FRANCISCAN HEALTH LAFAYETTE

In Lieu of Form CMS-2552-10

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED 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 Worksheet S Peri od. From 01/01/2017 Parts I-III AND SETTLEMENT SUMMARY 12/31/2017 Date/Time Prepared: То 5/31/2018 3:55 pm PART I - COST REPORT STATUS Provi der 1. [X] Electronically filed cost report Date: 5/31/2018 Time: 3:55 pm use only Manually submitted cost report 2 []If this is an amended report enter the number of times the provider resubmitted this cost report]Medicare Utilization. Enter "F" for full or "L" for low. 3 Ο Ē 4

 [1] Cost Report Status
 6. Date Received:

 (1) As Submitted
 7. Contractor No.

 (2) Settled without Audit
 8. [N] Initial Report for this Provider CCN

 (3) Settled with Audit
 9. [N] Final Report for this Provider CCN

 Contractor 5. use only Δ (3) Settled with Audit number of times reopened = 0-9. (4) Reopened (5) Amended 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 OF INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT. CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF PROVIDER(S) I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying

Expenses prepared by FRANCISCAN HEALTH LAFAYETTE (15-0109) for the cost report and statement of Revenue and Expenses prepared by FRANCISCAN HEALTH LAFAYETTE (15-0109) for the cost reporting period beginning 01/01/2017 and ending 12/31/2017 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.

[]I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification statement to be the legally binding equivalent of my original signature.

(Si gned)

Officer or Administrator of Provider(s)

Title

Date

			Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	-377, 823	-58, 581	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	-16, 968	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	1, 145		0	9.00
200.00	Total	0	-394, 791	-57, 436	0	0	200.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

	Financial Systems FAL AND HOSPITAL HEALTH CARE COMPLEX		AN HEALTH	-		15-0109	Peri od:		Worksh	eet S-2	2552-10
							From 01/01 To 12/31	/2017		ime Pre 018 3:5	
	1.00		00		3.00			4.00	5751720	516 5.5	
1.00	Hospital and Hospital Health Care Co Street: 1701 SOUTH CREASY LANE	PO Box:									1.00
2.00	Ci ty: LAFAYETTE	State: I		Zip Cod			nty: TIPPECAN			(5	2.00
		Component Na		CCN Number	CBSA Numbe		er Date Certified		nt Syst 0, or		
		1.00		2.00	3.00	4.00	5.00	V 6.00	XVIII 7.00	-	
	Hospital and Hospital-Based Componen	t Identification:					1				
3.00	Hospi tal	FRANCI SCAN HEALT	H	150109	29200) 1	07/01/1966	5 N	P	0	3.00
4.00 5.00	Subprovi der - IPF Subprovi der - IRF	FRNACI SCAN HEALT LAFAYETTE REHAB	н	15T109	29200	5	01/01/1995	5 N	P	0	4.00 5.00
6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00		FRANCI SCAN HOME		157124	29200		07/06/1966		Ρ	N	6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00
14.00 15.00 16.00 17.00 18.00 19.00	Hospital-Based Hospice Hospital-Based Health Clinic - RHC Hospital-Based Health Clinic - FQHC Hospital-Based (CMHC) I Renal Dialysis Other	FRNACI SCAN HEALTI LAFAYETTE HOSPI CI		151563	29200		01/01/1984				14.00 15.00 16.00 17.00 18.00 19.00
							From 1.00		Tc 2.		
20. 00 21. 00	Type of Control (see instructions)						01/01/2		12/31		20. 00 21. 00
22.00	Inpatient PPS Information Does this facility qualify and is it share hospital adjustment, in accord for yes or "N" for no. Is this facil amendment hospital?) In column 2, en	ance with 42 CFR ity subject to 42	§412.106 2 CFR Sect	? In co tion §41	olumn 1,	enter "Y	"		Ν	l	22.00
22. 01	Did this hospital receive interim un period? Enter in column 1, "Y" for y reporting period occurring prior to for no for the portion of the cost r (see instructions)	compensated care es or "N" for no October 1. Enter	payments for the p in column	for thi portion n 2, "Y"	of the for ye	cost es or "N"	Y		Y	,	22. 01
22. 02	Is this a newly merged hospital that determined at cost report settlement or "N" for no, for the portion of th in column 2, "Y" for yes or "N" for or after October 1.	? (see instruction e cost reporting	ons) Enter period pr	r in col rior to	umn 1, Octobei	"Y" for y r 1. Enter	es		Ν	l	22.02
22.03		statistical area no for the portic 2, "Y" for yes or r after October 1 t more than 499 b	as adopted on of the ~ "N" for 1. (see in peds (as d	d by CMS cost re no for nstructi counted	5 in FY2 eporting the poi ons) Do	2015? Ente g period rtion of t pes this	r he		Ν	I	22.03
23.00	Which method is used to determine Me 1, enter 1 if date of admission, 2 i method of identifying the days in th used in the prior cost reporting per	f census days, or is cost reporting	r 3 if dat g period o 2, enter '	te of di differer <u>"Y" for</u>	scharge nt from <u>yes or</u>	e. Is the the metho <u>"N" for p</u>	d o.	3	N		23.00
			In-State Medicaio paid day	d Medi rs elig unp da	caid ible aid p ys	Out-of State Medicaid Daid days	State Medi cai d el i gi bl e unpai d	Medicai HMO day	/s Med	ther di cai d days	
24.00	If this provider is an IPPS hospital in-state Medicaid paid days in colum Medicaid eligible unpaid days in col out-of-state Medicaid paid days in c out-of-state Medicaid eligible unpai 4, Medicaid HMO paid and eligible bu	n 1, in-state umn 2, olumn 3, d days in column t unpaid days in	<u> 1.00</u> 1,3:		<u>409</u>	3.00 84	4.00	<u>5.00</u> 9, (016	<u>5. 00</u> 249	24.00
25.00	column 5, and other Medicaid days in If this provider is an IRF, enter th Medicaid paid days in column 1, the Medicaid eligible unpaid days in col out-of-state Medicaid days in column Medicaid eligible unpaid days in col HMO paid and eligible but unpaid day	e in-state in-state umn 2, 3, out-of-state umn 4, Medicaid		50	59	0	O		142		25.00

Health Financial Systems FRANCISCA HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DAT		TH LAFAYETTE Provider CC	N: 15-0109	Peri od:	n Lie	Workshe		
				From 01/01 To 12/31		Part I Date/Ti	me Pre	pared:
				Urban/Ru	ral S	5/31/20 Date of		3 pm
				1.00		2.0		
26.00 Enter your standard geographic classification (not wa cost reporting period. Enter "1" for urban or "2" for			inning of th	ne	1			26.00
27.00 Enter your standard geographic classification (not wa reporting period. Enter in column 1, "1" for urban or	ge) sta "2" fo	atus at the enc or rural. If ap	l of the cost plicable,	t	1			27.00
enter the effective date of the geographic reclassifi 35.00 If this is a sole community hospital (SCH), enter the effect in the cost reporting period.			H status in		0			35.00
				Begi nni		Endi		
36.00 Enter applicable beginning and ending dates of SCH st	atus. S	Subscript line	36 for numbe	1.00)	2.0	0	36.00
of periods in excess of one and enter subsequent date 87.00 If this is a Medicare dependent hospital (MDH), enter	S.	•			0			37.00
is in effect in the cost reporting period. B7.01 Is this hospital a former MDH that is eligible for the accordance with FY 2016 OPPS final rule? Enter "Y" fo				N				37. 0 [.]
instructions) 88.00 If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of								38. 0
enter subsequent dates.				Y/N		Y/I	N	
				1.00		2.0	0	
39.00 Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(i) for yes or "N" for no. Does the facility meet the mil- with 42 CFR 412.101(b)(2)(i) or (ii)? Enter in column instructions)	or (ii eage re)? Enter in co equirements in	lumn 1 "Y" accordance			N		39.00
10.00 Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octob	er 1. E	Enter "Y" for y	" for yes on ves or "N" fo	- N pr		N		40.0
no in column 2, for discharges on or after October 1.	(see I	nstructions)			V 1.00	XVIII 0 2.00	XI X 3. 00	_
Prospective Payment System (PPS)-Capital 5.00 Does this facility qualify and receive Capital paymen	t for c	li sproporti onat	e share in a	accordance	N	Y	N	45. 0
 with 42 CFR Section §412.320? (see instructions) 16.00 Is this facility eligible for additional payment exception pursuant to 42 CFR §412.348(f)? If yes, complete Wkst Pt. III. 					N	N	N	46.0
7.00 Is this a new hospital under 42 CFR §412.300(b) PPS c 8.00 Is the facility electing full federal capital payment					N N	N N	N N	47. 0 48. 0
 Teaching Hospitals This a hospital involved in training residents in or "N" for no. 	approve	ed GME programs	? Enter "Y	' for yes	N			56.0
57.00 If line 56 is yes, is this the first cost reporting p GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first month for yes or "N" for no in column 2. If column 2 is "Y "N", complete Wkst. D, Parts III & IV and D-2, Pt. II	yes or h of th ", comp , if ap	"N" for no ir nis cost report blete Worksheet oplicable.	i column 1. ing period? E-4. lf col	f column 1 Enter "Y" umn 2 is				57.00
8.00 f ine 56 is yes, did this facility elect cost reimb defined in CMS Pub. 15-1, chapter 21, §2148? f yes, 00 ne costa claimed on Line 100 ef Workbact 22, f yes	complet	te Wkst. D-5.		s as	N			58.0
9.00 Are costs claimed on line 100 of Worksheet A? If yes	, compr	ete wkst. D-2,	NAHE 413.8	5 Workshe	et A	Pass-Th	rough	59.0
			Y/N	Li ne	#	Qualific Criteric		
			1.00	2.00	C	3.0	0	
 0.00 Are you claiming nursing and allied health education any programs that meet the criteria under §413.85? (2000) 0.01 If line 60 is yes, complete columns 2 and 3 for each 	see ins	structions)	Y		20. 00) 1		60.0 60.0
instructions) 0.02 If line 60 is yes, complete columns 2 and 3 for each	. 0	•			23.00			60.0
instructions) 00.03 If line 60 is yes, complete columns 2 and 3 for each instructions)	program	n. (see			23. 01	1		60. 0
	Y/N	IME	Direct GME	E I ME		Di rect	GME	
	1.00	2.00	3.00	4.00		5. C		
1.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)					0.00		0.00	61.0
51.01 Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see								61.0
instructions) 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								61.02
ACA). (see instructions)								

	n Financial Systems TAL AND HOSPITAL HEALTH CARE COMPL			TH LAFAYETTE	CN: 15-0109	Period:	u of Form CMS-: Worksheet S-2	
10321	TAL AND NUSPITAL HEALTH CARE COMPL	EX IDENTIFICATION DA	IA	Provider c		From 01/01/2017 To 12/31/2017	Part I	pared:
			Y/N	IME	Direct GME	IME	Direct GME	
			1.00	2.00	3.00	4.00	5.00	-
51.03	Enter the base line FTE count for and/or general surgery residents, determining compliance with the 7 instructions)	which is used for						61.03
1. 04	Enter the number of unweighted pr surgery allopathic and/or osteopa current cost reporting period. (se	thic FTEs in the						61.0
1. 05	Enter the difference between the and/or general surgery FTEs and 1 primary care and/or general surge 61.04 minus line 61.03). (see ins	baseline primary the current year's ery FTE counts (line						61.0
01. 06	Enter the amount of ACA §5503 awa used for cap relief and/or FTEs t care or general surgery. (see ins	hat are nonprimary						61.00
			Pro	ogram Name	Program Code	e Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
51.10	Of the FTEs in line 61.05, specif			1.00	2.00	3.00	4.00	61.10
	specialty, if any, and the number for each new program. (see instru- column 1, the program name. Enter program code. Enter in column 3, unweighted count. Enter in column FTE unweighted count.	of FTE residents ictions) Enter in in column 2, the the IME FTE 4, the direct GME						
1. 20	Of the FTEs in line 61.05, special program special ty, if any, and the residents for each expanded program instructions) Enter in column 1, Enter in column 2, the program co 3, the IME FTE unweighted count. the direct GME FTE unweighted count.	ie number of FTE ram. (see the program name. de. Enter in column Enter in column 4,				0.00		61.2
					(1.00	
2.00	ACA Provisions Affecting the Heal Enter the number of FTE residents	s that your hospital	trai ned			riod for which	0.00	62.00
2. 01	your hospital received HRSA PCRE Enter the number of FTE residents during in this cost reporting per Teaching Hospitals that Claim Res	that rotated from a iod of HRSA THC prog	i Teachi Iram. (s	ee instructio		o your hospital	0.00	62. 0 [.]
3. 00	Has your facility trained resider				ost reporting	period? Enter	N	63.00
	"Y" for yes or "N" for no in colu	umn 1. If yes, comple	ete line	es 64 through	67. (see inst Unweighted	ructions) Unweighted	Ratio (col. 1/	,
					FTĔs Nonprovider Site		(col. 1 + col. 2))	
	Section 5504 of the ACA Base Year	ETE Desidents in No	ppprovid	lar Sattings	1.00	2.00	3.00	
94. 00	period that begins on or after Ju	<u>ly 1, 2009 and befor</u> yes, or your facilit	<u>re June</u> y train	30, 2010. Ned residents	0.0			64.00
	resident FTEs attributable to rot settings. Enter in column 2 the resident FTEs that trained in you of (column 1 divided by (column 2	number of unweighted Ir hospital. Enter in	l non-pr column	imary care 3 the ratio				
		Program Name		ogram Code	Unweighted FTEs	FTEsin	Ratio (col. 3/ (col. 3 + col.	
					Nonprovi der Si te	Hospi tal	4))	

	EX IDENTIFICATION DA	TA Provider (Fr	eriod: com 01/01/2017		
			To		Date/Time Pre 5/31/2018 3:5	eparec 3 pm
	Program Name	Program Code	Unweighted FTEs Nonprovider	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
-	1.00	2.00	Si te 3. 00	4.00	5.00	-
.00 Enter in column 1, if line 63	1.00	2.00	0.00	4.00		65.0
is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by: colump 2, colump						
divided by (column 3 + column 4)). (see instructions)						
			Unweighted	Unweighted FTEs in	Ratio (col. 1/	
			FTEs Nonprovider	Hospital	(col. 1 + col. 2))	
			Si te			4
Section 5504 of the ACA Current Y	Voar ETE Posidonts i	n Nonnrovidor Sottin	1.00	2.00	3.00	-
beginning on or after July 1, 201 00 Enter in column 1 the number of u	10	•				
Enter in column 2 the number of u FTEs that trained in your hospita (column 1 divided by (column 1 +	al. Enter in column 3	3 the ratio of	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
.00 Enter in column 1, the program	1.00	2.00	3.00	4.00	5.00 0.000000	1
name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all						
non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)						
non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column				1.0	0 2.00 3.00	-
non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)				1.0		
non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)	/chiatric Facility (I	PF), or does it cont	tain an IPF subp			70.
non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) Inpatient Psychiatric Facility PP 00 Is this facility an Inpatient Psy Enter "Y" for yes or "N" for no. 00 If line 70 is yes: Column 1: Did recent cost report filed on or be 42 CFR 412.424(d)(1)(iii)(c)) Col program in accordance with 42 CFR Column 3: If column 2 is Y, indic (see instructions)	ychiatric Facility (I the facility have ar efore November 15, 20 umn 2: Did this faci & 412.424 (d)(1)(iii) cate which program ye	n approved GME teachi 004? Enter "Y" for ility train residents)(D)? Enter "Y" for	ing program in th yes or "N" for no s in a new teach yes or "N" for no	rovider? N he most o. (see ing o.		
non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) Inpatient Psychiatric Facility PF 00 Is this facility an Inpatient Psy Enter "Y" for yes or "N" for no. 1f line 70 is yes: Column 1: Did recent cost report filed on or be 42 CFR 412.424(d)(1)(iii)(c)) Col program in accordance with 42 CFR Column 3: If column 2 is Y, indic	ychiatric Facility (1 the facility have ar offore November 15, 20 umn 2: Did this faci 2 412.424 (d)(1)(iii) cate which program ye y PPS mabilitation Facility	n approved GME teachi DO4? Enter "Y" for y ility train residents)(D)? Enter "Y" for y ear began during this	ing program in th yes or "N" for n s in a new teach yes or "N" for n s cost reporting	rovider? N he most o. (see ing o.	0	70. (

	Financial Systems FRANCISCAN HEALT	H LAFAYETTE		In Lie	u of Form CMS-	2552-10
HOSPI T	TAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CO	CN: 15-0109	Period: From 01/01/2017 To 12/31/2017	Worksheet S-2 Part I Date/Time Pre 5/31/2018 3:5	epared:
					1.00	_
	Is this a LTCH co-located within another hospital for part or "Y" for yes and "N" for no.			g period? Enter	N N	80. 00 81. 00
	Did this facility establish a new Other subprovider (excluded				N	85. 00 86. 00
87.00	<pre>§413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no. Is this hospital an extended neoplastic disease care hospital 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.</pre>	cl assi fi ed	under section		Ν	87.00
				V 1.00	XI X 2.00	_
	Title V and XIX Services			1.00	2.00	
90.00	Does this facility have title V and/or XIX inpatient hospital yes or "N" for no in the applicable column.	servi ces? E	nter "Y" for	N	Y	90.00
91.00				Ν	Υ	91.00
92.00		al certificat			Ν	92.00
93.00			d XIX? Enter	Ν	Ν	93.00
94.00		and "N" for n	o in the	Ν	Ν	94.00
				0. 00 N	0. 00 N	95.00 96.00
	If line 96 is "Y", enter the reduction percentage in the appl Does title V or XIX follow Medicare (title XVIII) for the int stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for	terns and res	idents post	0. 00 Y	0. 00 Y	97.00 98.00
98. 01	column 1 for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for the rep C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for tit				Y	98. 01
98. 02	title XIX. Does title V or XIX follow Medicare (title XVIII) for the cal bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or			Y	Y	98. 02
98. 03	for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for a criti reimbursed 101% of inpatient services cost? Enter "Y" for yes			N 1	Ν	98. 03
98. 04	outpatient services cost? Enter "Y" for yes or "N" for no in			Ν	Ν	98.04
98. 05	in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) and add bac Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in co				Y	98. 05
98.06	column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) when cost r Pts. I through IV? Enter "Y" for yes or "N" for no in column column 2 for title XIX.			Y	Υ	98.06
	Rural Providers ODoes this hospital qualify as a CAH?			N		105.00
106.00	Olf this facility qualifies as a CAH, has it elected the all-i for outpatient services? (see instructions)	nclusive met	hod of paymen	t		106.00
107.00	Olf 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.	1. (see inst	ructions) lf	t		107.00
108.00	reimbursed. If yes complete Wkst. D-2, Pt. II. Ols this a rural hospital qualifying for an exception to the C CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	CRNA fee sche	dul e? See 42	Ν		108.00
		Physi cal	Occupationa		Respi ratory	
109.00	Olf 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.	<u>1.00</u> N	2.00 N	3.00 N	4.00 N	109.00
					1.00	-
110.00	Did this hospital participate in the Rural Community Hospital Demonstration)for the current cost reporting period? Enter "\ complete Worksheet E, Part A, lines 200 through 218, and Work applicable.	/" for yes or	"N" for no.	lf yes,	N	110.00

Health Financial Systems FRANCISCAN HEALT HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN	: 15-0109	Period: From 01/01		u of For Workshe Part I Date/Ti 5/31/20	et S-2 me Pre	2 epared:
				_		-	_
111.00 If this facility qualifies as a CAH, did it participate in th Health Integration Project (FCHIP) demonstration for this cos "Y" for yes or "N" for no in column 1. If the response to col integration prong of the FCHIP demo in which this CAH is part Enter all that apply: "A" for Ambulance services; "B" for add for tele-health services.	st reporting pe umn 1 is Y, en ticipating in c	riod? Enter ter the column 2.	1. 0	0	2.0		111.00
				1.00	2.00	3.00	
Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or is yes, enter the method used (A, B, or E only) in column 2. 3 either "93" percent for short term hospital or "98" percent psychiatric, rehabilitation and long term hospitals providers Pub. 15-1, chapter 22, §2208.1.	lf column 2 is t for long term s) based on the	E", enter care (incl definition	in column udes			0	115.00
116.00 s this facility classified as a referral center? Enter "Y" f 117.00 s this facility legally-required to carry malpractice insura no.			"N" for	N Y			116. 00 117. 00
118.00 Is the malpractice insurance a claims-made or occurrence poli claim-made. Enter 2 if the policy is occurrence.	cy? Enter 1 if	the policy	' i s	2			118.00
		Premiums	Loss	es	Insur	ance	
118.01 List amounts of malpractice premiums and paid losses:		1.00 979,1	<u>2.0</u> 45 2	0 24, 501	3. (0118.01
	I		1.0		2.0		-
18.02 Are malpractice premiums and paid losses reported in a cost c Administrative and General? If yes, submit supporting schedu			N	0	2.0		118. 02
and amounts contained therein. 119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qua Hold Harmless provision in ACA §3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no.	Harmless provi column 1, "Y" alifies for the	sion in ACA for yes or Outpatient			N		119. 00 120. 00
21.00 Did this facility incur and report costs for high cost implan patients? Enter "Y" for yes or "N" for no.	ntabl e devi ces	charged to	Y				121.0
22.00 Does the cost report contain healthcare related taxes as defi Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included.					5.0)6	122. 0
Transplant Center Information 25.00Does this facility operate a transplant center? Enter "Y" for	r yes and "N" f	orno.lf	N				125. 0
yes, enter certification date(s) (mm/dd/yyyy) below. 26.00 f this is a Medicare certified kidney transplant center, ent		cation date	2				126.0
in column 1 and termination date, if applicable, in column 2. 27.00 If this is a Medicare certified heart transplant center, enter	er the certific	ation date					127. 0
in column 1 and termination date, if applicable, in column 2. 28.00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 2.	er the certific	ation date					128. 0
in column 1 and termination date, if applicable, in column 2. 29.00 If this is a Medicare certified lung transplant center, enter column 1 and termination date, if applicable, in column 2.		tion date i	n				129. 0
30.00 If this is a Medicare certified pancreas transplant center, e date in column 1 and termination date, if applicable, in colu		fi cati on					130. 0
31.00 If this is a Medicare certified intestinal transplant center, date in column 1 and termination date, if applicable, in colu	enter the cer	ti fi cati on					131. 0
32.00 If this is a Medicare certified islet transplant center, enter in column 1 and termination date, if applicable, in column 2.	er the certific	ation date					132. 0
33.00 If this is a Medicare certified other transplant center, ente in column 1 and termination date, if applicable, in column 2.	er the certific	ation date					133. 0
34.00 If this is an organ procurement organization (OPO), enter the and termination date, if applicable, in column 2.		column 1					134. 0
All Providers 40.00 Are there any related organization or home office costs as de			Y		1580)14	140. 00
chapter 10? Enter "Y" for yes or "N" for no in column 1. If y are claimed, enter in column 2 the home office chain number.			•				

lealth Financial Systems HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX	FRANCI SCAN H		Provider CC	N: 15-0109	Peri Fror To			2 epared
1.00		2.00				3.00	5/31/2018 3:	<u>53 pm</u>
If this facility is part of a chai			es 141 throu	iah 143 the	name		of the	
home office and enter the home off					, maine			
41.00 Name: FRANCISCAN ALLIANCE, INC.	Contractor's Name	e: WPS		Contra	ctor' s	Number: 0810	1	141. (
42.00 Street: 1515 DRAGOON TRAIL	PO Box:	1290						142. (
43.00 City: MISHAWAKA	State:	IN		Zip Co	de:	4654	6-1290	143. (
							1.00	_
44.00 Are provider based physicians' cos	ts included in Worksho	ot 12					1.00 Y	144. (
14. Objerte provider based physicians cos	ts meruded mi worksne	CLA:					1	144.
						1.00	2.00	-
45.00 If costs for renal services are cla inpatient services only? Enter "Y" no, does the dialysis facility incl period? Enter "Y" for yes or "N"	for yes or "N" for no Lude Medicare utilizat for no in column 2.	in col ion foi	umn 1. lfc ^this cost	olumn 1 is reporting		Y		145.
46.00 Has the cost allocation methodology Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/de	column 1. (See CMS Pu				lf	N		146.
							1 00	-
47.00Was there a change in the statistic	cal basis? Enter "V" f	or ves	or "N" for	no			1.00 N	147.
48.00Was there a change in the order of							N N	147.
49.00 Was there a change to the simplific					or no.		N	149.
	<u> </u>		Part A	Part B		Title V	Title XIX	
			1.00	2.00		3.00	4.00	
Does this facility contain a provi								
or charges? Enter "Y" for yes or "	<u>N" for no for each com</u>	<u>iponent</u>			<u>. (See</u>		. 13) N	155
55.00Hospi tal 56.00Subprovi der – IPF			N I	N N		N N	N N	155. 156.
57.00 Subprovider - IRF			N	N		N	N	157.
58. OOSUBPROVI DER								158.
59.00 SNF			N	Ν		Ν	N	159.
60.00 HOME HEALTH AGENCY			N	N		Ν	N	160. (
60. 01			N	N		Ν	N	160. (
60. 02			N	N		N	N	160. (
61.00 CMHC			I	N		N	N	161. (
							1.00	-
Multicampus								
65.00 Is this hospital part of a Multican	mpus hospital that has	one or	r more campu	ses in dif	ferent	CBSAs?	N	165. (
Enter "Y" for yes or "N" for no.								_
-	Name	(County		Zip Co		FTE/Campus	-
66.00 If line 165 is yes, for each	0		1.00	2.00	3.00	4.00	5.00	0 166. (
campus enter the name in column O, 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	
							1.00	-
Health Information Technology (HIT) incentive in the Ame	eri can	Recovery and	Reinvestm	ent Ac	ct		
67.001s this provider a meaningful user 68.001f this provider is a CAH (line 109 reasonable cost incurred for the H	under §1886(n)? Ente 5 is "Y") and is a mea	er "Y" t ini ngful	for yes or "	N" for no.			Y	167. 0168.
 58.01 If this provider is a CAH and is no exception under §413.70(a)(6)(ii)? 59.00 If this provider is a meaningful used to the formation of the formation of	Enter "Y" for yes or ser (line 167 is "Y")	"N" foi	no. (see i	nstruction	s)		9.9	168. 99169.
transition factor. (see instruction	ns)					Begi nni ng	Endi ng	
					-	1. 00	2.00	-
70.00 Enter in columns 1 and 2 the EHR be period respectively (mm/dd/yyyy)	eginning date and endi	ng date	e for the re	porting		08/05/2017	11/03/2017	170.
					-	1.00	2.00	-
71.00 fline 167 is "Y", does this provi section 1876 Medicare cost plans re						N		0171.

	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-0109	Period: From 01/01/2017 To 12/31/2017	Worksheet S- Part II Date/Time Pro 5/31/2018 3:	epared:
				Y/N	Date	
		fair al 1 NO 114		1.00	2.00	_
	General Instruction: Enter Y for all YES responses. Enter N mm/dd/yyyy format.	TOT ALL NU TE	sponses. Ente	er all dates in t	ne	
	COMPLETED BY ALL HOSPITALS					-
	Provider Organization and Operation					
. 00	Has the provider changed ownership immediately prior to the			N		1.0
	reporting period? If yes, enter the date of the change in c	olumn 2. (see				
			Y/N	Date	V/I	
. 00	Has the provider terminated participation in the Medicare P	rogram2 lf	1.00 N	2.00	3.00	2.0
. 00	yes, enter in column 2 the date of termination and in column				1	2.0
	voluntary or "I" for involuntary.	-,				
. 00	Is the provider involved in business transactions, including		Y		1	3.0
	contracts, with individuals or entities (e.g., chain home o				1	
	or medical supply companies) that are related to the provide officers, medical staff, management personnel, or members of				1	
	of directors through ownership, control, or family and othe				1	
	relationships? (see instructions)	or in r dr			1	
			Y/N	Туре	Date	
			1.00	2.00	3.00	
. 00	Financial Data and Reports Column 1: Were the financial statements prepared by a Cert	ified Public	Y	A	01/01/2001	4.0
. 00	Accountant? Column 2: If yes, enter "A" for Audited, "C" for		'	~	01/01/2001	4.0
	or "R" for Reviewed. Submit complete copy or enter date ava				1	
	column 3. (see instructions) If no, see instructions.					
. 00	Are the cost report total expenses and total revenues diffe		Y		1	5.0
	those on the filed financial statements? If yes, submit rec	onciliation.		Y/N	Legal Oper.	_
				1.00	2.00	
	Approved Educational Activities					
. 00	Column 1: Are costs claimed for nursing school? Column 2:	lfyes, is th	ne provider is	s Y	Y	6.0
	the legal operator of the program?				1	
. 00	Are costs claimed for Allied Health Programs? If "Y" see in:			Y	1	7.0
. 00	Were nursing school and/or allied health programs approved a cost reporting period? If yes, see instructions.	and/or renewed	i during the	Ν	1	8.0
. 00	Are costs claimed for Interns and Residents in an approved	araduate medio	al education	Ν	1	9.0
	program in the current cost report? If yes, see instruction					
0. 00	Was an approved Intern and Resident GME program initiated o	r renewed in t	he current	N	1	10.0
1 00	cost reporting period? If yes, see instructions.		reved	Ν	1	11 0
1.00	Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	& R IN an App	loved	IN	1	11.0
					Y/N	
					1.00	
0 0-	Bad Debts					
	Is the provider seeking reimbursement for bad debts? If yes				Y	12.0
3.00	If line 12 is yes, did the provider's bad debt collection pr period? If yes, submit copy.	orrey change c	iuring this co	ost reporting	N	13.0
4.00		nts waived? If	yes, see in	structions.	Ν	14.0
	Bed Complement					
5.00	Did total beds available change from the prior cost reporti	<u>v</u> 1		tructions.	N	15.0
	-		t A		t B	_
		Y/N 1.00	Date 2.00	Y/N 3.00	Date 4.00	-
	PS&R Data	1.00	2.00	5.00	4.00	
6.00	Was the cost report prepared using the PS&R Report only?	Y	04/26/2018	Y	04/26/2018	16.0
	If either column 1 or 3 is yes, enter the paid-through				1	
	date of the PS&R Report used in columns 2 and 4 . (see				1	
7.00	instructions) Was the cost report prepared using the PS&R Report for	Ν		Ν	1	17.0
7.00	totals and the provider's records for allocation? If	N.		14	1	17.0
	either column 1 or 3 is yes, enter the paid-through date					
	in columns 2 and 4. (see instructions)				1	
3. 00	If line 16 or 17 is yes, were adjustments made to PS&R	Ν		Ν		18.
	Report data for additional claims that have been billed					
	but are not included on the PS&R Report used to file this					
	cost report? If yes, see instructions.	Ν		N		19. (
9 00	Ilf line 16 or 17 is ves were adjustments made to PSPD 1					1 1 7 . 1
9. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report	N.			1	

Health Financial Systems

FRANCISCAN HEALTH LAFAYETTE

In Lieu of Form CMS-2552-10

HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CC	CN: 15-0109	Peri od:	Worksheet S-2	
				From 01/01/2017 To 12/31/2017	Part II Date/Time Pre 5/31/2018 3:5	pared:
		Descri	ntion	Y/N	Y/N	
				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	20.00
		Y/N	Date	Y/N	Date	
	<u></u>	1.00	2.00	3.00	4.00	0.1.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
					1 00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXC	EPT CHILDRENS H	OSPI TALS)		1.00	
	Capital Related Cost					
	Have assets been relifed for Medicare purposes? If yes, se				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.	due to apprais	als made duri	ng the cost	N	23.00
24.00	Were new leases and/or amendments to existing leases enter If yes, see instructions	Ν	24.00			
25.00	Have there been new capitalized leases entered into during instructions.	the cost repor	ting period?	lfyes, see	Ν	25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during t instructions.	he cost reporti	ng period? If	yes, see	Ν	26.00
27.00	Has the provider's capitalization policy changed during th	e cost reportin	g period?lf	yes, submit	Ν	27.00
	copy. Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit e period? If yes, see instructions.	ntered into dur	ing the cost	reporting	Ν	28.00
29.00	Did the provider have a funded depreciation account and/or		bt Service Re	serve Fund)	Y	29.00
30.00	treated as a funded depreciation account? If yes, see inst Has existing debt been replaced prior to its scheduled mat		debt? If yes,	see	N	30.00
31.00	instructions. Has debt been recalled before scheduled maturity without i	ssuance of new	debt? If yes,	see	N	31.00
	instructions. Purchased Services					
32.00	Have changes or new agreements occurred in patient care se		d through con	tractual	Y	32.00
33.00	arrangements with suppliers of services? If yes, see instr If line 32 is yes, were the requirements of Sec. 2135.2 ap		g to competit	ive bidding? If	Ν	33.00
	no, see instructions. Provider-Based Physicians					-
34.00	Are services furnished at the provider facility under an a	rrangement with	provi der-bas	ed physi ci ans?	Y	34.00
	If yes, see instructions.	0				
35.00	If line 34 is yes, were there new agreements or amended ex physicians during the cost reporting period? If yes, see i		ts with the p	rovi der-based	Ν	35.00
				Y/N	Date	
	llama Offica Casta			1.00	2.00	
26 00	Home Office Costs Were home office costs claimed on the cost report?			Y		36.00
	If line 36 is yes, has a home office cost statement been p	repared by the	home office?	Y		37.00
38 00	If yes, see instructions. If line 36 is yes , was the fiscal year end of the home of	fice different	from that of	Ν		38.00
	the provider? If yes, enter in column 2 the fiscal year en	d of the home o	ffi ce.			
	If line 36 is yes, did the provider render services to oth see instructions.		5	N		39.00
40.00	If line 36 is yes, did the provider render services to the instructions.	home office?	If yes, see	N		40.00
		1.	00	2	00	-
	Cost Report Preparer Contact Information			2.		
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	STEVE		HOWELL		41.00
42.00	respectively. Enter the employer/company name of the cost report	FRANCI SCAN HEA	LTH			42.00
12 00	preparer.	745 400 5007				42.00
43. UU	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	765-428-5927 		STEVEN. HOWELL@ ANCE. ORG	I NANUI SUANALLI	43.00

Heal th	Financial Systems FRA	NCISCAN HEAL	TH LAFAYETTE	In Lie	u of Form CMS-:	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTI	ONNAI RE	Provider CCN: 15-01	Peri od:	Worksheet S-2	
				rom 01/01/2017 o 12/31/2017		pared: <u>3 pm</u>
			3.00			
	Cost Report Preparer Contact Information			_		
41.00	Enter the first name, last name and the title/po	osition 🛚 🛚	MANAGER REIMBURSEMENT			41.00
	held by the cost report preparer in columns 1,	2, and 3,				
	respectively.					
42.00	Enter the employer/company name of the cost repo	ort				42.00
	preparer.					
43.00	Enter the telephone number and email address of	the cost				43.00
	report preparer in columns 1 and 2, respectivel	у.				

	Financial Systems AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	FRANCISCAN HEAL	Provider CC	N: 15-0100	Peri od:	u of Form CMS-2 Worksheet S-3	2002-10
позетт	AL AND HUSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CC	N. 15-0109	From 01/01/2017	Part I	
					To 12/31/2017	Date/Time Pre	
						5/31/2018 3:5	3 pm
						I/P Days / O/P	
	Component	Waskahaat A	No. of Dodo	Ded Dave		Visits / Trips	
	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30.00	138	50, 3		0	1.00
1.00	8 exclude Swing Bed, Observation Bed and	00.00	100	00,0	0.00	Ű	1.00
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF 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, 3	0.00	0	7.00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT	31.00	16	5, 84	40 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, 1 ⁻	0.00	0	12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		168	61, 32	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	41.00	18	6, 5	70	0	17.00
18.00	SUBPROVI DER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23.00
24.00	HOSPI CE	116.00	0		0		24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC – CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26. 25
27.00	Total (sum of lines 14-26)		186				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambul ance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0		0		32.00
32.01	Total ancillary labor & delivery room						32.01
	outpatient days (see instructions)						
33.00	LTCH non-covered days						33.00
33 01	LTCH site neutral days and discharges						33.01

IOSPI TAL A	ND HOSPITAL HEALTH CARE COMPLEX STATISTIC		Provider CC	-	Period: From 01/01/2017 Fo 12/31/2017	Worksheet S-3 Part I Date/Time Pre 5/31/2018 3:5	pared:
		I/P Days	/ O/P Visits	/ Trips	Full Time E	Equi val ents	
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
8 e Hos	pital Adults & Peds. (columns 5, 6, 7 and xclude Swing Bed, Observation Bed and pice days)(see instructions for col. 2 the portion of LDP room available beds)	16, 565	1, 053	33, 860	5		1.00
	and other (see instructions)	0	9, 016				2.00
	IPF Subprovider	0	0				3.00
	IRF Subprovider	0	0				4.00
	pital Adults & Peds. Swing Bed SNF	0	0	(0		5.00
	pital Adults & Peds. Swing Bed NF		0	(5		6.00
.00 Tota	al Adults and Peds. (exclude observation s) (see instructions)	16, 565	1, 053	33, 860	6		7.00
	ENSIVE CARE UNIT	1, 734	142	4, 46	1		8.0
	ONARY CARE UNIT	.,		.,			9.0
	N INTENSIVE CARE UNIT						10.0
	GICAL INTENSIVE CARE UNIT						11.0
		0	187	2, 85 ⁻			
	NATAL INTENSIVE CARE UNIT	0	-				12.0
	SERY	10,000	476			1 011 10	13.0
	al (see instructions)	18, 299	1, 858			1, 344. 10	
	visits	0	0	(J		15.0
	PROVIDER - IPF						16. C
	PROVIDER – IRF	1, 607	251	2, 88	7 0.00	15.82	
	PROVI DER						18.0
	LLED NURSING FACILITY						19.0
0.00 NUR	SING FACILITY						20.0
1.00 OTH	ER LONG TERM CARE						21.0
2.00 HOM	E HEALTH AGENCY	7, 372	141	11, 549	9 0.00	35.51	22.0
3.00 AMB	ULATORY SURGICAL CENTER (D. P.)						23.0
4. 00 HOSI	PICE	0	0	(0.00	20.64	24.0
4. 10 HOSI	PICE (non-distinct part)	0	0	(D		24.1
5. OO CMH	C - CMHC						25.0
6. 00 RUR	AL HEALTH CLINIC						26.0
	ERALLY QUALIFIED HEALTH CENTER	o	0	(0.00	0.00	
	al (sum of lines 14-26)		0		0.00		
	ervation Bed Days		0	()	1, 110107	28.0
	ul ance Tri ps	0	0	,			29.0
	loyee discount days (see instruction)	0		(30.0
	loyee discount days - IRF						31.0
	5		240		-		
	or & delivery days (see instructions)	0	249				32.0
	al ancillary labor & delivery room			(D		32. C
	patient days (see instructions)	_					
	H non-covered days	0					33.0
3.01 LTC	H site neutral days and discharges	0					33.

HOSPI T	Financial Systems AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CC	CN: 15-0109	Period: From 01/01/2017	u of Form CMS-2 Worksheet S-3 Part I	
					To 12/31/2017	Date/Time Pre 5/31/2018 3:5	
		Full Time Equivalents		Di s	charges		
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers	10.00	10.00	11.00	Patients	
1.00	Hereital Adults & Dods (columns E 6 7 and	11.00	12.00	13.00 4,2	14.00 18 356	15.00 11,435	1.00
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and		0	4, 2	10 300	11, 455	1.00
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)				0 0		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation						7.00
8.00	beds) (see instructions) INTENSIVE CARE UNIT						8.00
8.00 9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGI CAL I NTENSI VE CARE UNI T						11.00
12.00	NEONATAL INTENSIVE CARE UNIT						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	4, 2	18 356	11, 435	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	0.00	0	1	40 0	245	
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY OTHER LONG TERM CARE						20.00
21.00	HOME HEALTH AGENCY	0.00					21.00
23.00	AMBULATORY SURGICAL CENTER (D. P.)	0.00					23.00
24.00	HOSPI CE	0.00					24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26. 25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00 31.00	Employee discount days (see instruction)						30.00 31.00
31.00	Employee discount days - IRF						31.00
32.00 32.01	Labor & delivery days (see instructions) Total ancillary labor & delivery room						32.00
JZ. UI	outpatient days (see instructions)						32.01
33.00	LTCH non-covered days				0		33.00
	LTCH site neutral days and discharges				0		33.01

PI TA	Financial Systems			LTH LAFAYETTE Provider C		Period: From 01/01/2017 To 12/31/2017	Date/Time Pre	pare
		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	5/31/2018 3:5: Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II – WAGE DATA SALARIES							
	Total salaries (see	200.00	94, 501, 844	-1, 337, 828	93, 164, 01	6 2, 945, 408.00	31. 63	1
	instructions) Non-physician anesthetist Part		C	0		0.00	0.00	2
							0.00	
0	Non-physician anesthetist Part B		C	0		0.00	0.00	3
	Physician-Part A - Administrative		C	0		0.00	0.00	4
	Physicians - Part A - Teaching		C	0		0.00	0. 00	4
	Physician and Non Physician-Part B		C	0		0.00	0.00	5
	Non-physician-Part B for		C	0		0.00	0. 00	6
	hospital-based RHC and FQHC services							
	Interns & residents (in an	21.00	C	0		0.00	0. 00	7
	approved program) Contracted interns and		C	0		0.00	0.00	5
	residents (in an approved		C			0.00	0.00	'
	programs) Home office and/or related		C	0		0.00	0.00	6
	organization personnel		C			0.00	0.00	
-	SNF Excluded area salaries (see	44.00	0 15, 986, 032	0 334, 463	16, 320, 49	0.00 5 342,654.86		
	instructions)		13, 700, 032		10, 320, 47	5 542,054.00	47.03	
	OTHER WAGES & RELATED COSTS Contract Labor: Direct Patient		2, 124, 012	0	2, 124, 01	2 29, 011. 69	73. 21	11
	Care		2, 124, 012	. 0	2, 124, 01.	2 27,011.07	73.21	'
	Contract labor: Top level management and other		C	0		0.00	0.00	12
	management and administrative							
	services Contract Labor: Physician-Part		C	0		0.00	0.00	1:
	A - Administrative							
	Home office and/or related orgainzation salaries and		C	0		0.00	0.00	14
	wage-related costs							
	Home office salaries Related organization salaries		C	-		0.00		
00	Home office: Physician Part A		C	-		0.00		
	- Administrative Home office and Contract		C	0		0.00	0.00	1
	Physicians Part A - Teaching					0.00	0.00	
	NAGE-RELATED COSTS Wage-related costs (core) (see		24, 617, 233	0	24, 617, 23	3		117
	instructions)							
	Wage-related costs (other) (see instructions)		C	0		D		18
00	Excluded areas		5, 257, 889	0	5, 257, 88	9		19
00	Non-physician anesthetist Part A		C	0		D		20
00	Non-physician anesthetist Part		C	0	(C		2'
00	B Physician Part A -		C	0		b		22
	Administrative							
	Physician Part A - Teaching Physician Part B		C					22
00	Wage-related costs (RHC/FQHC)		C			D		24
	Interns & residents (in an approved program)		C	0				25
50	Home office wage-related		C	0	(С		25
	(core) Related organization		C	0		b		25
	wage-related (core)		_					
	Home office: Physician Part A - Administrative -		C	0				25
	wage-related (core)							
	Home office & Contract Physicians Part A - Teaching -		C	0	(25
	wage-related (core)							
	OVERHEAD COSTS - DIRECT SALARIE Employee Benefits Department	<u>4.00</u>	1, 458, 776	-145, 371	1, 313, 40	5 38, 629. 00	34.00	24
	Administrative & General	4.00 5.00	7, 281, 356					

Heal th	Financial Systems	F	RANCI SCAN HEAL	LTH LAFAYETTE		In Lie	u of Form CMS-2	2552-10
HOSPI T	AL WAGE INDEX INFORMATION			Provider CO	F	Period: From 01/01/2017 To 12/31/2017	Worksheet S-3 Part II Date/Time Pre 5/31/2018 3:55	pared:
		Wkst. A Line	Amount	Recl assi fi cati	Adj usted	Paid Hours	Average Hourly	
		Number	Reported	on of Salaries	Sal ari es		Wage (col. 4 ÷	
				(from Wkst.	(col.2 ± col.	Salaries in	col. 5)	
				A-6)	3)	col. 4		
		1.00	2.00	3.00	4.00	5.00	6.00	
28.00	Administrative & General under contract (see inst.)		0	0	(0.00	0.00	28.00
29.00	Maintenance & Repairs	6.00	0	0	(0.00	0.00	29.00
30.00	Operation of Plant	7.00	3, 169, 054	0	3, 169, 054	120, 334. 00	26.34	30.00
31.00	Laundry & Linen Service	8.00	109, 139	0	109, 139	7, 243. 00	15.07	31.00
32.00	Housekeeping	9.00	2,077,119	0	2, 077, 119	140, 490. 00	14. 78	32.00
33.00	Housekeeping under contract (see instructions)		0	0	(0.00	0.00	33.00
34.00	Dietary	10.00	2, 242, 705	-1, 422, 631	820, 074	50, 034. 00	16.39	34.00
35.00	Dietary under contract (see instructions)		0	0	(0.00	0.00	35.00
36.00	Cafeteria	11.00	0	1, 422, 631	1, 422, 631	86, 796. 00	16. 39	36.00
37.00	Maintenance of Personnel	12.00	0	0	(0.00	0.00	37.00
38.00	Nursing Administration	13.00	2, 839, 682	-332, 409	2, 507, 273	70, 461. 00	35.58	38.00
39.00	Central Services and Supply	14.00	435, 882	0	435, 882	2 22, 437.00	19.43	39.00
40.00	Pharmacy	15.00	2, 990, 474	-130, 555	2, 859, 919	76, 244. 00	37.51	40.00
41.00	Medi cal Records & Medi cal Records Li brary	16. 00	58, 812	-41, 168	17, 644	2, 308.00		41.00
42.00	Soci al Servi ce	17.00	619, 866	0	619, 866	22, 276. 00	27.83	42.00
43.00	Other General Service	18.00	0	0		0.00	0.00	43.00

Heal th	Financial Systems	1	FRANCI SCAN HEA	LTH LAFAYETTE		In Lie	eu of Form CMS-2	2552-10
HOSPI	FAL WAGE INDEX INFORMATION			Provider CC		Period: From 01/01/2017 To 12/31/2017		
		Worksheet A		Recl assi fi cati			Average Hourly	
		Line Number	Reported	on of Salaries			Wage (col. 4 ÷	
				(from	(col.2 ± col.		col. 5)	
				Worksheet A-6)	,	col. 4		
	-	1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		94, 501, 844	-1, 337, 828	93, 164, 01	6 2, 945, 408. 00	31.63	1.00
	instructions)							
2.00	Excluded area salaries (see		15, 986, 032	334, 463	16, 320, 49	5 342, 654. 86	47.63	2.00
0.00	instructions)		70 545 040	1 (70 001	7/ 0/0 50	0 (00 750 44	00.50	0.00
3.00	Subtotal salaries (line 1 minus line 2)		78, 515, 812	-1, 672, 291	76, 843, 52	1 2, 602, 753. 14	29. 52	3.00
4.00	Subtotal other wages & related		2, 124, 012	0	2, 124, 01	2 29, 011. 69	73. 21	4.00
	costs (see inst.)							
5.00	Subtotal wage-related costs		24, 617, 233	0	24, 617, 23	3 0.00	32.04	5.00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		105, 257, 057	-1, 672, 291	103, 584, 76	6 2, 631, 764. 83	39.36	6.00
7.00	Total overhead cost (see		23, 282, 865	-1, 490, 636	21, 792, 22	9 873, 254. 00	24.96	7.00
	instructions)							

alth Financial Systems	FRANCI SCAN	HEALTH LAFAYETTE		u of Form CMS-2	
SPITAL WAGE RELATED COSTS		Provider CCN: 15-0109	Period: From 01/01/2017	Worksheet S-3 Part IV	
			To 12/31/2017		nar
			10 12/31/2017	5/31/2018 3:5	
				Amount	
				Reported	
				1.00	
PART IV - WAGE RELATED CO	ISIS				
Part A - Core List					-
RETIREMENT COST				0	
00 401K Employer Contributi				0	
	SA) Employer Contribution efit Plan Cost (see instructior			7, 364, 653	
	t Plan Cost (see instructions)	IS)		7, 364, 653	
	6 (Paid to External Organizatio			0	
00 401K/TSA PI an Administra		лт <i>)</i>		0	1 5
00 Legal /Accounting/Managem				0	
	ogram Administration Fees			456, 711	
HEALTH AND INSURANCE COS	0			430, 711	1
00 Heal th Insurance (Purcha				12, 812, 933	1 8
	unded without a Third Party Adm	ninistrator)		12, 012, 733	
	unded with a Third Party Admini			0	
03 Heal th Insurance (Purcha				0	
00 Prescription Drug Plan	()			0	
. 00 Dental, Hearing and Visi	on Plan			1, 025, 648	110
	yee is owner or beneficiary)			58, 784	
	nployee is owner or beneficiary	()			12
	employee is owner or beneficia			528, 024	1:
	(If employee is owner or benef			0	14
00 'Workers' Compensation I	nsurance			947, 571	15
.00 Retirement Health Care C	ost (Only current year, not the	e extraordinary accrual require	ed by FASB 106.	0	16
Non cumulative portion)		-	-		
TAXES					
.00 FICA-Employers Portion 0				4, 131, 831	
.00 Medicare Taxes - Employe	rs Portion Only			2, 522, 591	
.00 Unemployment Insurance					19
.00 State or Federal Unemplo	yment Taxes			26, 376	20
OTHER					
.00 Executive Deferred Compe (instructions))	nsation (Other Than Retirement	LOST Reported on lines 1 throu	ign 4 above. (see	0	2
. 00 Day Care Cost and Allowa	ices			0	22
.00 Tuition Reimbursement	1003			0	
. 00 Total Wage Related cost	(Sum of Lines 1 -23)			29, 875, 122	
Part B - Other than Core				27,075,122	1 2
. 00 OTHER WAGE RELATED COSTS				0	25

Heal th	Financial Systems	FRANCI SCAN HEALTH	LAFAYETTE	In Lie	u of Form CMS-2	2552-10
HOSPI T	AL CONTRACT LABOR AND BENEFIT COST		Provider CCN: 15-0109	Peri od:	Worksheet S-3	
				From 01/01/2017		
				To 12/31/2017	Date/Time Pre 5/31/2018 3:5	
	Cost Center Description			Contract Labor		5 pili
	Cost center bescription			1.00	2.00	
	PART V - Contract Labor and Benefit Cost			1.00	2.00	
	Hospital and Hospital-Based Component Ident	i fi cati on:				
1.00	Total facility's contract labor and benefit			2, 124, 012	24, 617, 233	1.00
2.00	Hospi tal			2, 124, 012	24, 617, 233	2.00
3.00	Subprovider - IPF					3.00
4.00	Subprovider - IRF			0	0	4.00
5.00	Subprovider - (Other)			0	0	5.00
6.00	Swing Beds - SNF			0	0	6.00
7.00	Swing Beds - NF			0	0	7.00
8.00	Hospital-Based SNF					8.00
9.00	Hospital-Based NF					9.00
10.00	Hospi tal -Based OLTC					10.00
11.00	Hospital-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					14.00
15.00	Hospital-Based Health Clinic FQHC					15.00
16.00	Hospital-Based-CMHC					16.00
17.00	Renal Dialysis			0	0	17.00
18.00	Other			0	0	18.00

	5	FRANCI SCAN HEALT				u of Form CMS-2	
HOME F	IEALTH AGENCY STATI STI CAL DATA		Provider Concernent	F	eriod: rom 01/01/2017 o 12/31/2017	Worksheet S-4 Date/Time Pre 5/31/2018 3:5	pared:
					Home Health Agency I	PPS	<u>5 piii</u>
						00	-
0.00	County				TI PPECANOE	00	0.00
			Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
1.00	HOME HEALTH AGENCY STATISTICAL DATA Home Health Aide Hours	0	194	0	57	251	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	390.00				2.00
		Enter the number			oyees (Full Ti Contract	me Equivalent) Total	
		your normal v	work week				
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES	0		1.00	2.00	3.00	
3.00	Administrator and Assistant Administrator(s)		40.00	0.00	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)			0.00			4.00
5.00	Other Administrative Personnel			12.36 8.06			
6.00 7.00	Direct Nursing Service Nursing Supervisor			0.00			
8.00	Physical Therapy Service			3.85			
9.00	Physical Therapy Supervisor			0.00			
10.00 11.00	Occupational Therapy Service Occupational Therapy Supervisor			0. 73 0. 00			
12.00	Speech Pathol ogy Servi ce			0.00			
13.00	Speech Pathology Supervisor			0.00			1
14.00	Medical Social Service			0.01	0.00		1
15.00 16.00	Medical Social Service Supervisor Home Health Aide			0.00			
17.00	Home Heal th Ai de Supervi sor			0.00			•
18.00	I NFUSI ON			6.30	0.00	6.30	18.00
19. 00	HOME HEALTH AGENCY CBSA CODES Enter in column 1 the number of CBSAs where			4			19.00
	you provided services during the cost reporting period.						
20. 00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20			23844			20.00
20. 01	contains the first code).			26900			20.01
20.02				29200			20.02
20. 03		<u> </u>		99915			20.03
		Full Epis		LUPA Epi sodes	PEP Only	Total (cols.	
		Outliers	2.00	3.00	Epi sodes	1-4) 5.00	
	PPS ACTIVITY DATA	1.00	2.00	3.00	4.00	5.00	
21.00	Skilled Nursing Visits	3, 007	331				21.00
22.00	Skilled Nursing Visit Charges	1,088,238	119, 702				
23.00 24.00	Physical Therapy Visits Physical Therapy Visit Charges	2, 086 779, 426	115 42, 849				
25.00	Occupational Therapy Visits	568	51		13		1
26.00	Occupational Therapy Visit Charges	211, 947	18, 967		4, 823		
27.00 28.00	Speech Pathol ogy Vi si ts Speech Pathol ogy Vi si t Charges	91 34, 359	13 4, 823		4 1, 484	108 40, 666	
29.00	Medical Social Service Visits	50	4, 023		1, 404	40,000	
30.00	Medical Social Service Visit Charges	21, 552	3, 440				1
31.00 32.00	Home Health Aide Visits Home Health Aide Visit Charges	649 113, 553	111 19, 346		8 1, 384		
32.00 33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	6, 451	19, 346 629				
34. 00 35. 00	Other Charges Total Charges (sum of lines 22, 24, 26, 28,	0 2, 249, 075	0 209, 127		-	-	
36.00	30, 32, and 34) Total Number of Episodes (standard/non outlier)	433		58	12	503	36.00
37.00	outlier) Total Number of Outlier Episodes		21		1	22	37.00
	Total Non-Routine Medical Supply Charges	0	0		0		38.00

	Financial Systems		FRANCISCAN HEA				eu of Form CMS-2	
HOSPI 1	FAL-BASED HOSPICE IDENTIFICATION	DATA		Provider CC Hospice CCN	CN: 15-0109 N: 15-1563	Period: From 01/01/2017 To 12/31/2017		GH IV pared:
						Hospi ce I		
		Unduplicated Days						
		Title XVIII	Title XIX	Title XVIII Skilled Nursing Facility	Title XIX Nursing Facility	All Other	Total (sum of cols. 1, 2 & 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART I - ENROLLMENT DAYS FOR CO	ST REPORTING P	PERIODS BEGINNI	NG BEFORE OCTO	BER 1, 2015			
1.00 2.00 3.00 4.00 5.00	Hospice Continuous Home Care Hospice Routine Home Care Hospice Inpatient Respite Care Hospice General Inpatient Care Total Hospice Days				1 0015			1.00 2.00 3.00 4.00 5.00
	Part II - CENSUS DATA FOR COST	REPORTING PERI	ODS BEGINNING	BEFORE OCTOBER	1, 2015			
6.00	Number of patients receiving hospice care							6. 00
7.00	Total number of unduplicated Continuous Care hours billable to Medicare							7.00
8.00	Average Length of Stay (line 5 / line 6)							8.00
9.00	Unduplicated census count							9.00
IOTE:	Parts I and II, columns 1 and 2	also include t	the days report		3 and 4.			
				Title XVIII	Title XIX	Other	Total (sum of cols. 1 through 3)	
				1.00	2.00	3.00	4.00	
	PART III - ENROLLMENT DAYS FOR	COST REPORTING	PERIODS BEGIN	INING ON OR AFT	ER OCTOBER 1,			
10.00				0		0 2		
11.00				18, 787		0 837		
12.00	The second secon			39		0 16		12.00
13.00				19		0 6		
14.00	Total Hospice Days PART IV - CONTRACTED STATISTICA	L DATA FOR COS	T REPORTING PF	18, 845 RI ODS BEGI NNI N		0 861 R OCTOBER 1, 201	1	14.00
15.00	Hospice Inpatient Respite Care			0		0 0	0	15.00

Heal th	Financial Systems FRANCISCAN HEALTH	LAFAYETTE		In Lie	eu of Form CMS-2	2552-10
	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CC		Peri od:	Worksheet S-1	
				From 01/01/2017		
				To 12/31/2017	Date/Time Pre 5/31/2018 3:5	
					1.00	
	Uncompensated and indigent care cost computation				1	
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 di	vided by li	ne 202 column	8)	0. 216815	1.00
	Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid				44, 133, 573	
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 and/or supplement			i d?		4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments f	rom Medical	d		0	5.00
6.00	Medicaid charges				193, 650, 028	6.00
7.00	Medicaid cost (line 1 times line 6)	(line 7 min	us sum of lin	and F. if	41, 986, 231	7.00
8.00	Difference between net revenue and costs for Medicaid program < zero then enter zero)	(The / min	us sum of fin	es z and s; TT	0	8.00
	Children's Health Insurance Program (CHIP) (see instructions f	or each line	2)			
9.00	Net revenue from stand-al one CHIP				0	9.00
10.00	Stand-al one CHIP charges				0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)				0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP	(line 11 mi)	nus line 9: i	f < zero then	0	12.00
	enter zero)					
	Other state or local government indigent care program (see ins	structions fo	or each line)			
13.00	Net revenue from state or local indigent care program (Not inc				0	13.00
14.00	Charges for patients covered under state or local indigent car	re program (I	Not included	in lines 6 or	0	14.00
	10)					
15.00	State or local indigent care program cost (line 1 times line 1				0	15.00
16.00	Difference between net revenue and costs for state or local in	ndigent care	program (lin	e 15 minus line	0	16.00
	13; if < zero then enter zero)	IID and state	/local india	ant core presso		
	Grants, donations and total unreimbursed cost for Medicaid, CH instructions for each line)	ir and state	errocar rhurg	ent care prograi	lis (see	
17.00	Private grants, donations, or endowment income restricted to f	[°] undi ng chari	ity care		0	17.00
18.00	Government grants, appropriations or transfers for support of				0	18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and loca			(sum of lines	0	19.00
	8, 12 and 16)					
			Uni nsured	Insured	Total (col. 1	
			patients	patients	+ col . 2)	
	Uncompensated Care (and instructions for each line)		1.00	2.00	3.00	
20.00	Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire fa	oci Li tv	30, 815, 67	0 4, 133, 279	34, 948, 949	20.00
20.00	(see instructions)	activity	30, 813, 07	4,133,279	34, 740, 747	20.00
21.00	Cost of patients approved for charity care and uninsured disco	nunts (see	6, 681, 29	9 4, 133, 279	10, 814, 578	21 00
21.00	instructions)		0,001,27	, 1, 100, 27,	10,011,070	21.00
22.00	Payments received from patients for amounts previously writter	n off as		o o	0	22.00
	charity care					
23.00	Cost of charity care (line 21 minus line 22)		6, 681, 29	9 4, 133, 279	10, 814, 578	23.00
					1.00	
24.00	Does the amount on line 20 column 2, include charges for patie		ond a length	of stay limit	N	24.00
	imposed on patients covered by Medicaid or other indigent care					
25.00	If line 24 is yes, enter the charges for patient days beyond t	the indigent	care program	's length of	0	25.00
26.00	stay limit Total bad debt expense for the entire hospital complex (see ir	octructions)			24, 071, 139	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see if		ructions)		720, 106	
27.00	Medicare allowable bad debts for the entire hospital complex (1, 107, 854	
28.00	Non-Medicare bad debt expense (see instructions)				22, 963, 285	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt ex	kpense (see	instructions)		5, 366, 533	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)				16, 181, 111	
	Total unreimbursed and uncompensated care cost (line 19 plus l	ine 30)			16, 181, 111	
	· · · · · · · · · · · · · · · · · · ·					-

