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 09-30-2025 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION | Provider CCN: 15-0126 Worksheet S Peri od: From 01/01/2023 Parts I-III AND SETTLEMENT SUMMARY 12/31/2023 Date/Time Prepared: 5/30/2024 10:06 am

				J/ JU/ ZUZ T I	0. 00 am
PART I - COST	REPORT STATUS				
Provi der use onl y	 [X] Electronically prepared cost report [] Manually prepared cost report [0] If this is an amended report enter the number [F] Medicare Utilization. Enter "F" for full, "L 	of times the provider resubmit	ate: 5/30/2020 tted this cos		10:06 am
Contractor use only	5. [1]Cost Report Status 6. Date Received: (1) As Submitted 7. Contractor No. (2) Settled without Audit 8. [N]Initial Report f (3) Settled with Audit 9. [N]Final Report for (4) Reopened (5) Amended	or this Provider CCN 12.[0]If	tor's Vendor	umn 1 is 4:	

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

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 CROWN POINT (15-0126) for the cost reporting period beginning 01/01/2023 and ending 12/31/2023 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	Justin Kats			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	Justin Kats			2
3	Signatory Title	CF0			3
4	Date	(Dated when report is electronical			4

			Title XVIII				
		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	147, 391	101, 829	0	0	1. 00
2.00	SUBPROVI DER - I PF	0	0	0		0	2. 00
3.00	SUBPROVI DER - I RF	0	87, 373	12		0	3. 00
5.00	SWING BED - SNF	0	0	0		0	5. 00
6.00	SWING BED - NF	0				0	6.00
200.00	TOTAL	0	234, 764	101, 841	0	0	200. 00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The number for this information collection is OMB 0938-0050 and the number for the Supplement to Form CMS 2552-10, Worksheet N95, is OMB 0938-1425. The time required to complete and review the information collection is estimated 675 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, Maryl and 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.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0126 Peri od: Worksheet S-2 From 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/30/2024 10:06 am 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 1201 SOUTH MAIN STREET 1.00 PO Box: 1.00 State: IN 2.00 City: CROWN POINT Zip Code: 46307 County 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, 0, or N) Number Number Certi fi ed Type XVIII XIX 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 FRANCISCAN HEALTH CROWN 150126 23844 12/31/1973 Ν 0 3.00 1 POI NT Subprovi der - IPF 4.00 4 00 5.00 Subprovider - IRF FRANCISCAN HEALTH CROWN 15T126 23844 5 01/01/2023 Ν Ρ Τ 5.00 POI NT 6.00 Subprovi der - (Other) 6.00 Swi ng Beds - SNF Swi ng Beds - NF 7.00 7.00 8.00 8.00 9.00 Hospi tal -Based SNF 9.00 10.00 Hospi tal -Based NF 10.00 11.00 Hospi tal -Based OLTC 11.00 12.00 Hospi tal -Based HHA 12.00 Separately Certified ASC 13.00 13.00 14.00 Hospi tal -Based Hospi ce 14 00 15.00 Hospital-Based Health Clinic - RHC 15.00 16.00 Hospital-Based Health Clinic - FQHC 16.00 17.00 Hospital -Based (CMHC) I 17.00 18.00 Renal Dialysis 18 00 19.00 Other 19.00 From: To: 1 00 2 00 20.00 Cost Reporting Period (mm/dd/yyyy) 12/31/2023 20.00 01/01/2023 21.00 Type of Control (see instructions) 21.00 1. 00 2. 00 3 00 Inpatient PPS Information 22. 00 Does this facility qualify and is it currently receiving payments for Υ N 22.00 disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim UCPs, including supplemental UCPs, for 22.01 Υ 22.01 this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1 Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) 22.02 Is this a newly merged hospital that requires a final UCP to be determined Ν Ν 22.02 at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1. 22.03 Did this hospital receive a geographic reclassification from urban to 22. 03 N Ν Ν rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for 22.04 Did this hospital receive a geographic reclassification from urban to 22.04 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 counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" Which method is used to determine Medicaid days on lines 24 and/or 25 23.00 3 Ν below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.

					To 12/3			ime Pre 024 10:	
		In-State	In-State	Out-of	Out-of	Medi cai	d (Other	00 4111
		Medicaid paid days	Medicaid eligible	State Medicaid	State Medicaid	HMO day		di cai d days	
		para days	unpai d	pai d days	el i gi bl e			uays	
			days		unpai d				
24.00	L6 this provided is an LDDC hard to an too the	1.00	2. 00	3. 00	4. 00	5. 00		6. 00	24.00
24. 00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state	86	5	99	246	7, 5	94	228	24. 00
	Medicaid eligible unpaid days in column 2,								
	out-of-state Medicaid paid days in column 3,								
	out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in								
	column 5, and other Medicaid days in column 6.								
25. 00	If this provider is an IRF, enter the in-state	C) c	0	0	3	18		25. 00
	Medicaid paid days in column 1, the in-state Medicaideligible unpaid days in column 2, out-of-state	d 							
	Medicaid days in column 3, out-of-state Medicaid								
	eligible unpaid days in column 4, Medicaid HMO paid								
	and eligible but unpaid days in column 5.				IIrhan/P	ural StD	ata of	Geogra	
					1.			00	
26. 00	Enter your standard geographic classification (not w		at the beq	ginning of	the	1			26. 00
27. 00	cost reporting period. Enter "1" for urban or "2" fo		o+ +bo on	d of the oo	.+	1			27.00
27.00	Enter your standard geographic classification (not wareporting period. Enter in column 1, "1" for urban o					'			27. 00
	the effective date of the geographic reclassification	n in column	1 2.	•					
35. 00	If this is a sole community hospital (SCH), enter the	e number of	periods S	CH status i	ו	0			35. 00
	effect in the cost reporting period.				Begi n	ni na:	Endi	i na:	
					1.			00	
36. 00	Enter applicable beginning and ending dates of SCH s	tatus. Subs	cript line	36 for numl	oer of				36. 00
37 00	periods in excess of one and enter subsequent dates. If this is a Medicare dependent hospital (MDH), ente	r the numbe	er of period	ds MDH stati	ıs is	0			37. 00
37.00	in effect in the cost reporting period.	THE HUMBE	a or perroc	as won state	13 13	J			37.00
37. 01	Is this hospital a former MDH that is eligible for t								37. 01
	accordance with FY 2016 OPPS final rule? Enter "Y" for instructions)	or yes or "	N" for no.	(see					
38. 00	If line 37 is 1, enter the beginning and ending date:	s of MDH st	atus. If li	ne 37 is qu	reater				38. 00
	than 1, subscript this line for the number of period								
	subsequent dates.				Y	/NI	V	/N	
					1.			00	-
39. 00	Does this facility qualify for the inpatient hospita					N .		N	39. 00
	hospitals in accordance with 42 CFR §412.101(b)(2)(i) "Y" for yes or "N" for no. Does the facility meet the								
	with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter								
	(see instructions)		,						
40. 00	Is this hospital subject to the HAC program reduction for no in column 1, for discharges prior to October					N	`	Y	40. 00
	column 2, for discharges on or after October 1. (see			OF IN TOTAL	10 111				
						V	XVIII		
	D					1. 00	2. 00	3.00	
45 00	Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital payment	nt for disp	roporti ona	te share in	accordance	N	Υ	N	45. 00
.0.00	with 42 CFR Section §412.320? (see instructions)	o. a.op	n opon trona	20 01.01 0 11.	4000. 4400	"		"	10.00
46. 00	Is this facility eligible for additional payment exc					N N	N	N	46. 00
	pursuant to 42 CFR §412.348(f)? If yes, complete Wks	t. L, Pt. I	II and wks	t. L-1, Pt.	i through	Pt.			
47. 00	Is this a new hospital under 42 CFR §412.300(b) PPS	capital? E	nter "Y for	r yes or "N'	' for no.	N	N	N	47. 00
48. 00	Is the facility electing full federal capital paymen	t? Enter "	Y" for yes	or "N" for	no.	N	N	N	48. 00
56. 00	Teaching Hospitals Is this a hospital involved in training residents in	approved C	ME programs	2 For cost	roporting	Y	Υ	T	56. 00
30.00	periods beginning prior to December 27, 2020, enter					'	1		30.00
	cost reporting periods beginning on or after Decembe	r 27, 2020,	under 42 (CFR 413.78(I	o)(2), see				
	instructions. For column 2, if the response to column in training residents in approved CME programs in the								
	in training residents in approved GME programs in the are impacted by CR 11642 (or applicable CRs) MA direction								
	otherwise, enter "N" for no in column 2.	. 3			,				
57. 00	For cost reporting periods beginning prior to December this the first cost reporting period during which re-								57. 00
	this the first cost reporting period during which rethis facility? Enter "Y" for yes or "N" for no in co								
	start training in the first month of this cost repor	ting period	l? Enter "\	Y" for yes o	or "N" for	no			
	in column 2. If column 2 is "Y", complete Worksheet								
	Parts III & IV and D-2, Pt. II, if applicable. For on December 27, 2020, under 42 CFR 413.77(e)(1)(iv) and								
	cost report the residents were on duty, if the respon	nse to line	e 56 is "Y"			r			
E0 00	yes in column 1, do not complete column 2, and complete line 54 is yes, did this facility clost cost roim			and same!	oc oc 4-£!	od N			E0 00
აგ. 00	If line 56 is yes, did this facility elect cost reim in CMS Pub. 15-1, chapter 21, §2148? If yes, complete			ario Selivi Ce	es as uerin	ed N			58. 00
						-			

			To	0 12/31/2023	Date/Time Pre 5/30/2024 10:	
				V	XVIII XIX	00 4111
EQ 00 Are costs claimed on line 100 of Workshoot A2 If you	compl	Loto Wkst D 2	Pt. I.	1. OO	0 2.00 3.00	59. 00
59.00 Are costs claimed on line 100 of Worksheet A? If yes	s, compi	Tele WKSt. D-2,	NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
			1. 00	2.00	3. 00	
Are you claiming nursing and allied health education programs that meet the criteria under 42 CFR 413.85? Enter "Y" for yes or "N" for no in column 1. If colu impacted by CR 11642 (or subsequent CR) NAHE MA payme "Y" for yes or "N" for no in column 2. If line 60 is yes, complete columns 2 and 3 for each instructions)	(see i umn 1 is ent adju	instructions) s "Y", are you ustment? Enter	Y	Y 23. 00	1	60.00
50.02 If line 60 is yes, complete columns 2 and 3 for each instructions)	progran	m. (see		23. 01	1	60. 0
j. 1.00. do 1. 0.10)	Y/N	I ME	Direct GME	I ME	Direct GME	
51.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1.	1. 00 N	2. 00	3. 00	4.00	5. 00	61. 0
(see instructions) 61.01 Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see						61. 0 ⁻
instructions) 11.02 Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, an primary care FTEs added under section 5503 of ACA). (see instructions)	nd					61.0
1.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61. C
 1.04 Enter the number of unweighted primary care/or surger allopathic and/or osteopathic FTEs in the current cos reporting period. (see instructions). 1.05 Enter the difference between the baseline primary 						61. 0
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 use for cap relief and/or FTEs that are nonprimary care of general surgery. (see instructions)						61.0
general surgery. (see Histructions)	Pro	ogram Name	Program Code	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 direct one intermedigited count.			1		1.00	
ACA Provisions Affecting the Health Resources and Ser 2.00 Enter the number of FTE residents that your hospital				od for which	0.00	62.0
your hospital received HRSA PCRE funding (see instruction 2.01 Enter the number of FTE residents that rotated from a	cti ons) n Teachi	ing Health Cent	ter (THC) into			62.0
during in this cost reporting period of HRSA THC prog Teaching Hospitals that Claim Residents in Nonprovide 3.00 Has your facility trained residents in nonprovider se	er Setti	i ngs		period? Enter "	Y" N	63. 0
for yes or "N" for no in column 1. If yes, complete I						-5.0

Heal th F	Financial Systems	FRANCI SCA	N HEALTH CROWN POINT		In Lie	u of Form CMS-2	2552-10
HOSPI TAI	L AND HOSPITAL HEALTH CARE COMP	LEX IDENTIFICATION DA	TA Provider CC		eriod: fom 01/01/2023 0 12/31/2023		pared:
				Unwei ghted FTEs	Unweighted FTEs in	Ratio (col. 1/	
				Nonprovi der	Hospi tal	2))	
				Si te 1. 00	2.00	3.00	
	ection 5504 of the ACA Base Yea						
64.00 E i r s	neriod that begins on or after J inter in column 1, if line 63 is n the base year period, the num resident FTEs attributable to ro lettings. Enter in column 2 the esident FTEs that trained in your of (column 1 divided by (column	yes, or your facilit ber of unweighted nor tations occurring in number of unweighted ur hospital. Enter ir	ty trained residents n-primary care all nonprovider d non-primary care n column 3 the ratio	0. 00	0. 00	0. 000000	64. 00
		Program Name	Program Code	Unwei ghted FTEs	Unweighted FTEs in	Ratio (col. 3/ (col. 3 + col.	
				Nonprovi der	Hospi tal	4))	
		1. 00	2.00	Si te 3. 00	4. 00	5. 00	
65. 00 E	inter in column 1, if line 63	1.00	2.00	0.00	0. 00		65. 00
i r p aa F p r t c u r r n c u F h r (s yes, or your facility trained residents in the base year heriod, the program name so sociated with primary care TEs for each primary care trogram in which you trained residents. Enter in column 2, he program code. Enter in column 3, the number of movel in the primary care FTE residents attributable to cotations occurring in all con-provider settings. Enter in column 4, the number of movel ighted primary care resident TEs that trained in your cospital. Enter in column 5, the ratio of (column 3 divided by column 3 + column 4)). (see nstructions)						
				Unwei ghted FTEs	Unweighted FTEs in	Ratio (col. 1/ (col. 1 + col.	
				Nonprovi der	Hospi tal	2))	
				Si te 1. 00	2. 00	3.00	
	ection 5504 of the ACA Current		n Nonprovider Settings				
	eginning on or after July 1, 20 Inter in column 1 the number of		ry care resident FTEs	0. 00	1. 50	0. 000000	66. 00
a c t	ttributable to rotations occurr column 2 the number of unweighte rained in your hospital. Enter cy (column 1 + column 2)). (see	ing in all nonprovide d non-primary care re in column 3 the ratio	er settings. Enter in esident FTEs that	1			
	277. (300	Program Name	Program Code	Unwei ghted	Unwei ghted	Ratio (col. 3/	
				FTEs Nonprovi der	FTEs in Hospital	(col. 3 + col. 4))	
		1 00	2.00	Si te	4.00	F 00	
67. 00 E	nter in column 1, the program	1.00	2.00	3. 00 0. 00	4. 00 0. 00	5. 00 0. 000000	67. 00
y w E c n c t n c u F h r (name associated with each of our primary care programs in which you trained residents. Inter in column 2, the program node. Enter in column 3, the number of unweighted primary hare FTE residents attributable or rotations occurring in all non-provider settings. Enter in column 4, the number of noweighted primary care resident TEs that trained in your nospital. Enter in column 5, the atio of (column 3 divided by column 3 + column 4)). (see nstructions)						

позетт	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CC	N. 13-0126	From 01/01/ To 12/31/		Part I Date/Ti 5/30/20	me Pre	pared:
					+	1. (20	-
	Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 I	FR 49065-490)72 (August 1	0, 2022)			30	
68. 00	For a cost reporting period beginning prior to October 1, 2022, to apply the new DGME formula in accordance with the FY 2023 IF 10, 2022)?							68. 00
					1.00	2 00	3.00	
	Inpatient Psychiatric Facility PPS					1 2. 00		
70. 00	Is this facility an Inpatient Psychiatric Facility (IPF), or do	oes it conta	in an IPF su	bprovi der?	N			70. 00
71 00	Enter "Y" for yes or "N" for no. If line 70 is yes: Column 1: Did the facility have an approved	GME teachin	na program in	the most	N	N	0	71. 00
71.00	recent cost report filed on or before November 15, 2004? Enter CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train re in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for column 2 is Y, indicate which program year began during this coinstructions)	r "Y" for ye esidents in r yes or "N"	es or "N" for a new teachi for no. Col	no. (see 4 ng program umn 3: If			Ü	71.00
75 00	Inpatient Rehabilitation Facility PPS Is this facility an Inpatient Rehabilitation Facility (IRF), or	does it co	ntain an IRE		Υ	Т		75. 00
	subprovider? Enter "Y" for yes and "N" for no.							
76. 00	If line 75 is yes: Column 1: Did the facility have an approved recent cost reporting period ending on or before November 15, 2 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. Cowhich program year began during this cost reporting period. (see	2004? Enter ng program olumn 3: If	"Y" for yes in accordanc column 2 is	or "N" for e with 42	N	N	0	76. 00
							20	
	Long Term Care Hospi tal PPS					1. (JU	
	00 Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.							
	TEFRA Providers .00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no. .00 Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section							
87. 00	§413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no. Is this hospital an extended neoplastic disease care hospital of 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	classified u	ınder section			N	ı	87. 00
	rood(a) (1) (b) (vr): Enter 1 For yes or 14 For he.			Approved	for	Numbe	r of	
				Permane Adjustm (Y/N)	ent	Appro Perma Adjust	nent	
				1. 00		2. (
88. 00	Column 1: Is this hospital approved for a permanent adjustment per discharge? Enter "Y" for yes or "N" for no. If yes, complet instructions) Column 2: Enter the number of approved permanent adjustments.						0	88.00
	por anni 2. Error the name of approved permanent day detinentes		Wkst. A Lin	e Effective	Date	Appro	oved	
			No.			Perma Adjus Amoun Disch	tment t Per	
			1. 00	2.00)	3. (
89. 00	Column 1: If line 88, column 1 is Y, enter the Worksheet A line which the per discharge permanent adjustment approval was based Column 2: Enter the effective date (i.e., the cost reporting perbeginning date) for the permanent adjustment to the TEFRA targe per discharge. Column 3: Enter the amount of the approved permanent adjustment	d. eriod et amount	0.	00			0	89.00
	TEFRA target amount per discharge.			V		ΧI	٧	
				1.00		2. (
90. 00	Title V and XIX Services Does this facility have title V and/or XIX inpatient hospital s	services? En	ter "V" for	yes N		Y	,	90.00
	or "N" for no in the applicable column. Is this hospital reimbursed for title V and/or XIX through the	cost report				Y		91.00
92. 00	or in part? Enter "Y" for yes or "N" for no in the applicable of Are title XIX NF patients occupying title XVIII SNF beds (dual	certi fi cati	on)? (see			N	l	92. 00
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 for yes or "N" for no in the applicable column.		I XIX? Enter	"Y" N		N	I	93. 00
94. 00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and applicable column.	d "N" for no	in the	N		N	l	94. 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			0. 00 N		O. (95. 00 96. 00
97. 00	applicable column. If line 96 is "Y", enter the reduction percentage in the applic	cable column	l.	0. 00		0.0	00	97. 00

	Provider CC		In Lie Period: From 01/01/2023 To 12/31/2023	Date/Time 5/30/2024	Prepared:
			V 1.00	XIX	
98.00 Does title V or XIX follow Medicare (title XVIII) for the inte	erns and resi	dents nost	1. 00 Y	2. 00 Y	98. 00
stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for					70.00
98.01 Does title V, and in column 2 for title XIX. 98.01 Does title V or XIX follow Medicare (title XVIII) for the report Pt. I? Enter "Y" for yes or "N" for no in column 1 for title VXIX.				Y	98. 01
98.02 Does title V or XIX follow Medicare (title XVIII) for the calc costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" V, and in column 2 for title XIX.	culation of o for no in co	bservation be lumn 1 for ti	ed Y tle	Y	98. 02
98.03 Does title V or XIX follow Medicare (title XVIII) for a critic reimbursed 101% of inpatient services cost? Enter "Y" for yes for title V, and in column 2 for title XIX.			N	N	98. 03
98.04 Does title V or XIX follow Medicare (title XVIII) for a CAH reservices cost? Enter "Y" for yes or "N" for no in column 1 for for title XIX.				N	98. 04
98.05 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 col column 2 for title XIX.			Y	Y	98. 05
98.06 Does title V or XIX follow Medicare (title XVIII) when cost rethrough IV? Enter "Y" for yes or "N" for no in column 1 for title XIX.				Y	98. 06
Rural Providers 105.00 Does this hospital qualify as a CAH?			N		105. 00
106.00 If this facility qualifies as a CAH, has it elected the all-ir	nclusive meth	od of paymen			106. 00
for outpatient services? (see instructions) 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 yo medical education program in the CAH's excluded IPF and/or IF	1. (see inst ou train I&Rs	ructions) in an approv			107. 00
yes or "N" for no in column 2. (see instructions) 107.01 If this facility is a REH (line 3, column 4, is "12"), is it experiment for I&R training programs? Enter "Y" for yes or					107. 01
instructions) 108.00 Is this a rural hospital qualifying for an exception to the CF Section §412.113(c). Enter "Y" for yes or "N" for no.	RNA fee sched	ul e? See 42 Occupati onal		Respi rato	108. 00
	1. 00	2. 00	3. 00	4.00	y y
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.					109. 00
				1.00	
110.00 Did this hospital participate in the Rural Community Hospital Demonstration) for the current cost reporting period? Enter "Y" Worksheet E, Part A, lines 200 through 218, and Worksheet E-2,	" for yes or	"N" for no. I	f yes, complete	N	110. 00
Demonstration) for the current cost reporting period? Enter "Y"	" for yes or	"N" for no. I	f yes, complete	N	110. 00
Demonstration) for the current cost reporting period? Enter "Y"	" for yes or , lines 200 t e Frontier Co ting period? Y, enter the column 2. En	"N" for no. I hrough 215, a mmunity Heal Enter "Y" for integration ter all that	f yes, complete as applicable. 1.00	N	110.00
Demonstration) for the current cost reporting period? Enter "Y" Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, 111.00 If this facility qualifies as a CAH, did it participate in the Integration Project (FCHIP) demonstration for this cost report yes or "N" for no in column 1. If the response to column 1 is prong of the FCHIP demo in which this CAH is participating in apply: "A" for Ambulance services; "B" for additional beds; and the services is the service of the services o	" for yes or , lines 200 t e Frontier Co ting period? Y, enter the column 2. En	"N" for no. I hrough 215, a mmunity Heal Enter "Y" for integration ter all that	f yes, complete as applicable. 1.00	N	
Demonstration) for the current cost reporting period? Enter "Y" Worksheet E, Part A, Lines 200 through 218, and Worksheet E-2, 111.00 If this facility qualifies as a CAH, did it participate in the Integration Project (FCHIP) demonstration for this cost report yes or "N" for no in column 1. If the response to column 1 is prong of the FCHIP demo in which this CAH is participating in apply: "A" for Ambulance services; "B" for additional beds; ar services. 112.00 Did this hospital participate in the Pennsylvania Rural Health (PARHM) demonstration for any portion of the current cost report period? Enter "Y" for yes or "N" for no in column 1. If column 1 in column 2, the date the hospital began participating in demonstration. In column 3, enter the date the hospital cease participation in the demonstration, if applicable.	" for yes or , lines 200 t e Frontier Co ting period? Y, enter the column 2. En nd/or "C" for h Model prting umn 1 is "Y",	"N" for no. I hrough 215, a mmunity Heal Enter "Y" for integration ter all that tele-health	f yes, completes applicable. 1.00 h N	2.00	
Demonstration) for the current cost reporting period? Enter "Y" Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, 111.00 If this facility qualifies as a CAH, did it participate in the Integration Project (FCHIP) demonstration for this cost report yes or "N" for no in column 1. If the response to column 1 is prong of the FCHIP demo in which this CAH is participating in apply: "A" for Ambulance services; "B" for additional beds; ar services. 112.00 Did this hospital participate in the Pennsylvania Rural Health (PARHM) demonstration for any portion of the current cost report period? Enter "Y" for yes or "N" for no in column 1. If columner in column 2, the date the hospital began participating in demonstration. In column 3, enter the date the hospital cease participation in the demonstration, if applicable. Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or "column 1. If column 1 is yes, enter the method used (A, B, or column 2. If column 2 is "E", enter in column 3 either "93" per short term hospital or "98" percent for long term care (included psychiatric, rehabilitation and long term hospitals providers) the definition in CMS Pub. 15-1, chapter 22, \$2208.1.	"For yes or lines 200 to tines 200 to tines 200 to tines 200 to tine period? Y, enter the column 2. En and/or "C" for the column 1 is "Y", in the ed "N" for no in E only) in ercent for des) based on	mmunity Heal Enter "Y" for integration ter all that tele-health N	f yes, completes applicable. 1.00 h N	2.00	111.00
Demonstration) for the current cost reporting period? Enter "Y" Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, 111.00 If this facility qualifies as a CAH, did it participate in the Integration Project (FCHIP) demonstration for this cost report yes or "N" for no in column 1. If the response to column 1 is prong of the FCHIP demo in which this CAH is participating in apply: "A" for Ambulance services; "B" for additional beds; ar services. 112.00 Did this hospital participate in the Pennsylvania Rural Health (PARHM) demonstration for any portion of the current cost report of the current cost r	"For yes or lines 200 to ting period? Y, enter the column 2. En mod/or "C" for home model or ting umn 1 is "Y", in the ed "N" for no in ercent for des) based on or yes or "N"	mmunity Heal Enter "Y" for integration ter all that tele-health N	f yes, completes applicable. 1.00 h N	2.00	111.00
Demonstration) for the current cost reporting period? Enter "Y" Worksheet E, Part A, Iines 200 through 218, and Worksheet E-2, 111.00 If this facility qualifies as a CAH, did it participate in the Integration Project (FCHIP) demonstration for this cost report yes or "N" for no in column 1. If the response to column 1 is prong of the FCHIP demo in which this CAH is participating in apply: "A" for Ambulance services; "B" for additional beds; ar services. 112.00 Did this hospital participate in the Pennsylvania Rural Health (PARHM) demonstration for any portion of the current cost reportion? Enter "Y" for yes or "N" for no in column 1. If columner in column 2, the date the hospital began participating in demonstration. In column 3, enter the date the hospital cease participation in the demonstration, if applicable. Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or "column 1. If column 1 is yes, enter the method used (A, B, or column 2. If column 2 is "E", enter in column 3 either "93" per short term hospital or "98" percent for long term care (inclus psychiatric, rehabilitation and long term hospitals providers) the definition in CMS Pub. 15-1, chapter 22, \$2208.1.	"For yes or lines 200 to ting period? Y, enter the column 2. En mod/or "C" for home model or ting umn 1 is "Y", in the ed "N" for no in ercent for des) based on or yes or "N"	mmunity Heal Enter "Y" for integration ter all that tele-health N	f yes, completes applicable. 1.00 h N	2.00	111.00

127.00 If this is a Medicare-certified hear		fication date in			127. 00
column 1 and termination date, if ap 128.00 If this is a Medicare-certified live		fication date in			128. 00
column 1 and termination date, if ap		Treation date in			120.00
129.00 If this is a Medicare-certified lung		ication date in			129. 00
column 1 and termination date, if ap					
130.00 If this is a Medicare-certified panc		rtification date			130. 00
in column 1 and termination date, if 131.00 If this is a Medicare-certified inte	stinal transplant program, enter the	certi fi cati on			131. 00
date in column 1 and termination dat		fication data in			132. 00
132.00 If this is a Medicare-certified isle column 1 and termination date, if ap		rication date in			132.00
133.00 Removed and reserved	pri cabi c, i i i coi anni 2.				133. 00
134.00 If this is a hospital-based organ pr	ocurement organization (OPO), enter t	he OPO number in			134. 00
column 1 and termination date, if ap					
All Providers					
140.00 Are there any related organization o			Υ		140. 00
	for no in column 1. If yes, and home				
	office chain number. (see instruction 2.00	(S)	3.00		
1.00		yugh 142 the name of		of the	
	e contractor name and contractor numb		iliu auul ess	or the	
141. 00 Name: FRANCI SCAN ALLI ANCE	Contractor's Name: WISCONSIN PHYSIC		Number 0800	 1	141. 00
TTT. CONTAINS. TTO WOT SOME MEET MADE	SERVICES (WPS)	Siril Golffi de toi S	ramber: 0000	•	1111.00
142.00 Street: 1717 W BROADWAY	PO Box:				142. 00
143.00 City: MADISON	State:	Zi p Code:	5371	3-1834	143.00
				1. 00	
144.00 Are provider based physicians' costs	included in Worksheet A?			Υ	144. 00
115 0010			1. 00	2. 00	1.15 00
145.00 If costs for renal services are clai			Υ		145. 00
	"N" for no in column 1. If column 1 i tilization for this cost reporting pe				
for yes or "N" for no in column 2.	till Zation for this cost reporting pe	irou: Litter i			
146.00 Has the cost allocation methodology	changed from the previously filed cos	t report? Enter	N		146, 00
	1. (See CMS Pub. 15-2, chapter 40, §4				1 10.00
enter the approval date (mm/dd/yyyy)		3.1,			
, , , , , , , , , , , , , , , , , , , ,		'			

FRAINCI SCAIN	HEALIH	CROWN POINT			In Lie	u of Form CMS	5-2552-10
			N: 15-0126	From	d: 01/01/2023	Worksheet S Part I Date/Time P	-2 repared:
						1 00	
cal basis? Enter "Y"	for ves	s or "N" for	no.			N N	147. 00
						N	148. 00
				for no.		N	149. 00
		Part A		3	Title V		
						1 1 1	
		N	N		N	N	155. 00
		N	N		N	N	156. 00
		N	N		N	N	157. 00
							158. 00
							159. 00
		N					160. 00
			N		N	N	161. 00
						1. 00	
ampus hospital that h	as one o	or more campu	ises in dif	ferent (CBSAs? Ent	er N	165. 00
Name		County	State	Zip Code	e CBSA	FTE/Campus	
0		1. 00	2. 00	3. 00	4. 00	5.00	
						0.	00 166. 00
[] incentive in the A	meri can	Recovery and	l Reinvestr	ment Act		1.00	
						Y	167. 00
				/"), ente	er the		168. 00
					rdshi p		168. 01
? Enter "Y" for yes o	r "N" fo	or no. (see i	nstruction	ıs)			00110 00
) and is	s not a CAH (iine 105 i	s "N"),	enter the	9.	99169.00
J113)				Е		Endi ng	
					1. 00	2. 00	
peginning date and en	ding da	te for the re	porting pe	eri od			170. 00
					1. 00	2.00	
vider have any days f	or indiv	vi dual s enrol	led in sec	ti on	N		0 171. 00
on Wkst. S-3, Pt. I,	line 2,	, col. 6? Ent	er "Y" for	yes			
iffi i ·	ical basis? Enter "Y" fallocation? Enter "ied cost finding meth ied cost finding meth ider that qualifies for no for each compared to the following state of the	ical basis? Enter "Y" for ye fallocation? Enter "Y" for je de cost finding method? Entitled cost finding method? Entitled cost finding method? Entitled cost finding method? Entitled cost finding method? Enter "N" for no for each component "N" for yes a meaningfall see instructions not a meaningful user, does? Enter "Y" for yes or "N" fuser (line 167 is "Y") and it ons) beginning date and ending da vider have any days for indition Wkst. S-3, Pt. I, line 2	ical basis? Enter "Y" for yes or "N" for fallocation? Enter "Y" for yes or "N" for ied cost finding method? Enter "Y" for ye or "N" for ied cost finding method? Enter "Y" for ye Part A 1.00 ider that qualifies for an exemption from "N" for no for each component for Part A N N N N N N N N N N N N N N N N N N	ical basis? Enter "Y" for yes or "N" for no. fallocation? Enter "Y" for yes or "N" for no. ied cost finding method? Enter "Y" for yes or "N" for no. ied cost finding method? Enter "Y" for yes or "N" for no ider that qualifies for an exemption from the appli "N" for no for each component for Part A and Part I N N N N N N N N N N N N N N N N N N	Provider CCN: 15-0126 Period From To ical basis? Enter "Y" for yes or "N" for no. f allocation? Enter "Y" for yes or "N" for no. ied cost finding method? Enter "Y" for yes or "N" for no. Part A Part B 1.00 2.00 ider that qualifies for an exemption from the application "N" for no for each component for Part A and Part B. (See N N N N N N N N N	Provider CCN: 15-0126 Period: From 01/01/2023 Period: From 01/01/2023 Period: From 01/01/2023 Period: Provider CCN: 15-0126 Period: Provider CCN: 15	Provider CCN: 15-0126 Period: From 01/01/2023 Part I Date/Time P 5/30/2024 10 Part I Date/Time P P P P P P P P P P P P P P P P P P P

Heal th	Financial Systems FRANCISCAN HEAL	TH CROWN POINT		In Li€	eu of Form CMS-	2552-10
	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE			Peri od:	Worksheet S-2	
				From 01/01/2023 To 12/31/2023	Date/Time Pre	
				Y/N	5/30/2024 10: Date	06 am
				1. 00	2. 00	
	PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURSE					
	General Instruction: Enter Y for all YES responses. Enter N mm/dd/yyyy format.	l for all NO re	esponses. Ente	r all dates in	the	
	COMPLETED BY ALL HOSPITALS					
1 00	Provider Organization and Operation		46	NI		1 00
1. 00	Has the provider changed ownership immediately prior to the reporting period? If yes, enter the date of the change in a			N		1.00
	,		Y/N	Date	V/I	
2. 00	Has the provider terminated participation in the Medicare F	Program2 If you	1.00 N	2. 00	3. 00	2.00
2.00	enter in column 2 the date of termination and in column 3,		, !\			2.00
2 00	voluntary or "I" for involuntary.		N.			2.00
3. 00	Is the provider involved in business transactions, includir contracts, with individuals or entities (e.g., chain home of		N or			3. 00
	medical supply companies) that are related to the provider	or its				
	officers, medical staff, management personnel, or members of directors through ownership, control, or family and other s	of the board of similar				
	relationships? (see instructions)					
			Y/N 1,00	Type	Date	
	Financial Data and Reports		1.00	2. 00	3. 00	
4.00	Column 1: Were the financial statements prepared by a Cert		Y	А	04/17/2024	4. 00
	Accountant? Column 2: If yes, enter "A" for Audited, "C" f "R" for Reviewed. Submit complete copy or enter date availa		pr			
	3. (see instructions) If no, see instructions.	abre in cordiiir				
5.00	Are the cost report total expenses and total revenues different the filed financial statements? If we are write recognition		se N			5. 00
	on the filed financial statements? If yes, submit reconcili	ation.		Y/N	Legal Oper.	
				1. 00	2. 00	
6. 00	Approved Educational Activities Column 1: Are costs claimed for a nursing program? Column	2. If ves is	the provider	Υ	Y	6. 00
0.00	the legal operator of the program?	2. 11 ycs, 15	the provider	'	'	0.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see in			Y		7.00
8. 00	Were nursing programs and/or allied health programs approve cost reporting period? If yes, see instructions.	ed and/or renev	vea during the	N		8. 00
9. 00	Are costs claimed for Interns and Residents in an approved	•	cal education	Y		9. 00
10. 00	program in the current cost report? If yes, see instruction Was an approved Intern and Resident GME program initiated of		he current co	st Y		10.00
10.00	reporting period? If yes, see instructions.					
11. 00	Are GME cost directly assigned to cost centers other than I	& R in an App	proved Teaching	g N		11. 00
	Program on Worksheet A? If yes, see instructions.				Y/N	
	T				1. 00	
12 00	Bad Debts Is the provider seeking reimbursement for bad debts? If yes	s see instruct	ions		Y	12. 00
	If line 12 is yes, did the provider's bad debt collection p			st reporting	Ň	13. 00
	period? If yes, submit copy.				<u></u>	14.00
14.00	If line 12 is yes, were patient deductibles and/or coinsura Bed Complement	ance amounts wa	iiveu? II yes,	see instruction	ηs. N	14. 00
15. 00	Did total beds available change from the prior cost reporti	,	-		N	15. 00
		Par Y/N	Tt A Date	Par Y/N	rt B Date	
		1.00	2.00	3. 00	4. 00	
4, 00	PS&R Data		1		1	1
16. 00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of			N		16. 00
	the PS&R Report used in columns 2 and 4 (see instructions)					
17. 00	Was the cost report prepared using the PS&R Report for	Y	04/09/2024	Y	04/09/2024	17. 00
	totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in column					
10.00	2 and 4. (see instructions)					10.00
18. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but	l N		N		18. 00
	are not included on the PS&R Report used to file this cost					
19. 00	report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R	N		N		19. 00
17.00	Report data for corrections of other PS&R Report	l IV		IN		1 7. 00
	information? If yes, see instructions.	1	1		I	1

Heal th	Financial Systems FRANCISCAN HEALTH	H CROWN POINT		In Lie	u of Form CMS-	2552-10			
	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der CC	CN: 15-0126	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part II Date/Time Pre 5/30/2024 10:	epared:			
		Descri	•	Y/N	Y/N				
20.00	LE Line 1/ au 17 in the property and to DCOD)	1.00	3. 00	20.00			
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			
	Troport data for other bessering the other day dother to	Y/N	Date	Y/N	Date				
		1. 00	2. 00	3. 00	4. 00				
21. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21. 00			
					1 00				
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEP	T CHILDRENS H	OSPLTALS)		1. 00				
	Capital Related Cost	· om Esterio m	001111120)						
22. 00	Have assets been relifed for Medicare purposes? If yes, see				N	22. 00			
23. 00	Have changes occurred in the Medicare depreciation expense d	lue to apprais	als made dur	ing the cost	N	23. 00			
24. 00	reporting period? If yes, see instructions. Were new leases and/or amendments to existing leases entered into during this cost reporting period? If N 24								
24.00	yes, see instructions	i iiito dairiig	11113 6031 16	por tring perrou: I		24. 00			
25. 00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see								
26. 00	instructions. Were assets subject to Sec. 2314 of DEFRA acquired during the	cost reporti	ng period? I	f yes, see	N	26. 00			
27. 00	instructions. Has the provider's capitalization policy changed during the	cost reportin	a neriod? If	ves submit conv	. N	27. 00			
	Interest Expense					28. 00			
28. 00	00 Were new Loans, mortgage agreements or letters of credit entered into during the cost reporting period? N								
29. 00	00 Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) N								
30. 00	treated as a funded depreciation account? If yes, see instru Has existing debt been replaced prior to its scheduled matur		debt? If ves	. see instruction	s. N	30.00			
31. 00	Has debt been recalled before scheduled maturity without iss					31. 00			
	Purchased Services								
32. 00	Have changes or new agreements occurred in patient care servarrangements with suppliers of services? If yes, see instruc	/ICES TURNISME Stions	a through co	ntractuai	N	32. 00			
33. 00	If line 32 is yes, were the requirements of Sec. 2135.2 appl		g to competi	tive bidding? If	N	33. 00			
	no, see instructions.	<u> </u>							
24.00	Provi der-Based Physi ci ans	rongomont wit	h neartidae b	acad nhyrai ai ana?	I.E. V	24.00			
34. 00	Were services furnished at the provider facility under an arves, see instructions.	rangement wit	n provider-b	ased physicians?	If Y	34. 00			
35. 00	If line 34 is yes, were there new agreements or amended exis	sting agreemen	ts with the	provi der-based	N	35. 00			
	physicians during the cost reporting period? If yes, see ins	tructions.							
				Y/N 1. 00	Date 2.00				
	Home Office Costs			1.00	2.00				
36.00	Were home office costs claimed on the cost report?			Y		36. 00			
37. 00	If line 36 is yes, has a home office cost statement been pre	epared by the	home office?	IF Y		37. 00			
38. 00	yes, see instructions. If line 36 is yes, was the fiscal year end of the home offi	ce different	from that of	the N		38. 00			
00.00	provider? If yes, enter in column 2 the fiscal year end of t					00.00			
39. 00	If line 36 is yes, did the provider render services to other see instructions.	chain compon	ents? If yes	, N		39. 00			
40. 00	If line 36 is yes, did the provider render services to the h	nome office?	If yes, see	N		40. 00			
	i nstructi ons.								
1.00 2.00									
Cost Report Preparer Contact Information									
41. 00									
	by the cost report preparer in columns 1, 2, and 3, respectively.								
42. 00	Enter the employer/company name of the cost report prepared	RANCISCAN ALL	I ANCE			42. 00			
43. 00	Enter the telephone number and email address of the cost (614) 565-2739		JAMES. HALL@FRAM	ICI SCANALLI ANCI	11			
	report preparer in columns 1 and 2, respectively.			. ORG					

Health Financial Systems FRANCISCAN HE			TH CROWN POINT	In Lie	In Lieu of Form CMS-2552-10		
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provi der CCN: 15-0126	Peri od: From 01/01/2023				
				To 12/31/2023	Date/Time Pre 5/30/2024 10:	pared: <u>06 am</u>	
			3. 00				
	Cost Report Preparer Contact Information						
41.00	Enter the first name, last name and the t	itle/position held	REIMBURSEMENT ANALYST			41.00	
	by the cost report preparer in columns 1,	2, and 3,					
	respecti vel y.						
42.00	Enter the employer/company name of the co	st report preparer				42.00	
43.00	Enter the telephone number and email addr	ess of the cost				43.00	
	report preparer in columns 1 and 2, respe	ecti vel y.					
	<u>'</u>						

| Peri od: | Worksheet S-3 | From 01/01/2023 | Part | | To 12/31/2023 | Date/Time Prepared: Health Financial Systems FRANCISCAN HEALTH CROWN POINT HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CO Provider CCN: 15-0126

				Т	o 12/31/2023	Date/Time Prep 5/30/2024 10:0	
						I/P Days / 0/P	JO alli
						Visits / Trips	
	Component	Worksheet A	No. of Beds	Bed Days	CAH/REH Hours	Title V	
	50mp6116111	Li ne No.	01 5000	Avai I abl e	o, and the moder of		
		1. 00	2. 00	3.00	4. 00	5. 00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00	132	48, 180	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		132	48, 180	0.00	0	7. 00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT	31. 00	20	7, 300	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		7, 300	0.00	0	12.00
13.00	NURSERY	43. 00				0	13.00
14.00	Total (see instructions)		172	62, 780	0.00	0	14.00
15. 00	CAH visits				0.00	0	15. 00
15. 10	REH hours and visits				0.00	0	15. 10
16.00	SUBPROVIDER - I PF	41 00	15	E 475		o	16.00
17. 00 18. 00	SUBPROVI DER - I RF SUBPROVI DER	41. 00	15	5, 475		U	17. 00 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						22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24. 00	HOSPI CE						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)		187				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)		19	6, 935			32.00
32. 01	Total ancillary labor & delivery room						32. 01
	outpatient days (see instructions)						
33. 00	LTCH non-covered days						33.00
33. 01	LTCH site neutral days and discharges						33. 01
34. 00	Temporary Expansion COVID-19 PHE Acute Care	30. 00	0	C		0	34.00

Health Financial Systems FRANCISCA
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CCN: 15-0126

				'	0 12/31/2023	5/30/2024 10:	
		I/P Days	/ O/P Visits	/ Trips	Full Time I	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	
	PART I - STATISTICAL DATA	0.00	7.00	0.00	7, 00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	12, 312	239	31, 417			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)	8, 285	7, 594				2. 00
3.00	HMO IPF Subprovider	0	0				3. 00
4.00	HMO IRF Subprovider	964	318				4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	C			5. 00
6.00	Hospital Adults & Peds. Swing Bed NF		0	C			6. 00
7. 00	Total Adults and Peds. (exclude observation	12, 312	239	31, 417			7. 00
0.00	beds) (see instructions)	4 440	0.5	2.044			0.00
8.00	INTENSIVE CARE UNIT	1, 449	25	3, 846			8. 00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00 12. 00	SURGICAL INTENSIVE CARE UNIT NEONATAL INTENSIVE CARE UNIT	0	150	3, 735			11. 00 12. 00
12.00	NURSERY	۷	22	2, 352			13.00
14. 00	Total (see instructions)	13, 761	436	41, 350		946. 73	1
15. 00	CAH visits	13, 701	430	41, 330		740. 73	15. 00
15. 10	REH hours and visits	0	0	0			15. 10
16. 00	SUBPROVI DER - I PF		J				16. 00
17. 00	SUBPROVI DER - I RF	1, 988	0	3, 989	0.00	22. 62	1
18. 00	SUBPROVI DER	., , , , ,	, i	0, 707	0.00		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						22. 00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24.00	HOSPI CE						24. 00
24. 10	HOSPICE (non-distinct part)			59	1		24. 10
25. 00	CMHC - CMHC						25. 00
26. 00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	C			
27. 00	Total (sum of lines 14-26)				1. 50	969. 35	1
28. 00	Observation Bed Days		593	4, 417			28. 00
29. 00	Ambul ance Tri ps	83		_			29. 00
30.00	Employee discount days (see instruction)			C			30.00
31.00	Employee discount days - IRF		200	0			31.00
32.00	Labor & delivery days (see instructions)	0	228	572			32. 00
32. 01	Total ancillary labor & delivery room			C			32. 01
33. 00	outpatient days (see instructions) LTCH non-covered days	0					33.00
33. 00	LTCH site neutral days and discharges	0					33. 00
	Temporary Expansion COVID-19 PHE Acute Care	0	0	C			34. 00
54.00	Tomporary Expansion Covid 17 The Acute Care	Ч	Ч		1	I	1 37.00

| Peri od: | Worksheet S-3 | From 01/01/2023 | Part | | To 12/31/2023 | Date/Time Prepared: Health Financial Systems FRANCISCAN HEALTH CROWN POINT HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CO Provider CCN: 15-0126

				To	o 12/31/2023	Date/Time Pre 5/30/2024 10:	
		Full Time	'	Di sch	arges	1070072021 10.	oo uiii
	C	Equi val ents	T: ±1 - \/	T: +1 - \\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	T: +1 - VIV	T-+-1 All	
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers 11.00	12. 00	13.00	14. 00	Pati ents 15.00	
	PART I - STATISTICAL DATA	11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and		(3, 032	1, 866	8, 586	1.00
1.00	8 exclude Swing Bed, Observation Bed and			3,032	1,000	0, 300	1.00
	Hospice days) (see instructions for col. 2 for	-					
	the portion of LDP room available beds)						
2.00	HMO and other (see instructions)			1, 534	0		2. 00
3.00	HMO IPF Subprovider				0		3. 00
4.00	HMO IRF Subprovider				0		4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF						5. 00
6.00	Hospital Adults & Peds. Swing Bed NF						6. 00
7.00	Total Adults and Peds. (exclude observation						7. 00
	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 NURSERY						12.00
13. 00 14. 00	Total (see instructions)	0. 00	(3, 032	1, 866	8, 586	13. 00 14. 00
15. 00	CAH visits	0.00	(3,032	1, 600	0, 300	15. 00
15. 10	REH hours and visits						15. 10
16. 00	SUBPROVI DER - I PF						16. 00
17. 00	SUBPROVI DER - I RF	0. 00	(160	23	309	
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						22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24. 00	HOSPI CE						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 29. 00	Observation Bed Days Ambulance Trips						28. 00 29. 00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days (see l'istruction)						31.00
32.00	Labor & delivery days (see instructions)						32.00
32. 01	Total ancillary labor & delivery room						32. 00
52. 51	outpatient days (see instructions)						32.01
33. 00	LTCH non-covered days			0			33. 00
33. 01	LTCH site neutral days and discharges			0			33. 01
34.00	Temporary Expansion COVID-19 PHE Acute Care						34. 00

Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0126

| Peri od: | Worksheet S-3 | From 01/01/2023 | Part | I | To 12/31/2023 | Date/Time Prepared: | To 12/31/2023 | Date/Time Prepared: | To 12/31/2023 | Date/Time Prepared: | To 12/31/2023 | To

					To	12/31/2023	Date/Time Pre 5/30/2024 10:	
		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst.	(col.2 ± col.	Paid Hours Related to Salaries in	Average Hourly Wage (col. 4 ÷ col. 5)	
		1. 00	2.00	A-6) 3.00	3) 4. 00	<u>col . 4</u> 5. 00	6. 00	
	PART II - WAGE DATA	1.00	2.00	3.00	4.00	5.00	0.00	
	SALARI ES			1 _	1		1	1
1. 00	Total salaries (see instructions)	200. 00	82, 272, 222	0	82, 272, 222	1, 969, 200. 00	41. 78	1.00
2.00	Non-physician anesthetist Part		0	О	О	0.00	0.00	2.00
3. 00	A Non physician aposthotist Dart		0			0. 00	0. 00	3.00
3.00	Non-physician anesthetist Part B		U	٥	0	0.00	0.00	3.00
4.00	Physician-Part A -		0	0	0	0.00	0. 00	4.00
4. 01	Administrative Physicians - Part A - Teaching		0	0	0	0. 00	0.00	4.01
5.00	Physician and Non		9, 866, 125	1	_	41, 875. 00		•
6. 00	Physician-Part B Non-physician-Part B for		0	0	0	0. 00	0.00	6.00
0.00	hospital -based RHC and FQHC		0	٥		0.00	0.00	0.00
	servi ces		_	_				
7. 00	Interns & residents (in an approved program)	21. 00	0	1	1	1. 00	1. 00	7.00
7. 01	Contracted interns and		0	О	0	0.00	0.00	7.0
	residents (in an approved programs)							
8. 00	Home office and/or related		0	О	0	0.00	0.00	8.00
0.00	organization personnel	44.00				0.00		
9. 00 10. 00	SNF Excluded area salaries (see	44. 00	4, 236, 608	947, 089	5, 183, 697	0. 00 155, 795. 00	l .	
	instructions)		.,	,	2, 122, 211			
11. 00	OTHER WAGES & RELATED COSTS Contract labor: Direct Patient		7, 194, 371	0	7, 194, 371	66, 342. 00	108. 44	11.00
11.00	Care		7, 174, 371	Ĭ	7, 174, 371	00, 342. 00	100. 44	11.00
12. 00	Contract labor: Top level		0	0	0	0. 00	0. 00	12.00
	management and other management and administrative services	t						
13. 00	Contract Labor: Physician-Part		213, 188	0	213, 188	1, 607. 00	132. 66	13.00
14. 00	A - Administrative Home office and/or related		0	0	0	0. 00	0.00	14.00
11.00	organization salaries and					0.00	0.00	11.00
14. 01	wage-related costs Home office salaries		21, 580, 351	0	21, 580, 351	574, 271. 00	27 50	14. 0
14. 01	Related organization salaries		21, 380, 331		21, 380, 331	0.00		1
15. 00	Home office: Physician Part A	-	0	0	0	0.00	0. 00	15.00
16. 00	Administrative Home office and Contract		0	0	o	0. 00	0. 00	16.00
	Physicians Part A - Teaching			_				
16. 01	Home office Physicians Part A Teaching	-	0	0	0	0. 00	0. 00	16. 01
16. 02	Home office contract Physician	5	0	О	0	0.00	0. 00	16. 02
	Part A - Teaching							_
17. 00	WAGE-RELATED COSTS Wage-related costs (core) (see		17, 809, 273	0	17, 809, 273			17. 00
40.00	instructions)							40.00
18. 00	Wage-related costs (other) (seinstructions)	9						18.00
19. 00	Excluded areas		1, 473, 744	0	1, 473, 744			19.00
20. 00	Non-physician anesthetist Part		0	0	9			20.00
21. 00	Non-physician anesthetist Part		0	0	o			21.00
22.00	B Physician Part A -							22.00
22. 00	Administrative		U	"] "			22. 00
22. 01	Physician Part A - Teaching		0	0	0			22. 01
23. 00 24. 00	Physician Part B Wage-related costs (RHC/FQHC)		1, 472, 224 0	0	1, 472, 224 0			23. 00 24. 00
25. 00	Interns & residents (in an		0	ő	ő			25. 00
25. 50	approved program) Home office wage-related (core		7, 006, 844	,	7, 006, 844			25. 50
25. 50	Related organization		7, 000, 844		7,000,844			25. 50
	wage-related (core)		-					
25. 52	Home office: Physician Part A Administrative - wage-related		0	0	9			25. 52
	(core)							
25. 53	Home office: Physicians Part A - Teaching - wage-related		0	0	9			25. 53
	core)							
	'	'						

| Peri od: | Worksheet S-3 | From 01/01/2023 | Part | I | To 12/31/2023 | Date/Time Prepared: | To 12/31/2023 | Date/Time Prepared: | To 12/31/2023 | Date/Time Prepared: | To 12/31/2023 | To Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION Provider CCN: 15-0126

					'	0 12/31/2023	5/30/2024 10:0	
		Wkst. A Line	Amount	Reclassi fi cati	Adj usted	Pai d Hours	Average Hourly	
		Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from Wkst.	(col.2 ± col.	Salaries in	col . 5)	
				A-6)	3)	col. 4		
		1.00	2.00	3.00	4. 00	5. 00	6. 00	
	OVERHEAD COSTS - DIRECT SALARIE							
26. 00	Employee Benefits Department	4. 00	2, 023, 700	-861, 711	1, 161, 989	25, 229. 00	46. 06	26. 00
27. 00	Administrative & General	5. 00	3, 833, 202	-2	3, 833, 200	114, 489. 00	33. 48	27. 00
28. 00	Administrative & General under		1, 366, 924	0	1, 366, 924	9, 534. 00	143. 37	28. 00
	contract (see inst.)							
29. 00	Maintenance & Repairs	6. 00	596, 831	0	596, 831	·		29. 00
30.00	Operation of Plant	7. 00	2, 670, 449	0	2, 670, 449	82, 861. 00	32. 23	30. 00
31. 00	Laundry & Linen Service	8. 00	73, 464	0	73, 464	4, 391. 00	16. 73	31. 00
32.00	Housekeepi ng	9. 00	1, 893, 025	0	1, 893, 025	103, 020. 00	18. 38	32. 00
33.00	Housekeeping under contract		0	0	0	0.00	0.00	33.00
	(see instructions)							
34.00	Di etary	10. 00	1, 382, 053	-819, 295	562, 758	27, 906. 00	20. 17	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	819, 295	819, 295	40, 628. 00	20. 17	36. 00
37.00	Maintenance of Personnel	12. 00	0	0	0	0.00	0.00	37. 00
38. 00	Nursing Administration	13. 00	2, 796, 897	0	2, 796, 897	65, 895. 00	42. 44	38. 00
39. 00	Central Services and Supply	14. 00	396, 277	0	396, 277	15, 783. 00	25. 11	39. 00
40.00	Pharmacy	15. 00	2, 633, 512	0	2, 633, 512	54, 301. 00	48. 50	40.00
41.00	Medical Records & Medical	16. 00	599, 273	0	599, 273	14, 512. 00	41. 29	41.00
	Records Library							
42.00	Social Service	17. 00	1, 837, 210	0	1, 837, 210	42, 792. 00	42. 93	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: 15-0126 Peri od: From 01/01/2023 To 12/31/2023 5/30/2024 10:06 am Average Hourly Worksheet A Amount Recl assi fi cati Adj usted Pai d Hours 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 6.00 2.00 5.00 3.00 4.00 PART III - HOSPITAL WAGE INDEX SUMMARY 1.00 Net salaries (see instructions 73, 773, 021 73, 773, 020 1, 936, 858. 00 38. 09 1.00 155, 795. 00 2.00 Excluded area salaries (see 4, 236, 608 947, 089 5, 183, 697 33. 27 2.00 instructions) 3.00 Subtotal salaries (line 1 minus 69, 536, 413 -947, 090 68, 589, 323 1, 781, 063. 00 38. 51 3.00 line 2) 4.00 Subtotal other wages & related 28, 987, 910 28, 987, 910 642, 220. 00 45. 14 4.00 costs (see inst.) Subtotal wage-related costs 5.00 24, 816, 117 0 24, 816, 117 0.00 36. 18 5.00 (see inst.) Total (sum of lines 3 thru 5) 6.00 123, 340, 440 -947, 090 122, 393, 350 2, 423, 283. 00 50.51 6.00

-861, 713

21, 241, 104

614, 051. 00

34. 59

7.00

22, 102, 817

7.00

Total overhead cost (see

instructions)

	To 12/31/2023	Date/Time Prep 5/30/2024 10:0	
		Amount	
		Reported	
		1. 00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETI REMENT COST		l
1.00	401K Employer Contributions	2, 319, 147	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	o	3. 00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	3, 010, 386	4. 00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		1
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	o	7. 00
	HEALTH AND INSURANCE COST		1
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8. 01	Health Insurance (Self Funded without a Third Party Administrator)	o	8. 01
8. 02	Health Insurance (Self Funded with a Third Party Administrator)	8, 092, 137	8. 02
8. 03	Health Insurance (Purchased)	ol	8. 03
9.00	Prescription Drug Plan	o	9. 00
10.00	Dental, Hearing and Vision Plan	328, 999	1
11. 00	Life Insurance (If employee is owner or beneficiary)	28, 744	11. 00
	Accident Insurance (If employee is owner or beneficiary)	0	12.00
	Disability Insurance (If employee is owner or beneficiary)	298, 844	13.00
	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14. 00
15. 00		1, 557, 412	15. 00
16. 00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	
	Noncumulative portion)	_	
	TAXES		1
17. 00	FICA-Employers Portion Only	5, 119, 570	17. 00
	Medicare Taxes - Employers Portion Only	0	1
	Unemployment Insurance	o	19.00
	State or Federal Unemployment Taxes	o	20.00
	OTHER		
21. 00	Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see	0	21. 00
	instructions))	_	
22. 00	Day Care Cost and Allowances	0	22. 00
23. 00	Tuition Reimbursement	2	23. 00
	Total Wage Related cost (Sum of Lines 1 -23)	20, 755, 241	
	Part B - Other than Core Related Cost	.,, =	
25. 00	OTHER WAGE RELATED COSTS (SPECIFY)		25. 00
		'	

Health Financial Systems	FRANCISCAN HEALTH CROWN POINT	In Lie	u of Form CMS-2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provider CCN: 15-0126	From 01/01/2023	Worksheet S-3 Part V Date/Time Prepared:

		0 12/31/2023	5/30/2024 10: 0				
	Cost Center Description	Contract Labor					
		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	8, 205, 671	20, 755, 241	1.00			
2.00	Hospi tal	8, 205, 671	20, 755, 241	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	SKILLED NURSING FACILITY			8. 00			
9.00	NURSING FACILITY			9. 00			
10.00	OTHER LONG TERM CARE I			10.00			
11. 00	Hospi tal -Based HHA			11. 00			
12.00	AMBULATORY SURGICAL CENTER (D. P.) I			12.00			
13.00	Hospi tal -Based Hospi ce			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 I	0	0	17.00			
18. 00	0ther	0	0	18.00			

	FINANCISCAN AL UNCOMPENSATED AND INDIGENT CARE DATA	HEALTH CROWN POINT Provider CO		In Lie Period: From 01/01/2023 To 12/31/2023		0 pared:		
					1. 00			
ſ	PART I - HOSPITAL AND HOSPITAL COMPLEX DATA				1.00			
Ī	Uncompensated and Indigent Care Cost-to-Charge Ratio]		
	Cost to charge ratio (see instructions)				0. 204762	1.0		
	Medicaid (see instructions for each line)							
	Net revenue from Medicaid				34, 560, 573			
	Did you receive DSH or supplemental payments from Medic					3.0		
	If line 3 is yes, does line 2 include all DSH and/or su			i d?		4.0		
	If line 4 is no, then enter DSH and/or supplemental pay Medicaid charges	yments from Medical	a		0	5. C		
	Medicaid cost (line 1 times line 6)				161, 397, 146 33, 048, 002			
		nrogram (see instru	ctions)		33, 046, 002			
	Difference between net revenue and costs for Medicaid program (see instructions) Ohildren's Health Insurance Program (CHIP) (see instructions for each line)							
	Net revenue from stand-alone CHIP							
	Stand-alone CHIP charges				0	9. C		
1. 00								
	Difference between net revenue and costs for stand-alone CHIP (see instructions)							
	Other state or local government indigent care program (
	Net revenue from state or local indigent care program				0	1		
	Charges for patients covered under state or local indig		Not included	in lines 6 or 10	1'			
	State or local indigent care program cost (line 1 times Difference between net revenue and costs for state or l		nrogram (000	i notrusti sno)	0	1		
	Grants, donations and total unreimbursed cost for Medic				-	10.0		
	instructions for each line)	caru, chir and stati	eziocai indigi	ent care program	115 (500			
	Private grants, donations, or endowment income restric	ted to funding char	itv care		0	17.0		
	Government grants, appropriations or transfers for supp				0	18.0		
9. 00	Total unreimbursed cost for Medicaid, CHIP and state a	and local indigent	care programs	(sum of lines 8	s , o	19. C		
	12 and 16)							
			Uni nsured	Insured	Total (col. 1			
			patients 1.00	pati ents 2.00	+ col . 2) 3.00			
lr.	Uncompensated care cost (see instructions for each line	2)	1.00	2.00	3.00			
	Charity care charges and uninsured discounts (see insti		12, 494, 24	0 4, 374, 242	16, 868, 482	20.0		
	Cost of patients approved for charity care and uninsure		2, 558, 34					
1. 00 l	instructions)		,, .		1, 122, 200			
	111311 4011 0113)			ما م				
2. 00	Payments received from patients for amounts previously	written off as		0	0	22. C		
22. 00	Payments received from patients for amounts previously charity care $% \left(1\right) =\left(1\right) +\left(1\right)$	written off as				22. 0		
2. 00	Payments received from patients for amounts previously	written off as	2, 558, 34					

	Financial Systems	FRANCISCAN HEALTH				u of Form CMS-2		
HOSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA		Provi der CC	CN: 15-0126	Peri od: From 01/01/2023 To 12/31/2023		pared:	
						4.00		
	PART II - HOSPITAL DATA					1.00		
	Uncompensated and Indigent Care Cost-to-Charge Ratio							
. 00	Cost to charge ratio (see instructions)					0. 200337	1.00	
	Medicaid (see instructions for each line)							
. 00	Net revenue from Medicaid						2.00	
00	Did you receive DSH or supplemental payme						3. 00	
00	If line 3 is yes, does line 2 include all If line 4 is no, then enter DSH and/or su				ai d'?		4. 00 5. 00	
00	Medicaid charges	ipprementar payments	irom wedicar	u			6.00	
00	Medicald cost (line 1 times line 6)						7.00	
00	Difference between net revenue and costs for Medicaid program (see instructions)							
	Children's Health Insurance Program (CHIF					l	1	
00	Net revenue from stand-alone CHIP 9							
	Stand-alone CHIP charges						10. 0	
							11.00	
2. 00	Difference between net revenue and costs	for stand-alone CHIP	(see instru	ctions)			12.00	
3. 00	Other state or local government indigent Net revenue from state or local indigent						13.00	
	Charges for patients covered under state						14. 0	
	State or local indigent care program cost			Not Theradea	THE THICS O OF TO		15. 0	
	Difference between net revenue and costs			program (see	e instructions)		16. 0	
	Grants, donations and total unreimbursed instructions for each line)	cost for Medicaid, C	HIP and state	e/local indig	jent care progran	ns (see		
	Private grants, donations, or endowment i						17.00	
	Government grants, appropriations or tran						18. 00	
9. 00	Total unreimbursed cost for Medicaid , CH 12 and 16)	HP and state and Loc	al indigent	care programs	s (sum of lines 8	B,	19.00	
	12 and 10)			Uni nsured	Insured	Total (col. 1		
				patients	pati ents	+ col . 2)		
				1.00	2. 00	3. 00		
	Uncompensated care cost (see instructions							
	Charity care charges and uninsured discou			12, 483, 46				
1. 00	Cost of patients approved for charity can instructions)	re and uninsured disc	ounts (see	2, 500, 90	00 4, 350, 104	6, 851, 004	21.00	
2. 00	Payments received from patients for amour	nts previously writte	n off as		0 0	0	22. 00	
3. 00	charity care Cost of charity care (see instructions)			2, 500, 90	00 4, 350, 104	6, 851, 004	22 0	
1. 00	cost of charity care (see Histructions)			2, 500, 90	JU ₁ 4, 330, 104	0, 631, 004	23.00	
						1 00		

	12 and 16)					
		Uni nsured	Insured	Total (col. 1		
		pati ents	pati ents	+ col . 2)		
		1.00	2. 00	3.00		
	Uncompensated care cost (see instructions for each line)					
20.00	Charity care charges and uninsured discounts (see instructions)	12, 483, 465	4, 350, 104	16, 833, 569	20.00	
21.00	Cost of patients approved for charity care and uninsured discounts (see	2, 500, 900	4, 350, 104	6, 851, 004	21.00	
	instructions)					
22. 00	Payments received from patients for amounts previously written off as	0	0	0	22. 00	
	chari ty care					
23. 00	Cost of charity care (see instructions)	2, 500, 900	4, 350, 104	6, 851, 004	23. 00	
				1. 00		
24.00	N	24. 00				
	imposed on patients covered by Medicaid or other indigent care program?					
25. 00	If line 24 is yes, enter the charges for patient days beyond the indigent	care program's	s length of sta	y 0	25. 00	
	limit					
25. 01	Charges for insured patients' liability (see instructions)			0	25. 01	
26. 00	Bad debt amount (see instructions)			6, 501, 496	26. 00	
27. 00	Medicare reimbursable bad debts (see instructions)			223, 567	27. 00	
27. 01	Medicare allowable bad debts (see instructions)			343, 949	27. 01	
28.00	Non-Medicare bad debt amount (see instructions)			6, 157, 547	28. 00	
29. 00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see	instructions)		1, 353, 966	29. 00	
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)			8, 204, 970	30.00	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			8, 204, 970	31.00	

