payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g).

OMB NO. 0938-0050

EXPIRES 05-31-2019

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION Provider CCN: 15-0109 Period: From 01/01/2016 Parts I-III Date/Time Prepared: 6/28/2017 3:38 pm

				10 12/31/2010	6/28/2017 3:	
PART I - COST	REPORT STATUS				., ., ., ., .,	
Provi der use only	1. [ X ] Electronically filed cost 2. [ ] Manually submitted cost r	•		Date: 6/28/20	17 Time:	3: 38 pr
,	3. [ 0 ] If this is an amended rep 4. [ F ] Medicare Utilization. Ent			resubmitted this co	ost report	
Contractor use only	(2) Settled without Audit 8. [	Contractor No.	this Provider CCN 12.	NPR Date: .Contractor's Vendc .[ 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 LAFAYETTE (15-0109) 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.

(Signed)\_\_\_\_\_\_Officer or Administrator of Provider(s)

-21, 300

-518, 155

0 200. 00

Title XVIII Part A Title XIX Title V HI T Cost Center Description Part B 1.00 2.00 3.00 4.00 5.00 PART III - SETTLEMENT SUMMARY 1.00 Hospi tal 526, 858 -21, 300 -518, 155 2.00 Subprovider - IPF 0 Λ 2.00 0 3.00 Subprovider - IRF -8, 097 0 3.00 SUBPROVI DER I 4.00 4.00 Swing bed - SNF Swing bed - NF 5.00 5.00 C 0 0 6.00 0 6.00 HOME HEALTH AGENCY I 9.00 0 0 9.00 RURAL HEALTH CLINIC I 0 10.00 0 0 10.00 11.00 FEDERALLY QUALIFIED HEALTH CENTER I 0 0 11 00

Date

518, 761

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-MEDI CARE.

200.00 Total

	used in the pirol cost reporting period? In cordini 2	z, enter i	TOT yes c	N IOI I	10.			
		In-State	In-State	Out-of	Out-of	Medi cai d	0ther	
		Medi cai d	Medi cai d	State	State	HMO days	Medi cai d	
		paid days	eligible	Medi cai d	Medi cai d		days	
		, ,	unpai d	paid days	eligible			
			days		unpai d			
		1.00	2. 00	3. 00	4. 00	5. 00	6. 00	
24. 00	If this provider is an IPPS hospital, enter the	5, 480	0	123	0	6, 180	0	24. 00
	in-state Medicaid paid days in column 1, in-state							
	Medicaid eligible unpaid days in column 2,							
	out-of-state Medicaid paid days in column 3,							
	out-of-state Medicaid eligible unpaid days in column							
	4, Medicaid HMO paid and eligible but unpaid days in							
	column 5, and other Medicaid days in column 6.							

Health Financial Systems FRANCISC	AN HEALTH	LAFAYETTE		In Lieu of Form CMS-2552-				2552-10	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA						Period: Worksheet S- From 01/01/2016 Part I			
						To 12/31/2016 Date/Time P			
	In-State	In-State	Out-of	Out-of	Medi ca		<u>2017 3:3</u> Other	b pm	
	Medicaid paid days		State Medicaid	State Medi cai d	HMO da	ays M	edi cai d days		
	paru uays	unpai d	paid days	el i gi bl e			uays		
	1.00	days	2.00	unpai d	F 00		/ 00	_	
25.00 If this provider is an IRF, enter the in-state	1.00	2. 00	3.00	4. 00	5. 00	177	6. 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/Rural S Date of Geogr									
26.00 Enter your standard geographic classification (not wa	age) statu	is at the bed	ainnina of t	he 1.	00 1	2	. 00	26. 00	
cost reporting period. Enter "1" for urban or "2" for	rural.	_							
27.00 Enter your standard geographic classification (not war reporting period. Enter in column 1, "1" for urban or				t	1			27. 00	
enter the effective date of the geographic reclassifi	cation in	column 2.			0			25.00	
35.00 If this is a sole community hospital (SCH), enter the effect in the cost reporting period.	e number o	or periods so	LH Status In		0			35. 00	
				Begi n	ni ng: 00		di ng: . 00		
36.00 Enter applicable beginning and ending dates of SCH s	tatus. Sub	script line	36 for numb		00		. 00	36. 00	
of periods in excess of one and enter subsequent date 37.00 If this is a Medicare dependent hospital (MDH), enter		er of period	de MDH etatu		0			37. 00	
is in effect in the cost reporting period.		•			Ü				
37.01 Is this hospital a former MDH that is eligible for the accordance with FY 2016 OPPS final rule? Enter "Y" for instructions)				1	N			37. 01	
38.00 If line 37 is 1, enter the beginning and ending dates								38. 00	
greater than 1, subscript this line for the number of enter subsequent dates.	f peri ods	in excess of	one and						
				Υ,			//N		
39.00 Does this facility qualify for the inpatient hospital	payment	adjustment f	for low volu		00 V	2	. 00 N	39. 00	
hospitals in accordance with 42 CFR §412.101(b)(2)(ii									
or "N" for no. Does the facility meet the mileage red CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes	or "N" fo	r no. (see i	nstructi ons						
40.00 Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octol					N		N	40. 00	
no in column 2, for discharges on or after October 1.									
					1. 00	XVI I 2. 00		-	
Prospective Payment System (PPS)-Capital								15.00	
45.00 Does this facility qualify and receive Capital paymer with 42 CFR Section §412.320? (see instructions)	nt for dis	proporti onat	te share in	accordance	N	Y	N	45. 00	
46.00 Is this facility eligible for additional payment excepursuant to 42 CFR §412.348(f)? If yes, complete Wks					N	N	N	46. 00	
Pt. III. 47.00 Is this a new hospital under 42 CFR §412.300 PPS capi	tal? Ent	er "Y for ye	es or "N" fo	r no.	N	N	N	47. 00	
48.00 Is the facility electing full federal capital paymen Teaching Hospitals	t? Enter	"Y" for yes	or "N" for	no.	N	N	N	48. 00	
56.00 Is this a hospital involved in training residents in	approved	GME programs	? Enter "Y	" for yes	N			56. 00	
or "N" for no. 57.00 If line 56 is yes, is this the first cost reporting;	neriod dur	ing which re	esidents in	annroved				57.00	
GME programs trained at this facility? Enter "Y" for	yes or "	N" for no ir	n column 1.	lf column				07.00	
is "Y" did residents start training in the first monfor yes or "N" for no in column 2. If column 2 is "					.				
"N", complete Wkst. D, Parts III & IV and D-2, Pt. II	, if appl	i cabl e.						F0.00	
58.00 If line 56 is yes, did this facility elect cost reiml defined in CMS Pub. 15-1, chapter 21, §2148? If yes,			ans service	s as	N			58. 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				ho	N Y			59. 00 60. 00	
provi der-operated criteria under §413.85? Enter "Y"					T			60.00	
	Y/N	IME	Direct GM	E IN	ИE	Di re	ct GME		
	1. 00	2. 00	3. 00	4.	00		. 00		
61.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in					0. 00	_	0. 00	61.00	
column 1. (see instructions)									
61.01 Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports		0.00	0	. 00				61. 01	
ending and submitted before March 23, 2010. (see									
i nstructi ons)	1 1		I	I		l		I	

Health Financial Systems FRANCISC HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA		TH LAFAYETTE Provider CC		eriod: rom 01/01/2016	Date/Time Pre	pared:
	Y/N	IME	Direct GME	IME	6/28/2017 3:3 Direct GME	o piii
	1. 00	2. 00	3. 00	4.00	5. 00	-
61.02 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				61. 02
61.03 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	0.00			61. 03
61.04 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. 04
61.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0. 00	0.00			61. 05
61.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)	0.0		0.00			61. 06
	Pr	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
61.10 Of the FTEs in line 61.05, specify each new program		1. 00	2. 00	3.00	4.00	61. 10
specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.  61.20 Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.				0. 00	0. 00	61. 20
					1.00	
ACA Provisions Affecting the Health Resources and Ser						
62.00 Enter the number of FTE residents that your hospital your hospital received HRSA PCRE funding (see instruction of FTE residents that rotated from a during in this cost reporting period of UNSA THE production.	ti ons) Teachi	ng Health Cent	ter (THC) into			62. 00
during in this cost reporting period of HRSA THC prog Teaching Hospitals that Claim Residents in Nonprovide	er Sett	i ngs				1
63.00 Has your facility trained residents in nonprovider se "Y" for yes or "N" for no in column 1. If yes, comple				eriod? Enter	N	63. 00
			Unwei ghted FTEs Nonprovi der	Unwei ghted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
			Si te 1. 00	2.00	3.00	
Section 5504 of the ACA Base Year FTE Residents in No						
period that begins on or after July 1, 2009 and before 64.00 Enter in column 1, if line 63 is yes, or your facilit in the base year period, the number of unweighted non resident FTEs attributable to rotations occurring in settings. Enter in column 2 the number of unweighted resident FTEs that trained in your hospital. Enter in of (column 1 divided by (column 1 + column 2)). (see	y trair -primar all nor   non-pr   columr	ned residents ry care nprovider rimary care n 3 the ratio	0.00	0. 00	0. 000000	64.00
Program Name		ogram Code	Unwei ghted	Unwei ghted	Ratio (col. 3/	

Program Name

1.00

Unwei ghted FTEs

Nonprovi der Si te

3. 00

Program Code

2.00

Unweighted FTEs in

Hospi tal

4.00

Ratio (col. 3/ (col. 3 + col. 4))

5.00

			To	12/31/2016	Date/Time Prep 6/28/2017 3:30	
	Program Name	Program Code	Unwei ghted FTEs Nonprovi der	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
			Si te	nospi tai	4//	
(5.00 E.)	1.00	2. 00	3. 00	4.00	5.00	<b>45.00</b>
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 i 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	n		0.00	0.00	0. 000000	65.00
4)). (see instructions)						
			Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
			1. 00	2.00	3.00	
Section 5504 of the ACA Currer beginning on or after July 1,		n Nonprovider Setting	sEffective fo	r cost reporti	ng peri ods	
66.00 Enter in column 1 the number of FTEs attributable to rotations Enter in column 2 the number of FTEs that trained in your hosp (column 1 divided by (column 1	of unweighted non-primal coccurring in all nonport funweighted non-primal ital. Enter in column + column 2)). (see in:	rovider settings. ry care resident 3 the ratio of	0.00	0. 00	0. 000000	66. 00
	Program Name	Program Code	Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
	1.00	2. 00	3. 00	4. 00	5. 00	
67.00 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents.  Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributabl to rotations occurring in all non-provider settings. Enter i 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)	e n		0.00	0.00	0. 000000	67. 00
				1.00	2 2 00 2 00	
Inpatient Psychiatric Facility	PPS			1.00	0   2.00   3.00	
70.00 Is this facility an Inpatient	Psychiatric Facility (	IPF), or does it conta	ain an IPF subp	rovi der? N		70. 00
Enter "Y" for yes or "N" for 71.00 If line 70 yes: Column 1: Did		pproved GME teaching p	orogram in the	most		71. 00

71.00 If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 0 71.00 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 subprovider? Enter "Y" for yes and "N" for no. 75.00 If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most Ν Ν 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)

Health Financial Systems FRANCISCAN HEALT	ΓΗ LAFAYETTE		In Li	eu of Form CMS	S-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der Co	CN: 15-0109	Period: From 01/01/201 To 12/31/201	6 Date/Time Pi	repared:
				6/28/2017 3:	: 36 pili
Long Term Care Hospital PPS				1.00	
80.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes 81.00 Is this a LTCH co-located within another hospital for part or "Y" for yes and "N" for no.			ng period? Enter	- N	80. 00 81. 00
TEFRA Providers  85.00   Is this a new hospital under 42 CFR Section §413.40(f)(1)(i)  86.00   Did this facility establish a new Other subprovider (excluded to the facility of the stable of the facility of the stable of the subprovider (excluded to the facility of the stable of the subprovider).				N	85. 00 86. 00
\$413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.  87.00 Is this hospital a "subclause (II)" LTCH classified under ser for yes or "N" for no.	ction 1886(d)	(1) (B) (i v) (I I	)? Enter "Y"	N	87. 00
profit yes of the for ho.			V 1. 00	XI X 2. 00	
Title V and XIX Services					
90.00 Does this facility have title V and/or XIX inpatient hospital yes or "N" for no in the applicable column.	I services? E	nter "Y" for	N	Y	90. 00
91.00 Is this hospital reimbursed for title V and/or XIX through the full or in part? Enter "Y" for yes or "N" for no in the appliance.			N	Y	91. 00
92.00 Are title XIX NF patients occupying title XVIII SNF beds (duinstructions) Enter "Y" for yes or "N" for no in the applical		on)? (see		N	92. 00
93.00 Does this facility operate an ICF/IID facility for purposes "Y" for yes or "N" for no in the applicable column.	of title V and	d XIX? Enter	N	N	93. 00
94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, applicable column.	and "N" for no	o in the	N	N	94. 00
95.00   If line 94 is "Y", enter the reduction percentage in the app 96.00   Does title V or XIX reduce operating cost? Enter "Y" for yes			0. 00 N	0. 00 N	95. 00 96. 00
applicable column. 97.00 If line 96 is "Y", enter the reduction percentage in the app	licable column	า.	0. 00	0.00	97. 00
Rural Providers  105.00 Does this hospital qualify as a critical access hospital (CA)			N		105. 00
106.00 If this facility qualifies as a CAH, has it elected the all- for outpatient services? (see instructions)	inclusive metH	nod of paymer	it		106. 00
107.00 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. reimbursed. If yes complete Wkst. D-2, Pt. II.  108.00 Is this a rural hospital qualifying for an exception to the	1. (see insti 25 and the p	ructions) If rogram is cos			107. 00
CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	Dhyoi ool	l Ossumati and	.l Cnaach	Dooni rotori	
	Physi cal 1.00	Occupationa 2.00	Speech 3.00	Respiratory 4.00	У
109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	109. 00
				1.00	
110.00 Did this hospital participate in the Rural Community Hospita the current cost reporting period? Enter "Y" for yes or "N"		on project (4	10A Demo)for	N N	110. 00
the eartent cost reporting period. Enter 1 101 year of 11	101 110.		1. (	00 2.00 3.00	0
Miscellaneous Cost Reporting Information					
115.00 s this an all-inclusive rate provider? Enter "Y" for yes or is yes, enter the method used (A, B, or E only) in column 2. 3 either "93" percent for short term hospital or "98" percent psychiatric, rehabilitation and long term hospitals provider: Pub. 15-1, chapter 22, §2208.1.	If column 2 i t for long te	is "E", enter rm care (incl	in column udes	N O	115. 00
116.00 s this facility classified as a referral center? Enter "Y" 117.00 s this facility legally-required to carry malpractice insurance.			"N" for Y		116. 00 117. 00
118.00 s the malpractice insurance a claims-made or occurrence pol- claim-made. Enter 2 if the policy is occurrence.	icy? Enter 1 i	f the policy	ris 2	?	118. 00
		Premi ums	Losses	Insurance	
		1. 00	2.00	3.00	
118.01 List amounts of malpractice premiums and paid losses:		900, 1		0	0 118. 01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0109	Peri od: From 01/01/2016	Worksheet S Part I	-2
		To 12/31/2016		
		1.00	2.00	
18.02 Are malpractice premiums and paid losses reported in a cost		N N	2.00	118. 0
Administrative and General? If yes, submit supporting sched and amounts contained therein.	dule listing cost centers			
19. 00 DO NOT USE THIS LINE				119. 0
20.00 s this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in			N	120. 0
"N" for no. Is this a rural hospital with < 100 beds that qu				
Hold Harmless provision in ACA §3121 and applicable amendmen	nts? (see instructions)			
Enter in column 2, "Y" for yes or "N" for no. 21.00 Did this facility incur and report costs for high cost impla	antable devices charged to	Υ		121. (
patients? Enter "Y" for yes or "N" for no.	3			
22.00 Does the cost report contain state health or similar taxes? for no in column 1. If column 1 is "Y", enter in column 2 th		N		122. (
where these taxes are included.	To not notice to the manuscr			
Transplant Center Information 25.00 Does this facility operate a transplant center? Enter "Y" for	or wes and "N" for no. If	N	I	125. (
yes, enter certification date(s) (mm/dd/yyyy) below.	or yes and it for no. If	Į į		125. (
26.00 If this is a Medicare certified kidney transplant center, er		е		126. (
in column 1 and termination date, if applicable, in column 2 27.00 f this is a Medicare certified heart transplant center, ent				127. (
in column 1 and termination date, if applicable, in column 2				1.00
28.00 If this is a Medicare certified liver transplant center, ent in column 1 and termination date, if applicable, in column 2				128. (
29.00 If this is a Medicare certified lung transplant center, ente		in		129.
column 1 and termination date, if applicable, in column 2. 30.00 f this is a Medicare certified pancreas transplant center,	enter the certification			130.
date in column 1 and termination date, if applicable, in col				130.
31.00 If this is a Medicare certified intestinal transplant center				131.
date in column 1 and termination date, if applicable, in col 32.00 f this is a Medicare certified islet transplant center, ent				132.
in column 1 and termination date, if applicable, in column 2	2.			
33.00  f this is a Medicare certified other transplant center, ent   in column 1 and termination date, if applicable, in column 2				133.
34.00 $^{I}$ f this is an organ procurement organization (OPO), enter th				134.
and termination date, if applicable, in column 2.  All Providers				
40.00 Are there any related organization or home office costs as o	defined in CMS Pub. 15-1,	Y	158014	140.
chapter 10? Enter "Y" for yes or "N" for no in column 1. If are claimed, enter in column 2 the home office chain number.		S		
1.00 2.00		3.00		
If this facility is part of a chain organization, enter on I		name and address	of the	
home office and enter the home office contractor name and co			or the	
				141.
41.00 Name: FRANCISCAN ALLIANCE, INC.   Contractor's Name: WP: 42.00 Street: 1515 DRAGOON TRAIL   PO Box: 12'	S Contrac <sup>-</sup> 90	tor's Number: 0810	01	142. (
41.00 Name: FRANCISCAN ALLIANCE, INC.   Contractor's Name: WP: 42.00 Street: 1515 DRAGOON TRAIL   PO Box: 12	S Contrac <sup>-</sup> 90	tor's Number: 0810		141. ( 142. ( 143. (
41.00 Name: FRANCISCAN ALLIANCE, INC.   Contractor's Name: WP: 42.00 Street: 1515 DRAGOON TRAIL   PO Box: 12'	S Contrac <sup>-</sup> 90	tor's Number: 0810	01	142. (
41.00 Name: FRANCISCAN ALLIANCE, INC. Contractor's Name: WP: 42.00 Street: 1515 DRAGOON TRAIL PO Box: 12' 43.00 City: MISHAWAKA State: IN	S Contract 90 Zip Code	tor's Number: 0810	6-1290	142. (
41.00 Name: FRANCISCAN ALLIANCE, INC. Contractor's Name: WP: 42.00 Street: 1515 DRAGOON TRAIL PO Box: 12' 43.00 Ci ty: MISHAWAKA State: IN	S Contract 90 Zip Code	tor's Number: 0810 e: 4654	1.00 Y	142. (
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41.00 Name: FRANCISCAN ALLIANCE, INC.  42.00 Street: 1515 DRAGOON TRAIL  43.00 City: MISHAWAKA  44.00 Are provider based physicians' costs included in Worksheet A  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 no, does the dialysis facility include Medicare utilization 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. 1 yes, enter the approval date (mm/dd/yyyy) in column 2.  47.00 Was there a change in the statistical basis? Enter "Y" for y49.00 Was there a change to the simplified cost finding method? Enter "Y" for y49.00 Was there a change to the simplified cost finding method? Enter "Y" for y49.00 Was there a change to the simplified cost finding method? Enter "Y" for y49.00 Was there a change to the simplified cost finding method? Enter "Y" for y49.00 Was there a change to the simplified cost finding method? Enter "Y" for y49.00 Was there a change to the simplified cost finding method? Enter "Y" for y49.00 Was there a change to the simplified cost finding method? Enter "Y" for y49.00 Was there a change to the simplified cost finding method? Enter "Y" for y49.00 Was there a change to the simplified cost finding method? Enter "Y" for y49.00 Was there a change to the simplified cost finding method? Enter "Y" for y49.00 Was there a change to the simplified cost finding method? Enter "Y" for y49.00 Was there a change to the simplified cost finding method? Enter "Y" for y49.00 Was there a change to the simplified cost finding method? Enter "Y" for y49.00 Was there a change to the simplified cost finding method? Enter "Y" for y49.00 Was there a change to the simplified cost finding method? Enter "Y" for y49.00 Was there a change to the simplified cost finding method? Enter "Y" for y49.00 Was there a change to the simplified cost finding was the part of the provided the provided the provided the provided th	are the costs for column 1 is for this cost reporting asly filed cost report?  [Is-2, chapter 40, §4020) Is yes or "N" for no.  Tyes or	1.00  Title V 3.00 ation of the lowe (See 42 CFR §413	1.00 Y 2.00 1.00 N N N Title XIX 4.00 er of costs 3.13)	142. 143. 144. 145. 146. 147. 148. 149. 155. 156. 157. 158. 159.
41.00 Name: FRANCISCAN ALLIANCE, INC.  42.00 Street: 1515 DRAGOON TRAIL  43.00 City: MISHAWAKA  44.00 Are provider based physicians' costs included in Worksheet A  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 no, does the dialysis facility include Medicare utilization 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. 1) 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 or 49.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no for each components of the simplified cost finding method? Enter "Y" for yes or "N" for no for each components of the simplified cost finding method? Enter "Y" for yes or "N" for no for each components of the simplified cost finding method? Enter "Y" for yes or "N" for no for each components of the simplified cost finding method? Enter "Y" for yes or "N" for no for each components of the simplified cost finding method? Enter "Y" for yes or "N" for no for each components of the simplified cost finding method? Enter "Y" for yes or "N" for no for each components of the simplified cost finding method? Enter "Y" for yes or "N" for no for each components of the simplified cost finding method? Enter "Y" for yes or "N" for no for each components of the simplified cost finding method? Enter "Y" for yes or "N" for no for each components of the simplified cost finding method? Enter "Y" for yes or "N" for no for each components of the simplified cost finding method? Enter "Y" for yes or "N" for no for each components of the simplified cost finding method? Enter "Y" for yes or "N" for no for each components of the simplified cost finding method? Enter "Y" for yes or "N" for no for each components of the simplified cost finding method? Enter "Y" for yes or "N" for no for each comp	are the costs for column 1. If column 1 is for this cost reporting usly filed cost report?  15-2, chapter 40, §4020) Is yes or "N" for no. Tyes or "N" for no. The "Y" for yes or "N" for part A	Title V 3.00 ation of the lowe (See 42 CFR §413  N N N N N N N N N N N N N N N N N N	1.00 Y 2.00 1.00 Y 2.00 1.00 N N N Title XIX 4.00 er of costs 3.13) N N N	144. 1 144. 1 145. 1 146. 1 146. 1 155. 1 156. 1 157. 1 158. 1 159. 1 160. 1 160. 1
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							-2552-10			
HOSPITAL AND HOSPITAL HEALTH CARE COMPLI	EX IDENTIFICATION DATA	Provider CCN	l: 15-010 <sup>6</sup>	From O	1/01/2016 2/31/2016	Worksheet S-: Part I Date/Time Pro 6/28/2017 3:	epared:			
						1. 00				
Multicampus						1.00				
	Name County State Zip Code CBSA									
	0	1. 00	2. 00	3.00	4. 00	5. 00				
166.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)	0.0	0 166. 00								
						1. 00	_			
Health Information Technology (HI	T) incentive in the Am	merican Recovery and	Rei nves	tment Act		1.00				
167.00 Is this provider a meaningful use 168.00 If this provider is a CAH (line 1 reasonable cost incurred for the	r under §1886(n)? Ent O5 is "Y") and is a me	er "Y" for yes or "Neaningful user (line	l" for no	).	the	Υ	167. 00 0168. 00			
168.01 If this provider is a CAH and is					lshi p		168. 01			
exception under §413.70(a)(6)(ii) 169.00 If this provider is a meaningful transition factor. (see instructi	user (line 167 is "Y")				nter the	0. 2	5169. 00			
				Ве	gi nni ng	Endi ng				
					1. 00	2. 00				
170.00 Enter in columns 1 and 2 the EHR period respectively (mm/dd/yyyy)	beginning date and end	ling date for the rep	orting	01/	′01/2016	03/30/2016	170. 00			
					1. 00	2. 00	-			
171.00  f  line 167 is "Y", does this pro section 1876 Medicare cost plans "Y" for yes and "N" for no in col 1876 Medicare days in column 2. (	reported on Wkst. S-3, umn 1. If column 1 is	Pt. I, line 2, col.	6? Ente		N N		0171.00			

Heal th	Financial Systems FRANCISCAN HEA	LTH LAFAYETTE		In Lie	u of Form CMS-	2552-10
	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C		Peri od:	Worksheet S-2	
				From 01/01/2016 Fo 12/31/2016		epared:
				\/ /NI	6/28/2017 3:3	36 pm
				Y/N 1. 00	<u>Date</u> 2.00	
	General Instruction: Enter Y for all YES responses. Enter N	N for all NO re	sponses. Enter			
	mm/dd/yyyy format.		•			
	COMPLETED BY ALL HOSPITALS Provider Organization and Operation					-
1.00	Has the provider changed ownership immediately prior to the	e beainnina of	the cost	N		1.00
	reporting period? If yes, enter the date of the change in					
			Y/N	Date	V/I	
2.00	Has the provider terminated participation in the Medicare I	Drogram2 If	1.00 N	2. 00	3. 00	2, 00
2.00	yes, enter in column 2 the date of termination and in column		IN IN			2.00
	voluntary or "I" for involuntary.	,				
3.00	Is the provider involved in business transactions, including		N			3. 00
	contracts, with individuals or entities (e.g., chain home or medical supply companies) that are related to the provide					
	officers, medical staff, management personnel, or members					
	of directors through ownership, control, or family and other					
	relationships? (see instructions)		V (N)		D 1	
			1.00	7ype 2. 00	Date 3.00	
	Financial Data and Reports			2.00	0.00	
4.00	Column 1: Were the financial statements prepared by a Cer	tified Public	Y	A	05/03/2016	4. 00
	Accountant? Column 2: If yes, enter "A" for Audited, "C"					
	or "R" for Reviewed. Submit complete copy or enter date avacolumn 3. (see instructions) If no, see instructions.	arrabre in				
5.00	Are the cost report total expenses and total revenues diffe	erent from	Y			5. 00
	those on the filed financial statements? If yes, submit re	conciliation.				
				Y/N 1. 00	Legal Oper. 2.00	
	Approved Educational Activities			1.00	2.00	
6.00	Column 1: Are costs claimed for nursing school? Column 2:	If yes, is th	ne provider is	Y	Y	6. 00
7.00	the legal operator of the program?					7.00
7. 00 8. 00	Are costs claimed for Allied Health Programs? If "Y" see in Were nursing school and/or allied health programs approved		l during the	Y N		7. 00 8. 00
0.00	cost reporting period? If yes, see instructions.	and/or renewed	r durring the	IN IN		0.00
9.00	Are costs claimed for Interns and Residents in an approved	graduate medic	al education	N		9. 00
40.00	program in the current cost report? If yes, see instruction					10.00
10. 00	Was an approved Intern and Resident GME program initiated cost reporting period? If yes, see instructions.	or renewed in t	ne current	N		10.00
11. 00	Are GME cost directly assigned to cost centers other than	I & R in an App	roved	N		11. 00
	Teaching Program on Worksheet A? If yes, see instructions.					
					Y/N 1. 00	
	Bad Debts				1.00	
12.00	Is the provider seeking reimbursement for bad debts? If yes				Y	12. 00
13. 00	If line 12 is yes, did the provider's bad debt collection	policy change o	luring this cos	st reporting	N	13. 00
14 00	period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or co-paymo	ents waived? If	ves see ins	tructions	N	14. 00
00	Bed Complement	onto mar vour in	J007 000 1110			1 00
15. 00	Did total beds available change from the prior cost report				N	15. 00
		Y/N	t A Date	Y/N	t B Date	
		1.00	2.00	3. 00	4. 00	
	PS&R Data					
16. 00	Was the cost report prepared using the PS&R Report only?	Y	05/25/2017	Υ	05/25/2017	16. 00
	If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 (see					
	instructions)					
17. 00	Was the cost report prepared using the PS&R Report for	N		N		17. 00
	totals and the provider's records for allocation? If					
	either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)					
18. 00	If line 16 or 17 is yes, were adjustments made to PS&R	N		N		18. 00
	Report data for additional claims that have been billed					
	but are not included on the PS&R Report used to file this					
19. 00	cost report? If yes, see instructions.  On If line 16 or 17 is yes, were adjustments made to PS&R N N N					19. 00
17.00	Report data for corrections of other PS&R Report	14		14		' 00
	information? If yes, see instructions.					

	Financial Systems FRANCISCAN HEAL  AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CO	CN: 15-0109	Peri od:	u of Form CMS- Worksheet S-2			
.50. 11			13 0107	From 01/01/2016 To 12/31/2016	Part II Date/Time Pre 6/28/2017 3:3	epared		
		Descri	pti on	Y/N	Y/N	T Pill		
		(		1. 00	3. 00			
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.0		
		Y/N 1. 00	Date 2.00	Y/N 3. 00	Date 4.00			
1. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N N	2.00	N N	4.00	21. 0		
	-				1. 00			
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	PT CHILDRENS H	OSPI TALS)		1.00			
	Capital Related Cost		ĺ					
2. 00 3. 00	Have assets been relifed for Medicare purposes? If yes, see Have changes occurred in the Medicare depreciation expense of the properties o		als made dur	ing the cost	N N	22. (		
4. 00	reporting period? If yes, see instructions.  Were new leases and/or amendments to existing leases entered into during this cost reporting period?  If yes, see instructions							
5. 00	Have there been new capitalized leases entered into during instructions.	the cost repor	ting period?	Plf yes, see	N	25.		
6. 00	Were assets subject to Sec. 2314 of DEFRA acquired during the instructions.	e cost reporti	ng period? I	f yes, see	N	26.		
7. 00	Has the provider's capitalization policy changed during the copy.	cost reportin	g period? If	yes, submit	N	27.		
3. 00	Interest Expense Were new loans, mortgage agreements or letters of credit en	tered into dur	ing the cost	reporting	N	28.		
9. 00	period? If yes, see instructions. Did the provider have a funded depreciation account and/or		bt Service F	Reserve Fund)	Υ	29.		
0. 00	treated as a funded depreciation account? If yes, see instru Has existing debt been replaced prior to its scheduled maturinstructions.		debt? If yes	s, see	N	30.		
1. 00	Has debt been recalled before scheduled maturity without is instructions.	suance of new	debt? If yes	s, see	N	31.		
2. 00	Purchased Services Have changes or new agreements occurred in patient care services.		d through co	ontractual	Υ	32.		
3. 00	arrangements with suppliers of services? If yes, see instructions.  arrangements with suppliers of services? If yes, see instructions.		g to competi	tive bidding? If	N	33.		
4. 00	Provider-Based Physicians  Are services furnished at the provider facility under an arm	rangomont with	provi don ba	seed physicians?	Υ	34.		
5. 00	If yes, see instructions.  If line 34 is yes, were there new agreements or amended exists.	Ü	•	. ,	N	35.		
J. 00	physicians during the cost reporting period? If yes, see in:		ts with the			35.		
				Y/N 1. 00	2. 00			
	Home Office Costs							
	Were home office costs claimed on the cost report?  If line 36 is yes, has a home office cost statement been pro	epared by the	home office?	P Y Y		36. (		
3. 00	If yes, see instructions. 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			F N		38.		
9. 00	If line 36 is yes, did the provider render services to other see instructions.			s, N		39.		
0. 00	If line 36 is yes, did the provider render services to the linstructions.	home office?	If yes, see	N		40.		
		1.	00	2.	00			
	Cost Report Preparer Contact Information							
1. 00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	PATRI CI A		GARREN		41.		
2. 00	1 ' "	FRANCISCAN HEA	LTH			42.		
		765-428-5928		PATRI CI A. GARREI	IOEDANICI CCANAI	43.		

Health Financial Systems FRANCISCAN HEA			ALTH	LAFAYETTE		In Lieu of Form CMS-2552-10				
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE			Provider CCN	I: 15-0109		m 01/01/2016			anad.	
						То	12/31/2016	6/28/2017		
				3.00	0					
	Cost Report Preparer Contact Information									
41.00	Enter the first name, last name and the tit	le/position	ADMI	IN DIRECTOR (	OF FINANCE					41.00
	held by the cost report preparer in columns	1, 2, and 3,								
	respecti vel y.									
42.00	Enter the employer/company name of the cost	report								42.00
	preparer.									
43.00	Enter the telephone number and email address									43.00
	report preparer in columns 1 and 2, respect	i vel y.								

| Peri od: | Worksheet S-3 | From 01/01/2016 | Part | To 12/31/2016 | Date/Time Prepared: 
 Heal th Financial
 Systems
 FRANCISC

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

					To	12/31/2016	Date/Time Prep	
							6/28/2017 3:30 I/P Days / 0/P	) pili
							Visits / Trips	
	Component	Worksheet A	No	of Beds	Bed Days	CAH Hours	Title V	
	35p3.112	Line Number		0. 2000	Avai I abl e	57.11 1.15 d.1 5		
		1.00		2. 00	3.00	4. 00	5. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00		138	50, 508	0.00	0	1. 00
	8 exclude Swing Bed, Observation Bed and							
	Hospice days) (see instructions for col. 2							
	for the portion of LDP room available beds)							
2.00	HMO and other (see instructions)							2.00
3.00	HMO IPF Subprovider							3.00
4.00	HMO IRF Subprovider							4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF						0	6.00
7.00	Total Adults and Peds. (exclude observation			138	50, 508	0.00	0	7.00
	beds) (see instructions)							
8. 00	INTENSIVE CARE UNIT	31. 00		17	6, 222	0. 00	0	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	NEONATAL INTENSIVE CARE UNIT	35. 00		14	5, 124	0. 00	0	12. 00
13. 00	NURSERY	43. 00					0	13.00
14. 00	Total (see instructions)			169	61, 854	0. 00	0	14.00
15. 00	CAH visits						0	15. 00
16. 00	SUBPROVIDER - IPF	40. 00		0	_		0	16. 00
17. 00	SUBPROVIDER - IRF	41. 00		18			0	17. 00
18. 00	SUBPROVI DER	42. 00		0	0		0	18. 00
19. 00	SKILLED NURSING FACILITY							19. 00
20. 00	NURSING FACILITY							20. 00
21. 00	OTHER LONG TERM CARE						_	21. 00
22. 00	HOME HEALTH AGENCY	101. 00					0	22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P. )	44, 00						23. 00
24. 00	HOSPI CE	116. 00		0	0			24. 00
24. 10	HOSPICE (non-distinct part)	30. 00						24. 10
25. 00	CMHC - CMHC	00.10						25. 00
25. 10	CMHC - CORF	99. 10					0	25. 10
26. 00	RURAL HEALTH CLINIC	88. 00					0	26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00		107			U	26. 25
27. 00	Total (sum of lines 14-26)			187				27. 00
28. 00	Observation Bed Days						0	28. 00
29. 00	Ambulance Trips							29. 00 30. 00
30.00	Employee discount days (see instruction)							
31.00	Employee discount days - IRF			0	0			31. 00 32. 00
32. 00	Labor & delivery days (see instructions)			Ü	ا ۱			32. 00 32. 01
32. 01	Total ancillary labor & delivery room outpatient days (see instructions)							32. UT
33. 00	LTCH non-covered days							33. 00
33.00	LIGH HOH COVERED Days		l		1			55.00

Provider CCN: 15-0109

Title XVIII						'	0 12/31/2010	6/28/2017 3: 3	
No.   Hospital Adults & Peds. (columns 5				I/P Days	/ O/P Visits	/ Trips	Full Time		
No.			Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
1.00   Hospi tail Adult is & Peds. (columns 5, 6, 7 and 8   8 exclude Swing Bed. Observation Bed and Hospi ce days) (see instructions for col. 2   7 or the portion of ILDP room avail able beds)   3,555   6,180   2.00   10   10   10   10   10   10   10			·			Pati ents	& Residents	Payrol I	
B exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)   2					7. 00			10.00	
Hospi ce days) (See Instructions for col. 2   for the portion of LDP room available beds)   2.00   HM0 and other (see Instructions)   3.555   6,180   3.00   MM0 IRF Subprovider   0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1.	00		16, 285	5, 603	35, 378			1. 00
For the portion of LDP room available beds)   2.00   MM and other (see instructions)   3.555   6.180   2.00   3.00   3.00   4.00   MM IPF Subprovider   0   0   0   0   0   0   0   0   0									
2.00 HM0 and other (see instructions)									
3.00   HMO IPF Subprovider	2	00		2 555	4 100				2 00
4. 00   HMO I RF Subprovider				3, 333	0, 100				
5.00			•	0	0				
6.00   Hospital Adults & Peds. Swing Bed NF   7.00   7.0			•		0	0			
7.00				٩	0	0			1
Beds) (see instructions)				16 285	٥	35 378			1
8. 00   INTENSIVE CARE UNIT   1,869   0   4,704   8. 00   0   0   0   0   0   0   0   0   0	, ,			10,200	0, 000	00,0,0			/
10. 00   BURN INTENSIVE CARE UNIT	8.	00		1, 869	0	4, 704			8.00
11. 00   SURGICAL INTENSIVE CARE UNIT   0   0   2,779   12. 00   13. 00   14. 00   15. 00   14. 00   15. 00   14. 00   15. 00	9.	00	CORONARY CARE UNIT						9. 00
12. 00   NEONATAL INTENSIVE CARE UNIT   0   0   2,779   1,222   13. 00   13. 00   14. 003   14. 003   14. 003   15. 00   14. 003   15. 00   15. 00   0   0   0   0   0   0   0   15. 00   15. 00   15. 00   15. 00   0   0   0   0   0   0   0   0   0	10	0. 00	BURN INTENSIVE CARE UNIT						10.00
13. 00   NURSERY	11	1. 00	SURGICAL INTENSIVE CARE UNIT						11. 00
14.00   Total (see instructions)   18,154   5,603   44,083   0.00   1,403.50   14.00     15.00   CAH visits	12	2. 00	NEONATAL INTENSIVE CARE UNIT	0	0	2, 779			12. 00
15. 00 CAH visits	13	3. 00	NURSERY		٥				13. 00
16. 00   SUBPROVIDER - IPF   0   0   0   0   0   0   0   0   0			Total (see instructions)	18, 154	5, 603	44, 083	0.00	1, 403. 50	1
17. 00 SUBPROVIDER - IRF			1	0		ŭ			
18.00   SUBPROVI DER   0   0   0   0   0   0   18.00   19.00   SKI LLED NURSI NG FACI LITY   20.00   0   0   0   0   0   20.00   OTHER LONG TERM CARE   21.00   21.00   OTHER LONG TERM CARE   21.00   22.00   HOME HEALTH AGENCY   9,731   0   15,374   0.00   35.44   22.00   23.00   AMBULATORY SURGI CAL CENTER (D.P.)   23.00   24.10   HOSPI CE   0   0   0   0   0   25.00   CMHC - CMHC   25.00   25.10   CMHC - CORF   0   0   0   0   0   26.00   RURAL HEALTH CLINI C   0   0   0   0   26.25   FEDERALLY QUALIFIED HEALTH CENTER   0   0   0   0   28.00   Observation Bed Days   0   0   29.00   Ambul ance Trip ps   0   30.00   Employee discount days (see instruction)   31.00   32.01   Total ancillary labor & delivery room outpatient days (see instructions)   0   32.01   Total ancillary labor & delivery room outpatient days (see instructions)   0   30.00   Total days (see instructions)   0   0   30.00   Total ancillary labor & delivery room outpatient days (see instructions)   0   30.00   Total ancillary labor & delivery room outpatient days (see instructions)   0   30.00   Total ancillary labor & delivery room outpatient days (see instructions)   0   30.00   Total ancillary labor & delivery room outpatient days (see instructions)   0   30.00   Total ancillary labor & delivery room outpatient days (see instructions)   0   30.00   Total ancillary labor & delivery room outpatient days (see instructions)   0   30.00   Total ancillary labor & delivery room outpatient days (see instructions)   0   30.00   Total ancillary labor & delivery room outpatient days (see instructions)   0   30.00   Total ancillary labor & delivery room outpatient days (see instructions)   0   30.00   Total ancillary labor & delivery room outpatient days (see instructions)   0   30.00   Total ancillary labor & delivery room outpatient days (see instructions)   0			1	0	-1	· ·			1
19.00   SKILLED NURSING FACILITY   20.00   20.			1	1, 655	249	3, 002			1
20.00   NURSING FACILITY   20.00   21.00   21.00   22.00   21.00   22.00   22.00   40ME HEALTH AGENCY   9,731   0   15,374   0.00   35.44   22.00   23.00   24.00   40SPICE   0   0   0   0   0   0   0   24.10   24.10   25.00   25.00   25.10   26.00   26.25   27.00   28.00   29.00   28.00   29.00   29.00   29.00   20			1		O	0	0.00	0.00	
21. 00 OTHER LONG TERM CARE 22. 00 HOME HEALTH AGENCY 9, 731 0 15, 374 0. 00 35. 44 22. 00 23. 00 AMBULATORY SURGI CAL CENTER (D. P.) 24. 00 HOSPI CE									1
22.00   HOME HEALTH AGENCY   9,731   0   15,374   0.00   35.44   22.00   23.00   24.00   HOSPICE (non-distinct part)   0   0   0   0   0   0   24.10   24.00   25.00   25.00   25.10   26.00   26.00   26.00   26.00   27.00   27.00   28.00   28.00   29.00   28.00   29.00									
23. 00 AMBULATORY SURGICAL CENTER (D.P.) 24. 00 HOSPICE			1	0.721		15 274	0.00	25 44	
24. 00 HOSPICE			1	9, /31	U	15, 3/4	0.00	35. 44	1
24. 10 HOSPICE (non-distinct part) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0						0	0.00	14 24	1
25. 00 CMHC - CMHC 25. 10 CMHC - CORF 26. 00 RURAL HEALTH CLINIC 26. 00 RURAL HEALTH CLINIC 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambul ance Trips 30. 00 Empl oyee discount days (see instruction) 31. 00 Empl oyee 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)				-1	٥	-		10. 24	
25. 10 CMHC - CORF 26. 00 RURAL HEALTH CLINIC 26. 00 RURAL HEALTH CLINIC 26. 00 Total (sum of lines 14-26) 27. 00 Observation Bed Days 29. 00 Ambul ance Trips 30. 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. 02 Company of the control of the con				J	o <sub>l</sub>	0			1
26. 00 RURAL HEALTH CLINIC 0 0 0 0 0 0.00 0.00 26. 00 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0.00 0.00 26. 25 27. 00 Total (sum of lines 14-26) 0.00 0 0.00 1, 471. 42 27. 00 28. 00 0bservation Bed Days 0 0 0 0 29. 00 Ambul ance Trips 0 29. 00 Employee discount days (see instruction) 31. 00 Employee discount days - IRF 0 0 32. 00 Labor & delivery days (see instructions) 0 0 2, 410 0 32. 01 Total ancillary labor & delivery room outpatient days (see instructions)				0	0	0	0.00	0.00	
26. 25   FEDERALLY QUALIFIED HEALTH CENTER   0   0   0   0   0   0   0   0   0			·		o	0		•	1
27.00   Total (sum of lines 14-26)   0.00   1,471.42   27.00   28.00   0   0   0   0   28.00   29.00   Ambulance Trips   0   0   0   0   29.00   30.00   Employee discount days (see instruction)   0   Employee discount days - IRF   0   31.00   32.00   Total ancillary labor & delivery room outpatient days (see instructions)   0   0   2,410   32.00   32.01   0   0   0   0   0   0   0   0   0				o o	0	0			1
28. 00   Observation Bed Days   0   0   28. 00   29. 00   Ambulance Trips   0   0   29. 00   30. 00   Employee discount days (see instruction)   0   30. 00   31. 00   Employee discount days - IRF   0   31. 00   32. 00   Labor & delivery days (see instructions)   0   0   2, 410   32. 00   32. 01   Total ancillary labor & delivery room outpatient days (see instructions)   0   32. 01					_	_			
29.00 Ambulance Trips 0 29.00 30.00 Employee discount days (see instruction) 0 30.00 31.00 Employee discount days - IRF 0 31.00 32.00 Labor & delivery days (see instructions) 0 2,410 32.00 32.01 Total ancillary labor & delivery room outpatient days (see instructions)					o	0		,	1
31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions)  Total ancillary labor & delivery room outpatient days (see instructions)  31.00 2,410 32.00 32.01	29	9. 00		О					29. 00
32.00 Labor & delivery days (see instructions) 0 0 2,410 32.00 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 0 0 2,410 0 32.01	30	0. 00				0			30.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)	31	1. 00	Employee di scount days - IRF			0			31. 00
outpatient days (see instructions)	32	2. 00	Labor & delivery days (see instructions)	o	o	2, 410			32.00
	32	2. 01	Total ancillary labor & delivery room			0			32. 01
33.00   LTCH non-covered days   0   33.00									
	33	3. 00	LTCH non-covered days	이					33.00

| Period: | Worksheet S-3 | From 01/01/2016 | Part | To 12/31/2016 | Date/Time Prepared: Provider CCN: 15-0109

					To	12/31/2016	Date/Time Prep 6/28/2017 3:30	
		Full Time Equivalents	<u> </u>		Di scha	arges		
	Component	Nonpai d Workers	Title V		Title XVIII	Title XIX	Total All Patients	
		11.00	12.00		13. 00	14. 00	15. 00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	11.00	12.00	0	4, 113	1, 904	9, 773	1. 00
	8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)				,,	1, 12 1	1, 110	
2.00	HMO and other (see instructions)				748	0		2. 00
3.00	HMO IPF Subprovider					0		3. 00
4.00	HMO IRF Subprovider					O		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	NEONATAL INTENSIVE CARE UNIT							12.00
13. 00	NURSERY							13. 00
14. 00	Total (see instructions)	0. 00		0	4, 113	1, 904	9, 773	
15. 00	CAH visits							15. 00
16.00	SUBPROVIDER - I PF	0.00		0	0	0	0	16.00
17. 00	SUBPROVI DER - I RF	0.00		0	132	23	247	17. 00
18.00	SUBPROVI DER	0. 00		0		٩	0	18.00
19.00	SKILLED NURSING FACILITY							19. 00 20. 00
20. 00 21. 00	NURSING FACILITY OTHER LONG TERM CARE							20.00
21.00	1	0. 00						21.00
23. 00	HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D. P. )	0.00						23. 00
24. 00	HOSPICE	0.00						24.00
24. 00	HOSPICE (non-distinct part)	0.00						24. 00
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	0.00						28. 00
29. 00	Ambulance Trips							29. 00
30. 00	Employee discount days (see instruction)							30. 00
31. 00	Employee discount days - IRF							31. 00
32. 00	Labor & delivery days (see instructions)							32. 00
32. 01	Total ancillary labor & delivery room							32. 01
22.00	outpatient days (see instructions)							33. 00
33.00	LTCH non-covered days	l l		- 1				33.UU

Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION Provider CCN: 15-0109

					10	12/31/2010	Date/lime Pre 6/28/2017 3:3	
		Worksheet A Line Number	Amount Reported	Reclassificati on of Salaries (from Worksheet A-6)			Average Hourly Wage (col. 4 ÷ col. 5)	
		1. 00	2. 00	3.00	4.00	5. 00	6. 00	
	PART II - WAGE DATA SALARIES							1
1. 00	Total salaries (see	200. 00	89, 570, 074	-1, 290, 467	88, 279, 607	3, 060, 532. 00	28. 84	1.00
2. 00	instructions) Non-physician anesthetist Part		0	0	0	0. 00	0. 00	2.00
3. 00	A Non-physician anesthetist Part		0	0	0	0.00	0. 00	3. 00
4. 00	Physician-Part A - Administrative		0	0	0	0.00	0. 00	4. 00
4. 01 5. 00	Physicians - Part A - Teaching Physician and Non		0	0	0	0. 00 0. 00		
6. 00	Physician-Part B Non-physician-Part B for hospital-based RHC and FQHC		0	0	0	0.00	0. 00	
7. 00	services Interns & residents (in an	21. 00	0	0	0	0. 00	0. 00	7. 00
7. 01	approved program) Contracted interns and residents (in an approved programs)		0	0	О	0.00	0. 00	7. 01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0. 00	8. 00
9. 00 10. 00	SNF Excluded area salaries (see	44. 00	0 15, 127, 922	0 412, 969	0 15, 540, 891	0. 00 351, 452. 00		
	instructions) OTHER WAGES & RELATED COSTS							-
11. 00	Contract labor: Direct Patient Care		437, 647	0	437, 647	6, 183. 00	70. 78	11. 00
12. 00	Contract labor: Top level management and other management and administrative services		0	0	0	0. 00	0. 00	12.00
13. 00	Contract Labor: Physician-Part A - Administrative		0	0	0	0. 00	0. 00	13. 00
14. 00	Home office and/or related orgainzation salaries and wage-related costs		0	О	0	0.00	0. 00	14. 00
14. 01	Home office salaries		0	0	0	0.00		14. 01
14. 02 15. 00	Related organization salaries Home office: Physician Part A		0	0	0	0. 00 0. 00		
16. 00	- Administrative Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0. 00	16. 00
17. 00	WAGE-RELATED COSTS Wage-related costs (core) (see		24, 672, 387	0	24, 672, 387			17. 00
18. 00	instructions) Wage-related costs (other) (see instructions)		0	0	0			18. 00
19. 00 20. 00	Excluded areas Non-physician anesthetist Part		2, 766, 658 0	0	2, 766, 658 0			19. 00 20. 00
21. 00	A Non-physician anesthetist Part		0	0	0			21. 00
22. 00	B Physician Part A - Administrative		0	О	О			22. 00
22. 01	Physician Part A - Teaching		0	О	О			22. 01
23.00	Physician Part B Wage-related costs (RHC/FQHC)		0	· -	0			23. 00
24. 00 25. 00	Interns & residents (in an approved program)		0	1	0			24. 00 25. 00
25. 50 25. 51	Home office wage-related Related orgainzation		0		0			25. 50 25. 51
25. 52	wage-related Home office: Physician Part A		0	0	О			25. 52
25. 53	- Administrative - wage-related Home office & Contract		0					25. 53
∠J. J3	Physicians Part A - Teaching - wage-related							25. 53
26. 00	OVERHEAD COSTS - DIRECT SALARIE Employee Benefits Department	4. 00	1, 114, 338	-125, 154	989, 184	31, 997. 00	30. 91	26. 00
	Administrative & General	5. 00	6, 492, 190	l	1			27. 00

Provider CCN: 15-0109

| Peri od: | Worksheet S-3 | From 01/01/2016 | Part II | To 12/31/2016 | Date/Time Prepared: | Cate/Odd 2017 | Part II | Part

							6/28/2017 3: 3	
		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)		col. 4		
		1.00	2.00	3. 00	4. 00	5. 00	6. 00	
28. 00	Administrative & General under		0	0	0	0.00	0.00	28. 00
	contract (see inst.)							
29. 00	Maintenance & Repairs	6. 00	0	0	0	0. 00	0. 00	29. 00
30.00	Operation of Plant	7. 00	2, 889, 608	0	2, 889, 608	121, 050. 00	23. 87	30. 00
31. 00	Laundry & Linen Service	8. 00	117, 313	0	117, 313	8, 093. 00	14. 50	31. 00
32.00	Housekeepi ng	9. 00	2, 063, 241	0	2, 063, 241	143, 657. 00	14. 36	32. 00
33.00	Housekeeping under contract		0	0	0	0. 00	0. 00	33. 00
	(see instructions)							
34.00	Di etary	10. 00	2, 122, 393	-1, 358, 712	763, 681	134, 740. 00	5. 67	34.00
35.00	Di etary under contract (see		0	0	0	0.00	0.00	35. 00
	instructions)							
36. 00	Cafeteri a	11. 00	0	1, 358, 712	1, 358, 712	0. 00		36. 00
37.00	Maintenance of Personnel	12. 00	0	0	0	0.00	0.00	37. 00
38.00	Nursing Administration	13. 00	2, 738, 850	-302, 515	2, 436, 335	68, 452. 00	35. 59	38. 00
39. 00	Central Services and Supply	14. 00	431, 320	0	431, 320	22, 598. 00	19. 09	39. 00
40.00	Pharmacy	15. 00	2, 858, 096	-130, 555	2, 727, 541	16. 00	170, 471. 31	40.00
41.00	Medical Records & Medical	16. 00	62, 090	0	62, 090	2, 501. 00	24. 83	41.00
	Records Library							
42.00	Soci al Servi ce	17. 00	634, 972	-43, 463	591, 509	22, 698. 00	26. 06	42.00
43.00	Other General Service	18. 00	0	0	0	0.00	0.00	43.00

| Peri od: | Worksheet S-3 | From 01/01/2016 | Part III | To 12/31/2016 | Date/Time Prepared: | Cate/Odd 2017 | Page 2017 | Pa

							6/28/2017 3: 3	
		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		89, 570, 074	-1, 290, 467	88, 279, 607	3, 060, 532. 00	28. 84	1.00
	instructions)							
2.00	Excluded area salaries (see		15, 127, 922	412, 969	15, 540, 891	351, 452. 00	44. 22	2.00
	instructions)							
3.00	Subtotal salaries (line 1		74, 442, 152	-1, 703, 436	72, 738, 716	2, 709, 080. 00	26. 85	3.00
	minus line 2)							
4.00	Subtotal other wages & related		437, 647	0	437, 647	6, 183. 00	70. 78	4. 00
	costs (see inst.)							
5.00	Subtotal wage-related costs		24, 672, 387	0	24, 672, 387	0. 00	33. 92	5. 00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		99, 552, 186	-1, 703, 436	97, 848, 750	2, 715, 263. 00	36. 04	6.00
7.00	Total overhead cost (see		21, 524, 411	-1, 445, 435	20, 078, 976	773, 069. 00	25. 97	7.00
	instructions)							

Health Financial Systems	FRANCISCAN HEALTH LAFAYETTE	In Lieu of Form CMS-2552-10
HOSPITAL WAGE RELATED COSTS	Provi der CCN: 15-0109	Period: Worksheet S-3 From 01/01/2016 Part IV To 12/31/2016 Date/Time Prepared:

	To 12/31/2016	Date/Time Prep 6/28/2017 3:30	
		Amount	э ріп
		Reported	
		1. 00	
	PART IV - WAGE RELATED COSTS		-
	Part A - Core List		
	RETI REMENT COST		
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	7, 458, 427	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal /Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	427, 499	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	9, 031, 910	8.00
8. 01	Health Insurance (Self Funded without a Third Party Administrator)	0	8. 01
8. 02	Health Insurance (Self Funded with a Third Party Administrator)	0	8. 02
8.03	Health Insurance (Purchased)	0	8. 03
9.00	Prescription Drug Plan	0	9. 00
10.00	Dental, Hearing and Vision Plan	1, 031, 628	10.00
11. 00	Life Insurance (If employee is owner or beneficiary)	50, 824	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)	415, 875	13.00
14.00		0	14.00
15. 00		-187, 976	
16. 00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16.00
	Non cumulative portion)		
	TAXES		
17. 00		4, 001, 301	
18. 00	Medicare Taxes - Employers Portion Only	2, 442, 899	18. 00
19. 00	1 1 1 3 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	0	19. 00
20. 00		0	20.00
	OTHER	_	
21. 00		0	21. 00
22.00	instructions))	0	22.00
22. 00	Day Care Cost and Allowances	0	22. 00
23. 00		0	23. 00
24. 00		24, 672, 387	24. 00
25 00	Part B - Other than Core Related Cost OTHER WAGE RELATED COSTS (SPECIFY)	0	25. 00
25.00	OTHER WAGE RELATED COSTS (SPECIFI)	ا	∠3.00

Health Financial Systems	FRANCISCAN HEALTH LAFAYETTE	In Lie	u of Form CMS-2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provi der CCN: 15-0109	From 01/01/2016 To 12/31/2016	Worksheet S-3 Part V Date/Time Prepared: 6/28/2017 3:36 pm
Cost Center Description		Contract Labor	Benefit Cost

			6/28/2017 3: 3				
	Cost Center Description	Contract Labor	Benefit Cost				
		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	437, 647	24, 672, 387	1.00			
2.00	Hospi tal	437, 647	24, 672, 387	2. 00			
3.00	Subprovi der - I PF	0	0	3. 00			
4.00	Subprovi der - I RF	0	0	4. 00			
5.00	Subprovi der - (Other)	0	0	5. 00			
6.00	Swing Beds - SNF	0	0	6. 00			
7. 00	Swing Beds - NF	0	0	7. 00			
8. 00	Hospi tal -Based SNF			8. 00			
9.00	Hospi tal -Based NF			9. 00			
10.00	Hospi tal -Based OLTC			10.00			
11. 00	Hospi tal -Based HHA	0	0	11.00			
12.00	Separately Certified ASC			12.00			
13.00	Hospi tal -Based Hospi ce	0	0	13.00			
14.00	Hospital-Based Health Clinic RHC	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 Di al ysi s	0	0	17.00			
18. 00	Other	0	0	18. 00			

		FRANCISCAN HEAL				eu of Form CMS-2	2552-10
HOME I	HEALTH AGENCY STATISTICAL DATA		Provider Company		eriod: rom 01/01/2016 o 12/31/2016	Worksheet S-4 Date/Time Prep	oorod:
			Component	UCIN. 15-7124 11	Home Health	6/28/2017 3: 3: PPS	6 pm
					Agency I	FFS	
	T.			-		00	
0.00	County	Title V	Title XVIII	Title XIX	TI PPEECANOE Other	Total	0. 00
	LIGHT HEALTH AGENOV CTATICTICAL DATA	1.00	2.00	3.00	4. 00	5. 00	
1. 00	HOME HEALTH AGENCY STATISTICAL DATA Home Health Aide Hours	0	710	0	260	970	1. 00
2. 00	Unduplicated Census Count (see instructions)	0.00	510. 00		438.00 oyees (Full Ti		2. 00
					.,	=4=: : =: : : : : :	
		Enter the number		Staff	Contract	Total	
		, , , , , , , , , , , , , , , , , , , ,					
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES	C	)	1.00	2. 00	3. 00	
3.00	Administrator and Assistant Administrator(s)		40.00				3. 00
4. 00 5. 00	Director(s) and Assistant Director(s) Other Administrative Personnel			0. 00 13. 57	0. 00 0. 00		4. 00 5. 00
6.00	Direct Nursing Service			7. 50			6. 00
7. 00 8. 00	Nursi ng Supervi sor Physi cal Therapy Servi ce			0. 00 1. 52			7. 00 8. 00
9.00	Physical Therapy Supervisor			0.00			9. 00
10. 00 11. 00	Occupational Therapy Service Occupational Therapy Supervisor			0. 07 0. 00			10. 00 11. 00
12.00	Speech Pathology Service			0. 12			12.00
13. 00 14. 00	Speech Pathology Supervisor Medical Social Service			0. 00 0. 10			13. 00 14. 00
15. 00	Medical Social Service Supervisor			0.00			15.00
16. 00 17. 00	Home Health Aide Home Health Aide Supervisor			1. 27 0. 00	0. 00 0. 00		16. 00 17. 00
18. 00	INFUSION HOME HEALTH AGENCY CBSA CODES			7. 61	0. 00	7. 61	18. 00
19. 00	Enter in column 1 the number of CBSAs where			3			19. 00
	you provided services during the cost reporting period.						
20. 00	List those CBSA code(s) in column 1 serviced			26900			20. 00
	during this cost reporting period (line 20 contains the first code).						
20. 01 20. 02				29200 99915			20. 01 20. 02
20.02		Full Ep					20. 02
		Without Outliers	With Outliers	LUPA Epi sodes	PEP Only Episodes	Total (cols. 1-4)	
	PPS ACTIVITY DATA	1.00	2.00	3.00	4. 00	5. 00	
21. 00	Skilled Nursing Visits	4, 124					
22. 00 23. 00	Skilled Nursing Visit Charges Physical Therapy Visits	1, 502, 409 3, 124		52, 880 45		1, 601, 205 3, 200	22. 00 23. 00
24. 00	Physical Therapy Visit Charges	1, 154, 510	0	14, 840	10, 017	1, 179, 367	24. 00
25. 00 26. 00	Occupational Therapy Visits Occupational Therapy Visit Charges	890 326, 193				914 335, 097	25. 00 26. 00
27. 00	Speech Pathology Visits	86	0	1	0	87	27. 00
28. 00 29. 00	Speech Pathology Visit Charges Medical Social Service Visits	31, 822 32			0	32, 193 40	28. 00 29. 00
30. 00	Medical Social Service Visit Charges	16, 315	2, 580	860	0	19, 755	30. 00
31. 00 32. 00	Home Health Aide Visits Home Health Aide Visit Charges	891 161, 341	46 7, 898			950 171, 488	31. 00 32. 00
33. 00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	9, 147	134	212	104	9, 597	33. 00
34. 00	Other Charges	0	0	_		0	34. 00
35. 00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	3, 192, 590	40, 095	74, 639	31, 781	3, 339, 105	35. 00
36. 00	Total Number of Episodes (standard/non outlier)	580		74	8	662	36. 00
37. 00	Total Number of Outlier Episodes		_ 4		0		37. 00
38. 00	Total Non-Routine Medical Supply Charges	313, 993	509	8, 182	0	322, 684	38. 00

Heal th	Financial Systems		FRANCISCAN HEA	LTH LAFAYETTE		In Lie	u of Form CMS-2	2552-10
	AL-BASED HOSPICE IDENTIFICATION	DATA		Provi der Co	CN: 15-0109	Peri od:	Worksheet S-9	
				Hospi ce CCI	N: 15-1563	From 01/01/2016 To 12/31/2016		pared:
						Hospi ce I	0/20/2017 0.0	о рііі
		Unduplicated		. '				
		Days						
		Title XVIII	Title XIX	Title XVIII	Title XIX	All Other	Total (sum of	
				Skilled	Nursi ng		cols. 1, 2 &	
				Nursi ng	Facility		5)	
				Facility				
		1.00	2.00	3.00	4. 00	5. 00	6. 00	
	PART I - ENROLLMENT DAYS FOR CO	ST REPORTING F	PERI ODS BEGINNI	NG BEFORE OCTO	BER 1, 2015			
1.00	Hospice Continuous Home Care							1. 00
2.00	Hospice Routine Home Care							2. 00
3.00	Hospice Inpatient Respite Care							3. 00
4.00	Hospice General Inpatient Care							4. 00
5.00	Total Hospice Days							5. 00
	Part II - CENSUS DATA FOR COST	REPORTING PERI	ODS BEGINNING	BEFORE OCTOBER	1, 2015			
6. 00	Number of patients receiving							6. 00
	hospi ce care							
7.00	Total number of unduplicated							7. 00
	Continuous Care hours billable to Medicare							
8. 00	Average Length of Stay (line 5							8.00
6.00	/ line 6)							0.00
9. 00	Unduplicated census count							9. 00
	Parts I and II, columns 1 and 2	alaa inaluda :	+ h o dovo nonon	tad in adjumpa	2 and 4			7.00
NOIE.	Parts Fand II, Corunnis Fand 2	at so Trici ude	the days repor	tea iii coruiiiis	3 aliu 4.			
				Title XVIII	Title XIX	0ther	Total (sum of	
							col s. 1	
							through 3)	
				1.00	2. 00	3. 00	4. 00	
	PART III - ENROLLMENT DAYS FOR	COST REPORTING	PERIODS BEGIN	1				
	Hospice Continuous Home Care			0		0		10.00
11. 00	Hospice Routine Home Care			16, 822		30 509		11.00
12.00	Hospice Inpatient Respite Care			30		0 11		12.00
	Hospice General Inpatient Care			5		1 3	9	
14. 00	Total Hospi ce Days	. DATA FOR	T DEBODELUS	16, 857		31 523		14.00
45.00	PART IV - CONTRACTED STATISTICA	L DATA FOR COS	SI KEPORIING PE					45.00
	Hospice Inpatient Respite Care			0		0 0		15.00
16.00	Hospice General Inpatient Care			0		0 0	0	16. 00

Heal th	Financial Systems FRANCISCAN HEALTI	H LAFAYFTTF		In Lie	u of Form CMS-2	2552-10
	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provi der CC	N: 15-0109	Peri od:	Worksheet S-10	
				From 01/01/2016 To 12/31/2016		pared:
		•				
					1. 00	
	Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 c	livided by lin	ne 202 columi	า 8)	0. 223587	1. 00
	Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		39, 722, 318			
3.00	Did you receive DSH or supplemental payments from Medicaid?				N	3. 00
4.00	If line 3 is "yes", does line 2 include all DSH or supplement		from Medicaio	1?		4. 00
5.00	If line 4 is "no", then enter DSH or supplemental payments fr	om Medicaid			0	5. 00
6.00	Medi cai d charges				202, 572, 577	
7.00	Medicaid cost (line 1 times line 6)	<i>-</i> .	6.11		45, 292, 595	
8.00	Difference between net revenue and costs for Medicaid program	n (line / mini	us sum of lii	nes 2 and 5; if	5, 570, 277	8. 00
	<pre>&lt; zero then enter zero) Children's Health Insurance Program (CHIP) (see instructions</pre>	for each line	2)			
9. 00	Net revenue from stand-alone CHIP	TOT EACH TITLE	=)		0	9. 00
10.00	Stand-allone CHIP charges				0	
11. 00	Stand-alone CHIP cost (line 1 times line 10)				0	
12. 00	Difference between net revenue and costs for stand-alone CHIF	(line 11 mi	nus line 0· i	f / zero then	0	12.00
12.00	enter zero)	(11116 11 11111	nus Tine 7, 1	1 \ Zero then	O	12.00
	Other state or local government indigent care program (see in	structions fo	or each line`			
13.00	Net revenue from state or local indigent care program (Not in		0	13. 00		
14.00	Charges for patients covered under state or local indigent ca	0	14. 00			
	10)					
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)	6 11				47.00
	Private grants, donations, or endowment income restricted to	9	,		- 1	17. 00
18.00	Government grants, appropriations or transfers for support of			. (6   !	0	
19. 00	Total unreimbursed cost for Medicaid , CHIP and state and loc	ai indigent o	care programs	s (sum or lines	5, 570, 277	19. 00
	8, 12 and 16)		Uni nsured	Insured	Total (col. 1	
			patients	patients	+ col . 2)	
			1. 00	2. 00	3. 00	
20. 00	Charity care charges for the entire facility (see instruction	ıs)	39, 650, 4		39, 650, 435	20. 00
21. 00	Cost of patients approved for charity care (line 1 times line		8, 865, 3		8, 865, 322	
22.00	Partial payment by patients approved for charity care	ŕ		0 0	0	22. 00
23.00	Cost of charity care (line 21 minus line 22)		8, 865, 3	22 0	8, 865, 322	23. 00
	•					
					1. 00	
24.00	Does the amount in line 20 column 2 include charges for patie		nd a Length o	of stay limit	N	24. 00
	imposed on patients covered by Medicaid or other indigent car					
25. 00	If line 24 is "yes," charges for patient days beyond an indi	th of stay limit	0			
26. 00	Total bad debt expense for the entire hospital complex (see i		3, 253, 052			
27. 00	Medicare bad debts for the entire hospital complex (see instr		752, 584			
28. 00	Non-Medicare and non-reimbursable Medicare bad debt expense (	•	,	0.0)	2, 500, 468	
29. 00	Cost of non-Medicare and non-reimbursable Medicare bad debt	expense (line	ı tımes line	28)	559, 072	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	line 20)			9, 424, 394	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus	1111e 30)			14, 994, 671	31.00

	Financial Systems	FRANCI SCAN HEALTI				u of Form CMS-2	2552-10
RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE (	OF EXPENSES	Provi der CO		Peri od:	Worksheet A	
					From 01/01/2016 o 12/31/2016	Date/Time Pre	nared·
						6/28/2017 3: 3	
	Cost Center Description	Sal ari es	0ther		Recl assi fi cati	Recl assi fi ed	
				+ col . 2)	ons (See A-6)	Trial Balance	
						(col. 3 +-	
		1.00	2.00	2.00	4.00	col . 4)	
	CENEDAL SEDVICE COST CENTERS	1.00	2. 00	3. 00	4. 00	5. 00	
1. 00	GENERAL SERVICE COST CENTERS  00100 CAP REL COSTS-BLDG & FIXT		15, 441, 812	15, 441, 812	5, 883, 074	21, 324, 886	1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP		13, 441, 612	15, 441, 612		3, 566, 611	2.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	1, 114, 338	25, 438, 286			26, 552, 624	4.00
5. 01	01160 COMMUNI CATI ONS	512, 854	764, 986			1, 277, 840	5. 01
5. 02	01140 MGMT INFO SYSTEMS	2, 801	14, 543, 864			14, 546, 665	5. 02
5.03	00550 PURCHASI NG	o	1, 496, 610			1, 496, 610	5. 03
5.04	00570 ADMITTING	-2, 111	1, 803	-308	o o	-308	5. 04
5.05	00580 PATIENT ACCOUNTING	0	5, 853, 175	5, 853, 175	0	5, 853, 175	5. 05
5.06	00560 OTHER ADMINISTRATIVE AND GENERAL	5, 978, 646	26, 532, 608			32, 470, 375	5. 06
7. 00	00700 OPERATION OF PLANT	2, 889, 608	7, 508, 577	10, 398, 185		10, 396, 703	7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	117, 313	777, 786			895, 099	8. 00
9.00	00900 HOUSEKEEPI NG	2, 063, 241	958, 257			3, 020, 021	9.00
10.00	01000 DI ETARY	2, 122, 393	1, 383, 895			1, 258, 689	10.00
11. 00 13. 00	01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON	0 720 050	112 047	2, 851, 897	_, _, _, , , , ,	2, 200, 410	11. 00 13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	2, 738, 850 431, 320	113, 047 864, 592			2, 851, 855 478, 730	14.00
15. 00	01500 PHARMACY	2, 858, 096	9, 450, 033			3, 558, 353	15.00
16. 00	01600 MEDICAL RECORDS & LIBRARY	62, 090	2, 620, 798			2, 682, 888	16.00
17. 00	01700 SOCI AL SERVI CE	634, 972	2, 383			451, 491	17. 00
20. 00	02000 NURSI NG SCHOOL	2, 030, 760	200, 704			2, 631, 509	20.00
23. 00	02301 PARAMED ED PRGM-(SPECIFY)	285, 366	42, 921	328, 287		653, 200	23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	· · ·			<u> </u>		
30.00	03000 ADULTS & PEDI ATRI CS	17, 990, 316	2, 039, 368	20, 029, 684	-6, 280, 161	13, 749, 523	30. 00
31.00	03100 INTENSIVE CARE UNIT	3, 500, 850	331, 468	3, 832, 318	-294, 109	3, 538, 209	31.00
35.00	02060 NEONATAL INTENSIVE CARE UNIT	1, 705, 874	828, 397	2, 534, 271	-67, 110	2, 467, 161	35. 00
40.00	04000 SUBPROVI DER - I PF	0	0	C	0	0	40. 00
41.00	04100 SUBPROVI DER - I RF	1, 101, 134	211, 917	1, 313, 051	-33, 743	1, 279, 308	41.00
42. 00	04200 SUBPROVI DER	0	0	C	0	0	42. 00
43. 00	04300 NURSERY	0	0		643, 536	643, 536	43. 00
F0 00	ANCILLARY SERVICE COST CENTERS	0.040.000	10 705 010	4/ /7/ 400	00 044 070	00.044.000	F0 00
50.00	05000 OPERATING ROOM	3, 940, 832	42, 735, 348				50.00
51.00	05100 RECOVERY ROOM	685, 439 0	38, 600	724, 039		688, 467	51.00
52. 00 54. 00	05200 DELIVERY ROOM & LABOR ROOM 05400 RADIOLOGY-DIAGNOSTIC	3, 344, 366	13, 407, 694	1	-,,	3, 869, 451 13, 964, 116	52. 00 54. 00
55. 00	03630 RADI OLOGY-THERAPEUTI C	412, 129	45, 860	457, 989		457, 989	55.00
56. 00	05600 RADI OI SOTOPE	226, 026	40, 034			260, 606	56.00
56. 01	03950 CARDI AC CATH LAB	1, 202, 447	3, 564, 378			1, 292, 467	56. 01
57. 00	05700 CT SCAN	644, 589	481, 786			1, 022, 535	
58. 00	05800 MRI	242, 782	229, 616			472, 398	58.00
60.00	06000 LABORATORY	0	9, 526, 570			9, 405, 253	60.00
65.00	06500 RESPIRATORY THERAPY	2, 105, 752	561, 818	2, 667, 570	-375, 855	2, 291, 715	65. 00
66.00	06600 PHYSI CAL THERAPY	2, 870, 676	507, 445	3, 378, 121	-209, 384	3, 168, 737	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	1, 057, 928	305, 126	1, 363, 054	-23, 345	1, 339, 709	67. 00
68. 00	06800 SPEECH PATHOLOGY	456, 195	15, 954	472, 149		467, 364	68. 00
69. 00	06900 ELECTROCARDI OLOGY	1, 417, 305	1, 366, 183			2, 757, 777	69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	609, 648	144, 004	1		708, 306	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	(	.0, , .0, 000	16, 940, 388	1
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	(	16, 360, 454	16, 360, 454	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	( 470	000 400	8, 518, 378	8, 518, 378	73.00
73. 01	07301 DI ABETES CENTER	301, 960	6, 470			307, 395	73. 01
74. 00 76. 98	07400 RENAL DIALYSIS 07698 HYPERBARIC OXYGEN THERAPY	117, 485	543, 838 332, 067			646, 887 330, 547	74. 00 76. 98
70. 90	OUTPATIENT SERVICE COST CENTERS	720	332, 007	332, 707	-2, 240	330, 347	70.90
88. 00	08800 RURAL HEALTH CLINIC		0		ار ار	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER		0			0	89. 00
90. 00	09000 CLINIC	372, 098	598, 927	971, 025	-301, 224	669, 801	90.00
91. 00	09100 EMERGENCY	6, 594, 571	1, 339, 527			6, 777, 986	91.00
91. 01	04950 WOUND CARE	1, 338, 554	383, 600			1, 382, 624	91. 01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	,				, , , , , ,	92.00
92. 01	09201 OBSERVATION BEDS (DISTINCT PART)	1, 779, 199	342, 047	2, 121, 246	-294, 951	1, 826, 295	92. 01
	OTHER REIMBURSABLE COST CENTERS			<u> </u>	<u> </u>		
95.00	09500 AMBULANCE SERVICES	2, 096, 678	838, 836	2, 935, 514	-235, 982	2, 699, 532	95. 00
99. 10	09910 CORF	0	0	C	0	0	99. 10
101. 00	10100 HOME HEALTH AGENCY	2, 621, 550	1, 407, 125	4, 028, 675	0	4, 028, 675	101. 00
	SPECIAL PURPOSE COST CENTERS						l
	10900 PANCREAS ACQUISITION	0	0	[ C	이		109. 00
	11000   NTESTI NAL ACQUI SI TI ON	0	0	]	0		110.00
	11100   SLET ACQUISITION	0	0 400 75-	0 400	0		111.00
	11300 I NTEREST EXPENSE	1 100 000	9, 408, 753			1, 790, 629	
116.00	11600 HOSPICE	1, 188, 820 83, 766, 460	662, 604			1, 851, 424 290, 007, 970	
110.00	SUBTOTALS (SUM OF LINES 1-117)	03, 700, 400	206, 241, 497	Z 7U, UU / , 95 /	13	270, 001, 9/0	1110.00

