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 01/01/2021 Parts I-III AND SETTLEMENT SUMMARY 12/31/2021 Date/Time Prepared: 5/2/2022 3:08 pm PART I - COST REPORT STATUS Provi der 1. [X] Electronically prepared cost report Date: 5/2/2022 3:08 pm] Manually prepared cost report use only Ilf 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. [1] Cost Report Status
[1] As Submitted
[2] Settled without Audit
[3] Settled with Audit
[4] Date Received:
[5] To. NPR Date:
[6] 10. NPR Date:
[7] 11. Contractor's Vendor Code:
[7] 12. [8] Final Report for this Provider CCN
[9] [8] Final Report for this Provider CCN
[10] NPR Date:
[11] 12. Contractor's Vendor Code:
[11] 12. [8] 13. Contractor's Vendor Code:
[12] 13. NPR Date:
[13] 14. Contractor's Vendor Code:
[14] 15. Contractor's Vendor Code:
[15] 16. NPR Date:
[16] 17. Contractor's Vendor Code:
[17] 18. Contractor's Vendor Code:
[18] 19. Contractor's Vendor Code:
[19] 19. Contractor's Vendor Code:
[1 Contractor use only

number of times reopened = 0-9.

PART II - CERTIFICATION BY A CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OR PROVIDER(S)

(3) Settled with Audit

(4) Reopened (5) Amended

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

CERTIFICATION BY 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 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 01/01/2021 and ending 12/31/2021 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINA	NCIAL OFFICER OR ADMINISTRATOR	CHECKBOX		
		1	2	SI GNATURE STATEMENT	
1				I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name				2
3	Signatory Title	CHIEF FINANCIAL OFFICER			3
4	Date				4

			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	683, 682	58, 067	0	0	1.00		
2.00	Subprovi der - IPF	0	0	0		0	2. 00		
3.00	Subprovider - IRF	0	38, 131	155		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	0		0	9. 00		
200.00	Total	0	721, 813	58, 222	0	0	200. 00		
The al	pove amounts represent "due to" or "due from"	the applicable	program for th	a alament of t	he above compl	av indicated			

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.

Ν

22.04

Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for

rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as

22.04 Did this hospital receive a geographic reclassification from urban to

yes or "N" for no.

GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.

N

58 00

59.00

58.00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.

59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.

OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DAT	Α	Provi der C	CN: 15-0109	Peri od: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part I Date/Time Pre 5/2/2022 3:08	pared:
			NAHE 413.8! 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 coluis "Y", are you impacted by CR 11642 (or subsequent Cadjustement? Enter "Y" for yes or "N" for no in coluing ustement? Enter "Y" for yes or "N" for no in coluing 1 li line 60 is yes, complete columns 2 and 3 for each instructions) 0.02 If line 60 is yes, complete columns 2 and 3 for each instructions)	85? (s umn 1. R) NAHE mn 2. program	lee If column 1 MA payment n. (see	Y	20. 00 23. 00	1	60. 0
0.03 If line 60 is yes, complete columns 2 and 3 for each instructions)			B1 + 0115	23. 01		60.0
	Y/N	I ME	Direct GME	IME	Direct GME	
1.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) 1.01 Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports	1.00	2. 00	3. 00	4.00	5.00	61.0
ending and submitted before March 23, 2010. (see instructions) 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						61. C
ACA). (see instructions) 1.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61. (
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. (
used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						01. (
care or general surgery. (See Tristraetrons)	Pro	ogram Name	Program Cod	e Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2. 00	3.00	4.00	
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.				0.00	0.00	61. 1
1.20 Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0. 00	0.00	61. 2
					1.00	
ACA Provisions Affecting the Health Resources and Ser 2.00 Enter the number of FTE residents that your hospital				eriod for which	0.00	62.0
your hospital received HRSA PCRE funding (see instruc 2.01 Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC prog	ti ons) Teachi	ng Health Cen	ter (THC) int			62.0

Health Financial Systems	FRANCISC	CAN HEALTH LAFAYETTE		In Lie	eu of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMP	LEX IDENTIFICATION DA	TA Provider Co	1	Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part I Date/Time Pre 5/2/2022 3:08	pared:
			Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	, piii
Section 5504 of the ACA Base Yea	ur FTF Residents in No	onnrovider Settings	This base year	2.00	3.00	
period that begins on or after 3 is in the base year period, the num resident FTEs attributable to rosettings. Enter in column 2 the resident FTEs that trained in you of (column 1 divided by (column 1 divided by (column 1 divided by (column 2 the resident FTEs that trained in your of (column 1 divided by (column 1 divided	uly 1, 2009 and before yes, or your facilitations occurring in number of unweighted ur hospital. Enter in	re June 30, 2010. ty trained residents n-primary care all nonprovider d non-primary care n column 3 the ratio	0. C			64. 00
joi (corumni i di vi ded by (corumni	Program Name	Program Code	Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
	1.00	2.00	3. 00	4. 00	5. 00	
65.00 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.0	0 0.00	0.000000 Ratio (col. 1/	65. 00
			FTEs Nonprovi der Si te	FTEs in Hospital	(col. 1 + col. 2))	
C+:	V FTE D! !.	- N	1.00	2.00	3.00	
Section 5504 of the ACA Current beginning on or after July 1, 20		n Nonprovider Setting	sEffective 1	or cost reporti	ng periods	
66.00 Enter in column 1 the number of FTEs attributable to rotations of Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 +	unweighted non-primar ccurring in all nonpr unweighted non-primar al. Enter in column 3	rovider settings. ry care resident 3 the ratio of	0.0	0.00	0. 000000	66. 00
(Cordini + drvi ded by (cordini +)	Program Name	Program Code	Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospi tal	Ratio (col. 3/ (col. 3 + col. 4))	
67.00 Enter in column 1, the program	1. 00	2.00	3.00	4. 00 0 0. 00	5. 00 0. 000000	67.00
name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.0	0.00	, J. 5555000	37. 00

HOSPII	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0109	Period: From 01/01/ To 12/31/	2021 2021	Workshe Part I Date/Ti 5/2/202	me Pre	pared:
				1. 00	2. 00	3. 00	1
70.00	Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or do	as it contain on LDE ou	hanayi dan2	NI			70.0
70. 00	Enter "Y" for yes or "N" for no.	es it contain an iPF su	pprovider?	N			70.0
71. 00	If line 70 is yes: Column 1: Did the facility have an approved recent cost report filed on or before November 15, 2004? Enter 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train	"Y" for yes or "N" for	no. (see			0	71.0
	program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter Column 3: If column 2 is Y, indicate which program year began c	"Y" for yes or "N" for	no.				
	(see instructions)		3 1				
75. 00	Inpatient Rehabilitation Facility PPS Is this facility an Inpatient Rehabilitation Facility (IRF), or	does it contain an IRF		Υ			75. 0
76. 00	subprovider? Enter "Y" for yes and "N" for no. If line 75 is yes: Column 1: Did the facility have an approved recent cost reporting period ending on or before November 15, 2			N	N	0	76.0
	no. Column 2: Did this facility train residents in a new teachi CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Co indicate which program year began during this cost reporting pe	ng program in accordanc Iumn 3: If column 2 is	e with 42 Y,				
	p. ar sace min on p. eg. am year began darring time ever reporting pe	110a. (300 1110t) ucti onio	,	-	1.0	00	
	Long Term Care Hospital PPS				1. 0	<i>,</i>	
80. 00 81. 00	Is this a long term care hospital (LTCH)? Enter "Y" for yes an is this a LTCH co-located within another hospital for part or a "Y" for yes and "N" for no.	g period? Er	iter	N N		80. C	
	TEFRA Providers Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TE Did this facility establish a new Other subprovider (excluded u	3		no.	N		85. 0 86. 0
37. 00	§413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no. Is this hospital an extended neoplastic disease care hospital o	·			N		87. 0
	1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.		V 1. 00		XI :		
90. 00	Title V and XIX Services Does this facility have title V and/or XIX inpatient hospital s	orvi cos2 Entor "V" for	N N		Υ Υ		90.0
91. 00	yes or "N" for no in the applicable column. Is this hospital reimbursed for title V and/or XIX through the		N		Y		91. (
92. 00	full or in part? Enter "Y" for yes or "N" for no in the application of the second of t	certification)? (see			N		92.0
93. 00	instructions) Enter "Y" for yes or "N" for no in the applicable Does this facility operate an ICF/IID facility for purposes of "Y" for yes or "N" for no in the applicable column.		N		N		93. (
94. 00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and applicable column.		N		N		94. (
95. 00 96. 00	If line 94 is "Y", enter the reduction percentage in the applic Does title V or XIX reduce operating cost? Enter "Y" for yes or applicable column.		0. 00 N		O. C N		95. (96. (
97. 00 98. 00	If line 96 is "Y", enter the reduction percentage in the applic Does title V or XIX follow Medicare (title XVIII) for the inter stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for	ns and residents post	0. 00 Y		0. C Y		97. (98. (
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 repor C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title title XIX.				Υ		98. (
98. 02	Does title V or XIX follow Medicare (title XVIII) for the calcubed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "for title V, and in column 2 for title XIX.		Y		Υ		98. (
98. 03	Does title V or XIX follow Medicare (title XVIII) for a critical reimbursed 101% of inpatient services cost? Enter "Y" for yes of for title V, and in column 2 for title XIX.				N		98. (
8. 04	Does title V or XIX follow Medicare (title XVIII) for a CAH rei outpatient services cost? Enter "Y" for yes or "N" for no in co in column 2 for title XIX.		N		N		98. (
8. 05	Does title V or XIX follow Medicare (title XVIII) and add back Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in colu				Υ		98. (
8. 06	column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) when cost rei Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 column 2 for title XIX.		Y		Y		98.
	Rural Providers Does this hospital qualify as a CAH?		N				105. (
106. 00	If this facility qualifies as a CAH, has it elected the all-inc for outpatient services? (see instructions)	lusive method of paymen	t				106. (
107. 00	Column 1: If line 105 is Y, is this facility eligible for cost training programs? Enter "Y" for yes or "N" for no in column 1. Column 2: If column 1 is Y and line 70 or line 75 is Y, do you	(see instructions) train L&Rs in an					107. (
	Column 2: If column 1 is Y and line 70 or line 75 is Y, do you approved medical education program in the CAH's excluded IPF a Enter "Y" for yes or "N" for no in column 2. (see instructions	nd/or IRF unit(s)?					

Health Financial Systems FRANCISCAN HEAL				eu of Form CMS	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CC	F	eriod: rom 01/01/2021 o 12/31/2021	Worksheet S- Part I Date/Time Pr	epared:
			V	5/2/2022 3: 0 XI X	8 pm
108.00 s this a rural hospital qualifying for an exception to the	CDNA foo sobor	dul o2 Soo 42	1. 00 N	2. 00	108. 00
CFR Section §412.113(c). Enter "Y" for yes or "N" for no.					
	Physi cal 1.00	0ccupati onal 2.00	Speech 3.00	Respi ratory 4.00	-
109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N N	N N	N N	109. 00
				1. 00	
110. 00 Did this hospital participate in the Rural Community Hospital Demonstration) for the current cost reporting period? Enter " complete Worksheet E, Part A, lines 200 through 218, and Wor applicable.	'Y" for yes or	"N" for no. If	yes,	N	110. 0
			1. 00	2.00	-
111.00 If this facility qualifies as a CAH, did it participate in the Health Integration Project (FCHIP) demonstration for this compared in the second of the FCHIP demoin which this CAH is participated in the second of the FCHIP demoin which this CAH is participated by the second of the second o	N	2.00	111. 00		
for tele-health services.					
112.00 Did this hospital participate in the Pennsylvania Rural Heal	th Madal	1. 00 N	2. 00	3. 00	112. 00
demonstration for any portion of the current cost reporting Enter "Y" for yes or "N" for no in column 1. If column 1 is in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceaparticipation in the demonstration, if applicable.	period? s "Y", enter ne	N			112.00
Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or	r "N" for no	N			0 115. 0
in column 1. If column 1 is yes, enter the method used (A, E in column 2. If column 2 is "E", enter in column 3 either "9 for short term hospital or "98" percent for long term care (psychiatric, rehabilitation and long term hospitals provider	3, or E only) 93" percent (includes				
the definition in CMS Pub.15-1, chapter 22, §2208.1. 116.00 Is this facility classified as a referral center? Enter "Y"	for yes or	N			116. 0
"N" for no. 117.00 s this facility legally-required to carry malpractice insur	rance? Enter	Υ			117. 0
"Y" for yes or "N" for no. 118.00 Is the malpractice insurance a claims-made or occurrence polif the policy is claim-made. Enter 2 if the policy is occurr		2			118. 0
		Premi ums	Losses	Insurance	
118.01 List amounts of malpractice premiums and paid losses:		1. 00 697, 857	2. 00 135, 001	3.00	8 118. 0
· · · · · · · · · · · · · · · · · · ·					
118.02 Are malpractice premiums and paid losses reported in a cost	center other	than the	1. 00 N	2. 00	118. 0
Administrative and General? If yes, submit supporting schedand amounts contained therein.					
119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter ir "N" for no. Is this a rural hospital with < 100 beds that qu Hold Harmless provision in ACA §3121 and applicable amendmen	n column 1, "Y' ualifies for th	" for yes or he Outpatient	N	N	119. 0 120. 0
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 devices	s charged to	Υ		121. 0
patients? Enter "Y" for yes or "N" for no. 122.00 Does the cost report contain healthcare related taxes as def Act?Enter "Y" for yes or "N" for no in column 1. If column 1			Y	5. 06	122. 0
the Worksheet A line number where these taxes are included.		33. 4111 2			
Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" for	or ves and "N"	for no lf	N	1	 125. 0
yes, enter certification date(s) (mm/dd/yyyy) below.	,		.,		
126.00 f this is a Medicare certified kidney transplant center, er in column 1 and termination date, if applicable, in column 2	2.				126. 0
127.00 If this is a Medicare certified heart transplant center, ent in column 1 and termination date, if applicable, in column 2		ication date			127. 0
128.00 If this is a Medicare certified liver transplant center, ent	ter the certifi	ication date			128. 0
1	2.				120.0
in column 1 and termination date, if applicable, in column 2 129.00 f this is a Medicare certified lung transplant center, ente		cation date in			1129.11
in column I and termination date, IT applicable, In column 2 129.00 f this is a Medicare certified lung transplant center, enter column 1 and termination date, if applicable, in column 2. 130.00 f this is a Medicare certified pancreas transplant center,	er the certific				129. 0

lealth Financial Systems HOSPITAL AND HOSPITAL HEALTH CARE COMPLE		EALTH LAFAYETTE Provi der CC	N: 15_0109	Peri od:		u of Form CMS- Worksheet S-2	
IOSTITAL AND HOSTITAL HEALTH CARE CONNEC	X IDENTITION DATA	Trovider cc	N. 13-0107	From O	1/01/2021 2/31/2021	Part I Date/Time Pre	epared:
					1. 00	2.00	
31.00 If this is a Medicare certified in	ntestinal transplant cen	ter, enter the ce	rti fi cati o		1. 00	2.00	131. 00
date in column 1 and termination of 32.00 If this is a Medicare certified is	slet transplant center,	enter the certifi	cation dat	е			132. 00
in column 1 and termination date, 33.00 Removed and reserved	ii appircabre, in corum	III Z.					133. 0
34.00 If this is an organ procurement or and termination date, if applicabl All Providers		the OPO number i	n column 1				134. 0
40.00 Are there any related organization chapter 10? Enter "Y" for yes or " are claimed, enter in column 2 the	N" for no in column 1.	If yes, and home	office cos	ts	Υ	158014	140. 0
1.00 If this facility is part of a chai		2.00	ah 1/2 tha	namo ano	3. 00	of the	
home office and enter the home off	<u>fice contractor name and</u>	l contractor numbe		rialle and	auui ess	or the	
41.00 Name: FRANCISCAN ALLIANCE, INC. 42.00 Street: 1515 DRAGOON TRAIL	Contractor's Name: PO Box:	WPS 1290	Contra	ctor's Nu	mber: 0810)1	141. 0 142. 0
43.00 City: MISHAWAKA		1 N	Zip Cod	de:	4654	16-1290	143. 0
	·					1.00	
44.00 Are provider based physicians' cos	sts included in Workshee	t A?				1. 00 Y	144. 0
					1 00	0.00	
45.00 f costs for renal services are cl	aimed on Wkst. A. Line	74. are the costs	for		1. 00 Y	2.00	145. 0
inpatient services only? Enter "Y" no, does the dialysis facility inc period? Enter "Y" for yes or "N"	for yes or "N" for no clude Medicare utilizati	in column 1. If c	olumn 1 is		·		
46.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/d	gy changed from the prevolence of the column 1. (See CMS Pub			lf	N		146. C
lyes, enter the approval date (min/e	idi yyyy) i ii corumii 2.			I			
47.00 Was there a change in the statisti	cal hasis? Enter "Y" fo	r ves or "N" for	no			1.00 N	147. 0
48.00 Was there a change in the order of						N	148. 0
49.00 Was there a change to the simplifi	ed cost finding method?	Enter "Y" for ye Part A	s or "N" f Part B		itle V	N Title XIX	149. 0
		1.00	2.00		3.00	4.00	+
Does this facility contain a provi or charges? Enter "Y" for yes or "		onent for Part A	and Part B		CFR §413	3. 13)	155.0
55.00 Hospi tal 56.00 Subprovi der - TPF		N N	N N		N N	N N	155. 0 156. 0
57. 00 Subprovi der – TRF		N	N		N	N	157. C
58. 00 SUBPROVI DER 59. 00 SNF		N	N		N	N	158. C
60.00 HOME HEALTH AGENCY		N	N		N	N	160. 0
61. 00 CMHC			N		N	N	161. C
Multicampus						1.00	
65.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.	mpus hospital that has	one or more campu			SAs?	N	165. C
	Name O	County 1.00	State 2.00	Zip Code	CBSA 4. 00	FTE/Campus 5.00	
66.00 f ine 165 is yes, for each	U	1.00	2.00	3. 00	4.00		0 166. C
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)							
Hool the Information Tools of 197	[) incentive in the A	si oon Doos	l Dolm:	on+ ^-+		1.00	
Health Information Technology (HII 67.00 s this provider a meaningful user 68.00 f this provider is a CAH (line 10	under §1886(n)? Enter O5 is "Y") and is a mean	"Y" for yes or " ingful user (line	N" for no.		the	Y	167. 0 168. 0
reasonable cost incurred for the H	HT assets (see instruct	ions)					1
68.01 If this provider is a CAH and is n	not a meaningful user d	oes this provider	qualify f	or a hard	shi p		168. 0
68.01 If this provider is a CAH and is n exception under §413.70(a)(6)(ii)? 69.00 If this provider is a meaningful u	PEnter "Y" for yes or "	N" for no. (see i	nstruction	s)	•		168. (9169. (

FRANCISCAN HEALTH LAFAYETTE			In Lieu of Form CMS-255			
ICATION DATA	Provider CCN: 15-0109		Worksheet S-2	!		
	10 12/31/2021					
			t e	pm		
170.00 Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)						
		1. 00	2.00			
171.00 f ine 167 is "Y", does this provider have any days for individuals enrolled in						
section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter						
"Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section						
1876 Medicare days in column 2. (see instructions)						
	date and ending date any days for indiversity on Wkst. S-3, Pt. I, column 1 is yes, en	date and ending date for the reporting e any days for individuals enrolled in on Wkst. S-3, Pt. I, line 2, col. 6? Enter column 1 is yes, enter the number of section	Provider CCN: 15-0109 Period: From 01/01/2021 To 12/31/2021 Beginning 1.00 date and ending date for the reporting 1.00 e any days for individuals enrolled in on Wkst. S-3, Pt. I, line 2, col. 6? Enter column 1 is yes, enter the number of section	Provider CCN: 15-0109 Period: From 01/01/2021 Part I Date/Time Presidence Provider CCN: 15-0109 Period: From 01/01/2021 Part I Date/Time Presidence Provider CCN: 15-0109 Period: From 01/01/2021 Part I Date/Time Presidence Provider Provid		

Heal th	Financial Systems FRANCISCAN HEA	LTH LAFAYETTE		In Lie	u of Form CMS-	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C		Peri od: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part II Date/Time Pre	epared:
	· · · · · · · · · · · · · · · · · · ·			Y/N	5/2/2022 3:08 Date	DIII
				1. 00	2.00	
	General Instruction: Enter Y for all YES responses. Enter Nmm/dd/yyyy format. COMPLETED BY ALL HOSPITALS	lfor all NO re	sponses. Ente			
1. 00	Provider Organization and Operation Has the provider changed ownership immediately prior to the	e heainning of	the cost	N		1.00
1.00	reporting period? If yes, enter the date of the change in o					1.00
			Y/N	Date	V/I	
	I		1.00	2. 00	3. 00	
 2. 00 3. 00 	Has the provider terminated participation in the Medicare F yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary. Is the provider involved in business transactions, including	nn 3, "V" for	N Y			3. 00
	or medical supply companies) that are related to the provious officers, medical staff, management personnel, or members of	acts, with individuals or entities (e.g., chain home offices, drug dical supply companies) that are related to the provider or its ers, medical staff, management personnel, or members of the board rectors through ownership, control, or family and other similar				
			Y/N	Type	Date	
	Fire and Day		1.00	2. 00	3. 00	
4.00	Financial Data and Reports Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" for "R" for Reviewed. Submit complete copy or enter date avaicolumn 3. (see instructions) If no, see instructions.	for Compiled,	Y	A		4. 00
5.00	Are the cost report total expenses and total revenues diffe	erent from	Y			5. 00
	those on the filed financial statements? If yes, submit rec	conciliation.				
				Y/N	Legal Oper.	
	Approved Educational Activities			1. 00	2. 00	
6. 00	Column 1: Are costs claimed for a nursing program? Column is the legal operator of the program?	2: If yes, is	the provider	- Y	Y	6. 00
7. 00 8. 00	Are costs claimed for Allied Health Programs? If "Y" see in Were nursing programs and/or allied health programs approve cost reporting period? If yes, see instructions.		ved during the	Y N		7. 00 8. 00
9. 00	Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction		al education	N		9. 00
10. 00	Was an approved Intern and Resident GME program initiated cost reporting period? If yes, see instructions.		he current	N		10. 00
11. 00	Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	& R in an App	roved	N		11. 00
					Y/N 1. 00	
	Bad Debts				1.00	
12. 00 13. 00	Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection provided to the provider's bad debt collection provided to the provider's bad debt collection provided to the provider of the provider o			ost reporting	Y N	12. 00 13. 00
14. 00	period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or co-payme Bed Complement	ents waived? If	yes, see ins	structi ons.	N	14. 00
15. 00	Did total beds available change from the prior cost reporti		yes, see inst		N N	15. 00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3. 00	4. 00	
16. 00	PS&R Data 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	N		N		16. 00
17. 00	instructions) 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	03/08/2022	Y	03/08/2022	17. 00
18. 00	Report data for additional claims that have been billed but are not included on the PS&R Report used to file this	N		N		18. 00
19. 00	cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report	N		N		19. 00

	Financial Systems FRANCISCAN HEAL AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	_TH_LAFAYETTE Provi der_C(`N: 15_∩1∩0	Period:	u of Form CMS- Worksheet S-2	
103111	AL AND HOSTITAL HEALTH CANE RETWINDINGSEMENT QUESTIONINALINE	Trovider C	SN. 13-0107	From 01/01/2021 To 12/31/2021	Part II Date/Time Pre 5/2/2022 3:08	epared:
		Descri	pti on	Y/N	Y/N	J DIII
		(1. 00	3. 00	
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N 1. 00	Date 2.00	Y/N 3. 00	Date 4.00	
21. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N N	2.00	N N	4.00	21. 0
					1. 00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	PT CHILDRENS H	OSPI TALS)		1.00	
	Capital Related Cost					
22. 00 23. 00	Have assets been relifed for Medicare purposes? If yes, see Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.		als made du	ring the cost	N N	22. 0 23. 0
4. 00	Were new leases and/or amendments to existing leases entere lf yes, see instructions	d into during	this cost re	eporting period?	N	24. 0
5. 00	Have there been new capitalized leases entered into during instructions.	the cost repor	ting period	? If yes, see	N	25. 0
26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during th instructions.	f yes, see	N	26. 0		
27. 00	Has the provider's capitalization policy changed during the copy.	f yes, submit	N	27. 0		
8. 00	Interest Expense Were new loans, mortgage agreements or letters of credit en	N	28. 0			
9. 00	period? If yes, see instructions. Did the provider have a funded depreciation account and/or	Reserve Fund)	Υ	29. 0		
0. 00	treated as a funded depreciation account? If yes, see instr Has existing debt been replaced prior to its scheduled matu instructions.		debt? If yes	s, see	N	30.0
1. 00	Has debt been recalled before scheduled maturity without is instructions.	suance of new	debt? If yes	s, see	N	31.0
2. 00	Purchased Services Have changes or new agreements occurred in patient care ser		d through co	ontractual	Y	32.0
33. 00	arrangements with suppliers of services? If yes, see instru If line 32 is yes, were the requirements of Sec. 2135.2 app no, see instructions.		g to competi	tive bidding? If	N	33. C
4 00	Provider-Based Physicians	vongomont with	ngovi dog be	Sono la lavela la nace	V	1 24 6
	Are services furnished at the provider facility under an ar If yes, see instructions.	0	•	. ,	Y	34.0
5. 00	If line 34 is yes, were there new agreements or amended exi physicians during the cost reporting period? If yes, see in		ts with the	·	N	35. C
				Y/N 1. 00	2. 00	
	Home Office Costs					
	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been pr	epared by the	home office	? Y Y		36. 0 37. 0
8. 00	If yes, see instructions. If line 36 is yes, was the fiscal year end of the home off			f N		38. 0
9. 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 see instructions.			s, N		39.0
0. 00	If line 36 is yes, did the provider render services to the instructions.	home office?	If yes, see	N		40. C
		1.	00	2	00	
	Cost Report Preparer Contact Information					
11. 00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	STEVE		HOWELL		41.0
42. 00		FRANCISCAN HEA	LTH			42. 0
						II .

Heal th	FRANCISCAN H	HEALTH	LAFAYETTE		In Li€	In Lieu of Form CMS-2552-			
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIR				Provi der	CCN: 15-0109	Peri od: From 01/01/2021	Worksheet S-2 Part II		
						To 12/31/2021	Date/Time Pre 5/2/2022 3:08	pared:	
				3	3. 00				
	Cost Report Preparer Contact Information				7. 00				
41. 00	Enter the first name, last name and the ti held by the cost report preparer in column respectively.			NAGER REIME	BURSEMENT			41. 00	
42.00	Enter the employer/company name of the cos	st report						42. 00	
43. 00	preparer. Enter the telephone number and email addre report preparer in columns 1 and 2, respec							43. 00	

| Peri od: | Worksheet S-3 | From 01/01/2021 | Part | To 12/31/2021 | Date/Time Prepared:
 Heal th Financial
 Systems
 FRANCISC

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

					רן	o 12/31/2021	Date/Time Pre 5/2/2022 3:08		
							I/P Days / 0/P	Pili	
							Visits / Trips		
	Component	Worksheet A	No.	of Beds	Bed Days	CAH Hours	Title V		
	30p01161112	Line Number		o. Bodo	Avai I abl e	57 III 110 GI 0			
		1.00		2. 00	3.00	4. 00	5. 00		
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00		153	55, 845	0.00	0	1. 00	
	8 exclude Swing Bed, Observation Bed and								
	Hospice days) (see instructions for col. 2								
	for the portion of LDP room available beds)								
2.00	HMO and other (see instructions)							2. 00	
3.00	HMO IPF Subprovider							3. 00	
4.00	HMO IRF Subprovider							4.00	
5.00	Hospital Adults & Peds. Swing Bed SNF						0	5. 00	
6.00	Hospital Adults & Peds. Swing Bed NF						0	6. 00	
7.00	Total Adults and Peds. (exclude observation			153	55, 845	0.00	0	7. 00	
	beds) (see instructions)								
8. 00	INTENSIVE CARE UNIT	31. 00		17	6, 205	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, 110	0.00		12. 00	
13. 00	NURSERY	43. 00					0	13. 00	
14. 00	Total (see instructions)			184	67, 160	0.00		14. 00	
15. 00	CAH visits						0	15. 00	
16. 00	SUBPROVI DER - I PF							16. 00	
17. 00	SUBPROVI DER - I RF	41. 00		15	5, 475	5	0	17. 00	
18. 00	SUBPROVI DER							18. 00	
19. 00	SKILLED NURSING FACILITY							19. 00	
20. 00	NURSING FACILITY							20.00	
21. 00	OTHER LONG TERM CARE							21. 00	
22. 00	HOME HEALTH AGENCY	101. 00					0	22. 00	
23. 00	AMBULATORY SURGICAL CENTER (D. P.)							23. 00	
24. 00	HOSPI CE	116. 00		0	()		24. 00	
24. 10	HOSPICE (non-distinct part)	30. 00						24. 10	
25. 00	CMHC - CMHC							25. 00	
26. 00	RURAL HEALTH CLINIC						_	26. 00	
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00					0	26. 25	
27. 00	Total (sum of lines 14-26)			199			_	27. 00	
28. 00	Observation Bed Days						0	28. 00	
29. 00	Ambul ance Tri ps							29. 00	
30.00	Employee discount days (see instruction)							30.00	
31.00	Employee discount days - IRF			_				31.00	
32. 00	Labor & delivery days (see instructions)			0	()		32.00	
32. 01	Total ancillary labor & delivery room							32. 01	
22.00	outpatient days (see instructions)							22.00	
33. 00	LTCH non-covered days							33.00	
33.01	LTCH site neutral days and discharges				l		l	33. 01	

Health Financial Systems FRANCISC HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-0109

Peri od: Worksheet S-3 From 01/01/2021 Part I To 12/31/2021 Date/Time Prepared: 5/2/2022 3: 08 pm

		_				5/2/2022 3:08	pm
		I/P Days	s / 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	
1.00	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)	12, 071	372	33, 604			1. 00
2.00	HMO and other (see instructions)	8,006	7, 422				2. 00
3.00	HMO IPF Subprovider	0	0				3. 00
4.00	HMO IRF Subprovider	458	559				4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF	O	0	C			5. 00
6.00	Hospital Adults & Peds. Swing Bed NF		O	C			6.00
7. 00	Total Adults and Peds. (exclude observation beds) (see instructions)	12, 071	372	33, 604			7. 00
8. 00 9. 00	INTENSIVE CARE UNIT	1, 684	548	4, 797			8. 00 9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11.00
12. 00	NEONATAL INTENSIVE CARE UNIT	0	1, 930	3, 762			12. 00
13. 00	NURSERY	Ĭ	1, 609	2, 942			13. 00
14. 00	Total (see instructions)	13, 755	4, 459	45, 105		1, 326. 75	1
15. 00	CAH visits	0	0	.0, .00	0.00	1,020.70	15. 00
16. 00	SUBPROVIDER - IPF			_			16. 00
17. 00	SUBPROVI DER - I RF	1, 103	27	2, 943	0.00	21. 74	
18. 00	SUBPROVI DER	.,		_,			18. 00
19. 00	SKILLED NURSING FACILITY						19. 00
20. 00	NURSING FACILITY						20. 00
21. 00	OTHER LONG TERM CARE						21. 00
22. 00	HOME HEALTH AGENCY	10, 885	o	22, 875	0.00	54. 90	
23. 00	AMBULATORY SURGICAL CENTER (D. P.)			,			23. 00
24. 00	HOSPICE	ol	o	C	0.00	39. 61	
24. 10	HOSPICE (non-distinct part)			C			24. 10
25.00	CMHC - CMHC						25. 00
26.00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	o	0	C	0.00	0.00	26. 25
27.00	Total (sum of lines 14-26)				0.00	1, 443. 00	27. 00
28.00	Observation Bed Days		0	5, 810			28. 00
29.00	Ambul ance Tri ps	o					29. 00
30.00	Employee discount days (see instruction)			C			30.00
31.00	Employee discount days - IRF			C			31. 00
32.00	Labor & delivery days (see instructions)	o	238	477			32. 00
32. 01	Total ancillary labor & delivery room			C			32. 01
	outpatient days (see instructions)						
33.00	LTCH non-covered days	o					33. 00
33. 01	LTCH site neutral days and discharges	o					33. 01
					•	•	

				To	12/31/2021	Date/Time Prep 5/2/2022 3:08	
		Full Time		Di scha	arges	37272022 3.00	Dill
		Equi val ents					
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Pati ents	
		11.00	12. 00	13.00	14. 00	15. 00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and		0	2, 961	2, 545	10, 419	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)			1, 406	٥		2. 00
3. 00	HMO IPF Subprovider			1, 400	ő		3. 00
4. 00	HMO IRF Subprovider				ol		4. 00
5. 00	Hospital Adults & Peds. Swing Bed SNF				Ĭ		5. 00
6.00	Hospital Adults & Peds. Swing Bed NF						6. 00
7.00	Total Adults and Peds. (exclude observation						7. 00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT						8. 00
9.00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00
12. 00	NEONATAL INTENSIVE CARE UNIT						12.00
13. 00			_				13. 00
14.00	Total (see instructions)	0. 00	0	2, 961	2, 545	10, 419	
15. 00	CAH visits						15.00
16. 00 17. 00	SUBPROVI DER - I PF SUBPROVI DER - I RF	0.00	0	96	37	219	16. 00 17. 00
18. 00	SUBPROVI DER - TRF	0.00	U	90	3/	219	18.00
19. 00	SKILLED NURSING FACILITY						19. 00
20. 00	NURSING FACILITY						20.00
21. 00	OTHER LONG TERM CARE						21. 00
22. 00	HOME HEALTH AGENCY	0. 00					22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24.00	HOSPI CE	0.00					24. 00
24. 10	HOSPICE (non-distinct part)						24. 10
25. 00	CMHC - CMHC						25. 00
26. 00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0. 00					26. 25
27. 00	Total (sum of lines 14-26)	0. 00					27. 00
28. 00	Observation Bed Days						28. 00
29. 00	Ambul ance Tri ps						29. 00
30.00	1 1 3 1 7						30.00
31.00							31.00
32. 00 32. 01							32. 00 32. 01
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33. 00				0			33. 00
	LTCH site neutral days and discharges			Ö			33. 01
	1	'	'	-1	'	'	

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

					To	12/31/2021	Date/Time Pre	pared:
		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst.	Adjusted Salaries (col.2 ± col.	Paid Hours Related to Salaries in	5/2/2022 3:08 Average Hourly Wage (col. 4 ÷ col. 5)	
				A-6)	3)	col. 4	ŕ	
	PART II - WAGE DATA	1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	
	SALARI ES							
1. 00	Total salaries (see instructions)	200. 00	136, 180, 164	-1, 476, 451	134, 703, 713	3, 002, 640. 00	44. 86	1.00
2. 00	Non-physician anesthetist Part		C	0	0	0. 00	0. 00	2. 00
3.00	Non-physician anesthetist Part B		C	0	0	0.00	0.00	3. 00
4. 00	Physician-Part A - Administrative		C	0	0	0.00	0.00	4. 00
4. 01 5. 00	Physicians - Part A - Teaching Physician and Non		0	1	0	0. 00 0. 00	l .	
6. 00	Physician-Part B Non-physician-Part B for hospital-based RHC and FQHC		C	0	О	0. 00	0.00	6. 00
7. 00	services Interns & residents (in an approved program)	21. 00	C	0	0	0. 00	0. 00	7. 00
7. 01	Contracted interns and residents (in an approved		C	0	0	0.00	0. 00	7. 01
8. 00	programs) Home office and/or related organization personnel		C	0	0	0.00	0. 00	8. 00
9. 00 10. 00	SNF Excluded area salaries (see instructions)	44. 00	28, 381, 877) 0 7 334, 463	0 28, 716, 340	0. 00 416, 133. 00		1
11. 00	OTHER WAGES & RELATED COSTS Contract labor: Direct Patient		3, 818, 278	3 0	3, 818, 278	37, 413. 75	102.06	11. 00
12. 00	Care Contract labor: Top level management and other		C	0	О	0.00	0.00	12. 00
13. 00	management and administrative services Contract Labor: Physician-Part		4, 865, 625	i 0	4, 865, 625	3, 252. 25	1, 496. 08	13.00
14. 00	A - Administrative Home office and/or related		(0.00		14. 00
	organization salaries and wage-related costs							
14. 01 14. 02	Home office salaries Related organization salaries		C	0	0	0. 00 0. 00	l .	14. 01 14. 02
15. 00	Home office: Physician Part A		C	Ö	Ö	0.00	l .	
16. 00	- Administrative Home office and Contract		C	0	0	0.00	0. 00	16. 00
16. 01	Physicians Part A - Teaching Home office Physicians Part A - Teaching		C	0	0	0. 00	0. 00	16. 01
16. 02	Home office contract Physicians Part A - Teaching		C	0	0	0. 00	0. 00	16. 02
17. 00	WAGE-RELATED COSTS Wage-related costs (core) (see		22, 727, 649) 0	22, 727, 649			17. 00
18. 00	instructions) Wage-related costs (other)							18. 00
19. 00 20. 00	(see instructions) Excluded areas Non-physician anesthetist Part		6, 156, 873 0	0 0	6, 156, 873 0			19. 00 20. 00
21. 00	A Non-physician anesthetist Part		C	0	0			21. 00
22. 00	Physician Part A - Administrative		C	0	0			22. 00
22. 01	Physician Part A - Teaching		C	0	0			22. 01
23. 00 24. 00	Physician Part B Wage-related costs (RHC/FQHC)		(0	0			23. 00 24. 00
25. 00	Interns & residents (in an approved program)		C	0	0			25. 00
25. 50	Home office wage-related (core)		C	0	0			25. 50
25. 51	Related organization wage-related (core)		C	0	0			25. 51
25. 52	Home office: Physician Part A - Administrative - wage-related (core)		C	0	О			25. 52
	130 . 3. 4. 54 (35. 6)	ļ		1	1		ı	1

In Lieu of Form CMS-2552-10
Period: Worksheet S-3
From 01/01/2021 Part II

						rom 01/01/2021	Part II	
					T	12/31/2021	Date/Time Pre	
		Wkst. A Line	Amount	Recl assi fi cati	Adjusted	Pai d Hours	5/2/2022 3:08 Average Hourly	
		Number		on of Salaries			Wage (col. 4 ÷	
		Nullibei	керог гец	(from Wkst.	(col. 2 ± col.	Salaries in	col. 5)	
				A-6)	3)	col. 4	COI. 5)	
		1.00	2.00	3.00	4, 00	5. 00	6. 00	
25. 53	Home office: Physicians Part A		2.00	0.00	7.00	3.00	0.00	25. 53
20.00	- Teaching - wage-related		O	Ĭ	Ĭ			20.00
	(core)							
	OVERHEAD COSTS - DIRECT SALARII	ES .						
26.00	Employee Benefits Department	4. 00	162, 842	-100, 409	62, 433	24, 485. 84	2. 55	26. 00
27.00	Administrative & General	5. 00	28, 260, 743	-943, 527	27, 317, 216	279, 215. 49	97. 84	27. 00
28.00	Administrative & General under		0	0	0	0.00	0. 00	28. 00
	contract (see inst.)							
29.00	Maintenance & Repairs	6. 00	0	0	0	0.00	0.00	29. 00
30.00	Operation of Plant	7. 00	2, 554, 572	0	2, 554, 572	160, 647. 91	15. 90	30.00
31.00	Laundry & Linen Service	8. 00	255, 176	0	255, 176	12, 080. 19	21. 12	31. 00
32.00	Housekeepi ng	9. 00	2, 295, 580	0	2, 295, 580	199, 599. 41	11. 50	32. 00
33.00	Housekeeping under contract		0	0	0	0.00	0.00	33. 00
	(see instructions)							
34.00	Di etary	10. 00	2, 342, 202	-974, 278	1, 367, 924	78, 390. 21	17. 45	34.00
35.00	Di etary under contract (see		0	0	0	0.00	0.00	35. 00
	instructions)							
36. 00	Cafeteri a	11. 00	0	974, 278	974, 278	·		
37.00	Maintenance of Personnel	12. 00	0	0	0	0.00	0. 00	37. 00
38. 00	Nursing Administration	13. 00	3, 606, 424	-449, 266	3, 157, 158	100, 565. 73	31. 39	38. 00
39.00	Central Services and Supply	14. 00	387, 725	0	387, 725	28, 289. 74	13. 71	39. 00
40.00	Pharmacy	15. 00	2, 841, 062	-94, 889	2, 746, 173	93, 348. 47	29. 42	40. 00
41.00	Medical Records & Medical	16. 00	87, 244	-41, 168	46, 076	3, 493. 78	13. 19	41.00
	Records Library							
42.00	Social Service	17. 00	0	0	0	0.00		42. 00
43.00	Other General Service	18. 00	0	0	0	0. 00	0.00	43. 00

HOSPITAL WAGE INDEX INFORMATION Worksheet S-3 Part III Date/Time Prepared: Provi der CCN: 15-0109 Peri od: From 01/01/2021 To 12/31/2021 5/2/2022 3:08 pm Worksheet A Amount Recl assi fi cati Adj usted Pai d Hours Average Hourly Line Number Reported on of Salaries Sal ari es Related to Wage (col. 4 (col . 2 ± col . col. 5) (from Salaries in Works<u>heet A-6)</u> 3) col. 4 1.00 5.00 6.00 2.00 3.00 4.00 PART III - HOSPITAL WAGE INDEX SUMMARY 1.00 Net salaries (see 136, 180, 164 -1, 476, 451 134, 703, 713 3, 002, 640. 00 1.00 44.86 instructions) 2.00 28, 381, 877 416, 133. 00 69.01 2.00 Excluded area salaries (see 334, 463 28, 716, 340 instructions) 3.00 Subtotal salaries (line 1 107, 798, 287 -1, 810, 914 105, 987, 373 2, 586, 507. 00 40.98 3.00 minus line 2) 4.00 Subtotal other wages & related 8, 683, 903 8, 683, 903 40, 666. 00 213.54 4.00 costs (see inst.) Subtotal wage-related costs 5.00 22, 727, 649 C 22, 727, 649 0.00 21.44 5.00

-1, 810, 914

-1, 629, 259

137, 398, 925

41, 164, 311

2, 627, 173. 00

1, 051, 110. 77

139, 209, 839

42, 793, 570

6.00

7.00

52 30

39. 16

(see inst.)

instructions)

6.00

7.00

Total (sum of lines 3 thru 5)

Total overhead cost (see

Health Financial Systems	FRANCISCAN HEALTH LAFAYETTE	In Lieu of Form CMS-2552-10
HOSPITAL WAGE RELATED COSTS	Provi der CCN: 15-0109	
		From 01/01/2021 Part IV

	10 12/31	1/2021 Date 5/2/2	/lime Prep 2022 3:08	
			nount	•
		Reg	orted	
		1	. 00	
	PART IV - WAGE RELATED COSTS			
	Part A - Core List			
	RETI REMENT COST			
1.00	401K Employer Contributions		0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution		0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	8	3, 124, 272	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)		0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)			
5.00	401K/TSA Plan Administration fees		0	5.00
6.00	Legal /Accounting/Management Fees-Pension Plan		0	6.00
7.00	Employee Managed Care Program Administration Fees		439, 864	7.00
	HEALTH AND INSURANCE COST			
8.00	Health Insurance (Purchased or Self Funded)		0	8.00
8. 01	Health Insurance (Self Funded without a Third Party Administrator)		0	8. 01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	9	9, 572, 601	8. 02
8.03	Health Insurance (Purchased)		0	8. 03
9.00	Prescription Drug Plan		0	9.00
10.00	Dental, Hearing and Vision Plan	1	, 022, 364	
	Life Insurance (If employee is owner or beneficiary)		70, 128	
12.00	1		0	12.00
13. 00	Disability Insurance (If employee is owner or beneficiary)		489, 782	
14. 00			0	14.00
15. 00			, 309, 844	
16. 00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 1	06.	0	16. 00
	Non cumulative portion)			
	TAXES			
	FICA-Employers Portion Only	7	7, 705, 837	
	Medicare Taxes - Employers Portion Only		0	18.00
19. 00	Unemployment Insurance		0	19. 00
20.00	State or Federal Unemployment Taxes		139, 895	20. 00
04 00	OTHER			04 00
21. 00	Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above.	(see	0	21. 00
22. 00	instructions)) Day Care Cost and Allowances		0	22. 00
	Tuition Reimbursement		9, 935	23. 00
	Total Wage Related cost (Sum of lines 1 -23)	20	9, 935 3, 884, 522	24. 00
24.00	Part B - Other than Core Related Cost		0, 004, 022	∠4. 00
25 00	OTHER WAGE RELATED COSTS (SPECIFY)			25. 00
23.00	TOTHER WIND REDUIED GOOTS (GLECTT)	I		25.00

Health Financial Systems	FRANCISCAN HEALTH LAFAYETTE	In Lie	u of Form CMS-2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provider CCN: 15-0109	From 01/01/2021	Worksheet S-3 Part V Date/Time Prepared:

		10 12/31/2021	5/2/2022 3:08					
	Cost Center Description	Contract Labor		DIII				
		1. 00	2. 00					
	PART V - Contract Labor and Benefit Cost							
	Hospital and Hospital-Based Component Identification:							
1.00	Total facility's contract labor and benefit cost	0	0	1. 00				
2.00	Hospi tal	0	0	2. 00				
3.00	Subprovi der - I PF			3. 00				
4.00	Subprovi der - I RF	0	0	4. 00				
5.00	Subprovi der - (Other)	0	0	5. 00				
6.00	Swing Beds - SNF	0	0	6. 00				
7.00	Swing Beds - NF	0	0	7. 00				
8.00	Hospi tal -Based SNF			8. 00				
9.00	Hospi tal -Based NF			9. 00				
10.00	Hospi tal -Based OLTC			10.00				
11. 00	Hospi tal -Based HHA	0	0	11. 00				
12.00	Separately Certified ASC			12.00				
13.00	Hospi tal -Based Hospi ce	0	0	13.00				
14.00	Hospital-Based Health Clinic RHC			14.00				
15. 00	Hospital-Based Health Clinic FQHC			15. 00				
16. 00	Hospi tal -Based-CMHC			16. 00				
17.00	Renal Dialysis	0	0	17. 00				
18. 00	Other	0	0	18. 00				

		FRANCISCAN HEALTH				eu of Form CMS-2	
HOME F	EALTH AGENCY STATISTICAL DATA		Provider Component (1	Period: From 01/01/2021 Fo 12/31/2021	Worksheet S-4 Date/Time Pre	
			- Somponione	90111 10 7121	Home Health	5/2/2022 3: 08 PPS	pm
					Agency I		
0.00	County				1.	00	0.00
		Title V 1	Title XVIII 2.00	Title XIX 3.00	0ther 4.00	Total 5. 00	
1.00	HOME HEALTH AGENCY STATISTICAL DATA						4.00
1. 00 2. 00	Home Health Aide Hours Unduplicated Census Count (see instructions)	0 0. 00	0. 00	0. 00		0.00	
				Number of Emp	loyees (Full Ti	me Equivalent)	
		Enter the number your normal w		Staff	Contract	Total	
		your norman r	NOTIC WOOK				
				1.00	0.00		
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES	0		1.00	2. 00	3. 00	
3. 00 4. 00	Administrator and Assistant Administrator(s) Director(s) and Assistant Director(s)		40. 00	1. 00 1. 00		l e	1
5. 00 6. 00	Other Administrative Personnel Direct Nursing Service			12. 09 23. 4		l e	
7.00	Nursi ng Supervi sor			2.00	0.00	2.00	7. 00
8. 00 9. 00	Physical Therapy Service Physical Therapy Supervisor			22. 7! 0. 00		l	
10. 00 11. 00	Occupational Therapy Service Occupational Therapy Supervisor			3. 23 0. 00		•	1
12.00	Speech Pathology Service			0. 70	0.00	0. 70	12. 00
13. 00 14. 00	Speech Pathology Supervisor Medical Social Service			0. 00 4. 7:		l	•
15. 00 16. 00	Medical Social Service Supervisor Home Health Aide			0. 00 1. 00		l .	15. 00 16. 00
17. 00	Home Health Aide Supervisor			0. 00	0.00	0.00	17. 00
18. 00	Other (specify)			0.00	0.00	CBSA Data	18. 00
	HOME HEALTH AGENCY CBSA CODES					1.00	
19. 00 20. 00	Enter in column 1 the number of CBSAs where y List those CBSA code(s) in column 1 serviced	, ,	J		9 1	6 23844	19. 00 20. 00
20. 01	first code).	3	3 1			26900	20. 01
20. 02						29200	20. 02
20. 03 20. 04						33140 45460	20. 03 20. 04
20. 05		Full Epis	sodes			99915	20. 05
		Wi thout Wi Outliers	ith Outliers	LUPA Epi sodes	PEP Only Epi sodes	Total (cols. 1-4)	
	PPS ACTIVITY DATA	1.00	2. 00	3. 00	4. 00	5. 00	
21. 00	Skilled Nursing Visits	470	4, 386			5, 013	1
22. 00 23. 00	Skilled Nursing Visit Charges Physical Therapy Visits	187, 530 426	1, 750, 014 3, 247	80		2, 000, 187 3, 763	1
24. 00 25. 00	Physical Therapy Visit Charges Occupational Therapy Visits	176, 364 282	1, 344, 258 1, 135	1		1, 557, 882 1, 447	1
26. 00 27. 00	Occupational Therapy Visit Charges Speech Pathology Visits	116, 748 63	469, 890 245	10, 350		599, 058 314	26. 00
28. 00	Speech Pathology Visit Charges	26, 082	101, 430	2, 48		129, 996	28. 00
29. 00 30. 00	Medical Social Service Visits Medical Social Service Visit Charges	24 11, 520	107 51, 360		1 0 0 0	132 63, 360	1
31. 00 32. 00	Home Health Aide Visits Home Health Aide Visit Charges	19 3, 667	196 37, 828		1 O	216 41, 688	•
33. 00	Total visits (sum of lines 21, 23, 25, 27,	1, 284	9, 316				1
34. 00	29, and 31) Other Charges	0	0			0	
35. 00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	521, 911	3, 754, 780			4, 392, 171	35. 00
36. 00	Total Number of Episodes (standard/non outlier)	0			0		
37. 00 38. 00	Total Number of Outlier Episodes Total Non-Routine Medical Supply Charges	o	0		0 0	0	•

Heal th	Financial Systems		FRANCISCAN HEA	LTH LAFAYFTTF		In Lie	eu of Form CMS-2	2552-10
	AL-BASED HOSPICE IDENTIFICATION			Provi der C		Peri od: From 01/01/2021	Worksheet S-9 PARTS I THROU	GH IV
				Hospi ce CCI	N: 15-1563	To 12/31/2021	Date/Time Prepared: 5/2/2022 3:08 pm	
						Hospi ce I	0,2,2022 0.00	
		Unduplicated						
		Days						
		Title XVIII	Title XIX	Title XVIII	Title XIX	All Other	Total (sum of	
				Skilled	Nursi ng		col s. 1, 2 &	
				Nursi ng	Facility		5)	
		1, 00	2.00	Facility 3.00	4. 00	5. 00	4 00	
	PART I - ENROLLMENT DAYS FOR CO					5.00	6. 00	
1. 00	Hospice Continuous Home Care	DOT REPORTING F	LKI ODS BEGINNI	NO BLICKE OCTO	BLK 1, 2015			1. 00
2. 00	Hospice Routine Home Care							2.00
3.00	Hospice Inpatient Respite Care							3.00
4.00	Hospice General Inpatient Care							4. 00
5.00	Total Hospice Days							5. 00
	Part II - CENSUS DATA FOR COST	REPORTING PERI	ODS BEGINNING	BEFORE OCTOBER	1, 2015			
6.00	Number of patients receiving							6. 00
	hospi ce care		4					
7. 00	Total number of unduplicated							7. 00
	Continuous Care hours billable							
0.00	to Medicare							0.00
8. 00	Average Length of Stay (line 5 / line 6)							8. 00
9. 00	Unduplicated census count							9. 00
	Parts I and II, columns 1 and 2	also include	the days reper	tod in columns	2 and 4			7.00
NOTE.	Parts I and II, Corumns I and 2	arso rrici ude	the days repor	_				
				Title XVIII	Title XIX	0ther	Total (sum of	
							col s. 1	
				4.00	0.00	2.00	through 3)	
	DADT III FNDOLIMENT DAVC FOR	COCT DEDODTING	DEDLODE DECLA	1. 00	2.00	3. 00	4. 00	
10.00	PART III - ENROLLMENT DAYS FOR Hospice Continuous Home Care	COST REPORTING	PERTUDS BEGIN	NNING ON OR AFT	ER UCTUBER I	, 2015	0	10.00
10. 00 11. 00	Hospice Continuous Home Care			33, 927			33, 927	
12. 00	Hospice Inpatient Respite Care			101	•	0 0		12.00
13. 00	Hospice General Inpatient Care			7		0 0	101	13. 00
	Total Hospi ce Days			34, 035		0 0	34, 035	
14.00	PART IV - CONTRACTED STATISTICA	AL DATA FOR COS	ST REPORTING PE					14.00
15. 00	Hospice Inpatient Respite Care			0		0 0		15. 00
	Hospice General Inpatient Care			0		0 0		
					•	•		•

Medicarid (see instructions for each line) Sale instructions for each line) Stand-alone CHIP color indigent care program (see instructions for each line) Stand-alone Instructions for each line) State or local indigent care program (see instructions for each line) State or local indigent care program (see instructions for each line) State or local indigent care program (see instructions for each line) State or local indigent care program (see instructions for each line) State or local indigent care program (see instructions for each line) State or local indigent care program (see instructions for each line) State or local indigent care program (see instructions for each line) State or local indigent care program (see instructions for each line) State or local indigent care program (see instructions for each line) State or local indigent care program (see instructions for each line) State or local indigent care program (see instructions for each line) State or local indigent care program (see instructions for each line) State or local indigent care program (see instructions for each line) State or local indigent care program (see instructions for each line) State or local indigent care program (see instructions for each line) State or local indigent care program (see instructions for each line) State or local indigent care program (see instructions for each line) State or local indigent care program (see instructions for each line) State or local indigent care program (see instructions for each line) State or local indigent care program (see instructions for each line) State or local indigent care program (see instructions for each line) State or local indigent care program (see instructions) State or local indigent care program (see instructions) State or local indigent care program (see instructions) State or local i	Heal th	Financial Systems FRANCISCAN HEALTH L	_AFAYETTE	In Lie	u of Form CMS-2	2552-10			
Incompensated and indigent care cost computation	HOSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 15-0109		Worksheet S-10	0			
1.00					Date/Time Pre	nared:			
Incompensated and indigent care cost computation 0.00				12, 31, 2021					
1.00 Cost to charge ratio (Worksheet C, Part 1 line 202 column 3 divided by line 202 column 8)					1. 00				
Medicald (see Instructions for each line) Set Not Set Se									
Not revenue from Medicaid 58,108,754 20	1.00		rided by line 202 colur	nn 8)	0. 186298	1.00			
If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	2.00				58, 108, 754	2.00			
1	3.00	Did you receive DSH or supplemental payments from Medicaid?				3. 00			
Medicaid charges	4.00	If line 3 is yes, does line 2 include all DSH and/or supplement	al payments from Medic	cai d?		4. 00			
Note		1	om Medicaid						
8.00 Oifference between net revenue and costs for Medicald program (line 7 minus sum of lines 2 and 5: if									
CRITICIPATE See Instructions See Instructions See Instructions See Instructions See Instructions See See Instructions See		· · · · · · · · · · · · · · · · · · ·	1: 7£ 1:	2 1 5 : 6					
Children's Health Insurance Program (CHIP) (see instructions for each line)	8.00		Time / minus sum of fi	nes 2 and 5; 11	U	8.00			
10.00 Stand-al one CHIP cost (line 1 times line 10) 0 10.00 0 11.0		Children's Health Insurance Program (CHIP) (see instructions fo	r each line)						
11.00 Stand-al one CHIP cost (line 1 times line 10) 2.00 1.00	9.00	Net revenue from stand-alone CHIP			0	9. 00			
12.00 Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero) Other state or local government indigent care program (see instructions for each line) 13.00 Not revenue from state or local indigent care program (Not included on lines 2, 5 or 9) 14.00 Charges for patients covered under state or local indigent care program (Not included in lines 6 or 0 1 14.00 10) 15.00 State or local lindigent care program cost (line 1 times line 14) 16.00 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 0 1 15.00 13; If < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see Instructions for each line) Private grants, donations, or endowment income restricted to funding charity care 17.00 Patients appropriations or transfers for support of hospital operations 18.12 and 16) Uncompensated Care (see instructions for each line) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility 25,812,645 2,985,342 28,797,987 (see instructions) 10.00 Cost of patients approved for charity care and uninsured discounts (see 4,808,844 2,985,342 7,794,186 21.00 charity care charges and uninsured patients patient	10.00	,							
enter zero) Other state or local government indigent care program (see instructions for each line) 13.00 Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9) 0 13.00 14.00 15.00									
Other state or local government indigent care program (see instructions for each line) 13.00 13.00 14.00 15.	12. 00		line 11 minus line 9;	if < zero then	0	12. 00			
13.00 Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)			ructions for each line	<i>i</i>)		1			
14.00 Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10) 15.00 State or local indigent care program cost (line 1 times line 14) 16.00 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13: If < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line) 17.00 Private grants, donations, or endowment income restricted to funding charity care 18.00 Ocernment grants, appropriations or transfers for support of hospital operations 19.00 Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 0 18.00 Charity care (see instructions) 19.00 Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 0 19.00 Charity care charges and uninsured discounts for the entire facility 25, 812, 645 2, 985, 342 28, 797, 987 (see instructions) 20.00 Charity care charges and uninsured discounts for the entire facility 25, 812, 645 2, 985, 342 28, 777, 94, 186 21.00 Cost of patients approved for charity care and uninsured discounts (see 4, 808, 844 2, 985, 342 7, 794, 186 21.00 Cost of patients approved for charity care and uninsured discounts (see 4, 808, 844 2, 985, 342 7, 794, 186 23.00 Cost of charity care (line 21 minus line 22) 4, 808, 844 2, 985, 342 7, 794, 186 23.00 Cost of charity care (line 22 minus line 22) 4, 808, 844 2, 985, 342 7, 794, 186 23.00 Cost of charity care by dedicaid or other indigent care program? 18.00 Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit limposed on patients covered by Medicaid or other indigent care program? 19.00 Does the amount on line 20 column 2, include charges for patient days beyond the indigent care program's length of stay limit limposed on patients covered by Medicaid or other indigent care program's length of stay limit limposed on patients covered by	13.00				0	13. 00			
15.00 State or local indigent care program cost (line 1 times line 14) 16.00 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line) 17.00 Private grants, donations, or endowment income restricted to funding charity care 0 18.00 Government grants, appropriations or transfers for support of hospital operations 0 18.00 Government grants, appropriations or transfers for support of hospital operations 0 19.00 8, 12 and 16) 18.00 Government grants, appropriations or transfers for support of hospital operations 0 19.00 8, 12 and 16) 19.00 Uninsured patients patients patients + col. 2) 10.00 Charity care charges and uninsured discounts for the entire facility 25, 812, 645 2, 985, 342 28, 797, 987 20.00 (see instructions) 20.00 Cost of patients approved for charity care and uninsured discounts (see 4, 808, 844 2, 985, 342 7, 794, 186 21.00 (see instructions) 20.00 Payments received from patients for amounts previously written off as 0 0 0 0 22.00 (cost of charity care (line 21 minus line 22) 4, 808, 844 2, 985, 342 7, 794, 186 23.00 (cost of charity care (line 21 minus line 22) 4, 808, 844 2, 985, 342 7, 794, 186 23.00 (cost of charity care (line 21 minus line 22) 4, 808, 844 2, 985, 342 7, 794, 186 23.00 (cost of charity care (line 21 minus line 22) 4, 808, 844 2, 985, 342 7, 794, 186 23.00 (cost of charity care (line 21 minus line 22) 4, 808, 844 2, 985, 342 7, 794, 186 23.00 (cost of charity care (line 24) minus line 22) 4, 808, 844 2, 985, 342 7, 794, 186 23.00 (cost of charity care (line 24) minus line 22) 4, 808, 844 2, 985, 342 7, 794, 186 23.00 (cost of charity care (line 24) minus line 26 (cost of charity care (line 24) minus line 26 (cost of charity care (line 24) minus line 26 (cost of charity care (line 24) minus line 27 (cost of charity care (line 24) minus line (cost of charity care (lin						1			
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31.00 Total unreimbursed and uncompensated care cost (line 19 plus line 30) 11,837,474 31.00	31.00	Total unreimbursed and uncompensated care cost (line 19 plus li	ne 30)		11, 837, 474	31.00			

Health Financial Systems	FRANCISCAN HEALT				u of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE (OF EXPENSES	Provi der CO		Peri od:	Worksheet A	
				From 01/01/2021 o 12/31/2021	Date/Time Pre	nared·
			'	0 12/01/2021	5/2/2022 3: 08	pm pm
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)	
OFNEDAL CEDIU OF COOT OFNEDO	1.00	2. 00	3. 00	4. 00	5. 00	
GENERAL SERVICE COST CENTERS		2 020 022	2 020 022	E 020 252	0.750.174	1 00
1. 00 00100 CAP REL COSTS-BLDG & FLXT 2. 00 00200 CAP REL COSTS-MVBLE EQUIP		3, 828, 823 0	3, 828, 823		9, 759, 176 20, 052, 522	1. 00 2. 00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	162, 842	37, 762, 420	37, 925, 262		37, 777, 602	4.00
5. 01 01160 COMMUNI CATI ONS	826, 930	656, 274	1, 483, 204		1, 482, 529	5. 01
5. 02 01140 MGMT I NFO SYSTEMS	871, 330	4, 352, 342		I I	4, 875, 581	5. 02
5. 03 00550 PURCHASI NG	290	260, 152	260, 442		203, 135	5. 03
5. 04 00570 ADMI TTI NG	321	3, 699			3, 090	5. 04
5. 05 00580 PATIENT ACCOUNTING	1, 630	1, 541, 743	1, 543, 373	I I	1, 543, 373	5. 05
5.06 00560 OTHER ADMINISTRATIVE AND GENERAL	26, 560, 242	48, 147, 720	74, 707, 962	I I	70, 326, 407	5. 06
7.00 00700 OPERATION OF PLANT	2, 554, 572	13, 088, 856	15, 643, 428		8, 623, 025	7. 00
8.00 00800 LAUNDRY & LINEN SERVICE	255, 176	720, 044	975, 220		959, 297	8. 00
9. 00 00900 HOUSEKEEPI NG	2, 295, 580	1, 083, 646			3, 334, 713	9. 00
10. 00 01000 DI ETARY	2, 342, 202	1, 865, 570	4, 207, 772	-1, 853, 144	2, 354, 628	10.00
11. 00 01100 CAFETERI A	0	0	(1, 645, 276	1, 645, 276	11. 00
13.00 01300 NURSING ADMINISTRATION	3, 606, 424	935, 497	4, 541, 921	-283, 362	4, 258, 559	13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	387, 725	750, 307	1, 138, 032	-402, 958	735, 074	14.00
15. 00 01500 PHARMACY	2, 841, 062	11, 091, 397	13, 932, 459	-452, 416	13, 480, 043	15. 00
16.00 01600 MEDICAL RECORDS & LIBRARY	87, 244	193, 458	280, 702	-159, 679	121, 023	16. 00
17.00 01700 SOCIAL SERVICE	0	0	C	0	0	17. 00
20. 00 02000 NURSI NG PROGRAM	2, 042, 701	1, 004, 551	3, 047, 252	-359, 947	2, 687, 305	20. 00
23. 00 02301 PHARMACY RESI DENCY	172, 750	13, 276	186, 02 <i>6</i>	172, 067	358, 093	23. 00
23. 01 02300 EMS EDUCATION	5, 210	12, 906	18, 11 <i>6</i>	145, 010	163, 126	23. 01
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	21, 677, 466	4, 774, 392	26, 451, 858		19, 427, 335	30. 00
31.00 03100 INTENSIVE CARE UNIT	4, 082, 153	1, 215, 896	5, 298, 049	-779, 300	4, 518, 749	31. 00
35.00 02060 NEONATAL INTENSIVE CARE UNIT	2, 395, 577	991, 248			3, 171, 085	35. 00
41. 00 04100 SUBPROVI DER - I RF	1, 753, 274	77, 439			1, 688, 548	41. 00
43. 00 04300 NURSERY	0	0	(750, 993	750, 993	43. 00
ANCI LLARY SERVI CE COST CENTERS						
50. 00 05000 OPERATING ROOM	3, 769, 034	20, 693, 538			5, 337, 118	50.00
51. 00 05100 RECOVERY ROOM	590, 529	25, 217	615, 746		591, 812	51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	0 E 401 301	10 220 00/	-,,	3, 384, 526	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 55. 00 05500 RADI OLOGY - THERAPEUTI C	4, 557, 603	5, 681, 391	10, 238, 994		6, 117, 952	54. 00 55. 00
56. 00 05600 RADI 0I SOTOPE	398, 229 82, 594	305, 084 31, 133	703, 313 113, 727		619, 978 97, 865	56.00
56. 01 03950 CARDI AC CATH LAB	1, 477, 704	4, 169, 785	5, 647, 489		1, 435, 972	56. 01
57. 00 05700 CT SCAN	684, 689	469, 032			950, 534	57. 00
58. 00 05800 MRI	310, 373	250, 698			360, 396	58.00
60. 00 06000 LABORATORY	310, 379	11, 630, 823			11, 462, 818	60.00
65. 00 06500 RESPIRATORY THERAPY	2, 331, 597	1, 203, 436			2, 555, 941	65.00
66. 00 06600 PHYSI CAL THERAPY	4, 840, 603	1, 869, 535			5, 298, 443	
67. 00 06700 OCCUPATI ONAL THERAPY	1, 529, 513	56, 182			1, 550, 763	
68. 00 06800 SPEECH PATHOLOGY	567, 531	30, 603			576, 045	
69. 00 06900 ELECTROCARDI OLOGY	1, 890, 705	2, 596, 955	4, 487, 660		4, 322, 529	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	678, 473	140, 577	819, 050		701, 592	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0			13, 913, 182	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	C	10, 088, 028	10, 088, 028	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS		0	C		12, 612, 838	73. 00
73. 01 07301 DI ABETES CENTER	435, 715	6, 483	442, 198	-921	441, 277	73. 01
74.00 07400 RENAL DIALYSIS	165, 398	1, 224, 881	1, 390, 279	-20, 497	1, 369, 782	74. 00
76. 00 03480 ONCOLOGY	2, 940, 050	7, 472, 692	10, 412, 742		3, 706, 213	76. 00
76. 01 03952 ANTI COAGULATI ON	305, 024	35, 838	340, 862	-7, 399	333, 463	76. 01
76. 02 03951 I NFUSI ON SERVI CES	617, 646	1, 157, 711	1, 775, 357	-189, 060	1, 586, 297	76. 02
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0		0	0	76. 98
OUTPATIENT SERVICE COST CENTERS	,					
90. 00 09000 CLI NI C	469, 914	847, 399	1, 317, 313		1, 289, 516	90.00
91. 00 09100 EMERGENCY	6, 057, 893	3, 942, 509			8, 317, 155	91.00
91. 01 04950 WOUND CARE	760, 654	-32, 430	728, 224	-5, 496	722, 728	91. 01
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
92. 01 09201 OBSERVATION BEDS (DISTINCT PART)	1, 388, 050	551, 124	1, 939, 174	-314, 922	1, 624, 252	92. 01
OTHER REIMBURSABLE COST CENTERS	1 4 70	a = · · ·			6 75	05.55
95. 00 09500 AMBULANCE SERVI CES	1, 737, 815	1, 462, 518			2, 752, 805	95. 00
101. 00 10100 HOME HEALTH AGENCY	4, 011, 177	426, 671	4, 437, 848	-12, 625	4, 425, 223	101.00
SPECIAL PURPOSE COST CENTERS		0.5/0.400	0.5/0.400	4 / 74 4 / -1	2 001 011	112 00
113. 00 11300 INTEREST EXPENSE	0 700 700	8, 563, 128			3, 891, 961	
116. 00 11600 HOSPI CE	2, 732, 738	2, 137, 963			4, 855, 042	
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	120, 253, 952	211, 322, 132	331, 576, 084	18, 249	331, 594, 333	1118.00
NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	54, 397	106, 376	160, 773	-5, 376	155, 397	190 00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 192.00 19200 PHYSICIANS' PRIVATE OFFICES	15, 871, 815	3, 616, 677			19, 475, 619	
192.00 19200 PHYSICIANS PRIVATE OFFICES 194.00 07950 MOB	15, 871, 815	3, 616, 677	19, 488, 492			194. 00
1 77. 00 07 700 WOD	ı V	U	1	<u>/</u>	0	1174.00

Health Financial Systems	FRANCISCAN HEAL	TH LAFAYETTE		In Lie	eu of Form CMS-	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE C	F EXPENSES	Provi der Co		Peri od:	Worksheet A	
				From 01/01/2021 Fo 12/31/2021	Date/Time Pre 5/2/2022 3:08	
Cost Center Description	Sal ari es	0ther	Total (col. 1	Recl assi fi cati	Reclassi fied	
			+ col. 2)	ons (See A-6)	Trial Balance	
					(col. 3 +-	
					col. 4)	
	1.00	2.00	3.00	4. 00	5. 00	
194. 01 07951 LI FELI NE	0	0	(0	0	194. 01
194.02 07952 PATIENT TRANSPORT	0	0	(0	0	194. 02
194.03 07954 OTHER NONREIMBURSABLE COST CENTERS	0	0	(0	0	194. 03
200.00 TOTAL (SUM OF LINES 118 through 199)	136, 180, 164	215, 045, 185	351, 225, 349	9 0	351, 225, 349	200. 00