Control Cont	Heal th	Financial Systems	FRANCISCAN HEALTH	I CROWN POINT		In Lie	eu of Form CMS-	2552-10
Cost Center Description	RECLAS	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE	OF EXPENSES	Provi der Co	CN: 15-0126	Peri od:	Worksheet A	
Cost Center Description								nared·
Control Cont						10 12/31/2023		
SPAREAR SERVICE COST CHAPTERS 1.00		Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cati		
					+ col . 2)	ons (See A-6)		
1,00 2,00 3,00 4,10,100 5,0								
The color of the color of the press 1								
001001 CAM PILL DOSTS-BLUC & FIXX		T	1. 00	2. 00	3. 00	4. 00	5. 00	
2.00 000000 LOW REL COSTS-WRISE LEGULP 2.023,700 2.034,203 2.365,903 1.294,425,900 2.00,407,000 2.00000 Albah INSTRATE & CORRESAL 5.833,202 9.351,803 2.23,855,903 1.294,425 9.00,800 5.00 0.00000 Albah INSTRATE & CORRESAL 2.000000 2.00000 2.00000 2.00000 2.00000 2.00000 2.00000 2.00000 2.00000 2.00000 2.00000 2.00000 2.00000 2.00000 2.00000 2.00000 2.00000 2.000000 2.00000 2.000000 2.000000 2.000000 2.000000 2.000000 2.000000 2.0000000 2.0000000 2.0000000000	4 00					11 10/ 050	44.404.050	1 00
4.00 OBDODIE DEPLOYEE BEREFITS DEPARTMENT 2,003,700 20,342,001 23,959,001 -1,799,428 21,070,430 5.00 6.00 OBDODIENT MISSIARITIVE & ELEMENT 3,833,202 93,851,851 97,835,185 -2,1799,428 -2,170,830 5.00 0.0000 CHERNITOR OF PARM -9P 2,670,404 0.10,23,594 0.0000 0.0000 CHERNITOR OF PARM -9P 2,670,404 0.10,23,594 0.0000 0.0000 CHERNITOR OF PARM -9P 103,464 0.10,23,594 0.0000 0.0000 CHERNITOR OF PARM -9P 0.0000 0.0000 0.0000 CHERNITOR OF PARM -9P 0.00000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000				0	1			
5.00 DISCOOL AMENIN INSTANT OF PLANT S. 670, 249 11, 10, 333, 390 17, 10, 200 1, 11, 12, 14, 14, 14, 14, 14, 14, 14, 14, 14, 14			2 022 700	-	1	-, -, -, -, -, -,		
5.00 DOCODINA NITAMACE & RIPAIRS 5-94, RETI 2,3813, 189 2,980, 200 -11,195 2,994, 000 4.7			1					
7. 00. 00000 DePERATION OF PLANT 2,670, 449 10,633, 394 -3,04,671 8,949,334 7. 0 8. 00. 00000 LAURIEY & LINEN SERVICE 120,000 1,225,766 1,297,233 1,203,394 -6,029 2,286,292 8,000 10. 00 00000 LAURIEY & LINEN SERVICES - FP 1,729,466 1,225,766 1,297,200 2,286,292 8,000 10. 00 010000 HETARY 1,338,003 1,378,600 0 1,500,600 1,500,600 1,500,800 3,600,800 1,000 1,000,800 1,500,800 1,500,800 1,500,800 1,000,800 1,000,800 1,500,800 3,000,800 1,000 1,000,800 3,000,800 3,000,800 1,000 1,000,800 3			1					1
7. OI DOTOIL DEFERATION OF PLANT FPP 0 1.003.394 1, D23.3947.019 986.375 7. DO DOTOIL DEFERMENT SERVICES FPP 1.789.566 1.525.66 1.979.250 1.529.250 1.529.375 1.338.263 9. DOTOIL DEFERMENT SERVICES FPP 1.789.566 1.525.66 1.979.250 1.529.260 1.388.263 9. DOTOIL DEFERMENT SERVICES FPP 1.382.053 1.337.360 2.2.131.580 1.2.213.580			1					
8.00 000000000000000000000000000000000			2,070,447					
9.00 0.0900 MUSEREEPING		1 1	73. 464					
9.01 0.01851 ENVIRONMENTAL SERVICES - FP 103.461 13.051 116.512 0.01100 110.07			1		1			1
10.00 01000 DETARY								1
13.00 01300 NURSING ADMINISTRATION 2,766,897 775,377 3,572,274 -519,962 3,052,288 14.00 14.00 01400 DISCHIRAL SERVICES & SUPPLY 396,277 777,2541 1,108,818 -2,244,833 2,719,050 15.00 15.00 01500 PHARMACY 2,633,512 6,329,927 8,903,439 -2,244,833 2,719,050 15.00 15.00 01500 PHARMACY 7,900 7			1					
14.00 01400 CENTRAL SERVICES & SUPPLY	11.00	01100 CAFETERI A	0	0)	1, 592, 483	1, 592, 483	11. 00
15.00 01500 PIARSMACY 2,633,512 6,329,927 8,903,439 -0,244,383 2,179.056 15.00 17.00 01700 SOCIAL SERVICE 1,837,210 534,796 2,372.006 -201 2,371.806 17.00 22 22.000 2.00 187.507 2.00 2.	13.00	01300 NURSING ADMINISTRATION	2, 796, 897	775, 377	3, 572, 27	4 -519, 986	3, 052, 288	13. 00
16.00 01-000 MEDICAL RECORDS & LIBRARY 599, 273 223, 135 822, 408 -2, 107 820, 211 66.00 10.00 1	14.00		396, 277	772, 541	1, 168, 81	-229, 482	939, 336	14. 00
17.00 01700 SSCI AL SERVICE 1.837,210 534,796 2,372,066 -201 2,371,805 17.00 220 0200 48 SERVICES-SHLARY & FRINGES APPRY 0 0 0 0 0 2 2 22.00 23.00	15. 00		2, 633, 512	6, 329, 927	8, 963, 43	9 -6, 244, 383		
21.00			1					ı
22.00 0.200 LAR SERVICES-OTHER PROX COSTS APPRIV 0 0 0 0 0 0 0 0 0			1			-201		
23.00			-1	0	1	0 2	2	
0.2301 CHIOCARDI OLOGY EDUCATION PROGRAM 64, 175 15, 125 79, 300 74, 931 154, 131 23, 010 03000 ADULTS & PEDI ATRIC SS 25, 768, 1992 5, 563, 450 31, 332, 342 -5, 669, 725 25, 662, 617 30, 00 03000 INTENSI VC CADE (WINT 2, 826, 669 2, 665, 959 5, 492, 653 -7, 94, 525 4, 198, 128 35, 00 03000 INTENSI VC CADE (WINT 2, 826, 669 2, 665, 959 5, 492, 653 -7, 94, 525 4, 198, 128 35, 00 03000 INTENSI VC CADE (WINT 2, 826, 669 2, 665, 959 5, 492, 653 -7, 94, 525 4, 198, 128 34, 00 03000 INTENSI VC CADE (WINT 2, 826, 669 2, 665, 959 5, 492, 653 -7, 94, 525 4, 198, 128 34, 00 03000 INTENSI VC CADE (WINT 2, 826, 669 2, 826, 949 4, 198, 128 34, 00 03000 INTENSI VC CADE (WINT 2, 826, 669 2, 826, 949 4, 198, 128			١	0	/=4 00	2	2	
INPATI ENT ROUTINE SERVICE COST CENTERS 25, 768, 892 5, 563, 450 31, 332, 342 -5, 669, 725 25, 662, 617 30. 00 3100 AURITS & PEDIDATRICS 25, 768, 892 5, 563, 450 31, 332, 342 -5, 669, 725 25, 662, 617 30. 00 3100 AURITS & PEDIDATRICS 2, 826, 694 2, 666, 995 5, 492, 605 -115, 704 4, 274, 966 31. 00 40. 00		1 1						
30.00 30.00 ADULTS & PEDIATRICS 25, 768, 892 5, 563, 450 31, 332, 342 -5, 669, 725 25, 662, 617 30, 00 31, 00 310, 00 310, 00 1 1 1 1 1 1 1 1 1	23.01		64, 175	15, 125	79, 30	J /4, 83 I	154, 131	23.01
31.00 03100 NTENSI VE CARE LIMIT 3,570, 362 1,620, 306 5,190, 670 -915, 704 4,274, 966 31.00 03100 04100 SUBPROVIDER - I RF 1,887, 738 306, 548 2,194, 266 -2,299, 947 1,934, 339 41.00 04100 SUBPROVIDER - I RF 1,887, 738 306, 548 2,194, 266 -2,299, 947 1,934, 339 41.00 04100 SUBPROVIDER - I RF 1,887, 738 306, 548 2,194, 266 2,299, 947 1,934, 339 41.00 04100 SUBPROVIDER - I RF 43.00 04100 SUBPROVIDER - I RF 43.00 04100 OBEATH IN REMOM 5,987, 412 30,426, 578 36,413, 990 -19,737, 076 16,676, 914 50.00 50.00 DELIVERY ROOM 42,853 16,076 58.31 2,054, 666 2,112, 999 52.00 05200 DELIVERY ROOM 42,853 16,076 58.31 2,054, 666 2,112, 999 52.00 05200 ARSTHIESI OLOGY 55,448 4,002,486 4,057,934 -314,844 3,743,090 53.00 05300 ARSTHIESI OLOGY 1,655 427,147 309,938 737,085 -188,884 588,501 54.01 54.00	20 00		25 760 002	5 562 450	21 222 24	5 660 725	25 662 617	20 00
1.00 0.4100 SUBPROVIDER - IRF 1.887.738 306.548 2.194.286 .259,947 1.934,339 41.00 .00 .00 .00 .00 .7845 1.784,455 455 450 .00		1 1						1
50.00 05000 0FEATI NG ROOM 5, 987, 412 30, 426, 578 36, 413, 990 -19, 737, 076 16, 676, 914 50.00 51.00 05100 RECOVERY ROOM 198 84, 340 84, 538 8.48 538 8.91 2, 054, 068 2, 112, 999 52.00 05200 DELI VERY ROOM & LABOR ROOM 42, 853 16, 078 58, 931 2, 054, 068 2, 112, 999 52.00 05400 RADI LICRY-DI JACINOSTI C 4, 876, 375 5, 108, 606 9, 984, 981 -1, 964, 201 88, 020, 780 54, 02	43.00	04300 NURSERY	o	0		1, 784, 645	1, 784, 645	43.00
51.00 05100 DEJOUREY ROOM 1480R ROOM 142, 853 16,078 84,340 84,538 -80,102 4,436 51.00 53.00 05300 DELIVERY ROOM & LABOR ROOM 42,853 16,078 58,931 2,054,068 2,112,999 52.00 53.00 05300 ARSTHESI OLOGY 55,448 4,002,486 4,057,934 -314,844 3,743,090 53.00 63.00 ARDIOLOGY - 1-65 4,876,375 5,108,606 0,00 0 0 0 0 0 0 0 0								
52.00 05200 DELIVERY ROOM & LABOR ROOM 42, B53 16, 078 58, 973 2, 054, 066 2, 112, 999 52.00 53.00 05300 ARSTHESIOLOGY 55, 448 4, 002, 486 40, 002, 486 40, 003, 481 -1, 904, 201 8, 020, 780 54.00 54.00 05400 RADIOLOGY - 1-65 48, 876, 375 5, 108, 666 9, 984, 981 -1, 904, 201 8, 020, 780 54.00 54.01 05401 RADIOLOGY 1-630 427, 147 309, 938 737, 085 -188, 584 548, 518, 514 54.02 05402 RADIOLOGY 1, 6306STIC - S.J 0 0 0 0 0 0 0 0 0 55.00 05500 RADIOLOGY 1, 6306STIC - S.J 0 0 0 0 0 0 0 0 0 55.01 05501 RADIOLOGY 1, 6206STIC - S.J 0 0 0 0 0 0 0 0 0 55.01 05501 RADIOLOGY 1, 6206STIC - S.J 0 0 0 0 0 0 0 0 0								1
53.00 05300 ANESTHESI OLOGY 55, 448 4, 002, 486 4, 057, 934 -314, 844 3, 743, 090 53.00 54.00 05400 RADIOLOGY - 1-65 4, 876, 375 5, 108, 606 9, 984, 981 -7, 984, 981 -			1					1
54. 00 05400 RADI OLOCY-DI ARONOSTIC 4,876,375 5,108,606 9,984,981 -1,964,201 8,020,780 54. 00 54. 01 54. 0			1					1
54. 01 05401 RADI DLOCY - I - 65 427, 147 309, 938 737, 085 -188, 584 548, 501 54. 01 05402 RADI DLOCY DI AGNOSTI C - SJ			1					1
54.02 OS402 RADIOLOGY DIAGNOSTIC - SJ 0 0 0 0 0 54.02 0.629 22,673 3.71,850 2.823 54.03 0.5500 RADIOLOGY 2.044 20.629 22,673 3.71,850 2.823 54.03 0.5500 RADIOLOGY - THERAPEUTIC 0 0 0 0 0 0 0 0 0			1					1
54. 03 O5403 LOWELL RADI OLOGY 2, 044 20, 629 22, 673 -19, 850 2, 823 54, 03 55, 00 55. 01 OS501 OS501 OS501 CARDI AC CATHERI ZATON LAB 1, 517, 300 7, 455, 372 8, 972, 672 -6, 522, 738 2, 449, 934 55, 01 55. 02 O3140 CARDI AC CATHERI ZATON LAB 1, 517, 300 7, 455, 372 8, 972, 672 -6, 522, 738 2, 449, 934 55, 01 55. 03 O3503 NEURO-DI JAGNOSTI CS 516, 666 122, 067 638, 733 -105, 724 533, 009 55, 03 60. 00 06000 LABORATORY 0 13, 615, 740 13, 615, 740 -44, 033 13, 571, 707 60, 00 60. 01 06001 BLODU LABORATORY 0 13, 615, 740 -44, 033 13, 571, 707 60, 00 65. 00 05000 PESPI RATORY THERAPY 1, 615, 511 881, 561 2, 467, 072 -552, 479 1, 914, 593 65, 00 66. 01 06001 PHYSI CAL THERAPY -65 762, 023 91, 417 853, 440 -17, 069 836, 371 66, 01 66. 02 06600 PHYSI CAL THERAPY ST JOHN 199, 994 31, 228 230, 322 -9, 563 220, 759 66, 02 67. 01 05701 0CCUPATI OTH NETHERAPY ST JOHN 10, 471 0 0, 10, 471 67, 02 68. 00 06800 SPEECH PATHOLOGY -65 311, 932 1, 441 313, 373 00 313, 373 86, 00 69. 00 06800 SPEECH PATHOLOGY -65 311, 932 1, 441 313, 373 00 313, 373 86, 00 69. 00 06800 SPEECH PATHOLOGY -65 311, 932 1, 441 313, 373 0 313, 373 68, 00 69. 00 06800 SPEECH PATHOLOGY -65 311, 932 1, 441 313, 373 0 313, 373 68, 00 69. 00 06900 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 0 0 0 0 0 0 0 69. 00 0700 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 0 0 0 0 0 0 0 69. 00 0700 O7800 DELICATORORIO LOGGY 382, 766 736, 302 1, 119, 068 -232, 158 886, 910 76, 00 69. 00 0700 DELICATORORIO COST SEA, 229 320, 229 320, 229 320, 229 69. 00 0700 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 0 0 0 0 0 0 69. 00 0700 O7800 CAR T-CELL IMMINOTHERAPY 0 0 0 0 0 0 0 0 0 69. 01 0700 0700 070			1	007, 700	707,00	0 0	l	1
55.00 05500 RADI OLOGY-THERAPEUTIC 0 0 0 0 0 0 55.00 50.50 1 05501 CARDI AC CATHERIZATON LAB 1,517,300 7,455,372 8,972,672 -6,522,738 2,449,944 55.01 55.02 03140 CARDI OLOGY 1,240,806 498,609 1,739,415 -517,155 1,222,260 55.03 03450 NEURO-DI AGNOSTI CS 516,666 122,067 638,733 -105,724 533,009 55.03 03450 NEURO-DI AGNOSTI CS 0 0 0 0 0 0 0 0 0		i i	2,044	20, 629	22, 67	3 -19, 850	2, 823	
55. 02 03140 CARDI OLOGY	55.00		o	0		0	0	
55 .03 03450 NEURO-DI AGNOSTI CS 516 .666 122 .067 638 .733 -105 .724 533 .009 55 .03		05501 CARDI AC CATHERI ZATON LAB	1, 517, 300	7, 455, 372	8, 972, 67	2 -6, 522, 738	2, 449, 934	55. 01
60. 00 06.000 LABORATORY 0 13, 615, 740 -44, 033 13, 571, 707 00, 00 00 00 00 00 00						5 -517, 155		
60.01 60.01 60.00 LABORATORY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		· · · · · · · · · · · · · · · · · · ·						
65.00 0650			-1		1			
66. 01 06600 PHYSI CAL THERAPY 983,027 9,342 992,369 -5,343 987,026 66. 00 66. 01 06601 PHYSI CAL THERAPY I -65 762,023 91,417 853,440 -17,069 836,371 66. 01 66. 02 06602 PHYSI CAL THERAPY ST JOHN 199,094 31,228 230,322 -9,563 220,759 66. 02 67. 00 06700 0CCUPATI ONAL THERAPY 596,351 3,206 599,557 -492 599,065 67. 00 67. 01 06701 0CCUPATI ON THERAPY I -65 98,385 3,381 101,766 -1,139 100,627 67. 01 67. 02 06702 0CCUPATI ONAL THERAPY ST. JOHN 10,471 0 10,471 0 10,471 0 68. 00 06800 SPEECH PATHOLOGY -55 311,932 1,441 313,373 0 313,373 68. 01 68. 01 06801 SPEECH PATHOLOGY I -65 3111,932 1,441 313,373 0 313,373 68. 01 69. 00 06900 ELECTROCARDI OLOGY -55 311,932 1,441 313,373 0 0 0 0 0 69. 00 06900 ELECTROCARDI OLOGY -55 503,767 42,402 546,169 -29,814 516,355 69.00 69. 00 06900 ELECTROCARDI OLOGY -50,3767 42,402 546,169 -29,814 516,355 69.00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 0 10,071,960 10,071,960 72. 00 07200 IMPL DEV. CHARGED TO PATI ENTS 0 0 0 0 0,522,239 6,532,239 73.00 74. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0,071,960 10,071,960 75. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0,071,960 10,071,960 76. 01 03040 ANGI CARDI OGRAPHY 243,320 21,945 265,265 -19,363 245,902 76. 00 77. 00 0700 ALLOGENEIC HSCT ACQUISI TION 0 0 0 0 0 0 78. 00 07000 CART T-CELL I IMMUNOTHERAPY 0 0 0 0 0 0 0 79. 01 07000 DIPATI ENT SERVICE COST CENTERS 79. 00 07000 07000 07000 07000 07000 07000 07000 79. 01 09000 EMERGENCY 4,352,095 3,902,474 8,545,69 -1,203,634 7,050,935 91,00 79. 00 09100 EMERGENCY ROOM PHYSI CANS 0 91.00 79. 01 09100 EMERGENCY ROOM PHYSI CANS 0 91.00 79. 01 09100 EMERGENCY ROOM PHYSI CANS 0			١			9	"	
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68. 01 06801 SPEECH PATHOLOGY I -65 311, 932 1, 441 313, 373 0 0 313, 373 68. 01 68. 02 06802 SPEECH THERAPY ST. JOHN 0 0 0 0 0 0 69. 00 06900 ELECTROCARDI OLOGY 503, 767 42, 402 546, 169 -29, 814 516, 355 69. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0 0 0 0 19, 584, 828 19, 584, 828 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 0, 071, 960 10, 071, 960 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 6, 532, 239 6, 532, 239 73. 00 74. 00 07400 RENAL DI ALYSI S 0 468, 007 468, 007 -4, 688 463, 319 74. 00 76. 00 03020 RADI ATI ON ONCOLOGY 382, 766 736, 302 1, 119, 068 -232, 158 886, 910 76. 00 76. 01 03040 ANGI OCARDI OGRAPHY 243, 320 21, 945 265, 265 -19, 363 245, 902 76. 01 77. 00 07700 ALLOGENEI C HSCT ACQUI SITI ON 0 0 0 0 0 0 78. 00 07800 CAR T-CELL I IMUNOTHERAPY 0 0 0 0 0 0 0 90. 01 09000 CLI NI C 0 0 0 0 0 0 90. 02 09000 CLI NI C 0 0 0 0 0 0 90. 03 09000 OUTPATI ENT SERVI CE COST CENTERS 90. 04 09004 NEONATOLOGY CLI NI C-FRANCI SCAN POI NT 16, 152 642 16, 794 -8 16, 786 90. 04 90. 05 09005 LACTATI ON CLI NI C 26, 267 0 26, 267 0 26, 267 0 26, 267 0 91. 01 09101 EMERGENCY ROOM PHYSI CANS 0 91. 01		1 1	1					1
68. 02 06802 SPEECH THERAPY ST. JOHN 0 0 0 0 0 0 68. 02 69. 00 06900 ELECTROCARDI OLOGY 503, 767 42, 402 546, 169 -29, 814 516, 355 69. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0 0 0 19, 584, 828 19, 584, 828 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 10, 071, 960 10, 071, 960 10, 071, 960 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 6, 532, 239 6, 532, 239 74. 00 07400 RENAL DIALYSIS 0 468, 007 468, 007 -4, 688 463, 319 74. 00 76. 00 03020 RADIATION ONCOLOGY 382, 766 736, 302 1, 119, 068 -232, 158 886, 910 76. 00 77. 00 07700 ALLOGENEI C HSCT ACOUI SITION 0 0 0 0 0 78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 0 78. 00 07800 CLINIC 0 0 0 0 790. 01 09001 DIABETES CLINIC 0 0 0 0 790. 02 09002 OUTPATI ENT CLINICS 0 -810 -810 -810 761 -49 790. 03 09003 OCCUPATI ONAL MEDI CINE CLINIC 0 0 0 0 790. 04 09004 NEONATOLOGY CLINIC - FRANCI SCAN POINT 16, 152 642 16, 794 -8 16, 786 90. 04 790. 05 09005 LACTATION CLINIC 26, 267 0 26, 267 0 791. 00 09101 EMERGENCY ROOM PHYSI CANS 0 0 0 0 791. 01 09101 EMERGENCY ROOM PHYSI CANS 0 0 0 791. 01 09101 EMERGENCY ROOM PHYSI CANS 0 0 0 71. 00 0 0 0 0 71. 00 0 0 0 0 72. 00 0 0 0 0 73. 00 0 0 0 0 74. 00 0 0 0 75. 00 0 0 0 76. 01 09101 EMERGENCY ROOM PHYSI CANS 0 0 77. 00 0 0 0 0 78. 00 0 0 0 79. 01 09101 EMERGENCY ROOM PHYSI CANS 0 79. 02 09101 EMERGENCY ROOM PHYSI CANS 0 79. 03 07002 07002 07002 07002 07002 07002 79. 00 07002 07002 07002 07002 79. 00 09102 07002 07002 07002 79. 00 09102 07002 07002 07002 79. 00 09102 07002 07002 07002 79. 00 09102 07002 07002 79. 00 09102 07002 07002 79. 00 07002		1 1	1					1
71. 00		1 1	1	0	1		1	•
72. 00	69.00	06900 ELECTROCARDI OLOGY	503, 767	42, 402	546, 16	9 -29, 814	516, 355	69. 00
73. 00	71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		19, 584, 828	19, 584, 828	71. 00
74. 00			0	0				
76. 00			0	0				
76. 01		i i	0 7.7					1
77. 00 07700 ALLOGENEIC HSCT ACQUISITION 0 0 0 0 0 0 77. 00 78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 0 0 78. 00 OUTPATIENT SERVICE COST CENTERS 90. 00 09000 CLINIC 0 0 0 0 0 0 0 90. 01 09001 DIABETES CLINIC 0 0 0 0 0 0 0 90. 02 09002 OUTPATIENT CLINICS 0 -810 -810 761 -49 90. 01 90. 03 09003 OCCUPATIONAL MEDICINE CLINIC 0 0 0 0 0 0 90. 04 09004 NEONATOLOGY CLINIC-FRANCISCAN POINT 16, 152 642 16, 794 -8 16, 786 90. 04 90. 05 09005 LACTATION CLINIC 26, 267 0 26, 267 0 26, 267 91. 00 09100 EMERGENCY 4, 352, 095 3, 902, 474 8, 254, 569 -1, 203, 634 7, 050, 935 91. 00 91. 01 09101 EMERGENCY ROOM PHYSICANS 0 0 0 0 0 0 91. 01 O9101 EMERGENCY ROOM PHYSICANS 0 0 0 0 0 0 17. 00 07800 0 0 0 0 0 0 0 18. 00 0 0 0 0 0 0 19. 00 0 0 0 0 0 10. 00 0 0 0 0 10. 00 0 0 0 10. 00 0 0 0 10. 00 0 0 0 10. 00 0 0 0 10. 00 0 0 10.		1 1	1					1
78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 0 0 0 0 0			1	21, 940			l	1
90. 00 09000 CLINIC 0 0 0 0 0 0 0 0 0		1 1	-1	0	1	-	1	
90. 00 09000 CLINI C 0 0 0 0 0 0 0 0 0	. 5. 55		<u> </u>		1			1 5.00
90. 02 09002 0UTPATI ENT CLINICS 0	90.00		0	0		0 0	0	90.00
90. 03 09003 0CCUPATIONAL MEDICINE CLINIC 0 0 0 0 0 0 90. 03 0 0 0 0 0 0 0 0 0	90. 01	09001 DI ABETES CLINIC	0	0		0 0		
90. 04 09004 NEONATOLOGY CLINIC-FRANCISCAN POINT 16, 152 642 16, 794 -8 16, 786 90. 04 90. 05 09005 LACTATI ON CLINIC 26, 267 0 26, 267 0 26, 267 91. 00 09100 EMERGENCY 4, 352, 095 3, 902, 474 8, 254, 569 -1, 203, 634 7, 050, 935 91. 00 91. 01 09101 EMERGENCY ROOM PHYSI CANS 0 0 0 0 0 91. 01		1 1	0	-810	-81	761	l	
90. 05 09005 LACTATI ON CLINI C 26, 267 0 26, 267 0 26, 267 90. 05 09100 EMERGENCY 09101 EMERGENCY 09101 EMERGENCY 09101 EMERGENCY 09101 EMERGENCY 09101		1 1	0	0	a	0		
91. 00 09100 EMERGENCY 4,352,095 3,902,474 8,254,569 -1,203,634 7,050,935 91.00 91.01 EMERGENCY ROOM PHYSI CANS 0 0 0 0 91.01		1 1		642	1			
91. 01 09101 EMERGENCY ROOM PHYSI CANS 0 0 0 0 91. 01				3 QA2 171				
		ļ ,	4, 332, 073	5, 702, 474 N	0, 254, 56) 1, 203, 034) 0		
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Health Financial Systems F	RANCISCAN HEALTI	H CROWN POINT		In Lie	eu of Form CMS-	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provider CO		Peri od:	Worksheet A	
				From 01/01/2023 To 12/31/2023	Date/Time Pre 5/30/2024 10:	pared: 06 am
Cost Center Description	Sal ari es	0ther	Total (col. 1			
			+ col. 2)	ons (See A-6)	Trial Balance	
					(col. 3 +-	
					col. 4)	
	1.00	2. 00	3. 00	4. 00	5. 00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
OTHER REIMBURSABLE COST CENTERS						ļ
102.00 10200 OPIOLD TREATMENT PROGRAM	0	0		0 0	0	102. 00
SPECIAL PURPOSE COST CENTERS				_		
113.00 11300 INTEREST EXPENSE		-9, 927, 697				113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	80, 355, 088	208, 268, 447	288, 623, 53	5 -1, 180, 200	287, 443, 335	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0		0		190. 00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	1, 744, 170	221, 517	1, 965, 68	7 1, 205, 883	3, 171, 570	192. 00
194. 00 07950 FHC	0	0		0 0	0	194. 00
194. 01 07951 CONVENT	0	0		0 0		194. 01
194.02 07952 OTHER NON REIMB - BUILDINGS	0	1, 443, 970	1, 443, 97	0 -21, 935	1, 422, 035	194. 02
194.03 07953 OTHR NON REIM-FHC BEHAVORIAL HEALTH	0	0		0	0	194. 03
194.04 07954 CENTER OF HOPE	134, 527	4, 215	138, 74	2 0	138, 742	194. 04
194. 05 07955 LAKESHORE JOINT VENTURE	38, 437	13, 888, 251	13, 926, 68	-3, 748	13, 922, 940	194. 05
194.06 07957 COVID VACCINE CLINIC	0	0		0	0	194. 06
200.00 TOTAL (SUM OF LINES 118 through 199)	82, 272, 222	223, 826, 400	306, 098, 62	2 0	306, 098, 622	200. 00

Provider CCN: 15-0126

Peri od: From 01/01/2023 To 12/31/2023 Date/Ti me Prepared: 5/30/2024 10:06 am

In Lieu of Form CMS-2552-10

				5/30/2024 10:0	06 am
	Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
		6.00	7.00	<u>'</u>	
	GENERAL SERVICE COST CENTERS				
1.00	00100 CAP REL COSTS-BLDG & FIXT	2, 230, 808	16, 416, 866		1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	0			2. 00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	-676, 527			4. 00
5.00	00500 ADMI NI STRATI VE & GENERAL	-11, 094, 761	1		5. 00
6.00	00600 MAI NTENANCE & REPAI RS	-71, 750			6.00
7. 00 7. 01	OO7OO OPERATION OF PLANT OO7O1 OPERATION OF PLANT - FP	-113, 311			7. 00 7. 01
8. 00	00800 LAUNDRY & LINEN SERVICE		1		8.00
9. 00	00900 HOUSEKEEPI NG	-42, 307	1		9. 00
9. 01	01851 ENVI RONMENTAL SERVI CES - FP	0	1		9. 01
10.00	01000 DI ETARY	-285	•		10.00
11. 00	01100 CAFETERI A	-711, 310			11. 00
13.00	01300 NURSI NG ADMI NI STRATI ON	-93, 885	2, 958, 403		13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	-1, 275, 791	1		14. 00
15. 00	01500 PHARMACY	578, 966	1		15. 00
16. 00	01600 MEDI CAL RECORDS & LI BRARY	1, 768, 312			16. 00
17. 00	01700 SOCIAL SERVICE	-293, 275			17. 00
21. 00 22. 00	O2100 I &R SERVICES-SALARY & FRINGES APPRV O2200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	•		21.00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	-104, 844	I -		23. 00
23. 00	02301 ECHOCARDI OLOGY EDUCATI ON PROGRAM	-90, 480			23. 01
20.01	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	70, 400	. 05, 051		20.01
30. 00	03000 ADULTS & PEDIATRICS	-9, 347, 171	16, 315, 446		30.00
31. 00	03100 NTENSI VE CARE UNI T	-101, 042	•		31.00
35.00	02060 NEONATAL INTENSIVE CARE UNIT	-2, 027, 017	2, 171, 111		35. 00
41.00	04100 SUBPROVI DER - I RF	0	1, 934, 339		41. 00
43.00	04300 NURSERY	0	1, 784, 645		43. 00
	ANCI LLARY SERVI CE COST CENTERS				
50.00	05000 OPERATI NG ROOM	-7, 200, 127	1		50.00
51.00	05100 RECOVERY ROOM	0 (022	1 .,		51.00
52. 00 53. 00	O5200 DELI VERY ROOM & LABOR ROOM O5300 ANESTHESI OLOGY	-6, 933 -3, 685, 825	1		52. 00 53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	-3, 665, 625	•		54.00
54. 01	05401 RADI 0LOGY - I -65	-27,000			54. 01
54. 02	05402 RADIOLOGY DIAGNOSTIC - SJ				54. 02
54. 03	05403 LOWELL RADIOLOGY		1		54. 03
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	1		55. 00
55. 01	05501 CARDI AC CATHERI ZATON LAB	-618	2, 449, 316		55. 01
55. 02	03140 CARDI OLOGY	-51, 855	1, 170, 405		55. 02
55. 03	03450 NEURO-DI AGNOSTI CS	-17, 153	1		55. 03
60.00	06000 LABORATORY	-8, 488	1		60.00
60. 01	06001 BLOOD LABORATORY	0	ł		60. 01
65. 00	06500 RESPIRATORY THERAPY	0	.,,		65. 00
66. 00	O6600 PHYSI CAL THERAPY O6601 PHYSI CAL THERAPY I -65	-150	1	· ·	66. 00
66. 01 66. 02	06602 PHYSICAL THERAPY ST JOHN	-5, 536			66. 01 66. 02
67. 00	06700 OCCUPATI ONAL THERAPY	-5, 550	1		67. 00
	06701 OCCUPATION THERAPY I -65		100, 627		67. 01
67. 02	06702 OCCUPATIONAL THERAPY ST. JOHN	0	l		67. 02
68. 00	06800 SPEECH PATHOLOGY	0	1		68. 00
68. 01	06801 SPEECH PATHOLOGY I -65	0	313, 373	3	68. 01
68. 02	06802 SPEECH THERAPY ST. JOHN	0	0		68. 02
69. 00	06900 ELECTROCARDI OLOGY	0			69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0			71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	10, 071, 960		72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	6, 532, 239		73.00
74.00	07400 RENAL DI ALYSI S	20 440	463, 319		74.00
76. 00 76. 01	03020 RADI ATI ON ONCOLOGY 03040 ANGI OCARDI OGRAPHY	-28, 468			76. 00 76. 01
77. 00	07700 ALLOGENEI C HSCT ACQUISITION	-4	1		77. 00
78.00	07800 CAR T-CELL IMMUNOTHERAPY		1		78.00
70.00	OUTPATIENT SERVICE COST CENTERS		,	<u> </u>	, 0. 00
90. 00	09000 CLINIC	0	0		90. 00
90. 01	09001 DI ABETES CLINIC	0	ł .		90. 01
90. 02	09002 OUTPATIENT CLINICS	868	819		90. 02
90. 03	09003 OCCUPATIONAL MEDICINE CLINIC	0	0		90. 03
90. 04	09004 NEONATOLOGY CLINIC-FRANCISCAN POINT	0	16, 786		90. 04
90. 05	09005 LACTATION CLINIC	0	26, 267		90.05
91.00	09100 EMERGENCY	-1, 864, 337	l .		91.00
91. 01	09101 EMERGENCY ROOM PHYSI CANS	0	1	1	91. 01
91. 02	O9102 EXPRESS CARE O9200 OBSERVATION BEDS (NON-DISTINCT PART		0	'	91. 02 92. 00
92.00	104200 ODSEKVATION DEDS (NON-DISTINCT PART	1	I	I I	J 7∠. UU

			5/30/2024 10	
Cost Center Description	Adjustments	Net Expenses		
	(See A-8)	For Allocation		
	6.00	7. 00		
OTHER REIMBURSABLE COST CENTERS				
102.00 10200 OPI OI D TREATMENT PROGRAM	0	0		102. 00
SPECIAL PURPOSE COST CENTERS				
113. 00 11300 I NTEREST EXPENSE	0	0		113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	-34, 361, 984	253, 081, 351		118. 00
NONREI MBURSABLE COST CENTERS				
190.00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0		190. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	-880, 153	2, 291, 417		192. 00
194. 00 07950 FHC	0	0		194. 00
194. 01 07951 CONVENT	0	0		194. 01
194.02 07952 OTHER NON REIMB - BUILDINGS	0	1, 422, 035		194. 02
194.03 07953 OTHR NON REIM-FHC BEHAVORIAL HEALTH	0	0		194. 03
194. 04 07954 CENTER OF HOPE	0	138, 742		194. 04
194. 05 07955 LAKESHORE JOINT VENTURE	0	13, 922, 940		194. 05
194.06 07957 COVID VACCINE CLINIC	0	0		194. 06
200.00 TOTAL (SUM OF LINES 118 through 199)	-35, 242, 137	270, 856, 485		200. 00

FRANCISCAN HEALTH CROWN POINT
Provider CCN: 15-0126 Health Financial Systems RECLASSIFICATIONS Peri od: Worksheet A-6 From 01/01/2023 To 12/31/2023 Date/Time Prepared: 5/30/2024 10:06 am

					10:06 am
	Cost Center	Increases Line #	Sal ary	Other	
	2. 00	3.00	4. 00	5. 00	
	A - DIETARY	44.00	212 225	770 400	1.00
1. 00	CAFETERI A		81 <u>9, 2</u> 95 819, 295	77 <u>3, 1</u> 88 773, 188	1. 00
	B - MEDICAL EDUCATION		0.77270		
1.00				<u>0</u>	1. 00
	C - LEASES & RENT		0	U	
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	508, 669	1. 00
2. 00 3. 00	CAP REL COSTS-MVBLE EQUIP CENTRAL SERVICES & SUPPLY	2. 00 14. 00	0	276, 307 371	2. 00 3. 00
4. 00	CENTRAL SERVICES & SUPPLY	0.00	o	0	4. 00
5.00		0.00	0	0	5. 00
6. 00 7. 00		0. 00 0. 00	0	0	6. 00 7. 00
8. 00		0.00	o	0	8. 00
9. 00		0.00	o	0	9. 00
10. 00 11. 00		0. 00 0. 00	0	0	10. 00 11. 00
12. 00		0.00	Ö	0	12. 00
13.00		0.00	0	0	13. 00
14. 00 15. 00		0. 00 0. 00	0	0	14. 00 15. 00
16. 00		0.00	Ö	0	16. 00
17. 00		0.00	0	0	17. 00
18. 00		0.00	0	000	18. 00
	D - DEPRECIATION			7007017	
1.00	CAP REL COSTS MARIE FOLLD	1. 00 2. 00	0	21, 968, 471 9, 002, 820	1.00
2. 00 3. 00	CAP REL COSTS-MVBLE EQUIP	0.00	0	9,002,820	2. 00 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	0	0	7. 00
8.00		0.00	0	0	8. 00
9. 00 10. 00	1	0. 00 0. 00	0	0	9. 00 10. 00
11. 00		0.00	Ö	Ö	11. 00
12.00		0.00	0	0	12.00
13. 00 14. 00		0. 00 0. 00	0	0	13. 00 14. 00
15. 00		0.00	ō	0	15. 00
16. 00 17. 00		0. 00 0. 00	0	0	16. 00 17. 00
18. 00		0.00	0	0	18. 00
19. 00		0.00	0	0	19. 00
20. 00 21. 00		0. 00 0. 00	0	0	20. 00 21. 00
22. 00		0.00	o	0	22. 00
23. 00		0.00	O	0	23. 00
24. 00 25. 00		0. 00 0. 00	0	0	24. 00 25. 00
26. 00		0.00	Ö	Ö	26. 00
27. 00		0.00	0	0	27. 00
28. 00 29. 00		0. 00 0. 00	0	0	28. 00 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 36. 00		0. 00 0. 00	0	0	35. 00 36. 00
37. 00		0.00	0	0	37. 00
	O CHARCEARIE MED CURRY 152	LANDLANTC		30, 971, 291	
1. 00	E - CHARGEABLE MED SUPPLIES & MEDICAL SUPPLIES CHARGED TO	R IMPLANTS 71.00	ol	19, 584, 828	1.00
	PATI ENT		7		
2.00	IMPL. DEV. CHARGED TO	72.00	0	10, 071, 960	2. 00
3. 00	PATIENTS OUTPATIENT CLINICS	90. 02	o	819	3. 00
4.00		0.00	O	0	4. 00
5. 00 6. 00		0. 00 0. 00	0	0	5. 00 6. 00
0.00	I	0.00	Ŋ	٥	1 0.00

Health Financial Systems RECLASSIFICATIONS FRANCISCAN HEALTH CROWN POINT
Provider CCN: 15-0126 In Lieu of Form CMS-2552-10
Worksheet A-6 Peri od: From 01/01/2023 To 12/31/2023 Date/Time Prepared: 5/30/2024 10:06 am

					5/30/2024 10:0	06 am_
		Increases		0.11		
	Cost Center	Li ne #	Sal ary	Other		
7.00	2. 00	3.00	4. 00	5. 00		7.00
7.00		0.00	0	0		7. 00
8. 00		0.00	0	0	III	8. 00
9. 00		0. 00	0	0		9. 00
10. 00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	o	0		14.00
15.00		0.00	o	0		15.00
16. 00		0.00	ol	Ō		16. 00
17. 00		0.00	0	Ö		17. 00
18. 00		0.00	o	0		18. 00
19. 00		0.00	o	0		19. 00
20. 00		0.00	o	0		20. 00
21. 00		0.00	0	0		21. 00
21.00			0	0		21.00
		0.00	0			
23. 00		0.00	0	0		23. 00
24. 00		0.00	0	0		24. 00
25. 00		0.00	0	0		25. 00
26. 00		0. 00	O	0		26. 00
27. 00		0. 00	0	0		27. 00
28. 00		0.00	0	0		28. 00
29. 00		0.00	0	0		29. 00
30.00		0.00	0	0		30.00
31.00		0.00	0	0		31.00
		- $ +$		29, 657, 607		
	F - PROPERTY INSURANCE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	444, 897		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2. 00	o	153, 785		2. 00
3. 00	CAP REL COSTS-MVBLE EQUIP	2. 00	ol	8, 339		3. 00
0.00	0 10010 1110000		— — ў	607, 021		0.00
	G - INTERNS AND RESIDENTS		<u> </u>	007, 021		
1.00	I&R SERVICES-SALARY & FRINGES	21. 00	1	1		1. 00
1.00	APPRV	21.00	'	!		1.00
2.00	I&R SERVICES-OTHER PRGM COSTS	22. 00	1	1		2. 00
2.00	APPRV	22.00	'	'		2.00
	APPRV	+	+	_ _		
	I - NURSERY			۷		
1.00	NEONATAL INTENSIVE CARE UNIT	35.00	4, 365	372		1. 00
		•				
2.00	NURSERY	43.00	1, 669, 366	115, 279		2.00
3. 00	DELIVERY ROOM & LABOR ROOM	5200	1, 893, 236	16 <u>1, 5</u> 51		3. 00
	0		3, 566, 967	277, 202		
	J - PHARMACY	70.00	ا م			
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	6, 532, 239		1. 00
2.00	CENTRAL SERVICES & SUPPLY	14. 00	0	3, 427		2. 00
3.00		0. 00	0	0		3. 00
4. 00		0. 00	0	0		4. 00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	o	0		10.00
11. 00		0.00	0	0		11.00
12. 00		0.00	Ō	0		12. 00
13. 00		0.00	0	0		13. 00
14. 00		0.00	0	0		14. 00
15. 00		0.00	0	0		15. 00
16. 00		0.00	0	0		16. 00
16.00		0.00	O O	0		16.00
17.00			— — — —			17.00
	N MODKING MELL		0	6, 535, 666		
1 00	K - WORKING WELL	400.00	0/4 741	044 470		1 00
1. 00	PHYSICIANS' PRIVATE OFFICES	1 <u>92.</u> 00	<u>861, 711</u>	34 <u>4, 1</u> 72		1. 00
	0		861, 711	344, 172		
	L - INTEREST EXPENSE					
1.00	INTEREST EXPENSE	113. 00	0	9, 927, 697		1.00
2.00	ADMINISTRATIVE & GENERAL	5. 00	0	7, 143		2.00
	0			9, 934, 840		
	M - PARAMEDICAL					
1.00	ECHOCARDI OLOGY EDUCATI ON	23. 01	85, 378	0		1. 00
55	PROGRAM	20.01	33, 573	٥		50
	TOTALS	+	85, 378		1	
500 00	Grand Total: Increases	+	5, 333, 353	79, 886, 336		500. 00
230.00	12. 2.14 . 0 . 0 . 1 . 1 . 1 . 1 . 1 . 1 . 1 . 1	I	5, 555, 555	, 555, 556	ı	_ 55. 56

Provider CCN: 15-0126

In Lieu of Form CMS-2552-10
Worksheet A-6

Peri od: From 01/01/2023 To 12/31/2023 Date/Ti me Prepared: 5/30/2024 10:06 am

COLL CONTENT							5/30/2024 1	0:06 am
Company Comp			Decreases		0.11		I	
A - DIETRINY								
1.00			7.00	8.00	9.00	10.00		
1.00	1 00		10.00	010 205	770 100	1		1 00
S. KENTOCAL EQUALITION	1.00	DIETARY						1.00
1.00 0 0 0 0 0 0 0 0		R - MEDICAL EDUCATION		019, 290	113, 100			
C. LEASES & RENI D. CHARLES & R	1 00	B - WEDI CAL EDUCATION		٥	0	1		1 00
C. LEASES & RENI D. CHARLES & R	1.00					 		1.00
		C - LEASES & RENT		<u> </u>		1		
2.00 MAIN INSTRATIVE A GENERAL 5.00 0 313,805 10 2.00 340 360	1.00		4.00	0	65, 851	10		1.00
2.00 OPERATION OF PLANT 7.00 0 2.944 0 4.00			· •	0		_	1	•
A.00 LAURGHY & LINEW SERVICE 8.00 0 65.298 0 0 5.0		OPERATION OF PLANT	· •	o			1	3. 00
MOUSEKEEPING			· •	O				1
7.00 PHARMACY 15.00 0 33.008 0 7.00 0 0 0 0 0 0 0 0 0	5.00	HOUSEKEEPI NG	9. 00	o				5. 00
8.00 AMULTS & PEDIATRICS 30.00 0 2.951 0 8.00 10	6.00	NURSING ADMINISTRATION	13.00	O	2, 272	. 0		6. 00
9.00 INTENSIVE CARE UNIT 31.00 0 0 9.00 10	7.00	PHARMACY	15. 00	O	53, 008	0		7. 00
10.00 SUBPRIVIDER 18F	8.00	ADULTS & PEDIATRICS	30.00	0	2, 951	0		8. 00
11.00 DEPART ING ROOM 50.00 0 29,741 0 11.00 13.	9.00	INTENSIVE CARE UNIT		0	-			9. 00
12.00 ADDICOSY-DI AGNOSTIC 54.00 0 133,927 0 12.00	10.00	SUBPROVI DER - I RF	l l	0				10. 00
13.00 LOWELL RADIOLOGY		1	· · · · · · · · · · · · · · · · · · ·	0				1
14.00				0			1	1
15.00 RESPIRATORY THERAPY 65.00 0 31,505 0 16.00			· · · · · · · · · · · · · · · · · · ·	0		_	1	1
16.00 MINSTOAL THERAPY ST JOIN 66.02 0 5,276 0 16.00 17.00 OTHER NON RETIME — BUILDINGS 194.05 0 21,935 0 17.00 18.00 TOTALS 0 785,3477 18.00 TOTALS 0 18.00 TO		1		0			•	
17.00 OTHER NON BER IMB - BILLININGS 194, 02 0 21, 935 0 17.00 TOTALS 0 18.00 IOTALS 0 IOTALS I		1		0				1
18.00 LAKESHORE_JOINT_VENTURE		1	· •	- 1			•	1
TOTALS				-			1	1
D	18.00		194.05					18.00
1.00				U	785, 347			
2.00 ADMINISTRATIVE & CEMERAL	1 00		4 00	ما	22 400			1 00
3.00 MAINTENANCE & REPAIRS 6.00 0 11.195 0 4.00 0 0 0 0 0 0 0 0 0				-				1
4.00			· •	-				1
5.00 OPERATION OF PLANT - FP		1	· •	- 1				1
6.00 HOUSEKEEPINS 9.00 0 27,703 0 6.00 7.00 8.00 7.00 8.00 7.00 8.00 7.00 8.00 7.00 8.00 7.00 8.00 7.00 8.00 7.00 8.00 7.00 8.00 7.00 8.00 7.00 8.00 7.00 8.00 7.00 8.00 7.00 8.00 7.00 8.00 7.00 8.00 7.00		1	· •	-			1	1
7.00 DIETARY 10.00 0 74, 326 0 7.00 8.00 9.00 NIRS NG ADMIN ISTRATI ON 13, 00 0 480, 907 0 9.00 9.00 CENTRAL SERVI CES & SUPPLY 14, 00 0 90, 220 0 9.00 11.00 MEDI CAL RECORDS & LI BRARY 16, 00 0 2, 197 0 11, 00 12.00 SOCI AL SERVI CE 17, 00 0 201 0 12, 200 13.00 PARAMED ED PROM-(SPECI FY) 23, 00 0 17, 290 0 13, 00 14.00 PROGRAM 15, 00 17, 290 0 13, 00 15.00 ADMINISTRATION 23, 01 0 10, 547 0 14, 00 15.00 ADMINISTRATION 23, 01 0 10, 547 0 14, 00 15.00 ADMINISTRATION 23, 01 0 10, 547 0 14, 00 15.00 ADMINISTRATION 23, 01 0 10, 547 0 14, 00 15.00 ADMINISTRATION 23, 01 0 10, 547 0 14, 00 16.00 INTENSIVE CARE UNIT 31, 00 0 255, 197 0 16, 00 17.00 NECOMATAL INTENSIVE CARE UNIT 31, 00 0 313, 379 0 17, 00 19.00 OPERATING ROOM 50, 00 0 1, 641, 903 0 19, 00 19.00 OPERATING ROOM 51, 00 0 60, 3 0 21, 00 20.00 ABCOVERY ROOM 51, 00 0 60, 812 0 20, 00 20.00 ABCOVERY ROOM 54, 00 0 885, 962 0 22, 00 23.00 RADIOLOGY 1-65 54, 01 0 154, 703 0 22, 00 24.00 RADIOLOGY 1-65 54, 01 0 154, 703 0 22, 00 25.00 LOWELL RADIOLOGY 55, 02 0 179, 373 0 22, 00 26.00 CARDIOLOGY 55, 02 0 179, 373 0 22, 00 27.00 CARDIOLOGY 55, 02 0 179, 373 0 22, 00 28.00 ADMINISTRATION 28, 00 29, 00 29.00 LABGRATORY 66, 00 0 4, 272 0 31, 00 29.00 LABGRATORY 66, 00 0 4, 272 0 31, 00 29.00 LABGRATORY 66, 00 0 4, 272 0 31, 00 29.00 ABCOLOGY 76, 00 0 25, 55 0 36, 607 29.00 ADMINISTRATION 13, 00 0 26, 507 0 20.00 PROGRAM 20, 20 20, 20 20, 20 20, 20 20.00 PROGRAM 20, 20 20, 20 20, 20 20, 20 20.00 PROGRAM 20, 20 20, 20 20, 20 20, 20 20.00 PROGRAM 20, 20 20, 20 20, 20				-				1
B. 00 NURSING ADMINISTRATION 13.00 0 480, 907 0 9.00			· •	-		_	1	1
9.00 CENTRAL SERVICES & SUPPLY 14.00 0 90.220 0 10.00 11.00 MEDICAL RECORDS & LIBRARY 16.00 0 2.197 0 11.00 12.00 SOCIAL SERVICE 17.00 0 201 0 12.00 13.00 PARAMED ED PREM-(SPECI FY) 23.00 0 17.290 0 13.00 14.00 PARAMED ED PREM-(SPECI FY) 23.00 0 17.290 0 13.00 14.00 PARAMED ED PREM-(SPECI FY) 23.00 0 17.547 0 13.00 14.00 PARAMED ED PREM-(SPECI FY) 23.00 0 17.547 0 14.00 14.00 PARAMED ED PREM-(SPECI FY) 23.00 0 17.547 0 14.00 14.00 PARAMED ED PREM-(SPECI FY) 23.00 0 17.547 0 14.00 14.00 PARAMED ED PREM-(SPECI FY) 23.00 0 17.547 0 14.00 14.00 PARAMED ED PREM-(SPECI FY) 23.00 0 253.197 0 14.00 16.00 INTENSI VE CARE UNIT 31.00 0 253.197 0 16.00 17.00 INTENSI VE CARE UNIT 31.00 0 253.197 0 17.00 18.00 SUBPROVI DER - I ER 41.00 0 190.734 0 17.00 19.00 OPERATING ROOM 50.00 0 1.641, 903 0 19.00 19.00 OPERATING ROOM 51.00 0 60.812 0 20.00 19.00 OPERATING ROOM 51.00 0 60.812 0 20.00 19.00 DELI VERY ROOM & LABOR ROOM 52.00 0 60.3 0 21.00 23.00 RADIOLOGY-I-65 54.00 0 885, 962 0 22.00 24.00 RADIOLOGY-I-65 54.01 0 154, 703 0 22.00 25.00 LOWELL RADIOLOGY 54.03 0 6.077 0 22.00 25.00 LOWELL RADIOLOGY 55.02 0 179, 373 0 27.00 26.00 CARDIOLOGY-I-65 55.01 0 466, 085 0 28.00 27.00 CARDIOLOGY-I-65 66.01 0 31, 345 0 28.00 29.00 LABORATORY 66.00 0 4.272 0 31.00 29.00 LABORATORY 66.00 0 4.272 0 31.00 29.00 LABORATORY 66.00 0 214, 701 0 35.00 29.00 LABORATORY 66.00 0 24.701 0 35.00 29.00 LABORATORY 66.00 0 24.701 0 35.00 20.00 PARSIPALITA LERRI PLATION 18.00 0 38.997 0 39.00 20.00 PARSIPALITA LERRI PLATION 66.02 0 3.0971, 291 20.00 PARAMED ED PREM-(SPECI FY) 14.00 0 14.006 0 30.971, 291 20.00 PARAME		1		O			1	1
10.00 PHARMACY 15.00 0 38,904 0 10.00 11.00 11.00 11.00 11.00 11.00 12.00 SCCI AL SERVICE 17.00 0 2.01 0 12.00 12.00 30.00 SCCI AL SERVICE 17.00 0 20.1 0 12.00 12.00 13.00 14.00 ECHOCARDI OLOGY EDUCATI ON 23.01 0 10.547 0 14.00				O			1	1
12.00 SOCI AL SERVICE 17.00 0 201 0 12.00 13.00 13.00 201 0 13.00 201 0 14.00 ECHOCARDIOLOGY EDUCATION 23.01 0 10.547 0 14.00 ECHOCARDIOLOGY EDUCATION 23.01 0 10.547 0 14.00 14.00 15.00 201	10.00		15. 00	О				10. 00
13. 00 PARAMED ED PRGM. (SPECI FY) 23. 00 0 17, 290 0 14. 00 PROGRAM 14. 00 PROGRAM 23. 01 0 10, 547 0 14. 00 PROGRAM 23. 01 0 10, 547 0 14. 00 PROGRAM 23. 01 0 10, 547 0 14. 00 PROGRAM 24. 00 25. 00 0 25. 00 0 15. 00 16. 00 17. 00 REDIATRIC S 28. 00 0 25. 00 0 25. 00 0 16. 00 17. 00 REDIATRIC S 28. 00 0 313. 379 0 17. 00 18. 00 19. 00	11.00	MEDICAL RECORDS & LIBRARY	16. 00	O	2, 197	0		11. 00
14. 00 ECHOCARDI OLOGY EDUCATI ON 23. 01 0 10, 547 0 PROGRAM 15. 00 10. 547 0 PROGRAM 15. 00 10. 547 0 PROGRAM 15. 00 10. 547 0 15. 00 15. 00 15. 00 15. 00 15. 00 17. 00 15. 00 17. 00 15. 00 17. 00 15. 00 17. 00 15. 00 17. 00 15. 00 17. 00 15. 00 17. 00 15. 00 17. 00 15. 00 17. 00 18. 00 18. 00 18. 00 18. 00 190, 734 0 18. 00 19	12.00	SOCIAL SERVICE	17. 00	0	201	0		12. 00
PROGRAM	13.00	PARAMED ED PRGM-(SPECIFY)	23. 00	0	17, 290	0		13. 00
15. 00 ADULTS & PEDIATRICS 30. 00 0 807, 050 0 15. 00 16. 00 17 17 17 18 19 19 19 19 19 19 19	14.00	ECHOCARDIOLOGY EDUCATION	23. 01	0	10, 547	0		14. 00
16. 00 NTENSIVE CARE UNIT 31. 00 0 253, 197 0 17. 00 NEONATAL INTENSIVE CARE UNIT 35. 00 0 313, 379 0 17. 00 NEONATAL INTENSIVE CARE UNIT 35. 00 0 190, 734 0 18. 00 190, 734 0 18. 00 190, 734 0 18. 00 190, 734 0 18. 00 190, 734 0 18. 00 190, 734 0 18. 00 190, 734 0 18. 00 190, 734 0 18. 00 190, 734 0 190, 734 0 18. 00 190, 734 0 18. 00 190, 734 0 190, 734 0 18. 00 190, 734 0 18. 00 190, 734 0 190, 734 0 18. 00 190, 734 0 18. 00 190, 734 0 190, 734 0 18. 00 190, 734 0 18. 00 190, 734 0 190, 734 0 18. 00 190, 734 0 190, 734 0 18. 00 190, 734 190, 734 190, 7								
17. 00 NEONATAL INTENSIVE CARE UNIT 35. 00 313, 379 0 17. 00		1		-		_	1	1
18. 00 SUBPROVI DER - I RF				-			1	1
19. 00 OPERATING ROOM				-1			1	1
20.00 RECOVERY ROOM 51.00 0 60,812 0 20.00			•	- 1	·			1
21.00 DELI VERY ROOM & LABOR ROOM 52.00 0 603 0 22.00 ANESTHESI OLOGY 53.00 0 111, 235 0 22.00 23.00 RADII OLOGY-DI AGNOSTI C 54.00 0 885, 962 0 23.00 24.00 RADII OLOGY-DI AGNOSTI C 54.01 0 154, 703 0 24.00 25.00 LOWELL RADI OLOGY 54.03 0 6,077 0 25.00 CARDI ACCATHERI ZATON LAB 55.01 0 466, 085 0 26.00 CARDI ACCATHERI ZATON LAB 55.01 0 466, 085 0 27.00 CARDI OLOGY 55.02 0 179, 373 0 27.00 28.00 NEURO-DI AGNOSTI CS 55.03 0 31, 345 0 28.00 29.00 LABORATORY 60.00 0 38, 997 0 29.00 29.00 LABORATORY 66.00 0 92, 601 0 30.00 31.00 PHYSI CAL THERAPY 66.00 0 4, 272 0 31.00 32.00 PHYSI CAL THERAPY 66.00 0 4, 272 0 31.00 33.00 34.00 ELECTROCARDI OLOGY 69.00 0 25, 454 0 34.00 35.00 RADII ATION ONCOLOGY 76.00 0 214, 701 0 35.00 36.00 37.00 EMERGENCY 91.00 0 189, 306 0 0 37.00 0 0 37.00 0 0 0 0 0 0 0 0 0			· •	-1			1	1
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27. 00 CARDI OLOGY 55. 02 0 179, 373 0 27. 00 28. 00 NEURO-DI AGNOSTI CS 55. 03 0 31, 345 0 28. 00 29. 00 LABORATORY 60. 00 0 38, 997 0 29. 00 30. 00 RESPI RATORY THERAPY 65. 00 0 92, 601 0 30. 00 31. 00 PHYSI CAL THERAPY 66. 00 0 4, 272 0 31. 00 32. 00 PHYSI CAL THERAPY 1 -65 66. 01 0 9, 139 0 32. 00 33. 00 PHYSI CAL THERAPY ST JOHN 66. 02 0 3, 216 0 33. 00 34. 00 ELECTROCARDI OLOGY 69. 00 0 25, 454 0 33. 00 36. 00 OUTPATI ENT CLINI CS 90. 02 58 0 36. 00 37. 00 EMERGENCY 91. 00 0 189, 306 0 37. 00 E - CHARGEABLE MED SUPPLIES & IMPLANTS 1. 00 CENTRAL SERVI CES & SUPPLY 14. 00 0 143, 060 0 2. 00 3. 00 PHARMACY 15. 00 0 178, 352 0 5. 00 4. 00 PHARMACY 15. 00 0 178, 352 0 6. 00 6. 00 INTENSI VE CARE UNIT 31. 00 0 578, 352 0 6. 00 6. 00 INTENSI VE CARE UNIT 31. 00 0 578, 352 0 6. 00 6. 00 INTENSI VE CARE UNIT 31. 00 0 578, 352 0 6. 00		1					•	1
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31. 00 PHYSI CAL THERAPY 66. 00 0 4, 272 0 31. 00 32. 00 PHYSI CAL THERAPY I -65 66. 01 0 9, 139 0 32. 00 33. 00 PHYSI CAL THERAPY ST JOHN 66. 02 0 3, 216 0 33. 00 34. 00 ELECTROCARDI OLOGY 69. 00 0 25, 454 0 34. 00 35. 00 RADI ATI ON ONCOLOGY 76. 00 0 214, 701 0 35. 00 36. 00 OUTPATI ENT CLI NI CS 90. 02 0 58 0 36. 00 37. 00 EMERGENCY 91. 00 0 189, 306 0 37. 00 E - CHARGEABLE MED SUPPLIES & IMPLANTS 1. 00 NURSI NG ADMI NI STRATI ON 13. 00 0 143, 060 0 2. 00 C CENTRAL SERVI CES & SUPPLY 14. 00 0 143, 060 0 2. 00 3. 00 PHARMACY 15. 00 0 63, 749 0 33. 00 5. 00 ADULTS & PEDI ATRI CS 30. 00 0 1, 618, 562 0 5. 00 6. 00 INTENSI VE CARE UNI T 31. 00 0 578, 352 0 6. 00	29.00			O				29. 00
32. 00 PHYSI CAL THERAPY I -65 66. 01 0 9, 139 0 33. 00 PHYSI CAL THERAPY ST JOHN 66. 02 0 3, 216 0 34. 00 ELECTROCARDI OLOGY 69. 00 0 25, 454 0 35. 00 RADI ATI ON ONCOLOGY 76. 00 0 214, 701 0 36. 00 OUTPATI ENT CLI NI CS 90. 02 58 0 37. 00 EMERGENCY 91. 00 0 189, 306 0 0	30.00	RESPIRATORY THERAPY	65.00	0	92, 601	0		30. 00
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35. 00 RADI ATI ON ONCOLOGY 76. 00 0 214, 701 0 35. 00 36. 00 OUTPATI ENT CLI NI CS 90. 02 0 58 0 37. 00 EMERGENCY 91. 00 0 189, 306 0 E - CHARGEABLE MED SUPPLIES & IMPLANTS 1. 00 NURSI NG ADMI NI STRATI ON 13. 00 0 36, 807 0 2. 00 CENTRAL SERVI CES & SUPPLY 14. 00 0 143, 060 0 3. 00 PHARMACY 15. 00 0 63, 749 0 3. 00 4. 00 PARAMED ED PRGM-(SPECI FY) 23. 00 0 10, 815 0 4. 00 5. 00 ADULTS & PEDI ATRI CS 30. 00 0 1, 618, 562 0 5. 00 6. 00 INTENSI VE CARE UNI T 31. 00 0 578, 352 0 6. 00	33.00	PHYSICAL THERAPY ST JOHN	66. 02	0	3, 216	0		33. 00
36. 00 OUTPATIENT CLINICS 90. 02 0 58 0 0 37. 00 EMERGENCY 91. 00 0 189, 306 0 0 37. 00 0 30, 971, 291	34.00	ELECTROCARDI OLOGY		0	25, 454	. 0		34. 00
37. 00 EMERGENCY 91. 00 189, 306 0 E - CHARGEABLE MED SUPPLIES & IMPLANTS 1. 00 NURSI NG ADMINISTRATION 13. 00 0 36, 807 0 2. 00 CENTRAL SERVICES & SUPPLY 14. 00 0 143, 060 0 2. 00 PHARMACY 15. 00 0 63, 749 0 3. 00 4. 00 PARAMED ED PRGM-(SPECIFY) 23. 00 0 10, 815 0 4. 00 5. 00 ADULTS & PEDIATRICS 30. 00 0 1, 618, 562 0 5. 00 6. 00 INTENSIVE CARE UNIT 31. 00 0 578, 352 0 6. 00		RADIATION ONCOLOGY		0	214, 701	0		35. 00
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3.00 PHARMACY 15.00 0 63,749 0 3.00 4.00 PARAMED ED PRGM-(SPECIFY) 23.00 0 10,815 0 4.00 5.00 ADULTS & PEDIATRICS 30.00 0 1,618,562 0 5.00 6.00 INTENSIVE CARE UNIT 31.00 0 578,352 0 6.00		1	•	-1				1
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RECLASSI FI CATIONS

In Lieu of Form CMS-2552-10

From 01/01/2023 To 12/31/2023 Da

Peri od:

Provider CCN: 15-0126

Worksheet A-6 3 Date/Time Prepared:

5/30/2024 10:06 am Decreases Wkst. A-7 Ref. Cost Center Sal ary 0ther Line # 6. 00 7.00 8.00 9.00 10.00 SUBPROVIDER - IRF 8.00 41.00 65, 749 0 8.00 9.00 OPERATING ROOM 50.00 17, 977, 086 9.00 0 RECOVERY ROOM 51.00 0 15, 995 10.00 10.00 DELIVERY ROOM & LABOR ROOM 52.00 0 0 11.00 116 11 00 o 0 12.00 ANESTHESI OLOGY 53.00 145,089 12.00 0 935, 284 0 13.00 RADI OLOGY-DI AGNOSTI C 54.00 13.00 0 0 14.00 RADIOLOGY - 1-65 54.01 33, 335 14.00 CARDIAC CATHERIZATON LAB 0 0 15.00 55.01 6,046,750 15.00 16.00 CARDI OLOGY 55.02 0 252, 391 0 16.00 o 0 17.00 NEURO-DI AGNOSTI CS 55.03 36,020 17.00 I ABORATORY 60 00 0 0 18 00 1, 105 18 00 RESPIRATORY THERAPY 0 0 19.00 65.00 427, 910 19.00 1, 071 20.00 PHYSICAL THERAPY 66.00 o 0 20.00 21.00 PHYSICAL THERAPY I-65 66.01 o 7,930 0 21.00 PHYSICAL THERAPY ST JOHN 0 0 1, 071 22 00 22 00 66.02 0 0 23.00 OCCUPATIONAL THERAPY 67.00 492 23.00 24.00 OCCUPATION THERAPY I-65 67.01 o 1, 139 0 24.00 SPEECH PATHOLOGY 0 0 25.00 68.00 883 25.00 Ol 0 69.00 ELECTROCARDI OLOGY 26.00 4.360 26.00 27.00 RENAL DIALYSIS 74.00 0 3, 528 0 27.00 RADIATION ONCOLOGY o 0 28.00 76.00 17, 376 28.00 ANGI OCARDI OGRAPHY 0 0 29.00 76.01 19, 363 29.00 30.00 NEONATOLOGY CLINIC-FRANCISCAN 90.04 0 0 30.00 POI NT 31.00 EMERGENCY 91.00 965, 903 0 31.00 ō 29, 657, 607 F - PROPERTY INSURANCE 1.00 ADMINISTRATIVE & GENERAL 5.00 0 607, 021 12 1.00 o 2.00 0.00 12 2.00 0 3.00 0.00 12 3.00 607, 021 - INTERNS AND RESIDENTS 1.00 ADMINISTRATIVE & GENERAL 5. 00 0 1.00 2 00 ADMINISTRATIVE & GENERAL 5.00 2 00 0 NURSERY 1.00 ADULTS & PEDIATRICS 30.00 2, 861, 529 244.176 0 1.00 2.00 NEONATAL INTENSIVE CARE UNIT 35.00 705, 438 33, 026 0 2.00 3.00 0.00 0 3.00 3, 566, 967 277, 202 J - PHARMACY 1.00 PHARMACY 15.00 6,088,722 0 1.00 2.00 ADULTS & PEDIATRICS 30.00 0 135, 457 0 2.00 3.00 INTENSIVE CARE UNIT 31.00 0 84, 155 0 3.00 0 NEONATAL INTENSIVE CARE UNIT 0 35.00 4 00 1 111 4 00 5.00 SUBPROVIDER - IRF 41.00 0 2, 510 0 5.00 6.00 OPERATING ROOM 50.00 o 88, 346 0 6.00 7.00 RECOVERY ROOM 51.00 0 3, 295 0 7.00 0 lanesthesi ology 53.00 0 8.00 58 520 8.00 9.00 RADI OLOGY-DI AGNOSTI C 54.00 0 9,028 0 9.00 o 0 10.00 RADI OLOGY - I -65 54.01 546 10.00 CARDIAC CATHERIZATON LAB 0 55.01 0 9,903 11.00 11.00 12 00 CARDI OLOGY 55.02 0 13 0 12 00 13.00 LABORATORY 60.00 0 3, 931 0 13.00 RESPIRATORY THERAPY 14.00 65.00 0 463 0 14.00 0 0 15.00 RENAL DIALYSIS 74.00 1, 160 15.00 16.00 RADIATION ONCOLOGY 76.00 0 81 0 16.00 **EMERGENCY** 48, 425 0 17.00 17.00 91.00 6, 535, 666 K - WORKING WELL 1.00 EMPLOYEE BENEFITS DEPARTMENT 4.00 861, 711 344, 172 0 1.00 861, 711 344, 172 - INTEREST EXPENSE 1.00 CAP REL COSTS-BLDG & FIXT 1.00 8.735.979 11 1.00 CAP REL COSTS-MVBLE EQUIP 1, 198, 861 2.00 2.00 11 2.00 9, 934, 840 M - PARAMEDICAL CARDI OLOGY 1.00 55.02 85, 378 0 1.00 TOTALS 85, 378 500.00 Grand Total: Decreases 5. 333. 353 79, 886, 336 500.00

RECONCILIATION OF CAPITAL COSTS CENTERS Provi der CCN: 15-0126 Peri od: Worksheet A-7 From 01/01/2023 Part I 12/31/2023 Date/Time Prepared: 5/30/2024 10:06 am Acqui si ti ons Begi nni ng Di sposal s and Purchases Donati on Total Bal ances Retirements 2.00 3.00 4. 00 1 00 5 00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 13, 758, 812 0 1.00 15, 969, 806 0 2.00 Land Improvements 0 2.00 353, 116, 047 0 3.00 143, 529, 248 143, 529, 248 3.00 Buildings and Fixtures 0 0 4.00 Building Improvements 796, 915 0 4.00 5.00 Fixed Equipment 84, 357, 871 69, 890 0 69, 890 5.00 83, 296, 868 0 6.00 Movable Equipment 1, 065, 507 1, 065, 507 431, 141 6.00 0 7.00 HIT designated Assets 0 7.00 8.00 Subtotal (sum of lines 1-7) 551, 296, 319 144, 664, 645 144, 664, 645 431, 141 8.00 9.00 Reconciling Items 202, 526, 608 143, 496, 631 0 143, 496, 631 9.00 348, 769, 711 Total (line 8 minus line 9) 1, 168, 014 1, 168, 014 10.00 431, 141 10.00 Endi ng Bal ance Fully Depreciated Assets 6.00 7.00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 Land 13, 758, 812 1.00 2.00 Land Improvements 15, 969, 806 0 2. 00 496, 645, 295 3.00 Buildings and Fixtures 0 3.00 0 4.00 Building Improvements 796, 915 4.00 5.00 Fi xed Equipment 84, 427, 761 0 5.00 Movable Equipment 0 6.00 83, 931, 234 6.00 7.00 HIT designated Assets 0 7.00 Subtotal (sum of lines 1-7) 695, 529, 823 8.00 0 8.00 9.00 Reconciling Items 346, 023, 239 9.00 10.00 Total (line 8 minus line 9) 349, 506, 584 10.00

Health Financial Systems	FRANCISCAN HEAL	TH CROWN POINT		In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der Co	CN: 15-0126	Peri od: From 01/01/2023 To 12/31/2023	Worksheet A-7 Part II Date/Time Pre 5/30/2024 10:0	pared:
		Sl	JMMARY OF CAF	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	KSHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00 CAP REL COSTS-BLDG & FLXT	0	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)	0	0		0 0	0	3. 00
	SUMMARY O	F CAPITAL				
Cost Center Description	0ther	Total (1) (sum				
	Capi tal -Rel ate	of cols. 9				
	d Costs (see	through 14)				
	instructions)					
	14. 00	15. 00				
PART II - RECONCILIATION OF AMOUNTS FROM WOF	KSHEET A, COLUM	N 2, LINES 1 a	ind 2			
1.00 CAP REL COSTS-BLDG & FLXT	0	0)			1. 00
2.00 CAP REL COSTS-MVBLE EQUIP	0	0)			2. 00
3.00 Total (sum of lines 1-2)	0	0)			3. 00

Heal th	n Financial Systems	FRANCISCAN HEAL	TH CROWN POINT		In Lie	u of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provider Co		Period: From 01/01/2023 To 12/31/2023	Worksheet A-7 Part III Date/Time Prep 5/30/2024 10:0	pared: O6 am
		COMI	PUTATION OF RAT	TI OS	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col 2)	instructions)	Insurance	
		1.00	2. 00	3. 00	4. 00	5. 00	
1 00	PART III - RECONCILIATION OF CAPITAL COSTS C			(11 500 50	0 005054	0	1 00
1. 00 2. 00	CAP REL COSTS-BLDG & FLXT CAP REL COSTS-MVBLE EQUIP	611, 598, 589		611, 598, 58 78, 806, 92		0	1. 00 2. 00
3. 00	Total (sum of lines 1-2)	83, 931, 235 695, 529, 824				0	3. 00
3.00	Total (Suil of Titles 1-2)		TION OF OTHER (F CAPITAL	3.00
		, ALLOON	THOM OF OTHER C	7.11 17.1 <u>C</u>	JONINI II C	0/11/1/12	
	Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
			Capi tal -Relate	cols. 5	·		
			d Costs	through 7)			
		6. 00	7. 00	8. 00	9. 00	10. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS C		_	l			
1.00	CAP REL COSTS-BLDG & FLXT	0	1		0 24, 199, 279		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		9, 002, 820		2.00
3.00	Total (sum of lines 1-2)	0	0	L JMMARY OF CAPI	33, 202, 099	784, 976	3. 00
			30	JIVIIVIARY OF CAPT	IAL		
	Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
			instructions)	instructions)	Capi tal -Relate	of cols. 9	
					d Costs (see	through 14)	
					instructions)		
		11. 00	12. 00	13. 00	14. 00	15. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS C				_1		
1.00	CAP REL COSTS-BLDG & FLXT	-8, 735, 979			0	16, 416, 866	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	-1, 198, 861			0	8, 242, 390	2.00
3. 00	Total (sum of lines 1-2)	-9, 934, 840	607, 021	I	0 0	24, 659, 256	3. 00

Provider CCN: 15-0126

				To	12/31/2023	Date/Time Prep 5/30/2024 10:0	oared: O6 am
				Expense Classification on		9, 00, 2021 10.	30 a
				To/From Which the Amount is	to be Adjusted		
	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	
1. 00	Investment income - CAP REL	1.00		CAP REL COSTS-BLDG & FIXT	1. 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)]	
3. 00	Investment income - other (chapter 2)		0	I NTEREST EXPENSE	113. 00	11	3. 00
4. 00	Trade, quantity, and time discounts (chapter 8)		0		0. 00	О	4. 00
5. 00	Refunds and rebates of expense	s	0		0. 00	0	5. 00
6. 00	(chapter 8) Rental of provider space by	В	-373 258	ADMINISTRATIVE & GENERAL	5. 00	0	6. 00
	suppliers (chapter 8)		373,233	A SENERAL STRAIN TO THE METERS OF THE SENERAL STRAIN TO THE SENERAL STRAIN THE SENERAL STRAI			
7. 00	Tel ephone servi ces (pay stations excluded) (chapter 21	 	0		0. 00	0	7. 00
8. 00	Television and radio service (chapter 21)		0		0. 00	o	8. 00
9. 00	Parking lot (chapter 21)		0		0.00	0	9. 00
10. 00	Provi der-based physician adjustment	A-8-2	-25, 107, 779			0	10. 00
11. 00	Sale of scrap, waste, etc.		0		0. 00	0	11. 00
12. 00	(chapter 23) Related organization	A-8-1	3, 626, 145			0	12. 00
13. 00	transactions (chapter 10)		0		0. 00	0	13. 00
14. 00	Laundry and linen service Cafeteria-employees and guests	В	-671, 239	CAFETERI A	11. 00	0	
15. 00	Rental of quarters to employee and others		0		0. 00	0	15. 00
16. 00	Sale of medical and surgical		0		0. 00	0	16. 00
17. 00	supplies to other than patient Sale of drugs to other than	\$	0		0. 00	0	17. 00
10.00	pati ents		0		0.00	0	10.00
18. 00	Sale of medical records and abstracts		Ü		0. 00	0	18. 00
19. 00	Nursing and allied health education (tuition, fees,		0		0. 00	0	19. 00
	books, etc.)	_				_	
20. 00 21. 00	Vending machines Income from imposition of	В	-40, 0/1 0	CAFETERI A	11. 00 0. 00	0	20. 00 21. 00
	interest, finance or penalty						
22. 00	charges (chapter 21) Interest expense on Medicare		0		0. 00	0	22. 00
	overpayments and borrowings to repay Medicare overpayments						
23. 00	Adjustment for respiratory	A-8-3	0	RESPIRATORY THERAPY	65. 00		23. 00
	therapy costs in excess of limitation (chapter 14)						
24. 00	Adjustment for physical therap costs in excess of limitation	y A-8-3	0	PHYSI CAL THERAPY	66. 00		24. 00
	(chapter 14)						
25. 00	Utilization review - physicians' compensation		0	*** Cost Center Deleted ***	114. 00		25. 00
27.00	(chapter 21)		0	CAD DEL COCTO DI DO A FLYT	1 00		27.00
26. 00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1. 00	0	26. 00
27. 00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	27. 00
28. 00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19. 00		28. 00
29. 00 30. 00	Physicians' assistant Adjustment for occupational	A-8-3	0	OCCUPATI ONAL THERAPY	0. 00 67. 00	0	29. 00 30. 00
	therapy costs in excess of		, and the second		21.30		
30. 99	limitation (chapter 14) Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30. 00		30. 99
31. 00	instructions) Adjustment for speech patholog	v A-8-3	Λ	SPEECH PATHOLOGY	68. 00		31. 00
51.00	costs in excess of limitation	, ,, ,,	0	5. 22511 1711102001	55. 66		51.00
32. 00	(chapter 14) CAH HIT Adjustment for		0		0. 00	0	32. 00
	Depreciation and Interest		100 100	EMDIOVEE BENEELTS DEDADTMENT		0	
33. 00 33. 01	PENSION EXPENSE HAF FEES	A A	-8, 806, 196	EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL	4. 00 5. 00	O	33. 01
34. 00	ADVERTI SI NG	A	-10, 429	EMPLOYEE BENEFITS DEPARTMENT	4. 00	9	34. 00
		'					

Provi der CCN: 15-0126 Peri od: Worksheet A-8 From 01/01/2023 | Worksheet A-o | To 12/31/2023 | Date/Time Prepared:

				T	o 12/31/2023	Date/Time Prep 5/30/2024 10:0	
				Expense Classification on	Worksheet A	373072024 10.	o alli
				To/From Which the Amount is			
	Cost Center Description	Basi s/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4. 00	5. 00	
34. 01	ADVERTI SI NG	A		ADMI NI STRATI VE & GENERAL	5. 00	0	34. 01
34. 02 34. 03	ADVERTI SI NG	A		OPERATION OF PLANT	7. 00 13. 00	0	34. 02 34. 03
34. 03	ADVERTI SI NG ADVERTI SI NG	A A		NURSING ADMINISTRATION PARAMED ED PRGM-(SPECIFY)	23.00	0	34. 03
34. 05	ADVERTI SI NG	A		OPERATING ROOM	50.00	o	34. 05
34.06	ADVERTI SI NG	A		RADI OLOGY-DI AGNOSTI C	54.00	0	34. 06
34. 07	ADVERTI SI NG	A		NEURO-DI AGNOSTI CS	55. 03	0	34. 07
34. 08	ADVERTI SI NG	A		PHYSICAL THERAPY ST JOHN	66. 02	0	34. 08
34. 09	ADVERTI SI NG	A		ANGI OCARDI OGRAPHY	76.01	0	34. 09
34. 10 35. 00	ADVERTISING NON ALLOWABLE INTEREST EXP	A B	-541 0	EMERGENCY	91. 00 0. 00	0	34. 10 35. 00
35. 00	LOBBYING EXP	A	-6. 903	ADMINISTRATIVE & GENERAL	5. 00	0	35. 00
35. 02	PATIENT PHONES	A		ADMINISTRATIVE & GENERAL	5. 00	0	35. 02
36.00	DEFERRED LEASE REVENUE	В	-1, 061	ADMINISTRATIVE & GENERAL	5. 00	0	36.00
37. 00	ADMINISTRATIVE FEE	В		EMPLOYEE BENEFITS DEPARTMENT	4.00	0	37. 00
37. 01	ADMINISTRATIVE FEE	В		OPERATING ROOM	50.00	0	37. 01
38. 00 39. 00	NRCC PHYS CONTRACT REVENUE	A B		PHYSICIANS' PRIVATE OFFICES OPERATING ROOM	192. 00 50. 00	0	38. 00 39. 00
39. 01	CONTRACT REVENUE	B		PHYSICAL THERAPY	66.00	0	39. 01
40. 00	DI SCOUNTS EARNED/REBATES	В		CENTRAL SERVICES & SUPPLY	14. 00	0	40. 00
41.00	EDUCATION MISC REV	В	-2, 250	ADMINISTRATIVE & GENERAL	5. 00	0	41.00
41. 01	EDUCATION MISC REV	В		PARAMED ED PRGM-(SPECIFY)	23. 00	0	41. 01
41. 02	EDUCATION MISC REV	В		ADULTS & PEDIATRICS	30.00	0	41. 02
42. 00	MI SC. SVCS/OTHER OPERATING. JOINT VE	В	-/1, /50	MAINTENANCE & REPAIRS	6. 00	0	42. 00
42. 01	MI SC. SVCS/OTHER	В	-1, 000	OPERATION OF PLANT	7. 00	0	42. 01
	OPERATING. JOINT VE		,				
42. 02	MI SC. SVCS/OTHER	В	-41, 000	HOUSEKEEPI NG	9. 00	0	42. 02
42.02	OPERATING. JOINT VE	В	OF 000	CENTRAL CERVICES & CURRIN	14.00		42.02
42. 03	MI SC. SVCS/OTHER OPERATING. JOINT VE	В	-95, 000	CENTRAL SERVICES & SUPPLY	14. 00	0	42. 03
43. 00	OTHER ADJUSTMENTS (SPECIFY) (3	sb	0		0.00	0	43. 00
43. 01	OTHER OPERATING REVENUES	В	-290	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	43. 01
43. 02	OTHER OPERATING REVENUES	В		ADMINISTRATIVE & GENERAL	5. 00	0	43. 02
43. 03	OTHER OPERATING REVENUES	В		OPERATION OF PLANT	7.00	0	43. 03
43. 04 43. 05	OTHER OPERATING REVENUES OTHER OPERATING REVENUES	B B		HOUSEKEEPI NG DI ETARY	9. 00 10. 00	0	43. 04 43. 05
43. 06	OTHER OPERATING REVENUES	В		NURSING ADMINISTRATION	13. 00	0	43. 06
43. 07	OTHER OPERATING REVENUES	В		ADULTS & PEDIATRICS	30.00	o	43. 07
43. 08	OTHER OPERATING REVENUES	В	-550	RADI OLOGY-DI AGNOSTI C	54.00	0	43.08
43. 09	OTHER OPERATING REVENUES	В		CARDIAC CATHERIZATON LAB	55. 01	0	43. 09
44. 00	MI SC. SERVI CES	В		EMPLOYEE BENEFITS DEPARTMENT	4.00	0	44. 00
	MI SC. SERVI CES MI SC. SERVI CES	B B		ADMINISTRATIVE & GENERAL RADIOLOGY-DIAGNOSTIC	5.00	0	44. 01 44. 02
44. 02 45. 00	PROGRAM FEES	В		EMPLOYEE BENEFITS DEPARTMENT	54. 00 4. 00	0	44. 02 45. 00
46. 00	PARAMED ED REV	В		PARAMED ED PRGM-(SPECIFY)	23. 00	ő	46. 00
46. 01	PARAMED ED REV	В		ECHOCARDIOLOGY EDUCATION	23. 01	0	46. 01
		_	_	PROGRAM		_	
47. 00	MEDICAL RECORDS	В		RADI OLOGY-DI AGNOSTI C	54.00	0	47. 00
47. 01 48. 00	MEDI CAL RECORDS GI FTS/DONATI ONS	B A		NURSING ADMINISTRATION OPERATION OF PLANT	13. 00 7. 00	0	47. 01 48. 00
48. 01	GI FTS/DONATI ONS	A		HOUSEKEEPI NG	9.00	0	48. 01
48. 02	GI FTS/DONATI ONS	A		PARAMED ED PRGM-(SPECIFY)	23. 00	0	48. 02
48. 03	FALL OUT ACCOUNTS	A	-9, 990	ADMINISTRATIVE & GENERAL	5. 00	0	48. 03
48. 04	FALL OUT ACCOUNTS	A		OUTPATIENT CLINICS	90. 02	0	48. 04
48. 05	FALL OUT ACCOUNTS	A		PHYSICIANS' PRIVATE OFFICES	192.00	0	48. 05
49. 00 49. 01	PROPERTY TAX ADJUSMTENT PROPERTY TAX ADJUSMTENT	A A		ADMINISTRATIVE & GENERAL OPERATING ROOM	5. 00 50. 00	0	49. 00 49. 01
49. 01	PROPERTY TAX ADJUSMITENT	A		DELIVERY ROOM & LABOR ROOM	52. 00	0	49. 01
49. 03	PROPERTY TAX ADJUSMTENT	A		RADI OLOGY-DI AGNOSTI C	54.00	Ö	49. 03
49. 04	PROPERTY TAX ADJUSMTENT	A		PHYSICAL THERAPY ST JOHN	66. 02	0	49. 04
50.00	TOTAL (sum of lines 1 thru 49)		-35, 242, 137				50.00
	(Transfer to Worksheet A,						
(4) 5	column 6, line 200.)			010 5 1 15 1			

⁽¹⁾ Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.
(2) Additional adjustments must be made and applicable and cubes into these fields.

