<u> </u>	<u> </u>	114. 00

FRANCISCAN HEALTH CRAWFORDSVILLE	In Lieu of Form CMS-2552-10
Provi der CCN: 15-0022	Peri od: Worksheet B
	From 01/01/2016   Part II

				1011 01/01/2016		
			T	o 12/31/2016		
					6/28/2017 3: 4	1 pm
Cost Center Description	ADMI NI STRATI VE	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
	& GENERAL	REPAI RS	PLANT	LINEN SERVICE		
	5.00	6.00	7. 00	8. 00	9. 00	
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	0	0	0	115. 00
116. 00 11600 H0SPI CE	0	0	0	0	0	116. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	995, 356	0	568, 012	236, 507	57, 799	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	666	0	2, 527	0	269	190. 00
191. 00 19100 RESEARCH	0	0	0	0	0	191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	57, 362	0	0	0	0	192. 00
193.00 19300 NONPALD WORKERS	0	0	0	0	0	193. 00
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194. 00
194. 01 07951 SPORTS MEDICINE	0	0	0	o	0	194. 01
194.02 07952 COMMUNITY IND HEALTH	3, 080	0	11, 692	o	1, 242	194. 02
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)	1, 056, 464	0	582, 231	236, 507	59, 310	202. 00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2016 | Part II | To 12/31/2016 | Date/Time Prepared: 6/28/2017 3:41 pm

COST CENTER   DISTARY   CAPETERIA   MAINTENANCE OF DILICS NO.   CENTRAL
CEMERAL SERVICE COST CENTERS   10.00   11.00   12.00   13.00   14.00   14.00   15.00   14.00   15.00   15.00   14.00   15.00
EENERAL SERVICE COST CENTERS
1.00
2. 00
4. 00
6. 00
7. 00 00700   00700
8. 00 00800 LAUNDRY & LINEN SERVI CE 9.00 00000 HOUSEKEEPING 9.00 10.00
9.00   00900   HOUSEKEEPI NG   243,678   0   134,911   10.00   11.00
10.00
11.00   01100   CAFETERIA   0   134,911   0   0   0   0   12.00   12
12.00
13.00   01300   NURSING ADMINISTRATION   0   1811   0   89,554   12.00
14. 00   01400   CENTRAL SERVICES & SUPPLY   0   1, 115   0   743   438, 399   14. 00   15. 00   105. 00
15. 00
16. 00   1600   MEDI CAL RECORDS & LI BRARY   0   0   0   0   0   0   0   16. 00
INPATI ENT ROUTINE SERVICE COST CENTERS   127, 737   20, 109   0   13, 368   0   30. 00   3
30. 00
31.00 03100   NTENSI VE CARE UNIT
32.00   03200   CORONARY CARE UNIT   0   0   0   0   0   32.00   33.00   03300   BURN INTENSIVE CARE UNIT   0   0   0   0   0   0   40.00   04000   SUBPROVI DER - I PF   90,091   11,396   0   7,576   0   40.00   41.00   04100   SUBPROVI DER - I RF   0   0   0   0   0   0   0   41.00   04100   SUBPROVI DER - I RF   0   0   0   0   0   0   0   42.00   04200   SUBPROVI DER - I RF   0   0   0   0   0   0   0   43.00   04200   SUBPROVI DER - I RF   0   0   0   0   0   0   0   44.00   04200   SUBPROVI DER - I RF   0   0   0   0   0   0   0   45.00   04300   NURSERY   0   0   0   0   0   0   0   46.00   04400   SKI LLED NURSI NG FACI LI TY   0   0   0   0   0   0   0   45.00   04500   NURSI NG FACI LI TY   0   0   0   0   0   0   0   45.01   04510   I CF/MR   0   0   0   0   0   0   0   46.00   04600   OTHER LONG TERM CARE   0   0   0   0   0   0   0   46.00   04600   OTHER LONG TERM CARE   0   0   0   0   0   0   0   46.00   05000   OPERATI NG ROOM   0   0   0   0   0   0   51.00   05000   DELIVERY ROOM & LABOR ROOM   0   0   0   0   0   0   52.00   05200   DELIVERY ROOM & LABOR ROOM   0   0   0   0   0   0   53.00   05300   ANESTHESI OLGY   0   0   0   0   0   0   53.00   54.00   05400   RADI OLOGY-DIAGNOSTI C   0   16,179   0   10,755   0   54.00   55.00   05500   RADI OLOGY-THERAPEUTI C   0   9,748   0   6,478   0   55.00   57.00   05700   CT SCAN   0   0   0   0   0   0   58.00   58.00   05800   MRI   0   0   0   0   0   0   0   0   0   59.00   05900   CARDI ACCATHETERI ZATI ON   0   0   0   0   0   0   60.00   06000   LABORATORY   0   0   0   0   0   0   0   61.00   06000   LABORATORY   0   0   0   0   0   0   0   62.00   06200   WHOLE BLOOD & PACKED RED BLOOD CELL   0   0   0   0   0   0   64.00   06400   INTRAVENOUS THERAPEY   0   0   0   0   0   0   0   64.00   06400   INTRAVENOUS THERAPEY   0   0   0   0   0   0   0   64.00   06400   INTRAVENOUS THERAPEY   0   0   0   0   0   0   0   64.00   06400   INTRAVENOUS THERAPEY   0   0   0   0   0   0   64.00   06400   INTRAVENOUS THERAPEY   0   0   0   0   0   0
33.00   03300   BURN I NTENSIVE CARE UNIT
40. 00   04000   SUBPROVI DER - I PF   90, 091   11, 396   0   7, 576   0   40. 00
41. 00   04100   SUBPROVI DER -   IRF   0   0   0   0   0   0   41. 00   42. 00   04200   SUBPROVI DER   0   0   0   0   0   0   0   42. 00   04300   NURSERY   0   0   0   0   0   0   0   43. 00   04300   NURSERY   0   0   0   0   0   0   44. 00   04400   SKI LLED NURSI NG FACI LI TY   0   0   0   0   0   0   45. 00   04500   NURSI NG FACI LI TY   0   0   0   0   0   0   45. 01   04510   I CF /MR   0   0   0   0   0   0   46. 00   04500   NURSI NG FACI LI TY   0   0   0   0   0   0   46. 00   04500   NURSI NG FACI LI TY   0   0   0   0   0   0   46. 00   04500   O   0   0   0   0   0   46. 00   04500   O   0   0   0   0   46. 00   04500   O   0   0   0   0   46. 00   04500   O   0   0   0   47. 01   04510   I CF /MR   0   0   0   0   0   48. 00   05000   OPERATI NG ROOM   0   0   0   0   49. 00   05000   OPERATI NG ROOM   0   0   0   0   40. 00   05100   RECOVERY ROOM   0   0   0   0   0   40. 00   05200   DELI VERY ROOM & LABOR ROOM   0   0   0   0   0   40. 00   05400   RADI OLOGY-DI AGNOSTI C   0   16, 179   0   10, 755   0   40. 01   05401   ULTRASOUND   0   1, 055   0   702   0   54. 01   40. 01   05401   ULTRASOUND   0   1, 055   0   702   0   54. 01   40. 02   05500   RADI OLOGY-THERAPEUTI C   0   9, 748   0   6, 478   0   55. 00   40. 03   0500   CT SCAN   0   0   0   0   0   0   41. 00   05700   CT SCAN   0   0   0   0   0   0   41. 00   05700   CT SCAN   0   0   0   0   0   0   41. 00   05700   CARDI AC CATHETERI ZATI ON   0   0   0   0   0   42. 00   06000   LABORATORY   0   0   0   0   0   0   41. 00   06100   PBP CLI NI CAL LAB SERVI CES-PRGM ONLY   0   0   0   0   0   0   41. 00   06400   HOTRAVENOUS THERAPY   0   0   0   0   0   0   0   41. 00   06400   INTRAVENOUS THERAPY   0   0   0   0   0   0   0   41. 00   06400   INTRAVENOUS THERAPY   0   0   0   0   0   0   0   41. 00   06400   INTRAVENOUS THERAPY   0   0   0   0   0   0   0   41. 00   06400   INTRAVENOUS THERAPY   0   0   0   0   0   0   0   0   41. 00   06400   INTRAVENOUS THERAPY   0   0   0   0   0   0   0   0   41. 00   06400   INTRAV
42. 00   04200   SUBPROVI DER
43. 00 04300 NURSERY 0 0 0 0 0 0 0 0 43. 00 44. 00 04400 SKI LLED NURSI NG FACI LITY 0 0 0 0 0 0 0 44. 00 45. 00 04500 NURSI NG FACI LITY 0 0 0 0 0 0 0 44. 00 45. 01 04501 I CF/MR 0 0 0 0 0 0 0 0 45. 00 46. 00 04500 OTHER LONG TERM CARE 0 0 0 0 0 0 0 0 0 45. 01 46. 00 04600 OTHER LONG TERM CARE 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0
44. 00   04400   SKI LLED NURSI NG FACI LI TY   0   0   0   0   0   0   44. 00   45. 00   04500   NURSI NG FACI LI TY   0   0   0   0   0   0   45. 01   04510   1CF/MR   0   0   0   0   0   0   0   46. 00   04600   OTHER LONG TERM CARE   0   0   0   0   0   0
45. 01
46.00
ANCI LLARY SERVI CE COST CENTERS   SO. 00   ODERATI NG ROOM   OD
50. 00         05000         OPERATI NG ROOM         0         20,852         0         13,858         0         50. 00           51. 00         05100         RECOVERY ROOM         0         0         0         0         0         0         51. 00           52. 00         05200         DELI VERY ROOM & LABOR ROOM         0         0         0         0         0         0         0         52. 00           53. 00         05300         ANESTHESI OLOGY         0         0         0         0         0         0         0         52. 00           54. 01         05401         RADI OLOGY-DI AGNOSTI C         0         16,179         0         10,755         0         54. 00           54. 01         05401         ULTRASOUND         0         1,055         0         702         0         54. 01           55. 00         05500         RADI OLOGY-THERAPEUTI C         0         9,748         0         6,478         0         55. 00           56. 00         05600         RADI OLOGY-THERAPEUTI C         0         9,748         0         6,478         0         55. 00           57. 00         05700         C         SCAN         0         0
51. 00         05100         RECOVERY ROOM         0         0         0         0         0         51. 00           52. 00         05200         DELI VERY ROOM & LABOR ROOM         0         0         0         0         0         0         52. 00           53. 00         05300         ANESTHESI OLOGY         0         0         0         0         0         0         0         52. 00           54. 00         05400         RADI OLOGY-DI AGNOSTI C         0         16, 179         0         10, 755         0         54. 00           54. 01         05401         ULTRASOUND         0         1, 055         0         702         0         54. 01           55. 00         05500         RADI OLOGY-THERAPEUTI C         0         9, 748         0         6, 478         0         55. 00           56. 00         05500         RADI OLOGY-THERAPEUTI C         0         9, 748         0         6, 478         0         55. 00           57. 00         05700         CT SCAN         0         0         0         0         679         0         56. 00           58. 00         05800         MRI         0         0         0         0         <
52. 00         05200   DELI VERY ROOM & LABOR ROOM         0         0         0         0         0         52. 00           53. 00         05300   ANESTHESI OLOGY         0         0         0         0         0         0         0         53. 00           54. 00         05400   RADI OLOGY-DI AGNOSTI C         0         16, 179         0         10, 755         0         54. 00           54. 01         05401   ULTRASOUND         0         1, 055         0         702         0         54. 01           55. 00         05500   RADI OLOGY-THERAPEUTI C         0         9, 748         0         6, 478         0         55. 00           56. 00         05600   RADI OLOGY-THERAPEUTI C         0         1, 025         0         679         0         56. 00           57. 00         05700   CT SCAN         0         0         0         679         0         56. 00           58. 00         05800   MRI         0         0         0         0         0         0         57. 00           59. 00         05900   CARDI AC CATHETERI ZATI ON         0         0         0         0         0         0         59. 00           60. 01         06000   LABORATORY
53. 00         05300   05300   ANESTHESI OLOGY         0         0         0         0         0         53. 00           54. 00         05400   RADI OLOGY - DI AGNOSTI C         0         16, 179         0         10, 755         0         54. 00           54. 01   05401   ULTRASOUND         0         1, 055         0         702         0         54. 01           55. 00   05500   RADI OLOGY - THERAPEUTI C         0         9, 748         0         6, 478         0         55. 00           56. 00   05600   RADI OLOGY - THERAPEUTI C         0         9, 748         0         6, 478         0         55. 00           56. 00   05600   RADI OLOGY - THERAPEUTI C         0         9, 748         0         6, 478         0         55. 00           57. 00   05700   CT SCAN         0         0         0         0         0         0         57. 00           58. 00   05800   MRI         0         0         0         0         0         0         0         0         58. 00           59. 00   05900   CARDI AC CATHETERI ZATI ON         0         0         0         0         0         0         0         0         59. 00         0         0         0         0         0         0
54. 00         05400   RADI OLOGY-DI AGNOSTI C         0         16, 179   0         10, 755   0         54. 00           54. 01   05401   ULTRASOUND   0         0         1, 055   0         0         702   0         54. 01           55. 00   05500   RADI OLOGY-THERAPEUTI C   0         0         9, 748   0         6, 478   0         0         55. 00           56. 00   05600   RADI OLOGY-THERAPEUTI C   0         0         0         679   0         55. 00           57. 00   05700   CT SCAN   0         0         0         0         0         0         56. 00           58. 00   05800   MR I   0         0         0         0         0         0         0         0         58. 00           59. 00   05900   CARDI AC CATHETERI ZATI ON   0         0         0         0         0         0         0         0         59. 00           60. 01   06000   LABORATORY   0         0 <t< td=""></t<>
54. 01         05401         ULTRASOUND         0         1,055         0         702         0         54. 01           55. 00         05500         RADI OLOGY-THERAPEUTI C         0         9,748         0         6,478         0         55. 00           56. 00         05600         RADI OLOGY-THERAPEUTI C         0         9,748         0         6,478         0         55. 00           57. 00         05700         CT SCAN         0         0         0         0         0         0         56. 00           58. 00         05800         MRI         0         0         0         0         0         0         0         57. 00           59. 00         05900         CARDI AC CATHETERI ZATI ON         0         0         0         0         0         0         0         59. 00           60. 00         06000         LABORATORY         0
55. 00         05500 RADI OLOGY-THERAPEUTI C         0         9, 748         0         6, 478         0         55. 00           56. 00         05600 RADI OLOGY-THERAPEUTI C         0         1, 025         0         679         0         56. 00           57. 00         05700 CT SCAN         0         0         0         0         0         0         57. 00           58. 00         05800 MRI         0         0         0         0         0         0         0         58. 00           59. 00         05900 CARDI AC CATHETERI ZATI ON         0         0         0         0         0         0         0         0         59. 00           60. 00         06000 LABORATORY         0
56. 00       05600 RADI OI SOTOPE       0       1,025       0       679       0       56. 00         57. 00       05700 CT SCAN       0       0       0       0       0       57. 00         58. 00       05800 MRI       0       0       0       0       0       0       58. 00         59. 00       05900 CARDI AC CATHETERI ZATI ON       0       0       0       0       0       0       0       59. 00         60. 00       06000 LABORATORY       0
57. 00       05700   CT SCAN       0       0       0       0       0       57. 00         58. 00       05800   MRI       0       0       0       0       0       0       0       58. 00         59. 00       05900   CARDI AC CATHETERI ZATI ON       0       0       0       0       0       59. 00         60. 00       06000   LABORATORY       0
58. 00       05800 MRI       0       0       0       0       0       58. 00         59. 00       05900 CARDI AC CATHETERI ZATI ON       0       0       0       0       0       59. 00         60. 00       06000 LABORATORY       0
59. 00       05900 CARDI AC CATHETERI ZATI ON       0       0       0       0       0       59. 00         60. 00       06000 LABORATORY       0       <
60. 00   06000   LABORATORY   0   0   0   0   0   0   0   0   0
60. 01   06001   BLOOD LABORATORY   0 0 0 0 0 0 0 60. 01 61. 00 61. 00 62. 00   062. 00   062. 00   063. 00   063. 00   064. 0
61. 00
62. 00   06200   WHOLE BLOOD & PACKED RED BLOOD CELL   0   0   0   0   0   62. 00   63. 00   06300   BLOOD STORING, PROCESSING & TRANS.   0   0   0   0   0   63. 00   64. 00   06400   INTRAVENOUS THERAPY   0   0   0   0   0   64. 00
63. 00   06300   BLOOD STORING, PROCESSING & TRANS.   0   0   0   0   0   63. 00   64. 00   06400   I NTRAVENOUS THERAPY   0   0   0   0   64. 00
64. 00 06400 I NTRAVENOUS THERAPY 0 0 0 0 64. 00
66. 00   06600   PHYSI CAL THERAPY   0   7, 235   0   4, 808   0   66. 00
67. 00   06700   0CCUPATI ONAL THERAPY   0   0   0   0   67. 00
68. 00   06800   SPEECH PATHOLOGY   0   0   0   0   68. 00
69. 00   06900   ELECTROCARDI OLOGY   0   3, 768   0   2, 502   0   69. 00
70. 00   07000   ELECTROENCEPHALOGRAPHY 0 0 0 0 0 70. 00
71. 00   07100   MEDICAL SUPPLIES CHARGED TO PATIENT   0   0   0   306, 879   71. 00
72.00   07200   1MPL. DEV. CHARGED TO PATIENTS   0   0   0   131,520   72.00
73. 00   07300   DRUGS CHARGED TO PATIENTS   0   0   0   0   0   73. 00
74. 00   07400   RENAL DI ALYSI S   0   0   0   0   74. 00
75. 00   07500   ASC (NON-DISTINCT PART)   0   0   0   0   75. 00
76. 00   03020   0NCOLOGY   0   0   0   0   76. 00
76. 98 <u>07698 HYPERBARI C OXYGEN THERAPY</u> 0 0 0 0 0 76. 98
OUTPATLENT SERVICE COST CENTERS
88. 00   08800   RURAL HEALTH CLINIC   0 0 0 0 0 88. 00
89. 00   08900  FEDERALLY QUALIFIED HEALTH CENTER   0   0   0   0   89. 00
90. 00   09000  CLI NI C
91. 00   09100   EMERGENCY   0   21, 667   0   14, 403   0   91. 00
92. 00   09200  0BSERVATI ON BEDS (NON-DI STI NCT PART   92. 00
OTHER REI MBURSABLE COST CENTERS         O         O         O         O         99. 10           99. 10         09910   CORF         O         O         O         O         O         99. 10
SPECIAL PURPOSE COST CENTERS
109. 00 10900 PANCREAS ACQUISITION 0 0 0 0 109. 00
110. 00 110900 PANCREAS ACQUISITION 0 0 0 0 0 0 1110. 00
111. 00 11100 I SLET ACQUI SI TI ON 0 0 0 0 0 1111. 00
113. 00 11300 I NTEREST EXPENSE

| Peri od: | Worksheet B | From 01/01/2016 | Part II | To 12/31/2016 | Date/Time Prepared:

					6/28/2017 3:4	
Cost Center Description	DI ETARY	CAFETERI A	MAINTENANCE OF	NURSI NG	CENTRAL	
			PERSONNEL	ADMI NI STRATI ON	SERVICES &	
					SUPPLY	
	10.00	11. 00	12. 00	13. 00	14. 00	
114.00 11400 UTI LI ZATI ON REVI EW-SNF						114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	0	0	0	115. 00
116. 00 11600 HOSPI CE	0	0	0	0	0	116. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	243, 678	134, 911	0	89, 554	438, 399	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
191. 00 19100 RESEARCH	0	0	0	0	0	191. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	0	0	192. 00
193. 00 19300 NONPALD WORKERS	0	0	0	0	0	193. 00
194.00 07950 OTHER NONREI MBURSABLE COST CENTERS	0	0	0	0	0	194. 00
194. 01 07951 SPORTS MEDICINE	0	0	0	0	0	194. 01
194. 02 07952 COMMUNITY IND HEALTH	0	0	0	0	0	194. 02
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)	243, 678	134, 911	0	89, 554	438, 399	202. 00

ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0022 Peri od: Worksheet B From 01/01/2016 Part II Date/Time Prepared: 12/31/2016 6/28/2017 3:41 pm Cost Center Description **PHARMACY** MEDI CAL Intern & Subtotal Total RECORDS & Residents Cost LI BRARY & Post Stepdown Adjustments 15.00 16.00 24.00 25.00 26.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 00600 MAINTENANCE & REPAIRS 6.00 6.00 00700 OPERATION OF PLANT 7.00 7 00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10 00 10 00 01100 CAFETERI A 11.00 11.00 12.00 01200 MAINTENANCE OF PERSONNEL 12.00 13.00 01300 NURSING ADMINISTRATION 13.00 01400 CENTRAL SERVICES & SUPPLY 14 00 14 00 01500 PHARMACY 15.00 50, 940 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 159, 837 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 5, 659 1, 485, 245 1, 485, 245 30.00 03100 INTENSIVE CARE UNIT 0 1, 869 224, 129 0 224, 129 31.00 31.00 0 03200 CORONARY CARE UNIT 32.00 0 0 0 32.00 03300 BURN INTENSIVE CARE UNIT 33 00 0 0 33 00 04000 SUBPROVIDER - IPF 0 40.00 3, 384 502, 016 502, 016 40.00 04100 SUBPROVI DER - I RF o 41.00 41.00 0 42.00 04200 SUBPROVI DER 0 0 0 0 0 42.00 C 04300 NURSERY 0 43 00 C 0 43 00 0 44.00 04400 SKILLED NURSING FACILITY C 0 0 44.00 04500 NURSING FACILITY 0 0 45.00 45.00 0 0 0 04510 I CF/MR 0 45.01 0 0 45.01 04600 OTHER LONG TERM CARE 0 46.00 0 46.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 611, 581 50 00 9, 340 611, 581 50 00 0 05100 RECOVERY ROOM 00000 51.00 51.00 0 0 05200 DELIVERY ROOM & LABOR ROOM 52 00 r 0 Λ 52 00 05300 ANESTHESI OLOGY 0 53.00 53.00 05400 RADI OLOGY-DI AGNOSTI C 1, 299, 589 54.00 32, 711 1, 299, 589 0 54.00 05401 ULTRASOUND 29, 085 54.01 2, 734 29, 085 54.01 3, 599 05500 RADI OLOGY-THERAPEUTI C 55.00 47,083 47,083 55.00 56, 00 05600 RADI OI SOTOPE 0 0 2,845 29,670 0 0 29,670 56,00 57.00 05700 CT SCAN 57.00 C 05800 MRI 0 58.00 Λ 58 00 0 59.00 05900 CARDIAC CATHETERIZATION C 0 0 59.00 60.00 06000 LABORATORY 17, 892 487, 208 487, 208 60.00 0 06001 BLOOD LABORATORY 60.01 0 0 60.01 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 61.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 62.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 0 0 63.00 C 63.00 06400 I NTRAVENOUS THERAPY 64.00 Ω Λ 64.00 65.00 06500 RESPIRATORY THERAPY 1,745 56, 721 56, 721 65.00 06600 PHYSI CAL THERAPY 0 2, 191 66.00 216, 494 0 216, 494 66.00 06700 OCCUPATIONAL THERAPY 67.00 C 0 67.00 68.00 06800 SPEECH PATHOLOGY Ω Λ 68.00 0 69.00 06900 ELECTROCARDI OLOGY 4,706 44.178 0 44, 178 69.00 0 70.00 07000 ELECTROENCEPHALOGRAPHY 0 70.00 0 71 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 11 845 455 323 455, 323 71 00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 0 3, 176 147, 837 147, 837 72.00 0 07300 DRUGS CHARGED TO PATIENTS 50, 940 616, 239 73.00 73.00 35, 628 616, 239 0 07400 RENAL DIALYSIS 74.00 C 74.00 0 0 0 07500 ASC (NON-DISTINCT PART) 75 00 0 0 75 00 C 0 03020 ONCOLOGY 0 76.00 0 0 76.00 07698 HYPERBARIC OXYGEN THERAPY 76.98 360 1, 796 1, 796 76.98 OUTPATIENT SERVICE COST CENTERS 88 00 08800 RURAL HEALTH CLINIC 88 00 0 Ω 0 0 0 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 C 0 0 0 89.00 09000 CLI NI C 0 74, 514 0 74, 514 90.00 580 90.00 91.00 09100 EMERGENCY 0 19, 573 389, 308 0 389, 308 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 92.00 OTHER REIMBURSABLE COST CENTERS 99.10 09910 CORE 0 0 0 0 0 99. 10 SPECIAL PURPOSE COST CENTERS 109.00 10900 PANCREAS ACQUISITION 0 0 109. 00 0 0 110.00 11000 INTESTINAL ACQUISITION 0 0 0 0 110.00

ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 15-0022 Peri od: Worksheet B From 01/01/2016 Part II 12/31/2016 Date/Time Prepared: 6/28/2017 3:41 pm Cost Center Description **PHARMACY** MEDI CAL Subtotal Intern & Total RECORDS & Residents Cost LI BRARY & Post Stepdown Adjustments 15.00 16.00 24.00 26.00 25.00 111.00 11100 | SLET ACQUISITION 0 111. 00 113.00 11300 INTEREST EXPENSE 113. 00 114.00 11400 UTILIZATION REVIEW-SNF 114. 00 115.00 11500 AMBULATORY SURGICAL CENTER (D.P.) 0 0 0 0 115. 00 0 116. 00 11600 HOSPI CE 0 0 116.00 118.00 | SUBTOTALS (SUM OF LINES 1-117)
| NONREI MBURSABLE COST CENTERS |
190.00 | 19000 | GIFT, FLOWER, COFFEE SHOP & CANTEEN | 50, 940 6, 718, 016 118. 00 159, 837 6, 718, 016 26, 478 190. 00 0 0 26, 478 0 191. 00 19100 RESEARCH 0 0 0 0 0 0 0 0 0 0 0 191.00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 57, 488 57, 488 192. 00 0 193. 00 19300 NONPAI D WORKERS 0 193. 00 0 0 194.00 07950 OTHER NONREIMBURSABLE COST CENTERS 0 0 0 194. 00 194. 01 07951 SPORTS MEDICINE 0 0 0 194. 01 0 194. 02 07952 COMMUNITY IND HEALTH 122, 506 122, 506 194. 02 Ω 0 200. 00 200.00 Cross Foot Adjustments 0 0

50, 940

159, 837

0 201.00

6, 924, 488 202. 00

0

6, 924, 488

201.00

202.00

Negative Cost Centers

TOTAL (sum lines 118-201)

CAPITAL RELAYED COSTS   CAPI							o 12/31/2016	Date/Time Pre	
COUNTY   C				CAPITAL REI	L LATED COSTS			6/28/201/ 3:4	ı pm
COUNTY   FEET   COUNTY   FEET   COUNTY   FEET   COUNTY   FEET			Cost Center Description	RIDG & FLYT	MVRLE FOLLE	FMPLOVEE	Reconciliation	ADMI NI STRATI VE	
1.00			cost center bescription				Reconciliation		
CEREMAL SERVICE DOST CENTERS   1.00								(ACCUM. COST)	
CHERNAL SERVICE COST CENTERS									
1.00		CENED	AL SERVICE COST CENTERS	1.00	2.00	4. 00	5A	5. 00	
4.00   00000   DOBOD   PURP CYPT   PURP TITS DEPARTMENT   773   773   10, 747, 651   3, 673, 490   5, 00   60000   AMINISTRATIVE & GENERAL   16, 0937   10, 174, 661   30, 633, 490   5, 00   60000   AMINISTRATIVE & GENERAL   16, 0937   17, 134, 600   36, 533, 490   6, 00   60000   AMINISTRATIVE & GENERAL   17, 900   174, 600   0, 22, 993, 90, 90, 90, 90, 90, 90, 90, 90, 90, 90	1.00			105, 598					1. 00
5.00   090000 JAMINIM STRATIVE & GERFERM   16,057   16,057   802,397   -7,134,360   36,533,499   6,00   000				700		1			
0.00 0.000 MINTERMANCE & REPAIR S 0.00 0.000 CHARLING OF PERSONNEL 1.00 0.000 CHARLING OF PERSONNEL 1.00 0.00 0.000 CHARLING OF PERSONNEL 1.00 0.00 0.000 CHARLING STRUCK 1.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00		1						36, 533, 490	
0.00   0.0000   LAURDRY & LINEN SERVICE   3,004   3,094   121,470   0   572,897   8,00   10.00   0.0000   DIETARY   3,081   3,081   185,703   0.502,600   10.00   10.000   DIETARY   3,081   3,081   185,703   0.502,600   10.00   10.000   DIETARY   1,000   10.000   DIETARY   1,000   10.000   DIETARY   1,000   10.000   DIETARY   1,000   10.000   13000   MIRSING AMON INSTRATION   1,013   1,013   1,015   176,796   0.487,740   15.00   15.00   15000   PARAMACY   3000   3000   414,584   0.673,473   15.00   15.00   15.00   PARAMACY   3000   3000   414,584   0.673,473   15.00   0.00   3000   PARAMACY   3000   3000   414,584   0.673,473   15.00   0.00   3000   PARAMACY   3000   3000   414,584   0.673,473   15.00   0.00   3000   PARAMACY   3000	6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6. 00
9.00   0.0900   MUSEKEFF NR   247		1	l e e e e e e e e e e e e e e e e e e e	1		1			
11.00   01100   CAF LETRIA   1,690   1,690   132,696   0 344,302   11.00   12.00   12.00   12.00   13.00   MIRST ING ADMINISTRATION   1,013   1,013   176,798   0 487,540   13.00		00900	HOUSEKEEPI NG	1		1			
12.00   0.1200   MAINTENANCE OF PERSONNEL   0   0   0   0   12.00									
14.00   01400   CENTRAL SERVICES & SUPPLY   5.061   5.061   6.4,870   0   609,899   14.00   16				0		132, 070	0		
15.00 0 1500 [PHARMACY] 1.00 0 1500 [PHARMACY		1	l e e e e e e e e e e e e e e e e e e e	1					
IMPATT ENT ROUTINE SERVICE COST CENTERS   15,728   15,728   1,382,002   0,2,902,901 30.00   30.00   30.00   0.1100   NITERS IVE CARE UNIT   1,879   694,003   0,1,178,811 31.00   0.00   30.00   30.00   30.00   0		1	l e e e e e e e e e e e e e e e e e e e						
03000   ADULTS & PEDIATRICS	16. 00			1, 935	1, 935	0	0	606, 551	16. 00
31.00 03000 (NTENSI VE CARE UNIT 1 1, 879 0 1, 879 694, 003 0 1, 178, 811 31, 00 0 0 0 0 0 32, 00 330 0 330 0 3300 (BURN INTENSI VE CARE UNIT 1 0 0 0 0 0 0 0 32, 00 330 0 330 0 3300 (BURN INTENSI VE CARE UNIT 1 0 0 0 0 0 0 0 0 32, 00 330 0 330 0 3300 (BURN INTENSI VE CARE UNIT 1 0 0 0 0 0 0 0 0 0 32, 00 330 0 341, 00 0 410, 00 410,	30. 00			15, 728	15, 728	1, 382, 002	0	2, 902, 901	30. 00
33. 00 0 33300 BURN INTENSIVE CARE UNIT 0 0 0 0 0 0 1, 598,872 40. 00 1 0 0 1, 598,872 40. 00 1 0 0 1 0 1, 598,872 40. 00 1 0 0 1 0 0 1 0 0 0 0 0 0 0 0 0 0	31.00	03100	INTENSIVE CARE UNIT		1, 879	694, 003	0	1, 178, 811	
40.00   04000 SUBPROVI DER - I PF				0	0		0		
42 00   04200   SUBROVI DER   0   0   0   0   0   0   2   20	40. 00	04000	SUBPROVI DER - I PF	4, 310	4, 310	979, 927	0	1, 598, 872	40. 00
43.00   04300 NURSERY   0   0   0   0   0   0   43.00   45.00   04500 NIRSI NG FACILITY   0   0   0   0   0   0   0   45.00   45.00   04500 NIRSI NG FACILITY   0   0   0   0   0   0   0   45.01   46.00   04500 NIRSI NG FACILITY   0   0   0   0   0   0   0   45.01   46.00   04500 OTHER LONG TERN CARE   0   0   0   0   0   0   0   0    MACILLARY SERVICE COST CENTERS				0	1	· -	0	_	
45. 00   04500   NURSING FACILITY				o o	ő	Ö	0		
45.01   04510   10F/NR				0	0	0	0		
ANCILLARY SERVICE COST CENTERS		1	l e e e e e e e e e e e e e e e e e e e				0	_	
50. 00	46. 00			0	0	0	0	0	46. 00
52 00   05200   05200   05200   05200   05200   0530	50. 00			6, 273	6, 273	1, 325, 850	0	2, 378, 440	50. 00
53.00   05300   ANESTHESI OLOGY   0   0   0   53.00   05.00		05100	RECOVERY ROOM		0	0		0	
54.00   05400   RADIOLOGY-DIACNOSTIC   15, 478   15, 478   1,093, 372   0 3, 046, 678   54, 010				0	1	1	0	-	
55. 00   05500   RADI OLOGY-THERAPEUTI C   0   0   456, 302   0   872, 998   55. 00   56. 00   0500   RADI OLOGY-THERAPEUTI C   267   267   79, 279   0   177, 611   56. 00   57. 00   57. 00   5700   CT SCAN   0   0   0   0   0   0   0   57. 00   58. 00   05900   RADI OLOGY   0   0   0   0   0   0   0   0   58. 00   59. 00   59. 00   59. 00   59. 00   59. 00   59. 00   59. 00   69. 00   0   0   0   0   0   0   0   0   0	54.00	05400	RADI OLOGY-DI AGNOSTI C	1					54.00
56.00   05700   CT SCAN   0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				281					
58.00   05900   0ARI   0   0   0   0   0   0   0   58.00	56. 00	05600	RADI OI SOTOPE	267				177, 611	56. 00
59.00   05900   CARDI AC CATHETERI ZATI ON   0   0   0   0   0   59.00		1	l e e e e e e e e e e e e e e e e e e e	0	0	0	0	-	
60.01   06001   BLOOD LABORATORY   0   0   0   0   0   0   0   60.01   61.00   06100   PBP CLINICAL LAB SERVICES-PRGM ONLY   0   0   0   0   61.00   62.00   06200   WHOLE BLOOD & PACKED RED BLOOD CELL   0   0   0   0   0   0   63.00   06300   BLOOD STORING, PROCESSING & TRANS.   0   0   0   0   0   0   64.00   06400   INTRAVENOUS THERAPY   0   0   0   0   0   0   65.00   06500   RESPI RATORY THERAPY   406   406   305, 397   0   468, 185   55.00   66.00   06500   PHYSI CAL THERAPY   2, 329   2, 329   479, 264   0   786, 029   66.00   67.00   06700   0CUPATI ONAL THERAPY   0   0   0   0   0   0   68.00   06600   PHYSI CAL THERAPY   0   0   0   0   0   69.00   06900   ELECTROCARDIOLOGY   323   323   323   202, 588   0   295, 860   69.00   69.00   06900   ELECTROCARDIOLOGY   323   323   323   202, 588   0   295, 860   69.00   71.00   07100   MEDICAL SUPPLIES CHARGED TO PATIENT   1, 412   1, 412   0   0   1, 132, 980   71.00   71.00   07100   MEDICAL SUPPLIES CHARGED TO PATIENTS   0   0   0   0   454, 437   72.00   73.00   07300   DRUGS CHARGED TO PATIENTS   4, 271   4, 271   0   0   7, 455, 651   73.00   74.00   07400   RENAL DI ALYSIS   0   0   0   0   0   0   75.00   07500   ASC (NON-DISTINCT PART)   0   0   0   0   0   0   76.90   07500   ASC (NON-DISTINCT PART)   0   0   0   0   0   76.90   07500   ONCOLOGY   0   0   0   0   0   76.90   09000   CLINI C   0   0   0   0   0   88.00   09000   CURRALLH CALLTH CLINI C   0   0   0   0   99.00   09000   CLINI C   0   0   0   0   99.00   09000   CLINI C   0   0   0   99.00   09000   C		05900	CARDI AC CATHETERI ZATI ON	Ö	ő	Ö	0	0	59. 00
61. 00		1	l e e e e e e e e e e e e e e e e e e e	5, 386	· ·	1	0		
63. 00   06300   BLOOD STORING, PROCESSING & TRANS.   0   0   0   0   0   0   0   63. 00   64. 00   06400   INTRAVENOUS THERAPY   406   406   305, 397   0   468, 185   65. 00   65. 00   06500   RESPIRATORY THERAPY   406   406   305, 397   0   468, 185   65. 00   66. 00   06600   PHYSI CAL THERAPY   2, 329   2, 329   479, 264   0   786, 029   66. 00   67. 00   06700   0CCUPATI ONAL THERAPY   0   0   0   0   0   0   68. 00   08600   SPECH PATHOLOGY   0   0   0   0   0   0   69. 00   06900   ELECTROCARDI OLOGY   323   323   202, 588   0   295, 860   69. 00   70. 00   07000   ELECTROCARDI OLOGY   323   323   202, 588   0   295, 860   69. 00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENT   1, 412   1, 412   0   0   1, 132, 980   71. 00   72. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   0   0   0   0   0   454, 437   72. 00   73. 00   07300   DRUGS CHARGED TO PATI ENTS   4, 271   4, 271   0   0   7, 455, 651   73. 00   74. 00   07400   RENAL DI ALYSIS   0   0   0   0   0   0   74. 00   75. 00   07500   ASC (NON-DI STI NCT PART)   0   0   0   0   0   0   76. 98   07698   HYPERBARI C OXYGEN THERAPY   0   0   0   0   0   0   88. 00   08900   FURAL HEALTH CLINIC   0   0   0   0   0   99. 00   09900   CLINIC   SETIMATION   ELECTROCENCY   2, 684   2, 684   1, 411, 359   0   2, 437, 808   91. 00   90. 00   09900   CLINIC   EMERGENCY   2, 684   2, 684   1, 411, 359   0   2, 437, 808   91. 00   90. 00   OTHER REIMBURSABLE COST CENTERS		1	l .				0		
64. 00   06400   INTRAVENOUS THERAPY   0   0   0   0   0   0   64. 00   65. 00   06500   RESPI RATORY THERAPY   406   406   305, 397   0   468, 185   65. 00   66. 00   06600   PHYSI CAL THERAPY   2, 329   2, 329   479, 264   0   786, 029   66. 00   67. 00   06700   OCCUPATI ONAL THERAPY   0   0   0   0   0   0   68. 00   06800   SPEECH PATHOLOGY   0   0   0   0   0   0   69. 00   06900   SEECTROCARDI OLOGY   323   323   320, 588   0   295, 860   69. 00   70. 00   07000   ELECTROCARDI OLOGY   323   323   320, 588   0   295, 860   69. 00   71. 00   07000   MEDI CAL SUPPLIES CHARGED TO PATI ENT   1, 412   1, 412   0   0   1, 132, 980   71. 00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0   0   0   0   454, 437   72. 00   72. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   4, 271   4, 271   0   0   7, 455, 651   73. 00   73. 00   07300   DRUGS CHARGED TO PATI ENTS   4, 271   4, 271   0   0   0   7, 455, 651   73. 00   74. 00   07400   RENAL DI ALYSI S   0   0   0   0   0   0   75. 00   07500   ASC (NON-DI STI NCT PART)   0   0   0   0   0   76. 09   07690   ASC (NON-DI STI NCT PART)   0   0   0   0   0   76. 98   07698   HYPERBARI C OXYGEN THERAPY   0   0   0   0   0   90. 00   08900   FEDERALLY QUALI FIED HEALTH CENTER   0   0   0   0   90. 00   08900   FEDERALLY QUALI FIED HEALTH CENTER   0   0   0   90. 00   09000   CLI NI C   0   0   0   90. 00   09200   OBSERVATI ON BEDS (NON-DI STI NCT PART   0   90. 00   09200   DESERVATI ON BEDS (NON-DI STI NCT PART   0   90. 00   095ERVATI ON BEDS (NON-DI STI NCT PART   0   90. 00   00   00   00   00   00   90. 00   00   00   00   00   90. 00   00   00   00   00   90. 00   00   00   00   00   90. 00   00   00   00   00   90. 00   00   00   00   00   90. 00   00   00   00   00   90. 00   00   00   00   00   90. 00   00   00   00   00   90. 00   00   00   00   00   90. 00   00   00   00   00   90. 00   00   00   00   00   90. 00   00   00   00   00   90. 00   00   00   00   00   90. 00   00   00   00   00   90. 00   00   00   00   00   90. 00   00   00   00		1	l e e e e e e e e e e e e e e e e e e e	0	0	0	0		
66. 00 06600 PHYSI CAL THERAPY 2, 329 2, 329 479, 264 0 786, 029 66. 00 6700 0CCUPATI ONAL THERAPY 0 0 0 0 0 0 0 0 67. 00 68. 00 6800 SPEECH PATHOLOGY 0 0 0 0 0 0 0 0 68. 00 69. 00 69. 00 69. 00 69. 00 0 0 0 0 0 0 68. 00 69. 00 69. 00 69. 00 69. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				0	0	0	0	-	
67. 00 06700 OCCUPATIONAL THERAPY 0 0 0 0 0 0 0 67. 00 68. 00 690. 0 669. 00 0 0 0 0 0 0 0 0 0 68. 00 690. 00 0 0 0 0 0 0 0 0 68. 00 690. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1							
69. 00				2, 329	1	· _	0		
70. 00		4		0	1		0		
71. 00		1	l e e e e e e e e e e e e e e e e e e e	323	323	202, 588	0		
73. 00 07300 DRUGS CHARGED TO PATIENTS	71. 00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1, 412	1, 412	Ö	Ö	1, 132, 980	71. 00
74. 00				0	0	0	0		
76. 00		07400	RENAL DIALYSIS	0	0	0	0		
76. 98 O7698 HYPERBARI C OXYGEN THERAPY O O O O O 49, 648 76. 98 OUTPATIENT SERVICE COST CENTERS  88. 00 08800 RURAL HEALTH CLINIC O O O O O 0 88. 00 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER O O O O O O S900 CLINIC SERVICE OST CENTERS  90. 00 09000 CLINIC SERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS)				0	1		0	-	
88. 00		1	l e e e e e e e e e e e e e e e e e e e	0	1				
89. 00	00.00							0	00.00
90. 00							0	-	
92. 00 O9200 OBSERVATION BEDS (NON-DISTINCT PART 92. 00 OTHER REIMBURSABLE COST CENTERS	90.00	09000	CLINIC	i e	l .				90. 00
OTHER REIMBURSABLE COST CENTERS		1	l e e e e e e e e e e e e e e e e e e e	2, 684	2, 684	]	0	2, 437, 808	
99. 10  09910  CORF   0  0  0  99. 10		OTHER	REIMBURSABLE COST CENTERS	1					
	99. 10	<sub>09910</sub>	CURF	0	1 0	1 0	0	0	99. 10

Health Financial Systems	FRANCISCAN HEALTH CRAWFORDSVILLE	In Lieu of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS	Provi der CCN: 15-0022	Period: Worksheet B-1
		From 01/01/2016

COST ALLOCAT	TION STATISTICAL BASIS		Trovider od		rom 01/01/2016	WOLKSHEET D. I	
					o 12/31/2016		
		0451741 551	ATER 000TO			6/28/2017 3:4	1 pm
		CAPITAL REL	ATED COSTS				
	Cost Center Description	BLDG & FLXT	MVBLE EQUIP	EMPLOYEE	Reconciliation	ADMINI CTDATIVE	
	cost center bescription	(SQUARE FEET)	(SQUARE FEET)	BENEFITS	Reconciliation	& GENERAL	
		(SQUARE FEET)	(SQUARE FEET)	DEPARTMENT		(ACCUM. COST)	
				(GROSS		(ACCOM. COST)	
				SALARI ES)			
		1.00	2.00	4. 00	5A	5. 00	
SPECI	AL PURPOSE COST CENTERS		2.00	11.00	071	0.00	
109. 00 10900	PANCREAS ACQUISITION	0	0	C	0	0	109. 00
	INTESTINAL ACQUISITION	o	0	C	0	0	110.00
	ISLET ACQUISITION	ol	0	O	o o		111. 00
	INTEREST EXPENSE						113. 00
	UTILIZATION REVIEW-SNF						114. 00
115.00 11500	AMBULATORY SURGICAL CENTER (D. P.)	o	0	C	0	0	115. 00
116.00 11600		ol	0	C	0	0	116. 00
118. 00	SUBTOTALS (SUM OF LINES 1-117)	103, 623	103, 623	10, 719, 149	-7, 134, 368	34, 420, 362	118. 00
NONRE'	IMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	351	351	C	0	23, 016	190. 00
191. 00 19100	RESEARCH	0	0	C	0	0	191. 00
	PHYSICIANS' PRIVATE OFFICES	0	0	28, 502	0	1, 983, 620	
193. 00 19300	NONPALD WORKERS	0	0	C	0		193. 00
194. 00 07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	C	0		194. 00
	SPORTS MEDICINE	0	0	C	0		194. 01
	COMMUNITY IND HEALTH	1, 624	1, 624	C	0	106, 492	
200. 00	Cross Foot Adjustments						200. 00
201. 00	Negative Cost Centers						201. 00
202. 00	Cost to be allocated (per Wkst. B,	6, 837, 195	87, 293	3, 638, 624		7, 134, 368	202. 00
	Part I)						
203. 00	Unit cost multiplier (Wkst. B, Part I)	64. 747391	0. 826654			0. 195283	
204. 00	Cost to be allocated (per Wkst. B,			47, 410	)	1, 056, 464	204. 00
005.00	Part II)						
205. 00	Unit cost multiplier (Wkst. B, Part			0. 004411		0. 028918	205. 00

