Health Financial Systems FRANCISCAN HEALTH	I NDI ANAPOLI S	In Lieu	u of Form CMS-2	552-10
This report is required by Iaw (42 USC 1395g; 42 CFR 413.20(b)). Fai	lure to report can resul	t in all interim	FORM APPROVED	
payments made since the beginning of the cost reporting period being	deemed overpayments (42	2 USC 1395g).	OMB NO. 0938-0	
	1		EXPIRES 09-30-	2025
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION	Provider CCN: 15-0162	Peri od:	Worksheet S	
AND SETTLEMENT SUMMARY		From 01/01/2023 To 12/31/2023	Parts I-III Date/Time Prep	ared
		10 12/31/2023	3/28/2024 2:21	
PART I – COST REPORT STATUS				
Provider 1. [X] Electronically prepared cost report		Date: 3/28/202	24 Time: 2:	:21 pm
use only 2. [] Manually prepared cost report				
3. [0] If this is an amended report enter the number			ost report	
4. [F] Medicare Utilization. Enter "F" for full, "L				
Contractor5. [1] Cost Report Status6. Date Received:use only(1) As Submitted7. Contractor No.		IPR Date: Contractor's Vendo	r Codo	4
use only (1) As Submitted 7. Contractor No. (2) Settled without Audit 8. [N]Initial Report for	or this Provider CCN 12 [0 llf line 5 co	lumn 1 is 4 [.] Fr	nter 4
(3) Settled with Audit 9. [N] Final Report for	this Provider CCN		es reopened = (
(4) Reopened				
(5) Amended				
PART II - CERTIFICATION BY A CHIEF FINANCIAL OFFICER OR ADMINISTRATO				
MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN T)
ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A				~
ADMINISTRATIVE ACTION. FINES AND/OR IMPRISONMENT MAY RESULT.	A KICKBACK OR WERE UTHERW	IISE ILLEGAL, URIN	INAL, CIVIL AND	J
CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF	F PROVIDER(S)			
I HEREBY CERTIFY that I have read the above certification s	tatement and that I have	examined the acco	mpanyi ng	
electronically filed or manually submitted cost report and s	submitted cost report and	d the Balance Shee	et and	
Statement of Revenue and Expenses prepared by FRANCISCAN HE				
period beginning 01/01/2023 and ending 12/31/2023 and to the				
statement are true, correct, complete and prepared from the				
applicable instructions, except as noted. I further certify				
regarding the provision of health care services, and that the	ne services identified in	n this cost report	were	
provided in compliance with such laws and regulations.				
SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR CHECH	KBOX	ELECTRONI C		

	SIGNATURE OF CHIEF FINA	NCIAL OFFICER OR ADMINISTRATOR	CHECKBOX	ELECTRONI C	
		1	2	SI GNATURE STATEMENT	
1	Ja	y Brehm	ř	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	Jay Brehm			2
3	Signatory Title	CFO			3
4	Date	(Dated when report is electronica			4

			Title	XVIII			
		Title V	Part A	Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPI TAL	0	126, 250	88, 964	0	224, 574	1.00
2.00	SUBPROVIDER - IPF	0	0	0		0	2.00
3.00	SUBPROVIDER - IRF	0	-117, 656	-9		2	3.00
5.00	SWING BED - SNF	0	0	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
200.0	DTOTAL	0	8, 594	88, 955	0	224, 576	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.

USPI	Financial Systems Financial Systems AL AND HOSPITAL HEALTH CARE COMPLEX	FRANCISCAN HEALT			N: 15-0162	Peri od:		Workshe		2552-
						From 01/01/ To 12/31/		Part I Date/Ti	me Pre	pared
	1.00	2.00		3.00			4.00	3/28/20	024 2:2	<u>1 pm</u>
	Hospital and Hospital Health Care Co			3.00			4.00			
. 00	Street: 8111 S. EMERSON AVENUE	P0 Box:								1.0
. 00	City: INDIANAPOLIS	State: IN	Zip Cod	1		ty: MARION	-			2.0
		Component Name	CCN Number	CBS Numb		- Date Certified		nt Syst 0, or		
			Number		l iybe		V I,			1
		1.00	2.00	3.0	0 4.00	5.00	6.00	7.00		
	Hospital and Hospital-Based Componer				1	1				
00	Hospi tal	FRANCI SCAN HEALTH	150162	2690	00 1	05/01/2006	N	P	P	3.0
. 00	Subprovider - IPF	I NDI ANAPULI S								4.0
00	Subprovider - IRF	REHAB UNIT	15T162	2690	00 5	01/01/2005	N	P	Р	5.
00	Subprovider - (Other)									6.
00	Swing Beds - SNF									7.
00	Swing Beds - NF									8.
00	Hospital-Based SNF Hospital-Based NF									9.
1.00	Hospi tal -Based OLTC									111.
2.00	Hospital-Based HHA									12.
3. 00	Separately Certified ASC									13.
1.00	Hospi tal -Based Hospi ce	HOSPI CE	151523	2690	00	01/01/2014				14.
5.00 5.00	Hospital-Based Health Clinic - RHC Hospital-Based Health Clinic - FQHC			-						15. 16.
. 00	Hospital-Based (CMHC) I									17.
. 00	Renal Dialysis									18.
. 00	Other									19.
						From: 1.00				-
. 00	Cost Reporting Period (mm/dd/yyyy)					01/01/2	023	12/31/		20.
	Type of Control (see instructions)					1				21.