Health Financial Systems	FRANCISCAN HEAL	TH_LAFAYETTE		In Lie	eu of Form CMS-	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der Co		Peri od:	Worksheet A	
				From 01/01/2016 Fo 12/31/2016		
Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cati		
			+ col . 2)	ons (See A-6)	Trial Balance	
					(col. 3 +-	
					col . 4)	
	1.00	2. 00	3.00	4. 00	5. 00	
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	46, 707	31, 331	78, 038	0	78, 038	190. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	5, 692, 665	7, 132, 137	12, 824, 802	-13	12, 824, 789	192. 00
192. 01 19201 PHYSI CLANS' PRI VATE OFFI CES	0	0	(	0	0	192. 01
194. 00 07950 MOB	47, 893	1, 049	48, 942	0	48, 942	194. 00
194. 01 07951 LI FELI NE	16, 349	46, 395	62, 744	1 0	62, 744	194. 01
194.02 07952 PATIENT TRANSPORT	o	99, 622	99, 622	0	99, 622	194. 02
194.03 07953 SETON LEASE 1 NORTH	0	0	(	0	0	194. 03
200.00 TOTAL (SUM OF LINES 118-199)	89, 570, 074	213, 552, 031	303, 122, 105	5 o	303, 122, 105	200. 00

Provider CCN: 15-0109

Peri od: From 01/01/2016 To 12/31/2016 Date/Ti me Prepared: 6/28/2017 3:36 pm

				6/28/2017 3:3	6 pm
	Cost Center Description	Adjustments	Net Expenses		
		(See A-8)	For Allocation		
	CENEDAL CEDVICE COCT CENTEDO	6. 00	7. 00		
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT	1, 308, 760	22, 633, 646		1.00
2. 00	00200 CAP REL COSTS-MVBLE EQUIP	1, 515, 941			2.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	1, 966, 417			4. 00
5. 01	01160 COMMUNI CATI ONS	1,700,117	1		5. 01
5. 02	01140 MGMT INFO SYSTEMS	-2, 447, 740	, , , , , , , , , , , , , , , , , , , ,	•	5. 02
5. 03	00550 PURCHASI NG	-246, 857			5. 03
5.04	00570 ADMI TTI NG				5. 04
5.05	00580 PATIENT ACCOUNTING	-760, 543	5, 092, 632		5. 05
5.06	00560 OTHER ADMINISTRATIVE AND GENERAL	-14, 528, 091	17, 942, 284		5. 06
7.00	00700 OPERATION OF PLANT	-85, 514	10, 311, 189		7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	C	895, 099		8. 00
9.00	00900 HOUSEKEEPI NG	C	3, 020, 021		9. 00
10.00	01000 DI ETARY	-356, 812	901, 877		10. 00
11. 00	01100 CAFETERI A	-1, 139, 193	1, 061, 217		11. 00
13.00	01300 NURSING ADMINISTRATION	-326, 860	2, 524, 995		13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	-109, 976	368, 754		14. 00
15. 00	01500 PHARMACY	-271, 049			15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	-443, 368			16. 00
17. 00	01700 SOCIAL SERVICE	C		•	17. 00
20. 00	02000 NURSI NG SCHOOL	-4, 812		•	20. 00
23. 00	02301 PARAMED ED PRGM-(SPECIFY)	-84, 046	569, 154		23. 00
00.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	440.050	40 (0) 470	I	00.00
30.00	03000 ADULTS & PEDIATRICS	-113, 350		•	30.00
31.00	03100   NTENSI VE CARE UNI T	440 570		•	31.00
35. 00	02060 NEONATAL INTENSIVE CARE UNIT	-448, 578		1	35. 00
40.00	04000 SUBPROVI DER - I PF	(0.730	1	l .	40. 00 41. 00
41. 00 42. 00	04100 SUBPROVI DER - I RF	-60, 730	1	1	41.00
42.00	04200  SUBPROVI DER 04300  NURSERY	C	l .	l control of the cont	42.00
43.00	ANCI LLARY SERVI CE COST CENTERS		643, 536		43.00
50. 00	05000 OPERATI NG ROOM	-295, 316	23, 569, 586		50.00
51. 00	05100 RECOVERY ROOM	-275, 510		•	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM		1	•	52.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	-2, 978, 846		•	54.00
55. 00	03630 RADI OLOGY-THERAPEUTI C	2, 7,0,010			55.00
56. 00	05600 RADI OI SOTOPE	-8, 075		1	56.00
56. 01	03950 CARDI AC CATH LAB	-145, 120	1	1	56. 01
57. 00	05700 CT SCAN	0.10,120	1	1	57. 00
58. 00	05800 MRI		l e		58. 00
60.00	06000 LABORATORY	-74, 748			60.00
65. 00	06500 RESPIRATORY THERAPY	-20, 917		•	65. 00
66.00	06600 PHYSI CAL THERAPY	-83, 334			66. 00
67.00	06700 OCCUPATI ONAL THERAPY	C	i e		67. 00
68.00	06800 SPEECH PATHOLOGY	C			68. 00
69.00	06900 ELECTROCARDI OLOGY	-1, 165, 727	1, 592, 050		69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	-15, 000	693, 306		70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	C	16, 940, 388		71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	C	16, 360, 454		72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	C			73. 00
73. 01	07301 DI ABETES CENTER	-7, 479	1	•	73. 01
	07400 RENAL DIALYSIS	C		•	74. 00
76. 98	07698 HYPERBARI C OXYGEN THERAPY	C	330, 547		76. 98
00.00	OUTPATIENT SERVICE COST CENTERS				00.00
88. 00	08800 RURAL HEALTH CLINIC	C	0		88. 00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER		0		89.00
90.00	09000 CLINIC	11 050		1	90.00
91.00	09100 EMERGENCY	-11, 850		1	91.00
91. 01	04950 WOUND CARE	-4, 414	1, 378, 210		91. 01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART 09201 OBSERVATION BEDS (DISTINCT PART)		1 024 205		92.00
92. 01	OTHER REIMBURSABLE COST CENTERS	C	1, 826, 295		92. 01
95. 00		-23, 995	2, 675, 537		95.00
	09910 CORF	-23, 995			95.00
	10100 HOME HEALTH AGENCY	-1, 673	1	l .	101.00
101.00	SPECIAL PURPOSE COST CENTERS	-1,0/3	4,021,002	1	1,01.00
109 00	10900 PANCREAS ACQUISITION		0		109. 00
	11000 INTESTINAL ACQUISITION		1		110.00
	11100 I SLET ACQUI SI TI ON		ا ا		111.00
	11300 INTEREST EXPENSE	-1, 790, 629	ol o		113. 00
	11600 HOSPI CE	-183	ł		116.00
118.00	1	-23, 263, 707		•	118. 00
2. 20	NONREI MBURSABLE COST CENTERS				1
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	C	78, 038		190. 00
-					

Health Financial Systems	FRANCISCAN HEALTH	LAFAYETTE	In Lie	u of Form CMS-2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIA	L BALANCE OF EXPENSES		Peri od: From 01/01/2016	Worksheet A
				Date/Time Prepared:

			0/28/201/ 3:3	o piii
Cost Center Description	Adjustments	Net Expenses		
	(See A-8)	For Allocation		
	6. 00	7.00		
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	12, 824, 789		192. 00
192.01 19201 PHYSICIANS' PRIVATE OFFICES	0	0		192. 01
194.00 07950 MOB	0	48, 942		194. 00
194. 01 07951 LI FELI NE	0	62, 744		194. 01
194. 02 07952 PATIENT TRANSPORT	0	99, 622		194. 02
194.03 07953 SETON LEASE 1 NORTH	0	0		194. 03
200.00 TOTAL (SUM OF LINES 118-199)	-23, 263, 707	279, 858, 398		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: 36 pm Provider CCN: 15-0109

COST CONTEST   CLIPS   SAILARY   CTHON						6/28/2017 3:	36 pm
100			Increases				
A - RESTIALS							
1 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			3. 00	4. 00	5. 00		
2 00	1 00		4 00	ما	4 545 400		4.00
3.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00		CAP REL CUSTS-BLDG & FIXT	•	- 1			1
4.00							1
5.00							1
6 - 00			•		-		1
7. 00 9. 00 10				-1			1
B. CO			•	-			1
9 - 00    Totals				-1	-		
TOTAL S							
1.00	9.00	TOTALS — — — —					9.00
1.00				U <sub>I</sub>	1, 343, 430		-
2.00   0.00   0.00   0   0   0   0   0	1 00		2 00	ام	274 270		1 00
3.00		CAP REL COSTS-WVBEL EQUIP	•				1
4.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00			•				1
5.00 6.00 7.00 8.00 9.00 9.00 9.00 9.00 9.00 9.00 9							1
6.00 7.00 8.00 9.00 10.0							1
7.00 8.00 9.00 10.00 9.00 11.0			•	- 1			1
8.00				- 1			1
9.00 11.00 1				-			1
10.00				-1			
11 0			l l				1
12.00			•	-			1
13.00			•	- 1			1
TOTALS			•	-	-		1
C - MEDICAL SUPPLIES   1.00	13.00	<del></del>					13.00
1.00				U	274, 270		
PATLENT   ATLENT   ATLENTS   A	1 00		71 00	ما	14 040 200		1 00
2.00   MPL. DEV. CHARGED TO   72.00   0   16,360,494   2.00   ATTENTS   0.00   0.00   0   0   0   5.00   0.00   0.00   0   0   7.00   0.00   0.00   0   0   7.00   0.00   0.00   0   0   7.00   0.00   0.00   0   7.00   0.00   0.00   0   7.00   0.00   0.00   0   7.00   0.00   0.00   0   7.00   0.00   0   0   7.00   0.00	1.00		71.00	٥	10, 940, 300		1.00
PATIENTS	2 00		72 00	0	16 360 454		2 00
3.00   0.	2.00		72.00	Ĭ	10, 000, 101		2.00
4. 00 6. 00 6. 00 6. 00 7. 00 8. 00 9. 00 9. 00 10. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 16. 00 17. 00 18. 00 19. 00 11. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19.	3 00	I ATT ENTO	0.00	0	0		3 00
5.00   0.00   0.00   0   0   0   0   0			•	•			1
6. 00 7. 00 8. 00 7. 00 9. 00 10. 00 11. 00				- 1			1
7. 00 8. 00 9. 00 10. 00 9. 00 11. 00				- 1			1
8. 00 9. 00 10. 00 10. 00 11.			•	- 1			1
9 00   0 0 0 0 0 0 0 0 0 0 0 0 0 10 0 11 00 11 00 11 10 00 11 10 00 11 10 00 11 10 00 11 10 00 11 10 00 11 10 00 11 10 00 11 10 00 11 10 00 11 10 00 11 10 00 11 10 00 11 10 00 11 10 00 11 11			l l	- 1			1
10.00   10.00   10.00   10.00   11.00   12.00   13.00   12.00   13.00   14.00   14.00   14.00   14.00   15.00   16.00   0.00   0.00   0.00   0.00   15.00   16.00   17.00   18.00   18.00   19.00   0.00   0.00   0.00   0.00   18.00   19.0				- 1			1
11. 00 12. 00 13. 00 14. 00 14. 00 15. 00 16. 00 16. 00 16. 00 17. 00 18. 00 18. 00 19							1
12.00				- 1			1
13.00			•				1
14. 00							
15. 00 16. 00 16. 00 16. 00 16. 00 17. 00 18. 00 19. 00 0				- 1			
16. 00				•			1
17. 00			•	•			
18. 00     19. 00     20. 00     0   0   0   0   0   0   19. 00   20. 00							1
19. 00     19. 00     20. 00				- 1			
20. 00 21. 00 22. 00 22. 00 23. 00 24. 00 24. 00 25. 00 26. 00 27. 00 28. 00 29. 00  TOTALS  D - DRUGS  D - DR							
21. 00 22. 00 22. 00 23. 00 24. 00 24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 29. 00 29. 00 29. 00 29. 00 20				- 1			1
23. 00 24. 00 24. 00 25. 00 26. 00 26. 00 27. 00 28. 00 29. 00  TOTALS  D - DRUGS  DRUGS CHARGED TO PATIENTS  TO 0. 00 T							
23. 00 24. 00 24. 00 25. 00 26. 00 26. 00 27. 00 28. 00 29. 00  TOTALS  D - DRUGS  DRUGS CHARGED TO PATIENTS  TO 0. 00 T					0		
24. 00				- 1			
25. 00 26. 00 26. 00 27. 00 28. 00 29. 00  TOTALS  D - DRUGS  DRUGS CHARGED TO PATIENTS  73. 00 0. 00				- 1			
26. 00 27. 00 28. 00 29. 00 29. 00  TOTALS  D - DRUGS  DRUGS CHARGED TO PATIENTS  73. 00  0.				- 1			
27. 00 28. 00 29. 00  TOTALS  D - DRUGS  1. 00  0. 00  11. 00  11. 00  12. 00  13. 00  13. 00				-			
28. 00 29. 00  TOTALS  D - DRUGS  1. 00  DRUGS CHARGED TO PATIENTS  73. 00  0. 00  0. 00  0. 33, 300, 842   1. 00  2. 00  3. 00  4. 00  5. 00  6. 00  7. 00  8. 00  9. 00  9. 00  1. 00				- 1			
29. 00   TOTALS		-		-1	-		
TOTALS D - DRUGS  1. 00 DRUGS CHARGED TO PATIENTS 73. 00 0.							
D - DRUGS  1. 00 DRUGS CHARGED TO PATIENTS 73. 00 0 8, 518, 378 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 9. 00 10. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 10. 00 10. 00 10. 00 10. 00 11. 00 11. 00 12. 00 13. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 10. 00 10. 00 11. 00 11. 00 12. 00 13. 00	29.00	L			0		29.00
1. 00   DRUGS CHARGED TO PATIENTS   73. 00   0   8, 518, 378   1. 00   2. 00   3. 00   4. 00   5. 00   6. 00   0   0   0   0   0   0   0   0   0				υĮ	33, 300, 842		-
2. 00     0. 00     0     0     0     3. 00       3. 00     0. 00     0     0     0     3. 00       4. 00     0. 00     0     0     0     4. 00       5. 00     0. 00     0     0     0     5. 00       6. 00     0. 00     0     0     0     6. 00       7. 00     0. 00     0     0     0     0     0       8. 00     0. 00     0     0     0     0     0     0       9. 00     0. 00     0     0     0     0     0     10. 00       11. 00     0. 00     0     0     0     0     12. 00       13. 00     0. 00     0     0     0     0     13. 00	1 00		72 00	Ol	Q 510 270		1 00
3. 00       0.00       0       0       0       3. 00         4. 00       0. 00       0       0       0       4. 00         5. 00       0. 00       0       0       0       5. 00         6. 00       0. 00       0       0       0       6. 00         7. 00       0. 00       0       0       0       7. 00         8. 00       0. 00       0       0       0       8. 00         9. 00       0. 00       0       0       9. 00       10. 00         10. 00       0. 00       0       0       0       11. 00         11. 00       0. 00       0       0       0       12. 00         13. 00       0. 00       0       0       0       13. 00		DRUGS CHARGED TO FATTENTS		•			
4.00     0.00     0     0     4.00       5.00     0.00     0     0     5.00       6.00     0.00     0     0     6.00       7.00     0.00     0     0     7.00       8.00     0.00     0     0     8.00       9.00     0.00     0     0     9.00       10.00     0.00     0     0     10.00       11.00     0.00     0     0     11.00       12.00     0.00     0     0     12.00       13.00     0.00     0     0     13.00							
5. 00     0. 00     0     0     5. 00       6. 00     0. 00     0     0     6. 00       7. 00     0. 00     0     0     7. 00       8. 00     0. 00     0     0     8. 00       9. 00     0. 00     0     0     9. 00       10. 00     0. 00     0     0     10. 00       11. 00     0. 00     0     0     11. 00       12. 00     0. 00     0     0     0     12. 00       13. 00     0. 00     0     0     0     13. 00							
6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 11. 00 11. 00 11. 00 12. 00 13. 00				•			
7. 00 8. 00 9. 00 0 0 0 0 8. 00 9. 0							
8. 00     0. 00     0     0     8. 00       9. 00     0. 00     0     0     9. 00       10. 00     0. 00     0     0     10. 00       11. 00     0. 00     0     0     11. 00       12. 00     0. 00     0     0     12. 00       13. 00     0. 00     0     0     13. 00							
9.00     0.00     0     0     9.00       10.00     0.00     0     0     10.00       11.00     0.00     0     0     11.00       12.00     0.00     0     0     12.00       13.00     0.00     0     0     13.00				- 1			
10. 00     0. 00     0     0     10. 00       11. 00     0. 00     0     0     11. 00       12. 00     0. 00     0     0     12. 00       13. 00     0. 00     0     0     0				•			
11. 00     0. 00     0     0     11. 00       12. 00     0. 00     0     0     12. 00       13. 00     0. 00     0     0     0				•			
12. 00 13. 00 0. 00 0 0 12. 00 13. 00 0 0 13. 00							
13.00							
14.00							
	14.00	1	0.00	이	0		14.00

Cost Center   Line # Sal ary   Other						То	12/31/2016	Date/Time Prepared: 6/28/2017 3:36 pm
Cost Center			Increases					072072017 3.30 piii
15.00		Cost Center		Salary	Other			
15.00								
16.00	15 00	2.00						15 00
17. 00				o	0			
18. 00				o	0			
19.00   0.00   0   0   0   0   0   0   0				Ö	0			
20.00				Ö	0			
TOTALS				Ö	0			
E - LDRP  NURSERY  1. 00  DELL VERY ROOM & LABOR ROOM  52. 00  3. 461, 692  4. 037, 413  475, 574  F - CAFETERIA  1. 00  CAFETERIA  1. 00  CAFETERIA  1. 00  CAP REL COSTS-MVBLE EQUIP  1. 00  CAP REL COSTS-MVBLE EQUIP  1. 00  CAP REL COSTS-MVBLE EQUIP  2. 00  0. 0  1. 00  TOTALS  1. NURSING SCHOOL  1. NURSING SCHOOL  1. 00  NURSING SCHOOL  1. 00  DARAMED ED PRGM- (SPECI FY)  2. 00  DARAMED ED PRGM- (SPECI FY)  2. 00  DARAMED ED PRGM- (SPECI FY)  2. 00  DARAMED SENEFITS DEPARTMENT  1. 00  RURSING SCHOOL  1. 00  TOTALS  TOTALS  1. 00  TOTALS  TOTALS  1. 00  TOTALS  TOTA	20.00	TOTALS — — — —	<u> </u>		8 518 378			25. 55
1. 00   NURSERY   43. 00   575, 721   67, 815   2. 00   DELI VERY ROOM & LABOR ROOM   52. 00   3, 461, 692   407, 759   10TALS   75, 741   75, 744   77, 759   75, 721   75, 744   77, 759   75, 744   77, 759   75, 744   77, 759   75, 744   77, 759   75, 744   77, 759   75, 744   77, 759   75, 744   77, 759   75, 744   77, 759   75, 744   77, 759   75, 744   77, 759   75, 744   75, 754   75, 744   75, 754   75, 744   75, 754   75, 754   75, 744   75, 754   75, 754   75, 744   75, 754   75, 744   75, 754   75, 744   75, 754   75, 744   75, 754   75, 744   75, 754   75, 744   75, 754   75, 744   75, 754   75, 744   75, 754   75, 744   75, 754   75, 744   75, 754   75, 744   75, 754   75, 744   75, 7					0,0.0,0.0			
DELIVERY ROOM & LABOR ROOM   52.00   3.461.692   407,759   707ALS   7.50   7.	1.00		43.00	575, 721	67. 815			1.00
TOTALS								2. 00
Totals								
1.00   CAFETERI A				.,,				
TOTALS	1.00		11. 00	1, 358, 712	841, 698			1, 00
Cap Rel Costs-Myble Equip   2.00								
1. 00 CAP REL COSTS-MVBLE EQUIP 2. 00 0 11, 861 TOTALS 0 1, 801 TOTALS 1. 00 11, 861 TOTALS 1. 00 CAP REL COSTS-BLDG & FIXT 1. 00 0 3, 280, 480 TOTALS 1. NURSI NG SCHOOL 1. NURSI NG SCHOOL 1. NURSI NG SCHOOL 1. 00 NURSI NG SCHOOL 20. 00 174, 618, 124 TOTALS 1. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		G - CAPITAL EXP (INT & DEP)		,				
TOTALS	1.00		2. 00	0	11, 861			1.00
1.00 CAP REL COSTS-BLDG & FIXT		TOTALS						
2. 00 CAP REL COSTS-MVBLE EQUI P 2. 00 0 3, 280, 480 TOTALS 0 7, 618, 124  1. ON NURSI NG SCHOOL  1. 00 NURSI NG SCHOOL  20. 00 79, 651 147, 092  3. 00 TOTALS 20. 00 9. 0 9. 0 9. 0 9. 0 9. 0 9. 0 9.		H - INTEREST		,	· · · · ·			
TOTALS	1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	4, 337, 644			1.00
1 - NURSI NG SCHOOL   20.00   173, 302   0   1.00	2.00	CAP REL COSTS-MVBLE EQUIP	2.00	O	3, 280, 480			2. 00
1. 00		TOTALS			7, 618, 124			
2. 00		I - NURSING SCHOOL						
3. 00 TOTALS	1.00	NURSING SCHOOL	20. 00	173, 302	0			1.00
TOTALS	2.00	NURSING SCHOOL	20.00	79, 651	147, 092			2. 00
J - PARAMED PROGRAM	3.00		0.00	0	0			3.00
1. 00 PARAMED ED PRGM-(SPECIFY) 23. 00 75, 317 96, 750 2. 00 PARAMED ED PRGM-(SPECIFY) 23. 00 153, 700 0 2. 00 3. 00 TOTALS 229, 017 96, 750   K - FSEH SHARED SERVICES  1. 00 EMPLOYEE BENEFITS DEPARTMENT 4. 00 0 125, 154 2. 00 OTHER ADMINISTRATIVE AND 5. 06 0 807, 560 GENERAL 3. 00 NURSING ADMINISTRATION 13. 00 0 302, 515 3. 00 PHARMACY 15. 00 155, 238 10. 00 1, 290, 467				252, 953	147, 092			
2. 00 PARAMED ED PRGM-(SPECIFY) 23. 00 153, 700 0 2. 00 3. 00								
3. 00 TOTALS 229, 017 96, 750					96, 750			1.00
TOTALS		PARAMED ED PRGM-(SPECIFY)		153, 700	0			2. 00
K - FSEH SHARED SERVICES	3.00		0. 00	0	0			3. 00
1. 00				229, 017	96, 750			
2. 00 OTHER ADMINISTRATIVE AND S. 06 O 807, 560 C 2. 00 GENERAL 3. 00 NURSING ADMINISTRATION 13. 00 O 302, 515 S. 00 O 1, 290, 467								
GENERAL 3. 00 NURSI NG ADMI NI STRATI ON 13. 00 0 302, 515 4. 00 PHARMACY 15. 00 0 55, 238 TOTALS 0 1, 290, 467				0				1.00
3. 00 NURSI NG ADMI NI STRATI ON 13. 00 0 302, 515 4. 00 PHARMACY 15. 00 55, 238 TOTALS 0 1, 290, 467	2.00		5. 06	0	807, 560			2. 00
4. 00 PHARMACY								
TOTALS 0 1,290,467				0				
	4.00		<u>15.</u> 00	•				4.00
				0				
500. 00   GLAND TOTAL: THE BASES   5,878,095   54,120,486   500.00	500.00	Grand Total: Increases		5, 878, 095	54, 120, 486			500. 00

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

					-	To 12/31/2016 Date/Time Pr 6/28/2017 3:	
		Decreases					
	Cost Center 6.00	Li ne # 7.00	Sal ary 8.00	0ther 9.00	Wkst. A-7 Ref. 10.00		
	A - RENTALS	71.00	0.00	7.00	10100		
1.00	DIETARY	10.00	0	45, 653		l control of the cont	1. 00
2. 00 3. 00	ADULTS & PEDIATRICS OPERATING ROOM	30. 00 50. 00	0	261, 732 112, 205		l control of the cont	2. 00 3. 00
4.00	RADI OLOGY-DI AGNOSTI C	54.00	0	686, 081	10	l control of the cont	4. 00
5. 00	LABORATORY	60.00	Ö	9, 247	10	l control of the cont	5. 00
6.00	PHYSI CAL THERAPY	66. 00	O	65, 956		l control of the cont	6. 00
7.00	EMERGENCY OBSERVATION BEDS (DISTINCT	91.00	0	126, 529		ł	7. 00
8. 00	PART)	92. 01	U	214, 586	10		8. 00
9.00	AMBULANCE SERVICES	95.00	0	23, 441	10		9. 00
	TOTALS			1, 545, 430			
1. 00	B - EQUIPMENT RENTAL OPERATION OF PLANT	7. 00	0	1, 482	10	ı	1.00
2.00	HOUSEKEEPI NG	9.00	0	1, 402		l control of the cont	2. 00
3.00	DI ETARY	10. 00	0	1, 536	10	l control of the cont	3. 00
4.00	CENTRAL SERVICES & SUPPLY	14.00	0	18, 765		l control of the cont	4. 00
5. 00 6. 00	PHARMACY ADULTS & PEDIATRICS	15. 00 30. 00	0	196, 371 14, 285	10	l control of the cont	5. 00 6. 00
7. 00	INTENSIVE CARE UNIT	31.00	0	2, 778		ł	7. 00
8.00	SUBPROVI DER - I RF	41. 00	0	35	10	l .	8. 00
9.00	OPERATING ROOM	50.00	0	6, 314		l control of the cont	9. 00
10. 00 11. 00	CT SCAN RESPIRATORY THERAPY	57. 00 65. 00	0	7, 000 19, 321	10	l control of the cont	10. 00 11. 00
12. 00	PHYSI CAL THERAPY	66.00	0	3, 057		l control of the cont	12.00
13. 00	ELECTROENCEPHALOGRAPHY	<u>70.</u> 00	O	1, 849		l control of the cont	13. 00
	TOTALS		0	274, 270			
1. 00	C - MEDICAL SUPPLIES NURSING ADMINISTRATION	13. 00	0	42			1.00
2.00	CENTRAL SERVICES & SUPPLY	14. 00	0	797, 673		l .	2. 00
3.00	PHARMACY	15. 00	0	555, 555		l .	3. 00
4.00	PARAMED ED PRGM-(SPECIFY)	23.00	0	854		l .	4. 00
5. 00 6. 00	ADULTS & PEDIATRICS INTENSIVE CARE UNIT	30. 00 31. 00	0	1, 246, 570 268, 967	0		5. 00 6. 00
7. 00	NEONATAL INTENSIVE CARE UNIT	35. 00	Ö	64, 535		l .	7. 00
8.00	SUBPROVI DER - I RF	41. 00	0	32, 433		l .	8. 00
9.00	OPERATING ROOM	50.00	0	22, 608, 741	O		9. 00
10. 00 11. 00	RECOVERY ROOM RADIOLOGY-DIAGNOSTIC	51. 00 54. 00	0	35, 250 2, 037, 707	0	l control of the cont	10. 00 11. 00
12. 00	RADI OI SOTOPE	56.00	Ö	5, 454		l control of the cont	12. 00
13. 00	CARDIAC CATH LAB	56. 01	0	3, 473, 608		l control of the cont	13. 00
14. 00 15. 00	LABORATORY RESPIRATORY THERAPY	60. 00 65. 00	0	112, 070 353, 105			14. 00 15. 00
16. 00	PHYSICAL THERAPY	66. 00	0	139, 567		l control of the cont	16. 00
17. 00	OCCUPATI ONAL THERAPY	67.00	o	23, 198	C		17. 00
18. 00	SPEECH PATHOLOGY	68. 00	0	4, 785		l control of the cont	18. 00
19. 00 20. 00	ELECTROCARDI OLOGY ELECTROENCEPHALOGRAPHY	69. 00 70. 00	0	24, 410 43, 497	C	·	19. 00 20. 00
21. 00	DI ABETES CENTER	73. 01	0	1, 035		ł	21.00
22. 00	RENAL DIALYSIS	74.00	0	14, 436		l control of the cont	22. 00
23. 00	HYPERBARIC OXYGEN THERAPY	76. 98	0	2, 240			23. 00
24. 00 25. 00	CLI NI C EMERGENCY	90. 00 91. 00	0	38, 569 894, 753		l control of the cont	24. 00 25. 00
26. 00	WOUND CARE	91.00	0	335, 447			26. 00
27. 00	OBSERVATION BEDS (DISTINCT	92. 01	0	73, 824			27. 00
20.00	PART)	05.00		112 50/			20.00
28. 00 29. 00	AMBULANCE SERVICES PHYSICIANS' PRIVATE OFFICES	95. 00 192. 00	0	112, 506 13		l control of the cont	28. 00 29. 00
27.00	TOTALS	172.00	0	33, 300, 844			27.00
	D - DRUGS						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	744			1. 00
2. 00 3. 00	PHARMACY ADULTS & PEDIATRICS	15. 00 30. 00	0	7, 825, 783 71, 285		l control of the cont	2. 00 3. 00
4. 00	INTENSIVE CARE UNIT	31.00	0	22, 364		l .	4. 00
5.00	NEONATAL INTENSIVE CARE UNIT	35. 00	0	2, 575	C		5. 00
6.00	SUBPROVI DER - I RF	41. 00	0	1, 275		l control of the cont	6.00
7. 00 8. 00	OPERATING ROOM RECOVERY ROOM	50. 00 51. 00	0	84, 018 322			7. 00 8. 00
9.00	RADI OLOGY-DI AGNOSTI C	54.00	0	52, 295		l .	9. 00
10. 00	CARDI AC CATH LAB	56. 01	o	750			10. 00
11.00	CT SCAN	57.00	0	96, 840			11.00
12. 00 13. 00	RESPI RATORY THERAPY PHYSI CAL THERAPY	65. 00 66. 00	0	3, 429 804			12. 00 13. 00
14. 00	OCCUPATIONAL THERAPY	67. 00	0	147		l .	14. 00
	1	37.30	9			I	

Period: Worksheet A-6 From 01/01/2016 To 12/31/2016 Date/Time Prepared: 6/28/2017 3:36 pm

						6/28/2017 3:36 pr	<u>m</u>
		Decreases					
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10. 00		
15. 00	ELECTROCARDI OLOGY	69.00	0	1, 301	0	15	5. 00
16.00	CLINIC	90.00	o	262, 655	ol	16	5. 00
17. 00	EMERGENCY	91, 00	0	50, 131	0	17	7. 00
18. 00	WOUND CARE	91. 01	0	4, 083	o o		3. 00
19. 00	OBSERVATION BEDS (DISTINCT	92. 01	0	6, 541	0		9. 00
17.00	PART)	72.01	Ĭ	0,011	١	''	. 00
20.00	AMBULANCE SERVICES	95.00	0	31, 034	0	20	0. 00
20.00	TOTALS	— — <del>70.</del> 00	— — — <del> </del>	8, 518, 376			00
	E - LDRP		9	0,010,070			
1.00	ADULTS & PEDIATRICS	30.00	4, 037, 413	475, 574	0	1	1. 00
2. 00	ADDETS & LEDIATRICS	0.00	4, 037, 413	473, 374	0		2. 00
2.00	TOTALS — — — —		4, 037, 413	475, 574			00
	F - CAFETERIA		4, 037, 413	4/5, 5/4			
4 00		40.00	4 050 740	0.44 (00			
1.00	DI ETARY	10.00	<u>1, 358, 712</u>	84 <u>1, 6</u> 98		1	1. 00
	TOTALS		1, 358, 712	841, 698			
	G - CAPITAL EXP (INT & DEP)						
1.00	RADI OLOGY-DI AGNOSTI C	<u>54.</u> 00		1 <u>1, 8</u> 61	9	1	1. 00
	TOTALS		0	11, 861			
	H - INTEREST						
1.00	INTEREST EXPENSE	113. 00	0	7, 618, 124			1. 00
2.00		0.00	0	0	11	2	2. 00
	TOTALS		0	7, 618, 124			
	I - NURSING SCHOOL						
1.00	ADULTS & PEDIATRICS	30.00	173, 302	0	0	1	1. 00
2.00	OTHER ADMINISTRATIVE AND	5.06	36, 188	4, 691	o	2	2. 00
	GENERAL						
3.00	SOCI AL SERVI CE	17. 00	43, 463	142, 401	o	3	3. 00
	TOTALS	$+$	252, 953	147, 092	- $  1$		
	J - PARAMED PROGRAM	<u>'</u>					
1.00	PHARMACY	15. 00	75, 317	96, 750	0	1	1. 00
2.00	EMERGENCY	91. 00	84, 699	0	1		2. 00
3. 00	AMBULANCE SERVICES	95.00	69, 001	0			3. 00
5.00	TOTALS		229, 017	96, 750	$-$		7. 00
	K - FSEH SHARED SERVICES		227, 017	70, 730			
1. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	125, 154	0	0	1	1. 00
2. 00	OTHER ADMINISTRATIVE AND	5. 06		0	0	·	2. 00
2.00		5.06	807, 560	U	U	2	1. 00
0.00	GENERAL ADMINISTRATION	40.00	200 545				
3.00	NURSI NG ADMI NI STRATI ON	13. 00	302, 515	0	0		3. 00
4.00	PHARMACY	1500	55, 238	0	— — Ч	4	4. 00
	TOTALS		1, 290, 467	0			
500.00	Grand Total: Decreases		7, 168, 562	52, 830, 019		500	0. 00

					To 12/31/2016		
				Acqui si ti ons		0/20/2017 3.30	J pili
		Begi nni ng	Purchases	Donati on	Total	Di sposal s and	
		Bal ances				Retirements	
		1.00	2. 00	3. 00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET						
1.00	Land	12, 785, 293	4, 280		0 4, 280		1. 00
2.00	Land Improvements	2, 289, 541	0		0	49, 023	2. 00
3.00	Buildings and Fixtures	241, 926, 704	13, 170, 851		0 13, 170, 851	0	3. 00
4.00	Building Improvements	0	0		0	0	4. 00
5.00	Fi xed Equi pment	0	0		0	0	5. 00
6.00	Movable Equipment	75, 546, 446	7, 114, 989		0 7, 114, 989	0	6. 00
7.00	HIT designated Assets	0	0		0	0	7. 00
8.00	Subtotal (sum of lines 1-7)	332, 547, 984	20, 290, 120		0 20, 290, 120	49, 023	
9.00	Reconciling Items	0	0		0	0	9. 00
10.00	Total (line 8 minus line 9)	332, 547, 984	20, 290, 120		0 20, 290, 120	49, 023	10.00
		Endi ng Bal ance	Fully				
			Depreci ated				
			Assets				
	T	6. 00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE		_				
1. 00	Land	12, 789, 573	0				1. 00
2.00	Land Improvements	2, 240, 518	0				2. 00
3.00	Buildings and Fixtures	255, 097, 555	0				3. 00
4. 00	Building Improvements	0	0				4. 00
5.00	Fixed Equipment	0	0				5. 00
6. 00	Movable Equipment	82, 661, 435	0				6. 00
7.00	HIT designated Assets	0	0				7. 00
8.00	Subtotal (sum of lines 1-7)	352, 789, 081	0				8. 00
9.00	Reconciling Items	0	0				9. 00
10. 00	Total (line 8 minus line 9)	352, 789, 081	0			l	10. 00

Heal th	Financial Systems	FRANCI SCAN HEAL	TH LAFAYETTE		In Lieu of Form CMS-2552-10			
RECONC	CILIATION OF CAPITAL COSTS CENTERS		Provi der Co	CN: 15-0109	Peri od:	Worksheet A-7		
					From 01/01/2016 To 12/31/2016		nared·	
					12,01,2010	6/28/2017 3:3		
			Sl	JMMARY OF CAP	PITAL			
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see	Taxes (see		
					instructions)			
		9. 00	10. 00	11.00	12. 00	13. 00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	KSHEET A, COLUM	N 2, LINES 1 a	nd 2				
1.00	CAP REL COSTS-BLDG & FIXT	15, 441, 812	0		0 0	0	1. 00	
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		0 0	0	2. 00	
3.00	Total (sum of lines 1-2)	15, 441, 812	0		0 0	0	3. 00	
		SUMMARY 0	F CAPITAL					
	Cost Center Description	Other	Total (1) (sum	_				
	'	Capi tal -Relate						
		d Costs (see	through 14)					
		instructions)						
		14. 00	15. 00					
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	KSHEET A, COLUM	N 2, LINES 1 a	nd 2				
1.00	CAP REL COSTS-BLDG & FIXT	0	15, 441, 812		·		1. 00	
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2. 00	
3.00	Total (sum of lines 1-2)	0	15, 441, 812				3. 00	

Heal th	n Financial Systems	FRANCISCAN HEAI	LTH LAFAYETTE		In Lie	eu of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provider C		Period: From 01/01/2016 To 12/31/2016	Worksheet A-7 Part III Date/Time Pre 6/28/2017 3:3	pared:
		COMI	PUTATION OF RA	TIOS	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets		Insurance	
			Leases	for Ratio	instructions)		
				(col . 1 - col 2)	•		
		1.00	2.00	3.00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS CI	ENTERS					
1.00	CAP REL COSTS-BLDG & FLXT	0	C	)	0 1.000000		1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		0. 000000		2. 00
3.00	Total (sum of lines 1-2)	0	0	0.451.741	0 1.000000		3. 00
		ALLUCA	TION OF OTHER (	CAPITAL	SUMMARY U	F CAPITAL	
	Cost Center Description	Taxes	Other	Total (sum o	f Depreciation	Lease	
			Capi tal -Rel ate				
		6. 00	d Costs 7.00	through 7) 8.00	9, 00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CI		7.00	0.00	9.00	10.00	
1.00	CAP REL COSTS-BLDG & FLXT	0	0	ol	0 17, 256, 639	1, 545, 430	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	Ö		0 1, 910, 532		2. 00
3.00	Total (sum of lines 1-2)	0	0		0 19, 167, 171	1, 819, 700	3. 00
			SI	JMMARY OF CAPI	TAL		
	Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
			instructions)	instructions	) Capital-Relate		
					d Costs (see	through 14)	
		11.00	12.00	13.00	instructions) 14.00	15. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS CI		12.00	13.00	14.00	15.00	
1.00	CAP REL COSTS-BLDG & FLXT	3, 831, 577	0		0 0	22, 633, 646	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2, 897, 750		1	0 0	1	2. 00
3.00	Total (sum of lines 1-2)	6, 729, 327			0 0		3. 00

				F Ti	rom 01/01/2016 o 12/31/2016		
				Expense Classification on	Worksheet A	6/28/2017 3: 36	5 pm
				To/From Which the Amount is			
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
1.00	Laurent in some CAR REL	1.00	2. 00	3.00	4. 00	5. 00	1.00
1. 00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	В	-506, 067	CAP REL COSTS-BLDG & FIXT	1. 00	11	1. 00
2.00	Investment income - CAP REL	В	-382, 730	CAP REL COSTS-MVBLE EQUIP	2. 00	11	2. 00
3.00	COSTS-MVBLE EQUIP (chapter 2) Investment income - other		0		0. 00	0	3. 00
	(chapter 2)						
4. 00	Trade, quantity, and time discounts (chapter 8)		0		0. 00	0	4. 00
5.00	Refunds and rebates of		0		0. 00	o	5. 00
6. 00	expenses (chapter 8) Rental of provider space by		0		0. 00	o	6. 00
7.00	suppliers (chapter 8)				0.00		7.00
7. 00	Telephone services (pay stations excluded) (chapter		Ü		0. 00	0	7. 00
0.00	21)				0.00		0.00
8. 00	Television and radio service (chapter 21)		U		0. 00	0	8. 00
9.00	Parking lot (chapter 21)	4 0 0	0		0. 00	0	
10. 00	Provider-based physician adjustment	A-8-2	-6, 973, 326			U	10. 00
11. 00	Sale of scrap, waste, etc. (chapter 23)		0		0. 00	0	11. 00
12. 00	Related organization	A-8-1	-5, 105, 779			0	12. 00
13. 00	transactions (chapter 10) Laundry and linen service		0		0. 00	0	13. 00
14. 00	Cafeteria-employees and guests	В	-1, 139, 193	CAFETERI A	11. 00	o	14. 00
15. 00	Rental of quarters to employee and others		0		0.00	0	15. 00
16. 00	Sale of medical and surgical supplies to other than		0		0. 00	0	16. 00
	pati ents						
17. 00	Sale of drugs to other than patients		0		0. 00	0	17. 00
18. 00	Sale of medical records and		0		0. 00	О	18. 00
19. 00	abstracts Nursing school (tuition, fees, books, etc.)		0		0. 00	0	19. 00
20. 00	Vending machines	В	-25, 051	DI ETARY	10.00	О	
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 overpayments and borrowings to		0		0. 00	0	22. 00
	repay Medicare overpayments			5505 54705 7455454	45.00		
23. 00	Adjustment for respiratory therapy costs in excess of	A-8-3	0	RESPI RATORY THERAPY	65. 00		23. 00
0.4.00	limitation (chapter 14)	4.0.0	0	DUVCI OAL THEDADY	44.00		0.4.00
24. 00	Adjustment for physical therapy costs in excess of	A-8-3	U	PHYSI CAL THERAPY	66. 00		24. 00
25 00	limitation (chapter 14)		0	*** Coot Conton Doloted ***	114. 00		25 00
25. 00	Utilization review - physicians' compensation		Ü	*** Cost Center Deleted ***	114.00		25. 00
26. 00	(chapter 21) Depreciation - CAP REL		0	CAD DEL COSTS BLDC # ELVT	1 00	0	26. 00
20.00	COSTS-BLDG & FLXT		Ü	CAP REL COSTS-BLDG & FIXT	1. 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 30. 00	Physicians' assistant Adjustment for occupational	A-8-3	0	OCCUPATI ONAL THERAPY	0. 00 67. 00	0	29. 00 30. 00
55. 55	therapy costs in excess of		0	TIEN I	37.00		55. 66
30. 99	Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30. 00		30. 99
	instructions)	4.0.0					
31. 00	Adjustment for speech pathology costs in excess of	A-8-3	0	SPEECH PATHOLOGY	68. 00		31. 00
22 00	limitation (chapter 14) CAH HIT Adjustment for		0		0.00	0	32. 00
32. 00	Depreciation and Interest				0. 00		
33. 00	RECRUI TMENT	A	-102, 560	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	33. 00

					o 12/31/2016		
				Expense Classification on	Worksheet A	6/28/2017 3: 3	o piii
				To/From Which the Amount is			
	Cost Center Description	Basis/Code (2)	Amount	Cost Center		Wkst. A-7 Ref.	
		1.00	2.00	3. 00	4. 00	5. 00	
33. 01	RECRUI TMENT	A		OTHER ADMINISTRATIVE AND	5. 06	0	33. 01
				GENERAL			
33. 02	HAF	A		OTHER ADMINISTRATIVE AND	5. 06	0	33. 02
	ABVERTI OLNIG EVE			GENERAL			
33. 03	ADVERTISING EXP	A		EMPLOYEE BENEFITS DEPARTMENT		0	33. 03
33. 04	ADVERTISING EXP	A		NURSI NG SCHOOL	20.00	0	33. 04
33. 05	ADVERTISING EXP	A		RADI OLOGY-DI AGNOSTI C	54.00	0	33. 05
33. 06	ADVERTI SI NG EXP	A		ELECTROCARDI OLOGY	69. 00	0	33. 06
33. 07	MARKETING EXP	A		SUBPROVI DER - I RF	41.00	0	33. 07
33. 08	MARKETING EXP	A		OTHER ADMINISTRATIVE AND	5. 06	0	33. 08
22.00	MADKETING EVD			GENERAL	10.00		22.00
33. 09	MARKETING EXP	A		DI ETARY	10.00	0	33. 09
33. 10	MARKETING EXP	A		PHYSI CAL THERAPY	66.00	0	33. 10
33. 11	MARKETING EXP	A		ELECTROCARDI OLOGY	69. 00	0	33. 11
33. 12	MARKETING EXP	A		WOUND CARE	91.01	0	33. 12
33. 13	MARKETING EXP	A		HOME HEALTH AGENCY	101.00	0	33. 13
33. 14	MARKETING EXP	A		HOSPI CE	116.00	0	33. 14
33. 15	BLDG RENT REV	В		CAP REL COSTS-BLDG & FIXT	1.00	9	33. 15
33. 16	DI SCOUNTS/REBATES	В		MGMT INFO SYSTEMS	5. 02	0	33. 16
33. 17	DI SCOUNTS/REBATES	В		PURCHASI NG	5. 03	0	33. 17
33. 18	MI SC REV	В		OTHER ADMINISTRATIVE AND	5. 06	0	33. 18
00.40	MALNITENANOE (CECURI TV. DEV			GENERAL	7.00		00.40
33. 19	MAINTENANCE/SECURITY REV	В		OPERATION OF PLANT	7.00	0	33. 19
33. 20	MI SC REV/DI SCOUNTS/REBATES	В		OPERATION OF PLANT	7.00	0	33. 20
33. 21	MI SC REV/DI SCOUNTS/REBATES	В	-144, 488		10.00	0	33. 21
33. 22	FOOD SERVICE DAY CARE	В	-187, 046		10.00	0	33. 22
33. 23	DI SCOUNTS/REBATES	В		CENTRAL SERVICES & SUPPLY	14.00	0	33. 23
33. 24	MI SC REV/DI SCOUNTS/REBATES	В	-212, 995		15.00	0	33. 24
33. 25	MI SC REV	В		MEDICAL RECORDS & LIBRARY	16.00	0	33. 25
33. 26	DI SCOUNTS/REBATES	B B		OPERATING ROOM	50.00	0	33. 26
33. 27 33. 28	DI SCOUNTS/REBATES	В		RADI OLOGY-DI AGNOSTI C	54.00	0	33. 27
33. 28	MI SC REV/DI SCOUNTS/REBATES	В		CARDIAC CATH LAB	56. 01	0	33. 28
33. 29	DI SCOUNTS/REBATES	В		LABORATORY	60.00	0	33. 29
33. 30	DI SCOUNTS/REBATES	В		RESPI RATORY THERAPY	65. 00	0	33. 30 33. 31
	ATHLETIC TRAINING REV			PHYSI CAL THERAPY	66.00	0	
33. 32	ST VINCENT PRUDENTIAL	В		ELECTROCARDI OLOGY	69. 00	ŭ	33. 32
33. 33	MI SC REV	В		DI ABETES CENTER	73. 01	0	33. 33
33. 34	EDUCATI ON	В		PARAMED ED PRGM-(SPECIFY)	23. 00	0	33. 34
33. 35	MI SC REV	В		WOUND CARE	91. 01	0	33. 35
33. 36	MI SC REV	В		AMBULANCE SERVICES	95.00	0	33. 36
33. 37	MI SC REV	В		EMPLOYEE BENEFITS DEPARTMENT		0	33. 37
33. 38	PENSION	A		EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33. 38
50. 00	TOTAL (sum of lines 1 thru 49)		-23, 263, 707				50. 00
	(Transfer to Worksheet A,						
(1) 5	column 6, line 200.)			010 0 1 15 1			

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

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

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

B. Amount Received - if cost cannot be determined.

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME Provider CCN: 15-0109 Peri od: Worksheet A-8-1 From 01/01/2016 OFFICE COSTS 12/31/2016 Date/Time Prepared:

				10 12/31/2010	6/28/2017 3:3	
	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 ADJUSTM	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATE	D ORGANIZATIONS OR	CLAI MED	
	HOME OFFICE COSTS:				_	
1.00	1	CAP REL COSTS-BLDG & FIXT	FRANCISCAN DEPRECIATION	2, 493, 481		1. 00
2.00	1	CAP REL COSTS-MVBLE EQUIP	FRANCISCAN DEPRECIATION	1, 898, 671		2. 00
3.00	l control of the cont	INTEREST EXPENSE	FRANCISCAN INTEREST	7, 401, 246		3. 00
3. 01	1	OTHER ADMINISTRATIVE AND GEN		8, 234, 999		3. 01
4.00	1	PHARMACY	FRANCI SCAN COEP	576, 513		4. 00
4.01	1	MGMT INFO SYSTEMS	INFORMATION TECHNOLOGY	11, 351, 566		4. 01
4.02	1	PURCHASI NG	PURCHASING SERVICES	1, 018, 958		4. 02
4.03	1	PATIENT ACCOUNTING	PATIENT ACCT	3, 588, 413	0	4. 03
4.04		MEDICAL RECORDS & LIBRARY	НІМ	1, 982, 915	0	4. 04
4.05	5. 02	MGMT INFO SYSTEMS	INFORMATION TECHNOLOGY	0	13, 757, 465	4. 05
4.06	5. 03	PURCHASI NG	PURCHASING SERVICES	0	1, 234, 920	4.06
4.07	5. 05	PATIENT ACCOUNTING	PATIENT ACCT	0	4, 348, 956	4. 07
4.08	5. 06	OTHER ADMINISTRATIVE AND GEN	ADMI NI STRATI ON	0	9, 980, 360	4. 08
4.09	15. 00	PHARMACY	PHARMACY	0	578, 664	4. 09
4.10	16. 00	MEDICAL RECORDS & LIBRARY	нім	0	2, 420, 706	4. 10
4. 11	113.00	INTEREST EXPENSE	INTEREST	0	9, 191, 875	4. 11
4.12	4. 00	EMPLOYEE BENEFITS DEPARTMENT	FSEH SHARED SERVICES	0	271, 527	4. 12
4. 15	5. 06	OTHER ADMINISTRATIVE AND GEN	FSEH SHARED SERVICES	0	1, 485, 970	4. 15
4. 17	13.00	NURSING ADMINISTRATION	FSEH SHARED SERVICES	0	326, 860	4. 17
4. 18	15. 00	PHARMACY	FSEH SHARED SERVICES	0	55, 238	4. 18
5.00	TOTALS (sum of lines 1-4).			38, 546, 762	43, 652, 541	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

 nad net been peeted to net keneet it, eet anne it and et 2, the amount arremable enter a be man eated in eet ann it er 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 SERVICE			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.
- 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

\* 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.

4.11

4 12

4. 15 4. 17

4. 18

5.00

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

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

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

6.00	HOME OFFICE	6	6. 00
7.00	SISTER FACILITY		7.00
8.00			8.00
9.00		9	9.00
10.00			10.00
100.00		100	00.00

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

0

0

0

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

4.11

4.12

4.15

4.17

4.18

5.00

-9, 191, 875

-1, 485, 970

-5, 105, 779

-271, 527

-326, 860

-55, 238

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT

Period: From 01/01/2016 To 12/31/2016 Worksheet A-8-2 Date/Time Prepared: 6/28/2017 3: 36 pm

							6/28/2017 3:3	6 pm
	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component		Physician/Prov ider Component	
				·	·		Hours	
1. 00	1. 00	2. 00 OTHER ADMI NI STRATI VE AND	3. 00 16, 800	4.00	5. 00 16, 800	6. 00 171, 400	7. 00 67	1. 00
1.00	5.00	GENERAL AND	10, 800	0	10, 800	171, 400	07	1.00
2.00	5. 06	OTHER ADMINISTRATIVE AND	120, 038	120, 038	0	171, 400	0	2. 00
3. 00	5. 06	GENERAL OTHER ADMINISTRATIVE AND	2, 700	2, 700	0	171, 400	0	3. 00
4 00	F 0/	GENERAL STRATING AND	2 447 007	1 5/1 275	00/ 510	171 400	4 444	4 00
4. 00	5.00	OTHER ADMINISTRATIVE AND GENERAL	2, 447, 887	1, 561, 375	886, 512	171, 400	4, 664	4. 00
5.00	5. 06	OTHER ADMINISTRATIVE AND GENERAL	110, 875	110, 875	0	171, 400	0	5. 00
6.00	15. 00	PHARMACY	4, 950	0	4, 950	171, 400	52	6. 00
7.00		ADULTS & PEDIATRICS	45, 817	45, 817		154, 100	0	7. 00
8.00		ADULTS & PEDIATRICS	67, 533			154, 100	0	8. 00
9. 00 10. 00		ADULTS & PEDIATRICS NEONATAL INTENSIVE CARE UNIT	13, 200 494, 500		13, 200 108, 000	154, 100 152, 100	206 628	9. 00 10. 00
11. 00		SUBPROVIDER - IRF	128, 116			171, 400	819	11. 00
12. 00		RADI OLOGY-DI AGNOSTI C	2, 969, 035	2, 908, 943		231, 100	429	12. 00
13. 00		RADI OI SOTOPE	12, 525	3, 525		171, 400	54	13. 00
14. 00	1	LABORATORY	67, 728	58, 395		219, 500	55	14. 00
15.00	1	RESPI RATORY THERAPY	32, 400		32, 400	171, 400	216	15.00
16.00	69. 00	ELECTROCARDI OLOGY	978, 189	978, 189	0	159, 800	0	16.00
17.00	69. 00	ELECTROCARDI OLOGY	900	900	0	159, 800	0	17. 00
18.00		ELECTROENCEPHALOGRAPHY	15, 000	15, 000		171, 400	0	18.00
19. 00		DI ABETES CENTER	9, 000	0	.,	171, 400	40	19. 00
20. 00		EMERGENCY	11, 850	11, 850		171, 400	0	20. 00
21. 00	l .	WOUND CARE	15, 000	0	15, 000	159, 800	190	21. 00
22. 00	95.00	AMBULANCE SERVICES	45, 000 7, 609, 043	6, 309, 756	45, 000 1, 299, 287	159, 800	278 7, 698	22. 00 200. 00
200.00	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE	· · · · · · · · · · · · · · · · · · ·	Cost of	Provi der	Physi ci an Cost	200.00
	WKSt. A LITTE #	I denti fi er	Li mi t	Unadjusted RCE			of Malpractice	
				Limit	Conti nui ng	Share of col.	Insurance	
					Educati on	12		
	1. 00	2.00	8.00	9. 00	12. 00	13. 00	14. 00	
1. 00	5.06	OTHER ADMINISTRATIVE AND GENERAL	5, 521	276	0	0	0	1. 00
2. 00	5. 06	OTHER ADMINISTRATIVE AND	О	О	0	0	0	2. 00
3. 00	5. 06	GENERAL OTHER ADMINISTRATIVE AND	0	0	O	0	0	3. 00
4. 00	5. 06	GENERAL OTHER ADMINISTRATIVE AND	384, 332	19, 217	0	0	0	4. 00
5. 00	5. 06	GENERAL OTHER ADMINISTRATIVE AND	0	0	0	0	0	5. 00
		GENERAL				-		
6.00		PHARMACY	4, 285	214		0	0	6. 00
7.00	l .	ADULTS & PEDLATRICS	0	0	0	0	0	7. 00
8. 00 9. 00		ADULTS & PEDIATRICS ADULTS & PEDIATRICS	15, 262	ŭ	0	0	0	8. 00 9. 00
10. 00		NEONATAL INTENSIVE CARE UNIT				0	0	
11. 00		SUBPROVIDER - IRF	67, 489		ا ۲	0	0	11. 00
12. 00		RADI OLOGY-DI AGNOSTI C	47, 664			0	0	12. 00
13. 00								
		RADI OI SOTOPE	4, 450			0	0	
14.00		RADI OI SOTOPE LABORATORY	4, 450 5, 804	223	0	0		13. 00 14. 00
14. 00 15. 00	60.00			223 290	0	0	0	13.00
	60. 00 65. 00 69. 00	LABORATORY RESPI RATORY THERAPY ELECTROCARDI OLOGY	5, 804	223 290 890	0 0 0	0 0 0 0	0	13. 00 14. 00
15. 00 16. 00 17. 00	60. 00 65. 00 69. 00 69. 00	LABORATORY RESPI RATORY THERAPY ELECTROCARDI OLOGY ELECTROCARDI OLOGY	5, 804 17, 799	223 290 890	0 0 0	0 0 0 0	0 0 0	13. 00 14. 00 15. 00 16. 00 17. 00
15. 00 16. 00 17. 00 18. 00	60. 00 65. 00 69. 00 69. 00 70. 00	LABORATORY RESPI RATORY THERAPY ELECTROCARDI OLOGY ELECTROCARDI OLOGY ELECTROENCEPHALOGRAPHY	5, 804 17, 799 0 0 0	223 290 890 0 0	0 0 0 0 0	0 0 0 0 0	0 0 0 0	13. 00 14. 00 15. 00 16. 00 17. 00 18. 00
15. 00 16. 00 17. 00 18. 00 19. 00	60. 00 65. 00 69. 00 69. 00 70. 00 73. 01	LABORATORY RESPI RATORY THERAPY ELECTROCARDI OLOGY ELECTROCARDI OLOGY ELECTROENCEPHALOGRAPHY DI ABETES CENTER	5, 804 17, 799 0	223 290 890 0 0 0	0 0 0 0 0	0 0 0 0 0 0	0 0 0 0 0 0	13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00
15. 00 16. 00 17. 00 18. 00 19. 00 20. 00	60. 00 65. 00 69. 00 69. 00 70. 00 73. 01 91. 00	LABORATORY RESPI RATORY THERAPY ELECTROCARDI OLOGY ELECTROCARDI OLOGY ELECTROENCEPHALOGRAPHY DI ABETES CENTER EMERGENCY	5, 804 17, 799 0 0 0 3, 296	223 290 890 0 0 165	0 0 0 0 0 0	0 0 0 0 0 0	0 0 0 0 0 0	13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00
15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00	60. 00 65. 00 69. 00 69. 00 70. 00 73. 01 91. 00	LABORATORY RESPI RATORY THERAPY ELECTROCARDI OLOGY ELECTROCARDI OLOGY ELECTROENCEPHALOGRAPHY DI ABETES CENTER EMERGENCY WOUND CARE	5, 804 17, 799 0 0 0 0 3, 296 0 14, 597	223 290 890 0 0 165 0 730	0 0 0 0 0 0	0 0 0 0 0 0 0	0 0 0 0 0 0 0	13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00
15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00 22. 00	60. 00 65. 00 69. 00 69. 00 70. 00 73. 01 91. 01 95. 00	LABORATORY RESPI RATORY THERAPY ELECTROCARDI OLOGY ELECTROCARDI OLOGY ELECTROENCEPHALOGRAPHY DI ABETES CENTER EMERGENCY	5, 804 17, 799 0 0 0 3, 296 0 14, 597 21, 358	223 290 890 0 0 165 0 730 1,068	0 0 0 0 0 0 0	0 0 0 0 0 0 0 0	0 0 0 0 0 0 0	13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00 22. 00
15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00 22. 00 200. 00	60. 00 65. 00 69. 00 69. 00 70. 00 73. 01 91. 00 91. 01 95. 00	LABORATORY RESPI RATORY THERAPY ELECTROCARDI OLOGY ELECTROCARDI OLOGY ELECTROENCEPHALOGRAPHY DI ABETES CENTER EMERGENCY WOUND CARE AMBULANCE SERVI CES	5, 804 17, 799 0 0 0 3, 296 0 14, 597 21, 358 637, 779	223 290 890 0 0 165 0 730 1,068 31,889	0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0	13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00
15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00 22. 00 200. 00	60. 00 65. 00 69. 00 69. 00 70. 00 73. 01 91. 01 95. 00	LABORATORY RESPI RATORY THERAPY ELECTROCARDI OLOGY ELECTROCARDI OLOGY ELECTROENCEPHALOGRAPHY DI ABETES CENTER EMERGENCY WOUND CARE AMBULANCE SERVI CES	5, 804 17, 799 0 0 0 3, 296 0 14, 597 21, 358	223 290 890 0 0 165 0 730 1,068	0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0	13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00 22. 00
15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00 22. 00 200. 00	60.00 65.00 69.00 69.00 70.00 73.01 91.01 95.00 Wkst. A Line #	LABORATORY RESPIRATORY THERAPY ELECTROCARDIOLOGY ELECTROCARDIOLOGY ELECTROCARDIOLOGY DIABETES CENTER EMERGENCY WOUND CARE AMBULANCE SERVICES  Cost Center/Physician I dentifier	5, 804 17, 799 0 0 0 3, 296 0 14, 597 21, 358 637, 779 Provi der Component Share of col.	223 290 890 0 0 165 0 730 1,068 31,889 Adjusted RCE Limit	0 0 0 0 0 0 0 0 0 0 RCE		0 0 0 0 0 0 0	13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00 22. 00
15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00 22. 00 200. 00	60.00 65.00 69.00 69.00 70.00 73.01 91.01 95.00 Wkst. A Line #	LABORATORY RESPI RATORY THERAPY ELECTROCARDI OLOGY ELECTROCARDI OLOGY ELECTROCARDI OLOGY ELECTROENCEPHALOGRAPHY DI ABETES CENTER EMERGENCY WOUND CARE AMBULANCE SERVICES  Cost Center/Physician I denti fier  2.00	5, 804 17, 799 0 0 0 3, 296 0 14, 597 21, 358 637, 779 Provi der Component Share of col. 14	223 290 890 0 0 0 165 0 730 1,068 31,889 Adjusted RCE Limit	0 0 0 0 0 0 0 0 0 RCE Di sal I owance	18. 00	0 0 0 0 0 0 0	13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00 22. 00 200. 00
15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00 22. 00 200. 00	60.00 65.00 69.00 69.00 70.00 73.01 91.01 95.00 Wkst. A Line #	LABORATORY RESPI RATORY THERAPY ELECTROCARDI OLOGY ELECTROCARDI OLOGY ELECTROCARDI OLOGY ELECTROENCEPHALOGRAPHY DI ABETES CENTER EMERGENCY WOUND CARE AMBULANCE SERVICES  Cost Center/Physician I denti fi er  2.00 OTHER ADMINISTRATI VE AND	5, 804 17, 799 0 0 0 3, 296 0 14, 597 21, 358 637, 779 Provi der Component Share of col.	223 290 890 0 0 0 165 0 730 1,068 31,889 Adjusted RCE Limit	0 0 0 0 0 0 0 0 0 0 RCE		0 0 0 0 0 0 0	13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00 22. 00
15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00 22. 00 200. 00	60.00 65.00 69.00 70.00 73.01 91.00 91.01 95.00 Wkst. A Line #	LABORATORY RESPIRATORY THERAPY ELECTROCARDI OLOGY ELECTROCARDI OLOGY ELECTROENCEPHALOGRAPHY DI ABETES CENTER EMERGENCY WOUND CARE AMBULANCE SERVICES  Cost Center/Physician I denti fi er  2.00 OTHER ADMINISTRATI VE AND GENERAL OTHER ADMINISTRATI VE AND	5, 804 17, 799 0 0 0 3, 296 0 14, 597 21, 358 637, 779 Provi der Component Share of col. 14	223 290 890 0 0 0 165 0 730 1,068 31,889 Adjusted RCE Limit	0 0 0 0 0 0 0 0 0 RCE Di sal I owance	18. 00	0 0 0 0 0 0 0	13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00 22. 00 200. 00
15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00 22. 00 200. 00	60. 00 65. 00 69. 00 69. 00 70. 00 73. 01 91. 00 91. 01 95. 00 Wkst. A Line #	LABORATORY RESPIRATORY THERAPY ELECTROCARDI OLOGY ELECTROCARDI OLOGY ELECTROCARDI OLOGY ELECTROENCEPHALOGRAPHY DI ABETES CENTER EMERGENCY WOUND CARE AMBULANCE SERVICES  Cost Center/Physician I denti fier  2.00 OTHER ADMINISTRATIVE AND GENERAL OTHER ADMINISTRATIVE AND	5, 804 17, 799 0 0 0 3, 296 0 14, 597 21, 358 637, 779 Provi der Component Share of col. 14 15. 00	223 290 890 0 0 165 0 730 1,068 31,889 Adjusted RCE Limit	0 0 0 0 0 0 0 0 0 RCE Di sal I owance	18. 00 11, 279	0 0 0 0 0 0 0	13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00 22. 00 200. 00
15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00 200. 00 1. 00	60.00 65.00 69.00 70.00 73.01 91.01 95.00 Wkst. A Line #	LABORATORY RESPIRATORY THERAPY ELECTROCARDI OLOGY ELECTROCARDI OLOGY ELECTROCARDI OLOGY ELECTROENCEPHALOGRAPHY DI ABETES CENTER EMERGENCY WOUND CARE AMBULANCE SERVICES  Cost Center/Physician I denti fi er  2.00  OTHER ADMINISTRATI VE AND GENERAL OTHER ADMINISTRATI VE AND GENERAL	5, 804 17, 799 0 0 0 3, 296 0 14, 597 21, 358 637, 779 Provi der Component Share of col. 14 15. 00	223 290 890 0 0 0 165 0 730 1,068 31,889 Adjusted RCE Limit  16.00 5,521 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	18. 00 11, 279 120, 038	0 0 0 0 0 0 0	13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 20. 00 21. 00 22. 00 200. 00

							6/28/2017 3:3	36 pm
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE		Adjustment		
		I denti fi er	Component	Li mi t	Di sal I owance			
			Share of col.					
			14					
	1. 00	2. 00	15. 00	16. 00	17. 00	18. 00		
5.00		OTHER ADMINISTRATIVE AND	0	(	0	110, 875		5. 00
	1	GENERAL						
6.00		PHARMACY	0	4, 28	665			6. 00
7.00	l l	ADULTS & PEDIATRICS	0	(	0	45, 817		7. 00
8.00		ADULTS & PEDIATRICS	0	(	0	67, 533		8. 00
9.00		ADULTS & PEDIATRICS	0	15, 26		0		9. 00
10.00		NEONATAL INTENSIVE CARE UNIT	0	45, 92				10. 00
11. 00	41. 00	SUBPROVIDER - IRF	0	67, 48	22, 511	60, 627		11. 00
12.00	54. 00	RADI OLOGY-DI AGNOSTI C	0	47, 66	12, 428	2, 921, 371		12. 00
13.00	56. 00	RADI OI SOTOPE	0	4, 450	4, 550	8, 075		13. 00
14.00	60.00	LABORATORY	0	5, 80	3, 529	61, 924		14.00
15.00	65. 00	RESPI RATORY THERAPY	0	17, 79	14, 601	14, 601		15. 00
16.00	69. 00	ELECTROCARDI OLOGY	0	(	0	978, 189		16. 00
17.00	69. 00	ELECTROCARDI OLOGY	0	(	0	900		17. 00
18.00	70.00	ELECTROENCEPHALOGRAPHY	0	(	0	15, 000		18. 00
19.00	73. 01	DIABETES CENTER	0	3, 29	5, 704	5, 704		19. 00
20.00	91.00	EMERGENCY	0	(	0	11, 850		20. 00
21.00	91. 01	WOUND CARE	0	14, 59	7 403	403		21. 00
22.00	95. 00	AMBULANCE SERVICES	0	21, 35	23, 642	23, 642		22. 00
200.00			0	637, 77	663, 570	6, 973, 326		200. 00

	n Financial Systems	FRANCISCAN HEAL				eu of Form CMS-2	2552-10
COST A	ALLOCATION - GENERAL SERVICE COSTS		Provi der Co		eriod: rom 01/01/2016 o 12/31/2016	Date/Time Pre	pared:
			CAPLTAL REI	LATED COSTS		6/28/2017 3:3	6 pm
			OALLIAE KEI	LATED COSTS			
	Cost Center Description	Net Expenses	BLDG & FLXT	MVBLE EQUIP	EMPLOYEE	COMMUNI CATI ONS	
		for Cost			BENEFITS		
		Allocation			DEPARTMENT		
		(from Wkst A					
		col. 7)	1. 00	2.00	4 00	5. 01	
	GENERAL SERVICE COST CENTERS	0	1.00	2.00	4. 00	5.01	
1. 00	00100 CAP REL COSTS-BLDG & FIXT	22, 633, 646	22, 633, 646				1.00
2. 00	00200 CAP REL COSTS-MVBLE EQUIP	5, 082, 552	,,,	5, 082, 552			2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	28, 519, 041	433, 548				4. 00
5. 01	01160 COMMUNI CATI ONS	1, 277, 840	48, 715	10, 939	168, 378	1, 505, 872	5. 01
5.02	01140 MGMT INFO SYSTEMS	12, 098, 925	720, 761	161, 852	920	49, 128	5. 02
5.03	00550 PURCHASI NG	1, 249, 753	444, 600			29, 904	5. 03
5. 04	00570 ADMI TTI NG	-308	64, 682				
5. 05	00580 PATIENT ACCOUNTING	5, 092, 632	164, 122				5. 05
5.06	00560 OTHER ADMINISTRATIVE AND GENERAL	17, 942, 284	1, 748, 910				5. 06
7. 00 8. 00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	10, 311, 189 895, 099	4, 848, 945 53, 793				
9. 00	00900 HOUSEKEEPING	3, 020, 021	401, 207		l		
10. 00	01000 DI ETARY	901, 877	605, 354				
11. 00	01100 CAFETERI A	1, 061, 217	414, 187				
13. 00	01300 NURSING ADMINISTRATION	2, 524, 995	139, 411				
14. 00	01400 CENTRAL SERVICES & SUPPLY	368, 754	160, 564				
15. 00	01500 PHARMACY	3, 287, 304	264, 865	59, 477	938, 356	49, 128	15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	2, 239, 520	142, 126	31, 916	20, 385	36, 312	16. 00
17. 00	01700 SOCI AL SERVI CE	451, 491	22, 104				
20. 00	I I	2, 626, 697	1, 390, 580			l .	
23. 00		569, 154	240, 371	53, 977	93, 690	0	23. 00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	12 (2( 172	2 470 740	FF/ /10	F 00/ F00	245 (25	20.00
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	13, 636, 173 3, 538, 209	2, 478, 740 393, 875				
35. 00		2, 018, 583	226, 903				1
40. 00	04000 SUBPROVI DER – I PF	2,010,000	0	00, 700	000,001	00, 312	
41. 00	I I	1, 218, 578	288, 027	64, 679	361, 519		
42. 00	04200 SUBPROVI DER	0	0	0	0	0	1
43.00	04300 NURSERY	643, 536	96, 425	21, 653	0	0	1
	ANCILLARY SERVICE COST CENTERS						
50.00	I I	23, 569, 586	942, 368				
51.00	I I	688, 467	86, 107				
52. 00	05200 DELIVERY ROOM & LABOR ROOM	3, 869, 451	579, 856			,	
54. 00 55. 00	05400  RADI OLOGY-DI AGNOSTI C   03630  RADI OLOGY-THERAPEUTI C	10, 985, 270					
56. 00		457, 989 252, 531	24, 222 12, 084				
56. 01	03950 CARDI AC CATH LAB	1, 147, 347	290, 335				1
57. 00		1, 022, 535	102, 943		l	l .	
	05800 MRI	472, 398					
60.00	1 1	9, 330, 505				l .	60.00
65.00	06500 RESPI RATORY THERAPY	2, 270, 798	75, 435	16, 940	691, 350	72, 624	65. 00
66. 00	06600 PHYSI CAL THERAPY	3, 085, 403	273, 011	61, 307	942, 486	12, 816	
67. 00	I I	1, 339, 709	136, 343		l	l .	
68. 00	06800 SPEECH PATHOLOGY	467, 364	73, 344			l .	
69. 00	I I	1, 592, 050	340, 245				
70. 00 71. 00	07000 ELECTROENCEPHALOGRAPHY	693, 306	109, 595	24, 610	200, 157		
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	16, 940, 388 16, 360, 454	0		0	0	
73. 00	07300 DRUGS CHARGED TO PATIENTS	8, 518, 378	0	0	0	0	73. 00
73. 01	07301 DI ABETES CENTER	299, 916	0	0	99, 138	12, 816	1
74. 00	07400 RENAL DI ALYSI S	646, 887	67, 859	15, 238			1
76. 98	07698 HYPERBARI C OXYGEN THERAPY	330, 547	81, 463				76. 98
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88. 00
89. 00	I I	0	0	0	0	0	
90. 00	I I	669, 801	0	0	122, 165		
91.00		6, 766, 136				l .	
91. 01	04950 WOUND CARE	1, 378, 210	188, 914	42, 422	439, 467	0	
92. 00 92. 01	09200 OBSERVATION BEDS (NON-DISTINCT PART 09201 OBSERVATION BEDS (DISTINCT PART)	1 024 205	_	0	584, 138	0	92. 00 92. 01
92.01	OTHER REIMBURSABLE COST CENTERS	1, 826, 295	U	0	304, 130	0	92.01
95. 00		2, 675, 537	96, 914	21, 763	672, 299	0	95. 00
	09910 CORF	2,373,337	0,714	0		ő	
	10100 HOME HEALTH AGENCY	4, 027, 002	0				101. 00
	SPECIAL PURPOSE COST CENTERS						
	10900 PANCREAS ACQUISITION	0	0	0			109. 00
	0 11000 INTESTINAL ACQUISITION	0	0	0		l .	110.00
177.00	D 11100 ISLET ACQUISITION	0	0	0	0	<u> </u>	111. 00