COST ALLOCATION - STATISTICAL BASIS

Health Financial Systems In Lieu of Form CMS-2552-10 FRANCISCAN HEALTH CRAWFORDSVILLE Provider CCN: 15-0022 Peri od: Worksheet B-1 From 01/01/2016 12/31/2016 Date/Time Prepared: 6/28/2017 3:41 pm Cost Center Description MAINTENANCE & OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY LINEN SERVICE **REPALRS** PLANT (SQUARE FEET) (MEALS SERVED) (SQUARE FEET) (SQUARE FEET) (POUNDS OF LAUNDRY) 7.00 6.00 9.00 10.00 8.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4 00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 00600 MAINTENANCE & REPAIRS 6.00 6.00 00700 OPERATION OF PLANT 0 7.00 80, 874 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 3,094 266, 263 8.00 29, 519 9.00 00900 HOUSEKEEPI NG 0000000 247 77.533 9.00 01000 DI ETARY 3, 081 1, 789 3, 081 21, 917 10.00 10.00 01100 CAFETERI A 1, 690 11.00 1, 690  $\cap$ Λ 11.00 01200 MAINTENANCE OF PERSONNEL 12.00 0 0 12.00 13.00 01300 NURSING ADMINISTRATION 1.013 C 1.013 0 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 983 14.00 5, 661 5, 661 0 01500 PHARMACY 15.00 300 C 300 0 15.00 01600 MEDICAL RECORDS & LIBRARY 1, 935 1, 935 0 16.00 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 0 03000 ADULTS & PEDIATRICS 15. 728 11, 489 30.00 15, 728 80 745 30.00 31.00 03100 INTENSIVE CARE UNIT 1, 879 7, 573 1, 879 2, 325 31.00 32.00 03200 CORONARY CARE UNIT 0 32.00 C 0 03300 BURN INTENSIVE CARE UNIT 33.00 000000 33.00 0 0 04000 SUBPROVI DER - I PF 24, 837 4, 310 4, 310 8, 103 40 00 40 00 41.00 04100 SUBPROVIDER - IRF C 0 0 41.00 04200 SUBPROVI DER 42.00 0 0 42.00 0 0 43 00 04300 NURSERY 0 43 00 Ω 0 04400 SKILLED NURSING FACILITY C 0 0 0 44.00 04500 NURSING FACILITY 0 45.00 0 04510 I CF/MR C 0 o 0 45.01 04600 OTHER LONG TERM CARE 0 46.00 0 0 ANCILLARY SERVICE COST CENTERS

44.00 45.00 45.01 46.00 05000 OPERATING ROOM 0 6, 273 35, 572 6, 273 0 50.00 50.00 51.00 05100 RECOVERY ROOM 0000000000 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 0 0 52.00 Ω 0 53.00 05300 ANESTHESI OLOGY 0 0 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 15, 478 9,898 15, 478 54.00 54.01 05401 ULTRASOUND 281 281 54.01 0 0 05500 RADI OLOGY-THERAPEUTI C 55.00 0 0 0 55.00 56.00 05600 RADI OI SOTOPE 267 0 56.00 267 57.00 05700 CT SCAN C 0 0 0 57.00 05800 MRI 58.00 0 0 58.00 C 0 05900 CARDIAC CATHETERIZATION 59.00 0 59 00 0 60.00 06000 LABORATORY 5, 386 5, 386 0 60.00 06001 BLOOD LABORATORY 60.01 60.01 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 61.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL C 0 0 Ω 62.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 63.00 00000000000000 06400 INTRAVENOUS THERAPY 0 64.00 0 0 64.00 06500 RESPIRATORY THERAPY 65.00 406 1.371 406 0 65.00 06600 PHYSI CAL THERAPY 2, 329 6, 918 66.00 2, 329 0 66.00 06700 OCCUPATI ONAL THERAPY 67.00 0 0 67.00 0 06800 SPEECH PATHOLOGY 68.00 0 0 0 68.00

07400 RENAL DIALYSIS 74.00 0 74.00 0 07500 ASC (NON-DISTINCT PART) ol 75.00 75.00 0 0 03020 ONCOLOGY 0 76.00 C 0 0 76.00 76.98 07698 HYPERBARI C OXYGEN THERAPY 0 76.98 OUTPATIENT SERVICE COST CENTERS 88 00 08800 RURAL HEALTH CLINIC 0 O n 88 00 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 89.00 09000 CLI NI C 0 851 851 90.00 90.00 0 0 91.00 0 09100 EMERGENCY 2,684 67, 058 2,684 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 09910 CORF 0 99. 10 99.10 0 0 0 0 SPECIAL PURPOSE COST CENTERS 109. 00 10900 PANCREAS ACQUISITION 0 109, 00 0 Ω 0 0 110.00 11000 INTESTINAL ACQUISITION 0 0 0 0 0 110.00 111.00 11100 I SLET ACQUISITION 0 0 0 0 111.00

323

1.412

4, 271

323

1.412

4, 271

0

0

0 69.00

0 72.00

0 73.00

70.00

71.00

69.00

70.00

71.00

72.00

73.00

06900 ELECTROCARDI OLOGY

07000 ELECTROENCEPHALOGRAPHY

07300 DRUGS CHARGED TO PATIENTS

07100 MEDICAL SUPPLIES CHARGED TO PATIENT

07200 IMPL. DEV. CHARGED TO PATIENTS

| Period: | Worksheet B-1 | From 01/01/2016 | To 12/31/2016 | Date/Time Prepared: Provi der CCN: 15-0022

				T T	o 12/31/2016	Date/Time Pre 6/28/2017 3:4	
	Cost Center Description	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	ı pili
	oost center bescription	REPAI RS	PLANT	LINEN SERVICE		(MEALS SERVED)	
		(SQUARE FEET)	(SQUARE FEET)	(POUNDS OF	(040/11/2 1221)	(	
		(======================================	(,	LAUNDRY)			
		6. 00	7. 00	8. 00	9. 00	10.00	
113. 00 11300	INTEREST EXPENSE						113. 00
114. 00 11400	UTILIZATION REVIEW-SNF						114. 00
115. 00 11500	AMBULATORY SURGICAL CENTER (D. P.)	0	0	0	0	0	115. 00
116. 00 11600	HOSPI CE	0	0	0	0	0	116. 00
118. 00	SUBTOTALS (SUM OF LINES 1-117)	0	78, 899	266, 263	75, 558	21, 917	118. 00
NONREI	MBURSABLE COST CENTERS						
190. 00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	351	0	351	0	190. 00
191. 00 19100	RESEARCH	0	0	0	0	0	191. 00
192. 00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192. 00
193. 00 19300	NONPALD WORKERS	0	0	0	0	0	193. 00
194. 00 07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194. 00
194. 01 07951	SPORTS MEDICINE	0	0	0	0	0	194. 01
194. 02 07952	COMMUNITY IND HEALTH	0	1, 624	0	1, 624	0	194. 02
200.00	Cross Foot Adjustments						200. 00
201.00	Negative Cost Centers						201. 00
202.00	Cost to be allocated (per Wkst. B,	0	2, 502, 442	542, 577	692, 567	734, 016	202. 00
	Part I)						
203.00	Unit cost multiplier (Wkst. B, Part I)	0. 000000	30. 942478	2. 037748	8. 932545	33. 490715	203. 00
204.00	Cost to be allocated (per Wkst. B,	0	582, 231	236, 507	59, 310	243, 678	204. 00
	Part II)						
	Unit cost multiplier (Wkst. B, Part	0. 000000	7. 199236	0. 888246	0. 764965	11. 118219	205. 00
	11)						

In Lieu of Form CMS-2552-10 Health Financial Systems FRANCISCAN HEALTH CRAWFORDSVILLE COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0022 Peri od: Worksheet B-1 From 01/01/2016 12/31/2016 Date/Time Prepared: 6/28/2017 3:41 pm Cost Center Description CAFETERI A MAINTENANCE OF NURSI NG CENTRAL **PHARMACY** PERSONNEL ADMI NI STRATI ON (FTES) SERVICES & (COSTED (NUMBER **SUPPLY** REQUIS.) (DIRECT NRS HOUSED) (COSTED REQUIS.) ING) 15.00 11.00 12.00 13.00 14.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 00600 MAINTENANCE & REPAIRS 6.00 6.00 00700 OPERATION OF PLANT 7.00 7 00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10 00 10 00 01100 CAFETERI A 11.00 13, 425 11.00 12.00 01200 MAINTENANCE OF PERSONNEL 12.00 13.00 01300 NURSING ADMINISTRATION 18 278, 845 13.00 01400 CENTRAL SERVICES & SUPPLY 100 14 00 Ω 2.312 14 00 111 01500 PHARMACY 15.00 453 0 9, 415 0 100 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 0 0 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 2,001 41, 623 0 30.00 03100 INTENSIVE CARE UNIT 858 0 17, 854 0 0 31.00 31.00 03200 CORONARY CARE UNIT 32.00 0 0 0 0 0 0 0 32.00 0 0 03300 BURN INTENSIVE CARE UNIT 33 00 Ω 0 C 0 33 00 04000 SUBPROVIDER - IPF 1, 134 40.00 0 23, 588 0 40.00 04100 SUBPROVI DER - I RF 41.00 41.00 42.00 04200 SUBPROVI DER 0 0 0 0 42.00 04300 NURSERY 0 0 43 00 43 00 0 0 04400 SKILLED NURSING FACILITY 44.00 0 0 0 0 44.00 04500 NURSING FACILITY 0 0 0 0 45.00 45.00 0 0 04510 I CF/MR 0 45.01 0 0 0 45.01 04600 OTHER LONG TERM CARE 0 0 46.00 0 0 46.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 50 00 2 075 43, 151 0 50 00 51.00 05100 RECOVERY ROOM 0 0 0 0 0 0 0 0 0 0 51.00 0 0 05200 DELIVERY ROOM & LABOR ROOM 52 00 0 Ω 0 0 52 00 05300 ANESTHESI OLOGY 53.00 53.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 1,610 0 33, 487 0 54.00 05401 ULTRASOUND 54.01 105 0 2, 187 54.01 0 05500 RADI OLOGY-THERAPEUTI C 55.00 970 0 20, 171 0 55.00 56, 00 05600 RADI OI SOTOPE 102 2, 115 0 56.00 57.00 05700 CT SCAN 57.00 0 C 0 05800 MRI 0 58.00 0 0 58.00 Λ 59.00 05900 CARDIAC CATHETERIZATION 0 0 0 0 59.00 60.00 06000 LABORATORY 0 0 0 60.00 06001 BLOOD LABORATORY 0 60. N1 0 0 0 60.01 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 61.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 62.00 0 0 0 0 0 0 0 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 63.00 0 0 63.00 06400 I NTRAVENOUS THERAPY 0 64.00 C  $\cap$ 0 64.00 65.00 06500 RESPIRATORY THERAPY 539 11, 203 0 65.00 06600 PHYSI CAL THERAPY 66.00 720 14, 972 0 66.00 06700 OCCUPATIONAL THERAPY 67.00 0 67.00 C 0 68.00 06800 SPEECH PATHOLOGY 0  $\cap$ 0 68.00 69.00 06900 ELECTROCARDI OLOGY 375 7, 792 0 69.00 07000 ELECTROENCEPHALOGRAPHY 0 70.00 0 0 70.00 C 0 71 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT Ω 0 70 71 00 0 07200 IMPL. DEV. CHARGED TO PATIENTS 0 30 72.00 C 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 0 100 73.00 73.00 0 0 07400 RENAL DIALYSIS 74.00 0 0 74.00 0 07500 ASC (NON-DISTINCT PART) 75 00 Ω 0 75 00 0 03020 ONCOLOGY 0 0 0 76.00 0 0 76.00 07698 HYPERBARIC OXYGEN THERAPY 0 76. 98 76.98 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 88 00 0 Ω 0 0 0 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 89.00 09000 CLI NI C 0 90.00 198 4.128 90.00 91.00 09100 EMERGENCY 2, 156 C 44, 847 0 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 OTHER REIMBURSABLE COST CENTERS 99.10 09910 CORE 0 0 0 0 0 99. 10 SPECIAL PURPOSE COST CENTERS 109.00 10900 PANCREAS ACQUISITION 0 109. 00 0 0 0

0

0

0

0 110.00

110.00 11000 INTESTINAL ACQUISITION

Heal th Financ	cial Systems F	RANCISCAN HEALTH	CRAWFORDSVI LL	E	In Lie	eu of Form CMS-2	2552-10
COST ALLOCAT	ION - STATISTICAL BASIS		Provi der C		Peri od:	Worksheet B-1	
					From 01/01/2016 o 12/31/2016		nared:
				'	0 12/31/2010	6/28/2017 3:4	
	Cost Center Description	CAFETERI A	MAINTENANCE OF	NURSI NG	CENTRAL	PHARMACY	
		(FTES)		ADMI NI STRATI ON		(COSTED	
			(NUMBER	/	SUPPLY	REQUIS.)	
			HOUSED)	(DI RECT NRS	(COSTED		
		11.00	12.00	1 NG) 13. 00	REQUIS. ) 14. 00	15. 00	
111 00 11100	I SLET ACQUI SI TI ON	11.00	12.00	13.00			111. 00
1 1	INTEREST EXPENSE	0		1	,	0	113. 00
	UTI LI ZATI ON REVI EW-SNF						114. 00
	AMBULATORY SURGICAL CENTER (D. P. )	0	0		0	0	115.00
116. 00 11600		0	l o		o o		116.00
118. 00	SUBTOTALS (SUM OF LINES 1-117)	13, 425	o c	278, 845	100	100	118. 00
NONREI	MBURSABLE COST CENTERS						
190. 00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	C	C	0		190. 00
191. 00 19100		0	0	(	0		191. 00
	PHYSICIANS' PRIVATE OFFICES	0	0	(	0		192. 00
	NONPALD WORKERS	0	0	(	0		193. 00
	OTHER NONREIMBURSABLE COST CENTERS	0	0		0		194. 00
	SPORTS MEDICINE	0	0		0		194. 01
	COMMUNITY IND HEALTH	0		1	) O	0	194. 02 200. 00
	Cross Foot Adjustments Negative Cost Centers						200.00
1 1	Cost to be allocated (per Wkst. B,	478, 927	_	623, 784	1, 025, 597	854, 176	
	Part I)	470, 727		023, 704	1,023,397	054, 170	202.00
203. 00	Unit cost multiplier (Wkst. B, Part I)	35. 674264	0. 000000	2. 237028	10, 255. 970000	8, 541. 760000	203. 00
	Cost to be allocated (per Wkst. B,	134, 911	O	89, 554			1
	Part II)						
205. 00	Unit cost multiplier (Wkst. B, Part	10. 049236	0. 000000	0. 321161	4, 383. 990000	509. 400000	205. 00
	11)						

From 01/01/2016 12/31/2016 Date/Time Prepared: 6/28/2017 3:41 pm Cost Center Description MEDI CAL RECORDS & LI BRARY (GROSS CHAR GES) 16.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 00600 MAINTENANCE & REPAIRS 6.00 6.00 00700 OPERATION OF PLANT 7.00 7 00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10 00 10 00 01100 CAFETERI A 11.00 11.00 12.00 01200 MAINTENANCE OF PERSONNEL 12.00 13.00 01300 NURSING ADMINISTRATION 13.00 01400 CENTRAL SERVICES & SUPPLY 14 00 14 00 01500 PHARMACY 15.00 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 170, 031, 105 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 6,019,809 30.00 31.00 03100 INTENSIVE CARE UNIT 1, 988, 516 31.00 03200 CORONARY CARE UNIT 32.00 32.00 03300 BURN INTENSIVE CARE UNIT 33 00 33 00 O 04000 SUBPROVI DER - I PF 40.00 3, 599, 869 40.00 04100 SUBPROVI DER - I RF 41.00 41.00 04200 SUBPROVI DER 42.00 0 42.00 0 04300 NURSERY 43 00 43 00 04400 SKILLED NURSING FACILITY 0 44.00 44.00 04500 NURSING FACILITY 0 45.00 45.00 0 04510 | CF/MR 45. 01 45.01 04600 OTHER LONG TERM CARE 46.00 46.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 9, 935, 878 50 00 51.00 05100 RECOVERY ROOM 51.00 0 05200 DELIVERY ROOM & LABOR ROOM 52 00 0 52 00 53.00 05300 ANESTHESI OLOGY 53.00 05400 RADI OLOGY-DI AGNOSTI C 34, 799, 049 54.00 54.00 2, 908, 972 05401 ULTRASOUND 54.01 54.01 05500 RADI OLOGY-THERAPEUTI C 3, 829, 075 55.00 55.00 56, 00 05600 RADI OI SOTOPE 3, 027, 054 56, 00 57.00 05700 CT SCAN 57.00 58.00 05800 MRI 0 58.00 59.00 05900 CARDI AC CATHETERI ZATI ON 59.00 60.00 06000 LABORATORY 19, 034, 263 60.00 06001 BLOOD LABORATORY 60.01 0 60.01 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 61.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 62.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 63.00 63.00 06400 I NTRAVENOUS THERAPY 64.00 n 64.00 65.00 06500 RESPIRATORY THERAPY 1, 856, 148 65.00 06600 PHYSI CAL THERAPY 2, 331, 230 66.00 66.00 06700 OCCUPATIONAL THERAPY 67.00 67.00 0 06800 SPEECH PATHOLOGY 68.00 68.00 69.00 06900 ELECTROCARDI OLOGY 5,006,325 69 00 07000 ELECTROENCEPHALOGRAPHY 70.00 70.00 71 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 12, 601, 235 71 00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 3, 378, 233 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 37, 893, 570 73.00 07400 RENAL DIALYSIS 74.00 0 74.00 07500 ASC (NON-DISTINCT PART) 75 00 0 75 00 03020 ONCOLOGY 76.00 76.00 07698 HYPERBARI C OXYGEN THERAPY 382, 476 76. 98 76.98 OUTPATIENT SERVICE COST CENTERS 88 00 08800 RURAL HEALTH CLINIC 88 00 0 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 89.00 09000 CLI NI C 617, 344 90.00 90.00 91.00 09100 EMERGENCY 20, 822, 059 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 OTHER REIMBURSABLE COST CENTERS 99. 10 09910 CORF 0 99. 10 SPECIAL PURPOSE COST CENTERS 109.00 10900 PANCREAS ACQUISITION 0 109.00 110.00 11000 INTESTINAL ACQUISITION 0 l110. 00

Health Financial Systems FRA	NCISCAN HEALTH C	RAWFORDSVI LLE	In Lie	u of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider CCN: 15-0022	Peri od:	Worksheet B-1
			From 01/01/2016 To 12/31/2016	Date/Time Prepared:
			10 12/31/2010	6/28/2017 3: 41 pm
Cost Center Description	MEDI CAL			
	RECORDS &			
	LI BRARY (GROSS CHAR			
	GES)			
	16.00			
111.00 11100 I SLET ACQUI SI TI ON	0			111. 00
113.00 11300 INTEREST EXPENSE				113. 00
114.00 11400 UTI LI ZATI ON REVI EW-SNF				114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0			115. 00
116. 00 11600 H0SPI CE	0			116. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	170, 031, 105			118. 00
NONREI MBURSABLE COST CENTERS				
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0			190. 00
191. 00 19100 RESEARCH	0			191. 00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	0			192.00
193. 00 19300 NONPALD WORKERS	0			193. 00 194. 00
194. 00 07950 0THER NONREIMBURSABLE COST CENTERS 194. 01 07951 SPORTS MEDICINE	0			194. 00
194. 02 07952 COMMUNI TY I ND HEALTH	0			194. 01
200.00 Cross Foot Adjustments	o o			200. 00
201.00 Negative Cost Centers				201. 00
202.00 Cost to be allocated (per Wkst. B,	802, 158			202. 00
Part I)	332, 130			202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	0. 004718			203. 00
204.00 Cost to be allocated (per Wkst. B,	159, 837			204. 00
Part II)				
20E 00   Unit aget multiplian (What B Dont	0 000040			205.00

0.000940

205. 00

205.00

Unit cost multiplier (Wkst. B, Part

	TATION OF RATIO OF COSTS TO CHARGES	ANCI SCAN HEALIF	Provi der Co		eri od:	Worksheet C	2332-10
· · · · · · · · · · · · · · · · · · ·	7.17 617 617 1017 10 617 10 617 11 617 11 617		11.01.40.	F	rom 01/01/2016	Part I	
				T	o 12/31/2016	Date/Time Pre 6/28/2017 3:4	
			Title	XVIII	Hospi tal	PPS	т ріп
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst. B,	Adj .		Di sal I owance		
		Part I, col.					
		26)	2.00	2.00	4.00	F 00	
	INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	3. 00	4. 00	5. 00	
30. 00	03000 ADULTS & PEDIATRICS	4, 839, 149		4, 839, 149	0	4, 839, 149	30.00
31.00	03100 INTENSIVE CARE UNIT	1, 657, 167		1, 657, 167		1, 657, 167	31.00
32.00	03200 CORONARY CARE UNIT	0	l .	0		0	32. 00
33. 00	03300 BURN INTENSIVE CARE UNIT	0		0	0	0	33. 00
40. 00	04000 SUBPROVI DER - I PF	2, 515, 159		2, 515, 159	0	2, 515, 159	40. 00
41.00	04100 SUBPROVI DER - I RF	0		0	0	0	41.00
42. 00 43. 00	04200 SUBPROVI DER 04300 NURSERY			0	0	0 0	42. 00 43. 00
44. 00	04400 SKILLED NURSING FACILITY			0	0	0	44.00
45. 00	04500 NURSING FACILITY			0	0	0	45. 00
45. 01	04510 I CF/MR	0		Ö	0	0	45. 01
46.00	04600 OTHER LONG TERM CARE	0		0	0	0	46. 00
	ANCILLARY SERVICE COST CENTERS		,		<u> </u>		
50.00	05000 OPERATI NG ROOM	3, 382, 963		3, 382, 963	7, 923		50.00
51.00	05100 RECOVERY ROOM	0		0	0	0	51.00
52. 00 53. 00	O5200   DELI VERY ROOM & LABOR ROOM   O5300   ANESTHESI OLOGY			0	0	0 0	52. 00 53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	4, 575, 527		4, 575, 527	0	4, 575, 527	54.00
54. 01	05401 ULTRASOUND	181, 852	l .	181, 852		181, 852	54. 01
55. 00	05500 RADI OLOGY-THERAPEUTI C	1, 141, 273		1, 141, 273		1, 141, 273	55. 00
56.00	05600 RADI 0I SOTOPE	245, 594		245, 594		245, 594	56. 00
57. 00	05700 CT SCAN	0		0	0	0	57. 00
58. 00	05800 MRI	0		0	0	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0 004 000		0	0	0	59. 00
60. 00 60. 01	O6000   LABORATORY   O6001   BLOOD   LABORATORY	3, 331, 839		3, 331, 839	4, 722	3, 336, 561 0	60. 00 60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY			J 0	0	0	61.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL			0	0	Ö	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0		0	0	0	63.00
64.00	06400 I NTRAVENOUS THERAPY	0		0	0	0	64. 00
65. 00	06500 RESPI RATORY THERAPY	631, 644	0	631, 644	0	631, 644	65. 00
66. 00	06600 PHYSI CAL THERAPY	1, 116, 670	0	1, 116, 670	0	1, 116, 670	66. 00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67. 00
68. 00 69. 00	O6800   SPEECH PATHOLOGY   O6900   ELECTROCARDI OLOGY	420, 944	0	420, 944	0	0 420, 944	68. 00 69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	420, 944		420, 944 0	0	420, 944	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	2, 187, 907		2, 187, 907	0	2, 187, 907	71.00
	07200 I MPL. DEV. CHARGED TO PATIENTS	866, 799	l .	866, 799		866, 799	•
73.00	07300 DRUGS CHARGED TO PATIENTS	10, 114, 826		10, 114, 826	0	10, 114, 826	73. 00
	07400 RENAL DIALYSIS	0		0	0	0	74. 00
	07500 ASC (NON-DISTINCT PART)	0		0			•
	03020 ONCOLOGY	(1 140		0			1
76. 98	O7698   HYPERBARI C OXYGEN THERAPY   OUTPATIENT SERVICE COST CENTERS	61, 148		61, 148	0	61, 148	76. 98
88. 00	08800 RURAL HEALTH CLINIC	0		0	0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER			0		Ö	89. 00
	09000 CLI NI C	359, 840		359, 840	0	359, 840	90.00
	09100 EMERGENCY	3, 433, 018		3, 433, 018	0	3, 433, 018	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 370, 283		1, 370, 283		1, 370, 283	92. 00
	OTHER REIMBURSABLE COST CENTERS	_	1				
99. 10	09910 CORF	0		0		0	99. 10
100 00	SPECIAL PURPOSE COST CENTERS 10900 PANCREAS ACQUISITION	0	1	0		0	109. 00
	11000 INTESTINAL ACQUISITION			0			110.00
	11100   SLET ACQUISITION			Ö			111. 00
	11300 INTEREST EXPENSE						113.00
	11400 UTILIZATION REVIEW-SNF						114. 00
	11500 AMBULATORY SURGICAL CENTER (D. P.)	0		0			115. 00
	11600 HOSPI CE	0	_	0	40 /		116. 00
200. 00 201. 00	,	42, 433, 602 1, 370, 283	l .	42, 433, 602 1, 370, 283		42, 446, 247 1, 370, 283	
201.00		41, 063, 319					
50	, , , , , , , , , , , , , , , , , , , ,	, 555, 517	,	1, 555, 517		1, 5, 5, , 01	,

Health Financial Systems

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

						6/28/2017 3: 4	ı pm
		_		XVIII	Hospi tal	PPS	
			Charges	1=			
	Cost Center Description	I npati ent	Outpati ent		Cost or Other	TEFRA	
				+ col. 7)	Ratio	Inpati ent	
		4.00	7.00	0.00	0.00	Ratio	
	INDATIENT DOUTINE SERVICE COST CENTERS	6.00	7. 00	8. 00	9. 00	10.00	
30. 00	O3000 ADULTS & PEDIATRICS	4, 519, 239		4, 519, 239			30.00
		1, 988, 516			1		1
	03100 I NTENSI VE CARE UNI T	1, 988, 516		1, 988, 516			31.00
	03200 CORONARY CARE UNIT 03300 BURN INTENSIVE CARE UNIT						32.00
	04000 SUBPROVI DER – I PF	3, 599, 869		3, 599, 869			33. 00 40. 00
	04100 SUBPROVIDER - TPF	3, 399, 609		3, 399, 609			41. 00
42.00	04200 SUBPROVI DER						42.00
	04300 NURSERY						43.00
	04400 SKILLED NURSING FACILITY						44. 00
	04500 NURSING FACILITY						45. 00
	04510 I CF/MR						45. 00
	04600 OTHER LONG TERM CARE						46. 00
40.00	ANCILLARY SERVICE COST CENTERS	<u> </u>					40.00
50. 00	05000 OPERATING ROOM	1, 174, 309	8, 761, 569	9, 935, 878	0. 340480	0. 000000	50.00
	05100 RECOVERY ROOM	1, 174, 309	0, 701, 309	7, 733, 676	l	0. 000000	
	05200 DELIVERY ROOM & LABOR ROOM		0		0.000000	0. 000000	
	05300 ANESTHESI OLOGY		0		0.000000	0. 000000	
	05400 RADI OLOGY-DI AGNOSTI C	3, 961, 894	30, 837, 155	34, 799, 049		0. 000000	1
	05400 RADI OLOGI - DI AGNOSTI C 05401 ULTRASOUND	263, 566	2, 645, 406		1	0. 000000	1
	05500 RADI OLOGY-THERAPEUTI C	4, 652	3, 824, 423			0. 000000	
	05600 RADI OI SOTOPE	105, 217	2, 921, 837			0. 000000	
	05700 CT SCAN	103, 217	2, 721, 037	3,027,034	0.000000	0. 000000	
	05800 MRI		0		0.000000	0. 000000	
	05900 CARDI AC CATHETERI ZATI ON		0		0.000000	0. 000000	
	06000 LABORATORY	4, 511, 826	14, 522, 437	19, 034, 263		0. 000000	
	06001 BLOOD LABORATORY	4, 311, 020	14, 322, 437	17, 034, 203	0. 000000	0. 000000	
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0		0. 000000	0. 000000	
	06200 WHOLE BLOOD & PACKED RED BLOOD CELL		0		0.000000	0. 000000	
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.		0		0.000000	0. 000000	1
	06400 INTRAVENOUS THERAPY		0		0.000000	0. 000000	
65. 00	06500 RESPIRATORY THERAPY	1, 272, 617	583, 531	1, 856, 148		0. 000000	
66. 00	06600 PHYSI CAL THERAPY	263, 734	2, 067, 496			0. 000000	
	06700 OCCUPATI ONAL THERAPY	203, 734	2,007,470	2, 331, 230	l	0. 000000	
	06800 SPEECH PATHOLOGY		0		0. 000000	0. 000000	
	06900 ELECTROCARDI OLOGY	911, 330	4, 094, 995	5, 006, 325		0. 000000	
	07000 ELECTROENCEPHALOGRAPHY	711, 330	4, 074, 773 N	3,000,320	0.000000	0. 000000	1
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	2, 334, 380	10, 266, 855	12, 601, 235		0. 000000	1
	07200 IMPL. DEV. CHARGED TO PATIENTS	1, 634, 250	1, 743, 983			0. 000000	1
	07300 DRUGS CHARGED TO PATIENTS	7, 180, 245	30, 713, 325			0. 000000	
	07400 RENAL DIALYSIS	7, 100, 210	00, 710, 020	07,070,070	0. 000000	0. 000000	
	07500 ASC (NON-DISTINCT PART)	0	0		0. 000000	0. 000000	
	03020 ONCOLOGY	0	0		0. 000000	0. 000000	
	07698 HYPERBARI C OXYGEN THERAPY	0	382, 476	382, 476		0. 000000	1
	OUTPATIENT SERVICE COST CENTERS	-1					1
88. 00	08800 RURAL HEALTH CLINIC	0	0	C			88. 00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	O	0		)		89. 00
	09000 CLI NI C	952	616, 392	617, 344	0. 582884	0. 000000	
	09100 EMERGENCY	2, 007, 677	18, 814, 382			0. 000000	
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	1, 500, 570			0. 000000	
	OTHER REIMBURSABLE COST CENTERS	-1	.,	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			1
99. 10	09910 CORF	0	0	C			99. 10
	SPECIAL PURPOSE COST CENTERS	'		•	'		1
109.00	10900 PANCREAS ACQUISITION	0	0	C	)		109. 00
	11000 INTESTINAL ACQUISITION	0	0		)		110.00
111.00	11100 ISLET ACQUISITION	0	0	l c	)		111. 00
113.00	11300 INTEREST EXPENSE						113.00
	11400 UTILIZATION REVIEW-SNF						114. 00
	11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	l c	)		115.00
	11600 HOSPI CE	0	0	d	)		116.00
200.00	l l	35, 734, 273	134, 296, 832	170, 031, 105	i		200.00
201.00							201. 00
202.00	Total (see instructions)	35, 734, 273	134, 296, 832	170, 031, 105			202. 00

6/28/2017 3:41 pm Title XVIII Hospi tal PPS PPS Inpatient Cost Center Description Ratio 11 00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 30.00 31.00 03100 INTENSIVE CARE UNIT 31.00 32.00 03200 CORONARY CARE UNIT 32.00 33.00 03300 BURN INTENSIVE CARE UNIT 33.00 40. 00 | 04000 | SUBPROVI DER - I PF 40.00 04100 SUBPROVI DER - I RF 41.00 41.00 04200 SUBPROVI DER 42.00 42.00 43.00 04300 NURSERY 43.00 44 00 04400 SKILLED NURSING FACILITY 44.00 45. 00 04500 NURSING FACILITY 45.00 45. 01 04510 I CF/MR 45.01 46.00 04600 OTHER LONG TERM CARE 46.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 50.00 0.341277 50.00 51.00 05100 RECOVERY ROOM 0.000000 51.00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 52.00 52.00 53.00 05300 ANESTHESI OLOGY 0.000000 53.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 0.131484 54 00 54.01 05401 ULTRASOUND 0.062514 54.01 05500 RADI OLOGY-THERAPEUTI C 55.00 0. 298054 55.00 05600 RADI OI SOTOPE 0.081133 56, 00 56.00 57.00 05700 CT SCAN 0.000000 57.00 58.00 05800 MRI 0.000000 58.00 05900 CARDIAC CATHETERIZATION 59.00 0.000000 59.00 06000 LABORATORY 0. 175292 60.00 60 00 60.01 06001 BLOOD LABORATORY 0.000000 60.01 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 0.000000 61.00 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 62.00 0.000000 62.00 06300 BLOOD STORING, PROCESSING & TRANS. 0.000000 63.00 63.00 64.00 | 06400 | I NTRAVENOUS THERAPY 0.000000 64.00 06500 RESPIRATORY THERAPY 65.00 0. 340298 65.00 66 00 06600 PHYSI CAL THERAPY 0.479005 66 00 06700 OCCUPATI ONAL THERAPY 0.000000 67.00 67.00 68.00 06800 SPEECH PATHOLOGY 0.000000 68.00 69.00 06900 ELECTROCARDI OLOGY 0.084082 69.00 07000 ELECTROENCEPHALOGRAPHY 70.00 0.000000 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0.173626 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0. 256584 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0. 266927 73 00 07400 RENAL DIALYSIS 74.00 0.000000 74.00 75.00 07500 ASC (NON-DISTINCT PART) 0.000000 75.00 76.00 03020 ONCOLOGY 0.000000 76.00 07698 HYPERBARI C OXYGEN THERAPY 0. 159874 76. 98 76.98 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 88.00 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 09000 CLI NI C 0.582884 90.00 90 00 91.00 09100 EMERGENCY 0. 164874 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0. 913175 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 99.10 09910 CORF 99. 10 SPECIAL PURPOSE COST CENTERS 109. 00 10900 PANCREAS ACQUISITION 109. 00 110.00 11000 INTESTINAL ACQUISITION 110.00 111.00 11100 I SLET ACQUISITION 111. 00 113.00 11300 INTEREST EXPENSE 113.00 114.00 11400 UTILIZATION REVIEW-SNF 114. 00 115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.) 115.00 116. 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

COMPUT	ATTON OF KATTO OF COSTS TO CHARGES		Frovider C	CN. 15-0022	From 01/01/2016 To 12/31/2016		pared:
			Ti tl	e XIX	Hospi tal	Cost	. p
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst. B, Part I, col.	Adj .		Di sal I owance		
		26)					
		1.00	2. 00	3.00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	4, 839, 149		4, 839, 14	.9 0	4, 839, 149	30.00
31. 00	03100 I NTENSI VE CARE UNI T	1, 657, 167		1, 657, 16	0 0	1, 657, 167	
32. 00	03200 CORONARY CARE UNIT	0			0	0	
33. 00 40. 00	03300 BURN INTENSIVE CARE UNIT	0		2 545 45	0	0	33.00
41. 00	04000   SUBPROVI DER	2, 515, 159		2, 515, 15	0 0	2, 515, 159 0	1
42. 00	04200 SUBPROVI DER	0			0 0	0	1
43. 00	04300 NURSERY	0			0 0	Ō	43. 00
44.00	04400 SKILLED NURSING FACILITY	0			0 0	0	44. 00
45.00	04500 NURSING FACILITY	0			0	0	
45. 01	04510   CF/MR	0			0	0	
46. 00	04600 OTHER LONG TERM CARE	0			0 0	0	46. 00
EO 00	ANCILLARY SERVICE COST CENTERS    O5000   OPERATING ROOM	3, 382, 963		3, 382, 96	7, 923	3, 390, 886	50.00
51. 00	05100 RECOVERY ROOM	3, 302, 903 0		3, 302, 90	0 1, 923 0 0	3, 390, 660	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0			0 0	0	1
53. 00	05300 ANESTHESI OLOGY	0			0 0	Ō	1
54.00	05400 RADI OLOGY-DI AGNOSTI C	4, 575, 527		4, 575, 52	27 0	4, 575, 527	54.00
54. 01	05401 ULTRASOUND	181, 852		181, 85	52 0	181, 852	54. 01
55. 00	05500 RADI OLOGY-THERAPEUTI C	1, 141, 273		1, 141, 27		1, 141, 273	1
56. 00	05600 RADI OI SOTOPE	245, 594		245, 59	0	245, 594	1
57. 00 58. 00	05700 CT SCAN 05800 MRI	0			0	0	
59. 00	05900 CARDI AC CATHETERI ZATI ON	0			0 0	0	
60. 00	06000 LABORATORY	3, 331, 839		3, 331, 83	4, 722		
60. 01	06001 BLOOD LABORATORY	0		3, 55., 55	0 0	0	1
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0			0 0	0	61. 00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0			0	0	62. 00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0			0	0	63. 00
64.00	06400   NTRAVENOUS THERAPY	0			0	0	64. 00
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	631, 644 1, 116, 670	0	631, 64 1, 116, 67		631, 644 1, 116, 670	
67. 00	06700 OCCUPATI ONAL THERAPY	1, 110, 070	0	1, 110, 07	0 0	1, 110, 070	1
68. 00	06800 SPEECH PATHOLOGY	0	Ö		0 0	Ö	1
69.00	06900 ELECTROCARDI OLOGY	420, 944		420, 94	4 0	420, 944	1
70.00	07000 ELECTROENCEPHALOGRAPHY	0			0 0	0	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	2, 187, 907		2, 187, 90		2, 187, 907	1
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	866, 799		866, 79		866, 799	1
73. 00 74. 00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	10, 114, 826		10, 114, 82	26 0	10, 114, 826	1
	07500 ASC (NON-DISTINCT PART)	0			0 0	0	1
	03020 ONCOLOGY	0			0 0		76. 00
76. 98	07698 HYPERBARI C OXYGEN THERAPY	61, 148		61, 14			76. 98
	OUTPATIENT SERVICE COST CENTERS						
88. 00	1	0			0 0	1	
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0			0 0		
90.00	1	359, 840		359, 84			
	O9100   EMERGENCY   O9200   OBSERVATI ON   BEDS   (NON-DI STI NCT   PART	3, 433, 018 1, 370, 283		3, 433, 01 1, 370, 28		3, 433, 018 1, 370, 283	
92.00	OTHER REIMBURSABLE COST CENTERS	1, 370, 203		1, 370, 20	) J	1, 370, 203	92.00
99. 10	09910 CORF	0			0	0	99. 10
	SPECIAL PURPOSE COST CENTERS						
109.00	10900 PANCREAS ACQUISITION	0			0		109. 00
	11000 I NTESTI NAL ACQUI SI TI ON	0			0		110.00
	11100   SLET ACQUISITION	0			0	0	111.00
	11300 INTEREST EXPENSE						113. 00 114. 00
	11400 UTILIZATION REVIEW-SNF  11500 AMBULATORY SURGICAL CENTER (D.P.)	_			0	0	115. 00
	11600 HOSPICE				o o	0	116. 00
200.00	1	42, 433, 602	0	42, 433, 60	12, 645		
201.00	Less Observation Beds	1, 370, 283		1, 370, 28	33	1, 370, 283	201. 00
202.00	Total (see instructions)	41, 063, 319	0	41, 063, 31	9 12, 645	41, 075, 964	202. 00

In Lieu of Form CMS-2552-10

Period: Worksheet C
From 01/01/2016 Part I
To 12/31/2016 Date/Time Prepared: 6/28/2017 3:41 pm Health Financial Systems

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

			'	0 12/31/2010	6/28/2017 3: 4	
			e XIX	Hospi tal	Cost	
		Charges		·		
Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
			+ col. 7)	Ratio	Inpatient	
		7.00		0.00	Ratio	
INDATI ENT. DOUTING CEDALOG COCT CENTERS	6. 00	7. 00	8. 00	9. 00	10.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	4 510 220		4 510 220			20.00
30. 00   03000   ADULTS & PEDI ATRI CS	4, 519, 239		4, 519, 239			30.00
31. 00   03100   INTENSIVE CARE UNIT	1, 988, 516		1, 988, 516			31.00
32. 00   03200   CORONARY CARE UNIT	0		0			32.00
33. 00   03300 BURN INTENSIVE CARE UNIT	0 500 0/0		0 500 0/0			33. 00
40. 00   04000   SUBPROVI DER -   PF	3, 599, 869		3, 599, 869			40.00
41. 00   04100   SUBPROVI DER -   RF	0		0			41.00
42. 00   04200   SUBPROVI DER	0		0			42.00
43. 00 04300 NURSERY	0		0			43. 00
44. 00 04400 SKI LLED NURSI NG FACI LI TY	0		0			44. 00
45. 00   04500   NURSING FACILITY	0		0			45. 00
45. 01   04510   CF/MR	0		0			45. 01
46. 00 04600 OTHER LONG TERM CARE	0		0			46. 00
ANCILLARY SERVICE COST CENTERS	1 174 200	0.7/1.5/0	0.025.070	0.240400	0.000000	FO 00
50.00   05000   OPERATI NG ROOM 51.00   05100   RECOVERY ROOM	1, 174, 309	8, 761, 569	9, 935, 878 0		0.000000	50.00
	0	0	0	0.000000	0.000000	
52. 00   05200   DELI VERY ROOM & LABOR ROOM   53. 00   05300   ANESTHESI OLOGY	0	0	0	0.000000	0.000000	52.00
	2 0/1 004	0 027 1EE	24 700 040	0.000000	0. 000000 0. 000000	53. 00 54. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	3, 961, 894	30, 837, 155	34, 799, 049 2, 908, 972			1
54. 01   05401   ULTRASOUND	263, 566	2, 645, 406	2, 908, 972 3, 829, 075	0.062514	0. 000000 0. 000000	54. 01
55. 00   05500   RADI OLOGY-THERAPEUTI C 56. 00   05600   RADI OI SOTOPE	4, 652	3, 824, 423			0. 000000	55. 00 56. 00
	105, 217	2, 921, 837	3, 027, 054 0		0. 000000	
57. 00   05700   CT   SCAN 58. 00   05800   MRI	0	0	0	0. 000000 0. 000000	0. 000000	57. 00 58. 00
59. 00   05900 CARDI AC CATHETERI ZATI ON	0	0	0	0. 000000	0. 000000	59.00
60. 00   06000   LABORATORY	4 511 024	14 E22 427	19, 034, 263		0. 000000	60.00
60. 01   06000   LABORATORY	4, 511, 826	14, 522, 437	19, 034, 203	0. 000000	0. 000000	60.00
	0	0	0		0. 000000	
	0	0	0	0.000000		1
62.00   06200   WHOLE BLOOD & PACKED RED BLOOD CELL 63.00   06300   BLOOD STORING, PROCESSING & TRANS.	0	0	0	0.000000	0. 000000 0. 000000	62. 00 63. 00
64. 00 06400 I NTRAVENOUS THERAPY	0	0	0	0. 000000 0. 000000	0. 000000	64.00
65. 00 06500 RESPI RATORY THERAPY	1, 272, 617	583, 531	1, 856, 148		0. 000000	
66. 00   06600   PHYSI CAL THERAPY	263, 734	2, 067, 496	2, 331, 230		0. 000000	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	203, 734	2,007,490	2, 331, 230	0. 479003	0. 000000	67.00
68. 00   06800   SPEECH PATHOLOGY		0	0	0. 000000	0. 000000	68. 00
69. 00   06900   ELECTROCARDI OLOGY	911, 330	4, 094, 995	5, 006, 325		0. 000000	69.00
70. 00 07000 ELECTROCARDI OLOGI 70. 00 07000 ELECTROENCEPHALOGRAPHY	711, 330	4,074,775	3,000,323	0. 000000	0. 000000	1
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	2, 334, 380	10, 266, 855	12, 601, 235		0. 000000	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	1, 634, 250	1, 743, 983	3, 378, 233		0. 000000	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	7, 180, 245	30, 713, 325	37, 893, 570		0. 000000	73.00
74. 00 07400 RENAL DI ALYSI S	7, 100, 245	30, 713, 3 <u>2</u> 3	37, 073, 370	0. 000000	0. 000000	74.00
75. 00   07500   ASC (NON-DISTINCT PART)		0	١	0. 000000	0. 000000	75.00
76. 00 03020 0NCOLOGY	0	0	0	0. 000000	0. 000000	76.00
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	382, 476	382, 476		0. 000000	
OUTPATIENT SERVICE COST CENTERS	<u> </u>	002, 170	002/1/0	3. 10707 1	0.00000	7 0. 70
88. 00 08800 RURAL HEALTH CLINIC	0	0	0	0. 000000	0. 000000	88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		0. 000000	
90. 00   09000   CLI NI C	952	616, 392	617, 344		0. 000000	
91. 00   09100   EMERGENCY	2, 007, 677	18, 814, 382			0. 000000	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	1, 500, 570			0. 000000	
OTHER REIMBURSABLE COST CENTERS	-	,	, ,			
99. 10 09910 CORF	0	0	0			99. 10
SPECIAL PURPOSE COST CENTERS	·			'		
109. 00 10900 PANCREAS ACQUISITION	0	0	0			109. 00
110.00 11000 INTESTINAL ACQUISITION	O	0	0			110. 00
111.00 11100 ISLET ACQUISITION	0	0	0			111. 00
113.00 11300 INTEREST EXPENSE						113. 00
114.00 11400 UTI LI ZATI ON REVI EW-SNF	]					114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	o	0	0			115. 00
116. 00 11600 H0SPI CE	o	0	0			116. 00
200.00 Subtotal (see instructions)	35, 734, 273	134, 296, 832	170, 031, 105			200. 00
201.00 Less Observation Beds						201. 00
202.00 Total (see instructions)	35, 734, 273	134, 296, 832	170, 031, 105			202. 00