Peri od: From 01/01/2021 To 12/31/2021

Date/Time Prepared: 5/2/2022 3:08 pm

			5/2/2022 3: 08	pm
Cost Center Description	Adjustments	Net Expenses		
	(See A-8) 6.00	For Allocation 7.00		
GENERAL SERVICE COST CENTERS	0.00	7.00		
1. 00 O0100 CAP REL COSTS-BLDG & FLXT	225, 490	9, 984, 666		1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP	2, 787, 702	22, 840, 224		2. 00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	-5, 274, 473	32, 503, 129		4. 00
5. 01 01160 COMMUNI CATI ONS	721, 277	2, 203, 806		5. 01
5.02 01140 MGMT INFO SYSTEMS	2, 342, 187	7, 217, 768		5. 02
5. 03 00550 PURCHASI NG	-940, 474	-737, 339		5. 03
5. 04 00570 ADMI TTI NG	1, 955	5, 045		5. 04
5. 05 00580 PATI ENT ACCOUNTI NG	736, 435	2, 279, 808		5. 05
5. 06 00560 OTHER ADMINISTRATIVE AND GENERAL	-25, 600, 677	44, 725, 730		5.06
7. 00 00700 0PERATI ON OF PLANT 8. 00 00800 LAUNDRY & LINEN SERVICE	-40, 245 0	8, 582, 780		7. 00 8. 00
9.00 00900 HOUSEKEEPI NG	-208, 517	959, 297 3, 126, 196		9.00
10. 00 01000 DI ETARY	-208, 517	2, 354, 626		10.00
11. 00 01100 CAFETERI A	-1, 235, 957	409, 319		11. 00
13. 00 01300 NURSI NG ADMI NI STRATI ON	-619, 459	3, 639, 100		13. 00
14. 00 01400 CENTRAL SERVICES & SUPPLY	0	735, 074		14. 00
15. 00 01500 PHARMACY	618, 581	14, 098, 624		15. 00
16.00 01600 MEDICAL RECORDS & LIBRARY	2, 031, 592	2, 152, 615		16. 00
17.00 01700 SOCIAL SERVICE	0	0		17. 00
20. 00 02000 NURSI NG PROGRAM	-2, 562, 149	125, 156		20. 00
23. 00 02301 PHARMACY RESI DENCY	0	358, 093	l .	23. 00
23. 01 02300 EMS EDUCATION	-15, 441	147, 685		23. 01
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	(00.057	40 74/ 470	T	00.00
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 NTENSIVE CARE UNIT	-680, 857	18, 746, 478	l control of the cont	30.00
31.00 03100 INTENSIVE CARE UNIT 35.00 02060 NEONATAL INTENSIVE CARE UNIT	0 -772, 475	4, 518, 749	l control of the cont	31. 00 35. 00
41. 00 04100 SUBPROVI DER - I RF	-172, 475	2, 398, 610 1, 553, 565		41.00
43. 00 04300 NURSERY	-134, 763	750, 993		43.00
ANCI LLARY SERVI CE COST CENTERS	١	730, 773		43.00
50. 00 05000 OPERATI NG ROOM	-531, 291	4, 805, 827		50.00
51.00 05100 RECOVERY ROOM	0	591, 812		51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	3, 384, 526		52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	-253, 736	5, 864, 216		54.00
55. 00 05500 RADI OLOGY - THERAPEUTI C	0	619, 978		55. 00
56. 00 05600 RADI 0I SOTOPE	-13, 737	84, 128		56. 00
56. 01 03950 CARDI AC CATH LAB	0	1, 435, 972		56. 01
57. 00 05700 CT SCAN	0	950, 534		57. 00
58. 00 05800 MRI	0	360, 396		58. 00
60. 00 06000 LABORATORY	-39, 286	11, 423, 532		60.00
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	-35, 046	2, 520, 895		65.00
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY	-240, 948 -65, 777	5, 057, 495 1, 484, 986		66. 00 67. 00
68. 00 06800 SPEECH PATHOLOGY	-05,777	575, 601		68.00
69. 00 06900 ELECTROCARDI OLOGY	-2, 171, 078	2, 151, 451		69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	-23, 717	677, 875		70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	13, 913, 182	l .	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	10, 088, 028	·	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	-51, 591	12, 561, 247		73. 00
73. 01 07301 DI ABETES CENTER	-1, 375	439, 902		73. 01
74. 00 07400 RENAL DI ALYSI S	0	1, 369, 782		74. 00
76. 00 03480 ONCOLOGY	-3, 596	3, 702, 617		76. 00
76. 01 03952 ANTI COAGULATI ON	-5, 818	327, 645		76. 01
76. 02 03951 I NFUSI ON SERVI CES	0	1, 586, 297	l .	76. 02
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0		76. 98
90. 00 OUTPATIENT SERVICE COST CENTERS 90. 00 O9000 CLINIC	-2, 775	1, 286, 741		90.00
90. 00 09000 CLI NI C 91. 00 09100 EMERGENCY	-2, 775 -2, 416, 909	1, 286, 741 5, 900, 246	l .	90.00
91. 01 04950 WOUND CARE	-2, 416, 909	706, 699		91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	-10,029	700, 099		92.00
92. 01 09201 OBSERVATION BEDS (DISTINCT PART)	0	1, 624, 252		92. 01
OTHER REIMBURSABLE COST CENTERS	·	., 52 1, 252		1
95. 00 09500 AMBULANCE SERVI CES	-33, 750	2, 719, 055		95. 00
101. 00 10100 HOME HEALTH AGENCY	-1, 403	4, 423, 820		101. 00
SPECIAL PURPOSE COST CENTERS	, , , , ,	, . = •]
113.00 11300 I NTEREST EXPENSE	-3, 891, 961	0		113. 00
116. 00 11600 HOSPI CE	0	4, 855, 042		116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	-38, 420, 757	293, 173, 576		118. 00
NONREI MBURSABLE COST CENTERS				
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	155, 397	·	190. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	19, 475, 619		192. 00
194. 00 07950 MOB	0	0	1	194. 00
194. 01 07951 LI FELI NE	0	0	l .	194. 01
194. 02 07952 PATI ENT TRANSPORT	1 0	0	1	194. 02

Health Financial Systems	FRANCISCAN HEAL	TH LAFAYETTE	In Lieu	u of Form CMS-2	552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE	OF EXPENSES	Provider CCN: 1!	From 01/01/2021 To 12/31/2021	Worksheet A Date/Time Prep 5/2/2022 3:08	
Cost Center Description	Adiustments	Net Expenses		3/2/2022 3.00	DIII
cost center bescription	Auj us tilierits	Net Expenses			

			37272022 3.00	PIII
Cost Center Description	Adjustments	Net Expenses		
	(See A-8)	For Allocation		
	6.00	7.00		
194. 03 07954 OTHER NONREIMBURSABLE COST CENTERS	0	0		194. 03
200.00 TOTAL (SUM OF LINES 118 through 199)	-38, 420, 757	312, 804, 592		200. 00

Health Financial Systems RECLASSIFICATIONS | Peri od: | From 01/01/2021 | To 12/31/2021 | Worksheet A-6 | To 12/31/2021 | Date/Time Prepared: | 5/2/2022 3:08 pm Provider CCN: 15-0109

					10 12/31/2021	5/2/2022 3: 08 pm	_
		Increases					
	Cost Center	Li ne #	Salary	Other			
	2.00 A - RENTALS	3.00	4. 00	5. 00			
1. 00	CAP REL COSTS-BLDG & FIXT	1. 00	ol	2, 338, 943		1.00	Λ
2. 00	ON REE GOOTS BEBG & TTXT	0.00	o	0		2. 00	
3.00		0.00	o	Ö		3.00	
4.00		0.00	O	0		4. 00	
5.00		0.00	0	0		5. 00	O
7.00		0.00	0	0		7. 00	C
8.00		0.00	0	0		8. 00	
9. 00		0.00	0	0		9. 00	
10. 00		0.00	•	0		10.00)
	D FOLLI DMENT DENTAL		0	2, 338, 943			
1. 00	B - EQUIPMENT RENTAL CAP REL COSTS-MVBLE EQUIP	2.00	ol	867, 796		1. 00	Λ
2. 00	CENTRAL SERVICES & SUPPLY	14. 00	o	973		2. 00	
3.00	CT SCAN	57. 00	o	8, 400		3.00	
4.00		0.00	O	0		4. 00	
6.00		0.00	0	0		6. 00	O
7.00		0.00	0	0		7. 00	Э
8.00		0. 00	0	0		8. 00	
9. 00		0.00	0	0		9. 00	
11.00		0.00	0	0		11. 00	
12.00		0.00	0	0		12.00	
13. 00 15. 00		0. 00 0. 00	0	0		13. 00 15. 00	
16. 00		0.00	0	0		16. 00	
17. 00		0.00	0	0		17. 00	
18. 00		0.00	o	Ö		18. 00	
19.00		0.00	O	0		19. 00	
	0			877, 169			
	C - MEDICAL SUPPLIES						
1. 00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	13, 913, 182		1. 00	J
2 00	PATI ENT	72.00		10 000 000		2.00	^
2. 00	IMPL. DEV. CHARGED TO PATIENTS	72. 00	0	10, 088, 028		2. 00	J
3. 00	DRUGS CHARGED TO PATIENTS	73. 00	o	12, 612, 838		3. 00	Λ
4. 00	NURSING ADMINISTRATION	13. 00	Ö	4, 108		4. 00	
5. 00		0.00	o	0		5. 00	
6.00		0.00	0	0		6. 00	
7.00		0.00	0	0		7. 00	J
8.00		0.00	0	0		8. 00	Э
9. 00		0. 00	0	0		9. 00	
10.00		0.00	0	0		10.00	
11. 00		0.00	0	0		11.00	
12. 00 13. 00		0. 00 0. 00	0	0		12. 00 13. 00	
14. 00		0.00	0	0		14. 00	
15. 00		0.00	Ö	0		15. 00	
16. 00		0.00	o	0		16. 00	
17.00		0.00	0	0		17. 00	
18.00		0.00	0	0		18. 00	O
19. 00		0.00	0	0		19. 00	
20.00		0.00	0	0		20. 00	
21.00		0.00	0	0		21. 00	
22. 00		0.00	0	0		22. 00	
23. 00 24. 00	•	0. 00 0. 00	0	0		23. 00 24. 00	
25. 00		0.00	0	0		25. 00	
26. 00		0.00	Ö	o		26. 00	
27. 00		0.00	o	Ö		27. 00	
28.00		0.00	0	0		28. 00	
29.00		0.00	0	0		29. 00	O
30.00		0.00	0	0		30.00	
31.00		0.00	0	0		31.00	
32.00		0.00	0	0		32. 00	
33. 00			•	0		33. 00	J
	U LDDD		0	36, 618, 156	 		
1. 00	E - LDRP NURSERY	43.00	651, 072	99, 921		1.00	n
2.00	DELIVERY ROOM & LABOR ROOM	52.00	2, 934, 207	450, 319		2.00	
2.00	0		3, 585, 279	550, 240		2.00	,
	F - CAFETERIA		-, 555, 277	333, 210			
1.00	CAFETERI A	11. 00	974, 278	670, 998		1. 00)
			974, 278	670, 998			

Peri od: From 01/01/2021 To 12/31/2021

Date/Time Prepared: 5/2/2022 3:08 pm

		Increases			5/2/2022 3: 08	IIII
	Cost Center	Li ne #	Sal ary	Other		
	2.00 G - CAPITAL EXP (INT & DEP)	3.00	4. 00	5. 00		
1. 00	CAP REL COSTS-MVBLE EQUIP	2. 00	0	18, 104, 969		1.00
2.00	NEE	0.00	Ö	0		2. 00
3.00		0. 00	0	0		3. 00
4.00		0.00	0	0		4. 00
5. 00 6. 00		0. 00 0. 00	0	0		5. 00 6. 00
7. 00		0.00	o	0		7. 00
8.00		0. 00	0	0		8. 00
9.00		0.00	0	0		9. 00
10. 00 11. 00		0. 00 0. 00	0	0		10.00
12. 00		0.00	0	0		12.00
13. 00		0.00	Ö	Ō		13. 00
14. 00		0. 00	0	0		14. 00
15. 00		0.00	0	0		15. 00
16. 00 17. 00		0. 00 0. 00	0	0		16. 00 17. 00
18. 00		0.00	Ö	Ö		18. 00
19. 00		0. 00	0	0		19. 00
20.00		0.00	0	0		20.00
21. 00 22. 00		0. 00 0. 00	0	0		21. 00 22. 00
23. 00		0.00	o	Ö		23. 00
24.00		0. 00	0	0		24. 00
25. 00		0.00	0	0		25. 00
26. 00 27. 00		0. 00 0. 00	0	0		26. 00 27. 00
28. 00		0.00	o	0		28. 00
29. 00		0.00	0	0		29. 00
30.00		0.00	0	0		30.00
31. 00 32. 00		0. 00 0. 00	0	0		31. 00 32. 00
33. 00		0.00	0	0		33. 00
34.00		0.00	0	0		34.00
35. 00		0. 00	0	0		35. 00
36. 00 37. 00		0. 00 0. 00	0	0		36. 00 37. 00
38. 00		0.00	0	0		38. 00
39. 00		0.00	ō	0		39. 00
40. 00		0. 00	0	0		40. 00
41. 00 42. 00		0. 00 0. 00	0	0		41. 00 42. 00
43. 00		0.00	0	0		43. 00
44. 00		0.00	ō	0		44. 00
45. 00		0. 00	0	0		45. 00
46. 00 47. 00		0. 00 0. 00	0	0		46. 00 47. 00
48. 00		0.00	0	0		48. 00
10.00	0			18, 104, 969] .0.00
4 00	H - INTEREST			0.504.440		1
	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP	1. 00 2. 00	0	3, 591, 410 <u>1, 079, 7</u> 57		1.00
2.00	0		— — —	4, 671, 167		2.00
	I - NURSING SCHOOL		-1			1
	NURSING PROGRAM	20.00	174, 447	122, 510		1.00
2. 00 3. 00		0. 00 0. 00	0	0		2. 00 3. 00
3.00			174, 447	122, 510		3.00
	J - PARAMED PROGRAM					1
	PHARMACY RESIDENCY	23. 00	75, 317	96, 750		1.00
2. 00 3. 00	EMS EDUCATION	23. 01 0. 00	153, 700	0		2. 00 3. 00
3.00			229, 017	96, 750		3.00
	K - FSEH SHARED SERVICES					1
	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	100, 409		1.00
2. 00	OTHER ADMINISTRATIVE AND GENERAL	5. 06	0	907, 204		2. 00
3. 00	NURSING ADMINISTRATION	13. 00	o	449, 266		3. 00
4. 00	PHARMACY	15. 00	0	1 <u>9, 5</u> 72		4. 00
F00 05	O Constant		0	1, 476, 451		F00 00
500.00	Grand Total: Increases	I	4, 963, 021	65, 527, 353		500.00

	Financial Systems	F	RANCISCAN HEAL	LTH_LAFAYETTE			f Form CMS-2552-10
RECLAS	SI FI CATI ONS			Provi der (Peri od: Wo From 01/01/2021	rksheet A-6
						To 12/31/2021 Da	te/Time Prepared:
		Decreases				5/	72/2022 3:08 pm
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.		
	6.00	7. 00	8. 00	9. 00	10. 00		
1. 00	A - RENTALS EMPLOYEE BENEFITS DEPARTMENT	4.00	ol	50, 359	10	<u> </u>	1.00
2. 00	OTHER ADMINISTRATIVE AND	5. 06	0	136, 196			2.00
	GENERAL		1	,			
3.00	DI ETARY	10.00	0	54, 074			3. 00
4. 00 5. 00	ADULTS & PEDIATRICS RADIOLOGY-DIAGNOSTIC	30. 00 54. 00	0	289, 195 757, 401	()	4. 00 5. 00
7. 00	PHYSI CAL THERAPY	66.00	0	660, 600)	7. 00
8. 00	EMERGENCY	91.00	Ö	153, 583			8. 00
9.00	OBSERVATION BEDS (DISTINCT	92. 01	0	217, 963	(9. 00
10.00	PART)	05.00		10 570			10.00
10. 00	AMBULANCE SERVICES	95.00	0	1 <u>9, 5</u> 72 2, 338, 943		<u>)</u>	10. 00
	B - EQUIPMENT RENTAL		<u> </u>	2, 330, 743			
1.00	OTHER ADMINISTRATIVE AND	5. 06	0	611, 369	10		1. 00
	GENERAL						
2.00	OPERATION OF PLANT	7. 00 9. 00	0	2, 008		1	2.00
3. 00 4. 00	HOUSEKEEPI NG NURSI NG ADMI NI STRATI ON	13. 00	0	9, 515 2, 117))	3. 00 4. 00
6. 00	ADULTS & PEDIATRICS	30.00	o	15, 164			6. 00
7.00	OPERATING ROOM	50.00	О	34, 200			7. 00
8. 00	RADI OLOGY-DI AGNOSTI C	54.00	0	27, 363			8. 00
9.00	RADI OI SOTOPE RESPI RATORY THERAPY	56.00	0	10, 500			9.00
11. 00 12. 00	PHYSICAL THERAPY	65. 00 66. 00	0	49, 225 47, 979))	12.00
13. 00	ELECTROENCEPHALOGRAPHY	70.00	o	2, 967			13. 00
15.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	26, 876			15. 00
16.00	PURCHASI NG	5. 03	0	1, 019			16. 00
17. 00	MGMT INFO SYSTEMS	5. 02	0	22, 310			17. 00
18. 00 19. 00	LAUNDRY & LINEN SERVICE NEONATAL INTENSIVE CARE UNIT	8. 00 35. 00	0	14, 377 180))	18. 00 19. 00
17.00	0						17.00
	C - MEDICAL SUPPLIES						
1.00	DADI OI COTODE	0.00	0	0			1.00
2. 00 3. 00	RADI OI SOTOPE	56. 00 0. 00	0	6			2. 00 3. 00
4. 00	CENTRAL SERVICES & SUPPLY	14.00	o	350, 734			4. 00
5.00	PHARMACY	15.00	0	273, 629			5. 00
6.00	ADULTS & PEDIATRICS	30.00	0	1, 970, 740			6. 00
7.00	INTENSIVE CARE UNIT	31.00	0	465, 087			7. 00
8. 00 9. 00	NEONATAL INTENSIVE CARE UNIT SUBPROVIDER - IRF	35. 00 41. 00	0	137, 233 51, 520			8. 00 9. 00
10.00	OPERATING ROOM	50.00	Ö	17, 705, 252			10.00
11. 00	RECOVERY ROOM	51.00	0	23, 874	(11. 00
12.00	RADI OLOGY-DI AGNOSTI C	54.00	0	2, 127, 863			12. 00
13. 00 14. 00	RADI OLOGY - THERAPEUTI C CARDI AC CATH LAB	55. 00 56. 01	0	11, 153 3, 717, 435) 	13. 00 14. 00
15. 00	CT SCAN	57.00	0	3, 717, 435 173, 822))	15. 00
16. 00	MRI	58.00	o	40, 414			16. 00
17.00	LABORATORY	60.00	0	111, 270			17. 00
18. 00	RESPI RATORY THERAPY	65. 00	0	739, 900			18. 00
19.00	PHYSICAL THERAPY	66.00	0	311, 956			19. 00
20. 00 21. 00	OCCUPATIONAL THERAPY SPEECH PATHOLOGY	67. 00 68. 00	0	24, 318 3, 581) 	20. 00 21. 00
22. 00	ELECTROCARDI OLOGY	69.00	Ö	50, 196			22. 00
23. 00	ELECTROENCEPHALOGRAPHY	70.00	0	76, 317			23. 00
24. 00	DI ABETES CENTER	73. 01	0	623			24. 00
25. 00	RENAL DI ALYSI S	74.00	0	20, 114			25. 00
26. 00 27. 00	CLINIC EMERGENCY	90. 00 91. 00	0	27, 528 1, 233, 262			26. 00 27. 00
28. 00	WOUND CARE	91. 01	0	1, 233, 202 2, 490		<u> </u>	28. 00
29. 00	OBSERVATION BEDS (DISTINCT	92. 01	o	89, 243			29. 00
00 ==	PART)			40			
30.00	AMBULANCE SERVICES	95. 00 76. 00	0	131, 891		ון	30.00
31. 00 32. 00	ONCOLOGY ANTI COAGULATI ON	76. 00 76. 01	0	6, 557, 616 29) 	31. 00 32. 00
33. 00	INFUSION SERVICES	76. 02	ol	189, 060		5	33.00
	0 — — — — —		0	36, 618, 156			
1 00	E - LDRP	22.22	2 505 235	FF0 0:5		\	4.5=
1. 00 2. 00	ADULTS & PEDIATRICS	30. 00 0. 00	3, 585, 279	550, 240	(ן ו	1.00
2.00	0 — — — — —	— 	3, 585, 279	550, 240	 	1	2.00
	1	i I	.,, -, /	220,210	ı	1	ı

Heal th	Financial Systems		FRANCISCAN HEAI	LTH_LAFAYETTE		In Lie	u of Form CMS-2552-10
RECLAS	SI FI CATI ONS			Provi der	CCN: 15-0109	Peri od: From 01/01/2021	Worksheet A-6
						To 12/31/2021	Date/Time Prepared:
		Decreases					5/2/2022 3:08 pm
	Cost Center	Li ne #	Salary	Other	Wkst. A-7 Ref.	.	
	6.00	7. 00	8.00	9. 00	10.00		
	F - CAFETERIA				_1	_	
1. 00	DI ETARY		97 <u>4, 278</u> 974, 278	67 <u>0, 9</u> 98 670, 998		0	1.00
	G - CAPITAL EXP (INT & DEP)		774, 270	070, 990	5		
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	70, 42	5	9	1.00
2.00	COMMUNI CATI ONS	5. 01	0	67		0	2. 00
3.00	MGMT INFO SYSTEMS	5. 02	0	325, 78		0	3.00
4. 00 5. 00	PURCHASI NG ADMI TTI NG	5. 03 5. 04	0	56, 28 930		0 0	4. 00 5. 00
6. 00	OTHER ADMINISTRATIVE AND	5. 06	0	3, 593, 480	-	0	6. 00
0.00	GENERAL	3.33		0,0,0,			0.00
7.00	OPERATION OF PLANT	7. 00	0	7, 018, 39		0	7. 00
8.00	LAUNDRY & LINEN SERVICE	8. 00	0	1, 54		0	8. 00
9. 00 10. 00	HOUSEKEEPI NG DI ETARY	9.00	0	34, 99		0	9. 00 10. 00
11. 00	NURSING ADMINISTRATION	10. 00 13. 00	0	153, 79, 285, 35		0	11. 00
12. 00	CENTRAL SERVICES & SUPPLY	14. 00	o	53, 19		0	12. 00
13.00	PHARMACY	15. 00	0	6, 720		0	13. 00
14.00	MEDICAL RECORDS & LIBRARY	16. 00	0	188		0	14. 00
15. 00	NURSI NG PROGRAM	20.00	0	656, 90		0	15.00
16.00	EMS EDUCATION	23. 01 30. 00	0	8, 69	-	0 0	16.00
17. 00 18. 00	ADULTS & PEDIATRICS INTENSIVE CARE UNIT	31.00	0	516, 94 ⁹ 314, 21		0	17. 00 18. 00
19. 00	NEONATAL INTENSIVE CARE UNIT	35. 00	o	78, 32		0	19. 00
20.00	SUBPROVI DER - I RF	41.00	O	90, 64		0	20. 00
21.00	OPERATING ROOM	50.00	0	1, 386, 00		0	21. 00
22. 00	RECOVERY ROOM	51. 00	0	60		0	22. 00
23. 00	RADI OLOGY - DI AGNOSTI C	54.00	0	1, 208, 41		0	23.00
24. 00 25. 00	RADI OLOGY - THERAPEUTI C RADI OI SOTOPE	55. 00 56. 00	0	72, 18: 5, 35		0	24. 00 25. 00
26. 00	CARDI AC CATH LAB	56. 01	o	494, 08		0	26. 00
27.00	CT SCAN	57. 00	0	37, 76		0	27. 00
28. 00	MRI	58. 00	0	160, 26		0	28. 00
29. 00	LABORATORY	60.00	0	56, 73	-	0	29. 00
30. 00 31. 00	RESPIRATORY THERAPY PHYSICAL THERAPY	65. 00 66. 00	0	189, 96 ⁻ 391, 16		0	30. 00 31. 00
32.00	OCCUPATIONAL THERAPY	67. 00	0	10, 61		0	32.00
33. 00	SPEECH PATHOLOGY	68. 00	Ö	18, 50		0	33. 00
34.00	ELECTROCARDI OLOGY	69. 00	0	114, 93		0	34.00
35.00	ELECTROENCEPHALOGRAPHY	70. 00	0	38, 17		0	35. 00
36. 00	DI ABETES CENTER	73. 01	0	298		0	36.00
37. 00 38. 00	RENAL DI ALYSI S ONCOLOGY	74. 00 76. 00	0	38: 148, 91:		0	37. 00 38. 00
39. 00	ANTI COAGULATI ON	76. 00 76. 01	0	7, 37		0	39. 00
40. 00	CLINIC	90.00	Ö	26		o	40.00
41.00	EMERGENCY	91. 00	0	211, 70	3	0	41.00
42. 00	WOUND CARE	91. 01	0	3, 00		0	42. 00
43. 00	OBSERVATION BEDS (DISTINCT	92. 01	0	7, 71	6	0	43. 00
44. 00	PART) AMBULANCE SERVICES	95. 00	o	227, 06	4	o	44. 00
45. 00	HOME HEALTH AGENCY	101.00	ol o	12, 62		o O	45. 00
46.00	HOSPI CE	116. 00	0	15, 65		0	46. 00
47. 00	GIFT, FLOWER, COFFEE SHOP &	190.00	0	5, 37	6	0	47. 00
49.00	CANTEEN PHYSICIANS' PRIVATE OFFICES	102.00	0	12, 87			49.00
48. 00	0	1 <u>92.</u> 00	}	1 <u>2, 8</u> 7.		0	48. 00
	H - INTEREST		<u> </u>	10, 101, 70	,		
1.00	INTEREST EXPENSE	113. 00	0	4, 671, 16			1. 00
2.00		0.00_	•		<u> </u>	1	2. 00
	O NITIDET NO. SCHOOL		0	4, 671, 16	/		
1. 00	I - NURSING SCHOOL ADULTS & PEDIATRICS	30.00	96, 956	-) (0	1.00
2. 00	OTHER ADMINISTRATIVE AND	5. 06	36, 323	4, 18		0	2.00
	GENERAL			.,			
3.00	MEDICAL RECORDS & LIBRARY	<u> </u>	41, 168	11 <u>8, 3</u> 2		0	3. 00
	U - PARAMED PROGRAM		174, 447	122, 510	U _I		
1. 00	PHARMACY	15. 00	75, 317	96, 75		0	1.00
2. 00	EMERGENCY	91.00	84, 699			0	2.00
3.00	AMBULANCE SERVICES	<u>95.</u> 00	69, 001	(Ō	3. 00
	0		229, 017	96, 75	D		

Heal th Financial Systems FRANCISCAN HEALTH LAFAYETTE In Lieu of Form CMS-2552-10
RECLASSIFICATIONS Provider CCN: 15-0109 From 01/01/2021 To 12/31/2021 Date/Time Prepared:

							12/01/2021	5/2/2022 3: 08	
		Decreases							
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref	<u>.</u>			
	6. 00	7. 00	8. 00	9. 00	10.00				
	K - FSEH SHARED SERVICES								
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	100, 409	(0			1.00
2.00	OTHER ADMINISTRATIVE AND	5. 06	907, 204	()	0			2. 00
	GENERAL								
3.00	NURSING ADMINISTRATION	13. 00	449, 266	(0			3. 00
4.00	PHARMACY	1500	19, 572	() (O			4. 00
	0		1, 476, 451	(
500.00	Grand Total: Decreases		6, 439, 472	64, 050, 902	2				500.00

				10	12/31/2021	5/2/2022 3:08	
				Acqui si ti ons		0, 2, 2022 0. 00	J
		Begi nni ng	Purchases	Donati on	Total	Di sposal s and	
		Bal ances				Retirements	
		1.00	2.00	3.00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	Γ BALANCES					
1.00	Land	12, 770, 293	0	0	0	29, 000	1. 00
2.00	Land Improvements	4, 407, 894	461, 103		461, 103	0	2. 00
3.00	Buildings and Fixtures	289, 378, 578	1, 548, 750		1, 548, 750		3. 00
4.00	Building Improvements	4, 917, 938	274, 549	0	274, 549	0	4. 00
5.00	Fi xed Equipment	0	0	0	0	0	5. 00
6.00	Movable Equipment	86, 355, 430	8, 356, 387	0	8, 356, 387	388, 879	6. 00
7.00	HIT designated Assets	0	0	0	0	0	7. 00
8.00	Subtotal (sum of lines 1-7)	397, 830, 133	10, 640, 789	0	10, 640, 789	417, 879	8. 00
9.00	Reconciling Items	0	0	0	0	0	9. 00
10.00	Total (line 8 minus line 9)	397, 830, 133	10, 640, 789	0	10, 640, 789	417, 879	10.00
		Endi ng Bal ance	Fully				
			Depreci ated				
			Assets				
	DART I ANALYGIC OF GUANGES IN CARLTAL ACCE	6.00	7. 00				
4 00	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET		0				4 00
1.00	Land	12, 741, 293	0				1.00
2.00	Land Improvements	4, 868, 997	0				2.00
3.00	Buildings and Fixtures	290, 927, 328	0				3.00
4.00	Building Improvements	5, 192, 487	0				4.00
5.00	Fi xed Equi pment	04 222 020	0				5. 00
6.00	Movable Equipment	94, 322, 938	0				6. 00
7.00	HIT designated Assets	400 052 042	0				7. 00
8.00	Subtotal (sum of lines 1-7)	408, 053, 043	0				8. 00
9.00	Reconciling Items	400 053 043	0				9.00
10. 00	Total (line 8 minus line 9)	408, 053, 043	0	l			10. 00

Heal th	Financial Systems	FRANCISCAN HEAL	TH LAFAYETTE		In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS			Provider CC	CN: 15-0109	Peri od: From 01/01/2021 To 12/31/2021	Worksheet A-7	pared:
			SL	JMMARY OF CAP	PITAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)		
		9. 00	10.00	11. 00	12.00	13. 00	
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	SHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	3, 828, 823	0		0 0	0	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		0 0	0	2. 00
3.00	Total (sum of lines 1-2)	3, 828, 823	0		0 0	0	3. 00
		SUMMARY O	F CAPITAL				
	Cost Center Description	Other	Total (1) (sum				
	·	Capi tal -Relate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14.00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	3, 828, 823				1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2. 00
	1 - 1 - (I .		,	

0 0 0

3, 828, 823

1. 00 2. 00 3. 00

3.00 Total (sum of lines 1-2)

Heal th	n Financial Systems	FRANCISCAN HEAI	LTH LAFAYETTE		In Lie	eu of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		F		Period: From 01/01/2021 To 12/31/2021	Worksheet A-7 Part III Date/Time Pre 5/2/2022 3:08	pared:
		COMI	PUTATION OF RAT	TIOS	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets		Insurance	
			Leases	for Ratio	instructions)		
				(col . 1 - col 2)			
		1. 00	2.00	3.00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS CI						
1.00	CAP REL COSTS-BLDG & FLXT	313, 730, 105	0				1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	94, 322, 938		94, 322, 93			2. 00
3.00	Total (sum of lines 1-2)	408, 053, 043		408, 053, 04			3. 00
		ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITAL					
	Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
			Capi tal -Relate				
			d Costs	through 7)	0.00	10.00	
	DART III DECONOLILIATION OF CARLTAL COSTS OF	6. 00	7. 00	8. 00	9. 00	10.00	
1. 00	PART III - RECONCILIATION OF CAPITAL COSTS CI	ENTERS		ı	0 4, 054, 313	2, 338, 943	1. 00
2.00	CAP REL COSTS-BEDG & TTXT	0			0 20, 892, 671		2.00
3.00	Total (sum of lines 1-2)	0			0 24, 946, 984		3. 00
0.00	Total (Sam of Triles 1 2)	J	SI	JMMARY OF CAPI		0,200,707	0.00
	Cost Center Description	Interest	Insurance (see			Total (2) (sum	
			instructions)	instructions)			
					d Costs (see	through 14)	
		11.00	12.00	12.00	instructions)	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CI	11.00	12.00	13.00	14. 00	15. 00	
1. 00	CAP REL COSTS-BLDG & FIXT	3, 591, 410	0		0 0	9, 984, 666	1. 00
2.00	CAP REL COSTS-BEDG & TTXT	1, 079, 757		1	0 0		2.00
3.00	Total (sum of lines 1-2)	4, 671, 167		1	o o	,,	
2.00	[., 0, ., .0,	1	1	-1	1, 02 1, 0, 0	00

				T	o 12/31/2021	Date/Time Prep	
				Expense Classification on		5/2/2022 3: 08	piii
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center		Wkst. A-7 Ref.	
1. 00	Investment income - CAP REL	1.00	2.00	3.00 CAP REL COSTS-BLDG & FIXT	4. 00	5. 00 0	1. 00
2. 00	COSTS-BLDG & FIXT (chapter 2) Investment income - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2. 00
	COSTS-MVBLE EQUIP (chapter 2)		0	CAP REE COSTS-WVBEE EQUIP			
3.00	Investment income - other (chapter 2)		0		0. 00	0	3. 00
4.00	Trade, quantity, and time		0		0.00	0	4. 00
5. 00	di scounts (chapter 8) Refunds and rebates of		0		0. 00	0	5. 00
6. 00	expenses (chapter 8) Rental of provider space by		0		0.00	0	6. 00
	suppliers (chapter 8)		0				
7. 00	Telephone services (pay stations excluded) (chapter		0		0. 00	0	7. 00
	21)						
8. 00	Television and radio service (chapter 21)		0		0.00	0	8. 00
9. 00 10. 00	Parking Lot (chapter 21) Provider-based physician	A-8-2	-8, 760, 253		0.00	0	9. 00 10. 00
	adj ustment	A-0-2	-0, 700, 253			J	
11. 00	Sale of scrap, waste, etc. (chapter 23)		0		0. 00	0	11. 00
12. 00	Related organization	A-8-1	-4, 261, 149			0	12. 00
13. 00	transactions (chapter 10) Laundry and Linen service		0		0.00	0	13. 00
14.00	Cafeteria-employees and guests		-1, 235, 931	CAFETERI A	11.00	0	
15. 00	Rental of quarters to employee and others		Ü		0.00	0	15. 00
16. 00	Sale of medical and surgical supplies to other than		0		0.00	0	16. 00
	pati ents						
17. 00	Sale of drugs to other than patients		0		0.00	0	17. 00
18. 00	Sale of medical records and	В	-2, 746	MEDICAL RECORDS & LIBRARY	16. 00	0	18. 00
19. 00	abstracts Nursing and allied health	В	-2, 558, 527	NURSING PROGRAM	20. 00	0	19. 00
	education (tuition, fees, books, etc.)						
19. 01	Nursing and allied health	В	-15, 441	EMS EDUCATION	23. 01	0	19. 01
	education (tuition, fees, books, etc.)						
20.00	Vending machines	В	0	DI ETARY	10.00	0	20.00
21. 00	Income from imposition of interest, finance or penalty		U		0.00	0	21. 00
22. 00	charges (chapter 21) Interest expense on Medicare		0		0.00	0	22. 00
22.00	overpayments and borrowings to		0		0.00	J	22.00
23. 00	repay Medicare overpayments Adjustment for respiratory	A-8-3	0	RESPI RATORY THERAPY	65. 00		23. 00
	therapy costs in excess of limitation (chapter 14)						
24. 00	Adjustment for physical	A-8-3	0	PHYSICAL THERAPY	66. 00		24. 00
	therapy costs in excess of limitation (chapter 14)						
25. 00	Utilization review -		0	*** Cost Center Deleted ***	114. 00		25. 00
	physicians' compensation (chapter 21)						
26. 00	Depreciation - CAP REL COSTS-BLDG & FLXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26. 00
27. 00	Depreciation - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	27. 00
28. 00	COSTS-MVBLE EQUIP Non-physician Anesthetist		0	*** Cost Center Deleted ***	19. 00		28. 00
29. 00	Physicians' assistant	1 400	0		0.00	0	29. 00 30. 00
30. 00	Adjustment for occupational therapy costs in excess of	A-8-3	0	OCCUPATI ONAL THERAPY	67.00		30.00
30. 99	limitation (chapter 14) Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30.00		30. 99
	instructions)						
31. 00	Adjustment for speech pathology costs in excess of	A-8-3	0	SPEECH PATHOLOGY	68. 00		31. 00
	limitation (chapter 14)						

Health Financial Systems
ADJUSTMENTS TO EXPENSES In Lieu of Form CMS-2552-10
Worksheet A-8 Provider CCN: 15-0109 | Peri od: | From 01/01/2021 | To 12/31/2021 | Date/Ti me Prepared:

				To	12/31/2021	Date/Time Prep 5/2/2022 3:08	
				Expense Classification on To/From Which the Amount is 1			
				10/11 oiii will cit the Amount 15 i	.o be Aujusteu		
	Cost Center Description	Basi s/Code (2) 1.00	Amount 2.00	Cost Center 3.00	Li ne # 4.00	Wkst. A-7 Ref. 5.00	
32. 00	CAH HIT Adjustment for	11.00	0		0.00	0	32. 00
33. 00	Depreciation and Interest RECRUITMENT	А	0	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	33. 00
33. 01	RECRUI TMENT	A		OTHER ADMINISTRATIVE AND	5. 06	Ö	33. 01
34. 00	HAF	А	-18. 794. 484	GENERAL OTHER ADMINISTRATIVE AND	5. 06	0	34. 00
				GENERAL		_	
35. 00	ADVERTI SI NG	A	-14/	OTHER ADMINISTRATIVE AND GENERAL	5. 06	0	35. 00
35. 01	ADVERTI SI NG	A		NURSING PROGRAM	20.00	0	35. 01
35. 02 35. 03	ADVERTI SING	A A		ADULTS & PEDIATRICS RESPIRATORY THERAPY	30. 00 65. 00	0	35. 02 35. 03
35. 03	ADVERTI SI NG ADVERTI SI NG	A		PHYSICAL THERAPY	66. 00	0	35. 03
35. 05	ADVERTI SI NG	A		OCCUPATI ONAL THERAPY	67. 00	Ö	35. 05
35. 06	ADVERTI SI NG	A		SPEECH PATHOLOGY	68. 00	0	35. 06
35. 07	ADVERTI SI NG	A		ELECTROCARDI OLOGY	69.00	0	35. 07
35. 08	ADVERTI SI NG	A	-3, 596	ONCOLOGY	76. 00	0	35. 08
35. 09	ADVERTI SI NG	A		WOUND CARE	91. 01	0	35. 09
35. 10	ADVERTI SI NG	Α		HOME HEALTH AGENCY	101. 00	0	35. 10
36. 00	ATHLETIC TRAINING	В		PHYSI CAL THERAPY	66.00	0	36. 00
37. 00	BLDG RENT	В	0	OTHER ADMINISTRATIVE AND GENERAL	5. 06	0	37. 00
38. 00	DI SCOUNTS / REBATES	В	-1. 067. 126	PURCHASI NG	5. 03	0	38. 00
38. 01	DI SCOUNTS / REBATES	В		PATIENT ACCOUNTING	5. 05	0	38. 01
38. 02	DI SCOUNTS / REBATES	В	-152, 459	OTHER ADMINISTRATIVE AND	5. 06	0	38. 02
00.00	DI COCUNTO / DEDATEC			GENERAL	40.00		00.00
38. 03	DI SCOUNTS / REBATES	В		DI ETARY	10.00	0	38. 03
38. 04 38. 05	DI SCOUNTS / REBATES DI SCOUNTS / REBATES	B B		DRUGS CHARGED TO PATIENTS OPERATING ROOM	73. 00 50. 00	0	38. 04 38. 05
38. 06	DI SCOUNTS / REBATES	В		RADI OLOGY-DI AGNOSTI C	54.00	0	38. 06
38. 07	DI SCOUNTS / REBATES	В		LABORATORY	60.00	ő	38. 07
38. 08	DI SCOUNTS / REBATES	В		RESPI RATORY THERAPY	65. 00	Ö	38. 08
39. 00	EDUCATI ON	В		PHARMACY RESIDENCY	23.00	0	39. 00
40.00	FOOD SERVICE DAY CARE	В	0	DI ETARY	10. 00	0	40.00
41. 00	MARKETING	A	0	OTHER ADMINISTRATIVE AND	5. 06	0	41. 00
41. 02	MARKETI NG	А	0	GENERAL ADULTS & PEDIATRICS	30.00	0	41. 02
41. 05	MARKETING	A		PHYSI CAL THERAPY	66.00	o	41. 05
41. 06	MARKETI NG	A		OCCUPATI ONAL THERAPY	67. 00	0	41. 06
41. 07	MARKETI NG	A	0	SPEECH PATHOLOGY	68. 00	0	41. 07
41. 08	MARKETI NG	A	0	ELECTROCARDI OLOGY	69. 00	0	41. 08
41. 09	MARKETI NG	A		DI ABETES CENTER	73. 01	0	41. 09
	MARKETI NG	A		WOUND CARE	91. 01	0	
	MARKETI NG	A		HOME HEALTH AGENCY	101.00	0	
42. 00	MI SCELLANEOUS REVENUE	B B		MGMT INFO SYSTEMS	5. 02	0	42.00
42. 01	MI SCELLANEOUS REVENUE	D		OTHER ADMINISTRATIVE AND GENERAL	5. 06		42. 01
42. 02	MI SCELLANEOUS REVENUE	В		OPERATION OF PLANT	7. 00	0	42. 02
42. 03	MI SCELLANEOUS REVENUE	В		HOUSEKEEPI NG	9. 00	0	42. 03
42.04	MI SCELLANEOUS REVENUE	В		CAFETERI A	11. 00	0	42. 04
42. 05	MI SCELLANEOUS REVENUE	В		NURSING ADMINISTRATION	13. 00	0	42. 05
42. 06	MI SCELLANEOUS REVENUE	В		PHARMACY	15. 00	0	42.06
42. 07	MI SCELLANEOUS REVENUE	В		ADULTS & PEDIATRICS	30.00	0	42. 07
42. 08	MI SCELLANEOUS REVENUE MI SCELLANEOUS REVENUE	B B		OPERATING ROOM	50. 00 54. 00	0	42. 08
42. 09 42. 10	MI SCELLANEOUS REVENUE	В		RADI OLOGY-DI AGNOSTI C RADI OI SOTOPE	54. 00 56. 00	0	42. 09 42. 10
42. 10	MI SCELLANEOUS REVENUE	В		PHYSI CAL THERAPY	66.00	0	42. 10
42. 12	MI SCELLANEOUS REVENUE	В		OCCUPATI ONAL THERAPY	67. 00	o	42. 12
42. 13	MI SCELLANEOUS REVENUE	В		ELECTROENCEPHALOGRAPHY	70. 00	0	42. 13
42. 14	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	42. 14
	(3)						
42. 15	MI SCELLANEOUS REVENUE	В	-1, 318	HOME HEALTH AGENCY	101.00	0	
42. 16	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0. 00	0	42. 16
43. 00	OTHER ADJUSTMENTS (SPECIFY)		0		0. 00	0	43. 00
44. 00	(3) OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	44. 00
	(3)						

Heal th	Financial Systems	1	FRANCISCAN HEAI	LTH LAFAYETTE	In Lie	eu of Form CMS-2	2552-10
ADJUSTMENTS TO EXPENSES					Peri od:	Worksheet A-8	
					From 01/01/2021 To 12/31/2021	Date/Time Pre 5/2/2022 3:08	
Expen				Expense Classification o	n Worksheet A		
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
		1.00	2. 00	3. 00	4. 00	5. 00	
50. 00	TOTAL (sum of lines 1 thru 49)		-38, 420, 757				50.00
	(Transfer to Worksheet A,						
	column 6, line 200.)						

- (1) Description all chapter references in this column pertain to CMS Pub. 15-1.(2) Basis for adjustment (see instructions).

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

 B. Amount Received if cost cannot be determined.

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME

Provider CCN: 15-0109

Worksheet A-8-1

Peri od: From 01/01/2021 OFFICE COSTS 12/31/2021 Date/Time Prepared:

					5/2/2022 3:08	, pm
	Li ne No.	Cost Center	Expense Items	Amount of	Amount	
			·	Allowable Cost	Included in	
					Wks. A, column	
					5	
	1. 00	2.00	3. 00	4. 00	5. 00	
		MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED OR	GANIZATIONS OR	CLAIMED	
	HOME OFFICE COSTS:					
1. 00	•	l .	HOME OFFICES	225, 490	0	1. 00
2.00	2. 00	CAP REL COSTS-MVBLE EQUIP	HOME OFFICES	2, 787, 702	0	2. 00
3.00	113. 00	INTEREST EXPENSE	INTEREST FA ALLOWCATION	4, 773, 773	8, 665, 734	3.00
3. 01	15. 00	PHARMACY		653, 173	0	3. 01
3.02	16. 00	MEDICAL RECORDS & LIBRARY	HO ALLOCATION	2, 034, 338	0	3. 02
4.00	4. 00	EMPLOYEE BENEFITS DEPARTMENT	HO ALLOCATION	0	5, 045, 383	4.00
4.01	5. 01	COMMUNI CATI ONS	HO ALLOCATION	721, 277	0	4. 01
4.02	5. 02	MGMT INFO SYSTEMS	HO ALLOCATION	2, 540, 253	0	4. 02
4.03	5. 03	PURCHASI NG	HO ALLOCATION	126, 652	0	4.03
4.04	5. 04	ADMITTING	HO ALLOCATION	1, 955	0	4.04
4. 05	5. 05	PATIENT ACCOUNTING	HO ALLOCATION	750, 537	0	4. 05
4.06	5. 06	OTHER ADMINISTRATIVE AND GEN	HO ALLOCATION	36, 330, 215	39, 017, 539	4.06
4.07	4.00	EMPLOYEE BENEFITS DEPARTMENT	FSEH SHARED SERVICES	o	229, 090	4.07
4. 08	5. 06	OTHER ADMINISTRATIVE AND GEN	FSEH SHARED SERVICES	o	1, 609, 766	4. 08
4.09	13. 00	NURSING ADMINISTRATION	FSEH SHARED SERVICES	o	619, 430	4.09
4. 10	15. 00	PHARMACY	FSEH SHARED SERVICES	o	19, 572	4. 10
5.00	TOTALS (sum of lines 1-4).			50, 945, 365	55, 206, 514	5.00
	Transfer column 6, line 5 to					
	Worksheet A-8, column 2,					
	line 12.					
	·	·	·			

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

	· · · · · · · · · · · · · · · · · · ·				
			Related Organization(s) and/	or Home Office	
Symbol (1)	Name	Percentage of	Name	Percentage of	
, , ,		Ownershi p		Ownershi p	
1. 00	2. 00	3. 00	4. 00	5. 00	
B. INTERRELATIONSHIP TO RELAT	ED ORGANIZATION(S) AND/OR HO	ME OFFICE:			

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

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

6.00	В	FRANCISCAN ALLI	100.00 FRANCISCAN 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.

Net Adjustments (col . 4 mi nus col . 5)*
Cod 4 minus Col 5) *
Col 5) *
Costs Incurred And Adjustments Required As A Result Of Transactions With Related Organizations Or Claimed
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS: 1. 00
HOME OFFICE COSTS:
1.00 225, 490 9 2.00 2, 787, 702 9 3.00 -3, 891, 961 11 3.01 653, 173 0 3.02 2, 034, 338 0 4.00 -5, 045, 383 0 4.01 721, 277 0 4.02 2, 540, 253 0 4.03 126, 652 0 4.04 1, 955 0 4.05 750, 537 0
2.00 2,787,702 9 3.00 -3,891,961 11 3.01 653,173 0 3.02 2,034,338 0 4.00 -5,045,383 0 4.01 721,277 0 4.02 2,540,253 0 4.03 126,652 0 4.04 1,955 0 4.05 750,537 0
3.00 -3, 891, 961 11 3.01 653, 173 0 3.02 2, 034, 338 0 4.00 -5, 045, 383 0 4.01 721, 277 0 4.02 2, 540, 253 0 4.03 126, 652 0 4.04 1, 955 0 4.05 750, 537 0
3. 01 653, 173 0 3. 02 2, 034, 338 0 4. 00 -5, 045, 383 0 4. 01 721, 277 0 4. 02 2, 540, 253 0 4. 03 126, 652 0 4. 04 1, 955 0 4. 05 750, 537 0
3. 02 2, 034, 338 0 4. 00 -5, 045, 383 0 4. 01 721, 277 0 4. 02 2, 540, 253 0 4. 03 126, 652 0 4. 04 1, 955 0 4. 05 750, 537 0
4. 00 -5, 045, 383 0 4. 01 721, 277 0 4. 02 2, 540, 253 0 4. 03 126, 652 0 4. 04 1, 955 0 4. 05 750, 537 0
4. 01 721, 277 0 4. 02 2, 540, 253 0 4. 03 126, 652 0 4. 04 1, 955 0 4. 05 750, 537 0
4. 02 2, 540, 253 0 4. 03 126, 652 0 4. 04 1, 955 0 4. 05 750, 537 0 4. 05 4. 05
4. 03 126, 652 0 4. 04 1, 955 0 4. 05 750, 537 0
4. 04 1, 955 0 4. 05 750, 537 0
4. 05 750, 537 0 4. 05
4. 06 -2, 687, 324 0 4. 06
4. 07 -229, 090 0 4. 07
4. 08 -1, 609, 766 0 4. 08
4. 09 -619, 430 0 4. 09
4. 10 -19, 572 0 4. 10
5. 00 -4, 261, 149 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.

 	cordinate i dilaret 27 the dimedite difference of cordinate be find out out in cordinate for this parti-	
Related Organization(s)		
and/or Home Office		
Type of Business		
6. 00		
B. INTERRELATIONSHIP TO RELAT	TED ORGANIZATION(S) AND/OR HOME OFFICE:	

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

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

6.00	HOME OFFICE	6. 00
7.00	SISTER FACILITY	7. 00
8.00		8. 00
9.00		9. 00
9. 00 10. 00		10. 00
100.00		100. 00

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

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 15-0109

Period: Worksheet A-8-2 From 01/01/2021 To 12/31/2021 Date/Time Prepared: 5/2/2022 3:08 pm

						12/01/202	5/2/2022 3: 08	pm pm
	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provi der Component	RCE Amount	Physi ci an/Prov i der Component	
		rdentiffer	Remuner at 1 on	Component	Component		Hours	
	1. 00	2.00	3.00	4. 00	5. 00	6. 00	7. 00	
1.00		ADULTS & PEDIATRICS	663, 250	663, 250		0		1.00
2. 00 3. 00		NEONATAL INTENSIVE CARE UNIT SUBPROVIDER - IRF	784, 474 134, 983	766, 737 134, 983		211, 500 0	1	2. 00 3. 00
4. 00		OPERATING ROOM	574, 865			211, 500	_	4. 00
5. 00		RADI OLOGY-DI AGNOSTI C	29, 493	17, 468		211, 500		5. 00
6. 00		RADI OI SOTOPE	19, 255	13, 630	1	211, 500	1	6. 00
7.00	60.00	LABORATORY	43, 963	3, 500		211, 500	1	7. 00
8.00		RESPI RATORY THERAPY	34, 961	34, 961		0		8. 00
9.00		PHYSI CAL THERAPY	27, 200	27, 200		0	0	9. 00
10. 00 11. 00		ELECTROCARDI OLOGY ELECTROENCEPHALOGRAPHY	2, 170, 405 23, 679	2, 170, 405 23, 679		0	0	10. 00 11. 00
12. 00		DI ABETES CENTER	1, 375	1, 375		0	0	12. 00
13. 00		ANTI COAGULATI ON	5, 818	5, 818		Ö	ő	13. 00
14.00		CLINIC	2, 775	2, 775		0	0	14. 00
15. 00		EMERGENCY	2, 416, 909	2, 416, 909		0	0	15. 00
16. 00		WOUND CARE	15, 000	15, 000		0	0	16. 00
17. 00		AMBULANCE SERVICES	33, 750	33, 750		0	0	17. 00
18. 00	5.06	OTHER ADMINISTRATIVE AND GENERAL	2, 024, 305	1, 783, 250	241, 055	211, 500	1, 648	18. 00
200.00		CENEIVIE	9, 006, 460	8, 611, 167	395, 293		2, 636	200. 00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE	5 Percent of	Cost of	Provi der	Physician Cost	
		I denti fi er	Limit		Memberships &	Component	of Malpractice	
				Limit	Continuing Education	Share of col. 12	Insurance	
	1. 00	2.00	8.00	9. 00	12. 00	13. 00	14.00	
1.00		ADULTS & PEDIATRICS	0	0	0	0		1. 00
2.00		NEONATAL INTENSIVE CARE UNIT	11, 999	600		0		
3.00		SUBPROVI DER - I RF	0 46, 876	0	0	0	0	3. 00
4. 00 5. 00		OPERATING ROOM RADIOLOGY-DIAGNOSTIC	46, 876 9, 457	2, 344 473		0	0	4. 00 5. 00
6. 00		RADI OI SOTOPE	27, 454	1, 373			0	6. 00
7. 00		LABORATORY	4, 677	234		0	Ö	7. 00
8.00	65. 00	RESPI RATORY THERAPY	0	0	0	0	0	8. 00
9.00		PHYSI CAL THERAPY	0	0	0	0	0	
10.00		ELECTROCARDI OLOGY	0	0	0	0	0	10.00
11. 00 12. 00		ELECTROENCEPHALOGRAPHY DI ABETES CENTER	0	0	0	0	0	11. 00 12. 00
13. 00		ANTI COAGULATI ON		0	0		0	13. 00
14. 00		CLINIC	0	Ö	Ö	Ö	ő	14. 00
15. 00		EMERGENCY	0	0	0	0	0	15. 00
16. 00		WOUND CARE	0	0	0	0	0	16. 00
17. 00		AMBULANCE SERVICES	0	0	0	0	0	17. 00
18. 00	5. 06	OTHER ADMINISTRATIVE AND GENERAL	167, 573	8, 379	0	0	0	18. 00
200.00		CENEIVAE	268, 036	13, 403	0	0	0	200. 00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		I denti fi er	Component	Li mi t	Di sal I owance			
			Share of col.					
	1. 00	2.00	14 15. 00	16. 00	17. 00	18. 00	-	
1. 00	30. 00	ADULTS & PEDIATRICS	0	0	0	663, 250		1. 00
2.00		NEONATAL INTENSIVE CARE UNIT	0	11, 999		772, 475	1	2. 00
3.00		SUBPROVI DER - I RF	0	0	0	134, 983		3. 00
4. 00 5. 00		OPERATING ROOM RADIOLOGY-DIAGNOSTIC	0 0	46, 876 9, 457		527, 989 20, 036	1	4. 00 5. 00
6. 00		RADI OLOGI - DI AGNOSTI C		27, 454		13, 630	1	6. 00
7. 00		LABORATORY	0	4, 677		39, 286		7. 00
8.00		RESPI RATORY THERAPY	0	0	0	34, 961		8. 00
9.00	66. 00	PHYSI CAL THERAPY	0	0	0	27, 200		9. 00
10.00		ELECTROCARDI OLOGY	0	0	0	2, 170, 405	1	10.00
11. 00		ELECTROENCEPHALOGRAPHY DI ABETES CENTER	0 0	0	0	23, 679	1	11.00
12. 00 13. 00		ANTI COAGULATI ON		0	0	1, 375 5, 818	1	12. 00 13. 00
14. 00		CLINIC		0	0	2, 775	1	14. 00
15. 00	91.00	EMERGENCY	0	, o	o o	2, 416, 909	1	15. 00
16.00	91. 01	WOUND CARE	0	0	0	15, 000	1	16. 00
17. 00		AMBULANCE SERVICES	0	0	0	33, 750	1	17. 00
18. 00	5.06	OTHER ADMINISTRATIVE AND GENERAL	0	167, 573	73, 482	1, 856, 732		18. 00
200.00		OLIVLIVAL	0	268, 036	149, 086	8, 760, 253		200. 00
	•	•						

Cost Center Description		Financial Systems LLOCATION - GENERAL SERVICE COSTS	FRANCISCAN HEAL		°N: 15_0100 D	In Lie eriod:	worksheet B	2552-10
COST Center Description	CUST A	ILLUCATION - GENERAL SERVICE COSTS		Provider Co	SN. 15-0109 P F T	rom 01/01/2021 o 12/31/2021	Part I Date/Time Pre	pared:
Cost Centur Description				CAPI TAL REI	ATED COSTS		5/2/2022 3: 08	pm
Company Comp								
A		Cost Center Description		BLDG & FIXT	MVBLE EQUIP		COMMUNI CATI ONS	
Seminary								
Company Comp						DEI / III CIII EI CI		
Section Control Cont				1.00	2.00	4.00	F 01	
1.00		GENERAL SERVICE COST CENTERS	0	1.00	2.00	4.00	5.01	
4.00 00400 EMPLOYEE ERREFITS DEPARTMENT 32,503, 129 129,256 350,236 32,982,621 4.00 4.00 5.00 10140 MART MIN O YSTHUS 7,217,768 191,450 518,757 213,447 100 444 5.00 5.00 5.00 5.01 5.00	1.00	00100 CAP REL COSTS-BLDG & FIXT	9, 984, 666	9, 984, 666				1.00
5. 01 01100 COMMUNICATIONS 2, 203, 806 12, 707 34, 430 202, 571 2, 435, 144 5. 0. 0 01100 COMMUNICATIONS 7, 77, 788 111, 450 518, 757 213, 474 80, 044 5. 0. 0 05050 PURCHASSING 7, 277, 788 111, 450 518, 757 213, 474 80, 044 5. 0. 0 05050 PURCHASSING 7, 277, 788 73, 339 138, 470 375, 202 51, 474 80, 044 5. 0. 0 05050 PURCHASSING 7, 277, 788 7, 278	2.00		1 ' ' 1					2.00
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170.00	68. 00			1, 227				1
71. 00	69. 00							
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90. 00 09000 CLI NI C 1, 286, 741 0 0 115, 113 111, 365 90. 00 91. 00 91. 00 99.	76. 98		0	0	0	0	0	76. 98
91. 00 09100 EMERGENCY 5, 900, 246 532, 674 1, 443, 347 1, 463, 235 0 91. 00 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART 92. 01 09201 OBSERVATI ON BEDS (DISTINCT PART) 1, 624, 252 100, 025 271, 030 340, 026 0 92. 00 09500 AMBULANCE SERVICES 2, 719, 055 116, 074 314, 517 408, 804 0 95. 00 09500 AMBULANCE SERVICES 2, 719, 055 116, 074 314, 517 408, 804 0 95. 00 00 00 00 00 00 00 00	90 00		1 286 741	0	0	115 113	111 365	90 00
92. 00 09200 085ERVATI ON BEDS (NON-DISTINCT PART 1,624,252 100,025 271,030 340,026 0 92. 00 071	91. 00	09100 EMERGENCY	1	532, 674	1, 443, 347			
92. 01	91. 01		706, 699	212, 231	575, 066	186, 335	0	
OTHER REIMBURSABLE COST CENTERS 95. 00			1 624 252	100 025	271 020	340 024	_	
95. 00	72. UI		1, 024, 232	100, 025	2/1,030	340, 020	ı	72.01
SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 113. 00 116. 00 11600 HOSPI CE 4, 855, 042 0 0 669, 431 0 116. 00		09500 AMBULANCE SERVICES	1					
113. 00 11300 NTEREST EXPENSE 113. 00 116. 00 HOSPI CE 4, 855, 042 0 0 669, 431 0 116. 00	101.00		4, 423, 820	98, 535	266, 994	982, 606	0	101.00
116. 00 11600 H0SPI CE 4, 855, 042 0 0 669, 431 0 116. 00	113 00							113 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) 293,173,576 8,288,283 22,458,136 29,081,225 2,453,514 118.0	116.00	11600 H0SPI CE	4, 855, 042	0	0			
	118.00	SUBTOTALS (SUM OF LINES 1 through 117)		8, 288, 283	22, 458, 136	29, 081, 225	2, 453, 514	118. 00

Health Financial Systems	FRANCI SCAN HEAL	TH LAFAYETTE		In Lie	eu of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CO		Period: From 01/01/2021 To 12/31/2021	Worksheet B Part I Date/Time Pre 5/2/2022 3:08	
		CAPI TAL REL	LATED COSTS			
Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	COMMUNI CATI ONS	
	0	1. 00	2.00	4. 00	5. 01	
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	155, 397	39, 159	106, 10	5 13, 325	0	190. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	19, 475, 619	101, 853	275, 98	3, 888, 071	0	192. 00
194. 00 07950 MOB	0	0		0	0	194. 00
194. 01 07951 LI FELI NE	0	0		0	0	194. 01
194. 02 07952 PATIENT TRANSPORT	0	0		0	0	194. 02
194.03 07954 OTHER NONREIMBURSABLE COST CENTERS 200.00 Cross Foot Adjustments	0	1, 555, 371		0		194. 03 200. 00
201.00 Negative Cost Centers		0		0		201. 00
202.00 TOTAL (sum lines 118 through 201)	312, 804, 592	9, 984, 666	22, 840, 22	4 32, 982, 621	2, 453, 514	202. 00

SYSTEMS) 12/31/2021	5/2/2022 3:08	
		Cost Center Description		PURCHASI NG	ADMI TTI NG		Subtotal	
CENTRAL SERVICE COST CENTERS 1.00				5. 03	5. 04		5A. 05	
2.00 OURDO CAP REL DOSISMORLE EDIT								
4.00 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0								1.00
0.11 0.11								1
5. DE 101 ACQ IMANI I FIND SYSTEMS 5. DE 30 GOSSOP QUESTIONS 5. DE 30 GOSSOP QUESTIONS 5. DE 30 GOSSOP QUESTIONS 5. DE 40 GOSSOP QUESTIONS 5. DE 40 GOSSOP QUESTIONS 7. DE 40 GOS								1
5.00 DISSIPPED MILETIMES 1.00			8, 221, 466					1
5.05 OBSME PATH FIRST ACCOUNT IN NO. 0 0 0 2,404, 746 5.58, 739 7.00 0 0 5.598, 739 7.00 0 0 5.598, 739 7.00 0 0 0 5.598, 739 7.00 0 0 0 5.598, 739 7.00 0 0 0 0 5.598, 739 7.00 0 0 0 0 5.598, 739 7.00 0 0 0 0 0 0 0 0 0				-174, 843				5. 03
5.00 OBACO GITTER AUMINISTRATI UT AND SENTERAL 509-941 0 0 545-596, 739 5.70 00000 (PREATI ON OF PLANE) 1.204, 301-1 2.204, 815 0 0 0 0 1.204, 301 1.204 1.2	5.04	00570 ADMI TTI NG	42	0	5, 166			5. 04
0.0000 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000000				-				5. 05
8.00 09800 LANDRY & LINEN SERVICE 28, 288 0 0 0 1, 271, 471 8, 00				-1	0	-		
9.00 000000				-	0	0		1
10.00 01000 01ETARY				- 1	0	0		1
11-00 0 10100 (APETERIA 0 0 0 0 0 0 1, 370, 384 11.00 11.00 0 101.00 (APETERIA 1.00 0 10.00 0 0 1.370, 385 13.00 0 10.00 0 1.00					-	ő		1
14.00 0 10400/ INTERIS SERVICES & SUPPLY	11. 00	01100 CAFETERI A	1	О	0	0		1
15.00 01500 PHARMACY 18.1 12.1 0 0 0 15, 463, 013 15.00 17.00 0 07.00 17.00 0 0 0 0 0 0 0 0 0				-	0	0		1
10.00 01000 MEDICAL RECORDS & LIBRARY 8,530 0 0 0 0 2,339,289 16,00 10.0				-	-	-		1
17.00 01700 SOCIAL SERVICE 0 0 0 0 59,324 77,000 220 00 20200 MIRSING PROGRAM 141,260 0 0 0 0 2,387,573 77,000 0 0 0 2,387,573 77,000 0 0 0 379,217 79,000 79,217 79,2		1		-	0	0		1
20.00 0.0000 NURSING PROGRAM		1	1	-1	0	0		1
23.00 0.2301 PIARMACY RESIDENCY 15.357				-	0	0		1
INPATIENT ROUTINE SERVICE COST CENTERS 1,861,386 0 372 216,660 31,135,143 30.00 3300 003000 DULTS & PEDIATRICS 1,861,386 0 372 216,660 31,135,143 30.00 3300 003000 DULTS & PEDIATRICS 1,861,386 0 372 216,660 31,135,143 31,000 31,00				-	Ö	-		1
30,00 03000 ADULTS & PEDIATRICS 1,861,386 0 372 216,660 31,135,143 31,00 31,00 3100 NTENSI VE CARE UNIT 161,596 0 61 35,433 36,14,475 31,00 3100 03000 NURSINEY CARE UNIT 161,596 0 61 35,433 36,14,475 35,00 04300 NURSINEY CARE UNIT 161,596 0 13 37,435 36,14,475 35,00 04300 NURSINEY 0 0 13 7,855 918,385 41,00 04100 O4100 O41		1	1	О	0	0		1
331.00 03100 INTENSIVE CARE UNIT 331.166 0 72 42.205 6.501.415 31.00 35.00 02000 NEONATAL INTENSIVE CARE UNIT 161.599 0 61 35.432 3.614.475 35.00 41.00 04100 SUBPROVIDER - I RF 125.521 0 20 11.414 2.873.388 41.00 41.00 04100 SUBPROVIDER - I RF 125.521 0 0 13 7.885 918.322 43.00 430.00 4								
33. 00		1		1				1
41.00 04100 SUBPROVIDER - IRF				-				1
ABOUND A								1
ANCILLARY SERVICE COST CENTERS 50.00 50.00 50.00 0.5				-				
50.00 050000 050000 050000 050000 050000 050000 050000 05000 05000 05000 05000 05000 05000 05000 050000 050000 050000 0500000 050000 050000 0500000000	43.00		j oj	υ	13	7, 655	710, 332	43.00
55.00 05100 RECOVERY ROOM & LABOR ROOM Sp. 40 Co. 10 C	50. 00		348, 826	0	501	292, 215	7, 981, 917	50.00
55. 00 05400 RADIOLOGY-DI AGNOSTIC 55. 00 05500 RADIOLOGY-DI AGNOSTIC 55. 00 05500 RADIOLOGY-DI THERAPEUTIC 55. 00 05500 RADIOLOGY-DI THERAPEUTIC 56. 01 05950 RADIOLOGY-DI THERAPEUTIC 57. 00 05950 RADIOLOGY-DI THERAPEUTIC 58. 01 05950 CARDIAC CATH LAB 59. 00 05950 CARDIAC CATH LAB 50. 01 05950 CARDIAC CATH LAB 50. 00 05800 MRI 50. 00 05800 MRI 60. 00 05800 MRI	51.00			О				51.00
55.0 0 0500 RADIOLOGY - THERAPEUTI C 34, 462 0 43 25, 083 89, 813 55.00 56.0 0 10500 RADIOLOGY OF THERAPEUTI C 6, 008 0 0 62 126, 313 56.00 56.0 0 10500 CARDINAC CATH LAB 101, 351 0 185 107, 694 2, 399, 423 56. 10 57.0 0 05700 CT SCAN 52, 730 0 205 119, 790 1, 362, 456 57. 00 58.0 0 05800 MRI 17, 259 0 33 19, 091 156, 662 58. 00 60.0 0 06000 LABORATORY 0 0 427 249, 131 12, 127, 844 60. 00 60.0 0 06000 RESPIRATORY THERAPY 176, 080 0 70 40, 885 3, 534, 602 58. 00 66.0 0 06000 RESPIRATORY THERAPY 176, 080 0 70 40, 885 3, 534, 602 65. 00 66.0 0 06000 RESPIRATORY THERAPY 115, 269 0 43 25, 170 2, 000, 148 67. 00 67.0 0 06700 0CCUPATI ONAL THERAPY 115, 269 0 43 25, 170 2, 000, 148 67. 00 68.0 0 06800 SPECCH PATHOLOGY 45, 566 0 15 8, 816 773, 575 68. 00 69.0 0 06900 LECETROCARDIOLOGY 148, 948 0 125 72, 676 3, 342, 307 69. 00 71.0 0 07100 DETIOLA LUPPLIES CHARGED TO PATIENT 0 0 1, 320 363, 353 14, 277, 855 71. 00 72.0 0 07200 IMPL. DEV. CHARGED TO PATIENT 0 0 1, 320 363, 353 14, 277, 855 71. 00 73.0 0 07300 DRUGS CHARGED TO PATIENTS 0 0 250 145, 504 12, 707, 707 73. 00 73.0 0 07300 DRUGS CHARGED TO PATIENTS 0 0 250 145, 504 12, 707, 707 73. 00 73.0 0 07300 DRUGS CHARGED TO PATIENTS 0 0 250 145, 504 12, 707, 707 73. 00 74.0 0 07400 PATO RESPIRATE ORDER	52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	61	35, 400	4, 229, 255	52. 00
56. 00 05600 RADI OI SOTIOPE 6, 0.08 0 0 6.2 126, 313 56. 00 56. 01 03950 CARDI AC CATH LAB 101, 351 0 185 107, 694 2, 399, 423 56. 01 57. 00 05700 CT SCAN 52, 730 0 205 119, 790 1, 362, 456 57. 00 65. 00 05800 MRI 17, 259 0 33 19, 091 53.6, 062 58. 00 65. 00 05800 MRI 17, 259 0 427 249, 131 12, 127, 844 60. 00 66. 00 06600 RESPI RATORY THERAPY 176, 080 0 70 40, 885 3, 534, 602 58. 00 67. 00 06600 PHYSI CAL THERAPY 386, 056 0 92 53. 484 6, 748, 146 66. 00 06600 PHYSI CAL THERAPY 115, 269 0 43 25, 170 2, 000, 148 67. 00 67. 00 06000 SPECH PATHOLOGY 45, 566 0 15 8, 816 773, 675 68. 00 08000 SPECH PATHOLOGY 45, 566 0 15 8, 816 773, 675 68. 00 08000 SPECH PATHOLOGY 48, 566 0 15 8, 816 773, 675 68. 00 08000 SPECH PATHOLOGY 48, 566 0 15 8, 816 773, 675 68. 00 08000 SPECH PATHOLOGY 48, 566 0 15 8, 816 773, 675 68. 00 08000 SPECH PATHOLOGY 48, 948 0 125 72, 676 3, 342, 307 69. 00 71. 00 07000 ELECTROCARDI OLOGY 148, 948 0 125 72, 676 3, 342, 307 69. 00 770. 00 77000 ELECTROCARDI OLOGY 71. 00 73. 00 73. 00 73.00 7				-				1
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57.00 05700 CT SCAN 52,730 0 205 119,790 1,362,456 57.00 8.00 05800 MRI 17,259 0 3.3 19,091 536,602 58.00 60.00 06000 LABORATORY 0 0 427 249,131 12,127,844 60.00 65.00 06500 RESPIRATORY THERAPY 176,080 0 70 40,855 3,534,602 65.00 66.00 06500 PHYSI CAL THERAPY 176,080 0 70 40,855 3,534,602 65.00 67.00 06700 DCCUPATIONAL THERAPY 115,269 0 43 25,170 2,000,148 67.00 68.00 06600 SPEECH PATHOLOGY 45,566 0 15 8,816 773,575 68.00 69.00 06900 ELECTROCARDI OLOGY 148,948 0 125 72,676 3,342 307 69.00 69.00 06900 ELECTROCREPHALOGRAPHY 50,323 0 16 9,582 1,152,871 70.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0 0 1,320 336,333 14,277,855 71.00 72.00 07200 MPL. DeV. CHARGED TO PATIENT 0 0 290 169,061 10,257,379 71.00 73.01 07300 DIABETES CENTER 35,985 0 0 250 145,504 12,707,001 73.00 74.00 07400 RENAL DI ALYSIS 11,021 0 10 5,943 1,512,769 74.00 76.01 03952 ANTI COAGULATI ON 19,301 0 3 1,833 423,503 76.01 76.02 03952 ANTI COAGULATI ON 19,301 0 3 1,833 423,503 76.01 76.09 07698 HYPERRABIC COXYGEN THERAPY 0 0 0 0 0 0 76.99 07698 HYPERRABIC COXYGEN THERAPY 0 0 0 0 0 0 76.99 07698 HYPERRABIC COXYGEN THERAPY 0 0 0 0 0 0 77.00 07000 085ERVATI ON BEDS (INDITINCT PART 117,261 0 0 0 0 0 0 0 78.00 07000 085ERVATI ON BEDS (INDITINCT PART 117,261 0 0 0 0 0 0 0 79.01 07200 085ERVATI ON BEDS (INDITINCT PART 117,261 0 0 0 0 0 0 0 0 79.01 07200 07500 07500 07500 07500 07500 0 0 0 0 0 0 0 79.00 07000 07500 07500 07500 07500 07500 0 0 0 0 0 0 0 79.00 07000 07500 07500 07500 0 0 0 0 0 0 0 0 0				-	-			1
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68.00 06800 SPECH PATHOLOGY	66.00	06600 PHYSI CAL THERAPY	386, 056	o	92	53, 484	6, 748, 146	66. 00
69.00 06900 ELECTROCARDIOLOCY		1		-				1
70.00 07000 ELECTROENCEPHALOGRAPHY 50, 323 0 16 9, 582 1, 152, 871 70.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0 0 1, 320 363, 353 14, 277, 855 71.00 72.00 07200 MPL. DEV. CHARGED TO PATIENTS 0 0 290 169, 061 10, 257, 379 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 250 145, 504 12, 707, 001 73.00 73.01 DIABETES CENTER 35, 985 0 0 13 603, 517 73.01 74.00 07400 RENAL DIALYSIS 11, 021 0 10 5, 943 1, 512, 769 74.00 76.01 03552 ANTICOAGULATION 19, 301 0 3 1, 833 423, 503 76.01 76.01 03552 ANTICOAGULATION 19, 301 0 3 1, 833 423, 503 76.01 76.02 03951 INFUSION SERVICES 41, 488 0 15 8, 570 1, 787, 673 76.02 76.98				-1				1
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 1,320 333,353 14,277,855 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 290 169,061 10,257,379 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 250 145,504 12,707,001 73.00 73.01 07301 DIABETES CENTER 35,985 0 0 250 145,504 12,707,001 73.00 73.01 07301 DIABETES CENTER 35,985 0 0 10 13 603,517 73.01 73.01 07301 DIABETES CENTER 35,985 0 0 0 133 603,517 73.01 73.00 07400 RENAL DIALYSIS 11,021 0 10 5,943 1,511,769 74.00 76.00 03480 0NCOLOGY 234,258 0 63 36,603 4,786,636 76.00 76.01 03952 ANTI COAGULATION 19,301 0 3 1,833 423,503 76.01 76.02 03951 INFUSION SERVICES 41,488 0 15 8,570 1,787,673 76.02 76.98 07698 HYPERBARI C OXYGEN THERAPY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				-				1
72. 00 07200 IMPL DEV. CHARGED TO PATIENTS 0 0 290 169, 061 10, 257, 379 72. 00 73. 01 07300 DRUGS CHARGED TO PATIENTS 0 0 0 250 145, 504 12, 707, 379 73. 01 07301 DI ABETES CENTER 35, 985 0 0 13 603, 517 73. 01 73. 01 07400 RENAL DI ALYSIS 11, 021 0 10 5, 943 1, 512, 769 74. 00 76. 00 03480 ONCOLOGY 234, 258 0 63 36, 603 4, 786, 636 76. 01 03952 ANTI COAGULATI ON 19, 301 0 3 1, 833 423, 503 76. 01 76. 02 03951 INFUSI ON SERVICES 41, 488 0 15 8, 570 1, 787, 673 76. 02 76. 98 76. 98 76. 98 76. 98 76. 90 76. 98 76. 98 76. 98 76. 98 76. 98 76. 98 76. 99 76. 98		1	1	-				1
73. 00 07300 DRUGS CHARGED TO PATIENTS				•				
73. 01 07301 DIABETES CENTER 35,985 0 0 13 603,517 73. 01 74. 00 7400 RENAL DIALYSIS 11,021 0 10 5,943 1,512,769 74. 00 74. 00 03480 NONCLOGY 234,258 0 63 36,603 4,786,636 76. 00 03480 NONCLOGY 234,258 0 63 36,603 4,786,636 76. 00 03952 ANTI COAGULATI ON 19,301 0 3 1,833 423,503 76. 01 76. 02 03951 INFUSI ON SERVI CES 41,488 0 15 8,570 1,787,673 76. 02 76. 98 HYPERBARI C OXYGEN THERAPY 0 0 0 0 0 0 0 76. 98 HYPERBARI C OXYGEN THERAPY 0 0 0 0 0 0 0 0 76. 98 10. 10. 10 10. 10. 10 10. 10. 10 10. 10. 10 10.			0	o				
76. 00 03480 ONCOLOGY 234, 258 0 63 36, 603 4, 786, 636 76. 00 76. 01 03952 ANTI COAGULATI ON 19, 301 0 3 1, 833 423, 503 76. 01 76. 02 03951 INFUSI ON SERVI CES 41, 488 0 15 8, 570 1, 787, 673 76. 02 76. 98 PYPERBARI C OXYGEN THERAPY 0 0 0 0 0 0 0 0 0			35, 985	o				
76. 01 03952 ANTI COAGULATI ON	74.00	07400 RENAL DIALYSIS	11, 021	O	10	5, 943	1, 512, 769	74. 00
76. 02				-1				
76. 98 07698 HYPERBARI C OXYGEN THERAPY 0 0 0 0 0 0 0 76. 98				-1	-			
OUTPATI ENT SERVI CE COST CENTERS 90.00 O9000 CLI NI C S9,944 O 2 1,216 1,574,381 90.00 91.00 O9100 EMERGENCY 455,136 O 360 209,824 10,004,822 91.00 91.01 O4950 WOUND CARE 46,206 O 2 1,126 1,727,665 91.01 92.00 O9200 OBSERVATI ON BEDS (NON-DI STI NCT PART O 92.00 O9201 OBSERVATI ON BEDS (DI STI NCT PART) 117,261 O 26 15,090 2,467,710 92.01 OTHER REI MBURSABLE COST CENTERS O 355 20,223 3,865,362 95.00 O9500 AMBULANCE SERVI CES 286,654 O 35 20,223 3,865,362 95.00 O9500 AMBULANCE SERVI CES 215,170 O 28 16,187 6,003,340 101.00 O10100 HOME HEALTH AGENCY 215,170 O 28 16,187 6,003,340 101.00 O11600 HOME HEALTH SERVI CES 214,480 O 65 37,791 5,776,809 116.00 116.00 I1600 HOSPI CE 214,480 O 5,166 2,604,766 287,350,138 118.00 NONREI MBURSABLE COST CENTERS O 0 0 319,837 190.00 192.00 19200 O1900 GIFT, FLOWER, COFFEE SHOP & CANTEEN 5,851 O O O 0 319,837 190.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 12,563 O O O O 0 0 194.00 194.01 07951 LI FELI NE O O O O 0 0 0 194.01 194.01 07951 LI FELI NE O O O O 0 0 0 0 0 0				•				1
90. 00 09000 CLINI C 59, 944 0 2 1, 216 1, 574, 381 90. 00 91. 00 09100 EMERGENCY 455, 136 0 360 209, 824 10, 004, 822 91. 00 91. 01 04950 WOUND CARE 46, 206 0 2 1, 126 1, 727, 665 91. 01 92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART 92. 01 09201 OBSERVATI ON BEDS (DISTINCT PART 117, 261 0 26 15, 090 2, 467, 710 92. 01 07HER REI MBURSABLE COST CENTERS 286, 654 0 35 20, 223 3, 865, 362 95. 00 101. 00 10100 HOME HEALTH AGENCY 215, 170 0 28 16, 187 6, 003, 340 101. 00 SPECI AL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 116. 00 11600 HOSPI CE 214, 480 0 65 37, 791 5, 776, 809 116. 00 11600 HOSPI CE 214, 480 0 5, 166 2, 604, 766 287, 350, 138 118. 00 NONREI MBURSABLE COST CENTERS 12, 563 0 0 0 0 319, 837 190. 00 192. 00 19200 PHYSI CI ANS PRI VATE OFFI CES 0 0 0 0 0 0 194. 01 194. 01 07951 LI FELI NE 0 0 0 0 0 0 194. 01 194. 01 07951 LI FELI NE 0 0 0 0 0 0 0 194. 01 194. 01 07951 LI FELI NE 0 0 0 0 0 0 0 0 0	70. 98		U U	U	U	U _I	0	76. 98
91. 00 09100 EMERGENCY 455, 136 0 360 209, 824 10, 004, 822 91. 00 91. 01 04950 WOUND CARE 46, 206 0 2 1, 126 1, 727, 665 91. 01 92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART 0 92. 00 92. 00 09201 OBSERVATI ON BEDS (DISTINCT PART) 117, 261 0 26 15, 090 2, 467, 710 92. 01 071HER REI MBURSABLE COST CENTERS 286, 654 0 35 20, 223 3, 865, 362 95. 00 101. 00 EMERGENCY 215, 170 0 28 16, 187 6, 003, 340 101. 00 11300 INTEREST EXPENSE 214, 480 0 65 37, 791 5, 776, 809 116. 00 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 8, 203, 052 0 5, 166 2, 604, 766 287, 350, 138 118. 00 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 12, 563 0 0 0 0 0 0 194. 01 194. 01 07951 Li FELI NE 0 0 0 0 0 194. 01 194. 01 07951 Li FELI NE 0 0 0 0 0 194. 01 194. 01 07951 Li FELI NE 0 0 0 0 0 194. 01 194. 01 07951 Li FELI NE 0 0 0 0 0 0 194. 01 194. 01 07951 Li FELI NE 0 0 0 0 0 0 0 0 0	90 00		59 944	O	2	1 216	1 574 381	90.00
91. 01				-	360			1
92. 01				o	2			1
OTHER REIMBURSABLE COST CENTERS 95. 00	92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART					0	92. 00
95. 00 09500 AMBULANCE SERVI CES 286, 654 0 35 20, 223 3, 865, 362 95. 00 101. 00 10100 HOME HEALTH AGENCY 215, 170 0 28 16, 187 6, 003, 340 101. 00 SPECI AL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 214, 480 0 65 37, 791 5, 776, 809 116. 00 11600 HOSPI CE 214, 480 0 5, 166 2, 604, 766 287, 350, 138 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 5, 851 0 0 0 0 319, 837 190. 00 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 12, 563 0 0 0 0 23, 754, 089 192. 00 194. 00 19751 LI FELI NE 0 0 0 0 0 194. 01 194. 01 19751 LI FELI NE 0 0 0 0 194. 01 194. 01 19751 LI FELI NE 0 0 0 0 194. 01 194. 01 19751 LI FELI NE 0 0 0 0 194. 01 194. 01 19751 LI FELI NE 0 0 0 0 0 194. 01 194. 01 194. 01 19751 LI FELI NE 0 0 0 0 0 194. 01	92. 01		117, 261	0	26	15, 090	2, 467, 710	92. 01
101. 00 10100 HOME HEALTH AGENCY 215, 170 0 28 16, 187 6, 003, 340 101. 00								
SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 116.00 11600 HOSPI CE 214,480 0 65 37,791 5,776,809 116.00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 8,203,052 0 5,166 2,604,766 287,350,138 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 5,851 0 0 0 319,837 190.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 12,563 0 0 0 0 23,754,089 192.00 194.00 07950 MOB 0 0 0 0 0 194.00 194.01 07951 LI FELI NE 0 0 0 0 0 194.01 194.01 07951 LI FELI NE 0 0 0 0 0 194.01 194.01 194.01 194.01 195.01 194.01 19								1
113. 00 11300 INTEREST EXPENSE 214, 480 0 65 37, 791 5, 776, 809 16. 00 18. 00 SUBTOTALS (SUM OF LINES 1 through 117) 8, 203, 052 0 5, 166 2, 604, 766 287, 350, 138 18. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 5, 851 0 0 0 319, 837 190. 00 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 12, 563 0 0 0 0 23, 754, 089 192. 00 194. 01 07951 LI FELI NE 0 0 0 0 0 194. 01 194. 01 07951 LI FELI NE 0 0 0 0 0 194. 01 194. 01 07951 LI FELI NE 0 0 0 0 0 0 194. 01 07951 LI FELI NE 0 0 0 0 0 0 0 0 0	101.00		215, 170	0	28	16, 187	6, 003, 340	101.00
116. 00 11600 HOSPI CE 214, 480 0 65 37, 791 5, 776, 809 116. 00 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 8, 203, 052 0 5, 166 2, 604, 766 287, 350, 138 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 5, 851 0 0 0 319, 837 190. 00 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 12, 563 0 0 0 0 23, 754, 089 192. 00 194. 01 07951 LI FELI NE 0 0 0 0 0 0 194. 01 194. 01 07951 LI FELI NE 0 0 0 0 0 0 194. 01 194. 01 07951 LI FELI NE 0 0 0 0 0 0 0 0 0	113 00							113 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) 8,203,052 0 5,166 2,604,766 287,350,138 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 5,851 0 0 0 319,837 190.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 12,563 0 0 0 0 23,754,089 192.00 194.00 194.00 19751 LI FELI NE 0 0 0 0 0 194.01 194.01 194.01 195.			214 480	n	65	37 791	5 776 809	1
NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 5, 851 0 0 0 319, 837 190. 00 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 12, 563 0 0 0 23, 754, 089 192. 00 194. 00 07950 MOB 0 0 0 0 0 194. 00 194. 01 07951 LI FELI NE 0 0 0 0 0 0 194. 01								1
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 5,851 0 0 319,837 190. 00 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 12,563 0 0 0 23,754,089 192. 00 194. 00 07950 MOB 0 0 0 0 0 0 194. 00 194. 01 07951 LI FELI NE 0 0 0 0 0 194. 01	. 5. 50			<u> </u>	2, .30	.,,	.,,,	1
194. 00 07950 MOB 0 0 0 0 194. 00 194. 01 194. 01 07951 LI FELI NE 0 0 0 0 0 194. 01		19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	5, 851	0	0	0		
194. 01 07951 LI FELI NE 0 0 0 0 0 0 194. 01			1	-	0	0		
			1	•	-	0		
194. UZ U/95Z PATIENT TKANSPUKT UJ UJ UJ 0 0 0 194. 02				-	-	0		
	194. 02	U/YOZ PATIENT TKANSPURT	<u> </u> 0	이	0	0	0	1194. 02