Health Financial Systems	FRANCISCAN HEAL	_TH_LAFAYETTE		In Lie	eu of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS	1   1   1   1   1   1   1   1   1   1			Period: From 01/01/2016 To 12/31/2016	Worksheet B Part I Date/Time Prepared: 6/28/2017 3:36 pm
		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	COMMUNI CATI ONS
	0	1.00	2.00	4. 00	5. 01
113. 00 11300 I NTEREST EXPENSE					113. 00
116. 00 11600 HOSPI CE	1, 851, 241	103, 431	23, 22	6 390, 307	0 116. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	266, 744, 263	22, 144, 078	4, 972, 61	6 27, 144, 531	<u>1, 505, 872</u> 118. 00
NONRE MBURSABLE COST CENTERS					
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	78, 038				
192.00 19200 PHYSICIANS' PRIVATE OFFICES	12, 824, 789	418, 233	93, 91	7 1, 868, 987	0 192. 00
192. 01 19201 PHYSI CLANS' PRI VATE OFFI CES	0	0		0	0 192. 01
194. 00 07950 MOB	48, 942	0		0 15, 724	0 194. 00
194. 01 07951 LI FELI NE	62, 744	0		0 5, 368	0 194. 01
194. 02 07952 PATIENT TRANSPORT	99, 622	0		0 0	0 194. 02
194.03 07953 SETON LEASE 1 NORTH	0	0		0 0	0 194. 03
200.00 Cross Foot Adjustments					200. 00
201.00 Negative Cost Centers		0		0	0 201. 00
202.00 TOTAL (sum lines 118-201)	279, 858, 398	22, 633, 646	5, 082, 55	29, 049, 945	1, 505, 872 202. 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 3:36 pm

				10	) 12/31/2016	6/28/2017 3:3	
	Cost Center Description	MGMT INFO	PURCHASI NG	ADMITTI NG	PATI ENT	Subtotal	
		SYSTEMS			ACCOUNTI NG		
	I	5. 02	5. 03	5. 04	5. 05	5A. 05	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01	01160 COMMUNI CATI ONS						5. 01
5. 02	01140 MGMT INFO SYSTEMS	13, 031, 586					5. 02
5. 03	00550 PURCHASI NG	0	1, 824, 095				5. 03
5. 04	00570 ADMITTING	0	0	78, 899	5 000 547		5. 04
5. 05	00580 PATIENT ACCOUNTING	0	4	0	5, 323, 517		5. 05
5.06	00560 OTHER ADMINISTRATIVE AND GENERAL	1, 594, 212	443	0	0	23, 797, 386	5. 06
7. 00	00700 OPERATION OF PLANT	526, 514	177	0	0	17, 841, 870	7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	35, 271	56	0	0	1, 036, 951	8. 00
9.00	00900 HOUSEKEEPI NG	626, 086	3, 193	0	0	4, 837, 218	9. 00
10.00	01000 DI ETARY	211, 294	410	0	0	2, 615, 765	10.00
11.00	01100 CAFETERI A	375, 930	730	0	0	1, 945, 073	11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	298, 328	44 400	0	0	3, 912, 472	13.00
14. 00	1	98, 487	41, 499	0	0	855, 513	14.00
15. 00	1	314, 065	28, 902	0	0	4, 942, 097	15.00
16.00	1	1, 085	I OF	0	0	2, 471, 345	16.00
17. 00	1	98, 922	25	0	0	805, 201	17. 00
20. 00 23. 00	1	295, 952	199	0	0	5, 292, 422	20.00
23.00	02301   PARAMED ED PRGM-(SPECIFY)   INPATIENT ROUTINE SERVICE COST CENTERS	79, 036	44	0	U	1, 036, 272	23. 00
20.00		1 0/5 001	42, 253	4 710	210 270	2F 0F4 74F	30.00
30.00	1	1, 865, 821		4, 718	318, 278 80, 179	25, 054, 745 5, 838, 519	
31. 00	· · · · · · · · · · · · · · · · · · ·	526, 253	13, 992	1, 189			31.00
35. 00	· · · · · · · · · · · · · · · · · · ·	208, 021	3, 701	915	61, 729	3, 167, 181	35.00
40.00	1 I	147 105	1 (07	0	21, 918	0	40.00
41. 00 42. 00		147, 185 0	1, 687	325 0	21, 918	2, 155, 182 0	41.00
42.00	· · · · · · · · · · · · · · · · · · ·	1	າ າາາ	233	15 715		42.00
43.00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	70, 786	3, 222	233	15, 715	851, 570	43. 00
50. 00		529, 896	1, 178, 972	13, 303	898, 865	28, 689, 704	50.00
51. 00		77, 171	1, 178, 972	831	56, 031	1, 171, 905	51.00
52. 00		425, 626	19, 375	1, 440	97, 108	5, 178, 603	52.00
54. 00		1					54. 00
55. 00		507, 935	123, 921	6, 095	411, 113	14, 544, 997	55. 00
		42, 798	678	569	38, 363	705, 366	
56. 00	1	27, 178	284	0	122 (54	368, 998	56.00
56. 01	03950 CARDI AC CATH LAB	139, 885	180, 711	1, 967	132, 654	2, 352, 877	56. 01
57. 00		88, 855	7, 461	4, 493	303, 078	1, 764, 110	57. 00
58. 00	1	25, 047	330	1, 071	72, 230	708, 111	58. 00
60.00		0	49, 492	7, 521	507, 319	10, 607, 411	60.00
65. 00	1	310, 007	24, 115	770	51, 936	3, 513, 975	65.00
66.00		425, 997	7, 261	996	67, 179	4, 876, 456	66.00
67. 00		133, 405	1, 207	617	41, 597	2, 030, 829	67. 00
68. 00	1	57, 302	249	147	9, 903	774, 555	68. 00
69. 00		193, 552	1, 375	1, 817	122, 555	2, 806, 137	69. 00
70.00		85, 181	2, 263	350	23, 576	1, 139, 038	70.00
71. 00		0	0	-,	549, 979	17, 498, 520	
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	6, 471	436, 487	16, 803, 412	
73. 00	1	0	0	6, 536	440, 879	8, 965, 793	73. 00
73. 01	l i	41, 189	54	16	1, 099	454, 228	73. 01
74. 00		17, 786	751	145	9, 778	797, 016	74. 00
76. 98		87	117	158	10, 652	441, 553	76. 98
00.00	OUTPATIENT SERVICE COST CENTERS				al		00.00
88. 00		0	0	0	0	0	88. 00
89. 00		0	0	0	0	0	89. 00
90.00		83, 612	2, 006	55	3, 739	949, 730	90.00
91. 00		949, 294	46, 569		329, 385	11, 689, 047	91.00
91. 01		173, 783	17, 451	426	28, 714	2, 269, 387	91. 01
92. 00						0	92.00
92. 01	,	250, 182	3, 841	715	48, 252	2, 713, 423	92. 01
	OTHER REIMBURSABLE COST CENTERS	400 077	=			0.075.050	
95. 00		439, 877	5, 668		62, 269	3, 975, 250	95. 00
	09910 CORF	0	U 5 222	0	44 544	0	99. 10
101.00	0 10100 HOME HEALTH AGENCY	321, 225	5, 320	615	41, 514	5, 280, 329	101.00
400.0	SPECIAL PURPOSE COST CENTERS				اه		
	0 10900 PANCREAS ACQUISITION	0	0	0	0		109. 00
	0 11000 INTESTINAL ACQUISITION	0	0	0	0		110.00
	0 11100 ISLET ACQUISITION	0	0	이	0	0	111.00
	0 11300 I NTEREST EXPENSE					0	113.00
	0 11600 HOSPI CE	147, 172	2, 249		29, 444	2, 547, 506	
118. 00	` '	12, 867, 290	1, 824, 094	78, 899	5, 323, 517	264, 075, 048	118. 00
100 5	NONREI MBURSABLE COST CENTERS	2 2 2 -1	-	-1	_1	400.015	100.00
190.00	0 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	9, 113	0	0	0	189, 840	190.00

Health Financial Systems	FRANCISCAN HEALTH LAFAYETTE	In Lie	u of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS	Provi der CCN: 15-0109	From 01/01/2016 To 12/31/2016	Worksheet B Part I Date/Time Prepared: 6/28/2017 3:36 pm

					6/28/201/ 3:3	<u>6 pm</u>
Cost Center Description	MGMT INFO	PURCHASI NG	ADMI TTI NG	PATI ENT	Subtotal	
	SYSTEMS			ACCOUNTI NG		
	5. 02	5. 03	5. 04	5. 05	5A. 05	
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	134, 124	1	0	0	15, 340, 051	192. 00
192. 01 19201 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	0	0	192. 01
194. 00 07950 MOB	16, 609	0	0	0	81, 275	194. 00
194. 01 07951 LI FELI NE	4, 450	0	0	0	72, 562	194. 01
194. 02 07952 PATIENT TRANSPORT	0	0	0	0	99, 622	194. 02
194.03 07953 SETON LEASE 1 NORTH	0	0	0	0	0	194. 03
200.00 Cross Foot Adjustments					0	200. 00
201.00 Negative Cost Centers	0	0	0	0	0	201. 00
202.00 TOTAL (sum lines 118-201)	13, 031, 586	1, 824, 095	78, 899	5, 323, 517	279, 858, 398	202. 00
				'	•	•

				1	0 12/31/2016	Date/lime Pre 6/28/2017 3:3	
	Cost Center Description	OTHER ADMI NI STRATI VE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	у рііі
		5. 06	7. 00	8.00	9. 00	10.00	
	GENERAL SERVICE COST CENTERS						
1. 00 2. 00 4. 00 5. 01 5. 02 5. 03 5. 04	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 01160 COMMUNICATIONS 01140 MGMT INFO SYSTEMS 00550 PURCHASING 00570 ADMITTING						1. 00 2. 00 4. 00 5. 01 5. 02 5. 03 5. 04
5. 05 5. 06 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00	OO580	23, 797, 386 1, 658, 152 96, 370 449, 552 243, 099 180, 767 363, 609 79, 508 459, 299	19, 500, 022 74, 083 552, 535 833, 683 570, 411 191, 994 221, 126 364, 767	1, 207, 404 27, 923 33, 911 0 0 30, 601	5, 867, 228 259, 169 177, 325 59, 686 68, 742 113, 396	3, 985, 627 0 0 0 0	5. 05 5. 06 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	229, 677	195, 734	0	60, 848	0	16.00
17. 00 20. 00	01700 SOCIAL SERVICE 02000 NURSING SCHOOL	74, 832 491, 857	30, 441 1, 915, 081	0	9, 463 595, 347	0	17. 00 20. 00
23. 00	02301 PARAMED ED PRGM-(SPECIFY)	96, 307	331, 035		· ·	0	23. 00
23.00	INPATIENT ROUTINE SERVICE COST CENTERS	70, 307	331, 033		102, 710	0	23.00
30.00	03000 ADULTS & PEDIATRICS	2, 328, 488	3, 413, 675	426, 234	1, 061, 219	3, 316, 762	30.00
31.00	03100 INTENSIVE CARE UNIT	542, 609	542, 438		168, 629	408, 819	31. 00
35. 00	02060 NEONATAL INTENSIVE CARE UNIT	294, 345	312, 486	27, 064	97, 143	0	35. 00
40. 00	04000 SUBPROVI DER - I PF	0	0	0	0	0	40. 00
41. 00	04100 SUBPROVIDER - I RF	200, 294	396, 666	22, 921	123, 313	260, 046	41.00
42. 00 43. 00	04200 SUBPROVI DER 04300 NURSERY	79, 142	132, 795	44, 480	41, 282	0	42. 00 43. 00
43.00	ANCI LLARY SERVI CE COST CENTERS	19, 142	132, 193	44, 460	41, 202	0	43.00
50. 00	05000 OPERATI NG ROOM	2, 666, 406	1, 297, 813	211, 756	403, 455	0	50.00
51. 00	05100 RECOVERY ROOM	108, 912	118, 585			0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	481, 279	798, 568	47, 556	248, 253	0	52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 351, 754	1, 444, 594	74, 302		0	54. 00
55. 00	03630 RADI OLOGY-THERAPEUTI C	65, 554	33, 358		10, 370	0	55.00
56.00	05600 RADI OI SOTOPE	34, 293	16, 641	0	5, 173	0	56.00
56. 01 57. 00	03950 CARDIAC CATH LAB 05700 CT SCAN	218, 667 163, 949	399, 845 141, 771	4, 910 0	l '	0	56. 01 57. 00
58. 00	05800 MRI	65, 809	64, 472	0	l '	Ö	58.00
60.00	06000 LABORATORY	985, 810	695, 689	7, 699		0	60.00
65.00	06500 RESPI RATORY THERAPY	326, 575	103, 888	9, 014		0	65. 00
66. 00	06600 PHYSI CAL THERAPY	453, 198	375, 986			0	66. 00
67. 00	06700 OCCUPATIONAL THERAPY	188, 737	187, 768		58, 372	0	67.00
68. 00 69. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	71, 984 260, 791	101, 008 468, 580		31, 401 145, 669	0	68. 00 69. 00
	07000 ELECTROCARDI OLOGI 07000 ELECTROENCEPHALOGRAPHY	105, 858	150, 933		l '	0	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 626, 242	0	Ö	0	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	1, 561, 642	0	0	0	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	833, 245	0	0	0	0	73. 00
73. 01	07301 DI ABETES CENTER	42, 214	0	0	0	0	73. 01
74. 00 76. 98	07400 RENAL DI ALYSI S 07698 HYPERBARI C OXYGEN THERAPY	74, 071 41, 036	93, 454 112, 190		29, 052 34, 877	0	74. 00 76. 98
70. 70	OUTPATIENT SERVICE COST CENTERS	41,030	112, 170		34, 077	0	70.70
88. 00	08800 RURAL HEALTH CLINIC	O	0	0	0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	o	0	89. 00
90.00	09000 CLI NI C	88, 264	0	0	0	0	90. 00
91.00	09100 EMERGENCY	1, 086, 333	1, 605, 624			0	91.00
91. 01	04950 WOUND CARE	210, 908	260, 168	0	80, 879	0	91. 01 92. 00
92. 00 92. 01	09200 OBSERVATION BEDS (NON-DISTINCT PART 09201 OBSERVATION BEDS (DISTINCT PART)	252, 175	0	0	0	0	92.00
72.01	OTHER REIMBURSABLE COST CENTERS	232, 173		· · · · · ·	<u> </u>	0	72.01
95.00	09500 AMBULANCE SERVI CES	369, 444	133, 469	0	41, 492	0	95.00
99. 10	09910 CORF	0	0	0	0	0	99. 10
101.00	10100 HOME HEALTH AGENCY	490, 733	0	0	0	0	101. 00
	SPECIAL PURPOSE COST CENTERS						
	10900 PANCREAS ACQUISITION		0		0		109. 00 110. 00
	11000 INTESTINAL ACQUISITION  11100 ISLET ACQUISITION		0				111.00
	111300 INTEREST EXPENSE		U	١		U	113.00
	11600 HOSPI CE	236, 755	142, 444	0	44, 282	0	116. 00
118.00		22, 330, 545	18, 825, 798			3, 985, 627	118. 00
					·		

Heal th Financial	Systems	FRANCISCAN HEALTH	LAFAYETTE	In Lieu	u of Form CMS-2552-10
COST ALLOCATION	- GENERAL SERVICE COSTS		Provi der CCN: 15	From 01/01/2016	
				∟T∩ 12/31/2016 l	Date/Time Prepared

			•		6/28/2017 3: 3	6 pm
Cost Center Description	OTHER	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	ADMI NI STRATI VE	PLANT	LINEN SERVICE			
	AND GENERAL					
	5. 06	7. 00	8. 00	9. 00	10.00	
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	17, 643	98, 241	0	30, 540	0	190. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	1, 425, 643	575, 983	0	179, 057	0	192. 00
192. 01 19201 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	0	0	192. 01
194. 00 07950 MOB	7, 553	0	0	0	0	194. 00
194. 01 07951 LI FELI NE	6, 744	0	0	0	0	194. 01
194. 02 07952 PATIENT TRANSPORT	9, 258	0	0	0	0	194. 02
194.03 07953 SETON LEASE 1 NORTH	o	0	0	0	0	194. 03
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	o	0	0	0	0	201. 00
202.00 TOTAL (sum lines 118-201)	23, 797, 386	19, 500, 022	1, 207, 404	5, 867, 228	3, 985, 627	202.00

			10	12/31/2010	Date/lime Pre 6/28/2017 3:3	
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	J
		ADMI NI STRATI ON	SERVICES & SUPPLY		RECORDS & LI BRARY	
	11. 00	13. 00	14. 00	15. 00	16. 00	
GENERAL SERVICE COST CENTERS						
1.00 00100 CAP REL COSTS-BLDG & FIXT						1.00
2. 00   00200   CAP   REL   COSTS-MVBLE   EQUI   P						2.00
4.00   00400   EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 01   01160 COMMUNI CATLONS 5. 02   01140 MGMT   INFO SYSTEMS						5. 01 5. 02
5. 03   00550 PURCHASI NG						5. 02
5. 04   00570 ADMI TTI NG						5. 04
5. 05   00580 PATIENT ACCOUNTING						5. 05
5.06 00560 OTHER ADMINISTRATIVE AND GENERAL						5. 06
7.00 00700 OPERATION OF PLANT						7. 00
8.00   00800   LAUNDRY & LINEN SERVICE						8. 00
9. 00   00900   HOUSEKEEPI NG						9.00
10. 00   01000   DI ETARY	2 072 57/					10.00
11. 00   01100   CAFETERI A 13. 00   01300   NURSI NG   ADMI NI STRATI ON	2, 873, 576	1 414 101				11. 00 13. 00
13. 00   01300   NURSI NG   ADMI NI STRATI ON 14. 00   01400   CENTRAL   SERVI CES & SUPPLY	88, 723 29, 290	4, 616, 484 0	1, 284, 780			14.00
15. 00   01500   PHARMACY	93, 403	0	1, 204, 700	5, 972, 962		15.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	323	0	ő	0, 772, 702	2, 957, 927	16.00
17. 00 01700 SOCI AL SERVI CE	29, 420	O	Ō	O	0	17. 00
20. 00   02000 NURSI NG SCHOOL	88, 017	0	0	0	0	20.00
23. 00 02301 PARAMED ED PRGM-(SPECIFY)	23, 505	0	0	0	0	23. 00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00   03000   ADULTS & PEDI ATRI CS	554, 894	1, 184, 825	0	0	176, 867	30.00
31. 00   03100   INTENSIVE CARE UNIT	156, 508	329, 833	0	0	44, 555	31.00
35. 00 02060 NEONATAL INTENSIVE CARE UNIT	61, 866	130, 379	0	0	34, 303	35.00
40. 00   04000   SUBPROVI DER - I PF 41. 00   04100   SUBPROVI DER - I RF	12 772	02 240	0	0	12 190	40.00
42. 00   04200   SUBPROVI DER - 1 RF	43, 773	92, 249	0	0	12, 180 0	41. 00 42. 00
43. 00   04300   NURSERY	21, 052	44, 366	0	0	8, 733	43.00
ANCI LLARY SERVI CE COST CENTERS	21,032	44, 300		<u> </u>	0, 133	1 43.00
50. 00 05000 OPERATI NG ROOM	157, 592	332, 117	0	0	499, 144	50.00
51. 00   05100   RECOVERY   ROOM	22, 951	48, 367	0	0	31, 137	51.00
52.00   05200   DELIVERY ROOM & LABOR ROOM	126, 582	266, 765	0	0	53, 963	52. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	151, 061	0	0	0	228, 456	54.00
55. 00 03630 RADI OLOGY-THERAPEUTI C	12, 728	0	0	0	21, 318	55. 00
56. 00   05600   RADI 01 SOTOPE	8, 083	17, 034	0	0	0	56.00
56. 01   03950   CARDI AC   CATH   LAB	41, 602	87, 674	0	0	73, 716	56. 01
57. 00   05700   CT   SCAN 58. 00   05800   MRI	26, 426 7, 449	0	0	0	168, 421 40, 138	57. 00 58. 00
60. 00   06000   LABORATORY	7,449	0	0	0	281, 917	60.00
65. 00   06500   RESPI RATORY THERAPY	92, 197	194, 300	0	0	28, 861	ł
66. 00 06600 PHYSI CAL THERAPY	126, 692	266, 997	ő	Ö	37, 331	•
67. 00 06700 OCCUPATI ONAL THERAPY	39, 675	83, 612	0	0	23, 116	67. 00
68. 00 06800 SPEECH PATHOLOGY	17, 042	35, 914	0	0	5, 503	68. 00
69. 00 06900 ELECTROCARDI OLOGY	57, 563	121, 310	0	0	68, 104	
70. 00 07000 ELECTROENCEPHALOGRAPHY	25, 333			0	13, 101	
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT	0	0	680, 933	0	305, 624	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	603, 847	E 072 042	242, 556	72.00
73. 00   07300   DRUGS CHARGED TO PATIENTS 73. 01   07301   DI ABETES CENTER	12, 250	25, 816	0	5, 972, 962	244, 997 611	73. 00 73. 01
74. 00   07400   RENAL DIALYSIS	5, 290		0	0	5, 434	74.00
76. 98 O7698 HYPERBARI C OXYGEN THERAPY	26	0	ő	Ö	5, 919	76. 98
OUTPATIENT SERVICE COST CENTERS	-		-	- 1		
88. 00 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   CLI NI C	24, 866	0	0	0	2, 078	90.00
91. 00   09100   EMERGENCY	282, 322	603, 306	0	0	183, 040	91.00
91. 01   04950   WOUND CARE	51, 683	108, 920	0	0	15, 956	
92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART	74 405	0		0	27 014	92.00
92. 01 09201 OBSERVATI ON BEDS (DI STINCT PART) OTHER REIMBURSABLE COST CENTERS	74, 405	U	0	U	26, 814	92. 01
95. 00 09500 AMBULANCE SERVICES	130, 820	284, 593	0	n	34, 603	95. 00
99. 10 09910 CORF	0	201, 070	ő	Ö	0 1, 000	99. 10
101.00 10100 HOME HEALTH AGENCY	95, 533	201, 331	Ö	Ö		101.00
SPECIAL PURPOSE COST CENTERS						
109.00 10900 PANCREAS ACQUISITION	0	0	0	0		109. 00
110. 00 11000 I NTESTI NAL ACQUI SI TI ON	0	0	0	0		110. 00
111. 00 11100   SLET ACQUI SI TI ON	0	0	0	0	0	111.00
113. 00 11300 I NTEREST EXPENSE	40.7/0	00.044	_	_ ا	1/ 0/0	113.00
116.00   11600   HOSPI CE 118.00   SUBTOTALS (SUM OF LINES 1-117)	43, 769 2, 824, 714		0 1, 284, 780	0 5, 972, 962		116.00
110.00   SUBTUTALS (SUM OF LINES 1-117)	2,024,/14	4, 010, 484	1, 204, /80	5, 712, 702	2, 901, 921	1110.00

Health Financial Systems	FRANCISCAN HEALTH LAFAYETTE	In Lieu of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS	Provi der CCN: 15-0109	Period: Worksheet B

			To	12/31/2016	Date/Time Pre 6/28/2017 3:3	
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		ADMI NI STRATI ON	SERVICES &		RECORDS &	
			SUPPLY		LI BRARY	
	11. 00	13. 00	14. 00	15. 00	16. 00	
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	2, 710	0	0	0	0	190. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	39, 889	0	0	0	0	192. 00
192. 01 19201 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	0	0	192. 01
194. 00 07950 MOB	4, 940	0	0	0	0	194. 00
194. 01 07951 LI FELI NE	1, 323	0	0	0	0	194. 01
194. 02 07952 PATIENT TRANSPORT	0	0	0	0	0	194. 02
194.03 07953 SETON LEASE 1 NORTH	0	0	0	0	0	194. 03
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	0	o	0	0	0	201. 00
202.00 TOTAL (sum lines 118-201)	2, 873, 576	4, 616, 484	1, 284, 780	5, 972, 962	2, 957, 927	202. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0109 

				lo	12/31/2010	Date/lime Prep   6/28/2017 3:30	
	Cost Center Description	SOCIAL SERVICE	NURSING SCHOOL	PARAMED ED	Subtotal	Intern &	
				PRGM		Residents Cost	
						& Post	
						Stepdown	
		17. 00	20.00	23. 00	24. 00	Adjustments 25.00	
	GENERAL SERVICE COST CENTERS	17.00	20.00	20.00	21.00	20.00	
1.00	00100 CAP REL COSTS-BLDG & FLXT						1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01	01160 COMMUNI CATI ONS						5. 01
5. 02 5. 03	01140 MGMT INFO SYSTEMS 00550 PURCHASING						5. 02 5. 03
5. 03	00570 ADMI TTI NG						5. 03
5. 05	00580 PATIENT ACCOUNTING						5. 05
5.06	00560 OTHER ADMINISTRATIVE AND GENERAL						5. 06
7.00	00700 OPERATION OF PLANT						7. 00
8.00	00800 LAUNDRY & LINEN SERVICE						8. 00
9.00	00900 HOUSEKEEPI NG						9. 00
10.00	01000 DI ETARY						10.00
11. 00 13. 00	O1100   CAFETERI A   O1300   NURSI NG   ADMI NI STRATI ON						11. 00 13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY						14. 00
15. 00	01500 PHARMACY						15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY						16. 00
17. 00	01700 SOCIAL SERVICE	949, 357					17. 00
20. 00	02000 NURSI NG SCHOOL	0	8, 382, 724				20. 00
23. 00	02301 PARAMED ED PRGM-(SPECIFY)	0		1, 590, 029			23. 00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	(70.450	0 000 704		47 570 004	0.000.004	00.00
30.00	03000 ADULTS & PEDIATRICS	670, 458	8, 382, 724	1	46, 570, 891	-2, 209, 926	30.00
31. 00 35. 00	03100   INTENSI VE CARE UNIT   02060   NEONATAL   INTENSI VE CARE UNIT	93, 216 54, 841	0	0	8, 190, 057 4, 179, 608	0	31. 00 35. 00
40. 00	04000 SUBPROVIDER - I PF	0	0	0	4, 177, 000	0	40.00
41. 00	04100 SUBPROVI DER - I RF	59, 219	0	0	3, 365, 843	o	41. 00
42.00	04200 SUBPROVI DER	0	0	0	0	0	42. 00
43.00	04300 NURSERY	71, 623	0	0	1, 295, 043	0	43. 00
	ANCILLARY SERVICE COST CENTERS					_	
50.00	05000 OPERATING ROOM	0	0	1	34, 257, 987	0	50.00
51. 00 52. 00	O5100 RECOVERY ROOM   O5200 DELIVERY ROOM & LABOR ROOM	0	0	1	1, 577, 661	0	51. 00 52. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	0	0	7, 201, 569 18, 244, 249		54. 00
55. 00	03630 RADI OLOGY-THERAPEUTI C	0	0	0	848, 694	Ö	55. 00
56. 00	05600 RADI OI SOTOPE	0	0	0	450, 222	O	56. 00
56. 01	03950 CARDI AC CATH LAB	0	0	0	3, 303, 592	0	56. 01
57. 00	05700 CT SCAN	0	0	0	2, 308, 750		57. 00
58. 00	05800 MRI	0	0	0	906, 022	0	58. 00
60.00	06000 LABORATORY	0	0	0	12, 794, 797	0	60.00
65. 00 66. 00	06500 RESPIRATORY THERAPY	0	0	0	4, 301, 106		65. 00
67. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	0	0	0	6, 270, 320 2, 612, 109	1	66. 00 67. 00
	06800 SPEECH PATHOLOGY	0	0		1, 037, 407	Ö	68. 00
	06900 ELECTROCARDI OLOGY	0	0	0	3, 934, 991	O	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	1, 534, 572	0	70. 00
71. 00	1	0	0	0	20, 111, 319		71. 00
72. 00		0	0	0	19, 211, 457	0	72. 00
73. 00	1 1	0	0	922, 217	16, 939, 214		73. 00
73. 01 74. 00	07301   DI ABETES CENTER   07400   RENAL DI ALYSI S	0	0	0	535, 119 1, 015, 464		73. 01 74. 00
76. 98		0	0		635, 601	0	76. 98
70. 70	OUTPATIENT SERVICE COST CENTERS	<u> </u>	<u> </u>	<u> </u>	000,001	Ü	70.70
88. 00		0	0	0	0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89. 00
90.00	1	0	0	0	1, 064, 938		90. 00
91. 00		0	0	667, 812	16, 728, 179	i .	91.00
91. 01	i i	0	0	0	2, 997, 901	0	91. 01
92. 00 92. 01	,	0	0	0	2 066 917	0	92. 00 92. 01
92. U I	09201 OBSERVATION BEDS (DISTINCT PART) OTHER REIMBURSABLE COST CENTERS	1 0	0	0	3, 066, 817	0	92.01
95. 00	09500 AMBULANCE SERVICES	0	0	0	4, 969, 671	0	95. 00
	09910 CORF	0	0		0	O	
	10100 HOME HEALTH AGENCY	0	0	0	6, 090, 995	0	101. 00
	SPECIAL PURPOSE COST CENTERS						
	10900 PANCREAS ACQUISITION	0	0	0	0		109. 00
	11000   INTESTINAL ACQUISITION	0	0	0	0		110.00
	D111100  SLET ACQUISITION D111300  NTEREST EXPENSE		0		0		111. 00 113. 00
	0 11600 HOSPI CE		0	0	3, 123, 359		116. 00
	i i	<u>,                                    </u>		,	,,		· · · · · ·

Health Financial Systems	FRANCISCAN HEAL	TH LAFAYETTE		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC	N: 15-0109	Peri od: From 01/01/2016 To 12/31/2016		
Cost Center Description	SOCIAL SERVICE	NURSING SCHOOL	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
	17. 00	20.00	23.00	24. 00	25. 00	
118.00 SUBTOTALS (SUM OF LINES 1-117)	949, 357	8, 382, 724	1, 590, 02	9 261, 675, 524	0	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 338, 974	0	190. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0		0 17, 560, 623	0	192. 00
192. 01 19201 PHYSI CLANS' PRI VATE OFFI CES	0	0		0	0	192. 01
194. 00 07950 MOB	0	0		0 93, 768	0	194. 00
194. 01 07951 LI FELI NE	0	0		0 80, 629	0	194. 01
194. 02 07952 PATIENT TRANSPORT	0	0		0 108, 880	0	194. 02
194.03 07953 SETON LEASE 1 NORTH	0	0		0 0	0	194. 03
200.00 Cross Foot Adjustments		0		0 0	0	200. 00
201.00 Negative Cost Centers	0	0		0	0	201. 00
202.00 TOTAL (sum lines 118-201)	949, 357	8, 382, 724	1, 590, 02	9 279, 858, 398	0	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 3:36 pm

			6/28/2017 3:3	6 pm
	Cost Center Description	Total		
	CENEDAL CEDALCE COCT CENTEDO	26. 00		
1 00	GENERAL SERVICE COST CENTERS			1 00
1.00	00100 CAP REL COSTS-BLDG & FLXT			1.00
2.00	00200 CAP REL COSTS-MVBLE EQUI P			2.00
4. 00 5. 01	00400 EMPLOYEE BENEFITS DEPARTMENT 01160 COMMUNI CATIONS			4. 00 5. 01
5. 01	01140 MGMT INFO SYSTEMS			5. 02
5. 02	00550 PURCHASI NG			5. 02
5. 04	00570 ADMITTING			5. 04
5. 05	00570 ADMITTING			5. 05
5. 06	00560 OTHER ADMINISTRATIVE AND GENERAL			5. 06
7. 00	00700 OPERATION OF PLANT			7.00
8. 00	00800 LAUNDRY & LINEN SERVICE			8.00
9. 00	00900 HOUSEKEEPI NG			9. 00
10.00	01000 DI ETARY			10.00
11. 00	01100 CAFETERI A			11.00
13. 00	01300 NURSI NG ADMINI STRATI ON			13. 00
	01400 CENTRAL SERVICES & SUPPLY			14. 00
	01500 PHARMACY			15. 00
	01600 MEDICAL RECORDS & LIBRARY			16.00
17. 00				17. 00
20. 00	02000 NURSI NG SCHOOL			20.00
23. 00	02301 PARAMED ED PRGM-(SPECIFY)			23. 00
23.00	INPATIENT ROUTINE SERVICE COST CENTERS			23.00
30. 00	03000 ADULTS & PEDIATRICS	44, 360, 965		30.00
30.00	03100   NTENSIVE CARE UNIT	8, 190, 057		30.00
35. 00		1		35.00
40. 00	04000 SUBPROVI DER – I PF	4, 179, 608		40.00
41. 00	04100 SUBPROVIDER - I PF	3, 365, 843		41.00
42. 00	04200 SUBPROVI DER	3, 303, 843		42.00
43. 00	1	1, 295, 043		43. 00
43.00	ANCI LLARY SERVI CE COST CENTERS	1, 273, 043		43.00
50. 00	05000 OPERATING ROOM	34, 257, 987		50.00
51. 00	1	1, 577, 661		51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	7, 201, 569		52.00
54. 00	1	18, 244, 249		54.00
55. 00	03630 RADI OLOGY-THERAPEUTI C	848, 694		55. 00
56. 00	05600 RADI OLOGI - MERAPEUTT C	450, 222		56.00
56. 01	03950 CARDI AC CATH LAB	3, 303, 592		56. 01
57. 00	05700 CT SCAN	2, 308, 750		57.00
58. 00	05800 MRI	906, 022		58.00
60.00	06000 LABORATORY	12, 794, 797		60.00
65. 00	06500 RESPIRATORY THERAPY	4, 301, 106		65. 00
66. 00	06600 PHYSI CAL THERAPY	6, 270, 320		66.00
67. 00	06700 OCCUPATI ONAL THERAPY	2, 612, 109		67. 00
68. 00	06800 SPEECH PATHOLOGY	1, 037, 407		68. 00
69. 00	06900 ELECTROCARDI OLOGY	3, 934, 991		69.00
70. 00	07000 ELECTROCARD OLOGT	1, 534, 572		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	20, 111, 319		71.00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	19, 211, 457		72.00
	07300 DRUGS CHARGED TO PATIENTS	16, 939, 214		73. 00
	07301 DI ABETES CENTER	535, 119		73. 00
	07400 RENAL DI ALYSI S	1, 015, 464		74.00
	07490 KENAE BYAETSTS	635, 601		76. 98
70.70	OUTPATIENT SERVICE COST CENTERS	033,001		7 0. 70
88. 00	08800 RURAL HEALTH CLINIC	0		88. 00
	08900   FEDERALLY QUALIFIED HEALTH CENTER			89.00
90.00	· ·	1, 064, 938		90.00
	09100 EMERGENCY	16, 728, 179		91.00
91.00	04950 WOUND CARE	2, 997, 901		91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	2, 997, 901		92.00
92. 00		2 066 917		92. 00
72. U1	OTHER REIMBURSABLE COST CENTERS	3, 066, 817		72.01
05 00	09500 AMBULANCE SERVICES	4, 969, 671		95. 00
	09910 CORF	4, 969, 671		95.00
	10100 HOME HEALTH AGENCY	6, 090, 995		101. 00
101.00	SPECIAL PURPOSE COST CENTERS	0, 090, 995		1101.00
100 00	10900 PANCREAS ACQUISITION	0		109. 00
	11000   NTESTINAL ACQUISITION			1109.00
	) 11100 I SLET ACQUISITION			111.00
	11300 I NTEREST EXPENSE	2 122 250		113.00
116.00	11600 HOSPI CE	3, 123, 359		116.00
118.00	,	259, 465, 598		118. 00
100.00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	220 074		100 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	338, 974		190.00
192.00	DI14500 LUISI CIANS LKI ANTE OLLICES	17, 560, 623		192. 00

Health Financial Systems	FRANCISCAN HEALT	H LAFAYETTE	In Lie	u of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 15-0109	Peri od: From 01/01/2016 To 12/31/2016	Worksheet B Part I Date/Time Prepared: 6/28/2017 3:36 pm
Cost Center Description	Total 26.00			
192. 01 19201 PHYSI CLANS' PRI VATE OFFI CES	0			192. 01
194. 00 07950 MOB	93, 768			194. 00
194. 01 07951 LI FELI NE	80, 629			194. 01
194. 02 07952 PATIENT TRANSPORT	108, 880			194. 02
194.03 07953 SETON LEASE 1 NORTH	0			194. 03
200.00 Cross Foot Adjustments	0			200. 00
201.00 Negative Cost Centers	0			201. 00
202.00 TOTAL (sum lines 118-201)	277, 648, 472			202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0109

				Io	12/31/2010	Date/lime Pre   6/28/2017 3:3	
			CAPI TAL REI	ATED COSTS		0,20,201, 0.0	рш
	Cost Center Description	Directly Assigned New Capital	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		Related Costs 0	1. 00	2.00	2A	4. 00	
	GENERAL SERVICE COST CENTERS		1.00	2.00	Zn	4.00	
1. 00 2. 00 4. 00 5. 01	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 01160 COMMUNICATIONS	0	433, 548 48, 715	10, 939	530, 904 59, 654	530, 904 3, 077	1.00 2.00 4.00 5.01
5. 02 5. 03 5. 04 5. 05 5. 06	01140 MGMT INFO SYSTEMS 00550 PURCHASING 00570 ADMITTING 00580 PATIENT ACCOUNTING 00560 OTHER ADMINISTRATIVE AND GENERAL	0 0 0	720, 761 444, 600 64, 682 164, 122 1, 748, 910	14, 525 36, 855	882, 613 544, 438 79, 207 200, 977 2, 141, 641	17 0 0 0 35, 872	5. 02 5. 03 5. 04 5. 05 5. 06
7. 00 8. 00 9. 00 10. 00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DI ETARY	1, 482 0 1, 477 47, 189	4, 848, 945 53, 793 401, 207 605, 354	1, 088, 864 12, 080	5, 939, 291 65, 873 492, 778 788, 480	17, 338 704 12, 379 12, 734	7. 00 8. 00 9. 00 10. 00
11. 00 13. 00 14. 00	01100 CAFETERIA 01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	0 0 60, 512	414, 187 139, 411 160, 564	93, 009 31, 306 36, 056	507, 196 170, 717 257, 132	0 16, 433 2, 588	11. 00 13. 00 14. 00
15. 00 16. 00 17. 00 20. 00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE 02000 NURSING SCHOOL	196, 371 0 0	264, 865 142, 126 22, 104 1, 390, 580	31, 916 4, 964 312, 265	520, 713 174, 042 27, 068 1, 702, 845	17, 149 373 3, 810 12, 185	15. 00 16. 00 17. 00 20. 00
23. 00	02301   PARAMED ED PRGM-(SPECIFY)   I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0	240, 371	53, 977	294, 348	1, 712	23. 00
30. 00 31. 00 35. 00	03100 INTENSIVE CARE UNIT 02060 NEONATAL INTENSIVE CARE UNIT	276, 017 2, 778 0	2, 478, 740 393, 875 226, 903	88, 448 50, 953	3, 311, 376 485, 101 277, 856	107, 953 21, 005 10, 235	30. 00 31. 00 35. 00
40. 00 41. 00 42. 00 43. 00	O4000   SUBPROVI DER - I PF   O4100   SUBPROVI DER - I RF   O4200   SUBPROVI DER   O4300   NURSERY	0 35 0 0	288, 027 0 96, 425	0 64, 679 0 21, 653	352, 741 0 118, 078	0 6, 607 0 0	40. 00 41. 00 42. 00 43. 00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	118, 519	942, 368	211, 616	1, 272, 503	23, 645	50. 00
51. 00 52. 00 54. 00 55. 00	05100 RECOVERY ROOM 05200 DELI VERY ROOM & LABOR ROOM 05400 RADI OLOGY-DI AGNOSTI C 03630 RADI OLOGY-THERAPEUTI C	0 0 0 686, 081	942, 366 86, 107 579, 856 1, 048, 949 24, 222	19, 336 130, 211 235, 549	1, 272, 303 105, 443 710, 067 1, 970, 579 29, 661	23, 643 4, 113 0 20, 066 2, 473	51. 00 52. 00 54. 00 55. 00
56. 00 56. 01 57. 00 58. 00		0 0 7,000 0	12, 084 290, 335 102, 943 46, 814	23, 117 10, 512	14, 797 355, 532 133, 060 57, 326	1, 356 7, 215 3, 868 1, 457	56. 00 56. 01 57. 00 58. 00
60. 00 65. 00 66. 00 67. 00	06700 OCCUPATI ONAL THERAPY	9, 247 19, 321 97, 289 0	505, 154 75, 435 273, 011 136, 343	16, 940 61, 307 30, 617	627, 837 111, 696 431, 607 166, 960	0 12, 635 17, 224 6, 348	67. 00
68. 00 69. 00 70. 00 71. 00 72. 00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	0 0 1,849 0 0	73, 344 340, 245 109, 595 0 0	76, 405	89, 814 416, 650 136, 054 0	2, 737 8, 504 3, 658 0 0	68. 00 69. 00 70. 00 71. 00 72. 00
73. 00 73. 01 74. 00 76. 98	07301 DI ABETES CENTER 07400 RENAL DI ALYSIS 07698 HYPERBARI C OXYGEN THERAPY	0 0 0 0	0 0 67, 859 81, 463		0 0 83, 097 99, 756	0 1, 812 705 4	73. 00 73. 01 74. 00 76. 98
88. 00 89. 00 90. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0 0 0	0 0	0 0 0	0 0 0	0 0 2, 233	88. 00 89. 00 90. 00
91. 00 91. 01 92. 00 92. 01	04950 WOUND CARE	126, 529 0 214, 586	1, 165, 877 188, 914		1, 554, 212 231, 336 0 214, 586	39, 567 8, 031 10, 675	91. 00 91. 01 92. 00 92. 01
95. 00 99. 10	OTHER REIMBURSABLE COST CENTERS	23, 441 0 39, 126	96, 914 0 0	21, 763	142, 118 0 39, 126	12, 286 0 16, 167	95. 00 99. 10
109. 00 110. 00	SPECIAL PURPOSE COST CENTERS 0 10900 PANCREAS ACQUISITION 0 11000 INTESTINAL ACQUISITION 0 11100 ISLET ACQUISITION	0 0	0 0	0 0	0 0	0	109. 00 110. 00 111. 00
	0 11300 I NTEREST EXPENSE				Ĭ		113. 00

Health Financial Systems	FRANCISCAN HEAL	TH LAFAYETTE		In Lie	u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der CCN: 15-0109			Worksheet B Part II Date/Time Pre 6/28/2017 3:3	
		CAPI TAL REI	LATED COSTS			
Cost Center Description	Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
	0	1.00	2.00	2A	4. 00	
116. 00 11600 HOSPI CE	155, 547	103, 431	23, 22	6 282, 204	7, 133	116. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	2, 084, 396	22, 144, 078	4, 972, 61	6 29, 201, 090	496, 083	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	29, 563	71, 335	16, 01	9 116, 917	280	190. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	418, 233	93, 91	7 512, 150	34, 156	192. 00
192. 01 19201 PHYSICIANS' PRIVATE OFFICES	0	0		0 0	0	192. 01
194. 00 07950 MOB	0	0		0 0	287	194. 00
194. 01 07951 LI FELI NE	0	0		0 0	98	194. 01
194. 02 07952 PATIENT TRANSPORT	0	0		0	0	194. 02
194.03 07953 SETON LEASE 1 NORTH	0	0		0 0	0	194. 03
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)	2, 113, 959	22, 633, 646	5, 082, 55	29, 830, 157	530, 904	202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0109

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2016 Part II
To 12/31/2016 Date/Time Prepared:
6/28/2017 3:36 pm

					12/31/2016	6/28/2017 3:3	
	Cost Center Description	COMMUNI CATI ONS	MGMT INFO	PURCHASI NG	ADMI TTI NG	PATI ENT	
		5. 01	SYSTEMS 5. 02	5. 03	5. 04	ACCOUNTI NG 5. 05	
	GENERAL SERVICE COST CENTERS			3.33	3. 0.		
1.00	00100 CAP REL COSTS-BLDG & FIXT						1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUI P						2.00
4. 00 5. 01	00400 EMPLOYEE BENEFITS DEPARTMENT 01160 COMMUNI CATIONS	62, 731					4. 00 5. 01
5. 02	01140 MGMT INFO SYSTEMS	2,047	884, 677				5. 02
5. 03	00550 PURCHASI NG	1, 246	0	545, 684			5. 03
5.04	00570 ADMI TTI NG	0	0	0	78, 899		5. 04
5.05	00580 PATIENT ACCOUNTING	1, 246	0	1	0	202, 224	5. 05
5.06	00560 OTHER ADMINISTRATIVE AND GENERAL	6, 496	108, 227	132	0	0	5. 06
7. 00 8. 00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	4, 894	35, 744 2, 394	53 17	0	0	7. 00 8. 00
9. 00	00900 HOUSEKEEPING	801	42, 503	955	0	0	9. 00
10. 00	1 I	2, 669	14, 344	123	Ö	0	10. 00
11. 00	1 1	0	25, 521	218	0	0	11. 00
13. 00	1	801	20, 253	1	0	0	13. 00
14. 00	1 I	356	6, 686		0	0	14.00
15.00	1 I	2,047	21, 321	8, 646 0	0	0	15.00
16. 00 17. 00	1 I	1, 513 801	74 6, 716	8	0	0	16. 00 17. 00
20. 00		0	20, 091	60	0	0	20. 00
23. 00	1 I	o	5, 366	13	Ö	0	23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS				,		
30. 00	1	10, 229	126, 664	12, 640	4, 718	12, 073	30.00
31. 00	• • •	1, 958	35, 726		1, 189	3, 041	31.00
35. 00	1 I	1, 513	14, 122	1, 107	915	2, 342	35. 00
40. 00 41. 00	1 I	2, 136	9, 992	0 505	325	0 831	40. 00 41. 00
41.00	· ·	2, 130	9, 992 0	0	323 0	031	41.00
43. 00	1 1		4, 805		233	596	43. 00
	ANCILLARY SERVICE COST CENTERS	· - · ·			,		
50. 00		2, 136	35, 973	·	13, 303	34, 383	50. 00
51. 00		712	5, 239		831	2, 125	51. 00
52. 00		2, 313	28, 895	5, 796	1, 440	3, 684	52.00
54. 00 55. 00		5, 339	34, 482	37, 072 203	6, 095 569	15, 595	54. 00 55. 00
56. 00	1		2, 905 1, 845	85	309	1, 455 0	56. 00
56. 01	1 I		9, 496		1, 967	5, 032	56. 01
57. 00	1 I		6, 032	2, 232	4, 493	11, 497	57. 00
58. 00		o	1, 700		1, 071	2, 740	58. 00
60.00	06000 LABORATORY	3, 915	0	14, 806	7, 521	19, 244	60.00
65. 00	1 I	3, 025	21, 046		770	1, 970	65. 00
66. 00	1	534	28, 920		996	2, 548	66. 00
67. 00	1	0	9, 056		617	1, 578	67. 00
68. 00 69. 00	1 I	534	3, 890 13, 140	74 411	147 1, 817	376 4, 649	68. 00 69. 00
70. 00	1 I	0	5, 783	677	350	894	70.00
71. 00	1 1		0, 709		8, 153	20, 863	
72. 00	1 1	o	0	Ö	6, 471	16, 557	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	6, 536	16, 724	73. 00
73. 01	• • •	534	2, 796		16	42	73. 01
74. 00		0	1, 207		145	371	74. 00
76. 98		0	6	35	158	404	76. 98
88. 00	OUTPATIENT SERVICE COST CENTERS  08800 RURAL HEALTH CLINIC	O	0	0	0	0	88. 00
89. 00			0	l ő	0	0	89. 00
90. 00		2, 847	5, 676		55	142	90. 00
91.00	09100 EMERGENCY	0	64, 445	13, 932	4, 883	12, 495	91. 00
91. 01		0	11, 798	5, 221	426	1, 089	91. 01
92. 00							92. 00
92. 01	,	0	16, 984	1, 149	715	1, 830	92. 01
95. 00	OTHER REIMBURSABLE COST CENTERS O9500 AMBULANCE SERVICES	O	29, 862	1, 696	923	2, 362	95. 00
	09910 CORF		29, 002 0	1, 696	923	2, 302	99. 10
	0 10100 HOME HEALTH AGENCY		21, 807	-	615		101. 00
	SPECIAL PURPOSE COST CENTERS			.,		.,	
109.0	0 10900 PANCREAS ACQUISITION	0	0	0	0	0	109. 00
	0 11000 INTESTINAL ACQUISITION	0	0	0	0		110. 00
	0 11100 I SLET ACQUI SI TI ON	0	0	0	0	0	111. 00
	0 11300 INTEREST EXPENSE		0.001	/70	407	4 447	113.00
116.0	O 11600 HOSPICE O  SUBTOTALS (SUM OF LINES 1-117)	62, 731	9, 991 873, 523	673 545, 684	436 78, 899	1, 117 202, 224	116. 00 118. 00
110. U	NONREI MBURSABLE COST CENTERS	02,731	013, 323	J40, 064	10,099	202, 224	110.00
190. 0	0 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	619	0	0	0	190. 00
				1	- 1	·	

Health Financial Systems	FRANCISCAN HEALTH LAFAYETTE	In Lieu of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS	Provider CCN: 15-0109	Period: Worksheet B From 01/01/2016 Part II
		To 12/31/2016 Date/Time Prepared

					6/28/201/ 3:3	6 pm
Cost Center Description	COMMUNI CATIONS	MGMT INFO	PURCHASI NG	ADMITTING	PATI ENT	
		SYSTEMS			ACCOUNTI NG	
	5. 01	5. 02	5. 03	5. 04	5. 05	
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	9, 105	0	0	0	192. 00
192. 01 19201 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	0	0	192. 01
194. 00 07950 MOB	0	1, 128	0	0	0	194. 00
194. 01 07951 LI FELI NE	0	302	0	0	0	194. 01
194. 02 07952 PATI ENT TRANSPORT	0	0	0	0	0	194. 02
194. 03 07953 SETON LEASE 1 NORTH	0	0	0	0	0	194. 03
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	0	0	0	308	0	201. 00
202.00 TOTAL (sum Lines 118-201)	62, 731	884, 677	545, 684	79. 207	202, 224	202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provi der CCN: 15-0109

Column   C					1	0 12/31/2016	Date/lime Pre 6/28/2017 3:3	
	Cost Cent	er Description	ADMI NI STRATI VE			HOUSEKEEPI NG		у рііі
1.00   001000   CAP   PEL DOSTS-BULDE & TAX				7. 00	8. 00	9. 00	10.00	
2.00								
4.00								1
1.0 10 11-00 COMMUNICATIONS 1.0 10 11-00 COMMUNICATIONS 1.0 10 10-00 COMMUNICATIONS 1								1
5.02   0.050   POLICIAN MINISTRATION   1.000								1
0.0550   RURCHASH INC								
5. OL   OSTOPA JABILITING   S. OL								
5.05   0.0580   PATIENT ACCOUNTING   1.05   7.00   0.05								
7.00   0.0700   DEPATION OF PLANT   159,720   6,157,040   7.00								5. 05
8.00   0.0000   JANINDRY & LINEN SERVICE			2, 292, 368					
9.00   0.990p    0.0150EFFP N6	1 1		1					1
10.00   010X0   DETARY   23, 416   265, 231   2,88   33, 992   1,141,87   10,00   11.00   0110X   CAFFERI A   17,417   180, 104   0   23, 258   0   11.00   13.00   0130X   MIRSI NIX ADMINI STRATION   35,024   60,621   0   7,828   0   13.00   14			1			7/0 500		
11.00 0 1100 CAFETERIA   17,412   100, 104   0 23,258   0 11.00   11.0		'I NG	1				1 141 047	1
13.00   01300   NURSI NG ADMIN STRATION   35.024   00.021   0   7.828   0   13.00			1					1
14.00   01400   CENTRAL SERVICES & SUPPLY   7, 659   99, 820   2,579   9,016   0   14.00			1		_			1
15.00 01500 [PHARMACY   44, 242   115, 173   0   14, 873   0   15, 00   17.			1		2. 579			1
17.00   01700   SOCIAL SERVICE   7, 208   9, 612   0   1, 241   0   17.00							0	
20.00	16.00 01600 MEDICAL R	ECORDS & LI BRARY	22, 123	61, 802	0	7, 981	0	16. 00
23.00	17. 00  01700  SOCIAL SE	RVI CE	7, 208	9, 612	0	1, 241		
INPATI ENT ROUTINE SERVICE COST CENTERS   1,077,853   35,918   139,187   950,223   30,00   30,00   30,00   ADULTS & PEDIDATRICS   224,290   1,077,853   35,918   139,187   950,223   30,00   31,000   3000   ADULTS & PEDIDATRICS   224,290   1,077,853   35,918   139,187   950,223   30,00   31,000   3000   ROUNTAL INTRUSIVE CARE UNIT   28,353   96,666   2,281   12,741   10,33   30,00   40,000   40000   800000   80000   80000   80000   80000   80000   80000   800000   800000   800000   800000			1					1
30.00   3000   ADULTS & PEDIATRICS   224, 290   1,077, 853   35, 918   139, 189   95, 223   30, 00   310, 00   3100   INTENSIVE CARE UNIT   52, 266   171, 272   5, 472   22, 117   117, 23   31, 00   35, 00   20060   NEONATAL INTENSIVE CARE UNIT   28, 353   98, 666   2, 281   12, 741   117, 23   31, 00   40			9, 277	104, 523	0	13, 497	0	23. 00
31.00   03100   NTENSI VE CARE UNIT   52, 266   171, 272   5, 472   22, 117   117, 123   31.00   035.00   02600   NEONATAL INTENSI VE CARE UNIT   28, 353   98, 666   2,81   12,741   0 35.00   040.00   040			224 200	1 077 052	25 010	120 107	0E0 222	20 00
15.00   02000 NEONATAL INTENSIVE CARE UNIT   28, 353   98, 666   2, 281   12, 741   0, 35, 00   0, 0			1					•
40. 00   04000 SUBPROVI DER - I PF   0   0   0   0   0   0   0   0   0								
11.00   0.4100   SUBPROVI DER - IRP   19, 293   125, 245   1, 932   16, 173   74, 501   41.00			1	0		0		•
A3. 00   04300   NURSERY   7, 623   41, 920   3, 748   5, 415   0   42, 00			19, 293	125, 245	1, 932	16, 173	74, 501	•
ANCILLARY SERVICE COST CENTERS	42. 00 04200 SUBPROVI D	ER	0	0	0	0	0	42. 00
50.00			7, 623	41, 930	3, 748	5, 415	0	43. 00
10			11					
S2 00   05200   05200   DELIVERY ROOM & LABOR ROOM			1					•
54. 00   0.5400   RADI OLOGY-DI AGNOSTIC   130, 207   456, 124   6, 262   58, 901   0   54, 00   55. 00   0.5500   0.3500   RADIO LOGY-THERAPPUT C   3, 303   5, 254   0   679   0   56, 00   65. 00   0.3650   RADIO LOGY-THERAPPUT C   3, 303   5, 254   0   679   0   56, 00   65. 01   0.3950   CARDIA C CATH LAB   21, 063   126, 249   414   16, 303   0   56, 00   0.550   0.550   0.3550   0.250   0.3550   0.250   0.3550   0.250   0.3550   0.250   0.3550   0.250   0.3550			1					
55. 00   03330   RADI DLOGY -THERAPEUTI C	1 1		1					
56. 00   05600   RADIO I SOTOPE   3, 303   5, 254   0   6.79   0   56. 00			1					•
15,700   05,700   05,700   05,700   05,700   05,700   05,700   05,700   05,800   05,800   05,800   06,800   0	56. 00 05600 RADI 0I SOT	OPE	1		0	679	0	56. 00
S8. 00   05800   NR		ATH LAB	21, 063	126, 249	414	16, 303		56. 01
60.00   06000   LABORATORY   94, 958   219, 661   649   28, 366   0 60, 00			1		-			
65.00   06500   RESPI RATORY THERAPY   31, 457   32, 802   760   4, 236   0   65.00   66.00   06600   PHYSI CAL THERAPY   43, 654   118, 716   1, 414   15, 330   0   66.00   67.00   06700   OCCUPATI ONAL THERAPY   18, 180   59, 287   0   7, 656   0   67.00   68.00   06800   SPEECH PATHOLOGY   6, 934   31, 893   0   4, 118   0   68.00   69.00   06900   ELECTROCARDI OLOGY   25, 121   147, 952   576   19, 106   0   69.00   70.00   07000   ELECTROCARDI OLOGY   25, 121   147, 952   576   19, 106   0   69.00   71.00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENT   156, 647   0   0   0   0   0   0   71.00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENT   156, 647   0   0   0   0   0   0   72.00   07200   IMPL. DEV. CHARGED TO PATI ENTS   150, 424   0   0   0   0   0   0   73.01   07301   DIABETES CENTER   4, 066   0   0   0   0   0   0   74.00   07400   RENAL DI ALYSI S   7, 135   29, 508   0   3, 810   0   74, 00   76.98   07698   HYPERBARI C DXYGEN THERAPY   3, 953   35, 423   0   4, 574   0   76, 98   00179ATI ENT SERVICE COST CENTERS   88.502   0   0   0   0   0   0   88.00   99.00   08900   FEDERALLY QUALIFIED HEALTH CENTER   0   0   0   0   0   0   0   0   99.00   09900   CLINI C   8, 5502   0   0   0   0   0   0   0   91.00   09100   EMERGENCY   104, 640   506, 968   9, 401   65, 467   0   91.00   91.01   04950   WOUND CARE   20, 316   82, 147   0   10, 608   0   91.00   95.00   09900   CLINI C   0   0   0   0   0   0   0   97.00   09900   DESERVATI ON BEDS (DISTINCT PART   24, 291   0   0   0   0   0   0   97.01   09910   CMPER			1		_			
66.00   06600   PHYSICAL THERAPY   43,654   118,716   1,414   15,330   0   66.00   67.00   06700   0CCUPATI ONAL THERAPY   18,180   59,287   0   7,656   0   67.00   68.00   06800   SPEECH PATHOLOGY   6,934   31,893   0   4,118   0   68.00   06900   ELECTROCARDI OLOGY   25,121   147,952   576   19,106   0   69.00   69.00   06900   ELECTROCARDI OLOGY   25,121   147,952   576   19,106   0   69.00   70.00   70700   ELECTROCARDI OLOGY   25,121   147,952   576   19,106   0   70.00   71.00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENT   156,647   0   0   0   0   0   0   72.00   07200   IMPL. DEV. CHARGED TO PATIENTS   150,424   0   0   0   0   0   0   73.00   07300   DRUGS CHARGED TO PATIENTS   80,262   0   0   0   0   0   0   73.00   07300   DRUGS CHARGED TO PATIENTS   80,262   0   0   0   0   0   0   74.00   07400   RENAL DI ALYSI S   7,135   29,508   0   3,810   0   74.00   76.98   07698   HYPERBARI C OXYGEN THERAPY   3,953   35,423   0   4,574   0   76.98    000   08900   FEDERALLY QUALIFIED HEALTH CENTER   0   0   0   0   0   0   0   89.00   08900   FEDERALLY QUALIFIED HEALTH CENTER   0   0   0   0   0   0   91.00   09100   EMERGENCY   104,640   506,968   9,401   65,467   0   91.00   91.01   04950   WOUND CARE   20,316   82,147   0   10,608   0   91.00   91.01   04950   WOUND CARE   20,316   82,147   0   10,608   0   91.00   99.00   09200   OSERVATI ON BEDS (INSTINCT PART   24,291   0   0   0   0   0   0   99.00   09200   OSERVATI ON BEDS (INSTINCT PART   24,291   0   0   0   0   0   0   99.10   09910   CORF   0   0   0   0   0   0   0    101.00   11000   INTERST INAL ACQUISITION   0   0   0   0   0    101.00   11000   INTERST INAL ACQUISITION   0   0   0   0   0    111.00   11100   ISLET ACQUISITION   0   0   0   0   0    111.00   11100   ISLET ACQUISITION   0   0   0   0    111.00   11100   INTERST INAL ACQUISITION   0   0   0   0    111.00   11100   INTERST INAL ACQUISITION   0   0   0   0    111.00   11100   INTERST INAL ACQUISITION   0   0   0   0    111.00   11100   INTERST INTERST   22,805   44,976   0								1
67.00   06700   05CUIPATI IONAL THERAPY   18,180   59,287   0   7,656   0   67.00   68.00   06800   SPEECH PATHOLOGY   6,934   31,893   0   4,118   0   68.00   69.00   06900   ELECTROCARDI OLOGY   25,121   147,952   576   19,106   0   69.00   70.00   07000   ELECTROENCEPHALOGRAPHY   10,197   47,656   0   6,154   0   70.00   71.00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENT   156,647   0   0   0   0   0   71.00   72.00   07200   IMPL. DEV. CHARGED TO PATIENTS   150,424   0   0   0   0   0   0   72.00   73.00   07300   DRUGS CHARGED TO PATIENTS   80,262   0   0   0   0   0   0   73.00   74.00   07400   RENAL DI ALYSIS   7,135   29,508   0   3,810   0   74.00   76.98   07698   HYPERBARI C OXYGEN THERAPY   3,953   35,423   0   4,574   0   76.98   88.00   08800   RURAL HEALTH CLINIC   0   0   0   0   0   0   89.00   89.00   08900   ELECTROENCEPHALOGRAPHY   10,197   47,656   0   0   0   0   0   90.00   09000   CLINIT C   8,502   0   0   0   0   0   0   0   91.00   09000   CLINIT C   8,502   0   0   0   0   0   0   92.00   08ERVATI ON BEDS (INSTINCT PART   20,316   82,147   0   10,608   0   91.01   92.01   07500   AMBULANCE SERVICE S   35,586   42,142   0   5,442   0   99.00   99.10   09900   OSERVATI ON BEDS (INSTINCT PART   24,291   0   0   0   0   0   0   99.00   99.10   09900   OSERVATI ON BEDS (INSTINCT PART   24,291   0   0   0   0   0   0   99.00   99.10   09900   OSERVATI ON BEDS (INSTINCT PART   24,291   0   0   0   0   0   0   99.10   00   09000   OSERVATI ON BEDS (INSTINCT PART   24,291   0   0   0   0   0   0   0   99.10   00   09000   OSERVATI ON BEDS (INSTINCT PART   24,291   0   0   0   0   0   0   0   0   00   09000   OSERVATI ON BEDS (INSTINCT PART   24,291   0   0   0   0   0   0   0   0   0   010   0710   ONTHER REIMBURSABLE COST CENTERS   0   0   0   0   0   0   0   0   0   0111.00   1100   INTERSTINAL ACQUISITION   0   0   0   0   0   0   0   0   0			1					1
68. 00   06800   SPECH PATHOLOGY   6, 934   31, 893   0   4, 118   0   68. 00   69. 00   06900   ELECTROCARDI OLOGY   25, 121   147, 952   576   19, 106   0   69. 00   70. 00   07000   ELECTROENCEPHALOGRAPHY   10, 197   47, 656   0   6, 154   0   70. 00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENT   156, 647   0   0   0   0   0   0   72. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   150, 424   0   0   0   0   0   0   73. 00   07300   DRUGS CHARGED TO PATI ENTS   80, 262   0   0   0   0   0   73. 01   07301   DIJABETES CENTER   4, 066   0   0   0   0   0   74. 00   07400   RENAL DI ALYSIS   77, 135   29, 508   0   3, 810   0   74. 00   07400   RENAL DI ALYSIS   77, 135   29, 508   0   3, 810   0   76. 98   07698   HYPERBARI C OXYGEN THERAPY   3, 953   35, 423   0   4, 574   0   76. 98   00   08800   RURAL HEALTH CLINIC   0   0   0   0   0   0   79. 00   09900   CLINIC   8, 502   0   0   0   0   0   79. 00   09900   CLINIC   8, 502   0   0   0   0   79. 00   09900   EDERRALLY QUALIFIED HEALTH CENTER   0   0   0   0   0   79. 01   04950   WOUND CARE   20, 316   82, 147   0   10, 608   0   79. 01   09201   0BSERVATI ON BEDS (DISTINCT PART   20, 200   09200   085ERVATI ON BEDS (DISTINCT PART   20, 200   0900   000   000   000   000   79. 00   09000   MBURNANCE SERVICES   35, 586   42, 142   0   5, 442   0   95, 00   79. 00   09000   MBURNANCE SERVICES   35, 586   42, 142   0   0   0   0   79. 01   01000   HOME HEALTH AGENCY   47, 270   0   0   0   0   79. 01   01000   NORESTINAL AGOUSTINON   0   0   0   0   0   71. 00   01100   DISTINATION   0   0   0   0   0   71. 00   01100   INTESTINAL AGOUSTINON   0   0   0   0   71. 00   01100   INTESTINAL AGOUSTINON   0   0   0   0   71. 00   01100   INTESTINAL AGOUSTINON   0   0   0   0   71. 00   01100   INTESTINAL AGOUSTINON   0   0   0   0   71. 00   01110   01   INTERST EXPENSE   113   00   71. 00   113. 00   11300   INTERST EXPENSE   113   00   71. 00   113. 00   11300   INTERST EXPENSE   113   00   71. 00   00   00   0   0   0   71. 00   00   00   00   00			1		· ·			1
69.00   06900   ELECTROCARDI OLOGY   25, 121   147, 952   576   19, 106   0   69.00   70.00   70.00   70.00   70.00   70.00   ELECTROCARDI OLOGY   10, 197   74, 656   0   6, 154   0   70.00   71.00			1					1
71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENT   156, 647   0   0   0   0   71. 00   72. 00   72. 00   72. 00   72. 00   72. 00   72. 00   72. 00   72. 00   73. 00   07300   DRUG. CHARGED TO PATI ENTS   150, 424   0   0   0   0   0   0   73. 00   07300   DRUG. CHARGED TO PATI ENTS   80, 262   0   0   0   0   0   0   0   73. 00   073. 01   07301   DI ABETES CENTER   4, 066   0   0   0   0   0   0   0   73. 01   074. 00   074. 00   074. 00   074. 00   0   0   0   0   0   0   0   0   0			25, 121	147, 952	576		0	69. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 150, 424 0 0 0 0 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 80, 262 0 0 0 0 0 73. 00 73. 01 07301 DI ABETES CENTER 4,066 0 0 0 0 0 73. 00 74. 00 07400 RENAL DI ALYSI S 7, 135 29, 508 0 3, 810 0 74. 00 76. 98 07698 HYPERBARI C OXYGEN THERAPY 3, 953 35, 423 0 4, 574 0 76. 98 00 07800 RIVAL HEALTH CLINI C 0 0 0 0 0 88. 00 88. 00 08900 RIVAL HEALTH CLINI C 0 0 0 0 0 0 88. 00 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 0 89. 00 90. 00 09000 CLINI C 8,502 0 0 0 0 0 0 90. 00 91. 00 09100 EMERGENCY 104, 640 506, 968 9, 401 65, 467 0 91. 00 91. 01 04950 WOUND CARE 20, 316 82, 147 0 10, 608 0 91. 01 92. 01 09201 DBSERVATI ON BEDS (NON-DISTINCT PART 92. 01 0200 DBSERVATI ON BEDS (DISTINCT PART) 24, 291 0 0 0 0 0 0 0 0 0 99. 10 0THER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVI CES 35, 586 42, 142 0 5, 442 0 95. 00 0THER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVI CES 35, 586 42, 142 0 5, 442 0 95. 00 0THER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVI CES 35, 586 42, 142 0 5, 442 0 95. 00 0THO 10100 HOME HEALTH AGENCY 47, 270 0 0 0 0 0 0 0 0 110. 00 0THO 10100 HOME HEALTH AGENCY 47, 270 0 0 0 0 0 0 0 110. 00 0THO 10100 HOME HEALTH AGENCY 47, 270 0 0 0 0 0 0 0 0 110. 00 0THIS DESTRUCTION 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			10, 197	47, 656	0	6, 154	-	70. 00
73. 00   07300   DRUGS CHARGED TO PATIENTS   80, 262   0   0   0   0   0   73. 00   73. 01   07301   DI ABETES CENTER   4,066   0   0   0   0   0   74. 00   07400   RENAL DI ALYSIS   7,135   29,508   0   3,810   0   74. 00   07400   RENAL DI ALYSIS   7,135   29,508   0   3,810   0   76. 98   O7698   HYPERBARI COXYGEN THERAPY   3,953   35,423   0   4,574   0   76. 98   OUTPATI ENT SERVI CE COST CENTERS				0	0	0		
73. 01   07301   DI ABETES CENTER				0	0	0	-	
74. 00			1	0	0	0		
76. 98			I I	29 508	0	3 810		
Second   Continue			I I					
89. 00			, , , , , ,			., .		
90. 00			0	0	0	0		
91. 00		QUALIFIED HEALTH CENTER		0	0	0		
91. 01 04950 WOUND CARE 92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART 92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART 92. 00 09201 OBSERVATI ON BEDS (DISTINCT PART) 24, 291 0 0 0 0 0 0 0 92. 01 OTHER REIMBURSABLE COST CENTERS  95. 00 09500 AMBULANCE SERVICES 35, 586 42, 142 0 5, 442 0 95. 00 99. 10 09910 CORF 0 0 0 0 0 0 0 0 0 99. 10 101. 00 10100 HOME HEALTH AGENCY 47, 270 0 0 0 0 0 0 101. 00 SPECIAL PURPOSE COST CENTERS  109. 00 10900 PANCREAS ACQUISITION 0 0 0 0 0 0 109. 00 110. 00 111. 00 11100 INTESTINAL ACQUISITION 0 0 0 0 0 0 1110. 00 111. 00 11100 ISLET ACQUISITION 0 0 0 0 0 0 111. 00 113. 00 11300 INTEREST EXPENSE 113. 00 116. 00 11600 HOSPICE 22, 805 44, 976 0 5, 808 0116. 00		,	1	0	0	0		
92. 00			1					
92. 01   09201   0BSERVATI ON BEDS (DISTINCT PART)   24, 291   0   0   0   0   92. 01			20, 310	02, 147	0	10, 606	U	
OTHER REIMBURSABLE COST CENTERS   35,586   42,142   0   5,442   0   95.00			24 291	0	0	0	0	
95. 00						-1		
101. 00 10100 HOME HEALTH AGENCY 47, 270 0 0 0 0 101. 00 SPECIAL PURPOSE COST CENTERS  109. 00 10900 PANCREAS ACQUISITION 0 0 0 0 109. 00 110. 00 111. 00 11100 I SLET ACQUISITION 0 0 0 0 0 1110. 00 111. 00 113. 00 11300 I NTEREST EXPENSE 113. 00 116. 00 11600 HOSPI CE 22, 805 44, 976 0 5, 808 0116. 00	95. 00 09500 AMBULANCE	SERVI CES	35, 586	42, 142	0	5, 442	0	95. 00
SPECIAL PURPOSE COST CENTERS   109. 00 10900   PANCREAS ACQUI SI TI ON   0   0   0   0   109. 00   110. 00   110. 00   110. 00   111.			1 -1	0				
109. 00 10900 PANCREAS ACQUISITION 0 0 0 0 109. 00 110. 00 1100 INTESTINAL ACQUISITION 0 0 0 0 1110. 00 1111. 00 11100 ISLET ACQUISITION 0 0 0 0 0 1111. 00 113. 00 11300 INTEREST EXPENSE 113. 00 1160 HOSPICE 22, 805 44, 976 0 5, 808 0 116. 00			47, 270	0	0	0	0	101. 00
110. 00   11000   INTESTINAL ACQUISITION				^	^	ما	0	100 00
111. 00 11100   SLET ACQUI SI TI ON 0 0 0 111. 00 113. 00 11300   NTEREST EXPENSE 116. 00 11600   HOSPI CE 22, 805 44, 976 0 5, 808 0 116. 00				0	0	0		
113. 00   11300   I NTEREST EXPENSE   113. 00   1160   HOSPI CE   22, 805   44, 976   0   5, 808   0   116. 00				0	l 0	0		
116. 00   11600   HOSPI CE   22, 805   44, 976   0   5, 808   0   116. 00	1 1			· ·		١		
118. 00   SUBTOTALS (SUM OF LINES 1-117)   2,151,075  5,944,157  101,751  742,041  1,141,847  118. 00	116. 00 11600 HOSPI CE						0	116. 00
	118. 00    SUBTOTALS	S (SUM OF LINES 1-117)	2, 151, 075	5, 944, 157	101, 751	742, 041	1, 141, 847	118. 00