				6/28/2017 3: 41 pm
	DD0	Title XIX	Hospi tal	Cost
Cost Center Description	PPS Inpatient			
	Rati o 11.00			
INPATIENT ROUTINE SERVICE COST CENTERS	11.00			
30. 00 03000 ADULTS & PEDIATRICS				30.00
31.00 03100 INTENSIVE CARE UNIT				31. 00
32. 00 03200 CORONARY CARE UNIT				32. 00
33.00 03300 BURN INTENSIVE CARE UNIT				33.00
40. 00   04000   SUBPROVI DER - 1 PF				40. 00
41. 00   04100   SUBPROVI DER - I RF				41.00
42. 00   04200   SUBPROVI DER				42. 00
43. 00   04300   NURSERY				43. 00
44.00 O4400 SKILLED NURSING FACILITY				44. 00
45. 00 O4500 NURSING FACILITY				45. 00
45. 01   04510   I CF/MR				45. 01
46. 00 O4600 OTHER LONG TERM CARE				46. 00
ANCI LLARY SERVI CE COST CENTERS	0.000000			F0.00
50.00   05000   0PERATING ROOM 51.00   05100   RECOVERY ROOM	0. 000000 0. 000000			50. 00 51. 00
52. 00   05200   DELIVERY ROOM & LABOR ROOM	0. 000000			52.00
53. 00   05300   ANESTHESI OLOGY	0. 000000			53.00
54. 00   05400   RADI OLOGY - DI AGNOSTI C	0. 000000			54.00
54. 01   05401   ULTRASOUND	0. 000000			54. 01
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000			55. 00
56. 00   05600 RADI OI SOTOPE	0. 000000			56. 00
57. 00 05700 CT SCAN	0. 000000			57. 00
58. 00   05800   MRI	0. 000000			58.00
59. 00   05900 CARDI AC CATHETERI ZATI ON	0. 000000			59. 00
60. 00   06000   LABORATORY	0. 000000			60. 00
60. 01  06001  BL00D   LABORATORY	0. 000000			60. 01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0. 000000			61. 00
62. 00   06200   WHOLE BLOOD & PACKED RED BLOOD CELL	0. 000000			62. 00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0.000000			63.00
64. 00   06400   I NTRAVENOUS THERAPY	0.000000			64.00
65. 00   06500   RESPI RATORY   THERAPY   66. 00   06600   PHYSI CAL   THERAPY	0. 000000 0. 000000			65. 00 66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000			67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 000000			68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000			69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000			70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000			71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000			72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73. 00
74. 00   07400   RENAL DI ALYSI S	0. 000000			74. 00
75. 00 07500 ASC (NON-DISTINCT PART)	0. 000000			75. 00
76. 00   03020   0NCOLOGY	0. 000000			76. 00
76. 98 O7698 HYPERBARI C OXYGEN THERAPY	0. 000000			76. 98
OUTPATIENT SERVICE COST CENTERS	0.000000			88.00
88.00   08800 RURAL HEALTH CLINIC 89.00   08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000 0. 000000			88. 00 89. 00
90. 00   009000   CLI NI C	0. 000000			90.00
91. 00 09100 EMERGENCY	0. 000000			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000			92.00
OTHER REIMBURSABLE COST CENTERS	0.000000			72. 00
99. 10 09910 CORF				99. 10
SPECIAL PURPOSE COST CENTERS				
109.00 10900 PANCREAS ACQUISITION				109. 00
110.00 11000 INTESTINAL ACQUISITION				110.00
111. 00 11100   SLET ACQUISITION				111.00
113. 00 11300   I NTEREST EXPENSE				113. 00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF				114.00
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.)				115.00
116.00 11600 HOSPICE 200.00 Subtotal (see instructions)				116.00
200.00 Subtotal (see instructions) 201.00 Less Observation Beds				200. 00 201. 00
202.00 Total (see instructions)				202. 00
202.00   10141 (300 111311 4011 0113)	ı I			1202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPIT	TAL COSTS	Provider C	CN: 15-0022	Peri od: From 01/01/2016 To 12/31/2016	Worksheet D Part I Date/Time Pre 6/28/2017 3:4	pared: 1 pm
		Titl∈	XVIII	Hospi tal	PPS	
Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capi tal Rel ated Cos (col. 1 - co 2)		Per Diem (col. 3 / col. 4)	
	1. 00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 31. 00 31. 00 31. 00 32. 00 32. 00 33. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 30		Inpatient Program Capital Cost (col. 5 x col. 6)	1, 485, 2: 224, 1: 502, 0	29 561 0 0 0 16 1, 955 0 0 0 0 0 0 0 0 0	384. 08 399. 52 0. 00 0. 00 256. 79 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00	31. 00 32. 00 33. 00 40. 00 41. 00 42. 00 43. 00 44. 00 45. 00
LANDATI ENT. DOUTLING OFFICE COOT OFFITEDO	6.00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS  30.00 ADULTS & PEDIATRICS  31.00 INTENSIVE CARE UNIT  32.00 CORONARY CARE UNIT  33.00 BURN INTENSIVE CARE UNIT  40.00 SUBPROVIDER - IPF  41.00 SUBPROVIDER - IRF  5UBPROVIDER NURSERY  44.00 SKILLED NURSING FACILITY  45.00 NURSING FACILITY  1 CF/MR  200.00 Total (lines 30-199)	1, 766 300 0 0 1, 631 0 0 0 0 0 0	678, 285 119, 856 0 0 418, 824 0 0 0 0 0 0 1, 216, 965				30. 00 31. 00 32. 00 33. 00 40. 00 41. 00 42. 00 43. 00 44. 00 45. 00 45. 01 200. 00

Health Financial Systems	FRANCISCAN HEALTH CR	RAWFO	RDSVI	LLE		n Lieu	ı of For	m CMS-2	2552-10
		_			 				

Health Financial Systems FR	ANCISCAN HEALTH	I CRAWFORDSVILL	E	In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	ORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS			Period: From 01/01/2016 To 12/31/2016		pared: 1 pm
		Title	xVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges		t Inpatient	Capital Costs	
·	Related Cost	(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,	Part I, col.	(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)	, and the second	,	
	26)		,			
	1.00	2.00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00   05000 OPERATING ROOM	611, 581	9, 935, 878	0. 06155	639, 776	39, 380	50. 00
51.00   05100   RECOVERY ROOM	0	0	0.00000	0 0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0.00000	0 0	0	52. 00
53. 00   05300   ANESTHESI OLOGY	0	0	0.00000	0	0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 299, 589	34, 799, 049			83, 420	54.00
54. 01   05401   ULTRASOUND	29, 085					
55. 00 05500 RADI OLOGY-THERAPEUTI C	47, 083		1		56	1
56. 00   05600   RADI OI SOTOPE	29, 670				l	1
57. 00   05700 CT SCAN	27,070	3,027,034	0.00000		0	57. 00
58. 00   05800 MRI			1		0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON			0.00000		0	59.00
60. 00   06000   LABORATORY	407 200	10 024 262				
	487, 208	19, 034, 263			66, 882	
60. 01 06001 BLOOD LABORATORY	0	0	0.00000	0	0	
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0.00000		0	
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0.00000		0	63. 00
64. 00   06400   I NTRAVENOUS THERAPY	0	0	0. 00000		0	64. 00
65. 00  06500 RESPIRATORY THERAPY	56, 721	1, 856, 148				
66. 00 06600 PHYSI CAL THERAPY	216, 494	2, 331, 230			13, 043	66. 00
67. 00  06700 OCCUPATI ONAL THERAPY	0	0			0	67. 00
68.00   06800   SPEECH PATHOLOGY	0	0	0.00000	0 0	0	68. 00
69. 00   06900   ELECTROCARDI OLOGY	44, 178	5, 006, 325	0. 00882	.4 562, 454	4, 963	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	0.00000	0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	455, 323	12, 601, 235	0. 03613	1, 106, 927	39, 997	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	147, 837	3, 378, 233	0.04376	2 884, 790	38, 720	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	616, 239	37, 893, 570	0. 01626	4, 214, 682	68, 539	73. 00
74. 00 07400 RENAL DIALYSIS	0	l	0.00000		0	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0	0.00000		0	75. 00
76. 00 03020 ONCOLOGY	0	0	0.00000		0	76.00
76. 98 07698 HYPERBARI C OXYGEN THERAPY	1, 796	382, 476	1			
OUTPATIENT SERVICE COST CENTERS	1,770	002, 170	0.00107	<u> </u>		70.70
88. 00 08800 RURAL HEALTH CLINIC	0	0	0.00000	00 0	0	88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0				0	89. 00
90. 00   09000   CLI NI C	74, 514	ı			0	90.00
91. 00   09100   EMERGENCY	389, 308	1			1	1
92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART	420, 571	1, 500, 570			10, 094	91.00
200.00 Total (lines 50-199)	4, 927, 197		1	14, 380, 906	1	
200.00    10tal (1111es 50-177)	4,721,191	107, 723, 401	I	14, 300, 900	370, /31	1200.00

Weeklah Firensial Costons	ANCI CCAN LIFALTI	L CDAWEODDCVIIII	F	1 1 : -	6 F ONC 1	2552 40
Health Financial Systems FR APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	ANCISCAN HEALTH ASS THROUGH COS		CN: 15-0022	Period: From 01/01/2016	Worksheet D Part III Date/Time Pre 6/28/2017 3:4	pared:
		Ti tl e	XVIII	Hospi tal	PPS	
Cost Center Description	Nursing School	Allied Health	All Other	Swi ng-Bed	Total Costs	
		Cost	Medi cal	Adjustment	(sum of cols.	
			Education Cos	st Amount (see	1 through 3,	
				instructions)	minus col. 4)	
	1.00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	O	)	0 0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	0	l o		0	0	31.00

		COST	Education Cost	Amount (see	1 through 3,	
			Ladeatron	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	O	0	0	C	0	30.00
31. 00   03100   NTENSIVE CARE UNIT	o	0	0		0	31.00
32.00 03200 CORONARY CARE UNIT	o	0	0		0	32. 00
33.00 03300 BURN INTENSIVE CARE UNIT	o	0	0		0	33. 00
40. 00   04000   SUBPROVI DER - 1 PF	o	0	0	C	0	40. 00
41. 00   04100   SUBPROVI DER - I RF	o	0	0	C	0	41. 00
42. 00   04200   SUBPROVI DER	o	0	0	C	0	42.00
43. 00   04300   NURSERY	o	0	0		0	43.00
44.00 04400 SKILLED NURSING FACILITY	0	0			0	44. 00
45.00 04500 NURSING FACILITY	0	0			0	45. 00
45. 01   04510   I CF/MR	0	0			0	45. 01
200.00 Total (lines 30-199)	0	0	0		0	200. 00
Cost Center Description	Total Patient		I npati ent	Inpati ent		
	Days	5 ÷ col. 6)	Program Days	Program		
				Pass-Through		
				Cost (col. 7 x	1	
		7.00	0.00	col . 8)	4	
LAIDATI ENT. DOUTLING CERVILOE COCT. CENTERO	6. 00	7. 00	8. 00	9. 00		
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	2.047	0.00	1 7//			20.00
30. 00   03000   ADULTS & PEDIATRICS 31. 00   03100   INTENSIVE CARE UNIT	3, 867	0.00			(	30.00
31. 00   03100   I NTENSI VE CARE UNI T 32. 00   03200   CORONARY CARE UNI T	561	0.00	•		(	31. 00 32. 00
33. 00   03200   CORONARY   CARE UNIT	0	0. 00 0. 00	•		<u>'</u>	32.00
40. 00   04000   SUBPROVI DER -   1 PF	1, 955	0.00	•		<u>'</u>	40.00
41. 00   04100   SUBPROVIDER - 1 PF	1, 900	0.00			<u> </u>	41. 00
41. 00   04100   SUBPROVIDER - TRF	0	0.00	•		<u>'</u>	42.00
43. 00   04300   NURSERY	0	0.00	•		1	43.00
44. 00   04400   SKILLED NURSING FACILITY	0	0.00	•			44.00
45. 00   04500   NURSING FACILITY		0.00			1	45.00
45. 01 04500 NORSTNG TACTETTT		0.00				45. 01
200.00 Total (lines 30-199)	6, 383	3.00	3, 697			200.00
1	2,000		1 2,0,,	,	T. Control of the Con	1

Provi der CCN: 15-0022 THROUGH COSTS

					10 12/31/2016	6/28/2017 3:4	oared: 1 nm
			Title	: XVIII	Hospi tal	PPS	Гріп
	Cost Center Description	Non Physician Nu				Total Cost	
	, , , , , , , , , , , , , , , , , , ,	Anesthetist	3		Medi cal	(sum of col 1	
		Cost			Education Cost	through col.	
						4)	
		1.00	2.00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0		0	0	50.00
51. 00	05100 RECOVERY ROOM	0	0		0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0	0	52.00
53.00	05300 ANESTHESI OLOGY	0	0		0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0	0	54.00
54. 01	05401 ULTRASOUND	0	0		0	0	54. 01
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0		0	0	55.00
56.00	05600  RADI OI SOTOPE	0	0		0	0	56.00
57. 00	05700 CT SCAN	0	0		0	0	57. 00
58. 00	05800  MRI	0	0		0	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0		0	0	59. 00
60.00	06000 LABORATORY	0	0		0	0	60.00
60. 01	06001 BLOOD LABORATORY	0	0		0	0	60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0	0	63.00
64. 00	06400 I NTRAVENOUS THERAPY	0	0		0	0	64.00
65.00	06500 RESPI RATORY THERAPY	0	0		0	0	65.00
66. 00	06600 PHYSI CAL THERAPY	0	0		0	0	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0		0	0	67.00
68. 00	06800 SPEECH PATHOLOGY	0	0		0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0		0	0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		0	0	70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0	0	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0	0	72.00
	07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0		0	0	74.00
75. 00	07500 ASC (NON-DISTINCT PART)	0	0		0	0	75. 00
76.00	03020 ONCOLOGY	0	0		0	0	76.00
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0		0	0	76. 98
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0	0		0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0	0	89. 00
90.00	09000 CLI NI C	0	0		0	0	90.00
	09100 EMERGENCY	0	0		0	0	91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		0	0	92.00
200.00	Total (lines 50-199)	0	0	1	0 0	0	200. 00

Health Financial Systems	FRANCISCAN HEALTH CF	RAWFORDSVI LLE	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0022	Peri od:	Worksheet D
THROUGH COSTS			From 01/01/2016	Part IV

THROUGH COSTS 12/31/2016 Date/Time Prepared: 6/28/2017 3:41 pm Title XVIII Hospi tal PPS I npati ent Cost Center Description Total Total Charges Ratio of Cost Outpati ent (from Wkst. C, to Charges Program Outpati ent Ratio of Cost Cost (sum of (col. 5 ÷ col to Charges Part I, col. Charges 7) col. 2, 3 and 8)  $(col. 6 \div col$ 4) 7) 6.00 7.00 8.00 9.00 10.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0.000000 0.000000 639, 776 50.00 9, 935, 878 0 51.00 05100 RECOVERY ROOM 0.000000 0.000000 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 0.000000 52.00 00000000 0 52.00 05300 ANESTHESI OLOGY 0.000000 0.000000 53.00 53.00 0 05400 RADI OLOGY-DI AGNOSTI C 34, 799, 049 0.000000 0.000000 54.00 2, 233, 714 54 00 54.01 05401 ULTRASOUND 2, 908, 972 0.000000 0.000000 153, 506 54.01 55.00 05500 RADI OLOGY-THERAPEUTI C 3, 829, 075 0.000000 0.000000 4,540 55.00 05600 RADI OI SOTOPE 3, 027, 054 0.000000 0.000000 85, 650 56 00 56 00 57.00 05700 CT SCAN 0.000000 0.000000 0 57.00 58.00 05800 MRI 0.000000 0.000000 0 58.00 59.00 05900 CARDIAC CATHETERIZATION 0 0 0.000000 0.000000 0 59.00 19, 034, 263 2, 612, 991 06000 LABORATORY 0.000000 0.000000 60 00 60 00 60.01 06001 BLOOD LABORATORY 0.000000 0.000000 0 60.01 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0.000000 0.000000 62 00 0000000000000 0 62 00 06300 BLOOD STORING, PROCESSING & TRANS. 63.00 0.000000 0.000000 0 63.00 06400 INTRAVENOUS THERAPY 0.000000 0.000000 0 64.00 64.00 06500 RESPIRATORY THERAPY 65.00 1, 856, 148 0.000000 0.000000 741, 604 65.00 06600 PHYSI CAL THERAPY 2, 331, 230 66.00 0.000000 0.000000 140, 446 66 00 67.00 06700 OCCUPATI ONAL THERAPY 0.000000 0.000000 0 67.00 06800 SPEECH PATHOLOGY 0.000000 0.000000 68.00 69.00 06900 ELECTROCARDI OLOGY 5,006,325 0.000000 0.000000 562, 454 69.00 07000 ELECTROENCEPHALOGRAPHY 0.000000 0.000000 70 00 Ω 70 00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 12, 601, 235 0.000000 0.000000 1, 106, 927 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 3, 378, 233 0.000000 0.000000 884, 790 72.00 72.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 73.00 37, 893, 570 0.000000 4, 214, 682 73.00 07400 RENAL DIALYSIS 0.000000 0.000000 74.00 0 74.00 0 75.00 07500 ASC (NON-DISTINCT PART) 0.000000 0.000000 0 75.00 03020 ONCOLOGY 76.00 0.000000 0.000000 0 76.00 76. 98 07698 HYPERBARI C OXYGEN THERAPY 382, 476 0.000000 0.000000 0 76.98 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0.000000 0.000000 88.00 0 0.000000 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0.000000 0 89.00 0.000000 90.00 09000 CLINIC 617, 344 0.000000 90.00 0 91. 00 | 09100 | EMERGENCY 20, 822, 059 0.000000 0.000000 999, 826 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 1, 500, 570 0.000000 0.000000 0 92.00 200.00 Total (lines 50-199) 159, 923, 481 14, 380, 906 200. 00

				10 12/31/2010	6/28/2017 3:4	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	I npati ent	Outpati ent	Outpati ent			
, , , , , , , , , , , , , , , , , , ,	Program	Program	Program			
	Pass-Through	Charges	Pass-Through			
	Costs (col. 8	3	Costs (col. 9			
	x col. 10)		x col. 12)			
	11.00	12.00	13.00			
ANCILLARY SERVICE COST CENTERS			•	1		
50. 00 05000 OPERATING ROOM	0	3, 725, 790		0		50.00
51. 00 05100 RECOVERY ROOM	o	0		0		51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	o	0		0		52. 00
53. 00   05300   ANESTHESI OLOGY	0	0		0		53.00
54. 00   05400 RADI OLOGY-DI AGNOSTI C	0	9, 509, 681		0		54.00
54. 01   05401   ULTRASOUND	0	749, 788		0		54. 01
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	2, 605, 904		o		55. 00
56. 00   05600   RADI OI SOTOPE	0	1, 647, 049		0		56.00
57. 00   05700 CT SCAN	0	1,017,017		o O		57. 00
58. 00   05800   MRI	0	0		Ö		58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON		0		0		59. 00
60. 00   06000 LABORATORY	0	2, 969, 448		0		60.00
60. 01   06001   BLOOD   LABORATORY		2, 707, 440		0		60.00
	9	U	'			
1 I		0				61.00
62.00   06200   WHOLE BLOOD & PACKED RED BLOOD CELL 63.00   06300   BLOOD STORING, PROCESSING & TRANS.	0	0		0		62. 00 63. 00
	0	0		~		
64. 00 06400 I NTRAVENOUS THERAPY	0	100 770		0		64.00
65. 00 06500 RESPIRATORY THERAPY	0	182, 779		0		65. 00
66. 00   06600   PHYSI CAL THERAPY	0	15, 914		0		66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0		0		67. 00
68. 00 06800 SPEECH PATHOLOGY	0			0		68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	1, 938, 910		0		69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0		70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	1, 774, 876		0		71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	665, 374		0		72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	11, 419, 921		0		73. 00
74. 00   07400   RENAL DI ALYSI S	0	0		0		74. 00
75.00 07500 ASC (NON-DISTINCT PART)	0	0		0		75. 00
76. 00   03020   ONCOLOGY	0	0		0		76. 00
76. 98 O7698 HYPERBARI C OXYGEN THERAPY	0	161, 174		0		76. 98
OUTPATIENT SERVICE COST CENTERS						
88. 00 08800 RURAL HEALTH CLINIC	0	0		0		88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0		89. 00
90. 00  09000 CLI NI C	0	0		0		90.00
91. 00 09100 EMERGENCY	0	4, 389, 260		0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		0		92.00
200.00 Total (lines 50-199)	0	41, 755, 868		0		200.00

Heal th	Financial Systems FR	ANCISCAN HEALTH	CRAWFORDSVILL	E	In Lie	u of Form CMS-	2552-10
	IONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der Co		Peri od:	Worksheet D	
					From 01/01/2016	Part V	
					To 12/31/2016		pared:
						6/28/2017 3:4	1 pm
			Title	XVIII	Hospi tal	PPS	
				Charges		Costs	
	Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
		Ratio From	Services (see		Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not	,	
		Part I, col. 9	ĺ	Subject To	Subject To		
				Ded. & Coins.			
				(see inst.)	(see inst.)		
		1.00	2. 00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS		2.00	0.00	00	0.00	
50.00	05000 OPERATING ROOM	0. 340480	3, 725, 790		0 0	1, 268, 557	50.00
51. 00	05100 RECOVERY ROOM	0. 000000			0 0	1, 200, 337	51.00
			0	1	0 0		
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		-	0	52.00
53. 00	05300 ANESTHESI OLOGY	0. 000000	0	1	0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 131484	9, 509, 681	1	0	1, 250, 371	54.00
54.01	05401 ULTRASOUND	0. 062514	749, 788		0	46, 872	54. 01
55.00	05500 RADI OLOGY-THERAPEUTI C	0. 298054	2, 605, 904		0	776, 700	55. 00
56.00	05600 RADI OI SOTOPE	0. 081133			0	133, 630	1
57. 00	05700 CT SCAN	0. 000000			o o	0	57. 00
58. 00	05800 MRI	0. 000000	٥	1	0 0	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0. 000000	0		0 0	_	59.00
		1	0 0 0 4 4 0		0	0	
60.00	06000 LABORATORY	0. 175044	2, 969, 448		0	519, 784	60.00
60. 01	06001 BLOOD LABORATORY	0. 000000	0		0	0	60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0. 000000		1	0		61. 00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 000000	0	)	0	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.000000	0	)	0	0	63.00
64.00	06400 I NTRAVENOUS THERAPY	0. 000000	l o		0	0	64.00
65. 00	06500 RESPI RATORY THERAPY	0. 340298	182, 779	,	0	62, 199	65. 00
66. 00	06600 PHYSI CAL THERAPY	0. 479005	15, 914		0	7, 623	
67. 00	06700 OCCUPATI ONAL THERAPY	0. 000000	13, 714		0 0	0	67. 00
		1	0	1	0 0		
68. 00	06800 SPEECH PATHOLOGY	0. 000000	1 000 040		0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0. 084082	1, 938, 910	l .	0	163, 027	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 000000	0		0	0	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 173626	1, 774, 876	1	0	308, 165	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 256584	665, 374		0	170, 724	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 266927	11, 419, 921	3	5 22, 517	3, 048, 285	73. 00
74.00	07400 RENAL DIALYSIS	0. 000000	0		0	0	74. 00
75. 00	07500 ASC (NON-DISTINCT PART)	0. 000000	0	,	0	0	75. 00
76. 00	03020 ONCOLOGY	0. 000000	١		0	n	76. 00
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0. 159874	161, 174		0 0	25, 768	1
70. 70	OUTPATIENT SERVICE COST CENTERS	0. 137074	101, 174	'	0	25, 700	70. 70
00 00	08800 RURAL HEALTH CLINIC	0. 000000				0	00 00
88. 00						_	
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000			_	0	89. 00
90. 00	09000 CLI NI C	0. 582884	0		0	0	90. 00
91. 00	09100 EMERGENCY	0. 164874		1	0	723, 675	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 913175	0	)	0	0	92. 00
200.00	Subtotal (see instructions)		41, 755, 868	3	5 22, 517	8, 505, 380	200.00
201.00				1	0 0		201. 00
	Only Charges						
202.00			41, 755, 868	3.	5 22, 517	8, 505, 380	202. 00
	3.2 ( 2.2. )	1		'	,		

Peri od: Worksheet D
From 01/01/2016
To 12/31/2016 Part V
Date/Time Prepared: 6/28/2017 3:41 pm

Cost Center Description							0/28/201/ 3:4	· i pili
Cost Center Description					XVIII	Hospi tal	PPS	
Reinbursed   Services   Subject To   Ded. & Coins.   (see Inst.)   Coins.   Subject To   Ded. & Coins								
Services   Subject To   Dod. & Coins.   Code		Cost Center Description						
Subject To Ded. & Coins.   Subject To Ded. & S								
Decl. & Colins.   See Inst.   (see Inst. )   See Inst.   See Ins								
See Inst.)   (see Inst.)   (see Inst.)								
ANCILLARY SERVICE COST CENTERS								
ANCILLARY SERVICE COST CENTERS								
50. 00     05000     05000   0   0   0   0		ANCILL ADV. CEDVI CE. COCT. CENTEDO	6.00	7.00				
51.00   05100   RECOVERY ROOM   0   0   0   52.00   05200   0ELIVERY ROOM   0   0   0   0   0   0   0   0   0	EO 00			1 0	I			FO 00
S2 00   05200   05200   05200   05200   05200   05200   05300   05300   05300   05300   05300   05300   05300   05300   05400   05400   05400   05400   05400   05400   05400   05400   05400   05400   0550			0					1
53.00   05300   ANESTHESI OLOGY   0   0   54.00   54.00   54.00   54.00   54.00   54.00   54.00   54.00   54.00   54.00   54.00   54.00   54.00   55			0	_				
54. 00   05400   RADIOLOGY-DIAGNOSTIC   0   0   0   054. 01   05401   ULTRASOUND   0   0   0   0   0   0   0   0   0			0					1
54.01   05401   UTRASOUND   0   0   0   0   55.00			0	_				1
55.00   05500   RADIOLOGY-THERAPEUTIC			0	_				1
56. 00   05700   05700   CT SCAN   0			0	_				1
57.00   05700   05700   05800   MRI   0 0 0 0   0   0   0   0   0   0   0			0					1
58. 00   05900   05900   CARDIAC CATHETERIZATION   0   0   0   0   0   0   0   0   0			0	_				
59.00   05900   CARDI AC CATHETERI ZATION   0   0   0   0   0   0   0   0   0			0					1
60. 00   06000   LABORATORY   0   0   0   0   0   0   0   0   0			0	_				1
60. 01   06001   BLOOD LABORATORY   0   0   0   0   61. 00   61. 00   06100   PBP CLINI CAL LAB SERVI CES-PRGM ONLY   0   0   0   0   62. 00   06200   WHOLE BLOOD & PACKED RED BLOOD CELL   0   0   0   0   63. 00   06300   BLOOD STORI NG, PROCESSI NG & TRANS.   0   0   0   0   64. 00   06400   INTRAVENOUS THERAPY   0   0   0   0   65. 00   06500   RESPIRATORY THERAPY   0   0   0   0   66. 00   06600   PHYSI CAL THERAPY   0   0   0   0   67. 00   06700   OCCUPATI ONAL THERAPY   0   0   0   0   68. 00   06800   SPECH PATHOLOGY   0   0   0   69. 00   06900   ELECTROCARDI OLOGY   0   0   0   69. 00   06900   ELECTROCARDI OLOGY   0   0   0   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0   0   0   72. 00   07200   IMPLE DEV. CHARGED TO PATI ENTS   0   0   0   73. 00   07300   DRUGS CHARGED TO PATI ENTS   9   6,010   73. 00   74. 00   07400   RENAL DI ALYSI S   0   0   0   75. 00   07500   ASC (NON-DI STI NCT PART)   0   0   0   76. 00   03020   ONCOLOGY   0   0   0   77. 00   07600   SUBSI NCT PARTICLE   0   0   88. 00   08900   FEDERALLY QUALIFIED HEALTH CENTER   0   0   90. 00   09900   CLI NI C   0   0   90. 00   09900   Subtrati Cals Services-Program   0   0   90. 10   Only (Charges)   0   0   90. 10   90. 10   0   90. 10   90. 10   0   90. 10   90. 10   0   90. 10   90. 10   0   90. 10   90. 10   0   90. 10   90. 10   0   90. 10   90. 10   0   90. 10   90. 10   0   90. 10   90. 10   0   90. 10   90. 10   0   90. 10   90. 10   0   90. 10   90. 10   0   90. 10   90. 10   0   90. 10   90. 10   0   90. 10   90. 10   90. 10   90. 10   0   90. 10   90. 10   90. 10   90. 10   90. 10   90. 10   90. 10   90. 10   90. 10   90. 10			0	_				
61. 00			0	_				1
62. 00			0	0				1
63. 00   06300   BLOOD STORING, PROCESSING & TRANS.   0   0   0   0   0   0   0   0   0			0					1
64. 00   06400   INTRAVENOUS THERAPY   0   0   0   0   0   0   0   0   0			0	_	1			1
65. 00		1	0	0				1
66. 00 06600 PHYSI CAL THERAPY 0 0 0 0 0 6700 OCCUPATI ONAL THERAPY 0 0 0 0 0 67. 00 06700 OCCUPATI ONAL THERAPY 0 0 0 0 0 6800 SPECCH PATHOLOGY 0 0 0 6800 SPECCH PATHOLOGY 0 0 0 6800 SPECCH PATHOLOGY 0 0 0 0 6800 OFFICE PATHOLOGY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0	0				1
67. 00 06700 OCCUPATIONAL THERAPY 0 0 0 0 68. 00 688.00 SPEECH PATHOLOGY 0 0 0 0 68. 00 6900 ELECTROCARDIOLOGY 0 0 0 0 0 68. 00 6900 ELECTROCARDIOLOGY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0	_				1
68.00 06800 SPEECH PATHOLOGY 0 0 0 69.00 69.00 69.00 ELECTROCARDI OLOGY 0 0 0 0 0 69.00 70.00 70.00 70.00 70.00 70.00 ELECTROCARDI OLOGY 0 0 0 70.00 ELECTROENCEPHALOGRAPHY 0 0 0 71.00 71.00 71.00 MEDI CAL SUPPLIES CHARGED TO PATIENT 0 0 0 71.00 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 0 72.00 73.00 73.00 DRUGS CHARGED TO PATIENTS 9 6,010 73.00 74.00 775.00 750.00 76.00 80.00 90.00			0	, and a				1
69. 00			0	_				1
70. 00			0	,				
71. 00			0					1
72.00   07200   IMPL. DEV. CHARGED TO PATIENTS   0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0					1
73. 00			0					1
74. 00 07400 RENAL DIALYSIS 0 0 0 0 75500 ASC (NON-DISTINCT PART) 0 0 0 755. 00 755. 00 75500 ASC (NON-DISTINCT PART) 0 0 0 0 755. 00 765. 00			0					1
75. 00			7		•			
76. 00								1
76. 98   07698   HYPERBARI C 0XYGEN THERAPY   0   0   0   76. 98				l .				1
SERVICE COST CENTERS   SERVICE COST CENTERS								
88.00   08800   RURAL HEALTH CLINIC   0 0 0 0   88.00   89.00   69.00   69.00   60.00	70. 70		0	<u> </u>				70. 70
89.00   08900   FEDERALLY QUALIFIED HEALTH CENTER   0   0   0   0   0   0   0   0   0	88 00			^				88 00
90. 00				_	•			1
91. 00								1
92. 00   09200   0BSERVATION BEDS (NON-DISTINCT PART   0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0								1
200.00       Subtotal (see instructions)       9       6,010         201.00       Less PBP Clinic Lab. Services-Program Only Charges       0								1
201.00 Less PBP Clinic Lab. Services-Program 0 0 201.00		1	0					1
Only Charges			7	0,010				1
	201.00							201.00
	202. 00		9	6, 010				202. 00

	Financial Systems FR TIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	ANCISCAN HEALTH AL COSTS	Provi der C		Peri od:	u of Form CMS-2 Worksheet D	2332-10
AITOK	TOWNER OF THE ATTENT AND LEARN SERVICE GALLIA	12 00010		CCN: 15-S022	From 01/01/2016 To 12/31/2016	Part II Date/Time Pre 6/28/2017 3:4	pared:
			Ti tl e	e XVIII	Subprovider -	PPS	т рііі
	Cost Center Description	Capi tal	Total Charges			Capital Costs	
			(from Wkst. C,		Program	(column 3 x	
		(from Wkst. B,		(col. 1 ÷ col	. Charges	column 4)	
		Part II, col.	8)	2)			
		26)	0.00	0.00	4.00	F 00	
	ANCILL ADV. CEDVI CE. COCT. CENTEDO	1.00	2. 00	3. 00	4. 00	5. 00	
50. 00	ANCILLARY SERVICE COST CENTERS  05000 OPERATING ROOM	/11 F01	9, 935, 878	0. 06155	2, 449	151	50.00
51.00	05100 RECOVERY ROOM	611, 581		1			51.00
51.00	05200 DELIVERY ROOM & LABOR ROOM	0		1		0	51.00
53. 00	05300 ANESTHESI OLOGY		1	0.00000		0	53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	1, 299, 589		1	I	4, 837	
54. 00	05400 RADI OLOGI - DI AGNOSTI C	29, 085		1		4, 637	1
55. 00	05500 RADI OLOGY-THERAPEUTI C	47, 083				0	
56. 00	05600 RADI OI SOTOPE	29, 670		1	I I	0	56.00
57. 00	05700 CT SCAN	27,070		0.00000		0	57.00
58. 00	05800 MRI		1	1	I I	0	
59. 00	05900 CARDI AC CATHETERI ZATI ON	0		0. 00000	I I	0	
60.00	06000 LABORATORY	487, 208				9, 153	
60. 01	06001 BLOOD LABORATORY	0		0.00000		0	
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY					_	61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	l c	0. 00000	ool ol	0	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	l c	0. 00000	ool ol	0	63.00
64.00	06400 I NTRAVENOUS THERAPY	0	l c	0.00000	ool ol	0	64.00
65.00	06500 RESPI RATORY THERAPY	56, 721	1, 856, 148	0. 03055	44, 961	1, 374	65.00
66.00	06600 PHYSI CAL THERAPY	216, 494	2, 331, 230	0. 09286	39, 949	3, 710	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	C	0.00000	00	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	C	0.00000	00	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	44, 178	5, 006, 325			369	
70.00	07000 ELECTROENCEPHALOGRAPHY	0		0. 00000		0	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	455, 323			·	1, 054	
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	147, 837				0	
73. 00	07300 DRUGS CHARGED TO PATIENTS	616, 239			·	7, 971	
74.00	07400 RENAL DIALYSIS	0	1	0.00000		0	
75. 00	07500 ASC (NON-DISTINCT PART)	0	1	1 0.0000		0	
76. 00	03020 ONCOLOGY	0	1	0.00000	I	0	
76. 98	07698 HYPERBARI C OXYGEN THERAPY	1, 796	382, 476	0.00469	96 0	0	76. 98
88. 00	OUTPATIENT SERVICE COST CENTERS  08800 RURAL HEALTH CLINIC	0		0.00000	ool oo	0	00 00
89.00		0		1	I I	0	
90.00	08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC	-	1	1	I I	0	
91.00	09100 EMERGENCY	74, 514 389, 308		1		1, 631	
91.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	369, 306		1		1, 031	
	10/20010D3ERVATION DED3 (NON-DISTING! FART	ı U					72.00

Health Financial Systems F APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RANCISCAN HEALTH ( FRVICE OTHER PASS	Provi der C		Peri od:	u of Form CMS Worksheet D	2332-10
THROUGH COSTS	INVICE OTHER LASS	Trovider C	CN. 13-0022	From 01/01/2016	Part IV	
THROUGH GOOTS		Component	CCN: 15-S022	To 12/31/2016	Date/Time Pre	
		Ti +Lo	· XVIII	Subprovi der -	6/28/2017 3: 4 PPS	I pm
		11116	Z AVIII	I PF	FF3	
Cost Center Description	Non Physician Nu	ursing School	Allied Heal	th All Other	Total Cost	
	Anesthetist			Medi cal	(sum of col 1	
	Cost			Education Cost		
					4)	
	1.00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS					_	
50. 00   05000   OPERATI NG ROOM	0	0	1	0 0	0	
51. 00   05100   RECOVERY ROOM	0	0		0 0	0	
52. 00   05200   DELIVERY ROOM & LABOR ROOM	0	0	1	0 0	0	
53. 00 05300 ANESTHESI OLOGY	0	Ü	1	0	0	
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	0	1	0 0	0	
54. 01   05401   ULTRASOUND	0	0	1	0 0	0	
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0	1	0 0	0	
56. 00   05600   RADI 01 SOTOPE	0	0	1	0 0	0	
57. 00   05700   CT   SCAN	0	0	1	0 0	0	
58. 00   05800   MRI	0	0	1	0 0	0	
59. 00   05900   CARDI AC CATHETERI ZATI ON	0	0	1	0 0	0	
60. 00   06000   LABORATORY	0	0	1	0 0	0	
60. 01   06001   BL00D   LABORATORY	0	0	1	0 0	0	
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0 0	0	
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0 0	0	
64.00  06400 INTRAVENOUS THERAPY	0	0		0 0	0	
65. 00 06500 RESPIRATORY THERAPY	0	0		0 0	0	
66. 00  06600 PHYSI CAL THERAPY	0	0		0 0	0	
67. 00  06700 0CCUPATIONAL THERAPY	0	0		0 0	0	
68.00  06800 SPEECH PATHOLOGY	0	0		0 0	0	
69. 00  06900 ELECTROCARDI OLOGY	0	0		0 0	0	
70. 00  07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 0	0	1
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	)	0	0	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	1	0 0	0	
74. 00   07400   RENAL DIALYSIS	0	0	1	0 0	0	
75.00 07500 ASC (NON-DISTINCT PART)	0	0		0 0	0	
76. 00   03020   0NC0L0GY	0	0	1	0 0	0	
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0		0 0	0	76. 98
OUTPATIENT SERVICE COST CENTERS						
38.00 08800 RURAL HEALTH CLINIC	0	0	1	0 0	0	
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	1	0 0	0	
90. 00  09000   CLI NI C	0	0	1	0	0	1
91. 00   09100   EMERGENCY	0	0	1	0	0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	o	0	)	0 0	0	92.00

0 92.00 0 200.00

0 0

92.00 | 09200 | OBSERVATION BEDS (NON-DISTINCT PART 200.00 | Total (lines 50-199)

	Financial Systems FR TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RANCISCAN HEALTH RVICE OTHER PAS:			Peri od:	u of Form CMS-2 Worksheet D	2552-10
THROUG	H COSTS		Component	CCN: 15-S022	From 01/01/2016 To 12/31/2016	Part IV Date/Time Pre 6/28/2017 3:4	pared: 1 pm
			Ti tl e	e XVIII	Subprovider -	PPS	- <b>F</b>
	Cost Center Description	Total	Total Charges			I npati ent	
		Outpati ent	(from Wkst. C,		Ratio of Cost	Program	
		Cost (sum of		(col . 5 ÷ col		Charges	
		col . 2, 3 and 4)	8)	7)	(col. 6 ÷ col. 7)		
		6. 00	7.00	8. 00	9. 00	10.00	
	ANCILLARY SERVICE COST CENTERS	0.00	7.00	0.00	7. 00	10100	
50.00	05000 OPERATI NG ROOM	0	9, 935, 878	0.00000	0. 000000	2, 449	50.00
51.00	05100 RECOVERY ROOM	0	C	0. 00000	0. 000000	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	C	0. 00000	0. 000000	0	52.00
53.00	05300 ANESTHESI OLOGY	0	C	0. 00000	0. 000000	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	34, 799, 049	0.00000	0. 000000	129, 515	54.00
54.01	05401 ULTRASOUND	0	2, 908, 972	0.00000	0. 000000	6, 910	54. 01
55.00	05500   RADI OLOGY-THERAPEUTI C	0	3, 829, 075	0.00000	0. 000000	0	55. 00
56.00	05600  RADI OI SOTOPE	0	3, 027, 054	0.00000	0. 000000	0	56. 00
57.00	05700  CT SCAN	0	C	1		0	57.00
58. 00	05800  MRI	0	-			0	
59. 00	05900 CARDI AC CATHETERI ZATI ON	0		0.00000		0	
60.00	06000 LABORATORY	0				357, 610	60.00
60. 01	06001 BLOOD LABORATORY	0	C	0.00000	0. 000000	0	
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	_	_			_	61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	1			0	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	1			0	63.00
64.00	06400 I NTRAVENOUS THERAPY	0	1 05/ 146	0.00000		0	64. 00 65. 00
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	0		1		44, 961 39, 949	
67. 00	06700 OCCUPATIONAL THERAPY		2,331,230			39, 949	1
68. 00	06800 SPEECH PATHOLOGY			0.00000		0	68.00
69. 00	06900 ELECTROCARDI OLOGY			•		41, 769	
70.00	07000 ELECTROENCEPHALOGRAPHY	0		0.00000		41, 707	1
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	Ö		•		29, 168	
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	Ö		1		0	1
73. 00	07300 DRUGS CHARGED TO PATIENTS	0				490, 168	
74.00	07400 RENAL DIALYSIS	0				0	1
75. 00	07500 ASC (NON-DISTINCT PART)	0	l c			0	•
76.00	03020 ONCOLOGY	0	C	0. 00000	0. 000000	0	76.00
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	382, 476	0.00000	0. 000000	0	76. 98
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0	-			0	
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0				0	
90.00	09000 CLI NI C	0				0	90.00
91.00	09100 EMERGENCY	0				87, 240	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0		•	0. 000000	0	
200.00	Total (lines 50-199)	0	159, 923, 481			1, 229, 739	J200. 00

Health Financial Systems	FRANCI SCAN HEALTH CR	AWFORDSVI LLE	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0022	Peri od: From 01/01/2016	Worksheet D Part IV
THOUGH COSTS		Component CCN: 15-S022		
		Title XVIII	Subprovi der -	PPS