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

Health Financial Systems	F	RANCISCAN HEAL	TH CROWN POINT	In Lie	eu of Form CMS-	2552-10
ADJUSTMENTS TO EXPENSES				Peri od:	Worksheet A-8	
				From 01/01/2023 To 12/31/2023	Date/Time Pre 5/30/2024 10:	
			Expense Classification or			
			To/From Which the Amount is	to be Adjusted		
0 1 0 1 0 1 1	D : (0 (0)	Δ .	0 1 0 1	1 . "	WI I A 7 D C	
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	

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

* 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.

COVP / PHARMACY

578, 966

46, 800, 947

C

0

0

Ω

43, 174, 802

4.00

4.01

4 02

5.00

			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			0.00		0. 00	7.00
8.00			0.00		0. 00	8. 00
9.00			0.00		0. 00	9. 00
10.00			0.00		0. 00	10.00
100.00	G. Other (financial or					100.00
	non-financial) specify:					

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

15. 00 PHARMACY

0.00

0 00

TOTALS (sum of lines 1-4).

Transfer column 6, line 5 to Worksheet A-8, column 2, line

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

4.00

4.01

4 02

5.00

Financial Syste	ems	F	RANCISCAN HEALTH	CROWN POINT	In Liei	u of Form CMS-	2552-10
NT OF COSTS OF	SERVICES FROM	RELATED ORGANIZ	ATIONS AND HOME	Provider CCN: 15-0126	Peri od:	Worksheet A-8	3-1
COSTS					From 01/01/2023		
					To 12/31/2023		
					<u> </u>	5/30/2024 10:	06 am
Net	Wkst. A-7 Ref.						
Adjustments							
(col. 4 minus							
col. 5)*							
6. 00	7. 00						
A. COSTS INCUR	RED AND ADJUSTI	MENTS REQUIRED A	AS A RESULT OF TRA	NSACTIONS WITH RELATED (ORGANIZATIONS OR (CLAI MED	
HOME OFFICE CO	STS:						
2, 230, 808	9						1. 00
-951, 941	0						2. 00
1, 768, 312	0						3. 00
578, 966	0						4. 00
	Net Adj ustments (col. 4 minus col. 5)* 6.00 A. COSTS INCUR HOME OFFICE CO 2,230,808 -951,941 1,768,312	Net Adjustments (col. 4 minus col. 5)* Net A6.00 Net A7 Ref.	Net Adj ustments (col. 4 minus col. 5)* 6.00 A. COSTS INCURRED AND ADJUSTMENTS REQUIRED A HOME OFFICE COSTS: 2,230,808 9 -951,941 0 1,768,312 0	Net Adjustments (col. 4 minus col. 5)* A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRAHOME OFFICE COSTS: 2, 230, 808 9 -951, 941 0 1, 768, 312 0	Net Adjustments (col. 4 minus col. 5)* 6.00 7.00 A. COSTS I NCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED (HOME OFFICE COSTS: 2,230,808 -951,941 1,768,312 0	Net Adjustments (col . 4 minus col . 5)* 6.00 7.00 A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR (HOME OFFICE COSTS: 2,230,808	Net Adj ustments (col. 4 minus col. 5)* A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS: 2, 230, 808 9 -951, 941 0 1, 768, 312 0

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

4.01

4 02

5.00

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

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

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

	· · · · · · · · · · · · · · · · · · ·	
	NON PROFIT	6.00
7. 00 8. 00		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:

0

0

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

4.01

4 02

5.00

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT Provider CCN: 15-0126

Sect of Control Properties 1.00						רן	To 12/31/2023	Date/Time Pre 5/30/2024 10:	
1.00		Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount		00 4111
1.00			l denti fi er	Remuneration	Component	Component			
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STATE STAT				·	·				
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				293, 275			0	0	
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Wikst. A Line F Cost Center/Physician Identifier Unadjusted RCE Limit Cost of Identifier Cost of Identifier Cost of Identifier Component Share of col. C		91. 00	AGGREGATE-EMERGENCY				0	-	
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14.00	12. 00	55. 02		0	0	0	0	0	12.00
15.00				0	0	0	0		
16.00				0	0	0	0		
Number N					1		0		
Identifier Component Share of col. 14	200.00			0	0		0	0	
1.00 2.00 15.00 16.00 17.00 18.00		Wkst. A Line #	3				Adjustment		
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DEPARTME	4.00			15. 00					4 00
2. 00 S. 00 AGGREGATE-ADMINISTRATIVE & O O O 12, 212 2. 00	1.00	4. 00		0	0	0	455, 314		1.00
3. 00 13. 00 AGGREGATE-NURSI NG ADMI NI STRATI ON 4. 00 17. 00 AGGREGATE-SOCI AL SERVI CE O O O O 293, 275 4. 00 5. 00 23. 00 AGGREGATE-PARAMED ED O O O O O PRGM-(SPECI FY) O O O O O 7. 00 31. 00 AGGREGATE-ADULTS & PEDI ATRI CS O O O O 8. 00 35. 00 AGGREGATE-INTENSI VE CARE UNI T O O O 8. 00 35. 00 AGGREGATE-NEONATAL INTENSI VE O O O CARE UN O O O O 9. 00 50. 00 AGGREGATE-OPERATI NG ROOM O O O 10. 00 53. 00 AGGREGATE-ANESTHESI OLOGY O O 11. 00 O O O CATHERI ZATON LAB	2. 00	5. 00		0	0	0	12, 212		2. 00
ADMI NI STRATI ON A. 00 17. 00 AGGREGATE - SOCI AL SERVI CE D		40.00							
4. 00 17. 00 AGGREGATE - SOCI AL SERVI CE 0 0 0 293, 275 4. 00 5. 00 23. 00 AGGREGATE - PARAMED ED 0 0 0 0 PRGM- (SPECI FY) 6. 00 0 9, 326, 159 6. 00 7. 00 31. 00 AGGREGATE - ADULTS & PEDI ATRI CS 0 0 0 0 8. 00 35. 00 AGGREGATE - NEONATAL I NTENSI VE 0 0 0 0 CARE UN 9. 00 50. 00 AGGREGATE - OPERATI NG ROOM 0 0 0 0 10. 00 53. 00 AGGREGATE - ANESTHESI OLOGY 0 0 0 11. 00 55. 01 AGGREGATE - CARDI AC 0 0 CATHERI ZATON LAB 0 0 0 11. 00 11. 00 15. 00 17. 191, 036 9. 00 11. 00 11. 00 0 0 11. 00 0 0 0 11. 00 0 0 0 1293, 275 4. 00 0 0 9, 326, 159 6. 00 0 0 0 0 0 0 0 0 0	3.00	13.00		0	0	0	46, 496		3. 00
5. 00 23. 00 AGGREGATE-PARAMED ED PRGM- (SPECI FY) 0 0 0 0 0 0 5. 00 6. 00 30. 00 AGGREGATE-ADULTS & PEDI ATRI CS 0 0 0 9, 326, 159 6. 00 7. 00 31. 00 AGGREGATE-INTENSI VE CARE UNIT 0 0 0 101, 042 7. 00 8. 00 35. 00 AGGREGATE-NEONATAL INTENSI VE CARE UNIT 0 0 0 2, 027, 017 8. 00 9. 00 50. 00 AGGREGATE-OPERATI NG ROOM 0 0 0 7, 191, 036 9. 00 10. 00 53. 00 AGGREGATE-ANESTHESI OLOGY 0 0 0 3, 685, 825 10. 00 11. 00 55. 01 AGGREGATE-CARDI AC CATHERI ZATON LAB 0 0 0 0 0 0 11. 00	4. 00	17. 00		О	О	0	293, 275		4. 00
6. 00 30. 00 AGGREGATE - ADULTS & PEDI ATRI CS 0 0 0 9, 326, 159 6. 00 7. 00 31. 00 AGGREGATE - I NTENSI VE CARE UNI T 0 0 0 101, 042 7. 00 8. 00 35. 00 AGGREGATE - NEONATAL I NTENSI VE 0 0 0 2, 027, 017 8. 00 CARE UN 7. 00 0 0 0 0 0 0 0 0 0		23. 00		0	0	0			5. 00
7. 00 31. 00 AGGREGATE - I NTENSI VE CARE UNI T 0 0 0 101, 042 7. 00 8. 00 35. 00 AGGREGATE - NEONATAL I NTENSI VE 0 0 0 2, 027, 017 8. 00 9. 00 50. 00 AGGREGATE - OPERATI NG ROOM 0 0 0 7, 191, 036 9. 00 10. 00 53. 00 AGGREGATE - ANESTHESI OLOGY 0 0 0 3, 685, 825 10. 00 11. 00 55. 01 AGGREGATE - CARDI AC 0 0 0 0 11. 00 CATHERI ZATON LAB	6.00	30 00		_	_	_	0 324 1E0		6 00
8. 00 35. 00 AGGREGATE-NEONATAL INTENSIVE 0 0 0 2, 027, 017 8. 00 9. 00 50. 00 AGGREGATE-OPERATING ROOM 0 0 0 7, 191, 036 9. 00 10. 00 53. 00 AGGREGATE-ANESTHESI OLOGY 0 0 0 3, 685, 825 10. 00 11. 00 55. 01 AGGREGATE-CARDIAC 0 0 0 0 11. 00 CATHERI ZATON LAB				•					
9. 00 50. 00 AGGREGATE-OPERATING ROOM 0 0 7, 191, 036 9. 00 10. 00 53. 00 AGGREGATE-ANESTHESI OLOGY 0 0 3, 685, 825 10. 00 11. 00 55. 01 AGGREGATE-CARDI AC 0 0 0 0 CATHERI ZATON LAB			AGGREGATE-NEONATAL INTENSIVE	0					
10. 00	0.00	FO 00		_	_	_	7 101 007		0.00
11. 00 55. 01 AGGREGATE-CARDI AC				0	1				
CATHERI ZATON LAB				0	1				
12. UU 55. UZ AGGKEGATE-CARDI ULUGY U U 0 51, 855 12. 00	10.00	== ==		_	_	_	E4 0E=		10.00
	12.00	55. 02	AGGKEGATE-CAKDI ULUGY	0	0	0	51, 855	l	12.00

Health Financial Systems			FRANCI SCAN HEAL	TH CROWN POINT	-	In Lieu of Form CMS-2552-10		
PROVI DE	ER BASED PHYSIC	IAN ADJUSTMENT		Provi der (CCN: 15-0126	Peri od: From 01/01/2023	Worksheet A-8	3-2
						To 12/31/2023		epared: 06 am_
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		I denti fi er	Component	Limit	Di sal I owance			
			Share of col.					
			14					
	1. 00	2. 00	15. 00	16. 00	17. 00	18. 00		
13.00	55. 03	AGGREGATE-NEURO-DI AGNOSTI CS	0	0		0 16, 796		13. 00
14.00	60.00	AGGREGATE-LABORATORY	0	0		0 8, 488		14. 00
15.00	76. 00	AGGREGATE-RADIATION ONCOLOGY	0	0		0 28, 468		15. 00
16.00	91.00	AGGREGATE-EMERGENCY	0	0		0 1, 863, 796		16. 00
200.00			0	0		0 25, 107, 779		200. 00
	•	•	•	•				

COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0126 Peri od: Worksheet B From 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/30/2024 10:06 am CAPITAL RELATED COSTS Cost Center Description Net Expenses BLDG & FIXT MVBLE EQUIP **EMPLOYEE** Subtotal for Cost **BENEFITS** DEPARTMENT Allocation (from Wkst A col. 7) 1.00 2.00 4. 00 4A GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS-BLDG & FLXT 16, 416, 866 16, 416, 866 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 8, 242, 390 8, 242, 390 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 20, 393, 952 198, 918 41, 413 20, 634, 283 4.00 00500 ADMINISTRATIVE & GENERAL 71, 268, 056 5 00 65, 281, 543 4, 875, 080 136, 275 975, 158 5 00 6.00 00600 MAINTENANCE & REPAIRS 2, 897, 275 36, 278 2, 175 151,833 3, 087, 561 6.00 2, 885, 027 7.00 00700 OPERATION OF PLANT 8, 836, 023 145, 798 679, 357 12, 546, 205 7.00 00701 OPERATION OF PLANT - FP 956, 375 9, 931 966, 306 7.01 7.01 00800 LAUNDRY & LINEN SERVICE 211, 977 8 00 1, 333, 932 18, 689 1, 564, 598 8 00 2, 343, 586 9.00 00900 HOUSEKEEPI NG 113, 652 53, 267 455, 262 2, 965, 767 9.00 01851 ENVIRONMENTAL SERVICES - FP 142, 832 9.01 116, 512 26, 320 9.01 01000 DI ETARY 584, 918 143, 165 10.00 1.093.561 129, 543 1. 951. 187 10.00 1, 089, 600 11.00 01100 CAFETERI A 881, 173 208.427 11.00 13.00 01300 NURSING ADMINISTRATION 2, 958, 403 626, 049 314,880 711, 525 4, 610, 857 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 -336, 455 473, 500 153, 374 100, 812 391, 231 14.00 669, 960 01500 PHARMACY 3, 298, 022 60, 964 9, 754 4, 038, 700 15.00 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 2, 588, 523 58, 520 3.340 152, 454 2, 802, 837 16.00 01700 SOCIAL SERVICE 2, 078, 530 134, 707 386 467, 383 2, 681, 006 17.00 17.00 21.00 02100 I&R SERVICES-SALARY & FRINGES APPRV C 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 22.00 22.00 0 0 02300 PARAMED ED PRGM-(SPECIFY) 23.00 518, 938 C 32, 972 93.507 645, 417 23.00 02301 ECHOCARDI OLOGY EDUCATI ON PROGRAM 23.01 63,651 20, 280 38,046 121, 977 23.01 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 16, 315, 446 1, 747, 525 393, 919 24, 284, 479 30.00 5, 827, 589 31.00 03100 INTENSIVE CARE UNIT 4, 173, 924 361, 104 485, 505 908, 293 5, 928, 826 31.00 02060 NEONATAL INTENSIVE CARE UNIT 2, 171, 111 200, 746 540, 754 35.00 453, 667 3, 366, 278 35.00 141, 953 3, 002, 410 41.00 04100 SUBPROVIDER - IRF 1, 934, 339 445, 881 480, 237 41.00 04300 NURSERY 43.00 1, 784, 645 424, 683 2, 209, 328 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 9, 476, 787 779, 506 2, 441, 756 1, 523, 186 14, 221, 235 50.00 05100 RECOVERY ROOM 51 00 4.436 312, 605 9,872 50 326, 963 51 00 52.00 05200 DELIVERY ROOM & LABOR ROOM 2, 106, 066 492, 537 2, 598, 603 52.00 05300 ANESTHESI OLOGY 14, 106 319, 226 53.00 57, 265 44, 379 203, 476 53.00 05400 RADI OLOGY-DI AGNOSTI C 7, 993, 092 1, 293, 591 1, 240, 540 11, 170, 800 54.00 643, 577 54.00 05401 RADIOLOGY - I-65 108, 665 885, 901 54.01 548, 501 C 228, 735 54.01 54.02 05402 RADIOLOGY DIAGNOSTIC - SJ C 0 54.02 54.03 05403 LOWELL RADIOLOGY 2,823 11, 685 520 15, 028 54.03 05500 RADI OLOGY-THERAPEUTI C 55 00 55 00 0 05501 CARDI AC CATHERI ZATON LAB 2, 449, 316 55.01 200, 070 749, 585 385, 998 3, 784, 969 55.01 55.02 03140 CARDI OLOGY 1, 170, 405 339, 211 293, 939 1, 803, 555 55.02 55.03 03450 NEURO-DI AGNOSTI CS 515, 856 58, 485 55, 482 131, 439 761, 262 55.03 06000 LABORATORY 13, 946, 161 60 00 13, 563, 219 309, 882 73,060 60 00 60.01 06001 BLOOD LABORATORY 60.01 06500 RESPIRATORY THERAPY 1, 914, 593 35, 126 174, 846 410, 983 2, 535, 548 65.00 65.00 66.00 06600 PHYSI CAL THERAPY 986, 876 117.458 3, 797 250, 080 1, 358, 211 66, 00 06601 PHYSI CAL THERAPY I -65 13, 877 66.01 836, 371 C 193.857 1, 044, 105 66 01 66.02 06602 PHYSI CAL THERAPY ST JOHN 215, 223 0 4, 207 50, 649 270,079 66.02 06700 OCCUPATIONAL THERAPY 599, 065 750, 776 67.00 151, 711 67.00 06701 OCCUPATION THERAPY I-65 25, 029 67.01 100.627 0 0 125, 656 67.01 06702 OCCUPATIONAL THERAPY ST. JOHN 0 67.02 10.471 C 2.664 13, 135 67 02 68.00 06800 SPEECH PATHOLOGY 371, 206 0 93, 202 464, 408 68.00 06801 SPEECH PATHOLOGY I -65 68.01 313, 373 Ω 0 79, 355 392, 728 68 01 06802 SPEECH THERAPY ST. JOHN 68 02 0 0 68 02 69.00 06900 ELECTROCARDI OLOGY 516, 355 47, 952 128, 157 695, 641 69.00 3, 177 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 19, 584, 828 19, 584, 828 71.00 0 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 10, 071, 960 10, 071, 960 72.00 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 6, 532, 239 73.00 6.532.239 0 73.00 74.00 07400 RENAL DIALYSIS 463, 319 18, 017 0 481, 336 74.00 03020 RADIATION ONCOLOGY 76 00 858, 442 116,020 97, 375 1,071,837 76.00 03040 ANGLOCARDLOGRAPHY 245, 898 61, 900 76.01 0 0 307, 798 76.01 07700 ALLOGENEIC HSCT ACQUISITION 77.00 C 0 0 77 00 07800 CAR T-CELL IMMUNOTHERAPY 78.00 78.00 0 0 0 0 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 0 0 90.00 90.01 09001 DIABETES CLINIC 0 0 Λ 90.01 90.02 09002 OUTPATIENT CLINICS 819 0 112 0 931 90.02 09003 OCCUPATIONAL MEDICINE CLINIC 0 90.03 90.03 0 0 0 09004 NEONATOLOGY CLINIC-FRANCISCAN POINT 0 0 4, 109 20.895 90 04 90 04 16, 786 6, 682 90.05 09005 LACTATION CLINIC 26, 267 0 32, 949 90.05

=						6.5. 0110	
		RANCISCAN HEALT				u of Form CMS-:	2552-10
COST ALLOCAT	FION - GENERAL SERVICE COSTS		Provi der CO		Period: From 01/01/2023	Worksheet B Part I	
					o 12/31/2023	Date/Time Pre	nared:
				'	0 12/01/2020	5/30/2024 10:	
			CAPI TAL REI	_ATED_COSTS			
	Cost Center Description	Net Expenses	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Subtotal	
		for Cost			BENEFITS		
		Allocation			DEPARTMENT		
		(from Wkst A					
		col . 7)	1.00		4.00		
04 00 00400	EMEDOENOV	0	1.00	2.00	4.00	4A	04.00
	EMERGENCY BOOM BUNGLOAMS	5, 186, 598	626, 817	155, 535	1, 107, 164	7, 076, 114	
	EMERGENCY ROOM PHYSI CANS	0	0	(0	
	EXPRESS CARE	0	0	() 이	0	91. 02
	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
	REI MBURSABLE COST CENTERS				, a		100.00
	OPI OI D TREATMENT PROGRAM	0	0		0	0	102. 00
	AL PURPOSE COST CENTERS INTEREST EXPENSE						112 00
		252 001 251	1/ 41/ 0//	0 100 210	10 007 051	252 220 220	113.00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117) IMBURSABLE COST CENTERS	253, 081, 351	16, 416, 866	8, 198, 310	19, 927, 351	252, 330, 339] 118.00
	GIFT, FLOWER, COFFEE SHOP, & CANTEEN				v ol		190. 00
	PHYSICIANS' PRIVATE OFFICES	2, 291, 417	0	9. 748	662, 931	2, 964, 096	
194. 00 07950		2, 271, 417	0	7, 740	002, 731		194. 00
194. 01 07951	l ·	0	0				194. 00
	OTHER NON REIMB - BUILDINGS	1, 422, 035	0	26, 504	íl ől	1, 448, 539	
	OTHE NON REIM-FHC BEHAVORIAL HEALTH	1, 422, 033	0	20, 30-			194. 02
	CENTER OF HOPE	138, 742	0	7, 828	34, 223		
	LAKESHORE JOINT VENTURE	13, 922, 940	0	7,020	9, 778	13, 932, 718	
	COVID VACCINE CLINIC	13, 722, 740	n) , , , , ol		194. 06
200.00	Cross Foot Adjustments				1		200. 00
201.00	Negative Cost Centers		n	(ا ا		201. 00
202.00	TOTAL (sum Lines 118 through 201)	270 856 485	16 416 866	8 242 300	20 634 283		

270, 856, 485

8, 242, 390

20, 634, 283

16, 416, 866

270, 856, 485 202. 00

202.00

TOTAL (sum lines 118 through 201)

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0126

| In Lieu of Form CMS-2552-10 | Period: Worksheet B | From 01/01/2023 Part I | To 12/31/2023 Date/Time Prepared: 5/30/2024 10: 06 am

	Cook Cooking Doorsi aki oo	ADMINI CTDATI VE	MAINTENANCE O	ODEDATION OF	ODEDATION OF	5/30/2024 10:	
	Cost Center Description	ADMI NI STRATI VE & GENERAL	REPAIRS	OPERATION OF PLANT	OPERATION OF PLANT - FP	LAUNDRY & LINEN SERVICE	
		5. 00	6. 00	7. 00	7. 01	8. 00	
1 00	GENERAL SERVI CE COST CENTERS	T T		I			1 1 00
1. 00 2. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						1. 00 2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00	00500 ADMINISTRATIVE & GENERAL	71, 268, 056					5. 00
6.00	00600 MAINTENANCE & REPAIRS	1, 102, 491	4, 190, 052				6. 00
7.00	00700 OPERATION OF PLANT	4, 479, 936	1, 069, 148		4 044 050		7. 00
7. 01 8. 00	00701 OPERATION OF PLANT - FP 00800 LAUNDRY & LINEN SERVICE	345, 044 558, 679	78, 555	1	1, 311, 350 28, 608		7. 01 8. 00
9. 00	00900 HOUSEKEEPING	1, 059, 001	42, 118		15, 339		9. 00
9. 01	01851 ENVI RONMENTAL SERVI CES - FP	51, 002	0	0	0	0	9. 01
10.00	01000 DI ETARY	696, 720	216, 762	1, 256, 804	78, 940	33, 472	10.00
11.00	01100 CAFETERI A	389, 069	0	0	0	0	11.00
13. 00 14. 00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	1, 646, 422 139, 699	232, 004 175, 472		84, 491 63, 903	0 8, 076	13. 00 14. 00
15. 00	01500 PHARMACY	1, 442, 119	22, 592		8, 228		15.00
16. 00	01600 MEDICAL RECORDS & LIBRARY	1, 000, 823	21, 687		7, 898		16. 00
17. 00	01700 SOCIAL SERVICE	957, 320	49, 920	289, 443	18, 180	0	17. 00
21. 00	02100 I &R SERVI CES-SALARY & FRINGES APPRV	1	0	0	0	0	21.00
22. 00 23. 00	02200 L&R SERVICES-OTHER PRGM COSTS APPRV 02300 PARAMED ED PRGM-(SPECIFY)	230, 462	0	0	0	0 0	22. 00 23. 00
23. 00	02301 ECHOCARDI OLOGY EDUCATI ON PROGRAM	43, 555	0	0	0	0	23. 00
20.0.	I NPATIENT ROUTINE SERVICE COST CENTERS	10,000		<u> </u>	<u> </u>		20.0.
30.00	03000 ADULTS & PEDIATRICS	8, 671, 400	647, 606			1, 249, 103	30. 00
31. 00	03100 INTENSIVE CARE UNIT	2, 117, 036	133, 820		•		31.00
35. 00 41. 00	02060 NEONATAL INTENSIVE CARE UNIT 04100 SUBPROVIDER - IRF	1, 202, 014 1, 072, 086	168, 122 165, 237	·	61, 227 60, 176	66, 001 155, 474	35. 00 41. 00
43.00	04300 NURSERY	788, 896	100, 207		00, 170	28, 931	1
10. 00	ANCILLARY SERVICE COST CENTERS	700,070			<u> </u>	20, 701	10.00
50.00	05000 OPERATING ROOM	5, 078, 047	288, 873				50. 00
51.00	05100 RECOVERY ROOM	116, 750	115, 847		42, 189		51.00
52. 00 53. 00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY	927, 896 113, 988	0 16, 446	_	0 5, 989	0	52. 00 53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	3, 988, 813	238, 500		86, 857	69, 839	54.00
54. 01	05401 RADI OLOGY - I -65	316, 333	0	0	0	68, 663	•
54. 02	05402 RADIOLOGY DIAGNOSTIC - SJ	0	0	0	0	0	54. 02
54. 03	05403 LOWELL RADI OLOGY	5, 366	0	0	0	0	54. 03
55. 00 55. 01	O5500 RADI OLOGY-THERAPEUTI C O5501 CARDI AC CATHERI ZATON LAB	1 251 510	74 142	0 429, 888	27 001	0	55.00
55. 02	03140 CARDI OLOGY	1, 351, 518 644, 004	74, 143 0	429, 000	27, 001 0	24, 352 0	55. 01 55. 02
55. 03	03450 NEURO-DI AGNOSTI CS	271, 828	21, 674	125, 665	7, 893		55. 03
60.00	06000 LABORATORY	4, 979, 825	114, 838	665, 839	41, 822	3, 204	60.00
60. 01	06001 BLOOD LABORATORY	0	0	0		0	60. 01
65. 00	06500 RESPIRATORY THERAPY	905, 381	13, 017			01 141	65. 00 66. 00
66. 00 66. 01	06600 PHYSI CAL THERAPY 06601 PHYSI CAL THERAPY I -65	484, 983 372, 824	43, 528 0	252, 381 0	15, 852 0	81, 141 0	66. 01
66. 02	06602 PHYSI CAL THERAPY ST JOHN	96, 438	0	ő	0	ő	66. 02
67. 00	06700 OCCUPATI ONAL THERAPY	268, 083	0	0	0	0	67. 00
67. 01	06701 OCCUPATION THERAPY I -65	44, 869	0	0	0	0	67. 01
67. 02	06702 OCCUPATIONAL THERAPY ST. JOHN	4, 690	0	0	0	0	67. 02
68. 00 68. 01	06800 SPEECH PATHOLOGY	165, 828 140, 233	0	0	0	0	68. 00 68. 01
68. 02	06802 SPEECH THERAPY ST. JOHN	0	0	ő	Ö	ő	68. 02
69. 00	06900 ELECTROCARDI OLOGY	248, 396	1, 177	6, 827	429	16, 536	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	6, 993, 252	0	0	0	0	71.00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	3, 596, 445	0	0	0	0	72.00
73. 00 74. 00	07400 RENAL DIALYSIS	2, 332, 499 171, 873	6, 677	38, 712	2, 432	0	73. 00 74. 00
76. 00	03020 RADIATION ONCOLOGY	382, 726	0, 077	0	2, 432	14, 008	76. 00
76. 01	03040 ANGI OCARDI OGRAPHY	109, 907	0	0	0	0	76. 01
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78. 00
90. 00	OUTPATIENT SERVICE COST CENTERS O9000 CLINIC	0	0	0	0	0	90.00
90.00	09001 DI ABETES CLINIC	0	0		0	0	90.00
90. 02	09002 OUTPATIENT CLINICS	332	0	o	0	0	90. 02
90. 03	09003 OCCUPATIONAL MEDICINE CLINIC	0	0	0	0	0	90. 03
90. 04	09004 NEONATOLOGY CLINIC-FRANCISCAN POINT	7, 461	0	0	0	0	90.04
90. 05 91. 00	09005 LACTATI ON CLI NI C 09100 EMERGENCY	11, 765 2, 526, 703	0 232, 289	0 1, 346, 833	0 84, 595	0 198, 305	90. 05 91. 00
91.00	09101 EMERGENCY ROOM PHYSI CANS	2, 320, 703	232, 209 N	1, 340, 633	04, 393 N	196, 303	91.00
	09102 EXPRESS CARE		Ö	Ŏ	0	Ö	91. 02
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00

Health Financial Systems	FRANCISCAN HEALTH CROWN POINT	In Lie	u of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Peri od: From 01/01/2023	Worksheet B Part I

					rom 01/01/2023		
				Te	0 12/31/2023		
						5/30/2024 10:	<u>06 am</u>
Co	ost Center Description	ADMI NI STRATI VE	MAINTENANCE &	OPERATION OF	OPERATION OF	LAUNDRY &	
		& GENERAL	REPAI RS	PLANT	PLANT - FP	LINEN SERVICE	
		5. 00	6. 00	7. 00	7. 01	8. 00	
OTHER RE	IMBURSABLE COST CENTERS						
102.00 10200 OP	PLOID TREATMENT PROGRAM	0	0	0	0	0	102. 00
SPECI AL	PURPOSE COST CENTERS						1
113. 00 11300 I N	ITEREST EXPENSE						113. 00
118. 00 SU	JBTOTALS (SUM OF LINES 1 through 117)	64, 652, 832	4, 190, 052	18, 095, 289	1, 136, 571	2, 685, 911	118.00
NONREI MB	BURSABLE COST CENTERS						1
190. 00 19000 GI	FT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190. 00
192. 00 19200 PH	IYSICIANS' PRIVATE OFFICES	1, 058, 405	0	0	32, 411	0	192. 00
194. 00 07950 FH	IC	0	0	0	0	0	194. 00
194. 01 07951 CO	NVENT	o	0	0	0	0	194. 01
194. 02 07952 OT	THER NON REIMB - BUILDINGS	517, 237	0	0	136, 308	0	194. 02
194. 03 07953 OT	THR NON REIM-FHC BEHAVORIAL HEALTH	0	0	0	6, 060	0	194. 03
194, 04 07954 CE	NTER OF HOPE	64, 557	0	0	0		194. 04
	KESHORE JOINT VENTURE	4, 975, 025	0	0	0		194. 05
	OVID VACCINE CLINIC	0	0	0	0		194. 06
1 1	ross Foot Adjustments		J	ŭ	· ·		200.00
1 1	egative Cost Centers	0	0	0	0	1 0	201. 00
1 1	OTAL (sum lines 118 through 201)	71, 268, 056	4, 190, 052	18, 095, 289	1, 311, 350		1
202.00	THE (Sum Titles 110 through 201)	, 1, 200, 030	4, 170, 032	10, 073, 207	1, 311, 330	2,003,711	1202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0126

Peri od: Worksheet B From 01/01/2023 Part I To 12/31/2023 Date/Time Prepared:

5/30/2024 10:06 am Cost Center Description HOUSEKEEPING ENVIRONMENTAL CAFETERI A NURSI NG DI ETARY ADMI NI STRATI ON SERVICES - FP 9.00 10.00 11.00 9.01 13.00 GENERAL SERVICE COST CENTERS 1.00 1.00 00100 CAP REL COSTS-BLDG & FLXT 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00500 ADMINISTRATIVE & GENERAL 5 00 5 00 6.00 00600 MAINTENANCE & REPAIRS 6.00 00700 OPERATION OF PLANT 7.00 7.00 7.01 00701 OPERATION OF PLANT - FP 7. 01 00800 LAUNDRY & LINEN SERVICE 8.00 8 00 9.00 00900 HOUSEKEEPI NG 4, 573, 309 9.00 9 01 01851 ENVIRONMENTAL SERVICES - FP 193, 834 9 01 01000 DI ETARY 10.00 4, 576, 372 10 00 330, 414 12,073 11.00 01100 CAFETERI A 1, 478, 669 11.00 12, 922 13.00 01300 NURSING ADMINISTRATION 353, 649 0 62, 611 8, 348, 138 13.00 01400 CENTRAL SERVICES & SUPPLY 9, 773 267.475 0 15. 140 14.00 14.00 0 01500 PHARMACY 0 15.00 34.438 1, 258 51, 475 0 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 33, 057 1, 208 0 13, 343 0 16.00 01700 SOCIAL SERVICE 0 17 00 76,095 2,780 40, 370 11, 934 17.00 02100 I &R SERVICES-SALARY & FRINGES APPRV 0 21.00 0 C 0 21.00 0 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 0 22 00 0 C 0 0 22 00 02300 PARAMED ED PRGM-(SPECIFY) 0 0 11, 274 23.00 15 23.00 02301 ECHOCARDI OLOGY EDUCATI ON PROGRAM 0 23.01 23.01 1.462 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 987, 157 36,070 3, 677, 357 479, 605 3, 778, 153 30.00 7, 453 31.00 03100 INTENSIVE CARE UNIT 203, 984 441, 299 80, 715 949, 454 31.00 35.00 02060 NEONATAL INTENSIVE CARE UNIT 256, 272 9, 364 58, 015 741, 480 35.00 04100 SUBPROVIDER - IRF 41.00 251, 874 9, 203 457, 716 45, 015 395, 046 41.00 43.00 04300 NURSERY 0 43.00 0 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 828.070 50.00 440, 335 16, 089 0 119, 385 05100 RECOVERY ROOM 0 51.00 176, 588 6, 452 0 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 710 0 52.00 53.00 05300 ANESTHESI OLOGY 25,069 916 0 3,064 0 53.00 99, 970 54 00 05400 RADI OLOGY-DI AGNOSTI C 363, 550 13. 284 O 110 658 54 00 0 54.01 05401 RADI OLOGY - I -65 0 C 10, 775 0 54.01 05402 RADIOLOGY DIAGNOSTIC - SJ 0 0 54.02 C 0 54.02 54.03 05403 LOWELL RADIOLOGY 0 0 54.03 C 69 0 05500 RADI OLOGY-THERAPEUTI C 0 55.00 Λ 55.00 23, 634 173, 516 55.01 05501 CARDI AC CATHERI ZATON LAB 113,018 4, 130 0 55.01 55.02 03140 CARDI OLOGY 25, 265 106, 047 55.02 03450 NEURO-DI AGNOSTI CS 33 037 1 207 0 55 03 14. 163 55 03 0 0 60.00 06000 LABORATORY 175,049 6, 396 0 60.00 06001 BLOOD LABORATORY 60.01 0 60.01 65.00 06500 RESPIRATORY THERAPY 19,842 725 0 37, 770 0 65.00 06600 PHYSI CAL THERAPY 0 2.424 19, 179 66.00 66, 351 0 66.00 66.01 06601 PHYSICAL THERAPY I-65 0 14, 897 0 66.01 66.02 06602 PHYSI CAL THERAPY ST JOHN 0 0 0 3.951 66.02 06700 OCCUPATIONAL THERAPY 0 11, 916 67.00 0 67.00 0 0 06701 OCCUPATION THERAPY I-65 0 0 67.01 Ω 1,659 0 67.01 67.02 06702 OCCUPATIONAL THERAPY ST. JOHN 0 0 0 226 0 67.02 06800 SPEECH PATHOLOGY 0 68.00 6.879 68.00 06801 SPEECH PATHOLOGY I -65 0 0 6, 237 68.01 0 68.01 0 68 02 06802 SPEECH THERAPY ST. JOHN 0 C 0 0 68 02 06900 ELECTROCARDI OLOGY 1, 795 84,005 69.00 69.00 66 11, 626 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 C 0 O 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72.000 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS r 0 0 0 73.00 07400 RENAL DIALYSIS 0 74.00 10, 178 372 0 74.00 76.00 03020 RADIATION ONCOLOGY 0 7, 555 29, 535 76.00 0 76.01 03040 ANGI OCARDI OGRAPHY 0 0 4.607 0 76.01 0 77.00 07700 ALLOGENEIC HSCT ACQUISITION 0 C 0 77.00 0 78.00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 0 78.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 0 0 0 90.00 09001 DIABETES CLINIC 0 90.01 90.01 90.02 09002 OUTPATIENT CLINICS 0 0 0 0 90.02 Ω 09003 OCCUPATIONAL MEDICINE CLINIC 0 0 90.03 C 0 0 90.03 0 90.04 09004 NEONATOLOGY CLINIC-FRANCISCAN POINT 0 Ω 335 1, 358 90.04 09005 LACTATION CLINIC 0 4, 294 90.05 705 90.05 91.00 09100 EMERGENCY 354.082 12, 938 0 112, 744 935, 300 91.00 09101 EMERGENCY ROOM PHYSICANS 0 91.01 91.01 0 C 0 Λ 09102 EXPRESS CARE 0 0 0 0 91.02 91.02 C 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00

Health Financial Systems	FRANCISCAN HEALTH CROWN POINT	In Lieu of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS	Provi der CCN: 15-0126	Peri od: Worksheet B From 01/01/2023 Part I

				1011 01/01/2023	rait i
			To	12/31/2023	
					5/30/2024 10:06 am
Cost Center Description	HOUSEKEEPI NG	ENVI RONMENTAL	DI ETARY	CAFETERI A	NURSI NG
		SERVICES - FP			ADMI NI STRATI ON
	9. 00	9. 01	10.00	11. 00	13. 00
OTHER REIMBURSABLE COST CENTERS					
102.00 10200 OPIOID TREATMENT PROGRAM	0	0	0	0	0 102. 00
SPECIAL PURPOSE COST CENTERS					
113. 00 11300 I NTEREST EXPENSE					113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	4, 573, 309	167, 103	4, 576, 372	1, 407, 039	8, 138, 177 118. 00
NONREI MBURSABLE COST CENTERS					
190.00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0 190. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	4, 957	0	34, 651	0 192.00
194. 00 07950 FHC	0	o	0	0	0 194. 00
194. 01 07951 CONVENT	0	o	0	0	0 194. 01
194.02 07952 OTHER NON REIMB - BUILDINGS	0	20, 847	0	0	0 194. 02
194.03 07953 OTHR NON REIM-FHC BEHAVORIAL HEALTH	0	927	0	0	0 194. 03
194. 04 07954 CENTER OF HOPE	0	l ol	0	2, 067	1, 826 194. 04
194. 05 07955 LAKESHORE JOINT VENTURE	0	o	0	34, 912	208, 135 194. 05
194. 06 07957 COVID VACCINE CLINIC	0	0	0	0	0 194. 06
200.00 Cross Foot Adjustments]	-		200.00
201.00 Negative Cost Centers			0	0	0 201.00
202.00 TOTAL (sum lines 118 through 201)	4, 573, 309	193, 834	4, 576, 372	1, 478, 669	
202.00 TOTAL (Sum TIMES THE UNITED TO	4, 373, 307	173,034	4, 370, 372	1, 470, 007	0, 340, 130 202. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provi der CCN: 15-0126

					12/31/2023	5/30/2024 10:	
						RESI DENTS	
	Cost Center Description	CENTRAL SERVICES &	PHARMACY	MEDICAL RECORDS &	SOCIAL SERVICE	SERVICES-SALAR Y & FRINGES	
		SUPPLY		LI BRARY		APPRV	
	JOSUS DE LO CONTROL DE LA CONT	14.00	15. 00	16. 00	17. 00	21. 00	
1. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT						1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 00 6. 00	00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS						5. 00 6. 00
7. 00	00700 OPERATION OF PLANT						7. 00
7. 01	00701 OPERATION OF PLANT - FP						7. 01
8.00	00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00 9. 01	00900 HOUSEKEEPI NG 01851 ENVI RONMENTAL SERVI CES - FP						9. 00 9. 01
10. 00	01000 DI ETARY						10. 00
11. 00	01100 CAFETERI A						11. 00
13.00	01300 NURSI NG ADMI NI STRATI ON	2 000 171					13.00
14. 00 15. 00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	2, 088, 171 905	5, 730, 707				14. 00 15. 00
16. 00		95	0, 730, 707	4, 006, 688			16. 00
17. 00	1 1	117	O	C	4, 127, 165		17. 00
21. 00	1 1	0	0	C	0	3	21. 00
22. 00 23. 00	02200 L&R SERVICES-OTHER PRGM COSTS APPRV 02300 PARAMED ED PRGM-(SPECIFY)	0 1, 862	0) C	0		22. 00 23. 00
23. 01	02301 ECHOCARDI OLOGY EDUCATI ON PROGRAM	15	0	Ö	o		23. 01
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	1 1	5, 614	0	222, 066		0	30.00
31. 00 35. 00		963 609	0	48, 972 72, 200		0	31. 00 35. 00
41. 00	04100 SUBPROVI DER – I RF	399	Ö	21, 994		0	41. 00
43. 00		0	0	13, 205	13, 600	0	43. 00
50. 00	ANCI LLARY SERVI CE COST CENTERS 05000 OPERATI NG ROOM	13, 210	O	477, 623	491, 897	0	50. 00
51. 00		13, 210	0	72, 539		0	51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	5	0	23, 383		0	52. 00
53.00	1	121	0	91, 265		0	53.00
54. 00 54. 01	05400 RADI OLOGY - DI AGNOSTI C 05401 RADI OLOGY - I -65	2, 689 136	0	776, 275 82, 704		0	54. 00 54. 01
54. 02	05402 RADI OLOGY DI AGNOSTI C - SJ	0	0	02, 704		0	54. 02
54. 03	05403 LOWELL RADI OLOGY	0	0	123	127	0	54. 03
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0	1/5 400		0	55. 00
55. 01 55. 02	05501 CARDI AC CATHERI ZATON LAB 03140 CARDI OLOGY	5, 904 571	0	165, 492 113, 494		0	55. 01 55. 02
55. 03	03450 NEURO-DI AGNOSTI CS	456	0	33, 836		0	55. 03
60.00	06000 LABORATORY	72	O	602, 879	620, 897	0	60. 00
60. 01	06001 BLOOD LABORATORY	0	0	(5.77/	(7.741	0	60. 01
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	115	0	65, 776 14, 717		0	65. 00 66. 00
66. 01	06601 PHYSI CAL THERAPY I -65	175	Ö	13, 398		0	66. 01
66. 02	+ I	58	0	4, 266		0	66. 02
67. 00 67. 01	06700 OCCUPATI ONAL THERAPY 06701 OCCUPATI ON THERAPY I -65	20	0	15, 363 1, 522		0	67. 00 67. 01
67. 02	06702 OCCUPATIONAL THERAPY ST. JOHN	0	0	275		0	67. 02
68. 00	1 1	2	O	13, 441		0	68. 00
68. 01	06801 SPEECH PATHOLOGY I -65	0	0	8, 508	8, 762	0	68. 01
68. 02 69. 00	+ I	216	0	10, 588	10, 904	0	68. 02 69. 00
71. 00	1 1	1, 376, 202	Ö	163, 233		0	71. 00
72. 00	+ I	672, 161	0	154, 784		0	72. 00
73. 00 74. 00	+ I	0	5, 730, 707	210, 631 4, 258		0	73. 00 74. 00
76.00	1	201	0	55, 405		0	74. 00 76. 00
76. 01	03040 ANGI OCARDI OGRAPHY	129	0	3, 855		0	76. 01
77. 00	1	0	0	C	0	0	77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY OUTPATIENT SERVICE COST CENTERS	0	0	C	0	0	78. 00
90. 00		0	0	С	O	0	90. 00
90. 01	09001 DI ABETES CLINIC	0	0	C	O	0	90. 01
90. 02	1	0	0	0	0	0	90. 02
90. 03 90. 04	09003 OCCUPATIONAL MEDICINE CLINIC 09004 NEONATOLOGY CLINIC-FRANCISCAN POINT	19	0	293	302	0	90. 03 90. 04
90. 05	09005 LACTATION CLINIC	O	0	68		0	90. 05
91.00	1 1	2, 016	0	448, 257		3	91.00
91. 01	09101 EMERGENCY ROOM PHYSI CANS	0	O	[C	ıl Ol	0	91. 01

			Т	o 12/31/2023	Date/Time Prepa 5/30/2024 10:06	
					INTERNS &	<u>J Gill</u>
					RESI DENTS	
Cost Center Description	CENTRAL	PHARMACY		SOCIAL SERVICE		
	SERVICES &		RECORDS &		Y & FRINGES	
	SUPPLY		LI BRARY		APPRV	
	14. 00	15. 00	16. 00	17. 00	21.00	
91. 02 09102 EXPRESS CARE	0	0	0	0	l	91. 02
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
OTHER REIMBURSABLE COST CENTERS	,					
102.00 10200 OPIOLD TREATMENT PROGRAM	0	0	0	0	0 1	02. 00
SPECIAL PURPOSE COST CENTERS				1		
113. 00 11300 I NTEREST EXPENSE					l	13. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	2, 085, 222	5, 730, 707	4, 006, 688	4, 127, 165	3 1	18. 00
NONREI MBURSABLE COST CENTERS				1		
190.00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0		90. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	2, 830	0	0	0	l l	92. 00
194. 00 07950 FHC	0	0	0	0		94. 00
194. 01 07951 CONVENT	0	0	0	0	l l	94. 01
194.02 07952 OTHER NON REIMB - BUILDINGS	2	0	0	0		94. 02
194.03 07953 OTHR NON REIM-FHC BEHAVORIAL HEALTH	0	0	0	0		94. 03
194.04 07954 CENTER OF HOPE	0	0	0	0		94. 04
194.05 07955 LAKESHORE JOINT VENTURE	117	0	0	0		94. 05
194. 06 07957 COVID VACCINE CLINIC	0	0	0	0	l	94. 06
200.00 Cross Foot Adjustments					l	00.00
201.00 Negative Cost Centers	0	0	0	0	0 2	01. 00
202.00 TOTAL (sum lines 118 through 201)	2, 088, 171	5, 730, 707	4, 006, 688	4, 127, 165	3 2	02. 00

Health Financial Systems COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0126 Peri od: Worksheet B From 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/30/2024 10:06 am INTERNS & **RESI DENTS** Cost Center Description SERVI CES-OTHER PARAMED ED ECHOCARDI OLOGY Subtotal Intern & PRGM COSTS Residents Cost **PRGM FDUCATION APPRV PROGRAM** & Post Stepdown Adjustments 22.00 23. 00 23. 01 24. 00 25. 00 GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS-BLDG & FLXT 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00500 ADMINISTRATIVE & GENERAL 5 00 5 00 6.00 00600 MAINTENANCE & REPAIRS 6.00 7.00 00700 OPERATION OF PLANT 7.00 7.01 00701 OPERATION OF PLANT - FP 7.01 00800 LAUNDRY & LINEN SERVICE 8 00 8 00 9.00 00900 HOUSEKEEPI NG 9.00 01851 ENVIRONMENTAL SERVICES - FP 9.01 9.01 01000 DI ETARY 10.00 10.00 11.00 01100 CAFETERI A 11.00 13.00 01300 NURSING ADMINISTRATION 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 14.00 01500 PHARMACY 15.00 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 16 00 17.00 01700 SOCIAL SERVICE 17.00 21.00 02100 I&R SERVICES-SALARY & FRINGES APPRV 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 22.00 22.00 02300 PARAMED ED PRGM-(SPECIFY) 23.00 889, 030 23.00 02301 ECHOCARDI OLOGY EDUCATI ON PROGRAM 23.01 167,009 23.01 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 48, 258, 042 30.00 0 0 0 0 31.00 03100 INTENSIVE CARE UNIT C 0 10, 883, 196 0 31.00 02060 NEONATAL INTENSIVE CARE UNIT 0 35.00 0 0 7, 050, 728 35.00 0 41.00 04100 SUBPROVIDER - IRF 0 0 6, 617, 339 0 41.00 04300 NURSERY 0 43.00 0 0 3, 053, 960 0 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 0 0 24, 058, 921 0 50.00 05100 RECOVERY ROOM 0 1.603.857 51.00 C 0 51.00 0 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 3, 574, 679 0 52.00 05300 ANESTHESI OLOGY 0 53.00 0 765, 433 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 19, 104, 288 54.00 54.00 0 0 1, 449, 687 05401 RADI OLOGY - 1-65 0 54.01 54.01 0 54.02 05402 RADIOLOGY DIAGNOSTIC - SJ 0 0 0 54.02 54.03 05403 LOWELL RADIOLOGY 20, 713 0 54.03 05500 RADI OLOGY-THERAPEUTI C 0 0 55 00 0 55 00 05501 CARDI AC CATHERI ZATON LAB 0 6, 348, 003 55.01 0 0 55.01 55.02 03140 CARDI OLOGY 2, 809, 822 0 55.02 55.03 03450 NEURO-DI AGNOSTI CS 0 0 1, 328, 146 0 55.03 06000 LABORATORY 0 60 00 Ω 21, 156, 982 60 00 0 60.01 06001 BLOOD LABORATORY 0 0 60.01 06500 RESPIRATORY THERAPY 3, 726, 130 65.00 65.00 0 66.00 06600 PHYSI CAL THERAPY 0 2, 353, 963 0 66, 00 0 06601 PHYSICAL THERAPY I-65 66.01 0 1, 459, 197 0 66.01 66.02 06602 PHYSI CAL THERAPY ST JOHN 0 0 379, 186 0 66.02 06700 OCCUPATIONAL THERAPY 1, 061, 980 67.00 67.00 06701 OCCUPATION THERAPY I-65 0 0 67.01 175.274 67.01 0 06702 OCCUPATIONAL THERAPY ST. JOHN 0 67.02 0 18, 609 0 67.02 68.00 06800 SPEECH PATHOLOGY 664, 400 0 68.00 06801 SPEECH PATHOLOGY I -65 68 01 0 556, 468 Ω 68 01 06802 SPEECH THERAPY ST. JOHN 68 02 68 02 Ω 0 0 69.00 06900 ELECTROCARDI OLOGY 167,009 1, 255, 215 0 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 28, 285, 626 71.00 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 0 14, 654, 760 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 15, 023, 002 73.00 0 0 73.00 74.00 07400 RENAL DIALYSIS 0 0 720, 223 74.00 0 03020 RADIATION ONCOLOGY 0 76 00 1, 618, 328 76.00 03040 ANGI OCARDI OGRAPHY 0 0 76.01 430, 266 0 76.01 07700 ALLOGENEIC HSCT ACQUISITION 0 77.00 C 0 77 00 07800 CAR T-CELL IMMUNOTHERAPY 78.00 78.00 0 0 OUTPATIENT SERVICE COST CENTERS 90.00 00 09000 CLI NI C C 0 0 90.00 0 90.01 09001 DIABETES CLINIC C 0 90.01 90.02 09002 OUTPATIENT CLINICS 0 0 0 1, 263 0 90.02 09003 OCCUPATIONAL MEDICINE CLINIC 0 0 90.03 90.03 0 09004 NEONATOLOGY CLINIC-FRANCISCAN POINT 0 0 90 04 90 04 30, 663 0

0

49, 851

0 90.05

09005 LACTATION CLINIC

90.05

				10	12/31/2023	5/30/2024 10:0	
		INTERNS &				373072024 10.1	OO alli
		RESI DENTS					
Co	ost Center Description	SERVI CES-OTHER	PARAMED ED	ECHOCARDI OLOGY	Subtotal	Intern &	
0.	ost contor bescription	PRGM COSTS	PRGM	EDUCATI ON		Residents Cost	
		APPRV		PROGRAM		& Post	
		7		T TOOTO WI		Stepdown	
						Adjustments	
		22.00	23. 00	23. 01	24. 00	25. 00	
91. 00 09100 El	MERGENCY	3	889, 030	0	14, 680, 865	-6	91.00
91. 01 09101 EI	MERGENCY ROOM PHYSICANS	0	0	0	o	0	91. 01
91. 02 09102 EX	XPRESS CARE	o	0	0	o	0	91. 02
92. 00 09200 01	BSERVATION BEDS (NON-DISTINCT PART					0	92.00
OTHER R	REIMBURSABLE COST CENTERS	'		<u> </u>			
102.00 10200 0	PIOID TREATMENT PROGRAM	0	0	0	0	0	102. 00
SPECI AL	PURPOSE COST CENTERS						
113.00 11300 11	NTEREST EXPENSE						113. 00
118. 00 SI	UBTOTALS (SUM OF LINES 1 through 117)	3	889, 030	167, 009	245, 229, 065	-6	118. 00
NONREI M	IBURSABLE COST CENTERS						
190. 00 19000 G	IFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190. 00
192. 00 19200 PI	HYSICIANS' PRIVATE OFFICES	0	0	0	4, 097, 350	0	192. 00
194. 00 07950 FI	HC	0	0	0	0	0	194. 00
194. 01 07951 C	ONVENT	0	0	0	0	0	194. 01
194. 02 07952 0 ⁻	THER NON REIMB - BUILDINGS	0	0	0	2, 122, 933	0	194. 02
194. 03 07953 0 ⁻¹	THR NON REIM-FHC BEHAVORIAL HEALTH	0	0	0	6, 987	0	194. 03
194. 04 07954 CI	ENTER OF HOPE	0	0	0	249, 243	0	194. 04
194. 05 07955 L	AKESHORE JOINT VENTURE	0	0	0	19, 150, 907	0	194. 05
194. 06 07957 C	OVID VACCINE CLINIC	0	0	0	0	0	194. 06
200. 00 Ci	ross Foot Adjustments	0	0	0	0	0	200. 00
201. 00 Ne	egative Cost Centers	0	0	0	0	0	201. 00
202. 00 To	OTAL (sum lines 118 through 201)	3	889, 030	167, 009	270, 856, 485	-6	202. 00

| Period: | Worksheet B | From 01/01/2023 | Part | | Part | | | Date/Time Prepared: | 5/30/2024 | 10: 06 am Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0126

			5/30/2024 10:	
	Cost Center Description	Total	070072021 10.	OG dill
	GENERAL SERVICE COST CENTERS	26.00		
1. 00				1.00
	00100 CAP REL COSTS BLDG & FLXT			1
2.00	00200 CAP REL COSTS-MVBLE EQUI P			2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT			4. 00
5.00	00500 ADMINISTRATIVE & GENERAL			5. 00
6. 00	00600 MAINTENANCE & REPAIRS			6. 00
7.00	00700 OPERATION OF PLANT			7.00
7.01	00701 OPERATION OF PLANT - FP			7. 01
8.00	00800 LAUNDRY & LINEN SERVICE			8.00
9.00	00900 HOUSEKEEPI NG			9.00
9. 01	01851 ENVIRONMENTAL SERVICES - FP			9. 01
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 SERVICES & SUPPLY			14.00
	01500 PHARMACY			15. 00
	01600 MEDICAL RECORDS & LIBRARY			16. 00
17. 00	01700 SOCIAL SERVICE			17. 00
21.00	02100 I&R SERVICES-SALARY & FRINGES APPRV			21.00
22.00	02200 I&R SERVICES-OTHER PRGM COSTS APPRV			22. 00
23.00	02300 PARAMED ED PRGM-(SPECIFY)			23. 00
	02301 ECHOCARDI OLOGY EDUCATI ON PROGRAM			23. 01
23.01	I NPATI ENT ROUTI NE SERVI CE COST CENTERS			25.01
20.00		40 250 042		30 00
30.00	03000 ADULTS & PEDI ATRI CS	48, 258, 042		30.00
31.00	03100 INTENSIVE CARE UNIT	10, 883, 196		31.00
35. 00	02060 NEONATAL INTENSIVE CARE UNIT	7, 050, 728		35. 00
41.00	04100 SUBPROVI DER – I RF	6, 617, 339		41.00
43.00	04300 NURSERY	3, 053, 960		43. 00
	ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATI NG ROOM	24, 058, 921		50.00
51. 00	05100 RECOVERY ROOM	1, 603, 857		51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	3, 574, 679		52. 00
53. 00	05300 ANESTHESI OLOGY	1 1		53.00
	1 1	765, 433		
54.00	05400 RADI OLOGY - DI AGNOSTI C	19, 104, 288		54.00
54. 01	05401 RADI OLOGY - I -65	1, 449, 687		54. 01
	05402 RADI OLOGY DI AGNOSTI C - SJ	0		54. 02
54. 03	05403 LOWELL RADI OLOGY	20, 713		54. 03
55.00	05500 RADI OLOGY-THERAPEUTI C	0		55. 00
55. 01	05501 CARDI AC CATHERI ZATON LAB	6, 348, 003		55. 01
55.02	03140 CARDI OLOGY	2, 809, 822		55. 02
55. 03	03450 NEURO-DI AGNOSTI CS	1, 328, 146		55. 03
60.00	06000 LABORATORY	21, 156, 982		60.00
60. 01	06001 BLOOD LABORATORY	0		60. 01
65. 00	06500 RESPI RATORY THERAPY	3, 726, 130		65. 00
66. 00	06600 PHYSI CAL THERAPY	1 1		
	1 1	2, 353, 963		66. 00
66. 01	06601 PHYSI CAL THERAPY I -65	1, 459, 197		66. 01
66. 02	06602 PHYSI CAL THERAPY ST JOHN	379, 186		66. 02
67. 00	06700 OCCUPATI ONAL THERAPY	1, 061, 980		67. 00
67. 01	06701 OCCUPATION THERAPY I -65	175, 274		67. 01
67. 02	06702 OCCUPATIONAL THERAPY ST. JOHN	18, 609		67. 02
68.00	06800 SPEECH PATHOLOGY	664, 400		68.00
68. 01	06801 SPEECH PATHOLOGY I -65	556, 468		68. 01
68. 02	06802 SPEECH THERAPY ST. JOHN	0		68. 02
	06900 ELECTROCARDI OLOGY	1, 255, 215		69. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	28, 285, 626		71.00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	14, 654, 760		72.00
		1		73.00
73.00	07300 DRUGS CHARGED TO PATIENTS	15, 023, 002		
74.00	07400 RENAL DIALYSIS	720, 223		74.00
	03020 RADI ATI ON ONCOLOGY	1, 618, 328		76. 00
76. 01	03040 ANGI OCARDI OGRAPHY	430, 266		76. 01
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0		77. 00
78.00	07800 CAR T-CELL IMMUNOTHERAPY	O		78. 00
	OUTPATIENT SERVICE COST CENTERS	- 1		
90.00	09000 CLI NI C	0		90.00
90. 01	09001 DI ABETES CLINIC			90. 01
	09002 OUTPATIENT CLINICS	1, 263		90. 02
90. 02	1 1	1, 203		90. 02
	09003 OCCUPATIONAL MEDICINE CLINIC	١		
	09004 NEONATOLOGY CLINIC-FRANCISCAN POINT	30, 663		90. 04
90. 05	09005 LACTATION CLINIC	49, 851		90. 05
	09100 EMERGENCY	14, 680, 859		91.00
	09101 EMERGENCY ROOM PHYSI CANS	0		91. 01
91.02	09102 EXPRESS CARE	0		91. 02
	09200 OBSERVATION BEDS (NON-DISTINCT PART			92.00
	OTHER REIMBURSABLE COST CENTERS			
102 00	10200 OPI OI D TREATMENT PROGRAM	0		102. 00
102.00	1.0200 OT OTO TREATMENT TROOKING	<u> </u>		1.02.0

Health Financial Systems	FRANCISCAN HEALTH CROWN POINT	In Lie	u of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS	Provi der CCN: 15-0126	Peri od: From 01/01/2023	

		To 12/31/2023 Date/Time P	
Cost Center Description	Total		
·	26. 00		
SPECIAL PURPOSE COST CENTERS			
113. 00 11300 I NTEREST EXPENSE			113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	245, 229, 059		118. 00
NONREI MBURSABLE COST CENTERS			
190.00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0		190. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	4, 097, 350		192. 00
194. 00 07950 FHC	0		194. 00
194. 01 07951 CONVENT	0		194. 01
194.02 07952 OTHER NON REIMB - BUILDINGS	2, 122, 933		194. 02
194.03 07953 OTHR NON REIM-FHC BEHAVORIAL HEALTH	6, 987		194. 03
194. 04 07954 CENTER OF HOPE	249, 243		194. 04
194. 05 07955 LAKESHORE JOINT VENTURE	19, 150, 907		194. 05
194.06 07957 COVID VACCINE CLINIC	0		194. 06
200.00 Cross Foot Adjustments	0		200. 00
201.00 Negative Cost Centers	0		201. 00
202.00 TOTAL (sum lines 118 through 201)	270, 856, 479		202. 00

Provider CCN: 15-0126

| Peri od: | Worksheet B | From 01/01/2023 | Part | I | To 12/31/2023 | Date/Time Prepared: | To 12/31/2023

				То	12/31/2023	Date/Time Pre 5/30/2024 10:	
			CAPI TAL REI	LATED COSTS			
	Cost Center Description	Di rectly	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
		Assigned New				BENEFITS	
		Capital Related Costs				DEPARTMENT	
		0	1.00	2.00	2A	4. 00	
1 00	GENERAL SERVI CE COST CENTERS						4 00
1. 00 2. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						1. 00 2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	198, 918	41, 413	240, 331	240, 331	4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL	0	4, 875, 080		5, 011, 355	11, 358	5. 00
6. 00 7. 00	00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT	0	36, 278 2, 885, 027		38, 453 3, 030, 825	1, 768 7, 913	6. 00 7. 00
7. 00	00700 OPERATION OF PLANT - FP	0	2, 883, 027	9, 931	9, 931	7, 413	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	211, 977	0	211, 977	218	8. 00
9.00	00900 HOUSEKEEPI NG	0	113, 652	53, 267	166, 919	5, 302	9. 00
9. 01 10. 00	01851 ENVI RONMENTAL SERVI CES - FP 01000 DI ETARY	0	584, 918	129, 543	714, 461	307 1, 667	9. 01 10. 00
11. 00	01100 CAFETERI A	Ö	0	0	0	2, 428	11. 00
13. 00	01300 NURSING ADMINISTRATION	0	626, 049	1	940, 929	8, 287	13. 00
14. 00 15. 00	01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY	0	473, 500 60, 964	1	626, 874 70, 718	1, 174 7, 803	14. 00 15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	58, 520	1	61, 860	1, 776	16. 00
17. 00	01700 SOCIAL SERVICE	0	134, 707	1	135, 093	5, 444	17. 00
21. 00	02100 I &R SERVI CES-SALARY & FRINGES APPRV	0	0	0	0	0	21. 00
22. 00 23. 00	02200 L&R SERVICES-OTHER PRGM COSTS APPRV 02300 PARAMED ED PRGM-(SPECIFY)	0	0	32, 972	32, 972	0 1, 089	22. 00 23. 00
23. 01	02301 ECHOCARDI OLOGY EDUCATI ON PROGRAM	0	0	1	20, 280	443	23. 01
	INPATIENT ROUTINE SERVICE COST CENTERS	1 -	4 747 505				
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	0	1, 747, 525 361, 104		2, 141, 444 846, 609	67, 872 10, 579	30. 00 31. 00
35. 00	02060 NEONATAL INTENSIVE CARE UNIT	0	453, 667		654, 413	6, 298	35. 00
41. 00	04100 SUBPROVI DER - I RF	0	445, 881	141, 953	587, 834	5, 593	41. 00
43. 00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	0	0	0	0	4, 946	43. 00
50. 00	05000 OPERATING ROOM	O	779, 506	2, 441, 756	3, 221, 262	17, 741	50. 00
51. 00	05100 RECOVERY ROOM	0	312, 605		322, 477	1	51. 00
52. 00 53. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	247.055	5, 737	52.00
54. 00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	0	44, 379 643, 577		247, 855 1, 937, 168	164 14, 449	53. 00 54. 00
54. 01	05401 RADI OLOGY - I -65	0	0	228, 735	228, 735	1, 266	54. 01
54. 02	05402 RADIOLOGY DIAGNOSTIC - SJ	0	0	0	0	0	54. 02
54. 03 55. 00	05403 LOWELL RADI OLOGY 05500 RADI OLOGY-THERAPEUTI C	0	0	11, 685	11, 685	6	54. 03 55. 00
55. 01	05501 CARDI AC CATHERI ZATON LAB	0	200, 070	749, 585	949, 655	4, 496	55. 01
55. 02	03140 CARDI OLOGY	O	0	339, 211	339, 211	3, 424	55. 02
55. 03 60. 00	03450 NEURO-DI AGNOSTI CS 06000 LABORATORY	0	58, 485 309, 882		113, 967 382, 942	1, 531 0	55. 03 60. 00
60. 00	06001 BLOOD LABORATORY	0	309, 662	73, 060	302, 942	0	60. 00
65. 00		0	35, 126	174, 846	209, 972	4, 787	65. 00
	1	0	117, 458	1	121, 255		66. 00
66. 01	06601 PHYSI CAL THERAPY I -65 06602 PHYSI CAL THERAPY ST JOHN	0	0	13, 877 4, 207	13, 877 4, 207	2, 258 590	66. 01 66. 02
67. 00	1	Ö	0	0	0	1, 767	67. 00
67. 01	06701 OCCUPATION THERAPY I -65	0	0	0	0	292	67. 01
67. 02 68. 00	06702 OCCUPATIONAL THERAPY ST. JOHN 06800 SPEECH PATHOLOGY	0	0	0	0	31 1, 086	67. 02 68. 00
68. 01	06801 SPEECH PATHOLOGY I -65	0	0	Ö	o	924	68. 01
	06802 SPEECH THERAPY ST. JOHN	0	0	0	О	0	68. 02
69.00	06900 ELECTROCARDIOLOGY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	3, 177	47, 952	51, 129	1, 493 0	69. 00 71. 00
71.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	71.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0	O	Ō	0	73. 00
74.00	07400 RENAL DIALYSIS	0	18, 017		18, 017	0	74.00
76. 00 76. 01	03020 RADI ATI ON ONCOLOGY 03040 ANGI OCARDI OGRAPHY	0	0	116, 020	116, 020	1, 134 721	76. 00 76. 01
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	0	Ö	o	0	77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78. 00
90. 00	OUTPATIENT SERVICE COST CENTERS O9000 CLINIC	0	0		ما	0	00.00
90.00	09000 CLINIC 09001 DI ABETES CLINIC		0	0	ol Ol	0	90. 00 90. 01
90. 02	09002 OUTPATIENT CLINICS	0	0	112	112	0	90. 02
90. 03	09003 OCCUPATIONAL MEDICINE CLINIC	0	0	0	0	0	90. 03
90. 04 90. 05	09004 NEONATOLOGY CLINIC-FRANCISCAN POINT 09005 LACTATION CLINIC		0		0 0	48 78	90. 04 90. 05
	09100 EMERGENCY	0	626, 817	155, 535	782, 352		
		<u>.</u>		<u> </u>	<u> </u>		

Health Financial Systems	FRANCI SCAN HEALTH	CROWN POINT	In Lie	eu of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der CCN: 15-0126		
		CAPITAL RELATED COSTS		

			To	12/31/2023	Date/Time Pre 5/30/2024 10:	
		CAPI TAL REL	ATED COSTS			
Cost Center Description	Di rectly	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
	Assigned New				BENEFI TS	
	Capi tal				DEPARTMENT	
	Related Costs	1.00				
O4 O4 OO4O4 ENEDOENOV DOOM DUVCLOANC	0	1.00	2.00	2A	4. 00	04.04
91. 01 09101 EMERGENCY ROOM PHYSI CANS	0	0	0	0	0	1 ,
91. 02 09102 EXPRESS CARE	0	O	0	0	0	1 / 02
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART				U		92.00
OTHER REIMBURSABLE COST CENTERS 102.00 10200 OPI OLD TREATMENT PROGRAM		ما		ما		100.00
SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	102. 00
113. 00 11300 I NTEREST EXPENSE						1 113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	16, 416, 866	8, 198, 310	24, 615, 176	232, 097	
NONREI MBURSABLE COST CENTERS	U U	10, 410, 600	0, 190, 310	24, 013, 170	232, 097	1116.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN		٥			0	190. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	5, 404	0	9, 748	15, 152		192. 00
194. 00 07950 FHC	5, 404	0	7, 740 O	15, 152		194. 00
194. 01 07951 CONVENT		0	0	0		194. 01
194. 02 07952 OTHER NON REIMB - BUILDINGS	945, 359	0	26, 504	971, 863	_	194. 02
194. 03 07953 OTHER NON REIM-FHC BEHAVORI AL HEALTH	743, 337	0	20, 304	771,005		194. 03
194. 04 07954 CENTER OF HOPE	4, 071	Ö	7, 828	11, 899		194. 04
194. 05 07955 LAKESHORE JOINT VENTURE	0	o	0	0		194. 05
194. 06 07957 COVID VACCINE CLINIC	0	o	0	0		194. 06
200.00 Cross Foot Adjustments]		Ö		200.00
201.00 Negative Cost Centers		o	0	0	0	201. 00
202.00 TOTAL (sum lines 118 through 201)	954, 834	16, 416, 866	8, 242, 390	25, 614, 090	240, 331	202. 00

