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 electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by FRANCISCAN HEALTH CRAWFORDSVILLE (15-0022) for the cost reporting period beginning 01/01/2018 and ending 12/31/2018 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 aned)

Officer or Administrator of Provider(s)

OMB NO. 0938-0050 EXPIRES 05-31-2019

Date/Time Prepared:

3:23 pm

Δ

5/30/2019 3:23 pm

Time:

Worksheet S

Parts I-III

Title

Date

			Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	HI T	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	-95, 973	154, 971	0	0	1.00
2.00	Subprovider - IPF	0	0	37		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	-95, 973	155, 008	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.

From 01/01/2018 Part Date/ 5/30// 5/30/ I 00 2.00 3.00 4.00 Hospital and Hospital Health Care Complex Address: Component Name County: Component Name Contry: Component Name Contry: Component Name Contry: Component Name Contry: County: Component Name Contry: County: Component Name CON CBate To, o, o Number Provider Date Certified T, o, o Component Name CON County: Component Name County: Component Name County: Component Name County: County: County: County: County: <td< th=""><th>Fine Prepare 2019 3:23 pm 1. 22. 5tem (P, r N) I XIX</th></td<>	Fine Prepare 2019 3:23 pm 1. 22. 5tem (P, r N) I XIX
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hospital?) In column 2, enter "Y" for yes or "N" for no. 2.01 Did this hospital receive interim uncompensated care payments for this N N	
2.01 Did this hospital receive interim uncompensated care payments for this N N	
cost reporting period? Enter in column 1. "Y" for yes or "N" for no for	22.
the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost	
reporting period occurring on or after October 1. (see instructions)	
2.02 Is this a newly merged hospital that requires final uncompensated care N N	22.
payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the	
cost reporting period prior to October 1. Enter in column 2, "Y" for yes	
or "N" for no, for the portion of the cost reporting period on or after October 1.	
2.03 Did this hospital receive a geographic reclassification from urban to NNN	N 22.
rural as a result of the OMB standards for delineating statistical areas	
adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter	
in column 2, "Y" for yes or "N" for no for the portion of the cost	
reporting period occurring on or after October 1. (see instructions)	
Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for	
yes or "N" for no.	1
3.00 Which method is used to determine Medicaid days on lines 24 and/or 25 2 N	
below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost	23.
reporting period different from the method used in the prior cost	23.
reporting period? In column 2, enter "Y" for yes or "N" for no. In-State In-State Out-of Out-of Medicaid	23.
paid days eligible Medicaid Medicaid	Other edi cai d
unpaid paid days eligible days unpaid	Other
1.00 2.00 3.00 4.00 5.00	Other edi cai d
1.00 If this provider is an IPPS hospital, enter the 0 0 0 0 0 0	Other edicaid days
in-state Medicaid paid days in column 1, in-state	Other edi cai d
	Other edicaid days 6.00
Medicaid eligible unpaid days in column 2,	Other edicaid days 6.00
	Other edicaid days 6.00

SPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION D		Provider CC			1/2018	Part I Date/T 5/30/2	ime Pre 2019 3:2	epared:
	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medica HMO da	ys Me	Other edi cai d days	_
00 If this provider is an LDE optor the in state	1.00	2.00	3.00	4.00	5.00	0	6.00	25.0
5.00 If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	e		0				6.0	25. (
				Urban/Ru 1.0			r Geogr 00	-
. 00 Enter your standard geographic classification (not v	wage) status	at the beg	jinning of t		2	٤.	00	26.0
 cost reporting period. Enter "1" for urban or "2" for Coo Enter your standard geographic classification (not wreporting period. Enter in column 1, "1" for urban center the effective date of the geographic reclassification Coo If this is a sole community hospital (SCH), enter the 	wage) status or "2" for r fication in (ural. If ap column 2.	pplicable,		2			27.0
effect in the cost reporting period.				Begi nn	i na:	End	i ng:	
				1. 0			00	1
0.00 Enter applicable beginning and ending dates of SCH		cript line	36 for numb					36. (
of periods in excess of one and enter subsequent dat 0.00 If this is a Medicare dependent hospital (MDH), enter		r of period	ls MDH statu	IS I	1			37.
is in effect in the cost reporting period. 2.01 Is this hospital a former MDH that is eligible for t								37.
accordance with FY 2016 OPPS final rule? Enter "Y" f instructions)								
3.00 If line 37 is 1, enter the beginning and ending date greater than 1, subscript this line for the number of enter subsequent dates.				01/01/	2018	12/31	1/2018	38.
				1\Y			/N	
0.00 Does this facility qualify for the inpatient hospita	al pormant a	diuatmant f	For Low volu	1.0 Ime Y			00 Y	39.
hospitals in accordance with 42 CFR §412.101(b)(2)(i 1 "Y" for yes or "N" for no. Does the facility meet accordance with 42 CFR 412.101(b)(2)(i), (ii), or (i or "N" for no. (see instructions) 0.00 Is this hospital subject to the HAC program reduction	i), (ii), or the mileage iii)? Enter	(iii)? Ent requiremen in column 2	er in colum nts in ? "Y" for ye	in :S			Y	40.
"N" for no in column 1, for discharges prior to Octo no in column 2, for discharges on or after October 1	ober 1. Ente	r "Y" for y						
					V 1.00	XVIII 2.00	_	-
Prospective Payment System (PPS)-Capital								
5.00 Does this facility qualify and receive Capital payme with 42 CFR Section §412.320? (see instructions)	ent for disp	roporti onat	e share in	accordance	N	N	N	45.
b. 00 Is this facility eligible for additional payment exc pursuant to 42 CFR §412.348(f)? If yes, complete Wks Pt. III.					N	N	N	46.
7.00 s this a new hospital under 42 CFR §412.300(b) PPS 8.00 s the facility electing full federal capital paymer			2		N N	N N	N N	47. 48.
Teaching Hospitals 0.00 Is this a hospital involved in training residents in	n approved G	ME programs	? Enter "Y	" for yes	N			56.
or "N" for no. If line 56 is yes, is this the first cost reporting GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mor	or yes or "N nth of this o	" for no in cost report	n column 1. ing period?	lf column 1 ' Enter "Y"				57.
Ifor yes or "N" for no in column 2 If column 2 is "	II, if appli	cabl e.			N			58.
for yes or "N" for no in column 2. If column 2 is " "N", complete Wkst. D, Parts III & IV and D-2, Pt. I 1.00 If line 56 is yes, did this facility elect cost reim								59.
"N", complete Wkst. D, Parts III & IV and D-2, Pt. I B.OO If line 56 is yes, did this facility elect cost reim defined in CMS Pub. 15-1, chapter 21, §2148? If yes,	, complete W		Pt. I.		I N			
"N", complete Wkst. D, Parts III & IV and D-2, Pt. I B.OO If line 56 is yes, did this facility elect cost reim	, complete W		Pt. I. NAHE 413.8 Y/N	35 Workshe Line	eet A #	Qualif	Through ication on Code	
"N", complete Wkst. D, Parts III & IV and D-2, Pt. I B.OO If line 56 is yes, did this facility elect cost reim defined in CMS Pub. 15-1, chapter 21, §2148? If yes,	, complete W		NAHE 413.8		eet A #	Qualif Criteri	ication	

IOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	TA	Provider CC	F	eriod: rom 01/01/2018 o 12/31/2018	Worksheet S-2 Part I Date/Time Pre 5/30/2019 3:2	pared:
		Y/N	IME	Direct GME	IME	Direct GME	
1 00	Did your boopital receive FTF alate under ACA	1.00	2.00	3.00	4.00	5.00	(1.0
	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) 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 instructions)	N			0.00		61.0
1. 02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.0
1. 03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.0
	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).						61.0
	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.0
1.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.0
		Pro	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
			1.00	2.00	3.00	4.00	
	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00		61. 1
						1.00	
0 00	ACA Provisions Affecting the Health Resources and Ser						-
	Enter the number of FTE residents that your hospital your hospital received HRSA PCRE funding (see instruct Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC prog	ctions) a Teachi gram. (s	ng Health Cent see instruction	ter (THC) into			62.C
3. 00	Teaching Hospitals that Claim Residents in Nonprovide Has your facility trained residents in nonprovider se "Y" for yes or "N" for no in column 1. If yes, complete	ettings	during this co			N	63. C
				Unweighted FTEs Nonprovider Site	FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	-
	Section 5504 of the ACA Base Year FTE Residents in No	onprovi	der Settings	1.00 This base year	2.00	3.00	
4.00	period that begins on or after July 1, 2009 and befor Enter in column 1, if line 63 is yes, or your facilit in the base year period, the number of unweighted non resident FTEs attributable to rotations occurring in settings. Enter in column 2 the number of unweighted resident FTEs that trained in your hospital. Enter in of (column 1 divided by (column 1 + column 2)). (see	<u>re June</u> y trair a-primar all nor l non-pr n columr	30, 2010. med residents y care provider imary care n 3 the ratio	0.00	-		64. C

IOSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DA	TA Provider		eriod: rom 01/01/2018	Worksheet S-2 Part I	
			T	o 12/31/2018	Date/Time Pre 5/30/2019 3:2	pared:
	Program Name	Program Code	Unweighted FTEs Nonprovider	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
			Si te			
5.00 Enter in column 1, if line 63	1.00	2.00	3.00	4.00 0.00	5.00 0.000000	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 (column 3 + column						
4)). (see instructions)			Unweighted	Unweighted	Ratio (col. 1/	,
			FTEs Nonprovi der Si te	FTEs in Hospital	(col . 1 + col . 2))	
			1.00	2.00	3.00	-
Section 5504 of the ACA Current Y beginning on or after July 1, 201		n Nonprovider Settin	gsEffective f	or cost reporti	ng periods	
6.00 Enter in column 1 the number of un FTEs attributable to rotations occ Enter in column 2 the number of un FTEs that trained in your hospital (column 1 divided by (column 1 + o	curring in all nonpr nweighted non-primar . Enter in column 3	ovider settings. Ty care resident the ratio of	0.00 Unweighted FTEs Nonprovider	0.00 Unweighted FTEs in Hospital	0.000000 Ratio (col. 3/ (col. 3 + col. 4))	
_	1.00	2.00	Si te 3. 00	4.00	5.00	-
 7.00 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care FTEs that trained in your hospital. Enter in column 3 divided by (column 3 + column 4)). (see instructions) 			0.00	0. 00	0. 000000	0 67.0
				1.00	0 2.00 3.00	-
Inpatient Psychiatric Facility PP						
0.00 Is this facility an Inpatient Psy Enter "Y" for yes or "N" for no.	cniatric Facility (I	PF), or does it con	tain an IPF subp	provider? Y		70.0
1.00 If line 70 is yes: Column 1: Did recent cost report filed on or be 42 CFR 412.424(d)(1)(iii)(c)) Coll program in accordance with 42 CFR Column 3: If column 2 is Y, indice (see instructions) Inpatient Rehabilitation Facility	fore November 15, 20 umn 2: Did this faci 412.424 (d)(1)(iii) ate which program ye	004? Enter "Y" for lity train resident (D)? Enter "Y" for	yes or "N" for r s in a new teach yes or "N" for r	no. (see ni ng no.	N O	71.0
5.00 Is this facility an Inpatient Reh	abilitation Facility	(IRF), or does it	contain an IRF	N		75.0
8.00 subprovider? Enter "Y" for yes and 16.00 If line 75 is yes: Column 1: Did recent cost reporting period endin no. Column 2: Did this facility to	the facility have ar ng on or before Nove	ember 15, 2004? Ente	r "Y" for yes or	"N" for	0	76.00

Heal th	Financial Systems FRANCISCAN HEALTH CRAWFORDSVILLE	In Lie	u of Form CMS-	2552-10
HOSPI T		eriod: rom 01/01/2018	Worksheet S-2 Part I	2
	t i i i i i i i i i i i i i i i i i i i		Date/Time Pre	
			5/30/2019 3::	23 pm
			1.00	
80. 00	Long Term Care Hospital PPS Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.		N	80.00
	Is this a LTCH co-located within another hospital for part or all of the cost reporting	period? Enter	N	81.00
	"Y" for yes and "N" for no.	-		-
85.00	TEFRA Providers Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes o	or "N" for no.	N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section			86.00
	§413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no. Is this hospital an extended neoplastic disease care hospital classified under section		N	87.00
87.00	1886(d) (1) (B) (vi)? Enter "Y" for yes or "N" for no.		IN IN	87.00
		V	XIX	_
	Title V and XIX Services	1.00	2.00	
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for	N	Y	90.00
01 00	yes or "N" for no in the applicable column.	N	Y	91.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	IN IN	T	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see		N	92.00
93.00	instructions) Enter "Y" for yes or "N" for no in the applicable column. Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter	N	N	93.00
,	"Y" for yes or "N" for no in the applicable column.			
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the	N	N	94.00
95.00	applicable column. If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the	N	N	96.00
97.00	applicable column. If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post	Y	Y	98.00
	stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in			
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 reporting of charges on Wkst.	Y	Y	98.01
	C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for			
98 02	title XIX. Does title V or XIX follow Medicare (title XVIII) for the calculation of observation	Y	Y	98.02
70.02	bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1			70.02
00 02	for title V, and in column 2 for title XIX.	N	N	98.03
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1	IN IN	IN IN	90.03
	for title V, and in column 2 for title XIX.			
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and	N	N	98.04
	in column 2 for title XIX.			
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in	Y	Y	98.05
	column 2 for title XIX.			
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D,	Y	Y	98.06
	Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			
	Rural Providers	1		
	Does this hospital qualify as a CAH? If this facility qualifies as a CAH, has it elected the all-inclusive method of payment	N		105.00 106.00
100.00	for outpatient services? (see instructions)			100.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for L&R	N		107.00
	training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost			
	reimbursed. If yes complete Wkst. D-2, Pt. II.			
	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00
	Physical Occupational	Speech	Respi ratory	
100.00	1.00 2.00 If this hospital qualifies as a CAH or a cost provider, are N N	3.00 N	4.00 N	109.00
109.00	therapy services provided by outside supplier? Enter "Y"	IN	IN IN	109.00
	for yes or "N" for no for each therapy.			
			1.00	-
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§4		N	110.00
	Demonstration)for the current cost reporting period? Enter "Y" for yes or "N" for no. It complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through			
		,		

Heal th Financial Systems FRANCISCAN HEALTH C							2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-002		riod: om 01/01/20 12/31/20	018 018	Workshe Part I Date/Ti 5/30/20	me Pre	epared:
111.00 If this facility qualifies as a CAH, did it participate in the Health Integration Project (FCHIP) demonstration for this cost "Y" for yes or "N" for no in column 1. If the response to colu integration prong of the FCHIP demo in which this CAH is parti Enter all that apply: "A" for Ambulance services; "B" for addi for tele-health services.	t reporting period?́E umn 1 is Y, enter the icipating in column 2	_	1.00 N		2.0	00	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. I 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 "E", e for long term care () based on the defini	nter ir include	n column es	N		0	115.00
116.00 Is this facility classified as a referral center? Enter "Y" for 117.00 Is this facility legally-required to carry malpractice insurar no.		s or "N	N" for	N Y			116. 00 117. 00
118.00 Is the malpractice insurance a claims-made or occurrence polic claim-made. Enter 2 if the policy is occurrence.	cy? Enter 1 if the po	licy is	3	2			118.00
	Premi	ums	Losses		Insur	ance	
118.01 List amounts of malpractice premiums and paid losses:	1.0	0 14, 556	2.00	0	3. (0 118. 01
		-	1.00		2. (00	-
118. 02 Are malpractice premiums and paid losses reported in a cost conduct Administrative and General? If yes, submit supporting schedul and amounts contained therein. 119. 00 D0 NOT USE THIS LINE		rs	N				118.02
120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold H §3121 and applicable amendments? (see instructions) Enter in o "N" for no. Is this a rural hospital with < 100 beds that qual Hold Harmless provision in ACA §3121 and applicable amendments Enter in column 2, "Y" for yes or "N" for no.	column 1, "Y" for yes lifies for the Outpat	or ient	Ν		Y		120. 00
121.00 Did this facility incur and report costs for high cost implant patients? Enter "Y" for yes or "N" for no.	table devices charged	to	Υ				121.00
122.00 Does the cost report contain healthcare related taxes as defin Act?Enter "Y" for yes or "N" for no in column 1. If column 1 i the Worksheet A line number where these taxes are included.			Y		5.0	00	122.00
Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" for	yes and "N" for no.	lf	N				125. 00
yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 f this is a Medicare certified kidney transplant center, enter	er the certification	date					126.00
in column 1 and termination date, if applicable, in column 2. 127.00 If this is a Medicare certified heart transplant center, enter in column 1 and termination date, if applicable, in column 2.	r the certification d	ate					127.00
128.00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 2.	r the certification d	ate					128.00
129.00 If this is a Medicare certified lung transplant center, enter column 1 and termination date, if applicable, in column 2.	the certification da	te in					129. 00
130.00 If this is a Medicare certified pancreas transplant center, er date in column 1 and termination date, if applicable, in colum		n					130.00
131.00 If this is a Medicare certified intestinal transplant center, date in column 1 and termination date, if applicable, in colum		i on					131.00
132.00 If this is a Medicare certified islet transplant center, enter in column 1 and termination date, if applicable, in column 2.							132.00
133.00 If this is a Medicare certified other transplant center, enter in column 1 and termination date, if applicable, in column 2. 124 00L this is an organ programmed organization (OPO) enter the							133.00
134.00 If this is an organ procurement organization (OPO), enter the and termination date, if applicable, in column 2. All Providers		I					134.00
140.00 Are there any related organization or home office costs as det chapter 10? Enter "Y" for yes or "N" for no in column 1. If ye	fined in CMS Pub. 15-		Y		1580)14	140.00

	X IDENTIFICATION DATA	ALTH CRAWFORDSVI I Provi der	CCN: 15-002		iod: m 01/01/2018 12/31/2018		2 epared:
1.00		2.00			3.00	5/ 50/ 2019 5.	<u>23 piii</u>
If this facility is part of a chai	in organization, enter		ough 143 t	he name		of the	
home office and enter the home of							
41.00 Name: FRANCI SCAN ALLI ANCE	Contractor's Nam		Cont	ractor's	s Number: 0810)1	141.0
42.00 Street: 1515 DRAGOON TRAIL	PO Box:	1290					142.0
43.00 City: MISHAWAKA	State:	IN	Zip	Code:	4654	6-1290	143.0
						1.00	-
44.00 Are provider based physicians' cos	sts included in Worksh	eet A?				Y	144.0
						•	111.0
				_	1.00	2.00	_
45.00 If costs for renal services are cl	aimed on Wkst. A, lin	ne 74, are the cos	sts for				145.0
inpatient services only? Enter "Y							
no, does the dialysis facility ind		ition for this cos	st reportin	g			
period? Enter "Y" for yes or "N"			-++0		N		14/ 0
46.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no in					N		146. 0
yes, enter the approval date (mm/d		ub. 15-2, Chapter	40, 94020				
				1			
						1.00	
47.00 Was there a change in the statisti	cal basis? Enter "Y"	for yes or "N" fo	or no.			N	147.0
48.00Was there a change in the order of	f allocation? Enter "Y	" for yes or "N"	for no.			N	148.0
49.00Was there a change to the simplifi	ed cost finding metho					N	149.0
		Part A	Part		Title V	Title XIX	_
		1.00	2.0		3.00	4.00	_
Does this facility contain a provi or charges? Enter "Y" for yes or '							
55. 00 Hospi tal		N	A and Part	D. (36	N	N	155. (
56.00 Subprovi der – IPF		N	N		N	N	156. 0
57.00 Subprovider - IRF		N	N		N	N	157.0
58. 00 SUBPROVI DER							158.0
59.00 SNF		N	N		Ν	N	159.0
60.00 HOME HEALTH AGENCY		N	N		Ν	N	160. C
61.00 CMHC			N		N	N	161. C
						1.00	_
						1.00	_
Multicampus 65.00 s this hospital part of a Multica	ample bospital that ha	s one or more can	pusos in d	ifforon	+ (PSAc2	N	165. 0
Enter "Y" for yes or "N" for no.	anipus nospi tai that na		ipuses in u	literen	CD3AS?	IN	105.0
	Name	County	State	Zip C	ode CBSA	FTE/Campus	
	0	1.00	2.00	3.0		5.00	
66.00 fline 165 is yes, for each						0.0)0 166. C
campus enter the name in column							
0, county in column 1, state in							
0, county in column 1, state in column 2, zip code in column 3,							
0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in							
0, county in column 1, state in column 2, zip code in column 3,							
0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in						1.00	_
0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in	T) incentive in the Am	nerican Recovery a	and Rei nves	tment A	ct	1.00	_
0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Health Information Technology (HI					ct	1.00 Y	167. (
0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Health Information Technology (HI 67.00 Is this provider a meaningful user 68.00 If this provider is a CAH (line 10	r under §1886(n)? Ent D5 is "Y") and is a me	er "Y" for yes or aningful user (li	"N" for n	0.		Y	
0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Health Information Technology (HI 67.00 Is this provider a meaningful user 68.00 If this provider is a CAH (line 10 reasonable cost incurred for the H	r under §1886(n)? Ent D5 is "Y") and is a me HIT assets (see instru	er "Y" for yes or eaningful user (li uctions)	"N" for n ne 167 is	o. "Y"), e	nter the	Y	0168. (
0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Health Information Technology (HI 67.00 Is this provider a meaningful user 68.00 If this provider is a CAH (line 10 reasonable cost incurred for the H 68.01 If this provider is a CAH and is n	r under §1886(n)? Ent D5 is "Y") and is a me HIT assets (see instru not a meaningful user,	er "Y" for yes or eaningful user (li uctions) does this provic	"N" for n ne 167 is ler qualify	o. "Y"), e for a	nter the	Y	0168. (
0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Heal th Information Technology (HI 67.00 Is this provider a meaningful user 68.00 If this provider is a CAH (line 10 reasonable cost incurred for the H 68.01 If this provider is a CAH and is n exception under §413.70(a) (6) (ii)?	r under §1886(n)? Ent D5 is "Y") and is a me HIT assets (see instru not a meaningful user, ? Enter "Y" for yes or	er "Y" for yes or eaningful user (li uctions) does this provic "N" for no. (see	"N" for n ne 167 is ler qualify e instructi	o. "Y"), e for a ons)	nter the hardship	Y	0168. (
0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Heal th Information Technology (HI 67.00 Is this provider a meaningful user 68.00 If this provider is a CAH (line 10 reasonable cost incurred for the H 68.01 If this provider is a CAH and is n exception under \$413.70(a)(6)(ii) 69.00 If this provider is a meaningful u	r under §1886(n)? Ent D5 is "Y") and is a me HIT assets (see instru- not a meaningful user, ? Enter "Y" for yes or user (line 167 is "Y")	er "Y" for yes or eaningful user (li uctions) does this provic "N" for no. (see	"N" for n ne 167 is ler qualify e instructi	o. "Y"), e for a ons)	nter the hardship	Y	0168.0
0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Health Information Technology (HI 67.00 Is this provider a meaningful user 68.00 If this provider is a CAH (line 10 reasonable cost incurred for the H 68.01 If this provider is a CAH and is n	r under §1886(n)? Ent D5 is "Y") and is a me HIT assets (see instru- not a meaningful user, ? Enter "Y" for yes or user (line 167 is "Y")	er "Y" for yes or eaningful user (li uctions) does this provic "N" for no. (see	"N" for n ne 167 is ler qualify e instructi	o. "Y"), e for a ons)	nter the hardship), enter the	Y 9.9	167. C 0168. C 168. C 29169. C
0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Heal th Information Technology (HI 67.00 Is this provider a meaningful user 68.00 If this provider is a CAH (line 10 reasonable cost incurred for the H 68.01 If this provider is a CAH and is n exception under \$413.70(a)(6)(ii) 69.00 If this provider is a meaningful u	r under §1886(n)? Ent D5 is "Y") and is a me HIT assets (see instru- not a meaningful user, ? Enter "Y" for yes or user (line 167 is "Y")	er "Y" for yes or eaningful user (li uctions) does this provic "N" for no. (see	"N" for n ne 167 is ler qualify e instructi	o. "Y"), e for a ons)	nter the hardship	Y	0168.0
0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Health Information Technology (HI 67.00 Is this provider a meaningful user 68.00 If this provider is a CAH (line 10 reasonable cost incurred for the H 68.01 If this provider is a CAH and is n exception under §413.70(a)(6)(ii)' 69.00 If this provider is a meaningful u transition factor. (see instruction	r under §1886(n)? Ent D5 is "Y") and is a me HIT assets (see instru- not a meaningful user, ? Enter "Y" for yes or user (line 167 is "Y") ons)	er "Y" for yes or eaningful user (li uctions) does this provic "N" for no. (see and is not a CAH	"N" for n ne 167 is ler qualify e instructi I (line 105	o. "Y"), e for a ons)	nter the hardship), enter the Beginning	Y 9. 9 Endi ng	0168. (168. (99169. (
0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Heal th Information Technology (HI 67.00 Is this provider a meaningful user 68.00 If this provider is a CAH (line 10 reasonable cost incurred for the H 58.01 If this provider is a CAH and is n exception under §413.70(a)(6)(ii)' 69.00 If this provider is a meaningful u transition factor. (see instruction	r under §1886(n)? Ent D5 is "Y") and is a me HIT assets (see instru- not a meaningful user, ? Enter "Y" for yes or user (line 167 is "Y") ons)	er "Y" for yes or eaningful user (li uctions) does this provic "N" for no. (see and is not a CAH	"N" for n ne 167 is ler qualify e instructi I (line 105	o. "Y"), e for a ons)	nter the hardshi p), enter the Begi nni ng 1.00	9.9 Endi ng 2.00	0168. (168. (99169. (
0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Heal th Information Technology (HI 57.00 Is this provider a meaningful user 68.00 If this provider is a CAH (line 10 reasonable cost incurred for the H 58.01 If this provider is a CAH and is n exception under §413.70(a) (6) (ii) 7 59.00 If this provider is a meaningful u transition factor. (see instruction 70.00 Enter in columns 1 and 2 the EHR H	r under §1886(n)? Ent D5 is "Y") and is a me HIT assets (see instru- not a meaningful user, ? Enter "Y" for yes or user (line 167 is "Y") ons)	er "Y" for yes or eaningful user (li uctions) does this provic "N" for no. (see and is not a CAH	"N" for n ne 167 is ler qualify e instructi I (line 105	o. "Y"), e for a ons)	nter the hardship), enter the Beginning 1.00 07/03/2018	Y 9.9 Endi ng 2.00 09/30/2018	0168. (168. (99169. (
0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Heal th Information Technology (HI 67.00 Is this provider a meaningful user 68.00 If this provider is a CAH (line 10 reasonable cost incurred for the H 68.01 If this provider is a CAH and is n exception under \$413.70(a)(6)(ii) 69.00 If this provider is a meaningful u transition factor. (see instruction 70.00 Enter in columns 1 and 2 the EHR H period respectively (mm/dd/yyyy)	r under §1886(n)? Ent D5 is "Y") and is a me HIT assets (see instru- not a meaningful user, ? Enter "Y" for yes or user (line 167 is "Y") ons) Deginning date and end	er "Y" for yes or eaningful user (li uctions) does this provic "N" for no. (see and is not a CAH	"N" for n ne 167 is ler qualify instructi (line 105 reporting	o. "Y"), e for a ons)	nter the hardship), enter the Beginning 1.00 07/03/2018 1.00	Y 9.9 Endi ng 2.00 09/30/2018 2.00	0 168. (168. (29 169. (
0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Heal th Information Technology (HI 67.00 Is this provider a meaningful user 68.00 If this provider is a CAH (line 10 reasonable cost incurred for the H 68.01 If this provider is a CAH and is n exception under §413.70(a)(6)(ii) 69.00 If this provider is a meaningful u transition factor. (see instruction 70.00 Enter in columns 1 and 2 the EHR H period respectively (mm/dd/yyyy)	r under §1886(n)? Ent D5 is "Y") and is a me HIT assets (see instru- not a meaningful user, ? Enter "Y" for yes or user (line 167 is "Y") ons) Deginning date and end vider have any days fo	er "Y" for yes or eaningful user (li ictions) does this provic "N" for no. (see and is not a CAH ling date for the	"N" for n ne 167 is ler qualify instructi (line 105 reporting	o. "Y"), e for a ons) is "N"	nter the hardship), enter the Beginning 1.00 07/03/2018	Y 9.9 Endi ng 2.00 09/30/2018 2.00	0168. (168. (99169. (
0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Health Information Technology (HI 57.00 Is this provider a meaningful user 58.00 If this provider is a CAH (line 10 reasonable cost incurred for the H seception under §413.70(a) (6) (ii) 59.00 If this provider is a meaningful u transition factor. (see instruction 70.00 Enter in columns 1 and 2 the EHR H period respectively (mm/dd/yyyy)	r under §1886(n)? Ent D5 is "Y") and is a me HIT assets (see instru- not a meaningful user, ? Enter "Y" for yes or user (line 167 is "Y") ons) Deginning date and end vider have any days for reported on Wkst. S-3,	er "Y" for yes or eaningful user (li loctions) does this provid "N" for no. (see and is not a CAH ling date for the pr individuals enr Pt. I, line 2, c	"N" for n ne 167 is ler qualify instructi (line 105 reporting rolled in colled in	o. "Y"), e for a ons) is "N"	nter the hardship), enter the Beginning 1.00 07/03/2018 1.00	Y 9.9 Endi ng 2.00 09/30/2018 2.00	0 168. 168. 29 169.

Health Financial Systems FRANCI SCAN HEALTH CRAWFORDSVILLE In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE Provider CCN: 15-0022 Peri od: Worksheet S-2 From 01/01/2018 Part II Date/Time Prepared: То 12/31/2018 5/30/2019 3:23 pm Y/N Date 1.00 2.00 General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS Provider Organization and Operation Has the provider changed ownership immediately prior to the beginning of the cost 1.00 Ν 1.00 reporting period? If yes, enter the date of the change in column 2. (see instructions) V/I Y/N Date 1.00 2.00 3.00 Has the provider terminated participation in the Medicare Program? If 2.00 Ν 2 00 yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary. Is the provider involved in business transactions, including management 3.00 γ 3.00 contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions) Y/N Date Туре 1.00 2.00 3.00 Financial Data and Reports Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, 4.00 Y А 4.00 or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions. 5.00 Are the cost report total expenses and total revenues different from Ν 5.00 those on the filed financial statements? If yes, submit reconciliation. Y/N Legal Oper 1.00 2.00 Approved Educational Activities Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is Ν 6.00 6.00 the legal operator of the program? Are costs claimed for Allied Health Programs? If "Y" see instructions. 7.00 Ν 7.00 8.00 Were nursing school and/or allied health programs approved and/or renewed during the Ν 8.00 cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved graduate medical education 9 00 Ν 9.00 program in the current cost report? If yes, see instructions. Was an approved Intern and Resident GME program initiated or renewed in the current 10.00 Ν 10.00 cost reporting period? If yes, see instructions. 11.00 Are GME cost directly assigned to cost centers other than I & R in an Approved Ν 11.00 Teaching Program on Worksheet A? If yes, see instructions Y/N 1.00 Bad Debts 12.00 Is the provider seeking reimbursement for bad debts? If yes, see instructions. Y 12.00 13.00 If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting Ν 13.00 period? If yes, submit copy. 14.00 If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions Ν 14.00 Bed Complement 15.00 Did total beds available change from the prior cost reporting period? If yes, Ν 15.00 see instructions. Part B Part A Y/N Date Y/N Date 1.00 2.00 3.00 4.00 PS&R Data Was the cost report prepared using the PS&R Report only? 16.00 Ν 16.00 Ν If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 . (see instructions) 17.00 Was the cost report prepared using the PS&R Report for Υ 04/03/2019 Y 04/03/2019 17.00 totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) 18.00 If line 16 or 17 is yes, were adjustments made to PS&R Ν Ν 18.00 Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions. 19.00 If line 16 or 17 is yes, were adjustments made to PS&R 19.00 Ν Ν Report data for corrections of other PS&R Report information? If yes, see instructions.

Health Financial Systems

In Lieu of Form CMS-2552-10

	TAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE Provider CCN: 15-0022 Period:					
				rom 01/01/2018 o 12/31/2018	Date/Time Pre	
		Descri	ption	Y/N	5/30/2019 3:2 Y/N	3 pm
)	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	Ν	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXC	EPT CHILDRENS H	OSPI TALS)			-
22.00	Capital Related Cost				N	
	Have assets been relifed for Medicare purposes? If yes, se Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.		als made durir	ng the cost	N N	22.00 23.00
24.00	Were new leases and/or amendments to existing leases enter If yes, see instructions	ed into during	this cost repo	orting period?	Ν	24.00
25.00	Have there been new capitalized leases entered into during instructions.	the cost repor	ting period? I	f yes, 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 copy.	ves, submit	Ν	27.00		
28.00	Interest Expense Were new Loans, mortgage agreements or letters of credit e	eporting	N	28.00		
29.00	period? If yes, see instructions. Did the provider have a funded depreciation account and/or	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	Ν	30.00
31.00	instructions. Has debt been recalled before scheduled maturity without i	ssuance of new	debt? If yes,	see	Ν	31.00
22.00	instructions. Purchased Services	und and found also			N	22.00
	Have changes or new agreements occurred in patient care se arrangements with suppliers of services? If yes, see instr If line 32 is yes, were the requirements of Sec. 2135.2 ap	uctions.	U		N	32.00 33.00
55.00	no, see instructions. Provider-Based Physicians					33.00
34.00	Are services furnished at the provider facility under an a If yes, see instructions.	rrangement with	provi der-base	ed physi ci ans?	Y	34.00
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 pr	ovi der-based	Ν	35.00
	physicialis during the cost reporting period? IT yes, see I	IISTI UCTI UIIS.		Y/N	Date	
				1.00	2.00	
	Home Office Costs					
	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been p	repared by the	home office?	Y Y		36.00 37.00
38.00	If yes, see instructions. If line 36 is yes, was the fiscal year end of the home of			N		38.00
39.00	the provider? If yes, enter in column 2 the fiscal year en If line 36 is yes, did the provider render services to oth			Ν		39.00
40.00	see instructions. If line 36 is yes, did the provider render services to the instructions.	home office?	lfyes, see	Ν		40.00
				_		
	Cost Report Preparer Contact Information	1.	00	2.	00	
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
43.00	preparer. Enter the telephone number and email address of the cost	765-428-5927		STEVEN. HOWELL@	FRANCI SCANALLI	43.00
	report preparer in columns 1 and 2, respectively.	I		ANCE. ORG		I

Heal th	Financial Systems	FRANCI SCAN HEALTH	CRAWFORDSVI LLE		In Lie	u of Form CMS-	2552-10
H0SPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT	QUESTI ONNAI RE	Provider CCN:		Period:	Worksheet S-2	
					From 01/01/2018 Fo 12/31/2018		pared: 3 pm
			3.00				
	Cost Report Preparer Contact Information						
41.00	Enter the first name, last name and the t	title/position	MANAGER REIMBURS	EMENT			41.00
	held by the cost report preparer in colum	nns 1, 2, and 3,					
	respecti vel y.						
42.00	Enter the employer/company name of the co	ost report					42.00
	preparer.						
43.00	Enter the telephone number and email addr	ess of the cost					43.00
	report preparer in columns 1 and 2, respe						

	Financial Systems FRA AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC. Complex Statistic.	<u>NCISCAN HEALTH</u> AL DATA	Provider CC		Period: From 01/01/2018	u of Form CMS- Worksheet S-3 Part I	;
					To 12/31/2018	Date/Time Pre 5/30/2019 3:2	
						I/P Days / O/P	
						Visits / Trips	
	Component	Worksheet A Line Number	No. of Beds	Bed Days Avai I abl e	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	21.00	8, 7		0.00	1.00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)						2.00
3.00	HMO I PF Subprovider						3.00
4.00	HMO I RF Subprovi der						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	
6.00	Hospital Adults & Peds. Swing Bed NF		24	0.7		0	
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		24	8, 7	60 0.00	0	7.00
8.00	INTENSI VE CARE UNIT	31.00	5	1, 8	25 0.00	0	8.00
9.00	CORONARY CARE UNI T	51.00	5	1, 0	2.5 0.00	0	9.00
10.00	BURN INTENSIVE CARE UNIT						10.0
11.00	SURGI CAL I NTENSI VE CARE UNI T						11.0
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		29	10, 5	85 0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF	40.00	11	4,0	15	0	16.00
17.00	SUBPROVIDER – IRF						17.00
18.00	SUBPROVI DER						18.00
19.00	SKILLED NURSING FACILITY						19.0
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.0
22.00	HOME HEALTH AGENCY						22.0
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23.0
24.00 24.10	HOSPICE	30.00					24.0
24.10	HOSPICE (non-distinct part) CMHC - CMHC	30.00					24.1
26.00	RURAL HEALTH CLINIC						26.0
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	
27.00	Total (sum of lines 14-26)	07.00	40			0	27.0
28.00	Observation Bed Days		10			0	
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.0
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						33.0

)SPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CC	F	Period: From 01/01/2018 To 12/31/2018	Worksheet S-3 Part I Date/Time Pre 5/30/2019 3:2	pared
		I/P Days	/ O/P Visits	/ Trips	Full Time E	qui 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	
00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1, 462	233	2, 581			1. (
00	HMO and other (see instructions)	650	0				2.0
00	HMO IPF Subprovider	377	0				3.0
00	HMO IRF Subprovider	0	0				4.0
00	Hospital Adults & Peds. Swing Bed SNF	0	0	C)		5.0
00	Hospital Adults & Peds. Swing Bed NF		0	C)		6.0
00	Total Adults and Peds. (exclude observation beds) (see instructions)	1, 462	233	2, 581			7.0
00	INTENSIVE CARE UNIT	220	53	450)		8.0
00	CORONARY CARE UNIT						9.1
0. 00	BURN INTENSIVE CARE UNIT						10.
. 00	SURGICAL INTENSIVE CARE UNIT						11.
2.00	OTHER SPECIAL CARE (SPECIFY)						12.
3.00	NURSERY						13.
1.00	Total (see instructions)	1, 682	286	3, 031	0.00	149.59	
5.00	CAH visits	0	0	C)		15.
. 00	SUBPROVI DER – I PF	1, 753	68	2, 286	0.00	12.89	16.
. 00	SUBPROVIDER - IRF	.,		_,			17.
. 00	SUBPROVIDER						18.
. 00	SKILLED NURSING FACILITY						19.
. 00	NURSING FACILITY						20.
. 00	OTHER LONG TERM CARE						21.
00	HOME HEALTH AGENCY						22
. 00	AMBULATORY SURGICAL CENTER (D. P.)						23.
. 00	HOSPICE						24.
. 10	HOSPICE (non-distinct part)			C			24.
00	CMHC - CMHC			e e			25.
. 00	RURAL HEALTH CLINIC						26.
. 25	FEDERALLY QUALIFIED HEALTH CENTER	o	0	C	0.00	0.00	
. 20	Total (sum of lines 14-26)	0	0	C C	0.00	162.48	
00	Observation Bed Days		217	1, 493		102.40	28.
. 00	Ambul ance Trips	0	217	1, 470			20.
. 00	Employee discount days (see instruction)	0		C			30.
. 00							31.
	Employee discount days - IRF		~				
. 00	Labor & delivery days (see instructions)	0	0	(32.
. 01	Total ancillary labor & delivery room			C	/		32.
00	outpatient days (see instructions)						0.0
3.00	LTCH non-covered days	0					33.