Health Financial Systems	FRANCISCAN HEALTH LAFAYETTE	In Lieu	of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS	Provi der CCN: 15-0109	From 01/01/2016 To 12/31/2016	Worksheet B Part II Date/Time Prepared: 6/28/2017 3:36 pm

					6/28/2017 3:3	6 pm
Cost Center Description	OTHER	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	ADMI NI STRATI VE	PLANT	LINEN SERVICE			
	AND GENERAL					
	5. 06	7.00	8. 00	9. 00	10.00	
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1, 699	31, 019	0	4, 006	0	190. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	137, 324	181, 864	0	23, 485	0	192. 00
192. 01 19201 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	0	0	192. 01
194. 00 07950 MOB	728	0	0	0	0	194. 00
194. 01 07951 LI FELI NE	650	0	0	0	0	194. 01
194. 02 07952 PATIENT TRANSPORT	892	0	0	0	0	194. 02
194.03 07953 SETON LEASE 1 NORTH	0	0	0	0	0	194. 03
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	0	0	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	2, 292, 368	6, 157, 040	101, 751	769, 532	1, 141, 847	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 3:36 pm

				12/31/2016	6/28/2017 3:3	
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		ADMI NI STRATI ON	SERVICES &		RECORDS &	
	11. 00	13. 00	SUPPLY 14.00	15. 00	LI BRARY 16. 00	
GENERAL SERVICE COST CENTERS	11.00	13.00	14.00	13.00	10.00	
1.00 O0100 CAP REL COSTS-BLDG & FIXT						1. 00
2.00 O0200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00   00400   EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01   01160   COMMUNI CATI ONS						5. 01
5. 02 01140 MGMT INFO SYSTEMS						5. 02
5. 03   00550  PURCHASI NG 5. 04   00570  ADMI TTI NG						5. 03 5. 04
5. 05   00580 PATI ENT ACCOUNTI NG						5. 05
5. 06 00560 OTHER ADMINISTRATIVE AND GENERAL						5. 06
7.00 OO700 OPERATION OF PLANT						7. 00
8.00   00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00   00900   HOUSEKEEPI NG						9. 00
10. 00   01000   DI ETARY						10. 00
11. 00   01100   CAFETERI A	753, 709	224 040				11.00
13. 00 O1300 NURSI NG ADMINI STRATI ON 14. 00 O1400 CENTRAL SERVI CES & SUPPLY	23, 271 7, 682	334, 949	375, 933			13. 00 14. 00
15. 00   01500   PHARMACY	24, 499	0	375, 733	768, 663		15. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	85	0	0	700,009	267, 993	16. 00
17. 00 01700 SOCIAL SERVICE	7, 716	0	0	ō	0	17. 00
20. 00   02000 NURSI NG SCHOOL	23, 086	0	0	o	0	20. 00
23. 00 02301 PARAMED ED PRGM-(SPECIFY)	6, 165	0	0	0	0	23. 00
I NPATIENT ROUTINE SERVICE COST CENTERS						
30. 00   03000   ADULTS & PEDI ATRI CS	145, 543	85, 962	0	0	16, 028	30.00
31. 00 03100 I NTENSI VE CARE UNIT	41, 051	23, 931	0	0	4, 038	31.00
35. 00   02060   NEONATAL INTENSIVE CARE UNIT 40. 00   04000   SUBPROVIDER - IPF	16, 227 0	9, 460	0	0	3, 109 0	35. 00 40. 00
41. 00   04100   SUBPROVI DER -   1 PF	11, 481	6, 693	0	0	1, 104	40.00
42. 00   04200   SUBPROVI DER	0	0, 073	0	0	0	42. 00
43. 00   04300   NURSERY	5, 522	3, 219	0	o	791	43. 00
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	41, 335	24, 097	0	0	45, 168	50. 00
51. 00   05100   RECOVERY ROOM	6, 020	3, 509	0	0	2, 822	51. 00
52. 00   05200   DELI VERY ROOM & LABOR ROOM	33, 201	19, 355	0	0	4, 890	52. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	39, 622	0	0	0	20, 704	54.00
55. 00   03630  RADI OLOGY-THERAPEUTI C 56. 00   05600  RADI OI SOTOPE	3, 338 2, 120	0 1, 236	0	0	1, 932 0	55. 00 56. 00
56. 01   03950   CARDI AC   CATH   LAB	10, 912	6, 361	0	0	6, 680	56. 00
57. 00 05700 CT SCAN	6, 931	0, 301	0	0	15, 263	57. 00
58. 00   05800   MRI	1, 954	0	0	ō	3, 638	58. 00
60. 00   06000   LABORATORY	0	0	0	o	25, 548	60.00
65. 00 06500 RESPI RATORY THERAPY	24, 182	14, 097	0	0	2, 616	65. 00
66. 00 06600 PHYSI CAL THERAPY	33, 230	19, 372	0	0	3, 383	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	10, 406	6, 067	0	0	2, 095	67. 00
68. 00   06800   SPEECH PATHOLOGY 69. 00   06900   ELECTROCARDI OLOGY	4, 470	2, 606	0	O O	499 6, 172	68. 00 69. 00
70. 00   07000   ELECTROEARDI OLOGI 70. 00   07000   ELECTROENCEPHALOGRAPHY	15, 098 6, 645	8, 802 3, 874	0	ol Ol		70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0, 043	3, 674	199, 244	0	27, 697	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	O	176, 689	Ö	21, 981	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	768, 663	22, 203	73. 00
73. 01 07301 DI ABETES CENTER	3, 213	1, 873	0	0	55	73. 01
74. 00   07400   RENAL DI ALYSI S	1, 387	809	0	0	492	74. 00
76. 98 O7698 HYPERBARI C OXYGEN THERAPY	7	0	0	0	536	76. 98
OUTPATIENT SERVICE COST CENTERS 88. 00 08800 RURAL HEALTH CLINIC	0	0	0	ما	0	00.00
88.00   08800   RURAL HEALTH CLINIC 89.00   08900   FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	88. 00 89. 00
90. 00   09000   CLINIC	6, 522	0	0	0	188	90. 00
91. 00 09100 EMERGENCY	74, 050	43, 773	0	o	16, 588	91. 00
91. 01   04950   WOUND CARE	13, 556	7, 903	0	О	1, 446	91. 01
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
92.01 O9201 OBSERVATION BEDS (DISTINCT PART)	19, 516	0	0	0	2, 430	92. 01
OTHER REIMBURSABLE COST CENTERS						
95. 00   09500   AMBULANCE   SERVI CES	34, 313	20, 649	0	0	3, 136	95. 00
99. 10   09910   CORF 101. 00   10100   HOME HEALTH AGENCY	0 25, 057	14, 608	0	0	2 001	99. 10 101. 00
SPECIAL PURPOSE COST CENTERS	25,057	14, 000	U	<u> </u>	2, 091	101.00
109. 00 10900 PANCREAS ACQUISITION	n	O	0	ol	n	109. 00
110. 00 11000   NTESTI NAL ACQUI SI TI ON	Ö	Ö	Ö	o		110. 00
111.00 11100 I SLET ACQUI SITION	0	0	0	o		111. 00
113.00 11300 INTEREST EXPENSE						113. 00
116. 00 11600 HOSPI CE	11, 480			0		116.00
118.00   SUBTOTALS (SUM OF LINES 1-117)	740, 893	334, 949	375, 933	768, 663	267, 993	118. 00

Health Financial Systems	FRANCISCAN HEALTH LAFAYETTE	In Lieu of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS	Provi der CCN: 15-0109	Peri od: Worksheet B From 01/01/2016 Part II To 12/31/2016 Date/Time Prepared:

			1	0 12/31/2016	6/28/2017 3:3	
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		ADMI NI STRATI ON	SERVICES &		RECORDS &	
			SUPPLY		LI BRARY	
	11.00	13. 00	14.00	15. 00	16. 00	
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	711	0	0	0	0	190. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	10, 462	0	0	0	0	192. 00
192. 01 19201 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	0	0	192. 01
194. 00 07950 MOB	1, 296	0	0	0	0	194. 00
194. 01 07951 LI FELI NE	347	0	0	0	0	194. 01
194.02 07952 PATIENT TRANSPORT	0	0	0	0	0	194. 02
194.03 07953 SETON LEASE 1 NORTH	0	0	0	0	0	194. 03
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	0	o	0	0	0	201. 00
202.00 TOTAL (sum lines 118-201)	753, 709	334, 949	375, 933	768, 663	267, 993	202. 00

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

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0109 Period: From 01/01/2016 To 12/31/2016 Part II Date/Time Prepared: 6/28/2017 3: 36 pm

Cost Center Description SOCIAL SERVICE NURSING SCHOOL PARAMED ED PRGM Residents Cost & Post Stepdown

							6/28/2017 3:3	6 pm
		Cost Center Description	SOCIAL SERVICE	NURSING SCHOOL		Subtotal	Intern &	
					PRGM		Residents Cost & Post	
							Stepdown	
							Adjustments	
			17. 00	20. 00	23. 00	24.00	25. 00	
	<b>GENER</b>	AL SERVICE COST CENTERS	•		•			
1.00	1	CAP REL COSTS-BLDG & FIXT						1. 00
2.00	1	CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	1	EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01 5. 02	1	COMMUNICATIONS MGMT INFO SYSTEMS						5. 01 5. 02
5. 02	1	PURCHASING						5. 02
5. 04		ADMITTING						5. 04
5. 05	1	PATIENT ACCOUNTING						5. 05
5.06	00560	OTHER ADMINISTRATIVE AND GENERAL						5. 06
7.00	1	OPERATION OF PLANT						7. 00
8.00	1	LAUNDRY & LINEN SERVICE						8. 00
9.00	1	HOUSEKEEPI NG						9.00
10. 00 11. 00	1	DI ETARY CAFETERI A						10. 00 11. 00
13. 00		NURSING ADMINISTRATION						13. 00
14. 00		CENTRAL SERVICES & SUPPLY	•					14. 00
15.00		PHARMACY						15. 00
16. 00	01600	MEDICAL RECORDS & LIBRARY						16. 00
17. 00	1	SOCIAL SERVICE	64, 180					17. 00
20.00		NURSI NG SCHOOL	0	2, 488, 407				20.00
23. 00		PARAMED ED PRGM-(SPECIFY)   ENT ROUTINE SERVICE COST CENTERS	0		434, 901			23. 00
30. 00		ADULTS & PEDIATRICS	45, 326			6, 305, 983	0	30. 00
31. 00		INTENSIVE CARE UNIT	6, 302			995, 778	Ö	31. 00
35. 00	1	NEONATAL INTENSIVE CARE UNIT	3, 707			482, 634	Ö	35. 00
40.00	04000	SUBPROVI DER - I PF	0			0	0	40. 00
41.00	04100	SUBPROVI DER - I RF	4, 003			633, 562	0	41. 00
42. 00	1	SUBPROVI DER	0				0	42. 00
43. 00		NURSERY	4, 842			197, 766	0	43. 00
50. 00		LARY SERVICE COST CENTERS OPERATING ROOM	1 0		I	2, 582, 710	0	50. 00
51.00		RECOVERY ROOM	0			187, 413		51.00
52. 00		DELIVERY ROOM & LABOR ROOM	0			1, 144, 712	Ö	52. 00
54.00		RADI OLOGY-DI AGNOSTI C	0			2, 801, 048	0	54.00
55. 00	03630	RADI OLOGY-THERAPEUTI C	0			60, 743	0	55. 00
56. 00	1	RADI OI SOTOPE	0			30, 675	0	56. 00
56. 01		CARDI AC CATH LAB	0			621, 285	0	56. 01
57. 00 58. 00	05800	CT SCAN	0			249, 711 99, 310	0	57. 00 58. 00
60.00		LABORATORY	0			1, 042, 505	0	60.00
65. 00	1	RESPI RATORY THERAPY	0			268, 506	ĺ	65. 00
66.00		PHYSI CAL THERAPY	0	•		719, 100	0	66. 00
67. 00	06700	OCCUPATIONAL THERAPY	0			288, 611	0	67. 00
68. 00	1	SPEECH PATHOLOGY	0			147, 558	l	68. 00
69. 00	1	ELECTROCARDI OLOGY	0			668, 532	0	
70.00		ELECTROENCEPHALOGRAPHY MEDICAL SUPPLIES CHARGED TO PATIENT	0			223, 129	l e	
71. 00 72. 00	1	IMPL. DEV. CHARGED TO PATIENTS	0			412, 604 372, 122		71.00
73. 00		DRUGS CHARGED TO PATIENTS				894, 388		73. 00
73. 01		DI ABETES CENTER	0	•		14, 423		73. 01
74.00	07400	RENAL DIALYSIS	0			128, 891	0	74. 00
76. 98		HYPERBARI C OXYGEN THERAPY	0			144, 856	0	76. 98
00.00		TIENT SERVICE COST CENTERS	1 0		I			00.00
88. 00 89. 00		RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER	0			0	0	88. 00 89. 00
90.00		CLINIC	0			26, 765	0	90.00
91. 00		EMERGENCY	0			2, 510, 421	Ö	91.00
91. 01		WOUND CARE	0			393, 877	0	91. 01
92. 00		OBSERVATION BEDS (NON-DISTINCT PART					0	92. 00
92. 01		OBSERVATION BEDS (DISTINCT PART)	] 0			292, 176	0	92. 01
05 00		REIMBURSABLE COST CENTERS  AMBULANCE SERVICES	0			220 545	0	05 00
95. 00 99. 10	1	l e e e e e e e e e e e e e e e e e e e	0			330, 515 0	0	
		HOME HEALTH AGENCY	0			169, 908		101. 00
		AL PURPOSE COST CENTERS						55
109.00		PANCREAS ACQUISITION	0			0	0	109. 00
		INTESTINAL ACQUISITION	0			0		110. 00
		I SLET ACQUI SI TI ON	0			0	0	111.00
	1	I NTEREST EXPENSE HOSPI CE	0			394, 799	_	113. 00 116. 00
110.00	111000	I I OSI I OL	1 0	<u> </u>	I	374, 799	1 0	1110.00

Health Financial Systems	FRANCISCAN HEAL	TH LAFAYETTE		In Lie	u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der CC		Peri od:	Worksheet B	
				From 01/01/2016 To 12/31/2016		pared:
					6/28/2017 3: 3	6 pm
Cost Center Description	SOCIAL SERVICE	NURSING SCHOOL		Subtotal	Intern &	
			PRGM		Residents Cost	
					& Post	
					Stepdown	
					Adjustments	
	17. 00	20. 00	23. 00	24. 00	25. 00	
118.00 SUBTOTALS (SUM OF LINES 1-117)	64, 180	0		0 25, 837, 016	0	118. 00
NONREI MBURSABLE COST CENTERS	,					
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0			155, 251		190. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0			908, 546		192. 00
192. 01 19201 PHYSI CLANS' PRI VATE OFFI CES	0			0		192. 01
194. 00 07950 MOB	0			3, 439	0	194. 00
194. 01 07951 LI FELI NE	0			1, 397		194. 01
194. 02 07952 PATI ENT TRANSPORT	0			892	0	194. 02
194.03 07953 SETON LEASE 1 NORTH	0			0	0	194. 03
200.00 Cross Foot Adjustments		2, 488, 407	434, 90	2, 923, 308	0	200. 00
201.00 Negative Cost Centers	0	0		0 308	0	201. 00
202.00 TOTAL (sum lines 118-201)	64, 180	2, 488, 407	434, 90	29, 830, 157	0	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 3:36 pm

		6/28/2017 3: 30	6 pm
Cost Center Description	Total		
	26. 00		
GENERAL SERVI CE COST CENTERS			
1.00 O0100 CAP REL COSTS-BLDG & FLXT			1. 00
2.00 O0200 CAP REL COSTS-MVBLE EQUIP			2. 00
4.00   00400   EMPLOYEE BENEFITS DEPARTMENT			4. 00
5. 01  01160  COMMUNI CATI ONS			5. 01
5.02 O1140 MGMT INFO SYSTEMS			5. 02
5. 03   00550   PURCHASI NG			5. 03
5. 04   00570   ADMI TTI NG			5. 04
5. 05   00580 PATIENT ACCOUNTING			5. 05
5.06   00560 OTHER ADMINISTRATIVE AND GENERAL			5. 06
7.00 00700 OPERATION OF PLANT			7. 00
8.00   00800 LAUNDRY & LINEN SERVICE			8. 00
9. 00   00900   HOUSEKEEPI NG			9. 00
10. 00  01000 DI ETARY			10.00
11. 00   01100   CAFETERI A			11. 00
13.00 01300 NURSING ADMINISTRATION			13. 00
14.00 01400 CENTRAL SERVICES & SUPPLY			14. 00
15. 00 01500 PHARMACY			15. 00
16.00 01600 MEDICAL RECORDS & LIBRARY			16. 00
17. 00 01700 SOCIAL SERVICE			17. 00
20. 00 02000 NURSI NG SCHOOL			20. 00
23. 00   02301 PARAMED ED PRGM-(SPECIFY)			23. 00
INPATIENT ROUTINE SERVICE COST CENTERS			
30. 00 03000 ADULTS & PEDIATRICS	6, 305, 983		30. 00
31. 00   03100   NTENSI VE CARE UNI T	995, 778		31. 00
35. 00 02060 NEONATAL INTENSIVE CARE UNIT	482, 634		35. 00
40. 00   04000   SUBPROVI DER -   PF	0		40. 00
41. 00   04100   SUBPROVI DER -   RF	633, 562		41. 00
42. 00   04200   SUBPROVI DER	000,002		42. 00
43. 00   04300   NURSERY	197, 766		43. 00
ANCI LLARY SERVI CE COST CENTERS	177,700		45.00
50. 00   05000   0PERATI NG   ROOM	2, 582, 710		50.00
51. 00   05100   RECOVERY ROOM	187, 413		51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	1, 144, 712		52.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	2, 801, 048		54.00
55. 00   03630   RADI OLOGY-THERAPEUTI C	60, 743		55. 00
56. 00   05600   RADI 0I SOTOPE	30, 675		56.00
56. 01   03950   CARDI AC   CATH   LAB	621, 285		56. 01
57. 00 05700 CT SCAN	249, 711		57. 00
58. 00   05800 MRI	99, 310		58.00
60. 00   06000   LABORATORY	1, 042, 505		60.00
65. 00 06500 RESPI RATORY THERAPY	268, 506		65. 00
66. 00   06600 PHYSI CAL THERAPY	719, 100		66.00
67. 00 06700 OCCUPATI ONAL THERAPY	288, 611		67. 00
68. 00 06800 SPEECH PATHOLOGY	147, 558		68. 00
69. 00   06900   ELECTROCARDI OLOGY	668, 532		69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	223, 129		70. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	412, 604		71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	372, 122		72.00
	894, 388		73.00
73. 00   07300  DRUGS CHARGED TO PATIENTS 73. 01   07301  DI ABETES CENTER	14, 423		73. 00
74. 00   07400   RENAL DIALYSIS	128, 891		74. 00
76. 98 07698 HYPERBARI C OXYGEN THERAPY	144, 856		76. 98
OUTPATIENT SERVICE COST CENTERS	144,000		, 0. 70
88. 00   08800   RURAL HEALTH CLINIC	0		88. 00
89. 00   08900   FEDERALLY QUALIFIED HEALTH CENTER	0		89. 00
90. 00   009000   CLINI C	26, 765		90.00
91. 00   09100   EMERGENCY	2, 510, 421		91.00
91. 00   09100  EMERGENCY 91. 01   04950  WOUND CARE	393, 877		91.00
· · · · · · · · · · · · · · · · · · ·	393,011		
92.00   09200   0BSERVATION BEDS (NON-DISTINCT PART 92.01   09201   0BSERVATION BEDS (DISTINCT PART)	202 174	-	92.00
OTHER REIMBURSABLE COST CENTERS	292, 176		92. 01
	220 515		0F 00
95. 00   09500   AMBULANCE SERVI CES 99. 10   09910   CORF	330, 515		95. 00
	140,000		99. 10
101. 00 10100 HOME HEALTH AGENCY	169, 908		101. 00
SPECIAL PURPOSE COST CENTERS			100.00
109. 00 10900 PANCREAS ACQUISITION	0		109.00
110. 00 11000   I NTESTI NAL ACQUI SI TI ON	0		110.00
111. 00 11100   I SLET ACQUI SI TI ON	0		111.00
113. 00 11300   I NTEREST EXPENSE	204 700		113.00
116. 00 11600 HOSPI CE	394, 799		116. 00
118. 00 SUBTOTALS (SUM OF LINES 1-117)	25, 837, 016		118. 00
NONREI MBURSABLE COST CENTERS			400
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	155, 251		190.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	908, 546		192. 00

Health Financial Systems	FRANCISCAN HEALT	H LAFAYETTE	In Lie	u of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0109	Peri od: From 01/01/2016 To 12/31/2016	Worksheet B Part II Date/Time Prepared: 6/28/2017 3:36 pm
Cost Center Description	Total		<u>'</u>	
	26.00			
192. 01 19201 PHYSI CLANS' PRI VATE OFFI CES	0			192. 01
194. 00 07950 MOB	3, 439			194. 00
194. 01 07951 LI FELI NE	1, 397			194. 01
194.02 07952 PATIENT TRANSPORT	892			194. 02
194.03 07953 SETON LEASE 1 NORTH	O			194. 03
200.00 Cross Foot Adjustments	2, 923, 308			200. 00
201.00 Negative Cost Centers	308			201. 00
202.00 TOTAL (sum lines 118-201)	29, 830, 157			202. 00

						6/28/2017 3:3	6 pm
		CAPITAL RE	LATED COSTS				
			1				
	Cost Center Description	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	COMMUNI CATI ONS	MGMT INFO	
		(SQUARE FEET)	(SQUARE FEET)	BENEFITS		SYSTEMS	
				DEPARTMENT	(PHONE LINE S)	(MANHOURS)	
				(GROSS			
				SALARI ES)			
		1. 00	2. 00	4. 00	5. 01	5. 02	
	GENERAL SERVICE COST CENTERS						
1. 00	00100 CAP REL COSTS-BLDG & FIXT	833, 515					1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP		833, 515				2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	15, 966	15, 966	88, 481, 869			4. 00
5. 01	01160 COMMUNI CATI ONS	1, 794	1, 794	512, 854	705		5. 01
5.02	01140 MGMT INFO SYSTEMS	26, 543	26, 543	2, 801	23	2, 990, 130	5. 02
5.03	00550 PURCHASI NG	16, 373	16, 373	0	14	0	5. 03
5.04	00570 ADMITTING	2, 382			o	0	5. 04
5.05	00580 PATIENT ACCOUNTING	6,044			14	0	5. 05
5.06	00560 OTHER ADMINISTRATIVE AND GENERAL	64, 406			73	365, 796	5. 06
7.00	00700 OPERATION OF PLANT	178, 569			l .	120, 810	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	1, 981		117, 313	l .	8, 093	1
9. 00	00900 HOUSEKEEPI NG	14, 775			9	143, 657	9. 00
10. 00	01000 DI ETARY	22, 293			30	48, 482	1
11. 00	01100 CAFETERI A	15, 253			0	86, 258	1
13. 00	01300 NURSI NG ADMI NI STRATI ON	5, 134			· ·	68, 452	1
14. 00	01400 CENTRAL SERVICES & SUPPLY	5, 913			1	22, 598	
15. 00	01500 PHARMACY	9, 754				72, 063	1
16. 00	01600 MEDICAL RECORDS & LIBRARY	5, 234		62, 090	l .	249	1
17. 00	01700 SOCIAL SERVICE	814		634, 972	l .	22, 698	1
20. 00	02000 NURSI NG SCHOOL	51, 210			l .		
					l .	67, 907	20.00
23. 00	02301 PARAMED ED PRGM-(SPECIFY)	8, 852	8, 852	285, 366	0	18, 135	23. 00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	01 202	01 202	17.000.01/	115	420 117	20.00
30.00	03000 ADULTS & PEDI ATRI CS	91, 283				428, 117	30.00
31. 00	03100 I NTENSI VE CARE UNI T	14, 505			l .	120, 750	
35. 00	02060 NEONATAL INTENSIVE CARE UNIT	8, 356		1, 705, 874	17	47, 731	
40. 00	04000 SUBPROVI DER - I PF	0	0	0	0	0	40. 00
41. 00	04100 SUBPROVI DER - I RF	10, 607	10, 607	1, 101, 134	24	33, 772	1
42.00	04200 SUBPROVI DER	0	0	0	0	0	42. 00
43. 00	04300  NURSERY	3, 551	3, 551	0	0	16, 242	43. 00
	ANCILLARY SERVICE COST CENTERS						
50. 00	05000 OPERATI NG ROOM	34, 704			l .	121, 586	•
51. 00	05100 RECOVERY ROOM	3, 171		685, 439	l .	17, 707	51. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	21, 354	21, 354	0	26	97, 661	
54.00	05400 RADI OLOGY-DI AGNOSTI C	38, 629	38, 629	3, 344, 366	60	116, 547	54.00
55. 00	03630 RADI OLOGY-THERAPEUTI C	892	892	412, 129	0	9, 820	55. 00
56. 00	05600  RADI OI SOTOPE	445	445	226, 026	0	6, 236	56. 00
56. 01	03950 CARDI AC CATH LAB	10, 692	10, 692	1, 202, 447	0	32, 097	56. 01
57.00	05700 CT SCAN	3, 791	3, 791	644, 589	0	20, 388	57. 00
58. 00	05800 MRI	1, 724	1, 724	242, 782	0	5, 747	58. 00
60.00	06000 LABORATORY	18, 603	18, 603	0	44	0	60.00
65.00	06500 RESPI RATORY THERAPY	2,778	2, 778	2, 105, 752	34	71, 132	65. 00
66.00	06600 PHYSI CAL THERAPY	10, 054	10, 054	2, 870, 676	6	97, 746	66.00
67.00	06700 OCCUPATI ONAL THERAPY	5, 021	5, 021	1, 057, 928	o	30, 610	67. 00
68. 00	06800 SPEECH PATHOLOGY	2, 701		456, 195	o	13, 148	
69.00	06900 ELECTROCARDI OLOGY	12, 530	12, 530	1, 417, 305	6	44, 411	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	4, 036	4, 036	609, 648	o	19, 545	70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	o	0	71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS		0	0	o	0	1
	07300 DRUGS CHARGED TO PATIENTS	0	0	o n	ol	0	73. 00
73. 01	07301 DI ABETES CENTER	0	0	301, 960	6	9, 451	1
74. 00	07400 RENAL DIALYSIS	2, 499	2, 499		l .	4, 081	1
76. 98	07698 HYPERBARI C OXYGEN THERAPY	3,000			l .	20	•
, 5. 70	OUTPATIENT SERVICE COST CENTERS	3,000	5, 500	, , , , , ,	<u> </u>	20	, 5. 75
88. 00	08800 RURAL HEALTH CLINIC	0	^	^	n	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER					0	89.00
	09000 CLINIC			372, 098	32	19, 185	•
91. 00	09100 EMERGENCY	42, 935	42, 935		32	217, 818	
91. 00	04950 WOUND CARE	6, 957		1, 338, 554		39, 875	•
91.01	09200 OBSERVATION BEDS (NON-DISTINCT PART	0, 95/	0, 937	1, 330, 354	١	37, 0/5	91.01
	09201 OBSERVATION BEDS (NON-DISTINCT PART	0	0	1 770 100	o	E7 40E	1
9∠. U I			1 0	1, 779, 199	ı U	57, 405	92.UI
OF 00	OTHER REIMBURSABLE COST CENTERS	2.5/0	2.5/2	2 047 725		100 001	05.00
	09500 AMBULANCE SERVICES	3, 569		2, 047, 725	l I	100, 931	1
	09910 CORF	0		2 (04 505	0	72.70/	
101.00	10100 HOME HEALTH AGENCY	0	0	2, 694, 525	0	73, 706	1101.00
100.00	SPECIAL PURPOSE COST CENTERS	_	_	_		_	100.00
	10900 PANCREAS ACQUISITION	0	l .	0	0		109.00
	11000 I NTESTI NAL ACQUI SI TI ON	0		0	-		110.00
111.00	11100   I SLET ACQUI SI TI ON	0	0	0	0	0	111. 00
						<u>-</u>	

Heal th Finar	icial Systems	FRANCISCAN HEAL	LTH_LAFAYETTE		In Lie	u of Form CMS-	2552-10
COST ALLOCA	TION - STATISTICAL BASIS		Provi der CO		Peri od:	Worksheet B-1	
					rom 01/01/2016	Date/Time Pre	narad.
				'	o 12/31/2016	6/28/2017 3: 3	
		CAPITAL REL	ATED COSTS			0,20,201, 0.0	J Pill
	Cost Center Description	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	COMMUNI CATI ONS	MGMT INFO	
	•	(SQUARE FEET)	(SQUARE FEET)	BENEFITS		SYSTEMS	
				DEPARTMENT	(PHONE LINE S)	(MANHOURS)	
				(GROSS			
				SALARI ES)			
		1. 00	2. 00	4.00	5. 01	5. 02	
	I NTEREST EXPENSE						113. 00
116. 00 11600	HOSPI CE	3, 809	3, 809	1, 188, 820	0	33, 769	116. 00
118. 00	SUBTOTALS (SUM OF LINES 1-117)	815, 486	815, 486	82, 678, 255	705	2, 952, 432	118. 00
NONRE	IMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2, 627	2, 627	46, 707	0	2, 091	190. 00
	PHYSICIANS' PRIVATE OFFICES	15, 402	15, 402	5, 692, 665	0		192. 00
	PHYSICIANS' PRIVATE OFFICES	0	0	(	0		192. 01
194. 00 07950		0	0	47, 893	0		194. 00
194. 01 07951	LIFELINE	0	0	16, 349	0	1, 021	194. 01
194. 02 07952	PATIENT TRANSPORT	0	0	(	0	0	194. 02
194. 03 07953	SETON LEASE 1 NORTH	0	0	(	0	0	194. 03
200. 00	Cross Foot Adjustments						200. 00
201. 00	Negative Cost Centers						201. 00
202. 00	Cost to be allocated (per Wkst. B,	22, 633, 646	5, 082, 552	29, 049, 945	1, 505, 872	13, 031, 586	202. 00
	Part I)						
203. 00	Unit cost multiplier (Wkst. B, Part I)	27. 154456	6. 097733	0. 328315	2, 135. 988652	4. 358200	203. 00
204.00	Cost to be allocated (per Wkst. B,			530, 904	62, 731	884, 677	204. 00
	Part II)						
205 00	Unit cost multiplier (Wkst B Part			0 006000	88 980142	0 295866	205 00

0.006000

88. 980142

0. 295866 205. 00

205.00

Unit cost multiplier (Wkst. B, Part

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0109

				1	0 12/31/2016	Date/lime Prep   6/28/2017 3:30	
	Cost Center Description	PURCHASI NG	ADMI TTI NG		Reconciliation	OTHER	
		(COSTED REQ ULSI)	(GROSS CHAR GES)	ACCOUNTING (GROSS CHAR		ADMI NI STRATI VE AND GENERAL	
				GES)		(ACCUM. COST)	
	CENEDAL SEDVICE COST CENTEDS	5. 03	5. 04	5. 05	5A. 06	5. 06	
1. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT						1. 00
2. 00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01	01160 COMMUNI CATI ONS						5. 01
5. 02	01140 MGMT INFO SYSTEMS	05.040.404					5. 02
5. 03 5. 04	00550 PURCHASI NG 00570 ADMI TTI NG	35, 063, 121	1 140 440 211				5. 03 5. 04
5. 05	00580 PATIENT ACCOUNTING	0 72	1, 160, 469, 211 0	1, 160, 469, 211			5. 04
5. 06	00560 OTHER ADMINISTRATIVE AND GENERAL	8, 509	0	0	-23, 797, 386	256, 061, 012	5. 06
7.00	00700 OPERATION OF PLANT	3, 410	0	0	0	17, 841, 870	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	1, 067	0	0	0	1, 036, 951	8. 00
9.00	00900 HOUSEKEEPI NG	61, 376	0	0	0	4, 837, 218	9. 00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	7, 887 14, 034	0	0	0	2, 615, 765 1, 945, 073	10. 00 11. 00
13. 00	01300 NURSI NG ADMI NI STRATI ON	42	0	0	0	3, 912, 472	13. 00
14. 00	01400 CENTRAL SERVI CES & SUPPLY	797, 700	Ö	Ö	Ö	855, 513	14. 00
15.00	01500 PHARMACY	555, 555	0	0	0	4, 942, 097	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	15	0	0	0	2, 471, 345	16. 00
17. 00	01700 SOCIAL SERVICE	488	0	0	0	805, 201	17. 00
20. 00 23. 00	02000 NURSI NG SCHOOL 02301 PARAMED ED PRGM-(SPECIFY)	3, 829 854	0	0	0	5, 292, 422 1, 036, 272	20. 00 23. 00
23.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	054	U	0	<u> </u>	1, 030, 272	23.00
30. 00	03000 ADULTS & PEDI ATRI CS	812, 206	69, 386, 982	69, 386, 982	0	25, 054, 745	30. 00
31. 00	03100 INTENSIVE CARE UNIT	268, 967	17, 479, 566	17, 479, 566	0	5, 838, 519	31.00
35. 00	02060 NEONATAL INTENSIVE CARE UNIT	71, 143	13, 457, 277	13, 457, 277	0	3, 167, 181	35. 00
40.00	04000 SUBPROVI DER - I PF	0	0	0	0	0	40.00
41. 00 42. 00	04100 SUBPROVI DER - I RF 04200 SUBPROVI DER	32, 433	4, 778, 387	4, 778, 387	0	2, 155, 182 0	41. 00 42. 00
43. 00	04300 NURSERY	61, 939	3, 426, 051	3, 426, 051	0	851, 570	43. 00
10.00	ANCILLARY SERVICE COST CENTERS	0.17.07	07 1207 00 1	0, 120, 001	<u> </u>	001,070	10.00
50.00	05000 OPERATING ROOM	22, 662, 392			0	28, 689, 704	50.00
51. 00	05100 RECOVERY ROOM	35, 250				1, 171, 905	51. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	372, 425	21, 170, 204	21, 170, 204	0	5, 178, 603	52.00
54. 00 55. 00	05400   RADI OLOGY-DI AGNOSTI C   03630   RADI OLOGY-THERAPEUTI C	2, 382, 036 13, 038	89, 625, 691 8, 363, 335	89, 625, 691 8, 363, 335	0	14, 544, 997 705, 366	54. 00 55. 00
56. 00	05600 RADI OI SOTOPE	5, 454	0, 303, 333	0, 303, 333	ő	368, 998	56. 00
56. 01	03950 CARDI AC CATH LAB	3, 473, 678	28, 919, 655	28, 919, 655	Ō	2, 352, 877	56. 01
57. 00	05700 CT SCAN	143, 424	66, 073, 172	66, 073, 172	0	1, 764, 110	57. 00
58. 00	05800 MRI	6, 340			0	708, 111	58. 00
60.00	06000 LABORATORY	951, 342	110, 599, 207	110, 599, 207	0	10, 607, 411	60.00
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	463, 544 139, 567	11, 322, 518 14, 645, 511	11, 322, 518 14, 645, 511	0	3, 513, 975 4, 876, 456	65. 00 66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	23, 198			ő	2, 030, 829	67. 00
68. 00	06800 SPEECH PATHOLOGY	4, 785		2, 158, 954	0	774, 555	
	06900 ELECTROCARDI OLOGY	26, 427	26, 717, 971	26, 717, 971	0	2, 806, 137	
	07000 ELECTROENCEPHALOGRAPHY	43, 497	5, 139, 814	5, 139, 814	0	1, 139, 038	
71. 00	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0	119, 899, 548		0	17, 498, 520	71.00
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	95, 157, 453 96, 114, 942		0	16, 803, 412 8, 965, 793	72. 00 73. 00
73. 00	07301 DI ABETES CENTER	1, 035			0	454, 228	73. 00
74. 00	07400 RENAL DIALYSIS	14, 436				797, 016	74. 00
76. 98	07698 HYPERBARI C OXYGEN THERAPY	2, 240	2, 322, 216	2, 322, 216	0	441, 553	76. 98
	OUTPATIENT SERVICE COST CENTERS		_			_	
88. 00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88. 00
89. 00 90. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC	0 38, 569	815, 114	0 815, 114	0	0 949, 730	89. 00 90. 00
91. 00	09100 EMERGENCY	895, 171	71, 808, 391	71, 808, 391	0	11, 689, 047	91.00
91. 01	04950 WOUND CARE	335, 447	6, 259, 818	6, 259, 818	Ō	2, 269, 387	91. 01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
92. 01	09201 OBSERVATION BEDS (DISTINCT PART)	73, 824	10, 519, 325	10, 519, 325	0	2, 713, 423	92. 01
05.00	OTHER REIMBURSABLE COST CENTERS  O9500 AMBULANCE SERVI CES	108, 960	12 575 152	12 575 152	٥	2 075 250	05 00
95. 00	09910 CORF	108, 960	13, 575, 152	13, 575, 152	0	3, 975, 250 0	95. 00 99. 10
	10100 HOME HEALTH AGENCY	102, 266	9, 050, 299	9, 050, 299		-	
250	SPECIAL PURPOSE COST CENTERS		.,,	., 233, 277	<u> </u>	-, -==, -=,	55
	10900 PANCREAS ACQUISITION	0	0	0	0		109. 00
	11000   NTESTINAL ACQUISITION	0	0	0	0		110.00
	11100   SLET ACQUI SITION	0	0	0	0	0	111.00
	11300   I NTEREST EXPENSE   11600   HOSPI CE	43, 237	6, 418, 976	6, 418, 976	0	2, 547, 506	113. 00 116. 00
118.00	1 1		1, 160, 469, 211				
	, , , , , , , , , , , , , , , , , , ,					., .,-32	

Health Financial Systems	FRANCISCAN HEALTH LAFAYETTE	In Lieu of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS	Provi der CCN: 15-0109	Peri od: Worksheet B-1 From 01/01/2016 Date/Time Prepared: Date/Control Prepared: Date/Time Prepared: Date

					0 12/31/2010	6/28/2017 3:3	
	Cost Center Description	PURCHASI NG	ADMI TTI NG	PATI ENT	Reconciliation		
		(COSTED REQ	(GROSS CHAR	ACCOUNTI NG		ADMI NI STRATI VE	
		UISI)	GES)	(GROSS CHAR		AND GENERAL	
				GES)		(ACCUM. COST)	
		5. 03	5. 04	5. 05	5A. 06	5. 06	
NONRE	EIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	C	0	189, 840	190. 00
192. 00 19200	PHYSICIANS' PRIVATE OFFICES	13	0	C	0	15, 340, 051	192. 00
192. 01 1920	1 PHYSICIANS' PRIVATE OFFICES	0	0	C	0	0	192. 01
194. 00 07950	D MOB	0	0	C	0	81, 275	194. 00
194. 01 07951	1 LI FELI NE	0	0	C	0	72, 562	194. 01
194. 02 07952	PATIENT TRANSPORT	0	0	C	0	99, 622	194. 02
194. 03 07953	SETON LEASE 1 NORTH	0	0	C	0	0	194. 03
200.00	Cross Foot Adjustments						200. 00
201.00	Negative Cost Centers						201. 00
202.00	Cost to be allocated (per Wkst. B,	1, 824, 095	78, 899	5, 323, 517	1	23, 797, 386	202. 00
	Part I)						
203.00	Unit cost multiplier (Wkst. B, Part I)	0. 052023	0. 000068	0. 004587		0. 092936	203. 00
204.00	Cost to be allocated (per Wkst. B,	545, 684	79, 207	202, 224		2, 292, 368	204. 00
	Part II)						
205.00	Unit cost multiplier (Wkst. B, Part	0. 015563	0. 000068	0. 000174		0. 008952	205. 00
	[11]						

COST A	ALLOCATION - STATISTICAL BASIS		Provi der Co		Period: From 01/01/2016	Worksheet B-1	
					o 12/31/2016		
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	6/28/2017 3: 3 CAFETERI A	6 pm
		PLANT	LINEN SERVICE		(MEALS SERVED)	(MANHOURS)	
		(SQUARE FEET)	(POUNDS OF LAUNDRY)				
		7. 00	8.00	9. 00	10.00	11. 00	
	GENERAL SERVI CE COST CENTERS				1		
1. 00 2. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						1. 00 2. 00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01	01160 COMMUNI CATI ONS						5. 01
5. 02	01140 MGMT INFO SYSTEMS						5. 02
5. 03 5. 04	00550 PURCHASI NG 00570 ADMI TTI NG						5. 03 5. 04
5. 05	00580 PATIENT ACCOUNTING		•				5. 05
5.06	00560 OTHER ADMINISTRATIVE AND GENERAL						5. 06
7.00	00700 OPERATION OF PLANT	521, 438	1 224 472				7. 00 8. 00
8. 00 9. 00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	1, 981 14, 775	1, 224, 673 28, 322		,		9.00
10. 00	01000 DI ETARY	22, 293	34, 396				10.00
11.00	01100 CAFETERI A	15, 253	0			2, 217, 034	1
13. 00 14. 00	01300 NURSI NG ADMINI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	5, 134 5, 913	0 31, 039	5, 134 5, 913		68, 452 22, 598	
15. 00	01500 PHARMACY	9, 754	0 31,039	9, 754		72, 063	1
16. 00	01600 MEDICAL RECORDS & LIBRARY	5, 234	0	5, 234		249	1
17. 00	01700 SOCIAL SERVICE	814	0	814		22, 698	1
20. 00 23. 00	02000 NURSI NG SCHOOL 02301 PARAMED ED PRGM-(SPECI FY)	51, 210 8, 852	0	51, 210 8, 852		67, 907 18, 135	
23.00	INPATIENT ROUTINE SERVICE COST CENTERS	0,032		0,032		10, 133	25.00
30. 00	03000 ADULTS & PEDIATRICS	91, 283	432, 330	91, 283	167, 518	428, 117	
31. 00	03100   NTENSI VE CARE UNI T	14, 505	65, 860			120, 750	
35. 00 40. 00	02060 NEONATAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF	8, 356	27, 451 0	8, 356	1	47, 731 0	1
41. 00	04100 SUBPROVI DER - I RF	10, 607	23, 249	1	-	33, 772	
42. 00	04200 SUBPROVI DER	0	0	C	0	0	
43. 00	04300 NURSERY ANCILLARY SERVICE COST CENTERS	3, 551	45, 116	3, 551	0	16, 242	43. 00
50. 00	05000 OPERATING ROOM	34, 704	214, 785	34, 704	O	121, 586	50.00
51. 00	05100 RECOVERY ROOM	3, 171	39, 496	3, 171		17, 707	
52.00	05200 DELIVERY ROOM & LABOR ROOM	21, 354	48, 236			97, 661	
54. 00 55. 00	05400 RADI OLOGY-DI AGNOSTI C 03630 RADI OLOGY-THERAPEUTI C	38, 629 892	75, 365 0			116, 547 9, 820	
56. 00	05600 RADI OI SOTOPE	445	Ö	445		6, 236	1
56. 01	03950 CARDI AC CATH LAB	10, 692	4, 980			32, 097	
57. 00 58. 00	05700 CT SCAN 05800 MRI	3, 791 1, 724	0	3, 791 1, 724		20, 388 5, 747	
60. 00	06000 LABORATORY	18, 603	7, 809			0,747	1
65. 00	06500 RESPI RATORY THERAPY	2, 778	9, 143	2, 778			65. 00
	06600 PHYSI CAL THERAPY	10, 054					66.00
	06700 OCCUPATIONAL THERAPY 06800 SPEECH PATHOLOGY	5, 021 2, 701	0	5, 021 2, 701			67. 00 68. 00
69. 00		12, 530	6, 935			44, 411	1
	07000 ELECTROENCEPHALOGRAPHY	4, 036	0	4, 036	0	19, 545	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	C	0	0	
73. 00	07300 DRUGS CHARGED TO PATIENTS	0				0	73.00
73. 01	07301 DI ABETES CENTER	0	0	C	O	9, 451	1
74.00	07400 RENAL DIALYSIS	2, 499	0	2, 499		4, 081	
76. 98	07698 HYPERBARI C OXYGEN THERAPY OUTPATIENT SERVICE COST CENTERS	3,000	0	3, 000	0	20	76. 98
88. 00	08800 RURAL HEALTH CLINIC	0	0	С	0	0	88. 00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	C	0	0	89. 00
90.00	09000 CLI NI C 09100 EMERGENCY	42, 935	0 113, 145	42, 935	0	19, 185 217, 818	
91.00	04950 WOUND CARE	6, 957	113, 143	6, 957		39, 875	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
92. 01	09201 OBSERVATION BEDS (DISTINCT PART)	0	0	C	0	57, 405	92. 01
95. 00	OTHER REIMBURSABLE COST CENTERS  09500 AMBULANCE SERVICES	3, 569	0	3, 569	0	100, 931	95.00
	09910 CORF	0,007	0	0,007		0	1
101.00	10100 HOME HEALTH AGENCY	0	0	C	0	73, 706	101. 00
100 00	SPECIAL PURPOSE COST CENTERS 10900 PANCREAS ACQUISITION	0	^			0	109. 00
	11000   NTESTINAL ACQUISITION	0	0		1		1109.00
111.00	11100 ISLET ACQUISITION	O	0	į č	o		111. 00
	11300 INTEREST EXPENSE	2 222	_	2.000		20 7/2	113.00
116.00	11600 HOSPICE   SUBTOTALS (SUM OF LINES 1-117)	3, 809 503, 409	1, 224, 673	3, 809 486, 653			116. 00 118. 00
	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	1 230, 107	., 221, 073		231, 330		1

Health Financial Systems	FRANCISCAN HEALTH LAFAYETTE	1	n Lieu of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS	Provider CCN: 15-010	9 Peri od:	Worksheet B-1

COST ALLOCATION - STATISTICAL BASIS		Provi der CO		eriod: rom 01/01/2016	Worksheet B-1	
				o 12/31/2016	Date/Time Pre	pared:
					6/28/2017 3: 3	6 pm
Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG		CAFETERI A	
		LINEN SERVICE	(SQUARE FEET)	(MEALS SERVED)	(MANHOURS)	
	(SQUARE FEET)	(POUNDS OF				
		LAUNDRY)				
	7.00	8. 00	9. 00	10.00	11. 00	
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	2, 627	0	2, 627		· ·	190. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	15, 402	0	15, 402	. 0	30, 775	1
192. 01 19201 PHYSI CLANS' PRI VATE OFFI CES	0	0	C	0	-	192. 01
194. 00 07950 MOB	0	0	C	0		194. 00
194. 01 07951 LI FELI NE	0	0	C	0	1, 021	194. 01
194. 02 07952 PATI ENT TRANSPORT	0	0	C	0	0	194. 02
194.03 07953 SETON LEASE 1 NORTH	0	0	C	0	0	194. 03
200.00 Cross Foot Adjustments					ļ	200. 00
201.00 Negative Cost Centers						201. 00
202.00 Cost to be allocated (per Wkst. B,	19, 500, 022	1, 207, 404	5, 867, 228	3, 985, 627	2, 873, 576	202. 00
Part I)						
203.00 Unit cost multiplier (Wkst. B, Part I)	37. 396626	0. 985899	11. 625594	19. 799439	1. 296135	203. 00
204.00 Cost to be allocated (per Wkst. B,	6, 157, 040	101, 751	769, 532	1, 141, 847	753, 709	204. 00
Part II)					ļ	
205.00 Unit cost multiplier (Wkst. B, Part	11. 807808	0. 083084	1. 524786	5. 672365	0. 339963	205. 00
1 )					ļ	

0001 7	ELECTRICAL STATES OF STATES		Trovider ex	1	From 01/01/2016 To 12/31/2016		pared:
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	6/28/2017 3: 3 SOCI AL SERVI CE	
		ADMI NI STRATI ON	SERVICES & SUPPLY	(COSTED REQUIS.)	RECORDS & LI BRARY	(TIME SPENT)	
		(DI RECT NRS I NG)	(COSTED REQUIS.)		(GROSS CHAR GES)		
		13. 00	14. 00	15. 00	16. 00	17. 00	
1. 00	GENERAL SERVICE COST CENTERS OO100 CAP REL COSTS-BLDG & FIXT			I		I	1.00
2. 00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4. 00 5. 01	OO400						4. 00 5. 01
5. 01	01140 MGMT INFO SYSTEMS						5. 02
5. 03	00550 PURCHASI NG						5. 03
5. 04 5. 05	OO570   ADMITTING   OO580   PATIENT   ACCOUNTING						5. 04 5. 05
5.06	00560 OTHER ADMINISTRATIVE AND GENERAL						5. 06
7. 00 8. 00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE						7. 00 8. 00
9.00	00900 HOUSEKEEPI NG						9.00
10. 00 11. 00	01000  DI ETARY  01100  CAFETERI A						10. 00 11. 00
13. 00	01300 NURSING ADMINISTRATION	1, 690, 069					13. 00
14. 00 15. 00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	0	100 0				14. 00 15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	0	1	1, 160, 469, 211		16. 00
17. 00 20. 00	01700 SOCIAL SERVICE 02000 NURSING SCHOOL	0	0		0 0	48, 142 0	17. 00 20. 00
	02301 PARAMED ED PRGM-(SPECIFY)	o	0	•	0	0	23. 00
30. 00	O3000 ADULTS & PEDIATRICS	433, 758	0	1	0 69, 386, 982	33, 999	30. 00
31. 00	03100 INTENSIVE CARE UNIT	120, 750	0		17, 479, 566	4, 727	31. 00
35. 00 40. 00	02060   NEONATAL   INTENSIVE CARE UNIT   04000   SUBPROVIDER - IPF	47, 731	0	1	0 13, 457, 277 0 0	2, 781 0	35. 00 40. 00
41. 00	04100 SUBPROVI DER - I RF	33, 772	0		4, 778, 387	3, 003	41. 00
42. 00 43. 00	04200 SUBPROVI DER 04300 NURSERY	16, 242	0	•	0 3, 426, 051	0 3, 632	42. 00 43. 00
	ANCILLARY SERVICE COST CENTERS						
50. 00 51. 00	O5000   OPERATING ROOM   O5100   RECOVERY ROOM	121, 586 17, 707	0	1	0 195, 861, 842 0 12, 215, 228	l e	50. 00 51. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	97, 661	0		21, 170, 204	0	52. 00
54. 00 55. 00	05400  RADI OLOGY-DI AGNOSTI C   03630  RADI OLOGY-THERAPEUTI C	0	0		89, 625, 691 8, 363, 335	0	54. 00 55. 00
56.00	05600 RADI OI SOTOPE	6, 236	0		0 0	0	56. 00
56. 01 57. 00	03950 CARDI AC CATH LAB 05700 CT SCAN	32, 097	0		28, 919, 655 66, 073, 172	0	56. 01 57. 00
58. 00	05800 MRI	Ö	0		15, 746, 763	0	58. 00
60. 00 65. 00	06000  LABORATORY  06500  RESPI RATORY THERAPY	71, 132	0		0 110, 599, 207 0 11, 322, 518	0	60. 00 65. 00
66.00	06600 PHYSI CAL THERAPY	97, 746	Ö	•	14, 645, 511	0	66. 00
	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	30, 610 13, 148	0		9, 068, 516 2, 158, 954	0	67. 00 68. 00
69. 00	06900 ELECTROCARDI OLOGY	44, 411	0		26, 717, 971	0	69. 00
70. 00 71. 00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	19, 545	0 53	•	5, 139, 814 119, 899, 548	0	70. 00 71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	Ö	47		95, 157, 453	0	72. 00
73. 00 73. 01	O7300   DRUGS CHARGED TO PATIENTS   O7301   DI ABETES CENTER	9, 451	0		96, 114, 942 239, 640	l e	73. 00 73. 01
74.00	07400 RENAL DIALYSIS	4, 081	Ö		2, 131, 693	0	74. 00
76. 98	O7698   HYPERBARI C OXYGEN THERAPY   OUTPATIENT SERVICE COST CENTERS	0	0	(	2, 322, 216	0	76. 98
	08800 RURAL HEALTH CLINIC	0	0		0	0	
89. 00 90. 00	08900   FEDERALLY QUALIFIED HEALTH CENTER   09000   CLINIC	0	0		0 0 815, 114	0	89. 00 90. 00
91. 00	09100 EMERGENCY	220, 867	0	1	71, 808, 391	0	91. 00
91. 01 92. 00	04950  WOUND CARE   09200  OBSERVATION BEDS (NON-DISTINCT PART	39, 875	0	1	6, 259, 818	0	91. 01 92. 00
92. 01	09201 OBSERVATION BEDS (DISTINCT PART)	0	0		10, 519, 325	0	92. 01
95. 00	OTHER REIMBURSABLE COST CENTERS O9500 AMBULANCE SERVI CES	104, 188	0		13, 575, 152	0	95. 00
	09910 CORF	0	0		0 050 300	0	
101.00	10100   HOME HEALTH AGENCY   SPECIAL PURPOSE COST CENTERS	73, 706	0		9, 050, 299	0	101. 00
	10900 PANCREAS ACQUISITION	0	0		0		109.00
	11000 INTESTINAL ACQUISITION  11100 ISLET ACQUISITION		0		0 0		110. 00 111. 00
	11300 INTEREST EXPENSE 11600 HOSPICE	33, 769	0		6, 418, 976	_	113. 00 116. 00
110.00	711000 11001100	33, 709	0	<u>'</u>	0,410,970	1 0	11 10.00

	ncial Systems	FRANCISCAN HEAL				u of Form CMS-2	
COST ALLOCA	TION - STATISTICAL BASIS		Provi der Co		Peri od:	Worksheet B-1	
					From 01/01/2016 To 12/31/2016		norod.
					10 12/31/2016	Date/Time Pre 6/28/2017 3:3	
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE	
	oost center bescription	ADMI NI STRATI ON		(COSTED	RECORDS &	SOUTHE SERVICE	
		A SHILL OF THE CITY OF	SUPPLY	REQUIS.)	LI BRARY	(TIME SPENT)	
		(DI RECT NRS	(COSTED	11201017	(GROSS CHAR	(	
		I NG)	REQUIS.)		GES)		
		13.00	14. 00	15. 00	16. 00	17. 00	
118. 00	SUBTOTALS (SUM OF LINES 1-117)	1, 690, 069	100				118. 00
	IMBURSABLE COST CENTERS						
	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0	0	190. 00
	PHYSICIANS' PRIVATE OFFICES	0	0		0	0	192. 00
	PHYSICIANS' PRIVATE OFFICES	0	0		0	0	192. 01
194. 00 07950	l e e e e e e e e e e e e e e e e e e e	0	0		0	•	194. 00
194. 01 07951		0	0		0	•	194, 01
	PATIENT TRANSPORT	0	0		0	0	194. 02
	SETON LEASE 1 NORTH	0	0		0	•	194. 03
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201. 00
202.00	Cost to be allocated (per Wkst. B,	4, 616, 484	1, 284, 780	5, 972, 96	2, 957, 927	949, 357	202. 00
	Part I)		,				
203. 00	Unit cost multiplier (Wkst. B, Part I)	2. 731536	12, 847, 800000	59, 729, 62000	0. 002549	19. 719933	203. 00
204.00	Cost to be allocated (per Wkst. B,	334, 949				64, 180	204.00
	Part II)						
205 00	Unit cost multiplion (Wkst P Port	0 100107	2 750 220000	7 404 42000	0 000221	1 222120	205 00

0. 198187

3, 759. 330000

7, 686. 630000

0.000231

1. 333139 205. 00

205.00

11)

Unit cost multiplier (Wkst. B, Part

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

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0109 Peri od: Worksheet B-1 From 01/01/2016 12/31/2016 Date/Time Prepared: 6/28/2017 3:36 pm Cost Center Description NURSING SCHOOL PARAMED ED PRGM (ASSI GNED (ASSI GNED TIME) TIME) 20.00 23.00 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 5.01 01160 COMMUNI CATI ONS 5.01 01140 MGMT INFO SYSTEMS 5.02 5.02 00550 PURCHASI NG 5.03 5.03 00570 ADMITTING 5.04 5.04 5.05 00580 PATIENT ACCOUNTING 5.05 00560 OTHER ADMINISTRATIVE AND GENERAL 5.06 5.06 7 00 00700 OPERATION OF PLANT 7 00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10.00 10.00 01100 CAFETERI A 11.00 11.00 13.00 01300 NURSING ADMINISTRATION 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 14.00 15. 00 01500 PHARMACY 15 00 16.00 01600 MEDICAL RECORDS & LIBRARY 16.00 17.00 01700 SOCIAL SERVICE 17.00 20.00 02000 NURSING SCHOOL 100 20.00 02301 PARAMED ED PRGM-(SPECIFY) 23.00 100 23 00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 100 30.00 31 00 03100 INTENSIVE CARE UNIT 0 31 00 0 02060 NEONATAL INTENSIVE CARE UNIT 35.00 0 35, 00 40. 00 | 04000 | SUBPROVI DER - I PF 0 40.00 0 04100 SUBPROVI DER - I RF 41.00 0 41.00 04200 SUBPROVI DER 42 00 0 42 00 04300 NURSERY 43.00 0 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0000000000000000000000 0 50.00 05100 RECOVERY ROOM 0 51.00 51.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 0 52.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 0 54.00 55.00 03630 RADI OLOGY-THERAPEUTI C 0 55.00 05600 RADI OI SOTOPE 0 56.00 56.00 56.01 03950 CARDIAC CATH LAB 0 56.01 57.00 05700 CT SCAN 0 57.00 05800 MRI 0 58.00 58.00 06000 LABORATORY 0 60.00 60.00 65.00 06500 RESPIRATORY THERAPY 0 65.00 66.00 06600 PHYSI CAL THERAPY 0 66.00 06700 OCCUPATI ONAL THERAPY 0 67.00 67.00 68.00 06800 SPEECH PATHOLOGY 0 68.00 69.00 06900 ELECTROCARDI OLOGY 69.00 07000 ELECTROENCEPHALOGRAPHY 0 70.00 70.00 |07100|MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 0 71 00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 0 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 58 73.00 07301 DI ABETES CENTER 73.01 0 73.01 74.00 07400 RENAL DIALYSIS 0 74.00 76. 98 07698 HYPERBARIC OXYGEN THERAPY 0 0 76. 98 OUTPATIENT SERVICE COST CENTERS 0 88.00 08800 RURAL HEALTH CLINIC 0 88 00 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 89.00 09000 CLI NI C 90.00 0 0 0 90.00 09100 EMERGENCY 91.00 91.00 42 04950 WOUND CARE 91.01 C 91.01 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 09201 OBSERVATION BEDS (DISTINCT PART) 92.01 0 92.01 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0 0 95.00 09910 CORF 0 0 99.10 99. 10 101.00 10100 HOME HEALTH AGENCY 0 0 101.00 SPECIAL PURPOSE COST CENTERS 109.00 10900 PANCREAS ACQUISITION 0 0 109.00 110.00 11000 INTESTINAL ACQUISITION 0 110.00 0 111.00 11100 | SLET ACQUISITION 0 0 111. 00 113.00 11300 INTEREST EXPENSE 113.00 116. 00 11600 HOSPI CE 116.00

100

100

118.00

SUBTOTALS (SUM OF LINES 1-117)

118.00

Health Financial Systems	FRANCISCAN HEALTH LAFAYETTE	In Lieu of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS	Provi der CCN: 15-0109	Period: Worksheet B-1 From 01/01/2016
		To 12/31/2016 Date/Time Prepared

			To 12/31/2016   Date/lime Pre   6/28/2017 3:3	
Cost Center Description	NURSING SCHOOL	PARAMED ED	072072017 0.0	J piii
		PRGM		
	(ASSI GNED	(ASSI GNED		
	TIME)	TIME)		
	20.00	23. 00		
NONREI MBURSABLE COST CENTERS				
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0		192. 00
192. 01 19201 PHYSICIANS' PRIVATE OFFICES	0	0		192. 01
194. 00 07950 MOB	0	0		194. 00
194. 01 07951 LI FELI NE	0	0		194. 01
194. 02 07952 PATIENT TRANSPORT	0	0		194. 02
194.03 07953 SETON LEASE 1 NORTH	0	0		194. 03
200.00 Cross Foot Adjustments				200.00
201.00 Negative Cost Centers				201. 00
202.00 Cost to be allocated (per Wkst. B,	8, 382, 724	1, 590, 029		202. 00
Part I)				
203.00 Unit cost multiplier (Wkst. B, Part I)	83, 827. 240000	15, 900. 290000		203. 00
204.00 Cost to be allocated (per Wkst. B,	2, 488, 407	434, 901		204.00
Part II)				
205.00 Unit cost multiplier (Wkst. B, Part	24, 884. 070000	4, 349. 010000		205. 00
11)				

Health Financial Systems
POST STEPDOWN ADJUSTMENTS In Lieu of Form CMS-2552-10
Worksheet B-2 FRANCISCAN HEALTH LAFAYETTE Period: Worksheet B-2 From 01/01/2016 To 12/31/2016 Date/Time Prepared: 6/28/2017 3:36 pm Provider CCN: 15-0109

				6/28/201/ 3:3	o pm
		Worl	sheet		
	Description	Part	Li ne No.	Amount	
	1.00	2.00	3. 00	4. 00	
1.00	ADJ FOR EPO COSTS IN RENAL		1 74.00	0	1.00
	DI ALYSI S				
2. 00	ADJ FOR EPO COSTS IN HOME		1 94.00	0	2.00
	PROGRAM				
3. 00	ADJ FOR ARANESP COSTS IN		1 74.00	0	3.00
	RENAL DIALYSIS				
4. 00	ADJ FOR ARANESP COSTS IN		1 94.00	0	4.00
	HOME PROGRAM				
5. 00	ADJ FOR ESA COSTS IN RENAL		1 74.00	0	5.00
	DIALYSIS				
6. 00	ADJ FOR ESA COSTS IN HOME		1 94.00	0	6.00
	PROGRAM				
7. 00	NURSING SCHOOL		1 30.00	-2, 209, 926	7. 00

Health Financial Systems	FRANCISCAN HEALTH LAFAYETTE	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0109	Peri od: Worksheet C From 01/01/2016 Part I To 12/31/2016 Date/Time Prepared:

				'	0 12/31/2010	6/28/2017 3:3	
			Title	: XVIII	Hospi tal	PPS	<u> </u>
			11 110	7,7,7,1,1	Costs	113	
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	cost center beserver on	(from Wkst. B,	Adj.	10141 00313	Di sal I owance	10101 00313	
		Part I, col.	Auj.		Di Sai i Owance		
		26)					
		1.00	2.00	3.00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	3.00	4.00	3.00	
20.00	03000 ADULTS & PEDIATRICS	44 240 045	ı	44 240 045	٥	44 240 045	20.00
	1	44, 360, 965		44, 360, 965	U	44, 360, 965	
31. 00	03100   INTENSI VE CARE UNI T	8, 190, 057		8, 190, 057	0	8, 190, 057	31. 00
35. 00	02060 NEONATAL INTENSIVE CARE UNIT	4, 179, 608		4, 179, 608	62, 078	4, 241, 686	•
40. 00	04000 SUBPROVI DER - I PF	0		0	0	0	40. 00
41. 00	04100 SUBPROVI DER - I RF	3, 365, 843		3, 365, 843	22, 511	3, 388, 354	
42. 00	04200 SUBPROVI DER	0		0	0	0	42. 00
43. 00	04300 NURSERY	1, 295, 043		1, 295, 043	0	1, 295, 043	43. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000   OPERATI NG ROOM	34, 257, 987		34, 257, 987	0	34, 257, 987	50.00
51.00	05100 RECOVERY ROOM	1, 577, 661		1, 577, 661	0	1, 577, 661	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	7, 201, 569		7, 201, 569	0	7, 201, 569	52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	18, 244, 249		18, 244, 249	12, 428	18, 256, 677	54.00
55. 00	03630 RADI OLOGY-THERAPEUTI C	848, 694		848, 694	ol	848, 694	55. 00
56. 00	05600 RADI OI SOTOPE	450, 222		450, 222	4, 550	454, 772	56.00
	03950 CARDI AC CATH LAB	3, 303, 592		3, 303, 592	0	3, 303, 592	56. 01
57. 00	05700 CT SCAN	2, 308, 750		2, 308, 750	o o	2, 308, 750	
58. 00	05800 MRI	906, 022		906, 022		906, 022	
60. 00	06000 LABORATORY	12, 794, 797		12, 794, 797	3, 529	12, 798, 326	60.00
65. 00	06500 RESPIRATORY THERAPY	4, 301, 106			14, 601	4, 315, 707	65.00
66. 00	06600 PHYSI CAL THERAPY	6, 270, 320	0		0	6, 270, 320	
67. 00	06700 OCCUPATI ONAL THERAPY	2, 612, 109		2, 612, 109	0	2, 612, 109	
68. 00	06800 SPEECH PATHOLOGY	1, 037, 407		1, 037, 407	0	1, 037, 407	68. 00
	06900 ELECTROCARDI OLOGY	3, 934, 991		3, 934, 991	0	3, 934, 991	69. 00
	07000 ELECTROENCEPHALOGRAPHY	1, 534, 572		1, 534, 572	0	1, 534, 572	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	20, 111, 319		20, 111, 319	0	20, 111, 319	
	07200 I MPL. DEV. CHARGED TO PATIENTS	19, 211, 457		19, 211, 457	0	19, 211, 457	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	16, 939, 214		16, 939, 214	0	16, 939, 214	73. 00
73. 01	07301   DI ABETES CENTER	535, 119		535, 119	5, 704	540, 823	73. 01
74.00	07400 RENAL DIALYSIS	1, 015, 464		1, 015, 464	0	1, 015, 464	74.00
76. 98	07698 HYPERBARI C OXYGEN THERAPY	635, 601		635, 601	0	635, 601	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		l o	ol	0	89. 00
90.00	09000 CLI NI C	1, 064, 938		1, 064, 938	0	1, 064, 938	90. 00
91. 00	09100 EMERGENCY	16, 728, 179		16, 728, 179	0	16, 728, 179	
91. 01	04950 WOUND CARE	2, 997, 901		2, 997, 901	403	2, 998, 304	91. 01
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	2, 777, 701		2, 777, 701	403	2, 770, 304	92. 00
	09201 OBSERVATION BEDS (NON-DISTINCT PART)	3, 066, 817		3, 066, 817	o	3, 066, 817	
72.01	OTHER REIMBURSABLE COST CENTERS	3,000,017		3,000,017	U O	3, 000, 017	92.01
95. 00	09500 AMBULANCE SERVICES	4, 969, 671		4, 969, 671	22 442	4 002 212	05 00
		4, 909, 071		4, 909, 0/1	23, 642	4, 993, 313	
99. 10	09910 CORF	( 000 005		( 000 005		( 000 005	99. 10
101.00	10100 HOME HEALTH AGENCY	6, 090, 995		6, 090, 995		6, 090, 995	101.00
400.55	SPECIAL PURPOSE COST CENTERS	-		-			400.00
	10900 PANCREAS ACQUISITION	0		0			109. 00
	11000 INTESTINAL ACQUISITION	0		0			110. 00
	11100 I SLET ACQUISITION	0		0		0	111. 00
	11300 INTEREST EXPENSE						113. 00
	11600 H0SPI CE	3, 123, 359		3, 123, 359		3, 123, 359	116. 00
200.00		259, 465, 598	0	259, 465, 598	149, 446	259, 615, 044	200. 00
201.00	Less Observation Beds	0		0		0	201. 00
202.00	Total (see instructions)	259, 465, 598	0	259, 465, 598	149, 446	259, 615, 044	202. 00
		•		•			-

Date/Time Prepared:

202.00

12/31/2016

6/28/2017 3:36 pm Title XVIII Hospi tal PPS Charges Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other TFFRA + col . 7) Ratio Inpati ent Ratio 6.00 7.00 8.00 9. 00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 69, 386, 982 69, 386, 982 30.00 30.00 31.00 03100 INTENSIVE CARE UNIT 17, 479, 566 17, 479, 566 31.00 02060 NEONATAL INTENSIVE CARE UNIT 35.00 13, 457, 277 13, 457, 277 35.00 04000 SUBPROVIDER - IPF 40.00 40.00 04100 SUBPROVI DER - I RF 41.00 4, 778, 387 4, 778, 387 41.00 42.00 04200 SUBPROVI DER 42.00 43.00 04300 NURSERY 3, 426, 051 3, 426, 051 43 00 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM 72, 772, 355 123, 089, 487 195, 861, 842 0.174909 0.000000 50.00 6, 721, 164 51.00 05100 RECOVERY ROOM 5, 494, 064 12, 215, 228 0.129155 0.000000 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 20, 600, 137 570, 067 21, 170, 204 0.340175 0.000000 52.00 14, 759, 062 05400 RADI OLOGY-DI AGNOSTI C 89, 625, 691 0.203560 0.000000 54.00 74, 866, 629 54.00 03630 RADI OLOGY-THERAPEUTI C 55.00 1, 969, 386 6, 393, 949 8, 363, 335 0.101478 0.000000 55.00 56, 00 05600 RADI OI SOTOPE 0.000000 0.000000 56,00 56.01 03950 CARDIAC CATH LAB 15, 450, 389 13, 469, 266 28, 919, 655 0.114233 0.000000 56.01 05700 CT SCAN 17.561,493 0.034942 57 00 48.511.679 66, 073, 172 0.000000 57 00 58.00 05800 MRI 5, 693, 344 10, 053, 419 15, 746, 763 0.057537 0.000000 58.00 06000 LABORATORY 49, 309, 972 61, 289, 235 110, 599, 207 60.00 0.115686 0.000000 60.00 06500 RESPIRATORY THERAPY 9, 917, 755 11, 322, 518 0.379872 0.000000 65.00 1, 404, 763 65.00 66.00 06600 PHYSI CAL THERAPY 6, 234, 309 8, 411, 202 14, 645, 511 0.428139 0.000000 66.00 67.00 06700 OCCUPATI ONAL THERAPY 6, 392, 469 2, 676, 047 9, 068, 516 0.288042 0.000000 67.00 68.00 06800 SPEECH PATHOLOGY 873, 956 1, 284, 998 2, 158, 954 0.480514 0.000000 68.00 17, 449, 298 26, 717, 971 69 00 06900 ELECTROCARDI OLOGY 9, 268, 673 0 147279 0 000000 69 00 70.00 07000 ELECTROENCEPHALOGRAPHY 860, 300 4, 279, 514 5, 139, 814 0.298566 0.000000 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 70, 038, 186 49, 861, 362 119, 899, 548 0.167735 0.000000 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 75, 625, 918 19, 531, 535 95, 157, 453 0.201891 0.000000 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 64, 392, 713 31, 722, 229 96, 114, 942 0.176239 0.000000 73.00 73.01 07301 DI ABETES CENTER 918 238, 722 239, 640 2. 233012 0.000000 73.01 74.00 07400 RENAL DIALYSIS 1, 632, 208 499, 485 2, 131, 693 0.476365 0.000000 74.00 76 98 07698 HYPERBARIC OXYGEN THERAPY 74, 365 2, 247, 851 2, 322, 216 0. 273705 0.000000 76 98 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 88.00 0 0 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 89.00 09000 CLI NI C 815, 114 815, 114 0 000000 90 00 1 306490 90 00 0 0.232956 0.000000 91.00 09100 EMERGENCY 12, 380, 821 59, 427, 570 71, 808, 391 91.00 6, 101, 445 6, 259, 818 0.478912 0.000000 91.01 04950 WOUND CARE 158, 373 91.01 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0.000000 0.000000 92.00 09201 OBSERVATION BEDS (DISTINCT PART) 10, 519, 325 0.000000 2, 533, 499 7, 985, 826 92.01 0.291541 92.01 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0 13, 575, 152 13, 575, 152 0.366086 0.000000 95.00 99. 10 09910 CORF 99.10 9, 050<u>, 299</u> 101. 00 101.00 10100 HOME HEALTH AGENCY 3.141 9,047,158 SPECIAL PURPOSE COST CENTERS 109. 00 10900 PANCREAS ACQUISITION 109.00 110.00 11000 INTESTINAL ACQUISITION 0 0 0 110.00 111.00 11100 I SLET ACQUISITION 0 O 111.00 113.00 11300 INTEREST EXPENSE 113.00 116.00 11600 HOSPI CE 6, 418, 976 6, 418, 976 116.00 200.00 Subtotal (see instructions) 572, 526, 069 587, 943, 142 1, 160, 469, 211 200. 00 201.00 Less Observation Beds 201.00

572, 526, 069

587, 943, 142 1, 160, 469, 211

202.00

Total (see instructions)

Health Financial Systems	FRANCISCAN HEALTH LAFAYETTE	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0109	Peri od: From 01/01/2016 To 12/31/2016	Worksheet C Part I Date/Time Prepared: 6/28/2017 3:36 pm