CLASS	inancial Systems FICATION AND ADJUSTMENTS OF TRIAL BALANCE OF	EXPENSES	Provider CO		eriod: rom 01/01/2017	u of Form CMS-: Worksheet A	
				Ţ,		Date/Time Pre 5/31/2018 3:5	
	Cost Center Description	Sal ari es	Other		Recl assi fi cati	Recl assi fi ed	
				+ col. 2)	ons (See A-6)	Trial Balance (col. 3 +-	
						col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	ENERAL SERVICE COST CENTERS 0100 CAP REL COSTS-BLDG & FIXT		16, 352, 525	16, 352, 525	5, 832, 404	22, 184, 929	1 1.
	0200 CAP REL COSTS-BEDG & TTXT		10, 352, 525	10, 352, 525		3, 775, 908	
	0400 EMPLOYEE BENEFITS DEPARTMENT	1, 458, 776	31, 115, 366	32, 574, 142		32, 574, 142	
	1160 COMMUNI CATI ONS	505, 811	838, 120	1, 343, 931	0	1, 343, 931	
	1140 MGMT INFO SYSTEMS 0550 PURCHASING	89, 358 0	16, 360, 648 1, 595, 069			16, 450, 006 1, 595, 069	
	0570 ADMI TTI NG	0	4, 460	4, 460		4, 460	
	0580 PATIENT ACCOUNTING	0	5, 771, 125	5, 771, 125		5, 771, 125	
	0560 OTHER ADMINISTRATIVE AND GENERAL	6, 686, 187	29, 734, 405	36, 420, 592		36, 380, 082	
	0700 OPERATION OF PLANT 0800 LAUNDRY & LINEN SERVICE	3, 169, 054 109, 139	7, 251, 782 869, 148			10, 410, 370 978, 287	
	0900 HOUSEKEEPING	2,077,119	1, 000, 457	3, 077, 576			
	1000 DI ETARY	2, 242, 705	1, 381, 743				
	1100 CAFETERIA 1300 NURSI NG ADMINI STRATI ON	0 2, 839, 682	0 73, 239	0 2, 912, 921			
	1400 CENTRAL SERVICE & SUPPLY	435, 882	1, 017, 860	1, 453, 742		553, 032	
00 0	1500 PHARMACY	2, 990, 474	11, 183, 741	14, 174, 215	-10, 520, 161	3, 654, 054	15
	1600 MEDI CAL RECORDS & LI BRARY	58, 812	2, 198, 163	2, 256, 975		2, 097, 484	
	1700 SOCIAL SERVICE 2000 NURSING SCHOOL	619, 866 2, 050, 883	2, 406 267, 951	622, 272 2, 318, 834		622, 272 2, 615, 791	
	2301 PHARMACY RESIDENCY	167, 386	15, 288			354, 741	
	2300 EMS EDUCATION	128, 505	28, 486	156, 991	153, 700	310, 691	23
	NPATIENT ROUTINE SERVICE COST CENTERS	10 205 002	2 (00 (00	20,005,401	E (4((EO	15 240 022	1 20
	3000 ADULTS & PEDIATRICS 3100 INTENSIVE CARE UNIT	18, 285, 803 3, 520, 941	2, 609, 688 279, 391	20, 895, 491 3, 800, 332			
	2060 NEONATAL INTENSIVE CARE UNIT	1, 717, 515	827, 683				
	4100 SUBPROVI DER – I RF	1, 143, 890	211, 165				
	4300 NURSERY NCI LLARY SERVICE COST CENTERS	0	0	0	551, 842	551, 842	43
	5000 OPERATING ROOM	4,024,082	26, 374, 077	30, 398, 159	-20, 477, 977	9, 920, 182	50
	5100 RECOVERY ROOM	678, 479	42, 216				
	5200 DELIVERY ROOM & LABOR ROOM	0	0	0			
	5400 RADI OLOGY-DI AGNOSTI C 3630 RADI OLOGY-THERAPEUTI C	3, 419, 790 404, 194	7, 134, 239 118, 566	10, 554, 029 522, 760		7, 855, 625 510, 672	
	5600 RADI OL SOTOPE	227, 290	52, 615	279, 905		268, 539	
	3950 CARDI AC CATH LAB	1, 286, 090	5, 123, 277	6, 409, 367			
	5700 CT SCAN 5800 MRI	672, 277	412,630				
	6000 LABORATORY	238, 057 0	123, 719 9, 848, 595				
	6500 RESPI RATORY THERAPY	2, 119, 971	648, 967				
	6600 PHYSI CAL THERAPY	3, 513, 127	482, 510				
	6700 OCCUPATI ONAL THERAPY 6800 SPEECH PATHOLOGY	1, 242, 520 412, 353	107, 174 10, 807	1, 349, 694 423, 160		1, 321, 001 420, 327	
	6900 ELECTROCARDI OLOGY	1, 545, 263	1, 214, 611	2, 759, 874		2, 738, 252	
	7000 ELECTROENCEPHALOGRAPHY	642, 584	163, 755	806, 339		759, 693	
	7100 MEDICAL SUPPLIES CHARGED TO PATIENT 7200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0			
	7300 DRUGS CHARGED TO PATIENTS	0	0	0			
01 0	7301 DI ABETES CENTER	335, 592	11, 004	346, 596	-2, 099	344, 497	73
	7400 RENAL DIALYSIS	122, 630	587, 975	710, 605			
	7698 HYPERBARI C OXYGEN THERAPY	1, 703	145, 815	147, 518	-2, 029	145, 489	76
	9000 CLINIC	456, 454	652, 806	1, 109, 260	-297, 287	811, 973	90
00 0	9100 EMERGENCY	7, 105, 568	1, 829, 929	8, 935, 497	-1, 182, 124	7, 753, 373	91
	4950 WOUND CARE 9200 OBSERVATION BEDS (NON-DISTINCT PART	1, 369, 459	430, 174	1, 799, 633	-387,078	1, 412, 555	
	9200 OBSERVATION BEDS (NON-DISTINCT PART 9201 OBSERVATION BEDS (DISTINCT PART)	1, 891, 205	680, 088	2, 571, 293	-316, 890	2, 254, 403	92
	THER REIMBURSABLE COST CENTERS	., 671, 200					1 12
	9500 AMBULANCE SERVICES	2, 243, 581	828, 348				
	0100 HOME HEALTH AGENCY PECIAL PURPOSE COST CENTERS	2, 469, 274	1, 370, 217	3, 839, 491	0	3, 839, 491	101
	1300 INTEREST EXPENSE		10, 218, 826	10, 218, 826	-7, 565, 352	2, 653, 474	113
. 00 1	1600 HOSPI CE	1, 463, 104	1, 426, 072	2, 889, 176		2, 889, 176	
3. 00	SUBTOTALS (SUM OF LINES 1 through 117)	88, 182, 435	201, 028, 921	289, 211, 356	0	289, 211, 356	118
	ONREI MBURSABLE COST CENTERS 9000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	46, 752	34, 375	81, 127	0	81, 127	100
	9000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 9200 PHYSICIANS' PRIVATE OFFICES	46, 752 6, 272, 054	34, 375 7, 532, 395			13, 804, 449	
1. 00 0	7950 MOB	0	171	171	0	171	194
	7951 LI FELI NE	603	5, 012			5, 615	
+ 0210	7952 PATIENT TRANSPORT	0	264, 376	264, 376	0	264, 376 0	[194

Health Financial Systems	FRANCI SCAN HEAL	TH LAFAYETTE		In Lie	eu of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF	F EXPENSES	Provider CC		Period: From 01/01/2017	Worksheet A	
					Date/Time Pre 5/31/2018 3:5	
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	
200.00 TOTAL (SUM OF LINES 118 through 199)	94, 501, 844	208, 865, 250	303, 367, 094	1 0	303, 367, 094	200.00

				From 01/01/2017 To 12/31/2017 Date/Time	
	Cost Center Description		Net Expenses	5/31/2018	<u>3:53 pr</u>
		(See A-8) F 6.00	For Allocation 7.00		
	GENERAL SERVICE COST CENTERS				
00	00100 CAP REL COSTS-BLDG & FIXT	880, 151	23, 065, 080		1
00	00200 CAP REL COSTS-MVBLE EQUIP	1, 586, 552	5, 362, 460		2
00	00400 EMPLOYEE BENEFITS DEPARTMENT	2, 680, 593	35, 254, 735		4
01 02	01160 COMMUNICATIONS 01140 MGMT INFO SYSTEMS	0 -624, 198	1, 343, 931 15, 825, 808		5
02	00550 PURCHASING	-92, 369	1, 502, 700		5
03	00570 ADMI TTI NG	- 72, 307	4, 460		5
05	00580 PATIENT ACCOUNTING	-159, 787	5, 611, 338		5
06	00560 OTHER ADMINISTRATIVE AND GENERAL	-15, 338, 270	21, 041, 812		5
00	00700 OPERATION OF PLANT	-55, 463	10, 354, 907		7
00	00800 LAUNDRY & LINEN SERVICE	0	978, 287		8
00	00900 HOUSEKEEPI NG	0	3, 075, 607		9
	01000 DI ETARY	-246, 870	1, 058, 934		10
	01100 CAFETERI A	-1, 269, 914	995, 341		11
	01300 NURSI NG ADMI NI STRATI ON	-348, 824	2, 563, 937		13
	01400 CENTRAL SERVICE & SUPPLY	-139, 331	413, 701		14
		-313, 959	3, 340, 095		15
	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	-413, 917 0	1, 683, 567 622, 272		16
	02000 NURSI NG SCHOOL	-2, 281, 083	334, 708		20
	02301 PHARMACY RESIDENCY	-2, 281, 083	236, 419		23
	02300 EMS EDUCATION	0	310, 691		23
	INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>			
0. 00	03000 ADULTS & PEDIATRICS	-70, 200	15, 178, 632		30
I. 00	03100 I NTENSI VE CARE UNI T	0	3, 547, 568		31
	02060 NEONATAL INTENSIVE CARE UNIT	-617,000	1, 866, 875		35
	04100 SUBPROVIDER - IRF	-116, 847	1, 209, 470		41
. 00	04300 NURSERY	0	551, 842		43
	ANCI LLARY SERVICE COST CENTERS	412 400	0 50/ 772		
	05000 OPERATING ROOM 05100 RECOVERY ROOM	-413, 409 0	9, 506, 773		50
	05200 DELIVERY ROOM & LABOR ROOM	0	683, 373 3, 597, 148		52
	05400 RADI OLOGY-DI AGNOSTI C	-91, 370	7, 764, 255		54
	03630 RADI OLOGY-THERAPEUTI C	0	510, 672		55
	05600 RADI OI SOTOPE	-4,875	263, 664		56
	03950 CARDI AC CATH LAB	-134,685	1, 591, 036		56
. 00	05700 CT SCAN	0	853, 098		57
8. 00	05800 MRI	0	299, 844		58
	06000 LABORATORY	-16, 989	9, 702, 207		60
	06500 RESPI RATORY THERAPY	-7,050	2, 355, 008		65
	06600 PHYSI CAL THERAPY	-174, 804	3, 607, 417		66
	06700 OCCUPATIONAL THERAPY	-10, 435	1, 310, 566		67
	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	0 -908, 021	420, 327 1, 830, 231		68
	07000 ELECTROCARDI OLOGI	-908, 021	759, 693		69 70
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	14, 860, 729		71
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	17, 212, 835		72
	07300 DRUGS CHARGED TO PATIENTS	0	10, 312, 748		73
	07301 DI ABETES CENTER	-888	343, 609		73
	07400 RENAL DIALYSIS	0	695, 745		74
. 98	07698 HYPERBARI C OXYGEN THERAPY	0	145, 489		76
	OUTPATIENT SERVICE COST CENTERS				
	09000 CLINIC	-192	811, 781		90
	09100 EMERGENCY	-349, 239	7,404,134		91
	04950 WOUND CARE	-1, 769	1, 410, 786		91 92
	09200 OBSERVATION BEDS (NON-DISTINCT PART 09201 OBSERVATION BEDS (DISTINCT PART)	0	2, 254, 403		92
. 01	OTHER REIMBURSABLE COST CENTERS	UU	2,234,403		
. 00	09500 AMBULANCE SERVICES	0	2, 813, 683		95
	10100 HOME HEALTH AGENCY	-1, 040	3, 838, 451		101
	SPECIAL PURPOSE COST CENTERS				
	11300 INTEREST EXPENSE	-2, 653, 474	0		113
	11600 HOSPI CE	-491	2, 888, 685		116
8.00		-21, 827, 789	267, 383, 567		118
	NONREI MBURSABLE COST CENTERS		i		
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	81, 127		190
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	13, 804, 449		192
		0	171		194
		0	5, 615		194
	07952 PATIENT TRANSPORT	0	264, 376		194
	07954 OTHER NONREIMBURSABLE COST CENTERS	0	0		194

FRANCISCAN HEALTH LAFAYETTE

In Lieu of Form CMS-2552-10

Health Financial Systems

	Financial Systems		FRANCI SCAN HEAL	TH LAFAYETTE Provider CCN: 1	5-0109	In Lie Period:	u of Form CMS- Worksheet A-6	
	· · ·					From 01/01/2017 To 12/31/2017	Date/Time Pre	epared:
		Increases					5/31/2018 3:5	53 pm
	Cost Center	Line #	Salary	Other				
	2.00 A - RENTALS	3.00	4.00	5.00		<u> </u>		
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1, 593, 314				1.00
2.00		0.00	0	0				2.00
3.00 4.00		0.00 0.00	0	0				3.00 4.00
5.00		0.00	0	0				5.00
6.00		0.00	0	0				6.00
7.00 8.00		0.00 0.00	0	0				7.00 8.00
9.00		0.00	0	0				9.00
	O B – EQUI PMENT RENTAL		0	1, 593, 314				
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	287, 335				1.00
2.00		0.00	0	0				2.00
3.00 4.00		0.00 0.00	0	0				3.00 4.00
4.00 5.00		0.00	0	0				5.00
6.00		0.00	0	0				6.00
7.00 8.00		0. 00 0. 00	0	0				7.00 8.00
9.00		0.00	0	0				9.00
10.00		0.00	0	0				10.00
11.00		0.00	0	0				11.00 12.00
12. 00 13. 00		0.00 0.00	0	0				12.00
	0 — — — — — —			287, 335				
1.00	C - MEDICAL SUPPLIES MEDICAL SUPPLIES CHARGED TO	71.00	0	14, 860, 729				1.00
1.00	PATIENT	71.00	0	14, 600, 729				1.00
2.00	IMPL. DEV. CHARGED TO	72.00	0	17, 212, 835				2.00
3.00	PATI ENTS	0.00	o	о				3.00
4.00		0.00	0	0				4.00
5.00		0.00	0	0				5.00
6.00 7.00		0.00 0.00	0	0				6.00 7.00
8.00		0.00	0	0				8.00
9.00		0.00	0	0				9.00
10. 00 11. 00		0.00 0.00	0	0				10.00 11.00
12.00		0.00	0	0				12.00
13.00		0.00	0	0				13.00
14.00 15.00		0.00 0.00	0	0				14.00 15.00
16.00		0.00	0	0				16.00
17.00		0.00	0	0				17.00
18. 00 19. 00		0. 00 0. 00	0	0				18.00 19.00
20.00		0.00	0	0				20.00
21.00		0.00	0	0				21.00
22. 00 23. 00		0. 00 0. 00	0	0				22.00 23.00
24.00		0.00	0	0				24.00
25.00		0.00	0	0				25.00
26. 00 27. 00		0. 00 0. 00	0	0				26.00 27.00
27.00		0.00	0	0				27.00
29.00		0.00	0	0				29.00
30.00		0.00	<u>0</u> 0	<u> </u>				30.00
	D - DRUGS		U	32,073,304				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	10, 312, 748				1.00
2.00 3.00		0. 00 0. 00	0	0				2.00 3.00
3.00 4.00		0.00	0	0				3.00 4.00
5.00		0.00	0	0				5.00
6.00		0.00	0	0				6.00
7.00 8.00		0. 00 0. 00	0	0				7.00 8.00
9.00		0.00	0	0				9.00
10.00		0.00	0	0				10.00
11. 00 12. 00		0. 00 0. 00	0	0				11. 00 12. 00
13.00		0.00	0	0				13.00
		· I	I	1				

FRANCI SCAN HEALTH LAFAYETTE

Provider CCN: 15-0109

In Lieu of Form CMS-2552-10 Period: Worksheet A-6 From 01/01/2017 To 12/31/2017

				To 12/31/2017 Date/Time F 5/31/2018 3	Prepared: 3:53 pm	
		Increases				
	Cost Center	Line #	Sal ary	0ther		
	2.00	3.00	4.00	5.00		
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
22.00	<u> </u>	0.00	0	0		22.00
			0	10, 312, 748		_
1 00	E - LDRP	42.00	E 4 E 400	(250		1 00
1.00	NURSERY	43.00	545, 492	6, 350		1.00
2.00	DELIVERY ROOM & LABOR ROOM	<u>52.</u> 00	<u>3, 555, 756</u> 4, 101, 248	<u>41, 392</u> 47, 742		2.00
	F – CAFETERIA		4, 101, 248	47,742		
1.00	CAFETERIA	11.00	1, 422, 631	842, 624		1.00
1.00			1, 422, 631	842, 624		1.00
	G - CAPITAL EXP (INT & DEP)		1, 422, 031	042, 024		_
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	162, 311		1.00
1.00			— — — ö	162, 311		1.00
	H - INTEREST	I		102, 011		
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	4, 239, 090		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	3, 326, 262		2.00
				7, 565, 352		
	I - NURSING SCHOOL	I		.,		
1.00	NURSI NG SCHOOL	20.00	96, 956	0		1.00
2.00	NURSING SCHOOL	20.00	77, 491	122, 510		2.00
3.00		0.00	0	0		3.00
			174, 447	122, 510		
	J - PARAMED PROGRAM					
1.00	PHARMACY RESIDENCY	23.00	75, 317	96, 750		1.00
2.00	EMS EDUCATION	23.01	153, 700	0		2.00
3.00		0.00	0	0		3.00
	0		229, 017	96, 750		
	K - FSEH SHARED SERVICES					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	145, 371		1.00
2.00	OTHER ADMINISTRATIVE AND	5.06	0	804, 810		2.00
	GENERAL					
3.00	NURSING ADMINISTRATION	13.00	0	332, 409		3.00
4.00	PHARMACY		0	5 <u>5, 2</u> 38		4.00
	0		0	1, 337, 828		
	Grand Total: Increases		5, 927, 343	54, 442, 078		

	Financial Systems SIFICATIONS	F	RANCI SCAN HEAL		CCN: 15-0109 Period: From 01/	In Lieu of Form CMS-2552-10 Worksheet A-6
						(31/2017 Date/Time Prepared: 5/31/2018 3:53 pm
		Decreases				
	Cost Center 6.00	Line #	Salary 8.00	0ther 9.00	Wkst. A-7 Ref. 10.00	
	A - RENTALS	7.00	8.00	9.00	10.00	
1.00	DI ETARY	10.00	0	52, 424	1	1.00
2.00 3.00	ADULTS & PEDIATRICS OPERATING ROOM	30. 00 50. 00	0	259, 667 119, 595	1	2.00
4.00	RADI OLOGY-DI AGNOSTI C	54.00	0	701, 510		4.00
5.00	LABORATORY	60.00	0	8, 267		5.00
6.00 7.00	PHYSICAL THERAPY EMERGENCY	66.00 91.00	0	68, 066 135, 019		6.00 7.00
7.00 8.00	OBSERVATION BEDS (DISTINCT	91.00	0	224, 657		8.00
	PART)					
9.00	AMBULANCE_SERVICES	<u>95.00</u>	0	2 <u>4, 1</u> 09 1, 593, 314		9.00
	B - EQUIPMENT RENTAL	I	0	1, 373, 314		
1.00	OPERATION OF PLANT	7.00	0	10, 466	1	1.00
2.00 3.00	HOUSEKEEPI NG DI ETARY	9.00 10.00	0	1, 969 965	1	2.00
4.00	CENTRAL SERVICE & SUPPLY	14.00	0	9, 412		4.00
5.00	PHARMACY	15.00	0	201, 519		5.00
6.00 7.00	ADULTS & PEDIATRICS SUBPROVIDER - IRF	30. 00 41. 00	0	9, 485 245	1	6.00 7.00
7.00 8.00	OPERATING ROOM	50.00	0	8, 421		8.00
9.00	CT SCAN	57.00	0	5, 050		9.00
10.00		65.00	0	29, 132	1	10.00
11. 00 12. 00	PHYSICAL THERAPY ELECTROENCEPHALOGRAPHY	66.00 70.00	0	464 2, 207		11.00
13.00	AMBULANCE_SERVICES	95.00	0	<u> </u>		13.00
			0	287, 335		
1.00	C - MEDICAL SUPPLIES NURSING ADMINISTRATION	13.00	0	160	0	1.00
2.00	CENTRAL SERVICE & SUPPLY	14.00	0	890, 771	1	2.00
3.00	PHARMACY	15.00	0	487, 918		3.00
4.00 5.00	ADULTS & PEDIATRICS INTENSIVE CARE UNIT	30.00 31.00	0 0	1, 084, 223 237, 754		4.00 5.00
6.00	NEONATAL INTENSIVE CARE UNIT	35.00	0	59, 262		6.00
7.00	SUBPROVIDER - IRF	41.00	0	28, 135		7.00
8.00 9.00	OPERATING ROOM RECOVERY ROOM	50.00 51.00	0	20, 271, 283 37, 040		8.00
7.00 10.00	RADI OLOGY-DI AGNOSTI C	54.00	0	1, 782, 861	1	10.00
11.00	RADI OLOGY-THERAPEUTI C	55.00	0	12, 054	1	11.00
12.00		56.00	0	11, 366		12.00
13.00 14.00	CARDIAC CATH LAB CT SCAN	56.01 57.00	0	4, 682, 855 140, 038	1	13.00 14.00
15.00	MRI	58.00	0	16, 336	0	15.00
		60.00	0	121, 132		16.00
17. 00 18. 00	RESPI RATORY THERAPY PHYSI CAL THERAPY	65.00 66.00	0	377, 198 144, 437		17.00
19.00	OCCUPATI ONAL THERAPY	67.00	0	28, 693		19.00
20.00	SPEECH PATHOLOGY	68.00	0	2, 829		20.00
21. 00 22. 00	ELECTROCARDI OLOGY ELECTROENCEPHALOGRAPHY	69.00 70.00	0	20, 123 44, 439	1	21.00 22.00
23.00	DI ABETES CENTER	73.01	0	2, 099	1	23.00
24.00	RENAL DIALYSIS	74.00	0	14, 860		24.00
25. 00 26. 00	HYPERBARIC OXYGEN THERAPY CLINIC	76. 98 90. 00	0	2, 029 47, 493	1	25. 00 26. 00
28.00	EMERGENCY	90.00	0	47, 493 926, 224	1	28.00
28.00	WOUND CARE	91.01	0	383, 557		28.00
29.00	OBSERVATION BEDS (DISTINCT	92.01	0	86, 844	0	29.00
30.00	PART) AMBULANCE SERVICES	95.00	О	129, 551	0	30.00
	0		ō	32,073,564		
1 00	D - DRUGS	14.00		FOR		1.00
1.00 2.00	CENTRAL SERVICE & SUPPLY PHARMACY	14.00 15.00	0	527 9, 658, 657		1.00
3.00	ADULTS & PEDIATRICS	30.00	0	47, 338	1	3.00
4.00	INTENSIVE CARE UNIT	31.00	0	15, 010		4.00
5.00 6.00	NEONATAL INTENSIVE CARE UNIT SUBPROVIDER - IRF	35.00 41.00	0	2, 061 358		5.00
8.00 7.00	OPERATING ROOM	50.00	0	358 78, 678	1	7.00
8.00	RECOVERY ROOM	51.00	0	282	0	8.00
9.00	RADI OLOGY-DI AGNOSTI C	54.00	0	51, 722		9.00
10. 00 11. 00	RADI OLOGY-THERAPEUTI C CARDI AC CATH LAB	55.00 56.01	0	34 791		10.00
12.00	CT SCAN	57.00	0	86, 721	0	12.00
13.00	MRI	58.00	0	45, 596	0	13.00

Health Financial Systems RECLASSIFICATIONS

FRANCI SCAN HEALTH LAFAYETTE

Provider CCN: 15-0109

In Lieu of Form CMS-2552-10 Period: Worksheet A-6 From 01/01/2017 To 12/31/2017 Date/Time Prepared:

$ \begin{array}{ c c c c c c c c c c c c c c c c c c c$							To 12/31/20	17 Date/Time Prepared: 5/31/2018 3:53 pm
$\begin{tabular}{ c c c c c c c c c c c c c c c c c c c$			Decreases					
14.00 RESPIRATORY THERAPY 65.00 0 550 0 14.00 15.00 PHOLSCAL THERAPY 66.00 0 449 0 15.00 15.00 PHOLSCALT THERAPY 66.00 0 449 0 15.00 16.00 SPEECH PATHOLOGY 68.00 0 449 0 16.00 17.00 ELFORCARDIOLOGY 69.00 0 1.499 0 17.00 18.00 OLINIC 90.00 0 36.182 0 19.00 10.00 DERVATION BEDS (DISTINCT 92.01 0 5.389 0 21.00 22.00 D 0 5.389 0 21.00 22.00 0 21.00 22.00 0 21.00 22.00 0 21.00 22.00 0 0 1.00 22.00 0 21.00 22.00 0 21.00 21.00 21.00 21.00 21.00 21.00 21.00 21.00 21.00 21.00 21.00 21.00 21.00 21.00 21.00 21.00 21.00 21.00 <		Cost Center		Salary	Other	Wkst. A-7 Ref.		
$ \begin{array}{c c c c c c c c c c c c c c c c c c c $		6.00	7.00	8.00	9.00	10.00	1	
16.00 SPEECH PATHOLOGY 68.00 0 4 0 16.00 16.00 17.00 17.00 ELEFECRCARDIOLOGY 90.00 0 249.794 0 17.00 18.00 17.00 18.00 17.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 20.00 0.00 3.5182 0 20.00 21.00 22.00 21.00 22.00 21.00 22.00 21.00 22.00 22.00 21.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 20.00 4.101.248 47.742 0 1.00 2.00	14.00	RESPI RATORY THERAPY	65.00	0	550) ()	14.00
	15.00	PHYSICAL THERAPY	66.00	0	449	(D	15.00
18.00 CLINIC 90.00 0 240.794 0 18.00 19.00 EREGREY 91.00 0 36.182 0 20.00 21.00 DBSERVATION BEDS (DISTINCT 92.01 0 5.899 0 21.00 22.00 AMEULANCE SERVICES 95.00 0 27.585 0 22.00 22.00 0 0 10.312.748 0 2.00 2.00 2.00 0 0 0.00 4.101.248 47.742 0 2.00 2.00 0 0 1.422.631 842.624 0 0 2.00 0 0 1.422.631 842.624 0 0 1.00 2.00 1.00 0 0 1.422.631 842.624 0 0 1.00 1.00 0 0 1.422.631 842.624 0 0 2.00 1.00 0 0 1.62.311 9 0 1.00 2.00 1.00 0 0 0 7.565.352 1 2.00 2.00	16.00	SPEECH PATHOLOGY	68.00	0	4	. (D	16.00
19.00 EVERCENCY 91.00 0 36.182 0 19.00 20.00 WOLMD CARE 91.01 0 3.521 0 20.00 20.00 OUND CARE 91.01 0 5.389 0 21.00 22.00 AMBULANCE SERVICES 95.00 0 27.585 0 22.00 0 - - 0 0 27.585 0 22.00 0 - - 0 - 0 22.00 22.00 0 - - 0 - 0 20.00 22.00 0 - - 0 - 0 0 20.00 20.00 0 - - 0.00 - 0 0 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 <t< td=""><td>17.00</td><td>ELECTROCARDI OLOGY</td><td>69.00</td><td>0</td><td>1, 499</td><td>(</td><td></td><td>17.00</td></t<>	17.00	ELECTROCARDI OLOGY	69.00	0	1, 499	(17.00
20.00 WOUND CARE 91.01 0 3.521 0 20.00 21.00 22	18.00	CLINIC	90.00	0	249, 794	. (18.00
21.00 DSSERVATION BEDS (DISTINCT 92.01 0 5,389 0 21.00 22.00 AMBULANCE SERVICES 95.00 0 27,585 0 22.00 0 0 10.12,748 0 10.01 22.00 22.00 22.00 0 0 0.00 0 0.12,748 0 20.00 20.00 0 0 0.00 0 0 0 0 20.00 20.00 0 0 0.00 0 0 0 0 20.00 <td< td=""><td>19.00</td><td>EMERGENCY</td><td>91.00</td><td>0</td><td>36, 182</td><td>(</td><td></td><td>19.00</td></td<>	19.00	EMERGENCY	91.00	0	36, 182	(19.00
PART) PART) 95.00 0 27,585 0 22.00 AMBULANCE SERVICES 95.00 0 10,312,748 0 10,312,748 0 10,012,748 10,00 10,012,748 0 10,00 10,012,748 0 10,00 10,00 10,00 10,012,748 0	20.00	WOUND CARE	91.01	0	3, 521	(20.00
O Image: Constraint of the second secon	21.00		92.01	0	5, 389	0		21.00
E L DRP Image: constraint of the second sec	22.00	AMBULANCE SERVICES	95.00	0	27, 585	(22.00
1.00 ADULTS & PEDIATRICS 30.00 4, 101, 248 47, 742 0 0 2.00 2.00		0			10, 312, 748	· · · · · ·	1	
$ \begin{array}{c ccccccccccccccccccccccccccccccccccc$		E - LDRP						
$ \begin{array}{c c c c c c c c c c c c c c c c c c c $	1.00	ADULTS & PEDIATRICS	30.00	4, 101, 248	47, 742	()	1.00
F CAFETERIA DIETARY	2.00		0.00	0	C) (2.00
1.00 DI ETARY		0	+	4, 101, 248	47,742		1	
$ \begin{array}{ c c c c c c c c c c c c c c c c c c c$		F - CAFETERIA						
$ \begin{array}{c c c c c c c c c c c c c c c c c c c $	1.00	DI ETARY	10.00	1, 422, 631)	1.00
$ \begin{array}{c c c c c c c c c c c c c c c c c c c $		0		1, 422, 631	842, 624		1	
O Image: colored state of the		G - CAPITAL EXP (INT & DEP)		· · · · · ·			·	
H INTEREST In	1.00	RADI OLOGY-DI AGNOSTI C	54.00	0	162, 311	, c	7	1.00
1.00 INTEREST EXPENSE 113.00 0 7,565,352 11 1.00 2.00 0 0 0 0 11 0 2.00 0 - 0 0 0 11 0 2.00 0 11 0 2.00 0 11 0 2.00 0 11 0 2.00 0 11 0 2.00 0 11 0 2.00 0 11 0 2.00 0 10 0 2.00 0 1.00 2.00 0 1.00 2.00 0 1.00 2.00 0 1.00 2.00 0 1.00 2.00 0 1.00 2.00 0 1.00 2.00 0 1.00 2.00 0 1.00 2.00 0 1.00 2.00 0 1.00 2.00 1.00 2.00 1.00 2.00 0 1.00 2.00 3.00 0 2.00 3.00 0 2.00 3.00 0 2.00 3.00 2.00 3.00 2.00 3.00 2		0	T	0	162, 311		1	
2.00		H - INTEREST	·	· ·				
O O 7,565,352 -	1.00	INTEREST EXPENSE	113.00	0	7, 565, 352	. 11	1	1.00
1 - NURSI NG SCHOOL 1 0 1 0 ADULTS & PEDI ATRI CS 30.00 96,956 0 0 1.00 2.00 0 1.00 2.00 0 1.00 2.00 0 0 0 2.00 0 0 1.00 2.00 0 1.00 2.00 0 1.00 2.00 1.00 2.00 1.00 2.00 1.00 2.00 3.00 0 0 1.00 2.00 3.00 0 0 1.00 2.00 3.00 0 3.00 0 3.00	2.00		0.00		C	11	1	2.00
1.00 ADULTS & PEDIATRICS 30.00 96,956 0 0 1.00 2.00 OTHER ADMI NI STRATI VE AND 5.06 36,323 4,187 0 2.00 3.00 MEDI CAL_RECORDS & LI BRARY		0	+	0	7, 565, 352	!	1	
2.00 OTHER ADMI NI STRATI VE AND 5.06 36,323 4,187 0 2.00 3.00 MEDI CAL_RECORDS & LI BRARY 16.00 41,168 118,323 0 0 3.00 0 174,447 122,510 0 1.00 174,447 122,510 1.00 1.00 2.00 EMERGENCY 15.00 75,317 96,750 0 1.00 2.00 3.00 AMBULANCE SERVICES 95.00 69,001 0 0 3.00 0 229,017 96,750 0 0 3.00 0 229,017 96,750 0 3.00 0 229,017 96,750 0 3.00 0 229,017 96,750 0 3.00 0 0 145,371 0 0 0 2.00 OTHER ADMI NI STRATI VE AND 5.06 804,810 0 0 2.00 OTHER ADMI NI STRATI VE AND 13.00 332,409 0 0 3.00 3.00 PHARMACY 15.00 55,238 0 0		I - NURSING SCHOOL						
3. 00 GENERAL MEDI CAL RECORDS & LI BRARY 16. 00 41, 168 118, 323 0 J - PARAMED PROGRAM 174, 447 122, 510 1 0 1.00 J - PARAMED PROGRAM 15. 00 75, 317 96, 750 0 1.00 2. 00 EMERGENCY 91. 00 84, 699 0 0 2.00 3. 00 MBULANCE SERVICES 95. 00 69, 001 0 0 2.00 A - 229, 017 96, 750 0 1.00 3.00 AMBULANCE SERVICES 95. 00 69, 001 0 0 2.00 K - FSEH SHARED SERVICES 10.00 145, 371 0 0 0 2.00 OTHER ADMINISTRATIVE AND 5. 06 804, 810 0 0 2.00 3.00 NURSI NG ADMINI STRATI ON 13. 00 332, 409 0 0 3.00 4. 00 14, 337, 828 0 0 0 4.00	1.00	ADULTS & PEDIATRICS	30.00	96, 956	C) ()	1.00
3.00 MEDI CAL RECORDS & LI BRARY 16.00 41,168 118,323 0 0 174,447 122,510 122,510 1 1.00 J - PARAMED PROGRAM 15.00 75,317 96,750 0 1.00 2.00 EMERGENCY 91.00 84,699 0 0 2.00 2.00 3.00 AMBULANCE SERVICES 95.00 69,001 0 0 2.00 3.00 0 - 229,017 96,750 0 0 3.00 0 - 229,017 96,750 0 1.00 2.00 OTHER ADMINISTRATI VE AND 5.06 804,810 0 0 2.00 3.00 OTHER ADMINISTRATI VE AND 5.06 804,810 0 0 2.00 2.00 3.00 NURSI NG ADMINI STRATI ON 13.00 332,409 0 0 3.00 3.00 4.00 14,337,828 0 0 0 4.00 4.00	2.00	OTHER ADMINISTRATIVE AND	5.06	36, 323	4, 187	(2.00
O Image: 10 minipage state		GENERAL						
J - PARAMED PROGRAM 1.00 1.00 PHARMACY 15.00 75,317 96,750 0 1.00 2.00 EMERGENCY 91.00 84,699 0 0 2.00 3.00 AMBULANCE SERVICES 95.00 69,001 0 0 2.00 0 229,017 96,750 0 3.00 3.00 3.00 K - FSEH SHARED SERVICES 229,017 96,750 0 3.00 3.00 1.00 EMPLOYEE BENEFITS DEPARTMENT 4.00 145,371 0 0 2.00 2.00 OTHER ADMINISTRATIVE AND 5.06 804,810 0 0 2.00 3.00 NURSI NG ADMINI STRATI ON 13.00 332,409 0 0 3.00 4.00 PHARMACY 15.00 55,238 0 0 4.00	3.00	MEDICAL RECORDS & LIBRARY	16.00	41, 168	118, 323	(D	3.00
1.00 PHARMACY 15.00 75,317 96,750 0 1.00 2.00 EMERGENCY 91.00 84,699 0 0 2.00 3.00 AMBULANCE_SERVICES 95.00 69,001 0 0 3.00 0 229,017 96,750 0 0 3.00 K - FSEH SHARED SERVICES 229,017 96,750 0 3.00 1.00 EMPLOYEE BENEFITS DEPARTMENT 4.00 145,371 0 0 0 2.00 OTHER ADMINISTRATIVE AND 5.06 804,810 0 0 2.00 3.00 NURSING ADMINISTRATION 13.00 332,409 0 0 3.00 4.00 PHARMACY 15.00 55,238 0 0 4.00		0		174, 447	122, 510			
2.00 EMERGENCY 91.00 84,699 0 0 2.00 3.00 AMBULANCE SERVICES 95.00 69,001 0 0 3.00 0 0 229,017 96,750 0 0 3.00 1.00 EMPLOYEE BENEFITS DEPARTMENT 4.00 145,371 0 0 0 2.00 OTHER ADMI NI STRATI VE AND 5.06 804,810 0 0 2.00 3.00 NURSI NG ADMI NI STRATI ON 13.00 332,409 0 0 3.00 4.00 PHARMACY 15.00 55,238 0 0 0 4.00		J - PARAMED PROGRAM						
3. 00 AMBULANCE SERVICES 95.00 69.001 0 0 3.00 0 229,017 96,750 0 0 1.00 1.00 1.00 1. 00 EMPLOYEE BENEFITS DEPARTMENT 4.00 145,371 0 0 0 1.00 2. 00 OTHER ADMI NI STRATI VE AND 5.06 804,810 0 0 2.00 2.00 3. 00 NURSI NG ADMI NI STRATI ON 13.00 332,409 0 0 3.00 3.00 4. 00 PHARMACY 15.00 55,238 0 0 4.00	1.00	PHARMACY	15.00	75, 317	96, 750) (D	1.00
O	2.00	EMERGENCY	91.00	84, 699	C) (2.00
K - FSEH SHARED SERVICES 1.00 EMPLOYEE BENEFITS DEPARTMENT 4.00 145, 371 0 0 1.00 2.00 OTHER ADMINISTRATIVE AND 5.06 804, 810 0 0 2.00 3.00 NURSI NG ADMINISTRATION 13.00 332, 409 0 0 3.00 4.00 PHARMACY	3.00	AMBULANCE SERVICES	95.00	69, 001	C) (3.00
1.00 EMPLOYEE BENEFITS DEPARTMENT 4.00 145,371 0 0 1.00 2.00 OTHER ADMINISTRATIVE AND 5.06 804,810 0 0 2.00 3.00 NURSING ADMINISTRATION 13.00 332,409 0 0 3.00 4.00 PHARMACY 15.00 55,238 0 0 13.37,828 0 0 4.00		0	T	229, 017	96, 750		1	
2. 00 OTHER ADMI NI STRATI VE AND 5. 06 804, 810 0 0 2. 00 3. 00 NURSI NG ADMI NI STRATI ON 13. 00 332, 409 0 0 3. 00 4. 00 PHARMACY		K - FSEH SHARED SERVICES		· · · · ·				
GENERAL 3.00 NURSI NG ADMI NI STRATI ON 13.00 332,409 0 0 3.00 4.00 PHARMACY	1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	145, 371	C) ()	1.00
3. 00 NURSI NG ADMI NI STRATI ON 13. 00 332, 409 0 0 0 3. 00 4. 00 PHARMACY	2.00	OTHER ADMINISTRATIVE AND	5.06	804, 810	C) (2.00
4.00 PHARMACY								
0 1, 337, 828 0	3.00	NURSING ADMINISTRATION	13.00	332, 409	C	0 0	D	3.00
	4.00	PHARMACY	15.00	55, 238	C	(כ	4.00
500. 00 Grand Total: Decreases 7, 265, 171 53, 104, 250 500. 00		0		1, 337, 828	C			
	500.00	Grand Total: Decreases		7, 265, 171	53, 104, 250			500.00

	Financial Systems CLLIATION OF CAPITAL COSTS CENTERS	FRANCI SCAN HEAL	Provider CC	N: 15-0109	Peri od:	eu of Form CMS-2 Worksheet A-7	
					From 01/01/2017 To 12/31/2017		narad
					10 12/31/2017	5/31/2018 3:5	areu. 3 pm
				Acqui si ti on	S	1	
		Begi nni ng	Purchases	Donati on	Total	Disposals and	
		Bal ances				Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	BALANCES					
1.00	Land	12, 789, 573	0		0 0	4, 280	1.00
2.00	Land Improvements	2, 240, 518	1, 006, 069		0 1, 006, 069	0	2.00
3.00	Buildings and Fixtures	255, 097, 555	47, 415, 201		0 47, 415, 201	0	3.00
4.00	Building Improvements	0	0		0 0	0 0	4.00
5.00	Fixed Equipment	0	0		0 0	0 0	5.00
6.00	Movable Equipment	82, 661, 435	0		0 0	5, 407, 792	6.00
7.00	HIT designated Assets	0	0		0 0	0 0	7.00
8.00	Subtotal (sum of lines 1-7)	352, 789, 081	48, 421, 270		0 48, 421, 270	5, 412, 072	8.00
9.00	Reconciling Items	0	0		0 0	0 0	9.00
10.00	Total (line 8 minus line 9)	352, 789, 081	48, 421, 270		0 48, 421, 270	5, 412, 072	10.00
		Ending Balance	Fully				
		U U	Depreci ated				
			Assets				
		6.00	7.00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET						
1.00	Land	12, 785, 293	0				1.00
2.00	Land Improvements	3, 246, 587	0				2.00
3.00	Buildings and Fixtures	302, 512, 756	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	77, 253, 643	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	395, 798, 279	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	395, 798, 279	0				10.00

Heal th	Financial Systems	FRANCI SCAN HEAL	TH LAFAYETTE		In Lieu of Form CMS-2552-10		
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provider C	CN: 15-0109	Peri od:	Worksheet A-7	
					From 01/01/2017 To 12/31/2017		narod:
					10 12/31/2017	5/31/2018 3:53	3 pm
			SL	JMMARY OF CAP	I TAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see		
						instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORK		N 2, LINES 1 a	nd 2	-		
1.00	CAP REL COSTS-BLDG & FIXT	16, 352, 525	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)	16, 352, 525			0 0	0	3.00
		SUMMARY O	F CAPITAL				
				-			
	Cost Center Description		Total (1) (sum				
		Capi tal -Rel ate					
		d Costs (see	through 14)				
		instructions)					
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	16, 352, 525				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	16, 352, 525				3.00

Health Financial Systems	FRANCI SCAN HEAI	LTH LAFAYETTE		In Lie	u of Form CMS-2	552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider C		Period: From 01/01/2017 To 12/31/2017		
	COM	PUTATION OF RAT	FI OS	ALLOCATION OF	OTHER CAPI TAL	
Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col. 2)		Insurance	
	1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE 1.00 CAP REL COSTS-BLDG & FIXT 2.00 CAP REL COSTS-MVBLE EQUIP 3.00 Total (sum of lines 1-2)	0 0 0 0	0 0 0	(0 1.000000 0 0.000000 0 1.000000	0	1.00 2.00 3.00
	ALLOCA	TION OF OTHER (CAPI TAL	SUMMARY O	F CAPI TAL	
Cost Center Description	Taxes	Other Capi tal -Rel ate d Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
	6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE	NTERS					
1.00 CAP REL COSTS-BLDG & FIXT 2.00 CAP REL COSTS-MVBLE EQUIP 3.00 Total (sum of lines 1-2)	0	0		17, 709, 987 2, 123, 392 19, 833, 379	287, 335	1.00 2.00 3.00
	0	SL	IMMARY OF CAPI		1, 000, 047	3.00
Cost Center Description	Interest	Insurance (see instructions)		Other Capital-Relate d Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
	11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE					00.015.000	1 00
1.00 CAP REL COSTS-BLDG & FIXT 2.00 CAP REL COSTS-MVBLE EQUIP	3, 761, 779 2, 951, 733				23, 065, 080 5, 362, 460	1.00 2.00
3.00 Total (sum of lines 1-2)	6, 713, 512		· · · · · ·		28, 427, 540	3.00

Heal th	Fi nanci	al	Systems	
AD IIIST	MENTS T	0 E)	VPENSES	

FRANCISCAN HEALTH LAFAVETTE

Health Financial Systems	F	RANCI SCAN HEAL	LTH LAFAYETTE	In Lie	eu of Form CMS-2	2552-10
ADJUSTMENTS TO EXPENSES			Provider CCN: 15-0109	Peri od:	Worksheet A-8	
				From 01/01/2017 To 12/31/2017		
			Expense Classification	on Worksheet A	5/31/2018 3:5	3 pm
			To/From Which the Amount i	s to be Adjusted		
Cost Center Description	Basi s/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
	1.00	2.00	3.00	4.00	5.00	1.00
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	В	-4//, 311	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00 Investment income - CAP REL	В	-374, 529	CAP REL COSTS-MVBLE EQUIP	2.00	11	2.00
3.00 COSTS-MVBLE EQUIP (chapter 2)		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	0	5.00
6.00 Rental of provider space by		0		0.00	0	6.00
suppliers (chapter 8)		0		0.00	0	7.00
7.00 Telephone services (pay stations excluded) (chapter		0		0.00	0	7.00
8.00 Television and radio service		0		0.00	0	8.00
(chapter 21)		0		0.00	0	0.00
9.00 Parking lot (chapter 21) 10.00 Provider-based physician	A-8-2	0 -4, 263, 354		0.00	0	
adjustment	A 0 2					
11.00 Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00 Related organization	A-8-1	-1, 543, 996			0	12.00
transactions (chapter 10) 13.00 Laundry and Linen service		0		0.00	0	13.00
14.00 Cafeteria-employees and guest	1	-1, 232, 732	CAFETERI A	11.00	0	14.00
15.00 Rental of quarters to employe and others	e	0		0.00	0	15.00
16.00 Sale of medical and surgical		0		0.00	0	16.00
supplies to other than patients						
17.00 Sale of drugs to other than patients		0		0.00	0	17.00
18.00 Sale of medical records and	В	-4, 695	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
abstracts 19.00 Nursing and allied health	В	-2 247 236	NURSING SCHOOL	20.00	0	19.00
education (tuition, fees,	U	2,247,230		20.00	0	17.00
books, etc.) 20.00 Vending machines	В	-87.842	DI ETARY	10.00	0	20.00
21.00 Income from imposition of		0		0.00		
interest, finance or penalty charges (chapter 21)						
22.00 Interest expense on Medicare		0		0.00	0	22.00
overpayments and borrowings t repay Medicare overpayments	0					
23.00 Adjustment for respiratory	A-8-3	0	RESPI RATORY THERAPY	65.00		23.00
therapy costs in excess of limitation (chapter 14)						
24.00 Adjustment for physical therapy costs in excess of	A-8-3	0	PHYSI CAL THERAPY	66.00		24.00
limitation (chapter 14)						
25.00 Utilization review - physicians' compensation		0	*** Cost Center Deleted **	114.00		25.00
(chapter 21)						
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00 Depreciation - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00 Non-physician Anesthetist		0	*** Cost Center Deleted *'	.* 19.00		28.00
29.00 Physicians' assistant		0		0.00		
30.00 Adjustment for occupational therapy costs in excess of	A-8-3	0	OCCUPATI ONAL THERAPY	67.00		30.00
limitation (chapter 14)		~		20.00		20.00
30.99 Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30. 99
31.00 Adjustment for speech pathology costs in excess of	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
limitation (chapter 14)						
32.00 CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33. 00 RECRUI TMENT	A	-143, 209	EMPLOYEE BENEFITS DEPARTME	NT 4.00	0	33.00

	Financial Systems		FRANCI SCAN HEAI			eu of Form CMS-2	
ADJUST	MENTS TO EXPENSES			Provider CCN: 15-0109	Period:	Worksheet A-8	
					From 01/01/2017 To 12/31/2017	Date/Time Pre	narod
					10 12/31/2017	5/31/2018 3:5	
				Expense Classification o	n Worksheet A		
				To/From Which the Amount is	to be Adjusted		
			A	Cont. Conton	1: //		
	Cost Center Description	Basis/Code (2) 1.00	Amount 2.00	Cost Center 3.00	Line # 4.00	Wkst. A-7 Ref. 5.00	
34.00	HAF	A		OTHER ADMI NI STRATI VE AND	4.00		34.00
34.00	HAF	A		GENERAL	5.00	0	34.00
35.00	ADVERTI SI NG	А		EMPLOYEE BENEFITS DEPARTMEN	T 4.00	0	35.00
35.00	ADVERTI SI NG	Â		DI ETARY	10.00		35.00
35.02	ADVERTI SI NG	A		NURSING SCHOOL	20.00		
35.02	ADVERTI SI NG	A		ELECTROCARDI OLOGY	69.00		
35.03	ADVERTI SI NG	A		CLINIC	90.00		
36.00	ATHLETIC TRAINING	B		PHYSICAL THERAPY	66.00		
37.00	BLDG RENT	B		CAP REL COSTS-BLDG & FIXT	1.00		37.00
38.00	DI SCOUNTS / REBATES	B		MGMT INFO SYSTEMS	5. 02		
38.01	DI SCOUNTS / REBATES	B		PURCHASING	5.02	0	
38.02	DI SCOUNTS / REBATES	B		CENTRAL SERVICE & SUPPLY	14.00	-	
38.03	DI SCOUNTS / REBATES	B		OPERATING ROOM	50.00		
38.04	DI SCOUNTS / REBATES	B		RADI OLOGY-DI AGNOSTI C	54.00		
38.05	DI SCOUNTS / REBATES	B		LABORATORY	60.00		
38.06	DI SCOUNTS / REBATES	B		RESPI RATORY THERAPY	65.00		
39.00	EDUCATION	В		PHARMACY RESIDENCY	23.00		
40.00	FOOD SERVICE DAY CARE	В	-158, 754		10.00		
41.00	MARKETING	A		OTHER ADMINISTRATIVE AND	5.06		
11.00				GENERAL	0.00		
41.01	MARKETING	A		DI ETARY	10.00	0	41.01
41.02	MARKETING	A		SUBPROVIDER - IRF	41.00	0	41.02
41.03	MARKETING	A		OPERATING ROOM	50.00		
41.04	MARKETING	A	-23, 118	PHYSICAL THERAPY	66.00	0	41.04
41.05	MARKETING	A	-6, 621	ELECTROCARDI OLOGY	69.00	0	41.05
41.06	MARKETING	A		DI ABETES CENTER	73.01	0	
41.07	MARKETING	A	-2, 275	EMERGENCY	91.00	0	41.07
41.08	MARKETING	A	-868	WOUND CARE	91.01	0	41.08
41.09	MARKETING	A	-1, 040	HOME HEALTH AGENCY	101.00	0	41.09
41.10	MARKETING	A		HOSPI CE	116.00	0	41.10
42.00	MI SCELLANEOUS REVENUE	В	-8, 038	EMPLOYEE BENEFITS DEPARTMEN	T 4.00	0	42.00
42.01	MI SCELLANEOUS REVENUE	В		CAP REL COSTS-BLDG & FIXT	1.00	9	42.01
42.02	MI SCELLANEOUS REVENUE	В	-10, 435	OCCUPATI ONAL THERAPY	67.00	0	42.02
42.03	MI SCELLANEOUS REVENUE	В	-901	WOUND CARE	91.01	0	42.03
43.00	MI SCELLANEOUS REVENUE	В	-55,463	OPERATION OF PLANT	7.00	0	43.00
43.01	MI SCELLANEOUS REVENUE	В	-37, 182	CAFETERI A	11.00	0	43.01
43.02	MI SCELLANEOUS REVENUE	В	-202, 760	PHARMACY	15.00	0	43.02
43.03	MI SCELLANEOUS REVENUE	В		CARDIAC CATH LAB	56.01	0	43.03
44.00	PENSION	A	3,007,000	EMPLOYEE BENEFITS DEPARTMEN	T 4.00	0	44.00
50.00	TOTAL (sum of lines 1 thru 49)		-21, 827, 789				50.00
	(Transfer to Worksheet A,						
	column 6, line 200.)					1	1

 column 6, line 200.)

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

 (2) Basis for adjustment (see instructions).

(2) basis for adjustment (see first definis).
A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
Note: See instructions for column 5 referencing to Worksheet A-7.

Health Financial Systems FRANCISCAN HEALTH LAFAYETTE In Lieu of Form CMS							
	ENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HOM	ME Provider CCN: 15-0109	Peri od:	Worksheet A-8	-1	
OFFICE	COSTS			From 01/01/2017 To 12/31/2017	Date/Time Pre	narod	
				10 12/31/2017	5/31/2018 3:5		
	Li ne No.	Cost Center	Expense Items	Amount of	Amount		
				Allowable Cost			
					Wks. A, column		
	1.00	0.00	2.00	1.00	5		
		2.00 MENTS REQUIRED AS A RESULT OF		4.00	5.00		
	HOME OFFICE COSTS:	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED U	RGANIZATIONS UR	CLAIMED		
1.00		CAP REL COSTS-BLDG & FIXT	FRANCI SCAN DEPRECIATION	2, 499, 261	0	1.00	
2.00			FRANCI SCAN DEPRECIATION	1, 961, 081	0	2.00	
3.00			FRANCI SCAN INTEREST	7, 565, 352	Ō	3.00	
3.01	5.06	OTHER ADMINISTRATIVE AND GEN	FRANCI SCAN A&G	10, 102, 564	0	3.01	
3.02	15.00	PHARMACY	EDUCATION	0	63, 759	3. 02	
3.03	91.00	EMERGENCY	EDUCATION	0	41, 207	3.03	
3.04	15.00	PHARMACY	EDUCATION	0	11, 966	3.04	
3.05	23.00	PHARMACY RESIDENCY	EDUCATI ON	3, 605	0	3.05	
4.00			FRANCI SCAN COEP	609, 936	0	4.00	
4.01			INFORMATION TECHNOLOGY	15, 055, 927	0	4.01	
4.02			PURCHASI NG SERVI CES	1, 260, 471	0	4.02	
4.03			PATIENT ACCT	4, 055, 320	0	4.03	
4.04			HIM	1, 620, 682	0	4.04	
4.05			INFORMATION TECHNOLOGY	0	15, 649, 156	4.05	
4.06			PURCHASI NG SERVI CES	0	1, 310, 136	4.06	
4.07			PATIENT ACCT	0	4, 215, 107	4.07	
4.08		OTHER ADMINISTRATIVE AND GEN		0	10, 500, 622	4.08	
4.09			PHARMACY	0	590, 172	4.09	
4.10			HIM	0	2, 029, 904	4.10	
4.11			INTEREST	0	10, 218, 826	4.11	
4.12		EMPLOYEE BENEFITS DEPARTMENT		0	173, 311	4.12	
4.15		OTHER ADMINISTRATIVE AND GEN		0	1,069,967	4.15	
4. 17 4. 18			FSEH SHARED SERVICES		348, 824 55, 238	4. 17 4. 18	
4.18 5.00	TOTALS (sum of lines 1-4).		FSER SHAKED SEKVICES	44, 734, 199	55, 238 46, 278, 195	4. 18 5. 00	
5.00	Transfer column 6, line 5 to			44, 734, 199	40, 278, 195	5.00	
	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.

1103 1101	been posted to worksheet A,		it allowable sh		or this part.			
				Related Organization(s) and/	or Home Office			
	Symbol (1)	Nama	Doroontogo of	Nomo	Democrategy of			
	Symbol (1)	Name	Percentage of	Name	Percentage of			
			Ownership		Ownership			
	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	FRANCI SCAN 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					100.00		
	non-financial) specify:							

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

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

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

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

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

E. Individual is director, officer, administrator, or key person of provider and related organization.

F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

Heal th [Financial Syste	ems	FRANCI SCAN	HEALTH	LAFAYETTE		In Lie	u of Form CM	8-2552-10
STATEME	NT OF COSTS OF	SERVICES FROM	RELATED ORGANIZATIONS AND	HOME	Provider (CCN: 15-0109	Period:	Worksheet A	-8-1
OFFICE	COSTS						From 01/01/2017 To 12/31/2017	Date/Time P	repared:
								5/31/2018 3	<u>53 pm</u>
	Net	Wkst. A-7 Ref.							
	Adjustments								
	(col. 4 minus								
	col. 5)*								
	6.00	7.00							
	A. COSTS INCUR	RED AND ADJUSTN	MENTS REQUIRED AS A RESULT	OF TRAN	SACTIONS \	NITH RELATED (ORGANIZATIONS OR	CLAI MED	
	HOME OFFICE CO	STS:							
1.00	2, 499, 261	9							1.00
2.00	1, 961, 081	9							2.00
									3.00
3.00	7, 565, 352	0							3.00

0.01	10, 102, 001	0		0.01			
3.02	-63, 759	0		3. 02			
3.03	-41, 207	0		3.03			
3.04	-11, 966	0		3.04			
3.05	3, 605	0		3.05			
4.00	609, 936	0		4.00			
4.01	15, 055, 927	0		4.01			
4.02	1, 260, 471	0		4.02			
4.03	4,055,320	0		4.03			
4.04	1, 620, 682	0		4.04			
4.05	-15, 649, 156	0		4.05			
4.06	-1, 310, 136	0		4.06			
4.07	-4, 215, 107	0		4.07			
4.08	-10, 500, 622	0		4.08			
4.09	-590, 172	0		4.09			
4.10	-2, 029, 904	0		4.10			
4.11	-10, 218, 826	0		4.11			
4.12	-173, 311	0		4.12			
4.15	-1, 069, 967	0		4.15			
4.17	-348, 824	0		4.17			
4.18	-55, 238	0		4. 18			
5.00	-1, 543, 996			5.00			
* The	* The amounts on lines 1-4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as						

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

Related Organization(s) and/or Home Office		
Type of Business		
6.00		
B. INTERRELATIONSHIP TO 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.

	HOME OFFICE	6.00
	SISTER FACILITY	7.00
8.00		8.00
9.00		9.00
10.00		10.00
100.00		100.00

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

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

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

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

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

E. Individual is director, officer, administrator, or key person of provider and related organization.

F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provi der.