HOSPI T	HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICA		Provider CO	CN: 15-0022	Period: From 01/01/2018 To 12/31/2018	Worksheet S-3 Part I Date/Time Pre 5/30/2019 3:2	pared:
		Full Time Equivalents	Di s		charges		
	Component	Nonpai d Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 11.00 12.00 13.00 14.00 15.00 14.00 15.00 14.00 15.00 14.00 20.00 21.00 22.00 23.00 24.10 25.00 24.00 25.00 26.05 27.00 28.00 29.00 30.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) HMO and other (see instructions) HMO IPF Subprovider HMO IPF Subprovider Hospital Adults & Peds. Swing Bed NF Total Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions) INTENSIVE CARE UNIT CORONARY CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY) NURSERY Total (see instructions) CAH visits SUBPROVIDER - IPF SUBPROVIDER - IPF SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER - IRF SUBPROVIDER - INF SUBPROVIDER - INF SUBPROV	0. 00 0. 00 0. 00 0. 00 0. 00	0	5:	34 75 79 0 00 0 34 75 25 1	856 163	15.00
31. 00 32. 00 32. 01 33. 00	Employee discount days (see instruction) Employee discount days - IRF Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions) LTCH non-covered days LTCH site neutral days and discharges				0		30. 00 31. 00 32. 00 32. 01 33. 00 33. 01

	AL WAGE INDEX INFORMATION				1	Period: From 01/01/2018 To 12/31/2018		pare
		Wkst. A Line Number		Reclassificati on of Salaries (from Wkst. A-6)	Adj usted Sal ari es (col . 2 ± col . 3)	Related to	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA SALARIES							-
0	Total salaries (see	200. 00	15, 053, 899	814, 933	15, 868, 83	2 350, 893. 52	45. 22	1
0	instructions) Non-physician anesthetist Part		0	0		0.00	0.00	2
	A							
0	Non-physician anesthetist Part B		0	0		0 0.00	0.00	3
0	Physician-Part A -		0	0		0 0.00	0.00	4
1	Administrative Physicians - Part A - Teaching		0	0		0.00	0.00	
0	Physician and Non		0	0		0 0.00	0.00	0 5
0	Physician-Part B Non-physician-Part B for hospital-based RHC and FOHC services		0	0		0.00	0.00	6
0	Interns & residents (in an	21.00	0	0		0.00	0.00	7
1	approved program) Contracted interns and residents (in an approved		0	0		0.00	0.00	7
0	programs) Home office and/or related		0	0		0.00	0.00	8
	organization personnel	11.00	0					
00	SNF Excluded area salaries (see instructions)	44.00	0 1, 563, 936	0		0 0.00 6 27,812.54		
	OTHER WAGES & RELATED COSTS Contract labor: Direct Patient		1, 934, 492	0	1, 934, 49	2 30, 235. 25	63.98	1
00	Care Contract Labor: Top Level management and other		0	0		0.00	0.00	12
	management and administrative services							
00	Contract Labor: Physician-Part		0	0		0.00	0.00	13
00	A - Administrative Home office and/or related organization salaries and		0	0		0 0.00	0. 00	14
01	wage-related costs Home office salaries		3, 336, 538	о	3, 336, 53	8 98, 725. 00	33.80	14
02	Related organization salaries		0	0		0.00	0.00	14
00	Home office: Physician Part A - Administrative		0	0		0 0.00	0.00	15
	Home office and Contract Physicians Part A - Teaching WAGE-RELATED COSTS		0	0		0 0.00	0.00	10
	Wage-related costs (core) (see		3, 292, 388	0	3, 292, 38	8		17
00	instructions) Wage-related costs (other)		0	0		0		18
	(see instructions)		-					
00 00	Excluded areas Non-physician anesthetist Part		365, 821 0	0	365, 82	0		19
00	A Non-physician anesthetist Part		Λ	0		n		2
	B Physician Part A -		0	0		0		2
01	Administrative Physician Part A - Teaching		Λ	0		0		22
00	Physician Part B		0	0		D		23
	Wage-related costs (RHC/FQHC) Interns & residents (in an approved program)		0 0	0		0		24 25
50	Home office wage-related		1, 426, 661	0	1, 426, 66	1		25
51	(core) Related organization		0	0		ο		25
52	wage-related (core) Home office: Physician Part A - Administrative -		0	0		ο		25
53	wage-related (core) Home office & Contract Physicians Part A - Teaching -		0	0		o		25
	wage-related (core)	S						
	OVERHEAD COSTS - DIRECT SALARIE Employee Benefits Department	4.00	0	56, 373	56, 37	3 0.00	0.00	1 ~

Heal th	ealth Financial Systems FRANCISCAN HEALTH CRAWFORDSVILLE In Lieu of Form CMS-2552-10									
HOSPI T	AL WAGE INDEX INFORMATION						Worksheet S-3 Part II Date/Time Prepared: 5/30/2019 3:23 pm			
		Wkst. A Line		Reclassi fi cati	Adj usted		Average Hourly			
		Number	Reported	on of Salaries			Wage (col. 4 ÷			
				(from Wkst.	$(col.2 \pm col.$	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.)		98, 838	0	98, 838	1, 070. 00	92.37	28.00		
29.00	Maintenance & Repairs	6.00	0	0	C	0.00	0.00	29.00		
30.00	Operation of Plant	7.00	227, 496	0	227, 496	9, 778. 93	23. 26	30.00		
31.00	Laundry & Linen Service	8.00	148, 665	0	148, 665	8, 527. 00	17.43	31.00		
32.00	Housekeepi ng	9.00	0	0	C C	0.00	0.00	32.00		
33.00	Housekeeping under contract (see instructions)		0	0	C	0.00	0.00	33.00		
34.00	Dietary	10.00	363, 973	-196, 246	167, 727	5, 346. 73	31.37	34.00		
35.00	Dietary under contract (see instructions)		0	0	C	0.00	0.00	35.00		
36.00	Cafeteria	11.00	0	196, 246	196, 246	12, 151. 46	16. 15	36.00		
37.00	Maintenance of Personnel	12.00	0	0	C	0.00	0.00	37.00		
38.00	Nursing Administration	13.00	277, 400	213, 922	491, 322	3, 805. 52	129. 11	38.00		
39.00	Central Services and Supply	14.00	73, 851		73, 851	2, 873. 21	25. 70	39.00		
40.00	Pharmacy	15.00	415, 120	0	415, 120	8, 799. 55	47.18	40.00		
41.00	Medi cal Records & Medi cal Records Library	16.00	0	0	C	0.00				
42.00	Soci al Servi ce	17.00	0	0	l c	0.00	0.00	42.00		
43.00	Other General Service	18.00	0	0	C	0.00		43.00		

Heal th	Financial Systems	FRA	NCISCAN HEALTH	CRAWFORDSVI LL	E	In Lieu of Form CMS-2552-10			
HOSPI	FAL WAGE INDEX INFORMATION	Provi der CCN: 15-002			Period: From 01/01/2018 To 12/31/2018				
		Worksheet A	Amount	Recl assi fi cati			Average Hourly		
		Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷		
				(from	(col.2 ± col.	Salaries in	col. 5)		
				Worksheet A-6)	3)	col. 4			
		1.00	2.00	3.00	4.00	5.00	6.00		
	PART III - HOSPITAL WAGE INDEX	SUMMARY							
1.00	Net salaries (see		15, 152, 737	814, 933	15, 967, 67	0 351, 963. 52	45.37	1.00	
	instructions)								
2.00	Excluded area salaries (see instructions)		1, 563, 936	0	1, 563, 93	6 27, 812. 54	56. 23	2.00	
3.00	Subtotal salaries (line 1 minus line 2)		13, 588, 801	814, 933	14, 403, 73	4 324, 150. 98	44.44	3.00	
4.00	Subtotal other wages & related costs (see inst.)		5, 271, 030	0	5, 271, 03	0 128, 960. 25	40. 87	4.00	
5.00	Subtotal wage-related costs (see inst.)		4, 719, 049	0	4, 719, 04	9 0.00	32. 76	5.00	
6.00	Total (sum of lines 3 thru 5)		23, 578, 880	814, 933	24, 393, 81	3 453, 111. 23	53.84	6.00	
7.00	Total overhead cost (see instructions)		5, 745, 668	814, 933	6, 560, 60	1 258, 646. 62	25. 37	7.00	

Heal th	Financial Systems FRANCI SCAN HEALTH C	RAWFORDSVI LLE	In Lie	u of Form CMS-2	2552-10
HOSPIT	AL WAGE RELATED COSTS	Provider CCN: 15-0022	Period: From 01/01/2018 To 12/31/2018		pared:
				Amount Reported	
				1.00	
	PART IV - WAGE RELATED COSTS				
	Part A - Core List				
	RETIREMENT COST				
1.00	401K Employer Contributions			0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution			0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)			0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	644, 863	4.00		
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)				
5.00	401K/TSA Plan Administration fees			0	
6.00	Legal /Accounting/Management Fees-Pension Plan			0	6.00
7.00	Employee Managed Care Program Administration Fees			0	7.00
	HEALTH AND INSURANCE COST				
8.00	Health Insurance (Purchased or Self Funded)			0	
8.01	Health Insurance (Self Funded without a Third Party Administr			0	
8.02	Health Insurance (Self Funded with a Third Party Administrato	or)		2, 039, 330	
8.03	Health Insurance (Purchased)			0	
9.00	Prescription Drug Plan			0	
10.00	Dental, Hearing and Vision Plan			136, 863	
11.00	Life Insurance (If employee is owner or beneficiary)			0	
12.00	Accident Insurance (If employee is owner or beneficiary)			0	
13.00	Disability Insurance (If employee is owner or beneficiary)			31, 120	
14.00	Long-Term Care Insurance (If employee is owner or beneficiary	()		0	
15.00	'Workers' Compensation Insurance			39, 166	
16.00	Retirement Health Care Cost (Only current year, not the extra	ordinary accrual require	ed by FASB 106.	0	16.00
	Non cumulative portion)				
47 00	TAXES				17.00
	FICA-Employers Portion Only			766, 867	
18.00	Medicare Taxes - Employers Portion Only			0	
19.00	Unemployment Insurance			0	
20.00	State or Federal Unemployment Taxes			0	20.00
01 00	OTHER Executive Deferred Compensation (Other Than Retirement Cost R		unh A shaves (see	0	01 00
21.00	instructions))	reported on Tines I through	ign 4 above. (see	0	
22.00	Day Care Cost and Allowances			0	
23.00	Tuition Reimbursement			0	
24.00				3, 658, 209	24.00
	Part B - Other than Core Related Cost				
25.00	OTHER WAGE RELATED COSTS (SPECIFY)			0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST Provider CCN: 15-0022 Period: Froid: To 12/31/2018 Worksheet S-3 Froid: To 12/31/2018 Cost Center Description Contract Labor and Benefit Cost Image: Contract Labor and Benefit Cost Image: Contract Labor and Benefit Cost Hospital and Hospital -Based Component Identification: 1.00 2.00 2.00 100 Total facility's contract labor and benefit cost 1,934,492 3,658,209 1.00 2.00 Hospital 1,934,492 3,658,209 2.00 3.00 Subprovider - IPF 0 0 3.00 4.00 Subprovider - IRF 0 0 5.00 5.00 Swing Beds - SNF 0 0 6.00 9.00 Hospital -Based NF 0 0 0 0 9.00 Hospital -Based NF 0 0 0 0 0 9.00 Hospital -Based NF 0 0 0 0 0 0 1.00 Separately Certified ASC 1 9.00 0 1.00 1.00 1.00 Separately Certified ASC 1 1.00 1.00 1	Heal th	Financial Systems	FRANCI SCAN HEALTH CF	RAWFORDSVI LLE	In Lie	u of Form CMS-2	2552-10
To 12/31/2018 Date/Time Prepared: 5/30/2019 Date/Time Prepare/2019 Date/201	H0SPI T	AL CONTRACT LABOR AND BENEFIT COST		Provider CCN: 15-0022			
Cost Center Description Contract Labor Benefit Cost Hospital and Hospital - Based Component Identification: 1.00 2.00 1.00 1.934,492 3,658,209 1.00 2.00 Hospital 1,934,492 3,658,209 2.00 3.00 Subprovider - 1PF 0 0 3.00 4.00 Subprovider - 1RF 0 0 3.00 5.00 Subprovider - 1RF 0 0 0 3.00 6.00 Swing Beds - SNF 0							
PART V - Contract Labor and Benefit Cost I.00 2.00 Hospital and Hospital -Based Component I dentification: 1,934,492 3,658,209 1.00 1.00 Subprovider - IPF 1,934,492 3,658,209 2.00 3.00 Subprovider - IRF 0 0 3.00 Subprovider - IRF 0 0 5.00 Swing Beds - SNF 0 0 5.00 8.00 Hospital -Based SNF 0 0 7.00 9.00 Hospital -Based NF 0 0 1.00 11.00 Hospital -Based NF 1.00 1.00 1.00 11.00 Hospital -Based NF 1.00 1.00 1.00 11.00 Hospital -Based HHA 1.00 1.00 1.00					10 12/31/2018		
PART V - Contract Labor and Benefit Cost Hospital and Hospital -Based Component Identification: 1.00 Total facility's contract labor and benefit cost 1,934,492 3,658,209 1.00 2.00 Hospital 1,934,492 3,658,209 1.00 3.00 Subprovider - IPF 0 0 3.00 4.00 Subprovider - IRF 0 0 3.00 5.00 Subprovider - (Other) 0 0 6.00 6.00 Swing Beds - SNF 0 0 6.00 7.00 Swing Beds - NF 0 0 7.00 8.00 Hospital -Based SNF 0 0 7.00 9.00 Hospital -Based NF 0 0 7.00 10.00 Hospital -Based NF 0 0 11.00 10.00 Hospital -Based HAA 11.00 12.00 13.00 Hospital -Based HeA 11.00 12.00 Separately Certified ASC 12.00 13.00 13.00 13.00 14.00 Hospital -Based Health Clin		Cost Center Description			Contract Labor		
PART V - Contract Labor and Benefit Cost Hospi tal and Hospi tal -Based Component Identification: 1.00 Total facility's contract labor and benefit cost 1,934,492 3,658,209 1.00 2.00 Hospi tal 1,934,492 3,658,209 2.00 3.00 Subprovider - IPF 0 0 3.00 4.00 Subprovider - IRF 0 0 5.00 5.00 Subprovider - (Other) 0 0 5.00 6.00 Swing Beds - SNF 0 0 6.00 7.00 Swing Beds - NF 0 0 7.00 8.00 Hospi tal -Based SNF 0 0 7.00 9.00 Hospi tal -Based NF 0 0 0 10.00 Hospi tal -Based HHA 11.00 11.00 12.00 12.00 Separately Certified ASC 12.00 13.00 13.00 14.00 Hospi tal -Based Heal th Clinic RHC 14.00 14.00 15.00 14.00 Hospi tal -Based Heal th Clinic FQHC 15.00 15.00		Cost center bescription					
Hospital and Hospital -Based Component I dentification: 1.00 Total facility's contract labor and benefit cost 1,934,492 3,658,209 1.00 2.00 Hospital 1,934,492 3,658,209 2.00 3.00 Subprovider - IPF 0 0 4.00 4.00 Subprovider - IRF 0 0 5.00 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 0 0 7.00 9.00 Hospital -Based NF 9.00 9.00 10.00 11.00 Hospital -Based NF 9.00 10.00 11.00 10.00 11.00 Hospital -Based HAA 11.00 12.00 11.00 12.00 13.00 13.00 14.00 13.00 13.00 14.00 13.00 14.00 14.00 15.00 15.00 15.00 15.00 15.00 <td< td=""><td></td><td>PART V - Contract Labor and Benefit Cost</td><td></td><td></td><td>1.00</td><td>2.00</td><td></td></td<>		PART V - Contract Labor and Benefit Cost			1.00	2.00	
1.00 Total facility's contract labor and benefit cost 1,934,492 3,658,209 1.00 2.00 Hospital 1,934,492 3,658,209 2.00 3.00 Subprovider - IPF 0 0 3.00 4.00 Subprovider - IRF 0 0 0 5.00 5.00 Swing Beds - SNF 0 0 0 5.00 6.00 Swing Beds - SNF 0 0 0 7.00 8.00 Hospital -Based SNF 0 0 7.00 9.00 Hospital -Based NF 0 0 7.00 9.00 Hospital -Based NF 0 0 10.00 11.00 Hospital -Based NF 10.00 10.00 11.00 10.00 Hospital -Based HHA 12.00 12.00 12.00 11.00 Hospital -Based HBA 11.00 12.00 13.00 11.00 Hospital -Based Heal th Clinic RHC 13.00 14.00 14.00 15.00 Hospital -Based-CMHC 15.00 15.00 16.00 16.00							
2.00 Hospi tal 1,934,492 3,658,209 2.00 3.00 Subprovi der - IPF 0 0 3.00 4.00 Subprovi der - IRF 0 0 3.00 5.00 Subprovi der - Other) 0 0 5.00 6.00 Swing Beds - SNF 0 0 5.00 7.00 Swing Beds - NF 0 0 7.00 8.00 Hospi tal -Based SNF 0 0 7.00 8.00 Hospi tal -Based SNF 0 0 7.00 9.00 Hospi tal -Based NF 10.00 10.00 10.00 10.00 11.00 10.00 Hospi tal -Based HHA 1 12.00 12.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 14.00 14.00 15.00 14.00 15.00 15.00 15.00 15.00 16.00 16.00 16.00 16.00	1.00				1, 934, 492	3, 658, 209	1.00
4.00 Subprovider - IRF 4.00 5.00 Subprovider - (Other) 0 5.00 6.00 Swing Beds - SNF 0 0 6.00 7.00 Swing Beds - NF 0 0 6.00 8.00 Hospital -Based SNF 0 0 7.00 9.00 Hospital -Based NF 0 0 7.00 10.00 Hospital -Based OLTC 10.00 10.00 11.00 10.00 11.00 11.00 Hospital -Based HHA 11.00 12.00 Separately Certified ASC 12.00 13.00 Hospital -Based Health Clinic RHC 13.00 13.00 14.00 14.00 15.00 Hospital -Based Health Clinic FOHC 15.00 15.00 15.00 15.00 16.00	2.00	Hospi tal					2.00
5.00 Subprovider - (Other) 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 0 0 7.00 9.00 Hospital - Based NF 9.00 9.00 10.00 Hospital - Based OLTC 10.00 10.00 11.00 Hospital - Based HHA 11.00 11.00 12.00 Separatel y Certified ASC 13.00 14.05 pital - Based Heal th Clinic RHC 14.00 15.00 Hospital - Based Heal th Clinic FOHC 14.00 15.00 15.00 16.00 Hospital - Based-CMHC 16.00 16.00 16.00	3.00	Subprovider - IPF			0	0	3.00
6.00 Swing Beds - SNF 0 0 6.00 7.00 Swing Beds - NF 0 0 7.00 8.00 Hospital -Based SNF 0 0 7.00 9.00 Hospital -Based NF 9.00 9.00 9.00 9.00 10.00 Hospital -Based OLTC 10.00 10.00 10.00 11.00 11.00 Hospital -Based HHA 11.00 12.00 13.00 13.00 Hospital -Based Health Clinic RHC 14.00 15.00 Hospital -Based Heal th Clinic FOHC 15.00 15.00 16.00 16.00	4.00	Subprovider - IRF					4.00
7.00 Swing Beds - NF 0 7.00 8.00 Hospital -Based SNF 8.00 9.00 Hospital -Based NF 9.00 10.00 Hospital -Based OLTC 10.00 11.00 Hospital -Based HHA 10.00 12.00 Separatel y Certified ASC 12.00 13.00 Hospital -Based Health Clinic RHC 13.00 14.00 Hospital -Based Health Clinic FOHC 15.00 16.00 Hospital -Based-CMHC 16.00	5.00	Subprovider - (Other)			0	0	5.00
8.00Hospital -Based SNF8.009.00Hospital -Based NF9.0010.00Hospital -Based OLTC10.0011.00Hospital -Based HHA11.0012.00Separatel y Certified ASC12.0013.00Hospital -Based Hospice13.0014.00Hospital -Based Heal th Clinic RHC14.0015.00Hospital -Based Heal th Clinic FOHC15.0016.00Hospital -Based-CMHC16.00	6.00	Swing Beds - SNF			0	0	6.00
9.00 Hospital -Based NF 9.00 10.00 Hospital -Based OLTC 10.00 11.00 Hospital -Based HHA 11.00 12.00 Separately Certified ASC 12.00 13.00 Hospital -Based Hospice 13.00 14.00 Hospital -Based Health Clinic RHC 14.00 15.00 Hospital -Based Health Clinic FOHC 15.00 16.00 Hospital -Based-CMHC 16.00	7.00	Swing Beds - NF			0	0	7.00
10.00 Hospital -Based OLTC 10.00 11.00 Hospital -Based HHA 11.00 12.00 Separately Certified ASC 12.00 13.00 Hospital -Based Hospice 13.00 14.00 Hospital -Based Health Clinic RHC 14.00 15.00 Hospital -Based -CMHC 15.00 16.00 Hospital -Based-CMHC 16.00	8.00	Hospital-Based SNF					8.00
11.00Hospital-Based HHA11.0012.00Separately Certified ASC12.0013.00Hospital-Based Hospice13.0014.00Hospital-Based Health Clinic RHC14.0015.00Hospital-Based Health Clinic FQHC15.0016.00Hospital-Based-CMHC16.00							
12.00Separately Certified ASC12.0013.00Hospital -Based Hospice13.0014.00Hospital -Based Health Clinic RHC14.0015.00Hospital -Based Health Clinic FQHC15.0016.00Hospital -Based-CMHC16.00							
13. 00Hospi tal -Based Hospi ce13. 0014. 00Hospi tal -Based Heal th Clinic RHC14. 0015. 00Hospi tal -Based Heal th Clinic FQHC15. 0016. 00Hospi tal -Based-CMHC16. 00	11.00						
14.00Hospital-Based Health Clinic RHC14.0015.00Hospital-Based Health Clinic FOHC15.0016.00Hospital-Based-CMHC16.00							
15.00 Hospital-Based Health Clinic FOHC 15.00 16.00 Hospital-Based-CMHC 16.00							
16.00 Hospital - Based-CMHC 16.00							
17.00 Renal Dialysis 17.00							
18.00 Other 0 18.00	18.00	Other			0	0	18.00

Heal th	Financial Systems FRANCI SCAN HEALTH CRAN	WFORDSVI LLE		In Lie	eu of Form CMS-2	2552-10
HOSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CC	N: 15-0022	Period:	Worksheet S-1	0
				From 01/01/2018 To 12/31/2018	Date/Time Pre 5/30/2019 3:2	
					1.00	
	Uncompensated and indigent care cost computation				1.00	
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 div	ided by lir	ne 202 column	18)	0. 227525	1.00
	Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid				6, 039, 492	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		с. н. н.		N	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplement			ii d?	N O	4.00 5.00
5.00 6.00	If line 4 is no, then enter DSH and/or supplemental payments fr Medicaid charges	om medicald	1		30, 127, 528	6.00
7.00	Medicaid cost (line 1 times line 6)				6, 854, 766	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minu	us sum of lir	ues 2 and 5 [.] if	815, 274	8.00
0.00	< zero then enter zero)				010/2/1	
	Children's Health Insurance Program (CHIP) (see instructions for	r each line	:)			
9.00	Net revenue from stand-alone CHIP				0	9.00
10.00	Stand-allone CHIP charges				0	10.00 11.00
	Stand-alone CHIP cost (line 1 times line 10) Difference between net revenue and costs for stand-alone CHIP (lipo 11 mir	us lino 0, i	f < zoro thon	0	12.00
12.00	enter zero)		IUS ITTE 9, 1		0	12.00
	Other state or local government indigent care program (see inst	ructions fo	r each line)			
13.00	Net revenue from state or local indigent care program (Not incl				0	13.00
14.00	Charges for patients covered under state or local indigent care	program (N	lot included	in lines 6 or	0	14.00
45 00	10)					15 00
15.00	State or local indigent care program cost (line 1 times line 14			- 15 minus line	0	15.00
16.00	Difference between net revenue and costs for state or local ind 13; if < zero then enter zero)	igent care	program (III	ie 15 minus line	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHI	P and state	/local indig	ent care program	ns (see	
	instructions for each line)		-	· · · · ·	r	
	Private grants, donations, or endowment income restricted to fu				0	17.00
	Government grants, appropriations or transfers for support of h Total unreimbursed cost for Medicaid , CHIP and state and local			(our of lines	0 815, 274	18.00 19.00
19.00	8, 12 and 16)	indigent c	are programs	s (suil of fiftes	015, 274	19.00
			Uni nsured	Insured	Total (col. 1	
		-	<u>patients</u> 1.00	patients 2.00	+ col. 2) 3.00	
	Uncompensated Care (see instructions for each line)		1.00	2.00	3.00	
20.00	Charity care charges and uninsured discounts for the entire fac	ility	3, 504, 31	8 3, 553, 132	7,057,450	20.00
	(see instructions)		-,,	-,,	.,,	
21.00	Cost of patients approved for charity care and uninsured discou instructions)	nts (see	797, 32	3, 553, 132	4, 350, 452	21.00
22.00	Payments received from patients for amounts previously written charity care	off as		0 0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)		797, 32	3, 553, 132	4, 350, 452	23.00
					1.00	
24.00	Does the amount on line 20 column 2, include charges for patien	t days heve	nd a length	of stay limit	1.00 N	24.00
21.00	imposed on patients covered by Medicaid or other indigent care		ind d Foligen	or stuy rimit		21.00
25.00	If line 24 is yes, enter the charges for patient days beyond th stay limit		care program	's length of	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see ins	tructions)			6, 637, 773	26.00
	Medicare reimbursable bad debts for the entire hospital complex		uctions)		218, 660	
	Medicare allowable bad debts for the entire hospital complex (s				336, 400	27.01
	Non-Medicare bad debt expense (see instructions)				6, 301, 373	
	Cost of non-Medicare and non-reimbursable Medicare bad debt exp	ense (see i	nstructions)		1, 551, 460	
	Cost of uncompensated care (line 23 column 3 plus line 29)				5, 901, 912	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus li	ne 30)			6, 717, 186	31.00

Heal th	Financial Systems FRA	NCISCAN HEALTH C	RAWFORDSVILL	E	In Lie	eu of Form CMS-2	2552-10
RECLAS	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF	F EXPENSES	Provider CC		Peri od:	Worksheet A	
					From 01/01/2018 To 12/31/2018		
	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	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT		4, 669, 297	4, 669, 29			1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP		141, 158				
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	3, 643, 615	3, 643, 61	5 0	3, 643, 615	4.00
5.00	00500 ADMINISTRATIVE & GENERAL	4, 140, 325	8, 558, 784	12, 699, 10			5.00
7.00	00700 OPERATION OF PLANT	227, 496	1, 246, 835	1, 474, 33	1 -5, 423	1, 468, 908	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	148, 665	35, 693	184, 35	3 – 1, 486	182, 872	8.00
9.00	00900 HOUSEKEEPI NG	0	555, 812	555, 81	2 - 3, 090	552, 722	9.00
10.00	01000 DI ETARY	363, 973	192, 690	556, 66	3 - 301, 466	255, 197	10.00
11.00	01100 CAFETERI A	0	0		298, 589	298, 589	11.00
13.00	01300 NURSING ADMINISTRATION	277, 400	164, 263	441, 66	3 -14	441, 649	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	73, 851	76, 964	150, 81	-66, 037	84, 778	14.00
15.00	01500 PHARMACY	415, 120	1, 266, 570	1, 681, 69	0 -1, 218, 018	463, 672	15.00
16.00	01600 MEDI CAL RECORDS & LI BRARY	0	0		o c		16.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	1, 271, 106	563, 880	1, 834, 98	6 -56, 453	1, 778, 533	30.00
31.00	03100 I NTENSI VE CARE UNI T	542,776	435, 519				
40.00	04000 SUBPROVI DER - I PF	1, 153, 934	184, 849				
	ANCILLARY SERVICE COST CENTERS	.,		.,		.,	
50,00	05000 OPERATING ROOM	1, 353, 136	1, 146, 252	2, 499, 38	-903, 193	1, 596, 195	50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 104, 544	829, 685	1, 934, 22			
54.01	05401 ULTRASOUND	131, 317	0	131, 31			
55.00	05500 RADI OLOGY-THERAPEUTI C	502, 642	7, 578, 021	8, 080, 66			
56.00	05600 RADI OI SOTOPE	79,049	146, 665	225, 71			
60.00	06000 LABORATORY	0	2, 323, 780	2, 323, 78			
65.00	06500 RESPI RATORY THERAPY	316, 871	149, 195	466, 06			
66, 00	06600 PHYSI CAL THERAPY	467, 690	59, 112	526, 80			
69.00	06900 ELECTROCARDI OLOGY	293, 186	22, 500	315, 68			
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2,0,100	22,000		995, 288		
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	o	0		482, 982		
73.00	07300 DRUGS CHARGED TO PATIENTS	0 0	0		8, 302, 117		
76.98	07698 HYPERBARI C OXYGEN THERAPY	0 0	8, 786				
70.70	OUTPATIENT SERVICE COST CENTERS	9	0,700	0,70	5 0	0,700	/0./0
90.00	09000 CLINIC	145, 557	28, 892	174, 44	-6, 508	167, 941	90.00
91.00	09100 EMERGENCY	1, 635, 259	1, 195, 099				
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1,000,207	1, 175, 077	2,000,00	201,100	2, 372, 372	92.00
72.00	SPECIAL PURPOSE COST CENTERS					1	72.00
113 00	11300 I NTEREST EXPENSE		0		0 0	0	113.00
118.00		14, 643, 897	35, 223, 916				
110.00	NONREI MBURSABLE COST CENTERS	14, 043, 077	33,223,710	47,007,01	<u> </u>	47,007,013	110.00
190 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0	0	190.00
	19200 PHYSI CLANS' PRI VATE OFFICES	30, 265	2, 546, 861	2, 577, 12		-	
	07953 OTHER NONREIMBURSABLE COST CENTERS	50, 205	2, 540, 001		0 0		192.00
	07951 SPORTS MEDI CI NE	160, 233	45, 434		0	-	
	07951 SPORTS MEDICINE	219, 504	45, 434 25, 556	205, 88			
200.00		15, 053, 899	25, 556 37, 841, 767				
200.00		13, 033, 079	57, 041, 707	JZ, 070, 00		JZ, 070, 000	200.00

RECLAS	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provider CCN:	: 15-0022	From 01/01/2018 To 12/31/2018	Worksheet A Date/Time Prep 5/30/2019 3:23	bared:
	Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		-1	0,00,201, 0120	, bui
		6.00	7.00				
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT	2, 171, 810	8, 128, 107				1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	0	142, 488				2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	131, 378	3, 774, 993				4.00
5.00	00500 ADMINI STRATI VE & GENERAL	-4, 102, 646	7, 314, 454				5.00
7.00	00700 OPERATION OF PLANT	0	1, 468, 908				7.00
8.00	00800 LAUNDRY & LINEN SERVICE	-10, 255	172, 617				8.00
9.00	00900 HOUSEKEEPI NG	0	552, 722				9.00
10.00	01000 DI ETARY	-54, 200	200, 997				10.00
11.00	01100 CAFETERI A	-106, 882	191, 707				11.00
13.00	01300 NURSING ADMINISTRATION	295, 980	737, 629				13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	84, 778				14.00
15.00	01500 PHARMACY	79, 465					15.00
	01600 MEDICAL RECORDS & LIBRARY	467,900					16.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	0	1, 778, 533				30.00
31.00	03100 INTENSIVE CARE UNIT	0	962, 916				31.00
40.00	04000 SUBPROVIDER - IPF	-239, 953					40.00
	ANCILLARY SERVICE COST CENTERS		.,				
50.00	05000 OPERATI NG ROOM	-21,060	1, 575, 135				50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	-19, 718					54.00
54.01	05401 ULTRASOUND	0	131, 317				54.01
55.00	05500 RADI OLOGY-THERAPEUTI C	-226, 202	860, 394				55.00
56.00	05600 RADI OI SOTOPE	220, 202	116, 556				56.00
60.00	06000 LABORATORY	0	2, 323, 780				60.00
65.00	06500 RESPI RATORY THERAPY	0	439, 583				65.00
66.00	06600 PHYSI CAL THERAPY	-13, 910					66.00
	06900 ELECTROCARDI OLOGY	10, 7.10	302, 509				69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	995, 288				71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	482, 982				72.00
	07300 DRUGS CHARGED TO PATIENTS	0	8, 302, 117				73.00
	07698 HYPERBARI C OXYGEN THERAPY	0					76.98
70.70	OUTPATIENT SERVICE COST CENTERS	0	0,700				/0. /0
90.00	09000 CLINIC	0	167, 941				90.00
	09100 EMERGENCY	-2,000					91.00
91.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	-2,000	2, 390, 392				92.00
92.00							92.00
112 00	SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE	0	0				112 00
		1 450 202	-				113.00
118.00		-1, 650, 293	48, 217, 522				118.00
100.00	NONREI MBURSABLE COST CENTERS						100 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0					190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	2, 577, 124				192.00
	07953 OTHER NONREIMBURSABLE COST CENTERS	0					194.00
	07951 SPORTS MEDICINE	0	205, 667				194.01
	07952 COMMUNITY IND HEALTH	1 (50 000	245,060				194.02
200.00	TOTAL (SUM OF LINES 118 through 199)	-1, 650, 293	51, 245, 373			12	200.00

Health Financial Systems RECLASSIFICATIONS

FRANCI SCAN HEALTH CRAWFORDSVILLE In Lieu of Form CMS-2552-10 Provider CCN: 15-0022 Period: From 01/01/2018 Worksheet A-6

Increases Cost Center Line # Sal ary Other 2.00 3.00 4.00 5.00 A - CAP	9 3:23 pm 1.00
A CAP A CAP REL_COSTS-BLDG & FIXT 1.00 0 9,368 2.00 CAP REL_COSTS-BLDG & FIXT 1.00 0 9,368 2.00 CAP REL_COSTS-MUBLE EQUIP 2.00 0 1,330 3.00 ADULTS & PEDIATRICS 30.00 0 3,466 4.00 5.00 0.00 0 0 5.00 0.00 0 0 0 6.00 0.00 0 0 0 6.00 0.00 0 0 0 7.00 0.00 0 0 0 8.00 0.00 0 0 0 9.00 0.00 0 0 0 10.00 0.00 0 0 0 11.00 0.00 0 1,277.632 0 10 CAP REL_COSTS-BLDC & FIXT 1.00 196.246 103.228 10 CAFETERIA 11.00 196.246 103.228	1.00
1.00 CAP REL COSTS-BLDG & FIXT 1.00 0 9,368 2.00 CAP REL COSTS-MVBLE EQUIP 2.00 0 1,330 3.00 ADULTS & PEDIATRICS 30.00 0 3,466 4.00 0.00 0 0 0 5.00 0.00 0 0 0 6.00 0.00 0 0 0 7.00 0.00 0 0 0 8.00 0.00 0 0 0 9.00 0.00 0 0 0 11.00 0.00 0 0 0 12.00 0 0.00 0 0 12.00 TOTALS 1.00 0 14,164 B - INTEREST EXPENSE 1.00 0 1,277,632 1.00 CAP REL COSTS-BLDG & FIXT 1.00 196,246 103,228 C - DI ETARY 11.00 196,246 103,228 103,228 D - CHARGEABLE SUPPLIES 196,246 103,228 103,228 D - CHARGEABLE SUPPLIES 0.00 0	1.00
3.00 ADULTS & PEDIATRICS 30.00 0 3,466 4.00 0.00 0 0 5.00 0.00 0 0 6.00 0.00 0 0 7.00 0.00 0 0 8.00 0.00 0 0 9.00 0.00 0 0 10.00 0.00 0 0 11.00 0.00 0 0 12.00 TOTALS 0 14,164 B - INTEREST EXPENSE 0 1,277,632 TOTALS 0 1,277,632 C - DI ETARY 11.00 196,246 103,228 TOTALS 196,246 103,228 D - CHARGEABLE SUPPLIES 196,246 103,228 D - CHARGEABLE SUPPLIES 196,246 103,228 D - CHARGEABLE SUPPLIES 196,246 103,228 1.00 MEDICAL SUPPLIES CHARGED TO 71.00 995,288 2.00 0.00 0 0 0 3.00 0.00 0 0 0 <td></td>	
4.00 0.00 0 0 5.00 0.00 0 0 6.00 0.00 0 0 7.00 0.00 0 0 8.00 0.00 0 0 9.00 0.00 0 0 10.00 0.00 0 0 11.00 0.00 0 0 12.00 0 0 0 0 12.00 0.00 0 0 0 11.00 0.00 0 0 0 12.00 0 14, 164 0 0 11.00 0.00 0 0 0 12.00 0 14, 164 0 0 11.00 0 14, 164 0 0 11.00 196, 246 103, 228 0 0 100 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 <td< td=""><td>2.00</td></td<>	2.00
5.00 0.00 0 0 6.00 0.00 0 0 7.00 0.00 0 0 8.00 0.00 0 0 9.00 0.00 0 0 10.00 0.00 0 0 11.00 0.00 0 0 12.00 0.00 0 0 TOTALS 0 14,164 B - INTEREST EXPENSE 1.00 CAP REL COSTS-BLDG & FIXT 1.00 0 1,277,632 TOTALS 0 196,246 103,228 1 TOTALS 196,246 103,228 1 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 1.00 PATI ENTS 0 0 0 2.00 0 0 0 0 0 3.00 0 0 0 0 0 0.00 0 0 0 0	3.00
6.00 0.00 0 0 7.00 0.00 0 0 8.00 0.00 0 0 9.00 0.00 0 0 10.00 0.00 0 0 11.00 0.00 0 0 12.00 100 0.00 0 0 12.00 100 0.00 0 0 12.00 100 0.00 0 0 12.00 101 0.00 0 0 12.00 101 0.00 0 0 12.00 101 0.00 0 0 12.00 101 1.00 0 1.277.632 1.00 12.077.632 0 1.277.632 1.00 196,246 103,228 0 1.00 196,246 103,228 0 1.00 D - CHARGEABLE SUPPLIES 0 0 1.00 MEDI CAL SUPPLIES CHARGED TO 71.00 0 1.00 0.00 0 0 0 3.	4.00
7.00 0.00 0 0 8.00 0.00 0 0 9.00 0.00 0 0 10.00 0.00 0 0 11.00 0.00 0 0 12.00 TOTALS 0 0 0 TOTALS 0 0 0 0 12.00 TOTALS 0 14,164 0 1.00 CAP REL COSTS-BLDG & FIXT 1.00 0 1,277,632 TOTALS 0 1,277,632 0 1,277,632 1.00 CAFETERIA 11.00 196,246 103,228 D CHARGEABLE SUPPLIES 196,246 103,228 1.00 PATI ENTS 0 0 995,288 2.00 0.00 0 0 0 3.00 0.00 0 0 0 3.00 0.00 0 0 0 3.00 0.00 0 0 0 3.00 0.00 0 0 0 3.00 0.	5.00
8.00 0.00 0 0 9.00 0.00 0 0 10.00 0.00 0 0 11.00 0.00 0 0 12.00 0 0 0 0 12.00 0 0 0 0 12.00 0 0 0 0 12.00 0 0 0 0 12.00 0 0 0 0 12.01 0 14,164 0 0 12.02 0 14,164 0 0 0 12.01 0 1,277,632 0 0 1,277,632 107ALS 0 196,246 103,228 0 0 0 1.00 CAFETERIA 11.00 196,246 103,228 0 0 0 1.00 0 0 0 0 0 0 0 0 1.00 0 0 0 0 0 0 0 0 0 0 0 <t< td=""><td>6.00 7.00</td></t<>	6.00 7.00
9.00 0.00 0 0 10.00 0.00 0 0 11.00 0.00 0 0 12.00	8.00
10.00 0.00 0 0 11.00 0.00 0 0 12.00 TOTALS 0 14, 164 B - INTEREST EXPENSE 0 14, 164 1.00 CAP REL_COSTS-BLDG & FIXT 1.00 0 1, 277, 632 TOTALS 0 1, 277, 632 0 1, 277, 632 C - DI ETARY 0 196, 246 103, 228 1.00 CAFETERIA 196, 246 103, 228 D - CHARGEABLE SUPPLIES 196, 246 103, 228 D - CHARGEABLE SUPPLIES 196, 246 103, 228 2.00 0.00 0 0 3.00 0.00 0 0 4.00 0.00 0 0 5.00 0.00 0 0	9.00
12.00	10.00
TOTALS 0 14, 164 B - INTEREST EXPENSE 0 14, 164 B - INTEREST EXPENSE 0 1, 277, 632 1.00 CAP REL COSTS-BLDG & FIXT 1.00 0 1, 277, 632 TOTALS 0 1, 277, 632 0 1, 277, 632 C - DI ETARY 0 196, 246 103, 228 TOTALS 196, 246 103, 228 0 D - CHARGEABLE SUPPLIES 196, 246 103, 228 D - CHARGEABLE SUPPLIES 196, 246 103, 228 2.00 0 0 0 3.00 0.00 0 0 4.00 0.00 0 0 5.00 0.00 0 0	11.00
B - INTEREST EXPENSE 1.00 CAP REL_COSTS-BLDG & FIXT	12.00
1.00 CAP REL COSTS-BLDG & FIXT 1.00 0 1,277,632 TOTALS 0 1,277,632 0 1,277,632 C - DI ETARY 11.00 103,228 TOTALS 196,246 103,228 D - CHARGEABLE SUPPLIES	
TOTALS 0 1, 277, 632 C - DI ETARY	1.00
C - DI ETARY 1.00 CAFETERI A	1.00
TOTALS	
D - CHARGEABLE SUPPLIES 1.00 MEDI CAL SUPPLIES CHARGED TO PATIENTS 71.00 0 995, 288 2.00 0.00 0 0 0 3.00 0.00 0 0 0 4.00 0.00 0 0 0 5.00 0.00 0 0 0	1.00
1.00 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 71.00 0 995, 288 2.00 0.00 0 0 3.00 0.00 0 0 4.00 0.00 0 0 5.00 0.00 0 0	
PATIENTS 0.00 0 0 2.00 0.00 0 0 3.00 0.00 0 0 4.00 0.00 0 0 5.00 0.00 0 0	
2.00 0.00 0 0 3.00 0.00 0 0 4.00 0.00 0 0 5.00 0.00 0 0	1.00
3.00 0.00 0 0 4.00 0.00 0 0 5.00 0.00 0 0	2.00
4.00 0.00 0 0 5.00 0.00 0 0	3.00
5.00 0.00 0 0	4.00
	5.00
6.00 0.00 0 0	6.00
7.00 0.00 0 0	7.00
8.00 0.00 0 0	8.00
9.00 0.00 0 0	9.00
	10.00
11.00 0.00 0 0 12.00 0.00 0 0	11.00
13.00 0.00 0 0	12.00
	14.00
	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
	20.00
21. 00 $ _{TOTALS}$	21.00
E - DRI GS CHARGED TO PTS	
1.00 DRUGS CHARGED TO PATIENTS 73.00 0 8,302,117	1.00
2.00 0.00 0 0	2.00
3.00 0.00 0 0	3.00
4.00 0.00 0 0	4.00
5.00 0.00 0 0	5.00
6.00 0.00 0 0 7.00 0.00 0 0	6.00 7.00
	8.00
9.00 0.00 0 0	9.00
	10.00
11.00 0.00 0 0	11.00
12.00 0.00 0 0	12.00
	13.00
TOTALS 0 8, 302, 117	
F - PROTHESIS & IMPLANTS 1.00 IMPL. DEV. CHARGED TO 72.00 0 482, 982	1.00
PATIENTS	1.00
2.00 0.00 0 0	2.00
TOTALS 0 482, 982	
G - SHARED SERVICES	
1. 00 EMPLOYEE BENEFITS DEPARTMENT 4. 00 56, 373 0	1 4 44
2. 00 ADMI NI STRATI VE & GENERAL 5. 00 544, 638 0	1.00
3. 00 <u>NURSING ADMINISTRATION</u> <u>13. 00</u> <u>213, 922</u> <u>0</u>	2.00
TOTALS 814, 933 0 500. 00 Grand Total : Increases 1, 011, 179 11, 175, 411	
	2.00