				6/28/2017 3: 3	6 pm
		Title XVIII	Hospi tal	PPS	
Cost Center Description	PPS Inpatient				
	Ratio				
	11.00				
INPATIENT ROUTINE SERVICE COST CENTERS	<u>'</u>				
30. 00 03000 ADULTS & PEDI ATRI CS					30.00
31. 00 03100 I NTENSI VE CARE UNI T					31.00
35. 00 02060 NEONATAL INTENSIVE CARE UNIT					35. 00
40. 00   04000   SUBPROVI DER -   PF					40.00
41. 00   04100   SUBPROVI DER -   1 FF					41. 00
					1
42. 00 04200 SUBPROVI DER					42.00
43. 00   04300   NURSERY					43. 00
ANCILLARY SERVICE COST CENTERS					4
50. 00   05000   OPERATI NG ROOM	0. 174909				50.00
51.00   05100   RECOVERY ROOM	0. 129155				51.00
52.00   05200   DELIVERY ROOM & LABOR ROOM	0. 340175				52. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0. 203699				54.00
55. 00 03630 RADI OLOGY-THERAPEUTI C	0. 101478				55.00
56. 00 05600 RADI 0I SOTOPE	0. 000000				56.00
56. 01   03950 CARDI AC CATH LAB	0. 114233				56. 01
57. 00 05700 CT SCAN	0. 034942				57. 00
58. 00   05800 MRI	0. 057537				58.00
60. 00   06000   LABORATORY	0. 115718				60.00
65. 00   06500   RESPI RATORY   THERAPY	0. 381161				65. 00
· ·					
66. 00   06600   PHYSI CAL THERAPY	0. 428139				66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 288042				67. 00
68. 00   06800   SPEECH PATHOLOGY	0. 480514				68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 147279				69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 298566				70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 167735				71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 201891				72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 176239				73. 00
73. 01   07301 DI ABETES CENTER	2. 256814				73. 01
74.00 07400 RENAL DIALYSIS	0. 476365				74.00
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 273705				76. 98
OUTPATIENT SERVICE COST CENTERS					
88. 00 08800 RURAL HEALTH CLINIC					88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER					89. 00
90. 00   09000   CLI NI C	1. 306490				90.00
91. 00 09100 EMERGENCY	0. 232956				91.00
91. 01   04950  WOUND CARE	1				91.00
	0. 478976				1
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000				92.00
92. 01 09201 OBSERVATION BEDS (DISTINCT PART)	0. 291541				92. 01
OTHER REIMBURSABLE COST CENTERS	0.047007				
95. 00 09500 AMBULANCE SERVICES	0. 367827				95. 00
99. 10   09910   CORF					99. 10
101.00 10100 HOME HEALTH AGENCY					101. 00
SPECIAL PURPOSE COST CENTERS					
109.00 10900 PANCREAS ACQUISITION					109. 00
110.00 11000 INTESTINAL ACQUISITION					110. 00
111.00 11100 ISLET ACQUISITION					111. 00
113.00 11300 INTEREST EXPENSE					113.00
116. 00 11600 HOSPI CE					116.00
200.00 Subtotal (see instructions)					200.00
201.00 Less Observation Beds					201. 00
202.00 Total (see instructions)					202. 00
i i i i i i i i i i i i i i i i i i i	1				

Health Financial Systems	FRANCISCAN HEALTH LAFAYETTE	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0109	From 01/01/2016	Worksheet C Part I Date/Time Prepared:

				'	0 12/31/2010	6/28/2017 3:3	
			Titl	e XIX	Hospi tal	Cost	
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	, and the second	(from Wkst. B,	Adj .		Di sal I owance		
		Part I, col.					
		26)					
		1.00	2.00	3.00	4. 00	5. 00	
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	1.00	2.00	3.00	4.00	3.00	
30. 00	03000 ADULTS & PEDIATRICS	44, 360, 965		44, 360, 965	: 0	44, 360, 965	30.00
	l I						
	03100 I NTENSI VE CARE UNI T	8, 190, 057		8, 190, 057		8, 190, 057	31.00
	02060 NEONATAL INTENSIVE CARE UNIT	4, 179, 608		4, 179, 608	62, 078	4, 241, 686	
	04000 SUBPROVI DER - I PF	0			0	0	40. 00
41. 00	04100 SUBPROVI DER – I RF	3, 365, 843		3, 365, 843		3, 388, 354	41. 00
42.00	04200 SUBPROVI DER	0		(	0	0	42. 00
43. 00	04300 NURSERY	1, 295, 043		1, 295, 043	8 0	1, 295, 043	43. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000  OPERATI NG ROOM	34, 257, 987		34, 257, 987	' 이	34, 257, 987	50.00
51.00	05100 RECOVERY ROOM	1, 577, 661		1, 577, 661	0	1, 577, 661	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	7, 201, 569		7, 201, 569	o	7, 201, 569	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	18, 244, 249		18, 244, 249	12, 428	18, 256, 677	54.00
55.00	03630 RADI OLOGY-THERAPEUTI C	848, 694		848, 694	ı ol	848, 694	55. 00
56.00	05600 RADI 0I SOTOPE	450, 222	l	450, 222		454, 772	56. 00
	03950 CARDI AC CATH LAB	3, 303, 592	l	3, 303, 592		3, 303, 592	
57. 00	05700 CT SCAN	2, 308, 750	l	2, 308, 750		2, 308, 750	1
58. 00	05800 MRI	906, 022	l	906, 022		906, 022	
60. 00	06000 LABORATORY	12, 794, 797		12, 794, 797		12, 798, 326	
65. 00	06500 RESPIRATORY THERAPY	4, 301, 106	0			4, 315, 707	65. 00
	l		l	.,			1
66. 00	06600 PHYSI CAL THERAPY	6, 270, 320	l			6, 270, 320	
67. 00	06700 OCCUPATI ONAL THERAPY	2, 612, 109	l	2, 612, 109		2, 612, 109	67. 00
68. 00	06800 SPEECH PATHOLOGY	1, 037, 407	0	.,,		1, 037, 407	68. 00
69. 00	06900 ELECTROCARDI OLOGY	3, 934, 991		3, 934, 991		3, 934, 991	69. 00
	07000 ELECTROENCEPHALOGRAPHY	1, 534, 572	ł	1, 534, 572		1, 534, 572	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	20, 111, 319		20, 111, 319		20, 111, 319	
	07200 I MPL. DEV. CHARGED TO PATIENTS	19, 211, 457		19, 211, 457		19, 211, 457	72. 00
	07300 DRUGS CHARGED TO PATIENTS	16, 939, 214		16, 939, 214	비	16, 939, 214	73. 00
	07301  DI ABETES CENTER	535, 119		535, 119		540, 823	73. 01
74.00	07400 RENAL DIALYSIS	1, 015, 464		1, 015, 464	ا ا	1, 015, 464	74. 00
76. 98	07698 HYPERBARI C OXYGEN THERAPY	635, 601		635, 601	0	635, 601	76. 98
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0		C	0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0			ol ol	0	89. 00
90. 00	09000 CLI NI C	1, 064, 938		1, 064, 938	sl ol	1, 064, 938	90.00
91.00	09100 EMERGENCY	16, 728, 179	l e	16, 728, 179		16, 728, 179	91.00
	04950 WOUND CARE	2, 997, 901		2, 997, 901		2, 998, 304	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	2,,,,,,,,		2, , , , , , ,		0	92. 00
	09201 OBSERVATION BEDS (DISTINCT PART)	3, 066, 817		3, 066, 817	í ol	3, 066, 817	1
72.01	OTHER REIMBURSABLE COST CENTERS	3,000,017		3,000,017	<u> </u>	3, 000, 017	72.01
05 00	09500 AMBULANCE SERVICES	4, 969, 671		4, 969, 671	23, 642	4, 993, 313	95. 00
		4, 909, 071		4, 909, 071	23, 042		
	09910 CORF	( 000 005		( 000 000	<u>'</u>	0 000 005	99. 10
101.00	10100 HOME HEALTH AGENCY	6, 090, 995		6, 090, 995		6, 090, 995	101.00
400.00	SPECIAL PURPOSE COST CENTERS	_					
	10900 PANCREAS ACQUISITION	0	l	(			109. 00
	11000 INTESTINAL ACQUISITION	0	l .	(			110. 00
	11100 I SLET ACQUI SI TI ON	0		C	)	0	111. 00
	11300 I NTEREST EXPENSE						113. 00
	11600 H0SPI CE	3, 123, 359		3, 123, 359		3, 123, 359	
200.00	Subtotal (see instructions)	259, 465, 598	0	259, 465, 598	149, 446	259, 615, 044	
201.00	Less Observation Beds	0	l	(			201. 00
202.00	Total (see instructions)	259, 465, 598	0	259, 465, 598	149, 446	259, 615, 044	202. 00
					'		

Date/Time Prepared:

202.00

12/31/2016

6/28/2017 3:36 pm Title XIX Hospi tal Cost Charges Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other **TFFRA** + col . 7) Ratio Inpati ent Ratio 6.00 7.00 8.00 9. 00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 69, 386, 982 69, 386, 982 30.00 30.00 31.00 03100 INTENSIVE CARE UNIT 17, 479, 566 17, 479, 566 31.00 02060 NEONATAL INTENSIVE CARE UNIT 35.00 13, 457, 277 13, 457, 277 35.00 04000 SUBPROVIDER - IPF 40.00 40.00 04100 SUBPROVI DER - I RF 41.00 4, 778, 387 4, 778, 387 41.00 42.00 04200 SUBPROVI DER 42.00 43.00 04300 NURSERY 3, 426, 051 3, 426, 051 43 00 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM 72, 772, 355 123, 089, 487 195, 861, 842 0.174909 0.000000 50.00 6, 721, 164 51.00 05100 RECOVERY ROOM 5, 494, 064 12, 215, 228 0. 129155 0.000000 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 20, 600, 137 570, 067 21, 170, 204 0.340175 0.000000 52.00 14, 759, 062 05400 RADI OLOGY-DI AGNOSTI C 89, 625, 691 0.203560 0.000000 54.00 74, 866, 629 54.00 03630 RADI OLOGY-THERAPEUTI C 55.00 1, 969, 386 6, 393, 949 8, 363, 335 0.101478 0.000000 55.00 56, 00 05600 RADI OI SOTOPE 0.000000 0.000000 56,00 56.01 03950 CARDIAC CATH LAB 15, 450, 389 13, 469, 266 28, 919, 655 0.114233 0.000000 56.01 05700 CT SCAN 17.561,493 0.034942 57 00 48.511.679 66, 073, 172 0.000000 57 00 58.00 05800 MRI 5, 693, 344 10, 053, 419 15, 746, 763 0.057537 0.000000 58.00 06000 LABORATORY 49, 309, 972 61, 289, 235 110, 599, 207 60.00 0.115686 0.000000 60.00 06500 RESPIRATORY THERAPY 9, 917, 755 11, 322, 518 0.379872 0.000000 65.00 1, 404, 763 65.00 66.00 06600 PHYSI CAL THERAPY 6, 234, 309 8, 411, 202 14, 645, 511 0.428139 0.000000 66.00 67.00 06700 OCCUPATI ONAL THERAPY 6, 392, 469 2, 676, 047 9, 068, 516 0.288042 0.000000 67.00 68.00 06800 SPEECH PATHOLOGY 873, 956 1, 284, 998 2, 158, 954 0.480514 0.000000 68.00 17, 449, 298 26, 717, 971 69 00 06900 ELECTROCARDI OLOGY 9, 268, 673 0 147279 0 000000 69 00 70.00 07000 ELECTROENCEPHALOGRAPHY 860, 300 4, 279, 514 5, 139, 814 0.298566 0.000000 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 70, 038, 186 49, 861, 362 119, 899, 548 0.167735 0.000000 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 75, 625, 918 19, 531, 535 95, 157, 453 0.201891 0.000000 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 64, 392, 713 31, 722, 229 96, 114, 942 0.176239 0.000000 73.00 73.01 07301 DI ABETES CENTER 918 238, 722 239, 640 2. 233012 0.000000 73.01 74.00 07400 RENAL DIALYSIS 1, 632, 208 499, 485 2, 131, 693 0.476365 0.000000 74.00 76 98 07698 HYPERBARIC OXYGEN THERAPY 74, 365 2, 247, 851 2, 322, 216 0 273705 0.000000 76 98 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0.000000 0.000000 88.00 0 0 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0.000000 0.000000 89.00 09000 CLI NI C 815, 114 815, 114 1 306490 0 000000 90 00 90 00 0 91.00 09100 EMERGENCY 12, 380, 821 59, 427, 570 71, 808, 391 0.232956 0.000000 91.00 6, 101, 445 6, 259, 818 0.478912 0.000000 91.01 04950 WOUND CARE 158, 373 91.01 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0.000000 0.000000 92.00 09201 OBSERVATION BEDS (DISTINCT PART) 10, 519, 325 2, 533, 499 7, 985, 826 92.01 0.291541 0.000000 92.01 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0 13, 575, 152 13, 575, 152 0.366086 0.000000 95.00 99. 10 09910 CORF 99.10 9, 050<u>, 299</u> 101. 00 101.00 10100 HOME HEALTH AGENCY 3.141 9,047,158 SPECIAL PURPOSE COST CENTERS 109. 00 10900 PANCREAS ACQUISITION 109.00 110.00 11000 INTESTINAL ACQUISITION 0 0 0 110.00 111.00 11100 I SLET ACQUISITION 0 O 111.00 113.00 11300 INTEREST EXPENSE 113.00 116.00 11600 HOSPI CE 6, 418, 976 6, 418, 976 116.00 200.00 Subtotal (see instructions) 572, 526, 069 587, 943, 142 1, 160, 469, 211 200. 00 201.00 Less Observation Beds 201.00

572, 526, 069

587, 943, 142 1, 160, 469, 211

202.00

Total (see instructions)

Health Financial Systems	FRANCISCAN HEALTH LAFAYETTE	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0109	Peri od: From 01/01/2016 To 12/31/2016	Worksheet C Part I Date/Time Prepared: 6/28/2017 3:36 pm

NPATIENT ROUTINE SERVICE COST CENTERS   11.00   30.0						6/28/2017 3:3	36 pm
INPATIENT ROUTINE SERVICE COST CENTERS   11.00				Title XIX	Hospi tal	Cost	
INPATIENT ROUTINE SERVICE COST CENTERS   11.00		Cost Center Description	PPS Inpatient		· ·		
INPATIENT ROUTINE SERVICE COST CENTERS   30.00   30000 ABULIS & PEDIATRICS   30.00   30000 ABULIS & PEDIATRICS   30.00   30000 ABULIS & PEDIATRICS   31.00		'					
INPATT ENT ROUTINE SERVICE COST CENTERS   30.00   31.00   300.00   AURLIS & PEDIA PARIES   30.00   31.00   300.00   AURLIS & PEDIA PARIES   31.00   31.00   300.00   AURLIS & PEDIA PARIES   31.00   31.00   400.00   AURLIS & PEDIA PARIES   40.00   41.00   400.00   AURLIS & PEDIA PARIES   40.00   41.00   400.00   SUBROVIDER - IPF   41.00   41.00   400.00   SUBROVIDER - IPF   42.00   42.00   42.00   42.00   AURLIS & PEDIA PARIES   42.00   43.00   43.00   AURLIS & PEDIA PARIES   42.00   43.00   AURLI							
30.00     30.0	I NPAT	TENT ROUTINE SERVICE COST CENTERS					
31.00   03100   INTENSIVE CARE UNIT     33.00   04000   0400000   0400000   0400000   0400000   04000000   0500000   05000000   05000000   05000000   05000000   05000000   05000000   05000000   05000000   05000000   05000000   05000000   05000000   050000000   050000000   050000000   05000000   05000000   050000000   050000000   050000000   050000000   050000000   050000000   050000000   050000000   050000000   05000000   050000000   050000000   050000000   05000000   0500000000							30.00
35.00   0.02000 NORMATAL INTENSIVE CARE UNIT   35.00   0.00   0.00000   0.410.00   0.510.00   0.510.00   0.510.00   0.510.00   0.510.00   0.510.00   0.510.00   0.510.00   0.520.00   0.5		l .					
A0, 00   04000   SUBPROVI DER - 1 PF		l .					
11 00   04100   SUBPROVI DER   1 EF							
42, 00   04200   SUPROVI DER   42, 00							
43. 00   04300   NURSERY							1
ANCI LLARY SERVICE COST CENTERS							
50.00     05000     05000   0FECHTING ROOM   0.000000   51.00   52.00   0							43.00
51.00   05100   05100   RECOVERY ROOM   0.000000   0.000000   0.52.00   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5200   0.5500   0			0.000000				
52.00   05200   DELLUYERY ROOM & LABOR ROOM   0.000000   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   54.00   54.00   54.00   55.00   0.3530 RADI D LOCY-THERAPEUTI C   0.000000   55.00   55.00   0.3500 RADI D LOCY-THERAPEUTI C   0.000000   55.00   55.00   0.3500 RADI D LOCY-THERAPEUTI C   0.000000   55.00   55.00   0.3500 RADI D LOCY-THERAPEUTI C   0.000000   55.00   0.3500 RADI D LOCY-THERAPEUTI C   0.000000   55.00   0.3500 RADI RADI RADI RADI RADI RADI RADI RADI		l .	1				1
54. 00   05400   RADIO LOGY - DI AGNOSTI C   0.000000   55. 00   055.00   056.00   057.00   057.00   057.00   058.00							1
55. 00   03303   RADI DLOGY-THERAPEUTIC   0.000000   55. 00	1						
5.6. 00   0.500   0.							
5.6			1				
57.00   05700   CT SCAN   0.000000   58.00   0.000000   58.00   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.00000000							56. 00
58. 00   05800   MR    0. 000000   0. 000000   58. 00   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 0000000   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. 000000   0. 000000   0. 000000   0. 0000000   0. 0000000   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. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 0000000   0. 000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 00000000	56. 01   03950	CARDIAC CATH LAB	0. 000000				56. 01
60. 00   06000   LABORATORY   0. 000000   065.00   06500   RESPIRATORY THERAPY   0. 0000000   065.00   065.00   06500   RESPIRATORY THERAPY   0. 0000000   066.00   06600   PHYSI CAL THERAPY   0. 0000000   067.00   067.00   066.00   06600   SPECEH PATHOLOGY   0. 0000000   068.00   06600   SPECEH PATHOLOGY   0. 0000000   069.00   069.00   06900   ELECTROCARDI OLOGY   0. 0000000   070.00   07000   ELECTROCARDI OLOGY   0. 0000000   77.00   070.00   07000   ELECTROCARDI OLOGRAPHY   0. 0000000   77.00   070.00   070000   07000   07000   07000   07000   07000   07000   07000   070000   07000   07000   07000   070000   07000   070000   070000   07000   070000   070000   070000   070000   070000   0700000   0700000   0700000   07000000   07000000   07000000   07000000   07000000   07000000   070000000   070000000   0700000000	57.00 05700	CT SCAN	0. 000000				57.00
65. 00   06500   RESPI RATORY THERAPY   0.000000   66.00   06600   PHYSI CAL THERAPY   0.000000   67.00   06700   0CCUPATI ONAL THERAPY   0.000000   67.00   068.00   06800   SPEECH PATHOLOGY   0.000000   68.00   069.00   06900   ELECTROCARDI OLOGY   0.000000   07.00   0	58.00 05800	MRI	0. 000000				58. 00
65. 00   06500   RESPI RATORY THERAPY   0.000000   66.00   06600   PHYSI CAL THERAPY   0.000000   67.00   06700   0CCUPATI ONAL THERAPY   0.000000   67.00   068.00   06800   SPEECH PATHOLOGY   0.000000   68.00   069.00   06900   ELECTROCARDI OLOGY   0.000000   07.00   0	60.00 06000	LABORATORY	0. 000000				60.00
67. 00   06700   05CUPATI ONAL THERAPY   0.000000   68. 00   06800   SPEECH PATHOLOGY   0.000000   69. 00   06900   ELECTROCARDI OLOGY   0.000000   70. 00   07000   ELECTROCARDI OLOGY   0.000000   70. 00   07000   ELECTROCARDI OLOGY   0.000000   70. 00			0. 000000				65.00
68.00 06900 SPECH PATHOLOGY 0.000000 69.00	66.00 06600	PHYSI CAL THERAPY	0. 000000				66. 00
68. 00   06800   SPECH PATHOLOGY   0. 000000   69. 00   69. 00   69.00	67.00 06700	OCCUPATIONAL THERAPY	0. 000000				67. 00
69. 00 0900   LECTROCARDIOLOGY   0.000000   70.00   70	68. 00 06800	SPEECH PATHOLOGY	1 1				68. 00
70. 00   07000   ELECTROENCEPHALGGRAPHY   0. 000000   71. 00   772. 00   772. 00   773. 00   773. 00   773. 00   773. 00   773. 01   07301   DIABETES CENTERS   0. 000000   773. 00   773. 01   07301   DIABETES CENTERS   0. 000000   774. 00   774	-	l .					1
71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENT   0. 000000   72. 00   0720   MPL. DEV. CHARGED TO PATIENTS   0. 000000   73. 00   07300   DRUGS CHARGED TO PATIENTS   0. 000000   73. 00   07300   DRUGS CHARGED TO PATIENTS   0. 000000   73. 01   07301   DI ABETES CENTER   0. 000000   73. 01   74. 00   07400   RENAL DI ALYSIS   0. 000000   74. 00   07400   RENAL DI ALYSIS   0. 000000   76. 98   07698   HYPERBARI C OXYGEN THERAPY   0. 000000   76. 98   0017PATIENT SERVICE COST CENTERS   0. 000000   08900   REURAL HEALTH CLINIC   0. 000000   08900   CLINIC   0. 000000   09000   CLINIC   0. 000000   09000   CLINIC   0. 000000   09000   09100   EMERGENCY   0. 000000   091. 00   09100   EMERGENCY   0. 000000   091. 00   09201   OBSERVATION BEDS (NON-DISTINCT PART   0. 000000   09201   OBSERVATION BEDS (DISTINCT PART   0. 000000   09201   OBSERVATION BEDS (DISTINCT PART   0. 000000   09201   OBSERVATION BEDS (DISTINCT PART   0. 000000   09910   CORF   09910   0007FE   09910   0007FE   0. 000000   09910   CORF   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. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 00000000	-	l .	1 1				1
72. 00 07200   IMPL. DEV. CHARGED TO PATIENTS   0. 000000   73. 00   7300   DRUGS CHARGED TO PATIENTS   0. 000000   73. 01   73. 01   73. 01   73. 01   73. 01   73. 01   73. 01   73. 01   73. 01   73. 01   74. 00   74.	1	l .	1 1				1
73. 00   07300   DRUGS CHARGED TO PATIENTS   0.000000   73. 01   73. 01   73. 01   07301   DIABETES CENTER   0.000000   74. 00   07400   RENAL DI ALYSI S   0.000000   74. 00   07400   RENAL DI ALYSI S   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.00000000	1		1				1
73. 01   07301   DI ABETES CENTER   0.000000   73. 01   74. 00   7400   RENAL DI ALYSIS   0.000000   76. 98   7			1				1
74. 00   07400   RENAL DIALYSIS   0.000000   76.98   MYPERBARIC OXYGEN THERAPY   0.000000   76.98   MYPERBARIC OXYGEN THERAPY   0.000000   76.98   0.0000000   0.0000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.00000000			1				1
76. 98							1
SECOND   SECOND   SERVICE COST CENTERS   SE		l .	1				
88. 00 08800 RURAL HEALTH CLINIC 0.000000 0890. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0.000000 90. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 01 04950 WOUND CARE 0.000000 92. 01 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.000000 92. 01 071 OFFER REIMBURSABLE COST CENTERS  95. 00 99. 10 09910 CORF 101. 00 101. 00 101. 00 101. 00 111. 00 111. 00 111. 00 111. 00 111. 00 111. 00 113. 00 113. 00 113. 00 113. 00 113. 00 113. 00 113. 00 201. 00 201. 00 201. 00 201. 00 202. 00 202. 00 202. 00 202. 00 202. 01 202. 01 202. 01 202. 01 203. 02 204. 02 205. 02 206. 02 207. 02			0.000000				70. 70
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER			0.000000				00 00
90. 00			1				1
91. 00			1				1
91. 01 04950 WOUND CARE							
92. 00   09200   OBSERVATI ON BEDS (NON-DISTINCT PART   0.000000   92. 01   O9201   OBSERVATI ON BEDS (DISTINCT PART)   0.000000   92. 01   OTHER REIMBURSABLE COST CENTERS   O9500   AMBULANCE SERVICES   O.000000   95. 00   99. 10   O9910   CORF   99. 10   O11000   HOME HEALTH AGENCY   99. 10   O11000   HOME HEALTH AGENCY   99. 10   O11000   PANCREAS ACQUISITION   109. 00   O11000   INTESTINAL ACQUISITION   110. 00   O11000   INTESTINAL ACQUISITION   111. 00   O113. 00   O113. 00   INTERST EXPENSE   O11. 00   O11000   HOSPICE   O11000   HOSPICE   O11000		l .	1				
92. 01   09201   0BSERVATI ON BEDS (DI STINCT PART)   0. 000000   95. 00   07HER REI MBURSABLE COST CENTERS   95. 00   09910   CORF   99. 10   10100   HOME HEALTH AGENCY   99. 10   10100   HOME HEALTH AGENCY   99. 10   10100   HOME PANCREAS ACQUISITION   109. 00   10100   INTESTINAL ACQUISITION   110. 00   111. 00   11100   ISLET ACQUISITION   111. 00   113. 00   11300   INTERST EXPENSE   113. 00   116. 00   11600   HOSPI CE   116. 00   200. 00   Subtotal (see instructions)   200. 00   201. 00   Less Observation Beds   201. 00	1	l .	1				1
OTHER REI MBURSABLE COST CENTERS   95. 00   995. 00   995. 00   999. 10   999. 10   999. 10   999. 10   999. 10   999. 10   10100   HOME HEALTH AGENCY   99. 10   101. 00   10900   PANCREAS ACQUI SI TI ON   110. 00   11000   INTESTI NAL ACQUI SI TI ON   110. 00   11100   ISLET ACQUI SI TI ON   111. 00   113. 00   11300   INTERST EXPENSE   113. 00   113. 00   116. 00   HOSPI CE   116. 00   1000   Subtotal (see instructions)   200. 00   201. 00   Less Observation Beds   201. 00			1				1
95. 00 99. 10 99. 10 101.00 101.00 101.00 101.00 10900   PANCREAS ACQUISITION 111.00 1			0. 000000				92.01
99. 10							
101. 00   10100   HOME   HEALTH   AGENCY   101. 00   SPECIAL   PURPOSE   COST   CENTERS   109. 00   10900   PANCREAS   ACQUI SI TI ON   110. 00   11100   INTESTI NAL   ACQUI SI TI ON   110. 00   113.00   113.00   INTERST   EXPENSE   113. 00   116. 00   116. 00   116. 00   116. 00   1000   Subtotal   (see instructions)   200. 00   201. 00   Less   Observation   Beds   201. 00			0. 000000				
SPECIAL PURPOSE COST CENTERS   109.00   10900   PANCREAS ACQUISITION   109.00   110.00   11000   INTESTINAL ACQUISITION   1110.00   11100   ISLET ACQUISITION   111.00   113.00   11300   INTERST EXPENSE   113.00   116.00   11600   HOSPI CE   116.00   200.00   Subtotal (see instructions)   200.00   201.00   Less Observation Beds   201.00	1	l control of the cont					
109. 00   10900   PANCREAS ACQUISITION   109. 00   110. 00   11000   INTESTINAL ACQUISITION   110. 00   111. 00   111. 00   111. 00   113. 00   11							101. 00
110. 00							
111. 00   11100   ISLET ACQUISITION   111. 00   113. 00   113. 00   11400   INTEREST EXPENSE   113. 00   116. 00   116. 00   200. 00   Subtotal (see instructions)   200. 00   201. 00   Less Observation Beds   201. 00							
113. 00	110. 00 11000	INTESTINAL ACQUISITION					110. 00
116. 00       116.00         200. 00       Subtotal (see instructions)         201. 00       Less Observation Beds	111. 00 11100	SLET ACQUISITION					111. 00
200. 00       Subtotal (see instructions)       200. 00         201. 00       Less Observation Beds       201. 00	113. 00 11300	INTEREST EXPENSE					113.00
201.00 Less Observation Beds 201.00	116. 00 11600	HOSPI CE					116. 00
201.00 Less Observation Beds 201.00	200.00	Subtotal (see instructions)					200.00
	202. 00	Total (see instructions)					202.00

Health Financial Systems	FRANCISCAN HEAI	LTH LAFAYETTE		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der C		Period: From 01/01/2016 To 12/31/2016		
			XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swi ng Bed	Reduced	Total Patient		
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col . 1 - col			
	26)		2)			
LANDATI ENT. DOUTLING OFFICE OF COOT OFFITEDS	1.00	2.00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	1	1		05.070	170.05	
30. 00 ADULTS & PEDI ATRI CS	6, 305, 983		-,,			
31. 00   INTENSIVE CARE UNIT	995, 778		995, 77		211. 69	1
35. 00 NEONATAL INTENSIVE CARE UNIT	482, 634		482, 63			1
40. 00 SUBPROVI DER – I PF	(00.5(0	0		0 0	0.00	1
41. 00 SUBPROVI DER - I RF	633, 562	0	633, 56		211. 05	
42. 00 SUBPROVI DER	0	0	1	0	0.00	
43. 00 NURSERY	197, 766		197, 76		161. 84	1
200.00 Total (lines 30-199)	8, 615, 723		8, 615, 72	3 47, 085		200. 00
Cost Center Description	I npati ent	Inpati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
	4.00	6)				
INDATI ENT DOUTINE CEDVI CE COCT CENTEDO	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS	16, 285	2 002 001	I			30.00
30. 00 ADULTS & PEDIATRICS						
31. 00 INTENSIVE CARE UNIT	1, 869	395, 649				31.00
35. 00 NEONATAL INTENSIVE CARE UNIT	0	0				35. 00
40. 00 SUBPROVI DER - I PF	1 /55	240 200				40.00
41. 00 SUBPROVI DER – I RF	1, 655	349, 288				41.00
42. 00 SUBPROVI DER						42.00
43. 00 NURSERY	10.000	0 (47 700				43.00
200.00 Total (lines 30-199)	19, 809	3, 647, 738	il .			200. 00

Heal th	Financial Systems	FRANCISCAN HEAL	_TH_LAFAYETTE		In Lie	eu of Form CMS-2	2552-10
	TIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA		Provider Co		Period: From 01/01/2016 To 12/31/2016	Worksheet D Part II	pared:
			Title	XVIII	Hospi tal	PPS	
	Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
		Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
		(from Wkst. B,	Part I, col.		. Charges	column 4)	
		Part II, col.	8)	2)			
		26)					
		1.00	2. 00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS	1					
		2, 582, 710					
51.00	05100 RECOVERY ROOM	187, 413					
52.00	05200 DELIVERY ROOM & LABOR ROOM	1, 144, 712				1, 925	
54.00	05400 RADI OLOGY-DI AGNOSTI C	2, 801, 048	89, 625, 691			256, 927	
55.00	03630 RADI OLOGY-THERAPEUTI C	60, 743	8, 363, 335	0.00726	983, 763	7, 145	55. 00
56.00	05600 RADI OI SOTOPE	30, 675	0	0.00000		0	56. 00
56. 01	03950 CARDI AC CATH LAB	621, 285	28, 919, 655	0. 02148	6, 940, 408	149, 101	56. 01
57.00	05700 CT SCAN	249, 711	66, 073, 172	0. 00377	9 8, 739, 945	33, 028	57. 00
58.00	05800 MRI	99, 310	15, 746, 763	0.00630	7 2, 873, 061	18, 120	58. 00
60.00	06000 LABORATORY	1, 042, 505	110, 599, 207	0.00942	6 25, 071, 418	236, 323	60.00
65.00	06500 RESPI RATORY THERAPY	268, 506	11, 322, 518	0. 02371	4 5, 027, 248	119, 216	65.00
66.00	06600 PHYSI CAL THERAPY	719, 100	14, 645, 511	0. 04910	0 2, 558, 856	125, 640	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	288, 611	9, 068, 516	0. 03182	631, 183	20, 088	67. 00
68.00	06800 SPEECH PATHOLOGY	147, 558	2, 158, 954	0. 06834	7 309, 527	21, 155	68. 00
69.00	06900 ELECTROCARDI OLOGY	668, 532	26, 717, 971	0. 02502	5, 010, 080	125, 362	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	223, 129	5, 139, 814	0. 04341	2 392, 797	17, 052	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	412, 604	119, 899, 548	0. 00344	1 30, 248, 845	104, 086	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	372, 122	95, 157, 453	0. 00391	1 38, 375, 031	150, 085	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	894, 388	96, 114, 942	0.00930	32, 408, 550	301, 562	73. 00
73. 01	07301 DI ABETES CENTER	14, 423	239, 640	0. 06018	6 0	0	73. 01
74.00	07400 RENAL DIALYSIS	128, 891	2, 131, 693	0. 06046	4 1, 317, 497	79, 661	74. 00
76. 98	07698 HYPERBARI C OXYGEN THERAPY	144, 856	2, 322, 216	0. 06237	8 8, 174	510	76. 98
	OUTPATIENT SERVICE COST CENTERS			•	•		
88.00	08800 RURAL HEALTH CLINIC	0	0	0.00000	0 0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0. 00000	0	0	89. 00
90.00	09000 CLI NI C	26, 765	815, 114	0. 03283	6 0	0	90.00
		1			. 1		1

26, 765 2, 510, 421

393, 877

292, 176

16, 326, 071 1, 022, 896, 521

815, 114 71, 808, 391

6, 259, 818

10, 519, 325

0. 032836 0. 034960

0.062921

0.000000

0. 027775

6, 795, 908

704, 975

215, 129, 854

0 90.00 35 91.00

91. 01

92.00

92. 01

95.00

237, 585

19, 581

0

2, 537, 326 200. 00

91. 00 09100 EMERGENCY

91.01

200.00

04950 WOUND CARE

95. 00 09500 AMBULANCE SERVICES

92. 01 09200 0BSERVATION BEDS (NON-DISTINCT PART 092.01 09201 0BSERVATION BEDS (DISTINCT PART)

OTHER REIMBURSABLE COST CENTERS

Total (lines 50-199)

	EDANIOL COAN LIEAL	TIL LAFAVETTE			6.5. 0116	0550 40
Health Financial Systems APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	FRANCISCAN HEAL ASS THROUGH COST				worksheet D Part III	2552-10
				To 12/31/2016		pared: 6 pm
			XVIII	Hospi tal	PPS	
Cost Center Description	Nursing School	Allied Health		Swi ng-Bed	Total Costs	
		Cost	Medi cal	Adjustment	(sum of cols.	
			Education Cos		1 through 3,	
					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	6, 172, 798	0		0	6, 172, 798	
31.00 03100 INTENSIVE CARE UNIT	0	0		0	0	
35.00  02060 NEONATAL INTENSIVE CARE UNIT	0	0		0	0	
40. 00   04000   SUBPROVI DER - 1 PF	0	0		0	0	40. 00
41. 00   04100   SUBPROVI DER - I RF	0	0		0	0	1
42. 00  04200  SUBPROVI DER	0	0		0 0	0	42.00
43. 00   04300   NURSERY	0	0		0	0	43.00
200.00 Total (lines 30-199)	6, 172, 798	0		0	6, 172, 798	200. 00
Cost Center Description	Total Patient	Per Diem (col.	I npati ent	I npati ent		
	Days	5 ÷ col. 6)	Program Days	Program		
				Pass-Through		
				Cost (col. 7 x		
				col . 8)		
	6.00	7. 00	8. 00	9. 00		
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00   03000   ADULTS & PEDI ATRI CS	35, 378	174. 48				30.00
31.00  03100   INTENSIVE CARE UNIT	4, 704	0.00	1, 86	9 0		31.00
35.00   02060   NEONATAL INTENSIVE CARE UNIT	2, 779	0.00		0 0		35. 00
40. 00   04000   SUBPROVI DER - 1 PF	0	0.00		0 0		40.00
41. 00   04100   SUBPROVI DER - I RF	3, 002	0.00	1, 65	5 0		41.00
42. 00   04200   SUBPROVI DER	0	0.00		0 0		42.00
43. 00   04300   NURSERY	1, 222	0.00		0		43.00
200.00   Total (lines 30-199)	47, 085		19, 80	9 2, 841, 407		200. 00

Health Financial Systems		FRANCI SCAN	HEALTH	LAFAYETTE	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY S	SERVI CE OTHER	PASS	Provider CCN: 15-0109	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part IV Date/Time Prepared:

				1	0 12/31/2016	6/28/2017 3:3	
			Title	XVIII	Hospi tal	PPS	о р
	Cost Center Description	Non Physician Nu	ırsing School	Allied Health	All Other	Total Cost	
		Anesthetist			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 OPERATI NG ROOM	0	0	0	0	0	00.00
	05100 RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
	05400 RADI OLOGY-DI AGNOSTI C	0	0	0	0	0	54.00
55. 00	03630 RADI OLOGY-THERAPEUTI C	0	0	0	0	0	55. 00
56. 00	05600 RADI OI SOTOPE	0	0	0	0	0	56.00
	03950 CARDI AC CATH LAB	0	0	0	0	0	56. 01
57. 00	05700 CT SCAN	0	0	0	0	0	57. 00
58. 00	05800 MRI	0	0	0	0	0	58. 00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
65. 00	06500 RESPIRATORY THERAPY	0	0	0	0	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	0	0	0	0	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	0	0	0	67. 00
	06800 SPEECH PATHOLOGY	0	0	0	0	0	68. 00
	06900 ELECTROCARDI OLOGY	0	0	0	0	0	69.00
	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0	0	0	0	0	71.00
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	000 047	0	000 017	72.00
	07300 DRUGS CHARGED TO PATIENTS	0	0	922, 217	0	922, 217	73.00
	07301 DI ABETES CENTER	0	0	0	0	0	73. 01
	07400 RENAL DIALYSIS	0	0	0	0	0	74.00
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	U	0	U	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	89.00
	09000 CLINIC		0	0	0	1	90.00
90.00	09100 EMERGENCY		0	667, 812	0	667, 812	
	04950 WOUND CARE		0	007, 812	0	007,812	1
	09200 OBSERVATION BEDS (NON-DISTINCT PART		0	0	0	1	91.01
	09201 OBSERVATION BEDS (NON-DISTINCT PART		0	0	0	1	
92. UT	OTHER REIMBURSABLE COST CENTERS	<u> </u>	U	<u> </u>	U	0	72.01
95. 00	09500 AMBULANCE SERVICES						95. 00
200.00		o	0	1, 590, 029	0	1, 590, 029	
200.00	1 1000 (11103 00 177)	١	Ч	1, 570, 027	O <sub>1</sub>	1, 370, 027	1200.00

Health Financial Systems	FRANCISCAN HEA	ITU IAFAVETTE		In Lio	u of Form CMS-2	2552 10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF			1	Period: From 01/01/2016 To 12/31/2016	Worksheet D	
		Titl∈	XVIII	Hospi tal	PPS	
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	8)	7)	(col. 6 ÷ col.		
	4)			7)		
ANOLILIADY OFFICE COOT, OFFITEDO	6. 00	7. 00	8. 00	9. 00	10. 00	
ANCILLARY SERVICE COST CENTERS		405 0/4 040	0.00000	0 000000	05 770 005	F0 00
50. 00   05000   OPERATI NG ROOM	0	,			35, 773, 885	
51. 00   05100   RECOVERY ROOM	0				2, 702, 233	
52. 00   05200   DELI VERY ROOM & LABOR ROOM	0	21, 170, 204	1		35, 599	
54. 00   05400   RADI OLOGY-DI AGNOSTI C 55. 00   03630   RADI OLOGY-THERAPEUTI C		89, 625, 691			8, 220, 871	54.00
56. 00   03630  RADI 0L0GY - THERAPEUTI C		8, 363, 335	0. 00000 0. 00000		983, 763 0	55. 00 56. 00
56. 00   03000  RADI 013010PE 56. 01   03950  CARDI AC CATH LAB		28, 919, 655	1		6, 940, 408	
57. 00   05700   CT SCAN		28, 919, 655 66, 073, 172	1		8, 739, 945	57.00
58. 00   05800   MRI			1		2, 873, 061	58.00
60. 00   06000   LABORATORY					25, 071, 418	
65. 00   06500   RESPI RATORY THERAPY		11, 322, 518			5, 027, 248	
66. 00   06600   PHYSI CAL THERAPY		14, 645, 511			2, 558, 856	
67. 00 06700 OCCUPATI ONAL THERAPY		9, 068, 516			631, 183	
68.00 06800 SPEECH PATHOLOGY		2, 158, 954			309, 527	68.00
69. 00   06900   ELECTROCARDI OLOGY	1 0	26, 717, 971			5, 010, 080	
70. 00 07000 ELECTROENCEPHALOGRAPHY		5, 139, 814			392, 797	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT			1		30, 248, 845	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS			1		38, 375, 031	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	922, 217		1		32, 408, 550	
73. 01 07301 DI ABETES CENTER	722,217	239, 640	1		02, 100, 000	73. 01
74. 00 07400 RENAL DI ALYSI S		2, 131, 693	1		1, 317, 497	74.00
76. 98 07698 HYPERBARI C OXYGEN THERAPY					8, 174	76. 98
OUTPATIENT SERVICE COST CENTERS		2,022,210	2. 23000	2, 2, 2, 2, 2, 2, 2, 2, 2, 2, 2, 2, 2, 2	5,171	1
88. 00 08800 RURAL HEALTH CLINIC	0	О	0.00000	0.000000	0	88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	_	0. 00000		0	89. 00
	1	1				00.00

667, 812

815, 114 71, 808, 391

6, 259, 818

1<u>0, 519, 325</u>

1, 590, 029 1, 022, 896, 521

0.000000

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90. 00 91. 00

91. 01

92.00

92. 01

95.00

0

6, 795, 908

704, 975

215, 129, 854 200. 00

90. 00 09000 CLINIC

200.00

91. 00 09100 EMERGENCY

91. 01 | 04950 | WOUND CARE

95. 00 09500 AMBULANCE SERVICES

92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART

92. 01 O9201 OBSERVATION BEDS (DISTINCT PART)
OTHER REIMBURSABLE COST CENTERS

Total (lines 50-199)

Health Financial Systems		FRANCI SCAI	I HEALTH	LAFAYETTE		In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCI LLARY	SERVI CE OTHEI	PASS	Provider CCN: 15-0	0109	Peri od: From 01/01/2016 To 12/31/2016	Worksheet D Part IV Date/Time Prepared:

				'	0 12/01/2010	6/28/2017 3: 3	36 pm
			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	_	Costs (col. 9			
		x col. 10)		x col. 12)			
		11.00	12.00	13.00			
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	14, 733, 739	C			50.00
51.00	05100 RECOVERY ROOM	0	1, 355, 600	C			51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	C	)		52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	11, 667, 395	(	)		54. 00
55.00	03630 RADI OLOGY-THERAPEUTI C	0	1, 138, 272	(	)		55. 00
56.00	05600 RADI OI SOTOPE	0	0	(	)		56. 00
56. 01	03950 CARDI AC CATH LAB	0	5, 793, 277	(	)		56. 01
57.00	05700 CT SCAN	0	12, 532, 001	(	)		57. 00
58.00	05800 MRI	0	3, 038, 729	1	)		58. 00
60.00	06000 LABORATORY	0	12, 250, 047	(	)		60.00
65.00	06500 RESPIRATORY THERAPY	0	458, 476	1	)		65. 00
66.00	06600 PHYSI CAL THERAPY	0	4, 438, 632	(	)		66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	41, 501	(	)		67. 00
68. 00	06800 SPEECH PATHOLOGY	0	7, 131	(	)		68. 00
69.00	06900 ELECTROCARDI OLOGY	0	6, 898, 713	1 0	)		69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	1, 467, 801	1 0	)		70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	O	11, 800, 031	1 0	)		71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	8, 995, 383	1 0	)		72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	310, 960	10, 148, 667	97, 376	,		73. 00
73. 01	07301 DI ABETES CENTER	0	3, 066	(	)		73. 01
74.00	07400 RENAL DIALYSIS	0	176, 123	1 0	)		74. 00
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	545, 850	(	)		76. 98
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0	0	(			88. 00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	C	)		89. 00
90.00	09000 CLI NI C	0	0	C	)		90. 00
91.00	09100 EMERGENCY	63, 202	10, 711, 544	99, 617	<b>'</b>		91. 00
91. 01	04950 WOUND CARE	0	0	(			91. 01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	(			92.00
92. 01	09201 OBSERVATION BEDS (DISTINCT PART)	0	1, 541, 968	C			92. 01
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVI CES						95. 00
200.00	Total (lines 50-199)	374, 162	119, 743, 946	196, 993	1		200. 00

Health Financial Systems	FRANCISCAN HEALTH	FRANCISCAN HEALTH LAFAYETTE		
APPORTI ONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0109	Peri od: From 01/01/2016	Worksheet D

ALTONITONIMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Trovider C	F		Part V Date/Time Pre 6/28/2017 3:3	pared: 6 pm
		Title	XVIII	Hospi tal	PPS	
			Charges		Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
	Ratio From	Services (see	Reimbursed	Rei mbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subj ect To		
			Ded. & Coins			
			(see inst.)	(see inst.)		
	1.00	2. 00	3. 00	4. 00	5. 00	
ANCI LLARY SERVI CE COST CENTERS			T			
50. 00 05000 OPERATING ROOM	0. 174909			0	2, 577, 064	
51.00   05100   RECOVERY ROOM	0. 129155	1, 355, 600		0	175, 083	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 340175	0		0	0	52. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0. 203560	11, 667, 395		0	2, 375, 015	54. 00
55. 00 03630 RADI OLOGY-THERAPEUTI C	0. 101478	1, 138, 272		0	115, 510	55. 00
56. 00   05600   RADI 0I SOTOPE	0. 000000	0		0	0	56. 00
56. 01   03950   CARDI AC CATH LAB	0. 114233	5, 793, 277		0	661, 783	56. 01
57.00  05700 CT SCAN	0. 034942	12, 532, 001		0	437, 893	57. 00
58. 00  05800 MRI	0. 057537	3, 038, 729		0	174, 839	58. 00
60. 00  06000 LABORATORY	0. 115686	12, 250, 047		0	1, 417, 159	60.00
65. 00  06500 RESPIRATORY THERAPY	0. 379872	458, 476		0 0	174, 162	65. 00
66. 00   06600 PHYSI CAL THERAPY	0. 428139	4, 438, 632		0	1, 900, 351	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 288042	41, 501		0 0	11, 954	67. 00
68.00 06800 SPEECH PATHOLOGY	0. 480514	7, 131		0 0	3, 427	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 147279	6, 898, 713		0 0	1, 016, 036	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 298566	1, 467, 801		0 0	438, 235	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 167735	11, 800, 031		0 0	1, 979, 278	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 201891	8, 995, 383		0 0	1, 816, 087	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 176239	10, 148, 667	1, 90	142, 931	1, 788, 591	73.00
73. 01   07301   DI ABETES CENTER	2. 233012	3, 066		0 0	6, 846	73. 01
74.00 07400 RENAL DIALYSIS	0. 476365	176, 123		0 0	83, 899	74.00
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 273705	545, 850		0 0	149, 402	76. 98
OUTPATIENT SERVICE COST CENTERS						1
88.00 08800 RURAL HEALTH CLINIC	0. 000000				0	88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000				0	89. 00
90. 00  09000 CLI NI C	1. 306490	0		0 0	0	90.00
91. 00 09100 EMERGENCY	0. 232956	10, 711, 544		0 0	2, 495, 318	91.00
91. 01 04950 WOUND CARE	0. 478912	0		0 0	0	91. 01
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	0		0 0	0	92.00
92.01 09201 OBSERVATION BEDS (DISTINCT PART)	0. 291541	1, 541, 968		0 0	449, 547	92. 01
OTHER REIMBURSABLE COST CENTERS		, , , , , , , , , , , , , , , , , , , ,				
95. 00 09500 AMBULANCE SERVI CES	0. 366086			0		95. 00
200.00 Subtotal (see instructions)		119, 743, 946	1, 90	142, 931	20, 247, 479	
201.00 Less PBP Clinic Lab. Services-Program		, , , 10		0 0		201.00
Only Charges						******
202.00   Net Charges (line 200 +/- line 201)		119, 743, 946	1, 90	142, 931	20, 247, 479	202. 00

Health Financial Systems	FRANCI SCAN HEALTH	LAFAYETTE	In Lie	u of Form CMS-2552-10
APPORTI ONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provi der CCN: 15-0109	Peri od: From 01/01/2016 To 12/31/2016	Worksheet D Part V Date/Time Prepared: 6/28/2017 3:36 pm

					To 12/31/2016	Date/Time Pro 6/28/2017 3:3	epared: 36 pm
			Title	XVIII	Hospi tal	PPS	
		Cos					
	Cost Center Description	Cost	Cost				
		Rei mbursed	Reimbursed				
		Servi ces	Services Not				
		Subject To	Subject To				
		Ded. & Coins. (see inst.)	Ded. & Coins. (see inst.)				
		6.00	7.00				
	ANCILLARY SERVICE COST CENTERS	0.00	7.00				
50.00	05000 OPERATING ROOM	0	0				50.00
51.00	05100 RECOVERY ROOM	0	0				51. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0				52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0				54.00
55.00	03630 RADI OLOGY-THERAPEUTI C	0	0				55. 00
56.00	05600 RADI OI SOTOPE	0	0				56. 00
56. 01	03950 CARDI AC CATH LAB	0	0				56. 01
57. 00	05700 CT SCAN	0	0				57. 00
58. 00	05800  MRI	0	0				58. 00
60.00	06000 LABORATORY	0	0				60.00
65. 00	06500 RESPI RATORY THERAPY	0	0				65. 00
66. 00	06600 PHYSI CAL THERAPY	0	0				66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0				67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0				68. 00
69. 00 70. 00	06900 ELECTROCARDI OLOGY	0	0				69. 00
	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0				70. 00 71. 00
71.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0				72.00
	07300 DRUGS CHARGED TO PATIENTS	336	25, 190				73. 00
	07301 DI ABETES CENTER	0	25, 170	i			73. 00
	07400 RENAL DIALYSIS	0	0				74.00
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0				76. 98
70.70	OUTPATIENT SERVICE COST CENTERS						70.70
88. 00	08800 RURAL HEALTH CLINIC	0	0				88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0				89. 00
90.00	09000 CLI NI C	0	0				90.00
91.00	09100 EMERGENCY	0	0				91.00
91. 01	04950 WOUND CARE	0	0				91. 01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0				92. 00
92. 01	09201 OBSERVATION BEDS (DISTINCT PART)	0	0				92. 01
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVICES	0					95. 00
200.00		336	25, 190				200. 00
201.00		0					201. 00
202.00	Only Charges (Line 200 / Line 201)	22/	25 100				202.00
202.00	Net Charges (line 200 +/- line 201)	336	25, 190	l			202. 00

		FRANCISCAN HEA			In Lie	u of Form CMS-:	<u>2552-10</u>
APP0RT	IONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der Co	CN: 15-0109	Peri od:	Worksheet D	
			Component (	CCN: 15-T109	From 01/01/2016 To 12/31/2016	Part II Date/Time Pre 6/28/2017 3:3	pared:
				XVIII	Subprovi der - I RF	PPS	
	Cost Center Description	Capi tal	Total Charges			Capital Costs	
			(from Wkst. C,		Program	(column 3 x	
		(from Wkst. B,	Part I, col.		. Charges	column 4)	
		Part II, col.	8)	2)			
		26)	0.00		1.00		
	ANOLILABLY DEBUT OF COOT OFFITEDO	1.00	2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS	2 502 710	105 0/1 042	0.01010	) / l	0	
	05000 OPERATING ROOM	2, 582, 710				0	
51.00	05100 RECOVERY ROOM	187, 413				0	
	05200 DELIVERY ROOM & LABOR ROOM	1, 144, 712				0	
	05400 RADI OLOGY THERAPELITIC	2, 801, 048				1, 467	54.00
	03630 RADI OLOGY-THERAPEUTI C	60, 743				51	
	05600 RADI OI SOTOPE	30, 675	ł	0.00000		0	
	03950 CARDI AC CATH LAB	621, 285				0	
	05700 CT SCAN	249, 711		0.00377		203	
	05800 MRI	99, 310				105	
	06000 LABORATORY	1, 042, 505				4, 365	
	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	268, 506				2, 607	
	l I	719, 100	1	0. 04910		52, 855	1
67.00	06700 OCCUPATI ONAL THERAPY	288, 611				34, 750	1
68. 00	06800 SPEECH PATHOLOGY	147, 558				14, 366	
69.00	06900  ELECTROCARDI OLOGY   07000  ELECTROENCEPHALOGRAPHY	668, 532				440	
70. 00 71. 00		223, 129				0 795	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	412, 604				12	
	07300 DRUGS CHARGED TO PATIENTS	372, 122 894, 388				4, 999	
	07301 DI ABETES CENTER	14, 423				4, 999	
74. 00	07400 RENAL DIALYSIS	128, 891				2, 888	
	07698 HYPERBARI C OXYGEN THERAPY	144, 856				2,000	
	OUTPATIENT SERVICE COST CENTERS	144,030	2, 322, 210	0.00237	o o	U	70. 70
	08800 RURAL HEALTH CLINIC	0	0	0.00000	00 0	0	88. 00
	08900 FEDERALLY QUALIFIED HEALTH CENTER					0	
	09000 CLINIC	26, 765				0	
	09100 EMERGENCY	2, 510, 421		0. 03283		307	
	04950 WOUND CARE	393, 877	6, 259, 818			0	
	09200 OBSERVATION BEDS (NON-DISTINCT PART	393, 6//				0	1
	09201 OBSERVATION BEDS (NON-DISTINCT PART)	292, 176				406	
	OTHER REIMBURSABLE COST CENTERS	272, 170	10, 317, 323	0.02777	J 14, 011	400	72.01
	09500 AMBULANCE SERVICES						95. 00
200.00	l I	16, 326, 071	1, 022, 896, 521		3, 935, 748	120, 616	

Heal th	Financial Systems	FRANCISCAN HEALTH	H LAFAYETTE		In Lie	u of Form CMS-2	2552-10
	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER		Provi der Co	CN: 15-0109	Peri od:	Worksheet D	
THROUG	H COSTS		Component	CCN: 15-T109	From 01/01/2016 To 12/31/2016	Part IV Date/Time Pre 6/28/2017 3:3	pared:
			Title	: XVIII	Subprovi der - I RF	PPS	о рііі
	Cost Center Description	Non Physician Nu	ırsi ng School	Allied Healt		Total Cost	
		Anesthetist			Medi cal	(sum of col 1	
		Cost			Education Cost		
		1.00	2.00	3.00	4.00	<u>4)</u> 5. 00	
	ANCILLARY SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
50. 00	05000 OPERATING ROOM		0		0 0	0	50.00
51.00	05100 RECOVERY ROOM	O	0		0 0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	54.00
55.00	03630 RADI OLOGY-THERAPEUTI C	0	0		0 0	0	55. 00
56.00	05600 RADI OI SOTOPE	0	0		0	0	56. 00
56. 01	03950 CARDI AC CATH LAB	0	0		0	0	56. 01
57. 00	05700 CT SCAN	0	0		0 0	0	57. 00
58. 00	05800 MRI	0	0		0 0	0	58.00
60.00	06000 LABORATORY	0	0		0 0	0	60.00
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	0	0		0 0	0	65. 00 66. 00
67. 00	06700 OCCUPATIONAL THERAPY		0		0	0	67.00
68. 00	06800 SPEECH PATHOLOGY		0			0	68.00
69. 00	06900 ELECTROCARDI OLOGY	0	0		0 0	0	69.00
70. 00	07000 ELECTROENCEPHALOGRAPHY	O	0		0 0	0	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	922, 2	17 0	922, 217	73.00
73. 01	07301 DI ABETES CENTER	0	0		0	0	
74. 00	07400 RENAL DI ALYSI S	0	0	1	0 0	0	74.00
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0		0 0	0	76. 98
88. 00	OUTPATIENT SERVICE COST CENTERS  08800 RURAL HEALTH CLINIC	0	0	I	0 0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER		0	•	0 0	0	89.00
90.00	09000 CLINIC		0			0	90.00
91. 00	09100 EMERGENCY		0	667, 8	9	667, 812	91.00
91. 01	04950 WOUND CARE	l o	0		0 0	0	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		0 0	0	92.00
92. 01	09201 OBSERVATION BEDS (DISTINCT PART)	0	0		0 0	0	92. 01
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	_	_		_	4 500	95. 00
200.00	Total (lines 50-199)	0	0	1, 590, 0	29  0	1, 590, 029	1200. OO

		FRANCI SCAN HEA			In Lie	u of Form CMS-2	2552-10
	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	RVICE OTHER PAS	S Provider Co	CN: 15-0109	Peri od:	Worksheet D	
THROUG	H COSTS		Component	CCN: 15-T109	From 01/01/2016 To 12/31/2016	Part IV Date/Time Pre 6/28/2017 3:3	pared: 6 pm
			Title	XVIII	Subprovi der - I RF	PPS	
	Cost Center Description	Total	Total Charges			Inpati ent	
		Outpati ent	(from Wkst. C,		Ratio of Cost	Program	
		Cost (sum of	Part I, col.			Charges	
		col . 2, 3 and	8)	7)	(col. 6 ÷ col.		
		4)			7)		
		6. 00	7. 00	8. 00	9. 00	10.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	195, 861, 842	0.00000		0	50.00
51.00	05100 RECOVERY ROOM	0			0. 000000	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	21, 170, 204	0.00000	0. 000000	0	52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	89, 625, 691	0.00000	0. 000000	46, 927	54.00
55.00	03630 RADI OLOGY-THERAPEUTI C	0	8, 363, 335	0.00000	0. 000000	7, 012	55. 00
56.00	05600 RADI OI SOTOPE	0	0	0.00000	0. 000000	0	56.00
56. 01	03950 CARDI AC CATH LAB	0	28, 919, 655	0.00000	0. 000000	0	56. 01
57.00	05700 CT SCAN	0	66, 073, 172	0.00000	0. 000000	53, 689	57.00
58.00	05800 MRI	0	15, 746, 763	0.00000	0. 000000	16, 587	58. 00
60.00	06000 LABORATORY	0	110, 599, 207	0. 00000	0. 000000	463, 077	60.00
65.00	06500 RESPI RATORY THERAPY	0			0. 000000	109, 916	65.00
66.00	06600 PHYSI CAL THERAPY	0	14, 645, 511	0. 00000	0. 000000	1, 076, 470	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	9, 068, 516	0. 00000	0. 000000	1, 091, 860	67.00
68. 00	06800 SPEECH PATHOLOGY	0				210, 196	
69.00	06900 ELECTROCARDI OLOGY	0		0. 00000		17, 587	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0				0	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0				230, 976	
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0				3, 104	1
	07300 DRUGS CHARGED TO PATIENTS	922, 217				537, 201	73.00
	07301 DI ABETES CENTER	0				0	
	07400 RENAL DIALYSIS					47, 758	
	07698 HYPERBARI C OXYGEN THERAPY		_,,			0	
70. 70	OUTPATIENT SERVICE COST CENTERS		2,022,210	0.00000	0. 000000		70.70
88. 00	08800 RURAL HEALTH CLINIC	0	0	0.00000	0. 000000	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER					0	89.00
90.00	09000 CLINIC					0	
91. 00	09100 EMERGENCY	667, 812		0.00000		8, 777	91.00
91.00	04950 WOUND CARE	007, 812				0,777	
	09200 OBSERVATION BEDS (NON-DISTINCT PART					0	
	09201 OBSERVATION BEDS (NON-DISTINCT PART					_	
<del>7</del> ∠. U I	OTHER REIMBURSABLE COST CENTERS		10, 319, 325	0.00000	U <sub>I</sub> U. UUUUUU	14, 611	72.01
05 00	09500 AMBULANCE SERVICES						95. 00
95. 00 200. 00	l	1 500 020	1, 022, 896, 521			3, 935, 748	
∠00.00		1, 390, 029	1,022,090,521	I	1	J, 730, 748	<sub>1</sub> 200.00

ealth Financial Systems	FRANCISCAN HEAL		011 45 0400		u of Form CMS	-2552-
PPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SI	ERVICE OTHER PASS	Provider C	CN: 15-0109	Period: From 01/01/2016	Worksheet D Part IV	
HROUGH COSTS		Component	CCN: 15-T109	To 12/31/2016	Date/Time Pr	epared
		00por.o	00.11 10 1107	10 12,01,2010	6/28/2017 3:	36 pm
		Ti tl e	e XVIII	Subprovi der -	PPS	
				IRF		
Cost Center Description	I npati ent	Outpati ent	Outpati ent			
	Program	Program	Program			
	Pass-Through	Charges	Pass-Throug			
	Costs (col. 8		Costs (col.			
	x col . 10)	10.00	x col . 12)			
ANOLI LADV CEDVI CE COCE CENTEDO	11.00	12. 00	13. 00			_
ANCILLARY SERVICE COST CENTERS  0.00 05000 OPERATING ROOM	O	C	\			50.0
			1	0		
1. 00   05100   RECOVERY ROOM	0	C	1	0		51.
2. 00   05200   DELIVERY ROOM & LABOR ROOM	0	C		0		52. (
4. 00   05400   RADI OLOGY - DI AGNOSTI C	0	(		0		54.
5. 00   03630   RADI OLOGY-THERAPEUTI C	0	C	1	0		55.0
5. 00   05600   RADI 01 SOTOPE	0	C	1	0		56.
5. 01 03950 CARDI AC CATH LAB	0	C	1	0		56.
7. 00   05700   CT   SCAN	0	C	1	0		57.
8. 00   05800   MRI	0	C	1	0		58.
0. 00   06000   LABORATORY	0	C	1	0		60.
5. 00 06500 RESPI RATORY THERAPY	0	C	1	0		65.
6. 00   06600   PHYSI CAL THERAPY	0	C	1	0		66.
7. 00 06700 OCCUPATI ONAL THERAPY	0	C	Ί	0		67.
8. 00 06800 SPEECH PATHOLOGY	0	C	1	0		68.
9. 00 06900 ELECTROCARDI OLOGY	0	C	1	0		69.
D. 00 07000 ELECTROENCEPHALOGRAPHY	0	C	1	0		70.
1. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	C	)	0		71.
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	(	)	0		72.
3.00 07300 DRUGS CHARGED TO PATIENTS	5, 154	C	Ί	0		73.
3. 01   07301   DI ABETES CENTER	0	C	1	0		73.
4. 00   07400   RENAL DI ALYSI S	0	C	1	0		74.
5. 98 07698 HYPERBARI C OXYGEN THERAPY	0		)	0		76.
OUTPATIENT SERVICE COST CENTERS			,			4
3. 00 08800 RURAL HEALTH CLINIC	0	C	1	0		88.
9. 00   08900   FEDERALLY QUALIFIED HEALTH CENTER	0	C	2	0		89.
0. 00   09000   CLI NI C	0	(	()	0		90.
I. 00 09100 EMERGENCY	82	C	Ί	0		91.
I. 01   04950   WOUND CARE	0	C	1	0		91.
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	C	1	0		92.
2. 01   09201   0BSERVATI ON BEDS (DI STI NCT PART)	0		יייייייייייייייייייייייייייייייייייייי	0		92.
OTHER REIMBURSABLE COST CENTERS						4
5. 00 09500 AMBULANCE SERVICES		_	]			95.
00.00 Total (lines 50-199)	5, 236	C	ון	0		200.

