laws and regulations.

FRANCI SCAN HEALTH LAFAYETTE

In Lieu of Form CMS-2552-10 This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED

payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 03-31-2022 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION Provider CCN: 15-0109 Worksheet S Peri od. From 01/01/2020 Parts I-III AND SETTLEMENT SUMMARY 12/31/2020 Date/Time Prepared: То 4/29/2021 3:52 pm PART I - COST REPORT STATUS Provi der 1. [X] Electronically prepared cost report Date: 4/29/2021 Time: 3:52 pm Manually prepared cost report use only 2 []If this is an amended report enter the number of times the provider resubmitted this cost report]Medicare Utilization. Enter "F" for full or "L" for low. 3 Ο Ē 4

 [1] Cost Report Status
 6. Date Received:

 (1) As Submitted
 7. Contractor No.

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

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

 Contractor 5. use only Δ (3) Settled with Audit number of times reopened = 0-9. (4) Reopened (5) Amended PART II - CERTIFICATION MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL. CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OF INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT. CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF PROVIDER(S) I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by FRANCISCAN HEALTH LAFAYETTE (15-0109) for the cost reporting period beginning 01/01/2020 and ending 12/31/2020 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

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

(Si	gned)	
(3)	queu)	

Officer or Administrator of Provider(s)

CHIEF FINANCIAL OFFICER

Title

Da	te	

			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	-51, 038	-23, 276	0	-160, 946	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	-9, 081	0		0	3.00
5.00	Swing Bed - SNF	0	0	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	1		0	9.00
200.00	Total	0	-60, 119	-23, 275	0	-160, 946	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.

	,	IDENTIFICATION DATA	Provi c	ler CCN: 1	5-0109	Period: From 01/01/ To 12/31/	2020	Worksho Part I Date/Ti 4/29/20	ime Pre	epared
	1.00	2.00		3.00		4	4.00			
~~	Hospital and Hospital Health Care Co									
00	Street: 1701 SOUTH CREASY LANE	PO Box:	Zin Cod	a. 4700F	Cours					1.0
00	City: LAFAYETTE	State: IN		e: 47905-		ty: TI PPECAN		nt Curat	(D	2.0
		Component Name	CCN Number	CBSA Number	Provi der	- Date Certified		ent Syst		
			Number	Number	Туре	Certifieu	V	, 0, or XVIII		-
		1.00	2.00	2 00	1 00	E 00				-
	Hospital and Hospital-Based Componer		2.00	3.00	4.00	5.00	6.00	7.00	8.00	
00	Hospi tal	FRANCI SCAN HEALTH	150109	29200	1	07/01/1966	N	Р	0	3.
00		LAFAYETTE	130109	29200	'	0770171900				3.
00	Subprovider - IPF									4.
00	Subprovider - IRF	FRNACI SCAN HEALTH	15T109	29200	5	01/01/1995	N	Р	0	5.
00		LAFAYETTE REHAB	131109	27200		01/01/1993		1		J.
00	Subprovider - (Other)	LAFATEITE KENAD								6.
00	Swing Beds - SNF									7.
00	0									8.
	Swing Beds - NF									
00	Hospital -Based SNF									9.
00	Hospital -Based NF									10.
00	Hospital-Based OLTC							-		11.
00	Hospital-Based HHA	FRANCISCAN HOME CARE	157124	29200		07/06/1966	N	P	N	12.
	Separately Certified ASC									13.
00	Hospi tal -Based Hospi ce	FRNACI SCAN HEALTH	151563	29200		01/01/1984				14.
		LAFAYETTE HOSPICE								
	Hospital-Based Health Clinic - RHC									15.
00	Hospital-Based Health Clinic - FQHC									16.
00	Hospital-Based (CMHC) I									17.
00	Renal Dialysis									18.
00	Other									19.
						From:		To):	
						1 00		2	00	
						1.00		2.	00	
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	Cost Reporting Period (mm/dd/yyyy) Type of Control (see instructions)						020			20. 21.
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00 00 01 02	Type of Control (see instructions) Inpatient PPS Information Does this facility qualify and is it disproportionate share hospital adju §412.106? In column 1, enter "Y" fof facility subject to 42 CFR Section § hospital?) In column 2, enter "Y" fof Did this hospital receive interim un cost reporting period? Enter in colu the portion of the cost reporting period Enter in column 2, "Y" for yes or "N reporting period occurring on or aft Is this a newly merged hospital that payments to be determined at cost ref Enter in column 1, "Y" for yes or "N cost reporting period prior to Octob or "N" for no, for the portion of th October 1. Did this hospital receive a geograph rural as a result of the OMB standar adopted by CMS in FY2015? Enter in co for the portion of the cost reportir in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least counted in accordance with 42 CFR 41	ustment, in accordance w or yes or "N" for no. Is 5412.106(c)(2)(Pickle an or yes or "N" for no. ncompensated care paymer mm 1, "Y" for yes or "N eriod occurring prior to "for no for the portic cer October 1. (see inst requires final uncompe port settlement? (see "for no, for the porti per 1. Enter in column 2 he cost reporting perior to delineating stat column 1, "Y" for yes or g period prior to Octob no for the portion of t er October 1. (see inst 100 but not more than 4	i th 42 CFF this hendment ts for thi o October on of the o rructions) insated can nstruction on of the c, "Y" for I on or aff m urban to istical an "N" for r he cost rructions) 99 beds (a	s for L. cost re ns) yes ter o reas no er	Y Y N	01/01/20 1 2.00 N Y N	020	3.1	/2020	21. 22. 22. 22.
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00 00 01 02 03	Type of Control (see instructions) Inpatient PPS Information Does this facility qualify and is it disproportionate share hospital adju §412.106? In column 1, enter "Y" fof facility subject to 42 CFR Section § hospital?) In column 2, enter "Y" fof Did this hospital receive interim un cost reporting period? Enter in colu the portion of the cost reporting period Enter in column 2, "Y" for yes or "M reporting period occurring on or aff Is this a newly merged hospital that payments to be determined at cost ref Enter in column 1, "Y" for yes or "N cost reporting period prior to Octob or "N" for no, for the portion of th October 1. Did this hospital receive a geograph rural as a result of the OMB standar adopted by CMS in FY2015? Enter in co for the portion of the cost reportir in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least counted in accordance with 42 CFR 41 yes or "N" for no.	ustment, in accordance w or yes or "N" for no. Is 5412.106(c)(2)(Pickle an or yes or "N" for no. acompensated care paymer mm 1, "Y" for yes or "N eriod occurring prior to " for no for the portic crequires final uncompe port settlement? (see i " for no, for the porti ber 1. Enter in column 2 the cost reporting period nic reclassification fro rds for delineating stat column 1, "Y" for yes or ng period prior to Octob no for the portion of t er October 1. (see inst column 1, "Y" for yes or ng period prior to Octob no for the portion of t er October 1. (see inst 100 but not more than 4 (2.105)? Enter in column 24	i th 42 CFF this hendment ts for this o October on of the o ructions) ensated can nstruction on of the c, "Y" for I on or aff om urban to istical an "N" for r ber 1. Enten he cost ructions) 99 beds (a 1 and/or 25	s For L. cost re ns) yes ter Preas no er	Y Y N	01/01/20 1 2.00 N Y N N	020	3.1	/2020	21 22 22 22 22 22
00 00 01 02 03	Type of Control (see instructions) Inpatient PPS Information Does this facility qualify and is it disproportionate share hospital adju \$412.106? In column 1, enter "Y" fof facility subject to 42 CFR Section 5 hospital?) In column 2, enter "Y" fof Did this hospital receive interim un cost reporting period? Enter in colu the portion of the cost reporting period Enter in column 2, "Y" for yes or "N reporting period occurring on or aft Is this a newly merged hospital that payments to be determined at cost re- Enter in column 1, "Y" for yes or "N cost reporting period prior to Octod or "N" for no, for the portion of th October 1. Did this hospital receive a geograph rural as a result of the OMB standar adopted by CMS in FY2015? Enter in c for the portion of the cost reportir in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least counted in accordance with 42 CFR 41 yes or "N" for no. Which method is used to determine Me	ustment, in accordance w or yes or "N" for no. Is 5412.106(c)(2)(Pickle am or yes or "N" for no. iccompensated care paymer umn 1, "Y" for yes or "N priod occurring prior to the for no for the portic cer October 1. (see inst crequires final uncompe port settlement? (see i " for no, for the porti- per 1. Enter in column 2 the cost reporting period nic reclassification fro ds for delineating stat column 1, "Y" for yes or ng period prior to Octob no for the portion of t ter October 1. (see inst 100 but not more than 4 (2.105)? Enter in column edicaid days on lines 24 of admission, 2 if cens	i th 42 CFF this hendment ts for thi o October of o October of no of the of rructions) insated car nstructions) insated car nstructions) insated car nstructions) m urban to istical ar "N" for i wer 1. Enter he cost rructions) igg beds (a a, "Y" for and/or 25 sus days, of the cost tructions)	s for l. cost re ns) yes ter preas no er as pr as pr 3	Y Y N	01/01/20 1 2.00 N Y N N	020	3.1	/2020	21 22 22 22 22 22
00 00 01 02 03	Type of Control (see instructions) Inpatient PPS Information Does this facility qualify and is it disproportionate share hospital adju §412.106? In column 1, enter "Y" fof facility subject to 42 CFR Section S hospital?) In column 2, enter "Y" fof Did this hospital receive interim un cost reporting period? Enter in colu- the portion of the cost reporting period Enter in column 2, "Y" for yes or "N reporting period occurring on or aft Is this a newly merged hospital that payments to be determined at cost re- Enter in column 1, "Y" for yes or "N cost reporting period prior to Octob or "N" for no, for the portion of th October 1. Did this hospital receive a geograph- rural as a result of the OMB standar adopted by CMS in FY2015? Enter in co for the portion of the cost reportir in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least counted in accordance with 42 CFR 41 yes or "N" for no.	ustment, in accordance w or yes or "N" for no. Is 5412.106(c)(2)(Pickle an or yes or "N" for no. compensated care paymer umn 1, "Y" for yes or "N eriod occurring prior to "for no for the portic cer October 1. (see inst requires final uncompe port settlement? (see i "for no, for the porti- per 1. Enter in column 2 he cost reporting perior to ds for delineating stat column 1, "Y" for yes or ng period prior to Octob no for the portion of t er October 1. (see inst 100 but not more than 4 (2.105)? Enter in column edicaid days on lines 24 of admission, 2 if cens	i th 42 CFF this hendment ts for thi o October o October in of the cructions) insated can nstruction on of the cruction or aff of urban to istical an or N" for r he cost ructions) 199 beds (a a, "Y" for and/or 25 us days, of in this of in this of in this of in this of in this of istical and/or the istical and/or the	s for l. cost re ns) yes ter preas no er as pr as pr 3	Y Y N	01/01/20 1 2.00 N Y N N	020	3.1	/2020	21 22 22 22 22 22 22

Health Financial Systems HOSPITAL AND HOSPITAL HEALTH CAI		AN HEALTH L	Provider CC	N: 15-0109	Peri od:			neet S-2	- <u>2552-10</u> 2
						′31/2020	Part I Date/1 4/29/2	ime Pre 2021 3:5	epared:
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medi cai d el i gi bl e unpai d	Medica HMO da	ays Me	Other edi cai d days	
24 00 If this provider is on ID	DC beenitel enter the	1.00	2.00	3.00	4.00	5.0		6.00	2 24 00
 Medicaid HMO paid and column 5, and other Medic OI If this provider is an IR Medicaid paid days in col Medicaid eligible unpaid out-of-state Medicaid day 	ys in column 1, in-state days in column 2, d days in column 3, gible unpaid days in column eligible but unpaid days in aid days in column 6. F, enter the in-state umn 1, the in-state days in column 2, s in column 3, out-of-state days in column 4, Medicaid	41	5		1	5	381	25.	3 24.00 25.00
						<u>'Rural S</u> .00		f Geogr 00	
	aphic classification (not wa		at the beg	jinning of t		. 00 1	2.	00	26.00
27.00 Enter your standard geogr reporting period. Enter i enter the effective date	ter "1" for urban or "2" for aphic classification (not wa n column 1, "1" for urban or of the geographic reclassifi	age) status ~ "2" for ru cation in d	ural. If ap column 2.	pl i cabl e,		1			27.00
35.00 If this is a sole communi effect in the cost report	ty hospital (SCH), enter the ing period.	e number of	periods SC	CH status in		(nni ng:		i ng:	35.00
					1	. 00		00	
36.00 Enter applicable beginnin of periods in excess of o	g and ending dates of SCH st ne and enter subsequent date		cript line	36 for numb	er				36.00
37.00 If this is a Medicare dep is in effect in the cost	endent hospital (MDH), enter reporting period.	the number	r of period	ls MDH statu	s	C			37.00
	MDH that is eligible for th PPS final rule? Enter "Y" fo								37.01
38.00 If line 37 is 1, enter th	e beginning and ending dates this line for the number of					//N		/N	38.00
					1	. 00		00	
hospitals in accordance w 1 "Y" for yes or "N" for accordance with 42 CFR 41 or "N" for no. (see instr), (ii), or the mileage i)? Enter i	(iii)? Ent requiremen n column 2	er in colum nts in ? "Y" for ye	in is	N		N	39.00
"N" for no in column 1, f	to the HAC program reduction or discharges prior to Octob arges on or after October 1.	per 1. Ente	°"Y" for y			Y		Y	40.00
						V 1.0	XVIII 2.00	_	-
Prospective Payment Syste				·					
with 42 CFR Section §412.		·	·				Y	N	45.00
	for additional payment exce 48(f)? If yes, complete Wks1					N	N	N	46.00
47.00 Is this a new hospital un 48.00 Is the facility electing	der 42 CFR §412.300(b) PPS o full federal capital payment					N N	N N	N N	47.00 48.00
"N" for no in column 1. I	ed in training residents in f column 1 is "Y", are you i	mpacted by	CR 11642 (2				56.00
	nter "Y" for yes or "N" for s the first cost reporting p	period duri	ng which re						57.00
GME programs trained at t is "Y" did residents star for yes or "N" for no in	his facility? Enter "Y" for t training in the first mont column 2. If column 2 is "Y	th of this ((", complete	cost report e Worksheet	ing period?					
GME programs trained at t is "Y" did residents star for yes or "N" for no in "N", complete Wkst. D, Pa 58.00 fline 56 is yes, did th	t training in the first mont	th of this (/", complete , if applic pursement fo	cost report e Worksheet cable. or physicia	ing period? E-4. If co	lumn 2 is				58.00

alth Financial Systems FRANCISC SPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	ATA	Provider C		eriod: rom 01/01/2020	Worksheet S-2 Part I	2552-1
			T		Date/Time Pre 4/29/2021 3:53	
			NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
			1.00	2.00	3.00	
0.00 Are you claiming nursing and allied health education any programs that meet the criteria under 42 CFR 413 instructions) Enter "Y" for yes or "N" for no in co is "Y", are you impacted by CR 11642 (or subsequent adjustement? Enter "Y" for yes or "N" for no in col 0.01 f line 60 is yes, complete columns 2 and 3 for each	.85? (s lumn 1. CR) NAHE umn 2.	ee If column 1 MA payment	Y	Y 20. 00	1	60. (60. (
instructions) 0.02 f ine 60 is yes, complete columns 2 and 3 for each				23.00		60.0
instructions) 0.03 f line 60 is yes, complete columns 2 and 3 for each				23. 01	1	60.0
instructions)	Y/N	IME	Direct GME	IME	Direct GME	
.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	1.00	2.00	3.00	4.00	5.00 0.00	61. (
 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) 						61. (
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.
 .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.
1.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).						61.
 1.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions) 1.06 Enter the amount of ACA §5503 award that is being 						61. 61.
used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						
	Pro	gram Name	Program Code		Direct GME FTE Count	
1.10 Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.		1.00	2.00	3.00	4.00	61.
 Definition of the FTEs in line 61.05, specify each expanded program special ty, 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	0.00	61.
					1.00	
ACA Provisions Affecting the Health Resources and Se 2.00 Enter the number of FTE residents that your hospital				od for which		62.
your hospital received HRSA PCRE funding (see instru 2.01 Enter the number of FTE residents that rotated from during in this cost reporting period of HRSA THC pro	ctions) a Teachi	ng Health Cen	ter (THC) into			62.
	yraill. LSi					

Health Financial Systems	FRANCI SCAI	N HEALTH LAFAYETTE		In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPL	EX IDENTIFICATION DATA	A Provider CO		eriod:	Worksheet S-2	
				rom 01/01/2020 0 12/31/2020	Part I Date/Time Pre	nared
					4/29/2021 3:5	2 pm
			Unwei ghted	Unwei ghted	Ratio (col. 1/	
			FTES	FTEs in	$(\operatorname{col} \cdot 1 + \operatorname{col} \cdot$	
			Nonprovider Site	Hospi tal	2))	
			1.00	2.00	3.00	-
Section 5504 of the ACA Base Year	FTF Residents in Non	nrovider Settings				
period that begins on or after Ju			This base year		oportring	
64.00 Enter in column 1, if line 63 is in the base year period, the numb resident FTEs attributable to rot settings. Enter in column 2 the resident FTEs that trained in you of (column 1 divided by (column 1	yes, or your facility er of unweighted non- ations occurring in a number of unweighted r hospital. Enter in	trained residents primary care II nonprovider non-primary care column 3 the ratio nstructions)	0. 00	0. 00	0. 000000	64.00
	Program Name	Program Code	Unwei ghted	Unwei ghted	Ratio (col. 3/	·
			FTES	FTEs in	$(col \cdot 3 + col \cdot$	
			Nonprovider Site	Hospi tal	4))	
-	1.00	2.00	3.00	4.00	5.00	-
65.00 Enter in column 1, if line 63	1.00	2.00	3.00			65 00
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		Nonprovider Setting	sEffective fo	or cost reporti	ng periods	
66.00 Enter in column 1 the number of u		care resident	0.00	0.00	0. 000000	66,00
FTEs attributable to rotations of Enter in column 2 the number of u FTEs that trained in your hospita	nweighted non-primary 1. Enter in column 3	care resident the ratio of				
(column 1 divided by (column 1 +	Program Name	Program Code	Unweighted	Unweighted	Ratio (col. 3/	,
	g. dii Mailo		FTEs	FTEs in	(col . 3 + col .	
			Nonprovi der	Hospi tal	4))	
			Si te			
	1.00	2.00	3.00	4.00	5.00	
 67.00 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 3 divided by (column 3 + column 4)). (see instructions) 			0.00	0. 00	0. 00000C	67.00

Heal th	Financial Systems FRANCISCAN HEALTH LAFAYETTE	I	n Lieu	of Form	n CMS-:	2552-10
	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0109	Period: From 01/01/ To 12/31/	2020 2020	Workshe Part I Date/Ti 4/29/20	et S-2 me Pre	pared:
				2.00	3.00	
70.00	Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF sub	provi der?	N			70.00
	Enter "Y" for yes or "N" for no. If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teac program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for	the most no. (see :hing no.			0	71.00
	Column 3: If column 2 is Y, indicate which program year began during this cost reportir (see instructions)	g period.				
75.00	Inpatient Rehabilitation Facility PPS Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF		Y			75.00
76.00	subprovider? Enter "Y" for yes and "N" for no. If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes o no. Column 2: Did this facility train residents in a new teaching program in accordance CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is N	r "N" for with 42	N	N	0	76.00
	indicate which program year began during this cost reporting period. (see instructions)				2	
	Long Term Care Hospital PPS			1.0		
	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no. Is this a LTCH co-located within another hospital for part or all of the cost reporting "Y" for yes and "N" for no.	period? E	nter	N N		80.00 81.00
	TEFRA Providers Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section 5412.405(1)(i) 22 Frame "V" for wards "" for an end of the former of the form		no.	N	_	85. 00 86. 00
87.00	\$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 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.			Ν		87.00
		V 1.00		XI) 2. 0		
90.00	Title V and XIX Services Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for	N		Y		90.00
91.00	yes or "N" for no in the applicable column. Is this hospital reimbursed for title V and/or XIX through the cost report either in	N		Y		91.00
92.00	full or in part? Enter "Y" for yes or "N" for no in the applicable column. Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			Ν		92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N		Ν		93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N		Ν		94.00
	IF line 94 is "Y", enter the reduction percentage in the applicable column. Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	0. 00 N		0. 0 N		95.00 96.00
	If line 96 is "Y", enter the reduction percentage in the applicable column. Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in	0. 00 Y		0. 0 Y	0	97.00 98.00
98. 01	column 1 for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. 1? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for	Y		Y		98.01
98. 02	title XIX. Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y		Y		98.02
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 for title V, and in column 2 for title XIX.	N		Ν		98.03
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 in column 2 for title XIX.	N		N		98.04
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 column 2 for title XIX.	Y		Y		98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, 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.	Y		Y		98.06
105.00	Rural Providers Does this hospital qualify as a CAH?	N				105.00
	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)					106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)					107.00

Health Financial Systems FRANC	CISCAN HEAL	TH LAFAYETTE		In Lie	u of Form CMS	-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION	N DATA	Provider C		eriod: com 01/01/2020 o 12/31/2020	Worksheet S- Part I Date/Time Pro 4/29/2021 3:	epared:
				V 1.00	XI X 2.00	_
108.00 Is this a rural hospital qualifying for an excepti		CRNA fee sche	dul e? See 42	N 1.00	2.00	108.00
CFR Section §412.113(c). Enter "Y" for yes or "N"	for no.	Physi cal	Occupati onal	Speech	Respi ratory	
	-	1.00	2.00	3.00	4.00	-
109.00 If this hospital qualifies as a CAH or a cost prov therapy services provided by outside supplier? En- for yes or "N" for no for each therapy.		N	N	N	N	109.00
					1.00	110.00
110.00 Did this hospital participate in the Rural Communi Demonstration) for the current cost reporting period complete Worksheet E, Part A, lines 200 through 2 applicable.	od? Enter "	Y" for yes or	"N" for no. If	yes,	N	110.00
				1.00	2.00	-
111.00 If this facility qualifies as a CAH, did it partic Health Integration Project (FCHIP) demonstration "Y" for yes or "N" for no in column 1. If the resp integration prong of the FCHIP demo in which this Enter all that apply: "A" for Ambulance services; for tele-health services.	for this co ponse to co CAH is par	ost reporting olumn 1 is Y, ticipating in	period? Enter enter the column 2.	N		111.00
			1.00	2.00	3.00	-
112.00 Did this hospital participate in the Pennsylvania demonstration for any portion of the current cost Enter "Y" for yes or "N" for no in column 1. If o in column 2, the date the hospital began participa demonstration. In column 3, enter the date the hospital participation in the demonstration, if applicable.	reporting column 1 is ating in th ospital cea	period? s "Y", enter ne	N	2.00	0.00	112.00
Miscellaneous Cost Reporting Information	for yoo or	"N" for no	N			0115 00
115.00 Is this an all-inclusive rate provider? Enter "Y" in column 1. If column 1 is yes, enter the method in column 2. If column 2 is "E", enter in column 3 for short term hospital or "98" percent for long psychiatric, rehabilitation and long term hospital	used (A, B 3 either "9 term care (Is provider	3, or E only) 23" percent (includes	N			0 115. 00
the definition in CMS Pub. 15-1, chapter 22, §2208. 116.00 Is this facility classified as a referral center?		for yes or	N			116. 00
"N" for no. 117.00 s this facility legally-required to carry malprac	ctice insur	ance? Enter	Y			117.00
"Y" for yes or "N" for no. 118.00 Is the malpractice insurance a claims-made or occu if the policy is claim-made. Enter 2 if the policy			2			118.00
	y 13 0ccurr		Premi ums	Losses	Insurance	
			1.00	2.00	3.00	-
118.01 List amounts of malpractice premiums and paid loss	ses:		635, 304	0		2 118. 01
				1.00	2.00	_
118.02 Are malpractice premiums and paid losses reported Administrative and General? If yes, submit suppor and amounts contained therein.				1.00 N	2.00	118. 02
119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpa §3121 and applicable amendments? (see instructions "N" for no. Is this a rural hospital with < 100 be Hold Harmless provision in ACA §3121 and applicable	s) Enter in eds that qu	n column 1, "Y ualifies for t	" for yes or he Outpatient	Ν	Ν	119.00 120.00
Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high	cost impla	antable device	s charged to	Y		121.00
patients? Enter "Y" for yes or "N" for no. 122.00 Does the cost report contain healthcare related to Act?Enter "Y" for yes or "N" for no in column 1. the Worksheet A line number where these taxes are	lf column 1			Y	5.06	122.00
Transplant Center Information 125.00 Does this facility operate a transplant center? En	nter "Y" fo	or ves and "N"	for no. If	N		125.00
yes, enter certification date(s) (mm/dd/yyyy) bel 126.00 If this is a Medicare certified kidney transplant	OW.	5				126.00
in column 1 and termination date, if applicable, i 127.00 If this is a Medicare certified heart transplant	in column 2	2.				127. 00
in column 1 and termination date, if applicable, i	in column 2	2.				
128.00 If this is a Medicare certified liver transplant of in column 1 and termination date, if applicable, if 129.00 If this is a Medicare certified lung transplant of	in column 2	2.				128.00
129.00 If this is a Medicare certified lung transplant co column 1 and termination date, if applicable, in a 130.00 If this is a Medicare certified pancreas transplan	column 2.					129.00 130.00
date in column 1 and termination date, if applical			ti i Cati Ull			130.00

	X IDENTIFICATION DATA	Provider CC	CN: 15-0109	From O	: 1/01/2020 2/31/2020	Worksheet S-2 Part I Date/Time Pre 4/29/2021 3:5	epared:
					1.00	2.00	-
31.00 If this is a Medicare certified in			ertificati	on			131.00
date in column 1 and termination d 32.00 If this is a Medicare certified is in column 1 and termination date,	let transplant center	r, enter the certifi	cation da	te			132. 00
33. 00 Removed and reserved		umr 2.					133. 0
34.00 If this is an organ procurement or and termination date, if applicabl		ter the OPO number i	n column	1		-	134.0
All Providers 40.00 Are there any related organization	or home office costs	as defined in CMS	Pub 15_1		Y	158014	140. 0
chapter 10? Enter "Y" for yes or " are claimed, enter in column 2 the	N" for no in column 1	1. If yes, and home	office co		•	130014	140.0
1.00		2.00			3.00	-6 +1	
If this facility is part of a chai home office and enter the home off				ie name and	a address	or the	
1.00 Name: FRANCISCAN ALLIANCE, INC.	Contractor's Nam	ne: WPS		actor's Nu	mber: 0810	1	141. 0
12.00 Street: 1515 DRAGOON TRAIL 13.00 City: MISHAWAKA	PO Box: State:	1290 I N	Zip C	odo:	1651	6-1290	142. 0 143. 0
	jotate.			oue.	4034	0-1270	143.0
		1.40				1.00	1
14.00 Are provider based physicians' cos	TS INCLUDED IN WORKS	neet A?				Y	144.0
					1.00	2.00	
15.00 If costs for renal services are cl inpatient services only? Enter "Y" no, does the dialysis facility inc	for yes or "N" for r lude Medicare utiliza	no in column 1. If c	column 1 i		Y		145. 0
period? Enter "Y" for yes or "N" 6.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no in	y changed from the pr column 1. (See CMS F			lf	Ν		146. C
yes, enter the approval date (mm/d	uryyyy) in corunn 2.					1.00	_
17.00Was there a change in the statisti	cal basis? Enter "Y"	for yes or "N" for	no.			N 1.00	147.0
18.00Was there a change in the order of	allocation? Enter "\	/" for yes or "N" fo	or no.	_		Ν	148.0
49.00Was there a change to the simplifi	ed cost finding metho	od? Enter "Y" for ye Part A	es or "N" Part		itle V	N Title XIX	149.0
		1.00	2.00		3.00	4.00	_
Does this facility contain a provi		or an exemption from	n the appl	ication o	f the lowe	4.00 r of costs	-
or charges? Enter"Y" for yes or "		or an exemption from	n the appl	ication o	f the lowe	4.00 r of costs	155. 0
or charges? Enter "Y" for yes or " 55.00 Hospi tal 66.00 Subprovi der - IPF		or an exemption from component for Part A N N	m the appl and Part N N	ication o	f the lowe 2 CFR §413 N N	4.00 r of costs .13) N N	156. C
or charges? Enter "Y" for yes or " 55.00 Hospi tal 56.00 Subprovi der - IPF 57.00 Subprovi der - IRF		or an exemption from component for Part A N	m the appl and Part N	ication o	f the lowe 2 CFR §413 N	4.00 r of costs .13) N	156. C
or charges? Enter "Y" for yes or " 55.00 Hospi tal 66.00 Subprovi der - IPF 57.00 Subprovi der - IRF 58.00 SUBPROVI DER		or an exemption from component for Part A N N	m the appl and Part N N	ication o	f the lowe 2 CFR §413 N N	4.00 r of costs .13) N N	156. C 157. C 158. C
or charges? Enter "Y" for yes or " 55.00 Hospi tal 66.00 Subprovi der - I PF 57.00 Subprovi der - I RF 88.00 SUBPROVI DER 59.00 SNF 50.00 HOME HEALTH AGENCY		or an exemption from component for Part A N N N N N	m the appl and Part N N N N	ication o	f the lowe 2 CFR §413 N N N N N	4.00 r of costs .13) N N N N N	156. C 157. C 158. C 159. C 160. C
or charges? Enter "Y" for yes or " 55.00 Hospi tal 66.00 Subprovi der - IPF 57.00 Subprovi der - IRF 58.00 SUBPROVI DER 99.00 SNF 90.00 SNF 50.00 HOME HEALTH AGENCY 50.01		or an exemption from component for Part A N N N N N N N	m the appl and Part N N N N N N	ication o	f the lowe 2 CFR §413 N N N N N N	4.00 r of costs .13) N N N N N N	156. 0 157. 0 158. 0 159. 0 160. 0
or charges? Enter "Y" for yes or " 5.00 Hospi tal 6.00 Subprovi der - I PF 57.00 Subprovi der - I RF 58.00 SUBPROVI DER 59.00 SNF 50.00 HOME HEALTH AGENCY 50.01 50.02		or an exemption from component for Part A N N N N N	m the appl and Part N N N N	ication o	f the lowe 2 CFR §413 N N N N N	4.00 r of costs .13) N N N N N	156. 0 157. 0 158. 0 159. 0 160. 0 160. 0
or charges? Enter "Y" for yes or " 55.00 Hospi tal 66.00 Subprovi der - I PF 57.00 Subprovi der - I RF 88.00 SUBPROVI DER 59.00 SNF 50.00 HOME HEALTH AGENCY 50.01 50.02 51.00 CMHC		or an exemption from component for Part A N N N N N N N	m the appl and Part N N N N N N N	ication o	f the lowe 2 CFR §413 N N N N N N N	4.00 r of costs .13) N N N N N N N N	155. 0 156. 0 157. 0 157. 0 159. 0 160. 0 160. 0 160. 0 160. 0
or charges? Enter "Y" for yes or " 55.00 Hospi tal 66.00 Subprovi der - I PF 57.00 Subprovi der - I RF 88.00 SUBPROVI DER 59.00 SNF 50.00 HOME HEALTH AGENCY 50.01 50.02 51.00 CMHC Mul ti campus	N" for no for each co	or an exemption from component for Part A N N N N N N N N N	n the appl and Part N N N N N N N N N	ication o B. (See 4:	f the Iowe 2 CFR §413 N N N N N N N N N	4.00 r of costs .13) N N N N N N N N 1.00	156. C 157. C 158. C 159. C 160. C 160. C 160. C 161. C
or charges? Enter "Y" for yes or " 55.00 Hospital 66.00 Subprovider - IPF 57.00 Subprovider - IRF 58.00 SUBPROVIDER 59.00 SNF 50.00 HOME HEALTH AGENCY 50.01 50.02 Multicampus 55.00 Is this hospital part of a Multica	N" for no for each co	or an exemption from component for Part A N N N N N N N N N	n the appl and Part N N N N N N N N N	ication o B. (See 4:	f the Iowe 2 CFR §413 N N N N N N N N N	4.00 r of costs .13) N N N N N N N N N N N	156.0 157.0 158.0 159.0 160.0 160.0
or charges? Enter "Y" for yes or " 5.00 Hospi tal 6.00 Subprovi der - IPF 7.00 Subprovi der - IRF 8.00 SUBPROVI DER 9.00 SNF 0.00 HOME HEALTH AGENCY 0.01 0.02 1.00 CMHC Mul ti campus	N" for no for each co mpus hospital that ha Name	or an exemption from component for Part A N N N N N N N N N N N N N N N N N N N	n the appl and Part N N N N N N N N N State	ication o B. (See 4: fferent CE Zip Code	f the Iowe 2 CFR §413 N N N N N N N N N N SSAs? CBSA	4.00 r of costs .13) N N N N N N N N N N N T.00	156. C 157. C 158. C 159. C 160. C 160. C 160. C 161. C
or charges? Enter "Y" for yes or " 5.00 Hospital 6.00 Subprovider - IPF 7.00 Subprovider - IRF 8.00 SUBPROVIDER 9.00 SNF 0.00 HOME HEALTH AGENCY 0.01 0.02 1.00 CMHC Multicampus 5.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.	N" for no for each co mpus hospital that ha	or an exemption from component for Part A N N N N N N N N N N N N	n the appl and Part N N N N N N N N Ses in di	ication o B. (See 4:	f the Iowe 2 CFR §413 N N N N N N N N N SSAS?	4.00 r of costs .13) N N N N N N N N N N N T.00 FTE/Campus 5.00	156. (157. (158. (159. (160. (160. (160. (161. (165. (
or charges? Enter "Y" for yes or " 5.00 Hospital 6.00 Subprovider - IPF 7.00 Subprovider - IRF 8.00 SUBPROVIDER 9.00 SNF 9.00 SNF 9.00 HOME HEALTH AGENCY 9.00 CMHC Multicampus 5.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no. 6.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3,	N" for no for each co mpus hospital that ha Name	or an exemption from component for Part A N N N N N N N N N N N N N N N N N N N	n the appl and Part N N N N N N N N N State	ication o B. (See 4: fferent CE Zip Code	f the Iowe 2 CFR §413 N N N N N N N N N N SSAs? CBSA	4.00 r of costs .13) N N N N N N N N N N N T.00 FTE/Campus 5.00	156. C 157. C 158. C 159. C 160. C 160. C 161. C 165. C
or charges? Enter "Y" for yes or " 5.00 Hospital 6.00 Subprovider - IPF 7.00 Subprovider - IRF 8.00 SUBPROVIDER 9.00 SNF 9.00 HOME HEALTH AGENCY 9.01 9.02 1.00 CMHC Multicampus 5.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no. 6.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in	<u>N" for no for each co</u> mpus hospital that ha Name	or an exemption from component for Part A N N N N N N N N N N N N N N N N N N N	n the appl and Part N N N N N N N N N State	ication o B. (See 4: fferent CE Zip Code	f the Iowe 2 CFR §413 N N N N N N N N N N SSAs? CBSA	4.00 r of costs .13) N N N N N N 1.00 FTE/Campus 5.00 0.00	156. C 157. C 158. C 159. C 160. C 160. C 161. C 161. C
or charges? Enter "Y" for yes or " 5.00 Hospital 6.00 Subprovider - IPF 7.00 Subprovider - IRF 8.00 SUBPROVIDER 9.00 SNF 0.00 HOME HEALTH AGENCY 0.01 0.02 1.00 CMHC Multicampus 5.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no. 6.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)	N" for no for each co mpus hospital that ha Name 0	or an exemption from pomponent for Part A N N N N N N N N N N N N N	n the appl and Part N N N N N N N State 2.00	ication o B. (See 4: fferent CE Zip Code 3.00	f the Iowe 2 CFR §413 N N N N N N N N N N SSAs? CBSA	4.00 r of costs .13) N N N N N N N N N N N T.00 FTE/Campus 5.00	156. 0 157. 0 158. 0 159. 0 160. 0 160. 0 160. 0 161. 0
or charges? Enter "Y" for yes or " 55.00 Hospital 56.00 Subprovider - IPF 57.00 Subprovider - IRF 58.00 SUBPROVIDER 59.00 SNF 50.00 HOME HEALTH AGENCY 50.01 50.02 51.00 CMHC 55.00 Is this hospital part of a Multical Enter "Y" for yes or "N" for no. 56.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Health Information Technology (HIT 57.00 Is this provider a meaningful user 58.00 If this provider is a CAH (line 10	N" for no for each co mpus hospital that ha Name 0 0) incentive in the Ar under §1886(n)? Ent 5 is "Y") and is a me	or an exemption from pomponent for Part A N N N N N N N N N N N N N	n the appl and Part N N N N N N N N State 2.00 d Rei nvest	ication o B. (See 4: fferent CE Zip Code 3.00	f the I owe 2 CFR §413 N N N N N N N N N N N N N	4.00 r of costs .13) N N N N N N 1.00 FTE/Campus 5.00 0.00	156. 0 157. 0 158. 0 159. 0 160. 0 160. 0 160. 0 161. 0 165. 0
or charges? Enter "Y" for yes or " 5.00 Hospital 6.00 Subprovider - IPF 7.00 Subprovider - IRF 8.00 SUBPROVIDER 9.00 SNF 9.00 HOME HEALTH AGENCY 9.00 HOME HEALTH AGENCY 9.00 CMHC Multicampus 55.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no. 6.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Heal th Information Technology (HIT 67.00 Is this provider a meaningful user	N" for no for each co mpus hospital that ha Name 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	or an exemption from pomponent for Part A N N N N N N N N N N N N N	n the appl and Part N N N N N N N Uses in di State 2.00 C Reinvest 'N" for no e 167 is "	ication o B. (See 4: See 4: fferent CE Zip Code 3.00	f the I owe 2 CFR §413 N N N N N N N N N N SSAS? CBSA 4.00	4.00 r of costs .13) N N N N N N N N N T.00 FTE/Campus 5.00 0.00	156. (157. (158. (159. (160. (160. (160. (161. (165. (165. (165. (166. (166. (166. (166. (166. (167. (167. (167. (

Health Financial Systems	FRANCI SCAN HEALTH	I LAFAYETTE	In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX	CIDENTIFICATION DATA		Period:	Worksheet S-2	2
			From 01/01/2020		
			To 12/31/2020	Date/Time Pre	
			-	4/29/2021 3:5	52 pm
			Begi nni ng	Endi ng	
			1.00	2.00	
170.00 Enter in columns 1 and 2 the EHR b	eginning date and ending dat	te for the reporting			170.00
period respectively (mm/dd/yyyy)					
			1.00	2.00	
171.00 If line 167 is "Y", does this prov	ider have any days for indiv	viduals enrolled in	N	(0171.00
section 1876 Medicare cost plans r	eported on Wkst. S-3, Pt. I,	line 2, col. 6? Enter			
"Y" for yes and "N" for no in colu	mn 1. If column 1 is yes, er	nter the number of section	1		
1876 Medicare days in column 2. (se	ee instructions)				

OSPI L	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-0109	Period: From 01/01/2020 To 12/31/2020	Worksheet S- Part II Date/Time Pr 4/29/2021 3:	epared:
				Y/N	Date	
	General Instruction: Enter Y for all YES responses. Enter N	for all NO re	snonses Ente	1.00	2.00	_
	mm/dd/yyyy format.		Sponses. Ente		iic iii	
	COMPLETED BY ALL HOSPITALS					
	Provider Organization and Operation	<u> </u>				
. 00	Has the provider changed ownership immediately prior to the reporting period? If yes, enter the date of the change in co	beginning of	the cost	N		1.0
	reporting period: in yes, enter the date of the change in et	51 dill1 2. (300	Y/N	Date	V/I	
			1.00	2.00	3.00	
. 00	Has the provider terminated participation in the Medicare Pr yes, enter in column 2 the date of termination and in column voluntary or "I" for involuntary.		N			2.0
. 00	Is the provider involved in business transactions, including contracts, with individuals or entities (e.g., chain home of or medical supply companies) that are related to the provide officers, medical staff, management personnel, or members of of directors through ownership, control, or family and other relationships? (see instructions)	ffices, drug er or its f the board	Y			3. 00
			Y/N	Туре	Date	
	Financial Data and Danasta		1.00	2.00	3.00	
. 00	Financial Data and Reports Column 1: Were the financial statements prepared by a Certi Accountant? Column 2: If yes, enter "A" for Audited, "C" fo or "R" for Reviewed. Submit complete copy or enter date avai column 3. (see instructions) If no, see instructions. Are the cost report total expenses and total revenues differ	or Compiled, lable in	Y	A		4.00
. 00	those on the filed financial statements? If yes, submit reco					5.0
				Y/N 1.00	Legal Oper. 2.00	
. 00	Approved Educational Activities Column 1: Are costs claimed for nursing school? Column 2:	lf vos is th	e provider is	s Y	Y	6.0
. 00	the legal operator of the program?	11 yes, 15 ti		5 1	I	0.0
. 00 . 00	Are costs claimed for Allied Health Programs? If "Y" see ins Were nursing school and/or allied health programs approved a cost reporting period? If yes, see instructions.		during the	Y N		7.0 8.0
. 00	Are costs claimed for Interns and Residents in an approved of	graduate medio	al education	Ν		9.0
0. 00	program in the current cost report? If yes, see instructions Was an approved Intern and Resident GME program initiated or seat reporting period? If yes, see instructions		he current	N		10. 0
1. 00	cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	& R in an App	proved	N		11.0
				-	Y/N 1.00	_
	Bad Debts				1.00	
2.00	Is the provider seeking reimbursement for bad debts? If yes, If line 12 is yes, did the provider's bad debt collection poperiod? If yes, submit copy.			ost reporting	Y N	12. 0 13. 0
	If line 12 is yes, were patient deductibles and/or co-paymer Bed Complement		-		N	14.0
5.00	Did total beds available change from the prior cost reportin		<u>yes, see ins</u> t A	tructions. Par	N 1	15.0
	-	Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data		1			
6. 00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Ν		N		16.0
7.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date	Y	03/08/2021	Y	03/08/2021	17.0
8. 00	in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this	Ν		Ν		18.0
9. 00	cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report	Ν		Ν		19. 0

Health Financial Systems

FRANCISCAN HEALTH LAFAYETTE

In Lieu of Form CMS-2552-10

	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-0109	Period:	Worksheet S-2	2002 10
			-	rom 01/01/2020 To 12/31/2020	Part II Date/Time Pre 4/29/2021 3:5	
			ption	Y/N	Y/N	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R)	1.00 N	3.00 N	20.00
20.00	Report data for Other? Describe the other adjustments:					20.00
		Y/N	Date	Y/N	Date	
21.00	Was the cost report prepared only using the provider's	1.00 N	2.00	3.00 N	4.00	21.00
	records? If yes, see instructions.					
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXC	EPT CHILDRENS H	OSPI TALS)		1.00	
	Capital Related Cost					
	Have assets been relifed for Medicare purposes? If yes, see		- 1		N	22.00
23.00	Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.	due to apprais	ais made durir	ig the cost	Ν	23.00
24.00	Were new leases and/or amendments to existing leases enter	ed into during	this cost repo	orting period?	Ν	24.00
25.00	If yes, see instructions Have there been new capitalized leases entered into during	the cost repor	ting pariod2	f yes see	Ν	25.00
25.00	instructions.	the cost repor	ting periods i	i yes, see	IN	25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the	he cost reporti	ng period? If	yes, see	Ν	26.00
27.00	instructions. Has the provider's capitalization policy changed during the	e cost reportin	a period? If y	ves submit	Ν	27.00
	сору.		5 F			
28.00	Interest Expense Were new Loans, mortgage agreements or letters of credit e	ntarad into dur	ing the east a	anarting	N	28.00
28.00	period? If yes, see instructions.		ing the cost i	eportring	IN	20.00
29.00	Did the provider have a funded depreciation account and/or		bt Service Res	serve Fund)	Y	29.00
30.00	treated as a funded depreciation account? If yes, see inst Has existing debt been replaced prior to its scheduled matu		debt? If ves	see	Ν	30.00
	instructions.	5	J			
31.00	Has debt been recalled before scheduled maturity without is instructions.	ssuance of new	debt? If yes,	see	N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care se		d through cont	ractual	Y	32.00
33.00	arrangements with suppliers of services? If yes, see instru If line 32 is yes, were the requirements of Sec. 2135.2 app		a to competiti	ve biddina? If	Ν	33.00
00100	no, see instructions.		g to comport ti	to braaring:		
24.00	Provi der-Based Physi ci ans			al altraited and	N N	1 24 00
34.00	Are services furnished at the provider facility under an all f yes, see instructions.	rrangement with	provider-base	a physicians?	Y	34.00
35.00	If line 34 is yes, were there new agreements or amended exi		ts with the pr	rovi der-based	Ν	35.00
	physicians during the cost reporting period? If yes, see in	nstructions.		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
	If yes, see instructions.					
38.00	If line 36 is yes, was the fiscal year end of the home of			Ν		38.00
39.00	the provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to othe			Ν		39.00
	see instructions.		5			
40.00	If line 36 is yes, did the provider render services to the instructions.	home office?	lf yes, see	N		40.00
	Cast Depart Droppers Contast Information	1.	00	2.	00	
41.00	Cost Report Preparer Contact Information Enter the first name, last name and the title/position	STEVE		HOWELL		41.00
	held by the cost report preparer in columns 1, 2, and 3,					
42.00	respectively. Enter the employer/company name of the cost report	FRANCI SCAN HEA	ІТЦ			42.00
4∠. UU	preparer.	I TANCI JUAN HEA				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	765-428-5927		STEVEN. HOWELL@ ANCE. ORG	FRANCI SCANALLI	43.00

Heal th	Financial Systems	FRANCI SCAN HEAL	TH LAFAYETTE	In Lie	u of Form CMS-:	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT Q	UESTI ONNAI RE	Provider CCN: 15-0109	Period: From 01/01/2020	Worksheet S-2 Part	
				To 12/31/2020		pared: 2 pm
			3.00			
	Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the til	tle/position 🛛 🛛	MANAGER REIMBURSEMENT			41.00
	held by the cost report preparer in columns	s 1, 2, and 3,				
	respecti vel y.					
42.00	Enter the employer/company name of the cost	t report				42.00
	preparer.					
43.00	Enter the telephone number and email addres	ss of the cost				43.00
	report preparer in columns 1 and 2, respect	ti vel y.				

	Financial Systems AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	FRANCISCAN HEAL AL DATA	Provi der CC	CN: 15-0109	Peri od:	u of Form CMS-2 Worksheet S-3	
					From 01/01/2020	Part I	norod.
					To 12/31/2020	Date/Time Prep 4/29/2021 3:52	
						1/P Days / 0/P	
						Visits / Trips	
	Component	Worksheet A	No. of Beds	Bed Days	CAH Hours	Title V	
		Line Number		Avai I abl e			
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00	153	55, 9	98 0.00	0	1.00
	8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)						2.00
3.00	HMO I PF Subprovi der						3.00
4.00	HMO I RF Subprovi der						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation		153	55, 9	98 0.00		7.00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT	31.00	17	6, 2	22 0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	NEONATAL INTENSIVE CARE UNIT	35.00	14	5, 12	24 0.00	0	12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		184	67, 3	44 0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	41.00	15	5, 49	90	0	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00 21.00	NURSING FACILITY OTHER LONG TERM CARE						20.00 21.00
21.00	HOME HEALTH AGENCY	101.00				0	21.00
22.00	AMBULATORY SURGICAL CENTER (D. P.)	101.00				0	22.00
24.00	HOSPICE	116.00	o		0		24.00
24.10	HOSPICE (non-distinct part)	30.00	0		0		24.10
25.00	CMHC - CMHC	00.00					25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		199				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0		0		32.00
32. 01	Total ancillary labor & delivery room						32. 01
	outpatient days (see instructions)						
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01

	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC		Provider CC	N. 15-0109	Period: From 01/01/2020 To 12/31/2020		parec
		I/P Days	/ O/P Visits	/ Trips	Full Time	Equi val ents	
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
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)	16, 220	359	31, 51	72		1.0
00	HMO and other (see instructions)	5, 728	5, 687				2.0
00	HMO IPF Subprovider	0	0				3.0
00	HMO IRF Subprovider	449	382				4.
00	Hospital Adults & Peds. Swing Bed SNF	0	0		0		5.
00	Hospital Adults & Peds. Swing Bed NF		0		0		6.
00	Total Adults and Peds. (exclude observation beds) (see instructions)	16, 220	359	31, 57	12		7.
00	INTENSIVE CARE UNIT	1, 659	528	4, 19	97		8.
00	CORONARY CARE UNI T						9.
. 00	BURN INTENSIVE CARE UNIT						10.
. 00	SURGICAL INTENSIVE CARE UNIT						11.
. 00	NEONATAL INTENSIVE CARE UNIT	0	1, 987	3, 66	57		12.
. 00	NURSERY		1, 707	3, 10)5		13
. 00	Total (see instructions)	17, 879	4, 581	42, 54	1 0.00	1, 350. 85	14
. 00	CAH visits	0	0		0		15
. 00	SUBPROVIDER - IPF						16
. 00	SUBPROVIDER – IRF	1, 621	46	3, 12	0.00	21.74	17
00	SUBPROVI DER						18
00	SKILLED NURSING FACILITY						19
. 00	NURSING FACILITY						20
. 00	OTHER LONG TERM CARE						21
00	HOME HEALTH AGENCY	13, 801	0	23, 83	36 0.00	54.90	
00	AMBULATORY SURGICAL CENTER (D. P.)						23
00	HOSPI CE	0	0		0 0.00	39.61	
10	HOSPICE (non-distinct part)				0		24
00	CMHC - CMHC						25
00	RURAL HEALTH CLINIC						26
25	FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0.00		
. 00	Total (sum of lines 14-26)				0.00	1, 467. 10	
00	Observation Bed Days		0		0		28
00	Ambulance Trips	0					29
00	Employee discount days (see instruction)				0		30
. 00	Employee discount days - IRF				0		31
. 00	Labor & delivery days (see instructions)	0	253	49			32
. 01	Total ancillary labor & delivery room				0		32
	outpatient days (see instructions)						
3.00	LTCH non-covered days LTCH site neutral days and discharges	0					33

10SPI 1	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CC	CN: 15-0109	Peri od: From 01/01/2020 To 12/31/2020	Worksheet S-3 Part I Date/Time Pre 4/29/2021 3:5	pared:
		Full Time Equivalents		Di s	charges	472772021 3.3.	
	Component	Nonpai d Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	11.00	12.00	3, 4		9, 319	1.00
2.00	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			1, 1:		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	2.00
4.00	HMO I RF Subprovider				31		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF				01		5.00
5.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
3.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.0
11.00	SURGICAL INTENSIVE CARE UNIT						11.0
12.00	NEONATAL INTENSIVE CARE UNIT						12.0
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	3, 4	77 305	9, 319	
15.00	CAH visits						15.0
16.00	SUBPROVIDER - IPF		_				16.0
7.00	SUBPROVIDER - IRF	0.00	0	1	34 4	245	
8.00	SUBPROVI DER						18.0
9.00	SKILLED NURSING FACILITY						19.0
0.00	NURSING FACILITY						20. C
2.00	OTHER LONG TERM CARE HOME HEALTH AGENCY	0.00					21.0
3.00	AMBULATORY SURGICAL CENTER (D. P.)	0.00					22.0
4.00	HOSPICE	0.00					24.0
4.10	HOSPICE (non-distinct part)	0.00					24.0
5.00	CMHC - CMHC						25.0
6.00	RURAL HEALTH CLINIC						26.0
6.25	FEDERALLY QUALIFIED HEALTH CENTER	0, 00					26.2
7.00	Total (sum of lines 14-26)	0,00					27.0
8.00	Observation Bed Days						28.0
9.00	Ambul ance Trips						29. (
0.00	Employee discount days (see instruction)						30.0
1.00	Employee discount days - IRF						31. (
2.00	Labor & delivery days (see instructions)						32. (
32.01	Total ancillary labor & delivery room						32.0
	outpatient days (see instructions)						
33.00	LTCH non-covered days				0		33. C
33.01	LTCH site neutral days and discharges				0		33.0

SPI T	AL WAGE INDEX INFORMATION			Provider C		Period:	Worksheet S-3 Part II	
						rom 01/01/2020 o 12/31/2020	Date/Time Pre	
		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	, J		4/29/2021 3:5 Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA SALARIES							
00	Total salaries (see	200. 00	126, 321, 518	-1, 604, 906	124, 716, 612	3, 063, 307. 28	40. 71	1
0	instructions) Non-physician anesthetist Part		C	0	c	0.00	0.00	2
0	Non-physician anesthetist Part B		C	0 0	C	0.00	0.00	
0	Physician-Part A - Administrative		C	0	C	0.00	0.00	4
1 0	Physicians - Part A - Teaching Physician and Non		C	-		0.00 0.00		
0	Physician-Part B Non-physician-Part B for hospital-based RHC and FQHC services		C	0	C	0.00	0. 00	6
0	Interns & residents (in an approved program)	21.00	C	0 0	C	0.00	0.00	
)1	Contracted interns and residents (in an approved programs)		C	0 0	C	0.00	0.00	
0	Home office and/or related organization personnel		C	0	C	0.00		
00 00	SNF Excluded area salaries (see instructions)	44.00	26, 249, 476	0 334, 463	26, 583, 939	0. 00 416, 133. 53		
00	OTHER WAGES & RELATED COSTS Contract Labor: Direct Patient		4, 016, 604	0	4, 016, 604	71, 792. 10	55. 95	1
00	Care Contract labor: Top level management and other management and administrative		C	0	C	0.00	0.00	1:
00	services Contract Labor: Physician-Part A - Administrative		C	0	C	0.00	0.00	1:
00	Home office and/or related organization salaries and wage-related costs		C	0	C	0.00	0. 00	1
01	Home office salaries		C	-	C	0.00		
02 00	Related organization salaries Home office: Physician Part A		C			0.00 0.00		
00	- Administrative Home office and Contract Physicians Part A - Teaching		C	0	C	0.00	0.00	10
01	Home office Physicians Part A - Teaching		C	0	C	0.00	0.00	16
02	Home office contract Physicians Part A - Teaching WAGE-RELATED COSTS		C	0	C	0.00	0.00	10
	Wage-related costs (core) (see instructions)		22, 727, 649	0	22, 727, 649			17
	Wage-related costs (other) (see instructions)							18
00 00	Excluded areas Non-physician anesthetist Part A		6, 156, 873 C		6, 156, 873 (20
	Non-physician anesthetist Part B		C	0	C			2'
00 01	Physician Part A - Administrative Physician Part A - Teaching		C	0				22
	Physician Part B		C					23
00	Wage-related costs (RHC/FQHC) Interns & residents (in an		C					24 25
50	approved program) Home office wage-related		C	0	C)		2!
51	(core) Related organization		C	0	c			2!
52	wage-related (core) Home office: Physician Part A - Administrative - wage-related (core)		C	0 0	C)		2!

	Financial Systems	ŀ	RANCI SCAN HEAL				u of Form CMS-2	
HOSPI T	AL WAGE INDEX INFORMATION			Provider CO		Period: From 01/01/2020 To 12/31/2020		pared
		Wkst. A Line		Reclassi fi cati			Average Hourly	
		Number	Reported	on of Salaries			Wage (col. 4 ÷	
				(from Wkst.	(col.2 ± col.		col. 5)	
		1.00		A-6)	3)	col . 4	(
		1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A		0	0		5		25.5
	- Teaching - wage-related							
	(core) OVERHEAD COSTS - DIRECT SALARIE	-c						-
26.00	Employee Benefits Department	4.00	2, 243, 567	-211, 321	2,032,24	6 37, 902. 67	53. 62	26.0
20.00	Administrative & General	4.00 5.00	24, 296, 659					
28.00	Administrative & General under	5.00	24, 290, 039	-1,004,002	23, 291, 99	0.00		
20.00	contract (see inst.)		0	0		0.00	0.00	20.0
29.00	Maintenance & Repairs	6, 00	0	0		0.00	0.00	29.0
30.00	Operation of Plant	7.00	3, 323, 041	0	3, 323, 04			
31.00	Laundry & Linen Service	8.00	125, 524	0	125, 52			
32.00	Housekeepi ng	9.00	2, 310, 535		2, 310, 53			
33.00	Housekeeping under contract	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	2,010,000	0	2,010,00	0.00		
	(see instructions)							
34.00	Dietary	10.00	2, 312, 636	-1, 299, 550	1, 013, 08	55, 344. 69	18. 31	34.0
35.00	Dietary under contract (see instructions)		0	0		0.00	0.00	35. C
36.00	Cafeteri a	11.00	0	1, 299, 550	1, 299, 55	70, 994. 16	18. 31	36.0
37.00	Maintenance of Personnel	12.00	0	0		0.00	0.00	37.0
38.00	Nursing Administration	13.00	3, 630, 296	-405, 674	3, 224, 62	2 88, 899. 25	36. 27	38.0
39.00	Central Services and Supply	14.00	379, 509	0	379, 50	9 20, 007. 10	18. 97	39.0
40.00	Pharmacy	15.00	3,004,228	-94, 889	2, 909, 33	9 75, 012. 84	38. 78	40.0
41.00	Medical Records & Medical Records Library	16.00	65, 500	-41, 168	24, 33	2 2, 463.00	9.88	41.0
42.00	Soci al Servi ce	17.00	621, 388	0	621, 38	8 20, 514. 85	30. 29	42.0
43.00	Other General Service	18.00	0	0		0.00	0.00	43 (

Heal th	Financial Systems	I	FRANCI SCAN HEA	LTH LAFAYETTE		In Lie	eu of Form CMS-2	2552-10
HOSPI T	AL WAGE INDEX INFORMATION			Provider CC		Period: From 01/01/2020 To 12/31/2020		pared:
		Worksheet A		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		126, 321, 518	-1, 604, 906	124, 716, 61	2 3, 063, 307. 28	40. 71	1.00
	instructions)							
2.00	Excluded area salaries (see		26, 249, 476	334, 463	26, 583, 93	9 416, 133. 53	63.88	2.00
	instructions)							
3.00	Subtotal salaries (line 1		100, 072, 042	-1, 939, 369	98, 132, 67	3 2, 647, 173. 75	37.07	3.00
	minus line 2)							
4.00	Subtotal other wages & related costs (see inst.)		4, 016, 604	0	4, 016, 60	4 71, 792. 10	55. 95	4.00
5.00	Subtotal wage-related costs		22, 727, 649	0	22, 727, 64	9 0.00	23, 16	5.00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		126, 816, 295	-1, 939, 369	124, 876, 92	6 2, 718, 965. 85	45. 93	6.00
7.00	Total overhead cost (see		42, 312, 883	-1, 757, 714	40, 555, 16	9 877, 325. 27	46. 23	7.00
	instructions)							
	· · · · · · · · · · · · · · · · · · ·			•		1		

	Financial Systems FRANCISCAN HE AL WAGE RELATED COSTS	ALTH LAFAYETTE Provider CCN: 15-0109	Period:	u of Form CMS-2 Worksheet S-3	
00111	AE WAGE REEATED 00013		From 01/01/2020	Part IV	
			To 12/31/2020		
				4/29/2021 3:5	<u>2 pm</u>
				Amount	
				Reported	
				1.00	
	PART IV - WAGE RELATED COSTS Part A - Core List				-
	RETIREMENT COST				-
. 00	401K Employer Contributions			0	1 1.0
. 00	Tax Sheltered Annuity (TSA) Employer Contribution			0	
. 00	Nongualified Defined Benefit Plan Cost (see instructions)			8, 124, 272	1
. 00	Qualified Defined Benefit Plan Cost (see instructions)			0, 124, 272	
00	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)			0	4.1
00	401K/TSA Plan Administration fees			0	5.
00	Legal /Accounting/Management Fees-Pension Plan			0	
. 00	Employee Managed Care Program Administration Fees			439, 864	1 0.
00	HEALTH AND INSURANCE COST			437,004	· · ·
00	Health Insurance (Purchased or Self Funded)			0	8.
01	Health Insurance (Self Funded without a Third Party Admin	istrator)		0	
02	Health Insurance (Self Funded with a Third Party Administ			9, 572, 601	
03	Heal th Insurance (Purchased)			7, 372, 001	
00	Prescription Drug Plan			0	
). 00	Dental, Hearing and Vision Plan			1, 022, 364	1
1.00	Life Insurance (If employee is owner or beneficiary)			70, 128	
2.00	Accident Insurance (If employee is owner or beneficiary)			,0,120	
3.00	Disability Insurance (If employee is owner or beneficiary)		489, 782	
I. 00	Long-Term Care Insurance (If employee is owner or benefic			407,702	
5.00	'Workers' Compensation Insurance	rury)		1, 309, 844	1
5.00	Retirement Health Care Cost (Only current year, not the e	xtraordinary accrual require	d by FASB 106	1, 307, 044	
5. 00	Non cumulative portion)		Ju by 1735 100.	0	10.
	TAXES				
7.00	FICA-Employers Portion Only			7, 705, 837	1 17.
	Medicare Taxes - Employers Portion Only			0	
9.00	Unemployment Insurance			0	
0. 00	State or Federal Unemployment Taxes			139, 895	20.
	OTHER				
I. 00	Executive Deferred Compensation (Other Than Retirement Co	st Reported on lines 1 throu	igh 4 above. (see	0	21.
	instructions))		- `		
2.00	Day Care Cost and Allowances			0	22.
3.00	Tuition Reimbursement			9, 935	23.
4.00	Total Wage Related cost (Sum of lines 1 -23)			28, 884, 522	24.
	Part B - Other than Core Related Cost				
5 00	OTHER WAGE RELATED COSTS (SPECIFY)				25.