Heal th	Financial Syste	ems	FRANCI SCAN HEA	ALTH LAFAYETTE		In Lie	eu of Form CMS-	2552-10
PROVI DE	ER BASED PHYSIC	I AN ADJUSTMENT		Provider (Period: From 01/01/2017 To 12/31/2017		epared:
	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Prov ider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.06	OTHER ADMINISTRATIVE AND GENERAL	2, 311, 612	2, 311, 612	(0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	70, 200	70, 200	(0	0	2.00
3.00	35.00	NEONATAL INTENSIVE CARE UNIT	617, 000	617,000	(0	0	3.00
4.00		SUBPROVIDER – IRF	116, 724	116, 724	(0	0	4.00
5.00		RADI OLOGY-DI AGNOSTI C	8, 816	8, 816	(0	0	5.00
6.00	56.00	RADI OI SOTOPE	4, 875	4, 875	(0	0	6.00
7.00	69.00	ELECTROCARDI OLOGY	828, 370	828, 370	(0	0	7.00
8.00	91.00	EMERGENCY	305, 757	305, 757	(0	0	8.00
9.00	0.00		0	0	(0	0	9.00
10.00	0.00		0	0	(0	0	10.00
200.00			4, 263, 354		()	0	200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE	5 Percent of	Cost of	Provi der	Physician Cost	
		I denti fi er	Limit	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		OTHER ADMI NI STRATI VE AND GENERAL	0	_				1.00
2.00		ADULTS & PEDIATRICS	0	0				2.00
3.00		NEONATAL INTENSIVE CARE UNIT	0	0				3.00
4.00		SUBPROVIDER – IRF	0	0		-	-	4.00
5.00		RADI OLOGY-DI AGNOSTI C	0	0	-	, s	-	5.00
6.00		RADI OI SOTOPE	0	0			0	6.00
7.00		ELECTROCARDI OLOGY	0	0	-	, v	0	7.00
8.00		EMERGENCY	0	0	-	, s	0	8.00
9.00	0.00		0	0		-	0	9.00
10.00	0.00		0	0	-	-	0	10.00
200.00			0	0		0	0	200.00
	Wkst. A Line #		Provi der	Adjusted RCE	RCE	Adjustment		
		Identifier	Component Share of col. 14	Limit	Di sal I owance			
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.06	OTHER ADMINI STRATI VE AND GENERAL	0		(2, 311, 612		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	(70, 200		2.00
3.00		NEONATAL INTENSIVE CARE UNIT	0	0				3.00
4.00		SUBPROVIDER - IRF	0	0				4.00
5.00		RADI OLOGY-DI AGNOSTI C	0	0				5.00
6.00		RADI OI SOTOPE	0	0				6.00
7.00		ELECTROCARDI OLOGY	0	0		.,		7.00
8.00		EMERGENCY	0	0				8.00
9.00	0.00		n	0		0001101		9,00
10.00	0.00		0	0				10.00
200.00			0	0		4, 263, 354		200.00
-		1						

	Financial Systems I ALLOCATION - GENERAL SERVICE COSTS	FRANCI SCAN HEAL	Provider CC	F	Period: From 01/01/2017 To 12/31/2017	worksheet B Worksheet B Part I Date/Time Pre	pared:
			CAPI TAL REL	ATED COSTS		5/31/2018 3:5	3 pm
	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	
	GENERAL SERVICE COST CENTERS	23, 065, 080					
1.00 2.00 4.00 5.01 5.02 5.03	00100 CAP REL COSTS-BLDG & FLXT 00200 CAP REL COSTS-MVBLE EQUI P 00400 EMPLOYEE BENEFLTS DEPARTMENT 01160 COMMUNI CATLONS 01140 MGMT I NFO SYSTEMS 00550 PURCHASI NG	5, 362, 460 35, 254, 735 1, 343, 931 15, 825, 808 1, 502, 700	23, 065, 080 388, 343 38, 471 494, 039 450, 223	5, 362, 460 104, 885 10, 390 133, 432 121, 598	35, 747, 963 196, 860 34, 778	1, 589, 652 51, 861 31, 568	5. 02
5.04 5.05 5.06 7.00 8.00	00570 ADMITTING 00580 PATIENT ACCOUNTING 00560 OTHER ADMINISTRATIVE AND GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	4, 460 5, 611, 338 21, 041, 812 10, 354, 907 978, 287	75, 342 112, 413 1, 843, 280 3, 023, 572 134, 107	20, 349 30, 361 497, 838 816, 618 36, 220	0 0 2, 274, 877 1, 233, 386	0 31, 568 164, 602	5.04 5.05 5.06 7.00
9.00 10.00 11.00 13.00 14.00	00900 HOUSEKEEPI NG 01000 DI ETARY 01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CE & SUPPLY	3, 075, 607 1, 058, 934 995, 341 2, 563, 937 413, 701	375, 996 581, 786 424, 414 157, 201 271, 729	101, 550 157, 130 114, 627 42, 457 73, 389	319, 170 553, 684 975, 823		10.00 11.00 13.00
15.00 16.00 17.00 20.00 23.00	01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY 01700 SOCI AL SERVI CE 02000 NURSI NG SCHOOL 02301 PHARMACY RESI DENCY	3, 340, 095 1, 683, 567 622, 272 334, 708 236, 419	174, 493 138, 537 19, 779 1, 117, 012 193, 671	47, 128 37, 416 5, 342 301, 686 52, 307	6, 867 241, 250 866, 092 94, 459	0	16.00 17.00 20.00 23.00
23. 01	02300 EMS EDUCATION	310, 691	0	(109, 833	0	23.01
 30. 00 31. 00 35. 00 41. 00 43. 00 	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 02060 NEONATAL INTENSIVE CARE UNIT 04100 SUBPROVIDER - IRF 04300 NURSERY	15, 178, 632 3, 547, 568 1, 866, 875 1, 209, 470 551, 842	2, 916, 762 318, 346 225, 455 364, 163 0	787, 767 85, 980 60, 891 98, 354	1, 370, 340 668, 452 445, 199	38, 332	31.00 35.00 41.00
43.00	ANCILLARY SERVICE COST CENTERS	331, 042	0		, 212, 304		45.00
50.00 51.00 52.00	05000 OPERATING ROOM 05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	9, 506, 773 683, 373 3, 597, 148	938, 403 103, 610 0	253, 447 27, 983 0	264, 062 1, 383, 890		51.00 52.00
54.00 55.00 56.00 56.01	05400 RADI OLOGY-DI AGNOSTI C 03630 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE 03950 CARDI AC CATH LAB	7, 764, 255 510, 672 263, 664 1, 591, 036	722, 695 38, 386 7, 031 207, 934	195, 188 10, 367 1, 899 56, 159	157, 311 88, 461	135, 290 0 0 0	55.00 56.00
57.00	05700 CT SCAN	853, 098 299, 844 9, 702, 207	113, 613 32, 383 509, 188	30, 685	261, 648 92, 651		57.00 58.00
65.00 66.00 67.00 68.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	2, 355, 008 3, 607, 417 1, 310, 566 420, 327	81, 201 333, 094 161, 602 88, 633	21, 931 89, 963 43, 646 23, 938	1, 367, 298 483, 585 160, 487	76, 664 13, 529 0 10, 500	67.00 68.00
69.00 70.00 71.00 72.00 73.00	06900 ELECTROCARDI 0LOGY 07000 ELECTROENCEPHALOGRAPHY 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 07200 MPL. DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS	1, 830, 231 759, 693 14, 860, 729 17, 212, 835 10, 312, 748	206, 390 129, 162 0 0 0	55, 743 34, 884 0 0 0		13, 529 0 0 0 0	70.00
73. 01 74. 00 76. 98	07301 DI ABETES CENTER 07400 RENAL DI ALYSI S 07698 HYPERBARI C OXYGEN THERAPY OUTPATI ENT SERVI CE COST CENTERS	343, 609 695, 745 145, 489	0 49, 047 101, 352	(13, 247 27, 373		13, 529 0 0	74.00
90. 00 91. 00 91. 01 92. 00	09000 CLINIC 09100 EMERGENCY 04950 WOUND CARE 09200 OBSERVATION BEDS (NON-DISTINCT PART	811, 781 7, 404, 134 1, 410, 786	0 756, 536 399, 347	0 204, 327 107, 857	2, 732, 501 532, 989	72, 154 0 0	92.00
	09201 OBSERVATION BEDS (DISTINCT PART) OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES	2, 254, 403	<u>176, 351</u> 214, 593	47, 629	846, 340		95.00
113.00	10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE	3, 838, 451	0	20.404			101. 00
118.00	NONREI MBURSABLE COST CENTERS	2, 888, 685 267, 383, 567	108, 869 19, 318, 554	29, 404 5, 217, 612	33, 288, 467	1, 589, 652	
192.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES 07950 MOB	81, 127 13, 804, 449 171	66, 396 469, 916 0	17, 932 126, 916 (2, 441, 065	0	190. 00 192. 00 194. 00

Health Financial Systems	FRANCI SCAN HEAL	TH LAFAYETTE		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC		Period: From 01/01/2017 To 12/31/2017	Worksheet B Part I Date/Time Pre 5/31/2018 3:5	
		CAPI TAL REL	LATED COSTS			
Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFI TS DEPARTMENT	COMMUNI CATI ONS	
	0	1.00	2.00	4.00	5. 01	
194. 0107951LI FELI NE194. 0207952PATI ENT TRANSPORT194. 0307954OTHER NONREI MBURSABLE COST CENTERS200. 00Cross Foot Adj ustments201. 00Negati ve Cost Centers	5, 615 264, 376 0	0 3, 210, 214 0		0 235 0 0 0 0 0 0	0	194. 01 194. 02 194. 03 200. 00 201. 00
202.00 TOTAL (sum lines 118 through 201)	281, 539, 305	23, 065, 080	5, 362, 46	0 35, 747, 963	1, 589, 652	202.00

DST A	Financial Systems LLOCATION - GENERAL SERVICE COSTS	FRANCI SCAN HEAL	Provi der CC	N: 15-0109	Period:	u of Form CMS-2 Worksheet B	2002-
					From 01/01/2017 To 12/31/2017	Part I Date/Time Pre 5/31/2018 3:5	pared
	Cost Center Description	MGMT INFO	PURCHASI NG	ADMI TTI NG	PATI ENT	Subtotal	3 pm
		SYSTEMS 5.02	5.03	5.04	ACCOUNTING 5.05	5A. 05	
	GENERAL SERVICE COST CENTERS						
00	00100 CAP REL COSTS-BLDG & FIXT						1.0
00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT						2.0 4.0
00	01160 COMMUNI CATI ONS						5.0
02	01140 MGMT INFO SYSTEMS	16, 539, 918					5.0
03	00550 PURCHASI NG	0	2, 106, 089				5.0
04	00570 ADMI TTI NG	0	0	100, 15			5.0
05	00580 PATIENT ACCOUNTING	0	1		0 5, 785, 681		5.0
06	00560 OTHER ADMINISTRATIVE AND GENERAL 00700 OPERATION OF PLANT	0 1, 128, 593	847 0		0 0	25, 823, 256 16, 681, 091	
00	00800 LAUNDRY & LINEN SERVICE	694, 369	0		0 0	1, 887, 715	
00	00900 HOUSEKEEPI NG	41, 795	3, 863		0 0	4, 427, 512	
D. 00	01000 DI ETARY	810, 676	167		0 0	2, 995, 508	
1.00	01100 CAFETERI A	789, 556	0		0 0	2, 877, 622	
3.00	01300 NURSING ADMINISTRATION	406, 584	0		0 0	4, 166, 295	
	01400 CENTRAL SERVICE & SUPPLY	129, 469	35		0 0	1, 066, 986	
5.00 5.00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	439, 954 13, 318	0		0 0 0 0	5, 166, 603 1, 918, 038	1
7.00	01700 SOCIAL SERVICE	128, 540	23		0 0	1, 918, 038	
D. 00	02000 NURSI NG SCHOOL	328, 667	308		0 0	2, 948, 473	
3.00	02301 PHARMACY RESIDENCY	31, 639	О		0 0	608, 495	
3. 01	02300 EMS EDUCATION	27, 276	5		0 0	447, 805	23.0
	INPATIENT ROUTINE SERVICE COST CENTERS						
	03000 ADULTS & PEDIATRICS	3, 189, 231	422	4,70		28, 092, 253	
1.00 5.00	03100 I NTENSI VE CARE UNI T 02060 NEONATAL I NTENSI VE CARE UNI T	678, 460 299, 989	99 1, 007	1, 40 1, 19		6, 133, 223 3, 231, 186	
	04100 SUBPROVI DER – I RF	189, 862	1,007	39			
	04300 NURSERY	0	0	29			
	ANCILLARY SERVICE COST CENTERS	· · · · ·	· · ·				
D. 00	05000 OPERATING ROOM	715, 402	40, 678	14, 00			
1.00	05100 RECOVERY ROOM	96, 509	0	1, 09		1, 258, 219	
2.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	1,85			
4.00 5.00	05400 RADI OLOGY-DI AGNOSTI C 03630 RADI OLOGY-THERAPEUTI C	686, 769 58, 961	24, 287 0	6, 76 80		11, 258, 772 822, 967	
5.00	05600 RADI OI SOTOPE	32, 499	0	00	0 0	393, 554	
5. 01	03950 CARDI AC CATH LAB	193, 509	12, 219	2, 79		2, 726, 099	
7.00	05700 CT SCAN	117, 652	145	5, 83		1, 720, 932	
3. 00	05800 MRI	32, 279	9	1, 39		547, 933	
0.00	06000 LABORATORY	0	41, 197	10, 72			
5.00 5.00		401, 535	8, 625	1,04		3, 831, 687	
7.00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	708, 622 201, 495	2 0	1,40 87		6, 202, 589 2, 252, 266	
	06800 SPEECH PATHOLOGY	69, 654	0	19			
	06900 ELECTROCARDI OLOGY	260, 641	20	2, 54		3, 118, 132	
	07000 ELECTROENCEPHALOGRAPHY	111, 472	0	45		1, 312, 261	
	07100 MEDI CAL SUPPLIES CHARGED TO PATIENT	0	909, 254	11, 03		16, 420, 780	
	07200 I MPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	1, 053, 172	8, 02		18, 739, 691	
3.00 3.01	07301 DI ABETES CENTER	55, 920	0	10, 83	37 628, 553 18 1, 048	10, 952, 138 544, 735	
	07400 RENAL DI ALYSI S	22, 481	0	21		840, 648	
	07698 HYPERBARI C OXYGEN THERAPY	225	Ö		4,602	279, 783	
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLINIC	135, 003	2		75 4, 363		
	09100 EMERGENCY	1, 345, 252	974	5, 67			
1.01	04950 WOUND CARE	222, 343	0	69	40, 113		
2.00 2.01	09200 OBSERVATION BEDS (NON-DISTINCT PART 09201 OBSERVATION BEDS (DISTINCT PART)	343, 918	33	95	56 55, 449	0 3, 614, 790	
2.01	OTHER REIMBURSABLE COST CENTERS	545, 710		70	50 55, 447	3, 014, 770	72.
5.00	09500 AMBULANCE SERVICES	617, 208	231	1, 20	69, 819	4, 621, 036	95.
	10100 HOME HEALTH AGENCY	426, 146	5, 816	59			
	SPECIAL PURPOSE COST CENTERS						-
	11300 I NTEREST EXPENSE						113.
	11600 HOSPICE	247,692	2,638	98 100 18		3, 904, 938	
18.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	16, 431, 165	2, 106, 088	100, 15	51 5, 785, 681	260, 923, 943	1118.
90 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	12,002	0		0 0	195, 653	190
	19200 PHYSI CLANS' PRI VATE OFFICES	96, 099	1		0 0	16, 938, 446	
	07950 MOB	0	o		0 0		194.
94.01	07951 LI FELI NE	652	О		0 0	6, 502	194.
94 02	07952 PATIENT TRANSPORT	0	о		0 0	264, 376	
			0		0 0	2 210 214	1104
	07954 OTHER NONREIMBURSABLE COST CENTERS Cross Foot Adjustments	U	U		0	3, 210, 214	200.

Health Financial Systems	FRANCI SCAN HEAL	TH LAFAYETTE		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CO		Period: From 01/01/2017 To 12/31/2017	Worksheet B Part I Date/Time Pre 5/31/2018 3:5	
Cost Center Description	MGMT INFO SYSTEMS	PURCHASI NG	ADMI TTI NG	PATI ENT ACCOUNTI NG	Subtotal	
	5. 02	5. 03	5.04	5, 05	5A, 05	
202.00 TOTAL (sum lines 118 through 201)	16, 539, 918			2.25		202.00

Health Financial Systems	FRANCI SCAN HEAL			In Lie	u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CO	F	eriod: rom 01/01/2017	Worksheet B Part I	
				o 12/31/2017	Date/Time Pre 5/31/2018 3:5	pared: <u>3 pm</u>
Cost Center Description	OTHER ADMI NI STRATI VE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	
	5.06	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS						1 00
1.00 00100 CAP REL COSTS-BLDG & FIXT 2.00 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 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	25, 823, 256					5.06
7. 00 00700 OPERATION OF PLANT	1, 684, 523	18, 365, 614				7.00
8. 00 00800 LAUNDRY & LINEN SERVICE 9. 00 00900 HOUSEKEEPING	190, 629 447, 108	148, 019 415, 003				8.00 9.00
10. 00 01000 DI ETARY	302, 498	642, 142			4, 243, 204	•
11. 00 01100 CAFETERI A	290, 594	468, 444			0	11.00
13. 00 01300 NURSING ADMINISTRATION	420, 729 107, 749	173, 509		,	0	•
14. 00 01400 CENTRAL SERVI CE & SUPPLY 15. 00 01500 PHARMACY	521, 744	299, 919 192, 595			0	14.00 15.00
16.00 01600 MEDI CAL RECORDS & LI BRARY	193, 691	152, 909			0	16.00
17. 00 01700 SOCI AL SERVI CE	104, 771	21, 831			0	17.00
20. 00 02000 NURSI NG SCHOOL	297, 749	1, 232, 894			0	20.00
23. 00 02301 PHARMACY RESI DENCY 23. 01 02300 EMS EDUCATI ON	61, 448 45, 221	213, 763 0			0	23.00 23.01
INPATIENT ROUTINE SERVICE COST CENTERS	10/221					20101
30. 00 03000 ADULTS & PEDI ATRI CS	2, 836, 896	3, 219, 355			3, 556, 234	
31. 00 03100 INTENSI VE CARE UNI T 35. 00 02060 NEONATAL INTENSI VE CARE UNI T	619, 357 326, 298	351, 372 248, 844			412, 045 0	31.00
41.00 04100 SUBPROVIDER - IRF	240, 800	401, 942			274, 925	41.00
43. 00 04300 NURSERY	78, 945	0			0	•
ANCI LLARY SERVI CE COST CENTERS	1		1			
50.00 05000 0PERATING ROOM 51.00 05100 RECOVERY ROOM	1, 401, 504 127, 060	1, 035, 756 114, 358			0 0	50.00 51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	519, 970	114, 336			0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 136, 956	797, 670			0	54.00
55. 00 03630 RADI OLOGY-THERAPEUTI C	83, 106	42, 368			0	55.00
56. 00 05600 RADI OI SOTOPE 56. 01 03950 CARDI AC CATH LAB	39, 743 275, 292	7, 761 229, 506			0	56.00 56.01
57. 00 05700 CT SCAN	173, 787	125, 400			0	57.00
58. 00 05800 MRI	55, 332	35, 743			0	58.00
60. 00 06000 LABORATORY	1, 123, 136	562, 012			0	60.00
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	386, 939 626, 362	89, 625 367, 650			0	65.00 66.00
67. 00 06700 OCCUPATI ONAL THERAPY	227, 443	178, 368			0	
68.00 06800 SPEECH PATHOLOGY	78, 193	97, 828			0	68.00
69. 00 06900 ELECTROCARDI OLOGY	314, 881	227, 802			0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	132, 517 1, 658, 236	142, 562		53, 399	0	70.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	1, 892, 409	0	c c	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	1, 105, 991	0	C	0	0	73.00
73. 01 07301 DI ABETES CENTER	55,010	0	C	0	0	73.01
74.00 07400 RENAL DIALYSIS 76.98 07698 HYPERBARIC OXYGEN THERAPY	84, 892 28, 254	54, 135 111, 866		==,=	0	74.00 76.98
OUTPATIENT SERVICE COST CENTERS	20, 234	111, 300		41,702	0	70.70
90. 00 09000 CLINIC	121, 285	0	C		0	90.00
91.00 09100 EMERGENCY	1, 290, 416	835, 021			0	91.00
91. 01 04950 WOUND CARE 92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART	274, 083	440, 777	C	165, 101	0	91.01 92.00
92. 01 09200 OBSERVATION BEDS (NON-DISTINCT PART 92. 01 09201 OBSERVATION BEDS (DISTINCT PART)	365, 036	194, 646	C	72, 908	0	•
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	466, 651	236, 856			0	•
101.00 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	531, 864	0	C	0	0	101.00
113. 00 11300 I NTEREST EXPENSE						113.00
116.00 11600 HOSPI CE	394, 336	120, 163		45, 009		116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	23, 741, 434	14, 230, 414	2, 226, 363	5, 119, 384	4, 243, 204	118.00
NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	19, 758	73, 284	. C	27, 450	0	190.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	1, 710, 512	518, 667		194, 277		192.00
194.0007950 MOB	17	0	C C	0	0	194.00
194. 01 07951 LI FELI NE	657	0	C	0		194.01
194.02 07952 PATIENT TRANSPORT 194.03 07954 OTHER NONREIMBURSABLE COST CENTERS	26, 698 324, 180	0 3, 543, 249		0		194. 02 194. 03
200.00 Cross Foot Adjustments	324, 180	3, 343, 249			0	200.00
	1 I		1	ı I		1

Health Fin	ancial Systems	FRANCISCAN HEA	LTH LAFAYETTE		In Lie	u of Form CMS-	2552-10
COST ALLO	CATION - GENERAL SERVICE COSTS		Provider C		Period: From 01/01/2017	Worksheet B Part I	
					To 12/31/2017		
	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	
201.00	Negative Cost Centers	0	0)	0 0	C	201.00
202.00	TOTAL (sum lines 118 through 201)	25, 823, 256	18, 365, 614	2, 226, 36	5, 341, 111	4, 243, 204	202.00

Heal th Financial Systems	FRANCI SCAN HEA		N 15 0100 D		u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC		eriod: rom 01/01/2017 o 12/31/2017	Worksheet B Part I Date/Time Pre	narodi
					5/31/2018 3:5	3 pm
Cost Center Description	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVICE &	PHARMACY	MEDI CAL RECORDS &	
	11.00	13.00	SUPPLY 14.00	15.00	LI BRARY 16.00	
GENERAL SERVICE COST CENTERS	1				10100	
1.00 00100 CAP REL COSTS-BLDG & FIXT 2.00 00200 CAP REL COSTS-MVBLE EQUIP						1.00 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 PATI ENT ACCOUNTI NG 5. 06 00560 OTHER ADMI NI STRATI VE AND GENERAL						5.05 5.06
7.00 00700 OPERATION OF PLANT						7.00
8. 00 00800 LAUNDRY & LI NEN SERVI CE 9. 00 00900 HOUSEKEEPI NG						8.00 9.00
10. 00 01000 DI ETARY						10.00
11.00 01100 CAFETERIA	3, 812, 125	1 1				11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON 14. 00 01400 CENTRAL SERVI CE & SUPPLY	118, 544 37, 748		1, 681, 169			13.00 14.00
15. 00 01500 PHARMACY	128, 273	1 1	0	6, 081, 355		15.00
16. 00 01600 MEDI CAL_RECORDS & LI BRARY 17. 00 01700 SOCI AL_SERVI CE	3, 883	1 1	1 18	0	2, 325, 797 0	16.00 17.00
20. 00 02000 NURSI NG SCHOOL	95, 826		246	0	0	1
23. 00 02301 PHARMACY RESI DENCY	9, 225	1	0	0	0	
23. 01 02300 EMS EDUCATION I NPATI ENT ROUTI NE SERVI CE COST CENTERS	7,953	3 0	4	0	0	23.01
30. 00 03000 ADULTS & PEDI ATRI CS	929, 851	1, 563, 345	338	0	109, 594	30.00
31.00 03100 INTENSIVE CARE UNIT	197, 812		80	0	32, 733	
35. 00 02060 NEONATAL INTENSIVE CARE UNIT 41. 00 04100 SUBPROVIDER - IRF	87, 465 55, 356		805 6	0	27, 738 9, 235	
43. 00 04300 NURSERY	C		0	0	6, 962	
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM	208, 583	3 350, 686	32, 547	0	317, 187	50.00
51.00 05100 RECOVERY ROOM	28, 138		0	0	25, 548	
52. 00 05200 DELIVERY ROOM & LABOR ROOM	200.224		0	0	43, 223	
54. 00 05400 RADI OLOGY-DI AGNOSTI C 55. 00 03630 RADI OLOGY-THERAPEUTI C	200, 234 17, 191	1 1	19, 432 0	0	157, 815 18, 682	
56. 00 05600 RADI OI SOTOPE	9, 475		0	0	0	
56. 01 03950 CARDI AC CATH LAB 57. 00 05700 CT SCAN	56, 419		9, 776 116	0	65, 092 135, 990	
58. 00 05800 MRI	9, 411	1 1	7	Ö	32, 416	
60. 00 06000 LABORATORY 65. 00 06500 RESPI RATORY THERAPY	117.072	-	32, 963 6, 901	0	250, 008 24, 360	
66.00 06600 PHYSI CAL THERAPY	117, 072 206, 606		0, 901	0	32, 670	66.00
67.00 06700 OCCUPATIONAL THERAPY	58, 748		0	0	20, 303	
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	20, 308		0 16	0	4, 456 59, 348	
70. 00 07000 ELECTROENCEPHALOGRAPHY	32, 501		0	0	10, 654	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		-	727, 507	0	257, 204	
73.00 07300 DRUGS CHARGED TO PATIENTS			842, 647 0	6, 081, 355	187, 206 252, 696	
73. 01 07301 DI ABETES CENTER	16, 304		0	0	421	1
74. 00 07400 RENAL DI ALYSI S 76. 98 07698 HYPERBARI C OXYGEN THERAPY	6, 555		0	0	4, 901 1, 850	
OUTPATIENT SERVICE COST CENTERS				۹ ۱		
90. 00 09000 CLI NI C 91. 00 09100 EMERGENCY	39, 361	1	2 780	0	1, 754	
91. 01 04950 WOUND CARE	392, 222		780 0	0	132, 277 16, 127	91.00 91.01
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
92.01 09201 OBSERVATI ON BEDS (DI STINCT PART) OTHER REIMBURSABLE COST CENTERS	100, 273	3 0	26	0	22, 292	92.01
95. 00 09500 AMBULANCE SERVI CES	179, 953	302, 552	185	0	28, 069	95.00
101.00 10100 HOME HEALTH AGENCY	124, 247	208, 895	4, 654	0	13, 979	101.00
SPECIAL PURPOSE COST CENTERS 113. 00 11300 I NTEREST EXPENSE						113.00
116. 00 11600 HOSPI CE	72, 217		2, 110	О		116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	3, 780, 417	4, 944, 068	1, 681, 168	6, 081, 355	2, 325, 797	118.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	3, 499		0	0	0	190.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	28, 019	0	1	0	0	192.00
194. 00 07950 MOB 194. 01 07951 LI FELI NE	190		0	0		194.00 194.01
194. 02 07952 PATI ENT TRANSPORT	0		0	0	0	194.02
194.03 07954 OTHER NONREIMBURSABLE COST CENTERS 200.00 Cross Foot Adjustments	0	0	0	0		194. 03 200. 00
200.00 Cross Foot Adjustments						1200.00

Health Financial Systems	FRANCI SCAN HEAI	LTH LAFAYETTE		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CO		Period:	Worksheet B	
				From 01/01/2017 Fo 12/31/2017		
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		ADMI NI STRATI ON	SERVICE &		RECORDS &	
			SUPPLY		LI BRARY	
	11.00	13.00	14.00	15.00	16.00	
201.00 Negative Cost Centers	0	0	(0 0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	3, 812, 125	4, 944, 068	1, 681, 169	6, 081, 355	2, 325, 797	202.00

	Financial Systems	FRANCI SCAN HEAL				u of Form CMS-	2552-10
COST A	ALLOCATION - GENERAL SERVICE COSTS		Provider CCN	N: 15-0109	Period: From 01/01/2017 To 12/31/2017	Worksheet B Part I Date/Time Pre	enared.
				BUABUAOV		5/31/2018 3:5	3 pm
	Cost Center Description	SOCI AL SERVI CE	NURSING SCHOOL	PHARMACY RESI DENCY	EMS EDUCATION	Subtotal	
	1	17.00	20.00	23.00	23.01	24.00	
1 00	GENERAL SERVICE COST CENTERS	1					1 00
1.00 2.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01160 COMMUNI CATI ONS						5.01
5.02	01140 MGMT INFO SYSTEMS						5.02
5.03	00550 PURCHASI NG 00570 ADMI TTI NG						5.03
5.04 5.05	00580 PATIENT ACCOUNTING						5.04 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 10.00	00900 HOUSEKEEPI NG 01000 DI ETARY						9.00 10.00
11.00	01100 CAFETERI A						11.00
13.00	01300 NURSI NG ADMI NI STRATI ON						13.00
14.00	01400 CENTRAL SERVICE & SUPPLY						14.00
15.00 16.00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY						15.00 16.00
17.00	01700 SOCIAL SERVICE	1, 209, 773					17.00
20.00	02000 NURSI NG SCHOOL	0	5, 036, 992				20.00
23.00	02301 PHARMACY RESIDENCY	0		973, 00			23.00
23.01	02300 EMS EDUCATION I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0			500, 983		23.01
30.00	03000 ADULTS & PEDIATRICS	854, 371	5, 036, 992		0 0	48, 191, 041	30.00
31.00	03100 I NTENSI VE CARE UNI T	118, 786	0		0 0	8, 449, 327	
35.00	02060 NEONATAL INTENSIVE CARE UNIT	69, 884	0		0 0	4, 282, 387	
41.00	04100 SUBPROVIDER - IRF	75, 463	0		0 0	3, 728, 156	1
43.00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	91, 269	0		0 0	1, 040, 954	43.00
50.00	05000 OPERATI NG ROOM	0	0		0 0	18, 003, 167	50.00
51.00	05100 RECOVERY ROOM	0	0		0 0	1, 715, 268	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	5, 799, 913	
54.00 55.00	05400 RADI OLOGY-DI AGNOSTI C 03630 RADI OLOGY-THERAPEUTI C	0	0		0 0	14, 006, 670 1, 000, 184	
56.00	05600 RADI OLOGI - THERAPEUTI C	0	0		0 0	469, 371	
56.01	03950 CARDI AC CATH LAB	0	0		0 0	3, 552, 061	
57.00	05700 CT SCAN	0	0		0 0	2, 237, 498	57.00
58.00		0	0		0 0	694, 230	
60.00 65.00	06000 LABORATORY 06500 RESPI RATORY THERAPY	0	0		0 0	13, 314, 744 4, 703, 608	
66.00	06600 PHYSI CAL THERAPY	0	0		0 0	7, 951, 887	1
67.00	06700 OCCUPATIONAL THERAPY	0	0		0 0	2, 902, 711	67.00
68.00	06800 SPEECH PATHOLOGY	0	0		0 0	1, 045, 885	
69.00 70.00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	4, 021, 871 1, 738, 537	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 0	19, 063, 727	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	21, 661, 953	
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	973, 00	0 0	19, 365, 180	
73. 01 74. 00	07301 DI ABETES CENTER 07400 RENAL DI ALYSI S	0	0		0 0	643, 882 1, 022, 428	
	07698 HYPERBARI C OXYGEN THERAPY	0	0		0 0	463, 721	
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0	0		0 0	1, 363, 431	
91.00	09100 EMERGENCY 04950 WOUND CARE	0	0		0 500, 983	17, 108, 017	
91.01 92.00	04950 WOUND CARE 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	U		0	3, 784, 032	91.01 92.00
92.00	09201 OBSERVATION BEDS (DISTINCT PART)	0	0		0 0	4, 369, 971	
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVICES	0	0		0 0		
101.00	10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0	0		0 0	6, 150, 455	
113.00	11300 INTEREST EXPENSE						113.00
116.00	11600 HOSPI CE	0	0		0 0	4, 683, 197	116.00
118.00		1, 209, 773	5, 036, 992	973, 00	500, 983	254, 453, 485	118.00
100.00	NONREIMBURSABLE COST CENTERS		0		0	319, 644	100 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	0	0		0 0	19, 389, 922	
	07950 MOB	0	Ő		0 0		194.00
	07951 LI FELI NE	0	0		0 0		194. 01
	07952 PATIENT TRANSPORT	0	0		0 0	291, 074	
194. 03 200. 00	07954 OTHER NONREIMBURSABLE COST CENTERS Cross Foot Adjustments	0				7, 077, 643 0	200.00
200.00		0	0		0 0		201.00
	· · · ·	· · ·	I				·

Health Financial Systems	FRANCI SCAN HEAL	_TH LAFAYETTE		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC		Period: From 01/01/2017	Worksheet B Part L	
					Date/Time Pre 5/31/2018 3:5	
Cost Center Description	SOCI AL SERVI CE	NURSING SCHOOL	PHARMACY	EMS EDUCATION	Subtotal	
			RESI DENCY			
	17.00	20.00	23.00	23.01	24.00	
202.00 TOTAL (sum lines 118 through 201)	1, 209, 773	5, 036, 992	973, 00	0 500, 983	281, 539, 305	202.00

ST ALLOCATI	al Systems ON - GENERAL SERVICE COSTS	FRANCI SCAN HEALT	Provider CCN: 15-0	0109 Period: From 01/01/2017	u of Form CMS-2552 Worksheet B Part I
				To 12/31/2017	Date/Time Prepare 5/31/2018 3:53 pm
C	ost Center Description	Intern &	Total		
		Residents Cost & Post			
		Stepdown			
		Adjustments			
		25.00	26.00		
	SERVICE COST CENTERS	F			
	AP REL COSTS-BLDG & FIXT				1
	AP REL COSTS-MVBLE EQUIP				2
	MPLOYEE BENEFITS DEPARTMENT				4
	COMMUNI CATLONS				5
	IGMT I NFO SYSTEMS PURCHASI NG				5
	DMI TTI NG				5
	ATLENT ACCOUNTING				5
	THER ADMINISTRATIVE AND GENERAL				5
00700 0	PERATION OF PLANT				7
DO 00800 L	AUNDRY & LINEN SERVICE				8
	IOUSEKEEPI NG				9
.00 01000 D					10
					11
					13
	ENTRAL SERVICE & SUPPLY PHARMACY				14
	IEDI CAL RECORDS & LI BRARY				15
	OCIAL SERVICE				10
	IURSI NG SCHOOL				20
	HARMACY RESIDENCY				23
1 1	MS EDUCATION				23
I NPATI E	ENT ROUTINE SERVICE COST CENTERS				
	DULTS & PEDIATRICS	0	48, 191, 041		30
	NTENSI VE CARE UNI T	0	8, 449, 327		31
	EONATAL INTENSIVE CARE UNIT	0	4, 282, 387		35
	UBPROVIDER - IRF	0	3, 728, 156		41
00 04300 N		0	1, 040, 954		43
	ARY SERVICE COST CENTERS	0	18, 003, 167		50
	ECOVERY ROOM	0	1, 715, 268		50
	ELIVERY ROOM & LABOR ROOM	0	5, 799, 913		52
	ADI OLOGY-DI AGNOSTI C	0	14,006,670		54
00 03630 R	ADI OLOGY-THERAPEUTI C	0	1, 000, 184		55
00 05600 R	ADI OI SOTOPE	0	469, 371		56
	ARDIAC CATH LAB	0	3, 552, 061		56
00 05700 C		0	2, 237, 498		57
00 05800 M		0	694, 230		58
00 06000 L		0	13, 314, 744		60
	ESPI RATORY THERAPY PHYSI CAL THERAPY	0	4, 703, 608		65
	ICCUPATIONAL THERAPY	0	7, 951, 887 2, 902, 711		66 67
	SPEECH PATHOLOGY	0	1, 045, 885		68
	LECTROCARDI OLOGY	0	4, 021, 871		69
	LECTROENCEPHALOGRAPHY	0	1, 738, 537		70
	IEDI CAL SUPPLI ES CHARGED TO PATI ENT	0	19, 063, 727		71
	MPL. DEV. CHARGED TO PATIENTS	0	21, 661, 953		72
	RUGS CHARGED TO PATIENTS	0	19, 365, 180		73
	I ABETES CENTER	0	643, 882		73
	ENAL DIALYSIS	0	1,022,428		74
	IYPERBARI C OXYGEN THERAPY	0	463, 721		76
00 09000 C	ENT SERVICE COST CENTERS	0	1, 363, 431		90
00 09000 C		0	17, 108, 017		90
01 04950 W		0	3, 784, 032		91
	BSERVATION BEDS (NON-DISTINCT PART	0			92
	BSERVATION BEDS (DISTINCT PART)	0	4, 369, 971		92
	REIMBURSABLE COST CENTERS				
	MBULANCE SERVI CES	0	5, 924, 021		95
	OME HEALTH AGENCY	0	6, 150, 455		101
	PURPOSE COST CENTERS				4.1.0
	NTEREST EXPENSE		4 402 107		113
5. 00 11600 H 3. 00 S	USPICE SUBTOTALS (SUM OF LINES 1 through 117)	0	4, 683, 197		116 118
	IBURSABLE COST CENTERS		254, 453, 485		118
	IFT, FLOWER, COFFEE SHOP & CANTEEN	0	319, 644		190
	HYSICIANS' PRIVATE OFFICES		19, 389, 922		190
1. 00 07950 M		0	188		192
		0	7, 349		194
4. 01 07951 L					

Health Financial Systems	FRANCI SCAN HEALT	H LAFAYETTE		In Lie	u of Form CMS-2	552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC	CN: 15-0109	Peri od:	Worksheet B	
				From 01/01/2017 To 12/31/2017	Part I Date/Time Prep	ared
					5/31/2018 3:53	pm
Cost Center Description	Intern &	Total				
	Residents Cost					
	& Post					
	Stepdown					
	Adjustments					
	25.00	26.00				
194.0307954 OTHER NONREI MBURSABLE COST CENTERS	0	7,077,643			1	194. 03
200.00 Cross Foot Adjustments	0	0			2	200.00
201.00 Negative Cost Centers	0	0			2	201.00
202.00 TOTAL (sum lines 118 through 201)	0	281, 539, 305			2	202.00

To 10:12/12/027 Diskoving Properties Diskoving Properties Cost Conter Description Diskoving Properties BLXX 5 FIXT MREE EXDIP Subtration 0:00000000000000000000000000000000000		Financial Systems TION OF CAPITAL RELATED COSTS	FRANCI SCAN HEAL	Provider C		In Lie eriod: rom 01/01/2017	u of Form CMS-: Worksheet B Part II	2552-10
Cost Openier Description Directly Legistal Bel afted Costs ADD A FIXT IMD F FUIP Subtoral IMP F FUIP Cost Openier Description Directly Legistal MOL F FUIP MOL F FUIP Subtoral IPP FOTF DEPERTS Cost Openier Description Directly Legistal Toto 2.00 2.4 4.00 100 Dirol Cost Cost Cost Exect Description Toto 2.00 2.00 2.4 4.00 100 Dirol Cost RLL COST SHUE A TIXT 0 38.471 10.030 483.221 2.71 6.01 5 01 Dirol Cost RLL COST SHUE Cost Cost Cost Cost Cost Cost Cost Cost							Date/Time Pre	
Assigned feex Output tell account of the service belieted Cases Job Z.00 3A 4.00 CBUREAL SIGNICE COST CENTERS 1.00 2.00 3A 4.00 1.00 Dirol Car P RL, COST CENTERS 1.00 2.00 3A 4.00 0.00 Dirol Car P RL, COST CENTERS 0.38, 471 10.03 34, 471 0.03 48, 651 2.716 5.17 0.03 5.00 DIROL CAR PEL COST CENTERS 0 38, 471 10.390 44, 865 2.716 6.16 0.715, 718 0.83, 717 0.03 45, 857 2.716 6.16 0.712, 413 33, 281 11.24, 747 0.85 5.05 0.050 0.050 1.016, 717, 718 1.18, 200 477, 783 2.941 1.18, 31, 388 5.03, 737, 757 6.16, 618 3.03, 717, 718 3.18, 31, 31, 31, 31, 31, 31, 328 5.03, 737, 758 6.16, 618, 737, 546 1.18, 520 477, 783 2.941, 11, 118 3.128, 521 1.12, 61, 71, 718, 71, 718 3.128, 717, 135, 31, 744, 114 3.13, 328, 114, 42, 77 55, 50, 71, 718, 74, 411 1.19, 71, 72, 73, 74, 529, 718, 71, 135, 744, 718, 71, 718, 73, 74, 416				CAPI TAL REL	ATED COSTS			
OPENERAL SERVICE COST OFFITES 0 100 2.00 22A 4.00 1.00 000000000000000000000000000000000000		Cost Center Description	Assigned New	BLDG & FIXT	MVBLE EQUIP	Subtotal	BENEFI TS	
MEMOR. SHAPPLE COST CENTERS Image: Cost Cente				1 00	2 00	24	4 00	
2.00 DOUDON GAR PIT LOSIS MUNIT FOULP 2.1 3.0 10.4, 68 4.33, 29 2.4 2.4 6.01 DITAG COMMUNIC AT DRES 0 3.8, 473 10, 590 4.46, 501 2.1 6.1 0.1 6.1 0.1 6.1 0.1 6.1 0.1 6.1 0.1 6.1 0.1 6.1 6.1 0.1 6.1 0.1 6.1 0.1 6.1 0.1 6.1 <td< td=""><td></td><td>GENERAL SERVICE COST CENTERS</td><td></td><td>1.00</td><td>2.00</td><td>211</td><td>1.00</td><td></td></td<>		GENERAL SERVICE COST CENTERS		1.00	2.00	211	1.00	
4.00 000000 DEPLOYEE EBREFITS DEPLOYEE State 10143 1004,852 403,228 403,228 403,228 403,228 403,228 403,228 403,228 403,228 403,228 403,228 4010 5.1 0 1140 MART INS D 444,030 133,420 C77,471 4010 5.1 5.00 000500 PATLENT ACCOUNTING 0 442,250 077,838 2.341,183 31,888 5.1 5.00 000500 PATLENT ACCOUNTING 0 1,22,452 816,618 3,840,190 17,018 7,01 50,60 00000 PARATIL 0 3,022,572 816,618 3,840,190 17,018 7,400 1,1 1,010 01000 PARATIL 0 3,022,572 816,618 3,840,190 17,018 7,400 1,1 1,018 1,1 1,41 1,4 1,4 1,4 1,4 1,4 1,4 1,4 1,4 1,4 1,4 1,4 1,4 1,4 1,4 1,4								1.00
5.01 01140 COMMUNICATIONS 0 38, 471 10, 390 48, 861 2, 716 5, 71 621 641 5, 71 621 641 5, 71 621 641 5, 71 621 641 5, 71 621 641 5, 71 621 641 5, 71 621 641 5, 71 621 651 5, 65 5, 65 5, 65 5, 65 5, 66 5, 72 56 64 11, 163 <			0	388 343	10/ 885	103 228	103 228	2.00 4.00
5.02 0140 NANT I INFO SYSTEMS 0 449, 039 133, 432 627, 471 480 5, 5 5.04 00507 ADM IT IN COUNT ADM IT IN 0 175, 342 20, 349 95, 691 0 5, 5 5.04 DOSTO, ADM IT IN COUNT ADM IT IN 0 17, 343 30, 363 2, 42, 774 480 5, 14 0 5, 14 0 5, 14 0 5, 14 0 5, 14 0 15, 14 17, 143 30, 363 2, 42, 77, 14 480 5, 14 17, 11 17, 11 17, 11 17, 11 17, 11 17, 11 17, 11 17, 11 17, 11 17, 11 17, 11 17, 11 14, 14 14, 14, 14 14, 14, 14 14, 14, 14 14, 14, 14 14, 14, 14 14, 14, 14 14, 14 14, 14 14, 14 14, 14, 14 14, 14, 14 14, 14, 14 14, 14 14, 14 14, 14 14, 14 14, 14 14, 14 14, 14 14, 14 14, 14 14, 14 14, 14, 14 14, 14, 14 14, 14, 14 14, 14, 14 14, 14, 14 14, 14, 14 14, 14, 14 14, 14, 14 14, 14, 14								•
5.04 OSO7G ADMITTIN CO O 75. 342 20. 349 95. 691 O 5.1 5.06 OSOSG PATTENT ACCOUNTING 0 11. 843.280 447.838 2. 341.118 31.388 5. 5.06 OSOSG PATTENT ACCOUNTING 0 11. 843.280 447.838 2. 341.118 31.388 5. 5.06 OSOSG PATTENT ACCOUNTING 0 17.056 4.44.44 11.4.627 37.896 10.1.556 4.44.44 11.4.627 37.896 11.1.56 11.2.66 11.2.66 11.2.66 11.2.66 11.2.66 11.2.66 11.2.66 11.2.66 11.2.66 11.2.66 11.2.66 11.2.66 11.2.66 11.2.67 12.2.67	5.02		0				480	5. 02
5.65 DOSEON PATTENT ACCOUNTING 0 112.413 30.361 142.714 0 5.7 5.06 DOSEON PERATION OF FLANT 0 3.023.72 B16.018 2.4118 31.88 5.6 5.05 DOSEON PERATION OF FLANT 0 3.023.72 B16.018 2.44118 31.88 5.6 5.05 DOSEON PERATION OF FLANT 0 3.023.72 B17.64 117.433 3.023.71 4.4401 1.4 4.401 1.4 4.401 1.4 4.401 1.4 4.401 1.4 4.401 1.4 4.401 1.4 4.401 1.4 4.401 1.4 4.401 1.4 4.401 1.4 4.401 1.4 1.40 1.40 1.40 1.40 1.40 1.40 1.40 1.41 4.40 1.41 1.41 1.40 1.41 4.41 1.41 1.40 1.41 1.41 1.40 1.41 1.41 1.40 1.41 1.41 1.41 1.41 1.41 1.41 1.41 1.41			8					
5.06 ODSCH OTHER AUM OFTERAL 0 1, 442, 280 4.97, 838 2, 441, 118 31, 388 5, 5, 0 6.00 DOSCO PEATION OF PLATT 0 32, 022, 572 86, 68 3, 48, 109 17, 327 56, 66 7.00 DOSCO PEATION OF PLATT 0 32, 022, 572 86, 68 3, 48, 109 17, 327 56, 66 0.00 DOSCO PEATION OF PLATT 0 32, 441 114, 627 33, 641 74, 441 114, 425 33, 641 74, 441 114, 425 33, 641 74, 441 114, 425 34, 451 12, 444 13, 12, 00 113, 00			S S				-	5.04
8.00 DOUCCI LANDREY & LINEN SERVICE 0 134, D7 36, 200 177, 327 386 8.1 0.00 DOTADIDEXELEP INA 0 581, 786 157, 136 11, 44, 441 10 10.00 DITADIDEXELEP INA 0 581, 786 157, 139 144, 627 538, 916 144, 641 10 10.00 DITADIDEXELEP INA 0 142, 414 114, 627 538, 916 144, 641 10 13, 941 14 13, 441 14 12, 411 14 14, 14, 627 538, 612 13, 541 14 14 627 538, 612 13, 541 15 13, 441 14 627 13, 611 13, 541 14 13, 441 14 627 13, 611 13, 531 13, 141 627 13, 611 13, 531 13, 14 62, 917, 747 13, 779, 753 75, 953 13, 531 33, 533 14, 14, 627 533, 623, 639, 623, 627 13, 533 13, 141, 849, 844 11, 91, 953 24, 918, 11, 91, 953 24, 918, 11, 91, 953 24, 918, 11, 91, 953 24, 918, 11, 91, 953			-				-	
0.00 0.000000 0.000000 0.000000 0.000000 0.00000000000 0.00000000000000000000000000000000000			-					
10.00 01000 DETARY 0 981,780 17.30 738,916 4,404 10.1 13.00 011300 CARFTERI A 0 424,414 114,427 539,041 7.640 11.4 13.00 01300 CHRALS,SERVC & SUPPLY 0 271,229 73,389 335,118 2.341 14.4 15.00 01300 PHARMACY ESIPPLY 0 174,493 47,129 221,621 538 118 53 10.00 101300 PHARMACY ESIPPLY 0 174,493 47,170 301,664 1.418,668 11.950 20.0 10.00 102300 PHARMACY RESUBLY 0 1.117,017 301,664 1.418,668 11.950 20.0 1.515 23.07 223.07 23.07 <td< td=""><td></td><td></td><td>-</td><td></td><td></td><td></td><td></td><td></td></td<>			-					
11.00 01100 CAFTERIA 0 424,414 114,627 539,041 7,640 11.1 13.00 01300 NURSIN KG ADMINISTRATION 0 157,207 73,389 345,118 2,311 14.4 14.00 01400 CENTRAL SERVICE & SUPPLY 0 177,493 47,128 221,621 153,581 15. 17.00 01700 SCIAL SERVICE 0 139,537 37,416 175,993 95 16.6 17.00 01700 SCIAL SERVICE 0 1,117,017 30,666 1,416,698 11.992 20.0 20.0 20.0 20.0 20.0 1.00200 NURSING SCHOOL 0 1,117,017 30,166 1,416,698 11.992 21.0 22.1 21.0 1.0020 21.0 22.1 21.0 22.1 21.0 21.0 22.1 21.0 22.1 21.0 22.1 21.0 21.0 22.1 21.0 21.0 21.0 22.1 21.0 21.0 21.0 21.0 21.0 21.0 21.0 21.0 21.0 21.0 21.0 21.0 21.0 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>								
14.00 CENTRAL SERVICE & SUPPLY 0 727, 729 73, 389 345, 118 2, 341 14, 1 15.00 D1500 (HER CAL RECORDS & LIBRARY 0 138, 537 37, 74, 617 75, 953 055 16, 6 10.00 D12000 (HER CAL SERVICE 0 174, 493 47, 128 221, 621 133, 329 14, 11, 956, 93 05 16, 1 329 17, 117, 012 30, 666 1, 418, 668 1, 418, 668 1, 418, 668 1, 418, 668 1, 418, 668 1, 418, 668 1, 418, 668 1, 418, 668 1, 418, 668 1, 418, 668 1, 418, 658 1, 418, 658 1, 418, 658 1, 418, 658 1, 418, 658 1, 418, 658 1, 418, 658 1, 418, 658 1, 418, 658 1, 418, 658 1, 418, 658 1, 418, 658 1, 418, 658 1, 418, 658 1, 418, 658 1, 513, 513, 513 1, 513, 513, 513			-					
15 D0 01500 HARMACY 0 174,493 471,128 221,421 15,388 18, 17 00 01700 SOCIAL SERVICE 0 19,779 5,342 25,121 3,329 17, 20 00 02000 MIRSIN S. SCHOOL 0 19,779 5,342 25,121 3,329 17, 21 00 02000 MIRSIN S. SCHOOL 0 19,779 5,342 25,207 245,978 1,303 23 21 00 02000 MIRSIN S. SCHOOL 0 0 0 0 1,515 24.0 20 002301 HARMARY MEST DELETY 0 2,916,762 787,767 2,704,429 75,643 30 002000 MERONIDER & FERNICE COST CENTERS 0 2,946,762 787,767 2,704,723 191,843 41,193 41 00 04300 MURES SERVICE COST CENTERS 0 20,412,847 1,911,840 21,607 50,103 51 00 05000 GRECOVENY ROM 0 193,8403 225,447 1,911,840 21,607 51,163 52 00 050200 DELIVERY ROM & LABOR ROM <t< td=""><td></td><td></td><td>-</td><td></td><td></td><td></td><td></td><td></td></t<>			-					
10. 00 01400 HEDICAL RECORDS & LIBRARY 0 138, 537 37, 416 175, 953 95 16, 175, 953 95 16, 175, 953 37, 29 17, 175 37, 20 17, 175, 953 37, 25, 175, 175, 175, 175, 175, 175, 175, 17			-					14.00
17.00 00 01700 SOCIAL SERVICE 0 19,779 5,342 25,121 3,329 17,17 23.00 02301 PHARNACY RESIDENCY 0 193,671 52,307 245,978 11,950 20 10 02300 EXE EDUCATION 0 0 0 0 0 1,515 23 10 0300 MURSIN ESCHOLE 0 0 0 0 0 0 0 0 1,515 23 00 03000 MURSIN ESCHOLE 0 2,916,762 787,767 3,704,529 75,643 30.0 00 03000 INTENSIVE CARE UNIT 0 236,465 98,934 462,517 6,143 41.00 00 0 0 0 0 0 0 0 2,999 43.3 4000 UNRESRY NOM 0 103,610 27,983 131,93 3,443 51.0 00.100,97,114,850 21,609 50.1 50.0 50.0 50.0 50.0 50.0 50.0 50.0 50.0 50.0 50.0								1
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INPART LENT ROUTI NE SERVICE COST CENTERS Investment 00 03000 ADULTS & PEDNATRI CS 0 2.916,762 787,762 37.04,529 75,643 30.0 31.00 03100 INTERS IVE CARE UNI T 0 318,346 85,960 404,326 18,907 31.1 30.00 03000 INTERS IVE CARE UNI T 0 225,455 60,991 286,346 92,223 35.1 30.00 04100 SUBPROVI DER - IRF 0 364,163 98,854 462,517 6,133 91,30 30.00 04000 PREATI IN RENOM 0 938,403 223,447 1,191,850 21,609 50.0 51.00 05100 PREATI IN RENOM 0 103,610 27,993 131,593 3,643 51.50 064,003,000 PREATI IN RENAPEUTI C 0 38.86 10,867 48.753 2,171 55.6 56.00 05600 RADI LOCY - FIARPAPEUTI C 0 38.86 10,867 48.753 2,171 55.6 56.00 05600 RADI LOCY - FIARPAPEUTI C 0 38.874 46.112 1,228 <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></t<>								
30:00 03000 ADULTS & PEDIATRICS 0 2.916, 762 787, 767 3, 704, 529 75, 643 30.0 31:00 03000 INTENSIVE CARE UNIT 0 318, 346 85, 900 404, 326 18, 907 31.1 41:00 041000 INTENSIVE CARE UNIT 0 364, 163 98, 354 442, 517 6, 143 41.1 43:00 04300 INURSERV 0 364, 163 98, 354 442, 517 6, 143 41.1 43:00 05000 OFEANT NG ROOM 0 93, 403, 253, 447 1, 101, 850 21, 609 50.4 50:00 05200 DELI VERY FOOM 0 03, 610 27, 93 131, 593 3, 643, 51.1 52:00 05200 DELI VERY FOOM 0 033, 640 56, 159 264, 093 6, 96 56 56:00 05300 CT SCAN 0 13, 633 30, 645 144, 288 56, 671 10, 783 30, 645 144, 288 56 59 195, 188 977, 573 646, 711 0 66, 56 56 500 133, 30, 645 144, 288 36, 465 56, 51 59, 73 52, 53 646, 711 0 <td>23.01</td> <td></td> <td>0</td> <td>0</td> <td>0</td> <td>U U</td> <td>1, 515</td> <td>23.01</td>	23.01		0	0	0	U U	1, 515	23.01
35: 00 02000 NEONATAL INTENSIVE CARE UNIT 0 225, 455 60, 891 226, 346 9, 223 35. 6 43: 00 04300 NURSERV 0 0 0 0 0 2, 993 43. 6 AMCULLARY SERVICE COST CENTERS 0 036, 4163 99, 354 442, 517 51, 503 <td>30.00</td> <td></td> <td>0</td> <td>2, 916, 762</td> <td>787, 767</td> <td>3, 704, 529</td> <td>75, 643</td> <td>30. 00</td>	30.00		0	2, 916, 762	787, 767	3, 704, 529	75, 643	30. 00
41.00 04100 SUBPROVIDER - IRF 0 364,163 99,354 462,517 6,143 41,43 40.00 04300 PERATINE ROOM 0 0 0 2,292 43. 00.00 05000 DPERATINE ROOM 0 938,403 253,447 1,191,850 31,1593 3,443 51. 00 1,000 0 0 1,000 1,01,8593 3,443 51. 00 0,000 0 0 0 1,01,853 3,443 54. 54. 00 0,000 0 0 1,000 1,000 1,000 1,01,853 1,01,8			-					31.00
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ANCILLARY SERVICE ODST CENTERS								
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54. 00 054.00 RADIOLOGY-DI AGNOSTIC 0 72.4 695 195. 188 191. 883 18. 364 54. 55. 00 0350 RADIOLOGY-DI AERAPEUTIC 0 38. 386 10. 367 48. 753 2. 171 55. 56. 01 0350 CARNIAC CATH LAB 0 207, 934 56. 159 264. 093 6. 006 56. 57. 00 05700 CTOO CTOO CTOO CTOO 58. 00 LABRATORY 0 33. 304 56. 144. 28 3.010 57. 58. 00 05800 IMRI 0 33.3, 094 89. 963. 423. 057 118. 864 66. 65. 00 06500 PHST ICAT. HIERAPY 0 81. 201 21. 931 103. 132 11. 886 66. 67. 00 00 00 00 88. 633 23. 938 112. 571 22.4 68. 70. 69. 00 06900 ELECTROCARDI 0LOGY 0 0 0 0 71. 71. 72.1 76. 748. 731 72.71 72.71<								51.00
56.00 05600 RADI AC CATH LAB 0 27, 931 1, 899 8, 930 1, 221 56. 50.01 03950 CARDI AC CATH LAB 0 27, 934 56, 159 264, 093 6, 006 56. 57.00 05700 CT SCAN 0 113, 613 30, 685 1444, 298 3, 610 57. 58.00 05800 MRI 0 32, 383 8, 746 41, 129 1, 278 56. 60.00 6600 06500 PESPIRATORY 118, 613 30, 685 1444, 298 66. 67. 65.00 06500 PESPIRATORY HERAPY 0 313, 094 89, 403 423, 057 18, 865 66. 66.00 06600 PESCH PATHOLOGY 0 86. 633 23, 938 112, 571 2, 214 68. 67. 67. 68. 00 00 000 0 0 0 71. 62. 73. 8.845 69. 74. 62. 73. 8.484 164.046 3.451 70. 71. 73. 71. 71. 71. 71.			S S	°	,	0		•
56.01 03950 CARDIAC CATH LAB 0 1207,934 56.159 264.093 66.000 57.00 57.00 05700 CT SCAN 0 113,613 30.685 144,298 3,610 57.0 60.00 06000 RABORATORY 0 32,333 8,746 41,129 1,278 58.0 60.00 06000 RESPI RATORY THERAPY 0 81,201 21,931 103,132 11,384 65.0 60.00 06000 RESPI RATORY THERAPY 0 81,201 21,931 103,132 11,384 65.0 66.00 06000 RESPI RATORY THERAPY 0 161.602 43,644 205,248 6.672 67.0 67.00 06700 00 0 0 0.0 0 0.0 71.0 60.2 73.48 69.0 74.3 262.133 8.98 69.0 71.0 70.0 72.0 72.0 72.0 72.0 72.0 72.0 72.0 72.0 72.0 72.0 72.0 72.0 72.0 72.0 72.0 73.0 73.0 73.00			-					55.00
57.00 05700 CT SCAN 0 113.613 30.6685 144.228 3.610 57.0 58.00 05800 MR 0 32.383 8,746 41,129 1.278 58.0 60.00 06000 LABORATORY 0 509,188 137.523 646.711 0 60.0 65.00 06500 PHYSI CAL THERAPY 0 333.094 89,963 423.057 18.865 66. 60.00 06000 SPECH PATHOLOGY 0 88.633 23.938 112.571 2.214 68.0 69.00 06900 ELECTROCARDIOLOGY 0 88.633 23.938 112.571 2.214 68.0 70.00 07000 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 0 0 71.0 73.01 07300 IABETES CENTER 0 0 0 0 73.0 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.01 89.746 43.257 90.0 73.73 73.247 62.294			-					
58. 00 OSB00 NRI 0 32, 383 6, 746 41, 129 1, 278 58. 60 60. 00 06000 LABORATORY 0 509, 188 137, 523 646, 71 0 60. 60 60. 00 06000 RESPI RATORY THERAPY 0 81, 201 21, 931 103, 132 11, 384 65. 60 66. 00 06000 RESPI RATORY THERAPY 0 333, 094 89, 963 423, 057 18. 865 66. 66 67. 00 06700 0CUPATIONAL THERAPY 0 161, 602 43, 646 205, 248 6, 672 67. 7 68. 00 06800 SPEECH PATHOLOGY 0 88, 633 23, 938 112, 571 2, 214 68. 67 67. 00 07000 ELCTROCARD ILOGRAPHY 0 129, 162 34, 884 164, 046 3, 51. 70. 71. 73. 73 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0 0 0 0 73. 73. 73 00 7300 DRUGS CHARGED TO PATIENTS 0 49, 047 1			-					
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74.00 07400 RENAL DI ALYSI S 0 49,047 13,247 62,294 659 74.0 76.98 07698 HYPERBARI C 0XYGEN THERAPY 0 101,352 27,373 128,725 9 76.9 0UTPATI ENT SERVICE COST CENTERS 0 0 0 0 0,44,327 960,863 37,702 91.0 91.00 09000 CLI NI C 0 76.98 0756,536 204,327 960,863 37,702 91.0 91.00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART 0 399,347 107,857 507,204 7,354 91.0 92.0 92.00 09200 0BSERVATI ON BEDS (DI STI NCT PART 0 176,351 47,629 223,980 10,156 92.0 92.01 09200 OBSERVATI ON BEDS (DI STI NCT PART) 0 176,351 47,629 223,980 10,156 92.0 95.00 09500 AMBULANCE SERVI CES 0 214,593 57,958 272,551 11,677 95.0 101.00 HOME HEALTH AGENCY 0 0 0 0 0 133.00 136.00 101.0 </td <td></td> <td></td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td>-</td> <td>73.00</td>			0	0	0	0	-	73.00
76.98 07698 HYPERBARI C 0XYGEN THERAPY 0 101, 352 27, 373 128, 725 9 76.97 0UTPATI ENT SERVICE COST CENTERS 0 0 0 2,451 90.00 90.00 2,451 90.00 90.00 2,451 90.00 90.00 2,451 90.00 90.00 2,451 90.00 91.00 0 0 2,451 90.00 91.00 90.00 2,451 90.00 91.00 92.01 92.01 92.01 085RVATI ON BEDS (NON-DI STI NCT PART 0 399,347 107,857 507,204 7,354 91.00 92.00 92.01 085RVATI ON BEDS (DI STI NCT PART 0 176,351 47,629 223,980 10,156 92.00 92.00 92.01 085RVATI ON BEDS (DI STI NCT PART) 0 176,351 47,629 223,980 10,156 92.00 92.00 95.00 09500 AMBULANCE SERVI CES 0 214,593 57,958 272,551 11,677 95.01 101.00 10100 HOME HEALTH AGENCY 0 0 0 0 101.00 13,260 101.00 101.00 133,260 101.00 138,			0	0	0 12 247	62 204		
OUTPATIENT SERVICE COST CENTERS 90.00 OPSOID CLINIC O O O Q. 451 90.0 91.00 OPSOID CLINIC O O O Q. 451 90.0 91.01 OPSOID CLINIC O O O Q. 451 90.0 91.01 OPSOID EMERGENCY O 756,536 204,327 960,863 37,702 91.0 92.00 O9200 (DSERVATION BEDS (NON-DISTINCT PART) O 399,347 107,857 507,204 7,354 92.0 92.01 OPSOID OBSERVATION BEDS (DISTINCT PART) O 176,351 47,629 223,980 10,156 92.0 95.00 OPSOID AMBULANCE SERVICES O 214,593 57,958 272,551 11,677 95.0 01000 HOME HEALTH AGENCY O			0					76.98
91.00 09100 EMERGENCY 0 756, 536 204, 327 960, 863 37, 702 91. 0 91.01 04950 WOUND CARE 0 399, 347 107, 857 507, 204 7, 354 91. 0 92.00 09200 DBSERVATI ON BEDS (NON-DI STI NCT PART 0 7, 354 91. 0 92. 0 92.01 09200 DBSERVATI ON BEDS (DI STI NCT PART) 0 176, 351 47, 629 223, 980 10, 156 92. 0 95.00 09500 AMBULANCE SERVI CES 0 214, 593 57, 958 272, 551 11, 677 95. 0 0 10100 HOME HEALTH AGENCY 0 0 0 0 133. 260 101. 0 113.00 11300 INTEREST EXPENSE 0 108, 869 29, 404 138, 273 7, 857 116. 0 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 0 19, 318, 554 5, 217, 612 24, 536, 166 459, 293 118. 0 NONREI MBURSABLE COST CENTERS 190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 66, 396 17, 932 84, 328 25		OUTPATIENT SERVICE COST CENTERS						
91. 01 04950 WOUND CARE 0 399, 347 107, 857 507, 204 7, 354 91. 0 92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART) 0 176, 351 47, 629 223, 980 10, 156 92. 0 92. 01 09200 0BSERVATI ON BEDS (DI STI NCT PART) 0 176, 351 47, 629 223, 980 10, 156 92. 0 95. 00 09500 AMBULANCE SERVI CES 0 214, 593 57, 958 272, 551 11, 677 95. 0 101.00 HOME HEALTH AGENCY 0 0 0 0 132, 601 101. 0 113.00 11300 INTEREST EXPENSE 0 108, 869 29, 404 138, 273 7, 857 116. 0 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 0 19, 318, 554 5, 217, 612 24, 536, 166 459, 293 118. 0 NONREI MBURSABLE COST CENTERS 190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 66, 396 17, 932 84, 328 251 190. 0 192.00 19200 PHYSI CLANS' PRI VATE OFFI CES 0 469, 916 126, 916				0	0	0		90.00
92.00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART) 0 176, 351 47, 629 223, 980 10, 156 92.01 92.01 09201 0BSERVATI ON BEDS (DI STI NCT PART) 0 176, 351 47, 629 223, 980 10, 156 92.01 0100 OP500 AMBULANCE SERVI CES 0 214, 593 57, 958 272, 551 11, 677 95.00 10100 HOME HEALTH AGENCY 0 0 0 0 13, 200 1300 INTEREST EXPENSE 113.00 11300 INTEREST EXPENSE 113.00 100, HOME HEALTH AGENCY 0 19, 318, 554 5, 217, 612 24, 536, 166 459, 293 116.00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 0 19, 318, 554 5, 217, 612 24, 536, 166 459, 293 118.00 190.00 I9000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 66, 396 17, 932 84, 328 251 190.00 192.00 PHYSI CI ANS' PRI VATE OFFI CES 0 469, 916 126, 916 596, 832 33, 681 192.00 194.00 07950 MOB 0 0 <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td>91.00 91.01</td></t<>								91.00 91.01
92.01 09201 0BSERVATI ON BEDS (DI STINCT PART) 0 176, 351 47, 629 223, 980 10, 156 92.01 OTHER REI MBURSABLE COST CENTERS 0 214, 593 57, 958 272, 551 11, 677 95.0 0 0 0 0 0 13, 261 101.0 101.00 HOME HEALTH AGENCY 0 0 0 0 13, 261 101.0 101.0 13, 261 101.0 101.0 13, 261 101.0 101.0 13, 261 101.0 101.0 13, 261 101.0 101.0 13, 261 101.0 101.0 13, 261 101.0 101.0 13, 261 101.0 101.0 13, 261 101.0 101.0 13, 261 101.0 101.0 13, 261 101.0 101.0 13, 261 101.0 11.0 13, 261 101.0 101.0 13, 261 101.0 11.0 11.0 11.0 11.0 11.0 11.0 11.0 11.0 11.0 11.0 11.0 11.0				577, 547	107,007	0	7, 334	91.01
95.00 09500 AMBULANCE SERVICES 0 214,593 57,958 272,551 11,677 95.0 101.00 HOME HEALTH AGENCY 0 0 0 0 13,260 101.0 SPECIAL PURPOSE COST CENTERS 113.00 INTEREST EXPENSE 0 108,869 29,404 138,273 7,857 116.0 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 0 19,318,554 5,217,612 24,536,166 459,293 118.0 NONREI MBURSABLE COST CENTERS 190.00 IFT, FLOWER, COFFEE SHOP & CANTEEN 0 66,396 17,932 84,328 251 190.0 192.00 19200 PHYSI CI ANS' PRI VATE OFFICES 0 469,916 126,916 596,832 33,681 192.0 194.00 07950 MOB 0 0 0 0 0 0 194.00		09201 OBSERVATION BEDS (DISTINCT PART)	0	176, 351	47, 629	223, 980	10, 156	•
101.00 10100 HOME HEALTH AGENCY 0 0 0 13,260 101.0 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 108,869 29,404 138,273 7,857 116.0 118.00 HOSPICE 0 108,869 29,404 138,273 7,857 116.0 116.0 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 0 19,318,554 5,217,612 24,536,166 459,293 118.0 NONREI MBURSABLE COST CENTERS 190.00 G IF, F, LOWER, COFFEE SHOP & CANTEEN 0 66,396 17,932 84,328 251 190.0 192.00 19200 PHYSI CI ANS' PRI VATE OFFICES 0 469,916 126,916 596,832 33,681 192.0 194.00 07950 MOB 0 0 0 0 0 0 194.00				014 500	57.050	070.554		1 05 00
SPECIAL PURPOSE COST CENTERS 113.00 INTEREST EXPENSE 113.00 INTEREST EXPENSE 113.00 11300 INTEREST EXPENSE 113.00 108,869 29,404 138,273 7,857 116.00 118.00 HOSPICE 0 108,869 29,404 138,273 7,857 116.00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 0 19,318,554 5,217,612 24,536,166 459,293 118.00 NONREI MBURSABLE COST CENTERS NONREI MBURSABLE COST CENTERS 118.00 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>								
113.00 11300 INTEREST EXPENSE 0 108,869 29,404 138,273 7,857 116.0 116.00 11600 HOSPI CE 0 108,869 29,404 138,273 7,857 116.0 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 0 19,318,554 5,217,612 24,536,166 459,293 118.0 NONREI MBURSABLE COST CENTERS 190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 66,396 17,932 84,328 251 190.0 192.00 19200 PHYSI CLANS' PRI VATE OFFI CES 0 469,916 126,916 596,832 33,681 192.0 194.00 07950 MOB 0 0 0 0 0 0 0 194.00	101.00		0	0	0	U	13, 200	101.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) 0 19, 318, 554 5, 217, 612 24, 536, 166 459, 293 118.0 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 66, 396 17, 932 84, 328 251 190.0 192.00 19200 PHYSI CLANS' PRI VATE OFFICES 0 469, 916 126, 916 596, 832 33, 681 192.00 194.00 0 0 0 0 194.00 0 10 194.00 194.00 0 0 0 194.00 194.00 1950 196.00 194.00 194.00 196.00 194.00 194.00 196.00 194.00 <td></td> <td>11300 INTEREST EXPENSE</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>113.00</td>		11300 INTEREST EXPENSE						113.00
NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 66, 396 17, 932 84, 328 251 190. 00 192. 00 19200 PHYSI CLANS' PRI VATE OFFICES 0 469, 916 126, 916 596, 832 33, 681 192. 00 194. 00 07950 MOB 0 0 0 0 194. 00								•
190. 00 19000 GI FT. FLOWER. COFFEE SHOP & CANTEEN 0 66, 396 17, 932 84, 328 251 190. 0 192. 00 19200 PHYSI CLANS' PRI VATE OFFICES 0 469, 916 126, 916 596, 832 33, 681 192. 0 194. 00 07950 MOB 0 0 0 0 194. 0	118.00		0	19, 318, 554	5,217,612	24, 536, 166	459, 293	1118.00
192.00 19200 PHYSI CLANS' PRI VATE OFFICES 0 469, 916 126, 916 596, 832 33, 681 192.00 194.00 07950 MOB 0 0 0 0 194.00	190.00		0	66, 396	17, 932	84, 328	251	190. 00
	192.00	19200 PHYSI CI ANS' PRI VATE OFFI CES	0					
194. 01 07951 LI FELI NE 0 0 0 3 194. 0			-	0	0	0		194.00 194.01