										-
	Inpatient PPS Information				1.00	2.00		3. (00	
2.00	Does this facility qualify and is it	currently receiving pa	yments for	-	Y	N				22.
	disproportionate share hospital adju	stment, in accordance w	vith 42 CFF							
	§412.106? In column 1, enter "Y" fo									
	facility subject to 42 CFR Section § hospital?) In column 2, enter "Y" for		ienament							
2. 01	Did this hospital receive interim UC		ntal UCPs.	for	Y	Y				22.
	this cost reporting period? Enter in									
	for the portion of the cost reportin									
	1. Enter in column 2, "Y" for yes or cost reporting period occurring on c			ne						
	instructions)	alter october 1. (see	;							
2. 02	Is this a newly merged hospital that	requires a final UCP t	o be		Ν	N				22.
	determined at cost report settlement			umn						
	1, "Y" for yes or "N" for no, for th									
	period prior to October 1. Enter in for the portion of the cost reportin			no,						
2. 03	Did this hospital receive a geograph			,	Ν	N		Ν		22.
	rural as a result of the OMB standar									
	adopted by CMS in FY2015? Enter in c									
	for the portion of the cost reportin in column 2, "Y" for yes or "N" for			er						
	reporting period occurring on or aft									
	Does this hospital contain at least			is						
	counted in accordance with 42 CFR 41	2.105)? Enter in columr	n 3, "Y" fo	or						
. 04	yes or "N" for no. Did this hospital receive a geograph	ic roclassification for	m urbon +-							22.
04	rural as a result of the revised OMB									22.
	adopted by CMS in FY 2021? Enter in									
	for the portion of the cost reportin	g period prior to Octob	oer 1. Ente							
	in column 2, "Y" for yes or "N" for									
	reporting period occurring on or aft									
	Does this hospital contain at least counted in accordance with 42 CFR 41									
			0, 1 1	5						
	yes or "N" for no.									
3. 00	Which method is used to determine Me					3 N				23.
3. 00	Which method is used to determine Me below? In column 1, enter 1 if date	of admission, 2 if cens	sus days, c	or 3		3 N				23.
. 00	Which method is used to determine Me	of admission, 2 if cens of identifying the days	sus days, c s in this c	or 3		3 N				23.

	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA		Provider CC		Peri od:			eet S-2	
24.00						/01/2023 /31/2023		ime Pre 024 2:2	epared:
24.00		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medi cai d el i gi bl e unpai d		iys Me	Other di cai d days	
24.00	If this provider is an IPPS hospital, enter the	1.00 921	2.00	3.00	4.00	<u>5.00</u>	105	<u>6.00</u> 368	3 24.00
25.00	in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 1, in-state 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. If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid	0				0	342	500	25. 00
	HMO paid and eligible but unpaid days in column 5.								
						<u>/Rural S</u> . 00		f Geogr 00	-
26.00	Enter your standard geographic classification (not wa		at the beg	jinning of		2			26.00
	cost reporting period. Enter "1" for urban or "2" for Enter your standard geographic classification (not we reporting period. Enter in column 1, "1" for urban or enter the effective date of the geographic reclassifi If this is a sole community hospital (SCH), enter the	age) status ~ "2" for r cation in	ural. If ap column 2.	ppl i cabl e,		2			27.00
	effect in the cost reporting period.						- ·	1.00	
					1	nni ng: . 00		i ng: 00	
36.00	Enter applicable beginning and ending dates of SCH st of periods in excess of one and enter subsequent date		cript line	36 for numb	ber				36.00
37.00	If this is a Medicare dependent hospital (MDH), enter		r of period	ds MDH statu	ls	0			37.00
37. 01	is in effect in the cost reporting period. Is this hospital a former MDH that is eligible for thaccordance with FY 2016 OPPS final rule? Enter "Y" for						a.		37.01
38. 00	instructions) If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of enter subsequent dates.								38.00
						//N . 00		/N 00	-
39.00	Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(i) 1 "Y" for yes or "N" for no. Does the facility meet 1 accordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii or "N" for no. (see instructions)	, (ii), or the mileage	(iii)? Ent requiremen	er in colur ts in	ume nn	N		N	39.00
40.00	Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octob no in column 2, for discharges on or after October 1.	per 1. Ente	r"Y" for y			Ν	n	Y	40.00
					I	V	XVIII 2.00	-	-
	Prospective Payment System (PPS)-Capital) 2.00	3.00	
45.00 46.00	Does this facility qualify and receive Capital paymer with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exce					e N N	N N	N	45.00
47.00	pursuant to 42 CFR §412.348(f)? If yes, complete Wks1 Pt. III. Is this a new hospital under 42 CFR §412.300(b) PPS of				0	N	N	N	47.00
48.00	Is the facility electing full federal capital payment	? 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 periods beginning prior to December 27, 2020, enter " cost reporting periods beginning on or after December the instructions. For column 2, if the response to co involved in training residents in approved GME progra and are you are impacted by CR 11642 (or applicable C "Y" for yes; otherwise, enter "N" for no in column 2.	'Y' for yes 27, 2020, Dumn 1 is ams in the CRs) MA dir	or "N" for under 42 ("Y", or if prior year	r no in colu CFR 413.78(k this hospit or penultin	umn 1. For b)(2), see tal was nate year,		Y		56.00
	For cost reporting periods beginning prior to Decembe is this the first cost reporting period during which at this facility? Enter "Y" for yes or "N" for no ir residents start training in the first month of this of "N" for no in column 2. If column 2 is "Y", complete complete Wkst. D, Parts III & IV and D-2, Pt. II, if beginning on or after December 27, 2020, under 42 CFF which month(s) of the cost report the residents were for yes, enter "Y" for yes in column 1, do not comple If line 56 is yes, did this facility elect cost reimt	er 27, 2020 residents column 1. cost report e Worksheet applicable & 413.77(e on duty, i ete column	in approved If column ing period? E-4. If cc . For cost)(1)(iv) ar f the respo 2, and comp	d GME progra 1 is "Y", c 2 Enter "Y' olumn 2 is ' reporting p nd (v), rega onse to line olete Worksh	ams traine did 'for yes 'N", beriods ardless of e 56 is "Y heet E-4.	or			57.00