Health F	Financial Systems	FRANCI SCAN HEALTH	LAFAYETTE	In Lie	u of Form CMS-2	2552-10
HOSPI TA	L CONTRACT LABOR AND BENEFIT COST		Provider CCN: 15-0109	Peri od:	Worksheet S-3	
				From 01/01/2020		
				To 12/31/2020	Date/Time Pre 4/29/2021 3:5	
	Cost Center Description			Contract Labor		2 011
	COST CENTER Description			1. 00	2.00	
P	PART V - Contract Labor and Benefit Cost				2100	
Н	lospital and Hospital-Based Component Ident	i fi cati on:				
1.00 1	Total facility's contract labor and benefit	t cost		0	0	1.00
2.00	Hospi tal			0	0	2.00
3.00 5	Subprovider - IPF					3.00
4.00 5	Subprovider - IRF			0	0	4.00
5.00 5	Subprovider - (Other)			0	0	5.00
6.00 5	Swing Beds - SNF			0	0	6.00
7.00 5	Swing Beds - NF			0	0	7.00
8.00 H	Hospital-Based SNF					8.00
9.00 H	Hospital-Based NF					9.00
10.00 H	Hospital-Based OLTC					10.00
11.00 H	Hospital-Based HHA			0	0	11.00
12.00 5	Separately Certified ASC					12.00
13.00 H	Hospital-Based Hospice			0	0	13.00
14.00 H	Hospital-Based Health Clinic RHC					14.00
15.00 H	Hospital-Based Health Clinic FQHC					15.00
16.00 H	Hospital-Based-CMHC					16.00
17.00 F	Renal Dialysis			0	0	17.00
18.00 0	Other			0	0	18.00

Heal th	Financial Systems	FRANCI SCAN HEAL	TH LAFAYETTE		In Lie	u of Form CMS-2	2552-10
HOME H	IEALTH AGENCY STATI STI CAL DATA		Provider C	F	Period: From 01/01/2020	Worksheet S-4	
			Component (CCN: 15-7124 1	To 12/31/2020	4/29/2021 3:5	pared: 2 pm
					Home Health Agency I	PPS	
					1.	00	-
0.00	County	Title V	Title XVIII	Title XIX	Other	Total	0.00
		1.00	2.00	3.00	4.00	5.00	
1.00	HOME HEALTH AGENCY STATISTICAL DATA Home Health Aide Hours	0	0	(0 0	0	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	0.00		0.00 0.00 O.		2.00
		Enter the numbe	or of hours in	Staff	Contract	Total	
		your normal		Starr	CONTRACT	Total	
		0		1.00	2.00	3.00	
3.00	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES Administrator and Assistant Administrator(s)		0.00	1	1		3.00
4.00	Director(s) and Assistant Director(s)		0.00	0.00	0.00	0.00	4.00
5.00 6.00	Other Administrative Personnel Direct Nursing Service			0.00			•
7.00 8.00	Nursi ng Supervi sor Physi cal Therapy Servi ce			0.00		0.00 0.00	•
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	9.00
10. 00 11. 00	Occupational Therapy Service Occupational Therapy Supervisor			0.00			•
12. 00 13. 00	Speech Pathology Service Speech Pathology Supervisor			0.00			•
14.00	Medical Social Service			0.00	0.00	0.00	14.00
15. 00 16. 00	Medical Social Service Supervisor Home Health Aide			0.00			
17. 00 18. 00	Home Health Aide Supervisor Other (specify)			0.00			•
	HOME HEALTH AGENCY CBSA CODES				1	0.00	
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost			Ę			19.00
20. 00	reporting period. List those CBSA code(s) in column 1 serviced			23844			20.00
	during this cost reporting period (line 20 contains the first code).						
20.01				26900			20.01
20. 02 20. 03				29200 45460			20. 02 20. 03
20.04		Full Epi		99915			20.04
		Without Outliers	With Outliers	LUPA Epi sodes	PEP Only Episodes	Total (cols. 1-4)	
		1.00	2.00	3.00	4.00	5.00	
21.00	PPS ACTIVITY DATA Skilled Nursing Visits	5, 460	712	224	1 37	6, 433	
22. 00 23. 00	Skilled Nursing Visit Charges Physical Therapy Visits	2, 172, 445 3, 944	283, 145 623				1
24.00	Physical Therapy Visit Charges	1, 628, 616	257, 922	37, 554	9, 498	1, 933, 590	24.00
25. 00 26. 00	Occupational Therapy Visits Occupational Therapy Visit Charges	1, 254 517, 212	377 156, 078	10, 326			26.00
27.00 28.00	Speech Pathology Visits Speech Pathology Visit Charges	222 91, 860	79 32, 706		4 O	305 126, 222	•
29. 00 30. 00	Medical Social Service Visits Medical Social Service Visit Charges	26 12, 424	11 5, 280	0	0 0	37 17, 704	29.00
31.00	Home Health Aide Visits	539	140	1	4	684	31.00
32.00 33.00	Home Health Aide Visit Charges Total visits (sum of lines 21, 23, 25, 27,	103, 543 11, 445	26, 877 1, 942				1
34.00	29, and 31) Other Charges	30, 427	14, 115				
34.00 35.00	Total Charges (sum of lines 22, 24, 26, 28,	4, 556, 527	776, 123				
	30, 32, and 34) Total Number of Episodes (standard/non	13, 387		345	69	13, 801	36.00
36.00							
36.00 37.00	outlier) Total Number of Outlier Episodes		1, 942		14	1, 956	37.00

IOSPI	AL-BASED HOSPICE IDENTIFICATION	DATA		Provider CC Hospice CCN	CN: 15-0109 N: 15-1563	Period: From 01/01/2020 To 12/31/2020		pared:
						Hospi ce I	4/29/2021 3. 32	z pili
		Unduplicated				nospi ce i		
		Days						
		Title XVIII	Title XIX	Title XVIII	Title XIX	All Other	Total (sum of	
				Skilled	Nursi ng		cols. 1, 2 &	
				Nursi ng	Facility		5)	
				Facility	•			
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART I - ENROLLMENT DAYS FOR CO	ST REPORTING P	PERIODS BEGINNI	NG BEFORE OCTO	BER 1, 2015			
. 00	Hospice Continuous Home Care							1.00
. 00	Hospice Routine Home Care							2.00
. 00	Hospice Inpatient Respite Care							3.00
. 00	Hospice General Inpatient Care							4.00
. 00	Total Hospice Days							5.00
	Part II - CENSUS DATA FOR COST	REPORTING PERI	ODS BEGINNING	BEFORE OCTOBER	1, 2015			
. 00	Number of patients receiving							6. 0
~~	hospice care							7 0
. 00	Total number of unduplicated							7.0
	Continuous Care hours billable to Medicare							
. 00	Average Length of Stay (line 5							8.0
. 00	/ line 6)							0.0
. 00	Unduplicated census count							9.0
	Parts I and II, columns 1 and 2	also include t	the days report	ted in columns	3 and 4			7. 0.
/IL.								
				Title XVIII	Title XIX	Other	Total (sum of	
							col s. 1	
				1.00	0.00		through 3)	
	PART III - ENROLLMENT DAYS FOR	COST DEDODTING			2.00	3.00	4.00	
0. 00	Hospice Continuous Home Care	CUST REPORTING	PERIODS BEGIN	INTING UN UK AFT	ER UCTUBER I	0 0	0	10. 0
	Hospice Routine Home Care			35, 413		0 0	35, 413	
1.00 2.00	•			110		0 0		12.0
3.00	Hospice General Inpatient Care			24		0 0		12.0
	Total Hospice Days			35, 547		0 0	24 35, 547	
+. 00	PART IV - CONTRACTED STATISTICA	L DATA FOR COS			G ON OR AFTE			14.0
	TAKT IV - CONTRACTED STATISTICA	L DATA FUR CUS	I KLFUKTING PE	RIODS DEGENINEN	O ON OK AFTE	K OCTOBER 1, ZUTC		
5 00	Hospice Inpatient Respite Care			0		0 0	0	15.00

Heal th	Financial Systems FRANCISCAN HEALTH L	AFAYETTE	In Li	eu of Form CMS-2	2552-10			
		rovider CCN: 15-010	9 Period:	Worksheet S-1				
			From 01/01/2020					
			To 12/31/2020					
				4/29/2021 3:5	z pili			
				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	ded by line 202 co	lumn 8)	0. 201851	1.00			
	Medicaid (see instructions for each line)							
2.00	Net revenue from Medicaid			61, 607, 839	2.00			
3.00	Did you receive DSH or supplemental payments from Medicaid?			Ν	3.00			
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?							
5.00	If line 4 is no, then enter DSH and/or supplemental payments from	om Medicaid		0	5.00			
6.00	Medi cai d charges			234, 738, 631	6.00			
7.00	Medicaid cost (line 1 times line 6)			47, 382, 227	7.00			
8.00	Difference between net revenue and costs for Medicaid program (ine 7 minus sum of	lines 2 and 5; if	0	8.00			
	< zero then enter zero)							
	Children's Health Insurance Program (CHIP) (see instructions for	each line)		-				
9.00	Net revenue from stand-al one CHIP			0				
10.00	Stand-alone CHIP charges			0	10.00			
11.00	Stand-alone CHIP cost (line 1 times line 10)	ino 11 minuo lino	0. if , zono than	0	11.00 12.00			
12.00	Difference between net revenue and costs for stand-alone CHIP (enter zero)	ine ii minus iine	9; IT < Zero then	0	12.00			
	Other state or local government indigent care program (see insti	ructions for each L	ine)					
13.00	Net revenue from state or local indigent care program (Not inclu			0	13.00			
14.00	Charges for patients covered under state or local indigent care			0	14.00			
	10)	p 9 (
15.00	State or local indigent care program cost (line 1 times line 14)		0	15.00			
16.00	Difference between net revenue and costs for state or local ind	gent care program	(line 15 minus line	0	16.00			
	13; if < zero then enter zero)							
	Grants, donations and total unreimbursed cost for Medicaid, CHII	P and state/local i	ndigent care progra	ms (see				
47.00	instructions for each line)				1 7 00			
17.00 18.00	Private grants, donations, or endowment income restricted to ful			0	17.00 18.00			
18.00	Government grants, appropriations or transfers for support of he Total unreimbursed cost for Medicaid , CHIP and state and local		rame (cum of lines		18.00			
19.00	8, 12 and 16)	That gent care prog		0	17.00			
		Uni nsu	red Insured	Total (col. 1				
		patien		+ col. 2)				
		1.00	2.00	3.00				
	Uncompensated Care (see instructions for each line)			1				
20.00	Charity care charges and uninsured discounts for the entire fac	lity 44,81	8, 303 5, 351, 109	50, 169, 412	20.00			
04 00	(see instructions)		<pre></pre>	44 007 700	01 00			
21.00	Cost of patients approved for charity care and uninsured discoul	nts (see 9,04	6, 619 5, 351, 109	14, 397, 728	21.00			
22.00	instructions) Payments received from patients for amounts previously written	off as	0	0 0	22.00			
22.00	charity care		0		22.00			
23.00	Cost of charity care (line 21 minus line 22)	9.04	6, 619 5, 351, 109	14, 397, 728	23 00			
20100		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	0,011 0,001,10	11/0/1/120	20100			
				1.00				
24.00	Does the amount on line 20 column 2, include charges for patien	t days beyond a len	gth of stay limit	N	24.00			
	imposed on patients covered by Medicaid or other indigent care	program?						
25.00	If line 24 is yes, enter the charges for patient days beyond the	e indigent care pro	gram's length of	0	25.00			
	stay limit							
26.00	Total bad debt expense for the entire hospital complex (see ins			18, 416, 001	26.00 27.00			
27.00								
27.01	Medicare allowable bad debts for the entire hospital complex (se	ee instructions)		845, 991	27.01			
28.00	Non-Medicare bad debt expense (see instructions)		``	17, 570, 010				
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt exp	ense (see instructi	ons)	3, 842, 621				
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	20)		18, 240, 349				
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line)	ie 30)		18, 240, 349	31.00			

ECLASSI	FICATION AND ADJUSTMENTS OF TRIAL BALANCE OF	EXPENSES	Provider CO	CN: 15-0109	Period: From 01/01/2020	Worksheet A	
					To 12/31/2020	Date/Time Pre 4/29/2021 3:5	
	Cost Center Description	Sal ari es	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 +-	
		1.00	2.00	3.00	4.00	<u>col. 4)</u> 5.00	<u> </u>
GE	ENERAL SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
	D100 CAP REL COSTS-BLDG & FIXT		18, 632, 088				
	0200 CAP REL COSTS-MVBLE EQUIP	2 242 5/7	0		0 1, 964, 050	1, 964, 050	
	0400 EMPLOYEE BENEFITS DEPARTMENT 1160 COMMUNI CATI ONS	2, 243, 567 630, 436	30, 393, 841 801, 949			32, 579, 519 1, 432, 385	
	1140 MGMT INFO SYSTEMS	030, 430	909, 838			909, 838	
	0550 PURCHASI NG	0	327, 348			327, 348	
	D570 ADMI TTI NG	О	573	57	3 0	573	
	D580 PATIENT ACCOUNTING	0	1, 528, 403			1, 528, 403	
	0560 OTHER ADMINISTRATIVE AND GENERAL 0700 OPERATION OF PLANT	23, 666, 223 3, 323, 041	50, 508, 170 8, 644, 635			73, 981, 575 11, 957, 603	
	0800 LAUNDRY & LINEN SERVICE	125, 524	603, 688			729, 212	
	0900 HOUSEKEEPING	2, 310, 535	853, 773				
	1000 DI ETARY	2, 312, 636	1, 345, 643	3, 658, 27	9 -2, 080, 107	1, 578, 172	10
	1100 CAFETERIA	0	0		0 2, 023, 972	2, 023, 972	
	1300 NURSING ADMINISTRATION 1400 CENTRAL SERVICES & SUPPLY	3, 630, 296 379, 509	135, 535			3, 763, 969	
	1500 PHARMACY	3, 004, 228	764, 184 9, 573, 761			515, 555 2, 995, 243	
	1600 MEDI CAL RECORDS & LI BRARY	65, 500	157, 595			63, 604	
	1700 SOCIAL SERVICE	621, 388	2, 512			623, 900	17
	2000 NURSI NG SCHOOL	2, 034, 594	368, 097			2, 699, 648	
	2301 PHARMACY RESIDENCY	177, 169	4, 237			353, 473	
	2300 EMS EDUCATION	74, 964	10, 527	85, 49	1 153, 700	239, 191	23
	3000 ADULTS & PEDI ATRI CS	19, 713, 903	3, 751, 277	23, 465, 18	0 -6, 427, 752	17, 037, 428	30
	3100 I NTENSI VE CARE UNI T	3, 547, 861	839, 547			4, 066, 783	
	2060 NEONATAL INTENSIVE CARE UNIT	2, 092, 642	888, 462			2, 873, 181	
	4100 SUBPROVIDER - IRF	1, 522, 781	207, 370			1, 694, 145	
	4300 NURSERY NCI LLARY SERVI CE COST CENTERS	0	0		0 602, 295	602, 295	43
	5000 OPERATI NG ROOM	3, 588, 540	16, 907, 990	20, 496, 53	0 -13, 563, 012	6, 933, 518	50
	5100 RECOVERY ROOM	573, 346	24, 086			576, 841	
	5200 DELIVERY ROOM & LABOR ROOM	0	0		0 3, 926, 024	3, 926, 024	52
	5400 RADI OLOGY-DI AGNOSTI C	3, 516, 297	5, 776, 990			7, 413, 134	
	5500 RADI OLOGY – THERAPEUTI C 5600 RADI OI SOTOPE	354, 269 359, 784	214, 782 68, 718			562, 104 418, 084	
	3950 CARDI AC CATH LAB	1, 311, 471	3, 795, 214			2, 612, 350	
	5700 CT SCAN	718, 068	284, 103			780, 285	
	5800 MRI	252, 045	64, 221	316, 26	6 -62, 155	254, 111	
	6000 LABORATORY	0	11, 146, 314			11, 050, 994	
	6500 RESPI RATORY THERAPY 6600 PHYSI CAL THERAPY	1, 998, 825 3, 690, 238	898, 830				
	6700 OCCUPATIONAL THERAPY	3, 690, 238	1, 062, 861 36, 160			4,001,895	
	6800 SPEECH PATHOLOGY	652, 980	13, 517			661, 231	
. 00 06	6900 ELECTROCARDI OLOGY	1, 680, 466	1, 754, 799	3, 435, 26	5 -26, 990	3, 408, 275	69
	7000 ELECTROENCEPHALOGRAPHY	595, 005	93, 347			639, 312	
	7100 MEDICAL SUPPLIES CHARGED TO PATIENT 7200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 10, 822, 744	10, 822, 744	
	7200 IMPL. DEV. CHARGED TO PATIENTS 7300 DRUGS CHARGED TO PATIENTS	0	0		0 11, 760, 544 0 9, 778, 079	11, 760, 544 9, 778, 079	
	7301 DI ABETES CENTER	397, 193	3, 706			400, 604	
. 00 07	7400 RENAL DI ALYSI S	105, 163	824, 596			905, 495	74
	7698 HYPERBARI C OXYGEN THERAPY	0	6, 400	6, 40	0 0	6, 400	76
	JTPATIENT SERVICE COST CENTERS	140 110	002 712	1 2/1 02	1 500 0/7	020 7/4	1
	9000 CLINIC 9100 EMERGENCY	468, 118 7, 816, 285	893, 713 4, 279, 521			839, 764 10, 865, 712	
	4950 WOUND CARE	1, 469, 585	347, 888			1, 490, 960	
	9200 OBSERVATION BEDS (NON-DISTINCT PART						92
	9201 OBSERVATION BEDS (DISTINCT PART)	1, 444, 747	316, 496	1, 761, 24	3 -291, 265	1, 469, 978	92
	THER REIMBURSABLE COST CENTERS	2 221 104	074 007	2 207 41	2 270 074	2 024 520	0.5
	9500 AMBULANCE SERVICES 0100 HOME HEALTH AGENCY	2, 331, 106 4, 882, 099	876, 307 7, 600, 269			2, 936, 539 12, 482, 368	
	PECIAL PURPOSE COST CENTERS	1, 002, 077	7, 300, 207	1 12, 402, 30	<u> </u>	12, 402, 500	1.01
3. 00 11	1300 INTEREST EXPENSE		8, 739, 070		0 -7, 567, 160	1, 171, 910	113
	1600 HOSPI CE	2, 731, 551	2, 224, 832			4, 950, 001	
3. 00	SUBTOTALS (SUM OF LINES 1 through 117)	113, 826, 306	199, 507, 783	313, 334, 08	9 0	313, 334, 089	118
	DNREIMBURSABLE COST CENTERS 9000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	53, 341	31, 848	85, 18	0	85, 189	100
	9000 GFFT, FLOWER, COFFEE SHOP & CANTEEN 9200 PHYSI CLANS' PRI VATE OFFI CES	53, 341	31, 848 5, 622, 926			85, 189 18, 064, 797	
	7950 MOB	12, 441, 071	3, 022, 720 0		0 0		194
4.0107	7951 LI FELI NE	0	0		0 0	0	194
	7952 PATIENT TRANSPORT	0	61, 106			61, 106	
	7954 OTHER NONREIMBURSABLE COST CENTERS	O	0	I	0 0	0	194

Health Financial Systems	RANCISCAN HEAL	TH LAFAYETTE		In Lie	u of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF	EXPENSES	Provider CC		Period: From 01/01/2020	Worksheet A	
				To 12/31/2020		
Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cati	Recl assi fi ed	
			+ col. 2)	ons (See A-6)	Trial Balance	
					(col. 3 +-	
					col. 4)	
	1.00	2.00	3.00	4.00	5.00	
200.00 TOTAL (SUM OF LINES 118 through 199)	126, 321, 518	205, 223, 663	331, 545, 181	0	331, 545, 181	200. 00

				To 12/31/2020 Date/	lime Prepar <u>2021 3:52 p</u>
	Cost Center Description	Adjustments	Net Expenses	4/29/	2021 3.52 L
			For Allocation		
	GENERAL SERVICE COST CENTERS	6.00	7.00		
	00100 CAP REL COSTS-BLDG & FIXT	1, 544, 223	28, 405, 239		
	00200 CAP REL COSTS-MVBLE EQUIP	1, 497, 813			
	00400 EMPLOYEE BENEFITS DEPARTMENT	-1,040,718			
	01160 COMMUNI CATI ONS	0			
	01140 MGMT INFO SYSTEMS	18, 525, 497			
	00550 PURCHASI NG	1, 531, 024			
	00570 ADMI TTI NG	0			
	00580 PATIENT ACCOUNTING	5,000,361			
	00560 OTHER ADMINISTRATIVE AND GENERAL	-52, 426, 060			
	00700 OPERATION OF PLANT	-221, 801			
	00800 LAUNDRY & LINEN SERVICE	0			8
	00900 HOUSEKEEPI NG	-207, 938			
	01000 DI ETARY	-409, 646			10
	01100 CAFETERI A	-819, 566			1
	01300 NURSI NG ADMI NI STRATI ON	-536, 026			1:
	01400 CENTRAL SERVICES & SUPPLY	-268, 293			14
	01500 PHARMACY	504, 205			1
	01600 MEDICAL RECORDS & LIBRARY	1, 877, 670			10
	01700 SOCIAL SERVICE	0			1
	02000 NURSI NG SCHOOL	-2, 361, 425			20
	02301 PHARMACY RESIDENCY	-7, 967			2
	02300 EMS EDUCATION	0	1 1		2
	INPATIENT ROUTINE SERVICE COST CENTERS	0	237, 171		2
	03000 ADULTS & PEDI ATRI CS	-655, 018	16, 382, 410		30
	03100 I NTENSI VE CARE UNI T	-055,010	1 1		3
	02060 NEONATAL INTENSIVE CARE UNIT	-717, 520			3!
	04100 SUBPROVI DER – I RF	-70, 459			4
	04300 NURSERY	-70,439			4
	ANCI LLARY SERVI CE COST CENTERS	0	002, 293		
	05000 OPERATI NG ROOM	-785, 149	6, 148, 369		50
	05100 RECOVERY ROOM	-785, 149			5
	05200 DELIVERY ROOM & LABOR ROOM	0	3, 926, 024		5
	05400 RADI OLOGY-DI AGNOSTI C	-202, 895			54
	05500 RADIOLOGY - THERAPEUTIC	-202, 075			5
	05600 RADI OLOGT - THERAFLUTTC	0			50
		-			
	03950 CARDIAC CATH LAB	-285, 314			50
	05700 CT SCAN				
	05800 MRI 06000 LABORATORY	-			58
		-23, 414			60
	06500 RESPIRATORY THERAPY	-10, 358			6!
	06600 PHYSI CAL THERAPY	-175, 575			60
	06700 OCCUPATI ONAL THERAPY	-49, 277			6
	06800 SPEECH PATHOLOGY	-1, 262			68
	06900 ELECTROCARDI OLOGY	-1, 292, 015			69
	07000 ELECTROENCEPHALOGRAPHY	6,000			70
	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0			7
	07200 I MPL. DEV. CHARGED TO PATIENTS	0			7:
	07300 DRUGS CHARGED TO PATIENTS	0	9, 778, 079		7
	07301 DI ABETES CENTER	-153			7:
	07400 RENAL DIALYSIS	0	905, 495		7
	07698 HYPERBARI C OXYGEN THERAPY	0	6, 400		
	OUTPATIENT SERVICE COST CENTERS	40.777	001.000		
	09000 CLINIC	-18, 735			90
1.00	09100 EMERGENCY	-2, 351, 596			9
	04950 WOUND CARE	-7, 358	1, 483, 602		9
	09200 OBSERVATION BEDS (NON-DISTINCT PART				92
	09201 OBSERVATION BEDS (DISTINCT PART)	0	1, 469, 978		93
	OTHER REIMBURSABLE COST CENTERS	-	0.004 500		
	09500 AMBULANCE SERVICES	0	2, 936, 539		9
	10100 HOME HEALTH AGENCY	-163, 243	12, 319, 125		10
	SPECIAL PURPOSE COST CENTERS				
	11300 INTEREST EXPENSE	-1, 171, 910			11:
	11600 HOSPI CE	0	.,		110
18.00		-35, 793, 898	277, 540, 191		11
	NONREIMBURSABLE COST CENTERS				
90.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0			19
92.00	19200 PHYSI CLANS' PRI VATE OFFI CES	0	18, 064, 797		19:
	07950 MOB	0	0		19
	07951 LI FELI NE	0	0		19
	07952 PATIENT TRANSPORT	0	61, 106		19
	07954 OTHER NONREI MBURSABLE COST CENTERS	0	0		194
24. O30					

FRANCI SCAN HEALTH LAFAYETTE

In Lieu of Form CMS-2552-10

Health Financial Systems

SS	Financial Systems IFICATIONS		FRANCI SCAN HEAL		CCN: 15-0109	Peri od: From 01/01/2020	u of Form CMS-2552 Worksheet A-6
						To 12/31/2020	Date/Time Prepare 4/29/2021 3:52 pm
	Cost Center	I ncreases Li ne #	Salary	Other	_		
	2.00	3.00	4.00	5.00	-		
	A - RENTALS	1 00		2 21/ 24/			1
	CAP REL COSTS-BLDG & FIXT	1.00 0.00	0	2, 316, 248 C			1.
		0.00	0	C			3
		0.00	0	C			4
		0.00	0	C			5
		0.00 0.00	0	C			6.
		0.00	0	C			8
		0.00	0	C			9.
)			0				10
	0 B - EQUIPMENT RENTAL		0	2, 316, 248	5		
	CAP REL COSTS-MVBLE EQUIP	2.00	0	298, 122	2		1
		0.00	0	C			2
		0.00	0	C			3
		0.00	0	C			4
		0.00 0.00	0	C			5.
		0.00	0	C			7
		0.00	0	C			8
		0.00	0	C			9
		0.00	0	C			10
		0.00 0.00	0	C			11.
		0.00	0	C			12
		0.00		C			14
	0		0	298, 122	2		
	C - MEDICAL SUPPLIES	10.00		251			1
	DI ETARY MEDI CAL SUPPLI ES CHARGED TO	10.00 71.00	0	351 10, 822, 744			1.
	PATI ENT	, 1. 00	0	10, 022, 711			-
	IMPL. DEV. CHARGED TO	72.00	0	11, 760, 544	Ļ		3
	PATIENTS	54 00					
	RADI OI SOTOPE	56.00 0.00	0	82 C			4.
		0.00	0	C			6
		0.00	0	C			7
		0.00	0	C			8
		0.00	0	C			9.
		0.00 0.00	0	C			10
		0.00	0	C			12
		0.00	0	C			13
		0.00	0	C			14
		0.00 0.00	0	C			15
		0.00	0	C			17
		0.00	0	C			18
		0.00	0	C			19
		0.00	0	C			20
		0.00	0	C			21
		0.00 0.00	0	C			22 23
		0.00	0	C			23
		0.00	0	C			25
		0.00	0	C			26
		0.00	0	C			27
		0.00 0.00	0	C			28 29
		0.00		C			30
l	0		00	22, 583, 721			
	D - DRUGS						
	DRUGS CHARGED TO PATIENTS	73.00	0	9, 778, 079			1
		0.00 0.00	0	C			2
		0.00	0	C			4
		0.00	0	C			5
		0.00	0	C			6
		0.00	0	C			7
		0.00	0	C			8
		0.00 0.00	0	C			9.

FRANCI SCAN HEALTH LAFAYETTE

Provider CCN: 15-0109

In Lieu of Form CMS-2552-10 Period: Worksheet A-6 From 01/01/2020 To 12/31/2020 Date/Time Prepared:

					To 12/31/2020 Date/Time Prepare 4/29/2021 3:52 pm	ed:
		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
12.00		0.00	0	0	12	2.00
13.00		0.00	0	0		3.00
14.00		0.00	0	0		1.00
15.00		0.00	0	0		5.00
16.00		0.00	0	0		5.00
17.00		0.00	0	0		7.00
18.00		0.00	0	0		3. 00
19.00		0.00	0	0		9.00
20.00		0.00	0	0		0. 00
21.00			0	0		1.00
	0		0	9, 778, 079		
1.00	E - LDRP NURSERY	43.00	524, 122	78, 173		1 00
		43.00 52.00				1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	<u>3, 416, 460</u> <u>3, 940, 582</u>	<u>509, 564</u> 587, 737		2.00
	G F – CAFETERIA		3, 940, 582	587,737		
1.00	CAFETERIA	11.00	1, 299, 550	724, 422	1	1.00
1.00			1, 299, 550	724, 422		. 00
	G - CAPITAL EXP (INT & DEP)		1, 277, 330	724,422		
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	11, 448	1	1.00
			— — — ,	11, 448		
	H - INTEREST		-1			
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	5, 912, 680	1	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1, 654, 480	2	2.00
	0 — — — — — — —			7, 567, 160		
	I - NURSING SCHOOL					
1.00	NURSING SCHOOL	20.00	96, 956			1.00
2.00	NURSING SCHOOL	20.00	77, 491	122, 510		2. 00
3.00		0.00	0	0		3.00
	0		174, 447	122, 510		
	J – PARAMED PROGRAM	T	T			
1.00	PHARMACY RESIDENCY	23.00	75, 317	96, 750		1.00
2.00	EMS EDUCATION	23.01	153, 700			2.00
3.00		0.00	0	0		3. 00
	0 K - FSEH SHARED SERVICES		229, 017	96, 750		
1 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	011 001	1	1 00
1.00 2.00	OTHER ADMINISTRATIVE AND	4.00 5.06	0	211, 321 968, 339		1.00 2.00
2.00	GENERAL	5.06	0	900, 339	2	
3.00	NURSING ADMINISTRATION	13.00	0	405, 674	2	3. 00
4.00	PHARMACY	15.00	0	19, 572		1. 00 1. 00
1.00			of	1,604,906		
500.00	Grand Total: Increases		5, 643, 596	45, 691, 103		0. 00
		1	2, 2.2, 3,0	,,		

Health Financial Systems RECLASSIFICATIONS

FRANCI SCAN HEALTH LAFAYETTE

Provider CCN: 15-0109

In Lieu of Form CMS-2552-10

Peri od: From 01/01/2020 To 12/31/2020 Date/Time Prepared:

						o 12/31/2020 Date/Time P 4/29/2021 3	
		Decreases					
	Cost Center 6.00	Li ne # 7.00	Salary 8.00	0ther 9.00	Wkst. A-7 Ref. 10.00		
	A - RENTALS	7.00	8.00	9.00	10.00		
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	52, 902	10		1.00
2.00	OTHER ADMI NI STRATI VE AND	5.06	0	120, 276	0		2.00
3.00	GENERAL DI ETARY	10.00	0	56, 486	o		3.00
3.00 4.00	ADULTS & PEDIATRICS	30.00	0	279, 997			4.00
5.00	RADI OLOGY-DI AGNOSTI C	54.00	0	762, 671			5.00
6.00	LABORATORY	60.00	0	4, 538			6.00
7.00	PHYSI CAL THERAPY	66.00	0	645, 580			7.00
8.00 9.00	EMERGENCY OBSERVATION BEDS (DISTINCT	91.00 92.01	0	138, 694 229, 505			8.00 9.00
7.00	PART)	72.01	0	227, 303	0		9.00
10.00	AMBULANCE_SERVICES	95.00	0	2 <u>5, 5</u> 99	0		10.00
			0	2, 316, 248			_
1.00	B - EQUI PMENT RENTAL OTHER ADMINI STRATI VE AND	5.06	0	32, 013	10		1.00
1.00	GENERAL	5.00	0	52, 015	10		1.00
2.00	OPERATION OF PLANT	7.00	0	10, 073	0		2.00
3.00	HOUSEKEEPI NG	9.00	0	1, 969			3.00
4.00	CENTRAL SERVICES & SUPPLY	14.00	0	21, 605			4.00
5.00 6.00	PHARMACY ADULTS & PEDIATRICS	15.00 30.00	0	18, 457 1, 050			5.00 6.00
7.00	OPERATING ROOM	50.00	0	28, 180	-		7.00
8.00	RADI OLOGY-DI AGNOSTI C	54.00	0	3, 900			8.00
9.00	RADI OI SOTOPE	56.00	0	10, 500			9.00
10.00	CT SCAN	57.00	0	6, 350			10.00
11. 00 12. 00	RESPI RATORY THERAPY ELECTROCARDI OLOGY	65.00 69.00	0	151, 095 4, 200	-		11.00 12.00
13.00	ELECTROENCEPHALOGRAPHY	70.00	0	2, 348	-		13.00
14.00	HOSPICE	1 <u>16.</u> 00	0	<u> </u>			14.00
	0 C – MEDI CAL SUPPLI ES		0	298, 122			-
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	4, 987	0		1.00
2.00	OTHER ADMINI STRATI VE AND	5.06	0	19			2.00
	GENERAL						
3.00	NURSING ADMINISTRATION	13.00	0	1, 862			3.00
4.00 5.00	CENTRAL SERVICES & SUPPLY PHARMACY	14.00 15.00	0	605, 627 329, 063			4.00 5.00
6.00	ADULTS & PEDIATRICS	30.00	0	1, 515, 271	-		6.00
7.00	INTENSIVE CARE UNIT	31.00	0	319, 644			7.00
8.00	NEONATAL INTENSIVE CARE UNIT	35.00	0	106, 823			8.00
9. 00 10. 00	SUBPROVIDER – IRF OPERATING ROOM	41.00 50.00	0	36, 006 13, 480, 459			9.00 10.00
11.00	RECOVERY ROOM	51.00	0	20, 532	-		11.00
12.00	RADI OLOGY-DI AGNOSTI C	54.00	0	1, 073, 613	0		12.00
13.00	RADI OLOGY - THERAPEUTI C	55.00	0	6, 923			13.00
14.00 15.00	CARDIAC CATH LAB CT SCAN	56. 01 57. 00	0	2, 492, 970 142, 212			14.00 15.00
16.00	MRI	58.00	0	24, 684	3		16.00
17.00	LABORATORY	60.00	0	90, 782			17.00
18.00	RESPI RATORY THERAPY	65.00	0	528, 144			18.00
19.00	PHYSICAL THERAPY	66.00	0	105, 375			19.00
20. 00 21. 00	OCCUPATI ONAL THERAPY SPEECH PATHOLOGY	67.00 68.00	0	16, 012 5, 266			20.00 21.00
21.00	ELECTROCARDI OLOGY	69.00	0	22, 687			21.00
23.00	ELECTROENCEPHALOGRAPHY	70.00	0	46, 692			23.00
24.00	DI ABETES CENTER	73.01	0	295			24.00
25.00	RENAL DI ALYSI S	74.00	0	16, 993			25.00
26. 00 27. 00	CLINIC EMERGENCY	90.00 91.00	0	41, 685 1, 004, 230			26.00 27.00
28.00	WOUND CARE	91.01	0	324, 146			28.00
29.00	OBSERVATION BEDS (DISTINCT	92.01	0	61, 219	0		29.00
20.00	PART)	05.00	0	150 500	0		20.00
30.00	AMBULANCE_SERVICES		0	<u>159, 5</u> 00 22, 583, 721			30.00
	D - DRUGS						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	906			1.00
2.00		15.00	0	9,063,159			2.00
3.00 4.00	ADULTS & PEDIATRICS INTENSIVE CARE UNIT	30. 00 31. 00	0	6, 159 981			3.00 4.00
5.00	NEONATAL INTENSIVE CARE UNIT	35.00	0	1, 100			5.00
6.00	OPERATING ROOM	50.00	0	54, 373	0		6.00
7.00	RECOVERY ROOM	51.00	0	59			7.00
8.00	RADI OLOGY-DI AGNOSTI C	54.00	0	28, 521	0		8.00

Health Financial Systems RECLASSIFICATIONS

FRANCI SCAN HEALTH LAFAYETTE

Provider CCN: 15-0109

In Lieu of Form CMS-2552-10 Period: Worksheet A-6 From 01/01/2020 To 12/31/2020 Date/Time Prepared:

						To 12/31/2020 Date/Time 4/29/2021	Prepared:
		Decreases				4/29/2021	3:52 pill
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00	7	
9.00	RADI OLOGY - THERAPEUTI C	55.00	0	24	(9.00
10.00	CARDIAC CATH LAB	56.01	0	1, 365	(10.00
11.00	CT SCAN	57.00	0	73, 324	(11.00
12.00	MRI	58.00	0	37, 471	0		12.00
13.00	RESPI RATORY THERAPY	65.00	0	479	(13.00
14.00	PHYSI CAL THERAPY	66.00	0	249	(14.00
15.00	ELECTROCARDI OLOGY	69.00	0	103	(15.00
16.00	RENAL DI ALYSI S	74.00	0	7, 271	(16.00
17.00	CLINIC	90.00	0	480, 382	(17.00
18.00	EMERGENCY	91.00	0	2, 471	(18.00
19.00	WOUND CARE	91.01	0	2, 367	(19.00
20.00	OBSERVATION BEDS (DISTINCT PART)	92.01	0	541	(2	20.00
21.00	AMBULANCE_SERVICES	95.00	0	1 <u>6, 7</u> 74	(<u>כ</u>	21.00
	0		0	9, 778, 079			
	E – LDRP					1	
1.00	ADULTS & PEDIATRICS	30.00	3, 940, 582	587, 737			1.00
2.00		0.00	0	0		<u>)</u>	2.00
	0		3, 940, 582	587, 737			
	F - CAFETERIA				1		
1.00	DI ETARY		<u>1, 299, 5</u> 50	724, 422		<u></u>	1.00
	0		1, 299, 550	724, 422			
	G - CAPITAL EXP (INT & DEP)				1		
1.00	RADI OLOGY-DI AGNOSTI C	<u>54.</u> 00	0	1 <u>1,448</u>		2	1.00
			U	11, 448			
1 00	H - INTEREST INTEREST EXPENSE	113.00	0	7, 567, 160	1.	1	1.00
1.00 2.00	INTEREST EXPENSE	0.00		7, 567, 160	1-		2.00
2.00			<u>0</u>	7, 567, 160			2.00
	U - NURSING SCHOOL		0	7, 567, 160			
1.00	ADULTS & PEDIATRICS	30.00	96, 956		(1.00
2.00	OTHER ADMINISTRATIVE AND	5.06	36, 323	4, 187			2.00
2.00	GENERAL	5.00	50, 525	4, 107			2.00
3.00	MEDICAL RECORDS & LIBRARY	16.00	41, 168	118, 323			3.00
0.00			174, 447	122, 510			0.00
	J - PARAMED PROGRAM			122,010			
1.00	PHARMACY	15.00	75, 317	96, 750	(1.00
2.00	EMERGENCY	91.00	84, 699		(-	2.00
3.00	AMBULANCE SERVICES	95.00	69,001		(3.00
			229, 017	96, 750		-	
	K - FSEH SHARED SERVICES	I				1	
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	211, 321	0	(1.00
2.00	OTHER ADMINISTRATIVE AND	5.06	968, 339	0	(2.00
	GENERAL						
3.00	NURSING ADMINISTRATION	13.00	405, 674	0	(3.00
4.00	PHARMACY	15.00	19, 572	0	(4.00
	0		1, 604, 906	0		_	
500.00	Grand Total: Decreases		7, 248, 502	44, 086, 197			500.00

		FRANCI SCAN HEAL	TH_LAFAYETTE			In Lie	u of Form CMS-2	2552-10
RECONC	ILIATION OF CAPITAL COSTS CENTERS		Provider CO	CN: 15-0109		i od:	Worksheet A-7	
					Fro	om 01/01/2020 12/31/2020		narodi
					10	12/ 31/ 2020	4/29/2021 3:5	2 pm
				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	12, 770, 293	0		0	0	0	1.00
2.00	Land Improvements	3, 684, 928	722, 966		0	722, 966	0	2.00
3.00	Buildings and Fixtures	281, 423, 128	7, 955, 450		0	7, 955, 450	0	3.00
4.00	Building Improvements	2, 998, 580	1, 919, 358		0	1, 919, 358	0	4.00
5.00	Fixed Equipment	0	0		0	0	0	5.00
6.00	Movable Equipment	79, 586, 588	11, 104, 730		0	11, 104, 730	4, 335, 888	6.00
7.00	HIT designated Assets	0	0		0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	380, 463, 517	21, 702, 504		0	21, 702, 504	4, 335, 888	8.00
9.00	Reconciling Items	0	0		0	0	0	9.00
10.00	Total (line 8 minus line 9)	380, 463, 517	21, 702, 504		0	21, 702, 504	4, 335, 888	10.00
	· · · ·	Ending Balance	Fully					
		-	Depreci ated					
			Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET							
1.00	Land	12, 770, 293	0					1.00
2.00	Land Improvements	4, 407, 894	0					2.00
3.00	Buildings and Fixtures	289, 378, 578	0					3.00
4.00	Building Improvements	4, 917, 938	0					4.00
5.00	Fixed Equipment	0	0					5.00
6.00	Movable Equipment	86, 355, 430	0					6.00
7.00	HIT designated Assets	0	0					7.00
8.00	Subtotal (sum of lines 1-7)	397, 830, 133	0					8.00
9.00	Reconciling Items	0	0					9.00
10.00	Total (line 8 minus line 9)	397, 830, 133	0					10.00

Heal th	Financial Systems	FRANCISCAN HEALTH LAFAYETTE			In Lieu of Form CMS-2552-10		
RECONO	CILIATION OF CAPITAL COSTS CENTERS		Provider C	CN: 15-0109	Period:	Worksheet A-7	
					From 01/01/2020 To 12/31/2020		narod
					10 12/31/2020	4/29/2021 3: 5:	
			SL	JMMARY OF CAP	I TAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see		
		0.00	10.00	11.00		instructions)	
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	9.00	10.00 N 2, LINES 1 a	<u>11.00</u> nd 2	12.00	13.00	
1.00	CAP REL COSTS-BLDG & FIXT	18, 632, 088	NZ, LINES I A		0 0		1.00
2.00	CAP REL COSTS-BEDG & TTXT	10, 032, 000	0		0 0	0	2.00
3.00	Total (sum of lines 1-2)	18, 632, 088	0		0 0	0	3.00
0.00		SUMMARY O	F CAPITAL		<u> </u>		01.00
	Cost Center Description	Other	Total (1) (sum				
		Capi tal -Rel ate	of cols. 9				
		d Costs (see	through 14)				
		instructions)	45.00				
	DADT IL DEGONOLILIATION OF ANOUNTO FROM WORK	14.00	15.00				
1 00	PART 11 - RECONCILIATION OF AMOUNTS FROM WORK	CSHEET A, COLUM					1 00
1.00	CAP REL COSTS-BLDG & FLXT	0	18, 632, 088				1.00
2.00 3.00	CAP REL COSTS-MVBLE EQUIP Total (sum of lines 1-2)	0	18, 632, 088			ſ	2.00 3.00
3.00	Tiorai (Sum OF TITLES 1-2)	I U	10, 032, 088	I			3.00

Health Financial Systems	FRANCI SCAN HEAL	_TH LAFAYETTE		In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider CO	F	Period: From 01/01/2020 Fo 12/31/2020		
	COM	PUTATION OF RAT	FI 0S	ALLOCATION OF	OTHER CAPITAL	
Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
PART III - RECONCILIATION OF CAPITAL COSTS CE	1.00	2.00	3.00	4.00	5.00	
1.00 CAP REL COSTS-BLDG & FIXT 2.00 CAP REL COSTS-MVBLE EQUIP 3.00 Total (sum of lines 1-2)	311, 474, 703 86, 355, 430 397, 830, 133	0	86, 355, 430 394, 616, 952	0. 218834	0 0	1.00 2.00 3.00
Cost Center Description	Taxes	Other Capi tal -Rel ate d Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
	6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE	INTERS		-	00 740 050	0.01/.0/0	
1.00 CAP REL COSTS-BLDG & FIXT 2.00 CAP REL COSTS-MVBLE EQUIP 3.00 Total (sum of lines 1-2)	0	0		20, 743, 053 1, 667, 846 22, 410, 899		1.00 2.00 3.00
		SL	JMMARY OF CAPIT		2,011,010	0.00
Cost Center Description	Interest	Insurance (see instructions)		Other Capital-Relate d Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
	11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE					20,405,220	1 00
1.00 CAP REL COSTS-BLDG & FIXT 2.00 CAP REL COSTS-MVBLE EQUIP	5, 345, 938 1, 495, 895	0	C		28, 405, 239 3, 461, 863	1.00 2.00
3.00 Total (sum of lines 1-2)	6, 841, 833	0	(0	31, 867, 102	3.00

Heal th	Fi nanci a	I Systems
AD IIIST	MENTS TO	EXPENSES

FRANCISCAN HEALTH LAFAYETTE

In Lieu of Form CMS-2552-10

	Financial Systems MENTS TO EXPENSES	•	RANCI SCAN HEAL	Provi der CCN: 15-0109	Period: From 01/01/2020	eu of Form CMS-2 Worksheet A-8	
					To 12/31/2020		
				Expense Classification o To/From Which the Amount is			
	Cost Center Description		Amount	Cost Center		Wkst. A-7 Ref.	
1.00	Investment income - CAP REL	1.00 B	2.00 -566,742	3.00 CAP REL COSTS-BLDG & FIXT	4.00	5.00 11	1.00
2.00	COSTS-BLDG & FIXT (chapter 2) Investment income - CAP REL	В	-158 5850	CAP REL COSTS-MVBLE EQUIP	2.00	11	2.00
	COSTS-MVBLE EQUIP (chapter 2)	U		CAI NEE COSTS-MUDEL EQUIT			
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
1.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of		О		0.00	0	5.00
. 00	expenses (chapter 8) Rental of provider space by		o		0.00	0	6.00
	suppliers (chapter 8)		0				
. 00	Telephone services (pay stations excluded) (chapter 21)				0.00		
8. 00	Television and radio service (chapter 21)		0		0.00	0	8.00
	Parking lot (chapter 21)		0		0.00		
0.00	Provider-based physician adjustment	A-8-2	-9, 752, 519			0	10.00
1.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
2.00	Related organization	A-8-1	-2, 110, 406			0	12.00
3.00	transactions (chapter 10) Laundry and linen service		0		0.00	0	13.00
	Cafeteria-employees and guests Rental of quarters to employee		-819, 566(CAFETERI A	11.00 0.00		
	and others		0				
6. 00	Sale of medical and surgical supplies to other than		0		0.00	0	16.00
7.00	patients Sale of drugs to other than patients		О		0.00	0	17.00
8. 00	Sale of medical records and	В	-897	MEDI CAL RECORDS & LI BRARY	16.00	0	18.00
9.00	abstracts Nursing and allied health	В	-2, 356, 895	NURSING SCHOOL	20.00	0	19.00
	education (tuition, fees, books, etc.)						
	Vending machines	В	-16, 081	DI ETARY	10.00		
1.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
2.00	Interest expense on Medicare		0		0.00	0	22.00
	overpayments and borrowings to repay Medicare overpayments						
23.00	Adjustment for respiratory therapy costs in excess of	A-8-3	OF	RESPI RATORY THERAPY	65.00		23.00
4 00	limitation (chapter 14) Adjustment for physical	A-8-3			((00		24.00
24.00	therapy costs in excess of	A-8-3	U	PHYSICAL THERAPY	66.00		24.00
5.00	limitation (chapter 14) Utilization review -		0	*** Cost Center Deleted ***	114.00		25.00
	physicians' compensation (chapter 21)						
6. 00	Depreciation - CAP REL		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
7.00	COSTS-BLDG & FIXT Depreciation - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
8. 00	COSTS-MVBLE EQUIP Non-physician Anesthetist		0,	*** Cost Center Deleted ***	19.00		28.00
9.00	Physicians' assistant		0		0.00	0	29.00
U. 00	Adjustment for occupational therapy costs in excess of	A-8-3	00	OCCUPATI ONAL THERAPY	67.00		30.00
0. 99	limitation (chapter 14) Hospice (non-distinct) (see				20.00		30. 99
	instructions)			ADULTS & PEDIATRICS	30.00		
1.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
2.00	CAH HIT Adjustment for		0		0.00	0	32.00
2 00	Depreciation and Interest RECRUITMENT	A	-18 686	EMPLOYEE BENEFITS DEPARTMEN	T 4.00	0	33.00

	Financial Systems	•		TH LAFAYETTE		u of Form CMS-	
ADJUST	MENTS TO EXPENSES			Provider CCN: 15-0109	Period: From 01/01/2020	Worksheet A-8	
					To 12/31/2020		pared:
					- Wassland	4/29/2021 3:5	2 pm
				Expense Classification of To/From Which the Amount is			
				To Trom will chi the Amount 13	to be Aujusted		
	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	RECRUI TMENT	A		OTHER ADMINISTRATIVE AND	5.06	0	33.0
34.00	HAF	٨		GENERAL OTHER ADMI NI STRATI VE AND	5.06	o	34.00
34.00		A		GENERAL	5.00	0	34.0
35.00	ADVERTI SI NG	А		EMPLOYEE BENEFITS DEPARTMEN	T 4.00	0	35.0
35.01	ADVERTI SI NG	A		NURSING SCHOOL	20.00	0	
35.02	ADVERTI SI NG	A		ELECTROCARDI OLOGY	69.00	0	
35.03	ADVERTI SI NG	A		CLINIC	90.00	0	
36.00	ATHLETIC TRAINING	В		PHYSICAL THERAPY	66.00	0	
37.00	BLDG RENT	В		OTHER ADMINISTRATIVE AND	5.06	0	
07.00		5		GENERAL	0.00	0	
38.00	DI SCOUNTS / REBATES	В	-39, 023	MGMT INFO SYSTEMS	5.02	0	38.0
38. 01	DI SCOUNTS / REBATES	В	-23, 184	PURCHASI NG	5.03	0	38.0
38. 02	DI SCOUNTS / REBATES	В	-55, 805	OTHER ADMINISTRATIVE AND	5.06	0	38.0
				GENERAL			
38.03	DI SCOUNTS / REBATES	В	-109, 245	DI ETARY	10.00	0	38.0
38. 04	DI SCOUNTS / REBATES	В	-268, 293	CENTRAL SERVICES & SUPPLY	14.00	0	38.0
38.05	DI SCOUNTS / REBATES	В	-215, 648	OPERATING ROOM	50.00	0	38.0
38.06	DI SCOUNTS / REBATES	В	-51, 059	RADI OLOGY-DI AGNOSTI C	54.00	0	38.0
38. 07	DI SCOUNTS / REBATES	В	-23, 414	LABORATORY	60.00	0	38.0
38. 08	DI SCOUNTS / REBATES	В	-10, 358	RESPI RATORY THERAPY	65.00	0	38.0
39.00	EDUCATI ON	В	-7, 967	PHARMACY RESIDENCY	23.00	0	39.0
40.00	FOOD SERVICE DAY CARE	В		DI ETARY	10.00	0	40.0
41.00	MARKETING	A		OTHER ADMINISTRATIVE AND	5.06	0	41.0
				GENERAL			
41.02	MARKETING	A		ADULTS & PEDIATRICS	30.00	0	
41.05	MARKETING	A		PHYSICAL THERAPY	66.00	0	
41.06	MARKETING	A		OCCUPATIONAL THERAPY	67.00	0	
41.07	MARKETING	A		SPEECH PATHOLOGY	68.00	0	
41.08	MARKETING	A		ELECTROCARDI OLOGY	69.00	0	
41.09	MARKETING	A		DI ABETES CENTER	73.01	0	
41.10	MARKETING	A		WOUND CARE	91.01	0	
41.11	MARKETING	A B		HOME HEALTH AGENCY	101.00	0	
42.00 42.01	MI SCELLANEOUS REVENUE	В		EMPLOYEE BENEFITS DEPARTMEN OTHER ADMINISTRATIVE AND	T 4.00 5.06	9	
42.01	MI SCELLANEOUS REVENUE	в		GENERAL	5.00	9	42.0
42. 02	MI SCELLANEOUS REVENUE	В		HOUSEKEEPING	9.00	0	42.0
	MI SCELLANEOUS REVENUE	В		OCCUPATI ONAL THERAPY	67.00	0	
	MI SCELLANEOUS REVENUE	B	-18, 535		90.00	0	
	MI SCELLANEOUS REVENUE	B		EMERGENCY	90.00	0	
42.05	MI SCELLANEOUS REVENUE	B		WOUND CARE	91.00	0	
42.00	MI SCELLANEOUS REVENUE	B		OPERATION OF PLANT	7.00	0	
42.08	MI SCELLANEOUS REVENUE	B	-279, 681		10.00	0	
	MI SCELLANEOUS REVENUE	B	-179, 169		15.00	0	
	MI SCELLANEOUS REVENUE	B		CARDIAC CATH LAB	56.01	0	
42.11	MI SCELLANEOUS REVENUE	B		HOME HEALTH AGENCY	101.00	0	
43.00	MAINTENANCE REVENUE	B		OPERATION OF PLANT	7.00	0	
44.00	PENSION	A		EMPLOYEE BENEFITS DEPARTMEN		0	
50.00	TOTAL (sum of lines 1 thru 49)		-35, 793, 898		1.00	0	50.0
	(Transfer to Worksheet A,		22, , , 2, 2, 0, 0				
	column 6, line 200.)				1		1

(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.
(2) Additional environment of the set of the set

(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 HE	ALTH_LAFAYETTE	In Lie	eu of Form CMS-2	2552-10
	ENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HOM	ME Provider CCN: 15-0109	Peri od:	Worksheet A-8	-1
OFFICE COSTS				From 01/01/2020 To 12/31/2020		
	Li ne No.	Cost Center	Expense Items	Amount of	Amount	
				Allowable Cost		
					Wks. A, column	
					5	
	1.00	2.00	3. 00	4.00	5.00	
		MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED C	ORGANIZATIONS OR	CLAI MED	
	HOME OFFICE COSTS:				-	
1.00		CAP REL COSTS-BLDG & FIXT	FRANCI SCAN DEPRECIATION	2, 110, 965		1.00
2.00		CAP REL COSTS-MVBLE EQUIP	FRANCI SCAN DEPRECIATION	1, 656, 398		2.00
3.00		INTEREST EXPENSE	FRANCI SCAN INTEREST	7, 567, 160		3.00
3.01		OTHER ADMINISTRATIVE AND GEN		12, 456, 839		3.01
3.02			FRANCI SCAN COEP	702, 946		3. 02
4.00			INFORMATION TECHNOLOGY	18, 564, 520		4.00
4.01			PURCHASI NG SERVI CES	1, 554, 208	0	4.01
4.02	5. 05 PATIENT ACCOUNTING		PATIENT ACCT	5, 000, 361	0	4.02
4.03	16.00	MEDICAL RECORDS & LIBRARY	HIM	1, 878, 567	0	4.03
4.04	5.06	OTHER ADMINISTRATIVE AND GEN	ADMI NI STRATI ON	0	41, 275, 658	4.04
4.05	4.00	EMPLOYEE BENEFITS DEPARTMENT	FSEH SHARED SERVICES	0	556, 897	4.05
4.06	5.06	OTHER ADMINISTRATIVE AND GEN	FSEH SHARED SERVICES	0	2, 475, 147	4.06
4.07	13.00	NURSING ADMINISTRATION	FSEH SHARED SERVICES	0	536, 026	4.07
4.08	15.00	PHARMACY	FSEH SHARED SERVICES	0	19, 572	4.08
5.00	TOTALS (sum of lines 1-4).			51, 491, 964	53, 602, 370	5.00
	Transfer column 6, line 5 to					
	Worksheet A-8, column 2,					
	line 12.					
* Tho	amounts on lines 1-1 (and sub	scripts as appropriate) and t	transforred in detail to Wer	kshoot A column	6 Linos as	

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 worksheet A, cordinas i and or 2, the amount arrowable should be mareated in cordinar 4 or this part.							
				Related Organization(s) and/	or Home Office		
	Symbol (1)	Name	Percentage of	Name	Percentage of		
			Ownershi p		Ownership		
	1.00	2.00	3.00	4.00	5.00		
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:						

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

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

Ternibur						
6.00	В	FRANCI SCAN ALLI	100. 00 FRANCI	ISCAN ALLI	100.00	6.00
7.00	G	FSEH	100. 00 FSEH		100.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or					100.00
	non-financial) specify:					

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

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
 B. Corporation, partnership, or other organization has financial interest in provider.

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

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

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

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

Health Financial Systems	FRANCI SCAN HEALTH	LAFAYETTE	In Lie	u of Form CMS-2552-10
STATEMENT OF COSTS OF SERVICES FROM OFFICE COSTS	RELATED ORGANIZATIONS AND HOME	Provider CCN: 15-0109	Period: From 01/01/2020	Worksheet A-8-1
			To 12/31/2020	Date/Time Prepared:

			4/29/2021 3:5	52 pm
	Net	Wkst. A-7 Ref.		
	Adjustments			
	(col. 4 minus			
	col. 5)*			
	6.00	7.00		
	A. COSTS INCUR	RED AND ADJUSTN	IENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED	
	HOME OFFICE CO	STS:		
1.00	2, 110, 965	9		1.00
2.00	1, 656, 398	9		2.00
3.00	-1, 171, 910	11		3.00
3.01	12, 456, 839	0		3.01
3.02	702, 946	0		3. 02
4.00	18, 564, 520	0		4.00
4.01	1, 554, 208	0		4.01
4.02	5, 000, 361	0		4. 02
4.03	1, 878, 567	0		4.03
4.04	-41, 275, 658	0		4.04
4.05	-556, 897	0		4.05
4.06	-2, 475, 147	0		4.06
4.07	-536, 026	0		4.07
4.08	-19, 572			4.08
5.00	-2, 110, 406			5.00

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

Rel ated Organization(s)		
and/or Home Office		
Type of Business		
51.00		
6.00		
B. INTERRELATIONSHIP TO RELAT	ED ORGANIZATION(S) AND/OR HOME OFFICE:	

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

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

HOME OFFICE	6.00
SISTER FACILITY	7.00
	8.00
	9.00
	10.00
	100.00

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

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

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

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

D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related 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	Fi nanci al	Systems	
	ED BASED E		AD ILISTMENT

FRANCI SCAN HEALTH LAFAYETTE Provi der CCN: 15-0109

In Lieu of Form CMS-2552-10 Worksheet A-8-2

Heal th	Financial Syste	ems	FRANCI SCAN HE	ALTH LAFAYETTE		In Lie	eu of Form CMS-	2552-10
	R BASED PHYSIC			Provider (Period:	Worksheet A-8	3-2
						From 01/01/2020 To 12/31/2020		epared: 2 pm
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		Identifier	Remunerati on	Component	Component		ider Component	
							Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.06	OTHER ADMINISTRATIVE AND	3, 957, 950	3, 957, 950	(0 0	0	1.00
		GENERAL						
2.00		ADULTS & PEDIATRICS	654, 500			-	0	2.00
3.00		NEONATAL INTENSIVE CARE UNIT	717, 520	717, 520			0	3.00
4.00		SUBPROVIDER – IRF	70, 459	70, 459	(0 0	0	4.00
5.00		OPERATING ROOM	569, 501	569, 501	(0 0	0	5.00
6.00		RADI OLOGY-DI AGNOSTI C	151, 836	151, 836	(0 0	0	6.00
7.00	69.00	ELECTROCARDI OLOGY	1, 280, 712	1, 280, 712	(0 0	0	7.00
8.00		ELECTROENCEPHALOGRAPHY	-6, 000			0 0	0	8.00
9.00		EMERGENCY	2, 351, 041	2, 351, 041	(0 0	0	9.00
10.00	91.01	WOUND CARE	5, 000	5, 000	(0 0	0	10.00
200.00			9, 752, 519		(200.00
	Wkst. A Line #		Unadjusted RCE		Cost of		Physician Cost	
		I denti fi er	Limit	Unadjusted RCE	Memberships &		of Malpractice	
				Limit	Conti nui ng	Share of col.	Insurance	
					Educati on	12		
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.06	OTHER ADMINISTRATIVE AND	0	0	0	0	0	1.00
		GENERAL						
2.00		ADULTS & PEDIATRICS	0	0			0	2.00
3.00		NEONATAL INTENSIVE CARE UNIT	0	0			0	3.00
4.00		SUBPROVIDER - IRF	0	0		-	0	4.00
5.00		OPERATING ROOM	0	0		0	0	5.00
6.00		RADI OLOGY-DI AGNOSTI C	0	0		-	0	6.00
7.00		ELECTROCARDI OLOGY	0	0			0	7.00
8.00		ELECTROENCEPHALOGRAPHY	0	0		0	0	8.00
9.00		EMERGENCY	0	0		-	0	9.00
10.00	91.01	WOUND CARE	0	0		-	0	10.00
200.00	With A Line //	Coot Conton (Dhuni si sa	U Disso i da is	0	``````````````````````````````````````		0	200.00
	Wkst. A Line #		Provi der	Adjusted RCE	RCE	Adjustment		
		Identifier	Component Share of col.	Limit	Di sal I owance			
			14					
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00		OTHER ADMINISTRATIVE AND	0					1.00
		GENERAL						
2.00	30.00	ADULTS & PEDIATRICS	0	0	(654, 500		2.00
3.00		NEONATAL INTENSIVE CARE UNIT	0	0	(3.00
4.00		SUBPROVIDER – IRF	0	0				4.00
5.00	50.00	OPERATING ROOM	l o	l o	0	569, 501		5.00
6.00	54.00	RADI OLOGY-DI AGNOSTI C	0	0	0	151,836		6.00
7.00	69.00	ELECTROCARDI OLOGY	0	0	0	1, 280, 712		7.00
8.00		ELECTROENCEPHALOGRAPHY	0	0	(8.00
9.00		EMERGENCY	0	0	(9.00
10.00		WOUND CARE	0	0				10.00
200.00			0	0	0			200.00
		•						

J31 P	LLOCATION - GENERAL SERVICE COSTS		Provider CC		eriod: rom 01/01/2020	Worksheet B Part I	
					o 12/31/2020		
			CAPI TAL REL	ATED COSTS		472972021 3. 3.	
	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	COMMUNI CATI ONS	
		0	1.00	2.00	4.00	5. 01	
. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT	28, 405, 239	28, 405, 239				1.(
. 00 . 00 . 01 . 02 . 03 . 04	00200 CAP REL COSTS-MVBLE EQUI P 00400 EMPLOYEE BENEFITS DEPARTMENT 01160 COMMUNI CATI ONS 01140 MGMT I NFO SYSTEMS 00550 PURCHASI NG 00570 ADMI TTI NG	3, 461, 863 31, 538, 801 1, 432, 385 19, 435, 335 1, 858, 372 573	367, 720 36, 149 544, 653 393, 932	3, 461, 863 53, 085 5, 219 78, 627 56, 869 0	31, 959, 606 164, 230 0 0	1, 637, 983 53, 438	2. (4. (5. (5. (
. 05 . 06 . 00 . 00 . 00 . 00 0. 00	00580 PATIENT ACCOUNTING 00560 OTHER ADMINISTRATIVE AND GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY	6, 528, 764 21, 555, 515 11, 735, 802 729, 212 2, 954, 401 1, 168, 526	211, 301 2, 173, 233 4, 231, 929 167, 103 345, 283 612, 819	30, 504 313, 733 610, 932 24, 123 49, 846 88, 468	5, 903, 369 5, 903, 662 865, 662 32, 699	32, 527 169, 607 127, 786 2, 323 20, 910	5. 5. 7. 8. 9.
1.00 3.00 4.00 5.00 6.00 7.00	01100 CAFETERIA 01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY 01700 SOCI AL SERVI CE	1, 204, 406 3, 227, 943 247, 262 3, 499, 448 1, 941, 274 623, 900	553, 734 122, 514 202, 789 328, 615 82, 590 21, 476	79, 938 17, 686 29, 275 47, 440 11, 923 3, 100	840, 024 98, 863 757, 892 6, 339	20, 910 9, 294 53, 438 39, 497	13. 14. 15. 16.
0. 00 3. 00 3. 01	02000 NURSI NG SCHOOL 02301 PHARMACY RESI DENCY 02300 EMS EDUCATI ON I NPATI ENT ROUTI NE SERVI CE COST CENTERS	338, 223 345, 506 239, 191	1, 187, 174 0 147, 195	171, 383 0 21, 249	575, 462 65, 773 59, 568	0	20. 23. 23.
0. 00 1. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	16, 382, 410 4, 066, 783	4, 219, 286 408, 498	609, 106 58, 972	4, 083, 740 924, 228		
5.00 1.00 3.00	02060 NEONATAL INTENSIVE CARE UNIT 04100 SUBPROVIDER – IRF 04300 NURSERY	4,066,783 2,155,661 1,623,686 602,295	408, 498 285, 878 513, 704 0	41, 270 74, 159		39, 497 55, 761	35. 41.
D. 00	ANCI LLARY SERVICE COST CENTERS	6, 148, 369	1, 171, 610	169, 136	934, 825	55, 761	50.
1.00	05100 RECOVERY ROOM	576, 841	96, 800	13, 974	149, 358 889, 998		
2.00 4.00	05200 DELIVERY ROOM & LABOR ROOM 05400 RADIOLOGY-DIAGNOSTIC	3, 926, 024 7, 210, 239	646, 937	0 93, 393	916, 006		
5.00	05500 RADI OLOGY - THERAPEUTI C	562, 104	25, 073	3, 620	92, 288		55.
5.00 5.01	05600 RADI OI SOTOPE 03950 CARDI AC CATH LAB	418, 084 2, 327, 036	12, 180 300, 800	1, 758 43, 424	93, 725 341, 642		56 56
7.00	05700 CT SCAN	780, 285	54, 811	7, 913	187, 059		
	05800 MRI	254, 111	48, 507	7,003			1 00
D. 00 5. 00	06000 LABORATORY 06500 RESPI RATORY THERAPY	11, 027, 580 2, 207, 579	231, 316 82, 198	33, 393 11, 866	0 520, 700		
6. 00	06600 PHYSI CAL THERAPY	3, 826, 320	34, 012	4, 910	961, 318	13, 940	66
7.00 8.00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	1, 383, 199 659, 969	0 3, 490	0 504	367, 916 170, 103		67 68
9.00	06900 ELECTROCARDI OLOGY	2, 116, 260	371, 994	53, 702	437, 766		
0. 00	07000 ELECTROENCEPHALOGRAPHY	645, 312	190, 858	27, 553	155, 001	0	70
1.00 2.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	10, 822, 744 11, 760, 544	0	0	0	0	71
3.00	07300 DRUGS CHARGED TO PATIENTS	9, 778, 079	0	0	0	0	73
3.01	07301 DI ABETES CENTER	400, 451	0	0	103, 470		
4.00 6.98	07400 RENAL DIALYSIS 07698 HYPERBARIC OXYGEN THERAPY	905, 495 6, 400	65, 566 71, 229	9, 465 10, 283	27, 395	0	74
	OUTPATIENT SERVICE COST CENTERS		., == /			· · ·	
0. 00 1. 00	09000 CLINIC 09100 EMERGENCY	821, 029 9 514 116	1 515 207	0			
1.00	04950 WOUND CARE	8, 514, 116 1, 483, 602	1, 515, 397 603, 773	218, 766 87, 162	2, 014, 101 382, 831	0	91. 91.
2. 00 2. 01	09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 09201 OBSERVATI ON BEDS (DI STI NCT PART) OTHER REI MBURSABLE COST CENTERS	1, 469, 978	284, 560	41, 080	376, 361	0	92.
	09500 AMBULANCE SERVICES 10100 HOME HEALTH AGENCY	2, 936, 539 12, 319, 125	330, 218 280, 322	47, 671 40, 468			95. 101.
U I . UL	SPECIAL PURPOSE COST CENTERS	12, 319, 125	200, 322	40, 408	1, 271, 801	1 0	
	11300 INTEREST EXPENSE 11600 HOSPICE SUBTOTALS (SUM OF LINES 1 through 117)	4, 950, 001 277, 540, 191	0 23, 579, 226	0 3, 403, 951	711, 577 28, 704, 566	0	113. 116. 118.
00.00	NONREIMBURSABLE COST CENTERS	05 400		14.000	10.005		100
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	85, 189	111, 402	16, 082	13, 895	0	190.