FRANCI SCAN HEALTH CRAWFORDSVILLE

Provider CCN: 15-0022

In Lieu of Form CMS-2552-10 Period: Worksheet A-6 From 01/01/2018

						From 01/01/2018 To 12/31/2018	Date/Time F 5/30/2019 3	
		Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref			
Δ	6.00	7.00	8.00	9.00	10.00			-
	PERATION OF PLANT	7.00	0	4, 906	1	9		1.
	AUNDRY & LINEN SERVICE	8.00	0	693		9		2.
	ETARY	10.00	0	1, 235		o		3.
00 SU	JBPROVIDER - IPF	40.00	0	1, 071		o		4.
00 OP	PERATING ROOM	50.00	0	2, 212		o		5.
	ADI OLOGY-DI AGNOSTI C	54.00	0	8		o		6.
	ADI OLOGY-THERAPEUTI C	55.00	0	57		0		7
		65.00	0	667		0		8
	IYSI CAL THERAPY	66.00	0	54		0		9
	LECTROCARDI OLOGY MERGENCY	69.00 91.00	0	1, 922 841		0		10
	ENTRAL SERVICES & SUPPLY	91.00 14.00	0	498		0		12
	DTALS		— — — 0	<u>496</u> 14, 164		<u>u</u>		12
	- INTEREST EXPENSE		U	14, 104				
	MINISTRATIVE & GENERAL	5.00	0	1, 277, 632	1	1		1
	DTALS		— — — o	1, 277, 632		-		
	- DIETARY		-1	.,,				
	ETARY	10.00	196, 246	103, 228		0		1
	DTALS	+	196, 246	103, 228		7		
D	- CHARGEABLE SUPPLIES							
	MINISTRATIVE & GENERAL	5.00	0	4, 003		0		1
00 OP	PERATION OF PLANT	7.00	0	517		o		2
	AUNDRY & LINEN SERVICE	8.00	0	793		0		3
ю но	OUSEKEEPI NG	9.00	0	3, 090		0		4
	ETARY	10.00	0	757		0		5
	AFETERI A	11.00	0	885		0		6
	JRSING ADMINI STRATION	13.00	0	14		0		7
	ENTRAL SERVICES & SUPPLY	14.00	0	65, 539		0		8
		15.00	0	38, 087		0		9
	OULTS & PEDIATRICS	30.00	0	59, 720		0		10
	ITENSI VE CARE UNI T JBPROVI DER – I PF	31.00 40.00	0	15, 377 10, 687				11
	PERATING ROOM	40.00 50.00	o	494, 535				13
	ADI OLOGY-DI AGNOSTI C	54.00	0	106, 353				14
	ADI OLOGY-THERAPEUTI C	55.00	o	4, 594		0		15
	SPIRATORY THERAPY	65.00	0	25, 731		0		16
	IYSI CAL THERAPY	66.00	Ő	3, 788		o		17
	ECTROCARDI OLOGY	69.00	0	10, 488		0		18
	INIC	90.00	0	6, 434		0		19
00 EN	IERGENCY	91.00	0	143, 894		o		20
00 PH	YSICIANS' PRIVATE OFFICES	192.00	0	2		o		21
то	DTALS	+		995, 288		7		
	- DRIGS CHARGED TO PTS							
	DMINISTRATIVE & GENERAL	5.00	0	374		0		1
	IARMACY	15.00	0	1, 179, 931		0		2
	OULTS & PEDIATRICS	30.00	0	199		0		3
	ITENSIVE CARE UNIT	31.00	0	2		0		4
	PERATING ROOM	50.00	0	12, 621		0		5
	ADI OLOGY-DI AGNOSTI C	54.00	0	5, 615		0		6
	ADI OLOGY-THERAPEUTI C	55.00	0	6, 989, 416				7
	ADI OI SOTOPE ESPI RATORY THERAPY	56.00	0	109, 158				8
	IYSICAL THERAPY	65.00 66.00	0	85 1				9
	LECTROCARDI OLOGY	69.00	0	767				11
	LINIC	90.00	0	74		0		12
	MERGENCY	91.00	0	3, 874				13
	DTALS		0	8, 302, 117				
	- PROTHESIS & IMPLANTS		9	5,002,117	1	1		_
	PERATING ROOM	50.00	0	393, 825		0		1
	MERGENCY	91.00	o	89, 157		0		2
	DTALS	+	<u>_</u>	482, 982		7		
	- SHARED SERVICES	1	-	=				
	IPLOYEE BENEFITS DEPARTMENT	4.00	0	56, 373		0		1
	MINISTRATIVE & GENERAL	5.00	О	544, 638		0		2
	JRSING ADMINISTRATION	13.00	0	21 <u>3, 9</u> 22		൭		3
	DTALS		0	814, 933				
	and Total: Decreases		196, 246	11, 990, 344				500

Heal th	Health Financial Systems FRANCISCAN HEALTH CRAWFORDSVILLE In Lieu of Form CMS-2552-10									
RECONC	RECONCILIATION OF CAPITAL COSTS CENTERS		Provider CC	CN: 15-0022	Period: From 01/01/2018 To 12/31/2018			pared:		
				Acqui si ti on	s					
		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									
1.00	Land	970, 120	0		0	0	0	1.00		
2.00	Land Improvements	3, 795, 628	3, 181		0	3, 181	0	2.00		
3.00	Buildings and Fixtures	39, 444, 492	151, 215		0	151, 215	0	3.00		
4.00	Building Improvements	507, 274	0		0	0	0	4.00		
5.00	Fixed Equipment	19, 623	1, 189		0	1, 189	0	5.00		
6.00	Movable Equipment	20, 101, 622	1, 784, 945		0	1, 784, 945	0	6.00		
7.00	HIT designated Assets	0	0		0	0	0	7.00		
8.00	Subtotal (sum of lines 1-7)	64, 838, 759	1, 940, 530		0	1, 940, 530	0	8.00		
9.00	Reconciling Items	0	0		0	0	0	9.00		
10.00	Total (line 8 minus line 9)	64, 838, 759	1, 940, 530		0	1, 940, 530	0	10.00		
		Ending Balance	Fully							
		-	Depreci ated							
			Assets							
		6.00	7.00							
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	BALANCES								
1.00	Land	970, 120	0					1.00		
2.00	Land Improvements	3, 798, 809	0					2.00		
3.00	Buildings and Fixtures	39, 595, 707	0					3.00		
4.00	Building Improvements	507, 274	0					4.00		
5.00	Fixed Equipment	20, 812	0					5.00		
6.00	Movable Equipment	21, 886, 567	0					6.00		
7.00	HIT designated Assets	0	0					7.00		
8.00	Subtotal (sum of lines 1-7)	66, 779, 289	0					8.00		
9.00	Reconciling Items	0	0					9.00		
10.00	Total (line 8 minus line 9)	66, 779, 289	0					10.00		

Health Financial Systems Fi	RANCI SCAN HEALTH	H CRAWFORDSVILL	E	In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der C	CN: 15-0022	Peri od:	Worksheet A-7	
				From 01/01/2018		
				To 12/31/2018	Date/Time Pre 5/30/2019 3:2	
		SI	JMMARY OF CAP	ΠΤΔΙ	<u> 37 307 2019 3. 2</u>	
		00		1 I/AE		
Cost Center Description	Depreciation	Lease	Interest	Insurance (see	Taxes (see	
				instructions)	instructions)	
	9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WO	RKSHEET A, COLUN	<u>MN 2, LINES 1 a</u>	nd 2			
1.00 CAP REL COSTS-BLDG & FLXT	4, 221, 993	447, 304		0 0	0	1.00
2.00 CAP REL COSTS-MVBLE EQUIP	C	141, 158		0 0	0	2.00
3.00 Total (sum of lines 1-2)	4, 221, 993	3 588, 462		0 0	0	3.00
	SUMMARY (OF CAPITAL				
Cost Center Description	Other	Total (1) (sum				
	Capi tal -Rel ate					
	d Costs (see	J J /				
	instructions)		-			
	14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WO	RESHEET A, COLUM		1			
1.00 CAP REL COSTS-BLDG & FIXT		4, 669, 297				1.00
2.00 CAP REL COSTS-MVBLE EQUIP		141, 158	1			2.00
3.00 Total (sum of lines 1-2)	(C	4, 810, 455				3.00

Health Financial System	s FR	ANCISCAN HEALTH	I CRAWFORDSVILL	E	In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPIT	AL COSTS CENTERS		Provider C	F	Period: From 01/01/2018 To 12/31/2018	Worksheet A-7 Part III Date/Time Prep 5/30/2019 3:23	bared:
		COMI	PUTATION OF RAT	TI OS	ALLOCATION OF	OTHER CAPITAL	
Cost Center	- Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col. 2)		Insurance	
	CILIATION OF CAPITAL COSTS C	1.00	2.00	3.00	4.00	5.00	
1.00 CAP REL COSTS-BL 2.00 CAP REL COSTS-MU 3.00 Total (sum of li	DG & FIXT BLE EQUIP	4, 848, 205 0 4, 848, 205	0	4, 848, 205 C 4, 848, 205 CAPI TAL	0.000000 5.1.000000	0 0 0 F CAPITAL	1.00 2.00 3.00
Cost Center	⁻ Description	Taxes	Other Capital-Relate d Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
1.00 CAP REL COSTS-BL	CILIATION OF CAPITAL COSTS C	ENTERS			4, 937, 628	1 000 005	1.00
2.00 CAP REL COSTS-BL 2.00 CAP REL COSTS-MV 3.00 Total (sum of li	BLE EQUIP	0			4, 937, 628 1, 330 4, 938, 958	141, 158	2.00 3.00
			SI	JMMARY OF CAPIT		2,001,170	0100
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 - RECON1.00CAP REL COSTS-BL2.00CAP REL COSTS-MV3.00Total (sum of li	BLE EQUIP	ENTERS 1, 270, 144 0 1, 270, 144	0	C		8, 128, 107 142, 488 8, 270, 595	1.00 2.00 3.00

FRANCISCAN HEALTH CRAWFORDSVILLE

Heal th	Financial Systems	FRAI	NCISCAN HEALTH	CRAWFORDSVI LLE	In Lie	u of Form CMS-2	2552-10
	MENTS TO EXPENSES				Period: From 01/01/2018	Worksheet A-8	
					To 12/31/2018	Date/Time Prep 5/30/2019 3:23	
				Expense Classification o			5 pili
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	В	-7,488	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	COSTS-MVBLE EQUIP (chapter 2) Investment income - other		0		0.00	o	3.00
0.00	(chapter 2)		0		0.00	Ű	0.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of	В	-177, 547	ADMI NI STRATI VE & GENERAL	5.00	О	5.00
4 00	expenses (chapter 8)		0		0.00	0	4 00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Tel ephone services (pay		0		0.00	0	7.00
	stations excluded) (chapter 21)						
8.00	Television and radio service		0		0.00	0	8.00
9.00	(chapter 21) Parking Lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician	A-8-2	-505, 626			0	10.00
11.00	adjustment Sale of scrap, waste, etc.		0		0.00	o	11.00
11.00	(chapter 23)		0		0.00	Ű	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	2, 747, 798			0	12.00
13.00	Laundry and Linen service	В	-10, 255	LAUNDRY & LINEN SERVICE	8.00	0	13.00
14.00	Cafeteria-employees and guests				11.00		14.00
15.00	Rental of quarters to employee and others	В	-26, 841	ADMINISTRATIVE & GENERAL	5.00	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		0		0.00	0	17.00
18.00	patients Sale of medical records and	В	-1 493	ADMI NI STRATI VE & GENERAL	5.00	o	18.00
10.00	abstracts	b			5.00	Ű	
19.00	Nursing and allied health education (tuition, fees,		0		0.00	0	19.00
	books, etc.)						
20. 00 21. 00	Vending machines Income from imposition of	В	-7, 545 0	DI ETARY	10.00 0.00		20. 00 21. 00
21.00	interest, finance or penalty		0		0.00	0	21.00
22.00	charges (chapter 21)		0		0.00		22.00
22.00	Interest expense on Medicare overpayments and borrowings to		0		0.00	0	22.00
	repay Medicare overpayments				(5.00		
23.00	Adjustment for respiratory therapy costs in excess of	A-8-3	0	RESPI RATORY THERAPY	65.00		23.00
	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		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	COSTS-BLDG & FIXT Depreciation - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
20 00	COSTS-MVBLE EQUIP						20 00
28. 00 29. 00	Non-physician Anesthetist Physicians' assistant		0	*** Cost Center Deleted ***	19.00 0.00		28.00 29.00
30.00	Adjustment for occupational	A-8-3	0	*** Cost Center Deleted ***			30.00
	therapy costs in excess of limitation (chapter 14)						
30. 99	Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30.00		30. 99
31.00	instructions) Adjustment for speech	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
51.00	pathology costs in excess of	N-0-3	0		08.00		51.00
32.00	limitation (chapter 14) CAH HIT Adjustment for		0		0.00	о	32.00
		1	0		0.00	, 0	JZ. UU
52.00	Depreciation and Interest						

Heal th	Financial Systems	FRA	NCISCAN HEALTH	I CRAWFORDSVI LLE	In Lie	u of Form CMS-2	2552-10
ADJUST	MENTS TO EXPENSES			Provider CCN: 15-0022	Peri od:	Worksheet A-8	
					From 01/01/2018		
					To 12/31/2018		
				Expense Classification o	n Workshoot A	5/30/2019 3:2	s pili
				To/From Which the Amount is			
					s to be Aujusteu		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.01	MI SC I NCOME	В	-46, 600	DI ETARY	10.00	0	33.01
33. 02	MI SC I NCOME		0		0.00	0	33.02
33.03	MI SC I NCOME	В	-13, 910	PHYSICAL THERAPY	66.00	0	33.03
33.04	MI SC I NCOME	В	-3, 307	RADI OLOGY-THERAPEUTI C	55.00	0	33.04
33.05	MI SC I NCOME	В	-424	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.06	MI SC I NCOME	В	-55	DI ETARY	10.00	0	33.06
33.07	ADVERTI SI NG EXPENSE		0		0.00	0	33.07
33.08	HAF ASSESSMENT	A	-2, 384, 507	ADMI NI STRATI VE & GENERAL	5.00	0	33.08
33.09	PENSION ADJ	A	193, 221	ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.10	INTEREST EXP	A	-1, 277, 632	ADMINISTRATIVE & GENERAL	5.00	11	33.10
33.11	MI SC I NCOME		0		0.00	0	33. 11
33. 12	MI SC I NCOME		0		0.00	0	33. 12
50.00	TOTAL (sum of lines 1 thru 49)		-1, 650, 293				50.00
	(Transfer to Worksheet A,						
	column 6, line 200.)						

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
Note: See instructions for column 5 referencing to Worksheet A-7.

Heal th	Financial Systems	FRANCI SCAN HEALT	H CRAWFORDSVILLE	In Lie	eu of Form CMS-	2552-10
	ENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HOM	ME Provider CCN: 15-0022	Period:	Worksheet A-8	-1
OFFICE	COSTS			From 01/01/2018 To 12/31/2018		
	Line No.	Cost Center	Expense Items	Amount of	Amount	
				Allowable Cost		
					Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED					
	HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	FA-I NT	2, 750, 663	1, 277, 632	1.00
2.00	1.00	CAP REL COSTS-BLDG & FIXT	FA-NEW CAP	706, 267	0	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	FA A&G	5, 729, 494	7, 023, 123	3.00
4.00	15.00	PHARMACY	PHARMACY	79, 465	0	4.00
4.04	16.00	MEDICAL RECORDS & LIBRARY	FA-HIM	467, 900	0	4.04
4.07	4.00	EMPLOYEE BENEFITS DEPARTMENT	FSEH SHARED SERVICES	131, 378	0	4.07
4.08	5.00	ADMINISTRATIVE & GENERAL	FSEH SHARED SERVICES	887, 406	0	4.08
4.09	13.00	NURSING ADMINISTRATION	FSEH SHARED SERVICES	295, 980	0	4.09
5.00	TOTALS (sum of lines 1-4).			11, 048, 553	8, 300, 755	5.00
	Transfer column 6, line 5 to					
	Worksheet A-8, column 2,					
	line 12.					

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

has not been posted to norksheet h, cordinas i dhayor 2, the amount arrowable should be indicated in cordinant of this part.									
				Related Organization(s) and/	or Home Office				
				-	1				
						1			
						i i			
	Symbol (1)	Name	Percentage of	Name	Percentage of				
	Symbol (1)	Name		Name		í.			
			Ownership		Ownershi p				
	1.00	2.00	3.00	4.00	5.00				
	B. INTERRELATIONSHIP TO RELAT	FED ORGANIZATION(S) AND/OR HO	ME OFFICE:						

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

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

1 CT IIIDUI					
6.00	В	HOME OFFICE	100.00	0.00	6.00
7.00		SISTER FACILITY	0.00	0.00	7.00
8.00			0.00	0.00	8.00
9.00			0.00	0.00	9.00
10.00			0.00	0.00	10.00
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 HE	ALTH CR	AWFORDSVI L	LE	In Lie	u of Form CMS	-2552-10
		SERVICES FROM	RELATED (ORGANIZATIONS AND	HOME	Provi der	CCN: 15-0022	Period:	Worksheet A-	8-1
OFFICE	COSTS							From 01/01/2018 To 12/31/2018	Date/Time Pr 5/30/2019 3:	
	Net	Wkst. A-7 Ref.				1			0,00,201, 01	
	Adjustments									
	(col. 4 minus									
	col. 5)*									
	6.00	7.00								
	A. COSTS INCUR	RED AND ADJUST	IENTS REQU	UIRED AS A RESULT	OF TRA	NSACTIONS	NITH RELATED (ORGANIZATIONS OR (CLAI MED	
	HOME OFFICE CO	STS:								
1.00	1, 473, 031	10								1.00
2.00	706, 267	9								2.00
3.00	-1, 293, 629	0								3.00
4.00	79, 465	0								4.00
4.04	467, 900	0								4.04

4.07

4.08

4.09

5 00

00000 4.08 887,406 4.09 295, 980 0 5.00 2, 747, 798 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 par

1143	not been posted to worksheet A,	cordinins i and/or z, the amount arrowable should be that cated in cordinin 4 or this part.						
	Related Organization(s)							
	and/or Home Office							
	Type of Business							
	6.00							
	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 7.00		6.00
7.00		7.00
8.00 9.00		8.00
9.00		9.00
10. 00 100. 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.

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

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

organi zati on.

131, 378

4.07

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 Financ	cial Systems	

FRANCI SCAN HEALTH CRAWFORDSVILLE In Lieu of Form CMS-2552-10

PROVI DE	R BASED PHYSIC	I AN ADJUSTMENT		Provider 0		Peri od:	Worksheet A-8	8-2
						From 01/01/2018 To 12/31/2018	B Date/Time Pre	pared.
						10 12/31/2010	5/30/2019 3:2	
	Wkst. A Line #		Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remunerati on	Component	Component		ider Component	
							Hours	
1.00	1.00	2.00	3.00	4.00	5.00	6.00	7.00	4 00
1.00		SUBPROVIDER - IPF	239, 953		(,		1.00
2.00		OPERATING ROOM	21,060		(2.00
3.00		RADI OLOGY-DI AGNOSTI C	19, 718		(,		3.00
4.00		RADI OLOGY-THERAPEUTI C	222, 895		(4.00
5.00		EMERGENCY	2,000		(5.00
6.00	0.00		0	0	(0	0	6.00
7.00	0. 00 0. 00		0	0			0	7.00
8.00 9.00	0.00		0				0	8.00 9.00
9.00 10.00	0.00		0	0			0	9.00 10.00
	0.00				(0	0	200.00
200.00	Wkst. A Line #	Cost Center/Physician	505, 626 Unadj usted RCE		Cost of	-	Physician Cost	200.00
	WKSL A LINE #	I denti fi er		Unadjusted RCE			of Malpractice	
		rdentifier		Limit	Conti nui ng	Share of col.	Insurance	
					Education	12	i nou unee	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00		SUBPROVIDER - IPF	0	0	(0	1.00
2.00	50.00	OPERATI NG ROOM	0	0	(o o	0	2.00
3.00	54.00	RADI OLOGY-DI AGNOSTI C	0	0	(o o	0	3.00
4.00	55.00	RADI OLOGY-THERAPEUTI C	0	0	(0 0	0	4.00
5.00	91.00	EMERGENCY	0	0	(o o	0	5.00
6.00	0.00		0	0	(0 0	0	6.00
7.00	0.00		0	0	(0 0	0	7.00
8.00	0.00		0	0	(0 0	0	8.00
9.00	0.00		0	0	(0 0	0	9.00
10.00	0.00		0	0	(0 0	0	10.00
200.00			0	0	(-	0	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		I denti fi er	Component	Limit	Di sal I owance			
			Share of col.					
	1.00	2.00	14 15.00	16.00	17.00	18.00		
1.00		SUBPROVIDER - IPF	15.00	18.00	17.00			1.00
2.00		OPERATING ROOM		0	(2.00
2.00 3.00		RADI OLOGY-DI AGNOSTI C			(,		2.00
3.00 4.00		RADI OLOGY - DI AGNOSTI C RADI OLOGY - THERAPEUTI C		0	(3.00 4.00
4.00 5.00		EMERGENCY		0				4.00 5.00
6.00	0.00		n	0	(6.00
7.00	0.00			0	(-		7.00
8.00	0.00			0	(°		8.00
9.00	0.00		0	0	(9,00
10.00	0.00		0	-	(-		10.00
200.00	5.00		0			505, 626		200.00
	•				1	,	· ·	

COSTA	LLOCATION - GENERAL SERVICE COSTS		Provider C	F	Period: From 01/01/2018 To 12/31/2018	Worksheet B Part I Date/Time Pre 5/30/2019 3:2	pared: 3 pm
			CAPI TAL REL	ATED COSTS			
	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFI TS DEPARTMENT	Subtotal	
		<u>col.7)</u> 0	1.00	2.00	4.00	4A	
	GENERAL SERVICE COST CENTERS	0	1.00	2.00	4.00	48	
1.00	00100 CAP REL COSTS-BLDG & FIXT	8, 128, 107	8, 128, 107				1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	142, 488	0, 120, 107	142, 488	3		2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	3, 774, 993	49, 972				4.00
5.00	00500 ADMI NI STRATI VE & GENERAL	7, 314, 454	1,049,069			9, 434, 145	5.00
7.00	00700 OPERATION OF PLANT	1, 468, 908	549,071	9, 625		2, 085, 421	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	172, 617	213, 850			427, 998	8.00
9.00	00900 HOUSEKEEPING	552, 722	17,072			570, 093	9,00
10.00	01000 DI ETARY	200, 997	212, 952			510, 183	
11.00	01100 CAFETERIA	191, 707	116, 809			310, 564	11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	737, 629	70, 016			879, 371	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	84, 778	391, 275			501, 681	
15.00	01500 PHARMACY	543, 137	20, 735			669, 735	•
16.00	01600 MEDICAL RECORDS & LIBRARY	467, 900	133, 743	2, 345		603, 988	
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	,		_/ _/ .			1
30, 00	03000 ADULTS & PEDIATRICS	1, 778, 533	1,087,087	19, 058	3 323, 043	3, 207, 721	30.00
31.00	03100 I NTENSI VE CARE UNI T	962, 916	129, 872			1, 233, 008	31.00
40.00	04000 SUBPROVIDER - IPF	1,087,072	297, 897	5, 222		1, 683, 455	40.00
	ANCILLARY SERVICE COST CENTERS	· · · · · ·			· · · · ·		1
50.00	05000 OPERATI NG ROOM	1, 575, 135	433, 576	7, 601	343, 890	2, 360, 202	50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 802, 535	1, 069, 804	18, 754	1 280, 712	3, 171, 805	54.00
54.01	05401 ULTRASOUND	131, 317	19, 422	340	33, 373	184, 452	54.01
55.00	05500 RADI OLOGY-THERAPEUTI C	860, 394	0	C	127, 743	988, 137	55.00
56.00	05600 RADI OI SOTOPE	116, 556	18, 454	324	1 20, 090	155, 424	56.00
60.00	06000 LABORATORY	2, 323, 780	372, 268	6, 526	5 O	2, 702, 574	60.00
65.00	06500 RESPI RATORY THERAPY	439, 583	28, 062	492	80, 531	548, 668	65.00
66.00	06600 PHYSI CAL THERAPY	509, 049	160, 975	2, 822	2 118, 860	791, 706	66.00
69.00	06900 ELECTROCARDI OLOGY	302, 509	22, 325	391	I 74, 511	399, 736	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	995, 288	97, 594	1, 711	0	1, 094, 593	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	482, 982	0	C	0 0	482, 982	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	8, 302, 117	295, 202	5, 175	5 0	8, 602, 494	73.00
76. 98	07698 HYPERBARI C OXYGEN THERAPY	8, 786	0	C	0 0	8, 786	76. 98
	OUTPATIENT SERVICE COST CENTERS	· · · · · · · · · · · · · · · · · · ·			1		
90.00	09000 CLI NI C	167, 941	58, 819	1, 031	36, 992	264, 783	90.00
91.00	09100 EMERGENCY	2, 590, 592	790, 707	13, 861	415, 590	3, 810, 750	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
	SPECIAL PURPOSE COST CENTERS	· · · · · ·			1		
	11300 INTEREST EXPENSE						113.00
118.00		48, 217, 522	7, 706, 628	135, 099	3, 721, 642	47, 684, 455	118.00
	NONREI MBURSABLE COST CENTERS	,					-
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	24, 260				190. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES	2, 577, 124	0	C	.,	2, 584, 816	
	07953 OTHER NONREIMBURSABLE COST CENTERS	0	284, 972	4, 996		289, 968	
	07951 SPORTS MEDI CI NE	205, 667	0	C	40, 722	246, 389	
	07952 COMMUNI TY I ND HEALTH	245, 060	112, 247	1, 968	3 55, 785	415, 060	
200.00			-	_			200.00
201.00		F4 0.5 0	0	0			201.00
202.00	TOTAL (sum lines 118 through 201)	51, 245, 373	8, 128, 107	142, 488	3, 825, 841	51, 245, 373	202.00

Heal th	Financial Systems FR	ANCI SCAN HEALTH	CRAWFORDSVI LL	E	In Lie	u of Form CMS-	2552-10
COST A	ALLOCATION - GENERAL SERVICE COSTS		Provider C	CN: 15-0022	Period: From 01/01/2018	Worksheet B	
					To 12/31/2018		pared:
	Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	5/30/2019 3:2 DI ETARY	3 pm
	cost center bescription	& GENERAL	PLANT	LINEN SERVIC		DIETART	
		5.00	7.00	8.00	9.00	10.00	
	GENERAL SERVICE COST CENTERS	T					
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMI NI STRATI VE & GENERAL	9, 434, 145					5.00
7.00	00700 OPERATION OF PLANT	470, 548	2, 555, 969				7.00
8.00	00800 LAUNDRY & LINEN SERVICE	96, 572	84, 351	608, 92	1		8.00
9.00	00900 HOUSEKEEPI NG	128, 634	6, 734	67, 50	772, 968		9.00
10.00	01000 DI ETARY	115, 116	83, 997	4, 09	26, 341	739, 728	10.00
11.00	01100 CAFETERI A	70, 075	46, 074		0 14, 448	0	11.00
13.00	01300 NURSING ADMINISTRATION	198, 419	27, 617		0 8, 661	0	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	113, 198	154, 335	1		0	1
15.00	01500 PHARMACY	151, 117	8, 179		0 2,565	0	
16.00	01600 MEDI CAL RECORDS & LI BRARY	136, 282	52, 754		0 16, 543	0	
10.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	130, 202	52,754	1	10, 343	0	10.00
30, 00	03000 ADULTS & PEDIATRICS	723, 781	428, 787	184, 66	1 134, 465	359, 020	30.00
31.00	03100 I NTENSI VE CARE UNI T	278, 212	51, 227			62, 726	
40.00	04000 SUBPROVIDER - IPF	379, 850	117, 503			317, 982	
40.00	ANCI LLARY SERVICE COST CENTERS	379,830	117, 303	50, 60	50, 040	317, 902	40.00
50, 00	05000 OPERATING ROOM	532, 549	171 000	01.25	D E2 (20	0	50.00
			171, 020				
54.00	05400 RADI OLOGY-DI AGNOSTI C	715, 677	421, 974			0	54.00
54.01	05401 ULTRASOUND	41, 619	7, 661	1	0 2, 402	0	
55.00	05500 RADI OLOGY-THERAPEUTI C	222, 960	0		0 0	0	
56.00	05600 RADI OI SOTOPE	35, 069	7, 279		0 2, 283	0	
60.00	06000 LABORATORY	609, 801	146, 837		0 46, 047	0	
65.00	06500 RESPI RATORY THERAPY	123, 800	11, 069			0	
66.00	06600 PHYSI CAL THERAPY	178, 638	63, 495			0	
69.00	06900 ELECTROCARDI OLOGY	90, 195	8, 806		0 2, 761	0	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	246, 981	38, 495		0 12, 072	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	108, 979	0		0 0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1, 941, 025	116, 439	,	0 36, 514	0	73.00
76. 98	07698 HYPERBARI C OXYGEN THERAPY	1, 982	0		0 0	0	76.98
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	59, 745	23, 201		0 7, 276	0	90.00
91.00	09100 EMERGENCY	859, 846	311, 886	153, 35	6 97, 805	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	SPECIAL PURPOSE COST CENTERS						
113.00	11300 I NTEREST EXPENSE						113.00
118.00		8, 630, 670	2, 389, 720	608, 92	1 720, 834	739, 728	
110.00	NONREI MBURSABLE COST CENTERS	0,000,070	2,007,720	000,72	720,001	107,120	110.00
190 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	5, 570	9, 569		0 3,001	0	190.00
	19200 PHYSI CLANS' PRI VATE OFFICES	583, 230	, JU7		0 3,001		192.00
	07953 OTHER NONREIMBURSABLE COST CENTERS	65, 428	112, 405		0 35, 249		194.00
	07955 OTHER NORREIMBURSABLE COST CENTERS	55, 594	112,400		0 35,249		194.00
	207951 SPORTS MEDICINE 207952 COMMUNITY IND HEALTH		44 075		0		194.01
194.02 200.00		93, 653	44, 275		0 13, 884	0	200.00
					0	_	
201.00		0 404 445		(00.00			201.00
202.00) TOTAL (sum lines 118 through 201)	9, 434, 145	2, 555, 969	608, 92	772, 968	739, 728	1202. UU

		NCISCAN HEALTH	I CRAWFORDSVILLE			u of Form CMS-	2552-10
COST A	LLOCATION - GENERAL SERVICE COSTS		Provider CC		Period: From 01/01/2018 To 12/31/2018	Worksheet B Part I Date/Time Pre 5/30/2019 3:2	pared: 3 pm
	Cost Center Description	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	
		11.00	13.00	14.00	15.00	16.00	
	GENERAL SERVICE COST CENTERS		,				
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINI STRATI VE & GENERAL						5.00
7.00	00700 OPERATION OF PLANT						7.00
8.00 9.00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG						9.00
9.00 10.00	01000 DI ETARY						10.00
11.00	01100 CAFETERI A	441, 161					11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	548					13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	4,077		834, 23	4		14.00
15.00	01500 PHARMACY	12,869		001/20	0 877, 022		15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0			0 0	809, 567	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS		•		-		
30.00	03000 ADULTS & PEDIATRICS	62, 458	158, 005		0 0	30, 129	30.00
31.00	03100 INTENSIVE CARE UNIT	21, 144	53, 490		0 0	7,032	31.00
40.00	04000 SUBPROVI DER – I PF	40, 675	102, 904		0 0	19, 614	40.00
	ANCI LLARY SERVI CE COST CENTERS		I I				
50.00	05000 OPERATING ROOM	62, 428			0 0	69, 780	
54.00	05400 RADI OLOGY-DI AGNOSTI C	49, 133			0 0	159, 536	1
54.01	05401 ULTRASOUND	5, 811			0 0	15, 663	
55.00 56.00	05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE	29, 753			0 0	25, 361	
56.00 60.00	06000 LABORATORY	3,042	7, 728		0 0	12, 197 98, 716	
65.00	06500 RESPIRATORY THERAPY	15, 090	Ű		0 0	12, 233	
66.00	06600 PHYSI CAL THERAPY	21, 661	54, 807		0 0	11, 009	
69.00	06900 ELECTROCARDI OLOGY	14, 542			0 0	27, 189	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		592, 30	-	2, 399	1
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	241, 92		18, 935	1
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 877, 022	174,090	
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0		0 0	307	76.98
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	5, 598			0 0	3, 487	
91.00	09100 EMERGENCY	72, 831	184, 253		0 0	121, 890	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE	401 ((0	1 0/5 017	004.00		000 5/7	113.00
118.00		421, 660	1, 065, 317	834, 23	877, 022	809, 567	118.00
100 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0		190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	2, 708	-		0 0		190.00
	07953 OTHER NONREI MBURSABLE COST CENTERS	2,700	0, 830		0 0		192.00
	07951 SPORTS MEDI CI NE	9, 096	23, 034		0 0		194.00
194 ()1	07952 COMMUNITY IND HEALTH	7,697	19, 435		0 0		194.02
		7,077	17,400			0	200.00
194.02		0	0		0 0		