	Financial Systems FRANCISCAN TAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA		Provider CC	CN: 15-0162 F	Period: From 01/01/2023	u of Form CMS-: Worksheet S-2 Part I	
					o 12/31/2023		
					V	XVIII XIX 2.00 3.00	-
59.00	Are costs claimed on line 100 of Worksheet A? If yes	, compl	ete Wkst. D-2,	Pt. I.	1. OC N	2.00 3.00	59.0
				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 any programs that meet the criteria under 42 CFR 413. instructions) Enter "Y" for yes or "N" for no in col is "Y", are you impacted by CR 11642 (or subsequent C adjustment? Enter "Y" for yes or "N" for no in colum	85? (s umn 1. CR) NAHE nn 2.	ee If column 1 MA payment	Y	Y		60.0
0. 01	If line 60 is yes, complete columns 2 and 3 for each instructions)	program	. (see		23.00	1	60.0
0. 02	If line 60 is yes, complete columns 2 and 3 for each instructions)	program	. (see		23. 01	1	60.0
0. 03	If line 60 is yes, complete columns 2 and 3 for each instructions)	program	. (see		23. 02	1	60.0
0. 04	If line 60 is yes, complete columns 2 and 3 for each instructions)	program	. (see		23. 03	1	60.0
0. 05	If line 60 is yes, complete columns 2 and 3 for each instructions)	program	. (see		23. 04	1	60.0
		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
1. 00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) 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	Y			0.81	0.00	61. C
1. 02	instructions) Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of						61. (
I. 03	ACA). (see instructions) 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						61. (
1.04	instructions) Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).						61. (
1. 05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.(
1. 06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61. (
		Pro	ogram Name			Direct GME FTE Count	
1 10	Of the FTEs in line 61.05, specify each new program		1.00	2.00	3.00	4.00	61.1
	special ty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. Of the FTEs in line 61.05, specify each expanded program special ty, if any, and the number of FTE residents for each expanded program. (see				0.00		61.2
	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.						

Heal th	Financial Systems	FRANCI SCAN	I HEALTH INDIANAPOLIS		In Lie	u of Form CMS-2	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE COMP	LEX IDENTIFICATION DA	TA Provider CO		Period: From 01/01/2023 To 12/31/2023		pared:
						1.00	
	ACA Provisions Affecting the Hea	alth Resources and Ser	vices Administration	(HRSA)		1.00	
62.00	Enter the number of FTE resident your hospital received HRSA PCRE	s that your hospital	trained in this cost		riod for which	0.00	62.00
62. 01	Enter the number of FTE resident during in this cost reporting pe	s that rotated from a riod of HRSA THC prog	Teaching Health Cen ram. (see instruction		o your hospital	0.00	62. 01
63.00	Teaching Hospitals that Claim Re Has your facility trained reside "Y" for yes or "N" for no in col	ents in nonprovider se	ttings during this co			Y	63.00
				Unweighted FTEs Nonprovider Site	Unweighted FTEs in	Ratio (col. 1/ (col. 1 + col. 2))	
				1.00	2.00	3.00	
	Section 5504 of the ACA Base Yea period that begins on or after .			This base yea	r is your cost r	reporting	
64.00	Enter in column 1, if line 63 is in the base year period, the num resident FTEs attributable to ro settings. Enter in column 2 the resident FTEs that trained in yo of (column 1 divided by (column	s yes, or your facilit aber of unweighted non stations occurring in e number of unweighted pur hospital. Enter in	y trained residents -primary care all nonprovider non-primary care column 3 the ratio	0.0	0.00	0. 000000	64.00
		Program Name	Program Code	Unwei ghted	Unwei ghted	Ratio (col. 3/	
				FTEs Nonprovider Site	FTEs in Hospital	(col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
	is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)	GENERAL				Datio (col. 1)	
				Unweighted FTEs Nonprovider Site 1.00	FTEsin	Ratio (col. 1/ (col. 1 + col. 2)) 3.00	
	Section 5504 of the ACA Current		Nonprovider Setting				
66.00	beginning on or after July 1, 20 Enter in column 1 the number of FTEs attributable to rotations co Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 +	unweighted non-primar occurring in all nonpr unweighted non-primar cal. Enter in column 3	ovider settings. y care resident the ratio of	0.0	0.00	0. 000000	66.00
		Program Name	Program Code	Unweighted FTEs Nonprovider Site		Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	

	Financial Systems		N HEALTH INDIANAPOLIS			u of Form CMS-2	
HOSPI T	AL AND HOSPITAL HEALTH CARE COMP	LEX IDENTIFICATION DA	ATA Provider CO	Fi	eriod: rom 01/01/2023	Worksheet S-2 Part I	
				T	o 12/31/2023	Date/Time Pre 3/28/2024 2:2	
		Program Name	Program Code	Unweighted FTEs		Ratio (col. 3/ (col. 3 + col.	
				Nonprovi der	Hospi tal	4))	
		1.00	2.00	Si te 3. 00	4.00	5.00	
67.00	Enter in column 1, the program name associated with each of	FAMILY MEDICINE GENERAL	1350	14.14	11.85	0. 544055	67.00
	your primary care programs in	GENERAL					
	which you trained residents. Enter in column 2, the program						
	code. Enter in column 3, the number of unweighted primary						
	care FTE residents attributable						
	to rotations occurring in all non-provider settings. Enter in						
	column 4, the number of unweighted primary care						
	resident FTEs that trained in						
	your hospital. Enter in column 5, the ratio of (column 3						
	divided by (column 3 + column 4)). (see instructions)						
			J	1	1	1.00	
	Direct GME in Accordance with th	ne FY 2023 IPPS Final	Rule, 87 FR 49065-49	072 (August 10,	2022)	1.00	
	For a cost reporting period begi MAC to apply the new DGME formul						68.00
	(August 10, 2022)?				49003-49072		
					1.00	0 2.00 3.00	
	Inpatient Psychiatric Facility F Is this facility an Inpatient Ps		LPE) or does it cont	ain an IPE subr	provider? N		70.00
	Enter "Y" for yes or "N" for no).					