Health Financial Systems	FRANCI SCAN HEAL	TH LAFAYETTE		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC		Period: From 01/01/2020 To 12/31/2020		
		CAPI TAL REL	ATED COSTS			
Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFI TS DEPARTMENT	COMMUNI CATI ONS	
	0	1.00	2.00	4.00	5. 01	
194. 01 07951LIFELINE194. 02 07952PATIENT TRANSPORT194. 03 07954OTHER NONREIMBURSABLE COST CENTERS200. 00Cross Foot Adjustments201. 00Negative Cost Centers202. 00TOTAL (sum lines 118 through 201)	0 61, 106 0 295, 751, 283	4, 424, 851 0	3, 461, 86	0 0 0 0 0 0 0 0 3 31, 959, 606	0	194. 01 194. 02 194. 03 200. 00 201. 00 202. 00

	Financial Systems LLOCATION - GENERAL SERVICE COSTS	FRANCI SCAN HEAL	Provider CC	F	In Lie Period: From 01/01/2020 To 12/31/2020	u of Form CMS- Worksheet B Part I Date/Time Pre	
						4/29/2021 3:5	2 pm
	Cost Center Description	MGMT INFO SYSTEMS	PURCHASI NG	ADMI TTI NG	PATI ENT ACCOUNTI NG	Subtotal	
		5.02	5.03	5.04	5.05	5A. 05	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01160 COMMUNI CATI ONS						5.01
5.02 5.03	01140 MGMT INFO SYSTEMS 00550 PURCHASING	20, 112, 053	2 241 700				5. 02 5. 03
5.03 5.04	00550 ADMI TTI NG	0	2, 341, 700	573			5.03
5.05	00580 PATI ENT ACCOUNTI NG	0	0	573			5.05
5.06	00560 OTHER ADMINISTRATIVE AND GENERAL	1, 378, 343	50, 357	C		31, 544, 157	5.06
7.00	00700 OPERATION OF PLANT	884, 612	2, 281	C	0 0	18, 459, 004	•
8.00	00800 LAUNDRY & LINEN SERVICE	46, 277	0	C	0	1,001,737	8.00
9.00 10.00	00900 HOUSEKEEPI NG 01000 DI ETARY	938, 871 878, 520	4, 690 2, 252	C		4, 915, 902 3, 084, 198	1
11.00	01100 CAFETERI A	078, 520	2, 252	C		2, 176, 615	1
13.00	01300 NURSI NG ADMI NI STRATI ON	618, 175	0	C		4, 847, 252	•
14.00	01400 CENTRAL SERVICES & SUPPLY	139, 122	489	C	0	727, 094	14.00
15.00	01500 PHARMACY	521, 616	48	C	0	5, 208, 497	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	17, 127	0	C	0	2, 098, 750	•
17.00 20.00	01700 SOCI AL SERVI CE 02000 NURSI NG SCHOOL	142, 655 375, 512	3 915	C	-	973, 917 2, 648, 669	17.00 20.00
23.00	02301 PHARMACY RESIDENCY	61, 457	0	C		472, 736	1
23.01	02300 EMS EDUCATION	0	6	C		467, 209	•
	INPATIENT ROUTINE SERVICE COST CENTERS	I					
30.00	03000 ADULTS & PEDI ATRI CS	4, 201, 067	5, 921	C		30, 138, 698	•
31.00 35.00	03100 I NTENSI VE CARE UNI T 02060 NEONATAL I NTENSI VE CARE UNI T	797, 385 376, 242	1, 977 2, 296	C		6, 404, 514 3, 550, 704	
41.00	04100 SUBPROVIDER - IRF	315,655	2, 290	C		3, 010, 755	•
43.00	04300 NURSERY	010,000	0	C		763, 888	•
	ANCILLARY SERVICE COST CENTERS						1
50.00	05000 OPERATING ROOM	705, 248	170, 591	C		10, 178, 563	•
51.00	05100 RECOVERY ROOM	94, 786	1	C		1, 013, 041	51.00
52.00 54.00	05200 DELIVERY ROOM & LABOR ROOM 05400 RADIOLOGY-DIAGNOSTIC	0 704, 783	0 112, 990	C		5, 027, 101 10, 327, 317	
55.00	05500 RADI OLOGY - THERAPEUTI C	62, 778	0	C		803, 185	•
56.00	05600 RADI OI SOTOPE	59, 781	16	C		585, 544	•
56.01	03950 CARDIAC CATH LAB	224, 805	99, 454	C	279, 786	3, 616, 947	56.01
57.00	05700 CT SCAN	136, 111	712	C		1, 461, 517	
58.00	05800 MRI 06000 LABORATORY	34, 205	79	C		455, 304	•
60.00 65.00	06500 RESPIRATORY THERAPY	0 416, 476	49, 102 9, 404	C		12, 127, 936 3, 425, 095	•
66.00	06600 PHYSI CAL THERAPY	781, 391	0	C		5, 736, 093	•
67.00	06700 OCCUPATI ONAL THERAPY	289, 648	0	C	68, 976	2, 109, 739	67.00
68.00	06800 SPEECH PATHOLOGY	133, 490	48	C	24, 071	991, 675	
69.00	06900 ELECTROCARDI OLOGY	334, 214	66	C		3, 483, 593	•
70.00 71.00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	117, 948	944, 557		25, 366 643, 744	1, 162, 038 12, 411, 045	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	838, 750	0	411, 736	13, 011, 030	
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	C	759, 381	10, 537, 460	
73.01	07301 DI ABETES CENTER	83, 479	62	C	472	601, 874	
74.00	07400 RENAL DI ALYSI S	23, 997	2	C	17, 468	1, 049, 388	•
76. 98	07698 HYPERBARI C OXYGEN THERAPY OUTPATI ENT SERVI CE COST CENTERS	0	0	C	0	87, 912	76. 98
90.00	09000 CLINIC	152, 577	1	C	7, 268	1, 177, 169	90.00
91.00	09100 EMERGENCY	1,655,301	7, 572	C	576, 410	14, 501, 663	•
91.01	04950 WOUND CARE	272, 883	34	C	35, 192	2, 865, 477	91.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
92.01	09201 OBSERVATI ON BEDS (DI STI NCT PART)	0	0	C	86, 058	2, 258, 037	92.01
95 00	OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES	748, 320	1, 267	C	68, 521	4, 721, 821	95.00
	10100 HOME HEALTH AGENCY	797,065	29, 622	C		14, 807, 563	•
	SPECIAL PURPOSE COST CENTERS	·					1
	11300 INTEREST EXPENSE						113.00
	11600 HOSPI CE	575, 166	6, 032	C		6, 356, 818	•
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	20, 097, 088	2, 341, 680	573	6, 803, 669	269, 386, 241	118.00
190 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	14, 742	10	C		241, 320	190 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	223	10	C	0	21, 637, 765	•
	07950 MOB	0	0	C	0		194.00
	07951 LI FELI NE	О	0	C	0		194. 01
	07952 PATIENT TRANSPORT	0	0	C	0		194.02
194.03 200.00	07954 OTHER NONREI MBURSABLE COST CENTERS	0	0	C	0	4, 424, 851	194.03 200.00
200.00		0	0	C	0		200.00
201.00		U	ų	C	., U	0	

Health Financial Systems	FRANCI SCAN HEAL	TH LAFAYETTE		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC		Period: From 01/01/2020 To 12/31/2020	Worksheet B Part I Date/Time Pre 4/29/2021 3:5	
Cost Center Description	MGMT INFO SYSTEMS	PURCHASI NG	ADMI TTI NG	PATI ENT ACCOUNTI NG	Subtotal	2 pm
	5.02	5.03	5.04	5. 05	5A. 05	
202.00 TOTAL (sum lines 118 through 201)	20, 112, 053	2, 341, 700	57	3 6, 803, 669	295, 751, 283	202.00

	Financial Systems	FRANCI SCAN HEAL			In Lie	u of Form CMS-	2552-10
COST /	ALLOCATION - GENERAL SERVICE COSTS		Provider C		eriod: rom 01/01/2020	Worksheet B Part I	
				Ţ	o 12/31/2020	Date/Time Pre 4/29/2021 3:5	pared: 2 pm
	Cost Center Description	OTHER ADMI NI STRATI VE	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	
		AND GENERAL		LINEN SERVICE			
	GENERAL SERVICE COST CENTERS	5.06	7.00	8.00	9.00	10.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00 5.01	00400 EMPLOYEE BENEFITS DEPARTMENT 01160 COMMUNI CATI ONS						4.00 5.01
5.01	01140 MGMT INFO SYSTEMS						5.01
5.03	00550 PURCHASI NG						5.03
5.04							5.04
5.05 5.06	00580 PATIENT ACCOUNTING 00560 OTHER ADMINISTRATIVE AND GENERAL	31, 544, 157					5.05 5.06
7.00	00700 OPERATION OF PLANT	2, 203, 857	20, 662, 861				7.00
8.00	00800 LAUNDRY & LINEN SERVICE	119, 599	168, 873				8.00
9.00 10.00	00900 HOUSEKEEPI NG 01000 DI ETARY	586, 919 368, 229	348, 939 619, 309			4, 340, 376	9.00 10.00
11.00	01100 CAFETERI A	259, 870	559, 599			0	1
13.00	01300 NURSI NG ADMI NI STRATI ON	578, 723	123, 811			0	1
14.00 15.00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	86, 809 621, 853	204, 937 332, 095			0	
16.00	01600 MEDICAL RECORDS & LIBRARY	250, 574	83, 465			0	1
17.00	01700 SOCIAL SERVICE	116, 278	21, 703			0	
20.00 23.00	02000 NURSI NG SCHOOL 02301 PHARMACY RESI DENCY	316, 230 56, 441	1, 199, 747 0			0	
23.00	02300 EMS EDUCATI ON	55, 781	148, 754			0	1
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 31.00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	3, 598, 256 764, 648	4, 263, 971 412, 825			3, 644, 520 398, 917	
35.00	02060 NEONATAL INTENSIVE CARE UNIT	423, 926	288, 905			398, 917	1
41.00	04100 SUBPROVI DER – I RF	359, 460	519, 144	24, 493	194, 815	296, 939	
43.00		91, 202	0	47, 529	0	0	43.00
50.00	ANCI LLARY SERVI CE COST CENTERS	1, 215, 239	1, 184, 018	226, 279	444, 316	0	50.00
51.00	05100 RECOVERY ROOM	120, 949	97, 825			0	1
52.00	05200 DELIVERY ROOM & LABOR ROOM	600, 196	0			0	
54.00 55.00	05400 RADI OLOGY - DI AGNOSTI C 05500 RADI OLOGY - THERAPEUTI C	1, 232, 999 95, 894	653, 789 25, 338			0	1
56.00	05600 RADI OI SOTOPE	69, 909	12, 309			0	
56.01	03950 CARDI AC CATH LAB	431,835	303, 986			0	
57.00 58.00	05700 CT SCAN 05800 MRI	174, 493 54, 360	55, 391 49, 021			0	1
60.00	06000 LABORATORY	1, 447, 979	233, 766			0	
65.00	06500 RESPI RATORY THERAPY	408, 929	83, 069			0	
66.00 67.00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	684, 844 251, 886	34, 372	17, 927	12, 899	0 0	
68.00		118, 398	3, 527	0	1, 324	0	
69.00	06900 ELECTROCARDI OLOGY	415, 913	375, 933			0	
70.00 71.00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	138, 738 1, 481, 779	192, 879	0	72, 380 0	0	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	1, 553, 413	0	0	0	0	
73.00	07300 DRUGS CHARGED TO PATIENTS	1, 258, 088	0	0	0	0	73.00
73.01 74.00	07301 DI ABETES CENTER 07400 RENAL DI ALYSI S	71,859	0	0	0	0	1
76.98		125, 289 10, 496	66, 261 71, 983		24, 865 27, 013	0 0	
	OUTPATIENT SERVICE COST CENTERS		. 1, 700		27,010		
90.00		140, 545	0	0	-	0	1
91.00 91.01	09100 EMERGENCY 04950 WOUND CARE	1, 731, 383 342, 115	1, 531, 446 610, 167		574, 693 228, 972	0	1
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	542, 115	010, 107		220, 772	0	92.00
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	269, 592	287, 574	0	107, 915	0	1
05 00	OTHER REI MBURSABLE COST CENTERS 09500 AMBULANCE SERVICES	563, 748	333, 715	0	125, 230	0	95.00
	D 10100 HOME HEALTH AGENCY	1, 767, 905	283, 291				101.00
	SPECIAL PURPOSE COST CENTERS			1			
	11300 I NTEREST EXPENSE	750 050	~	_	_	<u>^</u>	113.00
116.00	D11600 HOSPICE D SUBTOTALS (SUM OF LINES 1 through 117)	758, 953 28, 396, 381	0 15, 785, 737	1, 290, 209	0 5, 729, 463	0 4, 340, 376	116.00 118.00
	NONREI MBURSABLE COST CENTERS				1		
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	28, 812	112, 582				190.00
	D 19200 PHYSI CLANS' PRIVATE OFFICES D 07950 MOB	2, 583, 376	292, 828 0		109, 887 0		192.00 194.00
	1 07951 LI FELI NE	0	0	0	0	0	194.01
	2 07952 PATIENT TRANSPORT	7, 296	0	0	0		194.02
194.03 200.00	07954 OTHER NONREIMBURSABLE COST CENTERS Cross Foot Adjustments	528, 292	4, 471, 714	0	0	0	194. 03 200. 00
200.00				1			1200.00

Health Fin	ancial Systems	FRANCI SCAN HEAI	LTH_LAFAYETTE		In Lie	u of Form CMS-	2552-10
COST ALLOC	CATION - GENERAL SERVICE COSTS		Provider C		Period:	Worksheet B	
					rom 01/01/2020 0 12/31/2020		narod
					12/31/2020	4/29/2021 3:5	
	Cost Center Description	OTHER	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		ADMI NI STRATI VE	PLANT	LINEN SERVICE			
		AND GENERAL					
		5.06	7.00	8.00	9.00	10.00	
201.00	Negative Cost Centers	0	C	(0 0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	31, 544, 157	20, 662, 861	1, 290, 209	5, 881, 598	4, 340, 376	202.00

ST ALLO	nancial Systems CATION - GENERAL SERVICE COSTS	RANCI SCAN TILA	LTH LAFAYETTE Provider CC	N: 15-0109	Period:	u of Form CMS-2 Worksheet B	2552-
					From 01/01/2020 To 12/31/2020	Part I Date/Time Pre	pared
	Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	4/29/2021 3:5 MEDI CAL	2 pm
			ADMI NI STRATI ON	SERVICES & SUPPLY		RECORDS & LI BRARY	
0.51		11.00	13.00	14.00	15.00	16.00	
	NERAL SERVICE COST CENTERS 100 CAP REL COSTS-BLDG & FIXT						1.0
00 002	200 CAP REL COSTS-MVBLE EQUIP						2.0
	400 EMPLOYEE BENEFITS DEPARTMENT						4.0
	160 COMMUNI CATIONS 140 MGMT INFO SYSTEMS						5. C
	550 PURCHASI NG						5.0
	570 ADMI TTI NG						5.0
	580 PATIENT ACCOUNTING						5. 0 5. 0
	560 OTHER ADMINISTRATIVE AND GENERAL 700 OPERATION OF PLANT						5. 7.
	800 LAUNDRY & LINEN SERVICE						8.
	900 HOUSEKEEPI NG						9.
	000 DI ETARY 100 CAFETERI A	2 204 090					10.
1	300 NURSING ADMINISTRATION	3, 206, 080 123, 983	1 1				13.
	400 CENTRAL SERVICES & SUPPLY	27, 903		1, 156, 34	8		14.
	500 PHARMACY	104, 617	1	2			15.
	600 MEDICAL RECORDS & LIBRARY 700 SOCIAL SERVICE	3, 435	1		0 0	2, 467, 545	16.
	000 NURSING SCHOOL	28, 611 75, 314	1	46	2 0 4 0	0	17. 20.
	301 PHARMACY RESIDENCY	12, 326			0 0	0	23.
	300 EMS EDUCATION	C	0		3 0	0	23.
	PATIENT ROUTINE SERVICE COST CENTERS	942 574		2.00	1 0	124 105	20
	000 ADULTS & PEDIATRICS 100 INTENSIVE CARE UNIT	842, 574 159, 926		3, 00 1, 00		134, 185 34, 657	30. 31.
	060 NEONATAL INTENSIVE CARE UNIT	75, 460		1, 16		37, 980	35.
	100 SUBPROVI DER – I RF	63, 309		4		11, 250	41.
	300 NURSERY	C	0		0 0	9, 088	43.
	CILLARY SERVICE COST CENTERS	141, 446	310, 218	86, 45	7 0	298, 455	50.
	100 RECOVERY ROOM	19, 010			0 0	22, 738	51.
	200 DELIVERY ROOM & LABOR ROOM	C	-		0 0	54, 646	
	400 RADI OLOGY - DI AGNOSTI C 500 RADI OLOGY - THERAPEUTI C	141, 353 12, 591	1	57, 26	4 0 0 0	182, 636 20, 790	54. 55.
	600 RADI OL SOTOPE	11, 990	1		8 0	20, 770	56.
	950 CARDI AC CATH LAB	45, 088		50, 40	4 0	101, 474	56.
	700 CT SCAN	27, 299	1 1	36		106, 856	57.
1	800 MRI 000 LABORATORY	6, 860	1	4 24, 88		16, 590 248, 191	58. 60.
	500 RESPI RATORY THERAPY	83, 530		4, 76		35, 498	
00 060	600 PHYSI CAL THERAPY	156, 718			0 0	41, 419	66.
	700 OCCUPATI ONAL THERAPY	58, 093			0 0	25, 017	
	800 SPEECH PATHOLOGY 900 ELECTROCARDI OLOGY	26, 773 67, 031		2		8, 730 56, 452	68. 69.
	000 ELECTROENCEPHALOGRAPHY	23, 656			0 0	9, 200	70.
	100 MEDICAL SUPPLIES CHARGED TO PATIENT	C	0	478, 71	3 0	233, 477	
	200 I MPL. DEV. CHARGED TO PATIENTS	C	0	425, 08		149, 331	
	300 DRUGS CHARGED TO PATIENTS 301 DIABETES CENTER	16, 743	36, 720	3	0 6, 391, 709 1 0	275, 416 171	73. 73.
	400 RENAL DI ALYSI S	4, 813			1 0	6, 336	74.
	698 HYPERBARI C OXYGEN THERAPY	C	0		0 0	0	76.
	TPATIENT SERVICE COST CENTERS	20 (01			1 0	2 (2)	00
	000 CLI NI C 100 EMERGENCY	30, 601 331, 992		3, 83	7 0	2, 636 209, 055	90. 91.
	950 WOUND CARE	54, 730		1		12, 764	91.
	200 OBSERVATION BEDS (NON-DISTINCT PART						92.
	201 OBSERVATION BEDS (DISTINCT PART)	C	0		0 0	31, 212	92.
	HER REIMBURSABLE COST CENTERS 500 AMBULANCE SERVICES	150, 085	329, 164	64	2 0	24, 851	95.
	100 HOME HEALTH AGENCY	159, 861		15, 01		25, 083	
	ECIAL PURPOSE COST CENTERS						
	300 INTEREST EXPENSE	145 057		0.05	-	44 0/1	113.
00 110	600 HOSPICE SUBTOTALS (SUM OF LINES 1 through 117)	115, 357 3, 203, 078		3, 05 1, 156, 33		41, 361 2, 467, 545	
	NREIMBURSABLE COST CENTERS	3, 203, 078	y 0,720,231	1, 100, 33	0, 371, 709	2,407,045	110.
. 00 190	000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	2, 957	0		5 0		190.
	200 PHYSI CLANS' PRI VATE OFFI CES	45	0		5 0		192.
	950 MOB 951 LI FELI NE	C					194. 194.
	951 LIFELINE 952 PATIENT TRANSPORT						194. 194.
	954 OTHER NONRELMBURSABLE COST CENTERS	C			0 0		194.
	Cross Foot Adjustments		1 1				200.

Heal th Fin	ancial Systems	FRANCI SCAN HEA	LTH_LAFAYETTE		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS					Period:	Worksheet B	
					From 01/01/2020 Fo 12/31/2020		
	Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
			ADMI NI STRATI ON	SERVICES &		RECORDS &	
				SUPPLY		LI BRARY	
		11.00	13.00	14.00	15.00	16.00	
201.00	Negative Cost Centers	0	0	(0 0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	3, 206, 080	5, 720, 231	1, 156, 348	6, 391, 709	2, 467, 545	202.00

	Financial Systems LLOCATION - GENERAL SERVICE COSTS	FRANCI SCAN HEAL	Provi der CC	N: 15-0109	Period: From 01/01/2020	u of Form CMS- Worksheet B	2332-10
					To 12/31/2020	Part I Date/Time Pre	
	Cost Center Description	SOCI AL SERVI CE	NURSING SCHOOL	PHARMACY	EMS EDUCATION	<u>4/29/2021 3:5</u> Subtotal	
		17.00	20.00	RESI DENCY 23.00	23.01	24.00	
1 00	GENERAL SERVICE COST CENTERS						1 00
1.00 2.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01160 COMMUNI CATI ONS						5.01
5.02	01140 MGMT INFO SYSTEMS						5.02
5.03	00550 PURCHASI NG						5.03
5.04 5.05	00570 ADMI TTI NG 00580 PATI ENT ACCOUNTI NG						5.04 5.05
5.06	00560 OTHER ADMINISTRATIVE AND GENERAL						5.06
7.00	00700 OPERATION OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPING						9.00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A						10.00
13.00	01300 NURSI NG ADMI NI STRATI ON						13.00
14.00	01400 CENTRAL SERVICES & SUPPLY						14.00
15.00	01500 PHARMACY						15.00
	01600 MEDI CAL RECORDS & LI BRARY	1 1/0 455					16.00
	01700 SOCI AL SERVI CE 02000 NURSI NG SCHOOL	1, 148, 655 0	4, 690, 643				17.00
23.00	02301 PHARMACY RESIDENCY	0	1,0,0,010	541, 5C	3		23.00
23.01	02300 EMS EDUCATION	0			727, 569		23.01
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	011.00/	4 (00 (40			F0 000 F40	1 00 00
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	811, 206 112, 785	4, 690, 643 0		0 0	52, 030, 549 8, 864, 321	•
35.00	02060 NEONATAL INTENSIVE CARE UNIT	66, 354	0		0 0	4, 747, 326	1
41.00	04100 SUBPROVI DER – I RF	71, 651	О		0 0	4, 690, 705	41.00
43.00	04300 NURSERY	86, 659	0		0 0	998, 366	43.00
50.00	ANCI LLARY SERVI CE COST CENTERS	0	0		0 0	14, 084, 991	50.00
51.00	05100 RECOVERY ROOM	0	0		0 0	1, 393, 575	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	5, 732, 761	
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	12, 920, 098	
55.00	05500 RADI OLOGY - THERAPEUTI C	0	0		0 0	967, 306	
56. 00 56. 01	05600 RADI OI SOTOPE 03950 CARDI AC CATH LAB	0	0		0 0	710, 675 4, 767, 939	
57.00	05700 CT SCAN	0	0		0 0	1, 846, 703	1
58.00	05800 MRI	0	0		0 0	600, 571	
60.00	06000 LABORATORY	0	0		0 0	14, 178, 706	
65.00 66.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	0	0		0 0	4, 264, 889 7, 027, 983	
	06700 OCCUPATI ONAL THERAPY	0	0		0 0	2, 572, 143	
	06800 SPEECH PATHOLOGY	0	0		0 0	1, 209, 169	
	06900 ELECTROCARDI OLOGY	0	0		0 0	4, 694, 345	
	07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	1, 650, 773	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0			14, 605, 014 15, 138, 857	
	07300 DRUGS CHARGED TO PATIENTS	0	0	541, 50	3 0	19, 004, 176	
	07301 DI ABETES CENTER	0	0		0 0	727, 398	
	07400 RENAL DIALYSIS	0	0		0 0	1, 287, 509	
76. 98	07698 HYPERBARI C OXYGEN THERAPY OUTPATI ENT SERVI CE COST CENTERS	0	0		0 0	197, 404	76.98
90.00	09000 CLINIC	0	0		0 0	1, 350, 952	90.00
	09100 EMERGENCY	0	0		0 727, 569	20, 458, 956	
	04950 WOUND CARE	0	0		0 0	4, 234, 275	
	09200 OBSERVATION BEDS (NON-DISTINCT PART 09201 OBSERVATION BEDS (DISTINCT PART)	0	0		0 0	2, 954, 330	92.00
72.01	OTHER REIMBURSABLE COST CENTERS	0	U		<u> </u>	2, 734, 330	92.01
	09500 AMBULANCE SERVI CES	0	0		0 0	6, 249, 256	95.00
101.00	10100 HOME HEALTH AGENCY	0	0		0 0	17, 515, 628	101.00
113 00	SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE						113.00
	11600 HOSPI CE	0	о		0 0	7, 528, 545	
118.00		1, 148, 655	4, 690, 643	541, 50	3 727, 569	261, 206, 194	
400 07	NONREI MBURSABLE COST CENTERS		-1				100.05
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	0	0			427, 924 24, 623, 906	
	07950 MOB	0	0				192.00
	07951 LI FELI NE	0	0		o o		194.00
194.02	07952 PATI ENT TRANSPORT	0	0		0 0	68, 402	194. 02
194 03	07954 OTHER NONREIMBURSABLE COST CENTERS	0	0		0 0	9, 424, 857	
						-	000 07
200.00		_	0		0 0		200.00 201.00

Health Financial Systems	FRANCI SCAN HEAI	LTH LAFAYETTE		In Lieu of Form CMS-2552-1			
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CO		Period: From 01/01/2020			
				To 12/31/2020	Date/Time Pre 4/29/2021 3:5		
Cost Center Description	SOCI AL SERVI CE	NURSING SCHOOL	PHARMACY	EMS EDUCATION	Subtotal		
			RESI DENCY				
	17.00	20.00	23.00	23.01	24.00		
202.00 TOTAL (sum lines 118 through 201)	1, 148, 655	4, 690, 643	541, 50	3 727, 569	295, 751, 283	202.00	

ST ALLOCATI	al Systems ON - GENERAL SERVICE COSTS	FRANCI SCAN HEALT	Provider CCN: 15	5-0109	Period: From 01/01/2020	<u>of Form CMS</u> Worksheet B Part I	
					To 12/31/2020	Date/Time P 4/29/2021 3	
C	ost Center Description	Intern &	Total				
		Residents Cost					
		& Post Stepdown					
		Adjustments					
		25.00	26.00				
	SERVICE COST CENTERS	1 1					
	AP REL COSTS-BLDG & FIXT						1.
1 1	AP REL COSTS-MVBLE EQUI P						2.
	MPLOYEE BENEFITS DEPARTMENT						4.
1 1	OMMUNI CATI ONS						5.
1 1	GMT INFO SYSTEMS URCHASING						5. 5.
	DMI TTI NG						5.
	ATLENT ACCOUNTING						5.
	THER ADMINISTRATIVE AND GENERAL						5.
00700 0	PERATION OF PLANT						7.
	AUNDRY & LINEN SERVICE						8.
	OUSEKEEPING						9.
00 01000 D							10.
							11.
							13.
00 01400 C 00 01500 P	ENTRAL SERVICES & SUPPLY						14.
	EDICAL RECORDS & LIBRARY						16.
	OCIAL SERVICE						17.
	URSI NG SCHOOL						20.
	HARMACY RESIDENCY						23.
1 1	MS EDUCATION						23.
I NPATI E	NT ROUTINE SERVICE COST CENTERS						
	DULTS & PEDIATRICS	0	52, 030, 549				30.
1 1	NTENSIVE CARE UNIT	0	8, 864, 321				31.
	EONATAL INTENSIVE CARE UNIT	0	4, 747, 326				35.
	UBPROVIDER - IRF	0	4, 690, 705				41.
00 04300 N	RY SERVICE COST CENTERS	U	998, 366				43.
	PERATING ROOM	0	14, 084, 991				50.
	ECOVERY ROOM	0	1, 393, 575				51.
	ELIVERY ROOM & LABOR ROOM	0	5, 732, 761				52.
00 05400 R	ADI OLOGY-DI AGNOSTI C	0	12, 920, 098				54.
00 05500 R	ADI OLOGY – THERAPEUTI C	0	967, 306				55.
	ADI OI SOTOPE	0	710, 675				56.
	ARDIAC CATH LAB	0	4, 767, 939				56.
00 05700 C		0	1, 846, 703				57.
00 05800 M		0	600, 571				58.
00 06000 L	ESPIRATORY THERAPY	0	14, 178, 706				60.
	HYSICAL THERAPY	0	4, 264, 889 7, 027, 983				65. 66.
	CCUPATIONAL THERAPY	0	2, 572, 143				67.
	PEECH PATHOLOGY	0	1, 209, 169				68.
	LECTROCARDI OLOGY	0	4, 694, 345				69.
	LECTROENCEPHALOGRAPHY	0	1, 650, 773				70.
00 07100 M	EDICAL SUPPLIES CHARGED TO PATIENT	0	14, 605, 014				71
	MPL. DEV. CHARGED TO PATIENTS	0	15, 138, 857				72.
	RUGS CHARGED TO PATIENTS	0	19, 004, 176				73.
	I ABETES CENTER	0	727, 398				73.
	ENAL DIALYSIS	0	1, 287, 509				74.
	YPERBARI C OXYGEN THERAPY	0	197, 404				76.
00 09000 C	ENT SERVICE COST CENTERS	0	1, 350, 952				90.
00 09000 C		0	20, 458, 956				90.
01 04950 W		0	4, 234, 275				91.
	BSERVATION BEDS (NON-DISTINCT PART	0					92.
	BSERVATION BEDS (DISTINCT PART)	0	2, 954, 330				92.
	EI MBURSABLE COST CENTERS						
	MBULANCE SERVI CES	0	6, 249, 256				95.
	OME HEALTH AGENCY	0	17, 515, 628				101.
	PURPOSE COST CENTERS						1110
	NTEREST EXPENSE						113.
5. 00 11600 H 3. 00 S		0	7, 528, 545				116.
	UBTOTALS (SUM OF LINES 1 through 117) IBURSABLE COST CENTERS		261, 206, 194				118.
	IFT, FLOWER, COFFEE SHOP & CANTEEN	0	427, 924				190.
	HYSICIANS' PRIVATE OFFICES		24, 623, 906				190.
1. 00 07950 M		0	24, 023, 900				192.
		0	Ő				194.
4. 01 07951 L							

Health Financial Systems	FRANCI SCAN HEAL	TH LAFAYETTE		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC	CN: 15-0109	Peri od:	Worksheet B	
				From 01/01/2020 To 12/31/2020	Part I Date/Time Pre	nared
				10 12/31/2020	4/29/2021 3:5	2 pm
Cost Center Description	Intern &	Total				
	Residents Cost					
	& Post					
	Stepdown					
	Adjustments					
	25.00	26.00				
194.0307954OTHER NONREIMBURSABLE COST CENTERS	0	9, 424, 857				194.03
200.00 Cross Foot Adjustments	0	0				200.00
201.00 Negative Cost Centers	0	0				201.00
202.00 TOTAL (sum lines 118 through 201)	0	295, 751, 283				202.00

	Financial Systems TION OF CAPITAL RELATED COSTS	FRANCI SCAN HEAL	Provider CC		Period: From 01/01/2020 To 12/31/2020	u of Form CMS-: Worksheet B Part II Date/Time Pre	pared:
			CAPI TAL REL	ATED COSTS		4/29/2021 3:5	2 pm
	Cost Center Description	Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFI TS DEPARTMENT	
			1.00	2.00	2A	4.00	
	GENERAL SERVICE COST CENTERS			ľ			
1.00 2.00 4.00 5.01 5.02 5.03 5.04	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 01160 COMMUNI CATIONS 01140 MGMT INFO SYSTEMS 00550 PURCHASING 00570 ADMITTING	0 0 0 0 0	367, 720 36, 149 544, 653 393, 932 0	5, 21 78, 62 56, 86	9 41, 368 7 623, 280 9 450, 801 0 0	420, 805 2, 162 0 0 0 0	5. 02 5. 03 5. 04
$\begin{array}{c} 5.\ 05\\ 5.\ 06\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 20.\ 00\\ 23.\ 00\\ \end{array}$	00580 PATIENT ACCOUNTING 00560 OTHER ADMINISTRATIVE AND GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DI ETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE 02000 NURSING SCHOOL 02301 PHARMACY RESIDENCY		211, 301 2, 173, 233 4, 231, 929 167, 103 345, 283 612, 819 553, 734 122, 514 202, 789 328, 615 82, 590 21, 476 1, 187, 174 0	24, 12: 49, 84, 88, 46, 79, 93 17, 68, 29, 27; 47, 44, 11, 92; 3, 100 171, 38;	3 2, 486, 966 2 4, 842, 861 3 191, 226 6 395, 129 8 701, 287 8 633, 672 6 140, 200 5 232, 064 0 376, 055 3 94, 513 0 24, 576 3 1, 358, 557 0 0	0 77, 727 11, 398 431 7, 925 3, 475 4, 457 11, 060 1, 302 9, 979 83 2, 131 7, 577 866	8.00 9.00 10.00 11.00 13.00 14.00 15.00 16.00 17.00 20.00 23.00
23. 01	02300 EMS EDUCATION I NPATIENT ROUTINE SERVICE COST CENTERS	0	147, 195	21, 24	9 168, 444	784	23.01
30. 00 31. 00 35. 00 41. 00 43. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 02060 NEONATAL INTENSIVE CARE UNIT 04100 SUBPROVIDER - IRF 04300 NURSERY	0 0 0 0	4, 219, 286 408, 498 285, 878 513, 704 0	58, 97: 41, 27(74, 15)	2 467, 470 0 327, 148	53, 770 12, 169 7, 178 5, 223 1, 798	31.00 35.00 41.00
65. 00 66. 00 67. 00 68. 00 69. 00 70. 00 71. 00 72. 00 73. 00 73. 01 74. 00 76. 98	ANCI LLARY SERVI CE COST CENTERS 05000 OPERATI NG ROOM 05100 RECOVERY ROOM & LABOR ROOM 05200 DELI VERY ROOM & LABOR ROOM 05400 RADI OLOGY - DI AGNOSTI C 05500 RADI OLOGY - THERAPEUTI C 05600 RADI OLOGY - THERAPEUTI C 05600 CADI AC CATH LAB 05700 CT SCAN 05800 MRI 06000 LABORATORY 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06600 PHYSI CAL THERAPY 06600 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY 06900 ELECTROCARDI OLOGY 07000 ELECTROCARDI OLOGY 07000 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 07200 IMPL. DEV. CHARGED TO PATI ENTS 07301 DI ABETES CENTER 07400 RENAL DI ALYSI S 07698 HYPERBARI C OXYGEN THERAPY 00TPATI ENT SERVI CE COST CENTERS 000001		1, 171, 610 96, 800 0 646, 937 25, 073 12, 180 300, 800 54, 811 48, 507 231, 316 82, 198 34, 012 0 3, 490 371, 994 190, 858 0 0 0 65, 566 71, 229	13, 97- 93, 39 3, 62(1, 75; 43, 42- 7, 91; 7, 00; 33, 39; 11, 86(4, 91) 50; 53, 70; 27, 55; 0 (9, 46(10, 28;	4 110, 774 0 0 3 740, 330 0 28, 693 8 13, 938 8 13, 938 4 344, 224 3 62, 724 3 55, 510 3 264, 709 6 94, 064 0 38, 922 0 0	12, 309 1, 967 11, 718 12, 061 1, 215 1, 234 4, 498 2, 463 865 0 6, 856 12, 658 4, 844 2, 240 5, 764 2, 041 0 0 1, 362 361 0	54. 00 55. 00 56. 01 57. 00 58. 00 60. 00 65. 00 66. 00 67. 00 68. 00 69. 00 70. 00 71. 00 72. 00 73. 01 73. 01 74. 00 76. 98
90.00 91.00 91.01 92.00 92.01	09000 CLINIC 09100 EMERGENCY 04950 WOUND CARE 09200 OBSERVATION BEDS (NON-DISTINCT PART 09201 OBSERVATION BEDS (DISTINCT PART)	0 0 0	0 1, 515, 397 603, 773 284, 560	218, 76 87, 16	2 690, 935 0	1, 606 26, 519 5, 041 4, 955	90.00 91.00 91.01 92.00 92.01
	OTHER REIMBURSABLE COST CENTERS	0	330, 218			7, 759	
113.00	10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE 11600 HOSPICE SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	0	280, 322 0 23, 579, 226		o o		101. 00 113. 00 116. 00 118. 00
192.00 194.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES 07950 MOB 07951 LIFELINE	0 0 0 0	111, 402 289, 760 0 0			42, 676 0	190. 00 192. 00 194. 00 194. 01

Health Financial Systems	FRANCI SCAN HEAL	_TH LAFAYETTE		In Lie	eu of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CO		Period: From 01/01/2020 To 12/31/2020		pared: 2 pm
		CAPI TAL REL	LATED COSTS			
Cost Center Description	Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFI TS DEPARTMENT	
	0	1.00	2.00	2A	4.00	
194. 02 07952 PATI ENT TRANSPORT	0	0		0 0	0	194.02
194.0307954 OTHER NONREIMBURSABLE COST CENTERS	0	4, 424, 851		0 4, 424, 851	0	194.03
200.00 Cross Foot Adjustments				0		200.00
201.00 Negative Cost Centers		0		0 0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	0	28, 405, 239	3, 461, 86	3 31, 867, 102	420, 805	202.00

	Financial Systems	FRANCI SCAN HEALT				u of Form CMS-2	2552-10
ALLOCA	ATION OF CAPITAL RELATED COSTS		Provider CC	F	eriod: rom 01/01/2020	Worksheet B Part II	
				T	b 12/31/2020	Date/Time Pre 4/29/2021 3:5	pared: 2 pm
	Cost Center Description	COMMUNI CATI ONS	MGMT INFO SYSTEMS	PURCHASI NG	ADMI TTI NG	PATI ENT ACCOUNTI NG	
		5.01	5. 02	5.03	5.04	5. 05	
1 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT						1 1 00
1.00 2.00	00200 CAP REL COSTS-BEDG & FTXT						1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01160 COMMUNI CATI ONS	43, 530					5.01
5.02 5.03	01140 MGMT I NFO SYSTEMS 00550 PURCHASI NG	1, 420 864	624, 700 0	451, 665			5.02 5.03
5.03	00570 ADMI TTI NG	0	0	431,003	0		5.03
5.05	00580 PATI ENT ACCOUNTI NG	864	0	0	0	242, 669	5.05
5.06	00560 OTHER ADMINISTRATIVE AND GENERAL 00700 OPERATION OF PLANT	4, 507	42, 813	9, 713	0	0	5.06
7.00 8.00	00800 LAUNDRY & LINEN SERVICE	3, 396	27, 477 1, 437	440 0	0	0	•
9.00	00900 HOUSEKEEPI NG	556	29, 162	905	0	0	9.00
10.00	01000 DI ETARY	1, 852	27, 288	434	0	0	10.00
11.00 13.00	01100 CAFETERIA 01300 NURSING ADMINISTRATION	0 556	0 19, 201	0	0	0	11.00
13.00	01400 CENTRAL SERVICES & SUPPLY	247	4, 321	94	0	0	14.00
15.00	01500 PHARMACY	1, 420	16, 202	9	0	0	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	1,050	532	0	0	0	16.00
17.00 20.00	01700 SOCI AL SERVI CE 02000 NURSI NG SCHOOL	556 0	4, 431 11, 664	1 177	0	0	17.00
20.00	02301 PHARMACY RESIDENCY	0	1, 909	0	0	0	23.00
23. 01	02300 EMS EDUCATI ON	0	0	1	0	0	23.01
20.00	INPATIENT ROUTINE SERVICE COST CENTERS	7 100	120 400	1 140	ol	12 220	20.00
30.00 31.00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	7, 102 1, 358	130, 488 24, 768	1, 142 381	0	13, 229 3, 417	1
35.00	02060 NEONATAL INTENSIVE CARE UNIT	1,050	11, 686	443	0	3, 744	•
41.00	04100 SUBPROVI DER – I RF	1, 482	9, 805	16	0	1, 109	•
43.00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	0	0	0	0	896	43.00
50.00	05000 OPERATING ROOM	1, 482	21, 906	32, 903	0	28, 828	50.00
51.00	05100 RECOVERY ROOM	494	2, 944	0	0	2, 242	•
52.00	05200 DELIVERY ROOM & LABOR ROOM	1,605	0	0	0	5, 387	52.00
54.00 55.00	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY - THERAPEUTI C	3, 705	21, 891 1, 950	21, 793 0	0	18, 005 2, 050	•
56.00	05600 RADI OLOGT - MILKAI LOTTO	0	1, 857	3	0	2,030	56.00
56.01	03950 CARDI AC CATH LAB	0	6, 983	19, 182	0	10, 004	56.01
57.00	05700 CT SCAN	0	4, 228	137	0	10, 534	57.00
58.00 60.00	05800 MRI 06000 LABORATORY	0 2, 717	1, 062 0	15 9, 471	0	1, 635 24, 468	•
65.00	06500 RESPI RATORY THERAPY	2,099	12, 936	1, 814	0	3, 500	•
66.00	06600 PHYSI CAL THERAPY	370	24, 271	0	0	4, 083	
67.00	06700 OCCUPATI ONAL THERAPY	0	8, 997	0	0	2, 466	
68.00 69.00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	370	4, 146 10, 381	13	o	861 5, 565	•
70.00	07000 ELECTROENCEPHALOGRAPHY	0	3, 664	0	0	907	•
71.00	07100 MEDI CAL SUPPLIES CHARGED TO PATIENT	0	0	182, 189	0	23, 017	
72.00 73.00	07200 I MPL. DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS	0	0	161, 776 0	0	14, 722 27, 152	
73.00	07301 DI ABETES CENTER	370	2, 593	12	0	17	•
74.00	07400 RENAL DIALYSIS	0	745	0	0		74.00
76. 98	07698 HYPERBARI C OXYGEN THERAPY OUTPATI ENT SERVI CE COST CENTERS	0	0	0	0	0	76. 98
90.00	09000 CLINIC	1, 976	4, 739	0	0	260	90.00
91.00	09100 EMERGENCY	0	51, 415	1, 460	0	20, 610	•
91.01	04950 WOUND CARE	0	8, 476	7	0	1, 258	
92.00 92.01	09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 09201 OBSERVATI ON BEDS (DI STI NCT PART)	0	0	0	0	3, 077	92.00 92.01
72.01	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	3,077	72.01
	09500 AMBULANCE SERVI CES	0	23, 244	244	0		95.00
101.00	10100 HOME HEALTH AGENCY	0	24, 758	5, 713	0	2, 473	101.00
113 00	SPECIAL PURPOSE COST CENTERS						113.00
	11600 HOSPI CE	0	17, 865	1, 164	0	4, 078	116.00
118.00		43, 530	624, 235	451, 661	0	242, 669	118.00
100 0	NONREI MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	458	2	0	0	190.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	0	438 7	2	0		190.00
194.00	07950 МОВ	0	0	0	Ō	0	194.00
		0	0	0	0		194.01
	207952 PATIENT TRANSPORT 307954 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0		194.02 194.03
200.00			0	0	0		200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00

Health Financial Systems	FRANCI SCAN HEAL	TH LAFAYETTE		In Lieu of Form CMS-2552-10			
ALLOCATION OF CAPITAL RELATED COSTS		Provider CC		Period: From 01/01/2020	Worksheet B		
					Date/Time Pre 4/29/2021 3:5		
Cost Center Description	COMMUNI CATI ONS		PURCHASI NG	ADMI TTI NG	PATI ENT		
		SYSTEMS			ACCOUNTI NG		
	5.01	5.02	5.03	5.04	5.05		
202.00 TOTAL (sum lines 118 through 201)	43, 530	624, 700	451, 66	05 0	242, 669	202. 00	

Health Financial Systems ALLOCATION OF CAPITAL RELATED COSTS	FRANCI SCAN HEAL	TH LAFAYETTE	CN: 15-0109 P	In Lie eriod:	u of Form CMS-: Worksheet B	2552-10
ALLOSATION OF GALLIAE RELATED COSTS				rom 01/01/2020	Part II Date/Time Pre	pared:
Cost Center Description	OTHER	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	4/29/2021 3:5 DI ETARY	2 pm
	ADMI NI STRATI VE AND GENERAL	PLANT	LINEN SERVICE			
	5.06	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT						1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP						2.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 5. 01 01160 COMMUNI CATI ONS						4.00 5.01
5.02 01140 MGMT INFO SYSTEMS						5. 02
5. 03 00550 PURCHASI NG 5. 04 00570 ADMI TTI NG						5. 03 5. 04
5. 05 00580 PATIENT ACCOUNTING						5.04
5. 06 00560 OTHER ADMINISTRATIVE AND GENERAL 7. 00 00700 OPERATION OF PLANT	2, 621, 726 183, 169	5, 068, 741				5.06 7.00
8.00 00800 LAUNDRY & LINEN SERVICE	9, 940	41, 426				8.00
9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY	48, 780 30, 604	85, 597 151, 921			946, 398	9.00 10.00
11. 00 01100 CAFETERI A	21, 599	137, 273			940, 398	11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON 14. 00 01400 CENTRAL SERVI CES & SUPPLY	48, 099 7, 215	30, 372 50, 272		4, 532 7, 502	0 0	13.00 14.00
15. 00 01500 PHARMACY	51, 684	81, 465		12, 156	0	15.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY 17. 00 01700 SOCI AL SERVI CE	20, 826	20, 474		3, 055 794	0 0	16.00 17.00
20. 00 02000 NURSI NG SCHOOL	9, 664 26, 283	5, 324 294, 306			0	20.00
23. 00 02301 PHARMACY RESIDENCY 23. 01 02300 EMS EDUCATION	4, 691	0 36, 490			0	23.00
23. 01 02300 EMS EDUCATION INPATIENT ROUTINE SERVICE COST CENTERS	4,636	36, 490	0	5, 445	0	23.01
30. 00 03000 ADULTS & PEDIATRICS	299,065	1, 045, 981			794, 670	1
31. 00 03100 INTENSIVE CARE UNIT 35. 00 02060 NEONATAL INTENSIVE CARE UNIT	63, 552 35, 234	101, 269 70, 870		15, 111 10, 575	86, 982 0	31.00 35.00
41. 00 04100 SUBPROVI DER - I RF	29,876	127, 350		19, 003	64, 746	41.00
43. 00 04300 NURSERY ANCI LLARY SERVICE COST CENTERS	7, 580	0	9, 008	0	0	43.00
50. 00 05000 OPERATI NG ROOM	101,002	290, 448			0	50.00
51.00 05100 RECOVERY ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM	10, 052 49, 884	23, 997 0		3, 581 0	0	51.00 52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	102, 478	160, 379	15, 048		0	54.00
55. 00 05500 RADI OLOGY - THERAPEUTI C 56. 00 05600 RADI 0I SOTOPE	7, 970 5, 810	6, 216 3, 020		927 451	0	55.00 56.00
56.01 03950 CARDI AC CATH LAB	35, 891	74, 570	994	11, 127	0	56.01
57. 00 05700 CT_SCAN 58. 00 05800 MRI	14, 503 4, 518	13, 588 12, 025		2, 028 1, 794	0	57.00 58.00
60. 00 06000 LABORATORY	120, 346	57, 344	1, 559	8, 557	0	60.00
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	33, 987 56, 919	20, 377 8, 432			0	65.00 66.00
67.00 06700 OCCUPATI ONAL THERAPY	20, 935	0	0	0	0	67.00
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	9, 840 34, 568	865 92, 219		129 13, 761	0	68.00 69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	11, 531	47, 315		7, 060	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	123, 155 129, 108	0	0	0	0	71.00 72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	104, 563	0	0	0	0	73.00
73. 01 07301 DI ABETES CENTER 74. 00 07400 RENAL DI ALYSI S	5, 972 10, 413	0 16, 254	0	0 2, 425	0	73.01
76. 98 07698 HYPERBARI C OXYGEN THERAPY	872	17,658		2, 635	0	76.98
0UTPATIENT SERVICE COST CENTERS 90. 00 09000 CLINIC	11, 681	0	0	0	0	90.00
91. 00 09100 EMERGENCY	143, 900	375, 674	22, 591	56, 057	0	91.00
91. 01 04950 WOUND CARE 92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART	28, 434	149, 678	0	22, 335	0	91.01 92.00
92. 01 09201 OBSERVATION BEDS (NON-DISTINCT PART)	22, 407	70, 544	0	10, 526	0	
0THER REI MBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVI CES	46, 855	81, 863	0	12, 215	0	95.00
101.00 10100 HOME HEALTH AGENCY	146, 935	69, 493				101.00
SPECIAL PURPOSE COST CENTERS 113.00 11300 I NTEREST EXPENSE	1					113.00
116. 00 11600 HOSPI CE	63, 079	0	0	о		116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	2, 360, 105	3, 872, 349	244, 522	558, 869	946, 398	118.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	2, 395	27, 617	0	4, 121	0	190. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 194. 00 07950 MOB	214, 712	71, 833	0	10, 719		192.00
194. 00 07950 MOB 194. 01 07951 LI FELI NE	0	0	0	0		194. 00 194. 01
194. 02 07952 PATI ENT TRANSPORT	606	1 004 042	0	0		194. 02 194. 03
194.0307954OTHER NONREI MBURSABLE COST CENTERS200.00Cross Foot Adjustments	43, 908	1, 096, 942	0	0		194. 03 200. 00
	· · ·			. 1		·

Heal th Fin	ancial Systems	FRANCI SCAN HEAI	TH LAFAYETTE		In Lie	u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS					Period:	Worksheet B	
					From 01/01/2020 To 12/31/2020		pared:
						4/29/2021 3:5	
	Cost Center Description	OTHER	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		ADMI NI STRATI VE	PLANT	LINEN SERVICE			
		AND GENERAL					
		5.06	7.00	8.00	9.00	10.00	
201.00	Negative Cost Centers	0	0	(0 0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	2, 621, 726	5, 068, 741	244, 52	2 573, 709	946, 398	202.00

	Financial Systems TION OF CAPITAL RELATED COSTS	FRANCI SCAN HEA	LTH LAFAYETTE Provider CC	N: 15_0100 P	In Lie	u of Form CMS-2 Worksheet B	2552-10
ALLUCA	TTON OF CAPITAL RELATED COSTS		Provider CC	F	rom 01/01/2020 o 12/31/2020	Part II Date/Time Pre	pared:
	Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	4/29/2021 3:5 MEDI CAL	
	Cost conter bescription	GALETERIA	ADMI NI STRATI ON	SERVICES &		RECORDS &	
		11.00	13.00	SUPPLY 14.00	15.00	LI BRARY 16.00	
	GENERAL SERVICE COST CENTERS		1		,		
1.00 2.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01160 COMMUNI CATI ONS						5.01
5.02 5.03	01140 MGMT INFO SYSTEMS 00550 PURCHASING						5. 02 5. 03
5.03	00570 ADMI TTI NG						5.03
5.05	00580 PATIENT ACCOUNTING						5.05
5.06 7.00	00560 OTHER ADMINISTRATIVE AND GENERAL 00700 OPERATION OF PLANT						5.06
7.00 8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPI NG						9.00
10.00	01000 DI ETARY	017 405					10.00
11.00 13.00	01100 CAFETERIA 01300 NURSING ADMINISTRATION	817, 485 31, 613	1				11.00 13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	7, 115		316, 329			14.00
15.00	01500 PHARMACY	26, 675	1 1	7			15.00
16.00 17.00	01600 MEDI CAL RECORDS & LI BRARY 01700 SOCI AL SERVI CE	876 7, 295	1	0		141, 409 0	16.00 17.00
20.00	02000 NURSI NG SCHOOL	19, 203	1 1	127	-	0	20.00
23.00	02301 PHARMACY RESIDENCY	3, 143	1	0		0	23.00
23. 01	02300 EMS EDUCATION I NPATIENT ROUTINE SERVICE COST CENTERS	C	0	1	0	0	23.01
30.00	03000 ADULTS & PEDIATRICS	214, 841	92, 273	821	0	7,670	30.00
31.00	03100 I NTENSI VE CARE UNI T	40, 778	17, 514	274	0	1, 981	31.00
35.00	02060 NEONATAL INTENSIVE CARE UNIT	19, 241		318		2, 171	35.00
41.00 43.00	04100 SUBPROVIDER - IRF 04300 NURSERY	16, 142 C		11 0		643 519	
	ANCILLARY SERVICE COST CENTERS			-			
50.00	05000 OPERATING ROOM	36,066		23, 650		17,429	
51.00 52.00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	4, 847 C		0		1, 300 3, 123	
54.00	05400 RADI OLOGY-DI AGNOSTI C	36, 042	-	15, 665	-	10, 439	1
55.00	05500 RADI OLOGY - THERAPEUTI C	3, 210	1 1	0		1, 188	•
56.00 56.01	05600 RADI OI SOTOPE 03950 CARDI AC CATH LAB	3, 057 11, 496		2 13, 788	0	0 5, 800	
57.00	05700 CT SCAN	6, 961		99		6, 108	
58.00	05800 MRI	1, 749	1	11		948	
60.00 65.00	06000 LABORATORY 06500 RESPI RATORY THERAPY	C 21, 298	0	6, 807 1, 304		14, 186 2, 029	
66.00	06600 PHYSI CAL THERAPY	39, 960		1, 304		2,029	
	06700 OCCUPATI ONAL THERAPY	14, 812	6, 362	0	0	1, 430	67.00
68.00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	6, 827		7	0	499	•
69. 00 70. 00	07000 ELECTROCARDI OLOGY	17, 092 6, 032		9	0	3, 227 526	1
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	C	0	130, 961		13, 345	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	C	0	116, 282		8, 535	
73. 00 73. 01	07300 DRUGS CHARGED TO PATIENTS 07301 DIABETES CENTER	4, 269	1, 834	0	575, 652 0	15, 742 10	
74.00	07400 RENAL DI ALYSI S	1, 227		0	0	362	
76. 98	07698 HYPERBARI C OXYGEN THERAPY	С	0	0	0	0	76.98
90.00	OUTPATIENT SERVICE COST CENTERS	7,803	0	0	0	151	90.00
91.00	09100 EMERGENCY	84, 651	1	1, 050		11, 949	•
91.01	04950 WOUND CARE	13, 955	5, 994	5	0	730	
92.00 92.01	09200 OBSERVATION BEDS (NON-DISTINCT PART	C	0	0	o	1 704	92.00
92.01	09201 OBSERVATION BEDS (DISTINCT PART) OTHER REIMBURSABLE COST CENTERS		<u>y</u>	0	<u> </u>	1, 784	92.01
	09500 AMBULANCE SERVICES	38, 269	16, 436	176		1, 420	95.00
101.00	10100 HOME HEALTH AGENCY	40, 761	17, 507	4, 107	0	1, 434	101.00
113.00	SPECIAL PURPOSE COST CENTERS						113.00
	11600 HOSPI CE	29, 414	12, 633	836	0		116.00
118.00		816, 720	285, 633	316, 327	575, 652	141, 409	118.00
190 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	754	0	1	0	0	190.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSI CLANS' PRI VATE OFFI CES	11	1 1	1	0		190.00
194.00	07950 MOB	C	0	0	0	0	194.00
	07951 LI FELI NE 07952 PATI ENT TRANSPORT	C	0	0	0		194.01
101 00		C	y 0	0	0		194.02
	07954 OTHER NONREIMBURSABLE COST CENTERS	0		0	n	0	194.03

Heal th Fin	ancial Systems	FRANCI SCAN HEAI	LTH LAFAYETTE		In Lie	u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS					Period:	Worksheet B	
					From 01/01/2020		
					Го 12/31/2020	Date/Time Pre 4/29/2021 3:5	
	Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
			ADMI NI STRATI ON	SERVICES &		RECORDS &	
				SUPPLY		LI BRARY	
		11.00	13.00	14.00	15.00	16.00	
201.00	Negative Cost Centers	0	0	(0 0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	817, 485	285, 633	316, 329	9 575, 652	141, 409	202.00

From 010/12/2012 Pprivate		Financial Systems	FRANCI SCAN HEALT		N. 15 0100		u of Form CMS-	2552-10
Desit Centure Pascer pti on SOLAL SERVICE VARESTNO SCHOOL PARSMEY PMS EDUCATION Subtoal CEREMAL SERVICE COST CENTERS 17.00 20.00 23.00 23.01 24.60 10.00000 (24.0 FEL COST-SUME FOULPT SUBJOACTINE SERVICE COST CENTERS 5.01 17.00 20.00 23.01 24.60 10.0000 (24.0 FEL COST-SUME FOULPT SUBJOACTINE SERVICE SUBJOACTINE S	ALLUCA	TION OF CAPITAL RELATED COSTS		Provider CC			Date/Time Pre	pared:
DEVERAL SERVICE COST CENTERS 17.00 20.00 23.01 24.00 1.00 DOOD CAD FOR COST CAN DR A DAYT 1.00		Cost Center Description	SOCI AL SERVI CEN	URSING SCHOOL		EMS EDUCATION		
EREMAN_SERVICE COST_CENTERS 1:00 00000_CM_EL_COST_SHUEL_EGUIP_M 2:00 00000_CM_EL_COST_SHUEL_EGUIP_M 2:00 00000_CM_EL_COST_SHUEL_EGUIP_M 2:00 00000_CM_EL_COST_SHUEL_EGUIP_M 3:00 0000_CM_EL_COST_SHUEL_EGUIP_M 3:00 01000_CM_EL_COST_SHUEL_EGUIP_M 3:00 01000_CM_EL_COST_SHUEL_EGUIP_M 3:00 01000_CM_EL_COST_SHUEL_EGUIP_M 3:00 01000_CM_EL_COST_SHUEL_EGUIP_M 3:00 01000_CM_EL_COST_SHUEL_EGUIP_M 3:00 01000_CM_EL_COST_SHUEL_EGUIP_M 3:00 0100_CM_EL_COST_SHUEL_EGUIP_M 3:00 0100_CM_EL_COST_SHUEL_EGUIP_M 3:00 0100_CM_EL_LSEWUC_COST_SHUEL_GUIP_M 3:00 0100_CM_EL_LEGUIP_M 3:00 000_CM_EL_LEGUIP_M </th <th></th> <th></th> <th>17.00</th> <th>20.00</th> <th></th> <th>23.01</th> <th>24.00</th> <th></th>			17.00	20.00		23.01	24.00	
2.00 DODD (AP ENT LOSTS WHAT FOULP A CONSTRUME F		GENERAL SERVICE COST CENTERS			20100			
4 00 00000 EURLYSE EREFTS DEPARTMENT 5 07 01144 WOT LWG SYSTWS 5 09 01144 WOT LWG SYSTWS 5 09 01144 WOT LWG SYSTWS 5 00 0000 OPERATION SYSTWS 5 00 00000 OPERATION OF PLAYT 5 00 00000 OPERATION OF PLAYT 5 00 00000 OPERATION OF PLAYT 5 00 00000 OPERATION SYSTWS 5 00 000000 OPERATION SYSTWS 5 00 000000000000000000000000000000000								1.00
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67.00 06700 0CCUPATIONAL THERAPY 0 95,84 68.00 06800 SPECH PATHOLOGY 0 32,34 69.00 06900 ELECTROCARDIOLOGY 0 320,34 70.00 07000 ELECTROENCEPHALOGRAPHY 0 300,07 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 472,66 72.00 07200 INPL. DEV. CHARGED TO PATIENTS 0 723,10 73.00 07300 DRUGS CHARGED TO PATIENTS 0 723,10 73.01 07400 RENAL DI ALYSI S 0 723,10 70.00 07400 RENAL DI ALYSI S 0 102,67 00.00 09000 CLINIC CONTERTER 0 2,566,39 91.01 04950 WOUND CARE 0 2,566,39 92.01 095EVATION BEDS (IDISTINCT PART 0 2,566,39 91.01 04950 WOUND CARE 0 2,566,39 92.01 095EVATION BEDS (DISTINCT PART) 0 608,82 01.00 1000 HOME HEALTH AGENCY 0 608,82 91.00 09500 AMBULANCE SERVICES 0			0				209, 800	1
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70.00 07000 ELECTROENCEPHALOGRAPHY 0 300,07 71.00 07100 MEDI CAL. SUPPLIES CHARGED TO PATIENT 0 472,66 72.00 07300 DRUGS CHARGED TO PATIENTS 0 430,42 73.00 07300 DLABETES CENTER 0 723,10 73.01 07301 DLABETES CENTER 0 16,44 74.00 RFALA DI ALYSI S 0 723,10 76.98 07698 HYPERBARI C OXYGEN THERAPY 0 102,67 00.00 9000 CLI NI C 0 28,21 91.00 09000 CLI NI C 0 2,566,39 91.01 04950 WOUND CARE 0 2,566,39 92.00 09200 DBSERVATI ON BEDS (NON-DI STI NCT PART 926,84 92.00 09200 DBSERVATI ON BEDS (NON-DI STI NCT PART 9 95.00 09500 AWBURNES ECOST CENTERS 0 438,93 110.00 10100 HMER REL MAGENCY 0 601,82 101.00 INM			0				32, 349	68.00
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0 472, 66 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 430, 42 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 72.3, 40 73.01 07300 DRUGS CHARGED TO PATI ENTS 0 72.3, 40 73.01 07300 DRUGS CHARGED TO PATI ENTS 0 72.3, 40 73.01 01 ABETES CENTER 0 16, 44 74.00 O7400 RENAL DI ALYSI S 0 16, 44 76.98 MYERBARI C OXYGEN THERAPY 0 107, 67 102, 67 0UTPATI ENT SERVICE COST CENTERS 0 28, 21 27, 566, 39 90.00 O9000 CLINI C 0 2, 566, 39 91.01 04950 WOUND CARE 0 2, 566, 39 92.00 08SERVATI ON BEDS (NON-DI STI NCT PART 0 438, 93 01.00 IDBER REI MBURSABLE COST CENTERS 0 68 92.00 OPSOL AMBULANCE SERVICES 0 68 113.00 INTEREST EXPENSE 0 140, 80 113.00 INTEREST EXPENSE			0				617, 391	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 430, 42 73.00 07300 DRUGS CHARGED TO PATIENTS 0 723, 10 73.01 07300 DRUGS CHARGED TO PATIENTS 0 73, 10 74.00 07400 RENAL DIALYSIS 0 70, 10 76.98 07698 HYPERBARI C OXYGEN THERAPY 0 102, 67 90.00 09000 CLINIC 0 28, 21 91.00 09100 EMERGENCY 0 28, 21 92.00 09200 DBERVATI ON BEDS (NON-DI STINCT PART 926, 84 92.00 09200 DBERVATI ON BEDS (NON-DI STINCT PART 926 92.00 09200 DBERVATI ON BEDS (DI STINCT PART 926 95.00 09500 AMBUSABLE COST CENTERS 0 438, 93 91.101 04950 WOUND CARE 0 438, 93 91.100 INTER REI MBURSABLE COST CENTERS 0 681, 08 681, 08 92.00 OSERVATI ON BEDS (DI STINCT PART 0 140, 80 23, 478, 00 91.01 OTTOH HOME HEALTH AGENCY 0 0			0					
73.00 07300 DRUGS CHARGED TO PATIENTS 0 723.10 73.01 07301 DI ABETES CENTER 0 16.44 74.00 CY400 RENAL DI ALYSI S 0 107.97 76.98 07698 HYPERBARI C OXYGEN THERAPY 0 102.67 0UTPATIENT SERVICE COST CENTERS 0 28.21 102.67 0UTPATIENT SERVICE COST CENTERS 0 28.21 2.566.39 91.00 09000 CLINIC 0 28.21 92.01 095ERVATI ON BEDS (NON-DI STINCT PART 926.84 926.84 92.01 095ERVATI ON BEDS (DI STINCT PART) 0 438.93 0101.00 HOME HEALTH AGENCY 0 661.08 595.00 095001 AMBULANCE SERVICES 0 661.08 595.00 095002 INTEREST EXPENSE 0 140.80 113.00 11300 INTEREST EXPENSE 0 140.80 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 54, 772 0 0 23.478.00 190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 140.80 671.55 194.00 079			0					•
73.01 07301 DI ABETES CENTER 0 16,44 74.00 C7400 RENAL DI ALYSI S 0 107,97 76.98 D7698 HYPERBARI C OXYGEN THERAPY 0 102,67 0UTPATI ENT SERVICE COST CENTERS 0 28,21 28,21 90.00 O9100 EMERGENCY 0 28,21 91.01 04950 WOUND CARE 0 2,566,39 92.00 OSERVATI ON BEDS (NON-DI STI NCT PART 0 2,566,39 92.01 09200 OBSERVATI ON BEDS (DI STI NCT PART) 0 438,93 0 OTHER REI MBURSABLE COST CENTERS 0 0 661,08 50.00 O9500 AMBULANCE SERVI CES 0 0 23,478,00 01100 HOME HEALTH AGENCY 0 140,80 140,80 113.00 I 1300 I NTEREST EXPENSE 0 140,80 116.00 I 1000PICE 0 0 23,478,00 0000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 163,01 118.00 I 1300 I TALYSI PRI VATE OFFI CES 0 671,55			0					
74.00 07400 RENAL DI ALYSI S 0 107,97 76.98 07698 HYPERBARI C OXYGEN THERAPY 0 102,67 0UTPATI ENT SERVICE COST CENTERS 0 28,21 102,67 90.00 O9000 CLINIC 0 28,21 91.00 09000 EMERGENCY 0 2,566,39 92.00 09200 BSERVATI ON BEDS (NON-DI STINCT PART 926,84 92.01 09200 BSERVATI ON BEDS (DI STINCT PART) 0 438,93 0 OTHER REIMBURSABLE COST CENTERS 0 668,82 95.00 09500 AMBULANCE SERVICES 0 661,08 95.00 09500 AIBSPECIAL PURPOSE COST CENTERS 0 140,80 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 54,772 0 0 23,478,00 NONNER IMBURSABLE COST CENTERS 113.00 11300 ISTALS (SUM OF LINES 1 through 117) 54,772 0 0 23,478,00 NONNER IMBURSABLE COST CENTERS 190.00 IGOD GIFT, FLOWER, COFFEE SHOP & CANTEEN <td></td> <td></td> <td>0</td> <td></td> <td></td> <td></td> <td>16, 448</td> <td></td>			0				16, 448	
OUTPATIENT SERVICE COST CENTERS 90. 00 09000 CLINIC 0 28, 21 91. 00 09100 EMERGENCY 0 2, 566, 39 91. 01 04950 WOUND CARE 0 22, 566, 39 92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART 0 28, 21 92. 01 09201 OBSERVATI ON BEDS (DI STINCT PART) 0 438, 93 0THER REI MBURSABLE COST CENTERS 0 608, 82 95. 00 09500 AMBULANCE SERVI CES 0 608, 82 101. 00 10100 HOME HEALTH AGENCY 0 661, 08 SPECIAL PURPOSE COST CENTERS 0 140, 80 113.00 INTRERST EXPENSE 0 140, 80 116. 00 SUBTOTALS (SUM OF LINES 1 through 117) 54, 772 0 0 23, 478, 00 NONREI MBURSABLE COST CENTERS 0 163, 01 163, 01 163, 01 163, 01 190. 00 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 671, 55 671, 55 194. 00 07950 MOB 0 671, 55 671, 55 671, 55			0				107, 970	•
90. 00 09000 CLINIC 0 28, 21 91. 00 09100 EMERGENCY 0 2, 566, 39 91. 01 04950 WOUND CARE 0 926, 84 92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART 926, 84 92. 01 09200 OBSERVATI ON BEDS (DI STINCT PART) 0 438, 93 0THER REI MBURSABLE COST CENTERS 0 669, 82 101. 00 HOME HEALTH AGENCY 0 661, 08 SPECIAL PURPOSE COST CENTERS 0 661, 08 SPECIAL PURPOSE COST CENTERS 0 140, 80 113. 00 11300 INTEREST EXPENSE 0 116. 00 11600 HOSPI CE 0 140, 80 118. 00 SUBTOTALS (SUM OF LI NES 1 through 117) 54, 772 0 0 23, 478, 00 190. 00 197000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 140, 80 671, 55 194. 00 197005 MOB 0 0 23, 478, 00 671, 55 194. 00 07950 MOB 0 0 671, 55 671, 55	76. 98	07698 HYPERBARI C OXYGEN THERAPY	0				102, 677	76.98
91.00 09100 EMERGENCY 0 2,566,39 91.01 04950 WOUND CARE 0 926,84 92.00 09200 OBSERVATI ON BEDS (DI STI NCT PART) 0 438,93 01 09201 OBSERVATI ON BEDS (DI STI NCT PART) 0 438,93 01 09201 OBSERVATI ON BEDS (DI STI NCT PART) 0 438,93 01 09500 AMBULANCE SERVI CES 0 608,82 101.00 10100 HOME HEALTH AGENCY 0 661,08 SPECI AL PURPOSE COST CENTERS 0 140,80 140,80 113.00 11300 INTEREST EXPENSE 0 140,80 118.00 SUBTOTALS (SUM OF LI NES 1 through 117) 54,772 0 0 23,478,00 NORREI MBURSABLE COST CENTERS 0 163,01 192,00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 671,55 194.00 07950 MOB 0 0 671,55 671,55 194.01 07950 LI FELI NE 0 601 140,80 140,80 194.01 07950 MOB	00.55		. 1					0.0.7.7
91.01 04950 WOUND CARE 0 926,84 92.00 0BSERVATI ON BEDS (NON-DI STI NCT PART) 0 438,93 07HER REI MBURSABLE COST CENTERS 0 608,82 101.00 09500 AMBULANCE SERVI CES 0 661,08 SPECI AL PURPOSE COST CENTERS 0 661,08 140,80 116.00 11600 HOSPI CE 0 140,80 118.00 11600 HOSPI CE 0 140,80 118.00 11600 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 140,80 118.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 163,01 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 671,55 194.00 07950 MOB 0 671,55 194.01 07950 IFELI NE 0 60 194.02 07954 OTHER NONREI MBURSABLE COST CENTERS 0 60							28, 216	
92.00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) 0 438, 93 92.01 09201 OBSERVATI ON BEDS (DI STINCT PART) 0 438, 93 0THER REIMBURSABLE COST CENTERS 0 608, 82 95.00 09500 AMBULANCE SERVICES 0 661, 08 95.00 10100 HOME HEALTH AGENCY 0 661, 08 95.01 11300 INTEREST EXPENSE 0 140, 80 116.00 11600 HOSPI CE 0 140, 80 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 54, 772 0 0 0 23, 478, 00 NONREI MBURSABLE COST CENTERS 0 163, 01 140, 80 163, 01 140, 80 163, 01			-					
92.01 09201 0BERVATI ON BEDS (DI STINCT PART) 0 438,93 OTHER REI MBURSABLE COST CENTERS 0 608,82 95.00 09500 AMBULANCE SERVI CES 0 668,82 101.00 HOME HEALTH AGENCY 0 661,08 SPECI AL PURPOSE COST CENTERS 113.00 INTERST EXPENSE 0 113.00 INTERST EXPENSE 0 140,80 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 54,772 0 0 23,478,00 NONREI MBURSABLE COST CENTERS 0 163,01 163,01 163,01 163,01 163,01 192.00 19200 PHYSI CI ANS' PRI VATE OFFICES 0 671,55 6 194.00 07950 MOB 0 0 60 60 194.01 07951 LI FELI NE 0 60 60 60 194.02 07954 OTHER NONREI MBURSABLE COST CENTERS 0 60 60							7∠0, 048	91.01
OTHER REI MBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVI CES 0 608, 82 101.00 10100 HOME HEALTH AGENCY 0 661, 08 SPECI AL PURPOSE COST CENTERS 661, 08 661, 08 113.00 INTEREST EXPENSE 0 140, 80 140, 80 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 54, 772 0 0 0 23, 478, 00 NONREI MBURSABLE COST CENTERS 163, 01 163, 01 190.00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 671, 55 194.00 07950 MOB 0 0 163, 01 194.01 07951 LI FELINE 0 60 60 194.02 07952 PATI ENT TRANSPORT 0 60 194.03 07954 OTHER NONREI MBURSABLE 5, 565, 70 5, 565, 70			0				438, 933	•
101.00 HOME HEALTH AGENCY 0 661,08 SPECIAL PURPOSE COST CENTERS 113.00 INTEREST EXPENSE 1140,80 116.00 11600 HOSPICE 0 140,80 140,80 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 54,772 0 0 23,478,00 NORREI MBURSABLE COST CENTERS 0 163,01 190.00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 163,01 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 671,55 194.00 07950 MOB 0 671,55 194.01 07951 LI FELI NE 0 60 194.02 07952 PATI ENT TRANSPORT 0 60 194.03 07954 OTHER NONREI MBURSABLE COST CENTERS 0 5,565,70				I				
SPECIAL PURPOSE COST CENTERS 113.00 INTEREST EXPENSE 116.00 11600 116.00 SUBTOTALS (SUM OF LINES 1 through 117) 54,772 0 NONREI MBURSABLE COST CENTERS 190.00 IFT, FLOWER, COFFEE SHOP & CANTEEN 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 194.00 07950 194.01 07951 194.02 07952 194.01 07951 194.02 07952 194.01 07951 194.02 07952 194.01 07954 0140.01 07954 0140.02 07952 0157954 0140 017954 0140 017954 0140 0194.03 07954							608, 820	
113.00 11300 INTEREST EXPENSE 0 140,80 116.00 11600 HOSPI CE 0 0 23,478,00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 54,772 0 0 0 23,478,00 NONREI MBURSABLE COST CENTERS 190.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 163,01 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 671,55 194.00 07950 MOB 0 671,55 194.01 07951 LI FELI NE 0 60 194.02 07952 PATI ENT TRANSPORT 0 60 194.03 07954 OTHER NONREI MBURSABLE COST CENTERS 0 60	101.00		0				661, 087	101.00
116.00 HOSPI CE 0 140, 80 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 54, 772 0 0 23, 478, 00 NONREI MBURSABLE COST CENTERS 0 163, 01 163, 01 163, 01 190.00 19200 PHYSI CI ANS' PRI VATE OFFICES 0 671, 55 194.00 07950 MOB 0 671, 55 194.01 07951 LI FELI NE 0 60 194.02 07952 PATI ENT TRANSPORT 0 60 194.03 07954 OTHER NONREI MBURSABLE COST CENTERS 0 60	112 00							113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) 54,772 0 0 23,478,00 NONREI MBURSABLE COST CENTERS NONREI MBURSABLE COST CENTERS 190.00 GI FT., FLOWER, COFFEE SHOP & CANTEEN 0 163,01 192.00 19200 PHYSI CI ANS' PRI VATE OFFICES 0 671,55 194.00 07950 MOB 0 671,55 194.01 07951 LI FELI NE 0 60 194.02 07952 PATI ENT TRANSPORT 0 60 194.03 07954 OTHER NONREI MBURSABLE COST CENTERS 0 60			0				140 802	
NONREI MBURSABLE COST CENTERS 190.00 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 163, 01 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 671, 55 194.00 07950 MOB 0 174.00 194.01 07951 LI FELI NE 0 60 194.02 07952 PATI ENT TRANSPORT 0 60 194.03 07954 OTHER NONREI MBURSABLE COST CENTERS 0 5, 565, 70			-	0		0 0		
190.00 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 163, 01 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 671, 55 194.00 07950 MOB 0 671, 55 194.01 07951 LI FELI NE 0 60 194.02 07952 PATI ENT TRANSPORT 0 60 194.03 07954 OTHER NONREI MBURSABLE COST CENTERS 0 5, 565, 70	. 10. 00		57,772	0		- 0	20, 170, 007	1.10.00
194.00 07950 MOB 0 194.01 07951 LI FELI NE 0 194.02 07952 PATI ENT TRANSPORT 0 60 194.03 07954 OTHER NONREI MBURSABLE COST CENTERS 0 5, 565, 70	190.00		0				163, 015	190.00
194.01 07951 LI FELI NE 0 194.02 07952 PATI ENT TRANSPORT 0 60 194.03 07954 OTHER NONREI MBURSABLE COST CENTERS 0 5, 565, 70			0				671, 551	
194.02 07952 PATI ENT TRANSPORT 0 60 194.03 07954 OTHER NONREI MBURSABLE COST CENTERS 0 5, 565, 70			0					194.00
194. 03 07954 OTHER NONREI MBURSABLE COST CENTERS 0 5, 565, 70			0					194.01
			0					194.02
			0	1 761 010	10 40	0 215 001		
			0		10, 60	0 ∠15,801		200.00