Health Financial Systems	FRANCISCAN HEALTH LAFAYETTE	FAYETTE In Lie			
COST ALLOCATION - GENERAL SERVICE COSTS	Provi der CCN: 15-0109	From 01/01/2021 To 12/31/2021	Worksheet B Part I Date/Time Prepared: 5/2/2022 3:08 pm		

						3/2/2022 3.00	PIII
	Cost Center Description	MGMT INFO	PURCHASI NG	ADMI TTI NG	PATI ENT	Subtotal	
		SYSTEMS			ACCOUNTI NG		
		5. 02	5. 03	5. 04	5. 05	5A. 05	
194. 03 07954	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	1, 555, 371	194. 03
200.00	Cross Foot Adjustments					0	200. 00
201.00	Negative Cost Centers	0	-174, 843	0	0	-174, 843	201. 00
202.00	TOTAL (sum lines 118 through 201)	8, 221, 466	-174, 843	5, 166	2, 604, 766	312, 804, 592	202.00

				1	0 12/31/2021	Date/lime Pre 5/2/2022 3:08	
	Cost Center Description	OTHER ADMI NI STRATI VE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	piii -
		5. 06	7. 00	8.00	9. 00	10.00	
	GENERAL SERVICE COST CENTERS	,		,			
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 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 ADMITTING						5. 04
	00580 PATIENT ACCOUNTING 00560 OTHER ADMINISTRATIVE AND GENERAL	E4 E00 720					5. 05 5. 06
5.06		54, 598, 739 3, 212, 849	10 /17 210				7.00
7. 00 8. 00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	1 1	18, 417, 210 150, 520				8.00
9. 00	00900 HOUSEKEEPING	268, 676 953, 165	311, 016				9.00
10. 00	01000 DI ETARY	827, 924	552, 002		l ' '	5, 575, 177	10.00
11. 00	01100 CAFETERI A	289, 503	498, 781	1 47, 484		0, 373, 177	11. 00
13. 00	01300 NURSING ADMINISTRATION	1, 021, 242	110, 355	1	/	0	13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	245, 504	182, 664	42, 850		0	14. 00
15. 00	01500 PHARMACY	3, 267, 505	296, 003	1 42,030	123, 190	0	15. 00
16. 00	01600 MEDI CAL RECORDS & LI BRARY	494, 317	74, 394	Ö	30, 961	0	16. 00
17. 00	01700 SOCIAL SERVICE	12, 536	19, 344	0	8, 051	0	17. 00
20. 00	02000 NURSI NG PROGRAM	498, 181	1, 069, 358	0	l '	0	20.00
23. 00	02301 PHARMACY RESIDENCY	91, 755	0	0	0	0	23. 00
23. 01	02300 EMS EDUCATION	80, 133	132, 587	l o	55, 180	0	23. 01
	INPATIENT ROUTINE SERVICE COST CENTERS	227.22	,				
30.00	03000 ADULTS & PEDI ATRI CS	6, 579, 256	3, 800, 560	596, 834	1, 581, 716	4, 618, 494	30.00
31.00	03100 INTENSIVE CARE UNIT	1, 373, 821	367, 959			592, 923	31.00
35.00	02060 NEONATAL INTENSIVE CARE UNIT	763, 778	257, 507	37, 896	107, 169	0	35. 00
41.00	04100 SUBPROVI DER - I RF	607, 178	462, 723	32, 095	192, 576	363, 760	41. 00
43.00	04300 NURSERY	194, 058	0	62, 282	0	0	43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	1, 686, 667	1, 055, 339	296, 511	439, 210	0	50. 00
51.00	05100 RECOVERY ROOM	200, 956	87, 194	54, 524	36, 288	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	893, 688	0	66, 591	0	0	52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 807, 663	582, 735	104, 042	242, 522	0	54.00
55.00	05500 RADI OLOGY - THERAPEUTI C	171, 122	22, 584	0	9, 399	0	55. 00
56.00	05600 RADI OI SOTOPE	26, 691	10, 971	0	4, 566	0	56. 00
56. 01	03950 CARDI AC CATH LAB	507, 024	270, 948	6, 876	112, 763	0	56. 01
57.00	05700 CT SCAN	287, 902	49, 371	0	20, 547	0	57. 00
58. 00	05800 MRI	113, 276	43, 693	0	18, 184	0	58. 00
60.00	06000 LABORATORY	2, 562, 747	208, 360	10, 779	86, 715	0	60.00
65. 00	06500 RESPI RATORY THERAPY	746, 900	74, 041	12, 621		0	65. 00
66. 00	06600 PHYSI CAL THERAPY	1, 425, 957	30, 636	23, 491	12, 750	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	422, 653	0	0	0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	163, 465	3, 144	0	1, 308	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	706, 266	335, 077	9, 574		0	69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	243, 614	171, 917		,	0	70. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	3, 017, 068	0	0	0	0	71. 00
	07200 I MPL. DEV. CHARGED TO PATIENTS	2, 167, 497	0	0	0	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	2, 685, 129	0	0	0	0	73. 00
73. 01	07301 DI ABETES CENTER	127, 530	0	0	0	0	73. 01
74.00	07400 RENAL DI ALYSI S	319, 665	59, 059		24, 579	0	74.00
76. 00	03480 ONCOLOGY	1, 011, 469	64, 160	0	26, 702	0	76. 00
76. 01	03952 ANTI COAGULATI ON	89, 491	0	0	0	0	76. 01
76. 02	03951 NFUSION SERVICES	377, 755	0	0	0	0	76. 02
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0	0	0	0	76. 98
00 00	OUTPATIENT SERVICE COST CENTERS 09000 CLINIC	332, 684			٥	0	90. 00
90. 00 91. 00	09100 EMERGENCY	1 ' 1	1 245 000	154 100	· ·	0	
91.00	04950 WOUND CARE	2, 114, 129 365, 075	1, 365, 008 543, 854		568, 088 226, 341	0	91. 00 91. 01
91.01	09200 OBSERVATION BEDS (NON-DISTINCT PART	303, 073	343, 634	U	220, 341	U	91.01
92. 00	09201 OBSERVATION BEDS (NON-DISTINCT PART)	E21 4E4	256, 320		106, 675	0	92.00
92.01	OTHER REIMBURSABLE COST CENTERS	521, 454	200, 320		100, 675	0	92.01
05 00	09500 AMBULANCE SERVICES	816, 794	297, 447	0	123, 791	0	95. 00
	10100 HOME HEALTH AGENCY	1, 268, 572	252, 502				101.00
101.00	SPECIAL PURPOSE COST CENTERS	1, 200, 372	252, 502		105, 060	0	101.00
113 00	11300 INTEREST EXPENSE						113. 00
	11600 HOSPI CE	1, 220, 703	^	^	٨	0	116. 00
118.00		49, 182, 987	14, 070, 133	1, 690, 667	5, 663, 615		
110.00	NONREI MBURSABLE COST CENTERS	77, 102, 70/	14,070,133	1, 070, 007	J, 003, 015	3, 373, 177	1110.00
190 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	67, 585	100, 347	^	41, 762	0	190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	5, 019, 500	261, 004		108, 624		190.00
	07950 MOB	3,017,300	201,004	١	100, 024		194. 00
	07951 LI FELI NE		0	Ö	o		194. 01
	I I	, 9		<u>, </u>	<u>, </u>		

Health Financial Systems	FRANCISCAN HEALTH LAFAYETTE	In Lieu	of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS	Provider CCN: 15-0109	From 01/01/2021 To 12/31/2021	Worksheet B Part I Date/Time Prepared: 5/2/2022 3:08 pm

					5/2/2022 3:08	_pm
Cost Center Description	OTHER	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	ADMI NI STRATI VE	PLANT	LINEN SERVICE			
	AND GENERAL					
	5. 06	7. 00	8. 00	9. 00	10.00	
194. 02 07952 PATI ENT TRANSPORT	0	0	0	0	0	194. 02
194. 03 07954 OTHER NONREIMBURSABLE COST CENTERS	328, 667	3, 985, 726	0	0	0	194. 03
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	0	0	0	0	0	201. 00
202.00 TOTAL (sum lines 118 through 201)	54, 598, 739	18, 417, 210	1, 690, 667	5, 814, 001	5, 575, 177	202. 00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2021 | Part I | To 12/31/2021 | Date/Time Prepared: | 5/2/2022 3:08 pm

						5/2/2022 3:08	pm
	Cost Center Description	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVICES &	PHARMACY	MEDI CAL RECORDS &	
			ADMINISTRATION	SUPPLY		LI BRARY	
		11. 00	13.00	14.00	15. 00	16. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUI P						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 01	01160 COMMUNI 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						5. 04 5. 05
5.06	00580 PATIENT ACCOUNTING 00560 OTHER ADMINISTRATIVE AND GENERAL						5. 05
7. 00	00700 OPERATION OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9. 00	00900 HOUSEKEEPING						9. 00
10.00	01000 DI ETARY						10.00
11. 00	01100 CAFETERI A	2, 365, 900					11.00
13. 00	01300 NURSING ADMINISTRATION	80, 598	1				13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	18, 772		1, 727, 624			14. 00
15. 00	01500 PHARMACY	64, 363	l i	13, 103	19, 227, 177		15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	2, 998		0	17, 227, 177	2, 941, 959	16. 00
17. 00	01700 SOCIAL SERVICE	2, 7,0	1	Ö	0	2, 741, 737	17. 00
20. 00	02000 NURSI NG PROGRAM	49, 650	-	0	0	0	20. 00
23. 00	02301 PHARMACY RESIDENCY	5, 398		0	0	0	23. 00
23. 01	02300 EMS EDUCATION	235	1	0	Ö	0	23. 01
20.01	INPATIENT ROUTINE SERVICE COST CENTERS	200	<u> </u>	O .	<u> </u>	0	20.01
30. 00	03000 ADULTS & PEDIATRICS	654, 235	2, 197, 834	94, 369	0	244, 780	30.00
31. 00	03100 I NTENSI VE CARE UNI T	116, 397		22, 271	0	47, 682	31.00
35. 00	02060 NEONATAL INTENSIVE CARE UNIT	56, 798		6, 571	Ö	40, 032	35. 00
41. 00	04100 SUBPROVI DER - I RF	44, 118		2, 467	0	12, 895	41. 00
43. 00	04300 NURSERY	0		0	Ö	8, 874	43. 00
10.00	ANCILLARY SERVICE COST CENTERS		<u> </u>	3	٥,	3, 3, 1	10.00
50. 00	05000 OPERATING ROOM	122, 604	411, 875	847, 831	0	330, 141	50.00
51. 00	05100 RECOVERY ROOM	12, 599		1, 143	Ö	27, 761	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0		0	Ö	39, 994	52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	121, 588	o	101, 893	0	197, 952	54.00
55. 00	05500 RADI OLOGY - THERAPEUTI C	12, 112		534	Ö	28, 338	
56. 00	05600 RADI OI SOTOPE	2, 112	1	0	0	70	56. 00
56. 01	03950 CARDI AC CATH LAB	35, 623		178, 009	0	121, 672	56. 01
57.00	05700 CT SCAN	18, 533		8, 323	o	135, 338	57.00
58.00	05800 MRI	6, 066		1, 935	o	21, 569	58. 00
60.00	06000 LABORATORY	0	o	5, 328	o	281, 466	60.00
65.00	06500 RESPI RATORY THERAPY	61, 888	207, 907	35, 430	o	46, 192	65. 00
66.00	06600 PHYSI CAL THERAPY	135, 690		14, 938	О	60, 426	
67.00	06700 OCCUPATI ONAL THERAPY	40, 514		1, 164	О	28, 436	67. 00
68.00	06800 SPEECH PATHOLOGY	16, 016	53, 802	171	0	9, 960	68. 00
69.00	06900 ELECTROCARDI OLOGY	52, 352	175, 870	2, 404	0	82, 108	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	17, 688		3, 654	0	10, 826	70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	409, 637	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	О	0	0	191, 003	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	o	0	19, 227, 177	164, 389	73. 00
73. 01	07301 DI ABETES CENTER	12, 648	42, 489	30	0	15	73. 01
74.00	07400 RENAL DIALYSIS	3, 873	13, 013	314, 011	0	6, 714	74.00
76.00	03480 ONCOLOGY	82, 336	o	963	0	41, 354	76. 00
76. 01	03952 ANTI COAGULATI ON	6, 784	0	1	0	2, 071	76. 01
76. 02	03951 I NFUSI ON SERVI CES	14, 582	o	0	0	9, 682	76. 02
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0	0	0	0	76. 98
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	21, 069	0	1, 318	0	1, 374	90.00
91.00	09100 EMERGENCY	159, 970	537, 401	59, 055	0	237, 056	91. 00
91. 01	04950 WOUND CARE	16, 240	54, 557	119	0	1, 272	91. 01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
92. 01	09201 OBSERVATION BEDS (DISTINCT PART)	41, 214	0	4, 273	0	17, 049	92. 01
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVICES	100, 752	338, 466	6, 316	0	22, 847	95. 00
101.00	10100 HOME HEALTH AGENCY	75, 627	254, 062	0	0	18, 288	101. 00
	SPECIAL PURPOSE COST CENTERS						
113.00	11300 I NTEREST EXPENSE						113. 00
	11600 H0SPI CE	75, 385		0	o	42, 696	
118.00		2, 359, 427	6, 091, 011	1, 727, 624	19, 227, 177	2, 941, 959	118. 00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	2, 057	0	0	0		190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	4, 416	o	0	0		192. 00
	07950 MOB	0		0	0		194. 00
194. 01	07951 LI FELI NE	0	O	0	0	0	194. 01

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

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0109 | Period: | Worksheet B | From 01/01/2021 | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 2/2020 a control of the control of the

						5/2/2022 3:08	pm
	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	
194. 02 07952	PATIENT TRANSPORT	0	0	0	0	0	194. 02
194. 03 07954	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194. 03
200. 00	Cross Foot Adjustments						200.00
201. 00	Negative Cost Centers	0	0	0	0	0	201.00
202. 00	TOTAL (sum lines 118 through 201)	2, 365, 900	6, 091, 011	1, 727, 624	19, 227, 177	2, 941, 959	202. 00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2021 | Part I | To 12/31/2021 | Date/Time Prepared: | 5/2/2022 3:08 pm Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS FRANCISCAN HEALTH LAFAYETTE Provider CCN: 15-0109

						5/2/2022 3: 08	
	Cost Center Description	SOCIAL SERVICE	NURSI NG	PHARMACY	EMS EDUCATION	Subtotal	
		17.00	PROGRAM	RESI DENCY	22 01	24. 00	
	GENERAL SERVICE COST CENTERS	17. 00	20. 00	23. 00	23. 01	24.00	
1.00	00100 CAP REL COSTS-BLDG & FLXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01	01160 COMMUNI CATI ONS						5. 01
5. 02	01140 MGMT INFO SYSTEMS						5. 02
5. 03	00550 PURCHASI NG						5. 03
5. 04	00570 ADMITTING						5. 04
5. 05 5. 06	00580 PATIENT ACCOUNTING 00560 OTHER ADMINISTRATIVE AND GENERAL						5. 05 5. 06
7. 00	00700 OPERATION OF PLANT						7. 00
8.00	00800 LAUNDRY & LINEN SERVICE						8. 00
9.00	00900 HOUSEKEEPI NG						9. 00
10.00	01000 DI ETARY						10.00
11. 00	01100 CAFETERI A						11. 00
13.00	01300 NURSI NG ADMI NI STRATI ON						13.00
14. 00 15. 00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY						14.00
16. 00	01600 MEDICAL RECORDS & LIBRARY						15. 00 16. 00
17. 00	01700 SOCIAL SERVICE	99, 255					17. 00
20. 00	02000 NURSI NG PROGRAM	0	4, 419, 807				20.00
23. 00	02301 PHARMACY RESIDENCY	0	.,	531, 371			23. 00
23. 01	02300 EMS EDUCATION	0			647, 352		23. 01
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	03000 ADULTS & PEDIATRICS	69, 419	4, 419, 807	0		55, 992, 447	1
31. 00	03100 INTENSIVE CARE UNIT	9, 909	0			9, 667, 457	1
35.00	02060 NEONATAL INTENSIVE CARE UNIT	7, 771	0	1	_	5, 082, 804	1
41. 00 43. 00	04100 SUBPROVI DER - I RF 04300 NURSERY	6, 079 6, 077	0			4, 745, 488 1, 189, 643	1
43.00	ANCI LLARY SERVI CE COST CENTERS	0,077			U	1, 109, 043	43.00
50.00	05000 OPERATI NG ROOM	0	0	0	0	13, 172, 095	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	1, 413, 790	1
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	5, 229, 528	52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0			11, 712, 911	1
55. 00	05500 RADI OLOGY - THERAPEUTI C	0	0	0	-	1, 053, 902	1
56. 00	05600 RADI OI SOTOPE	0	0	0		177, 817	1
56. 01	03950 CARDI AC CATH LAB	0	0	0	_	3, 752, 008	1
57. 00 58. 00	05700 CT SCAN 05800 MRI	0	0	0		1, 882, 470 740, 785	1
60.00	06000 LABORATORY	0	0			15, 283, 239	1
65. 00	06500 RESPI RATORY THERAPY	0	0			4, 750, 395	1
66.00	06600 PHYSI CAL THERAPY	0	0	0		8, 907, 869	1
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	0	0	2, 629, 019	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0	0	0	1, 021, 441	1
69. 00	06900 ELECTROCARDI OLOGY	0	0	0	0	4, 845, 410	1
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0		1, 731, 537	1
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0		17, 704, 560	1
73. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	0		_	12, 615, 879 35, 315, 067	1
73. 00	07301 DI ABETES CENTER		0	0 331, 371		786, 229	
74. 00	07400 RENAL DI ALYSI S	0	0	Ö		2, 253, 683	1
76.00	03480 ONCOLOGY	0	0	0	0	6, 013, 620	1
76. 01	03952 ANTI COAGULATI ON	0	0	0	0	521, 850	76. 01
76. 02	03951 I NFUSI ON SERVI CES	0	0	0	0	2, 189, 692	76. 02
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0	0	0	0	76. 98
00.00	OUTPATIENT SERVICE COST CENTERS					4 000 007	00.00
90. 00 91. 00		0	0			1, 930, 826 15, 849, 079	
91.00			0			2, 935, 123	1
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART		U		U	2, 733, 123	92.00
92. 01	09201 OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	3, 414, 695	1
,2.0.	OTHER REIMBURSABLE COST CENTERS	<u> </u>				5/ 11 1/ 5/5	/2.0.
95.00	09500 AMBULANCE SERVICES	0	0	0	0	5, 571, 775	95. 00
101.00	10100 HOME HEALTH AGENCY	0	0	0	0	7, 977, 477	101. 00
	SPECIAL PURPOSE COST CENTERS						
	11300 INTEREST EXPENSE	_	_	_	_		113. 00
	11600 HOSPI CE	0	0	0		7, 368, 840	1
118.00	3 /	99, 255	4, 419, 807	531, 371	647, 352	277, 430, 450	1118.00
190 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	ام	^	0	0	531, 588	190 00
	19000 BIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES		0			29, 147, 633	
	07950 MOB		0	0			194. 00
194. 01	07951 LI FELI NE		0	Ö			194. 01
	207952 PATIENT TRANSPORT	0	0	0	0	0	194. 02

Heal th Financial	Systems	FRANCISCAN HEALT	H LAFAYETTE		In Lie	u of Form CMS-2552-10
COST ALLOCATION	- GENERAL SERVICE COSTS		Provider C	CN: 15-0109		Worksheet B Part I Date/Time Prepared: 5/2/2022 3:08 pm

						5/2/2022 3:08	pm
	Cost Center Description	SOCIAL SERVICE	NURSI NG	PHARMACY	EMS EDUCATION	Subtotal	
			PROGRAM	RESI DENCY			
		17. 00	20.00	23. 00	23. 01	24.00	
194. 03 07954	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	5, 869, 764	194. 03
200.00	Cross Foot Adjustments		0	0	0	0	200. 00
201.00	Negative Cost Centers	0	0	0	0	-174, 843	201. 00
202. 00	TOTAL (sum lines 118 through 201)	99, 255	4, 419, 807	531, 371	647, 352	312, 804, 592	202. 00

						To 12/	31/2021	Date/lime Prep 5/2/2022 3:08	
		Cost Center Description	Intern &	Total			.,		-
			Residents Cost						
			& Post Stepdown						
			Adjustments						
			25.00	26. 00					
1 00		AL SERVICE COST CENTERS							1 00
1. 00 2. 00	1	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP							1. 00 2. 00
4. 00	1	EMPLOYEE BENEFITS DEPARTMENT							4. 00
5. 01		COMMUNI CATI ONS							5. 01
5. 02	1	MGMT INFO SYSTEMS							5. 02
5. 03 5. 04	1	PURCHASI NG ADMI TTI NG							5. 03 5. 04
5. 05		PATIENT ACCOUNTING							5. 05
5.06		OTHER ADMINISTRATIVE AND GENERAL							5. 06
7.00		OPERATION OF PLANT							7. 00
8.00		LAUNDRY & LINEN SERVICE							8. 00
9. 00 10. 00		HOUSEKEEPI NG DI ETARY							9. 00 10. 00
11. 00	1	CAFETERI A							11. 00
13.00	01300	NURSING ADMINISTRATION							13. 00
14.00	1	CENTRAL SERVICES & SUPPLY							14.00
15. 00 16. 00	1	PHARMACY MEDICAL RECORDS & LIBRARY							15. 00 16. 00
17. 00	1	SOCIAL SERVICE							17. 00
20. 00	02000	NURSI NG PROGRAM							20. 00
23. 00	1	PHARMACY RESIDENCY							23. 00
23. 01		EMS EDUCATION IENT ROUTINE SERVICE COST CENTERS							23. 01
30. 00	-	ADULTS & PEDIATRICS	0	55, 992, 447					30.00
31.00	1	INTENSIVE CARE UNIT	0	9, 667, 457					31. 00
35. 00	1	NEONATAL INTENSIVE CARE UNIT	0	5, 082, 804					35. 00
41. 00 43. 00	1	SUBPROVI DER - I RF NURSERY	0	4, 745, 488 1, 189, 643					41. 00 43. 00
43.00		LARY SERVICE COST CENTERS	0	1, 107, 043					43.00
50.00		OPERATING ROOM	0	13, 172, 095					50. 00
51.00		RECOVERY ROOM	0	1, 413, 790					51.00
52. 00 54. 00		DELIVERY ROOM & LABOR ROOM RADIOLOGY-DIAGNOSTIC	0	5, 229, 528 11, 712, 911					52. 00 54. 00
55. 00		RADI OLOGY - THERAPEUTI C	0	1, 053, 902					55. 00
56. 00	1	RADI OI SOTOPE	0	177, 817					56. 00
56. 01		CARDI AC CATH LAB	0	3, 752, 008					56. 01
57. 00 58. 00	05800	CT SCAN	0	1, 882, 470 740, 785					57. 00 58. 00
60.00		LABORATORY	0	15, 283, 239					60.00
65.00	06500	RESPI RATORY THERAPY	0	4, 750, 395					65. 00
66.00	1	PHYSI CAL THERAPY	0	8, 907, 869	1				66. 00
67. 00 68. 00		CCUPATIONAL THERAPY SPEECH PATHOLOGY	0	2, 629, 019 1, 021, 441					67. 00 68. 00
		ELECTROCARDI OLOGY		4, 845, 410					69. 00
	07000	ELECTROENCEPHALOGRAPHY	0	1, 731, 537					70. 00
71.00	1	MEDICAL SUPPLIES CHARGED TO PATIENT	0	17, 704, 560					71. 00
72. 00 73. 00		IMPL. DEV. CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS	0	12, 615, 879 35, 315, 067					72. 00 73. 00
73. 00		DI ABETES CENTER	0	786, 229					73. 00
74. 00	1	RENAL DIALYSIS	0	2, 253, 683					74. 00
76. 00	1	ONCOLOGY	0	6, 013, 620					76. 00
76. 01 76. 02		ANTICOAGULATION INFUSION SERVICES	0	521, 850 2, 189, 692					76. 01 76. 02
76. 98		HYPERBARI C OXYGEN THERAPY	0	2, 107, 072					76. 98
		TIENT SERVICE COST CENTERS							
90.00	1	CLINIC	0	1, 930, 826					90.00
91. 00 91. 01		EMERGENCY WOUND CARE	0	15, 849, 079 2, 935, 123					91. 00 91. 01
91.01		OBSERVATION BEDS (NON-DISTINCT PART	0	2, 730, 123					91.01
92. 01	09201	OBSERVATION BEDS (DISTINCT PART)	O	3, 414, 695					92. 01
05.00		REIMBURSABLE COST CENTERS		E					05.00
		AMBULANCE SERVICES HOME HEALTH AGENCY	0	5, 571, 775 7, 977, 477					95. 00 101. 00
101.00		AL PURPOSE COST CENTERS	0	7, 711, 411					1.01.00
	11300	INTEREST EXPENSE							113. 00
		HOSPI CE	0	7, 368, 840	1				116.00
118. 00		SUBTOTALS (SUM OF LINES 1 through 117) IMBURSABLE COST CENTERS	0	277, 430, 450					118. 00
190.00		GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	531, 588					190. 00
		PHYSICIANS' PRIVATE OFFICES	o	29, 147, 633	1				192. 00

Health Financial Systems	FRANCISCAN HEALT	TH LAFAYETTE		In Lie	u of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC	CN: 15-0109	Peri od: From 01/01/2021 To 12/31/2021	Worksheet B Part I Date/Time Prepared: 5/2/2022 3:08 pm
Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total			
	25. 00	26.00			
194. 00 07950 MOB	0	0			194. 00
194. 01 07951 LI FELI NE	0	0			194. 01
194. 02 07952 PATIENT TRANSPORT	0	0			194. 02
194.03 07954 OTHER NONREIMBURSABLE COST CENTERS	0	5, 869, 764			194. 03
200.00 Cross Foot Adjustments	0	0			200. 00
201.00 Negative Cost Centers	0	-174, 843			201. 00
202.00 TOTAL (sum lines 118 through 201)	0	312, 804, 592			202. 00

In Lieu of Form CMS-2552-10
Worksheet B
01/2021 Part II
01/2021 Date/Time Prepared:
05/2/2022 3:08 pm Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS FRANCISCAN HEALTH LAFAYETTE Provider CCN: 15-0109 Peri od: From 01/01/2021 To 12/31/2021 CAPITAL RELATED COSTS Directly BLDG & FIXT MVBLE EQUIP Subtotal EMPLOYEE Cost Center Description

	Cost Center Description	Directly Assigned New Capital	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		Related Costs 0	1.00	2.00	2A	4. 00	
1. 00	GENERAL SERVICE COST CENTERS OO100 CAP REL COSTS-BLDG & FIXT	T					1. 00
2.00	00200 CAP REL COSTS-BLDG & FIXT						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	129, 256	350, 236	479, 492	479, 492	4. 00
5. 01	01160 COMMUNI CATI ONS	0	12, 707		47, 137	2, 945	5. 01
5. 02	01140 MGMT INFO SYSTEMS	0	191, 450		710, 207	3, 103	5. 02
5. 03 5. 04	OO550 PURCHASI NG OO570 ADMI TTI NG	0	138, 470 0		513, 672 0	1	5. 03 5. 04
5. 05	00580 PATIENT ACCOUNTING	0	74, 274	-	275, 528	6	5. 05
5.06	00560 OTHER ADMINISTRATIVE AND GENERAL	0	763, 908		2, 833, 813	91, 252	5. 06
7.00	00700 OPERATION OF PLANT	0	1, 487, 557		5, 518, 279	9, 097	7. 00
8. 00 9. 00	OO800 LAUNDRY & LINEN SERVICE OO900 HOUSEKEEPING	0	58, 738		217, 896 450, 236	909 8, 175	8. 00 9. 00
10.00	01000 DI ETARY	0	121, 370 215, 411		799, 093	4, 871	10. 00
11. 00	01100 CAFETERI A	Ö	194, 642		722, 049	3, 469	11. 00
13.00	01300 NURSING ADMINISTRATION	0	43, 065		159, 754	11, 243	13. 00
14. 00	01400 CENTRAL SERVI CES & SUPPLY	0	71, 282		264, 429	1, 381	
15. 00 16. 00	01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY	0	115, 511 29, 031		428, 502 107, 694	9, 779 164	15. 00 16. 00
17. 00	01700 SOCIAL SERVICE	0	7, 549		28, 003	0	17. 00
20. 00	02000 NURSI NG PROGRAM	0	417, 301		1, 548, 030	7, 895	20. 00
23. 00	02301 PHARMACY RESIDENCY	0	0		0	883	23. 00
23. 01	02300 EMS EDUCATION INPATIENT ROUTINE SERVICE COST CENTERS	0	51, 740	140, 196	191, 936	566	23. 01
30. 00	03000 ADULTS & PEDIATRICS	0	1, 483, 112	4, 018, 678	5, 501, 790	64, 081	30. 00
31. 00	03100 NTENSI VE CARE UNI T	0	143, 590		532, 666	14, 537	31. 00
35. 00	02060 NEONATAL INTENSIVE CARE UNIT	0	100, 488		372, 773	8, 531	35. 00
41.00	04100 SUBPROVI DER - I RF	0	180, 571		669, 850	6, 243	41.00
43. 00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	0	0	0	0	2, 318	43. 00
50.00	05000 OPERATING ROOM	0	411, 830	1, 115, 905	1, 527, 735	13, 422	50. 00
51. 00	05100 RECOVERY ROOM	0	34, 026		126, 224	2, 103	51. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		043 503	10, 449	
54. 00 55. 00	05400 RADI OLOGY - DI AGNOSTI C 05500 RADI OLOGY - THERAPEUTI C	0	227, 404 8, 813		843, 582 32, 694	16, 230 1, 418	
56. 00	05600 RADI OI SOTOPE	0	4, 281		15, 882	294	
56. 01	03950 CARDI AC CATH LAB	0	105, 734		392, 232	5, 262	56. 01
57. 00	05700 CT SCAN	0	19, 266		71, 471	2, 438	
58. 00 60. 00	05800 MRI	0	17, 051 81, 309		63, 252 301, 627	1, 105 0	58. 00 60. 00
65. 00	06500 RESPIRATORY THERAPY	0	28, 893		107, 183	8, 303	65. 00
66.00	06600 PHYSI CAL THERAPY	0	11, 955		44, 350	17, 237	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0			5, 447	67. 00
68. 00 69. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	0	1, 227 130, 759		4, 551 485, 066	2, 021 6, 733	68. 00 69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	67, 088		248, 872	2, 416	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0	0	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	
73. 00 73. 01	O7300 DRUGS CHARGED TO PATIENTS O7301 DI ABETES CENTER	0	0	0	0	0 1, 552	
74. 00	07400 RENAL DIALYSIS	0	23, 047	62, 449	85, 496	589	
76. 00	03480 ONCOLOGY	0	25, 038		92, 880	10, 470	
76. 01	03952 ANTI COAGULATI ON	0	0		0	1, 086	
76. 02	03951 I NFUSI ON SERVI CES 07698 HYPERBARI C OXYGEN THERAPY	0	0		0	2, 199	
76. 98	OUTPATIENT SERVICE COST CENTERS	0	0	l o	U	0	76. 98
90.00	09000 CLI NI C	0	0	0	0	1, 673	90. 00
91.00	09100 EMERGENCY	0	532, 674		1, 976, 021	21, 271	91.00
91. 01 92. 00	04950 WOUND CARE 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	212, 231	575, 066	787, 297	2, 709	91. 01 92. 00
92. 00	09201 OBSERVATION BEDS (NON-DISTINCT PART)	0	100, 025	271, 030	371, 055	4, 943	
	OTHER REIMBURSABLE COST CENTERS	_					
95.00	09500 AMBULANCE SERVICES	0			430, 591	5, 943	
101.00	10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0	98, 535	266, 994	365, 529	14, 284	101.00
	11300 I NTEREST EXPENSE						113. 00
	11600 HOSPI CE	0	_		0		116. 00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	0	8, 288, 283	22, 458, 136	30, 746, 419	422, 778	118.00
190. 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	39, 159	106, 105	145, 264	194	190. 00
				<u>.</u>			

MCRI F32 - 17. 4. 174. 0

Health Financial Systems	FRANCISCAN HEAL	TH LAFAYETTE		In L	eu of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der Co		Peri od: From 01/01/202		
				To 12/31/202	1 Date/Time Pre 5/2/2022 3:08	
		CAPI TAL REI	LATED COSTS			
Cost Center Description	Di rectly Assigned New Capital	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	

1.00

101, 853

1, 555, 371

9, 984, 666

2.00

275, 983

22, 840, 224

0 0 0

4. 00

377, 836

1, 555, 371

32, 824, 890

56, 520 192. 00 0 194. 00

479, 492 202. 00

192. 00 | 19200 | PHYSI CI ANS' PRI VATE OFFI CES 194. 00 | 07950 | MOB 194. 01 | 07951 | LI FELI NE 194. 02 | 07952 | PATI ENT TRANSPORT 194. 03 | 07954 | OTHER NONREI MBURSABLE COST CENTERS 200. 00 | Norative Cost Centers

Negative Cost Centers

TOTAL (sum lines 118 through 201)

200. 00 201. 00

202.00

Control Center Research Control						72/31/2021	5/2/2022 3: 08	
		Cost Center Description	COMMUNI CATI ONS		PURCHASI NG	ADMI TTI NG		
SERBEAL SERVICE COST CENTERS			5. 01		5. 03	5. 04		
2.00								
4.00 0.000 DEPROYER SPEET TO PERSONNETS 1.00 1.0								1
5.01 O 1100 COMMANICATIONS								1
1.0 10 10 10 10 10 10 10			50 082					1
DOSE PURCHANNING			1 ' 1	714, 944				1
5.05 0.0560 DATE INT ACCOUNT IN COUNTY I		1 1		3				1
0.0560 OTHER ABIN INSTRATIVE AND CENERAL 5, 186		1 1	-1	4	0	5		1
0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.00000 0.00000 0.00000 0.00000 0.00000000			1		0	0		1
0.000 0.0000 0.0000 0.000 0.0000 0.0000 0.0000 0.0000 0.0000 0.000		1				0		
0.000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0			1			0		
10.00 01000 DETARY 2,131 28,246 0 0 0 10.00			1			0		
13.00 13.00	10.00	01000 DI ETARY	2, 131		0	0	0	10. 00
14 00 0 1400 CENTRAL SERVICES & SUPPLY		1 1	1	O	-	0	0	11. 00
15.00 0 1500 [PHABMACY 1, 634 15, 924 0 0 0 15.00 15.00 17.0			· ·	•	0	0	0	1
16.00 01-000 MEDI CAL, RECORDS & LI BRARY 1,208 742 0 0 0 0 0 0 0 17.00 17.00 17.00 0 1700 17.00 0 1700 17.00 0 1700 17.00 0 1700 17.00 0 1700 17.00 0 17.00 0 17.00 17.00 0 17.00 0 17.00 17.00 0 17.00		1 1	1	•	0	0	0	1
17.00 01700 SOCIAL SERVICE 0.39 0 0 0 0 17.00		1 1	The state of the s		1	0	-	1
20 00		1 1	t t		o o	0	_	1
		1 1	1	12, 284	0	0	0	1
INPATI ENT ROUTINE SERVICE COST CENTERS 8,170 161,869 0 0 23,041 30,00 310,00 30100 AUDITS & PEDIATRICS 8,170 161,869 0 0 23,041 30,00 310,0		1 I	1	1, 335	0	0	0	
30 00 30000 ADULTS & PEDI ATRICS 8,170 161,669 0 0 23,041 30,00 310 03100 INTENSIVE CARE UNIT 1,563 26,796 0 0 4,488 31,00 35,00 20600 NEWATAL INTENSIVE CARE UNIT 1,208 14,053 0 0 0 3,768 35,00 0 3,768 35,00 0 3,768 35,00 0 3,768 35,00 0 3,768 35,00 0 3,768 35,00 0 3,768 35,00 0 3,768 35,00 0 3,768 35,00 0 3,768 35,00 0 3,768 35,00 0 3,00 3	23. 01		0	58	0	0	0	23. 01
33.00 03100 INTENSIVE CARE UNIT	20.00		0 170	141 040	1 0	0	22 041	20.00
13. 00 02060 NEONATAL INTENSIVE CARE UNIT 1, 208		1	1 ' 1	· ·		_	•	1
141 0.0 04100 SUBPROVIDER - I RF 1,705 10,915 0 0 3,214 41,00						ŭ		ı
ANCIL LARY SERVICE COST CENTERS		1				0		
50.00 05000 0FECRATING ROOM 1,705 30,334 0 0 31,076 50.00 51.00 05100 06100 06200 RECURERY ROOM 5.688 3,117 0 0 0 3,765 52.00 05200 0610 RECURERY ROOM 1,847 0 0 0 3,765 52.00 05500 RADIOLOGY - THERAPEUTI C 4,262 30,083 0 0 18,633 54.00 05400 RADIOLOGY - THERAPEUTI C 0 2,997 0 0 2,667 55.00 05500 RADIOLOGY - THERAPEUTI C 0 0 2,997 0 0 2,667 55.00 05500 RADIOLOGY - THERAPEUTI C 0 0 0 5.22 0 0 0 7 5.600 05600 RADIOLOGY - THERAPEUTI C 0 0 0 0 0 0.522 0 0 0 0 0.5500	43.00	04300 NURSERY	0	0	0	0	835	43. 00
51.00 OSTOO RECOVERY ROOM			4 705	22.22.	1 -		04.07/	
S2.00 05.200 05.200 05.200 05.000 0 0 0 0 0 0 0 0 0								
S4-00 OS4000 RADIO LOCY-DI ACMORSTIC 4, 262 30, 083 0 0 18, 633 54 00 0 55. 00 05500 RADIO LOCY-DI THERAPEUTIC 0 2, 997 0 0 2, 667 55 00 05600 RADIO LOCY-DI THERAPEUTIC 0 5.22 0 0 7, 55 00 05600 RADIO LOCY-DI THERAPEUTIC 0 5.22 0 0 7, 55 00 0 11, 453 56 01 01 11, 453 56 01 01 11, 453 56 01 01 11, 453 56 01 01 11, 453 56 01 01 11, 453 56 01 01 11, 453 56 01 01 01 01 01 01 01 0			l l			-		1
55.00 05500 RADIOLOGY - THERAPEUTIC		1 1	1	-	_	0		1
55.00 03950 CARDI AC CATH LAB	55. 00	1 1	1		0	0		1
57.00 05700 CT SCAN 0 4,585 0 0 12,739 57.00	56. 00		0	522	0	0	7	56. 00
58.00 05800 MR		1 1	0		_	0		1
60.0 06000 LABORATORY 3, 126 0 0 26, 494 60.00 65.0 0 06500 RESPIRATORY THERAPY 2, 415 15, 312 0 0 4, 348 65.00 66.0 0 06600 PAYSI CAL THERAPY 426 33, 572 0 0 5, 688 66.00 67.0 0 06700 0CCUPATI ONAL THERAPY 0 10, 024 0 0 2, 677 67.00 68.0 0 06800 SPEECH PATHOLOGY 0 3, 662 0 0 938 68.00 69.0 0 06900 ELECTROCARDI OLOGY 426 12, 953 0 0 7, 729 69.00 71.0 0 07000 ELECTROCHOEPHALOGRAPHY 0 4,376 0 0 1, 019 70.00 770.0 0 07000 ELECTROCHOEPHALOGRAPHY 0 4,376 0 0 1, 019 70.00 771.0 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 0 5 38, 190 71.00 772.00 07200 IMPL. DEV. CHARGED TO PATIENT 0 0 0 0 17, 979 72.00 773.00 07300 ORUGS CHARGED TO PATIENTS 0 0 0 0 15, 474 73.00 774.00 07400 RENAL DIALYSIS 0 0 0 0 15, 474 73.00 776.00 03480 ONCOLOGY 0 0 0 0 0 3, 893 76.00 776.01 03952 ANTICOAGULATI ON 0 0 0 0 195 76.00 776.02 03951 INFUSION SERVI CES 0 0 0 0 0 0 195 76.00 776.09 07699 HYPERBARIC COXYGEN THERAPY 0 0 0 0 0 0 0 777.00 07900 OLDINIC 0 0 0 0 0 0 0 777.00 07900 OLDINIC 0 0 0 0 0 0 777.00 07900 OSERVATION BEDS (NON-DISTINCT PART 0 0 0 0 0 0 0 777.00 07900 OSERVATION BEDS (NON-DISTINCT PART 0 0 0 0 0 0 0 777.00 07900 OSERVATION BEDS (NON-DISTINCT PART 0 0 0 0 0 0 0 0 777.00 07900 OSERVATION BEDS (NON-DISTINCT PART 0 0 0 0 0 0 0 0 0 777.00 07900 0 0 0 0 0 0 0 0 0			1			0		1
65.00 06500 RESPI RATORY THERAPY 2, 415 15, 312 0 0 4, 348 65.00 66.00 06600 PHYSI CAL THERAPY 426 33, 572 0 0 5, 688 66.00 67.00 06700 OCCUPATIONAL THERAPY 0 10, 024 0 0 2, 677 67.00 68.00 06800 SPEECH PATHOLOGY 0 3, 962 0 0 938 68.00 69.00 06900 ELECTROCARDI OLOGY 426 12,953 0 0 7, 729 69.00 70.00 07000 ELECTROCARDI OLOGY 426 12,953 0 0 7, 729 69.00 70.00 07000 CLECTROCARDI OLOGY 426 12,953 0 0 7, 729 69.00 70.00 07000 OTO OLOGO 10,000 0 0 0 0 0 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0 0 0 0 0 17, 979 72.00 72.00 07200 MPL DEV CHARGED TO PATI ENTS 0 0 0 0 0 17, 979 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 17, 73.00 73.01 07301 DI ABETES CENTER 426 3, 129 0 0 1 73.01 74.00 07400 RENAL DI ALYSIS 0 958 0 0 632 74.00 75.01 03952 ANTI COAGULATI ON 0 20, 371 0 0 3, 893 1 NFUSI ON SERVICES 0 3, 608 0 0 911 76.02 76.02 039531 INFUSI ON SERVICES 0 3, 608 0 0 911 76.02 76.03 07400 OTO		1 1	1 -1	1, 501	_	0		
66.00 06600 PhySi Cal Therapy 426 33, 572 0 0 5, 688 66, 00 67.00 06700 0CCUPATI ONAL THERAPY 0 10, 024 0 0 2, 677 67.00 06700 0CCUPATI ONAL THERAPY 0 10, 024 0 0 2, 677 67.00 0700 06800 SPEECH PATHOLOGY 0 3, 962 0 0 938 68.00 06900 ELECTROCARDI OLOGY 426 12, 953 0 0 7, 729 69.00 06900 ELECTROCARDI OLOGY 426 12, 953 0 0 7, 729 69.00 07000 ELECTROCARDI OLOGY 0 4, 376 0 0 1, 197 70.00 07000 ELECTROCHEPHALOGRAPHY 0 4, 376 0 0 5 38, 190 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0 0 0 0 0 17, 979 72.00 072.00 IMPL. DE DEV. CHARGED TO PATI ENTS 0 0 0 0 0 17, 979 73.01 07301 DI ABETES CENTER 426 3, 129 0 0 15, 474 73.01 07301 DI ABETES CENTER 426 3, 129 0 0 1 73, 01 74.00 07400 RENAL DI ALYSIS 0 958 0 0 632 74, 00 76.01 03952 ANTI COAGULATI ON 0 1,678 0 0 191 76.02 03951 INFUSI ON SERVICES 0 3, 608 0 0 911 76, 02 76.03 07698 VHYPERBAIC COXYGEN THERAPY 0 0 0 0 76.04 07698 VHYPERBAIC COXYGEN THERAPY 0 0 0 0 76.07 07600 09000 0 0 0 77.09 07900 EMERGENCY 0 39, 579 0 0 22, 314 78.00 07900 0 EMERGENCY 0 39, 579 0 0 22, 314 79.00 07900 0 EMERGENCY 0 39, 579 0 0 22, 314 79.00 07900 0 DESERVATI ON BEDS (DI STI NCT PART 0 0 1, 721 79.00 07900 0 0 0 0 0 70 0700 0 0 0 0 0 70 0 0 0 0 0 0 70 0 0 0 0 0 0 70 0 0 0 0 0 70 0 0 0 0 0 70 0 0 0 0 0 70 0 0 0 0 0 70 0 0 0 0 0 70 0 0 0 0 0 70 0 0 0 0 0 70 0 0 0 0 0 70 0 0 0 0 0 70 0 0 0 0 0 70 0 0 0 0 0 70 0 0 0 0 71 0 0 0 0 71 0 0 0 0 0 71 0 0 0 0 71 0 0 0 0 71 0 0 0 0 71 0 0		1		15. 312	_	0		
68.00 06800 SPEECH PATHOLOGY 0 3,962 0 0 938 68. 00 69.00 06900 ELECTROCARDI OLOGY 426 12,953 0 0 7,729 69. 00 70. 00		1	The state of the s		0	0		
69.00 0.0900 ELECTROCARDIOLOGY	67. 00	06700 OCCUPATI ONAL THERAPY	0	10, 024	0	0	2, 677	67. 00
70. 00 07000 ELECTROENCEPHALGGRAPHY 0 4,376 0 0 1,019 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0 0 0 0 0 17,979 72. 00 73. 00 07200 MPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 17,979 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 15,474 73. 00 73. 01 07301 DIABETES CENTER 426 3,129 0 0 1 73. 00 74. 00 07400 RENAL DIALYSIS 0 958 0 0 632 74. 00 76. 00 03480 0NCOLOGY 0 0 0 1,678 0 0 0 195 76. 01 76. 01 03952 ANTI CAGULATI ON 0 1,678 0 0 195 76. 01 76. 02 03951 INFUSION SERVICES 0 3,608 0 0 911 76. 02 76. 90 07698 HYPERBARI COXYGEN THERAPY 0 0 0 0 0 0 0 76. 98 07698 HYPERBARI COXYGEN THERAPY 0 0 0 0 0 0 0 0 0		1 1	1			0		
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0 0 0 5 38, 190 71. 00 72. 00 72. 00 72. 00 72. 00 72. 00 72. 00 72. 00 72. 00 73. 00 74. 73. 00 74. 00			1			0		
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 117, 979 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 15, 474 73.00 73.01 07301 DIABETES CENTER 426 3.129 0 0 1 73.01 74.00 07400 RENAL DIALYSIS 0 958 0 0 6.32 74.00 76.00 03480 000COLOGY 0 0 20.371 0 0 3.893 76.00 76.01 03952 ANTI COAGULATI ON 0 1,678 0 0 911 76.01 76.02 03951 INFUSI ON SERVI CES 0 0 3,608 0 0 911 76.02 76.98 PDEPRBARI COXYGEN THERAPY 0 0 0 0 0 0 0 76.98 PDEPRBARI COXYGEN THERAPY 0 0 0 0 0 0 0 0 0		1	1 -1		1	0		1
73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 15, 474 73. 00 73. 01 07301 DI ABETES CENTER 426 3, 129 0 0 1 73. 01 74. 00 07400 RENAL DI ALYSIS 0 958 0 0 0 632 74. 00 76. 01 03480 ONCOLOGY 0 1, 678 0 0 0 3, 893 76. 00 76. 01 03952 ANTI COAGULATI ON 0 1, 678 0 0 0 195 76. 01 76. 02 03951 INFUSION SERVI CES 0 0 3, 608 0 0 0 1915 76. 01 76. 98 07698 HYPERBARI C 0XYGEN THERAPY 0 0 0 0 0 0 0 0 0 76. 98 00. 00 09000 CLI IN C 2, 273 5, 213 0 0 0 129 90. 00 91. 00 09000 CLI IN C 2, 273 5, 213 0 0 0 129 90. 00 91. 00 09100 EMERGENCY 0 39, 579 0 0 129 90. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0 0 0 10, 197 0 0 1, 605 92. 01 07HER REI MBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVI CES 0 18, 711 0 0 0 1, 721 101. 00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 I INTEREST EXPENSE 119. 00 01900 GIFT, FLOWER, COFFEE SHOP & CANTEEN 190. 00 19000 OFFIT, F			1			0		
74. 00 07400 RENAL DIALYSIS 0 0 958 0 0 632 74. 00 76. 01 03480 ONCOLOGY 0 0 20, 371 0 0 3, 893 76. 00 76. 01 03952 ANTI COAGULATION 0 1, 678 0 0 0 195 76. 01 76. 02 03951 INFUSION SERVICES 0 3, 608 0 0 911 76. 02 76. 98 07698 HYPERBARIC OXYGEN THERAPY 0 0 0 0 0 0 0 0 0 0 00 0 0 0 0 0 0 0 0			0	0	Ō	0		1
76. 00	73. 01	07301 DI ABETES CENTER	426	3, 129	0	0	1	73. 01
76. 01 03952 ANTI COAGULATI ON			0		0	0		
76. 02 03951 NFUSION SERVICES 0 3,608 0 0 911 76. 02 76. 98 OT698 HYPERBARI C OXYGEN THERAPY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0		0	0		
76. 98 O7698 HYPERBARI C OXYGEN THERAPY O O O O O O O O O O O O O O O O O O O		l l	0			0		
OUTPATIENT SERVICE COST CENTERS OUTPATIENT SERVICE						0		
91. 00	70.70							70.70
91. 01	90.00	09000 CLI NI C	2, 273	5, 213	0	0	129	90. 00
92. 00		l l	0			0		
92. 01 09201 0BSERVATI ON BEDS (DISTINCT PART) 0 10, 197 0 0 1, 605 92. 01			0	4, 018	0	0	120	
OTHER REI MBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVI CES 0 24,928 0 0 2,151 95.00				10 107	0	0	1 605	
95. 00	92.01		<u> </u>	10, 197	U	0	1,005	92.01
101. 00 10100 HOME HEALTH AGENCY 0 18, 711 0 0 1, 721 101. 00	95. 00		0	24, 928	0	0	2, 151	95. 00
113. 00 11300 INTEREST EXPENSE 116. 00 11600 HOSPI CE 0 0 0 4, 019 116. 00 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 50, 082 713, 342 0 5 276, 556 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 509 0 0 0 190. 00 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 1, 093 0 0 0 192. 00 194. 00 07950 MOB 0 0 0 0 0 194. 00 194. 01 07951 LI FELI NE 0 0 0 0 0 194. 01		1						1
116. 00 11600 HOSPI CE 0 18, 651 0 0 4, 019 116. 00 118. 0								
118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 50, 082 713, 342 0 5 276, 556 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 509 0 0 0 190. 00 192. 00 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 1, 093 0 0 0 192. 00 194. 00 194. 01 194. 01 1975 LI FELI NE 0 0 0 0 194. 01 19					_	_		1
NONREI MBURSABLE COST CENTERS 190. 00		1	1					
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 509 0 0 0 190. 00 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 1,093 0 0 0 192. 00 194. 00 07950 MOB 0 0 0 0 0 194. 00 194. 01 07951 LI FELI NE 0 0 0 0 0 194. 01	118.00	3 /	50, 082	/13, 342	1 0	5	2/6, 556	1118.00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 1, 093 0 0 192. 00 194. 00 194. 00 0 0 0 0 0 194. 00 0 0 0 194. 01 01 01 01 01 01 01 01 01 01 01 01 01	190 00		n	509	n	0	n	190. 00
194. 00 07950 MOB 0 0 0 194. 00 194. 01 07951 LI FELI NE 0 0 0 0 0 194. 01						0		
	194.00	07950 MOB	0		1	0	0	194. 00
194. 02 07952 PATI ENT TRANSPORT 0 0 0 0 0 194. 02			1	0	1	0		
	194. 02	U/952 PAILENI IRANSPORT	0	0	0	0	0	194. 02

Health Financial Systems	FRANCISCAN HEALTH LAFAYETTE	In Lieu of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS	Provi der CCN: 15-0109	Period: Worksheet B From 01/01/2021 Part II To 12/31/2021 Date/Time Prepared:

						5/2/2022 3:08	_pm
	Cost Center Description	COMMUNI CATI ONS	MGMT INFO	PURCHASI NG	ADMI TTI NG	PATI ENT	
			SYSTEMS			ACCOUNTI NG	
		5. 01	5.02	5. 03	5. 04	5. 05	
194. 03 07954	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194. 03
200. 00	Cross Foot Adjustments						200. 00
201. 00	Negative Cost Centers	0	0	514, 671	0	0	201. 00
202.00	TOTAL (sum lines 118 through 201)	50, 082	714, 944	514, 671	5	276, 556	202.00

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

					'	0 12/31/2021	5/2/2022 3:08	
		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	
	GENER	AL SERVICE COST CENTERS	5.00	7.00	0.00	9.00	10.00	
1.00		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	1	COMMUNI CATI ONS						5. 01
5. 02		MGMT INFO SYSTEMS						5. 02
5. 03	1	PURCHASING						5. 03
5.04		ADMITTING						5. 04
5. 05 5. 06		PATIENT ACCOUNTING OTHER ADMINISTRATIVE AND GENERAL	2, 974, 596					5. 05 5. 06
7. 00		OPERATION OF PLANT	175, 033	5, 731, 196				7.00
8. 00		LAUNDRY & LINEN SERVICE	14, 637	46, 840				8.00
9. 00		HOUSEKEEPI NG	51, 927	96, 784		643, 922		9. 00
10.00		DI ETARY	45, 104	171, 776		25, 444	1, 084, 608	10.00
11.00	01100	CAFETERI A	15, 772	155, 214	0	22, 991	0	11. 00
13.00	1	NURSING ADMINISTRATION	55, 636	34, 341		5, 087	0	13. 00
14. 00		CENTRAL SERVICES & SUPPLY	13, 375	56, 843		8, 420	0	14. 00
15.00		PHARMACY	178, 010	92, 112		13, 644	0	15. 00
16.00		MEDICAL RECORDS & LIBRARY SOCIAL SERVICE	26, 930	23, 150		3, 429	0	16.00
17. 00 20. 00	1	NURSI NG PROGRAM	683 27, 140	6, 020 332, 770		892 49, 290	0	17. 00 20. 00
23. 00		PHARMACY RESIDENCY	4, 999	332, 770		49, 290	0	23. 00
23. 00	1	EMS EDUCATION	4, 366	41, 259		6, 111	0	23. 00
20.01		IENT ROUTINE SERVICE COST CENTERS	1,000	11, 20,		0, 111		20.01
30.00		ADULTS & PEDIATRICS	358, 544	1, 182, 685	99, 839	175, 180	898, 492	30. 00
31.00	03100	INTENSIVE CARE UNIT	74, 844	114, 504	15, 209	16, 960	115, 349	31. 00
35. 00		NEONATAL INTENSIVE CARE UNIT	41, 610	80, 133	6, 339		0	35. 00
41. 00		SUBPROVI DER - I RF	33, 078	143, 993		21, 328	70, 767	41. 00
43. 00		NURSERY	10, 572	0	10, 418	0	0	43. 00
FO 00		LARY SERVICE COST CENTERS	01 000	220, 400	10 (00	40 (44	0	
50. 00 51. 00		OPERATING ROOM RECOVERY ROOM	91, 888 10, 948	328, 408		48, 644 4, 019	0	50. 00 51. 00
52. 00	1	DELIVERY ROOM & LABOR ROOM	48, 687	27, 134 0		4,019	0	52.00
54. 00		RADI OLOGY-DI AGNOSTI C	98, 480	181, 339		26, 860	0	54.00
55. 00		RADI OLOGY - THERAPEUTI C	9, 323	7, 028		1, 041	0	•
56. 00		RADI OI SOTOPE	1, 454	3, 414		506	0	56. 00
56. 01	1	CARDI AC CATH LAB	27, 622	84, 316		12, 489	0	56. 01
57.00	05700	CT SCAN	15, 685	15, 364	0	2, 276	0	57. 00
58. 00	05800		6, 171	13, 597	0	2, 014	0	58. 00
60.00		LABORATORY	139, 616	64, 839		9, 604	0	60. 00
65. 00	1	RESPI RATORY THERAPY	40, 690	23, 041		3, 413	0	65. 00
66. 00		PHYSI CAL THERAPY	77, 685	9, 534		1, 412	0	66.00
67. 00		OCCUPATIONAL THERAPY	23, 026	0		0	0	67. 00
68. 00 69. 00	1	SPEECH PATHOLOGY ELECTROCARDI OLOGY	8, 905 38, 477	978 104, 271	1, 602	145 15, 445	0	68. 00 69. 00
70.00		ELECTROCARDIOLOGY	13, 272	53, 498		7, 924	0	ł
71. 00		MEDICAL SUPPLIES CHARGED TO PATIENT	164, 367	0 0			0	1
72. 00		IMPL. DEV. CHARGED TO PATIENTS	118, 083	0		o	0	
73. 00		DRUGS CHARGED TO PATIENTS	146, 283	0		o	0	73. 00
73. 01		DI ABETES CENTER	6, 948	0	0	0	0	73. 01
74.00	07400	RENAL DIALYSIS	17, 415	18, 379	0	2, 722	0	74. 00
76.00		ONCOLOGY	55, 104	19, 966	0	2, 957	0	76. 00
76. 01		ANTI COAGULATI ON	4, 875	0		0	0	76. 01
76. 02	1	INFUSION SERVICES	20, 580	0		0	0	76. 02
76. 98		HYPERBARI C OXYGEN THERAPY	0	0	0	0	0	76. 98
00 00		TIENT SERVICE COST CENTERS	10 104			ol	0	90. 00
90. 00 91. 00		CLI NI C EMERGENCY	18, 124 115, 176	0 424, 773		62, 918	0	90.00
91. 00		WOUND CARE	19, 889	169, 240		25, 068	0	91.00
92. 00	1	OBSERVATION BEDS (NON-DISTINCT PART	17,007	107, 240		25, 000	O	92. 00
92. 01		OBSERVATION BEDS (DISTINCT PART)	28, 408	79, 763	0	11, 815	0	•
		REI MBURSABLE COST CENTERS		,		, , , , ,		
		AMBULANCE SERVICES	44, 498	92, 561			0	95. 00
101.00		HOME HEALTH AGENCY	69, 110	78, 575	0	11, 639	0	101. 00
		AL PURPOSE COST CENTERS	Г		Т			
	1	INTEREST EXPENSE	// 500	_	_		~	113.00
116.00		HOSPICE SUBTOTALS (SUM OF LINES 1 through 117)	66, 503 2, 679, 552	4, 378, 442	0 282, 813	627, 266	0 1, 084, 608	116.00
118.UC		IMBURSABLE COST CENTERS	2,019,552	4, 3/8, 442	282,813	021, 200	1, 084, 608	ji 10. UU
190 00		GIFT, FLOWER, COFFEE SHOP & CANTEEN	3, 682	31, 227	0	4, 625	n	190. 00
		PHYSICIANS' PRIVATE OFFICES	273, 457	81, 221		12, 031		192. 00
194.00	07950	MOB		0	1	0	0	194. 00
		LIFELINE	o	0	0	o		194. 01

Health Financial Systems	FRANCISCAN HEALTH LAFAYETTE	In Lie	u of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS	Provi der CCN: 15-0109	Peri od: From 01/01/2021 To 12/31/2021	Worksheet B Part II Date/Time Prepared: 5/2/2022 3:08 nm

							5/2/2022 3:08	pm
		Cost Center Description	OTHER	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
			ADMI NI STRATI VE	PLANT	LINEN SERVICE			
			AND GENERAL					
			5.06	7. 00	8. 00	9. 00	10.00	
194	. 02 07952	PATIENT TRANSPORT	0	0	0	0	0	194. 02
194	. 03 07954	OTHER NONREIMBURSABLE COST CENTERS	17, 905	1, 240, 306	0	0	0	194. 03
200	. 00	Cross Foot Adjustments						200. 00
201	. 00	Negative Cost Centers	0	0	0	0	0	201. 00
202	. 00	TOTAL (sum lines 118 through 201)	2, 974, 596	5, 731, 196	282, 813	643, 922	1, 084, 608	202.00