71.00	If line 70 is yes: Column 1: Dic recent cost report filed on or b	d the facility have a before November 15, 20	n approved GME teachi 004? Enter "Y" for ye	ng program in t es or "N" for r	he most no. (see	0	71.00
	42 CFR 412.424(d)(1)(iii)(c)) Co program in accordance with 42 CF	olumn 2: Did this fac	ility train residents	in a new teach	ni ng		
	Column 3: If column 2 is Y, indi						
	(see instructions) Inpatient Rehabilitation Facili	ty PPS					
75.00	Is this facility an Inpatient Re subprovider? Enter "Y" for yes		y (IRF), or does it co	ontain an IRF	Y		75.00
76.00	If line 75 is yes: Column 1: Dic	d the facility have a	n approved GME teachi	ng program in t	he most N	N O	76.00
	recent cost reporting period end no. Column 2: Did this facility						
	CFR 412.424 (d)(1)(iii)(D)? Ente indicate which program year bega						
		in during this cost i	opor tring por rodr (coo		I	1.00	
	Long Term Care Hospital PPS					1.00	
	Is this a long term care hospita Is this a LTCH co-located withir				period? Enter	N	80.00 81.00
01.00	"Y" for yes and "N" for no.					14	01.00
85.00	TEFRA Providers Is this a new hospital under 42	CFR Section §413.40(f)(1)(i) TEFRA? Enter	r "Y" for yes c	or "N" for no.	N	85.00
	Did this facility establish a ne §413.40(f)(1)(ii)? Enter "Y" fo			42 CFR Section	1		86.00
	Is this hospital an extended neo	oplastic disease care		under section		N	87.00
	1886(d)(1)(B)(vi)? Enter "Y" for	r yes or "N" for no.			Approved for	Number of	
					Permanent Adjustment	Approved Permanent	
					(Y/N)	Adjustments	
88.00	Column 1: Is this hospital appro	oved for a permanent	adjustment to the TFF	RA target	1.00 N	2.00	88.00
	amount per discharge? Enter "Y" 89. (see instructions)						
	Column 2: Enter the number of ap	oproved permanent adj	ustments.				

PITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CC	1	Period: From 01/01/2023 Fo 12/31/2023	Worksheet S-2 Part I Date/Time Pre 3/28/2024 2:2	epared
		Wkst. A Line No.	Effecti ve Date	Approved Permanent Adjustment Amount Per Discharge	
		1.00	2.00	3.00	
00 Column 1: If line 88, column 1 is Y, enter the Worksheet A li on which the per discharge permanent adjustment approval was Column 2: Enter the effective date (i.e., the cost reporting beginning date) for the permanent adjustment to the TEFRA tan per discharge. Column 3: Enter the amount of the approved permanent adjustment TEFRA target amount per discharge.	based. period rget amount	0.0			0 89. (
			V	XIX	-
Title V and XIX Services			1.00	2.00	
00 Does this facility have title V and/or XIX inpatient hospital	I services? Er	nter "Y" for	N	Y	90.0
yes or "N" for no in the applicable column. 00 Is this hospital reimbursed for title V and/or XIX through th			Ν	Y	91. (
full or in part? Enter "Y" for yes or "N" for no in the appli ON Are title XIX NF patients occupying title XVIII SNF beds (dua instructions) Enter "Y" for yes or "N" for no in the application	al certificati			Ν	92. (
00 Does this facility operate an ICF/IID facility for purposes of "Y" for yes or "N" for no in the applicable column.		d XIX? Enter	Ν	Ν	93.
00 Does title V or XIX reduce capital cost? Enter "Y" for yes, a applicable column.	and "N" for no	o in the	N	Ν	94.
00 $ \dot{f} $ line 94 is "Y", enter the reduction percentage in the appl 00 Does title V or XLX reduce operating cost? Enter "Y" for yes			0. 00 N	0. 00 N	95. 96.
 applicable column. OI If line 96 is "Y", enter the reduction percentage in the appl Does title V or XIX follow Medicare (title XVIII) for the instepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for 	terns and resi	dents post	0. 00 N	0. 00 Y	97. 98.
 column 1 for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for the report C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title 			N	Y	98.
 title XIX. Does title V or XIX follow Medicare (title XVIII) for the cal bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes on 			N	Y	98.
 for title V, and in column 2 for title XIX. 03 Does title V or XIX follow Medicare (title XVIII) for a critic reimbursed 101% of inpatient services cost? Enter "Y" for yes 			N	Ν	98.
for title V, and in column 2 for title XIX. 04 Does title V or XIX follow Medicare (title XVIII) for a CAH i outpatient services cost? Enter "Y" for yes or "N" for no in	reimbursed 10° column 1 for	l% of title V, and	Ν	Ν	98.
 in column 2 for title XIX. 05 Does title V or XIX follow Medicare (title XVIII) and add bac Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in co 	ck the RCE dis	sallowance on	Ν	Y	98.
<pre>column 2 for title XIX. 06 Does title V or XIX follow Medicare (title XVIII) when cost n Pts. I through IV? Enter "Y" for yes or "N" for no in column column 2 for title XIX.</pre>			Ν	Y	98.
Rural Providers					
0.00 Does this hospital qualify as a CAH?		and of normant	N		105.
b. 00 f this facility qualifies as a CAH, has it elected the all-infor outpatient services? (see instructions)		1 5			106.