Health Financial Systems	FRANCI SCAN	FRANCI SCAN HEALTH LAFAYETTE			In Lieu of Form CMS-2552-10			
ALLOCATION OF CAPITAL RELATED COSTS				Period: From 01/01/2020	Worksheet B			
					Date/Time Pre 4/29/2021 3:5			
Cost Center Description	SOCI AL SERV	I CENURSI NG SCHOOL	PHARMACY	EMS EDUCATION	Subtotal			
			RESI DENCY					
	17.00	20.00	23.00	23.01	24.00			
202.00 TOTAL (sum lines 118 through 20	1) 54,	772 1, 761, 810	10, 609	215, 801	31, 867, 102	202.00		

_OCATI O	nancial Systems DN OF CAPITAL RELATED COSTS	FRANCI SCAN HEALT	Provider CCN: 15-0	109 Period: From 01/01/2020	<u>i of Form CMS-2552</u> Worksheet B Part II
				To 12/31/2020	Date/Time Prepare 4/29/2021 3:52 pr
	Cost Center Description	Intern &	Total		
		Residents Cost			
		& Post Stepdown			
		Adjustments			
		25.00	26.00		
GEN	NERAL SERVICE COST CENTERS	1 1			
00 00	100 CAP REL COSTS-BLDG & FIXT				1
00 002	200 CAP REL COSTS-MVBLE EQUIP				2
00 004	400 EMPLOYEE BENEFITS DEPARTMENT				4
01 01	160 COMMUNI CATI ONS				5
	140 MGMT INFO SYSTEMS				5
	550 PURCHASI NG				5
	570 ADMI TTI NG				5
	580 PATIENT ACCOUNTING				5
	560 OTHER ADMINISTRATIVE AND GENERAL				5
	700 OPERATION OF PLANT				7
	800 LAUNDRY & LI NEN SERVI CE 900 HOUSEKEEPI NG				9
	000 DI ETARY				10
	100 CAFETERIA				11
	300 NURSI NG ADMI NI STRATI ON				13
	400 CENTRAL SERVICES & SUPPLY				14
	500 PHARMACY				15
	600 MEDI CAL RECORDS & LI BRARY				16
	700 SOCI AL SERVI CE				17
00 020	000 NURSI NG SCHOOL				20
00 023	301 PHARMACY RESIDENCY				23
	300 EMS EDUCATION				23
	PATIENT ROUTINE SERVICE COST CENTERS	I I			
	000 ADULTS & PEDI ATRI CS	0	7, 770, 523		30
	100 INTENSIVE CARE UNIT	0	855, 552		31
	060 NEONATAL INTENSIVE CARE UNIT	0	506, 567		35
	100 SUBPROVI DER – I RF 300 NURSERY	0	878, 261 23, 933		41
	CI LLARY SERVI CE COST CENTERS	<u> </u>	23, 733		43
	000 OPERATING ROOM	0	2,008,484		50
	100 RECOVERY ROOM	0	172, 166		51
00 052	200 DELIVERY ROOM & LABOR ROOM	0	81, 348		52
00 054	400 RADI OLOGY-DI AGNOSTI C	0	1, 181, 767		54
	500 RADI OLOGY - THERAPEUTI C	0	53, 419		55
	600 RADI OI SOTOPE	0	30, 685		56
	950 CARDI AC CATH LAB	0	543, 495		56
	700 CT SCAN	0	123, 373		57
	800 MRI 000 LABORATORY	0	80, 132		58
	500 RESPIRATORY THERAPY	0	510, 164 214, 279		60
	600 PHYSI CAL THERAPY	0	209, 800		65
	700 OCCUPATIONAL THERAPY	0	59, 846		67
	800 SPEECH PATHOLOGY	0	32, 349		68
	900 ELECTROCARDI OLOGY	0	617, 391		69
	000 ELECTROENCEPHALOGRAPHY	0	300, 078		70
	100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	472, 667		71
00 072	200 IMPL. DEV. CHARGED TO PATIENTS	0	430, 423		72
	300 DRUGS CHARGED TO PATIENTS	0	723, 109		73
	301 DI ABETES CENTER	0	16, 448		73
	400 RENAL DIALYSIS	0	107, 970		74
	698 HYPERBARI C OXYGEN THERAPY	0	102, 677		76
	TPATIENT SERVICE COST CENTERS		20. 21/		
	000 CLINIC 100 EMERGENCY	0	28, 216 2, 566, 397		90 91
	950 WOUND CARE	0	2, 566, 397 926, 848		91
	200 OBSERVATION BEDS (NON-DISTINCT PART	0	,20,040		92
	201 OBSERVATION BEDS (DISTINCT PART)	0	438, 933		92
	HER REIMBURSABLE COST CENTERS	. 1			
	500 AMBULANCE SERVICES	0	608, 820		95
	100 HOME HEALTH AGENCY	0	661, 087		101
	ECIAL PURPOSE COST CENTERS				
	300 INTEREST EXPENSE				113
	600 HOSPICE	0	140, 802		116
. 00	SUBTOTALS (SUM OF LINES 1 through 117)	0	23, 478, 009		118
	NREIMBURSABLE COST CENTERS		142 015		100
	000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	163, 015		190
	200 PHYSICIANS' PRIVATE OFFICES 950 MOB	0	671, 551 0		192 194
$\sim 000/9$	950 MOB 951 LI FELI NE		0		194
01070					

Health Financial Systems	FRANCI SCAN HEALT	H LAFAYETTE		In Lie	u of Form CMS-2552	-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CC	CN: 15-0109	Peri od:	Worksheet B	
				From 01/01/2020 To 12/31/2020	Part II	d
				10 12/31/2020	Date/Time Prepare 4/29/2021 3:52 pm	iu.
Cost Center Description	Intern &	Total				
	Residents Cost					
	& Post					
	Stepdown					
	Adjustments					
	25.00	26.00				
194.0307954 OTHER NONREI MBURSABLE COST CENTERS	0	5, 565, 701			194.	03
200.00 Cross Foot Adjustments	0	1, 988, 220			200.	00
201.00 Negative Cost Centers	0	0			201.	00
202.00 TOTAL (sum lines 118 through 201)	0	31, 867, 102			202.	00

	Financial Systems LLOCATION - STATISTICAL BASIS	FRANCI SCAN HEAI	LTH LAFAYETTE Provider CO		eriod:	u of Form CMS-2 Worksheet B-1	2552-10
					rom 01/01/2020 o 12/31/2020	Date/Time Pre 4/29/2021 3:5	
		CAPI TAL REI	ATED COSTS			472772021 3.3	2 011
	Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	COMMUNI CATI ONS (PHONE LI NE S)	MGMT INFO SYSTEMS (MANHOURS)	
		1.00	2.00	4.00	5. 01	5.02	
	GENERAL SERVICE COST CENTERS	202 525			1		
1.00 2.00 4.00 5.01 5.02 5.03 5.04 5.05	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 01160 COMMUNICATIONS 01140 MGMT INFO SYSTEMS 00550 PURCHASING 00570 ADMITTING 00580 PATIENT ACCOUNTING	797, 575 10, 325 1, 015 15, 293 11, 061 0 5, 933	673, 332 10, 325 1, 015 15, 293 11, 061 0 5, 933	122, 684, 366 630, 436 C C C C	705 23 14 0	2, 892, 292 0 0 0	
5.06 7.00 8.00 9.00 10.00 11.00 13.00 14.00 15.00	00560 OTHER ADMI NI STRATI VE AND GENERAL 00700 OPERATI ON OF PLANT 00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG 01000 DI ETARY 01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY	61, 021 118, 826 4, 692 9, 695 17, 207 15, 548 3, 440 5, 694 9, 227	61, 021 118, 826 4, 692 9, 695 17, 207 15, 548 3, 440 5, 694 9, 227	3, 224, 622 379, 509 2, 909, 339	73 55 1 9 30 0 9 4 23	198, 218 127, 215 6, 655 135, 018 126, 339 0 88, 899 20, 007 75, 013	5. 06 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00
17.00 20.00 23.00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE 02000 NURSING SCHOOL 02301 PHARMACY RESIDENCY 02300 EMS EDUCATION INPATIENT ROUTINE SERVICE COST CENTERS	2, 319 603 33, 334 0 4, 133	2, 319 603 33, 334 0 4, 133	24, 332 621, 388 2, 209, 041 252, 486 228, 664	9 0 0	2, 463 20, 515 54, 002 8, 838 0	17.00 20.00 23.00
31.00 35.00 41.00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 02060 NEONATAL INTENSIVE CARE UNIT 04100 SUBPROVIDER - IRF 04300 NURSERY ANCILLARY SERVICE COST CENTERS	118, 471 11, 470 8, 027 14, 424 0	118, 471 11, 470 8, 027 14, 424 0		22 17 24	604, 151 114, 671 54, 107 45, 394 0	35.00 41.00
$\begin{array}{c} 51.\ 00\\ 52.\ 00\\ 54.\ 00\\ 55.\ 00\\ 56.\ 00\\ 56.\ 01\\ 57.\ 00\\ 58.\ 00\\ \end{array}$	05000 OPERATI NG ROOM 05100 RECOVERY ROOM 05200 DELI VERY ROOM & LABOR ROOM 05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY - THERAPEUTI C 05600 RADI OI SOTOPE 03950 CARDI AC CATH LAB 05700 CT SCAN 05800 MRI 06000 LABORATORY	32, 897 2, 718 0 18, 165 704 342 8, 446 1, 539 1, 362 6, 495	1, 362	252, 045	8 26 60 0 0 0 0 0 0 0	101, 421 13, 631 0 101, 354 9, 028 8, 597 32, 329 19, 574 4, 910 0	52.00 54.00 55.00 56.00 56.01 57.00 58.00
65.00 66.00 67.00 68.00 70.00 71.00 72.00 73.00 73.01 74.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 07200 IMPL. DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS 07301 DI ABETES CENTER 07400 RENAL DI ALYSI S 07698 HYPERBARI C OXYGEN THERAPY	0,493 2,308 955 0 98 10,445 5,359 0 0 0 0 0 1,841 2,000	2, 308 955 0 98 10, 445 5, 359 0 0 0 0 0 0 0 1, 841	1, 998, 825 3, 690, 238 1, 412, 328 652, 980 1, 680, 466 595, 005 0 0 397, 193 105, 163	34 6 0 6 0 0 0 0 0 0 0 0 0 0 0 0 0	59, 893 112, 371 41, 654 19, 197 48, 063 16, 962 0 0 0 12, 005 3, 451 0	65.00 66.00 67.00 68.00 70.00 71.00 72.00 73.00 73.01 74.00
91.00 91.01 92.00	OUTPATI ENT SERVICE COST CENTERS 09000 CLINIC 09100 EMERGENCY 04950 WOUND CARE 09200 OBSERVATION BEDS (NON-DISTINCT PART 09201 OBSERVATION BEDS (DISTINCT PART)	0 42, 550 16, 953 7, 990	0 42, 550 16, 953 7, 990	468, 118 7, 731, 586 1, 469, 585 1, 444, 747	0	21, 942 238, 047 39, 243 0	91.00 91.01 92.00
	OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	9, 272 7, 871	9, 272 7, 871	2, 262, 105 4, 882, 099		107, 615 114, 625	
116. 00 118. 00	11300 INTEREST EXPENSE 11600 HOSPICE SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	0 662, 068	0 662, 068	2, 731, 551 110, 189, 154	0 705	82, 714 2, 890, 140	
192.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSI CLANS' PRI VATE OFFI CES 07950 MOB	3, 128 8, 136 0	8, 136			32	190. 00 192. 00 194. 00

Health Financial Systems	FRANCI SCAN HEAL	TH LAFAYETTE		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider C		Period:	Worksheet B-1	
				From 01/01/2020 To 12/31/2020	Date/Time Pre 4/29/2021 3:5	epared: 52 pm
	CAPITAL REL	ATED COSTS				
Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT	COMMUNICATIONS (PHONE LINE S)	MGMT INFO SYSTEMS (MANHOURS)	
			(GROSS SALARI ES)			
	1.00	2.00	4.00	5. 01	5.02	
194. 01 07951 LI FELI NE	0	0	C	0 0		194.01
194. 02 07952 PATI ENT TRANSPORT	0	0	C	0 0		194. 02
194.03 07954 OTHER NONREI MBURSABLE COST CENTERS	124, 243	0	C	0 0	0	194.03
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers						201.00
202.00 Cost to be allocated (per Wkst. B, Part I)	28, 405, 239	3, 461, 863	31, 959, 606	5 1, 637, 983	20, 112, 053	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	35. 614505	5. 141391	0.260503	3 2, 323. 380142	6. 953673	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)			420, 805	43, 530	624, 700	204.00
205.00 Unit cost multiplier (Wkst. B, Part			0. 003430	61. 744681	0. 215988	205.00
206.00 NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00 NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

Health Financial Systems	FRANCI SCAN HEAI			In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider CC	Fi	eriod: rom 01/01/2020	Worksheet B-1	
			Т		Date/Time Pre 4/29/2021 3:5	
Cost Center Description	PURCHASI NG (COSTED REQ	ADMI TTI NG (GROSS CHAR	PATI ENT ACCOUNTI NG	Reconciliation	OTHER ADMI NI STRATI VE	
	UISI)	GES)	(GROSS CHAR GES)		AND GENERAL (ACCUM. COST)	
	5.03	5.04	5.05	5A. 06	5.06	
GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						2.00 4.00
5. 01 01160 COMMUNI CATI ONS						5. 01
5. 02 01140 MGMT I NF0 SYSTEMS 5. 03 00550 PURCHASI NG	27, 058, 588					5.02 5.03
5. 04 00570 ADMI TTI NG	0	1, 294, 056, 261				5.04
5. 05 00580 PATI ENT ACCOUNTI NG 5. 06 00560 OTHER ADMI NI STRATI VE AND GENERAL	0 581, 875	0	1, 294, 056, 261 0	-31, 544, 157	264, 207, 126	5.05 5.06
7.00 00700 OPERATION OF PLANT	26, 360	0	0	0	18, 459, 004	7.00
8. 00 00800 LAUNDRY & LINEN SERVICE 9. 00 00900 HOUSEKEEPING	0 54, 196	0	-	0 0	1, 001, 737 4, 915, 902	8.00 9.00
10. 00 01000 DI ETARY 11. 00 01100 CAFETERI A	26, 017 0	0		0	3, 084, 198 2, 176, 615	10.00 11.00
13.00 01300 NURSI NG ADMI NI STRATI ON	2	0	0	0	4, 847, 252	
14. 00 01400 CENTRAL SERVICES & SUPPLY 15. 00 01500 PHARMACY	5, 650 554	0		0	727, 094 5, 208, 497	14.00 15.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	0	0	0	0	2, 098, 750	16.00
17. 00 01700 SOCIAL SERVICE 20. 00 02000 NURSING SCHOOL	37 10, 576	0	0	0	973, 917 2, 648, 669	17.00 20.00
23. 00 02301 PHARMACY RESIDENCY	0	0	0	0	472, 736	23.00
23. 01 02300 EMS EDUCATION INPATIENT ROUTINE SERVICE COST CENTERS	66	0	0	0	467, 209	23.01
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 I NTENSI VE CARE UNIT	68, 423 22, 839			0 0	30, 138, 698 6, 404, 514	30.00 31.00
35.00 02060 NEONATAL INTENSIVE CARE UNIT	26, 528	19, 916, 275	19, 916, 275	0	3, 550, 704	35.00
41. 00 04100 SUBPROVI DER – I RF 43. 00 04300 NURSERY	956	5, 899, 155 4, 765, 766		0	3, 010, 755 763, 888	41.00 43.00
ANCI LLARY SERVI CE COST CENTERS						
50. 00 05000 OPERATI NG ROOM 51. 00 05100 RECOVERY ROOM	1, 971, 195			0	10, 178, 563 1, 013, 041	50.00 51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	28, 655, 566	28, 655, 566	0	5, 027, 101	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 55. 00 05500 RADI OLOGY - THERAPEUTI C	1, 305, 605			0 0	10, 327, 317 803, 185	54.00 55.00
56. 00 05600 RADI OI SOTOPE 56. 01 03950 CARDI AC CATH LAB	187	0 53, 211, 516	0 53, 211, 516	0	585, 544 3, 616, 947	56. 00 56. 01
57.00 05700 CT SCAN	8, 231	56, 033, 807	56, 033, 807	0	1, 461, 517	57.00
58. 00 05800 MRI 60. 00 06000 LABORATORY	915 567, 375			0	455, 304 12, 127, 936	
65. 00 06500 RESPI RATORY THERAPY	108, 660	18, 614, 778	18, 614, 778	0	3, 425, 095	65.00
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 0CCUPATI ONAL THERAPY	0			0	5, 736, 093 2, 109, 739	
68.00 06800 SPEECH PATHOLOGY	551	4, 577, 957	4, 577, 957	0	991, 675	
69. 00 06900 ELECTROCARDI OLOGY 70. 00 07000 ELECTROENCEPHALOGRAPHY	762	29, 602, 644 4, 824, 258		0	3, 483, 593 1, 162, 038	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	10, 914, 506 9, 691, 822			0	12, 411, 045 13, 011, 030	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	144, 423, 961	144, 423, 961	0	10, 537, 460	73.00
73. 01 07301 DI ABETES CENTER 74. 00 07400 RENAL DI ALYSI S	711	89, 684 3, 322, 268		0	601, 874 1, 049, 388	
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0			0	87, 912	
OUTPATI ENT SERVI CE COST CENTERS 90. 00 O90000 CLI NI C	14	1, 382, 301	1, 382, 301	0	1, 177, 169	90.00
91.00 09100 EMERGENCY 91.01 04950 WOUND CARE	87, 493 395			0	14, 501, 663 2, 865, 477	91.00 91.01
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	375	0, 093, 123	0, 093, 123	0	2, 865, 477	92.00
92. 01 09201 OBSERVATI ON BEDS (DI STI NCT PART) OTHER REI MBURSABLE COST CENTERS	0	16, 367, 140	16, 367, 140	0	2, 258, 037	92.01
95. 00 09500 AMBULANCE SERVICES	14, 642				4, 721, 821	
101. 00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	342, 282	13, 153, 346	13, 153, 346	0	14, 807, 563	00 . 101
113.00 11300 INTEREST EXPENSE	(0.705	21 (00 2/2	21 (00 2/2	0	4 254 010	113.00
116.00 11600 HOSPICE 118.00 SUBTOTALS (SUM OF LINES 1 through 117)	69, 705 27, 058, 358	21, 689, 262 1, 294, 056, 261		0 -31, 544, 157	6, 356, 818 237, 842, 084	
NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	113	0	0	0	241, 320	190 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	117	0	0	0	21, 637, 765	192.00
194. 00 07950 MOB 194. 01 07951 LI FELI NE	0	0	0	0		194. 00 194. 01
194. 02 07952 PATI ENT TRANSPORT	0	0	0	0	61, 106	194. 02
194.03 07954 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	4, 424, 851	194.03

Heal th F	inancial Systems	FRANCI SCAN HEAL	TH LAFAYETTE		In Lie	eu of Form CMS-:	2552-10
COST ALL	LOCATION - STATISTICAL BASIS		Provider C		Period: From 01/01/2020	Worksheet B-1	
					To 12/31/2020		
	Cost Center Description	PURCHASI NG	ADMI TTI NG	PATI ENT	Reconciliation	OTHER	
		(COSTED REQ	(GROSS CHAR	ACCOUNTI NG		ADMI NI STRATI VE	
		UISI)	GES)	(GROSS CHAR		AND GENERAL	
				GES)		(ACCUM. COST)	
		5.03	5.04	5.05	5A. 06	5.06	
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	2, 341, 700	573	6, 803, 66	9	31, 544, 157	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0. 086542	0. 000000	0.00525	8	0. 119392	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	451, 665	0	242, 66	9	2, 621, 726	204. 00
205.00	Unit cost multiplier (Wkst. B, Part	0. 016692	0. 000000	0. 00018	8	0. 009923	205. 00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

		FRANCI SCAN HEA				u of Form CMS-	
COST A	ALLOCATION - STATISTICAL BASIS		Provider C	F	eriod: rom 01/01/2020	Worksheet B-1	
					o 12/31/2020	Date/Time Pre 4/29/2021 3:5	
	Cost Center Description	OPERATION OF PLANT	LAUNDRY &	HOUSEKEEPING (SQUARE FEET)	DI ETARY (MEALS SERVED)	CAFETERI A (MANHOURS)	
		(SQUARE FEET)	(POUNDS OF			(
		7.00	LAUNDRY) 8.00	9.00	10.00	11.00	
	GENERAL SERVICE COST CENTERS	1		1			1
1.00 2.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						1.00 2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01 5.02	01160 COMMUNICATIONS 01140 MGMT INFO SYSTEMS						5. 01 5. 02
5.03	00550 PURCHASI NG						5.03
5.04 5.05	00570 ADMITTING 00580 PATIENT ACCOUNTING						5.04 5.05
5.06	00560 OTHER ADMINISTRATIVE AND GENERAL	574.404					5.06
7.00 8.00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	574, 101 4, 692	1, 183, 654				7.00
9.00	00900 HOUSEKEEPI NG	9, 695	27, 374	435, 471			9.00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	17, 207 15, 548				2, 298, 847	10.00
13.00	01300 NURSI NG ADMI NI STRATI ON	3, 440	0	3, 440	0	88, 899	13.00
14.00 15.00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	5, 694 9, 227	29, 999		0	20, 007 75, 013	
16.00	01600 MEDI CAL RECORDS & LI BRARY	2, 319	0	2, 319	0	2, 463	16.00
17.00 20.00	01700 SOCIAL SERVICE 02000 NURSING SCHOOL	603 33, 334				20, 515 54, 002	1
23.00	02301 PHARMACY RESIDENCY	0	0			8, 838	
23. 01	02300 EMS EDUCATION	4, 133	0	4, 133	0	0	23.01
30.00	03000 ADULTS & PEDIATRICS	118, 471	417, 849	118, 471	169, 720	604, 151	30.00
31.00 35.00	03100 I NTENSI VE CARE UNI T	11,470				114, 671	1
35.00 41.00	02060 NEONATAL INTENSIVE CARE UNIT 04100 SUBPROVIDER - IRF	8, 027 14, 424	26, 532 22, 470			54, 107 45, 394	
43.00		0	43, 604	0	0	0	43.00
50.00	ANCI LLARY SERVI CE COST CENTERS	32, 897	207, 591	32, 897	0	101, 421	50.00
51.00	05100 RECOVERY ROOM	2, 718				13, 631	
52.00 54.00	05200 DELIVERY ROOM & LABOR ROOM 05400 RADI OLOGY-DI AGNOSTI C	0 18, 165				0 101, 354	
55.00	05500 RADI OLOGY - THERAPEUTI C	704	0			9, 028	
56. 00 56. 01	05600 RADI OI SOTOPE 03950 CARDI AC CATH LAB	342 8, 446	0 4, 813			8, 597 32, 329	1
57.00	05700 CT SCAN	1, 539	0	1, 539	0	19, 574	57.00
58.00 60.00	05800 MRI 06000 LABORATORY	1, 362 6, 495		.,		4, 919 0	
65.00	06500 RESPI RATORY THERAPY	2, 308	8, 837	2, 308		59, 893	65.00
66.00 67.00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	955	16, 446	955	0	112, 371 41, 654	
68.00	06800 SPEECH PATHOLOGY	98	0	98	0	19, 197	68.00
69.00 70.00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	10, 445 5, 359		10, 445 5, 359		48, 063 16, 962	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0,007	0	0	1
72.00 73.00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	
73.00	07301 DI ABETES CENTER	0	0	0	0	12, 005	
74.00 76.98	07400 RENAL DI ALYSI S 07698 HYPERBARI C OXYGEN THERAPY	1, 841 2, 000		1, 841 2, 000		3, 451 0	1
70.90	OUTPATIENT SERVICE COST CENTERS	2,000	0	2,000	0	0	70.90
90.00 91.00	09000 CLINIC 09100 EMERGENCY	0 42, 550				21, 942 238, 047	
91.00 91.01	04950 WOUND CARE	16, 953		16, 953		39, 243	1
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	7.000		7.000		0	92.00
92. 01	09201 OBSERVATI ON BEDS (DI STI NCT PART) OTHER REIMBURSABLE COST CENTERS	7,990	0	7, 990	0	0	92.01
	09500 AMBULANCE SERVI CES	9, 272				107, 615	
101.00	DIO100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	7, 871	0	7, 871	0	114, 625	
	11300 INTEREST EXPENSE					00.714	113.00
116.00 118.00) 11600 HOSPICE) SUBTOTALS (SUM OF LINES 1 through 117)	0 438, 594	0 1, 183, 654	0 424, 207	0 202, 125	82, 714 2, 296, 695	116.00 118.00
	NONREI MBURSABLE COST CENTERS						
190.00	0 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 19200 PHYSICIANS' PRIVATE OFFICES	3, 128 8, 136		3, 128 8, 136		2, 120 32	190.00 192.00
194.00	07950 MOB	0	0	0	0	0	194.00
	07951 LIFELINE 207952 PATIENT_TRANSPORT	0			0		194.01 194.02
194.02							

Heal th F	inancial Systems	FRANCI SCAN HEAL	TH LAFAYETTE		In Lie	u of Form CMS-	2552-10
COST ALL	OCATION - STATISTICAL BASIS		Provider CO		Period:	Worksheet B-1	
					From 01/01/2020 To 12/31/2020		
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG		CAFETERI A	
		PLANT	LINEN SERVICE	(SQUARE FEET)	(MEALS SERVED)	(MANHOURS)	
		(SQUARE FEET)	(POUNDS OF				
			LAUNDRY)				
		7.00	8.00	9.00	10.00	11.00	
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B,	20, 662, 861	1, 290, 209	5, 881, 598	4, 340, 376	3, 206, 080	202.00
	Part I)						
203.00	Unit cost multiplier (Wkst. B, Part I)	35. 991683	1. 090022	13. 506291	21. 473722	1. 394647	203.00
204.00	Cost to be allocated (per Wkst. B,	5, 068, 741	244, 522	573, 709	9 946, 398	817, 485	204.00
	Part II)						
205.00	Unit cost multiplier (Wkst. B, Part	8. 829006	0. 206582	1. 317445	4. 682241	0. 355607	205.00
	11)						
206.00	NAHE adjustment amount to be allocated						206.00
	(per Wkst. B-2)						
207.00	NAHE unit cost multiplier (Wkst. D,						207.00
	Parts III and IV)						

	Financial Systems LLOCATION - STATISTICAL BASIS	FRANCISCAN HEAL	TH LAFAYETTE Provider CC	CN: 15-0109	Peri od:	u of Form CMS-2 Worksheet B-1	
					From 01/01/2020 To 12/31/2020	Date/Time Pre 4/29/2021 3:5	
	Cost Center Description	NURSI NG ADMI NI STRATI ON	CENTRAL SERVICES &	PHARMACY (COSTED	MEDI CAL RECORDS &	SOCIAL SERVICE	
		(DI RECT NRS	SUPPLY (COSTED REQ	REQUI S.)	LI BRARY (GROSS CHAR	(TIME SPENT)	
		I NG)	UISI)	15 00	GES)	17.00	
	GENERAL SERVICE COST CENTERS	13.00	14.00	15.00	16.00	17.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00 4.00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT						2.00 4.00
5.01	01160 COMMUNICATIONS						5.01
5.02	01140 MGMT INFO SYSTEMS						5.02
5.03	00550 PURCHASI NG						5.03
5.04 5.05	00570 ADMITTING 00580 PATIENT ACCOUNTING						5.04 5.05
5.05	00560 OTHER ADMINISTRATIVE AND GENERAL						5.06
7.00	00700 OPERATION OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00 10.00	00900 HOUSEKEEPI NG 01000 DI ETARY						9.00 10.00
11.00	01100 CAFETERIA						11.00
13.00	01300 NURSING ADMINISTRATION	1, 870, 141					13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	26, 364, 488	_			14.00
15.00 16.00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	0	554 0	1	00 0 1, 294, 056, 261		15.00 16.00
17.00	01700 SOCIAL SERVICE	0	37		0 1, 294, 050, 201	48, 142	17.00
20.00	02000 NURSI NG SCHOOL	0	10, 576		0 0	0	20.00
23.00	02301 PHARMACY RESIDENCY	0	0		0 0	0	23.00
23.01	02300 EMS EDUCATION I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0	66		0 0	0	23.01
30.00	03000 ADULTS & PEDIATRICS	604, 151	68, 423		0 70, 364, 439	33, 999	30.00
31.00	03100 I NTENSI VE CARE UNI T	114, 671	22, 839		0 18, 173, 682	4, 727	31.00
35.00	02060 NEONATAL INTENSIVE CARE UNIT	54, 107	26, 528		0 19, 916, 275		35.00
41.00 43.00	04100 SUBPROVIDER - IRF 04300 NURSERY	45, 394 0	956 0		0 5, 899, 155 0 4, 765, 766		41.00 43.00
43.00	ANCI LLARY SERVI CE COST CENTERS	<u> </u>	U		0 4,705,700	3, 032	43.00
50.00	05000 OPERATI NG ROOM	101, 421	1, 971, 195		0 156, 618, 877	0	50.00
51.00	05100 RECOVERY ROOM	13, 631	6		0 11, 923, 504	0	51.00
52.00 54.00	05200 DELIVERY ROOM & LABOR ROOM 05400 RADIOLOGY-DIAGNOSTIC	0	0 1, 305, 605		0 28, 655, 566 0 95, 771, 314	0	52.00 54.00
55.00	05500 RADI OLOGY - THERAPEUTI C	0	1, 303, 005		0 10, 901, 914	0	55.00
56.00	05600 RADI OI SOTOPE	8, 597	187		0 0	0	56.00
56.01	03950 CARDI AC CATH LAB	32, 329	1, 149, 197		0 53, 211, 516	0	56.01
57.00 58.00	05700 CT SCAN 05800 MRI	0	8, 231 915		0 56, 033, 807 0 8, 699, 308	0	57.00 58.00
60.00	06000 LABORATORY	0	567, 375		0 130, 147, 520	0	60.00
65.00	06500 RESPI RATORY THERAPY	59, 893	108, 660		0 18, 614, 778	0	65.00
66.00	06600 PHYSI CAL THERAPY	112, 371	0		0 21, 719, 620	0	66.00
67.00 68.00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	41, 654 19, 197	0 551		0 13, 118, 390 0 4, 577, 957	0	67.00 68.00
69.00	06900 ELECTROCARDI OLOGY	48, 063	762		0 29, 602, 644	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	16, 962	0		0 4, 824, 258	0	70.00
71.00	07100 MEDI CAL SUPPLIES CHARGED TO PATIENT	0	10, 914, 506		0 122, 431, 337	0	71.00
72.00 73.00	07200 I MPL. DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS	0	9, 691, 822 0	1	0 78, 306, 543 00 144, 423, 961	0	72.00 73.00
73.00	07301 DI ABETES CENTER	12,005	711	,	0 89, 684	0	73.00
74.00	07400 RENAL DIALYSIS	3, 451	25		0 3, 322, 268	0	74.00
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0		0 0	0	76. 98
90.00	OUTPATIENT SERVICE COST CENTERS	0	14		0 1, 382, 301	0	90.00
91.00	09100 EMERGENCY	238, 047	87, 493		0 109, 625, 296	0	91.00
91.01	04950 WOUND CARE	39, 243	395		0 6, 693, 123	0	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		0 1/ 2/7 1/0	0	92.00 92.01
92.01	09201 OBSERVATION BEDS (DISTINCT PART) OTHER REIMBURSABLE COST CENTERS	0	0		0 16, 367, 140	0	92.01
95.00	09500 AMBULANCE SERVICES	107, 615	14, 642		0 13, 031, 710		95.00
101.00	10100 HOME HEALTH AGENCY	114, 625	342, 282		0 13, 153, 346	0	101.00
112 00	SPECIAL PURPOSE COST CENTERS						113.00
	11600 HOSPI CE	82, 714	69, 705		0 21, 689, 262	0	116.00
118.00		1, 870, 141	26, 364, 258		00 1, 294, 056, 261		
	NONREI MBURSABLE COST CENTERS	1					
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	113		0 0		190.00
			117		0 0	^	102 00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	117 0		0 0 0 0		192.00 194.00
192.00 194.00		0 0 0			0 0 0 0 0 0	0	192. 00 194. 00 194. 01

Health Fina	ncial Systems	FRANCISCAN HEAL	TH LAFAYETTE		In Lie	u of Form CMS-:	2552-10
COST ALLOCA	5		Provider CC		Period:	Worksheet B-1	
					From 01/01/2020 To 12/31/2020	Date/Time Pre 4/29/2021 3:5	
	1	NURSI NG	CENTRAL	PHARMACY		SOCIAL SERVICE	
		ADMI NI STRATI ON	SERVICES &	(COSTED	RECORDS &		
		(SUPPLY	REQUIS.)	LIBRARY	(TIME SPENT)	
		(DI RECT NRS	(COSTED REQ		(GROSS CHAR		
		I NG)	UISI)		GES)		
		13.00	14.00	15.00	16.00	17.00	
		0	0		0 0		194.03
200.00	, , , , , , , , , , , , , , , , , , , ,						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	5, 720, 231	1, 156, 348	6, 391, 70	9 2, 467, 545	1, 148, 655	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	3. 058716	0. 043860	63, 917. 09000	0.001907	23. 859727	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	285, 633	316, 329	575, 65	2 141, 409	54, 772	204.00
205.00	Unit cost multiplier (Wkst. B, Part	0. 152733	0. 011998	5, 756. 52000	0 0. 000109	1. 137718	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

Health Financial Systems	FRANCI SCAN HEAL				u of Form CMS-2552-	10
COST ALLOCATION - STATISTICAL BASIS		Provider CC	1	Period: From 01/01/2020	Worksheet B-1	-J.
		DUADWAOY		Го 12/31/2020	Date/Time Prepared 4/29/2021 3:52 pm	1:
Cost Center Description	NURSING SCHOOL	PHARMACY RESI DENCY	EMS EDUCATION (ASSIGNED			
	(ASSIGNED TIME)	(ASSIGNED TIME)	TIME)			
	20.00	23.00	23.01	-		
GENERAL SERVI CE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT					1. C	00
2.00 00200 CAP REL COSTS-MVBLE EQUIP					2.0	00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 5. 01 01160 COMMUNI CATI ONS					4. C 5. C	
5.02 01140 MGMT INFO SYSTEMS					5.0	
5. 03 00550 PURCHASI NG 5. 04 00570 ADMI TTI NG					5. C	
5. 05 00580 PATIENT ACCOUNTING					5.0	
5. 06 00560 OTHER ADMINISTRATIVE AND GENERAL 7. 00 00700 OPERATION OF PLANT					5. C	
8.00 00800 LAUNDRY & LINEN SERVICE					8.0	
9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY					9. C 10. C	
11. 00 01100 CAFETERI A					11.0	
13. 00 01300 NURSI NG ADMI NI STRATI ON 14. 00 01400 CENTRAL SERVI CES & SUPPLY					13. C 14. C	
15. 00 01500 PHARMACY					15. C	00
16. 00 01600 MEDI CAL RECORDS & LI BRARY 17. 00 01700 SOCI AL SERVI CE					16. C 17. C	
20. 00 02000 NURSI NG SCHOOL	100				20. C	00
23. 00 02301 PHARMACY RESIDENCY 23. 01 02300 EMS EDUCATION		100	100		23. C 23. C	
INPATIENT ROUTINE SERVICE COST CENTERS					23.0	51
30. 00 03000 ADULTS & PEDI ATRI CS 31. 00 03100 I NTENSI VE CARE UNI T	100	0			30. C 31. C	
35.00 02060 NEONATAL INTENSIVE CARE UNIT	0	0	(5	35.0	
41. 00 04100 SUBPROVI DER – I RF 43. 00 04300 NURSERY	0	0		-	41. C 43. C	
ANCI LLARY SERVI CE COST CENTERS	-	-		-		
50.00 05000 OPERATING ROOM 51.00 05100 RECOVERY ROOM	0	0			50. C 51. C	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		5	52. C	00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 55. 00 05500 RADI OLOGY - THERAPEUTI C	0	0			54. C 55. C	
56. 00 05600 RADI OI SOTOPE	0	0		D D	56. C	00
56. 01 03950 CARDI AC_CATH_LAB 57. 00 05700 CT_SCAN	0	0			56. C 57. C	
58. 00 05800 MRI	0	0			58. C	00
60. 00 06000 LABORATORY 65. 00 06500 RESPI RATORY THERAPY	0	0		-	60. C 65. C	
66. 00 06600 PHYSI CAL THERAPY	0	0			66. C	00
67.00 06700 OCCUPATI ONAL THERAPY 68.00 06800 SPEECH PATHOLOGY	0	0			67. C 68. C	
69. 00 06900 ELECTROCARDI OLOGY	0	0	(69. C	00
70. 00 07000 ELECTROENCEPHALOGRAPHY 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0	0			70. C 71. C	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	(5	72.0	00
73. 00 07300 DRUGS CHARGED TO PATIENTS 73. 01 07301 DIABETES CENTER	0	100			73. C 73. C	
74. 00 07400 RENAL DI ALYSI S	0	0		D D	74. C	00
76. 98 07698 HYPERBARI C OXYGEN THERAPY OUTPATI ENT SERVI CE COST CENTERS	0	0	(76.9	98
90. 00 09000 CLI NI C	0	0		D	90. C	
91. 00 09100 EMERGENCY 91. 01 04950 WOUND CARE	0	0	100		91. C 91. C	
92.00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART					92. C	00
92. 01 09201 OBSERVATION BEDS (DISTINCT PART) OTHER REIMBURSABLE COST CENTERS	0	0	(92.0	01
95. 00 09500 AMBULANCE SERVI CES	0			0	95. C	
101.00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0	0	(101. C	00
113.00 11300 INTEREST EXPENSE					113.0	
116.00 11600 HOSPI CE 118.00 SUBTOTALS (SUM OF LINES 1 through 117	7) 0 100	0 100	100		116. C 118. C	
NONREI MBURSABLE COST CENTERS	-					
190. 00 19000 GLFT, FLOWER, COFFEE SHOP & CANTEEN 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0			190. C 192. C	
194. 00 07950 MOB	0	0			194. C	00
194. 01 07951 LI FELI NE 194. 02 07952 PATI ENT TRANSPORT	0	0			194. C 194. C	
194.0307954OTHER NONREIMBURSABLE COST CENTERS	0	0	(סן	194. C	

		FRANCI SCAN HEAL				u of Form CMS	
COST ALLOCATION - STATISTICAL BASIS			Provider C		Period:	Worksheet B-	-1
					From 01/01/2020 To 12/31/2020	Date/Time Pr 4/29/2021 3:	
	Cost Center Description	NURSING SCHOOL	PHARMACY	EMS EDUCATION	1		
			RESI DENCY	(ASSI GNED			
		(ASSI GNED	(ASSI GNED	TIME)			
		TIME)	TIME)				
		20.00	23.00	23.01			
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	4, 690, 643	541, 503	727, 56	9		202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	46, 906. 430000	5, 415. 030000	7, 275. 69000	0		203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	1, 761, 810	10, 609	215, 80	1		204.00
205. 00	Unit cost multiplier (Wkst. B, Part	17, 618. 100000	106. 090000	2, 158. 01000	0		205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)	0	0		0		206.00
207. 00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)	0. 000000	0. 000000	0. 00000	0		207.00

MPUTATION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-0109	Peri od:	Worksheet C	
			. 10 0107	From 01/01/2020	Part I	
				To 12/31/2020	Date/Time Pre 4/29/2021 3:5	pare
		Title	× XVIII	Hospi tal	472972021 3.5 PPS	z piii
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs		Total Costs	
	(from Wkst. B,	Adj .		Di sal I owance		
	Part I, col.					
	26) 1.00	2.00	2 00	4.00	E 00	
INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	-
. 00 03000 ADULTS & PEDI ATRI CS	52, 030, 549		52, 030, 5	49 0	52, 030, 549	30.
. 00 03100 I NTENSI VE CARE UNI T	8, 864, 321		8, 864, 3		8, 864, 321	
. 00 02060 NEONATAL INTENSIVE CARE UNIT	4, 747, 326		4, 747, 3		4, 747, 326	
. 00 04100 SUBPROVIDER - IRF	4, 690, 705		4, 690, 7		4, 690, 705	
. 00 04300 NURSERY	998, 366		998, 3		998, 366	
ANCI LLARY SERVICE COST CENTERS	770,000		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	00	770,000	1 10
. 00 05000 OPERATI NG ROOM	14, 084, 991		14, 084, 9	91 0	14, 084, 991	50
. 00 05100 RECOVERY ROOM	1, 393, 575		1, 393, 5		1, 393, 575	
. 00 05200 DELIVERY ROOM & LABOR ROOM	5, 732, 761		5, 732, 7		5, 732, 761	
. 00 05400 RADI OLOGY-DI AGNOSTI C	12, 920, 098		12, 920, 0		12, 920, 098	
. 00 05500 RADI OLOGY - THERAPEUTI C	967, 306		967, 3		967, 306	
. 00 05600 RADI OI SOTOPE	710, 675		710, 6		710, 675	
. 01 03950 CARDI AC CATH LAB	4, 767, 939		4, 767, 9		4, 767, 939	
. 00 05700 CT SCAN	1, 846, 703		1, 846, 7		1, 846, 703	
. 00 05800 MRI	600, 571		600, 5		600, 571	
. 00 06000 LABORATORY	14, 178, 706		14, 178, 7	-	14, 178, 706	
. 00 06500 RESPI RATORY THERAPY	4, 264, 889	0			4, 264, 889	
. 00 06600 PHYSI CAL THERAPY	7,027,983	0			7, 027, 983	
. 00 06700 OCCUPATIONAL THERAPY	2, 572, 143	0			2, 572, 143	
. 00 06800 SPEECH PATHOLOGY	1, 209, 169	0	1, 209, 1		1, 209, 169	
. 00 06900 ELECTROCARDI OLOGY	4, 694, 345	-	4, 694, 3		4, 694, 345	
. 00 07000 ELECTROENCEPHALOGRAPHY	1, 650, 773		1, 650, 7		1, 650, 773	
. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	14,605,014		14, 605, 0		14, 605, 014	
. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	15, 138, 857		15, 138, 8		15, 138, 857	
. 00 07300 DRUGS CHARGED TO PATIENTS	19,004,176		19,004,1		19,004,176	
. 01 07301 DI ABETES CENTER	727, 398		727, 3		727, 398	
. 00 07400 RENAL DI ALYSI S	1, 287, 509		1, 287, 5		1, 287, 509	
. 98 07698 HYPERBARI C OXYGEN THERAPY	197, 404		197, 4		197, 404	
OUTPATIENT SERVICE COST CENTERS						
. 00 09000 CLINIC	1, 350, 952		1, 350, 9	52 0	1, 350, 952	90
. 00 09100 EMERGENCY	20, 458, 956		20, 458, 9		20, 458, 956	
. 01 04950 WOUND CARE	4, 234, 275		4, 234, 2		4, 234, 275	
. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0			0	0	
. 01 09201 OBSERVATION BEDS (DISTINCT PART)	2, 954, 330		2, 954, 3	30 0	2, 954, 330	92
OTHER REIMBURSABLE COST CENTERS						
. 00 09500 AMBULANCE SERVICES	6, 249, 256		6, 249, 2		6, 249, 256	
1.00 10100 HOME HEALTH AGENCY	17, 515, 628		17, 515, 6	28	17, 515, 628	101
SPECIAL PURPOSE COST CENTERS						
3.00 11300 INTEREST EXPENSE						113
6. 00 11600 HOSPI CE	7, 528, 545		7, 528, 5		7, 528, 545	
0.00 Subtotal (see instructions)	261, 206, 194	0	261, 206, 1	94 0	261, 206, 194	
1.00 Less Observation Beds	0			0		201
2.00 Total (see instructions)	261, 206, 194	0	261, 206, 1	94 0	261, 206, 194	202

COMPUT	FATION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-0109	Period: From 01/01/2020 To 12/31/2020	Worksheet C Part I Date/Time Pre 4/29/2021 3:5	epared: 2 pm
				XVIII	Hospi tal	PPS	
	Cost Center Description	I npati ent	<u>Charges</u> Outpatient	Total (col. + col. 7)	6 Cost or Other Ratio	TEFRA I npati ent Rati o	
		6.00	7.00	8.00	9.00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	03000 ADULTS & PEDIATRICS	70, 364, 439		70, 364, 43			30.00
31.00	03100 I NTENSI VE CARE UNI T	18, 173, 682		18, 173, 68			31.00
35.00	02060 NEONATAL INTENSIVE CARE UNIT	19, 916, 275		19, 916, 27			35.00
41.00	04100 SUBPROVI DER – I RF	5, 899, 155		5, 899, 15			41.00
43.00	04300 NURSERY	4, 765, 766		4, 765, 76	6		43.00
	ANCI LLARY SERVI CE COST CENTERS						
50.00	05000 OPERATING ROOM	80, 672, 202	75, 946, 675			0.00000	
51.00	05100 RECOVERY ROOM	4, 828, 084	7,095,420			0.00000	
52.00	05200 DELIVERY ROOM & LABOR ROOM	27, 760, 141	895, 425			0.00000	
54.00	05400 RADI OLOGY-DI AGNOSTI C	20, 636, 082	75, 135, 232			0.00000	
55.00	05500 RADI OLOGY - THERAPEUTI C	2, 916, 039	7, 985, 875	10, 901, 91		0.00000	
56.00	05600 RADI OI SOTOPE	0	0		0 0. 000000	0.000000	
56. 01	03950 CARDIAC CATH LAB	30, 650, 486	22, 561, 030			0.00000	
57.00	05700 CT SCAN	16, 623, 675	39, 410, 132			0.00000	
58.00	05800 MRI	3, 155, 435	5, 543, 873			0.000000	
50.00	06000 LABORATORY	56, 546, 341	73, 601, 179			0.00000	
65.00	06500 RESPI RATORY THERAPY	15, 856, 302	2, 758, 476			0.00000	
56.00	06600 PHYSI CAL THERAPY	8, 474, 411	13, 245, 209			0.00000	
57.00	06700 OCCUPATI ONAL THERAPY	7,072,436	6, 045, 954			0.00000	
58.00	06800 SPEECH PATHOLOGY	1, 832, 492	2, 745, 465			0.00000	
59.00	06900 ELECTROCARDI OLOGY	10, 483, 750	19, 118, 894			0.00000	
70.00	07000 ELECTROENCEPHALOGRAPHY	1,043,242	3, 781, 016			0.00000	
1.00	07100 MEDI CAL SUPPLIES CHARGED TO PATIENT	70, 672, 107	51, 759, 230			0.00000	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	54, 839, 493	23, 467, 050			0.00000	
73.00 73.01	07300 DRUGS CHARGED TO PATIENTS	48, 801, 171	95, 622, 790			0. 000000	
	07301 DI ABETES CENTER	1, 190	88, 494			0.00000	
74.00	07400 RENAL DIALYSIS	2, 475, 736	846, 532			0.00000	
76. 98	07698 HYPERBARI C OXYGEN THERAPY OUTPATI ENT SERVI CE COST CENTERS	0	0		0 0.000000	0. 000000	76.9
90.00	09000 CLINIC	0	1 202 201	1 202 20	0. 977321	0,00000	90.0
90.00 91.00	09000 CLINIC 09100 EMERGENCY	-	1, 382, 301			0.00000	
91.00 91.01	04950 WOUND CARE	18, 890, 967 109, 674	90, 734, 329 6, 583, 449			0. 000000 0. 000000	
71.01 72.00		109, 674	6, 583, 449	6, 693, 12			
92.00 92.01	09200 OBSERVATION BEDS (NON-DISTINCT PART 09201 OBSERVATION BEDS (DISTINCT PART)	1, 703, 685	14 (42 455	14 247 14	0.000000	0. 000000 0. 000000	
72.01	OTHER REIMBURSABLE COST CENTERS	1, 703, 065	14, 663, 455	16, 367, 14	0 0.160304	0.00000	92.0
35 00	09500 AMBULANCE SERVICES	0	13, 031, 710	13, 031, 71	0 0. 479542	0. 000000	95.0
	10100 HOME HEALTH AGENCY	21, 194	13, 132, 152			0.00000	101.00
.01.00	SPECIAL PURPOSE COST CENTERS	21, 194	13, 132, 132	1 15, 155, 54			
13 00	DI1300 INTEREST EXPENSE						113.0
	11600 HOSPI CE	0	21, 689, 262	21, 689, 26	2		116.0
200.00		605, 185, 652	688, 870, 609				200. 0
200.00		000, 100, 002	000, 070, 009	, 2, 7, 030, 20			200.0
-01.00	Total (see instructions)	605, 185, 652		1, 294, 056, 26			201.00

	Financial Systems	FRANCI SCAN HEALTH			u of Form CMS-	-2552-10
COMPUT	ATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0109	Peri od: From 01/01/2020 To 12/31/2020	Worksheet C Part I Date/Time Pro 4/29/2021 3:5	epared: 52 pm
			Title XVIII	Hospi tal	PPS	
	Cost Center Description	PPS Inpatient				
		Ratio				
		11.00				
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS					30.00
31.00	03100 INTENSIVE CARE UNIT					31.00
35.00	02060 NEONATAL INTENSIVE CARE UNIT					35.00
41.00	04100 SUBPROVI DER – I RF					41.00
43.00	04300 NURSERY					43.00
	ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0. 089932				50.00
51.00	05100 RECOVERY ROOM	0. 116876				51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 200058				52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 134906				54.00
55.00	05500 RADI OLOGY - THERAPEUTI C	0. 088728				55.00
56.00	05600 RADI OI SOTOPE	0.000000				56.00
56.01	03950 CARDI AC CATH LAB	0. 089604				56.01
57.00	05700 CT SCAN	0. 032957				57.00
58.00	05800 MRI	0.069037				58.00
60.00	06000 LABORATORY	0. 108943				60.00
65.00	06500 RESPI RATORY THERAPY	0. 229113				65.00
66.00	06600 PHYSI CAL THERAPY	0. 323578				66.00
67.00	06700 OCCUPATI ONAL THERAPY	0. 196072				67.00
68.00	06800 SPEECH PATHOLOGY	0. 264129				68.00
69.00	06900 ELECTROCARDI OLOGY	0. 158579				69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 342182				70.00
70.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 119291				
72.00						71.00
	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 193328				72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 131586				73.00
73.01	07301 DI ABETES CENTER	8. 110677				73.01
	07400 RENAL DIALYSIS	0. 387539				74.00
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0. 000000				76.98
~~ ~~	OUTPATIENT SERVICE COST CENTERS	0.077004				
90.00	09000 CLINIC	0. 977321				90.00
91.00	09100 EMERGENCY	0. 186626				91.00
91.01	04950 WOUND CARE	0. 632631				91.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000				92.00
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	0. 180504				92.01
	OTHER REIMBURSABLE COST CENTERS					
	09500 AMBULANCE SERVICES	0. 479542				95.00
101.00	10100 HOME HEALTH AGENCY					101.00
	SPECIAL PURPOSE COST CENTERS					
	11300 INTEREST EXPENSE					113.00
	11600 HOSPI CE					116.00
200.00	Subtotal (see instructions)					200.00
201.00	Less Observation Beds					201.00
202.00	Total (see instructions)					202.00

MPUTATION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-0109	Period: From 01/01/2020 To 12/31/2020	Worksheet C Part I Date/Time Pre	nared.
				10 12/31/2020	4/29/2021 3:5	2 pm
		Titl	e XIX	Hospi tal	Cost	
Cost Center Description	Total Cost (from Wkst. B, Part I, col.	Therapy Limit Adj.	Total Costs	Costs RCE Di sal I owance	Total Costs	
	26)			4.00	- 00	
	1.00	2.00	3.00	4.00	5.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	52,030,549		52, 030, 5	49 0	52, 030, 549	30. 0
. 00 03100 INTENSIVE CARE UNIT	8, 864, 321		8, 864, 3		8, 864, 321	
5. 00 02060 NEONATAL INTENSIVE CARE UNIT	4, 747, 326		4, 747, 3		4, 747, 326	
. 00 04100 SUBPROVIDER - IRF	4, 690, 705		4, 747, 3		4, 690, 705	
8. 00 04300 NURSERY	998, 366		998, 3		998, 366	
ANCI LLARY SERVICE COST CENTERS	770, 300		770, 3	00 0	770, 300	
0. 00 05000 OPERATING ROOM	14, 084, 991		14, 084, 9	91 0	14, 084, 991	50.0
. 00 05100 RECOVERY ROOM	1, 393, 575		1, 393, 5		1, 393, 575	
2.00 05200 DELIVERY ROOM & LABOR ROOM	5, 732, 761		5, 732, 7		5, 732, 761	
. 00 05400 RADI OLOGY-DI AGNOSTI C	12, 920, 098		12, 920, 0		12, 920, 098	
5. 00 05500 RADI OLOGY - THERAPEUTI C	967, 306		967, 3	06 0	967, 306	55.0
0. 00 05600 RADI OI SOTOPE	710, 675		710, 6	75 0	710, 675	56.0
0. 01 03950 CARDIAC CATH LAB	4, 767, 939		4, 767, 9	39 0	4, 767, 939	56. C
7. 00 05700 CT SCAN	1, 846, 703		1, 846, 7	03 0	1, 846, 703	57.0
B. 00 05800 MRI	600, 571		600, 5	71 0	600, 571	
0. 00 06000 LABORATORY	14, 178, 706		14, 178, 7		14, 178, 706	
5. 00 06500 RESPI RATORY THERAPY	4, 264, 889	0			4, 264, 889	
0. 00 06600 PHYSI CAL THERAPY	7, 027, 983	0			7, 027, 983	
2.00 06700 OCCUPATIONAL THERAPY	2, 572, 143	0	_/ =/ • · =/ ·		2, 572, 143	
B. 00 06800 SPEECH PATHOLOGY	1, 209, 169	0	.,		1, 209, 169	
0. 00 06900 ELECTROCARDI OLOGY	4, 694, 345		4, 694, 3		4, 694, 345	
0. 00 07000 ELECTROENCEPHALOGRAPHY	1, 650, 773		1, 650, 7		1, 650, 773	
. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT	14, 605, 014		14, 605, 0		14, 605, 014	
2. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	15, 138, 857		15, 138, 8		15, 138, 857	
8. 00 07300 DRUGS CHARGED TO PATIENTS	19, 004, 176		19,004,1		19, 004, 176	
B. 01 07301 DI ABETES CENTER	727, 398		727, 3		727, 398	
00 07400 RENAL DIALYSIS 9.98 07698 HYPERBARI COXYGEN THERAPY	1, 287, 509 197, 404		1, 287, 5 197, 4		1, 287, 509	
OUTPATIENT SERVICE COST CENTERS	197, 404		197, 4	04 0	197, 404	1 /0. 9
0. 00 09000 CLINIC	1, 350, 952		1, 350, 9	52 0	1, 350, 952	90.0
. 00 09100 EMERGENCY	20, 458, 956		20, 458, 9		20, 458, 956	
. 01 04950 WOUND CARE	4, 234, 275		4, 234, 2		4, 234, 275	
2. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0		1, 201, 2	0	1, 201, 270	92.0
2. 01 09201 OBSERVATION BEDS (DISTINCT PART)	2, 954, 330		2, 954, 3		2, 954, 330	
OTHER REIMBURSABLE COST CENTERS	2,701,000		2,701,0		2/ /01/000	1 / 2 / 0
5. 00 09500 AMBULANCE SERVICES	6, 249, 256		6, 249, 2	56 0	6, 249, 256	95.0
1.00 10100 HOME HEALTH AGENCY	17, 515, 628		17, 515, 6		17, 515, 628	
SPECIAL PURPOSE COST CENTERS						1
3. 00 11300 INTEREST EXPENSE						113.0
6. 00 11600 HOSPI CE	7, 528, 545		7, 528, 5		7, 528, 545	
00.00 Subtotal (see instructions)	261, 206, 194	0	261, 206, 1	94 0	261, 206, 194	200. C
1.00 Less Observation Beds	0			0	0	201.0
2.00 Total (see instructions)	261, 206, 194	0	261, 206, 1	94 0	261, 206, 194	202.0

COMPUT	ATION OF RATIO OF COSTS TO CHARGES		Provider CO		Period: From 01/01/2020 To 12/31/2020	Worksheet C Part I Date/Time Pre 4/29/2021 3:5	pared: 2 pm
				e XIX	Hospi tal	Cost	
	Cost Center Description	I npati ent	Charges Outpati ent	Total (col. (+ col. 7)	6 Cost or Other Ratio	TEFRA I npati ent Rati o	
		6.00	7.00	8.00	9.00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS	· · · · · ·					
30.00	03000 ADULTS & PEDIATRICS	70, 364, 439		70, 364, 43			30.0
31.00	03100 I NTENSI VE CARE UNI T	18, 173, 682		18, 173, 68			31.0
35.00	02060 NEONATAL INTENSIVE CARE UNIT	19, 916, 275		19, 916, 27			35.0
11.00	04100 SUBPROVI DER – I RF	5, 899, 155		5, 899, 15			41.0
13.00	04300 NURSERY	4, 765, 766		4, 765, 76	6		43.0
	ANCI LLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	80, 672, 202	75, 946, 675			0.00000	
51.00	05100 RECOVERY ROOM	4, 828, 084	7,095,420			0.00000	
52.00	05200 DELIVERY ROOM & LABOR ROOM	27, 760, 141	895, 425			0.00000	
54.00	05400 RADI OLOGY-DI AGNOSTI C	20, 636, 082	75, 135, 232	95, 771, 31		0.00000	
55.00	05500 RADI OLOGY - THERAPEUTI C	2, 916, 039	7, 985, 875			0.00000	
56.00	05600 RADI OI SOTOPE	0	0		0 0. 000000	0.00000	
56. 01	03950 CARDI AC CATH LAB	30, 650, 486	22, 561, 030			0.00000	
57.00	05700 CT SCAN	16, 623, 675	39, 410, 132	56, 033, 80		0.00000	
58.00	05800 MRI	3, 155, 435	5, 543, 873			0.00000	
60.00	06000 LABORATORY	56, 546, 341	73, 601, 179			0.000000	
5.00	06500 RESPI RATORY THERAPY	15, 856, 302	2, 758, 476			0.00000	
6.00	06600 PHYSI CAL THERAPY	8, 474, 411	13, 245, 209			0.00000	
57.00	06700 OCCUPATI ONAL THERAPY	7,072,436	6, 045, 954			0.000000	
68.00	06800 SPEECH PATHOLOGY	1, 832, 492	2, 745, 465			0.00000	
59.00	06900 ELECTROCARDI OLOGY	10, 483, 750	19, 118, 894			0.000000	
70.00	07000 ELECTROENCEPHALOGRAPHY	1,043,242	3, 781, 016			0.000000	
71.00	07100 MEDI CAL SUPPLIES CHARGED TO PATIENT	70, 672, 107	51, 759, 230			0.000000	
2.00	07200 I MPL. DEV. CHARGED TO PATIENTS	54, 839, 493	23, 467, 050			0.000000	
73.00	07300 DRUGS CHARGED TO PATIENTS	48, 801, 171	95, 622, 790			0.000000	
73.01	07301 DI ABETES CENTER	1, 190	88, 494			0.000000	
4.00	07400 RENAL DI ALYSI S	2, 475, 736	846, 532			0.000000	
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0		0 0.000000	0.000000	76. 9
0.00	OUTPATIENT SERVICE COST CENTERS		1 202 201	1 202 20	1 0 077001	0.00000	
90.00	09000 CLINIC	0	1, 382, 301	1, 382, 30		0.000000	
91.00	09100 EMERGENCY	18, 890, 967	90, 734, 329			0.000000	
91.01	04950 WOUND CARE	109, 674	6, 583, 449	6, 693, 12		0.000000	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1 702 (05		1/ 2/7 1/	0 0.000000	0.000000	
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	1, 703, 685	14, 663, 455	16, 367, 14	0 0. 180504	0. 000000	92.0
95.00	OTHER REIMBURSABLE COST CENTERS		13,031,710	13, 031, 71	0 0. 479542	0.000000	95.0
	109500 AMBULANCE SERVICES	0 21, 194				0.000000	101.0
01.00	SPECIAL PURPOSE COST CENTERS	21, 194	13, 132, 152	13, 153, 34			101.0
13 00	11300 INTEREST EXPENSE	1					113. C
	11600 HOSPI CE	0	21, 689, 262	21, 689, 26			116.0
200.00		605, 185, 652		1, 294, 056, 26			200. 0
200.00 201.00		005, 165, 052	000, 070, 009	1, 274, 000, 20			200.0
		1 1		1	1		1201.0

Heal th	Financial Systems	FRANCI SCAN HEALT	H LAFAYETTE	In Lie	u of Form CMS-	2552-10
COMPUT	ATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0109	Peri od: From 01/01/2020 To 12/31/2020	Worksheet C Part I Date/Time Pre 4/29/2021 3:5	
			Title XIX	Hospi tal	Cost	
	Cost Center Description	PPS Inpatient				
		Ratio				
		11.00				
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS					30.00
31.00	03100 I NTENSI VE CARE UNI T					31.00
35.00	02060 NEONATAL INTENSIVE CARE UNIT					35.00
41.00	04100 SUBPROVI DER – I RF					41.00
43.00	04300 NURSERY					43.00
	ANCI LLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0. 000000				50.00
51.00	05100 RECOVERY ROOM	0. 000000				51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000				52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000				54.00
55.00	05500 RADI OLOGY - THERAPEUTI C	0.000000				55.00
56.00	05600 RADI OI SOTOPE	0. 000000				56.00
56.01	03950 CARDIAC CATH LAB	0.000000				56.01
57.00	05700 CT SCAN	0.000000				57.00
58.00	05800 MRI	0. 000000				58.00
60,00	06000 LABORATORY	0.000000				60.00
65.00	06500 RESPIRATORY THERAPY	0. 000000				65.00
66.00	06600 PHYSI CAL THERAPY	0. 000000				66.00
67.00	06700 OCCUPATI ONAL THERAPY	0. 000000				67.00
68.00	06800 SPEECH PATHOLOGY	0. 000000				68.00
69.00	06900 ELECTROCARDI OLOGY	0. 000000				69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 000000				70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000				71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000				72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 000000				73.00
73.00	07301 DI ABETES CENTER	0. 000000				73.01
74.00	07400 RENAL DI ALYSI S	0. 000000				74.00
76.98	07698 HYPERBARI C OXYGEN THERAPY	0. 000000				76.98
70. 70	OUTPATIENT SERVICE COST CENTERS	0.000000				70. 70
90.00	09000 CLINIC	0.000000				90.00
91.00	09100 EMERGENCY	0. 000000				91.00
91.00	04950 WOUND CARE	0. 000000				91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000				92.00
92.00 92.01	09201 OBSERVATION BEDS (NON-DISTINCT PART 09201 OBSERVATION BEDS (DISTINCT PART)	0.000000				92.00
92.01	OTHER REIMBURSABLE COST CENTERS	0.000000				92.01
95.00	09500 AMBULANCE SERVICES	0.000000				95.00
	10100 HOME HEALTH AGENCY	0.000000				101.00
101.00						
112 00	SPECIAL PURPOSE COST CENTERS					112 00
						113.00
	11600 HOSPICE					116.00
200.00						
201.00						201.00
202.00	Total (see instructions)	1				202.00

Health Financial Systems	FRANCI SCAN HEAI	TH_LAFAYETTE		In Li€	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provider C		Period: From 01/01/2020 To 12/31/2020		pared: 2 pm
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced		Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col. 1 - col			
	26)		2)			
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS	1	-	1	1	r	
30. 00 ADULTS & PEDIATRICS	7, 770, 523		1 1110102			
31.00 INTENSIVE CARE UNIT	855, 552		855, 55			•
35.00 NEONATAL INTENSIVE CARE UNIT	506, 567		506, 56			
41. 00 SUBPROVIDER - IRF	878, 261	0	878, 26			41.00
43.00 NURSERY	23, 933		23, 93			
200.00 Total (lines 30 through 199)	10, 034, 836		10, 034, 83	6 45, 665		200.00
Cost Center Description	Inpati ent	Inpati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)	-			
	6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS	1		1			
30. 00 ADULTS & PEDIATRICS	16, 220		•			30.00
31.00 INTENSIVE CARE UNIT	1, 659	338, 187				31.00
35.00 NEONATAL INTENSIVE CARE UNIT	0	0				35.00
41.00 SUBPROVIDER - IRF	1, 621		1			41.00
43.00 NURSERY	0	0				43.00
200.00 Total (lines 30 through 199)	19, 500	4, 785, 965				200.00

Health Financial Systems	FRANCI SCAN HEAI	LTH LAFAYETTE		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT.	AL COSTS	Provider C		Period: From 01/01/2020 To 12/31/2020	4/29/2021 3:5	
			XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,	Part I, col.		. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS	- 1	-	1	- F		
50.00 05000 OPERATI NG ROOM	2, 008, 484				405, 060	
51.00 05100 RECOVERY ROOM	172, 166				34, 017	
52.00 05200 DELIVERY ROOM & LABOR ROOM	81, 348				0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 181, 767			10, 118, 520	124, 852	54.00
55. 00 05500 RADI OLOGY - THERAPEUTI C	53, 419	10, 901, 914			5, 816	55.00
56. 00 05600 RADI OI SOTOPE	30, 685	0	0.00000	0 0	0	56.00
56. 01 03950 CARDI AC CATH LAB	543, 495	53, 211, 516	0. 01021	4 11, 044, 650	112, 810	56.01
57. 00 05700 CT SCAN	123, 373	56, 033, 807	0.00220	2 7, 273, 819	16, 017	57.00
58. 00 05800 MRI	80, 132	8, 699, 308	0. 00921	1 1, 027, 820	9, 467	58.00
60. 00 06000 LABORATORY	510, 164	130, 147, 520	0. 00392	22, 860, 251	89, 612	60.00
65. 00 06500 RESPI RATORY THERAPY	214, 279	18, 614, 778	0. 01151	1 6, 102, 709	70, 248	65.00
66. 00 06600 PHYSI CAL THERAPY	209, 800	21, 719, 620	0. 00965	i9 2, 778, 516	26, 838	66.00
67.00 06700 OCCUPATI ONAL THERAPY	59, 846	13, 118, 390	0. 00456	2, 166, 873	9, 885	67.00
68.00 06800 SPEECH PATHOLOGY	32, 349	4, 577, 957	0.00706	482, 394	3, 409	68.00
69. 00 06900 ELECTROCARDI OLOGY	617, 391	29, 602, 644	0. 02085	6 4, 977, 358	103, 808	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	300, 078	4, 824, 258	0.06220	425, 254	26, 452	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	472, 667			29, 907, 439	115, 473	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	430, 423	78, 306, 543	0.00549	28, 329, 041	155, 725	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	723, 109		0.00500		91, 801	
73. 01 07301 DI ABETES CENTER	16, 448		0. 18339		105	73.01
74.00 07400 RENAL DIALYSIS	107, 970	3, 322, 268	0. 03249	1, 487, 913	48, 356	74.00
76. 98 07698 HYPERBARI C OXYGEN THERAPY	102, 677				0	76.98
OUTPATIENT SERVICE COST CENTERS	· · · ·		•			1
90. 00 09000 CLINIC	28, 216	1, 382, 301	0. 02041	2 0	0	90.00
91. 00 09100 EMERGENCY	2, 566, 397				211, 129	
91. 01 04950 WOUND CARE	926, 848				15, 150	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0		0.00000		0	
92.01 09201 OBSERVATION BEDS (DISTINCT PART)	438, 933	16, 367, 140			40, 429	
OTHER REIMBURSABLE COST CENTERS		,,		, , , , , , , , , , , , , , , , , , , ,		1
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)	12, 032, 464	1, 127, 062, 626		193, 081, 933	1, 716, 459	