	<del></del>	FRANCISCAN HEALTH			u of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST		Provider CCN: 15-0109	Peri od: From 01/01/2016	Worksheet D-1	
				To 12/31/2016		pared:
			Title XVIII	Hospi tal	6/28/2017 3: 3 PPS	6 pm
	Cost Center Description		THE AVITE	nospi tai	113	
	·				1. 00	
	PART I - ALL PROVIDER COMPONENTS					
1. 00	INPATIENT DAYS Inpatient days (including private room days a	and swing had days	oveluding newborn)		35, 378	1.00
2. 00	Inpatient days (including private room days,				35, 376 35, 378	2.00
3.00	Private room days (excluding swing-bed and o			ivate room days	33, 370	3.00
3. 00	do not complete this line.	bool vation bed day	s). It you have only pr	rvate room days,	G	0.00
4. 00	Semi-private room days (excluding swing-bed	and observation be	ed days)		35, 378	4. 00
5. 00	Total swing-bed SNF type inpatient days (inc	luding private roo	m days) through Decembe	r 31 of the cost	0	5. 00
	reporting period					
. 00	Total swing-bed SNF type inpatient days (inc		om days) after December	31 of the cost	0	6. 00
. 00	reporting period (if calendar year, enter 0   Total swing-bed NF type inpatient days (incl		days) through December	31 of the cost	0	7. 00
. 00	reporting period	during private 1001	r days) till odgir becember	31 of the cost	O	7.00
3. 00	Total swing-bed NF type inpatient days (incl	uding private room	days) after December 3	1 of the cost	0	8. 00
	reporting period (if calendar year, enter 0					
9. 00	Total inpatient days including private room	days applicable to	the Program (excluding	swing-bed and	16, 285	9. 00
0. 00	newborn days) Swing-bed SNF type inpatient days applicable	to title V/III or	dy (including private r	room dove)	0	10. 00
0.00				Oolii days)	U	10.00
1. 00	through December 31 of the cost reporting period (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after					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		only (including privat	e room days)	0	12. 00
13. 00	through December 31 of the cost reporting pe Swing-bed NF type inpatient days applicable		anly (including privat	a maam day(a)	0	13. 00
13.00	after December 31 of the cost reporting periods				U	13.00
14. 00	Medically necessary private room days applic				0	14. 00
15. 00	Total nursery days (title V or XIX only)	3	, 3	,	0	15. 00
16. 00	Nursery days (title V or XIX only)				0	16. 00
	SWING BED ADJUSTMENT					
7. 00	Medicare rate for swing-bed SNF services appreporting period	licable to service	es through December 31 o	f the cost	0. 00	17. 00
18. 00	Medicare rate for swing-bed SNF services app	licable to service	es after December 31 of	the cost	0. 00	18. 00
0.00	reporting period		e a. te. Becombe. e. e.		0.00	
9.00	Medicaid rate for swing-bed NF services appl	icable to services	through December 31 of	the cost	0.00	19. 00
	reporting period		6. 5 . 6.			
0.00	Medicaid rate for swing-bed NF services applreporting period	icable to services	after December 31 of t	he cost	0. 00	20. 00
1. 00	Teportring perrou Total general inpatient routine service cost	(see instructions	.)		44, 360, 965	21. 00
22. 00	Swing-bed cost applicable to SNF type service			ing period (line	0	22. 00
	5 x line 17)			ring parties (rinis		
23. 00	Swing-bed cost applicable to SNF type service	es after December	31 of the cost reportin	g period (line 6	0	23. 00
	x line 18)		24 6 11			04.00
24. 00	Swing-bed cost applicable to NF type service 7 x line 19)	s through December	31 or the cost reporti	ng period (iine	0	24. 00
5. 00	Swing-bed cost applicable to NF type service	s after December 3	1 of the cost reporting	period (line 8	0	25. 00
	x line 20)					
6. 00	Total swing-bed cost (see instructions)				0	
7. 00	General inpatient routine service cost net o	f swing-bed cost (	line 21 minus line 26)		44, 360, 965	27. 00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	1 1				00.00
יא ממ	General inpatient routine service charges (e	xarudina swina-bed	rand observation bed ch	arges) l	Ο	28 00

3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days,	0	3. 00
4 00	do not complete this line.	05 070	4 00
4. 00 5. 00	Semi-private room days (excluding swing-bed and observation bed days) Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost	35, 378 0	4. 00 5. 00
5.00	reporting period	U	3.00
6. 00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	0	6. 00
	reporting period (if calendar year, enter 0 on this line)		
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost	0	7. 00
	reporting period		
8. 00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	0	8. 00
9. 00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to the Program (excluding swing-bed and	16, 285	9. 00
9.00	newborn days)	10, 200	9.00
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
10.00	December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	10.00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12. 00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XLX only (including private room days)	0	13. 00
	after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	_	
14. 00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15. 00	Total nursery days (title V or XIX only)	0	15. 00
16. 00	Nursery days (title V or XIX only)	0	16. 00
17. 00	SWING BED ADJUSTMENT  Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost	0.00	17. 00
17.00	reporting period	0.00	17.00
18. 00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost	0. 00	18. 00
	reporting period		
19. 00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost	0.00	19. 00
00.00	reporting period	0.00	00.00
20. 00	Medical drate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0. 00	20. 00
21. 00	Total general inpatient routine service cost (see instructions)	44, 360, 965	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line	0	22. 00
	5 x line 17)		
23. 00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6	0	23. 00
24. 00	x line 18) Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	0	24. 00
24.00	7 x line 19)	O	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	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	44, 360, 965	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)	0	29. 00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31. 00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31. 00
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)		33.00
34. 00	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)	0.00	
35. 00 36. 00	Private room cost differential adjustment (line 3 x line 35)	0.00	35. 00 36. 00
37. 00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line	44, 360, 965	37. 00
07.00	27 minus line 36)	11,000,700	07.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38. 00	Adjusted general inpatient routine service cost per diem (see instructions)	1, 253. 91	38. 00
39. 00	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)	20, 419, 924	39. 00 40. 00
40. 00 41. 00	Total Program general inpatient routine service cost (line 39 + line 40)	0 20, 419, 924	
41.00	Total Trogram general Theatrent Toutine Service Cost (Tine 37 + Tine 40)	20, 417, 724	71.00

	Financial Systems ATION OF INPATIENT OPERATING COST	FRANCISCAN HEALT	H LAFAYETTE Provider CCN	N: 15-0109	Period:	worksheet D-1	
					From 01/01/2016 To 12/31/2016		
			Title	XVIII	Hospi tal	6/28/2017 3: 3 PPS	6 pm
	Cost Center Description	Total Inpatient Cost	Total	Average Per	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2. 00	3. 00	4. 00	5. 00	
42. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	0	0.0	00 0	0	42.00
43. 00	INTENSIVE CARE UNIT	8, 190, 057	4, 704	1, 741. 0	1, 869	3, 254, 079	43.00
44.00							44. 00
45.00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						45. 00 46. 00
	NEONATAL INTENSIVE CARE UNIT	4, 241, 686	2, 779	1, 526. 3	34 0	0	
	Cost Center Description		·			4.00	
48. 00	Program inpatient ancillary service cost (Wk	st D-3 col 3	line 200)			1. 00 37, 706, 408	48. 00
49. 00	Total Program inpatient costs (sum of lines			s)		61, 380, 411	
F0 00	PASS THROUGH COST ADJUSTMENTS		. (6		6.5.1.1.1	( 400 057	
50. 00	Pass through costs applicable to Program inp	atient routine s	ervices (Trom	WKST. D, SUM	or Parts I and	6, 139, 857	50.00
51.00	Pass through costs applicable to Program inp	atient ancillary	services (fro	m Wkst. D, s	um of Parts II	2, 911, 488	51.00
52. 00	and IV) Total Program excludable cost (sum of lines	50 and 51)				9, 051, 345	52. 00
53. 00	Total Program inpatient operating cost exclu		ated, non-phys	ician anesth	etist, and	52, 329, 066	
	medical education costs (line 49 minus line				·		
54. 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54. 00
55. 00	, 9						55.00
56. 00	Target amount (line 54 x line 55)				>	0	
57. 00 58. 00	Difference between adjusted inpatient operat Bonus payment (see instructions)	ing cost and tar	get amount (li	ne 56 minus	line 53)	0	
59. 00	Lesser of lines 53/54 or 55 from the cost re	porting period e	ndi ng 1996, up	dated and co	mpounded by the		
	market basket					0.00	,,,,,,,
60. 00 61. 00	Lesser of lines 53/54 or 55 from prior year If line 53/54 is less than the lower of line				the amount by	0.00	60. 00 61. 00
	which operating costs (line 53) are less tha	n expected costs					
62. 00	amount (line 56), otherwise enter zero (see Relief payment (see instructions)	instructions)				0	62. 00
	Allowable Inpatient cost plus incentive paym		0				
	PROGRAM INPATIENT ROUTINE SWING BED COST				1 1 (0	1	
64. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts through Decem	ber 31 of the	cost reporti	ng period (See	0	64. 00
65. 00	Medicare swing-bed SNF inpatient routine cos	ts after Decembe	r 31 of the co	st reporting	period (See	0	65. 00
66. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi	no costs (lino 6	4 plus lino 65	) (+i +l o VVI I	Lonly) For	0	66. 00
00.00	CAH (see instructions)	ne costs (Time o	4 prus rine os	)(title xvii	i only). Tol		00.00
67. 00	9 1	e costs through	December 31 of	the cost re	porting period	0	67. 00
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routin	e costs after De	cember 31 of t	he cost repo	orting period	0	68. 00
	(line 13 x line 20)						
69. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N					0	69.00
70. 00	Skilled nursing facility/other nursing facil	·					70. 00
71. 00	Adjusted general inpatient routine service c		ne 70 ÷ line 2	)			71. 00
72. 00 73. 00	Program routine service cost (line 9 x line Medically necessary private room cost applic		(line 14 x lin	e 35)			72. 00 73. 00
74. 00	Total Program general inpatient routine serv	ice costs (line	72 + line 73)				74. 00
75. 00	Capital -related cost allocated to inpatient	routine service	costs (from Wo	rksheet B, F	Part II, column		75. 00
76. 00	26, line 45)   Per diem capital-related costs (line 75 ÷ li	ne 2)					76. 00
77. 00	Program capital-related costs (line 9 x line						77. 00
78. 00 79. 00	Inpatient routine service cost (line 74 minu Aggregate charges to beneficiaries for exces		ovi der records	)			78. 00 79. 00
80.00	Total Program routine service costs for comp			•	us line 79)		80.00
81.00	Inpatient routine service cost per diem limi						81.00
82. 00 83. 00	Inpatient routine service cost limitation (I Reasonable inpatient routine service costs (						82. 00 83. 00
84. 00	Program inpatient ancillary services (see in						84. 00
	Utilization review - physician compensation	(see instruction					85.00
86. 00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PAS		ougn 85)				86. 00
87. 00	Total observation bed days (see instructions					0	
88. 00	Adjusted general inpatient routine cost per		line 2)				88.00
07. UU	Observation bed cost (line 87 x line 88) (se	e mstructions)				1	89. 00

Health Financial Systems	FRANCISCAN HEAL	TH LAFAYETTE		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
				From 01/01/2016 To 12/31/2016		
		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	6, 305, 983	44, 360, 965	0. 14215	2 0	0	90.00
91.00 Nursing School cost	6, 172, 798	44, 360, 965	0. 13914	9 0	0	91.00
92.00 Allied health cost	o	44, 360, 965	0.00000	0	0	92.00
93.00 All other Medical Education	o	44, 360, 965	0. 00000	0 0	0	93. 00

Health Financial Systems	FRANCISCAN HEALTH LAFAYETTE	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0109	Peri od: From 01/01/2016	Worksheet D-1
	Component CCN: 15-T109		
	Title XVIII	Subprovi der -	PPS

		II the Aviii	I RF	FF3	
	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 days			3, 002	1.00
2. 00 3. 00	Inpatient days (including private room days, excluding swing-l Private room days (excluding swing-bed and observation bed day		vate room days	3, 002 0	2. 00 3. 00
3.00	do not complete this line.	73). The you have only pri	vate room days,	O	3.00
4.00	Semi-private room days (excluding swing-bed and observation be			3, 002	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private roomstrang paried	om days) through December	31 of the cost	0	5. 00
6. 00	reporting period Total swing-bed SNF type inpatient days (including private roo	om davs) after December 3	31 of the cost	0	6. 00
	reporting period (if calendar year, enter 0 on this line)				
7.00	Total swing-bed NF type inpatient days (including private roor	n days) through December	31 of the cost	0	7. 00
8. 00	reporting period Total swing-bed NF type inpatient days (including private roor	n days) after December 3	1 of the cost	0	8. 00
0.00	reporting period (if calendar year, enter 0 on this line)	radys) arter becomber o	1 01 1110 0031	O .	0.00
9. 00	Total inpatient days including private room days applicable to	the Program (excluding	swi ng-bed and	1, 655	9. 00
10. 00	newborn days) Swing-bed SNF type inpatient days applicable to title XVIII or	nly (including private r	nom days)	0	10. 00
10.00	through December 31 of the cost reporting period (see instructions)		Join days)	O	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		oom days) after	0	11. 00
12. 00	December 31 of the cost reporting period (if calendar year, en Swing-bed NF type inpatient days applicable to titles V or XI)		e room days)	0	12. 00
12.00	through December 31 of the cost reporting period	Comy (The during private	e room days)	O	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX			0	13. 00
14. 00	after December 31 of the cost reporting period (if calendar ye			0	14. 00
15. 00	Medically necessary private room days applicable to the Progra Total nursery days (title V or XIX only)	am (excluding swing-bed o	lays)	0	15. 00
16. 00	Nursery days (title V or XIX only)			0	16. 00
	SWING BED ADJUSTMENT				
17. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es through December 31 of	the cost	0.00	17. 00
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of i	the cost	0. 00	18. 00
	reporting period				
19. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	s through December 31 of	the cost	0. 00	19. 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
	reporting period				
21. 00 22. 00	Total general inpatient routine service cost (see instructions Swing-bed cost applicable to SNF type services through Decembe		ng poriod (line	3, 388, 354 0	21. 00 22. 00
22.00	5 x line 17)	er of the cost reporti	ng perrou (Trie	U	22.00
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reporting	g period (line 6	0	23. 00
24.00	X line 18)	21 of the cost reporting	ag ported (line	0	24. 00
24. 00	Swing-bed cost applicable to NF type services through December $7 \times 1$ ine 19)	31 of the cost reportin	ig perrou (Trile	U	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
27.00	x line 20)			0	26. 00
26. 00 27. 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost	Tine 21 minus line 26)		3, 388, 354	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			5, 555, 55	
	General inpatient routine service charges (excluding swing-bed	d and observation bed cha	arges)		28. 00
29. 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)	20)		0. 00	
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
34.00	Average per diem private room charge differential (line 32 min	, ,	tions)	0.00	
35. 00 36. 00	Average per diem private room cost differential (line 34 x line Private room cost differential adjustment (line 3 x line 35)	IC 31)		0.00	35. 00 36. 00
37. 00	General inpatient routine service cost net of swing-bed cost a	and private room cost di	fferential (line	3, 388, 354	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, 128. 70	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line	38)		1, 867, 999	39. 00
40.00	Medically necessary private room cost applicable to the Program			1 947 000	40.00
41. 00	Total Program general inpatient routine service cost (line 39	+ ITHE 4U)	l	1, 867, 999	41.00

		FRANCISCAN HEALTI				eu of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST		Provider CC Component C	F	Period: From 01/01/2016 Fo 12/31/2016		nared:
			Title		Subprovi der -	6/28/2017 3: 3 PPS	6 pm
					I RF		
	Cost Center Description	Total Inpatient CostIn	Total npati ent Days[	Average Per Diem (col. 1 - col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
42.00	NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00	5. 00	42. 00
42.00	Intensive Care Type Inpatient Hospital Units	j Oj	ΟĮ	0.00	<u>Л</u> О	0	42.00
43. 00 44. 00	INTENSIVE CARE UNIT CORONARY CARE UNIT	0	0	0.00	0	0	43. 00 44. 00
45. 00	BURN INTENSIVE CARE UNIT						45. 00
46.00	SURGICAL INTENSIVE CARE UNIT			0.00			46.00
47.00	NEONATAL INTENSIVE CARE UNIT   Cost Center Description	0	0	0.00	0	0	47. 00
49.00	Program inpatient ancillary service cost (Wk	c+ D 2 col 2	line 200)			1.00	49.00
48. 00 49. 00	Total Program inpatient and Train's Service Cost (wk Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS			ns)		1, 150, 657 3, 018, 656	
50. 00	Pass through costs applicable to Program inp	atient routine se	ervices (from	Wkst. D, sum	of Parts I and	349, 288	50. 00
51. 00	<pre>Pass through costs applicable to Program inpland IV)</pre>	atient ancillary	services (fro	om Wkst. D, su	um of Parts II	125, 852	51. 00
52. 00	Total Program excludable cost (sum of lines					475, 140	
53. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION		ated, non-phys	sician anesthe	etist, and	2, 543, 516	53. 00
54.00	Program di scharges					0	
55. 00 56. 00	Target amount per discharge Target amount (line 54 x line 55)					0.00	55. 00 56. 00
57. 00	Difference between adjusted inpatient operat	ing cost and targ	get amount (li	ne 56 minus I	ine 53)	o o	57. 00
58. 00 59. 00	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost re	porting ported or	nding 1006 ur	ndated and con	anounded by the	0.00	58. 00 59. 00
34.00	market basket	portring perrod er	idi ilg 1990, up	dated and con	ipounded by the	0.00	39.00
60.00	Lesser of lines 53/54 or 55 from prior year				-ha amaunt hu	0.00	
61. 00	If line 53/54 is less than the lower of line which operating costs (line 53) are less tha amount (line 56), otherwise enter zero (see	n expected costs				0	61. 00
62.00	Relief payment (see instructions)		.:>			0	
63.00	Allowable Inpatient cost plus incentive paym PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instruct	(Tons)			0	63. 00
64. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)						64. 00
65. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts after December	31 of the co	ost reporting	period (See	0	65. 00
66. 00	Total Medicare swing-bed SNF inpatient routi CAH (see instructions)	ne costs (line 64	plus line 65	5)(title XVIII	only). For	0	66. 00
67. 00	Title V or XIX swing-bed NF inpatient routing (line 12 x line 19)	e costs through [	December 31 of	the cost rep	porting period	0	67. 00
68. 00	Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)	e costs after Dec	cember 31 of t	the cost repor	ting period	0	68. 00
69. 00	Total title V or XIX swing-bed NF inpatient					0	69. 00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER NU Skilled nursing facility/other nursing facil						70. 00
71.00	Adjusted general inpatient routine service c	ost per diem (lir					71. 00
72. 00 73. 00	Program routine service cost (line 9 x line Medically necessary private room cost applications)	•	′line 14 x lir	ne 35)			72. 00 73. 00
74. 00	Total Program general inpatient routine serv	•	•	.0 00)			74. 00
75. 00	Capital-related cost allocated to inpatient 26, line 45)	routine service o	costs (from Wo	orksheet B, Pa	art II, column		75. 00
76. 00	Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line						76. 00 77. 00
78. 00	Inpatient routine service cost (line 74 minus						78. 00
79.00	Aggregate charges to beneficiaries for exces				1: 70)		79.00
80. 00 81. 00	Total Program routine service costs for comp. Inpatient routine service cost per diem limi		st iiiii tation	(iiie /8 minu	15 TINE /9)		80. 00 81. 00
82. 00	Inpatient routine service cost limitation (I	ine 9 x line 81)					82. 00
83. 00 84. 00	Reasonable inpatient routine service costs ( Program inpatient ancillary services (see in		)				83. 00 84. 00
85. 00	Utilization review - physician compensation		s)				85. 00
86. 00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS		ough 85)				86. 00
87. 00	Total observation bed days (see instructions	)				0	87. 00
88.00	Adjusted general inpatient routine cost per Observation bed cost (line 87 x line 88) (se	•	ine 2)				88. 00 89. 00
U 7. UU	lopper ration per cost (time of x time oo) (se	o man ucti una)				1	1 07.00

Health Financial Systems	FRANCISCAN HEAL	LTH_LAFAYETTE		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
				From 01/01/2016	5	
		Component	CCN: 15-T109	To 12/31/2016	Date/Time Pre 6/28/2017 3:3	
		Title	XVIII	Subprovi der -	PPS	<u> Бин</u>
		11 11 0	XVIII	IRF	113	
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	633, 562	3, 388, 354	0. 18698	2 0	0	90.00
91.00 Nursing School cost	0	3, 388, 354	0. 00000	0	0	91. 00
92.00 Allied health cost	0	3, 388, 354	0. 00000	0	0	92.00
93.00 All other Medical Education	0	3, 388, 354	0. 00000	0	0	93.00

Health Finan	rial Systems	FRANCISCAN HEALTH	ΙΔΕΔΥΕΤΤΕ	Inlie	u of Form CMS-2	2552_10
	OF INPATIENT OPERATING COST	TRANCISCAN HEALIN	Provider CCN: 15-0109	Peri od:	Worksheet D-1	
				From 01/01/2016 To 12/31/2016		pared:
			Title XIX	Hospi tal	Cost	<u>o p</u>
	Cost Center Description					
					1. 00	
	- ALL PROVIDER COMPONENTS ENT DAYS					
	ent days (including private room da	avs and swing-hed days	excluding newborn)		35, 378	1.00
	ent days (including private room da				35, 378	2.00
	e room days (excluding swing-bed an			ivate room days.	0	3.00
	complete this line.		, y y p.		_	
4.00 Semi -	orivate room days (excluding swing-b	oed and observation be	ed days)		35, 378	4. 00
5.00 Total	swing-bed SNF type inpatient days (	(including private roc	om days) through Decembe	r 31 of the cost	0	5. 00
	ing period					
	swing-bed SNF type inpatient days (		om days) after December	31 of the cost	0	6. 00
	ing period (if calendar year, enter				_	
	swing-bed NF type inpatient days (i	ncluding private room	n days) through December	31 of the cost	0	7. 00
	ing period	noludina privata paga	daya) after December 3	1 of the cost	0	8. 00
	swing-bed NF type inpatient days (i ing period (if calendar year, enter		i days) after December 3	or the cost	U	8.00
1 .	9.	•	the Program (evoluding	swing_bod and	5, 603	9. 00
	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)					
	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)					
	through December 31 of the cost reporting period (see instructions)					10. 00
	bed SNF type inpatient days applica			oom days) after	0	11. 00
Decem	per 31 of the cost reporting period	(if calendar year, er	nter O on this line)	,		
	bed NF type inpatient days applicab		Conly (including privat	e room days)	0	12. 00
	gh December 31 of the cost reporting					
	bed NF type inpatient days applicab				0	13. 00
	December 31 of the cost reporting p				0	14.00
	ally necessary private room days app nursery days (title V or XIX only)	officable to the Progra	illi (excruding swing-bed	uays)	0 1, 222	
	ry days (title V or XIX only)					16.00
	BED ADJUSTMENT				U	10.00
	are rate for swing-bed SNF services	applicable to service	es through December 31 o	f the cost	0.00	17. 00
	ing period	арр сар. с то со. т. сс	e in ough becomes of		0.00	17.00
	are rate for swing-bed SNF services	applicable to service	es after December 31 of	the cost	0. 00	18. 00
repor	ing period	• •				
19.00 Medic	nid rate for swing-bed NF services a	applicable to services	through December 31 of	the cost	0.00	19. 00
	ing period					
	id rate for swing-bed NF services a	applicable to services	after December 31 of t	he cost	0. 00	20. 00
1 .	ing period					
	general inpatient routine service of			: (1 :	44, 360, 965	
	bed cost applicable to SNF type ser ne 17)	rvices through Decembe	er 31 of the cost report	ing period (line	0	22. 00
1	bed cost applicable to SNF type ser	wices after December	31 of the cost reportin	a period (line 6	0	23. 00
x lin		vices arter becember	31 of the cost reportin	g period (Title o	U	23.00
4	bed cost applicable to NF type serv	/ices through December	31 of the cost reporti	na period (line	0	24. 00
	ne 19)	sagn bosomber	1. 5. the cost reporti	2011.03 (11110	Ĭ	50
	bed cost applicable to NF type serv	vices after December 3	31 of the cost reporting	period (line 8	0	25. 00
x lin	3.		, ,	,		
	swing-bed cost (see instructions)				0	26. 00
27.00 Gener	al inpatient routine service cost ne	et of swing-bed cost (	(line 21 minus line 26)		44, 360, 965	27.00

4. 00 5. 00	Semi-private room days (excluding swing-bed and observation bed days) Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost	35, 378 0	4. 00 5. 00
6. 00	reporting period Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	0	6. 00
7. 00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7. 00
8. 00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8. 00
9. 00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	5, 603	9. 00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10. 00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11. 00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12. 00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13. 00
14. 00 15. 00 16. 00	Medically necessary private room days applicable to the Program (excluding swing-bed days)  Total nursery days (title V or XIX only)  Nursery days (title V or XIX only)	0 1, 222 0	14. 00 15. 00 16. 00
16.00	SWING BED ADJUSTMENT	0	16.00
17. 00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0. 00	17. 00
18. 00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0. 00	18. 00
19. 00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0. 00	19. 00
20. 00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20. 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 5 x line 17)	44, 360, 965 0	21. 00 22. 00
23. 00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line $7 \times 1$ line 19)	0	24. 00
25. 00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25. 00
26. 00 27. 00	Total swing-bed cost (see instructions)  General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	0 44, 360, 965	26. 00 27. 00
27.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	44, 300, 703	27.00
28. 00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28. 00
	Private room charges (excluding swing-bed charges)	0	29. 00
	Semi-private room charges (excluding swing-bed charges)	0	30.00
31. 00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0. 000000	
	Average private room per diem charge (line 29 ÷ line 3)	0.00	
	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	
34. 00 35. 00	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. 00 0. 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 27 minus line 36)	44, 360, 965	37. 00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38. 00	Adjusted general inpatient routine service cost per diem (see instructions)	1, 253. 91	
	Program general inpatient routine service cost (line 9 x line 38)	7, 025, 658	
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)	7, 025, 658	41. 00

COMPLIA	Financial Systems TATION OF INPATIENT OPERATING COST	FRANCISCAN HEAL	TH LAFAYETTE  Provi der Co	CN: 15-0109	Period:	worksheet D-	
COMPU	ATTON OF THEATTENT OPERATING COST		Frovider Co	SN. 15-0109	From 01/01/2016		
					To 12/31/2016	Date/Time Pro 6/28/2017 3:	
		T		e XIX	Hospi tal	Cost	
	Cost Center Description	Total Inpatient Cost	Total Inpatient Davs	Average Per Diem (col. 1		Program Cost (col. 3 x col.	
		·		col . 2)		4)	
42.00	NURSERY (title V & XIX only)	1. 00 1, 295, 043	2. 00 1, 222	3. 00 1, 059. 7	4. 00 77 0	5. 00	1 42.00
42.00	Intensive Care Type Inpatient Hospital Unit		1, 222	1,037.	0		7 42.00
43.00	INTENSIVE CARE UNIT	8, 190, 057	4, 704	1, 741. (	0 8	(	43.00
44. 00 45. 00	CORONARY CARE UNIT						44. 00 45. 00
46. 00							46.00
47. 00	NEONATAL INTENSIVE CARE UNIT	4, 179, 608	2, 779	1, 504. (	00 0	(	47.00
	Cost Center Description					1.00	
48. 00	Program inpatient ancillary service cost (V	Wkst. D-3, col. 3	, line 200)			9, 255, 793	3 48.00
49. 00	Total Program inpatient costs (sum of lines	s 41 through 48)(	see instructio	ns)		16, 281, 45	1 49. 00
50. 00	PASS THROUGH COST ADJUSTMENTS  Pass through costs applicable to Program in	natient routine	services (from	Wkst D sum	n of Parts I and	Ι (	50.00
00.00			·			· ·	00.00
51. 00	Pass through costs applicable to Program in	npatient ancillar	y services (fr	om Wkst. D, s	sum of Parts II	(	51.00
52. 00	and IV) Total Program excludable cost (sum of lines	s 50 and 51)					52.00
53. 00	Total Program inpatient operating cost excl	uding capital re	lated, non-phy	sician anesth	netist, and		53.00
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	e 52)					
54.00	Program discharges						54.00
	Target amount per discharge						55.00
56. 00 57. 00	,	ating cost and ta	raet amount (1	ine 56 minus	line 53)		56.00
58. 00	Bonus payment (see instructions)	atting cost and ta	rget amount (r	THE 30 III HUS	11110 33)	l .	58.00
59. 00	Lesser of lines 53/54 or 55 from the cost r	reporting period	endi ng 1996, u	pdated and co	ompounded by the	0.00	59.00
60. 00	market basket Lesser of lines 53/54 or 55 from prior year	cost report. up	dated by the m	arket basket		0.00	60.00
61. 00	If line 53/54 is less than the lower of lir	nes 55, 59 or 60	enter the less	er of 50% of			61.00
	which operating costs (line 53) are less the amount (line 56), otherwise enter zero (see		s (lines 54 x	60), or 1% of	the target		
62. 00	Relief payment (see instructions)	e mistructions)					62.00
63. 00	Allowable Inpatient cost plus incentive pay	yment (see instru	ctions)				63.00
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST  Medicare swing-bed SNF inpatient routine co	osts through Dece	mber 31 of the	cost reporti	ng period (See		64.00
	instructions)(title XVIII only)	Ü		•			
65. 00	Medicare swing-bed SNF inpatient routine co instructions)(title XVIII only)	osts after Decemb	er 31 of the c	ost reporting	period (See	(	65. 00
66. 00	Total Medicare swing-bed SNF inpatient rout	tine costs (line	64 plus line 6	5)(title XVII	I only). For		66.00
<b>.</b>	CAH (see instructions)		D 1 04	6.11			
67. 00	Title V or XIX swing-bed NF inpatient routi (line 12 x line 19)	ne costs through	December 31 o	T the cost re	eporting period	(	67. 00
68. 00	Title V or XIX swing-bed NF inpatient routi	ne costs after D	ecember 31 of	the cost repo	orting period		68. 00
69 00	(line 13 x line 20)  Total title V or XLX swing-bed NF inpatient	t routine costs (	line 67 ± line	68)		,	69.00
07.00	PART III - SKILLED NURSING FACILITY, OTHER					\\	27.00
70.00	Skilled nursing facility/other nursing faci	,		, ,	1		70.00
71. 00 72. 00	Adjusted general inpatient routine service Program routine service cost (line 9 x line		rne 70 ÷ rrne	2)			71. 00
73. 00	Medically necessary private room cost appli	cable to Program		ne 35)			73. 00
74. 00 75. 00	Total Program general inpatient routine ser			orkshoot P [	Part II column		74. 00 75. 00
75.00	Capital-related cost allocated to inpatient 26, line 45)	i Toutine service	COSTS (110III W	OLKSHEEL B, F	rait II, Corumn		75.00
76. 00	Per diem capital-related costs (line 75 ÷ l						76. 00
77. 00 78. 00	Program capital-related costs (line 9 x lir Inpatient routine service cost (line 74 mir						77. 00 78. 00
79. 00	Aggregate charges to beneficiaries for exce	,	rovi der record	s)			79.00
	Total Program routine service costs for com	•	ost limitation	(line 78 mir	nus line 79)		80.00
81. 00 82. 00	Inpatient routine service cost per diem lin Inpatient routine service cost limitation (		)				81. 00 82. 00
83. 00	Reasonable inpatient routine service costs	* .	•				83. 00
84.00	Program inpatient ancillary services (see i		na)				84.00
85. 00 86. 00	Utilization review - physician compensation Total Program inpatient operating costs (su						85. 00 86. 00
	PART IV - COMPUTATION OF OBSERVATION BED PA					'	1 -3.00
							_
87. 00 88. 00	Total observation bed days (see instruction	ns)	line 2)				87. 00 88. 00

Health Financial Systems	FRANCI SCAN HEAL	TH LAFAYETTE		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
				From 01/01/2016 To 12/31/2016		
		Ti tl	e XIX	Hospi tal	Cost	
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 THROUGH	COST					
90.00 Capital-related cost	6, 305, 983	44, 360, 965	0. 14215	2 0	0	90.00
91.00 Nursing School cost	0	44, 360, 965	0.00000	0	0	91.00
92.00 Allied health cost	0	44, 360, 965	0.00000	0	0	92.00
93.00 All other Medical Education	0	44, 360, 965	0. 00000	0 0	0	93. 00

Health Financial Systems	FRANCISCAN HEALTH LAFAYETTE	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0109	Peri od: From 01/01/2016	Worksheet D-1
	Component CCN: 15-T109		
	Title XIX	Subprovi der -	Cost

PART L. ALL REQUERE CONCINENTS   1.00				I RF		
NeXT   1 - ALL PROVIDER CORPOWERS   1 - ALL PROVIDE		Cost Center Description			1 00	
IMPARTIENT DAYS		PART I - ALL PROVIDER COMPONENTS			1.00	
Impattent days (including private room days, excluding saring-bed and nebborn days)   1,000   2,000						
Private room days (excluding swing-bed and observation bed days). If you have only private room days, do do not complete this line.  4.00 Somi-private room days (excluding swing-bed and observation bed days).  5.00 Total swing-bed SW type inpatient days. (including private room days) after December 31 of the cost private room days and pated SW type inpatient days. (including private room days) after December 31 of the cost proporting period (if cale andary year, enter 0 on this line).  1.00 Total swing-bed NF type inpatient days. (including private room days) after December 31 of the cost proporting period (if cale andary year, enter 0 on this line).  1.00 Total swing-bed NF type inpatient days. (including private room days) after December 31 of the cost proporting period (if cale andary year, enter 0 on this line).  1.00 Swing-bed SW type inpatient days (including private room days) after December 31 of the cost proporting period (if cale andary year, enter 0 on this line).  1.00 Swing-bed SW type inpatient days applicable to the Program (excluding private room days) after December 31 of the cost reporting period (if cale andary year, enter 0 on this line).  1.00 Swing-bed SW type inpatient days applicable to trie trie XVIII only (including private room days) after December 31 of the cost reporting period (if cale andary year, enter 0 on this line).  1.00 Swing-bed SW type inpatient days applicable to trie VXVIII only (including private room days) after December 31 of the cost reporting period (if cale andary year, enter 0 on this line).  1.00 Swing-bed SW type inpatient days applicable to trie XVIII only (including private room days) after December 31 of the cost reporting period (including private room days).  1.00 Swing-bed SW type inpatient days applicable to trie XVIII only (including private room days).  1.00 Wed call year cost and year	1.00				3, 002	1. 00
do not complete this line.  4. 00 Semi-private room days (excluding swing-bed and observation bed days) through December 31 of the cost  7. 00 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost  8. 00 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost  9. 00 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost  9. 00 Total sing-bed SNF type inpatient days (including private room days) after December 31 of the cost  9. 00 Total sing-bed SNF type inpatient days (including private room days) after December 31 of the cost  10 Total sing-bed SNF type inpatient days (including private room days) after December 31 of the cost  10 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)  10 Sing-bed SNF type inpatient days applicable to the Program (excluding private room days)  11 Total inpatient days applicable to 11 the XNIII only (including private room days)  12 Sing-bed SNF type inpatient days applicable to 11 the XNIII only (including private room days)  13 Sing-bed SNF type inpatient days applicable to 11 the XNIII only (including private room days)  14 Total SNF type of NT type inpatient days applicable to 11 the XNIII only (including private room days)  15 SNF type of NT type inpatient days applicable to 11 the XNIII only (including private room days)  16 Total snF type inpatient days applicable to 11 the XNIII only (including private room days)  17 Total snF type inpatient days applicable to 11 the XNIII only (including private room days)  18 Total SNF type inpatient days applicable to 11 the XNIII only (including private room days)  19 Total snF type inpatient days applicable to 11 the XNIII only (including private room days)  19 Total snF type inpatient days applicable to 11 the XNIII only (including private room days)  19 Total snF type inpatient days applicable to 11 the XNIII only (including private room						
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Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period of 17.00 reporting period (if calendar year, enter 0 on this line)  7.00 reporting period (if calendar year, enter 0 on this line)  8.01 total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  8.02 total inpatient days including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  9.02 total inpatient days including private room days of period days (and the period of the cost reporting period (if calendar year, enter 0 on this line)  10.03 sing-bed SNF type inpatient days applicable to the Program (excluding swing-bed and period (if calendar year, enter 0 on this line)  11.00 Sking-bed SNF type inpatient days applicable to the Program (excluding swing-bed and period (if calendar year, enter 0 on this line)  12.00 Sking-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)  13.00 Sking-bed SNF type inpatient days applicable to titles V or XIX only (including private room days)  13.00 Sking-bed SNF type inpatient days applicable to titles V or XIX only (including private room days)  14.00 Sking-bed SNF type inpatient days applicable to the Program (excluding sking bed days)  15.00 Sking-bed SNF type inpatient days applicable to the Program (excluding sking bed days)  16.00 Number of the cost reporting period (if calendar year, enter 0 on this line)  17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost cost period reporting period (if calendar year, enter 0 on this line)  18.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost cost period (line 8 on the program (excluding swing-bed cost applicable to SNF type services through Dece	4 00		ed days)		3 002	4 00
Total sairing-bed SNF type Inpatient days (Including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)   Total sairing-bed NF type inpatient days (Including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)   Total sairing-bed NF type inpatient days (Including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)   Total Inpatient days including private room days)   Total Inpatient days including period (if calendar year, enter 0 on this line)   Total Inpatient days including period (if calendar year, enter 0 on this line)   Total Year of the cost reporting period (if calendar year, enter 0 on this line)   Total Year of the cost reporting period (if calendar year, enter 0 on this line)   Total Year of Year of Year of Year On Ye				31 of the cost		
reporting period (if Calendar year, enter 0 on this line) 7.00 Total saving-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period (if Calendar year, enter 0 on this line) 8.00 Total saving-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if Calendar year, enter 0 on this line) 9.00 North of the cost of th				_		
Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period   Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)   249	6. 00		om days) after December 31	of the cost	0	6. 00
reporting period   8.00   Total sing-bed NF type inpatient days (including private room days) after December 31 of the cost   9.00   Total inpatient days (including private room days) applicable to the Program (excluding swing-bed and newborn days)   10.00   Swing-bed SNMF type Inpatient days applicable to title XVIII only (including private room days)   10.00   Swing-bed SNMF type Inpatient days applicable to title XVIII only (including private room days)   11.00	7 00		n days) through December 3	R1 of the cost	0	7 00
reporting period (if calendar year, enter 0 on this line)  10. 00 Swing-bed SMF type inpatient days applicable to the Program (excluding swing-bed and newborn days)  10. 00 Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days)  11. 00 Seven bed SMF type inpatient days applicable to title XVIII only (including private room days) after through December 31 of the cost reporting period (see instructions) through December 31 of the cost reporting period (see instructions) through December 31 of the cost reporting period (see instructions) through December 31 of the cost reporting period (see instructions) through December 31 of the cost reporting period (see instructions) through December 31 of the cost reporting period (see instructions) through December 31 of the cost reporting period (see instructions) through December 31 of the cost reporting period (see instructions) through December 31 of the cost reporting period (if calendar year, enter 0 on this line) through December 31 of the cost reporting period (if calendar year, enter 0 on this line) through December 31 of the cost reporting period (if calendar year, enter 0 on this line) through December 31 of the cost reporting period (see instructions) through December 31 of the cost reporting period (line of the seed	7.00		radys) in odgr becember e	or the cost	G	7.00
10.00   Swing-bed SRF type inpatient days applicable to title XVIII only (including private room days)   0.00	8.00		days) after December 31	of the cost	0	8. 00
newborn days	0.00				0.40	0.00
10.00   Swing-bed SMF type inpatrient days applicable to title XVIII only (including private room days)   10.00   through December 31 of the cost reporting period (See instructions)   11.00   Swing-bed SMF type inpatrient days applicable to ittle XVIII only (including private room days) after   12.00   Swing-bed SMF type inpatrient days applicable to ittle XVIII only (including private room days)   0   12.00   through December 31 of the cost reporting period (if calendar year, enter 0 on this line)   13.00   Swing-bed NF type inpatrient days applicable to ittles V or XIX only (including private room days)   0   14.00   14.00   15.00   Total nursery days (ittle V or XIX only)   12.22   15.00   15.00   Total nursery days (ittle V or XIX only)   14.00   16.00   Nursery days (ittle V or XIX only)   17.00   16.00   Nursery days (ittle V or XIX only)   17.00   17.00   Nursery days (ittle V or XIX only)   17.00   18.00   Nursery days (ittle V or XIX only)   17.00   18.00   Nursery days (ittle V or XIX only)   17.00   18.00   Nursery days (ittle V or XIX only)   18.00   Nursery days (ittle	9.00		the Program (excluding s	swing-bed and	249	9.00
through December 31 of the cost reporting period (see instructions)  1.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this Iline)  1.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  1.10 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  1.11 Ostation of the cost reporting period (if calendar year, enter 0 on this Iline)  3.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  3.12 Ostation of the cost reporting period (if calendar year, enter 0 on this Iline)  3.12 Ostation of the cost reporting period (if calendar year, enter 0 on this Iline)  4.14 Okadicall yn eccassary private room days applicable to the Program (excluding swing-bed days)  4.15 Okadicall yn eccassary private room days applicable to the Program (excluding swing-bed days)  5.16 Okadicall yn eccassary private room days applicable to services through December 31 of the cost  6.17 Okadicare rate for swing-bed SNF services applicable to services after December 31 of the cost  7.17 Okadicare rate for swing-bed NF services applicable to services after December 31 of the cost  8.18 Okadicare rate for swing-bed NF services applicable to services after December 31 of the cost  9.18 Okadicald rate for swing-bed NF services applicable to services after December 31 of the cost  9.18 Okadicald rate for swing-bed NF services applicable to services after December 31 of the cost  9.19 Okadicald rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (line 6 okadicald rate for swing-bed NF services after December 31 of the cost reporting period (line 6 okadicald rate for swing-bed oct applicable to SNF type services after December 31 of the cost reporting period (line 6 okadicald rate for swing-bed cost applicable to SNF type services after De	10. 00		nly (including private roo	om days)	0	10. 00
December 31 of the cost reporting period (if calendar year, enter 0 on this line)   0   12.00						
12.00   Swing-bed NF type inpatient days applicable to titles \( V or XIX only \( (including private room days) \)	11. 00			om days) after	0	11. 00
through December 31 of the cost reporting period  13. 00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  14. 00 Medically necessary private room days applicable to the Program (excluding swing-bed days)  15. 00 Total nursery days (title V or XIX only)  16. 00 Nursery days (title V or XIX only)  17. 00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost  18. 00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost  19. 00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost  19. 00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost  19. 00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost  19. 00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost  19. 00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost  19. 00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost  19. 00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost  19. 00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost  19. 00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost reporting period (line 5 x line 17)  20. 00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 6 x line 18)  21. 10 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 19)  22. 00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 29)  23. 00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 29)  24. 00 Swing-bed cost applicable to NF type services after Decemb	12 00			room days)	0	12 00
after December'31 of the cost reporting period (if calendar year, enter 0 on this line)   14.00   Motically necessary private room days applicable to the Program (excluding swing-bed days)   0   14.00   15.00   16.00   1	12.00		comy (Therearing private	room days)	G	12.00
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   10.00     16.00   Nursery days (title V or XIX only)   0   10.00     17.00   Nursery days (title V or XIX only)   17.00     18.00   Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost   0.00     18.00   Repair of the cost   0.00   17.00     19.00   Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost   0.00     19.00   Medicare rate for swing-bed NF services applicable to services through December 31 of the cost   0.00     19.00   Reporting period   0.00     19.00   Redicare rate for swing-bed NF services applicable to services after December 31 of the cost   0.00     19.00   Redicare rate for swing-bed NF services applicable to services after December 31 of the cost   0.00     19.00   Redicare rate for swing-bed NF services applicable to services after December 31 of the cost   0.00     19.00   Redicare rate for swing-bed NF services applicable to services after December 31 of the cost   0.00     19.00   Redicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (line   0.00     19.00   Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line   0.00     19.00   Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line   0.00     19.00   Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line   0.00     19.00   Total swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line   0.00     19.00   Redicare rate for swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line   0.00     19.00   Redicare rate for swing-bed cost applicable to RF type services after December 31 of the cost reporting period (line   0	13.00				0	13. 00
15.00   Total nursery days (title V or XIX only)   0   16.00	44.00	after December 31 of the cost reporting period (if calendar ye	ear, enter 0 on this line)	,		44.00
16.00   Nursery days (title V or XIX only)   16.00   16.00   Nirsery days (title V or XIX only)   17.00   17.00   18.00   18.00   18.00   18.00   18.00   18.00   19			im (excluding swing-bed da	ays)	-	
SWING BED ADJUSTMENT  1. 00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period reporting reporting reporting reporting period reporting period reporting reporting reporting period reporting period reporting re		1 3,				
reporting period  18. 00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period reporting period wedicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period wedicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period reporting period wedicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period reporting peri						
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33.00 Average semi-private room per diem charge (line 30 ÷ line 4)  34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 365, 843)  27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost (line 9 x line 38)  Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		,	line 28)			
34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 365, 843)  PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost (line 9 x line 38)  Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0						
35. 00 Average per diem private room cost differential (line 34 x line 31)  36. 00 Private room cost differential adjustment (line 3 x line 35)  37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 365, 843)  PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38. 00 Adjusted general inpatient routine service cost per diem (see instructions)  Program general inpatient routine service cost (line 9 x line 38)  40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 . 00 35. 00  36. 00 36. 00  37. 00 10 10 10 10 10 10 10 10 10 10 10 10			nus line 33)(see instructi	ons)		
36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 365, 843 37.00 27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 36.00  37.00 In the service cost (line 3 x line 35)  0 36.00 In the service cost differential (line 3, 365, 843 and 37.00 and 3		, , , , , , , , , , , , , , , , , , , ,	, ,	0113)		
27 minus line 36) PART II - HOSPI TAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  39.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00		, , ,	,			
PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  1, 121.20 38.00  39.00 Program general inpatient routine service cost (line 9 x line 38)  279, 179 39.00  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00	37. 00		and private room cost diff	erential (line	3, 365, 843	37. 00
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  39.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  38.00 279, 179 39.00  40.00		2/ minus line 36)				
38.00 Adjusted general inpatient routine service cost per diem (see instructions)  1, 121.20 38.00  39.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00			STMENTS			
39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 279, 179 39.00 40.00	38. 00				1, 121. 20	38. 00
		Program general inpatient routine service cost (line 9 x line	38)		279, 179	
41.00   Total Program general inpatient routine service cost (line 39 + line 40)   279, 179   41.00		, , , , , , , , , , , , , , , , , , , ,	•		-	
	41.00	Tiotal Program general impatient routine service cost (line 39	+ ITHE 40)	ı	2/9, 1/9	41.00

		FRANCISCAN HEALTH				eu of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST		Provider CCN	F	Period: From 01/01/2016		
			Component CC		To 12/31/2016	6/28/2017 3:3	
			Title		Subprovi der - I RF	Cost	
	Cost Center Description	Total Inpatient Cost In		Average Per iem (col. 1 = col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
42.00	NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00	5. 00	42. 00
42.00	Intensive Care Type Inpatient Hospital Units		<u> </u>	0.00	<u> </u>		42.00
43. 00 44. 00	INTENSIVE CARE UNIT CORONARY CARE UNIT	0	0	0.00	0	0	43. 00 44. 00
45. 00	BURN INTENSIVE CARE UNIT						45. 00
46. 00 47. 00	SURGICAL INTENSIVE CARE UNIT NEONATAL INTENSIVE CARE UNIT	0	0	0. 00	0	0	46. 00 47. 00
47.00	Cost Center Description	<u> </u>	<u> </u>	0.00	,		47.00
48. 00	Program inpatient ancillary service cost (Wk	st D-3 col 3	line 200)			1. 00 148, 494	48. 00
49. 00	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS			s)		427, 673	
50. 00	Pass through costs applicable to Program inp	atient routine se	ervices (from N	Wkst. D, sum	of Parts I and	0	50. 00
51. 00	Pass through costs applicable to Program inp and IV)	atient ancillary	services (from	m Wkst. D, su	um of Parts II	0	51. 00
52. 00 53. 00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu		ited non-physi	cian anostho	atist and	0	52. 00 53. 00
33.00	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION		Trea, Horr-priysi	Crair anestrie	etist, and	0	33.00
54. 00 55. 00	Program discharges Target amount per discharge					0.00	
56. 00	Target amount (line 54 x line 55)					0.00	56. 00
57. 00 58. 00	Difference between adjusted inpatient operat Bonus payment (see instructions)	ing cost and targ	et amount (lir	ne 56 minus I	ine 53)	0	57. 00 58. 00
59. 00	Lesser of lines 53/54 or 55 from the cost re	porting period er	idi ng 1996, upo	dated and com	npounded by the		
60. 00	market basket Lesser of lines 53/54 or 55 from prior year	cost roport unds	tod by the may	rkat baskat		0.00	60. 00
61. 00	If line 53/54 is less than the lower of line which operating costs (line 53) are less than	s 55, 59 or 60 er	iter the Lessei	r of 50% of t		0.00	61. 00
62. 00	amount (line 56), otherwise enter zero (see Relief payment (see instructions)	instructions)				0	62. 00
	Allowable Inpatient cost plus incentive paym	ent (see instruct	i ons)			0	
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts through Decemb	er 31 of the o	cost reportir	ng period (See	0	64. 00
65. 00	Medicare swing-bed SNF inpatient routine cos	ts after December	31 of the cos	st reporting	period (See	0	65. 00
66. 00	<pre>instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi</pre>	ne costs (line 64	plus line 65`	)(title XVIII	only). For	0	66. 00
	CAH (see instructions) Title V or XIX swing-bed NF inpatient routing				•	0	
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)	e costs after Dec	ember 31 of th	ne cost repor	ting period	0	68. 00
69. 00	Total title V or XIX swing-bed NF inpatient					0	69. 00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER NU Skilled nursing facility/other nursing facil						70. 00
71. 00	Adjusted general inpatient routine service c	ost per diem (lir					71. 00
72. 00 73. 00	Program routine service cost (line 9 x line Medically necessary private room cost applications)	•	line 14 x line	- 35)			72. 00 73. 00
74. 00	Total Program general inpatient routine serv			3 00)			74. 00
75. 00	Capital-related cost allocated to inpatient 26, line 45)	routine service c	osts (from Wor	rksheet B, Pa	art II, column		75. 00
76. 00	Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line						76. 00 77. 00
78. 00	Inpatient routine service cost (line 74 minu						78. 00
79. 00 80. 00	Aggregate charges to beneficiaries for exces Total Program routine service costs for comp.				ıs line 70)		79. 00 80. 00
81. 00	Inpatient routine service cost per diem limi		te i i i ii i ta ti oii i	(11116 76 1111116	13 11110 77)		81.00
82. 00 83. 00	Inpatient routine service cost limitation (I Reasonable inpatient routine service costs (	* .					82. 00 83. 00
84. 00	Program inpatient ancillary services (see in	structions)					84. 00
85. 00 86. 00	Utilization review - physician compensation Total Program inpatient operating costs (sum						85. 00 86. 00
	PART IV - COMPUTATION OF OBSERVATION BED PASS	S THROUGH COST	gii 00 <i>)</i>			I	
87. 00 88. 00	Total observation bed days (see instructions Adjusted general inpatient routine cost per	•	ine 2)			0.00	87. 00 88. 00
	Observation bed cost (line 87 x line 88) (se	•	- 7				89. 00

Health Financial Systems	FRANCISCAN HEAL	TH LAFAYETTE		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2016		
		Component (	CN: 15-1109	To 12/31/2016	Date/Time Prep 6/28/2017 3:30	
		Ti +I	e XIX	Subprovi der -	Cost	o piii
		11 61	C XIX	IRF	0031	
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	633, 562	3, 365, 843	0. 18823	3 0	0	90. 00
91.00 Nursing School cost	0	3, 365, 843	0.00000	0	0	91. 00
92.00 Allied health cost	0	3, 365, 843	0.00000	0	ol	92. 00
93.00 All other Medical Education	0	3, 365, 843	0.00000	0	0	93. 00

Health Financial Systems FRANCISCAN HEALT INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 1E 0100	In Lie Period:	u of Form CMS-2 Worksheet D-3	
INPATIENT ANGILLARY SERVICE COST APPORTIONMENT	Provider C		From 01/01/2016	worksneet D-3	
			To 12/31/2016	Date/Time Pre	pared:
	Title	xVIII	Hospi tal	6/28/2017 3: 3 PPS	о рііі
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1.00	2. 00	3. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS					
30. 00   03000   ADULTS & PEDI ATRI CS			32, 123, 950		30. 00
31. 00 03100 INTENSIVE CARE UNIT			8, 961, 779		31. 00
35.00 02060 NEONATAL INTENSIVE CARE UNIT			0		35. 00
40. 00   04000   SUBPROVI DER - 1 PF			0		40. 00
41. 00   04100   SUBPROVI DER - 1 RF			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. 17490	9 35, 773, 885	6, 257, 174	50.00
51. 00   05100   RECOVERY ROOM		0. 17490		349.007	
52. 00   05200   DELIVERY ROOM & LABOR ROOM		0. 12913			
54. 00   05400   RADI OLOGY-DI AGNOSTI C		0. 20369		1, 674, 583	
55. 00   03630   RADI OLOGY-THERAPEUTI C		0. 20307		99, 830	
56. 00   05600   RADI OI SOTOPE		0. 00000		0	56.00
56. 01   03950   CARDI AC   CATH   LAB		0. 11423			1
57. 00   05700 CT SCAN		0. 03494		305, 391	57.00
58. 00   05800   MRI		0. 05753		165, 307	58.00
60. 00   06000   LABORATORY		0. 11571		2, 901, 214	
65. 00 06500 RESPIRATORY THERAPY		0. 38116			
66. 00   06600   PHYSI CAL THERAPY		0. 42813			
67. 00 06700 OCCUPATI ONAL THERAPY		0. 28804		181, 807	67. 00
68. 00   06800   SPEECH PATHOLOGY		0. 48051		148, 732	
69. 00 06900 ELECTROCARDI OLOGY		0. 14727		737, 880	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 29856	392, 797	117, 276	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 16773	30, 248, 845	5, 073, 790	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 20189	38, 375, 031	7, 747, 573	72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 17623	32, 408, 550	5, 711, 650	73.00
73. 01   07301   DI ABETES CENTER		2. 25681	4 0	0	73. 01
74. 00   07400   RENAL DI ALYSI S		0. 47636	1, 317, 497	627, 609	74.00
76. 98 07698 HYPERBARI C OXYGEN THERAPY		0. 27370	95 8, 174	2, 237	76. 98
OUTPATIENT SERVICE COST CENTERS		1			
88. 00   08800   RURAL HEALTH CLINIC		0.00000		0	88. 00
89. 00   08900   FEDERALLY QUALIFIED HEALTH CENTER		0.00000		0	89. 00
90. 00   09000   CLI NI C		1. 30649		0	90.00
91. 00   09100   EMERGENCY		0. 23295			
91. 01   04950   WOUND CARE		0. 47897		0	91.01

0.000000

0. 291541

704, 975

215, 129, 854 215, 129, 854 92.00

92.01

95.00

205, 529

37, 706, 408 200. 00 201. 00 202. 00

92.00

92. 01

200. 00 201. 00

202.00

09200 OBSERVATION BEDS (NON-DISTINCT PART 09201 OBSERVATION BEDS (DISTINCT PART) OTHER REIMBURSABLE COST CENTERS

Total (sum of lines 50-94 and 96-98)
Less PBP Clinic Laboratory Services-Program only charges (line 61)
Net Charges (line 200 minus line 201)

95. 00 09500 AMBULANCE SERVICES

C					3
	Component (	CCN: 15-T109	From 01/01/2016 To 12/31/2016		
	Title	XVIII	Subprovi der - I RF	PPS	
Cost Center Description		Ratio of Cos		I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
		1.00	2. 00	2) 3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
D. OO O3000 ADULTS & PEDI ATRI CS			0		30.
1.00 03100 INTENSIVE CARE UNIT			0		31.
5.00 02060 NEONATAL INTENSIVE CARE UNIT			0		35.
0. 00   04000   SUBPROVI DER - 1 PF			0		40.
1. 00   04100   SUBPROVI DER - 1 RF			2, 618, 730		41.
2. 00   04200   SUBPROVI DER			0		42.
3. 00 04300 NURSERY					43.
ANCILLARY SERVICE COST CENTERS					4
0.00   05000   OPERATI NG ROOM		0. 17490		-	1
1. 00 05100 RECOVERY ROOM		0. 12915		1	1
2.00 05200 DELIVERY ROOM & LABOR ROOM		0. 34017		-	
4. 00   05400   RADI OLOGY-DI AGNOSTI C		0. 20369	· ·	9, 559	
5. 00 03630 RADI OLOGY-THERAPEUTI C		0. 10147			
5. 00   05600   RADI 0I SOTOPE		0.00000			
5. 01   03950   CARDI AC CATH LAB		0. 11423		0	1
7. 00   05700   CT SCAN		0. 03494			
3. 00  05800 MRI 0. 00  06000 LABORATORY		0.05753	· ·	954	
D. 00   06000  LABORATORY 5. 00   06500  RESPI RATORY THERAPY		0. 11571 0. 3811 <i>6</i>			
6. 00   06600   PHYSI CAL THERAPY		0. 42813			
7. 00   06700   OCCUPATI ONAL THERAPY		0. 28804		1	
3. 00   06800   SPEECH PATHOLOGY		0. 48051			
P. 00 06900 ELECTROCARDI OLOGY		0. 14727		2, 590	
D. 00 07000 ELECTROENCEPHALOGRAPHY		0. 29856			
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 16773			
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 20189	· ·	627	1
3.00 07300 DRUGS CHARGED TO PATIENTS		0. 17623		94, 676	73.
3. 01   07301   DI ABETES CENTER		2. 25681		0	73.
4. 00   07400   RENAL DIALYSIS		0. 47636	47, 758	22, 750	74.
5. 98 07698 HYPERBARI C OXYGEN THERAPY		0. 27370	05 0	0	76.
OUTPATIENT SERVICE COST CENTERS					
3. 00 08800 RURAL HEALTH CLINIC		0. 00000		0	
P. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER		0. 00000		0	
0. 00   09000   CLI NI C		1. 30649		0	
1. 00   09100   EMERGENCY		0. 23295	· ·	2, 045	
I. 01   04950   WOUND CARE		0. 47897		0	
2. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0.00000		0	1
2. 01 O9201 OBSERVATION BEDS (DISTINCT PART)		0. 29154	11 14, 611	4, 260	92.
OTHER REIMBURSABLE COST CENTERS					4
5. 00 09500 AMBULANCE SERVICES			0.005.710	4 450 (53	95.
00.00 Total (sum of lines 50-94 and 96-98)	(1)		3, 935, 748	1, 150, 657	
D1.00 Less PBP Clinic Laboratory Services-Program only charges (D2.00 Net Charges (line 200 minus line 201)	(iine 61)		3, 935, 748		201. 202.

Heal th Financial Systems FRANCISI INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	CAN HEALTH LAFAYETTE Provi der CO	CN: 15-0109	Peri od:	u of Form CMS-2 Worksheet D-3	
THE ATTEM AND LEAR SERVICE COST ATTORTIONWENT	Trovider co		From 01/01/2016	Worksheet D-3	
			To 12/31/2016		
	Ti +I	e XIX	Hospi tal	6/28/2017 3:3 Cost	6 pm
Cost Center Description	11 (1	Ratio of Cos		Inpati ent	
cost deliter bescription		To Charges	Program	Program Costs	
		i onar goo	Charges	(col. 1 x col.	
			3	2)	
		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS			22, 116, 638		30.00
31. 00   03100   I NTENSI VE CARE UNI T			3, 120, 766		31.00
35. 00   02060   NEONATAL   NTENSIVE CARE UNIT			8, 838, 908		35. 00
40. 00   04000   SUBPROVI DER - I PF			0		40.00
41. 00   04100   SUBPROVI DER - I RF			0		41.00
42. 00   04200   SUBPROVI DER			0		42. 00
43. 00 04300 NURSERY			0		43. 00
ANCILLARY SERVICE COST CENTERS					
50. 00   05000   OPERATI NG ROOM		0. 17490		1, 193, 401	50.00
51. 00   05100   RECOVERY ROOM		0. 12915	500, 958	64, 701	51.00
52.00   05200   DELIVERY ROOM & LABOR ROOM		0. 34017	75 0	0	52. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C		0. 20356		359, 375	
55. 00 03630 RADI OLOGY-THERAPEUTI C		0. 10147	•	29, 572	
56. 00   05600   RADI 0I SOTOPE		0. 00000		0	56. 00
56. 01 03950 CARDI AC CATH LAB		0. 11423		155, 192	1
57. 00   05700   CT   SCAN		0. 03494		94, 910	
58. 00   05800   MRI		0. 05753		50, 779	
60. 00   06000   LABORATORY		0. 11568		1, 004, 140	
65. 00 06500 RESPI RATORY THERAPY		0. 37987		692, 055	1
66. 00   06600   PHYSI CAL THERAPY		0. 42813		266, 716	1
67. 00 06700 OCCUPATI ONAL THERAPY		0. 28804		412, 275	
68. 00 06800 SPEECH PATHOLOGY		0. 48051		50, 666	
69. 00 06900 ELECTROCARDI OLOGY		0. 14727		154, 939	
70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 29856		59, 819	1
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 16773			
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 20189		997, 897	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 17623		2, 047, 299	
73. 01   07301   DI ABETES CENTER		2. 23301		717	73. 01
74. 00   07400   RENAL DI ALYSI S		0. 47636		34, 984	
76. 98 07698 HYPERBARI C OXYGEN THERAPY		0. 27370	05 0	0	76. 98
OUTPATIENT SERVICE COST CENTERS					
88. 00 08800 RURAL HEALTH CLINIC		0.00000		0	00.00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER		0.00000		0	07.00
90. 00   09000   CLI NI C		1. 30649		0	70.00
91. 00   09100   EMERGENCY		0. 23295		384, 760	1
OT OT TOAUSOUNOUND CARE		l ∩ //7201		Λ	

0. 478912

0.000000

0. 291541

84, 867

53, 637, 669

53, 637, 669

0 91.01

92.00

92.01

95.00

201. 00

24, 742

9, 255, 793 200. 00

91. 01 | 04950 | WOUND CARE

95. 00 09500 AMBULANCE SERVICES

92.00

92. 01

200.00

201.00

202.00

09200 OBSERVATION BEDS (NON-DISTINCT PART 09201 OBSERVATION BEDS (DISTINCT PART) OTHER REIMBURSABLE COST CENTERS

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)

		CN: 15-0109	Peri From	01/01/2016		
Co	mponent (	CCN: 15-T109	То	12/31/2016	Date/Time Pre 6/28/2017 3:3	
	Ti tl	e XIX	Sub	provi der - I RF	Cost	
Cost Center Description		Ratio of Cos		I npati ent	Inpati ent	
		To Charges	•	Program	Program Costs (col. 1 x col.	
				Charges	2)	
		1.00		2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						4
00 03000 ADULTS & PEDI ATRI CS				0		30
. 00   03100   I NTENSI VE CARE UNI T				0		31
.00   02060   NEONATAL INTENSIVE CARE UNIT .00   04000   SUBPROVIDER - IPF				0		35 40
.00   04100   SUBPROVI DER - 1 PF				321, 458		41
00   04200   SUBPROVI DER				321, 430		42
00   04300   NURSERY				0		43
ANCI LLARY SERVI CE COST CENTERS						1
. 00 O5000 OPERATING ROOM		0. 1749	09	7, 294	1, 276	50
00 05100 RECOVERY ROOM		0. 1291	55	668	86	51
.00 05200 DELIVERY ROOM & LABOR ROOM		0. 3401	75	0	0	52
. 00   05400   RADI OLOGY-DI AGNOSTI C		0. 2035	60	2, 443	497	54
. 00   03630   RADI OLOGY-THERAPEUTI C		0. 1014	78	0	0	55
. 00   05600   RADI 0I SOTOPE		0. 0000		0	1	1 -
. 01  03950  CARDI AC CATH LAB		0. 1142		0	0	1
. 00   05700   CT   SCAN		0. 0349		6, 514	228	
00   05800   MRI		0.0575		0	0	
00 06000 LABORATORY		0. 1156		60, 606		
. 00   06500   RESPI RATORY THERAPY . 00   06600   PHYSI CAL THERAPY		0. 3798 0. 4281		47, 824	18, 167	
.00   06700   OCCUPATI ONAL THERAPY		0. 4281		101, 414 124, 139	43, 419 35, 757	
00   06800   SPEECH PATHOLOGY		0. 2880		39, 508		
00 06900 ELECTROCARDI OLOGY		0. 4803		2, 193		
00 07000 ELECTROENCEPHALOGRAPHY		0. 2985		558		
.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 1677		15, 886		
00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 2018	91	98, 639	19, 914	72
.00 07300 DRUGS CHARGED TO PATIENTS		0. 1762	39	0	0	73
. 01   07301   DI ABETES CENTER		2. 2330	12	0	0	73
00 07400 RENAL DIALYSIS		0. 4763		0		1 '
. 98 O7698 HYPERBARI C OXYGEN THERAPY		0. 2737	05	0	0	76
OUTPATIENT SERVICE COST CENTERS			0.0			١
.00   08800   RURAL HEALTH CLINIC		0.0000		0		
.00   08900   FEDERALLY QUALIFIED HEALTH CENTER .00   09000   CLINIC		0.0000		0	_	
. 00   09000  CLINI C . 00   09100  EMERGENCY		1. 3064 0. 2329		0	-	1
.01   04950   WOUND CARE		0. 2329		0		
.00   09200   0BSERVATI ON BEDS (NON-DI STI NCT PART		0.4789		0		
.01   09201   0BSERVATI ON BEDS (DI STI NCT PART)		0.0000		0		
OTHER REIMBURSABLE COST CENTERS		0.2713		0	0	1 ′′
. 00 O9500 AMBULANCE SERVICES						95
0.00 Total (sum of lines 50-94 and 96-98)				507, 686	148, 494	
1.00 Less PBP Clinic Laboratory Services-Program only charges (I	ine 61)			0		201
2.00 Net Charges (line 200 minus line 201)				507, 686	1	202

Health Financial Systems	FRANCISCAN HEALTH LAFAYETTE		In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CC	CN: 15-0109	From 01/01/2016	Worksheet E Part A Date/Time Prepared: 6/28/2017 3:36 pm

		Title XVIII	Hospi tal	6/28/2017 3: 30 PPS	5 pm
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS			1. 00	
1.00	DRG Amounts Other than Outlier Payments			0	1. 00
1. 01	DRG amounts other than outlier payments for discharges occurring plinstructions)	orior to October 1 (s	see	32, 005, 195	1. 01
1. 02	DRG amounts other than outlier payments for discharges occurring (instructions)	on or after October 1	l (see	9, 697, 456	1. 02
1.03	DRG for federal specific operating payment for Model 4 BPCI for di 1 (see instructions)	scharges occurring p	orior to October	0	1. 03
1. 04	DRG for federal specific operating payment for Model 4 BPCI for di October 1 (see instructions)	scharges occurring o	on or after	0	1. 04
2. 00 2. 01	Outlier payments for discharges. (see instructions) Outlier reconciliation amount			2, 096, 060 0	2. 00 2. 01
2. 01	Outlier payment for discharges for Model 4 BPCI (see instructions)	)		0	2. 01
3. 00	Managed Care Simulated Payments			Ö	3. 00
4.00	Bed days available divided by number of days in the cost reporting Indirect Medical Education Adjustment	g period (see instruc	ctions)	169. 00	4. 00
5. 00	FTE count for allopathic and osteopathic programs for the most record before 12/31/1996. (see instructions)	cent cost reporting p	period ending on	0.00	5. 00
6.00	FTE count for allopathic and osteopathic programs which meet the of for new programs in accordance with 42 CFR 413.79(e)	criteria for an add-d	on to the cap	0. 00	6. 00
7.00	MMA Section 422 reduction amount to the IME cap as specified under	42 CFR §412.105(f)	(1) (i v) (B) (1)	0.00	7. 00
7. 01	ACA Section 5503 reduction amount to the IME cap as specified under If the cost report straddles July 1, 2011 then see instructions.	er 42 CFR §412.105(f)	(1)(iv)(B)(2)	0. 00	7. 01
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) 1998), and 67 FR 50069 (August 1, 2002).		,	0. 00	8. 00
8. 01	The amount of increase if the hospital was awarded FTE cap slots the cost report straddles July 1, 2011, see instructions.	under section 5503 of	f the ACA. If	0. 00	8. 01
8. 02	The amount of increase if the hospital was awarded FTE cap slots 1 under section 5506 of ACA. (see instructions)	from a closed teachir	ng hospital	0. 00	8. 02
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)		0. 00	9. 00	
10.00	FTE count for allopathic and osteopathic programs in the current y	year from your record	ds	0.00	
11.00	FTE count for residents in dental and podiatric programs. Current year allowable FTE (see instructions)				11. 00 12. 00
13. 00	Total allowable FTE count for the prior year.			0.00	
14. 00	Total allowable FTE count for the penultimate year if that year er otherwise enter zero.	nded on or after Sept	tember 30, 1997,	0. 00	
15. 00	Sum of lines 12 through 14 divided by 3.			0.00	15. 00
	Adjustment for residents in initial years of the program				16.00
	Adjustment for residents displaced by program or hospital closure			0. 00	17.00
	Adjusted rolling average FTE count				18.00
	Current year resident to bed ratio (line 18 divided by line 4).			0. 000000	
	Prior year resident to bed ratio (see instructions)			0.000000	
21. 00	Enter the lesser of lines 19 or 20 (see instructions)			0. 000000 0	21. 00 22. 00
	IME payment adjustment (see instructions) IME payment adjustment - Managed Care (see instructions)			0	22. 00
22.01	Indirect Medical Education Adjustment for the Add-on for Section 4	122 of the MMA		- O	22.01
23. 00	Number of additional allopathic and osteopathic IME FTE resident $(f)(1)(iv)(C)$ .		ec. 412.105	0.00	23. 00
24.00	IME FTE Resident Count Over Cap (see instructions)			0.00	24.00
25. 00	If the amount on line 24 is greater than -0-, then enter the lower instructions)	of line 23 or line	24 (see	0. 00	25. 00
26.00	Resident to bed ratio (divide line 25 by line 4)			0. 000000	26.00
27.00	IME payments adjustment factor. (see instructions)			0.000000	27.00
28. 00	IME add-on adjustment amount (see instructions)			0	28. 00
	IME add-on adjustment amount - Managed Care (see instructions)			0	28. 01
29. 00	Total IME payment ( sum of lines 22 and 28)			0	29. 00
	Total IME payment - Managed Care (sum of lines 22.01 and 28.01) Disproportionate Share Adjustment			0	29. 01
	Percentage of SSI recipient patient days to Medicare Part A patier	nt days (see instruct	tions)	3. 14	
31.00	Percentage of Medicaid patient days (see instructions) Sum of lines 30 and 31			25. 34	
32. 00 33. 00	Allowable disproportionate share percentage (see instructions)			28. 48 12. 71	32. 00 33. 00
	Disproportionate share adjustment (see instructions)			1, 325, 102	
			'		

	Financial Systems FRANCISCAN HEALTH			u of Form CMS-2	2552-10	
CALCUL	CALCULATION OF REIMBURSEMENT SETTLEMENT Provider CCN: 15-0109 Period: From 01/01/2016 To 12/31/2016					
	To 12/31/2016					
		Title XVIII	Hospi tal	6/28/2017 3: 30 PPS		
			Prior to 10/1 1.00	0n/After 10/1 2.00		
	Uncompensated Care Adjustment		1.00	2.00		
35. 00	Total uncompensated care amount (see instructions)		0			
35. 01 35. 02	Factor 3 (see instructions) Hospital uncompensated care payment (If line 34 is zero, ent	er zero on this line)	0. 000000000 1, 704, 376	0. 000314880 1, 883, 768		
35. 03	(see instructions) Pro rata share of the hospital uncompensated care payment amo	ount (see instructions)	1, 275, 954	474, 813	35. 03	
36. 00	Total uncompensated care (sum of columns 1 and 2 on line 35.0 Additional payment for high percentage of ESRD beneficiary di		1, 750, 767 (ah 46)		36. 00	
40. 00	Total Medicare discharges on Worksheet S-3, Part I excluding 652, 682, 683, 684 and 685 (see instructions)	discharges for MS-DRGs	0		40. 00	
41. 00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 6 instructions)	83, 684 an 685. (see	0		41. 00	
41. 01	Total ESRD Medicare covered and paid discharges excluding MS- an 685. (see instructions)	DRGs 652, 682, 683, 684	0		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 instructions)	2, 683, 684 an 685. (see	0		43. 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 46. 00	Average weekly cost for dialysis treatments (see instructions Total additional payment (line 45 times line 44 times line 41		0.00		45. 00 46. 00	
47. 00	Subtotal (see instructions)	.01)	46, 874, 580		47.00	
48. 00	Hospital specific payments (to be completed by SCH and MDH, sonly (see instructions)	mall rural hospitals	0		48. 00	
				Amount 1.00		
49. 00	Total payment for inpatient operating costs (see instructions	5)		46, 874, 580	49. 00	
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I an	• • • • • • • • • • • • • • • • • • • •		3, 978, 126		
51. 00 52. 00	Exception payment for inpatient program capital (Wkst. L, Pt. Direct graduate medical education payment (from Wkst. E-4, Ii			0	51. 00 52. 00	
53. 00	Nursing and Allied Health Managed Care payment	The 47 See Thistructions).		767, 534		
54.00	Special add-on payments for new technologies			0	54.00	
54. 01	Islet isolation add-on payment	->		0	54. 01	
55. 00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 6	•		0	55. 00	
56. 00 57. 00	Cost of physicians' services in a teaching hospital (see intr Routine service other pass through costs (from Wkst. D, Pt. I	•	arough 25)	0 2, 841, 407	56. 00 57. 00	
58. 00	Ancillary service other pass through costs from Wkst. D, Pt. 1		ii ougii 35).	374, 162		
59. 00	Total (sum of amounts on lines 49 through 58)	11, 661. 11 11116 200)		54, 835, 809		
60.00	Pri mary payer payments			2, 486		
61.00	Total amount payable for program beneficiaries (line 59 minus	line 60)		54, 833, 323	61. 00	
62.00	Deductibles billed to program beneficiaries			3, 937, 696	62. 00	
63.00	Coinsurance billed to program beneficiaries			71, 799		
64. 00	l			413, 189		
	Adjusted reimbursable bad debts (see instructions)			268, 573		
66.00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		108, 622		
67. 00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	annliaghla ta MC DDCa (a	o i notruptions)	51, 092, 401	67.00	
68. 00 69. 00	Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96).			0	68. 00 69. 00	
70.00	NEW TECHNOLOGY	(101 3cm see mistractions	>)	8, 286		
70. 50	RURAL DEMONSTRATION PROJECT			0, 200	70. 50	
70. 88	SCH or MDH volume decrease adjustment			0	70. 88	
70. 89	Pioneer ACO demonstration payment adjustment amount (see inst	ructions)		0	70. 89	
70. 90	HSP bonus payment HVBP adjustment amount (see instructions)	•		0	1	
70. 91	HSP bonus payment HRR adjustment amount (see instructions)			0		
70. 92	Bundled Model 1 discount amount (see instructions)			0		
70. 93	HVBP payment adjustment amount (see instructions)			-88, 445		
	HRR adjustment amount (see instructions)			0		
70. 95	Recovery of accelerated depreciation			0	70. 95	

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der Co	CN: 15-0109	Peri od: From 01/01/2016 To 12/31/2016	Worksheet E Part A Date/Time Prep 6/28/2017 3:30	pared: 6 pm
		Title	XVIII	Hospi tal	PPS	
			FF	Y (yyyy)	Amount	
				0	1. 00	
70. 96	Low volume adjustment for federal fiscal year (yyyy) (Enter in	n column 0		0	0	70. 96
	the corresponding federal year for the period prior to 10/1)					
70. 97	Low volume adjustment for federal fiscal year (yyyy) (Enter in			0	0	70. 97
	the corresponding federal year for the period ending on or aft	ter 10/1)				
	Low Volume Payment-3				0	
	HAC adjustment amount (see instructions)				0	
	Amount due provider (line 67 minus lines 68 plus/minus lines 6	59 & 70)			51, 012, 242	
	Sequestration adjustment (see instructions)				1, 020, 245	
	Interim payments				49, 465, 139	
	Tentative settlement (for contractor use only)				0	
	Balance due provider (Program) (line 71 minus lines 71.01, 72,				526, 858	
75. 00	Protested amounts (nonallowable cost report items) in accordan	nce with			1, 717, 062	75.00
	CMS Pub. 15-2, chapter 1, §115.2					
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
	Operating outlier amount from Wkst. E, Pt. A, line 2 (see inst	tructions)			0	
	Capital outlier from Wkst. L, Pt. I, line 2				0	, , , , , ,
	Operating outlier reconciliation adjustment amount (see instru				0	92.00
	Capital outlier reconciliation adjustment amount (see instruct				0	93.00
	The rate used to calculate the time value of money (see instru	ıcti ons)			0. 00	
	Time value of money for operating expenses (see instructions)				0	95.00
96. 00	Time value of money for capital related expenses (see instruct	tions)			0	96.00
				Prior to 10/1		
				1. 00	2. 00	
	HSP Bonus Payment Amount					
	HSP bonus amount (see instructions)			0	0	100. 00
	HVBP Adjustment for HSP Bonus Payment					
	HVBP adjustment factor (see instructions)			0. 0000000000	0. 0000000000	
	HVBP adjustment amount for HSP bonus payment (see instructions	s)		0	0	102.00
	HRR Adjustment for HSP Bonus Payment					
	HRR adjustment factor (see instructions)			0.0000	0. 0000	
104.00	HRR adjustment amount for HSP bonus payment (see instructions)	)		0	0	104.00

Health Financial Systems	FRANCISCAN HEALTH LAFAYE	TTE	In Lie	u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi c	ler CCN: 15-0109	From 01/01/2016 Part B To 12/31/2016 Date/Time F 6/28/2017 3		
		Title XVIII	Hospi tal	PPS	

		10	12/31/2016	6/28/2017 3:30	
		Title XVIII	Hospi tal	PPS	о рііі
		Title XVIII	nospi tai	113	
				1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			25, 526	1.00
2.00	Medical and other services reimbursed under OPPS (see instruct	tions)		20, 050, 486	2. 00
3.00	PPS payments			17, 924, 413	3. 00
4.00	Outlier payment (see instructions)			223, 540	4. 00
5.00	Enter the hospital specific payment to cost ratio (see instruc	ctions)		0.000	5. 00
6.00	Line 2 times line 5			0	6. 00
7.00	Sum of line 3 plus line 4 divided by line 6			0.00	7. 00
8.00	Transitional corridor payment (see instructions)			0	8. 00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. I	V, col. 13, line 200		196, 993	9. 00
10.00	Organ acqui si ti ons			0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			25, 526	11. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonabl e charges				
12.00	Ancillary service charges			144, 837	12. 00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, Ii	ne 69)		0	13. 00
14.00	Total reasonable charges (sum of lines 12 and 13)			144, 837	14. 00
	Customary charges				
15. 00	Aggregate amount actually collected from patients liable for p			0	
16. 00	Amounts that would have been realized from patients liable for		chargebasi s	0	16. 00
	had such payment been made in accordance with 42 CFR §413.13(e	e)			
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0. 000000	•
18. 00	Total customary charges (see instructions)			144, 837	1
19. 00	Excess of customary charges over reasonable cost (complete onl	y if line 18 exceeds line 1	i) (see	119, 311	19. 00
	instructions)				
20. 00	Excess of reasonable cost over customary charges (complete onl	y if line 11 exceeds line 18	3) (see	0	20. 00
21 00	instructions) Lesser of cost or charges (line 11 minus line 20) (for CAH see	instructions)		25, 526	21. 00
21. 00 22. 00	Interns and residents (see instructions)	e mstructions)		25, 526	1
23. 00	,	suctions)			23. 00
24. 00	Cost of physicians' services in a teaching hospital (see instr Total prospective payment (sum of lines 3, 4, 8 and 9)	uctions)		18, 344, 946	
24.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT			10, 344, 940	24.00
25. 00	Deductibles and coinsurance (for CAH, see instructions)			0	25. 00
26. 00	Deductibles and Coinsurance relating to amount on line 24 (for	CAH see instructions)		3, 327, 423	ł
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) p		231 (see	15, 043, 049	1
	instructions)				
28.00	Direct graduate medical education payments (from Wkst. E-4, li	ne 50)		0	28. 00
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	29. 00
30.00	Subtotal (sum of lines 27 through 29)			15, 043, 049	30. 00
31.00	Primary payer payments			3, 712	31. 00
32.00	Subtotal (line 30 minus line 31)			15, 039, 337	32. 00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE)	CES)			
33. 00	Composite rate ESRD (from Wkst. I-5, line 11)			0	
34. 00	Allowable bad debts (see instructions)			744, 632	ł
35. 00	Adjusted reimbursable bad debts (see instructions)			484, 011	1
36. 00	Allowable bad debts for dual eligible beneficiaries (see instr	ructions)		484, 878	1
37. 00	Subtotal (see instructions)			15, 523, 348	
	MSP-LCC reconciliation amount from PS&R			0	
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	`		0	
39. 50	Pioneer ACO demonstration payment adjustment (see instructions	•	,	0	
39. 98	Partial or full credits received from manufacturers for replace	ced devices (see instructions	5)	0	
39. 99	RECOVERY OF ACCELERATED DEPRECIATION			0	
40.00	Subtotal (see instructions)			15, 523, 348	1
40. 01	Sequestration adjustment (see instructions)			310, 467	
41. 00	Interim payments			15, 234, 181	
42.00	Tentative settlement (for contractors use only)			0	•
43. 00	Balance due provider/program (see instructions)			-21, 300	1
44. 00	Protested amounts (nonallowable cost report items) in accordar	nce with CMS Pub. 15-2, chap	ter 1,	102, 703	44. 00
	§115. 2 TO BE COMPLETED BY CONTRACTOR				
90. 00	Original outlier amount (see instructions)			0	90.00
91. 00	Outlier reconciliation adjustment amount (see instructions)				•
	The rate used to calculate the Time Value of Money				92.00
93. 00	Time Value of Money (see instructions)			0.00	•
	Total (sum of lines 91 and 93)				94. 00
			'	٥١	

| Peri od: | Worksheet E-1 | From 01/01/2016 | Part | To 12/31/2016 | Date/Time Prepared: Provider CCN: 15-0109

				10 12/31/2010	6/28/2017 3: 30	
		Title	XVIII	Hospi tal	PPS	
	<u> </u>	Inpatien	t Part A	Part 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		49, 055, 23		15, 034, 681	1.00
2.00	Interim payments payable on individual bills, either		1	O	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	07/29/2016	409, 90		199, 500	3. 01
3. 02				0	0	3. 02
3.03				0	0	3. 03
3.04				O	0	3. 04 3. 05
3. 05	Provider to Program			0	0	3.05
3. 50	ADJUSTMENTS TO PROGRAM			ol	0	3. 50
3. 51	ADJUSTINIENTS TO TROUBLAND			0	0	3. 51
3. 52				0	0	3. 52
3. 53				0	Ö	3. 53
3.54				Ö	O	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		409, 90	0	199, 500	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		49, 465, 13	9	15, 234, 181	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
5.00	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		(	O	0	5. 01
5.02				C	0	5. 02
5.03			(	0	0	5. 03
	Provider to Program			_		
5. 50	TENTATI VE TO PROGRAM			O	0	5. 50
5. 51				0	0	5. 51
5. 52 5. 99	Subtatal (sum of lines E O1 E 40 minus sum of lines			0	0	5. 52 5. 99
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		1	J	U	5. 99
6. 00	Determined net settlement amount (balance due) based on					6. 00
0.00	the cost report. (1)					0.00
6. 01	SETTLEMENT TO PROVIDER		526, 85	8	o	6. 01
6. 02	SETTLEMENT TO PROGRAM			o O	21, 300	6. 02
7. 00	Total Medicare program liability (see instructions)		49, 991, 99		15, 212, 881	7. 00
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
8. 00	Name of Contractor	(	)	1. 00	2. 00	8. 00