				12/31/2021	5/2/2022 3:08	
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		ADMI NI STRATI ON	SERVI CES & SUPPLY		RECORDS & LI BRARY	
	11. 00	13. 00	14.00	15. 00	16. 00	
GENERAL SERVICE COST CENTERS						
1.00 O0100 CAP REL COSTS-BLDG & FIXT						1. 00
2. 00 00200 CAP REL COSTS-MVBLE EQUI P						2.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01 01160 COMMUNI CATIONS 5.02 01140 MGMT INFO SYSTEMS						5. 01 5. 02
5. 03 00550 PURCHASI NG						5. 02
5. 04 00570 ADMI TTI NG						5. 04
5. 05 00580 PATIENT ACCOUNTING						5. 05
5.06 00560 OTHER ADMINISTRATIVE AND GENERAL						5. 06
7.00 00700 OPERATION OF PLANT						7. 00
8.00 00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00 00900 HOUSEKEEPI NG						9. 00
10. 00 01000 DI ETARY	040 405					10.00
11. 00 01100 CAFETERIA	919, 495					11.00
13.00 O1300 NURSI NG ADMINI STRATI ON 14.00 O1400 CENTRAL SERVI CES & SUPPLY	31, 324 7, 296		363, 840			13. 00 14. 00
15. 00 01500 PHARMACY	25, 014	0	2, 760	767, 379		15. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	1, 165	o o	0	0	164, 482	16. 00
17. 00 01700 SOCIAL SERVICE	0	o	0	Ö	0	17. 00
20. 00 02000 NURSI NG PROGRAM	19, 296	O	0	o	0	20. 00
23. 00 02301 PHARMACY RESIDENCY	2, 098	0	0	o	0	23. 00
23. 01 02300 EMS EDUCATION	91	0	0	0	0	23. 01
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	254, 266		19, 875	0	13, 626	30. 00
31. 00 03100 INTENSIVE CARE UNIT	45, 237		4, 690	0	2, 654	31.00
35. 00 02060 NEONATAL INTENSIVE CARE UNIT	22, 074		1, 384	0	2, 228	35. 00
41. 00 04100 SUBPROVI DER - RF 43. 00 04300 NURSERY	17, 146 0		520 0	0	718 494	41. 00 43. 00
ANCI LLARY SERVI CE COST CENTERS		0	U	<u> </u>	494	43.00
50. 00 05000 OPERATI NG ROOM	47, 650	21, 501	178, 548	ol	18, 378	50. 00
51. 00 05100 RECOVERY ROOM	4, 897	2, 210	241	ő	1, 545	51. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	O	2, 226	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	47, 255	0	21, 459	o	11, 020	54.00
55. 00 05500 RADI OLOGY - THERAPEUTI C	4, 707	0	112	o	1, 578	55. 00
56. 00 05600 RADI OI SOTOPE	821	370	0	0	4	56. 00
56. 01 03950 CARDI AC CATH LAB	13, 845		37, 490	0	6, 773	56. 01
57. 00 05700 CT SCAN	7, 203		1, 753	0	7, 534	57. 00
58. 00 05800 MRI	2, 358	0	408	0	1, 201	58. 00
60. 00 06000 LABORATORY	0	10.053	1, 122	0	15, 669	60.00
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	24, 053 52, 735		7, 462 3, 146	0	2, 571 3, 364	65. 00 66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	15, 746		245	0	1, 583	67.00
68. 00 06800 SPEECH PATHOLOGY	6, 224		36	Ö	554	68. 00
69. 00 06900 ELECTROCARDI OLOGY	20, 346		506	o	4, 571	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	6, 874		770	o	603	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	o	23, 514	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	10, 633	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	767, 379	9, 151	73. 00
73. 01 07301 DI ABETES CENTER	4, 915		6	0	1	73. 01
74. 00 07400 RENAL DI ALYSI S	1, 505		66, 134	0	374	74.00
76. 00 03480 ONCOLOGY	32, 000		203	0	2, 302	76.00
76. 01 03952 ANTI COAGULATI ON 76. 02 03951 INFUSI ON SERVI CES	2, 636 5, 667	0	0	U	115 539	76. 01 76. 02
76. 02 03931 THPUSTON SERVICES 76. 98 07698 HYPERBARI C OXYGEN THERAPY	3,667	0	0	0	0	76. 02 76. 98
OUTPATIENT SERVICE COST CENTERS		U	U _I	<u> </u>	0	70. 70
90. 00 09000 CLINIC	8, 188	0	278	O	76	90.00
91. 00 09100 EMERGENCY	62, 171		12, 437	ol	13, 196	91. 00
91. 01 04950 WOUND CARE	6, 312			o	71	91. 01
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
92.01 09201 OBSERVATION BEDS (DISTINCT PART)	16, 018	0	900	0	949	92. 01
OTHER REIMBURSABLE COST CENTERS	•					
95. 00 09500 AMBULANCE SERVICES	39, 157		1, 330	0	1, 272	95. 00
101. 00 10100 HOME HEALTH AGENCY	29, 392	13, 263	0	0	1, 018	101. 00
SPECIAL PURPOSE COST CENTERS				Т		112 00
113. 00 11300 INTEREST_EXPENSE 116. 00 11600 H0SPI CE	20, 200	12 220			רדנ נ	113. 00 116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	29, 298 916, 980		363, 840	767, 379	2, 377 164, 482	
NONREI MBURSABLE COST CENTERS	710, 700	J 317, 7 00	303, 040	707, 379	104, 402	110.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	799	0	0	nl	0	190. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	1, 716		0	ol		192. 00
194. 00 07950 MOB	0		0	o	0	194. 00
194. 01 07951 LI FELI NE	0	0	0	o	0	194. 01

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

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0109 | Period: From 01/01/2021 | To 12/31/2021 | Date/Time Prepared: 5/2/2022 3: 08 pm

					5/2/2022 3:08	pm
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	
194. 02 07952 PATIENT TRANSPORT	0	0	0	0	0	194. 02
194.03 07954 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194. 03
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	0	0	0	0	0	201. 00
202.00 TOTAL (sum lines 118 through 201)	919, 495	317, 965	363, 840	767, 379	164, 482	202. 00

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

				'	o 12/31/2021	Date/lime Pre 5/2/2022 3:08	
	Cost Center Description	SOCI AL SERVI CE	NURSI NG	PHARMACY	EMS EDUCATION	Subtotal	J
		17.00	PROGRAM	RESI DENCY	22.01	24.00	
	GENERAL SERVICE COST CENTERS	17. 00	20. 00	23. 00	23. 01	24. 00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01	01160 COMMUNI CATI ONS						5. 01
5. 02	01140 MGMT INFO SYSTEMS						5. 02
5. 03	00550 PURCHASI NG						5. 03
5. 04 5. 05	OO570 ADMITTING OO580 PATIENT ACCOUNTING						5. 04 5. 05
5. 06	00560 OTHER ADMINISTRATIVE AND GENERAL	1					5. 06
7. 00	00700 OPERATION OF PLANT						7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE						8. 00
9.00	00900 HOUSEKEEPI NG						9. 00
10.00	01000 DI ETARY						10. 00
11. 00	01100 CAFETERI A						11. 00
13.00	01300 NURSI NG ADMI NI STRATI ON						13.00
14.00	01400 CENTRAL SERVI CES & SUPPLY						14.00
15. 00 16. 00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY						15. 00 16. 00
17. 00	01700 SOCIAL SERVICE	36, 237					17. 00
20. 00	02000 NURSI NG PROGRAM	0	1, 996, 705				20.00
23. 00	02301 PHARMACY RESIDENCY	0	., ,,,,,	9, 315	5		23. 00
23. 01	02300 EMS EDUCATION	O		,	244, 387		23. 01
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	25, 343				8, 901, 531	30. 00
	03100 INTENSIVE CARE UNIT	3, 618				995, 529	1
35. 00	02060 NEONATAL INTENSIVE CARE UNIT	2, 837				578, 768	
41. 00	04100 SUBPROVI DER - I RF	2, 220				992, 803	1
43. 00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	2, 219				26, 856	43. 00
50. 00	05000 OPERATING ROOM	0				2, 388, 889	50.00
51. 00	05100 RECOVERY ROOM	0				194, 740	1
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0				78, 113	1
54.00	05400 RADI OLOGY-DI AGNOSTI C	O				1, 316, 607	1
55.00	05500 RADI OLOGY - THERAPEUTI C	0				63, 565	55. 00
56. 00	05600 RADI OI SOTOPE	0				23, 274	56. 00
56. 01	03950 CARDI AC CATH LAB	0				607, 693	1
57. 00	05700 CT SCAN	0				141, 048	1
58. 00	05800 MRI	0				93, 637	1
60. 00 65. 00	06000 LABORATORY 06500 RESPI RATORY THERAPY	0				563, 900 251, 755	1
66. 00	06600 PHYSI CAL THERAPY					276, 874	1
67. 00	06700 OCCUPATI ONAL THERAPY					65, 853	
68. 00	06800 SPEECH PATHOLOGY	0				31, 123	1
69.00	06900 ELECTROCARDI OLOGY	0				707, 306	1
70.00	07000 ELECTROENCEPHALOGRAPHY	0				342, 726	70. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0				226, 076	71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0				146, 695	
	07300 DRUGS CHARGED TO PATIENTS	0				938, 287	1
	07301 DI ABETES CENTER	0				19, 196	1
	07400 RENAL DIALYSIS 03480 ONCOLOGY					194, 883 240, 146	1
	03952 ANTI COAGULATI ON					10, 585	1
	03951 I NFUSI ON SERVI CES	0				33, 504	1
	07698 HYPERBARI C OXYGEN THERAPY	0				0	1
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLI NI C	0				35, 954	1
	09100 EMERGENCY	0				2, 804, 039	1
	04950 WOUND CARE	0				1, 017, 597	1
	09200 OBSERVATION BEDS (NON-DISTINCT PART					FOF /FO	92.00
92.01	09201 OBSERVATION BEDS (DISTINCT PART) OTHER REIMBURSABLE COST CENTERS	0				525, 653	92. 01
95 00	09500 AMBULANCE SERVICES	0				673, 810	05.00
	10100 HOME HEALTH AGENCY					603, 242	1
	SPECIAL PURPOSE COST CENTERS	<u> </u>				000, 2.12	1.000
113.00	11300 NTEREST EXPENSE						113. 00
116.00	11600 H0SPI CE	0				143, 799	116. 00
118. 00	, ,	36, 237	0		0	26, 256, 056	118. 00
	NONREI MBURSABLE COST CENTERS				1		1
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0				186, 300	
	19200 PHYSI CLANS' PRI VATE OFFI CES					803, 874	
	07950 MOB	0					194. 00 194. 01
	07951 LIFELINE 07952 PATIENT TRANSPORT				1		194. 01
174.02	John Sell Miller House out	<u> </u>		I	<u>1 </u>	0	1. , 1. 02

Health Financial Systems	FRANCISCAN HEALTH	LAFAYETTE		In Lie	u of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der CO	CN: 15-0109		Worksheet B Part II Date/Time Prepared: 5/2/2022 3:08 pm

						5/2/2022 3:08	_pm
	Cost Center Description	SOCI AL SERVI CE	NURSI NG	PHARMACY	EMS EDUCATION	Subtotal	
			PROGRAM	RESI DENCY			
		17. 00	20.00	23. 00	23. 01	24.00	
194. 03 07954	OTHER NONREIMBURSABLE COST CENTERS	0				2, 813, 582	194. 03
200. 00	Cross Foot Adjustments		1, 996, 705	9, 315	244, 387	2, 250, 407	200. 00
201. 00	Negative Cost Centers	0	0	0	0	514, 671	201. 00
202. 00	TOTAL (sum lines 118 through 201)	36, 237	1, 996, 705	9, 315	244, 387	32, 824, 890	202. 00

FRANCISCAN HEALTH LAFAYETTE

Health Financial Systems In Lieu of Form CMS-2552-10 ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0109 Peri od: Worksheet B From 01/01/2021 Part II 12/31/2021 Date/Time Prepared: 5/2/2022 3:08 pm Cost Center Description Intern & Total Residents Cost & Post Stepdown Adjustments 25.00 26.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 01160 COMMUNI CATI ONS 5.01 5.01 01140 MGMT INFO SYSTEMS 5.02 5.02 00550 PURCHASING 5.03 5.03 5.04 00570 ADMITTING 5.04

Health Financial Systems	FRANCISCAN HEAL	TH LAFAYETTE		In Lie	u of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der CO	CN: 15-0109	Peri od:	Worksheet B
				From 01/01/2021 To 12/31/2021	Part II Date/Time Prepared:
				12/01/2021	5/2/2022 3: 08 pm
Cost Center Description	Intern &	Total			
	Residents Cost				
	& Post				
	Stepdown				
	Adjustments				
	25. 00	26.00			
194. 00 07950 MOB	0	0			194. 00
194. 01 07951 LI FELI NE	0	0			194. 01
194.02 07952 PATIENT TRANSPORT	o	0			194. 02
194.03 07954 OTHER NONREIMBURSABLE COST CENTERS	0	2, 813, 582			194. 03
200.00 Cross Foot Adjustments	0	2, 250, 407			200. 00
201.00 Negative Cost Centers	0	514, 671			201. 00
202.00 TOTAL (sum lines 118 through 201)	o	32, 824, 890			202. 00

				rom 01/01/2021 o 12/31/2021	Date/Time Pre 5/2/2022 3:08	
	CAPITAL RE	LATED COSTS			57272022 3.00	pili
Cost Center Description	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	COMMUNI CATI ONS	MGMT INFO	
	(SQUARE FEET)	(SQUARE FEET)	BENEFITS DEPARTMENT	(PHONE LINE S)	SYSTEMS (MANHOURS)	
			(GROSS SALARI ES)			
OFFICE OFFICE OFFICE	1.00	2.00	4. 00	5. 01	5. 02	
GENERAL SERVICE COST CENTERS 1. 00 00100 CAP REL COSTS-BLDG & FIXT	797, 575					1. 00
2.00 00200 CAP REL COSTS-MVBLE EQUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	10.225	673, 332 10, 325	124 /41 200			2. 00 4. 00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 5. 01 01160 COMMUNI CATI ONS	10, 325 1, 015		134, 641, 280 826, 930			5. 01
5. 02 01140 MGMT NFO SYSTEMS 5. 03 00550 PURCHASING	15, 293 11, 061		871, 330 290		2, 931, 063 11	5. 02 5. 03
5. 04 00570 ADMI TTI NG	0	0	321	0	15	5. 04
5. 05 00580 PATI ENT ACCOUNTI NG 5. 06 00560 OTHER ADMINI STRATI VE AND GENERAL	5, 933 61, 021	5, 933 61, 021	1, 630 25, 616, 715		110 181, 801	5. 05 5. 06
7.00 00700 OPERATION OF PLANT	118, 826	118, 826	2, 554, 572	55	102, 001	7. 00
8. 00 00800 LAUNDRY & LI NEN SERVI CE 9. 00 00900 HOUSEKEEPI NG	4, 692 9, 695	1	255, 17 <i>6</i> 2, 295, 580		10, 085 121, 438	8. 00 9. 00
10. 00 01000 DI ETARY 11. 00 01100 CAFETERI A	17, 207		1, 367, 924		115, 801	10. 00 11. 00
13. 00 O1100 CAFETERTA 13. 00 O1300 NURSI NG ADMI NI STRATI ON	15, 548 3, 440				0 81, 753	13. 00
14. 00 01400 CENTRAL SERVI CES & SUPPLY 15. 00 01500 PHARMACY	5, 694 9, 227	1	387, 725 2, 746, 173		19, 041 65, 285	14. 00 15. 00
16.00 01600 MEDICAL RECORDS & LIBRARY	2, 319	2, 319	46, 07 <i>6</i>	17	3, 041	16. 00
17. 00 01700 SOCI AL SERVI CE 20. 00 02000 NURSI NG PROGRAM	603 33, 334		2, 217, 148		0 50, 361	17. 00 20. 00
23. 00 02301 PHARMACY RESI DENCY	0	0	248, 067	o o	5, 475	23. 00
23. 01 02300 EMS EDUCATION I NPATIENT ROUTINE SERVICE COST CENTERS	4, 133	4, 133	158, 910	0	238	23. 01
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT	118, 471		17, 995, 231		663, 610	30. 00 31. 00
35. 00 03100 TWIENSIVE CARE UNIT	11, 470 8, 027		4, 082, 153 2, 395, 577		118, 065 57, 612	35. 00
41. 00 04100 SUBPROVI DER - I RF 43. 00 04300 NURSERY	14, 424		1, 753, 274 651, 072		44, 750 0	41. 00 43. 00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 0PERATING ROOM 51.00 05100 RECOVERY ROOM	32, 897 2, 718		3, 769, 034 590, 529		124, 361 12, 780	50. 00 51. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	2, 934, 207	26	0	52. 00
54. 00 05400 RADI OLOGY - DI AGNOSTI C 55. 00 05500 RADI OLOGY - THERAPEUTI C	18, 165 704		4, 557, 603 398, 229		123, 330 12, 286	54. 00 55. 00
56. 00 05600 RADI OI SOTOPE 56. 01 03950 CARDI AC CATH LAB	342 8, 446		82, 594 1, 477, 704		2, 142 36, 133	56. 00 56. 01
57.00 05700 CT SCAN	1, 539	1, 539	684, 689	0	18, 799	57. 00
58. 00 05800 MRI 60. 00 06000 LABORATORY	1, 362 6, 495		310, 373		6, 153 0	58. 00 60. 00
65. 00 06500 RESPIRATORY THERAPY	2, 308	2, 308		34	62, 775	65. 00
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY	955				137, 634 41, 095	
68.00 06800 SPEECH PATHOLOGY	98	1	567, 531	0	16, 245	68. 00 69. 00
69. 00 06900 ELECTROCARDI OLOGY 70. 00 07000 ELECTROENCEPHALOGRAPHY	10, 445 5, 359		1, 890, 705 678, 473		53, 102 17, 941	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 72.00 07200 MPL. DEV. CHARGED TO PATIENTS	0				0	71. 00 72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0			0	73. 00
73. 01 07301 DI ABETES CENTER 74. 00 07400 RENAL DI ALYSI S	1, 841	_	435, 715 165, 398		12, 829 3, 929	73. 01 74. 00
76. 00 03480 ONCOLOGY	2, 000		2, 940, 050	0	83, 516	76. 00
76. 01 03952 ANTI COAGULATI ON 76. 02 03951 I NFUSI ON SERVI CES	0	0	305, 024 617, 64 <i>6</i>		6, 881 14, 791	76. 01 76. 02
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0			0	76. 98
90. 00 09000 CLINIC	0	0	469, 914	32	21, 371	90. 00
91. 00 09100 EMERGENCY 91. 01 04950 WOUND CARE	42, 550 16, 953		5, 973, 194 760, 654		162, 262 16, 473	91. 00 91. 01
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	10, 753	10, 433			10, 473	92.00
92. 01 O9201 OBSERVATI ON BEDS (DI STINCT PART) OTHER REIMBURSABLE COST CENTERS	7, 990	7, 990	1, 388, 050	0	41, 805	92. 01
95. 00 09500 AMBULANCE SERVICES	9, 272				102, 196	
101. 00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	7, 871	7, 871	4, 011, 177	0	76, 711	101. 00
113. 00 11300 NTEREST EXPENSE 116. 00 11600 HOSPI CE	0		ין די פרד פ		76, 465	113.00
118. 00 SUBTOTALS (SUM OF LINES 1 through 117)	-	_	2, 732, 738 118, 715, 068		2, 924, 498	

Health Finar	ncial Systems	FRANCISCAN HEAL	_TH_LAFAYETTE		In Lie	u of Form CMS-2	2552-10
	TION - STATISTICAL BASIS		Provider CO		eri od:	Worksheet B-1	
					rom 01/01/2021 o 12/31/2021	Date/Time Pre 5/2/2022 3:08	
		CAPITAL REL	LATED COSTS				
	Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS	COMMUNICATIONS (PHONE LINE S)	SYSTEMS	
				SALARI ES)			
		1. 00	2.00	4. 00	5. 01	5. 02	
	IMBURSABLE COST CENTERS						
	GIFT, FLOWER, COFFEE SHOP & CANTEEN	3, 128		· ·			190. 00
	PHYSICIANS' PRIVATE OFFICES	8, 136	8, 136	15, 871, 815	0		192. 00
194. 00 07950		0	0	C	0	_	194. 00
194. 01 07951		0	0	C	0		194. 01
	PATIENT TRANSPORT	0	0		0		194. 02
	OTHER NONREIMBURSABLE COST CENTERS	124, 243	0		0	0	194. 03
200.00	Cross Foot Adjustments						200. 00
201. 00	Negative Cost Centers	0.004.777	22 040 224	22 002 /21	2 452 514		201. 00
202. 00	Cost to be allocated (per Wkst. B, Part I)	9, 984, 666	22, 840, 224	32, 982, 621	2, 453, 514	8, 221, 466	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	12. 518780	33. 921192	0. 244967	3, 480. 161702	2. 804943	203. 00
204. 00	Cost to be allocated (per Wkst. B,			479, 492	50, 082	714, 944	204. 00
005 00	Part II)				74 000000		
205. 00	Unit cost multiplier (Wkst. B, Part			0. 003561	71. 038298	0. 243920	205. 00
206. 00	NAHE adjustment amount to be allocated						206. 00
207. 00	(per Wkst. B-2) NAHE unit cost multiplier (Wkst. D,						207. 00
207.00	Parts III and IV)						207.00

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS In Lieu of Form CMS-2552-10
Worksheet B-1 Provider CCN: 15-0109

					То	12/31/2021	Date/Time Prep 5/2/2022 3:08	
		Cost Center Description	PURCHASI NG	ADMI TTI NG		Reconciliation	OTHER	, J
			(COSTED REQ	(GROSS CHAR	ACCOUNTI NG		ADMI NI STRATI VE	
			UISI)	GES)	(GROSS CHAR GES)		AND GENERAL (ACCUM. COST)	
			5. 03	5. 04	5. 05	5A. 06	5. 06	
		AL SERVICE COST CENTERS						
	1	CAP REL COSTS-BLDG & FIXT						1.00
		CAP REL COSTS-MVBLE EQUIP EMPLOYEE BENEFITS DEPARTMENT						2. 00 4. 00
		COMMUNI CATIONS						5. 01
	1	MGMT INFO SYSTEMS						5. 02
	00550	PURCHASI NG	36, 429, 096					5. 03
		ADMITTING	0	1, 489, 177, 940				5. 04
		PATIENT ACCOUNTING OTHER ADMINISTRATIVE AND GENERAL	0	0		-54, 598, 739	258, 380, 696	5. 05 5. 06
		OPERATION OF PLANT	0	0		-34, 396, 739	15, 204, 361	7. 00
		LAUNDRY & LINEN SERVICE	ő	Ö	Ö	Ö	1, 271, 471	8. 00
9.00	00900	HOUSEKEEPI NG	0	0	0	0	4, 510, 721	9. 00
	1	DI ETARY	0	0	0	0	3, 918, 035	10. 00
	1	CAFETERI A	0	0	0	0	1, 370, 034	11.00
		NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY	350, 734	0	0	0	4, 832, 888 1, 161, 813	13. 00 14. 00
	1	PHARMACY	273, 629	0		0	15, 463, 013	
		MEDICAL RECORDS & LIBRARY	0	0		Ö	2, 339, 289	16. 00
		SOCIAL SERVICE	0	0	0	0	59, 324	17. 00
		NURSI NG PROGRAM	0	0	0	0	2, 357, 574	20. 00
		PHARMACY RESIDENCY	0	0	0	0	434, 218	23. 00
23. 01		EMS EDUCATION TENT ROUTINE SERVICE COST CENTERS	0	0	0	0	379, 217	23. 01
30. 00		ADULTS & PEDIATRICS	1, 970, 740	123, 876, 635	123, 876, 635	0	31, 135, 143	30. 00
		INTENSIVE CARE UNIT	465, 087	24, 130, 725		0	6, 501, 415	31. 00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	137, 233	20, 258, 945	20, 258, 945	0	3, 614, 475	35. 00
		SUBPROVI DER - I RF	51, 520	6, 525, 906		0	2, 873, 388	41. 00
43. 00		NURSERY	0	4, 491, 042	4, 491, 042	0	918, 352	43. 00
50. 00		LARY SERVICE COST CENTERS OPERATING ROOM	17, 705, 252	167, 075, 504	167, 075, 504	0	7, 981, 917	50. 00
		RECOVERY ROOM	23, 874	14, 049, 173		Ö	950, 998	
52. 00	1	DELIVERY ROOM & LABOR ROOM	0	20, 239, 933		0	4, 229, 255	
54.00	05400	RADI OLOGY-DI AGNOSTI C	2, 127, 863	100, 177, 958	100, 177, 958	0	8, 554, 516	54.00
		RADI OLOGY - THERAPEUTI C	11, 153	14, 341, 317		0	809, 813	55. 00
		RADI OI SOTOPE	0 717 425	35, 213		0	126, 313	
		CARDIAC CATH LAB	3, 717, 435 173, 822	61, 574, 667 68, 490, 739		0	2, 399, 423 1, 362, 456	
	05800		40, 414	10, 915, 476		Ö	536, 062	58. 00
60.00	1	LABORATORY	111, 270	142, 442, 110		0	12, 127, 844	60.00
	1	RESPI RATORY THERAPY	739, 900	23, 376, 327		0	3, 534, 602	
66. 00		PHYSI CAL THERAPY	311, 956	30, 579, 869		0	6, 748, 146	
		OCCUPATIONAL THERAPY SPEECH PATHOLOGY	24, 318 3, 581	14, 390, 908 5, 040, 528		0	2, 000, 148 773, 575	
		ELECTROCARDI OLOGY	50, 196	41, 552, 879		0	3, 342, 307	
		ELECTROENCEPHALOGRAPHY	76, 317	5, 478, 642		Ö	1, 152, 871	
		MEDICAL SUPPLIES CHARGED TO PATIENT	0	207, 638, 554		0	14, 277, 855	
		IMPL. DEV. CHARGED TO PATIENTS	0	96, 661, 442		0	10, 257, 379	
		DRUGS CHARGED TO PATIENTS	0	83, 192, 858		0	12, 707, 001	
		DI ABETES CENTER RENAL DI ALYSI S	623	7, 707 3, 397, 701		0	603, 517	
		ONCOLOGY	6, 557, 616 20, 114	20, 927, 979	3, 397, 701 20, 927, 979	0	1, 512, 769 4, 786, 636	
		ANTI COAGULATI ON	29	1, 048, 137		Ö	423, 503	
		INFUSION SERVICES	0	4, 899, 796		0	1, 787, 673	
76. 98		HYPERBARI C OXYGEN THERAPY	0	0	0	0	0	76. 98
00.00		TIENT SERVICE COST CENTERS	07.500	, OF OFO	, or or o	ام	4 574 004	00.00
		CLINIC EMERGENCY	27, 528 1, 233, 262	695, 258 119, 967, 736		0	1, 574, 381 10, 004, 822	90. 00 91. 00
	1	WOUND CARE	2, 490	643, 728		0	1, 727, 665	91.00
	1	OBSERVATION BEDS (NON-DISTINCT PART	2, 170	010,720	010,720	Ŭ.	1,727,000	92. 00
		OBSERVATION BEDS (DISTINCT PART)	89, 243	8, 627, 926	8, 627, 926	0	2, 467, 710	92. 01
		REIMBURSABLE COST CENTERS						
		AMBULANCE SERVICES	131, 891	11, 562, 410		0	3, 865, 362	
		HOME HEALTH AGENCY AL PURPOSE COST CENTERS	0	9, 254, 945	9, 254, 945	0	6, 003, 340	101.00
		INTEREST EXPENSE						113. 00
		HOSPI CE	o	21, 607, 267	21, 607, 267	0	5, 776, 809	116. 00
118. 00		SUBTOTALS (SUM OF LINES 1 through 117)	36, 429, 096	1, 489, 177, 940	1, 489, 177, 940	-54, 598, 739	232, 751, 399	118. 00
		I MBURSABLE COST CENTERS					0.1	400 5
190.00		GIFT, FLOWER, COFFEE SHOP & CANTEEN	l Ol	0	0	Ol	310 8371	190.00
	19000	DHYSICIANS' DDIVATE OFFICES	٥	-				
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	23, 754, 089	

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

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0109 | Period: From 01/01/2021 | To 12/31/2021 | Date/Time Prepared:

Date/Time Prepared: 5/2/2022 3:08 pm Cost Center Description PURCHASI NG ADMI TTI NG PATI ENT Reconciliation OTHER (COSTED REQ (GROSS CHAR ACCOUNTI NG ADMI NI STRATI VE (GROSS CHAR UISI) GES) AND GENERAL (ACCUM. COST) GES) 5.04 5.03 5A. 06 5.05 5.06 194. 01 07951 LI FELI NE 0 0 0 194. 01 194. 02 07952 PATIENT TRANSPORT 0 0 0 0 194. 02 194.03 07954 OTHER NONREIMBURSABLE COST CENTERS 0 0 0 0 1, 555, 371 194. 03 Cross Foot Adjustments 200. 00 200.00 201.00 Negative Cost Centers 201. 00 202.00 Cost to be allocated (per Wkst. B, -174, 843 2, 604, 766 54, 598, 739 202. 00 5, 166 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 0. 000000 0. 000003 0.001749 0. 211311 203. 00 Cost to be allocated (per Wkst. B, 204.00 514, 671 276, 556 2, 974, 596 204. 00 Part II) 205.00 Unit cost multiplier (Wkst. B, Part 0.014128 0.000000 0.000186 0. 011512 205. 00 II) 206. 00 NAHE adjustment amount to be allocated 206.00 (per Wkst. B-2) NAHE unit cost multiplier (Wkst. D, 207.00 207.00 Parts III and IV)

COST A	ALLOCATION - STATISTICAL BASIS		Provi der C		Period: From 01/01/2021	Worksheet B-1	
					o 12/31/2021	Date/Time Pre	
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	5/2/2022 3: 08 CAFETERI A	piii
	·	PLANT	LINEN SERVICE	(SQUARE FEET)	(MEALS SERVED)	(MANHOURS)	
		(SQUARE FEET)	(POUNDS OF LAUNDRY)				
		7. 00	8.00	9. 00	10.00	11. 00	
1. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT			I			1.00
2.00	00200 CAP REL COSTS-BLDG & FIXT						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01	01160 COMMUNI CATI ONS						5. 01
5. 02 5. 03	01140 MGMT INFO SYSTEMS 00550 PURCHASING					•	5. 02 5. 03
5. 04	00570 ADMI TTI NG						5. 04
5.05	00580 PATIENT ACCOUNTING						5. 05
5.06	00560 OTHER ADMINISTRATIVE AND GENERAL	F74 101					5. 06
7. 00 8. 00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	574, 101 4, 692	1, 263, 835				7. 00 8. 00
9. 00	00900 HOUSEKEEPI NG	9, 695					9. 00
10. 00	01000 DI ETARY	17, 207	35, 496				10.00
11. 00 13. 00	01100 CAFETERIA	15, 548	ŀ			2, 399, 801	1
14. 00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	3, 440 5, 694	l e	3, 440 5, 694		81, 753 19, 041	1
15. 00	01500 PHARMACY	9, 227	02,002	9, 227		65, 285	1
16. 00	01600 MEDICAL RECORDS & LIBRARY	2, 319	l e	2, 319		3, 041	
17. 00	01700 SOCIAL SERVICE 02000 NURSING PROGRAM	603	0	603		0	
20. 00 23. 00	02301 PHARMACY RESIDENCY	33, 334		33, 334		50, 361 5, 475	
23. 01	02300 EMS EDUCATION	4, 133	Ö	4, 133			
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 31. 00	03000 ADULTS & PEDIATRICS	118, 471	446, 154			663, 610	1
35. 00	03100 INTENSIVE CARE UNIT 02060 NEONATAL INTENSIVE CARE UNIT	11, 470 8, 027	l			118, 065 57, 612	
41. 00	04100 SUBPROVI DER – I RF	14, 424	l	•			
43. 00	04300 NURSERY	0	46, 558	C	0	0	43. 00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	32, 897	221, 653	32, 897	' 0	124, 361	50.00
51. 00	05100 RECOVERY ROOM	2, 718	40, 759			124, 301	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	49, 779			0	1
54. 00	05400 RADI OLOGY-DI AGNOSTI C	18, 165	1				
55. 00 56. 00	05500 RADI OLOGY - THERAPEUTI C 05600 RADI OI SOTOPE	704 342	0	704 342		12, 286 2, 142	
56. 01	03950 CARDI AC CATH LAB	8, 446	ł	•		36, 133	1
57. 00	05700 CT SCAN	1, 539	l			18, 799	1
58. 00	05800 MRI	1, 362	0	1, 362		6, 153	1
60. 00 65. 00	06000 LABORATORY 06500 RESPI RATORY THERAPY	6, 495 2, 308	l			0 62, 775	
66. 00	06600 PHYSI CAL THERAPY	955				137, 634	
	06700 OCCUPATI ONAL THERAPY	0		-	-		67. 00
	06800 SPEECH PATHOLOGY	98		1			68.00
70.00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	10, 445 5, 359		10, 445 5, 359		17, 941	69. 00 70. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0,007	Ö	0,007) O	0	
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	C	0	0	72. 00
	07300 DRUGS CHARGED TO PATIENTS	0	0	C	0	0	73.00
73. 01 74. 00	07301 DI ABETES CENTER 07400 RENAL DI ALYSI S	1, 841	0	1, 841	0	12, 829 3, 929	1
76. 00	03480 ONCOLOGY	2,000	Ö	2, 000		83, 516	
76. 01	03952 ANTI COAGULATI ON	0	0	C	0	6, 881	
76. 02		0	0	C			
76. 98	07698 HYPERBARI C OXYGEN THERAPY OUTPATIENT SERVICE COST CENTERS	0		C	0	0	76. 98
90. 00	09000 CLINIC	0	0	С	0	21, 371	90.00
	09100 EMERGENCY	42, 550	1			162, 262	
91. 01 92. 00	04950 WOUND CARE	16, 953	0	16, 953	0	16, 473	91. 01 92. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART 09201 OBSERVATION BEDS (DISTINCT PART)	7, 990	0	7, 990	0	41, 805	
	OTHER REIMBURSABLE COST CENTERS	1,770		.,,,,		11,000	,2.0.
	09500 AMBULANCE SERVICES	9, 272					1
101.00	10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	7, 871	0	7, 871	0	76, 711	101. 00
113.00	11300 INTEREST EXPENSE						113. 00
116.00	11600 HOSPI CE	0	0	c	0		116. 00
118.00		438, 594	1, 263, 835	424, 207	177, 987	2, 393, 236	118. 00
190 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	3, 128	0	3, 128	0	2 086	190. 00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	8, 136	l .			4, 479	192. 00
	0 07950 MOB	0				0	194. 00

Health Financial Systems	FRANCISCAN HEALTH LAFAYETTE	In Lieu of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS	Provi der CCN: 15-0109	Peri od: Worksheet B-1

				T ₁	rom 01/01/2021 o 12/31/2021	Date/Time Pre	
		ODEDATION OF	I ALINDOV 0	HOUGEKEEDING	DIETADY	5/2/2022 3:08	pm
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG		CAFETERI A	
			LINEN SERVICE	(SQUARE FEET)	(MEALS SERVED)	(MANHOURS)	
		(SQUARE FEET)	(POUNDS OF				
		7. 00	LAUNDRY)	9, 00	10.00	11 00	
104 01 07051	LLEGUNG	7.00	8. 00	9.00	10.00	11.00	104 01
194. 01 07951	l .	0	0	0	U		194. 01
4	PATIENT TRANSPORT	0	0	0	0		194. 02
4	OTHER NONREIMBURSABLE COST CENTERS	124, 243	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,	18, 417, 210	1, 690, 667	5, 814, 001	5, 575, 177	2, 365, 900	202. 00
	Part I)						
203. 00	Unit cost multiplier (Wkst. B, Part I)	32. 080087	1. 337728	13. 351064	31. 323507	0. 985873	203. 00
204. 00	Cost to be allocated (per Wkst. B,	5, 731, 196	282, 813	643, 922	1, 084, 608	919, 495	204. 00
	Part II)						
205. 00	Unit cost multiplier (Wkst. B, Part	9. 982905	0. 223774	1. 478679	6. 093748	0. 383155	205. 00
	11)						
206. 00	NAHE adjustment amount to be allocated	1					206. 00
	(per Wkst. B-2)						
207. 00	NAHE unit cost multiplier (Wkst. D,	1					207. 00
	Parts III and IV)						
,					'		•

	FINANCIAI SYSTEMS	FRANCISCAN HEAL		N 15 0100 I		Wardington CMS-	
COST	LLOCATION - STATISTICAL BASIS		Provi der CC		Period: From 01/01/2021 Fo 12/31/2021	Worksheet B-1 Date/Time Pre 5/2/2022 3:08	pared:
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE	Pili
	·	ADMI NI STRATI ON	SERVICES &	(COSTED	RECORDS &		
		(DI DECT NDC	SUPPLY	REQUIS.)	LI BRARY	(TIME SPENT)	
		(DIRECT NRS ING)	(COSTED REQ ULSI)		(GROSS CHAR GES)		
		13. 00	14. 00	15. 00	16. 00	17. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUI P						2.00
4. 00 5. 01	OO4OO EMPLOYEE BENEFITS DEPARTMENT O116O COMMUNI CATIONS						4. 00 5. 01
5. 02	01140 MGMT INFO SYSTEMS						5. 02
5.03	00550 PURCHASI NG						5. 03
5.04	00570 ADMITTING						5. 04
5. 05 5. 06	00580 PATIENT ACCOUNTING 00560 OTHER ADMINISTRATIVE AND GENERAL						5. 05 5. 06
7. 00	00700 OPERATION OF PLANT						7. 00
8.00	00800 LAUNDRY & LINEN SERVICE						8. 00
9.00	00900 HOUSEKEEPI NG						9. 00
10.00	01000 DI ETARY 01100 CAFETERI A						10. 00 11. 00
11. 00 13. 00	01300 NURSI NG ADMI NI STRATI ON	1, 839, 110					13.00
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	36, 078, 362				14. 00
15. 00	01500 PHARMACY	0	273, 629	100			15. 00
	01600 MEDICAL RECORDS & LIBRARY	0	0	(1, 489, 177, 940		16.00
17. 00 20. 00	01700 SOCIAL SERVICE 02000 NURSING PROGRAM	0	0	(48, 048 0	1
23. 00	02301 PHARMACY RESIDENCY		o			0	•
23. 01	02300 EMS EDUCATION	0	0		0	0	23. 01
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS		4 070 740		100 07/ /05	00.404	
30.00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	663, 610 118, 065	1, 970, 740 465, 087		123, 876, 635 24, 130, 725	33, 604 4, 797	1
35. 00	02060 NEONATAL INTENSIVE CARE UNIT	57, 612	137, 233		20, 258, 945		
41.00	04100 SUBPROVI DER - I RF	44, 750	51, 520	(6, 525, 906		1
43. 00	04300 NURSERY	0	0	(4, 491, 042	2, 942	43. 00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	124, 361	17, 705, 252		167, 075, 504	0	50.00
51.00	05100 RECOVERY ROOM	124, 361	23, 874		14, 049, 173		ı
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0		20, 239, 933		52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	2, 127, 863		100, 177, 958		54.00
55. 00	O5500 RADI OLOGY - THERAPEUTI C	0	11, 153		14, 341, 317	0	
56. 00 56. 01	05600 RADI OI SOTOPE 03950 CARDI AC CATH LAB	2, 142 36, 133	3, 717, 435		35, 213 61, 574, 667	0	
57. 00	05700 CT SCAN	0	173, 822		68, 490, 739	-	1
58. 00	05800 MRI	0	40, 414	(10, 915, 476		
60.00	06000 LABORATORY	0	111, 270		142, 442, 110		
65.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	62, 775 137, 634	739, 900 311, 956		23, 376, 327 30, 579, 869	0	
67. 00	06700 OCCUPATI ONAL THERAPY	41, 095	24, 318		14, 390, 908	0	1
68. 00	06800 SPEECH PATHOLOGY	16, 245	3, 581	(5, 040, 528	0	1
69. 00	06900 ELECTROCARDI OLOGY	53, 102	50, 196	(41, 552, 879	0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	17, 941	76, 317 0	(5, 478, 642 207, 638, 554	0	
71.00	07200 IMPL. DEV. CHARGED TO PATIENTS		0	(96, 661, 442	0	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	o	O	100		0	
73. 01	07301 DI ABETES CENTER	12, 829	623	(7, 707	0	73. 01
74. 00 76. 00	07400 RENAL DI ALYSI S 03480 ONCOLOGY	3, 929	6, 557, 616 20, 114	(3, 397, 701 20, 927, 979	0 0	74. 00 76. 00
76. 00	03952 ANTI COAGULATI ON		20, 114	(1, 048, 137	0	76. 00
76. 02	03951 I NFUSION SERVICES	o	0	(4, 899, 796	0	ı
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0	(0 0	0	76. 98
00 00	OUTPATIENT SERVICE COST CENTERS O9000 CLINIC		27 520		695, 258	0	90.00
90. 00 91. 00	09100 EMERGENCY	162, 262	27, 528 1, 233, 262		695, 258 119, 967, 736	0	1
91. 01	04950 WOUND CARE	16, 473	2, 490		643, 728		91. 01
	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
92. 01	09201 OBSERVATION BEDS (DISTINCT PART)	0	89, 243	(8, 627, 926	0	92. 01
95 00	OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES	102, 196	131, 891	(11, 562, 410	0	95. 00
	10100 HOME HEALTH AGENCY	76, 711	0		9, 254, 945		101.00
	SPECIAL PURPOSE COST CENTERS						
	11300 I NTEREST EXPENSE	7, 4,-			24 (07 2)	_	113.00
116. 00 118. 00	11600 HOSPICE SUBTOTALS (SUM OF LINES 1 through 117)	76, 465 1, 839, 110	0 36, 078, 362		21, 607, 267 1, 489, 177, 940		116.00
110.00	NONREI MBURSABLE COST CENTERS	1,037,110	55, 676, 502	100	o ₁ 1, 707, 177, 740	40, 040	, , , 5. 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0		190. 00
192.00	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	(0	0	192. 00

Health Financial Systems	FRANCISCAN HEALTH LAFAYETTE	In Lieu of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS	Provi der CCN: 15-0109 Per	iod: Worksheet B-1

COST ALLOCA	TION STATISTICAL BASIS		Trovider ex		'nom 01/01/2021	WOLKSHEET D	
					rom 01/01/2021 o 12/31/2021	Date/Time Pre	parad.
				'	0 12/31/2021	5/2/2022 3: 08	
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE	
	oost conten bescription	ADMI NI STRATI ON	SERVICES &	(COSTED	RECORDS &	SOUTHE SERVICE	
		7.5 11. 5 11. 11. 1	SUPPLY	REQUIS.)	LI BRARY	(TIME SPENT)	
		(DI RECT NRS	(COSTED REQ		(GROSS CHAR	(
		I NG)	UISI)		GES)		
		13.00	14.00	15. 00	16.00	17. 00	
194. 00 07950	MOB	0	0	C	0	0	194. 00
194. 01 0795°	I LI FELI NE	0	0	l c	0	0	194. 01
194. 02 07952	PATIENT TRANSPORT	0	0	l c	0	0	194. 02
194. 03 07954	OTHER NONREIMBURSABLE COST CENTERS	o	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,	6, 091, 011	1, 727, 624	19, 227, 177	2, 941, 959	99, 255	202. 00
	Part I)						
203.00	Unit cost multiplier (Wkst. B, Part I)	3. 311934	0. 047885	192, 271. 770000	0. 001976	2. 065747	203. 00
204.00	Cost to be allocated (per Wkst. B,	317, 965	363, 840	767, 379	164, 482	36, 237	204.00
	Part II)						
205.00	Unit cost multiplier (Wkst. B, Part	0. 172891	0. 010085	7, 673. 790000	0. 000110	0. 754183	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)						

Health Financial Systems In Lieu of Form CMS-2552-10 FRANCISCAN HEALTH LAFAYETTE COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0109 Peri od: Worksheet B-1 From 01/01/2021 12/31/2021 Date/Time Prepared: 5/2/2022 3:08 pm Cost Center Description NURSI NG PHARMACY EMS EDUCATION (ASSI GNED **PROGRAM** RESI DENCY (ASSI GNED (ASSI GNED TIME) TIME) TIME) 23.01 20.00 23.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4 00 5.01 01160 COMMUNI CATI ONS 5.01 01140 MGMT INFO SYSTEMS 5.02 5.02 00550 PURCHASI NG 5.03 5.03 00570 ADMITTING 5.04 5.04 5.05 00580 PATIENT ACCOUNTING 5.05 00560 OTHER ADMINISTRATIVE AND GENERAL 5.06 5.06 7.00 00700 OPERATION OF PLANT 7 00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10.00 10.00 01100 CAFETERI A 11.00 11.00 13.00 01300 NURSING ADMINISTRATION 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 14.00 01500 PHARMACY 15 00 15 00 16.00 01600 MEDICAL RECORDS & LIBRARY 16.00 17.00 01700 SOCIAL SERVICE 17.00 02000 NURSING PROGRAM 20.00 100 20.00 02301 PHARMACY RESIDENCY 23 00 100 23 00 02300 EMS EDUCATION 23.01 100 23.01 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 30 00 100 n O 30 00 0 31.00 03100 INTENSIVE CARE UNIT 0 0 31.00 35.00 02060 NEONATAL INTENSIVE CARE UNIT 0 0 0 35.00 04100 SUBPROVI DER - I RF 0 0 41.00 0 41.00 04300 NURSERY 43.00 0 0 0 43 00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 0 0 0 50.00 50.00 51.00 05100 RECOVERY ROOM 000000000000000000000000 0 0 51.00 0 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 05500 RADI OLOGY - THERAPEUTI C 0 55.00 55.00 0 56, 00 05600 RADI OI SOTOPE 0 56, 00 0 03950 CARDI AC CATH LAB 56.01 0 56.01 0 57.00 05700 CT SCAN 57.00 58.00 05800 MRI 0 0 58.00 06000 LABORATORY 0 60.00 0 60.00 06500 RESPIRATORY THERAPY 0 65.00 65.00 66.00 06600 PHYSI CAL THERAPY 0 0 66.00 67.00 06700 OCCUPATIONAL THERAPY 0 67.00 06800 SPEECH PATHOLOGY 0 0 68.00 68.00 69.00 06900 ELECTROCARDI OLOGY 0 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 70.00 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 71.00 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72.00 r 72 00 07300 DRUGS CHARGED TO PATIENTS 100 73.00 73.00 0 73. 01 07301 DI ABETES CENTER 0 73.01 07400 RENAL DIALYSIS 0 74.00 C 74.00 76.00 03480 ONCOLOGY 0 76.00 76.01 03952 ANTI COAGULATI ON 0 0 76.01 03951 INFUSION SERVICES 0 76.02 0 76.02 07698 HYPERBARI C OXYGEN THERAPY 76. 98 C n 76.98 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 90.00 0 91.00 09100 EMERGENCY 0 100 91.00 0 91.01 04950 WOUND CARE C C 91.01 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 09201 OBSERVATION BEDS (DISTINCT PART) 92.01 0 92.01 OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 0 Ω 0 95.00 101.00 10100 HOME HEALTH AGENCY 0 0 0 101.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113 00 116. 00 11600 HOSPI CE 0 Λ 0 116.00 SUBTOTALS (SUM OF LINES 1 through 117) 100 100 100 118.00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 190.00 0 Ω 0 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 0 192.00

0

0

194.00

194. 00 07950 MOB

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

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0109 | Period: From 01/01/2021 | To 12/31/2021 | Date/Time Prepared:

					5/2/2022 3: 08 p	om
Co	ost Center Description	NURSI NG	PHARMACY	EMS EDUCATION		
		PROGRAM	RESI DENCY	(ASSI GNED		
		(ASSI GNED	(ASSI GNED	TIME)		
		TIME)	TIME)			
		20.00	23. 00	23. 01		
194. 01 07951 LI	FELINE	0	0	0	19	94. 01
194. 02 07952 PA	ATIENT TRANSPORT	0	0	0	19	94. 02
194. 03 07954 07	THER NONREIMBURSABLE COST CENTERS	0	0	0	11	94. 03
200. 00 Cr	ross Foot Adjustments				20	00.00
201. 00 Ne	egative Cost Centers				20	01. 00
202. 00 Co	ost to be allocated (per Wkst. B,	4, 419, 807	531, 371	647, 352	20	02.00
Pa	art I)					
203. 00 Ur	nit cost multiplier (Wkst. B, Part I)	44, 198. 070000	5, 313. 710000	6, 473. 520000	20	03. 00
204. 00 Cd	ost to be allocated (per Wkst. B,	1, 996, 705	9, 315	244, 387	20	04.00
Pa	art II)					
205. 00 Ur	nit cost multiplier (Wkst. B, Part	19, 967. 050000	93. 150000	2, 443. 870000	20	05.00
206. 00 NA	AHE adjustment amount to be allocated	0	0	0	20	06. 00
(r	per Wkst. B-2)					
207. 00 NA	AHE unit cost multiplier (Wkst. D,	0. 000000	0. 000000	0.000000	20	07. 00
Pa	arts III and IV)					

Health Financial Systems	FRANCISCAN HEALTH LAFAYETTE	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0109	From 01/01/2021	Worksheet C Part I Date/Time Prepared: 5/2/2022 3:08 pm

					10 12/31/2021	Date/lime Pre 5/2/2022 3:08	
			Title	XVIII	Hospi tal	PPS	
	<u> </u>				Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	·	(from Wkst. B,	Adj .		Di sal I owance		
		Part I, col.					
		26)					
		1.00	2. 00	3. 00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS	1					
30. 00	03000 ADULTS & PEDI ATRI CS	55, 992, 447		55, 992, 44		55, 992, 447	30. 00
31. 00	03100 INTENSIVE CARE UNIT	9, 667, 457		9, 667, 45		9, 667, 457	31. 00
35. 00	02060 NEONATAL INTENSIVE CARE UNIT	5, 082, 804		5, 082, 80		5, 088, 542	
41.00	04100 SUBPROVI DER - I RF	4, 745, 488		4, 745, 48		4, 745, 488	
43.00	04300 NURSERY	1, 189, 643		1, 189, 64	3 0	1, 189, 643	43. 00
F0 00	ANCILLARY SERVICE COST CENTERS	40 470 005		40 470 00	50 54 54 5	40.000.407	F0 00
50.00	05000 OPERATI NG ROOM	13, 172, 095		13, 172, 09		13, 203, 607	50.00
51.00	05100 RECOVERY ROOM	1, 413, 790		1, 413, 79		1, 413, 790	
52.00	05200 DELIVERY ROOM & LABOR ROOM	5, 229, 528		5, 229, 52		5, 229, 528	
54.00	05400 RADI OLOGY - THE PARENTI C	11, 712, 911		11, 712, 91		11, 715, 479	
55. 00	05500 RADI OLOGY - THERAPEUTI C	1, 053, 902		1, 053, 90		1, 053, 902	
56.00	05600 RADI OI SOTOPE	177, 817		177, 81		177, 817	
56. 01	03950 CARDI AC CATH LAB 05700 CT SCAN	3, 752, 008		3, 752, 00		3, 752, 008	
57. 00	05800 MRI	1, 882, 470		1, 882, 47		1, 882, 470	1
58. 00 60. 00	06000 LABORATORY	740, 785 15, 283, 239		740, 78 15, 283, 23		740, 785 15, 319, 025	
65. 00	06500 RESPI RATORY THERAPY	4, 750, 395	0			4, 750, 395	
66.00	06600 PHYSI CAL THERAPY	8, 907, 869	0			4, 750, 395 8, 907, 869	1
67. 00	06700 OCCUPATIONAL THERAPY	2, 629, 019	0	8, 907, 86 2, 629, 01		2, 629, 019	
68. 00	06800 SPEECH PATHOLOGY	1, 021, 441	0	1, 021, 44		1, 021, 441	68.00
69. 00	06900 ELECTROCARDI OLOGY	4, 845, 410	U	4, 845, 41		4, 845, 410	
70. 00	07000 ELECTROENCEPHALOGRAPHY	1, 731, 537		1, 731, 53		1, 731, 537	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	17, 704, 560		17, 704, 56		17, 704, 560	
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	12, 615, 879		12, 615, 87		12, 615, 879	
73. 00	07300 DRUGS CHARGED TO PATIENTS	35, 315, 067		35, 315, 06		35, 315, 067	
73. 00	07301 DI ABETES CENTER	786, 229		786, 22		786, 229	
74. 00	07400 RENAL DIALYSIS	2, 253, 683		2, 253, 68		2, 253, 683	
76. 00	03480 ONCOLOGY	6, 013, 620		6, 013, 62		6, 013, 620	
76. 01	03952 ANTI COAGULATI ON	521, 850		521, 85		521, 850	1
76. 02	03951 I NFUSI ON SERVI CES	2, 189, 692		2, 189, 69		2, 189, 692	
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0			ol ol	0	
	OUTPATIENT SERVICE COST CENTERS				-1		
90.00	09000 CLI NI C	1, 930, 826		1, 930, 82	6 0	1, 930, 826	90.00
91.00	09100 EMERGENCY	15, 849, 079		15, 849, 07		15, 849, 079	
91. 01	04950 WOUND CARE	2, 935, 123		2, 935, 12	3 0	2, 935, 123	91. 01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	8, 253, 802		8, 253, 80	2	8, 253, 802	92. 00
92. 01	09201 OBSERVATION BEDS (DISTINCT PART)	3, 414, 695		3, 414, 69	5 0	3, 414, 695	92. 01
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	5, 571, 775		5, 571, 77	5 0	5, 571, 775	95. 00
101.00	10100 HOME HEALTH AGENCY	7, 977, 477		7, 977, 47	7	7, 977, 477	101. 00
	SPECIAL PURPOSE COST CENTERS						
	11300 INTEREST EXPENSE						113. 00
	11600 H0SPI CE	7, 368, 840		7, 368, 84		7, 368, 840	
200.00	,	285, 684, 252	0			285, 759, 856	
201.00		8, 253, 802		8, 253, 80		8, 253, 802	
202.00	Total (see instructions)	277, 430, 450	0	277, 430, 45	0 75, 604	277, 506, 054	202. 00

				o 12/31/2021	Date/Time Pre	pared:
		Title	: XVIII	Hospi tal	5/2/2022 3: 08 PPS	рш
		Charges	AVIII	Hospi tai	113	
Cost Center Description	Inpati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
oost denter beserretten	ripatront	outputtent	+ col . 7)	Ratio	Inpati ent	
			' ' ' ' ' ' ' '		Ratio	
	6. 00	7. 00	8. 00	9. 00	10. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	<u>'</u>			<u> </u>		
30. 00 03000 ADULTS & PEDI ATRI CS	106, 207, 748		106, 207, 748	3		30.00
31.00 03100 INTENSIVE CARE UNIT	24, 130, 725		24, 130, 725	;		31.00
35. 00 02060 NEONATAL INTENSIVE CARE UNIT	20, 258, 945		20, 258, 945			35. 00
41. 00 04100 SUBPROVI DER - I RF	6, 525, 906		6, 525, 906			41.00
43. 00 04300 NURSERY	4, 491, 042		4, 491, 042			43.00
ANCILLARY SERVICE COST CENTERS			<u> </u>			
50. 00 05000 OPERATING ROOM	60, 913, 533	106, 161, 971	167, 075, 504	0. 078839	0.000000	50.00
51. 00 05100 RECOVERY ROOM	4, 055, 461	9, 993, 712	14, 049, 173	0. 100632	0.000000	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	19, 329, 748	910, 185	20, 239, 933	0. 258377	0.000000	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	21, 633, 792	78, 544, 166	100, 177, 958	0. 116921	0.000000	54.00
55. 00 05500 RADI OLOGY - THERAPEUTI C	3, 885, 275	10, 456, 042	14, 341, 317	0. 073487	0.000000	55. 00
56. 00 05600 RADI 0I SOTOPE	0	35, 213	35, 213	5. 049754	0.000000	56. 00
56. 01 03950 CARDI AC CATH LAB	34, 918, 587	26, 656, 080	61, 574, 667	0. 060934	0.000000	56. 01
57.00 05700 CT SCAN	20, 278, 303	48, 212, 436	68, 490, 739	0. 027485	0.000000	57. 00
58. 00 05800 MRI	3, 631, 043	7, 284, 433	10, 915, 476	0. 067866	0.000000	58. 00
60. 00 06000 LABORATORY	61, 478, 369	80, 963, 741	142, 442, 110	0. 107294	0.000000	60.00
65. 00 06500 RESPI RATORY THERAPY	19, 932, 350	3, 443, 977	23, 376, 327	0. 203214	0.000000	65. 00
66. 00 06600 PHYSI CAL THERAPY	8, 316, 231	22, 263, 638			0.000000	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	6, 920, 132	7, 470, 776	14, 390, 908	0. 182686	0.000000	67. 00
68. 00 06800 SPEECH PATHOLOGY	1, 784, 850	3, 255, 678	5, 040, 528	0. 202646	0.000000	68. 00
69. 00 06900 ELECTROCARDI OLOGY	14, 436, 395	27, 116, 484	41, 552, 879	0. 116608	0.000000	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	1, 188, 366	4, 290, 276	5, 478, 642	0. 316052	0.000000	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	79, 024, 662	128, 613, 892	207, 638, 554	0. 085266	0.000000	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	47, 491, 646	49, 169, 796	96, 661, 442	0. 130516	0.000000	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	48, 760, 608	34, 432, 250	83, 192, 858	0. 424496	0.000000	73. 00
73. 01 07301 DI ABETES CENTER	1, 243	6, 464	7, 707	102. 014921	0.000000	73. 01
74. 00 07400 RENAL DI ALYSI S	2, 245, 992	1, 151, 709	3, 397, 701	0. 663296	0.000000	74.00
76. 00 03480 0NCOLOGY	2, 771, 430	18, 156, 549	20, 927, 979	0. 287348	0.000000	76. 00
76. 01 03952 ANTI COAGULATI ON	1, 956	1, 046, 181	1, 048, 137	0. 497883	0.000000	76. 01
76. 02 03951 INFUSION SERVICES	o	4, 899, 796	4, 899, 796	0. 446895	0.000000	76. 02
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0	C	0. 000000	0.000000	76. 98
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	695, 258	695, 258	2. 777136	0. 000000	90.00
91. 00 09100 EMERGENCY	23, 040, 488	96, 927, 248	119, 967, 736	0. 132111	0.000000	91.00
91. 01 04950 WOUND CARE	0	643, 728	643, 728	4. 559570	0.000000	91. 01
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	3, 000, 000	14, 668, 887	17, 668, 887	0. 467138	0.000000	92.00
92.01 09201 OBSERVATION BEDS (DISTINCT PART)	1, 522, 424	7, 105, 502	8, 627, 926	0. 395772	0. 000000	92. 01
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	0	11, 562, 410	11, 562, 410	0. 481887	0.000000	95. 00
101.00 10100 HOME HEALTH AGENCY	0	9, 254, 945	9, 254, 945	5		101. 00
SPECIAL PURPOSE COST CENTERS						
113. 00 11300 I NTEREST EXPENSE						113. 00
116. 00 11600 HOSPI CE	0	21, 607, 267				116. 00
200.00 Subtotal (see instructions)	652, 177, 250	837, 000, 690	1, 489, 177, 940			200. 00
201.00 Less Observation Beds						201. 00
202.00 Total (see instructions)	652, 177, 250	837, 000, 690	1, 489, 177, 940)		202. 00

Health Financial Systems	FRANCISCAN HEALTH LAFAYETTE	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0109		Worksheet C Part I Date/Time Prepared: 5/2/2022 3:08 pm
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INPATI ENT ROUTI NE SERVICE COST CENTERS 11.00 10.00 1						5/2/2022 3:08	pm
INPATI ENT ROUTINE SERVICE COST CENTERS 11.00				Title XVIII	Hospi tal	PPS	
INPATI ENT ROUTI NE SERVI CE COST CENTERS 30.00 30000 ADULTS & PEDIATRI CS 31.00 3		Cost Center Description	PPS Inpatient				
INPATI ENT ROUTH NE SERVICE COST CENTERS 30.00 30.00 30.00 30.10 30.10 31.00 3			Rati o				
30. 00 30000 ADULTS & PEDIATRICS 31. 00 31. 00 31. 00 31. 00 35. 00 20260 NERONATAL INTENSIVE CARE UNIT 35. 50 41. 00 4100 SUBPROVIDES 18. 18. 50 41. 00 4100 50 50 50 50 50 50 50			11. 00				
31.00 03100 INTENSIVE CARE UNIT	I NF	PATIENT ROUTINE SERVICE COST CENTERS					
35. 00 20060 NEONATAL INTENSIVE CARE UNIT	30.00 030	000 ADULTS & PEDIATRICS					30. 00
35. 00 02060 NEONATAL INTENSIVE CARE UNIT	31.00 03	100 INTENSIVE CARE UNIT					31.00
1.1 00 0.4100 SUBPROVI DER - I RF 43.00	35. 00 020	060 NEONATAL INTENSIVE CARE UNIT	1				35. 00
43. 00 A300 AUBSERY							1
ANCILLARY SERVICE COST CENTERS 50,00							1
50. 00 05000 0FEATH NG ROOM 0. 079028 50. 00 51. 00 05200 05200 05200 05200 05200 05200 05200 052000 052							10.00
51.00 05100 RECOVERY ROOM 0.100632 5.100 52.00 05200 DELIVERY ROOM LABOR ROOM 0.258377 5.200 05200 DELIVERY ROOM LABOR ROOM 0.258377 5.200 05500 05500 05500 05500 05500 05500 05500 05500 05500 05500 05500 05500 05500 05500 05500 05500 05500 0500 05100 079748 5.600 05600 03950 CARDIA C CATH LAB 0.06934 5.600 05700 CT SCAN 0.027485 5.700 05700 CT SCAN 0.067366 5.800 05800 MRI 0.067366 5.800 05800 MRI 0.067366 5.800 05800 MRI 0.067366 6.000 05000 LABORATORY 0.107546 6.000 05000 PRIST GAT HERAPY 0.203214 6.500 05000 DECENTRATIONAL THERAPY 0.182686 6.700 0.7100 0.7100 DECENTRATIONAL THERAPY 0.182686 6.700 0.7100 0.7100 DECENTRATIONAL THERAPY 0.182686 6.700 0.7100 0.7100 DECENTRATIONAL THERAPY 0.085266 7.1000 0.7100 0.7100 DECENTRATIONAL THERAPY 0.085266 7.1000 0.7100			0.079028				50.00
S2.00 05.200 05.200 05.000 ALIVERY ROOM & LABOR ROOM 0.258.377 52.00 55.400 05.500 RADIO LOGY - THERAPEUTI C 0.073.487 55.00 55.00 05.500 RADIO LOGY - THERAPEUTI C 0.073.487 55.00 56.00 05.000 RADIO LOGY - THERAPEUTI C 0.073.487 55.00 56.00 05.000 RADIO LOGY - THERAPEUTI C 0.073.487 55.00 56.00 05.000 RADIO LOGY - THERAPEUTI C 0.060934 56.01 03.950 CARDI AC CATH LAB 0.060934 56.01 03.950 CARDI AC CATH LAB 0.060934 56.00 05.000 05.000 MIN 0.067866 55.00 05.000 MIN 0.067866 58.00 05.000 MEDIA RATIORY THERAPY 0.203.214 66.00 06.000 MEDIA RATIORY THERAPY 0.203.214 66.00 06.000 MEDIA RATIORY THERAPY 0.291.298 66.00 06.000 MEDIA RATIORY THERAPY 0.291.298 66.00 06.000 MEDIA RATIORAL THERAPY 0.291.298 66.00 06.000 MEDIA RATIORAL THERAPY 0.182.686 67.00 07.000 CICUPATI ONAL THERAPY 0.182.686 67.00 07.000 MEDICAL SUPPLIES CHARGED TO PATI ENT 0.316.052 70.000 07.000 MEDICAL SUPPLIES CHARGED TO PATI ENT 0.316.052 70.000 07.000 MEDICAL SUPPLIES CHARGED TO PATI ENT 0.424.496 72.00 07.000 MEDICAL SUPPLIES CHARGED TO PATI ENTS 0.105.16 72.00 07.000 MEDICAL SURFICIAL DIALYSIS 0.65.294 74.00 73.00 07.000 MEDICAL SURFICIAL DIALYSIS 0.65.294 74.00 74.000 7							
54.00		1					
55.00 05500 RADI OLOGY - THERAPEUTIC 0.073487 55.00 56.00 03950 RADI OLOGY - THERAPEUTIC 5.00 56.00 03950 CARDI AC CATH LAB 0.060934 56.01 57.00 05700 CT SCAN 0.027485 57.00 65.00 05600 MRI 0.067866 58.00 65.00 05600 MRI 0.067866 58.00 66.00 06500 RESPIRATORY THERAPY 0.203214 65.00 66.00 06600 RESPIRATORY THERAPY 0.203214 66.00 66.00 06600 RESPIRATORY THERAPY 0.203214 65.00 06600 RESPIRATORY THERAPY 0.203214 65.00 06900 RESPIRATORY THERAPY 0.202646 67.00 07.00		1					
56. 00 05600 RADIOI SOTOPE 5. 049754 56. 00 56. 01 57. 00 5700 CT SCAN 0. 067084 56. 01 57. 00 5700 CT SCAN 0. 027485 57. 00 58. 00 05800 MRI 0. 067866 68. 00 065000 LABORATORY THERAPY 0. 203214 65. 00 06500 RESPIRATORY THERAPY 0. 203214 65. 00 06500 RESPIRATORY THERAPY 0. 291298 66. 00 06700 0CCUPATI ONAL THERAPY 0. 182686 67. 00 06700 0CCUPATI ONAL THERAPY 0. 182686 67. 00 06900 ELECTROCARDI OLOGY 0. 116608 69. 00 06900 ELECTROCARDI OLOGY 0. 116608 69. 00 06900 ELECTROCARDI OLOGY 0. 116608 69. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0. 085266 71. 00 07200 IMPL. DEV. CHARGED TO PATIENT 0. 085266 73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 130516 72. 00 07300 DRUGS CHARGED TO PATIENTS 0. 130516 72. 00 07300 DRUGS CHARGED TO PATIENTS 0. 424496 73. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 424496 73. 00 74. 00 74.00 7							
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57. 00 05700 CT SCAN 0.027485 57. 00		1					
58.00 0500 06000 LABORATORY 0.067866 0.00 06000 LABORATORY 0.107546 0.00 06000 RESPIRATORY THERAPY 0.203214 065.00 06500 RESPIRATORY THERAPY 0.291298 060.00 06600 PHYSI CAL THERAPY 0.182686 070 060700 0CCUPRATI ONAL THERAPY 0.182686 070 060700 0CCUPRATI ONAL THERAPY 0.182686 070 06800 SPEECH PATHOLOGY 0.202646 0800 0800 SPEECH PATHOLOGY 0.116608 09.00 07000 ELECTROCRAPI OLOGY 0.116608 09.00 071.00							
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68. 00 06800 SPEECH PATHOLOGY 0. 202646 69. 00 699. 00 06900 ELECTROCARDIOLOGY 0. 116608 69. 00 07000 ELECTROCARDIOLOGY 0. 316052 70. 00 71. 00 71. 00 71. 00 71. 00 71. 00 FLECTROCARDIOLOGY 0. 316052 71. 00 71. 00 FLECTROCARDIOLOGY 0. 316052 71. 00 71. 00 71. 00 FLECTROCARDIOLOGY 0. 130516 72. 00 72. 00 72. 00 72. 00 72. 00 73.		600 PHYSI CAL THERAPY	0. 291298				66. 00
69. 00 06900 ELECTROCARDI OLOGY 0. 116608 70. 00 77000 CLECTROENCEPHALOGRAPHY 0. 316052 70. 00 7000 ELECTROCARDI OLOGY 0. 316052 71. 00 70100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0. 085266 71. 00 72. 00	67. 00 067	700 OCCUPATIONAL THERAPY	0. 182686				67. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY 0. 316052 70. 00 711. 00 77100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0. 085266 71. 00 7200 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0. 130516 72. 00 7300 DRUGS CHARGED TO PATIENTS 0. 424496 73. 00 73. 01 73. 01 73. 01 73. 01 73. 01 73. 01 73. 01 73. 01 73. 01 74. 00 74. 00 DRUGS CHARGED TO PATIENTS 0. 424496 73. 01 74. 00 74. 00 DRUGS CHARGED TO PATIENTS 0. 424496 73. 01 74. 00 74. 00 74. 00 DRUGS CHARGED TO PATIENTS 0. 663296 74. 00	68. 00 068	800 SPEECH PATHOLOGY	0. 202646				68. 00
70. 00 07000 LECTROENCEPHALOGRAPHY	69. 00 069	900 ELECTROCARDI OLOGY	0. 116608				69. 00
71. 00							
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0. 130516 73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 424496 73. 00 73. 01 07301 DI ABETES CENTER 102. 014921 73. 01 74. 00 07400 RENAL DI ALYSI S 0. 663296 74. 00 76. 00 03480 0NCOLOGY 0. 287348 76. 00 76. 01 03951 INFUSI ON SERVI CES 0. 446895 76. 02 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0. 000000 76. 98 0UTPATI ENT SERVI CE COST CENTERS 90. 00 90. 00 09000 CLI NI C 2. 777136 91. 00 91. 00 09100 EMERGENCY 0. 132111 91. 00 91. 01 04950 WOUND CARE 4. 559570 91. 01 92. 01 09201 DESERVATI ON BEDS (DI STI NCT PART) 0. 395772 92. 01 07101 09500 AMBULANCE SERVI CES 0. 481887 95. 00 07100 09500 AMBULANCE SERVI CES 0. 481887 95. 00 07100 09500 AMBULANCE SERVI CES 0. 481887 95. 00 07100 09100 INTEREST EXPENSE 113. 00 07100 00 07100 SOLOTATI ENT SERVI CES 0. 481887 95. 00 07100 09500 AMBULANCE SERVI CES 0. 481887 95. 00 07100 09500 AMBULANCE SERVI CES 0. 481887 95. 00 07100 09500 AMBULANCE SERVI CES 0. 481887 95. 00 07100 07100 HOME HEALTH AGENCY 97. 00 07100 07100 HOME HEALTH HOME 97. 00 07100 07100 HOME HE		1					
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73. 01 07301 DIABETES CENTER 102. 014921 74. 00 07400 RENAL DI ALYSI S 0. 663296 76. 00 03480 ONCOLOGY 0. 287348 76. 01 03952 ANTI COAGULATI ON 0. 497883 76. 02 03951 INFUSI ON SERVI CES 0. 446895 76. 02 07698 HYPERBARI C OXYGEN THERAPY 0. 000000 90. 00 UIPATI ENT SERVI CE COST CENTERS 90. 00 09000 CLI NI C 2. 777136 91. 00 09100 EMERGENCY 0. 132111 91. 00 09100 EMERGENCY 0. 132111 91. 01 04950 WOUND CARE 4. 559570 92. 01 09201 OBSERVATI ON BEDS (INSTINCT PART) 0. 395772 092. 01 09201 OBSERVATI ON BEDS (ISTINCT PART) 0. 395772 071 OF SET OF		· ·	1				
74. 00 07400 RENAL DIALYSIS 0.663296 76. 00 03480 ONCOLOGY 0.287348 76. 00 76. 01 03952 ANTI COAGULATI ON 0.497883 76. 01 76. 02 03951 I NFUSI ON SERVI CES 0.446895 76. 02 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0.000000 76. 98 0UTPATI ENT SERVI CE COST CENTERS 90. 00 99000 CLI NI C 2.777136 90. 00 91. 00 99100 EMERGENCY 0.132111 91. 00 91. 01 04950 WOUND CARE 4.559570 91. 01 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0.467138 92. 00 92. 01 09201 OBSERVATI ON BEDS (DI STI NCT PART) 0.395772 92. 01 0THER REI MBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVI CES 0.481887 95. 00 101. 00 10100 HOME HEALTH AGENCY 101. 00 116. 00 11000 HOME HEALTH AGENCY 101. 00 200. 00 Subtotal (see instructions) 200. 00 201. 00 Less Observation Beds 201. 00							
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76. 02							
76. 98 07698 HYPERBARI C 0XYGEN THERAPY 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.00000000		1					
OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLINIC 2.777136 90.00 91.00 09100 EMERGENCY 0.132111 91.00 91.00 91.01 04950 WOUND CARE 4.55970 91.01 92.00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART 0.467138 92.00 9201 009201 0BSERVATI ON BEDS (DISTINCT PART) 0.395772 92.01 07162 REI MBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0.481887 95.00 101.00 10100 HOME HEALTH AGENCY 101.00 SPECI AL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 116.00 11600 HOSPICE 116.00 200.00 Subtotal (see instructions) Less Observation Beds 201.00 200.00 201.00 Less Observation Beds 201.00		l control of the cont					
90. 00 09000 CLINIC 2.777136 90. 00 91. 00 09100 EMERGENCY 0. 132111 91. 00 91. 01 04950 WOUND CARE 4. 559570 91. 01 92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART 0. 467138 92. 00 99201 0BSERVATI ON BEDS (DISTINCT PART) 0. 395772 92. 01 07100			0. 000000				76. 98
91. 00 09100 EMERGENCY 0. 132111 91. 00 91. 01 04950 WOUND CARE 4. 559570 91. 01 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0. 467138 92. 00 09201 OBSERVATI ON BEDS (DI STI NCT PART 0. 395772 92. 01 07HER REI MBURSABLE COST CENTERS 095. 00 O9500 AMBURANCE SERVI CES 0. 481887 95. 00 O10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS 101. 00 11300 INTEREST EXPENSE 113. 00 116. 00 11600 HOSPI CE 116. 00 200. 00 Subtotal (see instructions) Less Observation Beds 201. 00 201. 00 0. 1000 1000			2 77712/				00 00
91. 01		1					1
92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART 0. 467138 0. 395772 92. 01 09201 0BSERVATI ON BEDS (DISTINCT PART) 0. 395772 92. 01 07							1
92. 01 09201 0BSERVATI ON BEDS (DISTINCT PART) 0. 395772 92. 01		1	1				1
OTHER REIMBURSABLE COST CENTERS 95.00							
95. 00			0. 395772				92. 01
101. 00							
SPECIAL PURPOSE COST CENTERS 113.00 11300 I NTEREST EXPENSE 113.00 116.00 11600		1	0. 481887				
113. 00 11300 INTEREST EXPENSE							101. 00
116. 00 116.00 200. 00 Subtotal (see instructions) 201. 00 Less Observation Beds 116. 00 200. 00 201. 00							
200.00 Subtotal (see instructions) 200.00 201.00 Less Observation Beds 201.00		1					113. 00
201.00 Less Observation Beds 201.00	116. 00 116	600 H0SPI CE					116. 00
	200.00	Subtotal (see instructions)					200. 00
202.00 Total (see instructions) 202.00	201.00	Less Observation Beds					201.00
	202. 00	Total (see instructions)					202. 00