OOCT A	2	FRANCI SCAN HEALTH (u of Form CMS-2552-
COST A	ALLOCATION - GENERAL SERVICE COSTS		Provider CC	N: 15-0022	Period: From 01/01/2018 To 12/31/2018	Worksheet B Part I Date/Time Prepared 5/30/2019 3:23 pm
	Cost Center Description	Subtotal	Intern &	Total		1 37 307 201 9 3. 23 pm
		Re	esidents Cost			
			& Post			
			Stepdown			
			Adjustments			
		24.00	25.00	26.00		
	GENERAL SERVICE COST CENTERS					
1.00	00100 CAP REL COSTS-BLDG & FIXT					1.0
2.00	00200 CAP REL COSTS-MVBLE EQUIP					2.0
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT					4.0
5.00	00500 ADMINI STRATI VE & GENERAL					5.0
7.00	00700 OPERATION OF PLANT					7.0
8.00	00800 LAUNDRY & LINEN SERVICE					8.0
9.00	00900 HOUSEKEEPI NG					9.0
10.00	01000 DI ETARY					10.0
11.00	01100 CAFETERI A					11.0
13.00	01300 NURSING ADMINISTRATION					13.0
14.00	01400 CENTRAL SERVICES & SUPPLY					14.0
15.00	01500 PHARMACY					15.0
16.00	01600 MEDICAL RECORDS & LIBRARY					16.0
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS	5, 289, 027	0	5, 289, 0	27	30. (
31.00	03100 I NTENSI VE CARE UNI T	1, 740, 221	0	1, 740, 2	21	31.0
40.00	04000 SUBPROVIDER - IPF	2, 755, 631	0	2, 755, 6	31	40. (
	ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATI NG ROOM	3, 488, 914	0	3, 488, 9	14	50.
54.00	05400 RADI OLOGY-DI AGNOSTI C	4, 797, 402	0	4, 797, 4	02	54.0
54.01	05401 ULTRASOUND	272, 272	0	272, 2	72	54.0
55.00	05500 RADI OLOGY-THERAPEUTI C	1, 341, 455	0	1, 341, 4	55	55.0
56.00	05600 RADI OI SOTOPE	223, 022	0	223, 0	22	56.0
60.00	06000 LABORATORY	3, 603, 975	0	3, 603, 9	75	60. (
65.00	06500 RESPI RATORY THERAPY	755, 647	0	755, 6		65.0
66.00	06600 PHYSI CAL THERAPY	1, 157, 049	o	1, 157, 0		66.
69.00	06900 ELECTROCARDI OLOGY	580, 015	o	580, 0	15	69.1
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 986, 846	0	1, 986, 8		71.
	07200 IMPL. DEV. CHARGED TO PATIENTS	852, 824	0	852, 8		72.0
	07300 DRUGS CHARGED TO PATIENTS	11, 747, 584	0	11, 747, 5		73.0
	07698 HYPERBARI C OXYGEN THERAPY	11,075	0	11, 0		76.
	OUTPATIENT SERVICE COST CENTERS		-1	, •		
90.00	09000 CLI NI C	378, 221	0	378, 2	21	90.0
91.00	09100 EMERGENCY	5, 612, 617	0	5, 612, 6		91.
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0			92.0
	SPECIAL PURPOSE COST CENTERS				I	
113.00	11300 I NTEREST EXPENSE					113.0
118.00	SUBTOTALS (SUM OF LINES 1 through 117	7) 46, 593, 797	0	46, 593, 7	97	118.0
	NONREI MBURSABLE COST CENTERS	/				
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	42, 825	0	42, 8	25	190. (
	19200 PHYSI CI ANS' PRI VATE OFFI CES	3, 177, 584	0	3, 177, 5		192.
	07953 OTHER NONREI MBURSABLE COST CENTERS	503, 050	0	503, 0		194.
	07951 SPORTS MEDICINE	334, 113	0	334, 1		194.0
	207952 COMMUNITY IND HEALTH	594, 004	0	594, 0		194.0
174.02		1	0	374, 0	0	200.
) (Cross Foot Adjustments					
200.00 201.00	5	0	0		0	200.0

Heal th	Fi na	nci a	l Syst	ems	
		OF C	ΔΡΙΤΔΙ	RELATED	CO

ALLOCATION OF CAPITAL RELATED COSTS	Provider CO	F	eriod: rom 01/01/2018 o 12/31/2018	Worksheet B Part II Date/Time Pre 5/30/2019 3:2	pared: 3 pm	
		CAPI TAL REL	LATED COSTS			
Cost Center Description	Directly Assigned New Capital	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFI TS DEPARTMENT	
	Related Costs 0	1.00	2.00	2A	4.00	
GENERAL SERVICE COST CENTERS	0	1.00	2.00	ZA	4.00	
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	0	49, 972	876	50, 848	50, 848	4.00
5. 00 00500 ADMINI STRATI VE & GENERAL	0	1, 049, 069	18, 390	1, 067, 459	13, 984	5.00
7.00 00700 OPERATION OF PLANT	0	549, 071	9, 625	558, 696	768	7.00
8.00 00800 LAUNDRY & LINEN SERVICE	0	213, 850	3, 749		502	8.00
9. 00 00900 HOUSEKEEPI NG	0	17, 072	299	17, 371	0	9.00
10. 00 01000 DI ETARY	0	212, 952	3, 733		1, 230	
11. 00 01100 CAFETERI A	0	116, 809	2, 048		0	11.00
13.00 01300 NURSI NG ADMI NI STRATI ON	0	70, 016	1, 227		937	13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	0	391, 275	6, 859		249	
15. 00 01500 PHARMACY	0	20, 735	363		1, 402	1
16.00 01600 MEDI CAL RECORDS & LI BRARY	0	133, 743	2, 345	136, 088	0	16.00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0	1 007 007	10.050	1 10/ 145	4.004	20.00
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT	0		19,058		4, 294	30.00
31. 00 03100 I NTENSI VE CARE UNI T 40. 00 04000 SUBPROVI DER – I PF	0	129, 872 297, 897	2, 277 5, 222		1, 833 3, 898	31.00 40.00
ANCI LLARY SERVICE COST CENTERS	0	271,071	J, 222	. 303, 119	5, 070	40.00
50. 00 05000 OPERATI NG ROOM	0	433, 576	7, 601	441, 177	4, 571	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	1, 069, 804	18, 754		3, 731	54.00
54. 01 05401 ULTRASOUND	0	19, 422	340		444	54.01
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0	C		1, 698	55.00
56. 00 05600 RADI OI SOTOPE	0	18, 454	324	18, 778	267	56.00
60. 00 06000 LABORATORY	0	372, 268	6, 526	378, 794	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0	28, 062	492	28, 554	1, 070	65.00
66. 00 06600 PHYSI CAL THERAPY	0	160, 975	2, 822		1, 580	
69. 00 06900 ELECTROCARDI OLOGY	0	22, 325	391		990	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	97, 594	1, 711		0	
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	C	-	0	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	295, 202	5, 175		0	73.00
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0	C	0	0	76. 98
	0	E0.010	1 021	E0.0E0	402	00.00
90. 00 09000 CLI NI C 91. 00 09100 EMERGENCY	0	58, 819 790, 707	1, 031 13, 861		492 5, 524	90.00 91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	190, 101	13, 801	804, 568	5, 524	91.00
SPECIAL PURPOSE COST CENTERS				0		72.00
113. 00 11300 I NTEREST EXPENSE						113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) 0	7, 706, 628	135, 099	7, 841, 727	49, 464	
NONREI MBURSABLE COST CENTERS	-	.,		.,		
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	24, 260	425	24, 685	0	190.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	C	0	102	192.00
194.0007953 OTHER NONREIMBURSABLE COST CENTERS	0	284, 972	4, 996	289, 968	0	194.00
194. 01 07951 SPORTS MEDI CI NE	0	0	C	0		194.01
194.0207952 COMMUNITY IND HEALTH	0	112, 247	1, 968	114, 215	741	194. 02
200.00 Cross Foot Adjustments				0		200. 00
201.00 Negative Cost Centers		0	C			201.00
202.00 TOTAL (sum lines 118 through 201)	0	8, 128, 107	142, 488	8, 270, 595	50, 848	202.00