7.00 Column 1: If line 105 is Y, is this facility eligible for costraining programs? Enter "Y" for yes or "N" for no in column Column 2: If column 1 is Y and line 70 or line 75 is Y, do approved medical education program in the CAH's excluded IPI Enter "Y" for yes or "N" for no in column 2. (see instruction program in the column 2. (see instruction) is the colu	1. (see inst you train I&Rs F and/or IRF u	tructions) s in an	N		107.
8. 00 Is this a rural hospital qualifying for an exception to the (CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	CRNÁ fee scheo		N		108.
	Physi cal	Occupational	Speech	Respi ratory	-
0.00 If this hospital qualifies as a CAH or a cost provider, are	1.00 N	2.00 N	3.00 N	4.00 N	100
	IN I	I N	I N	I N	109.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provide	er CCN: 15-0162	Period: From 01/01/2023 To 12/31/2023	Worksheet S-: Part I Date/Time Pro	
			3/28/2024 2::	
			1.00	-
10.00 Did this hospital participate in the Rural Community Hospital Demonstr Demonstration)for the current cost reporting period? Enter "Y" for yes complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2 applicable.	s or "N" for no.	lf yes,	N	110. 0
		1.00	2.00	-
11.00 If this facility qualifies as a CAH, did it participate in the Frontie Health Integration Project (FCHIP) demonstration for this cost reporti "Y" for yes or "N" for no in column 1. If the response to column 1 is integration prong of the FCHIP demo in which this CAH is participating Enter all that apply: "A" for Ambulance services; "B" for additional b for tele-health services.	ng period? Enter Y, enter the g in column 2.	N	2.00	111.0
	1.00	2.00	3.00	-
12.00 Did this hospital participate in the Pennsylvania Rural Health Model (PARHM) demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in t demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable. Miscellaneous Cost Reporting Information	N			112.0
15.00 Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for r in column 1. If column 1 is yes, enter the method used (A, B, or E onl in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based of the definition in CMS Pub. 15-1, chapter 22, §2208.1.	y)			0115.0
16.00 s this facility classified as a referral center? Enter "Y" for yes or "N" for no.	- Y			116. 0
17.00 s this facility legally-required to carry malpractice insurance? Ente "Y" for yes or "N" for no.	er N			117.0
18.00 s the malpractice insurance a claims-made or occurrence policy? Enter if the policy is claim-made. Enter 2 if the policy is occurrence.	- 1	2		118. 0
	Premi ums	Losses	Insurance	
	1.00	2.00	2.00	_
18.01 List amounts of malpractice premiums and paid losses:	1.00	2.00 0 207,030	3.00 1,598,16	3118.0
	I			
18.02 Are malpractice premiums and paid losses reported in a cost center oth	on then the	1.00 N	2.00	118.0
		IN		110.0
Administrative and General? If yes, submit supporting schedule listin and amounts contained therein.				
and amounts contained therein. 19.00 DO NOT USE THIS LINE 20.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless §3121 and applicable amendments? (see instructions) Enter in column 1, "N" for no. Is this a rural hospital with < 100 beds that qualifies for Hold Harmless provision in ACA §3121 and applicable amendments? (see i	provision in ACA "Y" for yes or or the Outpatient		N	
and amounts contained therein. 19.00 DO NOT USE THIS LINE 20.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless §3121 and applicable amendments? (see instructions) Enter in column 1, "N" for no. Is this a rural hospital with < 100 beds that qualifies for Hold Harmless provision in ACA §3121 and applicable amendments? (see i Enter in column 2, "Y" for yes or "N" for no. 21.00 Did this facility incur and report costs for high cost implantable dev	provision in ACA "Y" for yes or or the Outpatient nstructions)		Ν	120. (
 and amounts contained therein. 19.00 D0 NOT USE THIS LINE 20.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless \$3121 and applicable amendments? (see instructions) Enter in column 1, "N" for no. Is this a rural hospital with < 100 beds that qualifies for Hold Harmless provision in ACA \$3121 and applicable amendments? (see i Enter in column 2, "Y" for yes or "N" for no. 21.00 Did this facility incur and report costs for high cost implantable dev patients? Enter "Y" for yes or "N" for no. 22.00 Does the cost report contain heal thcare related taxes as defined in \$1 Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", et al. (and the cost of the cost	provision in ACA "Y" for yes or or the Outpatient nstructions) vices charged to	Y Y Y	N 5. 03	120. (
 and amounts contained therein. 19.00 D0 NOT USE THIS LINE 20.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless \$3121 and applicable amendments? (see instructions) Enter in column 1, "N" for no. Is this a rural hospital with < 100 beds that qualifies for Hold Harmless provision in ACA \$3121 and applicable amendments? (see i Enter in column 2, "Y" for yes or "N" for no. 21.00 Did this facility incur and report costs for high cost implantable dev patients? Enter "Y" for yes or "N" for no. 22.00 Does the cost report contain heal thcare related taxes as defined in \$1 Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", et the Worksheet A line number where these taxes are included. 23.00 Did the facility and/or its subproviders (if applicable) purchase prof services, e.g., legal, accounting, tax preparation, bookkeeping, payromanagement/consulting services, from an unrelated organization? In col for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., greater the professional services expenses, for services purchased from unrelated located in a CBSA outside of the main hospital CBSA? In column 2, enter "N" for no. 	provision in AC/ "Y" for yes or or the Outpatient nstructions) vices charged to 1903(w)(3) of the enter in column 2 fessional DII, and/or umn 1, enter "Y" chan 50% of total organizations	Y Y Y	N 5. 03 Y	120. (121. (122. (