Health Financial Systems	FRANCI SCAN HEAI	_TH LAFAYETTE		In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHE	R PASS THROUGH COS			Period: From 01/01/2020 To 12/31/2020	Date/Time Pre 4/29/2021 3:5	pared: 2 pm
			e XVIII	Hospi tal	PPS	
Cost Center Description	Nursing School Post-Stepdown	Nursing School	Allied Health Post-Stepdowr	Allied Health Cost	All Other Medical	
	Adjustments		Adjustments		Education Cost	
	1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS			-		•	
30. 00 03000 ADULTS & PEDIATRICS	0	4, 690, 643	5	0 0	0	00.00
31.00 03100 INTENSIVE CARE UNIT	0	0		0 0	0	31.00
35.00 02060 NEONATAL INTENSIVE CARE UNIT	0	0		0 0	0	35.00
41.00 04100 SUBPROVIDER - IRF	0	0		0 0	0	41.00
43. 00 04300 NURSERY	0	0		0 0	0	43.00
200.00 Total (lines 30 through 199)	0	4, 690, 643	5	0 0	0	200.00
Cost Center Description	Swing-Bed	Total Costs	Total Patient	Per Diem (col.	Inpati ent	
·	Adjustment	(sum of cols.	Days	5 ÷ col. 6)	Program Days	
	Amount (see	1 through 3,				
	instructions)	minus col. 4)				
	4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0	4, 690, 643	31, 57	2 148.57	16, 220	30.00
31. 00 03100 I NTENSI VE CARE UNI T		0	4, 19	7 0.00	1, 659	31.00
35.00 02060 NEONATAL INTENSIVE CARE UNIT		0	3,66	7 0.00	0	35.00
41. 00 04100 SUBPROVIDER - IRF	0	0	3, 12	4 0.00	1, 621	41.00
43.00 04300 NURSERY		0	3, 10	5 0.00	0	43.00
200.00 Total (lines 30 through 199)		4, 690, 643				200.00
Cost Center Description	I npati ent	.,,				
	Program					
	Pass-Through					
	Cost (col. 7 x					
	col. 8)					
	9.00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	2, 409, 805					30.00
31.00 03100 I NTENSI VE CARE UNI T	0					31.00
35.00 02060 NEONATAL INTENSIVE CARE UNIT	0					35.00
41.00 04100 SUBPROVIDER - IRF	0					41.00
43.00 04300 NURSERY	0					43.00
200.00 Total (lines 30 through 199)	2, 409, 805					200.00
	, , , , , , , , , , , , , , , , , , , ,	1				

Health Financial Systems	FRANCI SCAN HEAL	TH LAFAYETTE		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEI	RVICE OTHER PASS	S Provider C	CN: 15-0109	Peri od:	Worksheet D	
THROUGH COSTS				From 01/01/2020 To 12/31/2020	Part IV Date/Time Pre	nared
				10 12/31/2020	4/29/2021 3:5	2 pm
			XVIII	Hospi tal	PPS	
Cost Center Description			Nursing Scho	ol Allied Health	Allied Health	
		Post-Stepdown		Post-Stepdown		
	Cost	Adjustments		Adjustments		
	1.00	2A	2.00	3A	3.00	
ANCI LLARY SERVICE COST CENTERS		0		0		
50.00 05000 0PERATING ROOM 51.00 05100 RECOVERY ROOM	0	0		0 0	0	
	0	0		0 0	-	
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	
54. 00 05400 RADI OLOGY - DI AGNOSTI C	0	0		0 0	0	
55. 00 05500 RADI OLOGY - THERAPEUTI C	0	0		0 0	0	00.00
56. 00 05600 RADI 0I SOTOPE	0	0		0 0	0	
56. 01 03950 CARDI AC CATH LAB	0	0		0 0	0	
57.00 05700 CT SCAN	0	0		0 0	0	
58.00 05800 MRI	0	0		0 0	0	
	0	0		0 0	0	00.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0 0	0	
66. 00 06600 PHYSI CAL THERAPY	0	0		0 0	0	00.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0		0 0	0	07100
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	0	0		0 0	0	00.00
	0	0		0 0	0	
70. 00 07000 ELECTROENCEPHALOGRAPHY 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 0	0	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0		0 0	0	
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	541, 503	
73. 01 07301 DI ABETES CENTER	0	0		0 0	0 541, 503	1
74. 00 07400 RENAL DI ALYSI S	0	0		0 0	0	
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0		0 0	0	
OUTPATIENT SERVICE COST CENTERS	<u> </u>	0		0 0	0	70.70
90. 00 09000 CLINIC	0	0		0 0	0	90.00
91. 00 09100 EMERGENCY	0	0		0 0	727, 569	
91. 01 04950 WOUND CARE	0	0		0 0	0	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		õ	0	
92. 01 09201 OBSERVATION BEDS (DISTINCT PART)	0	0		0 0	0	
OTHER REIMBURSABLE COST CENTERS		0		<u> </u>	0	1,2.01
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)	0	0		0 0	1, 269, 072	
				-		

Health Financial Systems	FRANCI SCAN HEA	LTH LAFAYETTE		In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PAS	S Provider CO	CN: 15-0109	Period:	Worksheet D	
THROUGH COSTS				From 01/01/2020 To 12/31/2020		narod
				10 12/31/2020	4/29/2021 3:5	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,	to Charges	
	Education Cost	1, 2, 3, and	Cost (sum of		(col. 5 ÷ col.	
		4)	cols. 2, 3,	8)	7)	
			and 4)		(see	
					instructions)	
	4.00	5.00	6.00	7.00	8.00	
ANCI LLARY SERVI CE COST CENTERS				0 454 440 077	0.000000	50.00
50. 00 05000 OPERATING ROOM	0	0		0 156, 618, 877		
51.00 05100 RECOVERY ROOM	0	0		0 11, 923, 504		
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 28, 655, 566		
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 95, 771, 314		
55. 00 05500 RADI OLOGY - THERAPEUTI C	0	0		0 10, 901, 914		
56.00 05600 RADI OI SOTOPE	0	0		0 0	0.00000	
56. 01 03950 CARDI AC CATH LAB	0	0		0 53, 211, 516		
57. 00 05700 CT SCAN	0	0		0 56, 033, 807		
58.00 05800 MRI	0	0		0 8, 699, 308		
60. 00 06000 LABORATORY	0	0		0 130, 147, 520		•
65. 00 06500 RESPI RATORY THERAPY	0	0		0 18, 614, 778		
66.00 06600 PHYSI CAL THERAPY	0	0		0 21, 719, 620		•
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 13, 118, 390		•
68.00 06800 SPEECH PATHOLOGY	0	0		0 4, 577, 957		
69.00 06900 ELECTROCARDI OLOGY	0	0		0 29, 602, 644		
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 4, 824, 258		•
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT	0	0		0 122, 431, 337		•
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	E 44 E	0 78, 306, 543		
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	541, 503	541, 50		0.003749	
73. 01 07301 DI ABETES CENTER	0	0		0 89, 684		
74.00 07400 RENAL DIALYSIS	0	0		0 3, 322, 268		
76. 98 07698 HYPERBARI C OXYGEN THERAPY OUTPATI ENT SERVI CE COST CENTERS	0	0		0 0	0.000000	76. 98
90. 00 09000 CLINIC	0	0		0 1, 382, 301	0. 000000	90.00
	0	,	707 5/			90.00
91. 00 09100 EMERGENCY 91. 01 04950 WOUND CARE		727, 569	727, 56			
91.01 04950 WOUND CARE 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART				0 6, 693, 123 0 0	0. 000000	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92. 01 09201 OBSERVATION BEDS (DISTINCT PART)	0	-		0 16, 367, 140		
OTHER REIMBURSABLE COST CENTERS	0	0		0 10, 307, 140	0.00000	72.01
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)	0	1, 269, 072	1 269 0	2 1, 127, 062, 626		200.00
	1 0	1,207,072	1,207,01	2 1, 127, 002, 020	I	1200.00

Health Financial Systems	FRANCI SCAN HEAL			In Lie	u of Form CMS-	2552-1
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	ERVICE OTHER PASS	Provider C	CN: 15-0109	Peri od:	Worksheet D	
THROUGH COSTS				From 01/01/2020 To 12/31/2020	Part IV Date/Time Pre	nared
				10 12/31/2020	4/29/2021 3:5	2 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.	8	Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0. 000000	31, 586, 060		0 16, 107, 736		
51.00 05100 RECOVERY ROOM	0. 000000	2, 355, 945		0 1, 512, 538	0	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0 0	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	10, 118, 520		0 14, 405, 175	0	54.00
55.00 05500 RADIOLOGY - THERAPEUTIC	0. 000000	1, 186, 913		0 1, 273, 236	0	55.00
56. 00 05600 RADI OI SOTOPE	0. 000000	0		0 0	0	56.00
56. 01 03950 CARDI AC CATH LAB	0. 000000	11, 044, 650		0 7, 295, 403	0	56.0
57.00 05700 CT SCAN	0. 000000	7, 273, 819		0 9, 376, 414	0	57.00
58. 00 05800 MRI	0. 000000	1,027,820		0 1, 346, 688	0	58.00
60. 00 06000 LABORATORY	0. 000000	22, 860, 251		0 3, 994, 986	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	6, 102, 709		0 1, 079, 016		65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	2, 778, 516		0 80, 441	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000	2, 166, 873		0 21, 328	0	67.00
68.00 06800 SPEECH PATHOLOGY	0, 000000	482, 394		0 8, 713		68.00
69. 00 06900 ELECTROCARDI OLOGY	0, 000000	4, 977, 358		6, 958, 822	0	
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	425, 254		0 897, 495	-	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	29, 907, 439		0 16, 600, 628		
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000	28, 329, 041		0 10,007,350		
73. 00 07300 DRUGS CHARGED TO PATIENTS	0.003749	18, 334, 565	68, 73			
73. 01 07301 DI ABETES CENTER	0. 000000	573		0 85		
74. 00 07400 RENAL DI ALYSI S	0. 000000	1, 487, 913		0 119, 500		
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 000000	1, 407, 713		0 0		
OUTPATIENT SERVICE COST CENTERS	0.000000	0	I	0 0	0	/0. /
90. 00 09000 CLINIC	0. 000000	0		0 300, 580	0	90.00
91. 00 09100 EMERGENCY	0.006637	9, 018, 366				
91. 01 04950 WOUND CARE	0. 000000	109, 406		0 3, 614, 462	005, 201	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	109,400		0 3, 014, 402	0	
92. 01 09201 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	1, 507, 548		0 1, 734, 286	0	
OTHER REIMBURSABLE COST CENTERS	0.00000	1, 307, 340	1	1,734,200	0	72.0
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)		193, 081, 933	128, 59	91 145, 513, 628	227, 791	
	1 I	173,001,933	1 120, 3	71 140, 010, 020	221, 191	1200. U

Health Financial Systems	FRANCI SCAN HEA	LTH LAFAYETTE		In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C	CN: 15-0109	Period: From 01/01/2020 To 12/31/2020		epared: 52 pm
		Title	e XVIII	Hospi tal	PPS	•
			Charges		Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed		Cost	PPS Services	
	Ratio From	Services (see	Reimbursed	Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins	. Ded. & Coins.		
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS	_					
50.00 05000 OPERATING ROOM	0. 089932	16, 107, 736		0 0	1, 448, 601	50.00
51.00 05100 RECOVERY ROOM	0. 116876	1, 512, 538		0 0	176, 779	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 200058	0		0 0	0	52.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 134906	14, 405, 175		0 0	1, 943, 345	54.00
55. 00 05500 RADI OLOGY – THERAPEUTI C	0. 088728	1, 273, 236		0 0	112, 972	55.00
56. 00 05600 RADI OI SOTOPE	0. 000000	0		0 0	c c	56.00
56. 01 03950 CARDI AC CATH LAB	0. 089604	7, 295, 403		0 0	653, 697	56.01
57.00 05700 CT SCAN	0. 032957			0 0	309, 018	
58.00 05800 MRI	0.069037			0 0	92, 971	
60. 00 06000 LABORATORY	0. 108943			0 0	435, 226	
65. 00 06500 RESPI RATORY THERAPY	0. 229113			0 0	247, 217	
66.00 06600 PHYSI CAL THERAPY	0. 323578			0 0	26, 029	1
67.00 06700 OCCUPATI ONAL THERAPY	0, 196072			0 0	4, 182	
68.00 06800 SPEECH PATHOLOGY	0. 264129			0 0		
69. 00 06900 ELECTROCARDI OLOGY	0. 158579	6, 958, 822		0 0		
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 342182			0 0		
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 119291			0 0		
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0. 193328			0 0		
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 131586					
73. 01 07301 DI ABETES CENTER	8. 110677			0 0		
74. 00 07400 RENAL DI ALYSI S	0. 387539			0 0		1
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 000000			0 0		
OUTPATIENT SERVICE COST CENTERS	0100000	1 0	1	0		
90. 00 09000 CLINIC	0. 977321	300, 580		0 0	293, 763	90.00
91. 00 09100 EMERGENCY	0. 186626			0 0		1
91. 01 04950 WOUND CARE	0. 632631			0 0	_,,	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000			0 0	1 1 -	1
92. 01 09201 OBSERVATION BEDS (NON DISTINCT PART)	0. 180504			0 0		
OTHER REIMBURSABLE COST CENTERS	0. 100304	1,754,200		0 0	515, 040	72.01
95. 00 09500 AMBULANCE SERVICES	0. 479542			0		95.00
200.00 Subtotal (see instructions)	0. 479342	145, 513, 628	34, 82		20, 993, 091	
201.00 Less PBP Clinic Lab. Services-Program		140, 010, 020	34, 02	0 0		200.00
Only Charges						201.00
202.00 Net Charges (line 200 - line 201)		145, 513, 628	34, 82	22 0	20, 993, 091	202 00
	1	1 140, 010, 020	1 54, 02		20, 775, 071	1202.00

51:00 DS100 RECOVERY ROOM 0 0 52:00 DS200 DELIVERY ROOM & LABOR ROOM 0 0 52:00 DS200 DELIVERY ROOM & LABOR ROOM 0 0 54:00 DS400 RADIOLOGY - DIAGNOSTI C 0 0 55:00 DS500 RADIOLOGY - THERAPEUTI C 0 0 56:00 DS500 RADIOLOGY - THERAPEUTI C 0 0 56:00 DS500 RADIOLOGY - THERAPEUTI C 0 0 56:00 DS500 RADI AC CATH LAB 0 0 57:00 DS500 RADIA TARY 0 0 58:00 DS600 MRITORY 0 0 50:00 DS600 RSPI RATORY THERAPY 0 0 60:00 D6600 PASTORY THERAPY 0 0 61:00 D6600 RSPI RATORY THERAPY 0 0 66:00 D6600 SPECH PATHOLOGY 0 0 69:00 D6600 SPECH PATHOLOGY 0 0 71:00 DTOOL MEL DECK DERPALADGRAPHY 0	Health Financial Systems	FRANCI SCAN HEAL	TH LAFAYETTE		In Lie	u of Form CMS	-2552-10
Cost Center Description Cost Cost Center Description Cost Center Description <thcenter description<="" th=""> <thcenter descripti<="" td=""><td>APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND</td><td>) VACCINE COST</td><td>Provider CO</td><td>CN: 15-0109</td><td>From 01/01/2020</td><td>Part V Date/Time Pr</td><td>epared: 52 pm</td></thcenter></thcenter>	APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND) VACCINE COST	Provider CO	CN: 15-0109	From 01/01/2020	Part V Date/Time Pr	epared: 52 pm
Cost Center Description Cost Reimbursed Services Subject To Ded. & Coins. Cost Reimbursed Services Subject To Ded. & Coins. Cost Services Subject To Ded. & Coins. 50.00 05000 (PERATING ROOM 0 50.00			Title	XVIII	Hospi tal		
Reimbursed Subject To Ded: & Coins. (see inst.) Reimbursed Subject To Ded: & Coins. (see inst.) Reimbursed Subject To Ded: & Coins. (see inst.) 50.00 OSD00(PERATING ROM) 0 0 50.00 51.00 OSD00(PERATING ROM) 0 0 50.00 52.00 OSD00(PERATING ROM) 0 0 50.00 52.00 OSD00(PERATING ROM) 0 0 50.00 52.00 OSD00(PERATING ROM) 0 0 0 50.00 52.00 OSD00(PELVIEW ROM) & LABOR ROOM 0 0 0 52.20 52.00 OSD0 (RADI OLGGY - DI AGNOSTI C 0 0 0 55.61 53.00 OSD0 (RADI OLGGY - DI AGNOSTI C 0 0 0 55.61 54.00 OSD0 (RADI OLGGY - DI AGNOSTI C 0 0 0 55.61 55.00 OSD0 (RADI OLGGY - DI AGNOSTI C 0 0 0 56.61 56.01 OSB00 (RADI OLGGY - DI AGNOSTI C 0 0 0 56.61 56.61 56.61 56.61 56.61		Cos	sts				
Services Services Services Services Subject To Ded & Coins. (see inst.) Services	Cost Center Description	Cost	Cost				
Subject To Subject							
Ded. & Coin s. (see inst.) Ded. & Coin s. (see inst.) 50.00 05000 0FERATING ROOM 0 0 51.00 05100 RECOVERY ROOM 0 0 51.00 50.00 05100 RECOVERY ROOM 0 0 51.00 51.00 52.00 05200 DEL VERY ROOM & LABOR ROOM 0 0 52.10 54.00 05400 RADI LOGY - THERAPEUTIC 0 0 55.10 56.00 05600 RADI LOGY - THERAPEUTIC 0 0 55.60 56.00 05600 RADI NOSTOPE 0 0 56.56.00							
(see inst.) (see inst.) ANCILLARY SERVICE COST CENTERS 6.00 7.00 50.00 05000 (OPERATI NG ROOM 0 0 50.00 50.01 51.00 DSTOD (RECOVERY ROOM 0 0 51.00 51.00 50.01 50.01 50.01 50.01 50.01 50.01 50.01 50.01 50.01 50.01 51.01 50.01 50.01 50.01 50.01 51.01 51.01 52.00 52.00 52.00 55.00 60.01 54.1 55.00 55.00 56.00 57.00 50.00 56.00 56.00<			2				
ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 0 51.00 05100 RECOVERY ROOM 0 0 51.20 52.00 05200 DELIVERY ROOM 0 0 51.20 52.00 05200 DELIVERY ROOM 0 0 51.20 52.00 05200 DELIVERY ROOM 0 0 52.20 54.00 05400 RADIOLOGY-DIAGNOSTIC 0 0 55.50 50.00 05600 RADIOLOGY-THERAPEUTIC 0 0 55.50 55.00 05600 RADIOLOGY-THERAPEUTIC 0 0 56.57.00 05700 CT SCAN 0 0 56.00 05600 RADIALOGO CATH LAB 0 0 65.66.77.00 66.00							
ANCI LLARY SERVICE COST CENTERS Image: Cost Centers Solution							
50.00 05000 0FERATING ROOM 0 0 51.00 05100 05100 05100 05100 51 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 52 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 52 54.00 05400 RADI OLGOY-DI AGNOSTI C 0 0 0 55.00 05500 RADI OLGOY - THERAPEUTI C 0 0 0 56.00 05600 RADI OLSOTOPE 0 0 0 56 57.00 05700 CT SCAN 0 0 0 57 58.00 05800 MRI 0 0 0 60 66.00 06600 PHYSI CAL THERAPY 0 0 66 66 67.00 05700 OC CUPATI ONAL THERAPY 0 0 67 68 69.00 06900 SPECH PHOLOGY 0 0 68 69 0 69000 690 70 71 70 71		6.00	7.00				
51.00 05100 RECOVERY ROM 0 51.00 Status 51.00 Status 52.00 05200 DELIVERY ROM & LABOR ROM 0 0 52.00 54.00 55.00 Status 54.00 55.00 Status 54.00 55.00 Status 55.00 0 0 0 55.00 0 55.00 0 0 0 0 0 55.00 0 55.00 0 0 0 0 0 0 55.00 56.00 0 0 0 0 0 57.00 56.00 0 56.00 0 58.00 58.00 65.00 0 0 0 0 0 0 58.00 58.00 65.00 65.00 65.00 65.00 65.00 65.00 65.00 65.00 65.00 65.00 65.00 65.00 65.00 65.00 65.00 65.00 65.00 66.00 69.00 67.00 67.00 67.00 67.00 67.00 67.00 67.0		1		1			_
52.00 05200 DELIVERY ROM & LABOR ROOM 0 52. 54.00 05400 RADIOLOGY - THERAPEUTIC 0 0 55.00 05500 RADIOLOGY - THERAPEUTIC 0 0 56.01 05500 CARDIOLOGY - THERAPEUTIC 0 0 57.00 05700 CT SCAN 0 0 57.00 05700 CT SCAN 0 0 58.00 06500 RABIOLOGY - THERAPEUTIC 0 0 59.01 05700 CT SCAN 0 0 50.01 05000 LABORATORY 0 0 60.01 06000 LABORATORY 0 0 61.01 06700 OCUPATIONAL THERAPY 0 0 62.00 06000 SPECH PATHOLOGY 0 0 63.00 06000 SPECH PATHOLOGY 0 0 64.00 06000 SPECH PATHOLOGY 0 0 71.00 07000 ELECTROCARDIOLOGY 0 0 72.00 07200 INPL. DEV. CHARGED TO PATIENTS 0 0 73.01 07301 DI ABETES CENTER 0 0 72. 74.00 07200 INPL. DEV. CHARGED TO PATIENTS <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>50.00</td>							50.00
54.00 05400 RADIOLOGY-DIAGNOSTIC 0 54. 55.00 05500 RADIOLOGY - THERAPEUTIC 0 0 56.00 05600 RADIOLOGY - THERAPEUTIC 0 0 56.00 05500 RADIOLOGY - THERAPEUTIC 0 0 57.00 05700 RADIOLOGY - THERAPEUTIC 0 0 58.00 05500 RADIOLOGY - THERAPEUTIC 0 0 57.00 05700 CT SCAN 0 0 60.00 05800 MRI 0 0 60. 65.00 06500 RESPIRATORY THERAPY 0 0 60. 65.00 06600 PHYSICAL THERAPY 0 0 66. 66.00 06600 SPECH PATHOLOGY 0 0 68. 69.00 06700 CUPATIONAL THERAPY 0 0 68. 69.00 07000 ELECTROCARDIOLOGY 0 0 70. 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 72. 73. 73.01 07301 DIABETES CENTER<		0					51.00
55.00 V5500 RADI OLOGY - THERAPEUTI C 0 0 55. 56.00 V5600 RADI OLOGY - THERAPEUTI C 0 0 55. 56.00 V5600 RADI OLOGY - THERAPEUTI C 0 0 55. 56.01 V350 CARDI AC CATH LAB 0 0 55. 58.00 V500 CT SCAN 0 0 56. 60.00 O6000 LABORATORY 0 0 60. 60.00 O6000 LABORATORY 0 0 60. 65.00 V6000 LECTROLAT THERAPY 0 0 66. 66.00 O6000 SPECH PATHONCY THERAPY 0 0 67. 69.00 O6900 ELECTROCARDI OLOGY 0 0 0 69. 71.00 O7000 ELECTROCARDI OLOGY 0 0 0 72. 73.00 V7000 INPL. DEV. CHARGED TO PATI ENTS 4, 582 0 73. 74.00 V9000 DUTPATI		0	-				52.00
56.00 05600 RADI 0I SOTOPE 0 0 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 57.00 56.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 <t< td=""><td></td><td>0</td><td>0</td><td></td><td></td><td></td><td>54.00</td></t<>		0	0				54.00
56. 01 03950 CARDI AC CATH LAB 0 0 55. 57. 00 05700 CT SCAN 0 0 60. 00 06000 LABORATORY 0 0 60. 00 06000 LABORATORY 0 0 60. 00 06000 RESPI RATORY THERAPY 0 0 61. 00 06000 PHYSI CAL THERAPY 0 0 62. 00 06500 SPECH PATHOLOGY 0 0 63. 00 06400 SPECH PATHOLOGY 0 0 64. 00 06400 SPECH PATHOLOGY 0 0 70. 00 0000 ELECTROEARDI LOGY 0 0 71. 00 07000 ELECTROEARD TO PATI ENTS 0 0 73. 01 07300 DRUGS CHARGED TO PATI ENTS 0 0 73. 01 07300 DRUGS CHARGED TO PATI ENTS 4, 582 0 73. 73. 01 07300 DRUGS CHARGED TO PATI ENTS 0 0 74. 74.00 07400 RENTER 0 0 74. 7598<		0	0				55.00
57.00 05700 CT SCAN 0 0 57. 58.00 05800 MRI 0 0 58. 60.00 06000 LABORATORY 0 0 65. 65.00 06500 RESPI RATORY THERAPY 0 0 65. 66.00 0600 PHYSI CAL THERAPY 0 0 66. 67.00 06700 0CUPATI ONAL THERAPY 0 0 67. 68.00 06400 PEECH PATHOLOGY 0 0 68. 09.00 ELECTROCARDIOLOGY 0 0 68. 07.00 ELECTROENCEPHALOGRAPHY 0 0 71. 07.00 OTOO ELECTROENCEPHALOGRAPHY 0 0 71. 07.00 IMPL. DEV. CHARGED TO PATI ENTS 0 0 72. 73. 73.0 73.0 73.0 73.0 73.0 73.0 73.0 73.0 73.0 73.0 73. 74.0 74.0 74.0 74.0 74.0 74.0 74.0 74.0 74.0 74.0 74.0 74.0 74.0 <td></td> <td>0</td> <td>0</td> <td></td> <td></td> <td></td> <td>56.00</td>		0	0				56.00
58.00 05800 MRI 0 0 68.00 66.00 69.00 69.00 69.00 69.00 69.00 69.00 69.00 69.00 69.00 69.00 69.00 69.00 70.00 71.1 71.1 71.1 72.0 73.01 73.01 73.01 73.01 73.01 73.01 73.01 74.1 58.2 0 73.01 74.1 74.1 74.1 7	56. 01 03950 CARDI AC CATH LAB	0	0				56.01
60.00 06000 LABORATORY 0 0 60.00 65.00 06500 RESPI RATORY THERAPY 0 0 65.00 67.00 06000 PHYSI CAL THERAPY 0 0 66.00 67.00 06700 0CCUPATI ONAL THERAPY 0 0 66.00 68.00 06800 SPEECH PATHOLOGY 0 0 68.00 69.00 06000 ELECTROCARDIOLOGY 0 0 69.00 00 69.00 00 69.00 00 69.00 00 69.00 00 69.00 69.00 00 69.00 70.01 71.00 71.00 71.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 74.00 00	57.00 05700 CT SCAN	0	0				57.00
65.00 06500 RESPI RATORY THERAPY 0 0 65.00 66.00 68.00 69.00 68.00 69.00 68.00 69.00 69.00 69.00 69.00 69.00 69.00 69.00 69.00 69.00 69.00 69.00 69.00 69.00 69.00 69.00 69.00 69.00 69.00 69.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 71.00 70.00 71.00 70.00 71.00 70.00 71.00 72.01 73.01 73.01 73.01 73.01 73.01 73.01 73.01 73.01 73.01 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00	58. 00 05800 MRI	0	0				58.00
66.00 06600 PHYSI CAL THERAPY 0 0 66. 67.00 06700 0CCUPATI ONAL THERAPY 0 0 67. 68.00 0SPECH PATHOLOGY 0 0 68. 69.00 0SPECH PATHOLOGY 0 0 68. 70.00 07000 ELECTROCARDI OLOGY 0 0 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0 0 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 73.00 07300 DRUGS CHARGED TO PATIENTS 4,582 0 73. 73.01 07301 DI ABETES CENTER 0 0 73. 74.00 07400 RENAL DI ALYSI S 0 0 74. 74.00 09000 CLINIC 0 0 90. 91.01 04870 WOND CARE 0 0 91. 90.00 09000 CLINIC 0 0 91. 92.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0 0 92. 92.01	60. 00 06000 LABORATORY	0	0				60.00
67.00 06700 OCCUPATIONAL THERAPY 0 0 67. 68.00 06800 SPEECH PATHOLOGY 0 0 68. 69.00 06900 ELECTROENCEPHALOGRAPHY 0 0 69. 70.00 O7000 ELECTROENCEPHALOGRAPHY 0 0 70. 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0 0 71. 72.00 072001 INEL DEV. CHARGED TO PATIENTS 0 0 73. 73.00 07301 DI ABETES CENTER 0 0 73. 74.00 07400 RENAL DI ALYSI S 0 0 74. 76.98 074098 RENAL DI ALYSI S 0 0 74. 76.90 09000 CLI NI C 0 0 90. 91.00 09100 EMERGENCY 0 0 91. 91.00 09100 EMERGENCY 0 0 91. 92.01 092010 OBSERVATION BEDS (NON-DI STINCT PART 0 0 92. 92.01 092010 092010 MBUSABLE COST CEN	65. 00 06500 RESPI RATORY THERAPY	0	0				65.00
68.00 06800 SPEECH PATHOLOGY 0 0 68. 69.00 06900 ELECTROCARDI OLOGY 0 0 69. 70.00 OZOO ELECTROCARDI OLOGY 0 0 70. 70.00 OZOO ELECTROCARDI OLOGY 0 0 70. 71.00 OZOO IMPL. DEV. CHARGED TO PATI ENT 0 0 71. 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 72. 73.00 07301 DI ABETES CENTER 0 0 73. 74.00 07409 RENAL DI ALYSIS 0 0 74. 76.98 OT698 HYPERBARI C OXYGEN THERAPY 0 0 74. 76.90 09000 CLI N C 0 0 90. 91.00 09000 CLI N C 0 0 91. 91.01 04950 WOUND CARE 0 0 91. 92.01 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0 0 92. 92.01 09200 OBSERVATI ON BEDS (NON-DI STI NCT PA	66. 00 06600 PHYSI CAL THERAPY	0	0				66.00
69.00 06900 ELECTROCARDIOLOGY 0 0 69.00 70.00 71.00 70.00 71.00 70.00 71.00 72.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 74.00 74.74.00 74.74.74.74.74.74.74.74.74.74.74.74.74.7	67.00 06700 OCCUPATIONAL THERAPY	0	0				67.00
70.00 07000 ELECTROENCEPHALOGRAPHY 0 0 70. 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 71. 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 73. 73.00 07300 DRUGS CHARGED TO PATIENTS 4,582 0 73. 74.00 07400 RENAL DIALYSIS 0 0 73. 74.00 07400 RENAL DIALYSIS 0 0 74. 90.00 07608 HYPERBARIC OXYGEN THERAPY 0 0 74. 90.00 09000 CLINIC 0 0 90. 91.00 09100 EMERGENCY 0 0 91. 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 0 91. 92.01 085ERVATION BEDS (DISTINCT PART) 0 0 92. 92. 95.00 09500 AMBULANCE SERVICES 0 200. 200. 200. 201.00 Subtotal (see instructions) 4,582 0 200. 200. 201.	68.00 06800 SPEECH PATHOLOGY	0	0				68.00
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 71. 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 72. 73.00 07300 DRUGS CHARGED TO PATI ENTS 4,582 0 73. 73.01 D7301 DI ABETES CENTER 0 0 73. 74.00 07400 RENAL DI ALYSI S 0 0 74. 0.00 07400 RENAL DI ALYSI S 0 0 74. 0.00 07400 RENAL DI ALYSI S 0 0 74. 0.00 07400 RENAL DI ALYSI S 0 0 74. 0.00 07400 RENAL DI ALYSI S 0 0 74. 0.00 07400 RENAL DI ALYSI S 0 0 74. 0.00 07400 RENAL DI ALYSI S 0 0 74. 0.00 09000 CLI NI C 0 0 90. 90. 91.01 04950 WOND CARE 0 0 91. 92.00 085ERVATI ON BEDS (DI STI NCT PART 0	69. 00 06900 ELECTROCARDI OLOGY	0	0				69.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 72. 73.00 07300 DRUGS CHARGED TO PATIENTS 4,582 0 73. 73.01 07301 DLABETES CENTER 0 0 73. 74.00 O7400 RENAL DLALYSIS 0 0 74. 76.98 O7698 HYPERBARI C OXYGEN THERAPY 0 0 74. 90.00 OUTPATIENT SERVICE COST CENTERS 0 0 74. 90.00 OP000 CLINIC 0 0 90. 91.00 09000 CLINIC 0 0 91. 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 0 91. 92.01 09201 OBSERVATION BEDS (DISTINCT PART) 0 0 92. 92.01 09201 OBSERVATION BEDS (DISTINCT PART) 0 0 92. 92.01 09201 OBSERVATION BEDS (DISTINCT PART) 0 0 92. 92.01 09200 ABBULANCE SERVICES 0 95. 95. 200.00 Subtotal (see in	70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0				70.00
73.00 07300 DRUGS CHARGED TO PATIENTS 4,582 0 73. 73.01 07301 DLABETES CENTER 0 0 73. 74.00 07400 RENAL DLALYSIS 0 0 74. 76.98 07698 HYPERBARIC OXYGEN THERAPY 0 0 74. 76.98 07698 HYPERBARIC OXYGEN THERAPY 0 0 76. 0UTPATIENT SERVICE COST CENTERS 0 0 0 90. 90.00 09000 CLINIC 0 0 91. 91.00 09100 EMERGENCY 0 0 91. 91.01 04950 WOUND CARE 0 0 91. 92.00 09200 OBSERVATION BEDS (NON-DI STINCT PART 0 0 92. 92.01 09201 OBSERVATION BEDS (DI STINCT PART) 0 0 92. 92.01 092050 AMBULANCE SERVICES 0 95. 95. 920.00 Subtotal (see instructions) 4, 582 0 200. 200. 921.00 Less PBP Clinic Lab. Services-Program Onl	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0				71.00
73.01 07301 DI ABETES CENTER 0 0 73. 74.00 07400 RENAL DI ALYSI S 0 0 74. 76.98 07698 HYPERBARI C 0XYGEN THERAPY 0 0 76. 0UTPATI ENT SERVICE COST CENTERS 0 0 0 76. 90.00 09000 CLI NI C 0 0 90. 91.00 09100 EMERGENCY 0 0 91. 91.01 04950 WOUND CARE 0 0 91. 92.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0 0 92. 92.01 09201 0BSERVATI ON BEDS (DI STI NCT PART) 0 0 92. 92.01 092020 OBSERVATI ON BEDS (DI STI NCT PART) 0 0 92. 92.01 09204 OBSERVATI ON BEDS (DI STI NCT PART) 0 0 92. 92.01 092050 AMBULANCE SERVICES 0 95. 95. 920.00 Subtotal (see instructions) 4, 582 0 200. 921.01 Unity Charges 0 <td>72.00 07200 IMPL. DEV. CHARGED TO PATIENTS</td> <td>0</td> <td>0</td> <td></td> <td></td> <td></td> <td>72.00</td>	72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0				72.00
74.00 07400 RENAL DI ALYSI S 0 0 74. 76.98 07698 HYPERBARI C 0XYGEN THERAPY 0 0 76. 0UTPATI ENT SERVICE COST CENTERS 0 0 0 76. 90.00 09000 CLI NI C 0 0 90. 91.00 09100 EMERGENCY 0 0 91. 92.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0 0 91. 92.01 09201 OBSERVATI ON BEDS (DI STI NCT PART 0 0 92. 92.01 092020 OBSERVATI ON BEDS (DI STI NCT PART) 0 0 92. 92.01 09201 OBSERVATI ON BEDS (DI STI NCT PART) 0 0 92. 92.01 092020 OBSERVATI ON BEDS (DI STI NCT PART) 0 0 92. 01 019201 OBSERVATI ON BEDS (DI STI NCT PART) 0 0 92. 01 019203 OBSERVATI ON BEDS (DI STI NCT PART) 0 0 92. 01 019204 Subtotal (see instructions) 4, 582 0 200.	73.00 07300 DRUGS CHARGED TO PATIENTS	4, 582	0				73.00
76.98 07698 HYPERBARI C 0XYGEN THERAPY 0 0 76. 0UTPATI ENT SERVICE COST CENTERS 0 0 0 90. 0 90.00 CLINIC 0 90. 90. 91. 91. 91.01 04950 WOUND CARE 0 0 91. 92.00 09SERVATI ON BEDS (NON-DI STINCT PART 0 0 92. 92.01 09201 0BSERVATI ON BEDS (DI STINCT PART 0 0 92. 92. 92.01 09201 0BSERVATI ON BEDS (DI STINCT PART) 0 0 92. 93.	73. 01 07301 DI ABETES CENTER	0	0				73.01
OUTPATIENT SERVICE COST CENTERS 0 0 0 90. 90.00 09000 CLINIC 0 0 0 90. 90. 90.00 09100 EMERGENCY 0 0 91. 91. 91.01 04950 WOUND CARE 0 0 0 91. 92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART 0 0 91. 92. 92.01 09201 0BSERVATION BEDS (DISTINCT PART) 0 0 92. 92. 0 00 92. 92. 0 0 92. 92. 92.01 09201 0BSERVATION BEDS (DISTINCT PART) 0 0 92. 95.	74.00 07400 RENAL DIALYSIS	0	0				74.00
90.00 09000 CLINIC 0 0 90. 91.00 09100 EMERGENCY 0 0 91. 91.01 04950 WOUND CARE 0 0 91. 92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART 0 0 91. 92.01 09201 0BSERVATION BEDS (DISTINCT PART) 0 0 92. 0 0 0 0 0 92. 0 0 0 0 92. 92. 0 0 0 0 92. 0 0 0 92. 92. 0 0 0 0 92. 0 0 0 92. 92. 0 0 0 92. 92. 0 0 0 95. 95. 00 09500 AMBULANCE SERVICES 0 200. 201.00 Less PBP Clinic Lab. Services-Program 0 201. <td>76. 98 07698 HYPERBARI C OXYGEN THERAPY</td> <td>0</td> <td>0</td> <td></td> <td></td> <td></td> <td>76.98</td>	76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0				76.98
91.00 09100 EMERGENCY 0 0 91. 91.01 04950 WOUND CARE 0 0 91. 92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 0 0 92. 92.01 09201 0BSERVATION BEDS (DISTINCT PART) 0 0 92. 01.00 09200 0BSERVATION BEDS (DISTINCT PART) 0 0 92. 01.00 09500 AMBULANCE SERVICES 92. 92. 95. 0 95. 020.00 Subtotal (see instructions) 4,582 0 95. 200. 200. 00.1 Less PBP Clinic Lab. Services-Program Only Charges 0 201.	OUTPATIENT SERVICE COST CENTERS	· · · · · · · · · · · · · · · · · · ·					
91.01 04950 WOUND CARE 0 0 91. 92.00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART) 0 0 92. 92.01 09201 0BSERVATI ON BEDS (DI STI NCT PART) 0 0 92. 01.01 09201 0BSERVATI ON BEDS (DI STI NCT PART) 0 0 92. 01.02 01.02 09500 AMBULANCE SERVICES 92. 92. 01.00 Subtotal (see instructions) 4,582 0 200. 200. 201.00 Less PBP Clinic Lab. Services-Program Only Charges 0 201. 201. 201.	90. 00 09000 CLI NI C	0	0				90.00
92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 0 0 92. 92.01 09201 0BSERVATION BEDS (DISTINCT PART) 0 0 92. 01 0000 0000 0000 0000 92. 01 0000 0000 0000 92. 92. 01 00000 00000 00000 92. 92. 01000 000000 Subtotal (see instructions) 4,582 0 200. 001 Less PBP Clinic Lab. Services-Program 0 201. 201. 201.	91. 00 09100 EMERGENCY	0	0				91.00
92.01092010BSERVATI ON BEDS (DI STINCT PART)0092.OTHER REIMBURSABLE COST CENTERS95.0009500AMBULANCE SERVICES095.200.00Subtotal (see instructions)4,5820200.201.00Less PBP Clinic Lab. Services-Program0201.0nl y Charges0201.0201.	91.01 04950 WOUND CARE	0	0				91.01
92.01092010BSERVATI ON BEDS (DI STINCT PART)0092.OTHER REIMBURSABLE COST CENTERS95.0009500AMBULANCE SERVICES095.200.00Subtotal (see instructions)4,5820200.201.00Less PBP Clinic Lab. Services-Program0201.0nl y Charges0201.0201.	92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0				92.00
0THER REI MBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0 95. 200.00 Subtotal (see instructions) 4, 582 0 200. 201.00 Less PBP Clinic Lab. Services-Program 0 201. 201.		0	0				92.01
95.00 09500 AMBULANCE SERVICES 0 95. 200.00 Subtotal (see instructions) 4,582 0 200. 201.00 Less PBP Clinic Lab. Services-Program 0 201. 0 201.							
200. 00Subtotal (see instructions)4,5820200.201. 00Less PBP Clinic Lab. Services-Program00201.0nl y Charges000201.		0					95.00
201.00 Less PBP Clinic Lab. Services-Program 0 201. Only Charges 0 201.	200.00 Subtotal (see instructions)	4, 582	0				200.00
Only Charges							201.00
	5						
202. υσμ μινει υπαιχθες (THR 200 - THR 201) [4, 3δ2] U[[202.	202.00 Net Charges (line 200 - line 201)	4, 582	0				202.00

Health Financial Systems	FRANCI SCAN HEAL	TH LAFAYETTE		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provider C	CN: 15-0109	Period:	Worksheet D	
		Component	CCN: 15-T109	From 01/01/2020 To 12/31/2020	Part II Date/Time Pre	norod.
		component	CIN: 12-1104	10 12/31/2020	4/29/2021 3:5	
		Title	XVIII	Subprovider -	PPS	
				' I RF		
Cost Center Description	Capi tal	Total Charges			Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,	Part I, col.		. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	2, 008, 484				464	
51.00 O5100 RECOVERY ROOM	172, 166				90	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	81, 348				0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 181, 767				777	54.00
55. 00 05500 RADI OLOGY - THERAPEUTI C	53, 419	10, 901, 914			211	55.00
56. 00 05600 RADI OI SOTOPE	30, 685				0	56.00
56. 01 03950 CARDI AC CATH LAB	543, 495				0	56.01
57.00 05700 CT SCAN	123, 373				216	
58. 00 05800 MRI	80, 132	8, 699, 308	0.0092		125	58.00
60. 00 06000 LABORATORY	510, 164	130, 147, 520	0.00393	20 481, 833	1, 889	60.00
65. 00 06500 RESPI RATORY THERAPY	214, 279	18, 614, 778	0. 0115		2, 321	65.00
66. 00 06600 PHYSI CAL THERAPY	209, 800	21, 719, 620	0.0096	59 1, 417, 901	13, 696	66.00
67.00 06700 OCCUPATI ONAL THERAPY	59, 846	13, 118, 390	0.0045	52 1, 336, 467	6, 097	67.00
68.00 06800 SPEECH PATHOLOGY	32, 349	4, 577, 957	0.0070	56 361, 633	2, 555	68.00
69. 00 06900 ELECTROCARDI OLOGY	617, 391	29, 602, 644	0. 0208	56 20, 088	419	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	300, 078	4, 824, 258	0.06220	2, 120	132	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	472, 667	122, 431, 337	0.0038	51 391, 869	1, 513	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	430, 423	78, 306, 543	0.0054	97 3, 726	20	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	723, 109	144, 423, 961	0.0050	348, 360	1, 744	73.00
73. 01 07301 DI ABETES CENTER	16, 448	89, 684	0. 1833	99 0	0	73.01
74. 00 07400 RENAL DI ALYSI S	107, 970	3, 322, 268	0. 0324	99 52, 258	1, 698	74.00
76. 98 07698 HYPERBARI C OXYGEN THERAPY	102, 677	0	0.0000	0 00	0	76.98
OUTPATIENT SERVICE COST CENTERS						1
90. 00 09000 CLINIC	28, 216	1, 382, 301	0. 0204	12 0	0	90.00
91.00 09100 EMERGENCY	2, 566, 397	109, 625, 296	0. 0234	11 24, 000	562	91.00
91.01 04950 WOUND CARE	926, 848	6, 693, 123	0. 1384	78 0	0	91.01
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0.0000	0 00	0	92.00
92.01 09201 OBSERVATION BEDS (DISTINCT PART)	438, 933	16, 367, 140	0. 0268 [.]	18 176	5	92.01
OTHER REI MBURSABLE COST CENTERS	·					1
95.00 09500 AMBULANCE SERVICES						95.00

Health Financial Systems	FRANCI SCAN HEALT	TH LAFAYETTE		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PASS	Provider C	CN: 15-0109	Peri od:	Worksheet D	
THROUGH COSTS			00N 45 7400	From 01/01/2020	Part IV	
		Component	CCN: 15-T109	To 12/31/2020	Date/Time Pre 4/29/2021 3:5	
		Title	e XVIII	Subprovider -	PPS	2 pm
		in the		IRF	110	
Cost Center Description			Nursing Scho	ol Allied Health	Allied Health	
		Post-Stepdown		Post-Stepdown		
		Adjustments		Adjustments		
	1.00	2A	2.00	3A	3.00	
ANCI LLARY SERVI CE COST CENTERS			1			
50. 00 05000 OPERATI NG ROOM	0	0		0 0	0	
51.00 05100 RECOVERY ROOM	0	0		0 0	0	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	54.00
55. 00 05500 RADI OLOGY – THERAPEUTI C	0	C		0 0	0	55.00
56. 00 05600 RADI OI SOTOPE	0	C		0 0	0	56.00
56. 01 03950 CARDI AC CATH LAB	0	C)	0 0	0	56.01
57.00 05700 CT SCAN	0	C)	0 0	0	57.00
58. 00 05800 MRI	0	0)	0 0	0	58.00
60. 00 06000 LABORATORY	0	0		0 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	C		0 0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	C)	0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	C		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	C)	0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	C)	0 0	541, 503	73.00
73. 01 07301 DI ABETES CENTER	0	C)	0 0	0	73.01
74.00 07400 RENAL DIALYSIS	0	C		0 0	0	74.00
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	C)	0 0	0	76.98
OUTPATIENT SERVICE COST CENTERS	· · ·			- I		1
90. 00 09000 CLINIC	0	C		0 0	0	90.00
91. 00 09100 EMERGENCY	0	0		0 0	727, 569	
91. 01 04950 WOUND CARE	0	0		0 0	0	1
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	-		0	0	
92.01 09201 OBSERVATION BEDS (DISTINCT PART)	0	C		0 0	0	•
OTHER REI MBURSABLE COST CENTERS	· -	-				1
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)	0	C		0 0	1, 269, 072	200.00
	-1			-		

Health Financial Systems	FRANCI SCAN HEAI	LTH LAFAYETTE		In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PASS	S Provider C	CN: 15-0109	Peri od:	Worksheet D	
THROUGH COSTS				From 01/01/2020		
		Component	CCN: 15-T109	To 12/31/2020	Date/Time Pre 4/29/2021 3:5	epared:
		Title	XVIII	Subprovider -	472972021 3.3 PPS	iz pili
		in the	AVIII	IRF	rr3	
Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,		
	Education Cost	1, 2, 3, and	Cost (sum of	Part I, col.	(col. 5 ÷ col.	
		4)	col s. 2, 3,	8)	7)	
			and 4)		(see	
					instructions)	
	4.00	5.00	6.00	7.00	8.00	
ANCI LLARY SERVI CE COST CENTERS	-	1	1	-1	1	-
50. 00 05000 OPERATI NG ROOM	0	0		0 156, 618, 877		
51.00 05100 RECOVERY ROOM	0	0		0 11, 923, 504		
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 28, 655, 566		
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 95, 771, 314		
55. 00 05500 RADI OLOGY - THERAPEUTI C	0	0		0 10, 901, 914		
56.00 05600 RADI 0I SOTOPE	0	0		0 0	01000000	
56. 01 03950 CARDI AC CATH LAB	0	0		0 53, 211, 516		
57.00 05700 CT SCAN	0	0		0 56, 033, 807		
58.00 05800 MRI	0	0		0 8, 699, 308		
60. 00 06000 LABORATORY	0	0		0 130, 147, 520		
65. 00 06500 RESPI RATORY THERAPY	0	0		0 18, 614, 778		
66.00 06600 PHYSI CAL THERAPY	0	0		0 21, 719, 620		
67.00 06700 OCCUPATIONAL THERAPY	0	0		0 13, 118, 390		
68.00 06800 SPEECH PATHOLOGY	0	0		0 4, 577, 957		
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 29, 602, 644		
70. 00 07000 ELECTROENCEPHALOGRAPHY 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT	0			0 4, 824, 258		
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0			0 122, 431, 337 0 78, 306, 543		
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	541, 503	541, 50		0.000000	
73. 01 07301 DI ABETES CENTER	0	541, 503				
74. 00 07400 RENAL DIALYSIS	0			0 89,684 0 3,322,268		
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0			0 3, 322, 200		
OUTPATIENT SERVICE COST CENTERS	0	0			0.00000	/0.90
90. 00 09000 CLINIC	0	0		0 1, 382, 301	0.00000	90.00
91. 00 09100 EMERGENCY	0	727, 569				
91. 01 04950 WOUND CARE	0			0 6, 693, 123		
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0			0 0,093,123		
92. 01 09201 OBSERVATION BEDS (NON-DISTINCT PART)	0			0 16, 367, 140		
OTHER REIMBURSABLE COST CENTERS		. 0	1	10,007,140	0.00000	1 2.01
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)	0	1, 269, 072	1, 269. 07	2 1, 127, 062, 626		200.00
			, , , , , , , , ,		1	

lealth Financial Systems	FRANCI SCAN HEALT	H LAFAYETTE		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PASS	Provider CC	CN: 15-0109	Peri od:	Worksheet D	
THROUGH COSTS		Component (CON. 15 T100	From 01/01/2020 To 12/31/2020	Part IV Date/Time Pre	norod.
		component (CCN: 15-T109	10 12/31/2020	4/29/2021 3:5	
		Title	XVIII	Subprovider -	PPS	
				' I RF		
Cost Center Description	Outpati ent	Inpati ent	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Throug		Pass-Through	
	(col. 6 ÷ col.		Costs (col.	8	Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCI LLARY SERVI CE COST CENTERS					-	
50.00 05000 OPERATING ROOM	0. 000000	36, 204		0 0	0	
51.00 05100 RECOVERY ROOM	0. 000000	6, 231		0 0	0	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0 0	0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	62, 964		0 0	0	
55. 00 05500 RADI OLOGY – THERAPEUTI C	0. 000000	43, 103		0 0	0	55.00
56. 00 05600 RADI OI SOTOPE	0. 000000	0		0 0	0	
56. 01 03950 CARDIAC CATH LAB	0. 000000	0		0 0	0	56.01
57.00 05700 CT SCAN	0. 000000	98, 072		0 0	0	57.00
58. 00 05800 MRI	0. 000000	13, 568		0 0	0	58.00
60. 00 06000 LABORATORY	0. 000000	481, 833		0 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	201, 661		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	1, 417, 901		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000	1, 336, 467		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	361, 633		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	20, 088		0 0	0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	2, 120		0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	391, 869		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	3, 726		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 003749	348, 360	1, 30	0 0	0	73.00
73. 01 07301 DI ABETES CENTER	0. 000000	0		0 0	0	73.01
74.00 07400 RENAL DIALYSIS	0. 000000	52, 258		0 0	0	74.00
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 000000	0		0 0	0	76.98
OUTPATIENT SERVICE COST CENTERS	· · · · · · · · · · · · · · · · · · ·					1
90. 00 09000 CLINIC	0.000000	0		0 0	0	90.00
91. 00 09100 EMERGENCY	0. 006637	24, 000	1!	59 0	0	91.00
91. 01 04950 WOUND CARE	0. 000000	0		0 0	0	91.01
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0		0 0	0	92.00
92.01 09201 OBSERVATION BEDS (DISTINCT PART)	0.000000	176		0 0	0	92.01
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVI CES						95.00
75.00 07500 ANDOLANCE SERVICES						75.00

		FRANCI SCAN HEA				u of Form CMS-	2552-10
APPORTI ON	MENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C	CN: 15-0109	Period: From 01/01/2020 To 12/31/2020		
						4/29/2021 3:5	j2 pm
				e XIX	Hospi tal	Cost	
				Charges		Costs	
	Cost Center Description		PPS Reimbursed		Cost	PPS Services	
		Ratio From	Services (see	Reimbursed	Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins			
		1.00	0.00	(see inst.)	(see inst.)	F 00	
		1.00	2.00	3.00	4.00	5.00	
	CILLARY SERVICE COST CENTERS			0.074.7			1
	DOO OPERATING ROOM	0. 089932				0	
	IOO RECOVERY ROOM	0. 116876				0	
	200 DELIVERY ROOM & LABOR ROOM	0. 200058			0 0	0	
	100 RADI OLOGY-DI AGNOSTI C	0. 134906		4, 924, 9		0	
	500 RADI OLOGY - THERAPEUTI C	0. 088728		1, 783, 0		0	
	500 RADI OI SOTOPE	0. 000000			0 0	0	
	250 CARDIAC CATH LAB	0. 089604	0	1, 383, 3		0	
	700 CT SCAN	0. 032957		6, 352, 7		0	
	300 MRI	0. 069037		557, 0		0	
	DOO LABORATORY	0. 108943		,		0	
	500 RESPI RATORY THERAPY	0. 229113				0	
	600 PHYSI CAL THERAPY	0. 323578				0	
	00 OCCUPATI ONAL THERAPY	0. 196072		1, 186, 7		0	
	300 SPEECH PATHOLOGY	0. 264129		963, 23		0	
	200 ELECTROCARDI OLOGY	0. 158579		1, 869, 1		0	
	DOO ELECTROENCEPHALOGRAPHY	0. 342182		662, 70		0	
	IOO MEDICAL SUPPLIES CHARGED TO PATIENT	0. 119291		4, 780, 3		0	
	200 IMPL. DEV. CHARGED TO PATIENTS	0. 193328		2, 184, 43		0	
	BOO DRUGS CHARGED TO PATIENTS	0. 131586		10, 731, 3	54 0	0	
	301 DI ABETES CENTER	8. 110677		9, 9		0	
	100 RENAL DIALYSIS	0. 387539		,		0	
	598 HYPERBARI C OXYGEN THERAPY	0. 000000	0		0 0	0	76. 98
	PATIENT SERVICE COST CENTERS						
	DOO CLINIC	0. 977321	0	140, 9		0	90.00
	IOO EMERGENCY	0. 186626	0	19, 910, 8	36 0	0	91.00
91.01 049	950 WOUND CARE	0. 632631	0	486, 63	27 0	0	91.01
92.00 092	200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	0		0 0	0	92.00
92.01 092	201 OBSERVATION BEDS (DISTINCT PART)	0. 180504	0	1, 599, 00	0 80	0	92.01
	IER REI MBURSABLE COST CENTERS						
95.00 095	500 AMBULANCE SERVI CES	0. 479542	0		0		95.00
200.00	Subtotal (see instructions)		0	82, 290, 1	36 0	0	200.00
201.00	Less PBP Clinic Lab. Services-Program				0 0		201.00
	Only Charges	1					1
	Net Charges (line 200 - line 201)						202.00

Health Financial Systems	FRANCI SCAN HEA			In Lie	u of Form CMS-2552	2-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	O VACCINE COST	Provider CC		Peri od: From 01/01/2020 To 12/31/2020	Worksheet D Part V Date/Time Prepart 4/29/2021 3:52 pt	red:
			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.) 7.00				
	6.00	7.00				
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM	725, 913	0			FO	0.00
50. 00 05000 OPERATING ROOM 51. 00 05100 RECOVERY ROOM						1.00
	94, 612					2.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	-	-				
54. 00 05400 RADI OLOGY - DI AGNOSTI C	664, 409	-				4.00
55. 00 05500 RADI OLOGY - THERAPEUTI C	158, 210	, o				5.00
56. 00 05600 RADI 0I SOTOPE	0	, o				6.00
56. 01 03950 CARDI AC CATH LAB	123, 952					6.01
57. 00 05700 CT SCAN	209, 368					7.00
58. 00 05800 MRI	38, 457					8.00
60. 00 06000 LABORATORY	1, 255, 419					0.00
65. 00 06500 RESPI RATORY THERAPY	76, 611	0				5.00
66. 00 06600 PHYSI CAL THERAPY	574, 102					6.00
67. 00 06700 OCCUPATIONAL THERAPY	232, 683					7.00
68. 00 06800 SPEECH PATHOLOGY	254, 419					8.00
69. 00 06900 ELECTROCARDI OLOGY	296, 409					9.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	226, 787					0.00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT	570, 251					1.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	422, 313					2.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	1, 412, 096	, o				3.00
73. 01 07301 DI ABETES CENTER	80, 620					3.01
74.00 07400 RENAL DIALYSIS	96, 858					4.00
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0			/6	6. 98
	107.000					0 00
90. 00 09000 CLINIC	137,800					0.00
91.00 09100 EMERGENCY	3, 715, 880					1.00
91.01 04950 WOUND CARE	307, 855					1.01
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0					2.00
92. 01 09201 OBSERVATI ON BEDS (DI STINCT PART) OTHER REI MBURSABLE COST CENTERS	288, 627	0			92	2. 01
95. 00 09500 AMBULANCE SERVICES						5.00
	11 042 451					5.00 0.00
200.00Subtotal (see instructions)201.00Less PBP Clinic Lab. Services-Program	11, 963, 651	0				1.00
201.00 Less PBP CITRIC Lab. Services-Program	0				201	1.00
202.00 Net Charges (line 200 - line 201)	11, 963, 651	0			202	2.00
202.00 Net charges (The 200 - The 201)	11, 703, 051	1 0	I		202	2.00

	Financial Systems FRANCISCAN HEALTH ATLON OF INPATIENT OPERATING COST	H LAFAYETTE Provider CCN: 15-0109	Peri od:	u of Form CMS-2 Worksheet D-1	2002 10
COMPUT	ATTON OF INPATTENT OPERATING COST		From 01/01/2020 To 12/31/2020	Date/Time Pre	
		Title XVIII	Hospi tal	4/29/2021 3:52 PPS	z pili
	Cost Center Description				
	PART I - ALL PROVIDER COMPONENTS			1.00	
	INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed day			31, 572	
2.00 3.00	Inpatient days (including private room days, excluding swing- Private room days (excluding swing-bed and observation bed da		sivata room dave	31, 572 0	2.00 3.00
3.00	do not complete this line.	iys). Ti you nave only pi	TVate Toolii uays,	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation b			31, 572	4.00
5.00	Total swing-bed SNF type inpatient days (including private ro	oom days) through Decembe	er 31 of the cost	0	5.00
6.00	reporting period Total swing-bed SNF type inpatient days (including private ro	oom davs) after December	31 of the cost	0	6.00
	reporting period (if calendar year, enter 0 on this line)	5.1		-	
7.00	Total swing-bed NF type inpatient days (including private roc	om days) through December	⁻ 31 of the cost	0	7.00
8.00	reporting period Total swing-bed NF type inpatient days (including private roc	om davs) after December 3	31 of the cost	0	8.00
0.00	reporting period (if calendar year, enter 0 on this line)			J. J	0.00
9.00	Total inpatient days including private room days applicable t	the Program (excluding	g swing-bed and	16, 220	9.00
10.00	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII o	only (including private r	room days)	0	10.00
	through December 31 of the cost reporting period (see instruc	ctions)		J.	10100
11.00	Swing-bed SNF type inpatient days applicable to title XVIII o		room days) after	0	11.00
12.00	December 31 of the cost reporting period (if calendar year, e Swing-bed NF type inpatient days applicable to titles V or XI		te room days)	0	12.00
12.00	through December 31 of the cost reporting period	x only (merdaring privat	te room days)	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XI			0	13.00
14.00	after December 31 of the cost reporting period (if calendar y Medically necessary private room days applicable to the Progr			0	14.00
15.00	Total nursery days (title V or XIX only)	an (exer during swring bed	uuys)	0	15.00
16.00	Nursery days (title V or XIX only)			0	16.00
17.00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to servic	as through December 21 (of the cost	0.00	17.00
17.00	reporting period	les thiough becember 51 t	on the cost	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to servic	es after December 31 of	the cost	0.00	18.00
19.00	reporting period Medicaid rate for swing-bed NF services applicable to service	a through December 21 of	s the cost	0.00	19.00
19.00	reporting period	es through becember 31 01	the cost	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to service	es after December 31 of 1	the cost	0.00	20.00
21.00	reporting period Total general inpatient routine service cost (see instruction))		52, 030, 549	21.00
21.00	Swing-bed cost applicable to SNF type services through Decemb		ting period (line	52, 030, 549	21.00
	5 x line 17)				
23.00	Swing-bed cost applicable to SNF type services after December x line 18)	- 31 of the cost reportin	ng period (line 6	0	23.00
24.00	Swing-bed cost applicable to NF type services through Decembe	er 31 of the cost reporti	ng period (line	0	24.00
	7 x line 19)		0.1		
25.00	Swing-bed cost applicable to NF type services after December x line 20)	31 of the cost reporting	g period (line 8	0	25.00
26.00	Total swing-bed cost (see instructions)			0	26.00
27.00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		52, 030, 549	27.00
20 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-be	d and obconvetion had at		0	20 00
28.00 29.00	Private room charges (excluding swing-bed charges)	a and observation bed cr	larges)	0	28.00 29.00
30.00	Semi-private room charges (excluding swing-bed charges)			0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27	÷line 28)		0.00000	
32.00 33.00	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)			0.00 0.00	
34.00	Average per diem private room charge differential (line 32 mi	nus line 33)(see instruc	ctions)	0.00	
35.00	Average per diem private room cost differential (line 34 x li	ne 31)		0.00	
36.00 37.00	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost	and private room cost di	fforential (line	0 52, 030, 549	36.00 37.00
57.00	27 minus line 36)	and private room cost di		52, 030, 549	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
20 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ			1 (40 .00	20 00
38.00 39.00	Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line			1, 648. 00 26, 730, 560	
40.00	Medically necessary private room cost applicable to the Progr	-		20, 700, 000	40.00
	Total Program general inpatient routine service cost (line 39	11 10		26, 730, 560	1 1 00

MPUT	ATION OF INPATIENT OPERATING COST		Provider CO	CN: 15-0109	Period: From 01/01/2020	Worksheet D-1	1
					To 12/31/2020		
		T-+-1		XVIII	Hospi tal	PPS	
	Cost Center Description	Total Inpatient Costli	Total npatient Days			Program Cost (col. 3 x col.	
		1.00	2.00	<u>col.2)</u> 3.00	4.00	4) 5.00	-
. 00	NURSERY (title V & XIX only)	0	0	0.0) 42.
	Intensive Care Type Inpatient Hospital Units						
. 00 . 00	I NTENSI VE CARE UNI T CORONARY CARE UNI T	8, 864, 321	4, 197	2, 112. (06 1, 659	3, 503, 908	
. 00	BURN INTENSIVE CARE UNIT						44
. 00	SURGICAL INTENSIVE CARE UNIT						46
. 00	NEONATAL INTENSIVE CARE UNIT	4, 747, 326	3, 667	1, 294. (61 0	C	
	Cost Center Description					1.00	
. 00	Program inpatient ancillary service cost (Wk	at D-3 col 3	line 200)			1.00 26,224,196	5 48
. 00	Total Program inpatient costs (sum of lines			ns)		56, 458, 664	
	PASS THROUGH COST ADJUSTMENTS	······································					
. 00	Pass through costs applicable to Program inpa	atient routine s	ervices (from	Wkst. D, sur	m of Parts I and	6, 740, 058	3 50
. 00	III) Pass through costs applicable to Program inpa	tiont ancillary	convious (fr	om Wkat D	sum of Dorte II	1, 845, 050	51
. 00	and IV)	attent and traiy	Services (II	UNI WKSL. D, S	Sull OF Parts II	1, 645, 050	1 51
. 00	Total Program excludable cost (sum of lines !	50 and 51)				8, 585, 108	3 52
. 00	Total Program inpatient operating cost exclud		ated, non-phy	sician anesth	netist, and	47, 873, 556	53
	medical education costs (line 49 minus line !	52)					-
. 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					C	54
. 00	Target amount per discharge					0.00	
. 00	Target amount (line 54 x line 55)					0	56
. 00	Difference between adjusted inpatient operati	ng cost and tar	get amount (I	ine 56 minus	line 53)	0	
. 00 . 00	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost rep	porting period e	nding 1006 u	ndated and co	omnounded by the	0.00	
. 00	market basket	boi tring period e	narng 1770, a		shipounded by the	0.00	/ <i>[,]</i>
. 00	Lesser of lines 53/54 or 55 from prior year of					0.00	
. 00	If line 53/54 is less than the lower of lines					0) 61
	which operating costs (line 53) are less than amount (line 56), otherwise enter zero (see i		(TTHES 54 X	60), OF 1% OF	the target		
. 00	Relief payment (see instructions)					C	62
. 00	Allowable Inpatient cost plus incentive payme	ent (see instruc	tions)			C	63
. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cost	to through Docom	han 21 of the	aget report	ng pariod (Saa	C	64
. 00	instructions) (title XVIII only)	is through becen		cost reporti	ng period (see		04
. 00	Medicare swing-bed SNF inpatient routine cos	ts after Decembe	r 31 of the c	ost reporting	g period (See	C	65
	instructions)(title XVIII only)						
. 00	Total Medicare swing-bed SNF inpatient routin	ne costs (line 6	4 plus line 6	5)(title XVII	l only). For	C) 66
. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routing	e costs through	December 31 o	f the cost re	eporting period	l c	67
	(line 12 x line 19)	5				_	
. 00	Title V or XIX swing-bed NF inpatient routine	e costs after De	cember 31 of	the cost repo	orting period	0) 68
. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient n	coutine costs (1	ing 67 ± ling	68)		C	69
. 00	PART III - SKILLED NURSING FACILITY, OTHER NU			,			1 07
. 00	Skilled nursing facility/other nursing facili)		70
. 00	Adjusted general inpatient routine service co		ne 70 ÷ line	2)			71
. 00 . 00	Program routine service cost (line 9 x line)		(lipo 14 v li	no 25)			72
. 00	Medically necessary private room cost applica Total Program general inpatient routine servi			ne 33)			74
. 00	Capital-related cost allocated to inpatient			orksheet B, A	Part II, column		75
o -	26, line 45)						_
. 00	Per diem capital-related costs (line 75 ÷ lin Program capital-related costs (line 9 × line						76
. 00 . 00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minus						77
. 00	Aggregate charges to beneficiaries for excess	,	ovider record	s)			79
00	Total Program routine service costs for compa		st limitation	(line 78 mir	nus line 79)		80
00	Inpatient routine service cost per diem limi						81
. 00 . 00	Inpatient routine service cost limitation (li Reasonable inpatient routine service costs (82
. 00	Program inpatient ancillary services (see ins		,				84
. 00	Utilization review - physician compensation		s)				85
. 00	Total Program inpatient operating costs (sum		ough 85)				86
	PART IV - COMPUTATION OF OBSERVATION BED PASS					C	87
00						i ()	11 87
. 00 . 00	Total observation bed days (see instructions) Adjusted general inpatient routine cost per o		line 2)			0.00	

Health Financial Systems	FRANCI SCAN HEAI	LTH LAFAYETTE		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period: From 01/01/2020	Worksheet D-1	
				To 12/31/2020		pared: 2 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	7, 770, 523	52, 030, 549	0. 14934	5 0	0	90.00
91.00 Nursing School cost	4, 690, 643	52, 030, 549	0. 09015	2 0	0	91.00
92.00 Allied health cost	0	52, 030, 549	0. 00000	0 0	0	92.00
93.00 All other Medical Education	0	52, 030, 549	0. 00000	0 0	0	93.00

MPUL	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0109 Component CCN: 15-T109	Peri od: From 01/01/2020 To 12/31/2020	Worksheet D-1 Date/Time Pre 4/29/2021 3:5	pare
		Title XVIII	Subprovider -	PPS	
	Cost Center Description		-	1.00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS				
00	Inpatient days (including private room days and swing-bed days	s, excluding newborn)		3, 124	1 1
00	Inpatient days (including private room days, excluding swing-	bed and newborn days)		3, 124	2
00	Private room days (excluding swing-bed and observation bed day	ys). If you have only pr	ivate room days,	0	3
00	do not complete this line. Semi-private room days (excluding swing-bed and observation b	ed days)		3, 124	4
00	Total swing-bed SNF type inpatient days (including private ro		r 31 of the cost	0, 121	
	reporting period				
00	Total swing-bed SNF type inpatient days (including private row reporting period (if calendar year, enter 0 on this line)	om days) after December	31 of the cost	0	6
00	Total swing-bed NF type inpatient days (including private roo	m days) through December	31 of the cost	0	7
	reporting period	3.		-	
00	Total swing-bed NF type inpatient days (including private room	m days) after December 3	1 of the cost	0	8
00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to	o the Program (excluding	swing_bed and	1, 621	9
00	newborn days) (see instructions)		Sinnig bed and	1, 021	'
. 00	Swing-bed SNF type inpatient days applicable to title XVIII on		oom days)	0	10
. 00	through December 31 of the cost reporting period (see instruct Swing-bed SNF type inpatient days applicable to title XVIII of		oom dave) after	0	11
. 00	December 31 of the cost reporting period (if calendar year, end		oom uays) arter	0	''
. 00	Swing-bed NF type inpatient days applicable to titles V or XI		e room days)	0	12
00	through December 31 of the cost reporting period			0	1.2
. 00	Swing-bed NF type inpatient days applicable to titles V or XL after December 31 of the cost reporting period (if calendar ye			0	13
. 00	Medically necessary private room days applicable to the Progra			0	14
	Total nursery days (title V or XIX only)			0	
. 00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			0	16
. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 o	f the cost	0.00	17
	reporting period	Ū.			
. 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 service:	s through December 31 of	the cost	0.00	19
	reporting period	-			
. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	s after December 31 of t	he cost	0.00	20
. 00	Total general inpatient routine service cost (see instruction:	s)		4, 690, 705	21
2.00	Swing-bed cost applicable to SNF type services through December	er 31 of the cost report	ing period (line	0	
	5 x line 17)			0	0.00
8. 00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reportin	g period (iine 6	0	23
. 00	Swing-bed cost applicable to NF type services through December	r 31 of the cost reporti	ng period (line	0	24
	7 x line 19)				
5.00	Swing-bed cost applicable to NF type services after December 3 x line 20)	31 of the cost reporting	period (line 8	0	25
. 00	Total swing-bed cost (see instructions)			0	26
. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		4, 690, 705	27
00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	d and abcomunition had ab	07700)	0	1 20
	General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges)	d 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 mi	nus line 33)(see instruc	tions)	0.00 0.00	
	Average per diem private room cost differential (line 34 x lin	, (0.00	
. 00	Private room cost differential adjustment (line 3 x line 35)	-		0	36
. 00	General inpatient routine service cost net of swing-bed cost a	and private room cost di	fferential (line	4, 690, 705	37
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ	USTMENTS			1
	Adjusted general inpatient routine service cost per diem (see	instructions)		1, 501. 51	
. 00	Program general inpatient routine service cost (line 9 x line			2, 433, 948	
	Medically necessary private room cost applicable to the Progra	om (line 11 ··· line 25)		0	

ealth Financial Systems OMPUTATION OF INPATIENT OPERATING COST	FRANCI SCAN HEAL		CN: 15-0109	Peri od:	wof Form CMS- Worksheet D-1	
			CCN: 15-T109	From 01/01/2020 To 12/31/2020	Date/Time Pre	epared
		Title	e XVIII	Subprovider -	4/29/2021 3:5 PPS	52 pm
			-	IRF		
Cost Center Description	Total Inpatient Costl	Total npatient Days	Average Per Diem (col. 1 col. 2)		Program Cost (col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	12
2.00 NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital U	ni ts	(0.	0 00	0	42.
3. 00 INTENSIVE CARE UNIT	0	C	0.	0 00	0	
4. 00 CORONARY CARE UNIT 5. 00 BURN INTENSIVE CARE UNIT						44.
5. 00 BURN INTENSIVE CARE UNIT 6. 00 SURGICAL INTENSIVE CARE UNIT						45. 46.
7. 00 NEONATAL INTENSIVE CARE UNIT	0	C	0.	0 00	0	
Cost Center Description					1.00	
3.00 Program inpatient ancillary service cost	(Wkst. D-3, col. 3,	line 200)			1.00 1,057,509	48.
9.00 Total Program inpatient costs (sum of li	•		ons)		3, 491, 457	
PASS THROUGH COST ADJUSTMENTS	1		What D are		455 710	
0.00 Pass through costs applicable to Program	inpatient routine s	ervices (from	n WKST. D, SUN	n of Parts I and	455, 712	2 50.
1.00 Pass through costs applicable to Program	inpatient ancillary	services (fr	om Wkst. D, s	sum of Parts II	35, 999	51.
and IV) 2.00 Total Program excludable cost (sum of li	pac = E0 and $E1$				491, 711	50
2.00 Total Program excludable cost (sum of li 3.00 Total Program inpatient operating cost e		ated. non-phy	vsician anestl	netist. and	2, 999, 746	
medical education costs (line 49 minus l					_,,	
TARGET AMOUNT AND LIMIT COMPUTATION 4.00 Program discharges					0	
4.00 Program discharges 5.00 Target amount per discharge					0.00	
b. 00 Target amount (line 54 x line 55)					0	
7.00 Difference between adjusted inpatient op	erating cost and tar	get amount (I	ine 56 minus	line 53)	0	
3.00 Bonus payment (see instructions) 9.00 Lesser of lines 53/54 or 55 from the cos	t conarting pariod a	nding 1004	indated and a	ampounded by the	0.00	
market basket	t reporting period e	inui ng 1990, t		shipourided by the	0.00	, 37.
0.00 Lesser of lines 53/54 or 55 from prior y					0.00	
1.00 If line 53/54 is less than the lower of which operating costs (line 53) are less					0	61.
amount (line 56), otherwise enter zero ((THES 54 X	60), 01 1% 0	the target		
2.00 Relief payment (see instructions)	,				0	62.
3.00 Allowable Inpatient cost plus incentive		tions)			0	63.
PROGRAM INPATIENT ROUTINE SWING BED COST 4.00 Medicare swing-bed SNF inpatient routine		ber 31 of the	e cost reporti	na period (See	0	64.
instructions) (title XVIII only)	ocoto tin ough pooon			ng por ou (ooo		
5.00 Medicare swing-bed SNF inpatient routine	costs after Decembe	r 31 of the o	cost reporting	g period (See	0	65.
instructions)(title XVIII only) 5.00 Total Medicare swing-bed SNF inpatient r	outine costs (line 6	4 plus line 6	5)(title XVI)	lonly) For	0	66.
CAH (see instructions)						
7.00 Title V or XIX swing-bed NF inpatient ro	utine costs through	December 31 d	of the cost re	eporting period	0	67.
line 12 x line 19) B.OO Title V or XIX swing-bed NF inpatient ro	utine costs after De	cember 31 of	the cost rep	ortina period	0	68.
(line 13 x line 20)			the cost rep	si ting poir ou		
9.00 Total title V or XIX swing-bed NF inpati					0	69.
PART III - SKILLED NURSING FACILITY, OTH D. 00 Skilled nursing facility/other nursing f)		70.
1.00 Adjusted general inpatient routine servi				,		71.
2.00 Program routine service cost (line 9 x l			25)			72.
3.00 Medically necessary private room cost ap 4.00 Total Program general inpatient routine		•				73.
5.00 Capital -related cost allocated to inpati				Part II, column		75.
26, line 45)		-				
6.00 Per diem capital-related costs (line 75 7.00 Program capital-related costs (line 9 x						76.
3.00 Inpatient routine service cost (line 74						78.
9.00 Aggregate charges to beneficiaries for e	xcess costs (from pr					79.
0.00 Total Program routine service costs for		st limitation	n (line 78 min	nus line 79)		80.
1.00 Inpatient routine service cost per diem 2.00 Inpatient routine service cost limitatio						81. 82.
8.00 Reasonable inpatient routine service cost	. ,					83.
4.00 Program inpatient ancillary services (se						84.
5.00 Utilization review - physician compensat						85.
6.00 Total Program inpatient operating costs PART IV - COMPUTATION OF OBSERVATION BED		ouyn 85)			I	86.
7.00 Total observation bed days (see instruct					0	87.
8.00 Adjusted general inpatient routine cost		line 2)			0.00	
9.00 Observation bed cost (line 87 x line 88)	(see instructions)				1 0	89.