			Title	e XVIII	Subprovi der -	PPS	
	Cost Center Description	I npati ent	Outpati ent	Outpati ent	I PF		
	cost center bescription	Program	Program	Program			
		Pass-Through	Charges	Pass-Through			
		Costs (col. 8	Chai ges	Costs (col.			
		x col. 10)		x col. 12)	9		
		11.00	12. 00	13.00			
	ANCILLARY SERVICE COST CENTERS	11.00	12.00	13.00			
	05000 OPERATING ROOM	0	0		0		50.00
51. 00	05100 RECOVERY ROOM		0		0		51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM		0		0		52. 00
53. 00	05300 ANESTHESI OLOGY		0		0		53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C		0		0		54. 00
54. 01	05401 ULTRASOUND		0		0		54. 01
55. 00	05500 RADI OLOGY-THERAPEUTI C	ol	0	,	0		55. 00
56. 00	05600 RADI OI SOTOPE	ol	0	,	0		56. 00
57. 00	05700 CT SCAN	ol	0	,	0		57. 00
58. 00	05800 MRI	ol	0	,	0		58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	ol	0	,	0		59. 00
60.00	06000 LABORATORY	ol	0	,	0		60.00
60. 01	06001 BLOOD LABORATORY	ol	0	,	0		60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	ol	0	,	0		62. 00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	ol	0	,	0		63.00
64. 00	06400 I NTRAVENOUS THERAPY	o	0	)	0		64. 00
65.00	06500 RESPIRATORY THERAPY	o	0	)	0		65. 00
66.00	06600 PHYSI CAL THERAPY	o	0	)	0		66. 00
67.00	06700 OCCUPATI ONAL THERAPY	o	0	)	0		67. 00
68.00	06800 SPEECH PATHOLOGY	o	0	1	0		68. 00
69.00	06900 ELECTROCARDI OLOGY	o	0	1	0		69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	o	0	1	0		70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	o	0	)	0		71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	o	0	)	0		72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	)	0		73. 00
74.00	07400 RENAL DIALYSIS	o	0	)	0		74. 00
75.00	07500 ASC (NON-DISTINCT PART)	o	0	)	0		75. 00
76.00	03020 ONCOLOGY	o	0	)	0		76. 00
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0		0		76. 98
	OUTPATIENT SERVICE COST CENTERS						
	08800 RURAL HEALTH CLINIC	0	0		0		88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	)	0		89. 00
90.00	09000 CLI NI C	0	0	)	0		90.00
91. 00	09100 EMERGENCY	0	0	)	0		91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	)	0		92. 00
200.00	Total (lines 50-199)	0	0	1	0		200. 00

Heal th	Financial Systems FR	ANCISCAN HEALIF	I CRAWFORDSVILL	.E.	In Lie	u of Form CMS-	2552-10
APPORT	TIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	O VACCINE COST	Provi der C		Peri od:	Worksheet D	
					From 01/01/2016		narodi
					Γο 12/31/2016	6/28/2017 3: 4	
			Ti †I	e XIX	Hospi tal	Cost	т рііі
			11.61	Charges	поэрт саг	Costs	
	Cost Center Description	Cost to Charge	PPS Reimbursed		Cost	PPS Services	
	cost center bescription	Ratio From	Services (see	Rei mbursed	Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not	(366 11131.)	
		Part I, col. 9		Subject To	Subject To		
		art 1, cor. 7		Ded. & Coins.			
				(see inst.)	(see inst.)		
		1.00	2.00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
50. 00	05000 OPERATING ROOM	0. 340480	109, 199	1	0 0	37, 180	50.00
51. 00	05100 RECOVERY ROOM	0. 000000				0	1
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	l .	1		0	1
	05300 ANESTHESI OLOGY	0. 000000			-	_	1
53.00	l		l .	1	-	0	
54. 00	05400 RADI OLOGY - DI AGNOSTI C	0. 131484			0	51, 658	
54. 01	05401 ULTRASOUND	0. 062514	· ·		9	2, 440	1
55. 00	05500 RADI OLOGY-THERAPEUTI C	0. 298054	· ·		0	76, 078	1
56. 00	05600 RADI OI SOTOPE	0. 081133		1	-	1, 913	
57.00	05700 CT SCAN	0. 000000	0	)	٥	0	57. 00
58. 00	05800  MRI	0. 000000	0	)	0	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0. 000000	0	)	0	0	59. 00
60.00	06000 LABORATORY	0. 175044	293, 201		0	51, 323	60.00
60. 01	06001 BLOOD LABORATORY	0. 000000	0	)	0	0	60. 01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0. 000000			0		61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 000000	0	)	0	0	62. 00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	0	)	0	0	63. 00
64.00	06400 I NTRAVENOUS THERAPY	0. 000000	0	)	0	0	64. 00
65.00	06500 RESPI RATORY THERAPY	0. 340298	9, 137	1	0	3, 109	65. 00
66.00	06600 PHYSI CAL THERAPY	0. 479005			0	16, 028	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0. 000000	0	)	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0. 000000	0	)	0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	0. 084082	38, 727		0	3, 256	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 000000		1	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 173626			0	12, 804	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 256584			0	741	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 266927			0	28, 757	
74.00	07400 RENAL DIALYSIS	0. 000000		,	0	0	
75. 00	07500 ASC (NON-DISTINCT PART)	0. 000000		,	0	0	1
76. 00	03020 ONCOLOGY	0. 000000	l .		0	0	
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0. 159874			o o		1
70.70	OUTPATIENT SERVICE COST CENTERS	0. 10707 1			<u> </u>		70.70
88. 00	08800 RURAL HEALTH CLINIC	0. 000000				0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000				0	
90.00	09000 CLINIC	0. 582884			0	_	
91. 00	09100 EMERGENCY	0. 164874		1	0	92, 020	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 913175				18, 792	
200.00		0. 713173	1, 958, 365	1			
200.00		1	1, 750, 303	1		370, 440	200.00
201.00	Only Charges						201.00
202.00			1, 958, 365		o	396, 440	202 00
202.00	1.132 Sharges (11110 200 17 11110 201)	I	1, 700, 500	1	-1	375, 440	1-02.00

12/31/2016 Date/Time Prepared: 6/28/2017 3:41 pm Title XIX Hospi tal Cost Costs Cost Center Description Cost Cost Rei mbursed Rei mbursed Servi ces Services Not Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 6.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 50.00 51.00 05100 RECOVERY ROOM 0 51.00 52. 00 05200 DELIVERY ROOM & LABOR ROOM 0 52 00 05300 ANESTHESI OLOGY 53.00 0 53.00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 54. 01 05401 ULTRASOUND 0 54.01 05500 RADI OLOGY-THERAPEUTI C 0 55.00 55.00 56. 00 05600 RADI 0I SOTOPE 0 56.00 05700 CT SCAN 0 57.00 57.00 05800 MRI 58 00 0 58 00 59.00 05900 CARDIAC CATHETERIZATION 0 59.00 60.00 06000 LABORATORY 0 60.00 60.01 06001 BLOOD LABORATORY 60.01 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 61.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 62.00 06300 BLOOD STORING, PROCESSING & TRANS. 63.00 63.00 64.00 06400 I NTRAVENOUS THERAPY 0 64.00 06500 RESPIRATORY THERAPY 0 65.00 65.00 66.00 06600 PHYSI CAL THERAPY 0 66.00 06700 OCCUPATIONAL THERAPY 0 67.00 67.00 0 06800 SPEECH PATHOLOGY 68.00 68.00 06900 ELECTROCARDI OLOGY 69.00 69 00 70.00 07000 ELECTROENCEPHALOGRAPHY 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 71.00 0) 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 72.00 72.00 0 73.00 73.00 74.00 07400 RENAL DIALYSIS 74.00 07500 ASC (NON-DISTINCT PART) 0 75.00 75.00 03020 ONCOLOGY 76.00 0 76.00 07698 HYPERBARI C OXYGEN THERAPY 76. 98 0 76.98 OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 88.00 88.00 000000 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 0 89.00 90.00 09000 CLI NI C 0 90.00 91.00 09100 EMERGENCY 0 91.00

0

0

0

92.00

200.00

201.00

202. 00

200.00

201.00

202.00

92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART

Only Charges

Subtotal (see instructions)

Less PBP Clinic Lab. Services-Program

Net Charges (line 200 +/- line 201)

	Financial Systems FRANCISCAN HEALTH C			u of Form CMS-2	
COMPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0022	Peri od: From 01/01/2016	Worksheet D-1	
				Date/Time Pre 6/28/2017 3:4	
		Title XVIII	Hospi tal	PPS	
	Cost Center Description			1. 00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed day			3, 867	1. 00
2.00	Inpatient days (including private room days, excluding swing-			3, 867	2.00
3. 00	Private room days (excluding swing-bed and observation bed da do not complete this line.	ys). If you have only pr	rivate room days,	0	3. 00
4.00	Semi-private room days (excluding swing-bed and observation b	ed days)		2, 772	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private ro		er 31 of the cost	0	5. 00
	reporting period	3 / 3			
6.00	Total swing-bed SNF type inpatient days (including private ro	om days) after December	31 of the cost	0	6. 00
7 00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private roo	m daya) +brayab Dagambar	21 of the cost	0	7. 00
7. 00	reporting period	ili days) through becember	31 OF the Cost	0	7.00
8. 00	Total swing-bed NF type inpatient days (including private roo	m days) after December 3	1 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 t	o the Program (excluding	swing-bed and	1, 766	9. 00
10. 00	newborn days) Swing-bed SNF type inpatient days applicable to title XVIII o	nly (including private r	coom days)	0	10. 00
10.00	through December 31 of the cost reporting period (see instruc		oolii uays)	0	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII o		room days) after	0	11. 00
	December 31 of the cost reporting period (if calendar year, e	nter 0 on this line)	<b>3</b> ,		
12.00	Swing-bed NF type inpatient days applicable to titles V or XI	X only (including privat	e room days)	0	12.00
13. 00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XI	V only (including privat	o room dove)	0	13. 00
13.00	after December 31 of the cost reporting period (if calendar y			0	13.00
14. 00	Medically necessary private room days applicable to the Progr			0	14. 00
	Total nursery days (title V or XIX only)			0	15.00
16. 00	Nursery days (title V or XIX only)			0	16. 00
17 00	SWING BED ADJUSTMENT	+b	£ +1+	0.00	17.00
17.00	Medicare rate for swing-bed SNF services applicable to service reporting period	es through December 31 c	or the cost	0.00	17. 00
18. 00	Medicare rate for swing-bed SNF services applicable to servic	es after December 31 of	the cost	0.00	18. 00
	reporting period		5551	0.00	.0.00
19.00	Medicaid rate for swing-bed NF services applicable to service	s through December 31 of	the cost	0. 00	19. 00
00 00	reporting period			0.00	00.00
20. 00	Medicaid rate for swing-bed NF services applicable to service reporting period	s after December 31 of t	ne cost	0.00	20. 00
21. 00	Total general inpatient routine service cost (see instruction	s)		4, 839, 149	21. 00
22. 00	Swing-bed cost applicable to SNF type services through Decemb		ing period (line	0	22. 00
	5 x line 17)	·			
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reportin	g period (line 6	0	23. 00
24.00	x line 18)	r 21 of the cost resent:	ng pariod (line	0	24.00
24. 00	Swing-bed cost applicable to NF type services through Decembe $7 \times 1$ ine 19)	i si di the cost reporti	ng perroa (rine	0	24. 00
25. 00	Swing-bed cost applicable to NF type services after December	31 of the cost reporting	period (line 8	0	25. 00
	x line 20)				
26. 00	Total swing-bed cost (see instructions)			0	
27. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		4, 839, 149	27. 00
28. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-be	d and observation had ab	arnes)	0	28. 00
20.00	Drivete room charges (evaluding swing had charges)	a and observation bed Ci	iai ges)	U	20.00

	pecember 31 of the cost reporting period (if carendar year, enter 0 on this fine)		
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	12. 00
40.00	through December 31 of the cost reporting period		40.00
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)	0	13. 00
14. 00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14. 00
15. 00	Total nursery days (title V or XIX only)	0	15. 00
16. 00	Nursery days (title V or XIX only)	0	16. 00
10.00	SWING BED ADJUSTMENT	J	10.00
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	Medicare rate for swing-bed SNF services applicable to services 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 of the cost	0. 00	19. 00
	reporting period		
20. 00	Medical drate for swing-bed NF services applicable to services after December 31 of the cost	0. 00	20. 00
21 00	reporting period	4 020 140	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 reporting period (line	4, 839, 149 0	21. 00 22. 00
22.00	5 x line 17)	٥	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
20.00	x line 18)	ŭ	20.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	0	24. 00
	7 x line 19)		
25. 00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	0	25. 00
	x line 20)	_	
26. 00	Total swing-bed cost (see instructions)	0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	4, 839, 149	27. 00
20.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	0	20.00
28. 00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28. 00 29. 00
29. 00 30. 00	Pri vate room charges (excluding swing-bed charges) Semi-pri vate room charges (excluding swing-bed charges)		
30.00		Λ.	20 00
21 00		0 000000	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0. 000000	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
32. 00 33. 00	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)	0. 000000 0. 00 0. 00	31. 00 32. 00 33. 00
32. 00 33. 00 34. 00	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)	0. 000000 0. 00 0. 00 0. 00	31. 00 32. 00 33. 00 34. 00
32. 00 33. 00 34. 00 35. 00	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)	0. 000000 0. 00 0. 00 0. 00 0. 00	31. 00 32. 00 33. 00 34. 00 35. 00
32. 00 33. 00 34. 00 35. 00 36. 00	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)  Private room cost differential adjustment (line 3 x line 35)	0. 000000 0. 00 0. 00 0. 00 0. 00 0	31. 00 32. 00 33. 00 34. 00 35. 00 36. 00
32. 00 33. 00 34. 00 35. 00	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)  Private room cost differential adjustment (line 3 x line 35)  General inpatient routine service cost net of swing-bed cost and private room cost differential (line	0. 000000 0. 00 0. 00 0. 00 0. 00	31. 00 32. 00 33. 00 34. 00 35. 00 36. 00
32. 00 33. 00 34. 00 35. 00 36. 00	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)  Private room cost differential adjustment (line 3 x line 35)  General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	0. 000000 0. 00 0. 00 0. 00 0. 00 0	31. 00 32. 00 33. 00 34. 00 35. 00 36. 00
32. 00 33. 00 34. 00 35. 00 36. 00	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)  Private room cost differential adjustment (line 3 x line 35)  General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY	0. 000000 0. 00 0. 00 0. 00 0. 00 0	31. 00 32. 00 33. 00 34. 00 35. 00 36. 00
32. 00 33. 00 34. 00 35. 00 36. 00	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)  Private room cost differential adjustment (line 3 x line 35)  General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	0. 000000 0. 00 0. 00 0. 00 0. 00 0	31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00
32. 00 33. 00 34. 00 35. 00 36. 00 37. 00	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)  Private room cost differential adjustment (line 3 x line 35)  General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS	0. 000000 0. 00 0. 00 0. 00 0. 00 0 4, 839, 149	31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00
32. 00 33. 00 34. 00 35. 00 36. 00 37. 00	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)  Private room cost differential adjustment (line 3 x line 35)  General inpatient routine service cost net of swing-bed cost and private room cost differential (line 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)	0. 000000 0. 00 0. 00 0. 00 0. 00 4, 839, 149	31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00
32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00	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 cost 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)  General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  Adjusted general inpatient routine service cost per diem (see instructions)  Program general inpatient routine service cost (line 9 x line 38)  Medically necessary private room cost applicable to the Program (line 14 x line 35)	0. 000000 0. 00 0. 00 0. 00 0. 00 4, 839, 149 1, 251. 40 2, 209, 972	31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00
32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00	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 cost 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)  General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  Adjusted general inpatient routine service cost per diem (see instructions)  Program general inpatient routine service cost (line 9 x line 38)  Medically necessary private room cost applicable to the Program (line 14 x line 35)	0. 000000 0. 00 0. 00 0. 00 0. 00 4, 839, 149 1, 251. 40 2, 209, 972 0	31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00
32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00	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 cost 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)  General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  Adjusted general inpatient routine service cost per diem (see instructions)  Program general inpatient routine service cost (line 9 x line 38)  Medically necessary private room cost applicable to the Program (line 14 x line 35)	0. 000000 0. 00 0. 00 0. 00 0. 00 4, 839, 149 1, 251. 40 2, 209, 972 0	31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00
32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00	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 cost 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)  General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  Adjusted general inpatient routine service cost per diem (see instructions)  Program general inpatient routine service cost (line 9 x line 38)  Medically necessary private room cost applicable to the Program (line 14 x line 35)	0. 000000 0. 00 0. 00 0. 00 0. 00 4, 839, 149 1, 251. 40 2, 209, 972 0	31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00
32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00	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 cost 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)  General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  Adjusted general inpatient routine service cost per diem (see instructions)  Program general inpatient routine service cost (line 9 x line 38)  Medically necessary private room cost applicable to the Program (line 14 x line 35)	0. 000000 0. 00 0. 00 0. 00 0. 00 4, 839, 149 1, 251. 40 2, 209, 972 0	31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00

43. 00 In   44. 00	Cost Center Description  JRSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT DRONARY CARE UNIT JRN INTENSIVE CARE UNIT JRGICAL INTENSIVE CARE UNIT THER SPECIAL CARE (SPECIFY) Cost Center Description  Trogram inpatient ancillary service cost (Wkspotal Program inpatient costs (sum of lines 4 MSS THROUGH COST ADJUSTMENTS ass through costs applicable to Program inpatient in the service of the service cost (sum of lines 5 MSS THROUGH COST ADJUSTMENTS and IV) Datal Program excludable cost (sum of lines 5 MSS THROUGH costs applicable to Program inpatient operating cost excluded and IV) Datal Program excludable cost (sum of lines 5 MSS THROUGH COST ADJUSTMENTS and IV) Datal Program inpatient operating cost excluded and education costs (line 49 minus line 5 MSS THROUGH AND LIMIT COMPUTATION rogram discharges arget amount per discharge arget amount (line 54 x line 55) ifference between adjusted inpatient operationus payment (see instructions) besser of lines 53/54 or 55 from the cost rep	1.00 2  1.00 2  1.657,167 0 0  st. D-3, col. 3, line 11 through 48) (see in atient routine service atient ancillary service 50 and 51) ding capital related, 52)	nstructions)  ces (from Wkst. D, survices (from Wkst. D, s	4.00 00 0 0 95 300 00 0 0 00 0 0	Date/Time Prep 6/28/2017 3: 4	42. 00 43. 00 44. 00 45. 00 47. 00 50. 00 51. 00 52. 00
43. 00 In   44. 00	URSERY (title V & XIX only)  Intensive Care Type Inpatient Hospital Units  INTENSIVE CARE UNIT  URN INTENSIVE CARE UNIT  URN INTENSIVE CARE UNIT  URGICAL INTENSIVE CARE UNIT  THER SPECIAL CARE (SPECIFY)  Cost Center Description  Trogram inpatient ancillary service cost (Wks  Intensive Cost ADJUSTMENTS  Intens	1.00 2  1.00 2  1.657,167 0 0  st. D-3, col. 3, line 11 through 48) (see in atient routine service atient ancillary service 50 and 51) ding capital related, 52)	Average Per   Pe	Program Days  + 4.00  00	PPS Program Cost (col. 3 x col. 4) 5.00  886, 185 0 0  1.00 3,063,976 6,160,133  798,141 398,731 1,196,872 4,963,261	42. 00 43. 00 44. 00 45. 00 46. 00 47. 00 48. 00 49. 00 50. 00 51. 00
43. 00 In   44. 00	URSERY (title V & XIX only)  Intensive Care Type Inpatient Hospital Units  INTENSIVE CARE UNIT  URN INTENSIVE CARE UNIT  URN INTENSIVE CARE UNIT  URGICAL INTENSIVE CARE UNIT  THER SPECIAL CARE (SPECIFY)  Cost Center Description  Trogram inpatient ancillary service cost (Wks  Intensive Cost ADJUSTMENTS  Intens	1.00 2  1.00 2  1.657,167 0 0  st. D-3, col. 3, line 11 through 48) (see in atient routine service atient ancillary service 50 and 51) ding capital related, 52)	Sent Days   Diem (col. 1   col. 2)   2.00   3.00   0.10	4.00 00 0 0 95 300 00 0 0 00 0 0	(col. 3 x col. 4) 5.00 0 886, 185 0 0 1.00 3, 063, 976 6, 160, 133 798, 141 398, 731 1, 196, 872 4, 963, 261	43. 00 44. 00 45. 00 47. 00 48. 00 49. 00 50. 00 51. 00
43. 00 In   44. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT DRONARY CARE UNIT JUNITENSIVE CARE UNIT JUNITENSIVE CARE UNIT JUNITENSIVE CARE UNIT JUNITENSIVE CARE UNIT THER SPECIAL CARE (SPECIFY) Cost Center Description  Trogram inpatient ancillary service cost (Wks Datal Program inpatient costs (sum of lines 4 ASS THROUGH COST ADJUSTMENTS THROUGH COST ADJUSTMENTS THROUGH COST ADJUSTMENTS TO SERVICE OF THE SERVICE OF TH	atient ancillary service ating capital related, 52)	2.00 3.00 0 0.1  561 2,953. 0 0.1 0 0.1  e 200) e 200) estructions) ces (from Wkst. D, survices (from	00 0 95 300 00 0 00 0	5. 00 0 886, 185 0 0 1. 00 3, 063, 976 6, 160, 133 798, 141 398, 731 1, 196, 872 4, 963, 261	43. 00 44. 00 45. 00 47. 00 48. 00 49. 00 50. 00 51. 00
43. 00 In   44. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT DRONARY CARE UNIT JUNITENSIVE CARE UNIT JUNITENSIVE CARE UNIT JUNITENSIVE CARE UNIT JUNITENSIVE CARE UNIT THER SPECIAL CARE (SPECIFY) Cost Center Description  Trogram inpatient ancillary service cost (Wks Datal Program inpatient costs (sum of lines 4 ASS THROUGH COST ADJUSTMENTS THROUGH COST ADJUSTMENTS THROUGH COST ADJUSTMENTS TO SERVICE OF THE SERVICE OF TH	1,657,167 0 0 st. D-3, col. 3, line 11 through 48)(see in atient routine servic atient ancillary serv 50 and 51) ding capital related, 52)	561 2,953. 0 0.0 0 0.0 e 200) nstructions)  ces (from Wkst. D, survices (f	95 300 00 0 00 0 m of Parts I and	1. 00 3, 063, 976 6, 160, 133 798, 141 398, 731 1, 196, 872 4, 963, 261	43. 00 44. 00 45. 00 47. 00 48. 00 49. 00 50. 00 51. 00
43. 00 IN 44. 00 CC 45. 00 BL 46. 00 SL 47. 00 OT  48. 00 Pr A9. 00 Pr A9. 00 Pr A9. 00 Tc A9. 0	NTENSIVE CARE UNIT DRONARY CARE UNIT JRN INTENSIVE CARE UNIT JRGICAL INTENSIVE CARE UNIT THER SPECIAL CARE (SPECIFY) Cost Center Description  rogram inpatient ancillary service cost (Wkspotal Program inpatient costs (sum of lines 4 MSS THROUGH COST ADJUSTMENTS ass through costs applicable to Program inpatient of the program inpatient of the program inpatient program inpatient program inpatient program inpatient program inpatient program inpatient operating cost excluded called ucation costs (line 49 minus line 5 MRGET AMOUNT AND LIMIT COMPUTATION rogram discharges arget amount (line 54 x line 55) Ifference between adjusted inpatient operation on payment (see instructions)	st. D-3, col. 3, line 11 through 48)(see in 12 through 48)(see in 13 tient routine service 14 tient ancillary service 15 and 51) 16 ing capital related, 152)	e 200) nstructions) ces (from Wkst. D, survices (from Wkst. D, s	n of Parts I and	1. 00 3, 063, 976 6, 160, 133 798, 141 398, 731 1, 196, 872 4, 963, 261	44. 00 45. 00 46. 00 47. 00 48. 00 49. 00 50. 00 51. 00 52. 00
44. 00 CC 45. 00 BL 46. 00 SL 47. 00 OT  48. 00 Pr 49. 00 Pc PA 50. 00 Pc ar 51. 00 Pc 53. 00 Pc 55. 00 Tc 55. 00 Tc 55. 00 Tc 56. 00 Tc 57. 00 Di 58. 00 Bc 59. 00 Le 60. 00 Le 61. 00 If	DRONARY CARE UNIT JRN INTENSIVE CARE UNIT JRGICAL INTENSIVE CARE UNIT THER SPECIAL CARE (SPECIFY)  Cost Center Description  rogram inpatient ancillary service cost (Wks otal Program inpatient costs (sum of lines 4 ASS THROUGH COST ADJUSTMENTS ass through costs applicable to Program inpa and IV) otal Program excludable cost (sum of lines 5 otal Program inpatient operating cost excluded and IV) otal Program inpatient operating cost excluded and education costs (line 49 minus line 5 otal Program discharges arget amount per discharge arget amount (line 54 x line 55) ifference between adjusted inpatient operation onus payment (see instructions)	st. D-3, col. 3, line 11 through 48)(see in 12 through 48)(see in 13 tient routine service 14 tient ancillary service 15 and 51) 16 ing capital related, 152)	e 200) nstructions) ces (from Wkst. D, survices (from Wkst. D, s	n of Parts I and	1. 00 3, 063, 976 6, 160, 133 798, 141 398, 731 1, 196, 872 4, 963, 261	44. 00 45. 00 46. 00 47. 00 48. 00 49. 00 50. 00 51. 00 52. 00
45. 00 BL 46. 00 SL 47. 00 OT  48. 00 Pr 49. 00 Pc 11 51. 00 Pa 52. 00 Tc 53. 00 Pc 55. 00 Tc 55. 00 Tc 56. 00 Tc 57. 00 Di 58. 00 Bc 59. 00 Le 60. 00 Le 61. 00 If	URGICAL INTENSIVE CARE UNIT THER SPECIAL CARE (SPECIFY)  Cost Center Description  rogram inpatient ancillary service cost (Wks otal Program inpatient costs (sum of lines 4 MSS THROUGH COST ADJUSTMENTS ass through costs applicable to Program inpa II) ass through costs applicable to Program inpa II) otal Program excludable cost (sum of lines 5 otal Program inpatient operating cost excluded ical education costs (line 49 minus line 5 MRGET AMOUNT AND LIMIT COMPUTATION rogram discharges arget amount per discharge arget amount (line 54 x line 55) Ifference between adjusted inpatient operation onus payment (see instructions)	st. D-3, col. 3, line 11 through 48)(see in atient routine service atient ancillary service of and 51) ding capital related, 52)	e 200) nstructions) ces (from Wkst. D, sur vices (from Wkst. D, s	m of Parts I and sum of Parts II	1. 00 3, 063, 976 6, 160, 133 798, 141 398, 731 1, 196, 872 4, 963, 261	48. 00 47. 00 48. 00 49. 00 50. 00 51. 00 52. 00
48. 00 Pr 49. 00 Tc PA 50. 00 Pr 51. 00 Pr 51. 00 Pr 553. 00 Tc TA 554. 00 Pr 555. 00 Tc 56. 00 Tc 57. 00 Di 58. 00 Bc 59. 00 Le 60. 00 Le 61. 00 If	Cost Center Description  rogram inpatient ancillary service cost (Wks otal Program inpatient costs (sum of lines 4 MSS THROUGH COST ADJUSTMENTS ass through costs applicable to Program inpatient of lines through costs applicable to Program inpatient ly otal Program excludable cost (sum of lines 5 otal Program inpatient operating cost excluded all education costs (line 49 minus line 5 MRGET AMOUNT AND LIMIT COMPUTATION rogram discharges arget amount per discharge arget amount (line 54 x line 55)  Ifference between adjusted inpatient operation on spanner (see instructions)	atient routine servicatient ancillary servicatient ancillary servicatient ancillary servication and 51) ding capital related, 52)	nstructions)  ces (from Wkst. D, survices (from Wkst. D, s	sum of Parts II	3, 063, 976 6, 160, 133 798, 141 398, 731 1, 196, 872 4, 963, 261	48. 00 49. 00 50. 00 51. 00
48. 00 Pr 49. 00 Tc PA 50. 00 Pa 51. 00 Pa ar 52. 00 Tc 53. 00 Tc 55. 00 Ta 56. 00 Ta 57. 00 Di 58. 00 Bc 59. 00 Le 60. 00 Le 61. 00 If	Cost Center Description  rogram inpatient ancillary service cost (Wks otal Program inpatient costs (sum of lines 4 MSS THROUGH COST ADJUSTMENTS  ass through costs applicable to Program inpation of live and IV)  ass through costs applicable to Program inpation of live and IV)  botal Program excludable cost (sum of lines 5 otal Program inpatient operating cost excluded and education costs (line 49 minus line 5 MRGET AMOUNT AND LIMIT COMPUTATION rogram discharges arget amount per discharge arget amount (line 54 x line 55)  Ifference between adjusted inpatient operation on payment (see instructions)	atient routine servicatient ancillary servicatient ancillary servicatient ancillary servication and 51) ding capital related, 52)	nstructions)  ces (from Wkst. D, survices (from Wkst. D, s	sum of Parts II	3, 063, 976 6, 160, 133 798, 141 398, 731 1, 196, 872 4, 963, 261	48. 00 49. 00 50. 00 51. 00 52. 00
49. 00   Tc   PA   50. 00   Pa   51. 00   Pa   51. 00   Tc   52. 00   Tc   53. 00   Tc   55. 00   Ta   56. 00   Ta   57. 00   Di   58. 00   Bc   59. 00   Le   60. 00   Le   61. 00   If	rogram inpatient ancillary service cost (Wksptal Program inpatient costs (sum of lines 4 Mksptal Program inpatient costs (sum of lines 4 Mksptal Program inpatient costs applicable to Program inpatient of Program inpatie	atient routine servicatient ancillary servicatient ancillary servicatient ancillary servication and 51) ding capital related, 52)	nstructions)  ces (from Wkst. D, survices (from Wkst. D, s	sum of Parts II	3, 063, 976 6, 160, 133 798, 141 398, 731 1, 196, 872 4, 963, 261	50. 00 51. 00 52. 00
49. 00   Tc   PA   50. 00   Pa   51. 00   Pa   51. 00   Tc   52. 00   Tc   53. 00   Tc   55. 00   Ta   56. 00   Ta   57. 00   Di   58. 00   Bc   59. 00   Le   60. 00   Le   61. 00   If	otal Program inpatient costs (sum of lines 4 ASS THROUGH COST ADJUSTMENTS ass through costs applicable to Program inpatient of lines through costs applicable to Program inpatient of lines to line and ly) otal Program excludable cost (sum of lines to line 1 program inpatient operating cost excluded ical education costs (line 49 minus line 5 larget AMOUNT AND LIMIT COMPUTATION rogram discharges arget amount per discharge larget amount (line 54 x line 55) Ifference between adjusted inpatient operationus payment (see instructions)	atient routine servicatient ancillary servicatient ancillary servicatient ancillary servication and 51) ding capital related, 52)	nstructions)  ces (from Wkst. D, survices (from Wkst. D, s	sum of Parts II	3, 063, 976 6, 160, 133 798, 141 398, 731 1, 196, 872 4, 963, 261	50. 00 51. 00 52. 00
49. 00   Tc   PA   50. 00   Pa   51. 00   Pa   51. 00   Tc   52. 00   Tc   53. 00   Tc   55. 00   Ta   56. 00   Ta   57. 00   Di   58. 00   Bc   59. 00   Le   60. 00   Le   61. 00   If	otal Program inpatient costs (sum of lines 4 ASS THROUGH COST ADJUSTMENTS ass through costs applicable to Program inpatient of lines through costs applicable to Program inpatient of lines to line and ly) otal Program excludable cost (sum of lines to line 1 program inpatient operating cost excluded ical education costs (line 49 minus line 5 larget AMOUNT AND LIMIT COMPUTATION rogram discharges arget amount per discharge larget amount (line 54 x line 55) Ifference between adjusted inpatient operationus payment (see instructions)	atient routine servicatient ancillary servicatient ancillary servicatient ancillary servication and 51) ding capital related, 52)	nstructions)  ces (from Wkst. D, survices (from Wkst. D, s	sum of Parts II	6, 160, 133 798, 141 398, 731 1, 196, 872 4, 963, 261	50. 00 51. 00 52. 00
50. 00 Part   Pa	ass through costs applicable to Program inpa 11) ass through costs applicable to Program inpa not IV) otal Program excludable cost (sum of lines 5 otal Program inpatient operating cost excluded edical education costs (line 49 minus line 5 NRGET AMOUNT AND LIMIT COMPUTATION rogram discharges arget amount per discharge arget amount (line 54 x line 55) Ifference between adjusted inpatient operationus payment (see instructions)	atient ancillary serv 50 and 51) Hing capital related, 52)	vices (from Wkst. D, s	sum of Parts II	398, 731 1, 196, 872 4, 963, 261	51. 00 52. 00
51. 00 Pa ar 52. 00 Tc me TA 54. 00 Pr 55. 00 Ta 56. 00 Ta 57. 00 Di 58. 00 Bc 59. 00 Le 60. 00 Le 61. 00 If wh	ass through costs applicable to Program inpand IV) obtal Program excludable cost (sum of lines 5 otal Program inpatient operating cost excludedical education costs (line 49 minus line 5 NRGET AMOUNT AND LIMIT COMPUTATION rogram discharges arget amount per discharge arget amount (line 54 x line 55) ofference between adjusted inpatient operationus payment (see instructions)	atient ancillary serv 50 and 51) Hing capital related, 52)	vices (from Wkst. D, s	sum of Parts II	398, 731 1, 196, 872 4, 963, 261	51. 00 52. 00
51. 00 Pa ar 52. 00 To 53. 00 Pr 55. 00 Pr 55. 00 Ta 56. 00 Di 58. 00 Bc 59. 00 Le 61. 00 If wh	ass through costs applicable to Program inpand IV) otal Program excludable cost (sum of lines 5 otal Program inpatient operating cost excluded a ducation costs (line 49 minus line 5 kRGET AMOUNT AND LIMIT COMPUTATION rogram discharges arget amount per discharge arget amount (line 54 x line 55) ifference between adjusted inpatient operationus payment (see instructions)	50 and 51) ding capital related, 52)	•		1, 196, 872 4, 963, 261	52. 0
ar Tc	nd IV) potal Program excludable cost (sum of lines 5 potal Program inpatient operating cost excluded cal education costs (line 49 minus line 5 MRGET AMOUNT AND LIMIT COMPUTATION rogram discharges arget amount per discharge arget amount (line 54 x line 55) ifference between adjusted inpatient operationus payment (see instructions)	50 and 51) ding capital related, 52)	•		1, 196, 872 4, 963, 261	52. 0
53. 00 To me TA 54. 00 Pr 555. 00 Ta 56. 00 Ta 57. 00 Di 58. 00 Bc 59. 00 Le 60. 00 Le 61. 00 If	otal Program inpatient operating cost excluded calleducation costs (line 49 minus line 5 kRGET AMOUNT AND LIMIT COMPUTATION rogram discharges arget amount per discharge arget amount (line 54 x line 55) ifference between adjusted inpatient operationus payment (see instructions)	ding capital related, 52)	, non-physician anestl	netist, and	4, 963, 261	•
54. 00 Pr 55. 00 Ta 56. 00 Ta 57. 00 Di 58. 00 Bc 59. 00 Le 60. 00 Le 61. 00 If	edical education costs (line 49 minus line 5  RRGET AMOUNT AND LIMIT COMPUTATION  rogram discharges  arget amount per discharge  arget amount (line 54 x line 55)  Ifference between adjusted inpatient operationus payment (see instructions)	52)	, non-physician anestl	netist, and		53.0
TA 54. 00 Pr 55. 00 Ta 56. 00 Di 57. 00 Di 58. 00 Bc 59. 00 Le ma 60. 00 Le 61. 00 If wh	ARGET AMOUNT AND LIMIT COMPUTATION rogram discharges arget amount per discharge arget amount (line 54 x line 55) ifference between adjusted inpatient operationus payment (see instructions)					I
54. 00 Pr 55. 00 Ta 56. 00 Ta 57. 00 Di 58. 00 Bc 59. 00 Le ma 60. 00 Le 61. 00 If	rogram discharges arget amount per discharge arget amount (line 54 x line 55) ifference between adjusted inpatient operati onus payment (see instructions)	ng cost and target a				l
55. 00 Ta 56. 00 Ta 57. 00 Di 58. 00 Bc 59. 00 Le 60. 00 Le 61. 00 If	arget amount per discharge arget amount (line 54 x line 55) ifference between adjusted inpatient operati onus payment (see instructions)	ng cost and target a			1 0	54.0
57. 00 Di 58. 00 Bc 59. 00 Le ma 60. 00 Le 61. 00 I f	ifference between adjusted inpatient operationus payment (see instructions)	ng cost and target a			0.00	55. 0
58. 00 Bo 59. 00 Le 60. 00 Le 61. 00 I f	onus payment (see instructions)	ng cost and target a			0	
59. 00 Le ma 60. 00 Le 61. 00 I f wh			amount (line 56 minus	line 53)	0	
60. 00 Le 61. 00 I f wh		orting period ending	n 1996 undated and co	amnounded by the	0.00	
61. 00   I f wh	arket basket	or tring period charing	g 1770, apaated and e	ompounded by the	0.00	37.0
wh	esser of lines 53/54 or 55 from prior year o				0.00	
	fline 53/54 is less than the lower of lines				0	61. 0
ar	nich operating costs (line 53) are less than mount (line 56), otherwise enter zero (see i		nes 54 x 60), or 1% of	r the target		
	elief payment (see instructions)	nstructions)			0	62. 0
	llowable Inpatient cost plus incentive payme	ent (see instructions	s)		0	63.0
	ROGRAM I NPATIENT ROUTINE SWING BED COST		04 6 11 1			
	edicare swing-bed SNF inpatient routine cost nstructions)(title XVIII only)	s through December 3	31 of the cost report	ing period (See	0	64. 0
	edicare swing-bed SNF inpatient routine cost	s after December 31	of the cost reporting	a period (See	0	65. 0
ir	nstructions)(title XVIII only)					
	otal Medicare swing-bed SNF inpatient routin	ne costs (line 64 plu	us line 65)(title XVII	ll only). For	0	66. 0
	AH (see instructions) itle V or XIX swing-bed NF inpatient routine	costs through Decem	mbar 31 of the cost re	enorting period	0	67. 0
(1	line 12 x line 19)	o o				07.0
68. 00   Ťi	itle V or XIX swing-bed NF inpatient routine	e costs after Decembe	er 31 of the cost repo	orting period	0	68. 0
	line 13 x line 20)		(7 1' (0)			
	otal title V or XIX swing-bed NF inpatient r ART III – SKILLED NURSING FACILITY, OTHER NU	•	•		0	69. 0
	killed nursing facility/other nursing facili			)		70.0
71. 00 Ad	djusted general inpatient routine service co	ost per diem (line 70	,			71.0
	rogram routine service cost (line 9 x line 7		44 11 25			72. 0
	edically necessary private room cost applica otal Program general inpatient routine servi					73.00
	apital-related cost allocated to inpatient r			Part II. column		75. 0
	6, line 45)					
1	er diem capital-related costs (line 75 ÷ lin	•				76. 0
1	rogram capital-related costs (line 9 x line npatient routine service cost (line 74 minus					77. 0
	ggregate charges to beneficiaries for excess		er records)			79.0
	otal Program routine service costs for compa	, ,	,	nus line 79)		80.0
1	npatient routine service cost per diem limit			•		81. 0
1	npatient routine service cost limitation (li	•				82.0
1	easonable inpatient routine service costs (s rogram inpatient ancillary services (see ins	-				83.0
1	tilization review - physician compensation (					85. 0
1	otal Program inpatient operating costs (sum		85)		<u>                                       </u>	86. 0
PA	ART IV - COMPUTATION OF OBSERVATION BED PASS	THROUGH COST				
	otal observation bed days (see instructions)		2)		1, 095	
	djusted general inpatient routine cost per d oservation bed cost (line 87 x line 88) (see		۷)		1, 251. 40 1, 370, 283	

Health Financial Systems FF	ANCISCAN HEALTH	CRAWFORDSVI LLI	E	In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od: From 01/01/2016	Worksheet D-1	
				To 12/31/2016	Date/Time Pre 6/28/2017 3:4	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	1, 485, 245	4, 839, 149	0. 30692	3 1, 370, 283	420, 571	90.00
91.00 Nursing School cost	0	4, 839, 149	0.00000	0 1, 370, 283	0	91.00
92.00 Allied health cost	0	4, 839, 149	0.00000	0 1, 370, 283	0	92.00
93.00 All other Medical Education	0	4, 839, 149	0. 00000	0 1, 370, 283	l 0	93.00

Health Financial Systems	FRANCISCAN HEALTH CRAWFORDSVILLE	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0022	Peri od: From 01/01/2016	Worksheet D-1
	Component CCN: 15-S022	To 12/31/2016	Date/Time Prepared: 6/28/2017 3:41 pm
	Title XVIII	Subprovi der -	PPS

		II the Aviii	I PF	FF3	
	Cost Center Description				
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days	s, excluding newborn)		1, 955	1.00
2.00	Inpatient days (including private room days, excluding swing-b			1, 955	2. 00
3. 00	Private room days (excluding swing-bed and observation bed day do not complete this line.	(s). If you have only pri	vate room days,	0	3. 00
4.00	Semi-private room days (excluding swing-bed and observation be	ed days)		1, 955	4. 00
5.00	Total swing-bed SNF type inpatient days (including private roo		31 of the cost	0	5. 00
	reporting period				
6. 00	Total swing-bed SNF type inpatient days (including private roor reporting period (if calendar year, enter 0 on this line)	om days) after becember 3	31 of the cost	0	6. 00
7. 00	Total swing-bed NF type inpatient days (including private room	n days) through December	31 of the cost	0	7. 00
	reporting period				
8. 00	Total swing-bed NF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	n days) after December 31	of the cost	0	8. 00
9. 00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	1, 631	9. 00
	newborn days)		3	,	
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		oom days)	0	10. 00
11. 00	through December 31 of the cost reporting period (see instruct Swing-bed SNF type inpatient days applicable to title XVIII or		nom days) after	0	11. 00
11.00	December 31 of the cost reporting period (if calendar year, er	nter 0 on this line)	Join days) arter	Ü	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XI)		e room days)	0	12.00
13. 00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XI)	/ only (including private	room days)	0	13. 00
13.00	after December 31 of the cost reporting period (if calendar ve			U	13.00
14.00	Medically necessary private room days applicable to the Progra		, I	0	14.00
15. 00	Total nursery days (title V or XIX only)			0	15. 00
16. 00	Nursery days (title V or XLX only) SWING BED ADJUSTMENT			0	16. 00
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 of	the cost	0.00	17. 00
	reporting period				
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of t	the cost	0. 00	18. 00
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	s through December 31 of	the cost	0.00	19. 00
17.00	reporting period	o tili dagir becember or or	1110 0031	0.00	17.00
20. 00	Medicaid rate for swing-bed NF services applicable to services	s after December 31 of th	ne cost	0.00	20. 00
21. 00	reporting period Total general inpatient routine service cost (see instructions	:)		2, 515, 159	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December		ng period (line	2, 313, 137	22. 00
	5 x line 17)	·			
23. 00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reporting	g period (line 6	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December	31 of the cost reportir	na period (line	0	24. 00
	7 x line 19)				
25. 00	Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	period (line 8	0	25. 00
26. 00	x line 20) Total swing-bed cost (see instructions)			0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost (	(line 21 minus line 26)		2, 515, 159	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28. 00 29. 00	General inpatient routine service charges (excluding swing-bed	d and observation bed cha	arges)	0	28. 00
30.00	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	29. 00 30. 00
31. 00	General inpatient routine service cost/charge ratio (line 27	- line 28)		0. 000000	
32. 00	Average private room per diem charge (line 29 ÷ line 3)			0. 00	
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)	1: 22) ( :	.:>	0.00	
34. 00 35. 00	Average per diem private room charge differential (line 32 mir Average per diem private room cost differential (line 34 x line	, ,	LI OIIS)	0. 00 0. 00	
36. 00	Private room cost differential adjustment (line 3 x line 35)	: '/		0.00	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost a	and private room cost dif	ferential (line	2, 515, 159	37. 00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PART IT - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	ISTMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see			1, 286. 53	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line	•		2, 098, 330	
40.00	Medically necessary private room cost applicable to the Progra	,		2 009 220	40.00
41. 00	Total Program general inpatient routine service cost (line 39	T IIIIC 40)	ļ	2, 098, 330	41.00