Health Financial Systems	FRANCISCAN HEALTH LAFAYETTE	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provider CCN: 15-0109	Peri od: From 01/01/2021	Worksheet C Part I
		To 12/31/2021	Date/Time Prepared:

				Ť	o 12/31/2021	Date/Time Pre 5/2/2022 3:08	pared:
-			Ti tl	e XIX	Hospi tal	Cost	рш
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst. B,	Adj .		Di sal I owance		
		Part I, col.	,				
		26)					
		1.00	2.00	3.00	4. 00	5. 00	
I	NPATIENT ROUTINE SERVICE COST CENTERS						
30.00 0	3000 ADULTS & PEDIATRICS	55, 992, 447		55, 992, 447	0	55, 992, 447	30.00
31.00 0	3100 INTENSIVE CARE UNIT	9, 667, 457		9, 667, 457	0	9, 667, 457	31.00
35. 00 0	2060 NEONATAL INTENSIVE CARE UNIT	5, 082, 804		5, 082, 804	5, 738	5, 088, 542	35. 00
41.00 0	04100 SUBPROVIDER - IRF	4, 745, 488		4, 745, 488	0	4, 745, 488	41.00
43.00 0	04300 NURSERY	1, 189, 643		1, 189, 643	0	1, 189, 643	43.00
Α	NCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	13, 172, 095		13, 172, 095	31, 512	13, 203, 607	50. 00
51.00 0	05100 RECOVERY ROOM	1, 413, 790		1, 413, 790	0	1, 413, 790	51.00
52.00 0	D5200 DELIVERY ROOM & LABOR ROOM	5, 229, 528		5, 229, 528	0	5, 229, 528	52.00
54.00 0	05400 RADI OLOGY-DI AGNOSTI C	11, 712, 911		11, 712, 911	2, 568	11, 715, 479	54.00
55. 00 0	05500 RADIOLOGY - THERAPEUTIC	1, 053, 902		1, 053, 902	0	1, 053, 902	55. 00
	05600 RADI OI SOTOPE	177, 817		177, 817	0	177, 817	56.00
56. 01 0	3950 CARDIAC CATH LAB	3, 752, 008		3, 752, 008	0	3, 752, 008	56. 01
57.00 0	5700 CT SCAN	1, 882, 470		1, 882, 470	0	1, 882, 470	57.00
58. 00 0	05800 MRI	740, 785		740, 785	0	740, 785	58. 00
60.00 0	06000 LABORATORY	15, 283, 239		15, 283, 239	35, 786	15, 319, 025	60.00
65. 00 0	06500 RESPI RATORY THERAPY	4, 750, 395	0	4, 750, 395	0	4, 750, 395	65. 00
66. 00 0	06600 PHYSI CAL THERAPY	8, 907, 869	0	8, 907, 869	0	8, 907, 869	66. 00
67.00 0	06700 OCCUPATI ONAL THERAPY	2, 629, 019	0	2, 629, 019	0	2, 629, 019	67.00
68.00 0	06800 SPEECH PATHOLOGY	1, 021, 441	0	1, 021, 441	o	1, 021, 441	68. 00
69.00 0	06900 ELECTROCARDI OLOGY	4, 845, 410		4, 845, 410	0	4, 845, 410	
70.00 0	07000 ELECTROENCEPHALOGRAPHY	1, 731, 537		1, 731, 537	O	1, 731, 537	70. 00
71.00 0	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	17, 704, 560		17, 704, 560	0	17, 704, 560	71. 00
72.00 0	07200 IMPL. DEV. CHARGED TO PATIENTS	12, 615, 879		12, 615, 879	0	12, 615, 879	72. 00
73.00 0	7300 DRUGS CHARGED TO PATIENTS	35, 315, 067		35, 315, 067	O	35, 315, 067	73. 00
73. 01 0	07301 DI ABETES CENTER	786, 229		786, 229	o	786, 229	73. 01
74.00 0	7400 RENAL DIALYSIS	2, 253, 683		2, 253, 683	o	2, 253, 683	74. 00
76.00 0	03480 ONCOLOGY	6, 013, 620		6, 013, 620	o	6, 013, 620	76. 00
76. 01 0	03952 ANTI COAGULATI ON	521, 850		521, 850	l .	521, 850	1
	03951 INFUSION SERVICES	2, 189, 692		2, 189, 692		2, 189, 692	
76. 98 0	7698 HYPERBARIC OXYGEN THERAPY	0		0		0	1
	UTPATIENT SERVICE COST CENTERS	•					
90.00 0	99000 CLI NI C	1, 930, 826		1, 930, 826	0	1, 930, 826	90. 00
91.00 0	9100 EMERGENCY	15, 849, 079		15, 849, 079	o	15, 849, 079	91.00
91. 01 0	04950 WOUND CARE	2, 935, 123		2, 935, 123		2, 935, 123	
92.00 0	9200 OBSERVATION BEDS (NON-DISTINCT PART	8, 253, 802		8, 253, 802		8, 253, 802	
92. 01 0	09201 OBSERVATION BEDS (DISTINCT PART)	3, 414, 695		3, 414, 695	0	3, 414, 695	92. 01
	THER REIMBURSABLE COST CENTERS						
95. 00 0	9500 AMBULANCE SERVICES	5, 571, 775		5, 571, 775	0	5, 571, 775	95. 00
101.001	0100 HOME HEALTH AGENCY	7, 977, 477		7, 977, 477		7, 977, 477	101. 00
	PECIAL PURPOSE COST CENTERS						
	1300 INTEREST EXPENSE						113. 00
	1600 HOSPI CE	7, 368, 840		7, 368, 840		7, 368, 840	1
200.00	Subtotal (see instructions)	285, 684, 252	0			285, 759, 856	
201.00	Less Observation Beds	8, 253, 802		8, 253, 802		8, 253, 802	1
202.00	Total (see instructions)	277, 430, 450	0		I	277, 506, 054	
1			_				

					To 12/31/2021	Date/Time Pre 5/2/2022 3:08	pared:
			Ti +I	e XIX	Hospi tal	Cost	рш
			Charges	CAIA	1103pi tui	0031	
	Cost Center Description	Inpati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
	oost content beschiptren	ripatront	outputient	+ col . 7)	Ratio	Inpati ent	
				' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' '	, att o	Ratio	
		6. 00	7. 00	8. 00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	106, 207, 748		106, 207, 748	3		30. 00
31.00	03100 INTENSIVE CARE UNIT	24, 130, 725		24, 130, 72	5		31.00
35. 00	02060 NEONATAL INTENSIVE CARE UNIT	20, 258, 945		20, 258, 94!			35. 00
41.00	04100 SUBPROVI DER - I RF	6, 525, 906		6, 525, 900			41.00
43.00	04300 NURSERY	4, 491, 042		4, 491, 042			43.00
	ANCILLARY SERVICE COST CENTERS				<u>'</u>		
50.00	05000 OPERATI NG ROOM	60, 913, 533	106, 161, 971	167, 075, 504	0. 078839	0.000000	50.00
51.00	05100 RECOVERY ROOM	4, 055, 461	9, 993, 712	14, 049, 17	0. 100632	0. 000000	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	19, 329, 748	910, 185			0. 000000	
54.00	05400 RADI OLOGY-DI AGNOSTI C	21, 633, 792	78, 544, 166			0.000000	
55. 00	05500 RADI OLOGY - THERAPEUTI C	3, 885, 275	10, 456, 042			0. 000000	
56.00	05600 RADI OI SOTOPE	0	35, 213	1		0. 000000	
56. 01	03950 CARDI AC CATH LAB	34, 918, 587	26, 656, 080			0.000000	
57. 00	05700 CT SCAN	20, 278, 303	48, 212, 436			0. 000000	
58. 00	05800 MRI	3, 631, 043	7, 284, 433			0. 000000	
60.00	06000 LABORATORY	61, 478, 369	80, 963, 741			0.000000	
65. 00	06500 RESPIRATORY THERAPY	19, 932, 350	3, 443, 977			0. 000000	
66. 00	06600 PHYSI CAL THERAPY	8, 316, 231	22, 263, 638	1		0.000000	1
67. 00	06700 OCCUPATI ONAL THERAPY	6, 920, 132	7, 470, 776			0. 000000	
68. 00	06800 SPEECH PATHOLOGY	1, 784, 850	3, 255, 678			0. 000000	
69. 00	06900 ELECTROCARDI OLOGY	14, 436, 395	27, 116, 484			0. 000000	
70. 00	07000 ELECTROENCEPHALOGRAPHY	1, 188, 366	4, 290, 276			0.000000	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	79, 024, 662	128, 613, 892			0. 000000	
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	47, 491, 646	49, 169, 796			0.000000	
73. 00	07300 DRUGS CHARGED TO PATIENTS	48, 760, 608	34, 432, 250			0. 000000	
73. 01	07301 DI ABETES CENTER	1, 243	6, 464			0.000000	
74. 00	07400 RENAL DIALYSIS	2, 245, 992	1, 151, 709			0. 000000	
76. 00	03480 ONCOLOGY	2, 771, 430	18, 156, 549			0. 000000	1
76. 01	03952 ANTI COAGULATI ON	1, 956	1, 046, 181			0. 000000	
76. 02	03951 NFUSI ON SERVI CES	0	4, 899, 796			0. 000000	
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0			0. 000000	
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	695, 258	695, 258	2. 777136	0.000000	90.00
91. 00	09100 EMERGENCY	23, 040, 488	96, 927, 248			0.000000	1
91. 01	04950 WOUND CARE	0	643, 728			0. 000000	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	3, 000, 000	14, 668, 887			0.000000	
92. 01	09201 OBSERVATION BEDS (DISTINCT PART)	1, 522, 424	7, 105, 502			0. 000000	
,2.0.	OTHER REIMBURSABLE COST CENTERS	1,022,121	7, 100, 002	0,02,,,2	0.070772	0,00000	,2.0.
95.00	09500 AMBULANCE SERVI CES	0	11, 562, 410	11, 562, 410	0. 481887	0.000000	95. 00
	10100 HOME HEALTH AGENCY	0	9, 254, 945				101. 00
	SPECIAL PURPOSE COST CENTERS		.,,	., == .,	-1		
113.00	11300 INTEREST EXPENSE						113. 00
	11600 HOSPI CE	0	21, 607, 267	21, 607, 26	7		116. 00
200.00		652, 177, 250		1, 489, 177, 940			200. 00
201.00	Less Observation Beds						201. 00
202.00		652, 177, 250	837, 000, 690	1, 489, 177, 940			202. 00
				•	*	-	

Health Financial Systems	FRANCISCAN HEALTH LAFAYETTE	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0109	Peri od: From 01/01/2021 To 12/31/2021	Worksheet C Part I Date/Time Prepared: 5/2/2022 3:08 pm

				5/2/2022 3:08 pm
		Title XIX	Hospi tal	Cost
Cost Center Description	PPS Inpatient			
· ·	Ratio			
	11. 00			
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	,			
30. 00 03000 ADULTS & PEDI ATRI CS				30.00
31. 00 03100 NTENSI VE CARE UNI T				31.00
35. 00 02060 NEONATAL INTENSIVE CARE UNIT				35. 00
41. 00 04100 SUBPROVI DER - RF				41. 00
43. 00 04300 NURSERY				43. 00
ANCI LLARY SERVI CE COST CENTERS				43.00
50. 00 05000 OPERATING ROOM	0. 000000			50.00
	1			•
51. 00 05100 RECOVERY ROOM	0.000000			51.00
52. 00 05200 DELI VERY 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 01 SOTOPE	0. 000000			56. 00
56. 01 03950 CARDI AC CATH LAB	0. 000000			56. 01
57. 00 05700 CT SCAN	0. 000000			57. 00
58. 00 05800 MRI	0. 000000			58.00
60. 00 06000 LABORATORY	0. 000000			60.00
65. 00 06500 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 IMPL. DEV. CHARGED TO PATIENTS	0. 000000			72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73. 00
73. 01 07301 DI ABETES CENTER	0. 000000			73. 00
	1			•
	0.000000			74.00
76. 00 03480 ONCOLOGY	0. 000000			76. 00
76. 01 03952 ANTI COAGULATI ON	0. 000000			76. 01
76. 02 03951 I NFUSI ON SERVI CES	0. 000000			76. 02
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 000000			76. 98
OUTPATIENT SERVICE COST CENTERS				
90. 00 09000 CLI NI C	0. 000000			90.00
91. 00 09100 EMERGENCY	0. 000000			91. 00
91. 01 04950 WOUND CARE	0. 000000			91. 01
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000			92. 00
92.01 09201 OBSERVATION BEDS (DISTINCT PART)	0. 000000			92. 01
OTHER REIMBURSABLE COST CENTERS	'			
95. 00 09500 AMBULANCE SERVICES	0. 000000			95. 00
101.00 10100 HOME HEALTH AGENCY	1 222300			101.00
SPECIAL PURPOSE COST CENTERS	<u> </u>			131.00
113. 00 11300 I NTEREST EXPENSE				113. 00
116. 00 11600 HOSPI CE				116. 00
200.00 Subtotal (see instructions)				200. 00
201. 00 Subtotal (see Histructions) 201. 00 Less Observation Beds				200.00
				201.00
202.00 Total (see instructions)				J202. 00

Health Financial Systems	FRANCISCAN HEAI	LTH LAFAYETTE		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der C	!	Period: From 01/01/2021 To 12/31/2021	Worksheet D Part I Date/Time Pre 5/2/2022 3:08	pared:
			XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced		Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col. 1 - col			
	26)		2)			
	1.00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	8, 901, 531	l .	8, 901, 53		l e	1
31.00 INTENSIVE CARE UNIT	995, 529		995, 52		207. 53	
35.00 NEONATAL INTENSIVE CARE UNIT	578, 768		578, 76			
41. 00 SUBPROVI DER - I RF	992, 803	0	992, 80			
43. 00 NURSERY	26, 856		26, 85	6 2, 942	9. 13	
200.00 Total (lines 30 through 199)	11, 495, 487		11, 495, 48	7 53, 858		200. 00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	12, 071					30. 00
31.00 INTENSIVE CARE UNIT	1, 684	349, 481				31. 00
35.00 NEONATAL INTENSIVE CARE UNIT	0	0				35. 00
41. 00 SUBPROVI DER - I RF	1, 103	372, 086				41. 00
43. 00 NURSERY	0	0				43. 00
200.00 Total (lines 30 through 199)	14, 858	3, 447, 802				200. 00

lealth Financial Systems APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT	FRANCISCAN HEAD	Provider C	ON. 1E 0100	Peri od:	u of Form CMS-: Worksheet D	2552-10
APPORTIONMENT OF INPATTENT ANCILLARY SERVICE CAPIT	AL CUSTS	Provider Co	JN: 15-0109	From 01/01/2021	Part II	
				To 12/31/2021	Date/Time Pre 5/2/2022 3:08	pared:
		Title	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,			l. Charges	column 4)	
	Part II, col.	8)	2)			
	26)	0.00	0.00	4.00	F 00	
ANCILLARY SERVICE COST CENTERS	1.00	2. 00	3.00	4. 00	5. 00	
50. 00 O5000 OPERATING ROOM	2, 388, 889	167, 075, 504	0. 01429	98 20, 788, 156	297, 229	1 50. 00
51. 00 05100 RECOVERY ROOM	194, 740				19, 833	
52. 00 05200 DELIVERY ROOM & LABOR ROOM	78, 113				19, 633	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 316, 607				110, 738	
55. 00 05500 RADI OLOGY - THERAPEUTI C	63, 565		0. 00443		5, 242	
56. 00 05600 RADI OI SOTOPE	23, 274				0, 242	
56. 01 03950 CARDI AC CATH LAB	607, 693		0.00986		109, 645	
57. 00 05700 CT SCAN	141, 048				17, 577	57. 00
58. 00 05800 MRI	93, 637				13, 223	
50. 00 06000 LABORATORY	563, 900		0. 0039!		84, 512	
55. 00 06500 RESPIRATORY THERAPY	251, 755		0. 0107		72, 369	
66. 00 06600 PHYSI CAL THERAPY	276, 874		0.0090		22, 154	
57. 00 06700 OCCUPATI ONAL THERAPY	65, 853				8, 946	
58. 00 06800 SPEECH PATHOLOGY	31, 123				2, 407	68. 00
59. 00 06900 ELECTROCARDI OLOGY	707, 306			·	99, 214	
70. 00 07000 ELECTROENCEPHALOGRAPHY	342, 726		0. 0625		29, 225	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	226, 076	207, 638, 554	0. 00108	39 25, 370, 525	27, 629	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	146, 695	96, 661, 442	0. 0015 ⁴	18 22, 107, 133	33, 559	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	938, 287	83, 192, 858	0. 0112	78 16, 544, 552	186, 589	73.00
73. 01 07301 DI ABETES CENTER	19, 196	7, 707	2. 49072	23 411	1, 024	73. 01
74.00 07400 RENAL DIALYSIS	194, 883	3, 397, 701	0. 0573	57 6, 256	359	74.00
76. 00 03480 0NC0L0GY	240, 146	20, 927, 979			18, 095	76.00
76. 01 03952 ANTI COAGULATI ON	10, 585		0. 01009		0	
76.02 03951 INFUSION SERVICES	33, 504	4, 899, 796	0. 00683		0	76. 02
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0	0.00000	00	0	76. 98
OUTPATIENT SERVICE COST CENTERS	_					1
90. 00 09000 CLI NI C	35, 954				0	
91. 00 09100 EMERGENCY	2, 804, 039				216, 228	
91. 01 04950 WOUND CARE	1, 017, 597					
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 312, 165		0. 07426		165, 442	
92. 01 09201 OBSERVATION BEDS (DISTINCT PART)	525, 653	8, 627, 926	0. 06092	25 1, 000, 000	60, 925	92. 01
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	14 (51 000	1 205 120 252		170 252 224	1 (00 4(4	95.00
200.00 Total (lines 50 through 199)	14, 651, 883	1, 285, 138, 952	I	170, 253, 894	1, 602, 164	1200. OC

Health Financial Systems	FRANCISCAN HEAL	LTH LAFAYETTE		In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	SS THROUGH COS			Period: From 01/01/2021 To 12/31/2021	Date/Time Pre 5/2/2022 3:08	
		Titl∈	e XVIII	Hospi tal	PPS	
Cost Center Description	Nursi ng Program Post-Stepdown Adj ustments	Nursi ng Program	Post-Stepdowi Adjustments		Medical Education Cost	
	1A	1. 00	2A	2. 00	3. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT 35. 00 02060 NEONATAL INTENSIVE CARE UNIT	0 0 0	4, 419, 807 0	7	0 0 0	0	31. 00 35. 00
41. 00 04100 SUBPROVI DER - RF	0	0		0	0	
43. 00 04300 NURSERY	0	0)	0	0	
200.00 Total (lines 30 through 199)	0	4, 419, 807		0 0		200. 00
Cost Center Description	Swing-Bed Adjustment Amount (see	Total Costs (sum of cols. 1 through 3,	Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
	instructions) 4.00	mi nus col . 4) 5.00	6.00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	4.00	3.00	0.00	7.00	0.00	
30. 00 03000 ADULTS & PEDIATRICS	0	4, 419, 807	39, 41	4 112.14	12, 071	30.00
31. 00 03100 NTENSI VE CARE UNI T		4, 417, 607	4, 79			
35. 00 02060 NEONATAL INTENSIVE CARE UNIT		Ĭ	3, 76			1
41. 00 04100 SUBPROVI DER - I RF	0	ľ	2, 94			
43. 00 04300 NURSERY		l o	2, 94			
200.00 Total (lines 30 through 199)		4, 419, 807				200.00
Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT 35. 00 02060 NEONATAL INTENSIVE CARE UNIT 41. 00 04100 SUBPROVIDER - IRF	1, 353, 642 0 0 0					30. 00 31. 00 35. 00 41. 00
43. 00 04300 NURSERY	0					43.00
200.00 Total (lines 30 through 199)	1, 353, 642					200. 00

Health Financial Systems	FRANCISCAN HEALTH	LAFAYETTE	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provi der CCN: 15-0109	Peri od: From 01/01/2021 To 12/31/2021	Worksheet D Part IV Date/Time Prepared:

	666.6				To 12/31/2021	Date/Time Pre 5/2/2022 3:08	
			Title	XVIII	Hospi tal	PPS	
	Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
		Anesthetist	Program	Program	Post-Stepdown		
		Cost	Post-Stepdown		Adjustments		
			Adjustments				
	ANOLLI ADV. CEDVI OF COCT. OFNITEDO	1.00	2A	2. 00	3A	3. 00	
	ANCI LLARY SERVI CE COST CENTERS 05000 OPERATI NG ROOM					0	50.00
	05100 RECOVERY ROOM	0	0		0	0	51.00
	05200 DELIVERY ROOM & LABOR ROOM	0	0		0	0	52.00
	05400 RADI OLOGY-DI AGNOSTI C	0	0		0	0	54.00
	05500 RADI OLOGY - THERAPEUTI C	0	0			0	55.00
	05600 RADI OI SOTOPE		0			0	56.00
	03950 CARDI AC CATH LAB		0			0	56. 01
	05700 CT SCAN		0			0	57. 00
	05800 MRI	0	0			0	58. 00
	06000 LABORATORY		0			0	60.00
	06500 RESPIRATORY THERAPY	0	0			0	65. 00
	06600 PHYSI CAL THERAPY		0			0	66. 00
	06700 OCCUPATI ONAL THERAPY		0			o n	67. 00
	06800 SPEECH PATHOLOGY		0			0	68. 00
	06900 ELECTROCARDI OLOGY	0	0		0	,	69. 00
	07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	o o	70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 0	0	71. 00
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	72. 00
	07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	531, 371	73. 00
	07301 DI ABETES CENTER	0	0		0 0	0	73. 01
	07400 RENAL DIALYSIS	0	0		0	0	74. 00
	03480 ONCOLOGY	0	0		0 0	0	76. 00
	03952 ANTI COAGULATI ON	0	0		0	0	76. 01
	03951 NFUSION SERVICES	o	0		o o	0	76. 02
	07698 HYPERBARI C OXYGEN THERAPY	O	0		0	0	76. 98
	OUTPATIENT SERVICE COST CENTERS	-1					
90.00	09000 CLI NI C	0	0		0 0	0	90.00
91.00	09100 EMERGENCY	0	0		0	647, 352	91. 00
91. 01	04950 WOUND CARE	0	0		0	0	91. 01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0		651, 52	2	0	92. 00
92. 01	09201 OBSERVATION BEDS (DISTINCT PART)	0	0		0 0	0	92. 01
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVI CES						95. 00
200.00	Total (lines 50 through 199)	0	0	651, 52	2 0	1, 178, 723	200. 00

Heal th Financial Systems FRANCISCAN HEALTH LAFAYETTE APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider CCN: 15-0109 Period: From 01/01/2021 To 12/31/2021 Date/Time Prepared: 5/2/2022 3:08 pm PPS PROVIDED PART I V PROVIDED PROVIDE
THROUGH COSTS
To 12/31/2021 Date/Time Prepared: 5/2/2022 3: 08 pm PPS
Title XVIII Hospital Foctor Hospital Total Cost Sum of col s. Cost Center Description Hospital Total Cost (sum of col s. Sum of col s. Cost (sum of col s. Sum of col s. Cost (sum of col s. Sum of col s.
Title XVIII Hospital PPS
All Other Medical Education Cost Sum of cols. Cost (sum of cols. Lost (sum of col
Medical Education Cost Standard Cost (sum of cols. Cost (sum of
Education Cost 1, 2, 3, and Cost (sum of col s. 2, 3, and 4) Part I, col. (col. 5 ÷ col. 7) (see instructions)
4) col s. 2, 3, and 4) (see instructions) 4.00 5.00 6.00 7.00 8.00 ANCI LLARY SERVI CE COST CENTERS 50.00 05000 0PERATI NG ROOM 0 0 167, 075, 504 0.000000 50.00 51.00 05100 RECOVERY ROOM 0 0 0 14, 049, 173 0.000000 51.00 52.00 05200 DELI VERY ROOM 8 LABOR ROOM 0 0 0 0 20, 239, 933 0.000000 52.00 54.00 05400 RADI OLOGY - DI AGNOSTI C 0 0 0 100, 177, 958 0.000000 54.00 55.00 05500 RADI OLOGY - THERAPEUTI C 0 0 0 143, 341, 317 0.000000 55.00 56.00 05600 RADI OLOGY - THERAPEUTI C 0 0 0 143, 341, 317 0.000000 55.00 56.01 03950 CARDI AC CATH LAB 0 0 0 0 61, 574, 667 0.000000 56.01 57.00 05700 CT SCAN 0 0 0 0 68, 490, 739 0.000000 57.00 58.00 05800 MRI 0 0 0 0 10, 915, 476 0.000000 57.00 65.00 06500 RESPI RATORY THERAPY
ANCILLARY SERVICE COST CENTERS A.OO 5.0O 6.0O 7.0O 8.0O
ANCI LLARY SERVI CE COST CENTERS So. 00 So. 00 O O O O O O O O O
ANCILLARY SERVICE COST CENTERS 50. 00 05000 0PERATING ROOM 0 0 167, 075, 504 0.000000 50.00 51.00 05100 RECOVERY ROOM 0 0 0 0 14, 049, 173 0.000000 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0 0 20, 239, 933 0.000000 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 0 100, 177, 958 0.000000 54.00 55.00 05500 RADI OLOGY - THERAPEUTI C 0 0 0 14, 341, 317 0.000000 55.00 56.00 05600 RADI OLOGY - THERAPEUTI C 0 0 0 0 35, 213 0.000000 55.00 56.00 05600 RADI OLOGY - THERAPEUTI C 0 0 0 0 0 35, 213 0.000000 56.00 56.00 05500 CARDI AC CATH LAB 0 0 0 0 61, 574, 667 0.000000 56.00 57.00 05700 CT SCAN 0 0 0 0 68, 490, 739 0.000000 57.00 58.00 05800 MRI 0 0 0 0 10, 915, 476 0.000000 58.00 60.00 06000 LABORATORY 0 0 0 142, 442, 110 0.000000 60.00 65.00 06500 RESPIRATORY THERAPY 0 0 0 23, 376, 327 0.000000 65.00
50. 00 05000 OPERATI NG ROOM 0 0 167, 075, 504 0.000000 50. 00 51. 00 05100 RECOVERY ROOM 0 0 0 14, 049, 173 0.000000 51. 00 52. 00 05200 DELI VERY ROOM & LABOR ROOM 0 0 0 20, 239, 933 0.000000 52. 00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 0 0 100, 177, 958 0.000000 54. 00 55. 00 05500 RADI OLOGY - THERAPEUTI C 0 0 0 14, 341, 317 0.000000 55. 00 56. 01 03950 CARDI AC CATH LAB 0 0 0 35, 213 0.000000 56. 01 57. 00 05700 CT SCAN 0 0 0 61, 574, 667 0.000000 57. 00 58. 00 05800 MRI 0 0 0 0 142, 442, 110 0.000000 58. 00 60. 00 06500 RESPI RATORY THERAPY 0 0 23,
51. 00 05100 RECOVERY ROOM 0 0 14, 049, 173 0.000000 51. 00 52. 00 05200 DELI VERY ROOM & LABOR ROOM 0 0 0 20, 239, 933 0.000000 52. 00 54. 00 05400 RADI OLOGY - DI AGNOSTI C 0 0 100, 177, 958 0.000000 54. 00 55. 00 05500 RADI OLOGY - THERAPEUTI C 0 0 0 14, 341, 317 0.000000 55. 00 56. 01 03950 CARDI AC CATH LAB 0 0 0 61, 574, 667 0.000000 56. 01 57. 00 05700 CT SCAN 0 0 0 68, 490, 739 0.000000 57. 00 58. 00 05800 MRI 0 0 0 0 142, 442, 110 0.000000 60.00 65. 00 06500 RESPI RATORY THERAPY 0 0 23, 376, 327 0.000000 65. 00
52. 00 05200 DELI VERY ROOM & LABOR ROOM 0 0 20, 239, 933 0.000000 52. 00 54. 00 05400 RADI OLOGY - DI AGNOSTI C 0 0 100, 177, 958 0.000000 54. 00 55. 00 05500 RADI OLOGY - THERAPEUTI C 0 0 0 14, 341, 317 0.000000 55. 00 56. 01 05600 RADI OLOGY - THERAPEUTI C 0 0 0 35, 213 0.000000 56. 00 56. 01 03500 CARDI AC CATH LAB 0 0 61, 574, 667 0.000000 56. 01 57. 00 05700 CT SCAN 0 0 68, 490, 739 0.000000 56. 01 58. 00 05800 MRI 0 0 0 0 142, 442, 110 0.000000 58. 00 60. 00 06500 RESPI RATORY THERAPY 0 0 23, 376, 327 0.000000 65. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 0 100, 177, 958 0.000000 54. 00 55. 00 05500 RADI OLOGY - THERAPEUTI C 0 0 0 14, 341, 317 0.000000 55. 00 56. 01 05600 RADI OLOGY - THERAPEUTI C 0 0 0 35, 213 0.000000 56. 00 56. 01 03950 CARDI AC CATH LAB 0 0 61, 574, 667 0.000000 56. 01 57. 00 05700 CT SCAN 0 0 68, 490, 739 0.000000 56. 01 58. 00 05800 MRI 0 0 0 10, 915, 476 0.000000 58. 00 60. 00 06000 LABORATORY 0 0 142, 442, 110 0.000000 65. 00 65. 00 06500 RESPI RATORY THERAPY 0 0 23, 376, 327 0.000000 65. 00
55. 00 05500 RADI OLOGY - THERAPEUTI C 0 0 14, 341, 317 0.000000 55. 00 56. 00 05600 RADI OLOGY - THERAPEUTI C 0 0 0 14, 341, 317 0.000000 56. 00 56. 01 03950 CARDI AC CATH LAB 0 0 0 61, 574, 667 0.000000 56. 01 57. 00 05700 CT SCAN 0 0 0 68, 490, 739 0.000000 57. 00 58. 00 05800 MRI 0 0 0 10, 915, 476 0.000000 58. 00 60. 00 06000 LABORATORY 0 0 142, 442, 110 0.000000 65. 00 65. 00 06500 RESPI RATORY THERAPY 0 0 23, 376, 327 0.000000 65. 00
56. 00 05600 RADI OI SOTOPE 0 0 35, 213 0.000000 56. 00 56. 01 03950 CARDI AC CATH LAB 0 0 0 61, 574, 667 0.000000 56. 01 57. 00 05700 CT SCAN 0 0 0 68, 490, 739 0.000000 57. 00 58. 00 05800 MRI 0 0 0 10, 915, 476 0.000000 58. 00 60. 00 06000 LABORATORY 0 0 142, 442, 110 0.000000 65. 00 65. 00 06500 RESPI RATORY THERAPY 0 0 23, 376, 327 0.000000 65. 00
56. 01 03950 CARDI AC CATH LAB 0 0 61, 574, 667 0.000000 56. 01 57. 00 05700 CT SCAN 0 0 0 68, 490, 739 0.000000 57. 00 58. 00 05800 MRI 0 0 0 10, 915, 476 0.000000 58. 00 60. 00 06000 LABORATORY 0 0 142, 442, 110 0.000000 60. 00 65. 00 06500 RESPI RATORY THERAPY 0 0 23, 376, 327 0.000000 65. 00
57. 00 05700 CT SCAN 0 0 68, 490, 739 0.000000 57. 00 58. 00 05800 MRI 0 0 0 10, 915, 476 0.000000 58. 00 60. 00 06000 LABORATORY 0 0 0 142, 442, 110 0.000000 60. 00 65. 00 06500 RESPI RATORY THERAPY 0 0 0 23, 376, 327 0.000000 65. 00
58. 00 05800 MRI 0 0 0 10, 915, 476 0.000000 58. 00 60. 00 06000 LABORATORY 0 0 0 142, 442, 110 0.000000 60. 00 65. 00 06500 RESPI RATORY THERAPY 0 0 0 23, 376, 327 0.000000 65. 00
60. 00 06000 LABORATORY 0 0 142, 442, 110 0. 000000 60. 00 65. 00 06500 RESPIRATORY THERAPY 0 0 0 23, 376, 327 0. 000000 65. 00
65. 00 06500 RESPI RATORY THERAPY 0 0 0 23, 376, 327 0. 000000 65. 00
66. 00 06600 PHYSI CAL THERAPY 0 0 30, 579, 869 0. 000000 66. 00
67. 00 06700 OCCUPATI ONAL THERAPY 0 0 14, 390, 908 0. 000000 67. 00
68. 00 06800 SPEECH PATHOLOGY 0 0 5, 040, 528 0. 000000 68. 00
69. 00 06900 ELECTROCARDI OLOGY 0 0 41, 552, 879 0. 000000 69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 5, 478, 642 0. 000000 70. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 207, 638, 554 0.000000 71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 96, 661, 442 0.00000 72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS 0 531, 371 531, 371 83, 192, 858 0. 006387 73. 00
73. 01 07301 DI ABETES CENTER 0 0 7, 707 0. 000000 73. 01
74. 00 07400 RENAL DI ALYSI S 0 0 0 3, 397, 701 0. 000000 74. 00
76. 00 03480 0NC0LOGY 0 0 20, 927, 979 0. 000000 76. 00
76. 01 03952 ANTI COAGULATI ON 0 0 1, 048, 137 0. 000000 76. 01
76. 02 03951 INFUSION SERVICES 0 0 0 4, 899, 796 0. 000000 76. 02
76. 98 07698 HYPERBARI C 0XYGEN THERAPY 0 0 0 0.000000 76. 98

647, 352

651, 522

1, 830, 245

647, 352

651, 522

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1, 830, 245 1, 285, 138, 952

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92.00

92.01

95.00

200.00

695, 258

643, 728

119, 967, 736

17, 668, 887

8, 627, 926

OUTPATIENT SERVICE COST CENTERS
09000 CLINIC

OTHER REIMBURSABLE COST CENTERS
95. 00 09500 AMBULANCE SERVICES

09200 OBSERVATION BEDS (NON-DISTINCT PART O9201 OBSERVATION BEDS (DISTINCT PART)

Total (lines 50 through 199)

90.00

91. 01

92.00

92.01

200.00

91. 00 09100 EMERGENCY

04950 WOUND CARE

	Financial Systems	FRANCISCAN HEALT				eu of Form CMS-2	2552-10
	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEI H COSTS	RVICE OTHER PASS	Provi der Co		Period: From 01/01/2021 To 12/31/2021	Worksheet D Part IV Date/Time Pre 5/2/2022 3:08	
				XVIII	Hospi tal	PPS	
	Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)		Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		9.00	10.00	11.00	12.00	13.00	
	ANCILLARY SERVICE COST CENTERS	<u> </u>					
50.00	05000 OPERATI NG ROOM	0. 000000	20, 788, 156		0 23, 971, 109	0	50.00
51.00	05100 RECOVERY ROOM	0. 000000	1, 430, 885		0 2, 681, 590	0	51. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0	0	52. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	8, 425, 626		0 12, 873, 726	0	54. 00
55. 00	05500 RADI OLOGY - THERAPEUTI C	0. 000000	1, 182, 689		0 1, 662, 091	0	55. 00
56. 00	05600 RADI 0I SOTOPE	0. 000000	0		0	0	56. 00
56. 01	03950 CARDI AC CATH LAB	0. 000000	11, 110, 072		0 8, 484, 970	0	56. 01
57. 00	05700 CT SCAN	0. 000000	8, 536, 556		0 10, 180, 063	0	57. 00
58. 00	05800 MRI	0. 000000	1, 541, 520		0 1, 526, 598	0	58. 00
60. 00	06000 LABORATORY	0. 000000	21, 346, 767		0 3, 704, 292	l	60. 00
65. 00	06500 RESPI RATORY THERAPY	0. 000000	6, 719, 493		0 1, 058, 453	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	0. 000000	2, 446, 844		0 2, 419, 944	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0. 000000	1, 955, 034		0 28, 763	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0. 000000	389, 800		0 8, 960	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0. 000000	5, 828, 604		0 8, 634, 500	0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 000000	467, 168		0 1, 248, 857	0	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	25, 370, 525		0 21, 090, 175	0	71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	22, 107, 133		0 20, 472, 436		72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0. 006387	16, 544, 552	105, 67			
73. 01	07301 DI ABETES CENTER	0. 000000	411		0 4	0	73. 01
74. 00	07400 RENAL DI ALYSI S	0. 000000	6, 256		0 55, 939	0	74. 00
76. 00	03480 ONCOLOGY	0. 000000	1, 576, 880		0 7, 778, 689	0	76. 00
76. 01	03952 ANTI COAGULATI ON	0. 000000	0		0	0	76. 01
76. 02	03951 I NFUSI ON SERVI CES	0. 000000	0		0	0	76. 02
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0. 000000	0		0 0	0	76. 98
	OUTPATIENT SERVICE COST CENTERS	1 0 00051	_		-		
	09000 CLINIC	0.000000	0 9 251 170		0 0 13 460 795		90.00
91 (10)	ILIQ ILILI EMERGENICY	0.005396	9 751 1/0	1 49 91	91 13 46H /95	1 / / 634	

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9, 251, 170

2, 227, 753

1, 000, 000

170, 253, 894

49, 919

82, 146

237, 735

13, 460, 795

3, 458, 277

176, 426, 981

91.00

91. 01

92.00

92.01 0

95.00

402, 155 200. 00

72, 634

127, 521

91. 00 09100 EMERGENCY

92.00

92. 01

91. 01 | 04950 | WOUND CARE

09200 OBSERVATION BEDS (NON-DISTINCT PART O9201 OBSERVATION BEDS (DISTINCT PART)

OTHER REI MBURSABLE COST CENTERS

95.00 09500 AMBULANCE SERVICES

200.00 Total (lines 50 through 199)

Health Financial Systems	FRANCISCAN HEALTH	LAFAYETTE	Li	n Lieu of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0109	Peri od:	Worksheet D

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der Co	CN: 15-0109	Peri od: From 01/01/2021	Worksheet D Part V	
				To 12/31/2021	Date/Time Pre 5/2/2022 3:08	pared:
		Title	xVIII	Hospi tal	PPS	рш
			Charges		Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
	Ratio From	Services (see	Rei mbursed	Rei mbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subj ect To		
			Ded. & Coins			
			(see inst.)	(see inst.)		
	1.00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS			1			
50. 00 05000 OPERATI NG ROOM	0. 078839	23, 971, 109		0	1,007,000	
51.00 05100 RECOVERY ROOM	0. 100632	2, 681, 590		0	269, 854	1
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 258377	0		0	0	52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 116921	12, 873, 726		0	1, 505, 209	
55. 00 05500 RADI OLOGY - THERAPEUTI C	0. 073487	1, 662, 091		0	122, 142	55. 00
56. 00 05600 RADI 0I SOTOPE	5. 049754	0		0	0	56. 00
56. 01 03950 CARDI AC CATH LAB	0. 060934	8, 484, 970		0	517, 023	
57. 00 05700 CT SCAN	0. 027485	10, 180, 063		0	279, 799	57. 00
58. 00 05800 MRI	0. 067866	1, 526, 598		0	103, 604	
60. 00 06000 LABORATORY	0. 107294	3, 704, 292		0	397, 448	
65. 00 06500 RESPI RATORY THERAPY	0. 203214	1, 058, 453		0	215, 092	65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 291298	2, 419, 944	1	0	704, 925	1
67. 00 06700 OCCUPATI ONAL THERAPY	0. 182686	28, 763		0	5, 255	
68. 00 06800 SPEECH PATHOLOGY	0. 202646	8, 960		0	1, 816	
69. 00 06900 ELECTROCARDI OLOGY	0. 116608	8, 634, 500		0	1, 006, 852	
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 316052	1, 248, 857		0	394, 704	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 085266	21, 090, 175		0	1, 798, 275	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 130516	20, 472, 436	•	0 0	2, 671, 980	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 424496	31, 626, 750		0 23, 759		
73. 01 07301 DI ABETES CENTER	102. 014921	4		0	408	
74. 00 07400 RENAL DI ALYSI S	0. 663296	55, 939	•	0	37, 104	74.00
76. 00 03480 ONCOLOGY	0. 287348	7, 778, 689		0	2, 235, 191	76. 00
76. 01 03952 ANTI COAGULATI ON	0. 497883	0		0	0	76. 01
76. 02 03951 INFUSION SERVICES	0. 446895	0		0	0	76. 02
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 000000	0		0 0	0	76. 98
OUTPATIENT SERVICE COST CENTERS	2 77712/		ı			00 00
90. 00 09000 CLI NI C	2. 777136	12 4/0 705	l .	0		90.00
91. 00 09100 EMERGENCY	0. 132111	13, 460, 795		0	1, 778, 319	
91. 01 04950 WOUND CARE	4. 559570	0 450 077		0	0	91. 01
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 467138	3, 458, 277		0 0	1,0.0,170	
92. 01 09201 OBSERVATI ON BEDS (DI STI NCT PART)	0. 395772	0		0 0	0	92. 01
OTHER REIMBURSABLE COST CENTERS	0 401007					05 00
95. 00 09500 AMBULANCE SERVICES	0. 481887	174 404 001		0 22 750	20 075 700	95.00
200.00 Subtotal (see instructions) 201.00 Less PBP Clinic Lab. Services-Program		176, 426, 981		0 23, 759	30, 975, 780	
201.00 Less PBP Clinic Lab. Services-Program Only Charges					l	201. 00
202.00 Net Charges (line 200 - line 201)		176, 426, 981		0 23, 759	30, 975, 780	202 00
202. 00 ₁ Not onarges (11116 200 11116 201)	1 1	170, 420, 901	I .	25, 757	, 30, 773, 700	1202.00

In Lieu of Form CMS-2552-10

Period:	Worksheet D
From 01/01/2021	Part V
To 12/31/2021	Date/Time Prepared:
5/2/2022 3: 08 pm	

Cost Center Description Cost Reimbursed Services Subject To Ded. & Coins. (see inst.) (see inst.) 6.00 Title XVIII Hospital PPS Hospital PPS Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)
Cost Center Description Cost Rei mbursed Services Subject To Ded. & Coins. (see inst.) 6.00 Cost Rei mbursed Services Not Subject To Ded. & Coins. (see inst.) 6.00 Cost Rei mbursed Services Not Subject To Ded. & Coins. (see inst.)
Reimbursed Services Subject To Ded. & Coins. (see inst.) 6.00 Reimbursed Services Not Subject To Ded. & Coins. (see inst.) Reimbursed Services Not Subject To Ded. & Coins. (see inst.)
Services Services Not Subject To Ded. & Coins. (see inst.) (see inst.) Subject To Ded. & Coins. (see inst.) (see inst.)
Subject To Ded. & Coins. (see inst.) 6.00 Subject To Ded. & Coins. (see inst.)
Ded. & Coi ns. Ded. & Coi ns. (see i nst.) (see i nst.)
(see inst.) (see inst.) 6.00 7.00
6.00 7.00
ANCI LLARY SERVI CE COST CENTERS
50. 00 05000 OPERATI NG ROOM 0 0 50
51. 00 05100 RECOVERY ROOM 0 0 51
52. 00 05200 DELI VERY ROOM & LABOR ROOM 0 0 52
54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 0 54
55. 00 05500 RADI OLOGY - THERAPEUTI C 0 0 55
56. 00 05600 RADI 0I SOTOPE 0 0 56
56. 01 03950 CARDI AC CATH LAB 0 0 56
57. 00 05700 CT SCAN 0 0 57
58. 00 05800 MRI 0 0 58
60. 00 06000 LABORATORY 0 0
65. 00 06500 RESPI RATORY THERAPY 0 0 65
66. 00 06600 PHYSI CAL THERAPY 0 0 66
67. 00 06700 OCCUPATI ONAL THERAPY
68. 00 06800 SPEECH PATHOLOGY 0 0 68
69. 00 06900 ELECTROCARDI OLOGY
70. 00 07000 ELECTROENCEPHALOGRAPHY
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0 0 71
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 72
73. 00 07300 DRUGS CHARGED TO PATIENTS 0 10, 086 73
73. 01 07301 DI ABETES CENTER 0 0 73
74. 00 07400 RENAL DI ALYSI S 0 0 74
74. 00 07400 KENAL BI ALTSI S
76. 01 03952 ANTI COAGULATI ON 0 76
76. 02 03951 INFUSION SERVICES 0 0 76
76. 02 03931 TNF0310N SERVICES 76. 98 07698 HYPERBARI C 0XYGEN THERAPY 0 0 76
OUTPATIENT SERVICE COST CENTERS
90. 00 09000 CLINI C 0 0 90
91. 00 09100 EMERGENCY
91. 00 09100 EMERGENCT
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0 0 0 92
92. 01 09201 0BSERVATI ON BEDS (DI STI NCT PART) 0 0 92
OTHER REIMBURSABLE COST CENTERS
95. 00 09500 AMBULANCE SERVI CES 0 95
200. 00 Subtotal (see instructions) 0 10, 086 200
201.00 Less PAP Clinic Lab. Services-Program 0 201
Only Charges
202.00 Net Charges (line 200 - line 201) 0 10,086 202

Heal th	Financial Systems	FRANCI SCAN HEAL	LTH LAFAYETTE		In Lie	eu of Form CMS-:	2552-10
APPORT	TIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS		CN: 15-0109 CCN: 15-T109	Peri od: From 01/01/2021 To 12/31/2021	Worksheet D Part II Date/Time Pre	pared:
			oomporrorre			5/2/2022 3:08	pm
			Title	e XVIII	Subprovi der - I RF	PPS	
	Cost Center Description	Capi tal	Total Charges			Capital Costs	
			(from Wkst. C,		Program	(column 3 x	
		(from Wkst. B,			l. Charges	column 4)	
		Part II, col.	8)	2)			
		26)			4.00		
	ANOLILARY OF BUILDE COOT OF STEED	1. 00	2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS		4/7 075 50		20 25 4		
50.00	05000 OPERATING ROOM	2, 388, 889			· ·	570	
51.00	05100 RECOVERY ROOM	194, 740				42	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	78, 113				0	
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 316, 607		1	· ·	685	
55. 00	05500 RADI OLOGY - THERAPEUTI C	63, 565			· ·	100	
56.00	05600 RADI OI SOTOPE	23, 274		•		0	
56. 01	03950 CARDI AC CATH LAB	607, 693				23	
57.00	05700 CT SCAN	141, 048				94	
58. 00	05800 MRI	93, 637				214	
60.00	06000 LABORATORY	563, 900				1, 230	
65.00	06500 RESPI RATORY THERAPY	251, 755		•		1, 578	
66.00	06600 PHYSI CAL THERAPY	276, 874		•			
67.00	06700 OCCUPATI ONAL THERAPY	65, 853	14, 390, 908	0. 0045	76 894, 291	4, 092	67. 00
68.00	06800 SPEECH PATHOLOGY	31, 123		0. 0061	75 220, 736	1, 363	68. 00
69. 00	06900 ELECTROCARDI OLOGY	707, 306	41, 552, 879	0. 0170	22 32, 385	551	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	342, 726	5, 478, 642	0. 0625	57 0	0	70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	226, 076	207, 638, 554	0.0010	39 210, 158	229	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	146, 695	96, 661, 442	0. 0015	18 34, 731	53	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	938, 287	83, 192, 858	0. 0112	78 203, 756	2, 298	73. 00
73. 01	07301 DI ABETES CENTER	19, 196			23 2	5	73. 01
74.00	07400 RENAL DIALYSIS	194, 883			57 12, 439	713	74. 00
76.00	03480 ONCOLOGY	240, 146	20, 927, 979	0. 0114	75 5, 993	69	76. 00
76. 01	03952 ANTI COAGULATI ON	10, 585	1, 048, 137	0. 0100	99 0	0	76. 01
76. 02	03951 INFUSION SERVICES	33, 504	4, 899, 796	0. 0068	38 0	0	76. 02
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	(0.0000	00	0	76. 98
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	35, 954	695, 258	0. 0517	13 0	0	90.00
91.00	09100 EMERGENCY	2, 804, 039	119, 967, 736	0. 0233	73 14, 319	335	91.00
91. 01	04950 WOUND CARE	1, 017, 597	643, 728	1. 5807	37 0	0	91. 01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	1	0.0000	00	0	92.00
92. 01	09201 OBSERVATION BEDS (DISTINCT PART)	525, 653			25 4, 884	298	92. 01
	OTHER REIMBURSABLE COST CENTERS			•			
95.00	09500 AMBULANCE SERVI CES						95. 00
200.00	Total (lines 50 through 199)	13, 339, 718	1, 285, 138, 952	2	3, 257, 681	23, 382	200. 00

Heal th	Financial Systems	FRANCISCAN HEAL	TH LAFAYETTE			In Lie	u of Form CMS-:	2552-10
	TIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF SH COSTS	RVICE OTHER PASS	Provi der CC	CN: 15-0109	Period: From 01/01	/2021	Worksheet D Part IV	
THROUG	of CUSTS		Component (CCN: 15-T109		/2021	Date/Time Pre 5/2/2022 3:08	
				XVIII	Subprovi o		PPS	
	Cost Center Description	Non Physician Anesthetist	Nursi ng Program	Nursi ng Program	Allied H Post-Ste		Allied Health	
		Cost	Post-Stepdown	Frogram	Adj ustm	'		
		3331	Adjustments		/ lag do e			
		1.00	2A	2. 00	3A		3. 00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING 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	52.00
54. 00 55. 00	05400 RADI OLOGY - DI AGNOSTI C 05500 RADI OLOGY - THERAPEUTI C	0	0		0	0	0	
56. 00	05600 RADI OLOGT - THERAPEUTIC	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	Ö		0	0	0	
60.00	06000 LABORATORY	0	0		o	o	0	1
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	0		0	0	0	
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		0	0	0	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0	0	0	
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	0 531, 371	
73. 00	07301 DI ABETES CENTER	0	0		0		031, 3/1	1
74. 00	07400 RENAL DIALYSIS	0	0		0	0	0	
76. 00	03480 ONCOLOGY	o	0		Ö	o	0	
76. 01	03952 ANTI COAGULATI ON	0	0		0	0	0	76. 01
76. 02	03951 INFUSION SERVICES	0	0		0	0	0	76. 02
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0		0	0	0	76. 98
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLI NI C	0	0		0	0	0	
91.00	09100 EMERGENCY	0	0		0	0	647, 352	
91. 01	04950 WOUND CARE	0	0		0	o	0	
92. 00 92. 01	O9200 OBSERVATI ON BEDS (NON-DISTINCT PART O9201 OBSERVATI ON BEDS (DISTINCT PART)	0	0		0	0	0	
92. UI	OTHER REIMBURSABLE COST CENTERS	<u> </u>	0		J	<u> </u>	0	92.01
95. 00	09500 AMBULANCE SERVICES							95. 00
200.00		0	0		0	o	1, 178, 723	

APPOR	Financial Systems FIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE CH COSTS			CN: 15-0109 CCN: 15-T109	Period: From 01/01/2021 To 12/31/2021	worksheet D Part IV Date/Time Pre 5/2/2022 3:08	
			Title	XVIII	Subprovi der - I RF	PPS	рш
	Cost Center Description	All Other	Total Cost	Total	Total Charges	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	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0			0 167, 075, 504	l e	
51.00	05100 RECOVERY ROOM	0	-		0 14, 049, 173		
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0 20, 239, 933		52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0 100, 177, 958	0.000000	54.00
55.00	05500 RADI OLOGY - THERAPEUTI C	0	0		0 14, 341, 317	0.000000	
56.00	05600 RADI OI SOTOPE	0	0		0 35, 213	0.000000	56. 00
56. 01	03950 CARDI AC CATH LAB	0	0		0 61, 574, 667	0.000000	56. 01
57.00	05700 CT SCAN	0	0		0 68, 490, 739		57. 00
58.00	05800 MRI	0	0		0 10, 915, 476	0.000000	58. 00
60.00	06000 LABORATORY	0	0		0 142, 442, 110	0.000000	60.00
65.00	06500 RESPI RATORY THERAPY	0	0		0 23, 376, 327	0.000000	65. 00
66.00	06600 PHYSI CAL THERAPY	0	0		0 30, 579, 869	0.000000	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	0		0 14, 390, 908	0.000000	67. 00
68.00	06800 SPEECH PATHOLOGY	0	0		0 5, 040, 528		68. 00
69.00	06900 ELECTROCARDI OLOGY	0	0		0 41, 552, 879	0.000000	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		0 5, 478, 642		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 207, 638, 554	0.000000	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0 96, 661, 442		72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	531, 371	531, 37	71 83, 192, 858	0. 006387	73. 00
73. 01	07301 DI ABETES CENTER	0	0		0 7, 707	0.000000	73. 01
74.00	07400 RENAL DIALYSIS	0	0		0 3, 397, 701	0.000000	74. 00
76.00	03480 ONCOLOGY	0	0		0 20, 927, 979	0.000000	76. 00
76. 01	03952 ANTI COAGULATI ON	0	0		0 1, 048, 137	0.000000	76. 01
76.02	03951 I NFUSI ON SERVI CES	0	0		0 4, 899, 796	0.000000	76. 02
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0		0 0	0. 000000	76. 98
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0			0 695, 258		
91.00	09100 EMERGENCY	0	647, 352	647, 35	119, 967, 736	0. 005396	91.00
91. 01	04950 WOUND CARE	0	1		0 643, 728		
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		0 17, 668, 887		92.00
92. 01	09201 OBSERVATION BEDS (DISTINCT PART)	0	0		0 8, 627, 926	0. 000000	92. 01
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES						95. 00
200.00	Total (lines 50 through 199)	0	1, 178, 723	1 4 470 70	23 1, 285, 138, 952	I	200.00

Heal th	Financial Systems	FRANCISCAN HEALT	TH LAFAYETTE		In Lie	u of Form CMS-2	2552-10
APPORT	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVI CE OTHER PASS	Provi der CO		Peri od:	Worksheet D	
THROUG	COSTS		Component (From 01/01/2021 To 12/31/2021	Part IV Date/Time Pre 5/2/2022 3:08	pared:
			Title	XVIII	Subprovi der - I RF	PPS	- рш
	Cost Center Description	Outpati ent	I npati ent	I npati ent	Outpati ent	Outpati ent	
		Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through	Charges	Pass-Through	
		(col. 6 ÷ col.		Costs (col. 8	3	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	39, 854	(0	0	50.00
51.00	05100 RECOVERY ROOM	0. 000000	3, 039	(0 0	0	51.00
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	52, 118	(o o	0	54.00
55.00	05500 RADI OLOGY - THERAPEUTI C	0. 000000	22, 556	(o o	0	55. 00
56.00	05600 RADI OI SOTOPE	0. 000000	0	(ol ol	0	56.00
56. 01	03950 CARDI AC CATH LAB	0. 000000	2, 293	(ol ol	0	56. 01
57. 00	05700 CT SCAN	0. 000000	45, 542	(ol ol	0	
58. 00	05800 MRI	0. 000000	24, 998		o o	0	
60.00	06000 LABORATORY	0. 000000	310, 725		o o	0	60.00
65. 00	06500 RESPI RATORY THERAPY	0. 000000	146, 476			0	65. 00
66. 00	06600 PHYSI CAL THERAPY	0. 000000	976, 386			0	
67. 00	06700 OCCUPATI ONAL THERAPY	0. 000000	894, 291			0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0. 000000	220, 736			0	
69.00	06900 ELECTROCARDI OLOGY	0. 000000	32, 385			0	
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 000000	32, 303			0	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	210, 158			0	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	34, 731			0	
73. 00	07300 DRUGS CHARGED TO PATIENTS	0. 006387	203, 756	1, 30	-	0	
73. 00	07301 DI ABETES CENTER	0. 000387	203, 730		0 0	0	
74. 00	07400 RENAL DI ALYSI S	0. 000000	12. 439			0	
76. 00	03480 ONCOLOGY	0. 000000	5, 993			0	
76. 00	03952 ANTI COAGULATI ON	0. 000000	0, 443		0 0	0	
76. 01	03951 I NFUSI ON SERVI CES	0. 000000	0		0 0	0	
76. 02	07698 HYPERBARI C OXYGEN THERAPY	0. 000000	0		0 0	0	
70. 90	OUTPATIENT SERVICE COST CENTERS	0.000000	U		<u> </u>	0	70. 90
00 00		0.000000	0			0	00.00
90. 00 91. 00	09000 CLINIC	0. 000000 0. 005396	0 14, 319	7	0 7 0	0	
	09100 EMERGENCY					0	
91. 01	04950 WOUND CARE	0. 000000	0		0 0	0	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0		0 0	0	
92. 01	09201 OBSERVATION BEDS (DISTINCT PART)	0. 000000	4, 884		0 0	0	92. 01
	OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES						05 00
	ILIGATION AMERICANCE SERVICES	1			1		95.00
95. 00 200. 00			3, 257, 681	1, 37	8 0	^	200. 00

Health Financial Systems		FRANCI SCAN HEA				u of Form CMS-	<u> 2552-10</u>
APPORTIONMENT OF MEDICAL, OTH	ER HEALTH SERVICES AND	VACCINE COST	Provider Component		Period: From 01/01/2021 To 12/31/2021		pared:
			Title	XVIII	Subprovi der – I RF	PPS	
				Charges		Costs	
Cost Center Descr	i pti on	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
			Services (see		Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins			
		1.00	2.00	(see inst.) 3.00	(see inst.) 4.00	5. 00	
ANCILLARY SERVICE COST	CENTEDS	1.00	2.00	3.00	4.00	5.00	
50. 00 05000 OPERATING ROOM	CLIVIERS	0. 078839	0		0 0	0	50.00
51. 00 05100 RECOVERY ROOM		0. 100632			0 0	_	
52. 00 05200 DELIVERY ROOM & L	ABOR ROOM	0. 258377			0 0	o n	52.00
54. 00 05400 RADI OLOGY - DI AGNOS		0. 116921	0		0 0	, O	54.00
55. 00 05500 RADI OLOGY - THERA		0. 073487	0		0 0	o o	55.00
56. 00 05600 RADI 0I SOTOPE		5. 049754			0 0	Ō	56. 00
56. 01 03950 CARDI AC CATH LAB		0. 060934	0		0 0	0	56. 01
57.00 05700 CT SCAN		0. 027485	0		0 0	0	57.00
58. 00 05800 MRI		0. 067866	0		0 0	0	58. 00
60. 00 06000 LABORATORY		0. 107294	0		0 0	0	60.00
65. 00 06500 RESPIRATORY THERA	PY	0. 203214	0		0 0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY		0. 291298	0		0 0	0	66. 00
67. 00 06700 OCCUPATI ONAL THER	APY	0. 182686	0		0	0	67. 00
68. 00 06800 SPEECH PATHOLOGY		0. 202646	0		0 0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY		0. 116608	0		0 0	0	69. 00
70. 00 07000 ELECTROENCEPHALOG		0. 316052			0	0	70. 00
71.00 07100 MEDICAL SUPPLIES	CHARGED TO PATIENT	0. 085266	0		0	0	71. 00

0. 424496

0. 663296

0. 287348

0. 497883

0. 446895

0.000000

2. 777136 0. 132111 4. 559570

0. 467138

0. 395772

0.481887

102. 014921

0 72.00

0 74.00

0 76.00

0

0 76. 98

0 92.00

0 92.01

73.00

73. 01

76.01

76. 02

90.00

0 91.00

0 91.01

95.00

0 200.00

0 202. 00

201.00

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500

0

72.00 07200 I MPL. DEV. CHARGED TO PATIENTS

07301 DI ABETES CENTER

03952 ANTI COAGULATI ON

03951 INFUSION SERVICES

09500 AMBULANCE SERVICES

Only Charges

07400 RENAL DIALYSIS

03480 ONCOLOGY

09000 CLI NI C

09100 EMERGENCY

04950 WOUND CARE

73.01

74.00

76.00

76. 01

76.02

76. 98

90.00

91.00

91.01

92.00

92.01

95.00

200.00

201.00

202.00

07300 DRUGS CHARGED TO PATIENTS

07698 HYPERBARI C OXYGEN THERAPY

OUTPATIENT SERVICE COST CENTERS

09200 OBSERVATION BEDS (NON-DISTINCT PART

09201 OBSERVATION BEDS (DISTINCT PART)
OTHER REIMBURSABLE COST CENTERS

Subtotal (see instructions)

Less PBP Clinic Lab. Services-Program

Net Charges (line 200 - line 201)

Hool th	Financial Systems	FRANCISCAN HEA	ITU LAFAVETTE		In Lie	u of Form CMS-	2552 10
	TIONMENT OF MEDICAL. OTHER HEALTH SERVICES AN			CN: 15-0109	Peri od:	Worksheet D	2332-10
AFFORI	TONWENT OF WEDICAL, OTHER HEALTH SERVICES AN	ID VACCINE COST	FI OVI dei C	CN. 13-010 9	From 01/01/2021	Part V	
			·	CCN: 15-T109	To 12/31/2021	5/2/2022 3:08	
			Ti tl e	e XVIII	Subprovi der - I RF	PPS	
		Co	sts				
	Cost Center Description	Cost	Cost				
		Rei mbursed	Rei mbursed				
		Servi ces	Services Not				
		Subject To	Subject To				
		Ded. & Coins.	Ded. & Coins.				
		(see inst.)	(see inst.)				
	ANCILLARY SERVICE COST CENTERS	6. 00	7. 00				
50.00	05000 OPERATING ROOM	C		N .			50.00
	05100 RECOVERY ROOM		1	1			51.00
							52.00
							54.00
							55.00
	05600 RADI OI SOTOPE						56.00
	03950 CARDI AC CATH LAB						56. 01
	05700 CT SCAN	C	ol c				57. 00
58. 00	05800 MRI	C) (58. 00
60.00	06000 LABORATORY	C) (60.00
65. 00	06500 RESPI RATORY THERAPY	C) (65.00
66. 00	06600 PHYSI CAL THERAPY	C) (66. 00
67.00	06700 OCCUPATIONAL THERAPY	C) (67.00
	06800 SPEECH PATHOLOGY	C) ()			68. 00
	06900 ELECTROCARDI OLOGY	C) ()			69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	C) ()			70. 00
		C) ()			71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	C) (72. 00

0 0 0

0

0

212

ol

0

0

0

0

0

0

0

212

212

73.00

73. 01

74.00

76.00

76. 01

76. 02

76. 98

90.00

91.00

91.01

92.00

92. 01

95.00

200. 00

201. 00

202. 00

73. 00 07300 DRUGS CHARGED TO PATIENTS

03951 I NFUSION SERVICES 07698 HYPERBARIC OXYGEN THERAPY

OUTPATIENT SERVICE COST CENTERS

09200 OBSERVATION BEDS (NON-DISTINCT PART

09201 OBSERVATION BEDS (DISTINCT PART)
OTHER REIMBURSABLE COST CENTERS

Subtotal (see instructions)

Less PBP Clinic Lab. Services-Program

Net Charges (line 200 - line 201)

07301 DI ABETES CENTER

07400 RENAL DIALYSIS

03952 ANTI COAGULATI ON

03480 ONCOLOGY

04950 WOUND CARE

95. 00 09500 AMBULANCE SERVICES

Only Charges

90. 00 09000 CLI NI C 91. 00 09100 EMERGENCY

73. 01

74.00

76.00

76. 01

76. 02 76. 98

91.01

92.00

92.01

200.00

201.00

202.00

Health Financial Systems	FRANCISCAN HEALTH	LAFAYETTE	In Lie	u of Form CMS-	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0109	Peri od: From 01/01/2021	Worksheet D-1	
			To 12/31/2021	Date/Time Pre 5/2/2022 3:08	pared: _pm
		Title XVIII	Hospi tal	PPS	
Cost Center Description					
				1. 00	
PART I - ALL PROVIDER COMPONENTS					
INPATIENT DAYS					1

INVARIANT DATE: NAME TO ANY			Title XVIII	Hospi tal	PPS	
NAME FOR TAXES NAME OF TAX		Cost Center Description		-	1 00	
Impatient days (including private room days, and swing-bed days, excluding newborn) 39,414 2.00 Inpatient days (including private room days, excluding swing-bed and newborn days) 39,414 2.00 30,00 Private room days (excluding swing-bed and observation bed days). If you have only private room days. 30,414 2.00 30,00 3		PART I - ALL PROVIDER COMPONENTS			1.00	
Inpatient days (Including private room days, excluding swing-bed and newborn days) 39, 414 2.00						
private room days (excluding swing-bed and observation bed days). If you have only private room days. (excluding swing-bed and observation bed days) through December 31 of the cost of th						
do not complete this line. OS Memi-private room days (excluding swing bed and observation bed days) Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost 0 5.00 reporting period 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1						
3.604 4.00	3.00		ys). If you have only pri	vate room days,	Ü	3.00
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7 x line 19) Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26.00 Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 30.00 Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 20 ÷ line 4) Average per diem private room cost differential (line 32 minus line 33) (see instructions) Average per diem private room cost differential (line 34 x line 31) General inpatient routine service cost net of swing-bed cost and private room cost differential (line 55, 992, 447) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 55, 992, 447) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 55, 992, 447)	24 00	,	- 31 of the cost reportin	na neriod (line	0	24 00
x line 20) 26.00 Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 755, 992, 447 77.00 PRIVATE ROOM DIFFERNTIAL ADJUSTMENT 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 9.00 Private room charges (excluding swing-bed charges) 9.00 Semi-private room charges (excluding swing-bed charges) 9.00 Semi-private room charges (excluding swing-bed charges) 9.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 9.00 Average private room per diem charge (line 29 ÷ line 3) 9.00 Average semi-private room per diem charge (line 30 ÷ line 4) 9.00 Average per diem private room cost differential (line 32 minus line 33) (see instructions) 9.00 32.00 9.00 33.00 9.00 34.00 9.00 34.00 9.00 35.00 9.00 35.00 9.00 35.00 9.00 35.00 9.00 35.00 9.00 35.00 9.00 35.00 9.00 35.00 9.00 35.00 9.00 35.00 9.00 35.00 9.00 35.00	24.00		or the cost reporter	ig perrou (irric	O	24.00
Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) FRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed and observation bed charges) Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 ÷ line 28) Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room cost differential (line 32 minus line 33) (see instructions) Average per diem private room cost differential (line 3 x line 31) Average per diem private room cost differential djustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost and private room cost differential (line 55, 992, 447) 7.00 26.00 27.00 28.00 28.00 29.00 30.00	25. 00		31 of the cost reporting	period (line 8	0	25. 00
27. 00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28. 00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 9. 00 Private room charges (excluding swing-bed charges) 30. 00 Semi-private room charges (excluding swing-bed charges) 31. 00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32. 00 Average private room per diem charge (line 29 ÷ line 3) 33. 00 Average semi-private room per diem charge (line 30 ÷ line 4) 34. 00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35. 00 Average per diem private room cost differential (line 34 x line 31) 36. 00 Private room cost differential adjustment (line 3 x line 35) 37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 55, 992, 447) 37. 00	26 00				0	26 00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) O 28.00 Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) O 29.00 Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 ÷ line 28) O 0.000000 31.00 Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 minus line 33) (see instructions) Average per diem private room cost differential (line 34 x line 31) O 0.00 35.00 Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost and private room cost differential (line 55, 992, 447) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 55, 992, 447)		, ,	(line 21 minus line 26)		-	
29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 55, 992, 447) 37.00 27 minus line 36)		PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room cost differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 55, 992, 447) 37.00			d and observation bed cha	arges)		
31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 55, 992, 447) 37.00						
32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 55, 992, 447) 37.00			: line 28)			
34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 55, 992, 447) 37.00 37.00		,				
35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 55, 992, 447 37.00 27 minus line 36)						
36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 55, 992, 447 37.00 27 minus line 36)		, , ,	, ,	i ons)		
37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 55, 992, 447 27 minus line 36)		, , ,	le 31)	}		
27 minus line 36)		,	and private room cost dif	ferential (line	-	
		27 minus line 36)				
		PART II - HOSPITAL AND SUBPROVIDERS ONLY	ICTUENTO			
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1,420.62 38.00	38 00			T	1 420 42	38 00
38.00 Adjusted general impatient routine service cost per diem (see instructions) 1,420.62 38.00 appears general inpatient routine service cost (line 9 x line 38) 17,148,304 39.00		, , , , , , , , , , , , , , , , , , , ,	•		· ·	
40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00						
41.00 Total Program general inpatient routine service cost (line 39 + line 40) 17,148,304 41.00	41. 00	Total Program general inpatient routine service cost (line 39	+ line 40)		17, 148, 304	41.00

	TREVALE ROOM BITTERENTIAL ABSOSTMENT		
28. 00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)	0	29. 00
30.00	Semi -pri vate room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line	55, 992, 447	37.00
	27 minus line 36)		
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38. 00	Adjusted general inpatient routine service cost per diem (see instructions)	1, 420. 62	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line 38)	17, 148, 304	39. 00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	17, 148, 304	41.00