Health Financial Systems	FRANCISCAN HEALTH	I LAFAYETTE	In Lie	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO PROVIDERS FOR	R SERVICES RENDERED	Provider CCN: 15-0109	Peri od:	Worksheet E-1
		Component CCN: 15-T109	From 01/01/2016	Part     Date/Time Prepared:
		Component CCN. 13-1107	10 12/31/2010	6/28/2017 3: 36 pm
		Title XVIII	Subprovi der -	PPS
			IDE	

		Title	: XVIII	Subprovi der  - I RF	PPS	
		Inpatien	it Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
1 00	Tabel detector assessed to asset the	1.00	2.00	3. 00	4.00	1 0
1.00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		2, 606, 32	0	0	2.00
3. 00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					3.00
3. 01	ADJUSTMENTS TO PROVIDER			0	0	3.01
3.02				0	0	3. 02
3.03				0	0	
3.04				0	0	3.04
3.05				0	0	3. 0!
	Provider to Program	1	T	_		4
3.50	ADJUSTMENTS TO PROGRAM			0	0	
3. 51 3. 52				0	0 0	
3. 52		•		0	0	
3. 54				0	0	
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0	0	
3. 77	3. 50-3. 98)					] 5. /
4. 00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2, 606, 32	6	0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5. 00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider	1	1		_	4
5. 01	TENTATI VE TO PROVI DER		•	0	0	
5. 02 5. 03				0	0 0	
5.03	Provider to Program			U		] 5.0.
5. 50	TENTATI VE TO PROGRAM			0	0	5. 50
5. 51				o	0	
5. 52				0	0	
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 the cost report. (1)					6.00
6. 01	SETTLEMENT TO PROVIDER			0	0	
6. 02	SETTLEMENT TO PROGRAM		8, 09		0	
7. 00	Total Medicare program liability (see instructions)		2, 598, 22	Contractor	NPR Date	7.0
				Number	(Mo/Day/Yr)	
		(	)	1. 00	2. 00	
8.00	Name of Contractor	I			1	8.00

Heal th	Financial Systems	FRANCISCAN HEALTH	LAFAYETTE	In Lie	u of Form CMS-2	2552-10
	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 15-0109	Peri od:	Worksheet E-1	
				From 01/01/2016		
				To 12/31/2016	Date/Time Prep 6/28/2017 3:30	
			Title XVIII	Hospi tal	PPS	<u>о рін</u>
					1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDAR	RD COST REPORTS				
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION	ON AND CALCULATION				
1.00	Total hospital discharges as defined in AAR	A §4102 from Wkst.	S-3, Pt. I col. 15 line	14	9, 773	1. 00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6	sum of lines 1, 8-	-12		18, 154	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, co	l. 6. line 2			3, 555	3. 00
4.00	Total inpatient days from S-3, Pt. I col. 8	sum of lines 1, 8-	-12		42, 861	4.00
5.00	Total hospital charges from Wkst C, Pt. I,	col. 8 line 200			1, 160, 469, 211	5. 00
6.00	Total hospital charity care charges from Wk	st. S-10, col. 3 li	ne 20		39, 650, 435	6. 00
7.00	CAH only - The reasonable cost incurred for	the purchase of ce	ertified HIT technology	Wkst. S-2, Pt. I	0	7. 00
	line 168					
8. 00	Calculation of the HIT incentive payment (s				488, 321	8. 00
9.00	Sequestration adjustment amount (see instru				9, 766 478, 555	9. 00
10. 00	10.00 Calculation of the HIT incentive payment after sequestration (see instructions)					10. 00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS 8					
	Initial/interim HIT payment adjustment (see	instructions)			996, 710	
	Other Adjustment (specify)				0	31. 00
32. 00	Balance due provider (line 8 (or line 10) m	inus line 30 and li	ne 31) (see instruction	s)	-518, 155	32. 00

Health Financial Systems	FRANCISCAN HEALTH LAFAYETTE	In Lie	u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0109	Peri od: From 01/01/2016	Worksheet E-3	
	Component CCN: 15-T109			
	Title XVIII	Subprovi der -	PPS	
		I RF		

	IRF		
		1. 00	
	PART III - MEDICARE PART A SERVICES - IRF PPS		
1.00	Net Federal PPS Payment (see instructions)	2, 375, 850	
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)	0. 0177	2. 00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)	73, 414	3. 00
4.00	Outlier Payments	246, 081	4. 00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior	0. 00	5. 00
E 04	to November 15, 2004 (see instructions)	0.00	E 04
5. 01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by	0. 00	5. 01
	program or hospital closure, that would not be counted without a temporary cap adjustment under 42		
6. 00	CFR §412. 424(d)(1)(iii)(F)(1) or (2) (see instructions)	0. 00	6. 00
7. 00	New Teaching program adjustment. (see instructions)  Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new	0.00	
7.00	teaching program" (see instructions)	0.00	7.00
8. 00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new	0. 00	8. 00
0.00	teaching program" (see instructions)	0.00	0.00
9. 00	Intern and resident count for IRF PPS medical education adjustment (see instructions)	0. 00	9. 00
10.00	Average Daily Census (see instructions)	8. 202186	
11. 00	Teaching Adjustment Factor (see instructions)	0. 000000	
12. 00	Teaching Adjustment (see instructions)	0. 000000	12.00
13. 00	Total PPS Payment (see instructions)	2, 695, 345	
14. 00	Nursing and Allied Health Managed Care payments (see instruction)	0	
15. 00	Organ acquisition (DO NOT USE THIS LINE)	J.	15. 00
16. 00	Cost of physicians' services in a teaching hospital (see instructions)	0	
17. 00	Subtotal (see instructions)	2, 695, 345	
18. 00	Primary payer payments	15, 867	
19. 00	Subtotal (line 17 less line 18).	2, 679, 478	
20. 00	Deducti bl es	18, 004	
21. 00	Subtotal (line 19 minus line 20)	2, 661, 474	
22. 00	Coinsurance	15, 456	
23. 00	Subtotal (line 21 minus line 22)	2, 646, 018	
24. 00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	0	
25. 00	Adjusted reimbursable bad debts (see instructions)	0	25. 00
26. 00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	26. 00
27. 00	Subtotal (sum of lines 23 and 25)	2, 646, 018	
28. 00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	
29. 00	Other pass through costs (see instructions)	5, 236	
30.00	Outlier payments reconciliation	0	30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	31.00
31. 50	Pioneer ACO demonstration payment adjustment (see instructions)	0	31.50
31. 99	Recovery of Accel erated Depreciation	0	31. 99
32.00	Total amount payable to the provider (see instructions)	2, 651, 254	32.00
32. 01	Sequestration adjustment (see instructions)	53, 025	32. 01
33.00	Interim payments	2, 606, 326	33.00
34.00	Tentative settlement (for contractor use only)	0	34.00
35.00	Balance due provider/program (line 32 minus lines 32.01, 33, and 34)	-8, 097	35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	0	36.00
	§115. 2		
	TO BE COMPLETED BY CONTRACTOR		
	Original outlier amount from Wkst. E-3, Pt. III, line 4	246, 081	
51.00	Outlier reconciliation adjustment amount (see instructions)	0	
52.00	The rate used to calculate the Time Value of Money	0. 00	
53.00	Time Value of Money (see instructions)	0	53.00

Health Financial Systems	FRANCISCAN HEALTH LAFAYETTE	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0109	Period: From 01/01/2016	Worksheet E-3 Part VII Date/Time Prepared:
		10 12/31/2010	6/28/2017 3: 36 pm
	Title XIX	Hospi tal	Cost

			10 12/31/2010	6/28/2017 3:3	6 pm
		Title XIX	Hospi tal	Cost	
			Inpati ent	Outpati ent	
			1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SEF	RVICES FOR TITLES V OR XIX	SERVI CES		
	COMPUTATION OF NET COST OF COVERED SERVICES				1
1.00	Inpatient hospital/SNF/NF services		16, 281, 451		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)		16, 281, 451	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)		16, 281, 451	0	7. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonabl e Charges				
8.00	Routi ne servi ce charges		0		8. 00
9.00	Ancillary service charges		53, 637, 669	0	9. 00
10.00	Organ acquisition charges, net of revenue		0		10. 00
11. 00	Incentive from target amount computation		0		11. 00
12.00	Total reasonable charges (sum of lines 8 through 11)		53, 637, 669	0	12. 00
	CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for	r services on a charge	0	0	13. 00
	basis				
14. 00	Amounts that would have been realized from patients liable for		0	0	14. 00
	a charge basis had such payment been made in accordance with	42 CFR §413.13(e)			
15. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0. 000000	0. 000000	1
16. 00	Total customary charges (see instructions)		53, 637, 669	0	16. 00
17. 00	Excess of customary charges over reasonable cost (complete onl	ly if line 16 exceeds	37, 356, 218	0	17. 00
40.00	line 4) (see instructions)				40.00
18. 00	Excess of reasonable cost over customary charges (complete onl	ly it line 4 exceeds line	0	0	18. 00
10.00	16) (see instructions)			0	10.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see insti		0	0	20.00
21. 00	Cost of covered services (enter the lesser of line 4 or line 1		16, 281, 451	0	21. 00
22.00	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be	completed for PPS provide	ers.	0	22.00
22. 00 23. 00	Other than outlier payments			0	22. 00 23. 00
24. 00	Outlier payments Program capital payments			U	24.00
25. 00	Capital exception payments (see instructions)				25. 00
26. 00	Routine and Ancillary service other pass through costs		0	0	26.00
27. 00	Subtotal (sum of lines 22 through 26)			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)		16, 281, 451	0	29.00
27.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT		10, 201, 431		27.00
30. 00	Excess of reasonable cost (from line 18)			0	30.00
31. 00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	)	16, 281, 451	0	31.00
32. 00	Deductibles	,	10, 201, 431	0	32. 00
33. 00	Coinsurance			0	33. 00
34. 00	Allowable bad debts (see instructions)			0	34. 00
35. 00	Utilization review			O	35. 00
36. 00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	4 33)	16, 281, 451	0	36.00
37. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	u 00)	10, 201, 401	0	37. 00
38. 00	Subtotal (line 36 ± line 37)		16, 281, 451	0	38. 00
39. 00	Direct graduate medical education payments (from Wkst. E-4)		0, 201, 401	O	39. 00
40. 00	Total amount payable to the provider (sum of lines 38 and 39)		16, 281, 451	0	40.00
41. 00	Interim payments		16, 281, 451	0	41.00
42. 00	Balance due provider/program (line 40 minus line 41)		0	0	42.00
43. 00	Protested amounts (nonallowable cost report items) in accordan	nce with CMS Pub 15-2	0	0	43. 00
.5. 50	chapter 1, §115.2			Ŭ	
	1		1		

Health Financial Systems	FRANCISCAN HEALTH LAFAYETTE	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0109	Peri od: From 01/01/2016	Worksheet E-3 Part VII
	Component CCN: 15-T109	To 12/31/2016	Date/Time Prepared: 6/28/2017 3:36 pm
	Title XIX	Subprovi der -	Cost

		TI LI E XIX	I RF	COST	
			Inpatient	Outpati ent	
			1, 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERV	/ICES FOR TITLES V OR XIX		2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES		. 02.111 020		
1.00	Inpatient hospital/SNF/NF services		427, 673		1. 00
2.00	Medical and other services		,	ol	2. 00
3.00	Organ acquisition (certified transplant centers only)		0	-	3. 00
4.00	Subtotal (sum of lines 1, 2 and 3)		427, 673	ol	4. 00
5. 00	Inpatient primary payer payments		0	-	5. 00
6.00	Outpatient primary payer payments			ol	6. 00
7. 00	Subtotal (line 4 less sum of lines 5 and 6)		427, 673	ol	7. 00
	COMPUTATION OF LESSER OF COST OR CHARGES		,		
	Reasonable Charges				
8.00	Routine service charges		0		8. 00
9. 00	Ancillary service charges		507, 686		9. 00
10. 00	Organ acquisition charges, net of revenue		0	ĭ	10.00
11. 00	Incentive from target amount computation		o		11. 00
12. 00	Total reasonable charges (sum of lines 8 through 11)		507, 686	ol	12. 00
	CUSTOMARY CHARGES				
13. 00	Amount actually collected from patients liable for payment for	services on a charge	0	0	13. 00
	basis	g-		·	
14.00	Amounts that would have been realized from patients liable for	payment for services on	o	o	14.00
	a charge basis had such payment been made in accordance with 4				
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)		507, 686	o	16. 00
17.00	Excess of customary charges over reasonable cost (complete only	y if line 16 exceeds	80, 013	o	17. 00
	line 4) (see instructions)				
18.00	Excess of reasonable cost over customary charges (complete only	y if line 4 exceeds line	O	o	18.00
	16) (see instructions)				
19.00	Interns and Residents (see instructions)		0	0	19. 00
20.00	Cost of physicians' services in a teaching hospital (see instr	uctions)	0	0	20.00
21. 00	Cost of covered services (enter the lesser of line 4 or line 1		427, 673	0	21. 00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be	completed for PPS provide	ers.		
22. 00	Other than outlier payments		0		22. 00
23. 00	Outlier payments		0		23. 00
24. 00	Program capital payments		0		24.00
25. 00	Capital exception payments (see instructions)		0		25.00
26. 00	Routine and Ancillary service other pass through costs		0		26. 00
27. 00	Subtotal (sum of lines 22 through 26)		0	0	27. 00
28. 00	Customary charges (title V or XIX PPS covered services only)		0	-	28. 00
29. 00	Titles V or XIX (sum of lines 21 and 27)		427, 673	0	29. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)		0	-	30.00
31. 00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		427, 673		31. 00
32. 00	Deducti bl es		0		32.00
33. 00	Coi nsurance		0	0	33. 00
34. 00	Allowable bad debts (see instructions)		0	0	34. 00
35. 00	Utilization review		0		35. 00
36. 00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	33)	427, 673		36. 00
37. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37. 00
38. 00	Subtotal (line 36 ± line 37)		427, 673	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)		427, 673		40. 00
41. 00	Interim payments		427, 673		41. 00
42. 00	Balance due provider/program (line 40 minus line 41)		0		42.00
43. 00	Protested amounts (nonallowable cost report items) in accordance	ce with CMS Pub 15-2,	0	0	43. 00
	chapter 1, §115.2				

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

Provider CCN: 15-0109 Period: From 01/0

Peri od: From 01/01/2016 To 12/31/2016 Date/Ti me Prepared: 6/28/2017 3:36 pm

——————————————————————————————————————					6/28/2017 3:3	6 pm
		General Fund		Endowment Fund	Pl ant Fund	
		1.00	Purpose Fund	2.00	4.00	
	CURRENT ASSETS	1.00	2.00	3. 00	4. 00	
1.00	Cash on hand in banks	-104, 409	0	0	0	1.00
2.00	Temporary investments	916, 156		0	0	
3.00	Notes receivable	0	_	0	0	3. 00
4.00	Accounts receivable	46, 183, 318	0	0	0	4. 00
5.00	Other recei vable	0	0	0	0	5. 00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6. 00
7. 00	Inventory	5, 614, 729	0	0	0	7. 00
8.00	Prepaid expenses	0	0	0	0	
9.00	Other current assets	7, 875, 685		0	0	
10.00	Due from other funds	(0.405.470	0	0	0	10.00
11. 00	Total current assets (sum of lines 1-10) FIXED ASSETS	60, 485, 479	0	0	0	11. 00
12. 00	Land	T 0	0	0	0	12. 00
13. 00	Land improvements			0	0	13. 00
14. 00	Accumulated depreciation		Ö	0	0	14. 00
15. 00	Bui I di ngs	216, 082, 129	ō	0	0	15. 00
16.00	Accumul ated depreciation	0	o	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17. 00
18.00	Accumul ated depreciation	0	0	0	0	18. 00
19. 00	Fi xed equipment	0	0	0	0	19. 00
20.00	Accumulated depreciation	0	0	0	0	20. 00
21. 00	Automobiles and trucks	0	0	0	0	21. 00
22. 00	Accumul ated depreciation	0	0	0	0	22. 00
23. 00	Major movable equipment	0	0	0	0	23. 00
24. 00	Accumul ated depreciation	0	0	0	0	
25. 00	Mi nor equipment depreciable	0	0	0	0	25. 00
26. 00	Accumul ated depreciation	0	0	0	0	•
27. 00	HIT designated Assets	0	0	0	0	27. 00
28. 00	Accumulated depreciation	0	0	0	0	28. 00
29. 00	Mi nor equipment-nondepreciable	214 002 120	0	0	0	29. 00
30. 00	Total fixed assets (sum of lines 12-29) OTHER ASSETS	216, 082, 129	0	0	0	30. 00
31. 00	Investments	9, 114, 719	0	0	0	31. 00
32. 00	Deposits on Leases	,,,,,,,	Ŏ	0	0	
33. 00	Due from owners/officers	0	ő	0	0	
34. 00	Other assets	23, 622, 987	0	0	0	ł
35. 00	Total other assets (sum of lines 31-34)	32, 737, 706		0	0	35. 00
36.00	Total assets (sum of lines 11, 30, and 35)	309, 305, 314		0	0	36. 00
	CURRENT LI ABI LI TI ES		•			
37. 00	Accounts payable	18, 539, 443	0	0	0	37. 00
38. 00	Salaries, wages, and fees payable	9, 790, 712	0	0	0	38. 00
39.00	Payroll taxes payable	0	0	0	0	39. 00
40. 00	Notes and Loans payable (short term)	0	0	0	0	•
41. 00	Deferred income	0	0	0	0	41. 00
42. 00	Accel erated payments	0				42.00
43. 00	Due to other funds	0	0	0	0	
44. 00	Other current liabilities	1, 412, 250	1	0	0	•
45. 00	Total current liabilities (sum of lines 37 thru 44) LONG TERM LIABILITIES	29, 742, 405	0	0	0	45. 00
46. 00	Mortgage payable	0	0	0	0	46. 00
47. 00	Notes payable				0	1
48. 00	Unsecured Loans			0	0	
49. 00	Other long term liabilities	426, 720	_	0	0	49. 00
50. 00	Total long term liabilities (sum of lines 46 thru 49)	426, 720		Ö	0	1
51. 00	Total liabilities (sum of lines 45 and 50)	30, 169, 125		-	0	51.00
	CAPI TAL ACCOUNTS			-1		
52.00	General fund balance	279, 136, 189				52. 00
53.00	Specific purpose fund		0			53. 00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55. 00
56.00	Governing body created - endowment fund balance			0		56. 00
57. 00	Plant fund balance - invested in plant				0	1
58. 00	Plant fund balance - reserve for plant improvement,				0	58. 00
E0	repl acement, and expansi on					
59.00	Total fund balances (sum of lines 52 thru 58)	279, 136, 189		0	0	
60. 00	Total liabilities and fund balances (sum of lines 51 and	309, 305, 314	0	0	0	60. 00
	[59]	I	I	l l		I

STATEMENT OF CHANGES IN FUND BALANCES

sheet (line 11 minus line 18)

Provider CCN: 15-0109 Per

Peri od: Worksheet G-1 From 01/01/2016

12/31/2016 Date/Time Prepared: 6/28/2017 3:36 pm General Fund Special Purpose Fund Endowment Fund 1.00 3.00 4. 00 5. 00 2 00 1.00 Fund balances at beginning of period 257, 100, 000 0 1.00 2.00 Net income (loss) (from Wkst. G-3, line 29) 49, 194, 222 2.00 3.00 Total (sum of line 1 and line 2) 306, 294, 222 0 3.00 4.00 0 Additions (credit adjustments) (specify) 0 4.00 5.00 0 0 0 0 0 5.00 6.00 6.00 0 7.00 0 7.00 0 8.00 0 8.00 0 9.00 0 9.00 10.00 Total additions (sum of line 4-9) 10.00 Subtotal (line 3 plus line 10) 306, 294, 222 0 11.00 11.00 12.00 ADJUST TO AFS 27, 158, 033 0 12.00 13.00 13.00 14.00 0 14.00 0 0 0 0 0 15.00 0 15.00 16.00 0 16.00 17.00 17.00 27, 158, 033 18.00 Total deductions (sum of lines 12-17) 18.00 Fund balance at end of period per balance 19.00 279, 136, 189 19.00 sheet (line 11 minus line 18) Endowment Fund Plant Fund 7. 00 8.00 6. 00 1.00 Fund balances at beginning of period 0 0 1.00 Net income (loss) (from Wkst. G-3, line 29) 2.00 2.00 Total (sum of line 1 and line 2) 3.00 0 0 3.00 4.00 Additions (credit adjustments) (specify) 4.00 5.00 0 5.00 0 6.00 6.00 7.00 0 7 00 8.00 0 8.00 9.00 9.00 10.00 Total additions (sum of line 4-9) 0 0 10.00 11.00 Subtotal (line 3 plus line 10) 0 0 11.00 12.00 ADJUST TO AFS 12.00 13.00 13.00 14.00 0 14.00 0 15.00 15.00 16.00 16.00 17.00 17.00 Total deductions (sum of lines 12-17) 18.00 18.00 0 0 0 19.00 Fund balance at end of period per balance 19.00

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

		T	12/31/2016	Date/Time Pre 6/28/2017 3:3	
	Cost Center Description	Inpati ent	Outpati ent	Total	O PIII
		1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES	<u> </u>			
	General Inpatient Routine Services				
1.00	Hospi tal	69, 386, 982		69, 386, 982	1. 00
2.00	SUBPROVI DER - I PF	0		0	2. 00
3.00	SUBPROVI DER - I RF	4, 778, 387		4, 778, 387	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				7. 00
8.00	NURSING FACILITY				8. 00
9. 00 10. 00	OTHER LONG TERM CARE	74 1/5 2/0		74 1/5 2/0	9. 00 10. 00
10.00	Total general inpatient care services (sum of lines 1-9) Intensive Care Type Inpatient Hospital Services	74, 165, 369		74, 165, 369	10.00
11. 00	INTENSIVE CARE UNIT	17, 479, 566		17, 479, 566	11. 00
12. 00	CORONARY CARE UNIT	17, 479, 300		17, 479, 500	12.00
13. 00	BURN INTENSIVE CARE UNIT				13. 00
14. 00	SURGICAL INTENSIVE CARE UNIT				14. 00
15. 00	NEONATAL INTENSIVE CARE UNIT	13, 457, 277		13, 457, 277	15. 00
16. 00	Total intensive care type inpatient hospital services (sum of lines	30, 936, 843		30, 936, 843	
	11-15)			20,120,011	
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	105, 102, 212		105, 102, 212	17. 00
18.00	Ancillary services	448, 921, 972	484, 571, 901	933, 493, 873	18. 00
19.00	Outpati ent servi ces	15, 072, 693	87, 905, 107	102, 977, 800	19. 00
20.00	RURAL HEALTH CLINIC	0	0	0	20. 00
	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21. 00
22. 00	HOME HEALTH AGENCY		9, 050, 299	9, 050, 299	22. 00
23. 00	AMBULANCE SERVICES	0	0	0	23. 00
24. 00	CMHC				24. 00
24. 10	CORF	0	0	0	24. 10
25. 00	AMBULATORY SURGICAL CENTER (D. P. )				25. 00
26. 00	HOSPI CE	0	6, 418, 976		
27. 00 27. 01	NON-REI MBURSABLE NURSI NG FACI LI TY	1 002 27/	10, 865, 776	10, 865, 776	
27. 01	OTHER REVENUE	1, 882, 276 162	1, 543, 775 55, 990	3, 426, 051 56, 152	27. 01 27. 02
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst.	570, 979, 315	•	1, 171, 391, 139	
20.00	G-3. line 1)	370, 777, 313	000, 411, 024	1, 171, 371, 137	20.00
	PART II - OPERATING EXPENSES				
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		303, 122, 105		29. 00
30.00	DEDUCT (SPECIFY)	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	DEDUCT (SPECI FY)	0			37. 00
38. 00		0			38. 00
39. 00		0			39. 00
40.00		0			40.00
41. 00	Total deductions (our of lines 27 41)	0	^		41.00
42.00	Total deductions (sum of lines 37-41)		202 122 105		42.00
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		303, 122, 105		43. 00
	100 most. 0 0, 11110 7)	1		l	ı

Provider CCN: 15-0109	Heal th	Financial Systems FRANCISCAN HEALTH	H LAFAYETTE	In Lie	u of Form CMS-2	2552-10
To   12/31/2016   Date/Time Prepared:				Peri od:		
1.00					Date/Time Pre	nared·
1.00				10 12/01/2010		
1.00						
2.00   Less contractual allowances and discounts on patients' accounts   382, 641, 210   2.00   338, 749, 929   3.00   330, 122, 105   4.00   Less total operating expenses (from Wkst. G-2, Part II, line 43)   303, 122, 105   4.00   Net income from service to patients (line 3 minus line 4)   35, 627, 824   5.00   The RINCOME   35, 825, 725, 824   5.00   The RINCOME   36, 627, 825   5.00   The RINCOME   36, 627, 825   52, 627   32, 627, 824   52, 627						
338,749,929   3.00   1.00						
4. 00   Less' total operating expenses (from Wkst. G-2, Part II, line 43)   303, 122, 105   4. 00   Net income from service to patients (line 3 minus line 4)   35, 627, 824   5. 00   OTHER INCOME			its			
Net income from service to patients (line 3 minus line 4)   OTHER INCOME   OCONTRIBUTIONS			10)			ı
OTHER INCOME         OTHER INCOME           6. 00         Contributions, donations, bequests, etc         0         6. 00           7. 00         Income from investments         0         7. 00           8. 00         Revenues from tell ephone and other miscell aneous communication services         0         9. 00           9. 00         Revenue from tell evision and radio service         0         9. 00           10. 00         Purchase discounts         0         10. 00           11. 00         Rebates and refunds of expenses         1, 054, 117         11. 00           12. 00         Parking lot receipts         57, 206         12. 00           13. 00         Revenue from laundry and linen service         0         13. 00           14. 00         Revenue from meals sold to employees and guests         1, 139, 193         14. 00           15. 00         Revenue from sale of medical and surgical supplies to other than patients         0         15. 00           16. 00         Revenue from sale of medical and surgical supplies to other than patients         0         17. 00           18. 00         Revenue from sale of medical and surgical supplies to other than patients         0         17. 00           18. 00         Revenue from sale of medical records and abstracts         5, 577         18. 00			43)			
6.00         Contributions, donations, bequests, etc         0         6.00           7.00         Income from investments         0         7.00           8.00         Revenues from telephone and other miscel laneous communication services         0         8.00           9.00         Revenue from television and radio service         0         9.00           10.00         Purchase discounts         0         10.00           11.00         Rebates and refunds of expenses         1,054,117         11.00           12.00         Parking lot receipts         57,206         12.00           13.00         Revenue from laundry and linen service         0         13.00           14.00         Revenue from meals sold to employees and guests         1,139,193         14.00           15.00         Revenue from sale of medical and surgical supplies to other than patients         0         15.00           15.00         Revenue from sale of medical and surgical supplies to other than patients         0         16.00           17.00         Revenue from sale of medical records and abstracts         5,577         18.00           18.00         Revenue from sale of ferdical records and abstracts         5,577         18.00           19.00         Tuition (fees, sale of textbooks, uniforms, etc.)         2,209,926 </td <td>5.00</td> <td></td> <td></td> <td></td> <td>35, 627, 824</td> <td>5.00</td>	5.00				35, 627, 824	5.00
7.00       Income from investments       0       7.00         8.00       Revenues from telephone and other miscellaneous communication services       0       8.00         9.00       Revenue from television and radio service       0       9.00         11.00       Purchase discounts       0       10.00         11.00       Rebates and refunds of expenses       1,054,117       11.00         12.00       Parking lot receipts       57,206       12.00         13.00       Revenue from laundry and linen service       7,206       13.00         14.00       Revenue from meals sold to employees and guests       1,139,193       14.00         15.00       Revenue from meals of living quarters       0       15.00         16.00       Revenue from sale of medical and surgical supplies to other than patients       0       15.00         18.00       Revenue from sale of medical records and abstracts       5,577       18.00         19.00       Tuition (fees, sale of textbooks, uniforms, etc.)       2,209,926       19.00         20.00       Revenue from gifts, flowers, coffee shops, and canteen       25,051       21.00         21.00       Rental of vending machines       25,051       21.00         22.00       Rental of hospital space       678,654       <					0	/ 00
8.00       Revenues from telephone and other miscellaneous communication services       0       8.00         9.00       Revenue from television and radio service       0       9.00         10.00       Purchase discounts       0       10.00         11.00       Rebates and refunds of expenses       1,054,117       11.00         12.00       Parking lot receipts       57,206       12.00         13.00       Revenue from laundry and linen service       0       13.00         14.00       Revenue from meals sold to employees and guests       1,139,193       14.00         15.00       Revenue from sale of medical and surgical supplies to other than patients       0       15.00         16.00       Revenue from sale of medical records and abstracts       0       17.00         17.00       Revenue from sale of medical records and abstracts       5,577       18.00         19.00       Tuition (fees, sale of textbooks, uniforms, etc.)       2,209,926       19.00         20.00       Revenue from gifts, flowers, coffee shops, and canteen       25,051       21.00         22.00       Rental of hospital space       678,654       22.00         23.00       Governmental appropriations       25,051       21.00         24.01       CONTRI BUTIONS (UNRESTRI CTED)					- 1	1
9.00       Revenue from television and radio service       0       9.00         10.00       Purchase discounts       0       10.00         11.00       Rebates and refunds of expenses       1,054,117       11.00         12.00       Parking lot receipts       57,206       12.00         13.00       Revenue from laundry and linen service       0       13.00         14.00       Revenue from meals sold to employees and guests       1,139,193       14.00         15.00       Revenue from sale of dredical and surgical supplies to other than patients       0       15.00         16.00       Revenue from sale of medical and surgical supplies to other than patients       0       17.00         18.00       Revenue from sale of drugs to other than patients       0       17.00         19.00       Tuition (fees, sale of textbooks, uniforms, etc.)       2, 209,926       19.00         19.00       Revenue from gifts, flowers, coffee shops, and canteen       0       20.00         21.00       Rental of vending machines       25,051       21.00         22.00       Rental of hospital space       678,654       22.00         23.00       Governmental appropriations       44,370       24.00         24.01       CONTRIBUTIONS (UNRESTRICTED)       55,186       <					-	1
10. 00       Purchase discounts       0       10. 00         11. 00       Rebates and refunds of expenses       1, 054, 117       11. 00         12. 00       Parking lot receipts       57, 206       12. 00         13. 00       Revenue from laundry and linen service       0       13. 00         14. 00       Revenue from meals sold to employees and guests       1, 139, 193       14. 00         15. 00       Revenue from sale of living quarters       0       15. 00         16. 00       Revenue from sale of medical and surgical supplies to other than patients       0       15. 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       5, 577       18. 00         19. 00       Tuition (fees, sale of textbooks, uniforms, etc.)       2, 209, 926       19. 00         20. 00       Revenue from gifts, flowers, coffee shops, and canteen       25, 051       21. 00         21. 00       Rental of vending machines       25, 051       21. 00         22. 00       Rental of hospital space       678, 654       22. 00         23. 00       Governmental appropriations       0       23. 00         24. 01       INVESTMENT INCOME       551, 868			1 Services		-	
11. 00       Rebates and refunds of expenses       1, 054, 117       11. 00         12. 00       Parking lot receipts       57, 206       12. 00         13. 00       Revenue from laundry and linen service       0 13. 00         14. 00       Revenue from meals sold to employees and guests       1, 139, 193       14. 00         15. 00       Revenue from rental of living quarters       0 15. 00       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       5, 577       18. 00         19. 00       Tuition (fees, sale of textbooks, uniforms, etc.)       2, 209, 926       19. 00         20. 00       Revenue from gifts, flowers, coffee shops, and canteen       0 20. 00         21. 00       Rental of vending machines       25, 051       21. 00         23. 00       Governmental appropriations       0 23. 00       0         24. 00       INVESTMENT INCOME       44, 370       24. 00         24. 01       CONTRIBUTIONS (UNRESTRICTED)       551, 868       24. 01         24. 02       GAIN (LOSS) ON SALE OF ASSETS       24, 029       24. 02					ŭ,	
12. 00       Parking lot receipts       57, 206       12. 00         13. 00       Revenue from laundry and linen service       0       13. 00         14. 00       Revenue from meals sold to employees and guests       1, 139, 193       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 medical records and abstracts       5, 577       18. 00         19. 00       Tuition (fees, sale of textbooks, uniforms, etc.)       2, 209, 926       19. 00         20. 00       Revenue from gifts, flowers, coffee shops, and canteen       0       20. 00         21. 00       Rental of vending machines       25, 051       21. 00         23. 00       Governmental appropriations       25, 051       21. 00         24. 00       INVESTMENT INCOME       0       23. 00         24. 01       CONTRIBUTIONS (UNRESTRICTED)       551, 868       24. 01         24. 02       GAIN (LOSS) ON SALE OF ASSETS       24, 029       24. 02         24. 03       EQUITY IN EARNINGS OF AFFILIATES       5, 886, 472       24. 03         25. 00       Total other income (sum of lines 6-24)       1					- 1	
13.00   Revenue from laundry and linen service   0   13.00   14.00   Revenue from meals sold to employees and guests   1,139,193   14.00   15.00   Revenue from rental of living quarters   0   15.00   Revenue from sale of medical and surgical supplies to other than patients   0   16.00   Revenue from sale of drugs to other than patients   0   17.00   Revenue from sale of drugs to other than patients   0   17.00   Revenue from sale of medical records and abstracts   0   17.00   19.00   17.00   19.00   17.00   19.						
14.00       Revenue from meals sold to employees and guests       1, 139, 193       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       5,577       18.00         19.00       Tuition (fees, sale of textbooks, uniforms, etc.)       2,209,926       19.00         20.00       Revenue from gifts, flowers, coffee shops, and canteen       0 20.00         21.00       Rental of vending machines       25,051       21.00         22.00       Rental of hospital space       678,654       22.00         23.00       Governmental appropriations       0 23.00         24.00       INVESTMENT I NCOME       44,370       24.00         24.01       CONTRIBUTIONS (UNRESTRICTED)       551,868       24.01         24.02       GAIN (LOSS) ON SALE OF ASSETS       24,029       24.02         24.03       EQUITY IN EARNINGS OF AFFILIATES       5,886,472       24.02         25.00       Total other income (sum of lines 6-24)       13,607,038       25.00						1
15.00 Revenue from rental of living quarters 16.00 Revenue from sale of medical and surgical supplies to other than patients 17.00 Revenue from sale of drugs to other than patients 18.00 Revenue from sale of medical records and abstracts 19.00 Tuit ion (fees, sale of textbooks, uniforms, etc.) 19.00 Revenue from gifts, flowers, coffee shops, and canteen 19.00 Rental of vending machines 19.00 Rental of hospital space 19.00 Rental of hospital space 19.00 Rental of hospital space 19.00 Rovenmental appropriations 10.00 Rovenme					-	
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       5,577       18.00         19.00       Tuition (fees, sale of textbooks, uniforms, etc.)       2,209,926       19.00         20.00       Revenue from gifts, flowers, coffee shops, and canteen       0       20.00         21.00       Rental of vending machines       25,051       21.00         22.00       Rental of hospital space       678,654       22.00         23.00       Governmental appropriations       0       23.00         24.01       INVESTMENT INCOME       44,370       24.00         24.01       CONTRI BUTIONS (UNRESTRI CTED)       551,868       24.01         24.02       GAIN (LOSS) ON SALE OF ASSETS       5,864,72       24.02         24.03       EQUITY IN EARNINGS OF AFFILIATES       5,864,72       24.02         24.04       OTHER       1,930,575       24.04         25.00       Total other income (sum of lines 6-24)       13,607,038       25.00						1
17.00       Revenue from sale of drugs to other than patients       0       17.00         18.00       Revenue from sale of medical records and abstracts       5,577       18.00         19.00       Tuition (fees, sale of textbooks, uniforms, etc.)       2,209,926       19.00         20.00       Revenue from gifts, flowers, coffee shops, and canteen       0       20.00         21.00       Rental of vending machines       25,051       21.00         22.00       Rental of hospital space       678,654       22.00         23.00       Governmental appropriations       0       23.00         24.01       INVESTMENT INCOME       44,370       24.00         24.01       CONTRI BUTIONS (UNRESTRICTED)       551,868       24.01         24.02       GAIN (LOSS) ON SALE OF ASSETS       24,029       24.02         24.03       EQUITY IN EARNINGS OF AFFILIATES       5,886,472       24.02         24.04       OTHER       1,930,575       24.04         25.00       Total other income (sum of lines 6-24)       13,607,038       25.00			han nationts		-	1
18.00       Revenue from sale of medical records and abstracts       5,577       18.00         19.00       Tuition (fees, sale of textbooks, uniforms, etc.)       2,209,926       19.00         20.00       Revenue from gifts, flowers, coffee shops, and canteen       0       20.00         21.00       Rental of vending machines       25,051       21.00         22.00       Rental of hospital space       678,654       22.00         23.00       Governmental appropriations       0       23.00         24.01       INVESTMENT INCOME       44,370       24.00         24.01       CONTRIBUTIONS (UNRESTRICTED)       551,868       24.01         24.02       GAIN (LOSS) ON SALE OF ASSETS       24,029       24.02         24.03       EQUITY IN EARNINGS OF AFFILIATES       5,886,472       24.03         24.04       OTHER       1,930,575       24.04         25.00       Total other income (sum of lines 6-24)       13,607,038       25.00			man patrents		-	
19.00       Tuition (fees, sale of textbooks, uniforms, etc.)       2, 209, 926       19.00         20.00       Revenue from gifts, flowers, coffee shops, and canteen       0 20.00         21.00       Rental of vending machines       25, 051       21.00         22.00       Rental of hospital space       678, 654       22.00         23.00       Governmental appropriations       0 23.00         24.00       INVESTMENT INCOME       44, 370       24.00         24.01       CONTRIBUTIONS (UNRESTRICTED)       551, 868       24.01         24.02       GAIN (LOSS) ON SALE OF ASSETS       24,029       24.02         24.03       EQUITY IN EARNINGS OF AFFILIATES       5, 886, 472       24.03         24.04       OTHER       1, 930, 575       24.04         25.00       Total other income (sum of lines 6-24)       13, 607, 038       25.00					- 1	
20.00       Revenue from gifts, flowers, coffee shops, and canteen       0       20.00         21.00       Rental of vending machines       25,051       21.00         22.00       Rental of hospital space       678,654       22.00         23.00       Governmental appropriations       0       23.00         24.00       INVESTMENT I NCOME       44,370       24.00         24.01       CONTRIBUTIONS (UNRESTRICTED)       551,868       24.01         24.02       GAIN (LOSS) ON SALE OF ASSETS       24,029       24.02         24.03       EQUITY IN EARNINGS OF AFFILIATES       5,886,472       24.03         24.04       OTHER       1,930,575       24.04         25.00       Total other income (sum of lines 6-24)       13,607,038       25.00						
21. 00       Rental of vending machines       25, 051       21. 00         22. 00       Rental of hospital space       678, 654       22. 00         23. 00       Governmental appropriations       0 23. 00         24. 00       INVESTMENT INCOME       44, 370       24. 00         24. 01       CONTRIBUTIONS (UNRESTRICTED)       551, 868       24. 01         24. 02       GAIN (LOSS) ON SALE OF ASSETS       24, 029       24. 02         24. 03       EQUITY IN EARNINGS OF AFFILIATES       5, 886, 472       24. 02         24. 04       OTHER       1, 930, 575       24. 04         25. 00       Total other income (sum of lines 6-24)       13, 607, 038       25. 00						1
22.00       Rental of hospital space       678,654       22.00         23.00       Governmental appropriations       0 23.00         24.00       INVESTMENT INCOME       44,370       24.00         24.01       CONTRIBUTIONS (UNRESTRICTED)       551,868       24.01         24.02       GAIN (LOSS) ON SALE OF ASSETS       24,029       24.02         24.03       EQUITY IN EARNINGS OF AFFILIATES       5,886,472       24.02         24.04       OTHER       1,930,575       24.04         25.00       Total other income (sum of lines 6-24)       13,607,038       25.00					- 1	
23. 00       Governmental appropriations       0       23. 00         24. 00       INVESTMENT INCOME       44, 370       24. 00         24. 01       CONTRIBUTIONS (UNRESTRICTED)       551, 868       24. 01         24. 02       GAIN (LOSS) ON SALE OF ASSETS       24, 029       24. 02         24. 03       EQUITY IN EARNINGS OF AFFILIATES       5, 886, 472       24. 02         24. 04       OTHER       1, 930, 575       24. 04         25. 00       Total other income (sum of lines 6-24)       13, 607, 038       25. 00					· ·	l
24. 00       INVESTMENT I NCOME       44, 370       24. 00         24. 01       CONTRI BUTI ONS (UNRESTRI CTED)       551, 868       24. 01         24. 02       GAI N (LOSS) ON SALE OF ASSETS       24, 029       24. 02         24. 03       EQUITY IN EARNINGS OF AFFILIATES       5, 886, 472       24. 03         24. 04       OTHER       1, 930, 575       24. 04         25. 00       Total other income (sum of lines 6-24)       13, 607, 038       25. 00		·				l
24. 01       CONTRIBUTIONS (UNRESTRICTED)       551, 868       24. 01         24. 02       GAIN (LOSS) ON SALE OF ASSETS       24, 029       24. 02         24. 03       EQUITY IN EARNINGS OF AFFILIATES       5, 886, 472       24. 03         24. 04       OTHER       1, 930, 575       24. 04         25. 00       Total other income (sum of lines 6-24)       13, 607, 038       25. 00					-	
24. 02       GAIN (LOSS) ON SALE OF ASSETS       24, 029       24. 02         24. 03       EQUITY IN EARNINGS OF AFFILIATES       5, 886, 472       24. 03         24. 04       OTHER       1, 930, 575       24. 04         25. 00       Total other income (sum of lines 6-24)       13, 607, 038       25. 00					· ·	
24. 03       EQUITY IN EARNINGS OF AFFILIATES       5, 886, 472       24. 03         24. 04       OTHER       1, 930, 575       24. 04         25. 00       Total other income (sum of lines 6-24)       13, 607, 038       25. 00		· · ·				
24. 04     OTHER       25. 00     Total other income (sum of lines 6-24)       1, 930, 575     24. 04       13, 607, 038     25. 00						
25.00 Total other income (sum of lines 6-24) 13,607,038 25.00						
						1
26. 00   Total (line 5 plus line 25) 49, 234, 862   26. 00	26. 00	Total (line 5 plus line 25)				1
27. 00 OTHER-NON-OPERATING REV/EXP 40, 640 27. 00						
28.00 Total other expenses (sum of line 27 and subscripts) 40,640 28.00					· ·	
29.00 Net income (or loss) for the period (line 26 minus line 28) 49,194,222 29.00	29. 00				49, 194, 222	29. 00

4, 028, 674

-1, 672

4, 027, 002

24.00

24.00 Total (sum of lines 1-23)

Heal th	Financial Systems		FRANCISCAN HEAL	TH LAFAYETTE		In Lie	u of Form CMS-2	2552-10
	LLOCATION - HHA GENERAL SERVICE			Provi der CO	CN: 15-0109	Peri od: From 01/01/2016	Worksheet H-1	
				HHA CCN:	15-7124	To 12/31/2016	Date/Time Pre	pared:
						Home Health	6/28/2017 3: 3 PPS	6 pm
			C: +-1 D-1	-+  0+-		Agency I		
			Capital Rela	ated Costs				
		Net Expenses	BI dgs &	Movabl e	Plant	Transportati on		
		for Cost Allocation	Fi xtures	Equi pment	Operation 8 Maintenance		(cols. 0-4)	
		(from Wkst. H,						
		col . 10) 0	1.00	2. 00	3. 00	4. 00	4A. 00	
	GENERAL SERVICE COST CENTERS							
1. 00	Capital Related - Bldg. & Fixtures	0	0				0	1.00
2.00	Capital Related - Movable	39, 852		39, 852			0	2. 00
3. 00	Equipment Plant Operation & Maintenance	0	0	0		0	0	3. 00
4.00	Transportation	0	0	0		0 0		4. 00
5.00	Administrative and General HHA REIMBURSABLE SERVICES	822, 282	0	39, 852		0 0	862, 134	5.00
6.00	Skilled Nursing Care	645, 011	0	0		0 0	645, 011	6. 00
7.00	Physical Therapy	515, 448	0	0		0 0	515, 448	1
8. 00 9. 00	Occupational Therapy Speech Pathology	179, 475 19, 932	0	0		0 0	179, 475 19, 932	1
10.00	Medical Social Services	3, 531	0	0		0 0	3, 531	10. 00
11. 00 12. 00	Home Health Aide Supplies (see instructions)	80, 656 54, 093	0	0		0 0	80, 656 54, 093	1
13. 00	Drugs	126, 656	Ö	0		0	126, 656	1
14. 00	DME HHA NONREI MBURSABLE SERVI CES	0	0	0		0 0	0	14. 00
15. 00	Home Dialysis Aide Services	0	0	0		0 0	0	15. 00
16. 00	Respiratory Therapy	0	0	0		0 0	0	
17. 00 18. 00	Private Duty Nursing Clinic	0	0	0		0 0	0	
19. 00	Health Promotion Activities	Ö	ő	0		0 0	Ö	19. 00
20. 00 21. 00	Day Care Program Home Delivered Meals Program	0	0	0		0 0	0	20. 00 21. 00
21.00	Homemaker Service	0	0	0		0 0	0	22.00
23. 00	All Others (specify)	1, 540, 066	0	0		0 0	1, 540, 066	
23. 50 24. 00	Telemedicine Total (sum of lines 1-23)	4, 027, 002	0	0 39, 852		0 0	4, 027, 002	23. 50 24. 00
	, and the second	Admi ni strati ve		, , , ,				
		& General 5.00	4A + 5) 6.00					-
	GENERAL SERVICE COST CENTERS	0.00	0.00					
1. 00	Capital Related - Bldg. & Fixtures							1. 00
2.00	Capital Related - Movable							2. 00
3. 00	Equipment Plant Operation & Maintenance							3. 00
4. 00	Transportation							4. 00
5.00	Administrative and General HHA REIMBURSABLE SERVICES	862, 134						5. 00
6.00	Skilled Nursing Care	175, 706	820, 717					6. 00
7.00	Physical Therapy	140, 412	655, 860					7. 00
8. 00 9. 00	Occupational Therapy Speech Pathology	48, 890 5, 430	228, 365 25, 362					8. 00 9. 00
10.00	Medical Social Services	962	4, 493					10.00
11. 00 12. 00	Home Health Aide Supplies (see instructions)	21, 971 14, 735	102, 627 68, 828					11. 00 12. 00
13. 00	Drugs	34, 502	161, 158					13. 00
14. 00		0	0					14. 00
15. 00	HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services	0	0					15. 00
16. 00	Respi ratory Therapy	0	0					16. 00
17. 00 18. 00	Private Duty Nursing Clinic	0	0					17. 00 18. 00
19. 00	Health Promotion Activities	0	0					19. 00
20.00	Day Care Program	0	0					20. 00 21. 00
21.00	Home Delivered Meals Program Homemaker Service	0	0					21.00
23. 00	` ' ' ' ' '	419, 526	1, 959, 592					23. 00
23. 50 24. 00	Telemedicine Total (sum of lines 1-23)	0	4, 027, 002					23. 50 24. 00
			. ,					

Provider CN: 15-0109	Heal th	Financial Systems		FRANCISCAN HEAI	LTH LAFAYETTE		In Lie	eu of Form CMS-2	2552-10
Capital Related Costs   Bildgs & Bildgs & Bould   Bildg					Provi der C		Peri od: From 01/01/2016	Worksheet H-1 Part II Date/Time Pre	pared:
Capital Related Costs   Bidgs & Fixtures   Equipment (SQUARE FEET)   CQUARE FEE									о рііі
Fixtures			Capital Rel	ated Costs			Agency I		
Fixtures			BL L		5				
COULAR FEET   COULAR VALUE   Maintenance   COURRE FEET   COULAR FEET   COULAR FEET   COURT FEE							onReconciliation		
1.00						(WITELAGE)			
CENERAL SERVICE COST CENTERS			(**************************************	()				(	
1.00			1. 00	2.00	3.00	4. 00	5A. 00	5. 00	
Fixtures   Capital Related - Movable   Equipment   Sapital Related - Movable   Equipment   Sapital Related - Movable   Equipment   Sapital Related - Movable   Sapital Related   Sapital Related			1			1		ı	
2.00	1.00		0				0		1.00
3.00	2.00			39, 852			0		2. 00
4.00   Transportation (see instructions)   0   0   0   0   0   1.500	0.00								0.00
Instructions   Administrative and General   0   39,852   0   0   -862,134   3,164,868   5.00			0	O	0		0		
Administrative and General   0   39,852   0   0   -862,134   3,164,868   5.00   HHA REIMBURSABLE SERVICES	4.00			0	0		U		4.00
6. 00   Skilled Nursing Care   0   0   0   0   0   645,011   6. 00   7. 00   Physical Therapy   0   0   0   0   0   0   515,448   7. 00   8. 00   0   0   0   0   0   0   0   179,475   8. 00   9. 00   Speech Pathology   0   0   0   0   0   0   0   179,475   8. 00   0   0   0   0   0   0   179,475   8. 00   0   0   0   0   0   0   179,475   8. 00   0   0   0   0   0   0   0   0   0	5.00	1	0	39, 852	0		0 -862, 134	3, 164, 868	5. 00
7. 00 Physical Therapy									
8.00 Occupational Therapy 0 0 0 0 0 0 179,475 8.00 9.00 Speech Pathology 0 0 0 0 0 0 179,475 8.00 1.00 Medical Social Services 0 0 0 0 0 0 0 19,932 9.00 11.00 Home Health Aide 0 0 0 0 0 0 0 3,531 10.00 12.00 Supplies (see instructions) 0 0 0 0 0 0 0 54,093 12.00 13.00 Drugs 0 0 0 0 0 0 0 0 126,656 13.00 DME 0 0 0 0 0 0 0 0 126,656 13.00 DME 0 0 0 0 0 0 0 0 0 14.00 HHA NONREI MBURSABLE SERVICES  15.00 Home Dialysis Aide Services 0 0 0 0 0 0 0 0 15.00 14.00 Private Duty Nursing 0 0 0 0 0 0 0 0 17.00 18.00 Clinic 0 0 0 0 0 0 0 0 18.00 19.00 19.00 Day Care Program 0 0 0 0 0 0 0 0 0 18.00 19.00 Day Care Program 0 0 0 0 0 0 0 0 0 0 0 0 19.00 22.00 Home Delivered Meals Program 0 0 0 0 0 0 0 0 0 0 1, 540,066 23.00 23.50 Total (sum of lines 1-23) 0 39,852 0 0 -862,134 3,164,868 24.00 Cost To Be Allocated (per 0 0 39,852 0 0 Worksheet H-1, Part I)									
9. 00   Speech Pathology   0   0   0   0   0   0   19,932   9.00   10. 00   Medical Social Services   0   0   0   0   0   0   3,531   10.00   11. 00   Home Heal th Aide   0   0   0   0   0   0   0   12. 00   Supplies (see instructions)   0   0   0   0   0   54,093   12.00   13. 00   Drugs   0   0   0   0   0   0   126,656   13.00   14. 00   DME   HHA NONREIMBURSABLE SERVICES			0				-		
10.00 Medical Social Services 0 0 0 0 0 0 3,531 10.00 11.00 Home Health Aide 0 0 0 0 0 0 0 80,656 11.00 12.00 Supplies (see instructions) 0 0 0 0 0 0 54,093 12.00 13.00 Drugs 0 0 0 0 0 0 0 126,656 13.00 DME 0 0 0 0 0 0 0 126,656 13.00 DME 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1 '	0	0	0		-	· ·	
11. 00 Home Heal th Ai de			0	0	0		o o		
12.00   Supplies (see instructions)   0   0   0   0   0   0   126,656   13.00     13.00   Drugs   0   0   0   0   0   0   126,656   13.00     14.00   DME		1	0	0	0		0		1
13.00 Drugs			0	0	0		0		1
14.00 DME				· ·			o o		1
HHA NONREIMBURSABLE SERVICES   15.00   Home Dialysis Aide Services   0   0   0   0   0   0   15.00			0	-			_		1
16.00       Respiratory Therapy       0       0       0       0       0       0       16.00         17.00       Private Duty Nursing       0       0       0       0       0       0       0       0       17.00         18.00       Clinic       0       0       0       0       0       0       0       0       0       18.00         19.00       Heal th Promotion Activities       0       0       0       0       0       0       0       0       0       0       19.00         20.00       Day Care Program       0					-				
17. 00       Private Duty Nursing       0       0       0       0       0       0       17. 00         18. 00       Clinic       0       0       0       0       0       0       18. 00         19. 00       Heal th Promotion Activities       0       0       0       0       0       0       19. 00         20. 00       Day Care Program       0 <td></td> <td></td> <td>1</td> <td></td> <td>l e</td> <td></td> <td></td> <td></td> <td>15. 00</td>			1		l e				15. 00
18.00       Clinic       0       0       0       0       0       0       18.00         19.00       Health Promotion Activities       0       0       0       0       0       0       19.00         20.00       Day Care Program       0       0       0       0       0       0       0       0       0       20.00         21.00       Home Delivered Meals Program       0       0       0       0       0       0       0       0       0       0       0       0       0       21.00         22.00       Homemaker Service       0       0       0       0       0       0       0       0       0       22.00         23.00       All Others (specify)       0       0       0       0       0       0       0       1,540,066       23.00         24.00       Total (sum of lines 1-23)       0       39,852       0       0       -862,134       3,164,868       24.00         25.00       Cost To Be Allocated (per       0       39,852       0       0       0       862,134       25.00			0					1	
19.00     Health Promotion Activities     0     0     0     0     0     19.00       20.00     Day Care Program     0     0     0     0     0     0     0     0     0     20.00       21.00     Home Delivered Meals Program     0     0     0     0     0     0     0     0     0     0     0     21.00       22.00     Homemaker Service     0     0     0     0     0     0     0     0     0     22.00       23.00     All Others (specify)     0     0     0     0     0     0     0     1,540,066     23.00       24.00     Total (sum of lines 1-23)     0     39,852     0     0     -862,134     3,164,868     24.00       25.00     Cost To Be Allocated (per     0     39,852     0     0     862,134     25.00			0	0	0		٥	1	1
20.00     Day Care Program     0     0     0     0     0     0     20.00       21.00     Home Delivered Meals Program     0     0     0     0     0     0     0     0     21.00       22.00     Homemaker Service     0     0     0     0     0     0     0     0     0     22.00       23.00     All Others (specify)     0     0     0     0     0     0     0     1,540,066     23.00       24.00     Total (sum of lines 1-23)     0     39,852     0     0     -862,134     3,164,868     24.00       25.00     Cost To Be Allocated (per Worksheet H-1, Part I)     0     39,852     0     0     862,134     25.00			0	0	0		ŭ .	1	
21.00     Home Delivered Meals Program     0     0     0     0     0     0     21.00       22.00     Homemaker Service     0     0     0     0     0     0     0     0     0     22.00       23.00     All Others (specify)     0     0     0     0     0     0     1,540,066     23.00       23.50     Tel emedicine     0     0     0     0     0     0     0     23.50       24.00     Total (sum of lines 1-23)     0     39,852     0     0     -862,134     3,164,868     24.00       25.00     Cost To Be Allocated (per     0     39,852     0     0     862,134     25.00       Worksheet H-1, Part I)		The state of the s	0	0	0		0	1	
22.00     Homemaker Service     0     0     0     0     0     0     22.00       23.00     All Others (specify)     0     0     0     0     0     1,540,066     23.00       23.50     Tel emedicine     0     0     0     0     0     0     0     23.50       24.00     Total (sum of lines 1-23)     0     39,852     0     0     -862,134     3,164,868     24.00       25.00     Worksheet H-1, Part I)     39,852     0     0     862,134     25.00		1 3		0	0			Ĭ	
23.00 All Others (specify) 0 0 0 0 0 1,540,066 23.00 23.50 Telemedicine 0 0 0 0 0 0 0 23.50 24.00 Total (sum of lines 1-23) 0 39,852 0 0 -862,134 3,164,868 24.00 25.00 Worksheet H-1, Part I) 862,134 25.00		1		0				0	
23.50 Telemedicine 0 0 0 0 0 0 23.50 24.00 Total (sum of lines 1-23) 0 39,852 0 0 -862,134 3,164,868 24.00 25.00 Cost To Be Allocated (per Worksheet H-1, Part I) 862,134 25.00		1	l o	0	Ö		o o	1, 540, 066	
25.00 Cost To Be Allocated (per 0 39,852 0 0 862,134 25.00 Worksheet H-1, Part I)	23. 50		0	0	0		0 0	0	
Worksheet H-1, Part I)	24.00	Total (sum of lines 1-23)	0	39, 852	0		0 -862, 134	3, 164, 868	24. 00
	25. 00		0	39, 852	0		0	862, 134	25. 00
	26. 00		0. 000000	1. 000000	0. 000000	0.0000	00	0. 272408	26. 00

Peri od: Worksheet H-2
From 01/01/2016 Part I
To 12/31/2016 Date/Time Prepared: 6/28/2017 3:36 pm HHA CCN: 15-7124 Home Health PPS

						Agency I		
			CAPITAL REL	ATED COSTS		.,		
	Cost Center Description	HHA Trial Balance (1)	BLDG & FLXT	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	COMMUNI CATI ONS	MGMT INFO SYSTEMS	
		0	1.00	2.00	4.00	5. 01	5. 02	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 17. 00 18. 00 19. 50 20. 00 21. 00	Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to	0 820, 717 655, 860 228, 365 25, 362 4, 493 102, 627 68, 828 161, 158 0 0 0 0 0 0 0 0 1, 959, 592 0 4, 027, 002	0 0 0 0 0 0 0 0 0 0	000000000000000000000000000000000000000	884, 653	0 0 0 0 0 0 0 0 0 0	321, 225 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 19. 00 20. 00 21. 00
	6 decimal places.  Cost Center Description	PURCHASI NG	ADMI TTI NG	PATI ENT ACCOUNTI NG	Subtotal	OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	
		5. 03	5. 04	5. 05	5A. 05	5. 06	7. 00	
18. 00		5, 320 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0	000000000000000000000000000000000000000	1, 253, 327 820, 717 655, 860 228, 365 25, 362 4, 493 102, 627 68, 828 161, 158 0 0 0 0 0 0 1, 959, 592 0 5, 280, 329 0. 000000	76, 274 60, 953 21, 223 2, 357 411 9, 538 6, 397 14, 977 0 0 0 0 0 0 0 182, 117 0 490, 733	0 0 0 0 0 0 0 0 0 0 0 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 19. 00 20. 00 21. 00

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

0 0 0 0 0 Homemaker Service 0 0 0 0 18.00 18.00 All Others (specify) 0 19.00 0 0 2, 141, 709 19.00 0 19.50 Tel emedi ci ne Ω O 19 50 20.00 Total (sum of lines 1-19) (2) 23, 069 0 6,090,995 20.00 Unit Cost Multiplier: column 21.00 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.

0

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112, 165

75, 225

176, 135

7.00

8.00

9 00

10.00

11.00

12.00

13 00

14.00

15.00

16 00

17.00

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0 0 0

0 0 0

7.00

8.00

9 00

10.00

11.00

12.00

13.00

14.00

15.00

16 00

17.00

Home Heal th Aide

Respiratory Therapy

Private Duty Nursing

Day Care Program

Drugs

Clinic

DME

Supplies (see instructions)

Home Dialysis Aide Services

Health Promotion Activities

Home Delivered Meals Program

<sup>(1)</sup> Column O, line 20 must agree with Wkst. A, column 7, line 101.

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

						Agency I	
	Cost Center Description	Intern &	Subtotal	Allocated HHA	Total HHA		
		Residents Cost		A&G (see Part	Costs		
		& Post		11)			
		Stepdown					
		Adjustments					4
		25. 00	26. 00	27. 00	28. 00		
1.00	Administrative and General	0	1, 689, 739				1. 00
2.00	Skilled Nursing Care	0	896, 991				2. 00
3.00	Physi cal Therapy	0	716, 813		· ·		3. 00
4.00	Occupational Therapy	0	249, 588		· ·		4. 00
5.00	Speech Pathology	0	27, 719				5. 00
6.00	Medical Social Services	0	4, 911				6. 00
7.00	Home Health Aide	0	112, 165	43, 063	155, 228		7. 00
8.00	Supplies (see instructions)	0	75, 225	28, 881			8. 00
9.00	Drugs	0	176, 135	67, 622	243, 757		9. 00
10.00	DME	0	0	0	0		10.00
11. 00	Home Dialysis Aide Services	0	0	0	0		11. 00
12.00	Respiratory Therapy	0	0	0	0		12.00
13.00	Private Duty Nursing	0	0	0	0		13.00
14.00	Clinic	0	0	0	0		14.00
15.00	Health Promotion Activities	0	0	0	0		15. 00
16.00	Day Care Program	0	0	0	0		16. 00
17.00	Home Delivered Meals Program	0	0	0	0		17. 00
18.00	Homemaker Service	0	0	0	0		18. 00
19.00	All Others (specify)	0	2, 141, 709	822, 249	2, 963, 958		19. 00
19. 50	Tel emedi ci ne	0	0	0	0		19. 50
20.00	Total (sum of lines 1-19) (2)	0	6, 090, 995	1, 689, 739	6, 090, 995		20.00
21.00	Unit Cost Multiplier: column			0. 383922			21. 00
	26, line 1 divided by the sum						
	of column 26, line 20 minus						
	column 26, line 1, rounded to						
	6 decimal places.						

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

Health Financial Systems	FRANCISCAN HEALTH	LAFAYETTE	In Lie	u of Form CMS-2552-10
ALLOCATION OF GENERAL SERVICE COSTS TO BASIS	O HHA COST CENTERS STATISTICAL	Provi der CCN: 15-0109  HHA CCN: 15-7124	Peri od: From 01/01/2016 To 12/31/2016	Worksheet H-2 Part II Date/Time Prepared:
				6/28/2017 3:36 pm
			Home Health	PPS

						Home Health	PPS	
		CAPITAL REL	ATED COSTS			Agency I		
		OALTTAL REL	LATED COSTS					
	Cost Center Description	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	COMMUNI CATI ONS	MGMT INFO	PURCHASI NG	
		(SQUARE FEET)	(SQUARE FEET)	BENEFITS		SYSTEMS	(COSTED REQ	
				DEPARTMENT (GROSS	(PHONE LINE S)	(MANHOURS)	UI SI )	
				SALARI ES)				
		1.00	2.00	4.00	5. 01	5. 02	5. 03	
1.00	Administrative and General	0	C	2, 694, 525	0	73, 706	102, 266	1. 00
2.00	Skilled Nursing Care	0	_		0	0	0	2. 00
3.00	Physi cal Therapy	0	C	_	0	0	0	3. 00
4. 00 5. 00	Occupational Therapy Speech Pathology	0	C	0	0	0	0	4. 00 5. 00
6. 00	Medical Social Services	0			0	0	0	6. 00
7. 00	Home Heal th Aide	o o	C	Ö	ő	0	Ö	7. 00
8.00	Supplies (see instructions)	0	C	0	0	0	0	8. 00
9.00	Drugs	0	C		_	0	0	
10.00	DME	0	C	1	_	0	0	10.00
11. 00 12. 00	Home Dialysis Aide Services Respiratory Therapy	0	C			0	0	11. 00 12. 00
13. 00	Private Duty Nursing	0			_	0	0	13. 00
14. 00	Clinic	0		-	_	_	Ö	14. 00
15. 00	Health Promotion Activities	0	C	0	0	0	0	15. 00
16.00	Day Care Program	0	C	0	0	0	0	16. 00
17. 00	Home Delivered Meals Program	0	C	0	0	0	0	17. 00
18.00	Homemaker Service	0	C	0	0	0	0	18. 00
19. 00 19. 50	All Others (specify) Telemedicine	0			0	0	0	19. 00 19. 50
20. 00	Total (sum of lines 1-19)	0		2, 694, 525	0	73, 706	102, 266	
21. 00	Total cost to be allocated	0	C	884, 653		321, 225		
22. 00		0. 000000		0. 328315			0. 052021	22. 00
	Cost Center Description	ADMITTING	PATIENT	Reconciliation		OPERATION OF	LAUNDRY &	
		(GROSS CHAR GES)	ACCOUNTI NG (GROSS CHAR		ADMINISTRATIVE AND GENERAL	PLANT (SQUARE FEET)	LINEN SERVICE (POUNDS OF	
		GE3)	GES)		(ACCUM. COST)	(SQUARE TEET)	LAUNDRY)	
		5. 04	5. 05	5A. 06	5. 06	7. 00	8. 00	
1.00	Administrative and General	9, 050, 299	9, 050, 299	0		0	0	1. 00
2.00	Skilled Nursing Care	0	C	_	,	0	0	2. 00
3.00	Physical Therapy	0	C	1		0	0	3. 00
4. 00 5. 00	Occupational Therapy Speech Pathology	0	C	_		0	0	4. 00 5. 00
6. 00	Medical Social Services	0		_	1	0	0	6. 00
7. 00	Home Health Aide	0	C		1	0	0	7. 00
8.00	Supplies (see instructions)	0	C	0	68, 828	0	0	8. 00
9.00	Drugs	0	C		161, 158	0	0	9. 00
10.00	DME	0	C		0	0	0	10.00
11. 00 12. 00	Home Dialysis Aide Services Respiratory Therapy	0	C	1	0	0	0	11. 00 12. 00
13. 00	Private Duty Nursing	0		-	0	0	0	13. 00
14. 00	Clinic	0	C	Ö	Ō	0	Ō	14. 00
15. 00	Health Promotion Activities	0	C	0	0	0	0	15. 00
16. 00		0	C	0	0	0	0	16. 00
17. 00	Home Delivered Meals Program	0	C	0	0	0	0	17. 00
18. 00 19. 00	Homemaker Service All Others (specify)				0 1, 959, 592	0	0	18. 00 19. 00
19. 50	Telemedicine				1, 757, 572	0	0	
20. 00		9, 050, 299	9, 050, 299	J	5, 280, 329	Ö	ő	20. 00
21. 00	Total cost to be allocated	615	41, 514		490, 733	0	0	21. 00
22.00	Unit cost multiplier	0. 000068	0. 004587	1	0. 092936	0.000000	0. 000000	22 00

Health Financial Systems	FRANCISCAN HEALTH	LAFAYETTE	In Lie	u of Form CMS-2552-10
ALLOCATION OF GENERAL SERVICE COST	TO HHA COST CENTERS STATISTICAL	Provider CCN: 15-0109	Peri od:	Worksheet H-2
BASIS		HHA CCN: 15-7124	From 01/01/2016 To 12/31/2016	Date/Time Prepared:
				6/28/2017 3:36 pm

				TITIA CON.	15 7124	10 12/31/2010	6/28/2017 3: 3	
-						Home Health	PPS	
						Agency I		
	Cost Center Description	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	
		(SQUARE FEET)	(MEALS SERVED)	(MANHOURS)	ADMI NI STRATI (	N SERVICES &	(COSTED	
						SUPPLY	REQUIS.)	
					(DI RECT NRS	(COSTED		
					I NG)	REQUIS.)		
		9. 00	10.00	11. 00	13.00	14.00	15. 00	
1.00 Admi	inistrative and General	0	0	73, 706	73, 70	06 0	0	1. 00
2. 00 Ski I	lled Nursing Care	0	0	0	)	0 0	0	2.00
3.00 Phys	sical Therapy	0	ol	0	)	ol o	0	3. 00
	upational Therapy	0	ol	0	)	0 0	0	4. 00
	ech Pathology	0	0	0	,	0 0	0	5. 00
	ical Social Services	0	0	0	1	0	0	6. 00
4	e Heal th Ai de	0	0	0	1	0	0	
	plies (see instructions)	i n	0	0		0	o o	8. 00
9.00 Drug		l o		0			0	
10. 00 DME	_	l o		0			0	10. 00
4	e Dialysis Aide Services	0		0				11. 00
4	piratory Therapy	0	0	0			0	12. 00
		0		0		0	0	13. 00
4	vate Duty Nursing	0		0		0	1	
14. 00   Cl i i		0	0	0	1	0	0	
1	Ith Promotion Activities	0	0	0		0	0	15.00
1 7	Care Program	0	0	0	1	0	0	
1	e Delivered Meals Program	0	0	0	1	0	0	17. 00
	emaker Service	0	0	0	1	0	0	
	Others (specify)	0	0	0	1	0	0	19. 00
1	emedicine	0	0	0	1	0	0	19. 50
1	al (sum of lines 1-19)	0	0	73, 706			0	20. 00
	al cost to be allocated	0	0	95, 533			0	21. 00
22. 00 Uni	t cost multiplier	0. 000000	0. 000000	1. 296136		2 0.000000	0. 000000	22. 00
	Cost Center Description	MEDI CAL	SOCIAL SERVICE	NURSING SCHOOL				
		RECORDS &	(		PRGM			
		LI BRARY	(TIME SPENT)	(ASSI GNED	(ASSI GNED			
		(GROSS CHAR		TIME)	TIME)			
		GES)	17.00		22.22			
1 00 111		16. 00	17. 00	20.00	23. 00			1 00
1	inistrative and General	9, 050, 299	0	0	1	0		1. 00
	lled Nursing Care	0	0	0	1	0		2. 00
1 7	si cal Therapy	0	0	0	1	0		3. 00
1	upational Therapy	0	0	0	1	0		4. 00
	ech Pathology	0	0	0	1	0		5. 00
1	ical Social Services	0	0	0		0		6. 00
7.00 Home	e Health Aide	0	0	0	)	0		7. 00
	plies (see instructions)	0	0	0	)	0		8. 00
9.00 Drug	gs	0	0	0	1	0		9. 00
10. 00 DME		0	0	0		0		10.00
11.00 Home	e Dialysis Aide Services	0	0	0	)	0		11.00
12. 00 Res	piratory Therapy	0	0	0	)	0		12.00
13.00 Pri	vate Duty Nursing	0	o	0	1	0		13. 00
14.00 Clir		0	0	0	)	0		14.00
	Ith Promotion Activities	0	ol	0	)	0		15. 00
	Care Program	0	o	0	)	0		16. 00
	e Delivered Meals Program	0	0	0	,	0		17. 00
	emaker Service	i o	0	0		0		18. 00
	Others (specify)	l	ا	0	,	0		19. 00
	emedicine			0				19. 50
	al (sum of lines 1-19)	9, 050, 299		0		0		20. 00
	al cost to be allocated	23, 069		0		0		21. 00
	t cost multiplier	0. 002549	1	0. 000000	0. 00000	0		21.00
22.00   0111	1 0031 mai 11 pi 1 61	0.002349	0.000000	0.000000	0.00000	, o <sub>l</sub>		22.00

Hoal th	Financial Systems		FRANCISCAN HEAL	TH I VEVALLE		In Lie	eu of Form CMS-2	2552_10
	TIONMENT OF PATIENT SERVICE COST		TRANCI SCAN TIEAL		CN: 15-0109 F	Peri od:	Worksheet H-3	
				HHA CCN:		From 01/01/2016 To 12/31/2016	Part I Date/Time Prep 6/28/2017 3:30	pared:
				Ti tl e	e XVIII	Home Health Agency I	PPS	<u>o piii </u>
	Cost Center Description		Facility Costs		Total HHA	Total Visits	Average Cost	
		H-2, Part I, col. 28, line	(from Wkst.	Ancillary Costs (from	Costs (cols.		Per Visit (col. 3 ÷ col.	
		COI . 20, TITIE	n-2, Part I)	Part II)	+ 2)		4)	
		0	1.00	2. 00	3.00	4. 00	5. 00	
	PART I - COMPUTATION OF LESSER	OF AGGREGATE F	PROGRAM COST, A	GGREGATE OF TH	HE PROGRAM LIMI	TATION COST, OF	₹	
	BENEFICIARY COST LIMITATION							
1. 00	Cost Per Visit Computation Skilled Nursing Care	2. 00	1, 241, 366		1, 241, 366	7, 181	172. 87	1. 00
2.00	Physical Therapy	3.00		C	1 ' '			2.00
3.00	Occupational Therapy	4. 00		C				
4. 00	Speech Pathology	5. 00	1 '	Č				
5.00	Medical Social Services	6. 00			6, 796			5. 00
6.00	Home Health Aide	7. 00			155, 228			
7. 00	Total (sum of lines 1-6)		2, 779, 174					7. 00
			1		Program Visits	<u>S</u> ^t B		
	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Not Subject to			
	oost conten beschiptron	OUST ETHIN ES	OBON NO. (1)	rui t A	Deductibles &			
					Coi nsurance			
		0	1.00	2. 00	3.00	4. 00	5. 00	
	Limitation Cost Computation	T	T			. T		
8.00	Skilled Nursing Care		26900	C				8. 00
8. 01 8. 02	Skilled Nursing Care Skilled Nursing Care		29200 99915	(				8. 01 8. 02
9. 00	Physical Therapy		26900	(				9. 00
9. 01	Physical Therapy		29200	C	1			9. 01
9. 02	Physical Therapy		99915	Č				9. 02
10.00	Occupational Therapy		26900	C		1		10. 00
10. 01	Occupational Therapy		29200	C				10. 01
10. 02	Occupational Therapy		99915	C	1			10. 02
11.00	Speech Pathology		26900	C				11.00
11. 01 11. 02	Speech Pathology Speech Pathology		29200 99915	(				11. 01 11. 02
12. 00	Medical Social Services		26900	C				12. 00
12. 01	Medical Social Services		29200	C				12. 01
12. 02	Medical Social Services		99915	Č				12. 02
13.00	Home Health Aide		26900	C	950			13. 00
13. 01	Home Health Aide		29200	C				13. 01
13. 02	Home Heal th Ai de		99915	C	1			13. 02
14.00	Total (sum of lines 8-13)	From Wko+ II 2	Facility Coata	Chanad	-,		Dotio (ool 2	14. 00
	Cost Center Description	Part I, col.	Facility Costs (from Wkst.	Shared Ancillary	Total HHA Costs (cols.	Total Charges (from HHA	Ratio (col. 3 ÷ col. 4)	
		28, line	H-2, Part I)	Costs (from	+ 2)	Records)	+ (01. 4)	
		,		Part II)		,		
		0	1.00	2.00	3.00	4. 00	5. 00	
45.00	Supplies and Drugs Cost Computa		104.404					45.00
15.00	1	8. 00 9. 00		(	1			
16. 00	Cost of Drugs	9.00	243, 757 Program Vi si ts		243, 757 Cost of	0	0. 000000	16. 00
			11 Ogram VI 31 t3		Servi ces			
			Par	t B		Part B		
	Cost Center Description	Part A	Not Subject to	Subject to	Part A	Not Subject to	Subject to	
			Deductibles &			Deductibles &		
		/ 00	Coi nsurance	Coi nsurance	0.00	Coi nsurance	Coi nsurance	
	PART I - COMPUTATION OF LESSER	0.00	7.00 PROGRAM COST A	8.00 GGREGATE OF TH	9.00	TATION COST OF	11. 00	
	BENEFICIARY COST LIMITATION	O. AGGILLATE I	NOONAM COOT, A	SOMEONIE OF II	IL TROGRAM LIMI	TATION COST, OF	,	
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	0	.,		(		1	1. 00
2.00	Physical Therapy	0			(			2. 00
3.00	Occupational Therapy	0	914					3.00
4. 00 5. 00	Speech Pathology Medical Social Services		87 40					4. 00 5. 00
6. 00	Home Health Aide	0	950					6. 00
7. 00	Total (sum of lines 1-6)	Ö	1					7. 00
	-		,		•		,	