Health Financial Systems

ALLOCATION OF CAPITAL RELATED COSTS

Provi der CCN: 15-0126

Peri od: Worksheet B From 01/01/2023 Part II To 12/31/2023 Date/Time Prepared:

In Lieu of Form CMS-2552-10

5/30/2024 10:06 am

Cost Center Description ADMINISTRATIVE MAINTENANCE & OPERATION OF OPERATION OF LAUNDRY & & GENERAL **REPAIRS PLANT** PLANT - FP LINEN SERVICE 7. 01 5.00 6.00 7.00 8.00 GENERAL SERVICE COST CENTERS 1.00 1.00 00100 CAP REL COSTS-BLDG & FLXT 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00500 ADMINISTRATIVE & GENERAL 5 00 5, 022, 713 5 00 6.00 00600 MAINTENANCE & REPAIRS 77,698 117, 919 6.00 00700 OPERATION OF PLANT 315, 725 7.00 30,090 3, 384, 553 7.00 7.01 00701 OPERATION OF PLANT - FP 24, 317 34, 248 7. 01 00800 LAUNDRY & LINEN SERVICE 339, 718 8.00 39.373 2, 211 85, 192 747 8 00 9.00 00900 HOUSEKEEPI NG 74,634 1, 185 401 31, 226 45, 676 9.00 9 01 01851 ENVIRONMENTAL SERVICES - FP 3, 594 9 01 01000 DI ETARY 10.00 49, 102 235.073 4.234 6, 100 2,062 10.00 11.00 01100 CAFETERI A 27, 420 0 11.00 13.00 01300 NURSING ADMINISTRATION 116,032 6, 529 251, 604 2.207 0 13.00 01400 CENTRAL SERVICES & SUPPLY 4, 938 14.00 9.845 190, 295 1,669 1,021 14.00 01500 PHARMACY 24, 501 15.00 101, 634 636 215 0 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 70,533 610 23, 519 206 0 16.00 01700 SOCIAL SERVICE 17 00 67, 468 1, 405 54, 138 475 0 17.00 02100 I &R SERVICES-SALARY & FRINGES APPRV 21.00 0 C 0 0 0 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 0 22 00 0 C 0 0 22 00 02300 PARAMED ED PRGM-(SPECIFY) 16, 242 0 0 23.00 0 23.00 02301 ECHOCARDI OLOGY EDUCATI ON PROGRAM 23.01 3,070 0 23.01 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 611, 190 18, 225 702, 312 6, 159 157, 988 30.00 12, 092 31.00 03100 INTENSIVE CARE UNIT 149, 199 3, 766 145, 125 1, 273 31.00 35.00 02060 NEONATAL INTENSIVE CARE UNIT 84, 712 4, 731 182, 325 1, 599 8, 348 35.00 04100 SUBPROVIDER - IRF 41.00 75, 556 4,650 179, 196 1, 572 19, 665 41.00 43.00 04300 NURSERY 55, 598 3, 659 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 357.877 38, 456 50.00 8, 130 313. 277 2.748 05100 RECOVERY ROOM 51.00 8, 228 3, 260 125, 633 1, 102 0 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 65, 394 0 52.00 53.00 05300 ANESTHESI OLOGY 8,033 17,835 156 0 53.00 463 54 00 05400 RADI OLOGY-DI AGNOSTI C 281 113 6, 712 258, 648 2.268 8.833 54 00 54.01 05401 RADI OLOGY - I -65 22, 294 C 0 0 8,685 54.01 05402 RADIOLOGY DIAGNOSTIC - SJ 0 0 54.02 54.02 C 0 54.03 05403 LOWELL RADIOLOGY 378 0 0 54.03 C 0 05500 RADI OLOGY-THERAPEUTI C 55.00 \cap Λ 55.00 80, 407 55.01 05501 CARDI AC CATHERI ZATON LAB 95, 249 2,087 705 3,080 55.01 55.02 03140 CARDI OLOGY 45, 386 0 55.02 03450 NEURO-DI AGNOSTI CS 19 157 23 505 206 2 818 55 03 610 55 03 60.00 06000 LABORATORY 350, 955 3, 232 124, 539 1,092 405 60.00 06001 BLOOD LABORATORY 60.01 0 60.01 65.00 06500 RESPIRATORY THERAPY 63,807 14, 117 124 366 0 65.00 06600 PHYSI CAL THERAPY 10, 263 34, 179 66.00 1. 225 47, 206 414 66.00 66.01 06601 PHYSI CAL THERAPY I -65 26, 275 0 0 66.01 66.02 06602 PHYSI CAL THERAPY ST JOHN 6, 797 0 0 0 0 66.02 06700 OCCUPATIONAL THERAPY 18, 893 0 67.00 0 67.00 0 0 06701 OCCUPATION THERAPY I-65 0 67.01 3, 162 Ω 0 67.01 67.02 06702 OCCUPATIONAL THERAPY ST. JOHN 331 0 0 0 0 67.02 06800 SPEECH PATHOLOGY 0 68.00 11,687 0 0 68.00 0 06801 SPEECH PATHOLOGY I -65 9, 883 68.01 0 0 68.01 0 68 02 06802 SPEECH THERAPY ST. JOHN C 0 0 0 68 02 06900 ELECTROCARDI OLOGY 17,506 11 2,091 69.00 69.00 33 1, 277 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 492, 852 C 0 0 O 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72.00253, 461 C 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 164, 384 r 0 0 0 73.00 07400 RENAL DIALYSIS 188 74.00 12, 113 7, 241 64 0 74.00 76.00 03020 RADIATION ONCOLOGY 26, 973 0 1,772 76.00 C C 0 76.01 03040 ANGI OCARDI OGRAPHY 7, 746 0 0 0 76.01 77.00 07700 ALLOGENEIC HSCT ACQUISITION C 0 0 0 77.00 0 78.00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 0 78.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 0 0 0 90.00 09001 DIABETES CLINIC 90.01 90.01 90.02 09002 OUTPATIENT CLINICS 23 0 0 0 90.02 0 09003 OCCUPATIONAL MEDICINE CLINIC 0 0 90.03 90.03 0 C 0 90.04 09004 NEONATOLOGY CLINIC-FRANCISCAN POINT 526 Ω 0 0 0 90.04 09005 LACTATION CLINIC 90.05 829 0 90.05 91.00 09100 EMERGENCY 178,070 6.537 251, 912 2.209 25, 082 91.00 09101 EMERGENCY ROOM PHYSI CANS 91.01 91.01 0 0 0 09102 EXPRESS CARE 0 0 0 0 91.02 91.02 C 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00

Health Financial Systems	FRANCISCAN HEALTH CROWN POINT	In Lieu of Form CMS-2552	-10
ALLOCATION OF CAPITAL RELATED COSTS	Provi der CCN: 15-0126	Period: Worksheet B	

			F	rom 01/01/2023 o 12/31/2023	Part II Date/Time Pre 5/30/2024 10:	
Cost Center Description	ADMI NI STRATI VE	MAINTENANCE &	OPERATION OF	OPERATION OF	LAUNDRY &	OO diii
	& GENERAL	REPAI RS	PLANT	PLANT - FP	LINEN SERVICE	
	5. 00	6. 00	7. 00	7. 01	8. 00	
OTHER REIMBURSABLE COST CENTERS						
102. 00 10200 OPI OI D TREATMENT PROGRAM	0	0	0	0	0	102. 00
SPECIAL PURPOSE COST CENTERS						
113. 00 11300 I NTEREST EXPENSE						113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	4, 556, 503	117, 919	3, 384, 553	29, 684	339, 718	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	74, 591	0	0	846	0	192. 00
194. 00 07950 FHC	0	0	0	0	0	194. 00
194. 01 07951 CONVENT	0	0	0	0	0	194. 01
194.02 07952 OTHER NON REIMB - BUILDINGS	36, 452	0	0	3, 560	0	194. 02
194.03 07953 OTHR NON REIM-FHC BEHAVORIAL HEALTH	0	0	0	158	0	194. 03
194.04 07954 CENTER OF HOPE	4, 550	0	0	0	0	194. 04
194. 05 07955 LAKESHORE JOINT VENTURE	350, 617	0	0	0	0	194. 05
194.06 07957 COVID VACCINE CLINIC	0	0	0	0	0	194. 06
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)	5, 022, 713	117, 919	3, 384, 553	34, 248	339, 718	202. 00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0126

Peri od: Worksheet B From 01/01/2023 Part II To 12/31/2023 Date/Time Prepared:

5/30/2024 10:06 am Cost Center Description HOUSEKEEPING ENVIRONMENTAL CAFETERI A NURSI NG DI ETARY ADMI NI STRATI ON SERVICES - FP 9.00 10.00 11.00 9.01 13.00 GENERAL SERVICE COST CENTERS 1.00 1.00 00100 CAP REL COSTS-BLDG & FLXT 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00500 ADMINISTRATIVE & GENERAL 5 00 5 00 6.00 00600 MAINTENANCE & REPAIRS 6.00 00700 OPERATION OF PLANT 7.00 7.00 7.01 00701 OPERATION OF PLANT - FP 7. 01 00800 LAUNDRY & LINEN SERVICE 8.00 8 00 9.00 00900 HOUSEKEEPI NG 325, 343 9.00 9 01 01851 ENVIRONMENTAL SERVICES - FP 3, 901 9 01 01000 DI ETARY 10.00 10 00 23, 505 243 1, 036, 447 11.00 01100 CAFETERI A 29, 848 11.00 13.00 01300 NURSING ADMINISTRATION 25, 158 260 0 1.264 1, 352, 270 13.00 01400 CENTRAL SERVICES & SUPPLY 19.028 197 0 14.00 306 14.00 0 01500 PHARMACY 0 15.00 2.450 25 1.039 0 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 2, 352 24 0 269 0 16.00 01700 SOCIAL SERVICE 0 17 00 5, 413 56 815 1,933 17.00 02100 I &R SERVICES-SALARY & FRINGES APPRV 0 0 21.00 0 0 21.00 0 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 0 22 00 0 0 0 0 22 00 02300 PARAMED ED PRGM-(SPECIFY) 0 0 23.00 228 23.00 02301 ECHOCARDI OLOGY EDUCATI ON PROGRAM 30 23.01 23.01 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 70.228 727 832.840 9,679 612,003 30.00 99, 944 153, 797 31.00 03100 INTENSIVE CARE UNIT 14.511 150 1,629 31.00 35.00 02060 NEONATAL INTENSIVE CARE UNIT 18, 231 120, 108 188 0 1.171 35.00 04100 SUBPROVIDER - IRF 17, 918 63, 991 41.00 185 103, 663 909 41.00 43.00 04300 NURSERY 0 43.00 C 0 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 134, 135 50.00 31.325 324 0 2, 410 05100 RECOVERY ROOM 0 51.00 12, 562 130 0 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 14 0 52.00 53.00 0 05300 ANESTHESI OLOGY 1,783 18 62 0 53.00 54 00 05400 RADI OLOGY-DI AGNOSTI C 25, 863 0 2 234 16, 194 54 00 267 0 54.01 05401 RADI OLOGY - I -65 0 C 217 0 54.01 05402 RADIOLOGY DIAGNOSTIC - SJ 0 0 0 0 54.02 54.02 54.03 05403 LOWELL RADIOLOGY 0 0 54.03 0 0 05500 RADI OLOGY-THERAPEUTI C 0 55.00 C Λ 55.00 8,040 55.01 05501 CARDI AC CATHERI ZATON LAB 83 0 477 28, 107 55.01 55.02 03140 CARDI OLOGY 0 510 17, 178 55.02 03450 NEURO-DI AGNOSTI CS 2 350 24 0 286 55 03 0 55 03 0 60.00 06000 LABORATORY 12, 453 129 0 0 60.00 06001 BLOOD LABORATORY 0 60.01 0 60.01 65.00 06500 RESPIRATORY THERAPY 1,412 15 0 762 0 65.00 0 06600 PHYSI CAL THERAPY 66.00 4.720 49 387 0 66.00 66.01 06601 PHYSICAL THERAPY I-65 C 0 301 0 66.01 66.02 06602 PHYSI CAL THERAPY ST JOHN 0 0 0 80 66.02 06700 OCCUPATIONAL THERAPY 0 0 67.00 0 241 67.00 0 0 06701 OCCUPATION THERAPY I-65 Ω 67.01 33 0 67.01 67.02 06702 OCCUPATIONAL THERAPY ST. JOHN 0 0 0 5 0 67.02 06800 SPEECH PATHOLOGY 0 68.00 139 68.00 06801 SPEECH PATHOLOGY I -65 0 0 0 68.01 68.01 126 0 0 68 02 06802 SPEECH THERAPY ST. JOHN 0 Ω 0 Ω 68 02 06900 ELECTROCARDI OLOGY 128 13, 607 69.00 69.00 235 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 0 O 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 72.000 0 0 72.00 0 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 73.00 07400 RENAL DIALYSIS 0 0 74.00 0 74.00 76.00 03020 RADIATION ONCOLOGY 0 0 0 4, 784 76.00 153 0 0 76.01 03040 ANGI OCARDI OGRAPHY 0 93 0 76.01 0 77.00 07700 ALLOGENEIC HSCT ACQUISITION 0 C 0 0 77.00 78.00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 0 78.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 0 0 0 90.00 09001 DIABETES CLINIC 0 0 90.01 90.01 0 0 90.02 09002 OUTPATIENT CLINICS 0 0 90.02 0 09003 OCCUPATIONAL MEDICINE CLINIC 0 0 0 90.03 0 0 90.03 0 90.04 09004 NEONATOLOGY CLINIC-FRANCISCAN POINT 0 0 7 220 90.04 09005 LACTATION CLINIC 0 90.05 0 696 90.05 91.00 09100 EMERGENCY 25.189 0 2, 276 151, 504 91.00 260 09101 EMERGENCY ROOM PHYSICANS 0 91.01 91.01 0 C 0 09102 EXPRESS CARE 0 0 0 0 91.02 91.02 C 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00

Health Financial Systems	FRANCISCAN HEALTH CROWN POINT	In Lie	u of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS	Provi der CCN: 15-0126	Peri od:	Worksheet B

ALEGORITOR OF GATTIAL RELATED GOSTS		Trovider ex		rom 01/01/2023 o 12/31/2023	Part II Date/Time Prepared: 5/30/2024 10:06 am
Cost Center Description	HOUSEKEEPI NG	ENVI RONMENTAL	DI ETARY	CAFETERI A	NURSI NG
	9.00	SERVICES - FP 9. 01	10.00	11. 00	ADMI NI STRATI ON 13. 00
OTHER REIMBURSABLE COST CENTERS	7.00	7.01	10.00	11.00	13.00
102. 00 10200 OPI OI D TREATMENT PROGRAM	0	0	0	0	0 102. 00
SPECIAL PURPOSE COST CENTERS	· ·				
113. 00 11300 NTEREST EXPENSE					113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	325, 343	3, 362	1, 036, 447	28, 402	1, 318, 259 118. 00
NONREI MBURSABLE COST CENTERS					
190.00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0 190. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	100	0	699	0 192. 00
194. 00 07950 FHC	0	0	0	0	0 194. 00
194. 01 07951 CONVENT	0	0	0	0	0 194. 01
194.02 07952 OTHER NON REIMB - BUILDINGS	0	420	0	0	0 194. 02
194.03 07953 OTHR NON REIM-FHC BEHAVORIAL HEALTH	0	19	0	0	0 194. 03
194. 04 07954 CENTER OF HOPE	0	0	0	42	296 194. 04
194. 05 07955 LAKESHORE JOINT VENTURE	0	0	0	705	33, 715 194. 05
194. 06 07957 COVID VACCINE CLINIC	0	0	0	0	0 194. 06
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)	325, 343	3, 901	1, 036, 447	29, 848	1, 352, 270 202. 00

Health Financial Systems FRANCISCAN HEALTH CROWN POINT In Lieu of Form CMS-2552-10 ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0126 Peri od: Worksheet B From 01/01/2023 Part II Date/Time Prepared: 12/31/2023 5/30/2024 10:06 am INTERNS & **RESI DENTS** CENTRAL **PHARMACY** MEDI CAL SOCIAL SERVICE SERVICES-SALAR Cost Center Description Y & FRINGES SERVICES & RECORDS & **APPRV** SUPPLY LI BRARY 14.00 15.00 16.00 17.00 21.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 00600 MAINTENANCE & REPAIRS 6.00 6.00 00700 OPERATION OF PLANT 7.00 7 00 7.01 00701 OPERATION OF PLANT - FP 7.01 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 00900 HOUSEKEEPI NG 9 00 9 00 9.01 01851 ENVIRONMENTAL SERVICES - FP 9.01 10.00 01000 DI ETARY 10.00 11.00 01100 CAFETERI A 11.00 01300 NURSING ADMINISTRATION 13 00 13 00 14.00 01400 CENTRAL SERVICES & SUPPLY 736, 655 14.00 01500 PHARMACY 15.00 319 209, 340 15.00 01600 MEDICAL RECORDS & LIBRARY 16 00 33 161, 182 16 00 01700 SOCIAL SERVICE 17.00 41 C 272, 281 17.00 02100 I &R SERVICES-SALARY & FRINGES APPRV 0 O 21.00 21.00 0 C 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 22.00 0 0 0 22.00 0 02300 PARAMED ED PRGM-(SPECIFY) O 23 00 23 00 657 C 0 02301 ECHOCARDIOLOGY EDUCATION PROGRAM 23.01 0 0 23.01 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 1, 981 0 8, 960 15, 065 30.00 03100 INTENSIVE CARE UNIT 0 1.976 31.00 340 3.322 31 00 35.00 02060 NEONATAL INTENSIVE CARE UNIT 215 0 2, 913 4, 898 35.00 04100 SUBPROVIDER - IRF 41.00 141 0 887 1, 492 41.00 04300 NURSERY 43.00 0 533 896 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 4,660 0 19, 271 32, 403 50.00 05100 RECOVERY ROOM 51.00 45 2, 927 4, 921 51.00 05200 DELIVERY ROOM & LABOR ROOM 0 943 1, 586 52.00 2 52.00 05300 ANESTHESI OLOGY 53 00 43 0 3.682 6, 192 53 00 05400 RADI OLOGY-DI AGNOSTI C 30, 845 54.00 948 53, 123 54.00 54.01 05401 RADI OLOGY - I -65 48 0 3, 337 5, 611 54.01 05402 RADIOLOGY DIAGNOSTIC - SJ 54.02 0 54.02 0 C 0 54.03 05403 LOWELL RADIOLOGY 0 0 5 8 54.03 55, 00 05500 RADI OLOGY-THERAPEUTI C 0 0 55.00 05501 CARDI AC CATHERI ZATON LAB 0 6, 677 11, 227 55.01 2.083 55.01 7, 700 03140 CARDI OLOGY 0 4.579 55.02 202 55.02 55.03 03450 NEURO-DI AGNOSTI CS 161 0 1, 365 2, 296 55.03 60.00 06000 LABORATORY 25 40, 901 60.00 24.324 06001 BLOOD LABORATORY 60.01 0 0 C 60.01 65.00 06500 RESPIRATORY THERAPY 41 0 2,654 4, 462 65.00 66, 00 06600 PHYSI CAL THERAPY 594 998 66, 00 06601 PHYSI CAL THERAPY I -65 62 0 541 909 66.01 66.01 06602 PHYSI CAL THERAPY ST JOHN 21 0 66.02 172 289 66.02 67.00 06700 OCCUPATIONAL THERAPY 0 620 1,042 67.00 06701 OCCUPATION THERAPY I-65 0 67.01 0 61 103 67.01 06702 OCCUPATIONAL THERAPY ST. JOHN 0 67.02 67.02 19 11 68.00 06800 SPEECH PATHOLOGY 1 0 542 912 68.00 68.01 06801 SPEECH PATHOLOGY I -65 0 0 343 577 68.01 06802 SPEECH THERAPY ST. JOHN 0 68.02 0 68.02 69 00 06900 ELECTROCARDI OLOGY 76 Ω 427 718 69 00 |07100|MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 485, 489 C 6,586 11,074 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 237, 121 6, 245 10, 501 72.00 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 209, 340 8, 498 14, 290 73.00 0 07400 RENAL DIALYSIS 74 00 172 289 0 74 00 76.00 03020 RADIATION ONCOLOGY 71 0 2, 235 3, 759 76.00 03040 ANGI OCARDI OGRAPHY 0 76.01 45 156 262 76.01 77.00 07700 ALLOGENEIC HSCT ACQUISITION 0 0 C 77.00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 78.00 78.00 OUTPATIENT SERVICE COST CENTERS 09000 CLI NI C 90.00 90.00 90.01 09001 DIABETES CLINIC 0 0 0 0 90.01 90.02 09002 OUTPATIENT CLINICS 0 0 0 0 90.02 09003 OCCUPATIONAL MEDICINE CLINIC 0 0 90.03 0 90.03 90.04 09004 NEONATOLOGY CLINIC-FRANCISCAN POINT 7 0 12 20 90.04

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711

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18,086

30, 411

90.05

91.00

91.01

90 05

91.00

09005 LACTATION CLINIC

09101 EMERGENCY ROOM PHYSI CANS

09100 EMERGENCY

| Peri od: | Worksheet B | From 01/01/2023 | Part | I | To | 12/31/2023 | Date/Time Prepared: Provider CCN: 15-0126

			1	0 12/31/2023	5/30/2024 10:0	
					INTERNS &	oo am
					RESI DENTS	
Cost Center Description	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE	SERVI CES-SALAR	
	SERVICES &		RECORDS &		Y & FRINGES	
	SUPPLY		LI BRARY		APPRV	
	14. 00	15. 00	16. 00	17. 00	21. 00	
91. 02 09102 EXPRESS CARE	0	0	0	0		91. 02
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS						
102.00 10200 OPI OI D TREATMENT PROGRAM	0	0	0	0		102. 00
SPECIAL PURPOSE COST CENTERS	1					
113. 00 11300 I NTEREST EXPENSE						113. 00
118. 00 SUBTOTALS (SUM OF LINES 1 through 117)	735, 615	209, 340	161, 182	272, 281	0	118. 00
NONREI MBURSABLE COST CENTERS			_	_		
190. 00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0		190. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	998	0	0	0		192. 00
194. 00 07950 FHC	0	0	0	0		194. 00
194. 01 07951 CONVENT	0	0	0	0		194. 01
194. 02 07952 OTHER NON REIMB - BUILDINGS	1	0	0	0		194. 02
194. 03 07953 OTHR NON REIM-FHC BEHAVORIAL HEALTH	0	0	0	0		194. 03
194. 04 07954 CENTER OF HOPE	0	0	0	0		194. 04
194. 05 07955 LAKESHORE JOINT VENTURE	41	0	0	0		194. 05
194. 06 07957 COVID VACCINE CLINIC	O	0	0	0		194. 06
200.00 Cross Foot Adjustments	110 (00					200. 00
201.00 Negative Cost Centers	118, 692	000.040	0	070.004		201. 00
202.00 TOTAL (sum lines 118 through 201)	855, 347	209, 340	161, 182	272, 281	0	202. 00

					o 12/31/2023	Date/lime Pre 5/30/2024 10:	
	Cost Center Description	I NTERNS & RESI DENTS SERVI CES-OTHER PRGM COSTS APPRV	PARAMED ED PRGM	ECHOCARDI OLOG' EDUCATI ON PROGRAM	/ Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	J J J J J J J J J J J J J J J J J J J
		22. 00	23. 00	23. 01	24. 00	25.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMINISTRATIVE & GENERAL						5. 00
6.00	00600 MAINTENANCE & REPAIRS						6. 00
7.00	00700 OPERATION OF PLANT						7. 00
7. 01	00701 OPERATION OF PLANT - FP						7. 01
8.00	00800 LAUNDRY & LINEN SERVICE						8. 00
9.00	00900 HOUSEKEEPI NG	1					9. 00
9. 01	01851 ENVIRONMENTAL SERVICES - FP	1					9. 01
10.00	01000 DI ETARY	1					10.00
11. 00	01100 CAFETERI A	i					11. 00
13.00	01300 NURSING ADMINISTRATION						13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	1					14.00
15.00	01500 PHARMACY						15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY						16. 00
17.00	01700 SOCIAL SERVICE						17. 00
21.00	02100 I&R SERVICES-SALARY & FRINGES APPRV						21. 00
22.00	02200 I&R SERVICES-OTHER PRGM COSTS APPRV	0					22. 00
23.00	02300 PARAMED ED PRGM-(SPECIFY)		51, 190				23. 00
23. 01	02301 ECHOCARDI OLOGY EDUCATI ON PROGRAM			23, 828	3		23. 01
	INPATIENT ROUTINE SERVICE COST CENTERS				_		
30. 00	03000 ADULTS & PEDI ATRI CS				5, 256, 673	1	30. 00
31. 00	03100 INTENSIVE CARE UNIT				1, 444, 312	1	31. 00
35. 00	02060 NEONATAL INTENSIVE CARE UNIT				1, 090, 150	1	35. 00
41. 00	04100 SUBPROVI DER – I RF				1, 063, 252	1	41. 00
43. 00	04300 NURSERY				65, 632	. 0	43. 00
50. 00	ANCI LLARY SERVI CE COST CENTERS 05000 OPERATI NG ROOM				4, 184, 019	0	50.00
51. 00	05100 RECOVERY ROOM				481, 286	1	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	1			73, 676	1	52.00
53. 00	05300 ANESTHESI OLOGY				286, 286	1	53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C				2, 638, 665	l .	54.00
54. 01	05401 RADI OLOGY - I -65				270, 193	1	54. 01
54. 02	05402 RADIOLOGY DIAGNOSTIC - SJ					1	54. 02
54. 03	05403 LOWELL RADI OLOGY				12, 083	0	54. 03
55.00	05500 RADI OLOGY-THERAPEUTI C				C	0	55. 00
55. 01	05501 CARDI AC CATHERI ZATON LAB				1, 192, 373	0	55. 01
55. 02	03140 CARDI OLOGY				418, 190	0	55. 02
55. 03	03450 NEURO-DI AGNOSTI CS				168, 276	0	55. 03
60. 00	I I				940, 997		60. 00
	1 1				C	1	60. 01
65.00	06500 RESPIRATORY THERAPY				302, 519	1	65. 00
66.00	06600 PHYSI CAL THERAPY				224, 217	1	66. 00
66. 01	06601 PHYSI CAL THERAPY I -65				44, 223	1	66. 01
66. 02	06602 PHYSI CAL THERAPY ST JOHN 06700 OCCUPATI ONAL THERAPY				12, 156	1	66. 02
67. 00 67. 01	06701 OCCUPATION THERAPY I -65	1			22, 570 3, 651		67. 00 67. 01
67. 01	06702 OCCUPATION THERAPY ST. JOHN	1			3, 031	1	67. 02
68. 00	06800 SPEECH PATHOLOGY				14, 367	1	68. 00
68. 01	06801 SPEECH PATHOLOGY I -65				11, 853		68. 01
68. 02	I I				, 555	1	68. 02
69. 00	06900 ELECTROCARDI OLOGY				88, 732		69. 00
71.00					996, 001	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS				507, 328	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS				396, 512	. 0	73. 00
74.00	07400 RENAL DIALYSIS				38, 815	0	74.00
76. 00	03020 RADI ATI ON ONCOLOGY				156, 901	1	76. 00
76. 01	03040 ANGI OCARDI OGRAPHY				9, 023	1	76. 01
77. 00	07700 ALLOGENEIC HSCT ACQUISITION				C		77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY				C	0	78. 00
00.00	OUTPATIENT SERVICE COST CENTERS						00.00
	· · · · · · · · · · · · · · · · · · ·	1		1	C	1	90.00
90. 01 90. 02	09001 DI ABETES CLINIC 09002 OUTPATIENT CLINICS	1			135		90. 01 90. 02
90. 02	09003 OCCUPATIONAL MEDICINE CLINIC	1			133	l .	90. 02
90. 03		1			840	1	90.03
	09005 LACTATION CLINIC	1		1	1, 625	1	90. 05
	· · · · ·			•	•	•	

	RANCI SCAN HEALT	_			eu of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der C		Period: From 01/01/2023 To 12/31/2023		
Cost Center Description	I NTERNS & RESI DENTS SERVI CES-OTHER PRGM COSTS APPRV	PARAMED ED PRGM	ECHOCARDI OLOG EDUCATI ON PROGRAM		Intern & Residents Cost & Post Stepdown Adjustments	
	22.00	23. 00	23. 01	24.00	25.00	
91. 00 09100 EMERGENCY				1, 487, 494	0	91.00
91. 01 09101 EMERGENCY ROOM PHYSI CANS				0	0	91. 01
91. 02 09102 EXPRESS CARE				0	0	91. 02
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART					0	92. 00
OTHER REIMBURSABLE COST CENTERS						
102.00 10200 OPIOLD TREATMENT PROGRAM				0	0	102. 00
SPECIAL PURPOSE COST CENTERS						
113. 00 11300 I NTEREST EXPENSE						113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	(0 23, 905, 422	0	118. 00
NONREI MBURSABLE COST CENTERS				_		
190.00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN				0		190. 00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES				100, 107		192. 00
194. 00 07950 FHC				0		194. 00
194. 01 07951 CONVENT				0		194. 01
194.02 07952 OTHER NON REIMB - BUILDINGS				1, 012, 296		194. 02
194.03 07953 OTHR NON REIM-FHC BEHAVORIAL HEALTH				177		194. 03
194. 04 07954 CENTER OF HOPE				17, 186		194. 04
194. 05 07955 LAKESHORE JOINT VENTURE				385, 192		194. 05
194. 06 07957 COVID VACCINE CLINIC				0		194. 06
200.00 Cross Foot Adjustments	0	51, 190	23, 82			200. 00
201.00 Negative Cost Centers	0	(0 118, 692		201. 00
202.00 TOTAL (sum lines 118 through 201)	0	51, 190	23, 82	8 25, 614, 090	1 0	202.00

51, 190

25, 614, 090

23, 828

0 194.05 0 194.06 0 200.00 0 201.00 0 202.00

202.00

TOTAL (sum lines 118 through 201)

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0126

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2023 Part II
To 12/31/2023 Date/Time Prepared: 5/30/2024 10:06 am

			5/30/2024 10:	
	Cost Center Description	Total		
	CENEDAL CEDULCE COCT CENTEDO	26. 00		
1. 00	GENERAL SERVICE COST CENTERS 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
5.00	00500 ADMINISTRATIVE & GENERAL			5. 00
6.00	00600 MAI NTENANCE & REPAI RS			6. 00
7.00	00700 OPERATION OF PLANT			7.00
7. 01 8. 00	00701 OPERATION OF PLANT - FP 00800 LAUNDRY & LINEN SERVICE			7. 01 8. 00
9. 00	00900 HOUSEKEEPI NG			9. 00
9. 01	01851 ENVI RONMENTAL SERVI CES - FP			9. 01
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 15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY			16. 00
17. 00	01700 SOCIAL SERVICE			17. 00
21. 00	02100 I&R SERVICES-SALARY & FRINGES APPRV			21. 00
22. 00	02200 I&R SERVICES-OTHER PRGM COSTS APPRV			22. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)			23. 00
23. 01	O2301 ECHOCARDI OLOGY EDUCATI ON PROGRAM INPATI ENT ROUTI NE SERVI CE COST CENTERS			23. 01
30. 00	03000 ADULTS & PEDIATRICS	5, 256, 673		30.00
31. 00	03100 I NTENSI VE CARE UNI T	1, 444, 312		31.00
35. 00	02060 NEONATAL INTENSIVE CARE UNIT	1, 090, 150		35. 00
41.00	04100 SUBPROVI DER - I RF	1, 063, 252		41. 00
43.00	04300 NURSERY	65, 632		43. 00
FO 00	ANCILLARY SERVICE COST CENTERS	4 104 010		F0 00
50. 00 51. 00	05000 OPERATING ROOM 05100 RECOVERY ROOM	4, 184, 019 481, 286		50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	73, 676		52.00
53. 00	05300 ANESTHESI OLOGY	286, 286		53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	2, 638, 665		54. 00
54. 01	05401 RADI OLOGY - I -65	270, 193		54. 01
54. 02	05402 RADIOLOGY DIAGNOSTIC - SJ	0		54. 02
54. 03	05403 LOWELL RADI OLOGY	12, 083		54. 03
55. 00 55. 01	05500 RADI OLOGY-THERAPEUTI C 05501 CARDI AC CATHERI ZATON LAB	0 1, 192, 373		55. 00 55. 01
55. 02	03140 CARDI OLOGY	418, 190		55. 02
55. 03	03450 NEURO-DI AGNOSTI CS	168, 276		55. 03
60.00	06000 LABORATORY	940, 997		60.00
60. 01	06001 BLOOD LABORATORY	0		60. 01
65. 00	06500 RESPI RATORY THERAPY	302, 519		65. 00
66. 00 66. 01	06600 PHYSI CAL THERAPY 06601 PHYSI CAL THERAPY I -65	224, 217 44, 223		66. 00 66. 01
66. 02		12, 156		66. 02
67. 00	1	22, 570		67. 00
67. 01		3, 651		67. 01
67. 02	06702 OCCUPATIONAL THERAPY ST. JOHN	397		67. 02
68. 00	1	14, 367		68. 00
68. 01	1	11, 853		68. 01
68. 02 69. 00	06802 SPEECH THERAPY ST. JOHN 06900 ELECTROCARDI OLOGY	0 88, 732		68. 02 69. 00
71. 00	1	996, 001		71.00
72.00	1 1	507, 328		72.00
73. 00		396, 512		73. 00
74. 00		38, 815		74. 00
76.00	1	156, 901		76.00
76. 01	03040 ANGI OCARDI OGRAPHY	9, 023		76. 01
77. 00 78. 00	07700 ALLOGENEIC HSCT ACQUISITION 07800 CAR T-CELL IMMUNOTHERAPY	0 0		77. 00 78. 00
70.00	OUTPATIENT SERVICE COST CENTERS	ı U		, 0.00
90.00	09000 CLINIC	0		90.00
90. 01	09001 DIABETES CLINIC	O		90. 01
90. 02	1	135		90. 02
90. 03	09003 OCCUPATIONAL MEDICINE CLINIC	0		90. 03
90.04		840		90.04
90. 05 91. 00	09005 LACTATI ON CLI NI C 09100 EMERGENCY	1, 625 1, 487, 494		90. 05 91. 00
91.00	09101 EMERGENCY ROOM PHYSI CANS	1, 467, 494		91.00
	09102 EXPRESS CARE			91. 02
92. 00				92.00
	OTHER REIMBURSABLE COST CENTERS			1
102.00	0 10200 OPIOID TREATMENT PROGRAM	0		102. 00

Health Financial Systems	FRANCISCAN HEALTH CROWN POINT	In Lie	u of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS	Provider CCN: 15-0126	Peri od:	Worksheet B
		From 01/01/2023	

		To 12/31/2023 Date/Time P	
Cost Center Description	Total	5, 66, 2521	3. 00 a
·	26.00		
SPECIAL PURPOSE COST CENTERS			
113. 00 11300 I NTEREST EXPENSE			113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	23, 905, 422		118. 00
NONREI MBURSABLE COST CENTERS			
190.00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0		190. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	100, 107		192. 00
194. 00 07950 FHC	0		194. 00
194. 01 07951 CONVENT	0		194. 01
194.02 07952 OTHER NON REIMB - BUILDINGS	1, 012, 296		194. 02
194.03 07953 OTHR NON REIM-FHC BEHAVORIAL HEALTH	177		194. 03
194. 04 07954 CENTER OF HOPE	17, 186		194. 04
194. 05 07955 LAKESHORE JOINT VENTURE	385, 192		194. 05
194.06 07957 COVID VACCINE CLINIC	0		194. 06
200.00 Cross Foot Adjustments	75, 018		200. 00
201.00 Negative Cost Centers	118, 692		201. 00
202.00 TOTAL (sum lines 118 through 201)	25, 614, 090		202. 00

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0126 Peri od: Worksheet B-1 From 01/01/2023 12/31/2023 Date/Time Prepared: 5/30/2024 10:06 am CAPITAL RELATED COSTS Cost Center Description BLDG & FIXT MVBLE EQUIP **EMPLOYEE** Reconciliation ADMINISTRATIVE (SQUARE FEET) (DOLLAR VALUE) BENEFITS & GENERAL DEPARTMENT (ACCUM. COST) (GROSS SALARI ES) 1.00 2.00 5. 00 4.00 5A GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS-BLDG & FLXT 470 178 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 4, 286, 711 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 5, 697 21,538 81, 110, 233 4.00 00500 ADMINISTRATIVE & GENERAL 70, 874 5 00 3, 833, 200 -71, 268, 056 199 588 429 5 00 139, 622 6.00 00600 MAINTENANCE & REPAIRS 1,039 1, 131 596, 831 3, 087, 561 6.00 12, 546, 205 7.00 00700 OPERATION OF PLANT 82, 627 75, 827 2, 670, 449 7.00 00701 OPERATION OF PLANT - FP 0 966, 306 7.01 7.01 5, 165 00800 LAUNDRY & LINEN SERVICE 6,071 0 8 00 73.464 1, 564, 598 8 00 9.00 00900 HOUSEKEEPI NG 3, 255 27, 703 1, 789, 564 0 2, 965, 767 9.00 01851 ENVIRONMENTAL SERVICES - FP 103, 461 0 9.01 142, 832 9.01 0 01000 DI ETARY 16, 752 562, 758 10.00 67, 373 1. 951. 187 10.00 819, 295 11.00 01100 CAFETERI A 1,089,600 11.00 13.00 01300 NURSING ADMINISTRATION 17, 930 163, 763 2, 796, 897 0 4, 610, 857 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 13, 561 79, 767 396, 277 391, 231 14.00 0 01500 PHARMACY 1, 746 5, 073 2, 633, 512 4, 038, 700 15.00 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 1,676 1, 737 599, 273 2, 802, 837 16.00 01700 SOCIAL SERVICE 3,858 201 1, 837, 210 2, 681, 006 17.00 17.00 21.00 02100 I&R SERVICES-SALARY & FRINGES APPRV 0 C 0 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 0 22.00 22.00 0 23.00 02300 PARAMED ED PRGM-(SPECIFY) 0 17, 148 367, 561 0 645, 417 23.00 02301 ECHOCARDI OLOGY EDUCATI ON PROGRAM 23.01 10, 547 149, 553 121, 977 23.01 INPATIENT ROUTINE SERVICE COST CENTERS 30 00 03000 ADULTS & PEDIATRICS 204.870 22, 907, 363 24, 284, 479 30.00 50.049 0 31.00 03100 INTENSIVE CARE UNIT 10, 342 252, 502 3, 570, 362 0 5, 928, 826 31.00 02060 NEONATAL INTENSIVE CARE UNIT 12, 993 0 35.00 104, 404 2, 125, 621 3, 366, 278 35.00 1, 887, 738 o 3, 002, 410 41.00 04100 SUBPROVIDER - IRF 12,770 73, 827 41.00 04300 NURSERY 43.00 1, 669, 366 0 2, 209, 328 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 22, 325 1, 269, 912 5, 987, 412 0 14, 221, 235 50.00 05100 RECOVERY ROOM 0 51 00 8,953 5, 134 198 326, 963 51 00 0 52.00 05200 DELIVERY ROOM & LABOR ROOM 1, 936, 089 2, 598, 603 52.00 05300 ANESTHESI OLOGY 53.00 1, 271 105, 824 55, 448 0 319, 226 53.00 05400 RADI OLOGY-DI AGNOSTI C 672, 772 11, 170, 800 54.00 18.432 4, 876, 375 54.00 05401 RADIOLOGY - I-65 54.01 0 118, 961 427, 147 885, 901 54.01 54.02 05402 RADIOLOGY DIAGNOSTIC - SJ 0 0 0 54.02 54.03 05403 LOWELL RADIOLOGY 0 6, 077 2,044 0 0 0 15, 028 54.03 05500 RADI OLOGY-THERAPEUTI C 55 00 55 00 0 05501 CARDI AC CATHERI ZATON LAB 55.01 5,730 389, 845 1, 517, 300 3, 784, 969 55.01 55.02 03140 CARDI OLOGY 176, 417 1, 155, 428 1, 803, 555 55.02 55.03 03450 NEURO-DI AGNOSTI CS 1,675 28, 855 516, 666 0 761, 262 55.03 06000 LABORATORY 13, 946, 161 60 00 37, 997 60 00 8,875 C 60.01 06001 BLOOD LABORATORY 60.01 06500 RESPIRATORY THERAPY 1,006 90, 934 1, 615, 511 2, 535, 548 65.00 0 65.00 66.00 06600 PHYSI CAL THERAPY 3.364 1, 975 983, 027 1, 358, 211 66, 00 06601 PHYSICAL THERAPY I-65 762, 023 66.01 0 7, 217 1, 044, 105 66 01 0 66.02 06602 PHYSI CAL THERAPY ST JOHN 0 2, 188 199, 094 270,079 66.02 596, 351 06700 OCCUPATIONAL THERAPY 0 750, 776 67.00 67.00 0 06701 OCCUPATION THERAPY I-65 0 125, 656 98. 385 67.01 67.01 0 06702 OCCUPATIONAL THERAPY ST. JOHN 67.02 C 10.471 13, 135 67 02 68.00 06800 SPEECH PATHOLOGY 0 366, 363 464, 408 68.00 06801 SPEECH PATHOLOGY I -65 0 68.01 311, 932 0 392, 728 68 01 06802 SPEECH THERAPY ST. JOHN 0 68 02 0 68 02 69.00 06900 ELECTROCARDI OLOGY 91 24, 939 503, 767 695, 641 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 19, 584, 828 71.00 0 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 10, 071, 960 72.00 0 0 72.00 6, 532, 239 07300 DRUGS CHARGED TO PATIENTS 0 0 73.00 73.00 0 74.00 07400 RENAL DIALYSIS 481, 336 74.00 516 0 03020 RADIATION ONCOLOGY 76 00 0 60, 340 382, 766 1,071,837 76.00 0 0 03040 ANGLOCARDLOGRAPHY 243, 320 76.01 307, 798 76.01 C 07700 ALLOGENEIC HSCT ACQUISITION 0 0 77.00 r C Ω 77 00 07800 CAR T-CELL IMMUNOTHERAPY 78.00 78.00 0 0 0 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 0 0 0 90.00 0 90.01 09001 DIABETES CLINIC 0 0 Λ 90.01 0 90.02 09002 OUTPATIENT CLINICS 58 0 0 931 90.02 09003 OCCUPATIONAL MEDICINE CLINIC 0 90.03 90.03 0 0 0 0 09004 NEONATOLOGY CLINIC-FRANCISCAN POINT 0 0 20.895 90 04 90 04 16, 152 90.05 09005 LACTATION CLINIC 26, 267 32, 949 90.05

		RANCISCAN HEAL	TH CROWN POINT		In Lie	eu of Form CMS-	2552-10
COST ALLOCAT	TION - STATISTICAL BASIS		Provi der CO		Peri od:	Worksheet B-1	
					From 01/01/2023 To 12/31/2023	Date/Time Pre 5/30/2024 10:	pared: 06 am
		CAPI TAL REI	LATED COSTS				
	Cost Center Description	Í	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)		ADMINISTRATIVE & GENERAL (ACCUM. COST)	
04 00 00400	Energe No.	1.00	2.00	4.00	5A	5. 00	04.00
	EMERGENCY POOM PHYSICANS	17, 952	80, 891	4, 352, 09	0	.,	
	EMERGENCY ROOM PHYSICANS EXPRESS CARE	0	0	(0	0	
	OBSERVATION BEDS (NON-DISTINCT PART	0	U	()	0	91.02
	REIMBURSABLE COST CENTERS						72.00
	OPI OI D TREATMENT PROGRAM	0	0	(0	0	102. 00
	AL PURPOSE COST CENTERS				-		
	INTEREST EXPENSE						113. 00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	470, 178	4, 263, 786	78, 331, 388	-71, 268, 056	181, 062, 283	118. 00
	IMBURSABLE COST CENTERS	T					
	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0 (05 00)	0		190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	5, 070	2, 605, 88	0	2, 964, 096	194. 00
194. 00 07950		0	0		0		194. 00
	OTHER NON REIMB - BUILDINGS		13, 784			1, 448, 539	
	OTHE NON REIM-FHC BEHAVORIAL HEALTH		13, 704				194. 02
	CENTER OF HOPE	0	4, 071	134, 52	7	180, 793	
	LAKESHORE JOINT VENTURE	0	0	38, 43		13, 932, 718	
194. 06 07957	COVID VACCINE CLINIC	0	О	. (0		194. 06
200. 00	Cross Foot Adjustments						200. 00
201.00	Negative Cost Centers						201. 00
202. 00	Cost to be allocated (per Wkst. B, Part	16, 416, 866	8, 242, 390	20, 634, 283	3	71, 268, 056	202. 00
203. 00	Únit cost multiplier (Wkst. B, Part I)	34. 916279	1. 922777	0. 254398	3	0. 357075	203. 00
204. 00	Cost to be allocated (per Wkst. B, Part			240, 33		5, 022, 713	204. 00

0.002963

0. 025165 205. 00 206. 00

207. 00

205.00

206.00 207.00 11)

Unit cost multiplier (Wkst. B, Part II)
NAHE adjustment amount to be allocated
(per Wkst. B-2)
NAHE unit cost multiplier (Wkst. D,
Parts III and IV)

| Period: | Worksheet B-1 | From 01/01/2023 | To 12/31/2023 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provi der CCN: 15-0126

				Ţ	o 12/31/2023	Date/Time Pre 5/30/2024 10:	
	Cost Center Description	MAINTENANCE &		OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	00 4111
		REPAIRS (SQUARE FEET)	PLANT (SQUARE FEET)	PLANT - FP (ASSIGNED	LINEN SERVICE (POUNDS OF	(SQUARE FEET)	
			, ,	TIME)	LAUNDRY)		
	GENERAL SERVICE COST CENTERS	6. 00	7.00	7. 01	8. 00	9. 00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1. 00
2. 00 4. 00	OO200 CAP REL COSTS-MVBLE EQUIP OO400 EMPLOYEE BENEFITS DEPARTMENT						2. 00 4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL						5. 00
6.00	00600 MAINTENANCE & REPAIRS	323, 820	ł				6. 00
7. 00 7. 01	OO7OO OPERATION OF PLANT OO7O1 OPERATION OF PLANT - FP	82, 627 0	241, 193 0				7. 00 7. 01
8.00	00800 LAUNDRY & LINEN SERVICE	6, 071	6, 071				8. 00
9. 00 9. 01	O0900 HOUSEKEEPI NG O1851 ENVI RONMENTAL SERVI CES - FP	3, 255 0	3, 255 0	1		231, 867 0	9. 00 9. 01
10.00	01000 DI ETARY	16, 752	16, 752				10. 00
11. 00 13. 00	O1100 CAFETERI A O1300 NURSI NG ADMI NI STRATI ON	17, 930	0 17, 930	0 17, 930	_	0 17, 930	11. 00 13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	13, 561	13, 561				14. 00
15. 00 16. 00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	1, 746 1, 676	l			1, 746 1, 676	15. 00 16. 00
17. 00	01700 SOCIAL SERVICE	3, 858	l			3, 858	17. 00
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRV	0	0	· -		0	21.00
22. 00 23. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV 02300 PARAMED ED PRGM-(SPECIFY)	0		0		0	22. 00 23. 00
23. 01	02301 ECHOCARDI OLOGY EDUCATI ON PROGRAM	0	0	0	0	0	23. 01
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	50, 049	50, 049	50, 049	380, 497	50, 049	30. 00
31. 00	03100 INTENSIVE CARE UNIT	10, 342	10, 342	10, 342	29, 123	10, 342	31. 00
35. 00 41. 00	02060 NEONATAL INTENSIVE CARE UNIT 04100 SUBPROVIDER - IRF	12, 993 12, 770	l				35. 00 41. 00
43. 00	04300 NURSERY	0	1	1			43. 00
50. 00	ANCILLARY SERVICE COST CENTERS O5000 OPERATING ROOM	22, 325	22, 325	22, 325	92, 616	22, 325	50. 00
51. 00	05100 RECOVERY ROOM	8, 953	1				51. 00
52.00	O5200 DELIVERY ROOM & LABOR ROOM O5300 ANESTHESI OLOGY	1 271	0	· -		0	52.00
53. 00 54. 00	05400 RADI OLOGY	1, 271 18, 432	1, 271 18, 432			1, 271 18, 432	53. 00 54. 00
54. 01	05401 RADI OLOGY - I -65	0	0	0	20, 916	0	54. 01
54. 02 54. 03	05402 RADI OLOGY DI AGNOSTI C - SJ 05403 LOWELL RADI OLOGY	0	0	0		0 0	54. 02 54. 03
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0	0	_	0	55. 00
55. 01 55. 02	O5501 CARDI AC CATHERI ZATON LAB O3140 CARDI OLOGY	5, 730 0	5, 730 0	5, 730 0		5, 730 0	55. 01 55. 02
55. 03	03450 NEURO-DI AGNOSTI CS	1, 675	l	1, 675	6, 786	1, 675	55. 03
60. 00 60. 01	06000 LABORATORY 06001 BLOOD LABORATORY	8, 875	8, 875 0			8, 875 0	60. 00 60. 01
65. 00	06500 RESPIRATORY THERAPY	1, 006	1			1, 006	
66. 00 66. 01	O6600 PHYSI CAL THERAPY O6601 PHYSI CAL THERAPY I -65	3, 364	3, 364	3, 364	24, 717	3, 364 0	66. 00 66. 01
66. 02	06602 PHYSI CAL THERAPY ST JOHN	0	0	0	0	0	66. 02
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	0	0	0	67. 00
67. 01 67. 02	O6701 OCCUPATION THERAPY I -65 O6702 OCCUPATIONAL THERAPY ST. JOHN	0		0	0	0	67. 01 67. 02
68. 00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68. 00
68. 01 68. 02	06801 SPEECH PATHOLOGY I -65 06802 SPEECH THERAPY ST. JOHN	0		0		0	68. 01 68. 02
69. 00	06900 ELECTROCARDI OLOGY	91	91	91		91	69. 00
71. 00 72. 00	O7100 MEDICAL SUPPLIES CHARGED TO PATIENT O7200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	_	0 0	71. 00 72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	Ö			0	73. 00
74. 00 76. 00	07400 RENAL DI ALYSI S 03020 RADI ATI ON ONCOLOGY	516	516 0	1		516 0	74. 00 76. 00
76. 01	03040 ANGI OCARDI OGRAPHY	0	ő	Ö		0	76. 01
77. 00 78. 00	07700 ALLOGENEI C HSCT ACQUISITION	0	0	0		0	77. 00
10.UU	07800 CAR T-CELL IMMUNOTHERAPY OUTPATIENT SERVICE COST CENTERS					0	78. 00
90.00	09000 CLINIC	0	0			0	90.00
90. 01 90. 02	O9001 DI ABETES CLINI C O9002 OUTPATI ENT CLINI CS	0		0	0	0	90. 01 90. 02
90. 03	09003 OCCUPATIONAL MEDICINE CLINIC	0	0	0	0	0	90. 03
90. 04 90. 05	09004 NEONATOLOGY CLINIC-FRANCISCAN POINT 09005 LACTATION CLINIC	0	0	0		0	90. 04 90. 05
91. 00	09100 EMERGENCY	17, 952	17, 952			17, 952	91. 00
91. 01 91. 02	09101 EMERGENCY ROOM PHYSI CANS 09102 EXPRESS CARE	0	0	0	0	0	91. 01 91. 02
	1 1	<u> </u>	·		<u> </u>		

Health Financial Systems	FRANCISCAN HEALTH CROWN POINT	In Lieu of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS	Provi der CCN: 15-0126	Peri od: Worksheet B-1 From 01/01/2023 To 12/31/2023 Date/Ti me Prepared:

COST ALLOCATION - STATISTICAL BASIS		Provider CO	F T	eriod: rom 01/01/2023 o 12/31/2023	Worksheet B-1 Date/Time Pre 5/30/2024 10:	pared:
Cost Center Description	MAINTENANCE &	OPERATION OF	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
	REPAI RS	PLANT	PLANT - FP	LINEN SERVICE	(SQUARE FEET)	
	(SQUARE FEET)	(SQUARE FEET)	(ASSI GNED	(POUNDS OF		
			TIME)	LAUNDRY)		
	6. 00	7. 00	7. 01	8. 00	9. 00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
OTHER REIMBURSABLE COST CENTERS						
102.00 10200 OPIOLD TREATMENT PROGRAM	0	0	0	0	0	102. 00
SPECIAL PURPOSE COST CENTERS						
113. 00 11300 I NTEREST EXPENSE						113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	323, 820	241, 193	241, 193	818, 172	231, 867	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	6, 878	0	0	192. 00
194. 00 07950 FHC	0	0	0	0	0	194. 00
194. 01 07951 CONVENT	0	0	0	o	0	194. 01
194.02 07952 OTHER NON REIMB - BUILDINGS	0	0	28, 926	o	0	194. 02
194.03 07953 OTHR NON REIM-FHC BEHAVORIAL HEALTH	0	0	1, 286	o	0	194. 03
194. 04 07954 CENTER OF HOPE	0	0	0	0	0	194. 04
194. 05 07955 LAKESHORE JOINT VENTURE	0	0	0	0		194. 05
194. 06 07957 COVID VACCINE CLINIC	0	0	0	0		194. 06
200.00 Cross Foot Adjustments		_	_			200. 00
201.00 Negative Cost Centers						201. 00
202.00 Cost to be allocated (per Wkst. B, Part	4, 190, 052	18, 095, 289	1, 311, 350	2, 685, 911	4, 573, 309	
1)	17 1707 002	.0,0,0,20,	1,011,000	2,000,7.1	1,0,0,00,	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	12, 939448	75. 024105	4. 712289	3. 282820	19. 723846	203 00
204.00 Cost to be allocated (per Wkst. B, Part						
[1])	, , , , ,	0,001,000	0.72.0	00777.10	020, 0.0	201100
205.00 Unit cost multiplier (Wkst. B, Part II)	0. 364150	14. 032551	0. 123069	0. 415216	1. 403145	205. 00
206.00 NAHE adjustment amount to be allocated						206. 00
(per Wkst. B-2)						
207.00 NAHE unit cost multiplier (Wkst. D,						207. 00
Parts III and IV)						

	Financial Systems	FRANCI SCAN HEALT		N. 15 0124 F		u of Form CMS-2	2552-10
COST	ALLOCATION - STATISTICAL BASIS		Provi der CC	F	Period: From 01/01/2023	Worksheet B-1	
				Т	o 12/31/2023	Date/Time Pre 5/30/2024 10:	
	Cost Center Description	ENVI RONMENTAL	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	oo aiii
		SERVICES - FP	(PATLENT ME	(FTE' S)	ADMI NI STRATI ON	SERVICES &	
		(ASSI GNED TIME)	ALS)		(DIRECT NRSING HRS)	SUPPLY (COSTED	
		IT WIL)			11(3)	REQUIS.)	
		9. 01	10.00	11. 00	13.00	14. 00	
1. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT	1 1	ı				1.00
2.00	00200 CAP REL COSTS-BLDG & FTXT						2.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMINISTRATIVE & GENERAL						5. 00
6. 00 7. 00	00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT						6. 00 7. 00
7. 01	00700 OPERATION OF PLANT - FP						7. 00
8.00	00800 LAUNDRY & LINEN SERVICE						8. 00
9.00	00900 HOUSEKEEPI NG	2/0 057					9. 00
9. 01 10. 00	O1851 ENVI RONMENTAL SERVI CES - FP O1000 DI ETARY	268, 957 16, 752	167, 811				9. 01 10. 00
11. 00	01100 CAFETERI A	0	107, 011	1, 404, 900			11. 00
13.00	01300 NURSI NG ADMI NI STRATI ON	17, 930	0	59, 487	571, 517		13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	13, 561	0	14, 385		31, 274, 980	14. 00
15. 00 16. 00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	1, 746 1, 676	0	48, 907 12, 677		13, 558 1, 419	15. 00 16. 00
17. 00	01700 SOCIAL SERVICE	3, 858	o	38, 356		1, 754	17. 00
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRV	0	О	. (o	0	21. 00
22. 00	02200 I &R SERVI CES-OTHER PRGM COSTS APPRV	0	0	(0	0	22. 00
23. 00 23. 01	02300 PARAMED ED PRGM- (SPECIFY) 02301 ECHOCARDI OLOGY EDUCATION PROGRAM	0	0	10, 712 1, 389		27, 891 232	23. 00 23. 01
23. 01	I NPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>	<u> </u>	1, 30	<u>/I </u>	232	25.01
30.00	03000 ADULTS & PEDIATRICS	50, 049	134, 845	455, 678		84, 089	30. 00
31.00	03100 INTENSIVE CARE UNIT	10, 342	16, 182	76, 688		14, 420	31.00
35. 00 41. 00	02060 NEONATAL INTENSIVE CARE UNIT 04100 SUBPROVIDER - IRF	12, 993 12, 770	16, 784	55, 121 42, 769		9, 115 5, 979	35. 00 41. 00
43. 00	04300 NURSERY	0	0, 704	42, 707		0,777	43. 00
	ANCILLARY SERVICE COST CENTERS						
50. 00 51. 00	05000 OPERATING ROOM 05100 RECOVERY ROOM	22, 325 8, 953	0	113, 429		197, 846 1, 890	50. 00 51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0, 953	0	675	1	1, 690	52.00
53. 00	05300 ANESTHESI OLOGY	1, 271	Ö	2, 911		1, 816	53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	18, 432	0	105, 137		40, 267	54. 00
54. 01 54. 02	05401 RADI OLOGY - I - 65 05402 RADI OLOGY DI AGNOSTI C - SJ	0	0	10, 237 (2, 035 0	54. 01 54. 02
54. 02	05403 LOWELL RADI OLOGY	0	o	66	-	0	54. 02
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	О	(0	55. 00
55. 01	05501 CARDI AC CATHERI ZATON LAB	5, 730	0	22, 455		88, 426	55. 01
55. 02 55. 03	03140 CARDI OLOGY 03450 NEURO - DI AGNOSTI CS	0 1, 675	0	24, 005 13, 45 <i>6</i>		8, 558 6, 833	55. 02 55. 03
	06000 LABORATORY	8, 875	o	13, 430		1, 074	
60. 01	06001 BLOOD LABORATORY	0	o	C	0	0	60. 01
65. 00	06500 RESPI RATORY THERAPY	1, 006	0	35, 886		1, 726	65.00
66. 00 66. 01	06600 PHYSI CAL THERAPY 06601 PHYSI CAL THERAPY I -65	3, 364	0	18, 222 14, 154		580 2, 614	66. 00 66. 01
66. 02	1	o	o	3, 754		872	66. 02
67. 00	06700 OCCUPATI ONAL THERAPY	0	О	11, 322		300	67. 00
67. 01	06701 OCCUPATION THERAPY I -65	0	0	1, 576		0	67. 01
67. 02 68. 00	06702 OCCUPATIONAL THERAPY ST. JOHN 06800 SPEECH PATHOLOGY	0	0	215 6, 53 <i>6</i>		0 23	67. 02 68. 00
68. 01	06801 SPEECH PATHOLOGY I -65	Ö	o	5, 926		0	68. 01
68. 02	06802 SPEECH THERAPY ST. JOHN	0	o	C	0	0	68. 02
69.00		91	0	11, 046	5, 751	3, 240	69.00
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	(20, 611, 673 10, 067, 110	71. 00 72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	Ö	o	C		0	73. 00
74. 00	07400 RENAL DIALYSIS	516	o	C	0	0	74. 00
76. 00		0	0	7, 178		3, 004	76.00
76. 01 77. 00	03040 ANGI OCARDI OGRAPHY 07700 ALLOGENEI C HSCT ACQUI SITION	0	0	4, 377 (1, 926 0	76. 01 77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0	Ö	Č	1	0	78. 00
0-	OUTPATIENT SERVICE COST CENTERS						
90. 00 90. 01	09000	0	0	(0	90. 00 90. 01
90. 01	09001 DI ABETES CLINIC	0	0	(0	90.01
90. 03	09003 OCCUPATIONAL MEDICINE CLINIC	o	ő	C		0	90. 03
90. 04	09004 NEONATOLOGY CLINIC-FRANCISCAN POINT	0	o	318		279	90. 04
90. 05 91. 00	09005 LACTATION CLINIC 09100 EMERGENCY	0 17, 952	0	670 107, 119		0 30, 193	90. 05 91. 00
91.00	1 1	17, 952	o	107, 119		30, 193	91.00
	•	· '			'		

Heal th Finan		RANCISCAN HEALT				u of Form CMS-	
COST ALLOCATION - STATISTICAL BASIS			Provi der CC		eriod: rom 01/01/2023	Worksheet B-1	
					o 12/31/2023	Date/Time Pre 5/30/2024 10:	pared: 06 am_
	Cost Center Description	ENVIRONMENTAL SERVICES - FP	DI ETARY (PATI ENT ME	CAFETERI A (FTE' S)	NURSI NG ADMI NI STRATI ON	CENTRAL SERVICES &	
		(ASSI GNED	ALS)	(112 3)	(DIRECT NRSING	SUPPLY	
		TIME)	ALS)		HRS)	(COSTED	
						REQUIS.)	
		9. 01	10.00	11. 00	13.00	14. 00	
	EXPRESS CARE	0	0	C	0	0	1 / 02
	OBSERVATION BEDS (NON-DISTINCT PART						92. 00
	REIMBURSABLE COST CENTERS	1			T. T.		
	OPLOID TREATMENT PROGRAM	0	0	C	0	0	102. 00
	AL PURPOSE COST CENTERS						112 00
1	INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1 through 117)	231, 867	167, 811	1, 336, 844	557, 143	31, 230, 824	113.00
	IMBURSABLE COST CENTERS	231, 007	107, 611	1, 330, 644	337, 143	31, 230, 624	1110.00
	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0		O	0	190. 00
	PHYSICIANS' PRIVATE OFFICES	6, 878	Ö	32, 922	0		192. 00
194. 00 07950		0	O	0	0		194. 00
194. 01 07951	CONVENT	0	0	C	0	0	194. 01
194. 02 07952	OTHER NON REIMB - BUILDINGS	28, 926	0	C	0	29	194. 02
194.03 07953 OTHR NON REIM-FHC BEHAVORIAL HEALTH		1, 286	0	C	0	0	194. 03
194.04 07954 CENTER OF HOPE		0	0	1, 964			194. 04
	LAKESHORE JOINT VENTURE	0	0	33, 170	14, 249		194. 05
	COVID VACCINE CLINIC	0	0	C	0	0	194. 06
200. 00	Cross Foot Adjustments						200. 00
201. 00	Negative Cost Centers	400.004		4 470 //0	0.040.400		201. 00
202.00	Cost to be allocated (per Wkst. B, Part I)	193, 834	4, 576, 372	1, 478, 669	8, 348, 138	2, 088, 171	202. 00
203. 00	Unit cost multiplier (Wkst. B, Part I)	0. 720688	27. 270989	1. 052508	14. 606981	0. 066768	203.00
204. 00	Cost to be allocated (per Wkst. B, Part	3, 901	1, 036, 447	29, 848	1, 352, 270	855, 347	204. 00
	1115						I

0. 014504

0. 023554 205. 00 206. 00

207. 00

0. 021246

2. 366106

6. 176276

11)

205.00

206. 00 207. 00 Unit cost multiplier (Wkst. B, Part II)
NAHE adjustment amount to be allocated
(per Wkst. B-2)
NAHE unit cost multiplier (Wkst. D,
Parts III and IV)

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0126

Peri od: Worksheet B-1 From 01/01/2023 To 12/31/2023 Date/Ti me Prepared:

5/30/2024 10:06 am INTERNS & RESIDENTS **PHARMACY** MEDI CAL SOCI AL SERVI CE SERVI CES-SALAR SERVI CES-OTHER Cost Center Description (GROSS CHAR Y & FRINGES (COSTED RECORDS & PRGM COSTS REQUIS.) LI BRARY **APPRV APPRV** GES) (GROSS CHAR (ASSI GNED (ASSI GNED GES) TIME) TIME) 15. 00 17.00 16. 00 21. 00 22. 00 GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS-BLDG & FLXT 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00500 ADMINISTRATIVE & GENERAL 5 00 5 00 6.00 00600 MAINTENANCE & REPAIRS 6.00 7.00 00700 OPERATION OF PLANT 7.00 00701 OPERATION OF PLANT - FP 7.01 7.01 00800 LAUNDRY & LINEN SERVICE 8 00 8 00 9.00 00900 HOUSEKEEPI NG 9.00 01851 ENVIRONMENTAL SERVICES - FP 9.01 9.01 01000 DI ETARY 10.00 10.00 11.00 01100 CAFETERI A 11.00 13.00 01300 NURSING ADMINISTRATION 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 14.00 01500 PHARMACY 15.00 15.00 100 01600 MEDICAL RECORDS & LIBRARY 16.00 1, 197, 627, 882 16.00 17.00 01700 SOCIAL SERVICE 1, 197, 627, 882 17.00 21.00 02100 I&R SERVICES-SALARY & FRINGES APPRV 0 100 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 22.00 0 100 22.00 0 0 02300 PARAMED ED PRGM-(SPECIFY) 0 0 23.00 C 23.00 02301 ECHOCARDI OLOGY EDUCATI ON PROGRAM 0 23.01 23.01 INPATIENT ROUTINE SERVICE COST CENTERS 30 00 03000 ADULTS & PEDIATRICS 30.00 0 66, 367, 751 66, 367, 751 0 0 0 31.00 03100 INTENSIVE CARE UNIT 0 14, 635, 935 14, 635, 935 0 31.00 02060 NEONATAL INTENSIVE CARE UNIT 0 21, 577, 991 21, 577, 991 0 35.00 35.00 0 o 41.00 04100 SUBPROVIDER - IRF 6.573.261 6, 573, 261 0 41.00 04300 NURSERY 43.00 3, 946, 546 3, 946, 546 0 0 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 142, 744, 483 142, 744, 483 0 0 50.00 0 0 05100 RECOVERY ROOM 21, 679, 290 21, 679. 290 51 00 0 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 6, 988, 298 6, 988, 298 0 52.00 05300 ANESTHESI OLOGY 27, 275, 880 53.00 0 0 27, 275, 880 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 232, 172, 476 232, 172, 476 54.00 0 54.00 05401 RADI OLOGY - 1-65 54.01 24, 717, 168 24, 717, 168 0 54.01 0 54.02 05402 RADIOLOGY DIAGNOSTIC - SJ 0 54.02 54.03 05403 LOWELL RADIOLOGY 0 0 0 36, 824 36, 824 0 54.03 05500 RADI OLOGY-THERAPEUTI C 55 00 0 55 00 05501 CARDI AC CATHERI ZATON LAB 49, 459, 743 49, 459, 743 55.01 0 55.01 55.02 03140 CARDI OLOGY 33, 919, 362 33, 919, 362 0 55.02 55.03 03450 NEURO-DI AGNOSTI CS 0 0 10, 112, 496 10, 112, 496 0 55.03 06000 LABORATORY 180, 178, 953 60 00 180, 178, 953 60 00 0 60.01 06001 BLOOD LABORATORY 0 60.01 06500 RESPIRATORY THERAPY 0000 19, 657, 993 19, 657, 993 65.00 65.00 0 66.00 06600 PHYSI CAL THERAPY 4, 398, 506 4, 398, 506 0 66, 00 4, 004, 113 4, 004, 113 06601 PHYSI CAL THERAPY I -65 66.01 0 66.01 66.02 06602 PHYSI CAL THERAPY ST JOHN 1, 275, 061 1, 275, 061 0 66.02 06700 OCCUPATIONAL THERAPY 4, 591, 392 4, 591, 392 67.00 67.00 06701 OCCUPATION THERAPY I-65 00000 454, 988 67.01 454, 988 0 67.01 06702 OCCUPATIONAL THERAPY ST. JOHN 82, 240 82, 240 67.02 0 67.02 68.00 06800 SPEECH PATHOLOGY 4, 016, 943 4, 016, 943 0 68.00 06801 SPEECH PATHOLOGY I -65 68.01 2, 542, 739 2, 542, 739 0 68 01 06802 SPEECH THERAPY ST. JOHN 68 02 0 68 02 0 69.00 06900 ELECTROCARDI OLOGY 3, 164, 363 3, 164, 363 0 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 48, 784, 521 48, 784, 521 71.00 71.00 0 07200 IMPL. DEV. CHARGED TO PATIENTS 46, 259, 532 46, 259, 532 72.00 0 72.00 62, 950, 139 07300 DRUGS CHARGED TO PATIENTS 100 62, 950, 139 73.00 0 73.00 74.00 07400 RENAL DIALYSIS 0 1, 272, 481 1, 272, 481 0 74.00 03020 RADIATION ONCOLOGY 0 76 00 16, 558, 543 16, 558, 543 0 76.00 0 03040 ANGI OCARDI OGRAPHY 1, 152, 047 1, 152, 047 76.01 0 76.01 07700 ALLOGENEIC HSCT ACQUISITION 0 77.00 C 0 77 00 07800 CAR T-CELL IMMUNOTHERAPY 78.00 78.00 0 OUTPATIENT SERVICE COST CENTERS 90.00 00 09000 CLI NI C 0 0 90.00 0 90.01 09001 DIABETES CLINIC C 0 0 90.01 90.02 09002 OUTPATIENT CLINICS 0 0 0 0 0 90.02 09003 OCCUPATIONAL MEDICINE CLINIC 90.03 90.03 0 0 09004 NEONATOLOGY CLINIC-FRANCISCAN POINT 90 04 90 04 87, 567 87.567 0 90.05 09005 LACTATION CLINIC 20, 350 20, 350 0 90.05

			To	12/31/2023	Date/Time Pre 5/30/2024 10:	
		'		INTERNS &		- Cam
Cost Conton Decement on	PHARMACY	MEDICAL	SOCIAL SERVICE	CEDVICES CALAD	CEDVI CEC OTHER	
Cost Center Description	(COSTED	MEDI CAL RECORDS &	(GROSS CHAR	Y & FRINGES	PRGM COSTS	
	REQUIS.)	LI BRARY	GES)	APPRV	APPRV	
	ĺ	(GROSS CHAR	ĺ	(ASSI GNED	(ASSI GNED	
		GES)		TIME)	TIME)	
	15. 00	16. 00	17. 00	21. 00	22. 00	
91. 00 09100 EMERGENCY	0	133, 967, 907	133, 967, 907	100	100	
91. 01 09101 EMERGENCY ROOM PHYSI CANS	0	0	0	0	0	
91. 02 09102 EXPRESS CARE 92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART	o	0	0	O	0	91. 02 92. 00
OTHER REIMBURSABLE COST CENTERS						92.00
102. OO 10200 OPI OI D TREATMENT PROGRAM	0	0	0	ol	0	102. 00
SPECIAL PURPOSE COST CENTERS	<u> </u>		0	<u> </u>		102.00
113. 00 11300 NTEREST EXPENSE						113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	100	1, 197, 627, 882	1, 197, 627, 882	100	100	118. 00
NONREI MBURSABLE COST CENTERS	<u>'</u>			<u> </u>		1
190.00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0		190. 00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	0		192. 00
194. 00 07950 FHC	0	0	0	0		194. 00
194. 01 07951 CONVENT	0	0	0	0		194. 01
194. 02 07952 OTHER NON REIMB - BUILDINGS	0	0	0	0		194. 02
194. 03 07953 OTHR NON REIM-FHC BEHAVORIAL HEALTH	0	0	0	0		194. 03
194. 04 07954 CENTER OF HOPE 194. 05 07955 LAKESHORE JOINT VENTURE	O O	0	0	0		194. 04 194. 05
194.06 07957 COVID VACCINE CLINIC	0	0	0	0		194. 05
200.00 Cross Foot Adjustments	٥	0		٩	U	200. 00
201.00 Negative Cost Centers						201.00
202.00 Cost to be allocated (per Wkst. B, Part	5, 730, 707	4, 006, 688	4, 127, 165	3	3	202.00
1)	2,.22,.21	.,,	1, 121, 133	آ	_	
203.00 Unit cost multiplier (Wkst. B, Part I)	57, 307. 070000	0. 003346	0. 003446	0. 030000	0. 030000	203. 00
204.00 Cost to be allocated (per Wkst. B, Part	209, 340	161, 182	272, 281	0	0	204. 00
205.00 Unit cost multiplier (Wkst. B, Part II)	2, 093. 400000	0. 000135	0. 000227	0. 000000	0. 000000	
206.00 NAHE adjustment amount to be allocated						206. 00
(per Wkst. B-2)						207. 00
207.00 NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00
	I		1	ı		I

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS In Lieu of Form CMS-2552-10
Worksheet B-1 FRANCISCAN HEALTH CROWN POINT Peri od: From 01/01/2023 To 12/31/2023 Date/Ti me Prepared: 5/30/2024 10:06 am Provider CCN: 15-0126