Heal th	Financial Systems FR	ANCI SCAN HEALTH	CRAWFORDSVI LL	E	In Lie	u of Form CMS-	2552-10
	TION OF CAPITAL RELATED COSTS		Provider C		Period: From 01/01/2018		
					To 12/31/2018	Date/Time Pre 5/30/2019 3:2	epared: 23 pm
	Cost Center Description	ADMI NI STRATI VE & GENERAL	OPERATION OF PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		5.00	7.00	8.00	9.00	10.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINISTRATIVE & GENERAL	1, 081, 443					5.00
7.00	00700 OPERATION OF PLANT	53, 939	613, 403				7.00
8.00	00800 LAUNDRY & LINEN SERVICE	11, 070	20, 243				8.00
9.00	00900 HOUSEKEEPI NG	14, 745	1, 616				9.00
10.00	01000 DI ETARY	13, 196	20, 158			255, 037	
11.00	01100 CAFETERI A	8, 033	11, 057		0 1, 147	0	
13.00	01300 NURSING ADMINISTRATION	22, 745	6, 628		0 688	0	
14.00	01400 CENTRAL SERVICES & SUPPLY	12, 976	37, 039			0	
15.00	01500 PHARMACY	17, 323	1, 963	1	0 204	0	
16.00	01600 MEDICAL RECORDS & LIBRARY	15, 622	12, 660		0 1, 314	0	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS	1			. 1		-
30.00	03000 ADULTS & PEDIATRICS	82, 968	102, 905			123, 780	
31.00	03100 I NTENSI VE CARE UNI T	31, 892	12, 294			21, 626	
40.00	04000 SUBPROVIDER - IPF	43, 543	28, 199	23, 26	5 2, 926	109, 631	40.00
	ANCI LLARY SERVICE COST CENTERS					-	
50.00	O5000 OPERATING ROOM	61, 047	41, 043			0	
54.00	05400 RADI OLOGY-DI AGNOSTI C	82, 039	101, 269			0	
54.01	05401 ULTRASOUND	4, 771	1, 839		0 191	0	
55.00	05500 RADI OLOGY-THERAPEUTI C	25, 558	0		0 0	0	00.00
56.00	05600 RADI OI SOTOPE	4,020	1, 747		0 181	0	
60.00	06000 LABORATORY	69, 902	35, 239		0 3, 657	0	
65.00	06500 RESPI RATORY THERAPY	14, 191	2, 656			0	
66.00	06600 PHYSI CAL THERAPY	20, 477	15, 238			0	
69.00	06900 ELECTROCARDI OLOGY	10, 339	2, 113		0 219	0	
71.00	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	28, 312	9, 238		0 959	0	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	12, 492	0		0 0	0	
73.00	07300 DRUGS CHARGED TO PATIENTS	222, 499	27, 944		0 2, 900	0	
76. 98	07698 HYPERBARI C OXYGEN THERAPY	227	0	1	0 0	0	76. 98
~~~~~	OUTPATIENT SERVICE COST CENTERS	( 0.10	F F ( 0		0 570	0	
90.00		6,849	5, 568		0 578	0	
91.00	09100 EMERGENCY	98, 565	74, 849	62, 81	5 7, 767	0	/ / / 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
112 00	SPECIAL PURPOSE COST CENTERS	1		1			1112 00
	11300 INTEREST EXPENSE	000 040		240.41	1 57 040	255 027	113.00
118.00		989, 340	573, 505	249, 41	4 57, 243	255, 037	118.00
100.00	NONREI MBURSABLE COST CENTERS	( 20	2 207	1	0 220	0	100.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	638	2, 297		0 238 0 0		190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	66, 856	0		0		192.00
	07953 OTHER NONRELMBURSABLE COST CENTERS	7,500	26, 976	1	0 2, 799		194.00
	07951 SPORTS MEDICINE	6, 373			0 0		194.01
	07952 COMMUNITY IND HEALTH	10, 736	10, 625		0 1, 103	0	194.02
200.00	5		_		0	~	200. 00 201. 00
201.00 202.00	5	1, 081, 443	613, 403		0 0 4 61, 383		
202.00	I INAL (Sum THES TIG UNDUGN 201)	1,001,443	013,403	1 249,41	4 01,383	200, 037	1202.00

	2	NCISCAN HEALIH	CRAWFORDSVI LLE			u of Form CMS-2	2552-10
ALLOCA	TION OF CAPITAL RELATED COSTS		Provider CC		Period: From 01/01/2018 To 12/31/2018	Worksheet B Part II Date/Time Pre 5/30/2019 3:2	pared:
	Cost Center Description	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	
		11.00	13.00	14.00	15.00	16.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINISTRATIVE & GENERAL						5.00
7.00	00700 OPERATION OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPI NG						9.00
10.00	01000 DI ETARY						10.00
11.00	01100 CAFETERIA	139, 094	100 111				11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	173	102, 414	455.00			13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	1, 285	946	455, 39			14.00
15.00 16.00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	4, 057 0	2, 992 0		0 49,039 0 0	1/5 /04	15.00
16.00	INPATIENT ROUTINE SERVICE COST CENTERS	0	U		0 0	165, 684	16.00
30.00	03000 ADULTS & PEDIATRICS	19, 692	14, 520		0 0	6, 166	30.00
30.00	03100 I NTENSI VE CARE UNI T	6, 666	4, 915		0 0	1, 439	31.00
40.00	04000 SUBPROVI DER – I PF	12, 825	9, 456		0 0	4, 014	•
40.00	ANCI LLARY SERVICE COST CENTERS	12,023	7,400		0 0	4,014	40.00
50.00	05000 OPERATI NG ROOM	19, 683	14, 515		0 0	14, 281	1 50. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	15, 491	11, 424		0 0	32,650	
54.01	05401 ULTRASOUND	1,832	1, 348		0 0	3, 206	54.01
55.00	05500 RADI OLOGY-THERAPEUTI C	9, 381	6, 915		0 0	5, 190	
56.00	05600 RADI OI SOTOPE	959	710		0 0	2, 496	56.00
60.00	06000 LABORATORY	0	0		0 0	20, 203	60.00
65.00	06500 RESPI RATORY THERAPY	4, 758	3, 509		0 0	2, 504	65.00
66.00	06600 PHYSI CAL THERAPY	6, 830	5, 036		0 0	2, 253	66.00
69.00	06900 ELECTROCARDI OLOGY	4, 585	3, 380		0 0	5, 564	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	323, 32		491	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	132, 06		3, 875	
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 49, 039	35, 630	
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0		0 0	63	76. 98
~~ ~~	OUTPATIENT SERVICE COST CENTERS		1 000				
90.00	09000 CLINIC	1, 765	1, 299		0 0	714	90.00
91.00	09100 EMERGENCY	22, 963	16, 918		0 0	24, 945	
92.00	09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)						92.00
112 00	SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE						1112 00
113.00		132, 945	97, 883	155 20	49,039	14E 404	113.00
116.00	NONREIMBURSABLE COST CENTERS	132, 943	97,003	455, 39	49,039	165, 684	1118.00
190 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0	0	190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	854	628		0 0		192.00
	07953 OTHER NONREIMBURSABLE COST CENTERS	004	020		0 0		194.00
	07951 SPORTS MEDI CI NE	2,868	2, 117		0 0		194.01
	07952 COMMUNITY IND HEALTH	2, 427	1, 786		0 0		194.02
		2, 127	., /00		-	0	200.00
200.00							
		0	0		0 0	0	201.00

Heal th	Fina	inci	al	Syst	ems		
		OF	CAL		DEL	ATED	6

## FRANCI SCAN HEALTH CRAWFORDSVILLE In Lieu of Form CMS-2552-10

ALLOCATION OF CAPITAL	RELATED COSTS		Provider C	CN: 15-0022	Period: From 01/01/2018	Worksheet B Part II	
					To 12/31/2018	Date/Time Pre	
Cost Cent	ter Description	Subtotal	Intern &	Total		5/30/2019 3:2	
			Residents Cost				
			& Post				
			Stepdown				
	_		Adjustments				
		24.00	25.00	26.00			
GENERAL SERVICI				1			
	COSTS-BLDG & FIXT						1.00
	COSTS-MVBLE EQUIP						2.00
	BENEFITS DEPARTMENT RATIVE & GENERAL						4.00 5.00
7.00 00700 OPERATION							7.00
	LINEN SERVICE						8.00
9.00 00900 HOUSEKEEF							9.00
10. 00 01000 DI ETARY	1110						10.00
11.00 01100 CAFETERIA	A						11.00
13.00 01300 NURSI NG A							13.00
	SERVICES & SUPPLY						14.00
15.00 01500 PHARMACY							15.00
16.00 01600 MEDICAL F	RECORDS & LI BRARY						16.00
I NPATI ENT ROUT	INE SERVICE COST CENTERS						
30.00 03000 ADULTS &		1, 546, 785			35		30.00
31.00 03100 I NTENSI VE		221, 183	0				31.00
40. 00 04000 SUBPROVI [		540, 876	0	540, 87	6		40.00
	I CE COST CENTERS		-	1	_		
50.00 05000 0PERATI NO		633, 897	0				50.00
54.00 05400 RADI OLOG		1, 354, 941	0				54.00
54. 01 05401 ULTRASOUN 55. 00 05500 RADI 0L0G		33, 393	0				54.01 55.00
56. 00 05600 RADI 0100		48, 742 29, 158		48, 74			56.00
60.00 06000 LABORATOF		507, 795	0				60.00
65. 00 06500 RESPI RATO		58, 802		58, 80			65.00
66. 00 06600 PHYSI CAL		223, 272	0				66.00
69.00 06900 ELECTROCA		49,906	0	49,90			69.00
	SUPPLIES CHARGED TO PATIENTS	461, 633	l o				71.00
	/. CHARGED TO PATIENTS	148, 431	0				72.00
73.00 07300 DRUGS CHA	ARGED TO PATIENTS	638, 389	0	638, 38	39		73.00
	C OXYGEN THERAPY	290	0	29	90		76. 98
	VICE COST CENTERS						
90. 00 09000 CLI NI C		77, 115					90.00
91.00 09100 EMERGENCY		1, 118, 914	0		4		91.00
	ON BEDS (NON-DISTINCT PART)		0				92.00
SPECIAL PURPOSI							110.00
113.00 11300 I NTEREST				7 (02 50	22		113.00
118.00 SUBTOTALS	S (SUM OF LINES 1 through 117)	7, 693, 522	0	7, 693, 52	.2		118.00
	DWER, COFFEE SHOP & CANTEEN	27, 858	0	27, 85	8		190.00
192. 00 19200 PHYSI CI AM		68, 440	0				192.00
	NREIMBURSABLE COST CENTERS	327, 243	0				192.00
194. 01 07951 SPORTS ME		11, 899	0				194.00
194. 02 07952 COMMUNI TY		141, 633	0	141, 63			194.02
	ot Adjustments	0	0		0		200.00
	Cost Centers	0	0		0		201.00
	um lines 118 through 201)	8, 270, 595	0	8, 270, 59	95		202.00
•	-						

## FRANCI SCAN HEALTH CRAWFORDSVILLE

In Lieu of Form CMS-2552-10

	ncial Systems FR/	ANCI SCAN HEALTH	CRAWFORDSVI LLI	E	In Lie	u of Form CMS-	2552-
COST ALLOCA	TION - STATISTICAL BASIS		Provider CC	CN: 15-0022 P	eri od:	Worksheet B-1	
					rom 01/01/2018		
				1	o 12/31/2018	Date/Time Pre 5/30/2019 3:2	eparec 23 nm
		CAPI TAL REL	ATED COSTS				
	Cost Center Description	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Reconciliation	ADMI NI STRATI VE	:
	·	(SQUARE FEET)	(SQUARE FEET)	BENEFITS		& GENERAL	
			. ,	DEPARTMENT		(ACCUM. COST)	
				(GROSS			
				SALARI ES)			
		1.00	2.00	4.00	5A	5.00	
GENER	RAL SERVICE COST CENTERS						
	O CAP REL COSTS-BLDG & FIXT	117, 598					1 1.
	O CAP REL COSTS-MVBLE EQUIP		117, 598				2.
	O EMPLOYEE BENEFITS DEPARTMENT	723		15, 053, 899			4.
	0 ADMINISTRATIVE & GENERAL	15, 178				41, 811, 228	
	O OPERATION OF PLANT	7,944		227, 496			
	O LAUNDRY & LINEN SERVICE						
		3, 094		148, 665			
	O HOUSEKEEPI NG	247	247	0	-	570, 093	
	0 DI ETARY	3, 081	3, 081	363, 973		510, 183	
	O CAFETERI A	1, 690		C	0 0	310, 564	
	ONURSING ADMINISTRATION	1, 013		277, 400		879, 371	
	O CENTRAL SERVICES & SUPPLY	5, 661		73, 851			
	0 PHARMACY	300	300	415, 120	0 0	669, 735	15.
6.00 01600	0 MEDICAL RECORDS & LIBRARY	1, 935	1, 935	C	0 0	603, 988	16.
I NPA	TIENT ROUTINE SERVICE COST CENTERS						
0.00 03000	0 ADULTS & PEDIATRICS	15, 728	15, 728	1, 271, 106	0 0	3, 207, 721	30.
1.00 0310	OINTENSIVE CARE UNIT	1, 879	1, 879	542, 776	0	1, 233, 008	31.
	O SUBPROVIDER - IPF	4, 310					
	LLARY SERVICE COST CENTERS	,,	.,	.,,	-	.,	
	O OPERATI NG ROOM	6, 273	6, 273	1, 353, 136	0	2, 360, 202	50.
	0 RADI OLOGY-DI AGNOSTI C	15, 478					
	1 ULTRASOUND	281	281			184, 452	
				131, 317			
	0 RADI OLOGY-THERAPEUTI C	0		502, 642			
	0 RADI 0I SOTOPE	267	267	79, 049		155, 424	
	O LABORATORY	5, 386		0	0 0	2, 702, 574	
	0 RESPI RATORY THERAPY	406		316, 871		548, 668	
	O PHYSI CAL THERAPY	2, 329		467,690		791, 706	
	0 ELECTROCARDI OLOGY	323	323	293, 186	0	399, 736	69.
1.00 0710	O MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 412	1, 412	C	0 0	1, 094, 593	71.
2.00 0720	OIMPL. DEV. CHARGED TO PATIENTS	0	0	C	0 0	482, 982	72.
3.00 0730	O DRUGS CHARGED TO PATIENTS	4, 271	4, 271	C	0 0	8, 602, 494	73.
6. 98 07698	8 HYPERBARI C OXYGEN THERAPY	0	0	C	0 0	8, 786	76.
OUTPA	ATIENT SERVICE COST CENTERS					•	
0.00 0900	O CLINIC	851	851	145, 557	0	264, 783	90.
1.00 0910		11, 440	11, 440	1, 635, 259	0		
	O OBSERVATION BEDS (NON-DISTINCT PART)		,	.,,	-		92.
	I AL PURPOSE COST CENTERS	1					1
	OINTEREST EXPENSE				-		113.
18.00	SUBTOTALS (SUM OF LINES 1 through 117)	111, 500	111, 500	14, 643, 897	-9, 434, 145	38, 250, 310	
	EIMBURSABLE COST CENTERS	111, 300	111, 300	17, 043, 077	7, 434, 143	50, 200, 510	1 10.
	O GIFT, FLOWER, COFFEE SHOP & CANTEEN	351	351	C	0	24, 685	100
	O PHYSICIANS' PRIVATE OFFICES	301	301	30, 265			
		4 100	4 100	30, 265			
	3 OTHER NONREI MBURSABLE COST CENTERS	4, 123	4, 123	1/0.000	0		
	1 SPORTS MEDICINE	0	0	160, 233		246, 389	
	2 COMMUNITY IND HEALTH	1, 624	1, 624	219, 504	0	415, 060	
00.00	Cross Foot Adjustments						200.
01.00	Negative Cost Centers						201.
02.00	Cost to be allocated (per Wkst. B,	8, 128, 107	142, 488	3, 825, 841		9, 434, 145	202.
	Part I)						
03.00	Unit cost multiplier (Wkst. B, Part I)	69. 117732	1. 211653	0. 254143	8	0. 225637	
04.00	Cost to be allocated (per Wkst. B,			50, 848	8	1, 081, 443	204.
	Part II)						
1	Unit cost multiplier (Wkst. B, Part			0.003378	3	0. 025865	205.
205.00							
205.00		1	1				206.
	NAHE adjustment amount to be allocated						
205.00 206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						200.
	NAHE adjustment amount to be allocated (per Wkst. B-2) NAHE unit cost multiplier (Wkst. D,						207.

STAL	LLOCATION - STATISTICAL BASIS		Provider C	1	Period: From 01/01/2018 To 12/31/2018	Worksheet B-1 Date/Time Pre 5/30/2019 3:2	epare
	Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPI NG (SQUARE FEET)	DI ETARY (MEALS SERVED)	CAFETERI A (FTES)	
		7.00	8.00	9.00	10.00	11.00	
	GENERAL SERVICE COST CENTERS				1		
00 00 00 00 00 00 00 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA	93, 753 3, 094 247 3, 081 1, 690	252, 282 27, 969 1, 695 0	90, 41. 3, 08 1, 69	1 22, 442 0 0	14, 501	
	01300 NURSI NG ADMI NI STRATI ON	1,013	0	1, 01		18	
	01400 CENTRAL SERVICES & SUPPLY	5, 661	931	5,66		134	
	01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY	300 1, 935	0	30 1, 93		423 0	
	INPATIENT ROUTINE SERVICE COST CENTERS	1,755	0	1, 75	<u> </u>	0	
- H	03000 ADULTS & PEDIATRICS	15, 728	76, 506	15, 72	8 10, 892	2, 053	30
. 00	03100 INTENSIVE CARE UNIT	1, 879	7, 175	1, 87	9 1, 903	695	31
	04000 SUBPROVI DER – I PF	4, 310	23, 533	4, 31	9, 647	1, 337	40
	ANCI LLARY SERVICE COST CENTERS	( 070	22.704	( )7		2.052	1
	05000 OPERATI NG ROOM 05400 RADI OLOGY-DI AGNOSTI C	6, 273 15, 478	33, 704 9, 378	6, 27 15, 47		2, 052 1, 615	
	05401 ULTRASOUND	281	, 3,0	28	-	1, 013	
	05500 RADI OLOGY-THERAPEUTI C	0	0		0 0	978	
00	05600 RADI OI SOTOPE	267	0	26	7 0	100	56
	06000 LABORATORY	5, 386	0	5, 38	6 0	0	60
	06500 RESPI RATORY THERAPY	406	1, 299	40		496	
	06600 PHYSI CAL THERAPY	2, 329	6, 555	2, 32		712	
	06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	323 1, 412	0	32 1, 41		478 0	
	07200 IMPL. DEV. CHARGED TO PATIENTS	1,412	0		0 0	0	
	07300 DRUGS CHARGED TO PATIENTS	4, 271	0	4, 27	-	0	
	07698 HYPERBARI C OXYGEN THERAPY	0	0		0 0	0	
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLI NI C	851	0	85		184	
	09100 EMERGENCY	11, 440	63, 537	11, 44	0 0	2, 394	
	09200 OBSERVATI ON BEDS (NON-DI STINCT PART) SPECI AL PURPOSE COST CENTERS						92
	11300 I NTEREST EXPENSE						1113
B. 00	SUBTOTALS (SUM OF LINES 1 through 117)	87,655	252, 282	84, 31	4 22, 442	13, 860	118
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	351	0	35			190
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		5		192
	07953 OTHER NONREI MBURSABLE COST CENTERS 07951 SPORTS MEDICINE	4, 123	0	4, 12	3 0	299	194
	07952 COMMUNITY IND HEALTH	1, 624	0	1, 62	s	253	
0. OO	Cross Foot Adjustments	.,	-	.,			200
1.00	Negative Cost Centers						201
2.00	Cost to be allocated (per Wkst. B, Part I)	2, 555, 969		772, 96		441, 161	
3.00	Unit cost multiplier (Wkst. B, Part I)	27. 262797	2. 413652	8. 54939		30. 422798	
4. 00	Cost to be allocated (per Wkst. B, Part II)	613, 403	249, 414	61, 38	3 255, 037	139, 094	204
5. 00	Part II) Unit cost multiplier (Wkst. B, Part II)	6. 542756	0. 988632	0. 67892	5 11. 364272	9. 592028	205
6. 00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206

ALLU	CATION - STATISTICAL BASIS		Provider CC	CN: 15-0022	Period: From 01/01/2018 To 12/31/2018	Worksheet B-1 Date/Time Prepar 5/30/2019 3:23 p
	Cost Center Description	NURSI NG ADMI NI STRATI ON (DI RECT NURS. )	CENTRAL SERVI CES & SUPPLY (COSTED REQUI S.)	PHARMACY (COSTED REQUIS.)	MEDI CAL RECORDS & LI BRARY (GROSS CHARGES)	
		13.00	14.00	15.00	16.00	
	VERAL SERVICE COST CENTERS	TT				
00 002 00 004 00 005 00 005	100 CAP REL COSTS-BLDG & FIXT 200 CAP REL COSTS-MVBLE EQUI P 400 EMPLOYEE BENEFITS DEPARTMENT 500 ADMINISTRATIVE & GENERAL 700 OPERATION OF PLANT 800 LAUNDRY & LINEN SERVICE 900 HOUSEKEEPING					
	DOO DI ETARY					10
	100 CAFETERI A					11
	300 NURSI NG ADMI NI STRATI ON	30, 125, 497				1:
	400 CENTRAL SERVICES & SUPPLY	278, 321	100			14
	500 PHARMACY	879, 955	0	1	00	1
	500 MEDI CAL RECORDS & LI BRARY	0	0		0 204, 785, 236	10
I NF	PATIENT ROUTINE SERVICE COST CENTERS	1 1				
00 030	DOO ADULTS & PEDIATRICS	4, 270, 508	0		0 7, 621, 756	30
00 031	100 INTENSIVE CARE UNIT	1, 445, 719	0		0 1, 778, 826	3
	DOO SUBPROVIDER - IPF	2, 781, 254	0		0 4, 961, 845	40
	CILLARY SERVICE COST CENTERS	11			-	
	DOO OPERATING ROOM	4, 269, 157	0		0 17, 652, 344	50
	400 RADI OLOGY-DI AGNOSTI C	3, 359, 933	0		0 40, 358, 311	54
	401 ULTRASOUND	396, 325	0		0 3, 962, 420	54
	500 RADI OLOGY-THERAPEUTI C	2,033,681	0		0 6, 415, 617 0 3, 085, 461	55
	600 RADI OI SOTOPE 2000 LABORATORY	208, 860	0		0 3, 085, 461 0 24, 972, 459	50
	500 RESPIRATORY THERAPY	1, 031, 947	0		0 24, 972, 439	6
	600 PHYSI CAL THERAPY	1, 481, 322	0		0 2, 785, 016	60
	900 ELECTROCARDI OLOGY	994, 251	0		0 6, 878, 046	60
	100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	71		0 607,001	7
	200 IMPL. DEV. CHARGED TO PATIENTS	0	29		0 4, 790, 010	72
00 073	300 DRUGS CHARGED TO PATIENTS	0	0	1	00 44, 026, 805	7:
98 076	698 HYPERBARI C OXYGEN THERAPY	0	0		0 77, 577	70
	TPATIENT SERVICE COST CENTERS					
	DOO CLINIC	381, 925	0		0 882, 138	90
	100 EMERGENCY	4, 979, 898	0		0 30, 834, 894	9
	200 OBSERVATION BEDS (NON-DISTINCT PART)					92
	ECIAL PURPOSE COST CENTERS 300 INTEREST EXPENSE					11:
3. 00 1 1. 3. 00	SUBTOTALS (SUM OF LINES 1 through 117)	28, 793, 056	100	1	204, 785, 236	118
	VREIMBURSABLE COST CENTERS	20, 770, 000	100		201,700,200	
	DOO GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0	190
	200 PHYSI CLANS' PRI VATE OFFI CES	184, 600	0		0 0	192
	953 OTHER NONREIMBURSABLE COST CENTERS	0	0		0 0	194
	951 SPORTS MEDI CI NE	622, 550	0		0 0	194
	952 COMMUNITY IND HEALTH	525, 291	0		0 0	194
0.00	Cross Foot Adjustments					200
. 00	Negative Cost Centers		004.004	077 0		20
2. 00	Cost to be allocated (per Wkst. B, Part I)	1, 114, 616	834, 234	877, 0	22 809, 567	202
3. 00	Unit cost multiplier (Wkst. B, Part I)	0. 036999	8, 342. 340000	8, 770. 2200	0. 003953	203
. 00	Cost to be allocated (per Wkst. B,	102, 414	455, 392	49, 0	39 165, 684	204
. 00	Part II) Unit cost multiplier (Wkst. B, Part	0. 003400	4, 553. 920000	490. 3900	0. 000809	20!
	11)	0.003400	7, 555. 720000	÷70. 3700	0.00009	
. 00	NAHE adjustment amount to be allocated (per Wkst. B-2)					200
	(per wkst. D-2)					

COMPUTATION OF RATIO OF COSTS TO CHARGES		<b>D 1</b> 1 <b>0</b>	AN 15 0000	B 1 1		
		Provider C		Peri od: From 01/01/2018 To 12/31/2018		epared: 23 pm
		Title	XVIII	Hospi tal	PPS	
				Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I, col.	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
	26)	2.00	3.00	4.00	5.00	+
INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	-
30. 00 03000 ADULTS & PEDI ATRI CS	5, 289, 027		5, 289, 02	0	5, 289, 027	30.00
31. 00 03100 I NTENSI VE CARE UNI T	1, 740, 221		1, 740, 22		1, 740, 221	
40. 00 04000 SUBPROVIDER - IPF	2, 755, 631		2, 755, 63		2, 755, 631	
ANCI LLARY SERVICE COST CENTERS		1	_/,			-
50. 00 05000 OPERATI NG ROOM	3, 488, 914		3, 488, 91	4 0	3, 488, 914	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	4, 797, 402		4, 797, 40	02 0	4, 797, 402	2 54.00
54. 01 05401 ULTRASOUND	272, 272		272, 27	0 0	272, 272	2 54.0
55. 00 05500 RADI OLOGY-THERAPEUTI C	1, 341, 455		1, 341, 45	55 0	1, 341, 455	55.00
56. 00 05600 RADI OI SOTOPE	223, 022		223, 02		223, 022	
60. 00 06000 LABORATORY	3, 603, 975		3, 603, 97	75 0	3, 603, 975	60.00
65. 00 06500 RESPI RATORY THERAPY	755, 647		755, 64		755, 647	
66. 00 06600 PHYSI CAL THERAPY	1, 157, 049	0	1, 157, 04	19 0	1, 157, 049	
69. 00 06900 ELECTROCARDI OLOGY	580, 015		580, 01		580, 015	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT			1, 986, 84		1, 986, 846	
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	852, 824		852, 82		852, 824	
73.00 07300 DRUGS CHARGED TO PATIENTS	11, 747, 584		11, 747, 58		11, 747, 584	
76. 98 07698 HYPERBARI C OXYGEN THERAPY	11, 075		11, 07	/5 0	11, 075	76.98
OUTPATIENT SERVICE COST CENTERS	070.004	1	070.00		070.001	
90. 00 09000 CLINIC	378, 221		378, 22			
91.00 09100 EMERGENCY	5, 612, 617		5, 612, 61		5, 612, 617	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PAR SPECIAL PURPOSE COST CENTERS	T) 1, 938, 272		1, 938, 27		1, 938, 272	92.00
113. 00 11300 I NTEREST EXPENSE						113.00
200.00 Subtotal (see instructions)	48, 532, 069	0	48, 532, 06	59 0	48, 532, 069	
201.00 Less Observation Beds	48, 532, 009		1, 938, 27		48, 532, 009	
202.00 Total (see instructions)	46, 593, 797					

Health Financial Systems FR	ANCI SCAN HEALTH	CRAWFORDSVI LL	E	In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CC		Period: From 01/01/2018 To 12/31/2018		
		Title	XVIII	Hospi tal	PPS	
		Charges				
Cost Center Description	Inpati ent	Outpati ent		6 Cost or Other	TEFRA	
			+ col. 7)	Rati o	Inpati ent	
					Ratio	
	6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS				-		
30. 00 03000 ADULTS & PEDI ATRI CS	3, 776, 782		3, 776, 78			30.00
31.00 03100 I NTENSI VE CARE UNI T	1, 719, 574		1, 719, 57			31.00
40. 00 04000 SUBPROVI DER - I PF	4, 770, 834		4, 770, 83	4		40.00
ANCI LLARY SERVI CE COST CENTERS	1			1		
50.00 O5000 OPERATING ROOM	2, 246, 246	14, 078, 504			0.00000	
54.00 05400 RADI OLOGY-DI AGNOSTI C	3, 521, 084	35, 745, 877			0.000000	
54. 01 05401 ULTRASOUND	280, 226	3, 672, 648			0.00000	
55. 00 05500 RADI OLOGY-THERAPEUTI C	31, 858	6, 155, 622			0.00000	
56. 00 05600 RADI OI SOTOPE	101, 196	2, 523, 737			0.000000	
60. 00 06000 LABORATORY	4, 821, 786	19, 181, 340			0.00000	
65. 00 06500 RESPI RATORY THERAPY	1, 507, 932	821, 561			0. 000000	
66. 00 06600 PHYSI CAL THERAPY	371, 945	2, 413, 071			0. 000000	
69. 00 06900 ELECTROCARDI OLOGY	961, 066	5, 864, 472			0. 000000	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 463, 027	5, 222, 023			0. 000000	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	801, 834	3, 988, 176			0.000000	
73.00 07300 DRUGS CHARGED TO PATIENTS	5, 569, 709	38, 457, 096			0.000000	
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	77, 577	77, 57	7 0. 142761	0. 000000	76. 98
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	882, 138			0. 000000	
91. 00 09100 EMERGENCY	2, 435, 078	27, 418, 563			0. 000000	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	3, 902, 654	3, 902, 65	4 0. 496655	0. 000000	92.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300 I NTEREST EXPENSE						113.00
200.00 Subtotal (see instructions)	34, 380, 177	170, 405, 059	204, 785, 23	6		200.00
201.00 Less Observation Beds						201.00
202.00  Total (see instructions)	34, 380, 177	170, 405, 059	204, 785, 23	6		202.00

Heal th	Financial Systems	FRANCI SCAN HEALTH	CRAWFORDSVI LLE	In Lie	u of Form CMS-	2552-10
COMPUT	ATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0022	Peri od: From 01/01/2018 To 12/31/2018	Worksheet C Part I Date/Time Pre 5/30/2019 3:2	
			Title XVIII	Hospi tal	PPS	
	Cost Center Description	PPS Inpatient				
		Ratio				
	Γ	11.00				
	INPATIENT ROUTINE SERVICE COST CENTERS					
	03000 ADULTS & PEDIATRICS					30.00
	03100 I NTENSI VE CARE UNI T					31.00
	04000 SUBPROVI DER – I PF					40.00
	ANCI LLARY SERVI CE COST CENTERS					
	05000 OPERATI NG ROOM	0. 213719				50.00
	05400 RADI OLOGY-DI AGNOSTI C	0. 122174				54.00
	05401 ULTRASOUND	0. 068880				54.01
	05500 RADI OLOGY-THERAPEUTI C	0. 216802				55.00
	05600 RADI OI SOTOPE	0. 084963				56.00
60.00	06000 LABORATORY	0. 150146				60.00
65.00	06500 RESPI RATORY THERAPY	0. 324383				65.00
66.00	06600 PHYSI CAL THERAPY	0. 415455				66.00
69.00	06900 ELECTROCARDI OLOGY	0. 084977				69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 297207				71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 178042				72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 266828				73.00
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0. 142761				76.98
	OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLI NI C	0. 428755				90.00
	09100 EMERGENCY	0. 188004				91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 496655				92.00
	SPECIAL PURPOSE COST CENTERS					
113.00	11300 INTEREST EXPENSE					113.00
200.00	Subtotal (see instructions)					200.00
201.00	Less Observation Beds					201.00
202.00	Total (see instructions)					202.00

	· · · · · · · · · · · · · · · · · · ·	RANCI SCAN HEALTH				u of Form CMS-	2552-10
COMPUTATI	ION OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 01/01/2018 To 12/31/2018		epared: 23 pm
		1	Titl	e XIX	Hospi tal	Cost	-
					Costs		
	Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.		Di sal I owance	Total Costs	
		1.00	2.00	3.00	4.00	5.00	
	PATIENT ROUTINE SERVICE COST CENTERS						
	000 ADULTS & PEDI ATRI CS	5, 289, 027		5, 289, 02		5, 289, 027	
	100 INTENSIVE CARE UNIT	1, 740, 221		1, 740, 22		1, 740, 221	
	000 SUBPROVI DER – I PF	2, 755, 631		2, 755, 63	31 0	2, 755, 631	40.00
	CILLARY SERVICE COST CENTERS	1					
	OOO OPERATING ROOM	3, 488, 914		3, 488, 9		3, 488, 914	
	400 RADI OLOGY-DI AGNOSTI C	4, 797, 402		4, 797, 40		4, 797, 402	
	401 ULTRASOUND	272, 272		272, 2		272, 272	
	500 RADI OLOGY-THERAPEUTI C	1, 341, 455		1, 341, 4		1, 341, 455	
	600 RADI OI SOTOPE	223, 022		223, 02		223, 022	
	000 LABORATORY	3, 603, 975		3, 603, 9		3, 603, 975	
	500 RESPI RATORY THERAPY	755, 647				755, 647	
	600 PHYSI CAL THERAPY	1, 157, 049		1, 157, 04		1, 157, 049	
	900 ELECTROCARDI OLOGY	580, 015		580, 01		580, 015	
	100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 986, 846		1, 986, 84		1, 986, 846	
	200 IMPL. DEV. CHARGED TO PATIENTS	852, 824		852, 82		852, 824	
	300 DRUGS CHARGED TO PATIENTS	11, 747, 584		11, 747, 58		11, 747, 584	
	698 HYPERBARI C OXYGEN THERAPY	11,075		11, 0	75 0	11, 075	76. 98
	TPATIENT SERVICE COST CENTERS						
	2000 CLINIC	378, 221		378, 22		378, 221	
	100 EMERGENCY	5, 612, 617		5, 612, 61		5, 612, 617	
	200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 938, 272		1, 938, 2	72	1, 938, 272	92.00
	ECIAL PURPOSE COST CENTERS						
	300 INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	48, 532, 069				48, 532, 069	
201.00	Less Observation Beds	1, 938, 272		1, 938, 2		1, 938, 272	
202.00	Total (see instructions)	46, 593, 797	0	46, 593, 79	97 0	46, 593, 797	202.00

Health Financial Systems COMPUTATION OF RATIO OF COSTS TO CHARGES	FRANCI SCAN HEALTH	Provider CC	CN: 15-0022	Period: From 01/01/2018	u of Form CMS- Worksheet C Part I	
				To 12/31/2018	Date/Time Pre 5/30/2019 3:2	pared: 23 pm
		Titl	e XIX	Hospi tal	Cost	<u>.o piii</u>
		Charges				
Cost Center Description	I npati ent	Outpatient	Total (col.	6 Cost or Other	TEFRA	
·		·	+ col. 7)	Ratio	Inpati ent	
					Ratio	
	6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	3, 776, 782		3, 776, 78	32		30.00
31.00 03100 INTENSIVE CARE UNIT	1, 719, 574		1, 719, 57	4		31.00
40. 00 04000 SUBPROVIDER - IPF	4, 770, 834		4, 770, 83	4		40.00
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	2, 246, 246	14, 078, 504	16, 324, 75	0. 213719	0. 000000	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	3, 521, 084	35, 745, 877	39, 266, 96	0. 122174	0.000000	54.00
54.01 05401 ULTRASOUND	280, 226	3, 672, 648	3, 952, 87	4 0.068880	0.00000	54.01
55. 00 05500 RADI OLOGY-THERAPEUTI C	31, 858	6, 155, 622	6, 187, 48	0. 216802	0.000000	55.00
56. 00 05600 RADI 0I SOTOPE	101, 196	2, 523, 737	2, 624, 93	0. 084963	0.000000	56.00
60. 00 06000 LABORATORY	4, 821, 786	19, 181, 340	24, 003, 12	0. 150146	0.00000	60.00
65. 00 06500 RESPI RATORY THERAPY	1, 507, 932	821, 561	2, 329, 49	0. 324383	0.000000	65.00
66. 00 06600 PHYSI CAL THERAPY	371, 945	2, 413, 071	2, 785, 01	6 0. 415455	0.000000	66.00
69. 00 06900 ELECTROCARDI OLOGY	961, 066	5, 864, 472	6, 825, 53	0. 084977	0.00000	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIE	NTS 1, 463, 027	5, 222, 023	6, 685, 05	0. 297207	0.00000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	801, 834	3, 988, 176	4, 790, 01	0 0.178042	0.00000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	5, 569, 709	38, 457, 096	44, 026, 80	0. 266828	0.00000	73.00
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	77, 577	77, 57	0. 142761	0.00000	76.98
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0	882, 138	882, 13	0. 428755	0.00000	90.00
91.00 09100 EMERGENCY	2, 435, 078	27, 418, 563	29, 853, 64	0. 188004	0.00000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PA	ART) O	3, 902, 654	3, 902, 65	0. 496655	0.000000	92.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300 INTEREST EXPENSE						113.00
200.00 Subtotal (see instructions)	34, 380, 177	170, 405, 059	204, 785, 23	6		200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	34, 380, 177	170, 405, 059	204, 785, 23	6		202.00

Health Financial Systems	FRANCI SCAN HEALTH	CRAWFORDSVI LLE	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0022	Period: From 01/01/2018 To 12/31/2018	Worksheet C Part I Date/Time Pre 5/30/2019 3:2	
		Title XIX	Hospi tal	Cost	
Cost Center Description	PPS Inpatient				
	Ratio				
	11.00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS					30.00
31.00 03100 INTENSIVE CARE UNIT					31.00
40. 00 04000 SUBPROVI DER – I PF					40.00
ANCI LLARY SERVI CE COST CENTERS					
50.00 05000 OPERATING ROOM	0. 000000				50.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000				54.00
54.01 05401 ULTRASOUND	0. 000000				54.01
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000				55.00
56. 00 05600 RADI OI SOTOPE	0. 000000				56.00
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
69. 00 06900 ELECTROCARDI OLOGY	0. 000000				69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIE					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
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 000000				76. 98
OUTPATIENT SERVICE COST CENTERS	F				
90. 00 09000 CLINIC	0. 000000				90.00
91.00 09100 EMERGENCY	0. 000000				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PA	RT) 0. 000000				92.00
SPECIAL PURPOSE COST CENTERS	F				
113.00 11300 INTEREST EXPENSE					113.00
200.00 Subtotal (see instructions)					200. 00
201.00 Less Observation Beds					201.00
202.00  Total (see instructions)					202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS         Provider CCN: 15-0022         Period: From 01/01/2018         Worksheet D Part I Date 71 me Prepared: 5/30/2019 3:23 pm           Cost Center Description         Capital Rel ated Cost (from Wkst. B) Part II, col. 26)         Swing Bed Adjustment         Reduced Capital Rel ated Cost (col. 1 - col. 20)         Total Patient Days         Per Diem (col. 3 / col. 4)         Per Diem (col. 3 / col. 4)           1.00         2.00         3.00         4.00         5.00         3         3         0           30.00         ADULTS & PEDIATRICS         1,546,785         0         1,546,785         4,074         379.67         30.00           30.00         INPATIENT ROUTINE SERVICE COST CENTERS         1,546,785         0         1,546,785         4,074         379.67         30.00           30.00         INTENSIVE CARE UNIT         221,183         450         491.52         31.00           40.00         Distrovice Cost Centers         0         2,308,844         0         2,308,844         6,810         200.00         200.00           Cost Center Description         Inpatient Program days         Program Capital Cost (col. 5 x col. 6)         7.00         30.00         30.00         30.00         30.00         30.00           1NPATIENT ROUTINE SERVICE COST CENTERS <td< th=""><th>Health Financial Systems</th><th>FRANCI SCAN HEALTH</th><th>I CRAWFORDSVI LL</th><th>E</th><th>In Lie</th><th>eu of Form CMS-:</th><th>2552-10</th></td<>	Health Financial Systems	FRANCI SCAN HEALTH	I CRAWFORDSVI LL	E	In Lie	eu of Form CMS-:	2552-10
Impact of the service cost center Description         Capital Related Cost (col. 1 - col. 26)         Total Patient Prepared: 5/30/2019 (col. 3)         Date/Time Prepared: 5/30/2019 (col. 3)           Impact of the service cost center Description         Related Cost (col. 1 - col. 26)         Total Patient Per Diem (col. 3)         Per Diem (col. 3)         3 / col. 4)           Impact of the service cost centers         1.00         2.00         3.00         4.00         5.00           Impact of the service cost centers         1.546,785         0         1.546,785         0         1.546,785         4.074         379,67         30.00           30.00         ADULTS & PEDIATRICS         1.546,785         0         1.540,876         2.2,183         450         491,52         31.00           40.00         SUBPROVIDER - 1PF         540,876         0         540,876         2.308,844         2.308,844         6,810         200.00           200.00         Total (lines 30 through 199)         2.308,844         1.101         2.00.00         2.00.00         2.00.00         2.00.00         2.00.00         2.00.00         2.00.00         2.00.00         2.00.00         2.00.00         2.00.00         2.00.00         2.00.00         2.00.00         2.00.00         2.00.00         2.00.00         2.00.00         2.00.00	APPORTIONMENT OF INPATIENT ROUTINE SERVICE C	API TAL COSTS	Provider C				
Cost Center Description         Capital Related Cost (from Wkst. B, Part II, col. 26)         Swing Bed Adjustment         Reduced Capital Related Cost (col. 1 - col. 2)         Total Patient Days         Per Diem (col. 3 / col. 4)           30.00         ADULTS & PEDIATRICS         1,546,785         0         1,546,785         4,074         379.67         30.00           40.00         SUBPROVIDER - IPF         20,844         0         540,876         231.00         20.00         30.00         4.00         5.00           INPATIENT ROUTINE SERVICE COST CENTERS           30.00         ADULTS & PEDIATRICS         1,546,785         0         1,546,785         4,074         379.67         30.00           200.00         Total (Lines 30 through 199)         2,308,844         221,183         221,183         450         491.52         31.00           Cost Center Description         Inpatient Program days         Inpatient Program         2,308,844         6,810         200.00           Inpatient Program days         1.462         555,078         30.00         30.00           INPATIENT ROUTINE SERVICE COST CENTERS           30.00         AULT S & PEDIATRICS           1.462         555,078         30.00							nored.
Cost Center Description         Capital Related Cost (from Wkst. B, Part II, col. 26)         Swing Bed Adjustment         Reduced Capital Related Cost (col. 1 - col. 2)         Total Patient Days         Per Diem (col. 3 / col. 4)           1.00         2.00         3.00         4.00         5.00           1.00         2.00         3.00         4.00         5.00           1.00         2.00         3.00         4.00         5.00           1.00         2.00         3.00         4.00         5.00           1.00         SUBPROVIDER - IPF         1,546,785         4,074         379.67         30.00           200.00         Total Patient Program         22,308,844         22,308,844         22,308,844         22,308,844         6,810         200.00           200.00         Total (lines 30 through 199)         2,308,844         2,308,844         2,308,844         6,810         200.00         200.00           200.00         Total (lines 30 through 199)         2,308,844         2,308,844         6,810         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00 </td <td></td> <td></td> <td></td> <td></td> <td>10 12/31/2018</td> <td>5/30/2019 3·2</td> <td>pared: 3 nm</td>					10 12/31/2018	5/30/2019 3·2	pared: 3 nm
Cost Center Description         Capital Rel ated Cost (from Wkst. B, Part I I, col. 26)         Swing Bed Adjustment         Reduced Capital Rel ated Cost (col. 1 - col. 2)         Total Patient Days         Per Diem (col. 3 / col. 4)           30.00         INPATIENT ROUTINE SERVICE COST CENTERS         1.00         2.00         3.00         4.00         5.00           31.00         INTENSIVE CARE UNIT         221, 183         450         491, 52         31.00           30.00         SUBPROVIDER - IPF         540, 876         0         540, 876         230, 844         2, 308, 844         2, 308, 844         2, 308, 844         2, 308, 844         200.00         200.00         200.00         200.00         200.00         50.00         200.00         200.00         50.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00			Title	2 XVIII	Hospi tal		<u>5 piii</u>
Related Cost (from Wkst. B, Part II, col. 26)         Adjustment Related Cost (col. 1 - col. 2)         Capital Related Cost (col. 1 - col. 2)         Days         3 / col. 4)           1NPATI ENT ROUTINE SERVICE COST CENTERS         1, 546, 785         2)         2)         1.00         5.00           ADULTS & PEDIATRICS         1, 546, 785         0         1, 546, 785         4, 074         379. 67         30. 00           31.00         INTENSIVE CARE UNIT         221, 183         221, 183         450         491.52         31. 00           40.00         SUBPROVIDER - IPF         540, 876         0         540, 876         2, 308, 844         6, 810         200. 00           Cost Center Description         Inpati ent Program Capital Cost (col. 5 x col. 6)         Inpati ent Program Capital Cost (col. 5 x col. 6)         1, 462         555, 078         30. 00           30.00         ADULTS & PEDIATRICS         1, 462         555, 078         30. 00           30.00         ADULTS & PEDIATRICS         1, 462         555, 078         30. 00	Cost Center Description	Capi tal				Per Diem (col.	
Part II, col.         (col. 1 - col.         2)         4           26)         20         3.00         4.00         5.00           30.00         ADULTS & PEDIATRICS         1.00         2.00         3.00         4.00         5.00           31.00         INPATI ENT ROUTINE SERVICE COST CENTERS         1,546,785         0         1,546,785         4,074         379.67         30.00           40.00         SUBPROVIDER - IPF         540,876         0         540,876         2,286         236.60         40.00           200.00         Total (lines 30 through 199)         2,308,844         2,308,844         2,308,844         6,810         200.00           200.00         Total (lines 30 through 199)         2,308,844         2,308,844         6,810         200.00           Cost Center Description         Inpatient Program days         Program Capital Cost (col. 5 x col. 6)         6)         30.00           30.00         ADULTS & PEDIATRICS         1,462         555,078         30.00           31.00         INTENSI VE CARE UNIT         220         108,134         31.00           40.00         SUBPROVIDER - IPF         1,753         414,760         40.00		Related Cost		Capi tal			
26)         2)         2)           1.00         2.00         3.00         4.00         5.00           30.00         ADULTS & PEDIATRICS         1,546,785         0         1,546,785         4,074         379.67         30.00           40.00         SUBPROVIDER - IPF         540,876         0         540,876         2,308,844         2,308,844         6,810         200.00         200.00         Total (lines 30 through 199)         2,308,844         2,308,844         6,810         200.00         200.00         Cost Center Description         Inpatient Program Capital Cost (col . 5 x col . 6)         6.00         7.00         200.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.		(from Wkst. B,		Related Cost		,	
INPATI ENT ROUTINE SERVICE COST CENTERS         1.00         2.00         3.00         4.00         5.00           30.00         ADULTS & PEDIATRICS         1,546,785         0         1,546,785         4,074         379.67         30.00           31.00         INTENSI VE CARE UNIT         221,183         450         491.52         31.00           40.00         SUBPROVI DER - I PF         540,876         0         540,876         2,308,844         2,308,844         6,810         200.00           200.00         Total (Lines 30 through 199)         2,308,844         2,308,844         6,810         200.00         200.00           Cost Center Description         Inpatient Program days         Inpatient Program days         Inpatient Cost cost         1,462         555,078         30.00           30.00         ADULTS & PEDIATRICS         1,462         555,078         30.00         30.00           31.00         INTENSIVE CARE UNIT         220         108,134         31.00         31.00		Part II, col.		(col. 1 - col.			
INPATI ENT ROUTI NE SERVI CE COST CENTERS           30. 00         ADULTS & PEDI ATRI CS         1, 546, 785         0         1, 546, 785         4, 074         379. 67         30. 00           31. 00         INTENSI VE CARE UNI T         221, 183         450         491. 52         31. 00           40. 00         SUBPROVI DER - I PF         540, 876         0         540, 876         2, 286         236. 60         40. 00           200. 00         Total (Lines 30 through 199)         2, 308, 844         2, 308, 844         2, 308, 844         200. 00         200. 00         200. 00         20. 00         20. 00         20. 00         200. 00         20. 00         20. 00         20. 00         20. 00         20. 00         20. 00         20. 00         20. 00         20. 00         200. 00         200. 00         200. 00         200. 00         200. 00         200. 00         200. 00         200. 00         200. 00         200. 00         200. 00         200. 00         200. 00         200. 00         200. 00         200. 00         200. 00         200. 00         200. 00         200. 00         200. 00         200. 00         200. 00         200. 00         200. 00         200. 00         200. 00         200. 00         200. 00         200. 00         200. 00		26)		2)			
30. 00       ADULTS & PEDIATRICS       1,546,785       0       1,546,785       4,074       379.67       30.00         31. 00       INTENSI VE CARE UNIT       221,183       450       491.52       31.00         40. 00       SUBPROVIDER - IPF       540,876       0       540,876       2,286       236.60       40.00         200. 00       Total (Lines 30 through 199)       2,308,844       2,308,844       2,308,844       200.00         Cost Center Description       Inpatient       Program Capital Cost (col. 5 x col. 6)       Inpatient       Program Capital Cost (col. 5 x col. 6)       30.00         30. 00       ADULTS & PEDIATRICS       1,462       555,078       30.00         31. 00       INTENSI VE CARE UNIT       220       108,134       31.00		1.00	2.00	3.00	4.00	5.00	
31. 00       INTENSIVE CARE UNIT       221, 183       450       491. 52       31. 00         40. 00       SUBPROVIDER - IPF       540, 876       0       540, 876       2, 286       236. 60       40. 00         200. 00       Total (lines 30 through 199)       2, 308, 844       2, 308, 844       6, 810       200. 00         Cost Center Description       Inpati ent Program days       Program Capital Cost (col. 5 x col. 6)	INPATIENT ROUTINE SERVICE COST CENTERS	S					
40. 00       SUBPROVIDER - IPF       540, 876       0       540, 876       2, 286       236. 60       40. 00         200. 00       Total (lines 30 through 199)       2, 308, 844       1 npati ent       2, 308, 844       6, 810       200. 00         Cost Center Description       Inpati ent       Program days       Capital Cost       (col. 5 x col. 6)       6.00       7.00         INPATI ENT ROUTINE SERVICE COST CENTERS         30. 00       ADULTS & PEDIATRICS       1, 462       555, 078       30. 00         31. 00       INTENSI VE CARE UNIT       220       108, 134       31. 00         40. 00       SUBPROVIDER - IPF       1, 753       414, 760       40. 00	30. 00 ADULTS & PEDIATRICS	1, 546, 785	0	1, 546, 78	5 4, 074	379.67	30.00
200. 00         Total (lines 30 through 199)         2, 308, 844         2, 308, 844         2, 308, 844         6, 810         200. 00           Cost Center Description         Inpatient Program days         Inpatient Program Capital Cost (col. 5 x col. 6)         Inpatient Program Capital Cost (col. 5 x col. 6)         Inpatient Program Capital Cost (col. 5 x col. 6)         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1 <t< td=""><td>31.00 INTENSIVE CARE UNIT</td><td>221, 183</td><td></td><td>221, 183</td><td>3 450</td><td>491.52</td><td>31.00</td></t<>	31.00 INTENSIVE CARE UNIT	221, 183		221, 183	3 450	491.52	31.00
Cost Center Description       Inpatient Program days       Inpatient Program Capital Cost (col. 5 x col. 6)         30.00       ADULTS & PEDI ATRICS       1,462       555,078       30.00         31.00       INTENSI VE CARE UNI T       220       108,134       31.00         40.00       SUBPROVI DER - I PF       1,753       414,760       40.00	40.00 SUBPROVIDER - IPF	540, 876	0	540, 870	5 2, 286	236.60	40.00
INPATI ENT ROUTI NE SERVI CE COST CENTERS         1,462         555,078         30.00         31.00         1NTENSI VE CARE UNI T         220         108,134         31.00         31.00         40.00         SUBPROVI DER - I PF         1,753         414,760         40.00         40.00	200.00 Total (lines 30 through 199)	2, 308, 844		2, 308, 844	4 6, 810		200.00
INPATI ENT ROUTI NE SERVI CE COST CENTERS         6.00         7.00           30.00         ADULTS & PEDI ATRI CS         1,462         555,078         30.00           31.00         INTENSI VE CARE UNI T         220         108,134         31.00           40.00         SUBPROVI DER - I PF         1,753         414,760         40.00	Cost Center Description	I npati ent	I npati ent				
INPATI ENT ROUTI NE SERVI CE COST CENTERS         6.00         7.00           30.00         ADULTS & PEDI ATRI CS         1,462         555,078         30.00           31.00         INTENSI VE CARE UNI T         220         108,134         31.00           40.00         SUBPROVI DER - I PF         1,753         414,760         40.00		Program days	Program				
INPATI ENT ROUTI NE SERVI CE COST CENTERS         6)         30. 00         7. 00           30. 00         ADULTS & PEDI ATRI CS         1, 462         555, 078         30. 00           31. 00         INTENSI VE CARE UNI T         220         108, 134         31. 00           40. 00         SUBPROVI DER - I PF         1, 753         414, 760         40. 00			Capital Cost				
6.00         7.00           INPATIENT ROUTINE SERVICE COST CENTERS         30.00           ADULTS & PEDIATRICS         1,462         555,078         30.00           31.00         INTENSIVE CARE UNIT         220         108,134         31.00           40.00         SUBPROVIDER - IPF         1,753         414,760         40.00							
INPATIENT ROUTINE SERVICE COST CENTERS           30.00         ADULTS & PEDIATRICS         1,462         555,078         30.00           31.00         INTENSIVE CARE UNIT         220         108,134         31.00           40.00         SUBPROVIDER - IPF         1,753         414,760         40.00			(				
30. 00       ADULTS & PEDIATRICS       1,462       555,078       30. 00         31. 00       INTENSIVE CARE UNIT       220       108,134       31. 00         40. 00       SUBPROVIDER - IPF       1,753       414,760       40. 00			7.00				
31.00         INTENSIVE CARE UNIT         220         108, 134         31.00           40.00         SUBPROVIDER - IPF         1, 753         414, 760         40.00			r				
40. 00 SUBPROVIDER - IPF 1,753 414,760 40. 00							
200.00 Total (lines 30 through 199)   3,435  1,077,972  200.00							
	200.00 Total (lines 30 through 199)	3, 435	1, 077, 972	1			200. 00

Health Financial Systems FR	ANCISCAN HEALTH	CRAWFORDSVI LL	E	In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provider C		Period: From 01/01/2018 To 12/31/2018		
			XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,			. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	633, 897					
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 354, 941					54.00
54. 01 05401 ULTRASOUND	33, 393					
55. 00 05500 RADI OLOGY - THERAPEUTI C	48, 742					55.00
56. 00 05600 RADI OI SOTOPE	29, 158					
60. 00 06000 LABORATORY	507, 795					60.00
65. 00 06500 RESPI RATORY THERAPY	58, 802					
66. 00 06600 PHYSI CAL THERAPY	223, 272					
69. 00 06900 ELECTROCARDI OLOGY	49, 906					
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	461, 633				7, 336	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	148, 431				0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	638, 389					
76. 98 07698 HYPERBARI C OXYGEN THERAPY	290	77, 577	0.00373	38 0	0	76. 98
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	77, 115				0	
91. 00 09100 EMERGENCY	1, 118, 914				47, 950	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	566, 852				0	
200.00   Total (lines 50 through 199)	5, 951, 530	194, 518, 046		12, 581, 909	332, 335	200. 00

Health Financial Systems	FRANCI SCAN HEALTH	CRAWFORDSVI LL	E	In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER	PASS THROUGH COSTS			Period: From 01/01/2018 To 12/31/2018	Date/Time Pre 5/30/2019 3:2	
			XVIII	Hospi tal	PPS	
Cost Center Description	Nursing School N Post-Stepdown Adjustments	-	Post-Stepdow Adjustments	n Cost	Medical Education Cost	
	1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS 31. 00 03100 I NTENSI VE CARE UNI T	0	0 0		0 0 0 0	0	
40. 00 04000 SUBPROVIDER - IPF	0	0		0 0	0	40.00
200.00 Total (lines 30 through 199)	0	0		0 0	0	200.00
Cost Center Description		Total Costs	Total Patien	t Per Diem (col.	Inpati ent	
	Amount (see	(sum of cols. 1 through 3,	Days	5 ÷ col. 6)	Program Days	
	instructions) n 4.00	ninus col. 4) 5.00	6,00	7.00	8,00	
INPATIENT ROUTINE SERVICE COST CENTERS	4.00	5.00	0.00	7.00	0.00	
30. 00 03000 ADULTS & PEDI ATRI CS	0	0	4,07	4 0.00	1, 462	30.00
31.00 03100 INTENSIVE CARE UNIT		0	45			•
40. 00 04000 SUBPROVIDER - IPF	0	0	2, 28	6 0.00	1, 753	40.00
200.00 Total (lines 30 through 199)		0	6, 81		3, 435	200.00
Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00         03000         ADULTS & PEDIATRICS           31. 00         03100         INTENSIVE CARE UNIT           40. 00         04000         SUBPROVIDER - IPF           200. 00         Total (lines 30 through 199)	0 0 0 0					30.00 31.00 40.00 200.00

Health Financial Systems FR	ANCI SCAN HEALTH	CRAWFORDSVI LL	E	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEE THROUGH COSTS	RVICE OTHER PASS	S Provider C		Period: From 01/01/2018	Worksheet D Part IV	
THROUGH COSTS				To 12/31/2018	Date/Time Pre	
		Title	2 XVIII	Hospi tal	5/30/2019 3: 2: PPS	<u>3 pili</u>
Cost Center Description	Non Physician					
cost center bescription		Post-Stepdown		Post-Stepdown		
	Cost	Adjustments		Adjustments		
	1.00	2A	2.00	3A	3.00	
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATI NG ROOM	0	0		0 0	0	50.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	54.00
54. 01 05401 ULTRASOUND	0	0		0 0	0	54.01
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0 0	0	55.00
56. 00 05600 RADI OI SOTOPE	0	0		0 0	0	56.00
60. 00 06000 LABORATORY	0	0		0 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 0	0	66.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0		0 0	0	76. 98
OUTPATIENT SERVICE COST CENTERS	-	_	1	-1 -	-	
90. 00 09000 CLINIC	0	0		0 0	0	90.00
91.00 09100 EMERGENCY	0	0		0 0	0	91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)	0				0	92.00
200.00   Total (lines 50 through 199)	0	0	1	0 0	0	200. 00

Heal th	Financial Systems FR	ANCI SCAN HEALTH	CRAWFORDSVI LL	E	In Lie	u of Form CMS-	2552-10
	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PASS	S Provider C		Period:	Worksheet D	
THROUG	H COSTS				From 01/01/2018 To 12/31/2018		narodi
					10 12/31/2010	5/30/2019 3:2	
-			Title	XVIII	Hospi tal	PPS	<u> </u>
	Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
		Medi cal	(sum of cols.	Outpatient	(from Wkst. C,	to Charges	
		Education Cost	1, 2, 3, and	Cost (sum of		(col. 5 ÷ col.	
			4)	col s. 2, 3,	8)	7)	
				and 4)			
		4.00	5.00	6.00	7.00	8.00	
	ANCI LLARY SERVI CE COST CENTERS	1		1			
50.00	05000 OPERATING ROOM	0	C		0 16, 324, 750		
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	C		0 39, 266, 961	0.000000	•
54.01	05401 ULTRASOUND	0	C		0 3, 952, 874		
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0		0 6, 187, 480		
56.00	05600 RADI OI SOTOPE	0	0		0 2, 624, 933		
60.00	06000 LABORATORY	0	0		0 24, 003, 126		
65.00	06500 RESPI RATORY THERAPY	0	0		0 2, 329, 493		
66.00	06600 PHYSI CAL THERAPY	0	0		0 2, 785, 016		
	06900 ELECTROCARDI OLOGY	0	0		0 6, 825, 538		
	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	0		0 6, 685, 050		•
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0 4, 790, 010		
	07300 DRUGS CHARGED TO PATIENTS	0	0		0 44, 026, 805		
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0		0 77, 577	0.00000	76. 98
	OUTPATIENT SERVICE COST CENTERS	-		1			
	09000 CLINIC	0	0		0 882, 138		
	09100 EMERGENCY	0	0		0 29, 853, 641	0.000000	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 3, 902, 654		
200.00	Total (lines 50 through 199)	0	C	1	0 194, 518, 046		200.00

	ANCI SCAN HEALTH		E	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER THROUGH COSTS	EVICE OTHER PASS	Provider CO		Period: From 01/01/2018 To 12/31/2018		pared: 3 pm
		Title	XVIII	Hospi tal	PPS	
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.		Costs (col.	3	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 OPERATI NG ROOM	0. 000000	1, 531, 304		0 5, 738, 477	0	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	2, 008, 269		0 10, 835, 268	0	54.00
54. 01 05401 ULTRASOUND	0. 000000	164, 690		0 1, 092, 674	0	54.01
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000	31, 858		0 2, 677, 433	0	55.00
56. 00 05600 RADI 0I SOTOPE	0. 000000	71, 955		0 1, 083, 318	0	56.00
60. 00 06000 LABORATORY	0. 000000	2, 729, 785		0 4, 161, 830	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	1, 015, 496		0 456, 763	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	204, 918		0 40, 433	0	66.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	530, 284		0 2, 162, 881	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	106, 229		0 95, 537	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	2, 907, 760		0 15, 215, 080	0	73.00
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 000000	0		0 77, 463	0	76. 98
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0. 000000	0		0 403, 708	0	90.00
91.00 09100 EMERGENCY	0. 000000	1, 279, 361		0 7, 146, 511	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	0		0 1, 458, 060	0	92.00
200.00 Total (lines 50 through 199)		12, 581, 909		0 52, 645, 436	0	200. 00

Health Financial Systems Fi	ANCI SCAN HEALTE	I CRAWFORDSVILL	E .	In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AN	D VACCINE COST	Provider C		Period: From 01/01/2018 To 12/31/2018	Date/Time Pre 5/30/2019 3:2	
		Title	XVIII	Hospi tal	PPS	
			Charges		Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed		Cost	PPS Services	
	Ratio From	Services (see		Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins			
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 O5000 OPERATING ROOM	0. 213719			0 0	1, 226, 422	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 122174			0 0	1, 323, 788	
54. 01 05401 ULTRASOUND	0. 068880			0 0	75, 263	
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 216802			0 0	580, 473	
56. 00 05600 RADI OI SOTOPE	0. 084963	1, 083, 318		0 0	92, 042	56.00
60. 00 06000 LABORATORY	0. 150146			0 0	624, 882	
65. 00 06500 RESPI RATORY THERAPY	0. 324383	456, 763		0 0	148, 166	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 415455	40, 433		0 0	16, 798	66.00
69. 00 06900 ELECTROCARDI OLOGY	0. 084977	2, 162, 881		0 0	183, 795	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 297207	95, 537		0 0	28, 394	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 178042	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 266828	15, 215, 080		0 2,402	4, 059, 809	73.00
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 142761	77, 463		0 0	11, 059	76.98
OUTPATIENT SERVICE COST CENTERS	<u>.</u>	·	•			1
90. 00 09000 CLI NI C	0. 428755	403, 708		0 0	173, 092	90.00
91.00 09100 EMERGENCY	0. 188004	7, 146, 511	1	0 0	1, 343, 573	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 496655	1, 458, 060	1	0 0	724, 153	92.00
200.00 Subtotal (see instructions)		52, 645, 436	1	0 2,402	10, 611, 709	200.00
201.00 Less PBP Clinic Lab. Services-Program	1			0 0		201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)		52, 645, 436		0 2,402	10, 611, 709	202.00

Health Financial Systems	FRANCISCAN HEALTH	CRAWFORDSVI LL	E	In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES A	ND VACCINE COST	Provider CO		Peri od: From 01/01/2018 To 12/31/2018	Date/Time Pre 5/30/2019 3:2	
			XVIII	Hospi tal	PPS	
	Cos					
Cost Center Description	Cost	Cost				
	Reimbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7.00				
ANCI LLARY SERVI CE COST CENTERS						
50. 00 05000 OPERATING ROOM	0	0				50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0				54.00
54. 01 05401 ULTRASOUND	0	0				54.01
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0				55.00
56. 00 05600 RADI OI SOTOPE	0	0				56.00
60. 00 06000 LABORATORY	0	0				60.00
65. 00 06500 RESPI RATORY THERAPY	0	0				65.00
66. 00 06600 PHYSI CAL THERAPY	0	0				66.00
69. 00 06900 ELECTROCARDI OLOGY	0	0				69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	641				73.00
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0				76. 98
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0	0				90.00
91. 00 09100 EMERGENCY	0	0				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0				92.00
200.00 Subtotal (see instructions)	0	641				200.00
201.00 Less PBP Clinic Lab. Services-Program	ח   0					201.00
Only Charges						
202.00   Net Charges (line 200 - line 201)	0	641				202.00

Health Financial Systems FR	ANCISCAN HEALTH	CRAWFORDSVI LL	E	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provider C	CN: 15-0022	Peri od:	Worksheet D	
		Component	CCN: 15-S022	From 01/01/2018 To 12/31/2018		narod
		component	CCN. 15-3022	10 12/31/2016	5/30/2019 3:2	areu. 3 pm
		Title	× XVIII	Subprovider -	PPS	
				I PF		
Cost Center Description	Capi tal	Total Charges			Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,		(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)			
	26)				5.00	
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	(00.007	44 004 750	0.0000		0	50.00
50.00 O5000 OPERATING ROOM	633, 897				0	
54.00 O5400 RADI OLOGY-DI AGNOSTI C	1, 354, 941				2, 616	
54. 01 05401 ULTRASOUND	33, 393				141	54.01
55. 00 05500 RADI OLOGY-THERAPEUTI C	48, 742				0	55.00
56. 00 05600 RADI 0I SOTOPE	29, 158				76	56.00
60. 00 06000 LABORATORY	507, 795					
65. 00 06500 RESPI RATORY THERAPY	58, 802					
66.00 06600 PHYSI CAL THERAPY	223, 272					
69.00 06900 ELECTROCARDI OLOGY	49, 906					69.00
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	461, 633				1, 308	
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	148, 431				0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	638, 389				5, 322	73.00
76. 98 07698 HYPERBARI C OXYGEN THERAPY	290	77, 577	0.00373	38 0	0	76. 98
OUTPATIENT SERVICE COST CENTERS	77.445	000.400	0.0074		0	00.00
90. 00 09000 CLINIC	77, 115				0	
91.00 09100 EMERGENCY	1, 118, 914				429	
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)	0 E 204 (70	-,,			0	
200.00   Total (lines 50 through 199)	5, 384, 678	194, 518, 046	1	1, 080, 880	29, 789	∠UU. UU

Health Financial Systems FR	ANCI SCAN HEALTH	CRAWFORDSVI LL	E	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	RVICE OTHER PASS	S Provider C	CN: 15-0022	Peri od:	Worksheet D	
THROUGH COSTS		Component	CCN: 15-S022	From 01/01/2018 To 12/31/2018		narad
		component	CCN. 15-3022	10 12/31/2016	Date/Time Pre 5/30/2019 3:23	aneu. 3 pm
		Title	e XVIII	Subprovider -	PPS	
				I PF		
Cost Center Description				ol Allied Health	Allied Health	
	Anestheti st	Post-Stepdown		Post-Stepdown		
	Cost	Adjustments		Adj ustments		
	1.00	2A	2.00	3A	3.00	
ANCI LLARY SERVICE COST CENTERS	-	-	1	-	-	
50. 00 05000 OPERATING ROOM	0	0		0 0	0	50.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	54.00
54. 01 05401 ULTRASOUND	0	0		0 0	0	54.01
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	C		0 0	0	55.00
56. 00 05600 RADI OI SOTOPE	0	0		0 0	0	56.00
60. 00 06000 LABORATORY	0	0		0 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 0	0	66.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0		0 0	0	76. 98
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0	0		0 0	0	90.00
91.00 09100 EMERGENCY	0	C		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0	0	92.00
200.00   Total (lines 50 through 199)	0	0	1	0 0	0	200. 00

Heal th	Financial Systems Ff	RANCI SCAN HEALTH	CRAWFORDSVI LL	E	In Li€	u of Form CMS-	2552-10
	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PASS	S Provider C		Peri od:	Worksheet D	
THROUG	H COSTS		Component	CCN: 15-S022	From 01/01/2018 To 12/31/2018		narod
			component	GCN. 15-3022	10 12/31/2010	5/30/2019 3:2	
			Title	e XVIII	Subprovider -	PPS	
		-			I PF		
	Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
		Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,		
		Education Cost				(col. 5 ÷ col.	
			4)	col s. 2, 3,	8)	7)	
				and 4)			
		4.00	5.00	6.00	7.00	8.00	
F0 00	ANCI LLARY SERVICE COST CENTERS		0		0 1( 224 750	0.00000	50.00
50.00	05000 OPERATING ROOM	0	0		0 16, 324, 750		
	05400 RADI OLOGY-DI AGNOSTI C	0	0		0 39, 266, 961		•
54.01	05401 ULTRASOUND	0	0		0 3, 952, 874		•
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0		0 6, 187, 480		
56.00		0	0		0 2, 624, 933		
60.00		0	0		0 24,003,126		•
65.00	06500 RESPIRATORY THERAPY	0	0		0 2, 329, 493		
	06600 PHYSI CAL THERAPY 06900 ELECTROCARDI OLOGY	0			0 2, 785, 016		
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0			0 6, 825, 538 0 6, 685, 050		•
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 4, 790, 010		
	07300 DRUGS CHARGED TO PATIENTS	0	0		0 44, 026, 805		•
	07698 HYPERBARI C OXYGEN THERAPY	0	0		0 44, 028, 805		•
70.90	OUTPATIENT SERVICE COST CENTERS	0	0		0 11, 311	0.000000	70.90
00 00	09000 CLINIC	0	0		0 882, 138	0, 000000	90.00
	09100 EMERGENCY	0			0 29, 853, 641		
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0 29, 853, 641		
200.00					0 194, 518, 046		200.00
200.00				I	1, 1, 1, 1, 10, 040	I	1-00.00

Health Financial Systems FR	ANCI SCAN HEALTH	CRAWFORDSVI LL	E	In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEI	RVICE OTHER PASS	Provider CC	CN: 15-0022	Peri od:	Worksheet D	
THROUGH COSTS		Component (	CCN: 15-S022	From 01/01/2018 To 12/31/2018		nared
		•		10 12/01/2010	5/30/2019 3:2	
		Title	XVIII	Subprovider -	PPS	
				I PF		
Cost Center Description	Outpatient	Inpati ent	Inpatient	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through		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 SERVI CE COST CENTERS	0.000000	0				50.00
50. 00 05000 OPERATING ROOM	0. 000000	0		0 0	0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	75, 806		0 0	0	54.00
54. 01 05401 ULTRASOUND	0. 000000	16, 731		0 0	0	54.01
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000	0		0 0	0	55.00
56. 00 05600 RADI OI SOTOPE	0. 000000	6, 850		0 0	0	56.00
60. 00 06000 LABORATORY	0. 000000	424, 608		0 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	25, 930		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	127, 422		0 0	0	66.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	6, 075		0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	18, 947		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	367, 060		0 0	0	73.00
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 000000	0		0 0	0	76. 98
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0. 000000	0		0 1, 240	0	90.00
91. 00 09100 EMERGENCY	0. 000000	11, 451		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	0		0 0	0	92.00
200.00 Total (lines 50 through 199)		1, 080, 880		0 1, 240	0	200. 00

Health Financial Systems FR	ANCISCAN HEALTH	CRAWFORDSVI LL	E	In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider CC Component (		Period: From 01/01/2018 To 12/31/2018		
		Ti tl e	XVIII	Subprovider -	PPS	•
			Charges	I PF	Costs	
Cost Center Description	Cost to Charge	DDS Daimbursad		Cost	PPS Services	
cost center bescription	Ratio From	Services (see	Reimbursed	Reimbursed	(see inst.)	
	Worksheet C.	inst.)	Servi ces	Servi ces Not	(300 1131.)	
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins			
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0. 213719	0		0 0	0	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 122174	0		0 0	0	54.00
54. 01 05401 ULTRASOUND	0. 068880	0		0 0	0	54.01
55. 00 05500 RADI OLOGY - THERAPEUTI C	0. 216802	0		0 0	0	55.00
56. 00 05600 RADI OI SOTOPE	0. 084963	0		0 0	0	56.00
60. 00 06000 LABORATORY	0. 150146	0		0 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 324383	0		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 415455	0		0 0	0	66.00
69. 00 06900 ELECTROCARDI OLOGY	0. 084977	0		0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 297207	0		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 178042	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 266828	0		0 570	0	73.00
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 142761	0		0 0	0	76.98
OUTPATIENT SERVICE COST CENTERS	·	•		<u>.</u>		
90. 00 09000 CLINIC	0. 428755	1, 240		0 0	532	90.00
91.00 09100 EMERGENCY	0. 188004	0		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 496655	0		0 0	0	92.00
200.00 Subtotal (see instructions)		1, 240		0 570	532	200.00
201.00 Less PBP Clinic Lab. Services-Program				0 0		201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)		1, 240		0 570	532	202.00

Health Financial Systems Ff	RANCI SCAN HEALTH	CRAWFORDSVI LL	E	In Lie	u of Form CMS-	-2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AN	D VACCINE COST	Provider Concernent (	CN: 15-0022 CCN: 15-S022	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part V Date/Time Pro 5/30/2019 3:2	
		Title	e XVIII	Subprovider - IPF	PPS	
	Cos	sts		· · · · · · · · · · · · · · · · · · ·	·	
Cost Center Description	Cost	Cost				
	Reimbursed Services	Reimbursed Services Not				
	Subject To	Subject To				
		Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7.00	1			
ANCI LLARY SERVI CE COST CENTERS			1			
50. 00 05000 OPERATI NG ROOM	0	0				50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0				54.00
54. 01 05401 ULTRASOUND	0	0				54.01
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0				55.00
56. 00 05600 RADI 0I SOTOPE	0	0				56.00
60. 00 06000 LABORATORY	0	0				60.00
65. 00 06500 RESPI RATORY THERAPY	0	0				65.00
66. 00 06600 PHYSI CAL THERAPY	0	0				66.00
69. 00 06900 ELECTROCARDI OLOGY	0	0				69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	152	1			73.00
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0				76. 98
OUTPATIENT SERVICE COST CENTERS	-	-	1			
90. 00 09000 CLINIC	0	0				90.00
91.00 09100 EMERGENCY	0	0				91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)	0	0				92.00
200.00 Subtotal (see instructions)	0	152				200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201.00
0nl y Charges202.00Net Charges (line 200 - line 201)	0	152				202.00

Health Financial Systems FR	ANCI SCAN HEALTH	CRAWFORDSVI LL	E	In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	) VACCINE COST	Provider CO		Period: From 01/01/2018 To 12/31/2018	Worksheet D Part V Date/Time Pre 5/30/2019 3:2	
		Titl	e XIX	Hospi tal	Cost	
			Charges	-	Costs	
Cost Center Description	Cost to Charge			Cost	PPS Services	
		Services (see		Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins			
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATI NG ROOM	0. 213719			0 1, 895, 935	0	50.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 122174			0 6, 245, 823	0	54.00
54.01 05401 ULTRASOUND	0. 068880			0 642, 906	0	54.01
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 216802			0 2, 434, 981	0	55.00
56. 00 05600 RADI OI SOTOPE	0. 084963			0 226, 973	0	56.00
60. 00 06000 LABORATORY	0. 150146			0 4, 077, 906	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 324383	0		0 274, 117	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 415455	0		0 466, 173	0	66.00
69. 00 06900 ELECTROCARDI OLOGY	0. 084977	0		0 679, 630	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 297207	0		0 120, 849	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 178042	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 266828	0		0 1, 352, 523	0	73.00
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 142761	0		0 0	0	76. 98
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0. 428755	0		0 120, 815	0	90.00
91.00 09100 EMERGENCY	0. 188004	0		0 8, 269, 353	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 496655	0		0 0	0	92.00
200.00 Subtotal (see instructions)	1	0		0 26, 807, 984	0	200.00
201.00 Less PBP Clinic Lab. Services-Program				0 0		201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)		0		0 26, 807, 984	0	202.00

Health Financial Systems FR	ANCISCAN HEALTH	CRAWFORDSVILL	E	In Lie	u of Form CMS	-2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider CO		Peri od: From 01/01/2018 To 12/31/2018	Date/Time Pr 5/30/2019 3::	
			e XIX	Hospi tal	Cost	
		sts				
Cost Center Description	Cost	Cost				
	Reimbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)	-			
	6.00	7.00				
ANCI LLARY SERVI CE COST CENTERS						_
50.00 05000 OPERATING ROOM	0	405, 197	1			50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	763, 077				54.00
54. 01 05401 ULTRASOUND	0	44, 283	1			54.01
55. 00 05500 RADI OLOGY - THERAPEUTI C	0	527, 909				55.00
56. 00 05600 RADI 0I SOTOPE	0	19, 284				56.00
60. 00 06000 LABORATORY	0	612, 281				60.00
65. 00 06500 RESPI RATORY THERAPY	0	88, 919				65.00
66. 00 06600 PHYSI CAL THERAPY	0	193, 674				66.00
69. 00 06900 ELECTROCARDI OLOGY	0	57, 753				69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	35, 917				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	360, 891				73.00
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0				76.98
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0	51, 800				90.00
91.00 09100 EMERGENCY	0	1, 554, 671				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0				92.00
200.00 Subtotal (see instructions)	0	4, 715, 656				200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)	0	4, 715, 656				202.00

FRANCI SCAN	HEALTH	CRAWFORDSVI LLE	

In Lieu of Form CMS-2552-10

	Financial Systems FRANCISCAN HEALTH C	RAWFORDSVI LLE	In Lie	u of Form CMS-2	2552-1
COMPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0022	Peri od:	Worksheet D-1	
			From 01/01/2018 To 12/31/2018	Date/Time Pre	pared.
			10 12/01/2010	5/30/2019 3:2	
		Title XVIII	Hospi tal	PPS	
	Cost Center Description			1 00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
	INPATIENT DAYS				1
	Inpatient days (including private room days and swing-bed day	/s, excluding newborn)		4, 074	1.00
	Inpatient days (including private room days, excluding swing-			4, 074	2.00
	Private room days (excluding swing-bed and observation bed da	ays). If you have only p	rivate room days,	0	3.00
	do not complete this line.			2 501	
	Semi-private room days (excluding swing-bed and observation b Total swing-bed SNF type inpatient days (including private ro		or 21 of the cost	2, 581 0	4.00 5.00
J. 00	reporting period	through becen		0	3.0
6.00	Total swing-bed SNF type inpatient days (including private ro	oom days) after December	31 of the cost	0	6.00
	reporting period (if calendar year, enter 0 on this line)	-			
7.00	Total swing-bed NF type inpatient days (including private roo	om days) through Decembe	r 31 of the cost	0	7.00
8.00	reporting period	m dave) after December	21 of the cost	0	8.00
	Total swing-bed NF type inpatient days (including private roo reporting period (if calendar year, enter 0 on this line)	on days) at ter becenber	ST OF THE COST	0	0.00
	Total inpatient days including private room days applicable t	to the Program (excludin	a swina-bed and	1, 462	9.00
	newborn days)	5 .	5 5		
	Swing-bed SNF type inpatient days applicable to title XVIII o		room days)	0	10.00
	through December 31 of the cost reporting period (see instruc				11 0
	Swing-bed SNF type inpatient days applicable to title XVIII o December 31 of the cost reporting period (if calendar year, e		room days) arter	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XI	X only (including priva	te room days)	0	12.00
	through December 31 of the cost reporting period	3 ( 31	5 /		
	Swing-bed NF type inpatient days applicable to titles V or XI			0	13.00
	after December 31 of the cost reporting period (if calendar y			0	14.0
	Medically necessary private room days applicable to the Progr Total nursery days (title V or XIX only)	all (excluding swing-bed	uays)	0	14.0
	Nursery days (title V or XIX only)			0	
	SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to servic	ces through December 31	of the cost	0.00	17.00
	reporting period				
18.00	Medicare rate for swing-bed SNF services applicable to servic 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 o	f the cost	0.00	19.00
	reporting period				
	Medicaid rate for swing-bed NF services applicable to service	es after December 31 of	the cost	0.00	20.00
	reporting period			E 200 027	21 0
	Total general inpatient routine service cost (see instruction Swing-bed cost applicable to SNF type services through Decemb		ting period (line	5, 289, 027 0	
	5 x line 17)	the cost repor	ting period (inite	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December	- 31 of the cost reporti	ng period (line 6	0	23.00
	x line 18)				
	Swing-bed cost applicable to NF type services through Decembe 7 x line 19)	er 31 of the cost report	ing period (line	0	24.0
	Swing-bed cost applicable to NF type services after December	31 of the cost reportin	a period (line 8	0	25.00
	x line 20)		5 F (	-	
	Total swing-bed cost (see instructions)			0	
	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		5, 289, 027	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-be	d and observation had a	harges)	0	200
	Private room charges (excluding swing-bed charges)	and observation bed c	narges)	0	28.0 29.0
	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	32.0
	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
	Average per diem private room charge differential (line 32 mi	, ,	CTIONS)	0.00 0.00	34.0
	Average per diem private room cost differential (line 34 x li Private room cost differential adjustment (line 3 x line 35)	ne 31)		0.00	
	General inpatient routine service cost net of swing-bed cost	and private room cost d	ifferential (line	5, 289, 027	
	27 minus line 36)			-,, , , , , , , , , , , , , , , , , ,	
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
					1
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ			4 000 5	00.00
38. 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ Adjusted general inpatient routine service cost per diem (see	e instructions)		1, 298. 24	
38. 00 39. 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ	e instructions) e 38)		1, 298. 24 1, 898, 027 0	39.00

		ANCI SCAN HEALTH	CRAWFORDSVILL	E .	In Lie	u of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST		Provider CC		Period: From 01/01/2018	Worksheet D-1	
					o 12/31/2018	Date/Time Pre	pared:
						5/30/2019 3:2	3 pm
	Cost Center Description	Total	Total	XVIII Average Per	Hospital Program Days	PPS Program Cost	
	cost center bescription		Inpatient Days			(col. 3 x col.	
			inpact one bays	col . 2)		4)	
		1.00	2.00	3.00	4.00	5.00	10.00
	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units						42.00
	INTENSIVE CARE UNIT	1, 740, 221	450	3, 867. 16	220	850, 775	43.00
	CORONARY CARE UNIT					-	44.00
	BURN INTENSIVE CARE UNIT						45.00
	SURGI CAL I NTENSI VE CARE UNI T						46.00
47.00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47.00
						1.00	
	Program inpatient ancillary service cost (Wk			-		2, 514, 433	
49.00	Total Program inpatient costs (sum of lines	41 through 48)(	(see instructio	ns)		5, 263, 235	49.00
50.00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inp	atient routine	services (from	Wkst D sum	of Parts L and	663, 212	50.00
00.00			301 11 003 (11 0	intot. D, Sum		000,212	00.00
51.00	Pass through costs applicable to Program inp and IV)	atient ancillar	ry services (fr	om Wkst. D, su	m of Parts II	332, 335	51.00
52.00	Total Program excludable cost (sum of lines					995, 547	
53.00	Total Program inpatient operating cost exclu medical education costs (line 49 minus line		elated, non-phy	sician anesthe	etist, and	4, 267, 688	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION	52)					
54.00	Program di scharges					0	54.00
55.00	Target amount per discharge					0.00	
	Target amount (line 54 x line 55) Difference between adjusted inpatient operat	ing eact and to	arget employet ()	ing E( minug l	ing F2)	0	56.00
	Bonus payment (see instructions)	ing cost and ta	arget amount (i	The so minus i	The 53)	0	57.00 58.00
59.00	Lesser of lines 53/54 or 55 from the cost re	porting period	ending 1996, u	pdated and com	pounded by the	0.00	
	market basket		Ū		. ,		
60.00	Lesser of lines 53/54 or 55 from prior year If line 53/54 is less than the lower of line				be amount by	0.00	60. 00 61. 00
01.00	which operating costs (line 53) are less that					0	01.00
	amount (line 56), otherwise enter zero (see				<u>.</u>		
	Relief payment (see instructions)					0	62.00
	Allowable Inpatient cost plus incentive paym PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see Instru	uctions)			0	63.00
	Medicare swing-bed SNF inpatient routine cos	ts through Dece	ember 31 of the	cost reportir	ng period (See	0	64.00
( 5 00	instructions)(title XVIII only)						( = 00
65.00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts atter Decemb	per 31 of the c	ost reporting	period (See	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line 6	5)(title XVIII	only). For	0	66.00
67.00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routin	e costs through	n December 31 o	f the cost rep	orting period	0	67.00
	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routin	-				0	68.00
00.00	(line 13 x line 20)		becember 31 01	the cost repor	ting period		
69.00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N					0	69.00
70.00	Skilled nursing facility/other nursing facil		•				70.00
71.00	Adjusted general inpatient routine service c	5					71.00
72.00	Program routine service cost (line 9 x line			>			72.00
73.00 74.00	Medically necessary private room cost applic Total Program general inpatient routine serv			ne 35)			73.00 74.00
75.00	Capital -related cost allocated to inpatient	•	,	orksheet B. Pa	rt II. column		75.00
	26, line 45)						
76.00	Per diem capital-related costs (line 75 ÷ li						76.00
77.00 78.00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minu						77.00 78.00
79.00	Aggregate charges to beneficiaries for exces		orovi der record	s)			79.00
80.00	Total Program routine service costs for comp	arison to the c	cost limitation	(line 78 minu	ıs line 79)		80.00
81.00	Inpatient routine service cost per diem limi						81.00
82.00 83.00	Inpatient routine service cost limitation (I Reasonable inpatient routine service costs (						82.00 83.00
83.00 84.00	Program inpatient ancillary services (see in		137				84.00
85.00	Utilization review - physician compensation		ons)				85.00
86.00	Total Program inpatient operating costs (sum		nrough 85)				86.00
87 00	PART IV - COMPUTATION OF OBSERVATION BED PAS					1 402	87.00
87.00 88.00	Total observation bed days (see instructions Adjusted general inpatient routine cost per		⊧line 2)			1, 493	87.00
	Observation bed cost (line 87 x line 88) (se	•	,			1, 938, 272	

Health Financial Systems FR/	ANCISCAN HEALTH	CRAWFORDSVI LL	E	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period: From 01/01/2018	Worksheet D-1	
				To 12/31/2018	Date/Time Pre 5/30/2019 3:2	pared: 3 pm
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (	COST					
90.00 Capital-related cost	1, 546, 785	5, 289, 027	0. 29245	2 1, 938, 272	566, 852	90.00
91.00 Nursing School cost	0	5, 289, 027	0.00000	1, 938, 272	0	91.00
92.00 Allied health cost	0	5, 289, 027	0.00000	1, 938, 272	0	92.00
93.00 All other Medical Education	0	5, 289, 027	0.00000	1, 938, 272	0	93.00

MPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0022 Component CCN: 15-S022	Period: From 01/01/2018 To 12/31/2018	Worksheet D-1 Date/Time Pre 5/30/2019 3:2	pare
		Title XVIII	Subprovider - IPF	PPS	
	Cost Center Description		-	1.00	
	PART I - ALL PROVIDER COMPONENTS				
00	INPATIENT DAYS Inpatient days (including private room days and swing-bed days	s. excluding newborn)		2, 286	1 1.
00 00	Inpatient days (including private room days, excluding swing-t Private room days (excluding swing-bed and observation bed day	bed and newborn days)	ivate room days,	2, 286 0	2
00 00	do not complete this line. Semi-private room days (excluding swing-bed and observation be Total swing-bed SNF type inpatient days (including private roo	5 /	r 31 of the cost	2, 286 0	
00	reporting period Total swing-bed SNF type inpatient days (including private roo	om days) after December	31 of the cost	0	6
00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room reporting period	n days) through December	31 of the cost	0	7
00	Total swing-bed NF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)			0	8
00	Total inpatient days including private room days applicable to newborn days)		Ū.	1, 753	
. 00 . 00	Swing-bed SNF type inpatient days applicable to title XVIII or through December 31 of the cost reporting period (see instruct Swing-bed SNF type inpatient days applicable to title XVIII or	i ons)	3,	0	
. 00	December 31 of the cost reporting period (if calendar year, er Swing-bed NF type inpatient days applicable to titles V or XI)	nter 0 on this line)	5 /	0	
. 00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XI>			0	13
	after December 31 of the cost reporting period (if calendar ye Medically necessary private room days applicable to the Progra			0	
	Total nursery days (title V or XIX only) Nursery days (title V or XIX only) SWING BED ADJUSTMENT			0	
. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es through December 31 c	f the cost	0.00	17
. 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 reporting period	C		0.00	
	Medicaid rate for swing-bed NF services applicable to services reporting period Total general inpatient routine service cost (see instructions		he cost	0. 00 2, 755, 631	
. 00 . 00	Swing-bed cost applicable to SNF type services through December 5 x line 17)		ing period (line	2, 755, 631 0	
	Swing-bed cost applicable to SNF type services after December x line 18)	•		0	
	Swing-bed cost applicable to NF type services through December 7 x line 19) Swing bed cost applicable to NF type convices often December 7		0 1 1	0	
. 00 . 00	Swing-bed cost applicable to NF type services after December 3 x line 20) Total swing-bed cost (see instructions)	on the cost reporting	perrou (TINE 8	0	
	General inpatient routine service cost net of swing-bed cost ( PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(line 21 minus line 26)		2, 755, 631	
	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	
. 00	General inpatient routine service cost/charge ratio (line 27 +	- line 28)		0. 000000	31
	Average private room per diem charge (line 29 ÷ line 3)			0.00	
	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 mir	nus line 33) (coo instruc	tions)	0.00 0.00	
	Average per diem private room cost differential (line 34 x lir			0.00	
. 00	Private room cost differential adjustment (line 3 x line 35)		ffananti-1 (1)	0	36
. 00	General inpatient routine service cost net of swing-bed cost a 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY	anu private room cost di	TTEFENTIAL (TINE	2, 755, 631	37
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU				
	Adjusted general inpatient routine service cost per diem (see			1, 205. 44	
. 00	Program general inpatient routine service cost (line 9 x line			2, 113, 136	
	Medically necessary private room cost applicable to the Progra			0	40

MPUTATI ON	ancial Systems FRA N OF INPATIENT OPERATING COST	NCISCAN HEALTH	Provi der C	CN: 15-0022	Period: From 01/01/2018	eu of Form CMS- Worksheet D-1	
			Component		To 12/31/2018		
			Title	e XVIII	Subprovider -	PPS	<u>23 pii</u>
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	SERY (title V & XIX only)						42
	nsive Care Type Inpatient Hospital Units	0	0	0.0	0 0	0	43
	DNARY CARE UNI T						44
	N INTENSIVE CARE UNIT SICAL INTENSIVE CARE UNIT						45
	ER SPECIAL CARE (SPECIFY)						40
	Cost Center Description				!		
00 Proc	gram inpatient ancillary service cost (Wks	st D-3 col 3	Line 200)			1.00	48
00 Tota	al Program inpatient costs (sum of lines 4			ons)		2, 355, 476	
00 Pass	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and						50
1 1	) Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts						51
and	IV)		-				
	al Program excludable cost (sum of lines 5 al Program inpatient operating cost exclud	,	lated non-nhy	sician anesth	etist, and	444, 549 1, 910, 927	
medi	cal education costs (line 49 minus line 5					1, 710, 727	
	ET AMOUNT AND LIMIT COMPUTATION					0	54
	get amount per discharge					0.00	
	get amount (line 54 x line 55)					0	
	erence between adjusted inpatient operati	ng cost and ta	rget amount (I	ine 56 minus	line 53)	0	
	us payment (see instructions) ser of lines 53/54 or 55 from the cost rep	orting period	ending 1996 i	indated and co	mounded by the	0.00	
	ket basket	berring perrou			inpounded by the	0.00	<u> </u>
	ser of lines 53/54 or 55 from prior year of					0.00	
	ine 53/54 is less than the lower of lines ch operating costs (line 53) are less thar					0	61
	unt (line 56), otherwise enter zero (see i		5 (TTTES 54 X	00), 01 1% 01	the target		
. 00   Rel i	ef payment (see instructions)					0	
	wable Inpatient cost plus incentive payme	ent (see instru	ctions)			0	63
	RAM INPATIENT ROUTINE SWING BED COST care swing-bed SNF inpatient routine cost	s through Dece	mber 31 of the	e cost reporti	ng period (See	0	64
inst	tructions)(title XVIII only)	0			0 1 1		
	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						65
	al Medicare swing-bed SNF inpatient routir	ne costs (line	64 plus line 6	5)(title XVII	l only). For	0	66
	CAH (see instructions)						
	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						67
							68
1 -	(line 13 x line 20)						69
	III - SKILLED NURSING FACILITY, OTHER NU					0	1 0,
	led nursing facility/other nursing facili	2		• •			70
	usted general inpatient routine service co		ine 70 ÷ line	2)			71
	Program routine service cost (line 9 x line 71) Medically necessary private room cost applicable to Program (line 14 x line 35)						73
. 00 Tota	al Program general inpatient routine servi	ce costs (line	72 + line 73)				74
	tal-related cost allocated to inpatient r line 45)	routine service	costs (from W	lorksheet B, P	Part II, column		75
.00 Per	diem capital-related costs (line 75 ÷ lin						76
	<b>3</b>						77
							79
. 00   Tota	al Program routine service costs for compa	arison to the c			us line 79)		80
· ·	atient routine service cost per diem limit		<b>`</b>				81
	atient routine service cost limitation (li sonable inpatient routine service costs (s		•				82
	gram inpatient ancillary services (see ins		<i></i>				84
.00 Utiľ	ization review - physician compensation (	see instructio					85
	al Program inpatient operating costs (sum		rough 85)				86
	<u>IV - COMPUTATION OF OBSERVATION BED PASS</u> al observation bed days (see instructions)					0	87
	isted general inpatient routine cost per c		line 2)			0.00	
00 lobes	ervation bed cost (line 87 x line 88) (see	e instructions)				0	89

Health Financial Systems FR	ANCI SCAN HEALTH CRAWFORDSVILLE			In Lieu of Form CMS-2552-10			
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period: From 01/01/2018	Worksheet D-1		
		Component (		To 12/31/2018			
		Title	XVIII	Subprovider - IPF	PPS		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on		
		(from line 21)	column 2	Observati on	Bed Pass		
				Bed Cost (from	Through Cost		
				line 89)	(col. 3 x col.		
					4) (see		
					instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00 Capital-related cost	540, 876	2, 755, 631	0. 19628	0 0	0	90.00	
91.00 Nursing School cost	0	2, 755, 631	0. 00000	0 0	0	91.00	
92.00 Allied health cost	0	2, 755, 631	0. 00000	0 0	0	92.00	
93.00 All other Medical Education	0	2, 755, 631	0.00000	0 0	0	93.00	

Health Financial Systems FRANCISCAN HEALTH	CRAWFORDSVI LLE		In Lie	u of Form CMS-	2552-10
I NPATI ENT ANCI LLARY SERVI CE COST APPORTI ONMENT	Provider CCN: 15-00		eriod: rom 01/01/2018 o 12/31/2018		epared:
				5/30/2019 3:23 pm	
	Title XVIII	<u> </u>	Hospi tal	PPS	
Cost Center Description	Ratioo			Inpatient	
	To Cha	arges		Program Costs	
			Charges	(col. 1 x col. 2)	
	1. (	00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS			2, 248, 040		30.00
31. 00 03100 I NTENSI VE CARE UNI T			943, 268		31.00
40. 00 04000 SUBPROVI DER – I PF			0		40.00
ANCI LLARY SERVI CE COST CENTERS					
50. 00 05000 OPERATI NG ROOM		. 213719		327, 269	
54. 00 05400 RADI OLOGY-DI AGNOSTI C		. 122174		245, 358	
54. 01 05401 ULTRASOUND		068880		11, 344	
55. 00 05500 RADI OLOGY-THERAPEUTI C		216802		6, 907	
56. 00 05600 RADI OI SOTOPE		084963		6, 114	
60. 00 06000 LABORATORY	0.	150146	2, 729, 785	409, 866	60.00
65. 00 06500 RESPI RATORY THERAPY	-	. 324383		329, 410	65.00
66. 00 06600 PHYSI CAL THERAPY		415455		85, 134	66.00
69. 00 06900 ELECTROCARDI OLOGY	0.	. 084977	530, 284	45, 062	69.00
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS		297207		31, 572	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		178042		0	
73.00 07300 DRUGS CHARGED TO PATIENTS		266828		775, 872	
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0.	142761	0	0	76. 98
OUTPATIENT SERVICE COST CENTERS		100755			
90. 00 09000 CLINIC		428755		0	
91.00 09100 EMERGENCY		188004		240, 525	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.	496655		0	
200.00 Total (sum of lines 50 through 94 and 96 through 98)			12, 581, 909	2, 514, 433	
201.00 Less PBP Clinic Laboratory Services-Program only charge	ges (line 61)		0		201.00
202.00 Net charges (line 200 minus line 201)			12, 581, 909		202.00

	omponent C Title	N: 15-0022 CCN: 15-S022 XVIII Ratio of Cos To Charges 1.00	Program	Worksheet D-3 Date/Time Pre 5/30/2019 3:2 PPS Inpatient Program Costs (col. 1 x col. 2)	pared:
Cost Center Description	Title	XVIII Ratio of Cos To Charges	To 12/31/2018 Subprovi der - IPF t Inpati ent Program Charges	5/30/2019 3:2 PPS Inpatient Program Costs (col. 1 x col.	
Cost Center Description	Title	XVIII Ratio of Cos To Charges	Subprovider - IPF t Inpatient Program Charges	5/30/2019 3:2 PPS Inpatient Program Costs (col. 1 x col.	
		Ratio of Cos To Charges	IPF t Inpatient Program Charges	Inpatient Program Costs (col. 1 x col.	
		To Charges	t Inpatient Program Charges	Program Costs (col. 1 x col.	
		To Charges	Program Charges	Program Costs (col. 1 x col.	
		0	Charges	(col. 1 x col.	
		1.00	3		
		1.00	2 00		
INDATIENT DOUTINE SERVICE COST CENTERS				3.00	
INFATTLINT RUUTINE SERVICE CUST CENTERS	I		2100	0100	
30. 00 03000 ADULTS & PEDI ATRI CS			0		30.00
31.00 03100 INTENSIVE CARE UNIT			0		31.00
40. 00 04000 SUBPROVIDER - IPF			3, 664, 720		40.00
ANCI LLARY SERVI CE COST CENTERS					
50.00 05000 OPERATING ROOM		0. 21371		0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 12217			1
54. 01 05401 ULTRASOUND		0. 06888		1, 152	
55. 00 05500 RADI OLOGY-THERAPEUTI C		0. 21680		0	55.00
56. 00 05600 RADI 0I SOTOPE		0.08496			
60. 00 06000 LABORATORY		0. 15014			
65. 00 06500 RESPIRATORY THERAPY		0. 32438			
66. 00 06600 PHYSI CAL THERAPY		0. 41545			
69. 00 06900 ELECTROCARDI OLOGY 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS		0.08497 0.29720			
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 29720		5, 631	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 26682		-	
76. 98 07698 HYPERBARI C OXYGEN THERAPY		0. 14276		0	
OUTPATIENT SERVICE COST CENTERS	I.	0.14270		0	/0. /0
90. 00 09000 CLINIC		0. 42875	5 0	0	90.00
91.00 09100 EMERGENCY		0. 18800		2, 153	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 49665		0	
200.00 Total (sum of lines 50 through 94 and 96 through 98)			1, 080, 880	242, 340	200.00
201.00 Less PBP Clinic Laboratory Services-Program only charges (I	ine 61)		0		201.00
202.00 Net charges (line 200 minus line 201)			1, 080, 880		202.00

Health Financial Systems FRANCISCAN	N HEALTH CRAWFORDSVILLE	In Lie	u of Form CMS-	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 15-0022	Period: From 01/01/2018 To 12/31/2018		epared:
			5/30/2019 3:2	23 pm
	Title XIX	Hospi tal	Cost	
Cost Center Description	Ratio of Cos To Charges	t Inpatient Program	Inpatient Program Costs	
	To charges		(col. 1 x col.	
		charges	2)	
	1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS		356, 954		30.00
31. 00 03100 I NTENSI VE CARE UNI T		205, 364		31.00
40. 00 04000 SUBPROVIDER - IPF		142, 920		40.00
ANCI LLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0. 2137			
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 1221	74 263, 974	32, 251	54.00
54. 01 05401 ULTRASOUND	0.0688		1, 603	
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 2168	-	0	
56. 00 05600 RADI OI SOTOPE	0. 0849		515	
60. 00 06000 LABORATORY	0. 1501	46 452, 287	67, 909	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 3243	83 125, 376	40, 670	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 4154		4, 564	
69. 00 06900 ELECTROCARDI OLOGY	0. 0849	77 77, 457	6, 582	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 2972		5, 779	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 1780		0	
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 2668		131, 898	
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 1427	61 0	0	76.98
OUTPATIENT SERVICE COST CENTERS				
90. 00 09000 CLINIC	0. 4287		0	
91.00 09100 EMERGENCY	0. 1880		38, 301	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 4966		0	
200.00 Total (sum of lines 50 through 94 and 96 throu		1, 934, 715	385, 171	
201.00 Less PBP Clinic Laboratory Services-Program on	ly charges (line 61)	0		201.00
202.00 Net charges (line 200 minus line 201)		1, 934, 715		202.00

Health Financial Systems FRANCISCAN HEAL	TH CRAWFORDSVILL	E	In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0022	Peri od:	Worksheet D-3	
	Component	CCN: 15-S022	From 01/01/2018 To 12/31/2018	Date/Time Pre	narod
	Component	CCN. 15-3022	10 12/31/2016	5/30/2019 3:2	
	Ti tl	e XIX	Subprovider -	Cost	
			I PF		
Cost Center Description		Ratio of Cos		Inpatient	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
		1.00	2.00	<u>2)</u> 3. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS		1.00	2.00	3.00	
30. 00 03000 ADULTS & PEDI ATRI CS			0		30.00
31. 00 03100 I NTENSI VE CARE UNI T			0		31.00
40. 00 04000 SUBPROVI DER - I PF			0		40.00
ANCI LLARY SERVICE COST CENTERS					10.00
50. 00 05000 OPERATI NG ROOM		0. 2137	19 0	0	50.00
54.00 05400 RADI OLOGY-DI AGNOSTI C		0. 1221		0	54.00
54. 01 05401 ULTRASOUND		0. 0688	30 0	0	54.01
55. 00 05500 RADI OLOGY-THERAPEUTI C		0. 2168	02 0	0	55.00
56. 00 05600 RADI 0I SOTOPE		0.0849	53 0	0	56.00
60. 00 06000 LABORATORY		0. 1501	16 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY		0. 3243	33 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY		0. 4154	55 0	0	66.00
69. 00 06900 ELECTROCARDI OLOGY		0. 0849	77 0	0	69.00
71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS		0. 29720		0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 1780		0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 2668		0	73.00
76. 98 07698 HYPERBARI C OXYGEN THERAPY		0. 1427	51 0	0	76. 98
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLINIC		0. 4287		0	
91.00 09100 EMERGENCY		0. 1880		0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 4966	05 0	0	
200.00 Total (sum of lines 50 through 94 and 96 through 98) 201.00 Less PBP Clinic Laboratory Services-Program only cha			0		200. 00 201. 00
201.00 Less PBP Clinic Laboratory Services-Program only cha 202.00 Net charges (line 200 minus line 201)	arges (ITHE 61)		0		201.00
zuz. vuj jivet charges (Trhe zuu inithus trhe zut)		I	I U		202.00

LCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0022	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part A Date/Time Pre 5/30/2019 3:2	
		Title XVIII	Hospi tal	PPS	- p
				1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS			1.00	
00	DRG Amounts Other than Outlier Payments			0	
01	DRG amounts other than outlier payments for discharges occurr	ing prior to October 1 (	(see	3, 010, 037	1.0
02	instructions) DRG amounts other than outlier payments for discharges occurr	ing on or after October	1 (see	683, 324	1.0
02	instructions)	ing on or arter betober	1 (300	003, 324	1.0
03	DRG for federal specific operating payment for Model 4 BPCI f	or discharges occurring	prior to October	0	1.0
04	1 (see instructions) DRG for federal specific operating payment for Model 4 BPCI f	or discharges occurring	on or after	0	1.0
04	October 1 (see instructions)	of discharges occurring		0	1.0
00	Outlier payments for discharges. (see instructions)			13, 149	
01	Outlier reconciliation amount			0	
02 00	Outlier payment for discharges for Model 4 BPCI (see instruct Managed Care Simulated Payments	I ons)		0	
00	Bed days available divided by number of days in the cost repo	rting period (see instru	uctions)	24.91	
	Indirect Medical Education Adjustment				
00	FTE count for allopathic and osteopathic programs for the mos	t recent cost reporting	period ending on	0.00	5.0
00	or before 12/31/1996. (see instructions) FTE count for allopathic and osteopathic programs that meet t	be criteria for an add-	on to the can for	0.00	6.0
00	new programs in accordance with 42 CFR 413.79(e)		on to the cap for	0.00	0.0
00	MMA Section 422 reduction amount to the IME cap as specified			0.00	
01	ACA § 5503 reduction amount to the IME cap as specified under	42 CFR §412.105(f)(1)(i	v)(B)(2) If the	0.00	7.0
00	cost report straddles July 1, 2011 then see instructions. Adjustment (increase or decrease) to the FTE count for allopa	thic and osteonathic pro	ograms for	0.00	8. (
00	affiliated programs in accordance with 42 CFR 413.75(b), 413.		5	0.00	0.
	1998), and 67 FR 50069 (August 1, 2002).				
01	The amount of increase if the hospital was awarded FTE cap slo	ots under § 5503 of the	ACA. If the cost	0.00	8. (
02	report straddles July 1, 2011, see instructions. 2 The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital				
	under § 5506 of ACA. (see instructions)			0.00	8.0
00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lin	es (8, 8,01 and 8,02)	(see	0.00	9. (
. 00	instructions) FTE count for allopathic and osteopathic programs in the curr	ent year from your recor	ds	0.00	10. (
. 00	FTE count for residents in dental and podiatric programs.		43	0.00	
. 00	Current year allowable FTE (see instructions)			0.00	
. 00	Total allowable FTE count for the prior year.	an and d an an after Car	t	0.00	
. 00	Total allowable FTE count for the penultimate year if that ye otherwise enter zero.	ar ended on or after Sep	otember 30, 1997,	0.00	14.0
. 00	Sum of lines 12 through 14 divided by 3.			0.00	15. (
. 00	Adjustment for residents in initial years of the program				16. (
. 00	Adjustment for residents displaced by program or hospital clo	sure		0.00	
. 00 . 00	Adjusted rolling average FTE count Current year resident to bed ratio (line 18 divided by line 4	)		0.00 0.000000	
. 00	Prior year resident to bed ratio (see instructions)			0.000000	
. 00	Enter the lesser of lines 19 or 20 (see instructions)			0.000000	
. 00	IME payment adjustment (see instructions)			0	
. 01	IME payment adjustment - Managed Care (see instructions) Indirect Medical Education Adjustment for the Add-on for § 42:	2 of the MMA		0	22.
. 00	Number of additional allopathic and osteopathic IME FTE resid		CFR 412.105	0.00	23.0
	(f)(1)(iv)(C).				
. 00	IME FTE Resident Count Over Cap (see instructions)	Lower of Line 22 L'	24 (coo	0.00	
. 00	If the amount on line 24 is greater than -O-, then enter the instructions)	Tower of line 23 of line	e 24 (see	0.00	25.
. 00	Resident to bed ratio (divide line 25 by line 4)			0.000000	26.
. 00	IME payments adjustment factor. (see instructions)			0.000000	
. 00	IME add-on adjustment amount (see instructions)	)		0	
. 01 . 00	IME add-on adjustment amount - Managed Care (see instructions Total IME payment ( sum of lines 22 and 28)	)		0	
. 00	Total IME payment - Managed Care (sum of lines 22.01 and 28.0	1)		0	
	Disproportionate Share Adjustment				
. 00	Percentage of SSI recipient patient days to Medicare Part A p	atient days (see instruc	ctions)	0.00	
. 00	Percentage of Medicaid patient days (see instructions)			0.00	
. 00 . 00	Sum of lines 30 and 31 Allowable disproportionate share percentage (see instructions	)		0.00 0.00	
	Disproportionate share adjustment (see instructions)				34.

ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0022	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part A Date/Time Prep 5/30/2019 3:23	
		Title XVIII	Hospi tal	PPS	
			Prior to 10/1		
			1.00	2.00	
	Uncompensated Care Adjustment				
	Total uncompensated care amount (see instructions)		0	0	35.
	Factor 3 (see instructions)		0. 00000000	0. 000000000	35.
5. 02	Hospital uncompensated care payment (If line 34 is zero, ent	ter zero on this line) (se	ee 0	0	35.
	instructions)		_		
	Pro rata share of the hospital uncompensated care payment an		0	0	35.
6.00	Total uncompensated care (sum of columns 1 and 2 on line 35.		0		36.
0 00	Additional payment for high percentage of ESRD beneficiary of				10
0.00	Total Medicare discharges on Worksheet S-3, Part I excluding	g discharges for MS-DRGS	0		40.
1.00	652, 682, 683, 684 and 685 (see instructions)	492 494 ap 495 (coo	0		41.
1.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, instructions)	003, 004 all 005. (See	0		41.
1.01	Total ESRD Medicare covered and paid discharges excluding MS	S-DRGS 652 682 682 69	4 0		41.
1. 01	an 685. (see instructions)	5 5103 552, 552, 552, 553, 564	.		71.
2.00	Divide line 41 by line 40 (if less than 10%, you do not qual	lify for adjustment)	0.00		42.
3.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 6	<b>j</b>			43.
	instructions)	(	-		
4.00	Ratio of average length of stay to one week (line 43 divided	d by line 41 divided by 7	0.00000		44.
	days)	5			
5.00	Average weekly cost for dialysis treatments (see instruction	ns)	0.00		45.
6.00	Total additional payment (line 45 times line 44 times line 4	41.01)	0		46.
7.00	Subtotal (see instructions)		3, 706, 510		47.
8.00	Hospital specific payments (to be completed by SCH and MDH,	small rural hospitals	3, 549, 516		48.
	only. (see instructions)				
				Amount	
0.00	Total normant for innations operating costs (coo instruction	nc)		1.00	40
9.00 0.00	Total payment for inpatient operating costs (see instruction	-	N N	3, 706, 510 310, 099	49. 50.
	Payment for inpatient program capital (from Wkst. L, Pt. I a Exception payment for inpatient program capital (Wkst. L, Pt		)	310, 044	50.
2.00	Direct graduate medical education payment (from Wkst. E.4, I			0	52.
	Nursing and Allied Health Managed Care payment			0	53.
4.00	Special add-on payments for new technologies			0	54.
	Islet isolation add-on payment			0	54.
5.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line	69)		0	55.
6.00	Cost of physicians' services in a teaching hospital (see int			0	56.
7.00	Routine service other pass through costs (from Wkst. D, Pt.	III, column 9, lines 30	through 35).	0	57.
8.00	Ancillary service other pass through costs from Wkst. D, Pt.	. IV, col. 11 line 200)		0	58.
9.00	Total (sum of amounts on lines 49 through 58)			4, 016, 609	59
0.00	Primary payer payments			4, 634	60.
	Total amount payable for program beneficiaries (line 59 minu	us line 60)		4, 011, 975	61
2.00	Deductibles billed to program beneficiaries			489, 028	62.
3.00	Coinsurance billed to program beneficiaries			1, 675	
4.00	Allowable bad debts (see instructions)			93, 604	
5.00	Adjusted reimbursable bad debts (see instructions)			60, 843	
	Allowable bad debts for dual eligible beneficiaries (see ins	structions)		28, 067	66
7.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			3, 582, 115	67.
8.00	Credits received from manufacturers for replaced devices for			0	68
9.00	Outlier payments reconciliation (sum of lines 93, 95 and 96)	). (FOR SCH SEE INSTRUCTION	15)	0	69
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	stration) adjustment (	instructions)	0	70
0. 00	Rural Community Hospital Demonstration Project (§410A Demons	· •	instructions)	0	70
0. 00 0. 50		11		0	70 70
0. 00 0. 50 0. 87	Demonstration payment adjustment amount before sequestration			0	10
0. 00 0. 50 0. 87 0. 88	Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only)	structions)			70
0. 00 0. 50 0. 87 0. 88 0. 89	Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see ins	structions)			
0. 00 0. 50 0. 87 0. 88 0. 89 0. 90	Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see ins HSP bonus payment HVBP adjustment amount (see instructions)	structions)		0	70
0. 00 0. 50 0. 87 0. 88 0. 89 0. 90 0. 91	Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see ins HSP bonus payment HVBP adjustment amount (see instructions) HSP bonus payment HRR adjustment amount (see instructions)	structions)		0	70 70
0. 00 0. 50 0. 87 0. 88 0. 89 0. 90 0. 91 0. 92	Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see ins HSP bonus payment HVBP adjustment amount (see instructions) HSP bonus payment HRR adjustment amount (see instructions) Bundled Model 1 discount amount (see instructions)	structions)		0 0	70 70 70
0. 00 0. 50 0. 87 0. 88 0. 89 0. 90 0. 91 0. 92 0. 93	Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see ins HSP bonus payment HVBP adjustment amount (see instructions) HSP bonus payment HRR adjustment amount (see instructions)	structions)		0	70. 70. 70. 70. 70. 70.

	Provider CC		Period: From 01/01/2018 To 12/31/2018	5/30/2019 3:2	oare 3 pm
	litle	XVIII	Hospi tal	PPS	
			(уууу)	Amount	
			0	1.00	
96 Low volume adjustment for federal fiscal year (yyyy) (Enter in	column 0	4	2018	464, 730	70.
<ul> <li>the corresponding federal year for the period prior to 10/1)</li> <li>20 Low volume adjustment for federal fiscal year (yyyy) (Enter in the corresponding federal year for the period ending on or after</li> </ul>		2	2019	150, 640	70.
98 Low Volume Payment-3				0	70.
99 HAC adjustment amount (see instructions)				11, 924	
00 Amount due provider (line 67 minus lines 68 plus/minus lines 69	& 70)			4, 170, 042	
01 Sequestration adjustment (see instructions)	u , o,			83, 401	
02 Demonstration payment adjustment amount after sequestration				03,401	71.
1 5 5				-	
				4, 182, 614	
00 Tentative settlement (for contractor use only)	70 1			0	73.
00 Balance due provider/program (line 71 minus lines 71.01, 71.02, 73)				-95, 973	
00 Protested amounts (nonallowable cost report items) in accordance CMS Pub. 15-2, chapter 1, §115.2 TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)	ewith			0	75.
	2.02			0	90.
00 Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of plus 2.04 (see instructions)	∠.∪3			0	90.
				0	01
00 Capital outlier from Wkst. L, Pt. I, line 2				-	91.
00 Operating outlier reconciliation adjustment amount (see instruc				0	92.
00 Capital outlier reconciliation adjustment amount (see instruction				0	93
00 The rate used to calculate the time value of money (see instruc	tions)			0.00	94
00 Time value of money for operating expenses (see instructions)				0	95.
00 Time value of money for capital related expenses (see instruction	ons)			0	96.
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
HSP Bonus Payment Amount					
D. 00 HSP bonus amount (see instructions)			0	0	100.
HVBP Adjustment for HSP Bonus Payment					
1.00 HVBP adjustment factor (see instructions)			1.0035125329	0.000000000	101.
					102
2.00 HVBP adjustment amount for HSP bonus payment (see instructions)			0	0	102.
2.00 HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment			0	0	102.
2. 00 HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment 3. 00 HRR adjustment factor (see instructions)			0. 9914	0. 9941	
HRR Adjustment for HSP Bonus Payment 3.00 HRR adjustment factor (see instructions)				0. 9941	103
HRR Adjustment for HSP Bonus Payment 3.00 HRR adjustment factor (see instructions) 4.00 HRR adjustment amount for HSP bonus payment (see instructions)	tion) Adjus	stment	0. 9914	0. 9941	103
HRR Adjustment for HSP Bonus Payment 3. 00 HRR adjustment factor (see instructions) 4. 00 HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstra			0. 9914	0. 9941 0	103 104
HRR Adjustment for HSP Bonus Payment 3. 00 HRR adjustment factor (see instructions) 4. 00 HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration 0. 00 Is this the first year of the current 5-year demonstration period			0. 9914	0. 9941 0	103 104
HRR Adjustment for HSP Bonus Payment         3. 00 HRR adjustment factor (see instructions)         4. 00 HRR adjustment amount for HSP bonus payment (see instructions)         Rural Community Hospital Demonstration Project (§410A Demonstration period)         0. 00 Is this the first year of the current 5-year demonstration period         Century Cures Act? Enter "Y" for yes or "N" for no.			0. 9914	0. 9941 0	103 104
<ul> <li>HRR Adjustment for HSP Bonus Payment</li> <li>3. 00 HRR adjustment factor (see instructions)</li> <li>4. 00 HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration Project (§410A Demonstration periodential Section 2018)</li> <li>5. 00 Is this the first year of the current 5-year demonstration periodection (Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement</li> </ul>	od under tl		0. 9914	0. 9941 0	103 104 200
HRR Adjustment for HSP Bonus Payment         3. 00       HRR adjustment factor (see instructions)         4. 00       HRR adjustment amount for HSP bonus payment (see instructions)         Rural Community Hospital Demonstration Project (§410A Demonstration Project (§410A Demonstration periodent)         0. 00       Is this the first year of the current 5-year demonstration periodent         0. 00       Century Cures Act? Enter "Y" for yes or "N" for no.         Cost Reimbursement       1. 00         1. 00       Medicare inpatient service costs (from Wkst. D-1, Pt. II, line	od under tl		0. 9914	0. 9941 0	103 104 200
HRR Adjustment for HSP Bonus Payment         3. 00       HRR adjustment factor (see instructions)         4. 00       HRR adjustment amount for HSP bonus payment (see instructions)         Rural Community Hospital Demonstration Project (§410A Demonstration Project (§410A Demonstration period)         0. 00       Is this the first year of the current 5-year demonstration period         Century Cures Act? Enter "Y" for yes or "N" for no.         Cost Reimbursement         1. 00       Medicare inpatient service costs (from Wkst. D-1, Pt. II, line -         2. 00       Medicare discharges (see instructions)	od under tl		0. 9914	0. 9941 0	103 104 200 201 202
HRR Adjustment for HSP Bonus Payment         3.00       HRR adjustment factor (see instructions)         4.00       HRR adjustment amount for HSP bonus payment (see instructions)         Rural Community Hospital Demonstration Project (§410A Demonstration Project (§410A Demonstration period Century Cures Act? Enter "Y" for yes or "N" for no.         Cost Reimbursement       Cost Reimbursement         1.00       Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 42.00         2.00       Case-mix adjustment factor (see instructions)	od under tl 49)	he 21st	0. 9914	0. 9941 0	103 104 200 201 202
HRR Adjustment for HSP Bonus Payment         3.00       HRR adjustment factor (see instructions)         4.00       HRR adjustment amount for HSP bonus payment (see instructions)         Rural Community Hospital Demonstration Project (§410A Demonstration Project (§410A Demonstration period Century Cures Act? Enter "Y" for yes or "N" for no.         Cost Reimbursement       Cost Reimbursement         1.00       Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 42.00         2.00       Case-mix adjustment factor (see instructions)         3.00       Case-mix adjustment factor (see instructions)         Computation of Demonstration Target Amount Limitation (N/A in file)	od under tl 49)	he 21st	0. 9914	0. 9941 0	103 104 200 201 202
HRR Adjustment for HSP Bonus Payment         3. 00 HRR adjustment factor (see instructions)         4. 00 HRR adjustment amount for HSP bonus payment (see instructions)         Rural Community Hospital Demonstration Project (§410A Demonstration 0 ls this the first year of the current 5-year demonstration period Century Cures Act? Enter "Y" for yes or "N" for no.         Cost Reimbursement         1. 00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 2.00 Medicare discharges (see instructions)         3. 00 Case-mix adjustment factor (see instructions)         Computation of Demonstration Target Amount Limitation (N/A in fiperiod)	od under tl 49)	he 21st	0. 9914	0. 9941 0	103 104 200 201 202 203
HRR Adjustment for HSP Bonus Payment         3. 00 HRR adjustment factor (see instructions)         4. 00 HRR adjustment amount for HSP bonus payment (see instructions)         Rural Community Hospital Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (See instructions))         0. 00 Is this the first year of the current 5-year demonstration period Century Cures Act? Enter "Y" for yes or "N" for no.         Cost Reimbursement         1. 00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, line - 2. 00 Medicare discharges (see instructions)         3. 00 Case-mix adjustment factor (see instructions)         Computation of Demonstration Target Amount Limitation (N/A in fiperiod)         4. 00 Medicare target amount	od under tl 49)	he 21st	0. 9914	0.9941 0	103 104 200 201 202 203
HRR Adjustment for HSP Bonus Payment         3. 00       HRR adjustment factor (see instructions)         4. 00       HRR adjustment amount for HSP bonus payment (see instructions)         Rural Community Hospital Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (§410A Demonstration Project (S410A Demonstration S)         0.00       Medicare discharges (see instructions)         3. 00       Case-mix adjustment factor (see instructions)         Computation of Demonstration Target Amount Limitation (N/A in fiperiod)         4. 00       Medicare target amount         5. 00       Case-mix adjusted target amount (line 203 times line 204)	od under tl 49)	he 21st	0. 9914	0.9941 0	103. 104. 200. 201. 202. 203. 204. 204.
HRR Adjustment for HSP Bonus Payment         3. 00       HRR adjustment factor (see instructions)         4. 00       HRR adjustment amount for HSP bonus payment (see instructions)         Rural Community Hospital Demonstration Project (§410A Demonstration Project (§410A Demonstration period)         0. 00       Is this the first year of the current 5-year demonstration period         Century Cures Act? Enter "Y" for yes or "N" for no.         Cost Reimbursement         1. 00       Medicare inpatient service costs (from Wkst. D-1, Pt. II, line -         2. 00       Medicare discharges (see instructions)         3. 00       Case-mix adjustment factor (see instructions)         3. 00       Case-mix adjustment factor (see instructions)         4. 00       Medicare target amount         5. 00       Case-mix adjusted target amount (line 203 times line 204)         6. 00       Medicare inpatient routine cost cap (line 202 times line 205)	od under tl 49)	he 21st	0. 9914	0.9941 0	103 104 200 201 202 203 203
HRR Adjustment for HSP Bonus Payment         3. 00       HRR adjustment factor (see instructions)         4. 00       HRR adjustment amount for HSP bonus payment (see instructions)         Rural Community Hospital Demonstration Project (§410A Demonstration Project (§410A Demonstration period)         0. 00       Is this the first year of the current 5-year demonstration period         0. 00       Is this the first year of the current 5-year demonstration period         0. 01       sthis the first year of the current 5-year demonstration period         0. 02       Is this the first year of the current 5-year demonstration period         0. 04       Sthis the first year of the current 5-year demonstration period         0. 05       Reimbursement         1. 00       Medicare inpatient service costs (from Wkst. D-1, Pt. II, line         2. 00       Medicare discharges (see instructions)         3. 00       Case-mix adjustment factor (see instructions)         Computation of Demonstration Target Amount Limitation (N/A in fiperiod)         4. 00       Medicare target amount         5. 00       Case-mix adjusted target amount (line 203 times line 204)         5. 00       Medicare inpatient routine cost cap (line 202 times line 205)         Adjustment to Medicare Part A Inpatient Reimbursement	49) rst year o	he 21st	0. 9914	0.9941 0	103 104 200 201 202 203 204 205 206
HRR Adjustment for HSP Bonus Payment         3.00       HRR adjustment factor (see instructions)         4.00       HRR adjustment amount for HSP bonus payment (see instructions)         Rural Community Hospital Demonstration Project (§410A Demonstration Project (§410A Demonstration period)         0.00       Is this the first year of the current 5-year demonstration period         0.00       Is this the first year of the current 5-year demonstration period         0.00       Reimbursement         1.00       Medicare inpatient service costs (from Wkst. D-1, Pt. II, line         2.00       Medicare discharges (see instructions)         3.00       Case-mix adjustment factor (see instructions)         3.00       Case-mix adjustment factor (see instructions)         3.00       Case-mix adjustment factor (see instructions)         4.00       Medicare target amount         5.00       Case-mix adjusted target amount (line 203 times line 204)         5.00       Medicare inpatient routine cost cap (line 202 times line 205)         Adjustment to Medicare Part A Inpatient Reimbursement         7.00       Program reimbursement under the §410A Demonstration (see instruction)	49) rst year ( ctions)	he 21st	0. 9914	0.9941 0	103. 104. 200. 201. 202. 203. 204. 205. 206. 207.
<ul> <li>HRR Adjustment for HSP Bonus Payment</li> <li>3. 00 HRR adjustment factor (see instructions)</li> <li>4. 00 HRR adjustment amount for HSP bonus payment (see instructions)</li> <li>Rural Community Hospital Demonstration Project (§410A Demonstration Period Century Cures Act? Enter "Y" for yes or "N" for no.</li> <li>Cost Reimbursement</li> <li>1. 00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 4.</li> <li>2. 00 Medicare discharges (see instructions)</li> <li>3. 00 Case-mix adjustment factor (see instructions)</li> <li>3. 00 Case-mix adjustment factor (see instructions)</li> <li>4. 00 Medicare target amount</li> <li>5. 00 Case-mix adjusted target amount (line 203 times line 204)</li> <li>6. 00 Medicare inpatient routine cost cap (line 202 times line 205)</li> <li>Adjustment to Medicare Part A Inpatient Reimbursement</li> <li>7. 00 Program reimbursement under the §410A Demonstration (see instructions)</li> </ul>	49) rst year ( ctions)	he 21st	0. 9914	0. 9941 0	103 104 200 201 202 203 204 205 206 207 208
<ul> <li>HRR Adjustment for HSP Bonus Payment</li> <li>3. 00 HRR adjustment factor (see instructions)</li> <li>4. 00 HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration period Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement</li> <li>1. 00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, line - Computation of Demonstration Target Amount Limitation (N/A in fingeriod)</li> <li>4. 00 Medicare target amount</li> <li>5. 00 Case-mix adjustment factor (see instructions)</li> <li>6. 00 Medicare target amount</li> <li>7. 00 Medicare inpatient cortained target amount (line 203 times line 204)</li> <li>6. 00 Medicare inpatient cortaine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement</li> <li>7. 00 Program reimbursement under the §410A Demonstration (see instructions)</li> <li>8. 00 Medicare Part A Inpatient Service costs (from Wkst. E, Pt. A, I 9. 00 Adjustment to Medicare IPPS payments (see instructions)</li> </ul>	49) rst year ( ctions)	he 21st	0. 9914	0.9941 0	103. 104. 200. 201. 202. 203. 204. 205. 206. 207. 208. 207. 208. 209.
<ul> <li>HRR Adjustment for HSP Bonus Payment</li> <li>3. 00 HRR adjustment factor (see instructions)</li> <li>4. 00 HRR adjustment amount for HSP bonus payment (see instructions)</li> <li>Rural Community Hospital Demonstration Project (§410A Demonstration Period Century Cures Act? Enter "Y" for yes or "N" for no.</li> <li>Cost Reimbursement</li> <li>1. 00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 4.</li> <li>2. 00 Medicare discharges (see instructions)</li> <li>3. 00 Case-mix adjustment factor (see instructions)</li> <li>3. 00 Case-mix adjustment factor (see instructions)</li> <li>4. 00 Medicare target amount</li> <li>5. 00 Case-mix adjusted target amount (line 203 times line 204)</li> <li>6. 00 Medicare inpatient routine cost cap (line 202 times line 205)</li> <li>Adjustment to Medicare Part A Inpatient Reimbursement</li> <li>7. 00 Program reimbursement under the §410A Demonstration (see instructions)</li> </ul>	49) rst year ( ctions)	he 21st	0. 9914	0.9941 0	103 104 200 201 202 203 204 205 206 207 208 207
<ul> <li>HRR Adjustment for HSP Bonus Payment</li> <li>Adjustment factor (see instructions)</li> <li>Adjustment amount for HSP bonus payment (see instructions)</li> <li>Rural Community Hospital Demonstration Project (§410A Demonstration period)</li> <li>Colls this the first year of the current 5-year demonstration period</li> <li>Cost Reimbursement</li> <li>Computation of Demonstration Target Amount Limitation (N/A in fiperiod)</li> <li>Computation of Demonstration Target Amount Limitation (N/A in fiperiod)</li> <li>Compare inpatient cost cap (line 202 times line 204)</li> <li>Compare inpatient to Medicare Part A Inpatient Reimbursement</li> <li>Od Medicare Part A inpatient service costs (from Wkst. E, Pt. A, I</li> <li>Od Medicare Part A inpatient service costs (from Wkst. E, Pt. A, I</li> <li>Od Medicare to Medicare IPPS payments (see instructions)</li> </ul>	49) rst year ( ctions)	he 21st	0. 9914	0.9941 0	103 104 200 201 202 203 204 205 206 207 208 207 208 209 210
<ul> <li>HRR Adjustment for HSP Bonus Payment</li> <li>A. 00 HRR adjustment factor (see instructions)</li> <li>A. 00 HRR adjustment factor (see instructions)</li> <li>Rural Community Hospital Demonstration Project (§410A Demonstration period)</li> <li>Cool Is this the first year of the current 5-year demonstration period</li> <li>Century Cures Act? Enter "Y" for yes or "N" for no.</li> <li>Cost Reimbursement</li> <li>Cool Medicare inpatient service costs (from Wkst. D-1, Pt. II, line -</li> <li>Cool Medicare discharges (see instructions)</li> <li>Computation of Demonstration Target Amount Limitation (N/A in fiperiod)</li> <li>Cool Medicare target amount</li> <li>Cool Case-mix adjusted target amount (line 203 times line 204)</li> <li>Cool Medicare inpatient routine cost cap (line 202 times line 205)</li> <li>Adjustment to Medicare Part A Inpatient Reimbursement</li> <li>Cool Medicare Part A inpatient service costs (from Wkst. E, Pt. A, I</li> <li>Cool Medicare to Medicare IPPS payments (see instructions)</li> </ul>	49) rst year ( ctions)	he 21st	0. 9914	0.9941 0	103 104 200 201 202 203 204 205 206 207 208 209 210
HRR Adjustment for HSP Bonus Payment         3. 00       HRR adjustment factor (see instructions)         4. 00       HRR adjustment factor (see instructions)         8. 00       HRR adjustment amount for HSP bonus payment (see instructions)         8. 00       HRR the first year of the current 5-year demonstration period         0. 01       Is this the first year of the current 5-year demonstration period         Century Cures Act? Enter "Y" for yes or "N" for no.         Cost Reimbursement         1. 00       Medicare inpatient service costs (from Wkst. D-1, Pt. II, line -         2. 00       Medicare discharges (see instructions)         3. 00       Case-mix adjustment factor (see instructions)         Computation of Demonstration Target Amount Limitation (N/A in fiperiod)         4. 00       Medicare target amount         5. 00       Case-mix adjusted target amount (line 203 times line 204)         6. 00       Medicare inpatient routine cost cap (line 202 times line 205)         Adjustment to Medicare Part A Inpatient Reimbursement       1.         7. 00       Program reimbursement under the §410A Demonstration (see instructions)         8. 00 <td>49) rst year o ctions) ne 59)</td> <td>he 21st</td> <td>0. 9914</td> <td>0.9941 0</td> <td>103 104 200 201 202 203 204 205 206 207 208 209 210 211</td>	49) rst year o ctions) ne 59)	he 21st	0. 9914	0.9941 0	103 104 200 201 202 203 204 205 206 207 208 209 210 211
<ul> <li>HRR Adjustment for HSP Bonus Payment</li> <li>3.00 HRR adjustment factor (see instructions)</li> <li>4.00 HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration period Century Cures Act? Enter "Y" for yes or "N" for no.</li> <li>Cost Reimbursement</li> <li>1.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 42, 200 Medicare discharges (see instructions)</li> <li>3.00 Case-mix adjustment factor (see instructions)</li> <li>Computation of Demonstration Target Amount Limitation (N/A in fiperiod)</li> <li>4.00 Medicare target amount</li> <li>5.00 Case-mix adjusted target amount (line 203 times line 204)</li> <li>6.00 Medicare part A Inpatient Reimbursement</li> <li>7.00 Program reimbursement under the §410A Demonstration (see instructions)</li> <li>Adjustment to Medicare IPPS payments (see instructions)</li> <li>0.00 Reserved for future use</li> <li>1.00 Total adjustment to Medicare Part A IPPS payments (from line 21</li> </ul>	49) rst year o ctions) ne 59)	he 21st	0. 9914	0. 9941 0	103 104 200 201 202 203 204 205 206 207 208 209 210 211 212
HRR Adjustment for HSP Bonus Payment         3. 00       HRR adjustment factor (see instructions)         4. 00       HRR adjustment factor (see instructions)         8. 00       HRR adjustment amount for HSP bonus payment (see instructions)         8. 00       HRR the first year of the current 5-year demonstration period         0. 01       Is this the first year of the current 5-year demonstration period         Century Cures Act? Enter "Y" for yes or "N" for no.         Cost Reimbursement         1. 00       Medicare inpatient service costs (from Wkst. D-1, Pt. II, line -         2. 00       Medicare discharges (see instructions)         3. 00       Case-mix adjustment factor (see instructions)         Computation of Demonstration Target Amount Limitation (N/A in fiperiod)         4. 00       Medicare target amount         5. 00       Case-mix adjusted target amount (line 203 times line 204)         6. 00       Medicare inpatient routine cost cap (line 202 times line 205)         Adjustment to Medicare Part A Inpatient Reimbursement       1.         7. 00       Program reimbursement under the §410A Demonstration (see instructions)         8. 00 <td>49) rst year of ctions) ine 59) 1)</td> <td>of the currer</td> <td>0. 9914</td> <td>0. 9941 0</td> <td>103 104 200 201 202 203 204 205 206 207 208 209 210 211</td>	49) rst year of ctions) ine 59) 1)	of the currer	0. 9914	0. 9941 0	103 104 200 201 202 203 204 205 206 207 208 209 210 211

OV VC	LUME CALCULATION EXHIBIT 4			Provider C	F	Period: From 01/01/2018 Fo 12/31/2018	5/30/2019 3:2	pare
		line	Amounts (from E, Part A)	Pre/Post Entitlement	XVIII Period Prior to 10/01	Hospi tal Peri od On/After 10/01	PPS Total (Col 2 through 4)	
00	DRG amounts other than outlier	0	1.00	2.00	3.00	4.00	5.00	1.
01	payments DRG amounts other than outlier payments for discharges		3, 010, 037	0			3, 010, 037	
02	occurring prior to October 1 DRG amounts other than outlier payments for discharges occurring on or after October	1. 02	683, 324	0		683, 324	683, 324	1.
03	1 DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1. 03	0	0	C		0	1.
04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1. 04	0	0		0	0	1.
00	Outlier payments for	2.00	13, 149	0	13, 149	9 0	13, 149	2.
01	discharges (see instructions) Outlier payments for	2. 02	0	Ω	0		0	2.
00	discharges for Model 4 BPCI Operating outlier	2. 01	0	0	(	0 0	0	
00	reconciliation Managed care simulated payments	3.00	0	0	C	0 0	0	4.
00	Indirect Medical Education Adju Amount from Worksheet E, Part	21.00	0. 000000	0. 000000	0.00000	0.00000		5.
00	A, line 21 (see instructions) IME payment adjustment (see	22.00	0	0			0	
01	instructions) IME payment adjustment for managed care (see instructions)	22.01	0	0	(	0 0	0	6
	Indirect Medical Education Adju					1		
00	IME payment adjustment factor (see instructions)	27.00	0. 000000	0.00000	0.000000	0.000000		7
00	IME adjustment (see instructions)	28.00	0	0	(	0 0	0	
01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	(	0 0	0	8
00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	(	0 0	0	
01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	C	0 0	0	9
. 00	Disproportionate Share Adjustme Allowable disproportionate	ent 33.00	0.0000	0.0000	0,0000	0.0000		10
. 00	share percentage (see instructions)	33.00	0.0000	0.0000	0.0000	0.0000		
. 00 . 01	Disproportionate share adjustment (see instructions) Uncompensated care payments	34.00 36.00	0	0				11
	Additional payment for high per	centage of ES	RD beneficiary	di scharges	1			
00	Total ESRD additional payment (see instructions)	46.00	0	0				12
. 00 . 00	Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH, small rural hospitals only.)	47.00 48.00	3, 706, 510 0	0 0	3, 023, 186 (	6 683, 324 0 0	3, 706, 510 0	
. 00	(see instructions) Total payment for inpatient operating costs (see instructions)	49.00	3, 706, 510	0	3, 023, 186	683, 324	3, 706, 510	15
. 00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	310, 099	0	254, 501	1 55, 598	310, 099	16
. 00	Special add-on payments for new technologies	54.00	0	0	C	0 0	0	17
. 01 . 02	Net organ aquisition cost Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	О	0	C	0 0	0	17 17

Heal th	Financial Systems	FRA	NCI SCAN HEALTH	CRAWFORDSVI LL	E	In Lie	eu of Form CMS-:	2552-10
	LUME CALCULATION EXHIBIT 4			Provider C		Period: From 01/01/2018 To 12/31/2018		pared:
				Title	XVIII	Hospi tal	PPS	
		W/S E, Part A	Amounts (from	Pre/Post	Period Prior	Period	Total (Col 2	
		line	E, Part A)	Entitlement	to 10/01	0n/After 10/01	through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0		0 0	0	18.00
19 00	SUBTOTAL			0	3, 277, 68	7 738, 922	4, 016, 609	19 00
17.00		W/S L, line	(Amounts from	0	3, 211, 00	130,722	4,010,007	17.00
		0	L) 1.00	2.00	2.00	4.00	F 00	
20,00		0			3.00	4.00	5.00	20,00
20. 00 20. 01	Capital DRG other than outlier Model 4 BPCI Capital DRG other than outlier	1.00	300, 712 0	0 0		4 55, 598 0 0	300, 712 0	•
21.00	Capital DRG outlier payments	2.00	9, 387	0	9, 38	7 0	9, 387	
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0		0 0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0. 0000	0.0000	0.000	0 0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0		o o	0	23.00
24.00	Al lowable disproportionate share percentage (see instructions)	10.00	0. 0000	0. 0000	0.000	0 0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0		0 0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	310, 099	0	254, 50	1 55, 598	310, 099	26.00
	······································	W/S E, Part A	(Amounts to E,					
		line	Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0. 14178	6 0. 203864		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E,	70.96			464, 73	0	464, 730	28.00
29.00	Pt. A, line) Low volume adjustment (transfer amount to Wkst. E,	70. 97				150, 640	150, 640	29.00
100.00	Pt. A, line) Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100. 00

HOSPI T	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	TION EXHIBIT 5			Period: From 01/01/2018 To 12/31/2018	Date/Time Pre 5/30/2019 3:2	pared:
				XVIII	Hospi tal	PPS	
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	3, 010, 037	3, 010, 03	37	3, 010, 037	1. 01
1. 02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	683, 324		683, 324	683, 324	1. 02
1. 03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0		0	0	1. 03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1. 04
2.00	Outlier payments for discharges (see instructions)	2.00	13, 149	13, 14	19 0	13, 149	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0		0 0	0	2. 01
3.00	Operating outlier reconciliation	2.01	0		0 0	0	3.00
4.00	Managed care simulated payments	3.00	0		0 0	-	4.00
F 00	Indirect Medical Education Adjustment	01.00	0.00000	0.0000	0 00000		F 00
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0. 000000	0.00000			5.00
6.00	IME payment adjustment (see instructions)	22.00	0		0 0	0	6.00
6. 01	IME payment adjustment for managed care (see instructions)	22.01	0		0 0	0	6. 01
7.00	Indirect Medical Education Adjustment for the IME payment adjustment factor (see	27.00	0. 000000		0.00000		7.00
7.00	instructions)	27.00	0.000000	0.00000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0		0 0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0		0 0	0	8. 01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0		0 0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0		0 0	0	9. 01
	Disproportionate Share Adjustment						
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0000	0.000	0.0000		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	0		0 0	0	11.00
11.01	Uncompensated care payments	36.00	0		0 0	0	11.01
	Additional payment for high percentage of ESR		di scharges				
12.00	Total ESRD additional payment (see instructions)	46.00	0		0 0	0	12.00
	Subtotal (see instructions)	47.00	3, 706, 510	3, 023, 18			
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0		0 0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	3, 706, 510	3, 023, 18	683, 324	3, 706, 510	15. 00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	310, 099	-48, 57	358, 676	310, 099	16. 00
17.00	Special add-on payments for new technologies	54.00	0		0 0	0	17.00
17.01	Net organ acquisition cost						17.01
17. 02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0		0 0	0	17. 02
18. 00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0		0 0	0	18. 00
19 00	SUBTOTAL			2, 974, 60	1, 042, 000	4, 016, 609	19 00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	TION EXHIBIT 5	Provider CO		Period: From 01/01/2018 To 12/31/2018		pared:
		Title	XVIII	Hospi tal	PPS	
	Wkst. L, line	(Amt. from Wkst. L)				
	0	1.00	2.00	3.00	4.00	
20.00 Capital DRG other than outlier	1.00	300, 712	-55, 59	98 356, 310	300, 712	20.00
20.01 Model 4 BPCI Capital DRG other than outlier	1.01	0		0 0	0	20.01
21.00 Capital DRG outlier payments	2.00	9, 387	7, 02	2, 366	9, 387	21.00
21.01 Model 4 BPCI Capital DRG outlier payments	2.01	0		0 0	0	21.01
22.00 Indirect medical education percentage (see instructions)	5.00	0.0000	0.000	0.0000		22.00
23.00 Indirect medical education adjustment (see instructions)	6.00	0		0 0	0	23.00
24.00 Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.000	0.0000		24.00
25.00 Disproportionate share adjustment (see instructions)	11.00	0		0 0	0	25.00
26.00 Total prospective capital payments (see instructions)	12.00	310, 099	-48, 57	358, 676	310, 099	26.00
	Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
	0	1.00	2.00	3.00	4.00	
27.00						27.00
28.00 Low volume adjustment prior to October 1	70. 96	464, 730	464, 73	0	464, 730	28.00
29.00 Low volume adjustment on or after October 1	70. 97	150, 640		150, 640	150, 640	29.00
30.00 HVBP payment adjustment (see instructions)	70. 93	14, 399	10, 57	3 3, 826	14, 399	30.00
30.01 HVBP payment adjustment for HSP bonus payment (see instructions)	70. 90	0		0 0	0	30. 01
<ul> <li>B1.00 HRR adjustment (see instructions)</li> <li>B1.01 HRR adjustment for HSP bonus payment (see instructions)</li> </ul>	70. 94 70. 91	-29, 918 0	-25, 88	36 -4, 032 0 0	-29, 918 0	
,					(Amt. to Wkst. E, Pt. A)	
	0	1.00	2.00	3.00	4.00	
32.00 HAC Reduction Program adjustment (see instructions)	70. 99			0 11, 924	11, 924	32.00
100.00 Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100.00

ALCUL	Financial Systems         FRANCISCAN HEALTH C           ATION OF REIMBURSEMENT SETTLEMENT         FRANCISCAN HEALTH C	CRAWFORDSVILLE Provider CCN: 15-0022	Period: From 01/01/2018	u of Form CMS-: Worksheet E Part B	
			To 12/31/2018		
		Title XVIII	Hospi tal	PPS	s pili
				1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
. 00	Medical and other services (see instructions)	ati ana)		641	
. 00 . 00	Medical and other services reimbursed under OPPS (see instruc OPPS payments	ctions)		10, 611, 709 8, 265, 906	
. 00	Outlier payment (see instructions)			33, 677	
. 01	Outlier reconciliation amount (see instructions)			0	
. 00	Enter the hospital specific payment to cost ratio (see instru	uctions)		0.000	
. 00 . 00	Line 2 times line 5 Sum of lines 3, 4, and 4.01, divided by line 6			0.00	
. 00	Transitional corridor payment (see instructions)			0	
. 00	Ancillary service other pass through costs from Wkst. D, Pt.	IV, col. 13, line 200		0	
0.00	Organ acquisitions			0	
1. 00	Total cost (sum of lines 1 and 10) (see instructions) COMPUTATION OF LESSER OF COST OR CHARGES			641	11. (
	Reasonable charges				
2.00	Ancillary service charges	inc (0)		2, 402	
3.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, I Total reasonable charges (sum of lines 12 and 13)	The 69)		0 2, 402	
1.00	Customary charges			2,102	
5.00	Aggregate amount actually collected from patients liable for			0	
6. 00	Amounts that would have been realized from patients liable for		on a chargebasis	0	16. (
7.00	had such payment been made in accordance with 42 CFR §413.13( Ratio of line 15 to line 16 (not to exceed 1.000000)	(e)		0. 000000	17 (
8.00	Total customary charges (see instructions)			2, 402	
9.00	Excess of customary charges over reasonable cost (complete or	nly if line 18 exceeds li	ne 11) (see	1, 761	19.0
0. 00	instructions) Excess of reasonable cost over customary charges (complete or	alv if line 11 exceeds li	no 19) (coo	0	20. (
0.00	instructions)	If y IT ITTLE IT exceeds IT	The To) (See	0	20.
1.00	Lesser of cost or charges (see instructions)			641	21.0
	Interns and residents (see instructions)			0	
3.00 4.00	Cost of physicians' services in a teaching hospital (see inst Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	tructions)		0 8, 299, 583	
4.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT			0,277,303	27.0
5.00	Deductibles and coinsurance amounts (for CAH, see instruction	-		0	
6.00 7.00	Deductibles and Coinsurance amounts relating to amount on lin	•		1, 614, 330	
7.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) instructions)	prus the sum of times 2.		6, 685, 894	27.0
8.00	Direct graduate medical education payments (from Wkst. E-4, I	ine 50)		0	28. (
9.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	)		0	
0.00 1.00	Subtotal (sum of lines 27 through 29) Primary payer payments			6, 685, 894	30. ( 31. (
2.00	51515			6, 685, 836	
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVI	CES)			1
	Composite rate ESRD (from Wkst. I-5, line 11)				33.
4.00 5.00	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			242, 796 157, 817	
	Allowable bad debts for dual eligible beneficiaries (see inst	tructions)		178, 139	
7.00	Subtotal (see instructions)			6, 843, 653	
	MSP-LCC reconciliation amount from PS&R			0	
9.00 9.50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructior	ns)		0	39. 39.
9.97	Demonstration payment adjustment amount before sequestration	13)		0	
9. 98	Partial or full credits received from manufacturers for repla	aced devices (see instru	ctions)	0	
9.99	RECOVERY OF ACCELERATED DEPRECIATION			0	
0. 00 0. 01	Subtotal (see instructions)			6, 843, 653	
0.01	Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration			136, 873 0	
	Interim payments			6, 551, 809	41.0
2.00	Tentative settlement (for contractors use only)			0	
3.00 4.00	Balance due provider/program (see instructions)	ance with CMS Dub 15 2	chanter 1	154, 971	
4. UU	Protested amounts (nonallowable cost report items) in accorda §115.2	ance with GWS PUD. 15-2,	chaptel I,	0	44. (
	TO BE COMPLETED BY CONTRACTOR				1
	Original outlier amount (see instructions)				90. (
1.00 2.00	Outlier reconciliation adjustment amount (see instructions) The rate used to calculate the Time Value of Money				91. ( 92. (
2.00	Time Value of Money (see instructions)				92.0
3.00				, v	

LUUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0022	Period: From 01/01/2018		
		Component CCN: 15-S022	To 12/31/2018	Date/Time Pre 5/30/2019 3:2	parec 3 pm
		Title XVIII	Subprovider - IPF	PPS	
				1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES				
00 00	Medical and other services (see instructions) Medical and other services reimbursed under OPPS (see instruc	ctions)		152 532	
00	OPPS payments			336	
00	Outlier payment (see instructions)			0	
01 00	Outlier reconciliation amount (see instructions) Enter the hospital specific payment to cost ratio (see instru	uctions)		0.000	4. 5.
00	Line 2 times line 5			0.000	
00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	
00	Transitional corridor payment (see instructions)			0	
00 . 00	Ancillary service other pass through costs from Wkst. D, Pt. Organ acquisitions	TV, COL. 13, TI në 200		0	9. 10.
. 00	Total cost (sum of lines 1 and 10) (see instructions)			152	
	COMPUTATION OF LESSER OF COST OR CHARGES			·	
. 00	Reasonable charges Ancillary service charges			570	12.
. 00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, I		0	12.	
. 00	Total reasonable charges (sum of lines 12 and 13)			570	14.
~~	Customary charges				1 1 5
. 00 . 00	Aggregate amount actually collected from patients liable for Amounts that would have been realized from patients liable for			0	
. 00	had such payment been made in accordance with 42 CFR §413.13(		in a chargebasi s	0	10.
. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0. 000000	
. 00 . 00	Total customary charges (see instructions) Excess of customary charges over reasonable cost (complete on	alvifling 19 overede li	no 11) (coo	570 418	
. 00	instructions)	IT y IT ITTLE To exceeds IT	lie II) (See	410	19.
. 00	Excess of reasonable cost over customary charges (complete on	nly if line 11 exceeds li	ne 18) (see	0	20.
00	instructions)			150	01
. 00 . 00	Lesser of cost or charges (see instructions) Interns and residents (see instructions)			152 0	
. 00	Cost of physicians' services in a teaching hospital (see inst	tructions)		0	
. 00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) COMPUTATION OF REIMBURSEMENT SETTLEMENT			336	24.
. 00	Deductibles and coinsurance amounts (for CAH, see instruction	ns)		0	25.
. 00	Deductibles and Coinsurance amounts relating to amount on lin	•	· ·	0	
. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) instructions)	plus the sum of lines 22	and 23] (see	488	27.
. 00	Direct graduate medical education payments (from Wkst. E-4, I	line 50)		0	28.
. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)	)		0	
. 00 . 00	Subtotal (sum of lines 27 through 29) Primary payer payments			488	30. 31.
. 00	Subtotal (line 30 minus line 31)			488	
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVI	CES)			
. 00	Composite rate ESRD (from Wkst. I-5, line 11)			0	
. 00 . 00	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			0	
. 00	Allowable bad debts for dual eligible beneficiaries (see inst	tructions)		0	
. 00	Subtotal (see instructions)			488	
. 00 . 00	MSP-LCC reconciliation amount from PS&R			0	
. 50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instruction	ns)		0	39. 39.
. 97	Demonstration payment adjustment amount before sequestration			0	
. 98	Partial or full credits received from manufacturers for repla	aced devices (see instruc	tions)	0	39.
. 99 . 00	RECOVERY OF ACCELERATED DEPRECIATION Subtotal (see instructions)			0 488	
. 00	Sequestration adjustment (see instructions)			10	
. 02	Demonstration payment adjustment amount after sequestration			0	40.
. 00	Interim payments			441	
. 00 . 00	Tentative settlement (for contractors use only) Balance due provider/program (see instructions)			0 37	
. 00	Protested amounts (nonallowable cost report items) in accorda	ance with CMS Pub. 15-2,	chapter 1,	0	
. 00	§115. 2		• •		
. 00	TO BE COMPLETED BY CONTRACTOR			0	90.
	Original outlier amount (coo instructions)				
. 00	Original outlier amount (see instructions) Outlier reconciliation adjustment amount (see instructions)			-	
	Original outlier amount (see instructions) Outlier reconciliation adjustment amount (see instructions) The rate used to calculate the Time Value of Money			0 0.00	91.

IALY:	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC	CN: 15-0022	Period: From 01/01/2018 To 12/31/2018		
		Title	XVIII	Hospi tal	PPS	
		I npati en	t Part A	Par	t 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		4, 182, 6	14 O	6, 551, 809 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	0	3.0
02				0	0	3. (
03				0	0	3.
04 05				0	0	3. 3.
05	Provider to Program			0	0	3.
50	ADJUSTMENTS TO PROGRAM			0	0	3.
51				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)			0	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)		4, 182, 6	14	6, 551, 809	4.
00	TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after					5.
50	desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					J.
01	TENTATI VE TO PROVIDER			0	0	5.
)2				0	0	5
3				0	0	5
~	Provider to Program					-
50 51	TENTATI VE TO PROGRAM			0	0	5 5
52				0	0	5
9	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	0	5
00	Determined net settlement amount (balance due) based on the cost report. (1)					6
)1	SETTLEMENT TO PROVIDER			0	154, 971	6.
)2	SETTLEMENT TO PROGRAM		95, 9		0	6
00	Total Medicare program liability (see instructions)		4, 086, 64		6, 706, 780	7
				Contractor Number	NPR Date (Mo/Day/Yr)	
	Name of Contractor	(	J	1.00	2.00	8

IALYS	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC Component C	CN: 15-0022 CCN: 15-S022		d: 01/01/2018 12/31/2018		
		Title	XVIII	Subp	rovider - IPF	PPS	
		Inpatien	t Part A			t B	
		mm/dd/yyyy	Amount	mm	/dd/yyyy	Amount	
		1.00	2.00		3.00	4.00	
00 00 00 00 00 00 00 00 00 00 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 List separately each retroactive lump sum adjustment		1, 632, 3	86 0		441 0	1. 2. 3.
00	amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider						
)1	ADJUSTMENTS TO PROVIDER			0		0	3
)2				0		0	3
)3				0		0	3
)4				0		0	3
)5	Provider to Program			0		0	3
0	ADJUSTMENTS TO PROGRAM			0		0	3
1				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			0		0	3
0	3.50-3.98) Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1, 632, 3	86		441	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			0			
)1 )2	TENTATI VE TO PROVI DER			0		0	5
)2 )3				0		0	
-	Provider to Program			-1			
0	TENTATI VE TO PROGRAM			0		0	5
51				0		0	5
2	Subtotal (cum of lines 5 01 5 40 minus cum of lines			0		0	5
9	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			U		0	5
00	Determined net settlement amount (balance due) based on the cost report. (1)						6
)1 )2	SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM			0		37 0	6
)2 )0	Total Medicare program liability (see instructions)		1, 632, 3			478	
.0	Total modeled program traditity (see that detroits)		1, 032, 3		ntractor	NPR Date	
					Number	(Mo/Day/Yr)	
		(	)		1.00	2.00	

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT       Provider CCN: 15-0022       Period: From 01/01/2018 To 12/31/2018       Worksheet E-1 Part II Date/Time Prepared: 5/30/2019 3:23 pm         To BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS       Hospital       PPS         HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION       1.00         1.00       Total hospital discharges as defined in AARA \$4102 from Wkst. S-3, Pt. I col. 15 line 14       2.00         Medicare days from Wkst. S-3, Pt. I, col. 6 line 2       3.00         3.00       Medicare HMO days from S+5, Pt. I, col. 6 line 2       4.00         5.00       Total hospital charity care charges from Wkst. S-10, col. 3 line 20       5.00         6.00       Total hospital charity care charges from Wkst. S-10, col. 3 line 20       5.00         7.00       CALculation of the HIT incentive payment (see instructions)       9.00         9.00       Sequestration adjustment amount (see instructions)       9.00         9.00       Initial /interim HIT payment adjustment (see instructions)       9.00         9.00       Initial /interim HIT payment adjustment (see instructions)       30.00         9.00       Initial /interim HIT payment adjustment (see instructions)       30.00         9.00       Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)       31.00	Heal th	Financial Systems FRANCISCAN HEALTH CI	RAWFORDSVI LLE	In Lie	u of Form CMS-	2552-10
To     12/31/2018     Date/Time Prepared: 5/30/2019 3: 23 pm       Title XVIII     Hospital     PPS       IO     BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS     1.00       HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION     1.00       1.00     Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14     2.00       Medicare days from Wkst. S-3, Pt. I, col. 6. Line 2     3.00       4.00     Total inpatient days from Wkst. S-3, Pt. I, col. 6. Line 2     4.00       5.00     Total hospital charges from Wkst. S-10, col. 3 line 20     5.00       6.00     Total hospital charges from Wkst. S-10, col. 3 line 20     5.00       7.00     CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I     6.00       7.00     Calculation of the HIT incentive payment after sequestration (see instructions)     9.00       9.00     Sequestration adjustment amount (see instructions)     9.00       10.00     INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH     10.00       30.00     Initial/interim HIT payment adjustment (see instructions)     30.00       31.00     Other Adjustment (specify)     31.00	CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0022			
Title XVIII       Hospital       PPS         1.00       1.00         To BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS         HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION         1.00       Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14       1.00         2.00       Medicare days from Wkst. S-3, Pt. I, col. 6 une 2       2.00         3.00       Total inpatient days from S-3, Pt. I col. 8 um of lines 1, 8-12       3.00         5.00       Total hospital charges from Wkst C, Pt. I, col. 8 line 200       4.00         5.00       Total hospital charity care charges from Wkst. S-10, col. 3 line 20       5.00         6.00       Total hospital charity care charges from Wkst. S-10, col. 3 line 20       5.00         7.00       CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I       7.00         8.00       Calculation of the HIT incentive payment (see instructions)       9.00         9.00       Sequestration adjustment amount (see instructions)       9.00         10.00       Initial/interim HIT payment adjustment (see instructions)       10.00         10.00       Initial/interim HIT payment adjustment (see instructions)       30.00         31.00       Other Adjustment (specify)       31.00					Date/Time Pre	
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION1.00Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 141.002.00Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-122.003.00Medicare HMO days from Wsst. S-3, Pt. I, col. 6. line 23.004.00Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-124.005.00Total hospital charges from Wkst C, Pt. I, col. 8 line 2005.006.00Total hospital charges from Wkst. S-10, col. 3 line 205.007.00CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I7.008.00Calculation of the HIT incentive payment (see instructions)8.009.00Sequestration adjustment amount (see instructions)9.0010.00Inital /interim HIT payment adjustment (see instructions)10.0031.00Other Adjustment (specify)30.00			Title XVIII	Hospi tal		
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION1.00Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 141.002.00Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-122.003.00Medicare HMO days from Wsst. S-3, Pt. I, col. 6. line 23.004.00Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-124.005.00Total hospital charges from Wkst C, Pt. I, col. 8 line 2005.006.00Total hospital charges from Wkst. S-10, col. 3 line 205.007.00CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I7.008.00Calculation of the HIT incentive payment (see instructions)8.009.00Sequestration adjustment amount (see instructions)9.0010.00Inital /interim HIT payment adjustment (see instructions)10.0031.00Other Adjustment (specify)30.00						
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION1.00Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 141.002.00Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-122.003.00Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 23.004.00Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-123.005.00Total hospital charges from Wkst C, Pt. I, col. 8 line 2006.006.00Total hospital charity care charges from Wkst. S-10, col. 3 line 206.007.00CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I7.001.00Calculation of the HIT incentive payment (see instructions)8.009.00Calculation of the HI incentive payment after sequestration (see instructions)9.0010.00Initial/interim HIT payment adjustment (see instructions)30.0030.00Initial/interim HIT payment adjustment (see instructions)30.0031.00Other Adjustment (specify)31.00					1.00	
1.00Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 141.002.00Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-122.003.00Medicare HM0 days from Wkst. S-3, Pt. I, col. 6. line 23.004.00Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-124.005.00Total hospital charges from Wkst C, Pt. I, col. 8 line 2005.006.00Total hospital charity care charges from Wkst. S-10, col. 3 line 205.007.00CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I7.001 line 1688.00Calculation of the HIT incentive payment (see instructions)8.009.00Sequestration adjustment amount (see instructions)9.0010.00Initial/interim HIT payment adjustment (see instructions)9.0030.00Initial/interim HIT payment adjustment (see instructions)30.0031.00Other Adjustment (specify)30.00						-
2.00Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-122.003.00Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 23.004.00Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-124.005.00Total hospital charges from Wkst C, Pt. I, col. 8 line 2005.006.00Total hospital charity care charges from Wkst. S-10, col. 3 line 205.007.00CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I7.008.00Calculation of the HIT incentive payment (see instructions)8.009.00Sequestration adjustment amount (see instructions)9.0010.00Initial/interim HIT payment adjustment (see instructions)9.0030.00Initial/interim HIT payment adjustment (see instructions)30.0031.00Other Adjustment (specify)30.00						
3.00Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 23.004.00Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-124.005.00Total hospital charges from Wkst C, Pt. I, col. 8 line 2005.006.00Total hospital charity care charges from Wkst. S-10, col. 3 line 205.007.00CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I6.008.00Calculation of the HIT incentive payment (see instructions)8.009.00Sequestration adjustment amount (see instructions)9.0010.00INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH10.0030.0031.00Other Adjustment (specify)30.00				e 14		
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       5.00         7.00       CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I       7.00         1 line 168       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 sequestration (see instructions)       9.00         10.00       INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH       30.00         30.00       Initial/interim HIT payment adjustment (see instructions)       30.00         31.00       Other Adjustment (specify)       31.00			-12			1
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 certified HIT technology Wkst. S-2, Pt. I       7.00         8.00       Cal culation of the HIT incentive payment (see instructions)       8.00         9.00       Sequestration adjustment amount (see instructions)       9.00         10.00       INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH       10.00         30.00       Initial/interim HIT payment adjustment (see instructions)       30.00         31.00       Other Adjustment (specify)       31.00						
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 certified HIT technology Wkst. S-2, Pt. I       7.00         1 ine 168       8.00       Cal culation of the HIT incentive payment (see instructions)       8.00         9.00       Sequestration adjustment amount (see instructions)       9.00         10.00       Cal culation of the HIT incentive payment after sequestration (see instructions)       9.00         10.00       INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH       30.00         30.00       Initial/interim HIT payment adjustment (see instructions)       30.00         31.00       Other Adjustment (specify)       31.00	4.00		-12			1
7.00       CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I       7.00         1 ine 168       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 sequestration (see instructions)       9.00         10.00       INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH       10.00         30.00       Initial/interim HIT payment adjustment (see instructions)       30.00         31.00       Other Adjustment (specify)       31.00	5.00					5.00
I ine 168       8.00       Cal cul ation of the HIT incentive payment (see instructions)       8.00         9.00       Sequestration adjustment amount (see instructions)       9.00         10.00       Cal cul ation of the HIT incentive payment after sequestration (see instructions)       9.00         10.00       INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH       10.00         30.00       Initial / interim HIT payment adjustment (see instructions)       30.00         31.00       Other Adjustment (specify)       31.00	6.00	Total hospital charity care charges from Wkst. S-10, col. 3	ine 20			6.00
9.00       Sequestration adjustment amount (see instructions)       9.00         10.00       Calculation of the HIT incentive payment after sequestration (see instructions)       10.00         1NPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH       30.00         30.00       Initial/interim HIT payment adjustment (see instructions)       30.00         31.00       Other Adjustment (specify)       31.00	7.00		ertified HIT technology	Wkst. S-2, Pt. I		7.00
10. 00       Calculation of the HIT incentive payment after sequestration (see instructions)       10. 00         INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH       30. 00         30. 00       Initial/interim HIT payment adjustment (see instructions)       30. 00         31. 00       Other Adjustment (specify)       31. 00	8.00	Calculation of the HIT incentive payment (see instructions)				8.00
10.00       Calculation of the HIT incentive payment after sequestration (see instructions)       10.00         INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH       30.00         30.00       Initial/interim HIT payment adjustment (see instructions)       30.00         31.00       Other Adjustment (specify)       31.00	9.00	Sequestration adjustment amount (see instructions)				9.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH         30.00       Initial/interim HIT payment adjustment (see instructions)       30.00         31.00       Other Adjustment (specify)       31.00	10.00	Calculation of the HIT incentive payment after sequestration	(see instructions)			10.00
31.00 Other Adjustment (specify) 31.00		INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				1
	30.00	Initial/interim HIT payment adjustment (see instructions)				30.00
	31.00					31.00
	32.00		ine 31) (see instruction	is)		32.00

LCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0022	Peri od:	Worksheet E-3	
		Component CCN: 15-S022	From 01/01/2018 To 12/31/2018	Part II Date/Time Pre 5/30/2019 3:2	
		Title XVIII	Subprovider -	PPS	<u>5 pii</u>
				1.00	
	PART II - MEDICARE PART A SERVICES - IPF PPS				
00	Net Federal IPF PPS Payments (excluding outlier, ECT, and me	edical education payments)		1, 754, 383	
00	Net IPF PPS Outlier Payments			23, 087	2
00	Net IPF PPS ECT Payments			0	
00	Unweighted intern and resident FTE count in the most recent	cost report filed on or b	etore November	0.00	4
01	15, 2004. (see instructions) Cap increases for the unweighted intern and resident FTE cou	unt for residents that wer	e displaced by	0.00	4
	program or hospital closure, that would not be counted with			0.00	
	CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)				
00	New Teaching program adjustment. (see instructions)			0.00	5
00	Current year's unweighted FTE count of I&R excluding FTEs in	n the new program growth p	eriod of a "new	0.00	6
	teaching program" (see instuctions)				
00	Current year's unweighted I&R FTE count for residents within	n the new program growth p	eriod of a "new	0.00	
00	teaching program" (see instuctions) Intern and resident count for IPF PPS medical education adju	ustmont (soo instructions)		0.00	8
00	Average Daily Census (see instructions)			6. 263014	
00	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to	o the power of 5150 -1}		0.000000	
00	Teaching Adjustment (line 1 multiplied by line 10).			0.000000	
00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)	)		1, 777, 470	
00	Nursing and Allied Health Managed Care payment (see instruct			0	
00	Organ acquisition (DO NOT USE THIS LINE)				14
00	Cost of physicians' services in a teaching hospital (see ins	structions)		0	
00	Subtotal (see instructions)			1, 777, 470	
00	Primary payer payments			0	1
00 00	Subtotal (line 16 less line 17). Deductibles			1, 777, 470 107, 080	
00	Subtotal (line 18 minus line 19)			1, 670, 390	
00	Coi nsurance			4, 690	
00	Subtotal (line 20 minus line 21)			1, 665, 700	
00	Allowable bad debts (exclude bad debts for professional serv	vices) (see instructions)		0	
00	Adjusted reimbursable bad debts (see instructions)			0	2
00	Allowable bad debts for dual eligible beneficiaries (see ins	structions)		0	
00	Subtotal (sum of lines 22 and 24)			1, 665, 700	
00	Direct graduate medical education payments (from Wkst. E-4,	line 49)		0	
00	Other pass through costs (see instructions)			0	
00 00	Outlier payments reconciliation OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
50	Pioneer ACO demonstration payment adjustment (see instruction	ons)		0	3
99	Demonstration payment adjustment amount before sequestration			0	
00	Total amount payable to the provider (see instructions)			1, 665, 700	
01	Sequestration adjustment (see instructions)			33, 314	
02	Demonstration payment adjustment amount after sequestration			0	
00	Interim payments			1, 632, 386	
00	Tentative settlement (for contractor use only)			0	
00	Balance due provider/program (line 31 minus lines 31.01, 31.			0	
00	Protested amounts (nonallowable cost report items) in accord §115.2	dance with CMS Pub. 15-2,	cnapter I,	0	35
00	TO BE COMPLETED BY CONTRACTOR			22.007	
00 00	Original outlier amount from Worksheet E-3, Part II, line 2 Outlier reconciliation adjustment amount (see instructions)			23, 087 0	
00	The rate used to calculate the Time Value of Money			0.00	
	Time Value of Money (see instructions)				5

I CUL	Financial Systems FRANCISCAN HEALTH C ATION OF REIMBURSEMENT SETTLEMENT	RAWFORDSVILLE Provider CCN: 15-0022	Peri od:	u of Form CMS-2 Worksheet E-3	
LOOL			From 01/01/2018	Part VII	
			To 12/31/2018	Date/Time Pre 5/30/2019 3:2	
		Title XIX	Hospi tal	Cost	<u>, p</u>
			Inpatient	Outpati ent	
				2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SE COMPUTATION OF NET COST OF COVERED SERVICES	RVICES FOR TITLES V OR 7	IX SERVICES		1
00	Inpatient hospital/SNF/NF services		0		1.0
00	Medical and other services			4, 715, 656	
00	Organ acquisition (certified transplant centers only)		0		3. (
00	Subtotal (sum of lines 1, 2 and 3)		0	4, 715, 656	
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) COMPUTATION OF LESSER OF COST OR CHARGES		0	4, 715, 656	7.
	Reasonable Charges				-
00	Routi ne servi ce charges		0		8.
00	Ancillary service charges		1, 934, 715	26, 807, 984	
. 00	Organ acquisition charges, net of revenue		0		10.
. 00	Incentive from target amount computation		0		11.
. 00	Total reasonable charges (sum of lines 8 through 11)		1, 934, 715	26, 807, 984	12.
	CUSTOMARY CHARGES				
. 00	Amount actually collected from patients liable for payment fo	r services on a charge	0	0	13.
00	basis	n normant for convious		0	11
. 00	Amounts that would have been realized from patients liable fo a charge basis had such payment been made in accordance with		on 0	0	14.
. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)	42 CIR 9413. 13(e)	0. 000000	0.000000	15.
	Total customary charges (see instructions)		1, 934, 715	26, 807, 984	
. 00	Excess of customary charges over reasonable cost (complete on	ly if line 16 exceeds	1, 934, 715	22, 092, 328	
	line 4) (see instructions)	5			
. 00	Excess of reasonable cost over customary charges (complete on	ly if line 4 exceeds lir	ne O	0	18.
	16) (see instructions)				
	Interns and Residents (see instructions)		0	0	
	Cost of physicians' services in a teaching hospital (see inst		0	0	20.
. 00	Cost of covered services (enter the lesser of line 4 or line		dore	4, 715, 656	21.
. 00	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be Other than outlier payments	compreted for PPS provi	ders.	0	22
	Outlier payments		0	0	
	Program capital payments		0	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	27.
	Customary charges (title V or XIX PPS covered services only)		0	0	28.
. 00	Titles V or XIX (sum of lines 21 and 27)		0	4, 715, 656	29.
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
	Excess of reasonable cost (from line 18)		0	0	
. 00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6		0	4, 715, 656	
. 00 . 00	Deductibles		0	0	
	Coinsurance Allowable bad debts (see instructions)		0	0	
	Utilization review		0	0	35.
. 00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 an	d 33)	0	4, 715, 656	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	/	0	0	
	Subtotal (line 36 $\pm$ line 37)		0	4, 715, 656	
	Direct graduate medical education payments (from Wkst. E-4)		0		39
	Total amount payable to the provider (sum of lines 38 and 39)		0	4, 715, 656	
. 00	Interim payments		0	4, 715, 656	41.
	Balance due provider/program (line 40 minus line 41)		0	0	42.
. 00	Protested amounts (nonallowable cost report items) in accorda	nce with CMS Pub 15-2,	0	0	43.

LCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0022	Peri od:	Worksheet E-3	
		Component CCN: 15-S022	From 01/01/2018 To 12/31/2018	Part VII Date/Time Prep 5/30/2019 3:23	
		Title XIX	Subprovider - IPF	Cost	
			I npati ent	Outpatient	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH S	SERVICES FOR TITLES V OR X	1.00	2.00	
	COMPUTATION OF NET COST OF COVERED 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	6
00	Subtotal (line 4 less sum of lines 5 and 6)		0	0	7
	COMPUTATION OF LESSER OF COST OR CHARGES				-
~~	Reasonable Charges				
00 00	Routine service charges		0	0	8
00	Ancillary service charges Organ acquisition charges, net of revenue		0	0	10
. 00	Incentive from target amount computation		0		11
. 00	Total reasonable charges (sum of lines 8 through 11)		0	0	
. 00	CUSTOMARY CHARGES				1 ' '
8. 00	Amount actually collected from patients liable for payment f	for services on a charge	0	0	113
	basi s	5			
. 00	Amounts that would have been realized from patients liable f	for payment for services o	n 0	0	14
	a charge basis had such payment been made in accordance with	n 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)		0	0	16
. 00	Excess of customary charges over reasonable cost (complete c	only if line 16 exceeds	0	0	17
~~~	line 4) (see instructions)		-	0	1
. 00	Excess of reasonable cost over customary charges (complete c 16) (see instructions)	only if line 4 exceeds lin	e u	0	18
. 00	Interns and Residents (see instructions)		0	0	19
. 00	Cost of physicians' services in a teaching hospital (see ins	structions)	0	0	20
. 00	Cost of covered services (enter the lesser of line 4 or line		0	0	
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only b				
. 00	Other than outlier payments	1. I	0	0	22
. 00	Outlier payments		0	0	23
. 00	Program capital payments		0		24
. 00	Capital exception payments (see instructions)		0		25
. 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	28
. 00	Titles V or XIX (sum of lines 21 and 27)		0	0	29
00	COMPUTATION OF REIMBURSEMENT SETTLEMENT Excess of reasonable cost (from line 18)		0	0	1 20
0. 00 . 00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and	6)	0	0	
	Deductiblies	6)	0	0	
. 00	Coi nsurance		0	0	
. 00	Allowable bad debts (see instructions)		0	0	
. 00	Utilization review		0		35
. 00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 a	and 33)	0	0	36
. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	-	0	0	
. 00	Subtotal (line 36 ± line 37)		0	0	38
. 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	7)	0	0	
. 00	Interim payments		0	0	
2.00	Balance due provider/program (line 40 minus line 41)		0	0	
3. 00	Protested amounts (nonallowable cost report items) in accord	dance with CMS Pub 15-2,	0	0	43