Health Financial Systems	FRANCI SCAN HEA	LTH LAFAYETTE		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period: From 01/01/2020	Worksheet D-1	
		Component (To 12/31/2020		
		Title	XVIII	Subprovider - IRF	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	878, 261	4, 690, 705	0. 18723	4 0	0	90.00
91.00 Nursing School cost	0	4, 690, 705	0.00000	0 0	0	91.00
92.00 Allied health cost	0	4, 690, 705	0.00000	0 0	0	92.00
93.00 All other Medical Education	0	4, 690, 705	0.00000	0 0	0	93.00

	ALTH LAFAYETTE	01 45 0400		u of Form CMS-2	
NPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0109	Period: From 01/01/2020	Worksheet D-3	
			To 12/31/2020	Date/Time Pre	pared.
			10 12/01/2020	4/29/2021 3:5	
	Title	e XVIII	Hospi tal	PPS	
Cost Center Description		Ratio of Cos	t Inpatient	Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		1			
30. 00 03000 ADULTS & PEDIATRICS			36, 833, 157		30.0
31. 00 03100 I NTENSI VE CARE UNI T			7, 030, 856		31.0
35.00 02060 NEONATAL INTENSIVE CARE UNIT			0		35.0
41.00 O4100 SUBPROVIDER - IRF			0		41.0
43.00 04300 NURSERY					43.0
ANCI LLARY SERVI CE COST CENTERS		0.0000		0.040.500	50.0
50. 00 05000 OPERATING ROOM		0.0899			
51.00 O5100 RECOVERY ROOM		0. 1168		275, 353	
52.00 O5200 DELIVERY ROOM & LABOR ROOM		0.2000		0	52.0
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0.13490		1, 365, 049	
55. 00 O5500 RADI OLOGY - THERAPEUTI C		0.08872			
56. 00 05600 RADI OI SOTOPE		0.0000		0	
56. 01 03950 CARDI AC CATH LAB		0.08960			
57.00 05700 CT SCAN		0.0329			
58.00 05800 MRI		0.06903		70, 958	
		0. 1089		2, 490, 464	
55.00 06500 RESPIRATORY THERAPY		0. 2291		1, 398, 210	
56.00 O6600 PHYSI CAL THERAPY		0. 3235			
57.00 06700 OCCUPATI ONAL THERAPY		0. 1960			
58.00 O6800 SPEECH PATHOLOGY		0. 26412		127, 414	•
59.00 06900 ELECTROCARDI OLOGY		0. 1585			
70.00 07000 ELECTROENCEPHALOGRAPHY		0.3421		145, 514	
71.00 O7100 MEDI CAL SUPPLIES CHARGED TO PATI ENT		0. 1192		3, 567, 688	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 1933		5, 476, 797	
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 1315		2, 412, 572	1
73. 01 07301 DI ABETES CENTER		8. 1106			
74.00 07400 RENAL DIALYSIS		0.3875			
76. 98 07698 HYPERBARI C OXYGEN THERAPY		0.0000	0 00	0	76.9
		0.0770	21		
20. 00 09000 CLINIC		0.9773		0	
91.00 09100 EMERGENCY		0. 1866		1, 683, 062	
91. 01 04950 WOUND CARE		0.6326		69, 214	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0.0000		0	
92. 01 09201 OBSERVATI ON BEDS (DI STI NCT PART)		0. 18050	1, 507, 548	272, 118	92.0
OTHER REIMBURSABLE COST CENTERS 05.00 09500 AMBULANCE SERVICES		1			
			102 001 000	26 224 104	95.0
200.00 Total (sum of lines 50 through 94 and 96 through 98)			193, 081, 933	26, 224, 196	
201.00 Less PBP Clinic Laboratory Services-Program only cha	iges (ine 61)				201.0
202.00 Net charges (line 200 minus line 201)		1	193, 081, 933		202.0

ealth Financial Systems FRANCISCAN HEALTH	LAFAYETTE Provider C	CN: 15-0109	In Lie Period:	Worksheet D-3	
			From 01/01/2020		
	Component	CCN: 15-T109	To 12/31/2020	Date/Time Pre 4/29/2021 3:5	
	Titl€	e XVIII	Subprovider -	PPS	
Cost Conton Description		Ratio of Cos	I RF	Innoti ont	1
Cost Center Description		To Charges		Inpatient Program Costs	
		10 charges		(col. 1 x col.	
			charges	2)	
		1.00	2.00	3.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS		1			
0. 00 03000 ADULTS & PEDIATRICS			0		30.
1.00 03100 INTENSIVE CARE UNIT			0		31.
5.00 02060 NEONATAL INTENSIVE CARE UNIT			0		35.
1.00 04100 SUBPROVIDER - IRF			3, 031, 146		41.
3. 00 04300 NURSERY					43.
ANCI LLARY SERVI CE COST CENTERS					
0. 00 05000 OPERATING ROOM		0. 0899	32 36, 204	3, 256	50.
1.00 05100 RECOVERY ROOM		0. 1168		728	
2.00 05200 DELIVERY ROOM & LABOR ROOM		0. 2000		0	
4. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 1349	06 62, 964	8, 494	54.
5. 00 05500 RADI OLOGY - THERAPEUTI C		0. 0887			
6. 00 05600 RADI OI SOTOPE		0.0000		0	
6. 01 03950 CARDI AC CATH LAB		0. 0896		0	
7.00 05700 CT SCAN		0. 0329		3, 232	
8. 00 05800 MRI		0. 0690			
0. 00 06000 LABORATORY		0. 1089			
5. 00 06500 RESPI RATORY THERAPY		0. 2291		46, 203	
6. 00 06600 PHYSI CAL THERAPY		0. 3235		458, 802	
7. 00 06700 OCCUPATI ONAL THERAPY		0. 1960		262, 044	
8. 00 06800 SPEECH PATHOLOGY		0.2641			
9. 00 06900 ELECTROCARDI OLOGY		0. 1585			
0.00 07000 ELECTROENCEPHALOGRAPHY		0.3421			
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 2.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 1192			
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS 3.00 07300 DRUGS CHARGED TO PATIENTS		0. 1933 0. 1315			
3. 01 07300 DR0GS CHARGED TO PATTENTS		8. 1106		45, 839	
4. 00 07400 RENAL DIALYSIS		0. 3875			
6. 98 07698 HYPERBARI C OXYGEN THERAPY		0. 3873			
OUTPATIENT SERVICE COST CENTERS		0.0000	00 0	0	70.
0. 00 09000 CLINIC		0. 9773	21 0	0	90.
1. 00 09100 EMERGENCY		0. 1866			
1. 01 04950 WOUND CARE		0. 6326		0	
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0.0000		0	
2. 01 09201 OBSERVATION BEDS (DISTINCT PART)		0. 1805		-	
OTHER REIMBURSABLE COST CENTERS					1
5. 00 09500 AMBULANCE SERVICES					95.
00.00 Total (sum of lines 50 through 94 and 96 through 98)		1	4, 902, 234	1, 057, 509	
01.00 Less PBP Clinic Laboratory Services-Program only charges	(line 61)		0		201.
02.00 Net charges (line 200 minus line 201)		1	4, 902, 234		202.

leal th Financial Systems FRANCI SCAN HEALTH		01 45 0400		eu of Form CMS-	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0109	Period: From 01/01/2020	Worksheet D-3	
			To 12/31/2020		
	Titl	e XIX	Hospi tal	Cost	
Cost Center Description		Ratio of Cos	st Inpatient	Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
		1.00	0.00	2)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
30. 00 03000 ADULTS & PEDIATRICS		1	12, 952, 487	1	30. 0
31. 00 03100 NTENSI VE CARE UNI T			1, 924, 726		31.0
35. 00 02060 NEONATAL INTENSIVE CARE UNIT			6, 312, 505		35.0
41. 00 04100 SUBPROVIDER - IRF			0, 512, 505		41.0
43. 00 04300 NURSERY			0		43.0
ANCI LLARY SERVI CE COST CENTERS			0		
50. 00 05000 OPERATI NG ROOM		0.0899	32 6, 543, 228	588, 446	50. C
51.00 05100 RECOVERY ROOM		0. 1168			
52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 2000		0	52.0
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 1349		-	1
55. 00 05500 RADI OLOGY - THERAPEUTI C		0. 0887			
56. 00 05600 RADI OI SOTOPE		0.0000			56.0
56. 01 03950 CARDI AC CATH LAB		0. 0896		156, 469	56.0
57. 00 05700 CT SCAN		0.0329			57. C
58. 00 05800 MRI		0.0690			58.0
50. 00 06000 LABORATORY		0. 1089			
65. 00 06500 RESPI RATORY THERAPY		0. 2291	13 1, 629, 102	373, 248	65.0
66. 00 06600 PHYSI CAL THERAPY		0. 3235	78 416, 121	134, 648	66.0
57.00 06700 OCCUPATI ONAL THERAPY		0. 1960		68, 226	67.0
58.00 06800 SPEECH PATHOLOGY		0. 2641	29 100, 410	26, 521	68.0
59. 00 06900 ELECTROCARDI OLOGY		0. 1585	79 801,030	127, 027	69.0
70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 3421	82 109, 090	37, 329	70.0
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 1192	91 5, 144, 553	613, 699	71.0
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 1933	28 1, 773, 081	342, 786	72.0
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 1315	86 4, 849, 029	638, 064	73.0
73. 01 07301 DIABETES CENTER		8. 1106	77 101	819	73.0
74. 00 07400 RENAL DIALYSIS		0. 3875	39 161, 597	62, 625	74.0
76. 98 07698 HYPERBARI C OXYGEN THERAPY		0.0000	00 0	0	76.9
OUTPATIENT SERVICE COST CENTERS				1	
70. 00 09000 CLINIC		0. 9773	-	0	90.0
21. 00 09100 EMERGENCY		0. 1866			91.0
91. 01 04950 WOUND CARE		0. 6326			
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0.0000		-	92.0
92. 01 09201 OBSERVATI ON BEDS (DI STI NCT PART)		0. 1805	04 195, 961	35, 372	92.0
OTHER REIMBURSABLE COST CENTERS		1			
95.00 09500 AMBULANCE SERVICES					95.0
Total (sum of lines 50 through 94 and 96 through 98)			35, 126, 256	4, 492, 317	
201.00 Less PBP Clinic Laboratory Services-Program only charge	s (line 61)		0		201.0
202.00 Net charges (line 200 minus line 201)			35, 126, 256		202.0

IPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0109	Peri od:	Worksheet D-3	3
	Component	CCN. 15 T100	From 01/01/2020	Data /Tima Dra	
	component	CCN: 15-T109	To 12/31/2020	Date/Time Pre 4/29/2021 3:5	pari 52 p
	Ti tl	e XIX	Subprovider -	Cost	
Cost Center Description		Ratio of Cos	IRF st Inpatient	Inpati ent	
cost center bescription		To Charges	Program	Program Costs	
		10 charges		(col. 1 x col.	
			onar ges	2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
0. 00 03000 ADULTS & PEDI ATRI CS			0		30
. 00 03100 INTENSIVE CARE UNIT			0		31
0. 00 02060 NEONATAL INTENSIVE CARE UNIT			0		35
. 00 04100 SUBPROVIDER - IRF			356, 645		41
. 00 04300 NURSERY			0		43
ANCI LLARY SERVI CE COST CENTERS					
. 00 05000 OPERATI NG ROOM		0. 0899		0	
. OO 05100 RECOVERY ROOM		0. 1168		0	
2. 00 05200 DELIVERY ROOM & LABOR ROOM		0. 2000		0	
. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 1349		2, 323	
0. 00 05500 RADI OLOGY - THERAPEUTI C		0. 0887		338	
. 00 05600 RADI OI SOTOPE		0.0000		0	
. 01 03950 CARDI AC CATH LAB		0. 0896		0	
7. 00 05700 CT SCAN		0. 0329		348	
8. 00 05800 MRI		0.0690	37 1, 218	84	
0. 00 06000 LABORATORY		0. 1089		7,420	
0. 00 06500 RESPI RATORY THERAPY		0. 2291		5, 283	
0. 00 06600 PHYSI CAL THERAPY		0. 3235		45, 381	
06700 OCCUPATI ONAL THERAPY		0. 1960		25, 629	
8. 00 06800 SPEECH PATHOLOGY		0. 2641		12, 295	
0. 00 06900 ELECTROCARDI OLOGY		0. 1585		1, 845	
00 07000 ELECTROENCEPHALOGRAPHY		0. 3421		0	70
. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 1192	91 38, 345	4, 574	7
. 00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 1933		584	
. 00 07300 DRUGS CHARGED TO PATIENTS		0. 1315	86 62, 834	8, 268	8 73
. 01 07301 DI ABETES CENTER		8. 1106		0	
. 00 07400 RENAL DI ALYSI S		0. 3875		3, 269	
. 98 07698 HYPERBARI C OXYGEN THERAPY		0.0000	00 0	0	0 76
OUTPATIENT SERVICE COST CENTERS					4
. 00 09000 CLINIC		0. 9773		0	
. 00 09100 EMERGENCY		0. 1866		1, 663	
. 01 04950 WOUND CARE		0. 6326		0	
. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0.0000		0	
. 01 09201 OBSERVATI ON BEDS (DI STI NCT PART)		0. 1805	04 0	0	92
OTHER REI MBURSABLE COST CENTERS		1	1		4
00 09500 AMBULANCE SERVICES					95
0.00 Total (sum of lines 50 through 94 and 96 through 98)			574, 665	119, 304	
1.00 Less PBP Clinic Laboratory Services-Program only charges	(line 61)		0		201
2.00 Net charges (line 200 minus line 201)			574, 665		202

	Financial Systems FRANCISCAN HEALTH ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0109	Peri od: From 01/01/2020 To 12/31/2020	u of Form CMS-2 Worksheet E Part A Date/Time Pre 4/29/2021 3:5	pared:
		Title XVIII	Hospi tal	472972021 3.5 PPS	2 piii
				1 00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS			1.00	-
1.00 1.01	DRG Amounts Other than Outlier Payments DRG amounts other than outlier payments for discharges occurr	ing prior to October 1 ((see	0 27, 795, 275	1.00 1.01
1. 02	instructions) DRG amounts other than outlier payments for discharges occurr	ing on or after October	1 (see	10, 442, 319	1.02
1. 03	instructions) DRG for federal specific operating payment for Model 4 BPCI f	or discharges occurring	prior to October	0	1.03
1.04	1 (see instructions) DRG for federal specific operating payment for Model 4 BPCI f October 1 (see instructions)	or discharges occurring	on or after	0	1.04
2. 00 2. 01	Outlier payments for discharges. (see instructions) Outlier reconciliation amount			0	2.00 2.01
2.01	Outlier payment for discharges for Model 4 BPCI (see instruct	ions)		0	2.01
2.03	Outlier payments for discharges occurring prior to October 1	-		526, 409	•
2.04	Outlier payments for discharges occurring on or after October	1 (see instructions)		158, 249	
3.00	Managed Care Simulated Payments			0	
4.00	Bed days available divided by number of days in the cost repo Indirect Medical Education Adjustment	rting period (see instru	JCTI ONS)	184.00	4.00
5.00	FTE count for allopathic and osteopathic programs for the mos or before 12/31/1996. (see instructions)	t recent cost reporting	period ending on	0.00	5.00
6.00	FTE count for allopathic and osteopathic programs that meet t new programs in accordance with 42 CFR 413.79(e)	he criteria for an add-o	on to the cap for	0.00	6.00
7.00 7.01	MMA Section 422 reduction amount to the IME cap as specified ACA § 5503 reduction amount to the IME cap as specified under			0. 00 0. 00	7.00 7.01
	cost report straddles July 1, 2011 then see instructions.		, , , , , ,		
8.00	Adjustment (increase or decrease) to the FTE count for allopa affiliated programs in accordance with 42 CFR 413.75(b), 413. 1998), and 67 FR 50069 (August 1, 2002).	5	0.00	8.00	
8.01	The amount of increase if the hospital was awarded FTE cap sl	ots under § 5503 of the	ACA. If the cost	0.00	8. 01
8. 02	report straddles July 1, 2011, see instructions. The amount of increase if the hospital was awarded FTE cap sl	0.00	8. 02		
9.00	under § 5506 of ACA. (see instructions) Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lin instructions)	es (8, 8,01 and 8,02)	(see	0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the curr	ent year from your recor	-ds	0.00	
11.00 12.00	FTE count for residents in dental and podiatric programs. Current year allowable FTE (see instructions)			0.00 0.00	•
12.00	Total allowable FTE count for the prior year.			0.00	•
14.00	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	•
15.00	Sum of lines 12 through 14 divided by 3.			0.00	15.00
16.00	Adjustment for residents in initial years of the program			0.00	16.00
17.00	Adjustment for residents displaced by program or hospital clo	sure		0.00	•
18.00	Adjusted rolling average FTE count Current year resident to bed ratio (line 18 divided by line 4	`		0.00 0.000000	
20.00	Prior year resident to bed ratio (see instructions)).		0.000000	
21.00	Enter the lesser of lines 19 or 20 (see instructions)			0. 000000	
22.00	IME payment adjustment (see instructions)			0	22.00
22. 01	IME payment adjustment - Managed Care (see instructions)			0	22.01
23. 00	Indirect Medical Education Adjustment for the Add-on for § 42. Number of additional allopathic and osteopathic IME FTE resid		CFR 412.105	0.00	23.00
24.00	(f)(1)(iv)(C). IME FTE Resident Count Over Cap (see instructions)			0.00	24.00
24.00 25.00	If the amount on line 24 is greater than -0-, then enter the instructions)	lower of line 23 or line	e 24 (see	0.00	
26.00	Resident to bed ratio (divide line 25 by line 4)			0. 000000	26.00
27.00	IME payments adjustment factor. (see instructions)			0.000000	
28.00	IME add-on adjustment amount (see instructions)			0	
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0	•
29. 00 29. 01	Total IME payment (sum of lines 22 and 28) Total IME payment - Managed Care (sum of lines 22.01 and 28.0	1)		0	29.00 29.01
30. 00	<u>Disproportionate Share Adjustment</u> Percentage of SSI recipient patient days to Medicare Part A p	atient dave (coo inctave	stions)	3.54	30.00
30.00	Percentage of Medicaid patient days (see instructions)	arrent udys (see Instruc		3.54 24.45	1
32.00	Sum of lines 30 and 31			27.99	
33.00	Allowable disproportionate share percentage (see instructions)			33.00
24 00	Disproportionate share adjustment (see instructions)			1, 132, 789	34 00

	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0109	Period: From 01/01/2020	Worksheet E Part A	
			To 12/31/2020		
		Title XVIII	Hospi tal	PPS	<u>z pii</u>
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
	Uncompensated Care Adjustment				
5.00	Total uncompensated care amount (see instructions)			8, 290, 014, 521	
5.01	Factor 3 (see instructions)		0.000417165	0.000582028	
5. 02	Hospital uncompensated care payment (If line 34 is zero, en	iter zero on this line) (see	3, 483, 575	4, 825, 019	35
- 02	instructions) Pro rata share of the hospital uncompensated care payment a	mount (and instructions)	2 (07 022	1 01/ 170	25
5.03 6.00	Total uncompensated care (sum of columns 1 and 2 on line 35		2, 607, 923 3, 824, 093	1, 216, 170	35
0.00	Additional payment for high percentage of ESRD beneficiary				30
D. 00	Total Medicare discharges, excluding MS-DRGs 652, 682, 683,		0		40
0.00	instructions)		Ŭ		
1.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682,	683, 684 an 685, (see	0		41
	instructions)				
1. 01	Total ESRD Medicare covered and paid discharges excluding M	IS-DRGs 652, 682, 683, 684	0		41
	an 685. (see instructions)				
	Divide line 41 by line 40 (if less than 10%, you do not qua		0.00		42
3.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652,	682, 683, 684 an 685. (see	0		43
	instructions)		0 00000		
4.00	Ratio of average length of stay to one week (line 43 divide	d by line 41 divided by 7	0.000000		44
E 00	days) Average weekly cost for dialycic treatments (see instructio		0.00		1
5.00	Average weekly cost for dialysis treatments (see instructio Total additional payment (line 45 times line 44 times line		0.00		45
7.00	Subtotal (see instructions)	41.01)	43, 879, 134		40
8.00	Hospital specific payments (to be completed by SCH and MDH,	small rural bosnitals	43, 079, 134		48
0.00	only. (see instructions)		0		40
				Amount	
				1.00	
9.00	Total payment for inpatient operating costs (see instructio	ins)		43, 879, 134	49
0. 00	Payment for inpatient program capital (from Wkst. L, Pt. I	and Pt. II, as applicable)		3, 291, 105	50
1.00	Exception payment for inpatient program capital (Wkst. L, P	t. III, see instructions)		0	51
2.00	Direct graduate medical education payment (from Wkst. E-4,	line 49 see instructions).		0	52
3.00	Nursing and Allied Health Managed Care payment			490, 307	53
4.00	Special add-on payments for new technologies			87, 403	
4. 01	Islet isolation add-on payment			0	
	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line			0	
	Cost of physicians' services in a teaching hospital (see in	-		0	
	Routine service other pass through costs (from Wkst. D, Pt.		rougn 35).	2, 409, 805	
8.00	Ancillary service other pass through costs from Wkst. D, Pt	. IV, COL. II II ne 200)		128, 591	
9.00	Total (sum of amounts on lines 49 through 58) Primary payer payments			50, 286, 345	
0. 00 1. 00	Total amount payable for program beneficiaries (line 59 min	us line 60)		37, 476 50, 248, 869	
	Deductibles billed to program beneficiaries			3, 553, 660	
	Coinsurance billed to program beneficiaries			55, 264	
4.00	Allowable bad debts (see instructions)			284, 217	
	Adjusted reimbursable bad debts (see instructions)			184, 741	
	Allowable bad debts for dual eligible beneficiaries (see in	structions)		61, 012	
7.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			46, 824, 686	
B. 00	Credits received from manufacturers for replaced devices fo	r applicable to MS-DRGs (se	e instructions)	0	
	Outlier payments reconciliation (sum of lines 93, 95 and 96			0	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
	Rural Community Hospital Demonstration Project (§410A Demon	stration) adjustment (see i	nstructions)	0	70
D. 87	Demonstration payment adjustment amount before sequestratio	n		0	70
0. 88	SCH or MDH volume decrease adjustment (contractor use only)			0	70
0. 89	Pioneer ACO demonstration payment adjustment amount (see in	structions)			70
0. 90	HSP bonus payment HVBP adjustment amount (see instructions)			0	70
0.90	HSP bonus payment HRR adjustment amount (see instructions)			0	
0. 91					1 7/
0. 91 0. 92	Bundled Model 1 discount amount (see instructions)			0	
0. 91 0. 92 0. 93	Bundled Model 1 discount amount (see instructions) HVBP payment adjustment amount (see instructions) HRR adjustment amount (see instructions)			0 0 0	70

	ATION OF REIMBURSEMENT SETTLEMENT	Provider C	CN: 15-0109	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part A Date/Time Pre 4/29/2021 3:5	pared
		Title	e XVIII	Hospi tal	PPS	<u>z piii</u>
				(уууу)	Amount	
				0	1.00	
0. 96	Low volume adjustment for federal fiscal year (yyyy) (Enter in	n column O		0	0	70. 9
0. 97	the corresponding federal year for the period prior to 10/1) Low volume adjustment for federal fiscal year (yyyy) (Enter ir	n column O		0	0	70.9
0. 77	the corresponding federal year for the period ending on or aft			0	0	/0./
0. 98	Low Volume Payment-3	,			0	70.9
0. 99	HAC adjustment amount (see instructions)				472, 576	70. 9
1.00	Amount due provider (line 67 minus lines 68 plus/minus lines 6	69 & 70)			46, 352, 110	1
1.01	Sequestration adjustment (see instructions)				305, 924	
1.02 1.03	Demonstration payment adjustment amount after sequestration Sequestration adjustment-PARHM pass-throughs				0	71.0
2.00	Interim payments				46, 097, 224	
2.00	Interim payments-PARHM				40, 077, 224	72.0
3.00	Tentative settlement (for contractor use only)				0	
3. 01	Tentative settlement-PARHM (for contractor use only)					73.0
4.00	Balance due provider/program (line 71 minus lines 71.01, 71.02	2, 72, and			-51, 038	74.C
1 01						
4.01 5.00	Balance due provider/program-PARHM (see instructions) Protested amounts (nonallowable cost report items) in accordar	nco with			200 054	74.0
5.00	CMS Pub. 15-2, chapter 1, §115.2	ice with			280, 856	/ / 3. 0
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)		1			
0. 00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum o	of 2.03			0	90.0
	plus 2.04 (see instructions)					
1.00	Capital outlier from Wkst. L, Pt. I, line 2				0	91.0
2.00	Operating outlier reconciliation adjustment amount (see instru Capital outlier reconciliation adjustment amount (see instruct				0	92.
3.00 4.00	The rate used to calculate the time value of money (see instruct	,			0.00	
5.00	Time value of money for operating expenses (see instructions)				0.00	
6. 00	Time value of money for capital related expenses (see instruct	tions)			0	96.0
				Prior to 10/1		
	USD Denus Deument Amerint			1.00	2.00	
	HSP Bonus Payment Amount HSP bonus amount (see instructions)			0	0	100. 0
00.00				0	0	100.0
	IHVBP Adjustment for HSP Bonus Pavment					
	HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions)			0.000000000	0.000000000	101.0
01. 00		s)		0.0000000000000000000000000000000000000		
01. 00 02. 00	HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions HRR Adjustment for HSP Bonus Payment	s)		0	0	102. (
01. 00 02. 00 03. 00	HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions)			0.0000	0. 0000	102. (103. (
01. 00 02. 00 03. 00	HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions))	stmont	0	0. 0000	102. (103. (
01.00 02.00 03.00 04.00	HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr) ration) Adju		0.0000	0. 0000	102. (103. (104. (
01.00 02.00 03.00 04.00	HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per) ration) Adju		0.0000	0. 0000	102. (103. (104. (
01.00 02.00 03.00 04.00	HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr) ration) Adju		0.0000	0. 0000	102. (103. (104. (
01.00 02.00 03.00 04.00 00.00	HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line) ration) Adju riod under t		0.0000	0. 0000	102. (103. (104. (200. (201. (
01.00 02.00 03.00 04.00 00.00 00.00	HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions)) ration) Adju riod under t		0.0000	0. 0000	102. 103. 104. 200. 201. 201.
01.00 02.00 03.00 04.00 00.00 00.00	HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions)) ration) Adju riod under t e 49)	he 21st	0.0000	0.0000	102. (103. (104. (200. (201. (202. (
01.00 02.00 03.00 04.00 00.00 01.00 02.00	HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in) ration) Adju riod under t e 49)	he 21st	0.0000	0.0000	102. (103. (104. (200. (201. (202. (
01.00 02.00 03.00 04.00 00.00 01.00 02.00 03.00	HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions)) ration) Adju riod under t e 49)	he 21st	0.0000	0.0000	102. (103. (104. (200. (201. (202. (203. (
01.00 02.00 03.00 04.00 00.00 01.00 02.00 03.00	HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period)) ration) Adju riod under t e 49)	he 21st	0.0000	0.0000	102. (103. (
01.00 02.00 03.00 04.00 00.00 01.00 02.00 03.00	HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205)) ration) Adju riod under t e 49)	he 21st	0.0000	0.0000	102. (103. (104. (200. (201. (202. (203. (203. (
01.00 02.00 04.00 00.00 01.00 02.00 03.00 03.00 04.00 05.00	HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement) ration) Adju riod under t e 49) first year	he 21st	0.0000	0.0000	102. (103. (104. (200. (202. (203. (203. (204. (205. (206. (
01.00 02.00 03.00 04.00 00.00 01.00 01.00 02.00 03.00 04.00 05.00 06.00	HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions)) ration) Adju riod under t e 49) first year ructions)	he 21st	0.0000	0.0000	102. (103. (104. (200. (201. (202. (203. (203. (205. (205. (206. (207. (
01.00 02.00 03.00 04.00 00.00 01.00 02.00 03.00 04.00 05.00 06.00 06.00	HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions) Medicare Part A inpatient service costs (from Wkst. E, Pt. A,) ration) Adju riod under t e 49) first year ructions)	he 21st	0.0000	0.0000	102. (103. (104. (200. (201. (202. (203. (203. (205. (206. (206. (207. (208. (
 D1. 00 D2. 00 D3. 00 D4. 00 D0. 00 D1. 00 D2. 00 D3. 00 D4. 00 D5. 00 D6. 00 D7. 00 D8. 00 D9. 00 	HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions) Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions)) ration) Adju riod under t e 49) first year ructions)	he 21st	0.0000	0.0000 0	102. 103. 104. 200. 201. 202. 203. 204. 206. 206. 206. 206. 206. 206.
01. 00 02. 00 03. 00 04. 00 00. 00 01. 00 02. 00 02. 00 03. 00 04. 00 05. 00 04. 00 05. 00 06. 00 07. 00 08. 00 09. 00	HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions) Reserved for future use) ration) Adju riod under t e 49) first year ructions)	he 21st	0.0000	0.0000 0	102. 1 103. 1 200. 1 201. 2 203. 1 204. 2 205. 2 206. 1 207. 2 208. 1 209. 1 209. 1 209. 1 209. 1
01. 00 02. 00 03. 00 04. 00 00. 00 01. 00 02. 00 02. 00 03. 00 04. 00 05. 00 04. 00 05. 00 06. 00 07. 00 08. 00 09. 00	HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions) Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions)) ration) Adju riod under t e 49) first year ructions)	he 21st	0.0000	0.0000 0	102. 103. 104. 200. 201. 202. 203. 204. 205. 206. 207. 208.
01. 00 02. 00 03. 00 04. 00 00. 00 01. 00 02. 00 03. 00 05. 00 05. 00 05. 00 05. 00 07. 00 08. 00 09. 00 10. 00 01. 00 09. 00	HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions)) ration) Adju riod under t e 49) first year ructions) line 59)	he 21st	0.0000	0.0000 0	102. 103. 104. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209. 210.
01. 00 02. 00 04. 00 00. 00 00. 00 01. 00 02. 00 02. 00 02. 00 02. 00 05. 00 06. 00 07. 00 08. 00 09. 00 01. 00 11. 00 12. 00 13. 00	HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement) ration) Adju riod under t e 49) first year ructions) line 59) 211)	of the currer	0.0000	0.0000 0	102. 103. 104. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209. 210. 211.

		FRANCI SCAN HEA		N 15 0100		eu of Form CMS-2	2552-1
1059117	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	IION EXHIBIT 5	Provider CO		Period: From 01/01/2020 To 12/31/2020		
						4/29/2021 3:5	
		Wkst. E, Pt.	Amt. from	XVIII Period to	Hospital Period on	PPS Total (cols. 2	
		A, line	Wkst. E, Pt. A)	10/01	after 10/01	and 3)	
		0	1.00	2.00	3.00	4.00	
	DRG amounts other than outlier payments	1.00					1.0
. 01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	27, 795, 275	27, 795, 27	5	27, 795, 275	1.0
02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	10, 442, 319		10, 442, 319	10, 442, 319	1.0
03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October	1.03	0		o	0	1.0
04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1. C
. 00	Outlier payments for discharges (see	2.00					2.0
. 01	instructions) Outlier payments for discharges for Model 4	2.02	0		o o	0	2.0
. 02	BPCI Outlier payments for discharges occurring	2.03	526, 409	526, 40	9	526, 409	2.0
. 03	prior to October 1 (see instructions) Outlier payments for discharges occurring on	2.04	158, 249		158, 249	158, 249	2.0
	or after October 1 (see instructions) Operating outlier reconciliation	2.01	0		0 0	-	3.0
	Managed care simulated payments	3.00	0		0 0	0	4.0
00	Indirect Medical Education Adjustment Amount from Worksheet E, Part A, line 21	21.00	0. 000000	0. 00000	0 0. 000000		5.0
00	(see instructions) IME payment adjustment (see instructions)	22.00	0		0 0	0	6.0
01	IME payment adjustment for managed care (see instructions) instructions)	22.00	0		0 0	0	6.0
	Indirect Medical Education Adjustment for the	Add-on for Se	ction 422 of t	he MMA			
	IME payment adjustment factor (see instructions)	27.00	0. 000000		0 0. 000000		7.0
00	IME adjustment (see instructions)	28.00	0		o o	0	8. (
	IME payment adjustment add on for managed care (see instructions)	28.01	0		0 0	0	8. (
00	Total IME payment (sum of lines 6 and 8)	29.00	0		0	0	9.1
01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0		0 0	0	9. 0
	Di sproporti onate Share Adjustment		1				
	Allowable disproportionate share percentage (see instructions)	33.00	0. 1185	0. 118	5 0. 1185		10.
. 00	Disproportionate share adjustment (see instructions)	34.00	1, 132, 789	823, 43	5 309, 354	1, 132, 789	11.0
	Uncompensated care payments	36.00	3, 824, 093	2, 607, 92	3 1, 216, 170	3, 824, 093	11.0
	Additional payment for high percentage of ESR Total ESRD additional payment (see instructions)	46. 00	0 of scharges		0 0	0	12.0
. 00	Subtotal (see instructions)	47.00	43, 879, 134	31, 753, 04	2 12, 126, 092	43, 879, 134	13.
	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see	48.00	0	0.,,,00,,01	0 0	0	1
. 00	instructions) Total payment for inpatient operating costs (see instructions)	49.00	43, 879, 134	31, 753, 04	2 12, 126, 092	43, 879, 134	15.
. 00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	3, 291, 105	2, 468, 32	9 822, 776	3, 291, 105	16.
	Special add-on payments for new technologies Net organ acquisition cost	54.00	87, 403	65, 43	3 21, 970	87, 403	17. 17.
	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0		0 0	0	
. 00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0		o o	0	18. (
	SUBTOTAL			34, 286, 80	4 12, 970, 838	47, 257, 642	19.0

Health Financial Systems		FRANCI SCAN HEAI	LTH LAFAYETTE		In Lie	u of Form CMS-:	2552-10
HOSPITAL ACQUIRED CONDITION (HAC) F	REDUCTION CALCULA	TION EXHIBIT 5	Provider CO		Period: From 01/01/2020 To 12/31/2020		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 outli	er	1.00	2, 968, 743			2, 968, 743	20.00
20.01 Model 4 BPCI Capital DRG oth		1.01	0		0 0	0	•
21.00 Capital DRG outlier payments		2.00	149, 284	111, 90	63 37, 321	149, 284	
21.01 Model 4 BPCI Capital DRG out		2.01	0	, .	0 0	0	
22.00 Indirect medical education p		5.00	0.0000	0.000	0.0000	-	22.00
instructions)	ion contrago (coo	0.00		0.00	0.0000		22.00
23.00 Indirect medical education a instructions)	adjustment (see	6.00	0		0 0	0	23.00
24.00 Allowable disproportionate s (see instructions)	share percentage	10.00	0. 0583	0. 05	83 0. 0583		24.00
25.00 Di sproporti onate share adjus i nstructi ons)	stment (see	11.00	173, 078	129, 80	09 43, 269	173, 078	25.00
26.00 Total prospective capital pa	ayments (see	12.00	3, 291, 105	2, 468, 32	29 822, 776	3, 291, 105	26.00
		Wkst. E, Pt.	(Amt. from				
		A, line	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	0		0	0	28.00
29.00 Low volume adjustment on or	after October 1	70. 97	0		0	0	29.00
30.00 HVBP payment adjustment (see	e instructions)	70. 93	0		0 0	0	30.00
30.01 HVBP payment adjustment for	HSP bonus	70.90	0		0 0	0	30.01
payment (see instructions)							
31.00 HRR adjustment (see instruct	i ons)	70.94	0		0 0	0	31.00
31.01 HRR adjustment for HSP bonus instructions)	s payment (see	70. 91	0		0 0	0	31.01
						(Amt. to Wkst.	
						E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00 HAC Reduction Program adjust instructions)	ment (see	70. 99		342, 8	68 129, 708	472, 576	32.00
100.00 Transfer HAC Reduction Progr Wkst. E, Pt. A.	ram adjustment to		Y				100. 00

CALCUL	Financial Systems FRANCISCAN HEALTH ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0109	Peri od:	worksheet E	2552-10
			From 01/01/2020 To 12/31/2020	Date/Time Pre	
		Title XVIII	Hospi tal	4/29/2021 3: 5: PPS	2 pm
				1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
1.00 2.00	Medical and other services (see instructions) Medical and other services reimbursed under OPPS (see instruct	i one)		4, 582 20, 765, 300	1
3.00	OPPS payments	10115)		18, 033, 847	
4.00	Outlier payment (see instructions)			153, 394	
4.01 5.00	Outlier reconciliation amount (see instructions) Enter the hospital specific payment to cost ratio (see instruc	tions)		0.000	
6.00	Line 2 times line 5			0	
7.00 8.00	Sum of lines 3, 4, and 4.01, divided by line 6 Transitional corridor payment (see instructions)			0.00	
9.00	Ancillary service other pass through costs from Wkst. D, Pt. I	V, col. 13, line 200		227, 791	1
10.00 11.00	Organ acquisitions Total cost (sum of lines 1 and 10) (see instructions)			0 4, 582	
11.00	COMPUTATION OF LESSER OF COST OR CHARGES			1,002	
12.00	Reasonable charges Ancillary service charges			34, 822	1 1 2 00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, Ii	ne 69)		0	1
14.00	Total reasonable charges (sum of lines 12 and 13)			34, 822	14.00
15.00	Customary charges Aggregate amount actually collected from patients liable for p	ayment for services on	a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for	payment for services		0	16.00
17.00	had such payment been made in accordance with 42 CFR §413.13(e Ratio of line 15 to line 16 (not to exceed 1.000000)	.)		0. 000000	17.00
18.00	Total customary charges (see instructions)			34, 822	18.00
19.00	Excess of customary charges over reasonable cost (complete onl instructions)	y if line 18 exceeds l	ine 11) (see	30, 240	19.00
20.00	Excess of reasonable cost over customary charges (complete onl	y if line 11 exceeds l	ine 18) (see	0	20.00
21.00	instructions) Lesser of cost or charges (see instructions)			4, 582	21.00
22.00	Interns and residents (see instructions)			0	
23.00 24.00	Cost of physicians' services in a teaching hospital (see instr Total processitive payment (sum of lines 2, 4, 4,01, 8, and 0)	uctions)		19 415 022	
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) COMPUTATION OF REIMBURSEMENT SETTLEMENT			18, 415, 032	24.00
25.00	Deductibles and coinsurance amounts (for CAH, see instructions	-		3, 235, 933	•
26.00 27.00	Deductibles and Coinsurance amounts relating to amount on line Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) p			0 15, 183, 681	26.00
	instructions)] (
28.00 29.00	Direct graduate medical education payments (from Wkst. E-4, li ESRD direct medical education costs (from Wkst. E-4, line 36)	ne 50)		0	
30.00	Subtotal (sum of lines 27 through 29)			15, 183, 681	•
31.00 32.00	Primary payer payments Subtotal (line 30 minus line 31)			2, 226	1
32.00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVIC	ES)		15, 181, 455	32.00
	Composite rate ESRD (from Wkst. 1-5, line 11)			0	
34.00 35.00	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			561, 774 365, 153	
36.00	Allowable bad debts for dual eligible beneficiaries (see instr	uctions)		298, 663	36.00
37.00 38.00	Subtotal (see instructions) MSP-LCC reconciliation amount from PS&R			15, 546, 608	1
38.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			84	
39.50	Pioneer ACO demonstration payment adjustment (see instructions)			39.50
39.97	Demonstration payment adjustment amount before sequestration			0	
39.98	Partial or full credits received from manufacturers for replac	ed devices (see instru	ctions)	0	
39. 99 40. 00	RECOVERY OF ACCELERATED DEPRECIATION Subtotal (see instructions)			0 15, 546, 524	39.99 40.00
40.01	Sequestration adjustment (see instructions)			102, 607	
40. 02	Demonstration payment adjustment amount after sequestration			0	
40.03	Sequestration adjustment-PARHM pass-throughs			15 447 102	40.03
41.00 41.01	Interim payments Interim payments-PARHM			15, 467, 193	41.00 41.01
42.00	Tentative settlement (for contractors use only)			0	
42.01	Tentative settlement-PARHM (for contractor use only)				42.01
43.00 43.01	Balance due provider/program (see instructions) Balance due provider/program-PARHM (see instructions)			-23, 276	43.00 43.01
44.00	Protested amounts (nonallowable cost report items) in accordan §115.2	ce with CMS Pub. 15-2,	chapter 1,	0	
90 00	TO BE COMPLETED BY CONTRACTOR Original outlier amount (see instructions)			0	90.00
90.00 91.00	Outlier reconciliation adjustment amount (see instructions)			0	
	The rate used to calculate the Time Value of Money				92.00
92.00 93.00	Time Value of Money (see instructions)			0	93.00

ANALY	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC	CN: 15-0109	Period: From 01/01/2020 To 12/31/2020		pared:
		Title	XVIII	Hospi tal	PPS	2 pm
		I npati en			rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		45, 580, 6	24	15, 467, 193	1.00
2.00	Interim payments payable on individual bills, either			0	0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3.00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	11/07/2020	516, 6	00	0	3.01
3.02				0	0	3.02
3.03				0	0	3. 03
3.04				0	0	3.04
3.05				0	0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM			0	0	3.50
3.51				0	0	3.51
3.52				0	0	3.52
3.53				0	0	3.53
3.54 3.99	Subtatal (sum of lines 2 01 2 40 minus sum of lines		F1/ /	0	0	3.54 3.99
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		516, 6	00	0	3.95
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		46,097,2	24	15, 467, 193	4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as		10/07/12		10, 10, 17, 17, 0	
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5.00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
5.01	Program to Provider TENTATIVE TO PROVIDER			0	0	5.0 ²
5.01	TENTATIVE TO PROVIDER			0	0	5.02
5.02				0	0	5.02
0.00	Provider to Program	II		0		0.00
5.50	TENTATI VE TO PROGRAM			0	0	5.50
5.51				0	0	5.51
5.52				0	0	5.52
5.99	Subtotal (sum of lines 5.01–5.49 minus sum of lines			0	0	5.99
	5. 50-5. 98)					
6.00	Determined net settlement amount (balance due) based on					6.00
6. 01	the cost report. (1) SETTLEMENT TO PROVIDER			0	0	6. 0 ⁻
6.01	SETTLEMENT TO PROVIDER		51, C	0	23, 276	6.02
0.02 7.00	Total Medicare program liability (see instructions)		46, 046, 1		15, 443, 917	7.0
			10, 040, 1	Contractor	NPR Date	7.00
				Number	(Mo/Day/Yr)	
		C)	1.00	2.00	
3.00	Name of Contractor					8.0

IALYS	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC Component C	CN: 15-0109 CCN: 15-T109	Period: From 01/01/202 To 12/31/202		epare
		Title	XVIII	Subprovider - IRF		
		Inpatien	t Part A		art B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
00 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		3, 098, 7	0		0 1. 0 2.
00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					3.
01	ADJUSTMENTS TO PROVIDER			0		3.
02				0		3
)3				0	() 3
)4				0) 3
)5				0	(<u>)</u> 3
	Provider to Program			0		1 .
0	ADJUSTMENTS TO PROGRAM			0		2 3 2 3
52				0		
53				0		5 3 5 3
54				0		5 3
9	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)		3, 098, 7	49		2 4
	TO BE COMPLETED BY CONTRACTOR					
00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5
	Program to Provider					_
)1	TENTATI VE TO PROVI DER			0		0 5
)2)3				0		0 5 0 5
5	Provider to Program					의 이
50	TENTATI VE TO PROGRAM			0	(5 5
51				0		5 5
52				0		D 5
9	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0		D 5
00	Determined net settlement amount (balance due) based on the cost report. (1)					6
)1	SETTLEMENT TO PROVIDER			0) 6
02	SETTLEMENT TO PROGRAM		9,0			
00	Total Medicare program liability (see instructions)		3, 089, 6	68 Contractor	NPR Date	<u>7 C</u>
				Number	(Mo/Day/Yr)	
		(1.00	2.00	-

Heal th	Financial Systems	FRANCI SCAN HEALTH	LAFAYETTE	In Lie	u of Form CMS-	2552-10	
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 15-0109	Peri od: From 01/01/2020 To 12/31/2020		epared:	
			Title XVIII	Hospi tal	PPS		
					1.00		
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDA						
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTI						
1.00	Total hospital discharges as defined in AAR	e 14		1.00			
2.00							
3.00	Medicare HMO days from Wkst. S-3, Pt. I, co					3.00	
4.00	Total inpatient days from S-3, Pt. I col. 8		12			4.00	
5.00	Total hospital charges from Wkst C, Pt. I,					5.00	
6.00	Total hospital charity care charges from Wk					6.00	
7.00	CAH only - The reasonable cost incurred for line 168	the purchase of ce	ertified HIT technology	Wkst. S-2, Pt. I		7.00	
8.00	Calculation of the HIT incentive payment (s	see instructions)				8.00	
9.00	Sequestration adjustment amount (see instru	uctions)				9.00	
10.00	Calculation of the HIT incentive payment af	ter sequestration (see instructions)			10.00	
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS	& CAH		· · · · · · · · · · · · · · · · · · ·			
30.00	Initial/interim HIT payment adjustment (see	e instructions)				30.00	
31.00	Other Adjustment (specify)					31.00	
32.00	Balance due provider (line 8 (or line 10) m	ninus line 30 and li	ne 31) (see instruction	ns)		32.00	

AL CUI	Financial Systems FRANCISCAN HE ATION OF REIMBURSEMENT SETTLEMENT	ALTH LAFAYETTE Provider CCN: 15-0109	Peri od:	u of Form CMS-2 Worksheet E-3	
.2001		Component CCN: 15-T109	From 01/01/2020 To 12/31/2020	Part III	
			10 12/31/2020	4/29/2021 3:5	
		Title XVIII	Subprovider - IRF	PPS	
				1.00	
	PART III - MEDICARE PART A SERVICES - IRF PPS				
00	Net Federal PPS Payment (see instructions)			2, 857, 927	
00	Medicare SSI ratio (IRF PPS only) (see instructions)			0.0055	
00	Inpatient Rehabilitation LIP Payments (see instructions)			123, 462	
00	Outlier Payments			139, 617	
00	Unweighted intern and resident FTE count in the most rece to November 15, 2004 (see instructions)		0 1	0.00	
01	Cap increases for the unweighted intern and resident FTE program or hospital closure, that would not be counted wi CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00	1
0C	New Teaching program adjustment. (see instructions)			0.00	6
00	Current year's unweighted FTE count of I&R excluding FTEs	in the new program growth p	eriod of a "new	0.00	
	teaching program" (see instructions)				
00	Current year's unweighted I&R FTE count for residents wit teaching program" (see instructions)			0.00	
00	Intern and resident count for IRF PPS medical education a	djustment (see instructions)		0.00	
. 00	Average Daily Census (see instructions)			8. 535519	
00	Teaching Adjustment Factor (see instructions)			0.000000	
00 00	Teaching Adjustment (see instructions) Total PPS Payment (see instructions)			0 3, 121, 006	
00	Nursing and Allied Health Managed Care payments (see inst	ruction)		3, 121, 000	
00	Organ acquisition (DO NOT USE THIS LINE)	r de tr ony		0	1
00	Cost of physicians' services in a teaching hospital (see	instructions)		0	
00	Subtotal (see instructions)			3, 121, 006	
00	Primary payer payments			0	1
00	Subtotal (line 17 less line 18).			3, 121, 006	1
00	Deducti bl es			4, 180	
00	Subtotal (line 19 minus line 20)			3, 116, 826	
00	Coinsurance			8, 096	
00	Subtotal (line 21 minus line 22)	anviere) (and instructions)		3, 108, 730	
00 00	Allowable bad debts (exclude bad debts for professional s Adjusted reimbursable bad debts (see instructions)	ervices) (see instructions)		0	2
00	Allowable bad debts for dual eligible beneficiaries (see	instructions)		0	2
00	Subtotal (sum of lines 23 and 25)	Thisti detrons)		3, 108, 730	
00	Direct graduate medical education payments (from Wkst. E-	4 line 49)		3, 100, 730	
00	Other pass through costs (see instructions)			1, 465	
00	Outlier payments reconciliation			0	
00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	3
50	Pioneer ACO demonstration payment adjustment (see instruc	tions)		0	3
99	Demonstration payment adjustment amount before sequestrat	i on		0	3
00	Total amount payable to the provider (see instructions)			3, 110, 195	
01	Sequestration adjustment (see instructions)			20, 527	
02		on			3
00	Interim payments			3, 098, 749	
00	Tentative settlement (for contractor use only) Balance due provider/program (line 32 minus lines 32.01,	32 02 33 and 24		0 -9, 081	
00 00	Protested amounts (nonallowable cost report items) in acc §115.2		chapter 1,	-9,081	
	TO BE COMPLETED BY CONTRACTOR				
. 00	Original outlier amount from Wkst. E-3, Pt. III, line 4			139, 617	50
. 00	Outlier reconciliation adjustment amount (see instruction	s)		0	
2.00	The rate used to calculate the Time Value of Money	-		0.00	
	Time Value of Money (see instructions)			0	5

	FINANCI SCAN HEALTH			u of Form CMS-2	
ALCUL#	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0109	Period: From 01/01/2020 To 12/31/2020	Worksheet E-3 Part VII Date/Time Pre 4/29/2021 3:5	pare
		Title XIX	Hospi tal	Cost	2 pm
		· ·	I npati ent	Outpati ent	
			1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SE	RVICES FOR TITLES V OR >	I X SERVICES		
	COMPUTATION OF NET COST OF COVERED SERVICES				
	Inpatient hospital/SNF/NF services		0		1.
	Medical and other services			11, 963, 651	2.
	Organ acquisition (certified transplant centers only)		0	11 0/0 /51	3.
	Subtotal (sum of lines 1, 2 and 3) Inpatient primary payer payments		0	11, 963, 651	4.
	Outpatient primary payer payments		0	0	6
	Subtotal (line 4 less sum of lines 5 and 6)		0	11, 963, 651	
	COMPUTATION OF LESSER OF COST OR CHARGES			11, 700, 001	1 '
	Reasonable Charges				1
	Routine service charges		0		8
00	Ancillary service charges		35, 126, 256	82, 290, 136	9
0. 00	Organ acquisition charges, net of revenue		0		10
	Incentive from target amount computation		0		11
	Total reasonable charges (sum of lines 8 through 11)		35, 126, 256	82, 290, 136	12
	CUSTOMARY CHARGES				
	Amount actually collected from patients liable for payment fo	or services on a charge	0	0	13
1	basis Amounts that would have been realized from nationts lights fo	r novmant for carvicor	n O	0	11
	Amounts that would have been realized from patients liable fo a charge basis had such payment been made in accordance with		лт – О	0	14
	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)		35, 126, 256	82, 290, 136	
	Excess of customary charges over reasonable cost (complete on	ly if line 16 exceeds	35, 126, 256	70, 326, 485	
	line 4) (see instructions)	j			
3. 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	19
	Cost of physicians' services in a teaching hospital (see inst		0	0	20
1.00	Cost of covered services (enter the lesser of line 4 or line	16)	0	11, 963, 651	21
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be	completed for PPS provi	olders.	0	1 22
	Other than outlier payments Outlier payments		0	0	
	Program capital payments		0	0	24
	Capital exception payments (see instructions)		0		25
5.00	Routine and Ancillary service other pass through costs		0	0	
	Subtotal (sum of lines 22 through 26)		0	0	27
	Customary charges (title V or XIX PPS covered services only)		0	0	28
	Titles V or XIX (sum of lines 21 and 27)		0	11, 963, 651	29
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
0. 00	Excess of reasonable cost (from line 18)		0	0	30
	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6))	0	11, 963, 651	
	Deducti bl es		0	0	
	Coinsurance		0	0	
	Allowable bad debts (see instructions)		0	0	
	Utilization review Subtatal (sum of Lines 21, 24 and 25 minus sum of Lines 22 an	4 22)	0	11 0/0 /54	35
	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 an	iu 33)	0	11, 963, 651	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Subtotal (line 36 ± line 37)		0	0 11, 963, 651	37
	Direct graduate medical education payments (from Wkst. E-4)		0	11, 903, 051	38
	Total amount payable to the provider (sum of lines 38 and 39)		0	11, 963, 651	
	Interim payments		0	12, 124, 597	
	Balance due provider/program (line 40 minus line 41)		0	-160, 946	
	Protested amounts (nonallowable cost report items) in accorda	nce with CMS Pub 15-2	0	- 100, 940	42
	chapter 1, §115.2		Ĭ	0	1 '

LCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0109 Component CCN: 15-T109	Period: From 01/01/2020 To 12/31/2020	Worksheet E-3 Part VII Date/Time Pre	
				4/29/2021 3:5	2 p
		Title XIX	Subprovider - IRF	Cost	
			Inpatient 1.00	Outpatient	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SEF	RVICES FOR TITLES V OR X		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	
	COMPUTATION OF LESSER OF COST OR CHARGES				-
0	Reasonable Charges		0		1
)0)0	Routine service charges Ancillary service charges		574, 665	0	
00	Organ acquisition charges, net of revenue		0,14,003	0	10
00	Incentive from target amount computation		0		1
00	Total reasonable charges (sum of lines 8 through 11)		574, 665	0	
	CUSTOMARY CHARGES				
00	Amount actually collected from patients liable for payment for	r services on a charge	0	0	1:
	basi s				
00	Amounts that would have been realized from patients liable for		n 0	0	14
	a charge basis had such payment been made in accordance with 4	42 CFR §413.13(e)			
00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	
00	Total customary charges (see instructions)		574, 665	0	10
00	Excess of customary charges over reasonable cost (complete onl line 4) (see instructions)	y IT line 16 exceeds	574, 665	0	1
00	Excess of reasonable cost over customary charges (complete onl	vifling 4 exceeds lin	e 0	0	18
00	16) (see instructions)	y II IIIle 4 exceeds III	0	0	
00	Interns and Residents (see instructions)		0	0	19
00	Cost of physicians' services in a teaching hospital (see inst	ructions)	0	0	20
00	Cost of covered services (enter the lesser of line 4 or line		0	0	2
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be	completed for PPS provi	ders.		
00	Other than outlier payments		0	0	
00	Outlier payments		0	0	
00	Program capital payments		0		24
00	Capital exception payments (see instructions)		0		2!
00	Routine and Ancillary service other pass through costs		0	0	
00	Subtotal (sum of lines 22 through 26)		0	0	27
00 00	Customary charges (title V or XIX PPS covered services only) Titles V or XIX (sum of lines 21 and 27)		0	0	
00	COMPUTATION OF REIMBURSEMENT SETTLEMENT		V	0	2
00	Excess of reasonable cost (from line 18)		0	0	30
00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6))	0	0	
	Deducti bl es		0	0	
00	Coinsurance		0	0	3
00	Allowable bad debts (see instructions)		0	0	3.
00	Utilization review		0		3
00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	33)	0	0 0	
00	, , , ,	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			
00	Subtotal (line 36 ± line 37)		0	0	
00	Direct graduate medical education payments (from Wkst. E-4)		0	~	3
00	Total amount payable to the provider (sum of lines 38 and 39)		0	0	
00	Interim payments Relance due provider/program (Lipe 40 minus Lipe 41)		0	0	4
00 00	Balance due provider/program (line 40 minus line 41) Protested amounts (nonallowable cost report items) in accordar	ace with CMS Dub 15 2	0	0	
00	chapter 1, §115.2	ice with Gwb Fub 15-2,	0	0	1 4

	Financial Systems FRANCISCAN HEAL E SHEET (If you are nonproprietary and do not maintain ype accounting records, complete the General Fund column	Provider C		Period: From 01/01/2020 To 12/31/2020	Worksheet G Date/Time Pre	pare
		General Fund	Speci fi c Purpose Func			2 pm
	CURRENT ASSETS	1.00	2.00	3.00	4.00	-
00	Cash on hand in banks	-24, 345		0 0	0	1.
00	Temporary investments	37, 557, 701		0 0	0	2.
00	Notes receivable	0		0 0	0	3
00	Accounts receivable	70, 046, 843		0 0	0	4
00	Other receivable	0		0 0	0	5
00	Allowances for uncollectible notes and accounts receivable	-18, 307, 339		0 0	0	6
00	Inventory	5, 076, 454		0 0	0	
00	Prepaid expenses	20, 876, 960		0 0	0	
00	Other current assets	0		0 0	0	
. 00	Due from other funds	0		0 0	0	
. 00	Total current assets (sum of lines 1-10)	115, 226, 274	<u> </u>	0 0	0	11
. 00	FI XED ASSETS Land	12, 770, 293	1	0 0	0	12
. 00	Land improvements	4, 407, 894		0 0	0	
	Accumulated depreciation			0 0	0	
	Buildings	285, 042, 253		0 0	0	
	Accumulated depreciation	0		0 0	0	
	Leasehold improvements	811, 902		0 0	0	
. 00	Accumul ated depreciation	0		0 0	0	18
. 00	Fixed equipment	0		0 0	0	19
. 00	Accumulated depreciation	0		0 0	0	20
. 00	Automobiles and trucks	0		0 0	0	21
	Accumulated depreciation	0		0 0	0	
	Major movable equipment	94, 797, 791		0 0	0	
	Accumulated depreciation	-130, 210, 024		0 0	0	
	Minor equipment depreciable	0		0 0	0	
	Accumulated depreciation	0		0 0	0	
	HIT designated Assets Accumulated depreciation	0		0 0	0	
	Mi nor equi pment-nondepreci abl e	0		0 0	0	
	Total fixed assets (sum of lines 12-29)	267, 620, 109		0 0		
	OTHER ASSETS	20170207107	1	0		
. 00	Investments	600, 808		0 0	0	31
. 00	Deposits on Leases	0		0 0	0	32
. 00	Due from owners/officers	0		0 0	0	33
. 00	Other assets	43, 711, 461		0 0	0	34
. 00	Total other assets (sum of lines 31-34)	44, 312, 269		0 0	0	35
. 00	Total assets (sum of lines 11, 30, and 35)	427, 158, 652		0 0	0	36
	CURRENT LI ABI LI TI ES					
	Accounts payable	11, 375, 781		0 0		
	Salaries, wages, and fees payable	16, 468, 768		0 0	0	
	Payroll taxes payable Notes and Loans payable (short term)	0		0 0	0	
	Deferred i ncome	0		0 0	0	
	Accel erated payments			0	0	42
	Due to other funds	50, 422, 724		0 0	0	
	Other current liabilities	2, 464, 359		0 0		
	Total current liabilities (sum of lines 37 thru 44)	80, 731, 632		0 0	-	
	LONG TERM LI ABI LI TI ES			<u> </u>		
. 00	Mortgage payable	0		0 0	0	46
. 00	Notes payable	0		0 0	0	47
. 00	Unsecured Loans	0		0 0	0	48
	Other long term liabilities	-13, 069, 950		0 0	0	
	Total long term liabilities (sum of lines 46 thru 49)	-13, 069, 950		0 0	0	
. 00	Total liabilities (sum of lines 45 and 50)	67, 661, 682		0 0	0	51
~ ~	CAPI TAL ACCOUNTS	050 404 070	1		1	1
	General fund balance	359, 496, 970				52
. 00	Specific purpose fund			0		53
. 00	Donor created - endowment fund balance - restricted Donor created - endowment fund balance - unrestricted			0		54
. 00	Governing body created - endowment fund balance - unrestricted				1	56
. 00	Plant fund balance - invested in plant			0	0	
. 00	Plant fund balance - reserve for plant improvement,				0	
. 50	replacement, and expansion				l	
		359, 496, 970		0 0	0	59
. 00	Total fund balances (sum of lines 52 thru 58)	337,470,770		0	0	1 °

Heal th	Financial Systems	FRANCI SCAN HEALT	H LAFAYETTE			In Lie	u of Form CMS	-25	52-10
STATEM	ENT OF CHANGES IN FUND BALANCES		Provider CC	CN: 15-0109		eriod: com 01/01/2020 o 12/31/2020	Worksheet G- Date/Time Pr 4/29/2021 3:	epa	ared: pm
		General	Fund	Speci al	Pur	rpose Fund	Endowment Fun		
		1.00	2.00	3.00		4.00	5.00	+	
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ \end{array}$	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) CHANGE IN NON CONTROLLING INT SUBSID CHANGE IN DONOR RESTRICTIONS Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	4, 691, 954 -2, 234, 759 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	381, 642, 104 -26, 098, 883 355, 543, 221 2, 457, 195 358, 000, 416 0 358, 000, 416			0 0 0 0 0 0 0 0			1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00
		Endowment Fund	PI ant						
1 00	Fund halonage at heripping of pariod	6.00	7.00	8.00	0				1 00
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) CHANGE IN NON CONTROLLING INT SUBSID CHANGE IN DONOR RESTRICTIONS	0	0 0 0 0 0		0				1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00
10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0 0 0 0	0 0 0 0 0		0 0 0 0				10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00