				5/30/2024 10): 06 am_
	Cost Center Description		ECHOCARDI OLOGY		
		PRGM	EDUCATI ON		
		(ASSIGNED TIME)	PROGRAM (ASSI GNED		
		I I WL)	TIME)		
		23. 00	23. 01		
	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 5. 00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL				4.00
6. 00	00600 MAINTENANCE & REPAIRS				5. 00 6. 00
7. 00	00700 OPERATION OF PLANT				7. 00
7. 01	00701 OPERATION OF PLANT - FP				7. 01
8.00	00800 LAUNDRY & LINEN SERVICE				8. 00
9.00	00900 HOUSEKEEPI NG				9. 00
9. 01	01851 ENVI RONMENTAL SERVI CES - FP				9. 01
10.00	01000 DI ETARY				10.00
11.00	01100 CAFETERI A				11.00
13. 00 14. 00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY				13. 00 14. 00
15. 00	01500 PHARMACY				15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY				16. 00
17. 00	01700 SOCIAL SERVICE				17. 00
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRV				21. 00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV				22. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	100			23. 00
23. 01	02301 ECHOCARDI OLOGY EDUCATI ON PROGRAM		100		23. 01
30. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	O	0		30.00
31. 00	03100 INTENSIVE CARE UNIT		0		31.00
35. 00	02060 NEONATAL INTENSIVE CARE UNIT		0		35. 00
41. 00	04100 SUBPROVI DER – I RF	O	o		41. 00
43.00	04300 NURSERY	0	0		43. 00
	ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATI NG ROOM	0	0		50.00
51.00	05100 RECOVERY ROOM	0	0		51.00
52. 00 53. 00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY	0	0		52. 00 53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C		0		54. 00
54. 01	05401 RADI OLOGY - I -65		0		54. 01
54. 02	05402 RADIOLOGY DIAGNOSTIC - SJ	0	0		54. 02
54. 03	05403 LOWELL RADI OLOGY	0	0		54. 03
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0		55. 00
55. 01	05501 CARDI AC CATHERI ZATON LAB	0	0		55. 01
55. 02	03140 CARDI OLOGY 03450 NEURO-DI AGNOSTI CS	0	0		55. 02
55. 03 60. 00	06000 LABORATORY	0	0		55. 03 60. 00
60. 01	06001 BLOOD LABORATORY		0		60. 01
65. 00	06500 RESPI RATORY THERAPY	o	Ö		65. 00
66. 00	06600 PHYSI CAL THERAPY	o	0		66. 00
66. 01	06601 PHYSI CAL THERAPY I -65	0	0		66. 01
66. 02	06602 PHYSI CAL THERAPY ST JOHN	0	0		66. 02
67. 00	06700 OCCUPATIONAL THERAPY	0	0		67. 00
67. 01 67. 02	06701 OCCUPATION THERAPY I -65 06702 OCCUPATIONAL THERAPY ST. JOHN	0	O O		67. 01 67. 02
68. 00	06800 SPEECH PATHOLOGY		0		68. 00
68. 01	06801 SPEECH PATHOLOGY I -65	o	o		68. 01
68. 02	06802 SPEECH THERAPY ST. JOHN	o	0		68. 02
69. 00	06900 ELECTROCARDI OLOGY	0	100		69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73. 00 74. 00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	0	0		73.00
76. 00	03020 RADI ATI ON ONCOLOGY		0		74. 00 76. 00
76. 01	03040 ANGI OCARDI OGRAPHY		o		76. 00
77. 00	07700 ALLOGENEIC HSCT ACQUISITION		Ö		77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0	0		78. 00
_	OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0	0		90.00
90. 01	09001 DI ABETES CLINI C	0	0		90. 01
90. 02 90. 03	O9002 OUTPATIENT CLINICS O9003 OCCUPATIONAL MEDICINE CLINIC		0		90. 02 90. 03
90. 03	09004 NEONATOLOGY CLINIC-FRANCISCAN POINT		0		90.03
90. 05	09005 LACTATION CLINIC		ol		90. 05
91. 00	09100 EMERGENCY	100	ō		91. 00
91. 01	09101 EMERGENCY ROOM PHYSI CANS	0	o		91. 01

From 01/01/2023 To 12/31/2023 Date/Time Prepared: 5/30/2024 10:06 am ECHOCARDI OLOGY Cost Center Description PARAMED ED PRGM **EDUCATION** (ASSI GNED PROGRAM (ASSI GNED TIME) TIME) 23.00 23.01 91. 02 09102 EXPRESS CARE 0 91.02 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 0 102.00 10200 OPI OI D TREATMENT PROGRAM 0 102.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 I NTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1 through 117) 100 118.00 100 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN 190. 00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 0 0 0 0 192. 00 194. 00 07950 FHC 0 194. 00 194. 01 07951 CONVENT 0 194. 01 194. 02 07952 OTHER NON REIMB - BUILDINGS 0 194. 02 194. 03 07953 OTHR NON REIM-FHC BEHAVORIAL HEALTH 0 194. 03 194. 04 194. 04 07954 CENTER OF HOPE 0 194. 05 07955 LAKESHORE JOINT VENTURE 0 0 194. 05 194.06 07957 COVID VACCINE CLINIC 194. 06 200.00 Cross Foot Adjustments 200. 00 201.00 Negative Cost Centers 201.00 202.00 Cost to be allocated (per Wkst. B, Part 889, 030 167, 009 202. 00 1) 203.00 Unit cost multiplier (Wkst. B, Part I) 1, 670. 090000 8, 890. 300000 203. 00 204.00 Cost to be allocated (per Wkst. B, Part 51, 190 23, 828 204.00 H) 205.00 Unit cost multiplier (Wkst. B, Part II) 511. 900000 205. 00 238. 280000 206.00 NAHE adjustment amount to be allocated 206. 00 (per Wkst. B-2)

0.000000

0.000000

207.00

207.00

NAHE unit cost multiplier (Wkst. D,

Parts III and IV)

COMITO	ATTON OF NATIO OF COSTS TO CHANGES		Trovider co	F	rom 01/01/2023 o 12/31/2023	Part I Date/Time Pre	pared:
			Ti +l o	XVIII	Hospi tal	5/30/2024 10:0 PPS	06 am_
			II ti e	AVIII	Hospital Costs	PPS	
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	p	(from Wkst. B,	Adj .		Di sal I owance		
		Part I, col.					
		26)	2. 00	2.00	4.00	F 00	
	INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	3.00	4. 00	5. 00	
30. 00	03000 ADULTS & PEDI ATRI CS	48, 258, 042		48, 258, 042	. 0	48, 258, 042	30. 00
31.00	03100 INTENSIVE CARE UNIT	10, 883, 196		10, 883, 196		10, 883, 196	31.00
	02060 NEONATAL INTENSIVE CARE UNIT	7, 050, 728		7, 050, 728	0	7, 050, 728	35.00
	04100 SUBPROVI DER - I RF	6, 617, 339		6, 617, 339		6, 617, 339	41. 00
43.00	04300 NURSERY ANCI LLARY SERVICE COST CENTERS	3, 053, 960		3, 053, 960	0	3, 053, 960	43. 00
50 00	05000 OPERATING ROOM	24, 058, 921		24, 058, 921	0	24, 058, 921	50. 00
	05100 RECOVERY ROOM	1, 603, 857		1, 603, 857		1, 603, 857	51. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	3, 574, 679		3, 574, 679		3, 574, 679	52.00
	05300 ANESTHESI OLOGY	765, 433		765, 433		765, 433	53.00
54.00	05400 RADI OLOGY - DI AGNOSTI C	19, 104, 288		19, 104, 288		19, 104, 288	54.00
	05401 RADI OLOGY - 1 - 65	1, 449, 687		1, 449, 687	0	1, 449, 687	54. 01
	05402 RADI OLOGY DI AGNOSTI C - SJ 05403 LOWELL RADI OLOGY	20, 713		20, 713	0	0 20, 713	54. 02 54. 03
	05500 RADI OLOGY-THERAPEUTI C	20,710		20, 710	Ö	20, 710	55. 00
55. 01	05501 CARDI AC CATHERI ZATON LAB	6, 348, 003		6, 348, 003	0	6, 348, 003	55. 01
55. 02	03140 CARDI OLOGY	2, 809, 822		2, 809, 822	. 0	2, 809, 822	55. 02
55. 03	03450 NEURO-DI AGNOSTI CS	1, 328, 146		1, 328, 146		1, 328, 146	55. 03
	06000 LABORATORY	21, 156, 982		21, 156, 982	0	21, 156, 982	60.00
60. 01	06001 BLOOD LABORATORY 06500 RESPIRATORY THERAPY	3, 726, 130	0	3, 726, 130	0	0 3, 726, 130	60. 01 65. 00
66. 00	06600 PHYSI CAL THERAPY	2, 353, 963	0	2, 353, 963		2, 353, 963	66. 00
66. 01	06601 PHYSI CAL THERAPY I -65	1, 459, 197	0	1, 459, 197		1, 459, 197	66. 01
	06602 PHYSI CAL THERAPY ST JOHN	379, 186	0	379, 186		379, 186	66. 02
67. 00	06700 OCCUPATI ONAL THERAPY	1, 061, 980	0	1, 061, 980		1, 061, 980	67. 00
67. 01	06701 OCCUPATION THERAPY I -65	175, 274	0	175, 274		175, 274	67. 01
67. 02 68. 00	06702 OCCUPATIONAL THERAPY ST. JOHN 06800 SPEECH PATHOLOGY	18, 609	0	18, 609		18, 609	67. 02 68. 00
68. 01	06801 SPEECH PATHOLOGY I -65	664, 400 556, 468	0	664, 400 556, 468		664, 400 556, 468	68. 01
	06802 SPEECH THERAPY ST. JOHN	0	0	000, 100	o o	0	68. 02
	06900 ELECTROCARDI OLOGY	1, 255, 215		1, 255, 215	0	1, 255, 215	69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	28, 285, 626		28, 285, 626		28, 285, 626	71. 00
	07200 I MPL. DEV. CHARGED TO PATIENTS	14, 654, 760		14, 654, 760		14, 654, 760	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	15, 023, 002 720, 223		15, 023, 002 720, 223		15, 023, 002 720, 223	73. 00 74. 00
76.00	03020 RADI ATI ON ONCOLOGY	1, 618, 328		1, 618, 328		1, 618, 328	74. 00 76. 00
	03040 ANGI OCARDI OGRAPHY	430, 266		430, 266		430, 266	76. 01
	07700 ALLOGENEIC HSCT ACQUISITION	0		· c		0	77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0		C	0	0	78. 00
00.00	OUTPATIENT SERVICE COST CENTERS					0	00.00
	O9000 CLINIC O9001 DIABETES CLINIC	0		0	0	0	90. 00 90. 01
	09002 OUTPATIENT CLINICS	1, 263		1, 263	0		90.01
	09003 OCCUPATIONAL MEDICINE CLINIC	0		0,7200	0	0	90. 03
90. 04	09004 NEONATOLOGY CLINIC-FRANCISCAN POINT	30, 663		30, 663	0	30, 663	90. 04
	09005 LACTATION CLINIC	49, 851		49, 851		49, 851	90. 05
	09100 EMERGENCY	14, 680, 859		14, 680, 859	0	14, 680, 859	91.00
	O9101 EMERGENCY ROOM PHYSICANS O9102 EXPRESS CARE	0			0	0	91. 01 91. 02
	09200 OBSERVATION BEDS (NON-DISTINCT PART	5, 948, 418		5, 948, 418		5, 948, 418	92.00
,2.00	OTHER REIMBURSABLE COST CENTERS	5, 740, 410		5, 770, 410		5, 740, 410	,2.00
102.00	10200 OPI OI D TREATMENT PROGRAM	0		C		0	102. 00
	SPECIAL PURPOSE COST CENTERS				1		
113. 00 200. 00	11300 INTEREST EXPENSE	251 177 477	^	051 177 477			113.00
200.00	,	251, 177, 477 5, 948, 418	0	251, 177, 477 5, 948, 418		251, 177, 477 5, 948, 418	
202.00		245, 229, 059	0			245, 229, 059	
		· '		-		· ·	

COMPUTATI ON	OF RATIO OF COSTS TO CHARGES		Provider Co		Period: From 01/01/2023 To 12/31/2023	Worksheet C Part I Date/Time Pre 5/30/2024 10:	pared: 06 am
		_		XVIII	Hospi tal	PPS	
	Cost Center Description	I npati ent	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA I npati ent Rati o	
		6.00	7. 00	8. 00	9. 00	10.00	
I NPAT	IENT ROUTINE SERVICE COST CENTERS						
	ADULTS & PEDIATRICS	55, 469, 013		55, 469, 01	1	ı	30.00
	INTENSIVE CARE UNIT	14, 635, 935		14, 635, 93		i	31. 00
	NEONATAL INTENSIVE CARE UNIT	21, 577, 991		21, 577, 99		ı	35. 00
	SUBPROVIDER - IRF	6, 573, 261		6, 573, 26		ı	41. 00
	NURSERY LARY SERVICE COST CENTERS	3, 946, 546		3, 946, 54	0		43. 00
	OPERATI NG ROOM	53, 596, 594	89, 147, 889	142, 744, 48	0. 168545	0. 000000	50.00
	RECOVERY ROOM	6, 404, 771	15, 274, 519			0. 000000	
	DELIVERY ROOM & LABOR ROOM	6, 918, 154	70, 144			0.000000	
53.00 05300	ANESTHESI OLOGY	8, 574, 451	18, 701, 429	27, 275, 880	0. 028063	0.000000	53. 00
54.00 05400	RADI OLOGY-DI AGNOSTI C	62, 781, 033	169, 391, 443	232, 172, 47	0. 082285	0. 000000	54. 00
	RADI OLOGY - I -65	112, 824	24, 604, 344	24, 717, 16		0. 000000	
	RADIOLOGY DIAGNOSTIC - SJ	0	0	(0.000000	0. 000000	
	LOWELL RADI OLOGY	0	36, 824	36, 82		0. 000000	1
	RADI OLOGY-THERAPEUTI C	21 220 010	00 221 724	40 450 74	0.000000	0.000000	
	CARDI AC CATHERI ZATON LAB CARDI OLOGY	21, 228, 019 11, 683, 453	28, 231, 724 22, 235, 909			0. 000000 0. 000000	1
	NEURO-DI AGNOSTI CS	1, 528, 208	8, 584, 288		1	0.000000	
	LABORATORY	64, 612, 743	115, 566, 210		1	0. 000000	
	BLOOD LABORATORY	01,012,710	0 110,000,210		0.000000	0. 000000	
	RESPI RATORY THERAPY	15, 391, 553	4, 266, 440	19, 657, 99		0. 000000	1
	PHYSI CAL THERAPY	4, 135, 049	263, 457			0.000000	
66. 01 06601	PHYSICAL THERAPY I -65	1, 439	4, 002, 674	4, 004, 11	0. 364425	0.000000	66. 01
	PHYSICAL THERAPY ST JOHN	0	1, 275, 061	1, 275, 06		0.000000	
	OCCUPATI ONAL THERAPY	4, 306, 276	285, 116			0. 000000	
	OCCUPATION THERAPY I-65	693	454, 295		1	0. 000000	1
	OCCUPATIONAL THERAPY ST. JOHN	0	82, 240			0. 000000	1
	SPEECH PATHOLOGY	3, 824, 106	192, 837		1	0.000000	
	SPEECH PATHOLOGY I -65 SPEECH THERAPY ST. JOHN	472	2, 542, 267	2, 542, 73	0. 218846 0. 000000	0. 000000 0. 000000	1
	ELECTROCARDI OLOGY	74, 836	3, 089, 527	3, 164, 36	1	0. 000000	
	MEDICAL SUPPLIES CHARGED TO PATIENT	23, 764, 620	25, 019, 901			0. 000000	1
	IMPL. DEV. CHARGED TO PATIENTS	19, 342, 079	26, 917, 453			0. 000000	
	DRUGS CHARGED TO PATIENTS	46, 027, 625	16, 922, 514			0.000000	
74. 00 07400	RENAL DIALYSIS	1, 171, 587	100, 894		0. 565999	0. 000000	74. 00
	RADIATION ONCOLOGY	418, 960	16, 139, 583			0. 000000	1
	ANGI OCARDI OGRAPHY	29, 233	1, 122, 814			0. 000000	
	ALLOGENEIC HSCT ACQUISITION	0	0		0.00000	0.000000	
	CAR T-CELL IMMUNOTHERAPY TIENT SERVICE COST CENTERS	0	0	1	0. 000000	0. 000000	78. 00
90. 00 09000		0	0		0. 000000	0. 000000	90.00
	DI ABETES CLINIC	o	0		0. 000000	0. 000000	
	OUTPATIENT CLINICS	0	0		0. 000000	0. 000000	
	OCCUPATIONAL MEDICINE CLINIC	0	0		0. 000000	0.000000	
90. 04 09004	NEONATOLOGY CLINIC-FRANCISCAN POINT	0	87, 567	87, 56	0. 350166	0. 000000	90. 04
	LACTATION CLINIC	0	20, 350			0. 000000	
	EMERGENCY	36, 866, 361	97, 101, 546			0. 000000	
	EMERGENCY ROOM PHYSI CANS	0	0			0.000000	
	EXPRESS CARE	0	7 000 453		0.00000	0.000000	
	OBSERVATION BEDS (NON-DISTINCT PART REIMBURSABLE COST CENTERS	2, 999, 085	7, 899, 653	10, 898, 73	0. 545790	0. 000000	92. 00
	OPIOID TREATMENT PROGRAM	0	0				102. 00
	AL PURPOSE COST CENTERS	<u> </u>	0				102.00
	I NTEREST EXPENSE						113. 00
200.00	Subtotal (see instructions)	497, 996, 970	699, 630, 912	1, 197, 627, 88:	2		200. 00
201. 00	Less Observation Beds						201. 00
202. 00	Total (see instructions)	497, 996, 970	699, 630, 912	1, 197, 627, 88	2		202. 00

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. 168545	50. 00
51. 00 05100 RECOVERY ROOM	51.00
	•
52. 00 05200 DELI VERY ROOM & LABOR ROOM	52.00
53. 00 05300 ANESTHESI OLOGY	53. 00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	54. 00
54. 01 05401 RADI OLOGY - I -65 0. 058651 0. 000000	54. 01
54. 02 05402 RADI OLOGY DI AGNOSTI C - SJ	54. 02
54. 03 05403 LOWELL RADI OLOGY	54. 03
55. 00 05500 RADI OLOGY - THERAPEUTI C	55. 00
55. 01 05501 CARDI AC CATHERI ZATON LAB	55. 01
55. 02 03140 CARDI OLOGY 0. 082838	55. 02
55. 03 03450 NEURO-DI AGNOSTI CS	55. 03
60. 00 06000 LABORATORY 0. 117422	60.00
60. 01 06001 BL00D LABORATORY	60. 01
65. 00 06500 RESPI RATORY THERAPY	65. 00
66. 00 06600 PHYSI CAL THERAPY	66.00
66. 01 06601 PHYSI CAL THERAPY I - 65	66. 01
66. 02 06602 PHYSI CAL THERAPY ST JOHN 0. 297387	66. 02
67. 00 06700 OCCUPATI ONAL THERAPY 0. 231298	67. 00
67. 01 06701 OCCUPATI ON THERAPY 1-65 0. 385228	67. 01
67. 02 06702 OCCUPATI ONAL THERAPY ST. JOHN 0. 226277	67. 02
68. 00 06800 SPEECH PATHOLOGY 0. 165399	68. 00
68. 01 06801 SPEECH PATHOLOGY I -65 0. 218846	68. 01
68. 02 06802 SPEECH THERAPY ST. JOHN 0. 000000	68. 02
69. 00 06900 ELECTROCARDI OLOGY 0. 396672	69. 00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0. 579807	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0. 316794	72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 238649	73. 00
74. 00 07400 RENAL DI ALYSI S 0. 565999	74. 00
76. 00 03020 RADI ATI ON ONCOLOGY 0. 097734	76. 00
76. 01 03040 ANGI OCARDI OGRAPHY	76. 01
77. 00 07700 ALLOGENEI C HSCT ACQUI SITION 0. 000000	77. 00
78. 00 07800 CAR T - CELL IMMUNOTHERAPY 0. 000000	78. 00
OUTPATIENT SERVICE COST CENTERS	
90. 00 09000 CLINIC	90.00
90. 01 09001 DI ABETES CLINI C 0. 000000	90. 01
90. 02 09002 OUTPATIENT CLINICS 0. 000000	90. 02
90. 03 OCCUPATIONAL MEDICINE CLINIC 0. 000000	90. 03
90. 04 09004 NEONATOLOGY CLI NI C-FRANCI SCAN POI NT 0. 350166	90. 04
90. 05 09005 LACTATI ON CLI NI C 2. 449681	90. 05
91. 00 09100 EMERGENCY	91. 00
91. 01 09101 EMERGENCY ROOM PHYSI CANS 0. 000000	91. 01
91. 02 09102 EXPRESS CARE 0. 000000	91. 02
92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART 0. 545790	92. 00
OTHER REIMBURSABLE COST CENTERS	4
102.00 OPI 0I D TREATMENT PROGRAM	102. 00
SPECIAL PURPOSE COST CENTERS	
113.00 11300 I NTEREST EXPENSE	113. 00
200.00 Subtotal (see instructions)	200. 00
201.00 Less Observation Beds	201. 00
202.00 Total (see instructions)	202. 00

COMPUT	ATION OF RATIO OF COSTS TO CHARGES		Provi der Co		Peri od:	Worksheet C	
					From 01/01/2023 Fo 12/31/2023	Part I	narod:
					10 12/31/2023	Date/Time Pre 5/30/2024 10:	pareu. 06 am
			Ti tl	e XIX	Hospi tal	Cost	
					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)	0.00	2.22			
	INDATIENT POLITIME CERVI CE COCT CENTERC	1. 00	2. 00	3. 00	4. 00	5. 00	
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	48, 258, 042		48, 258, 04	2 0	48, 258, 042	30. 00
31. 00	03100 INTENSIVE CARE UNIT	10, 883, 196	l .	10, 883, 19		10, 883, 196	
35. 00	02060 NEONATAL INTENSIVE CARE UNIT	7, 050, 728		7, 050, 72		7, 050, 728	
41. 00	04100 SUBPROVI DER - I RF	6, 617, 339	l .	6, 617, 33		6, 617, 339	
43. 00	04300 NURSERY	3, 053, 960		3, 053, 96		3, 053, 960	
	ANCILLARY SERVICE COST CENTERS		'		-		
50.00	05000 OPERATING ROOM	24, 058, 921		24, 058, 92	1 0	24, 058, 921	50.00
51.00	05100 RECOVERY ROOM	1, 603, 857		1, 603, 85	7 0	1, 603, 857	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	3, 574, 679		3, 574, 67	9 0	3, 574, 679	52. 00
53. 00	05300 ANESTHESI OLOGY	765, 433	l .	765, 43		765, 433	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	19, 104, 288	l .	19, 104, 28		19, 104, 288	
54. 01	05401 RADI OLOGY - I -65	1, 449, 687		1, 449, 68		1, 449, 687	54. 01
54. 02	05402 RADIOLOGY DIAGNOSTIC - SJ	0		00.74	0	0	54. 02
54. 03	05403 LOWELL RADI OLOGY	20, 713		20, 71		20, 713	
55. 00 55. 01	05500 RADI OLOGY-THERAPEUTI C 05501 CARDI AC CATHERI ZATON LAB	4 249 002		4 240 00	0 3	0 6, 348, 003	55. 00 55. 01
55. 02	03140 CARDI OLOGY	6, 348, 003 2, 809, 822		6, 348, 00 2, 809, 82		2, 809, 822	55. 02
55. 02	03450 NEURO-DI AGNOSTI CS	1, 328, 146		1, 328, 14		1, 328, 146	
60. 00	06000 LABORATORY	21, 156, 982		21, 156, 98		21, 156, 982	1
60. 01	06001 BLOOD LABORATORY	0			0	0	60. 01
65. 00	06500 RESPIRATORY THERAPY	3, 726, 130				3, 726, 130	1
66. 00	06600 PHYSI CAL THERAPY	2, 353, 963	l .			2, 353, 963	66. 00
66. 01	06601 PHYSI CAL THERAPY I -65	1, 459, 197	l .			1, 459, 197	
66. 02	06602 PHYSI CAL THERAPY ST JOHN	379, 186	0	379, 18	6 0	379, 186	66. 02
67.00	06700 OCCUPATI ONAL THERAPY	1, 061, 980	0	1, 061, 980	0	1, 061, 980	67.00
67. 01	06701 OCCUPATION THERAPY I -65	175, 274	0	175, 27	4 0	175, 274	67. 01
67. 02	06702 OCCUPATIONAL THERAPY ST. JOHN	18, 609	l .			18, 609	67. 02
68. 00	06800 SPEECH PATHOLOGY	664, 400	l .			664, 400	
68. 01	06801 SPEECH PATHOLOGY I -65	556, 468				556, 468	68. 01
68. 02	06802 SPEECH THERAPY ST. JOHN	0	0		0	0	68. 02
69.00	06900 ELECTROCARDI OLOGY	1, 255, 215	l .	1, 255, 21		1, 255, 215	69. 00
71. 00 72. 00	O7100 MEDICAL SUPPLIES CHARGED TO PATIENT O7200 MPL. DEV. CHARGED TO PATIENTS	28, 285, 626	l .	28, 285, 62		28, 285, 626	
73. 00	07300 DRUGS CHARGED TO PATIENTS	14, 654, 760 15, 023, 002		14, 654, 760 15, 023, 003		14, 654, 760 15, 023, 002	
74. 00	07400 RENAL DIALYSIS	720, 223	l .	720, 223		720, 223	74. 00
76. 00	03020 RADIATION ONCOLOGY	1, 618, 328	l .	1, 618, 32		1, 618, 328	76.00
76. 01	03040 ANGI OCARDI OGRAPHY	430, 266		430, 26		430, 266	
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0			0	0	77. 00
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0			0	0	78. 00
	OUTPATIENT SERVICE COST CENTERS	,					
	09000 CLI NI C	0			0	Ĭ	90.00
	09001 DI ABETES CLINIC	0			0		90. 01
90. 02	09002 OUTPATIENT CLINICS	1, 263		1, 26	3 0		90. 02
90. 03	09003 OCCUPATIONAL MEDICINE CLINIC	0	1		0		
90. 04	09004 NEONATOLOGY CLINIC-FRANCISCAN POINT	30, 663		30, 66		30, 663	1
90. 05	09005 LACTATION CLINIC	49, 851		49, 85		49, 851	
91. 00 91. 01	O9100 EMERGENCY O9101 EMERGENCY ROOM PHYSI CANS	14, 680, 859 0		14, 680, 85		14, 680, 859 0	1
91.01	09101 EMERGENCY ROOM PHYSICANS	0	•		0	0	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	5, 948, 418		5, 948, 41	٥	5, 948, 418	
12.00	OTHER REIMBURSABLE COST CENTERS	5, 740, 410	1	3, 740, 410	<u> </u>	3, 740, 410	/2.00
102.00	10200 OPI OI D TREATMENT PROGRAM	0			D	n	102. 00
50	SPECIAL PURPOSE COST CENTERS				<u></u>		1
113.00	11300 NTEREST EXPENSE						113. 00
200.00	,	251, 177, 477	0	251, 177, 47 ⁻	7 0		
201.00		5, 948, 418		5, 948, 41		5, 948, 418	
202.00	Total (see instructions)	245, 229, 059	0	245, 229, 05	9 0	245, 229, 059	202. 00

Health Financial Systems FRANCISCAN HEALTH CROWN POINT In Lieu of Form CMS-2552-10 COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-0126 Peri od: Worksheet C From 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/30/2024 10:06 am Title XIX Hospi tal Cost Charges Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other **TFFRA** + col . 7) Ratio Inpati ent Ratio 6.00 7.00 8.00 9. 00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 55, 469, 013 55, 469, 013 30.00 31.00 03100 INTENSIVE CARE UNIT 14, 635, 935 14, 635, 935 02060 NEONATAL INTENSIVE CARE UNIT 21, 577, 991 21, 577, 991 35.00 04100 SUBPROVIDER - IRF 41.00 6.573.261 6, 573, 261 04300 NURSERY 43.00 3, 946, 546 3, 946, 546 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM 53, 596, 594 89, 147, 889 142 744 483 0 168545 0 168545 05100 RECOVERY ROOM 15, 274, 519 6.404.771 21, 679, 290 0.073981 0.073981 51.00 05200 DELIVERY ROOM & LABOR ROOM 6, 988, 298 52.00 6, 918, 154 70, 144 0.511524 0.511524 53.00 05300 ANESTHESI OLOGY 8, 574, 451 18, 701, 429 27, 275, 880 0.028063 0.028063 54.00 05400 RADI OLOGY-DI AGNOSTI C 62, 781, 033 169, 391, 443 232, 172, 476 0.082285 0.082285 112, 824 24, 604, 344 05401 RADI OLOGY - 1-65 0.058651 0.058651 54.01 24, 717, 168 54.02 05402 RADIOLOGY DIAGNOSTIC - SJ 0 0.000000 0.000000 54.03 0. 562486 05403 LOWELL RADI OLOGY 0 36,824 36,824 0.562486 55.00 05500 RADI OLOGY-THERAPEUTI C 0.000000 0.000000 05501 CARDIAC CATHERIZATON LAB 21, 228, 019 28, 231, 724 49, 459, 743 55 01 0.128347 0.128347 55.02 03140 CARDI OLOGY 11, 683, 453 22, 235, 909 33, 919, 362 0.082838 0.082838 55.03

202.00 Total (see instructions) 497, 996, 970 699, 630, 912 1, 197, 627, 882 202.00

				5/30/2024 10:	06 am_
		Title XIX	Hospi tal	Cost	
Cost Center Description	PPS Inpatient				
·	Ratio				
	11.00				
INPATIENT ROUTINE SERVICE COST CENTERS					
					30.00
31.00 03100 INTENSIVE CARE UNIT	1				31.00
35.00 02060 NEONATAL INTENSIVE CARE UNIT					35. 00
41. 00 04100 SUBPROVI DER - I RF					41.00
43. 00 04300 NURSERY	1				43. 00
					45.00
ANCILLARY SERVICE COST CENTERS					4
50. 00 05000 OPERATI NG ROOM	0. 000000				50.00
51.00 05100 RECOVERY ROOM	0. 000000				51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000				52. 00
53. 00 05300 ANESTHESI OLOGY	0. 000000				53. 00
	1 1				1
	0. 000000				54. 00
54. 01 05401 RADI OLOGY - I -65	0. 000000				54. 01
54.02 05402 RADIOLOGY DIAGNOSTIC - SJ	0. 000000				54. 02
54. 03 05403 LOWELL RADI OLOGY	0. 000000				54. 03
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000				55. 00
55. 01 05501 CARDI AC CATHERI ZATON LAB	0. 000000				55. 01
• • • • • • • • • • • • • • • • • • •	1 1				
55. 02 03140 CARDI OLOGY	0. 000000				55. 02
55. 03 03450 NEURO-DI AGNOSTI CS	0. 000000				55. 03
60. 00 06000 LABORATORY	0. 000000				60.00
60. 01 06001 BLOOD LABORATORY	0. 000000				60. 01
65. 00 06500 RESPI RATORY THERAPY	0. 000000				65. 00
• • • • • • • • • • • • • • • • • • •	1 1				
66. 00 06600 PHYSI CAL THERAPY	0. 000000				66. 00
66. 01 06601 PHYSI CAL THERAPY I -65	0. 000000				66. 01
66.02 06602 PHYSICAL THERAPY ST JOHN	0.000000				66. 02
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000				67. 00
67. 01 06701 0CCUPATI ON THERAPY 1 - 65	0. 000000				67. 01
•					
67. 02 06702 OCCUPATIONAL THERAPY ST. JOHN	0. 000000				67. 02
68. 00 06800 SPEECH PATHOLOGY	0. 000000				68. 00
68. 01 06801 SPEECH PATHOLOGY I-65	0. 000000				68. 01
68. 02 06802 SPEECH THERAPY ST. JOHN	0. 000000				68. 02
69. 00 06900 ELECTROCARDI OLOGY	0. 000000				69. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000				71. 00
	1 1				
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000				72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000				73. 00
74.00 07400 RENAL DIALYSIS	0. 000000				74.00
76.00 03020 RADIATION ONCOLOGY	0. 000000				76. 00
76. 01 03040 ANGI OCARDI OGRAPHY	0. 000000				76. 01
l l	1 1				
77. 00 07700 ALLOGENEIC HSCT ACQUISITION	0. 000000				77. 00
78.00 O7800 CAR T-CELL IMMUNOTHERAPY	0. 000000				78. 00
OUTPATIENT SERVICE COST CENTERS					1
90. 00 09000 CLI NI C	0.000000				90. 00
90. 01 09001 DI ABETES CLINIC	0. 000000				90. 01
90. 02 09002 0UTPATI ENT CLINI CS	0. 000000				90. 02
• • • • • • • • • • • • • • • • • • •					1
	0. 000000				90. 03
90.04 09004 NEONATOLOGY CLINIC-FRANCISCAN POINT	0. 000000				90. 04
90. 05 09005 LACTATION CLINIC	0. 000000				90. 05
91. 00 09100 EMERGENCY	0. 000000				91.00
91. 01 09101 EMERGENCY ROOM PHYSI CANS	0. 000000				91. 01
91. 02 09102 EXPRESS CARE	0. 000000				91. 02
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000				92. 00
OTHER REIMBURSABLE COST CENTERS					
102.00 10200 OPI OI D TREATMENT PROGRAM					102. 00
SPECIAL PURPOSE COST CENTERS	•				1
113. 00 11300 NTEREST EXPENSE					113. 00
					200. 00
201.00 Less Observation Beds					201. 00
202.00 Total (see instructions)					202. 00

Health Financial Systems	FRANCI SCAN HEAL	TH CROWN POINT		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITA	AL COSTS	Provi der Co		Period: From 01/01/2023 To 12/31/2023	Worksheet D Part I Date/Time Pre 5/30/2024 10:	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient		
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col. 1 - col			
	26)		2)			
	1.00	2.00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS		1				
30. 00 ADULTS & PEDI ATRI CS	5, 256, 673	l .	5, 256, 67			
31.00 INTENSIVE CARE UNIT	1, 444, 312	l .	1, 444, 31			
35.00 NEONATAL INTENSIVE CARE UNIT	1, 090, 150	l .	1, 090, 15			
41. 00 SUBPROVI DER - I RF	1, 063, 252	0	1, 063, 25			
43. 00 NURSERY	65, 632		65, 63			
200.00 Total (lines 30 through 199)	8, 920, 019		8, 920, 01	9 49, 756		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			1			
30. 00 ADULTS & PEDIATRICS	12, 312		1			30.00
31. 00 INTENSIVE CARE UNIT	1, 449		1			31.00
35. 00 NEONATAL INTENSIVE CARE UNIT	0	0	1			35. 00
41. 00 SUBPROVI DER - I RF	1, 988					41. 00
43. 00 NURSERY	0	_	1			43. 00
200.00 Total (lines 30 through 199)	15, 749	2, 880, 228				200. 00

Heal th	Financial Systems F	RANCISCAN HEAL	TH CROWN POINT		In Li∈	eu of Form CMS-:	2552-10
APPORT	FIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provi der C	CN: 15-0126	Peri od: From 01/01/2023 To 12/31/2023	Worksheet D Part II Date/Time Pre 5/30/2024 10:	pared: 06 am
			Titl∈	XVIII	Hospi tal	PPS	
	Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
	·	Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
		(from Wkst. B,			. Charges	column 4)	
		Part II, col.	8)	2)		,	
		26)	,	· ·			
		1.00	2.00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	4, 184, 019	142, 744, 483	0. 02931	11 19, 174, 406	562, 021	50.00
51.00	05100 RECOVERY ROOM	481, 286	21, 679, 290	0. 02220	1, 760, 487	39, 083	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	73, 676	6, 988, 298	0. 01054	13 24, 644	260	52.00
53.00	05300 ANESTHESI OLOGY	286, 286	27, 275, 880	0. 01049	3, 016, 339	31, 659	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	2, 638, 665	232, 172, 476	0. 01136	24, 218, 860	275, 247	54.00
54. 01	05401 RADI OLOGY - I -65	270, 193	24, 717, 168	0. 01093	41, 012	448	54. 01
54. 02	05402 RADIOLOGY DIAGNOSTIC - SJ	0	0	0.00000		0	54. 02
54. 03	05403 LOWELL RADI OLOGY	12, 083	36, 824			0	54. 03
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0	0.00000		0	55. 00
55. 01	05501 CARDI AC CATHERI ZATON LAB	1, 192, 373	49, 459, 743			196, 512	1
55. 02	03140 CARDI OLOGY	418, 190				63, 330	
55. 03	03450 NEURO-DI AGNOSTI CS	168, 276		1		9, 725	
60. 00	06000 LABORATORY	940, 997				135, 475	
60. 01	06001 BLOOD LABORATORY	710,777		0.00000		0	1
65. 00	06500 RESPIRATORY THERAPY	302, 519	· · · · · ·			96, 016	1
66. 00	06600 PHYSI CAL THERAPY	224, 217		•		45, 170	
66. 01	06601 PHYSI CAL THERAPY I -65	44, 223				3	66. 01
66. 02	06602 PHYSICAL THERAPY ST JOHN	12, 156				0	
67. 00	06700 OCCUPATI ONAL THERAPY	22, 570				5, 254	
67. 01	06701 OCCUPATION THERAPY I -65	3, 651		•		5, 254	67. 00
67. 01	06702 OCCUPATION THERAPY ST. JOHN	3,031		1		Ö	
68. 00	06800 SPEECH PATHOLOGY	14, 367				2, 771	
68. 01	06801 SPEECH PATHOLOGY I -65	11, 853				2, 7/1	68. 01
68. 02	06802 SPEECH THERAPY ST. JOHN	11,033	l .	1		Ö	1
69. 00	06900 ELECTROCARDI OLOGY	88, 732	1	1		811	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	996, 001		•		276, 347	
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	507, 328				92, 978	
73.00	07300 DRUGS CHARGED TO PATIENTS	396, 512				105, 891	73.00
74.00	07400 RENAL DIALYSIS	38, 815				14, 907	
76.00	03020 RADIATION ONCOLOGY	156, 901				729	
76. 00	03040 ANGI OCARDI OGRAPHY	9, 023				24	
77. 00	07700 ALLOGENEI C HSCT ACQUI SITION	9,023		1		0	
78.00	07800 CAR T-CELL IMMUNOTHERAPY						
70.00	OUTPATIENT SERVICE COST CENTERS		1	η <u>0.0000</u> 0	0	0	78.00
90. 00	09000 CLINIC	1 0	0	0.00000	00 0	0	90.00
90. 01	09001 DI ABETES CLINIC					0	
90. 01	09002 OUTPATIENT CLINICS	135		•		0	90.01
90. 02	09003 OCCUPATIONAL MEDICINE CLINIC	0		•		0	
90.03	09004 NEONATOLOGY CLINIC-FRANCISCAN POINT	840	_			0	1
90.04	09004 NEUNATOLOGY CLINIC-FRANCISCAN POINT	1		•			
		1, 625					
91.00	09100 EMERGENCY	1, 487, 494				130, 639	
91. 01 91. 02	09101 EMERGENCY ROOM PHYSI CANS	0	-			0	
91.02	09102 EXPRESS CARE 09200 OBSERVATION BEDS (NON-DISTINCT PART	647, 949	_			74 420	
200.00		· ·	1, 095, 425, 136	•	52 1, 288, 763 149, 492, 505	76, 620 2, 161, 922	
200.00	p Total (Times so till bugli 177)	15,055,552	1,075,425,130	1	147, 472, 303	1 2, 101, 722	₁ 200.00

Health Financial Systems F	FRANCISCAN HEAL	TU CDOWN DOINT		In Lie	eu of Form CMS	2552 10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA				Period: From 01/01/2023 To 12/31/2023	Worksheet D Part III	pared:
		Ti tl e	e XVIII	Hospi tal	PPS	
Cost Center Description	Nursi ng Program Post-Stepdown Adj ustments	Nursi ng Program	Post-Stepdowr Adjustments		All Other Medical Education Cost	
	1A	1. 00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS 31.00 03100 INTENSIVE CARE UNIT 35.00 02060 NEONATAL INTENSIVE CARE UNIT 41.00 04100 SUBPROVIDER - RF	0 0 0 0	0 0	1		0 0 0	31. 00 35. 00 41. 00
43. 00 04300 NURSERY	0	0)	0	0	
200.00 Total (lines 30 through 199) Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	200. 00
	4.00	5. 00	6, 00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	0	0	3, 84 3, 73 3, 98 2, 35	6 0. 00 5 0. 00 9 0. 00 2 0. 00	0 1, 988 0	31. 00 35. 00 41. 00
Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00		., .,,,,,	·		250.50
30.00 03000 ADULTS & PEDIATRICS 31.00 03100 INTENSIVE CARE UNIT 35.00 02060 NEONATAL INTENSIVE CARE UNIT 41.00 04100 SUBPROVIDER - IRF 43.00 04300 NURSERY 200.00 Total (lines 30 through 199)	0 0 0 0 0					30. 00 31. 00 35. 00 41. 00 43. 00 200. 00

| Peri od: | Worksheet D | From 01/01/2023 | Part IV | To 12/31/2023 | Date/Time Prepared: | To 12/31/2023 | Provi der CCN: 15-0126 THROUGH COSTS

				10 12/31/2023	5/30/2024 10:	
		Ti tl e	e XVIII	Hospi tal	PPS	
Cost Center Description	Non Physician	Nursi ng	Nursi ng		Allied Health	
	Anestheti st	Program	Program	Post-Stepdown		
	Cost	Post-Stepdown		Adjustments		
		Adjustments				
	1.00	2A	2.00	3A	3. 00	
ANCILLARY SERVICE COST CENTERS	_		.1		_	
50. 00 05000 OPERATI NG ROOM	0	C	1	0 0	0	50.00
51. 00 05100 RECOVERY ROOM	0	1	1	0 0	1	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	C		0	1	52. 00
53. 00 05300 ANESTHESI OLOGY	0	C		0	0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	C		0	0	54. 00
54. 01 05401 RADI OLOGY - I -65	0	C		0	0	54. 01
54.02 05402 RADIOLOGY DIAGNOSTIC - SJ	0	C		0	0	54. 02
54. 03 05403 LOWELL RADI OLOGY	0	[C		0	0	54. 03
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	[C		0	0	55. 00
55. 01 05501 CARDI AC CATHERI ZATON LAB	0	C		0	0	55. 01
55. 02 03140 CARDI OLOGY	0	C		0 0	0	55. 02
55. 03 03450 NEURO-DI AGNOSTI CS	0	C		0 0	0	55. 03
60. 00 06000 LABORATORY	0	C		0 0	0	60.00
60. 01 06001 BLOOD LABORATORY	0	l c		0 0	0	60. 01
65. 00 06500 RESPIRATORY THERAPY	0	l c		0 0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0	l c		0 0	0	66. 00
66. 01 06601 PHYSI CAL THERAPY I -65	0	l	ol	0 0	0	66. 01
66. 02 06602 PHYSI CAL THERAPY ST JOHN	0	l	ol	0 0	0	66. 02
67. 00 06700 OCCUPATI ONAL THERAPY	0	l	ol	0 0	0	67. 00
67. 01 06701 OCCUPATION THERAPY I -65	0	l c		0 0	0	67. 01
67.02 06702 OCCUPATIONAL THERAPY ST. JOHN	0			0 0	0	67. 02
68.00 06800 SPEECH PATHOLOGY	0			0	0	68. 00
68. 01 06801 SPEECH PATHOLOGY I -65	0	Ĭ		0 0	Ö	68. 01
68. 02 06802 SPEECH THERAPY ST. JOHN	0	ا ا		0 0	Ö	68. 02
69. 00 06900 ELECTROCARDI OLOGY	0	آ ا		0 0	167, 009	69.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	Ì		0 0	0	71. 00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	7			Ö	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	7			Ö	73. 00
74. 00 07400 RENAL DI ALYSI S	0	7			Ö	74.00
76. 00 03020 RADI ATI ON ONCOLOGY	0	7			Ö	76.00
76. 01 03040 ANGI OCARDI OGRAPHY	0	7			0	76. 01
77. 00 07700 ALLOGENEI C HSCT ACQUI SI TI ON	0				0	77. 00
78. 00 07700 ALLOGENETE TISCT ACCOUNT TON 78. 00 07800 CAR T-CELL IMMUNOTHERAPY			1		0	78.00
OUTPATIENT SERVICE COST CENTERS	0		4	0 0	0	70.00
90. 00 09000 CLI NI C	0		7	0 0	0	90.00
90. 01 09001 DI ABETES CLINI C		1	1		1	90. 01
90. 02 09002 0UTPATI ENT CLINI CS	0				0	90. 01
90. 03 09003 OCCUPATIONAL MEDICINE CLINIC	0				0	90. 02
	0			0 0	0	
90.04 09004 NEONATOLOGY CLINIC-FRANCISCAN POINT 90.05 09005 LACTATION CLINIC			(0	90. 04 90. 05
	0			0		•
91. 00 09100 EMERGENCY	0			0 0	889, 030	91.00
91. 01 09101 EMERGENCY ROOM PHYSI CANS	0				0	91. 01
91. 02 09102 EXPRESS CARE	0		ή		0	91.02
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART	0		,	U	0	92.00
200.00 Total (lines 50 through 199)	0	[C	기	0 0	1, 056, 039	J200. 00

| Peri od: | Worksheet D | From 01/01/2023 | Part IV | To 12/31/2023 | Date/Time Prepared: | To 12/31/2023 |
 Heal th Financial
 Systems
 FRANCISCAN HEALTH

 APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY
 SERVICE OTHER PASS
 Provi der CCN: 15-0126 THROUGH COSTS

					10 12/31/2023	5/30/2024 10:	
			Title	XVIII	Hospi tal	PPS	
	Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
		Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,	to Charges	
		Education Cost		Cost (sum of	Part I, col.	(col. 5 ÷ col.	
			4)	col s. 2, 3,	8)	7)	
				and 4)		(see	
		4.00	F 00	4 00	7.00	instructions)	
	ANCILLARY SERVICE COST CENTERS	4. 00	5. 00	6. 00	7. 00	8. 00	
50. 00	05000 OPERATING ROOM		0		142, 744, 483	0. 000000	50.00
51. 00	05100 RECOVERY ROOM	0	0		21, 679, 290		51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0		6, 988, 298	l e	52.00
53. 00	05300 ANESTHESI OLOGY	0	0		27, 275, 880	0.000000	53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	0		232, 172, 476	0. 000000	
54. 01	05401 RADI OLOGY - I -65	0	0		24, 717, 168	0. 000000	54. 01
54. 02	05402 RADIOLOGY DIAGNOSTIC - SJ	0	0		0 24,717,100	0. 000000	54. 02
54. 03	05403 LOWELL RADI OLOGY	0	0		36, 824	0. 000000	54. 03
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0		0 0	0. 000000	55. 00
55. 01	05501 CARDI AC CATHERI ZATON LAB	0	0		49, 459, 743	0. 000000	55. 01
55. 02	03140 CARDI OLOGY	0	0		33, 919, 362	0. 000000	55. 02
55. 03	03450 NEURO-DI AGNOSTI CS	0	0		10, 112, 496	l e	55. 03
60.00	06000 LABORATORY	0	0		180, 178, 953	0. 000000	60.00
60. 01	06001 BLOOD LABORATORY	0	0		0	0. 000000	60. 01
65. 00	06500 RESPI RATORY THERAPY	0	0	•	19, 657, 993		65. 00
66. 00	06600 PHYSI CAL THERAPY	0	0		4, 398, 506	0. 000000	66. 00
66. 01	06601 PHYSI CAL THERAPY I -65	0	0		4, 004, 113	0. 000000	66. 01
66. 02	06602 PHYSI CAL THERAPY ST JOHN	0	0		1, 275, 061	0. 000000	66. 02
67. 00	06700 OCCUPATI ONAL THERAPY	0	0		4, 591, 392	0. 000000	67. 00
67. 01	06701 OCCUPATION THERAPY I -65	o	0		454, 988	0.000000	67. 01
67. 02	06702 OCCUPATIONAL THERAPY ST. JOHN	O	0		82, 240	0.000000	67. 02
68.00	06800 SPEECH PATHOLOGY	o	0		4, 016, 943	0.000000	68. 00
68. 01	06801 SPEECH PATHOLOGY I -65	o	0		2, 542, 739	0.000000	68. 01
68. 02	06802 SPEECH THERAPY ST. JOHN	0	0		0	0.000000	68. 02
69.00	06900 ELECTROCARDI OLOGY	0	167, 009	167, 00	3, 164, 363	0. 052778	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		48, 784, 521	0.000000	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		46, 259, 532	0.000000	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		62, 950, 139	0.000000	73. 00
74. 00	07400 RENAL DI ALYSI S	0	0		1, 272, 481	0.000000	74. 00
76. 00	03020 RADIATION ONCOLOGY	0	0		16, 558, 543	0.000000	76. 00
76. 01	03040 ANGI OCARDI OGRAPHY	0	0		1, 152, 047	0. 000000	76. 01
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	0		0		77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0	0		0	0. 000000	78. 00
	OUTPATIENT SERVICE COST CENTERS	1		1			
90. 00	09000 CLINIC	0	0		0		90. 00
90. 01	09001 DI ABETES CLINI C	0	0	1	0	0. 000000	90. 01
90. 02	09002 OUTPATIENT CLINICS	0	0	ł	0	0.000000	90. 02
90. 03	09003 OCCUPATIONAL MEDICINE CLINIC	0	0		0	0.000000	90. 03
90. 04	09004 NEONATOLOGY CLINIC-FRANCISCAN POINT	0	0	•	87, 567	0.000000	90. 04
90. 05	09005 LACTATION CLINIC	0	0		20, 350	0.000000	1
91.00	09100 EMERGENCY	0	889, 030			0.006636	91.00
91. 01	09101 EMERGENCY ROOM PHYSI CANS	0	0		0	0.000000	91. 01
91. 02 92. 00	09102 EXPRESS CARE		0		0 10, 898, 738	0.00000	1
92. 00 200. 00	O9200 OBSERVATION BEDS (NON-DISTINCT PART Total (lines 50 through 199)		1, 056, 039		10, 898, 738 9 1, 095, 425, 136		
200.00	Tiotal (Titles 50 tillough 199)	ı V	1, 000, 039	1, 050, 03	7 1,090,420,130	I	200. 00

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet D | From 01/01/2023 | Part IV | To 12/31/2023 | Date/Time Prepared: | To 12/31/2023 | T
 Heal th Financial
 Systems
 FRANCISCAN HEALTH

 APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY
 SERVICE OTHER PASS
 Provi der CCN: 15-0126 THROUGH COSTS

			10) 12/31/2023	5/30/2024 10:	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Outpati ent	I npati ent	Inpati 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		Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9. 00	10. 00	11. 00	12. 00	13. 00	
ANCILLARY SERVICE COST CENTERS	0.000000	40 474 407		00 050 455		F0 00
50. 00 05000 OPERATING ROOM	0.000000	19, 174, 406		20, 253, 455	0	50.00
51. 00 05100 RECOVERY ROOM	0.000000	1, 760, 487	0	3, 451, 575	0	51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0.000000	24, 644	0	2 200 104	0	52. 00 53. 00
53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C	0.000000	3, 016, 339		3, 208, 196	0	
· · · · · · · · · · · · · · · · · · ·	0.000000	24, 218, 860	1	38, 410, 185	0	54. 00 54. 01
54. 01 05401 RADI OLOGY 1 -65	0.000000	41, 012	0	5, 538, 972		
54. 02 05402 RADI OLOGY DI AGNOSTI C - SJ	0.000000	0	0	0	0	54. 02
54. 03 05403 LOWELL RADI OLOGY	0.000000	0	0	0		54. 03
55. 00 05500 RADI OLOGY-THERAPEUTI C	0.000000	0 151 210	0	10 100 513	0	55. 00
55. 01 05501 CARDI AC CATHERI ZATON LAB	0.000000	8, 151, 310	1	10, 190, 513	0	55. 01
55. 02 03140 CARDI OLOGY	0.000000	5, 136, 697	0	7, 173, 930	0	55. 02
55. 03 03450 NEURO-DI AGNOSTI CS	0.000000	584, 463		1, 471, 994	0	55. 03
60. 00 06000 LABORATORY	0.000000	25, 938, 130		4, 622, 759	0	60.00
60. 01 06001 BLOOD LABORATORY	0.000000	0000047	0	4 205 05/	0	60. 01
65. 00 06500 RESPIRATORY THERAPY	0. 000000	6, 239, 247	0	1, 395, 056	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	886, 100		73	0	66.00
66. 01 06601 PHYSI CAL THERAPY I -65	0. 000000	294	0	3, 305	0	66. 01
66. 02 06602 PHYSI CAL THERAPY ST JOHN	0.000000	0	0	1, 029	0	66. 02
67. 00 06700 OCCUPATI ONAL THERAPY	0.000000	1, 068, 691	0	265	0	67.00
67. 01 06701 0CCUPATION THERAPY I -65	0.000000	130	1	1, 662	0	67. 01
67. 02 06702 OCCUPATIONAL THERAPY ST. JOHN	0.000000	0	0	335	0	67. 02
68. 00 06800 SPEECH PATHOLOGY	0.000000	774, 544	0	1, 327	0	68. 00
68. 01 06801 SPEECH PATHOLOGY I -65	0.000000	120	0	17, 415	0	68. 01
68. 02 06802 SPEECH THERAPY ST. JOHN 69. 00 06900 ELECTROCARDI OLOGY	0.000000	O		1 220 4/5	0 70, 114	68. 02
	0. 052778 0. 000000	28, 906 13, 535, 829		1, 328, 465 8, 967, 088	70, 114	69. 00 71. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 72.00 07200 MPL. DEV. CHARGED TO PATIENTS	0.000000	8, 477, 993		8, 967, 088 8, 218, 181	0	71.00
73. 00 07300 DRUGS CHARGED TO PATTENTS	0.000000	16, 810, 781		4, 240, 003	0	73.00
74. 00 07400 RENAL DIALYSIS	0.000000	488, 722		4, 240, 003	0	74.00
74. 00 07400 RENAL DI ALYSIS 76. 00 03020 RADI ATI ON ONCOLOGY	1	76, 891		40, 908 4, 879, 764	0	76.00
76. 00 03020 RADI ATTON ONCOLOGY 76. 01 03040 ANGI OCARDI OGRAPHY	0. 000000 0. 000000	3, 060	١		0	76. 00
77. 00 07700 ALLOGENEI C HSCT ACQUI SI TI ON	0. 000000	3,000		566, 267 0	0	77. 00
78. 00 07800 CAR T-CELL IMMUNOTHERAPY	0. 000000	0	-	0	0	78.00
OUTPATIENT SERVICE COST CENTERS	0.000000		0	<u> </u>	0	76.00
90. 00 09000 CLINIC	0. 000000	0	0	0	0	90.00
90. 01 09001 DI ABETES CLINI C	0. 000000	0	-	0	0	90. 01
90. 02 09002 OUTPATIENT CLINICS	0. 000000	0	0	0	0	90. 02
90. 03 09003 OCCUPATIONAL MEDICINE CLINIC	0. 000000	0	٥	0	0	90. 03
90. 04 09004 NEONATOLOGY CLINIC-FRANCISCAN POINT	0. 000000	0	0	386	0	90. 04
90. 05 09005 LACTATION CLINIC	0. 000000	0	٥	192	0	90. 05
91. 00 09100 EMERGENCY	0. 006636	11, 766, 086	78, 080	12, 585, 667	83, 518	91.00
91. 01 09101 EMERGENCY ROOM PHYSI CANS	0. 000000	0	0	0	0	91. 01
91. 02 09102 EXPRESS CARE	0. 000000	0	Ö	ol	0	91. 02
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	1, 288, 763	Ö	1, 124, 150	0	92.00
200.00 Total (lines 50 through 199)		149, 492, 505		137, 693, 117	153, 632	200.00
, , ,					•	•

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der CO		Peri od: From 01/01/2023 To 12/31/2023	Worksheet D Part V Date/Time Pre 5/30/2024 10:	pared: O6 am
		litle	XVIII	Hospi tal	PPS	
			Charges		Costs	
Cost Center Description	Cost to Charge			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	Subject To		
			Ded. & Coins	. Ded. & Coins.		
			(see inst.)	(see inst.)		
	1.00	2. 00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0. 168545	20, 253, 455		0 0	3, 413, 619	50. 00
51. 00 05100 RECOVERY ROOM	0. 073981	3, 451, 575		0 0	255, 351	51. 00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0. 511524	3,431,373		0 0	255, 551	52. 00
	1	2 200 107		-		
53. 00 05300 ANESTHESI OLOGY	0. 028063	3, 208, 196		0	90, 032	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 082285			0	3, 160, 582	54. 00
54. 01 05401 RADI OLOGY - I -65	0. 058651	5, 538, 972		0	324, 866	54. 01
54.02 05402 RADIOLOGY DIAGNOSTIC - SJ	0.000000	0		0	0	54.02
54. 03 05403 LOWELL RADI OLOGY	0. 562486	0		0 0	0	54.03
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000	l		0	0	55. 00
55. 01 05501 CARDI AC CATHERI ZATON LAB	0. 128347	10, 190, 513		0	1, 307, 922	55. 01
55. 02 03140 CARDI OLOGY	0. 082838	7, 173, 930	1	0 0	594, 274	55. 02
			1	-		
55. 03 03450 NEURO-DI AGNOSTI CS	0. 131337	1, 471, 994	1	0	193, 327	55. 03
60. 00 06000 LABORATORY	0. 117422	1		0	542, 814	60.00
60. 01 06001 BLOOD LABORATORY	0. 000000	ł		0	0	60. 01
65. 00 06500 RESPI RATORY THERAPY	0. 189548	1, 395, 056		0	264, 430	65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 535173	73		0	39	66.00
66. 01 06601 PHYSI CAL THERAPY I -65	0. 364425	3, 305		0 0	1, 204	66. 01
66. 02 06602 PHYSI CAL THERAPY ST JOHN	0. 297387	1, 029	1	0	306	66. 02
67. 00 06700 OCCUPATI ONAL THERAPY	0. 231298			0	61	67. 00
67. 01 06701 0CCUPATION THERAPY I -65	0. 385228	1, 662	1	0 0	640	67. 01
67. 02 06702 OCCUPATI ONAL THERAPY ST. JOHN	1	335			76	67. 02
· ·	0. 226277	l e	l .	٥		
68. 00 06800 SPEECH PATHOLOGY	0. 165399	l	1	0	219	68. 00
68. 01 06801 SPEECH PATHOLOGY I -65	0. 218846	l		0	3, 811	68. 01
68.02 06802 SPEECH THERAPY ST. JOHN	0. 000000	l e		0	0	68. 02
69. 00 06900 ELECTROCARDI OLOGY	0. 396672	1, 328, 465		0	526, 965	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 579807	8, 967, 088		0	5, 199, 180	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 316794	8, 218, 181		0 0	2, 603, 470	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 238649			0 2, 797	1, 011, 872	73. 00
74.00 07400 RENAL DIALYSIS	0. 565999	1		0	23, 154	74. 00
76. 00 03020 RADI ATI ON ONCOLOGY	0. 097734	1		0	476, 919	76. 00
76. 01 03040 ANGI OCARDI OGRAPHY	0. 373480			0 0	211, 489	76. 01
				7		
77. 00 07700 ALLOGENEIC HSCT ACQUISITION	0. 000000	l		0	0	77. 00
78. 00 07800 CAR T-CELL IMMUNOTHERAPY	0. 000000	0		0 0	0	78. 00
OUTPATIENT SERVICE COST CENTERS			ı			
90. 00 09000 CLI NI C	0. 000000	0		0	0	90. 00
90. 01 09001 DI ABETES CLINIC	0. 000000	0		0	0	90. 01
90. 02 09002 0UTPATIENT CLINICS	0.000000	0		0	0	90. 02
90. 03 09003 OCCUPATIONAL MEDICINE CLINIC	0.000000	0		0 0	0	90. 03
90.04 09004 NEONATOLOGY CLINIC-FRANCISCAN POINT	0. 350166	386		0	135	90. 04
90. 05 09005 LACTATION CLINIC	2. 449681	192		0 0		90. 05
91. 00 09100 EMERGENCY	0. 109585			0 0	1, 379, 200	
				7		
91. 01 09101 EMERGENCY ROOM PHYSI CANS	0.000000			0	0	91. 01
91. 02 09102 EXPRESS CARE	0. 000000	ł		0	0	91. 02
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 545790			0 0	613, 550	92. 00
200.00 Subtotal (see instructions)		137, 693, 117		0 2, 797	22, 199, 977	
201.00 Less PBP Clinic Lab. Services-Program				0		201. 00
Only Charges						
202.00 Net Charges (line 200 - line 201)	[137, 693, 117		0 2, 797	22, 199, 977	202. 00

Health Financial Systems FRANCISCAN HEALTH CROWN POINT In Lieu of Form CMS-2552-10 APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-0126 Peri od: Worksheet D From 01/01/2023 Part V Date/Time Prepared: 12/31/2023 5/30/2024 10:06 am Title XVIII Hospi tal PPS Costs 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.) 6.00 7.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 50.00 51.00 05100 RECOVERY ROOM 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 0 52 00 52 00 53.00 05300 ANESTHESI OLOGY 0 53.00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 54. 01 05401 RADI OLOGY - 1-65 0 54.01 05402 RADIOLOGY DIAGNOSTIC - SJ 0 54.02 54.02 54.03 05403 LOWELL RADIOLOGY 0 54.03 05500 RADI OLOGY-THERAPEUTI C 0 55.00 55.00 05501 CARDI AC CATHERI ZATON LAB 0 55 01 55 01 03140 CARDI OLOGY 55.02 0 55.02 55.03 03450 NEURO-DI AGNOSTI CS 0 55.03 60.00 06000 LABORATORY 0 60.00 0 60.01 06001 BLOOD LABORATORY 60.01 65.00 06500 RESPIRATORY THERAPY 0 65.00 06600 PHYSI CAL THERAPY 66.00 66.00 06601 PHYSICAL THERAPY I-65 0 66, 01 66.01 06602 PHYSI CAL THERAPY ST JOHN 0 66.02 66.02 67.00 06700 OCCUPATIONAL THERAPY 0 67.00 06701 OCCUPATION THERAPY I-65 0 67.01 67.01 0 06702 OCCUPATIONAL THERAPY ST. JOHN 67.02 67.02 06800 SPEECH PATHOLOGY 68.00 68 00 68.01 06801 SPEECH PATHOLOGY I -65 0 68.01 06802 SPEECH THERAPY ST. JOHN 68.02 68.02 06900 ELECTROCARDI OLOGY 0 69.00 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 668 73.00 07400 RENAL DIALYSIS 74 00 C 74 00 76.00 03020 RADIATION ONCOLOGY 0 76.00 03040 ANGI OCARDI OGRAPHY 76. 01 0 76.01 07700 ALLOGENEIC HSCT ACQUISITION 77.00 77.00 0 07800 CAR T-CELL IMMUNOTHERAPY 78.00 0 78.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 90.00 000000000000 90.01 09001 DIABETES CLINIC 0 90.01 90.02 09002 OUTPATIENT CLINICS 0 90.02 90.03 09003 OCCUPATIONAL MEDICINE CLINIC 0 90.03 0 09004 NEONATOLOGY CLINIC-FRANCISCAN POINT 90.04 90.04 09005 LACTATION CLINIC 0 90.05 90.05 91.00 09100 EMERGENCY 0 91.00 09101 EMERGENCY ROOM PHYSICANS 91.01 0 91.01 91 02 09102 EXPRESS CARE 91 02 0 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART

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668

668

92.00

200.00

201.00

202.00

200.00

201.00

202.00

Subtotal (see instructions)

Only Charges

Less PBP Clinic Lab. Services-Program

Net Charges (line 200 - line 201)

		FRANCI SCAN HEAL		CN. 1E 012/		u of Form CMS-	2552-10
APPUR	TIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL CUS15	Provi der C	CN: 15-0126	Peri od: From 01/01/2023	Worksheet D Part II	
			Component	CCN: 15-T126	To 12/31/2023		pared:
			Title	e XVIII	Subprovi der - I RF	PPS	00 4111
	Cost Center Description	Capi tal	Total Charges			Capital Costs	
			(from Wkst. C,		Program	(column 3 x	
		(from Wkst. B,		1	. Charges	column 4)	
		Part II, col.	8)	2)			
		26)					
	ANOLILIADY CEDYLOG COCT CENTERS	1.00	2. 00	3. 00	4. 00	5. 00	
FO 00	ANCI LLARY SERVI CE COST CENTERS	4 104 010	140 744 400	0.00001	01.0/0	2.27/	
50.00	05000 OPERATI NG ROOM	4, 184, 019				2, 376	
51.00	05100 RECOVERY ROOM	481, 286				151	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	73, 676				0	
53.00	05300 ANESTHESI OLOGY	286, 286				73	
54.00	05400 RADI OLOGY - DI AGNOSTI C	2, 638, 665				2, 340	
54. 01	05401 RADI OLOGY - I -65	270, 193	1			4	54. 01
54. 02	05402 RADI OLOGY DI AGNOSTI C - SJ	12.003	1	0.00000		0	
54. 03 55. 00	O5403 LOWELL RADI OLOGY O5500 RADI OLOGY-THERAPEUTI C	12, 083	36, 824	0. 32812 0. 00000			
55. 00	05501 CARDI AC CATHERI ZATON LAB	1, 192, 373	49, 459, 743			1, 473	
55. 02	03140 CARDI OLOGY	418, 190				1, 473	
55. 02	03450 NEURO-DI AGNOSTI CS	1		1		l .	
60.00	06000 LABORATORY	168, 276 940, 997				230 3, 391	
60. 00	06001 BLOOD LABORATORY	940, 997	1 ' '	0.00522		3, 391	
65. 00	06500 RESPIRATORY THERAPY	302, 519	1			2, 226	
66. 00	06600 PHYSI CAL THERAPY	224, 217		1		51, 337	
66. 01	06601 PHYSI CAL THERAPY I -65	44, 223				1 31, 337	1
66. 02	06602 PHYSI CAL THERAPY ST JOHN	12, 156				0	66. 02
67. 00	06700 OCCUPATI ONAL THERAPY	22, 570				5, 266	
67. 01	06701 OCCUPATION THERAPY I -65	3, 651				3, 200	
67. 02	06702 OCCUPATIONAL THERAPY ST. JOHN	397		1		0	
68. 00	06800 SPEECH PATHOLOGY	14, 367	1			1, 580	
68. 01	06801 SPEECH PATHOLOGY I -65	11, 853				0	
68. 02	06802 SPEECH THERAPY ST. JOHN	0		1		Ö	
69. 00	06900 ELECTROCARDI OLOGY	88, 732	1			0	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	996, 001				4, 706	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	507, 328				54	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	396, 512			536, 939	3, 382	73.00
74.00	07400 RENAL DI ALYSI S	38, 815		1		254	1
76.00	03020 RADI ATI ON ONCOLOGY	156, 901	16, 558, 543	0.00947	76 0	0	76.00
76. 01	03040 ANGI OCARDI OGRAPHY	9, 023	1, 152, 047	0.00783	32 204	2	76. 01
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0	0	0.00000	00	0	77. 00
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0	0	0. 00000	00	0	78. 00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0				0	90.00
90. 01	09001 DI ABETES CLINIC	0				0	
90. 02	09002 OUTPATIENT CLINICS	135	0			0	90. 02
90. 03	09003 OCCUPATIONAL MEDICINE CLINIC	0	1	0.00000		0	90. 03
90. 04	09004 NEONATOLOGY CLINIC-FRANCISCAN POINT	840				0	90. 04
90. 05	09005 LACTATION CLINIC	1, 625				0	
91.00	09100 EMERGENCY	1, 487, 494				36	
	09101 EMERGENCY ROOM PHYSI CANS	0				0	
01 02	09102 EXPRESS CARE		ol o	n nonno	00 0	l o	91 02

0 0 0 0 10, 898, 738 14, 985, 403 1, 095, 425, 136

0.000000

0.000000

4, 511, 966

0 91. 02

0 92.00 79, 347 200.00

91. 02 | 09102 EXPRESS CARE 92. 00 | 09200 OBSERVATION BEDS (NON-DISTINCT PART 200. 00 | Total (lines 50 through 199)

Health Financial Systems	FRANCISCAN HEALTH CROWN POINT				In Lieu of Form CMS-2552-10		
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SE	ERVICE OTHER PASS	Provi der C	CN: 15-0126	Peri od: From 01/01/2023	Worksheet D Part IV	
TIROUGII CUSTS			Component	CCN: 15-T126	To 12/31/2023		
			Ti tl e	e XVIII	Subprovi der -	PPS	
					l RF		
Cost Center Description		Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	

		Title	e XVIII	Subprovi der -	PPS	
Cost Center Description	Non Physician	Nursi ng	Nursi ng	IRF Allied Health	Allied Health	
cost center bescription	Anesthetist	Program	Program	Post-Stepdown	Airreu nearth	
	Cost	Post-Stepdown	1 rogram	Adjustments		
	0031	Adjustments		Adj d3 tilicitt3		
	1.00	2A	2.00	3A	3. 00	
ANCILLARY SERVICE COST CENTERS			1			
50.00 05000 OPERATING ROOM	0	0)	0 0	0	50. 00
51.00 05100 RECOVERY ROOM	0			0	0	51. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0)	0	0	52. 00
53. 00 05300 ANESTHESI OLOGY	0	0)	0	0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0		1	0	0	54. 00
54. 01 05401 RADI OLOGY - I -65	0	0	1	0	0	54. 01
54. 02 05402 RADI OLOGY DI AGNOSTI C - SJ	0	· -	1	0	0	54. 02
54. 03 05403 LOWELL RADI OLOGY	0	0)	0	0	54. 03
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0)	0	0	55. 00
55. 01 05501 CARDI AC CATHERI ZATON LAB	0	0	1	0	0	55. 01
55. 02 03140 CARDI OLOGY	0	0	1	0	0	55. 02
55. 03 03450 NEURO-DI AGNOSTI CS	0	1	1	0	1	55. 03
60. 00 06000 LABORATORY	0	0	1	0	0	60.00
60. 01 06001 BLOOD LABORATORY 65. 00 06500 RESPI RATORY THERAPY	0	0	1	0 0	0	60. 01
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	0		•	0	0	65. 00 66. 00
66. 01 06601 PHYSI CAL THERAPY 1-65			1	0 0	0	66. 01
66. 02 06602 PHYSI CAL THERAPY ST JOHN			•	0 0	0	66. 02
67. 00 06700 OCCUPATI ONAL THERAPY	0		1	0 0	0	67. 00
67. 01 06701 0CCUPATI ON THERAPY 1 - 65	0		1	0 0	0	67. 00
67. 02 06701 OCCUPATIONAL THERAPY ST. JOHN	0		1	0 0	0	67. 01
68. 00 06800 SPEECH PATHOLOGY		-	1	o o	0	68. 00
68. 01 06801 SPEECH PATHOLOGY 1 -65	0		•	0 0	0	68. 01
68. 02 06802 SPEECH THERAPY ST. JOHN	0	0	1	0 0	l o	68. 02
69. 00 06900 ELECTROCARDI OLOGY	0	l o		0 0	167, 009	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73. 00
74.00 07400 RENAL DIALYSIS	0	0		0 0	0	74.00
76.00 03020 RADIATION ONCOLOGY	0	0		0 0	0	76. 00
76. 01 03040 ANGI OCARDI OGRAPHY	0	0		0	0	76. 01
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0)	0	0	77. 00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0	0)	0 0	0	78. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0		1	0	-	90. 00
90. 01 09001 DI ABETES CLINI C	0	1	1	0	1	90. 01
90. 02 09002 0UTPATI ENT CLINI CS	0		1	0	0	90. 02
90. 03 09003 OCCUPATI ONAL MEDI CI NE CLI NI C	0	0	1	0	0	90. 03
90. 04 09004 NEONATOLOGY CLINIC-FRANCISCAN POINT	0	1	1	0	0	90. 04
90. 05 09005 LACTATION CLINIC	0	0)	0	0	90. 05
91. 00 09100 EMERGENCY				0	889, 030	91.00
91. 01 09101 EMERGENCY ROOM PHYSI CANS	0	0		0	0	91. 01
91. 02 09102 EXPRESS CARE 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART		١	ή	0	0	91. 02 92. 00
200.00 Total (lines 50 through 199)		ł .		0 0	-	
200.00 Total (Times 50 tillough 199)	1	ı	′1	υ	1, 000, 039	₁ 200.00

PPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY S HROUGH COSTS	ERVICE UTHER PAS		CN: 15-0126 CCN: 15-T126	Peri od: From 01/01/2023 To 12/31/2023	Date/Time Pre	pared
		·	· XVIII	Subprovi der -	5/30/2024 10: PPS	06 an
		11 (16	, AVIII	I RF	113	
Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
	Medical	(sum of cols.	Outpatient	(from Wkst. C,	to Charges	
	Education Cost		Cost (sum of cols. 2, 3,	8)	(col. 5 ÷ col. 7)	
		4)	and 4)	0)	(see	
			and 4)		instructions)	
	4.00	5.00	6. 00	7. 00	8. 00	
ANCILLARY SERVICE COST CENTERS	11.00	0.00	0.00	7.00	0.00	
0. 00 05000 OPERATING ROOM	0	0		0 142, 744, 483	0.000000	50.
1.00 05100 RECOVERY ROOM	0	0		0 21, 679, 290	0.000000	
2.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 6, 988, 298	0.000000	
8. 00 05300 ANESTHESI OLOGY	0	0		0 27, 275, 880	0.000000	53.
I. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 232, 172, 476	0.000000	54.
1. 01 05401 RADI OLOGY - I -65	0	0		0 24, 717, 168	0.000000	54.
. 02 05402 RADIOLOGY DIAGNOSTIC - SJ	0	0		0 0	0.000000	1
. 03 05403 LOWELL RADI OLOGY	0	0		0 36, 824	0.000000	
. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0 0	0.000000	55.
. 01 05501 CARDI AC CATHERI ZATON LAB	0	0		0 49, 459, 743	0.000000	
. 02 03140 CARDI OLOGY	0	0		0 33, 919, 362	0.000000	55.
03 03450 NEURO-DI AGNOSTI CS	0	0		0 10, 112, 496	0.000000	
. 00 06000 LABORATORY	0	0		0 180, 178, 953	0.000000	
. 01 06001 BLOOD LABORATORY	0	0		0 0	0.000000	
. 00 06500 RESPIRATORY THERAPY	0	0		0 19, 657, 993	0.000000	65.
. 00 06600 PHYSI CAL THERAPY	0	0		0 4, 398, 506	0.000000	
. 01 06601 PHYSI CAL THERAPY 1-65	0	0		0 4, 004, 113	0.000000	66.
. 02 06602 PHYSI CAL THERAPY ST JOHN	0	0		0 1, 275, 061	0.000000	66.
. 00 06700 OCCUPATI ONAL THERAPY	0	0		0 4, 591, 392	0.000000	67.
. 01 06701 OCCUPATION THERAPY I-65	0	0		0 454, 988	0. 000000	67.
. 02 06702 OCCUPATIONAL THERAPY ST. JOHN	0	0		0 82, 240	0. 000000	67.
. 00 06800 SPEECH PATHOLOGY	0	0		0 4, 016, 943	0. 000000	68
. 01 06801 SPEECH PATHOLOGY I -65	0	0		0 2, 542, 739	0. 000000	68
.02 06802 SPEECH THERAPY ST. JOHN	0	0		0 0	0.000000	68
. 00 06900 ELECTROCARDI OLOGY	0	167, 009	167, 00	3, 164, 363	0. 052778	69
.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 48, 784, 521	0.000000	71
.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 46, 259, 532	0.000000	72
.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 62, 950, 139	0.000000	73.
.00 07400 RENAL DIALYSIS	0	0		0 1, 272, 481	0.000000	74.
. OO O3O2O RADIATION ONCOLOGY	0	0		0 16, 558, 543	0.000000	76.
. 01 03040 ANGI OCARDI OGRAPHY	0	0		0 1, 152, 047	0.000000	76.
.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0		0 0	0.000000	77.
.00 07800 CAR T-CELL IMMUNOTHERAPY	0	0		0 0	0.000000	78.
OUTPATIENT SERVICE COST CENTERS						
. 00 09000 CLI NI C	0	0		0	0. 000000	90.
. 01 09001 DIABETES CLINIC	0	_		0	0. 000000	
.02 09002 OUTPATIENT CLINICS	0	0		0	0. 000000	
.03 09003 OCCUPATIONAL MEDICINE CLINIC	0	0		0 0	0. 000000	
04 09004 NEONATOLOGY CLINIC-FRANCISCAN POINT	0	0		0 87, 567	0. 000000	
.05 09005 LACTATION CLINIC	0	0		0 20, 350	0. 000000	
. 00 09100 EMERGENCY	0	889, 030	889, 03		0. 006636	
. 01 09101 EMERGENCY ROOM PHYSICANS	0	0		0	0. 000000	
. 02 09102 EXPRESS CARE	0	0		0	0. 000000	
OO OOOOOOOOOOOOOOOOOOOOOOOOOOOOOOOOOOO	1	ı o	I	0 10 898 738	0 000000	91

92.00

200.00

0.000000

0

1, 056, 039

1, 056, 039 1, 095, 425, 136

10, 898, 738

92. 00 | 09200 | 085ERVATION BEDS (NON-DISTINCT PART 200. 00 | Total (lines 50 through 199)

APP0R	TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	FRANCISCAN HEALTH RVICE OTHER PASS	Provi der Co	CN: 15-0126	Peri od:	worksheet D	
THROUG	H COSTS		Component (CCN: 15-T126	From 01/01/2023 To 12/31/2023		
			Title	XVIII	Subprovider -	PPS	
	Cost Center Description	Outpati ent	I npati ent	Inpati ent	Outpati ent	Outpati ent	
		Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Throug		Pass-Through	
		(col . 6 ÷ col .		Costs (col.	8	Costs (col. 9	
		7)	40.00	x col . 10)	10.00	x col . 12)	
	ANGLI LADV CEDVICE COCT CENTERS	9. 00	10.00	11.00	12.00	13. 00	
EO 00	ANCI LLARY SERVI CE COST CENTERS	0.000000	01.0/0			1 0	F0 00
50.00	05000 OPERATI NG ROOM	0. 000000	81, 068		0 0		
51.00	05100 RECOVERY ROOM	0.000000	6, 822		0 0		
52. 00 53. 00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY	0.000000	0		0 0	_	1
54.00	1 1	0.000000	6, 972		0 0		
	05400 RADI OLOGY - DI AGNOSTI C 05401 RADI OLOGY - I -65	0.000000	205, 852		0 0		1
54. 01 54. 02	05401 RADIOLOGY - 1-65 05402 RADIOLOGY DIAGNOSTIC - SJ	0. 000000	345 0		0 0		
54. 02	05402 RADI OLOGY DI AGNOSTIC - 35	0. 000000 0. 000000	0		0 0	0	
55. 00	05500 RADI OLOGY-THERAPEUTI C	0. 000000	0		0 0	0	
55. 00	05501 CARDI AC CATHERI ZATON LAB	0. 000000	61, 093		0 0		1
55. 02	03140 CARDI OLOGY	0. 000000	37, 205		0 0		
55. 02	03450 NEURO-DI AGNOSTI CS	0. 000000	13, 831				
60.00	06000 LABORATORY	0. 000000	649, 203		0 0	_	
60. 00	06001 BL00D LABORATORY	0. 000000	049, 203 N		0 0		
65. 00	06500 RESPIRATORY THERAPY	0. 000000	144, 661			_	
66. 00	06600 PHYSI CAL THERAPY	0. 000000	1, 007, 083				
66. 01	06601 PHYSI CAL THERAPY I -65	0. 000000	370			l .	
66. 02	06602 PHYSI CAL THERAPY ST JOHN	0. 000000	0		o c	ő	
67. 00	06700 OCCUPATI ONAL THERAPY	0. 000000	1, 071, 266		o c		1
67. 01	06701 OCCUPATION THERAPY I -65	0. 000000	371		o c		
67. 02	06702 OCCUPATIONAL THERAPY ST. JOHN	0. 000000	0		o c		1
68. 00	06800 SPEECH PATHOLOGY	0. 000000	441, 595		o c	0	
68. 01	06801 SPEECH PATHOLOGY I -65	0. 000000	68		o c	0	1
68. 02	06802 SPEECH THERAPY ST. JOHN	0. 000000	0		0 0	0	68. 02
69.00	06900 ELECTROCARDI OLOGY	0. 052778	0		0 0	0	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	230, 514		0 0	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	4, 891		0 0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	536, 939		0 116	0	73. 00
74.00	07400 RENAL DIALYSIS	0. 000000	8, 334		0 0	0	74. 00
76.00	03020 RADI ATI ON ONCOLOGY	0. 000000	0		0 0	0	76. 00
76. 01	03040 ANGI OCARDI OGRAPHY	0. 000000	204		0 0	0	76. 01
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0. 000000	0		0 0	0	77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0. 000000	0		0 0	0	78. 00
	OUTPATIENT SERVICE COST CENTERS						_
90.00	09000 CLINIC	0. 000000	0		0 0		
90. 01	09001 DI ABETES CLINI C	0. 000000	0		0 0	_	
90. 02	09002 OUTPATIENT CLINICS	0. 000000	0		0 0	_	
90. 03	09003 OCCUPATIONAL MEDICINE CLINIC	0. 000000	0		0 0	_	
90. 04	09004 NEONATOLOGY CLINIC-FRANCISCAN POINT	0. 000000	0		0 0	0	
90.05	09005 LACTATION CLINIC	0.000000	0		0 0	0	
91.00	09100 EMERGENCY	0. 006636	3, 279	•	22 0	0	
91. 01	09101 EMERGENCY ROOM PHYSICANS	0.000000	0				
91. UZ	09102 EXPRESS CARE	0. 000000	U	I	0 0	0	91. 02

0. 000000 0.000000

4, 511, 966

0 91.02 0 92.00 0 200.00

91. 02 | 09102 | EXPRESS CARE 92. 00 | 09200 | 0BSERVATI ON BEDS (NON-DI STINCT PART 200. 00 | Total (lines 50 through 199)

					5/30/2024 10:	06 am_
		Title	XVIII	Subprovi der -	PPS	
				I RF		
			Charges		Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed		Cost	PPS Services	
, , , , , , , , , , , , , , , , , , ,		Services (see	Rei mbursed	Rei mbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not	()	
	Part I, col. 9	11131.)	Subject To	Subject To		
	urt 1, cor. 7		Ded. & Coins.	Ded. & Coins.		
			(see inst.)	(see inst.)		
	1.00	2. 00	3.00	4. 00	5. 00	
ANCILL ADV. CEDVI CE. COCT. CENTEDO	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	0.4/0545	_			0	F0 00
50. 00 05000 OPERATI NG ROOM	0. 168545	0	l .		0	
51. 00 05100 RECOVERY ROOM	0. 073981	0	1		0	51. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 511524	0			0	52. 00
53. 00 05300 ANESTHESI OLOGY	0. 028063	0	(0	0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 082285	0) (0	0	54.00
54. 01 05401 RADI OLOGY - I -65	0. 058651	0)	0	0	54. 01
54.02 05402 RADIOLOGY DIAGNOSTIC - SJ	0. 000000	0) (0	0	54. 02
54. 03 05403 LOWELL RADI OLOGY	0. 562486	0		0	0	54. 03
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000	Ö	1		0	55. 00
55. 01 05501 CARDI AC CATHERI ZATON LAB	0. 128347	0	1		0	55. 01
55. 02 03140 CARDI OLOGY			l .		0	1
	0. 082838	0	l .		_	
55. 03 03450 NEURO-DI AGNOSTI CS	0. 131337	0	l .		0	55. 03
60. 00 06000 LABORATORY	0. 117422	0	l .		0	60. 00
60. 01 06001 BLOOD LABORATORY	0. 000000	0			0	60. 01
65. 00 06500 RESPI RATORY THERAPY	0. 189548	0) (0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 535173	0) (0	0	66. 00
66. 01 06601 PHYSI CAL THERAPY 1-65	0. 364425	0)	0	0	66. 01
66. 02 06602 PHYSI CAL THERAPY ST JOHN	0. 297387	0		0	0	66. 02
67. 00 06700 OCCUPATI ONAL THERAPY	0. 231298	0		0	0	67. 00
67. 01 06701 0CCUPATI ON THERAPY 1 -65	0. 385228	Ö	1		0	
67. 02 06702 OCCUPATI ONAL THERAPY ST. JOHN	0. 226277	0	1		0	67. 02
68. 00 06800 SPEECH PATHOLOGY	0. 165399	0	1		0	68. 00
		0	1			1
68. 01 06801 SPEECH PATHOLOGY I - 65	0. 218846		1		0	
68. 02 06802 SPEECH THERAPY ST. JOHN	0.000000	0	1		0	
69. 00 06900 ELECTROCARDI OLOGY	0. 396672	0	1		0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 579807	0	l .		0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 316794	0	1		0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 238649	116	1		28	1
74.00 07400 RENAL DIALYSIS	0. 565999	0	(0	0	74.00
76.00 03020 RADIATION ONCOLOGY	0. 097734	0) (0	0	76. 00
76. 01 03040 ANGI OCARDI OGRAPHY	0. 373480	0) (0	0	76. 01
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0. 000000	0) (0	0	77. 00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0. 000000	0	1		0	1
OUTPATIENT SERVICE COST CENTERS				-1		1
90. 00 09000 CLINIC	0. 000000	0	(0	0	90.00
90. 01 09001 DI ABETES CLINIC	0. 000000	0	1		0	1
90. 02 09002 00TPATI ENT CLINICS	0. 000000	0	1		0	1
			1			1
90. 03 09003 OCCUPATI ONAL MEDI CI NE CLI NI C	0.000000	0	1		0	90. 03
90. 04 09004 NEONATOLOGY CLINIC-FRANCISCAN POINT	0. 350166	0	1		0	
90. 05 09005 LACTATI ON CLI NI C	2. 449681	0	1		0	
91. 00 09100 EMERGENCY	0. 109585	0	1		0	
91.01 09101 EMERGENCY ROOM PHYSICANS	0. 000000	0)	0	0	91. 01
91. 02 09102 EXPRESS CARE	0. 000000	0) (0	0	91. 02
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 545790	0) (0	0	92.00
200.00 Subtotal (see instructions)		116	,	300	28	200. 00
201.00 Less PBP Clinic Lab. Services-Program		1				201. 00
Only Charges]			
202.00 Net Charges (line 200 - line 201)		116	,	300	28	202. 00
1.11 1.11 2.11 3.11 (1.110 200)	1	, ,,,,	'	300	20	,

Health Financial Systems	FRANCI SCAN HEALTH	In Lieu of Form CMS-2552-		
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0126	Peri od: From 01/01/2023	Worksheet D Part V
		Component CCN: 15-T126		
		Title XVIII	Subprovi der -	PPS

		Title	XVIII	Subprovi der - I RF	PPS	
	Co	sts		IKF		
Cost Center Description	Cost	Cost				
	Rei mbursed	Rei mbursed				
	Servi ces	Servi ces Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.) 6.00	(see inst.) 7.00				
ANCILLARY SERVICE COST CENTERS	6.00	7.00				
50. 00 05000 OPERATING ROOM	С	0				50.00
51. 00 05100 RECOVERY ROOM	Č					51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	C	l .	1			52. 00
53. 00 05300 ANESTHESI OLOGY	C					53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	C	0				54.00
54. 01 05401 RADI OLOGY - I -65	C	0				54. 01
54.02 05402 RADIOLOGY DIAGNOSTIC - SJ	C	0				54. 02
54. 03 05403 LOWELL RADI OLOGY	C					54. 03
55. 00 05500 RADI OLOGY-THERAPEUTI C	C					55. 00
55. 01 05501 CARDI AC CATHERI ZATON LAB	C					55. 01
55. 02 03140 CARDI OLOGY	C	_				55. 02
55. 03 03450 NEURO-DI AGNOSTI CS	C					55. 03
60. 00 06000 LABORATORY 60. 01 06001 BLOOD LABORATORY	C					60. 00 60. 01
65. 00 06500 RESPI RATORY THERAPY						65. 00
66. 00 06600 PHYSI CAL THERAPY		_				66.00
66. 01 06601 PHYSI CAL THERAPY I -65						66. 01
66. 02 06602 PHYSI CAL THERAPY ST JOHN						66. 02
67. 00 06700 OCCUPATI ONAL THERAPY						67. 00
67. 01 06701 OCCUPATION THERAPY I -65	C	0				67. 01
67.02 06702 OCCUPATIONAL THERAPY ST. JOHN	C	0				67. 02
68.00 06800 SPEECH PATHOLOGY	C	0				68. 00
68. 01 06801 SPEECH PATHOLOGY I-65	C	0				68. 01
68. 02 06802 SPEECH THERAPY ST. JOHN	C					68. 02
69. 00 06900 ELECTROCARDI OLOGY	C	_				69. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	C					71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	C					72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 74. 00 07400 RENAL DIALYSIS		. –				73. 00 74. 00
76. 00 03020 RADIATION ONCOLOGY		_	1			76.00
76. 01 03040 ANGI OCARDI OGRAPHY						76. 01
77. 00 07700 ALLOGENEIC HSCT ACQUISITION		l .				77. 00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	C	0				78. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	C	0				90. 00
90. 01 09001 DI ABETES CLI NI C	C					90. 01
90. 02 09002 OUTPATIENT CLINICS	C					90. 02
90. 03 09003 OCCUPATIONAL MEDICINE CLINIC	C					90. 03
90. 04 09004 NEONATOLOGY CLINIC-FRANCISCAN POINT	C					90.04
90. 05 09005 LACTATION CLINIC 91. 00 09100 EMERGENCY	C					90. 05 91. 00
91. 00 09100 EMERGENCY 91. 01 09101 EMERGENCY ROOM PHYSI CANS		_				91.00
91. 02 09102 EXPRESS CARE						91.01
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
200.00 Subtotal (see instructions)		_				200. 00
201. 00 Less PBP Clinic Lab. Services-Progra	-					201. 00
Only Charges						
202.00 Net Charges (line 200 - line 201)	c	72				202. 00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der Co		Period: From 01/01/2023	Worksheet D Part V	
				To 12/31/2023	Date/Time Pre 5/30/2024 10:	pared: 06 am
		Titl	e XIX	Hospi tal	Cost	
			Charges		Costs	
Cost Center Description		PPS Reimbursed		Cost	PPS Services	
	Ratio From	Services (see	Reimbursed	Rei mbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subj ect To		
			Ded. & Coins.	Ded. & Coins.		
			(see inst.)	(see inst.)		
ANOLLI ADV. CERVI OF COCT. CENTERC	1.00	2.00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS	0.1/0545		11 770 10	F 0	1 0	F0 00
50. 00 05000 OPERATING ROOM	0. 168545	l	, ,		0	
51. 00 05100 RECOVERY ROOM	0. 073981	0			-	51.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM	0. 511524	0	8, 84		0	52.00
53. 00 05300 ANESTHESI OLOGY	0. 028063	0			0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 082285	0	,, .		0	54. 00
54. 01 05401 RADI 0L0GY - I -65	0. 058651	0	2, 443, 89	8 0	0	54. 01
54.02 05402 RADIOLOGY DIAGNOSTIC - SJ	0. 000000	0		0	0	54. 02
54. 03 05403 LOWELL RADI OLOGY	0. 562486	0		0	0	54. 03
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000	0		0	0	55. 00
55. 01 05501 CARDI AC CATHERI ZATON LAB	0. 128347	0	1, 040, 25	5 0	0	55. 01
55. 02 03140 CARDI OLOGY	0. 082838	0	2, 253, 48	6 0	0	55. 02
55. 03 03450 NEURO-DI AGNOSTI CS	0. 131337	0	1, 589, 13	5 0	0	55. 03
60. 00 06000 LABORATORY	0. 117422	0	19, 623, 53	1 0	0	60.00
60. 01 06001 BL00D LABORATORY	0. 000000	0		0 0	0	60. 01
65. 00 06500 RESPIRATORY THERAPY	0. 189548	0	487, 76	1 0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 535173	0	20, 44	0 0	0	66.00
66. 01 06601 PHYSI CAL THERAPY I -65	0. 364425	0	483, 85	5 0	0	66. 01
66. 02 06602 PHYSI CAL THERAPY ST JOHN	0. 297387	0			0	66. 02
67. 00 06700 OCCUPATI ONAL THERAPY	0. 231298	0	19, 99		l o	67. 00
67. 01 06701 0CCUPATI ON THERAPY 1 -65	0. 385228	l e	1			67. 01
67. 02 06702 OCCUPATI ONAL THERAPY ST. JOHN	0. 226277	0	1,	0 0	l ő	67. 02
68. 00 06800 SPEECH PATHOLOGY	0. 165399	0	16, 19	9 0	l o	68.00
68. 01 06801 SPEECH PATHOLOGY I -65	0. 218846	0	942, 70		l o	68. 01
68. 02 06802 SPEECH THERAPY ST. JOHN	0. 000000	0	1 , 12, , 0	0 0	l ő	68. 02
69. 00 06900 ELECTROCARDI OLOGY	0. 396672	l ő	160, 08	6 0	Ö	69.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 579807	0			Ö	71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0. 316794	0			0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 238649	0	2, 218, 33		0	73.00
74. 00 07400 RENAL DI ALYSI S	0. 565999	0			0	74.00
76. 00 03020 RADI ATI ON ONCOLOGY	0. 097734	0	1, 657, 91			76.00
76. 01 03040 ANGI OCARDI OGRAPHY	0. 373480	0	83, 26		0	76. 00
77. 00 07700 ALLOGENEIC HSCT ACQUISITION	0. 000000	0		0 0	0	77.00
78. 00 07800 CAR T-CELL IMMUNOTHERAPY	0.000000	-		0 0		78.00
OUTPATIENT SERVICE COST CENTERS	0.000000			0 0		76.00
90. 00 09000 CLINIC	0. 000000	0		0 0	0	90.00
90. 01 09001 DI ABETES CLINI C	1	ł		0	0	1
	0.000000	ł		0	0	1
90. 02 09002 OUTPATIENT CLINICS	0. 000000			0		90. 02
90. 03 09003 OCCUPATIONAL MEDICINE CLINIC	0. 000000	ł		0	0	90. 03
90. 04 09004 NEONATOLOGY CLINIC-FRANCISCAN POINT	0. 350166	l			-	
90. 05 09005 LACTATI ON CLI NI C	2. 449681	0			0	
91. 00 09100 EMERGENCY	0. 109585		21, 957, 22	0	0	91.00
91. 01 09101 EMERGENCY ROOM PHYSI CANS	0. 000000	ł		U 0	0	
91. 02 09102 EXPRESS CARE	0. 000000			0	0	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 545790	0	1, 058, 59		0	
200.00 Subtotal (see instructions)		0	104, 110, 56	2 0	0	200. 00
201.00 Less PBP Clinic Lab. Services-Program				0		201. 00
Only Charges		_		-	_	
202.00 Net Charges (line 200 - line 201)		0	104, 110, 56	2 0	1 0	202. 00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-0126 Peri od: Worksheet D From 01/01/2023 Part V Date/Time Prepared: 12/31/2023 5/30/2024 10:06 am Title XIX Hospi tal Cost Costs 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.) 6.00 7.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 1, 985, 309 0 50.00 51.00 05100 RECOVERY ROOM 164, 987 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 0 52 00 4 526 52 00 53.00 05300 ANESTHESI OLOGY 60,875 0 53.00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 1, 958, 031 54.00 54. 01 05401 RADI OLOGY - 1-65 143.337 0 54.01 05402 RADIOLOGY DIAGNOSTIC - SJ 0 54.02 0 54.02 54.03 05403 LOWELL RADIOLOGY 0 0 54.03 05500 RADI OLOGY-THERAPEUTI C 0 55.00 0 55.00 05501 CARDI AC CATHERI ZATON LAB 0 133 514 55 01 55 01 03140 CARDI OLOGY 55.02 186, 674 0 55.02 55.03 03450 NEURO-DI AGNOSTI CS 208, 712 0 55.03 60.00 06000 LABORATORY 2, 304, 234 0 60.00 60.01 06001 BLOOD LABORATORY 0 60.01 65.00 06500 RESPIRATORY THERAPY 92, 454 0 65.00 06600 PHYSI CAL THERAPY 10, 939 66.00 66.00 06601 PHYSICAL THERAPY I-65 0 66, 01 176, 329 66.01 06602 PHYSI CAL THERAPY ST JOHN 0 66.02 37,060 66.02 67.00 06700 OCCUPATI ONAL THERAPY 4,626 0 67.00 06701 OCCUPATION THERAPY I-65 0 67.01 24, 406 67.01 06702 OCCUPATIONAL THERAPY ST. JOHN 0 67.02 67.02 06800 SPEECH PATHOLOGY 2.679 0 68.00 68 00 68.01 06801 SPEECH PATHOLOGY I -65 206, 308 0 68.01 06802 SPEECH THERAPY ST. JOHN 68.02 68.02 Ol 06900 ELECTROCARDI OLOGY 69.00 63.502 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 1, 914, 384 0 71.00 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 1, 433, 522 72.00 72.00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 529, 404 73.00 07400 RENAL DIALYSIS 74 00 3, 395 0 74 00 76.00 03020 RADIATION ONCOLOGY 162, 035 0 76.00 03040 ANGI OCARDI OGRAPHY 0 76. 01 31, 099 76.01 07700 ALLOGENEIC HSCT ACQUISITION 77.00 0 77.00 0 07800 CAR T-CELL IMMUNOTHERAPY 78.00 0 78.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 90.00 09001 DIABETES CLINIC 90.01 0 0 90.01 90.02 09002 OUTPATIENT CLINICS 0 0 90.02 90.03 09003 OCCUPATIONAL MEDICINE CLINIC 0 0 90.03 0 09004 NEONATOLOGY CLINIC-FRANCISCAN POINT 15, 438 90.04 90.04 09005 LACTATION CLINIC 0 90.05 14, 551 90.05 91.00 09100 EMERGENCY 2, 406, 182 0 91.00 09101 EMERGENCY ROOM PHYSICANS 91.01 0 0 91.01 91 02 09102 EXPRESS CARE 0 91.02 0 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 577, 769 0 92.00 200.00 Subtotal (see instructions) 14, 856, 281 0 200.00

14, 856, 281

0

201.00

202.00

201.00

202.00

Less PBP Clinic Lab. Services-Program

Net Charges (line 200 - line 201)

Only Charges

Hoal th	Financial Systems F	FRANCISCAN HEAL	TU CDOWN DOINT		In Lie	eu of Form CMS-:	2552 10
	FIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA		Provi der C	CN: 15_0126	Peri od:	Worksheet D	2332-10
ALLOK	TOMMENT OF THEATTENT ANOTEENIN SERVICE CALLER	L 00313	Trovider C	CIV. 13-0120	From 01/01/2023	Part II	
			Component	CCN: 15-T126	To 12/31/2023	Date/Time Pre	
						5/30/2024 10:	<u>06 am</u>
			litl	e XIX	Subprovi der – I RF	TEFRA	
	Cost Center Description	Capi tal	Total Charges	Ratio of Cos		Capital Costs	
	•	Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
		(from Wkst. B,	Part I, col.	(col . 1 ÷ col	. Charges	column 4)	
		Part II, col.	8)	2)	·		
		26)					
		1.00	2.00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00		4, 184, 019				0	
51.00	05100 RECOVERY ROOM	481, 286				0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	73, 676	6, 988, 298			0	52. 00
53.00	05300 ANESTHESI OLOGY	286, 286				0	
54.00	05400 RADI OLOGY-DI AGNOSTI C	2, 638, 665	232, 172, 476			0	
54. 01	05401 RADI OLOGY - I -65	270, 193	24, 717, 168			0	
54. 02	05402 RADI OLOGY DI AGNOSTIC - SJ	0	0	0. 00000		0	
54. 03	05403 LOWELL RADI OLOGY	12, 083	36, 824	1		0	
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0	0.0000	00	0	55. 00
55. 01	05501 CARDI AC CATHERI ZATON LAB	1, 192, 373	49, 459, 743	0. 02410	0 80	0	
55. 02	03140 CARDI OLOGY	418, 190	33, 919, 362	0. 0123	29 0	0	55. 02
55. 03	03450 NEURO-DI AGNOSTI CS	168, 276		0. 0166	40 0	0	55. 03
60.00	06000 LABORATORY	940, 997	180, 178, 953	0.0052	1, 848	10	60.00
60. 01	06001 BLOOD LABORATORY	0	ή	0.0000		0	
65. 00	06500 RESPI RATORY THERAPY	302, 519	19, 657, 993	0. 0153	39 0	0	65. 00
66.00	06600 PHYSI CAL THERAPY	224, 217				0	
66. 01	06601 PHYSI CAL THERAPY I -65	44, 223	4, 004, 113	0.0110		0	66. 01
66. 02	06602 PHYSI CAL THERAPY ST JOHN	12, 156				0	
67.00	06700 OCCUPATI ONAL THERAPY	22, 570	4, 591, 392	0.0049		0	67. 00
67. 01	06701 OCCUPATION THERAPY I-65	3, 651	454, 988	0.0080	24 0	0	67. 01
67. 02	06702 OCCUPATIONAL THERAPY ST. JOHN	397	82, 240	0. 00482	27 0	0	67. 02
68. 00	06800 SPEECH PATHOLOGY	14, 367	4, 016, 943	0.0035	77 0	0	68. 00
68. 01	06801 SPEECH PATHOLOGY I -65	11, 853	2, 542, 739	0. 0046	52 0	0	68. 01
68. 02	06802 SPEECH THERAPY ST. JOHN	0	0	0.0000	00	0	68. 02
69. 00	06900 ELECTROCARDI OLOGY	88, 732	3, 164, 363	0. 0280	41 0	0	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	996, 001	48, 784, 521	0. 0204	16 0	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	507, 328				0	
73.00	07300 DRUGS CHARGED TO PATIENTS	396, 512	62, 950, 139	0. 00629	99 0	0	73. 00
74.00	07400 RENAL DIALYSIS	38, 815				0	
76.00	03020 RADIATION ONCOLOGY	156, 901	16, 558, 543	0.0094	76 0	0	76. 00
76. 01	03040 ANGI OCARDI OGRAPHY	9, 023	1, 152, 047	0.0078	32 0	0	76. 01
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0				0	
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0	0	0.0000	00	0	78. 00
	OUTPATIENT SERVICE COST CENTERS						
90. 00	09000 CLI NI C	0				0	
90. 01	09001 DI ABETES CLI NI C	0	1			0	
90. 02	09002 OUTPATIENT CLINICS	135	ł			0	
90. 03	09003 OCCUPATIONAL MEDICINE CLINIC	0	1	1 0.0000		0	
90. 04	09004 NEONATOLOGY CLINIC-FRANCISCAN POINT	840				0	
90. 05	09005 LACTATION CLINIC	1, 625				0	
91.00	09100 EMERGENCY	1, 487, 494		1		0	
91. 01		0				0	
91. 02	09102 EXPRESS CARE	0)l o	0.0000	00 0	0	91. 02

0 0 0 0 10,898,738 14,985,403 1,095,425,136

0.000000

0.000000

1, 848

91. 02 0 92.00 10 200.00

91. 02 | 09102 EXPRESS CARE 92. 00 | 09200 OBSERVATION BEDS (NON-DISTINCT PART 200. 00 | Total (lines 50 through 199)

Health Financial Systems	FRANCI SCAN HEALTH	CROWN POINT	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0126 Component CCN: 15-T126	Peri od: From 01/01/2023 To 12/31/2023	Worksheet D Part IV Date/Time Prepared: 5/30/2024 10:06 am

		'			5/30/2024 10:	06 am_
		Ti tl	e XIX	Subprovi der -	TEFRA	
	T			IRF		
Cost Center Description	Non Physician	Nursi ng	Nursi ng		Allied Health	
	Anesthetist	Program	Program	Post-Stepdown		
	Cost	Post-Stepdown		Adjustments		
	1.00	Adjustments 2A	2.00	3A	3. 00	
ANCILLARY SERVICE COST CENTERS	1.00	ZA	2.00	JA	3.00	
50. 00 05000 OPERATING ROOM	0	Ο	1	0 0	0	50. 00
51. 00 05100 RECOVERY ROOM		ا				51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM				0 0		52. 00
53. 00 05300 ANESTHESI OLOGY					0	53. 00
54. 00 05400 RADI OLOGY - DI AGNOSTI C				0 0	-	54. 00
54. 01 05400 RADI 0LOGY - I -65				0 0	0	54. 00
54. 02 05402 RADI OLOGY DI AGNOSTI C - SJ				0 0	0	54. 01
54. 03 05403 LOWELL RADI OLOGY				0 0	· -	54. 02
				0 0	1	55. 00
		0		0 0	1	
55. 01 05501 CARDI AC CATHERI ZATON LAB		0				55. 01
55. 02 03140 CARDI OLOGY		0		0		55. 02
55. 03 03450 NEURO-DI AGNOSTI CS		0		0		55. 03
60. 00 06000 LABORATORY	0	0		0 0		60.00
60. 01 06001 BLOOD LABORATORY	0	0		0	0	60. 01
65. 00 06500 RESPIRATORY THERAPY	0	0		0		65. 00
66. 00 06600 PHYSI CAL THERAPY	0	0	•	0		66. 00
66. 01 06601 PHYSI CAL THERAPY I - 65	0	0		0		66. 01
66. 02 06602 PHYSI CAL THERAPY ST JOHN	0	0		0	0	66. 02
67. 00 06700 OCCUPATI ONAL THERAPY	0	0		0	0	67.00
67. 01 06701 0CCUPATI ON THERAPY I -65		0		0	0	67. 01
67. 02 06702 OCCUPATIONAL THERAPY ST. JOI	in O	0		0		67. 02
68. 00 06800 SPEECH PATHOLOGY	0	0		0	0	68. 00
68. 01 06801 SPEECH PATHOLOGY I -65	0	0		0		68. 01
68. 02 06802 SPEECH THERAPY ST. JOHN	0	0		0		68. 02
69. 00 06900 ELECTROCARDI OLOGY	0	0		0		1
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO		0		0	0	71. 00
72. 00 07200 I MPL. DEV. CHARGED TO PATIE	VIS 0	0		0		
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0		0		73. 00
74. 00 07400 RENAL DI ALYSI S	0	0		0		74. 00
76. 00 03020 RADI ATI ON ONCOLOGY	0	0		0	0	76. 00
76. 01 03040 ANGI OCARDI OGRAPHY	0	0		0	-	76. 01
77. 00 07700 ALLOGENEIC HSCT ACQUISITION	0	0		0		77. 00
78. 00 O7800 CAR T-CELL IMMUNOTHERAPY	0	0		0 0	0	78. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	0		0		1
90. 01 09001 DI ABETES CLINI C	0	0	•	0		90. 01
90. 02 09002 OUTPATIENT CLINICS	0	0		0		90. 02
90. 03 09003 OCCUPATIONAL MEDICINE CLINIC		0		0	0	90. 03
90. 04 09004 NEONATOLOGY CLINIC-FRANCISC	AN POINI O	0		0		90. 04
90. 05 09005 LACTATION CLINIC	0	0	•	0		90. 05
91. 00 09100 EMERGENCY	0	0		0		
91. 01 09101 EMERGENCY ROOM PHYSI CANS	0	0		0	0	91. 01
91. 02 09102 EXPRESS CARE	0	0		0	· -	
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI)	1	_		0	0	92. 00
200.00 Total (lines 50 through 199)) 0	0	1	0	1, 056, 039	[200. 00

	FLONMENT OF INPATLENT/OUTPATLENT ANCILLARY SE SH COSTS	RVICE OTHER PASS	S Provider Co	CN: 15-0126	Peri od: From 01/01/2023	Worksheet D Part IV	
TINOU	JII 00313		Component	CCN: 15-T126	To 12/31/2023		pared: 06 am
			Ti tI	e XIX	Subprovider - IRF	TEFRA	
	Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
		Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,	to Charges	
		Education Cost		Cost (sum of		(col. 5 ÷ col.	
			4)	col s. 2, 3, and 4)	8)	7) (see	
				and 4)		instructions)	
		4.00	5. 00	6. 00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0			0 142, 744, 483	0. 000000	
51.00	05100 RECOVERY ROOM	0			0 21, 679, 290	0. 000000	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0 6, 988, 298	0.000000	
53.00	05300 ANESTHESI OLOGY	0	0		0 27, 275, 880	0.000000	
54.00	05400 RADI OLOGY - DI AGNOSTI C	0	0		0 232, 172, 476	0.000000	
54. 01 54. 02	05401 RADI OLOGY - I - 65 05402 RADI OLOGY DI AGNOSTI C - SJ	0	0		0 24, 717, 168 0 0	0. 000000 0. 000000	
54. 02	05403 LOWELL RADIOLOGY	0	0		0 36, 824	0.000000	
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0		0 30, 624	0. 000000	
55. 01	05501 CARDI AC CATHERI ZATON LAB	0	Ö		0 49, 459, 743	0. 000000	
55. 02	03140 CARDI OLOGY	0	Ö		0 33, 919, 362	0. 000000	
55. 03	03450 NEURO-DI AGNOSTI CS	0	0		0 10, 112, 496	0.000000	55. 03
60.00	06000 LABORATORY	0	0		0 180, 178, 953	0. 000000	60.00
60. 01	06001 BLOOD LABORATORY	0	0		0	0. 000000	60. 01
65.00	06500 RESPI RATORY THERAPY	0	0		0 19, 657, 993	0. 000000	
66.00	06600 PHYSI CAL THERAPY	0	0		0 4, 398, 506	0. 000000	
66. 01	06601 PHYSI CAL THERAPY I -65	0	0		0 4, 004, 113	0.000000	
66. 02 67. 00	06602 PHYSI CAL THERAPY ST JOHN 06700 OCCUPATI ONAL THERAPY	0	0		0 1, 275, 061 0 4, 591, 392	0. 000000 0. 000000	
67. 00	06701 OCCUPATIONAL THERAPY I -65	0			0 4, 591, 392 0 454, 988	0.000000	
67. 02	06702 OCCUPATION THERAPY ST. JOHN	0	0		0 82, 240	0.000000	
68. 00	06800 SPEECH PATHOLOGY	0	0		0 4, 016, 943	0. 000000	
68. 01	06801 SPEECH PATHOLOGY I -65	Ö	Ö		0 2, 542, 739	0. 000000	
68. 02	06802 SPEECH THERAPY ST. JOHN	0	0		0 0	0.000000	
69.00	06900 ELECTROCARDI OLOGY	0	167, 009	167, 00	3, 164, 363	0. 052778	69.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 48, 784, 521	0. 000000	
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0 46, 259, 532	0. 000000	
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 62, 950, 139	0.000000	
74.00	07400 RENAL DIALYSIS	0	0		0 1, 272, 481	0.000000	
76. 00 76. 01	03020 RADI ATI ON ONCOLOGY 03040 ANGI OCARDI OGRAPHY	0	0		0 16, 558, 543 0 1, 152, 047	0. 000000 0. 000000	
77. 00	07700 ALLOGENEIC HSCT ACQUISITION		-		0 1, 152, 047	0. 000000	
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0			0 0	0.000000	
, 5. 55	OUTPATIENT SERVICE COST CENTERS				<u> </u>	3.000000	1 , 5. 50
90. 00	09000 CLI NI C	0	0		0 0	0. 000000	90.00
90. 01	09001 DI ABETES CLINIC	0	1		0 0	0. 000000	
90. 02	09002 OUTPATIENT CLINICS	0	0		0	0. 000000	90. 02
90. 03	09003 OCCUPATIONAL MEDICINE CLINIC	0	0		0	0. 000000	
90. 04	09004 NEONATOLOGY CLINIC-FRANCISCAN POINT	0	0		0 87, 567	0. 000000	
90.05	09005 LACTATION CLINIC	0	0		0 20, 350	0.000000	
91.00	09100 EMERGENCY 09101 EMERGENCY ROOM PHYSI CANS	0	889, 030	889, 03		0.006636	
	TO STOLLE MERGENCY ROOM PHYSICANS	1 ()	1 0	l	0 0	0.000000	91.01
91. 01 91. 02		o o	1			0. 000000	

1, 056, 039

0 10, 898, 738 1, 056, 039 1, 095, 425, 136

0.000000

92.00

200.00

92. 00 | 09200 | 098ERVATION BEDS (NON-DISTINCT PART 200. 00 | Total (lines 50 through 199)

Health Financial Systems	FRANCISCAN HEALT				u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLAR	RY SERVICE OTHER PASS	Provider C		Peri od: From 01/01/2023	Worksheet D Part IV	
THROUGH COSTS		Component		To 12/31/2023		epared:
		Ti tl	e XIX	Subprovi der - I RF	TEFRA	00 aiii
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		Pass-Through	
	(col. 6 ÷ col.		Costs (col. 8	3	Costs (col. 9	
	7)	10.00	x col. 10) 11.00	12.00	x col . 12) 13.00	_
ANCI LLARY SERVI CE COST CENTERS	7.00	10.00	11.00	12.00	13.00	_
50. 00 05000 OPERATING ROOM	0. 000000	C)	0 0	0	50.00
51. 00 05100 RECOVERY ROOM	0. 000000	C		0 0	· -	
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	C	•	o o	o o	1
53. 00 05300 ANESTHESI OLOGY	0. 000000	C	1	o o	Ö	1
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	Č	1	0 0	Ö	1
54. 01 05401 RADI OLOGY - I -65	0. 000000	Ć		0 0	0	1
54. 02 05402 RADIOLOGY DIAGNOSTIC - SJ	0. 000000	Č		0 0	Ö	1
54. 03 05403 LOWELL RADI OLOGY	0. 000000	C		0	0	1
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000	C	•	0 0	Ō	1
55. 01 05501 CARDI AC CATHERI ZATON LAB	0. 000000	C	•	0	0	55. 01
55. 02 03140 CARDI OLOGY	0. 000000	C		0 0	0	1
55. 03 03450 NEURO-DI AGNOSTI CS	0. 000000	C		0 0	0	55. 03
60. 00 06000 LABORATORY	0. 000000	1, 848	3	0 0	0	60.00
60. 01 06001 BLOOD LABORATORY	0. 000000	C		0 0	0	60. 01
65. 00 06500 RESPI RATORY THERAPY	0. 000000	C		0 0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	C		0	0	66.00
66. 01 06601 PHYSI CAL THERAPY I -65	0. 000000	C		0	0	66. 01
66. 02 06602 PHYSI CAL THERAPY ST JOHN	0. 000000	C		0 0	0	66. 02
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	C		0 0	0	67. 00
67.01 06701 OCCUPATION THERAPY I-65	0. 000000	C		0	0	67. 01
67. 02 06702 OCCUPATI ONAL THERAPY ST. JOHN	0. 000000	C	l .	0	0	67. 02
68. 00 06800 SPEECH PATHOLOGY	0. 000000	C	l .	0	0	
68. 01 06801 SPEECH PATHOLOGY I -65	0. 000000	C		0	0	
68. 02 06802 SPEECH THERAPY ST. JOHN	0. 000000	C		0	0	
69. 00 06900 ELECTROCARDI OLOGY	0. 052778	C	1	0	0	
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI EI		C		0	0	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	C	l	0	0	
73. 00 O7300 DRUGS CHARGED TO PATIENTS	0. 000000	C	1	0	0	1
74. 00 07400 RENAL DI ALYSI S	0. 000000	C	1	0	0	
76. 00 03020 RADI ATI ON ONCOLOGY	0. 000000	C		0	0	
76. 01 03040 ANGI OCARDI OGRAPHY 77. 00 07700 ALLOGENEI C HSCT ACQUI SI TI ON	0. 000000	(0 0	0	1
77.00 07700 ALLOGENEIC HSCT ACQUISITION 78.00 07800 CAR T-CELL IMMUNOTHERAPY	0. 000000 0. 000000	C		0 0	0	
OUTPATIENT SERVICE COST CENTERS	0.000000		1	0	U	78.00
90. 00 09000 CLI NI C	0. 000000	C)	0 0	0	90.00
90. 01 09001 DI ABETES CLINI C	0. 000000	C	•	o o		
90. 02 09002 0UTPATI ENT CLINICS	0. 000000		•	0 0	Ö	1
90. 03 09003 OCCUPATIONAL MEDICINE CLINIC	0. 000000	C	1	0 0	l	1
90. 04 09004 NEONATOLOGY CLINIC-FRANCISCAN POIN		C	1	0 0	Ö	1
90. 05 09005 LACTATION CLINIC	0. 000000	Ć	•	0 0	Ö	1
91. 00 09100 EMERGENCY	0. 006636	C	•	0 0	1	1
91. 01 09101 EMERGENCY ROOM PHYSI CANS	0. 000000	C	1	0 0	Ō	1
	0. 000000	(•	0	Ō	1
91. 02 09102 EXPRESS CARE	0. 000000					
91. 02 09102 EXPRESS CARE 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PAR		Č	•	0 0	Ō	1

		FRANCI SCAN HEALTH CF			of Form CMS-	
COMPUT	ATION OF INPATIENT OPERATING COST		Provider CCN: 15-0126	Peri od:	Worksheet D-1	
				From 01/01/2023 To 12/31/2023	Date/Time Pre 5/30/2024 10:	
			Title XVIII	Hospi tal	PPS	
	Cost Center Description					
					1. 00	
	PART I - ALL PROVIDER COMPONENTS					1
1 00	INPATIENT DAYS				25 024	1 00
1. 00 2. 00	Inpatient days (including private room days Inpatient days (including private room days				35, 834	
3.00	Private room days (excluding swing-bed and			ivata room days	35, 834 do 0	
3.00	not complete this line.	observation bed days	s). If you have only pr	I vate 100iii days,	uo 0	3.00
4.00	Semi-private room days (excluding swing-bed	and observation bed	days)		31, 417	4. 00
5. 00	Total swing-bed SNF type inpatient days (in			r 31 of the cost	0.,	1
	reporting period	3				
6.00	Total swing-bed SNF type inpatient days (in	ncluding private room	n days) after December	31 of the cost	0	6. 00
	reporting period (if calendar year, enter 0					
7.00	Total swing-bed NF type inpatient days (inc	cluding private room	days) through December	31 of the cost	0	7. 00
	reporting period				_	
8.00	Total swing-bed NF type inpatient days (inc		days) after December 3	1 of the cost	0	8. 00
9. 00	reporting period (if calendar year, enter O Total inpatient days including private room		the Drogram (eveluding	cwing had and	12, 312	9.00
9.00	newborn days) (see instructions)	days applicable to	the Program (excluding	Swing-bed and	12, 312	9.00
10. 00	Swing-bed SNF type inpatient days applicable	e to title XVIII onl	v (including private r	oom davs) through	0	10.00
10.00	December 31 of the cost reporting period (see instructions)				· ·	10.00
11.00					0	11. 00
	December 31 of the cost reporting period (i	f cal endar year, ent	er O on this line)			
12.00	Swing-bed NF type inpatient days applicable		only (including privat	e room days)	0	12. 00
	through December 31 of the cost reporting p					
13. 00	Swing-bed NF type inpatient days applicable			e room days) afte	r 0	13. 00
14. 00	December 31 of the cost reporting period (i Medically necessary private room days appli			daye)	0	14. 00
15. 00		cable to the Program	(excluding swing-bed	uays)	0	
16. 00	Nursery days (title V or XIX only)				0	
10.00	SWING BED ADJUSTMENT					10.00
17. 00	Medicare rate for swing-bed SNF services ap	pplicable to services	s through December 31 o	f the cost	0.00	17. 00
	reporting period	.,	3			
18.00	Medicare rate for swing-bed SNF services ap	oplicable to services	after December 31 of	the cost reportin	g 0.00	18. 00
	peri od					
19. 00	Medicaid rate for swing-bed NF services app	olicable to services	through December 31 of	the cost reporti	ng 0.00	19. 00
	peri od					
20. 00	Medicaid rate for swing-bed NF services app	of cable to services	after December 31 of t	ne cost reporting	0. 00	20. 00
21 00	period	et (coo inctructions)			40 250 042	21. 00
21. 00 22. 00	Total general inpatient routine service cos Swing-bed cost applicable to SNF type servi	,		ing ported (line	48, 258, 042 5 0	1
ZZ. UU	x line 17)	ces thi ough beceiliber	or or the cost report	ing period (Tine	5 0	22.00
23. 00	Swing-bed cost applicable to SNF type servi	ces after December 3	31 of the cost reportin	a period (line 6	x 0	23. 00
00	line 18)			3 ,	· ·	
24. 00	Swing-bed cost applicable to NF type servic	ces through December	31 of the cost reporti	ng period (line 🕇	x 0	24. 00
	line 19)	-	•	- ,		
25. 00	Swing-bed cost applicable to NF type service	ces after December 31	of the cost reporting	period (line 8 🛊	0	25. 00
	line 20)					1

	I NPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	35, 834	1. 00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	35, 834	2. 00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days,	do 0	3. 00
	not complete this line.		
4.00	Semi-private room days (excluding swing-bed and observation bed days)	31, 417	4. 00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost	0	5. 00
	reporting period		
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	0	6. 00
	reporting period (if calendar year, enter 0 on this line)	-	
7. 00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost	0	7. 00
7.00	reporting period	Ü	7.00
8. 00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	0	8. 00
0.00	reporting period (if calendar year, enter 0 on this line)	U	0.00
9. 00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and	12 212	9. 00
9.00		12, 312	9.00
10.00	newborn days) (see instructions)		10.00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through	0	10. 00
	December 31 of the cost reporting period (see instructions)		
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after	0	11. 00
	December 31 of the cost reporting period (if calendar year, enter 0 on this line)	_	
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	12. 00
	through December 31 of the cost reporting period		
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) afte	er 0	13. 00
	December 31 of the cost reporting period (if calendar year, enter 0 on this line)		
14. 00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14. 00
15. 00	Total nursery days (title V or XIX only)	0	15. 00
16.00	Nursery days (title V or XIX only)	0	16. 00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost	0.00	17. 00
	reporting period		
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reportin	ng 0.00	18. 00
	peri od	•	
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporti	ng 0.00	19. 00
	peri od	· ·	
20.00	Medical drate for swing-bed NF services applicable to services after December 31 of the cost reporting	0.00	20. 00
	period	,	
21. 00	Total general inpatient routine service cost (see instructions)	48, 258, 042	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line		22. 00
22.00	x line 17)		22.00
23. 00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6	x 0	23. 00
	line 18)	•	
24. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	' x 0	24. 00
21.00	line 19)	х о	21.00
25. 00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x	. 0	25. 00
20.00	line 20)		20.00
26. 00	Total swing-bed cost (see instructions)	0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	48, 258, 042	
27.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	40, 230, 042	27.00
20.00		0	20.00
	General inpatient routine service charges (excluding swing-bed and observation bed charges)	-	28. 00
29. 00	Private room charges (excluding swing-bed charges)	0	29. 00
30. 00	Semi-private room charges (excluding swing-bed charges)	0	30. 00
31. 00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	
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)	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	27 48, 258, 042	37. 00
	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, 346. 71	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line 38)	16, 580, 694	
	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0, 300, 074	40.00
	Total Program general inpatient routine service cost (line 39 + line 40)	16, 580, 694	
00	1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-	.5,555,574	

	Financial Systems FR ATION OF INPATIENT OPERATING COST	ANCISCAN HEALT	H CROWN POINT Provider CO	CN: 15-0126	In Lie Period:	u of Form CMS- Worksheet D-1	
					From 01/01/2023 To 12/31/2023	Date/Time Pre 5/30/2024 10:	
				XVIII	Hospi tal	PPS	
	Cost Center Description	Total npatient Cost	Total npati ent Days	Average Per Diem (col. 1 col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4. 00	5. 00	
42. 00	NURSERY (title V & XIX only)	0	0		_		42. 00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	10, 883, 196	3, 846	2, 829. 7	1, 449	4, 100, 293	1
44. 00	CORONARY CARE UNIT						44.00
45. 00	BURN INTENSIVE CARE UNIT						45. 00
	SURGICAL INTENSIVE CARE UNIT NEONATAL INTENSIVE CARE UNIT	7, 050, 728	3, 735	1, 887. 7	5 0	0	46. 00 47. 00
17.00	Cost Center Description	7,000,720	0, 700	1,007.7	<u> </u>	0	17.00
	·					1. 00	
48. 00	Program inpatient ancillary service cost (Wks					28, 916, 354	1
48. 01	Program inpatient cellular therapy acquisition				column 1)	0	
49. 00	Total Program inpatient costs (sum of lines 47 PASS THROUGH COST ADJUSTMENTS	through 48.0	i)(see instruc	tions)		49, 597, 341	49.00
50. 00	Pass through costs applicable to Program inpa	ient routine s	services (from	Wkst D sum	of Parts L and	2, 350, 327	50.00
00.00		o out	30. 7. 000 (0	mot. by cam	or ranto r and	2,000,02,	00.00
51. 00	Pass through costs applicable to Program inparIV)	ient ancillary	y services (fr	om Wkst. D, s	um of Parts II a	ind 2, 241, 528	51.00
52.00	Total Program excludable cost (sum of lines 50					4, 591, 855	
53. 00	Total Program inpatient operating cost excludi	ng capital rel	ated, non-phy	sician anesth	etist, and medic	al 45, 005, 486	53. 00
	education costs (line 49 minus line 52) TARGET AMOUNT AND LIMIT COMPUTATION						
54. 00	Program discharges					0	54.00
55. 00	Target amount per discharge						55. 00
55. 01	Permanent adjustment amount per discharge					0.00	1
55. 02	Adjustment amount per discharge (contractor us					0. 00	55. 02
56. 00	Target amount (line 54 x sum of lines 55, 55.0					0	
57. 00		ng cost and tar	get amount (I	ine 56 minus	line 53)	0	
58. 00 59. 00	Bonus payment (see instructions) Trended costs (lesser of line 53 ÷ line 54, or	line 55 from	the cost reno	rting period	anding 1006	0 00	58. 00 59. 00
37.00	updated and compounded by the market basket)	11110 33 11 0111	the cost repo	rting perrou	charing 1770,	0.00	37.00
60.00	Expected costs (lesser of line 53 ÷ line 54, o	or line 55 from	n prior year c	ost report, u	pdated by the	0. 00	60.00
61. 00	market basket) Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53)					0	61. 00
	are less than expected costs (lines 54 x 60), zero. (see instructions)		-	•	•		
62. 00	Relief payment (see instructions)					0	
63. 00	Allowable Inpatient cost plus incentive paymer	nt (see instruc	ctions)			0	63. 00
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine costs	through Decer	mber 31 of the	cost reporti	na period (See	0	64. 00
01.00	instructions)(title XVIII only)	o till odgi. Boosi			g po ou (000		000
65. 00	Medicare swing-bed SNF inpatient routine costs instructions)(title XVIII only)	after Decembe	er 31 of the c	ost reporting	period (See	0	65. 00
66. 00	Total Medicare swing-bed SNF inpatient routine	e costs (line d	64 plus line 6	5)(title XVII	l only); for CAH	l, 0	66. 00
67. 00	see instructions Title V or XIX swing-bed NF inpatient routine	costs through	December 31 o	f the cost re	porting period	0	67. 00
68. 00		costs after De	ecember 31 of	the cost repo	rting period (li	ne 0	68. 00
69. 00	13 x line 20) Total title V or XIX swing-bed NF inpatient ro					0	69. 00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER NUR Skilled nursing facility/other nursing facility						70. 00
71. 00	Adjusted general inpatient routine service cos						71.00
72. 00	Program routine service cost (line 9 x line 7	,		-			72. 00
73. 00	Medically necessary private room cost applicat			ne 35)			73. 00
74.00	Total Program general inpatient routine service	•	,			,	74.00
75. 00	Capital-related cost allocated to inpatient rolline 45)	outine service	costs (from W	orksneet B, P	art II, column 2	26,	75. 00
76. 00	Per diem capital-related costs (line 75 ÷ line	2)					76. 00
77. 00	Program capital -related costs (line 9 x line 7	,					77. 00
78. 00	,			_			78. 00
79. 00	Aggregate charges to beneficiaries for excess			· *.	1!- 70`		79. 00
80. 00 81. 00	Total Program routine service costs for compar		ost limitation	(iine /8 mín	us line /9)		80. 00 81. 00
81.00	Inpatient routine service cost per diem limita Inpatient routine service cost limitation (lim)				82.00
83. 00	Reasonable inpatient routine service costs (se						83. 00
84. 00	Program inpatient ancillary services (see ins	ructions)	,				84. 00
85. 00	Utilization review - physician compensation (s						85. 00
86. 00	Total Program inpatient operating costs (sum of		ough 85)				86. 00
87. 00	PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions)	INKUUGH CUST				4, 417	87. 00
88. 00	Adjusted general inpatient routine cost per di	em (line 27 ÷	line 2)			1, 346. 71	1
89. 00	Observation bed cost (line 87 x line 88) (see	•				5, 948, 418	1

Health Financial Systems F	RANCI SCAN HEAL	TH CROWN POINT		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2023 To 12/31/2023	Date/Time Prep 5/30/2024 10:0	pared: 06 am
		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	5, 256, 673	48, 258, 042	0. 10892	5, 948, 418	647, 949	90.00
91.00 Nursing Program cost	0	48, 258, 042	0.00000	0 5, 948, 418	0	91.00
92.00 Allied health cost	0	48, 258, 042	0.00000	5, 948, 418	0	92.00
93.00 All other Medical Education	0	48, 258, 042	0. 00000	5, 948, 418	0	93. 00

Health Financial Systems	FRANCISCAN HEALTH CROWN POINT	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0126	Peri od: From 01/01/2023	Worksheet D-1
	Component CCN: 15-T126	To 12/31/2023	Date/Time Prepared: 5/30/2024 10:06 am
	Title XVIII	Subprovi der -	PPS
		IRF	

		litle XVIII	I RF	PPS	
	Cost Center Description		TIG		
	T			1. 00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days	s excluding newborn)		3, 989	1. 00
2. 00	Inpatient days (including private room days, excluding swing-			3, 989	2. 00
3.00	Private room days (excluding swing-bed and observation bed day		ivate room days, d	lo 0	3. 00
	not complete this line.				
4.00	Semi-private room days (excluding swing-bed and observation be		. 21 -6	3, 989	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private roof reporting period	om days) through becembe	1 31 OF the Cost	0	5. 00
6.00	Total swing-bed SNF type inpatient days (including private roo	om days) after December	31 of the cost	0	6. 00
	reporting period (if calendar year, enter 0 on this line)	-			
7.00	Total swing-bed NF type inpatient days (including private room	m days) through December	31 of the cost	0	7. 00
8. 00	reporting period Total swing-bed NF type inpatient days (including private room	m days) after December 3	1 of the cost	0	8. 00
8.00	reporting period (if calendar year, enter 0 on this line)	ii days) ai tei beceiibei 3	i or the cost	U	8.00
9.00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	1, 988	9. 00
	newborn days) (see instructions)				
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or	nly (including private r	oom days) through	0	10. 00
11. 00	December 31 of the cost reporting period (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII on	alv (including private r	nom days) after	0	11. 00
00	December 31 of the cost reporting period (if calendar year, en		oom dayo, areo	Ü	
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX		e room days)	0	12. 00
12.00	through December 31 of the cost reporting period	/ (:			12.00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX December 31 of the cost reporting period (if calendar year, en		e room days) arter	. 0	13. 00
14. 00	Medically necessary private room days applicable to the Progra	am (excluding swing-bed	davs)	0	14. 00
15. 00	Total nursery days (title V or XIX only)			0	15. 00
16. 00	Nursery days (title V or XIX only)			0	16. 00
47.00	SWING BED ADJUSTMENT		6.11	0.00	47.00
17. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es through December 31 o	r the cost	0.00	17. 00
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost reporting	0.00	18. 00
	peri od "		'	•	
19. 00	Medicaid rate for swing-bed NF services applicable to services	s through December 31 of	the cost reportin	ig 0.00	19. 00
20. 00	period Medicaid rate for swing-bed NF services applicable to services	after December 31 of t	he cost reporting	0.00	20. 00
20.00	period	s arter becember 31 or t	ne cost reporting	0.00	20.00
21. 00	Total general inpatient routine service cost (see instructions			6, 617, 339	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December	er 31 of the cost report	ing period (line 5	0	22. 00
23. 00	x line 17) Swing-bed cost applicable to SNF type services after December	31 of the cost reportin	a period (line 6)v	. 0	23. 00
23.00	line 18)	31 of the cost reportin	g period (iiile o	. 0	23.00
24. 00	Swing-bed cost applicable to NF type services through December	31 of the cost reporti	ng period (line 🕇	x 0	24. 00
	line 19)				05.00
25. 00	Swing-bed cost applicable to NF type services after December 3 line 20)	31 of the cost reporting	period (line 8 x	0	25. 00
26. 00	Total swing-bed cost (see instructions)			0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		6, 617, 339	27. 00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
	General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges)	d and observation bed ch	arges)		28. 00
29. 00 30. 00	Semi - pri vate room charges (excluding swing-bed charges)			0	29. 00 30. 00
31. 00	General inpatient routine service cost/charge ratio (line 27	: line 28)		0. 000000	
32.00	Average private room per diem charge (line 29 ÷ line 3)	•		0.00	
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
34. 00	Average per diem private room charge differential (line 32 min		tions)	0.00	
35.00	Average per diem private room cost differential (line 34 x line Private room cost differential adjustment (line 3 x line 35)	ne 31)		0.00	35. 00 36. 00
36. 00 37. 00	General inpatient routine service cost net of swing-bed cost a	and private room cost di	fferential (line 2	-	36.00
200	minus Line 36)				27.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
20.00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU			1 (50.00	20.00
38. 00 39. 00	Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line			1, 658. 90 3, 297, 893	
40.00	Medically necessary private room cost applicable to the Programme			3, 297, 693	
	Total Program general inpatient routine service cost (line 39	•		3, 297, 893	
			·		

COMPUT	Financial Systems FATION OF INPATIENT OPERATING COST	FRANCISCAN HEALTH		CN: 15-0126	Peri od:	ieu of Form CM Worksheet D	
				CCN: 15-T126	From 01/01/202 To 12/31/202	23	
						5/30/2024 1	0:06 am
			Titl€	e XVIII	Subprovi der - I RF	PPS	
	Cost Center Description	Total	Total	Average Pe		Program Cos	t
	·	Inpatient Cost	npatient Days		÷	(col. 3 x co	l.
		1.00	2. 00	col . 2) 3.00	4. 00	4) 5. 00	
2. 00	NURSERY (title V & XIX only)	1.00	2.00		00	0	0 42.0
	Intensive Care Type Inpatient Hospital Units					-1	
3. 00	INTENSIVE CARE UNIT	0	C	0.	00	0	0 43.0
4. 00 5. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						44. 0 45. 0
16.00	SURGICAL INTENSIVE CARE UNIT						46. 0
7. 00	NEONATAL INTENSIVE CARE UNIT	0	C	0.	00	0	0 47.0
	Cost Center Description					1.00	
18. 00	Program inpatient ancillary service cost (Wk	est D_3 col 3	line 200)			1. 00 1, 276, 2	88 48.0
8. 01	Program inpatient cellular therapy acquisiti			III, line 10), column 1)	1,270,2	0 48.0
9. 00	Total Program inpatient costs (sum of lines	41 through 48.01)(see instruc	ctions)		4, 574, 1	81 49. 0
0.00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inp	ationt routing s	orvi cos (from	. Wkst D su	um of Dorte L on	d E20 0	01 50 0
0.00	Pass through costs applicable to Program The	batient routine s	ervices (iron	I WKSt. D, SU	IIII OI PAILS I AN	d 529, 9	01 50.0
1. 00	Pass through costs applicable to Program inp IV)	oatient ancillary	services (fr	rom Wkst. D,	sum of Parts II	and 79, 3	69 51.0
2. 00	Total Program excludable cost (sum of lines					609, 2	
3. 00	Total Program inpatient operating cost exclueducation costs (line 49 minus line 52)	uding capital rel	ated, non-phy	sician anest	hetist, and med	i ¢al 3, 964, 9	11 53. 0
1 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges						0 54.6
4. 00 5. 00	Target amount per discharge					0.	0 54.0 00 55.0
5. 01	Permanent adjustment amount per discharge					•	00 55.0
5. 02	Adjustment amount per discharge (contractor					0.	00 55.0
6.00	Target amount (line 54 x sum of lines 55, 55		ast smount (ino E/ minus	Line E2)		0 56.0
7. 00 8. 00	Difference between adjusted inpatient operat Bonus payment (see instructions)	ing cost and tar	get amount (i	ine 56 minus	i i i ne 53)		0 57. 0 0 58. 0
9. 00	Trended costs (lesser of line 53 ÷ line 54,	or line 55 from	the cost repo	orting period	l endi ng 1996,	0.	00 59.0
	updated and compounded by the market basket)					_	
0. 00	Expected costs (lesser of line 53 ÷ line 54, market basket)			•		0.	00 60.0
1. 00	Continuous improvement bonus payment (if lir 55.01, or line 59, or line 60, enter the les are less than expected costs (lines 54 x 60) zero. (see instructions)	sser of 50% of th	e amount by w	which operati	ng costs (line		0 61.0
2. 00 3. 00	Relief payment (see instructions) Allowable Inpatient cost plus incentive paym	ment (see instruc	tions)				0 62. 0 0 63. 0
	PROGRAM INPATIENT ROUTINE SWING BED COST	(00000000000000000000000000000000000000					
4. 00	Medicare swing-bed SNF inpatient routine cos	sts through Decem	ber 31 of the	cost report	ing period (See		0 64.0
5. 00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos</pre>	sts after Decembe	r 31 of the d	cost reportin	a period (See		0 65.0
0.00	instructions) (title XVIII only)	710 4. 10. B000b0	. 0. 0	, og c 1 op c 1 1 1	.g po ou (000		
6. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line 6	4 plus line 6	55)(title XVI	II only); for C	АĦ,	0 66.0
7. 00	see instructions Title V or XIX swing-bed NF inpatient routin	ne costs through	December 31 d	of the cost r	eportina period		0 67.0
	(line 12 x line 19)	Ü					
8. 00	Title V or XIX swing-bed NF inpatient routin 13 x line 20)				oorting period (I i ne	0 68.0
9. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N	JURSING FACILITY,	AND ICF/IID	ONLY			0 69.0
0.00	Skilled nursing facility/other nursing facil	,		•	")		70.0
1. 00 2. 00	Adjusted general inpatient routine service of Program routine service cost (line 9 x line		ne /U ÷ line	2)			71. (
3. 00	Medically necessary private room cost applic		(line 14 x li	ne 35)			73. 0
4. 00	Total Program general inpatient routine serv	/ice costs (line	72 + line 73)		_		74. 0
5. 00	Capital-related cost allocated to inpatient line 45)		costs (from V	Vorksheet B,	Part II, column	26,	75. (
6.00	Per diem capital related costs (line 75 ÷ li						76. (
7. 00 3. 00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minu						77. 78.
9. 00	Aggregate charges to beneficiaries for excess	,	ovi der record	ls)			79.
0.00	Total Program routine service costs for comp		st limitation	n (line 78 mi	nus line 79)		80.
1.00	Inpatient routine service cost per diem limi						81.
2.00	Inpatient routine service cost limitation (I Reasonable inpatient routine service costs ()				82. 83.
4. 00	Program inpatient ancillary services (see in	•	,				84.
5. 00	Utilization review - physician compensation						85.
6. 00	Total Program inpatient operating costs (sun		ough 85)				86. (
7. 00	PART IV - COMPUTATION OF OBSERVATION BED PAS Total observation bed days (see instructions						0 87.0
	Adjusted general inpatient routine cost per	•	1: 0)			1	00 88.