 and amounts contained therein. 19.00 DO NOT USE THIS LINE 20.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless §3121 and applicable amendments? (see instructions) Enter in column 1, "N" for no. Is this a rural hospital with < 100 beds that qualifies for Hold Harmless provision in ACA §3121 and applicable amendments? (see i Enter in column 2, "Y" for yes or "N" for no. 21.00 Did this facility incur and report costs for high cost implantable dev patients? Enter "Y" for yes or "N" for no. 22.00 Does the cost report contain heal thcare related taxes as defined in §1 Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", e the Worksheet A line number where these taxes are included. 23.00 Did the facility and/or its subproviders (if applicable) purchase prof management/consulting services, from an unrelated organization? In col for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., greater t professional services expenses, for services purchased from unrelated located in a CBSA outside of the main hospital CBSA? In column 2, enter "N" for no. 25.00 Does this facility operate a Medicare-certified transplant center? Enter "P" 	provision in AC/ "Y" for yes or or the Outpatient nstructions) vices charged to 1903(w)(3) of the enter in column 2 fessional oll, and/or umn 1, enter "Y" chan 50% of total organizations er "Y" for yes or	Y Y Y		119. (120. (122. (123. (123. (
 and amounts contained therein. 19.00 D0 NOT USE THIS LINE 20.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless \$3121 and applicable amendments? (see instructions) Enter in column 1, "N" for no. Is this a rural hospital with < 100 beds that qualifies for Hold Harmless provision in ACA \$3121 and applicable amendments? (see i Enter in column 2, "Y" for yes or "N" for no. 21.00 Did this facility incur and report costs for high cost implantable dev patients? Enter "Y" for yes or "N" for no. 22.00 Does the cost report contain heal thcare related taxes as defined in \$1 Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", et the Worksheet A line number where these taxes are included. 23.00 Did the facility and/or its subproviders (if applicable) purchase prof services, e.g., legal, accounting, tax preparation, bookkeeping, payrom management/consulting services, for services purchased from unrelated located in a CBSA outside of the main hospital CBSA? In column 2, enter "N" for no. 25.00 Does this facility operate a Medicare-certified transplant center? Enter "N" for no. 	provision in AC/ "Y" for yes or or the Outpatient nstructions) vices charged to 1903(w)(3) of the enter in column 2 Fessional bil, and/or umn 1, enter "Y" chan 50% of total organizations er "Y" for yes or	Y Y Y		120. (121. (122. (123. (125. (
 and amounts contained therein. 19.00 D0 NOT USE THIS LINE 20.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless §3121 and applicable amendments? (see instructions) Enter in column 1, "N" for no. Is this a rural hospital with < 100 beds that qualifies for Hold Harmless provision in ACA §3121 and applicable amendments? (see i Enter in column 2, "Y" for yes or "N" for no. 21.00 Did this facility incur and report costs for high cost implantable dev patients? Enter "Y" for yes or "N" for no. 22.00 Does the cost report contain heal thcare related taxes as defined in §1 Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", et the Worksheet A line number where these taxes are included. 23.00 Did the facility and/or its subproviders (if applicable) purchase prof services, e.g., legal, accounting, tax preparation, bookkeeping, payrod management/consulting services, from an unrelated organization? In col for yes or "N" for no. 11 f column 1 is "Y", were the majority of the expenses, i.e., greater the professional services expenses, for services purchased from unrelated located in a CBSA outside of the main hospital CBSA? In column 2, enter "N" for no. 25.00 Does this facility operate a Medicare-certified transplant center? Ent and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below 26.00 If this is a Medicare-certified kidney transplant program, enter the certified transplant center? Ent and "N" for no. If yes, enter certified is the transplant program, enter the certified heart transplant program, enter the certified transplant center? Ent and "N" for no. If yes, enter certified heart transplant program, enter the certified heart transplant program, enter the certified heart transplant program. 	provision in ACA "Y" for yes or or the Outpatient nstructions) vices charged to 1903(w)(3) of the enter in column 2 fessional oll, and/or umn 1, enter "Y" chan 50% of total organizations er "Y" for yes or cer "Y" for yes v. certification dat	e N		120. (121. (122. (123. (125. (126. (