	Financial Systems FRA	NCISCAN HEALTH		E CN: 15-0022	In Lie	eu of Form CMS-2 Worksheet D-1	
				CCN: 15-S022	From 01/01/2016 To 12/31/2016	Date/Time Pre	pared:
			Ti tl e	e XVIII	Subprovi der -	6/28/2017 3: 4 PPS	1 pm
	Cost Center Description	Total Inpatient Cost	Total npatient Days	Average Per Diem (col. 1		Program Cost (col. 3 x col.	
		1.00	2. 00	col. 2) 3.00	4. 00	4) 5. 00	
42. 00	NURSERY (title V & XIX only)	0	2. 00 C				42. 00
43. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	O	C	0.	00 0	0	43.00
44. 00	CORONARY CARE UNIT	0	C	0.	00 0	0	44. 00
45. 00 46. 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT	0	C	0.	00 0	0	45. 00 46. 00
	OTHER SPECIAL CARE (SPECIFY)						47. 00
	Cost Center Description					1.00	
48. 00	Program inpatient ancillary service cost (Wk					269, 218	1
	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS	¥ , ,		,		2, 367, 548	
50. 00	Pass through costs applicable to Program inpa		•				
51. 00	Pass through costs applicable to Program inpa and IV)	atient ancillary	services (fr	om Wkst. D,	sum of Parts II	30, 319	51.00
52. 00 53. 00	Total Program excludable cost (sum of lines ! Total Program inpatient operating cost exclu		ated, non-phy	sician anestl	netist, and	449, 143 1, 918, 405	1
	medical education costs (line 49 minus line ! TARGET AMOUNT AND LIMIT COMPUTATION	52)					-
	Program discharges					0	
55. 00 56. 00	Target amount per discharge Target amount (line 54 x line 55)					0.00	1
57. 00	Difference between adjusted inpatient operat	ng cost and tar	get amount (I	ine 56 minus	line 53)	0	57. 00
58. 00 59. 00	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost re	porting poriod o	nding 1006 i	indated and co	ampounded by the	0.00	
37.00	market basket	on tring period e	naring 1990, c	ipuateu anu ci	Silipourided by the	0.00	39.00
60. 00 61. 00	Lesser of lines 53/54 or 55 from prior year					0.00	1
61.00	00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target						81.00
62. 00	amount (line 56), otherwise enter zero (see Relief payment (see instructions)	nstructions)				0	62. 00
63. 00	63.00 Allowable Inpatient cost plus incentive payment (see instructions)						63.00
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Decem	ber 31 of the	cost report	na period (See	l 0	64. 00
65. 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	Ü		•		0	65. 00
	instructions)(title XVIII only)			·			
66.00	Total Medicare swing-bed SNF inpatient routing CAH (see instructions)	•	·	, ,	3,	0	
	Title V or XIX swing-bed NF inpatient routine (line 12 x line 19)	-				0	
68. 00	Title V or XIX swing-bed NF inpatient routine (line 13 x line 20)			·	orting period	0	
69. 00	Total title V or XIX swing-bed NF inpatient   PART III - SKILLED NURSING FACILITY, OTHER NU					0	69. 00
70.00	Skilled nursing facility/other nursing facil				)		70.00
71. 00 72. 00	Adjusted general inpatient routine service of Program routine service cost (line 9 x line	, ,	ne 70 ÷ Tine	2)		•	71.00
73.00	Medically necessary private room cost application						73. 00
74. 00 75. 00	Total Program general inpatient routine serv Capital-related cost allocated to inpatient				Part II, column		74. 00 75. 00
76. 00	26, line 45)  Per diem capital-related costs (line 75 ÷ li	ne 2)					76. 00
77. 00 78. 00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minus						77. 00 78. 00
79. 00	Aggregate charges to beneficiaries for excess		ovi der record	ls)			79.00
80. 00 81. 00	Total Program routine service costs for compa		st limitation	n (line 78 mi	nus line 79)		80.00
81.00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (I						81. 00 82. 00
83.00	Reasonable inpatient routine service costs (		)				83.00
84. 00 85. 00	Program inpatient ancillary services (see in: Utilization review - physician compensation		s)				84. 00 85. 00
86. 00	Total Program inpatient operating costs (sum	of lines 83 thr					86. 00
87. 00	PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions					0	87. 00
88. 00	Adjusted general inpatient routine cost per	diem (line 27 ÷	line 2)			1	88. 00
69. UU	Observation bed cost (line 87 x line 88) (see	e instructions)				1 0	89.00

Health Financial Systems FR	RANCISCAN HEALTH CRAWFORDSVILLE			In Lieu of Form CMS-		2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Peri od:	Worksheet D-1	
		Component (		From 01/01/2016 To 12/31/2016		
		Title	XVIII	Subprovi der -	PPS	
				I PF		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
				,	4) (see	
					instructions)	
	1.00	2.00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (	COST					
90.00 Capital -related cost	502, 016	2, 515, 159	0. 19959	6 0	0	90.00
91.00 Nursing School cost	0	2, 515, 159	0. 00000	0 0	0	91.00
92.00 Allied health cost	0	2, 515, 159	0. 00000	0	0	92.00
93.00 All other Medical Education	0	2, 515, 159	0. 00000	0 0	0	93. 00

Heal th	Financial Systems	FRANCISCAN HEALTH C	CRAWFORDSVI LLE	In Lie	u of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST		Provider CCN: 15-0022	Peri od: From 01/01/2016	Worksheet D-1	
				To 12/31/2016	Date/Time Pre	
			Title XIX	Hospi tal	6/28/2017 3: 4 Cost	т ріп
	Cost Center Description					
					1. 00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS					1
1.00	Inpatient days (including private room d	avs and swing-bed day	vs. excluding newborn)		3, 867	1.00
2.00	Inpatient days (including private room d	ays, excluding swing-	-bed and newborn days)		3, 867	2. 00
3.00	Private room days (excluding swing-bed a	nd observation bed da	ays). If you have only p	rivate room days,	0	3. 00
4. 00	do not complete this line. Semi-private room days (excluding swing-	and observation b	and days)		2, 772	4. 00
5. 00	Total swing-bed SNF type inpatient days			er 31 of the cost	2, 772	5.00
	reporting period		3 ,			
6.00	Total swing-bed SNF type inpatient days		oom days) after December	31 of the cost	0	6. 00
7. 00	reporting period (if calendar year, ente Total swing-bed NF type inpatient days (		om davs) through December	31 of the cost	0	7. 00
,, 00	reporting period	nor during private rec	siii aaye, tiii eagii beeeiiize.	0. 0. 1 0001	, and the second	,,,,,
8.00	Total swing-bed NF type inpatient days (		om days) after December 3	31 of the cost	0	8. 00
9. 00	reporting period (if calendar year, ente		to the Program (evoluding	r swing-bod and	279	9. 00
7. 00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)					7.00
10. 00	0 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)					10. 00
11. 00	through December 31 of the cost reporting period (see instructions)					11. 00
11.00	00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)					11.00
12. 00	20 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)					12. 00
13. 00	through December 31 of the cost reporting period  Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)					13.00
10.00	after December 31 of the cost reporting period (if calendar year, enter 0 on this line)					10.00
14. 00	Medically necessary private room days ap	olicable to the Progr	ram (excluding swing-bed	days)	0	
15. 00 16. 00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)				0	
16.00	SWING BED ADJUSTMENT				0	16.00
17. 00	Medicare rate for swing-bed SNF services	applicable to service	ces through December 31 o	of the cost	0.00	17. 00
40.00	reporting period					40.00
18. 00	Medicare rate for swing-bed SNF services reporting period	applicable to service	ces after December 31 of	the cost	0. 00	18. 00
19. 00	Medicaid rate for swing-bed NF services	applicable to service	es through December 31 of	the cost	0. 00	19. 00
20. 00	reporting period Medicaid rate for swing-bed NF services	annlicable to service	os after December 21 of	the cost	0. 00	20.00
20.00	reporting period	appircable to service	es al tel December 51 01	the cost	0.00	20.00
21. 00	Total general inpatient routine service				4, 839, 149	
22. 00	Swing-bed cost applicable to SNF type se	rvices through Decemb	per 31 of the cost report	ting period (line	0	22. 00
23. 00	5 x line 17) Swing-bed cost applicable to SNF type se	rvices after December	- 31 of the cost reportin	na neriod (line 6	0	23. 00
20.00	x line 18)	77 000 47 00 2000201	or or the deat reporter.	.g po ou ( o	, and the second	20.00
24. 00						24. 00
25. 00	Swing-bed cost applicable to NF type ser	vices after December	31 of the cost reporting	g period (line 8	0	25. 00
27.00	x line 20)					24 00
26. 00 27. 00						26. 00 27. 00
27.00	PRI VATE ROOM DI FFERENTI AL ADJUSTMENT	st of oming bed cost	(o 21 minus iino 20)		1, 007, 147	27.00
28. 00	General inpatient routine service charge	, ,	ed and observation bed ch	narges)	0	
29. 00	Pri vate room charges (excluding swing-be				0	
30. 00	Semi-private room charges (excluding swi	ig-neu ciiai ges)			0	30.00

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)	2, 772	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost	0	5. 00
6. 00	reporting period Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	o	6. 00
0.00	reporting period (if calendar year, enter 0 on this line)	۷	6.00
7. 00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost	0	7. 00
7.00	reporting period	ď	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	279	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	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
12 00	through December 31 of the cost reporting period		12 00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XLX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	۷	13. 00
14. 00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	ام	14. 00
15. 00	Total nursery days (title V or XIX only)		15. 00
	Nursery days (title V or XIX only)		16. 00
	SWI NG BED ADJUSTMENT		10.00
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	Medicare rate for swing-bed SNF services applicable to services 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 of 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
04 00	reporting period	4 000 440	04 00
21. 00	Total general inpatient routine service cost (see instructions)	4, 839, 149	
22. 00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line $5 \times 1$ ) x line 17)	۷	22. 00
23. 00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6	٥	23. 00
23.00	x line 18)	Ĭ	23.00
24. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	0	24. 00
	7 x line 19)	-	
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	0	25.00
	x line 20)		
	Total swing-bed cost (see instructions)	0	26.00
27. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	4, 839, 149	27. 00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28. 00
29. 00	Pri vate room charges (excluding swing-bed charges)	0	29. 00
30.00	Semi-private room charges (excluding swing-bed charges)	0 000000	
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	31.00
33. 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
36. 00	Private room cost differential adjustment (line 3 x line 35)	0.00	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line	4, 839, 149	
	27 minus line 36)	., 50 /, . 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, 251. 40	38.00
39. 00	Program general inpatient routine service cost (line 9 x line 38)	349, 141	
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)	349, 141	41.00

42.00   NURSERY (title V & XIX only)   1.00   Intensive Care Type Inpatient Hospital Units   1.657,167   44.00   OCRONARY CARE UNIT   1.657,167   67.00   CORONARY CARE UNIT   0   OCRONARY CARE UNIT   0   OSRIGICAL INTENSIVE CARE UNIT   0   OSRIGICAL INTENSIVE CARE UNIT   0   OTHER SPECIAL CARE (SPECIFY)   0   OTHER SPECIAL CARE (SPECIAL CARE CARE UNIT OF SPECIAL CARE OF SPECIAL CARE CARE (SPECIAL CARE CARE UNIT OTHER SPECIAL CARE (SPECIAL CARE CARE UNIT OTHER SPECIAL CARE CARE UNIT OTHER SPECIAL CARE CARE UNIT OTHER SPECIAL CARE CARE UNIT OTHER SPECIAL CARE CARE CARE UNIT OTHER SPECIAL CARE CARE UNIT OTHER SPECIAL CARE CARE CARE CARE UNIT OTHER SPECIAL CARE CARE CARE CARE CARE CAR		Peri od:	worksheet D-1	∠טט∠- I
42.00   NURSERY (title V & XIX only)   1.00		From 01/01/2016 To 12/31/2016	Date/Time Prep 6/28/2017 3:4	
42.00 NURSERY (title V & XIX only)  Intensive Care Type Inpatient Hospital Units  1.00  Intensive Care Type Inpatient Hospital Units  1.657,167  48.00 BURN INTENSIVE CARE UNIT  48.00 BURN INTENSIVE CARE UNIT  47.00 OTHER SPECIAL CARE (SPECIFY)  OTHER SPECIAL CARE (SPECIFY)  Total Program inpatient ancillary service cost (Wkst. D-3, col. 3, I Program inpatient costs (sum of lines 41 through 48) (see PASS THROUGH COST ADJUSTIMENTS  50.00 Pass through costs applicable to Program inpatient routine ser III)  51.00 Pass through costs applicable to Program inpatient routine ser III)  52.00 Total Program excludable cost (sum of lines 50 and 51)  53.00 Total Program inpatient operating cost excluding capital relating medical education costs (line 49 minus line 52)  TARGET AMOUNT AND LIMIT COMPUTATION  54.00 Program discharges  55.00 Target amount per discharge  56.00 Target amount per discharge  56.00 Discere of lines 53/54 or 55 from prior year cost report, updated in the program of the pr	Title XIX	Hospi tal	Cost	. piii
NURSERY (title V & XIX only)	Total Average Per patient Days Diem (col. 1 col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
Intensive Care Type Inpatient Hospital Units  43.00 INTENSIVE CARE UNIT  44.00 GORNARY CARE UNIT  45.00 BURNI INTENSIVE CARE UNIT  46.00 SURGICAL INTENSIVE CARE UNIT  47.00 OTHER SPECIAL CARE (SPECIFY)  Cost Center Description  48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, I are to the cost of th	2.00 3.00	4. 00	5. 00	
43.00   INTENSIVE CARE UNIT   1,657,167  44.00   CORONARY CARE UNIT   0   45.00   BURN INTENSIVE CARE UNIT   0   46.00   SURGICAL INTENSIVE CARE UNIT   0   47.00   OTHER SPECIAL CARE (SPECIFY)   0   48.00   Program inpatient ancillary service cost (Wkst. D-3, col. 3, I   49.00   Total Program inpatient costs (sum of lines 41 through 48) (see PASS THROUGH COST ADJUSTMENTS)   1115   50.00   Pass through costs applicable to Program inpatient routine ser I   111   51.00   Pass through costs applicable to Program inpatient routine ser I   111   52.00   Total Program excludable cost (sum of lines 50 and 51)   10   53.00   Total Program excludable cost (sum of lines 50 and 51)   10   54.00   Program discharges   16   16   16   16   16   16   16   1	0 0.00	0	0	42. 00
44.00 CORONARY CARE UNIT 45.00 BURN INTENSIVE CARE UNIT 46.00 SURGICAL INTENSIVE CARE UNIT 47.00 [OTHER SPECIAL CARE (SPECIFY)]  48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, I Total Program inpatient ancillary service cost (Wkst. D-3, col. 3, I Total Program inpatient costs (sum of lines 41 through 48) (see PASS THROUGH COST ADJUSTMENTS  50.00 Pass through costs applicable to Program inpatient routine ser IIII)  51.00 Pass through costs applicable to Program inpatient ancillary sand IV)  52.00 Total Program excludable cost (sum of lines 50 and 51)  53.00 Total Program inpatient operating cost excluding capital relating medical education costs (line 49 minus line 52)  54.00 Total Program inpatient operating cost excluding capital relating medical education costs (line 49 minus line 52)  54.00 Total Program inpatient operating cost excluding capital relating medical education costs (line 45 minus line 52)  55.00 Target amount (line 54 x line 55)  56.00 Target amount (line 54 x line 55)  57.00 Difference between adjusted inpatient operating cost and targe Bonus payment (see instructions)  67.00 Lesser of lines 53/54 or 55 from the cost reporting period end market basket  67.00 Lesser of lines 53/54 or 55 from prior year cost report, updated in the service of lines 55, 59 or 60 end which operating costs (line 53) are less than expected costs (amount (line 56), otherwise enter zero (see instructions)  67.00 Alowable Inpatient cost plus incentive payment (see instructions)  67.00 Medicare swing-bed SNF inpatient routine costs through December instructions (little XVIII only)  68.00 Title V or XIX swing-bed SNF inpatient routine costs (line 64 CAH (see instructions)  69.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 CAH (see instructions)  69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 64 CAH (see instructions)  69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 CAH (see instructions)  69.00 Total title V or XIX swing-bed NF inpatient	561 2, 953. 9	5 64	189, 053	43.00
45.00 BURN INTENSIVE CARE UNIT 47.00 OTHER SPECIAL CARE (SPECIFY)  Cost Center Description  48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, I and the cost of the cost	0 0.00		189, 033	44.00
47.00 OTHER SPECIAL CARE (SPECIFY) Cost Center Description  48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, I description  48.00 Total Program inpatient costs (sum of lines 41 through 48) (see PASS THROUGH COST ADJUSTMENTS  50.00 Pass through costs applicable to Program inpatient routine ser and IV)  51.00 Total Program excludable cost (sum of lines 50 and 51)  52.00 Total Program inpatient operating cost excluding capital relation medical education costs (line 49 minus line 52)  TARGET AMOUNT AND LIMIT COMPUTATION  54.00 Program discharges  55.00 Target amount per discharge  Target amount (line 54 x line 55)  57.00 Difference between adjusted inpatient operating cost and targe bonus payment (see instructions)  59.00 Lesser of lines 53/54 or 55 from the cost reporting period end which operating costs (line 53) are less than expected costs (amount (line 54 x line 55)  62.00 Target amount (line 54 x line 56)  63.00 Target amount (line 54 x line 56)  64.00 Lesser of lines 53/54 or 55 from prior year cost report, updated in the operating costs (line 53) are less than expected costs (amount (line 56), otherwise enter zero (see instructions)  64.00 Allowable Inpatient cost plus incentive payment (see instructions)  65.00 Allowable Inpatient cost plus incentive payment (see instructions) (title Fayment for the costs through December instructions) (title XVIII only)  66.00 Medicare swing-bed SNF inpatient routine costs through December instructions) (title XVIII only)  67.00 Total Medicare swing-bed SNF inpatient routine costs through December instructions) (title XVIII only)  68.00 Total title V or XIX swing-bed NF inpatient routine costs (line 64 CAH (see instructions)  69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 71 Total Program routine service cost (line 72 x line 20)  69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 72 x line 20)  69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 72 x line 20)  69.00 Total tropam general inpatien	0 0.00		Ö	45. 00
48.00 Program inpatient anciliary service cost (Wkst. D-3, col. 3, I Total Program inpatient costs (sum of lines 41 through 48) (see PASS THROUGH COST ADJUSTMENTS  50.00 Pass through costs applicable to Program inpatient routine ser III)  51.00 Pass through costs applicable to Program inpatient routine ser III)  51.00 Pass through costs applicable to Program inpatient ancillary s and IV)  52.00 Total Program excludable cost (sum of lines 50 and 51)  53.00 Total Program inpatient operating cost excluding capital relation medical education costs (line 49 minus line 52)  54.00 Program discharges  55.00 Target amount per discharge  55.00 Target amount per discharge  56.00 Target amount (line 54 x line 55)  51.00 Lesser of lines 53/54 or 55 from the cost reporting period encomarket basket  60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated because the cost of lines 53/54 or 55 from prior year cost report, updated lesser of lines 55/54 or 55 from prior year cost report, updated lesser of lines 53/54 or 55 from prior year cost report, updated lesser of lines 53/54 or 55 from prior year cost report, updated lesser of lines 53/54 or 55 from prior year cost report, updated lesser of lines 56/, otherwise enter zero (see instructions)  62.00 Relief payment (see instructions)  63.00 Allowable Inpatient cost plus incentive payment (see instructions)  64.00 Medicare swing-bed SNF inpatient routine costs through December instructions) (title XVIII only)  65.00 Medicare swing-bed SNF inpatient routine costs through December instructions) (title XVIII only)  66.00 Total Medicare swing-bed SNF inpatient routine costs after December instructions) (title XVIII only)  67.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 (see instructions))  68.00 Total Hedicare swing-bed SNF inpatient routine costs (line 64 (see instructions))  69.00 Total Hedicare swing-bed SNF inpatient routine costs (line 64 (see instructions))  69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 77)  69.00 Pog				46. 00
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, I Total Program inpatient costs (sum of lines 41 through 48) (see PASS THROUGH COST ADJUSTMENTS  50.00 Pass through costs applicable to Program inpatient routine ser III)  51.00 Pass through costs applicable to Program inpatient ancillary s and IV)  52.00 Total Program excludable cost (sum of lines 50 and 51)  53.00 Total Program inpatient operating cost excluding capital relate medical education costs (line 49 minus line 52)  54.00 Program discharges  55.00 Target amount per discharge  56.00 Target amount (line 54 x line 55)  57.00 Difference between adjusted inpatient operating cost and target 80.00 Program discharges  58.00 Beser of lines 53/54 or 55 from the cost reporting period encomarket basket  60.00 Lesser of lines 53/54 or 55 from the cost report, updated in 15 lines 53/54 is less than the lower of lines 55, 59 or 60 entower with the cost cost of the cost costs (line 53) are less than expected costs (amount (line 56), otherwise enter zero (see instructions)  62.00 Alonable inpatient cost plus incentive payment (see instructions)  63.00 Alonable inpatient cost plus incentive payment (see instructions)  64.00 Medicare swing-bed SNF inpatient routine costs through December instructions) (title XVIII only)  65.00 Title Vor XIX swing-bed NF inpatient routine costs through December instructions)  67.00 Title Vor XIX swing-bed NF inpatient routine costs (line 64 CAH (see instructions)  68.00 Title Vor XIX swing-bed NF inpatient routine costs (line 72.00 Title VIII or VIX swing-bed NF inpatient routine costs (line 73.00 Nedical program general inpatient cost (line 74.00 Title VIII or VIX swing-bed NF inpatient routine costs (line 77.00 Total title V or XIX swing-bed NF inpatient routine costs (line 77.00 Total regram general inpatient cost (line 75.00 Title VIII or VIX Swing-bed NF inpatient routine service cost (line 77.00 Aggregate charges to beneficiaries for excess costs (from program (patient routine service cost (line 74 minus line 77)				47. 00
Total Program inpatient costs (sum of lines 41 through 48) (see PASS THROUGH COST ADJUSTMENTS			1. 00	
PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inpatient routine ser IIII) Pass through costs applicable to Program inpatient ancillary s and IV) Pass through costs applicable to Program inpatient ancillary s and IV) Total Program excludable cost (sum of lines 50 and 51) Total Program inpatient operating cost excluding capital relat medical education costs (line 49 minus line 52) TARGET AMOUNT AND LIMIT COMPUTATION Program discharges Target amount (line 54 x line 55) Target amount per discharge Target amount (line 54 x line 55) Difference between adjusted inpatient operating cost and targe Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost reporting period end market basket Lesser of lines 53/54 or 55 from prior year cost report, updat line 55, 59 or 60 ent which operating costs (line 53) are less than expected costs (amount (line 56), otherwise enter zero (see instructions) Allowable Inpatient cost plus incentive payment (see instructions) Compared to the cost plus incentive payment (see instructions) Compared to the cost plus incentive payment (see instructions) Compared to the cost plus incentive payment (see instructions) Compared to the cost plus incentive payment (see instructions) Compared to the cost plus incentive payment (see instructions) Compared to the cost plus incentive payment (see instructions) Compared to the cost plus incentive payment (see instructions) Compared to the cost plus incentive payment (see instructions) Compared to the cost plus incentive payment (see instructions) Compared to the cost plus incentive payment (see instructions) Compared to the cost inpatient routine costs through December instructions) (title XVIII only) Compared to the cost plus incentive payment (see instructions) Compared to the cost plus incentive payment (see instr			434, 687	48. 0
Pass through costs applicable to Program inpatient routine ser III)  51.00 Pass through costs applicable to Program inpatient ancillary s and IV)  52.00 Total Program excludable cost (sum of lines 50 and 51)  Total Program excludable cost (sum of lines 50 and 51)  Total Program inpatient operating cost excluding capital relat medical education costs (line 49 minus line 52)  TARGET AMOUNT AND LIMIT COMPUTATION  Program discharges  55.00 Program discharges  56.00 Target amount per discharge  57.00 Difference between adjusted inpatient operating cost and targe Bonus payment (see instructions)  59.00 Lesser of lines 53/54 or 55 from the cost reporting period end market basket  60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated in 15 lines 53/54 is less than the lower of lines 55, 59 or 60 ent which operating costs (line 53) are less than expected costs (amount (line 56), otherwise enter zero (see instructions)  62.00 Relief payment (see instructions)  63.00 Relief payment (see instructions)  64.00 Medicare swing-bed SNF inpatient routine costs through December instructions) (title XVIII only)  65.00 Medicare swing-bed SNF inpatient routine costs after December instructions) (title XVIII only)  66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 (SAH (see instructions))  67.00 Title V or XIX swing-bed NF inpatient routine costs after December (line 12 x line 19)  68.00 Total Medicare swing-bed SNF inpatient routine costs after December instructions) (title XVIII only)  70.00 Total Medicare swing-bed SNF inpatient routine costs after December instructions) (title XVIII only)  67.00 Total Medicare swing-bed NF inpatient routine costs after December instructions)  68.00 Total Medicare swing-bed NF inpatient routine costs (line 64 CAH (see instructions)  69.00 Total Medicare swing-bed NF inpatient routine costs (line 64 CAH (see instructions))  70.00 Total Program general inpatient routine service cost per diem (line 72 CAM (see instructions))  70.01 Total Program general inpatient ro	e instructions)		972, 881	49.00
111)  Pass through costs applicable to Program inpatient ancillary sand IV)  132.00  Total Program excludable cost (sum of lines 50 and 51)  Total Program inpatient operating cost excluding capital relating medical education costs (line 49 minus line 52)  TARGET AMOUNT AND LIMIT COMPUTATION  Program discharges  Target amount per discharge  Target amount per discharge  Target amount (line 54 x line 55)  Difference between adjusted inpatient operating cost and target and see instructions)  Esser of lines 53/54 or 55 from the cost reporting period end market basket  Lesser of lines 53/54 or 55 from prior year cost report, updated in the lower of lines 55, 59 or 60 ent which operating costs (line 53) are less than expected costs (amount (line 56), otherwise enter zero (see instructions)  Eale payment (see instructions)  Allowable Inpatient cost plus incentive payment (see instructions)  Allowable Inpatient cost plus incentive payment (see instructions)  Medicare swing-bed SNF inpatient routine costs through December instructions) (title XVIII only)  Medicare swing-bed SNF inpatient routine costs through December instructions) (title XVIII only)  Total Medicare swing-bed SNF inpatient routine costs through December instructions) (title XVIII only)  Total Medicare swing-bed SNF inpatient routine costs through December instructions) (title XVIII only)  Total Medicare swing-bed SNF inpatient routine costs after December instructions)  Title V or XIX swing-bed NF inpatient routine costs after December instructions in title VIII only  Total Medicare swing-bed SNF inpatient routine costs (line 64 CAH (see instructions)  Total Title V or XIX swing-bed NF inpatient routine costs (line 64 CAH (see instructions)  Total Program general inpatient routine service cost per diem (line 12 x line 19)  Total Program general inpatient routine service cost (line 72 CAH (see instructions)  Total Program general inpatient routine service cost (line 74 Minus line 77)  Aggregate charges to beneficiaries for excess costs (from prov Approgra	rvices (from Wkst D sum	of Parts I and	0	50. 00
and IV) Total Program excludable cost (sum of lines 50 and 51) Total Program inpatient operating cost excluding capital relatemedical education costs (line 49 minus line 52)  TARGET AMOUNT AND LIMIT COMPUTATION  Program discharges Target amount per discharge Target amount per discharge Target amount (line 54 x line 55) Difference between adjusted inpatient operating cost and target sold border between adjusted inpatient operating cost and target amount per discharges Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost reporting period end market basket Lesser of lines 53/54 or 55 from prior year cost report, updat which operating costs (line 53) are less than expected costs (amount (line 56), otherwise enter zero (see instructions) Allowable Inpatient cost plus incentive payment (see instructions) Allowable Inpatient cost plus incentive payment (see instructions) Allowable Inpatient cost plus incentive payment (see instructions) Medicare swing-bed SNF inpatient routine costs through December instructions) (title XVIII only) Medicare swing-bed SNF inpatient routine costs (line 64 CAH (see instructions) Title V or XIX swing-bed NF inpatient routine costs through December instructions (title XVIII)  Medicare swing-bed SNF inpatient routine costs through December instructions) Title V or XIX swing-bed NF inpatient routine costs through December instructions (title XVIII)  Medicare swing-bed SNF inpatient routine costs through December instructions)  Medicare swing-bed SNF inpatient routine costs (line 64 CAH (see instructions)  Title V or XIX swing-bed NF inpatient routine costs through December instructions (title XVIII)  Medicare swing-bed NF inpatient routine costs (line 72 CAH (see instructions)  Medically necessary private room cost applicable to Program (line 12 x line 19)  Medicare swing-bed NF inpatient routine service cost (line 75 tine 2)  Porgram routine service cost (line 9 x line 76)  Medicarely SNF inpatient routine service costs (from provice costs)  Medically necessary private	TVICES (TIOIII WKSt. D, Suiii	or rarts r and	J	30.00
52.00 Total Program excludable cost (sum of lines 50 and 51) 53.00 Total Program inpatient operating cost excluding capital relation medical education costs (line 49 minus line 52)  TARGET AMOUNT AND LIMIT COMPUTATION  54.00 Program discharges 55.00 Target amount per discharge 55.00 Target amount (line 54 x line 55) 57.00 Difference between adjusted inpatient operating cost and targe 80 mous payment (see instructions) 58.00 Lesser of lines 53/54 or 55 from the cost reporting period end market basket 60.00 Lesser of lines 53/54 or 55 from prior year cost report, updat 61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 ent which operating costs (line 53) are less than expected costs (amount (line 56), otherwise enter zero (see instructions) 62.00 Relief payment (see instructions) 63.00 Allowable Inpatient cost plus incentive payment (see instructions) 64.00 Medicare swing-bed SNF inpatient routine costs through December instructions) (title XVIII only) 65.00 Medicare swing-bed SNF inpatient routine costs after December instructions) (title XVIII only) 66.00 Total Medicare swing-bed SNF inpatient routine costs through December instructions) (title XVIII only) 67.00 Title V or XIX swing-bed NF inpatient routine costs through December instructions) 68.00 Total title V or XIX swing-bed NF inpatient routine costs for December instructions 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 64 CAH (see instructions) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 64 CAH (see instructions) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 64 CAH (see instructions) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 64 CAH (see instructions) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 64 CAH (see instructions) 69.00 Total Program general inpatient routine service cost (line 75 ÷ line 2) 69.00 Total Program general inpatient routine service cost (line 77 title V or XIX swing-bed NF inpatient routine servic	services (from Wkst. D, su	um of Parts II	0	51.00
Total Program inpatient operating cost excluding capital relationedical education costs (line 49 minus line 52)  TARGET AMOUNT AND LIMIT COMPUTATION  Program discharges  55.00  Frogram discharges  Target amount per discharge  Target amount (line 54 x line 55)  Difference between adjusted inpatient operating cost and target amount (line 54 x line 55)  Difference between adjusted inpatient operating cost and target amount (line 54 x line 55)  Doublesser of lines 53/54 or 55 from the cost reporting period end market basket  Lesser of lines 53/54 or 55 from prior year cost report, updat (line 56), otherwise enter zero (see instructions)  Relief payment (see instructions)  Allowable Inpatient cost plus incentive payment (see instructions)  Relief payment (see instructions)  Allowable Inpatient cost plus incentive payment (see instructions)  Redicare swing-bed SNF inpatient routine costs through December instructions) (title XVIII only)  65.00  Medicare swing-bed SNF inpatient routine costs after December instructions) (title XVIII only)  Total Medicare swing-bed SNF inpatient routine costs through December instructions)  Title V or XIX swing-bed NF inpatient routine costs through December instructions  Title V or XIX swing-bed NF inpatient routine costs through December instructions  Title V or XIX swing-bed NF inpatient routine costs through December instructions  Title V or XIX swing-bed NF inpatient routine costs after December instructions  Title V or XIX swing-bed NF inpatient routine costs after December instructions  Title V or XIX swing-bed NF inpatient routine costs after December instructions  Total Program facility/other nursing facility/ICF/IID routine PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, A  Adjusted general inpatient routine service cost per diem (line Program (line 45)  Total Program general inpatient routine service costs (from prov. Operam capital-related costs (line 75 + line 2)  Program routine service cost (line 75 + line 2)  Program capital-related costs (line 75 + line 2)			0	52.00
medical education costs (line 49 minus line 52)  TARGET AMOUNT AND LIMIT COMPUTATION  54.00 Program discharges  55.00 Target amount per discharge  55.00 Target amount per discharge  56.00 Target amount per discharge  57.00 Difference between adjusted inpatient operating cost and targe  58.00 Bonus payment (see instructions)  59.00 Lesser of lines 53/54 or 55 from the cost reporting period end market basket  60.00 Lesser of lines 53/54 or 55 from prior year cost report, updat  61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 end which operating costs (line 53) are less than expected costs ( amount (line 56), otherwise enter zero (see instructions)  62.00 Relief payment (see instructions)  63.00 Allowable Inpatient cost plus incentive payment (see instructions)  64.00 Medicare swing-bed SNF inpatient routine costs through December instructions) (title XVIII only)  65.00 Medicare swing-bed SNF inpatient routine costs after December instructions) (title XVIII only)  66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64  CAH (see instructions)  67.00 Title V or XIX swing-bed NF inpatient routine costs through December instructions) (title XVIII only)  68.00 Title V or XIX swing-bed NF inpatient routine costs (line 64  CAH (see instructions)  69.00 Total Hedicare swing-bed NF inpatient routine costs (line 64  CAH (see instructions)  69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 64  CART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, A  70.00 Skilled nursing facility/other nursing facility/ICF/IID routin  71.00 Adjusted general inpatient routine service cost per diem (line PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, A  70.00 Total reparament of the facility of the partient routine service cost  60.01 Total Program general inpatient routine service costs (line 77)  71.00 Program capital -related costs (line 9 x line 71)  72.01 Dipatient routine service cost (line 9 x line 72)  73.02 Program capital -related costs (line 9 x line 73)  74.05 C	ted non-physician anesthe	etist and	0	ı
54.00 Program discharges 55.00 Target amount per discharge 56.00 Target amount per discharge 57.00 Difference between adjusted inpatient operating cost and target amount per discharge 58.00 Bonus payment (see instructions) 59.00 Lesser of lines 53/54 or 55 from the cost reporting period end market basket 60.00 Lesser of lines 53/54 or 55 from prior year cost report, updat 61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 ent which operating costs (line 53) are less than expected costs (amount (line 56), otherwise enter zero (see instructions) 62.00 Relief payment (see instructions) 63.00 Allowable Inpatient cost plus incentive payment (see instructions) 64.00 Medicare swing-bed SNF inpatient routine costs through December instructions) (title XVIII only) 65.00 Medicare swing-bed SNF inpatient routine costs after December instructions) (title XVIII only) 66.00 Total Medicare swing-bed SNF inpatient routine costs through December instructions) (title XVIII only) 67.00 Title V or XIX swing-bed NF inpatient routine costs through December instructions) 68.00 Title V or XIX swing-bed NF inpatient routine costs (line 64 CAH (see instructions) 69.00 Title V or XIX swing-bed NF inpatient routine costs through December instructions (line 12 x line 19) 69.00 Title V or XIX swing-bed NF inpatient routine costs (line 64 CAH (see instructions) 69.00 Title V or XIX swing-bed NF inpatient routine costs (line 64 CAH (see instructions)) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 64 CAH (see instructions)) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 64 CAH (see instructions)) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 75 capital related costs (line 75 capital tyl/CF/IID routine 75 capital related cost allocated to inpatient routine service cost (line 75 capital related cost allocated to inpatient routine service cost (line 77 capital related cost (line 75 capital related cost allocated to inpatient routine service cost (line 77 minus li	ted, non physician anestin	oti oti, una	J	00.0
<ul> <li>Target amount per discharge</li> <li>56.00 Target amount (line 54 x line 55)</li> <li>57.00 Difference between adjusted inpatient operating cost and targe</li> <li>88.00 Bonus payment (see instructions)</li> <li>59.00 Lesser of lines 53/54 or 55 from the cost reporting period end market basket</li> <li>60.00 Lesser of lines 53/54 or 55 from prior year cost report, updat</li> <li>61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 ent which operating costs (line 53) are less than expected costs (amount (line 56), otherwise enter zero (see instructions)</li> <li>62.00 Relief payment (see instructions)</li> <li>63.00 Allowable Inpatient cost plus incentive payment (see instructions)</li> <li>64.00 Medicare swing-bed SNF inpatient routine costs through December instructions) (title XVIII only)</li> <li>65.00 Medicare swing-bed SNF inpatient routine costs after December instructions) (title XVIII only)</li> <li>66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 CAH (see instructions)</li> <li>67.00 Title V or XIX swing-bed NF inpatient routine costs through December instructions (line 12 x line 19)</li> <li>68.00 Title V or XIX swing-bed NF inpatient routine costs after December instructions (line 19 x line 20)</li> <li>69.00 Total title V or XIX swing-bed NF inpatient routine costs (line PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, OTHER NURSING FACILITY, A cost program routine service cost (line 9 x line 71)</li> <li>70.00 Skilled nursing facility/other nursing facility/ICF/IID routing Adjusted general inpatient routine service cost per diem (line 75 total Program general inpatient routine service cost (line 75 total Program general inpatient routine service cost (line 75 total Program capital-related costs (line 9 x line 76)</li> <li>71.00 Program capital-related costs (line 9 x line 76)</li> <li>72.00 Program capital-related costs (line 75 total Program routine service cost for comparison to the cost (line) routine routine service cost (from provice) routine</li></ul>				
56.00 Target amount (line 54 x line 55) 57.00 Difference between adjusted inpatient operating cost and targe 88.00 Bonus payment (see instructions) 59.00 Lesser of lines 53/54 or 55 from the cost reporting period end market basket 60.00 Lesser of lines 53/54 or 55 from prior year cost report, updat 1f line 53/54 is less than the lower of lines 55, 59 or 60 ent which operating costs (line 53) are less than expected costs (amount (line 56), otherwise enter zero (see instructions) 62.00 Relief payment (see instructions) 63.00 Allowable Inpatient cost plus incentive payment (see instructi PROGRAM INPATIENT ROUTINE SWING BED COST 64.00 Medicare swing-bed SNF inpatient routine costs through December instructions) (title XVIII only) 65.00 Medicare swing-bed SNF inpatient routine costs after December instructions) (title XVIII only) 66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 CAH (see instructions)) 67.00 Title V or XIX swing-bed NF inpatient routine costs through December instructions) 67.00 Title V or XIX swing-bed NF inpatient routine costs (line 64 CAH (see instructions)) 68.00 Total title V or XIX swing-bed NF inpatient routine costs after December instructions (line 12 x line 19) 70.00 Total title V or XIX swing-bed NF inpatient routine costs (line 11 in 2 x line 20) 71.00 Total title V or XIX swing-bed NF inpatient routine costs (line 9 x line 70) 72.00 Program routine service cost (line 9 x line 71) 73.00 Medically necessary private room cost applicable to Program (lotal Program general inpatient routine service cost per diem (line 72 capital-related cost allocated to inpatient routine service cost (line 74 minus line 77) 73.00 Program capital-related costs (line 75 + line 2) 74.00 Program capital-related costs (line 74 minus line 77) 75.00 Capital-related cost (line 75 + line 2) 76.00 Program capital-related costs (line 74 minus line 77) 77.00 Ragregate charges to beneficiaries for excess costs (from prov 77) 78.00 Inpatient routine service cost per diem limitation (line) inpatient rout			0	1
57. 00  Difference between adjusted inpatient operating cost and target Bonus payment (see instructions)  59. 00  Lesser of lines 53/54 or 55 from the cost reporting period end market basket  60. 00  Lesser of lines 53/54 or 55 from prior year cost report, update the lost of lines 53/54 is less than the lower of lines 55, 59 or 60 ent which operating costs (line 53) are less than expected costs (amount (line 56), otherwise enter zero (see instructions)  62. 00  Relief payment (see instructions)  63. 00  Allowable Inpatient cost plus incentive payment (see instructions)  64. 00  Medicare swing-bed SNF inpatient routine costs through December instructions) (title XVIII only)  65. 00  Medicare swing-bed SNF inpatient routine costs after December instructions) (title XVIII only)  66. 00  Total Medicare swing-bed SNF inpatient routine costs (line 64 CAH (see instructions))  67. 00  Title V or XIX swing-bed NF inpatient routine costs through December instructions (line 12 x line 19)  68. 00  Title V or XIX swing-bed NF inpatient routine costs after December (line 13 x line 20)  Total title V or XIX swing-bed NF inpatient routine costs (line PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, Adjusted general inpatient routine service cost per diem (line Program routine service cost (line 9 x line 71)  70. 00  71. 00  Medically necessary private room cost applicable to Program (lotal related costs (line 9 x line 71)  72. 00  Medically necessary private room cost applicable to Program (lotal related costs (line 9 x line 71)  73. 00  Medically necessary private room cost applicable to Program (lotal related costs (line 9 x line 76)  74. 00  Total Program general inpatient routine service costs (line 77)  75. 00  Aggregate charges to beneficiaries for excess costs (from prov 10 program routine service cost (line 74 minus line 77)  76. 00  77. 00  78. 00  79. 00			0.00	55. 0 56. 0
Lesser of lines 53/54 or 55 from the cost reporting period end market basket  60.00 Lesser of lines 53/54 or 55 from prior year cost report, updat lesser of lines 53/54 is less than the lower of lines 55, 59 or 60 ent which operating costs (line 53) are less than expected costs (amount (line 56), otherwise enter zero (see instructions)  62.00 Relief payment (see instructions)  63.00 Allowable Inpatient cost plus incentive payment (see instructions)  64.00 Medicare swing-bed SNF inpatient routine costs through December instructions) (title XVIII only)  65.00 Medicare swing-bed SNF inpatient routine costs after December instructions) (title XVIII only)  66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 CAH (see instructions))  77.00 Title V or XIX swing-bed NF inpatient routine costs through December (line 12 x line 19)  78.00 Title V or XIX swing-bed NF inpatient routine costs after December (line 13 x line 20)  79.00 Skilled nursing facility/other nursing facility/ICF/IID routine Adjusted general inpatient routine service cost (line 72 Capital-related cost allocated to inpatient routine service cost (line 73 capital-related cost allocated to inpatient routine service cost (line 74 minus line 45)  79.00 Per diem capital-related costs (line 75 + line 2)  Program routine service cost (line 75 + line 2)  Program routine service cost (line 75 + line 2)  Program routine service cost (line 75 + line 2)  Program routine service cost (line 75 + line 2)  Program routine service cost (line 75 + line 2)  Program routine service cost (line 75 + line 2)  Program routine service cost (line 75 + line 2)  Program routine service cost (line 9 x line 76)  Inpatient routine service cost (line 10 minus line 10 minus lin	et amount (line 56 minus l	ine 53)	Ö	57.00
market basket  60.00 Lesser of lines 53/54 or 55 from prior year cost report, updat 61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 ent which operating costs (line 53) are less than expected costs ( amount (line 56), otherwise enter zero (see instructions)  Relief payment (see instructions)  Allowable Inpatient cost plus incentive payment (see instructi PROGRAM INPATIENT ROUTINE SWING BED COST  64.00 Medicare swing-bed SNF inpatient routine costs through December instructions) (title XVIII only)  65.00 Medicare swing-bed SNF inpatient routine costs after December instructions) (title XVIII only)  66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 CAH (see instructions)  71 Title V or XIX swing-bed NF inpatient routine costs through December (line 12 x line 19)  72 Total title V or XIX swing-bed NF inpatient routine costs after December (line 13 x line 20)  73 Total title V or XIX swing-bed NF inpatient routine costs (line 13 x line 20)  74 Total title V or XIX swing-bed NF inpatient routine costs (line 14 x line 15)  75 Skilled nursing facility/other nursing facility/ICF/IID routine 22  76 Adjusted general inpatient routine service cost per diem (line 17 routine service cost (line 9 x line 71)  77 Total Program general inpatient routine service costs (line 72  78 Total Program general inpatient routine service costs (line 73  79 Per diem capital-related costs (line 75 ± line 2)  79 Program capital-related costs (line 74 minus line 77)  79 Aggregate charges to beneficiaries for excess costs (from prov 10 patient routine service cost (line 9 x line 76)  80 Inpatient routine service cost limitation (line 9 x line 81)  81 Reasonable inpatient routine service (see instructions)  82 Program inpatient arcillary services (see instructions)  83 Program inpatient arcillary service (see instructions)  84 Ou Total Program inpatient routine service cost (see instructions)			0	58. 0
<ul> <li>60.00 Lesser of lines 53/54 or 55 from prior year cost report, updat 1f line 53/54 is less than the lower of lines 55, 59 or 60 ent which operating costs (line 53) are less than expected costs (amount (line 56), otherwise enter zero (see instructions)</li> <li>62.00 Relief payment (see instructions)</li> <li>63.00 Allowable Inpatient cost plus incentive payment (see instructi PROGRAM INPATIENT ROUTINE SWING BED COST</li> <li>64.00 Medicare swing-bed SNF inpatient routine costs through December instructions) (title XVIII only)</li> <li>65.00 Medicare swing-bed SNF inpatient routine costs after December instructions) (title XVIII only)</li> <li>66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 CAH (see instructions)</li> <li>67.00 Title V or XIX swing-bed NF inpatient routine costs through December instructions)</li> <li>68.00 Title V or XIX swing-bed NF inpatient routine costs through December instructions</li> <li>69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 13 x line 20)</li> <li>69.00 Total title V or XIX swing-bed NF inpatient routine costs (line PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, Adjusted general inpatient routine service cost per diem (line Program routine service cost (line 9 x line 71)</li> <li>Medically necessary private room cost applicable to Program (I Total Program general inpatient routine service costs (line 75 capital-related costs allocated to inpatient routine service costs (line 75 capital-related costs (line 75 capital-related costs (line 75 capital-related costs (line 76)</li> <li>70.00 Program capital-related costs (line 74 minus line 77)</li> <li>70.00 Aggregate charges to beneficiaries for excess costs (from prov Total Program routine service cost (line 74 minus line 77)</li> <li>70.00 Aggregate charges to beneficiaries for excess costs (from prov Total Program routine service cost limitation (line 9 x line 81)</li> <li>83.00 Reasonable inpatient routine services (see instructions)</li> <li>Program inpatient rou</li></ul>	ding 1996, updated and cor	mpounded by the	0. 00	59. 0
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 ent which operating costs (line 53) are less than expected costs (amount (line 56), otherwise enter zero (see instructions) 62.00 Relief payment (see instructions) 63.00 Allowable Inpatient cost plus incentive payment (see instructions) 64.00 Medicare swing-bed SNF inpatient routine costs through December instructions) (title XVIII only) 65.00 Medicare swing-bed SNF inpatient routine costs after December instructions) (title XVIII only) 66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 CAH (see instructions) 67.00 Title V or XIX swing-bed NF inpatient routine costs through December (line 12 x line 19) 68.00 Title V or XIX swing-bed NF inpatient routine costs after December (line 13 x line 20) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 13 x line 20) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 13 x line 20) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 13 x line 20) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 13 x line 20) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 72 costs) (line 13 x line 20) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 72 costs) (line 9 x line 71) 60 Medically necessary private room cost applicable to Program (line 72 costs) (line 9 x line 74) 61 Medically necessary private room cost applicable to Program (line 74 costs) (line 74 minus line 77) 62 Capital-related cost allocated to inpatient routine service cost (line 74 minus line 77) 63 Medically necessary private room cost applicable to Program cost applicable to	ted by the market basket		0. 00	60.0
amount (line 56), otherwise enter zero (see instructions)  Relief payment (see instructions)  Allowable Inpatient cost plus incentive payment (see instructions)  Allowable Inpatient cost plus incentive payment (see instructions)  Regram INPATIENT ROUTINE SWING BED COST  Medicare swing-bed SNF inpatient routine costs through December instructions) (title XVIII only)  Medicare swing-bed SNF inpatient routine costs after December instructions) (title XVIII only)  Total Medicare swing-bed SNF inpatient routine costs (line 64 CAH (see instructions)  Title V or XIX swing-bed NF inpatient routine costs through December (line 12 x line 19)  Medicare swing-bed NF inpatient routine costs after December instructions)  Title V or XIX swing-bed NF inpatient routine costs (line 12 x line 19)  Skilled vor XIX swing-bed NF inpatient routine costs (line PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, Adjusted general inpatient routine service cost per diem (line Program routine service cost (line 9 x line 71)  Medically necessary private room cost applicable to Program (lout Program general inpatient routine service costs (line 72 Capital-related cost allocated to inpatient routine service cost (line 74 minus line 77)  Medically necessary private room cost applicable to Program (lout Program capital-related costs (line 9 x line 76)  Program capital-related costs (line 9 x line 76)  Inpatient routine service cost (line 74 minus line 77)  Aggregate charges to beneficiaries for excess costs (from prov Total Program routine service cost for comparison to the cost Inpatient routine service cost (see instructions)  Program inpatient routine service cost (see instructions)  Program inpatient routine service (see instructions)  Program inpatient operating costs (sum of lines 83 throught)  Total Program inpatient operating costs (sum of lines 83 throught)	ter the lesser of 50% of		0	61.0
62.00 Relief payment (see instructions) 63.00 Allowable Inpatient cost plus incentive payment (see instructions) 64.00 Medicare swing-bed SNF inpatient routine costs through December instructions) (title XVIII only) 65.00 Medicare swing-bed SNF inpatient routine costs after December instructions) (title XVIII only) 66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 CAH (see instructions) 67.00 Title V or XIX swing-bed NF inpatient routine costs through December (line 12 x line 19) 68.00 Title V or XIX swing-bed NF inpatient routine costs after December (line 13 x line 20) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 13 x line 20) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, A Skilled nursing facility/other nursing facility/ICF/IID routine 200 Adjusted general inpatient routine service cost per diem (line Program routine service cost (line 9 x line 71) 60.00 Medically necessary private room cost applicable to Program (land Program general inpatient routine service costs (line 72 Capital-related cost allocated to inpatient routine service cost (line 45) 60.00 Program capital-related costs (line 75 ± line 2) 61.00 Aggregate charges to beneficiaries for excess costs (from provation to the cost inpatient routine service cost limitation (line 9 x line 81) 61.00 Inpatient routine service cost per diem limitation (line 9 x line 81) 62.00 Inpatient routine service cost per diem limitation (line 9 x line 81) 63.00 Reasonable inpatient routine services (see instructions) 64.00 Program inpatient ancillary services (see instructions) 65.00 Total Program inpatient outine service (see instructions) 66.00 Total Program inpatient operating costs (sum of lines 83 throutions) 67.00 Total Program inpatient operating costs (sum of lines 83 throutions)	(lines 54 x 60), or 1% of	the target		
Allowable Inpatient cost plus incentive payment (see instruction PROGRAM INPATIENT ROUTINE SWING BED COST  64.00 Medicare swing-bed SNF inpatient routine costs through December instructions) (title XVIII only)  65.00 Medicare swing-bed SNF inpatient routine costs after December instructions) (title XVIII only)  66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 CAH (see instructions)  67.00 Title V or XIX swing-bed NF inpatient routine costs through December (line 12 x line 19)  68.00 Title V or XIX swing-bed NF inpatient routine costs after December (line 13 x line 20)  69.00 Total title V or XIX swing-bed NF inpatient routine costs (line PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, A Skilled nursing facility/other nursing facility/ICF/IID routine Adjusted general inpatient routine service cost per diem (line Program routine service cost (line 9 x line 71)  70.00 Medically necessary private room cost applicable to Program (land) Program general inpatient routine service costs (line 72 capital-related cost allocated to inpatient routine service cost (line 73 tine 20)  76.00 Per diem capital-related costs (line 75 tine 2)  77.00 Program capital-related costs (line 75 tine 2)  78.00 Inpatient routine service cost (line 74 minus line 77)  Aggregate charges to beneficiaries for excess costs (from proval) Aggregate charges to beneficiaries for excess costs (from proval) Total Program routine service cost per diem limitation linpatient routine service cost per diem limitation linpatient routine service cost per diem limitation linpatient routine service cost see instructions)  80.00 Program inpatient ancillary services (see instructions)  81.00 Program inpatient ancillary services (see instructions)  82.00 Total Program inpatient operating costs (sum of lines 83 throutines)			o	62.00
64.00 Medicare swing-bed SNF inpatient routine costs through December instructions) (title XVIII only) 65.00 Medicare swing-bed SNF inpatient routine costs after December instructions) (title XVIII only) 66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 CAH (see instructions) 67.00 Title V or XIX swing-bed NF inpatient routine costs through December (line 12 x line 19) 68.00 Title V or XIX swing-bed NF inpatient routine costs after December (line 12 x line 20) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, A Adjusted general inpatient routine service cost per diem (line Program routine service cost (line 9 x line 71) 73.00 Medically necessary private room cost applicable to Program (land) Total Program general inpatient routine service costs (line 72 Capital-related cost allocated to inpatient routine service costs (line 73 Capital-related cost allocated to inpatient routine service costs (line 74 minus line 77) 75.00 Program capital-related costs (line 75 ± line 2) 77.00 Program capital-related costs (line 74 minus line 77) 78.00 Aggregate charges to beneficiaries for excess costs (from provated program routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provated program routine service cost (line 74 minus line 77) 79.00 Reasonable inpatient routine service cost (see instructions) 70 Reasonable inpatient routine service cost (see instructions) 71 Program inpatient ancillary services (see instructions) 72 Drogram inpatient ancillary services (see instructions) 73 Drogram inpatient operating costs (sum of lines 83 throughter toutine program inpatient operating costs (sum of lines 83 throughter toutine program inpatient operating costs (sum of lines 83 throughter toutine program inpatient operating costs (sum of lines 83 throughter toutine program inpatient operating costs (sum of lines 83 throughter program in patient operating costs (sum of lines 83 throu	i ons)		0	63.00
instructions) (title XVIII only)  Medicare swing-bed SNF inpatient routine costs after December instructions) (title XVIII only)  Total Medicare swing-bed SNF inpatient routine costs (line 64 CAH (see instructions)  Title V or XIX swing-bed NF inpatient routine costs through December (line 12 x line 19)  68.00 Title V or XIX swing-bed NF inpatient routine costs after December (line 13 x line 20)  Total title V or XIX swing-bed NF inpatient routine costs (line 13 x line 20)  Total title V or XIX swing-bed NF inpatient routine costs (line PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, A Adjusted general inpatient routine service cost per diem (line Program routine service cost (line 9 x line 71)  Medically necessary private room cost applicable to Program (land) (line 45)  Total Program general inpatient routine service costs (line 75 capital-related cost allocated to inpatient routine service cost (line 75)  Aggregate charges to beneficiaries for excess costs (from provated Program routine service cost (line 74 minus line 77)  Aggregate charges to beneficiaries for excess costs (from provated Program routine service cost (line 74 minus line 77)  Aggregate charges to beneficiaries for excess costs (from provated Program routine service cost (line 74 minus line 77)  Aggregate charges to beneficiaries for excess costs (from provated Program routine service cost (line 74 minus line 77)  Aggregate charges to beneficiaries for excess costs (from provated Program routine service cost (line 74 minus line 77)  Reasonable inpatient routine service cost (line 74 minus line 77)  Reasonable inpatient routine service cost (line 74 minus line 77)  Program inpatient routine service cost (line 74 minus line 77)  Reasonable inpatient routine service cost (line 74 minus line 77)  Reasonable inpatient routine service cost (line 74 minus line 77)  Reasonable inpatient routine service cost (line 75 minus line 77)  Reasonable inpatient routine service (see instructions)  Program inpatient ancillary services (see instruct	24 6 11		0	
65.00 Medicare swing-bed SNF inpatient routine costs after December instructions) (title XVIII only) 66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 CAH (see instructions) 67.00 Title V or XIX swing-bed NF inpatient routine costs through De (line 12 x line 19) 68.00 Title V or XIX swing-bed NF inpatient routine costs after Dece (line 13 x line 20) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, A Skilled nursing facility/other nursing facility/ICF/IID routine Adjusted general inpatient routine service cost per diem (line Program routine service cost (line 9 x line 71) 60 Medically necessary private room cost applicable to Program (land Total Program general inpatient routine service costs (line 75 tine 2) 60 Capital-related cost allocated to inpatient routine service cost (line 74 minus line 77) 61 Aggregate charges to beneficiaries for excess costs (from program capital routine service cost (line 74 minus line 77) 62 Aggregate charges to beneficiaries for excess costs (from program capital routine service cost per diem limitation linpatient routine service cost per diem limitation linpatient routine service cost (line 9 x line 81) 63 No Reasonable inpatient routine service (see instructions) 64 On Total Program inpatient ancillary services (see instructions) 65 Utilization review - physician compensation (see instructions) 66 Total Program inpatient operating costs (sum of lines 83 throughter total program inpatient operating costs (sum of lines 83 throughter)	er 31 of the cost reportin	ng perioa (See	0	64.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 CAH (see instructions)  67.00 Title V or XIX swing-bed NF inpatient routine costs through De (line 12 x line 19)  68.00 Title V or XIX swing-bed NF inpatient routine costs after Dece (line 13 x line 20)  69.00 Total title V or XIX swing-bed NF inpatient routine costs (line PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, A Skilled nursing facility/other nursing facility/ICF/IID routine Adjusted general inpatient routine service cost per diem (line Program routine service cost (line 9 x line 71)  73.00 Medically necessary private room cost applicable to Program (I Total Program general inpatient routine service costs (line 72 Capital-related cost allocated to inpatient routine service cost (line 45)  76.00 Per diem capital-related costs (line 9 x line 76)  1 Inpatient routine service cost (line 74 minus line 77)  Aggregate charges to beneficiaries for excess costs (from proving 10 program routine service cost per diem limitation (line 10 program routine service cost limitation (line 11 program inpatient routine service (see instructions)  80.00 Program inpatient ancillary services (see instructions)  10 Utilization review - physician compensation (see instructions)  10 Total Program inpatient operating costs (sum of lines 83 throughter)	31 of the cost reporting	period (See	0	65.00
CAH (see instructions)  67.00 Title V or XIX swing-bed NF inpatient routine costs through De (line 12 x line 19)  68.00 Title V or XIX swing-bed NF inpatient routine costs after Dece (line 13 x line 20)  69.00 Total title V or XIX swing-bed NF inpatient routine costs (line PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, A Adjusted general inpatient routine service cost per diem (line Program routine service cost (line 9 x line 71)  73.00 Medically necessary private room cost applicable to Program (later to program capital related costs (line 75 ± line 2)  75.00 Capital -related costs (line 75 ± line 2)  76.00 Per diem capital -related costs (line 74 minus line 77)  79.00 Aggregate charges to beneficiaries for excess costs (from provator)  79.00 Total Program routine service cost (line 74 minus line 77)  79.00 Aggregate charges to beneficiaries for excess costs (from provator)  80.00 Total Program routine service cost per diem limitation  81.00 Inpatient routine service cost per diem limitation  82.00 Reasonable inpatient routine service (see instructions)  83.00 Program inpatient ancillary services (see instructions)  84.00 Utilization review - physician compensation (see instructions)  85.00 Total Program inpatient operating costs (sum of lines 83 through the program inpatient operating costs (sum of lines 83 through the program inpatient operating costs (sum of lines 83 through the program inpatient operating costs (sum of lines 83 through the program inpatient operating costs (sum of lines 83 through the program inpatient operating costs (sum of lines 83 through the program inpatient operating costs (sum of lines 83 through the program inpatient operating costs (sum of lines 83 through the program inpatient operating costs (sum of lines 83 through the program inpatient operating costs (sum of lines 83 through the program inpatient operating costs (sum of lines 83 through the program inpatient operating costs (sum of lines 83 through the program inpatient operating costs (sum of lines 83 through			_	
67.00 Title V or XIX swing-bed NF inpatient routine costs through Dec (line 12 x line 19) 68.00 Title V or XIX swing-bed NF inpatient routine costs after Dece (line 13 x line 20) 70.00 Total title V or XIX swing-bed NF inpatient routine costs (line PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, A Adjusted general inpatient routine service cost per diem (line 72.00 Program routine service cost (line 9 x line 71) 73.00 Medically necessary private room cost applicable to Program (later of 14.00 Total Program general inpatient routine service costs (line 75.00 Capital-related cost allocated to inpatient routine service cost (line 45) 76.00 Per diem capital-related costs (line 75 ÷ line 2) 77.00 Program capital-related costs (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provated program routine service cost (line 74 minus line 77) 79.00 Total Program routine service cost for comparison to the cost line 1 patient routine service cost per diem limitation line 1 program routine service cost per diem limitation line 1 program inpatient routine service (see instructions) 80.00 Program inpatient ancillary services (see instructions) 81.00 Utilization review - physician compensation (see instructions) 82.00 Total Program inpatient operating costs (sum of lines 83 throughters)	plus line 65)(title XVIII	only). For	0	66. 00
(line 12 x line 19)  68.00 Title V or XIX swing-bed NF inpatient routine costs after Dece (line 13 x line 20)  69.00 Total title V or XIX swing-bed NF inpatient routine costs (line PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, A Skilled nursing facility/other nursing facility/ICF/IID routine Adjusted general inpatient routine service cost per diem (line Program routine service cost (line 9 x line 71)  70.00 Medically necessary private room cost applicable to Program (lateral Program general inpatient routine service costs (line 72 capital -related cost allocated to inpatient routine service cost (line 45)  76.00 Per diem capital -related costs (line 75 ÷ line 2)  77.00 Inpatient routine service cost (line 9 x line 76)  18.00 Inpatient routine service cost (line 74 minus line 77)  79.00 Aggregate charges to beneficiaries for excess costs (from provated provat	ecember 31 of the cost rep	porting period	o	67.00
(line 13 x line 20) Total title V or XIX swing-bed NF inpatient routine costs (line PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, A Skilled nursing facility/other nursing facility/ICF/IID routine Adjusted general inpatient routine service cost per diem (line Program routine service cost (line 9 x line 71)  Medically necessary private room cost applicable to Program (land Program general inpatient routine service costs (line 72 Capital -related cost allocated to inpatient routine service costs (line 73 Capital -related costs (line 75 + line 2)  Program capital -related costs (line 75 + line 2)  Program capital -related costs (line 74 minus line 77)  Aggregate charges to beneficiaries for excess costs (from proval Program routine service cost for comparison to the cost (line 10 patient routine service cost per diem limitation line 11 patient routine service cost limitation (line 9 x line 81)  Reasonable inpatient routine service costs (see instructions)  Program inpatient ancillary services (see instructions)  Utilization review - physician compensation (see instructions)  Total Program inpatient operating costs (sum of lines 83 throughter)	·	0 .		
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, A Skilled nursing facility/other nursing facility/ICF/IID routine Adjusted general inpatient routine service cost per diem (line Program routine service cost (line 9 x line 71)  Medically necessary private room cost applicable to Program (land Program general inpatient routine service costs (line 72 Capital -related cost allocated to inpatient routine service costs (line 73 Capital -related costs (line 75 ± line 2)  Program capital -related costs (line 75 ± line 2)  Program capital -related costs (line 74 minus line 77)  Aggregate charges to beneficiaries for excess costs (from proval Program routine service cost for comparison to the cost line 10 line 11 must routine service cost per diem limitation line 12 matient routine service cost limitation (line 9 x line 81)  Reasonable inpatient routine service (see instructions)  Program inpatient ancillary services (see instructions)  Utilization review - physician compensation (see instructions)  Total Program inpatient operating costs (sum of lines 83 throuteness)	ember 31 of the cost repo	rting period	0	68.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, A 70.00 Skilled nursing facility/other nursing facility/ICF/IID routin 71.00 Adjusted general inpatient routine service cost per diem (line 72.00 Program routine service cost (line 9 x line 71) 3.00 Medically necessary private room cost applicable to Program (l 74.00 Total Program general inpatient routine service costs (line 72 75.00 Capital-related cost allocated to inpatient routine service co 26, line 45) 76.00 Per diem capital-related costs (line 75 ÷ line 2) 77.00 Program capital-related costs (line 7 x line 76) 8.00 Inpatient routine service cost (line 74 minus line 77) 8.00 Aggregate charges to beneficiaries for excess costs (from prov 80.00 Total Program routine service cost for comparison to the cost 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine services (see instructions) 84.00 Utilization review - physician compensation (see instructions) 85.00 Utilization review - physician compensation (see instructions) Total Program inpatient operating costs (sum of lines 83 throu	ne 67 + line 68)		o	69.00
71.00 Adjusted general inpatient routine service cost per diem (line 72.00 Program routine service cost (line 9 x line 71)  73.00 Medically necessary private room cost applicable to Program (l 74.00 Total Program general inpatient routine service costs (line 72.00 Capital-related cost allocated to inpatient routine service costs (line 75.00 Per diem capital-related costs (line 75.00 Program capital-related costs (line 75.00 Program capital-related costs (line 75.00 Program capital-related costs (line 74.00 Program capital-related costs (line 74.00 Program capital-related costs (line 75.00 Program routine service cost (line 75.00 Program routine service costs for comparison to the cost line 10.00 Program routine service cost per diem limitation (line 9 x line 81) Reasonable inpatient routine service costs (see instructions) Program inpatient ancillary services (see instructions) Utilization review - physician compensation (see instructions) Total Program inpatient operating costs (sum of lines 83 throughted the program inpatient operating costs (sum of lines 83 throughted the program inpatient operating costs (sum of lines 83 throughted the program inpatient operating costs (sum of lines 83 throughted the program inpatient operating costs (sum of lines 83 throughted the program inpatient operating costs (sum of lines 83 throughted the program inpatient operating costs (sum of lines 83 throughted the program inpatient progra	,			
72.00 Program routine service cost (line 9 x line 71) 73.00 Medically necessary private room cost applicable to Program (l 74.00 Total Program general inpatient routine service costs (line 72.00 Capital-related cost allocated to inpatient routine service costs (line 75.00 Per diem capital-related costs (line 75.00 Program capital-related costs (line 75.00 Program capital-related costs (line 75.00 Program capital-related costs (line 75.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provable 10 Program routine service costs for comparison to the cost 10 Inpatient routine service cost per diem limitation 10 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 97.00 Program inpatient ancillary services (see instructions) 98.00 Utilization review - physician compensation (see instructions) 98.00 Total Program inpatient operating costs (sum of lines 83 throughten the program inpatient operating costs (sum of lines 83 throughten the program inpatient operating costs (sum of lines 83 throughten the program inpatient operating costs (sum of lines 83 throughten the program inpatient operating costs (sum of lines 83 throughten the program inpatient operating costs (sum of lines 83 throughten the program in patient operating costs (sum of lines 83 throughten the program in patient operating costs (sum of lines 83 throughten the program in patient operating costs (sum of lines 83 throughten the program in patient program in pati	, , , , , , , , , , , , , , , , , , , ,			70.00
73.00 Medically necessary private room cost applicable to Program (174.00 Total Program general inpatient routine service costs (line 72.75.00 Capital-related cost allocated to inpatient routine service costs (line 75.00 Per diem capital-related costs (line 75.00 Program capital-related costs (line 75.00 Program capital-related costs (line 75.00 Program capital-related costs (line 74.00 Program inpatient service costs for comparison to the cost 1.00 Program routine service costs for comparison to the cost 1.00 Program inpatient routine service costs (see instructions) Program inpatient ancillary services (see instructions) Utilization review - physician compensation (see instructions) Total Program inpatient operating costs (sum of lines 83.00 Program inpatient operatin	e /U ÷ line 2)			71.00
74.00 Total Program general inpatient routine service costs (line 72 Capital-related cost allocated to inpatient routine service costs (line 45)  76.00 Per diem capital-related costs (line 75 ÷ line 2)  77.00 Program capital-related costs (line 9 x line 76)  1 Inpatient routine service cost (line 74 minus line 77)  79.00 Aggregate charges to beneficiaries for excess costs (from provable)  80.00 Total Program routine service costs for comparison to the cost 1 inpatient routine service cost per diem limitation  81.00 Inpatient routine service cost limitation (line 9 x line 81)  82.00 Reasonable inpatient routine service costs (see instructions)  84.00 Program inpatient ancillary services (see instructions)  85.00 Utilization review - physician compensation (see instructions)  Total Program inpatient operating costs (sum of lines 83 through	line 14 x line 35)			73.00
26, line 45) 76.00 Per diem capital-related costs (line 75 ÷ line 2) 77.00 Program capital-related costs (line 9 x line 76) 1 Inpatient routine service cost (line 74 minus line 77) 4 Aggregate charges to beneficiaries for excess costs (from prov. 10 line	2 + line 73)			74.00
76.00 Per diem capital-related costs (line 75 ÷ line 2) 77.00 Program capital-related costs (line 9 x line 76) 78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from prov 10 mounts) 70.00 Inpatient routine service costs for comparison to the cost 10 mounts of	osts (from Worksheet B, Pa	art II, column		75. 00
77. 00 Program capital-related costs (line 9 x line 76) 78. 00 Inpatient routine service cost (line 74 minus line 77) 79. 00 Aggregate charges to beneficiaries for excess costs (from prov 80. 00 Total Program routine service costs for comparison to the cost 81. 00 Inpatient routine service cost per diem limitation Inpatient routine service cost limitation (line 9 x line 81) 83. 00 Reasonable inpatient routine service costs (see instructions) 84. 00 Program inpatient ancillary services (see instructions) 85. 00 Utilization review - physician compensation (see instructions) 86. 00 Total Program inpatient operating costs (sum of lines 83 through				76.00
79. 00 Aggregate charges to beneficiaries for excess costs (from provided in the cost of t				77.00
80.00 Total Program routine service costs for comparison to the cost 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through	data a constant to			78. 0
81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through	•	ıs line 70)		79. 0 80. 0
82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through	t it in tation (Time 70 IIIIII	.S 11110 /7)		81.0
84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through				82. 0
85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 throu				83.0
86.00 Total Program inpatient operating costs (sum of lines 83 throu	)			84. 0 85. 0
				86. 0
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST	<del>-</del> ,			
87.00 Total observation bed days (see instructions)	ino 2)		1, 095	
88.00   Adjusted general inpatient routine cost per diem (line 27 ÷ li 89.00   Observation bed cost (line 87 x line 88) (see instructions)	rne 2)		1, 251. 40 1, 370, 283	