Health Financial Systems F	RANCISCAN HEALT	ANCISCAN HEALTH CROWN POINT In Li				2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0126 Period:			Worksheet D-1	
		Component (From 01/01/2023 To 12/31/2023		
		Title	XVIII	Subprovi der -	PPS	
				I RF		
Cost Center Description						
					1. 00	
89.00 Observation bed cost (line 87 x line 88) (see	e instructions)				0	89. 00
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST					
90.00 Capital -related cost	1, 063, 252	6, 617, 339	0. 16067	7 0	0	90.00
91.00 Nursing Program cost	0	6, 617, 339	0.00000	0 0	0	91.00
92.00 Allied health cost	0	6, 617, 339	0.00000	0	0	92.00
93.00 All other Medical Education	0	6, 617, 339	0.00000	0	0	93. 00

Heal th Financial Systems FRANCISCAN HEALTH CROWN FOINT In Lieu of Form CMS-2552-10 COMPUTATION OF INPATIENT OPERATING COST Provider CCR: 15-0126 Period: Morksheet D-1 Francisch Cost Provider CCR: 15-0126 Period: 1/31/2020 Per						
Provider CCN: 15-0120 Period: Total provider CN: 15-0120 Period: Total provider CN: 15-0120 Period: Total provider Provider CN: 15-0120 Period: Total provider Provider CN: 15-0120 Period: Total provider CN: 15-0120 Period: Total provider CN: 15-0120 Period: Total provider Provider CN: 15-0120 Period: Total provider CN: 15-012	Heal th	Financial Systems FRANCISCAN HEALTH	CROWN POLNT	Inlieu	of Form CMS_	2552_10
Cost Center Description PART I - ALL PROVIDER COMPONENTS						
Cost Center Description Title XIX Hospital Cost PART I = ALL PROVIDER COMPONENTS INPATIENT DAYS INPATIEN	001111 0 1	ATTOM OF THE ATTEM OF ENVITTING GOOT	11.001.001. 10.0120	From 01/01/2023		
Cost Center Description PART 1 - ALL PROVIDER COMPONENTS 1.00				To 12/31/2023		
PART I - ALL PROVIDER COMPONENTS 1.00			Ti +I o VI V	Hooni tol		<u>06 am</u>
PART I - ALL PROVIDER COMPONENTS		Cost Center Description	I tie xix	поѕрітаі	COST	
PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS		cost center bescription			1 00	
1.00 Inpatient days (including private room days and swing-bed days, excluding newborn) 35, 834 1.00		PART I - ALL PROVIDER COMPONENTS			1.00	
2.00 Inpatient days (including private room days, excluding swing-bed and newborn days) do 0.00 not complete this line. 8.00 End of the private room days (excluding swing-bed and observation bed days). If you have only private room days. 0.00 not complete this line. 8.00 End of the private room days (excluding swing-bed and observation bed days). If you have only private room days. 0.00 not complete this line. 8.00 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line). 8.00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line). 8.00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line). 9.00 Total inpatient days including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line). 10.00 Swing-bed SNF type inpatient days (and the private room days) after December 31 of the cost reporting period (see instructions). 10.00 Swing-bed SNF type inpatient days applicable to the Program (excluding swing-bed and newborn days). 10.00 Swing-bed SNF type inpatient days applicable to the VIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line). 10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line). 10.00 Swing-bed SNF type inpatient days applicable to title V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line). 10.00 Total unvisery days (title V or XIX only). 10.00 Total unvisery days (title V or XIX only). 10.00 Total unvisery days (title V or XIX only). 10.00 Total general inpat		I NPATI ENT DAYS				
Private room days (excluding swing-bed and observation bed days). If you have only private room days, do 0 3.00 not complete this line. Semi-private room days (excluding swing-bed and observation bed days) Semi-private room days (excluding swing-bed and observation bed days) To complete this line. Semi-private room days (excluding swing-bed and observation bed days) To comporting period of the cost reporting period (if calendar year, enter 0 on this line) To comporting period (if the cost reporting period (if calendar year	1.00	Inpatient days (including private room days and swing-bed day	ys, excluding newborn)		35, 834	1.00
not complete this line. 1.00 Sem-private room days (excluding swing-bed and observation bed days) 1.01 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period 1.00 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 1.00 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 1.00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 1.00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 1.00 Swing-bed SNF type inpatient days applicable to the Program (excluding swing-bed and newborn days) (see instructions) 1.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (if calendar year, enter 0 on this line) 1.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 1.00 Swing-bed SNF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 1.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 1.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting Period (if calendar year, enter 0 on this line) 1.00 Swing-bed Cost applicable SNF services applicable to services through December 31 o	2.00	Inpatient days (including private room days, excluding swing-	-bed and newborn days)		35, 834	2. 00
4.00 Semi-private room days (excluding swing-bed and observation bed days) 5.00 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if callendar year, enter 0 on this line) 7.00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if callendar year, enter 0 on this line) 7.00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if callendar year, enter 0 on this line) 7.00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if callendar year, enter 0 on this line) 7.00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions) 7.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions) 7.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if callendar year, enter 0 on this line) 7.00 Swing-bed SNF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if callendar year, enter 0 on this line) 7.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if callendar year, enter 0 on this line) 8.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if callendar year, enter 0 on this line) 8.00 Total nursery days (title V or XIX only) 8.00 Total nursery days (title V or XIX only) 8.00 Total nursery days (title V or XIX only) 8.00 Total nursery days (title V or XIX only) 8.00 Total nursery days (title V or XIX only) 8.00 Total swing	3.00		ays). If you have only pr	ivate room days, c	0 ob	3. 00
5.00 Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost proporting period of Inclais swing-bed SNF type inpatient days (including private room days) after December 31 of the cost proporting period of Inclais swing-bed NF type inpatient days (including private room days) after December 31 of the cost proporting period of Inclais swing-bed NF type inpatient days (including private room days) after December 31 of the cost proporting period of Inclais swing-bed NF type inpatient days (including private room days) after December 31 of the cost proporting period of Inclais swing-bed NF type inpatient days (including private room days) after December 31 of the cost proporting period of Inclais swing-bed SNF type inpatient days applicable to the Program (excluding swing-bed and proporting period of Inclais swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period of Inclais Swing-bed NF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period of Inclais Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period of Inclais Inclais Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period of Inclais						
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reporting period (if calendar year, enter 0 on this line) 7.00 Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost 9.00 Total inpatient days including private room days) after December 31 of the cost 9.00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions) 10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions) 11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (see instructions) 12.00 Swing-bed NF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 14.00 Medically necessary private room days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 15.00 Total nursery days (title V or XIX only) 16.00 Nursery days (title V or XIX only) 17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period 18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting 19.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting 19.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting 19.00 Medicare rate for swing-bed NF services after December 31 of the cost reporting 19.00 Medicare rate for swin						
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reporting period 8. 00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 9. 00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions) 10. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions) 11. 00 Swing-bed NF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 12. 00 Swing-bed NF type inpatient days applicable to titles VVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 13. 00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 14. 00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 14. 00 Total nursery days (title V or XIX only) 15. 00 Total nursery days (title V or XIX only) 16. 00 Nursery days (title V or XIX only) 17. 00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting Period (If calendar year, enter 0 on this line) 18. 00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting December 31 of the cost repo	7.00			04 6 11		7.00
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22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) 23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x 0 23.00 line 18) 24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x 0 24.00 line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x 0 25.00 line 20) 26.00 Total swing-bed cost (see instructions) 26.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 48,258,042 27.00	21. 00		ns)		48, 258, 042	21.00
x line 17) 23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x 0 23.00 line 18) 24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x 0 24.00 line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x 0 25.00 line 20) 26.00 Total swing-bed cost (see instructions) 26.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 48,258,042 27.00		, ,		ing period (line 5		
line 18) 24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x 0 24.00 line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x 0 25.00 line 20) 26.00 Total swing-bed cost (see instructions) 26.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 48,258,042 27.00						
24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x 0 24.00 line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x 0 25.00 line 20) 26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 24.00 48,258,042 27.00	23.00	Swing-bed cost applicable to SNF type services after December	31 of the cost reportin	g period (line 6)	(0	23. 00
Line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x 0 25.00 line 20) 26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 48,258,042 27.00			-			
25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x 0 25.00 line 20) 26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 48,258,042 27.00	24. 00		er 31 of the cost reporti	ng period (line 🕇	x 0	24. 00
line 20) 26.00 Total swing-bed cost (see instructions) 0 26.00 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 48,258,042 27.00						
26.00 Total swing-bed cost (see instructions) 0 26.00 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 48,258,042 27.00	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) 48,258,042 27.00	0,					
			(1) 04 1 11 20		-	
	27.00		(line 21 minus line 26)		48, 258, 042	27.00

	I NPATI ENT DAYS		
1. 00	Inpatient days (including private room days and swing-bed days, excluding newborn)	35, 834	1. 00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	35, 834	2. 00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days,		3. 00
	not complete this line.		
4. 00	Semi-private room days (excluding swing-bed and observation bed days)	31, 417	4.00
5. 00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost	0	5. 00
	reporting period		
6. 00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	0	6. 00
7 00	reporting period (if calendar year, enter 0 on this line)		7.00
7. 00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost	0	7. 00
0.00	reporting period		0.00
8. 00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	0	8. 00
9. 00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to the Program (excluding swing-bed and	239	9. 00
9.00	newborn days) (see instructions)	237	7.00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through	0	10. 00
10.00	December 31 of the cost reporting period (see instructions)	ľ	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after	0	11. 00
	December 31 of the cost reporting period (if calendar year, enter 0 on this line)		
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	12.00
	through December 31 of the cost reporting period		
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after	r 0	13.00
	December 31 of the cost reporting period (if calendar year, enter 0 on this line)		
	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	
	Total nursery days (title V or XIX only)		15. 00
16. 00	Nursery days (title V or XIX only)	22	16. 00
	SWING BED ADJUSTMENT		
17. 00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost	0.00	17. 00
40.00	reporting period	0.00	10.00
18. 00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting	ng 0.00	18. 00
19. 00	period Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporti	0.00	19. 00
19.00	period	11g 0.00	19.00
20. 00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting	0.00	20. 00
20.00	period	0.00	20.00
21. 00	Total general inpatient routine service cost (see instructions)	48, 258, 042	21 00
22. 00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line		
	x line 17)		
23. 00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6	x 0	23. 00
	line 18)		
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	x 0	24.00
	line 19)		
25. 00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x	ķ 0	25. 00
	line 20)		
	Total swing-bed cost (see instructions)	0	
27. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	48, 258, 042	27. 00
20.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	1 0	20.00
	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	
	Private room charges (excluding swing-bed charges)	0	
	Semi-private room charges (excluding swing-bed charges)	0.000000	
	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		32.00
	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)		33. 00
34. 00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	
	Average per diem private room cost differential (line 34 x line 31)	0.00	
36. 00	Private room cost differential adjustment (line 3 x line 35)	0.00	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line		
37.00	minus line 36)	2, 40, 230, 042	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	1	
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38. 00	Adjusted general inpatient routine service cost per diem (see instructions)	1, 346. 71	38, 00
	Program general inpatient routine service cost (line 9 x line 38)	321, 864	
	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	
	Total Program general inpatient routine service cost (line 39 + line 40)	321, 864	
	• • • • • • • • • • • • • • • • • • • •		

	Financial Systems F ATION OF INPATIENT OPERATING COST	FRANCI SCAN HEALT	H CROWN POINT	N: 15-0126 P	In Lie	u of Form CMS-2 Worksheet D-1	<u>2552-10</u>		
30m 31			Trovider of	F	rom 01/01/2023 o 12/31/2023	Date/Time Prep 5/30/2024 10:0			
			Title	e XIX	Hospi tal	Cost	00 aiii		
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days[Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)			
		1.00	2.00	3.00	4. 00	5. 00			
42. 00	NURSERY (title V & XIX only)	3, 053, 960	2, 352	1, 298. 45	22	28, 566	42. 00		
42.00	Intensive Care Type Inpatient Hospital Units	10 002 104	2 044	2 020 74	25	70. 744	1 42 00		
43. 00 44. 00	INTENSIVE CARE UNIT CORONARY CARE UNIT	10, 883, 196	3, 846	2, 829. 74	25	70, 744	43. 00 44. 00		
45. 00	BURN INTENSIVE CARE UNIT						45. 00		
46.00	SURGICAL INTENSIVE CARE UNIT						46. 00		
47. 00	NEONATAL INTENSIVE CARE UNIT	7, 050, 728	3, 735	1, 887. 75	150	283, 163	47. 00		
	Cost Center Description					1. 00			
48. 00	Program inpatient ancillary service cost (Wk	st. D-3, col. 3	, line 200)			7, 321, 549	48. 00		
48. 01	Program inpatient cellular therapy acquisiti				column 1)	0			
49. 00	Total Program inpatient costs (sum of lines		8, 025, 886	49. 00					
50. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inp	atient routine	services (from	Wkst D sum	of Parts I and	0	50.00		
30.00	III)	attent routine	SCI VICCS (IIOIII	WKSt. D, Sum	or rarts rana	O	30.00		
51. 00	Pass through costs applicable to Program inp IV)	atient ancillar	y services (fro	om Wkst. D, su	m of Parts II a	and 0	51. 00		
52. 00	Total Program excludable cost (sum of lines	,				0			
53. 00	Total Program inpatient operating cost exclueducation costs (line 49 minus line 52)	ding capital re	lated, non-phys	sician anesthe	tist, and medic	al 0	53. 00		
	TARGET AMOUNT AND LIMIT COMPUTATION								
54.00	Program di scharges					0	54.00		
55. 00	Target amount per discharge						55. 00		
55. 01 55. 02	Permanent adjustment amount per discharge Adjustment amount per discharge (contractor	uco onlu)				0.00	55. 01 55. 02		
56. 00	Target amount (line 54 x sum of lines 55, 55		0.00	1					
57. 00	Difference between adjusted inpatient operat	ine 53)	0	•					
58. 00	Bonus payment (see instructions)	0							
59. 00	Trended costs (lesser of line 53 ÷ line 54,	0. 00	59. 00						
60. 00	updated and compounded by the market basket) Expected costs (lesser of line 53 ÷ line 54,	0. 00	60. 00						
61. 00	market basket) Continuous improvement bonus payment (if lin 55.01, or line 59, or line 60, enter the les are less than expected costs (lines 54 x 60)	0	61. 00						
	zero. (see instructions)								
62.00	Relief payment (see instructions)	0							
63. 00	Allowable Inpatient cost plus incentive paym PROGRAM INPATIENT ROUTINE SWING BED COST	0	63. 00						
64. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	0	64. 00						
65. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	0	65. 00						
66. 00	Total Medicare swing-bed SNF inpatient routi see instructions	Ι, Ο	66. 00						
67. 00	Title V or XIX swing-bed NF inpatient routin (line 12 x line 19)	0	67. 00						
68. 00	Title V or XIX swing-bed NF inpatient routin 13 x line 20)	ne 0	68. 00						
69. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N	0	69. 00						
70. 00	Skilled nursing facility/other nursing facil						70. 00		
71.00	Adjusted general inpatient routine service c		ine 70 ÷ line 2	2)			71. 00 72. 00		
72. 00 73. 00									
74. 00									
75. 00									
76. 00	Per diem capital-related costs (line 75 ÷ li		76. 00						
77. 00	Program capital -related costs (line 9 x line			77.00					
78. 00 79. 00	Inpatient routine service cost (line 74 minu Aggregate charges to beneficiaries for exces			78. 00 79. 00					
80.00	Total Program routine service costs for comp	s line 79)		80.00					
81. 00	Inpatient routine service cost per diem limi	ĺ		81. 00					
82. 00	Inpatient routine service cost limitation (I			82.00					
83. 00 84. 00	Reasonable inpatient routine service costs (83. 00 84. 00						
85. 00									
86. 00	Total Program inpatient operating costs (sum	of lines 83 th					85. 00 86. 00		
07.00	PART IV - COMPUTATION OF OBSERVATION BED PAS					4 44-	07.00		
87. 00 88. 00	Total observation bed days (see instructions Adjusted general inpatient routine cost per	•	line 2)			4, 417 1, 346. 71	1		
89. 00	Observation bed cost (line 87 x line 88) (se		2)			5, 948, 418			

Health Financial Systems	FRANCI SCAN HEAL	TH CROWN POINT		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2023 To 12/31/2023		
		Ti tl	e XIX	Hospi tal	Cost	
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	5, 256, 673	48, 258, 042	0. 10892	5, 948, 418	647, 949	90.00
91.00 Nursing Program cost	0	48, 258, 042	0.00000	5, 948, 418	0	91.00
92.00 Allied health cost	0	48, 258, 042	0.00000	5, 948, 418	0	92.00
93 00 All other Medical Education	0	48 258 042	0.00000	5 948 418	0	93 00

Health Financial Systems	FRANCISCAN HEALTH CROWN POINT	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0126	Peri od: From 01/01/2023	Worksheet D-1
	Component CCN: 15-T126	To 12/31/2023	Date/Time Prepared: 5/30/2024 10:06 am
	Title XIX	Subprovi der -	TEFRA
		IRF	

		II the XIX	IRF	ILIKA	
	Cost Center Description			1.00	
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days			3, 989	1.00
2. 00 3. 00	Inpatient days (including private room days, excluding swing-le Private room days (excluding swing-bed and observation bed day		vate room days	3, 989 do 0	2. 00 3. 00
3.00	not complete this line.	73). The you have only pri	vate 100m days,	40	3.00
4.00	Semi-private room days (excluding swing-bed and observation be			3, 989	4. 00
5.00	Total swing-bed SNF type inpatient days (including private roo	om days) through Decembe	r 31 of the cost	0	5. 00
6. 00	reporting period Total swing-bed SNF type inpatient days (including private roo	om davs) after December :	31 of the cost	0	6. 00
	reporting period (if calendar year, enter 0 on this line)			_	
7. 00	Total swing-bed NF type inpatient days (including private room	n days) through December	31 of the cost	0	7. 00
8. 00	reporting period Total swing-bed NF type inpatient days (including private room	n days) after December 3	1 of the cost	0	8. 00
0.00	reporting period (if calendar year, enter 0 on this line)	radys) arter becomber o	1 01 1110 0031	Ĭ	0.00
9.00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	0	9. 00
10. 00	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII or	nly (including private r	nom dave) through		10.00
10.00	December 31 of the cost reporting period (see instructions)	ing (frictualing private in	John days) trii odgi		10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		oom days) after	0	11. 00
12. 00	December 31 of the cost reporting period (if calendar year, er Swing-bed NF type inpatient days applicable to titles V or XI)		s room days)	0	12. 00
12.00	through December 31 of the cost reporting period	t only (including private	e 100III days)	١	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XI)		e room days) afte	er 0	13. 00
14.00	December 31 of the cost reporting period (if calendar year, er		-1		14.00
14. 00 15. 00	Medically necessary private room days applicable to the Progra Total nursery days (title V or XIX only)	am (excluding swing-bed o	days)	0 2 352	14. 00 15. 00
16. 00	Nursery days (title V or XIX only)			22	
	SWING BED ADJUSTMENT		-		
17. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es through December 31 o	f the cost	0. 00	17. 00
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost reportir	ig 0.00	18. 00
	peri od				
19. 00	Medicaid rate for swing-bed NF services applicable to services period	s through December 31 of	the cost reporti	ng 0.00	19. 00
20. 00	Medicaid rate for swing-bed NF services applicable to services	after December 31 of th	ne cost reporting	0.00	20.00
	period				
21. 00 22. 00	Total general inpatient routine service cost (see instructions Swing-bed cost applicable to SNF type services through Decembe		ng period (line	6, 617, 339 5 0	21. 00 22. 00
22.00	x line 17)	or or the cost reporti	riig perrou (Triie		22.00
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reporting	g period (line 6	x 0	23. 00
24. 00	line 18) Swing-bed cost applicable to NF type services through December	21 of the cost reportion	ng poriod (lino T	x o	24. 00
24.00	line 19)	31 of the cost reportin	ig period (Title 1	^	24.00
25. 00	Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	period (line 8 x	0	25. 00
26. 00	line 20) Total swing-bed cost (see instructions)			0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost ((line 21 minus line 26)		6, 617, 339	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
	General inpatient routine service charges (excluding swing-bed	d and observation bed cha	arges)		28. 00
29. 00 30. 00	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	l
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)	ŕ		0. 00	32. 00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	•
34. 00 35. 00	Average per diem private room charge differential (line 32 mir Average per diem private room cost differential (line 34 x lin		tions)	0. 00 0. 00	1
36. 00	Private room cost differential adjustment (line 3 x line 35)	ic 51)		0.00	36.00
37. 00	General inpatient routine service cost net of swing-bed cost a	and private room cost di	fferential (line	27 6, 617, 339	37. 00
	minus line 36)				
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	ISTMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see			1, 658. 90	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line	38)		0	39. 00
40.00	Medically necessary private room cost applicable to the Program	•		0	40.00
41. 00	Total Program general inpatient routine service cost (line 39	+ ITHE 40)		υĮ	41. 00

	ATION OF INPATIENT OPERATING COST	THE WATER OF THE PROPERTY OF T	Provider C	CN: 15-0126	Peri od:	Worksheet D-	S-2552- -1
				CCN: 15-T126	From 01/01/2023 To 12/31/2023	3	
			'			5/30/2024 10	0: 06 am
			Ti tl	e XIX	Subprovi der -	TEFRA	A
	Cost Center Description	Total	Total	Average Per	IRF r Program Days	Program Cost	t I
		Inpatient Cost Ir				(col. 3 x col	
		1.00	2.00	col . 2)	4.00	4)	_
12. 00	NURSERY (title V & XIX only)	1.00	2.00	3.00	4. 00	5. 00	0 42.0
2.00	Intensive Care Type Inpatient Hospital Uni			<u> </u>	00	21	12. (
	INTENSIVE CARE UNIT	0	0	0.	00	D	0 43.0
4.00	CORONARY CARE UNIT						44. (45. (
5. 00 6. 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						46. (
	NEONATAL INTENSIVE CARE UNIT	0	0	0.	00 0		0 47.0
	Cost Center Description					1.00	
8. 00	Program inpatient ancillary service cost (Wkst D-3 col 3	line 200)			1.00	17 48.0
8. 01	Program inpatient cellular therapy acquisi			III, line 10	, column 1)		0 48.0
9. 00	Total Program inpatient costs (sum of line	s 41 through 48.01)	(see instruc	ti ons)		21	17 49. (
0. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program i	nnationt routing s	arvicas (fram	Wkst D su	m of Darts L and	ıT	0 50.0
0. 00	[111]	ilpati ent Toutine Se	ervices (IIOII	. WKSt. D, Su	III OI FAILS I AIIU		0 30.
1. 00	Pass through costs applicable to Program i	npatient ancillary	services (fr	om Wkst. D,	sum of Parts II	and 1	10 51.
2 00	Total Program excludable cost (sum of line	c 50 and 51)				1	10 52
52. 00 53. 00	Total Program excludable cost (sum of line Total Program inpatient operating cost exc		ated, non-phy	sician anest	hetist, and medi	l .	10 52. ()7 53. (
	education costs (line 49 minus line 52)	. 5			,		
	TARGET AMOUNT AND LIMIT COMPUTATION					1 ^	23 54. (
	Program discharges Target amount per discharge					0.0	
5. 01	Permanent adjustment amount per discharge					0.0	
	Adjustment amount per discharge (contracto					0.0	
6. 00 7. 00	Target amount (line 54 x sum of lines 55, Difference between adjusted inpatient oper		act amount (1	ino 56 minus	lino 52)	-20	0 56.
8. 00	Bonus payment (see instructions)	attrig cost and targ	get amount (i	The 50 minus	111le 53)		0 58.
9. 00	Trended costs (lesser of line 53 ÷ line 54	, or line 55 from [.]	the cost repo	rting period	endi ng 1996,	0.0	00 59.
0 00	updated and compounded by the market baske		nni anan .	ant manant	undated by the		00 40
0. 00	Expected costs (lesser of line 53 ÷ line 5 market basket)	4, or time 55 from	prior year c	ost report,	updated by the	0.0	00 60.
1. 00	Continuous improvement bonus payment (if I 55.01, or line 59, or line 60, enter the l are less than expected costs (lines 54 x 6 zero. (see instructions)	esser of 50% of the	e amount by w	hich operati	ng costs (line 5	3)	0 61.
2. 00	Relief payment (see instructions)						0 62.
	Allowable Inpatient cost plus incentive pa	yment (see instruc	tions)			1	63.
	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine c	osts through Decemb	per 31 of the	cost report	ina period (See		0 64.
	instructions)(title XVIII only)	<u>-</u>			g por (coo		
5. 00	Medicare swing-bed SNF inpatient routine c	osts after Decembe	r 31 of the c	ost reportin	g period (See		0 65.
6. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient rou	tine costs (line 64	4 plus line 6	5)(title XVI	II only): for CA	Н.	0 66.
	see instructions	·	•	, ,	3,		
7. 00	Title V or XIX swing-bed NF inpatient rout	ine costs through [December 31 c	f the cost r	eporting period		0 67.
8. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient rout	ine costs after Dec	cember 31 of	the cost rep	orting period (I	i ne	0 68.
	13 x line 20)						
9. 00	Total title V or XIX swing-bed NF inpatien PART III - SKILLED NURSING FACILITY, OTHER						0 69.
0. 00	Skilled nursing facility/other nursing fac)	1	70.
1. 00	Adjusted general inpatient routine service	cost per diem (li		•			71.
	Program routine service cost (line 9 x lin		(lino 14 × !:	no 2E)			72.
3. 00 4. 00	Medically necessary private room cost appl Total Program general inpatient routine se						73. 74.
5. 00	Capital-related cost allocated to inpatien	•			Part II, column	2 6,	75.
4 00	line 45)	lino 2)					7,
	Per diem capital-related costs (line 75 ÷ Program capital-related costs (line 9 x li						76. 77.
	Inpatient routine service cost (line 74 mi						78.
	Aggregate charges to beneficiaries for exc			*.	70)		79.
	Total Program routine service costs for co Inpatient routine service cost per diem li	•	st limitation	(line 78 mi	nus line 79)		80. 81.
	Inpatient routine service cost per diem in						82.
3. 00	Reasonable inpatient routine service costs	* . * .)				83.
4. 00	Program inpatient ancillary services (see	,	`				84.
	Utilization review - physician compensatio	n (see instructions	S)			1	85.
5. 00			nuah 85)				26
35. 00	Total Program inpatient operating costs (s PART IV - COMPUTATION OF OBSERVATION BED PA	um of lines 83 thro	ough 85)				86.

Heal th	Financial Systems	FRANCISCAN HEAL	TH CROWN POINT		In Lie	eu of Form CMS-2	2552-10
COMPUTA	ATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
			Component (From 01/01/2023 To 12/31/2023		
			Ti tl	e XIX	Subprovi der - I RF	TEFRA	
•	Cost Center Description						
						1. 00	
89. 00	Observation bed cost (line 87 x line 88) (see	e instructions)				0	89. 00
	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	Capi tal -rel ated cost	0	6, 617, 339	0.00000	0 0	0	90. 00
91.00	Nursing Program cost	0	6, 617, 339	0.00000	0	0	91. 00
92.00	Allied health cost	0	6, 617, 339	0.00000	0	0	92.00
93. 00	All other Medical Education	0	6, 617, 339	0.00000	0 0	0	93. 00

Health Financial Systems	FRANCISCAN HEALTH CROWN POINT	In Lie	u of Form CMS-2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 15-0126	Peri od: From 01/01/2023	Worksheet D-3
			Date/Time Prepared

Title XVIII Repair To Charges To C	INPAII	ENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0126	From 01/01/2023	worksneet D-3	
NATI COST Center Description Ratio of Cost Inpatient Program Pro						Date/Time Pre	
Cost Center Description			T: +1 a	VVIIII	Hooni tol		06 am_
IMPACTION NOW IMPACTION NOW IMPACTION NOW Impact		Coot Contan Decemintion	II LIE			+	
NATT ENT ROUTINE SERVICE COST CENTERS 1.00 2.00 3.		Cost Center Description					
INPATIENT ROUTINE SERVICE COST CENTERS				To charges			
NATI ENT ROUTINE SERVICE COST CENTERS 20, 983, 984 30, 00 300					Charges		
IMPART INT ROUTINE SERVICE OOST CENTERS 20,983,984 30,00 310.00 2000 ABURTS & PEDIATRIC S 20,983,984 30,00 310.00 2000 ABURTS & PEDIATRIC S 31,000 35,000 2000 ABURTS & PEDIATRIC S 31,000 35,000 2000 ABURTS & PEDIATRIC S 31,000 35,000 2000 ABURTS & PEDIATRIC S 20,983,984 30,000				1 00	2 00		
30.00 30.00 ADULTS & PEDIATRICS 20, 983, 984 30.00 31.00 3		I NPATI ENT ROUTI NE SERVI CE COST CENTERS			2.00	0.00	
35.00	30.00				20, 983, 984		30.00
14.00 04.0	31.00	03100 INTENSIVE CARE UNIT			5, 545, 567	1	31. 00
	35.00	02060 NEONATAL INTENSIVE CARE UNIT			C)	35. 00
MICH LARY SERVICE COST CENTERS 19,174,406 3,231,750 50,00 510.00 61000 (PERATIN REGION) 19,174,406 3,231,750 50,00 510.00 61000 (PERATIN REGION) 19,174,406 52,00 520.00 52	41.00	04100 SUBPROVI DER - I RF			C)	41. 00
50.00	43.00						43. 00
52.00							
53.00 05300 ANESTHESI OLOCY 0.028063 3.016.339 84.648 53.00 0.0540 0.0540 RADI OLOCY - 1.65 0.056081 CADIDORY - 1.65 0.058651 41.012 2.405 54.01 0.0540 RADI OLOCY - 1.65 0.058651 41.012 2.405 54.01 0.0540 RADI OLOCY - 1.65 0.056081 CADIDORY - 1.65 0.05608 0.05608 0.056081 0.05608		1		1		1	
54.00 05400 RADIOLOGY-DIAGNOSTIC 0.082/285 24.218, 860 1.992, 849 54.00 54.00 54.00 54.00 54.00 54.00 54.00 54.00 54.00 54.00 54.00 54.00 54.00 54.00 54.00 54.00 54.00 54.00 55.00				1		1	1
54. 01 05401 RADIOLOGY - 1 - 65 0.058651 41.012 2, 405 54. 01 54. 02 05402 RADIOLOGY DIAGNOSTIC - SJ 0.050000 0.054.02 54. 03 05403 LOWELL RADIOLOGY 0.562466 0.050000 0.554.02 55. 01 05500 RADIOLOGY - HERAPEUTIC 0.000000 0.055.00 55. 01 05500 RADIOLOGY - HERAPEUTIC 0.000000 0.055.00 55. 02 03450 RADIOLOGY - 14ERAPEUTIC 0.000000 0.055.00 55. 02 03450 RADIOLOGY - 14ERAPEUTIC 0.000000 0.000000 0.000000 55. 02 03450 RADIOLOGY - 14ERAPEUTIC 0.000000 0.000000 0.0000000 0.00000000				i		•	
54. 02 05402 ANDIOLOGY DI AGNOSTIC - SJ							
54. 03 05403 LOWELL RADI DULOGY 0. 55.408 0. 0 0. 55.00 0550.0 0ADI DULOGY - HIERAPEUTIC 0. 0000000 0. 0 0. 55.00 0. 550.0 0ADI DULOGY - HIERAPEUTIC 0. 022437 8. 151.310 1. 046. 196. 55. 07 0. 150.0 0. 000000 0. 0 0. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0.				1			1
55. 00 05500 05500 05500 05500 05500 0550 0550							
55. 02 OSFOI CARDI AC CATHERIZATON LAB				1			
55. 02 03140 CARDIOLOGY 0.082838 5, 136, 697 425, 514 55. 02 55. 03 03550 NEURO-DIA GNOSTICS 0.131337 584, 463 76, 762 55. 03 03550 NEURO-DIA GNOSTICS 0.131337 584, 463 3, 045, 707 60. 00 60. 01 60. 00 60. 01 60. 00							
55. 03 03450 NEURO-DI AGNOSTI CS 0.131337 584, 463 76, 762 55. 03				1			
0. 0000 0.0000 0. 00000 0. 00000 0. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0.				1			
60.01 0.0001 0.0001 0.000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.000000 0.000000 0.0000000 0.00000000				1			1
66.00 06600 PHYSI CAL THERAPY -65 0.66.01 06601 PHYSI CAL THERAPY ST JOHN 0.297387 0 0.66.02 06602 PHYSI CAL THERAPY ST JOHN 0.297387 0 0.66.02 06602 06602 PHYSI CAL THERAPY ST JOHN 0.297387 0 0.66.02 06602 0				1			1
66. 01 06601 PHYSICAL THERAPY I -65 0.364425 294 107 66. 01				1			
66. 02 06602 PHYSI CAL THERAPY ST JOHN 0. 297387 0 0 0 6. 02				1		1	1
67. 00 06700 05000 06700 05000 06700 05000 06700 05000 06700 05000 06700 05000 06700 05000 06700 05000 06700 05000 06700 05000 06700 06700 06700 06700 06700 06700 06700 06700 06700 06700 06700 06700 06700 06700 068				1		1	
67. 01 06701 0CCUPATI ON THERAPY I - 65 0.385228 130 50 67. 01 67. 02 0CCUPATI ONAL THERAPY ST. JOHN 0.26277 0 0.70 0.000000 0 0.000000 0 0.000000 0				1			1
67. 02 06702 OCCUPATI ONAL THERAPY ST. JOHN 0.226277 0 0.70268.00 06800 SPEECH PATHOLOGY 1-65 0.218846 120 26 68. 01 06801 SPEECH PATHOLOGY 1-65 0.218846 120 26 68. 01 06801 SPEECH PATHOLOGY 1-65 0.218846 120 26 68. 01 06802 SPEECH THERAPY ST. JOHN 0.000000 0 0 0 0.80. 02 069. 00 000000 0 0 0 0 0.000000 0				1		•	
68. 00 06800 SPEECH PATHOLOGY 0. 165399 774, 544 128, 109 68. 00 68. 01 06801 SPEECH PATHOLOGY I - 65 0. 218846 120 26 68. 01 68. 02 06802 SPEECH THERAPY ST. JOHN 0. 0000000 0 0 68. 02 06. 00 0				1		1	1
68. 01 06801 SPEECH PATHOLOGY I -65 0. 218846 120 26 68. 01 68. 02 06802 SPEECH THERAPY ST. JOHN 0. 000000 0 0 68. 02 68. 02 06802 SPEECH THERAPY ST. JOHN 0. 000000 0 0 68. 02 69. 00 06900 ELECTROCARDIOLOGY 0. 396672 28. 906 11. 466 69. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0. 579807 13, 535, 829 7, 848, 168 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0. 238649 16. 810, 781 4. 011, 876 73. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 238649 16. 810, 781 4. 011, 876 73. 00 74. 00 07400 RENAL DIALYSIS 0. 565999 488, 722 276, 616 74. 00 75. 00 07300 AUGI CARDIOGRAPHY 0. 373480 3, 060 1, 143 75. 01 07400 AUGI CARDIOGRAPHY 0. 373480 3, 060 1, 143 76. 01 77. 00 07500 ALLOGENEIC HSCT ACQUI SITION 0. 000000 0 0 77. 00 78. 00 07800 CAR T-CELL I IMMUNOTHERAPY 0. 000000 0 0 77. 00 79. 01 09000 CLI NI C 0. 000000 0 0 0 0 90. 01 09000 CLI NI C 0. 000000 0 0 0 0 90. 02 09002 OUTPATIENT SERVICE COST CENTERS 0. 000000 0 0 90. 02 90. 03 09003 OCCUPATIONAL MEDI CI NE CLI NI C 0. 000000 0 0 0 0 90. 04 09004 AUGINI C-FRANCI SCAN POI NT 0. 350166 0 0 0 0 90. 05 09005 LACTATI ON CLI NI C - FRANCI SCAN POI NT 0. 350166 0 0 0 0 91. 01 09101 EMERGENCY 0. 109585 11, 766, 086 1, 289, 387 91. 00 91. 01 09101 EMERGENCY 0. 000000 0 0 91. 02 92. 00 09200 OSSERVATI ON BEDS (NON-DISTINCT PART 0. 000000 0 0 549, 349, 349 20. 00 92. 00 09200 OSSERVATI ON BEDS (NON-DISTINCT PART 0. 000000 0 0 0. 545790 1, 288, 763 703, 394 92. 00 92. 00 09200 OSSERVATI ON BEDS (NON-DISTINCT PART 0. 000000 0 0 0. 545790 1, 288, 763 703, 394 92. 00 92. 00 09200 OSSERVATI ON BEDS (NON-DISTINCT PART 0. 000000 0 0 0. 000000 0 0				1		1	
68. 02 06802 SPEECH THERAPY ST. JOHN 0.000000 0 0 68. 02 69. 00 06900 ELECTROCARDI OLOGY 13, 846 69. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0.579807 13, 535, 829 7, 848, 146 69. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.316794 8, 477, 993 2, 685, 777 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0.238649 16, 810, 781 4, 011, 876 73. 00 74. 00 07300 DRUGS CHARGED TO PATI ENTS 0.238649 16, 810, 781 4, 011, 876 73. 00 74. 00 07300 DRUGS CHARGED TO PATI ENTS 0.565999 488, 722 276, 616 74. 00 76. 01 03040 ANGI OCARDI OGRAPHY 0.373480 3, 060 1, 143 76. 01 77. 00 07700 ALDGENEI C HSCT ACQUI SITION 0.000000 0 0 0 78. 00 07800 CAR T-CELL I IMJUNOTHERAPY 0.000000 0 0 78. 00 78. 00 07800 CLINIC 0.000000 0 0 0 79. 0.0 09000 CLINIC 0.000000 0 0 0 79. 0.1 09001 DIABETES CLINIC 0.000000 0 0 0 79. 0.2 09002 OUTPATI ENT CLINIC 0.000000 0 0 0 79. 0.3 09003 OCCUPATI ONAL MEDI CINE CLINIC 0.000000 0 0 0 79. 0.4 09004 NEONATOLOGY CLINIC CLINIC 0.000000 0 0 0 79. 0.5 09005 LACTATI ON CLINIC 0.000000 0 0 0 79. 0.5 09005 LACTATI ON CLINIC 0.000000 0 0 79. 0.7 0.000000 0 0 0 79. 0.7 0.000000 0 0 79. 0.7 0.000000 0 0 79. 0.7 0.000000 0 0 79. 0.7 0.000000 0 0 79. 0.7 0.000000 0 0 79. 0.7 0.000000 0 0 79. 0.7 0.000000 0 0 79. 0.7 0.000000 0 0 79. 0.7 0.000000 0 0 79. 0.7 0.000000 0 0 79. 0.7 0.000000 0 0 79. 0.7 0.000000 0 0 79. 0.7 0.000000 0 0 79. 0.7 0.000000 0 0 79. 0.7 0.000000 0 0 79. 0.7 0.000000 0 0 79. 0.7 0.000000 0 0 79. 0.7 0.0000000 0 0 79. 0.7 0.0000000 0 0 79. 0.7 0.0000000 0 0 79. 0.7 0.0000000 0 0 79. 0.7 0.00000000 0 0 79. 0.7 0.000000000 0 0 79. 0.7 0.0000000000						•	
69. 00 06900 CLECTROCARDIOLOGY 0.396672 28,906 11,466 69. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0.579807 13,535,829 7,848,168 71. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.316794 8,477,993 2,685,777 72. 00 07300 DRUGS CHARGED TO PATIENTS 0.238649 16,810,781 4,011,876 73. 00 07400 RENAL DIALYSIS 0.565999 488,722 276,616 74. 00 76. 01 03040 ANGIOCARDIOGRAPHY 0.097734 76,891 7,515 76. 00 77. 00						1	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.316794 8,477,993 2,685,777 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0.238649 16,810,781 4,011,876 73. 00 74. 00 07400 RENAL DIALYSIS 0.565999 488,722 276,616 74. 00 07400 RENAL DIALYSIS 0.097734 76,891 7,515 76. 00 03020 RADIATION ONCOLOGY 0.097734 76,891 7,515 76. 00 77. 00 07700 ALLOGENEIC HSCT ACQUISITION 0.000000 0 0 0 77. 00 07700 ALLOGENEIC HSCT ACQUISITION 0.000000 0 0 0 0 77. 00 07800 CAR T-CELL IMMUNOTHERAPY 0.000000 0 0 0 0 0 0 0	69.00			1		11, 466	69. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 238649 16, 810, 781 4, 011, 876 73. 00 74. 00 07400 RENAL DI ALYSIS 0. 565999 488, 722 276, 616 74. 00 76. 01 03040 ANGI OCARDI OGRAPHY 0. 373480 3, 060 1, 143 76. 00 77. 00 07700 ALLOGENEI C HSCT ACQUISITION 0. 000000 0 0 0 77. 00 07800 CAR T-CELL IMMUNOTHERAPY 0. 000000 0 0 0 0 78. 00 000000 0 0 0 0 0 0	71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 5798	07 13, 535, 829	7, 848, 168	71. 00
74. 00 07400 RENAL DIALYSIS 0.565999 488,722 276,616 74. 00 76. 00 03020 RADIATION ONCOLOGY 0.097734 76,891 7,515 76. 00 76. 01 03040 ANGI OCARDI OGRAPHY 0.373480 3,060 1,143 76. 01 77. 00 07700 ALLOGENEIC HSCT ACQUISITION 0.000000 0 0 0 77. 00 78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0.000000 0 0 0 78. 00 0000 CAR T-CELL IMMUNOTHERAPY 0.000000 0 0 0 78. 00 90. 01 09001 DI ABETES CLINIC 0.000000 0 0 0 0 90. 01 90. 01 09001 DI ABETES CLINIC 0.000000 0 0 0 90. 01 90. 02 09002 OUTPATIENT CLINICS 0.000000 0 0 0 90. 02 90. 03 09003 OCCUPATIONAL MEDICINE CLINIC 0.000000 0 0 0 90. 02 90. 04 09004 NEONATOLOGY CLINIC-FRANCISCAN POINT 0.350166 0 0 90. 04 90. 05 09005 LACTATION CLINIC 2.449681 0 0 0 90. 05 91. 00 09100 EMERGENCY ROOM PHYSI CANS 0.000000 0 0 0 91. 01 91. 01 09101 EMERGENCY ROOM PHYSI CANS 0.000000 0 0 0 91. 01 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0.000000 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	72.00			0. 3167	94 8, 477, 993	2, 685, 777	72. 00
76. 00	73.00	07300 DRUGS CHARGED TO PATIENTS		0. 2386	49 16, 810, 781	4, 011, 876	73. 00
76. 01 03040 ANGI OCARDI OGRAPHY 0. 373480 3, 060 1, 143 76. 01 77. 00 07700 ALLOGENEI C HSCT ACQUI SITI ON 0. 000000 0 0 0 77. 00 07800 CAR T-CELL I MMUNOTHERAPY 0. 0.000000 0 0 0 0 78. 00 000000 0 0 0 0 0 0 0 0 0 0 0 0 0 0	74.00	07400 RENAL DI ALYSI S		0. 5659	99 488, 722	276, 616	74. 00
77. 00 07700 ALLOGENEIC HSCT ACQUISITION 0.000000 0 0 77. 00 78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0.000000 0 0 78. 00 000000 0 0 0 0 0 0				1			1
78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0.000000 0 0 0 0 0 0 0				1		•	1
90. 00 O9000 CLI NI C O. 000000 O O O90. 00 90. 01 O9001 DI ABETES CLI NI C O. 000000 O O O90. 01 90. 02 O9002 OUTPATI ENT SERVI CE COST CENTERS O. 000000 O O90. 00 90. 02 O9002 OUTPATI ENT CLI NI C O. 000000 O O O90. 01 90. 02 O9002 OUTPATI ENT CLI NI CS O. 000000 O O O90. 02 90. 03 O9003 OCCUPATI ONAL MEDI CI NE CLI NI C O. 000000 O O O90. 02 90. 04 O9004 NEONATOLOGY CLI NI C-FRANCI SCAN POI NT O. 350166 O O O90. 04 90. 05 O9005 LACTATI ON CLI NI C O. 000000 O O O90. 05 91. 00 O9100 EMERGENCY O. 109585 11, 766, 086 1, 289, 387 91. 01 O9101 EMERGENCY ROOM PHYSI CANS O. 000000 O O O1. 01 91. 02 O9102 EXPRESS CARE O. 000000 O O O1. 01 92. 00 O9200 OBSERVATI ON BEDS (NON-DI STI NCT PART O. 0545790 1, 288, 763 703, 394 92. 00 200. 00 Total (sum of lines 50 through 94 and 96 through 98) Less PBP Clinic Laboratory Services-Program only charges (line 61) O C01. 00 201. 00 O9000 O O00000 O O00000 201. 00 O00000 O O000000 O O000000 201. 00 O000000 O O0000000 201. 00 O0000000 O O00000000000000000				1		1	1
90. 00 09000 CLINIC 0.000000 0 0 0 90. 00 90. 01 90. 01 90. 02 09002 0UTPATIENT CLINICS 0.000000 0 0 90. 02 90. 03 09003 0CCUPATIONAL MEDICINE CLINIC 0.000000 0 0 90. 03 90. 04 90. 05 90. 05 09005 LACTATION CLINIC 0.000000 0 0 90. 05	78. 00			0.0000	00	0	78. 00
90. 01 09001 09001 09002 000000 00 00 00 00						1	
90. 02 09002 0UTPATI ENT CLINICS 0.000000 0 0 90. 02 90. 03 09003 0CCUPATI ONAL MEDI CINE CLINIC 0.000000 0 0.000000 0 90. 03 090. 04 09004 NEONATOLOGY CLINIC-FRANCISCAN POINT 0.350166 0 0.000000 0 0.000000 0 0						•	
90. 03 09003 0CCUPATI ONAL MEDI CI NE CLI NI C 0.000000 0 0.000000 0 0.000000 0				1		1	1
90. 04 09004 NEONATOLOGY CLINIC-FRANCISCAN POINT 0. 350166 0 0 0 90. 04 09005 LACTATION CLINIC 09100 LACTATION CLINIC 09100 EMERGENCY 0. 109585 11, 766, 086 1, 289, 387 91. 00 09101 EMERGENCY ROOM PHYSICANS 0. 000000 0 0 91. 01 09101 EMERGENCY ROOM PHYSICANS 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 00000000						1	
90. 05 09005 LACTATI ON CLINI C 0 0 0 0 0 0 0 0 0							
91. 00 09100 09100 EMERGENCY 0.109585 0.000000 0 0.000000 0 0.000000 0						1	1
91. 01 09101 EMERGENCY ROOM PHYSICANS 0.000000 0 0 91. 01 09102 EXPRESS CARE 0.000000 0 0.000000 0 0 91. 02 09200 0920							
91. 02 09102 EXPRESS CARE 0.000000 0 0 91. 02 09200 09							1
92. 00 09200 08SERVATION BEDS (NON-DISTINCT PART 0.545790 1,288,763 703,394 92.00 200.00 Total (sum of lines 50 through 94 and 96 through 98) 201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201.00							
200.00 Total (sum of lines 50 through 94 and 96 through 98) 149,492,505 28,916,354 200.00 201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201.00						1	
201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201.00		1 1		0.545/		•	
			(Line (1)		149, 492, 505	28, 916, 354	
202. 00			(Title 61)		140 402 505	<u>'</u>	
	202. UL	Inet charges (Title 200 millius Title 201)		I	147, 472, 505	'I	1202.00

AITH FINANCIAL SYSTEMS FRANCISCAN IPATIENT ANCILLARY SERVICE COST APPORTIONMENT	HEALTH CROWN POINT Provider C	CN: 15-0126	Peri od:	eu of Form CMS- Worksheet D-3	
		CCN: 15-T126	From 01/01/2023 To 12/31/2023		par
	Titl∈	e XVIII	Subprovider - IRF	PPS	
Cost Center Description		Ratio of Cos To Charges		Inpatient Program Costs (col. 1 x col.	
		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS		1		T	
. 00 03000 ADULTS & PEDIATRICS . 00 03100 NTENSIVE CARE UNIT					30
5. 00 02060 NEONATAL INTENSIVE CARE UNIT					35
. 00 04100 SUBPROVI DER - I RF			3, 278, 212		41
. 00 04300 NURSERY			7, 2, 2, 2, 2		43
ANCILLARY SERVICE COST CENTERS		•	•	•	
00 05000 OPERATING ROOM		0. 1685	45 81, 068	13, 664	50
00 05100 RECOVERY ROOM		0. 0739			
. OO O5200 DELI VERY ROOM & LABOR ROOM		0. 5115		_	1
00 05300 ANESTHESI OLOGY 00 05400 RADI OLOGY-DI AGNOSTI C		0. 0280 0. 0822		l .	
01 05401 RADI 0L0GY - I -65		0. 0522			1
02 05402 RADI OLOGY DI AGNOSTI C - SJ		0.0000		1	
. 03 05403 LOWELL RADI OLOGY		0. 5624		0	5
00 05500 RADI OLOGY-THERAPEUTI C		0.0000	00 0	0	
01 05501 CARDI AC CATHERI ZATON LAB		0. 1283			
02 03140 CARDI OLOGY		0. 0828			
. 03 03450 NEURO-DI AGNOSTI CS . 00 06000 LABORATORY		0. 1313			
00 06000 LABORATORY 01 06001 BLOOD LABORATORY		0. 1174 0. 0000			1
. 00 06500 RESPIRATORY THERAPY		0. 1895		-	
00 06600 PHYSI CAL THERAPY		0. 5351			
01 06601 PHYSI CAL THERAPY I -65		0. 3644	25 370	135	6
02 06602 PHYSI CAL THERAPY ST JOHN		0. 2973		_	
00 06700 OCCUPATIONAL THERAPY		0. 2312			
.01 06701 0CCUPATION THERAPY I -65 .02 06702 0CCUPATIONAL THERAPY ST. JOHN		0. 3852 0. 2262			
. 00 06800 SPEECH PATHOLOGY		0. 2262			
01 06801 SPEECH PATHOLOGY I -65		0. 2188			
02 06802 SPEECH THERAPY ST. JOHN		0.0000			
. 00 06900 ELECTROCARDI OLOGY		0. 3966	72 0	0	6
00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 5798			
. 00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 3167			
.00 07300 DRUGS CHARGED TO PATLENTS .00 07400 RENAL DLALYSES		0. 2386 0. 5659			
00 03020 RADIATION ONCOLOGY		0. 0977			1
. 01 03040 ANGI OCARDI OGRAPHY		0. 3734			1
.00 07700 ALLOGENEIC HSCT ACQUISITION		0.0000	00 0	0	7
.00 07800 CAR T-CELL IMMUNOTHERAPY		0.0000	00 0	0	78
OUTPATIENT SERVICE COST CENTERS			0.0		۱.
00 09000 CLINIC 01 09001 DIABETES CLINIC		0.0000			
01 09001 DI ABETES CLINI C 02 09002 OUTPATI ENT CLINI CS		0. 0000 0. 0000		_	
03 09003 OCCUPATIONAL MEDICINE CLINIC		0.0000		l .	
. 04 09004 NEONATOLOGY CLINIC-FRANCISCAN POINT		0. 3501		_	
. 05 09005 LACTATION CLINIC		2. 4496		Ō	
.00 09100 EMERGENCY		0. 1095		l .	
. 01 09101 EMERGENCY ROOM PHYSI CANS		0.0000		0	
. 02 09102 EXPRESS CARE		0.0000		0	
.00 09200 0BSERVATION BEDS (NON-DISTINCT PART 0.00 Total (sum of lines 50 through 94 and 96 through	00)	0. 5457		1 276 200	
0.00 Total (sum of lines 50 through 94 and 96 through 1.00 Less PBP Clinic Laboratory Services-Program only			4, 511, 966	1, 276, 288	200
OUL LEGGS FOR CITTLE EQUULATOR & SELVICES FICULIAN CITTLE	Characs (TITE OIL		1	i e	140

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)

200. 00 201. 00 202. 00

Health Financial Systems	FRANCISCAN HEALTH CROWN POINT			In Lieu of Form CMS-2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0126	Peri od:	Worksheet D-3

Health Financial Systems FRANCISCAN HEALTH	CROWN POINT		In Lie	u of Form CMS-	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-0126	Peri od:	Worksheet D-3	
			From 01/01/2023		
			To 12/31/2023	Date/Time Pre	
				5/30/2024 10:	06 am
	Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description		Ratio of Cos	t Inpatient	Inpati ent	
		To Charges	Program	Program Costs	
		10 0.10. 900	Charges	(col. 1 x col.	
			criai ges	2)	
		4 00	0.00		
		1. 00	2. 00	3. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS			5, 980, 106		30.00
31.00 03100 INTENSIVE CARE UNIT			1, 735, 949		31.00
35. 00 02060 NEONATAL INTENSIVE CARE UNIT			8, 224, 373		35.00
41. 00 04100 SUBPROVI DER - RF			0, == 1, 0.0		41.00
43. 00 04300 NURSERY			1 152 154		43. 00
		1	1, 152, 154		43.00
ANCI LLARY SERVI CE COST CENTERS		T			l
50. 00 05000 OPERATING ROOM		0. 16854		955, 354	1
51.00 05100 RECOVERY ROOM		0. 07398	930, 185	68, 816	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 51152	1, 280, 188	654, 847	52. 00
53. 00 05300 ANESTHESI OLOGY		0. 02806	854, 339	23, 975	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 08228		475, 965	1
54. 01 05401 RADI OLOGY - I - 65		0. 05865		686	1
		1			1
54. 02 05402 RADI OLOGY DI AGNOSTI C - SJ		0.00000		0	
54. 03 05403 LOWELL RADI OLOGY		0. 56248		0	
55. 00 05500 RADI OLOGY-THERAPEUTI C		0.00000	0 0	0	55. 00
55. 01 05501 CARDIAC CATHERIZATON LAB		0. 12834	1, 177, 181	151, 088	55. 01
55. 02 03140 CARDI OLOGY		0. 08283		78, 636	55. 02
55. 03 03450 NEURO-DI AGNOSTI CS		0. 13133		29, 261	1
60. 00 06000 LABORATORY		0. 11742		979, 125	
60. 01 06001 BLOOD LABORATORY		0.00000		0	1
65. 00 06500 RESPI RATORY THERAPY		0. 18954	1, 771, 378	335, 761	65. 00
66. 00 06600 PHYSI CAL THERAPY		0. 53517	340, 630	182, 296	66.00
66. 01 06601 PHYSI CAL THERAPY I -65		0. 36442	25 0	0	66, 01
66. 02 06602 PHYSI CAL THERAPY ST JOHN		0. 29738		0	66. 02
67. 00 06700 OCCUPATI ONAL THERAPY		0. 23129		54, 973	1
		1			1
67. 01 06701 0CCUPATI ON THERAPY 1-65		0. 38522		0	
67. 02 06702 OCCUPATIONAL THERAPY ST. JOHN		0. 22627		0	
68. 00 06800 SPEECH PATHOLOGY		0. 16539	606, 024	100, 236	68. 00
68. 01 06801 SPEECH PATHOLOGY I -65		0. 21884	6 0	0	68. 01
68.02 O6802 SPEECH THERAPY ST. JOHN		0.00000	0 0	0	68. 02
69. 00 06900 ELECTROCARDI OLOGY		0. 39667		1, 824	69.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 57980		1, 141, 174	1
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 31679			1
		1		264, 183	1
73. 00 O7300 DRUGS CHARGED TO PATIENTS		0. 23864			1
74. 00 07400 RENAL DI ALYSI S		0. 56599		33, 019	1
76. 00 03020 RADI ATI ON ONCOLOGY		0. 09773	63, 301	6, 187	76. 00
76. 01 03040 ANGI OCARDI OGRAPHY		0. 37348	21, 072	7, 870	76. 01
77. 00 07700 ALLOGENEIC HSCT ACQUISITION		0.00000		0	1
78. 00 O7800 CAR T-CELL IMMUNOTHERAPY		0.00000		Ō	1
OUTPATIENT SERVICE COST CENTERS		0.00000			1 , 5. 55
		0.00000	2	^	00 00
90. 00 09000 CLI NI C		0.00000			
90. 01 09001 DI ABETES CLI NI C		0.00000		0	
90. 02 09002 0UTPATIENT CLINICS		0.00000	0 0	0	
90. 03 09003 OCCUPATIONAL MEDICINE CLINIC		0.00000	0 0	0	90.03
90. 04 09004 NEONATOLOGY CLINIC-FRANCISCAN POINT		0. 35016	0	0	90.04
90. 05 09005 LACTATI ON CLI NI C		2. 44968		0	1
91. 00 09100 EMERGENCY		•		-	
		0. 10958			1
91. 01 09101 EMERGENCY ROOM PHYSI CANS		0.00000		0	1
91. 02 09102 EXPRESS CARE		0.00000		0	1
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 54579		128, 151	92.00
200.00 Total (sum of lines 50 through 94 and 96 through 98)			40, 294, 591	7, 321, 549	200.00
201.00 Less PBP Clinic Laboratory Services-Program only charges	s (line 61)		0		201.00
202.00 Net charges (line 200 minus line 201)	/		40, 294, 591		202. 00
		ı	1 .5,271,571	ı	,_02.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0126	Peri od: From 01/01/2023	Worksheet D-3	
	Component	CCN: 15-T126	To 12/31/2023	Date/Time Pre 5/30/2024 10:	pare
	Ti tl	e XIX	Subprovi der -	TEFRA	00 2
Cost Center Description		Ratio of Cos	IRF t Inpatient	Inpati ent	
·		To Charges	Program	Program Costs	
			Charges	(col. 1 x col. 2)	
		1.00	2. 00	3.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS				ı	١
10.00 03000 ADULTS & PEDIATRICS 11.00 03100 INTENSIVE CARE UNIT					30
31.00 03100 INTENSIVE CARE UNIT 35.00 02060 NEONATAL INTENSIVE CARE UNIT					35
H1. 00 04100 SUBPROVI DER - RF			394, 111		41
13. 00 04300 NURSERY					43
ANCILLARY SERVICE COST CENTERS					
50. 00 05000 OPERATI NG ROOM		0. 16854			
51. 00 05100 RECOVERY ROOM		0. 07398			
2.00 05200 DELIVERY ROOM & LABOR ROOM 3.00 05300 ANESTHESI OLOGY		0. 51152			
4. 00 05400 RADI OLOGY - DI AGNOSTI C		0. 0280 <i>6</i> 0. 08228			1
4. 01 05401 RADI OLOGY - 1 -65		0. 05865			1
4. 02 05402 RADIOLOGY DIAGNOSTIC - SJ		0.00000			
4. 03 05403 LOWELL RADI OLOGY		0. 56248	86 0	0	54
5. 00 05500 RADI OLOGY-THERAPEUTI C		0.00000			
5. 01 05501 CARDI AC CATHERI ZATON LAB		0. 12834			
5. 02 03140 CARDI 0L0GY		0.08283			
5. 03 03450 NEURO-DI AGNOSTI CS 0. 00 06000 LABORATORY		0. 13133			55
0. 00 06000 LABORATORY		0. 11742 0. 00000			1
5. 00 06500 RESPI RATORY THERAPY		0. 18954			
6. 00 06600 PHYSI CAL THERAPY		0. 53517		0	1
6. 01 06601 PHYSI CAL THERAPY I -65		0. 36442	25 0	0	66
6. 02 06602 PHYSI CAL THERAPY ST JOHN		0. 29738			1
57. 00 06700 OCCUPATI ONAL THERAPY		0. 23129			
7. 01 06701 OCCUPATION THERAPY I - 65		0. 38522			
57. 02 06702 OCCUPATI ONAL THERAPY ST. JOHN 58. 00 06800 SPEECH PATHOLOGY		0. 22627 0. 16539			67
8. 01 06801 SPEECH PATHOLOGY 1 -65		0. 21884			
8. 02 06802 SPEECH THERAPY ST. JOHN		0.00000			
9. 00 06900 ELECTROCARDI OLOGY		0. 39667	2 0	0	69
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 57980			1
2. 00 07200 I MPL. DEV. CHARGED TO PATIENTS		0. 31679			
3.00 07300 DRUGS CHARGED TO PATIENTS 4.00 07400 RENAL DIALYSIS		0. 23864			
4. 00 07400 RENAL DIALYSIS 6. 00 03020 RADIATION ONCOLOGY		0. 56599 0. 09773			
6. 01 03040 ANGI OCARDI OGRAPHY		0. 37348			
7. 00 07700 ALLOGENEI C HSCT ACQUI SITION		0.00000			
8.00 07800 CAR T-CELL IMMUNOTHERAPY		0.00000	00	0	78
OUTPATIENT SERVICE COST CENTERS			_		
0. 00 09000 CLI NI C		0.00000			
0. 01 09001 DI ABETES CLINI C 0. 02 09002 OUTPATI ENT CLINI CS		0.00000			
0.02 09002 001PATIENT CLINICS 0.03 09003 0CCUPATIONAL MEDICINE CLINIC		0.00000		l .	
0. 03 09003 0000FATTONAL MILDTOTNE CETNIC		0. 35016		l .	
0. 05 09005 LACTATI ON CLI NI C		2. 44968		-	
01.00 09100 EMERGENCY		0. 10958			
11.01 09101 EMERGENCY ROOM PHYSICANS		0.00000			1
1. 02 09102 EXPRESS CARE		0.00000			
2. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 54579			
200.00 Total (sum of lines 50 through 94 and 96 through 98)		1	1. 848	l 217	1200

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)

0 1, 848

217 200. 00 201. 00 202. 00

200.00

201.00 202.00

Health Financial Systems	FRANCISCAN HEALTH CROWN POINT	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0126	Peri od: From 01/01/2023 To 12/31/2023	Worksheet E Part A Date/Time Prepared: 5/30/2024 10:06 am

		Title XVIII	Hospi tal	5/30/2024 TO: PPS	uo aiii
			_	1 00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		L	1. 00	
1.00	DRG Amounts Other than Outlier Payments			0	1. 00
1.01	DRG amounts other than outlier payments for discharges occurring			25, 612, 882	1. 01
1. 02	DRG amounts other than outlier payments for discharges occurring instructions)	g on or after October 1	(see	9, 150, 693	1. 02
1.03	DRG for federal specific operating payment for Model 4 BPCI for	discharges occurring p	orior to October 1	0	1. 03
	(see instructions)	0 0 1			
1. 04	DRG for federal specific operating payment for Model 4 BPCI for 1 (see instructions)	discharges occurring o	on or after Octobe	er 0	1. 04
2.00	Outlier payments for discharges. (see instructions)				2. 00
2. 01	Outlier reconciliation amount			0	2. 01
2. 02	Outlier payment for discharges for Model 4 BPCI (see instruction			0	2. 02
2. 03 2. 04	Outlier payments for discharges occurring prior to October 1 (se Outlier payments for discharges occurring on or after October 1			963, 799 148, 570	2. 03 2. 04
3. 00	Managed Care Simulated Payments	(see mistructions)		19, 190, 137	3. 00
4.00	Bed days available divided by number of days in the cost reporti	ng period (see instruc	ctions)	178. 74	4. 00
	Indirect Medical Education Adjustment				
5. 00	FTE count for allopathic and osteopathic programs for the most r before 12/31/1996. (see instructions)	recent cost reporting p	period ending on c	or 0.00	5. 00
5. 01	FTE cap adjustment for qualifing hospitals under §131 of the CAA	A 2021 (see instruction	ns)	0. 00	5. 01
6.00	FTE count for allopathic and osteopathic programs that meet the	criteria for an add-or	to the cap for	0.00	6. 00
	new programs in accordance with 42 CFR 413.79(e)	had talked and add a state		- 0.00	
6. 26	Rural track program FTE cap limitation adjustment after the cap- CAA 2021 (see instructions)	-building window crosed	under 9127 of th	e 0.00	6. 26
7.00	MMA Section 422 reduction amount to the IME cap as specified und	der 42 CFR §412.105(f)((1) (i v) (B) (1)	0. 43	7. 00
7. 01	ACA § 5503 reduction amount to the IME cap as specified under 42	2 CFR §412.105(f)(1)(i\	/)(B)(2) If the	0.00	7. 01
7. 02	cost report straddles July 1, 2011 then see instructions. Adjustment (increase or decrease) to the hospital's rural track	program ETE limitation	(c) for rural	0.00	7. 02
7.02	track programs with a rural track for Medicare GME affiliated pr				7.02
	87 FR 49075 (August 10, 2022) (see instructions)	3			
8.00	Adjustment (increase or decrease) to the FTE count for allopathi			2. 00	8. 00
	affiliated programs in accordance with 42 CFR 413.75(b), 413.79(and 67 FR 50069 (August 1, 2002).	(C)(2)(IV), 64 FR 26340) (May 12, 1998),		
8. 01	The amount of increase if the hospital was awarded FTE cap slots	under § 5503 of the A	ACA. If the cost	0. 00	8. 01
	report straddles July 1, 2011, see instructions.				
8. 02	The amount of increase if the hospital was awarded FTE cap slots 5506 of ACA. (see instructions)	s from a closed teachir	ng hospital under	§ 0.00	8. 02
8. 21	The amount of increase if the hospital was awarded FTE cap slots	s under §126 of the CAA	2021 (see	0.00	8. 21
	instructions)	J. 2. 2. 2. 2. 2. 2. 2. 2. 2. 2. 2. 2. 2.			
9. 00	Sum of lines 5 and 5.01, plus line 6, plus lines 6.26 through 6.		7.01, plus or	1. 57	9. 00
10. 00	minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.27 FTE count for allopathic and osteopathic programs in the current		ls	1. 50	10. 00
11. 00	FTE count for residents in dental and podiatric programs.	. Joan Trom Joan Toolis	.5		11. 00
12.00	Current year allowable FTE (see instructions)			1. 50	
	Total allowable FTE count for the prior year.	anded on or often Cont	-amban 20 1007		13. 00 14. 00
14. 00	Total allowable FTE count for the penultimate year if that year otherwise enter zero.	ended on or arter Sept	.elliber 30, 1997,	0. 98	14.00
15. 00	Sum of lines 12 through 14 divided by 3.			1. 05	15. 00
16. 00	Adjustment for residents in initial years of the program (see in			0.00	
17. 00 18. 00	Adjustment for residents displaced by program or hospital closur	re e		0. 00 1. 05	17. 00 18. 00
	Adjusted rolling average FTE count Current year resident to bed ratio (line 18 divided by line 4).			0. 005874	
	Prior year resident to bed ratio (see instructions)			0. 003542	
	Enter the lesser of lines 19 or 20 (see instructions)			0. 003542	1
	IME payment adjustment (see instructions)			67, 268	
22. 01	IME payment adjustment - Managed Care (see instructions) Indirect Medical Education Adjustment for the Add-on for § 422 o	of the MMA		37, 133	22. 01
23.00	Number of additional allopathic and osteopathic IME FTE resident		R 412. 105	0.00	23. 00
	(f)(1)(iv)(C).				
24. 00 25. 00	IME FTE Resident Count Over Cap (see instructions) If the amount on line 24 is greater than -0-, then enter the low	wor of line 22 or line	24 (600	-0. 07 0. 00	•
25.00	instructions)	ver of fille 23 of fille	24 (366	0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)			0. 000000	
27. 00	IME payments adjustment factor. (see instructions)			0. 000000	
	IME add-on adjustment amount (see instructions) IME add-on adjustment amount - Managed Care (see instructions)			0	28. 00 28. 01
	Total IME payment (sum of lines 22 and 28)			67, 268	1
29. 01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)			37, 133	
20.00	Disproportionate Share Adjustment		-1 >		20.00
	Percentage of SSI recipient patient days to Medicare Part A pati Percentage of Medicaid patient days (see instructions)	ent days (see instruct	i ons)	1. 41 19. 70	30. 00 31. 00
31.00	Sum of Lines 30 and 31			19. 70 21. 11	
33.00	Allowable disproportionate share percentage (see instructions)			6. 63	
34. 00	Disproportionate share adjustment (see instructions)			576, 207	34.00

ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0126	Peri od: From 01/01/2023 To 12/31/2023	Worksheet E Part A Date/Time Pre 5/30/2024 10:	
		Title XVIII	Hospi tal	PPS	
			Prior to 10/1 1.00	0n/After 10/1 2.00	
	Uncompensated Care Payment Adjustment		1.00	2.00	
5. 00	Total uncompensated care amount (see instructions)		6, 874, 403, 459	5, 938, 006, 757	35.0
5. 01	Factor 3 (see instructions)		0. 000309438	0. 000281719	
5. 02	Hospital UCP, including supplemental UCP (see instructions)		2, 127, 201	1, 672, 847	35.0
5. 03	Pro rata share of the hospital UCP, including supplemental UC	CP (see instructions)	1, 591, 029	420, 497	35.0
6. 00	Total UCP adjustment (sum of columns 1 and 2 on line 35.03)	<u>.</u>	2, 011, 526		36.0
	Additional payment for high percentage of ESRD beneficiary di	scharges (lines 40 throu			
0.00	Total Medicare discharges (see instructions)		0		40.0
1.00	Total ESRD Medicare discharges (see instructions)	ti ana)	0		41. (
1. 01 2. 00	Total ESRD Medicare covered and paid discharges (see instruct Divide line 41 by line 40 (if less than 10%, you do not quali		0.00		41. (
3. 00	Total Medicare ESRD inpatient days (see instructions)	ry ror adjustment)	0.00		43. (
4. 00	Ratio of average length of stay to one week (line 43 divided	by line 41 divided by 7	0.000000		44.
00	days)	25	0.00000		
5. 00	Average weekly cost for dialysis treatments (see instructions	s)	0.00		45. (
6. 00	Total additional payment (line 45 times line 44 times line 41	1. 01)	0		46. (
7. 00	Subtotal (see instructions)		38, 530, 945		47. (
8. 00	Hospital specific payments (to be completed by SCH and MDH, s	small rural hospitals	0		48.
	only. (see instructions)			Amazint	
				Amount 1.00	
9. 00	Total payment for inpatient operating costs (see instructions	5)		38, 568, 078	49.
0.00	Payment for inpatient program capital (from Wkst. L, Pt. I an			2, 829, 208	
1. 00	Exception payment for inpatient program capital (Wkst. L, Pt.			0	51.
2. 00	Direct graduate medical education payment (from Wkst. E-4, li	ne 49 see instructions).		54, 211	52.
3. 00	Nursing and Allied Health Managed Care payment			0	53.
4. 00	Special add-on payments for new technologies			101, 407	1
4. 01	Islet isolation add-on payment	(0)		0	
5.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 6	59)		0	
5. 01 6. 00	Cellular therapy acquisition cost (see instructions)	suctions)		0	55. 56.
7. 00	Cost of physicians' services in a teaching hospital (see intr Routine service other pass through costs (from Wkst. D, Pt. I		hrough 35)	0	57.
8. 00	Ancillary service other pass through costs from Wkst. D, Pt.		in ough 33).	79, 606	
9. 00	Total (sum of amounts on lines 49 through 58)	,		41, 632, 510	1
0. 00	Primary payer payments			23, 217	1
1. 00	Total amount payable for program beneficiaries (line 59 minus	s line 60)		41, 609, 293	61.
2. 00	Deductibles billed to program beneficiaries			3, 349, 036	62.
3. 00	Coinsurance billed to program beneficiaries			99, 736	
4. 00	Allowable bad debts (see instructions)			143, 972	1
5.00	Adjusted reimbursable bad debts (see instructions)	h		93, 582	1
	Allowable bad debts for dual eligible beneficiaries (see inst	tructions)		32, 792	1
7.00	Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for	applicable to MS DDCs (s	eas instructions)	38, 254, 103 0	
9.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).			0	
0.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	(10) John Joe Hilath dethor	<i>,</i>	0	
0. 50	Rural Community Hospital Demonstration Project (§410A Demonst	tration) adjustment (see	instructions)	0	
0. 75	N95 respirator payment adjustment amount (see instructions)	, , , , , , , , , , , , , , , , , , ,		0	1
0. 87	Demonstration payment adjustment amount before sequestration			0	1
0. 88	SCH or MDH volume decrease adjustment (contractor use only)			0	70.
0. 89	Pioneer ACO demonstration payment adjustment amount (see inst	tructions)			70.
0. 90	HSP bonus payment HVBP adjustment amount (see instructions)			0	
0. 91	HSP bonus payment HRR adjustment amount (see instructions)			0	
0. 92	Bundled Model 1 discount amount (see instructions)			0	
0 00	HVBP payment adjustment amount (see instructions)			-123, 670	70.
0. 93	HRR adjustment amount (see instructions)			-513, 001	70.

Heal th	Financial Systems FRANCISCAN HEALTH	CROWN POINT		In Lie	eu of Form CMS-:	2552-10
	ATION OF REIMBURSEMENT SETTLEMENT	Provider C	CN: 15-0126	Peri od: From 01/01/2023 To 12/31/2023	Worksheet E Part A	pared:
		Title	XVIII	Hospi tal	PPS	<u> </u>
			FFY	(уууу)	Amount	
				0	1.00	
70. 96	Low volume adjustment for federal fiscal year (yyyy) (Enter i	n column 0		0	0	70. 96
70. 97	the corresponding federal year for the period prior to 10/1) Low volume adjustment for federal fiscal year (yyyy) (Enter i the corresponding federal year for the period ending on or af			0	0	70. 97
70. 98	Low Volume Payment-3	10/1)		0	0	70. 98
	HAC adjustment amount (see instructions)			O	104, 173	
	Amount due provider (line 67 minus lines 68 plus/minus lines	69 & 70)			37, 513, 259	1
	Seguestration adjustment (see instructions)	o, a ,o,			750, 265	1
	Demonstration payment adjustment amount after sequestration				0	1
	Sequestration adjustment-PARHM pass-throughs					71. 03
72.00	, , , , , , , , , , , , , , , , , , , ,				36, 615, 603	72.00
72. 01	Interim payments-PARHM					72. 01
73.00	Tentative settlement (for contractor use only)				0	73. 00
73. 01	Tentative settlement-PARHM (for contractor use only)					73. 01
74. 00	Balance due provider/program (line 71 minus lines 71.01, 71.073)	2, 72, and			147, 391	74. 00
74.01	Balance due provider/program-PARHM (see instructions)					74. 01
75. 00	Protested amounts (nonallowable cost report items) in accorda Pub. 15-2, chapter 1, §115.2	nce with CMS	5		532, 119	75. 00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)				1	
90. 00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum	of 2.03 plus	5		0	90.00
04 00	2.04 (see instructions)					04 00
91.00	Capital outlier from Wkst. L, Pt. I, line 2				0	
	Operating outlier reconciliation adjustment amount (see instr Capital outlier reconciliation adjustment amount (see instruc				0	92. 00 93. 00
	The rate used to calculate the time value of money (see instruc				0.00	
	Time value of money for operating expenses (see instructions)	uctions)			0.00	1
96.00	Time value of money for capital related expenses (see instructions)	tions)			0	
70.00	Titille value of money for capital related expenses (see flistruc	11 0113)		Drior to 10/1	On/After 10/1	70.00
				1. 00	2.00	
	HSP Bonus Payment Amount			11.00	2.00	
	HSP bonus amount (see instructions)			0	0	100.00
	HVBP Adjustment for HSP Bonus Payment					1
101.00	HVBP adjustment factor (see instructions)			0. 000000000	0.000000000	101. 00
	HVBP adjustment amount for HSP bonus payment (see instruction	s)		0		102. 00
	HRR Adjustment for HSP Bonus Payment	,				1
103.00	HRR adjustment factor (see instructions)			0.0000	0.0000	103. 00
	HRR adjustment amount for HSP bonus payment (see instructions)		0	0	104.00
	Rural Community Hospital Demonstration Project (§410A Demonst	ration) Adju				
200.00	Is this the first year of the current 5-year demonstration pe	riod under t	he 21st Centu	ıry		200. 00

Health Financial Systems

LOW VOLUME CALCULATION EXHIBIT 4

Provi der CCN: 15-0126

				T: ±1 -	VA /I I I	11: 4-1	5/30/2024 10:0	06 am_
		W/S F Part A	Amounts (from	Pre/Post	XVIII Period Prior	Hospi tal Peri od	PPS Total (Col 2	
		line	E, Part A)	Entitlement	to 10/01	On/After 10/01	through 4)	
		0	1.00	2. 00	3. 00	4. 00	5. 00	
1. 00	DRG amounts other than outlier	1. 00	0	0	C	0	0	1. 00
1. 01	payments DRG amounts other than outlier payments for discharges	1. 01	25, 612, 882	O	25, 612, 882		25, 612, 882	1. 01
1. 02	occurring prior to October 1 DRG amounts other than outlier payments for discharges	1. 02	9, 150, 693	O		9, 150, 693	9, 150, 693	1. 02
1. 03	occurring on or after October DRG for Federal specific operating payment for Model 4 BPCI occurring prior to Octobe	1. 03	0	0	C		0	1. 03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after	1. 04	0	0		0	0	1. 04
2. 00	October 1 Outlier payments for discharge (see instructions)	s 2.00						2. 00
2. 01	Outlier payments for discharge for Model 4 BPCI	5 2.02	0	0	С	0	0	2. 01
2. 02	Outlier payments for discharge occurring prior to October 1 (see instructions)	s 2. 03	963, 799	O	963, 799		963, 799	2. 02
2. 03	Outlier payments for discharge occurring on or after October	s 2. 04 1	148, 570	O		148, 570	148, 570	2. 03
3. 00	(see instructions) Operating outlier reconciliation	2. 01	0	0	c	0	0	3. 00
4.00	Managed care simulated payment Indirect Medical Education Adju		19, 190, 137	0	14, 306, 879	4, 883, 258	19, 190, 137	4. 00
5.00	Amount from Worksheet E, Part	21. 00	0. 003542	0. 003542	0. 003542	0. 003542		5. 00
6. 00	A, line 21 (see instructions) IME payment adjustment (see instructions)	22. 00	67, 268	0	49, 561	17, 707	67, 268	6. 00
6. 01	IME payment adjustment for managed care (see instructions	22. 01	37, 133	0	27, 684	9, 449	37, 133	6. 01
	Indirect Medical Education Adju							
7.00	IME payment adjustment factor	27. 00	0. 000000	0. 000000	0. 000000	0. 000000		7. 00
8. 00	(see instructions) IME adjustment (see instructions)	28. 00	0	0	С	0	0	8. 00
8. 01	IME payment adjustment add on for managed care (see	28. 01	0	0	C	0	0	8. 01
9. 00	<pre>instructions) Total IME payment (sum of line 6 and 8)</pre>	5 29.00	67, 268	0	49, 561	17, 707	67, 268	9. 00
9. 01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29. 01	37, 133	0	27, 684	9, 449	37, 133	9. 01
	Di sproporti onate Share Adjustme							
10. 00	Allowable disproportionate share percentage (see instructions)	33. 00	0. 0663	0. 0663	0. 0663	0. 0663		10. 00
11. 00	Disproportionate share adjustment (see instructions)	34.00	576, 207	0	424, 534	151, 673	576, 207	11. 00
11. 01	Uncompensated care payments Additional payment for high per	36.00	2, 011, 526	0	1, 591, 029	420, 497	2, 011, 526	11. 01
12. 00	Total ESRD additional payment	46. 00	O Delie IT Crary 0	0 o	С	0	0	12. 00
12.00	(see instructions)	47.00	20 520 045	0	20 /41 005	0 000 140	20 520 045	12.00
13. 00 14. 00	Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	47. 00 48. 00	38, 530, 945 0	0	28, 641, 805 C	9, 889, 140 0	38, 530, 945 0	14. 00
15. 00	Total payment for inpatient operating costs (see	49. 00	38, 568, 078	O	28, 669, 489	9, 898, 589	38, 568, 078	15. 00
16. 00	instructions) Payment for inpatient program capital (from Wkst. L, Pt. I,	50. 00	2, 829, 208	0	2, 085, 218	743, 990	2, 829, 208	16. 00
17. 00	if applicable) Special add-on payments for neitechnologies	v 54.00	101, 407	0	101, 407	0	101, 407	17. 00
17. 01	Net organ aquisition cost							17. 01

Health Financial Systems	F	RANCISCAN HEALT	TH CROWN POINT		In Lie	u of Form CMS-	2552-10
LOW VOLUME CALCULATION EXHIBIT 4			Provider Co		Period: From 01/01/2023 To 12/31/2023	Worksheet E Part A Exhibi Date/Time Pre 5/30/2024 10:	pared:
			Title	: XVIII	Hospi tal	PPS	
	W/S E, Part A	Amounts (from	Pre/Post	Period Prior	Peri od	Total (Col 2	
	line	E, Part A)	Entitlement	to 10/01	On/After 10/01	through 4)	
	0	1.00	2. 00	3.00	4. 00	5. 00	
17 02 Credita received from	(0.00	0	0		0		17 02

				Title	XVIII	Hospi tal	PPS	
		W/S E, Part A	Amounts (from	Pre/Post	Period Prior	Peri od	Total (Col 2	
		line	E, Part A)	Entitlement	to 10/01	On/After 10/01	through 4)	
		0	1.00	2. 00	3.00	4. 00	5. 00	
17. 02	Credits received from	68. 00	0	0	C	0	0	17. 02
	manufacturers for replaced							
	devices for applicable MS-DRGs							
18.00	Capital outlier reconciliation	93.00	0	0		0	0	18. 00
	adjustment amount (see							
	instructions)							
19.00	SUBTOTAL			0	30, 856, 114	10, 642, 579	41, 498, 693	19. 00
		W/S L, line	(Amounts from					
			L)					
		0	1. 00	2. 00	3.00	4. 00	5. 00	
20.00	Capital DRG other than outlier	1. 00	2, 645, 892	0	1, 936, 303	709, 589	2, 645, 892	20. 00
20. 01	Model 4 BPCI Capital DRG other	1. 01	0	0	C	0	0	20. 01
	than outlier							
21.00	Capital DRG outlier payments	2. 00	60, 811	0	59, 264	1, 547	60, 811	21. 00
21. 01	Model 4 BPCI Capital DRG	2. 01	0	0	C	0	0	21. 01
	outlier payments							
22.00	Indirect medical education	5. 00	0. 0027	0. 0027	0. 0027	0. 0027		22. 00
	percentage (see instructions)							
23.00	Indirect medical education	6. 00	7, 144	0	5, 228	1, 916	7, 144	23. 00
	adjustment (see instructions)							
24.00	Allowable disproportionate	10.00	0. 0436	0. 0436	0. 0436	0. 0436		24. 00
	share percentage (see							
	instructions)							
25.00	Di sproporti onate share	11. 00	115, 361	0	84, 423	30, 938	115, 361	25. 00
	adjustment (see instructions)							
26. 00	Total prospective capital	12.00	2, 829, 208	0	2, 085, 218	743, 990	2, 829, 208	26. 00
	payments (see instructions)							
		W/S E, Part A						
		line	Part A)					
		0	1.00	2.00	3. 00	4. 00	5. 00	
27. 00	Low volume adjustment factor				0.000000	0. 000000		27. 00
28. 00	Low volume adjustment (transfe				C		0	28. 00
	amount to Wkst. E, Pt. A, line							
29. 00	Low volume adjustment (transfe					0	0	29. 00
	amount to Wkst. E, Pt. A, line							
100.00	Transfer low volume adjustment	\$	Y					100. 00
	to Wkst. E, Pt. A.							