	E SHEET (If you are nonproprietary and do not maintain	Provider C	CN: 15-0022	Period: From 01/01/2018	Worksheet G	
ina-t il y)	ype accounting records, complete the General Fund column			To 12/31/2018	Date/Time Pre 5/30/2019 3:2	
		General Fund	Specific Purpose Func		Plant Fund	
	CUDDENT ASSETS	1.00	2.00	3.00	4.00	
00	CURRENT ASSETS Cash on hand in banks	459		0 0	0	1 1
00	Temporary investments			0 0	0	
00	Notes receivable	0		0 0	0	
00	Accounts receivable	10, 131, 241		0 0	0	
00	Other receivable	0		0 0	0	
00	Allowances for uncollectible notes and accounts receivable	-2, 878, 653		0 0	0	6
00	Inventory	1, 309, 975		0 0	0	
00	Prepaid expenses	329, 357		0 0	0	6
00	Other current assets	0		0 0	0	9
. 00	Due from other funds	0		0 0	0	10
. 00	Total current assets (sum of lines 1-10)	8, 892, 379		0 0	0	
	FIXED ASSETS					
. 00	Land	970, 120		0 0	0	1 12
. 00	Land improvements	3, 798, 810		0 0	0	13
. 00	Accumulated depreciation	0		0 0	0	14
. 00	Bui I di ngs	39, 595, 706		0 0	0	15
. 00	Accumulated depreciation	0		0 0	0	16
	Leasehold improvements	507, 273		0 0	0	17
	Accumulated depreciation	0		0 0	0	18
	Fixed equipment	0		0 0	0	19
	Accumulated depreciation	0		0 0	0	20
	Automobiles and trucks	0		0 0	0	21
	Accumulated depreciation	0		0 0	0	22
	Major movable equipment	23, 422, 928		0 0	0	23
	Accumul ated depreciation	-35, 694, 523		0 0	0	24
. 00	Mi nor equipment depreciable	00,071,020		0 0	0	25
	Accumul ated depreciation	0		0 0	0	26
	HIT designated Assets	0		0 0	0	
	Accumulated depreciation	0		0 0	0	28
	Mi nor equi pment-nondepreci abl e			0 0	0	29
	Total fixed assets (sum of lines 12-29)	32, 600, 314		0 0	0	30
	OTHER ASSETS	02/000/01/	1	<u> </u>		
. 00	Investments	0		0 0	0	31
2.00	Deposits on Leases	0		0 0	0	32
8.00	Due from owners/officers	0		0 0	0	
	Other assets	0		0 0	0	
	Total other assets (sum of lines 31-34)	0		0 0	0	
	Total assets (sum of lines 11, 30, and 35)	41, 492, 693		0 0	0	
. 00	CURRENT LIABILITIES	41, 472, 073		0 0	0	1 30
00	Accounts payable	2, 990, 279		0 0	0	37
	Salaries, wages, and fees payable	951, 917		0 0	0	38
9.00	Payroll taxes payable	, , , , , , , , , , , , , , , , , , , ,		0 0	0	
). 00	Notes and Loans payable (short term)	0		0 0	0	
	Deferred income	0		0 0	0	
2.00	Accel erated payments	0		0 0	0	42
	Due to other funds	207 254		0 0	0	
		387, 356		0 0	0	
	Other current liabilities Total current liabilities (sum of lines 37 thru 44)	184, 543		0 0		
5. 00		4, 514, 095		0 0	0	43
00	LONG TERM LIABILITIES	0		0 0	0	1
b. 00	Mortgage payable	0		-	0	
. 00	Notes payable	0		0 0	0	
	Unsecured Loans			0 0	0	
9.00	Other long term liabilities	-3, 701, 440		0 0	0	
	Total long term liabilities (sum of lines 46 thru 49)	-3, 701, 440		0 0	0	
. 00	Total liabilities (sum of lines 45 and 50)	812, 655	l	0 0	0	51
	CAPI TAL ACCOUNTS	40 (00 677				
. 00	General fund balance	40, 680, 038				52
8.00	Specific purpose fund			0		53
1.00	Donor created - endowment fund balance - restricted			0		54
5.00	Donor created - endowment fund balance - unrestricted			0		55
b. 00	Governing body created - endowment fund balance			0		56
7.00	Plant fund balance - invested in plant				0	
3. 00	Plant fund balance - reserve for plant improvement,				0	58
	replacement, and expansion					
9.00	Total fund balances (sum of lines 52 thru 58)	40, 680, 038		0 0	0	59
. 00						