	Financial Systems TATION OF INPATIENT OPERATING COST	FRANCISCAN HEAL	TH LAFAYETTE Provi der C	CN: 15-0109	In Lie	worksheet D-1	
COMPUI	ATION OF INFATIENT OFERATING COST		FIOVIDE	GN. 13-0109	From 01/01/2021		
					To 12/31/2021	Date/Time Pre 5/2/2022 3:08	
			_	XVIII	Hospi tal	PPS	
	Cost Center Description	Total Inpatient Cost	Total Inpatient Davs	Average Per Diem (col. 1		Program Cost (col. 3 x col.	
		·		col . 2)		4)	
42 00	NURSERY (title V & XIX only)	1.00	2.00	3.00	4. 00 00 C	5.00	42. 00
12.00	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	9, 667, 457	4, 797	2, 015.	1, 684	3, 393, 782	
44. 00 45. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						44. 00 45. 00
46. 00	1						46. 00
47. 00	NEONATAL INTENSIVE CARE UNIT Cost Center Description	5, 088, 542	3, 762	1, 352.	62 C	0	47. 00
	cost center bescription					1. 00	
48. 00	Program inpatient ancillary service cost (W					24, 742, 288	1
49. 00	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS	41 through 48)(see instructio	ons)		45, 284, 374	49. 00
50. 00	Pass through costs applicable to Program in	patient routine	services (from	n Wkst. D, sur	m of Parts I and	4, 429, 358	50.00
E4 00				W . B		4 000 000	F4 00
51. 00	Pass through costs applicable to Program inpand IV)	patient anciliar	y services (Tr	OM WKST. D, S	sum of Parts II	1, 839, 899	51.00
52. 00	Total Program excludable cost (sum of lines					6, 269, 257	1
53. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line		lated, non-phy	sician anestl	netist, and	39, 015, 117	53. 00
	TARGET AMOUNT AND LIMIT COMPUTATION	52)				1	
	Program di scharges					0	
55. 00 56. 00	Target amount per discharge Target amount (line 54 x line 55)						55. 00 56. 00
57. 00	,	ting cost and ta	rget amount (I	ine 56 minus	line 53)	0	
58. 00	Bonus payment (see instructions)					0	
59. 00	Lesser of lines 53/54 or 55 from the cost remarket basket	eporting period	ending 1996, u	ipdated and co	ompounded by the	0.00	59. 00
60.00	Lesser of lines 53/54 or 55 from prior year					0.00	60.00
61. 00						0	61. 00
	which operating costs (line 53) are less that amount (line 56), otherwise enter zero (see		s (Tines 54 x	60), or 1% or	r the target		
	62.00 Relief payment (see instructions)					0	
63. 00	Allowable Inpatient cost plus incentive payr PROGRAM INPATIENT ROUTINE SWING BED COST	ment (see instru	ctions)			0	63.00
64.00	Medicare swing-bed SNF inpatient routine cos	sts through Dece	mber 31 of the	cost reporti	ng period (See	0	64. 00
65. 00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos</pre>	ets after Decemb	er 31 of the c	ost reporting	a neriod (See	0	65.00
03.00	instructions) (title XVIII only)	sts after becemb	er 31 or the c	ost reporting	g perrou (see		03.00
66. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line 6	5)(title XVI	II only). For	0	66. 00
67. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routing	ne costs through	December 31 c	of the cost re	eporting period	0	67. 00
	(line 12 x line 19)						/ 0 00
68.00	Title V or XIX swing-bed NF inpatient routing (line 13 x line 20)	ne costs arter D	ecember 31 or	the cost repo	orting period	0	68. 00
69. 00	Total title V or XIX swing-bed NF inpatient					0	69. 00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER N Skilled nursing facility/other nursing facil)		70.00
71. 00	Adjusted general inpatient routine service				,		71.00
72.00			<i>(</i> 1)	05)			72.00
73. 00 74. 00	Medically necessary private room cost applications and program general inpatient routine services.						73.00
75. 00	Capital -related cost allocated to inpatient	•			Part II, column		75. 00
74 00	26, line 45) Per diem capital-related costs (line 75 ÷ li	no 2)					76. 00
76. 00 77. 00	Program capital-related costs (line 9 x line	. *					77.00
78. 00	· ·	,					78. 00
79.00	Aggregate charges to beneficiaries for excess Total Program routine service costs for comp	, ,		,	nus line 70)		79.00
81. 00	Inpatient routine service costs for comp		ost irim tati Ol	. (11116 70 11111	143 11110 17)		81.00
82.00	Inpatient routine service cost limitation (· ·					82.00
83. 00 84. 00	Reasonable inpatient routine service costs Program inpatient ancillary services (see in	•	S)				83.00
85. 00	Utilization review - physician compensation		ns)				85. 00
86. 00	Total Program inpatient operating costs (sur	m of lines 83 th					86. 00
87. 00	PART IV - COMPUTATION OF OBSERVATION BED PAS Total observation bed days (see instructions					5 810	87. 00
	Adjusted general inpatient routine cost per	•	line 2)			1, 420. 62	1
88. 00	Observation bed cost (line 87 x line 88) (se	•				., .20.02	

Health Financial Systems	FRANCI SCAN HEAL	LTH LAFAYETTE		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
				From 01/01/2021 To 12/31/2021	Date/Time Prep 5/2/2022 3:08	
		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	8, 901, 531	55, 992, 447	0. 15897	7 8, 253, 802	1, 312, 165	90.00
91.00 Nursing Program cost	4, 419, 807	55, 992, 447	0. 07893	6 8, 253, 802	651, 522	91.00
92.00 Allied health cost	0	55, 992, 447	0.00000	8, 253, 802	0	92.00
93.00 All other Medical Education	0	55, 992, 447	0.00000	8, 253, 802	0	93.00

Health Financial Systems	FRANCISCAN HEALTH LAFAYETTE	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0109	Period: From 01/01/2021	Worksheet D-1
	Component CCN: 15-T109		
	Title XVIII	Subprovi der -	PPS
		IRF	

			. I RF		
	Cost Center Description		-	1. 00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
1 00	INPATIENT DAYS	avaludina nawbann		2, 943	1 1 00
1. 00 2. 00	Inpatient days (including private room days and swing-bed days Inpatient days (including private room days, excluding swing-b			2, 943	
3.00	Private room days (excluding swing-bed and observation bed day		vate room days,	0	3. 00
	do not complete this line.		_		
4. 00 5. 00	Semi-private room days (excluding swing-bed and observation be Total swing-bed SNF type inpatient days (including private roo		21 of the cost	2, 943 0	4. 00 5. 00
5.00	reporting period	ill days) till odgir becellber	31 Of the Cost	Ü	3.00
6.00	Total swing-bed SNF type inpatient days (including private rooreporting period (if calendar year, enter 0 on this line)	m days) after December 3	1 of the cost	0	6. 00
7. 00	Total swing-bed NF type inpatient days (including private room	days) through December	31 of the cost	0	7. 00
8. 00	reporting period Total swing-bed NF type inpatient days (including private room	days) after December 31	of the cost	0	8. 00
9. 00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	1, 103	9. 00
	newborn days) (see instructions)		_		
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or through December 31 of the cost reporting period (see instruct	i ons)		0	10. 00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or December 31 of the cost reporting period (if calendar year, er		om days) after	0	11. 00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX through December 31 of the cost reporting period		room days)	0	12. 00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX			0	13. 00
14. 00	after December 31 of the cost reporting period (if calendar ye Medically necessary private room days applicable to the Progra			0	14. 00
15. 00	Total nursery days (title V or XIX only)			0	15. 00
16. 00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			0	16. 00
17. 00	Medicare rate for swing-bed SNF services applicable to service	s through December 31 of	the cost	0.00	17. 00
18. 00	reporting period Medicare rate for swing-bed SNF services applicable to service	s after December 31 of t	he cost	0.00	18. 00
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	through December 31 of	the cost	0.00	19. 00
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	after December 31 of th	e cost	0.00	20. 00
21. 00	reporting period Total general inpatient routine service cost (see instructions)		4, 745, 488	21. 00
22. 00	Swing-bed cost applicable to SNF type services through Decembe		ng period (line	0	22. 00
23. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December	31 of the cost reporting	period (line 6	0	23. 00
24. 00	x line 18) Swing-bed cost applicable to NF type services through December			0	24. 00
	7 x line 19)	·			
25. 00	Swing-bed cost applicable to NF type services after December 3×1 ine 20)	1 of the cost reporting	period (line 8	0	25. 00
26.00	Total swing-bed cost (see instructions)	04		0	
27. 00	General inpatient routine service cost net of swing-bed cost (PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	line 21 minus line 26)		4, 745, 488	27. 00
28. 00	General inpatient routine service charges (excluding swing-bed	and observation bed cha	rges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)			0	
30.00	Semi-private room charges (excluding swing-bed charges)			0	
31.00	General inpatient routine service cost/charge ratio (line 27 ÷	line 28)		0.000000	
32. 00	Average private room per diem charge (line 29 ÷ line 3)			0.00	•
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)	us line 22) (see inst	i one)	0.00	•
34. 00 35. 00	Average per diem private room charge differential (line 32 mir		1 0115)	0.00	•
36.00	Average per diem private room cost differential (line 34 x line Private room cost differential adjustment (line 3 x line 35)	E 31)	-	0.00	35. 00 36. 00
37. 00	General inpatient routine service cost net of swing-bed cost a	nd private room cost dif	ferential (line	4, 745, 488	1
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	STMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see			1, 612. 47	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line	*		1, 778, 554	1
40. 00	Medically necessary private room cost applicable to the Progra	,		0	40. 00
41. 00	Total Program general inpatient routine service cost (line 39	+ line 40)		1, 778, 554	41.00

	<u> </u>	FRANCISCAN HEALTI				u of Form CMS-2	<u> 2552-10</u>
COMPUT	TATION OF INPATIENT OPERATING COST		Provider CCN:	Fi	eriod: com 01/01/2021	Worksheet D-1	
			Component CCN:			Date/Time Prep 5/2/2022 3:08	
			Title XV	111 :	Subprovider - IRF	PPS	
	Cost Center Description	Total Inpatient Cost In	patient Days Die	/erage Per m (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
	1.00 2.00 3.00 4.00						
42. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	0	0.00	0	0	42. 00
43. 00	INTENSIVE CARE UNIT	0	0	0.00	0	0	
44. 00 45. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						44. 00 45. 00
46.00	SURGICAL INTENSIVE CARE UNIT						46. 00
47. 00	NEONATAL INTENSIVE CARE UNIT Cost Center Description	0	0	0. 00	0	0	47. 00
10.00	·					1.00	10.00
48. 00 49. 00	Program inpatient ancillary service cost (Wk Total Program inpatient costs (sum of lines					696, 729 2, 475, 283	48. 00 49. 00
50. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inp.	atient routine se	ervices (from Wks	st. D, sum o	of Parts I and	372, 086	50. 00
51. 00		atient ancillary	services (from \	Wkst. D, sun	n of Parts II	24, 760	51. 00
52. 00	and IV) Total Program excludable cost (sum of lines	,		,		396, 846	
53. 00	Total Program inpatient operating cost exclu	ding capital rela	ited, non-physic	ian anesthe	ist, and	2, 078, 437	
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)					
	Program di scharges					0	
55. 00 56. 00	00 Target amount per discharge 00 Target amount (line 54 x line 55)					0. 00 0	55. 00 56. 00
57. 00	00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57. 00
58. 00 59. 00							58. 00 59. 00
60. 00	market basket 00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0. 00	60. 00
61. 00						0	61. 00
	amount (line 56), otherwise enter zero (see instructions)						
62. 00 63. 00						0	
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST					0	64. 00
65. 00	instructions) (title XVIII only)	3				0	
66. 00	instructions)(title XVIII only)					0	
	CAH (see instructions)					0	
	O Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						
68. 00	70 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68. 00
69. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER NI					0	69. 00
70. 00	Skilled nursing facility/other nursing facil	ity/ICF/IID routi	ne service cost				70. 00
71. 00 72. 00	Adjusted general inpatient routine service of Program routine service cost (line 9 x line	,	ne 70 ÷ line 2)				71. 00 72. 00
73. 00	Medically necessary private room cost applications	•	(line 14 x line :	35)			73. 00
74. 00 75. 00	Total Program general inpatient routine serv Capital-related cost allocated to inpatient	•	,	sheet B, Par	t II, column		74. 00 75. 00
76. 00	26, line 45) Per diem capital-related costs (line 75 ÷ li	ne 2)					76. 00
77. 00 78. 00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minu	•					77. 00 78. 00
79. 00	Aggregate charges to beneficiaries for exces	,	ovi der records)				79. 00
80.00	00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)				s line 79)		80.00
81. 00 82. 00						81. 00 82. 00	
83. 00	.00 Reasonable inpatient routine service costs (see instructions)						83. 00
84. 00 85. 00	00 Program inpatient ancillary services (see instructions)						84. 00 85. 00
	Total Program inpatient operating costs (sum						86. 00
	PART IV - COMPUTATION OF OBSERVATION BED PASS	S THROUGH COST					07.00
87. 00 88. 00	Total observation bed days (see instructions Adjusted general inpatient routine cost per	•	ine 2)			0 0. 00	87. 00 88. 00
89. 00	Observation bed cost (line 87 x line 88) (se						89. 00

Health Financial Systems	FRANCISCAN HEAL	TH LAFAYETTE		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Peri od:	Worksheet D-1	
		Component (From 01/01/2021 To 12/31/2021	Date/Time Prep 5/2/2022 3:08	
		Title	XVIII	Subprovi der – I RF	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	992, 803	4, 745, 488	0. 20921	0	0	90. 00
91.00 Nursing Program cost	0	4, 745, 488	0. 00000	0	0	91. 00
92.00 Allied health cost	0	4, 745, 488	0. 00000	0	0	92. 00
93.00 All other Medical Education	0	4, 745, 488	0.00000	0 0	0	93. 00

Health Financial Systems FRANCIS INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der Co	CN: 15-0109	Peri od:	Worksheet D-3	
			From 01/01/2021 To 12/31/2021	Date/Time Pre	nara
				5/2/2022 3:08	pare
	Title	XVIII	Hospi tal	PPS	
Cost Center Description		Ratio of Cos		Inpatient	
		To Charges	Program	Program Costs (col. 1 x col.	
			Charges	2)	
		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	-	1.00	2.00	3.00	
30. 00 03000 ADULTS & PEDIATRICS			39, 421, 288		30.
11.00 03100 INTENSIVE CARE UNIT			9, 404, 123		31.
35.00 02060 NEONATAL INTENSIVE CARE UNIT			0		35.
1. 00 04100 SUBPROVI DER - I RF			0		41.
3. 00 04300 NURSERY					43.
ANCILLARY SERVICE COST CENTERS					1
0.00 05000 OPERATING ROOM		0. 07902	20, 788, 156	1, 642, 846	50.
51.00 05100 RECOVERY ROOM		0. 10063	1, 430, 885	143, 993	51.
2.00 05200 DELIVERY ROOM & LABOR ROOM		0. 25837	7 0	0	52.
4. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 11694	7 8, 425, 626	985, 352	54.
5. 00 05500 RADI OLOGY - THERAPEUTI C		0. 07348		86, 912	
6. 00 05600 RADI 0I SOTOPE		5. 04975	64 0	0	
6. 01 03950 CARDI AC CATH LAB		0. 06093		676, 981	56.
7. 00 05700 CT SCAN		0. 02748		234, 627	
88. 00 05800 MRI		0. 06786		104, 617	
0. 00 06000 LABORATORY		0. 10754		2, 295, 759	
5. 00 06500 RESPI RATORY THERAPY		0. 20321		1, 365, 495	
6. 00 06600 PHYSI CAL THERAPY		0. 29129		712, 761	
7. 00 06700 OCCUPATI ONAL THERAPY		0. 18268		357, 157	
8. 00 06800 SPEECH PATHOLOGY		0. 20264		78, 991	
9. 00 06900 ELECTROCARDI OLOGY		0. 11660		679, 662	
0. 00 07000 ELECTROENCEPHALOGRAPHY		0. 31605		147, 649	
1. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 08526		2, 163, 243	
2. 00 07200 I MPL. DEV. CHARGED TO PATIENTS		0. 13051		2, 885, 335	
3. 00 07300 DRUGS CHARGED TO PATIENTS		0. 42449		7, 023, 096	
3. 01 07301 DI ABETES CENTER		102. 01492		41, 928	
4. 00 07400 RENAL DI ALYSI S		0. 66329		4, 150	
6. 00 03480 ONCOLOGY		0. 28734		453, 113	
6. 01 03952 ANTI COAGULATI ON		0. 49788		0	
6. 02 03951 I NFUSI ON SERVI CES		0. 44689		0	
6. 98 O7698 HYPERBARI C OXYGEN THERAPY OUTPATIENT SERVICE COST CENTERS		0. 00000	00 0	0	76.
0. 00 09000 CLINI C		2. 77713	6 0	0	90.
1. 00 09100 EMERGENCY		0. 13211		1, 222, 181	
1. 01 04950 WOUND CARE		4. 55957		1, 222, 101	1
12.00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 46713		1, 040, 668	
22. 01 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 39577		395, 772	
OTHER REIMBURSABLE COST CENTERS		0. 37377	2, 1,000,000	373, 112	, 72
5 OO O9500 AMBULANCE SERVICES					95

170, 253, 894

170, 253, 894

24, 742, 288 200. 00 201. 00

95.00

202. 00

95. 00 09500 AMBULANCE SERVICES

200.00

201.00 202.00 Total (sum of lines 50 through 94 and 96 through 98)
Less PBP Clinic Laboratory Services-Program only charges (line 61)
Net charges (line 200 minus line 201)

	Financial Systems FRANCISCAN HEAL ENT ANCILLARY SERVICE COST APPORTIONMENT		CN: 15-0109	Peri od:	eu of Form CMS- Worksheet D-3	
		Component	CCN: 15-T109	From 01/01/2021 To 12/31/2021	Date/Time Pre 5/2/2022 3:08	
		Titl€	e XVIII	Subprovi der - I RF	PPS	
	Cost Center Description		Ratio of Cos		I npati ent	
			To Charges	9	Program Costs	
				Charges	(col. 1 x col. 2)	
	LADATI ENT. POUTLNE CEDUI OF COCT CENTEDO		1.00	2. 00	3. 00	
80. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS		I			30.0
31. 00	03100 NTENSI VE CARE UNIT					31. 0
35. 00	02060 NEONATAL INTENSIVE CARE UNIT					35. 0
11.00	04100 SUBPROVI DER - I RF			2, 274, 316		41. 0
	04300 NURSERY			2/2/1/010	1	43. 0
	ANCILLARY SERVICE COST CENTERS		•		1	
0.00	05000 OPERATI NG ROOM		0.0790	28 39, 854	3, 150	50. (
1.00	05100 RECOVERY ROOM		0. 1006	32 3, 039	306	51. (
2. 00	05200 DELIVERY ROOM & LABOR ROOM		0. 2583	77 (-	
4. 00	05400 RADI OLOGY-DI AGNOSTI C		0. 1169	·		
5. 00	05500 RADI OLOGY - THERAPEUTI C		0. 0734		1	
6. 00	05600 RADI 0I SOTOPE		5. 0497		1 -	
6. 01	03950 CARDI AC CATH LAB		0. 0609			
7.00	05700 CT SCAN		0.0274			
8. 00	05800 MRI		0.0678	·		
0. 00 5. 00	06000 LABORATORY 06500 RESPI RATORY THERAPY		0. 1075 0. 2032	1		
6. 00	06600 PHYSI CAL THERAPY		0. 2032	·		1
7. 00	06700 OCCUPATI ONAL THERAPY		0. 2912	·		
8. 00	06800 SPEECH PATHOLOGY		0. 2026			1
9. 00	06900 ELECTROCARDI OLOGY		0. 1166			
	07000 ELECTROENCEPHALOGRAPHY		0. 3160		1	
1. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 0852		17, 919	
2.00	07200 I MPL. DEV. CHARGED TO PATIENTS		0. 1305		1	
3.00	07300 DRUGS CHARGED TO PATIENTS		0. 4244	96 203, 756	86, 494	73.
3. 01	07301 DI ABETES CENTER		102. 0149	21 2	204	73.
4.00	07400 RENAL DI ALYSI S		0. 6632	·		1
6. 00	03480 ONCOLOGY		0. 2873	1		
6. 01	03952 ANTI COAGULATI ON		0. 4978		-	
6. 02	03951 I NFUSI ON SERVI CES		0. 4468			
6. 98	07698 HYPERBARI C 0XYGEN THERAPY OUTPATIENT SERVICE COST CENTERS		0.0000	00 (0	76.
0. 00	09000 CLINIC		2. 7771	36 (0	90.
1. 00	09100 EMERGENCY		0. 1321		1	
	04950 WOUND CARE		4. 5595	·		
2. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 4671		1	1
92. 01	09201 OBSERVATION BEDS (DISTINCT PART)		0. 3957		1	1
	OTHER REIMBURSABLE COST CENTERS		2.2707	1, 00	.,,,,,,	1
5. 00	09500 AMBULANCE SERVICES					95.
00.00	Total (sum of lines 50 through 94 and 96 through 98)			3, 257, 681	696, 729	200.
201.00		es (line 61)		(I .	201.
202.00	Net charges (line 200 minus line 201)		1	3, 257, 681	d.	202.

	FRANCISCAN HEALTH LAFAYETTE			u of Form CMS-2	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CC		Peri od:	Worksheet D-3	
			From 01/01/2021 To 12/31/2021	Date/Time Pre	
				5/2/2022 3:08	pm
	Ti tle		Hospi tal	Cost	
Cost Center Description		Ratio of Cost	•	Inpatient Program Costs	
		To Charges	Program Charges	(col. 1 x col.	
			Charges	2)	
		1.00	2.00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS			2.00	0.00	
30. 00 03000 ADULTS & PEDI ATRI CS			30, 765, 004		30.00
31.00 03100 INTENSIVE CARE UNIT			4, 649, 545		31.00
35.00 02060 NEONATAL INTENSIVE CARE UNIT			11, 335, 320		35.00
41. 00 04100 SUBPROVI DER - I RF			1, 190, 387		41.00
43. 00 04300 NURSERY			0		43.00
ANCILLARY SERVICE COST CENTERS					
50. 00 05000 OPERATI NG ROOM		0. 07883			1
51. 00 05100 RECOVERY ROOM		0. 10063		1	
52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 25837		0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 11692			
55. 00 05500 RADI OLOGY - THERAPEUTI C		0. 07348		0	
56. 00 05600 RADI 01 SOTOPE		5. 04975		0	
56. 01 03950 CARDI AC CATH LAB		0. 06093			
57. 00 05700 CT SCAN		0. 02748		1	
58. 00 05800 MRI		0.06786			
60. 00 06000 LABORATORY		0. 10729			
65. 00 06500 RESPI RATORY THERAPY		0. 20321		680, 132	1
66. 00 06600 PHYSI CAL THERAPY		0. 29129			
67. 00 06700 OCCUPATI ONAL THERAPY		0. 18268			
68. 00 06800 SPEECH PATHOLOGY		0. 20264			
69. 00 06900 ELECTROCARDI OLOGY		0. 11660			
70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 31605			
71.00 O7100 MEDICAL SUPPLIES CHARGED TO PATIENT 72.00 O7200 IMPL. DEV. CHARGED TO PATIENTS		0. 08526			
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 13051 0. 42449		442, 717 3, 923, 216	
73. 00 07300 DRUGS CHARGED TO PATTENTS 73. 01 07301 DI ABETES CENTER		102. 01492		3, 923, 216	
74. 00 07400 RENAL DI ALYSI S		0. 66329			
74. 00 07400 RENAL DIALISIS 76. 00 03480 ONCOLOGY		0. 28734			
76. 00 03480 0NCOLOGY 76. 01 03952 ANTI COAGULATI ON		0. 49788		12, 910	
76. 02 03951 NFUSI ON SERVI CES		0. 44689		0	
76. 98 07698 HYPERBARI C OXYGEN THERAPY		0. 00000		l	
OUTPATIENT SERVICE COST CENTERS		0.00000	<u>.</u>		1 ,0. 70
00 10 10000 CLINIC		2 77712	6 0	0	00 00

0. 132111

4. 559570

0. 467138

0.395772

3, 894, 505

64, 906, 766

64, 906, 766

446, 354

90.00

91.00

0 91.01

92.00

95.00

201. 00

202. 00

514, 507

208, 509

0 92.01

10, 399, 853 200. 00

90. 00 09000 CLINIC

91.00

91.01

92.00

92.01

200.00

201.00

202.00

09100 EMERGENCY

04950 WOUND CARE

95. 00 09500 AMBULANCE SERVICES

09200 OBSERVATION BEDS (NON-DISTINCT PART

Total (sum of lines 50 through 94 and 96 through 98)

Less PBP Clinic Laboratory Services-Program only charges (line 61) Net charges (line 200 minus line 201)

09201 OBSERVATION BEDS (DISTINCT PART)
OTHER REIMBURSABLE COST CENTERS

Health Financial Systems	FRANCISCAN HEALTH LAFAYETTE	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0109	Peri od: From 01/01/2021 To 12/31/2021	Worksheet E Part A Date/Time Prepared: 5/2/2022 3:08 pm

PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS 1.00 DRG amounts Other than Outlier Payments 1.01 DRG amounts other than outlier payments for discharges occurring prior to October 1 (see 25,519,870 1. instructions) 1.02 DRG amounts other than outlier payments for discharges occurring on or after October 1 (see 9,155,794 1. instructions) 1.03 DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions) 1.04 DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after 0ctober 1 (see instructions) 2.00 Outlier payments for discharges. (see instructions) 2.01 Outlier payments for discharges occurring prior to October 1 (see instructions) 2.02 Outlier payment for discharges for Model 4 BPCI (see instructions) 2.03 Outlier payments for discharges occurring prior to October 1 (see instructions) 2.04 Outlier payments for discharges occurring prior to October 1 (see instructions) 2.05 Outlier payments for discharges occurring prior to October 1 (see instructions) 2.06 Managed Care Simulated Payments 3.00 Managed Care Simulated Payments 4.00 Bed days available divided by number of days in the cost reporting period (see instructions) 4.00 Bed days available divided by number of days in the cost reporting period ending on or before 12/31/1996. (see instructions) 5.00 FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions) 6.00 MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412. 105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions. 8.00 MA Section 422 reduction amount to the IME cap as specified under 42 CFR §412. 105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions. 8.01 The amount of increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413. 75(b), 413. 79(c)(2)(iv), 64 FR 2634
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS 1.00 DRG Amounts Other than Outlier Payments DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions) 1.02 DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions) 1.03 DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions) 1.04 DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions) 1.04 DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions) 2.00 Outlier payments for discharges. (see instructions) 2.01 Outlier payments for discharges (see instructions) 2.02 Outlier payment for discharges for Model 4 BPCI (see instructions) 2.03 Outlier payment for discharges occurring prior to October 1 (see instructions) 2.04 Outlier payments for discharges occurring on or after October 1 (see instructions) 2.05 Outlier payments for discharges occurring on or after October 1 (see instructions) 3.00 Managed Care Simulated Payments 4.00 Bed days available divided by number of days in the cost reporting period (see instructions) 4.00 Bed days available divided by number of days in the cost reporting period ending on or before 12/31/1996. (see instructions) 5.00 FE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions) 5.00 FE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e) 7.01 ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions. 8.00 Adjustment (increase or decrease) to the FIE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv
1.00 DRG Amounts Other than Outlier Payments 1.01 DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions) 1.02 DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions) 1.03 DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions) 1.04 DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions) 2.00 Outlier payments for discharges. (see instructions) 2.01 Outlier payments for discharges for Model 4 BPCI (see instructions) 2.02 Outlier payments for discharges occurring prior to October 1 (see instructions) 2.03 Outlier payments for discharges occurring prior to October 1 (see instructions) 2.04 Outlier payments for discharges occurring prior to October 1 (see instructions) 3.00 Managed Care Simulated Payments 3.00 Managed Care Simulated Payments 4.00 Bed days available divided by number of days in the cost reporting period (see instructions) 4.00 FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions) 4.00 FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e) 5.00 FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e) 6.00 FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e) 7.01 ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddle sJuly 1, 2011 then see instructions. 8.00 Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340
1.02 DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions) 1.03 DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions) 1.04 DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions) 2.00 Outlier payments for discharges. (see instructions) 2.01 Outlier payments for discharges for Model 4 BPCI (see instructions) 2.02 Outlier payment for discharges occurring prior to October 1 (see instructions) 2.03 Outlier payments for discharges occurring prior to October 1 (see instructions) 2.04 Outlier payments for discharges occurring on or after October 1 (see instructions) 3.00 Managed Care Simulated Payments 4.00 Bed days available divided by number of days in the cost reporting period (see instructions) 1.00 Indirect Medical Education Adjustment 5.00 FTE count for all opathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions) 6.00 FTE count for all opathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e) 7.00 MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1) 8.00 Adjustment (increase or decrease) to the FTE count for all opathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002). 8.01 The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost
1.03 DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions) 2.00 DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions) 2.00 Outlier payments for discharges. (see instructions) 2.01 Outlier payment for discharges for Model 4 BPCI (see instructions) 2.02 Outlier payment for discharges for Model 4 BPCI (see instructions) 2.03 Outlier payments for discharges occurring prior to October 1 (see instructions) 2.04 Outlier payments for discharges occurring on or after October 1 (see instructions) 3.00 Managed Care Simulated Payments 4.00 Bed days available divided by number of days in the cost reporting period (see instructions) 3.01 Indirect Medical Education Adjustment 5.00 FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions) 6.00 FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e) 7.00 MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1) 7.01 ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions. 8.00 Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002). 8.01 The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost
1.04 DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions) 2.00 Outlier payments for discharges. (see instructions) 2.01 Outlier payment for discharges for Model 4 BPCI (see instructions) 2.02 Outlier payment for discharges occurring prior to October 1 (see instructions) 2.03 Outlier payments for discharges occurring on or after October 1 (see instructions) 2.04 Outlier payments for discharges occurring on or after October 1 (see instructions) 3.00 Managed Care Simulated Payments 4.00 Bed days available divided by number of days in the cost reporting period (see instructions) 5.00 Indirect Medical Education Adjustment FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions) 6.00 FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413. 79(e) 7.00 MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412. 105(f)(1)(iv)(B)(1) 7.01 ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412. 105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions. 8.00 Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413. 75(b), 413. 79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002). 8.01 The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost
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2.02 Outlier payment for discharges for Model 4 BPCI (see instructions) 2.03 Outlier payments for discharges occurring prior to October 1 (see instructions) 2.04 Outlier payments for discharges occurring on or after October 1 (see instructions) 3.00 Managed Care Simulated Payments 4.00 Bed days available divided by number of days in the cost reporting period (see instructions) 5.00 Indirect Medical Education Adjustment 5.00 FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions) 6.00 FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413. 79(e) 7.00 MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412. 105(f)(1)(iv)(B)(1) 7.01 ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412. 105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions. 8.00 Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413. 75(b), 413. 79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002). 8.01 The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost
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report straddles July 1, 2011, see instructions.
8.02 The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital 0.00 8. under § 5506 of ACA. (see instructions)
9.00 Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see 0.00 9. instructions)
10.00 FTE count for all opathic and osteopathic programs in the current year from your records 0.00 10.
11.00 FTE count for residents in dental and podiatric programs. 0.00 11.
12.00 Current year allowable FTE (see instructions) 0.00 12.13.00 Total allowable FTE count for the prior year. 0.00 13.13.0
14.00 Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, 0.00 14.
otherwise enter zero.
15.00 Sum of Lines 12 through 14 divided by 3. 0.00 15.
16.00 Adjustment for residents in initial years of the program 0.00 16.
17.00 Adjustment for residents displaced by program or hospital closure 0.00 17.
18.00 Adjusted rolling average FTE count 0.00 18.
19.00 Current year resident to bed ratio (line 18 divided by line 4). 0.000000 19.
20.00 Prior year resident to bed ratio (see instructions) 21.00 Enter the lesser of lines 19 or 20 (see instructions) 0.000000 20.
22. 00 IME payment adjustment (see instructions)
22.01 IME payment adjustment - Managed Care (see instructions) 0 22.
Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA
23.00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 0.00 23. (f)(1)(iv)(C).
24.00 IME FTE Resident Count Over Cap (see instructions) 0.00 24.
25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see 0.00 25. instructions)
26.00 Resident to bed ratio (divide line 25 by line 4) 0.000000 26.
27.00 IME payments adjustment factor. (see instructions) 0.000000 27.
28.00 IME add-on adjustment amount (see instructions) 0 28. 28.01 IME add-on adjustment amount - Managed Care (see instructions) 0 28.
28.01 IME add-on adjustment amount - Managed Care (see instructions) 0 28. 29.00 Total IME payment (sum of lines 22 and 28) 0 29.
29. 01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) Disproportionate Share Adjustment 0 29.
30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 3.62 30.
31. 00 Percentage of Medicaid patient days (see instructions) 26. 59 31.
32. 00 Sum of lines 30 and 31 30. 21 32.
33.00 Allowable disproportionate share percentage (see instructions) 14.14 33.
34.00 Disproportionate share adjustment (see instructions) 1,225,785 34.

		ALTH LAFAYETTE		eu of Form CMS-:	2552-1
CALCULA	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0109	Period: From 01/01/2021 To 12/31/2021		
				5/2/2022 3:08	pm
		Title XVIII	Hospi tal	PPS 10./1	
			Prior to 10/1 1.00	2. 00	
li li	Uncompensated Care Adjustment		1.00	2.00	
	Total uncompensated care amount (see instructions)		8, 290, 014, 521	7, 192, 008, 710	35.0
5. 01	Factor 3 (see instructions)		0. 000582028	0. 000550953	35. 0
	Hospital uncompensated care payment (If line 34 is zero, ε instructions)	enter zero on this line) (s	ee 4, 825, 019	3, 962, 460	35. 0
	Pro rata share of the hospital uncompensated care payment		3, 608, 849		
	Total uncompensated care (sum of columns 1 and 2 on line 3		4, 607, 607		36.0
	Additional payment for high percentage of ESRD beneficiary	/ discharges (lines 40 thro			40.0
1	Total Medicare discharges (see instructions) Total ESRD Medicare discharges (see instructions)		0	1	40. C
4	Total ESRD Medicare covered and paid discharges (see instructions)	cuctions)	0	l	41.0
	Divide line 41 by line 40 (if less than 10%, you do not qu		0.00	1	42.0
1	Total Medicare ESRD inpatient days (see instructions)	aarrig ron aag ao imonity	0		43.0
1	Ratio of average length of stay to one week (line 43 divid	ded by line 41 divided by 7	0. 000000		44. C
	days)				
4	Average weekly cost for dialysis treatments (see instructi	•	0.00		45. C
	Total additional payment (line 45 times line 44 times line	e 41.01)	41 224 070		46.0
4	Subtotal (see instructions)	l amall mumal baanitala	41, 334, 869		47.0
8. 00	Hospital specific payments (to be completed by SCH and MDF only. (see instructions)	a, Siliari Turai nospitars	0		48.0
	only. (See Thistractions)			Amount	
				1. 00	
	Total payment for inpatient operating costs (see instructi	•	_	41, 334, 869	
	Payment for inpatient program capital (from Wkst. L, Pt. I			3, 026, 381	
	Exception payment for inpatient program capital (Wkst. L,			0	
1	Direct graduate medical education payment (from Wkst. E-4, Nursing and Allied Health Managed Care payment	Title 49 See Histructions)		551, 278	
	Special add-on payments for new technologies			347, 830	
	Islet isolation add-on payment			0 17,000	1
1	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, lir	ne 69)		0	1
6. 00	Cost of physicians' services in a teaching hospital (see i	ntructions)		0	56.
7. 00	Routine service other pass through costs (from Wkst. D, Pt	t. III, column 9, lines 30	through 35).	1, 353, 642	
	Ancillary service other pass through costs from Wkst. D, F	Pt. IV, col. 11 line 200)		237, 735	1
	Total (sum of amounts on lines 49 through 58)			46, 851, 735	1
	Primary payer payments			11, 604	1
	Total amount payable for program beneficiaries (line 59 mi Deductibles billed to program beneficiaries	nus i i ne 60)		46, 840, 131 3, 222, 680	
	Coinsurance billed to program beneficiaries			72, 602	1
	Allowable bad debts (see instructions)			231, 932	
	Adjusted reimbursable bad debts (see instructions)			150, 756	1
	Allowable bad debts for dual eligible beneficiaries (see i	nstructions)		46, 016	1
	Subtotal (line 61 plus line 65 minus lines 62 and 63)	,		43, 695, 605	1
3. 00	Credits received from manufacturers for replaced devices f	for applicable to MS-DRGs (see instructions)	0	68. (
	Outlier payments reconciliation (sum of lines 93, 95 and 9	96).(For SCH see instructio	ns)	0	1
1	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	1
	Rural Community Hospital Demonstration Project (§410A Demo		instructions)	0	1
	Demonstration payment adjustment amount before sequestrati			0	1
1	SCH or MDH volume decrease adjustment (contractor use only	• •		0	1
	Pioneer ACO demonstration payment adjustment amount (see i	•		0	70. 70.
	HSP bonus payment HVBP adjustment amount (see instructions HSP bonus payment HRR adjustment amount (see instructions)			0	1
1	Bundled Model 1 discount amount (see instructions)	,		0	1
	HVBP payment adjustment amount (see instructions)			-48, 220	1
1	HRR adjustment amount (see instructions)			-932	
0. 94				0	

Health Financial Systems FRANCIS	CAN HEALTH LAFAYETTE		In Lie	u of Form CMS-2	2552_10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider Co		Period: From 01/01/2021 To 12/31/2021	Worksheet E Part A Date/Time Pre 5/2/2022 3:08	pared:
	Title	e XVIII	Hospi tal	PPS	
		FFY	(уууу)	Amount	
			0	1.00	
70.96 Low volume adjustment for federal fiscal year (yyyy) the corresponding federal year for the period prior			0	0	70. 96
70.97 Low volume adjustment for federal fiscal year (yyyy) the corresponding federal year for the period ending			0	0	70. 97
70. 98 Low Volume Payment-3	,			0	70. 98
70.99 HAC adjustment amount (see instructions)				316, 910	70. 99
71.00 Amount due provider (line 67 minus lines 68 plus/mir	nus Lines 69 & 70)			43, 329, 543	
71.01 Seguestration adjustment (see instructions)				0	
71.02 Demonstration payment adjustment amount after seques	stration			0	71. 02
71. 03 Seguestration adjustment-PARHM pass-throughs	, i. a i. a i.			Ü	71. 03
72.00 Interim payments				42, 645, 861	
72.01 Interim payments-PARHM				12,010,001	72. 01
73.00 Tentative settlement (for contractor use only)				0	
73. 01 Tentative settlement-PARHM (for contractor use only)	1			· ·	73. 01
74.00 Balance due provider/program (line 71 minus lines 7				683, 682	
73)				000, 002	/ 00
74.01 Balance due provider/program-PARHM (see instructions	5)				74. 01
75.00 Protested amounts (nonallowable cost report items) i				977, 732	
CMS Pub. 15-2, chapter 1, §115.2				,	
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			·]
90.00 Operating outlier amount from Wkst. E, Pt. A, line 2	2, or sum of 2.03			0	90. 00
plus 2.04 (see instructions)					
91.00 Capital outlier from Wkst. L, Pt. I, line 2				0	91.00
92.00 Operating outlier reconciliation adjustment amount (,			0	92. 00
93.00 Capital outlier reconciliation adjustment amount (se				0	
94.00 The rate used to calculate the time value of money (0.00	
95.00 Time value of money for operating expenses (see inst				0	
96.00 Time value of money for capital related expenses (se	ee instructions)		5	0	96. 00
			Prior to 10/1 1.00	2.00	
HSP Bonus Payment Amount			1.00	2.00	
100.00 HSP bonus amount (see instructions)			0	0	100.00
HVBP Adjustment for HSP Bonus Payment			<u> </u>		100.00
101.00 HVBP adjustment factor (see instructions)			0.000000000	0.000000000	101 00
102.00 HVBP adjustment amount for HSP bonus payment (see ir	nstructions)		0		102.00
HRR Adjustment for HSP Bonus Payment	,		-1	_	
103.00 HRR adjustment factor (see instructions)			0.0000	0.0000	103. 00
104.00 HRR adjustment amount for HSP bonus payment (see ins	structions)		0		104. 00
Rural Community Hospital Demonstration Project (§410	OA Demonstration) Adju	ıstment	<u>'</u>		
200.00 Is this the first year of the current 5-year demonst	tration period under t	the 21st			200. 00
Century Cures Act? Enter "Y" for yes or "N" for no.					1
Cost Reimbursement					
201.00 Medicare inpatient service costs (from Wkst. D-1, Pt	t. II, line 49)				201. 00
202.00 Medicare discharges (see instructions)					202. 00
203.00 Case-mix adjustment factor (see instructions)	(1) (1) (1)	6 11	1		203. 00
Computation of Demonstration Target Amount Limitation	on (N/A in first year	or the curren	ιτ 5-year demonst	ration	

74. 00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and		683, 682	74. 00
74 01	73)			74 01
74. 01	Balance due provider/program-PARHM (see instructions)		077 722	74. 01
75. 00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		977, 732	75. 00
	TO BE COMPLETED BY CONTRACTOR (Lines 90 through 96)			
90. 00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03		0	90.00
70.00	plus 2.04 (see instructions)		O	70.00
91. 00	Capital outlier from Wkst. L, Pt. I, line 2		0	91. 00
92. 00	Operating outlier reconciliation adjustment amount (see instructions)		0	
93. 00	Capital outlier reconciliation adjustment amount (see instructions)		0	
94. 00	The rate used to calculate the time value of money (see instructions)			94. 00
	Time value of money for operating expenses (see instructions)		0	1
96. 00	Time value of money for capital related expenses (see instructions)		0	
		Prior to 10/1	On/After 10/1	
		1.00	2. 00	
	HSP Bonus Payment Amount			
100.00	HSP bonus amount (see instructions)	0	0	100. 00
	HVBP Adjustment for HSP Bonus Payment			
	HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000	
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)	0	0	102. 00
	HRR Adjustment for HSP Bonus Payment	, , , , , , , , , , , , , , , , , , , ,		
	HRR adjustment factor (see instructions)	0.0000	0.0000	
104.00	HRR adjustment amount for HSP bonus payment (see instructions)	0	0	104. 00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st			200. 00
	Century Cures Act? Enter "Y" for yes or "N" for no.			
201 00	Cost Reimbursement			201 00
	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201. 00
	Medicare discharges (see instructions)			202. 00 203. 00
203.00	Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year of the current	E vees demands	ration	203.00
	period)	5-year delilorist	ration	
204 00	Medicare target amount			204. 00
	Case-mix adjusted target amount (line 203 times line 204)			205. 00
	Medicare inpatient routine cost cap (line 202 times line 205)			206. 00
200.00	Adjustment to Medicare Part A Inpatient Reimbursement			200.00
207 00	Program reimbursement under the §410A Demonstration (see instructions)			207. 00
	Medicare Part A inpatient service costs (from Wkst E, Pt A, line 59)			208. 00
	Adjustment to Medicare IPPS payments (see instructions)			209. 00
	Reserved for future use			210. 00
	Total adjustment to Medicare IPPS payments (see instructions)			211. 00
	Comparision of PPS versus Cost Reimbursement			
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212. 00
	Low-volume adjustment (see instructions)			213. 00
	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement)			218. 00
	(line 212 minus line 213) (see instructions)			
		·		

Health Financial Systems	FRANCISCAN HEALTH LAFAYETTE	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0109	Peri od: From 01/01/2021 To 12/31/2021	Worksheet E Part B Date/Time Prepared: 5/2/2022 3:08 pm

PRET. N. WITEOU AND OTHER WITH SERVICES			Title XVIII	Hospi tal	5/2/2022 3: 08 PPS	pm
RRT 8 . IMPLICAL AND OTHER HEATH SERVICES 10.0000 10.000 10.000 10.000 10.000 10.000 10.000 10.0000 10.000 10.000 10.000 10.000 10.000 10.000 10.0000 10.000 10.000 10.000 10.000 10.000 10.000 10.0000 10.000 10.000 10.000 10.000 10.000 10.000 10.0000 10.000 10.000 10.000 10.000 10.000 10.000 10.00000 10.00000 10.00000 10.00000 10.00000 10.00000 10.00000 10.00000 10.00000 10.00000 10.00000 10.000000 10.000000 10.0000000 10.0000000000				110061 (41		
		DADT D. MEDICAL AND OTHER HEALTH SERVICES			1.00	
Medical and other services relationsed under DPPS (see Instructions) 20, 573, 223 2.00 09PS pagements 22, 27, 163 3.00 09PS pagements 22, 27, 163 3.00 09PS pagements 22, 27, 163 3.00 4.0	1 00				10 086	1 00
BPS payments			is)			
0.011 pr reconcilitation arount (see instructions) 0.000 0.000		· · · · · · · · · · · · · · · · · · ·	-,			
Instant the hospit als specific payment to cost ratio (see instructions) 0.000 5.000 1	4.00	Outlier payment (see instructions)			209, 786	4. 00
Line 2 times line 5 0 6.00		· · · · · · · · · · · · · · · · · · ·				
			ons)			
1.00 Acot Transit tional corridor payment (see Instructions) 402, 15 5 90 00 00 10 10 10 10 10						
9,00 Ancillary service other pass through costs from Wist. D. Pt. IV, col. 13, line 200 402, 155 9, 90 10. 00 Graph acquisit from acquisit from acquisit from acquisit from the pass through costs from Wist. D. Pt. IV, col. 13, line 200 10, 00 10. 00 Graph acquisit from the pass of the						
0.00 0.00			col. 13. line 200			
Computation of Lisser of Cost Oxio Colombia S 12,00 Ancillary service charges 12,00 Ancillary service charges 12,00 Ancillary service charges 12,00 Ancillary service charges (sum of lines 12 and 13) 12,00 13,00 Organ acquisition charges (sum of lines 12 and 13) 12,00 13,00 13,00 13,00 14,00 14,00 15,00 14,00 15,00 14,00 15,00 14,00 15,00 14,00 15,00						
Reasonable charges	11.00	Total cost (sum of lines 1 and 10) (see instructions)			10, 086	11. 00
23, 799 12.00						
3.00 Organ acquisition charges (from Wist. D-4, Pt. III. col. 4, line 69) 0 13.00	10.00				22.750	10.00
1.0 Total reasonable chargés (sum of lines 12 and 13) 23,759 14,00		, , , , , , , , , , , , , , , , , , , ,	60)			
Customary charges			07)			
15.00 Aggregate amount actually collected from patients liable for payment for services on a charge basis 0 15.00	11.00				20,707	11.00
had such payment been made in accordance with 42 CFR §413.13(e)	15.00		ent for services on a	charge basis	0	15. 00
17.00 Ratio of Line 1s to Line 16 (not to exceed 1.000000) 17.00	16. 00	Amounts that would have been realized from patients liable for pa	yment for services or	n a chargebasis	0	16. 00
18. 00 Total customary charges (see instructions) 12.3, 797 18. 00 19. 00						
19. 00 Excess of customarry Charges over reasonable cost (complete only if line 18 exceeds line 11) (see 13. 673 19. 00						
Instructions			flino 10 overode lin	0 11) (600		
20. 00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see 0 20. 00	17.00		I TITLE TO EXCEEUS TIT	ie II) (see	13,073	19.00
Instructions 10,086 21.00 10.086 21.00 10.086 21.00 10.086 21.00 10.086 21.00 10.086 21.00 10.086 21.00 10.086 21.00 21.00 21.00 21.00 22.00 23.0	20. 00		f line 11 exceeds lir	ne 18) (see	0	20.00
22.00 Interns and residents (see instructions) 0 22.00 0 23.00 23.00				, ,		
23.00 Cost of physicians' services in a teaching hospital (see instructions) 21,939,102 24,00 COMPUTATION OF RELIMBURSEMENT SETTLEMENT 25.00 Deductible and coinsurance amounts (for CAH, see instructions) 3,598,102 25.00 Deductible and coinsurance amounts relating to amount on line 24 (for CAH, see instructions) 26.00 Deductible and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions) 26.00 Deductible and Coinsurance amounts (for CAH, see instructions) 26.00 Deductible and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions) 26.00 27.00 Descriptions 28.00 Direct graduate medical education payments (from Wkst. E-4, line 36) 0 28.00 ESRD direct medical education costs (from Wkst. E-4, line 36) 0 29.00 Descriptions 18, 351,088 30.00 31.00 Descriptions 30.00 Descriptions 30.00		, , , , , , , , , , , , , , , , , , ,				
24. 00 Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) 21,939,104 24. 00		· · · · · · · · · · · · · · · · · · ·				
COMPUTATION OF RELIMBURSEMENT SETTLEMENT 25.00 Deductible sand coinsurance amounts (For CAH, see instructions) 3,598,102 25.00 Deductibles and coinsurance amounts relating to amount on line 24 (For CAH, see instructions) 0 26.00 Deductible sand Coinsurance amounts relating to amount on line 24 (For CAH, see instructions) 0 26.00 Deductible sand Coinsurance amounts relating to amount on line 24 (For CAH, see instructions) 0 26.00 Deductible sand Coinsurance amounts relating to amount on line 24 (For CAH, see instructions) 0 27.00 Description 0 28.00 Description 0 28.00 Description 0 28.00 Description 0 28.00 Description 0 29.00 Description 0 29.			ions)		_	
25.00 Deductible sand coinsurance amounts (for CAH, see instructions) 0.26.00	24.00				21, 939, 104	24.00
26.00 Deductible sand Coinsurance amounts relating to amount on line 24 (for CAH, see instructions) 0 26.00	25 00				3 598 102	25 00
27.00 Subtotal [(I ines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see 18,351,088 27.00		· · · · · · · · · · · · · · · · · · ·	(for CAH, see instru	ıctions)		1
28.00 Direct graduate medical education payments (From Wkst. E-4, line 50) 0 28.00 0 29.00	27. 00				18, 351, 088	27. 00
29.00 ESRD direct medical education costs (from Wkst. E-4, line 36) 29.00 30.00 Subtotal (sum of lines 27 through 29) 18, 351,088 30.00 31.00 7 primary payer payments 18, 351,088 30.00 31.00 32.00		·				
30.00 Subtotal (sum of lines 27 through 29) 18,351,088 30.00 31.00			50)		0	
31.00		, , , , , , , , , , , , , , , , , , ,			10 351 000	
32.00 Subtortal (line 30 minus line 31) 18,351,088 32.00		, ,			10, 331, 000	1
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) 33.00 Composite rate ESRD (from Wkst. I-5, I ine 11) 33.00 34.00 All lowable bad debts (see instructions) 372, 425 34.00 35.00 Adjusted reimbursable bad debts (see instructions) 242, 076 35.00 36.00 All lowable bad debts for dual eligible beneficiaries (see instructions) 163, 012 36.00 37.00 Subtotal (see instructions) 18,593, 164 37.00 38.00 MSP-LCC reconciliation amount from PS&R 7,991 38.00 MSP-LCT reconciliation amount from PS&R 7,991 38.00 7.00					18, 351, 088	1
34.00 All owable bad debts (see instructions) 372, 425 34.00 35.00 Adjusted reimbursable bad debts (see instructions) 242, 076 35.00 36.00 All owable bad debts for dual eligible beneficiaries (see instructions) 163, 012 36.00 37.00 Subtotal (see instructions) 18, 593, 164 37.00 38.00 MSP-LCC reconciliation amount from PS&R 7, 901 38.00 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39.00 39.50 Pioneer ACO demonstration payment adjustment (see instructions) 39.50 Pioneer ACO demonstration payment adjustment (see instructions) 39.50 99.97 Demonstration payment adjustment (see instructions) 0 39.98 99.98 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39.99 99.90 Protected for manufacturers for replaced devices (see instructions) 18, 585, 173 40.00 40.01 Sequestration adjustment (see instructions) 18, 585, 173 40.00 40.01 Sequestration adjustment amount after sequestration 40.01 40.		ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
35.00						
36. 00						1
37.00 Subtotal (see instructions) 18,593,164 37.00 39.00 MSP-LCC reconciliation amount from PS&R 7,991 38.00 39.00 39.00 MSP-LCC reconciliation amount from PS&R 7,991 38.00 39.90 39.90 39.90 39.90 39.90 39.90 39.90 39.00 39.00 39.00 39.00 39.00 39.00 39.90 39.90 39.00			i ana)			
38. 00 MSP-LCC reconciliation amount from PS&R 7, 991 38. 00 39. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39. 00 39. 50 Pioneer ACO demonstration payment adjustment (see instructions) 39. 90 39. 97 Demonstration payment adjustment amount before sequestration 0 39. 97 39. 98 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39. 98 40. 00 Subtotal (see instructions) 0 39. 99 40. 01 Sequestration adjustment (see instructions) 18, 585, 173 40. 00 40. 02 Demonstration payment adjustment amount after sequestration 0 40. 01 40. 02 Demonstration payment adjustment amount after sequestration 0 40. 01 40. 02 Demonstration payments 18, 587, 106 41. 00 41. 01 Interim payments 18, 527, 106 41. 00 41. 01 Interim payments-PARHM 42. 00 42. 00 42. 01 Tentative settlement (for contractor use only) 42. 01 43. 01 Bal ance due provider/program (see instructions) 58, 067 43. 00 44. 00			10115)			
39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 39.50 39.00 39.00 39.50 39.						
39.50 Pioneer ACO demonstration payment adjustment (see instructions) 39.50						
39. 98 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39. 98 39. 99 RECOVERY OF ACCELERATED DEPRECIATION 0 39. 99 40. 00 Subtotal (see instructions) 18, 585, 173 40. 00 40. 01 Sequestration adjustment (see instructions) 0 40. 01 40. 02 Demonstration payment adjustment amount after sequestration 0 40. 02 40. 03 Sequestration adjustment-PARHM pass-throughs 18, 527, 106 41. 00 41. 01 Interim payments-PARHM 18, 527, 106 41. 01 42. 01 Tentative settlement (for contractors use only) 42. 01 43. 00 Bal ance due provider/program (see instructions) 58, 067 43. 00 43. 01 Bal ance due provider/program (see instructions) 58, 067 43. 01 44. 00 Fotested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44. 00 90. 00 Original outlier amount (see instructions) 0 90. 00 91. 00 Outlier reconciliation adjustment amount (see instructions) 0 91. 00 92. 00 The rate used to calculate the Time Value of Money						39. 50
39. 99 RECOVERY OF ACCELERATED DEPRECIATION 0 39. 99 40. 00 Subtotal (see instructions) 18, 585, 173 40. 00 40. 01 Sequestration adjustment (see instructions) 0 40. 02 Demonstration payment adjustment amount after sequestration 0 40. 02 40. 03 Sequestration adjustment-PARHM pass-throughs 18, 527, 106 41. 00 Interim payments 1 18, 527, 106 41. 00 Interim payments-PARHM 1 18, 527, 106 41. 00 41. 01 Interim payments 1 18, 527, 106 41. 00 42. 01 Tentative settlement (for contractors use only) 1 42. 01 43. 00 Bal ance due provider/program (see instructions) 1 58, 067 43. 00 43. 01 Bal ance due provider/program-PARHM (see instructions) 1 58, 067 43. 01 44. 00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 1 0 44. 00 90. 00 Original outlier amount (see instructions) 1 90. 00 91. 00 Outlier reconciliation adjustment amount (see instructions) 1 90. 00 92. 00 The rate used to calculate the Time Value of Money (see instructions) 0 93. 00	39. 97	Demonstration payment adjustment amount before sequestration			0	
40.00 Subtotal (see instructions) 18,585,173 40.00 40.01 Sequestration adj ustment (see instructions) 0 40.01 40.02 Demonstration payment adj ustment amount after sequestration 0 40.02 40.03 Sequestration adj ustment-PARHM pass-throughs 18,527,106 41.03 41.01 Interim payments 18,527,106 41.01 41.01 Interim payments-PARHM 41.01 42.00 Tentative settlement (for contractors use only) 0 42.00 42.01 Tentative settlement-PARHM (for contractor use only) 42.01 43.01 Balance due provider/program (see instructions) 58,067 43.00 43.01 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00 90.00 Original outlier amount (see instructions) 0 90.00 91.00 Outlier reconciliation adjustment amount (see instructions) 0 91.00 92.00 The rate used to calculate the Time Value of Money (see instructions) 0 93.00		· ·	devices (see instruct	i ons)	_	
40.01 Sequestration adjustment (see instructions) 0 40.01 40.02 Demonstration payment adjustment amount after sequestration 0 40.02 40.03 Sequestration adjustment-PARHM pass-throughs 40.03 41.00 Interim payments 18,527,106 41.00 41.01 Interim payments-PARHM 41.00 41.00 42.01 Tentative settlement (for contractors use only) 0 42.01 43.00 Balance due provider/program (see instructions) 58,067 43.00 43.01 Balance due provider/program-PARHM (see instructions) 43.01 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, spi15.2 0 44.00 70.00 Original outlier amount (see instructions) 0 90.00 91.00 Outlier reconciliation adjustment amount (see instructions) 0 91.00 92.00 The rate used to calculate the Time Value of Money 0 92.00 93.00 Time Value of Money (see instructions) 0 93.00						
40.02 Demonstration payment adjustment amount after sequestration 40.03 Sequestration adjustment-PARHM pass-throughs 41.00 Interim payments Interim payments-PARHM 41.01 Interim payments-PARHM 42.00 Tentative settlement (for contractors use only) 42.01 Tentative settlement-PARHM (for contractor use only) 43.00 Balance due provider/program (see instructions) 43.01 Balance due provider/program-PARHM (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00 Original outlier amount (see instructions) 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 79.00 The rate used to calculate the Time Value of Money 79.00 Time Value of Money (see instructions) 79.00 Time Value of Money (see instructions) 79.00 Time Value of Money (see instructions) 80.00 Value of Money (see instructions)						1
40. 03 Sequestration adjustment-PARHM pass-throughs 40. 03 41. 00 1nterim payments 41. 00 1nterim payments 41. 00 41. 01 1nterim payments 42. 00 42. 00 42. 00 43. 00 43. 00 8al ance due provider/program (see instructions) 43. 00 8al ance due provider/program PARHM (see instructions) 43. 01 44. 00						
11.00						
41.01 Interim payments-PARHM		, ,			18, 527, 106	1
42.01 Tentative settlement-PARHM (for contractor use only) 43.00 Balance due provider/program (see instructions) 43.01 Balance due provider/program-PARHM (see instructions) 43.01 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5115.2 70 BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 Time Value of Money (see instructions) 94.01 Time Value of Money (see instructions) 95.02 Time Value of Money (see instructions) 97.03 Time Value of Money (see instructions) 98.00 Time Value of Money (see instructions) 99.00 Time Value of Money (see instructions)						
43.00 Balance due provider/program (see instructions) 43.01 Balance due provider/program-PARHM (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 Time Value of Money (see instructions) 94.00 Outlier reconciliation adjustment amount (see instructions) 93.00 Time Value of Money (see instructions) 94.00 Outlier reconciliation adjustment amount (see instructions) 95.00 Outlier reconciliation adjustment amount (see instructions) 96.00 Outlier reconciliation adjustment amount (see instructions) 97.00 Outlier reconciliation adjustment amount (see instructions)					0	
43.01 Balance due provider/program-PARHM (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 Time Value of Money (see instructions) 94.00 Outlier reconciliation adjustment amount (see instructions) 95.00 Outlier reconciliation adjustment amount (see instructions) 96.00 Outlier reconciliation adjustment amount (see instructions) 97.00 Outlier reconciliation adjustment amount (see instructions)					50.017	
44.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$\frac{\$115.2}{70 BE COMPLETED BY CONTRACTOR}\$ 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0 44.00 90.00 91.00 92.00 93.00					58, 067	
\$115.2 TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 0 Outlier reconciliation adjustment amount (see instructions) 0 Uniting reconciliation adjustment amount (see instructions) 0 91.00 92.00 The rate used to calculate the Time Value of Money 0.00 Outlier reconciliation adjustment amount (see instructions) 0 93.00 Time Value of Money (see instructions) 0 93.00			with CMS Dub 15 2	chanter 1		
TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 10 90.00 91.00 92.00 93.00	44.00		with GWS FUD. 13-2, (παρισι Ι,		44.00
90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0 90.00 91.00 92.00 93.00						1
91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0 91.00 0.00 92.00 0.00 93.00	90.00				0	90.00
93.00 Time Value of Money (see instructions) 0 93.00	91.00	Outlier reconciliation adjustment amount (see instructions)				91.00
94. 00 Total (Sum of Tines 91 and 93) 0 94. 00						
	94.00	Tiorai (sum of filles at and as)			1 0	J 94. UU

Health Financial Systems	FRANCISCAN HEALTH LAFAYETTE	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0109	Peri od:	Worksheet E
		From 01/01/2021	Part B
	Component CCN: 15-T109	To 12/31/2021	Date/Time Prepared:
			5/2/2022 3:08 pm
	Title XVIII	Subprovi der -	PPS

		Title XVIII	Subprovi der - I RF	PPS	
				1. 00	
4 00	PART B - MEDICAL AND OTHER HEALTH SERVICES			040	4 00
1. 00 2. 00	Medical and other services (see instructions) Medical and other services reimbursed under OPPS (see instruct	tions)		212 0	1. 00 2. 00
3.00	OPPS payments	11 0113)		119	3. 00
4.00	Outlier payment (see instructions)			0	4. 00
4.01	Outlier reconciliation amount (see instructions)			0	4. 01
5.00	Enter the hospital specific payment to cost ratio (see instruc	ctions)		0. 000	5. 00
6.00	Line 2 times line 5			0 0. 00	6. 00
7. 00 8. 00	Sum of lines 3, 4, and 4.01, divided by line 6 Transitional corridor payment (see instructions)			0.00	7. 00 8. 00
9. 00	Ancillary service other pass through costs from Wkst. D, Pt. I	V. col. 13. line 200		o	9. 00
10.00	Organ acqui si ti ons			0	10.00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			212	11. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
12. 00	Reasonable charges Ancillary service charges			500	12. 00
13. 00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, Ii	ne 69)		0	13. 00
14.00	Total reasonable charges (sum of lines 12 and 13)	,		500	14.00
	Customary charges				
15.00	Aggregate amount actually collected from patients liable for particular that would be a particular form.			0	15. 00
16. 00	Amounts that would have been realized from patients liable for had such payment been made in accordance with 42 CFR §413.13(e)		n a chargebasis	0	16. 00
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)	-,		0. 000000	17. 00
18. 00	Total customary charges (see instructions)			500	18. 00
19. 00	Excess of customary charges over reasonable cost (complete onl	y if line 18 exceeds lin	ne 11) (see	288	19. 00
20. 00	instructions) Excess of reasonable cost over customary charges (complete onl	y if line 11 exceeds lin	ne 18) (see	0	20. 00
21 00	instructions)			212	21 00
21. 00 22. 00	Lesser of cost or charges (see instructions) Interns and residents (see instructions)			212 0	21. 00 22. 00
23. 00	Cost of physicians' services in a teaching hospital (see instr	ructions)		0	23. 00
24. 00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	,		119	24. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			_	
25. 00 26. 00	Deductibles and coinsurance amounts (for CAH, see instructions Deductibles and Coinsurance amounts relating to amount on line		ictions)	0	25. 00 26. 00
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) p	•	•	331	27. 00
	instructions)				
28. 00	Direct graduate medical education payments (from Wkst. E-4, li	ne 50)		0	28. 00
29. 00 30. 00	ESRD direct medical education costs (from Wkst. E-4, line 36) Subtotal (sum of lines 27 through 29)			0 331	29. 00 30. 00
31. 00	Primary payer payments			0	31. 00
32.00	Subtotal (line 30 minus line 31)			331	32. 00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE)	CES)		_	
33. 00 34. 00	Composite rate ESRD (from Wkst. I-5, line 11) Allowable bad debts (see instructions)			0	33. 00 34. 00
35. 00	Adjusted reimbursable bad debts (see instructions)			0	35. 00
36.00	Allowable bad debts for dual eligible beneficiaries (see instr	ructions)		0	36.00
37. 00	Subtotal (see instructions)			331	37. 00
38.00					38. 00
39. 00 39. 50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions	-)		0	39. 00 39. 50
39. 97	Demonstration payment adjustment amount before sequestration	3)		o	39. 97
39. 98	Partial or full credits received from manufacturers for replace	ced devices (see instruc	tions)	0	39. 98
39. 99	RECOVERY OF ACCELERATED DEPRECIATION			0	39. 99
40.00	Subtotal (see instructions)			331	40.00
40. 01 40. 02	Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration			0	40. 01 40. 02
40. 02	Sequestration adjustment-PARHM pass-throughs			ı	40. 02
41. 00	Interim payments			176	
41. 01	Interim payments-PARHM				41. 01
42. 00	Tentative settlement (for contractors use only)			0	42.00
42. 01 43. 00	Tentative settlement-PARHM (for contractor use only) Balance due provider/program (see instructions)			155	42. 01 43. 00
43. 00	Balance due provider/program-PARHM (see instructions)			155	43. 00
44. 00	Protested amounts (nonallowable cost report items) in accordan	nce with CMS Pub. 15-2, o	chapter 1,	0	44. 00
	§115. 2 TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)			0	90. 00
91.00	Outlier reconciliation adjustment amount (see instructions)			0	91.00
92.00	The rate used to calculate the Time Value of Money			0. 00 0	
93. 00 94. 00	Time Value of Money (see instructions) Total (sum of lines 91 and 93)			0	93. 00 94. 00
55			l	٥١	

| Period: | Worksheet E-1 | From 01/01/2021 | Part | To 12/31/2021 | Date/Time Prepared: | 5/2/2022 3:08 pm Health Financial Systems FRANCANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provider CCN: 15-0109

Inpatient Part A						5/2/2022 3:08	pm
mm/dd/yyyy						PPS	
Total interim payments paid to provider 1,00° 2,00 3,00° 4,00 1,00° 1,			Inpatier	t Part A	Part B		
Total interim payments paid to provider 42,645,861 18,527,106 10, 20 2.00							
Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero.			1.00		3. 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 amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) 3.00 3							1.00
Services rendered in the cost reporting period. If none, write "NoNE" or enter a zero that it 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)	2.00			0		0	2.00
write "NONE" or enter a zero 3.00							
List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider ADJUSTMENTS TO PROVIDER 0 0 0 3.0 3.0 3.0 3.0 4 0 0 0 0 3.0 3.0 3.0 3.0 4 0 0 0 0 3.0 3.0 3.0 5 0 0 0 0 0 3.0 3.0 3.0 5 0 0 0 0 0 0 3.0 3.0 5 0 0 0 0 0 0 3.0 3.0 5 0 0 0 0 0 0 3.0 3.0 5 0 0 0 0 0 0 0 0 3.0 3.0 5 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0							
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)							
For the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)	3.00						3.00
payment, If none, write "NONE" or enter a zero. (1)							
Program to Provider ADJUSTMENTS TO PROVIDER 0 0 0 3.0							
ADJUSTMENTS TO PROVIDER							
3.03 3.03 3.04 3.05 3.05 3.06 3.06 3.07 3.07 3.07 3.07 3.07 3.07 3.08 3.08 3.08 3.09 3.08 3.09	2 01			1		1	2 01
3.03 3.04 3.05 Provider to Program 3.50 3.51 3.52 3.53 3.59 3.50 3.50 3.50 3.51 3.52 3.53 3.99 3.50-3.98) 3.50-3.98) 4.00 Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wist. E or Wist. E-3, line and column as appropriate) To BE COMPLETED BY CONTRACTOR 1.50 1.50 1.50 1.50 1.50 1.50 1.50 1.50		ADJUSTMENTS TO PROVIDER					
3.04 0 0 0 3.0				_		_	
Solid Soli						_	
Provider to Program ADJUSTMENTS TO PROGRAM 0 0 3.5						_	
3.50 ADJUSTMENTS TO PROGRAM	3.05	Dravi dan ta Dragnam		0		0	3.05
3.51 0	2 EO						2 50
3.52 3.53 3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.35 3.50-3.98) 3.50-3.98) 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 42,645,861 18,527,106 4.00 (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR		ADJUSTIMENTS TO PROGRAM					
3.53 3.54 3.54 3.55 3.59 3.50-3,98 3.50-						_	
3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.35-3.98) 42,645,861 18,527,106 4.00 (transfer to Wkst. E or wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR						_	
3. 99 Subtotal (sum of lines 3. 01-3. 49 minus sum of lines 3. 50-3. 98) 42,645,861 18,527,106 4. 01 10 10 10 10 10 10 10				1		_	
3.50-3.98 Total interim payments (sum of lines 1, 2, and 3.99)		Subtotal (sum of lines 2 01 2 40 minus sum of lines					
A. 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) TO BE COMPLETED BY CONTRACTOR	3. 77			0			3. 77
(transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR	4 00			42 645 861		18 527 106	4 00
appropriate TO BE COMPLETED BY CONTRACTOR	1. 00			12,010,001		10,027,100	1.00
TO BE COMPLÉTED BY CONTRACTOR							
List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider							ĺ
desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider	5.00						5.00
Write "NONE" or enter a zero. (1) Program to Provider S. 01 TENTATIVE TO PROVIDER O O S. 02 S. 03 O O S. 02 O O S. 03 O O S. 03 O O S. 04 O O S. 05 O O O O S. 05 O O O O O O O O O							
TENTATIVE TO PROVIDER		write "NONE" or enter a zero. (1)					
5.02 0		Program to Provider					
Description	5. 01	TENTATI VE TO PROVI DER		0		0	5. 01
Provider to Program	5.02					0	5. 02
TENTATI VE TO PROGRAM 0 0 5.50	5.03			0		0	5. 03
5.51 5.52 5.52 5.52 5.52 5.52 5.52 5.50 5.52 5.50							
5.52 5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor NPR Date (Mo/Day/Yr) O 1.00 2.00		TENTATI VE TO PROGRAM				_	
5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 683,682 58,067 6.00 7.00 Total Medicare program liability (see instructions) 43,329,543 18,585,173 7.00 Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00				_			0.0.
5.50-5.98) 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00				1		_	
6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor NPR Date (Mo/Day/Yr) Number (Mo/Day/Yr) 0 1.00 2.00	5. 99	,		0		0	5. 99
the cost report. (1) 6. 01 SETTLEMENT TO PROVIDER 6. 02 SETTLEMENT TO PROGRAM 7. 00 Total Medicare program liability (see instructions) Contractor NPR Date (Mo/Day/Yr) Number (Mo/Day/Yr) 0 1. 00 2. 00	6 00						6.00
6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor Number (Mo/Day/Yr) 0 1.00 2.00	0.00						0.00
6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) 0 43,329,543 Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00	6. 01			683, 682		58, 067	6. 01
7.00 Total Medicare program liability (see instructions) 43,329,543 Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00				0			
Contractor NPR Date Number (Mo/Day/Yr) 0 1.00 2.00				43, 329, 543		_	
Number (Mo/Day/Yr) 0 1.00 2.00		, , , , , , , , , , , , , , , , , , , ,		,, 310	Contractor		
0 1.00 2.00							
8.00 Name of Contractor 8.00)	1. 00	2. 00	
	8.00	Name of Contractor					8. 00

Component CCN: 15-T109

Title XVIII Subprovi der

		Title	e XVIII	Subprovi der - I RF	PPS	
		Inpatien	Inpatient Part A Part		t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3. 00	4. 00	
1. 00	Total interim payments paid to provider		2, 226, 555		176	1, 00
2. 00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero				0	2. 00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					3. 00
3. 01	ADJUSTMENTS TO PROVIDER			1	0	3. 01
3. 01	ADJUSTNIENTS TO PROVIDER			1		
3. 02						
3. 03						
3. 05						
3.03	Provider to Program	L		7		3.03
3. 50	ADJUSTMENTS TO PROGRAM				0	3. 50
3. 51					o	
3.52					0	3. 52
3.53					0	3. 53
3.54					0	3. 54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines				0	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		2, 226, 555	5	176	4. 00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR	1	1	1		
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			1	0	5. 01
5. 01	TENTATIVE TO PROVIDER					
5. 02						
5.05	Provider to Program			1	<u> </u>	3.03
5. 50	TENTATI VE TO PROGRAM				0	5. 50
5. 51	TERMINE TO TROOM WIT				Ö	
5. 52					o o	
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines				o o	
	5. 50-5. 98)]			/
6. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6. 00
6. 01	SETTLEMENT TO PROVIDER		38, 131		155	6. 01
6. 02	SETTLEMENT TO PROGRAM		(0	
7. 00	Total Medicare program liability (see instructions)		2, 264, 686	5	331	
	1 13 1 13 13 13 13 13 13 13 13 13 13 13		, , , , , , , , , ,	Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
		()	1. 00	2. 00	
0 00	Nome of Contractor	I	·	1		0 00

8.00 Name of Contractor

Heal th	Financial Systems FRANCISCAN HEALTH	l LAFAYETTE	In Lie	u of Form CMS-	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 15-0109 Period: Worksheet E-1					
			From 01/01/2021 To 12/31/2021	Part II	narad.
			To 12/31/2021	Date/Time Pre 5/2/2022 3:08	
		Title XVIII	Hospi tal	PPS	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1. 00	Total hospital discharges as defined in AARA §4102 from Wkst.	The state of the s			1. 00
2. 00	Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, and	8 through 12, and plus f	or cost		2. 00
	reporting periods beginning on or after 10/01/2013, line 32)				
3. 00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3. 00
4. 00	Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines	1, and 8 through 12, and	plus for cost		4. 00
	reporting periods beginning on or after 10/01/2013, line 32)				
5. 00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5. 00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 I				6. 00
7. 00	CAH only - The reasonable cost incurred for the purchase of c	ertified HIT technology	Wkst. S-2, Pt. I		7. 00
	line 168				
8. 00	Calculation of the HIT incentive payment (see instructions)				8. 00
9.00	Sequestration adjustment amount (see instructions)				9. 00
10. 00	Calculation of the HIT incentive payment after sequestration	(see instructions)			10. 00
	I NPATI ENT HOSPITAL SERVICES UNDER THE I PPS & CAH		1		
	Initial/interim HIT payment adjustment (see instructions)				30. 00
	Other Adjustment (specify)				31. 00
32. 00	Balance due provider (line 8 (or line 10) minus line 30 and l	ine 31) (see instruction	s)		32. 00