Provider CCN: 15-0126

Peri od:

From 01/01/2023

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Part A Exhibit 5

Date/Time Prepared: 12/31/2023 5/30/2024 10:06 am Hospi tal Title XVIII Period to Total (cols. 2 Wkst. E, Pt. Amt. from Peri od on Wkst. E, Pt. 10/01 A. line after 10/01 and 3) A) 2.00 3. 00 0 4.00 1.00 1.00 DRG amounts other than outlier payments 1. 00 1. 00 DRG amounts other than outlier payments for 1.01 1.01 25, 612, 882 25, 612, 882 25, 612, 882 1.01 discharges occurring prior to October 1 9, 150, 693 1.02 DRG amounts other than outlier payments for 1.02 9, 150, 693 9, 150, 693 1.02 discharges occurring on or after October 1 1.03 DRG for Federal specific operating payment 1.03 C 0 1.03 for Model 4 BPCI occurring prior to October 1 04 DRG for Federal specific operating payment 1.04 0 1.04 for Model 4 BPCI occurring on or after October 1 2.00 Outlier payments for discharges (see 2.00 2.00 instructions) Outlier payments for discharges for Model 4 2.01 2.02 2.01 0 Outlier payments for discharges occurring 2.02 963, 799 963, 799 963, 799 2.02 2.03 prior to October 1 (see instructions) 2.03 Outlier payments for discharges occurring on 2.04 148, 570 148, 570 148, 570 2.03 or after October 1 (see instructions) Operating outlier reconciliation 2.01 3.00 3.00 Managed care simulated payments 4.00 3.00 19, 190, 137 14, 306, 879 4, 883, 258 19, 190, 137 4.00 Indirect Medical Education Adjustment 5.00 Amount from Worksheet E, Part A, line 21 (see 21.00 0.003542 0.003542 0.003542 5.00 instructions) 6.00 IME payment adjustment (see instructions) 22.00 67, 268 49, 561 17, 707 67, 268 6.00 IME payment adjustment for managed care (see 27, 684 9, 449 37, 133 6 01 22 01 37.133 6 01 instructions) Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA 7.00 IME payment adjustment factor (see 0.000000 0.000000 0.000000 7.00 instructions) 8.00 28.00 8.00 IME adjustment (see instructions) 0 Ω 0 8.01 IME payment adjustment add on for managed 28.01 0 0 Ω 8.01 care (see instructions) 9.00 Total IME payment (sum of lines 6 and 8) 29.00 67, 268 49, 561 17, 707 67, 268 9.00 Total IME payment for managed care (sum of 29.01 37, 133 27, 684 9, 449 37, 133 9.01 9.01 lines 6.01 and 8.01) Disproportionate Share Adjustment 10.00 Allowable disproportionate share percentage 33.00 0.0663 0.0663 0.0663 10.00 (see instructions) 11.00 Disproportionate share adjustment (see 34.00 576, 207 424, 534 151, 673 576, 207 11.00 instructions) Uncompensated care payments 2, 011, 526 11.01 36, 00 1, 591, 029 420, 497 11.01 2, 011, 526 Additional payment for high percentage of ESRD beneficiary discharges 12.00 Total ESRD additional payment (see 46.00 12.00 instructions) 13.00 47.00 38, 530, 945 28, 641, 805 9, 889, 140 Subtotal (see instructions) 38, 530, 945 13.00 Hospital specific payments (completed by SCH 14.00 48.00 14.00 and MDH, small rural hospitals only.) (see instructions) 15.00 Total payment for inpatient operating costs 49.00 38, 568, 078 28, 669, 489 9, 898, 589 38, 568, 078 15.00 (see instructions) Payment for inpatient program capital (from 16.00 50.00 2, 829, 208 2.085.218 743.990 2, 829, 208 16.00 Wkst. L, Pt. I, if applicable) 17.00 Special add-on payments for new technologies 54.00 101, 407 101, 407 0 101, 407 17.00 Net organ acquisition cost 17.01 17.01 Credits received from manufacturers for 17.02 68.00 0 0 0 17.02 replaced devices for applicable MS-DRGs Capital outlier reconciliation adjustment 18 00 93.00 0 18.00 amount (see instructions) 19.00 SUBTOTAL 30, 856, 114 10, 642, 579 41, 498, 693 19.00

		RANCISCAN HEAL			In Li€	eu of Form CMS-	2552-10
HOSPI T	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	TION EXHIBIT 5	Provider CO		Peri od: From 01/01/2023 To 12/31/2023	Date/Time Pre 5/30/2024 10:	pared:
				XVIII	Hospi tal	PPS	
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3. 00	4. 00	
20. 00	Capital DRG other than outlier	1.00	2, 645, 892	1, 936, 30	709, 589	2, 645, 892	20.00
20. 01	Model 4 BPCI Capital DRG other than outlier	1. 01	0		0 0		
21.00	Capital DRG outlier payments	2.00	60, 811	59, 20	54 1, 547	60, 811	21. 00
21. 01	Model 4 BPCI Capital DRG outlier payments	2. 01	0	·	0 0	0	21. 01
22. 00	Indirect medical education percentage (see	5. 00	0. 0027	0. 00:	0. 0027		22. 00
	instructions)						
23. 00	Indirect medical education adjustment (see instructions)	6. 00	7, 144	5, 2:	1, 916	7, 144	23. 00
24. 00	Allowable disproportionate share percentage (see instructions)	10. 00	0. 0436	0. 04:	0. 0436		24. 00
25. 00	Disproportionate share adjustment (see instructions)	11. 00	115, 361	84, 42	23 30, 938	115, 361	25. 00
26. 00	Total prospective capital payments (see instructions)	12. 00	2, 829, 208	2, 085, 2 ⁻	18 743, 990	2, 829, 208	26. 00
	1.1.30. 40.1.01.07	Wkst. E, Pt.	(Amt. from				
		A, line	Wkst. E, Pt. A)				
		0	1.00	2.00	3. 00	4.00	
27. 00							27. 00
28. 00	Low volume adjustment prior to October 1	70. 96	0		0	0	28. 00
29. 00	Low volume adjustment on or after October 1	70. 97	0		0	0	29. 00
30.00	HVBP payment adjustment (see instructions)	70, 93	-123, 670		0 -123, 670	-123, 670	30.00
30. 01	HVBP payment adjustment for HSP bonus paymen (see instructions)	70. 90	0		0 0	0	30. 01
31. 00	HRR adjustment (see instructions)	70. 94	-513, 001	-411, 4:	-101, 573	-513, 001	31.00
31. 00	HRR adjustment for HSP bonus payment (see	70. 91	-515,001	-411, 4.	0 -101, 373	-513,001	
31.01	instructions)	70. 71	٥				31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3. 00	4.00	
32. 00	HAC Reduction Program adjustment (see instructions)	70. 99			0 104, 173	104, 173	32. 00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100. 00

Health Financial Systems	FRANCISCAN HEALTH CROWN POINT	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0126	Peri od: From 01/01/2023 To 12/31/2023	Worksheet E Part B Date/Time Prepared: 5/30/2024 10:06 am

		! 4-!	5/30/2024 10:0	06 am_
	Title XVIII Ho	spi tal	PPS	
			1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			
1.00	Medical and other services (see instructions)		668	1. 00
2.00	Medical and other services reimbursed under OPPS (see instructions)		22, 046, 345	2.00
3. 00 4. 00	OPPS or REH payments Outlier payment (see instructions)		17, 035, 122 80, 508	3. 00 4. 00
4. 00	Outlier reconciliation amount (see instructions)		0, 508	4. 00
5. 00	Enter the hospital specific payment to cost ratio (see instructions)		0. 000	5. 00
6.00	Line 2 times line 5		0	6. 00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7. 00
8.00	Transitional corridor payment (see instructions)		0	8. 00
9. 00	Ancillary service other pass through costs including REH direct graduate medical education of	costs from	153, 632	9. 00
10. 00	Wkst. D, Pt. IV, col. 13, line 200 Organ acquisitions		o	10. 00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)		668	11. 00
11.00	COMPUTATION OF LESSER OF COST OR CHARGES		000	11.00
	Reasonable charges			
12.00	Ancillary service charges		2, 797	12.00
13.00			0	13.00
14. 00			2, 797	14. 00
15 00	Customary charges		0	15 00
15. 00 16. 00	Aggregate amount actually collected from patients liable for payment for services on a charge Amounts that would have been realized from patients liable for payment for services on a charge amounts.		0 nad 0	15. 00 16. 00
10.00	such payment been made in accordance with 42 CFR §413.13(e)	ii gebasi s il	lau 0	10.00
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)		2, 797	18.00
19. 00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11)	(see	2, 129	19.00
	instructions)			
20. 00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18)	(see	0	20. 00
21. 00	instructions) Lesser of cost or charges (see instructions)		668	21. 00
22. 00	Interns and residents (see instructions)	•	000	22. 00
23. 00	· · · · · · · · · · · · · · · · · · ·		Ö	23. 00
24. 00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)		17, 269, 262	24. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
25. 00	Deductibles and coinsurance amounts (for CAH, see instructions)		0	25. 00
26. 00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions		3, 008, 240	26. 00
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23	}] (see	14, 261, 690	27. 00
28. 00	instructions) Direct graduate medical education payments (from Wkst. E-4, line 50)	ŀ	22, 217	28. 00
28. 50	REH facility payment amount (see instructions)		22, 217	28. 50
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29. 00
30. 00	Subtotal (sum of lines 27, 28, 28.50 and 29)		14, 283, 907	30. 00
31.00	Primary payer payments		9, 090	31.00
32. 00	,		14, 274, 817	32.00
00.00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		0	00.00
33. 00 34. 00			0 199, 977	33. 00 34. 00
35. 00			129, 985	
	,		151, 709	
37. 00			14, 404, 802	
38.00	MSP-LCC reconciliation amount from PS&R		-239	38. 00
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39. 00
39. 50	1.3			39. 50
39. 75	N95 respirator payment adjustment amount (see instructions)		0	39. 75
39. 97 39. 98	Demonstration payment adjustment amount before sequestration Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39. 97 30. 08
39. 98 39. 99	Partial or full credits received from manufacturers for replaced devices (see instructions) RECOVERY OF ACCELERATED DEPRECIATION		0	39. 98 39. 99
40. 00	Subtotal (see instructions)		14, 405, 041	40. 00
40. 01	Sequestration adjustment (see instructions)		288, 101	40. 01
40. 02	Demonstration payment adjustment amount after sequestration		0	40. 02
40. 03	Sequestration adjustment-PARHM pass-throughs	ļ		40. 03
41. 00			14, 015, 111	
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)		101 020	42. 01
43. 00 43. 01	Balance due provider/program (see instructions) Balance due provider/program-PARHM (see instructions)		101, 829	43. 00 43. 01
	, , , , , , , , , , , , , , , , , , , ,	- 1, §115 :	0	44. 00
00	TO BE COMPLETED BY CONTRACTOR	., 3110.4		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		0.00	92.00
93. 00	Time Value of Money (see instructions)		0	93.00
94. 00	Total (sum of lines 91 and 93)		0	94. 00

Health Financial Systems	FRANCISCAN HEALTH	CROWN POINT	In Lie	u of Form CMS-	-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0126	Peri od:	Worksheet E	
			From 01/01/2023		
			To 12/31/2023	Date/Time Pro	
				5/30/2024 10	:06 am_
		Title XVIII	Hospi tal	PPS	
				1. 00	
MEDICARE PART B ANCILLARY COSTS					
200.00 Part B Combined Billed Days				(200. 00

Health Financial Systems	FRANCISCAN HEALTH CROWN PO	I NT	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi de	er CCN: 15-0126	Peri od: From 01/01/2023	Worksheet E Part B
	Compone	ent CCN: 15-T126		Date/Time Prepared: 5/30/2024 10:06 am
	Т	itle XVIII	Subprovi der -	PPS

		litle XVIII	Subprovi der – I RF	PPS	
	·			1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			11.00	
1.00	Medical and other services (see instructions)	,		72	1.00
2. 00 3. 00	Medical and other services reimbursed under OPPS (see instructi OPPS or REH payments		28 163	2. 00 3. 00	
4. 00	Outlier payment (see instructions)			0	4. 00
4. 01	Outlier reconciliation amount (see instructions)			Ö	4. 01
5.00	Enter the hospital specific payment to cost ratio (see instruct		0. 000	5. 00	
6.00	Line 2 times line 5			0	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 including REH direct	graduate medical educa	ation costs from	0	9. 00
7.00	Wkst. D, Pt. IV, col. 13, line 200	g. addatood. od. oddo		Ĭ	7.00
10.00	Organ acquisitions			0	10. 00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			72	11. 00
	COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges				
12. 00	Ancillary service charges			300	12. 00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, lin	e 69)		0	13. 00
14.00	Total reasonable charges (sum of lines 12 and 13)			300	14. 00
15. 00	Customary charges	ymont for convices on	s charge basis	0	15. 00
16. 00	Aggregate amount actually collected from patients liable for pa Amounts that would have been realized from patients liable for				16. 00
	such payment been made in accordance with 42 CFR §413.13(e)	payment to de trode e.	. a ona gozao o n		10.00
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0. 000000	
18.00	Total customary charges (see instructions)		44) (300	
19. 00	Excess of customary charges over reasonable cost (complete only instructions)	IT line 18 exceeds lin	ne II) (see	228	19. 00
20. 00	Excess of reasonable cost over customary charges (complete only	if line 11 exceeds lin	ne 18) (see	0	20. 00
	instructions)		, ,		
21. 00	Lesser of cost or charges (see instructions)			72	21. 00
22. 00 23. 00	Interns and residents (see instructions) Cost of physicians' services in a teaching hospital (see instru	ctions)		0	22. 00 23. 00
24. 00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	ctrons)		163	24. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25. 00	Deductibles and coinsurance amounts (for CAH, see instructions)			0	25. 00
26. 00 27. 00	Deductibles and Coinsurance amounts relating to amount on line Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) pl			0 235	26. 00 27. 00
27.00	instructions)	us the sum of filles 22	and 23] (See	235	27.00
28. 00	Direct graduate medical education payments (from Wkst. E-4, lin	e 50)		0	28. 00
28. 50	REH facility payment amount (see instructions)				28. 50
29. 00 30. 00	ESRD direct medical education costs (from Wkst. E-4, line 36) Subtotal (sum of lines 27, 28, 28.50 and 29)			0 235	29. 00 30. 00
31. 00	Primary payer payments			233	31. 00
32. 00	Subtotal (line 30 minus line 31)			235	32. 00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE	S)			
33. 00	Composite rate ESRD (from Wkst. I-5, line 11)			0	33. 00
34. 00 35. 00	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			0	34. 00 35. 00
36. 00	Allowable bad debts for dual eligible beneficiaries (see instru	ctions)		0	36. 00
37.00	Subtotal (see instructions)	,		235	37. 00
38. 00	MSP-LCC reconciliation amount from PS&R			0	38. 00
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39. 00
39. 50 39. 75	Pioneer ACO demonstration payment adjustment (see instructions) N95 respirator payment adjustment amount (see instructions)			0	39. 50 39. 75
39. 97	Demonstration payment adjustment amount before sequestration			0	39. 97
39. 98	Partial or full credits received from manufacturers for replace	d devices (see instruct	tions)	0	39. 98
39. 99	RECOVERY OF ACCELERATED DEPRECIATION			0	39. 99
40.00	Subtotal (see instructions)			235	40.00
40. 01 40. 02	Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration			5 0	40. 01 40. 02
40. 03	Sequestration adjustment-PARHM pass-throughs			ĭ	40. 03
41.00	Interim payments			218	41. 00
	Interim payments-PARHM			_	41. 01
42. 00 42. 01	Tentative settlement (for contractors use only) Tentative settlement-PARHM (for contractor use only)			0	42. 00 42. 01
42.01	Balance due provider/program (see instructions)			12	42.01
43. 01	Balance due provider/program-PARHM (see instructions)			12	43. 01
44.00	Protested amounts (nonallowable cost report items) in accordance	e with CMS Pub. 15-2, o	chapter 1, §115.2	0	44. 00
00.00	TO BE COMPLETED BY CONTRACTOR		1		00.00
90. 00 91. 00	Original outlier amount (see instructions) Outlier reconciliation adjustment amount (see instructions)			0	90. 00 91. 00
92. 00	The rate used to calculate the Time Value of Money			0.00	
93. 00	Time Value of Money (see instructions)		j	0	93. 00

Health Financial Systems	FRANCI SCAN HEALTH	CROWN POINT	In Lie	u of Form CMS-	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0126	Peri od:	Worksheet E	
			From 01/01/2023		
		Component CCN: 15-T126	To 12/31/2023		
				5/30/2024 10:	06 am_
		Title XVIII	Subprovi der -	PPS	
			IRF		
				1. 00	
94.00 Total (sum of lines 91 and 93)				0	94.00
			·		
				1. 00	
MEDICARE PART B ANCILLARY COSTS					
200.00 Part B Combined Billed Days					200. 00

Health Financial Systems FRANCI ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Peri od: | Worksheet E-1 | From 01/01/2023 | Part | To 12/31/2023 | Date/Time Prepared: Provider CCN: 15-0126

				10 12/31/2023	5/30/2024 10: 0	
		Ti tl e	XVIII	Hospi tal	PPS	
		Inpatier	nt Part A	Par	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		36, 615, 60)3	14, 015, 111	1. 00
2.00	Interim payments payable on individual bills, either			0	0	2. 00
	submitted or to be submitted to the contractor for services					
	rendered in the cost reporting period. If none, write					
	"NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment amount					3.00
	based on subsequent revision of the interim rate for the					
	cost reporting period. Also show date of each payment. If					
	none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER			0	0	3. 01
3. 02			l	0	0	3. 02
3. 03				0	0	3. 03
3. 04				0	0	3. 04
3. 05				0	0	3. 05
2 50	Provider to Program				0	2 50
3.50	ADJUSTMENTS TO PROGRAM			0		3. 50
3. 51				0	0 0	3. 51
3. 52				0	0	3. 52
3. 53 3. 54				0		3. 53 3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0		3. 99
3. 99	3. 50-3. 98)			٩	ا	3. 99
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		36, 615, 60	13	14, 015, 111	4. 00
1. 00	(transfer to Wkst. E or Wkst. E-3, line and column as		00,010,00	.5	11,010,111	1. 00
	appropriate)					
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after des	k				5. 00
	review. Also show date of each payment. If none, write					
	"NONE" or enter a zero. (1)					
	Program to Provider					
5.01	TENTATI VE TO PROVI DER			0	0	5. 01
5.02				0	0	5. 02
5.03				0	0	5. 03
	Provider to Program					
5. 50	TENTATI VE TO PROGRAM		l .	0	0	5. 50
5. 51				0	0	5. 51
5. 52				0	0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	5. 99
	5. 50-5. 98)					, 00
6.00	Determined net settlement amount (balance due) based on the					6. 00
6. 01	cost report. (1) SETTLEMENT TO PROVIDER		147, 39	11	101, 829	6. 01
6. 01	SETTLEMENT TO PROGRAM		147, 39		101, 829	6. 01
			26 742 00	0	ı "	
7. 00	Total Medicare program liability (see instructions)		36, 762, 99	Contractor	14, 116, 940 NPR Date	7. 00
				Number	(Mo/Day/Yr)	
			0	1. 00	2.00	
8. 00	Name of Contractor		-	1.00	2.00	8. 00
	1			1		50

Component CCN: 15-T126 Date/Time Prepared: To 12/31/2023

4, 179, 931

0

Contractor

Number

1.00

Λ

230

NPR Date

(Mo/Day/Yr)

2 00

6.02

7.00

8.00

5/30/2024 10:06 am Title XVIII Subprovi der PPS **IRF** Inpatient Part A Part B mm/dd/yyyy mm/dd/yyyy Amount Amount 1.00 3. 00 4, 092, 558 1.00 1.00 Total interim payments paid to provider 218 2.00 Interim payments payable on individual bills, either 2.00 submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero 3.00 List separately each retroactive lump sum adjustment amount 3.00 based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 3.01 ADJUSTMENTS TO PROVIDER 0 0 3. 01 0 3.02 0 3.02 0 3 03 3.03 0 3.04 0 3.04 3.05 0 0 3.05 Provider to Program 3 50 ADJUSTMENTS TO PROGRAM 0 3.50 0 0 3.51 0 3.51 3.52 0 0 3. 52 0 3.53 0 3.53 0 3.54 0 3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 0 0 3.99 3.50-3.98) 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 4, 092, 558 218 4.00 (transfer to Wkst. E or Wkst. E-3, line and column as appropri ate) TO BE COMPLETED BY CONTRACTOR 5.00 List separately each tentative settlement payment after desk 5.00 review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 5.01 TENTATI VE TO PROVIDER 0 0 5.01 5.02 0 0 5.02 5.03 5.03 0 0 Provider to Program 5.50 TENTATI VE TO PROGRAM 0 0 5.50 5.51 0 0 5.51 0 Ω 5 52 5 52 5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 0 0 5.99 5.50-5.98) 6.00 Determined net settlement amount (balance due) based on the 6.00 cost report. (1) SETTLEMENT TO PROVIDER 6.01 87.373 12 6.01

SETTLEMENT TO PROGRAM

8.00 Name of Contractor

Total Medicare program liability (see instructions)

6.02

7.00

Heal th	Financial Systems FRANCISCAN HEALTH	CROWN POINT	In Lie	u of Form CMS-	2552-10
CALCUL					epared:
		T: +1 - W/III	11	5/30/2024 10:	<u>06 am</u>
		Title XVIII	Hospi tal	PPS	
				4.00	
	TO DE COMPLETED DV CONTRACTOR FOR MONOTANDARD COCT REPORTS			1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				4
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				4
1. 00	Total hospital discharges as defined in AARA §4102 from Wkst.	S-3, Pt. I col. 15 line	e 14		1. 00
2.00	Medicare days (see instructions)				2. 00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3. 00
4.00	Total inpatient days (see instructions)				4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5. 00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 I	ine 20			6. 00
7.00	CAH only - The reasonable cost incurred for the purchase of cline 168		Wkst. S-2, Pt. I		7. 00
8. 00	Calculation of the HIT incentive payment (see instructions)				8.00
9. 00	Sequestration adjustment amount (see instructions)				9. 00
	, ,	(!+:)			
10. 00	Calculation of the HIT incentive payment after sequestration	(see instructions)			10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				4
	Initial/interim HIT payment adjustment (see instructions)				30. 00
31. 00	Other Adjustment (specify)				31. 00
22 00	Delance due provider (line 0 (er line 10) minus line 20 and l	ing 21) (coo inctruction	·~)		22 00

32.00 Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)

30. 00 31. 00 32. 00

Health Financial Systems	FRANCISCAN HEALTH CROWN POINT	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0126	Peri od: From 01/01/2023	Worksheet E-3
	Component CCN: 15-T126		
	Title XVIII	Subprovi der -	PPS
		IRF	

DART_III			IRF		
PART_III - MEDICAME FART A SERVICES - IBF PPS			L		
1.00 Met Federal PFS Payment (see Instructions) 0.0000 2.00				1. 00	
Medicare SSI ratio (IRF PPS only) (see instructions) 0.0000 2.00					
Inpati ent Rehabilitation LIP Payments (see instructions)					
4.00 OutTielr Payments 594,551 4.00 November 15, 2004 (see Instructions) 0.00 0.00 5.01 Cap Increases for the unwellphted 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(c)(1)(11)(17)(1) or (2) (see Instructions) 0.00 6.00					
Damei phted intern and resident FTE count in the most recent cost reporting period ending on or prior to 0.00 s.00					
November 15, 2004 (see instructions) 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 s412.44(d)(1)(ii)(ii)(f)(1) or (2) (see instructions) 6.00 New Teaching program (see instructions) 7.00 Current year's unmediated program (see instructions) 8.01 Eaching program (see instructions) 8.02 Intern and resident count for IRR PPS medical education adjustment (see instructions) 9.00 Intern and resident count for IRR PPS medical education adjustment (see instructions) 9.00 Intern and resident count for IRR PPS medical education adjustment (see instructions) 9.00 Total PPS Payment (see instructions) 9.00 Organ acquisition (D0 NOT USE THIS LINE) 9.00 Total PPS Payment (see instructions) 9.00 Subtotal (see instructions) 9.00 Total PPS Payment (see instructions) 9.00 Total PPS Payment (see instructions) 9.00 Subtotal (see instructions) 9.00 Corporation (D0 NOT USE THIS LINE) 9.00 Corporation (D0 NOT USE THIS LINE) 9.00 Subtotal (see instructions) 9.00 Subtotal (see instructions) 9.00 Eductible See instructions) 9.00 Eductible See instructions			.	·	
5.01 Cap Increases for the unweighted Intern and resident FTE count for residents that were displaced by program or nospital closure, that would not be counted without a temporary cap adjustment under 42 CPE \$412, 424(d)(1)(iii)(F)(1) or (2) (see instructions)	5.00		or prior	0.00	5.00
program or hospital closure. That would not be counted wit hout a temporary cap adjustment under 42 CFR \$412.44(d)(1)(ii)(ii)(f)(1) or (2) (see instructions) New Teaching program adjustment. (see instructions) 8.00 Current year's unweighted FTR count for IRR excluding FTEs in the new program growth period of a "new teaching program" (see instructions) 10.00 Intern year's unweighted IRR FTE count for residents within the new program growth period of a "new teaching program" (see instructions) 10.00 Intern and resident count for IRR PPS medical education adjustment (see instructions) 10.00 Average Dail Iy Census (see instructions) 10.00 Average Dail Iy Census (see instructions) 10.00 Teaching Adjustment Factor (see instructions) 10.00 Teaching Adjustment factor (see instructions) 10.00 Teaching Adjustment (see instructions) 10.00	E 01		acad by	0.00	E 01
\$412, 424(d) (1) (II) (F) (1) or (2) (see Instructions) 0.00 6.00	5.01				5.01
0.00 New Teaching program adjustment. (see Instructions) 0.00 0.			JC1 42 011		
2.00 Current year's unweighted FTE count of IAR excluding FTES in the new program growth period of a "new teaching program" (see instructions) 0.00 0.00	6. 00			0.00	6. 00
teaching program" (see instructions) 10.00			fa"new		
teaching program" (see instructions) 0.00 9.00					
9.00	8.00	Current year's unweighted I&R FTE count for residents within the new program growth period or	fa "new	0. 00	8. 00
10.00 Average Dail y Census (see instructions) 10.928767 10.00		teaching program" (see instructions)			
11.00	9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)		0. 00	9. 00
12.00 Teaching Adjustment (see instructions) 0 12.00 13.00 Total PPS Payment (see instructions) 4.292.141 13.00 14.00 Nursing and Allied Heal th Managed Care payments (see instruction) 15.00 16.00 15.00 15.00 16.00 15.00 15.00 16.00 15.00 16.00					
13. 00 Total PPS Payment (see instructions)					
14. 00					
15. 00					
16.00				0	
17.00 Subtotal (ise instructions) 4, 292, 414 17.00 18.00				_	
18. 00 Primary payer payments					
19. 00					
20.00 Deductibles					
21.00 Subtotal (line 19 minus line 20)					
22.00					
23. 00 Subtotal (line 21 minus line 22) 4, 265, 214 23. 00 24. 00 24. 00 24. 00 24. 00 24. 00 25. 00 26. 00					
24. 00 All owable Dad debts (exclude bad debts for professional services) (see instructions) 0 24. 00					
25.00 Adjusted reimbursable bad debts (see instructions) 0 25.00					
26. 00 Allowable bad debts for dual eligible beneficiaries (see instructions) 27. 00 Subtotal (sum of lines 23 and 25) 28. 00 Direct graduate medical education payments (from Wkst. E-4, line 49) 29. 00 Other pass through costs (see instructions) 20. 00 Outlier payments reconciliation 30. 00 Outlier payments reconciliation 31. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 31. 50 Pioneer ACO demonstration payment adjustment (see instructions) 31. 98 Recovery of accelerated depreciation. 31. 99 Demonstration payment adjustment amount before sequestration 31. 99 Demonstration payment adjustment (see instructions) 32. 00 Total amount payable to the provider (see instructions) 32. 01 Sequestration adjustment (see instructions) 32. 02 Demonstration payment adjustment amount after sequestration 33. 00 Interim payments 4, 265, 214 27. 00 30. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 90 32. 01 32. 02 33. 00 34. 00 35. 00 36. 00 70 Interim payments 4, 092, 558 37. 30 38. 30 39. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 31. 00 31. 50 31. 90 32. 01 33. 02 34. 00 35. 00 36. 00 37. 00 38. 30 38. 30 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 31. 00 31. 50 31. 90 32. 01 33. 02 34. 00 35. 00 36. 00 37. 00 38. 30 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 30. 00					
27.00 Subtotal (sum of lines 23 and 25) 4, 265, 214 27. 00 28.00 Direct graduate medical education payments (from Wkst. E-4, line 49) 0 28. 00 29.00 Other pass through costs (see instructions) 22 29. 00 30.00 Outlier payments reconciliation 0 30. 00 31.00 31. 50 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 31. 00 31. 99 Pioneer ACO demonstration payment adjustment (see instructions) 0 31. 50 31. 99 Demonstration payment adjustment amount before sequestration 0 31. 99 32. 00 Sequestration adjustment (see instructions) 4, 265, 236 32. 01 32. 01 Sequestration adjustment (see instructions) 85, 305 32. 01 32. 02 Demonstration payment adjustment amount after sequestration 0 32. 02 33. 00 Interim payments 4, 265, 236 32. 01 34. 00 Tentative settlement (for contractor use only) 0 34. 00 35. 00 Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34) 87, 373 35. 00 50. 00 Original outlier amount from Wkst. E-3, Pt. III, line 4 594, 561 50. 00 50. 00 The rate used to calc					
28.00 Direct graduate medical education payments (from Wkst. E-4, line 49) 29.00 Other pass through costs (see instructions) 30.00 Outlier payments reconciliation 31.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 31.50 Pi oneer ACO demonstration payment adjustment (see instructions) 31.98 Recovery of accelerated depreciation. 31.99 Demonstration payment adjustment amount before sequestration 32.00 Total amount payable to the provider (see instructions) 32.01 Sequestration adjustment (see instructions) 32.02 Demonstration payment adjustment amount after sequestration 33.00 Interim payments 4, 092, 558 33.00 34.00 Sequestration adjustment (for contractor use only) 35.00 Bal ance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34) 36.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115. 2 50.00 Other and the provider of Money 50.00 The rate used to calculate the Time Value of Money 51.00 Outlier reconciliation adjustment amount (see instructions) FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING ON OR BEFORE MAY 11, 2023 (THE END OF THE COVID-19 PHE) 79.00 Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020.		, , ,			
29. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 01 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 31. 00 31. 00 31. 50 31. 90 Pi oneer ACO demonstration payment adjustment (see instructions) 31. 90 Bemonstration payment adjustment amount before sequestration 32. 00 32. 01 32. 01 32. 02 32. 01 32. 02 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30					
30.00 Outlier payments reconciliation 0 30.00 31.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 31.00 31.50 Sincer ACO demonstration payment adjustment (see instructions) 0 31.50 31.99 Recovery of accelerated depreciation. 0 31.59 31.99 Demonstration payment adjustment amount before sequestration 0 31.99 32.01 Sequestration adjustment (see instructions) 4,265,236 32.01 Sequestration adjustment (see instructions) 85,305 32.02 Demonstration payment adjustment amount after sequestration 0 32.01 32.02 Demonstration payment adjustment amount after sequestration 0 32.01 33.00 Interim payments 4,092,558 34.00 Tentative settlement (for contractor use only) 0 34.00 35.00 Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34) 87,373 35.00 To BE COMPLETED BY CONTRACTOR 50.00 50.00 Original outlier amount from Wkst. E-3, Pt. III, line 4 594,561 50.00 Outlier reconciliation adjustment amount (see instructions) 0 51.00 51.00 Other are used to calculate the Time Value of Money 0.00 52.00 The rate used to calculate the Time Value of Money 0.00 52.00 To REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING ON OR BEFORE MAY 11, 2023 (THE END OF THE COVID-19 PHE) 59.00 Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020. 0.000000 59.00 Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020. 0.000000 59.00 Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020. 0.000000					
31. 00 31. 50 31. 90 31. 50 31. 98 Recovery of accel erated depreciation. 31. 99 32. 00 33. 99 32. 00 33. 00 34. 00 35. 20 36. 00 36. 00 37. 20 38. 00 39. 00 30. 0		,			
31. 50 31. 98 31. 99 31. 99 32. 00 32. 01 32. 02 33. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 38. 00 39. 00 30					
31. 99 32.00 32.01 32.02 32.02 32.02 32.03 32.02 32.03 32.00 32.01 32.02 32.02 32.03 32.02 32.02 32.03 32.02 32.02 32.02 32.03 32.02	31. 50			0	
31.99 Demonstration payment adjustment amount before sequestration Total amount payable to the provider (see instructions) 32.00 Sequestration adjustment (see instructions) 32.01 Demonstration payment adjustment (see instructions) 32.02 Demonstration payment adjustment amount after sequestration 33.00 Interim payments 4, 092, 558 33.00 34.00 Tentative settlement (for contractor use only) 35.00 Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34) Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$115.2 0 TO BE COMPLETED BY CONTRACTOR 50.00 Original outlier amount from Wkst. E-3, Pt. III, line 4 0 utlier reconciliation adjustment amount (see instructions) 1 The rate used to calculate the Time Value of Money 1 Outlier of Money (see instructions) 1 Time Value of Money (see instructions) 2 Original Outlier PEPRIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING ON OR BEFORE MAY 11, 2023 (THE END OF THE COVID-19 PHE) 99.00 Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020. 0 0.000000 99.00	31. 98	,		0	31. 98
32.01 Sequestration adjustment (see instructions) 32.02 Demonstration payment adjustment amount after sequestration 32.03 Interim payments 33.00 Interim payments 34.00 Tentative settlement (for contractor use only) 35.00 Bal ance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34) 36.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2 0 36.00 TO BE COMPLETED BY CONTRACTOR 50.00 Original outlier amount from Wkst. E-3, Pt. III, line 4 50.00 Outlier reconciliation adjustment amount (see instructions) 50.00 The rate used to calculate the Time Value of Money 50.00 Time Value of Money (see instructions) 50.00 FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING ON OR BEFORE MAY 11, 2023 (THE END OF THE COVID-19 PHE) 99.00 Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020. 50.00 O.000000 99.00	31. 99			0	31. 99
32.02 33.00 Interim payments Interim payments 34.00 Secondary Interim payments 35.00 Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34) Belance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34) Belance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34) Belance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34) Belance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34) Belance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34) Belance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34) Belance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34) Belance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34) Belance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34) Belance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34) Belance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34) Belance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34) Belance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34) Belance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34) Belance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34) Belance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34) Belance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34) Belance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34) Belance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34) Belance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34) Belance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34) Belance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34) Belance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34) Belance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34) Belance due provider/program (line 32 minus lines 32.01, 32.0	32.00	Total amount payable to the provider (see instructions)		4, 265, 236	32.00
33.00 Interim payments Tentative settlement (for contractor use only) 35.00 Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34) Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2 TO BE COMPLETED BY CONTRACTOR Original outlier amount from Wkst. E-3, Pt. III, line 4 Outlier reconciliation adjustment amount (see instructions) Time Value of Money (see instructions) FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING ON OR BEFORE MAY 11, 2023 (THE END OF THE COVID-19 PHE) 99.00 Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020. 0 34.00 4, 092, 558 33.00 4, 092, 558 33.00 57.00 58.00 67.00	32. 01	Sequestration adjustment (see instructions)		85, 305	32. 01
34.00 35.00 Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34) 87, 373 35.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2 0 36.00 TO BE COMPLETED BY CONTRACTOR Original outlier amount from Wkst. E-3, Pt. III, line 4 0 utlier reconciliation adjustment amount (see instructions) The rate used to calculate the Time Value of Money Time Value of Money (see instructions) FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING ON OR BEFORE MAY 11, 2023 (THE END OF THE COVID-19 PHE) 99.00 Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020. 0 34.00 34.00 34.00 34.00 34.00 34.00 34.00 34.00 34.00 36.00 70 70 70 70 70 70 70 70 70 70 70 70 7	32. 02	Demonstration payment adjustment amount after sequestration		0	32. 02
35.00 Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34) 87, 373 35.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2 0 36.00 TO BE COMPLETED BY CONTRACTOR 50.00 Original outlier amount from Wkst. E-3, Pt. III, line 4 594, 561 50.00 Outlier reconciliation adjustment amount (see instructions) 0 51.00 The rate used to calculate the Time Value of Money 0.00 52.00 Time Value of Money (see instructions) 0 53.00 FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING ON OR BEFORE MAY 11, 2023 (THE END OF THE COVID-19 PHE) 99.00 Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020. 0.000000 99.00	33.00	Interim payments		4, 092, 558	33.00
36.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2 0 TO BE COMPLETED BY CONTRACTOR 50.00 Original outlier amount from Wkst. E-3, Pt. III, line 4 Outlier reconciliation adjustment amount (see instructions) The rate used to calculate the Time Value of Money Time Value of Money (see instructions) FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING ON OR BEFORE MAY 11, 2023 (THE END OF THE COVID-19 PHE) 99.00 Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020. 0 36.00 3	34.00	Tentative settlement (for contractor use only)		0	34.00
TO BE COMPLETED BY CONTRACTOR 50.00 Original outlier amount from Wkst. E-3, Pt. III, line 4 594, 561 50.00 51.00 Outlier reconciliation adjustment amount (see instructions) 0 51.00 The rate used to calculate the Time Value of Money 0.00 52.00 Time Value of Money (see instructions) 0 53.00 FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING ON OR BEFORE MAY 11, 2023 (THE END OF THE COVID-19 PHE) 99.00 Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020. 0.000000 99.00					
50.00 Original outlier amount from Wkst. E-3, Pt. III, line 4 50.00 Outlier reconciliation adjustment amount (see instructions) 51.00 The rate used to calculate the Time Value of Money 52.00 Time Value of Money (see instructions) FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING ON OR BEFORE MAY 11, 2023 (THE END OF THE COVID-19 PHE) 99.00 Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020. 0.000000 99.00	36. 00		1, §115. 2	0	36. 00
51.00 Outlier reconciliation adjustment amount (see instructions) The rate used to calculate the Time Value of Money Time Value of Money (see instructions) FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING ON OR BEFORE MAY 11, 2023 (THE END OF THE COVID-19 PHE) 99.00 Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020. 0.000000 99.00					
52.00 53.00 The rate used to calculate the Time Value of Money Time Value of Money (see instructions) FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING ON OR BEFORE MAY 11, 2023 (THE END OF THE COVID-19 PHE) 99.00 Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020. 0.000000 0.99.00					
53.00 Time Value of Money (see instructions) 0 53.00 FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING ON OR BEFORE MAY 11, 2023 (THE END OF THE COVID-19 PHE) 99.00 Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020. 0.000000 99.00		,			
FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING ON OR BEFORE MAY 11, 2023 (THE END OF THE COVID-19 PHE) 99.00 Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020. 0.000000 99.00					
THE COVID-19 PHE) 99.00 Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020. 0.000000 99.00	53.00		2022 (TUE		53.00
99.00 Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020. 0.000000 99.00			2023 (THE	END OF	
	00 00		2020	0.000000	00 00
77. or particulated reaching haj detinient ractor for the current year. (See Histractions)			2020.		
	77.01	pear out a teat in the factor for the current year. (See That detroits)	ı	0.000000	77.01

Health Financial Systems	FRANCISCAN HEALTH CROWN POINT	Γ	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der (CCN: 15-0126	Peri od: From 01/01/2023 To 12/31/2023	Worksheet E-3 Part VII Date/Time Prepared: 5/30/2024 10:06 am
	Ti t	tle XLX	Hospi tal	Cost

				5/30/2024 10:	06 am
		Title XIX	Hospi tal	Cost	
			I npati ent	Outpati ent	
			1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVI	ICES FOR TITLES V OR XIX	SERVI CES		
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services		8, 025, 886		1. 00
2.00	Medical and other services			14, 856, 281	2. 00
3.00	Organ acquisition (certified transplant programs only)		o		3. 00
4.00	Subtotal (sum of lines 1, 2 and 3)		8, 025, 886	14, 856, 281	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)		8, 025, 886	14, 856, 281	7. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonabl e Charges				
8.00	Routi ne servi ce charges		0		8. 00
9.00	Ancillary service charges		40, 294, 591	104, 110, 562	9. 00
10.00	Organ acquisition charges, net of revenue		0		10.00
11. 00	Incentive from target amount computation		o		11. 00
12.00	Total reasonable charges (sum of lines 8 through 11)		40, 294, 591	104, 110, 562	12. 00
	CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for	services on a charge basi	s 0	0	13. 00
14.00	Amounts that would have been realized from patients liable for i			0	14.00
	charge basis had such payment been made in accordance with 42 Cl	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)		40, 294, 591	104, 110, 562	16. 00
17.00	Excess of customary charges over reasonable cost (complete only	if line 16 exceeds line	32, 268, 705	89, 254, 281	17. 00
	4) (see instructions)				
18.00	Excess of reasonable cost over customary charges (complete only	if line 4 exceeds line	0	0	18. 00
	16) (see instructions)				
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instruc	ctions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16))	8, 025, 886	14, 856, 281	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be co	ompleted for PPS provider	S.		
22. 00	Other than outlier payments		0	0	22. 00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25. 00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27. 00	Subtotal (sum of lines 22 through 26)		0	0	27. 00
28. 00	Customary charges (title V or XIX PPS covered services only)		0	0	28. 00
29.00	Titles V or XIX (sum of lines 21 and 27)		8, 025, 886	14, 856, 281	29. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		8, 025, 886	14, 856, 281	31.00
32.00	Deducti bl es		0	0	32.00
33.00	Coinsurance		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 3	33)	8, 025, 886	14, 856, 281	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38.00	Subtotal (line 36 ± line 37)		8, 025, 886	14, 856, 281	38. 00
39.00	Direct graduate medical education payments (from Wkst. E-4)		O		39. 00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		8, 025, 886	14, 856, 281	40. 00
41.00	Interim payments		8, 025, 886	14, 856, 281	41.00
42.00	Balance due provider/program (line 40 minus line 41)		o	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance	e with CMS Pub 15-2,	О	0	43.00
	chapter 1, §115.2				
		"			

Health Financial Systems	FRANCISCAN HEALTH CROWN POINT	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0126	Peri od: From 01/01/2023	Worksheet E-3 Part VII
	Component CCN: 15-T126	To 12/31/2023	Date/Time Prepared: 5/30/2024 10:06 am
	Title XIX	Subprovi der -	TEFRA

		II tie xix	I RF	IEFRA	
			Inpatient	Outpati ent	
			1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICE	ES FOR TITLES V OR XIX			
	COMPUTATION OF NET COST OF COVERED SERVICES				Ī
1. 00	Inpatient hospital/SNF/NF services		10		1.00
2. 00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant programs only)		0		3.00
4. 00	Subtotal (sum of lines 1, 2 and 3)		10	0	4.00
5. 00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7. 00	Subtotal (line 4 less sum of lines 5 and 6)		10	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonabl e Charges				
8. 00	Routine service charges		0		8. 00
9.00	Ancillary service charges		1, 848	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11. 00	Incentive from target amount computation		0		11.00
12. 00	Total reasonable charges (sum of lines 8 through 11)		1, 848	0	12.00
	CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for se			0	
14. 00	Amounts that would have been realized from patients liable for pa		a 0	0	14.00
15 00	charge basis had such payment been made in accordance with 42 CFR	§413. 13(e)	0.000000	0.000000	15 00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0. 000000	0. 000000	
16.00	Total customary charges (see instructions)	fline 1/ avecede line	1, 848	0	
17. 00	Excess of customary charges over reasonable cost (complete only i	Time 16 exceeds line	1, 838	Ü	17. 00
18. 00	4) (see instructions) Excess of reasonable cost over customary charges (complete only i	fling 4 avende ling	0	0	18.00
16.00	16) (see instructions)	Title 4 exceeds fille	o o	U	10.00
19. 00	Interns and Residents (see instructions)		o	0	19. 00
20. 00	Cost of physicians' services in a teaching hospital (see instruct	i ons)	0	0	
21. 00	Cost of covered services (enter the lesser of line 4 or line 16)	. 61.6)	10	0	
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be com	pleted for PPS provide			1
22. 00	Other than outlier payments		0	0	22.00
	Outlier payments		0	0	
24.00	Program capital payments		0		24.00
25. 00	Capital exception payments (see instructions)		0		25. 00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27. 00
28. 00	Customary charges (title V or XIX PPS covered services only)		0	0	28. 00
29. 00	Titles V or XIX (sum of lines 21 and 27)		10	0	29. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				1
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)		10	0	
32. 00	Deducti bl es		0	0	
33.00	Coinsurance		0	0	
34.00	Allowable bad debts (see instructions)		0	0	
	Utilization review		0		35.00
	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	10	0	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	
	Subtotal (line 36 ± line 37) Direct graduate medical education payments (from Wkst E 4)		10	Ü	39.00
40.00	Direct graduate medical education payments (from Wkst. E-4) Total amount payable to the provider (sum of lines 38 and 39)		- 1	0	
	, , , , , , , , , , , , , , , , , , , ,		10	0	
41. 00 42. 00	Interim payments Balance due provider/program (line 40 minus line 41)		10	0	
42.00	Protested amounts (nonallowable cost report items) in accordance	with CMS Dub 15 2		0	
7J. UU	chapter 1, §115.2	WI CII CIVIS I UD 10-2,	١	U	43.00
	Silap to: 1, 3110.2		ı		1

	Financial Systems FRANCISCAN HEALTH (eu of Form CMS-2	2552-10
	GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT	Provi der CC	CN: 15-0126	Peri od: From 01/01/2023	Worksheet E-4	
WLDI CA	LE EDUCATION COSTS			To 12/31/2023		
		Title	XVIII	Hospi tal	5/30/2024 10: PPS	uo alli
	COMPUTATION OF TOTAL DIRECT GME AMOUNT				1. 00	
1.00	Unweighted resident FTE count for allopathic and osteopathic p	programs for	cost reporti	ng periods endir	g 0.00	1. 00
1 01	on or before December 31, 1996.	>			0.00	1 01
1. 01 2. 00	FTE cap adjustment under §131 of the CAA 2021 (see instruction Unweighted FTE resident cap add-on for new programs per 42 CFF	•	1) (see instr	ructions)	0. 00 0. 00	1. 01 2. 00
2. 26	Rural track program FTE cap limitation adjustment after the ca				l	2. 26
3. 00	CAA 2021 (see instructions) Amount of reduction to Direct GME cap under section 422 of MMA				0.44	3. 00
3. 00	Direct GME cap reduction amount under ACA §5503 in accordance		§413.79 (m).	(see instruction	l e	
2 02	for cost reporting periods straddling 7/1/2011)	ETE :: +	-+:(-)		0.00	2 02
3. 02	Adjustment (increase or decrease) to the hospital's rural track programs with a rural track Medicare GME affiliation agreement				0.00	3. 02
	49075 (August 10, 2022) (see instructions)			• •		
4. 00	Adjustment (plus or minus) to the FTE cap for allopathic and capfiliation agreement (42 CFR §413.75(b) and § 413.79 (f))	osteopathi c	programs due	to a Medicare GN	IE 2.00	4. 00
4. 01	ACA Section 5503 increase to the Direct GME FTE Cap (see instr	ructions for	cost reporti	ng periods	0.00	4. 01
4 00	straddling 7/1/2011)					4 00
4. 02	ACA Section 5506 number of additional direct GME FTE cap slots periods straddling 7/1/2011)	s (see inst	ructions for	cost reporting	0.00	4. 02
4. 21	The amount of increase if the hospital was awarded FTE cap slo	ots under §1	26 of the CAA	2021 (see	0.00	4. 21
5. 00	instructions) FTE adjusted cap (line 1 plus and 1.01, plus line 2, plus line	s 2 26 thro	uah 2 40 mir	nue linge 3 and	1. 56	5. 00
5.00	3.01, plus or minus line 3.02, plus or minus line 4, plus line		9	ius i i iles 3 ailu	1.50	3.00
6.00	Unweighted resident FTE count for allopathic and osteopathic p	programs for	the current	year from your	1.50	6. 00
7. 00	records (see instructions) Enter the lesser of line 5 or line 6				1.50	7. 00
7.00	Effect the resser of time 5 of time 6		Primary Care	e Other	Total	7.00
0.00	lw : 1 + 1 FTE		1.00	2. 00	3.00	0.00
8. 00	Weighted FTE count for physicians in an allopathic and osteopa for the current year.	itnic progra	m O.(1. 50	1. 50	8. 00
9.00	If line 6 is less than 5 enter the amount from line 8, otherwi		y 0.0	1. 50	1.50	9. 00
	lline 8 times the result of line 5 divided by the amount on lir cost reporting periods beginning on or after October 1, 2022,					
	Worksheet S-2, Part I, line 68, is "Y", see instructions.	01 11				
10.00	Weighted dental and podiatric resident FTE count for the curre			0.00	l	10.00
10. 01 11. 00	Unweighted dental and podiatric resident FTE count for the cur Total weighted FTE count	rent year	0.0	0. 00 0. 1. 50	l	10. 01 11. 00
12. 00	Total weighted resident FTE count for the prior cost reporting	year (see	0. (l e	12. 00
12.00	instructions)			0.00		12.00
13. 00	Total weighted resident FTE count for the penultimate cost rep (see instructions)	orting year	0. (0. 98		13. 00
14. 00	Rolling average FTE count (sum of lines 11 through 13 divided	by 3).	0.0		l .	14. 00
15. 00 15. 01	Adjustment for residents in initial years of new programs Unweighted adjustment for residents in initial years of new pr	roarome	0. (0. (l	15. 00 15. 01
	Adjustment for residents displaced by program or hospital clos		0.0		l	16.00
	Unweighted adjustment for residents displaced by program or ho		0. 0		l	16. 01
17. 00	closure Adjusted rolling average FTE count		0. (00 1. 24		17. 00
18. 00	Per resident amount		0.0		l	18. 00
18. 01	1		103, 623. 3			18. 01
19.00	Approved amount for resident costs			0 134, 806	134, 806	19. 00
					1. 00	
20.00	Additional unweighted allopathic and osteopathic direct GME FT	E resident	cap slots red	ceived under 42	0.00	20. 00
21. 00	Sec. 413.79(c)(4) Direct GME FTE unweighted resident count over cap (see instruc	ctions)			0.00	21. 00
22. 00	Allowable additional direct GME FTE Resident Count (see instru				i e	22. 00
23. 00	Enter the locality adjustment national average per resident am	nount (see i	nstructions)		i e	23. 00
	Multiply line 22 time line 23 Total direct GME amount (sum of lines 19 and 24)				0 134, 806	
20.00	1. Stat. al. 1901 Sime amount (Sam of Titles 17 and 24)				1 154, 000	20.00

	FRANCISCAN HEALTH GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT	Provi der Co	CN: 15-0126	Peri od:	Worksheet E-4	
MEDI CA	L EDUCATION COSTS			From 01/01/2023 To 12/31/2023	Date/Time Pre	narod:
				10 12/31/2023	5/30/2024 10:0	
			XVIII	Hospi tal	PPS	
				rt Managed Care	Total	
			1. 00	2. 00	3. 00	
	COMPUTATION OF PROGRAM PATIENT LOAD		1.00	2.00	0.00	
26. 00	Inpatient Days (see instructions) (Title XIX - see S-2 Part I)	K, line 3.02	, 15, 74	9, 249		26. 00
	column 2)					
27. 00	Total Inpatient Days (see instructions)		43, 55			27. 00
28. 00	Ratio of inpatient days to total inpatient days		0. 3615			28. 00
29. 00	Program direct GME amount		48, 74		77, 364	
	Percent reduction for MA DGME			3. 27		29. 01
30. 00	Reduction for direct GME payments for Medicare Advantage			936	936	
31. 00	Net Program direct GME amount				76, 428	31.00
					1. 00	
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE	XVIII ONLY	(NURSING PRO	GRAM AND PARAMET		
	EDUCATION COSTS)		(11011011101110	7010 1111 71110 17110 111122		
32. 00	Renal dialysis direct medical education costs (from Wkst. B, F	Pt. I, sum o	f col. 20 and	d 23, lines 74 ar	nd 0	32. 00
	94)					
33. 00	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I			74 and 94)	1, 272, 481	
34.00	Ratio of direct medical education costs to total charges (line	e 32 ÷ line	33)		0. 000000	
35. 00	Medicare outpatient ESRD charges (see instructions)		=>		0	
36. 00	Medicare outpatient ESRD direct medical education costs (line		5)		0	36. 00
	APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII Part A Reasonable Cost	UNLY				ļ
37. 00	Reasonable cost (see instructions)				54, 171, 522	37. 00
38. 00	Organ acquisition and HSCT acquisition costs (see instructions	z)			0 0	38.00
39. 00	Cost of physicians' services in a teaching hospital (see insti				0	39.00
40. 00	Primary payer payments (see instructions)	401.01.07			23, 217	
41. 00	Total Part A reasonable cost (sum of lines 37 through 39 minus	s line 40)			54, 148, 305	
	Part B Reasonable Cost	,				ĺ
42.00	Reasonable cost (see instructions)				22, 200, 745	42.00
43.00	Primary payer payments (see instructions)				9, 090	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)				22, 191, 655	
45.00	Total reasonable cost (sum of lines 41 and 44)				76, 339, 960	
46.00	Ratio of Part A reasonable cost to total reasonable cost (line				0. 709305	
47. 00	Ratio of Part B reasonable cost to total reasonable cost (line		45)		0. 290695	47. 00
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART	RT B			-,	
	Total program GME payment (line 31)	(! !	-+!>		76, 428	
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only)				54, 211 22, 217	
SU. UU	Part B Medicare GME payment (line 47 x 48) (title XVIII only)	(see instru	CTLOUS)		22.21/	1 20 00

Heal th	Financial Systems FRANCISCAN HE	ALTH CROWN POINT	In Lie	u of Form CMS-2	2552-10
				Worksheet E-5	
			From 01/01/2023 To 12/31/2023	Date/Time Prep 5/30/2024 10:0	
		Title XVIII		PPS	
	<u> </u>				
				1. 00	
	TO BE COMPLETED BY CONTRACTOR				
1.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or	sum of 2.03 plus 2.04 (see i	nstructions)	0	1.00
2.00	Capital outlier from Wkst. L, Pt. I, line 2			0	2.00
3.00	Operating outlier reconciliation adjustment amount (see i	nstructions)		0	3.00
4.00	Capital outlier reconciliation adjustment amount (see ins	structions)		o	4.00
5.00	The rate used to calculate the time value of money (see i	nstructions)		0.00	5.00
6.00 Time value of money for operating expenses (see instructions)				o	6.00
7.00	Time value of money for capital related expenses (see ins	structions)		ol	7.00

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

Provider CCN: 15-0126

| Period: | Worksheet G | From 01/01/2023 | To 12/31/2023 | Date/Time Prepared: 5/30/2024 10:06 am

			'		5/30/2024 10:	06 am
		General Fund	Speci fi c	Endowment Fund	Plant Fund	
			Purpose Fund			
		1. 00	2.00	3. 00	4. 00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	-164, 187, 356	0	0	0	1. 00
2.00	Temporary investments	0	0	0	0	2. 00
3.00	Notes receivable	0	0	0	0	3. 00
4.00	Accounts receivable	49, 069, 592	0	0	0	4.00
5.00	Other recei vable	0	0	0	0	5. 00
6.00	Allowances for uncollectible notes and accounts receivable	-10, 034, 630	0	0	0	6. 00
7.00	Inventory	4, 356, 442	0	0	0	7. 00
8.00	Prepai d expenses	1, 595, 765	0	0	0	8. 00
9.00	Other current assets	1, 575, 872	0	0	0	9. 00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	-117, 624, 315	0	0	0	11. 00
	FIXED ASSETS					
12.00	Land	13, 758, 812	0	0	0	12.00
13.00	Land improvements	15, 969, 806	0	0	0	13. 00
14.00	Accumulated depreciation	-6, 056, 592	0	0	0	14.00
15. 00	Bui I di ngs	496, 645, 295	0	0	0	15. 00
16. 00	Accumulated depreciation	-188, 354, 072	0	0	0	16. 00
17. 00	Leasehold improvements	796, 915		0	0	17. 00
18. 00	Accumulated depreciation	-302, 232		0	0	18. 00
19. 00	Fi xed equipment	86, 216, 892	1	0	0	19. 00
20.00	Accumulated depreciation	-32, 697, 990	0	0	0	20. 00
21. 00	Automobiles and trucks	0	0	0	0	21. 00
22. 00	Accumulated depreciation	0	0	0	0	22. 00
23. 00	Major movable equipment	82, 142, 103	1	0	0	23. 00
24. 00	Accumul ated depreciation	-31, 152, 615	0	0	0	24. 00
25. 00	Mi nor equi pment depreci able	0	0	0	0	25. 00
26. 00	Accumulated depreciation	0	0	0	0	26. 00
27. 00	HIT designated Assets	0	0	0	0	27. 00
28. 00	Accumulated depreciation	0	0	0	0	28. 00
29. 00	Mi nor equi pment-nondepreci abl e	0	0	0	0	29. 00
30. 00	Total fixed assets (sum of lines 12-29)	436, 966, 322	0	0	0	30. 00
	OTHER ASSETS		1			
31. 00	Investments	0		0	0	31. 00
32. 00	Deposits on Leases	0	0	0	0	32. 00
33. 00	Due from owners/officers	0	0	0	0	33. 00
34. 00	Other assets	40, 496, 091	1	0	0	34. 00
35. 00	Total other assets (sum of lines 31-34)	40, 496, 091	1	0	0	35. 00
36. 00	Total assets (sum of lines 11, 30, and 35)	359, 838, 098	0	0	0	36. 00
07.00	CURRENT LIABILITIES	40.0/4.055		ام		07.00
37. 00	Accounts payable	19, 364, 255	1		0	
38. 00	Salaries, wages, and fees payable	1, 972, 343	1	0	0	38. 00
39. 00	Payroll taxes payable	7, 618, 706	1	0	0	39. 00
40.00	Notes and Loans payable (short term)	851, 165		0	0	40.00
41. 00	Deferred income	0	0	U	0	41.00
42. 00 43. 00	Accel erated payments Due to other funds	-24, 860, 977	0	0	0	42. 00 43. 00
	Other current liabilities	1, 020, 073	1	0	0	
						45. 00
45. 00	Total current liabilities (sum of lines 37 thru 44) LONG TERM LIABILITIES	5, 965, 565	0	0	0	45.00
46. 00	Mortgage payable	1, 738, 052	0	0	0	46. 00
47. 00	Notes payable	813, 142	1	0	0	47. 00
48. 00	Unsecured Loans	922, 474	1	0	0	48. 00
49. 00	Other long term liabilities	12, 011, 667	1	0	0	49. 00
50.00	Total long term liabilities (sum of lines 46 thru 49)	15, 485, 335	1	0	0	50.00
51. 00	Total liabilities (sum of lines 45 and 50)	21, 450, 900	1		0	
31.00	CAPITAL ACCOUNTS	21, 430, 700	<u> </u>	O _I	0	31.00
52. 00	General fund balance	338, 387, 198				52. 00
53. 00	Specific purpose fund	000,007,170	l o			53. 00
54. 00	Donor created - endowment fund balance - restricted		Ĭ	0		54. 00
55. 00	Donor created - endowment fund balance - unrestricted			0		55. 00
56. 00	Governing body created - endowment fund balance			n		56.00
57. 00	Plant fund balance - invested in plant			Ĭ	0	57. 00
58. 00	Plant fund balance - reserve for plant improvement,				0	58. 00
	replacement, and expansion				ŭ	
59. 00	Total fund balances (sum of lines 52 thru 58)	338, 387, 198	0	0	0	59. 00
60.00	Total liabilities and fund balances (sum of lines 51 and 59		1	0	0	60. 00
	•		•	. '		•

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES Provider CCN: 15-0126

					To 12/31/2023	Date/Time Prep 5/30/2024 10:0	
		General	Fund	Speci al	Purpose Fund	Endowment Fund	
		1.00	2. 00	3. 00	4. 00	5. 00	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) CHANGE IN FUND BALANCE Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)	8, 933, 275 0 0 0 0 0	292, 254, 051 37, 199, 872 329, 453, 923 8, 933, 275 338, 387, 198		0 0 0 0 0 0 0 0	0 0 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 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 0 0	0 338, 387, 198		0 0 0 0 0	0 0 0 0	13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00
		Endowment Fund	PI ant	Fund			
		6. 00	7. 00	8. 00			
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) CHANGE IN FUND BALANCE	0	0 0 0		0		1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00
9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)	0	0 0 0 0 0		0 0		9. 00 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 FRA STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider CCN: 15-0126

			То	12/31/2023	Date/Time Pre 5/30/2024 10:	
	Cost Center Description	Inpatient		Outpati ent	Total	
		1.00		2. 00	3. 00	
	PART I - PATIENT REVENUES	1.00		2.00	0.00	
	General Inpatient Routine Services					İ
1.00	Hospi tal	80, 000, 0	00		80, 000, 000	1.00
2.00	SUBPROVI DER - I PF				,,	2. 00
3.00	SUBPROVI DER - I RF	5, 929, 1	62		5, 929, 162	3. 00
4.00	SUBPROVI DER		_		-,,	4.00
5. 00	Swing bed - SNF		0		0	5. 00
6.00	Swing bed - NF		0		0	6. 00
7. 00	SKILLED NURSING FACILITY					7. 00
8.00	NURSING FACILITY					8. 00
9. 00	OTHER LONG TERM CARE					9. 00
10.00	Total general inpatient care services (sum of lines 1-9)	85, 929, 1	62		85, 929, 162	
	Intensive Care Type Inpatient Hospital Services	00/72//			00/ 72 7/ 102	
11. 00	INTENSIVE CARE UNIT	14, 651, 9	07		14, 651, 907	11. 00
12. 00	CORONARY CARE UNIT				,,	12.00
13. 00	BURN INTENSIVE CARE UNIT					13. 00
14. 00	SURGI CAL INTENSI VE CARE UNI T					14. 00
15. 00	NEONATAL INTENSIVE CARE UNIT	16, 912, 6	50		16, 912, 650	
16. 00	Total intensive care type inpatient hospital services (sum of lines 11-15				31, 564, 557	ı
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	117, 493, 7			117, 493, 719	1
18. 00	Ancillary services	366, 780, 7		652 252 245	1, 019, 033, 002	1
19. 00	Outpatient services	28, 608, 2		82, 445, 403	111, 053, 628	
20. 00	RURAL HEALTH CLINIC	,, -	0	0_,,	0	20.00
21. 00	FEDERALLY QUALIFIED HEALTH CENTER		0	0	0	21. 00
22. 00	HOME HEALTH AGENCY			Ŭ.	Ü	22. 00
23. 00	AMBULANCE SERVI CES					23. 00
24. 00	CMHC					24. 00
25. 00	AMBULATORY SURGICAL CENTER (D. P.)					25. 00
26. 00	HOSPI CE					26. 00
27. 00	PHYSIIANS PRIVATE OFFICES	74, 8	36	904, 027	978, 863	27. 00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst.	512, 957, 5			1, 248, 559, 212	
20.00	G-3, line 1)	0.2,707,0	·	70070017070	., 2.0, 00,, 2.2	20.00
	PART II - OPERATING EXPENSES	,				İ
29.00	Operating expenses (per Wkst. A, column 3, line 200)			306, 098, 622		29. 00
30.00	ADD (SPECIFY)		0			30.00
31.00			0			31.00
32.00			0			32. 00
33.00			0			33. 00
34.00			0			34.00
35. 00			0			35. 00
36, 00	Total additions (sum of lines 30-35)			0		36. 00
37. 00	DEDUCT (SPECIFY)		0			37. 00
38. 00		1	0			38. 00
39. 00		1	0			39. 00
40. 00		1	0			40. 00
41. 00		1	0			41. 00
42. 00	Total deductions (sum of lines 37-41)	[-	0		42. 00
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer	İ		306, 098, 622		43. 00
· · · · · ·	to Wkst. G-3, line 4)					
		•				

	Financial Systems FRANCISCAN HE ENT OF REVENUES AND EXPENSES	ALTH CROWN POINT Provider CCN: 15-0126	Peri od:	u of Form CMS-2 Worksheet G-3	
IAIEW	ENT OF REVENUES AND EXPENSES	Provider CCN. 15-0126	From 01/01/2023	WOLKSHEEL G-3	
			To 12/31/2023		
				5/30/2024 10:	06 am
	T + 1	1: 00)		1.00	4.4
. 00	Total patient revenues (from Wkst. G-2, Part I, column 3			1, 248, 559, 212	1.0
. 00	Less contractual allowances and discounts on patients' a	ccounts		914, 749, 799	
. 00	Net patient revenues (line 1 minus line 2)	1: 42)		333, 809, 413	
. 00	Less total operating expenses (from Wkst. G-2, Part II,			306, 098, 622	4.
. 00	Net income from service to patients (line 3 minus line 4 OTHER INCOME)		27, 710, 791	5.
. 00	Contributions, donations, bequests, etc		1	175, 968	6.
. 00	Income from investments			175, 900	
. 00	Revenues from telephone and other miscellaneous communic	ation corvices		0	
. 00	Revenue from television and radio service	ation services		0	
0.00	Purchase di scounts			1, 180, 791	10.
	Rebates and refunds of expenses			1, 160, 791	
	Parking Lot receipts			0	12.
	Revenue from laundry and linen service			0	13.
	Revenue from meals sold to employees and guests			671, 239	
	Revenue from rental of living quarters			0/1, 239	
	Revenue from sale of medical and surgical supplies to ot	har than nationts		0	
	Revenue from sale of drugs to other than patients	lei than patrents		0	17.
	Revenue from sale of medical records and abstracts			5	17.
				10, 098	
). 00). 00	Tuition (fees, sale of textbooks, uniforms, etc.)				
	Revenue from gifts, flowers, coffee shops, and canteen			123, 552 40, 071	20.
	Rental of vending machines Rental of hospital space			1, 160, 525	
	Governmental appropriations			(12(022	
	OTHER OPERATIN REVENUES			6, 126, 832	
	COVID-19 PHE Funding			0 400 001	24.
	Total other income (sum of lines 6-24)			9, 489, 081	25.
	Total (line 5 plus line 25)			37, 199, 872	
	OTHER EXPENSES (SPECIFY)			0	27.
	Total other expenses (sum of line 27 and subscripts)	20)		0	28. 29.
9.00	Net income (or loss) for the period (line 26 minus line	28)	ļ	37, 199, 872	4

CALCUL	ATION OF CAPITAL PAYMENT	Provider CCN: 15-0126	Peri od: From 01/01/2023 To 12/31/2023	Worksheet L Parts I-III Date/Time Pre 5/30/2024 10:	pared: 06 am
		Title XVIII	Hospi tal	PPS	
	DADT I FULLY DROCDECTIVE METHOD			1. 00	
	PART I - FULLY PROSPECTIVE METHOD				ł
	CAPITAL FEDERAL AMOUNT Capital DRG other than outlier		1	2 (45 002	1. C
I . 00 I . 01	Model 4 BPCI Capital DRG other than outlier			2, 645, 892 0	1
2. 00	Capital DRG outlier payments				2.0
2. 00	Model 4 BPCI Capital DRG outlier payments			60, 811 0	
3. 00	Total inpatient days divided by number of days in the cost re	enerting period (see ins	tructions)	108. 41	3.0
1.00	Number of interns & residents (see instructions)	eporting period (see ins	ir uc trons)	1. 05	1
5. 00	Indirect medical education percentage (see instructions)			0. 27	1
6. 00	Indirect medical education percentage (see instructions)	sum of lines 1 and 1 0	1 columns 1 and	7, 144	1
, 00	1.01) (see instructions)	Sam of Times Fana 1.0	i, corumiis rana	7, 144	0.0
7. 00	Percentage of SSI recipient patient days to Medicare Part A	oatient days (Worksheet L	nart A line 30	1. 41	7.0
	(see instructions)		1		
3. 00	Percentage of Medicaid patient days to total days (see instru	uctions)		19. 70	8.0
9. 00	Sum of lines 7 and 8	•		21. 11	9.0
10.00	Allowable disproportionate share percentage (see instructions	s)		4. 36	10. C
11. 00	Disproportionate share adjustment (see instructions)			115, 361	11. 0
12. 00	Total prospective capital payments (see instructions)			2, 829, 208	12. 0
				1. 00	
	PART II - PAYMENT UNDER REASONABLE COST			1.00	
1.00	Program inpatient routine capital cost (see instructions)			0	1.0
2. 00	Program inpatient ancillary capital cost (see instructions)			0	1
3. 00	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)			0	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS			1. 00	
. 00	Program inpatient capital costs (see instructions)			0	1. (
2. 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstance	res (see instructions)		0	1
3. 00	Net program inpatient capital costs for extraordinary circumstant (Net program inpatient capital costs (line 1 minus line 2)	ces (see mistructions)		0	
1. 00	Applicable exception percentage (see instructions)			0.00	
5. 00	Capital cost for comparison to payments (line 3 x line 4)			0.00	1
5. 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	Capital minimum payment level (line 5 plus line 7)	,		0	
9. 00	Current year capital payments (from Part I, line 12, as appli	cabl e)		0	
10.00	Current year comparison of capital minimum payment level to o		less line 9)	0	
11. 00	Carryover of accumulated capital minimum payment level over			0	
	L, Part III, line 14)	. 13			1
12 00	Not comparison of capital minimum payment level to capital no	. (11 40 1 11		0	121

12.00 Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)

13.00 Current year exception payment (if line 12 is positive, enter the amount on this line)

14.00 Carryover of accumulated capital minimum payment level over capital payment for the following period (if

line 12 is negative, enter the amount on this line)

17.00 Current year exception offset amount (see instructions)

15.00 Current year allowable operating and capital payment (see instructions)
16.00 Current year operating and capital costs (see instructions)

0 12.00

0 13.00

0 14.00

0 16.00 0 17.00

15.00