Health Financial Systems	FRANCI SCAN HEAL	TH LAFAYETTE		In Lie	u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CC		Period: From 01/01/2017 To 12/31/2017		
		CAPI TAL REL	LATED COSTS			
Cost Center Description	Di rectl y Assi gned New Capi tal Rel ated Costs	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
	0	1.00	2.00	2A	4.00	
194. 02 07952 PATI ENT TRANSPORT	0	0		0 0	0	194.02
194.03 07954 OTHER NONREI MBURSABLE COST CENTERS	0	3, 210, 214		0 3, 210, 214	0	194.03
200.00 Cross Foot Adjustments				0		200.00
201.00 Negative Cost Centers		0		0 0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	0	23, 065, 080	5, 362, 46	28, 427, 540	493, 228	202.00

	Financial Systems ATION OF CAPITAL RELATED COSTS	FRANCI SCAN HEAL	TH LAFAYETTE Provider CO		eri od:	u of Form CMS-2 Worksheet B	2552-10
					rom 01/01/2017 p 12/31/2017	Part II Date/Time Pre	pared:
	Cost Center Description	COMMUNI CATI ONS	MGMT INFO	PURCHASI NG	ADMI TTI NG	5/31/2018 3:5 PATI ENT	3 pm
		5.01	SYSTEMS 5.02	5.03	5. 04	ACCOUNTING 5.05	
	GENERAL SERVICE COST CENTERS	5.01	5.02	5.03	5.04	5.05	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00 4.00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT						2.00 4.00
4.00 5.01	01160 COMMUNI CATI ONS	51, 577					5.01
5.02	01140 MGMT INFO SYSTEMS	1, 683	629, 634				5.02
5.03	00550 PURCHASI NG	1,024	0		05 (01		5.03
5.04 5.05	00570 ADMITTING 00580 PATIENT ACCOUNTING	0 1, 024	0	0	95, 691 0	143, 798	5.04 5.05
5.06	00560 OTHER ADMINISTRATIVE AND GENERAL	5, 341	0	-	0	0	5.06
7.00	00700 OPERATION OF PLANT	4,024	42, 963		0	0	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	73	26, 433		0	0	8.00
9.00 10.00	00900 HOUSEKEEPI NG 01000 DI ETARY	658 2, 195	1, 591 30, 860	1, 051 45	0	0	9.00
11.00	01100 CAFETERIA	0	30, 056		0	0	11.00
13.00	01300 NURSING ADMINISTRATION	658	15, 478		0	0	13.00
14.00 15.00	01400 CENTRAL SERVICE & SUPPLY 01500 PHARMACY	293 1, 683	4,929		0	0	14.00
16.00	01600 MEDICAL RECORDS & LIBRARY	1, 083	16, 748 507	0	0	0	15.00 16.00
17.00	01700 SOCIAL SERVICE	658	4, 893		Ő	0	17.00
20.00	02000 NURSI NG SCHOOL	0	12, 512		0	0	20.00
23.00 23.01	02301 PHARMACY RESIDENCY 02300 EMS EDUCATION	0	1, 204	0	0	0	23.00 23.01
23.01	INPATIENT ROUTINE SERVICE COST CENTERS	0	1, 038	<u> </u>	0	0	23.01
30.00	03000 ADULTS & PEDI ATRI CS	8, 413	121, 406	115	4, 534	6, 801	30.00
31.00	03100 INTENSIVE CARE UNIT	1, 609	25, 827		1, 354	2, 031	31.00
35.00 41.00	02060 NEONATAL INTENSIVE CARE UNIT 04100 SUBPROVIDER - IRF	1, 244 1, 756	11, 420 7, 228		1, 148 382	1, 721 573	35.00 41.00
41.00	04300 NURSERY	0	7,228		288	432	41.00
	ANCI LLARY SERVICE COST CENTERS			-			
50.00	05000 OPERATING ROOM	1, 756	27, 234		12, 591	19, 149	1
51.00 52.00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	585 1, 902	3, 674 0		1, 057 1, 788	1, 585 2, 682	1
52.00	05400 RADI OLOGY-DI AGNOSTI C	4, 390	26, 144	-	6, 529	9, 794	54.00
55.00	03630 RADI OLOGY-THERAPEUTI C	0	2, 245		773	1, 159	55.00
56.00	05600 RADI OI SOTOPE	0	1, 237		0	0	56.00
56.01 57.00	03950 CARDI AC CATH LAB 05700 CT SCAN	0	7, 366 4, 479		2, 693 5, 626	4, 039 8, 439	56.01 57.00
58.00	05800 MRI	0	1, 229		1, 341	2, 012	
60.00	06000 LABORATORY	3, 219	0	11, 205	10, 343	15, 515	60.00
65.00		2,487	15, 285		1,008	1, 512	
66.00 67.00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	439	26, 975 7, 670		1, 352 840	2, 027 1, 260	66.00 67.00
68.00		0	2,652		184	277	68.00
69.00	06900 ELECTROCARDI OLOGY	439	9, 922		2, 455	3, 683	
70.00 71.00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	4, 243		441	661	70.00
71.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	247, 312 286, 459	10, 641 7, 745	15, 962 11, 618	1
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	10, 455	15, 682	
73.01	07301 DI ABETES CENTER	439	2, 129		17	26	
74.00 76.98	07400 RENAL DI ALYSI S 07698 HYPERBARI C OXYGEN THERAPY	0	856 9		203 77	304 115	
70.90	OUTPATIENT SERVICE COST CENTERS	<u> </u>	7	0	//	115	70.90
90.00	09000 CLI NI C	2, 341	5, 139	1	73	109	90.00
91.00	09100 EMERGENCY	0	51, 210	265	5, 473	8, 209	91.00
91.01 92.00	04950 WOUND CARE 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	8, 464	0	667	1, 001	91.01 92.00
92.00	09201 OBSERVATION BEDS (NON-DISTINCT PART)	0	13, 092	9	922	1, 383	92.00
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVI CES	0	23, 496		1, 161	1, 742	
101.00	DIO100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0	16, 222	1, 582	578	867	101.00
113.00	D11300 INTEREST EXPENSE						113.00
116.00	11600 HOSPI CE	0	9, 429		952		116.00
118.00		51, 577	625, 494	572, 845	95, 691	143, 798	118.00
190 0	NONREI MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	457	0	0	0	190.00
	19200 PHYSI CI ANS' PRI VATE OFFICES	0	3, 658		0		190.00
194.00	07950 МОВ	0	0	0	0	0	194.00
		0	25		0		194.01
	207952 PATIENT TRANSPORT 307954 OTHER NONREIMBURSABLE COST CENTERS	0	0		0		194.02 194.03
200.00			0	0	0		200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00

Health Financial Systems	In Lieu of Form CMS-2552-10					
ALLOCATION OF CAPITAL RELATED COSTS		Provider CC		Period: From 01/01/2017	Worksheet B	
					Date/Time Pre 5/31/2018 3:5	
Cost Center Description	COMMUNI CATI ONS	MGMT INFO SYSTEMS	PURCHASI NG	ADMI TTI NG	PATI ENT ACCOUNTI NG	
	5.01	5.02	5.03	5.04	5. 05	
202.00 TOTAL (sum lines 118 through 201)	51, 577	629, 634	572, 84	95, 691	143, 798	202.00

Health Financial Systems ALLOCATION OF CAPITAL RELATED COSTS	FRANCI SCAN HEAL	TH LAFAYETTE Provider CO	N. 15 0100 D	In Lie	u of Form CMS-: Worksheet B	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider co	F	rom 01/01/2017 o 12/31/2017	Part II Date/Time Pre 5/31/2018 3:5	pared:
Cost Center Description	OTHER ADMI NI STRATI VE AND GENERAL	OPERATI ON OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	
	5.06	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS	1			I		1.00
1.00 00100 CAP REL COSTS-BLDG & FLXT 2.00 00200 CAP REL COSTS-MVBLE EQUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 5.01 01160 COMMUNI CATIONS 5.02 01140 MGMT INFO SYSTEMS 5.03 00550 PURCHASI NG 5.04 00570 ADMITTI NG 5.05 00580 PATIENT ACCOUNTING 5.06 00560 OTHER ADMINISTRATIVE AND GENERAL 7.00 00700 OPERATION OF PLANT 8.00 00800 LAUNDRY & LINEN SERVICE	2, 378, 077 155, 134 17, 556	4, 059, 329 32, 717 37, 717	247, 692			$\begin{array}{c} 2.\ 00\\ 4.\ 00\\ 5.\ 01\\ 5.\ 02\\ 5.\ 03\\ 5.\ 04\\ 5.\ 05\\ 5.\ 06\\ 7.\ 00\\ 8.\ 00\\ \end{array}$
9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY 11. 00 01100 CAFETERI A 13. 00 01300 NURSI NG ADMI NI STRATI ON	41, 176 27, 858 26, 762	91, 728 141, 932 103, 540	6, 957 0	28, 399 20, 717	981, 566 0	11.00
14.00 01400 CENTRAL SERVICE & SUPPLY 15.00 01500 PHARMACY 16.00 01600 MEDICAL RECORDS & LIBRARY 17.00 01700 SOCIAL SERVICE 20.00 02000 NURSING SCHOOL 23.00 02301 PHARMACY RESIDENCY 23.01 02300 EMS EDUCATION	38, 747 9, 923 48, 049 17, 838 9, 649 27, 421 5, 659 4, 165	38, 351 66, 291 42, 569 33, 797 4, 825 272, 505 47, 248 0	6, 278 0 0 0 0 0 0 0	13, 264 8, 518 6, 763 965 54, 526 9, 454	0 0 0 0 0 0 0 0 0	13.00 14.00 15.00 16.00 17.00 20.00 23.00 23.01
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS	2(1 172	711 570	07.420	142.270	022 (52	30.00
30. 00 03000 ADULTS & PEDI ATRI CS 31. 00 03100 INTENSI VE CARE UNI T 35. 00 02060 NEONATAL INTENSI VE CARE UNI T 41. 00 04100 SUBPROVI DER - RF 43. 00 04300 NURSERY	261, 172 57, 039 30, 050 22, 176 7, 270	711, 570 77, 663 55, 002 88, 841 0	13, 320 5, 552 4, 702	15, 540 11, 005 17, 776	822, 652 95, 317 0 63, 597 0	30.00 31.00 35.00 41.00 43.00
ANCILLARY SERVICE COST CENTERS	· · · ·					
50. 00 05000 0PERATI NG ROOM 51. 00 05100 RECOVERY ROOM 52. 00 05200 DELI VERY ROOM & LABOR ROOM 54. 00 05400 RADI OLOGY - DI AGNOSTI C 55. 00 03630 RADI OLOGY - THERAPEUTI C 56. 00 05600 RADI OLOGY - THERAPEUTI C 56. 01 03950 CARDI AC CATH LAB 57. 00 05700 CT SCAN 58. 00 05800 MRI 60. 00 06000 LABORATORY 65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	$\begin{array}{c} 129,070\\ 11,701\\ 47,886\\ 104,707\\ 7,654\\ 3,660\\ 25,353\\ 16,005\\ 5,096\\ 103,434\\ 35,635\\ 57,684\\ \end{array}$	228, 932 25, 276 0 176, 308 9, 365 1, 715 50, 727 27, 717 7, 900 124, 221 19, 810 81, 261	7, 988 9, 756 15, 243 0 1, 007 0 1, 579 1, 849	5, 058 0 35, 278 1, 874 343 10, 150 5, 546 1, 581 24, 855 3, 964 16, 260	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	$\begin{array}{c} 50.\ 00\\ 51.\ 00\\ 52.\ 00\\ 54.\ 00\\ 55.\ 00\\ 56.\ 01\\ 57.\ 00\\ 58.\ 00\\ 60.\ 00\\ 65.\ 00\\ 66.\ 00\\ \end{array}$
67.00 06700 0CCUPATI ONAL THERAPY 68.00 06800 SPEECH PATHOLOGY 69.00 06900 ELECTROCARDI OLOGY 70.00 07000 ELECTROENCEPHALOGRAPHY 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 73.00 07300 DRUGS CHARGED TO PATI ENTS 73.01 07301 DI ABETES CENTER 74.00 07400 RENAL DI ALYSIS 76.98 07698 HYPERBARI C OXYGEN THERAPY	20, 946 7, 201 28, 999 12, 204 152, 713 174, 279 101, 855 5, 066 7, 818 2, 602	39, 424 21, 623 50, 351 31, 510 0 0 0 11, 965 24, 726	1, 403 0 0 0 0 0 0 0 0 0 0	4, 327 10, 075 6, 305 0 0 0 0 0 0 2, 394	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	67.00 68.00 69.00 70.00 71.00 72.00 73.00 73.01 74.00 76.98
OUTPATIENT SERVICE COST CENTERS	· · · ·		-			
90. 00 09000 CLINIC 91. 00 09100 EMERGENCY 91. 01 04950 WOUND CARE 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	11, 170 118, 839 25, 241	0 184, 564 97, 424		-	0 0 0	90.00 91.00 91.01 92.00
92. 01 09201 OBSERVATI ON BEDS (DI STI NCT PART) OTHER REI MBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES	33, 618	43, 022	1	· · · ·	0	1
101.00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	48, 981	0				101.00
113. 00 11300 INTEREST EXPENSE 116. 00 11600 HOSPI CE 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	36, 316 2, 186, 353	26, 559 3, 145, 331			0 981, 566	113. 00 116. 00 118. 00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 194.00 07950 MOB 194.01 07951 LI FELI NE	1, 820 157, 528 2 60	16, 198 114, 640 0 0			0 0	190. 00 192. 00 194. 00 194. 01
194.0107951 LIFELINE 194.02 07952 PATIENT TRANSPORT 194.03 07954 OTHER NONREIMBURSABLE COST CENTERS 200.00 Cross Foot Adjustments	60 2, 459 29, 855	0 0 783, 160		0	0 0	194. 01 194. 02 194. 03 200. 00

Heal th Fin	ancial Systems	FRANCI SCAN HEAI	TH LAFAYETTE		In Lie	u of Form CMS-	2552-10
ALLOCATI ON	I OF CAPITAL RELATED COSTS		Provider C		Period:	Worksheet B	
					From 01/01/2017 To 12/31/2017		pared:
						5/31/2018 3:5	
	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	
201.00	Negative Cost Centers	0	0		0 0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	2, 378, 077	4, 059, 329	247, 69	2 630, 632	981, 566	202.00

Heal th	Financial Systems	FRANCI SCAN HEA	LTH_LAFAYETTE		In Lie	u of Form CMS-	2552-10
ALLOCA	TION OF CAPITAL RELATED COSTS		Provi der CC	N: 15-0109	Period: From 01/01/2017	Worksheet B Part II	
					To 12/31/2017	Date/Time Pre 5/31/2018 3:5	pared:
	Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
			ADMI NI STRATI ON	SERVICE & SUPPLY		RECORDS & LI BRARY	
		11.00	13.00	14.00	15.00	16.00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT	1	1				1.00
2.00	00200 CAP REL COSTS-BEDG & TTXT						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01 5.02	01160 COMMUNICATIONS 01140 MGMT INFO SYSTEMS						5. 01 5. 02
5.03	00550 PURCHASI NG						5.03
5.04	00570 ADMI TTI NG						5.04
5.05 5.06	00580 PATIENT ACCOUNTING 00560 OTHER ADMINISTRATIVE AND GENERAL						5.05 5.06
7.00	00700 OPERATION OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY						9.00
11.00	01100 CAFETERIA	727, 756					11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	22, 631					13.00
14.00 15.00	01400 CENTRAL SERVI CE & SUPPLY 01500 PHARMACY	7, 206 24, 488		455, 65	0 379, 034		14.00
16.00	01600 MEDICAL RECORDS & LIBRARY	741	1 1		0 0	236, 938	•
17.00	01700 SOCIAL SERVICE	7, 155		,	5 0	0	
20. 00 23. 00	02000 NURSI NG SCHOOL 02301 PHARMACY RESI DENCY	18, 294		e	0 0 0	0	
23.00	02300 EMS EDUCATI ON	1, 518	1 1		1 0	0	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	177, 511 37, 763			02 0 22 0	11, 169 3, 336	•
35.00	02060 NEONATAL INTENSIVE CARE UNIT	16, 698		21		2, 827	•
41.00	04100 SUBPROVI DER - I RF	10, 568			2 0	941	•
43.00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	C	0		0 0	710	43.00
50.00	05000 OPERATI NG ROOM	39, 820	23, 880	8, 82	21 0	32, 223	50.00
51.00	05100 RECOVERY ROOM	5, 372			0 0	2, 604	1
52.00 54.00	05200 DELIVERY ROOM & LABOR ROOM 05400 RADI OLOGY-DI AGNOSTI C	38, 226	-	5, 26	0 0 7 0	4, 405 16, 084	
55.00	03630 RADI OLOGY-THERAPEUTI C	3, 282	1 1	5,20	0 0	1, 904	
56.00	05600 RADI OI SOTOPE	1, 809			0 0	0	
56. 01 57. 00	03950 CARDI AC CATH LAB 05700 CT SCAN	10, 771 6, 549		2,65	50 0 32 0	6, 634 13, 860	•
58.00	05800 MRI	1, 797			2 0	3, 304	•
60.00	06000 LABORATORY	0	-	8, 93		25, 480	1
65.00 66.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	22, 350 39, 442		1, 87	0 0 0 0	2, 483 3, 330	•
	06700 OCCUPATI ONAL THERAPY	11, 215			0 0	2, 069	
68.00	06800 SPEECH PATHOLOGY	3,877			0 0	454	•
69.00 70.00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	14, 507 6, 205			4 0	6, 049 1, 086	•
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0,200		197, 17	2 0	26, 214	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	228, 39		19, 080	•
73. 00 73. 01	07300 DRUGS CHARGED TO PATIENTS 07301 DIABETES CENTER	3, 113	1,867		0 379, 034 0 0	25, 754 43	•
74.00	07400 RENAL DIALYSIS	1, 251			0 0	499	
76. 98	07698 HYPERBARI C OXYGEN THERAPY	13	3 0		0 0	189	76.98
90.00	OUTPATIENT SERVICE COST CENTERS	7, 514			1 0	179	90.00
91.00	09100 EMERGENCY	74, 877	44, 904	21	1 0	13, 481	91.00
91.01	04950 WOUND CARE	12, 376	5 7, 422		0 0	1, 644	
92. 00 92. 01	09200 OBSERVATION BEDS (NON-DISTINCT PART 09201 OBSERVATION BEDS (DISTINCT PART)	19, 143	3 0		7 0	2, 272	92.00 92.01
	OTHER REIMBURSABLE COST CENTERS					21272	/2:01
	09500 AMBULANCE SERVICES	34, 354			0 0	2, 861	•
101.00	10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	23, 719	9 14, 224	1, 26	01 0	1, 425	101.00
	11300 I NTEREST EXPENSE						113.00
	11600 HOSPICE	13, 787		57			116.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	721, 703	336, 661	455, 65	379, 034	236, 938	118.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	668	1 1		0 0		190. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES	5, 349			0 0		192.00
	07950 MOB 07951 LI FELI NE	36					194.00 194.01
194.02	07952 PATI ENT TRANSPORT	C	1 1		0 0	0	194. 02
	07954 OTHER NONREIMBURSABLE COST CENTERS	C			0 0		194.03
200.00	Cross Foot Adjustments						200.00

Health Financial Systems	FRANCI SCAN HEA	LTH_LAFAYETTE		In Lie	u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider C		Period:	Worksheet B	
				From 01/01/2017 To 12/31/2017		parad
					5/31/2018 3:5	
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		ADMI NI STRATI ON	SERVICE &		RECORDS &	
			SUPPLY		LI BRARY	
	11.00	13.00	14.00	15.00	16.00	
201.00 Negative Cost Centers	0	0	(0 0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	727, 756	336, 661	455, 653	3 379, 034	236, 938	202.00

	Financial Systems TION OF CAPITAL RELATED COSTS	FRANCI SCAN HEAL	Provider CC	N. 15-0100	In Lie Period:	u of Form CMS-: Worksheet B	2552-10
ALLUUP	TTON OF CAPITAL RELATED COSTS		Provider CC		From 01/01/2017	Part II	
					To 12/31/2017	Date/Time Pre 5/31/2018 3:5	
	Cost Center Description	SOCI AL SERVI CE	NURSING SCHOOL	PHARMACY	EMS EDUCATION	Subtotal	
		17.00		RESI DENCY	00.01	04.00	
	GENERAL SERVICE COST CENTERS	17.00	20.00	23.00	23.01	24.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01160 COMMUNI CATI ONS						5.01
5.02 5.03	01140 MGMT I NFO SYSTEMS 00550 PURCHASI NG						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 10.00	00900 HOUSEKEEPING						9.00
11.00	01000 DI ETARY 01100 CAFETERI A						10.00
13.00	01300 NURSI NG ADMI NI STRATI ON						13.00
14.00	01400 CENTRAL SERVI CE & SUPPLY						14.00
15.00	01500 PHARMACY						15.00
16.00	01600 MEDI CAL RECORDS & LI BRARY						16.00
17.00	01700 SOCI AL SERVI CE	56, 606	4 944 957				17.00
20.00 23.00	02000 NURSI NG SCHOOL 02301 PHARMACY RESI DENCY	0	1, 816, 057	212 40	7		20.00
23.00	02300 EMS EDUCATION	0		312, 60	8, 238		23.00
25.01	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	<u> </u>			0,230		20.01
30.00	03000 ADULTS & PEDI ATRI CS	39, 976				6, 281, 855	30.00
31.00	03100 INTENSIVE CARE UNIT	5, 558				782, 286	31.00
35.00	02060 NEONATAL INTENSIVE CARE UNIT	3, 270				446, 011	1
41.00	04100 SUBPROVIDER - IRF	3, 531				697,072	
43.00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	4, 271				25, 025	43.00
50.00	05000 OPERATING ROOM	0				1, 837, 246	50.00
51.00	05100 RECOVERY ROOM	0				203, 357	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0				87, 513	
54.00	05400 RADI OLOGY-DI AGNOSTI C	0				1, 380, 823	54.00
55.00	03630 RADI OLOGY-THERAPEUTI C	0				79, 180	
56.00	05600 RADI OI SOTOPE	0				20, 000	1
56.01 57.00	03950 CARDI AC CATH LAB 05700 CT SCAN	0				402, 171 236, 201	
57.00	05800 MRI	0				66, 672	1
60.00	06000 LABORATORY	0				975, 496	
65.00	06500 RESPIRATORY THERAPY	0				238, 518	
66.00	06600 PHYSI CAL THERAPY	0				697, 787	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0				309, 958	
	06800 SPEECH PATHOLOGY	0				157, 705	
	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	0				407, 023 233, 873	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0				650, 014	
	07200 I MPL. DEV. CHARGED TO PATIENTS	0				727, 573	
	07300 DRUGS CHARGED TO PATIENTS	0				532, 780	
73.01	07301 DI ABETES CENTER	0					73.01
	07400 RENAL DI ALYSI S	0				88, 993	
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0				161, 412	76. 98
90 00	OUTPATIENT SERVICE COST CENTERS	0				28, 978	90.00
91.00	09100 EMERGENCY	0				1, 560, 412	1
91.00	04950 WOUND CARE	0				688, 291	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	0				356, 212	92.01
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVICES	0				474, 360	
101.00	10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0				122, 119	
113 00	11300 INTEREST EXPENSE						113.00
	11600 HOSPI CE	0				251, 817	
118.00			0		0 0		
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0				106, 963	
	19200 PHYSI CLANS' PRI VATE OFFI CES	0				934, 626	
		0					194.00
	07951 LIFELINE	0					194.01 194.02
	07952 PATIENT TRANSPORT 07954 OTHER NONREIMBURSABLE COST CENTERS	0				2, 459 4, 023, 229	
			1, 816, 057	312, 60	7 8, 238	2, 136, 902	
200.00				, 50	5,200		

Health Financial Systems FRANCISCAN HEALTH LAFAYETTE					u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CC		Period: From 01/01/2017	Worksheet B	
					Date/Time Pre 5/31/2018 3:5	
Cost Center Description	SOCI AL SERVI CE	NURSING SCHOOL	PHARMACY	EMS EDUCATION	Subtotal	
			RESI DENCY			
	17.00	20.00	23.00	23.01	24.00	
202.00 TOTAL (sum lines 118 through 201)	56, 606	1, 816, 057	312, 60	7 8, 238	28, 427, 540	202.00

	Financial Systems TION OF CAPITAL RELATED COSTS	FRANCI SCAN HEALT	H LAFAYETTE Provider CCI	N: 15-0109	In Lie Period: From 01/01/2017 To 12/31/2017	u of Form CMS-255 Worksheet B Part II Date/Time Prepar 5/31/2018 3:53 p	red:
	Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total				piii
	GENERAL SERVICE COST CENTERS	25.00	26.00				
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01160 COMMUNI CATI ONS						5. 01
5.02	01140 MGMT INFO SYSTEMS						5.02
5.03	00550 PURCHASI NG						5.03
5.04 5.05	00570 ADMI TTI NG 00580 PATI ENT ACCOUNTI NG						5.04 5.05
5.05	00560 OTHER ADMINISTRATIVE AND GENERAL						5.05
7.00	00700 OPERATI ON OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPI NG						9.00
10.00	01000 DI ETARY					1	10.00
11.00	01100 CAFETERI A						11.00
13.00	01300 NURSI NG ADMI NI STRATI ON						13.00
14.00	01400 CENTRAL SERVICE & SUPPLY 01500 PHARMACY						14.00
15.00 16.00	01600 MEDICAL RECORDS & LIBRARY						15.00 16.00
17.00	01700 SOCIAL SERVICE						17.00
20.00	02000 NURSI NG SCHOOL						20.00
23.00	02301 PHARMACY RESIDENCY						23.00
23.01	02300 EMS EDUCATI ON						23. 01
	INPATIENT ROUTINE SERVICE COST CENTERS	1 1					
30.00	03000 ADULTS & PEDIATRICS	0	6, 281, 855				30.00
31.00	03100 I NTENSI VE CARE UNI T	0	782, 286				31.00
35.00 41.00	02060 NEONATAL INTENSIVE CARE UNIT 04100 SUBPROVIDER - IRF	0	446, 011 697, 072				35.00 41.00
41.00	04300 NURSERY	0	25, 025				43.00
10.00	ANCI LLARY SERVI CE COST CENTERS		20, 020			•	10.00
50.00	05000 OPERATING ROOM	0	1, 837, 246			5	50.00
51.00	05100 RECOVERY ROOM	0	203, 357			5	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	87, 513				52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	1, 380, 823				54.00
55.00 56.00	03630 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE	0	79, 180 20, 000				55.00 56.00
56.00	03950 CARDI AC CATH LAB	0	402, 171				56.00
57.00	05700 CT SCAN	0	236, 201				57.00
58.00	05800 MRI	0	66, 672				58.00
60.00	06000 LABORATORY	0	975, 496			6	50.00
	06500 RESPI RATORY THERAPY	0	238, 518				65.00
	06600 PHYSI CAL THERAPY	0	697, 787				66.00
67.00 68.00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0	309, 958 157, 705				57.00 58.00
69.00	06900 ELECTROCARDI OLOGY	0	407, 023				58.00 59.00
	07000 ELECTROENCEPHALOGRAPHY	0	233, 873				70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	650, 014				71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	727, 573			7.	72.00
	07300 DRUGS CHARGED TO PATIENTS	0	532, 780				73.00
73.01	07301 DI ABETES CENTER	0	14, 502				73.01
	07400 RENAL DIALYSIS	0	88, 993				74.00
10.98	07698 HYPERBARI C OXYGEN THERAPY OUTPATIENT SERVICE COST CENTERS		161, 412				76. 98
90.00		0	28, 978			9	90.00
	09100 EMERGENCY	0	1, 560, 412				91.00
91.01	04950 WOUND CARE	0	688, 291				91.01
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0					92.00
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	0	356, 212			9.	92.01
0F 00	OTHER REIMBURSABLE COST CENTERS	0	474 240				95.00
	09500 AMBULANCE SERVICES 10100 HOME HEALTH AGENCY	0	474, 360 122, 119				95.00 01.00
101.00	SPECIAL PURPOSE COST CENTERS		122, 119			10	, 00
113.00	11300 I NTEREST EXPENSE					11	13.00
	11600 HOSPI CE	0	251, 817				16.00
118.00	· · · · · · · · · · · · · · · · · · ·	0	21, 223, 235			11	18.00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	106, 963				90.00
197 00	19200 PHYSI CLANS' PRI VATE OFFI CES	0	934, 626				92.00 94.00
						119	74 UU
194.00	07950 MOB 07951 LI FELI NE	0	124				94.01

Health Financial Systems	FRANCISCAN HEAL	TH LAFAYETTE		In Lieu	u of Form CMS-2552-	-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CC	CN: 15-0109	Peri od:	Worksheet B	
				From 01/01/2017 To 12/31/2017	Part II Date/Time Prepared	d٠
				10 12/31/2017	5/31/2018 3:53 pm	л.
Cost Center Description	Intern &	Total				
	Residents Cost					
	& Post					
	Stepdown					
	Adjustments					
	25.00	26.00				
194.0307954 OTHER NONREIMBURSABLE COST CENTERS	0	4, 023, 229			194.	03
200.00 Cross Foot Adjustments	0	2, 136, 902			200.	00
201.00 Negative Cost Centers	0	0			201.	00
202.00 TOTAL (sum lines 118 through 201)	0	28, 427, 540			202.	00

	Financial Systems LLOCATION - STATISTICAL BASIS	FRANCI SCAN HEAI	LTH LAFAYETTE Provider CO		eri od:	u of Form CMS-: Worksheet B-1	2552-10
					rom 01/01/2017 o 12/31/2017	Date/Time Pre 5/31/2018 3:5	
		CAPI TAL REI	ATED COSTS				
	Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS	COMMUNI CATI ONS (PHONE LI NE S)	MGMT INFO SYSTEMS (MANHOURS)	
		1.00	2.00	SALARIES) 4.00	5. 01	5. 02	
1 00	GENERAL SERVICE COST CENTERS						1 00
1.00 2.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP	806, 980	694, 664				1.00 2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	13, 587	13, 587				4.00
5.01	01160 COMMUNI CATI ONS	1, 346					5.01
5.02 5.03	01140 MGMT INFO SYSTEMS 00550 PURCHASING	17, 285 15, 752	17, 285 15, 752			2, 866, 365 0	
5.03	00570 ADMI TTI NG	2,636				0	
5.05	00580 PATIENT ACCOUNTING	3, 933	3, 933			0	5.05
5.06	00560 OTHER ADMINISTRATIVE AND GENERAL	64, 491	64, 491	5, 845, 054		0	5.06
7.00 8.00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	105, 786 4, 692	105, 786 4, 692	3, 169, 054 109, 139		195, 585 120, 334	7.00 8.00
9.00	00900 HOUSEKEEPING	13, 155	13, 155			7, 243	
10.00	01000 DI ETARY	20, 355	20, 355			140, 490	
11.00		14, 849				136, 830	
13.00 14.00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CE & SUPPLY	5, 500 9, 507	5, 500 9, 507	2, 507, 273 435, 882		70, 461 22, 437	13.00 14.00
15.00	01500 PHARMACY	6, 105	6, 105			76, 244	
16.00	01600 MEDI CAL RECORDS & LI BRARY	4, 847	4, 847			2, 308	
17.00	01700 SOCIAL SERVICE	692	692			22, 276	
20. 00 23. 00	02000 NURSI NG SCHOOL 02301 PHARMACY RESI DENCY	39, 081 6, 776	39, 081 6, 776	2, 225, 330 242, 703		56, 958 5, 483	
23.01	02300 EMS EDUCATION	0	0			4, 727	
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	100.010	100.010				
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	102, 049 11, 138	102, 049 11, 138			552, 693 117, 577	
35.00	02060 NEONATAL INTENSIVE CARE UNIT	7,888	7, 888			51, 988	
41.00	04100 SUBPROVIDER - IRF	12, 741	12, 741	1, 143, 890		32, 903	
43.00		0	0	545, 492	0	0	43.00
50.00	ANCI LLARY SERVI CE COST CENTERS	32, 832	32, 832	4, 024, 082	24	123, 979	50.00
51.00	05100 RECOVERY ROOM	3, 625	3, 625			16, 725	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	3, 555, 756		0	52.00
54.00 55.00	05400 RADI OLOGY-DI AGNOSTI C 03630 RADI OLOGY-THERAPEUTI C	25, 285 1, 343	25, 285 1, 343	3, 419, 790 404, 194		119, 017 10, 218	
	05600 RADI OI SOTOPE	246	246			5, 632	
56.01	03950 CARDI AC CATH LAB	7, 275	7, 275	1, 286, 090		33, 535	56. 01
57.00	05700 CT SCAN 05800 MRI	3, 975	3, 975			20, 389	
58.00 60.00	06000 LABORATORY	1, 133 17, 815			-	5, 594 0	
65.00	06500 RESPI RATORY THERAPY	2, 841	2, 841	2, 119, 971		69, 586	
66.00	06600 PHYSI CAL THERAPY	11, 654	11, 654	3, 513, 127		122, 804	66.00
67.00 68.00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	5, 654 3, 101	5, 654 3, 101	1, 242, 520 412, 353		34, 919 12, 071	67.00 68.00
69.00	06900 ELECTROCARDI OLOGY	7, 221	7, 221	1, 545, 263		45, 169	
70.00	07000 ELECTROENCEPHALOGRAPHY	4, 519	4, 519	642, 584	0	19, 318	
71.00 72.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		-	0	71.00 72.00
72.00	07300 DRUGS CHARGED TO PATIENTS	0	0		-	0	73.00
73.01	07301 DI ABETES CENTER	0	0	335, 592	6	9, 691	
74.00	07400 RENAL DIALYSIS	1, 716				3, 896	
76. 98	07698 HYPERBARI C OXYGEN THERAPY OUTPATI ENT SERVI CE COST CENTERS	3, 546	3, 546	1, 703	0	39	76. 98
90.00	09000 CLINIC	0	0	456, 454	32	23, 396	90.00
91.00	09100 EMERGENCY	26, 469	26, 469		0	233, 132	
91.01 92.00	04950 WOUND CARE 09200 OBSERVATION BEDS (NON-DISTINCT PART	13, 972	13, 972	1, 369, 459	0	38, 532	91.01 92.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART 09201 OBSERVATION BEDS (DISTINCT PART)	6, 170	6, 170	1, 891, 205	0	59, 601	
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVICES	7, 508				106, 962	
101.00	10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0	0	2, 469, 274	0	73, 851	101.00
113.00	11300 I NTEREST EXPENSE						113.00
	11600 HOSPI CE	3,809	3, 809				116.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	675, 900	675, 900	85, 531, 202	705	2, 847, 518	118.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	2, 323	2, 323	46, 752	0	2, 080	190. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES	16, 441	16, 441			16, 654	
194.00	07950 MOB	0	0	C	0	0	194.00

Health Financial Systems	FRANCI SCAN HEAL	LTH LAFAYETTE		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider CC		Period:	Worksheet B-1	
				rom 01/01/2017 o 12/31/2017	Date/Time Pre 5/31/2018 3:5	
	CAPI TAL REL	LATED COSTS				
Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFI TS DEPARTMENT (GROSS	COMMUNI CATI ONS (PHONE LI NE S)	MGMT INFO SYSTEMS (MANHOURS)	
			SALARI ES)			
	1.00	2.00	4.00	5. 01	5. 02	
194. 01 07951 LI FELI NE	0	0	603	3 0	113	194.01
194. 02 07952 PATI ENT TRANSPORT	0	0	0	0 0	0	194.02
194.0307954 OTHER NONREI MBURSABLE COST CENTERS	112, 316	0	C	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, Part I)	23, 065, 080	5, 362, 460	35, 747, 963	1, 589, 652	16, 539, 918	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	28. 581972	7. 719502	0. 389197	2, 254. 825532	5. 770346	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)			493, 228	51, 577	629, 634	204.00
205.00 Unit cost multiplier (Wkst. B, Part			0.005370	73. 158865	0. 219663	205. 00
206.00 NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207.00 NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

	FRANCI SCAN HEAL	TH_LAFAYETTE		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider C	F	eriod: rom 01/01/2017	Worksheet B-1	
			T	o 12/31/2017	Date/Time Pre 5/31/2018 3:5	
Cost Center Description	PURCHASI NG (COSTED REQ	ADMI TTI NG (GROSS CHAR	PATI ENT ACCOUNTI NG	Reconciliation	OTHER ADMI NI STRATI VE	
	UISI)	GES)	(GROSS CHAR		AND GENERAL	
	5.03	5.04	GES) 5.05	5A. 06	(ACCUM. COST) 5.06	
GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT			1			1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP						2.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 5. 01 01160 COMMUNI CATI ONS						4.00 5.01
5. 02 01140 MGMT I NFO SYSTEMS						5.02
5. 03 00550 PURCHASI NG 5. 04 00570 ADMI TTI NG	34, 421, 597 0	1, 173, 596, 803				5.03 5.04
5. 05 00580 PATI ENT ACCOUNTI NG	20	0	1, 173, 596, 803		055 744 040	5.05
5. 06 00560 OTHER ADMINISTRATIVE AND GENERAL 7. 00 00700 OPERATION OF PLANT	13, 839 0	0			255, 716, 049 16, 681, 091	5.06 7.00
8.00 00800 LAUNDRY & LINEN SERVICE	0	0	0	0	1, 887, 715	8.00
9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY	63, 135 2, 734	0 0		0	4, 427, 512 2, 995, 508	9.00 10.00
11.00 01100 CAFETERIA	0	0		0	2, 877, 622	11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON 14. 00 01400 CENTRAL SERVI CE & SUPPLY	0 579	0 0		0	4, 166, 295 1, 066, 986	13.00 14.00
	0	0		-	5, 166, 603	15.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY 17. 00 01700 SOCI AL SERVI CE	18 374	0 0			1, 918, 038 1, 037, 499	16.00 17.00
20. 00 02000 NURSI NG SCHOOL	5, 032	0	0	-	2, 948, 473	20.00
23. 00 02301 PHARMACY RESIDENCY 23. 01 02300 EMS EDUCATION	0	0 0			608, 495 447, 805	23. 00 23. 01
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	(007	FF 004 404	55 004 404			
30. 00 03000 ADULTS & PEDI ATRI CS 31. 00 03100 I NTENSI VE CARE UNI T	6, 897 1, 626	55, 294, 494 16, 515, 160			28, 092, 253 6, 133, 223	30. 00 31. 00
35.00 02060 NEONATAL INTENSIVE CARE UNIT	16, 453	13, 995, 022	13, 995, 022	0	3, 231, 186	
41. 00 04100 SUBPROVIDER - TRF 43. 00 04300 NURSERY	132	4, 659, 672 3, 512, 425			2, 384, 540 781, 761	41.00 43.00
ANCI LLARY SERVICE COST CENTERS	((4.020		1		12 070 400	F0 00
50.00 05000 OPERATING ROOM 51.00 05100 RECOVERY ROOM	664, 839 0	160, 171, 447 12, 889, 844		0	13, 878, 480 1, 258, 219	50.00 51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM 54. 00 05400 RADIOLOGY-DIAGNOSTIC	0	21, 807, 941		0	5, 149, 030 11, 258, 772	52.00 54.00
55. 00 03630 RADI OLOGY-DI AGNOSTI C	396, 944 0	79, 624, 339 9, 425, 701		0	822, 967	54.00 55.00
56. 00 05600 RADI OI SOTOPE 56. 01 03950 CARDI AC CATH LAB	0 199, 702	0 32, 841, 368	-	-	393, 554 2, 726, 099	56. 00 56. 01
57. 00 05700 CT SCAN	2, 375	68, 612, 295			1, 720, 932	
58. 00 05800 MRI 60. 00 06000 LABORATORY	153 673, 325	16, 355, 206 126, 139, 458			547, 933 11, 121, 917	58.00 60.00
65. 00 06500 RESPI RATORY THERAPY	140, 971	12, 290, 452			3, 831, 687	
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 0CCUPATI 0NAL THERAPY	29 0	16, 483, 280 10, 243, 554			6, 202, 589 2, 252, 266	
68. 00 06800 SPEECH PATHOLOGY	0	2, 248, 167		0	774, 313	
69. 00 06900 ELECTROCARDI OLOGY 70. 00 07000 ELECTROENCEPHALOGRAPHY	326	29, 943, 341 5, 375, 533		0	3, 118, 132 1, 312, 261	69. 00 70. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	14, 860, 729	129, 770, 114			16, 420, 780	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 73.00 07300 DRUGS CHARGED TO PATIENTS	17, 212, 835 0	94, 453, 257 127, 495, 596			18, 739, 691 10, 952, 138	72.00 73.00
73. 01 07301 DI ABETES CENTER	0	212, 480	212, 480		544, 735	
74.00 07400 RENAL DIALYSIS 76.98 07698 HYPERBARIC 0XYGEN THERAPY	0	2, 472, 754 933, 426			840, 648 279, 783	74.00 76.98
OUTPATIENT SERVICE COST CENTERS			T			
90. 00 09000 CLI NI C 91. 00 09100 EMERGENCY	39 15, 926	884, 955 66, 739, 014			1, 201, 029 12, 778, 420	90.00 91.00
91. 01 04950 WOUND CARE	0	8, 136, 522			2, 714, 127	91.01
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.01 09201 OBSERVATION BEDS (DISTINCT PART)	532	11, 247, 316	11, 247, 316	o	3, 614, 790	92.00 92.01
OTHER REIMBURSABLE COST CENTERS	1		1	-		
95. 00 09500 AMBULANCE SERVICES 101. 00 10100 HOME HEALTH AGENCY	3, 771 95, 059				4, 621, 036 5, 266, 816	
SPECIAL PURPOSE COST CENTERS						
113. 00 11300 I NTEREST EXPENSE 116. 00 11600 HOSPI CE	43, 107	11, 607, 916	11, 607, 916	0	3, 904, 938	113.00 116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)			1, 173, 596, 803		235, 100, 687	
NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	195, 653	190. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	16	0			16, 938, 446	192.00
194. 00 07950 MOB 194. 01 07951 LI FELI NE	1	0	0	0		194. 00 194. 01
194. 02 07952 PATI ENT TRANSPORT	0	0	0	0	264, 376	194. 02
194.03 07954 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	3, 210, 214	194.03

Health F	inancial Systems	FRANCI SCAN HEAL	TH LAFAYETTE		In Lie	u of Form CMS-:	2552-10
COST ALI	LOCATION - STATISTICAL BASIS		Provider CO		Peri od:	Worksheet B-1	
					From 01/01/2017 To 12/31/2017	Date/Time Pre 5/31/2018 3:5	
	Cost Center Description	PURCHASI NG	ADMI TTI NG	PATI ENT	Reconciliation	OTHER	
		(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	
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	2, 106, 089	100, 151	5, 785, 68	1	25, 823, 256	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0. 061185	0. 000085	0.004930	D	0. 100984	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	572, 845	95, 691	143, 798	3	2, 378, 077	204.00
205.00	Unit cost multiplier (Wkst. B, Part	0. 016642	0. 000082	0.000123	3	0. 009300	205. 00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00

	FRANCI SCAN HEAI				u of Form CMS-2	
COST ALLOCATION - STATISTICAL BASIS		Provider C	F	eriod: rom 01/01/2017	Worksheet B-1	
					Date/Time Pre 5/31/2018 3:5	
Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF	HOUSEKEEPI NG (SQUARE FEET)	DI ETARY (MEALS SERVED)	CAFETERIA (MANHOURS)	
	7.00	LAUNDRY) 8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS		0.00		10100	11100	
1.00 00100 CAP REL COSTS-BLDG & FIXT 2.00 00200 CAP REL COSTS-MVBLE EQUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 5.01 01160 COMMUNI CATIONS 5.02 01140 MGMT INFO SYSTEMS 5.03 00550 PURCHASING 5.04 00570 ADMITTING 5.05 00580 PATIENT ACCOUNTING 5.06 00560 OTHER ADMINISTRATIVE AND GENERAL 7.00 00700 OPERATION OF PLANT 8.00 00800 LAUNDRY & LINEN SERVICE 9.00 00900 HOUSEKEEPING 10.00 01000 DI ETARY 11.00 01300 NURSING ADMINISTRATION 14.00 01400 CENTRAL SERVICE & SUPPLY 15.00 01500 PHARMACY 16.00 01600 MEDI CAL RECORDS & LI BRARY 17.00 02000 NURSING SCHOOL 23.01 02301 PHARMACY RESI DENCY 23.01 023001 EDUCATION	582, 164 4, 692 13, 155 20, 355 14, 849 5, 500 9, 507 6, 105 4, 847 692 39, 081 6, 776 0	1, 251, 418 28, 941 35, 147 0 31, 717 0 0 0 0 0 0 0 0 0 0 0 0	452, 001 20, 355 14, 849 5, 500 9, 507 6, 105 4, 847 692 39, 081 6, 776	0 0 0 0 0 0 0 0	2, 265, 883 70, 461 22, 437 76, 244 2, 308 22, 276 56, 958 5, 483 4, 727	13.00 14.00 15.00 16.00 17.00 20.00
INPATI ENT ROUTI NE SERVI CE COST CENTERS 30.00 03000 ADULTS & PEDI ATRI CS 31.00 03100 INTENSI VE CARE UNI T 35.00 02060 NEONATAL INTENSI VE CARE UNI T 41.00 04100 SUBPROVI DER - I RF 43.00 04300 NURSERY	102, 049 11, 138 7, 888 12, 741 0	67, 298 28, 051 23, 757	11, 138 7, 888	21, 660	552, 693 117, 577 51, 988 32, 903 0	
ANCI LLARY SERVI CE COST CENTERS	32, 832	219, 475	32, 832	0	123, 979	50.00
51.00 05100 RECOVERY ROOM	3, 625	40, 359	3, 625	0	16, 725	51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM 54. 00 05400 RADI 0LOGY-DI AGNOSTI C	0 25, 285		0 25, 285	0	0 119, 017	52.00 54.00
55. 00 03630 RADI OLOGY-THERAPEUTI C	1, 343	0	1, 343	0	10, 218	55.00
56. 00 05600 RADI OI SOTOPE	246			0	5, 632	
56. 01 03950 CARDI AC CATH LAB 57. 00 05700 CT SCAN	7, 275 3, 975				33, 535 20, 389	
58. 00 05800 MRI	1, 133				5, 594	58.00
60. 00 06000 LABORATORY	17, 815			0	0	60.00
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	2,841			0	69, 586	
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 0CCUPATI ONAL THERAPY	11, 654 5, 654			0	122, 804 34, 919	
68. 00 06800 SPEECH PATHOLOGY	3, 101		3, 101	0	12, 071	
69. 00 06900 ELECTROCARDI OLOGY	7, 221				45, 169	
70.00 07000 ELECTROENCEPHALOGRAPHY 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	4, 519 0		4, 519 0		19, 318 0	70.00 71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73. 01 07301 DI ABETES CENTER	0	-	0	0	9, 691	73.01
74.00 07400 RENAL DIALYSIS 76.98 07698 HYPERBARIC OXYGEN THERAPY	1, 716 3, 546		1, 716 3, 546		3, 896 39	1
OUTPATIENT SERVICE COST CENTERS	0,010		0,010			/0./0
90. 00 09000 CLINIC	0	-		-	23, 396	
91. 00 09100 EMERGENCY 91. 01 04950 WOUND CARE	26, 469 13, 972				233, 132 38, 532	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	13, 772		13, 772	0	30, 332	92.00
92. 01 09201 OBSERVATI ON BEDS (DI STINCT PART) OTHER REI MBURSABLE COST CENTERS	6, 170	0	6, 170	0	59, 601	
95. 00 09500 AMBULANCE SERVICES	7, 508	0	7, 508	0	106, 962	95.00
101.00 10100 HOME HEALTH AGENCY	0	0	0	0	73, 851	101.00
SPECIAL PURPOSE COST CENTERS 113. 00 11300 I NTEREST EXPENSE						113.00
116. 00 11600 HOSPI CE	3, 809	0	3, 809	0	42, 925	
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	451, 084				2, 247, 036	
NONREI MBURSABLE COST CENTERS	0.000		0.000		2,000	100.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	2, 323 16, 441		2, 323 16, 441	0		190. 00 192. 00
194. 00 07950 MOB	0	0	0	0		192.00
194. 01 07951 LI FELI NE	0	0	0	0	113	194.01
194. 02 07952 PATI ENT TRANSPORT 194. 03 07954 OTHER NONREI MBURSABLE COST CENTERS	0 112, 316	0	0	0		194. 02 194. 03
	1 12,310	. 0	ı 0	u u	0	1.71.00

Heal th F	inancial Systems	FRANCI SCAN HEAL	TH LAFAYETTE		In Lie	u of Form CMS-	2552-10
COST ALI	LOCATION - STATISTICAL BASIS		Provider C		Period:	Worksheet B-1	
					From 01/01/2017 Fo 12/31/2017	Date/Time Pre 5/31/2018 3:5	
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG		CAFETERI A	
		PLANT	LINEN SERVICE	(SQUARE FEET)	(MEALS SERVED)	(MANHOURS)	
		(SQUARE FEET)	•				
			LAUNDRY)				
		7.00	8.00	9.00	10.00	11.00	
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B,	18, 365, 614	2, 226, 363	5, 341, 111	1 4, 243, 204	3, 812, 125	202.00
	Part I)						
203.00	Unit cost multiplier (Wkst. B, Part I)	31. 547148	1.779072	11. 816591	1 19. 023299	1. 682402	203.00
204.00	Cost to be allocated (per Wkst. B,	4, 059, 329	247, 692	630, 632	2 981, 566	727, 756	204.00
	Part II)						
205.00	Unit cost multiplier (Wkst. B, Part	6. 972827	0. 197929	1. 395200	4. 400595	0. 321180	205.00
	11)						
206.00	NAHE adjustment amount to be allocated						206.00
	(per Wkst. B-2)						
207.00	NAHE unit cost multiplier (Wkst. D,						207.00
	Parts III and IV)						1

	Financial Systems LLOCATION - STATISTICAL BASIS	FRANCISCAN HEAL	TH LAFAYETTE Provider CO	CN: 15-0109	Period:	u of Form CMS-2 Worksheet B-1	
					From 01/01/2017 To 12/31/2017	Date/Time Pre 5/31/2018 3:5	
	Cost Center Description	NURSI NG ADMI NI STRATI ON	CENTRAL SERVICE &	PHARMACY (COSTED	MEDI CAL RECORDS &	SOCI AL SERVI CE	
		(DI RECT NRS	SUPPLY (COSTED REQ	REQUIS.)	LI BRARY (GROSS CHAR	(TIME SPENT)	
		I NG)	UISI)	15.00	GES)	17.00	
	GENERAL SERVICE COST CENTERS	13.00	14.00	15.00	16.00	17.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT						2.00
4.00 5.01	01160 COMMUNI CATI ONS						4.00 5.01
5.02	01140 MGMT INFO SYSTEMS						5. 02
5.03	00550 PURCHASI NG						5.03
5.04	00570 ADMI TTI NG						5.04
5.05 5.06	00580 PATIENT ACCOUNTING 00560 OTHER ADMINISTRATIVE AND GENERAL						5.05 5.06
7.00	00700 OPERATION OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPI NG 01000 DI ETARY						9.00
10.00 11.00	01100 CAFETERIA						10.00
13.00	01300 NURSI NG ADMI NI STRATI ON	1, 747, 888					13.00
14.00	01400 CENTRAL SERVICE & SUPPLY	0	34, 341, 290				14.00
15.00		0	0		00		15.00
16.00 17.00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	0	18 374		0 1, 173, 596, 803	48, 142	16.00 17.00
20.00	02000 NURSI NG SCHOOL	0	5, 032		0 0	0	20.00
23.00	02301 PHARMACY RESIDENCY	0	0		0 0	0	
23.01	02300 EMS EDUCATION	0	79		0 0	0	23.01
30.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	552, 693	6, 897		0 55, 294, 494	33, 999	30.00
31.00	03100 I NTENSI VE CARE UNI T	117, 577	1, 626		0 16, 515, 160		•
35.00	02060 NEONATAL INTENSIVE CARE UNIT	51, 988	16, 453		0 13, 995, 022		•
41.00 43.00	04100 SUBPROVIDER - IRF 04300 NURSERY	32, 903 0	132 0		0 4, 659, 672 0 3, 512, 425		•
43.00	ANCI LLARY SERVI CE COST CENTERS	<u> </u>	0		0 3, 512, 425	3, 632	43.00
50.00	05000 OPERATI NG ROOM	123, 979	664, 839		0 160, 171, 447	0	50.00
51.00	05100 RECOVERY ROOM	16, 725	0		0 12, 889, 844		51.00
52.00 54.00	05200 DELIVERY ROOM & LABOR ROOM 05400 RADIOLOGY-DIAGNOSTIC	0	0 396, 944		0 21, 807, 941 0 79, 624, 339	0	52.00 54.00
55.00	03630 RADI OLOGY - THERAPEUTI C	0	0 390, 944		0 9, 425, 701	0	55.00
56.00	05600 RADI OI SOTOPE	5, 632	0		0 0	0	56.00
56.01	03950 CARDI AC CATH LAB	33, 535	199, 702		0 32, 841, 368		56.01
57.00 58.00	05700 CT SCAN 05800 MRI	0	2, 375 153		0 68, 612, 295 0 16, 355, 206		57.00 58.00
60.00	06000 LABORATORY	0	673, 325		0 126, 139, 458		•
65.00	06500 RESPI RATORY THERAPY	69, 586	140, 971		0 12, 290, 452		
66.00	06600 PHYSI CAL THERAPY	122, 804	29		0 16, 483, 280		
67.00 68.00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	34, 919 12, 071	0		0 10, 243, 554 0 2, 248, 167	0	67.00 68.00
69.00	06900 ELECTROCARDI OLOGY	45, 169	326		0 29, 943, 341	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	19, 318	0		0 5, 375, 533		70.00
71.00 72.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	0	14, 860, 729 17, 212, 835		0 129, 770, 114 0 94, 453, 257		71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		00 127, 495, 596		73.00
73.01	07301 DI ABETES CENTER	9, 691	0		0 212, 480		73.01
74.00	07400 RENAL DI ALYSI S	3, 896	0		0 2, 472, 754		74.00
76. 98	07698 HYPERBARI C OXYGEN THERAPY OUTPATI ENT SERVI CE COST CENTERS	0	0		0 933, 426	0	76. 98
90.00	09000 CLINIC	0	39		0 884, 955	0	90.00
91.00	09100 EMERGENCY	233, 132	15, 926		0 66, 739, 014	0	91.00
91.01	04950 WOUND CARE	38, 532	0		0 8, 136, 522	0	
92.00 92.01	09200 OBSERVATION BEDS (NON-DISTINCT PART 09201 OBSERVATION BEDS (DISTINCT PART)	0	532		0 11, 247, 316	0	92.00 92.01
72.01	OTHER REIMBURSABLE COST CENTERS	<u> </u>	552		0 11,247,310		/2.01
	09500 AMBULANCE SERVI CES	106, 962	3, 771		0 14, 162, 017		•
101.00	10100 HOME HEALTH AGENCY	73, 851	95, 059		0 7, 052, 737	0	101.00
113 00	SPECIAL PURPOSE COST CENTERS						113.00
	11600 H0SPI CE	42, 925	43, 107		0 11, 607, 916	0	116.00
118.00		1, 747, 888	34, 341, 273	1	00 1, 173, 596, 803	48, 142	118. 00
100.00	NONREI MBURSABLE COST CENTERS		0		0	<u>^</u>	100.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	0	0 16		0 0		190. 00 192. 00
	07950 MOB	0	1		0 0		194.00
	07951 LI FELI NE	0	0		0 0		194.01
194.02	07952 PATIENT TRANSPORT	0	0		0 0	0	194.02