Health Financial Systems F	RANCISCAN HEALTH	I CRAWFORDSVILLI	E	In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Period: From 01/01/2016	Worksheet D-1	
				To 12/31/2016		
		Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	1, 485, 245	4, 839, 149	0. 30692	1, 370, 283	420, 571	90.00
91.00 Nursing School cost	0	4, 839, 149	0. 00000	1, 370, 283	0	91.00
92.00 Allied health cost	0	4, 839, 149	0.00000	1, 370, 283	0	92.00
93.00 All other Medical Education	0	4, 839, 149	0. 00000	1, 370, 283	0	93. 00

Health Financial Systems	FRANCISCAN HEALTH CRAWFORDSVILLE	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0022	Peri od: From 01/01/2016	Worksheet D-1
	Component CCN: 15-S022	To 12/31/2016	Date/Time Prepared: 6/28/2017 3:41 pm
	Title XIX	Subprovi der -	Cost

		I F	PF		
	Cost Center Description			4.00	
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days	s, excluding newborn)		1, 955	1. 00
2.00	Inpatient days (including private room days, excluding swing-b			1, 955	2. 00
3. 00	Private room days (excluding swing-bed and observation bed day	ys). If you have only private roo	m days,	0	3. 00
4. 00	do not complete this line.  Semi-private room days (excluding swing-bed and observation be	ad days)		1, 955	4. 00
5.00	Total swing-bed SNF type inpatient days (including private room		he cost	1, 739	5. 00
	reporting period				
6.00	Total swing-bed SNF type inpatient days (including private roo	om days) after December 31 of the	cost	0	6. 00
7. 00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room	a daya) through Dagambar 21 of th		0	7. 00
7.00	reporting period	days) through becember 31 of th	ie cost	U	7.00
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 swing-be	ed and	17	9. 00
10. 00	<pre>newborn days) Swing-bed SNF type inpatient days applicable to title XVIII or</pre>	nly (including private room days)		0	10. 00
10.00	through December 31 of the cost reporting period (see instruct			G	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		after	0	11. 00
40.00	December 31 of the cost reporting period (if calendar year, er				40.00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX through December 31 of the cost reporting period	conly (including private room da	iys)	0	12. 00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI)	only (including private room da	ıys)	0	13. 00
	after December 31 of the cost reporting period (if calendar ye	ear, enter 0 on this line)	·		
14. 00	Medically necessary private room days applicable to the Progra	am (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) SWING BED ADJUSTMENT			0	16. 00
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 of the cos	t	0.00	17. 00
	reporting period				
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of the cost		0. 00	18. 00
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	through Docombor 21 of the cost		0.00	19. 00
17.00	reporting period	s through becember 31 of the cost		0.00	17.00
20.00	Medicaid rate for swing-bed NF services applicable to services	s after December 31 of the cost		0.00	20.00
	reporting period				
21. 00 22. 00	Total general inpatient routine service cost (see instructions Swing-bed cost applicable to SNF type services through Decembe		d (Line	2, 515, 159 0	
22.00	5 x line 17)	er 31 of the cost reporting perior	u (IIIIe	U	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
	x line 18)			_	
24. 00	Swing-bed cost applicable to NF type services through December $7 \times 1$ ine 19)	31 of the cost reporting period	I (IIne	0	24. 00
25. 00	Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting period (	line 8	0	25. 00
	x line 20)	Special Specia			
26. 00	Total swing-bed cost (see instructions)			0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost ( PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	line 21 minus line 26)		2, 515, 159	27. 00
28 00	General inpatient routine service charges (excluding swing-bed	and observation bed charges)		0	28. 00
29. 00	Pri vate room charges (excluding swing-bed charges)	and observation bod onal gos,		0	
30.00	Semi -pri vate room charges (excluding swing-bed charges)			0	30.00
31. 00	General inpatient routine service cost/charge ratio (line 27	- line 28)		0. 000000	
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	
33. 00 34. 00	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 mir	nus line 33)(see instructions)		0. 00 0. 00	
35. 00	Average per diem private room cost differential (line 34 x lin			0.00	
36. 00	Private room cost differential adjustment (line 3 x line 35)	,		0	36.00
37. 00	General inpatient routine service cost net of swing-bed cost a	and private room cost differentia	ıl (line	2, 515, 159	37. 00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	ISTMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see			1, 286. 53	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line			21, 871	
40. 00	Medically necessary private room cost applicable to the Progra	· ·		0	40. 00
41. 00	Total Program general inpatient routine service cost (line 39	+ IIne 40)		21, 871	41. 00

orm CMS-2 heet D-1	
Time Prep	pared:
2017 3:41 Cost	1 pm
am Cost	
3 x col.	
. 00	10.00
0	42.00
0	
0	
	46.00
	47. 00
. 00	48. 00
21, 871	
0	50.00
0	51.00
0	
0	
	-
0	
0.00	1
0	57.00
0. 00	
0.00	•
0	•
0	63.00
0	64. 00
0	65. 00
0	66.00
0	67. 00
0	68. 00
0	69. 00
	70.00
	71.00
	73.00
	74. 00 75. 00
	76.00
	77.00
	78. 00 79. 00
	80. 00 81. 00
	82.00
	83. 00 84. 00
	85.00
	86.00
0	
	88. 00 89. 00
_	0.00

Health Financial Systems	FRANCI SCAN HEALTH	ANCISCAN HEALTH CRAWFORDSVILLE			In Lieu of Form CMS-25		
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Peri od:	Worksheet D-1		
		C (		From 01/01/2016			
		Component	CCN: 15-S022	To 12/31/2016	Date/Time Prep 6/28/2017 3:4		
		Ti tl	e XIX	Subprovi der -	Cost	· p	
				I PF			
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation		
		(from line 21)	column 2	Observati on	Bed Pass		
				Bed Cost (from	Through Cost		
				line 89)	(col. 3 x col.		
					4) (see		
					instructions)		
	1. 00	2.00	3. 00	4. 00	5. 00		
COMPUTATION OF OBSERVATION BED PASS TI	HROUGH COST						
90.00 Capital -related cost	502, 016	2, 515, 159	0. 19959	6 0	0	90.00	
91.00 Nursing School cost	0	2, 515, 159	0.00000	0	0	91.00	
92.00 Allied health cost	0	2, 515, 159	0.00000	0	0	92.00	
93.00 All other Medical Education	0	2, 515, 159	0.00000	0 0	0	93.00	

Health Financial Systems	FRANCI SCAN HEALTH CRAWFORDSVI LLE	In Lieu of Form CMS-2552-1		
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der CCN: 15-0022	Peri od: From 01/01/2016	Worksheet D-3	
		To 12/31/2016	Date/Time Prepared: 6/28/2017 3:41 pm	
	Title XVIII	Hospi tal	PPS	

			To 12/31/2016	Date/Time Pre 6/28/2017 3:4	
		Title XVIII	Hospi tal	PPS	Гріп
	Cost Center Description	Ratio of Cos		Inpatient	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1. 00	2. 00	3. 00	
	NPATIENT ROUTINE SERVICE COST CENTERS			I	
	03000 ADULTS & PEDI ATRI CS		2, 241, 907		30.00
	03100 INTENSIVE CARE UNIT		1, 113, 324		31.00
	03200 CORONARY CARE UNIT		0	•	32.00
	03300 BURN INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF	ł	0		33. 00 40. 00
	04100 SUBPROVI DER – I RF		0		41.00
	04200 SUBPROVI DER		0		42.00
	04300 NURSERY				43. 00
	NCILLARY SERVICE COST CENTERS	<b>'</b>			10.00
	D5000 OPERATING ROOM	0. 3412	77 639, 776	218, 341	50.00
	D5100 RECOVERY ROOM	0.0000	00	0	51.00
52.00	D5200 DELIVERY ROOM & LABOR ROOM	0.0000	00	0	52.00
53.00	D5300 ANESTHESI OLOGY	0.0000	00	0	53. 00
	D5400 RADI OLOGY-DI AGNOSTI C	0. 1314	2, 233, 714	293, 698	54.00
	D5401 ULTRASOUND	0. 0625			1
	D5500 RADI OLOGY-THERAPEUTI C	0. 2980	· ·		1
	D5600 RADI OI SOTOPE	0. 0811	· ·		1
	D5700 CT SCAN	0.0000		-	
	05800 MRI	0.0000		1	
	05900 CARDI AC CATHETERI ZATI ON	0.0000		0	1
	06000 LABORATORY	0. 1752		458, 036	1
	06001 BLOOD LABORATORY 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0. 0000 0. 0000		0	
	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.0000			
	06300 BLOOD STORING, PROCESSING & TRANS.	0.0000			63.00
	06400 I NTRAVENOUS THERAPY	0.0000		0	
	06500 RESPI RATORY THERAPY	0. 3402			
	06600 PHYSI CAL THERAPY	0. 4790			1
	06700 OCCUPATI ONAL THERAPY	0.0000			1
	06800 SPEECH PATHOLOGY	0.0000	00	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	0. 0840	562, 454	47, 292	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.0000		0	70. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 1736			1
	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 2565			
	07300 DRUGS CHARGED TO PATIENTS	0. 2669	· · ·		
	07400 RENAL DI ALYSI S	0.0000		-	
	07500 ASC (NON-DISTINCT PART)	0.0000		-	1
	03020 ONCOLOGY	0.0000			
	07698 HYPERBARIC OXYGEN THERAPY DUTPATIENT SERVICE COST CENTERS	0. 1598	74 0	0	76. 98
	08800 RURAL HEALTH CLINIC	0.0000	20	0	88. 00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.0000		Ö	1
	09000 CLINIC	0. 5828		0	1
	09100 EMERGENCY	0. 1648			
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 9131		0	
200.00	Total (sum of lines 50-94 and 96-98)		14, 380, 906	3, 063, 976	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (I	ine 61)	0		201. 00
202. 00	Net Charges (line 200 minus line 201)		14, 380, 906		202. 00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-0022	Peri od:	Worksheet D-3	
	Component	CCN: 15-S022	From 01/01/2016 To 12/31/2016	Date/Time Pre 6/28/2017 3:4	
	Ti tl e	e XVIII	Subprovi der - I PF	PPS	. р
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges		Program Costs	
			Charges	(col. 1 x col.	
		1.00	2. 00	2) 3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
30. 00   03000   ADULTS & PEDI ATRI CS			0		30.0
31.00 03100 INTENSIVE CARE UNIT			0		31.0
32. 00 03200 CORONARY CARE UNIT			0		32.0
33.00 03300 BURN INTENSIVE CARE UNIT			0		33.0
40. 00   04000   SUBPROVI DER - 1 PF			3, 009, 260		40.0
41. 00   04100   SUBPROVI DER - I RF			0		41.0
42. 00   04200   SUBPROVI DER			0		42.0
43. 00 O4300 NURSERY					43. C
ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM		0. 3412	77 2, 449	836	50. C
51. 00   05100   RECOVERY   ROOM		0.0000	· ·	030	
52. OO O5200 DELIVERY ROOM & LABOR ROOM		0.0000		0	
33. 00   05300   ANESTHESI OLOGY		0.0000		0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 1314		17, 029	54. 0
54. 01   05401   ULTRASOUND		0.0625	14 6, 910	432	54.0
55. 00   05500   RADI OLOGY-THERAPEUTI C		0. 2980		0	
56. 00   05600   RADI OI SOTOPE		0. 0811		0	
57. 00   05700   CT   SCAN		0.0000		0	
58. 00   05800   MRI		0.0000		0	
59. 00   05900   CARDI AC   CATHETERI ZATI ON 50. 00   06000   LABORATORY		0.0000		0 62, 686	
50. 01   O6000   LABORATORY		0. 1752 0. 0000		02,000	1
on the second begon laboratory  on the second begon laboratory		0.0000		0	
52.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL		0.0000		0	
3.00 06300 BLOOD STORING, PROCESSING & TRANS.		0.0000		0	1
04.00 06400 INTRAVENOUS THERAPY		0.0000	00 0	0	64. (
5. 00 06500 RESPIRATORY THERAPY		0. 3402		15, 300	
6. 00 06600 PHYSI CAL THERAPY		0. 4790		19, 136	1
57. 00 06700 OCCUPATI ONAL THERAPY		0.0000		0	
98. 00   06800   SPEECH PATHOLOGY		0.0000		0	
9. 00  06900  ELECTROCARDI OLOGY 0. 00  07000  ELECTROENCEPHALOGRAPHY		0. 0840 0. 0000		3, 512 0	1
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.0000		5, 064	
2.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 1736		5, 064	72. (
3. 00 07300 DRUGS CHARGED TO PATIENTS		0. 2669		130, 839	
4. 00 07400 RENAL DIALYSIS		0.0000	· ·	0	1
75.00 07500 ASC (NON-DISTINCT PART)		0.0000		0	
76. 00   03020   0NCOLOGY		0.0000		0	76.0
76. 98 07698 HYPERBARI C OXYGEN THERAPY		0. 1598	74 0	0	76.
OUTPATIENT SERVICE COST CENTERS					
38. 00   08800   RURAL HEALTH CLINIC		0.0000		0	
89.00   08900   FEDERALLY QUALIFIED HEALTH CENTER		0. 0000 0. 5828		0	
90. 00   09000  CLI NI C		0. 3626		14 384	

201. 00 202. 00

14, 384 91. 00 0 92. 00 269, 218 200. 00

0. 164874

0. 913175

91. 00 09100 EMERGENCY

201.00

202.00

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

Net Charges (line 200 minus line 201)

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

Health Financial Systems	FRANCISCAN HEALTH CRAWFORDSVILLE	In Lieu	u of Form CMS-2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der CCN: 15-0022	Period: From 01/01/2016	Worksheet D-3

12/31/2016 Date/Time Prepared: 6/28/2017 3:41 pm Title XIX Hospi tal Cost Inpati ent Cost Center Description Ratio of Cost Inpati ent To Charges Program Costs Program (col. 1 x col Charges 2) 1.00 2.00 3.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 247, 778 30.00 30.00 03100 INTENSIVE CARE UNIT 31.00 175, 121 31 00 32.00 03200 CORONARY CARE UNIT 32.00 03300 BURN INTENSIVE CARE UNIT 0 33.00 33.00 ol 04000 SUBPROVIDER - IPF 40.00 40.00 04100 SUBPROVI DER - I RF 41.00 0 41.00 42.00 04200 SUBPROVI DER 0 42.00 43.00 04300 NURSERY 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0.340480 122, 553 41, 727 50.00 51.00 05100 RECOVERY ROOM 0.000000 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 0 0 52.00 05300 ANESTHESI OLOGY 0.000000 53.00 0 Ω 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.131484 325, 293 42, 771 54.00 05401 ULTRASOUND 54.01 0.062514 17, 422 1,089 54.01 05500 RADI OLOGY-THERAPEUTI C 0.298054 55 00 0 55 00 56.00 05600 RADI OI SOTOPE 0.081133 4, 718 383 56.00 57.00 05700 CT SCAN 0.000000 0 57.00 05800 MRI 58.00 0.000000 0 58.00 0 05900 CARDIAC CATHETERIZATION 59 00 0.000000 59 00 0 60.00 06000 LABORATORY 0.175044 333, 458 58, 370 60.00 06001 BLOOD LABORATORY 60.01 0.000000 60.01 0 61 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 0.000000 0 61 00 0 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 62.00 0.000000 0 0 62.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0.000000 0 0 63.00 06400 I NTRAVENOUS THERAPY 64.00 0.000000 0 64.00 0 06500 RESPIRATORY THERAPY 31, 223 65 00 0.340298 91 753 65 00 06600 PHYSI CAL THERAPY 66.00 0.479005 6, 942 3, 325 66.00 06700 OCCUPATI ONAL THERAPY 0.000000 67.00 67.00 0 68.00 06800 SPEECH PATHOLOGY 0.000000 0 68.00 06900 ELECTROCARDI OLOGY 69 00 0.084082 33, 918 2, 852 69 00 70.00 07000 ELECTROENCEPHALOGRAPHY 0.000000 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0.173626 210, 197 36, 496 71.00 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.256584 143, 551 36, 833 72.00 07300 DRUGS CHARGED TO PATIENTS 581, 981 155, 346 73.00 0.266927 73.00 74.00 07400 RENAL DIALYSIS 0.000000 0 74.00 75.00 07500 ASC (NON-DISTINCT PART) 0.000000 0 0 75.00 03020 ONCOLOGY 76.00 0.0000000 0 76.00 07698 HYPERBARIC OXYGEN THERAPY 76. 98 0.159874 0 76.98 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0.000000 88.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0.000000 89.00 0 0 89.00 90.00 09000 CLI NI C 0.582884 Λ 90.00 91.00 09100 EMERGENCY 0.164874 147, 216 24, 272 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0.913175 92.00 0 200.00 Total (sum of lines 50-94 and 96-98) 2, 019, 002 434, 687 200. 00 201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 201.00 202.00 Net Charges (line 200 minus line 201) 2, 019, 002 202.00

Health Financial Systems	FRANCISCAN HEALTH CRAWFORDSVILLE	In Lieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0	022 Period: Worksheet E From 01/01/2016 Part A To 12/31/2016 Date/Time Prepared: 6/28/2017 3:41 pm