STATE	Financial Systems FRANCISCAN HEALT	Provider CO	N· 15-0109	Peri od:	Worksheet G-2	2552-10
STATE	IENT OF TATTENT REVENUES AND OFENATING EXTENSES		N. 15 0107	From 01/01/2020 To 12/31/2020	Parts I & II	pared:
	Cost Center Description		Inpati ent	Outpati ent	Total	
			1.00	2.00	3.00	
	PART I – PATIENT REVENUES					
	General Inpatient Routine Services					
1.00	Hospi tal		75, 130, 2	04	75, 130, 204	1.00
2.00	SUBPROVIDER - IPF					2.00
3.00	SUBPROVIDER - IRF		5, 899, 1	55	5, 899, 155	3.00
4.00	SUBPROVIDER					4.00
5.00	Swing bed - SNF			0	0	5.00
6.00	Swing bed - NF			0	0	
7.00	SKILLED NURSING FACILITY					7.00
8.00 9.00	NURSING FACILITY OTHER LONG TERM CARE					8.00 9.00
9.00			81, 029, 3	50	81, 029, 359	
10.00	Total general inpatient care services (sum of lines 1-9) Intensive Care Type Inpatient Hospital Services		01, 029, 3	39	01, 029, 339	10.00
11.00	INTENSIVE CARE UNIT		18, 173, 6	82	18, 173, 682	11.00
12.00	CORONARY CARE UNIT		10, 175, 0	02	10, 175, 002	12.00
13.00	BURN INTENSIVE CARE UNIT					13.00
14.00						14.00
15.00	NEONATAL INTENSIVE CARE UNIT		19, 916, 2	75	19, 916, 275	
16.00		flines	38, 089, 9		38, 089, 957	
	11-15)					
17.00	Total inpatient routine care services (sum of lines 10 and 10	6)	119, 119, 3	16	119, 119, 316	17.00
18.00	Ancillary services		465, 340, 8	15 527, 653, 950	992, 994, 765	18.00
19.00	Outpatient services		20, 534, 5	10 131, 924, 559	152, 459, 069	19.00
20.00	RURAL HEALTH CLINIC			0 0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER			0 0	0	21.00
22.00	HOME HEALTH AGENCY			13, 153, 346		
23.00	AMBULANCE SERVICES			0 13, 031, 710	13, 031, 710	
24.00	СМНС					24.00
25.00	AMBULATORY SURGICAL CENTER (D. P.)					25.00
26.00	HOSPICE			0 21, 689, 262		
27.00	OTHER PATIENT REVENUE			12 609, 693		
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3	3 TO WKST.	604, 994, 8	53 708, 062, 520	1, 313, 057, 373	28.00
	G-3, line 1) PART II - OPERATING EXPENSES					-
29.00	Operating expenses (per Wkst. A, column 3, line 200)			331, 545, 181		29.00
30.00	ADD (SPECIFY)			0		30.00
31.00				0		31.00
32.00				0		32.00
33.00				0		33.00
34.00				0		34.00
35.00				0		35.00
36.00	Total additions (sum of lines 30-35)			0		36.00
37.00	DEDUCT (SPECI FY)			0		37.00
38.00				0		38.00
39.00				0		39.00
40.00				0		40.00
41.00				0		41.00
42.00	Total deductions (sum of lines 37-41)			0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line -	42)(transfer		331, 545, 181		43.00
	to Wkst. G-3, line 4)					

Heal th	Financial Systems	FRANCI SCAN HEALTH	LAFAYETTE	In Lie	u of Form CMS-2	2552-10
STATEN	IENT OF REVENUES AND EXPENSES		Provider CCN: 15-0109	Period: From 01/01/2020 To 12/31/2020	Worksheet G-3 Date/Time Pre 4/29/2021 3:5	pared:
					1.00	
1.00	Total patient revenues (from Wkst. G-2,	Part L column 2 Line	20)		1, 313, 057, 373	1.00
2.00	Less contractual allowances and discour				971, 434, 869	2.00
3.00	Net patient revenues (line 1 minus line				341, 622, 504	
4.00	Less total operating expenses (from Wks		3)		331, 545, 181	
5.00	Net income from service to patients (li				10, 077, 323	5.00
	OTHER I NCOME					
6.00	Contributions, donations, bequests, etc				68, 431	6.00
7.00	Income from investments				799, 703	7.00
8.00	Revenues from telephone and other misce	llaneous communication	servi ces		0	8.00
9.00	Revenue from television and radio servi	се			0	9.00
10.00	Purchase di scounts				1, 272, 101	10.00
	Rebates and refunds of expenses				0	
	Parking lot receipts				0	12.00
	Revenue from laundry and linen service				0	13.00
	Revenue from meals sold to employees an	id guests			819, 566	
	Revenue from rental of living quarters				0	15.00
	Revenue from sale of medical and surgio		nan patients		0	16.00
	Revenue from sale of drugs to other that				103, 213	
	Revenue from sale of medical records an				897	18.00
	Tuition (fees, sale of textbooks, unife				2, 487, 690	
	Revenue from gifts, flowers, coffee sho	pps, and canteen			0	20.00
	Rental of vending machines				0	21.00 22.00
	Rental of hospital space				188, 350 0	22.00
	Governmental appropriations OTHER OPERATING REVENUE				4, 151, 421	
	NON-OPERATING REVENUE				4, 151, 421 844, 293	
	COVID-19 PHE Funding				11, 631, 505	
	Total other income (sum of lines 6-24)				22, 367, 170	
	Total (line 5 plus line 25)				32, 444, 493	
	EQUITY TRANSFERS				56, 136, 551	
	CONTRIBUTIONS OF PPE				-2, 285, 129	
	MI NORI TY I NTEREST				4, 691, 954	
	Total other expenses (sum of line 27 ar	d subscripts)			58, 543, 376	
	Net income (or loss) for the period (li				-26, 098, 883	

MLI C	i Financial Systems SIS OF HOSPITAL-BASED HOME HEALT		FRANCI SCAN HEAL	Provider C	CN: 15-0109	Peri od:	wof Form CMS-2 Worksheet H	2002-
				HHA CCN:	15-7124	From 01/01/2020 To 12/31/2020		pared 2 pm
						Home Health Agency I	PPS	F
		Sal ari es	Employee Benefits	Transportation (see	chased		Total (sum of cols. 1 thru	
		1.00	2.00	<u>instructions)</u> 3.00	Services 4.00	5.00	5) 6.00	
	GENERAL SERVICE COST CENTERS				1		I	
00	Capital Related - Bldg. &			0		0	0	1. C
00	Fixtures Capital Related - Movable Equipment			0		26, 617	26, 617	2.0
00	Plant Operation & Maintenance	0	0	0		0 0	0	3.0
00	Transportation	0	0	0		0 0	0	4. C
00	Administrative and General	783, 138	1, 879	17, 144	134, 4	27 -22, 932	913, 656	5. C
00	HHA REIMBURSABLE SERVICES Skilled Nursing Care	1, 492, 455	0	102, 279	2,0	13 -94	1, 596, 653	6.0
00	Physical Therapy	929, 922	0	65, 871	18, 1			
00	Occupational Therapy	357, 481	0	19, 587				
00	Speech Pathology	47, 471	0	1, 861	41, 0	91 0	90, 423	9.0
. 00	Medical Social Services	2, 898		130		0 0	3, 028	
. 00	Home Health Aide	79, 292		19, 711		0 0		
. 00	Supplies (see instructions)	0		0		0 6,773		
. 00 . 00	Drugs DME	0	-	0		0 252, 797 0 0		
. 00	HHA NONREI MBURSABLE SERVI CES	0	0	0		0 0	0	1 1 7. (
. 00	Home Dialysis Aide Services	0	0	0		0 0	0	15. (
. 00	Respiratory Therapy	0	-	0		0 0	0	
. 00	Private Duty Nursing	0	0	0		0 0	0	
. 00 . 00	Clinic Health Promotion Activities	0	0	0		0 0	0	
. 00	Day Care Program	0	0	0		0 0		1
. 00	Home Delivered Meals Program	0	0	0		0 0	0	
. 00	Homemaker Service	0	0	0		0 0	0	
. 00		1, 189, 442	225	16, 984	151, 1	98 6, 544, 347	7, 902, 196	
. 50	Tel emedi ci ne	0	0	0	202.0	0 0	0 12, 319, 125	
. 00	Total (sum of lines 1-23)	4, 882, 099 Recl assi fi cati		243,567 Adjustments	383,8 Net Expense		12, 319, 125	24.0
		on	Trial Balance	naj as tilon to	for Allocati			
			(col. 6 +		(col. 8 + co	Ι.		
		7.00	col . 7)	0.00	9)			-
	GENERAL SERVICE COST CENTERS	7.00	8.00	9.00	10.00			
00	Capital Related - Bldg. &	0	0	0		0		1 1.0
	Fixtures							
00	Capital Related - Movable Equipment	0	26, 617	0	26, 6	17		2.
	Plant Operation & Maintenance	0	0	0		0		3.
00			-	0		0		
00	Transportation	0	0	0		0		
	Administrative and General	0	0	-		0		
00 00			0 913, 656	0	913, 6	0 56		5.
00	Administrative and General HHA REIMBURSABLE SERVICES	0	0 913, 656 1, 596, 653	0	913, 6	0 56 53		5. 6.
00 00 00 00 00	Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy	0 0 0 0	0 913, 656 1, 596, 653 1, 013, 959 414, 020	0 0 0 0 0 0	913, 6 1, 596, 6 1, 013, 9 414, 0	0 56 53 59 20		5. 6. 7. 8.
00 00 00 00 00 00	Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology	0 0 0 0 0	0 913, 656 1, 596, 653 1, 013, 959 414, 020 90, 423	0 0 0 0 0 0	913, 6 1, 596, 6 1, 013, 9 414, 0 90, 4	0 55 53 59 20 23		5. 6. 7. 8. 9.
00 00 00 00 00 00 . 00	Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services	0 0 0 0	0 913, 656 1, 596, 653 1, 013, 959 414, 020 90, 423 3, 028	0 0 0 0 0 0	913, 6 1, 596, 6 1, 013, 9 414, 0 90, 4 3, 0	0 56 53 59 20 23 28		5. 6. 7. 8. 9. 10.
00 00 00 00 00 00 . 00 . 00	Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide		0 913, 656 1, 596, 653 1, 013, 959 414, 020 90, 423 3, 028 99, 003		913, 6 1, 596, 6 1, 013, 9 414, 0 90, 4 3, 0 99, 0	0 55 53 59 20 23 28 03		5. 6. 7. 8. 9. 10. 11.
00 00 00 00 00 00 . 00 . 00 . 00	Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions)		0 913, 656 1, 596, 653 1, 013, 959 414, 020 90, 423 3, 028 99, 003 6, 773		913, 6 1, 596, 6 1, 013, 9 414, 0 90, 4 3, 0 99, 0 6, 7	0 56 53 59 20 23 28 03 73		4. 5. 6. 7. 8. 9. 10. 11. 12. 13.
00 00 00 00 00 00 . 00 . 00	Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs		0 913, 656 1, 596, 653 1, 013, 959 414, 020 90, 423 3, 028 99, 003 6, 773 252, 797		913, 6 1, 596, 6 1, 013, 9 414, 0 90, 4 3, 0 99, 0 6, 7 252, 7	0 56 53 59 20 23 28 03 73		5. 6. 7. 8. 9. 10. 11. 12. 13.
00 00 00 00 00 00 . 00 . 00 . 00 . 00	Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME HHA NONREIMBURSABLE SERVICES		0 913, 656 1, 596, 653 1, 013, 959 414, 020 90, 423 3, 028 99, 003 6, 773 252, 797 0		913, 6 1, 596, 6 1, 013, 9 414, 0 90, 4 3, 0 99, 0 6, 7 252, 7	0 55 53 59 20 23 28 03 73 97 0		5. 6. 7. 8. 9. 10. 11. 12. 13. 14.
00 00 00 00 00 00 . 00 . 00 . 00 . 00	Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services		0 913, 656 1, 596, 653 1, 013, 959 414, 020 90, 423 3, 028 99, 003 6, 773 252, 797 0		913, 6 1, 596, 6 1, 013, 9 414, 0 90, 4 3, 0 99, 0 6, 7 252, 7	0 55 53 59 20 23 28 03 73 97 0 0		5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15.
00 00 00 00 00 00 00 00 00 00 00 00 00	Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services Respiratory Therapy		0 913, 656 1, 596, 653 1, 013, 959 414, 020 90, 423 3, 028 99, 003 6, 773 252, 797 0 0		913, 6 1, 596, 6 1, 013, 9 414, 0 90, 4 3, 0 99, 0 6, 7 252, 7	0 55 53 59 20 23 28 03 73 97 0		5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16.
00 00 00 00 00 00 00 00 00 00 00 00 00	Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing		0 913, 656 1, 596, 653 1, 013, 959 414, 020 90, 423 3, 028 99, 003 6, 773 252, 797 0		913, 6 1, 596, 6 1, 013, 9 414, 0 90, 4 3, 0 99, 0 6, 7 252, 7	0 55 53 59 20 23 28 03 73 97 0 0		5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17.
00 00 00 00 00 00 00 00 00 00 00 00 00	Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing		0 913, 656 1, 596, 653 1, 013, 959 414, 020 90, 423 3, 028 99, 003 6, 773 252, 797 0 0		913, 6 1, 596, 6 1, 013, 9 414, 0 90, 4 3, 0 99, 0 6, 7 252, 7	0 55 53 59 20 23 28 03 73 97 0 0		5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18.
00 00 00 00 00 00 00 00 00 00 00 00 00	Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities		0 913, 656 1, 596, 653 1, 013, 959 414, 020 90, 423 3, 028 99, 003 6, 773 252, 797 0 0 0 0 0 0 0 0		913, 6 1, 596, 6 1, 013, 9 414, 0 90, 4 3, 0 99, 0 6, 7 252, 7	0 56 53 59 20 23 28 03 73 97 0 0 0 0 0 0 0		5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19.
00 00 00 00 00 00 00 00 00 00 00 00 00	Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program		0 913, 656 1, 596, 653 1, 013, 959 414, 020 90, 423 3, 028 99, 003 6, 773 252, 797 0 0 0 0 0 0 0 0		913, 6 1, 596, 6 1, 013, 9 414, 0 90, 4 3, 0 99, 0 6, 7 252, 7	0 56 53 59 20 23 28 03 73 97 0 0 0 0 0 0 0		5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21.
00 00 00 00 00 00 00 00 00 00 00 00 00	Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service		0 913, 656 1, 596, 653 1, 013, 959 414, 020 90, 423 3, 028 99, 003 6, 773 252, 797 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		913, 6 1, 596, 6 1, 013, 9 414, 0 90, 4 3, 0 99, 0 6, 7 252, 7	0 56 53 59 20 23 28 03 73 97 0 0 0 0 0 0 0 0 0 0 0 0 0		5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22.
00 00 00 00 00 00 00 00 00 00 00 00 00	Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify)		0 913, 656 1, 596, 653 1, 013, 959 414, 020 90, 423 3, 028 99, 003 6, 773 252, 797 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		913, 6 1, 596, 6 1, 013, 9 414, 0 90, 4 3, 0 99, 0 6, 7 252, 7 7, 902, 1	0 56 53 59 20 23 28 03 73 97 0 0 0 0 0 0 0 0 0 0 0 0 0		5. 6. 7. 8. 9. 10.

Heal th	Financial Systems	1	RANCISCAN HEAL	TH LAFAYETTE		In Lie	u of Form CMS-	2552-10
COST A	LLOCATION - HHA GENERAL SERVICE	COST		Provider CO HHA CCN:	CN: 15-0109 15-7124	Period: From 01/01/2020 To 12/31/2020	Date/Time Pre	pared:
						Home Health	4/29/2021 3:5 PPS	2 pm
			Capital Rel	ated Costs		Agency I		
		Net Expenses for Cost Allocation (from Wkst. H,	BIdgs & Fixtures	Movable Equipment	Plant Operation & Maintenance		Subtotal (cols. 0-4)	
	1	col. 10) 0	1.00	2.00	3.00	4.00	4A. 00	
1.00	GENERAL SERVICE COST CENTERS Capital Related - Bldg. &	0	0				0	1.00
	Fixtures		-					
2.00	Capital Related – Movable Equipment	26, 617		26, 617			0	2.00
3.00	Plant Operation & Maintenance	0	0	0		0	C	
4.00 5.00	Transportation Administrative and General	0 913, 656	0	0 26, 617		0 0	940, 273	4.00
	HHA REIMBURSABLE SERVICES		-					1
6.00 7.00	Skilled Nursing Care Physical Therapy	1, 596, 653 1, 013, 959	0	0		0 0 0 0		
8.00	Occupational Therapy	414, 020	0	0		0 0	414, 020	8.00
9.00 10.00	Speech Pathology Medical Social Services	90, 423 3, 028	0	0		0 0	90, 423 3, 028	
11.00	Home Heal th Aide	99, 003	0	0		0 0	99, 003	1
12.00	Supplies (see instructions)	6, 773	0	0		0 0	6, 773	
13.00 14.00	Drugs DME	252, 797 0	0	0 0		0 0	252, 797 0	
	HHA NONREI MBURSABLE SERVI CES						-	
15.00 16.00	Home Dialysis Aide Services Respiratory Therapy	0	0	0		0 0	0	
17.00	Private Duty Nursing	0	0	0		0 0	0	1
18.00	Clinic	0	0	0		0 0	0	
19.00 20.00	Health Promotion Activities Day Care Program	0	0	0 0		0 0 0 0	0	
21.00	Home Delivered Meals Program	0	0	0		0 0	0	21.00
22. 00 23. 00	Homemaker Service All Others (specify)	0 7, 902, 196	0	0		0 0	0 7, 902, 196	
23.50	Tel emedi ci ne	0	0	0		0 0	C	23.50
24.00	Total (sum of lines 1-23)	12, 319, 125 Admi ni strati ve	0 Total (cols	26, 617		0 0	12, 319, 125	24.00
		& General	4A + 5)					
	GENERAL SERVICE COST CENTERS	5.00	6.00					
1.00	Capital Related - Bldg. &							1.00
2.00	Fixtures							2.00
2.00	Capital Related - Movable Equipment							2.00
3.00	Plant Operation & Maintenance							3.00
4.00 5.00	Transportation Administrative and General	940, 273						4.00 5.00
(00	HHA REIMBURSABLE SERVICES		1 700 500					
6.00 7.00	Skilled Nursing Care Physical Therapy	131, 936 83, 786	1, 728, 589 1, 097, 745					6.00 7.00
8.00	Occupational Therapy	34, 212	448, 232					8.00
9.00 10.00	Speech Pathology Medical Social Services	7, 472 250	97, 895 3, 278					9.00 10.00
11.00	Home Heal th Ai de	8, 181	107, 184					11.00
12.00	Supplies (see instructions)	560	7, 333					12.00
13.00 14.00	Drugs DME	20, 889 0	273, 686 0					13.00 14.00
15 00	HHA NONREI MBURSABLE SERVI CES							15 00
15.00 16.00	Home Dialysis Aide Services Respiratory Therapy	0	0					15.00 16.00
17.00	Private Duty Nursing	0	0					17.00
18. 00 19. 00	Clinic Health Promotion Activities	0	0					18.00 19.00
20.00	Day Care Program	0	0					20.00
21.00	Home Delivered Meals Program	0	0					21.00
22. 00 23. 00	Homemaker Service All Others (specify)	0 652, 987	0 8, 555, 183					22.00 23.00
23.50	Tel emedi ci ne	0	0					23.50
24.00	Total (sum of lines 1-23)	1	12, 319, 125					24.00

	Financial Systems ALLOCATION - HHA STATISTICAL BAS		FRANCI SCAN HEAL	Provider C	^N· 15_0109	Peri od:	u of Form CMS-: Worksheet H-1	
C031 P	LEUCATION - THA STATISTICAL DA	5		HHA CCN:	15-7124	From 01/01/2020 To 12/31/2020	Part II Date/Time Pre 4/29/2021 3:5	pared:
						Home Health	PPS	2 pm
		Conital Do	ated Costs			Agency I		
		BIdgs &	Movabl e	PI ant	Transportati	onReconciliation	Admi ni strati ve	1
		Fixtures	Equi pment	Operation &	(MI LEAGE)		& General	
		(SQUARE FEET)	(DOLLAR VALUE)	Maintenance			(ACCUM. COST)	
		1.00	2.00	(SQUARE FEET) 3.00	4.00	5A. 00	5.00	
	GENERAL SERVICE COST CENTERS	1.00	2.00	5.00	4.00	5A. 00	5.00	
1.00	Capital Related - Bldg. &	7, 871				0		1.00
	Fixtures							
2.00	Capital Related - Movable		7, 871			0		2.00
2 00	Equipment Plant Operation & Maintenance	0	0	7, 871		0		3.00
3.00 4.00	Transportation (see		0	, 8/1		0		4.00
4.00	i nstructi ons)		0	0		Ŭ		4.00
5.00	Administrative and General	7, 871	7, 871	7, 871		0 -940, 273	11, 378, 852	5.00
	HHA REIMBURSABLE SERVICES		1					
6.00	Skilled Nursing Care	0		0		0 0	1, 596, 653	
7.00	Physical Therapy	0	0	0		0 0	1, 013, 959	
8.00 9.00	Occupational Therapy Speech Pathology	0	0	0		0 0	414, 020 90, 423	
9.00	Medical Social Services	0	0	0		0 0	90, 423 3, 028	
11.00	Home Heal th Ai de		0	0		0 0	99,003	
12.00	Supplies (see instructions)	0	0	0		0 0	6, 773	
13.00	Drugs	0	0	0		0	252, 797	13.00
14.00	DME	0	0	0		0 0	0	14.0
	HHA NONREI MBURSABLE SERVI CES	-	-	-				
15.00	Home Dialysis Aide Services Respiratory Therapy	0		0		0 0	0	
16.00 17.00	Private Duty Nursing	0	0	0		0 0	0	
18.00	Clinic		0	0		0 0	0	
19.00	Health Promotion Activities	0	0	0		0 0	0	
20.00	Day Care Program	0	0	0		0 0	0	20.0
21.00	Home Delivered Meals Program	0	0	0		0 0	0	
22.00	Homemaker Service	0	0	0		0 0	0	
23.00	All Others (specify)	0	0	0		0 0	7, 902, 196	
23.50	Telemedicine					0 0 -940 273	11 270 052	23.5
24.00 25.00	Total (sum of lines 1-23) Cost To Be Allocated (per	7,871		7, 871 0		0 -940, 273	11, 378, 852 940, 273	
∠0. UU	Worksheet H-1, Part I)		20,017				940, 273	25.0
2/ 00	Unit Cost Multiplier	0. 000000	3. 381654	0. 000000	0.0000	00	0. 082633	26 00

ALLOC	n Financial Systems ATION OF GENERAL SERVICE COSTS T			TH LAFAYETTE Provider CC	CN: 15-0109	Period: From 01/01/2020	Worksheet H-2	2552-10
				HHA CCN:		To 12/31/2020	Date/Time Pre 4/29/2021 3:5	pared: 2 pm
						Home Health Agency I	PPS	
			CAPITAL REL	ATED COSTS				
	Cost Center Description	HHA Trial Balance (1)	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	COMMUNI CATI ONS	MGMT INFO SYSTEMS	
		0	1.00	2.00	4.00	5. 01	5.02	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 11. 00 11. 00 12. 00 13. 00 14. 00 15. 00 14. 00 19. 00 19. 00 19. 00 21. 00	Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to	0 1, 728, 589 1, 097, 745 448, 232 97, 895 3, 278 107, 184 7, 333 273, 686 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	280, 322 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	40, 468 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			797, 065 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 14.00 15.00 14.00 17.00 18.00 19.00 19.50
	6 decimal places. Cost Center Description	PURCHASI NG	ADMI TTI NG	PATI ENT ACCOUNTI NG	Subtotal	OTHER ADMI NI STRATI VE	OPERATION OF PLANT	
		5. 03	5.04	5.05	5A. 05	AND GENERAL 5.06	7.00	
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 11.00 12.00 13.00 14.00 15.00 14.00 15.00 14.00 19.00 19.00 19.00 19.00 20.00 21.00	Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2)	29, 622 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		69, 160 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2, 488, 43 1, 728, 58 1, 097, 74 448, 23 97, 89 3, 27 107, 18 7, 33 273, 68	$\begin{array}{c ccccccccccccccccccccccccccccccccccc$	283, 291 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	3.00 4.00 5.00 6.00 7.00 8.00 9.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.50

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

ALLOC	Financial Systems ATION OF GENERAL SERVICE COSTS 1		<u>FRANCI SCAN_HEAL</u> TERS	Provider C	CN: 15-0109	Period:	Worksheet H-2	
				HHA CCN:	15-7124	From 01/01/2020 To 12/31/2020	4/29/2021 3:5	pared: 2 pm
						Home Health Agency I	PPS	
	Cost Center Description	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	
	1	8.00	9.00	10.00	11.00	13.00	14.00	
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ 20.\ 00\\ 21.\ 00\\ \end{array}$	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.					0 0 0 0	15, 012 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.50
	Cost Center Description	PHARMACY	MEDI CAL S RECORDS & LI BRARY	SOCIAL SERVICE	NURSING SCHOO	DL PHARMACY RESI DENCY	EMS EDUCATION	
	1	15.00	16.00	17.00	20.00	23.00	23.01	
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ 19.\ 50\\ 20.\ 00\\ 21.\ 00\\ \end{array}$								2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00

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

Heal th	Financial Systems		FRANCI SCAN HEAL	TH LAFAYETTE		In Lie	u of Form CMS-	2552-10
ALLOCA	ATION OF GENERAL SERVICE COSTS TO	D HHA COST CEN	TERS	Provider CO	CN: 15-0109 15-7124	Period: From 01/01/2020 To 12/31/2020	Worksheet H-2 Part I Date/Time Pre 4/29/2021 3:5	pared:
						Home Health	PPS	
						Agency I		
	Cost Center Description	Subtotal	Intern &	Subtotal	Allocated HH			
			Residents Cost		A&G (see Par	t Costs		
			& Post)			
			Stepdown Adjustments					
	-	24.00	25.00	26.00	27.00	28.00		
1.00	Administrative and General	3, 725, 698		3, 725, 698		20.00		1.00
2.00	Skilled Nursing Care	1, 934, 969		1, 934, 969		2, 457, 749		2.00
3.00	Physical Therapy	1, 228, 807	0	1, 228, 807				3.00
4.00	Occupational Therapy	501, 747	0	501, 747				4.00
5.00	Speech Pathol ogy	109, 583	0	109, 583				5.00
6.00	Medical Social Services	3, 669	0	3, 669				6.00
7.00	Home Health Aide	119, 981	0	119, 981				7.00
8.00	Supplies (see instructions)	8, 209	0	8, 209				8.00
9.00	Drugs	306, 362	0	306, 362	82, 77	1 389, 133		9.00
10.00	DME	0	0	0		0 0		10.00
11.00	Home Dialysis Aide Services	0	0	0		0 0		11.00
12.00	Respiratory Therapy	0	0	0		0 0		12.00
13.00	Private Duty Nursing	0	0	0		0 0		13.00
14.00	Clinic	0	0	0		0 0		14.00
15.00	Health Promotion Activities	0	0	0		0 0		15.00
16.00	Day Care Program	0	0	0		0 0		16.00
17.00	Home Delivered Meals Program	0	0	0		0 0		17.00
18.00	Homemaker Service	0	0	0		0 0		18.00
19.00		9, 576, 603	0	9, 576, 603	2, 587, 36	3 12, 163, 966		19.00
19.50		0	0	0		0 0		19.50
20.00	Total (sum of lines 1-19) (2)	17, 515, 628	0	17, 515, 628				20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.				0. 27017	5		21.00

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

BASIS HHA CCN: 15-7124 From 01/01/2020 PD To 12/31/2020 PD To 12/31/2000 PD To 12/31/200	Worksheet H-2 Part II Date/Time Prepared: 4/29/2021 3:52 pm PPS PURCHASI NG (COSTED REQ UI SI) 5.03 342,282 1.00 0 3.00 0 3.00 0 </th
Cost Center Description CAPITAL RELATED COSTS EMPLOYEE EMPLOYEE COMMUNICATIONS MGRT INFO 1.00 Administrative and General 7.871 7.871 6.00 6.00 0 <th>PPS PURCHASI NG (COSTED REQ UI SI) 5.03 342, 282 1.00 0 2.00 0 </th>	PPS PURCHASI NG (COSTED REQ UI SI) 5.03 342, 282 1.00 0 2.00 0
Cost Center Description CAPITAL RELATED COSTS EMPLOYEE COMMUNICATIONS MGMT INFO SYSTEMS	PURCHASI NG (COSTED REQ UI SI) 5.03 342, 282 0 2.00 0
Cost Center Description BLDG & FIXT (SOUARE FEET) NVBLE EOUIP (SOUARE FEET) EMPLOYEE (SOUARE FEET) COMMUNICATIONS (PHONE LINES) MGMT INFO (PHONE LINES) 1.00 Administrative and General 2.00 1.00 2.00 4.00 5.01 5.02 1.00 Administrative and General 2.00 7,871 7,871 4,882,099 0 114,625 2.00 Skilled Nursing Care 3.00 0 <td>(COSTED REQ UI SI) 5. 03 342, 282 1. 00 0 2. 00 0 3. 00 0 4. 00 0 5. 00 0 6. 00 0 7. 00 0 8. 00 0 9. 00 0 10. 00 0 11. 00 0 12. 00</td>	(COSTED REQ UI SI) 5. 03 342, 282 1. 00 0 2. 00 0 3. 00 0 4. 00 0 5. 00 0 6. 00 0 7. 00 0 8. 00 0 9. 00 0 10. 00 0 11. 00 0 12. 00
Image: second	(COSTED REQ UI SI) 5. 03 342, 282 1. 00 0 2. 00 0 3. 00 0 4. 00 0 5. 00 0 6. 00 0 7. 00 0 8. 00 0 9. 00 0 10. 00 0 11. 00 0 12. 00
Image: Construction of the problem of the p	UISI) 5.03 342,282 1.00 0 2.00 0 3.00 0 4.00 0 5.00 0 6.00 0 7.00 0 8.00 0 9.00 0 9.00 0 10.00 0 11.00 0 12.00
Image: 1.00 1.00 2.00 4.00 5.01 5.02 1.00 Administrative and General 7,871 7,871 4,882,099 0 114,625 2.00 Skilled Nursing Care 0	342, 282 1.00 0 2.00 0 3.00 0 4.00 0 5.00 0 6.00 0 7.00 0 8.00 0 9.00 0 10.00 0 11.00 0 12.00
2.00 Skilled Nursing Care 0	0 2.00 0 3.00 0 4.00 0 5.00 0 6.00 0 7.00 0 8.00 0 9.00 0 10.00 0 11.00 0 12.00
3.00 Physical Therapy 0	0 3.00 0 4.00 0 5.00 0 6.00 0 7.00 0 8.00 0 9.00 0 10.00 0 11.00 0 12.00
4.00 Occupational Therapy 0	0 4.00 0 5.00 0 6.00 0 7.00 0 8.00 0 9.00 0 10.00 0 11.00 0 12.00
5.00 Speech Pathology 0	0 5.00 0 6.00 0 7.00 0 8.00 0 9.00 0 10.00 0 11.00 0 12.00
6.00 Medical Social Services 0 </td <td>0 6.00 0 7.00 8.00 9.00 10.00 11.00 0 12.00</td>	0 6.00 0 7.00 8.00 9.00 10.00 11.00 0 12.00
8.00 Supplies (see instructions) 0 <th< td=""><td>0 8.00 9.00 0 10.00 0 11.00 0 12.00</td></th<>	0 8.00 9.00 0 10.00 0 11.00 0 12.00
9.00 Drugs 0<	0 9.00 0 10.00 0 11.00 0 12.00
10.00 DME 0 </td <td>0 10.00 0 11.00 0 12.00</td>	0 10.00 0 11.00 0 12.00
11.00 Home Dialysis Aide Services 0 0 0 0 0 12.00 Respiratory Therapy 0 0 0 0 0 0 13.00 Private Duty Nursing 0 0 0 0 0 0 14.00 Clinic 0 0 0 0 0 0 0 15.00 Heal th Promotion Activities 0 0 0 0 0 0 17.00 Home Delivered Meals Program 0	0 11.00 0 12.00
12.00 Respiratory Therapy 0 0 0 0 0 13.00 Private Duty Nursing 0 0 0 0 0 14.00 Clinic 0 0 0 0 0 0 15.00 Heal th Promotion Activities 0 0 0 0 0 0 16.00 Day Care Program 0 0 0 0 0 0 17.00 Home Delivered Meals Program 0 0 0 0 0 0 18.00 Homemaker Service 0 0 0 0 0 0 0 19.00 All Others (specify) 0 0 0 0 0 0 19.00 Total (sum of lines 1-19) 7, 871 7, 871 4, 882, 099 0 114, 625 21.00 Total cost to be allocated 280, 322 40, 468 1, 271, 801 0 797, 065 22.00 Unit cost multiplier 35. 614534 5. 141405 0. 260503 0. 000000 6. 953675 Cost Cente	0 12.00
14.00 Clinic 0 0 0 0 0 15.00 Heal th Promotion Activities 0 0 0 0 0 16.00 Day Care Program 0 0 0 0 0 0 17.00 Home Delivered Meals Program 0 0 0 0 0 0 18.00 Homemaker Service 0 0 0 0 0 0 19.00 All Others (specify) 0 0 0 0 0 0 19.50 Tel emedicine 0 0 0 0 0 0 20.00 Total (sum of lines 1-19) 7, 871 7, 871 4, 882, 099 0 114, 625 21.00 Total cost to be allocated 280, 322 40, 468 1, 271, 801 0 797, 065 22.00 Unit cost multiplier 35. 614534 5. 141405 0. 260503 0. 000000 6. 953675 Cost Center Description ADMITTING (GROSS CHAR PATIENT (GROSS CHAR ADMI NI STRATI VE (ACCUM. COST) ADMI NI STRATI VE ADM GENERAL ADMI NI	0 10 00
15.00 Heal th Promotion Activities 0 0 0 0 0 16.00 Day Care Program 0 0 0 0 0 0 17.00 Home Delivered Meals Program 0 0 0 0 0 0 18.00 Homemaker Service 0 0 0 0 0 0 19.00 All Others (specify) 0 0 0 0 0 0 19.50 Tel emedicine 0	0 13.00
16.00 Day Care Program 0 0 0 0 0 0 17.00 Home Delivered Meals Program 0 <	0 14.00
17.00 Home Delivered Meals Program 0 0 0 0 0 18.00 Homemaker Service 0 0 0 0 0 0 19.00 All Others (specify) 0 0 0 0 0 0 19.50 Telemedicine 0 0 0 0 0 0 20.00 Total (sum of lines 1-19) 7, 871 7, 871 4, 882, 099 0 114, 625 21.00 Total cost to be allocated 280, 322 40, 468 1, 271, 801 0 797, 065 22.00 Unit cost multiplier 35.614534 5.141405 0.260503 0.000000 6.953675 Cost Center Description ADMITTING (GROSS CHAR GES) PATIENT ACCOUNTING (GROSS CHAR ACCOUNTING (ACCUM. COST) OPERATION OF PLANT PLANT LI Second Cost Center Description 5.04 5.05 5A.06 5.06 7.00	0 15.00
18.00 Homemaker Service 0 0 0 0 0 19.00 All Others (specify) 0 0 0 0 0 0 19.00 All Others (specify) 0 0 0 0 0 0 0 19.50 Telemedicine 0 0 0 0 0 0 0 0 20.00 Total (sum of lines 1-19) 7,871 7,871 4,882,099 0 114,625 0 20.00 797,065 20.00 797,065 0.000000 6.953675 0 0 0 797,065 0.000000 6.953675 0 </td <td>0 16.00 0 17.00</td>	0 16.00 0 17.00
19.50 Telemedicine 0	0 18.00
20.00 Total (sum of lines 1-19) 7,871 7,871 4,882,099 0 114,625 21.00 Total cost to be allocated 280,322 40,468 1,271,801 0 797,065 22.00 Unit cost multiplier 35.614534 5.141405 0.260503 0.000000 6.953675 Cost Center Description ADMITTING (GROSS CHAR GES) PATIENT (GROSS CHAR GES) Reconciliation (GROSS CHAR GES) OTHER (ACCUM. COST) OPERATION OF PLANT LI (SQUARE FEET) 5.04 5.05 5A.06 5.06 7.00	0 19.00
21.00 Total cost to be allocated 280, 322 40, 468 1, 271, 801 0 797, 065 22.00 Unit cost multiplier 35.614534 5.141405 0.260503 0.000000 6.953675 Cost Center Description ADMITTING (GROSS CHAR GES) PATIENT (GROSS CHAR GES) Reconciliation (GROSS CHAR GES) OTHER (ACCUM. COST) OPERATION OF PLANT LI (SQUARE FEET) 5.04 5.05 5A.06 5.06 7.00	0 19.50
22.00 Unit cost multiplier 35.614534 5.141405 0.260503 0.000000 6.953675 Cost Center Description ADMITTING (GROSS CHAR GES) PATIENT (GROSS CHAR (GROSS CHAR GES) Reconciliation (ADMINISTRATIVE (ACCUM. COST) OPERATION OF PLANT LI (SQUARE FEET) 5.04 5.05 5A.06 5.06 7.00	342, 282 20. 00 29, 622 21. 00
Cost Center Description ADMITTING (GROSS CHAR GES) PATIENT ACCOUNTING (GROSS CHAR GES) Reconciliation ADMINISTRATIVE (GROSS CHAR GES) OPERATION OF ADMINISTRATIVE (SQUARE FEET) 1 0 Control (Control (Contro) (C	0. 086543 22. 00
GES) (GROSS CHAR GES) AND GENERAL (ACCUM. COST) (SQUARE FEET) (COMPARING CO	LAUNDRY &
GES) (ACCUM. COST) 5.04 5.05 5A.06 5.06 7.00	LINEN SERVICE
5.04 5.05 5A.06 5.06 7.00	(POUNDS OF
	LAUNDRY) 8.00
	0 1.00
2.00 Skilled Nursing Care 0 0 0 1,728,589 0	0 2.00
3.00 Physical Therapy 0 0 0 1,097,745 0 4.00 Occupational Therapy 0 0 0 48.232 0	0 3.00
4.00 Occupational Therapy 0 0 0 448,232 0 5.00 Speech Pathology 0 0 0 97,895 0	0 4.00 0 5.00
6.00 Medical Services 0 0 0 3,278 0	0 6.00
7.00 Home Heal th Ai de 0 0 107, 184 0	0 7.00
8.00 Supplies (see instructions) 0 0 0 7,333 0	0 8.00
9.00 Drugs 0 0 0 273,686 0	0 9.00
10.00 DME 0 </td <td>0 10.00 0 11.00</td>	0 10.00 0 11.00
12.00 Respiratory Therapy 0 0 0 0 0	0 12.00
13.00 Private Duty Nursing 0 0 0 0 0	0 13.00
14.00 Clinic 0 0 0 0	
15.00 Health Promotion Activities 0 0 0 0 0	0 14.00
16.00 Day Care Program 0	0 15.00
18.00 Homemaker Service 0 0 0 0 0 0	0 15.00 0 16.00
19.00 All Others (specify) 0 0 0 8, 555, 183 0	0 15.00
19.50 Telemedicine 0	0 15.00 0 16.00 0 17.00
20.00 Total (sum of lines 1-19) 13,153,346 13,153,346 14,807,563 7,871	0 15.00 0 16.00 0 17.00 0 18.00 0 19.00 0 19.50
21.00 Total cost to be allocated 0 69, 160 1, 767, 905 283, 291 22.00 Unit cost multiplier 0.000000 0.005258 0.119392 35.991742	0 15.00 0 16.00 0 17.00 0 18.00 0 19.00

Health Financial Systems		FRANCI SCAN HEALT				u of Form CMS-2	
ALLOCATION OF GENERAL SERVICE COSTS TO BASIS	O HHA COST CEN	TERS STATI STI CAL	- Provider C HHA CCN:	CN: 15-0109 15-7124	Period: From 01/01/2020 To 12/31/2020	Worksheet H-2 Part II Date/Time Pre	pared:
					Home Health	4/29/2021 3:5 PPS	2 pm
Cost Center Description	HOUSEKEEPI NG	DIETARY	CAFETERI A	NURSI NG	Agency I CENTRAL	PHARMACY	
		(MEALS SERVED)		ADMI NI STRATI ((DI RECT NRS	ON SERVICES & SUPPLY (COSTED REQ	(COSTED REQUIS.)	
	9.00	10.00	11.00	I NG) 13.00	UI SI) 14.00	15.00	
1.00 Administrative and General	7, 871	0	114, 625			0	1.00
 2.00 Skilled Nursing Care 3.00 Physical Therapy 4.00 Occupational Therapy 5.00 Speech Pathology 6.00 Medical Social Services 7.00 Home Health Aide 8.00 Supplies (see instructions) 9.00 Drugs 10.00 DME 11.00 Home Dialysis Aide Services 12.00 Respiratory Therapy 13.00 Private Duty Nursing 14.00 Clinic 15.00 Health Promotion Activities 16.00 Day Care Program 17.00 Home Delivered Meals Program 18.00 Homemaker Service 19.00 All Others (specify) 19.50 Telemedicine 20.00 Total (sum of lines 1-19) 21.00 Total cost to be allocated 22.00 Unit cost multiplier 	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	5 5 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7	05 15, 012		$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ 19.\ 00\\ 19.\ 50\\ 20.\ 00\\ 21.\ 00\\ 22.\ 00\\ \end{array}$
	RECORDS & LI BRARY (GROSS CHAR GES)	(TIME SPENT)	(ASSI GNED TI ME)	RESI DENCY (ASSI GNED TI ME)	(ASSIGNED TIME)		
1.00 Administrative and General	<u>16.00</u> 13,153,346	17.00	20.00	23.00	23.01 0 0		1.00
 Administrative and General Administrative and General Skilled Nursing Care O Skilled Nursing Care O Physical Therapy O Occupational Therapy So Speech Pathology O Medical Social Services O Home Health Aide Supplies (see instructions) O Drugs O DME O Home Dialysis Aide Services O Respiratory Therapy O Private Duty Nursing O Home Delivered Meals Program O Home Delivered Meals Program O Home Delivered Meals Program O Home Delivered Service O All Others (specify) So Tel emedicine O Total (sum of lines 1-19) O Total cost to be allocated O Unit cost multiplier 	13, 153, 346 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				0 0 0 0		1. 00 2. 00 3. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 50 20. 00 21. 00 22. 00

DDODT	Financial Systems TONMENT OF PATIENT SERVICE COST		FRANCI SCAN HEAL		CN: 15-0109	Peri od:	u of Form CMS-2 Worksheet H-3	
PPURI	TUNMENT OF PATTENT SERVICE COST	3		HHA CCN:		From 01/01/2020 To 12/31/2020	Part I Date/Time Pre	pared
				Title	e XVIII	Home Health	4/29/2021 3:53 PPS	2 pm
	Cost Center Description	From, Wkst.	Facility Costs	Shared	Total HHA	Agency I Total Visits	Average Cost	
	cost center bescription	H-2, Part I,	(from Wkst.	Ancillary	Costs (col s.		Per Visit	
		col. 28, line		Costs (from	+ 2)		(col. 3 ÷ col.	
				Part II)			4)	
	PART I - COMPUTATION OF LESSER		1.00		3.00	4.00	5.00	
	BENEFICIARY COST LIMITATION Cost Per Visit Computation	OF AGGREGATE F	PRUGRAM CUST, A	GGREGATE OF TH	1E PRUGRAM LIM	TTATION COST, OF	<	
. 00	Skilled Nursing Care	2.00	2, 457, 749		2, 457, 74	9 11, 831	207.74	1.0
2.00	Physical Therapy	3.00		C				
. 00	Occupational Therapy	4.00		C	1 1 1			
. 00	Speech Pathology	5.00	139, 190	C	139, 19	0 545	255.39	4. (
6. 00	Medical Social Services	6.00			4,66			5.0
. 00	Home Health Aide	7.00			152, 39			
. 00	Total (sum of lines 1-6)		4, 952, 102	(7.0
					Program Visit	<u>s</u> ırt B		
	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Not Subject t			
	cost center bescription		CDSA NO. (1)	Tart A	Deducti bl es			
					Coi nsurance			
		0	1.00	2.00	3.00	4.00	5.00	
	Limitation Cost Computation	1	I			_1		
8.00	Skilled Nursing Care		23844	0				8.0
8. 01 8. 02	Skilled Nursing Care Skilled Nursing Care		26900 29200	C		4		8. (8. (
3. 02 3. 03	Skilled Nursing Care		45460	C		0		8.0
3. 03 8. 04	Skilled Nursing Care		99915	(8.0
0.00	Physical Therapy		23844	(9.0
0.01	Physical Therapy		26900	C		0		9.0
. 02	Physical Therapy		29200	C	2, 20	1		9.0
03	Physical Therapy		45460	C		4		9. (
04	Physical Therapy		99915	C				9.0
0.00	Occupational Therapy		23844	C				10.0
0.01	Occupational Therapy		26900	0		0		10.0
0.02	Occupational Therapy		29200 45460	C		1		10. (10. (
0. 03 0. 04	Occupational Therapy Occupational Therapy		99915	C				10.0
1.00	Speech Pathol ogy		23844	(2		11.0
1.01	Speech Pathology		26900	C		0		11.0
1.02	Speech Pathol ogy		29200	C				11. (
1.03	Speech Pathology		45460	C		0		11. (
1.04	Speech Pathology		99915	C	14	0		11. (
2.00	Medical Social Services		23844	C		3		12. (
2. 01	Medical Social Services		26900	C		0		12. (
2.02			29200	C		0		12. (
2.03	Medical Social Services		45460	0		0		12.0
2.04	Medical Social Services		99915	0		4		12.
3.00	Home Health Aide		23844 26900	C		8		13. 13.
3. 01 3. 02	Home Health Aide Home Health Aide		29200	(16			13.
3.02	Home Heal th Ai de		45460	(0		13.0
3.03	Home Heal th Aide		99915	(13. (
4.00	Total (sum of lines 8-13)			C				14. (
	Cost Center Description	From Wkst. H-2	Facility Costs	Shared	Total HHA		Ratio (col. 3	
		Part I, col.	(from Wkst.	Ancillary	Costs (cols.		÷ col. 4)	
		28, line	H-2, Part I)	Costs (from	+ 2)	Records)		
		0	1.00	Part II)	2.00	4.00	F 00	
	Supplies and Drugs Cost Computa	0 Detions	1.00	2.00	3.00	4.00	5.00	
5.00	Cost of Medical Supplies	8.00	10, 427		10, 42	7 0	0. 000000	15.
5.00								

PORT	IONMENT OF PATIENT SERVICE COSTS	S		Provider C	CN: 15-0109	Peri od:	Worksheet H-3	2552-
1 OKT		5		HHA CCN:	15-7124	From 01/01/2020 To 12/31/2020	Part I	parec
				Ti tl e	XVIII	Home Health Agency I	PPS	2 pm
			Program Visits	I	Cost of Services		1	
			Part	B	Services	Part B		
	Cost Center Description	Part A	Not Subject to		Part A	Not Subject to	Subject to	
		i di c i i	Deductibles & [, are n	Deductibles &	Deductibles &	
			Coi nsurance	Coi nsurance		Coi nsurance	Coi nsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	PART I - COMPUTATION OF LESSER	OF AGGREGATE	PROGRAM COST, AG	GREGATE OF TH	E PROGRAM LI	MITATION COST, OF	2	
	BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation		1 1					
00	Skilled Nursing Care	(0 1, 336, 391		1.
00	Physical Therapy	(0 930, 817		2.
00	Occupational Therapy	(.,			0 385, 219		3.
00	Speech Pathol ogy	(0 77, 894		4.
00	Medical Social Services	(0 2, 463		5.
00	Home Heal th Aide	(0 131, 451		6.
00	Total (sum of lines 1-6)	(13, 801			0 2, 864, 235		7.
	Cost Center Description	(00	7.00	0.00	0.00	10,00	11 00	
	Limitation Cost Computation	6.00	7.00	8.00	9.00	10.00	11.00	
00	Limitation Cost Computation Skilled Nursing Care				[8.
01	S S							8.
01	Skilled Nursing Care Skilled Nursing Care							8.
02	Skilled Nursing Care							8.
03 04	Skilled Nursing Care							8.
04 00	Physical Therapy							9.
00	Physical Therapy							9.
02	Physical Therapy							9.
02	Physical Therapy							9.
04	Physical Therapy							9.
0.00	Occupational Therapy							10.
). 01	Occupational Therapy							10.
). 02	Occupational Therapy							10.
). 02	Occupational Therapy							10.
). 03	Occupational Therapy							10.
. 00	Speech Pathol ogy							11.
. 01	Speech Pathology							11.
. 02	Speech Pathol ogy							11.
. 03	Speech Pathol ogy							11.
. 03	Speech Pathology							11.
. 00	Medical Social Services							12.
. 01	Medical Social Services							12.
. 02	Medical Social Services							12.
. 03	Medical Social Services							12.
. 04	1 1							12.
. 00	Home Heal th Aide							13.
. 01	Home Heal th Aide							13.
. 02	Home Heal th Ai de							13.
. 02	Home Heal th Aide							13.
. 04	Home Heal th Ai de							13.
. 00	Total (sum of lines 8-13)							14.
		Proo	ram Covered Char	ges	Cost of			
		-3		0	Servi ces			
			Part			Part B		
	Cost Center Description	Part A	Not Subject to	Subject to	Part A	Not Subject to	Subject to	
			Deductibles & [Deductibles &	Deductibles &	
			Coi nsurance	Coi nsurance		Coi nsurance	Coi nsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	Supplies and Drugs Cost Computa	tions						
. 00	Cost of Medical Supplies	(0	0		0 0	0	15.

APPORT	IONMENT OF PATIENT SERVICE COST	S		Provider CCN:	1E 0100		I Workohoot II '	
				FIOVILLEI CON.	12-0109	Period: From 01/01/2020	Worksheet H-3 Part I	3
				HHA CCN:	15-7124	To 12/31/2020	Date/Time Pre	epared:
							4/29/2021 3:5	
				Title X	VIII	Home Health Agency I	PPS	
	Cost Center Description	Total Program				Agency		
		Cost (sum of						
		cols. 9-10)				-		4
		12.00						
	PART I - COMPUTATION OF LESSER	OF AGGREGATE P	ROGRAM COST, AGGR	REGATE OF THE F	PROGRAM LI	MITATION COST, OR		
	BENEFICIARY COST LIMITATION							-
1.00	Cost Per Visit Computation Skilled Nursing Care	1, 336, 391						1.0
2.00	Physical Therapy	930, 817						2.0
2.00 3.00	Occupational Therapy	385, 219						3.0
4.00	Speech Pathol ogy	77, 894						4.0
4.00 5.00	Medical Social Services	2,463						5.0
5.00	Home Heal th Aide	131, 451						6.0
7.00	Total (sum of lines 1-6)	2, 864, 235						7.0
	Cost Center Description							
		12.00						1
	Limitation Cost Computation							
3.00	Skilled Nursing Care							8.0
3. 01	Skilled Nursing Care							8.0
3. 02	Skilled Nursing Care							8.0
3.03	Skilled Nursing Care							8.
8.04	Skilled Nursing Care							8.0
9.00	Physical Therapy							9.0
9.01 9.02	Physical Therapy							9.0
7.02 7.03	Physical Therapy Physical Therapy							9.0
7.03 7.04	Physical Therapy							9.0
10.00	Occupational Therapy							10. (
10.01	Occupational Therapy							10. (
10.02	Occupational Therapy							10.
0.03	Occupational Therapy							10.
0.04	Occupational Therapy							10.
1.00	Speech Pathology							11.
1.01	Speech Pathology							11.
1.02	Speech Pathology							11.
1.03	Speech Pathology							11.
1.04	Speech Pathol ogy							11.
2.00	Medical Social Services							12.
2.01	Medical Social Services							12.
2.02	Medical Social Services							12.
12.03	Medical Social Services							12.
12.04	Medical Social Services							12.
13.00	Home Health Aide							13.
13.01	Home Health Aide							13.
13.02	Home Health Aide							13.0
13.03	Home Health Aide							13. (
13.04	Home Health Aide Total (sum of lines 8–13)							13.0

Heal th	Financial Systems		FRANCISCAN HEAL	TH LAFAYETTE		In Lie	u of Form CMS-2	2552-10
APPORT	FIONMENT OF PATIENT SERVICE COST	S		Provider C	CN: 15-0109	Period: From 01/01/2020	Worksheet H-3 Part II	
				HHA CCN:	15-7124	To 12/31/2020		
				Title	e XVIII	Home Health	PPS	
						Agency I		
	Cost Center Description	From Wkst. C,	Cost to Charge	Total HHA	HHA Shared	Transfer to		
		Part I, col.	Ratio	Charge (from	Ancillary	Part I as		
		9, line		provi der	Costs (col.	1 Indicated		
				records)	x col. 2)			
		0	1.00	2.00	3.00	4.00		
	PART II - APPORTIONMENT OF COS	T OF HHA SERVIC	ES FURNI SHED B	Y SHARED HOSPI	TAL DEPARTMEN	NTS		
1.00	Physical Therapy	66.00	0. 323578	0		0 col. 2, line 2	. 00	1.00
2.00	Occupational Therapy	67.00	0. 196072	0		Ocol. 2, line 3	. 00	2.00
3.00	Speech Pathology	68.00	0. 264129	0		Ocol. 2, line 4	. 00	3.00
4.00	Cost of Medical Supplies	71.00	0. 119291	0		0 col. 2, line 1	5.00	4.00
5.00	Cost of Drugs	73.00	0. 131586	0		0 col. 2, line 1	6. 00	5.00
5.01	Cost of Drugs 1	73.01	8. 110677	0		0 col. 2, line 1	6. 01	5.01
		•	'		•	,		

	Financial Systems FRANCISCAN HEALTH	Provider CC	N: 15-0109	Period:	u of Form CMS-2 Worksheet H-4	
_00LF	THE OF THE REPORT OF THE MENT	HHA CCN:	15-7124	From 01/01/2020 To 12/31/2020	Part I-II	
		TITA CON.	13-7124	10 12/31/2020	4/29/2021 3:5	
		Title	XVIII	Home Health Agency I	PPS	
				Par	t B	
			Part A	Not Subject to Deductibles &		
				Coi nsurance	Coi nsurance	
			1.00	2.00	3.00	
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTO Reasonable Cost of Part A & Part B Services	MARY CHARGES	>			+
	Reasonable cost of services (see instructions)			0 0	0	1 1
	Total charges			0 0	0	2
	Customary Charges Amount actually collected from patients liable for payment for	services		0 0	0	
	on a charge basis (from your records)	Ser Vi Ces		0	0	
0	Amount that would have been realized from patients liable for			0 0	0	4
	for services on a charge basis had such payment been made in a with 42 CFR §413.13(b)	iccordance				
	Ratio of line 3 to line 4 (not to exceed 1.000000)		0.0000	0. 000000	0. 000000	
	Total customary charges (see instructions)			0 0		
0	Excess of total customary charges over total reasonable cost (complete		0 0	0	'
0	only if line 6 exceeds line 1) Excess of reasonable cost over customary charges (complete onl	vifline		0 0	0	
	1 exceeds line 6)	5			-	
0	Primary payer amounts			0 0	-	
				Part A Servi ces	Part B Services	
				1.00	2.00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT			0	0	1 1
	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers			0		
	Total PPS Reimbursement - Full Episodes with Outliers			0	1	
	Total PPS Reimbursement - LUPA Episodes			0	57, 822	
	Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers			0	9, 081 45, 175	
	Total PPS Outlier Reimbursement - PEP Episodes			0	420	
	Total Other Payments			0	0	
	DME Payments Oxygen Payments			0	0	
	Prosthetic and Orthotic Payments			0	0	
00	Part B deductibles billed to Medicare patients (exclude coinsu	irance)			0	2
	Subtotal (sum of lines 10 thru 20 minus line 21)			0		
	Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23)			0	0 2, 951, 676	
	Coinsurance billed to program patients (from your records)				0	
	Net cost (line 24 minus line 25)			0	2, 951, 676	
	Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see ir	etructione)				2
	Total costs - current cost reporting period (line 26 plus line			0	2, 951, 676	
	OTHER PS&R ADJUSTMENTS	·		0		3
	Pioneer ACO demonstration payment adjustment (see instructions	5)		0	0	
	Demonstration payment adjustment amount before sequestration Subtotal (see instructions)			0	0 2, 942, 861	
	Sequestration adjustment (see instructions)			0		
	Demonstration payment adjustment amount after sequestration			0		
00	Interim payments (see instructions) Tentative settlement (for contractor use only)			0	1	
00 1						1 3.
	Balance due provider/program (line 31 minus lines 31.01, 32, a	ind 33)		0		34

PROGRAM BENEFICIARI	.5	HHA CCN:	15-7124	Tc	om 01/01/2020 12/31/2020	Date/Time Prep	
					, 12,01,2020	4/29/2021 3:52	
					Home Health Agency I	PPS	. p
		I npati en	t Part A		Par	t B	
		mm/dd/yyyy	Amount	_	mm/dd/yyyy	Amount	
Total interim no	vmente paid te provider	1.00	2.00	0	3.00	4.00	1
D Interim payments submitted or to	yments paid to provider payable on individual bills, either be submitted to the contractor for d in the cost reporting period. If none, enter a zero			0		2, 923, 974 0	1. (2. (
amount based on for the cost rep	each retroactive lump sum adjustment subsequent revision of the interim rate orting period. Also show date of each , write "NONE" or enter a zero. (1)						3.
1				0		0	3.
2				0		0	3.
3				0		0	3.
4				0		0	3.
5 Provider to Prog	nom.			0		0	3
)				0		0	3
1				0		0	3
2				0		0	3
3				0		0	3
1				0		0	3
	Flines 3.01-3.49 minus sum of lines			0		0	3
3.50-3.98) Total interim pa	yments (sum of lines 1, 2, and 3.99)			0		2, 923, 974	4
	t. H-4, Part II, column as appropriate,			U		2, 723, 774	4
TO BE COMPLETED	BY CONTRACTOR						
desk review. Als	each tentative settlement payment after o show date of each payment. If none, enter a zero. (1)						5
Program to Provi	der						
1				0		0	5
2				0 0		0	5 5
Provider to Prog	ram			0		0	5
)				0		0	5
1				0		0	5
2				0		0	5
	lines 5.01-5.49 minus sum of lines			0		0	5
5.50-5.98) Determined net s the cost report.	ettlement amount (balance due) based on						6
1 SETTLEMENT TO PR				0		1	6
2 SETTLEMENT TO PR				0		o	6
	rogram liability (see instructions)			0		2, 923, 975	7
					Contractor	NPR Date	
					Number 1.00	(Mo/Day/Yr) 2.00	

			Hospi ce CC	CCN: 15-0109 CN: 15-1563	Period: From 01/01/202 To 12/31/202 Hospice I		
		SALARI ES	OTHER	SUBTOTAL (cc 1 plus col.		SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
. 00	GENERAL SERVICE COST CENTERS	1		1	0		1 1 0
. 00	CAP REL COSTS-BLDG & FIXT* CAP REL COSTS-MVBLE EQUIP*		(6, 382		-	0 0 2 0	
. 00	EMPLOYEE BENEFITS DEPARTMENT*	0	0, 302	0, 0	0		
. 00	ADMI NI STRATI VE & GENERAL*	722, 410	118, 852	841, 2	62	0 841, 262	
. 00	PLANT OPERATION & MAINTENANCE*	0	(D	0	0 0	5.0
. 00	LAUNDRY & LINEN SERVICE*	0	(D	0	0 0	
. 00	HOUSEKEEPI NG*	0	(0	0 0	
. 00		150.057	(150.0	0		
. 00	NURSI NG ADMI NI STRATI ON*	158, 957	(,		0 158,957	
0.00 1.00	ROUTI NE MEDI CAL SUPPLI ES* MEDI CAL RECORDS*	0	4, 709	9 4,7	09	0 4,709 0 0	1
2.00	STAFF TRANSPORTATION*	0	(0		
3.00	VOLUNTEER SERVICE COORDINATION*	54, 469	(54,4	-	0 54, 469	
4.00	PHARMACY*	2, 519	(0 2, 519	
5.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	169, 290			0 169, 290	
6. 00	OTHER GENERAL SERVICE*	0	(b	0	o 0	16. 0
7.00	PATIENT/RESIDENTIAL CARE SERVICES						17.0
	DIRECT PATIENT CARE SERVICE COST CENTERS			-1	-		
5.00	INPATIENT CARE-CONTRACTED**		(-	-	0 0	
6.00	PHYSICIAN SERVICES**	0	(0		
7.00 8.00	NURSE PRACTITIONER** REGISTERED NURSE**	1, 148, 830	() 1,148,8	0	0 0 0 1, 148, 830	
9.00	LPN/LVN**	1, 148, 830	(, 140, C	0	0 1, 148, 830	1
0.00	PHYSICAL THERAPY**	0	(0		
1.00	OCCUPATIONAL THERAPY**	0	(0	0 0	
2.00	SPEECH/LANGUAGE PATHOLOGY**	0	(D	0	o o	32.
3.00	MEDICAL SOCIAL SERVICES**	115, 356	(0 115, 3	56	0 115, 356	33.
	SPIRITUAL COUNSELING**	147, 261	(0 147,2		0 147, 261	
5.00	DI ETARY COUNSELI NG**	0	(-	0	0 0	
6.00	COUNSELING - OTHER**	100 72((-	0	0 0	
7.00 8.00	HOSPICE AIDE & HOMEMAKER SERVICES** DURABLE MEDICAL EQUIPMENT/OXYGEN**	108, 736 0	250, 017	0 108, 7 7 250, 0		0 108, 736 0 250, 017	
	PATIENT TRANSPORTATION**	0	10, 706			0 250, 017	
0.00	I MAGI NG SERVI CES**	0	10, 700	0	0		
1.00	LABS & DI AGNOSTI CS**	0	(0		
2.00	MEDI CAL SUPPLI ES-NON-ROUTI NE**	0	52, 106	5 52, 1	06	0 52, 106	
2.50	DRUGS CHARGED TO PATI ENTS**	0	383, 338	383, 3	38	0 383, 338	42.
3.00	OUTPATIENT SERVICES**	0	(0	o o	43.
4.00	PALLIATIVE RADIATION THERAPY**	0	(C	0	0 0	
5.00	PALLIATIVE CHEMOTHERAPY**	0	(0	0	0 0	
6. 00	OTHER PATIENT CARE SERVICES (SPECIFY)**	273, 013	1, 229, 432	2 1, 502, 4	45	0 1, 502, 445	46.
0. 00	NONREIMBURSABLE COST CENTERS BEREAVEMENT PROGRAM *	0			0	0 0	60.
	VOLUNTEER PROGRAM *	0	(0		
	FUNDRAI SI NG*	0	(0		
	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	(0		
	PALLIATIVE CARE PROGRAM*	0	(0	0 0	
	OTHER PHYSI CI AN SERVI CES*	0	(D	0	0 0	
6.00	RESIDENTIAL CARE*	0	(D	0	o o	66.
	ADVERTI SI NG*	0	(כ	0	o o	
	TELEHEALTH/TELEMONI TORI NG*	0	(D	0	0 0	
	THRIFT STORE*	0	(0	0 0	
	NURSING FACILITY ROOM & BOARD*	0	(0	0 0	
1.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	(기	0	0 0	71.

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

ANALYSI	S OF HOSPITAL-BASED HOSPICE COSTS		Provider CCN:	15-0109	Period:	Worksheet 0	
			Hospi ce CCN:	15-1563	From 01/01/2020 To 12/31/2020	Date/Time Pre 4/29/2021 3:5	
					Hospi ce I		
		ADJUSTMENTS T	OTAL (col. 5 ± col. 6)				
	GENERAL SERVICE COST CENTERS	6.00	7.00				-
	CAP REL COSTS-BLDG & FIXT*	0	0				1.
	CAP REL COSTS-MVBLE EQUIP*	0	0				2.
	EMPLOYEE BENEFITS DEPARTMENT*	0	0				3.
. 00	ADMINISTRATIVE & GENERAL*	0	841, 262				4.
. 00	PLANT OPERATION & MAINTENANCE*	0	0				5.
00	LAUNDRY & LINEN SERVICE*	0	0				6.
	HOUSEKEEPI NG*	0	0				7.
	DI ETARY*	0	0				8.
1	NURSING ADMINISTRATION*	0	158, 957				9.
	ROUTINE MEDICAL SUPPLIES*	0	4, 709				10.
	MEDI CAL RECORDS*	0	0				11.
	STAFF TRANSPORTATION*	0	0				12.
	VOLUNTEER SERVICE COORDINATION* PHARMACY*	0	54, 469 2, 519				13.
	PHARMAGT PHYSI CI AN ADMI NI STRATI VE SERVI CES*	0	169, 290				14.
	OTHER GENERAL SERVICE*	0	109, 290				16.
1	PATI ENT/RESI DENTI AL CARE SERVI CES	Ŭ	0				17.
	DI RECT PATIENT CARE SERVICE COST CENTERS						
	INPATIENT CARE-CONTRACTED**	0	0				25.
6.00	PHYSI CI AN SERVI CES**	0	0				26.
7.00	NURSE PRACTITIONER**	0	o				27.
8.00	REGI STERED NURSE**	0	1, 148, 830				28.
9.00	LPN/LVN**	0	0				29.
	PHYSI CAL THERAPY**	0	0				30.
	OCCUPATIONAL THERAPY**	0	0				31.
	SPEECH/LANGUAGE PATHOLOGY**	0					32.
	MEDICAL SOCIAL SERVICES** SPIRITUAL COUNSELING**	0	115, 356				33.
	DIETARY COUNSELING**	0	147, 261 0				34.
	COUNSELING - OTHER**	0	0				36.
	HOSPICE AIDE & HOMEMAKER SERVICES**	0	108, 736				37.
	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	250, 017				38.
	PATIENT TRANSPORTATION**	0	10, 706				39.
0.00	I MAGI NG SERVI CES**	0	0				40.
1.00	LABS & DI AGNOSTI CS**	0	0				41.
2.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	52, 106				42.
1	DRUGS CHARGED TO PATIENTS**	0	383, 338				42.
	OUTPATIENT SERVICES**	0	0				43.
	PALLIATIVE RADIATION THERAPY**	0	0				44.
	PALLIATIVE CHEMOTHERAPY**	0	1 502 445				45.
	OTHER PATIENT CARE SERVICES (SPECIFY)** NONREIMBURSABLE COST CENTERS	UU	1, 502, 445				46.
	BEREAVEMENT PROGRAM *	0	0				60.
1	VOLUNTEER PROGRAM *	0	o				61.
	FUNDRAI SI NG*	0	0				62.
	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0				63.
	PALLI ATI VE CARE PROGRAM*	0	o				64.
1	OTHER PHYSICIAN SERVICES*	0	0				65.
	RESIDENTIAL CARE*	0	0				66.
7.00	ADVERTI SI NG*	0	o				67.
8.00	TELEHEALTH/TELEMONI TORI NG*	0	0				68.
	THRI FT STORE*	0	0				69.
	NURSING FACILITY ROOM & BOARD*	0	0				70.
	OTHER NONREIMBURSABLE (SPECIFY)*	0	0				71.
00.00	TOTAL	0	4, 950, 001				100.