Health Fina	ancial Systems	FRANCI SCAN HEAL	TH LAFAYETTE		In Lie	eu of Form CMS-:	2552-10
COST ALLOC	ATION - STATISTICAL BASIS		Provider CC		Peri od:	Worksheet B-1	
					rom 01/01/2017 To 12/31/2017	Date/Time Pre 5/31/2018 3:5	
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY		SOCIAL SERVICE	
		ADMI NI STRATI ON		(COSTED	RECORDS &		
		(DI DEAT NDC	SUPPLY	REQUIS.)	LIBRARY	(TIME SPENT)	
		(DI RECT_NRS	(COSTED REQ		(GROSS CHAR		
		I NG) 13.00	<u>UISI)</u> 14.00	15.00	GES) 16.00	17.00	
104 02 0705	4 OTHER NONREIMBURSABLE COST CENTERS	13.00	14.00	15.00	10.00		194.03
200.00	Cross Foot Adjustments	0	0	(0	0	200.00
200.00	Negative Cost Centers						200.00
201.00	8	4 044 049	1 401 140	4 001 250	2, 325, 797	1, 209, 773	
202.00	Cost to be allocated (per Wkst. B, Part I)	4, 944, 068	1, 681, 169	6, 081, 355	2, 325, 191	1, 209, 773	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	2. 828595	0. 048955	60, 813. 550000	0. 001982	25. 129263	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	336, 661	455, 653	379, 034	1 236, 938	56, 606	204.00
205.00	Unit cost multiplier (Wkst. B, Part	0. 192610	0. 013268	3, 790. 340000	0. 000202	1. 175813	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00
I		1 1		1	1	I	I

	i nanci al Systems OCATI ON - STATI STI CAL BASI S	FRANCI SCAN HEAL	Provider C		Peri od:	u of Form CMS-2552 Worksheet B-1
					From 01/01/2017 To 12/31/2017	Date/Time Prepare
						5/31/2018 3:53 pm
	Cost Center Description	NURSING SCHOOL	PHARMACY RESI DENCY	EMS EDUCATION (ASSIGNED	N	
		(ASSI GNED	(ASSI GNED	TI ME)		
		TIME)	TIME)			
CE		20.00	23.00	23.01		
	ENERAL SERVICE COST CENTERS					1
	D200 CAP REL COSTS-MVBLE EQUIP					2
	0400 EMPLOYEE BENEFITS DEPARTMENT					4
	1160 COMMUNI CATI ONS					5
	1140 MGMT INFO SYSTEMS					5.
	D550 PURCHASI NG D570 ADMI TTI NG					5
	D580 PATIENT ACCOUNTING					5
	0560 OTHER ADMINISTRATIVE AND GENERAL					5
1	0700 OPERATION OF PLANT					7.
	D800 LAUNDRY & LINEN SERVICE D900 HOUSEKEEPING					8
	1000 DI ETARY					9.
	1100 CAFETERI A					11
00 01	1300 NURSING ADMINISTRATION					13
	1400 CENTRAL SERVICE & SUPPLY					14
						15
	1600 MEDICAL RECORDS & LIBRARY 1700 SOCIAL SERVICE					16
	2000 NURSI NG SCHOOL	100				20
	2301 PHARMACY RESIDENCY		100			23
01 02	2300 EMS EDUCATION			10	0	23
	NPATIENT ROUTINE SERVICE COST CENTERS	1			_1	
1	3000 ADULTS & PEDIATRICS	100	0		0	30
1	3100 INTENSIVE CARE UNIT 2060 NEONATAL INTENSIVE CARE UNIT	0	0		0	31
	4100 SUBPROVIDER - IRF	0	0		0	41
	4300 NURSERY	0	0		0	43
	ICI LLARY SERVI CE COST CENTERS					
	5000 OPERATING ROOM	0	0		0	50
	5100 RECOVERY ROOM 5200 DELIVERY ROOM & LABOR ROOM	0	0		0	51
	5400 RADI OLOGY – DI AGNOSTI C	0	0		0	54
	3630 RADI OLOGY-THERAPEUTI C	0	0		0	55
00 05	5600 RADI OI SOTOPE	0	0		0	56
	3950 CARDI AC CATH LAB	0	0		0	56
	5700 CT SCAN	0	0		0	57
	5800 MRI 5000 LABORATORY	0	0		0	58
	5500 RESPI RATORY THERAPY	0	0		0	65
	5600 PHYSI CAL THERAPY	0	0		0	66
	5700 OCCUPATI ONAL THERAPY	0	0		0	67
	5800 SPEECH PATHOLOGY	0	0		0	68
	5900 ELECTROCARDI OLOGY 7000 ELECTROENCEPHALOGRAPHY	0	0		0	69 70
	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0	70
	7200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0	72
	7300 DRUGS CHARGED TO PATIENTS	0	100		0	73
	7301 DI ABETES CENTER	0	0		0	73
	7400 RENAL DIALYSIS	0	0		0	74
	7698 HYPERBARI C OXYGEN THERAPY JTPATI ENT SERVI CE COST CENTERS	0	0		0	76
	2000 CLINIC	0	0		0	90
00 109	P100 EMERGENCY	0	0	10	-	91
			0		0	91
00 09 01 04	1950 WOUND CARE	9				92
00 09 01 04 00 09	4950 WOUND CARE 9200 OBSERVATION BEDS (NON-DISTINCT PART		-			
00 09 01 04 00 09 01 <u>09</u>	4950 WOUND CARE 9200 OBSERVATION BEDS (NON-DISTINCT PART 9201 OBSERVATION BEDS (DISTINCT PART)	0	0		0	
00 09 01 04 00 09 01 09 01 09	4950 WOUND CARE 9200 OBSERVATION BEDS (NON-DISTINCT PART 9201 OBSERVATION BEDS (DISTINCT PART) THER REIMBURSABLE COST CENTERS		0		0	92
00 09 01 04 00 09 01 09 01 09 01 09	4950 WOUND CARE 9200 OBSERVATION BEDS (NON-DISTINCT PART 9201 OBSERVATION BEDS (DISTINCT PART)		0		0 0 0	92
00 09 01 04 00 09 01 <u>09</u> 01 <u>09</u> 01 09 01 09	4950 WOUND CARE 9200 OBSERVATI ON BEDS (NON-DI STINCT PART 9201 OBSERVATI ON BEDS (DI STINCT PART) FHER REI MBURSABLE COST CENTERS 9500 AMBULANCE SERVICES					92
00 09 01 04 00 09 01 09 01 09 01 09 . 00 10 SP . 00 11	4950 WOUND CARE 9200 OBSERVATI ON BEDS (NON-DI STINCT PART) 2201 OBSERVATI ON BEDS (DI STINCT PART) THER REI MBURSABLE COST CENTERS 9500 9500 AMBULANCE SERVICES 9100 HOME HEALTH AGENCY PECIAL PURPOSE COST CENTERS 1300 1NTEREST EXPENSE 1400	0			<u>o</u>	92 95 101 113
00 09 01 04 00 09 01 09 01 09 01 09 00 09 . 00 10 SF . 00 11 . 00 11	4950 WOUND CARE 9200 OBSERVATI ON BEDS (NON-DI STINCT PART) 9201 OBSERVATI ON BEDS (DI STINCT PART) THER REIMBURSABLE COST CENTERS 9500 9500 AMBULANCE SERVICES 9100 HOME HEALTH AGENCY 9201 DITERS 9201 NTEREST EXPENSE 1600 HOSPICE	0	0		0	92 95 101 113 116
00 09 01 04 00 09 01 09 01 09 01 09 00 09 . 00 10 SF . 00 11 . 00 11 . 00	4950 WOUND CARE 9200 OBSERVATI ON BEDS (NON-DI STINCT PART) 9201 OBSERVATI ON BEDS (DI STINCT PART) THER REIMBURSABLE COST CENTERS 9500 AMBULANCE SERVICES 9100 HOME HEALTH AGENCY 9201 INTEREST EXPENSE 1300 INTEREST EXPENSE 1600 HOSPICE SUBTOTALS (SUM OF LINES 1 through 117)	0	0		0	92 95 101 113 116
00 09 01 04 00 09 01 09 01 09 00 09 . 00 10 . 00 11 . 00 11 . 00 NC	4950 WOUND CARE 9200 OBSERVATI ON BEDS (NON-DI STINCT PART) 9201 OBSERVATI ON BEDS (DI STINCT PART) THER REI MBURSABLE COST CENTERS 9500 AMBULANCE SERVI CES 9100 HOME HEALTH AGENCY 9201 OBSPRIATION EST EXPENSE 1000 HORE FEST EXPENSE 1000 HORPSPICE 9201 BUBTOTALS (SUM OF LINES 1 through 117) 9000 MBURSABLE COST CENTERS	0	0		0	92 95 101 113 116 118
00 09 01 04 00 09 01 09 00 09 00 09 00 09 00 09 00 09 0 00 09 0 09 0 0 0 0 09 0 0 0 0 0	4950 WOUND CARE 9200 OBSERVATI ON BEDS (NON-DI STINCT PART) 9201 OBSERVATI ON BEDS (DI STINCT PART) THER REIMBURSABLE COST CENTERS 9500 AMBULANCE SERVICES 9100 HOME HEALTH AGENCY 9201 INTEREST EXPENSE 1600 HOSPICE 91600 HOSPICE 91700 SUBTOTALS (SUM OF LINES 1 through 117) 9000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0	92 95 101 113 116 118 1190
00 09 01 04 00 09 01 09 00 09 00 09 00 09 00 09 00 10 SF 00 11 00 11 00 11 00 11 00 11 00 19 00 19 00 19	4950 WOUND CARE 9200 OBSERVATI ON BEDS (NON-DI STINCT PART) 9201 OBSERVATI ON BEDS (DI STINCT PART) THER REI MBURSABLE COST CENTERS 9500 AMBULANCE SERVI CES 9100 HOME HEALTH AGENCY 9201 OBSPRIATION EST EXPENSE 1000 HORE FEST EXPENSE 1000 HORPSPICE 9201 BUBTOTALS (SUM OF LINES 1 through 117) 9000 MBURSABLE COST CENTERS	0	0		0	92 95 101 113 116 118 118 190 192
00 09 01 04 00 09 01 09 01 09 01 09 01 09 01 00 09 . 00 10 . 00 11 . 00 11 . 00 11 . 00 19 . 00 19 . 00 07 . 00 07 . 01 07	4950 WOUND CARE 9200 OBSERVATION BEDS (NON-DISTINCT PART) 10BSERVATION BEDS (DISTINCT PART) THER REIMBURSABLE COST CENTERS 9500 AMBULANCE SERVICES 9100 HOME HEALTH AGENCY PECIAL PURPOSE COST CENTERS 1300 INTEREST EXPENSE 1600 HOSPICE SUBTOTALS (SUM OF LINES 1 through 117) DNREI MBURSABLE COST CENTERS 9000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 9200 PHYSICIANS' PRIVATE OFFICES	0	0		0	92 92 95 101 113 116 118 118 190 192 194 194 194

		FRANCI SCAN HEAL				u of Form CMS-2552-
COST ALL	OCATION - STATISTICAL BASIS		Provider C		Peri od:	Worksheet B-1
					From 01/01/2017 To 12/31/2017	Date/Time Prepared 5/31/2018 3:53 pm
	Cost Center Description	NURSING SCHOOL	PHARMACY	EMS EDUCATIO	N	
			RESI DENCY	(ASSI GNED		
		(ASSI GNED	(ASSI GNED	TIME)		
		TIME)	TIME)			
		20.00	23.00	23.01		
200.00	Cross Foot Adjustments					200.
201.00	Negative Cost Centers					201.
202.00	Cost to be allocated (per Wkst. B,	5, 036, 992	973, 000	500, 98	33	202.
	Part I)					
203.00	Unit cost multiplier (Wkst. B, Part I)	50, 369. 920000	9, 730. 000000	5, 009. 83000	00	203.
204.00	Cost to be allocated (per Wkst. B,	1, 816, 057	312, 607	8, 23	38	204.
	Part II)					
205.00	Unit cost multiplier (Wkst. B, Part	18, 160. 570000	3, 126. 070000	82. 38000	00	205.
	11)					
206.00	NAHE adjustment amount to be allocated	0	0		0	206.
	(per Wkst. B-2)					
207.00	NAHE unit cost multiplier (Wkst. D,	0. 000000	0. 000000	0.00000	00	207.
	Parts III and IV)					

MPUTATION OF RATIO OF COSTS TO CHARGES	FRANCI SCAN HEAL	Provider C	CN: 15-0109	Peri od:	Worksheet C	2552-
				From 01/01/2017	Part I	
				To 12/31/2017	Date/Time Pre 5/31/2018 3:5	pared
		Title	xviii	Hospi tal	PPS	3 pili
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	(from Wkst. B,	Adj.		Di sal I owance		
	Part I, col.					
	26)	2.00	2.00	4.00	F 00	
INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
. 00 03000 ADULTS & PEDIATRICS	48, 191, 041		48, 191, 0	41 0	48, 191, 041	30. (
00 03100 I NTENSI VE CARE UNI T	8, 449, 327		8, 449, 3			
00 02060 NEONATAL INTENSIVE CARE UNIT	4, 282, 387		4, 282, 3	-		
00 04100 SUBPROVIDER - IRF	3, 728, 156		3, 728, 1			
00 04300 NURSERY	1, 040, 954		1, 040, 9			
ANCI LLARY SERVICE COST CENTERS					L	
. 00 05000 OPERATI NG ROOM	18, 003, 167		18, 003, 1	67 0	18, 003, 167	50.
. 00 05100 RECOVERY ROOM	1, 715, 268		1, 715, 2	68 0	1, 715, 268	51.
. 00 05200 DELIVERY ROOM & LABOR ROOM	5, 799, 913		5, 799, 9			52.
. 00 05400 RADI OLOGY-DI AGNOSTI C	14, 006, 670		14, 006, 6			
. 00 03630 RADI OLOGY-THERAPEUTI C	1, 000, 184		1, 000, 1			
. 00 05600 RADI OI SOTOPE	469, 371		469, 3		469, 371	
01 03950 CARDI AC CATH LAB	3, 552, 061		3, 552, 0			
. 00 05700 CT SCAN	2, 237, 498		2, 237, 4			
. 00 05800 MRI	694, 230		694, 2			
00 06000 LABORATORY	13, 314, 744		13, 314, 7			
00 06500 RESPIRATORY THERAPY	4, 703, 608					
00 06600 PHYSI CAL THERAPY 00 06700 OCCUPATI ONAL THERAPY	7, 951, 887					
	2, 902, 711	-	_,,		2, 902, 711	
00 06800 SPEECH PATHOLOGY 00 06900 ELECTROCARDI OLOGY	1, 045, 885 4, 021, 871	0	1, 045, 8 4, 021, 8		1, 045, 885	
. 00 07000 ELECTROCARDI OLOGY	1, 738, 537		1, 738, 5			
. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	19,063,727		19,063,7			
. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	21, 661, 953		21, 661, 9			
00 07300 DRUGS CHARGED TO PATIENTS	19, 365, 180		19, 365, 1			
01 07301 DI ABETES CENTER	643, 882		643, 8			
00 07400 RENAL DIALYSIS	1, 022, 428		1, 022, 4			
98 07698 HYPERBARI C OXYGEN THERAPY	463, 721		463, 7			
OUTPATIENT SERVICE COST CENTERS			1			
. 00 09000 CLINIC	1, 363, 431		1, 363, 4	31 0	1, 363, 431	90.
. 00 09100 EMERGENCY	17, 108, 017		17, 108, 0	17 0	17, 108, 017	91.
. 01 04950 WOUND CARE	3, 784, 032		3, 784, 0	32 0	3, 784, 032	91.
. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0			0	0	1
. 01 09201 OBSERVATION BEDS (DISTINCT PART)	4, 369, 971		4, 369, 9	71 0	4, 369, 971	92.
OTHER REIMBURSABLE COST CENTERS	E 001 651		F 66 7	-	E 004 653	1
00 09500 AMBULANCE SERVICES	5, 924, 021		5, 924, 0	-	-, ,	
1.00 10100 HOME HEALTH AGENCY	6, 150, 455		6, 150, 4	55	6, 150, 455	101.
SPECIAL PURPOSE COST CENTERS			1			1110
3. 00 11300 I NTEREST EXPENSE 6. 00 11600 H0SPI CE	1 402 107		1 400 1	70	1 402 107	113.
	4, 683, 197	C	4, 683, 1		4, 683, 197	
	254, 453, 485		254, 453, 4	0		200.
		C	254 452 4	-		
2.00 Total (see instructions)	254, 453, 485		254, 453, 4	0 0	254, 453, 485	202

COMPUTAT	ION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-0109	Period: From 01/01/2017 To 12/31/2017	Worksheet C Part I Date/Time Pre 5/31/2018 3:5	pared: 3 pm
		-		XVIII	Hospi tal	PPS	
	Cost Center Description	I npati ent	Charges Outpatient	Total (col. + col. 7)	6 Cost or Other Ratio	TEFRA I npati ent Rati o	
		6.00	7.00	8.00	9.00	10.00	
I N	NPATIENT ROUTINE SERVICE COST CENTERS			•			
30.00 03	3000 ADULTS & PEDI ATRI CS	55, 294, 494		55, 294, 49	94		30.00
31.00 03	3100 INTENSIVE CARE UNIT	16, 515, 160		16, 515, 16			31.00
35.00 02	2060 NEONATAL INTENSIVE CARE UNIT	13, 995, 022		13, 995, 02	22		35.00
	4100 SUBPROVI DER – I RF	4, 659, 672		4, 659, 67	/2		41.00
	4300 NURSERY	3, 512, 425		3, 512, 42	25		43.00
	ICI LLARY SERVICE COST CENTERS	-ii					
	5000 OPERATING ROOM	79, 041, 968	81, 129, 479			0.00000	
	5100 RECOVERY ROOM	5, 974, 284	6, 915, 560			0.00000	
	5200 DELIVERY ROOM & LABOR ROOM	21, 119, 485	688, 456			0.00000	
	5400 RADI OLOGY-DI AGNOSTI C	14, 705, 203	64, 919, 136			0.000000	
	3630 RADI OLOGY-THERAPEUTI C	2, 172, 658	7, 253, 043	9, 425, 70		0.000000	
	5600 RADI OI SOTOPE	0	0		0 0.000000	0.000000	
	3950 CARDIAC CATH LAB	15, 474, 635	17, 366, 733			0.000000	
	5700 CT SCAN	21, 600, 112	47, 012, 183			0.000000	
	5800 MRI	5, 126, 691	11, 228, 515			0.000000	•
	5000 LABORATORY	54, 101, 867	72, 037, 591			0.000000	
	5500 RESPI RATORY THERAPY	10, 658, 674	1, 631, 778			0.000000	
	5600 PHYSI CAL THERAPY	6, 757, 281	9, 725, 999			0.000000	•
	5700 OCCUPATIONAL THERAPY	6, 746, 890	3, 496, 664			0.000000	
	5800 SPEECH PATHOLOGY	1, 255, 874	992, 293			0.000000	
		10, 174, 368	19, 768, 973			0.000000	
	7000 ELECTROENCEPHALOGRAPHY	962,040	4, 413, 493			0.000000	
	7100 MEDI CAL SUPPLIES CHARGED TO PATIENT	71, 400, 549	58, 369, 565			0.000000	
	7200 IMPL. DEV. CHARGED TO PATIENTS 7300 DRUGS CHARGED TO PATIENTS	72, 536, 825	21, 916, 432			0.000000	
	7300 DRUGS CHARGED TO PATTENTS 7301 DI ABETES CENTER	68, 212, 795	59, 282, 801			0. 000000 0. 000000	
	7301 DI ABETES CENTER 7400 RENAL DI ALYSI S	428	212, 052				
	7400 RENAL DIALYSIS 7698 HYPERBARIC OXYGEN THERAPY	1, 862, 186	610, 568			0. 000000 0. 000000	
	JTPATIENT SERVICE COST CENTERS	4, 544	928, 882	933, 42	0. 496795	0.00000	76.98
	2000 CLINIC	0	884, 955	884, 95	1. 540678	0. 000000	90.00
	P100 EMERGENCY	10, 281, 791	56, 457, 223			0.000000	•
	4950 WOUND CARE	10, 201, 7,71	8, 136, 522			0. 000000	
	2200 OBSERVATION BEDS (NON-DISTINCT PART	0	0, 130, 322	0, 130, 32	0 0. 000000	0.000000	
	9201 OBSERVATION BEDS (NON-DISTINCT PART	3, 257, 896	7, 989, 420	11, 247, 31		0.000000	•
	THER REIMBURSABLE COST CENTERS	5,257,070	7, 909, 420	11, 247, 3	0. 300333	0.000000	72.0
	2500 AMBULANCE SERVICES	0	14, 162, 017	14, 162, 01	0, 418303	0.00000	95.00
	D100 HOME HEALTH AGENCY	12,078	7, 040, 659			0.000000	101.00
	PECIAL PURPOSE COST CENTERS	12,070	7,010,007	7,002,70	··		1.01.00
	1300 I NTEREST EXPENSE	1					113.00
	1600 HOSPI CE	0	11, 607, 916	11, 607, 91	6		116.00
200.00	Subtotal (see instructions)	577, 417, 895		1, 173, 596, 80			200.00
201.00	Less Observation Beds	3,, 0.0	2,0,0, ,00				201.0
202.00	Total (see instructions)	577, 417, 895		1, 173, 596, 80			202. 0

Heal th	Financial Systems	FRANCI SCAN HEALT	H_LAFAYETTE	In Lie	u of Form CMS-	2552-10
COMPUT	ATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0109	Peri od: From 01/01/2017 To 12/31/2017	Worksheet C Part I Date/Time Pre 5/31/2018 3:5	
			Title XVIII	Hospi tal	PPS	
	Cost Center Description	PPS Inpatient				
		Ratio				
		11.00				
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS					30.00
	03100 INTENSIVE CARE UNIT					31.00
35.00	02060 NEONATAL INTENSIVE CARE UNIT					35.00
41.00	04100 SUBPROVIDER - IRF					41.00
43.00	04300 NURSERY					43.00
	ANCILLARY SERVICE COST CENTERS					1
50.00	05000 OPERATING ROOM	0. 112399				50.00
51.00	05100 RECOVERY ROOM	0. 133071				51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 265954				52.00
	05400 RADI OLOGY-DI AGNOSTI C	0. 175909				54.00
55.00	03630 RADI OLOGY-THERAPEUTI C	0. 106112				55.00
	05600 RADI OI SOTOPE	0.000000				56.00
	03950 CARDI AC CATH LAB	0. 108158				56.01
	05700 CT SCAN	0. 032611				57.00
	05800 MRI	0. 042447				58.00
	06000 LABORATORY	0. 105556				60.00
	06500 RESPI RATORY THERAPY	0. 382704				65.00
	06600 PHYSI CAL THERAPY	0. 482421				66.00
	06700 OCCUPATI ONAL THERAPY	0. 283370				67.00
	06800 SPEECH PATHOLOGY	0. 465217				68.00
	06900 ELECTROCARDI OLOGY	0. 134316				69.00
	07000 ELECTROENCEPHALOGRAPHY	0. 323417				70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 146904				71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 229340				72.00
	07300 DRUGS CHARGED TO PATIENTS	0. 151889				73.00
	07301 DI ABETES CENTER	3. 030318				73.00
	07400 RENAL DI ALYSI S	0. 413477				74.00
	07698 HYPERBARI C OXYGEN THERAPY	0. 496795				76.98
70. 70	OUTPATIENT SERVICE COST CENTERS	0.490793				70.70
90.00	09000 CLINIC	1. 540678				90.00
	09100 EMERGENCY	0. 256342				90.00
	04950 WOUND CARE	0. 465068				91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000				92.00
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	0. 388535				92.01
05 00	OTHER REI MBURSABLE COST CENTERS	0.440000				1 05 00
	09500 AMBULANCE SERVICES	0. 418303				95.00
101.00	10100 HOME HEALTH AGENCY					101.00
440.00	SPECIAL PURPOSE COST CENTERS	1				110 00
	11300 INTEREST EXPENSE					113.00
	11600 HOSPI CE					116.00
200.00	Subtotal (see instructions)					200.00
201.00						201.00
202.00	Total (see instructions)	1				202.00

ealth Financial Systems	FRANCI SCAN HEAL		01 45 0400		u of Form CMS-	2332-1
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C	UN: 15-0109	Period: From 01/01/2017	Worksheet C Part I	
				To 12/31/2017	Date/Time Pre	pared:
			e XIX	Hospi tal	5/31/2018 3:5 Cost	3 pm
				Costs	COST	
Cost Center Description	Total Cost	Therapy Limit	Total Costs		Total Costs	
	(from Wkst. B,	Adj .		Di sal I owance		
	Part I, col.					
	26)	2.00	2.00	4.00	F 00	+
INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	+
0. 00 03000 ADULTS & PEDIATRICS	48, 191, 041		48, 191, 04	41 0	48, 191, 041	30.00
1. 00 03100 I NTENSI VE CARE UNI T	8, 449, 327		8, 449, 3		8, 449, 327	
15. 00 02060 NEONATAL INTENSIVE CARE UNIT	4, 282, 387		4, 282, 3		4, 282, 387	
1. 00 04100 SUBPROVI DER – I RF	3, 728, 156		3, 728, 1		3, 728, 156	
3. 00 04300 NURSERY	1, 040, 954		1, 040, 9		1, 040, 954	
ANCILLARY SERVICE COST CENTERS			-			
0. 00 05000 OPERATI NG ROOM	18, 003, 167		18, 003, 10	67 0	18, 003, 167	50.00
1.00 05100 RECOVERY ROOM	1, 715, 268		1, 715, 20		1, 715, 268	
2.00 05200 DELIVERY ROOM & LABOR ROOM	5, 799, 913		5, 799, 9		5, 799, 913	
4.00 05400 RADI OLOGY-DI AGNOSTI C	14, 006, 670		14, 006, 6		14, 006, 670	
55.00 03630 RADI OLOGY-THERAPEUTI C	1,000,184		1,000,1		1,000,184	
6. 00 05600 RADI OI SOTOPE	469, 371		469, 3		469, 371	
6. 01 03950 CARDI AC CATH LAB	3, 552, 061		3, 552, 0		3, 552, 061	
77. 00 05700 CT_SCAN 38. 00 05800 MRI	2, 237, 498 694, 230		2, 237, 49		2, 237, 498 694, 230	
0. 00 06000 LABORATORY	13, 314, 744		13, 314, 7		13, 314, 744	
5. 00 06500 RESPIRATORY THERAPY	4, 703, 608	0			4, 703, 608	
6. 00 06600 PHYSI CAL THERAPY	7, 951, 887	0			7, 951, 887	
7. 00 06700 OCCUPATI ONAL THERAPY	2, 902, 711	0			2, 902, 711	
8.00 06800 SPEECH PATHOLOGY	1, 045, 885	0			1, 045, 885	
9. 00 06900 ELECTROCARDI OLOGY	4, 021, 871		4, 021, 8		4, 021, 871	
0.00 07000 ELECTROENCEPHALOGRAPHY	1, 738, 537		1, 738, 5		1, 738, 537	
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	19, 063, 727		19, 063, 7	27 0	19, 063, 727	71.0
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS	21, 661, 953		21, 661, 9	53 0	21, 661, 953	72.0
3.00 07300 DRUGS CHARGED TO PATIENTS	19, 365, 180		19, 365, 18		19, 365, 180	
3. 01 07301 DI ABETES CENTER	643, 882		643, 8		643, 882	
4.00 07400 RENAL DIALYSIS	1, 022, 428		1, 022, 4		1, 022, 428	
6. 98 07698 HYPERBARI C OXYGEN THERAPY	463, 721		463, 72	21 0	463, 721	76.9
	1 2/2 /21		1 2/2 4	21 0	1 2/2 /21	
0. 00 09000 CLINIC 1. 00 09100 EMERGENCY	1, 363, 431 17, 108, 017		1, 363, 43 17, 108, 0		1, 363, 431 17, 108, 017	
1. 01 04950 WOUND CARE	3, 784, 032		3, 784, 0		3, 784, 032	
22.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	3,704,032		3,704,0	0	3, 704, 032	
2. 01 09201 OBSERVATION BEDS (DISTINCT PART)	4, 369, 971		4, 369, 9		4, 369, 971	
OTHER REIMBURSABLE COST CENTERS	1,007,771		1,007,7		1,007,771	1 /2.10
95. 00 09500 AMBULANCE SERVICES	5, 924, 021		5, 924, 0	21 0	5, 924, 021	95.0
01.00 10100 HOME HEALTH AGENCY	6, 150, 455		6, 150, 4	55	6, 150, 455	101. 0
SPECIAL PURPOSE COST CENTERS						
13.00 11300 INTEREST EXPENSE						113. 0
16.00 11600 HOSPI CE	4, 683, 197		4, 683, 19		4, 683, 197	
200.00 Subtotal (see instructions)	254, 453, 485	0	254, 453, 4		254, 453, 485	
201.00 Less Observation Beds	0	-		0		201.00
202.00 Total (see instructions)	254, 453, 485	0	254, 453, 4	85 0	254, 453, 485	1202. O

COMPUT	ATION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-0109	Period: From 01/01/2017 To 12/31/2017	Worksheet C Part I Date/Time Pre 5/31/2018 3:5	pared: 3 pm
			Titl	e XIX	Hospi tal	Cost	-
	Cost Center Description	I npati ent	Charges Outpatient	Total (col. + col. 7)	6 Cost or Other Ratio	TEFRA I npati ent Rati o	
		6.00	7.00	8.00	9.00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	55, 294, 494		55, 294, 4	94		30.00
31.00	03100 I NTENSI VE CARE UNI T	16, 515, 160		16, 515, 1			31.00
35.00	02060 NEONATAL INTENSIVE CARE UNIT	13, 995, 022		13, 995, 0			35.00
41.00	04100 SUBPROVI DER – I RF	4, 659, 672		4, 659, 6			41.00
43.00	04300 NURSERY	3, 512, 425		3, 512, 4	25		43.00
	ANCI LLARY SERVI CE COST CENTERS						
50.00	05000 OPERATING ROOM	79,041,968	81, 129, 479			0.000000	
51.00	05100 RECOVERY ROOM	5, 974, 284	6, 915, 560	12, 889, 8		0.000000	
52.00	05200 DELIVERY ROOM & LABOR ROOM	21, 119, 485	688, 456	21, 807, 9		0.000000	
54.00	05400 RADI OLOGY-DI AGNOSTI C	14, 705, 203	64, 919, 136	79, 624, 3		0.000000	
55.00 56.00	03630 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE	2, 172, 658	7, 253, 043	9, 425, 7	01 0. 106112 0 0. 000000	0.000000	
56.00	03950 CARDI AC CATH LAB	15, 474, 635	17, 366, 733	32, 841, 3		0.000000	
57.00	05700 CT SCAN	21, 600, 112	47,012,183	68, 612, 2		0.000000	
57.00	05800 MRI	5, 126, 691	11, 228, 515	16, 355, 2		0.000000	
50.00 50.00	06000 LABORATORY	54, 101, 867	72, 037, 591	126, 139, 4		0.000000	
65.00	06500 RESPI RATORY THERAPY	10, 658, 674	1, 631, 778			0. 000000	
55.00 56.00	06600 PHYSI CAL THERAPY	6, 757, 281	9, 725, 999	16, 483, 2		0. 000000	
67.00	06700 OCCUPATI ONAL THERAPY	6, 746, 890	3, 496, 664	10, 243, 5		0. 000000	
68.00	06800 SPEECH PATHOLOGY	1, 255, 874	992, 293	2, 248, 1		0. 000000	
69.00	06900 ELECTROCARDI OLOGY	10, 174, 368	19, 768, 973			0. 000000	
70.00	07000 ELECTROENCEPHALOGRAPHY	962,040	4, 413, 493	5, 375, 5		0. 000000	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	71, 400, 549	58, 369, 565	129, 770, 1		0.000000	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	72, 536, 825	21, 916, 432	94, 453, 2		0.000000	
73.00	07300 DRUGS CHARGED TO PATIENTS	68, 212, 795	59, 282, 801	127, 495, 5	96 0. 151889	0.000000	73.00
73.01	07301 DI ABETES CENTER	428	212, 052	212, 4	80 3. 030318	0.000000	73.01
74.00	07400 RENAL DIALYSIS	1, 862, 186	610, 568	2, 472, 7	54 0. 413477	0.000000	74.00
76. 98	07698 HYPERBARI C OXYGEN THERAPY	4, 544	928, 882	933, 4	0. 496795	0. 000000	76. 98
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	884, 955	884, 9		0.000000	
91.00	09100 EMERGENCY	10, 281, 791	56, 457, 223	66, 739, 0		0.000000	
91.01	04950 WOUND CARE	0	8, 136, 522	8, 136, 5		0.000000	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		0 0.000000	0.000000	
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	3, 257, 896	7, 989, 420	11, 247, 3	16 0. 388535	0.00000	92.01
	OTHER REIMBURSABLE COST CENTERS		44.440.047	44.4(0.0	17 0 440000	0.00000	05 00
	09500 AMBULANCE SERVICES	12 078	14, 162, 017	14, 162, 0		0. 000000	
101.00	10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	12, 078	7, 040, 659	7, 052, 7	57		101.00
113 00	11300 INTEREST EXPENSE	1					113.00
	11600 HOSPI CE	0	11, 607, 916	11, 607, 9	16		116.00
200.00		577, 417, 895	596, 178, 908				200.00
200.00 201.00		577,417,075	370, 170, 900	1, 175, 570, 0			200.00
0		1 1					1201.00

Health Financial Systems	FRANCI SCAN HEALT			u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0109	Peri od: From 01/01/2017 To 12/31/2017	Worksheet C Part I Date/Time Pre 5/31/2018 3:5	
		Title XIX	Hospi tal	Cost	•
Cost Center Description	PPS Inpatient				
	Ratio				
	11.00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS					30.00
31. 00 03100 INTENSIVE CARE UNIT					31.00
35.00 02060 NEONATAL INTENSIVE CARE UNIT					35.00
41.00 04100 SUBPROVIDER - IRF					41.00
43. 00 04300 NURSERY					43.00
ANCILLARY SERVICE COST CENTERS					
50. 00 05000 OPERATING ROOM	0. 000000				50.00
51.00 05100 RECOVERY ROOM	0. 000000				51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000				52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000				54.00
55. 00 03630 RADI OLOGY-THERAPEUTI C	0. 000000				55.00
56. 00 05600 RADI 0I SOTOPE	0. 000000				56.00
56. 01 03950 CARDI AC CATH LAB	0. 000000				56.01
57. 00 05700 CT SCAN	0. 000000				57.00
58. 00 05800 MRI	0. 000000				58.00
60. 00 06000 LABORATORY	0. 000000				60.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000				65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000				66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000				67.00
68. 00 06800 SPEECH PATHOLOGY	0. 000000				68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000				69.00
70. 00 07000 ELECTROEARDI OLOGI	0. 000000				70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000				71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000				72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0.000000				73.00
	0. 000000				73.0
74.00 07400 RENAL DIALYSIS	0. 000000				74.00
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 000000				76.98
	0.000000				
90. 00 09000 CLINIC	0.000000				90.00
91.00 09100 EMERGENCY	0. 000000				91.00
91. 01 04950 WOUND CARE	0. 000000				91.01
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000				92.00
92. 01 09201 OBSERVATION BEDS (DISTINCT PART)	0. 000000				92.01
OTHER REIMBURSABLE COST CENTERS					
95. 00 09500 AMBULANCE SERVICES	0. 000000				95.00
101.00 10100 HOME HEALTH AGENCY					101.00
SPECIAL PURPOSE COST CENTERS					-
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

Health Financial Systems	FRANCI SCAN HEA	LTH_LAFAYETTE		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provider C		Period: From 01/01/2017 To 12/31/2017		pared: 3 pm
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced		Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col. 1 - col			
	26)		2)			
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDI ATRI CS	6, 281, 855	0	6, 281, 85	5 33, 866	185.49	30.00
31. 00 I NTENSI VE CARE UNI T	782, 286		782, 28	6 4, 461	175.36	31.00
35.00 NEONATAL INTENSIVE CARE UNIT	446, 011		446, 01	1 2, 851	156.44	35.00
41.00 SUBPROVIDER - IRF	697, 072	0	697, 07	2 2, 887	241.45	41.00
43.00 NURSERY	25, 025		25, 02	5 3, 530	7.09	43.00
200.00 Total (lines 30 through 199)	8, 232, 249		8, 232, 24	9 47, 595		200.00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS	_					
30. 00 ADULTS & PEDIATRICS	16, 565	3, 072, 642				30.00
31. 00 I NTENSI VE CARE UNI T	1, 734	304, 074				31.00
35.00 NEONATAL INTENSIVE CARE UNIT	0	, °				35.00
41.00 SUBPROVIDER - IRF	1, 607	388, 010				41.00
43. 00 NURSERY	0)			43.00
200.00 Total (lines 30 through 199)	19, 906	3, 764, 726				200. 00

lealth Financial Systems	FRANCI SCAN HEAI				u of Form CMS-	2552-1
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE	CAPI TAL COSTS	Provider C		Period: From 01/01/2017 To 12/31/2017	Worksheet D Part II Date/Time Pre 5/31/2018 3:5	pared:
		Title	XVIII	Hospi tal	PPS	зрш
Cost Center Description	Capi tal	Total Charges			Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,		(col. 1 ÷ col		column 4)	
	Part II, col.	8)	2)	Ŭ	, , , , , , , , , , , , , , , , , , ,	
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS		1		- 1		
50.00 05000 OPERATING ROOM	1, 837, 246				394, 374	
51.00 05100 RECOVERY ROOM	203, 357					
52.00 05200 DELIVERY ROOM & LABOR ROOM	87, 513					
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 380, 823					
55. 00 03630 RADI OLOGY-THERAPEUTI C	79, 180					
56. 00 05600 RADI OI SOTOPE	20, 000				0	
56. 01 03950 CARDI AC CATH LAB	402, 171					
57. 00 05700 CT SCAN	236, 201				33, 217	
58. 00 05800 MRI	66, 672					
50. 00 06000 LABORATORY	975, 496					
55. 00 06500 RESPI RATORY THERAPY	238, 518					
66. 00 06600 PHYSI CAL THERAPY	697, 787					
57.00 06700 OCCUPATIONAL THERAPY	309, 958					
58.00 06800 SPEECH PATHOLOGY	157, 705					
59. 00 06900 ELECTROCARDI OLOGY	407, 023					
70. 00 07000 ELECTROENCEPHALOGRAPHY	233, 873					
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI					152, 603	
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	727, 573					
73. 00 07300 DRUGS CHARGED TO PATIENTS	532, 780					
73. 01 07301 DI ABETES CENTER	14, 502				-	
74.00 07400 RENAL DI ALYSI S 76.98 07698 HYPERBARI C OXYGEN THERAPY	88, 993					
76. 98 07698 HYPERBARI C OXYGEN THERAPY OUTPATI ENT SERVICE COST CENTERS	161, 412	933, 426	0. 17292	24 0	0	/0.9
PO. 00 09000 CLINIC	28, 978	884, 955	0. 03274	15 0	0	90.0
90.00 09000 CETNIC 91.00 09100 EMERGENCY	1, 560, 412					
91. 00 109100 EMERGENCT	688, 291				199, 399	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT P					0	
22. 00 09200 OBSERVATION BEDS (NON-DISTINCT P	356, 212				-	1
OTHER REIMBURSABLE COST CENTERS	550, 212	1, 247, 310	0.03107	, , , , , , , , , , , , , , , , , , , ,	27, 331	1 /2.0
25. 00 09500 AMBULANCE SERVICES						95.0
200.00 Total (lines 50 through 199)	10 110 (00	1, 046, 797, 360		218, 231, 602	2, 144, 686	

Health Financial Systems	FRANCI SCAN HEA	LTH LAFAYETTE		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTH	HER PASS THROUGH COS		F	Period: From 01/01/2017 To 12/31/2017	Date/Time Pre 5/31/2018 3:5	pared: 3 pm
			XVIII	Hospi tal	PPS	
Cost Center Description	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments		All Other Medical Education Cost	
	1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS			·			
30.00 03000 ADULTS & PEDIATRICS 31.00 03100 INTENSIVE CARE UNIT	0	5, 036, 992 0	C C	-	0	31.00
35. 00 02060 NEONATAL INTENSIVE CARE UNIT 41. 00 04100 SUBPROVIDER - IRF 43. 00 04300 NURSERY	0				0	41.00
200.00 Total (lines 30 through 199)	0	5, 036, 992		0	-	200.00
Cost Center Description	Swing-Bed Adjustment Amount (see	Total Costs (sum of cols. 1 through 3,		Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
		minus col. 4) 5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS 30.00 O3000 ADULTS & PEDIATRICS 31.00 O3100 INTENSIVE CARE UNIT 35.00 O2060 NEONATAL INTENSIVE CARE UNIT 41.00 O4100 SUBPROVIDER - IRF 43.00 O4300 NURSERY 200.00 Total (lines 30 through 199)	0	0	4, 461 2, 851 2, 887 3, 530	0.00 0.00 0.00 0.00 0.00	1, 734 0 1, 607 0	31.00 35.00 41.00
Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00					
INPATI ENT ROUTI NE SERVI CE COST CENTERS 30.00 03000 ADULTS & PEDI ATRI CS 31.00 03100 INTENSI VE CARE UNI T 35.00 02060 NEONATAL INTENSI VE CARE UNI T 41.00 04100 SUBPROVI DER - IRF 43.00 04300 NURSERY 200.00 Total (lines 30 through 199)	2, 463, 712 0 0 0 0 2, 463, 712					30.00 31.00 35.00 41.00 43.00 200.00

Health Financial Systems	FRANCI SCAN HEAL	TH LAFAYETTE		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PASS	S Provider C	CN: 15-0109	Peri od:	Worksheet D	
THROUGH COSTS				From 01/01/2017 To 12/31/2017		pared.
				10 12/01/2017	5/31/2018 3:5	3 pm
			XVIII	Hospi tal	PPS	
Cost Center Description			Nursing Scho	ol Allied Health	Allied Health	
		Post-Stepdown		Post-Stepdown		
	Cost	Adjustments	0.00	Adjustments	0.00	
	1.00	2A	2.00	3A	3.00	
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM		0	1	0 0	0	50.00
51. 00 05100 RECOVERY ROOM	0	0		0 0		
	0	0		0 0	-	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C 55. 00 03630 RADI OLOGY-THERAPEUTI C	0	0		0 0	0	
	0	0		0 0	Ű	00.00
56. 00 05600 RADI 0I SOTOPE 56. 01 03950 CARDI AC CATH LAB	0	0		0 0	0	
57. 00 05700 CT SCAN	0	0		0 0	-	
58. 00 105700 CT SCAN 58. 00 105800 MRI	0	0		0 0	0	
	0	0		0 0	0	
60. 00 06000 LABORATORY 65. 00 06500 RESPI RATORY THERAPY	0	0		0 0	, o	
	0	0		0 0	0	
	0	0		0 0		00.00
	0	0		0 0	Ű	
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	0	0		0 0	0	00.00
69. 00 06900 ELECTROCARDI OLOGY 70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 0		
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0		0 0		•
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	973,000	
73. 01 07301 DIABETES CENTER	0	0		0 0	973,000	1
74. 00 07400 RENAL DI ALYSI S	0	0			0	
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0		0 0		
OUTPATIENT SERVICE COST CENTERS	<u> </u>	0		0 0	0	70.70
90. 00 09000 CLINIC	0	0		0 0	0	90.00
91. 00 09100 EMERGENCY	0	0		0 0	500, 983	
91. 01 04950 WOUND CARE	0	0		0 0	0	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		õ	0	
92. 01 09201 OBSERVATION BEDS (DISTINCT PART)	0	0		0 0	-	
OTHER REIMBURSABLE COST CENTERS		0	1	<u> </u>	0	12.01
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)	0	0		0 0	1, 473, 983	
			•	-		

	FRANCI SCAN HEAL			In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER THROUGH COSTS	VICE OTHER PASS	6 Provider C		Period: From 01/01/2017 To 12/31/2017		epared:
		Title	XVIII	Hospi tal	PPS	o piii
Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
···· · · · · · · · · · · · · ·	Medi cal	(sum of col 1	Outpati ent	(from Wkst. C,		
	Education Cost	through col.	Cost (sum of	Part I, col.	(col. 5 ÷ col.	
		4)	col. 2, 3 an	(8 t	7)	
			4)			
	4.00	5.00	6.00	7.00	8.00	
ANCI LLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0	0		0 160, 171, 447	0.00000	
51.00 05100 RECOVERY ROOM	0	0		0 12, 889, 844	0.00000	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 21, 807, 941	0. 000000	•
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 79, 624, 339	0.00000	
55. 00 03630 RADI OLOGY-THERAPEUTI C	0	0		0 9, 425, 701	0.00000	
56. 00 05600 RADI OI SOTOPE	0	0		0 0	0.00000	
56. 01 03950 CARDI AC CATH LAB	0	0		0 32, 841, 368	0.00000	56.01
57. 00 05700 CT SCAN	0	0		0 68, 612, 295	0.00000	57.00
58. 00 05800 MRI	0	0		0 16, 355, 206	0.00000	58.00
60. 00 06000 LABORATORY	0	0		0 126, 139, 458	0.00000	60.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0 12, 290, 452	0. 000000	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 16, 483, 280	0. 000000	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 10, 243, 554	0. 000000	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0 2, 248, 167	0. 000000	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 29, 943, 341	0.00000	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 5, 375, 533	0. 000000	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 129, 770, 114	0. 000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 94, 453, 257	0.00000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	973, 000	973, 00	0 127, 495, 596	0.007632	73.00
73. 01 07301 DI ABETES CENTER	0	0		0 212, 480	0. 000000	73.01
74.00 07400 RENAL DIALYSIS	0	0		0 2, 472, 754	0. 000000	74.00
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0		0 933, 426	0. 000000	76.98
OUTPATIENT SERVICE COST CENTERS			•			
90. 00 09000 CLINIC	0	0		0 884, 955	0.00000	90.00
91.00 09100 EMERGENCY	0	500, 983	500, 98		0.007507	
91.01 04950 WOUND CARE	0	0		0 8, 136, 522	0.00000	91.01
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		0 0	0.00000	
92.01 09201 OBSERVATION BEDS (DISTINCT PART)	0	0		0 11, 247, 316	0. 000000	92.01
OTHER REIMBURSABLE COST CENTERS			•			1
95.00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)	0	1, 473, 983	1 472 00	3 1,046,797,360		200.00

lealth Financial Systems	FRANCI SCAN HEALT	TH LAFAYETTE		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEA	RVICE OTHER PASS	Provider CC		Peri od:	Worksheet D	
THROUGH COSTS				From 01/01/2017	Part IV	norod.
				To 12/31/2017	Date/Time Pre 5/31/2018 3:5	pared: 3 nm
		Title	XVIII	Hospi tal	PPS	5 pili
Cost Center Description	Outpati ent	Inpati ent	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through		Pass-Through	
	(col. 6 ÷ col.	J	Costs (col.		Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATING ROOM	0. 000000	34, 383, 101		0 17, 839, 451	0	50.00
51.00 05100 RECOVERY ROOM	0. 000000	19, 698		0 2, 283, 112	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	23, 556		0 0	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	9, 334, 391		0 10, 003, 129	0	54.00
55. 00 03630 RADI OLOGY-THERAPEUTI C	0. 000000	0		0 2, 295, 986	0	55.00
56. 00 05600 RADI 0I SOTOPE	0. 000000	0		0 0	0	56.00
56. 01 03950 CARDI AC CATH LAB	0.000000	8, 028, 761		0 9, 417, 643	0	56.01
57. 00 05700 CT SCAN	0.000000	9,647,597		0 14, 272, 888	0	57.00
58. 00 05800 MRI	0.000000	2, 592, 200		0 3, 175, 008	0	58.00
50, 00 06000 LABORATORY	0, 000000	27, 697, 032		0 14, 122, 877	0	60.00
55, 00 06500 RESPI RATORY THERAPY	0, 000000	5, 428, 655		0 1, 451, 739	0	65.00
56. 00 06600 PHYSI CAL THERAPY	0.000000	2,277,406		0 522, 225	0	66.00
57. 00 06700 OCCUPATI ONAL THERAPY	0.000000	1,822,306		0 55, 692	0	67.00
58.00 06800 SPEECH PATHOLOGY	0, 000000	342, 888		0 9, 532	0	68.00
59. 00 06900 ELECTROCARDI OLOGY	0. 000000	7, 160, 959		0 4, 544, 707	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	437, 621		0 1, 426, 512	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	30, 465, 711		0 14, 922, 103	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0, 000000	35, 533, 606		0 11, 097, 720	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.007632	32, 376, 416			173, 769	73.00
73.01 07301 DI ABETES CENTER	0. 000000	0	,	0 3, 127	0	73.01
74.00 07400 RENAL DIALYSIS	0. 000000	1, 362, 583		0 158, 152	0	74.00
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 000000	0		0 310, 950	0	76.98
OUTPATIENT SERVICE COST CENTERS		-				1
20. 00 09000 CLINIC	0, 000000	0		0 0	0	90.00
91.00 09100 EMERGENCY	0.007507	8, 528, 230	64, 02	5, 219, 435	39, 182	91.00
91.01 04950 WOUND CARE	0. 000000	0	,	0 7, 174, 500	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. 000000	768, 885		0 1, 994, 738	0	92.01
OTHER REIMBURSABLE COST CENTERS					-	1
	1					1
95. 00 09500 AMBULANCE SERVICES						95.00

Health Financial Systems	FRANCI SCAN HEA	LTH LAFAYETTE		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C	CN: 15-0109	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part V Date/Time Pre 5/31/2018 3:5	
		Title	× XVIII	Hospi tal	PPS	
			Charges	10301 tu	Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed		Cost	PPS Services	
oust contor bescription	Ratio From	Services (see	Reimbursed	Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Servi ces Not	(300 11131.)	
	Part I, col. 9	· · · ·	Subject To	Subject To		
			Ded. & Coi ns			
			(see inst.)			
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS		2.00	0.00		0,00	
50. 00 05000 OPERATI NG ROOM	0. 112399	17, 839, 451		0 0	2, 005, 136	50.00
51.00 05100 RECOVERY ROOM	0. 133071			0 0	303, 816	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 265954			0 0	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 175909			0 0	1, 759, 640	•
55. 00 03630 RADI OLOGY-THERAPEUTI C	0. 106112			0 0	243, 632	
56. 00 05600 RADI 0I SOTOPE	0. 000000			0 0	0	56.00
56. 01 03950 CARDI AC CATH LAB	0. 108158			0 0	1, 018, 593	
57. 00 05700 CT SCAN	0. 032611			0 0	465, 453	
58. 00 05800 MRI	0. 032011			0 0	134, 770	
60. 00 06000 LABORATORY	0. 105556			0 0	1, 490, 754	
65. 00 06500 RESPI RATORY THERAPY	0. 382704			0 0		
					555, 586	
66. 00 06600 PHYSI CAL THERAPY	0. 482421			0 0	251, 932	
67. 00 06700 OCCUPATI ONAL THERAPY	0. 283370			0 0	15, 781	
68. 00 06800 SPEECH PATHOLOGY	0. 465217			0 0	4, 434	
69. 00 06900 ELECTROCARDI OLOGY	0. 134316			0 0	610, 427	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 323417			0 0	461, 358	
71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0. 146904			0 0	2, 192, 117	
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0. 229340			0 0	2, 545, 151	•
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 151889			0 156, 943	3, 458, 275	•
73. 01 07301 DI ABETES CENTER	3. 030318			0 0	9, 476	•
74.00 07400 RENAL DIALYSIS	0. 413477			0 0	65, 392	•
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 496795	310, 950		0 0	154, 478	76.98
OUTPATIENT SERVICE COST CENTERS	1					-
90. 00 09000 CLINIC	1. 540678			0 0		90.00
91.00 09100 EMERGENCY	0. 256342			0 0	1, 337, 960	
91.01 04950 WOUND CARE	0. 465068			0 0	3, 336, 630	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000			0 0	0	92.00
92.01 09201 OBSERVATION BEDS (DISTINCT PART)	0. 388535	1, 994, 738		0 0	775, 026	92.01
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	0. 418303			0		95.00
200.00 Subtotal (see instructions)		145, 069, 660		0 156, 943	23, 195, 817	200.00
201.00 Less PBP Clinic Lab. Services-Program				0 0		201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)		145, 069, 660		0 156, 943	23, 195, 817	202.00

		FRANCI SCAN HEAL				u of Form CMS-	-2552-
PPORTIONME	ENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C	JN: 15-0109	Period: From 01/01/2017	Worksheet D Part V	
					To 12/31/2017	Date/Time Pre	
						5/31/2018 3: 5	53 pm
				XVIII	Hospi tal	PPS	_
		Cos					
	Cost Center Description	Cost	Cost				
		Reimbursed	Reimbursed				
		Services Subject To	Services Not Subject To				
		Ded. & Coins.	Ded. & Coins.				
		(see inst.)	(see inst.)				
		6.00	7.00				
ANCI	LLARY SERVICE COST CENTERS	0.00	7.00				
	O OPERATING ROOM	0	0				50. 0
	O RECOVERY ROOM	0	0				51.0
	O DELIVERY ROOM & LABOR ROOM	0	0				52.0
	0 RADI OLOGY - DI AGNOSTI C		0				54.0
	0 RADI OLOGY-THERAPEUTI C	0	0				54.
	0 RADI OLOGI - THERA LOTT C	0	0				56.
	O CARDI AC CATH LAB	0	0				56.
	OCT SCAN	0	0				50.
	00 MRI	0	0				57.
	IO ABORATORY	0	0				60.
	0 RESPIRATORY THERAPY	0	0				65.
	0 PHYSI CAL THERAPY	0	0				66.
	0 OCCUPATIONAL THERAPY	0	0				67.
	O SPEECH PATHOLOGY	0	0				68.
	0 ELECTROCARDI OLOGY	0	0				69.
	0 ELECTROENCEPHALOGRAPHY	0	0				70.
-	0 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0				71.
	0 IMPL. DEV. CHARGED TO PATIENTS	0	0				72.
	DO DRUGS CHARGED TO PATIENTS	0	23, 838				73.
	DI ABETES CENTER	0	23, 030				73.
	O RENAL DI ALYSI S	0	0				74.
	8 HYPERBARI C OXYGEN THERAPY	0	0				76.
	ATIENT SERVICE COST CENTERS	U 0	0				- '0.
		0	0				90.
	0 EMERGENCY	0	0				91.
	0 WOUND CARE		0				91.
	0 OBSERVATION BEDS (NON-DISTINCT PART	0	0				92.
	01 OBSERVATION BEDS (DISTINCT PART)	0	0				92.
	R REIMBURSABLE COST CENTERS		0	I			- '2.
	0 AMBULANCE SERVICES	0					95.
00.00	Subtotal (see instructions)	0	23, 838				200.
00.00	Less PBP Clinic Lab. Services-Program		25,050				200.
01.00	Only Charges	0					201.
02.00	Net Charges (line 200 - line 201)	0	23, 838				202.