Heal th	Financial Systems FR/	ANCI SCAN HEALTH	CRAWFORDSVI LLI	E		In Lie	u of Form CMS-	2552-10
	ENT OF CHANGES IN FUND BALANCES		Provider CC			riod: om 01/01/2018	Worksheet G-	l epared:
		General	Fund	Speci al	Pur	pose Fund	Endowment Fund	1
		1.00	0.00	0.00		1.00	F 00	
1.00	Fund balances at beginning of period	1.00	2.00 41,911,470	3.00		4.00	5.00	1.00
2.00 3.00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2)		6, 377, 859 48, 289, 329			0		2.00 3.00
4.00	Additions (credit adjustments) (specify)	0	40, 207, 327		0	0	C	4.00
5.00 6.00		0			0		(
7.00		0			0		(7.00
8.00 9.00		0			0		(
10.00	Total additions (sum of line 4-9)	J	0		Ŭ	0		10.00
11.00 12.00	Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)	0	48, 289, 329		0	0	C	11.00
13.00	EQUITY TRANSFERS	7, 609, 291			0		(13.00
14.00 15.00		0			0		(
16.00		0			0		(16.00
17.00 18.00	Total deductions (sum of lines 12-17)	0	7, 609, 291		0	0	(17.00
19.00	Fund balance at end of period per balance		40, 680, 038			0		19.00
	sheet (line 11 minus line 18)	Endowment Fund	PI ant	Fund				
		6.00	7.00	8,00				
1.00	Fund balances at beginning of period	0.00	7.00	0.00	0			1.00
2.00 3.00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2)	0			0			2.00 3.00
4.00	Additions (credit adjustments) (specify)	0	0		0			4.00
5.00 6.00			0					5.00 6.00
7.00			0					7.00
8.00 9.00			0					8.00 9.00
10.00	Total additions (sum of line 4–9)	0	0		0			10.00
11.00 12.00	Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)	0	0		0			11.00 12.00
13.00	EQUITY TRANSFERS		0					13.00
14.00 15.00			0					14.00 15.00
16.00			0					16.00
17.00 18.00	Total deductions (sum of lines 12-17)	0	0		0			17.00 18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0			0			19.00