Health Financial Systems	FRANCISCAN HEALTH LAFAYETTE	In Lie	eu of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0109	Peri od:	Worksheet E-3	
		From 01/01/2021		
	Component CCN: 15-T109	To 12/31/2021	Date/Time Pre	pared:
	·		5/2/2022 3:08	pm
	Title XVIII	Subprovi der -	PPS	
		IRF		
			1. 00	
PART III - MEDICARE PART A SERVICES - IRF PI	PS			
1.00 Net Federal PPS Payment (see instructions)			2, 063, 708	1.00

		•	
		1. 00	
	PART III - MEDICARE PART A SERVICES - IRF PPS	1.00	
1. 00	Net Federal PPS Payment (see instructions)	2, 063, 708	1.0
2. 00	Medicare SSI ratio (IRF PPS only) (see instructions)	0.0055	2.0
3. 00	Inpatient Rehabilitation LIP Payments (see instructions)	125, 680	3.0
. 00	Outlier Payments	108, 794	4. 0
5. 00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)	0. 00	5.0
5. 01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412. 424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	5. 0
. 00	New Teaching program adjustment. (see instructions)	0.00	6.0
. 00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)	0. 00	7.0
. 00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)	0. 00	8. 0
. 00	Intern and resident count for IRF PPS medical education adjustment (see instructions)	0.00	9. 0
0.00	Average Daily Census (see instructions)	8. 063014	10.0
1. 00	Teaching Adjustment Factor (see instructions)	0.000000	11. 0
2. 00	Teaching Adjustment (see instructions)	0	12. (
3.00	Total PPS Payment (see instructions)	2, 298, 182	13. 0
4. 00	Nursing and Allied Health Managed Care payments (see instruction)	0	14. (
5. 00	Organ acquisition (DO NOT USE THIS LINE)		15. (
6. 00	Cost of physicians' services in a teaching hospital (see instructions)	0	16.
7. 00	Subtotal (see instructions)	2, 298, 182	17.
3. 00	Primary payer payments	0	18.
. 00	Subtotal (line 17 less line 18).	2, 298, 182	19.
0. 00	Deducti bl es	34, 132	20.
1.00	Subtotal (line 19 minus line 20)	2, 264, 050	21.
2. 00	Coinsurance	742	22.
3. 00	Subtotal (line 21 minus line 22)	2, 263, 308	23.
1. 00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	0	24.
5. 00	Adjusted reimbursable bad debts (see instructions)	0	25.
5. 00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	26.
7. 00	Subtotal (sum of lines 23 and 25)	2, 263, 308	27.
3. 00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	28.
9. 00	Other pass through costs (see instructions)	1, 378	29.
0. 00	Outlier payments reconciliation	0	30.
. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	31.
. 50	Pioneer ACO demonstration payment adjustment (see instructions)	0	31.
I. 98	Recovery of accelerated depreciation.	0	31.
1. 99	Demonstration payment adjustment amount before sequestration	0	31.
2. 00	Total amount payable to the provider (see instructions)	2, 264, 686	32.
2. 01	Sequestration adjustment (see instructions)	0	
2. 02	Demonstration payment adjustment amount after sequestration	0	32.
3. 00	Interim payments	2, 226, 555	33.
1. 00	Tentative settlement (for contractor use only)	0	34.
5. 00	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)	38, 131	35.
5. 00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	36.
	TO BE COMPLETED BY CONTRACTOR		
	Original outlier amount from Wkst. E-3, Pt. III, line 4	108, 794	
1. 00	Outlier reconciliation adjustment amount (see instructions)	0	51.
2. 00	The rate used to calculate the Time Value of Money	0.00	
3.00	Time Value of Money (see instructions)	0	53.
	FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING BEFORE THE END OF THE COVID-15		
9. 00	Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020.	0.000000	
	Calculated Teaching Adjustment Factor for the current year. (see instructions)	0. 000000	l oo

Health Financial Systems	FRANCISCAN HEALTH LAFAYETTE	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0109	Peri od: From 01/01/2021 To 12/31/2021	Worksheet E-3 Part VII Date/Time Prepared: 5/2/2022 3:08 pm

				5/2/2022 3:08	pm
		Title XIX	Hospi tal	Cost	
			Inpati ent	Outpati ent	
			1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SEF	RVICES FOR TITLES V OR XIX	SERVI CES		
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services		0		1.00
2.00	Medical and other services			0	2. 00
3.00	Organ acquisition (certified transplant centers only)		0		3. 00
4.00	Subtotal (sum of lines 1, 2 and 3)		0	0	4.00
5.00	Inpatient primary payer payments		O		5. 00
6.00	Outpatient primary payer payments			0	6, 00
7. 00	Subtotal (line 4 less sum of lines 5 and 6)		0	0	
	COMPUTATION OF LESSER OF COST OR CHARGES		-1		1
	Reasonable Charges				1
8.00	Routine service charges		0		8.00
9. 00	Ancillary service charges		64, 906, 766	0	
10.00	Organ acquisition charges, net of revenue		01, 700, 700	Ü	10.00
11. 00	Incentive from target amount computation		0		11.00
12. 00	Total reasonable charges (sum of lines 8 through 11)		64, 906, 766	0	1
12.00	CUSTOMARY CHARGES		04, 900, 700	0	12.00
13. 00	Amount actually collected from patients liable for payment for	r sorvicos on a chargo	0	0	13.00
13.00	basis	services on a charge	U	U	13.00
14. 00	Amounts that would have been realized from patients liable for	s navment for services on	0	0	14. 00
14.00	a charge basis had such payment been made in accordance with		U	U	14.00
15. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)	42 CIR 9413. 13(E)	0. 000000	0.000000	15. 00
16. 00	Total customary charges (see instructions)		64, 906, 766	0.000000	
	, , , , , , , , , , , , , , , , , , , ,	ly if line 1/ evenede		0	
17. 00	Excess of customary charges over reasonable cost (complete onl	y if line 16 exceeds	64, 906, 766	Ü	17.00
10 00	line 4) (see instructions)	ly if lime 4 avecade lime	0	0	10.00
18. 00	Excess of reasonable cost over customary charges (complete onl	y if line 4 exceeds line	0	0	18. 00
10.00	16) (see instructions)			0	10.00
19. 00	Interns and Residents (see instructions)		0	0	
	Cost of physicians' services in a teaching hospital (see insti			0	
21. 00	Cost of covered services (enter the lesser of line 4 or line		0	0	21. 00
22 00	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be	completed for PPS provide		0	22 00
	Other than outlier payments		0	0	1
	Outlier payments		0	Ü	
	Program capital payments		0		24. 00
	Capital exception payments (see instructions)		0		25. 00
	Routine and Ancillary service other pass through costs		0	0	
	Subtotal (sum of lines 22 through 26)		0	0	
28. 00	Customary charges (title V or XIX PPS covered services only)		0	0	
29. 00	Titles V or XIX (sum of lines 21 and 27)		0	0	29. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		1		
	Excess of reasonable cost (from line 18)		0	0	
31. 00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6))	0	0	
32.00	Deducti bl es		0	0	
33.00	Coi nsurance		0	0	33. 00
34.00	Allowable bad debts (see instructions)		0	0	34. 00
35.00	Utilization review		0		35. 00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	d 33)	0	0	36. 00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38.00	Subtotal (line 36 ± line 37)		0	0	38. 00
	Direct graduate medical education payments (from Wkst. E-4)		0		39. 00
	Total amount payable to the provider (sum of lines 38 and 39)		0	0	1
41. 00	Interim payments		0	0	
42. 00	Balance due provider/program (line 40 minus line 41)		o	0	
43. 00	Protested amounts (nonallowable cost report items) in accordan	nce with CMS Pub 15-2	o	0	
	chapter 1, §115.2			O	.5. 55
			1		•

Health Financial Systems	FRANCISCAN HEALTH LAFAYETTE	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Peri od: From 01/01/2021	Worksheet E-3
	Component CCN: 15-T109		
	Title XIX	Subprovi der -	Cost
		I RF	
		Innationt	Outpationt

		II ti e xi x	I RF	COST	
			Inpati ent	Outpati ent	
			1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVIC	FS FOR TITLES V OR XIX		2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES	23 1 31 11 1223 1 31 717	OLIVI OLO		
1. 00	Inpatient hospital/SNF/NF services		0		1.00
2. 00	Medical and other services		J	0	1
3. 00	Organ acquisition (certified transplant centers only)		o	O	3. 00
4. 00	Subtotal (sum of lines 1, 2 and 3)		o	0	4. 00
5. 00	Inpatient primary payer payments		0	Ü	5. 00
6. 00	Outpatient primary payer payments		Ĭ	0	6.00
7. 00	Subtotal (line 4 less sum of lines 5 and 6)		0	0	
7.00	COMPUTATION OF LESSER OF COST OR CHARGES		<u> </u>		7.00
	Reasonable Charges				1
8. 00	Routine service charges		0		8.00
9. 00	Ancillary service charges		o	0	1
10.00	Organ acquisition charges, net of revenue		o		10.00
11. 00	Incentive from target amount computation		o		11.00
12. 00	Total reasonable charges (sum of lines 8 through 11)		o	0	•
	CUSTOMARY CHARGES		,		
13.00	Amount actually collected from patients liable for payment for se	rvices on a charge	0	0	13.00
	basis	3			
14.00	Amounts that would have been realized from patients liable for pa	yment for services on	0	0	14. 00
	a charge basis had such payment been made in accordance with 42 C	FR §413. 13(e)			
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15. 00
16.00	Total customary charges (see instructions)		0	0	16. 00
17.00	Excess of customary charges over reasonable cost (complete only i	fline 16 exceeds	0	0	17. 00
	line 4) (see instructions)				
18. 00	Excess of reasonable cost over customary charges (complete only i	f line 4 exceeds line	0	0	18. 00
	16) (see instructions)				
19. 00	Interns and Residents (see instructions)		0	0	
	Cost of physicians' services in a teaching hospital (see instruct	ions)	0	0	
21. 00	Cost of covered services (enter the lesser of line 4 or line 16)		0	0	21. 00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be com	pleted for PPS provide			
	Other than outlier payments		0	0	
23. 00	Outlier payments		0	0	23. 00
	Program capital payments		0		24.00
25. 00	Capital exception payments (see instructions)		0	0	25. 00
26. 00	Routine and Ancillary service other pass through costs		0	0	
27. 00	Subtotal (sum of lines 22 through 26)		0	0	
28. 00	Customary charges (title V or XIX PPS covered services only)		0	0	1
29. 00	Titles V or XIX (sum of lines 21 and 27)		0	0	29. 00
20.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT				1 20 00
30.00	Excess of reasonable cost (from line 18)		0	0	
31. 00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		0	0	31.00
32. 00	Deducti bl es		0	0	
33. 00	Coinsurance		١	0	1
	Allowable bad debts (see instructions)		0	Ü	34.00
35. 00 36. 00	Utilization review	1	0	0	35. 00
	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY))		0	
	Subtotal (line 36 ± line 37)			0	38.00
	Direct graduate medical education payments (from Wkst. E-4)			U	39.00
40. 00	Total amount payable to the provider (sum of lines 38 and 39)			0	
	Interim payments			0	
41.00	Balance due provider/program (line 40 minus line 41)			0	42.00
43. 00	Protested amounts (nonallowable cost report items) in accordance	with CMS Pub 15-2		0	43.00
73.00	chapter 1, §115.2	w. c.i owo i ub 15-2,	١	U	75.00
			1		1

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

Provi der CCN: 15-0109 Pe Fr

Peri od: From 01/01/2021 To 12/31/2021 Date/Ti me Prepared: 5/2/2022 3:08 pm

Speci fi c Endowment Fund General Fund Plant Fund Purpose Fund 1.00 3.00 4.00 2.00 CURRENT ASSETS 1.00 1.00 Cash on hand in banks 69, 918, 961 0 0 0 0 0 2.00 Temporary investments 0 2.00 3.00 Notes receivable 0 0 0 0 0 3.00 0 4 00 221, 115, 431 4 00 Accounts receivable 0 5.00 Other receivable 0 0 5.00 -164, 687, 618 6.00 Allowances for uncollectible notes and accounts receivable 6.00 0 7.00 Inventory 5, 445, 843 0 0 7.00 0 8.00 Prepaid expenses 3, 813, 055 0 8.00 0 9.00 Other current assets 17, 934, 431 0 9.00 10 00 Due from other funds 3, 212, 226 0 0 0 10 00 Total current assets (sum of lines 1-10) 156, 752, 329 0 0 11.00 0 11 00 FIXED ASSETS 12.00 Land 12, 741, 293 0 0 0 12.00 Land improvements 4, 868, 998 0 13.00 0 0 0 0 0 0 0 0 0 0 0 0 0 13.00 οĺ Accumulated depreciation 14.00 0 14.00 15.00 Bui I di ngs 286, 591, 002 0 0 15.00 0 16.00 Accumulated depreciation -147, 884, 607 16.00 1, 086, 452 0 17.00 Leasehold improvements 17.00 0 0 18 00 Accumulated depreciation 0 18.00 Fi xed equipment 97, 781, 466 19.00 19.00 0 20.00 Accumulated depreciation 0 20.00 0 21.00 Automobiles and trucks 0 21.00 22.00 Accumulated depreciation 0 22.00 23.00 Major movable equipment 10, 221, 723 0 23.00 Accumulated depreciation 24.00 0 24.00 0 25.00 Mi nor equi pment depreci able Λ 25, 00 26.00 Accumulated depreciation C 0 0 26.00 27.00 HIT designated Assets 0 0 0 0 27.00 0 28.00 Accumulated depreciation Ω 0 28.00 0 29.00 Mi nor equi pment-nondepreci abl e 0 29.00 30.00 Total fixed assets (sum of lines 12-29) 265, 406, 328 0 30.00 OTHER ASSETS 31 00 Investments 722, 715 0 n 31 00 0 0 32.00 Deposits on Leases 0 32.00 Due from owners/officers 10, 954, 167 0 0 0 33.00 33.00 0 34.00 Other assets 26, 489, 988 0 0 34.00 0 Total other assets (sum of lines 31-34) 35.00 38, 166, 870 0 35, 00 36.00 Total assets (sum of lines 11, 30, and 35) 460, 325, 527 0 0 0 36.00 CURRENT LIABILITIES 37 00 20, 187, 921 O 0 n 37 00 Accounts payable 0 0 38.00 Salaries, wages, and fees payable 13, 989, 115 0 38.00 0 Payroll taxes payable 33, 494, 501 0 39.00 39.00 0 Notes and Loans payable (short term) 488, 010 0 40.00 40.00 0 0 Deferred income 41 00 41 00 C 0 42.00 Accelerated payments C 42.00 43.00 Due to other funds 0 0 0 43.00 Other current liabilities 0 0 44.00 -766, 536 0 44.00 Total current liabilities (sum of lines 37 thru 44) 0 0 45.00 67, 393, 011 0 45.00 ONG TERM LIABILITIES 46.00 Mortgage payable 2, 554, 934 0 46.00 0 0 47.00 Notes payable 9, 655, 955 0 47.00 48 00 Unsecured Loans 846, 602 0 0 0 48 00 Other long term liabilities -29, 602, 919 0 0 49.00 49.00 0 50 00 Total long term liabilities (sum of lines 46 thru 49) -16, 545, 428 0 0 0 50.00 50, 847, 583 Total liabilities (sum of lines 45 and 50) 51.00 0 0 0 51.00 CAPITAL ACCOUNTS General fund balance 52.00 409, 477, 944 52.00 53.00 Specific purpose fund 0 53.00 Donor created - endowment fund balance - restricted Donor created - endowment fund balance - unrestricted 54.00 0 54.00 55.00 0 55.00 56.00 Governing body created - endowment fund balance 0 56.00 Plant fund balance - invested in plant Plant fund balance - reserve for plant improvement, 57.00 0 57.00 58.00 0 58.00 replacement, and expansion 59.00 Total fund balances (sum of lines 52 thru 58) 409, 477, 944 0 59.00 60.00 Total liabilities and fund balances (sum of lines 51 and 460, 325, 527 0 0 0 60.00

Provider CCN: 15-0109

					То	12/31/2021	Date/Time Pre 5/2/2022 3:08	
		General	Fund	Speci al	Purp	oose Fund	Endowment Fund	
		1.00	2.00	3.00		4. 00	5. 00	
1. 00 2. 00 3. 00 4. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	0	358, 000, 416 52, 238, 409 410, 238, 825		0	0	0	1. 00 2. 00 3. 00 4. 00
5. 00 6. 00 7. 00 8. 00 9. 00		0 0			0 0 0		0 0 0	5. 00 6. 00 7. 00 8. 00 9. 00
10. 00 11. 00 12. 00 13. 00 14. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)	0	0 410, 238, 825		0	0	0 0	10. 00 11. 00 12. 00 13. 00
15. 00 16. 00 17. 00 18. 00	Total deductions (sum of lines 12-17)	0 0	0		0 0	0	0 0	15. 00 16. 00 17. 00 18. 00
19. 00	Fund balance at end of period per balance sheet (line 11 minus line 18)		410, 238, 825			0		19. 00
		Endowment Fund	PI ant	Fund			,	
		6.00	7. 00	8. 00				
1. 00 2. 00 3. 00 4. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	0	0	3.00	0			1. 00 2. 00 3. 00 4. 00
5. 00 6. 00 7. 00 8. 00 9. 00			0 0 0 0					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	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)	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	Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0			0			18. 00 19. 00

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

			10) 12/31/2021	5/2/2022 3:08	
	Cost Center Description	Inpat	ient	Outpati ent	Total	
	'	1.0		2. 00	3. 00	
	PART I - PATIENT REVENUES	<u> </u>				
	General Inpatient Routine Services					
1.00	Hospi tal	649,	177, 250		649, 177, 250	1.00
2.00	SUBPROVI DER - I PF					2.00
3.00	SUBPROVI DER - I RF		0		o	3.00
4.00	SUBPROVI DER					4.00
5.00	Swing bed - SNF		0		ol	5. 00
6.00	Swing bed - NF		0		o	6. 00
7.00	SKILLED NURSING FACILITY					7. 00
8.00	NURSING FACILITY					8. 00
9. 00	OTHER LONG TERM CARE					9. 00
10.00	Total general inpatient care services (sum of lines 1-9)	649.	177, 250		649, 177, 250	
	Intensive Care Type Inpatient Hospital Services		,		0.11, 111, 200	
11. 00	INTENSIVE CARE UNIT		0		0	11.00
12. 00	CORONARY CARE UNIT				-	12. 00
13. 00	BURN INTENSIVE CARE UNIT					13. 00
14. 00	SURGI CAL INTENSIVE CARE UNIT					14. 00
15. 00	NEONATAL INTENSIVE CARE UNIT		0		0	
16. 00	Total intensive care type inpatient hospital services (sum of	Lines	0		ő	16. 00
10.00	11-15)	Times	J		ĭ	10.00
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	649	177, 250		649, 177, 250	17 00
18. 00	Ancillary services	017,	0	0	017, 177, 200	18. 00
19. 00	Outpati ent servi ces		0	865, 743, 354	865, 743, 354	19. 00
20. 00	RURAL HEALTH CLINIC		0	000, 7 10, 00 1	0	20. 00
21. 00	FEDERALLY QUALIFIED HEALTH CENTER		0	0	ő	21. 00
22. 00	HOME HEALTH AGENCY		J	0	ő	22. 00
23. 00	AMBULANCE SERVICES		0	0	0	23. 00
24. 00	CMHC		J	J	Ĭ	24. 00
25. 00	AMBULATORY SURGICAL CENTER (D. P.)					25. 00
26. 00	HOSPI CE		0	0	0	26. 00
27. 00	OTHER (SPECIFY)		0	0	0	27. 00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3	to Wkst 640	177, 250	865 743 354	1, 514, 920, 604	28. 00
20.00	G-3, line 1)	10 WK31. 047,	177, 230	003, 743, 334	1, 314, 720, 004	20.00
	PART II - OPERATING EXPENSES					
29. 00	Operating expenses (per Wkst. A, column 3, line 200)			351, 225, 349		29. 00
30.00	ADD (SPECIFY)		0	001/220/01/		30. 00
31. 00	(SI ESTITY)		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)		J	0		36. 00
37. 00	DEDUCT (SPECIFY)		0	J		37. 00
38. 00	DEBOOT (SECOTT)		0			38. 00
39. 00			0		ŀ	39. 00
40.00			0			40. 00
41.00			0			41. 00
42.00	Total deductions (sum of lines 37-41)		U	Λ		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer		351, 225, 349		43. 00
10.00	to Wkst. G-3, line 4)	, (21 01131 01		331, 223, 347		10.00
	1	1	1		Į.	

Heal th	Financial Systems FRANCISCAN HEAL	ΤΗ ΙΔΕΔΥΕΤΤΕ	In lie	u of Form CMS-2	2552_10
	MENT OF REVENUES AND EXPENSES	Provi der CCN: 15-0109	Peri od:	Worksheet G-3	
			From 01/01/2021 To 12/31/2021	Date/Time Prep 5/2/2022 3:08	
				1. 00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, Ii			1, 514, 920, 604	
2.00	Less contractual allowances and discounts on patients' accounts	unts		1, 134, 688, 954	•
3.00	Net patient revenues (line 1 minus line 2)			380, 231, 650	
4.00	Less total operating expenses (from Wkst. G-2, Part II, line	e 43)		351, 225, 349	
5.00	Net income from service to patients (line 3 minus line 4)			29, 006, 301	5. 00
	OTHER I NCOME				
6.00	Contributions, donations, bequests, etc			0	
7.00	Income from investments			280, 007	
8. 00	Revenues from telephone and other miscellaneous communication	on services		0	
9.00	Revenue from television and radio service			0	
10. 00	Purchase di scounts			0	
11. 00	Rebates and refunds of expenses			0	11. 00
12.00	Parking Lot receipts			0	12.00
13.00	Revenue from Laundry and Linen service			0	
14.00	Revenue from meals sold to employees and guests			0	
15. 00	Revenue from rental of living quarters			0	15. 00
16.00	Revenue from sale of medical and surgical supplies to other	than patients		0	16. 00
17. 00	Revenue from sale of drugs to other than patients			0	17.00
18. 00	Revenue from sale of medical records and abstracts			0	18. 00
19. 00	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19. 00
20.00	Revenue from gifts, flowers, coffee shops, and canteen			0	20. 00
21.00	Rental of vending machines			0	21. 00
22.00	Rental of hospital space			0	22. 00
23.00	Governmental appropriations			o	23. 00
24.00	OTHER REVENUE			11, 186, 721	24. 00
24. 50	COVI D-19 PHE Fundi ng			11, 765, 380	24. 50
25.00	Total other income (sum of lines 6-24)			23, 232, 108	25. 00
26.00	Total (line 5 plus line 25)			52, 238, 409	26. 00
27. 00	OTHER EXPENSES (SPECIFY)			0	27. 00
28. 00	Total other expenses (sum of line 27 and subscripts)			0	28. 00
	Net income (or loss) for the period (line 26 minus line 28)			52, 238, 409	29. 00
					•

4, 425, 223

-1, 403

4, 423, 820

24.00

24.00 Total (sum of lines 1-23)

Heal th	Financial Systems		FRANCISCAN HEAL	TH LAFAYETTE		In Lie	eu of Form CMS-:	2552-10
	LLOCATION - HHA GENERAL SERVICE				CN: 15-0109	Peri od:	Worksheet H-1	
				HHA CCN:	15-7124	From 01/01/2021 To 12/31/2021	Part I Date/Time Pre	pared:
						Home Health	5/2/2022 3: 08 PPS	pm
						Agency I	113	
			Capital Rela	ated Costs				
		Net Expenses	BI dgs &	Movabl e	PI ant	Transportati on		
		for Cost Allocation	Fixtures	Equi pment	Operation 8		(cols. 0-4)	
		(from Wkst. H,			war rrecharice			
		col . 10) 0	1.00	2. 00	3.00	4. 00	4A. 00	
	GENERAL SERVICE COST CENTERS	0	1.00	2.00	3.00	4.00	1 4A. 00	
1.00	Capital Related - Bldg. & Fixtures	0	0				0	1. 00
2.00	Capital Related - Movable	0		(О	2. 00
3. 00	Equipment Plant Operation & Maintenance	36, 313	0	(36, 3	12	,	3. 00
4.00	Transportation	0	ő	(1	0 0		4. 00
5.00	Administrative and General	1, 177, 376	0	(36, 3	13 0	1, 213, 689	5. 00
6. 00	HHA REIMBURSABLE SERVICES Skilled Nursing Care	1, 479, 788	O	(0 0	1, 479, 788	6.00
7.00	Physi cal Therapy	897, 590	0	(1	0 0	897, 590	1
8. 00 9. 00	Occupational Therapy Speech Pathology	312, 164 92, 724	0	(0 0	312, 164 92, 724	1
10.00	Medical Social Services	300, 306	ő	(0 0	300, 306	1
11.00	Home Heal th Ai de	32, 856	0	(0 0	32, 856	1
12. 00 13. 00	Supplies (see instructions) Drugs	47, 939 46, 088	0	(1	0 0	47, 939 46, 088	1
14. 00	DME	0	0	(0 0	1	1
15. 00	HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services	0	ol	(ol .	0 0	0	15. 00
16. 00	Respiratory Therapy	o o	Ö	(1	0 0	Ö	
17. 00 18. 00	Private Duty Nursing Clinic	0	0	(0 0	0	
19. 00	Health Promotion Activities	0	0	(0 0	0	1
20.00	Day Care Program	0	0	(0 0	0	
21. 00 22. 00	Home Delivered Meals Program Homemaker Service	0	0	()	0 0	0 0	
23. 00	All Others (specify)	676	O	(0 0	676	23. 00
23. 50	Telemedicine Total (sum of lines 1-23)	0 4, 423, 820	0	(1	0 13	0 4, 423, 820	
21.00	Trotal (Sam of Trines 1 20)	Admi ni strati ve			<u>, </u>	10 0	1, 120, 020	21.00
		& General 5.00	4A + 5) 6.00					-
	GENERAL SERVICE COST CENTERS	3.00	0.00					
1.00	Capital Related - Bldg. &							1. 00
2.00	Fixtures Capital Related - Movable							2. 00
2 00	Equi pment							2.00
3. 00 4. 00	Plant Operation & Maintenance Transportation							3. 00 4. 00
5.00	Administrative and General	1, 213, 689						5. 00
6. 00	HHA REIMBURSABLE SERVICES Skilled Nursing Care	559, 479	2, 039, 267					6.00
7.00	Physical Therapy	339, 362	1, 236, 952					7. 00
8. 00 9. 00	Occupational Therapy Speech Pathology	118, 023 35, 057	430, 187 127, 781					8. 00 9. 00
10.00	Medical Social Services	113, 540	413, 846					10. 00
11.00	Home Heal th Ai de	12, 422	45, 278					11. 00
12. 00 13. 00	Supplies (see instructions) Drugs	18, 125 17, 425	66, 064 63, 513					12. 00 13. 00
14. 00		0	0					14. 00
15. 00	HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services	0	0					15. 00
16. 00	Respi ratory Therapy	0	0					16. 00
17. 00 18. 00	Private Duty Nursing Clinic	0	0					17. 00 18. 00
19. 00		0	О					19. 00
20.00	Day Care Program	0	0					20.00
21.00	Home Delivered Meals Program Homemaker Service	0	0					21. 00 22. 00
23. 00	All Others (specify)	256	932					23. 00
23. 50 24. 00	Telemedicine Total (sum of lines 1-23)	0	0 4, 423, 820					23. 50 24. 00
55			.,3, 320					55

	Financial Systems LLOCATION - HHA STATISTICAL BAS		FRANCISCAN HEAL		ON 15 0100	In Li	eu of Form CMS-2	
CUST A	LLUCATION - HHA STATISTICAL BAS	01.5		Provi der Co	UN: 15-0109	From 01/01/2021	Worksheet H-1	
				HHA CCN:	15-7124	To 12/31/2021		
						Home Health Agency I	PPS	
		Capital Re	lated Costs					
		DI I o		D 1 1				
		Bl dgs & Fixtures	Movable Equipment	Plant Operation &	(MI LEAGE)	on Reconciliation	& General	
			(DOLLAR VALUE)	Mai ntenance	(WILLEAGE)		(ACCUM. COST)	
		(SQUARE FEET)	(DOLLAR VALUE)	(SQUARE FEET)			(ACCOM. COST)	
		1.00	2.00	3.00	4.00	5A. 00	5. 00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. &	7, 871				(1. 00
	Fixtures							
2.00	Capital Related - Movable		7, 871			(2. 00
	Equi pment	_	_					
3.00	Plant Operation & Maintenance	0	0	7, 871		()	3.00
4.00	Transportation (see instructions)	0	0	0		0		4. 00
5. 00	Administrative and General	7, 871	7, 871	7, 871		0 -1, 213, 689	3, 210, 131	5. 00
3.00	HHA REIMBURSABLE SERVICES	7,071	7,071	7,071		0 -1,213,00	7 3, 210, 131	3.00
6.00	Skilled Nursing Care	0	0	0		0 (1, 479, 788	6.00
7. 00	Physical Therapy	Ö		0	1	0	1	
8.00	Occupational Therapy	0	0	0		0	312, 164	1
9.00	Speech Pathology	0	0	0		0	92, 724	9. 00
10.00	Medical Social Services	0	0	0		0 (300, 306	10. 00
11.00	Home Health Aide	0	0	0		0 (32, 856	11. 00
12.00	Supplies (see instructions)	0	0	0		0	47, 939	
13.00	Drugs	0		0		(13. 00
14.00	DME	0	0	0		0 (0	14. 00
15 00	HHA NONREI MBURSABLE SERVI CES	0	1 0	0	ı	0 (0	15 00
15. 00 16. 00	Home Dialysis Aide Services Respiratory Therapy			0			1	
17. 00	Private Duty Nursing		0	0				
18.00	Clinic		0	0				
19. 00	Health Promotion Activities		0	0				
20.00	Day Care Program		0	0				1
21.00	Home Delivered Meals Program	1 0	0	0		0		
22. 00	Homemaker Service	ĺ	Ö	Ö		0	ol o	
23. 00	All Others (specify)	0	0	Ō		0	676	
23. 50	Tel emedi ci ne	0	0	0		0	0	23. 50
24.00	Total (sum of lines 1-23)	7, 871	7, 871	7, 871		0 -1, 213, 689	3, 210, 131	24. 00
25. 00	Cost To Be Allocated (per	0	0	36, 313		0	1, 213, 689	25. 00
	Worksheet H-1, Part I)							
	Unit Cost Multiplier	0. 000000	0. 000000	4. 613518	0.0000		0. 378081	

Worksheet H-2 Part I Date/Time Prepared: 5/2/2022 3:08 pm From 01/01/2021 To 12/31/2021 HHA CCN: 15-7124 Home Health

						Agency I	PPS	
			CAPITAL REL	ATED COSTS		Agency 1		
	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 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 19. 50 20. 00 21. 00	Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus	0 2, 039, 267 1, 236, 952 430, 187 127, 781 413, 846 45, 278 66, 064 63, 513 0 0 0 0 0 0 0 0 0 0 0 0 0 0 4, 423, 820	98, 535 0 0 0 0 0 0 0 0 0 0 0 0 0	266, 994 266, 994 0 0 0 0 0 0 0 0 0 0 0 0 0	982, 606 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0	215, 170 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 19. 50
	column 26, line 1, rounded to 6 decimal places. Cost Center Description	PURCHASI NG	ADMI TTI NG	PATI ENT ACCOUNTI NG	Subtotal	OTHER ADMI NI STRATI VE	OPERATION OF PLANT	
		F 02	F 04		FA 0F	AND GENERAL		
1 00	Administrative and Constal	5. 03	5. 04	5. 05	5A. 05	5. 06	7. 00	1 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 17. 00 18. 00 19. 50 20. 00 21. 00	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.	000000000000000000000000000000000000000	28 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	16, 187	63, 513 0 0 0 0 0 0 0 0 0 932	333, 770 430, 919 261, 382 90, 903 27, 002 87, 450 9, 568 13, 960 13, 421 0 0 0 0 0 0 0 1977 0 1, 268, 572	252, 502 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 50

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

						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	
		8. 00	9. 00	10.00	11.00	13. 00	14. 00	
1.00	Administrative and General	0	105, 086	0	75, 62	7 254, 062	0	1. 00
2.00	Skilled Nursing Care	0	0	0		0	0	2.00
3.00	Physi cal Therapy	0	0	0		0	0	3. 00
4.00	Occupational Therapy	0	0	0	1	0	0	4. 00
5.00	Speech Pathology	0	0	0		0	0	5. 00
6.00	Medical Social Services	0	0	0		0	0	6. 00
7. 00 8. 00	Home Health Aide Supplies (see instructions)	0	0	0		0 0	0	7. 00 8. 00
9. 00	Drugs	0	0	0			0	9. 00
10. 00	DME	0	0	0			0	10. 00
11. 00	Home Dialysis Aide Services	0	0	0			o o	11. 00
12. 00	Respiratory Therapy	l o	0	0		0	o	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	1	0	0	17. 00
18.00	Homemaker Service	0	0	0	1	0	0	18.00
19.00	All Others (specify)	0	0	0		0	0	19. 00
19. 50 20. 00	Telemedicine Total (sum of lines 1-19) (2)	0	105.094	0	75, 62	7 254 042	0	19. 50 20. 00
21. 00	Unit Cost Multiplier: column	U	105, 086	U	75, 62	254, 062	l	21. 00
21.00	26, line 1 divided by the sum							21.00
	of column 26, line 20 minus							
	column 26, line 1, rounded to							
	6 decimal places.							
	Cost Center Description	PHARMACY	MEDICAL RECORDS &	SOCIAL SERVICE	NURSI NG PROGRAM	PHARMACY RESI DENCY	EMS EDUCATION	
			LI BRARY					
1.00		15. 00	16.00	17. 00	20.00	23. 00	23. 01	1 00
1. 00 2. 00	Administrative and General Skilled Nursing Care	0	18, 288 0	0		0	0	1. 00 2. 00
3. 00	Physical Therapy	0	0	0			0	3. 00
4. 00	Occupational Therapy	0	0	0			Ö	4. 00
5.00	Speech Pathology	0	0	0		0	0	5.00
6.00	Medical Social Services	0	0	0		0	0	6.00
7.00	Home Health Aide	0	0	0		0	0	7. 00
8. 00	Supplies (see instructions)	0	0	0	1	0	0	8. 00
9.00	Drugs	0	0	0	1	0	0	9. 00
10.00	DME	0	0	0		0	0	10.00
11. 00 12. 00	Home Dialysis Aide Services Respiratory Therapy	0	0	0			0	11. 00 12. 00
13. 00	Pri vate Duty Nursing	0	0	0			0	13. 00
14. 00	Clinic	0	0	0			Ö	14. 00
15. 00	Health Promotion Activities	0	0	0		o o	o o	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			0	0		0	0	18.00
	Homemaker Service		o o					
19. 00	All Others (specify)	o o	0	0	1	0	0	19. 00
19. 50	All Others (specify) Telemedicine	0	0	0		0 0	0	19. 50
19. 50 20. 00	All Others (specify) Telemedicine Total (sum of lines 1-19) (2)	0 0	0 0 18, 288	0 0 0		0 0		19. 50 20. 00
19. 50	All Others (specify) Telemedicine Total (sum of lines 1-19) (2) Unit Cost Multiplier: column	0 0	-	0 0 0		0 0	0	19. 50
19. 50 20. 00	All Others (specify) Telemedicine Total (sum of lines 1-19) (2)	0 0	-	0 0 0		0 0	0	19. 50 20. 00
19. 50 20. 00	All Others (specify) Telemedicine Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum	0 0	-	0 0		0 0	0	19. 50 20. 00
19. 50 20. 00	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	0 0 0	-	0 0 0		0 0	0	19. 50 20. 00

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

Health Financial Systems		FRANCISCAN HEAL	TH LAFAYETTE		In Lie	u of Form CMS-:	2552-10
ALLOCATION OF GENERAL SERVICE COSTS T	O HHA COST CEN	TERS	Provi der CO	CN: 15-0109	Peri od:	Worksheet H-2	
					From 01/01/2021	Part I	
			HHA CCN:	15-7124	To 12/31/2021	Date/Time Pre	
						5/2/2022 3:08	pm
					Home Health	PPS	
					Agency I		
Cost Center Description	Subtotal	Intern &	Subtotal	Allocated HHA			
		Residents Cost		A&G (see Part	Costs		
		& Post		11)			
		Stepdown					
		Adjustments					
	24. 00	25. 00	26. 00	27. 00	28. 00		
1.00 Administrative and General	2, 618, 855		2, 618, 855				1.00
2.00 Skilled Nursing Care	2, 470, 186	0	2, 470, 186	1, 207, 22	5 3, 677, 411		2. 00
3.00 Physical Therapy	1, 498, 334	0	1, 498, 334	732, 26	3 2, 230, 597		3. 00
4.00 Occupational Therapy	521, 090	0	521, 090	254, 66	6 775, 756		4. 00
5.00 Speech Pathology	154, 783	0	154, 783	75, 64	5 230, 428		5. 00
6.00 Medical Social Services	501, 296	0	501, 296	244, 99	2 746, 288		6. 00
7.00 Home Health Aide	54, 846	О	54, 846	26, 80	4 81, 650		7. 00
8.00 Supplies (see instructions)	80, 024	0	80, 024	39, 10	9 119, 133		8. 00
9. 00 Drugs	76, 934	0	76, 934	37, 59	9 114, 533		9.00
10. 00 DME	0	0	0	·	ol o		10.00
11.00 Home Dialysis Aide Services	0	0	0		0		11.00
12.00 Respiratory Therapy	0	0	0		0		12. 00
13.00 Private Duty Nursing	0	0	0		0		13. 00
14. 00 Clinic	0	0	0		0		14. 00
15.00 Health Promotion Activities	0	0	0		0		15. 00
16.00 Day Care Program	١	0	0				16. 00
17.00 Home Delivered Meals Program	١	0	0				17. 00
18.00 Homemaker Service	0	0	0		0		18. 00
19.00 All Others (specify)	1, 129	0	1, 129	55	2 1, 681		19.00
19. 50 Tel emedi ci ne	1, 127	0	1, 127	33	1,001		19. 50
20. 00 Total (sum of lines 1-19) (2)	7, 977, 477		7, 977, 477	2, 618, 85	5 7, 977, 477		20.00
21.00 Unit Cost Multiplier: column	1,711,411	U	1, 711, 411	0. 48871			21.00
				0.400/1	0		21.00
26, line 1 divided by the sum							
of column 26, line 20 minus							
column 26, line 1, rounded to						I	
6 decimal places.	l						I

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

Health Financial Systems	FRANCISCAN HEALTH	LAFAYETTE		In Lie	u of Form CMS-2552-10
ALLOCATION OF GENERAL SERVICE COSTS T	O HHA COST CENTERS STATISTICAL	Provider CCN:	15-0109	Peri od: From 01/01/2021	Worksheet H-2 Part II
B/G/G		HHA CCN:	15-7124	To 12/31/2021	Date/Time Prepared: 5/2/2022 3:08 pm
				Home Health Agency I	PPS
	CAPITAL RELATED COSTS				

						Home Health Agency I	PPS	
		CAPITAL REL	ATED COSTS			rigeriey		
	Cost Center Description	BLDG & FLXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT	COMMUNICATIONS (PHONE LINE S)	MGMT INFO SYSTEMS (MANHOURS)	PURCHASING (COSTED REQ UISI)	
				(GROSS SALARI ES)				
		1.00	2.00	4.00	5. 01	5. 02	5. 03	
1.00	Administrative and General	7, 871	7, 871	4, 011, 177			0	1. 00
2.00	Skilled Nursing Care	0	0	0	0	_	0	2.00
3. 00 4. 00	Physical Therapy Occupational Therapy	0	0	0	0	0	0	3. 00 4. 00
5. 00	Speech Pathology	0	0	0	0	0	o	5. 00
6. 00	Medical Social Services	l o	Ö	0	ő	0	o	6. 00
7.00	Home Health Aide	0	0	0	0	0	0	7. 00
8.00	Supplies (see instructions)	0	0	0	0	_	_	8. 00
9.00	Drugs	0	0	0	0	0		9. 00
10. 00 11. 00	DME Home Dialysis Aide Services	0	0	0	0	0	0	10. 00 11. 00
12.00	Respiratory Therapy		0	0		_		12.00
13. 00	Private Duty Nursing	0	Ö	Ö	ő	0	Ö	13. 00
14. 00	Clinic	0	0	O	0	0	0	14. 00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16. 00	Day Care Program	0	0	0	0	0	0	16.00
17. 00	Home Delivered Meals Program	0	0	0	0	0	0	17. 00
18. 00 19. 00	Homemaker Service All Others (specify)	0	0	0	0	0	0	18. 00 19. 00
19. 50	Tel emedi ci ne		0	0	0	0	0	19. 50
20. 00	Total (sum of lines 1-19)	7, 871	7, 871	4, 011, 177	o o	76, 711	o	20. 00
21. 00	Total cost to be allocated	98, 535	266, 994	982, 606	1	215, 170	0	21.00
22. 00	Unit cost multiplier	12. 518740	33. 921230	0. 244967				22. 00
	Cost Center Description	ADMITTING (GROSS CHAR	PATI ENT ACCOUNTI NG	Reconciliation	OTHER ADMI NI STRATI VE	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
		GES)	(GROSS CHAR		AND GENERAL	(SQUARE FEET)		
		/					I (POUNDS OF I	
			GES)		(ACCUM. COST)		(POUNDS OF LAUNDRY)	
		5. 04	5. 05	5A. 06	5. 06	7. 00	LAUNDRY) 8. 00	
1.00	Administrative and General	5. 04 9, 254, 945		C	5. 06 1, 579, 520	7, 871	LAUNDRY) 8. 00 0	1. 00
2.00	Skilled Nursing Care		5. 05		5. 06 1, 579, 520 2, 039, 267	7, 871 0	LAUNDRY) 8.00 0	2.00
2. 00 3. 00	Skilled Nursing Care Physical Therapy		5. 05	C	5. 06 1, 579, 520 2, 039, 267 1, 236, 952	7, 871	8. 00 0 0 0	2. 00 3. 00
2.00	Skilled Nursing Care Physical Therapy Occupational Therapy		5. 05	C	5. 06 1, 579, 520 2, 039, 267 1, 236, 952 430, 187	7, 871 0	LAUNDRY) 8.00 0 0 0 0 0	2.00
2.00 3.00 4.00	Skilled Nursing Care Physical Therapy		5. 05	C	5. 06 1, 579, 520 2, 039, 267 1, 236, 952	7, 871 0 0 0 0	8.00 0 0 0 0 0	2. 00 3. 00 4. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide		5. 05	C	5. 06 1, 579, 520 2, 039, 267 1, 236, 952 430, 187 127, 781 413, 846 45, 278	7, 871 0 0 0 0 0 0	8.00 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions)		5. 05	C	5. 06 1, 579, 520 2, 039, 267 1, 236, 952 430, 187 127, 781 413, 846 45, 278 66, 064	7, 871 0 0 0 0 0 0 0	8.00 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs		5. 05	C	5. 06 1, 579, 520 2, 039, 267 1, 236, 952 430, 187 127, 781 413, 846 45, 278 66, 064 63, 513	7, 871 0 0 0 0 0 0 0	8.00 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
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME		5. 05	C	5. 06 1, 579, 520 2, 039, 267 1, 236, 952 430, 187 127, 781 413, 846 45, 278 66, 064	7, 871 0 0 0 0 0 0 0 0	8.00 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
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services		5. 05	C	5. 06 1, 579, 520 2, 039, 267 1, 236, 952 430, 187 127, 781 413, 846 45, 278 66, 064 63, 513	7, 871 0 0 0 0 0 0 0	8.00 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
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME		5. 05	C	5. 06 1, 579, 520 2, 039, 267 1, 236, 952 430, 187 127, 781 413, 846 45, 278 66, 064 63, 513	7, 871 0 0 0 0 0 0 0 0 0	8.00 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
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00	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		5. 05	C	5. 06 1, 579, 520 2, 039, 267 1, 236, 952 430, 187 127, 781 413, 846 45, 278 66, 064 63, 513	7, 871 0 0 0 0 0 0 0 0 0	8.00 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
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	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		5. 05	C	5. 06 1, 579, 520 2, 039, 267 1, 236, 952 430, 187 127, 781 413, 846 45, 278 66, 064 63, 513 0 0 0 0 0	7, 871 0 0 0 0 0 0 0 0 0 0	B. 00 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
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	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		5. 05	C	5. 06 1, 579, 520 2, 039, 267 1, 236, 952 430, 187 127, 781 413, 846 45, 278 66, 064 63, 513 0 0 0 0 0 0	7, 871 0 0 0 0 0 0 0 0 0 0	B. 00 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
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00	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		5. 05	C	5. 06 1, 579, 520 2, 039, 267 1, 236, 952 430, 187 127, 781 413, 846 45, 278 66, 064 63, 513 0 0 0 0 0 0 0	7, 871 0 0 0 0 0 0 0 0 0 0	LAUNDRY) 8.00 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00
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	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		5. 05	C	5. 06 1, 579, 520 2, 039, 267 1, 236, 952 430, 187 127, 781 413, 846 45, 278 66, 064 63, 513 0 0 0 0	7, 871 0 0 0 0 0 0 0 0 0 0	B. 00 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00	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		5. 05	C	5. 06 1, 579, 520 2, 039, 267 1, 236, 952 430, 187 127, 781 413, 846 45, 278 66, 064 63, 513 0 0 0 0 0 0 0	7, 871 0 0 0 0 0 0 0 0 0 0	B. 00 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 19. 50 20. 00	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)		5. 05 9, 254, 945 0 0 0 0 0 0 0 0 0 0 0 0 0	C	5. 06 1, 579, 520 2, 039, 267 1, 236, 952 430, 187 127, 781 413, 846 45, 278 66, 064 63, 513 0 0 0 0 0 0 0 0 932 0 6, 003, 340	7, 871 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	B. 00 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 19. 50 20. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 50 20. 00 21. 00	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	9, 254, 945 0 0 0 0 0 0 0 0 0 0 0 0 0 0	5. 05 9, 254, 945 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	C	5. 06 1, 579, 520 2, 039, 267 1, 236, 952 430, 187 127, 781 413, 846 45, 278 66, 064 63, 513 0 0 0 0 0 0 0 932	7, 871 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	LAUNDRY) 8.00 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 14. 00 15. 00 16. 00 17. 00 18. 00 19. 50 20. 00 21. 00

				HHA CCN:	15-7124 T	o 12/31/2021	Date/Time Prep 5/2/2022 3:08	pared: pm
						Home Health	PPS	
						Agency I		
	Cost Center Description	HOUSEKEEPI NG	DIETARY	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	
		(SQUARE FEET)	(MEALS SERVED)	(MANHOURS)	ADMI NI STRATI ON	SERVICES &	(COSTED	
					(DI RECT NRS	SUPPLY (COSTED REQ	REQUIS.)	
					I NG)	UISI)		
		9. 00	10.00	11. 00	13.00	14. 00	15. 00	
1.00	Administrative and General	7, 871	0	76, 711	76, 711	0	0	1. 00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physi cal Therapy	0	0	0	0	0	0	3. 00
4.00	Occupational Therapy	0	0	0	0	0	0	4. 00
5.00	Speech Pathology	0	0	0	0	0	0	5. 00
6. 00	Medical Social Services	0	0	0	0	0	0	6. 00
7.00	Home Health Aide	0	0	0	0	0	0	7. 00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8. 00
9.00	Drugs	0	0	0	0	0	0	9.00
10. 00 11. 00	DME Home Dialysis Aide Services	0	0	0		0	0	10. 00 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	l ő	0	0		0	Ö	15. 00
16. 00	Day Care Program	0	o	0	o o	0	0	16. 00
17. 00	Home Delivered Meals Program	0	0	0	o o	0	0	17. 00
18.00	Homemaker Service	0	0	0	0	0	0	18. 00
19.00	All Others (specify)	0	0	0	0	0	0	19. 00
19. 50	Tel emedi ci ne	0	0	0	0	0	0	19. 50
20.00	Total (sum of lines 1-19)	7, 871	0	76, 711	76, 711	0	0	20.00
21. 00	Total cost to be allocated	105, 086	0	75, 627		0	0	21. 00
22. 00	Unit cost multiplier	13. 351035	0. 000000	0. 985869		0. 000000	0. 000000	22. 00
	Cost Center Description		SOCIAL SERVICE	NURSI NG	PHARMACY	EMS EDUCATION		
		RECORDS & LI BRARY	(TIME SPENT)	PROGRAM (ASSI GNED	RESI DENCY (ASSI GNED	(ASSIGNED TIME)		
		(GROSS CHAR	(ITWL SELIVI)	TI ME)	TIME)	IIIWL)		
		GES)		II WIL)	I I WE			
		16. 00	17. 00	20. 00	23.00	23. 01		
1.00	Administrative and General	9, 254, 945	0	0	0	0		1. 00
2.00	Skilled Nursing Care	0	0	0	0	0		2.00
3.00	Physi cal Therapy	0	0	0	0	0		3. 00
4.00	Occupational Therapy	0	0	0	0	0		4. 00
5.00	Speech Pathology	0	0	0	0	0		5. 00
6. 00	Medical Social Services	0	0	0	0	0		6. 00
7.00	Home Health Aide	0	0	0	0	0		7. 00
8.00	Supplies (see instructions)	0	0	0	0	0		8. 00
9.00	Drugs	0	0	0		0		9.00
10. 00 11. 00	DME Home Dialysis Aide Services	0	0	0		0		10. 00 11. 00
12. 00	Respiratory Therapy	0	0	0		0		12.00
13. 00	Private Duty Nursing	0	0	0		0		13. 00
14. 00	Clinic	0	0	0		0		14. 00
15. 00	Health Promotion Activities	0	o	0	o o	0		15. 00
16. 00	Day Care Program	0	Ö	0	Ö	0		16. 00
17. 00	Home Delivered Meals Program	0	o	0	0	o		17. 00
18. 00	Homemaker Service	0	О	0	0	o		18. 00
19. 00	All Others (specify)	0	0	0	0	0		19. 00
19. 50	Tel emedi ci ne	0	0	0	0	0		19. 50
20.00	Total (sum of lines 1-19)	9, 254, 945	0	0	0	0		20.00
21. 00	Total cost to be allocated	18, 288		0	0	0		21. 00
22. 00	Unit cost multiplier	0. 001976	0. 000000	0. 000000	0.000000	0. 000000		22. 00

Heal th	Financial Systems		FRANCISCAN HEAL	TH LAFAYETTE		In Li€	eu of Form CMS-2	2552-10
	IONMENT OF PATIENT SERVICE COST				CCN: 15-0109	Peri od:	Worksheet H-3	
				HHA CCN:	15-7124	From 01/01/2021 To 12/31/2021	Part I Date/Time Prep 5/2/2022 3:08	
				Ti tl	e XVIII	Home Health Agency I	PPS	рііі
	Cost Center Description	From, Wkst.	Facility Costs		Total HHA	Total Visits	Average Cost	
		H-2, Part I,	(from Wkst.	Ancillary	Costs (cols.	1	Per Visit	
		col. 28, line	п-2, Pait I)	Costs (from Part II)	+ 2)		(col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4. 00	5. 00	
	PART I - COMPUTATION OF LESSER	OF AGGREGATE I	PROGRAM COST, A	GGREGATE OF T		MITATION COST, O		
	BENEFICIARY COST LIMITATION							
1 00	Cost Per Visit Computation	2.00	2 (77 411		2 (77 4	11 11, 045	222.05	1. 00
1. 00 2. 00	Skilled Nursing Care Physical Therapy	2. 00 3. 00			3, 677, 4 0 2, 230, 5	,	332. 95 290. 78	2. 00
3.00	Occupational Therapy	4.00			0 775, 7			3. 00
4. 00	Speech Pathology	5. 00	1 ' 1		0 230, 4		l	4. 00
5.00	Medical Social Services	6. 00	746, 288		746, 2	88 340	2, 194. 96	5. 00
6.00	Home Heal th Aide	7. 00			81, 6		l .	6. 00
7. 00	Total (sum of lines 1-6)		7, 742, 130		0 7, 742, 1			7. 00
					Program Visi	art B		
	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Not Subject			
					Deducti bl es			
					Coi nsurance			
		0	1.00	2. 00	3.00	4. 00	5. 00	
8. 00	Limitation Cost Computation Skilled Nursing Care		23844		0 6	33		8. 00
8. 01	Skilled Nursing Care		26900		ol o	5		8. 01
8. 02	Skilled Nursing Care		29200		2, 0			8. 02
8.03	Skilled Nursing Care		33140		o	0		8. 03
8. 04	Skilled Nursing Care		45460		•	26		8. 04
8.05	Skilled Nursing Care		99915		0 2, 2 0 5			8. 05
9. 00 9. 01	Physical Therapy Physical Therapy		23844 26900		0	07 9		9. 00 9. 01
9. 02	Physical Therapy		29200		0 1, 7			9. 02
9. 03	Physical Therapy		33140		o	5		9. 03
9.04	Physi cal Therapy		45460			11		9. 04
9. 05	Physical Therapy		99915		0 1, 5			9. 05
10.00	Occupational Therapy		23844			05		10.00
10. 01 10. 02	Occupational Therapy Occupational Therapy		26900 29200		0 0 6	1 78		10. 01 10. 02
10. 02	Occupational Therapy		33140			1		10. 02
10. 04	Occupational Therapy		45460		ō	4		10. 04
10. 05	Occupational Therapy		99915		•	58		10. 05
11.00	Speech Pathology		23844		•	57		11. 00
11. 01	Speech Pathology Speech Pathology		26900 29200		0 0 1	0		11. 01 11. 02
11. 02 11. 03	Speech Pathology		33140			14 0		11. 02
11. 04	Speech Pathology		45460		ol	0		11. 04
11. 05	Speech Pathology		99915		1	43		11. 05
12.00	Medical Social Services		23844		0	16		12.00
12. 01	Medical Social Services		26900		0	0		12. 01
12. 02	Medical Social Services		29200		•	61		12. 02
12. 03 12. 04	Medical Social Services Medical Social Services		33140 45460		0	0		12. 03 12. 04
12. 04	Medical Social Services		99915		•	55		12. 04
13. 00	Home Heal th Aide		23844			63		13. 00
13. 01	Home Health Aide		26900		o	0		13. 01
13. 02	Home Health Aide		29200			29		13. 02
13. 03	Home Health Aide		33140		0	0		13. 03
13. 04 13. 05	Home Health Aide Home Health Aide		45460 99915		0 0 1	0 24		13. 04 13. 05
	Total (sum of lines 8-13)		7,713		0 10, 8			14. 00
= =		'	1			1	'	

⊣eai th	Financial Systems		FRANCISCAN HEAL	TH LAFAYETTE		In Li	eu of Form CMS-2	2552-10
	TONMENT OF PATIENT SERVICE COST			Provi der C	CN: 15-0109	Peri od:	Worksheet H-3	
				HHA CCN:	15-7124	From 01/01/202 To 12/31/202		
				Ti tl e	× XVIII	Home Health Agency I	PPS	рш
	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	3.00	4. 00	5. 00	
	Supplies and Drugs Cost Comput		1.00	2.00	3.00	4.00	3.00	
15. 00		8. 00		C			0. 000000	
16. 00	Cost of Drugs	9. 00		0		33	0. 000000	16. 00
			Program Visits		Cost of Services			
			Par	t B	J Services	Part B		
	Cost Center Description	Part A	Not Subject to	Subject to	Part A	Not Subject t	Subject to	
			Deductibles &			Deductibles 8		
		/ 00	Coi nsurance	Coi nsurance	0.00	Coi nsurance	Coi nsurance	
	PART I - COMPUTATION OF LESSER	6. 00	7.00 DEPOCEDAM COST A	8.00	9.00	10.00	11.00	
	BENEFICIARY COST LIMITATION	OI AUUNLUATE F	NOUNAM COST, A	SURLUATE OF TH	IL I NOOKAW EIN	WITATION COST, (/IX	
	Cost Per Visit Computation]
1. 00	Skilled Nursing Care	0				0 1, 669, 07		1.00
2.00	Physical Therapy	0				0 1, 094, 20		2.00
3. 00 4. 00	Occupational Therapy Speech Pathology		1, 447 314			0 389, 35 0 118, 61		3. 00 4. 00
4. 00 5. 00	Medical Social Services		132			0 118, 61 0 289, 73		5.00
6. 00	Home Heal th Aide		216		•	0 54, 09		6.00
7. 00	Total (sum of lines 1-6)	Ö	10, 885			0 3, 615, 09		7. 00
	Cost Center Description							
	Transaction of the second	6. 00	7. 00	8. 00	9. 00	10. 00	11. 00	
0.00	Limitation Cost Computation							
8. 00 8. 01	Skilled Nursing Care Skilled Nursing Care							8. 00
8. 02	Skilled Nursing Care							8. 02
8. 03	Skilled Nursing Care							8. 03
8. 04	Skilled Nursing Care							8. 04
8. 05	Skilled Nursing Care							8. 05
9.00	Physical Therapy							9.00
9. 01 9. 02	Physical Therapy Physical Therapy							9. 01 9. 02
9. 02 9. 03	Physical Therapy							9. 03
9. 04	Physical Therapy							9.04
9. 05	Physi cal Therapy							9. 05
10. 00	Occupational Therapy							10.00
10. 01	Occupational Therapy							10.01
10. 02 10. 03	Occupational Therapy Occupational Therapy							10. 02
10. 03	Occupational Therapy							10.04
10. 05	Occupational Therapy							10. 0!
11. 00	Speech Pathology							11.00
11. 01	Speech Pathology							11. 0°
11. 02	1 33							11. 02
11. 03	1 33							11. 0
11. 04	. 03							11.0
1. 05 2. 00	Speech Pathology Medical Social Services							11. 0 12. 0
12. 00	Medical Social Services							12. 0
12. 02	Medical Social Services							12. 0
2. 03	Medical Social Services							12. 0
12. 04	Medical Social Services							12. 0
12. 05								12. 0
13.00	Home Heal th Aide							13.00
13. 01	Home Health Aide							13.0
1.5 U.J	Home Heal th Ai de							13. 02 13. 03
	THOME HEALTH ALGE							
13. 03	Home Heal th Ai de Home Heal th Ai de							
13. 02 13. 03 13. 04 13. 05	Home Health Aide Home Health Aide							13. 0 ² 13. 05

	Financial Systems		FRANCISCAN HEAL		ON 45 0400		eu of Form CMS-	
PPORT	IONMENT OF PATIENT SERVICE COST	S		Provider Co	CN: 15-0109 15-7124	Peri od: From 01/01/2021 To 12/31/2021		
					XVIII	Home Health	5/2/2022 3: 08 PPS	
		_				Agency I	FF3	
		Prog	ram Covered Char	rges	Cost of Services			
			Part			Part B		
	Cost Center Description	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	Not Subject to Deductibles & Coinsurance		
	Constitution and December Control	6.00	7. 00	8. 00	9. 00	10.00	11. 00	
5. 00	Supplies and Drugs Cost Computation Cost of Medical Supplies	0	0	0		0 0) C	15.
5. 00	Cost of Drugs	T	0	0		C	C	16. (
	Cost Center Description	Total Program Cost (sum of cols. 9-10)						
	PART I - COMPUTATION OF LESSER	12.00	PROGRAM COST AG	GREGATE OF TH	F PROGRAM II	MITATION COST O	P	
	BENEFICIARY COST LIMITATION	OF AGGREGATE T	NOONAW COST, AC	JONEONIE OF TH	L I KOOKAWI LI	WITATION COST, O	IX.	
00	Cost Per Visit Computation	1 //0 070	T					1
00	Skilled Nursing Care Physical Therapy	1, 669, 078 1, 094, 205						1. (
00	Occupati onal Therapy	389, 359						3.
00	Speech Pathology	118, 614						4.
00 00	Medical Social Services Home Health Aide	289, 735 54, 099						5. 6.
00	Total (sum of lines 1-6)	3, 615, 090						7.
	Cost Center Description							
	Limitation Cost Computation	12. 00						
00	Skilled Nursing Care							8.
01	Skilled Nursing Care							8.
02 03	Skilled Nursing Care							8.
03 04	Skilled Nursing Care Skilled Nursing Care							8.
05	Skilled Nursing Care							8.
00	Physical Therapy							9.
01 02	Physical Therapy Physical Therapy							9. 9.
03	Physical Therapy							9.
04	Physical Therapy							9.
05 . 00	Physical Therapy Occupational Therapy							9. 10.
. 00	Occupational Therapy							10.
. 02	Occupational Therapy							10.
). 03). 04	Occupational Therapy Occupational Therapy							10.
. 05	Occupational Therapy							10.
. 00	Speech Pathology							11.
. 01	Speech Pathology							11.
. 02 . 03	Speech Pathology Speech Pathology							11.
. 04	Speech Pathology							11.
. 05	Speech Pathology							11.
. 00 . 01	Medical Social Services Medical Social Services							12. 12.
. 02	Medical Social Services							12.
. 03	Medical Social Services							12.
. 04	Medical Social Services							12.
. 05 . 00	Medical Social Services Home Health Aide							12. 13.
. 01	Home Heal th Ai de							13.
. 02	Home Heal th Aide							13.
. 03 . 04	Home Health Aide Home Health Aide							13. 13.
3. 05	Home Heal th Ai de							13.
		1	I .					14.

Heal th	Financial Systems		FRANCISCAN HEAL	TH LAFAYETTE		In Lie	u of Form CMS-2	2552-10
APPORT	TIONMENT OF PATIENT SERVICE COST	S		Provider Co		Peri od:	Worksheet H-3	
				HHA CCN:	15-7124	From 01/01/2021 To 12/31/2021	Part II Date/Time Pre 5/2/2022 3:08	
				Title	Title XVIII Home Health		PPS	
						Agency I		
	Cost Center Description	From Wkst. C,	Cost to Charge	Total HHA	HHA Shared	Transfer to		
		Part I, col.	Rati o	Charge (from	Ancillary	Part I as		
		9, line		provi der	Costs (col.	1 Indicated		
				records)	x col. 2)			
		0	1.00	2.00	3. 00	4. 00		
	PART II - APPORTIONMENT OF COST	T OF HHA SERVIC	ES FURNISHED B	Y SHARED HOSPI	TAL DEPARTMEN	ITS		
1.00	Physical Therapy	66. 00	0. 291298	0		0 col. 2, line 2	. 00	1. 00
2.00	Occupational Therapy	67. 00	0. 182686	0		0 col. 2, line 3	. 00	2. 00
3.00	Speech Pathology	68. 00	0. 202646	0		0 col. 2, line 4	. 00	3. 00
4.00	Cost of Medical Supplies	71. 00	0. 085266	0		0 col. 2, line 1	5. 00	4. 00
5.00	Cost of Drugs	73.00	0. 424496	0		0 col. 2, line 1	6. 00	5. 00
5.01	Cost of Drugs 1	73. 01	102. 014921	0		0 col. 2, line 1	6. 01	5. 01

- COMPUTATION OF THE LESSER OF REASONABLE COST OR CUStable Cost of Part A & Part B Services able cost of services (see instructions) charges ary Charges actually collected from patients liable for payment finances on a charge basis (from your records) that would have been realized from patients liable for revices on a charge basis had such payment been made in 2 CFR §413.13(b) of line 3 to line 4 (not to exceed 1.000000) customary charges (see instructions) of total customary charges over total reasonable cost f line 6 exceeds line 1) of reasonable cost over customary charges (complete ceeds line 6)	TOMARY CHARGES or services r payment accordance (complete	15-7124 XVIII Part A	Not Subject to Deductibles & Coinsurance 2.00	Date/Time Prep 5/2/2022 3:08 PPS Tt B Subject to Deductibles & Coinsurance 3:00 0 0	epare 3 pm
able Cost of Part A & Part B Services able cost of services (see instructions) charges actually collected from patients liable for payment f charge basis (from your records) that would have been realized from patients liable for crvices on a charge basis had such payment been made in 2 CFR §413.13(b) of line 3 to line 4 (not to exceed 1.000000) customary charges (see instructions) of total customary charges over total reasonable cost f line 6 exceeds line 1) of reasonable cost over customary charges (complete coeds line 6)	TOMARY CHARGES or services r payment accordance (complete	Part A 1.00 S	Agency I Par Not Subject to Deductibles & Coinsurance 2.00 0 0 0 0 0 0 0	PPS The Body and the second s	0 1
able Cost of Part A & Part B Services able cost of services (see instructions) charges ary Charges actually collected from patients liable for payment f charge basis (from your records) that would have been realized from patients liable for rivices on a charge basis had such payment been made in 2 CFR §413.13(b) of line 3 to line 4 (not to exceed 1.000000) customary charges (see instructions) of total customary charges over total reasonable cost f line 6 exceeds line 1) of reasonable cost over customary charges (complete coeds line 6)	or services r payment accordance (complete	1.00 S	Par Not Subject to Deductibles & Coinsurance 2.00 0 0 0 0 0 0 0	Subject to Deductibles & Coinsurance 3.00	1 2
able Cost of Part A & Part B Services able cost of services (see instructions) charges ary Charges actually collected from patients liable for payment f charge basis (from your records) that would have been realized from patients liable for rivices on a charge basis had such payment been made in 2 CFR §413.13(b) of line 3 to line 4 (not to exceed 1.000000) customary charges (see instructions) of total customary charges over total reasonable cost f line 6 exceeds line 1) of reasonable cost over customary charges (complete coeds line 6)	or services r payment accordance (complete	1.00 S	Deductibles & Coinsurance 2.00	Deductibles & Coinsurance 3.00	1 2
able Cost of Part A & Part B Services able cost of services (see instructions) charges ary Charges actually collected from patients liable for payment f charge basis (from your records) that would have been realized from patients liable for rivices on a charge basis had such payment been made in 2 CFR §413.13(b) of line 3 to line 4 (not to exceed 1.000000) customary charges (see instructions) of total customary charges over total reasonable cost f line 6 exceeds line 1) of reasonable cost over customary charges (complete coeds line 6)	or services r payment accordance (complete	S	0 0 0 0 0 0	0 0) 2
able Cost of Part A & Part B Services able cost of services (see instructions) charges ary Charges actually collected from patients liable for payment f charge basis (from your records) that would have been realized from patients liable for rivices on a charge basis had such payment been made in 2 CFR §413.13(b) of line 3 to line 4 (not to exceed 1.000000) customary charges (see instructions) of total customary charges over total reasonable cost f line 6 exceeds line 1) of reasonable cost over customary charges (complete coeds line 6)	or services r payment accordance (complete		0 0	0) 2
charges ary Charges actually collected from patients liable for payment findings basis (from your records) that would have been realized from patients liable for rivices on a charge basis had such payment been made in 2 CFR §413.13(b) of line 3 to line 4 (not to exceed 1.000000) customary charges (see instructions) of total customary charges over total reasonable cost fline 6 exceeds line 1) of reasonable cost over customary charges (complete coeds line 6)	r payment accordance (complete	0.0000	0 0	0) 2
ary Charges actually collected from patients liable for payment f harge basis (from your records) that would have been realized from patients liable for rvices on a charge basis had such payment been made in 2 CFR §413.13(b) of line 3 to line 4 (not to exceed 1.000000) customary charges (see instructions) of total customary charges over total reasonable cost f line 6 exceeds line 1) of reasonable cost over customary charges (complete coeds line 6)	r payment accordance (complete	0.0000	0 0	0	
actually collected from patients liable for payment fharge basis (from your records) that would have been realized from patients liable for revices on a charge basis had such payment been made in 2 CFR §413.13(b) of line 3 to line 4 (not to exceed 1.000000) customary charges (see instructions) of total customary charges over total reasonable cost fline 6 exceeds line 1) of reasonable cost over customary charges (complete coeds line 6)	r payment accordance (complete	0. 0000	0 0		3
that would have been realized from patients liable for the control of the control	accordance (complete	0. 0000		0	
2 CFR §413.13(b) of line 3 to line 4 (not to exceed 1.000000) customary charges (see instructions) of total customary charges over total reasonable cost f line 6 exceeds line 1) of reasonable cost over customary charges (complete ceds line 6)	(complete	0. 0000	0. 000000) 4
of line 3 to line 4 (not to exceed 1.000000) customary charges (see instructions) of total customary charges over total reasonable cost fline 6 exceeds line 1) of reasonable cost over customary charges (complete ceds line 6)		0.0000	0. 000000		
of total customary charges over total reasonable cost fline 6 exceeds line 1) of reasonable cost over customary charges (complete c eds line 6)				1	
f line 6 exceeds line 1) of reasonable cost over customary charges (complete c eds line 6)			0 0		
eds line 6)	nly if line				
ny payor amounts			0 0	0) (
y payer amounts			0 0 Part A	0 Part B) (
			Servi ces	Servi ces	
I - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT			1. 00	2. 00	-
reasonable cost (see instructions)			0	0	10
PPS Reimbursement - Full Episodes without Outliers			0		
PPS Reimbursement - Full Episodes with Outliers PPS Reimbursement - LUPA Episodes			0	1	
PPS Reimbursement - PEP Episodes			0	3, 375	
PPS Outlier Reimbursement - Full Episodes with Outlier	S		0	31, 525	
PPS Outlier Reimbursement - PEP Episodes			0	0	
Other Payments			0	o	1
yments			0	0	18
Payments			0	0	
etic and Orthotic Payments			0	-	
deductibles billed to Medicare patients (exclude coin	surance)			0	
al (sum of lines 10 thru 20 minus line 21)			0	, , , , , , , ,	
reasonable cost (from line 8) al (line 22 minus line 23)			0	1 "	
rance billed to program patients (from your records)				2, 424, 634	. 1
ist (line 24 minus line 25)			0	1	
rsable bad debts (from your records)			0		
rsable bad debts for dual eligible beneficiaries (see	instructions)		0	0	28
costs - current cost reporting period (line 26 plus li			0	2, 424, 634	29
ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	1	
ur ACO demonstration nayment adjustment (see instruction					
tration payment adjustment amount before sequestration					
tration payment adjustment amount before sequestration al (see instructions)			_		
tration payment adjustment amount before sequestration al (see instructions) tration adjustment (see instructions)					
tration payment adjustment amount before sequestration al (see instructions) tration adjustment (see instructions) tration payment adjustment amount after sequestration	nstructions)				
tration payment adjustment amount before sequestration al (see instructions) tration adjustment (see instructions) tration payment adjustment amount after sequestration tration adjustment for non-claims based amounts (see i	nstructions)				
tration payment adjustment amount before sequestration al (see instructions) tration adjustment (see instructions) tration payment adjustment amount after sequestration tration adjustment for non-claims based amounts (see impayments (see instructions)	nstructions)		0	ol ol	
tration payment adjustment amount before sequestration al (see instructions) tration adjustment (see instructions) tration payment adjustment amount after sequestration tration adjustment for non-claims based amounts (see i m payments (see instructions) ive settlement (for contractor use only)	·				
r	ration payment adjustment amount before sequestration (see instructions) ration adjustment (see instructions) ration payment adjustment amount after sequestration	(see instructions) ration adjustment (see instructions) ration payment adjustment amount after sequestration ration adjustment for non-claims based amounts (see instructions) payments (see instructions) ve settlement (for contractor use only)	ration payment adjustment amount before sequestration (see instructions) ration adjustment (see instructions) ration payment adjustment amount after sequestration ration adjustment for non-claims based amounts (see instructions) payments (see instructions) ve settlement (for contractor use only) due provider/program (line 31 minus lines 31.01, 32, and 33)	ration payment adjustment amount before sequestration (see instructions) ration adjustment (see instructions) ration payment adjustment amount after sequestration ration adjustment for non-claims based amounts (see instructions) payments (see instructions) ve settlement (for contractor use only)	ration payment adjustment amount before sequestration (see instructions) ation adjustment (see instructions) ation payment adjustment amount after sequestration ation adjustment for non-claims based amounts (see instructions) payments (see instructions) ve settlement (for contractor use only) due provider/program (line 31 minus lines 31.01, 32, and 33) 0 0 0 0 0 0 0 0 0 0 0 0 0

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

Heal th Financial Systems FRANCISCAN HEAL ANALYSIS OF PAYMENTS TO HOSPITAL-BASED HHAS FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES Provider CCN: 15-0109 HHA CCN: 15-7124

				Home Health Agency I	PPS	
		I npati en	t Part A		t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2.00	3. 00	4.00	
1. 00 2. 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero			0	2, 424, 634	1. 00 2. 00
3. 00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					3. 00
3.01				0	0	3. 01
3.02				0	0	3. 02
3.03				0	0	3. 03
3.04				0	0	3. 04
3.05				0	0	3. 05
3. 50	Provider to Program			ol	0	3. 50
3. 50				0		3. 50
3. 51				o		3. 52
3. 53				0	l ől	3. 53
3. 54				Ö	0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			o	l ol	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)			0	2, 424, 634	4. 00
	TO BE COMPLETED BY CONTRACTOR					
5. 00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5. 00
г 01	Program to Provider					г 01
5. 01 5. 02				0	0	5. 01 5. 02
5. 02				0		5. 02
3.03	Provider to Program			<u> </u>	0	5. 05
5.50	The state of the s			0	0	5. 50
5. 51				О	0	5. 51
5.52				0	0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	0	5. 99
6. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6. 00
6. 01	SETTLEMENT TO PROVIDER			0	0	6. 01
6. 02	SETTLEMENT TO PROGRAM			0	0 404 (04	6. 02
7. 00	Total Medicare program liability (see instructions)			Contractor	2, 424, 634	7. 00
				Contractor Number	NPR Date (Mo/Day/Yr)	
8. 00	Name of Contractor	()	1. 00	2.00	8. 00
6.00	Name of Contractor				ı l	6.00

						3/2/2022 3.00	рш
					Hospi ce I		
		SALARI ES	OTHER	SUBTOTAL (col.	RECLASSIFI -	SUBTOTAL	
				1 plus col. 2)	CATI ONS		
		1.00	2. 00	3. 00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT*		0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP*		15, 659	15, 659	-15, 659	0	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	ol	0	ol	0	0	3.00
4.00	ADMINISTRATIVE & GENERAL*	241, 099	1, 356, 334	1, 597, 433	0	1, 597, 433	4. 00
5. 00	PLANT OPERATION & MAINTENANCE*		.,,		0	0	5. 00
6. 00	LAUNDRY & LINEN SERVICE*		0		0	0	6. 00
7. 00	HOUSEKEEPI NG*		0		0	0	7. 00
	l control of the cont	0	0		0		
8.00	DI ETARY*	000,000	U	0 00	0	0	8. 00
9.00	NURSING ADMINISTRATION*	226, 093	Ü	226, 093	U	226, 093	9. 00
10. 00	ROUTINE MEDICAL SUPPLIES*	0	15, 453	15, 453	0	15, 453	10. 00
11. 00	MEDI CAL RECORDS*	0	0	0	0	0	11. 00
12.00	STAFF TRANSPORTATION*	0	0	0	0	0	12.00
13.00	VOLUNTEER SERVICE COORDINATION*	44, 227	0	44, 227	o	44, 227	13.00
14.00	PHARMACY*	0	0	ol ol	0	0	14.00
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	192, 420	192, 420	0	192, 420	15. 00
16. 00	OTHER GENERAL SERVICE*		172, 420	172, 420	0	172, 420	16. 00
			C	,	O I	O	
17. 00	PATIENT/RESIDENTIAL CARE SERVICES						17. 00
	DIRECT PATIENT CARE SERVICE COST CENTERS			ı al	al		
25. 00	INPATIENT CARE-CONTRACTED**	_	0	0	0	0	25. 00
26. 00	PHYSI CI AN SERVI CES**	0	0	이	0	0	26. 00
27. 00	NURSE PRACTITIONER**	0	0	0	0	0	27. 00
28. 00	REGI STERED NURSE**	1, 582, 400	0	1, 582, 400	0	1, 582, 400	28. 00
29.00	LPN/LVN**	0	0	0	0	0	29. 00
30.00	PHYSI CAL THERAPY**	o	0	ol	0	0	30.00
31.00	OCCUPATIONAL THERAPY**	ol	0	ol ol	0	0	31.00
32. 00	SPEECH/LANGUAGE PATHOLOGY**	2, 169	0	2, 169	0	2, 169	32. 00
33. 00	MEDICAL SOCIAL SERVICES**	258, 415	0	258, 415	0	258, 415	33. 00
34. 00	SPIRITUAL COUNSELING**	201, 122	0		0	201, 122	34.00
		201, 122	0	201, 122	0	201, 122	
35. 00	DI ETARY COUNSELI NG**	0	U		U		35. 00
36. 00	COUNSELING - OTHER**	0	Ü	0	0	0	36. 00
37. 00	HOSPICE AIDE & HOMEMAKER SERVICES**	177, 213	0	177, 213	0	177, 213	37. 00
38. 00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	0	0	0	0	38. 00
39. 00	PATIENT TRANSPORTATION**	0	184, 237	184, 237	0	184, 237	39. 00
40.00	I MAGING SERVI CES**	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS**	o	0	ol ol	0	0	41.00
42.00	MEDI CAL SUPPLI ES-NON-ROUTI NE**	ol	66, 481	66, 481	0	66, 481	42.00
42. 50	DRUGS CHARGED TO PATIENTS**		307, 379		0	307, 379	42. 50
43. 00	OUTPATIENT SERVICES**		007, 077	007,077	0	007,077	43. 00
44. 00	PALLIATIVE RADIATION THERAPY**		0		0	0	44. 00
	PALLIATIVE CHEMOTHERAPY**	0	0		0	0	•
45. 00		0	0		0		45. 00
46. 00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	U) 0	U	0	46. 00
	NONREI MBURSABLE COST CENTERS	1		1			
60. 00	BEREAVEMENT PROGRAM *	0	0	이	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*	l ol	0	ol ol	o	0	64. 00
	OTHER PHYSICIAN SERVICES*	0	0		0	0	65.00
66. 00	RESI DENTI AL CARE*		0	ا م	n	0	66. 00
67. 00		0	0		0	0	67. 00
	ADVERTI SI NG*		0		U A	0	1
68. 00	TELEHEALTH/TELEMONI TORI NG*		0	(O ₁		68.00
	THRIFT STORE*	0	0	<u>[</u>	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD*	0	0	미	이	0	70.00
	OTHER NONREIMBURSABLE (SPECIFY)*	0	0	이	0	0	71. 00
100.00	TOTAL	2, 732, 738	2, 137, 963	4, 870, 701	-15, 659	4, 855, 042	100. 00
* Tran	sfer the amounts in column 7 to Wkst. 0-5, co	lumn 1 line as	annronri ate				

^{*} Transfer the amounts in column 7 to Wkst. 0-5, column 1, line as appropriate.
** See instructions. Do not transfer the amounts in column 7 to Wkst. 0-5.