Health Financial Systems	FRANCI SCAN HEAI			In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provider Component	CN: 15-0109 CCN: 15-T109	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part II Date/Time Pre	pared:
		•			5/31/2018 3:5	
		Title	e XVIII	Subprovider - IRF	PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos		Capital Costs	
	Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,	Part I, col.	(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)	-		
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS						
50.00 O5000 OPERATING ROOM	1, 837, 246	160, 171, 447	0.0114	70 24, 764	284	50.00
51.00 05100 RECOVERY ROOM	203, 357	12, 889, 844	0. 0157	77 4, 544	72	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	87, 513	21, 807, 941	0.0040	13 0	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 380, 823	79, 624, 339	0.0173	42 37, 948	658	54.00
55. 00 03630 RADI OLOGY-THERAPEUTI C	79, 180			5, 199	44	55.00
56. 00 05600 RADI OI SOTOPE	20,000				0	56.00
56. 01 03950 CARDI AC CATH LAB	402, 171				0	•
57. 00 05700 CT SCAN	236, 201				183	
58. 00 05800 MRI	66, 672				18	•
60. 00 06000 LABORATORY	975, 496				3, 491	60.00
65. 00 06500 RESPI RATORY THERAPY	238, 518					
66. 00 06600 PHYSI CAL THERAPY	697, 787					
67. 00 06700 OCCUPATI ONAL THERAPY	309, 958					•
68. 00 06800 SPEECH PATHOLOGY	157, 705					
69. 00 06900 ELECTROCARDI OLOGY	407, 023					
70. 00 07000 ELECTROCARDI OLOGT	233, 873				97	•
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT					-	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	650, 014					•
	727, 573					
	532, 780				1, 795	
73. 01 07301 DI ABETES CENTER	14, 502				0	
74.00 07400 RENAL DI ALYSI S	88, 993				1, 020	
76. 98 07698 HYPERBARI C OXYGEN THERAPY	161, 412	933, 426	0. 1729:	24 0	0	76. 98
OUTPATIENT SERVICE COST CENTERS	00.070	004.055				
90. 00 09000 CLINIC	28, 978				0	
91.00 09100 EMERGENCY	1, 560, 412				204	
91.01 04950 WOUND CARE	688, 291				0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	-			0	92.00
92. 01 09201 OBSERVATION BEDS (DISTINCT PART)	356, 212	11, 247, 316	0. 0316	71 0	0	92.01
OTHER REIMBURSABLE COST CENTERS	1	I	1	1		
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)	12, 142, 690	1, 046, 797, 360	1	4, 104, 107	116, 853	200. 00

Health Financial Systems	FRANCI SCAN HEAL	TH LAFAYETTE		In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PASS	Provider C	CN: 15-0109	Peri od:	Worksheet D	
THROUGH COSTS				From 01/01/2017		
		Component	CCN: 15-T109	To 12/31/2017		
			xviii	Subprovider -	5/31/2018 3:5 PPS	3 pili
		iiiie	. VIII	IRF	PP3	
Cost Center Description	Non Physician	Jursing School	Nursing Scho	ol Allied Health	Allied Health	
Cost Center Description		Post-Stepdown	indi si ng seno	Post-Stepdown	Airred fiedren	
	Cost	Adjustments		Adjustments		
	1.00	2A	2.00	3A	3.00	
ANCI LLARY SERVI CE COST CENTERS	1.00	211	2.00	ON	0.00	
50. 00 05000 OPERATING ROOM	0	0		0 0	0	50.00
51. 00 05100 RECOVERY ROOM	0	0		0 0	0	
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0			0	
55. 00 03630 RADI OLOGY-THERAPEUTI C	0			0 0	0	
56. 00 05600 RADI 0I SOTOPE	0	0			0	
56. 01 03950 CARDI AC CATH LAB	0	0		0 0		
57. 00 05700 CT SCAN	0	0		0 0	0	
58. 00 05800 MRI	0	0		0 0	0	
60. 00 06000 LABORATORY	0	0		0 0	0	
65. 00 06500 RESPIRATORY THERAPY	0	0		0 0		
	0	0		0 0	, o	•
	0	U		0 0	0	
67.00 06700 OCCUPATI ONAL THERAPY	0	U		0 0	0	
68.00 06800 SPEECH PATHOLOGY	0	U		0 0	0	
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 0	0	
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0	
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT	0	0		0 0	0	
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	973, 000	
73. 01 07301 DI ABETES CENTER	0	C		0 0	0	
74.00 07400 RENAL DIALYSIS	0	C		0 0	0	
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0		0 0	0	76.98
OUTPATIENT SERVICE COST CENTERS	1		1		1	
90. 00 09000 CLINIC	0	C		0 0	0	
91.00 09100 EMERGENCY	0	C		0 0	500, 983	•
91.01 04950 WOUND CARE	0	C		0 0	0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0			0	0	
92. 01 09201 OBSERVATION BEDS (DISTINCT PART)	0	0		0 0	0	92.01
OTHER REIMBURSABLE COST CENTERS	T T		1			-
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)	0	C	1	0 0	1, 473, 983	200.00

Health Financial Systems	FRANCI SCAN HEAL	LTH LAFAYETTE		In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PASS	S Provider C	CN: 15-0109	Peri od:	Worksheet D	
THROUGH COSTS		Company	CON 15 T100	From 01/01/2017	Part IV	
		Component	CCN: 15-T109	To 12/31/2017	Date/Time Pre 5/31/2018 3:5	
		Title	XVIII	Subprovider -	PPS	
				' I RF		
Cost Center Description	All Other	Total Cost	Total	Total Charges		
	Medi cal	(sum of col 1	Outpatient	(from Wkst. C,	to Charges	
	Education Cost	through col.	Cost (sum of	Part I, col.	(col. 5 ÷ col.	
		4)	col. 2, 3 an	(8 b	7)	
			4)			
	4.00	5.00	6.00	7.00	8.00	
ANCI LLARY SERVI CE COST CENTERS	1					
50.00 05000 OPERATI NG ROOM	0	-		0 160, 171, 447		
51.00 05100 RECOVERY ROOM	0	0		0 12, 889, 844		
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 21, 807, 941		
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 79, 624, 339		
55. 00 03630 RADI OLOGY-THERAPEUTI C	0	0		0 9, 425, 701		
56. 00 05600 RADI OI SOTOPE	0	0		0 0		
56. 01 03950 CARDI AC CATH LAB	0	0		0 32, 841, 368		
57.00 05700 CT SCAN	0	0		0 68, 612, 295	0.00000	
58. 00 05800 MRI	0	0		0 16, 355, 206		
60. 00 06000 LABORATORY	0	0		0 126, 139, 458	0.000000	60.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0 12, 290, 452	0.000000	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 16, 483, 280	0.000000	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0		0 10, 243, 554	0.000000	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0 2, 248, 167	0.000000	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 29, 943, 341	0.000000	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 5, 375, 533	0.000000	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 129, 770, 114	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 94, 453, 257	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	973, 000	973, 00	0 127, 495, 596	0.007632	73.00
73. 01 07301 DI ABETES CENTER	0	0		0 212, 480	0.000000	73.01
74. 00 07400 RENAL DIALYSIS	0	0		0 2, 472, 754	0.000000	74.00
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0		0 933, 426	0.000000	76. 98
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0	0		0 884, 955	0.00000	90.00
91. 00 09100 EMERGENCY	0	500, 983	500, 98	3 66, 739, 014	0.007507	91.00
91.01 04950 WOUND CARE	0	0		0 8, 136, 522	0. 000000	91.01
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		0 0	0. 000000	92.00
92.01 09201 OBSERVATION BEDS (DISTINCT PART)	0	0		0 11, 247, 316	0. 000000	92.01
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVI CES						95.00
200.00 Total (lines 50 through 199)	0	1, 473, 983	1, 473, 98	3 1, 046, 797, 360		200.00

Health Financial Systems	FRANCI SCAN HEALT	H LAFAYETTE		In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PASS	Provider C	CN: 15-0109	Period:	Worksheet D	
THROUGH COSTS		Component	CCN: 15-T109	From 01/01/2017 To 12/31/2017		narod
		component	JCN. 13-1107	10 12/31/2017	5/31/2018 3:5	3 pm
		Title	XVIII	Subprovider -	PPS	
			-	I RF	-	
Cost Center Description	Outpati ent	Inpati ent	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Throug		Pass-Through	
	(col. 6 ÷ col.		Costs (col.	8	Costs (col. 9	
	7)	10.00	x col. 10)	10.00	x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCI LLARY SERVICE COST CENTERS	0.000000	24 7/4		0		50.00
50. 00 05000 OPERATING ROOM	0.000000	24, 764		0 0		
51.00 O5100 RECOVERY ROOM	0.000000	4, 544		0 0		
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.000000	0		0 0	u u	
54.00 05400 RADI OLOGY-DI AGNOSTI C	0.000000	37, 948		0 0	0	
55. 00 03630 RADI OLOGY-THERAPEUTI C	0.000000	5, 199		0 0	0	55.00
56. 00 05600 RADI OI SOTOPE	0.000000	0		0 0	0	
56. 01 03950 CARDI AC CATH LAB	0.000000	0		0 0	0	
57. 00 05700 CT SCAN	0.000000	53, 026		0 0	i i	57.00
58.00 05800 MRI	0.000000	4, 367		0 0	-	1
60.00 06000 LABORATORY	0.000000	451, 461		0 0	-	
65. 00 06500 RESPI RATORY THERAPY	0.000000	109, 956		0 0	, i i i i i i i i i i i i i i i i i i i	65.00
66.00 06600 PHYSI CAL THERAPY	0.000000	1, 176, 374		0 0	-	
67.00 06700 OCCUPATIONAL THERAPY	0.000000	1, 197, 756		0 0	, i i i i i i i i i i i i i i i i i i i	67.00
68.00 06800 SPEECH PATHOLOGY	0.000000	275, 454		0 0	-	68.00
69.00 06900 ELECTROCARDI OLOGY	0.000000	7, 115		0 0	, i i i i i i i i i i i i i i i i i i i	
70.00 07000 ELECTROENCEPHALOGRAPHY	0.000000	0		0 0	, i i i i i i i i i i i i i i i i i i i	
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT	0.000000	275, 870		0 0	-	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	13, 700		0 0	0	
73. 00 07300 DRUGS CHARGED TO PATIENTS	0.007632	429, 519	3, 2		0	
73. 01 07301 DI ABETES CENTER	0.000000	0		0 0	u u	
74.00 07400 RENAL DIALYSIS	0.000000	28, 348		0 0		
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 000000	0		0 0	0	76. 98
0UTPATIENT SERVICE COST CENTERS 90.00 09000 CLINIC	0.000000	0		0 0	0	90.00
	0.000000	-				
91. 00 09100 EMERGENCY 91. 01 04950 WOUND CARE	0.007507	8, 706	'	65 C	-	
91. 01 04950 WOUND CARE 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0		-		
	0.000000	0				1
92. 01 09201 OBSERVATI ON BEDS (DI STI NCT PART) OTHER REI MBURSABLE COST CENTERS	0.00000	0	I	U C	0	92.01
95. 00 09500 AMBULANCE SERVICES					1	95.00
200.00 Total (lines 50 through 199)		4, 104, 107	3, 3	43 C	0	200.00
		4, 104, 107	ı ۵, ۵,		'I U	I∠00. 00

COMPUT	Financial Systems FRANCISCAN HEALT	Provider CCN: 15-0109	Peri od:	u of Form CMS-2 Worksheet D-1	
			From 01/01/2017 To 12/31/2017	Date/Time Pre	pared:
		Title XVIII	Hospi tal	5/31/2018 3:53 PPS	3 pm
	Cost Center Description			1.00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
1 00	INPATIENT DAYS			22.044	1 00
1.00 2.00	Inpatient days (including private room days and swing-bed day Inpatient days (including private room days, excluding swing			33, 866 33, 866	
3.00	Private room days (excluding swing-bed and observation bed da	5,	rivate room days,	0	
4.00	do not complete this line. Semi-private room days (excluding swing-bed and observation b	(aveb bed		33, 866	4.00
5.00	Total swing-bed SNF type inpatient days (including private ro		er 31 of the cost	33, 800	5.00
(00	reporting period		21 -6		
6.00	Total swing-bed SNF type inpatient days (including private ro reporting period (if calendar year, enter 0 on this line)	bom days) after December	31 of the cost	0	6.00
7.00	Total swing-bed NF type inpatient days (including private roo	om days) through December	31 of the cost	0	7.00
8.00	reporting period Total swing-bed NF type inpatient days (including private roo	om davs) after December 3	1 of the cost	0	8.00
	reporting period (if calendar year, enter 0 on this line)			-	
9.00	Total inpatient days including private room days applicable t newborn days)	to the Program (excluding	swing-bed and	16, 565	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII of		room days)	0	10.00
11.00	through December 31 of the cost reporting period (see instruc Swing-bed SNF type inpatient days applicable to title XVIII of		soom dave) after	0	11.00
11.00	December 31 of the cost reporting period (if calendar year, e		oom days) arter	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XI	IX only (including privat	e room days)	0	12.00
13.00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XI	IX only (including privat	e room days)	0	13.00
	after December 31 of the cost reporting period (if calendar v	year, enter O on this lir	ne)		
14.00 15.00	Medically necessary private room days applicable to the Prog Total nursery days (title V or XIX only)	ram (excluding swing-bed	days)	0	
16.00	Nursery days (title V or XIX only)			0	
17.00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to servic	ces through December 31 c	of the cost	0.00	17.00
17.00	reporting period	C C			
18.00	Medicare rate for swing-bed SNF services applicable to service reporting period	ces after December 31 of	the cost	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to service	es through December 31 of	the cost	0.00	19.00
20.00	reporting period Medicaid rate for swing-bed NF services applicable to service	es after December 31 of t	he cost	0.00	20.00
20.00	reporting period			0.00	20.00
21.00 22.00	Total general inpatient routine service cost (see instruction Swing-bed cost applicable to SNF type services through Decemb		ing pariod (line	48, 191, 041 0	
22.00	5 x line 17)	bei 31 01 the cost report	ing period (inte	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December x line 18)	r 31 of the cost reportir	ng period (line 6	0	23.00
24.00	Swing-bed cost applicable to NF type services through December	er 31 of the cost reporti	ng period (line	0	24.00
25.00	7 x line 19)	21 of the east reporting	noried (line 0	0	25.00
25.00	Swing-bed cost applicable to NF type services after December x line 20)	31 OF the cost reporting	period (inne 8	0	25.00
26.00	Total swing-bed cost (see instructions)			0	
27.00	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(line 21 minus line 26)		48, 191, 041	27.00
28.00	General inpatient routine service charges (excluding swing-be	ed and observation bed ch	arges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)			0	
30.00	Semi-private room charges (excluding swing-bed charges)			0	
31.00	General inpatient routine service cost/charge ratio (line 27	÷ IINE 28)		0.00000	
~~	Average private room per diem charge (line 29 ÷ line 3)			0.00	
32.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
33.00	Average per diem private room charge differential (line 32 mi	, ,	ctions)	0.00	
33. 00 34. 00		ine 31)		0.00	
33. 00 34. 00 35. 00	Average per diem private room cost differential (line 34 x li			0	36.00 37.00
33.00 34.00 35.00 36.00	Private room cost differential adjustment (line 3 x line 35)	and private room cost di	fforontial (line)	10 101 011	
33. 00 34. 00 35. 00	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost 27 minus line 36)	and private room cost di	fferential (line	48, 191, 041	37.00
33.00 34.00 35.00 36.00	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY	·	fferential (line	48, 191, 041	37.00
33.00 34.00 35.00 36.00 37.00	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AD.	JUSTMENTS	fferential (line		
33.00 34.00 35.00 36.00 37.00 38.00	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AD. Adjusted general inpatient routine service cost per diem (see	JUSTMENTS e instructions)	fferential (line	1, 422. 99	38.00
33.00 34.00 35.00 36.00 37.00	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AD.	JUSTMENTS e instructions) e 38)	fferential (line		38. 00 39. 00

	ATION OF INPATIENT OPERATING COST		Provider CO	CN: 15-0109	Period: From 01/01/2017		
					To 12/31/2017	5/31/2018 3:5	
	Cost Center Description	Total	Title Total	XVIII Average Per	Hospital Program Days	PPS Program Cost	
		Inpatient Cost		Diem (col. 1		(col. 3 x col.	
		1.00	2.00	col. 2) 3.00	4.00	4) 5.00	
. 00	NURSERY (title V & XIX only)	0	0				42
~~	Intensive Care Type Inpatient Hospital Units	0 440 227	4 4/1	1 004 /	1 704	2 204 2/5	1 40
. 00	I NTENSI VE CARE UNI T CORONARY CARE UNI T	8, 449, 327	4, 461	1, 894. (1, 734	3, 284, 265	43
. 00	BURN INTENSIVE CARE UNIT						45
. 00	SURGI CAL I NTENSI VE CARE UNI T						46
. 00	NEONATAL INTENSIVE CARE UNIT	4, 282, 387	2, 851	1, 502. (060	0	47
	Cost Center Description					1.00	+
00	Program inpatient ancillary service cost (Wks					35, 278, 345	
00	Total Program inpatient costs (sum of lines 4	41 through 48)(s	ee instructio	ns)		62, 134, 439	49
00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inpa	atient routine s	ervices (from	Wkst D sur	n of Parts L and	5, 840, 428	50
. 00						0,010,120	
. 00	Pass through costs applicable to Program inpa	atient ancillary	services (fr	om Wkst. D, s	sum of Parts II	2, 455, 804	51
. 00	and IV) Total Program excludable cost (sum of lines 5	50 and 51)				8, 296, 232	52
. 00	Total Program inpatient operating cost exclude		ated, non-phy	sician anestl	netist, and	53, 838, 207	
	medical education costs (line 49 minus line 5	52)					
. 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54
. 00	Target amount per discharge					0.00	
. 00	Target amount (line 54 x line 55)					0	56
. 00	Difference between adjusted inpatient operati	ing cost and tar	get amount (I	ine 56 minus	line 53)	0	
. 00 . 00	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost rep	porting period e	ndina 1996 u	ndated and co	monunded by the	0.00	
. 00	market basket	conting period e	narng 1770, a		inpounded by the	0.00	
. 00	Lesser of lines 53/54 or 55 from prior year of					0.00	
. 00	If line 53/54 is less than the lower of lines which operating costs (line 53) are less than					0	61
	amount (line 56), otherwise enter zero (see i				the target		
. 00	Relief payment (see instructions)					0	
. 00	Allowable Inpatient cost plus incentive payme PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instruc	tions)			0	63
. 00	Medicare swing-bed SNF inpatient routine cost	ts through Decem	ber 31 of the	cost reporti	ng period (See	0	64
~ ~	instructions)(title XVIII only)						
. 00	Medicare swing-bed SNF inpatient routine cost instructions)(title XVIII only)	ts after Decembe	r 31 of the c	ost reportino	g period (See	0	65
. 00	Total Medicare swing-bed SNF inpatient routin	ne costs (line 6	4 plus line 6	5)(title XVII	l only). For	0	66
	CAH (see instructions)						
. 00	Title V or XIX swing-bed NF inpatient routine (line 12 x line 19)	e costs through	December 31 o	f the cost re	eporting period	0	67
. 00	Title V or XIX swing-bed NF inpatient routine	e costs after De	cember 31 of	the cost repo	orting period	C	68
	(line 13 x line 20)					_	
. 00	Total title V or XIX swing-bed NF inpatient r PART III - SKILLED NURSING FACILITY, OTHER NU			,		0	69
. 00	Skilled nursing facility/other nursing facili)		70
. 00	Adjusted general inpatient routine service co		ne 70 ÷ line	2)			71
. 00	Program routine service cost (line 9 x line 7 Medically necessary private room cost application		(lino 14 v li	po 25)			72
. 00	Total Program general inpatient routine servi			ne 35)			74
. 00	Capital-related cost allocated to inpatient r			orksheet B, A	Part II, column		75
00	26, line 45)	20 2)					-,
. 00 . 00	Per diem capital-related costs (line 75 ÷ lir Program capital-related costs (line 9 x line						76
. 00	Inpatient routine service cost (line 74 minus						78
00	Aggregate charges to beneficiaries for excess	• •		· · · · · · · · · · · · · · · · · · ·			79
00	Total Program routine service costs for compa Inpatient routine service cost per diem limit		SCIEMITATION	(IINe /8 MI	ius i i ne 79)		80
. 00	Inpatient routine service cost per drem rimit						82
. 00	Reasonable inpatient routine service costs (s	see instructions					83
. 00	Program inpatient ancillary services (see ins		c)				84
. 00 . 00	Utilization review - physician compensation (Total Program inpatient operating costs (sum	•					85
55	PART IV - COMPUTATION OF OBSERVATION BED PASS						1
	Total observation bed days (see instructions))				0	87
. 00 . 00	Adjusted general inpatient routine cost per o					0.00	88

Health Financial Systems	FRANCI SCAN HEAI	LTH LAFAYETTE		In Lie	eu of Form CMS-:	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period:	Worksheet D-1	
				From 01/01/2017 To 12/31/2017	Date/Time Pre 5/31/2018 3:5	
		Title	XVIII	Hospi tal	PPS	
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, 281, 855	48, 191, 041	0. 13035	3 0	0	90.00
91.00 Nursing School cost	5, 036, 992	48, 191, 041	0. 10452	1 0	0	91.00
92.00 Allied health cost	0	48, 191, 041	0. 00000	0 0	0	92.00
93.00 All other Medical Education	0	48, 191, 041	0.00000	0 0	0	93.00

MPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0109	Peri od:	Worksheet D-1	
		Component CCN: 15-T109	From 01/01/2017 To 12/31/2017	Date/Time Pre	
		Title XVIII	Subprovider -	5/31/2018 3:5: PPS	<u>3 pr</u>
	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	5		2, 887	
00	Inpatient days (including private room days, excluding swing-k		iveta reem dava	2, 887	2
00	Private room days (excluding swing-bed and observation bed day do not complete this line.	ys). Ir you nave only pr	Ivate room days,	0	3
00	Semi-private room days (excluding swing-bed and observation be	ed days)		2, 887	4
00	Total swing-bed SNF type inpatient days (including private roo	om days) through Decembe	r 31 of the cost	0	5
00	reporting period Total swing-bed SNF type inpatient days (including private roo	m dave) after December	21 of the cost	0	6
00	reporting period (if calendar year, enter 0 on this line)	nii days) al ter becenber	ST OF THE COST	0	0
00	Total swing-bed NF type inpatient days (including private room	n days) through December	31 of the cost	0	7
	reporting period				
00	Total swing-bed NF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	n days) after December 3	1 of the cost	0	8
00	Total inpatient days including private room days applicable to	o the Program (excluding	swing-bed and	1, 607	9
	newborn days)	0 1 0	Ũ		
. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		oom days)	0	10
. 00	through December 31 of the cost reporting period (see instruct Swing-bed SNF type inpatient days applicable to title XVIII or		oom days) after	0	11
. 00	December 31 of the cost reporting period (if calendar year, er		oom days) arter	0	''
. 00	Swing-bed NF type inpatient days applicable to titles V or XI>		e room days)	0	12
00	through December 31 of the cost reporting period			0	1.2
. 00	Swing-bed NF type inpatient days applicable to titles V or XI) after December 31 of the cost reporting period (if calendar ye			0	13
. 00	Medically necessary private room days applicable to the Progra			0	14
. 00	Total nursery days (title V or XIX only)		5 .	0	
. 00	Nursery days (title V or XIX only)			0	16
. 00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to service	es through December 31 o	f the cost	0.00	17
	reporting period				
. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es after December 31 of	the cost	0.00	18
. 00	Medicaid rate for swing-bed NF services applicable to services	s through December 31 of	the cost	0.00	19
~~	reporting period				
. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	s after December 31 of t	he cost	0.00	20
. 00	Total general inpatient routine service cost (see instructions	5)		3, 728, 156	21
. 00	Swing-bed cost applicable to SNF type services through Decembe		ing period (line	0	
~~	5 x line 17)				
. 00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reportin	g period (line 6	0	23
. 00	Swing-bed cost applicable to NF type services through December	- 31 of the cost reporti	ng period (line	0	24
	7 x line 19)			_	
. 00	Swing-bed cost applicable to NF type services after December 3 x line 20)	31 of the cost reporting	period (line 8	0	25
. 00	Total swing-bed cost (see instructions)			0	26
	General inpatient routine service cost net of swing-bed cost ((line 21 minus line 26)		3, 728, 156	
~~	PRI VATE ROOM DI FFERENTI AL ADJUSTMENT		<u> </u>		
	General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges)	and observation bed ch	arges)	0	
	Semi-private room charges (excluding swing-bed charges)			0	
	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)	nue line 22) (coo inctrue	tions)	0.00	
	Average per diem private room charge differential (line 32 mir Average per diem private room cost differential (line 34 x lir		u uns <i>j</i>	0.00 0.00	
. 00	Private room cost differential adjustment (line 3 x line 35)			0.00	
. 00	General inpatient routine service cost net of swing-bed cost a	and private room cost di	fferential (line	3, 728, 156	37
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				-
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	ISTMENTS			
. 00	Adjusted general inpatient routine service cost per diem (see			1, 291. 36	38
	Program general inpatient routine service cost (line 9 x line			2, 075, 216	
. 00	Medically necessary private room cost applicable to the Progra Total Program general inpatient routine service cost (line 39			0	
. 00				2, 075, 216	1 4

OMPUTATION OF INPATIENT OPERATING COST		TH LAFAYETTE Provider C	CN: 15-0109	Peri od:	eu of Form CMS- Worksheet D-1	
			CCN: 15-T109	From 01/01/2017 To 12/31/2017		
			e XVIII	Subprovider -	5/31/2018 3:5 PPS	53 pm
				I RF	FF3	_
Cost Center Description	Total Inpatient Costl	Total npatient Days	Average Per Diem (col. 1 col. 2)		Program Cost (col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	10
2.00 NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Ur	0 i ts	(0.	00 C	C	42.
3. 00 INTENSIVE CARE UNIT	0	0	0.	00 0	0	
4. 00 CORONARY CARE UNIT						44.
5. 00 BURN INTENSIVE CARE UNIT 5. 00 SURGICAL INTENSIVE CARE UNIT						45.
7. 00 NEONATAL INTENSIVE CARE UNIT	0	C	0.	00 C	0	
Cost Center Description			•	·	1.00	
3.00 Program inpatient ancillary service cost	(Wkst D-3 col 3	Line 200)			1.00 1,261,142	48
9.00 Total Program inpatient costs (sum of lin	•		ons)		3, 336, 358	
PASS THROUGH COST ADJUSTMENTS						
0.00 Pass through costs applicable to Program	inpatient routine s	services (from	n Wkst. D, su	n of Parts I and	388, 010	50.
1.00 Pass through costs applicable to Program	inpatient ancillary	/ services (fr	om Wkst. D,	sum of Parts II	120, 196	51.
and IV)						
2.00 Total Program excludable cost (sum of lin 3.00 Total Program inpatient operating cost ex		atod non nh	sician anost	notist and	508, 206 2, 828, 152	
medical education costs (line 49 minus li		ated, non-phy		letist, anu	2, 020, 152	. 55.
TARGET AMOUNT AND LIMIT COMPUTATION	· · · ·				1	
1.00 Program discharges 5.00 Target amount per discharge					0.00	
b. 00 Target amount (line 54 x line 55)					0.00	
2.00 Difference between adjusted inpatient ope	erating cost and tar	get amount (I	ine 56 minus	line 53)	0	
3.00 Bonus payment (see instructions)	- concerting partial	anding 100(undeted and a	ampounded by the	0	
2.00 Lesser of lines 53/54 or 55 from the cosmarket basket	reporting period e	ending 1996, t	ipuated and c	Silipounded by the	0.00	59.
0.00 Lesser of lines 53/54 or 55 from prior ye					0.00	60.
1.00 If line 53/54 is less than the lower of I which operating costs (line 53) are less					0	61.
amount (line 56), otherwise enter zero (s		5 (TTHES 54 X	00), 01 1% 0	i the target		
2.00 Relief payment (see instructions)	,				0	
3.00 Allowable Inpatient cost plus incentive p	bayment (see instruc	ctions)			0	63.
PROGRAM INPATIENT ROUTINE SWING BED COST 4.00 Medicare swing-bed SNF inpatient routine	costs through Decer	ber 31 of the	e cost report	ng period (See	0	64.
instructions)(title XVIII only)	0			0 1 1		
5.00 Medicare swing-bed SNF inpatient routine instructions)(title XVIII only)	costs after Decembe	er 31 of the c	cost reporting	g period (See	0	65.
5.00 Total Medicare swing-bed SNF inpatient ro	outine costs (line d	54 plus line 6	5)(title XVI	ll only). For	C	66.
CAH (see instructions)		·	, .	5.		
7.00 Title V or XIX swing-bed NF inpatient rou	itine costs through	December 31 d	of the cost re	eporting period	C	67.
line 12 x line 19) B.OO Title V or XIX swing-bed NF inpatient rou	utine costs after De	ecember 31 of	the cost rep	orting period	0	68.
(line 13 x line 20)				•		
9.00 Total title V or XIX swing-bed NF inpation PART III - SKILLED NURSING FACILITY, OTHE					C	69.
0.00 Skilled nursing facility/other nursing facility/)		70.
1.00 Adjusted general inpatient routine servio	ce cost per diem (li					71.
2.00 Program routine service cost (line 9 x li 3.00 Medically necessary private room cost app		(line 14 v li	ne 35)			72.
4.00 Total Program general inpatient routine s	Ũ	•				74.
5.00 Capital-related cost allocated to inpatio	ent routine service	costs (from V	lorksheet B, I	Part II, column		75.
26, line 45) 5.00 Per diem capital-related costs (line 75 ·	line 2)					76.
7.00 Program capital-related costs (line 9 x l						77.
3.00 Inpatient routine service cost (line 74 m						78.
0.00 Aggregate charges to beneficiaries for ex 0.00 Total Program routine service costs for e				nus line 70)		79. 80.
.00 Inpatient routine service costs for a				103 IIIE 17)		80.
2.00 Inpatient routine service cost limitation	n (line 9 x line 81)					82.
8.00 Reasonable inpatient routine service cos		5)				83.
4.00 Program inpatient ancillary services (see 5.00 Utilization review - physician compensati		ls)				84. 85.
5.00 Total Program inpatient operating costs						86.
PART IV - COMPUTATION OF OBSERVATION BED	PASS THROUGH COST				1	
7.00 Total observation bed days (see instructi					0.00	
3.00 Adjusted general inpatient routine cost p						

Health Financial Systems	FRANCI SCAN HEA	ALTH L	AFAYETTE		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		F	Provider CO		Period: From 01/01/2017	Worksheet D-1	
		C	Component (CCN: 15-T109	To 12/31/2017	Date/Time Pre 5/31/2018 3:5	pared: 3 pm
			Title	XVIII	Subprovider - IRF	PPS	
Cost Center Description	Cost		tine Cost	column 1 ÷	Total	Observati on	
		(fror	m 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	697, 07	2	3, 728, 156	0. 18697	/5 0	0	90.00
91.00 Nursing School cost		0	3, 728, 156	0.0000	0 0	0	91.00
92.00 Allied health cost		0	3, 728, 156	0.0000	0 0	0	92.00
93.00 All other Medical Education		0	3, 728, 156	0.00000	0 0	0	93.00

INPATIE	Financial Systems FRANCISCAN HEALTH NT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN· 15-0109	In Lie Period:	Worksheet D-3	
				From 01/01/2017 To 12/31/2017		pared:
		Title	e XVIII	Hospi tal	PPS	
	Cost Center Description		Ratio of Cos To Charges	t Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
	NPATIENT ROUTINE SERVICE COST CENTERS					
	03000 ADULTS & PEDIATRICS			34, 808, 325		30.00
	03100 I NTENSI VE CARE UNI T			8, 810, 648		31.00
	D2060 NEONATAL INTENSIVE CARE UNIT			0		35.00
	04100 SUBPROVIDER – IRF			0		41.00
	04300 NURSERY					43.00
	NCI LLARY SERVICE COST CENTERS					
	D5000 OPERATING ROOM		0. 1123			
	D5100 RECOVERY ROOM		0. 1330			
	D5200 DELIVERY ROOM & LABOR ROOM		0. 2659			
	05400 RADI OLOGY-DI AGNOSTI C		0. 1759		1, 642, 003	
	03630 RADI OLOGY-THERAPEUTI C		0. 1061		-	
	05600 RADI OI SOTOPE		0.0000		0	
	03950 CARDIAC CATH LAB		0. 1081		868, 375	
	D5700 CT SCAN		0.0326			
			0.0424			
	06000 LABORATORY 06500 RESPI RATORY_THERAPY		0. 1055			
	0600 PHYSICAL THERAPY		0. 3827			
	06700 OCCUPATIONAL THERAPY		0. 4824			
	06800 SPEECH PATHOLOGY		0. 2833			
	06900 ELECTROCARDI OLOGY		0. 4052			
	07000 ELECTROEARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY		0. 1343		141, 534	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 3234			
	07200 IMPL. DEV. CHARGED TO PATIENTS		0. 1489			
	07300 DRUGS CHARGED TO PATIENTS		0. 1518			
	07301 DI ABETES CENTER		3. 0303			
	07400 RENAL DI ALYSI S		0. 4134		-	
	07698 HYPERBARI C OXYGEN THERAPY		0. 4967			
	DUTPATIENT SERVICE COST CENTERS		0.4907	75 0	0	1 /0. 70
	D9000 CLINIC		1.5406	78 0	0	90.00
	09100 EMERGENCY		0. 2563		-	
	04950 WOUND CARE		0. 4650			
	09200 OBSERVATION BEDS (NON-DISTINCT PART		0.0000		0	
	09201 OBSERVATI ON BEDS (DI STINCT PART)		0. 3885			
	THER REIMBURSABLE COST CENTERS					1
	09500 AMBULANCE SERVI CES					95.0
200.00	Total (sum of lines 50 through 94 and 96 through 98)			218, 231, 602	35, 278, 345	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges	(line 61)		0		201.0
202.00	Net charges (line 200 minus line 201)			218, 231, 602		202.00

	AFAYETTE Provider C	CN: 15-0109	Peri od:	u of Form CMS-2 Worksheet D-3	
	i official of		From 01/01/2017		
	Component	CCN: 15-T109	To 12/31/2017	Date/Time Pre 5/31/2018 3:5	
	Title	e XVIII	Subprovider -	PPS	
			I RF		
Cost Center Description		Ratio of Cos		Inpatient	
		To Charges	Program	Program Costs (col. 1 x col.	
			Charges	(201. 1 x 201. 2)	
		1.00	2.00	3.00	-
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
0. 00 03000 ADULTS & PEDI ATRI CS			0		1 30
. 00 03100 INTENSIVE CARE UNIT			0		31
00 02060 NEONATAL INTENSIVE CARE UNIT			0		35
. 00 04100 SUBPROVIDER - IRF			2, 594, 996		41
0 04300 NURSERY					43
ANCI LLARY SERVI CE COST CENTERS					
0. 00 O5000 OPERATING ROOM		0. 1123	99 24, 764	2, 783	50
. 00 05100 RECOVERY ROOM		0. 1330	71 4, 544	605	51
2. 00 05200 DELIVERY ROOM & LABOR ROOM		0. 2659	54 0	0	52
. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 17590	09 37, 948	6, 675	54
. 00 03630 RADI OLOGY-THERAPEUTI C		0. 1061		552	
0. 00 05600 RADI OI SOTOPE		0.0000		0	
0. 01 03950 CARDI AC CATH LAB		0. 1081		0	
7. 00 05700 CT SCAN		0. 0326			
8. 00 05800 MRI		0. 0424		185	
0. 00 06000 LABORATORY		0. 1055		47, 654	
0.00 06500 RESPI RATORY THERAPY		0. 38270		42, 081	
0. 00 06600 PHYSI CAL THERAPY		0. 48242		567, 508	
00 06700 OCCUPATI ONAL THERAPY		0. 2833		339, 408	
0.00 06800 SPEECH PATHOLOGY		0. 4652		128, 146	
00 06900 ELECTROCARDI OLOGY		0. 1343		956	
		0. 3234		0	
. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 14690		40, 526	
2. OO 07200 IMPL. DEV. CHARGED TO PATIENTS 3. OO 07300 DRUGS CHARGED TO PATIENTS		0. 2293		3, 142	
. 00 07300 DRUGS CHARGED TO PATIENTS . 01 07301 DIABETES CENTER		0. 1518 3. 0303		65, 239 0	
. 00 07400 RENAL DIALYSIS		0. 4134		11, 721	
. 98 07698 HYPERBARI C OXYGEN THERAPY		0. 4134		0	
OUTPATIENT SERVICE COST CENTERS		0.4907	75 0	0	
0. 00 09000 CLINIC		1.5406	78 0	0	90
. 00 09100 EMERGENCY		0. 2563		2, 232	
. 01 04950 WOUND CARE		0. 4650		2,232	
. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0.0000		0	
01 09201 OBSERVATION BEDS (INON DISTINCT PART)		0. 38853		0	
OTHER REIMBURSABLE COST CENTERS				Ŭ	1
0 09500 AMBULANCE SERVICES					95
0.00 Total (sum of lines 50 through 94 and 96 through 98)			4, 104, 107	1, 261, 142	
1.00 Less PBP Clinic Laboratory Services-Program only charges	(line 61)		0		201
2.00 Net charges (line 200 minus line 201)			4, 104, 107		202

ealth Financial Systems FRANCISCAN HEALTH NPATIENT ANCILLARY SERVICE COST APPORTIONMENT		CN: 15-0109	Peri od:	u of Form CMS-2 Worksheet D-3	
NPATTENT ANCILLARY SERVICE CUST APPORTIONMENT	Provider C	CN: 15-0109	From 01/01/2017	worksneet D-3	
			To 12/31/2017	Date/Time Pre 5/31/2018 3:5	
	Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description		Ratio of Cos	st Inpatient	I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
		1.00		2)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
0.00 03000 ADULTS & PEDIATRICS		1	14, 358, 984		30.0
1. 00 03100 I NTENSI VE CARE UNI T			2, 633, 012		31.0
15. 00 02060 NEONATAL INTENSIVE CARE UNIT			9, 023, 029		35.0
1. 00 04100 SUBPROVIDER - IRF			9, 023, 029		41.0
3. 00 04300 NURSERY			0		41.0
ANCI LLARY SERVICE COST CENTERS			0		43.0
IO. 00 05000 OPERATI NG ROOM		0. 1123	99 3, 292, 669	370, 093	50.0
1. 00 05100 RECOVERY ROOM		0.1330		42, 275	
22.00 05200 DELIVERY ROOM & LABOR ROOM		0. 2659			
4. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 1759			
55. 00 03630 RADI OLOGY - THERAPEUTI C		0. 1061			
6. 00 05600 RADI OLSOT THEIRI EDITIO		0.0000			56.0
6. 01 03950 CARDI AC CATH LAB		0. 1081		-	
7. 00 05700 CT SCAN		0. 0326			
18. 00 05800 MRI		0.0424			58.0
0. 00 06000 LABORATORY		0. 1055			
5. 00 06500 RESPIRATORY THERAPY		0. 3827			
6. 00 06600 PHYSI CAL THERAPY		0. 4824			
7. 00 06700 OCCUPATI ONAL THERAPY		0. 2833			67.0
18. 00 06800 SPEECH PATHOLOGY		0. 4652			
9. 00 06900 ELECTROCARDI OLOGY		0. 1343			
0.00 07000 ELECTROENCEPHALOGRAPHY		0. 3234			
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 1469			
2.00 07200 I MPL. DEV. CHARGED TO PATIENTS		0. 2293			
3.00 07300 DRUGS CHARGED TO PATIENTS		0. 1518			
3. 01 07301 DI ABETES CENTER		3.0303			1
4.00 07400 RENAL DIALYSIS		0. 4134		128, 102	
6. 98 07698 HYPERBARI C OXYGEN THERAPY		0. 4967			
OUTPATIENT SERVICE COST CENTERS			!		
0. 00 09000 CLINIC		1. 5406	78 0	0	90. (
1.00 09100 EMERGENCY		0. 2563	42 111, 620	28, 613	91.0
1.01 04950 WOUND CARE		0. 4650	68 0	0	91. (
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0.0000	00 0	0	92. (
2.01 09201 OBSERVATION BEDS (DISTINCT PART)		0. 3885	35 4, 820	1, 873	92. (
OTHER REI MBURSABLE COST CENTERS		1		1	
5. 00 09500 AMBULANCE SERVI CES					95.0
200.00 Total (sum of lines 50 through 94 and 96 through 98)			47, 219, 764	6, 490, 190	
201.00 Less PBP Clinic Laboratory Services-Program only charges	(line 61)		0		201.0
202.00 Net charges (line 200 minus line 201)			47, 219, 764		202.0

PATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0109	Peri od:	Worksheet D-3	;
	0t	CON 15 T100	From 01/01/2017		
	Component	CCN: 15-T109	To 12/31/2017	Date/Time Pre 5/31/2018 3:5	
	Titl	e XIX	Subprovider -	Cost	
			I RF		
Cost Center Description		Ratio of Cos		Inpatient	
		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	5.00	
00 03000 ADULTS & PEDI ATRI CS			0		1 30
00 03100 I NTENSI VE CARE UNI T			0		31
00 02060 NEONATAL INTENSIVE CARE UNIT			0		35
00 04100 SUBPROVIDER - IRF			439, 761		41
00 04300 NURSERY			0		43
ANCI LLARY SERVI CE COST CENTERS		•			
00 05000 OPERATING ROOM		0. 1123	99 0	0	50
00 05100 RECOVERY ROOM		0. 1330	71 0	0	51
. 00 05200 DELIVERY ROOM & LABOR ROOM		0. 2659	54 0	0	52
00 05400 RADI OLOGY-DI AGNOSTI C		0. 17590	09 5, 199	915	54
00 03630 RADI OLOGY-THERAPEUTI C		0. 1061	12 0	0	55
00 05600 RADI 0I SOTOPE		0.0000	0 00	0	56
01 03950 CARDIAC CATH LAB		0. 1081	58 0	0	56
. 00 05700 CT SCAN		0. 0326	11 8, 279	270	57
. 00 05800 MRI		0.0424	47 0	0	58
00 06000 LABORATORY		0. 1055	56 69, 016	7, 285	60
00 06500 RESPI RATORY THERAPY		0. 3827	04 19, 835	7, 591	65
. 00 06600 PHYSI CAL THERAPY		0. 48242	21 213, 026	102, 768	66
. 00 06700 OCCUPATI ONAL THERAPY		0. 2833	70 206, 372	58, 480	67
00 06800 SPEECH PATHOLOGY		0. 4652	17 55, 158	25, 660	68
. 00 06900 ELECTROCARDI OLOGY		0. 1343		42	69
00 07000 ELECTROENCEPHALOGRAPHY		0. 3234	17 0	0	70
. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 14690		5, 689	71
.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 2293		112	
00 07300 DRUGS CHARGED TO PATIENTS		0. 1518		18, 479	
01 07301 DI ABETES CENTER		3. 0303		0	
00 07400 RENAL DIALYSIS		0. 4134		617	
. 98 07698 HYPERBARI C OXYGEN THERAPY		0. 4967	95 0	0	76
OUTPATI ENT SERVICE COST CENTERS		1 5 10 1			
		1.5406		0	
		0. 2563		0	
01 04950 WOUND CARE		0.4650		0	
00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0.0000		0	
01 09201 OBSERVATI ON BEDS (DI STI NCT PART)		0. 3885	35 0	0	92
		1			
.00 09500 AMBULANCE SERVICES			720 547	227 000	95
D. 00Total (sum of lines 50 through 94 and 96 through 98)1. 00Less PBP Clinic Laboratory Services-Program only charges	(Lino (1)		739, 567	227, 908	200
T TOTAL THESE FOR CLIDIC LADOLATORY SERVICES-PLOOPAM ONLY CHARGES.	UTHE OF	1	()		1201

ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0109	Period: From 01/01/2017 To 12/31/2017	Worksheet E Part A Date/Time Pre 5/31/2018 3:5	
		Title XVIII	Hospi tal	PPS	
				1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS			1.00	
. 00	DRG Amounts Other than Outlier Payments			0	1.00
. 01	DRG amounts other than outlier payments for discharges occurrin instructions)	ng prior to October 1 ((see	31, 810, 723	1.01
. 02	DRG amounts other than outlier payments for discharges occurrin	ng on or after October	1 (see	10, 552, 673	1.02
	instructions)	0			
. 03	DRG for federal specific operating payment for Model 4 BPCI for 1 (see instructions)	r discharges occurring	prior to October	0	1.03
. 04	DRG for federal specific operating payment for Model 4 BPCI for	r discharges occurring	on or after	0	1.04
	October 1 (see instructions)	5 5			
. 00	Outlier payments for discharges. (see instructions)			1, 591, 654	2.00
. 01 . 02	Outlier reconciliation amount Outlier payment for discharges for Model 4 BPCI (see instruction	ons)		0	2.01 2.02
. 00	Managed Care Simulated Payments	51137		9, 313, 102	3.00
. 00	Bed days available divided by number of days in the cost repor-	ting period (see instru	uctions)	168.00	4.00
. 00	Indirect Medical Education Adjustment FTE count for allopathic and osteopathic programs for the most	recent cost reporting	partial anding on	0.00	5.00
. 00	or before 12/31/1996. (see instructions)	recent cost reporting	period ending on	0.00	5.00
. 00	FTE count for allopathic and osteopathic programs which meet th	he criteria for an add-	on to the cap	0.00	6.00
00	for new programs in accordance with 42 CFR 413.79(e)	40 CED 6410 10E(E)	(1)(1,)(D)(1)	0.00	7 00
. 00 . 01	MMA Section 422 reduction amount to the IME cap as specified un ACA § 5503 reduction amount to the IME cap as specified under 4			0.00	7.00
	cost report straddles July 1, 2011 then see instructions.	12 0110 3112. 100(1)(1)(1		0.00	/ / . 01
. 00	Adjustment (increase or decrease) to the FTE count for allopat	hic and osteopathic pro	ograms for	0.00	8.00
	affiliated programs in accordance with 42 CFR 413.75(b), 413.74 1998), and 67 FR 50069 (August 1, 2002).	9(c)(2)(iv), 64 FR 2634	40 (May 12,		
. 01	The amount of increase if the hospital was awarded FTE cap slo	ts under § 5503 of the	ACA. If the cost	0.00	8.01
	report straddles July 1, 2011, see instructions.				
. 02	The amount of increase if the hospital was awarded FTE cap slo	ts from a closed teachi	ng hospital	0.00	8. 02
. 00	under § 5506 of ACA. (see instructions) Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines	s (8 8 01 and 8 02) (See	0.00	9.00
	instructions)		(
0.00	FTE count for allopathic and osteopathic programs in the current	nt year from your recor	~ds		10.00
1.00 2.00	FTE count for residents in dental and podiatric programs. Current year allowable FTE (see instructions)				11.00 12.00
3.00	Total allowable FTE count for the prior year.			0.00	
4.00	Total allowable FTE count for the penultimate year if that year	r ended on or after Sep	otember 30, 1997,	0.00	14.00
5.00	otherwise enter zero. Sum of lines 12 through 14 divided by 3.			0.00	15.00
	Adjustment for residents in initial years of the program				16.00
7.00	Adjustment for residents displaced by program or hospital close	ure			17.00
	Adjusted rolling average FTE count				18.00
9.00	Current year resident to bed ratio (line 18 divided by line 4). Prior year resident to bed ratio (see instructions)			0. 000000 0. 000000	
	Enter the lesser of lines 19 or 20 (see instructions)			0.000000	
2.00	IME payment adjustment (see instructions)			0	
2. 01	IME payment adjustment - Managed Care (see instructions)	of the MMA		0	22.01
3. 00	Indirect Medical Education Adjustment for the Add-on for § 422 Number of additional allopathic and osteopathic IME FTE resider		CFR 412, 105	0.00	23.00
	(f)(1)(iv)(C).				
4.00	IME FTE Resident Count Over Cap (see instructions)		24 (0.00	1
5.00	If the amount on line 24 is greater than -O-, then enter the lo instructions)	ower of line 23 or line	e 24 (see	0.00	25.00
6.00	Resident to bed ratio (divide line 25 by line 4)			0.000000	26.00
7.00	IME payments adjustment factor. (see instructions)			0.000000	
8.00	IME add-on adjustment amount (see instructions)			0	
9.00	IME add-on adjustment amount - Managed Care (see instructions) Total IME payment (sum of lines 22 and 28)			0	
9.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01))		0	
0 0-	Disproportionate Share Adjustment				0.0.
0.00	Percentage of SSI recipient patient days to Medicare Part A par Percentage of Medicaid patient days (see instructions)	tient days (see instruc	ctions)		30.00 31.00
1.00	Percentage of Medicaid patient days (see instructions) Sum of lines 30 and 31			24.61 27.90	31.00
3.00	Allowable disproportionate share percentage (see instructions)			13.30	33.00
4.00	Disproportionate share adjustment (see instructions)			1, 408, 584	34.0

ALCOL	Financial Systems FRANCISCAN HEALTH ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0109	Peri od:	u of Form CMS-2 Worksheet E	
			From 01/01/2017 To 12/31/2017	Part A Date/Time Pre	narc
			10 12/31/2017	5/31/2018 3:5	
		Title XVIII	Hospi tal	PPS	
			Prior to 10/1		
	Uncompanyated Care Adjustment		1.00	2.00	
5.00	Uncompensated Care Adjustment Total uncompensated care amount (see instructions)		E 077 402 147	4 744 40E 144	35.
	Factor 3 (see instructions)		0. 000314880	6, 766, 695, 164 0. 000312205	
	Hospital uncompensated care payment (If line 34 is zero, ente	or zoro on this line) (sou		2, 112, 594	
5. UZ	instructions)		1,002,109	2, 112, 394	30
5.03	Pro rata share of the hospital uncompensated care payment amo	unt (see instructions)	1, 407, 774	532, 490	35
	Total uncompensated care (sum of columns 1 and 2 on line 35.0		1, 940, 264	002, 170	36
	Additional payment for high percentage of ESRD beneficiary di				
0. 00	Total Medicare discharges on Worksheet S-3, Part I excluding		0		40
	652, 682, 683, 684 and 685 (see instructions)	C			
1. 00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 6	983, 684 an 685. (see	0		41
	instructions)				
1. 01	Total ESRD Medicare covered and paid discharges excluding MS-	DRGs 652, 682, 683, 684	0		41
	an 685. (see instructions)				
	Divide line 41 by line 40 (if less than 10%, you do not quali		0.00		42
3.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 68	32, 683, 684 an 685. (see	0		43
1 00	instructions)	by Line 41 divided by 7	0,000000		44
4.00	Ratio of average length of stay to one week (line 43 divided days)	by The 41 divided by 7	0.00000		44
5.00	Average weekly cost for dialysis treatments (see instructions	:)	0.00		45
	Total additional payment (line 45 times line 44 times line 41		0.00		46
	Subtotal (see instructions)		47, 303, 898		47
8.00	Hospital specific payments (to be completed by SCH and MDH, s	small rural hospitals	0		48
	only. (see instructions)				
				Amount	
		-		1.00	
	Total payment for inpatient operating costs (see instructions			47, 303, 898	
	Payment for inpatient program capital (from Wkst. L, Pt. I an			3, 894, 243	
	Exception payment for inpatient program capital (Wkst. L, Pt.			0	51
	Direct graduate medical education payment (from Wkst. E-4, li	ne 49 see finstructions).		0 825, 525	52 53
4.00	Nursing and Allied Health Managed Care payment Special add-on payments for new technologies			025, 525	54
	Islet isolation add-on payment			0	54
5.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 6	9)		0	55
6.00	Cost of physicians' services in a teaching hospital (see intr			0	56
7.00	Routine service other pass through costs (from Wkst. D, Pt. I		rouah 35).	2, 463, 712	
8.00	Ancillary service other pass through costs from Wkst. D, Pt.			311, 118	
9.00	Total (sum of amounts on lines 49 through 58)			54, 798, 496	59
D. 00	Primary payer payments			7, 889	60
	Total amount payable for program beneficiaries (line 59 minus	sline 60)		54, 790, 607	
2.00	Deductibles billed to program beneficiaries			4, 097, 828	62
3.00	Coinsurance billed to program beneficiaries			110, 215	63
	Allowable bad debts (see instructions)			465, 910	
	Adjusted reimbursable bad debts (see instructions)			302, 842	
4.00 5.00				167, 540	66
4.00 5.00 6.00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)			
4.00 5.00 6.00 7.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			50, 885, 406	67
4.00 5.00 6.00 7.00 8.00	Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for	applicable to MS-DRGs (se		0	67 68
4.00 5.00 6.00 7.00 8.00 9.00	Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96).	applicable to MS-DRGs (se		0 0	67 68 69
4.00 5.00 6.00 7.00 8.00 9.00 0.00	Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96). NEW TECHNOLOGY	applicable to MS-DRGs (se (For SCH see instructions	5)	0 0 8, 286	67 68 69 70
4.00 5.00 6.00 7.00 8.00 9.00 0.00 0.50	Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96). NEW TECHNOLOGY Rural Community Hospital Demonstration Project (§410A Demonst	applicable to MS-DRGs (se (For SCH see instructions	5)	0 0 8, 286 0	67 68 69 70 70
4.00 5.00 6.00 7.00 8.00 9.00 0.00 0.50 0.87	Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96). NEW TECHNOLOGY Rural Community Hospital Demonstration Project (§410A Demonst Demonstration payment adjustment amount before sequestration	applicable to MS-DRGs (se (For SCH see instructions	5)	0 0 8, 286 0 0	67 68 69 70 70 70
4.00 5.00 6.00 7.00 8.00 9.00 0.00 0.50 0.87 0.88	Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96). NEW TECHNOLOGY Rural Community Hospital Demonstration Project (§410A Demonst Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only)	applicable to MS-DRGs (se (For SCH see instructions ration) adjustment (see i	5)	0 0 8, 286 0	67 68 69 70 70 70 70
4.00 5.00 6.00 7.00 8.00 9.00 0.00 0.50 0.87 0.88 0.89	Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96). NEW TECHNOLOGY Rural Community Hospital Demonstration Project (§410A Demonst Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see inst	applicable to MS-DRGs (se (For SCH see instructions ration) adjustment (see i	5)	0 0 8, 286 0 0 0	67 68 69 70 70 70 70 70
4.00 5.00 6.00 7.00 8.00 9.00 0.00 0.50 0.87 0.88 0.89 0.90	Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96). NEW TECHNOLOGY Rural Community Hospital Demonstration Project (§410A Demonst Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see inst HSP bonus payment HVBP adjustment amount (see instructions)	applicable to MS-DRGs (se (For SCH see instructions ration) adjustment (see i	5)	0 0 8, 286 0 0 0 0	67 68 69 70 70 70 70 70 70
4.00 5.00 6.00 7.00 8.00 9.00 0.00 0.50 0.87 0.88 0.89 0.90 0.91	Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96). NEW TECHNOLOGY Rural Community Hospital Demonstration Project (§410A Demonst Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see inst HSP bonus payment HVBP adjustment amount (see instructions) HSP bonus payment HRR adjustment amount (see instructions)	applicable to MS-DRGs (se (For SCH see instructions ration) adjustment (see i	5)	0 0 8, 286 0 0 0 0 0	67 68 69 70 70 70 70 70 70 70 70
4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 0. 00 0. 50 0. 87 0. 88 0. 89 0. 90 0. 91 0. 92	Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96). NEW TECHNOLOGY Rural Community Hospital Demonstration Project (§410A Demonst Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see inst HSP bonus payment HVBP adjustment amount (see instructions) HSP bonus payment HRR adjustment amount (see instructions) Bundled Model 1 discount amount (see instructions)	applicable to MS-DRGs (se (For SCH see instructions ration) adjustment (see i	5)	0 0 8, 286 0 0 0 0 0 0 0	67 68 70 70 70 70 70 70 70 70 70
4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 0. 00 0. 50 0. 87 0. 88 0. 89 0. 90 0. 91 0. 92 0. 93	Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96). NEW TECHNOLOGY Rural Community Hospital Demonstration Project (§410A Demonst Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see inst HSP bonus payment HVBP adjustment amount (see instructions) HSP bonus payment HRR adjustment amount (see instructions)	applicable to MS-DRGs (se (For SCH see instructions ration) adjustment (see i	5)	0 0 8, 286 0 0 0 0 0	67 68 69 70 70 70 70 70 70 70 70 70

	Financial Systems FRANCISCAN HEALTI		2N 1E 0100		u of Form CMS-2	2552-
UALUULA	ATION OF REIMBURSEMENT SETTLEMENT	Provider C	JN: 15-0109	Period: From 01/01/2017	Worksheet E Part A	
				To 12/31/2017	Date/Time Pre	pared
					5/31/2018 3:5	3 pm
		Title	XVIII	Hospi tal	PPS	
			FF Y	(уууу)	Amount	
0.96	Low volume adjustment for foderal fiscal year (yawa) (Enter i	n column 0		0	1.00	70
0.90	Low volume adjustment for federal fiscal year (yyyy) (Enter i the corresponding federal year for the period prior to 10/1)			0	0	70.
	Low volume adjustment for federal fiscal year (yyyy) (Enter i	n column O		0	0	70.
	the corresponding federal year for the period ending on or af			-	-	
	Low Volume Payment-3	,			0	70.
70. 99	HAC adjustment amount (see instructions)				0	70.
1.00	Amount due provider (line 67 minus lines 68 plus/minus lines	69 & 70)			50, 885, 431	71.
1.01	Sequestration adjustment (see instructions)				1, 017, 709	71.
1	Demonstration payment adjustment amount after sequestration				0	
1	Interim payments				50, 245, 545	
	Tentative settlement (for contractor use only)				0	73.
	Balance due provider/program (line 71 minus lines 71.01, 71.0)2, 72, and			-377, 823	74.
1	73)	noo with			0	75
	Protested amounts (nonallowable cost report items) in accorda CMS Pub. 15-2, chapter 1, §115.2	ince with			0	75.
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
	Operating outlier amount from Wkst. E, Pt. A, line 2 (see ins	structions)			0	90.
	Capital outlier from Wkst. L, Pt. I, line 2				0	91.
	Operating outlier reconciliation adjustment amount (see instr	uctions)			0	92.
3.00	Capital outlier reconciliation adjustment amount (see instruc	ctions)			0	93.
4.00	The rate used to calculate the time value of money (see instr	ructions)			0.00	94.
5.00	Time value of money for operating expenses (see instructions)				0	95.
96.00	Time value of money for capital related expenses (see instruc	ctions)			0	96.
				Prior to 10/1		
i	HSP Bonus Payment Amount			1.00	2.00	
	HSP bonus amount (see instructions)					1
				0	0	1100
	HVBP Adjustment for HSP Bonus Payment			0	0	100.
	HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions)			0. 000000000	0.000000000	
01.00	HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructior	ns)			0. 000000000	
101.00 102.00	HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructior	ns)		0.000000000	0. 000000000	101.
101.00 102.00	HVBP adjustment factor (see instructions)	is)		0.000000000	0. 000000000	101. 102.
01.00 02.00 03.00 04.00	HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions	3)		0.000000000	0. 000000000 0 0. 0000	101. 102.
01.00 02.00 03.00 04.00	HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst	s) ration) Adju		0. 0000000000 0 0. 0000	0. 000000000 0 0. 0000 0	101. 102. 103. 104.
01.00 02.00 03.00 04.00 00.00	HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe	s) ration) Adju		0. 0000000000 0 0. 0000	0. 000000000 0 0. 0000 0	101. 102. 103. 104.
01.00 02.00 03.00 04.00 00.00	HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no.	s) ration) Adju		0. 0000000000 0 0. 0000	0. 000000000 0 0. 0000 0	101. 102. 103. 104.
01.00 02.00 03.00 04.00 00.00	HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement	s) rration) Adju eriod under t		0. 0000000000 0 0. 0000	0. 000000000 0 0. 0000 0	101. 102. 103. 104. 200.
01.00 02.00 03.00 04.00 00.00 01.00	HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, lir	s) rration) Adju eriod under t		0. 0000000000 0 0. 0000	0. 000000000 0 0. 0000 0	101. 102. 103. 104. 200.
01.00 02.00 03.00 04.00 00.00 01.00 02.00	HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, lir Medicare discharges (see instructions)	s) rration) Adju eriod under t		0. 0000000000 0 0. 0000	0. 000000000 0 0. 0000 0	101. 102. 103. 104. 200. 201. 202.
01.00 02.00 03.00 04.00 00.00 01.00 02.00 03.00	HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, lir Medicare discharges (see instructions) Case-mix adjustment factor (see instructions)	s) ration) Adju eriod under t ne 49)	he 21st	0.0000000000000000000000000000000000000	0.000000000 0 0.0000 0	101. 102. 103.
01.00 02.00 03.00 04.00 00.00 01.00 02.00 03.00	HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, lir Medicare discharges (see instructions)	s) ration) Adju eriod under t ne 49)	he 21st	0.0000000000000000000000000000000000000	0.000000000 0 0.0000 0	101. 102. 103. 104. 200. 201. 202.
01.00 02.00 03.00 04.00 00.00 01.00 02.00 03.00 04.00	HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount	s) ration) Adju eriod under t ne 49)	he 21st	0.0000000000000000000000000000000000000	0.000000000 0 0.0000 0	101. 102. 103. 104. 200. 201. 202. 203. 204.
01.00 02.00 03.00 04.00 00.00 01.00 02.00 03.00 03.00 04.00 05.00	HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iir Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204)	s) ration) Adju eriod under t ne 49) n first year	he 21st	0.0000000000000000000000000000000000000	0.000000000 0 0.0000 0	101. 102. 103. 104. 200. 201. 202. 203. 204. 204. 205.
01.00 02.00 03.00 04.00 00.00 01.00 02.00 03.00 04.00 05.00 06.00	HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iir Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205)	s) ration) Adju eriod under t ne 49) n first year	he 21st	0.0000000000000000000000000000000000000	0.000000000 0 0.0000 0	101. 102. 103. 104. 200. 201. 202. 203. 204. 205.
01.00 02.00 03.00 04.00 00.00 01.00 02.00 03.00 04.00 05.00 06.00	HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, lir Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement	s) ration) Adju eriod under t ne 49) n first year	he 21st	0.0000000000000000000000000000000000000	0.000000000 0 0.0000 0	101. 102. 103. 104. 200. 201. 202. 203. 204. 205. 206.
D1.00 D2.00 D3.00 D4.00 D0.00 D1.00 D2.00 D3.00 D4.00 D5.00 D4.00 D5.00 D6.00 D7.00	HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, lir Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst	s) rration) Adju eriod under t ne 49) i first year rructions)	he 21st	0.0000000000000000000000000000000000000	0.000000000 0 0.0000 0 0	101. 102. 103. 104. 200. 201. 202. 203. 204. 205. 206. 206.
01.00 02.00 03.00 04.00 00.00 01.00 02.00 03.00 03.00 04.00 05.00 06.00 07.00 08.00	HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, lir Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst Medicare Part A inpatient service costs (from Wkst. E, Pt. A,	s) rration) Adju eriod under t ne 49) i first year rructions)	he 21st	0.0000000000000000000000000000000000000	0.000000000 0 0.0000 0 	101. 102. 103. 104. 200. 201. 202. 203. 204. 205. 206. 206. 207. 208.
01.00 02.00 03.00 04.00 00.00 01.00 02.00 03.00 04.00 05.00 06.00 07.00 08.00 09.00	HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Rural Community Hospital Demonstration Project (§410A Demonst constructions) Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions)	s) rration) Adju eriod under t ne 49) i first year rructions)	he 21st	0.0000000000000000000000000000000000000	0.000000000 0 0.0000 0 	101. 102. 103. 104. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209.
01.00 02.00 03.00 04.00 00.00 01.00 02.00 03.00 04.00 05.00 06.00 07.00 08.00 09.00 10.00	HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions) Reserved for future use	s) ration) Adju eriod under t ne 49) n first year ructions) line 59)	he 21st	0.0000000000000000000000000000000000000	0.000000000 0 0.0000 0 0	101. 102. 103. 104. 200. 201. 202. 203. 204. 205. 206. 206. 207. 208. 209. 210.
01.00 02.00 03.00 04.00 00.00 01.00 02.00 03.00 04.00 05.00 06.00 07.00 08.00 09.00 10.00 11.00	HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iir Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions)	s) ration) Adju eriod under t ne 49) n first year ructions) line 59)	he 21st	0.0000000000000000000000000000000000000	0.000000000 0 0.0000 0 0	101. 102. 103. 104. 200. 201. 202. 203. 204. 205. 206. 206. 207. 208. 209. 210.
01.00 02.00 03.00 04.00 00.00 01.00 02.00 03.00 03.00 04.00 05.00 06.00 07.00 08.00 09.00 10.00 11.00	HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, lir Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement	s) ration) Adju eriod under t ne 49) n first year ructions) line 59)	he 21st	0.0000000000000000000000000000000000000	0.000000000 0 0.0000 0	101. 102. 103. 104. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209. 210. 211.
01.00 02.00 03.00 04.00 00.00 01.00 02.00 03.00 03.00 05.00 06.00 07.00 08.00 09.00 10.00 11.00 12.00	HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, lir Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare Part A IPPS payments (from line Total adjustment to Medicare Part A IPPS payments (from line	s) ration) Adju eriod under t ne 49) n first year ructions) line 59)	he 21st	0.0000000000000000000000000000000000000	0.000000000 0 0.0000 0 	101. 102. 103. 104. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209. 210. 211. 211.
01.00 02.00 03.00 04.00 00.00 01.00 02.00 03.00 03.00 04.00 05.00 06.00 07.00 08.00 09.00 10.00 11.00 11.00 13.00	HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, lir Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement	s) ration) Adju eriod under t ne 49) i first year ructions) line 59) 211)	he 21st	0.0000000000000000000000000000000000000	0.000000000 0 0.0000 0 	101. 102. 103. 104. 200. 201. 202. 203. 204. 205. 206. 206. 207. 208.