STATE	IENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provider C	CN: 15-0022	Period: From 01/01/2018	Worksheet G-2 Parts I & II	2552-1
			1	To 12/31/2018	Date/Time Pre 5/30/2019 3:2	
	Cost Center Description		Inpatient	Outpati ent	Total	
			1.00	2.00	3.00	
	PART I - PATIENT REVENUES General Inpatient Routine Services					-
1.00	Hospi tal		3, 776, 7	82	3, 776, 782	1 1.00
2.00	SUBPROVIDER - IPF		4, 770, 8		4, 770, 834	
3.00	SUBPROVIDER - IRF		4,770,0	54	4, 770, 034	3.00
4.00	SUBPROVI DER					4.00
5.00	Swing bed - SNF			0	0	•
6.00	Swing bed - NF			0	0	
7.00	SKILLED NURSING FACILITY					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)		8, 547, 6	16	8, 547, 616	10.00
	Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT		1, 719, 5	74	1, 719, 574	11.00
12.00	CORONARY CARE UNI T					12.00
13.00	BURN INTENSIVE CARE UNIT					13.00
14.00	SURGICAL INTENSIVE CARE UNIT					14.00
15.00	OTHER SPECIAL CARE (SPECIFY)					15.00
16.00	Total intensive care type inpatient hospital services (sum	oflines	1, 719, 5	74	1, 719, 574	16.00
	11-15)					
17.00	Total inpatient routine care services (sum of lines 10 and	16)	10, 267, 1		10, 267, 190	•
18.00	Ancillary services		21, 677, 9			
19.00 20.00	Outpatient services		2, 435, 0			
	RURAL HEALTH CLINIC			0 0		
21.00	FEDERALLY QUALIFIED HEALTH CENTER HOME HEALTH AGENCY			0 0	0	21.00
22.00	AMBULANCE SERVICES					22.00
23.00	CMHC					23.00
25.00	AMBULATORY SURGICAL CENTER (D. P.)					25.00
26.00	HOSPICE					26.00
27.00	NON REIMBURSABLE			0 2, 863, 039	2, 863, 039	
28.00	Total patient revenues (sum of lines 17-27)(transfer column	n 3 to Wkst	34, 380, 1			
20.00	G-3, line 1)		01,000,1		20770107270	20.00
	PART II - OPERATING EXPENSES		1		1	
29.00	Operating expenses (per Wkst. A, column 3, line 200)			52, 895, 666		29.00
30.00	ADD (SPECI FY)		1	0		30.00
31.00				0		31.00
32.00				0		32.00
33.00				0		33.00
34.00				0		34.00
35.00				0		35.00
36.00	Total additions (sum of lines 30-35)			0		36.00
37.00	DEDUCT (SPECI FY)			0		37.0
38.00				0		38.00
39.00				0		39.0
40.00				0		40.0
41.00				0		41.00
42.00	Total deductions (sum of lines 37-41)	10) (1)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line	47)(transfer	1	52, 895, 666	1	43.00

Heal th	Financial Systems	FRANCI SCAN HEALTH CR	AWFORDSVI LLE	In Lie	u of Form CMS-2	2552-10
STATEM	ENT OF REVENUES AND EXPENSES		Provider CCN: 15-0022	Peri od:	Worksheet G-3	
				From 01/01/2018 To 12/31/2018	Date/Time Pre	nared
				10 12/01/2010	5/30/2019 3:2	
					1.00	
1.00	Total patient revenues (from Wkst. G-2				207, 648, 275	1.00
2.00	Less contractual allowances and discou		ts		149, 128, 610	
3.00	Net patient revenues (line 1 minus lin				58, 519, 665	3.00
4.00	Less total operating expenses (from Wk		13)		52, 895, 666	
5.00	Net income from service to patients (I	ine 3 minus line 4)			5, 623, 999	5.00
	OTHER I NCOME					
6.00	Contributions, donations, bequests, et	С			4, 653	6.00
7.00	Income from investments				0	7.00
8.00	Revenues from telephone and other misc		services		0	8.00
9.00	Revenue from television and radio serv	ice			0	9.00
10.00	Purchase di scounts				177, 472	
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				10, 255	
14.00	Revenue from meals sold to employees a				106, 882	
15.00	Revenue from rental of living quarters				0	15.00
16.00	Revenue from sale of medical and surgi		nan patrents		0	16.00
	Revenue from sale of drugs to other th				0	17.00
	Revenue from sale of medical records a				1, 493	
19.00	Tuition (fees, sale of textbooks, unif				0	19.00 20.00
20. 00 21. 00	Revenue from gifts, flowers, coffee sh	ops, and canteen			0	
21.00	Rental of vending machines				7, 545 277, 356	
	Rental of hospital space					22.00
23.00 24.00	Governmental appropriations OTHER OPERATING REVENUE				0	
	NON OPERATING REVENUE				156, 643	
24.01	Total other income (sum of lines 6-24)				11, 561	
25.00 26.00					753, 860 6, 377, 859	
26.00 27.00	Total (line 5 plus line 25) NON OPERATING REVENUE				6, 377, 859	26.00
27.00	Total other expenses (sum of line 27 a	nd subserints)			0	27.00
	Net income (or loss) for the period (1	1 /			6, 377, 859	
27.00	ine theome (of toss) for the period (I	THE 20 III HUS TITLE 20)		I	0, 377, 009	27.00

CALCUL	ATION OF CAPITAL PAYMENT	Provider CCN: 15-0022	Peri od:	Worksheet L	
			From 01/01/2018 To 12/31/2018		pared
		Title XVIII	Hospi tal	PPS	5 piii
	PART I - FULLY PROSPECTIVE METHOD			1.00	
	CAPITAL FEDERAL AMOUNT				
. 00	Capital DRG other than outlier			300, 712	1.0
. 01	Model 4 BPCI Capital DRG other than outlier			0	1.0
. 00	Capital DRG outlier payments			9, 387	2. (
2. 01	Model 4 BPCI Capital DRG outlier payments			0	2. (
3.00	Total inpatient days divided by number of days in the cost re	eporting period (see inst	ructions)	8.30	3. (
l. 00	Number of interns & residents (see instructions)			0.00	4. (
5.00	Indirect medical education percentage (see instructions)			0.00	5.0
. 00	Indirect medical education adjustment (multiply line 5 by the 1.01) (see instructions)	e sum of lines 1 and 1.01	, columns 1 and	0	6.
. 00	Percentage of SSI recipient patient days to Medicare Part A p 30) (see instructions)	oatient days (Worksheet E	E, part A line	0.00	7.
. 00	Percentage of Medicaid patient days to total days (see instru	uctions)		0.00	
. 00	Sum of lines 7 and 8			0.00	
0.00	Allowable disproportionate share percentage (see instructions	5)		0.00	
1.00	Disproportionate share adjustment (see instructions)			0	
2.00	Total prospective capital payments (see instructions)			310, 099	12.
				1.00	
	PART II - PAYMENT UNDER REASONABLE COST				
. 00	Program inpatient routine capital cost (see instructions)			0	1.
2.00	Program inpatient ancillary capital cost (see instructions)			0	2.
3.00 1.00	Total inpatient program capital cost (line 1 plus line 2)			0	3. 4.
i. 00 5. 00	Capital cost payment factor (see instructions) Total inpatient program capital cost (line 3 x line 4)			0	
. 00				0	<u>J.</u>
				1.00	
~~	PART III - COMPUTATION OF EXCEPTION PAYMENTS				1
. 00 . 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstance			0	1. 2.
. 00	Net program inpatient capital costs (line 1 minus line 2)	ces (see instructions)		0	2.
. 00	Applicable exception percentage (see instructions)			0.00	3. 4.
	Capital cost for comparison to payments (line 3 x line 4)			0.00	4. 5.
$\cap \cap$	Percentage adjustment for extraordinary circumstances (see in	ostructions)		0.00	6.
				0.00	7.
. 00		د circumstances (line 2	(IIne 6) I		
. 00 . 00	Adjustment to capital minimum payment level for extraordinary	y circumstances (line 2 >	(TINE 6)	0	8.
. 00 . 00 . 00	Adjustment to capital minimum payment level for extraordinary Capital minimum payment level (line 5 plus line 7)		(TINE 6)	-	
. 00 . 00 . 00 . 00	Adjustment to capital minimum payment level for extraordinary Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as appli	cabl e)	,	0	9.
0.00 .00 .00 .00 0.00	Adjustment to capital minimum payment level for extraordinary Capital minimum payment level (line 5 plus line 7)	cable) capital payments (line 8	less line 9)	0	9. 10.
5.00 5.00 7.00 8.00 9.00 0.00 1.00	Adjustment to capital minimum payment level for extraordinary Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as appli Current year comparison of capital minimum payment level to c	cable) capital payments (line 8	less line 9)	0 0 0	8. 9. 10. 11.
 00 00 00 00 00 00 00 	Adjustment to capital minimum payment level for extraordinary Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as appli Current year comparison of capital minimum payment level to c Carryover of accumulated capital minimum payment level over c	cable) capital payments (line 8 capital payment (from pri	less line 9) or year	0 0 0	9. 10.
 a. 00 b. 00 c. 00 c. 00 c. 00 c. 00 c. 00 d. 00 d. 00 d. 00 	Adjustment to capital minimum payment level for extraordinary Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as appli Current year comparison of capital minimum payment level to c Carryover of accumulated capital minimum payment level over c Worksheet L, Part III, line 14)	cable) capital payments (line 8 capital payment (from pri ayments (line 10 plus lin the amount on this line	less line 9) or year ne 11) e)	0 0 0 0	9. 10. 11. 12.

 13.00 Current year exception payment (if line 12 is positive, enter the amount on this line)
 14.00 Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line) 15.00 Current year allowable operating and capital payment (see instructions)
16.00 Current year operating and capital costs (see instructions)
17.00 Current year exception offset amount (see instructions)

0 15.00 0 16.00 0 17.00