			·		5/2/2022 3: 0	8 pm
				Hospi ce I		
		ADJUSTMENTS	TOTAL (col. 5			
			± col. 6)			
	CENEDAL CEDVICE COST CENTEDS	6. 00	7.00			
1. 00	GENERAL SERVICE COST CENTERS CAP REL COSTS-BLDG & FLXT*	1 0	ol ol			1.00
2. 00	CAP REL COSTS-BLDG & FIXT		1			2. 00
3.00	EMPLOYEE BENEFITS DEPARTMENT*		1			3. 00
4. 00	ADMINISTRATIVE & GENERAL*		1			4. 00
5. 00	PLANT OPERATION & MAINTENANCE*		1, 577, 455			5. 00
6. 00	LAUNDRY & LINEN SERVICE*					6. 00
7. 00	HOUSEKEEPI NG*					7. 00
8.00	DI ETARY*					8. 00
9. 00	NURSING ADMINISTRATION*		226, 093			9. 00
10. 00	ROUTINE MEDICAL SUPPLIES*		1			10.00
11. 00	MEDI CAL RECORDS*					11.00
12. 00	STAFF TRANSPORTATION*		1			12. 00
13. 00	VOLUNTEER SERVICE COORDINATION*		44, 227			13. 00
14. 00	PHARMACY*		1 77, 227			14. 00
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES*		192, 420			15. 00
16. 00	OTHER GENERAL SERVICE*		1			16. 00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES		1			17. 00
	DIRECT PATIENT CARE SERVICE COST CENTERS					1
25. 00	I NPATI ENT CARE-CONTRACTED**	0	0			25. 00
26. 00	PHYSI CI AN SERVI CES**	0	1			26. 00
27. 00	NURSE PRACTITIONER**	0	1			27. 00
28. 00	REGI STERED NURSE**	0	1			28. 00
29. 00	LPN/LVN**	0				29. 00
30. 00	PHYSI CAL THERAPY**	0				30.00
31.00	OCCUPATI ONAL THERAPY**	0	ol ol			31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	2, 169			32. 00
33.00	MEDICAL SOCIAL SERVICES**	0	258, 415			33. 00
34.00	SPIRITUAL COUNSELING**	0	201, 122			34.00
35.00	DI ETARY COUNSELI NG**	0	o o			35. 00
36.00	COUNSELING - OTHER**	0	0			36. 00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES**	0	177, 213			37. 00
38. 00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	0			38. 00
39. 00	PATIENT TRANSPORTATION**	0	184, 237			39. 00
40.00	I MAGING SERVI CES**	0	0			40. 00
41. 00	LABS & DIAGNOSTICS**	0	0			41. 00
42.00	MEDI CAL SUPPLI ES-NON-ROUTI NE**	0	66, 481			42. 00
42. 50	DRUGS CHARGED TO PATI ENTS**	0	307, 379			42. 50
43.00	OUTPATIENT SERVICES**	0	0			43. 00
44. 00	PALLIATIVE RADIATION THERAPY**	0	0			44. 00
45. 00	PALLI ATI VE CHEMOTHERAPY**	0	1			45. 00
46. 00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	0			46. 00
	NONREI MBURSABLE COST CENTERS					
60. 00	BEREAVEMENT PROGRAM *	0	1			60. 00
61. 00	VOLUNTEER PROGRAM *	0	1			61. 00
62. 00	FUNDRAI SI NG*	0				62. 00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	1			63. 00
64.00	PALLIATIVE CARE PROGRAM*	0	1			64. 00
65.00	OTHER PHYSI CI AN SERVI CES*	0				65. 00
66.00	RESI DENTI AL CARE*	0	0			66. 00
67. 00		0				67. 00
68.00	TELEHEALTH/TELEMONI TORI NG*	0	1			68. 00
69.00	THRIFT STORE*	0	1			69. 00
70.00	NURSING FACILITY ROOM & BOARD*	0	1			70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0				71. 00
100.00	TOTAL	0	4, 855, 042			100. 00

^{*} Transfer the amounts in column 7 to Wkst. 0-5, column 1, line as appropriate.
** See instructions. Do not transfer the amounts in column 7 to Wkst. 0-5.

Peri od:

Hospice CCN: 15-1563 To 12/31/2021 Date/Time Prepared:

		HOSPI CE CCIV	15-1503	0 12/31/2021	5/2/2022 3:08	
				Hospi ce I		
	SALARI ES	OTHER	SUBTOTAL (col.	RECLASSIFI -	SUBTOTAL	
			1 + col . 2)	CATI ONS		
	1.00	2. 00	3.00	4. 00	5. 00	
DIRECT PATIENT CARE SERVICE COST CENTERS						
25. 00 I NPATI ENT CARE-CONTRACTED						25. 00
26. 00 PHYSI CI AN SERVI CES	0	0	0	0	0	26. 00
27. 00 NURSE PRACTITIONER	0	0	0	0	0	27. 00
28. 00 REGI STERED NURSE	0	0	0	0	0	28. 00
29. 00 LPN/LVN	0	0	0	0	0	29. 00
30. 00 PHYSI CAL THERAPY	0	0	0	0	0	30.00
31. 00 OCCUPATIONAL THERAPY	0	0	0	0	0	31. 00
32.00 SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32. 00
33.00 MEDICAL SOCIAL SERVICES	0	0	0	0	0	33. 00
34.00 SPIRITUAL COUNSELING	0	0	0	0	0	34. 00
35. 00 DI ETARY COUNSELING	0	0	0	0	0	35. 00
36. 00 COUNSELING - OTHER	0	0	0	0	0	36. 00
37.00 HOSPICE AIDE & HOMEMAKER SERVICES	0	0	0	0	0	37. 00
38.00 DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38. 00
39.00 PATIENT TRANSPORTATION	0	0	0	0	0	39. 00
40.00 I MAGI NG SERVI CES	0	0	0	0	0	40.00
41.00 LABS & DIAGNOSTICS	0	0	0	0	0	41. 00
42. 00 MEDI CAL SUPPLI ES-NON-ROUTI NE	0	0	0	0	0	42. 00
42.50 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	42. 50
43.00 OUTPATIENT SERVICES	0	0	0	0	0	43. 00
44.00 PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44. 00
45.00 PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45. 00
46.00 OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46. 00
100. 00 TOTAL *	0	0	0	0	0	100.00

^{*} Transfer the amount in column 7 to Wkst. 0-5, column 1, line 50.

		AD ILLOTATIVE	TOTAL (1 5	1	
		ADJUSTMENTS	TOTAL (col. 5		
		4 00	± col. 6)	-	
	DI DECT DATIENT CADE CEDVI CE COCT CENTEDO	6. 00	7. 00		
05 00	DIRECT PATIENT CARE SERVICE COST CENTERS	I	I	T	05.00
25. 00	I NPATI ENT CARE-CONTRACTED				25. 00
26. 00	PHYSI CI AN SERVI CES	0	0		26. 00
27. 00	NURSE PRACTITIONER	0	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	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0		32. 00
33.00	MEDICAL SOCIAL SERVICES	0	0		33. 00
34.00	SPI RI TUAL COUNSELI NG	0	0		34. 00
35.00	DI ETARY COUNSELING	0	0		35. 00
36.00	COUNSELING - OTHER	0	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	OUTPATIENT SERVICES	0	0		43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0		44.00
45. 00	PALLIATIVE CHEMOTHERAPY	0	0		45. 00
46. 00	OTHER PATIENT CARE SERVICES (SPECIFY)	1 0	0		46, 00
	TOTAL *	0	0		100.00

^{*} Transfer the amount in column 7 to Wkst. 0-5, column 1, line 50.

CARE

Worksheet 0-2

Provider CCN: 15-0109 Period: From 01/01/2021 To 12/31/2021 Date/Time Prepared: 5/2/2022 3:08 pm Hospi ce CCN: 15-1563 Hospi ce I

	·	SALARI ES	OTHER	SUBTOTAL (col.	RECLASSIFI -	SUBTOTAL	
				1 + col . 2)	CATI ONS		
		1.00	2.00	3.00	4. 00	5. 00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED						25. 00
26.00	PHYSI CI AN SERVI CES	0	0	0	0	0	26. 00
27. 00	NURSE PRACTITIONER	0	0	0	0	0	27. 00
28. 00	REGI STERED NURSE	1, 579, 606	0	1, 579, 606	0	1, 579, 606	28. 00
29. 00	LPN/LVN	0	0	0	0	0	29. 00
30.00	PHYSI CAL THERAPY	0	0	0	0	0	30.00
31. 00	OCCUPATI ONAL THERAPY	0	0	0	0	0	31. 00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32. 00
33.00	MEDICAL SOCIAL SERVICES	257, 260	0	257, 260	0	257, 260	33. 00
34.00	SPI RI TUAL COUNSELI NG	200, 997	0	200, 997	0	200, 997	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	177, 213	0	177, 213	0	177, 213	37. 00
38. 00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38. 00
39. 00	PATI ENT TRANSPORTATION	0	180, 692	180, 692	0	180, 692	39. 00
40.00	I MAGING SERVICES	0	0	0	0	0	40. 00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	66, 481	66, 481	0	66, 481	42. 00
42. 50	DRUGS CHARGED TO PATIENTS	0	307, 208	307, 208	0	307, 208	42. 50
43.00	OUTPATI ENT SERVI CES	0	0	0	0	0	43. 00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44. 00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45. 00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46. 00
	TOTAL *	2, 215, 076	554, 381	2, 769, 457	0	2, 769, 457	100.00
* Tran	sfer the amount in column 7 to Wkst 0-5 col	umn 1 line 51					

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

Transfer the amount in cordini 7 to wast. 0-5, co			
	ADJUSTMENTS	TOTAL (col. 5	
		± col. 6)	
DUDGOT DATIENT CARE OFFICE OF COAT OFFITEDO	6. 00	7. 00	
DIRECT PATIENT CARE SERVICE COST CENTERS			25.20
25. 00 INPATIENT CARE-CONTRACTED	_	_	25. 00
26. 00 PHYSI CI AN SERVI CES		0	26. 00
27. 00 NURSE PRACTITIONER	C	0	27. 00
28. 00 REGISTERED NURSE	C	1, 579, 606	28. 00
29. 00 LPN/LVN	C	0	29. 00
30. 00 PHYSI CAL THERAPY	C	0	30.00
31. 00 OCCUPATI ONAL THERAPY	C	0	31.00
32.00 SPEECH/LANGUAGE PATHOLOGY	C	0	32. 00
33.00 MEDICAL SOCIAL SERVICES	C	257, 260	33.00
34. 00 SPI RI TUAL COUNSELI NG	C	200, 997	34.00
35. 00 DI ETARY COUNSELING	C	0	35.00
36. 00 COUNSELING - OTHER	C	0	36.00
37.00 HOSPICE AIDE & HOMEMAKER SERVICES	C	177, 213	37.00
38.00 DURABLE MEDICAL EQUIPMENT/OXYGEN	C	0	38.00
39. 00 PATI ENT TRANSPORTATI ON	C	180, 692	39.00
40.00 I MAGI NG SERVI CES	C	0	40.00
41.00 LABS & DIAGNOSTICS	C	0	41. 00
42.00 MEDICAL SUPPLIES-NON-ROUTINE	C	66, 481	42. 00
42.50 DRUGS CHARGED TO PATIENTS	C	307, 208	42. 50
43.00 OUTPATIENT SERVICES	C	0	43.00
44.00 PALLIATIVE RADIATION THERAPY	C	o	44.00
45.00 PALLIATIVE CHEMOTHERAPY	C	o	45. 00
46.00 OTHER PATIENT CARE SERVICES (SPECIFY)	C	o	46.00
100.00 TOTAL *	C	2, 769, 457	100.00
*	1 1 1: F1		·

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

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

Hospi ce CCN: 15-1563

Peri od: Worksheet 0-3 From 01/01/2021 To 12/31/2021 Date/Ti me Prepared:

5/2/2022 3:08 pm Hospi ce I SALARI ES OTHER SUBTOTAL (col RECLASSI FI -SUBTOTAL 1 + col. CATI ONS 1.00 2.00 5. 00 3 00 4.00 DIRECT PATIENT CARE SERVICE COST CENTERS 25.00 INPATIENT CARE-CONTRACTED 0 25.00 0 PHYSICIAN SERVICES 26.00 0 0 0 26.00 NURSE PRACTITIONER 27.00 0 0 0 27.00 0 0 28.00 REGISTERED NURSE 2, 208 0 2, 208 2, 208 28.00 29.00 LPN/LVN 0 29.00 30.00 PHYSI CAL THERAPY 0 0 0 0 30.00 OCCUPATIONAL THERAPY 31.00 0 0 0 0 31.00 32.00 SPEECH/LANGUAGE PATHOLOGY 2, 169 2, 169 2, 169 32.00 33.00 MEDICAL SOCIAL SERVICES 219 219 219 33.00 SPIRITUAL COUNSELING 34.00 0 0 34.00 0 0 0 35.00 DIETARY COUNSELING 0 0 0 35.00 36.00 COUNSELING - OTHER 0 0 0 36.00 HOSPICE AIDE & HOMEMAKER SERVICES 0 0 0 0 0 0 0 0 0 37.00 0 0 37.00 0 DURABLE MEDICAL EQUIPMENT/OXYGEN 38.00 38.00 0 0 39.00 PATIENT TRANSPORTATION 3, 545 3, 545 3, 545 39.00 40.00 I MAGING SERVICES 40.00 0 LABS & DIAGNOSTICS 0 41.00 0 0 41.00 MEDICAL SUPPLIES-NON-ROUTINE 0 42.00 C 0 42.00 42.50 DRUGS CHARGED TO PATIENTS 42.50 OUTPATIENT SERVICES 0 43.00 0 0 43.00 PALLIATIVE RADIATION THERAPY 44.00 C 0 0 44.00 45.00 PALLIATIVE CHEMOTHERAPY C 0 0 45.00 46.00 OTHER PATIENT CARE SERVICES (SPECIFY) 0 0 0 0 46.00 100.00 TOTAL * 3, 545 8, 141 100. 00 4.596 8.141

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

	AR HIGHERITO	T0T11 (1 5	
	ADJUSTMENTS	TOTAL (col. 5	
	4 00	± col. 6)	
DI DECT DATIENT CADE CEDVI CE COCT CENTEDO	6. 00	7.00	
DI RECT PATIENT CARE SERVICE COST CENTERS	1		05 00
25. 00 INPATIENT CARE-CONTRACTED		0	25. 00
26. 00 PHYSI CI AN SERVI CES		이	26. 00
27. 00 NURSE PRACTITIONER		이	27. 00
28. 00 REGI STERED NURSE	0	2, 208	28. 00
29. 00 LPN/LVN	(이	29. 00
30. 00 PHYSI CAL THERAPY	C	0	30.00
31. 00 OCCUPATIONAL THERAPY	C	0	31. 00
32.00 SPEECH/LANGUAGE PATHOLOGY	C	2, 169	32. 00
33.00 MEDICAL SOCIAL SERVICES		219	33.00
34.00 SPIRITUAL COUNSELING	C	ol ol	34.00
35. 00 DI ETARY COUNSELING		ol ol	35. 00
36. 00 COUNSELING - OTHER		ol ol	36. 00
37.00 HOSPICE AIDE & HOMEMAKER SERVICES		ol ol	37. 00
38. 00 DURABLE MEDICAL EQUIPMENT/OXYGEN		ol ol	38. 00
39. 00 PATIENT TRANSPORTATION		3, 545	39.00
40.00 I MAGING SERVICES		ol ol	40.00
41.00 LABS & DIAGNOSTICS		ol ol	41.00
42.00 MEDICAL SUPPLIES-NON-ROUTINE			42.00
42.50 DRUGS CHARGED TO PATIENTS			42. 50
43. 00 OUTPATIENT SERVICES			43.00
44. 00 PALLIATIVE RADIATION THERAPY		ol ol	44. 00
45. 00 PALLIATIVE CHEMOTHERAPY			45. 00
46. 00 OTHER PATIENT CARE SERVICES (SPECIFY)			46. 00
100. 00 TOTAL *		8, 141	100.00
		-,	

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

INPATIENT CARE

Peri od: Worksheet 0-4 From 01/01/2021 To 12/31/2021

Date/Time Prepared: 5/2/2022 3:08 pm Hospi ce CCN: 15-1563

					Hospi ce I		
		SALARI ES	OTHER	SUBTOTAL (col.	RECLASSIFI -	SUBTOTAL	
				1 + col . 2)	CATI ONS		
		1.00	2.00	3. 00	4. 00	5. 00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	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	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	OCCUPATI ONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	936	0	936	0	936	33. 00
34.00	SPIRITUAL COUNSELING	125	0	125	o	125	34.00
35.00	DI ETARY COUNSELI NG	0	0	0	o	0	35. 00
36.00	COUNSELING - OTHER	o	0	0	o	0	36. 00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	o	0	0	o	0	37. 00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	o	0	0	o	0	38. 00
39.00	PATIENT TRANSPORTATION	o	0	0	o	0	39. 00
40.00	I MAGING SERVICES	o	0	0	o	0	40. 00
41.00	LABS & DIAGNOSTICS	o	0	0	o	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	o	0	0	o	0	42. 00
42.50	DRUGS CHARGED TO PATIENTS	o	171	171	o	171	42. 50
43.00	OUTPATIENT SERVICES	o	0	0	o	0	43. 00
44.00	PALLIATIVE RADIATION THERAPY	o	0	0	o	0	44. 00
45.00	PALLI ATI VE CHEMOTHERAPY	o	0	0	o	0	45. 00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	o	0	0	o	0	46. 00
	TOTAL *	1, 647	171	1, 818	o	1, 818	100. 00
* Tran	efor the amount in column 7 to Wket O.E. colu	ump 1 line E2			•		

^{*} Transfer the amount in column 7 to Wkst. 0-5, column 1, line 53.

		ADJUSTMENTS	TOTAL (col. 5		
		ADSOSTMENTS	± col. 6)		
		6. 00	7.00		
	DIRECT PATIENT CARE SERVICE COST CENTERS	<u>'</u>	'		
25.00	I NPATI ENT CARE-CONTRACTED	0	0	2	25. 00
26.00	PHYSI CI AN SERVI CES	0	0	2	26. 00
27. 00	NURSE PRACTITIONER	0	0	2	27. 00
28. 00	REGI STERED NURSE	0	586	2	28. 00
29. 00	LPN/LVN	0	0	2	29. 00
30.00	PHYSI CAL THERAPY	0	0	3	30.00
31.00	OCCUPATI ONAL THERAPY	0	0	3	31. 00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	3	32. 00
33.00	MEDICAL SOCIAL SERVICES	0	936	3	33. 00
34.00	SPI RI TUAL COUNSELI NG	0	125	3	34. 00
35.00	DI ETARY COUNSELING	0	0	3	35. 00
36.00	COUNSELING - OTHER	0	0	3	36. 00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	0	3	37. 00
38. 00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	3	38. 00
39. 00	PATI ENT TRANSPORTATION	0	0	3	39. 00
40.00	I MAGING SERVICES	0	0	4	40. 00
41.00	LABS & DIAGNOSTICS	0	0	4	41. 00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	4	42. 00
42. 50	DRUGS CHARGED TO PATIENTS	0	171	4	42. 50
43.00	OUTPATI ENT SERVI CES	0	0	4	43. 00
44.00	PALLIATIVE RADIATION THERAPY	0	0	4	44. 00
45.00	PALLI ATI VE CHEMOTHERAPY	0	0	4	45. 00
	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	4	46. 00
100.00	TOTAL *	0	1, 818		00.00

^{*} Transfer the amount in column 7 to Wkst. 0-5, column 1, line 53.

15. 00 PHYSICIAN ADMINISTRATIVE SERVICES 192, 420 15. 16. 00 THER GENERAL SERVICE 0 0 0 0 16. 17. 17. 00 PATIENT/RESI DENTIAL CARE SERVICES 0 0 0 0 17. 18. 18. 18. 18. 18. 19. 19. 19. 19. 19. 19. 19. 19. 19. 19	Heal th	Financial Systems FRANCISCAN HEAL	TH LAFAYETTE		In Lie	eu of Form CMS-2	2552-10
Descriptions	COST A	LLOCATION - DETERMINATION OF HOSPITAL-BASED HOSPICE NET	Provi der C	CN: 15-0109		Worksheet 0-5	
Descriptions	EXPENS	ES FOR ALLOCATION	Hospi ce CC	:N: 15-1563			
CEMERAL SERVICE COST CENTERS 1.00 2.00 3.00					Hospi ce I		
SEMERAL SERVICE COST CENTERS 1.00 2.00 3.00 1.00 2.00 3.00 1.00 3.00 1.00 3.00		Descriptions					
CONTROL CONT							
CSENERAL SERVICE COST CENTERS 1.00 2.00 3.00 2.00 3.00 2.00 3.0				instructions		1 + 2)	
CENERAL SERVICE COST CENTERS							
CONTROL CONT					,		
GENERAL SERVICE COST CENTERS				1.00		2.00	
1.00		CENEDAL CEDALCE COCT CENTEDO		1.00	2.00	3.00	
2.00	1 00			T			1 00
3.00 MPLOYEE BENEFITS DEPARTMENT 0 669, 431 669, 431 3.							
4. O					-	1	
SOCIO PLANT OPERATION & MAINTENANCE 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				1 507 4			1
6. 00				1, 597, 4.			
7. 00 HOUSEKEEPING					9		
8.00 DI ETARY					-		
9.00 NURSING ADMINISTRATION 226,093 253,247 479,340 9,010.00 ROUTINE MEDICAL SUPPLIES 15,453 0 15,453 0 15,453 11.00 MEDICAL RECORDS 5 0 42,696 42,696 11.10 15,453 0 15,453 11.00 15,453 10.00 15,453 11.00 MEDICAL RECORDS 5 0 42,696 42,696 11.10 12.00 STAFF TRANSPORTATION 0 0 42,696 42,696 11.10 12.00 STAFF TRANSPORTATION 144,227 44,227 13.10 13.00 VOLUNTEER SERVICE COORDINATION 144,227 44,227 13.10 15.00 PHARMACY 0 0 0 0 14.00 15.00 THER GENERAL SERVICE COORDINATION 14,00 0 0 15.00 15.00 THER GENERAL SERVICE 0 0 0 0 15.00 15.00 THER GENERAL SERVICE 0 0 0 0 15.00 15.00 THER GENERAL SERVICE 0 0 0 0 17.00 15.00 THER GENERAL SERVICE 0 0 0 0 15.00 15.00 THER GENERAL SERVICE 0 0 0 0 0 15.00 15.00 THER GENERAL SERVICE 0 0 0 0 0 15.00 15.00 THER GENERAL SERVICE 0 0 0 0 0 15.00 15.00 THER GENERAL SERVICE 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0					9		
10. 00 ROUTINE MEDICAL SUPPLIES 15, 453 0 15, 453 10. 11. 00 MEDICAL RECORDS 0 42, 696 42, 696 11. 11. 00 MEDICAL RECORDS 0 0 0 0 12. 11. 00 12. 00 STAFF TRANSPORTATION 0 0 0 0 12. 11. 11. 00 0 0 0 12. 11. 11. 00 0 0 0 0 0 14. 11. 11. 11. 11. 11. 11. 11. 11. 11.				224 0	o o		
11. 00 MEDI CAL RECORDS 0 42, 696 42, 696 11. 01. 01. 01. 01. 01. 01. 01. 01. 01.						1	1
12. 00 STAFF TRANSPORTATION				15, 4		1	1
13. 00 VOLUNTEER SERVICE COORDINATION 44, 227 44, 227 13. 14. 00 PHARMACY 0 0 0 0 0 14. 15. 15. 10 PHYSICIAN ADMINISTRATIVE SERVICES 192, 420 192, 420 15. 15. 16. 00 OTHER GENERAL SERVICE 0 0 0 0 0 16. 16. 17. 17. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18						l	1
14. 00 PHARMACY				14 2	9		
15. 00 PHYSICIAN ADMINISTRATIVE SERVICES 192, 420 192, 420 15. 00 0 0 0 0 16. 00 0 0 0 0 0 0 16. 00 0 0 0 0 0 0 0 0 0				77, 2		1	1
16. 00 OTHER GENERAL SERVICE 0 0 0 0 16. 0 17. 00 PATIENT/RESI DENTIAL CARE SERVICES 0 0 0 0 17. 0 LEVEL OF CARE 50. 00 HOSPICE CONTINUOUS HOME CARE 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				192 4	٥	1	
17. 00 PATI ENT/RESI DENTI AL CARE SERVI CES 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				1			1
LEVEL OF CARE					0		
Description							1
10	50.00				0	0	50.00
HOSPICE GENERAL INPATIENT CARE 1,818 1,818 53.0 NONREI MBURSABLE COST CENTERS	51.00	HOSPICE ROUTINE HOME CARE		2, 769, 4	57	2, 769, 457	51.00
NONREIMBURSABLE COST CENTERS O	52.00	HOSPICE INPATIENT RESPITE CARE		8, 14	11	8, 141	52. 00
60. 00 BEREAVEMENT PROGRAM 61. 00 VOLUNTEER PROGRAM 62. 00 FUNDRAI SI NG 63. 00 HOSPI CE/PALLI ATI VE MEDI CI NE FELLOWS 63. 00 PALLI ATI VE CARE PROGRAM 64. 00 PALLI ATI VE CARE PROGRAM 65. 00 OTHER PHYSI CI AN SERVI CES 66. 00 RESI DENTI AL CARE 67. 00 ADVERTI SI NG 67. 00 ADVERTI SI NG 68. 00 TELEHEALTH/TELEMONI TORI NG 69. 00 THRI FT STORE 69. 00 NURSI NG FACILI TY ROOM & BOARD 71. 00 OTHER NONREI MBURSABLE (SPECI FY) 99. 00 NEGATI VE COST CENTER 0 0 0 0 71.	53.00	HOSPICE GENERAL INPATIENT CARE		1, 8	18	1, 818	53.00
61. 00 VOLUNTEER PROGRAM 62. 00 FUNDRAI SI NG 0 0 0 62. 0 63. 00 HOSPI CE/PALLI ATI VE MEDI CI NE FELLOWS 0 0 0 0 63. 0 64. 00 PALLI ATI VE CARE PROGRAM 0 0 0 0 64. 0 65. 00 OTHER PHYSI CI AN SERVI CES 0 0 0 0 65. 0 66. 00 RESI DENTI AL CARE 0 0 0 0 67. 0 68. 00 TELEHEALTH/TELEMONI TORI NG 69. 00 THRI FT STORE 0 0 0 69. 00 71. 00 OTHER NONREI MBURSABLE (SPECI FY) 99. 00 NEGATI VE COST CENTER		NONREI MBURSABLE COST CENTERS					
62. 00 FUNDRAISING 0 0 62. 0 63. 00 HOSPI CE/PALLI ATI VE MEDI CI NE FELLOWS 0 0 63. 0 64. 00 PALLI ATI VE CARE PROGRAM 0 0 0 64. 0 65. 00 OTHER PHYSI CI AN SERVI CES 0 0 0 65. 0 66. 00 RESI DENTI AL CARE 0 0 0 66. 0 67. 00 ADVERTI SI NG 0 0 0 67. 0 68. 00 TELEHEALTH/TELEMONI TORI NG 0 0 0 68. 0 69. 00 THRI FT STORE 0 0 0 0 69. 0 70. 00 NURSI NG FACI LI TY ROOM & BOARD 0 70. 0 71. 00 OTHER NONREI MBURSABLE (SPECI FY) 0 0 71. 0 99. 00 NEGATI VE COST CENTER 0 99. 0	60.00	BEREAVEMENT PROGRAM			0	0	60.00
63.00 HOSPI CE/PALLI ATI VE MEDI CI NE FELLOWS 64.00 PALLI ATI VE CARE PROGRAM 65.00 OTHER PHYSI CI AN SERVI CES 66.00 RESI DENTI AL CARE 67.00 ADVERTI SI NG 68.00 TELEHEALTH/TELEMONI TORI NG 69.00 THRI FT STORE 70.00 NURSI NG FACI LI TY ROOM & BOARD 71.00 OTHER NONREI MBURSABLE (SPECI FY) 99.00 NEGATI VE COST CENTER 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	61. 00					0	61.00
64. 00 PALLIATIVE CARE PROGRAM 65. 00 OTHER PHYSICIAN SERVICES 66. 00 RESIDENTIAL CARE 67. 00 ADVERTISING 68. 00 TELEHEALTH/TELEMONITORING 69. 00 THRIFT STORE 69. 00 NURSING FACILITY ROOM & BOARD 71. 00 OTHER NONREIMBURSABLE (SPECIFY) 99. 00 NEGATIVE COST CENTER 0 0 0 64. 0 0 0 65. 0 0 66. 0 0 0 67. 0 0 0 0 70. 0 0 71. 0 0 71. 0 0 99. 0	62.00				0		
65.00 OTHER PHYSICIAN SERVICES 66.00 RESIDENTIAL CARE 67.00 ADVERTISING 68.00 TELEHEALTH/TELEMONITORING 69.00 THRIFT STORE 0 0 0 0 67.4 67.00 NURSING FACILITY ROOM & BOARD 0 0 0 0 70.4 71.00 OTHER NONREIMBURSABLE (SPECIFY) 99.00 NEGATIVE COST CENTER 0 0 0 99.4					9	1	
66. 00 RESI DENTI AL CARE 0 0 66. 0 67. 00 ADVERTI SI NG 0 0 67. 0 68. 00 TELEHEALTH/TELEMONI TORI NG 0 0 68. 0 69. 00 THRI FT STORE 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0					0		
67. 00 ADVERTISING 0 0 67. 0 68. 00 TELEHEALTH/TELEMONITORING 0 0 68. 0 69. 00 THRIFT STORE 0 0 0 69. 0 70. 00 NURSING FACILITY ROOM & BOARD 0 0 70. 0 71. 00 OTHER NONREIMBURSABLE (SPECIFY) 0 0 71. 0 99. 00 NEGATIVE COST CENTER 0 99. 0					0		65. 00
68. 00 TELEHEALTH/TELEMONITORING 0 0 68. 0 69. 00 THRI FT STORE 0 0 69. 00 70. 00 NURSI NG FACILITY ROOM & BOARD 0 70. 00 OTHER NONREI MBURSABLE (SPECI FY) 99. 00 NEGATI VE COST CENTER 0 99. 00 NEGATI VE COST CENTER					0		
69.00 THRIFT STORE 0 0 69.0 70.00 NURSING FACILITY ROOM & BOARD 0 70.0 71.00 OTHER NONREIMBURSABLE (SPECIFY) 0 0 71.0 99.00 NEGATIVE COST CENTER 0 99.0					0		
70.00 NURSING FACILITY ROOM & BOARD 0 70.00 71.00 OTHER NONREIMBURSABLE (SPECIFY) 0 71.00 99.00 NEGATIVE COST CENTER 0 99.00					0	-	
71.00 OTHER NONREIMBURSABLE (SPECIFY) 0 0 71.099.00 NEGATIVE COST CENTER 0 99.00					0		
99. 00 NEGATIVE COST CENTER 0 99. 0					O		
		` ,			U	1	
100 001T0TAL A DEC 040 0 E40 700 7 040 040 400				4 055 0	U 12 2 512 700	-	
100. 00 TOTAL 4, 855, 042 2, 513, 798 7, 368, 840 100.	100.00	IUIAL		4, 855, 04	+2 2,513,798	1, 368, 840	1100.00

Heal th Financial	Systems	FRANCISCAN HEALTH	LAFAYETTE		In Lieu of Form CMS-2552-10
COST ALLOCATION	- HOSDITAL BASED HOSDICE GENERAL	SERVICE COSTS	Provider CCN: 15-0100	Dari od:	Workshoot 0-6

From 01/01/2021 Part I Hospi ce CCN: 15-1563 12/31/2021 Date/Time Prepared: 5/2/2022 3:08 pm Hospi ce I TOTAL EXPENSES CAP REL BLDG & CAP REL MVBLE EMPLOYEE SUBTOTAL Descriptions FIX EQUI P **BENEFITS** DEPARTMENT 1.00 2.00 0 3.00 3A GENERAL SERVICE COST CENTERS CAP REL COSTS-BLDG & FLXT 1.00 2.00 CAP REL COSTS-MVBLE EQUIP 0 2.00 0 3.00 EMPLOYEE BENEFITS DEPARTMENT 669, 431 669, 431 3.00 4.00 ADMINISTRATIVE & GENERAL 3, 145, 857 3, 145, 857 4.00 5.00 PLANT OPERATION & MAINTENANCE 0 0 0 5.00 0 LAUNDRY & LINEN SERVICE 0 0 6.00 0 0 0 6.00 7.00 HOUSEKEEPI NG 0 0 0 7.00 8.00 DI ETARY 0 0 0 8.00 NURSING ADMINISTRATION 479, 340 0 479, 340 9.00 9.00 0 ROUTINE MEDICAL SUPPLIES 10.00 15.453 15, 453 10.00 11.00 MEDICAL RECORDS 42,696 0 42,696 11.00 12.00 STAFF TRANSPORTATION 12.00 VOLUNTEER SERVICE COORDINATION 0 13.00 13.00 44, 227 44, 227 0 14.00 PHARMACY Ω 14.00 15.00 PHYSICIAN ADMINISTRATIVE SERVICES 192, 420 15.00 192, 420 OTHER GENERAL SERVICE 0 16.00 16.00 0 PATIENT/RESIDENTIAL CARE SERVICES 0 17.00 0 17.00 LEVEL OF CARE HOSPICE CONTINUOUS HOME CARE 50.00 50.00 HOSPICE ROUTINE HOME CARE 2, 769, 457 0 2, 769, 457 51.00 51.00 HOSPICE INPATIENT RESPITE CARE 8, 141 52.00 8, 141 0 0 0 52.00 53.00 HOSPICE GENERAL INPATIENT CARE 1,818 0 0 669, 431 671, 249 53.00 NONREI MBURSABLE COST CENTERS 60.00 BEREAVEMENT PROGRAM n 0 0 60.00 0 0 0 VOLUNTEER PROGRAM 0 0 0 61.00 0 61.00 62.00 FUNDRAI SI NG 0 62.00 HOSPICE/PALLIATIVE MEDICINE FELLOWS 0 0 63.00 000000 0 0 63.00 PALLIATIVE CARE PROGRAM 0 0 64.00 0 64.00 65.00 OTHER PHYSICIAN SERVICES 0 0 65.00 0 RESIDENTIAL CARE 0 0 66.00 0 66.00 67 00 ADVERTI SI NG 0 0 67.00 0 TELEHEALTH/TELEMONI TORI NG 0 68.00 0 0 68.00 69.00 THRIFT STORE 0 0 69.00 0 NURSING FACILITY ROOM & BOARD 70.00 0 70.00 71 00 OTHER NONREIMBURSABLE (SPECIFY) 0 71.00 Ω 0 99.00 NEGATIVE COST CENTER 0 0 0 99.00 100.00 TOTAL 7, 368, 840 669, 431 7, 368, 840 100. 00

			·			5/2/2022 3:08	pm
					Hospi ce I		
	Descriptions	ADMI NI STRATI VE	PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		& GENERAL	OPERATION &	LINEN SERVICE			
			MAI NTENANCE				
		4.00	5. 00	6.00	7. 00	8. 00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1. 00
2.00	CAP REL COSTS-MVBLE EQUIP						2. 00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL	3, 145, 857					4. 00
5.00	PLANT OPERATION & MAINTENANCE	0	0	,			5. 00
6.00	LAUNDRY & LINEN SERVICE		0				6.00
7. 00	HOUSEKEEPING		0	-	0		7. 00
8.00	DI ETARY		0		0	0	1
9. 00	NURSING ADMINISTRATION	357, 078	0		0	Ĭ	9. 00
10.00	ROUTINE MEDICAL SUPPLIES	11, 512	0		0		10.00
11. 00	MEDI CAL RECORDS	31, 806	0		0		11.00
12. 00	STAFF TRANSPORTATION	31,000	0		0		12.00
13. 00	VOLUNTEER SERVICE COORDINATION	32, 946	0		0		13. 00
14. 00	PHARMACY	32, 740	0		0		14. 00
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES	143, 341	0		0		15.00
16. 00	OTHER GENERAL SERVICES	143, 341	0		0		16.00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES		0		0		17. 00
17.00	LEVEL OF CARE	ı o	U	1	U		17.00
50. 00	HOSPICE CONTINUOUS HOME CARE						50.00
51.00	HOSPICE CONTINUOUS HOME CARE	2, 063, 071					51.00
52.00	HOSPICE ROUTINE HOME CARE HOSPICE INPATIENT RESPITE CARE	6, 065	0	l c	0	0	1
53. 00	HOSPICE GENERAL INPATIENT CARE	500, 038	0	l .	1	0	53.00
53.00	NONREI MBURSABLE COST CENTERS	500, 038	U	1	y U	U	53.00
60.00	BEREAVEMENT PROGRAM		0	ı	0		60.00
61.00	VOLUNTEER PROGRAM		0		0		61.00
62.00	FUNDRAI SI NG	0	0		0		62.00
		0	0		0		63.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	U		0		1
64. 00	PALLIATIVE CARE PROGRAM	0	U	1	0		64.00
65. 00	OTHER PHYSICIAN SERVICES	0	Ü	1	0		65.00
66.00	RESI DENTI AL CARE	0	Ü	C	0	0	
67. 00	ADVERTI SI NG	0	Ü		0		67.00
68. 00	TELEHEALTH/TELEMONI TORI NG	0	Ü		0		68. 00
69. 00	THRIFT STORE	0	O	1	0		69.00
70.00	NURSING FACILITY ROOM & BOARD	_	_	_	_	_	70.00
71. 00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	<u> </u>	0	0	
99.00	NEGATIVE COST CENTER	0	0	<u> </u>	0	0	
100.00	TOTAL	3, 145, 857	0) C	0	0	100. 00

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

Heal th	Financial Systems	FRANCISCAN HEALT	H LAFAYETTE		In Lie	u of Form CMS-2	2552-10
COST A	ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL S	SERVICE COSTS	Provi der Co	CN: 15-0109	Peri od:	Worksheet 0-6	
					From 01/01/2021	Part I	
			Hospi ce CCI	N: 15-1563	To 12/31/2021	Date/Time Pre	pared:
						5/2/2022 3: 08	pm
					Hospi ce I		
	Descriptions	NURSI NG	ROUTI NE	MEDI CAL	STAFF	VOLUNTEER	
		ADMI NI STRATI ON	MEDI CAL	RECORDS	TRANSPORTATI ON	SERVI CE	
			SUPPLI ES			COORDI NATI ON	
		9.00	10.00	11.00	12.00	13. 00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FLXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2. 00
3.00	EMPLOYEE BENEFITS DEPARTMENT	1					3. 00
4.00	ADMINISTRATIVE & GENERAL						4. 00
5.00	PLANT OPERATION & MAINTENANCE						5. 00
6.00	LAUNDRY & LINEN SERVICE						6. 00
7.00	HOUSEKEEPI NG						7. 00
8. 00	DI ETARY						8. 00
9.00	NURSING ADMINISTRATION	836, 418					9. 00
10.00	ROUTINE MEDICAL SUPPLIES	o	26, 965				10.00
11. 00	MEDI CAL RECORDS	0		74, 50	2	· '	11. 00
12. 00	STAFF TRANSPORTATION				0		12. 00
13. 00	VOLUNTEER SERVICE COORDINATION	o o			0	77, 173	13. 00
14. 00	PHARMACY	ŏ			0	77, 173	14. 00
15. 00					0	0	15. 00
	PHYSICIAN ADMINISTRATIVE SERVICES	0			0		
16. 00	OTHER GENERAL SERVICE	0			0	0	16. 00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES						17. 00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0		0	0	50.00
51. 00	HOSPICE ROUTINE HOME CARE	0	26, 879			76, 928	51. 00
52.00	HOSPICE INPATIENT RESPITE CARE	0	80	22	1 0	229	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	836, 418	6	1	5 0	16	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	Ö	62. 00
63. 00	HOSPICE/PALLIATIVE MEDICINE FELLOWS				0	0	63. 00
64. 00	PALLIATIVE CARE PROGRAM				0	0	64. 00
		0			0		
65. 00	OTHER PHYSI CI AN SERVI CES	0			0	0	65. 00
66. 00	RESI DENTI AL CARE				0	0	66. 00
67. 00	ADVERTI SI NG	O			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	71. 00
99. 00	NEGATIVE COST CENTER	o	0)	0	0	99. 00
100, 00	TOTAL	836, 418	26, 965	74, 50	2 0	77, 173	100.00
	I · ·	1 222/ 119	, ,00	,	1	, . , . , . ,	

 Heal th Financial
 Systems
 FRANCISCAN H

 COST ALLOCATION
 - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS
 Provider CCN: 15-0109 | Peri od: | From 01/01/2021 | From 01/01/2021 | Part I | To 12/31/2021 | Date/Time Prepared: | 5/2/2022 3:08 pm

						5/2/2022 3:08	pm
					Hospi ce I		
	Descriptions	PHARMACY	PHYSI CI AN	OTHER GENERAL	PATI ENT/	TOTAL	
	·		ADMI NI STRATI VE	SERVI CE	RESI DENTI AL		
			SERVI CES		CARE SERVICES		
		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	HOUSEKEEPI NG						7. 00
8.00	DI ETARY						8. 00
9.00	NURSING ADMINISTRATION						9.00
10.00	ROUTINE MEDICAL SUPPLIES						10.00
11. 00	MEDICAL RECORDS						11. 00
12. 00	STAFF TRANSPORTATION						12.00
13. 00	VOLUNTEER SERVICE COORDINATION						13. 00
14. 00	PHARMACY		,				14. 00
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES		335, 761				15. 00
16. 00	OTHER GENERAL SERVICE		000, 701				16.00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES			Ĭ	0		17. 00
.,, 00	LEVEL OF CARE		1	1			
50.00	HOSPICE CONTINUOUS HOME CARE		0	C		0	50.00
51. 00	HOSPICE ROUTINE HOME CARE		334, 696			5, 345, 297	
52. 00	HOSPICE INPATIENT RESPITE CARE		996			15, 732	1
53. 00	HOSPICE GENERAL INPATIENT CARE		69		-	2, 007, 811	1
	NONREI MBURSABLE COST CENTERS	_					
60.00	BEREAVEMENT PROGRAM	C))	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		j			0	64.00
65.00	OTHER PHYSICIAN SERVICES		j			0	65. 00
66.00	RESI DENTI AL 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	1				0	70.00
71. 00	OTHER NONREIMBURSABLE (SPECIFY)		0		o	0	71. 00
99. 00	NEGATIVE COST CENTER		o		0	0	•
	TOTAL		335, 761		-	7, 368, 840	
	1	'		'			

Health Financial Systems	FRANCISCAN HEALTH	LAFAYETTE		In Lie	u of Form CMS-2552-10
COST ALLOCATION - HOSPITAL-BASED HOSPI STATISTICAL BASIS	CE GENERAL SERVICE COSTS	Provider CCN: Hospice CCN:	15-0109 15-1563	Peri od: From 01/01/2021 To 12/31/2021	Worksheet 0-6 Part II Date/Time Prepared: 5/2/2022 3:08 pm

			Tiospi ce con	. 13-1303 1	0 12/31/2021	5/2/2022 3:08	
					Hospi ce I		
	Cost Center Descriptions	CAP REL BLDG & CA	AP REL MVBLE	EMPLOYEE		ADMI NI STRATI VE	
	'	FIX	EQUI P	BENEFITS		& GENERAL	
		(SQUARE FEET) (D	OLLAR VALUE)	DEPARTMENT		(ACCUMULATED	
		/ (,	(GROSS		COSTS)	
				SALARI ES)			
		1.00	2.00	3. 00	4A	4. 00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FLXT	0					1.00
2.00	CAP REL COSTS-MVBLE EQUIP		0				2. 00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	2, 731, 551			3. 00
4. 00	ADMINISTRATIVE & GENERAL		0	2,70.,00.	-3, 145, 857	4, 222, 983	4. 00
5. 00	PLANT OPERATION & MAINTENANCE		0		0,110,007	1, 222, 700	5. 00
6. 00	LAUNDRY & LINEN SERVICE		0			0	6.00
7. 00	HOUSEKEEPI NG		0			0	7. 00
8. 00	DI ETARY		0			0	1
9. 00	NURSING ADMINISTRATION	0	0			479, 340	
10. 00	ROUTINE MEDICAL SUPPLIES		0				1
			0			15, 453	1
11. 00	MEDI CAL RECORDS	0	0	C		42, 696	1
12.00	STAFF TRANSPORTATION	0	0	C	0	0	12.00
13. 00	VOLUNTEER SERVICE COORDINATION	0	0	(0	44, 227	13. 00
14. 00	PHARMACY	0	0	C	0	0	14. 00
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	C	0	192, 420	1
	OTHER GENERAL SERVICE	0	0	C	0	0	
17. 00	PATIENT/RESIDENTIAL CARE SERVICES	0	0		0	0	17. 00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE			C	0	0	50. 00
51.00	HOSPICE ROUTINE HOME CARE			C	0	2, 769, 457	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	C	0	8, 141	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	2, 731, 551	0	671, 249	53. 00
	NONREI MBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	0	C	0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0	C	0	0	61.00
62.00	FUNDRAI SI NG	0	0	C	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	o	O	C	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	o	0	C	0	0	64. 00
65.00	OTHER PHYSICIAN SERVICES	o	o	C	0	0	65. 00
66.00	RESI DENTI AL CARE	o	o	C	0	0	66. 00
67. 00	ADVERTI SI NG	0	0	C	0	0	67. 00
68. 00	TELEHEALTH/TELEMONI TORI NG	0	0	-	0	0	68. 00
69. 00	THRI FT STORE		0	Č	n n	0	69. 00
70. 00	NURSING FACILITY ROOM & BOARD		J		n		70.00
	OTHER NONREIMBURSABLE (SPECIFY)		n	^		0	1
	NEGATIVE COST CENTER		٩				99.00
	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)		O	669, 431		3, 145, 857	
	UNIT COST MULTIPLIER	0. 000000	0. 000000	0. 245074		0. 744937	
101.00	ONLY COST MODELLI FIELD	0.000000	0. 000000	0. 243074	TI .	0.744737	1101.00

Heal th	Financial Systems	FRANCISCAN HEA	LTH LAFAYETTE		In Li€	eu of Form CMS-2	2552-10
COST A	LLOCATION - HOSPITAL-BASED HOSPICE GENERAL S	ERVICE COSTS	Provi der C		Peri od:	Worksheet 0-6	
STATIS	STICAL BASIS				From 01/01/2021		
			Hospi ce CC	N: 15-1563	To 12/31/2021	Date/Time Prep 5/2/2022 3:08	pared:
					Hospi ce I	3/2/2022 3.00	рііі
	Cost Center Descriptions	PLANT	LAUNDRY &	HOUSEKEEPI NG		NURSI NG	
	cost center bescriptions	OPERATION &	LINEN SERVICE			ADMI NI STRATI ON	
		MAI NTENANCE	(IN-FACILITY	(SQUARE TEET)	DAYS)	ADMINI STRATION	
		(SQUARE FEET)	DAYS)		DATO)	(DIRECT NURS.	
		(SQUARE TEET)	DATS)			HRS.)	
		5. 00	6, 00	7.00	8. 00	9, 00	
	GENERAL SERVICE COST CENTERS	3.00	0.00	7.00	0.00	7.00	
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	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE		ól				6.00
7. 00	HOUSEKEEPI NG			1	0		7.00
8.00	DI ETARY				0	,	8.00
9.00	NURSING ADMINISTRATION					82, 714	
10.00	ROUTINE MEDICAL SUPPLIES				0	02, 714	10.00
11. 00	MEDICAL RECORDS				o		1
12. 00	STAFF TRANSPORTATION				0	0	12.00
13. 00	VOLUNTEER SERVICE COORDINATION				0		13. 00
14. 00	PHARMACY			1	0		1
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES				0	1	
16. 00	OTHER GENERAL SERVICES				0	0	16.00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES				0	0	17. 00
17.00	LEVEL OF CARE		ή		U		17.00
50. 00	HOSPICE CONTINUOUS HOME CARE					0	50.00
51. 00	HOSPICE CONTINUOUS HOME CARE					0	00.00
52. 00	HOSPICE ROUTINE HOWE CARE HOSPICE INPATIENT RESPITE CARE				0	"	1
	HOSPICE THRAITENT RESPITE CARE		1	•		1	1
53. 00	NONREI MBURSABLE COST CENTERS	1	ή	ή	0	82,714	53.00
60. 00	BEREAVEMENT PROGRAM		\		o	0	60.00
	VOLUNTEER PROGRAM			•	0	0	
61. 00 62. 00	FUNDRAI SI NG		(1	0		61.00
63. 00	HOSPICE/PALLIATIVE MEDICINE FELLOWS		(0	0	62. 00 63. 00
	PALLIATIVE CARE PROGRAM		(0	0	1
64.00			(1	0	0	64.00
65. 00	OTHER PHYSICIAN SERVICES		(٥		65. 00

0.000000

0.000000

66.00

68.00

69. 00

70.00

71.00

99.00

0 0 67.00

836, 418 100. 00

10. 112170 101. 00

0 0 0

0

0.000000

0.000000

66. 00 RESI DENTI AL CARE
67. 00 ADVERTI SI NG

THRI FT STORE

99.00 NEGATIVE COST CENTER

101.00 UNIT COST MULTIPLIER

68.00

69.00

TELEHEALTH/TELEMONI TORI NG

70. 00 NURSING FACILITY ROOM & BOARD 71. 00 OTHER NONREIMBURSABLE (SPECIFY)

100.00 COST TO BE ALLOCATED (per Wkst. 0-6, Part I)

Health Financial Systems	FRANCISCAN HEAL	_TH_LAFAYETTE		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SE STATISTICAL BASIS	RVICE COSTS	Provider CCI Hospice CCN		Peri od: From 01/01/2021 To 12/31/2021		pared:
				Hospi ce I		
Cost Contor Dosorintions	DOUTLNE	MEDICAL	CTAFE	VOLUNTEED	DHADMACV	

			Hospi ce CC	N: 15-1563 1	To 12/31/2021	Date/Time Pre 5/2/2022 3:08	
					Hospi ce I		
	Cost Center Descriptions	ROUTI NE MEDI CAL SUPPLI ES (PATI ENT DAYS)	MEDICAL RECORDS (PATIENT DAYS)	STAFF TRANSPORTATION (MI LEAGE)	COORDI NATI ON (HOURS OF	PHARMACY (CHARGES)	
		10.00	11.00	12.00	SERVI CE) 13. 00	14.00	
	GENERAL SERVICE COST CENTERS	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 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL PLANT OPERATION & MAINTENANCE LAUNDRY & LINEN SERVICE HOUSEKEEPING DIETARY NURSING ADMINISTRATION ROUTINE MEDICAL SUPPLIES MEDICAL RECORDS STAFF TRANSPORTATION VOLUNTEER SERVICE COORDINATION PHARMACY PHYSICIAN ADMINISTRATIVE SERVICES OTHER GENERAL SERVICE PATIENT/RESIDENTIAL CARE SERVICES	34, 035	34, 035		34, 035 0 0 0 0	34, 035 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00
50. 00	LEVEL OF CARE HOSPICE CONTINUOUS HOME CARE	1 0			ol ol	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	33, 927	33, 927		33, 927	33, 927	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	101	101	1		101	
53.00	HOSPICE GENERAL INPATIENT CARE	7	7	' (7	7	53. 00
	NONREIMBURSABLE COST CENTERS BEREAVEMENT PROGRAM VOLUNTEER PROGRAM FUNDRAI SI NG HOSPICE/PALLI ATIVE 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 I) 26, 965 0. 792273		l	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	62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 69. 00 70. 00 71. 00 99. 00

Health Financial Systems	FRANCISCAN HEALTH	LAFAYETTE		In Lie	u of Form CMS-2552-10
COST ALLOCATION - HOSPITAL-BASED HOSPICE STATISTICAL BASIS	GENERAL SERVICE COSTS	Provider CCN: Hospice CCN:	15-0109 15-1563	Peri od: From 01/01/2021 To 12/31/2021	Worksheet 0-6 Part II Date/Time Prepared: 5/2/2022 3:08 pm

						5/2/2022 3: 08	3 pm
				_	Hospi ce I		
	Cost Center Descriptions	PHYSI CI AN	OTHER GENERAL	PATI ENT/			
		ADMI NI STRATI VE	SERVI CE	RESI DENTI AL			
		SERVI CES	(SPECI FY	CARE SERVICES			
		(PATIENT DAYS)	BASIS)	(IN-FACILITY			
				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	4					5. 00
6. 00	LAUNDRY & LINEN SERVICE						6.00
7. 00	HOUSEKEEPI NG	•					7. 00
8. 00	DI ETARY						8.00
9.00	NURSING ADMINISTRATION	1					9. 00
10. 00							1
	ROUTINE MEDICAL SUPPLIES						10.00
11. 00	MEDI CAL RECORDS						11. 00
12.00	STAFF TRANSPORTATION						12.00
13. 00	VOLUNTEER SERVICE COORDINATION						13. 00
	PHARMACY						14. 00
	PHYSICIAN ADMINISTRATIVE SERVICES	34, 035	l e				15. 00
	OTHER GENERAL SERVICE		0	1			16. 00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES						17. 00
	LEVEL OF CARE	1					4
50. 00	HOSPICE CONTINUOUS HOME CARE	0	1	1			50. 00
51. 00	HOSPICE ROUTINE HOME CARE	33, 927	0	1			51. 00
52. 00	HOSPICE INPATIENT RESPITE CARE	101	0)		52. 00
53. 00	HOSPICE GENERAL INPATIENT CARE	7	0) C			53. 00
	NONREI MBURSABLE COST CENTERS						
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 PHYSICIAN SERVICES		0				65. 00
66.00	RESI DENTI AL CARE	0		ol c)		66. 00
67.00	ADVERTI SI NG		l 0	ol			67. 00
68. 00	TELEHEALTH/TELEMONI TORI NG		0				68. 00
	THRI FT STORE	1	l				69. 00
	NURSING FACILITY ROOM & BOARD]				70.00
	OTHER NONREIMBURSABLE (SPECIFY)	0	0				71.00
	NEGATIVE COST CENTER		١	1			99. 00
	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	335, 761	0		,		100.00
	UNIT COST MULTIPLIER	9. 865168	0. 000000	0.000000			101.00
101.00	OWN T OOOT MOLITICIEN	7. 555 100	0.00000	0.000000	1		1.01.00

Heal th	Financial Systems	FRANCISCAN HEAL	TH LAFAYETTE		In Lie	u of Form CMS-2	2552-10
	TIONMENT OF HOSPITAL-BASED HOSPICE SHARED SE	RVICE COSTS BY	Provi der CO	CN: 15-0109 F	Peri od:	Worksheet 0-7	
LEVEL	OF CARE				From 01/01/2021	5	
			Hospi ce CCN	N: 15-1563	Γο 12/31/2021	Date/Time Pre 5/2/2022 3:08	pared:
					Hospi ce I	37272022 3.00	рш
			,	Charges by	LOC (from Provi	der Records)	
				9 9	•	ŕ	
	Cost Center Descriptions	From Wkst. C, (HCHC	HRHC	HI RC	
		Part I, Col. 9	Ratio				
		line 0	1. 00	2.00	3. 00	4. 00	
	ANCILLARY SERVICE COST CENTERS	0	1.00	2.00	3.00	4.00	
1.00	PHYSI CAL THERAPY	66.00	0. 291298		0	0	1.00
2.00	OCCUPATI ONAL THERAPY	67. 00	0. 182686		0	0	
3.00	SPEECH PATHOLOGY	68. 00	0. 202646		0	0	
4.00	DRUGS CHARGED TO PATIENTS	73. 00	0. 424496		0	0	4. 00
4.01	DI ABETES CENTER	73. 01	102. 014921		0	0	4. 01
5.00	DURABLE MEDICAL EQUIP-RENTED	96. 00					5. 00
6.00	LABORATORY	60.00	0. 107294	(0	0	6.00
7.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71. 00	0. 085266	(0	0	7. 00
8.00	OTHER OUTPATIENT SERVICE COST CENTER	93. 00					8. 00
9.00	RADI OLOGY - THERAPEUTI C	55. 00	0. 073487		0	0	1 7.00
10.00	ONCOLOGY	76. 00	0. 287348		0	0	1
10. 01	ANTI COAGULATI ON	76. 01	0. 497883		0	0	1
	I NFUSI ON SERVI CES	76. 02	0. 446895		0	0	1
	HYPERBARI C OXYGEN THERAPY	76. 98	0. 000000	(0	0	1
11.00	Totals (sum of lines 1-11)	Ch 1 00		Charant Carril	0		11. 00
		Charges by LOC		Snared Service	ce Costs by LOC		
		Records)					
	Cost Center Descriptions		HCHC (col 1 x	HRHC (col 1:	HIRC (col. 1 x	HGIP (col 1 x	
			col . 2)	col . 3)	col . 4)	col . 5)	
	ANGLELADY CERVICE COCT CENTERS	5. 00	6.00	7. 00	8. 00	9. 00	

0

0

0

0

0

0

1.00

2.00

3.00

4.00

4.01

5.00

6.00

7.00

8. 00 9. 00

10.01 10. 02

0

0 10.00

0

0 10. 98

0 11.00

ANCILLARY SERVICE COST CENTERS

PHYSI CAL THERAPY

SPEECH PATHOLOGY

DI ABETES CENTER

ANTI COAGULATI ON

10. 98 HYPERBARI C OXYGEN THERAPY

11.00 Totals (sum of lines 1-11)

LABORATORY

ONCOLOGY

10.02 INFUSION SERVICES

OCCUPATIONAL THERAPY

DRUGS CHARGED TO PATIENTS

DURABLE MEDICAL EQUIP-RENTED

MEDICAL SUPPLIES CHARGED TO PATIENT

OTHER OUTPATIENT SERVICE COST CENTER
RADIOLOGY - THERAPEUTIC

1.00

2.00

3.00

4.00

4.01

5.00

6.00

7.00

8.00

9.00 10.00

10.01

Health Financial Systems	FRANCISCAN HEALT	H LAFAYETTE		In Lieu	u of Form CMS-2552-10
CALCULATION OF HOSPITAL-BASED HOSPICE PE	R DIEM COST	Provider CCN: 15			Worksheet 0-8
		Hospice CCN: 15	5-1563	From 01/01/2021 To 12/31/2021	Date/Time Prepared

		HOSPI CE CCN	: 15-1563 1	0 12/31/2021	5/2/2022 3:08	
				Hospi ce I		
			TITLE XVIII	TITLE XIX	TOTAL	
			MEDI CARE	MEDI CAI D		
			1. 00	2. 00	3. 00	
	HOSPICE CONTINUOUS HOME CARE					
1. 00	Total cost (Wkst. 0-6, Part I, col. 18, line 50 plus Wkst. 0-7 line 11)	, col. 6,			0	1. 00
2.00	Total unduplicated days (Wkst. S-9, col. 4, line 10)				0	2. 00
3.00	Total average cost per diem (line 1 divided by line 2)				0.00	3. 00
4.00	Unduplicated program days (Wkst. S-9 col. as appropriate, line	: 10)	C	ol		4. 00
5. 00	Program cost (line 3 times line 4)	,	Ċ	o		5. 00
	HOSPI CE ROUTI NE HOME CARE	·		-1		
6.00	Total cost (Wkst. 0-6, Part I, col. 18, line 51 plus Wkst. 0-7	, col. 7,			5, 345, 297	6. 00
	line 11)					
7.00	Total unduplicated days (Wkst. S-9, col. 4, line 11)				33, 927	7. 00
8.00	Total average cost per diem (line 6 divided by line 7)				157. 55	8. 00
9.00	Unduplicated program days (Wkst. S-9, col. as appropriate, lin	ie 11)	33, 927	o o		9. 00
10.00	Program cost (line 8 times line 9)	İ	5, 345, 199	o		10.00
	HOSPICE INPATIENT RESPITE CARE					
11.00	Total cost (Wkst. 0-6, Part I, col. 18, line 52 plus Wkst. 0-7	', col. 8,			15, 732	11. 00
	line 11)					
12.00	Total unduplicated days (Wkst. S-9, col. 4, line 12)				101	12.00
13.00	Total average cost per diem (line 11 divided by line 12)				155. 76	13.00
14. 00	Unduplicated program days (Wkst. S-9, col. as appropriate, lin	ie 12)	101	0		14.00
15. 00	Program cost (line 13 times line 14)		15, 732	2 0		15. 00
	HOSPICE GENERAL INPATIENT CARE					
16. 00	Total cost (Wkst. 0-6, Part I, col. 18, line 53 plus Wkst. 0-7	', col . 9,			2, 007, 811	16. 00
	line 11)					
17. 00	Total unduplicated days (Wkst. S-9, col. 4, line 13)				7	17. 00
	Total average cost per diem (line 16 divided by line 17)				286, 830. 14	18. 00
19. 00	Unduplicated program days (Wkst. S-9, col. as appropriate, lin	ie 13)	7	0		19. 00
20. 00	Program cost (line 18 times line 19)		2, 007, 811	0		20. 00
	TOTAL HOSPICE CARE					
	Total cost (sum of line 1 + line 6 + line 11 + line 16)				7, 368, 840	
	Total unduplicated days (Wkst. S-9, col. 4, line 14)				34, 035	
23. 00	Average cost per diem (line 21 divided by line 22)				216. 51	23. 00

Heal th	Financial Systems FRANCISCAN HEALTH	H LAFAYETTE	In Lie	eu of Form CMS-2	2552-10		
	ATION OF CAPITAL PAYMENT	Provider CCN: 15-0109	Peri od: From 01/01/2021 To 12/31/2021	Worksheet L Parts I-III Date/Time Pre 5/2/2022 3:08	pared:		
	Title XVIII Hospital						
	DADT I FULLY DROCDECTIVE METHOD			1.00			
	PART I - FULLY PROSPECTIVE METHOD CAPITAL FEDERAL AMOUNT		-				
1.00	Capital DRG other than outlier			2, 634, 387	1.00		
1. 01	Model 4 BPCI Capital DRG other than outlier			2,034,307	1		
2. 00	Capital DRG outlier payments	225, 764					
2. 01	Model 4 BPCI Capital DRG outlier payments			0			
3.00	Total inpatient days divided by number of days in the cost re	eporting period (see inst	ructions)	116. 82			
4.00	Number of interns & residents (see instructions)		,	0.00	4. 00		
5.00	Indirect medical education percentage (see instructions)			0.00	5. 00		
6.00	Indirect medical education adjustment (multiply line 5 by the	e sum of lines 1 and 1.01	, columns 1 and	0	6. 00		
	1.01)(see instructions)						
7. 00	Percentage of SSI recipient patient days to Medicare Part A p	oatient days (Worksheet E	, part A line	3. 62	7. 00		
0.00	30) (see instructions)	+:>		2/ 50	0.00		
8. 00 9. 00	Percentage of Medicaid patient days to total days (see instru Sum of lines 7 and 8	ictions)		26. 59 30. 21			
10. 00	Allowable disproportionate share percentage (see instructions	.)		6. 31			
11. 00	Disproportionate share adjustment (see instructions)	5)		166, 230			
12. 00	1 ' '			3, 026, 381			
12.00	prospective capital payments (see mistinations)			3, 020, 301	12.00		
				1. 00			
	PART II - PAYMENT UNDER REASONABLE COST			_			
1.00	Program inpatient routine capital cost (see instructions)			0			
2. 00 3. 00	Program inpatient ancillary capital cost (see instructions) Total inpatient program capital cost (line 1 plus line 2)			0			
4. 00	Capital cost payment factor (see instructions)			0			
5.00	Total inpatient program capital cost (line 3 x line 4)						
3.00	Trotal Tripatricit program capital cost (Trile 3 x Trile 4)				3.00		
				1. 00			
	PART III - COMPUTATION OF EXCEPTION PAYMENTS						
1.00	Program inpatient capital costs (see instructions)			0			
2.00	Program inpatient capital costs for extraordinary circumstance	ces (see instructions)		0			
3. 00 4. 00	Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions)			0.00			
5. 00	Capital cost for comparison to payments (line 3 x line 4)			0.00			
6. 00	Percentage adjustment for extraordinary circumstances (see in	nstructions)		0.00			
7. 00	Adjustment to capital minimum payment level for extraordinary		Line 6)	0.00			
8. 00	Capital minimum payment level (line 5 plus line 7)	r erreamstarioes (Trrie 2)	. 11110 0)	Ö			
9. 00	Current year capital payments (from Part I, line 12, as appli	cable)		Ö			
10.00	Current year comparison of capital minimum payment level to capital minimum payment level minimum paym		less line 9)	0			
11. 00	Carryover of accumulated capital minimum payment level over o			0			
10.00	Worksheet L, Part III, line 14)		- 11)	_	10.00		
12.00	Net comparison of capital minimum payment level to capital pa			0			
13.00	Current year exception payment (if line 12 is positive, enter						
14. 00	Carryover of accumulated capital minimum payment level over c (if line 12 is negative, enter the amount on this line)	apitai payillent for the f	orrowing period	0	14. 00		
15. 00	Current year allowable operating and capital payment (see ins	structions)		0	15. 00		
	16.00 Current year operating and capital costs (see instructions)				16. 00		
	17. 00 Current year exception offset amount (see instructions)						
	1 3		!		17. 00		