CALCUL		LAFAYETTE Provider CCN: 15-0109	Peri od:	Worksheet E	2552-10
			From 01/01/2017 To 12/31/2017	Part B Date/Time Pre	pared:
			Hocpi tol	5/31/2018 3:5	
		Title XVIII	Hospi tal	PPS	
				1.00	
1.00	PART B - MEDICAL AND OTHER HEALTH SERVICES Medical and other services (see instructions)			23, 838	1.00
2.00	Medical and other services reimbursed under OPPS (see instructi	ons)		22, 982, 866	
3.00	OPPS payments			20, 396, 484	
4.00	Outlier payment (see instructions)			200, 311	
4.01 5.00	Outlier reconciliation amount (see instructions) Enter the hospital specific payment to cost ratio (see instruct	ions)		0.000	
6.00	Line 2 times line 5	1013)		0.000	
7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	7.00
8.00	Transitional corridor payment (see instructions)			0	8.00
9.00 10.00	Ancillary service other pass through costs from Wkst. D, Pt. IV Organ acquisitions	, col. 13, line 200		212, 951 0	9.00 10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			23, 838	
	COMPUTATION OF LESSER OF COST OR CHARGES			20,000	
	Reasonable charges			45 (0 (0	
12.00 13.00	Ancillary service charges Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, lir	a 60)		156, 943 0	
14.00	Total reasonable charges (sum of lines 12 and 13)	ie 09)		156, 943	
	Customary charges			1007 710	
15.00	Aggregate amount actually collected from patients liable for pa			0	
16.00	Amounts that would have been realized from patients liable for		n a chargebasis	0	16.00
17.00	had such payment been made in accordance with 42 CFR §413.13(e) Ratio of line 15 to line 16 (not to exceed 1.000000)			0. 000000	17.00
18.00	Total customary charges (see instructions)			156, 943	
19.00	Excess of customary charges over reasonable cost (complete only	/ifline 18 exceeds li	ne 11) (see	133, 105	
~~ ~~	instructions)		10) (
20.00	Excess of reasonable cost over customary charges (complete only instructions)	if line 11 exceeds li	ne 18) (see	0	20.00
21.00	Lesser of cost or charges (see instructions)			23, 838	21.00
22.00	Interns and residents (see instructions)			0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instru	ıcti ons)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) COMPUTATION OF REIMBURSEMENT SETTLEMENT			20, 809, 746	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, 688, 472	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) pl	us the sum of lines 22	and 23] (see	17, 145, 112	27.00
28.00	instructions) Direct graduate medical education payments (from Wkst. E-4, lir	ne 50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	le 30)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)			17, 145, 112	30.00
31.00	Primary payer payments			7, 317	
32.00	Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE	S)		17, 137, 795	32.00
33.00		5)		0	33.00
34.00	Allowable bad debts (see instructions)			641, 944	
35.00	Adjusted reimbursable bad debts (see instructions)			417, 264	
36.00 37.00	Allowable bad debts for dual eligible beneficiaries (see instru	ictions)		399, 218	
38.00	Subtotal (see instructions) MSP-LCC reconciliation amount from PS&R			17, 555, 059 0	37.00 38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
39.50	Pioneer ACO demonstration payment adjustment (see instructions)				39.50
39.97	Demonstration payment adjustment amount before sequestration			0	
39. 98 39. 99	Partial or full credits received from manufacturers for replace RECOVERY OF ACCELERATED DEPRECIATION	d devices (see instruc	tions)	0	39.98 39.99
39.99 40.00	Subtotal (see instructions)			17, 555, 059	
40. 01	Sequestration adjustment (see instructions)			351, 101	
40. 02	Demonstration payment adjustment amount after sequestration			0	
41.00	Interim payments			17, 262, 539	
42.00 43.00	Tentative settlement (for contractors use only) Balance due provider/program (see instructions)			0 -58, 581	
44.00	Protested amounts (nonallowable cost report items) in accordance	e with CMS Pub. 15-2,	chapter 1,	-30, 301	
	§115. 2		· ·		
00.00	TO BE COMPLETED BY CONTRACTOR			0	
90.00 91.00	Original outlier amount (see instructions) Outlier reconciliation adjustment amount (see instructions)			0	
91.00 92.00	The rate used to calculate the Time Value of Money				91.00
	5				
93.00	Time Value of Money (see instructions) Total (sum of lines 91 and 93)			0	94.00

NALY	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC	CN: 15-0109	Period: From 01/01/2017 To 12/31/2017	Date/Time Prep	
			X4.1.1		5/31/2018 3:53	3 pm
		Inpati en	XVIII t Part A	Hospi tal Pai	T B PPS	
			A		Americant	
		mm/dd/yyyy 1.00	Amount 2.00		Amount 4.00	
. 00	Total interim payments paid to provider	1.00	49, 814, 1		17, 262, 539	1.
. 00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		,, .	0	0	2.
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)					3.
	Program to Provider					
. 01	ADJUSTMENTS TO PROVIDER	07/31/2017	431, 4		0	3. 3.
02 03				0	0	3. 3.
04				0	0	3.
05				0	0	3.
50	Provider to Program					
50 51	ADJUSTMENTS TO PROGRAM			0	0	3
52				0	0	3
53				0	0	3
54				0	0	3
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		431, 4	00	0	3
00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		50, 245, 5	45	17, 262, 539	4
	TO BE COMPLETED BY CONTRACTOR	I I				
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
	Program to Provider					_
01 02	TENTATI VE TO PROVI DER			0	0	5 5
02				0	0	5
	Provider to Program					
50	TENTATI VE TO PROGRAM			0	0	5
51 52				0	0	5 5
92 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	5
	5. 50-5. 98)					
00	Determined net settlement amount (balance due) based on the cost report. (1)					6
01 02	SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM		377, 8	0	0 58, 581	6
02	Total Medicare program liability (see instructions)		49,867,7		17, 203, 958	7
			· · ·	Contractor Number	NPR Date (Mo/Day/Yr)	,
		C)	1.00	2.00	

IALYS	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC Component (CN: 15-0109 CCN: 15-T109	Period: From 01/01/201 To 12/31/201		epare
		Title	XVIII	Subprovider - IRF		
		Inpatien	t Part A		art B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
00 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		2, 729, 9	25 0) 1.) 2.
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.
01	ADJUSTMENTS TO PROVIDER			0	(3.
02				0	(
03				0		3 3
)4				0) 3
)5				0	(3 3
	Provider to Program		[2		
50 51	ADJUSTMENTS TO PROGRAM			0) 3) 3
52				0) 3) 3
53				0		
54 54				0		
99	Subtotal (sum of lines 3.01–3.49 minus sum of lines 3.50–3.98)			0		5 3
00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2, 729, 9	25	(0 4
	TO BE COMPLETED BY CONTRACTOR					_
00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5
	Program to Provider					
)1)2	TENTATI VE TO PROVI DER			0		
)2)3				0) 5) 5
	Provider to Program					4 7
50	TENTATI VE TO PROGRAM			0	(5 5
51				0	(
52				0	(
99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0) 5
00	Determined net settlement amount (balance due) based on the cost report. (1)					6
)1	SETTLEMENT TO PROVIDER		14 0	0		
)2)0	SETTLEMENT TO PROGRAM Total Medicare program liability (see instructions)		16, 9 2, 712, 9) 6) 7
50			2, /12, 9	Contractor	NPR Date	, <i>'</i>
				Number	(Mo/Day/Yr)	
		()	1.00	2.00	

Heal th	Financial Systems FRANCISCAN HEAL	TH LAFAYETTE	In Lie	u of Form CMS-	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0109	Period: From 01/01/2017	Worksheet E-1 Part II	
			To 12/31/2017		
		Title XVIII	Hospi tal	PPS	
				1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				4
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATI				4
1.00	Total hospital discharges as defined in AARA §4102 from Wks		e 14		1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1,	8-12			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1,	8-12			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3	line 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of line 168	certified HIT technology	Wkst. S-2, Pt. I		7.00
8.00	Calculation of the HIT incentive payment (see instructions)				8.00
9.00	Sequestration adjustment amount (see instructions)				9.00
10.00	Calculation of the HIT incentive payment after sequestratio	n (see instructions)			10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				1
30.00	Initial/interim HIT payment adjustment (see instructions)				30.00
31.00	Other Adjustment (specify)				31.00
	Balance due provider (line 8 (or line 10) minus line 30 and	line 31) (see instruction	ns)		32.00

ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	LTH LAFAYETTE Provi der CCN: 15-0109	Peri od:	Worksheet E-3	2552
		Component CCN: 15-T109	From 01/01/2017 To 12/31/2017	Part III Date/Time Pre 5/31/2018 3:55	pare
		Title XVIII	Subprovider -	PPS	<u>5 pin</u>
				1.00	
	PART III - MEDICARE PART A SERVICES - IRF PPS				
. 00	Net Federal PPS Payment (see instructions)			2, 466, 812	1.
. 00	Medicare SSI ratio (IRF PPS only) (see instructions)			0. 0231	2.
. 00	Inpatient Rehabilitation LIP Payments (see instructions)			83, 132	3.
. 00 . 00	Outlier Payments	t cost concrting pariod on	ding on or prior	237, 051 0. 00	4. 5.
	Unweighted intern and resident FTE count in the most recent to November 15, 2004 (see instructions)		0 1		5.
. 01	Cap increases for the unweighted intern and resident FTE coprogram or hospital closure, that would not be counted with CFR 412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00	5.
. 00	New Teaching program adjustment. (see instructions)			0.00	6.
. 00	Current year's unweighted FTE count of I&R excluding FTEs i teaching program" (see instructions)	n the new program growth p	eriod of a "new	0.00	7.
. 00	Current year's unweighted I&R FTE count for residents withi teaching program" (see instructions)	n the new program growth p	eriod of a "new	0.00	8
. 00	Intern and resident count for IRF PPS medical education adj	ustment (see instructions)		0.00	9
0. 00	Average Daily Census (see instructions)	· · · · · · · · · · · · · · · · · · ·		7.909589	10
. 00	Teaching Adjustment Factor (see instructions)			0.00000	11
. 00	Teaching Adjustment (see instructions)			0	12
. 00	Total PPS Payment (see instructions)			2, 786, 995	13
. 00	Nursing and Allied Health Managed Care payments (see instru	uction)		0	14
5.00	Organ acquisition (DO NOT USE THIS LINE)				15
. 00	Cost of physicians' services in a teaching hospital (see in	nstructions)		0	16
. 00	Subtotal (see instructions)			2, 786, 995	
. 00	Primary payer payments			0	18
00	Subtotal (line 17 less line 18).			2, 786, 995	
00 . 00 .	Deductibles			11,816	
2.00	Subtotal (line 19 minus line 20) Coinsurance			2, 775, 179 10, 199	
. 00 . 00	Subtotal (line 21 minus line 22)			2, 764, 980	
. 00	Allowable bad debts (exclude bad debts for professional ser	vices) (see instructions)		2,704,900	24
5.00	Adjusted reimbursable bad debts (see instructions)			0	25
. 00	Allowable bad debts for dual eligible beneficiaries (see in	nstructions)		0	26
. 00	Subtotal (sum of lines 23 and 25)			2, 764, 980	
3.00	Direct graduate medical education payments (from Wkst. E-4,	line 49)		0	28
. 00	Other pass through costs (see instructions)			3, 343	
. 00	Outlier payments reconciliation			0	30
. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	31
1.50	Pioneer ACO demonstration payment adjustment (see instructi	ons)		0	31
1.99	Demonstration payment adjustment amount before sequestration	on		0	31
2.00	Total amount payable to the provider (see instructions)			2, 768, 323	
2. 01	Sequestration adjustment (see instructions)			55, 366	
2. 02	Demonstration payment adjustment amount after sequestration	1			32
3.00	Interim payments			2, 729, 925	
4.00	Tentative settlement (for contractor use only)			0	34
5.00 5.00	Balance due provider/program (line 32 minus lines 32.01, 32 Protested amounts (nonallowable cost report items) in accor		chapter 1,	-16, 968 0	35 36
	\$115.2 TO BE COMPLETED BY CONTRACTOR				
D. 00	Original outlier amount from Wkst. E-3, Pt. III, line 4			237, 051	50
1 00	Outlier reconciliation adjustment amount (see instructions))		0	51
1.00					

LCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0109	Peri od:	Worksheet E-3	
			From 01/01/2017 To 12/31/2017	Part VII Date/Time Pre	pare
		Title XIX	Hospi tal	5/31/2018 3:5 Cost	3 pr
		II LIE XIX	Inpatient	Outpati ent	
			1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SER	VICES FOR TITLES V OR		2100	
	COMPUTATION OF NET COST OF COVERED SERVICES				1
00	Inpatient hospital/SNF/NF services		0] 1
00	Medical and other services			0	2
00	Organ acquisition (certified transplant centers only)		0		3
00	Subtotal (sum of lines 1, 2 and 3)		0	0	
00	Inpatient primary payer payments		0		5
00	Outpatient primary payer payments			0	6
00	Subtotal (line 4 less sum of lines 5 and 6)		0	0	7
	COMPUTATION OF LESSER OF COST OR CHARGES				-
00	Reasonable Charges Routine service charges		0		6
00	Ancillary service charges		47, 219, 764	0	
00	Organ acquisition charges, net of revenue		47, 219, 704	0	10
00	Incentive from target amount computation		0		11
00	Total reasonable charges (sum of lines 8 through 11)		47, 219, 764	0	
	CUSTOMARY CHARGES		11/21///01		1
00	Amount actually collected from patients liable for payment for	services on a charge	0	0	1 13
	basi s	Ũ			
00	Amounts that would have been realized from patients liable for		on 0	0	14
	a charge basis had such payment been made in accordance with 4	2 CFR §413.13(e)			
00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0. 000000	0.000000	
00	Total customary charges (see instructions)		47, 219, 764	0	16
00	Excess of customary charges over reasonable cost (complete onl)	y IT line 16 exceeds	47, 219, 764	0	17
00	line 4) (see instructions) Excess of reasonable cost over customary charges (complete onl	viflipo 4 ovecode li	no 0	0	18
00	16) (see instructions)	y IT ITTLE 4 exceeds IT	0	0	
00	Interns and Residents (see instructions)		0	0	19
00	Cost of physicians' services in a teaching hospital (see instr	uctions)	0	0	
00	Cost of covered services (enter the lesser of line 4 or line 1		0	0	21
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be (i ders.		1
00	Other than outlier payments		0	0	22
00	Outlier payments		0	0	23
	Program capital payments		0		24
	Capital exception payments (see instructions)		0		25
	Routine and Ancillary service other pass through costs		0	0	
00	Subtotal (sum of lines 22 through 26)		0	0	
00	Customary charges (title V or XIX PPS covered services only)		0	0	
00	Titles V or XIX (sum of lines 21 and 27) COMPUTATION OF REIMBURSEMENT SETTLEMENT		0	0	29
00	Excess of reasonable cost (from line 18)		0	0	30
00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		0	0	31
00	Deductibles		0	0	
00	Coinsurance		0	0	
00	Allowable bad debts (see instructions)		0	0	
00	Utilization review		0	Ŭ	35
00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	33)	0	0	
00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	-	0	0	
00	Subtotal (line 36 ± line 37)		0	0	
00	Direct graduate medical education payments (from Wkst. E-4)		0		39
00	Total amount payable to the provider (sum of lines 38 and 39)		0	0	40
00	Interim payments		0	0	4
	Balance due provider/program (line 40 minus line 41)		0	0	42
00			°	Ũ	

_CUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0109 Component CCN: 15-T109	Period: From 01/01/2017 To 12/31/2017	Worksheet E-3 Part VII Date/Time Pre	
				5/31/2018 3:5	3 p
		Title XIX	Subprovider - IRF	Cost	
		·	Inpatient	Outpati ent	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SEF	RVICES FOR TITLES V OR X	1.00	2.00	-
	COMPUTATION OF NET COST OF COVERED SERVICES		TX SERVICES		1
00	Inpatient hospital/SNF/NF services		0		1 1
00	Medical and other services			0	2
00	Organ acquisition (certified transplant centers only)		0		3
00	Subtotal (sum of lines 1, 2 and 3)		0	0	4
00	Inpatient primary payer payments		0		5
00	Outpatient primary payer payments			0	
00	Subtotal (line 4 less sum of lines 5 and 6)		0	0	7
	COMPUTATION OF LESSER OF COST OR CHARGES				-
20	Reasonable Charges				
00 00	Routine service charges Ancillary service charges		0 739, 567	0	
00	Organ acquisition charges, net of revenue		/37, 30/	0	10
00	Incentive from target amount computation		0		1
00	Total reasonable charges (sum of lines 8 through 11)		739, 567	0	
00	CUSTOMARY CHARGES		, , , , , , , , , , , , , , , , , , , ,		1
00	Amount actually collected from patients liable for payment for	r services on a charge	0	0	11:
	basi s	5			
00	Amounts that would have been realized from patients liable for	⁻ payment for services c	n 0	0	14
	a charge basis had such payment been made in accordance with 4	42 CFR §413.13(e)			
00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0. 000000	0.00000	
00	Total customary charges (see instructions)		739, 567	0	
00	Excess of customary charges over reasonable cost (complete onl	y if line 16 exceeds	739, 567	0	1
~~	line 4) (see instructions)		-	0	1
00	Excess of reasonable cost over customary charges (complete onl 16) (see instructions)	y IF IIne 4 exceeds IIn	e 0	0	18
00	Interns and Residents (see instructions)		0	0	10
00	Cost of physicians' services in a teaching hospital (see instr	ructions)	0	0	
00	Cost of covered services (enter the lesser of line 4 or line		0	0	
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be		ders.		
00	Other than outlier payments		0	0	22
00	Outlier payments		0	0	23
00	Program capital payments		0		24
00	Capital exception payments (see instructions)		0		2!
00	Routine and Ancillary service other pass through costs		0	0	
00	Subtotal (sum of lines 22 through 26)		0	0	
00	Customary charges (title V or XIX PPS covered services only)		0	0	
00	Titles V or XIX (sum of lines 21 and 27) COMPUTATION OF REIMBURSEMENT SETTLEMENT		0	0	2
00	Excess of reasonable cost (from line 18)		0	0	30
00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		0	0	
	Deducti bl es		0	0	
00	Coinsurance		0	0	
00	Allowable bad debts (see instructions)		0	0	
00	Utilization review		0		3
00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	33)	0	0	
00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	
00	Subtotal (line 36 ± line 37)		0	0	
00	Direct graduate medical education payments (from Wkst. E-4)		0		3
00	Total amount payable to the provider (sum of lines 38 and 39)		0	0	
00	Interim payments		0	0	
00	Balance due provider/program (line 40 minus line 41)		0	0	
00	Protested amounts (nonallowable cost report items) in accordar	ice with CMS PUB 15-2,	0	0	43

	E SHEET (If you are nonproprietary and do not maintain ype accounting records, complete the General Fund column	Provider C		Period: From 01/01/2017	Worksheet G	
ly)			1	Го 12/31/2017	Date/Time Pre 5/31/2018 3:5	
		General Fund	Specific Purpose Fund	Endowment Fund		
	CURRENT ASSETS	1.00	2.00	3.00	4.00	
00	Cash on hand in banks	-103, 113	(0	1. (
00	Temporary investments	0		-	0	2.0
00 00	Notes receivable Accounts receivable	45, 572, 379		- -	0	3. (4. (
00	Other receivable	0,072,077		- -	0	5.0
00	Allowances for uncollectible notes and accounts receivable	0	(0 0	0	6.
00	Inventory	5, 604, 246	(- -	0	7.
00 00	Prepaid expenses Other current assets	0 17, 586, 835		- -	0	8. 9.
. 00	Due from other funds	17, 560, 655		-	0	10.
. 00	Total current assets (sum of lines 1-10)	68, 660, 347	(0 0	0	11.
	FI XED ASSETS					
. 00	Land	12, 785, 293	(0	12.
. 00 . 00	Land improvements Accumulated depreciation	3, 246, 587			0	13. 14.
. 00	Buildings	299, 700, 853		-	0	15.
. 00	Accumulated depreciation	-140, 698, 210	(0 0	0	16.
. 00	Leasehold improvements	2, 811, 902	(0 0	0	17.
. 00	Accumulated depreciation	0	(- -	0	18.
. 00	Fixed equipment	77, 253, 643		- -	0	19. 20.
. 00 . 00	Accumulated depreciation Automobiles and trucks	0		-	0	20
. 00	Accumulated depreciation	0		- -	0	22
	Major movable equipment	0	(0 0	0	23
	Accumulated depreciation	0	(0 0	0	24
	Minor equipment depreciable	0	(- -	0	25
. 00	Accumulated depreciation HIT designated Assets	0		- -	0	26
00	Accumulated depreciation	0		- -	0	27
. 00	Mi nor equi pment-nondepreci abl e	0		-	0	29
. 00	Total fixed assets (sum of lines 12-29)	255, 100, 068	(0 0	0	30.
	OTHER ASSETS			-1 -1	-	
. 00	Investments	6, 122, 929			0	31
. 00	Deposits on leases Due from owners/officers	0		-	0	32
. 00	Other assets	24, 475, 001			0	34
. 00	Total other assets (sum of lines 31-34)	30, 597, 930		-	0	35
. 00	Total assets (sum of lines 11, 30, and 35)	354, 358, 345	(0 0	0	36
	CURRENT LI ABI LI TI ES		I	1		
	Accounts payable	21, 403, 295 9, 769, 926			0	37.
00	Salaries, wages, and fees payable Payroll taxes payable	9, 709, 920			0	38
	Notes and Loans payable (short term)	0		0 0	0	40
. 00	Deferred income	0		0 0	0	41
00	Accelerated payments	0				42
. 00	Due to other funds	0		-	0	
. 00 . 00	Other current liabilities Total current liabilities (sum of lines 37 thru 44)	3, 283, 964 34, 457, 185			0	
. 00	LONG TERM LI ABI LI TI ES	54,457,105			0	45.
. 00	Mortgage payable	0	(0 0	0	46.
. 00	Notes payable	0	(0 0	0	47.
00	Unsecured Loans	0	(-	0	48.
00 00	Other long term liabilities	590, 967 590, 967		-	0	49 50
00	Total long term liabilities (sum of lines 46 thru 49) Total liabilities (sum of lines 45 and 50)	35, 048, 152			0	50
00	CAPITAL ACCOUNTS	00,010,102		<u> </u>		
00	General fund balance	319, 310, 193				52
00	Specific purpose fund		(53
00	Donor created - endowment fund balance - restricted			0		54
00	Donor created - endowment fund balance - unrestricted			0		55 56
00	Governing body created - endowment fund balance Plant fund balance - invested in plant			0	0	56
. 00	Plant fund balance - reserve for plant improvement,				0	58
	replacement, and expansion					
. 00	Total fund balances (sum of lines 52 thru 58)	319, 310, 193			0	59.
. 00	Total liabilities and fund balances (sum of lines 51 and	354, 358, 345	(0 0	0	60

Health Financial Systems		FRANCI SCAN HEAL	TH LAFAYETTE			In Lie	u of Form CM	S-2	552-10
STATEMENT OF CHANGES IN FU	ND BALANCES		Provider CC	CN: 15-0109	Peri Fror To	iod: m 01/01/2017 12/31/2017	Worksheet G Date/Time P 5/31/2018 3	rep	ared:
		General	Fund	Speci al	Purp	ose Fund	Endowment Fu		
		1.00	2.00	3.00		4.00	5.00		
3.00 Total (sum of line 1 4.00 ADJUST TO AFS 5.00 6.00 7.00 8.00 9.00 10.00 Total additions (sum 11.00 Subtotal (line 3 plu 12.00 Deductions (debit ad 13.00 14.00 15.00 16.00 17.00 18.00 Total deductions (su	rom Wkst. G-3, line 29) and line 2) n of line 4–9) Is line 10) Jjustments) (specify) m of lines 12–17) of period per balance	1, 130, 518 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	279, 136, 189 39, 043, 486 318, 179, 675 1, 130, 518 319, 310, 193 0 319, 310, 193			0 0 0 0 0 0 0 0		0 0 0 0 0 0 0 0 0 0 0 0 0	$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 13.\ 00\\ 15.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ \end{array}$
		Endowment Fund	PI ant						
1.00 Fund hal analysis at has	inning of poriod	6.00	7.00	8.00	0			_	1 00
1.00 Fund balances at beg 2.00 Net income (loss) (f 3.00 Total (sum of line 1 4.00 ADJUST TO AFS 5.00 6.00 7.00 8.00 9.00 9.00	rom Wkst. G-3, line 29)	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
13.00 14.00 15.00 16.00 17.00 18.00 Total deductions (su	us line 10) ljustments) (specify) um of lines 12-17) of period per balance	0 0 0 0	0 0 0 0 0 0		0 0 0 0				10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00

	Financial Systems FRANCISCAN HEALTH				eu of Form CMS-	
STATEN	IENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provider C	CN: 15-0109	Period: From 01/01/2017 To 12/31/2017	Date/Time Pre	pared:
	Cost Center Description		Inpati ent	Outpati ent	5/31/2018 3:5 Total	
			1.00	2.00	3.00	
	PART I – PATIENT REVENUES					
	General Inpatient Routine Services				1	
1.00	Hospi tal		70, 255, 2	78	70, 255, 278	1.00
2.00	SUBPROVIDER - IPF					2.00
3.00	SUBPROVIDER - IRF		4, 680, 2	25	4, 680, 225	3.00
4.00 5.00	SUBPROVI DER			0	0	4.00 5.00
5.00 6.00	Swing bed - SNF Swing bed - NF			0	0	6.00
7.00	SKILLED NURSING FACILITY			0	0	7.00
8.00	NURSING FACILITY					8.00
9.00	OTHER LONG TERM CARE					9.00
10.00	Total general inpatient care services (sum of lines 1-9)		74, 935, 5	03	74, 935, 503	10.00
	Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT		16, 860, 3	66	16, 860, 366	
12.00	CORONARY CARE UNI T					12.00
13.00	BURN INTENSIVE CARE UNIT					13.00
14.00 15.00	SURGI CAL I NTENSI VE CARE UNI T		12 005 0	22	12 005 022	14.00 15.00
16.00	NEONATAL INTENSIVE CARE UNIT Total intensive care type inpatient hospital services (sum of	linos	13, 995, 0 30, 855, 3		13, 995, 022 30, 855, 388	
10.00	11-15)	TTHES	30, 855, 5	00	30, 033, 300	10.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	105, 790, 8	91	105, 790, 891	17.00
18.00	Ancillary services	, ,	454, 245, 5			
19.00	Outpatient services		17, 061, 2	79 79, 938, 589	96, 999, 868	19.00
20.00	RURAL HEALTH CLINIC			0 0	0	
21.00	FEDERALLY QUALIFIED HEALTH CENTER			0 0		
22.00	HOME HEALTH AGENCY			7, 685, 337		
23.00	AMBULANCE SERVICES			0 14, 162, 017	14, 162, 017	
24.00 25.00	CMHC AMBULATORY SURGI CAL CENTER (D. P.)					24.00 25.00
25.00	HOSPICE			0 11, 607, 916	11, 607, 916	
20.00	OTHER REVENUE		13, 2			
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3	to Wkst.	577, 110, 9		1, 185, 082, 685	
	G-3, line 1)		- , -, -			
	PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)			303, 367, 094		29.00
30.00	ADD (SPECIFY)			0		30.00
31.00 32.00				0		31.00
32.00				0		32.00 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				0		41.00
42.00	Total deductions (sum of lines 37-41)	2) (traf-		202 247 004		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 4 to Wkst. G-3, line 4)	2) (transfer		303, 367, 094		43.00
	10 mkst. 0-3, 1106 4)		I	I	I	I

Heal th	Financial Systems	FRANCISCAN HEALTH LAFAYETTE	In Lie	u of Form CMS-2	2552-10
STATEN	ENT OF REVENUES AND EXPENSES	Provider CCN: 15-010		Worksheet G-3	
			From 01/01/2017 To 12/31/2017	Date/Time Pre	narod
			10 12/31/2017	5/31/2018 3:5	
				1.00	
1.00	Total patient revenues (from Wkst. G-2, Par			1, 185, 082, 685	1.00
2.00	Less contractual allowances and discounts o	on patients' accounts		857, 162, 569	2.00
3.00	Net patient revenues (line 1 minus line 2)			327, 920, 116	3.00
4.00	Less total operating expenses (from Wkst. G			303, 367, 094	
5.00	Net income from service to patients (line 3	3 minus line 4)		24, 553, 022	5.00
	OTHER INCOME				
6.00	Contributions, donations, bequests, etc			0	6.00
7.00	Income from investments			0	7.00
8.00	Revenues from telephone and other miscellan	neous communication services		0	
9.00	Revenue from television and radio service			0	9.00
10.00	Purchase di scounts			0	
11.00	Rebates and refunds of expenses			0	11.00
12.00	Parking lot receipts			0	12.00
13.00	Revenue from laundry and linen service			0	13.00
14.00	Revenue from meals sold to employees and gu	iests		0	
15.00	Revenue from rental of living quarters			0	15.00
	Revenue from sale of medical and surgical s			0	16.00
	Revenue from sale of drugs to other than pa			0	17.00
	Revenue from sale of medical records and ab			0	18.00
	Tuition (fees, sale of textbooks, uniforms,			0	19.00
20.00	Revenue from gifts, flowers, coffee shops,	and canteen		0	20.00
21.00	Rental of vending machines			0	21.00
22.00	Rental of hospital space			0	22.00
	Governmental appropriations			0	23.00
	OTHER INCOME			14, 490, 464	24.00
	Total other income (sum of lines 6-24)			14, 490, 464	
	Total (line 5 plus line 25)			39, 043, 486	26.00
	OTHER EXPENSES (SPECIFY)			0	27.00
28.00	Total other expenses (sum of line 27 and su	ıbscri pts)		0	28.00
29.00	Net income (or loss) for the period (line 2	26 minus line 28)		39, 043, 486	29.00

	Financial Systems SIS OF HOSPITAL-BASED HOME HEALT		FRANCI SCAN HEA	LTH LAFAYETTE Provider C	CN: 15-0109	In Lie Period:	u of Form CMS-2 Worksheet H	2552-10
	JI J OF HOST TAL-DAGED HOME HEALT	II AGENCI COSIS		HHA CCN:		From 01/01/2017 To 12/31/2017	Date/Time Pre	
						Home Health Agency I	5/31/2018 3:5 PPS	<u>3 pm</u>
		Sal ari es	Employee Benefits	Transportation (see	chased		Total (sum of cols. 1 thru	
		1.00	2.00	instructions) 3.00	Services 4.00	5.00	5) 6.00	
	GENERAL SERVICE COST CENTERS		2.00				0100	
. 00	Capital Related - Bldg. & Fixtures			0		0	0	1.00
. 00	Capital Related - Movable			0		0	0	2.00
	Equipment							
. 00	Plant Operation & Maintenance Transportation	0	0	-		0 0	0	3.00 4.00
. 00	Administrative and General	551, 224	0	-	128, 97	6 77, 791	765, 091	
00	HHA REIMBURSABLE SERVICES	(OF 701	0	40.000	140.00	7	704 (70	
. 00 . 00	Skilled Nursing Care Physical Therapy	605, 781 384, 522	0				794, 678 599, 850	
. 00	Occupational Therapy	100, 653				0 0	103, 584	•
. 00	Speech Pathol ogy	20, 378	0	_/ _/ ~		0 0	22, 676	•
0.00	Medical Social Services Home Health Aide	335 51, 783		32 27, 128		0 0 0 0	367 78, 911	
2.00	Supplies (see instructions)	0		0)	0 57, 905	57, 905	
3.00	Drugs	1, 962				0 117, 549		•
4.00	DME HHA NONREI MBURSABLE SERVI CES	0	0	0	1	0 0	0	14.00
5.00	Home Dialysis Aide Services	0	0	0		0 0	0	15.00
6.00	Respiratory Therapy	0	0	-		0 0	0	
7.00 8.00	Private Duty Nursing Clinic	0	0			0 0	0	
9.00	Health Promotion Activities	0	0	0		0 0	0	1
0.00	Day Care Program	0	0	0		0 0	0	
1.00	Home Delivered Meals Program Homemaker Service	0	0	-		0 0	0	
3.00	All Others (specify)	752, 636	-	-		0	1, 296, 723	
3. 50	Tel emedi ci ne	0	0	0		0 0	0	23.50
4.00	Total (sum of lines 1-23)	2, 469, 274 Recl assi fi cati	74 Recl assi fi ed	130,295 Adjustments	590,14 Net Expenses		3, 839, 491	24.00
		on	Trial Balance	Aujustilientis	for Allocatio			
			(col. 6 +		(col. 8 + col			
		7.00	col . 7) 8. 00	9.00	9) 10.00	-		1
	GENERAL SERVICE COST CENTERS			I	1			
. 00	Capital Related - Bldg. & Fixtures	0	0	0		0		1.00
. 00	Capital Related - Movable	0	0	0		0		2.00
	Equipment							
. 00	Plant Operation & Maintenance Transportation	0		-		0		3.00
. 00	Administrative and General	0		-		1		5.00
	HHA REIMBURSABLE SERVICES		704 (70		-			
. 00 . 00	Skilled Nursing Care Physical Therapy	0						6.00 7.00
. 00	Occupational Therapy	0						8.00
. 00	Speech Pathology	0	22, 676	0	22, 67	6		9.00
0.00	Medical Social Services	0	367		36			10.00
2.00	Home Health Aide Supplies (see instructions)	0	78, 911 57, 905		78, 91 57, 90			11.00
3.00	Drugs	0	119, 706	0	119, 70	6		13.00
4.00		0	0	0	1	0		14.00
	HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services	0	0	0		0		15.00
5.00	Respiratory Therapy	0	0	0	1	0		16.00
6. 00		0	0	0		0		17.00
6. 00 7. 00	Private Duty Nursing	0	~		1	9		•
6. 00 7. 00 8. 00	Private Duty Nursing Clinic	0	0	0		0		19.00
6.00 7.00 8.00 9.00 0.00	Private Duty Nursing Clinic Health Promotion Activities Day Care Program	0	0 0 0			0 0		20.00
6.00 7.00 8.00 9.00 0.00	Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program		0 0 0 0	0		0 0 0		20.00 21.00
6.00 7.00 8.00 9.00 0.00 1.00 2.00	Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service		0 0 0	0		0 0 0		20.00 21.00 22.00
6.00 7.00 8.00 9.00 0.00 1.00 2.00 3.00 3.50	Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program	0 0 0 0 0 0 0 0 0	0 0 0 1, 296, 723		1, 296, 72 3, 838, 45	0 0 0 3 0		19.00 20.00 21.00 22.00 23.00 23.50

Heal th	Financial Systems	1	FRANCI SCAN HEAL	TH LAFAYETTE		In Lie	eu of Form CMS-	2552-10
COST A	LLOCATION - HHA GENERAL SERVICE	COST		Provider CO	CN: 15-0109	Period: From 01/01/2017	Worksheet H-1 Part I	
				HHA CCN:	15-7124	To 12/31/2017		epared:
						Home Health	PPS	
			Capital Rela	atad Casta		Agency I		
			Capital Rela					
		Net Expenses	BIdgs &	Movabl e	Plant	Transportation		1
		for Cost Allocation	Fixtures	Equi pment	Operation 8 Maintenance		(cols. 0-4)	
		(from Wkst. H,						
		<u>col. 10)</u> 0	1.00	2.00	3.00	4.00	4A. 00	
	GENERAL SERVICE COST CENTERS	1					1	
1.00	Capital Related - Bldg. & Fixtures	0	0				C	1.00
2.00	Capital Related - Movable	0		0			C	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	764, 051	0	0		0 0	764, 051	5.00
6.00	Skilled Nursing Care	794, 678	0	0		0 0	794, 678	6.00
7.00	Physical Therapy	599, 850	0	0		0 0		
8.00 9.00	Occupational Therapy Speech Pathology	103, 584 22, 676	0	0				
10.00	Medical Social Services	367	0	0		0 0	367	7 10.00
11.00 12.00	Home Health Aide Supplies (see instructions)	78, 911 57, 905	0	0				
13.00	Drugs	119, 706	0	0		0	119, 706	
14.00	DME HHA NONREI MBURSABLE SERVI CES	0	0	0		0 0	C	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		
17.00 18.00	Private Duty Nursing Clinic	0	0	0				
19.00	Health Promotion Activities	0	0	0		0 0	C	19.00
20. 00 21. 00	Day Care Program Home Delivered Meals Program	0	0	0				
22.00	Homemaker Service	0	0	0		0 0	-	
23. 00 23. 50	All Others (specify) Telemedicine	1, 296, 723	0	0 0			.,	
23. 50		3, 838, 451	0	0		0 0	3, 838, 451	
		Admi ni strati ve						
		& General 5.00	<u>4A + 5)</u> 6.00					-
	GENERAL SERVICE COST CENTERS	1						
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	764, 051						5.00
6.00	Skilled Nursing Care	197, 493	992, 171					6.00
7.00 8.00	Physical Therapy Occupational Therapy	149, 075 25, 743	748, 925 129, 327					7.00
8.00 9.00	Speech Pathol ogy	25, 743 5, 635	28, 311					9.00
10.00	Medical Social Services	91	458					10.00
11. 00 12. 00	Home Health Aide Supplies (see instructions)	19, 611 14, 391	98, 522 72, 296					11.00 12.00
13.00	Drugs	29, 749	149, 455					13.00
14.00	DME HHA NONREI MBURSABLE SERVI CES	0	0					14.00
15.00	Home Dialysis Aide Services	0	0					15.00
16. 00 17. 00	Respiratory Therapy Private Duty Nursing	0	0					16.00 17.00
17.00	Clinic	0	0					17.00
19.00	Health Promotion Activities	0	0					19.00
20. 00 21. 00	Day Care Program Home Delivered Meals Program	0	0					20.00
22.00	Homemaker Service	0	О					22.00
23. 00 23. 50	All Others (specify) Telemedicine	322, 263	1, 618, 986					23.00 23.50
24.00			3, 838, 451					24.00

Heal th	Financial Systems		FRANCI SCAN HEAL	_TH LAFAYETTE		In Lie	u of Form CMS-2	2552-10
	LLOCATION - HHA STATISTICAL BAS	il S		Provider CO	CN: 15-0109 15-7124	Period: From 01/01/2017 To 12/31/2017	Worksheet H-1 Part II Date/Time Pre 5/31/2018 3:5	pared:
						Home Health Agency I	PPS	
		Capital Rel	ated Costs					
		BIdgs &	Movabl e			onReconciliation		-
		Fixtures (SQUARE FEET)	Equipment (DOLLAR VALUE)	Operation & Maintenance (SQUARE FEET)	(MI LEAGE)		& General (ACCUM. COST)	
		1.00	2.00	3.00	4.00	5A. 00	5.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. &	0				0		1.00
0.00	Fixtures							0.00
2.00	Capital Related - Movable		0			0		2.00
3.00	Equipment Plant Operation & Maintenance	0	0	0		0		3.00
4.00	Transportation (see	0	0	0		0		4.00
	i nstructi ons)		0	0		0		
5.00	Administrative and General	0	0	0		0 -764,051	3,074,400	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	-			0 0	794, 678	
7.00	Physical Therapy	0	5	0		0 0	599, 850	
8.00	Occupational Therapy	0	0	0		0 0	103, 584	
9.00	Speech Pathology Medical Social Services	0	0	0		0 0	22, 676	
10. 00 11. 00	Home Health Aide	0	0	0		0 0	367 78, 911	
12.00	Supplies (see instructions)		0	0		0 0	57,905	
13.00	Drugs	0	s	0		0	119, 706	1
14.00	DME	0	-	-		0 0	0	
	HHA NONREI MBURSABLE SERVI CES							
15.00	Home Dialysis Aide Services	0	0	0		0 0	0	15.00
16.00	Respiratory Therapy	0	0	0		0 0	0	16.00
17.00	Private Duty Nursing	0	0	0		0 0	0	
18.00	Clinic	0	0	0		0 0	0	10.00
19.00	Health Promotion Activities	0	0	0		0 0	0	
20.00	Day Care Program	0	0	0		0 0	0	20.00
	Home Delivered Meals Program Homemaker Service		0	0		0 0	0	
	All Others (specify)		0				1, 296, 723	
	Tel emedi ci ne	0	0	0		0 0	1, 2, 0, 720	23.50
	Total (sum of lines 1-23)	0	0	0		0 -764,051	3, 074, 400	
25.00	Cost To Be Allocated (per	0	0	0		0	764, 051	1
	Worksheet H-1, Part I)							
26.00	Unit Cost Multiplier	0. 000000	0. 000000	0.00000	0.0000	00	0. 248520	26.00

LOCATION OF GENERAL S	SERVICE COSTS T	O HHA COST CEN	TERS	Provider C	1	Period: From 01/01/2017	Worksheet H-2 Part I	
				HHA CCN:	15-7124	To 12/31/2017 Home Health	Date/Time Pre 5/31/2018 3:5 PPS	parec 3 pm
						Agency I	PP3	
			CAPI TAL REL	ATED COSTS				
Cost Center	r Description	HHA Trial Balance (1)	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	COMMUNI CATI ONS	MGMT INFO SYSTEMS	
		0	1.00	2.00	4.00	5. 01	5. 02	
00 Administrative a 00 Skilled Nursing 00 Physical Therapy 00 Occupational The 00 Speech Pathology 00 Medical Social S 00 Home Health Aide 00 Drugs 00 Drugs 00 Home Dialysis Ai 00 Respiratory Ther 00 Clinic 00 Halth Promotion 00 Day Care Program 00 Home Delivered M 00 Home Medicine 00 All Others (spec 50 Telemedicine 00 Total (sum of li 00 Unit Cost Multip 26, line 1 divid of column 26, li 00 Line 2, li	Care rapy ervices structions) de Services apy sing Activities leals Program e ify) nes 1-19) (2) lier: column led by the sum ne 20 minus	0 992, 171 748, 925 129, 327 28, 311 458 98, 522 72, 296 149, 455 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		,		426, 146 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 19.
6 decimal places Cost Center	Description	PURCHASI NG	ADMI TTI NG	PATI ENT ACCOUNTI NG	Subtotal	OTHER ADMI NI STRATI VE	OPERATION OF PLANT	
		5. 03	5.04	5.05	5A. 05	AND GENERAL 5.06	7.00	
00Administrative a00Skilled Nursing00Physical Therapy00Occupational The00Speech Pathology00Medical Social S00Medical Social S00Bome Health Aide00Drugs.00DME.00Home Dialysis Ai.00Respiratory Ther.00Private Duty Nur.00Clinic.00Home Delivered M.00Home Delivered M.00All Others (spector).00Telemedicine.00Total (sum of li.00Unit Cost Multip.01Line 1 divid	Care Care rapy ervices structions) de Services apy sing Activities leals Program e ify) nes 1-19) (2) lier: column	5, 816 5, 816 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	5797 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	34, 770 34, 770 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1, 428, 36 992, 17 748, 92 129, 32 28, 31 45 98, 52 72, 29 149, 45 149, 45 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	5 144, 242 1 100, 193 5 75, 629 7 13, 060 1 2, 859 3 46 2 9, 949 5 75, 029 6 7, 301 5 15, 093 0 0		2 3 4 5 6 6 7 7 8 9 9 100 111 122 133 144 155 166 177 18 19 19

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

	n Financial Systems		FRANCI SCAN HEAL				u of Form CMS-	
ALLOC	ATION OF GENERAL SERVICE COSTS	TO HHA COST CEN	TERS	Provider C		Period: From 01/01/2017	Worksheet H-2 Part I	
				HHA CCN:	15-7124	To 12/31/2017	5/31/2018 3:5	pared: 3 pm
						Home Health Agency I	PPS	
	Cost Center Description	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CE & SUPPLY	
		8.00	9.00	10.00	11.00	13.00	14.00	
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 15.\ 00\\ 21.\ 00\\ 21.\ 00\\ 21.\ 00\\ \end{array}$	Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2)					0 0 0 0	4, 654 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00 19.50
	Cost Center Description	PHARMACY	MEDI CAL RECORDS & LI BRARY	SOCIAL SERVICE	NURSING SCHO	OL PHARMACY RESI DENCY	EMS EDUCATION	
4 . 0.0		15.00	16.00	17.00	20.00	23.00	23.01	1.00
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ 19.\ 00\\ 21.\ 00\\ 21.\ 00\\ \end{array}$	Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2)							2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00 19.00 19.50

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

Heal th	Financial Systems		FRANCI SCAN HEAL	TH LAFAYETTE		In Lie	eu of Form CMS-:	2552-10
	TION OF GENERAL SERVICE COSTS TO	D HHA COST CEN	TERS	Provider CO		Period: From 01/01/2017 To 12/31/2017		epared:
						Home Health Agency I	PPS	
	Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HH A&G (see Par II)	A Total HHA		
		24.00	25.00	26.00	27.00	28.00		
1.00	Administrative and General	1, 924, 382	0	1, 924, 382				1.00
2.00	Skilled Nursing Care	1,092,364	0	1, 092, 364	497, 41	8 1, 589, 782		2.00
3.00	Physical Therapy	824, 554	0	824, 554	375, 46	8 1, 200, 022		3.00
4.00	Occupational Therapy	142, 387	0	142, 387	64, 83	7 207, 224		4.00
5.00	Speech Pathology	31, 170	0	31, 170	14, 19	4 45, 364		5.00
6.00	Medical Social Services	504	0	504	23	0 734		6.00
7.00	Home Health Aide	108, 471	0	108, 471	49, 39	3 157, 864		7.00
8.00	Supplies (see instructions)	79, 597	0	79, 597	36, 24	5 115, 842		8.00
9.00	Drugs	164, 548	0	164, 548	74, 92	8 239, 476		9.00
10.00	DME	0	0	0		0 0		10.00
11.00	Home Dialysis Aide Services	0	0	0		0 0		11.00
12.00	Respiratory Therapy	0	0	0		0 0		12.00
13.00	Private Duty Nursing	0	0	0		0 0		13.00
14.00	Clinic	0	0	0		0 0		14.00
15.00	Health Promotion Activities	0	0	0		0 0		15.00
16.00	Day Care Program	0	0	0		0 0		16.00
17.00	Home Delivered Meals Program	0	0	0		0 0		17.00
18.00	Homemaker Service	0	0	0		0 0		18.00
19.00	All Others (specify)	1, 782, 478	0	1, 782, 478	811, 66	9 2, 594, 147		19.00
19.50	Tel emedi ci ne	0	0	0		0 0		19.50
20.00	Total (sum of lines 1-19) (2)	6, 150, 455	0	6, 150, 455	1, 924, 38	6, 150, 455		20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.				0. 45535	9		21.00

			CN: 15-0109			
		HHA CCN:	15-7124	From 01/01/2017	Part II	pared:
				Home Health	PPS	
CAPI TAL REI	ATED COSTS			Agency		
BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS		SYSTEMS	PURCHASI NG (COSTED REQ UI SI)	
1.00	2.00	4. 00	5.01	5. 02	5.03	
		2, 469, 274 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0. 00000	0 73,851 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 73,851 0 426,146 00 5.770348	95, 059 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	$\begin{array}{c} 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 15.\ 00\\ 15.\ 00\\ 15.\ 00\\ 15.\ 00\\ 25.\ 00\\ 20.\ 00\\ 21.\ 00\\ 21.\ 00\\ \end{array}$
ADMI TTI NG (GROSS CHAR GES)	ACCOUNTI NG (GROSS CHAR GES)		ADMI NI STRATI AND GENERAL (ACCUM. COST	(SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	
7, 052, 737 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	7, 052, 737 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1, 428, 3 992, 1 748, 9 129, 3 28, 3 4 98, 5 72, 2 149, 4	65 0 71 0 25 0 27 0 58 0 22 0 96 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00
	CAPI TAL REI BLDG & FI XT (SOUARE FEET) 1.00 0	CAPI TAL RELATED COSTS BLDG & FIXT (SOUARE FEET) MVBLE EQUIP (SQUARE FEET) 1.00 2.00 0 0	TO HHA COST CENTERS STATI STI CAL Provi der C HHA CCN: HHA CCN: HHA CCN: BLDG & FIXT MVBLE EQUI P EMPLOYEE BENEFI TS DEPARTMENT (SQUARE FEET) SALARIES) 1.00 2.00 4.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	HHA CCN: 15-7124 CAPI TAL RELATED COSTS EMPLOYEE COMMUNI CATI O BLDG & FIXT MVBLE EQUIP BENEFITS COMMUNI CATI O (SQUARE FEET) (SQUARE FEET) DEPARTMENT (GROSS COMMUNI CATI O 1.00 2.00 4.00 5.01 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0<	ID HHA COST CENTERS STATISTICAL Provider CN: 15-0109 HHA CO: Provider CN: 15-0109 From 01/01/2017 To 12/31/2017 ID CAPITAL RELATED COSTS Home Heal th Agency 1 BLDG & FIXT (SQUARE FEET) MVBLE EQUIP (SQUARE FEET) EMPLOYEE BENEFITS 0 COMMUNICATIONS (PHONE LINE S) MGMT 1NFO SYSTEMS (MANHOURS) 1.00 2.00 4.00 5.01 5.02 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	ID ID <thid< th=""> ID ID ID<!--</td--></thid<>

Heal th	Financial Systems		FRANCISCAN HEALT	TH LAFAYETTE		In Lie	u of Form CMS-:	2552-10
ALLOCA BASI S	TION OF GENERAL SERVICE COSTS 1	FO HHA COST CEN	TERS STATISTICAL	Provider C HHA CCN:	CN: 15-0109 15-7124	Period: From 01/01/2017 To 12/31/2017	Worksheet H-2 Part II Date/Time Pre 5/31/2018 3:5	
						Home Health	5/31/2018 3:5 PPS	3 pm
						Agency I	DUI DUI OV	
	Cost Center Description	HOUSEKEEPI NG (SQUARE FEET)	DI ETARY (MEALS SERVED)	CAFETERI A (MANHOURS)	NURSI NG ADMI NI STRATI ((DI RECT NRS	SUPPLY (COSTED REQ	PHARMACY (COSTED REQUIS.)	
		9.00	10.00	11.00	I NG) 13.00	UISI) 14.00	15.00	
1.00	Administrative and General	0		73, 851			0	1.00
2.00	Skilled Nursing Care	0	0	0		0 0	0	
3.00	Physical Therapy	0	0	0		0 0	0	
4.00 5.00	Occupational Therapy Speech Pathology	0	0	0		0 0	0	
6.00	Medical Social Services		0	0		0 0	0	
7.00	Home Heal th Aide	0	o	0		0 0	0	
8.00	Supplies (see instructions)	0	0	C		0 0	0	
9.00	Drugs	0	0	C		0 0	0	9.00
10.00	DME	0	0	C)	0 0	0	
11.00	Home Dialysis Aide Services	0	0	0		0 0	0	
12.00 13.00	Respiratory Therapy Private Duty Nursing	0	0	0		0 0	0	
14.00	Clinic	0	0	0		0 0	0	
15.00	Health Promotion Activities	0	0	Ő		0 0	0	
16.00	Day Care Program	0	0	C		0 0	0	16.00
17.00	Home Delivered Meals Program	0	0	0		0 0	0	
18.00	Homemaker Service	0	0	0		0 0	0	
19. 00 19. 50	All Others (specify) Telemedicine	0	0	0		0 0	0	
20.00	Total (sum of lines 1-19)	0	0	73, 851	73, 85	0	0	20.00
21.00	Total cost to be allocated	0	0	124, 247			0	21.00
22.00	Unit cost multiplier	0. 000000		1. 682401		0. 048959	0. 000000	22.00
	Cost Center Description		SOCIAL SERVICEN	URSING SCHOOL		EMS EDUCATION		
		RECORDS & LI BRARY	(TIME SPENT)	(ASSI GNED	RESI DENCY (ASSI GNED	(ASSI GNED TI ME)		
		(GROSS CHAR		TI ME)	TI ME)	11WL)		
		GES)		,	,			
1.00		16.00	17.00	20.00	23.00	23.01		
1.00 2.00	Administrative and General Skilled Nursing Care	7,052,737	0	0	1	0 0		1.00 2.00
2.00	Physical Therapy		0	0		0 0		3.00
4.00	Occupational Therapy	0	0	C		0 0		4.00
5.00	Speech Pathology	0	0	C		0 0		5.00
6.00	Medical Social Services	0	0	0		0 0		6.00
7.00	Home Heal th Ai de	0	0	0		0 0		7.00
8.00 9.00	Supplies (see instructions) Drugs	0	0	0		0 0		8.00 9.00
9.00 10.00	DME		0	0				10.00
11.00	Home Dialysis Aide Services	0	0	C C		0 0		11.00
12.00	Respiratory Therapy	0	0	C		0 0		12.00
13.00	Private Duty Nursing	0	0	0		0 0		13.00
14.00	Clinic	0	0	0		0 0		14.00
15.00 16.00	Health Promotion Activities Day Care Program	0	0	0		0 0		15.00 16.00
16.00	Home Delivered Meals Program		0			0 0		17.00
18.00	Homemaker Service	0	0	0		0 0		18.00
19.00	All Others (specify)	0	0	0		0 0		19.00
19.50	Tel emedi ci ne	0	0	C		0 0		19.50
20.00	Total (sum of lines 1-19)	7,052,737		C		0 0		20.00
21.00	Total cost to be allocated	13, 979		0				21.00
22.00	Unit cost multiplier	0. 001982	0. 000000	0.00000	0.0000	0. 000000		22.00

PPORT	IONMENT OF PATIENT SERVICE COST	S			Provi der	CCI	N: 15-0109		eri od:	Worksheet H-3	
					HHA CCN:		15-7124	Fr To	rom 01/01/2017 0 12/31/2017	Part I Date/Time Prep 5/31/2018 3:53	pared: 3 pm
					Tit	le	XVIII		Home Health Agency I	PPS	
	Cost Center Description	From, Wkst.	Facilit				Total HHA	4	Total Visits	Average Cost	
		H-2, Part I, col. 28, line	(from H-2, P		Ancillary Costs (from		Costs (cols. + 2)	1		Per Visit (col. 3 ÷ col.	
		20, 11110	П-Z, Г		Part II)	1	+ 2)			(cor. 3 ÷ cor. 4)	
	_	0	1.		2.00		3.00		4.00	5.00	
	PART I - COMPUTATION OF LESSER	OF AGGREGATE F	PROGRAM	COST, A	GGREGATE OF	THE	PROGRAM LIN	ЛΤ	ATION COST, OF	2	
	BENEFICIARY COST LIMITATION										
. 00	Cost Per Visit Computation Skilled Nursing Care	2.00	1	589, 782		- 1	1, 589, 78	22	5, 584	284. 70	1.0
2.00	Physical Therapy	3.00		200, 022		0	1, 200, 02		3, 739	320. 95	2.0
. 00	Occupational Therapy	4.00		207, 224		0	207, 22		991	209.11	3.0
. 00	Speech Pathology	5.00		45, 364		0	45, 36		131	346. 29	4.0
6.00	Medical Social Services	6.00		734			73	34	103	7. 13	5.0
. 00	Home Health Aide	7.00		157, 864			157, 86		1, 001	157. 71	6.0
. 00	Total (sum of lines 1-6)		3,	200, 990		0	3, 200, 99		11, 549		7.0
			1			P	Program Visit				
	Cost Center Description	Cost Limits	CBSA N	a (1)	Part A	N	lot Subject 1		t B Subject to		
	cost center bescription		CD3A N	J. (1)	Fait A		Deductibles Coinsurance	&	Deducti bl es		
		0	1.	00	2.00		3.00		4.00	5.00	
	Limitation Cost Computation	1									
. 00	Skilled Nursing Care		23844			0		1			8.0
. 01	Skilled Nursing Care		26900			0		17			8.0
3. 02	Skilled Nursing Care		29200 99915			0	1, 64				8.0
. 03	Skilled Nursing Care Physical Therapy		23844			0	1, 84	44 0			8. (9. (
. 01	Physical Therapy		26900			0		9			9.0
. 02	Physical Therapy		29200			0	1, 26	1			9.0
. 03	Physical Therapy		99915			0	1, 00				9. (
0. 00	Occupational Therapy		23844			0		0			10. (
0. 01	Occupational Therapy		26900			0		5			10. (
0. 02	Occupational Therapy		29200			0		76			10.
0. 03	Occupational Therapy		99915			0	26	60			10.
1.00	Speech Pathology		23844			0		0			11.
1.01	Speech Pathology		26900 29200			0	-	0 73			11.
1.02 1.03	Speech Pathology Speech Pathology		29200 99915			0		73 35			11. 11.
2.00	Medical Social Services		23844			0		0			12.
2.01	Medical Social Services		26900			0		0			12.
2.02	Medical Social Services		29200			0	3	30			12.
2. 03	Medical Social Services		99915			0		30			12.
3.00	Home Health Aide		23844			0		0			13.0
3. 01	Home Health Aide		26900			0		18			13.0
3. 02			29200			0		39			13.0
3.03	Home Health Aide		99915			0		18			13. (
4.00		From Wkst. H-2	Facilit	V Coste	Shared	0	7,37 Total HHA		Total Charges	Ratio (col. 3	14. (
	Cost Center Description	Part I, col.	from		Ancillary	C	Costs (cols.		(from HHA	÷ col. 4)	
		28, line	H-2, P		Costs (from Part II)		+ 2)		Records)		
		0	1.	00	2.00		3.00		4.00	5.00	
-	Supplies and Drugs Cost Computa	ations									
5.00	Cost of Medical Supplies	8.00		115, 842		0	115, 84		139, 937	0. 827815	

PPORT	Financial Systems	S		Provider C	CN: 15-0109	Peri od:	u of Form CMS-: Worksheet H-3	
				HHA CCN:	15-7124	From 01/01/2017 To 12/31/2017	Part I Date/Time Pre	pare
				Title	XVIII	Home Health	5/31/2018 3:5 PPS	3 pm
			Program Visits		Cost of	Agency I		
			Part	+ D	Servi ces	Part B		
	Cost Center Description	Part A	Not Subject to		Part A	Not Subject to	Subject to	<u> </u>
		i di ti A	Deductibles &		rui e n	Deductibles &		
			Coinsurance	Coi nsurance		Coi nsurance	Coi nsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	PART I - COMPUTATION OF LESSER	OF AGGREGATE I	PROGRAM COST, A	GGREGATE OF TH	E PROGRAM LI	MITATION COST, OF	{	
	BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							1
00	Skilled Nursing Care	C	3, 510			0 999, 297		1.
00	Physical Therapy	C	2, 278			0 731, 124		2.
00	Occupational Therapy	C	641			0 134, 040		3.
00	Speech Pathology	C	108			0 37, 399		4.
00	Medical Social Services	C				0 428		5.
00	Home Health Aide	C	1			0 122, 225		6.
00	Total (sum of lines 1-6)	C	1			0 2, 024, 513		7.
	Cost Center Description	-						
		6.00	7.00	8.00	9.00	10.00	11.00	
	Limitation Cost Computation							
00	Skilled Nursing Care							8.
01	Skilled Nursing Care							8.
02	Skilled Nursing Care							8.
03	Skilled Nursing Care							8
00	Physical Therapy							9.
01	Physical Therapy							9
02	Physical Therapy							9.
03	Physical Therapy							9.
). 00	Occupational Therapy							10.
). 01	Occupational Therapy							10.
). 02	Occupational Therapy							10.
). 02	Occupational Therapy							10.
. 00	Speech Pathol ogy							11
. 01	Speech Pathology							11
. 02	Speech Pathology							11
. 02	Speech Pathology							11
2.00	Medi cal Soci al Servi ces							12.
	1 1							12
2.01 2.02	Medical Social Services							12.
	Medical Social Services							
2.03	Medical Social Services							12.
8.00	Home Health Aide							13.
3.01	Home Health Aide							13.
3. 02	Home Health Aide							13.
3.03	Home Health Aide							13.
. 00	Total (sum of lines 8-13)							14.
		Prog	ram Covered Cha	rges	Cost of Servi ces			
			Part			Part B		
	Cost Center Description	Part A	Not Subject to	Subject to	Part A	Not Subject to		
			Deductibles &			Deductibles &	Deductibles &	
			Coi nsurance	Coi nsurance		Coi nsurance	Coi nsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	Supplies and Drugs Cost Computa		I			_		
	Cost of Medical Supplies	C	102, 918	0		0 85, 197	0	15

Heal th	Financial Systems		RANCI SCAN HEALTH	LAFAYETTE	In Lie	u of Form CMS-2	2552-10
APPORT	IONMENT OF PATIENT SERVICE COST	S		Provider CCN: 15-0109	Peri od:	Worksheet H-3	
					From 01/01/2017	Part I	
				HHA CCN: 15-7124	To 12/31/2017	Date/Time Prep	
				Title XVIII	Home Health	5/31/2018 3:53 PPS	s pili
				II LIE XVIII	Agency I	PP3	
	Cost Center Description	Total Program			rigency		
		Cost (sum of					
		col s. 9-10)					
		12.00					
	PART I - COMPUTATION OF LESSER	OF AGGREGATE P	ROGRAM COST, AGGI	REGATE OF THE PROGRAM LI	MITATION COST, OF	1	
	BENEFICIARY COST LIMITATION						
	Cost Per Visit Computation	000.007					
1.00	Skilled Nursing Care	999, 297					1.00
2.00	Physical Therapy	731, 124					2.00
3.00	Occupational Therapy	134, 040					3.00
4.00	Speech Pathology	37, 399					4.00
5.00	Medical Social Services	428					5.00
6.00	Home Health Aide	122, 225					6.00
7.00	Total (sum of lines 1-6)	2, 024, 513					7.00
	Cost Center Description						
	h	12.00					
	Limitation Cost Computation						
8.00	Skilled Nursing Care						8.00
8.01	Skilled Nursing Care						8.01
8.02	Skilled Nursing Care						8.02
8.03	Skilled Nursing Care						8.03
9.00	Physical Therapy						9.00
9.01	Physical Therapy						9.01
9.02	Physical Therapy						9.02
9.03	Physical Therapy						9.03
10.00	Occupational Therapy						10.00
10.01	Occupational Therapy						10.01
10.02	Occupational Therapy						10.02
10.03	Occupational Therapy						10.03
11.00	Speech Pathol ogy						11.00
11.01	Speech Pathol ogy						11.01
11.02	Speech Pathology						11.02
11.03	Speech Pathol ogy						11.03
12.00	Medical Social Services						12.00
12.01	Medical Social Services						12.01
12.02	Medical Social Services						12.02
12.03	Medical Social Services						12.03
13.00	Home Health Aide						13.00
13.01	Home Health Aide						13.01
13.02	Home Health Aide						13.02
13.03	Home Health Aide						13.03
14.00	Total (sum of lines 8–13)						14.00

Heal th	Financial Systems		FRANCISCAN HEAL	TH LAFAYETTE		In Lie	u of Form CMS-2	2552-10
APPORT	IONMENT OF PATIENT SERVICE COST	S		Provider C	CN: 15-0109	Period: From 01/01/2017	Worksheet H-3 Part II	
				HHA CCN:	15-7124	To 12/31/2017		
				Title	e XVIII	Home Health	PPS	•
		-				Agency I		
	Cost Center Description	From Wkst. C,	Cost to Charge	Total HHA	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 COS	T OF HHA SERVIC	ES FURNI SHED B	Y SHARED HOSPI	TAL DEPARTMEN	NTS		
1.00	Physical Therapy	66.00	0. 482421	0	I	0 col. 2, line 2	. 00	1.00
2.00	Occupational Therapy	67.00	0. 283370	0		Ocol. 2, line 3	. 00	2.00
3.00	Speech Pathology	68.00	0. 465217	0		0 col. 2, line 4	. 00	3.00
4.00	Cost of Medical Supplies	71.00	0. 146904	0		0 col. 2, line 1	5.00	4.00
5.00	Cost of Drugs	73.00	0. 151889	0		0col. 2, line 1	6. 00	5.00
5.01	Cost of Drugs 1	73.01	3. 030318	0		Ocol. 2, line 1	6. 01	5.01
			'			1		•