 and amounts contained therein. 19.00 DO NOT USE THIS LINE 20.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless §3121 and applicable amendments? (see instructions) Enter in column 1, "N" for no. Is this a rural hospital with < 100 beds that qualifies for Hold Harmless provision in ACA §3121 and applicable amendments? (see i Enter in column 2, "Y" for yes or "N" for no. 21.00 Did this facility incur and report costs for high cost implantable dev patients? Enter "Y" for yes or "N" for no. 22.00 Does the cost report contain heal thcare related taxes as defined in §1 Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", e the Worksheet A line number where these taxes are included. 23.00 Did the facility and/or its subproviders (if applicable) purchase prof services, e.g., legal, accounting, tax preparation, bookkeeping, payror management/consulting services, from an unrelated organization? In col for yes or "N" for no. 11 f column 1 is "Y", were the majority of the expenses, i.e., greater t professional services expenses, for services purchased from unrelated located in a CBSA outside of the main hospital CBSA? In column 2, enter "N" for no. 25.00 Does this facility operate a Medicare-certified transplant center? Ent and "N" for no. If yes, enter certification date(s) (mm/dd/yyy) below 26.00 If this is a Medicare-certified kidney transplant program, enter the ce in column 1 and termination date, if applicable, in column 2. 27.00 If this is a Medicare-certified liver transplant program, enter the ce in column 1 and termination date, if applicable, in column 2. 28.00 If this is a Medicare-certified liver transplant program, enter the ce in column 1 and termination date, if applicable, in column 2. 	provision in AC/ "Y" for yes or or the Outpatient nstructions) vices charged to 1903(w)(3) of the enter in column 2 fessional oll, and/or umn 1, enter "Y" chan 50% of total organizations er "Y" for yes or cer "Y" for yes or cer tification date	e		120. (121. (122. (123. (
 and amounts contained therein. 19.00 D0 NOT USE THIS LINE 20.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless \$3121 and applicable amendments? (see instructions) Enter in column 1, "N" for no. Is this a rural hospital with < 100 beds that qualifies for Hold Harmless provision in ACA \$3121 and applicable amendments? (see i Enter in column 2, "Y" for yes or "N" for no. 21.00 Did this facility incur and report costs for high cost implantable dev patients? Enter "Y" for yes or "N" for no. 22.00 Does the cost report contain heal thcare related taxes as defined in \$1 Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", et the Worksheet A line number where these taxes are included. 23.00 Did the facility and/or its subproviders (if applicable) purchase prof services, e.g., legal, accounting, tax preparation, bookkeeping, payrod management/consulting services, from an unrelated organization? In col for yes or "N" for no. 1f column 1 is "Y", were the majority of the expenses, i.e., greater t professional services expenses, for services purchased from unrelated located in a CBSA outside of the main hospital CBSA? In column 2, enter "N" for no. 25.00 Does this facility operate a Medicare-certified transplant center? Ent and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below 26.00 If this is a Medicare-certified kidney transplant program, enter the ce in column 1 and termination date, if applicable, in column 2. 	provision in AC/ "Y" for yes or or the Outpatient nstructions) vices charged to 1903(w)(3) of the enter in column 2 fessional oll, and/or umn 1, enter "Y" than 50% of total organizations er "Y" for yes or cer "Y" for yes or certification date ertification date	e		120. (121. (122. (123. (125. (126. (127. (

SPITAL AND HOSPITAL HEALTH CARE COMPLEX I	DENTIFICATION DATA	Provider CC	N: 15-0162			u of Form CMS- Worksheet S-2 Part I	
					2/31/2023		
					1.00	2.00	-
1.00 If this is a Medicare-certified inte			erti fi cati	on			131.0
date in column 1 and termination dat 2.00 If this is a Medicare-certified isle			ication da	ate			132.0
in column 1 and termination date, if				ite			132.0
3.00 Removed and reserved		(000)	000				133.0
4.00 If this is a hospital-based organ pr in column 1 and termination date, if			e upu nump	ber			134. (
Al I Provi ders				i			
0.00 Are there any related organization o chapter 10? Enter "Y" for yes or "N"					Y	158014	140. (
are claimed, enter in column 2 the h				513			
1.00 If this facility is part of a chain		2.00	ab 142 th		3.00	of the	-
home office and enter the home offic				e name and	u address	or the	
1.00 Name: SISTERS OF ST. FRANCIS HEALTH		: WISCONSIN PHYSICI		nctor's Nu	mber: 0810	1	141. (
SERVIC 2.00 Street: 1515 W DRAGOON TRL	PO Box:	SERVI CES 1290					142. (
3. 00 Ci ty: MI SHAWAKA	State:	IN	Zip Cc	de:	4654	4	143. (
						1.00	-
4.00 Are provider based physicians' costs	included in Workshee	et A?				1.00 Y	144.0
5.00 If costs for renal services are clai	mod on Wkst A lino	74 are the costs	for		1.00 Y	2.00	145. 0
inpatient services only? Enter "Y" f				5	T		145.0
no, does the dialysis facility inclu	de Medicare utilizati						
period? Enter "Y" for yes or "N" fo 6.00 Has the cost allocation methodology		viously filed cost	report?		N		146. (
Enter "Y" for yes or "N" for no in c				lf			
yes, enter the approval date (mm/dd/	yyyy) in column 2.						
						1.00	-
7.00 Was there a change in the statistica	L basis? Enter "Y" fo						
						N	147. (
8.00 Was there a change in the order of a	llocation? Enter "Y"	for yes or "N" fo	r no.	for no		Ν	148. (
8.00Was there a change in the order of a 9.00Was there a change to the simplified	llocation? Enter "Y"	for yes or "N" fo	r no.		ītle V		
9.00 Was there a change to the simplified	llocation? Enter "Y" cost finding method	for yes or "N" fo ? Enter "Y" for ye Part A 1.00	r no. <u>s or "N" f</u> Part E 2.00	3 T	3.00	N N Title XIX 4.00	148. (
9.00 Was there a change to the simplified	Ilocation? Enter "Y" cost finding method r that qualifies for	for yes or "N" fo ? Enter "Y" for ye Part A 1.00 an exemption from	r no. s or "N" f Part E 2.00 n the appli	ication o	3.00 f the lowe	N N Title XIX 4.00 r of costs	148. (