PART A - IMPATIENT HOSPITAL SERVICES UNDER IPPS   0.00			T' 11 \0/111		6/28/2017 3: 4	1 pm
PART A - INACTION FOSPITAL SERVICES LINDRE IPPS					PPS	
DRC Amounts Other than Outlier Payments   0   1.0   10   10   10   10   10   10					1. 00	
DRC amounts other than outlier payments for discharges occurring prior to October 1 (see   1,283.81   1.0   DRC amounts other than outlier payments for discharges occurring prior to October 1 (see   1,283.83   1.0   DRC amounts other than outlier payment for Model 4 BPCI for discharges occurring prior to October 1 (see   1,283.83   1.0   DRC for Foderal specific operating payment for Model 4 BPCI for discharges occurring on or after					_	
DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)   DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)   O. 1.0		DRG amounts other than outlier payments for discharges occurring prior to October 1 (see				1. 00 1. 01
1.03 BRC for federal specific operating payment for Model 4 BPCL for discharges occurring prior to October 1 (see instructions)   1.04 DRC for federal specific operating payment for Model 4 BPCL for discharges occurring on or after   0.15 Coches of 1 (see instructions)   2.05 Coches of 1 (see instructions)   2.06 Coches of 1 (see instructions)   2.07 Coches of 1 (see instructions)   2.08 Coches of 1 (see instructions)   2.09 Coches of 1 (see instructions)   2.00 Coches of 1 (see instructions)   2.00 Coches of 1 (see instructions)   2.01 Coches of 1 (see instructions)   2.02 Coches of 1 (see instructions)   2.03 Coches of 1 (see instructions)   2.04 Coches of 1 (see instructions)   2.05 Coches of 1 (see instructions)   2.06 Coches of 1 (see instructions)   2.07 Coches of 1 (see instructions)   2.08 Coches of 1 (see instructions)   2.09 Coches of 1 (see instructions)   2.00 Coches of 2 (see instructions)   2.00 Coches of 2 (see instructions)   2.00 Coches of 2 (see instructions)   2.00 Coches of 3 (see inst	1. 02	DRG amounts other than outlier payments for discharges occurring o	on or after October	1 (see	1, 263, 153	1. 02
October 1 (see instructions)  Outlier payments for discharges. (see instructions)  Outlier payments for discharges. (see instructions)  Outlier payments for discharges (see instructions)  Outlier payments for discharges for Model 4 BPCI (see instructions)  Description of the payment for discharges for Model 4 BPCI (see instructions)  Read and care Similar and Payments  Description of the payment for discharges for Model 4 BPCI (see instructions)  Read and care Similar and Payments  Description of the payment for discharges for Model 4 BPCI (see instructions)  Read and payment for discharges for Model 4 BPCI (see instructions)  Description of the payments for discharges for Model 4 BPCI (see instructions)  Description of the payment for discharges for Model 4 BPCI (see instructions)  Description of the payments for discharges for Model 4 BPCI (see instructions)  Description of the payments for discharges for Model 4 BPCI (see instructions)  Description of the payments for discharges for Model 4 BPCI (see instructions)  Description of the payments for discharges for the most recent cost reporting period ending on or before 12/31/1996 (see instructions)  Description of the payments for the most recent cost reporting period ending on or before 12/31/1996 (see instructions)  Description of the payments for discharges for the most recent cost reporting period ending on or before 12/31/1996 (see instructions)  Description of the payments for discharges with 42 CFR 4413.79(c) (21) (1) (1) (1) (1) (1) (1) (1) (1) (1) (	1. 03	DRG for federal specific operating payment for Model 4 BPCI for di	scharges occurring p	orior to October	0	1. 03
2.00   Outlier payments for discharges (see instructions)   0.02   0.00   0.0	1. 04	DRG for federal specific operating payment for Model 4 BPCI for di	scharges occurring o	on or after	0	1. 04
2.0.2   Outlier payment for discharges for Model 4 BPCI (see Instructions)   0.2.0   2.0.0   Managed Care Simulated Payments   0.3.0   2.0.0   Ead days available divided by number of days in the cost reporting period (see Instructions)   2.8.01   2.0.0   FIE count for all opathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/19/96, (see Instructions)   7.0.0   2.0.0   FIE count for all opathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/19/96, (see Instructions)   7.0.0   2.0.0   FIE count for all opathic and osteopathic programs which meet the criteria for an add-on to the cap for meet programs in accordance with 42 CFR 413.79(6)   7.0.0   2.0.0   MMA Section 422 reduction amount to the IME cap as specified under 42 CFR 5412.105(f)(1)(iv)(B)(2)   7.0.0   2.0.0   Adjustment (Increase or decrease) to the FIE count for all opathic and osteopathic programs for seff listed programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).   7.0.0   2.0.1   7.0.0   7.0.		Outlier payments for discharges. (see instructions)				2. 00 2. 01
4.00 Bed days available divided by number of days in the cost reporting period (see instructions)  5.00 Indirect Medical Education Adjustment  FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/19/96. (see instructions)  FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)  7.00 IMA Section 422 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(iv)(B)(1)  8.00 Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1999), and 67 FR 50069 (August) 1, 2002.  8.01 The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddle is July 1, 2011, see instructions.  8.02 The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. See instructions)  8.02 The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. See instructions)  8.03 The count for increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. See instructions)  9.00 The count for increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. See instructions)  9.01 The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. See instructions)  9.02 The count for free idents in dental and podiatric programs in the current year from your records  110 The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital program in the current year increase year.  110 The amount of the program in the current year from your records  111 The program in the program in the cu			)		0	2. 02
Indirect Medical Education Adjustment		1 9				3. 00
or before 12/31/1996. (see instructions)  6.00  FIE count for all opathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)  7.01  7.01  ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2)  8.00  AJ ustment (increase or decrease) to the FIE count for all opathic and osteopathic programs for arfiliated programs in accordance with 42 CFR 413.5(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).  8.01  Ramount of increase if the hospital was awarded FIE cap slots under section 5503 of the ACA. If the cost report straddle is July 1, 2011, see instructions.  8.02  Ramount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddle is July 1, 2011, see instructions.  9.00  Sun of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8, 02) (see under section 5506 of ACA. (see instructions) under section 5506 of ACA. (see instructions)  10.00  FTE count for residents in dental and podiatric programs.  10.01  11.00  TEC count for residents in dental and podiatric programs.  10.00  11.00  TEC count for residents in dental and podiatric programs.  10.00  11.	4. 00	Indirect Medical Education Adjustment	,	,		4. 00
for new programs in accordance with 42 CFR 413.79(e) 7.00 MAC Section 422 reduction amount to the LME cap as specified under 42 CFR \$412.105(f)(1)(iv)(B)(1) 7.01 ACA Section 5503 reduction amount to the LME cap as specified under 42 CFR \$412.105(f)(1)(iv)(B)(2) 8.00 AJ ustment (increase or decrease) to the FTE count for all opathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002). 8.01 The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddle s July 1, 2011, see instructions. 8.02 The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddle s July 1, 2011, see instructions. 9.00 Sun of lines 5 Blus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see		or before 12/31/1996. (see instructions)				5. 00
ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(iv)(8)(2)		for new programs in accordance with 42 CFR 413.79(e)		·		6. 00
Adjustment (Increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		ACA Section 5503 reduction amount to the IME cap as specified under				7. 00 7. 01
8.01 The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddle sully 1, 2011, see instructions.  8.02 The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)  9.00 Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8, 01 and 8, 02) (see	8. 00	Adjustment (increase or decrease) to the FTE count for allopathic affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)			0.00	8. 00
8.02 The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA (see instructions)  9.00 Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)  10.00 FTE count for allopathic and osteopathic programs in the current year from your records  11.00 FTE count for residents in dental and podiatric programs.  12.00 Current year allowable FTE count for the prior year.  13.00 Total allowable FTE count for the prior year.  14.00 Total allowable FTE count for the prior year.  15.00 Sum of lines 12 through 14 divided by 3.  16.00 Adjustment for residents in initial years of the program  17.00 Adjustment for residents in initial years of the program  18.00 Adjustment for residents in initial years of the program  19.00 Current year resident to bed ratio (line 18 divided by line 4).  19.00 Current year resident to bed ratio (see instructions)  20.00 Prior year resident to bed ratio (see instructions)  21.01 IME payment adjustment (see instructions)  22.02 IME payment adjustment (see instructions)  23.03 Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA  24.00 IME payment adjustment factor. (see instructions)  25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)  26.00 Resident to bed ratio (divide line 25 by line 4)  27.00 IME FTE Resident Count Over Cap (see instructions)  28.01 IME add-on adjustment amount (see instructions)  29.02 Total IME payment as djustment factor. (see instructions)  29.03 Total IME payment - Managed Care (see instructions)  29.04 Total IME payment - Managed Care (see instructions)  29.07 Total IME payment - Managed Care (see instructions)  29.08 Total IME payment - Managed Care (see instructions)  29.09 Total IME payment - Managed Care (see instructions)  30.00 Percentage of SSI reciple not patient days to Medicare Part A patient days (see instructions)	8. 01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If				8. 01
instructions) FTE count for allopathic and osteopathic programs in the current year from your records  0.00 10.00 FTE count for residents in dental and podiatric programs.  12.00 Current year allowable FTE (see instructions) 13.00 Total allowable FTE count for the prior year.  14.00 Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, 0.00 14.00 otherwise enter zero.  15.00 Sum of lines 12 through 14 divided by 3.  16.00 Adjustment for residents in initial years of the program  17.00 Adjustment for residents displaced by program or hospital closure  18.00 Adjustment for residents displaced by program or hospital closure  18.00 Adjustment for resident to bed ratio (line 18 divided by line 4).  19.00 Current year resident to bed ratio (line 18 divided by line 4).  20.00 Prior year resident to bed ratio (see instructions)  19.00 Current year resident to bed ratio (see instructions)  10.00 Enter the lesser of lines 19 or 20 (see instructions)  10.00 Enter the lesser of lines 19 or 20 (see instructions)  10.00 Enter the lesser of lines alloyable for the Add-on for Section 422 of the MMA  19.00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105  10.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see  10.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see  10.00 IME payment adjustment factor. (see instructions)  26.00 Resident to bed ratio (divide line 25 by line 4)  27.00 IME payments adjustment factor. (see instructions)  28.01 IME add-on adjustment amount (see instructions)  29.00 Total IME payment amount - Managed Care (see instructions)  29.00 Total IME payment amount - Managed Care (see instructions)  29.00 Total IME add-on adjustment amount - Managed Care (see instructions)  29.00 Total IME payment Share Adjustment  30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	8. 02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital				8. 02
11. 00 FTE count for residents in dental and podiatric programs. 12. 00 Current year allowable FTE (see instructions) 13. 00 Total allowable FTE count for the prior year. 14. 00 Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero. 15. 00 Sum of lines 12 through 14 divided by 3. 16. 00 Adjustment for residents in initial years of the program 17. 00 Adjustment for residents displaced by program or hospital closure 18. 00 Adjustment for residents displaced by program or hospital closure 19. 00 Current year resident to bed ratio (line 18 divided by line 4). 19. 00 Current year resident to bed ratio (see instructions) 19. 00 Enter the lesser of lines 19 or 20 (see instructions) 20. 00 IME payment adjustment (see instructions) 20. 01 IME payment adjustment (see instructions) 20. 01 IME payment adjustment (see instructions) 20. 01 IME payment adjustment Gee instructions) 20. 01 IME payment adjustment of Managed Care (see instructions) 20. 02 Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA 23. 00 IME FTE count for the Justment of the Add-on for Section 422 of the MMA 24. 00 IME FTE resident Count Over Cap (see instructions) 25. 00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions) 26. 00 Resident to bed ratio (divide line 25 by line 4) 27. 00 IME payment adjustment factor. (see instructions) 28. 01 IME payment adjustment factor. (see instructions) 29. 00 Total IME payment adjustment Amanaged Care (see instructions) 29. 01 Total IME payment - Managed Care (see instructions) 29. 01 Total IME payment - Managed Care (see instructions) 29. 01 Total IME payment - Managed Care (see instructions) 29. 01 Total IME payment - Managed Care (see instructions) 29. 01 Total IME payment - Managed Care (see instructions) 29. 01 Total IME payment - Managed Care (see instructions) 29. 01 Total IME payment - Managed Care (see instructions) 29. 01 Total IME payment - Managed Care (s	9. 00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see				9. 00
13.00 Total allowable FTE count for the prior year.  14.00 Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.  15.00 Sum of lines 12 through 14 divided by 3.  16.00 Adjustment for residents in initial years of the program  17.00 Adjustment for residents displaced by program or hospital closure  18.00 Adjustment for residents displaced by program or hospital closure  19.00 Current year resident to bed ratio (line 18 divided by line 4).  20.00 Prior year resident to bed ratio (see instructions)  21.00 Enter the lesser of lines 19 or 20 (see instructions)  22.01 IME payment adjustment (see instructions)  22.01 IME payment adjustment - Managed Care (see instructions)  23.00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105  24.00 IME FTE Resident Count Over Cap (see instructions)  25.00 IME FTE Resident Count Over Cap (see instructions)  26.00 Resident to bed ratio (divide line 25 by line 4)  27.00 IME payments adjustment factor. (see instructions)  28.01 IME payments adjustment factor. (see instructions)  29.00 IME payments adjustment factor. (see instructions)  20.00 Resident to bed ratio (divide line 25 by line 4)  20.00 IME payments adjustment factor. (see instructions)  20.00 Resident to bed ratio (divide line 25 by line 4)  20.00 IME payments adjustment factor. (see instructions)  20.00 Resident to bed ratio (divide line 25 by line 4)  20.00 IME payments adjustment factor. (see instructions)  20.00 Resident to bed ratio (divide line 25 by line 4)  20.00 Resident to bed ratio (divide line 25 by line 4)  20.00 Resident to bed ratio (divide line 25 by line 4)  20.00 Resident to bed ratio (divide line 25 by line 4)  20.00 Resident to bed ratio (divide line 25 by line 4)  20.00 Resident to bed ratio (divide line 25 by line 4)  20.00 Resident to bed ratio (divide line 25 by line 4)  20.00 Resident to bed ratio (divide line 25 by line 4)  20.00 Resident to bed ratio (divide line 25 by line 4)  20.0	11. 00	FTE count for residents in dental and podiatric programs.	year from your record	ds	0. 00	
14.00 Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.  15.00 Sum of lines 12 through 14 divided by 3.  16.00 Adjustment for residents in initial years of the program  17.00 Adjustment for residents displaced by program or hospital closure  18.00 Adjustment for residents displaced by program or hospital closure  19.00 Current year resident to bed ratio (line 18 divided by line 4).  19.00 Current year resident to bed ratio (see instructions)  19.00 Prior year resident to bed ratio (see instructions)  10.00 IME payment adjustment (see instructions)  10.00 IME payment adjustment (see instructions)  10.00 IME payment adjustment - Managed Care (see instructions)  10.00 IME payment adjustment for the Add-on for Section 422 of the MMA  23.00 IME paddical Education Adjustment for the Add-on for Section 422 of the MMA  24.00 IME FTE Resident Count Over Cap (see instructions)  10.00 IME FTE Resident Count Over Cap (see instructions)  25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see  10.00 instructions)  26.00 Resident to bed ratio (divide line 25 by line 4)  27.00 IME payments adjustment factor. (see instructions)  28.01 IME add-on adjustment amount (see instructions)  29.02 Total IME payment (sum of lines 22 and 28)  29.03 Total IME payment - Managed Care (see instructions)  29.04 Total IME payment - Managed Care (sum of lines 22.01 and 28.01)  29.05 Disproportionate Share Adjustment  30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)						
15.00       Sum of lines 12 through 14 divided by 3.       0.00       15.00         16.00       Adjustment for residents in initial years of the program       0.00       16.00         17.00       Adjustment for residents displaced by program or hospital closure       0.00       16.00         18.00       Adjusted rolling average FTE count       0.00       18.00         19.00       Current year resident to bed ratio (line 18 divided by line 4).       0.000000       19.00         20.00       Prior year resident to bed ratio (see instructions)       0.000000       20.00         21.00       Enter the lesser of lines 19 or 20 (see instructions)       0.000000       20.00         22.01       IME payment adjustment (see instructions)       0.000000       22.00         1 IME payment adjustment - Managed Care (see instructions)       0.000000       22.00         1 Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA       0.000000       23.00         23.00       IME FTE Resident Count Over Cap (see instructions)       0.00       23.00         25.00       If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)       0.00       25.00         26.00       Resident to bed ratio (divide line 25 by line 4)       0.0000000       26.00       27.00 <td< td=""><td></td><td>Total allowable FTE count for the penultimate year if that year er</td><td>nded on or after Sep</td><td>tember 30, 1997,</td><td></td><td>13.00</td></td<>		Total allowable FTE count for the penultimate year if that year er	nded on or after Sep	tember 30, 1997,		13.00
17. 00 Adjustment for residents displaced by program or hospital closure  18. 00 Adjusted rolling average FTE count  19. 00 Current year resident to bed ratio (line 18 divided by line 4).  20. 00 Prior year resident to bed ratio (see instructions)  21. 00 Enter the lesser of lines 19 or 20 (see instructions)  22. 01 IME payment adjustment (see instructions)  22. 01 IME payment adjustment - Managed Care (see instructions)  23. 00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105  24. 00 IME FTE Resident Count Over Cap (see instructions)  25. 00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)  26. 00 Resident to bed ratio (divide line 25 by line 4)  27. 00 IME payments adjustment factor. (see instructions)  28. 01 IME add-on adjustment amount (see instructions)  29. 00 Total IME payment (sum of lines 22 and 28)  29. 01 Total IME payment (sum of lines 22 and 28)  30. 00 Prior year resident to bed ratio (divident patient days to Medicare Part A patient days (see instructions)  30. 00 Prior year resident to bed ratio (divident patient days to Medicare Part A patient days (see instructions)  30. 00 Prior year resident to bed ratio (divident patient days to Medicare Part A patient days (see instructions)	15. 00				0. 00	15. 00
18.00 Adjusted rolling average FTE count  19.00 Current year resident to bed ratio (line 18 divided by line 4).  20.00 Prior year resident to bed ratio (see instructions)  21.00 Enter the lesser of lines 19 or 20 (see instructions)  22.00 IME payment adjustment (see instructions)  22.01 IME payment adjustment - Managed Care (see instructions)  23.00 IME payment adjustment - Managed Care (see instructions)  23.00 IME payment adjustment - Managed Care (see instructions)  24.00 IME FTE Resident Count Over Cap (see instructions)  25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)  26.00 Resident to bed ratio (divide line 25 by line 4)  27.00 IME payments adjustment factor. (see instructions)  28.00 IME add-on adjustment amount (see instructions)  29.00 IME add-on adjustment amount (see instructions)  29.00 Total IME payment (sum of lines 22 and 28)  29.01 Total IME payment (sum of lines 22 and 28)  29.02 Total IME payment - Managed Care (sum of lines 22.01 and 28.01)  Disproportionate Share Adjustment  Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)  0.000000 20.00  0.000000 21.00  0.000000 22.00  0.000000 24.00  0.000000 25.00  0.000000 26.00  0.000000 26.00  0.000000 27.						
19.00 Current year resident to bed ratio (line 18 divided by line 4).  20.00 Prior year resident to bed ratio (see instructions)  21.00 Enter the lesser of lines 19 or 20 (see instructions)  22.00 IME payment adjustment (see instructions)  22.01 IME payment adjustment - Managed Care (see instructions)  22.01 IME payment adjustment for the Add-on for Section 422 of the MMA  23.00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105  24.00 IME FTE Resident Count Over Cap (see instructions)  25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see  26.00 Resident to bed ratio (divide line 25 by line 4)  27.00 IME payments adjustment factor. (see instructions)  28.01 IME add-on adjustment amount (see instructions)  29.00 Total IME payment (sum of lines 22 and 28)  29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01)  Disproportionate Share Adjustment  Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)  0.000000  20.00  0.000000  21.00  0.000000  22.00  10.000000  22.00  10.00000000						
20.00 Prior year resident to bed ratio (see instructions) 21.00 Enter the lesser of lines 19 or 20 (see instructions) 22.00 IME payment adjustment (see instructions) 22.01 IME payment adjustment - Managed Care (see instructions) 22.02 Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA 23.00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 24.00 IME FTE Resident Count Over Cap (see instructions) 25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see 26.00 Resident to bed ratio (divide line 25 by line 4) 27.00 IME payments adjustment factor. (see instructions) 28.00 IME add-on adjustment amount (see instructions) 28.01 IME add-on adjustment amount (see instructions) 29.00 Total IME payment (sum of lines 22 and 28) 29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) Disproportionate Share Adjustment  Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 0.0000000 20.00 20.00 20.00 21.00 20.00 21.00 22.00						
21.00 Enter the lesser of lines 19 or 20 (see instructions)  22.00 IME payment adjustment (see instructions)  1ME payment adjustment - Managed Care (see instructions)  1ndi rect Medical Education Adjustment for the Add-on for Section 422 of the MMA  23.00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105  (f)(1)(iv)(C).  24.00 IME FTE Resident Count Over Cap (see instructions)  1f the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)  26.00 Resident to bed ratio (divide line 25 by line 4)  27.00 IME payments adjustment factor. (see instructions)  28.00 IME add-on adjustment amount (see instructions)  29.00 IME add-on adjustment amount - Managed Care (see instructions)  29.00 Total IME payment ( sum of lines 22 and 28)  29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01)  Disproportionate Share Adjustment  Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)  0.000000  21.00  22.00  22.00  23.00  24.00  25.00  26.00  27.00  28.00  29.00  29.00  20		, ,				20.00
22.00   IME payment adjustment (see instructions)   0   22.00     IME payment adjustment - Managed Care (see instructions)   0   22.00     Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA     Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA     Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA     Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA     Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA     Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA     Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA     Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA     Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA     Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA     Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA     Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA     Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA     Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA     Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA     Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA     Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA     Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA     Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA     Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA     Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA     Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA     Indirect Medication Adjustment for the Add-on for Section						
22.01   IME payment adjustment - Managed Care (see instructions)   0   1ndirect Medical Education Adjustment for the Add-on for Section 422 of the MMA   23.00   Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105   0.00   (f) (1) (iv) (C) .   0   0   0   0   0   0   0   0   0		1				22. 00
23.00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).  24.00 IME FTE Resident Count Over Cap (see instructions)  25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)  26.00 Resident to bed ratio (divide line 25 by line 4)  27.00 IME payments adjustment factor. (see instructions)  28.00 IME add-on adjustment amount (see instructions)  28.01 IME add-on adjustment amount - Managed Care (see instructions)  29.00 Total IME payment (sum of lines 22 and 28)  29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01)  Disproportionate Share Adjustment  30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)  0.00 23.0  0.00 24.0  0.00 25.0  0.00 25.0  0.00 26.0  0.000000  27.0  28.0  0.00 29.0  0.000000  0.000000  0.000000  0.000000	22. 01	IME payment adjustment - Managed Care (see instructions)			0	22. 01
(f)(1)(iv)(C).  24.00 IME FTE Resident Count Over Cap (see instructions)  1 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)  26.00 Resident to bed ratio (divide line 25 by line 4)  27.00 IME payments adjustment factor. (see instructions)  28.00 IME add-on adjustment amount (see instructions)  28.01 IME add-on adjustment amount - Managed Care (see instructions)  29.00 Total IME payment (sum of lines 22 and 28)  29.01 Disproportionate Share Adjustment  30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)  0.00 24.0  0.00 25.0  0.00 26.0  0.000000  27.0  28.0  0.000000  29.0  0.000000  29.0  0.000000  29.0  0.000000  29.0  0.000000  0.000000  0.000000  0.000000	23 00	Indirect Medical Education Adjustment for the Add-on for Section 4	122 of the MMA	ec 412 105	0.00	23 00
25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see  0.00 25.00 Resident to bed ratio (divide line 25 by line 4)  27.00 IME payments adjustment factor. (see instructions)  1ME add-on adjustment amount (see instructions)  1ME add-on adjustment amount - Managed Care (see instructions)  28.01 IME add-on adjustment amount - Managed Care (see instructions)  29.00 Total IME payment (sum of lines 22 and 28)  29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01)  Disproportionate Share Adjustment  30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)  0.00 25.00  0.000000  26.00  0.000000  27.00  0.000000  0.000000  0.000000  0.000000	20.00		5ap 5. 5.5 a. a		0.00	20.00
instructions)  26. 00 Resident to bed ratio (divide line 25 by line 4)  27. 00 IME payments adjustment factor. (see instructions)  28. 00 IME add-on adjustment amount (see instructions)  29. 01 IME add-on adjustment amount - Managed Care (see instructions)  29. 00 Total IME payment (sum of lines 22 and 28)  29. 01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01)  Disproportionate Share Adjustment  30. 00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)  26. 00  26. 00  27. 00  28. 00  28. 00  29. 00  Total IME payment (sum of lines 22 and 28)  0 29. 00  Disproportionate Share Adjustment	24.00	IME FTE Resident Count Over Cap (see instructions)			0.00	24. 00
26.00 Resident to bed ratio (divide line 25 by line 4)  27.00 IME payments adjustment factor. (see instructions)  28.00 IME add-on adjustment amount (see instructions)  29.00 IME add-on adjustment amount - Managed Care (see instructions)  29.00 Total IME payment (sum of lines 22 and 28)  29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01)  Disproportionate Share Adjustment  30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)  0.000000 26.00 0.000000 27.00 0.000000 27.00 0.000000 27.00 0.000000 27.00 0.000000 27.00 0.000000 27.00 0.000000 27.00 0.000000 27.00 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.000000 0.0000000 0.000000 0.0000000 0.000000 0.0000000 0.000000 0.0000000 0.000000 0.0000000 0.000000 0.0000000 0.000000 0.0000000 0.000000 0.0000000 0.000000 0.0000000 0.000000 0.0000000 0.000000 0.0000000 0.000000 0.0000000 0.000000 0.0000000 0.000000 0.0000000 0.000000 0.0000000 0.000000 0.00000000	25. 00		r of line 23 or line	24 (see	0. 00	25. 00
27. 00 IME payments adjustment factor. (see instructions)  28. 00 IME add-on adjustment amount (see instructions)  28. 01 IME add-on adjustment amount - Managed Care (see instructions)  29. 00 Total IME payment (sum of lines 22 and 28)  29. 01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01)  Disproportionate Share Adjustment  30. 00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)  0. 000000  27. 0  28. 0  29. 0  29. 0  29. 0  0. 000000  27. 0  28. 0  29. 0  29. 0  0. 000000  29. 0  29. 0  0. 000000  20. 0000000  20. 0000000  21. 0000000  22. 0000000  23. 0000000  24. 00000000  25. 0000000  26. 00000000  27. 0000000  28. 0000000  29. 00000000  29. 00000000  29. 000000000000000000000000000000000000	26. 00				0. 000000	26. 00
28.00 IME add-on adjustment amount (see instructions)  28.01 IME add-on adjustment amount - Managed Care (see instructions)  29.00 Total IME payment (sum of lines 22 and 28)  29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01)  Disproportionate Share Adjustment  30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)  0 28.00  29.00  29.00  29.00  0 29.00						27. 00
28.01 IME add-on adjustment amount - Managed Care (see instructions)  29.00 Total IME payment (sum of lines 22 and 28)  29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01)  Disproportionate Share Adjustment  30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)  0 28.00 29.						28. 00
29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01)  Disproportionate Share Adjustment  30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)  0.00 30.00	28. 01			0	28. 01	
Disproportionate Share Adjustment  30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)  0.00 30.00	29. 00	, , , , , , , , , , , , , , , , , , ,			0	29. 00
30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 0.00 30.0	29. 01	Total IME payment - Managed Care (sum of Lines 22.01 and 28.01)			0	29. 01
	30.00		nt days (see instruc	tions)	0.00	30. 00
31.00   Percentage of Medicaid patient days (see instructions) 0.00   31.0	31.00	Percentage of Medicaid patient days (see instructions)	<b>3</b> ,	·		
	32.00	, , , , , , , , , , , , , , , , , , , ,				32. 00
		, , , , , , , , , , , , , , , , , , , ,				33. 00
34.00   Disproportionate share adjustment (see instructions) 0   34.0	34. 00	Disproportionate share adjustment (see instructions)			0	34. 00

	Financial Systems FRANCISCAN HEALTH C ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0022	Period:	u of Form CMS-2 Worksheet E	2552-10
CALCUL	ATTON OF REIMBURSEMENT SETTLEMENT	Frovider Con. 15-0022	From 01/01/2016 To 12/31/2016		
		Title XVIII	Hospi tal	PPS	, p
			Prior to 10/1		
	Na		1. 00	2. 00	
35. 00	Uncompensated Care Adjustment Total uncompensated care amount (see instructions)		6 406 145 534	5, 977, 483, 147	35. 00
35. 00	Factor 3 (see instructions)		0, 400, 143, 334	0. 000006951	35. 00
35. 02		ter zero on this line)	0	0	
	(see instructions)				
35. 03	' ' '		0	0	
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.0 Additional payment for high percentage of ESRD beneficiary di				36. 00
40. 00	Total Medicare discharges on Worksheet S-3, Part I excluding		0		40. 00
	652, 682, 683, 684 and 685 (see instructions)	3			
41. 00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 6	683, 684 an 685. (see	0		41. 00
41 O1	instructions)	DDCc 4E2 402 402 40	4 0		41 01
41. 01	Total ESRD Medicare covered and paid discharges excluding MS- an 685. (see instructions)	- 002, 002, 003, 084	, I		41. 01
42. 00	Divide line 41 by line 40 (if less than 10%, you do not quali		0.00		42. 00
43. 00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 68	82, 683, 684 an 685. (see	e 0		43. 00
44.00	instructions)	by line 41 divided by 7	0.000000		44 00
44. 00	Ratio of average length of stay to one week (line 43 divided days)	by line 41 divided by 7	0. 000000		44. 00
45. 00	Average weekly cost for dialysis treatments (see instructions	s)	0.00		45. 00
46. 00	Total additional payment (line 45 times line 44 times line 47	ı. 01)	0		46. 00
47. 00	Subtotal (see instructions)		4, 401, 038		47. 00
48. 00		small rural hospitals	4, 153, 662		48. 00
	only. (see instructions)			Amount	
				1. 00	
49. 00	Total payment for inpatient operating costs (see instructions			4, 401, 038	49. 00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I ar		)	356, 556	
51.00	Exception payment for inpatient program capital (Wkst. L, Pt.			0	51.00
52. 00 53. 00	Direct graduate medical education payment (from Wkst. E-4, li Nursing and Allied Health Managed Care payment	ine 49 see instructions).		0	52. 00 53. 00
54. 00	Special add-on payments for new technologies			0	54.00
54. 01	Islet isolation add-on payment			Ö	54. 01
55. 00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 6	69)		0	55. 00
56. 00	Cost of physicians' services in a teaching hospital (see into			0	56. 00
57. 00	Routine service other pass through costs (from Wkst. D, Pt. I		through 35).	0	57.00
58. 00	Ancillary service other pass through costs from Wkst. D, Pt.	IV, col. 11 line 200)		0	58.00
59. 00 60. 00	Total (sum of amounts on lines 49 through 58) Primary payer payments			4, 757, 594 3, 400	
61. 00	. 3 1.3. 1.3	s line 60)		4, 754, 194	
62. 00	Deductibles billed to program beneficiaries			619, 276	
63. 00	Coinsurance billed to program beneficiaries			8, 372	
64. 00	Allowable bad debts (see instructions)			81, 702	64.00
	Adjusted reimbursable bad debts (see instructions)			53, 106	
66.00	3	tructions)		23, 409	
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)  Credits received from manufacturers for replaced dayless for	applicable to MC DDCs (	coo instructions)	4, 179, 652	
68. 00 69. 00	Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96).	• •	,	0 0	
07.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	. (101 301 300 111311 4011 01	13)	o o	70.00
70.00	RURAL DEMONSTRATION PROJECT			Ö	70. 50
70. 00 70. 50	SCH or MDH volume decrease adjustment			0	70. 88
		tructions)		0	70. 89
70. 50 70. 88 70. 89	Pioneer ACO demonstration payment adjustment amount (see inst	,		0	70. 90
70. 50 70. 88 70. 89 70. 90	Pioneer ACO demonstration payment adjustment amount (see inst HSP bonus payment HVBP adjustment amount (see instructions)	· · · · · · · · · · · · · · · · · · ·			
70. 50 70. 88 70. 89 70. 90 70. 91	Pioneer ACO demonstration payment adjustment amount (see inst HSP bonus payment HVBP adjustment amount (see instructions) HSP bonus payment HRR adjustment amount (see instructions)	,		0	70. 91
70. 50 70. 88 70. 89 70. 90 70. 91 70. 92	Pioneer ACO demonstration payment adjustment amount (see inst HSP bonus payment HVBP adjustment amount (see instructions) HSP bonus payment HRR adjustment amount (see instructions) Bundled Model 1 discount amount (see instructions)	· · · · · · ,		0	70. 91 70. 92
70. 50 70. 88 70. 89 70. 90 70. 91 70. 92 70. 93	Pioneer ACO demonstration payment adjustment amount (see inst HSP bonus payment HVBP adjustment amount (see instructions) HSP bonus payment HRR adjustment amount (see instructions) Bundled Model 1 discount amount (see instructions)	,		0	70. 91 70. 92 70. 93

	Financial Systems FRANCISCAN HEALTH C ATION OF REIMBURSEMENT SETTLEMENT	Provi der CO		Peri od:	u of Form CMS-2 Worksheet E	2332 10
CALCUL	ATTOM OF RETWIDURSEWIENT SETTLEWIENT	Provider Co	JN. 13-0022	From 01/01/2016	Part A	
				To 12/31/2016	Date/Time Pre	
					6/28/2017 3: 4 <sup>2</sup>	1 pm
		Title	XVIII	Hospi tal	PPS	
			FFY	′ (yyyy)	Amount	
				0	1. 00	
70. 96	Low volume adjustment for federal fiscal year (yyyy) (Enter i	n column 0		2016	528, 130	70. 96
	the corresponding federal year for the period prior to 10/1)					
70. 97	Low volume adjustment for federal fiscal year (yyyy) (Enter i	n column 0		2017	197, 918	70. 97
	the corresponding federal year for the period ending on or af	ter 10/1)			_	
70. 98	Low Volume Payment-3				0	
70. 99	HAC adjustment amount (see instructions)				-39, 962	
71. 00	Amount due provider (line 67 minus lines 68 plus/minus lines	69 & 70)			4, 904, 052	
71. 01	Sequestration adjustment (see instructions)				98, 081	
72. 00	1 1				4, 829, 410	
	Tentative settlement (for contractor use only)				0	
	Balance due provider (Program) (line 71 minus lines 71.01, 72				-23, 439	
75. 00	Protested amounts (nonallowable cost report items) in accorda	ince with			0	75. 00
	CMS Pub. 15-2, chapter 1, §115.2					
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)				_	
90.00		structions)			0	
91.00	Capital outlier from Wkst. L, Pt. I, line 2				0	
92.00	Operating outlier reconciliation adjustment amount (see instr				0	
93.00	Capital outlier reconciliation adjustment amount (see instruc				0	93.00
	The rate used to calculate the time value of money (see instr				0. 00	
95. 00					0	95. 00
96. 00	Time value of money for capital related expenses (see instruc	tions)		5	0	96. 00
				Prior to 10/1		
	luon n			1. 00	2. 00	
	HSP Bonus Payment Amount					
100.00	HSP bonus amount (see instructions)			0	0	100. 00
	HVBP Adjustment for HSP Bonus Payment			4 0004407770	1 0055017700	
	HVBP adjustment factor (see instructions)			1. 0034197779	1. 0055317790	
102.00	HVBP adjustment amount for HSP bonus payment (see instruction	is)		0	0	102. 00
400.00	HRR Adjustment for HSP Bonus Payment			0.0000	0.0000	400.00
	HRR adjustment factor (see instructions)	`		0. 9890	0. 9803	
104.00	HRR adjustment amount for HSP bonus payment (see instructions	;)		0	01	104.00

Health Financial Systems	FRANCISCAN HEALTH CRAWFOR	RDSVI LLE	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT				
		Ti +1 o V\/I I I	Hospi tal	DDC

			To 12/31/2016	Date/Time Pre 6/28/2017 3:4	
		Title XVIII	Hospi tal	PPS	<u> </u>
				1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
1.00	Medical and other services (see instructions)			6, 019	1.00
2.00	Medical and other services reimbursed under OPPS (see instruc	tions)		8, 505, 380	
3.00	PPS payments			7, 398, 630	1
4.00	Outlier payment (see instructions)			3, 839	
5.00	Enter the hospital specific payment to cost ratio (see instruction 2 times 1	ctions)		0.000	
6. 00 7. 00	Line 2 times line 5 Sum of line 3 plus line 4 divided by line 6			0.00	
8. 00	Transitional corridor payment (see instructions)			0.00	1
9. 00	Ancillary service other pass through costs from Wkst. D, Pt.	IV. col. 13. line 200		Ö	1
10.00	Organ acquisitions	,		0	ı
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			6, 019	11. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
40.00	Reasonable charges			00.550	40.00
12.00	Ancillary service charges	ina (0)		22, 552	1
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, Ii Total reasonable charges (sum of lines 12 and 13)	THE 69)		0 22, 552	
14.00	Customary charges			22, 552	14.00
15. 00	Aggregate amount actually collected from patients liable for	payment 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	1
	Total customary charges (see instructions)	l ! & l 10	11) /	22, 552	
19. 00	Excess of customary charges over reasonable cost (complete onlinstructions)	TY IT TIME 18 exceeds IT	ne II) (see	16, 533	19. 00
20. 00	Excess of reasonable cost over customary charges (complete on	lv if line 11 exceeds li	ne 18) (see	0	20.00
20.00	instructions)	.ye execede	(555		20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see	e instructions)		6, 019	21. 00
	Interns and residents (see instructions)			0	22. 00
	Cost of physicians' services in a teaching hospital (see insti	ructions)		0	
24. 00	Total prospective payment (sum of lines 3, 4, 8 and 9)			7, 402, 469	24. 00
25. 00	COMPUTATION OF REIMBURSEMENT SETTLEMENT  Deductibles and coinsurance (for CAH, see instructions)			0	25. 00
26. 00	Deductibles and Coinsurance relating to amount on line 24 (for	r CAH see instructions)		1, 489, 518	1
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26)]		and 231 (see	5, 918, 970	1
	instructions)	•	- `		
28. 00	Direct graduate medical education payments (from Wkst. E-4, Ii	ine 50)		0	
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	
	Subtotal (sum of lines 27 through 29)			5, 918, 970	1
31.00	Primary payer payments Subtotal (line 30 minus line 31)			329 5, 918, 641	1
32.00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE	CES)		3, 710, 041	32.00
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	,		0	33. 00
34.00	Allowable bad debts (see instructions)			209, 334	34.00
	Adjusted reimbursable bad debts (see instructions)			136, 067	1
	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		128, 117	1
	Subtotal (see instructions)			6, 054, 708	1
38. 00 39. 00	MSP-LCC reconciliation amount from PS&R OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	1
39. 50	Pioneer ACO demonstration payment adjustment (see instructions	5)		0	1
39. 98	Partial or full credits received from manufacturers for replacements		tions)	Ö	39. 98
39. 99	RECOVERY OF ACCELERATED DEPRECIATION		,	0	39. 99
40.00	Subtotal (see instructions)			6, 054, 708	40.00
40. 01	Sequestration adjustment (see instructions)			121, 094	
	O Interim payments			5, 796, 300	
42. 00	Tentative settlement (for contractors use only)			127 214	
43.00	Balance due provider/program (see instructions)	nco with CMS Pub. 15.3	chantor 1	137, 314	
44. 00	Protested amounts (nonallowable cost report items) in accordar §115.2	TICE WITTI CINS PUB. 10-2,	υπαρτει Ι,	0	44. 00
	TO BE COMPLETED BY CONTRACTOR				1
90.00	Original outlier amount (see instructions)			0	90.00
	Outlier reconciliation adjustment amount (see instructions)			0	
	The rate used to calculate the Time Value of Money			0.00	
93.00	Time Value of Money (see instructions)			0	
94.00	Total (sum of lines 91 and 93)			, 0	94. 00

 
 Heal th
 Financial
 Systems
 FRANCISO

 ANALYSIS
 OF
 PAYMENTS
 TO
 PROVIDERS
 FOR
 SERVICES
 RENDERED
 Peri od: Worksheet E-1
From 01/01/2016 Part I
To 12/31/2016 Part I
Date/Time Prepared: 6/28/2017 3:41 pm Provider CCN: 15-0022

					6/28/2017 3: 4 <sup>2</sup>	1 pm
			XVIII	Hospi tal	PPS	
		Inpatien	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, 829, 410		5, 796, 300	1. 00
2.00	Interim payments payable on individual bills, either		(	ס	0	2. 00
	submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3. 00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER			0	0	3. 01
3. 02				0	0	3. 02
3.03					0	3. 03
3. 04 3. 05					0	3. 04 3. 05
3.05	Provider to Program			<u>J</u>	U	3. 05
3.50	ADJUSTMENTS TO PROGRAM				0	3. 50
3. 51	ABSOSTMENTS TO TROOK IIII			Ď		3. 51
3. 52					0	3. 52
3.53			(	o o	0	3. 53
3.54				o	0	3. 54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			O	0	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		4, 829, 410	)	5, 796, 300	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
3.00	desk review. Also show date of each payment. If none,					3. 00
	write "NONE" or enter a zero. (1)					
	Program to Provider			·		
5. 01	TENTATI VE TO PROVI DER			D	0	5. 01
5.02				D	0	5. 02
5.03			(	D	0	5. 03
F F0	Provi der to Program					F F0
5. 50 5. 51	TENTATIVE TO PROGRAM				0	5. 50 5. 51
5. 51				0		5. 51
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines					5. 99
3. 77	5. 50-5. 98)		,			3. 77
6.00	Determined net settlement amount (balance due) based on					6. 00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVIDER			o l	137, 314	6. 01
6.02	SETTLEMENT TO PROGRAM		23, 43		0	6. 02
7. 00	Total Medicare program liability (see instructions)		4, 805, 97		5, 933, 614	7. 00
				Contractor	NPR Date	
		,	`	Number	(Mo/Day/Yr)	
8. 00	Name of Contractor	(	)	1.00	2. 00	8. 00
0.00	Inalie of contractor			1	1	0.00

Component CCN: 15-S022

Title XVIII Subprovi der -

		litle	XVIII	Subprovider - IPF	PPS	
		I npati en	t Part A		t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2.00	3. 00	4. 00	
1.00	Total interim payments paid to provider		1, 488, 658		0	1. 00
2.00	Interim payments payable on individual bills, either		0		0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3. 00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
3. 01	Program to Provider ADJUSTMENTS TO PROVIDER		0		0	3. 01
3. 01	ADJUSTMENTS TO PROVIDER				0	3.01
3. 02			0		0	3.02
3. 04					0	3.04
3. 05			ĺ		0	3.05
0.00	Provider to Program					0.00
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3. 51			0		0	3. 51
3.52			0		0	3. 52
3.53			0		0	3. 53
3.54			0		0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		0		0	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		1, 488, 658		0	4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					ļ
5. 00	TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after			1	I	l 5.00
5.00	desk review. Also show date of each payment. If none,					5.00
	write "NONE" or enter a zero. (1)					
	Program to Provider					ł
5. 01	TENTATI VE TO PROVI DER		0		0	5. 01
5. 02	TERMINA TO TROVIDER		Ö		l ő	
5. 03			Ö		0	
	Provider to Program					
5.50	TENTATI VE TO PROGRAM		0		0	5. 50
5. 51			0		0	5. 51
5.52			0		0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		0		0	5. 99
	5. 50-5. 98)					
6.00	Determined net settlement amount (balance due) based on					6. 00
,	the cost report. (1)		_		_	
6. 01	SETTLEMENT TO PROVIDER		0		0	6. 01
6. 02	SETTLEMENT TO PROGRAM		1 400 450		0	6. 02
7. 00	Total Medicare program liability (see instructions)		1, 488, 658		NPR Date	7. 00
				Contractor Number	(Mo/Day/Yr)	
		(	 )	1. 00	2. 00	
8. 00	Name of Contractor			1.00	2.00	8. 00
5. 50		1		I .	I	, 5.50

Health Financial Systems FRANCISCAN HEALTH CRAWFORDSVILLE In Lieu of					
	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0022	Peri od: From 01/01/2016	Worksheet E-1	
			To 12/31/2016		
		Title XVIII	Hospi tal	PPS	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1. 00	Total hospital discharges as defined in AARA §4102 from Wkst.		14	1, 277 2, 066	1. 00
2.00 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12					2. 00
3. 00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			569	3. 00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8	3-12		3, 333	4. 00
5. 00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			170, 031, 105	
6. 00	Total hospital charity care charges from Wkst. S-10, col. 3 I			7, 878, 608	6. 00
7. 00	CAH only - The reasonable cost incurred for the purchase of c line 168	certified HII technology	Wkst. S-2, Pt. I	0	7. 00
8. 00	Calculation of the HIT incentive payment (see instructions)			419, 806	8. 00
9. 00					
10.00 Calculation of the HIT incentive payment after sequestration (see instructions)					10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH					
30.00 Initial/interim HIT payment adjustment (see instructions)					30.00
31.00 Other Adjustment (specify)					31.00
32. 00	31.00 Other Adjustment (specify) 32.00 Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions) -376,60				

Health Financial Systems	FRANCISCAN HEALTH CRAWFORDSVILLE	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0022		Worksheet E-3
	Component CCN: 15-S022	From 01/01/2016 To 12/31/2016	
	Title XVIII	Subprovi der -	PPS
	little XVIII	Subprovider -	PPS