TION OF HHA REIMBURSEMENT SETTLEMENT	Provi der CC	N: 15-0109	Peri od:	Worksheet H-4	
	HHA CCN:	15-7124	From 01/01/2017	Part I-II Date/Time Pre	par
	Ti tl e	XVIII	Home Health	PPS	
				~† B	
		Part A	Not Subject to	Subject to	
			Coi nsurance	Coi nsurance	
			2.00	3.00	
	MARY CHARGES	•			1
			0 0	0 0	1 1
			0 0	0	2
	· · ·				
	services		0 0	0	3
	pavment		0 0	0	
for services on a charge basis had such payment been made in ac				-	
		0.0000	0.00000	0. 000000	1
			0 0	0	
	complete		0 (0	
	yifline		0 0	0	8
				_	
Primary payer amounts			-	-	-
			Services		
			1.00	2.00	
					1 1/
•			0	69, 755	
•			0	24, 996	1
•			0	11, 650	
			(
			0	0 0	
30 3			0	0 0	
			0	0	
	rance)		(
			0	0	
Subtotal (line 22 minus line 23)			C	1, 353, 031	2
			_	0	
, ,			0	1, 353, 031	
	structions)				2
5	,		0	1, 353, 031	
			0		
)			0	
				-	
				27,050	
			0	0 0	3
			0		
Tentative settlement (for contractor use only)			(0	
Balance due provider/program (line 31 minus lines 31.01, 32, ar	nd 22)		· · · · · · · · · · · · · · · · · · ·	1,145	34
	Reasonable Cost of Part A & Part B Services Reasonable cost of services (see instructions) Total charges Customary Charges Amount actually collected from patients liable for payment for on a charge basis (from your records) Amount that would have been realized from patients liable for p for services on a charge basis had such payment been made in an with 42 CFR §413.13(b) Ratio of line 3 to line 4 (not to exceed 1.000000) Total customary charges (see instructions) Excess of total customary charges over total reasonable cost (conly if line 6 exceeds line 1) Excess of reasonable cost over customary charges (complete onl) 1 exceeds line 6) Primary payer amounts PART 11 - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - FUL Episodes Total PPS Reimbursement - PEP Episodes Total PPS Quitier Reimbursement - PEP Episodes Total Other Payments DME Payments DME Payments DME Payments Part B deductibles billed to Medicare patients (exclude coinsus Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from your records) Reimbursable bad debts for dual eligible beneficiaries (see inst Total costs - current cost reporting period (line 26 plus line OTHER Pioneer ACO demostration payment adjustment amount before sequestration Subtotal (see instructions) Sequestration adjustment (see instructions) Demostration payment adjustment amount after sequestration Subtotal (see instructions) Demostration payment adjustment amount after sequestration Interim payments (see instructions)	Title PART 1 - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES Reasonable Cost of Part A & Part B Services Reasonable cost of services (see instructions) Total charges Customary Charges Amount actually collected from patients liable for payment for services on a charge basis (from your records) Amount that would have been realized from patients liable for payment for or services on a charge basis had such payment been made in accordance with 42 CFR §413.13(b) Ratio of line 3 to line 4 (not to exceed 1.000000) Total customary charges (see instructions) Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6) Primary payer amounts PART 11 - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT Total PS Relimbursement - Full Episodes without Outliers Total PPS Relimbursement - Full Episodes with Outliers Total PPS Relimbursement - Full Episodes Total PPS Relimbursement - FULP Episodes Total PPS Relimbursement - FULP Episodes Total Other Payments DWLIP Rayments DWS Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coinsurance) Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost	Title XVIII PART 1 - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES Reasonable Cost of Part A & Part B Services Reasonable cost of Services (see Instructions) Total charges Customary Charges Amount actually collected from patients liable for payment for services on a charge basis (from your records) Amount that would have been realized from patients liable for payment for services on a charge basis shad such payment been made in accordance with 42 CFR §413.13(b) Recess on total customary charges over total reasonable cost (complete only if line 3 to line 4 (not to exceed 1.000000) 0.0000 Total customary charges over total reasonable cost (complete only if line 1 exceeds line 1) Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6) Primary payer amounts Primary payer amounts 0.0000 PART 11 - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT Total PS Reimbursement - Full Episodes without Outliers Total PS Reimbursement - Full Episodes Total PS Reimbursement - FULP Episodes Total PS Reimbursement - PEP Episodes Total PPS Reimbursement - PEP Episodes Total PS Reimbursement - PEP Episodes Total PS Reimbursement - PEP Episodes Total PPS Reimbursement - PEP Episodes Total PS Reimbursement - PEP Episodes Total PS Reimbursement = 23) Su	HHA CCN: 15-7124 To 12/31/2017 Title XVIII Home Heal th Agency I Part A Part A PART 1 - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES 1.00 2.00 Reasonable cost of Part A & Part B Services 0 0 Customary Charges 0 0 Anount actually collected from patients liable for payment for services 0 0 Anount actually collected from patients liable for payment for services 0 0 Anount actually collected from patients liable for payment for services 0 0 Anount actually collected from patients liable for payment for services 0 0 Ratin of Fine 3 to line 4 (not to exceed 1.00000) 0.000000 0.000000 Total customary charges (see instructions) 0 0 Excess of total customary charges (see instructions) 0 0 Excess of total customary charges (see instructions) 0 0 Primary payer amounts 0 0 0 Part A Services 1.00 0 Total PS Reinbursement - Full Episodes with 0utliers 0 0 Total PS Reinbursement - Full Episodes with 0utliers 0 0 Total PS Reinbursement - Full Episodes with 0utliers 0 0 Total PS Reinbur	HHA CCN: 15-7124 To 12/31/2017 DeterTime Press Title XVIII Home Health Agency 1 Part B Agency 1 - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARCES Part A Not Subject to Subject to Reasonable Cost of Part A & Part B Services -

	SIS OF PAYMENTS TO HOSPITAL-BASED HHAS FOR SERVICES RENDERED	Provider CC	CN: 15-0109		riod: om 01/01/2017	Worksheet H-5	
PRU	OGRAM BENEFI CI ARI ES	HHA CCN:	15-7124	To		Date/Time Prep 5/31/2018 3:53	
					Home Health Agency I	PPS	<u>o p</u>
		I npati en	t Part A		Par	tВ	
	-	mm/dd/yyyy	Amount		mm/dd/yyyy	Amount	
		1.00	2.00	-	3.00	4.00	
00 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero			0 0		1, 325, 409 0	1 2
0	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)						
1	Program to Provider			0		0	
)2				0		0	3
)3				0		0	3
)4				0		0	3
5	Dravidar to Dragram			0		0	
0	Provider to Program			0		0	1
1				0		o	
2				0		0	:
3				0		0	3
54				0		0	
9	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			0		0	
0	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)			0		1, 325, 409	4
	TO BE COMPLETED BY CONTRACTOR				1		
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)						Ę
	Program to Provider						
)1)2				0		0	5
)2)3				0		0	5
	Provider to Program			9	I	0	
0				0		0	Ę
1				0		0	Ę
2	Subtotal (sum of lines 5.01–5.49 minus sum of lines			0		0	5
7	5. 50-5. 98)			U		0	5
0	Determined net settlement amount (balance due) based on the cost report. (1)						e
)1	SETTLEMENT TO PROVIDER			0		1, 145	6
)2	SETTLEMENT TO PROGRAM			0		0	6
00	Total Medicare program liability (see instructions)			0	Contractor	1, 326, 554 NPR Date	7
					Number	(Mo/Day/Yr)	
		()		1.00	2.00	

	Financial Systems IS OF HOSPITAL-BASED HOSPICE COSTS	FRANCI SCAN HEALTH	I LAFAYETTE Provider C	CN: 15-0109	In Lie Period:	u of Form CMS- Worksheet O	2552-10
			Hospi ce CC	N: 15-1563	From 01/01/2017 To 12/31/2017	Date/Time Pre 5/31/2018 3:5	pared: 3 pm
		SALARI ES	OTHER	SUBTOTAL (co	Hospi ce I	SUBTOTAL	
		1.00	2.00	1 pl us col . 3.00		5.00	
	GENERAL SERVICE COST CENTERS	1.00	2.00	0.00	1.00	0.00	
1.00	CAP REL COSTS-BLDG & FIXT*		750	7	50 0	750	1.00
2.00	CAP REL COSTS-MVBLE EQUIP*		0		0 0	0	•
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	0		0 0	0	
4.00	ADMI NI STRATI VE & GENERAL*	579, 112	44, 657			623, 769	
5.00	PLANT OPERATION & MAINTENANCE*	0	0		0 0	0	
6.00	LAUNDRY & LINEN SERVICE*	0	0		0 0	0	
7.00 8.00	HOUSEKEEPI NG* DI ETARY*	0	0		0 0	0	7.00
8.00 9.00	NURSI NG ADMI NI STRATI ON*	39, 971	0	39, 9	71 0	39, 971	8.00 9.00
9.00 10.00	ROUTINE MEDICAL SUPPLIES*	39,971	0				
10.00	MEDICAL RECORDS*	0	4, 270	4, 2	0 0	4, 270 0	1
12.00	STAFF TRANSPORTATI ON*	0	0		0 0	0	
12.00	VOLUNTEER SERVICE COORDINATION*	39, 465	0	39, 4	-	39, 465	
14.00	PHARMACY*	0	317		17 0	317	
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	105, 593			105, 593	•
16.00	OTHER GENERAL SERVICE*	0	100, 070	100,0	0 0	0	1
17.00	PATI ENT/RESI DENTI AL CARE SERVI CES		-		-		17.00
	DIRECT PATIENT CARE SERVICE COST CENTERS	<u> </u>		1	I		1
25.00	INPATIENT CARE-CONTRACTED**		0)	0 0	0	25.00
26.00	PHYSI CI AN SERVI CES**	0	0)	0 0	0	26.00
27.00	NURSE PRACTITIONER**	0	0		0 0	0	27.00
28.00	REGI STERED NURSE**	497, 605	0	497,6	05 0	497, 605	28.00
29.00	LPN/LVN**	0	0		0 0	0	29.00
30.00	PHYSICAL THERAPY**	185	0	1 1	85 0	185	30.00
31.00	OCCUPATIONAL THERAPY**	0	0		0 0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0		0 0	0	
33.00	MEDICAL SOCIAL SERVICES**	103, 991	0			103, 991	
34.00	SPI RI TUAL COUNSELI NG**	79, 901	0	79,9		79, 901	34.00
35.00	DI ETARY COUNSELI NG**	0	0		0 0	0	
36.00	COUNSELING - OTHER**	100 500	0		0 0	0	
37.00	HOSPICE AIDE & HOMEMAKER SERVICES**	100, 590	170 411			100, 590	•
38.00 39.00	DURABLE MEDI CAL EQUI PMENT/OXYGEN**	0	178, 411			178, 411	•
39.00 40.00	PATIENT TRANSPORTATION** IMAGING SERVICES**	0	4, 846 0		46 U 0 0	4, 846 0	
40.00	LABS & DI AGNOSTI CS**	0	0		0 0	0	
41.00	MEDI CAL SUPPLI ES-NON-ROUTI NE**	0	38, 837	38, 8	37 0	38, 837	
42.50	DRUGS CHARGED TO PATI ENTS**	0	326, 247			326, 247	1
43.00	OUTPATI ENT SERVI CES**	0	020,211		0 0	020,21	1
44.00	PALLIATIVE RADIATION THERAPY**	0	0)	0 0	0	
45.00	PALLIATIVE CHEMOTHERAPY**	0	0)	0 0	0	1
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	22, 284	722, 144	744, 4	28 0	744, 428	46.00
	NONREIMBURSABLE 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	
64.00	PALLIATIVE CARE PROGRAM*	0	0		0 0	0	
65.00	OTHER PHYSICIAN SERVICES*	0	0		0 0	0	
66.00	RESIDENTIAL CARE*	0	0		0 0	0	
67.00	ADVERTI SI NG*	0	0	1	0 0	0	
68.00	TELEHEALTH/TELEMONI TORI NG*	0	0		0 0	0	
69.00	THRIFT STORE*	0	0		0 0	0	
70.00	NURSING FACILITY ROOM & BOARD*	0	0		0 0	0	
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	U	0	1	0 0	0	
100.00		1, 463, 104	1, 426, 072	2, 889, 1	76 0	2, 889, 176	1100 00

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

	Financial Systems IS OF HOSPITAL-BASED HOSPICE COSTS		Provider CCN	: 15-0109	Peri od:	Worksheet 0	
			Hospice CCN:	15-1563	From 01/01/2017 To 12/31/2017	Date/Time Pre	
					Hospi ce I	5/31/2018 3:5	53 pm
		ADJUSTMENTS	TOTAL (col. 5				
		6.00	<u>± col. 6)</u> 7.00				
	GENERAL SERVICE COST CENTERS	0.00	7.00				
00	CAP REL COSTS-BLDG & FIXT*	0	750				1.
. 00	CAP REL COSTS-MVBLE EQUIP*	0	o				2.
00	EMPLOYEE BENEFITS DEPARTMENT*	0	0				3
00	ADMINISTRATIVE & GENERAL*	-491	623, 278				4
00	PLANT OPERATION & MAINTENANCE*	0	0				5
00	LAUNDRY & LINEN SERVICE*	0	0				6
00	HOUSEKEEPI NG*	0	0				7
00	DI ETARY*	0	0				8
00	NURSING ADMINISTRATION*	0	39, 971				9
. 00	ROUTINE MEDICAL SUPPLIES*	0	4, 270				10
. 00	MEDI CAL RECORDS*	0	0				11
. 00	STAFF TRANSPORTATION*	0	0				12
. 00	VOLUNTEER SERVICE COORDINATION*	0	39, 465				13
. 00	PHARMACY*	0	317				14
. 00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	105, 593				15
. 00	OTHER GENERAL SERVICE*	0	0				16
. 00	PATIENT/RESIDENTIAL CARE SERVICES						17
	DIRECT PATIENT CARE SERVICE COST CENTERS						
. 00	INPATIENT CARE-CONTRACTED**	0	0				25
00	PHYSI CI AN SERVI CES**	0	0				26
. 00	NURSE PRACTITIONER**	0	0				27
. 00	REGI STERED NURSE**	0	497, 605				28
. 00	LPN/LVN**	0	0				29
. 00	PHYSICAL THERAPY**	0	185				30
. 00	OCCUPATIONAL THERAPY**	0	0				31
2.00	SPEECH/LANGUAGE PATHOLOGY**	0	0				32
8.00	MEDICAL SOCIAL SERVICES**	0	103, 991				33
. 00	SPI RI TUAL COUNSELI NG**	0	79, 901				34
. 00	DI ETARY COUNSELI NG**	0	0				35
. 00	COUNSELING - OTHER**	0	0				36
. 00	HOSPICE AIDE & HOMEMAKER SERVICES**	0	100, 590				37
. 00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	178, 411				38
. 00	PATIENT TRANSPORTATION**	0	4, 846				39
. 00	I MAGI NG SERVI CES**	0	0				40
. 00	LABS & DI AGNOSTI CS**	0	0				41
2.00	MEDI CAL SUPPLI ES-NON-ROUTI NE**	0	38, 837				42
. 50	DRUGS CHARGED TO PATIENTS**	0	326, 247				42
3. 00	OUTPATIENT SERVICES**	0	0				43
. 00	PALLIATIVE RADIATION THERAPY**	0	0				44
. 00	PALLIATIVE CHEMOTHERAPY**	0	0				45
o. 00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	744, 428				46
	NONREIMBURSABLE COST CENTERS						
. 00	BEREAVEMENT PROGRAM *	0	0				60
. 00	VOLUNTEER PROGRAM *	0	0				61
. 00	FUNDRALSING*	0	0				62
. 00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0				63
. 00	PALLIATIVE CARE PROGRAM*	0	0				64
. 00	OTHER PHYSI CI AN SERVI CES*	0	0				65
. 00	RESIDENTIAL CARE*	0	0				66
. 00	ADVERTI SI NG*	0	0				67
. 00	TELEHEALTH/TELEMONI TORI NG*	0	0				68
. 00	THRI FT STORE*	0	0				69
). 00	NURSING FACILITY ROOM & BOARD*	0	0				70
	OTHER NONREI MBURSABLE (SPECI FY)*	0	0				71
പറവ	TOTAL	-491	2,888,685				100

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

Health Financial Systems	FRANCI SCAN HEALT				u of Form CMS-2	2552-10
ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOS	SPICE CONTINUOUS	Provi der CCI		Peri od:	Worksheet 0-1	
HOME CARE		Hospice CCN:		From 01/01/2017 To 12/31/2017	Date/Time Pre 5/31/2018 3:5	
				Hospi ce I		
	SALARI ES	OTHER S	SUBTOTAL (col 1 + col. 2)	. RECLASSI FI - CATI ONS	SUBTOTAL	
	1.00	2.00	3.00	4.00	5.00	
DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00 INPATIENT CARE-CONTRACTED						25.00
26. 00 PHYSI CI AN SERVI CES	0	0		0 0	0	
27.00 NURSE PRACTITIONER	0	0		0 0	0	27.00
28.00 REGI STERED NURSE	1, 526	0	1, 52	6 0	1, 526	28.00
29.00 LPN/LVN	0	0		0 0	0	29.00
30. 00 PHYSI CAL THERAPY	0	0		0 0	0	30.00
31.00 OCCUPATIONAL THERAPY	0	0		0 0	0	31.00
32.00 SPEECH/LANGUAGE PATHOLOGY	0	0		0 0	0	32.00
33.00 MEDICAL SOCIAL SERVICES	0	0		0 0	0	33.00
34.00 SPI RI TUAL COUNSELI NG	0	0		0 0	0	34.00
35. 00 DI ETARY COUNSELI NG	0	0		0 0	0	35.00
36.00 COUNSELING - OTHER	0	0		0 0	0	36.00
37.00 HOSPICE AIDE & HOMEMAKER SERVICES	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 MAGI NG SERVI CES	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
42.50 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	42.50
43.00 OUTPATIENT SERVICES	0	0		0 0	0	
44.00 PALLIATIVE RADIATION THERAPY	0	0		0 0	0	
45.00 PALLIATIVE CHEMOTHERAPY	0	0		0 0	0	
46.00 OTHER PATIENT CARE SERVICES (SPECIFY)	0	9		9 0	9	46.00
100.00 TOTAL *	1, 526	9	1, 53	5 0	1, 535	100.00
* 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			l .	
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	1, 526		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
	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
	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0		38.00
	PATIENT TRANSPORTATION	0	0		39.00
40.00	I MAGI NG SERVI CES	0	0		40.00
41.00	LABS & DI AGNOSTI CS	0	0		41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0		42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0		42.50
43.00	OUTPATIENT SERVICES	0	0		43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0		44.00
45.00	PALLI ATI VE CHEMOTHERAPY	0	0		45.00
	OTHER PATIENT CARE SERVICES (SPECIFY)	0	9		46.00
100.00	TOTAL *	0	1, 535		100.00
* Tran	sfer the amount in column 7 to Wkst. 0-5, colu	umn 1, line 50.			

Health Financial Systems	FRANCI SCAN HEAL				u of Form CMS-2	
ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSP	PICE ROUTINE HOME	Provider C	CN: 15-0109	Peri od:	Worksheet 0-2	
CARE		Hospi ce CCI	N: 15-1563	From 01/01/2017 To 12/31/2017	Date/Time Pre	pared:
					5/31/2018 3:5	3 pm
				Hospice I		
	SALARI ES	OTHER	SUBTOTAL (co		SUBTOTAL	
	1.00		<u>1 + col. 2</u>)		5.00	
	1.00	2.00	3.00	4.00	5.00	
DI RECT PATI ENT CARE SERVI CE COST CENTERS						1 05 00
25. 00 INPATIENT CARE-CONTRACTED		0				25.00
26. 00 PHYSI CI AN SERVI CES	0	0		0 0	0	
27. 00 NURSE PRACTITIONER	0	0	100.0	0 0	0	27.00
28. 00 REGI STERED NURSE	493, 301	0	493, 3	01 0	493, 301	28.00
29.00 LPN/LVN	0	0		0 0	0	29.00
30. 00 PHYSI CAL THERAPY	185	0	1	85 0	185	
31. 00 OCCUPATI ONAL THERAPY	0	0		0 0	0	31.00
32. 00 SPEECH/LANGUAGE PATHOLOGY	0	0	100.0	0 0	0	32.00
33. 00 MEDICAL SOCIAL SERVICES	103, 919	0	103, 9		103, 919	•
34.00 SPIRITUAL COUNSELING	79, 740	0	79, 7	40 0	79, 740	
35. 00 DI ETARY COUNSELI NG	0	0		0 0	0	35.00
36.00 COUNSELING - OTHER	0	0		0 0	0	36.00
37.00 HOSPICE AIDE & HOMEMAKER SERVICES	100, 590	0	100, 5		100, 590	
38.00 DURABLE MEDICAL EQUIPMENT/OXYGEN	0	178, 411	178, 4		178, 411	
39. 00 PATI ENT TRANSPORTATI ON	0	3, 578	3, 5	78 0	3, 578	
40.00 I MAGI NG SERVI CES	0	0		0 0	0	40.00
41.00 LABS & DIAGNOSTICS	0	0		0 0	0	41.00
42.00 MEDI CAL SUPPLI ES-NON-ROUTI NE	0	38, 837			38, 837	42.00
42.50 DRUGS CHARGED TO PATIENTS	0	326, 247	326, 2	47 0	326, 247	
43. 00 OUTPATI ENT SERVICES	0	0		0 0	0	43.00
44.00 PALLIATIVE RADIATION THERAPY	0	0		0 0	0	44.00
45. 00 PALLIATIVE CHEMOTHERAPY	0	0		0 0	0	
46.00 OTHER PATIENT CARE SERVICES (SPECIFY)	22, 168	706, 464			728, 632	
100.00 TOTAL *	799, 903	1, 253, 537	2, 053, 4	40 0	2, 053, 440	100. OC

* 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 CLAN SERVI CES	0	0	26.00
27.00	NURSE PRACTITIONER	0	0	27.00
28.00	REGI STERED NURSE	0	493, 301	28.00
29.00	LPN/LVN	0	0	29.00
30.00	PHYSI CAL THERAPY	0	185	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	103, 919	33.00
34.00	SPI RI TUAL COUNSELI NG	0	79, 740	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	100, 590	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	178, 411	38.00
39.00	PATI ENT TRANSPORTATI ON	0	3, 578	39.00
40.00	I MAGI NG SERVI CES	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	41.00
42.00	MEDI CAL SUPPLI ES-NON-ROUTI NE	0	38, 837	
42.50	DRUGS CHARGED TO PATIENTS	0	326, 247	42.50
43.00	OUTPATI ENT SERVICES	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	728, 632	46.00
100.00	TOTAL *	0	2, 053, 440	100.00
* Trar	sfer the amount in column 7 to Wkst. 0-5, col	umn 1, line 51.		

Transfer the amount in column 7 to Wkst. 0-5, column 1, line 51.

Health Financial Systems	FRANCI SCAN HEALT	H_LAFAYETTE		In Lie	u of Form CMS-2	2552-10
ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FO	R HOSPICE INPATIENT	Provider CC	N: 15-0109	Peri od:	Worksheet 0-3	
RESPI TE CARE		Hospi ce CCN		From 01/01/2017 To 12/31/2017	Date/Time Pre 5/31/2018 3:5	pared: 3 pm
				Hospi ce I		
	SALARI ES	OTHER S	SUBTOTAL (col	. RECLASSI FI -	SUBTOTAL	
			1 + col. 2)	CATI ONS		
	1.00	2.00	3.00	4.00	5.00	
DIRECT PATIENT CARE SERVICE COST CENT	ERS					
25.00 INPATIENT CARE-CONTRACTED		0		0 0	0	25.00
26.00 PHYSI CI AN SERVI CES	0	0		0 0	0	26.00
27.00 NURSE PRACTITIONER	0	0		0 0	0	27.00
28.00 REGI STERED NURSE	1,000	0	1, 00	0 0	1, 000	28.00
29.00 LPN/LVN	0	0		0 0	0	29.00
30. 00 PHYSI CAL THERAPY	0	0		0 0	0	30.00
31.00 OCCUPATIONAL THERAPY	0	0		0 0	0	31.00
32.00 SPEECH/LANGUAGE PATHOLOGY	0	0		0 0	0	32.00
33.00 MEDICAL SOCIAL SERVICES	0	0		0 0	0	33.00
34.00 SPI RI TUAL COUNSELI NG	93	0	9	3 0	93	34.00
35.00 DI ETARY COUNSELI NG	0	0		0 0	0	35.00
36.00 COUNSELING - OTHER	0	0		0 0	0	36.00
37.00 HOSPICE AIDE & HOMEMAKER SERVICES	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 MAGI NG SERVI CES	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
42.50 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	42.50
43.00 OUTPATI ENT SERVICES	0	o		0 0	0	43.00
44.00 PALLIATIVE RADIATION THERAPY	0	О		0 0	0	44.00
45.00 PALLIATIVE CHEMOTHERAPY	0	О		0 0	0	45.00
46.00 OTHER PATIENT CARE SERVICES (SPECIFY)	116	2, 615	2, 73	1 0	2, 731	46.00
100.00 TOTAL *	1, 209	2, 615	3, 82	4 0	3, 824	100.00

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

		ADJUSTMENTS	TOTAL (col. 5	
		6,00	<u>± col. 6)</u> 7.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS			
25.00	INPATIENT CARE-CONTRACTED	0	0	25.00
26.00	PHYSI CI AN SERVI CES	0	0	26.00
27.00	NURSE PRACTITIONER	0	0	27.00
28.00	REGI STERED NURSE	0	1,000	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	93	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 TRANSPORTATI ON	0	0	39.00
40.00	I MAGI NG SERVI CES	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	41.00
42.00	MEDI CAL SUPPLI ES-NON-ROUTI NE	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	42.50
43.00	OUTPATI ENT SERVI CES	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	45.00
	OTHER PATIENT CARE SERVICES (SPECIFY)	0	2, 731	46.00
100.00	TOTAL *	0	3, 824	100.00
* Tran	sfer the amount in column 7 to Wkst. 0-5, col	umn 1, line 52.		

ealth Financial Systems	RANCI SCAN HEALT	H_LAFAYETTE		In Lie	u of Form CMS-	2552-10
NALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPIC	E GENERAL	Provider CC		Peri od:	Worksheet 0-4	
NPATI ENT CARE		Hospi ce CCN		From 01/01/2017 To 12/31/2017	Date/Time Pre 5/31/2018 3:5	
				Hospi ce I	0/01/2010 010	<u>o p</u>
	SALARI ES	OTHER	SUBTOTAL (col 1 + col. 2)	. RECLASSI FI - CATI ONS	SUBTOTAL	
	1.00	2.00	3.00	4.00	5.00	
DIRECT PATIENT CARE SERVICE COST CENTERS						
5.00 INPATIENT CARE-CONTRACTED		0		0 0	0	25.00
6. 00 PHYSI CI AN SERVI CES	0	0		0 0	0	26.00
7.00 NURSE PRACTITIONER	0	0		0 0	0	27.00
8.00 REGI STERED NURSE	1, 778	0	1, 77	8 0	1, 778	28.00
9.00 LPN/LVN	0	0		0 0	0	29.00
0. 00 PHYSI CAL THERAPY	0	0		0 0	0	30.00
1. 00 OCCUPATI ONAL THERAPY	0	0		0 0	0	31.00
2.00 SPEECH/LANGUAGE PATHOLOGY	0	0		0 0	0	32.00
3.00 MEDICAL SOCIAL SERVICES	72	0	7	2 0	72	33.00
4.00 SPIRITUAL COUNSELING	68	0	6	0 8	68	34.00
5. 00 DI ETARY COUNSELI NG	0	0		0 0	0	35.00
6.00 COUNSELING - OTHER	0	0		0 0	0	36.00
7.00 HOSPICE AIDE & HOMEMAKER SERVICES	0	0		0 0	0	37.00
8.00 DURABLE MEDICAL EQUI PMENT/OXYGEN	0	0		0 0	0	38.00
9.00 PATIENT TRANSPORTATION	O	1, 268	1, 26	0 8	1, 268	39.00
0. 00 I MAGI NG SERVI CES	O	0		0 0	0	40.00
1.00 LABS & DIAGNOSTICS	o	О		0 0	0	41.00
2.00 MEDI CAL SUPPLI ES-NON-ROUTI NE	o	О		0 0	0	42.00
2.50 DRUGS CHARGED TO PATIENTS	o	О		0 0	0	42.50
3. 00 OUTPATI ENT SERVICES	o	О		0 0	0	43.00
4.00 PALLIATIVE RADIATION THERAPY	o	О		0 0	0	44.00
5.00 PALLIATIVE CHEMOTHERAPY	0	О		0 0	0	45.00
6.00 OTHER PATIENT CARE SERVICES (SPECIFY)	0	13, 056	13, 05	6 0	13, 056	46.00
00. 00 TOTAL *	1, 918	14, 324	16, 24	2 0	16, 242	100.00
Transfer the amount in column 7 to Wkst. 0-5, colu	umn 1, line 53.					

		ADJUSTMENTS	TOTAL (col. 5		
		(00	<u>± col. 6)</u>		
	DUDENT DATIENT ANDE OFDIVINE ANAT AFAITEDA	6.00	7.00		
	DI RECT PATIENT CARE SERVICE COST CENTERS	-	-		
25.00	INPATIENT CARE-CONTRACTED	0	0		25.00
26.00	PHYSI CI AN SERVI CES	0	0		26.00
27.00	NURSE PRACTITIONER	0	0		27.00
28.00	REGI STERED NURSE	0	1, 778		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	72		33.00
34.00	SPI RI TUAL COUNSELI NG	0	68		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	PATIENT TRANSPORTATION	0	1, 268		39.00
40.00	I MAGI NG SERVI CES	0	0		40.00
41.00	LABS & DI AGNOSTI CS	0	0		41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0		42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0		42.50
43.00	OUTPATI ENT SERVICES	0	0		43.00
44.00	PALLIATIVE RADIATION THERAPY		0		44.00
45.00	PALLIATIVE CHEMOTHERAPY		0		45.00
	OTHER PATIENT CARE SERVICES (SPECIFY)		13,056		46.00
	TOTAL *		16, 242		100.00
	sfer the amount in column 7 to Wkst. 0-5, colu	ump 1 line F2	10,212	1	1.00.00
11 di	ister the amount in cordina 7 to west. 0-3, cor	umin i, ittie 55.			

Heal th	Financial Systems FRANCI SCAN HEALTI	H LAFAYETTE		In Lie	eu of Form CMS-2	2552-10
COST A	LLOCATION - DETERMINATION OF HOSPITAL-BASED HOSPICE NET	Provider C	CN: 15-0109	Peri od:	Worksheet 0-5	
EXPENS	ES FOR ALLOCATION			From 01/01/2017		
		Hospi ce CC	N: 15-1563	To 12/31/2017		
				Hospi ce I	5/31/2018 3:5	3 pm
	Descriptions		HOSPICE DIRE		TOTAL EXPENSES	
	bescriptions		EXPENSES (se		(sum of cols.	
			i nstructi ons		1 + 2)	
				WKST B PART I	1 1 2)	
				(see		
				instructions)		
			1.00	2.00	3.00	
	GENERAL SERVICE COST CENTERS					
1.00	CAP REL COSTS-BLDG & FIXT		7	50 108, 869	109, 619	1.00
2.00	CAP REL COSTS-MVBLE EQUIP			0 29, 404	29, 404	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT			0 569, 436	569, 436	3.00
4.00	ADMINI STRATI VE & GENERAL		623, 2	78 775, 097	1, 398, 375	4.00
5.00	PLANT OPERATION & MAINTENANCE			0 120, 163		5.00
6.00	LAUNDRY & LINEN SERVICE			0 0		6.00
7.00	HOUSEKEEPING			0 45,009	45,009	7.00
8.00	DI ETARY			0 0		8.00
9.00	NURSI NG ADMI NI STRATI ON		39, 9	71 121, 417		9.00
10.00	ROUTI NE MEDI CAL SUPPLI ES		4, 2			10.00
11.00	MEDICAL RECORDS		., _	0 23,007		11.00
12.00	STAFF TRANSPORTATION			0	0	12.00
13.00	VOLUNTEER SERVI CE COORDI NATI ON		39, 4	-	39, 465	13.00
14.00	PHARMACY			17 O		14.00
15.00	PHYSI CI AN ADMI NI STRATI VE SERVI CES		105, 5		105, 593	
16.00	OTHER GENERAL SERVICE			0 0		16.00
17.00	PATI ENT/RESI DENTI AL CARE SERVI CES			0		17.00
	LEVEL OF CARE		1	-	-	
50.00	HOSPICE CONTINUOUS HOME CARE		1,5	35	1, 535	50.00
51.00	HOSPICE ROUTINE HOME CARE		2,053,4		2, 053, 440	51.00
52.00	HOSPICE INPATIENT RESPITE CARE		3, 8		3, 824	52.00
53.00	HOSPICE GENERAL INPATIENT CARE		16, 2		16, 242	53.00
	NONREI MBURSABLE COST CENTERS					
60.00	BEREAVEMENT PROGRAM			0	0	60.00
61.00	VOLUNTEER PROGRAM			0	0	61.00
62.00	FUNDRAI SI NG			0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS			0	0	63.00
64.00	PALLIATIVE CARE PROGRAM			0	0	64.00
65.00	OTHER PHYSI CLAN SERVI CES			0	0	65.00
66.00	RESI DENTI AL CARE			0	0	66.00
67.00	ADVERTI SI NG			0	0	67.00
68.00	TELEHEALTH/TELEMONI TORI NG			0	0	68.00
69.00	THRI FT STORE			0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD			0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)			0	0	71.00
99.00	NEGATIVE COST CENTER			0	0	99.00
100.00	TOTAL		2, 888, 6	85 1, 794, 512	4, 683, 197	100.00

Heal th	n Financial Systems	FRANCI SCAN HEALT	H LAFAYETTE		In Lie	u of Form CMS-2	2552-10
	ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL S		Provider CC Hospice CC		Period: From 01/01/2017 To 12/31/2017	Worksheet 0-6 Part I	pared:
					Hospi ce I		
	Descriptions	TOTAL EXPENSES C/	AP REL BLDG & FIX	CAP REL MVBL EQUI P		SUBTOTAL	
		0	1.00	2.00	3.00	3A	
	GENERAL SERVICE COST CENTERS			_			
1.00	CAP REL COSTS-BLDG & FIXT	109, 619	109, 619				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	29, 404		29, 40	04		2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	569, 436	0		0 569, 436		3.00
4.00	ADMI NI STRATI VE & GENERAL	1, 398, 375	0		0 0	1, 398, 375	4.00
5.00	PLANT OPERATION & MAINTENANCE	120, 163	0		0 0	120, 163	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0		0 0	0	6.00
7.00	HOUSEKEEPING	45,009	0		0 0	45,009	7.00
8.00	DIETARY	0	0		0 0	0	8.00
9.00	NURSING ADMINISTRATION	161, 388	0		0 0	161, 388	
10.00	ROUTI NE MEDI CAL SUPPLI ES	6, 380	0		0 0	6, 380	
11.00	MEDI CAL RECORDS	23,007	0		0 0	23, 007	
12.00	STAFF TRANSPORTATION	0	0		0 0	0	
13.00	VOLUNTEER SERVICE COORDINATION	39, 465	0		0 0	39, 465	
14.00		317	0		0 0	317	
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	105, 593	0		0 0	105, 593	
16.00		0	0		0 0	0	16.00
17.00		Ŭ	0		0	0	
17.00	LEVEL OF CARE		0	I	0	0	17.00
50.00	HOSPICE CONTINUOUS HOME CARE	1, 535			0	1, 535	50.00
50.00		2,053,440			0	2, 053, 440	
52.00	HOSPICE INPATIENT RESPITE CARE	3, 824	0		0 0	3, 824	
53.00		16, 242	109, 619	29, 40	569, 436		
55.00	NONREI MBURSABLE COST CENTERS	10, 242	107, 017	27, 4	54 507, 450	724,701	33.00
60.00		0	0		0 0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0		0 0	0	61.00
62.00		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 PHYSICIAN SERVICES	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		0	0		0 0	0	
69.00		0	0		0 0	0	69.00
70.00		0	0		0	0	
70.00		0	0		0	0	70.00
99.00		0	0		0 0	0	99.00
	D TOTAL	4, 683, 197	0 109, 619	29, 40	0 0 04 569, 436	1 400 107	
100.0		4,003,197	109, 019	29,40	J4 307, 430	4, 683, 197	100.00

	Financial Systems	FRANCI SCAN HEAL			_		u of Form CMS		<u>52-10</u>
COST A	LLOCATION - HOSPITAL-BASED HOSPICE GENERAL	SERVICE COSTS	Provider C Hospice CC	CN: 15-0109 N: 15-1563		eriod: rom 01/01/2017 o 12/31/2017	Worksheet O- Part I Date/Time Pr 5/31/2018 3:	ера	ared: pm
				_		Hospi ce I			
	Descriptions	ADMI NI STRATI VE & GENERAL	PLANT OPERATI ON & MAI NTENANCE	LAUNDRY & LINEN SERVIO		HOUSEKEEPI NG	DI ETARY		
		4.00	5.00	6.00		7.00	8.00		
	GENERAL SERVICE COST CENTERS	· · ·							
1.00	CAP REL COSTS-BLDG & FIXT								1.00
2.00	CAP REL COSTS-MVBLE EQUIP								2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT								3.00
4.00	ADMINISTRATIVE & GENERAL	1, 398, 375							4.00
5.00	PLANT OPERATION & MAINTENANCE	51, 154	171, 317	7					5.00
6.00	LAUNDRY & LINEN SERVICE	0	C		0				6.00
7.00	HOUSEKEEPING	19, 161	C			64, 170			7.00
8.00	DI ETARY	0	C			0		0	8.00
9.00	NURSING ADMINISTRATION	68, 704	C			0			9.00
10.00	ROUTI NE MEDI CAL SUPPLI ES	2, 716	C			0			10.00
11.00	MEDI CAL RECORDS	9, 794	C			0			11.00
12.00	STAFF TRANSPORTATION	0	C			0			12.00
13.00	VOLUNTEER SERVICE COORDINATION	16, 801	C			0			13.00
14.00	PHARMACY	135	C			0			14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	44, 952	C			0			15.00
16.00	OTHER GENERAL SERVICE	0	C			0			16.00
17.00	PATI ENT/RESI DENTI AL CARE SERVI CES	0	C			0			17.00
	LEVEL OF CARE								
50.00	HOSPICE CONTINUOUS HOME CARE	653							50.00
51.00	HOSPICE ROUTINE HOME CARE	874, 166							51.00
52.00	HOSPICE INPATIENT RESPITE CARE	1, 628	C		0	0		0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	308, 511	171, 317	7	0	64, 170		0	53.00
	NONREIMBURSABLE COST CENTERS								
60.00	BEREAVEMENT PROGRAM	0	C)		0			60.00
61.00	VOLUNTEER PROGRAM	0	C			0			61.00
62.00	FUNDRAI SI NG	0	C			0			62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	C			0			63.00
64.00	PALLIATIVE CARE PROGRAM	0	C			0			64.00
65.00	OTHER PHYSICIAN SERVICES	0	C			0			65.00
66.00	RESI DENTI AL CARE	0	C		0	0		0	66.00
67.00	ADVERTI SI NG	0	C			0			67.00
68.00	TELEHEALTH/TELEMONI TORI NG	0	C			0			68.00
69.00	THRI FT STORE	0	C			0			69.00
70.00	NURSING FACILITY ROOM & BOARD								70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	C)	0	0			71.00
99.00	NEGATIVE COST CENTER	0	C)	0	0		0	99.00
100 00	TOTAL	1, 398, 375	171, 317	71	0	64, 170		011	00.00

Heal th	Financial Systems	FRANCI SCAN HEAL	TH LAFAYETTE		In Lie	u of Form CMS-2	2552-10
COST A	ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL S	SERVICE COSTS	Provider CC Hospice CC		Period: From 01/01/2017 To 12/31/2017	Worksheet 0-6 Part I Date/Time Pre 5/31/2018 3:5	pared:
					Hospi ce I		
	Descriptions	NURSI NG ADMI NI STRATI ON	ROUTI NE MEDI CAL SUPPLI ES	MEDI CAL RECORDS	STAFF TRANSPORTATI ON	VOLUNTEER SERVI CE COORDI NATI ON	
		9.00	10.00	11.00	12.00	13.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMI NI STRATI VE & GENERAL						4,00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DI ETARY						8.00
9.00	NURSI NG ADMI NI STRATI ON	230, 092					9,00
10.00	ROUTINE MEDICAL SUPPLIES	200,072	9, 096				10.00
11.00	MEDI CAL RECORDS	0	,,,,,,	32, 8	01		11.00
12.00	STAFF TRANSPORTATION	0		02,0	0		12.00
13.00	VOLUNTEER SERVICE COORDINATION	0			0	56, 266	13.00
14.00	PHARMACY	0			0	00,200	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0			0	0	15.00
16.00	OTHER GENERAL SERVICE	0			0	0	16.00
17.00	PATI ENT/RESI DENTI AL CARE SERVI CES	Ŭ			0	Ŭ	17.00
17.00	LEVEL OF CARE			I			17.00
50,00	HOSPICE CONTINUOUS HOME CARE	0	1		3 0	6	50.00
51.00	HOSPICE ROUTINE HOME CARE	0	9, 058	32, 6		-	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	25		92 0	157	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	230, 092	12		42 0		53.00
00.00	NONREI MBURSABLE COST CENTERS	200/0/2			.2	, , ,	00100
60,00	BEREAVEMENT PROGRAM	0			0	0	60.00
61.00	VOLUNTEER PROGRAM	0			0		61.00
62.00	FUNDRALSING	0			0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0			0	0	63.00
64.00	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	66.00
67.00	ADVERTI SI NG	0			0	0	67.00
68.00	TELEHEALTH/TELEMONI TORI NG	0			0	0	68.00
69.00	THRI FT STORE	0			0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0			0	0	70.00
70.00	OTHER NONREIMBURSABLE (SPECIFY)	0			0	0	70.00
99.00	NEGATI VE COST CENTER	0	0		0 0	-	99.00
	TOTAL	230, 092	9, 096		-	-	100.00
100.00	1.0	200,072	,,070	1 52, 0	0.1	00,200	1.00.00

		RVICE COSTS	Provider CC Hospice CCN		Period: From 01/01/2017 To 12/31/2017	Worksheet 0-6 Part I Date/Time Pre 5/31/2018 3:5	epared:
					Hospi ce I		
	Descriptions	PHARMACY A	PHYSI CI AN ADMI NI STRATI VE SERVI CES	OTHER GENERA SERVI CE	AL PATI ENT/ RESI DENTI AL CARE SERVI CES	TOTAL	
		14.00	15.00	16.00	17.00	18.00	
	GENERAL SERVICE COST CENTERS	· · · · · · · · · · · · · · · · · · ·					
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMI NI STRATI VE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DI ETARY						8.00
9.00	NURSING 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	VOLUNTEER SERVICE COORDINATION						13.00
	PHARMACY	452					14.00
	PHYSICIAN ADMINISTRATIVE SERVICES	0	150, 545				15.00
	OTHER GENERAL SERVICE	0			0		16.00
17.00	PATI ENT/RESI DENTI AL CARE SERVI CES				0		17.00
	LEVEL OF CARE		4 5			0.010	
50.00	HOSPICE CONTINUOUS HOME CARE	0	15		0	2, 213	
51.00	HOSPICE ROUTINE HOME CARE	450	149, 919		0	3, 175, 729	
52.00	HOSPICE INPATIENT RESPITE CARE	1	420 191		0 0	6, 147	
53.00	HOSPICE GENERAL INPATIENT CARE		191		0 0	1, 499, 108	53.00
60, 00	NONREI MBURSABLE COST CENTERS BEREAVEMENT PROGRAM	0			0	0	60.00
61.00	VOLUNTEER PROGRAM	0			0	0	
62.00	FUNDRAL SI NG	0			0	0	000
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0			0	0	
64.00	PALLIATIVE CARE PROGRAM	0			0	0	
	OTHER PHYSICIAN SERVICES	0			0	0	
66.00	RESI DENTI AL CARE	0	0		0 0	0	
	ADVERTI SI NG	0	0		0	0	
68.00	TELEHEALTH/TELEMONI TORI NG	0			0	0	
	THRI FT STORE	0			0	0	
70.00	NURSING FACILITY ROOM & BOARD					0	
	OTHER NONREIMBURSABLE (SPECIFY)		0		0 0	0	
	NEGATIVE COST CENTER		0		0 0	0	
100.00		452	150, 545		0 0	4, 683, 197	

Heal th	Financial Systems	FRANCI SCAN HEALT	TH LAFAYETTE		In Lie	u of Form CMS-2	2552-10
COST A	LLOCATION - HOSPITAL-BASED HOSPICE GENERAL	SERVICE COSTS	Provider CC	N: 15-0109	Peri od:	Worksheet 0-6	
STATI S	TI CAL BASI S				From 01/01/2017	Part II	
			Hospi ce CCN	l: 15-1563	To 12/31/2017	Date/Time Pre	
					Hospi ce I	5/31/2018 3:5	<u>s pili</u>
	Cost Center Descriptions	CAP REL BLDG & C		EMPLOYEE	RECONCI LI ATI ON		
	cost center bescriptions	FIX	EQUIP	BENEFITS	RECONCILIATION	& GENERAL	
		(SQUARE FEET) (DEPARTMENT		(ACCUMULATED	
			DOLLAR VALUE)	(GROSS		COSTS)	
				SALARI ES)		00010)	
		1.00	2.00	3.00	4A	4.00	
	GENERAL SERVICE COST CENTERS		2100	0100			
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	0	0	1, 463, 10)4		3.00
4.00	ADMINISTRATIVE & GENERAL	0	0	.,, .	0 -1, 398, 375	3, 284, 822	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0		0 0	120, 163	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0		0 0	0	6.00
7.00	HOUSEKEEPING	0	0		0 0	45,009	7.00
8.00	DI ETARY	0	0		0 0	0	8.00
9.00	NURSI NG ADMI NI STRATI ON	0	0		0 0	161, 388	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0		0 0	6, 380	1
11.00	MEDI CAL RECORDS	0	0		0 0	23,007	11.00
12.00	STAFF TRANSPORTATION	0	0		0 0	23,007	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0		0 0	39, 465	
14.00	PHARMACY	0	0		0 0	317	14.00
14.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0		0 0	105, 593	
16.00	OTHER GENERAL SERVICE	0	0		0 0	105, 545	16.00
17.00	PATI ENT/RESI DENTI AL CARE SERVI CES	0	0		0	0	17.00
17.00	LEVEL OF CARE	<u>Ч</u>	U		0	0	17.00
50.00	HOSPICE CONTINUOUS HOME CARE				0 0	1, 535	50.00
51.00	HOSPICE ROUTINE HOME CARE				0 0	2, 053, 440	
52.00	HOSPICE INPATIENT RESPICE CARE	0	0		0 0	2, 033, 440	52.00
52.00 53.00	HOSPICE GENERAL INPATIENT CARE	3, 809	3, 809	1, 463, 10		724, 701	53.00
55.00	NONREI MBURSABLE COST CENTERS	3,009	3,007	1, 403, 10	0	724,701	55.00
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	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0		0 0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0		0 0	0	65.00
66. 00	RESIDENTIAL 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
69.00	THRIFT STORE	0	0			0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0	0		0 0	0	70.00
70.00	OTHER NONREIMBURSABLE (SPECIFY)	_	0		0 0	0	71.00
	NEGATIVE COST CENTER	0	0		0	0	99.00
	COST TO BE ALLOCATED (per Wkst. 0-6, Part) 109, 619	29, 404	569, 43	26	1, 398, 375	
	UNIT COST MULTIPLIER	28. 778945	7. 719611	0. 38919		0. 425708	
101.00		20.770743	,,,,,,,,,,,	0. 3091		0. 420700	1.01.00

Heal th	Financial Systems	FRANCI SCAN HEAL	TH LAFAYETTE		In Lie	eu of Form CMS-2	2552-10
COST A	LLOCATION - HOSPITAL-BASED HOSPICE GENERAL S	ERVICE COSTS	Provider C	CN: 15-0109	Peri od:	Worksheet 0-6	
STATI S	TICAL BASIS		Hospi ce CC	N: 15-1563	From 01/01/2017 To 12/31/2017		pared:
			10000100000		10 12/01/2017	5/31/2018 3:5	
					Hospi ce I		
	Cost Center Descriptions	PLANT	LAUNDRY &	HOUSEKEEPI N		NURSI NG	
			LINEN SERVICE	(SQUARE FEET		ADMI NI STRATI ON	
		MAI NTENANCE	(IN-FACILITY		DAYS)		
		(SQUARE FEET)	DAYS)			(DI RECT NURS. HRS.)	
		5.00	6.00	7.00	8.00	9.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE	3, 809					5.00
6.00	LAUNDRY & LINEN SERVICE	0	0				6.00
7.00	HOUSEKEEPING	0		3, 8	09		7.00
8.00	DI ETARY	0			0 0		8.00
9.00	NURSING ADMINISTRATION	0			0	42, 925	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0			0	0	10.00
11.00	MEDI CAL RECORDS	0			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	0			0		17.00
F0 00	LEVEL OF CARE	1		1			
50.00	HOSPICE CONTINUOUS HOME CARE					0	50.00 51.00
51.00 52.00	HOSPICE ROUTINE HOME CARE HOSPICE INPATIENT RESPITE CARE	0	0		0		51.00
52.00 53.00	HOSPICE INPATIENT RESPITE CARE HOSPICE GENERAL INPATIENT CARE	3, 809	0		0 0 09 0	-	52.00
55.00	NONREI MBURSABLE COST CENTERS	3, 009	0	3,0	09 0	42, 923	53.00
60, 00	BEREAVEMENT PROGRAM	0			0	0	60.00
61.00	VOLUNTEER PROGRAM	0			0	0	61.00
62.00	FUNDRALSING	0			0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0			0	0	63.00
64.00	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	0	66.00
67.00	ADVERTI SI NG	0			0	0	67.00
68.00	TELEHEALTH/TELEMONI TORI NG	0			0	0	68.00
69.00	THRI FT STORE	0			0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0)	0 0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)) 171, 317	0	64, 1	70 0	230, 092	100. 00
101.00	UNIT COST MULTIPLIER	44. 976897	0. 000000	16. 8469	41 0. 000000	5. 360326	101. 00

Heal tl	n Financial Systems	FRANCI SCAN HEALT	H LAFAYETTE		In Lie	u of Form CMS-	2552-10
	ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SE STICAL BASIS	ERVICE COSTS	Provider C Hospice CC		Period: From 01/01/2017 To 12/31/2017	Worksheet 0-6 Part II Date/Time Pre 5/31/2018 3:5	pared:
				_	Hospi ce I		
	Cost Center Descriptions	ROUTI NE MEDI CAL SUPPLI ES (PATI ENT DAYS)	MEDI CAL RECORDS PATI ENT DAYS)	STAFF TRANSPORTATI ((MI LEAGE)	VOLUNTEER DN SERVI CE COORDI NATI ON (HOURS OF SERVI CE)	PHARMACY (CHARGES)	
		10.00	11.00	12.00	13.00	14.00	
	GENERAL SERVICE COST CENTERS						
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 17.\ 00\\ \end{array}$	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL PLANT OPERATION & MAINTENANCE LAUNDRY & LINEN SERVICE HOUSEKEEPING DI ETARY NURSING ADMINISTRATION ROUTINE MEDICAL SUPPLIES MEDICAL RECORDS STAFF TRANSPORTATION VOLUNTEER SERVICE COORDINATION PHARMACY PHYSICIAN ADMINISTRATIVE SERVICES OTHER GENERAL SERVICE	19, 706	19, 706		0 0 19, 706 0 0 0 0 0 0	19, 706 0 0	15.00
50.00		2		1	0 2	2	50.00
50.00 51.00 52.00 53.00	HOSPI CE ROUTI NE HOME CARE HOSPI CE I NPATI ENT RESPI TE CARE	2 19, 624 55 25	2 19, 624 55 25		0 2 0 19,624 0 55 0 25	19, 624	51.00 52.00
100.0	BEREAVEMENT PROGRAM VOLUNTEER PROGRAM FUNDRAI SI NG HOSPI CE/PALLI ATI VE MEDI CI NE FELLOWS PALLI ATI VE CARE PROGRAM OTHER PHYSI CI AN SERVI CES RESI DENTI AL CARE ADVERTI SI NG TELEHEALTH/TELEMONI TORI NG THRI FT STORE NURSI NG FACI LI TY ROOM & BOARD	9, 096 0. 461585	32, 801 1. 664518		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 56, 266 2. 855273	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	61.00 62.00 63.00 64.00 65.00 66.00 67.00 68.00 69.00 70.00 71.00 99.00 100.00

Heal th	Financial Systems	FRANCI SCAN HEAL	TH LAFAYETTE		In Lie	u of Form CMS	-2552-10
	LLOCATION - HOSPITAL-BASED HOSPICE GENERAL SE	RVICE COSTS	Provider C	CN: 15-0109	Peri od:	Worksheet 0-	.6
STATI S	TICAL BASIS		Hospi ce CC	N: 15-1563	From 01/01/2017 To 12/31/2017	Part II Date/Time Pr	enared.
				10 1000	10 12/01/2017	5/31/2018 3:	
					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			
		(PATIENT DAYS)	BASI S)	(IN-FACILIT	Y		
		15.00	16.00	DAYS) 17.00			
	GENERAL SERVICE COST CENTERS	15.00	10.00	17.00			_
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	ADMI NI STRATI VE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSI NG ADMI NI STRATI ON						9.00
10.00	ROUTINE MEDICAL SUPPLIES						10.00
11.00	MEDI CAL RECORDS						11.00
12.00	STAFF TRANSPORTATION						12.00
13.00	VOLUNTEER SERVICE COORDINATION						13.00
14.00	PHARMACY						14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	19, 706					15.00
16.00	OTHER GENERAL SERVICE		0				16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES				0		17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	2	0				50.00
51.00	HOSPICE ROUTINE HOME CARE	19, 624	0				51.00
52.00	HOSPICE INPATIENT RESPITE CARE	55	0		0		52.00
53.00	HOSPICE GENERAL INPATIENT CARE	25	0		0		53.00
	NONREI MBURSABLE COST CENTERS	1	-	1			
60.00	BEREAVEMENT PROGRAM		0				60.00
61.00	VOLUNTEER PROGRAM		0				61.00
62.00			0				62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS		0				63.00
64.00 65.00	PALLIATIVE CARE PROGRAM		0				64.00
65.00 66.00	OTHER PHYSI CI AN SERVI CES RESI DENTI AL CARE	0	0		0		65.00 66.00
67.00	ADVERTI SI NG	0	0		0		67.00
68.00	TELEHEALTH/TELEMONI TORI NG		0				68.00
69.00	THRIFT STORE		0				69.00
70.00	NURSING FACILITY ROOM & BOARD		0				70.00
70.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0		0		71.00
99.00	NEGATI VE COST CENTER	0	0		~		99.00
	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	150, 545	0		0		100.00
	UNIT COST MULTIPLIER	7. 639551		0.0000	-		101.00
	1			1 20000	1		1

Heal th	Financial Systems	FRANCI SCAN HEALT	TH LAFAYETTE		In Lie	eu of Form CMS-	2552-10
	IONMENT OF HOSPITAL-BASED HOSPICE SHARED SER	VICE COSTS BY	Provider CO	CN: 15-0109	Peri od:	Worksheet 0-7	
LEVEL	OF CARE		Hospi ce CCN	N: 15-1563	From 01/01/2017 To 12/31/2017	Date/Time Pre 5/31/2018 3:5	pared:
					Hospi ce I	3/31/2010 3.3	
				Charges by	/ LOC (from Provi	der Records)	
	Cost Center Descriptions	From Wkst. C, C	ost to Charge	НСНС	HRHC	HI RC	
		Part I, Col. 9	Ratio				
		line					
		0	1.00	2.00	3.00	4.00	
	ANCILLARY SERVICE COST CENTERS						
1.00	PHYSI CAL THERAPY	66.00	0. 482421		0 0	0	1.00
2.00	OCCUPATIONAL THERAPY	67.00	0. 283370		0 0	0	2.00
3.00	SPEECH PATHOLOGY	68.00	0.465217		0 0	0	3.00
4.00	DRUGS CHARGED TO PATIENTS	73.00	0. 151889		0 0	0	4.00
4.01	DI ABETES CENTER	73.01	3. 030318		0 0	0	4.01
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00					5.00
6.00	LABORATORY	60, 00	0. 105556		0 0	0	6.00
7.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0. 146904		0 0	0	7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER	93.00					8.00
9.00	RADI OLOGY-THERAPEUTI C	55.00	0. 106112		0 0	0	9.00
10. 98	HYPERBARI C OXYGEN THERAPY	76. 98	0. 496795		0 0	0	10. 98
11.00	Totals (sum of lines 1-11)						11.00
		Charges by LOC		Shared Serv	ice Costs by LOC		
		(from Provider					
		Records)					
	Cost Center Descriptions	HGI P H	CHC (col. 1 x	HRHC (col. 1	xHIRC (col. 1 x	HGIP (col. 1 x	
			col. 2)	col. 3)	col. 4)	col. 5)	
		5.00	6.00	7.00	8.00	9.00	
	ANCI LLARY SERVI CE COST CENTERS					1	
1.00	PHYSI CAL THERAPY	0	0		0 0	0	
2.00	OCCUPATIONAL THERAPY	0	0		0 0	-	
3.00	SPEECH PATHOLOGY	0	0		0 0	0	
4.00	DRUGS CHARGED TO PATIENTS	0	0		0 0	0	4.00
4.01	DI ABETES CENTER	0	0		0 0	0	
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	
8.00	OTHER OUTPATIENT SERVICE COST CENTER						8.00
9.00	RADI OLOGY-THERAPEUTI C	0	0		0 0	0	
10. 98	HYPERBARI C OXYGEN THERAPY	0	0		0 0	0	
11.00	Totals (sum of lines 1-11)		0		0 0	0	11.00

	Financial Systems FRANCISCAN HEALTH	Provi der C	°N: 15 0100	Perio		u of Form CMS-2 Worksheet 0-8	
ALCULA	ATTON OF HUSPITAL-BASED HUSPICE PER DIEM CUST	Provider C	CN: 12-0109		01/01/2017	worksneet 0-8	
		Hospi ce CC	N: 15-1563		12/31/2017	Date/Time Pre	pared
						5/31/2018 3:5	3 pm
					ospice I		
			TITLE XVIII		ITLE XIX	TOTAL	
			MEDI CARE	!	MEDI CAI D		
			1.00		2.00	3.00	
	HOSPICE CONTINUOUS HOME CARE						
	Total cost (Wkst. 0-6, Part I, col. 18, line 50 plus Wkst. 0-	7, col. 6,				2, 213	1.
	line 11)						
	Total unduplicated days (Wkst. S-9, col. 4, line 10)					2	
	Total average cost per diem (line 1 divided by line 2)					1, 106. 50	
	Unduplicated program days (Wkst. S-9 col. as appropriate, lin	ne 10)		0	0		4.
	Program cost (line 3 times line 4)			0	0		5.
	HOSPICE ROUTINE HOME CARE		1			-	
	Total cost (Wkst. 0-6, Part I, col. 18, line 51 plus Wkst. 0-	7, col. 7,				3, 175, 729	6.
	line 11)						
	Total unduplicated days (Wkst. S-9, col. 4, line 11)					19, 624	
	Total average cost per diem (line 6 divided by line 7)					161.83	
	Unduplicated program days (Wkst. S-9, col. as appropriate, li	ne 11)	18, 7		0		9.
	Program cost (line 8 times line 9)		3, 040, 3	00	0		10.
	HOSPICE INPATIENT RESPITE CARE						
	Total cost (Wkst. 0-6, Part I, col. 18, line 52 plus Wkst. 0-	7, col. 8,				6, 147	11.
	line 11)						
	Total unduplicated days (Wkst. S-9, col. 4, line 12)						12.
	Total average cost per diem (line 11 divided by line 12)					111.76	
	Unduplicated program days (Wkst. S-9, col. as appropriate, li	ne 12)		39	0		14.
	Program cost (line 13 times line 14)		4, 3	59	0		15.
	HOSPICE GENERAL INPATIENT CARE						
	Total cost (Wkst. 0-6, Part I, col. 18, line 53 plus Wkst. 0-	7, col. 9,				1, 499, 108	16.
	line 11)						
	Total unduplicated days (Wkst. S-9, col. 4, line 13)					25	
	Total average cost per diem (line 16 divided by line 17)					59, 964. 32	
	Unduplicated program days (Wkst. S-9, col. as appropriate, li	ne 13)		19	0		19.
	Program cost (line 18 times line 19)		1, 139, 3	22	0		20.
	TOTAL HOSPICE CARE						
	Total cost (sum of line 1 + line 6 + line 11 + line 16)					4, 683, 197	21.
2.00	Total unduplicated days (Wkst. S-9, col. 4, line 14)					19, 706	
3.00	Average cost per diem (line 21 divided by line 22)					237.65	22

Health Financial Systems	FRANCISCAN HEALTH LAFAYETTE	In Lie	u of Form CMS-2	2552-10
CALCULATION OF CAPITAL PAYMENT	Provider CCN: 15-0109	Period: From 01/01/2017 To 12/31/2017	Worksheet L Parts I-III Date/Time Pre 5/31/2018 3:5	
	Title XVIII	Hospi tal	PPS	

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	3, 430, 648	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	264, 274	2.00
2.01	Model 4 BPCI Capital DRG outlier payments	0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)	114.17	3.00
4.00	Number of interns & residents (see instructions)	0.00	4.00
5.00	Indirect medical education percentage (see instructions)	0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the 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 patient days (Worksheet E, part A line	3.29	7.00
	30) (see instructions)		
8.00	Percentage of Medicaid patient days to total days (see instructions)	24.61	8.00
9.00	Sum of Lines 7 and 8	27.90	•
10.00	Allowable disproportionate share percentage (see instructions)	5.81	•
11.00	Disproportionate share adjustment (see instructions)	199, 321	
12.00	Total prospective capital payments (see instructions)	3, 894, 243	12.00
		1.00	
	PART II - PAYMENT UNDER REASONABLE COST	1.00	
1.00	Program inpatient routine capital cost (see instructions)	0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)	0	
3.00	Total inpatient program capital cost (line 1 plus line 2)	0	
4.00	Capital cost payment factor (see instructions)	0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)	0	
0.00			0.00
		1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS		
1.00	Program inpatient capital costs (see instructions)	0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)	0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)	0	
4.00	Applicable exception percentage (see instructions)	0.00	
5.00	Capital cost for comparison to payments (line 3 x line 4)	0	
6.00	Percentage adjustment for extraordinary circumstances (see instructions)	0.00	
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)	0	
8.00	Capital minimum payment level (line 5 plus line 7)	0	
9.00	Current year capital payments (from Part I, line 12, as applicable)	0	
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)	0	
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year	0	11.00
	Worksheet L, Part III, line 14)		10.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)	0	
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)	0	
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period	0	14.00
15 00	(if line 12 is negative, enter the amount on this line)	0	15.00
15.00	Current year allowable operating and capital payment (see instructions)	0	
16.00	Current year operating and capital costs (see instructions) Current year exception offset amount (see instructions)	0	
17.00	Content year exception offset amount (see fisting tions)	0	117.00