	Financial Systems TONMENT OF PATIENT SERVICE COST		FRANCISCAN HEAI	LTH LAFAYETTE Provi der CO	°N: 15-0109	In Lie	u of Form CMS-   Worksheet H-3	
711 1 01(1	TOWNER OF TAITEN SERVICE GOST	J		HHA CCN:	15-7124	From 01/01/2016 To 12/31/2016	Part I Date/Time Pre 6/28/2017 3:3	epared:
				Title	XVIII	Home Health Agency I	PPS	
	Cost Center Description					Agency I		
	Limitation Cost Computation	6. 00	7. 00	8. 00	9. 00	10.00	11. 00	
8. 00 8. 01 8. 02 9. 00 9. 01 9. 02 10. 00 10. 01 11. 00 11. 01 11. 02 12. 00 12. 01 12. 02 13. 00 13. 01	Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Physical Therapy Physical Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Speech Pathology Speech Pathology Speech Pathology Medical Social Services Medical Social Services Home Health Aide Home Health Aide							8. 00 8. 01 8. 02 9. 00 9. 01 9. 02 10. 00 10. 02 11. 00 11. 01 11. 02 12. 00 12. 01 12. 02 13. 00 13. 01
13. 02	1							13. 02
14.00	Total (sum of lines 8-13)	Prog	 ram Covered Cha	l arges	Cost of Services			14.00
	Cost Center Description	Part A	Not Subject to Deductibles & Coinsurance	Deductibles & Coinsurance	Part A	Part B Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
	Supplies and Drugs Cost Computa	6.00 ations	7. 00	8. 00	9. 00	10. 00	11. 00	
15. 00	Cost of Medical Supplies	C	-		1	0 0	C	
16.00	Cost Center Description	Total Program Cost (sum of cols. 9-10) 12.00	0	0		0	C	16.00
	PART I - COMPUTATION OF LESSER		PROGRAM COST, A	GGREGATE OF TH	E PROGRAM LI	MITATION COST, OR		
	BENEFICIARY COST LIMITATION Cost Per Visit Computation							-
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6) Cost Center Description	761, 665 597, 152 1, 783, 644 2, 393 3, 829 119, 501 3, 268, 184						1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00
	Limitation Cost Computation	12. 00						
	Speech Pathology Speech Pathology Speech Pathology Medical Social Services Medical Social Services Medical Social Services							8. 00 8. 01 8. 02 9. 00 9. 01 9. 02 10. 00 10. 01 11. 02 11. 00 12. 00 12. 01 12. 02 13. 00 13. 01 13. 02 14. 00

Heal th	Financial Systems		FRANCISCAN HEAL	TH LAFAYETTE	u of Form CMS-2	2552-10		
APP0R1	TIONMENT OF PATIENT SERVICE COST	S		Provi der C	CN: 15-0109	Peri od:	Worksheet H-3	
			HHA CCN:	15-7124	From 01/01/2016 To 12/31/2016		pared:	
						6/28/2017 3:3		
				Title	: XVIII	Home Health	PPS	
Agency I								
	Cost Center Description	From Wkst. C,	Cost to Charge		HHA Shared	Transfer to		
		Part I, col.	Ratio	Charge (from	Ancillary	Part I as		
		9, line		provi der	Costs (col.	1 Indicated		
				records)	x col. 2)			
		0	1.00	2. 00	3. 00	4. 00		
	PART II - APPORTIONMENT OF COST	T OF HHA SERVIC	ES FURNI SHED B	Y SHARED HOSPI	TAL DEPARTMEN	ITS		
1.00	Physical Therapy	66. 00	0. 428139	0		0 col. 2, line 2	. 00	1. 00
2.00	Occupational Therapy	67. 00	0. 288042	0		0 col. 2, line 3	. 00	2. 00
3.00	Speech Pathology	68. 00	0. 480514	0		0 col. 2, line 4	. 00	3. 00
4.00	Cost of Medical Supplies	71. 00	0. 167735	0		0 col. 2, line 1	5. 00	4. 00
5.00	Cost of Drugs	73. 00	0. 176239	0		0 col. 2, line 1	6. 00	5. 00
5. 01	Cost of Drugs 1	73. 01	2. 233012	0		0 col. 2, line 1	6. 01	5. 01

th Financial Systems FRANCISCAN HEALTH CULATION OF HHA REIMBURSEMENT SETTLEMENT	Provider CC	CN: 15-0109	Peri od:	u of Form CMS-2 Worksheet H-4	
21.1.5.1.5.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1	HHA CCN:	15-7124	From 01/01/2016 To 12/31/2016	Part I-II Date/Time Pre	par
	Ti tl e	XVIII	Home Health Agency I	6/28/2017 3: 3: PPS	ю р
				t B	
		Part A	Not Subject to Deductibles &	Deductibles &	
	-	1 00	Coi nsurance	Coi nsurance	-
PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTO	MARY CHARGE	1. 00 S	2. 00	3. 00	
Reasonable Cost of Part A & Part B Services	WINTER OF INTEREST	<u> </u>			
Reasonable cost of services (see instructions)			0 0	0	1 -
Total charges			0 0	0	
Customary Charges					
Amount actually collected from patients liable for payment for	servi ces		0 0	0	1
on a charge basis (from your records)  Amount that would have been realized from patients liable for	novmont		0 0	0	
for services on a charge basis had such payment been made in a with 42 CFR §413.13(b)			0	U	'
Ratio of line 3 to line 4 (not to exceed 1.000000)		0. 0000	0. 000000	0. 000000	
Total customary charges (see instructions)			0 0	0	1
Excess of total customary charges over total reasonable cost (	complete		0 0	0	
only if line 6 exceeds line 1)	., : 6   !				
Excess of reasonable cost over customary charges (complete onl 1 exceeds line 6)	y IT II ne		0 0	0	
Primary payer amounts	ŀ		0 0	0	
			Part A	Part B	
			Servi ces	Servi ces	
PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT			1. 00	2. 00	
700 Total reasonable cost (see instructions)			0	0	1
00 Total PPS Reimbursement - Full Episodes without Outliers			0	1, 750, 751	
00 Total PPS Reimbursement - Full Episodes with Outliers			0	8, 468	
Total PPS Reimbursement - LUPA Episodes			0	31, 626	1
Total PPS Reimbursement - PEP Episodes			0	6, 001	1
Total PPS Outlier Reimbursement - Full Episodes with Outliers			0	0	
7 Total PPS Outlier Reimbursement - PEP Episodes			0	0	
70 Total Other Payments			0	400	
00   DME Payments 00   Oxygen Payments			0	0	
00 Prosthetic and Orthotic Payments			0	0	
Part B deductibles billed to Medicare patients (exclude coinsu	rance)			0	
Subtotal (sum of lines 10 thru 20 minus line 21)			0	1, 797, 246	
Excess reasonable cost (from line 8)			0	0	
OD Subtotal (line 22 minus line 23)			0	1, 797, 246	
Coinsurance billed to program patients (from your records)			_	0	
Not cost (line 24 minus line 25)			0	1, 797, 246	
00 Reimbursable bad debts (from your records) 00 Reimbursable bad debts for dual eligible beneficiaries (see in	structions)				2
00 Total costs - current cost reporting period (line 26 plus line	,		0	1, 797, 246	
NO NET MSP	/		0	0	
Pioneer ACO demonstration payment adjustment (see instructions	)		0	0	
OD Subtotal (see instructions)			0	1, 797, 246	
Sequestration adjustment (see instructions)			0	35, 945	
00  Interim payments (see instructions)			0	1, 761, 301	
			Ι Λ	0	3:
Tentative settlement (for contractor use only)	nd 22)				
Tentative settlement (for contractor use only) Balance due provider/program (line 31 minus lines 31.01, 32, a Protested amounts (nonallowable cost report items) in accordan		Dub 15 2	0	0	34

FRANCISCAN HEALTH LAFAYETTE In Lieu of Form CMS-2552-10

Heal th Financial Systems FRANCISCAN HEAL ANALYSIS OF PAYMENTS TO HOSPITAL-BASED HHAS FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES Provider CCN: 15-0109 Peri od: From 01/01/2016 To 12/31/2016 Worksheet H-5 Date/Time Prepared: 6/28/2017 3:36 pm HHA CCN: 15-7124

				Home Health Agency I	PPS	
		Inpatien	t Part A		t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2. 00	3. 00	4. 00	
1. 00 2. 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero			0	1, 761, 301 0	1. 00 2. 00
3. 00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)  Program to Provider					3. 00
3. 01				0	0	3. 01
3. 02					0	3. 02
3. 03 3. 04					0	3. 03 3. 04
3. 05						3. 05
0.00	Provider to Program			<u> </u>	<u> </u>	0.00
3.50			(	D	0	3. 50
3. 51				D	0	3. 51
3. 52				0	0	3. 52
3.53					0	3. 53
3. 54 3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0	0	3. 54 3. 99
3. 77	3. 50-3. 98)		'		ا	3. 77
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)		(	)	1, 761, 301	4. 00
	TO BE COMPLETED BY CONTRACTOR					
5. 00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5. 00
	Program to Provider					
5. 01					0	5. 01
5. 02 5. 03					0	5. 02 5. 03
5.05	Provider to Program			<u> </u>	U	5.05
5. 50	Trevitadi te Tregitani		(	O	0	5. 50
5. 51				o l	0	5. 51
5. 52			(	D	0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		(	D	0	5. 99
6. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6. 00
6. 01	SETTLEMENT TO PROVIDER			ס	0	6. 01
6. 02	SETTLEMENT TO PROGRAM				0	6. 02
7. 00	Total Medicare program liability (see instructions)		(	Cantractor	1, 761, 301	7. 00
		(	)	Contractor Number	NPR Date (Mo/Day/Yr)	
8. 00	Name of Contractor		J	1. 00	2. 00	8. 00
0.00	Indine of Contractor			Ţ	ı l	0.00

		SALARI ES	OTHER	SUBTOTAL (col. 1 plus col. 2)	RECLASSIFI - CATIONS	SUBTOTAL	
		1.00	2. 00	3.00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT*		0	0	0	0	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP*		0	0	0	0	2. 00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	0	0	0	0	3. 00
4.00	ADMINISTRATIVE & GENERAL*	0	0	0	0	0	4. 00
5.00	PLANT OPERATION & MAINTENANCE*	0	0	0	0	0	5. 00
6.00	LAUNDRY & LINEN SERVICE*	0	0	0	0	0	6. 00
7.00	HOUSEKEEPI NG*	0	0	0	0	0	7. 00
8.00	DI ETARY*	0	0	0	0	0	8. 00
9.00	NURSING ADMINISTRATION*	0	0	0	0	0	9. 00
10.00	ROUTINE MEDICAL SUPPLIES*	0	0	0	0	0	10.00
11.00	MEDI CAL RECORDS*	0	0	0	0	0	11.00
12. 00 13. 00	STAFF TRANSPORTATION* VOLUNTEER SERVICE COORDINATION*	0	U	0	O O	0	12. 00 13. 00
14. 00	PHARMACY*		0	0	0	0	14. 00
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES*		0	0	0	0	15. 00
16. 00	OTHER GENERAL SERVICE*		0	0	0	0	16.00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES		J	O		O	17. 00
17.00	DIRECT PATIENT CARE SERVICE COST CENTERS						17.00
25.00	INPATIENT CARE-CONTRACTED**	0	0	0	0	0	25. 00
26.00	PHYSI CI AN SERVI CES**	0	0	0	0	0	26. 00
27. 00	NURSE PRACTITIONER**	15, 919	0	15, 919	0	15, 919	27. 00
28. 00	REGI STERED NURSE**	440, 062	0	440, 062	0	440, 062	28. 00
29. 00	LPN/LVN**	0	0	0	0	0	29. 00
30. 00	PHYSI CAL THERAPY**	0	0	0	0	0	30. 00
31. 00	OCCUPATI ONAL THERAPY**	19, 010	0	19, 010	0	19, 010	31. 00
32. 00	SPEECH/LANGUAGE PATHOLOGY**	0	0	0	0	0	32. 00
33. 00	MEDICAL SOCIAL SERVICES**	0	0	0	0	0	33.00
34. 00	SPIRITUAL COUNSELING**	0	0	0	0	0	34.00
35. 00	DI ETARY COUNSELI NG**	(4.222)	0	(4.222	0	(4.222	35. 00
36. 00 37. 00	COUNSELING - OTHER** HOSPICE AIDE & HOMEMAKER SERVICES**	64, 322	U	64, 322	O O	64, 322	36. 00 37. 00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	169, 353	0	169, 353 0	0	169, 353 0	38.00
39. 00	PATIENT TRANSPORTATION**		0	0	0	0	39.00
40. 00	IMAGING SERVICES**		0	0	0	0	40.00
41. 00	LABS & DI AGNOSTI CS**		0	0	0	0	41.00
42. 00	MEDICAL SUPPLIES-NON-ROUTINE**		0	0	0	0	42.00
43. 00	OUTPATIENT SERVICES**		0	0	0	0	43. 00
44. 00	PALLIATIVE RADIATION THERAPY**	o	0	0	0	0	44. 00
45. 00	PALLIATIVE CHEMOTHERAPY**	o	o	0	o	0	45. 00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	480, 154	662, 604	1, 142, 758	0	1, 142, 758	46. 00
	NONREI MBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM *	0	0	0	0	0	60.00
61. 00	VOLUNTEER PROGRAM *	0	0	0	0	0	61. 00
62.00	FUNDRAI SI NG*	0	0	0	0	0	62. 00
63. 00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0	0	0	0	63. 00
64. 00	PALLIATIVE CARE PROGRAM*	0	0	0	0	0	64. 00
65. 00	OTHER PHYSI CI AN SERVI CES*	0	0	0	0	0	65. 00
66.00	RESI DENTI AL CARE*	0	0	0	0	0	66.00
67. 00	ADVERTI SI NG*	0	0	0	0	0	67.00
68. 00 69. 00	TELEHEALTH/TELEMONI TORI NG* THRI FT STORE*		0	0	O	0	68. 00 69. 00
70.00	NURSING FACILITY ROOM & BOARD*		0	0	0	0	70.00
71. 00	OTHER NONREIMBURSABLE (SPECIFY)*		0	0	0	0	70.00
	TOTAL	1, 188, 820	662, 604	1, 851, 424	0	1, 851, 424	ł
	-6 tht- il 7 t- Wi-t 0.5		332, 004	1,001,424	<u> </u>	1, 001, 424	. 55. 55

<sup>\*</sup> Transfer the amounts in column 7 to Wkst. 0-5, column 1, line as appropriate.
\*\* See instructions. Do not transfer the amounts in column 7 to Wkst. 0-5.

			·		6/28/2017 3:	36 pm
		AB WOTHENTS	 	Hospi ce I		
		ADJUSTMENTS	TOTAL (col. 5			
		6. 00	± col. 6) 7.00			
	GENERAL SERVICE COST CENTERS	0.00	7.00			
1. 00	CAP REL COSTS-BLDG & FIXT*		0			1.00
2. 00	CAP REL COSTS-MVBLE EQUIP*	d	1			2. 00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	C				3. 00
4.00	ADMINISTRATIVE & GENERAL*	C	ol			4.00
5.00	PLANT OPERATION & MAINTENANCE*	C	o			5. 00
6.00	LAUNDRY & LINEN SERVICE*	C	o			6. 00
7.00	HOUSEKEEPI NG*	C	o			7.00
8.00	DI ETARY*	C	0			8. 00
9.00	NURSING ADMINISTRATION*	C	0			9. 00
10.00	ROUTINE MEDICAL SUPPLIES*	C	0			10.00
11.00	MEDI CAL RECORDS*	C	0			11. 00
12.00	STAFF TRANSPORTATION*	C	0			12. 00
13.00	VOLUNTEER SERVICE COORDINATION*	C	0			13. 00
14.00	PHARMACY*	C	0			14. 00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	C	0			15. 00
16. 00	OTHER GENERAL SERVICE*	C	0			16. 00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES					17. 00
	DIRECT PATIENT CARE SERVICE COST CENTERS					
25. 00	INPATIENT CARE-CONTRACTED**	C	1 -1			25. 00
26. 00	PHYSI CI AN SERVI CES**	C	1			26. 00
27. 00	NURSE PRACTITIONER**	C				27. 00
28. 00	REGI STERED NURSE**	C				28. 00
29. 00	LPN/LVN**	C	1			29. 00
30.00	PHYSI CAL THERAPY**	C	1			30.00
31.00	OCCUPATIONAL THERAPY**	C	1			31.00
32. 00 33. 00	SPEECH/LANGUAGE PATHOLOGY** MEDICAL SOCIAL SERVICES**	C	1			32. 00 33. 00
34. 00	SPIRITUAL COUNSELING**		1			34. 00
35. 00	DI ETARY COUNSELING**					35. 00
36. 00	COUNSELING - OTHER**		1			36. 00
37. 00	HOSPICE AIDE & HOMEMAKER SERVICES**		1			37. 00
38. 00	DURABLE MEDICAL EQUIPMENT/OXYGEN**					38. 00
39. 00	PATIENT TRANSPORTATION**		1			39. 00
40. 00	IMAGING SERVICES**		1			40.00
41. 00	LABS & DI AGNOSTI CS**		1			41. 00
42. 00	MEDI CAL SUPPLI ES-NON-ROUTI NE**		1			42. 00
43. 00	OUTPATIENT SERVICES**	l c	1			43. 00
44. 00	PALLIATIVE RADIATION THERAPY**	d	1			44. 00
45. 00	PALLIATIVE CHEMOTHERAPY**	C				45. 00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	-183	1, 142, 575			46. 00
	NONREI MBURSABLE COST CENTERS		<u> </u>			
60.00	BEREAVEMENT PROGRAM *	C	0			60.00
61.00	VOLUNTEER PROGRAM *	C	o			61. 00
62.00	FUNDRAI SI NG*	C	o			62. 00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	C	0			63. 00
64. 00	PALLIATIVE CARE PROGRAM*	C	0			64. 00
65. 00	OTHER PHYSICIAN SERVICES*	C	0			65. 00
66. 00	RESI DENTI AL CARE*	C	0			66. 00
67. 00	ADVERTI SI NG*	C	0			67. 00
68. 00	TELEHEALTH/TELEMONI TORI NG*	C	0			68. 00
69. 00	THRI FT STORE*	C	0			69. 00
70. 00	NURSING FACILITY ROOM & BOARD*	C	1			70. 00
71. 00	OTHER NONREIMBURSABLE (SPECIFY)*	C	1			71. 00
100.00	TOTAL	-183	1, 851, 241			100. 00

<sup>\*</sup> Transfer the amounts in column 7 to Wkst. 0-5, column 1, line as appropriate.
\*\* See instructions. Do not transfer the amounts in column 7 to Wkst. 0-5.

Peri od: Worksheet 0-1

From 01/01/2016 To 12/31/2016 HOME CARE Date/Time Prepared: 6/28/2017 3:36 pm Hospi ce CCN: 15-1563

					Hospi ce I		
		SALARI ES	OTHER	SUBTOTAL (col.	RECLASSIFI -	SUBTOTAL	
				1 + col . 2)	CATI ONS		
		1.00	2. 00	3. 00	4. 00	5. 00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	I NPATI ENT CARE-CONTRACTED						25. 00
26.00	PHYSI CI AN SERVI CES	0	0	0	0	0	26. 00
27.00	NURSE PRACTITIONER	0	0	0	0	0	27. 00
28.00	REGI STERED NURSE	0	0	0	0	0	28. 00
29. 00	LPN/LVN	0	0	0	0	0	29. 00
30.00	PHYSI CAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATI ONAL THERAPY	0	0	0	0	0	31. 00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	0	0	0	0	33. 00
34.00	SPIRITUAL COUNSELING	0	0	0	0	0	34.00
35.00	DI ETARY COUNSELING	0	0	0	0	0	35. 00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	0	0	0	0	37. 00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38. 00
39.00	PATIENT TRANSPORTATION	0	0	0	0	0	39. 00
40.00	I MAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	0	0	42.00
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	o	0	0	o	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	o	0	0	o	0	45. 00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	o	0	0	o	0	46. 00
100.00	TOTAL *	0	0	0	o	0	100.00
* Tran	sfer the amount in column 7 to Wkst 0-5 colu	umn 1 line 50			•		

<sup>\*</sup> Transfer the amount in column 7 to Wkst. 0-5, column 1, line 50.

		ADJUSTMENTS	TOTAL (col. 5	
			± col. 6)	
		6. 00	7. 00	
	DIRECT PATIENT CARE SERVICE COST CENTERS			
25. 00	INPATIENT CARE-CONTRACTED			25. 00
26. 00	PHYSI CI AN SERVI CES	0	0	26. 00
27. 00	NURSE PRACTITIONER	0	0	27. 00
28. 00	REGI STERED NURSE	0	0	28. 00
29. 00	LPN/LVN	0	0	29. 00
30.00	PHYSI CAL THERAPY	0	0	30.00
31. 00	OCCUPATIONAL THERAPY	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	0	33.00
34.00	SPI RI TUAL COUNSELI NG	0	0	34.00
35.00	DI ETARY COUNSELI NG	0	0	35.00
36.00	COUNSELING - OTHER	0	0	36.00
37. 00	HOSPICE AIDE & HOMEMAKER SERVICES	0	0	37.00
38. 00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	38. 00
39. 00	PATI ENT TRANSPORTATION	0	0	39. 00
40.00	I MAGI NG SERVI CES	0	0	40.00
41. 00	LABS & DIAGNOSTICS	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	42.00
43.00	OUTPATI ENT SERVI CES	0	0	43.00
44. 00	PALLIATIVE RADIATION THERAPY	0	0	44.00
45. 00	PALLI ATI VE CHEMOTHERAPY	0	0	45. 00
46. 00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	46. 00
100.00	TOTAL *	0	0	100.00

<sup>\*</sup> Transfer the amount in column 7 to Wkst. 0-5, column 1, line 50.

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

Hospi ce CCN: 15-1563 Peri od: Worksheet 0-2 From 01/01/2016 12/31/2016 To Date/Time Prepared:

6/28/2017 3:36 pm Hospi ce I SUBTOTAL (col SALARI ES OTHER RECLASSI FI -SUBTOTAL 1 + col. CATI ONS 2) 1.00 2.00 5. 00 3 00 4 00 DIRECT PATIENT CARE SERVICE COST CENTERS 25.00 INPATIENT CARE-CONTRACTED 25.00 PHYSICIAN SERVICES 0 26.00 26.00 15, 919 NURSE PRACTITIONER 15, 919 15, 919 27.00 0 27.00 0 28.00 REGISTERED NURSE 436, 466 0 436, 466 436, 466 28.00 29.00 LPN/LVN 29.00 30.00 PHYSI CAL THERAPY 0 0 0 0 0 0 0 0 0 0 0 0 0 30.00 0 OCCUPATIONAL THERAPY 19,010 0 19,010 19,010 31.00 31.00 32.00 SPEECH/LANGUAGE PATHOLOGY 32.00 33.00 MEDICAL SOCIAL SERVICES 0 0 0 33.00 SPIRITUAL COUNSELING 34.00 0 0 34.00 0 35.00 DIETARY COUNSELING 0 35.00 36.00 COUNSELING - OTHER 64,073 64,073 64,073 36.00 HOSPICE AIDE & HOMEMAKER SERVICES 169, 297 169, 297 169, 297 37.00 37.00 DURABLE MEDICAL EQUIPMENT/OXYGEN 38.00 38.00 0 0 0 39.00 PATIENT TRANSPORTATION 0 0 0 39.00 40.00 I MAGING SERVICES 0 0 40.00 0 0 LABS & DIAGNOSTICS 0 0 41.00 41.00 0 MEDICAL SUPPLIES-NON-ROUTINE 0 0 42.00 0 42.00 43.00 OUTPATIENT SERVICES 0 43.00 PALLIATIVE RADIATION THERAPY 0 0 44.00 0 0 0 44.00 PALLIATIVE CHEMOTHERAPY 45.00 0 C 0 0 45.00 46.00 OTHER PATIENT CARE SERVICES (SPECIFY) 273, 271 654, 569 927, 840 0 927, 840 46. 00 100.00 TOTAL 978, 036 654, 569 1, 632, 605 1, 632, 605 100. 00

<sup>\*</sup> Transfer the amount in column 7 to Wkst. 0-5, column 1, line 51.

		ADJUSTMENTS	TOTAL (col. 5		
			± col. 6)		
		6. 00	7. 00		
	DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	I NPATI ENT CARE-CONTRACTED				25.00
26.00	PHYSI CI AN SERVI CES	0	0		26.00
27.00	NURSE PRACTITIONER	0	15, 919		27.00
28.00	REGI STERED NURSE	0	436, 466		28.00
29. 00	LPN/LVN	0	0		29. 00
30.00	PHYSI CAL THERAPY	0	0		30.00
31.00	OCCUPATIONAL THERAPY	0	19, 010		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0		32.00
33.00	MEDICAL SOCIAL SERVICES	0	0		33.00
34.00	SPIRITUAL COUNSELING	0	0		34.00
35.00	DI ETARY COUNSELING	0	0		35.00
36.00	COUNSELING - OTHER	0	64, 073		36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	169, 297		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0		38.00
39.00	PATIENT TRANSPORTATION	0	0		39.00
40.00	I MAGING SERVICES	0	0		40.00
41.00	LABS & DIAGNOSTICS	0	0		41.00
42.00	MEDI CAL SUPPLI ES-NON-ROUTI NE	0	0		42.00
43.00	OUTPATIENT SERVICES	0	o		43.00
44.00	PALLIATIVE RADIATION THERAPY	0	o		44.00
45.00	PALLI ATI VE CHEMOTHERAPY	0	o		45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	-183	927, 657		46.00
100.00	TOTAL *	-183	1, 632, 422	<u>                                     </u>	100.00

<sup>\*</sup> Transfer the amount in column 7 to Wkst. 0-5, column 1, line 51.

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

Hospi ce CCN: 15-1563

Peri od: Worksheet 0-3 From 01/01/2016 To 12/31/2016 Date/Time Prepared:

6/28/2017 3:36 pm Hospi ce I SUBTOTAL (col SALARI ES OTHER RECLASSI FI -SUBTOTAL 1 + col. CATI ONS 2) 1.00 2.00 5. 00 3 00 4 00 DIRECT PATIENT CARE SERVICE COST CENTERS 25.00 INPATIENT CARE-CONTRACTED 0 25.00 0 PHYSICIAN SERVICES 26.00 0 0 0 0 26.00 NURSE PRACTITIONER O 27.00 0 0 27.00 0 28.00 REGISTERED NURSE 3, 596 0 3, 596 0 0 0 0 0 0 0 0 0 3, 596 28.00 29.00 LPN/LVN 29.00 0 30.00 PHYSI CAL THERAPY 0 0 0 0 30.00 OCCUPATIONAL THERAPY 0 0 0 31.00 0 31.00 32.00 SPEECH/LANGUAGE PATHOLOGY 0 0 32.00 33.00 MEDICAL SOCIAL SERVICES 0 0 0 33.00 0 SPIRITUAL COUNSELING 0 34.00 0 34.00 0 35.00 DIETARY COUNSELING 0 0 0 35.00 36.00 COUNSELING - OTHER 249 249 249 36.00 HOSPICE AIDE & HOMEMAKER SERVICES 37.00 37.00 56 56 56 DURABLE MEDICAL EQUIPMENT/OXYGEN 38.00 38.00 39.00 PATIENT TRANSPORTATION 0 0 0 0 0 0 39.00 I MAGING SERVICES 40.00 40.00 0 0 0 0 LABS & DIAGNOSTICS 0 0 41.00 41.00 0 MEDICAL SUPPLIES-NON-ROUTINE 0 0 42.00 0 42.00 43.00 OUTPATIENT SERVICES 0 43.00 PALLIATIVE RADIATION THERAPY 0 0 44.00 0 0 44.00 PALLIATIVE CHEMOTHERAPY 0 45.00 C 0 0 45.00 46.00 OTHER PATIENT CARE SERVICES (SPECIFY) 213 5, 493 5, 706 0 5, 706 46. 00 100.00 TOTAL 4, 114 5, 493 9,607 9, 607 100. 00

<sup>\*</sup> Transfer the amount in column 7 to Wkst. 0-5, column 1, line 52.

		ADJUSTMENTS	TOTAL (col. 5	
			± col. 6)	
		6. 00	7. 00	
	DIRECT PATIENT CARE SERVICE COST CENTERS			
25.00	I NPATI ENT CARE-CONTRACTED	0	0	25. 00
26.00	PHYSI CI AN SERVI CES	0	0	26. 00
27.00	NURSE PRACTITIONER	0	0	27. 00
28.00	REGI STERED NURSE	0	3, 596	28. 00
29.00	LPN/LVN	0	0	29. 00
30.00	PHYSI CAL THERAPY	0	0	30.00
31.00	OCCUPATI ONAL THERAPY	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	32. 00
33.00	MEDICAL SOCIAL SERVICES	0	0	33. 00
34.00	SPI RI TUAL COUNSELI NG	0	0	34. 00
35.00	DI ETARY COUNSELING	0	0	35. 00
36.00	COUNSELING - OTHER	0	249	36. 00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	56	37. 00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN			38. 00
39.00	PATIENT TRANSPORTATION	0	0	39. 00
40.00	I MAGI NG SERVI CES	0	0	40. 00
41.00	LABS & DIAGNOSTICS	0	0	41. 00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	42. 00
43.00	OUTPATIENT SERVICES	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	44. 00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	45. 00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	5, 706	46. 00
100.00	TOTAL *	0	9, 607	100.00

 $<sup>^{\</sup>star}$  Transfer the amount in column 7 to Wkst. 0-5, column 1, line 52.

Hospice CCN: 15-1563 From 01/01/2016 To 12/31/2016 Date/Time Prepared: 6/28/2017 3:36 pm

				Hospi ce I		
	SALARI ES	OTHER	SUBTOTAL (col.	RECLASSIFI -	SUBTOTAL	
			1 + col . 2)	CATI ONS		
	1.00	2. 00	3.00	4. 00	5. 00	
DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00   INPATIENT CARE-CONTRACTED	0	0	0	0	0	25. 00
26. 00 PHYSI CI AN SERVI CES	0	0	0	0	0	26. 00
27. 00 NURSE PRACTITIONER	0	0	0	0	0	27. 00
28. 00 REGI STERED NURSE	0	0	0	0	0	28. 00
29. 00 LPN/LVN	0	0	0	0	0	29. 00
30. 00 PHYSI CAL THERAPY	0	0	0	0	0	30. 00
31. 00 OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00 SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00 MEDICAL SOCIAL SERVICES	0	0	0	0	0	33. 00
34.00 SPIRITUAL COUNSELING	0	0	0	0	0	34.00
35. 00 DI ETARY COUNSELING	0	0	0	0	0	35. 00
36. 00 COUNSELING - OTHER	0	0	0	0	0	36. 00
37.00 HOSPICE AIDE & HOMEMAKER SERVICES	0	0	0	0	0	37. 00
38.00 DURABLE MEDICAL EQUIPMENT/OXYGEN						38. 00
39.00 PATIENT TRANSPORTATION	O	0	0	0	0	39. 00
40.00 I MAGI NG SERVI CES	0	0	0	o	0	40. 00
41.00 LABS & DIAGNOSTICS	0	0	0	o	0	41.00
42. 00 MEDI CAL SUPPLI ES-NON-ROUTI NE	0	0	0	o	0	42. 00
43. 00 OUTPATIENT SERVICES	O	0	0	o	0	43.00
44.00 PALLIATIVE RADIATION THERAPY	O	0	0	o	0	44. 00
45.00 PALLIATIVE CHEMOTHERAPY	0	0	0	o	0	45. 00
46.00 OTHER PATIENT CARE SERVICES (SPECIFY)	206, 670	2, 542	209, 212	O	209, 212	46. 00
100. 00 TOTAL *	206, 670	2, 542	209, 212	O	209, 212	100.00
* T	1 1: 50					

<sup>\*</sup> Transfer the amount in column 7 to Wkst. 0-5, column 1, line 53.

		ADJUSTMENTS	TOTAL (col. 5		
			± col. 6)		
		6. 00	7.00		
	DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	I NPATI ENT CARE-CONTRACTED	0	0		25. 00
26. 00	PHYSI CI AN SERVI CES	0	0		26. 00
27. 00	NURSE PRACTITIONER	0	0		27. 00
28. 00	REGI STERED NURSE	0	0		28. 00
29. 00	LPN/LVN	0	0		29. 00
30.00	PHYSI CAL THERAPY	0	0		30. 00
31. 00	OCCUPATI ONAL THERAPY	0	0		31. 00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0		32. 00
33.00	MEDICAL SOCIAL SERVICES	0	0		33. 00
34.00	SPIRITUAL COUNSELING	0	0		34.00
35. 00	DI ETARY COUNSELI NG	0	0		35. 00
36. 00	COUNSELING - OTHER	0	0		36. 00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	0		37. 00
38. 00	DURABLE MEDICAL EQUIPMENT/OXYGEN				38. 00
39. 00	PATI ENT TRANSPORTATION	0	0		39. 00
40.00	I MAGI NG SERVI CES	0	0		40. 00
41. 00	LABS & DIAGNOSTICS	0	0		41. 00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0		42. 00
43.00	OUTPATI ENT SERVI CES	0	0		43. 00
44.00	PALLIATIVE RADIATION THERAPY	0	0		44. 00
45.00	PALLI ATI VE CHEMOTHERAPY	0	0		45. 00
46. 00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	209, 212	•	46. 00
100.00	TOTAL *	0	209, 212		100.00

<sup>\*</sup> Transfer the amount in column 7 to Wkst. 0-5, column 1, line 53.

	FINANCI SUSTEMS FRANCI SCAN HEAD ALLOCATION - DETERMINATION OF HOSPITAL-BASED HOSPICE NET	Provider C	^N: 15_0109	Peri od:	wof Form CMS-2 Worksheet 0-5	
	SES FOR ALLOCATION			From 01/01/2016		
		Hospi ce CCN: 15-15		To 12/31/2016	Date/Time Pre 6/28/2017 3:3	
				Hospi ce I	0,20,201, 010	<u> </u>
	Descriptions		HOSPICE DIRE		TOTAL EXPENSES	
			EXPENSES (se	ee SERVICE S) EXPENSES FROM	(sum of cols. 1 + 2)	
			Instructions	WKST B PART I	1 + 2)	
				(see		
				instructions)		
			1.00	2. 00	3. 00	
	GENERAL SERVI CE COST CENTERS		1			
1.00	CAP REL COSTS ANGLE FOULD			0 103, 431	103, 431	
2.00	CAP REL COSTS-MVBLE EQUIP EMPLOYEE BENEFITS DEPARTMENT			0 23, 226 0 390, 307	23, 226 390, 307	
4.00	ADMINISTRATIVE & GENERAL			0 459, 825	459, 825	
5. 00	PLANT OPERATION & MAINTENANCE			0 142, 444	142, 444	
6. 00	LAUNDRY & LINEN SERVICE			0 0	0	
7. 00	HOUSEKEEPI NG			0 44, 282	44, 282	7. 00
8.00	DI ETARY			0 0	0	
9.00	NURSI NG ADMI NI STRATI ON			0 92, 241	92, 241	9. 00
10.00	ROUTINE MEDICAL SUPPLIES			0 0	0	
11. 00	MEDI CAL RECORDS			0 16, 362	16, 362	
12.00	STAFF TRANSPORTATION			0	0	
13.00	VOLUNTEER SERVICE COORDINATION			0	0 0	
14.00	PHARMACY   PHYSICIAN ADMINISTRATIVE SERVICES			0		
16. 00	OTHER GENERAL SERVICE			0 0	0	16.00
	PATIENT/RESIDENTIAL CARE SERVICES			0	Ö	
	LEVEL OF CARE			<u> </u>		Ī
50.00	HOSPI CE CONTI NUOUS HOME CARE			0	0	50.00
51.00	HOSPI CE ROUTI NE HOME CARE		1, 632, 4		1, 632, 422	
52. 00	HOSPICE INPATIENT RESPITE CARE		9, 6		9, 607	
53. 00			209, 2	12	209, 212	53.00
60 00	NONREI MBURSABLE COST CENTERS BEREAVEMENT PROGRAM		I	0	0	60.00
61. 00	VOLUNTEER PROGRAM			0		61.00
62. 00	FUNDRAI SI NG			ŏ	ĺ	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS			0	Ö	63. 00
64.00	PALLIATIVE CARE PROGRAM			0	0	64.00
65.00	OTHER PHYSICIAN SERVICES			0	0	65. 00
66. 00				0	0	66. 00
67. 00				0	0	
	TELEHEALTH/TELEMONI TORI NG			0	0	

68. 00 69. 00 70. 00

0 71.00 0 99.00

0

3, 123, 359 100. 00

1, 272, 118

69.00 THELEHEALTH/TELEMONTTORING
69.00 THRIFT STORE
70.00 NURSING FACILITY ROOM & BOARD
71.00 OTHER NONREIMBURSABLE (SPECIFY)
99.00 NEGATIVE COST CENTER

100. 00 TOTAL

Heal th Financial	Systems		FRANCI SCAN	N HEALTH	LAFAYETTE			In Lieu of	Form CMS-2552-1	0
COST ALLOCATION	- HOSPI TAL-BASED	HOSPI CE GENERAL	SERVICE COST	ΓS	Provider CCN	: 15-0109	Peri od:	Work	ksheet 0-6	

From 01/01/2016 Part I
To 12/31/2016 Date/Time Prepared: Hospi ce CCN: 15-1563 6/28/2017 3:36 pm Hospi ce I TOTAL EXPENSES CAP REL BLDG & CAP REL MVBLE EMPLOYEE SUBTOTAL Descriptions FIX EQUI P **BENEFITS** DEPARTMENT 1.00 2.00 0 ЗА 3.00 GENERAL SERVICE COST CENTERS CAP REL COSTS-BLDG & FLXT 103, 431 103, 431 1.00 1.00 2.00 CAP REL COSTS-MVBLE EQUIP 23, 226 23, 226 2.00 390, 307 3.00 EMPLOYEE BENEFITS DEPARTMENT 0 390, 307 3.00 4.00 ADMINISTRATIVE & GENERAL 459, 825 0 459, 825 4.00 0 5.00 PLANT OPERATION & MAINTENANCE 142, 444 0 0 142, 444 5.00 LAUNDRY & LINEN SERVICE 0 0 6.00 0 6.00 7.00 HOUSEKEEPI NG 44, 282 0 44, 282 7.00 8.00 DI ETARY 0 0 0 8.00 NURSING ADMINISTRATION 0 9.00 92, 241 92, 241 9.00 0 ROUTINE MEDICAL SUPPLIES 10.00 Λ 10.00 11.00 MEDICAL RECORDS 16, 362 0 0 0 0 16, 362 11.00 12.00 STAFF TRANSPORTATION 12.00 VOLUNTEER SERVICE COORDINATION 0 13.00 0 13.00 0 0 14.00 PHARMACY 0 0 14.00 15.00 PHYSICIAN ADMINISTRATIVE SERVICES 0 15.00 OTHER GENERAL SERVICE 0 16.00 0 16.00 PATIENT/RESIDENTIAL CARE SERVICES 0 17.00 17.00 Λ LEVEL OF CARE HOSPICE CONTINUOUS HOME CARE 50.00 50.00 HOSPICE ROUTINE HOME CARE o 51.00 1, 632, 422 1, 632, 422 51.00 HOSPICE INPATIENT RESPITE CARE 52.00 9, 607 0 9, 607 52.00 209, 212 390, 307 53.00 HOSPICE GENERAL INPATIENT CARE 103, 431 23, 226 726, 176 53.00 NONREI MBURSABLE COST CENTERS BEREAVEMENT PROGRAM 60.00 n 60.00 0 0 0 VOLUNTEER PROGRAM 0 61.00 0 0 61.00 0 62.00 FUNDRAI SI NG 0 0 62.00 HOSPICE/PALLIATIVE MEDICINE FELLOWS 0 0 63.00 000000 0 0 63.00 PALLIATIVE CARE PROGRAM 0 0 64.00 0 64.00 65.00 OTHER PHYSICIAN SERVICES 0 65.00 RESIDENTIAL CARE 0 66.00 0 0 66.00 67 00 ADVERTI SI NG Ω 0 67.00 TELEHEALTH/TELEMONI TORI NG 0 68.00 0 0 68.00 69.00 THRIFT STORE 0 0 69.00 0 NURSING FACILITY ROOM & BOARD 70.00 0 70.00 OTHER NONREIMBURSABLE (SPECIFY) 71 00 71.00 0

3, 123, 359

103, 431

0

3, 123, 359 100. 00

99.00

0

390, 307

23, 226

99.00 NEGATIVE COST CENTER

100.00 TOTAL

			nospi ce coi	10 1000	12/01/2010	6/28/2017 3:3	
					Hospi ce I		
	Descriptions	ADMI NI STRATI VE	PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		& GENERAL	OPERATION &	LINEN SERVIC			
			MAI NTENANCE				
		4. 00	5. 00	6. 00	7. 00	8. 00	
	GENERAL SERVICE COST CENTERS						_
1.00	CAP REL COSTS-BLDG & FLXT						1. 00
2.00	CAP REL COSTS-MVBLE EQUIP						2. 00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3. 00
4.00	ADMINISTRATIVE & GENERAL	459, 825					4. 00
5.00	PLANT OPERATION & MAINTENANCE	24, 591	167, 035				5. 00
6.00	LAUNDRY & LINEN SERVICE	0	0	)	0		6. 00
7.00	HOUSEKEEPI NG	7, 645	0	)	51, 927		7. 00
8.00	DI ETARY	0	0	1	0	C	8.00
9.00	NURSING ADMINISTRATION	15, 924	0	1	0		9. 00
10.00	ROUTINE MEDICAL SUPPLIES	0	0	)	0		10.00
11. 00	MEDI CAL RECORDS	2, 825	0	)	0		11. 00
12.00	STAFF TRANSPORTATION	0	0	)	0		12. 00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	)	0		13. 00
14.00	PHARMACY	0	0	)	0		14. 00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	)	0		15. 00
16.00	OTHER GENERAL SERVICE	0	0	)	0		16. 00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	o	0	)	0		17. 00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0					50.00
51.00	HOSPICE ROUTINE HOME CARE	281, 816					51.00
52.00	HOSPICE INPATIENT RESPITE CARE	1, 659	0	)	0 0	C	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	125, 365	167, 035		0 51, 927	C	53.00
	NONREI MBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	0	1	0		60.00
61. 00	VOLUNTEER PROGRAM	0	0	1	0		61. 00
62.00	FUNDRAI SI NG	0	0	1	0		62. 00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	1	0		63. 00
64.00	PALLIATIVE CARE PROGRAM	0	0		0		64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	)	0		65. 00
66.00	RESI DENTI AL CARE	0	0	)	0 0	C	66. 00
67.00	ADVERTI SI NG	0	0	)	0		67. 00
68.00	TELEHEALTH/TELEMONI TORI NG	0	0	)	0		68. 00
69.00	THRI FT STORE	0	0	)	0		69. 00
70.00	NURSING FACILITY ROOM & BOARD						70. 00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	)	0 0	C	71. 00
99. 00	NEGATIVE COST CENTER	0	0		0 0	C	99.00
100.00	TOTAL	459, 825	167, 035		0 51, 927	C	100. 00

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

near th	Financiai Systems	FRANCISCAN HEALI	H LAFAYETTE		in Lie	U OT FORM CWS	2552-10
COST A	LLOCATION - HOSPITAL-BASED HOSPICE GENERAL S	ERVICE COSTS	Provi der Co		Peri od:	Worksheet 0-6	
					From 01/01/2016		
			Hospi ce CCN	N: 15-1563	To 12/31/2016		
					Hospi ce I	6/28/2017 3:3	o piii
	Descriptions	NURSI NG	ROUTI NE	MEDI CAL	STAFF	VOLUNTEER	
	besci i pti ons	ADMI NI STRATI ON	MEDI CAL	RECORDS	TRANSPORTATI ON		
		ADMINI STRATION	SUPPLI ES	KLCOKDS	INANSFORTATION	COORDI NATI ON	
		9. 00	10.00	11. 00	12.00	13. 00	
	GENERAL SERVICE COST CENTERS	7.00	10.00	11.00	12.00	13.00	
1.00	CAP REL COSTS-BLDG & FLXT						1.00
2. 00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00							4. 00
	ADMINISTRATIVE & GENERAL						•
5.00	PLANT OPERATION & MAINTENANCE						5. 00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPI NG						7. 00
8.00	DI ETARY						8. 00
9.00	NURSING ADMINISTRATION	108, 165					9. 00
10. 00	ROUTINE MEDICAL SUPPLIES	0	0				10.00
11. 00	MEDI CAL RECORDS	0		19, 18	37		11. 00
12.00	STAFF TRANSPORTATION	0			0		12.00
13. 00	VOLUNTEER SERVICE COORDINATION	0			0	0	13. 00
14.00	PHARMACY	0			0	0	14. 00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0			0	0	15. 00
16.00	OTHER GENERAL SERVICE	0			0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17. 00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0		0 0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	0	0	19, 13	0	0	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	4	5 0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	108, 165	0	1	0	0	53.00
	NONREI MBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0			0	0	60.00
61.00	VOLUNTEER PROGRAM	0			0	0	61. 00
62.00	FUNDRAI SI NG	0			0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0			0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0			0	0	64. 00
65.00	OTHER PHYSICIAN SERVICES	0			0	0	65. 00
66. 00	RESI DENTI AL CARE	o			0	0	66. 00
67. 00	ADVERTI SI NG	0			0	0	67. 00
68. 00	TELEHEALTH/TELEMONI TORI NG	0			n	n	68. 00
69. 00	THRI FT STORE				n n	0	69. 00
	NURSING FACILITY ROOM & BOARD					Ĭ	70.00
	OTHER NONREIMBURSABLE (SPECIFY)				0	0	ı
	NEGATIVE COST CENTER		0			0	99.00
100.00	4	108, 165	0		37 0	·	100.00
100.00	TIVIAL	100, 105	U	1 17, 10	,,,	U	1100.00

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

From 01/01/2016 | Part | To 12/31/2016 | Date/Time Prepared: Hospi ce CCN: 15-1563 6/28/2017 3:36 pm Hospi ce I PHARMACY PHYSI CI AN OTHER GENERAL PATI ENT/ TOTAL Descriptions ADMI NI STRATI VE SERVI CE RESI DENTI AL SERVI CES CARE SERVICES 14. 00 16. 00 18.00 15.00 17.00 GENERAL SERVICE COST CENTERS CAP REL COSTS-BLDG & FLXT 1.00 2.00 CAP REL COSTS-MVBLE EQUIP 2.00 3.00 EMPLOYEE BENEFITS DEPARTMENT 3.00 4.00 ADMINISTRATIVE & GENERAL 4.00 5.00 PLANT OPERATION & MAINTENANCE 5.00 LAUNDRY & LINEN SERVICE 6.00 6.00 7.00 HOUSEKEEPI NG 7.00 8.00 DI ETARY 8.00 9.00 NURSING ADMINISTRATION 9.00 ROUTINE MEDICAL SUPPLIES 10.00 10.00 11.00 MEDICAL RECORDS 11.00 12.00 STAFF TRANSPORTATION 12.00 VOLUNTEER SERVICE COORDINATION 13.00 13.00 14.00 PHARMACY 14.00 15.00 PHYSICIAN ADMINISTRATIVE SERVICES 0 15.00 OTHER GENERAL SERVICE 0 16.00 0 16.00 PATIENT/RESIDENTIAL CARE SERVICES 17.00 17.00 LEVEL OF CARE 50.00 HOSPICE CONTINUOUS HOME CARE 50.00 0 0 0 0 HOSPICE ROUTINE HOME CARE 0 1, 933, 370 51.00 0 51.00 0 HOSPICE INPATIENT RESPITE CARE 0 52.00 0 11, 311 52.00 53.00 HOSPICE GENERAL INPATIENT CARE 1, 178, 678 53.00 NONREI MBURSABLE COST CENTERS 60.00 BEREAVEMENT PROGRAM 0 60.00 0 0 0 0 0 0 0 0 0 0 VOLUNTEER PROGRAM 61.00 0 61.00 62.00 FUNDRAI SI NG 0 62.00 HOSPICE/PALLIATIVE MEDICINE FELLOWS 0 63.00 0 63.00 0 PALLIATIVE CARE PROGRAM 64.00 0 64.00 65.00 OTHER PHYSICIAN SERVICES 0 65.00 RESIDENTIAL CARE 0 66.00 0 0 0 66.00 67 00 ADVERTI SI NG 0 67.00 TELEHEALTH/TELEMONI TORI NG 68.00 0 68.00 69.00 THRIFT STORE 0 0 69.00 NURSING FACILITY ROOM & BOARD 70.00 0 70.00 OTHER NONREIMBURSABLE (SPECIFY) 71 00 0 71.00 0 0 Ω 99.00 NEGATIVE COST CENTER 0 0 0 0 99.00

3, 123, 359 100. 00

100.00 TOTAL

Health Financial Systems	FRANCISCAN HEALTH	LAFAYETTE		In Lie	u of Form CMS-2552-10
COST ALLOCATION - HOSPITAL-BASED HOSPIC STATISTICAL BASIS	E GENERAL SERVICE COSTS	Provider CCN: Hospice CCN:	15-0109 15-1563		Worksheet 0-6 Part II Date/Time Prepared: 6/28/2017 3:36 pm

			Hospi ce cci	: 15-1563   1	0 12/31/2016	6/28/2017 3:3	
					Hospi ce I	072072017 0.0	Орш
	Cost Center Descriptions	CAP REL BLDG & C	AP REL MVBLE	EMPLOYEE	RECONCI LI ATI ON	ADMI NI STRATI VE	
	μ	FIX	EQUI P	BENEFITS		& GENERAL	
		(SQUARE FEET) (	OOLLAR VALUE)	DEPARTMENT		(ACCUMULATED	
		, (	,	(GROSS		COSTS)	
				SALARI ES)		, , ,	
		1.00	2. 00	3. 00	4A	4. 00	
_	GENERAL SERVICE COST CENTERS		'				
1.00	CAP REL COSTS-BLDG & FIXT	3, 809					1.00
2.00	CAP REL COSTS-MVBLE EQUIP		3, 809				2. 00
3.00	EMPLOYEE BENEFITS DEPARTMENT	l ol	0	1, 188, 820			3.00
4.00	ADMINISTRATIVE & GENERAL	o	0	0	-459, 825	2, 663, 534	4.00
5. 00	PLANT OPERATION & MAINTENANCE	o	0	0	0	142, 444	5.00
6.00	LAUNDRY & LINEN SERVICE	أم	0	0	0	0	6. 00
7. 00	HOUSEKEEPI NG	0	0	0	0	44, 282	7. 00
8.00	DI ETARY		0	0	0	0	8.00
9. 00	NURSI NG ADMI NI STRATI ON		0	0	0	92, 241	9.00
10. 00	ROUTINE MEDICAL SUPPLIES		0	0	0	72, 241	10.00
11. 00	MEDI CAL RECORDS		0	0	0	16, 362	11. 00
12. 00	STAFF TRANSPORTATION		0	0	0	10, 302	12.00
13. 00	VOLUNTEER SERVICE COORDINATION		0	0	0	0	13. 00
14. 00	PHARMACY	0	0	0	0	0	14. 00
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0	0	15. 00
16. 00	OTHER GENERAL SERVICES	0	0	0	0	0	16. 00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES		0	U	0	0	17. 00
17.00	LEVEL OF CARE	U U	U <sub>I</sub>		U	U	17.00
50. 00	HOSPICE CONTINUOUS HOME CARE			0	0	0	50.00
51. 00	HOSPICE CONTINUOUS HOME CARE			0	0		51.00
52.00	HOSPICE ROUTINE HOME CARE	0	0	0	0	1, 632, 422	52.00
52.00		3, 809	3, 809	1, 188, 820	0	9, 607	
53.00	HOSPICE GENERAL INPATIENT CARE NONREIMBURSABLE COST CENTERS	3, 809	3, 809	1, 188, 820	U	726, 176	53. 00
60. 00	BEREAVEMENT PROGRAM	O	0	0	0	0	60.00
61. 00	VOLUNTEER PROGRAM		0	0	0	0	61.00
62. 00	FUNDRAI SI NG	0	0	0	0	0	ı
63. 00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	0	0	62. 00 63. 00
64. 00	PALLIATIVE CARE PROGRAM	0	0	0	0	0	64. 00
		0	0	0	0	0	
65. 00	OTHER PHYSI CI AN SERVI CES	0	0	0	0	0	65. 00
66.00	RESI DENTI AL CARE	0	0	0	0	0	66.00
67. 00	ADVERTI SI NG	0	0	0	0	0	67. 00
68. 00	TELEHEALTH/TELEMONI TORI NG	0	0	0	0	0	68. 00
	THRIFT STORE	U	U	0	0	0	69. 00
70.00	NURSING FACILITY ROOM & BOARD			-	0	_	70.00
71. 00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99. 00	NEGATIVE COST CENTER	400 401	00.00	200 227		450.005	99. 00
	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	103, 431	23, 226	390, 307		459, 825	
101.00	UNIT COST MULTIPLIER	27. 154371	6. 097663	0. 328315		0. 172637	1101.00

Heal th	Financial Systems	FRANCISCAN HEA	LTH LAFAYETTE		In Lie	eu of Form CMS-2	2552-10
COST A	LLOCATION - HOSPITAL-BASED HOSPICE GENERAL SE TICAL BASIS	ERVICE COSTS	Provi der C Hospi ce CC		Period: From 01/01/2016 To 12/31/2016		
					Hospi ce I		
	Cost Center Descriptions	PLANT OPERATION & MAINTENANCE	LAUNDRY & LINEN SERVICE (IN-FACILITY	HOUSEKEEPING (SQUARE FEET)		NURSI NG ADMI NI STRATI ON	
		(SQUARE FEET)	DAYS)			(DI RECT NURS. HRS.)	
		5. 00	6. 00	7.00	8. 00	9, 00	
	GENERAL SERVICE COST CENTERS	0.00	0.00	7.00	0.00	7. 00	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL PLANT OPERATION & MAINTENANCE LAUNDRY & LINEN SERVICE HOUSEKEEPING DIETARY NURSING ADMINISTRATION	3, 000 0 0 0	c	3, 00	00 0 0	20	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
10.00	ROUTINE MEDICAL SUPPLIES	0			0	0	10.00
	MEDICAL RECORDS STAFF TRANSPORTATION	0			0	0	11. 00 12. 00
13. 00 14. 00	VOLUNTEER SERVICE COORDINATION PHARMACY				0	0	13. 00 14. 00
15. 00 16. 00	PHARWALT PHYSICIAN ADMINISTRATIVE SERVICES OTHER GENERAL SERVICE	0			0	0	15. 00 15. 00
	PATI ENT/RESI DENTI AL CARE SERVI CES	0			ŏ		17. 00

3,000

0

3,000

0

0

0

0 51.00

0 52.00

20

0 60.00

0

0 64.00

0

0

50.00

53.00

61.00

62.00

63.00 0

65.00

66.00

67.00

68.00

69. 00

LEVEL OF CARE

HOSPICE CONTINUOUS HOME CARE

HOSPICE INPATIENT RESPITE CARE

HOSPICE GENERAL INPATIENT CARE NONREIMBURSABLE COST CENTERS

HOSPICE/PALLIATIVE MEDICINE FELLOWS

HOSPICE ROUTINE HOME CARE

BEREAVEMENT PROGRAM

PALLIATIVE CARE PROGRAM

OTHER PHYSICIAN SERVICES

TELEHEALTH/TELEMONI TORI NG

VOLUNTEER PROGRAM

RESIDENTIAL CARE

FUNDRAI SI NG

ADVERTI SI NG

THRIFT STORE

50.00

51.00

52.00

53.00

60.00

61.00

62.00

63.00

64.00

65.00

66. 00

67.00

68.00

69. 00

Health Financial Syste	ems		FRANCI	SCAN HEAL	_TH_LAF	FAYETTE				In Lie	u of Form CMS	-2552	2-10
COST ALLOCATION - HOS STATISTICAL BASIS	PITAL-BASED HOSP	ICE GENERAL	SERVI CE	COSTS				15-0109		01/01/2016			
					Hos	spice C	CN:	15-1563	То	12/31/2016	Date/Time Pr 6/28/2017 3:		
									Н	ospi ce I			

			Hospi ce cc	N: 15-1563   1	0 12/31/2016	6/28/2017 3:3	
					Hospi ce I		
	Cost Center Descriptions	ROUTI NE	MEDI CAL	STAFF	VOLUNTEER	PHARMACY	
	•	MEDI CAL	RECORDS	TRANSPORTATION	SERVI CE	(CHARGES)	
		SUPPLI ES	(PATIENT DAYS)		COORDI NATI ON	· ´	
		(PATIENT DAYS)	(	(MI LEAGE)	(HOURS OF		
					SERVICE)		
		10.00	11.00	12.00	13. 00	14. 00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FLXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5. 00	PLANT OPERATION & MAINTENANCE						5. 00
6. 00	LAUNDRY & LINEN SERVICE						6.00
7. 00	HOUSEKEEPI NG						7. 00
8. 00	DI ETARY						8.00
9. 00	NURSING ADMINISTRATION						9. 00
10. 00	ROUTINE MEDICAL SUPPLIES	0					10.00
11. 00	MEDI CAL RECORDS		17, 611				11.00
12. 00	STAFF TRANSPORTATION		17,011	۱ (			12.00
13. 00	VOLUNTEER SERVICE COORDINATION						13.00
						0	1
14.00	PHARMACY  PHARMACY  PHARMACY  PHARMACY  PHARMACY  PHARMACY				0	0	
15. 00	PHYSI CI AN ADMINI STRATI VE SERVI CES			C	0	0	
16.00	OTHER GENERAL SERVICE			C	U	0	
17. 00	PATIENT/RESIDENTIAL CARE SERVICES						17. 00
	LEVEL OF CARE						
50. 00	HOSPI CE CONTI NUOUS HOME CARE	0		1	-	0	
51. 00	HOSPICE ROUTINE HOME CARE	0		1		0	
52. 00	HOSPICE INPATIENT RESPITE CARE	0		1		0	
53. 00	HOSPICE GENERAL INPATIENT CARE	0	9	) <u> </u>	0	0	53. 00
	NONREI MBURSABLE COST CENTERS	1	T	Г			
60. 00	BEREAVEMENT PROGRAM			C		0	
61. 00	VOLUNTEER PROGRAM			C	-	0	1
62. 00	FUNDRAI SI NG			C	0	0	
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS			( C	0	0	1
64.00	PALLIATIVE CARE PROGRAM			( C	0	0	
65. 00	OTHER PHYSICIAN SERVICES			C	0	0	65. 00
66.00	RESI DENTI AL CARE			C	0	0	66. 00
67.00	ADVERTI SI NG				0	0	67. 00
68.00	TELEHEALTH/TELEMONI TORI NG			c	o	0	68. 00
69. 00	THRI FT STORE				0	0	69. 00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)				o	0	71. 00
99. 00	NEGATI VE COST CENTER						99. 00
100.00	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	0	19, 187	'l c	o	0	100.00
	UNIT COST MULTIPLIER	0. 000000		1	0. 000000	0. 000000	

Health Financial Systems	FRANCI SCAN HEALTH	LAFAYETTE	In Lie	u of Form CMS-2552-10
COST ALLOCATION - HOSPITAL-BASED HOSPI STATISTICAL BASIS	CE GENERAL SERVICE COSTS	Provider CCN Hospice CCN:		Worksheet 0-6 Part II Date/Time Prepared: 6/28/2017 3:36 pm
			11 1 1	

			nospi ce coi	N. 13-1303	10 12/31/2010	6/28/2017 3: 30	
					Hospi ce I		
	Cost Center Descriptions	PHYSI CI AN	OTHER GENERAL	PATI ENT/			
		ADMI NI STRATI VE		RESI DENTI AL			
		SERVI CES	(SPECI FY	CARE SERVICE	S		
		(PATIENT DAYS)		(IN-FACILITY			
		( )		DAYS)			
		15. 00	16. 00	17. 00			
	GENERAL SERVICE COST CENTERS	1					
1.00	CAP REL COSTS-BLDG & FLXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3. 00
4. 00	ADMINISTRATIVE & GENERAL						4.00
5. 00	PLANT OPERATION & MAINTENANCE						5. 00
6.00	LAUNDRY & LINEN SERVICE					ŀ	6. 00
7. 00	HOUSEKEEPING					ŀ	7. 00
8.00	DI ETARY						8.00
9.00	NURSING ADMINISTRATION						9.00
10.00	ROUTINE MEDICAL SUPPLIES						10.00
11.00	MEDI CAL RECORDS						11.00
12. 00	STAFF TRANSPORTATION						12. 00
13. 00							13. 00
14. 00	PHARMACY						14. 00
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES	0					15. 00
16. 00	OTHER GENERAL SERVICE		0	)			16. 00
17. 00	PATI ENT/RESI DENTI AL CARE SERVI CES				0		17. 00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	1			50.00
51.00	HOSPICE ROUTINE HOME CARE	0	0				51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	)	0		52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	)	0		53. 00
	NONREI MBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM		0	1			60. 00
61.00	VOLUNTEER PROGRAM		0	1			61.00
62.00	FUNDRAI SI NG		0	1			62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS		l o	)			63. 00
64.00	PALLIATIVE CARE PROGRAM		l o	)			64. 00
65. 00			0	)			65. 00
66. 00	RESI DENTI AL CARE	0	0	,	0		66. 00
67. 00	ADVERTI SI NG		0	1			67. 00
68. 00	TELEHEALTH/TELEMONI TORI NG		1				68. 00
69. 00	THRI FT STORE						69. 00
70. 00			١	Ī			70.00
71. 00				J	0		71.00
	NEGATIVE COST CENTER		١	1			99.00
	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)		_	J			100.00
	UNIT COST MULTIPLIER	0. 000000	0. 000000	0. 00000	0		100.00
101.00	JONET COST MULTIFETER	0.000000	1 0.00000	J 0.00000	امر	ļ	1101.00

Heal th	Financial Systems	FRANCISCAN HEALT	H LAFAYETTE		In Lie	u of Form CMS-2	2552-10
APP0R1	TIONMENT OF HOSPITAL-BASED HOSPICE SHARED SE	RVICE COSTS BY	Provi der CO	CN: 15-0109	Peri od:	Worksheet 0-7	
LEVEL	OF CARE		Hospi ce CCN	N: 15-1563	From 01/01/2016 To 12/31/2016	Date/Time Pre 6/28/2017 3:3	
					Hospi ce I		
				Charges by	LOC (from Provi	der Records)	
	Cost Center Descriptions	From Wkst. C, Co Part I, Col. 9 line	Ratio		HRHC	HI RC	
	T	0	1. 00	2. 00	3. 00	4. 00	
	ANCILLARY SERVICE COST CENTERS						
1.00	PHYSI CAL THERAPY	66. 00	0. 428139		0 0	0	
2.00	OCCUPATIONAL THERAPY	67. 00	0. 288042		0 0	0	
3.00	SPEECH PATHOLOGY	68. 00	0. 480514		0	0	
4. 00 4. 01	DRUGS CHARGED TO PATIENTS DI ABETES CENTER	73. 00 73. 01	0. 176239 2. 233012			0	
5. 00	DURABLE MEDICAL EQUIP-RENTED	96. 00	2. 233012		٩	U	5.00
6.00	LABORATORY	60.00	0. 115686		0	0	
7. 00	MEDICAL SUPPLIES CHARGED TO PATIENT	71. 00	0. 167735			0	
8.00	OTHER OUTPATIENT SERVICE COST CENTER	93. 00	0. 107700			Ü	8.00
9. 00	RADI OLOGY-THERAPEUTI C	55. 00	0. 101478		ol ol	0	
10. 98	HYPERBARI C OXYGEN THERAPY	76. 98	0. 273705		0 0	0	10. 98
11. 00	Totals (sum of lines 1-11)						11. 00
		Charges by LOC (from Provider Records)			ce Costs by LOC		
	Cost Center Descriptions	HGI P H	CHC (col. 1 x col. 2)	HRHC (col. 1 col. 3)	xHIRC (col. 1 x col. 4)	HGIP (col. 1 x	
		5. 00	6.00	7.00	8.00	9.00	
	ANCILLARY SERVICE COST CENTERS	1 2.22			1 2.22		
1.00	PHYSI CAL THERAPY	0	0		0 0	0	1.00
2.00	OCCUPATI ONAL THERAPY	0	0		0 0	0	2. 00
3.00	SPEECH PATHOLOGY	O	0		0 0	0	3. 00
4.00	DRUGS CHARGED TO PATIENTS	0	0		0 0	0	4. 00
4.01	DI ABETES CENTER	0	0		0 0	0	1
5.00	DURABLE MEDICAL EQUIP-RENTED						5. 00
6. 00	LABORATORY	0	0		0 0	0	
7.00	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 0	0	1.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER		-				8. 00
9.00	RADI OLOGY-THERAPEUTI C	0	0		0 0	0	
10. 98	HYPERBARIC OXYGEN THERAPY Totals (sum of lines 1-11)	0	0		0 0	0	
11.00	Tiotal's (sull of filles 1-11)	1 1	U	I	o <sub>l</sub> o <sub>l</sub>	U	1 11.00

Health Financial Systems	FRANCISCAN HEALTH	LAFAYETTE		In Lieu	u of Form CMS-2552-10
CALCULATION OF HOSPITAL-BASED HOSPICE PER DIEM COS	Т	Provi der CC	N: 15-0109	Peri od: From 01/01/2016	Worksheet 0-8
		Hospi ce CCN		To 12/31/2016	Date/Time Prepared:

					6/28/2017 3: 3	6 pm
				Hospi ce I		
			TITLE XVIII	TITLE XIX	TOTAL	
			MEDI CARE	MEDI CAI D		
			1.00	2. 00	3. 00	
	HOSPICE CONTINUOUS HOME CARE					
1.00	Total cost (Wkst. 0-6, Part I, col. 18, line 50 plus Wkst. 0-7,	col. 6,			0	1.00
	line 11)					
2.00	Total unduplicated days (Wkst. S-9, col. 4, line 10)				0	2. 00
3.00	Total average cost per diem (line 1 divided by line 2)				0.00	3.00
4.00	Unduplicated program days (Wkst. S-9 col. as appropriate, line	10)	0	0		4. 00
5.00	Program cost (line 3 times line 4)		0	0		5. 00
	HOSPICE ROUTINE HOME CARE					
6.00	Total cost (Wkst. 0-6, Part I, col. 18, line 51 plus Wkst. 0-7,	col . 7,			1, 933, 370	6. 00
	line 11)					
7. 00	Total unduplicated days (Wkst. S-9, col. 4, line 11)				17, 561	7. 00
8.00	Total average cost per diem (line 6 divided by line 7)				110. 09	8. 00
9.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line	9 11)	16, 822	230		9. 00
10.00	Program cost (line 8 times line 9)		1, 851, 934	25, 321		10.00
	HOSPICE INPATIENT RESPITE CARE					
11. 00	Total cost (Wkst. 0-6, Part I, col. 18, line 52 plus Wkst. 0-7,	col. 8,			11, 311	11. 00
	line 11)					
	Total unduplicated days (Wkst. S-9, col. 4, line 12)				41	12. 00
	Total average cost per diem (line 11 divided by line 12)				275. 88	
14. 00	Unduplicated program days (Wkst. S-9, col. as appropriate, line	12)	30	0		14. 00
15. 00	Program cost (line 13 times line 14)		8, 276	0		15. 00
	HOSPICE GENERAL INPATIENT CARE					
16. 00	Total cost (Wkst. 0-6, Part I, col. 18, line 53 plus Wkst. 0-7,	col . 9,			1, 178, 678	16. 00
	line 11)				_	
	Total unduplicated days (Wkst. S-9, col. 4, line 13)				9	17. 00
	Total average cost per diem (line 16 divided by line 17)				130, 964. 22	18. 00
19. 00	Unduplicated program days (Wkst. S-9, col. as appropriate, line	e 13)	5	1		19. 00
20. 00	Program cost (line 18 times line 19)		654, 821	130, 964		20. 00
	TOTAL HOSPICE CARE					
	Total cost (sum of line 1 + line 6 + line 11 + line 16)				3, 123, 359	
	Total unduplicated days (Wkst. S-9, col. 4, line 14)				17, 611	
23. 00	Average cost per diem (line 21 divided by line 22)			l	177. 35	23. 00

Heal th	Financial Systems FRANCISCAN HEALTH	H LAFAYETTE	In Lie	u of Form CMS-2	2552-10
CALCUL	ATION OF CAPITAL PAYMENT	Provi der CCN: 15-0109	Peri od: From 01/01/2016 To 12/31/2016		
		Title XVIII	Hospi tal	PPS	o piii
				1. 00	
	PART I - FULLY PROSPECTIVE METHOD				
4 00	CAPI TAL FEDERAL AMOUNT			0.040.404	4 00
1.00	Capital DRG other than outlier			3, 349, 696	1. 00 1. 01
1. 01 2. 00	Model 4 BPCI Capital DRG other than outlier Capital DRG outlier payments			0 429, 458	
2.00	Model 4 BPCI Capital DRG outlier payments			427, 430	2. 00
3.00	Total inpatient days divided by number of days in the cost re	eporting period (see inst	ructions)	123. 69	
4. 00	Number of interns & residents (see instructions)	pper tring per real (eee rine)	401. 51.5)	0.00	
5.00	Indirect medical education percentage (see instructions)			0.00	5. 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	E, part A line	3. 14	7. 00
	30) (see instructions)				
8.00	Percentage of Medicaid patient days to total days (see instru	icti ons)		25. 34	
9.00	Sum of lines 7 and 8	. \		28. 48	
10. 00 11. 00	Allowable disproportionate share percentage (see instructions Disproportionate share adjustment (see instructions)	5)		5. 94 198, 972	
12. 00	Total prospective capital payments (see instructions)			3, 978, 126	
12.00	Total prospective capital payments (see Histiactions)			3, 976, 120	12.00
	DADT II DAVMENT INDED DEACONADLE COCT			1. 00	
1. 00	PART II - PAYMENT UNDER REASONABLE COST  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)			Ö	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	
5.00	Capital cost for comparison to payments (line 3 x line 4)			0	5. 00
6.00	Percentage adjustment for extraordinary circumstances (see in			0.00	6. 00
7.00	Adjustment to capital minimum payment level for extraordinary	circumstances (line 2 >	(line 6)	0	
8.00	Capital minimum payment level (line 5 plus line 7)			0	8. 00
9. 00 10. 00	Current year capital payments (from Part I, line 12, as appli Current year comparison of capital minimum payment level to c		Loca Lino O)	0	9. 00 10. 00
11. 00	Carryover of accumulated capital minimum payment level over c	1 1 3 1	,	0	11. 00
11.00	Worksheet L, Part III, line 14)	sapital payment (110ml pl1	or your		11.00
12.00	Net comparison of capital minimum payment level to capital pa			0	12. 00
13.00	Current year exception payment (if line 12 is positive, enter		,	0	13. 00
14. 00	Carryover of accumulated capital minimum payment level over c	capital payment for the f	following 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	structions)		0	15. 00
16. 00	Current year operating and capital costs (see instructions)	on actions,		0	16. 00
	Current year exception offset amount (see instructions)			Ö	
	122. 2 J. 2 2 200pt on 2 200 amount (200 1 21 dot1010)			·	