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

26.00 PHYSI CLAN SERVICES 0 0 0 0 2 27.00 NURSE PRACTI TI ONER 0 0 0 0 2 28.00 REGI STERED NURSE 0 0 0 0 2 28.00 REGI STERED NURSE 0 0 0 0 2 28.00 REJ STERED NURSE 0 0 0 0 2 29.00 LPN/LVN 0 0 0 0 0 3 30.00 PHYSI CAL THERAPY 0 0 0 0 0 3 31.00 OCCUPATI ONAL THERAPY 0 0 0 0 0 3 32.00 SPECH/LANGUAGE PATHOLOGY 0 0 0 0 3 3 33.00 MEDI CAL SOCI AL SERVI CES 0 0 0 0 0 3 34.00 SPI RI TUAL COUNSELI NG 0 0 0 0 0 3 35.00 DI ETARY COUNSELING 0 0 0 0 0 3 <th>Health Financial Systems</th> <th>FRANCI SCAN HEALT</th> <th></th> <th></th> <th></th> <th>u of Form CMS-</th> <th>2552-1</th>	Health Financial Systems	FRANCI SCAN HEALT				u of Form CMS-	2552-1
Nome Owner Hospi ce CCN: 15-1563 To 12/31/2020 Date/Time Prepar A/29/2021 3: 52 / A/29/2021 3: 52 / Log Image: Construct the server of the		FOR HOSPICE CONTINUOUS	Provider CC			Worksheet 0-1	
SALARI ES OTHER SUBTOTAL (col.) RECLASSI FI- 1 + col.2) SUBTOTAL (CTI ONS DI RECT PATIENT CARE SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00 DI PATIENT CARE-CONTRACTED 0 0 0 0 2.00 3.00 4.00 5.00 26.00 PHYSI CIAN SERVICES 0 0 0 0 2 27.00 NURSE PRACTITIONER 0 0 0 0 2 29.00 LPN/LVN 0 0 0 0 0 2 30.00 PHYSI CAL THERAPY 0 0 0 0 0 2 31.00 OCCUPATIONAL THERAPY 0 0 0 0 0 3 3 32.00 SPECH/LANGUAGE PATHOLOGY 0 0 0 0 3 3 33.00 MEDI CAL SOCIAL SERVICES 0 0 0 0 0 3 36.00 DURALE MEMAKER SERVICES 0 0	HOME CARE		Hospice CCN				
DIRECT PATIENT CARE SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00 25.00 IMPATIENT CARE-CONTRACTED 0 0 0 0 2 26.00 PHYSICIAN SERVICES 0 0 0 0 2 26.00 PHYSICIAN SERVICES 0 0 0 0 2 27.00 NURSE PRACTITIONER 0 0 0 0 0 2 28.00 LPN/LVN 0 0 0 0 0 2 29.00 LPN/LVN 0 0 0 0 0 0 2 31.00 OCUPATIONAL THERAPY 0 0 0 0 3 3 32.00 SPEECH/LANGUAGE PATHOLOGY 0 0 0 0 0 3 33.00 MEDI CAL SERVI CES 0 0 0 0 0 3 34.00 SPI RT TUAL COUNSELING 0 0 0 0 0					Hospi ce I		
DI RECT PATI ENT CARE SERVICE COST CENTERS 25.00 INPATI ENT CARE SERVICES 0 0 0 0 0 0 2 2 0 1.00 2.00 3.00 4.00 5.00 1 2 0 1 1.00 2.00 3.00 4.00 5.00 1 2 2 0 0 0 0 0 0 2 2 0 0 0 0 0 0 2 2 0		SALARI ES	OTHER	•		SUBTOTAL	
DI RECT PATIENT CARE SERVICE COST CENTERS 1 INPATIENT CARE-CONTRACTED 2 25. 00 INPATIENT CARE-CONTRACTED 2 26. 00 PHYSI CLAN SERVICES 0 0 0 0 2 27. 00 NURSE PRACTITIONER 0 0 0 0 0 2 28. 00 RGI STERED NURSE 0 0 0 0 0 0 2 20. 01 PHYLICAL THERAPY 0		1.00	2.00			F 00	
25.00 INPATIENT CARE-CONTRACTED 2 26.00 PHYSICIAN SERVICES 0 0 0 0 2 26.00 NURSE PRACTITIONER 0 0 0 0 2 27.00 NURSE PRACTITIONER 0 0 0 0 0 2 28.00 REGISTERED NURSE 0 0 0 0 0 2 29.00 LPN/LVN 0 0 0 0 0 2 30.00 PHYSICAL THERAPY 0 0 0 0 0 3 31.00 OCCUPATIONAL THERAPY 0 0 0 0 0 3 32.00 SPECH/LANGUAGE PATHOLOGY 0 0 0 0 3 33.00 MEDI CAL SOCIAL SERVICES 0 0 0 0 3 35.00 DI ETARY COUNSELING 0 0 0 0 0 3 36.00 DVATIENT CRAMER SERVICES 0 0 0 0 0 3 37.00 HOSPICEA LIOE & HOMEMA	DIRECT PATIENT CARE SERVICE COST CI		2.00	3.00	4.00	5.00	
26.00 PHYSI CI AN SERVI CES 0<							25.0
27.00 NURSE PRACTITIONER 0		0	0		0 0	0	
28.00 REGISTERED NURSE 0		0	0		0 0	•	
9.00 LPN/LVN 0		0	0		0 0	0	
0.00 PHYSI CAL THERAPY 0 0 0 0 3 1.00 OCCUPATI ONAL THERAPY 0 0 0 0 3 2.00 SPEECH/LANGUAGE PATHOLOGY 0 0 0 0 0 3 3.00 MEDI CAL SOCI AL SERVI CES 0 0 0 0 0 3 4.00 SPI RI TUAL COUNSELI NG 0 0 0 0 0 3 5.00 DI ETARY COUNSELI NG 0 0 0 0 0 3 6.00 COUNSELI NG - OTHER 0 0 0 0 0 3 8.00 DURABLE MEDI CAL EQUI PMENT/OXYGEN 0 0 0 0 0 3 9.00 PATI ENT TRANSPORTATI ON 0 0 0 0 3 3 0.00 IMAGI NG SERVI CES 0 0 0 0 0 3 9.00 PATI ENT TRANSPORTATI ON 0 0 0 0 0 4 0.00 IMAGI NG SERVI CES 0		0	0		0 0	0	
1.00 OCCUPATIONAL THERAPY 0 0 0 0 3 2.00 SPEECH/LANGUAGE PATHOLOGY 0 0 0 0 3 3.00 MEDI CAL SOCI AL SERVI CES 0 0 0 0 3 4.00 SPI RI TUAL COUNSELI NG 0 0 0 0 3 5.00 DI ETARY COUNSELI NG 0 0 0 0 3 6.00 COUNSELI NG - OTHER 0 0 0 0 3 7.00 HOSPI CE AI DE & HOMEMAKER SERVI CES 0 0 0 0 3 8.00 DURABLE MEDI CAL EQUI PMENT/OXYGEN 0 0 0 0 3 9.00 PATI ENT TRANSPORTATI ON 0 0 0 0 3 0.00 IMAGIN GS ERVI CES 0 0 0 0 4 1.00 LABS & DI AGNOSTI CS 0 0 0 0 4 2.00 MEDI CAL SUPPLI ES-NON-ROUTI NE 0 0 0 0 4 2.50 DRUGS CHARGED TO PA		o	o		0 0	0	
3.00 MEDI CAL SOCI AL SERVICES 0 0 0 0 3 4.00 SPI RI TUAL COUNSELI NG 0 0 0 0 3 5.00 DI ETARY COUNSELI NG 0 0 0 0 3 6.00 COUNSELI NG 0 0 0 0 0 3 6.00 COUNSELI NG 0 THER 0 0 0 0 3 7.00 HOSPI CE AI DE & HOMEMAKER SERVI CES 0 0 0 0 3 8.00 DURABLE MEDI CAL EQUI PMENT/OXYGEN 0 0 0 0 3 9.00 PATI ENT TRANSPORTATI ON 0 0 0 0 3 9.00 PATI ENT RANSPORTATI ON 0 0 0 0 4 1.00 LABS & DI AGNOSTI CS 0 0 0 0 4 2.00 MEDI CAL SUPPLI ES-NON-ROUTI NE 0 0 0 0 4 2.00 MEDI CAL SUPPLI ES-NON-ROUTI NE 0 0 0 0 4 3.00 <td>1.00 OCCUPATIONAL THERAPY</td> <td>0</td> <td>0</td> <td></td> <td>0 0</td> <td>0</td> <td></td>	1.00 OCCUPATIONAL THERAPY	0	0		0 0	0	
4.00 SPIRITUAL COUNSELING 0 0 0 0 3 5.00 DIETARY COUNSELING 0 0 0 0 3 6.00 COUNSELING - OTHER 0 0 0 0 3 6.00 COUNSELING - OTHER 0 0 0 0 3 7.00 HOSPICE AI DE & HOMEMAKER SERVICES 0 0 0 0 3 8.00 DURABLE MEDICAL EQUIPMENT/OXYGEN 0 0 0 0 3 9.00 PATIENT TRANSPORTATION 0 0 0 0 3 0.00 IMAGING SERVICES 0 0 0 0 3 0.00 IMAGING SERVICES 0 0 0 0 4 1.00 LABS & DI AGNOSTICS 0 0 0 0 4 2.00 MEDI CAL SUPPLI ES-NON-ROUTI NE 0 0 0 0 4 2.00 MEDI CAL SUPPLI ES-NON-ROUTI NE 0 0 0 0 4 3.00 OUTPATI ENT SERVI CES 0 </td <td>2.00 SPEECH/LANGUAGE PATHOLOGY</td> <td>0</td> <td>0</td> <td></td> <td>0 0</td> <td>0</td> <td>32.</td>	2.00 SPEECH/LANGUAGE PATHOLOGY	0	0		0 0	0	32.
5.00 DI ETARY COUNSELING 0 0 0 0 3 6.00 COUNSELING - OTHER 0 0 0 0 0 3 7.00 HOSPICE AI DE & HOMEMAKER SERVICES 0 0 0 0 3 8.00 DURABLE MEDI CAL EQUI PMENT/0XYGEN 0 0 0 0 3 9.00 PATI ENT TRANSPORTATION 0 0 0 0 3 9.00 PATI ENT TRANSPORTATION 0 0 0 0 3 9.00 IMAGI NG SERVI CES 0 0 0 0 4 1.00 LABS & DI AGNOSTI CS 0 0 0 0 4 2.00 MEDI CAL SUPPLI ES-NON-ROUTI NE 0 0 0 0 4 2.50 DRUGS CHARGED TO PATI ENTS 0 0 0 0 4 3.00 OUTPATI ENT SRADI ATI ON THERAPY 0 0 0 0 4 5.00 PALLI ATI VE RADI ATI ON THERAPY 0 0 0 0 4 6.00 <td>3.00 MEDICAL SOCIAL SERVICES</td> <td>0</td> <td>0</td> <td></td> <td>0 0</td> <td>0</td> <td>33.</td>	3.00 MEDICAL SOCIAL SERVICES	0	0		0 0	0	33.
16.00 COUNSELING - OTHER 0 0 0 0 3 17.00 HOSPICE AIDE & HOMEMAKER SERVICES 0 0 0 0 3 18.00 DURABLE MEDICAL EQUIPMENT/OXYGEN 0 0 0 0 3 19.00 PATIENT TRANSPORTATION 0 0 0 0 0 3 10.00 IMAGING SERVICES 0 0 0 0 0 0 4 11.00 LABS & DIAGNOSTICS 0 0 0 0 0 0 4 12.00 MEDICAL SUPPLIES-NON-ROUTINE 0 0 0 0 0 4 13.00 OUTPATIENT SERVICES 0 0 0 0 4 13.00 OUTPATIENT SERVICES 0 0 0 0 4 14.00 PALLIATIVE RADIATION THERAPY 0 0 0 0 4 15.00 PALLIATIVE CHEMOTHERAPY 0 0 0 0 0 0 16.00 OTHER PATIENT CARE SERVICES (SPECIFY) 0 <t< td=""><td>4.00 SPIRITUAL COUNSELING</td><td>0</td><td>0</td><td></td><td>0 0</td><td>0</td><td>34.</td></t<>	4.00 SPIRITUAL COUNSELING	0	0		0 0	0	34.
7.00 HOSPICE AI DE & HOMEMAKER SERVICES 0 0 0 0 3 8.00 DURABLE MEDICAL EQUIPMENT/OXYGEN 0 0 0 0 3 9.00 PATI ENT TRANSPORTATION 0 0 0 0 3 0.00 IMAGI NG SERVICES 0 0 0 0 0 4 1.00 LABS & DI AGNOSTICS 0 0 0 0 0 4 2.00 MEDI CAL SUPPLI ES-NON-ROUTI NE 0 0 0 0 4 2.50 DRUGS CHARGED TO PATI ENTS 0 0 0 0 4 3.00 OUTPATI ENT SERVICES 0 0 0 0 4 3.00 OUTPATI ENT SERVICES 0 0 0 0 4 3.00 OUTPATI ENT SERVICES 0 0 0 0 4 5.00 PALLI ATI VE RADI ATI ON THERAPY 0 0 0 0 4 6.00 OTHER PATI ENT CARE SERVICES (SPECI FY) 0 0 0 0 0 4	5.00 DI ETARY COUNSELING	0	0		0 0	0	35.
8.00 DURABLE MEDICAL EQUIPMENT/OXYGEN 0 0 0 0 0 3 9.00 PATI ENT TRANSPORTATION 0 0 0 0 3 0.00 I MAGI NG SERVICES 0 0 0 0 0 4 1.00 LABS & DI AGNOSTICS 0 0 0 0 0 4 2.00 MEDI CAL SUPPLI ES-NON-ROUTI NE 0 0 0 0 4 2.00 MEDI CAL SUPPLI ES-NON-ROUTI NE 0 0 0 0 4 2.00 MEDI CAL SUPPLI ES-NON-ROUTI NE 0 0 0 4 2.50 DRUGS CHARGED TO PATI ENTS 0 0 0 4 3.00 OUTPATI ENT SERVICES 0 0 0 0 4 4.00 PALLI ATI VE RADI ATI ON THERAPY 0 0 0 0 4 5.00 PALLI ATI VE CHEMOTHERAPY 0 0 0 0 4 6.00	6.00 COUNSELING - OTHER	0	0		0 0	0	36.
9.00 PATI ENT TRANSPORTATION 0 </td <td>7.00 HOSPICE AIDE & HOMEMAKER SERVICES</td> <td>0</td> <td>0</td> <td></td> <td>0 0</td> <td>0</td> <td>37.</td>	7.00 HOSPICE AIDE & HOMEMAKER SERVICES	0	0		0 0	0	37.
0.00 IMAGING SERVICES 0	8.00 DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0		0 0	0	38.
1.00 LABS & DI AGNOSTI CS 0 0 0 0 4 2.00 MEDI CAL SUPPLI ES-NON-ROUTI NE 0 0 0 0 4 2.50 DRUGS CHARGED TO PATI ENTS 0 0 0 0 4 3.00 OUTPATI ENT SERVI CES 0 0 0 0 0 4 4.00 PALLI ATI VE RADI ATI ON THERAPY 0 0 0 0 4 5.00 PALLI ATI VE CHEMOTHERAPY 0 0 0 0 4 6.00 OTHER PATI ENT CARE SERVI CES (SPECI FY) 0 0 0 0 0 0 00.00 TOTAL * 0 0 0 0 0 0 0		0	0		0 0	0	39.
2.00 MEDICAL SUPPLIES-NON-ROUTINE 0 0 0 0 4 2.50 DRUGS CHARGED TO PATIENTS 0 0 0 0 4 3.00 OUTPATIENT SERVICES 0 0 0 0 4 4.00 PALLIATIVE RADIATION THERAPY 0 0 0 0 4 5.00 PALLIATIVE CHEMOTHERAPY 0 0 0 0 4 6.00 OTHER PATIENT CARE SERVICES (SPECIFY) 0		0	0		0 0	0	1 .0.
2.50 DRUGS CHARGED TO PATIENTS 0 0 0 0 4 3.00 OUTPATIENT SERVICES 0 0 0 0 4 4.00 PALLIATIVE RADIATION THERAPY 0 0 0 0 4 5.00 PALLIATIVE CHEMOTHERAPY 0 0 0 0 4 6.00 OTHER PATIENT CARE SERVICES (SPECIFY) 0 0 0 0 4 00.00 TOTAL * 0 0 0 0 0 0 0		0	0		0 0	0	1
3.00 OUTPATI ENT SERVICES 0 0 0 0 4 4.00 PALLIATIVE RADIATION THERAPY 0 0 0 0 4 5.00 PALLIATIVE CHEMOTHERAPY 0 0 0 0 4 6.00 OTHER PATI ENT CARE SERVICES (SPECIFY) 0 0 0 0 4 00.00 TOTAL * 0 0 0 0 0 0		0	0		0 0	0	1
4.00 PALLIATIVE RADIATION THERAPY 0 0 0 0 4 5.00 PALLIATIVE CHEMOTHERAPY 0 0 0 0 4 6.00 OTHER PATIENT CARE SERVICES (SPECIFY) 0 0 0 0 4 00.00 TOTAL * 0 0 0 0 0 0		0	0		0 0	0	1
5.00 PALLIATIVE CHEMOTHERAPY 0 0 0 4 6.00 OTHER PATIENT CARE SERVICES (SPECIFY) 0 0 0 0 4 00.00 TOTAL * 0		0	0		0 0	Ű	1 .0.
6.00 OTHER PATI ENT CARE SERVICES (SPECIFY) 0 0 0 0 4 00.00 TOTAL * 0 0 0 0 0 10		0	0		0 0	e e e	1
00.00 TOTAL * 0 0 0 0 0 10		0	0		0 0	-	
		-Y) 0	0		0 0		
Transfer the amount in column 7 to Wkst. 0-5, column 1, line 50.		0	0		0 0	0	100.
	Iransfer the amount in column 7 to Wkst	. 0-5, column 1, line 50.					

		ADJUSTMENTS	TOTAL (col. 5	
			± col. 6)	
		6.00	7.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS			
25.00	INPATIENT CARE-CONTRACTED			25.00
26.00	PHYSI CI AN SERVI CES	0	0	26.00
27.00	NURSE PRACTITIONER	0	0	27.00
28.00	REGI STERED NURSE	0	0	28.00
29.00	LPN/LVN	0	0	29.00
30.00	PHYSI CAL THERAPY	0	0	30.00
31.00	OCCUPATI ONAL THERAPY	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	0	33.00
34.00	SPI RI TUAL COUNSELI NG	0	0	34.00
35.00	DI ETARY COUNSELI NG	0	0	35.00
36.00	COUNSELING - OTHER	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	0	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	39.00
40.00	I MAGI NG SERVI CES	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	42.50
43.00	OUTPATI ENT SERVICES	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	46.00
100.00	TOTAL *	0	0	100.00
* Trar	sfer the amount in column 7 to Wkst. 0-5, col	umn 1, line 50.		

ealth Financial Systems	FRANCI SCAN HEAL				u of Form CMS-2	
NALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOS	SPICE ROUTINE HOME	Provider C	CN: 15-0109	Period:	Worksheet 0-2	
ARE		Hospi ce CCI	N: 15-1563	From 01/01/2020 To 12/31/2020	Date/Time Pre 4/29/2021 3:5	
				Hospi ce I		
	SALARI ES	OTHER	SUBTOTAL (co 1 + col. 2)		SUBTOTAL	
	1.00	2.00	3.00	4.00	5.00	
DIRECT PATIENT CARE SERVICE COST CENTERS			-			
5.00 INPATIENT CARE-CONTRACTED						25.00
6. 00 PHYSI CI AN SERVI CES	0	0		0 0	0	
7.00 NURSE PRACTITIONER	0	0		0 0	0	27.00
8.00 REGI STERED NURSE	1, 146, 036	0	1, 146, 0	36 0	1, 146, 036	
9.00 LPN/LVN	0	0		0 0	0	29.00
0. 00 PHYSI CAL THERAPY	0	0		0 0	0	30.00
1.00 OCCUPATIONAL THERAPY	0	0		0 0	0	31.00
2.00 SPEECH/LANGUAGE PATHOLOGY	0	0		0 0	0	32.00
3.00 MEDICAL SOCIAL SERVICES	112, 251	0	112, 2	51 0	112, 251	33.00
4. 00 SPI RI TUAL COUNSELI NG	146, 917	0	146, 9	17 0	146, 917	34.00
5.00 DIETARY COUNSELING	0	0		0 0	0	35.00
6.00 COUNSELING - OTHER	0	0		0 0	0	36.0
7.00 HOSPICE AIDE & HOMEMAKER SERVICES	108, 736	0	108, 7	36 0	108, 736	37.00
8.00 DURABLE MEDICAL EQUIPMENT/OXYGEN	0	250, 017	250, 0	17 0	250, 017	38.0
9.00 PATIENT TRANSPORTATION	0	7, 161	7, 1	61 0	7, 161	39.0
0.00 I MAGI NG SERVI CES	0	0		0 0	0	40.00
1.00 LABS & DIAGNOSTICS	0	0		0 0	0	41.0
2.00 MEDICAL SUPPLIES-NON-ROUTINE	0	51, 935	51, 9	35 0	51, 935	42.0
2.50 DRUGS CHARGED TO PATIENTS	0	383, 338	383, 3	38 0	383, 338	42.50
3. 00 OUTPATI ENT SERVICES	0	0		0 0	0	43.00
4.00 PALLIATIVE RADIATION THERAPY	0	0		0 0	0	44.00
5.00 PALLIATIVE CHEMOTHERAPY	0	0		0 0	0	45.0
6.00 OTHER PATIENT CARE SERVICES (SPECIFY)	269, 724	1, 229, 037	1, 498, 7	61 0	1, 498, 761	46.0
00.00 TOTAL *	1, 783, 664	1, 921, 488	3, 705, 1	52 0	3, 705, 152	100. 0

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

		ADJUSTMENTS	TOTAL (col. 5	
		7105051mEltito	± col. 6)	
		6.00	7.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS		•	
25.00	INPATIENT CARE-CONTRACTED			25.
26.00	PHYSI CI AN SERVI CES	0	0	26.
27.00	NURSE PRACTITIONER	0	0	27.
28.00	REGI STERED NURSE	0	1, 146, 036	28.
29.00	LPN/LVN	0	0	29.
30.00	PHYSI CAL THERAPY	0	0	30.
31.00	OCCUPATIONAL THERAPY	0	0	31.
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	32.
33.00	MEDICAL SOCIAL SERVICES	0	112, 251	33.
34.00	SPI RI TUAL COUNSELI NG	0	146, 917	34.
35.00	DI ETARY COUNSELI NG	0	0	35.
36.00	COUNSELING - OTHER	0	0	36.
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	108, 736	37.
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	250, 017	38.
39.00	PATI ENT TRANSPORTATI ON	0	7, 161	39.
40.00	I MAGI NG SERVI CES	0	0	40.
41.00	LABS & DI AGNOSTI CS	0	0	41.
42.00	MEDI CAL SUPPLI ES-NON-ROUTI NE	0	51, 935	42.
42.50	DRUGS CHARGED TO PATIENTS	0	383, 338	42.
43.00	OUTPATI ENT SERVICES	0	0	43.
44.00	PALLIATIVE RADIATION THERAPY	0	0	44.
45.00	PALLIATIVE CHEMOTHERAPY	0	0	45.
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	1, 498, 761	46.
100.00	D TOTAL *	0	3, 705, 152	100.

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

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HO	SPICE INPATIENT	Provider CO		Period:	Worksheet 0-3	
RESPI TE CARE		Hospi ce CCI		From 01/01/2020 To 12/31/2020	Date/Time Pre 4/29/2021 3:5	
				Hospi ce I		
	SALARI ES	OTHER	SUBTOTAL (col 1 + col. 2)	. RECLASSI FI - CATI ONS	SUBTOTAL	
	1.00	2.00	3.00	4.00	5.00	
DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00 INPATIENT CARE-CONTRACTED		0		0 0	0	25.00
26. 00 PHYSI CI AN SERVI CES	0	0		0 0	0	26.00
27.00 NURSE PRACTITIONER	0	0		0 0	0	27.00
28. 00 REGI STERED NURSE	2, 208	0	2, 20	8 0	2, 208	28.0
29. 00 LPN/LVN	0	0		0 0	0	29.0
30. 00 PHYSI CAL THERAPY	0	0		0 0	0	30.0
31.00 OCCUPATIONAL THERAPY	0	0		0 0	0	31.0
32.00 SPEECH/LANGUAGE PATHOLOGY	0	0		0 0	0	
33.00 MEDICAL SOCIAL SERVICES	2, 169	0	2, 16	9 0	2, 169	33.0
34. 00 SPIRITUAL COUNSELING	219	0	21	9 0	219	34.0
35. 00 DI ETARY COUNSELI NG	0	0		0 0	0	1 00.0
36. 00 COUNSELING - OTHER	0	0		0 0	0	1 00.0
37.00 HOSPICE AIDE & HOMEMAKER SERVICES	0	0		0 0	0	
38.00 DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0		0 0	0	
9.00 PATIENT TRANSPORTATION	0	3, 545	3, 54	5 0	3, 545	
0. 00 I MAGI NG SERVI CES	0	0		0 0	0	40.0
1.00 LABS & DIAGNOSTICS	0	0		0 0	0	1
2.00 MEDICAL SUPPLIES-NON-ROUTINE	0	0		0 0	0	
2.50 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	
3. 00 OUTPATIENT SERVICES	0	0		0 0	0	
4.00 PALLIATIVE RADIATION THERAPY	0	0		0 0	0	1
5. 00 PALLIATIVE CHEMOTHERAPY	0	0		0 0	0	
16.00 OTHER PATIENT CARE SERVICES (SPECIFY)	3, 289	150			3, 439	
100.00 TOTAL *	7, 885	3, 695	11, 58	0 0	11, 580	100. C

		ADJUSTMENTS	TOTAL (col. 5		
			± col. 6)		
	T	6.00	7.00		
	DIRECT PATIENT CARE SERVICE COST CENTERS		1	1	
25.00	INPATIENT CARE-CONTRACTED	0	0		25.00
26.00	PHYSI CI AN SERVI CES	0	0		26.00
27.00	NURSE PRACTITIONER	0	0		27.00
28.00	REGI STERED NURSE	0	2, 208		28.00
29.00	LPN/LVN	0	0		29.00
30.00	PHYSI CAL THERAPY	0	0		30.00
31.00	OCCUPATIONAL THERAPY	0	0		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0		32.00
33.00	MEDICAL SOCIAL SERVICES	0	2, 169		33.00
34.00	SPI RI TUAL COUNSELI NG	0	219		34.00
35.00	DI ETARY COUNSELI NG	0	0		35.00
36.00	COUNSELING - OTHER	0	0		36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	0		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0		38.00
39.00	PATI ENT TRANSPORTATI ON	0	3, 545		39.00
40.00	I MAGI NG SERVI CES	0	0		40.00
41.00	LABS & DI AGNOSTI CS	0	0		41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0		42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0		42.50
43.00	OUTPATI ENT SERVICES	0	0		43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0		44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0		45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	3, 439		46.00
100.00	TOTAL *	0	11, 580		100.00
* Tran	sfer the amount in column 7 to Wkst. 0-5, col	umn 1, line 52.			

Health Financial Systems	FRANCI SCAN HEALT	H_LAFAYETTE		In Lie	u of Form CMS-	2552-10
ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HO	SPICE GENERAL	Provider CCN		Period:	Worksheet 0-4	
INPATIENT CARE		Hospice CCN:		From 01/01/2020 To 12/31/2020	Date/Time Pre 4/29/2021 3:5	
				Hospi ce I		
	SALARI ES	OTHER S	UBTOTAL (col. 1 + col. 2)	RECLASSIFI - CATIONS	SUBTOTAL	
	1.00	2.00	3.00	4.00	5.00	
DIRECT PATIENT CARE SERVICE COST CENTERS		· ·				
25.00 INPATIENT CARE-CONTRACTED		0	(0 0	0	25.00
26.00 PHYSI CI AN SERVI CES	0	0	(0 0	0	26.00
27.00 NURSE PRACTITIONER	0	0	(0 0	0	27.00
28.00 REGI STERED NURSE	586	0	586	6 0	586	28.00
29.00 LPN/LVN	0	0	(0 0	0	29.00
30. 00 PHYSI CAL THERAPY	0	0	(0 0	0	30.00
31.00 OCCUPATIONAL THERAPY	0	0	(0 0	0	31.00
32.00 SPEECH/LANGUAGE PATHOLOGY	0	0	(0 0	0	32.00
33.00 MEDICAL SOCIAL SERVICES	936	0	936	6 0	936	33.00
34.00 SPI RI TUAL COUNSELI NG	125	0	125	5 0	125	34.00
35. 00 DI ETARY COUNSELI NG	0	0	(0 0	0	35.00
36.00 COUNSELING - OTHER	0	0	(0 0	0	36.00
37.00 HOSPICE AIDE & HOMEMAKER SERVICES	0	0	(0 0	0	37.00
38.00 DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	(0 0	0	38.00
39.00 PATIENT TRANSPORTATION	0	0	(0 0	0	39.00
40.00 I MAGI NG SERVI CES	0	0	(0 0	0	40.00
41.00 LABS & DIAGNOSTICS	0	0	(0 0	0	
42.00 MEDI CAL SUPPLI ES-NON-ROUTI NE	0	171	171	1 0	171	42.00
42.50 DRUGS CHARGED TO PATIENTS	0	0	(0 0	0	
43.00 OUTPATIENT SERVICES	0	0	(0 0	0	
44.00 PALLIATIVE RADIATION THERAPY	0	0	(0 0	0	
45.00 PALLIATIVE CHEMOTHERAPY	0	0	(0 0	0	
46.00 OTHER PATIENT CARE SERVICES (SPECIFY)	0	245	245		245	
100.00 TOTAL *	1,647	416	2,063	3 0	2, 063	100.00
* Transfer the amount in column 7 to Wkst. 0-5,	column 1, line 53.					

		ADJUSTMENTS	TOTAL (col. 5	
			± col. 6)	
		6.00	7.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS			
25.00	INPATIENT CARE-CONTRACTED	0	0	25.00
26.00	PHYSI CI AN SERVI CES	0	0	26.00
27.00	NURSE PRACTITIONER	0	0	27.00
28.00	REGI STERED NURSE	0	586	28.00
29.00	LPN/LVN	0	0	29.00
30.00	PHYSI CAL THERAPY	0	0	30.00
31.00	OCCUPATI ONAL THERAPY	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	936	33.00
34.00	SPI RI TUAL COUNSELI NG	0	125	34.00
35.00	DI ETARY COUNSELI NG	0	0	35.00
36.00	COUNSELING - OTHER	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	0	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	39.00
40.00	I MAGI NG SERVI CES	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	171	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	42.50
43.00	OUTPATI ENT SERVICES	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	245	46.00
100.00	TOTAL *	0	2, 063	100.00
* Tran	sfer the amount in column 7 to Wkst. 0-5, col	umn 1, line 53.		

Heal th	Financial Systems FRANCISCAN HEALT	H LAFAYETTE		In Lie	eu of Form CMS-2	2552-10
COST A	LLOCATION - DETERMINATION OF HOSPITAL-BASED HOSPICE NET	Provider C	CN: 15-0109	Peri od:	Worksheet 0-5	
EXPENS	ES FOR ALLOCATION			From 01/01/2020		
		Hospi ce CC	N: 15-1563	To 12/31/2020	Date/Time Pre 4/29/2021 3:5	
				Hospi ce I	4/29/2021 3. 5.	<u>z μιι</u>
	Descriptions		HOSPICE DIRE		TOTAL EXPENSES	
			EXPENSES (se		(sum of cols.	
) EXPENSES FROM	1 + 2)	
				WKST B PART I	,	
				(see		
				instructions)		
			1.00	2.00	3.00	
	GENERAL SERVICE COST CENTERS					
1.00	CAP REL COSTS-BLDG & FIXT			0 0		1.00
2.00	CAP REL COSTS-MVBLE EQUIP			0 0	-	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT			0 711, 577		3.00
4.00	ADMINISTRATIVE & GENERAL		841, 2	52 1, 569, 550		4.00
5.00	PLANT OPERATION & MAINTENANCE			0 0	0	5.00
6.00	LAUNDRY & LINEN SERVICE			0 0	0	6.00
7.00	HOUSEKEEPING			0 0	0	7.00
8.00	DI ETARY			0 0	0	8.00
9.00	NURSI NG ADMI NI STRATI ON		158, 9			9.00
10.00	ROUTINE MEDICAL SUPPLIES		4, 7			
11.00	MEDI CAL RECORDS			0 41, 361		11.00
12.00	STAFF TRANSPORTATION			0	0	12.00
13.00	VOLUNTEER SERVICE COORDINATION		54, 4		54, 469	
14.00			2, 5			
15.00	PHYSI CI AN ADMI NI STRATI VE SERVI CES		169, 2		169, 290	
16.00	OTHER GENERAL SERVICE			0 0		16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES			0	0	17.00
50, 00	LEVEL OF CARE HOSPI CE CONTI NUOUS HOME CARE		1	0	0	50.00
50.00 51.00	HOSPICE CONTINUOUS HOME CARE		3, 705, 1		3, 705, 152	
52.00	HOSPICE INPATIENT RESPITE CARE		3, 703, 1		11, 580	
52.00	HOSPICE TREATENT RESPICE CARE		2,0		2, 063	52.00
55.00	NONREIMBURSABLE COST CENTERS		2,0	55	2,003	55.00
60.00	BEREAVEMENT PROGRAM			0	0	60.00
61.00	VOLUNTEER PROGRAM			0	0	61.00
62.00	FUNDRAI SI NG			0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS			0	0	63.00
64.00	PALLI ATI VE CARE PROGRAM			0	0	64.00
65.00	OTHER PHYSI CI AN SERVI CES			0	0	65.00
66.00	RESI DENTI AL CARE			0	0	66.00
67.00	ADVERTI SI NG			0	0	67.00
68.00	TELEHEALTH/TELEMONI TORI NG			0	0	68.00
69.00	THRIFT STORE			0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD		1	0	0	70.00
71.00	OTHER NONREI MBURSABLE (SPECI FY)			0	0	71.00
99.00	NEGATI VE COST CENTER			0	0	99.00
100.00	TOTAL		4, 950, 0	2, 578, 544	7, 528, 545	100.00
	,					•

	Financial Systems LLOCATION - HOSPITAL-BASED HOSPICE GENERAL	FRANCI SCAN HEALT	Provi der C	NI 15 0100	Dor	i od:	u of Form CMS-2 Worksheet 0-6	2002-10
CUST A	LLUCATION - HUSPITAL-BASED HUSPICE GENERAL	SERVICE COSTS	Hospice CCI			01/01/2020 12/31/2020	Part I Date/Time Pre	pared:
						Hospi ce I	4/29/2021 3:5	2 pm
	Descriptions	TOTAL EXPENSESC/	AP REL BLDG & FIX	CAP REL MVBI EQUI P	LE	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL	
		0	1.00	2.00		3.00	ЗA	
	GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0					1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0			0			2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	711, 577	0		0	711, 577		3.00
4.00	ADMINISTRATIVE & GENERAL	2, 410, 812	0		0	0	2, 410, 812	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0		0	0	0	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0		0	0	0	6.00
7.00	HOUSEKEEPING	0	0		0	0	0	7.00
8.00	DI ETARY	0	0		0	0	0	8.00
9.00	NURSI NG ADMI NI STRATI ON	411, 956	0		0	0	411, 956	9.00
10.00	ROUTINE MEDICAL SUPPLIES	7,766	0		0	0	7,766	
11.00	MEDI CAL RECORDS	41, 361	0		0	0	41, 361	11.00
12.00	STAFF TRANSPORTATION	0	0		0	0	0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	54, 469	0		0	0	54, 469	13.00
14.00 15.00	PHARMACY PHYSI CI AN ADMI NI STRATI VE SERVI CES	2, 519	0		0	0	2, 519	
15.00	OTHER GENERAL SERVICE	169, 290	0		0	0	169, 290 0	15.00 16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0		0	0	0	17.00
17.00	LEVEL OF CARE	L	0		0		0	17.00
50.00	HOSPICE CONTINUOUS HOME CARE	0				0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	3, 705, 152				0	3, 705, 152	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	11, 580	0		0	0	11, 580	
53.00	HOSPICE GENERAL INPATIENT CARE	2,063	0		0	711, 577	713, 640	53.00
00.00	NONREI MBURSABLE COST CENTERS	2,000				, , . , . ,	, 10, 010	00.00
60,00	BEREAVEMENT PROGRAM	0	0		0	0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0		0	0	0	61.00
62.00	FUNDRAI SI NG	0	0		0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0		0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0		0	0	0	64.00
65.00	OTHER PHYSI CI AN SERVI CES	0	0		0	0	0	65.00
66.00	RESI DENTI AL CARE	0	0		0	0	0	66.00
67.00	ADVERTI SI NG	0	0		0	0	0	67.00
68.00	TELEHEALTH/TELEMONI TORI NG	0	0		0	0	0	68.00
69.00	THRIFT STORE	0	0		0	0	0	69.00
	NURSING FACILITY ROOM & BOARD	0					0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0		0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0		0	0		99.00
100 00	TOTAL	7, 528, 545	0	1	0	711, 577	7, 528, 545	100 00

	2	FRANCI SCAN HEAL					u of Form CM		552-10
COST /	ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SE	ERVICE COSTS	Provider C Hospice CC	CN: 15-0109 N: 15-1563		eriod: com 01/01/2020 p 12/31/2020	Worksheet O Part I Date/Time P 4/29/2021 3	rer	pared:
						Hospice I			
	Descriptions	ADMI NI STRATI VE & GENERAL	PLANT OPERATI ON & MAI NTENANCE	LAUNDRY &		HOUSEKEEPI NG	DI ETARY		
		4.00	5.00	6.00		7.00	8.00		
	GENERAL SERVICE COST CENTERS			·					
1.00	CAP REL COSTS-BLDG & FIXT								1.00
2.00	CAP REL COSTS-MVBLE EQUIP								2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT								3.00
4.00	ADMI NI STRATI VE & GENERAL	2, 410, 812							4.00
5.00	PLANT OPERATION & MAINTENANCE	0	C						5.00
6.00	LAUNDRY & LINEN SERVICE	0	C		0				6.00
7.00	HOUSEKEEPING	0	C			0			7.00
8.00	DI ETARY	0	C			o		ol	8.00
9.00	NURSING ADMINISTRATION	194,060	C			0			9,00
10.00	ROUTINE MEDICAL SUPPLIES	3, 658	C			0			10.00
11.00	MEDICAL RECORDS	19, 484	C			0			11.00
12.00	STAFF TRANSPORTATION	0	C			0			12.00
13.00	VOLUNTEER SERVICE COORDINATION	25, 659	C			0			13.00
14.00	PHARMACY	1, 187	Ċ			0			14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	79, 747	Ċ			0			15.00
16.00		0	Ċ			0			16.00
17.00		0	Ċ			0			17.00
	LEVEL OF CARE	-	-	1		-1			
50.00	HOSPICE CONTINUOUS HOME CARE	0			1				50.00
51.00	HOSPICE ROUTINE HOME CARE	1, 745, 388							51.00
52.00	HOSPICE INPATIENT RESPITE CARE	5, 455	C		0	0		0	52.00
53.00		336, 174	C		0	0		0	53.00
	NONREI MBURSABLE COST CENTERS	1	-			<u>_</u>		_	
60.00	BEREAVEMENT PROGRAM	0	C			0			60.00
61.00	VOLUNTEER PROGRAM	0	C			0			61.00
62.00	FUNDRAI SI NG	0	C			0			62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	C			0			63.00
64.00	PALLIATIVE CARE PROGRAM	0	C			0			64.00
65.00	OTHER PHYSICIAN SERVICES	0	C			0			65.00
66.00	RESI DENTI AL CARE	0	C		0	0		0	66.00
67.00	ADVERTI SI NG	0	C		-	0		-	67.00
68.00	TELEHEALTH/TELEMONI TORI NG	0	C			o			68.00
69.00	THRIFT STORE	0	C			0			69.00
70.00	NURSING FACILITY ROOM & BOARD					-			70.00
71.00	OTHER NONREI MBURSABLE (SPECIFY)	0	C		0	о		0	71.00
99.00	. ,	0	C		0	o		0	99.00
	TOTAL	2, 410, 812	C		0	0		0	100.00
	'					- 1			

Heal th	n Financial Systems	FRANCI SCAN HEALT	H LAFAYETTE		In Lie	u of Form CMS-2	2552-10
	ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL		Provider CC Hospice CC		Period: From 01/01/2020 To 12/31/2020	Worksheet 0-6 Part I	pared:
					Hospi ce I		
	Descriptions	NURSI NG ADMI NI STRATI ON	ROUTI NE MEDI CAL SUPPLI ES	MEDI CAL RECORDS	STAFF TRANSPORTATI ON	VOLUNTEER SERVI CE COORDI NATI ON	
		9.00	10.00	11.00	12.00	13.00	
	GENERAL SERVICE COST CENTERS			·			
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DI ETARY						8.00
9.00	NURSI NG ADMI NI STRATI ON	606, 016					9.00
10.00	ROUTI NE MEDI CAL SUPPLI ES	0	11, 424				10.00
11.00	MEDICAL RECORDS	0	,	60, 8	45		11.00
12.00	STAFF TRANSPORTATION	0		00,0	0		12.00
13.00	VOLUNTEER SERVICE COORDINATION	0			0	80, 128	13.00
14.00		0			0	00, 120	14.00
15.00	PHYSI CI AN ADMI NI STRATI VE SERVI CES	0			0	0	15.00
16.00		0			0	0	16.00
17.00		Ŭ			0	Ū	17.00
17.00	LEVEL OF CARE			I			17.00
50.00	HOSPICE CONTINUOUS HOME CARE	0	0		0 0	0	50.00
50.00		0	11, 381	60, 6	-	79, 826	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	35		38 0	248	52.00
53.00		606, 016	8		41 0	54	53.00
55.00	NONREI MBURSABLE COST CENTERS	000,010	0	· · · · · ·	1 0	54	33.00
60.00		0			0	0	60.00
61.00	VOLUNTEER PROGRAM	0			0	0	61.00
62.00	FUNDRAI SI NG	0			0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0			0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0			0	0	64.00
65.00	OTHER PHYSI CI AN SERVI CES	0			0	0	65.00
66.00	RESIDENTIAL CARE	0			0	0	66.00
67.00	ADVERTI SI NG	0			0	0	67.00
68.00	TELEHEALTH/TELEMONI TORI NG	0			0	0	68.00
69.00	THRI FT_STORE	0			0	0	69.00
70.00		0			0	0	70.00
70.00	OTHER NONREIMBURSABLE (SPECIFY)				0	0	70.00
99.00	. ,		0		0	0	71.00 99.00
	D TOTAL	606, 016	11, 424	60, 8	45 0	-	
100.0		000,010	11, 424	I 00, 0		00, 120	100.00

COST A	LLOCATI ON - HOSPI TAL-BASED HOSPI CE GENERAL	SERVICE COSTS	Provider C Hospice CC		Period: From 01/01/2020 To 12/31/2020	Worksheet 0-6 Part I Date/Time Pre 4/29/2021 3:5	epared:
	Descriptions	PHARMACY	PHYSI CI AN	OTHER GENERA	Hospice I	TOTAL	
			ADMI NI STRATI VE SERVI CES		RESIDENTIAL CARE SERVICES	TOTAL	
		14.00	15.00	16.00	17.00	18.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DI ETARY						8.00
9.00	NURSING ADMINISTRATION						9.00
10.00	ROUTINE MEDICAL SUPPLIES						10.00
11.00	MEDI CAL RECORDS						11.00
12.00	STAFF TRANSPORTATION						12.00
13.00	VOLUNTEER SERVICE COORDINATION	0.70/					13.00
14.00	PHARMACY	3, 706					14.00
15.00	PHYSI CLAN ADMI NI STRATI VE SERVI CES	0	249, 037				15.00
16.00	OTHER GENERAL SERVICE	0			0		16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES				0		17.00
50.00	HOSPICE CONTINUOUS HOME CARE	0	0		0	C	50.00
51.00	HOSPICE CONTINUOUS HOME CARE	3, 692	248, 098		0	5, 854, 153	
52.00	HOSPICE INPATIENT RESPITE CARE	11	240, 070		0 0	18, 288	
53.00	HOSPICE GENERAL INPATIENT CARE	3	168		0 0	1, 656, 104	
55.00	NONREI MBURSABLE COST CENTERS		100	1	0	1,000,104	55.00
60.00	BEREAVEMENT PROGRAM	0			0	C	60.00
61.00	VOLUNTEER PROGRAM	0			0	C	
62.00	FUNDRAI SI NG	0			0	C	
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0			0	C	
64.00	PALLIATIVE CARE PROGRAM	0			0	C	64.00
65.00	OTHER PHYSI CLAN SERVI CES	0			0	C	65.00
66.00	RESI DENTI AL CARE	0	0		0 0	C	66.00
67.00	ADVERTI SI NG	0			0	C	67.00
68.00	TELEHEALTH/TELEMONI TORI NG	0			0	C	68.00
69.00	THRI FT STORE	0			0	C	69.00
70.00	NURSING FACILITY ROOM & BOARD					C	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0		0 0	C	71.00
99.00	NEGATIVE COST CENTER	0	0)	0 0	C	99.00
100 00	TOTAL	3, 706	249, 037		0 0	7, 528, 545	100 00

Heal th	Financial Systems	FRA	ANCISCAN HEALT	H LAFAYETTE		In Lie	u of Form CMS-:	2552-10
COST A	LLOCATION - HOSPITAL-BASED HOSPICE GEN	NERAL SERVI	CE COSTS	Provider CC	CN: 15-0109	Peri od:	Worksheet 0-6	
STATI S	TICAL BASIS				45 45 40	From 01/01/2020	Part II	
				Hospi ce CCN	N: 15-1563	To 12/31/2020	Date/Time Pre 4/29/2021 3:5	
						Hospi ce I	4/29/2021 3.5	<u>z μιι</u>
	Cost Center Descriptions	CA	P REL BLDG & C	AP REL MVBLE	EMPLOYEE	RECONCI LI ATI ON	ADMI NI STRATI VE	
		0,1	FIX	EQUI P	BENEFITS	RECONCILEMENT ON	& GENERAL	
		(5	QUARE FEET) (I		DEPARTMENT		(ACCUMULATED	
					(GROSS		COSTS)	
					SALARI ES)		· ·	
			1.00	2.00	3.00	4A	4.00	
	GENERAL SERVICE COST CENTERS	· · ·						
1.00	CAP REL COSTS-BLDG & FIXT		0					1.00
2.00	CAP REL COSTS-MVBLE EQUIP			0				2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT		0	0	2, 731, 5	51		3.00
4.00	ADMINISTRATIVE & GENERAL		0	0		0 -2, 410, 812	5, 117, 733	4.00
5.00	PLANT OPERATION & MAINTENANCE		0	0		0 0	0	5.00
6.00	LAUNDRY & LINEN SERVICE	1	0	0		0 0	0	6.00
7.00	HOUSEKEEPING	1	0	0		0 0	0	7.00
8.00	DI ETARY		0	0		0 0	0	8.00
9.00	NURSING ADMINISTRATION		0	0		0 0	411, 956	9.00
10.00	ROUTINE MEDICAL SUPPLIES		0	0		0 0	7, 766	10.00
11.00	MEDI CAL RECORDS		0	0		0 0	41, 361	11.00
12.00	STAFF TRANSPORTATION	1	0	0		0 0	0	12.00
13.00	VOLUNTEER SERVICE COORDINATION		0	0		0 0	54, 469	13.00
14.00	PHARMACY	1	О	0		0 0	2, 519	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES		0	0		0 0	169, 290	15.00
16.00	OTHER GENERAL SERVICE		0	0		0 0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES		0	0		0	0	17.00
	LEVEL OF CARE							
50.00	HOSPICE CONTINUOUS HOME CARE					0 0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE					0 0	3, 705, 152	51.00
52.00	HOSPICE INPATIENT RESPITE CARE		0	0		0 0	11, 580	52.00
53.00	HOSPICE GENERAL INPATIENT CARE		0	0	2, 731, 5	51 0	713, 640	53.00
	NONREIMBURSABLE COST CENTERS							
60.00	BEREAVEMENT PROGRAM		0	0		0 0	0	60.00
61.00	VOLUNTEER PROGRAM		0	0		0 0	0	61.00
62.00	FUNDRAI SI NG		0	0		0 0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS		0	0		0 0	0	63.00
64.00	PALLIATIVE CARE PROGRAM		0	0		0 0	0	64.00
65.00	OTHER PHYSICIAN SERVICES		0	0		0 0	0	65.00
66.00	RESI DENTI AL CARE		0	0		0 0	0	66.00
67.00	ADVERTI SI NG		0	0		0 0	0	67.00
68.00	TELEHEALTH/TELEMONI TORI NG		0	0		0 0	0	68.00
69.00	THRIFT STORE		0	0		0 0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD					0		70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)		0	0		0 0	0	71.00
99.00	NEGATI VE COST CENTER							99.00
	COST TO BE ALLOCATED (per Wkst. 0-6,	Part I)	0	0	711, 5		2, 410, 812	
101.00	UNIT COST MULTIPLIER		0. 000000	0. 000000	0.2605	J3	0. 471070	101.00

Heal th	Financial Systems	FRANCI SCAN HEAL	TH LAFAYETTE		In Lie	u of Form CMS-2	2552-10
	LLOCATION - HOSPITAL-BASED HOSPICE GENERAL SE TICAL BASIS	RVICE COSTS	Provider CC Hospice CCI		Period: From 01/01/2020 To 12/31/2020	Worksheet O-6 Part II Date/Time Pre	
			1030100 001	N. 15 1505	10 12/31/2020	4/29/2021 3:5	
				_	Hospi ce I		
	Cost Center Descriptions	PLANT	LAUNDRY &	HOUSEKEEPI N		NURSI NG	
		OPERATION &	LINEN SERVICE	(SQUARE FEET		ADMI NI STRATI ON	
		MAI NTENANCE	(IN-FACILITY		DAYS)		
		(SQUARE FEET)	DAYS)			(DI RECT NURS.	
		F 00	(00	7.00	0.00	HRS.)	
	GENERAL SERVICE COST CENTERS	5.00	6.00	7.00	8.00	9.00	
1.00	CAP REL COSTS-BLDG & FLXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMI NI STRATI VE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE	o					5.00
6.00	LAUNDRY & LINEN SERVICE	0	0				6.00
7.00	HOUSEKEEPING	0	0		0		7.00
8.00	DI ETARY	0			0 0		8.00
9.00	NURSI NG ADMI NI STRATI ON	0			0	82, 714	9.00
10.00	ROUTI NE MEDI CAL SUPPLI ES	0			0	02,711	10.00
11.00	MEDI CAL RECORDS	0			0	0	11.00
12.00	STAFF TRANSPORTATION	0			0	0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0			0	0	13.00
14.00	PHARMACY	0			0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0			0	0	15.00
16,00	OTHER GENERAL SERVICE	0			0	0	16,00
17.00	PATI ENT/RESI DENTI AL CARE SERVI CES	0			0		17.00
	LEVEL OF CARE	•					
50.00	HOSPICE CONTINUOUS HOME CARE					0	50.00
51.00	HOSPICE ROUTINE HOME CARE					0	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0)	0 0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0		0 0	82, 714	53.00
	NONREI MBURSABLE COST CENTERS	,					
60.00	BEREAVEMENT PROGRAM	0			0	0	60.00
61.00	VOLUNTEER PROGRAM	0			0	0	61.00
62.00	FUNDRAI SI NG	0			0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0			0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0			0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0			0	0	65.00
66.00	RESIDENTIAL CARE	0	0		0 0	0	66.00
67.00	ADVERTI SI NG	0			0	0	67.00
68.00	TELEHEALTH/TELEMONI TORI NG	0			0	0	68.00
69.00	THRI FT STORE	0			0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD		-				70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0		0 0	0	71.00
99.00	NEGATIVE COST CENTER		0			(0(01)	99.00
	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	0	0	0.0000		606, 016	
101.00	UNIT COST MULTIPLIER	0. 000000	0. 000000	0.0000	0. 000000	7. 326644	101.00

Heal th	Financial Systems	FRANCI SCAN HEAL	TH_LAFAYETTE		In Lie	u of Form CMS-	2552-10
	ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL S TICAL BASIS	ERVICE COSTS	Provider C Hospice CC		Period: From 01/01/2020 To 12/31/2020	Worksheet 0-6 Part II Date/Time Pre 4/29/2021 3:5	pared:
					Hospi ce I		
	Cost Center Descriptions	ROUTI NE MEDI CAL SUPPLI ES (PATI ENT DAYS)	MEDI CAL RECORDS (PATI ENT DAYS)	STAFF TRANSPORTATI ((MI LEAGE)	VOLUNTEER	PHARMACY (CHARGES)	
		10.00	11.00	12.00	13.00	14.00	
-	GENERAL SERVICE COST CENTERS	-					
$\begin{array}{c} 1. \ 00\\ 2. \ 00\\ 3. \ 00\\ 4. \ 00\\ 5. \ 00\\ 6. \ 00\\ 7. \ 00\\ 8. \ 00\\ 9. \ 00\\ 10. \ 00\\ 11. \ 00\\ 12. \ 00\\ 13. \ 00\\ 14. \ 00\\ 15. \ 00\\ 16. \ 00\\ 17. \ 00\end{array}$	CAP REL COSTS-BLOG & FIXT CAP REL COSTS-BLOG & FIXT CAP REL COSTS-MVBLE EQUIP EMPLOYEE BENEFITS DEPARTMENT ADMINI STRATI VE & GENERAL PLANT OPERATI ON & MAI NTENANCE LAUNDRY & LINEN SERVI CE HOUSEKEEPING DI ETARY NURSI NG ADMINI STRATI ON ROUTI NE MEDI CAL SUPPLIES MEDI CAL RECORDS STAFF TRANSPORTATI ON VOLUNTEER SERVI CE COORDINATI ON PHARMACY PHYSI CI AN ADMINI STRATI VE SERVI CES OTHER GENERAL SERVI CE PATI ENT/RESI DENTI AL CARE SERVI CES LEVEL OF CARE	35, 547	35, 547		0 0 35, 547 0 0 0 0 0	35, 547 0 0	15.00
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	1	0 0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	35, 413	35, 413		0 35, 413	35, 413	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	110	110		0 110	110	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	24	24		0 24	24	53.00
	NONREI MBURSABLE COST CENTERS						
	BEREAVEMENT PROGRAM VOLUNTEER PROGRAM FUNDRAISING HOSPICE/PALLIATIVE MEDICINE FELLOWS PALLIATIVE CARE PROGRAM OTHER PHYSICIAN SERVICES RESIDENTIAL CARE ADVERTISING TELEHEALTH/TELEMONITORING THRIFT STORE NURSING FACILITY ROOM & BOARD OTHER NONREIMBURSABLE (SPECIFY) NEGATIVE COST CENTER COST TO BE ALLOCATED (per Wkst. 0-6, Part 1) UNIT COST MULTIPLIER) 11, 424 0. 321377	60, 845 1. 711677		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	61.00 62.00 63.00 64.00 65.00 66.00 67.00 68.00 69.00 70.00 71.00 99.00 100.00

Heal th	Financial Systems	FRANCI SCAN HEAL	_TH_LAFAYETTE		In Lie	u of Form CMS	-2552-10
	LLOCATION - HOSPITAL-BASED HOSPICE GENERAL SE TICAL BASIS	RVICE COSTS	Provider C Hospice CC		Period: From 01/01/2020 To 12/31/2020	Worksheet O- Part II Date/Time Pr	repared:
-			-			4/29/2021 3:	52 pm
	Cast Canton Decenintiano				Hospi ce I		
	Cost Center Descriptions	PHYSI CI AN ADMI NI STRATI VE	OTHER GENERAL SERVI CE	PATI ENT/ RESI DENTI AL			
		SERVI CES	(SPECI FY	CARE SERVICE			
		(PATIENT DAYS)	BASIS)	(IN-FACILIT			
		(DAYS)			
		15.00	16.00	17.00			
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DI ETARY						8.00
9.00	NURSI NG ADMI NI STRATI ON						9.00
10.00	ROUTINE MEDICAL SUPPLIES						10.00
11.00	MEDI CAL RECORDS						11.00
12.00	STAFF TRANSPORTATION						12.00
13.00	VOLUNTEER SERVICE COORDINATION						13.00
14.00		05 5 47					14.00
15.00	PHYSI CI AN ADMI NI STRATI VE SERVI CES	35, 547					15.00
16.00	OTHER GENERAL SERVICE		0		0		16.00
17.00	PATI ENT/RESI DENTI AL CARE SERVI CES				0		17.00
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	1			50.00
51.00	HOSPICE ROUTINE HOME CARE	35, 413					51.00
52.00	HOSPICE INPATIENT RESPITE CARE	110			0		52.00
53.00	HOSPICE GENERAL INPATIENT CARE	24	0		0		53.00
00.00	NONREI MBURSABLE COST CENTERS				3		
60.00	BEREAVEMENT PROGRAM		0				60.00
61.00	VOLUNTEER PROGRAM		0				61,00
62.00	FUNDRAI SI NG		0				62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS		0				63.00
64.00	PALLIATIVE CARE PROGRAM		0				64.00
65.00	OTHER PHYSI CLAN SERVI CES		0				65.00
66.00	RESIDENTIAL CARE	0	0		0		66.00
67.00	ADVERTI SI NG		0				67.00
68.00	TELEHEALTH/TELEMONI TORI NG		0				68.00
69.00	THRI FT STORE		0				69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0		0		71.00
99.00	NEGATIVE COST CENTER						99.00
	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)				0		100. 00
101.00	UNIT COST MULTIPLIER	7.005851	0. 000000	0.0000	00		101.00

LEVEL OF CARE Hospice CCN: 15-1563 From 01/01/2020 To Date, 4/29, Hospice I Hospice I	heet 0-7 Time Prep 2021 3:5	pared:
Hospi ce CCN: 15-1563 To 12/31/2020 Date. 4/29. Hospi ce I Hospi ce I Hospi ce I Hospi ce I	2021 3:5	bared:
Hospi ce I		2 nm
Charges by LOC (from Provider Re	cords)	
Cost Center Descriptions From Wkst. C, Cost to Charge HCHC HRHC H	I RC	
Part I, Col. 9 Ratio		
line		
0 1.00 2.00 3.00 4	. 00	
ANCI LLARY SERVICE COST CENTERS		
1.00 PHYSI CAL THERAPY 66.00 0.323578 0 0	0	1.00
2.00 OCCUPATIONAL THERAPY 67.00 0.196072 0 0	0	2.00
3.00 SPEECH PATHOLOGY 68.00 0.264129 0 0	0	3.00
4.00 DRUGS CHARGED TO PATIENTS 73.00 0.131586 0 0	0	4.00
4.01 DI ABETES CENTER 73.01 8.110677 0 0	0	4.01
5.00 DURABLE MEDICAL EQUIP-RENTED 96.00		5.00
6.00 LABORATORY 60.00 0.108943 0 0	0	6.00
7. 00 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 71. 00 0. 119291 0 0	0	7.00
8.00 OTHER OUTPATIENT SERVICE COST CENTER 93.00		8.00
9.00 RADI OLOGY - THERAPEUTI C 55.00 0.088728 0 0	0	9.00
10. 98 HYPERBARI C 0XYGEN THERAPY 76. 98 0. 000000 0 0	0	10. 98
11.00 Totals (sum of lines 1-11)		11.00
Charges by LOC Shared Service Costs by LOC		
(from Provider		
Records)		
Cost Center Descriptions HGLP HCHC (col. 1 xHRHC (col. 1 xHIRC (col. 1 xHGLP (
	. 5)	
	. 00	
ANCI LLARY SERVICE COST CENTERS	0	1 00
1. 00 PHYSI CAL THERAPY 0 0 0 0	0	1.00
2. 00 OCCUPATIONAL THERAPY O O O O	0	2.00
3. 00 SPEECH PATHOLOGY 0 0 0	0	3.00
4. 00 DRUGS CHARGED TO PATI ENTS 0 0 0 0	0	4.00
4. 01 DI ABETES CENTER 0 0 0 0	0	4.01
5. 00 DURABLE MEDI CAL EQUI P-RENTED	0	5.00
6.00 LABORATORY 0 0 0 0	0	6.00
7. 00 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0 0 0 0	0	7.00
8.00 OTHER OUTPATIENT SERVICE COST CENTER		8.00
9.00 RADI OLOGY - THERAPEUTI C 0 0 0	0	9.00
10.98 HYPERBARI C OXYGEN THERAPY 0 0 0 11.00 Table (sum of lines 1.11) 0 0 0	0	10.98
11.00 Totals (sum of lines 1-11) 0 0 0	0	11.00

	FINANCI SUSTEMS FRANCI SCAN HEALTH ATION OF HOSPITAL-BASED HOSPICE PER DIEM COST	LAFAYETTE Provider C	CN: 15-0109	Peri od:		of Form CMS-2 Norksheet 0-8	
				From 01/01/2	2020		
		Hospi ce CCI	N: 15-1563	To 12/31/2	4	Date/Time Prep 4/29/2021 3:52	
				Hospi ce			
			TITLE XVIII			TOTAL	
			MEDI CARE	MEDI CAI			
			1.00	2.00		3.00	
	HOSPICE CONTINUOUS HOME CARE		1			-	
. 00	Total cost (Wkst. 0-6, Part I, col. 18, line 50 plus Wkst. 0-	7, col. 6,				0	1.0
~~	line 11)						
. 00	Total unduplicated days (Wkst. S-9, col. 4, line 10)					0	2.0
. 00	Total average cost per diem (line 1 divided by line 2)	4.0.				0.00	
. 00	Unduplicated program days (Wkst. S-9 col. as appropriate, lin	e 10)		0	0		4.
. 00	Program cost (line 3 times line 4)			0	0		5.
~ ~	HOSPICE ROUTINE HOME CARE		1			5 05 1 150	
00	Total cost (Wkst. 0-6, Part I, col. 18, line 51 plus Wkst. 0-	/, COL. /,				5, 854, 153	6.
00	line 11)					25 412	_
00	Total unduplicated days (Wkst. S-9, col. 4, line 11)					35, 413	7.
. 00	Total average cost per diem (line 6 divided by line 7)			10		165.31	8.
. 00	Unduplicated program days (Wkst. S-9, col. as appropriate, li	ne II)	35, 4		0		9.
0.00	Program cost (line 8 times line 9)		5, 854, 1	23	0		10.
1 00	HOSPICE INPATIENT RESPITE CARE	7 0	1	-		10,000	1 1 1
1. 00	Total cost (Wkst. 0-6, Part I, col. 18, line 52 plus Wkst. 0- line 11)	7, COL. 8,				18, 288	11.
2.00	Total unduplicated days (Wkst. S-9, col. 4, line 12)					110	12.
2.00 3.00	Total average cost per diem (line 11 divided by line 12)					166, 25	
4.00	Unduplicated program days (Wkst. S-9, col. as appropriate, li	no 12)	1	10	o	100.25	14.
+. 00 5. 00	Program cost (line 13 times line 14)		18, 2		0		14.
5.00	HOSPICE GENERAL INPATIENT CARE		10,2	.00	0		15.
5.00	Total cost (Wkst. 0-6, Part I, col. 18, line 53 plus Wkst. 0-	7 col 9	1			1, 656, 104	16
0.00	line 11)	,				1,000,101	10.
7.00	Total unduplicated days (Wkst. S-9, col. 4, line 13)					24	17.
3.00	Total average cost per diem (line 16 divided by line 17)					69,004.33	
9.00	Unduplicated program days (Wkst. S-9, col. as appropriate, li	ne 13)		24	o	0,,00,100	19.
). 00	Program cost (line 18 times line 19)	,	1, 656, 1		0		20.
	TOTAL HOSPICE CARE		.,				1 _ 0.
1.00	Total cost (sum of line 1 + line 6 + line 11 + line 16)					7, 528, 545	21.
2.00	Total unduplicated days (Wkst. S-9, col. 4, line 14)					35, 547	
	Average cost per diem (line 21 divided by line 22)		1			211.79	

Health Financial Systems	FRANCI SCAN HEALTH LAFAYETTE	In Lie	u of Form CMS-2552-10
CALCULATION OF CAPITAL PAYMENT	Provider CCN: 15-0109	Period: From 01/01/2020 To 12/31/2020	Worksheet L Parts I-III Date/Time Prepared: 4/29/2021 3:52 pm
	Title XVIII	Hospi tal	PPS

				4/29/2021 3:52	2 pm
		Title XVIII	Hospi tal	PPS	
				1.00	
	PART I - FULLY PROSPECTIVE METHOD CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier			2, 968, 743	1.00
1.00	Model 4 BPCI Capital DRG other than outlier			2,900,743	1.00
2.00	Capital DRG outlier payments			149, 284	2.00
2.00	Model 4 BPCI Capital DRG outlier payments			149, 204	2.00
3.00	Total inpatient days divided by number of days in the cost re	porting ported (see inst	ructions)	109. 11	3.00
4.00	Number of interns & residents (see instructions)	por tring period (see trist	ructrons)	0, 00	4.00
4.00 5.00	Indirect medical education percentage (see instructions)			0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the	sum of lines 1 and 1 01	columns 1 and	0.00	6.00
0.00	1.01) (see instructions)	suil of fiftes falle f. of		0	0.00
7.00	Percentage of SSI recipient patient days to Medicare Part A pa	ationt days (Workshoot F	part A lino	3. 54	7.00
7.00	30) (see instructions)	attent days (worksheet L	, part A THe	5.54	7.00
8.00	Percentage of Medicaid patient days to total days (see instru	ctions)		24.45	8.00
9.00	Sum of lines 7 and 8			27.99	9.00
10.00	Allowable disproportionate share percentage (see instructions))		5.83	
	Di sproporti onate share adjustment (see instructions))		173, 078	
	Total prospective capital payments (see instructions)			3, 291, 105	
12.00	Total prospective capital payments (see thistractions)			5, 271, 105	12.00
				1.00	
	PART II – PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)			0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)			0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)			0	3.00
4.00	Capital cost payment factor (see instructions)			0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)				
0.00				0	5.00
0.00				0	5.00
0.00	PART III - COMPUTATION OF EXCEPTION PAYMENTS				5.00
					5.00
1.00	PART III - COMPUTATION OF EXCEPTION PAYMENTS	es (see instructions)		1.00	1.00
1. 00 2. 00	PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions)	es (see instructions)		1.00	
1.00 2.00 3.00	PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstance	es (see instructions)		1.00 0 0	1. 00 2. 00
1.00 2.00 3.00 4.00	PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstance Net program inpatient capital costs (line 1 minus line 2)	es (see instructions)		1.00 0 0 0	1.00 2.00 3.00 4.00
1.00 2.00 3.00 4.00 5.00	PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstance Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions)	. , ,		1.00 0 0 0 0 0.00	1.00 2.00 3.00 4.00 5.00
1.00 2.00 3.00 4.00 5.00 6.00	PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstance Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4)	structions)	line 6)	1.00 0 0 0 0 0.00 0	1.00 2.00 3.00 4.00 5.00 6.00
1.00 2.00 3.00 4.00 5.00 6.00 7.00	PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstance Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see inst	structions)	line 6)	1.00 0 0 0 0.00 0.00 0.00	1. 00 2. 00 3. 00
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00	PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstance Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see inst Adjustment to capital minimum payment level for extraordinary	structions) circumstances (line 2 x	line 6)	1.00 0 0 0.00 0.00 0.00 0.00 0	1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00	PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstance Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see in: Adjustment to capital minimum payment level for extraordinary Capital minimum payment level (line 5 plus line 7)	structions) circumstances (line 2 x cable)	,	1.00 0 0 0.00 0.00 0 0.00 0 0 0	1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00	PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstance Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see inst 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 applic Current year comparison of capital minimum payment level to c Carryover of accumulated capital minimum payment level over ca	structions) circumstances (line 2 x cable) apital payments (line 8	less line 9)	1.00 0 0 0.00 0.00 0.00 0 0.00 0 0 0 0 0	1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00	PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstance Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see inst 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 applic Carryover of accumulated capital minimum payment level to ca Worksheet L, Part III, line 14)	structions) circumstances (line 2 x cable) apital payments (line 8 apital payment (from pri	less line 9) or year	1.00 0 0 0.00 0.00 0.00 0 0 0 0 0 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00	PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstance Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see inst 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 applic Carryover of accumulated capital minimum payment level over ca Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital payment	structions) circumstances (line 2 x cable) apital payments (line 8 apital payment (from pri yments (line 10 plus lin	less line 9) or year e 11)	1.00 0 0 0.00 0.00 0 0.00 0 0 0 0 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00	PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstance Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see ins 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 applic Carryover of accumulated capital minimum payment level over ca Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital pay Current year exception payment (if line 12 is positive, enter	structions) circumstances (line 2 x cable) apital payments (line 8 apital payment (from pri yments (line 10 plus lin the amount on this line	less line 9) or year e 11))	1.00 0 0 0.00 0 0.00 0 0 0 0 0 0 0 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00
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	PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstance Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see ins 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 applic Carryover of accumulated capital minimum payment level to capital Net comparison of capital minimum payment level to capital pay Current year exception payment (if line 12 is positive, enter Carryover of accumulated capital minimum payment level over capital pay	structions) circumstances (line 2 x cable) apital payments (line 8 apital payment (from pri yments (line 10 plus lin the amount on this line	less line 9) or year e 11))	1.00 0 0 0.00 0.00 0 0.00 0 0 0 0 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 11. 00 12. 00 13. 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00	PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstance Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see in: 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 applic Current year comparison of capital minimum payment level to ca Carryover of accumulated capital minimum payment level to capital pay Current year exception payment (if line 12 is positive, enter Carryover of accumulated capital minimum payment level over ca (if line 12 is negative, enter the amount on this line)	structions) circumstances (line 2 x cable) apital payments (line 8 apital payment (from pri yments (line 10 plus lin the amount on this line apital payment for the f	less line 9) or year e 11))	1.00 0 0 0.00 0 0.00 0 0 0 0 0 0 0 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00	PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstance Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see inst 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 applic Carryover of accumulated capital minimum payment level to capital Net comparison of capital minimum payment level to capital pay Current year exception payment (if line 12 is positive, enter Carryover of accumulated capital minimum payment level over capital pay	structions) circumstances (line 2 x cable) apital payments (line 8 apital payment (from pri yments (line 10 plus lin the amount on this line apital payment for the f	less line 9) or year e 11))	1.00 0 0 0.00 0 0.00 0 0 0 0 0 0 0 0 0 0	1.00 2.00 3.00 4.00 5.00 6.00 7.00