29,484   20,		I PF		
New Tenders   Tenders   PART   A SERVICES - IPF PRS			1 00	
1.00   Met Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)		PART II - MEDICARE PART A SERVICES - IPF PPS	1.00	
Net IFP PPS ECT Payments	1.00		1, 579, 281	1.00
Unweighted Intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)   Cap Increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(III)(F)(1) or (2) (see instructions)   Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)   Current year's unweighted FTE count for residents within the new program growth period of a "new teaching program" (see instructions)   0.00   6.00   Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)   0.00   Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)   0.00   Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)   0.00   0.00   Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)   0.00   0	2.00	Net IPF PPS Outlier Payments	29, 484	2. 00
15, 2004, (see instructions)   4,00	3.00	Net IPF PPS ECT Payments	0	3. 00
4.01   Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42   CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	4. 00		0.00	4. 00
Each   Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)   0.00	4. 01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42	0.00	4. 01
teaching program" (see Instructions)  1.00 Current year's unwelghted IRR FIE count for residents within the new program growth period of a "new teaching program" (see instructions)  1.00 Intern and resident count for IPF PPS medical education adjustment (see instructions)  1.00 Average Dally Census (see instructions)  1.00 Teaching Adjustment Factor ((1 + (line B/line 9)) raised to the power of .5150 -1).  1.00 Teaching Adjustment (line 1 multiplied by line 10).  1.00 Teachin	5.00	New Teaching program adjustment. (see instructions)	0.00	5. 00
2.00   Current 'year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)   0.00	6. 00		0.00	6. 00
8.00	7. 00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new	0.00	7. 00
9.00   Average Daily Census (see instructions)   5.341530   9.00	8.00		0.00	8. 00
10.00   Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to the power of .5150 -1).				
11.00   Teaching Adjustment (line 1 multiplied by line 10).   0   11.00   12.00   Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)   1,608,765   12.00   13.00   Nursing and Allied Health Managed Care payment (see instructions)   14.00   0   13.00   0   13.00   0   14.00   0   0   0   0   0   0   0   0   0	10.00	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to the power of .5150 -1}.	0.000000	10. 00
13. 00   Nursing and Allied Health Managed Care payment (see instruction)   14. 00   0rgan acquisition (D0 NOT USE THIS LINE)   14. 00   0rgan acquisition (D0 NOT USE THIS LINE)   14. 00   0rgan acquisition (D0 NOT USE THIS LINE)   15. 00   0rgan acquisition (D0 NOT Use Instructions)   15. 00   0rgan acquisition (D0 NOT Excellent the Drovider (see instructions)   15. 00   0rgan acquisition (D0 NOT Excellent the Drovider (see instructions)   15. 00   0rgan acquisition (D0 NOT Excellent the Drovider (see instructions)   15. 00   0rgan acquisition (D0 NOT Excellent the Drovider (see instructions)   15. 00   0rgan acquisition (D0 NOT Excellent the Drovider (see instruction	11.00		0	11. 00
13. 00   Nursing and Allied Health Managed Care payment (see instruction)   13. 00   0rgan acquisition (D0 NOT USE THIS LINE)   14. 00   0rgan acquisition (D0 NOT USE THIS LINE)   14. 00   15. 00   1	12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)	1, 608, 765	12. 00
15. 00   Cost of physicians' services in a teaching hospital (see instructions)   15. 00   16. 00   Subtotal (see instructions)   1,608,765   16. 00   17.	13.00	Nursing and Allied Health Managed Care payment (see instruction)		13. 00
1.608,765   16.00   17.00	14.00	Organ acquisition (DO NOT USE THIS LINE)		14. 00
17. 00	15.00	Cost of physicians' services in a teaching hospital (see instructions)	0	15. 00
18.00   Subtotal (line 16 less line 17).   1,608,765   18.00   19.00   Deductibles   34,896   19.00   Coinsurance   4,830   21.00   Coinsurance   4,830   Coinsura	16.00	Subtotal (see instructions)	1, 608, 765	16. 00
19.00   Deductibles	17.00	Primary payer payments	0	17. 00
20.00   Subtotal (line 18 minus line 19)   1,523,869   20.00   21.00   Coinsurance   4,830   21.00   22.00   Subtotal (line 20 minus line 21)   1,519,039   22.00   23.00   Allowable bad debts (exclude bad debts for professional services) (see instructions)   0 23.00   24.00   Adjusted reimbursable bad debts (see instructions)   0 25.00   25.00   Allowable bad debts for dual eligible beneficiaries (see instructions)   0 25.00   25.00   Subtotal (sum of lines 22 and 24)   1,519,039   26.00   27.00   Direct graduate medical education payments (from Wkst. E-4, line 49)   0 27.00   Direct graduate medical education payments (from Wkst. E-4, line 49)   0 27.00   Outlier payments reconciliation   0 29.00   Outlier payments reconciliation   0 29.00   29.00   Outlier payments reconciliation   0 29.00   30.50   Pioneer ACO demonstration payment adjustment (see instructions)   0 30.50   20.00   20.	18.00	Subtotal (line 16 less line 17).	1, 608, 765	18. 00
21.00   Coinsurance   4,830   21.00   22.00   Subtotal (line 20 minus line 21)   1,519,039   22.00   23.00   Allowable bad debts (exclude bad debts for professional services) (see instructions)   0   23.00   24.00   25.00   Allowable bad debts for dual eligible beneficiaries (see instructions)   0   24.00   25.00	19.00	Deducti bl es	84, 896	19. 00
22.00   Subtotal (line 20 minus line 21)   1,519,039   22.00   23.00   Allowable bad debts (exclude bad debts for professional services) (see instructions)   0 23.00   24.00   Adjusted reimbursable bad debts (see instructions)   0 25.00   Allowable bad debts for dual eligible beneficiaries (see instructions)   0 25.00   Allowable bad debts for dual eligible beneficiaries (see instructions)   0 25.00   26.00   Subtotal (sum of lines 22 and 24)   1,519,039   26.00   27.00   Direct graduate medical education payments (from Wkst. E-4, line 49)   0 27.00   Other pass through costs (see instructions)   0 28.00   Other pass through costs (see instructions)   0 29.00   Outlier payments reconciliation   0 29.00   Outlier payments reconciliation   0 29.00   Outlier payments reconciliation   0 30.00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0 30.00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0 30.00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0 30.00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS)	20.00	Subtotal (line 18 minus line 19)	1, 523, 869	20. 00
23.00       Allowable bad debts (exclude bad debts for professional services) (see instructions)       0       23.00         24.00       Adjusted reimbursable bad debts (see instructions)       0       24.00         25.00       Allowable bad debts for dual eligible beneficiaries (see instructions)       0       25.00         26.00       Subtotal (sum of lines 22 and 24)       1,519,039       26.00         27.00       Direct graduate medical education payments (from Wkst. E-4, line 49)       0       27.00         28.00       Other pass through costs (see instructions)       0       28.00         29.00       Outlier payments reconciliation       0       29.00         30.00       OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)       0       30.00         30.50       Pioneer ACO demonstration payment adjustment (see instructions)       0       30.50         30.99       Recovery of Accelerated Depreciation       0       30.99         31.01       Sequestration adjustment (see instructions)       1,519,039       31.00         32.00       Interim payments       1,488,658       32.00         33.00       Tentative settlement (for contractor use only)       0       30.381         35.00       Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,       0	21.00	Coi nsurance	4, 830	21. 00
24.00       Adjusted reimbursable bad debts (see instructions)       0       24.00         25.00       Allowable bad debts for dual eligible beneficiaries (see instructions)       0       25.00         26.00       Subtotal (sum of lines 22 and 24)       1,519,039       26.00         27.00       Direct graduate medical education payments (from Wkst. E-4, line 49)       0       27.00         28.00       Other pass through costs (see instructions)       0       28.00         29.00       Outlier payments reconciliation       0       29.00         30.00       OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)       0       30.00         30.50       Pioneer ACO demonstration payment adjustment (see instructions)       0       30.00         30.99       Recovery of Accelerated Depreciation       0       30.99         31.01       Sequestration adjustment (see instructions)       1,519,039       31.00         31.01       Sequestration adjustment (see instructions)       30.99       1,488,658       32.00         33.00       Tentative settlement (for contractor use only)       33.00       33.00         34.00       Balance due provider/program (line 31 minus lines 31.01, 32 and 33)       0       34.00         35.15.2       TO BE COMPLETED BY CONTRACTOR       29,484	22.00	Subtotal (line 20 minus line 21)	1, 519, 039	22. 00
25.00 Allowable bad debts for dual eligible beneficiaries (see instructions)  26.00 Subtotal (sum of lines 22 and 24)  27.00 Direct graduate medical education payments (from Wkst. E-4, line 49)  28.00 Other pass through costs (see instructions)  29.00 Outlier payments reconciliation  30.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  30.50 Pioneer ACO demonstration payment adjustment (see instructions)  30.97 Recovery of Accelerated Depreciation  31.00 Total amount payable to the provider (see instructions)  31.01 Sequestration adjustment (see instructions)  32.00 Interim payments  33.00 Tentative settlement (for contractor use only)  34.00 Bal ance due provider/program (line 31 minus lines 31.01, 32 and 33)  35.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,  35.00 Original outlier amount from Worksheet E-3, Part II, line 2  37.00 Outlier reconciliation adjustment amount (see instructions)  38.00 Outlier reconciliation adjustment amount (see instructions)  39.90 Outlier reconciliation adjustment amount (see instructions)  40.00 Sequestration adjustment from Worksheet E-3, Part II, line 2  40.00 Outlier reconciliation adjustment amount (see instructions)  40.00 Sequestration adjustment from Worksheet E-3, Part II, line 2  40.00 Outlier reconciliation adjustment amount (see instructions)  40.00 Sequestration adjustment amount (see instructions)	23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	0	23. 00
26.00 Subtotal (sum of lines 22 and 24)  27.00 Direct graduate medical education payments (from Wkst. E-4, line 49)  28.00 Other pass through costs (see instructions)  30.00 OUTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  30.50 Pi oneer ACO demonstration payment adjustment (see instructions)  30.99 Recovery of Accelerated Depreciation  31.00 Total amount payable to the provider (see instructions)  31.01 Sequestration adjustment (see instructions)  32.00 Interim payments  33.00 Tentative settlement (for contractor use only)  34.00 Balance due provider/program (line 31 minus lines 31.01, 32 and 33)  35.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,  50.00 Original outlier amount from Worksheet E-3, Part II, line 2  Outlier reconciliation adjustment amount (see instructions)  The rate used to calculate the Time Value of Money  30.00 1,511,00 2,00 22,	24.00	Adjusted reimbursable bad debts (see instructions)	0	24. 00
27.00       Direct graduate medical education payments (from Wkst. E-4, line 49)       0       27.00         28.00       Other pass through costs (see instructions)       0       28.00         29.00       Outlier payments reconciliation       0       29.00         30.00       OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)       0       30.50         30.50       Pioneer ACO demonstration payment adjustment (see instructions)       0       30.50         30.99       Recovery of Accelerated Depreciation       0       30.96         31.00       Total amount payable to the provider (see instructions)       1,519,039       31.00         32.00       Interim payments       30.381       31.00         33.00       Tentative settlement (for contractor use only)       0       33.00         34.00       Balance due provider/program (line 31 minus lines 31.01, 32 and 33)       0       34.00         35.00       Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,       0       35.00         50.00       Original outlier amount from Worksheet E-3, Part II, line 2       29,484       50.00         51.00       Outlier reconciliation adjustment amount (see instructions)       0       51.00         50.00       The rate used to calculate the Time Value of Money       0.00	25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	25. 00
27.00       Direct graduate medical education payments (from Wkst. E-4, line 49)       0       27.00         28.00       Other pass through costs (see instructions)       0       28.00         29.00       Outlier payments reconciliation       0       29.00         30.00       OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)       0       30.50         30.50       Pioneer ACO demonstration payment adjustment (see instructions)       0       30.50         30.99       Recovery of Accelerated Depreciation       0       30.96         31.00       Total amount payable to the provider (see instructions)       1,519,039       31.00         32.00       Interim payments       30.381       31.00         33.00       Tentative settlement (for contractor use only)       0       33.00         34.00       Balance due provider/program (line 31 minus lines 31.01, 32 and 33)       0       34.00         35.00       Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,       0       35.00         50.00       Original outlier amount from Worksheet E-3, Part II, line 2       29,484       50.00         51.00       Outlier reconciliation adjustment amount (see instructions)       0       51.00         50.00       The rate used to calculate the Time Value of Money       0.00	26.00	Subtotal (sum of lines 22 and 24)	1, 519, 039	26. 00
28.00 Other pass through costs (see instructions) 0 28.00   29.00 Outlier payments reconciliation 0 29.00   30.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 30.00   30.50 Pioneer ACO demonstration payment adjustment (see instructions) 0 30.99 Recovery of Accel erated Depreciation 0 30.99   31.00 Total amount payable to the provider (see instructions) 1,519,039 31.00 Sequestration adjustment (see instructions) 30.91   32.00 Interim payments 30,381 31.01   32.00 Interim payments 1,488,658 32.00   33.00 Balance due provider/program (line 31 minus lines 31.01, 32 and 33) 0 34.00 Balance due provider/program (line 31 minus lines 31.01, 32 and 33) 0 34.00   35.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 35.00   35.00 Original outlier amount from Worksheet E-3, Part II, line 2    50.00 Outlier reconciliation adjustment amount (see instructions) 0 51.00   51.00 Outlier reconciliation adjustment amount (see instructions) 0 51.00   52.00 The rate used to calculate the Time Value of Money 0.00 52.00	27.00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	27. 00
29. 00       Outlier payments reconciliation       0       29. 00         30. 00       OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)       0       30. 00         30. 50       Pioneer ACO demonstration payment adjustment (see instructions)       0       30. 50         30. 99       Recovery of Accelerated Depreciation       0       30. 95         31. 00       Total amount payable to the provider (see instructions)       1, 519, 039       31. 01         32. 00       Interim payments       30, 381       31. 07         32. 00       Interim payments       1, 488, 658       32. 00         33. 00       Tentative settlement (for contractor use only)       0       33. 00         34. 00       Balance due provider/program (line 31 minus lines 31.01, 32 and 33)       0       34. 00         35. 00       Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0       0       35. 00         50. 00       Original outlier amount from Worksheet E-3, Part II, line 2       29, 484       50. 00         51. 00       Outlier reconciliation adjustment amount (see instructions)       0       51. 00         52. 00       The rate used to calculate the Time Value of Money       0. 00       52. 00	28. 00		0	28. 00
30. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 30. 50 Pi oneer ACO demonstration payment adjustment (see instructions) 30. 99 Recovery of Accelerated Depreciation 31. 00 Total amount payable to the provider (see instructions) 31. 01 Sequestration adjustment (see instructions) 32. 00 Interim payments 32. 00 Interim payments 33. 00 Tentative settlement (for contractor use only) 34. 00 Balance due provider/program (line 31 minus lines 31. 01, 32 and 33) 35. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 35. 00  50. 00 Original outlier amount from Worksheet E-3, Part II, line 2 50. 00 Outlier reconciliation adjustment amount (see instructions) 52. 00 The rate used to calculate the Time Value of Money 50. 00 The rate used to calculate the Time Value of Money 50. 00 The rate used to calculate the Time Value of Money 50. 00 The rate used to calculate the Time Value of Money 50. 00 The rate used to calculate the Time Value of Money 50. 00 The rate used to calculate the Time Value of Money 50. 00 The rate used to calculate the Time Value of Money 50. 00 The rate used to calculate the Time Value of Money 50. 00 The rate used to calculate the Time Value of Money 50. 00 The rate used to calculate the Time Value of Money 50. 00 The rate used to calculate the Time Value of Money 50. 00 The rate used to calculate the Time Value of Money 50. 00 The rate used to calculate the Time Value of Money	29.00	, ,	0	29. 00
30. 50 Pi oneer ACO demonstration payment adjustment (see instructions)  30. 99 Recovery of Accelerated Depreciation  31. 00 Total amount payable to the provider (see instructions)  31. 01 Sequestration adjustment (see instructions)  32. 00 Interim payments  33. 00 Tentative settlement (for contractor use only)  34. 00 Balance due provider/program (line 31 minus lines 31. 01, 32 and 33)  35. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 35. 00  50. 00 Original outlier amount from Worksheet E-3, Part II, line 2  50. 00 Outlier reconciliation adjustment amount (see instructions)  50. 00 The rate used to calculate the Time Value of Money  0 30. 50  30. 99  31. 00  30. 99  31. 00  31. 00  32. 00  33. 00  34. 00  35. 00  36. 00  37. 00  38. 00  39. 00  39. 00  30. 99  30. 99  30. 90  3			0	30.00
30. 99 Recovery of Accelerated Depreciation  Total amount payable to the provider (see instructions)  Sequestration adjustment (see instructions)  1, 519, 039 31. 00  Sequestration adjustment (see instructions)  30. 381 31. 00  Interim payments  Tentative settlement (for contractor use only)  31. 00 Balance due provider/program (line 31 minus lines 31. 01, 32 and 33)  Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 31. 02  TO BE COMPLETED BY CONTRACTOR  Original outlier amount from Worksheet E-3, Part II, line 2  Outlier reconciliation adjustment amount (see instructions)  The rate used to calculate the Time Value of Money  0 30. 99  1, 519, 039  31. 00  32. 00  1, 488, 658  32. 00  33. 00  34. 00  35. 00  36. 00  37. 00  38. 00  39. 99  30. 00  30. 99  30. 00  30. 99  31. 00  30. 99  30. 00  30. 99  30. 00  30. 99  30. 00  30. 99  31. 00  30. 99  30. 00  30. 99  30. 00  30. 99  30. 00  30. 99  31. 00  30. 99  30. 00  30. 99  30. 00  30. 99  30. 00  30. 99  31. 00  30. 99  30. 00  30. 99  30. 00  30. 99  30. 00  30. 99  31. 00  30. 99  30. 00  30. 99  30. 00  30. 99  30. 00  30. 99  31. 00  30. 99  30. 00  30. 99  30. 00  30. 99  30. 00  30. 99  31. 00  30. 99  30. 00  30. 99  30. 00  30. 99  30. 00  30. 99  31. 00  30. 99  30. 00  30. 99  30. 00  30. 00  30. 00  30. 00  30. 00  32. 00  33. 00  34. 00  35. 00  35. 00  35. 00  35. 00  35. 00  35. 00  35. 00  35. 00  35. 00  35. 00  35. 00  36. 00  37. 00  37. 00  38. 00  39	30. 50		0	30. 50
31.00   Total amount payable to the provider (see instructions)   1,519,039   31.00   31.01   Sequestration adjustment (see instructions)   30,381   31.07   32.00   Interim payments   1,488,658   32.00   33.00   Tentative settlement (for contractor use only)   0   33.00   34.00   Balance due provider/program (line 31 minus lines 31.01, 32 and 33)   0   34.00   35.00   Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,   0   35.00   The rate used to calculate the Time Value of Money   0.00   52.00   52.00   The rate used to calculate the Time Value of Money   0.00   52.00   30.			0	30. 99
31. 01 Sequestration adjustment (see instructions) 30, 381 31. 07 32. 00 Interim payments 31. 01 Interim payments 32. 00 Interim payments 33. 00 Tentative settlement (for contractor use only) 34. 00 Balance due provider/program (line 31 minus lines 31. 01, 32 and 33) 35. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 35. 00 Silborous Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 36. 00 Original outlier amount from Worksheet E-3, Part II, line 2 37. 00 Outlier reconciliation adjustment amount (see instructions) 30, 381 31. 07 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 38. 00 39. 00 39. 00 39. 00 30. 00		•	1, 519, 039	
32.00 Interim payments  1,488,658 32.00 33.00 Tentative settlement (for contractor use only) 34.00 Balance due provider/program (line 31 minus lines 31.01, 32 and 33) 35.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,  50.00 Original outlier amount from Worksheet E-3, Part II, line 2  50.00 Outlier reconciliation adjustment amount (see instructions)  The rate used to calculate the Time Value of Money  1,488,658 32.00 33.00 34.00 35.00  94.00 35.00 26.00 35.00 35.00 35.00 36.00 37.00 38.00 39.00 39.00 30.00 3				31. 01
33.00 Tentative settlement (for contractor use only)  34.00 Balance due provider/program (line 31 minus lines 31.01, 32 and 33)  35.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,  35.00 Original outlier amount from Worksheet E-3, Part II, line 2  50.00 Outlier reconciliation adjustment amount (see instructions)  52.00 The rate used to calculate the Time Value of Money  33.00 33.00 33.00 34.00 34.00 35.00 90 90 90 90 90 90 90 90 90 90 90 90 9				
34.00 Balance due provider/program (line 31 minus lines 31.01, 32 and 33)  35.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 35.00 St. 00 Original outlier amount from Worksheet E-3, Part II, line 2 29,484 50.00 Outlier reconciliation adjustment amount (see instructions) 0 51.00 The rate used to calculate the Time Value of Money 0.00 52.00				33.00
35.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2  TO BE COMPLETED BY CONTRACTOR  50.00 Original outlier amount from Worksheet E-3, Part II, line 2 29, 484 50.00 Outlier reconciliation adjustment amount (see instructions) 51.00 The rate used to calculate the Time Value of Money 0.00 52.00		· · · · · · · · · · · · · · · · · · ·		34.00
50.00 Original outlier amount from Worksheet E-3, Part II, line 2 51.00 Outlier reconciliation adjustment amount (see instructions) 52.00 The rate used to calculate the Time Value of Money 50.00 Original outlier amount from Worksheet E-3, Part II, line 2 51.00 Outlier reconciliation adjustment amount (see instructions) 51.00 Original outlier amount from Worksheet E-3, Part II, line 2 51.00 Original outlier amount from Worksheet E-3, Part II, line 2 51.00 Outlier reconciliation adjustment amount (see instructions) 52.00 Original outlier amount from Worksheet E-3, Part II, line 2 51.00 Original outlier amount from Worksheet E-3, Part II, line 2 51.00 Original outlier amount from Worksheet E-3, Part II, line 2 51.00 Original outlier amount from Worksheet E-3, Part II, line 2 51.00 Original outlier reconciliation adjustment amount (see instructions) 52.00 Original outlier reconciliation adjustment amount (see instructions)		Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	35. 00
51.00 Outlier reconciliation adjustment amount (see instructions)  52.00 The rate used to calculate the Time Value of Money  0 51.00 0.00 52.00				
52.00 The rate used to calculate the Time Value of Money 0.00 52.00				
		,	-	
53.00   Time Value of Money (see instructions) 0   53.00				
	53.00	Time Value of Money (see instructions)	0	53. 00

Health Financial Systems	FRANCISCAN HEALTH CRAWFORDSVILLE	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0022		Worksheet E-3 Part VII Date/Time Prepared: 6/28/2017 3:41 pm
	T		<u> </u>

			10 12/31/2016	Date/lime Pre 6/28/2017 3:4	
		Title XIX	Hospi tal	Cost	ı pııı
			Inpatient	Outpati ent	
			1. 00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SER	RVICES FOR TITLES V OR XI)	SERVI CES		
	COMPUTATION OF NET COST OF COVERED SERVICES				1
1.00	Inpatient hospital/SNF/NF services		972, 881		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)		972, 881	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)		972, 881	0	7. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonabl e Charges				
8.00	Routine service charges		0		8. 00
9. 00	Ancillary service charges		2, 019, 002	1, 958, 365	9. 00
	Organ acquisition charges, net of revenue		0		10. 00
	Incentive from target amount computation		0		11. 00
12. 00	Total reasonable charges (sum of lines 8 through 11)		2, 019, 002	1, 958, 365	12. 00
	CUSTOMARY CHARGES	<del></del>			
13. 00	Amount actually collected from patients liable for payment for	services on a charge	0	0	13. 00
44.00	basi s				44.00
14. 00	Amounts that would have been realized from patients liable for		0	0	14. 00
15. 00	a charge basis had such payment been made in accordance with 4 Ratio of line 13 to line 14 (not to exceed 1.000000)	12 CFR 9413. 13(e)	0. 000000	0. 000000	15. 00
16. 00	Total customary charges (see instructions)		2, 019, 002	1, 958, 365	1
17. 00	Excess of customary charges over reasonable cost (complete onl	v if line 16 evceeds	1, 046, 121	1, 958, 365	1
17.00	line 4) (see instructions)	y II IIIle 10 exceeds	1,040,121	1, 750, 505	17.00
18. 00	Excess of reasonable cost over customary charges (complete onl	vifline 4 exceeds line	0	0	18. 00
10.00	16) (see instructions)	y IT TITLE I EXCEEDED TITLE		Ü	10.00
19. 00	Interns and Residents (see instructions)		0	0	19.00
	Cost of physicians' services in a teaching hospital (see instr	ructions)	0	0	20.00
21. 00	Cost of covered services (enter the lesser of line 4 or line 1		972, 881	0	21. 00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be				
22. 00	Other than outlier payments		0	0	22. 00
23. 00	Outlier payments		0	0	23. 00
24.00	Program capital payments		0		24. 00
25.00	Capital exception payments (see instructions)		0		25. 00
	Routine and Ancillary service other pass through costs		0	0	26. 00
27. 00	Subtotal (sum of lines 22 through 26)		0	0	27. 00
	Customary charges (title V or XIX PPS covered services only)		0	0	
29. 00	Titles V or XIX (sum of lines 21 and 27)		972, 881	0	29. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
	Excess of reasonable cost (from line 18)		0	0	
	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	l e e e e e e e e e e e e e e e e e e e	972, 881	0	
	Deducti bl es		0	0	
	Coinsurance		0	0	
	Allowable bad debts (see instructions)		0	0	34.00
	Utilization review	>	0	_	35. 00
	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	1 33)	972, 881	0	36. 00
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		070 001	0	
	Subtotal (line 36 ± line 37)		972, 881	0	38. 00
	Direct graduate medical education payments (from Wkst. E-4)		072 001	0	39. 00
	Total amount payable to the provider (sum of lines 38 and 39)		972, 881	0	40.00
	Interim payments		972, 881	0	
42.00			0	0	
43. 00	chapter 1, §115.2	ICE WI LII CWS PUD 15-2,		Ü	43.00
	Shaptor 1, 3110.2		1		ı

Health Financial Systems	FRANCISCAN HEALTH CRAWFORDSVILLE	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0022	Peri od: From 01/01/2016	Worksheet E-3
	Component CCN: 15-S022		
	Title XIX	Subprovi der -	Cost
		. I PF	

		THE XIX	IPF	0031	
			Inpatient	Outpati ent	
			1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICE	S FOR TITLES V OR XIX	SERVI CES		
	COMPUTATION OF NET COST OF COVERED SERVICES				İ
1.00	Inpatient hospital/SNF/NF services		21, 871		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)		21, 871	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)		21, 871	0	7. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonable Charges				
8.00	Routine service charges		0		8.00
9. 00	Ancillary service charges		O	0	9. 00
10.00	Organ acquisition charges, net of revenue		O		10.00
11. 00	Incentive from target amount computation		O		11.00
12. 00	Total reasonable charges (sum of lines 8 through 11)		0	0	•
	CUSTOMARY CHARGES		· · · · · · · · · · · · · · · · · · ·		
13.00	Amount actually collected from patients liable for payment for ser	vices on a charge	0	0	13.00
	basis	3			
14.00	Amounts that would have been realized from patients liable for pay	ment for services on	0	0	14. 00
	a charge basis had such payment been made in accordance with 42 CF	R §413.13(e)			
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15. 00
16.00	Total customary charges (see instructions)		0	0	16. 00
17.00	Excess of customary charges over reasonable cost (complete only if	Fline 16 exceeds	0	0	17. 00
	line 4) (see instructions)				
18.00	Excess of reasonable cost over customary charges (complete only if	Fline 4 exceeds line	21, 871	0	18. 00
	16) (see instructions)				
19. 00	Interns and Residents (see instructions)		0	0	19. 00
20.00	Cost of physicians' services in a teaching hospital (see instructi	ons)	0	0	20. 00
21. 00	Cost of covered services (enter the lesser of line 4 or line 16)		0	0	21. 00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be comp	leted for PPS provide	rs.		
	Other than outlier payments		0	0	
23.00	Outlier payments		0	0	23. 00
24.00	Program capital payments		0		24. 00
	Capital exception payments (see instructions)		0		25. 00
26. 00	Routine and Ancillary service other pass through costs		0	0	
27. 00	Subtotal (sum of lines 22 through 26)		0	0	
28. 00	Customary charges (title V or XIX PPS covered services only)		0	0	28. 00
29. 00	Titles V or XIX (sum of lines 21 and 27)		0	0	29. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)		21, 871	0	1
31. 00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		0	0	31. 00
32.00	Deducti bl es		0	0	
33.00	Coinsurance		0	0	
34.00	Allowable bad debts (see instructions)		0	0	34. 00
35.00	Utilization review		0		35. 00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	l .	0	0	36. 00
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	
38. 00			0	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	0	
41.00	Interim payments		0	0	
42.00	Balance due provider/program (line 40 minus line 41)		0	0	42. 00
43.00	Protested amounts (nonallowable cost report items) in accordance w	vith CMS Pub 15-2,	0	0	43. 00
	chapter 1, §115.2				

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

Provider CCN: 15-0022 Period: From 01/

| Period: | Worksheet G | From 01/01/2016 | To 12/31/2016 | Date/Time Prepared: 6/28/2017 3:41 pm |

oni y)				12/01/2010	6/28/2017 3: 4	1 pm
		General Fund	Speci fi c	Endowment Fund	Plant Fund	
		1.00	Purpose Fund 2.00	3. 00	4. 00	
	CURRENT ASSETS	11.00	2.00	0.00	11 00	
1.00	Cash on hand in banks	83, 928	•	0	0	1
2.00	Temporary investments	1, 134, 387	(	-	0	
3. 00 4. 00	Notes recei vabl e Accounts recei vabl e	4 002 047	(	0	0	
5.00	Other receivable	6, 982, 947			0	
6.00	Allowances for uncollectible notes and accounts receivable	ا			0	
7.00	Inventory	1, 032, 444		0	0	
8.00	Prepai d expenses	0	(	0	0	
9.00	Other current assets	4, 337, 348		0	0	
10.00	Due from other funds	0	(	-	0	1
11. 00	Total current assets (sum of lines 1-10) FIXED ASSETS	13, 571, 054		0	0	11. 00
12. 00	Land	0		0	0	12. 00
13. 00	Land improvements	0		-	0	
14. 00	Accumulated depreciation	Ö		o o		
15.00	Bui I di ngs	0	(	o	0	15. 00
16.00	Accumulated depreciation	0	(	0	0	
17. 00	Leasehold improvements	0	(	0	0	
18.00	Accumulated depreciation	0	(	0	0	
19.00	Fixed equipment	25, 693, 809	(	0	0	
20. 00 21. 00	Accumulated depreciation Automobiles and trucks	0		0	0 0	
22. 00	Accumulated depreciation	0		-	0	
23. 00	Major movable equipment	0		-	0	
24. 00	Accumulated depreciation	Ö		o o	0	
25.00	Mi nor equi pment depreci abl e	0	(	0	0	25. 00
26.00	Accumulated depreciation	0	(	0	0	26. 00
27. 00	HIT designated Assets	0	(	0	0	
28. 00	Accumulated depreciation	0	(	-	0	
29. 00	Mi nor equi pment-nondepreci abl e	0	(	-	0	
30. 00	Total fixed assets (sum of lines 12-29) OTHER ASSETS	25, 693, 809		0	0	30.00
31. 00	Investments	4, 479, 617		0	0	31. 00
32. 00	Deposits on Leases	0		-	0	
33.00	Due from owners/officers	0	(	0	0	
34.00	Other assets	0	(	0	0	34.00
35. 00	Total other assets (sum of lines 31-34)	4, 479, 617		_	0	1
36. 00	Total assets (sum of lines 11, 30, and 35)	43, 744, 480	(	0	0	36. 00
27 00	CURRENT LIABILITIES	2 140 024		0	0	27.00
37. 00 38. 00	Accounts payable Salaries, wages, and fees payable	2, 140, 026		-	0	
39. 00	Payroll taxes payable	846, 819		-	0	
40.00	Notes and Loans payable (short term)	0 10, 017		o o	0	
41.00	Deferred income	0		0	0	
42.00	Accel erated payments	0				42. 00
43.00	Due to other funds	-347, 489		0	0	
44.00	Other current liabilities	115, 151		1	0	
45. 00	Total current liabilities (sum of lines 37 thru 44)	2, 754, 507	(	0	0	45. 00
46. 00	LONG TERM LIABILITIES  Mortgage payable	Ι ο			0	46. 00
47. 00	Notes payable	0	1		-	
48. 00	Unsecured Loans	0		-	0	1
49. 00	Other long term liabilities	-2, 537, 787		-	0	
50.00	Total long term liabilities (sum of lines 46 thru 49)	-2, 537, 787		0	0	50.00
51. 00	Total liabilities (sum of lines 45 and 50) CAPITAL ACCOUNTS	216, 720	(	0	0	51.00
52.00	General fund balance	43, 527, 760				52. 00
53.00	Specific purpose fund	, , , , , , , , , , , , , , , , , , , ,				53. 00
54.00	Donor created - endowment fund balance - restricted			0		54. 00
55. 00	Donor created - endowment fund balance - unrestricted			0		55. 00
56.00	Governing body created - endowment fund balance			0		56. 00
57. 00	Plant fund balance - invested in plant				0	1
58. 00	Plant fund balance - reserve for plant improvement,				0	58. 00
59. 00	replacement, and expansion Total fund balances (sum of lines 52 thru 58)	43, 527, 760			0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and	43, 744, 480			0	
	[59]		]			
				•		-

					To	12/31/2016	Date/Time Pro 6/28/2017 3:4	pared: 1 pm
		General	Fund	Speci al	Pu	rpose Fund	Endowment Fund	
		1.00	2. 00	3. 00		4. 00	5. 00	
1.00	Fund balances at beginning of period		39, 945, 000			0		1.00
2. 00 3. 00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2)		6, 801, 097 46, 746, 097			0		2. 00 3. 00
4. 00	Additions (credit adjustments) (specify)	О	40, 740, 077		0	O	o	
5.00		0			0		O	
6.00		0			0		0	
7. 00 8. 00		0			0			
9. 00					0			
10.00	Total additions (sum of line 4-9)		0			0	-	10.00
11. 00	Subtotal (line 3 plus line 10)		46, 746, 097			0	l	11. 00
12.00	ADJUST TO AFS	3, 218, 337			0			1
13. 00 14. 00					0			
15. 00		O			0		Ö	
16. 00		0			0		0	1
17. 00	T + 1 + 1 + 1 + 1 + 1 + 1 + 1 + 1 + 1 +	0	0.040.007		0		0	1
18. 00 19. 00	Total deductions (sum of lines 12-17) Fund balance at end of period per balance		3, 218, 337 43, 527, 760			0	l .	18. 00 19. 00
	sheet (line 11 minus line 18)		43, 321, 100			0		17.00
		Endowment Fund	PI ant	Fund				
		6.00	7. 00	8.00				
1. 00	Fund balances at beginning of period	0	71.00	0.00	0			1. 00
2.00	Net income (loss) (from Wkst. G-3, line 29)							2. 00
3. 00 4. 00	Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	0	0		0			3. 00 4. 00
4. 00 5. 00	Additions (credit adjustments) (specify)		0					5. 00
6. 00			0					6. 00
7.00			0					7. 00
8. 00 9. 00			0					8. 00
10.00	Total additions (sum of line 4-9)	0	U		0			9. 00 10. 00
11. 00	Subtotal (line 3 plus line 10)	o o			0			11. 00
12.00	ADJUST TO AFS		0					12. 00
13.00			0					13.00
14. 00 15. 00			0					14. 00 15. 00
16. 00			0					16. 00
17. 00			0					17. 00
18.00	Total deductions (sum of lines 12-17)	0			0			18.00
19. 00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0			0			19. 00

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

			10 12/31/2016	Date/lime Pre 6/28/2017 3:4	
	Cost Center Description	Inpatient	Outpati ent	Total	
	·	1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospi tal	4, 519, 23	9	4, 519, 239	1. 00
2.00	SUBPROVI DER - I PF	3, 599, 86	9	3, 599, 869	2. 00
3.00	SUBPROVI DER - I RF		0	0	3. 00
4.00	SUBPROVI DER		0	0	4. 00
5.00	Swing bed - SNF		0	0	5. 00
6.00	Swing bed - NF		0	0	6. 00
7. 00	SKILLED NURSING FACILITY		0	0	7. 00
8.00	NURSI NG FACILITY		0	0	8. 00
8. 01	I CF/MR		0	0	8. 01
9. 00	OTHER LONG TERM CARE		0	0	9. 00
10. 00	Total general inpatient care services (sum of lines 1-9)	8, 119, 10	8	8, 119, 108	10. 00
	Intensive Care Type Inpatient Hospital Services	1 000 54		4 000 544	
11.00	INTENSIVE CARE UNIT	1, 988, 51		1, 988, 516	11.00
12.00	CORONARY CARE UNIT		0	0	12.00
13.00	BURN INTENSIVE CARE UNIT		0	0	13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15. 00	OTHER SPECIAL CARE (SPECIFY)	1 000 51		1 000 51/	15.00
16. 00	Total intensive care type inpatient hospital services (sum of lines	1, 988, 51	0	1, 988, 516	16. 00
17. 00	11-15)   Total inpatient routine care services (sum of lines 10 and 16)	10, 107, 62	4	10, 107, 624	17. 00
18. 00	Ancillary services	23, 618, 02		136, 983, 507	18.00
19. 00	Outpatient services	2, 008, 62		22, 939, 973	19.00
20. 00	RURAL HEALTH CLINIC		0 20, 931, 344	22, 939, 973	20.00
21. 00	FEDERALLY QUALIFIED HEALTH CENTER		0 0	0	21.00
22. 00	HOME HEALTH AGENCY		U U	U	22.00
23. 00	AMBULANCE SERVICES				23. 00
24. 00	CMHC				24.00
24. 10	CORF		0	0	24. 10
25. 00	AMBULATORY SURGICAL CENTER (D. P. )		0 0	Ö	25. 00
26. 00	HOSPI CE		0	0	26. 00
27. 00	THOSE TOE		0 0	0	27. 00
27. 01			0 0	0	27. 01
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst	. 35, 734, 27	3 134, 296, 831	170, 031, 104	28. 00
	G-3, line 1)				
	PART II - OPERATING EXPENSES	<u> </u>			
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		45, 606, 545		29. 00
30.00			0		30. 00
31.00			0		31. 00
32.00			0		32. 00
33.00			0		33. 00
34.00			0		34.00
35.00			0		35. 00
36.00	Total additions (sum of lines 30-35)		0		36. 00
37. 00			0		37. 00
38. 00			0		38. 00
39. 00			0		39. 00
40.00			0		40. 00
41. 00			0		41. 00
42.00	Total deductions (sum of lines 37-41)		0		42. 00
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)(trans	fer	45, 606, 545		43. 00
	to Wkst. G-3, line 4)				l

Health Financial Systems FRANCISCAN HEALTH CRAWFORDSVILLE	In Lieu of Form CMS-2552-10
STATEMENT OF REVENUES AND EXPENSES Provider CCN: 15-0022 Period:	Worksheet G-3
From 01/0 To 12/3	01/2016 31/2016 Date/Time Prepared: 6/28/2017 3:41 pm
	1. 00
1.00 Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	170, 031, 104 1. 00
2.00 Less contractual allowances and discounts on patients' accounts	118, 669, 272 2. 00
3.00 Net patient revenues (line 1 minus line 2)	51, 361, 832 3. 00
4.00 Less total operating expenses (from Wkst. G-2, Part II, line 43)	45, 606, 545 4. 00
5.00 Net income from service to patients (line 3 minus line 4)	5, 755, 287 5. 00
OTHER I NCOME	25 440 7 00
6.00 Contributions, donations, bequests, etc	35, 440 6.00
7.00   Income from investments	5, 295 7. 00
8.00 Revenues from telephone and other miscellaneous communication services 9.00 Revenue from television and radio service	0 8.00
10. 00   Purchase di scounts	0 9.00
	0 10.00
	0 11.00
12.00   Parking Lot receipts 13.00   Revenue from Laundry and Linen service	17, 022 13. 00
14.00 Revenue from meals sold to employees and quests	0 14.00
15.00 Revenue from rental of living quarters	0 15.00
16.00 Revenue from sale of medical and surgical supplies to other than patients	0 16.00
17.00 Revenue from sale of drugs to other than patients	0 17.00
18.00 Revenue from sale of medical records and abstracts	1, 580 18. 00
19.00 Tuition (fees, sale of textbooks, uniforms, etc.)	0 19.00
20.00 Revenue from gifts, flowers, coffee shops, and canteen	0 20.00
21. 00 Rental of vending machines	87, 651 21. 00
22.00 Rental of hospital space	39, 482 22. 00
23.00 Governmental appropriations	0 23.00
24. 00 OTHER OPERATING REVEN	859. 340 24. 00
25. 00 Total other income (sum of lines 6-24)	1, 045, 810 25. 00
26. 00   Total (line 5 plus line 25)	6, 801, 097 26. 00
27. 00 OTHER EXPENSES (SPECIFY)	0 27.00
28.00 Total other expenses (sum of line 27 and subscripts)	0 28.00
29.00 Net income (or loss) for the period (line 26 minus line 28)	6, 801, 097 29. 00
	, 2,223,233,270

Hool +b	Financial Systems FRANCISCAN HEALTH C	PDAWEODDSVIII E	In Lie	u of Form CMS '	DEE2 10
	FINANCI SCAN HEALTH C ATION OF CAPITAL PAYMENT	Provi der CCN: 15-0022	Peri od: From 01/01/2016 To 12/31/2016		pared:
		Title XVIII	Hospi tal	PPS	
	DART I FILLY PROCRECTIVE METHOD			1. 00	
	PART I - FULLY PROSPECTIVE METHOD				
1. 00	CAPITAL FEDERAL AMOUNT Capital DRG other than outlier			352, 904	1. 00
1. 00	Model 4 BPCI Capital DRG other than outlier			352, 904	1. 00
2. 00	Capital DRG outlier payments			3, 652	2.00
2. 00	Model 4 BPCI Capital DRG outlier payments			0,032	2.00
3. 00	Total inpatient days divided by number of days in the cost re	enorting period (see inst	ructions)	9. 11	3. 00
4. 00	Number of interns & residents (see instructions)	portring period (see That	1 40 (1 0113)	0.00	
5. 00	Indirect medical education percentage (see instructions)			0.00	
6. 00	Indirect medical education adjustment (multiply line 5 by the	e sum of lines 1 and 1.01	. columns 1 and	0	6. 00
	1.01) (see instructions)		,	-	
7.00	Percentage of SSI recipient patient days to Medicare Part A p	oatient days (Worksheet E	, part A line	0.00	7. 00
	30) (see instructions)				
8. 00	Percentage of Medicaid patient days to total days (see instru	uctions)		0. 00	
9. 00	Sum of lines 7 and 8	_		0.00	
10.00	Allowable disproportionate share percentage (see instructions	5)		0. 00 0	
11. 00					11. 00
12. 00	12.00   Total prospective capital payments (see instructions)				12. 00
				1. 00	
	PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)			0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)			0	2. 00
3.00	Total inpatient program capital cost (line 1 plus line 2)			0	3. 00
4.00	Capital cost payment factor (see instructions)			0	4. 00
5.00	Total inpatient program capital cost (line 3 x line 4)			0	5. 00
				1. 00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS		<u> </u>	1.00	
1. 00	Program inpatient capital costs (see instructions)			0	1.00
2.00	Program inpatient capital costs for extraordinary circumstance	ces (see instructions)		0	2. 00
3.00	Net program inpatient capital costs (line 1 minus line 2)	,		0	3. 00
4.00	Applicable exception percentage (see instructions)			0.00	4. 00
5.00	Capital cost for comparison to payments (line 3 x line 4)			0	5. 00
6.00	Percentage adjustment for extraordinary circumstances (see ir	nstructions)		0.00	6. 00
7.00	Adjustment to capital minimum payment level for extraordinary	, circumstances (line 2 x	(line 6)	0	7. 00
8.00	Capital minimum payment level (line 5 plus line 7)			0	8. 00
9.00	Current year capital payments (from Part I, line 12, as appli	cabl e)		0	9. 00
10.00	Current year comparison of capital minimum payment level to c	capital payments (line 8	less line 9)	0	10.00
11. 00	Carryover of accumulated capital minimum payment level over of	capital payment (from pri	or year	0	11. 00
10.00	Worksheet L, Part III, line 14)		- 11)	_ ا	10.00
12.00				0	12.00
13.00					13.00
14. 00		capital payment for the f	orrowing period	0	14. 00
15. 00	(if line 12 is negative, enter the amount on this line) Current year allowable operating and capital payment (see ins	etructions)		0	15. 00
	Current year operating and capital costs (see instructions)	511 4011 0113)		0	16. 00
50	, learners year energer amount (ede : netraction)				