9.00 Was there a change to the simplified Does this facility contain a provide or charges? Enter "Y" for yes or "N" 5.00 Hospital	Ilocation? Enter "Y" cost finding method r that qualifies for	for yes or "N" fo ? Enter "Y" for ye Part A 1.00 an exemption from ponent for Part A N	r no. s or "N" f Part E 2.00 n the appli and Part I N	ication o	3.00 f the Lowe 2 CFR §413 N	N N Title XIX 4.00 r of costs .13) N	148. (149. (- - 155. (
9.00 Was there a change to the simplified Does this facility contain a provide or charges? Enter "Y" for yes or "N" 5.00 Hospital 6.00 Subprovider - IPF	Ilocation? Enter "Y" cost finding method r that qualifies for	for yes or "N" fo ? Enter "Y" for ye Part A 1.00 an exemption from ponent for Part A N N	nr no. <u>s or "N" f</u> <u>Part E</u> 2.00 n the appli <u>and Part I</u> N N	ication o	3.00 f the lowe 2 CFR §413 N N	N N Title XIX 4.00 r of costs .13) N N	148. (149. (155. (156. (
9.00 Was there a change to the simplified Does this facility contain a provide or charges? Enter "Y" for yes or "N" 5.00 Hospital	Ilocation? Enter "Y" cost finding method r that qualifies for	for yes or "N" fo ? Enter "Y" for ye Part A 1.00 an exemption from ponent for Part A N	r no. s or "N" f Part E 2.00 n the appli and Part I N	ication o	3.00 f the Lowe 2 CFR §413 N	N N Title XIX 4.00 r of costs .13) N	148. (
9.00 Was there a change to the simplified Does this facility contain a provide or charges? Enter "Y" for yes or "N" 5.00 Hospital 6.00 Subprovider - IPF 7.00 Subprovider - IRF 8.00 SUBPROVIDER 9.00 SNF	Ilocation? Enter "Y" cost finding method r that qualifies for	for yes or "N" fo ? Enter "Y" for ye Part A 1.00 an exemption from ponent for Part A N N N N	r no. s or "N" f Part E 2.00 n the appli and Part I N N N	ication o	3.00 f the lowe 2 CFR §413 N N N N	N N Title XIX 4.00 r of costs .13) N N N N	148. (149. (155. (156. (157. (158. (159. (
9.00 Was there a change to the simplified Does this facility contain a provide or charges? Enter "Y" for yes or "N" 5.00 Hospital 6.00 Subprovider - IPF 7.00 Subprovider - IRF 8.00 SUBPROVIDER 9.00 SNF 0.00 HOME HEALTH AGENCY	Ilocation? Enter "Y" cost finding method r that qualifies for	for yes or "N" fo ? Enter "Y" for ye Part A 1.00 an exemption from ponent for Part A N N N	r no. s or "N" f Part E 2.00 n the appli and Part I N N N N N	ication o	3.00 f the lowe 2 CFR §413 N N N N N	N N Title XIX 4.00 r of costs .13) N N N N N	148. (149. (149. (155. (156. (157. (158. (159. (160. (
9.00 Was there a change to the simplified Does this facility contain a provide or charges? Enter "Y" for yes or "N" 5.00 Hospital 6.00 Subprovider - IPF 7.00 Subprovider - IRF 8.00 SUBPROVIDER 9.00 SNF 0.00 HOME HEALTH AGENCY	Ilocation? Enter "Y" cost finding method r that qualifies for	for yes or "N" fo ? Enter "Y" for ye Part A 1.00 an exemption from ponent for Part A N N N N	r no. s or "N" f Part E 2.00 n the appli and Part I N N N	ication o	3.00 f the lowe 2 CFR §413 N N N N	N N Title XIX 4.00 r of costs .13) N N N N	148. (149. (149. (155. (156. (157. (158. (159. (160. (
9.00 Was there a change to the simplified Does this facility contain a provide or charges? Enter "Y" for yes or "N" 5.00 Hospital 6.00 Subprovider - IPF 7.00 Subprovider - IRF 8.00 SUBPROVIDER 9.00 SNF 0.00 HOME HEALTH AGENCY 1.00 CMHC	Ilocation? Enter "Y" cost finding method r that qualifies for	for yes or "N" fo ? Enter "Y" for ye Part A 1.00 an exemption from ponent for Part A N N N N	r no. s or "N" f Part E 2.00 n the appli and Part I N N N N N	ication o	3.00 f the lowe 2 CFR §413 N N N N N	N N Title XIX 4.00 r of costs .13) N N N N N	148. (149. (149. (155. (156. (157. (158. (159. (160. (
9.00 Was there a change to the simplified Does this facility contain a provide or charges? Enter "Y" for yes or "N" 5.00 Hospital 6.00 Subprovider - IPF 7.00 Subprovider - IRF 8.00 SUBPROVIDER 9.00 SNF 0.00 HOME HEALTH AGENCY 1.00 CMHC Multicampus	llocation? Enter "Y" cost finding method r that qualifies for for no for each com	for yes or "N" fo ? Enter "Y" for ye Part A 1.00 an exemption from ponent for Part A N N N N N	r no. s or "N" f Part E 2.00 n the appli and Part I N N N N N N	3 T i cati on o B. (See 4:	3.00 f the Iowe 2 CFR §413 N N N N N N	N N Title XIX 4.00 r of costs .13) N N N N N N N N N N N N N N	148. (149. (155. (156. (156. (157. (158. (159. (159. (160. (161. (
9.00 Was there a change to the simplified Does this facility contain a provide or charges? Enter "Y" for yes or "N" 5.00 Hospital 6.00 Subprovider - IPF 7.00 Subprovider - IRF 8.00 SUBPROVIDER 9.00 SNF 0.00 HOME HEALTH AGENCY 1.00 CMHC	llocation? Enter "Y" cost finding method r that qualifies for for no for each com	for yes or "N" fo ? Enter "Y" for ye Part A 1.00 an exemption from ponent for Part A N N N N N	r no. s or "N" f Part E 2.00 n the appli and Part I N N N N N N	3 T i cati on o B. (See 4:	3.00 f the Iowe 2 CFR §413 N N N N N N	N N Title XIX 4.00 r of costs .13) N N N N N N N N N	148. (149. (155. (156. (156. (157. (158. (159. (160. (161. (
9.00 Was there a change to the simplified Does this facility contain a provide or charges? Enter "Y" for yes or "N" 5.00 Hospital 6.00 Subprovider - IPF 7.00 Subprovider - IRF 8.00 SUBPROVIDER 9.00 SNF 0.00 HOME HEALTH AGENCY 1.00 CMHC Multicampus 5.00 Is this hospital part of a Multicamp	llocation? Enter "Y" cost finding method r that qualifies for for no for each com us hospital that has Name	for yes or "N" fo ? Enter "Y" for ye Part A 1.00 an exemption from ponent for Part A N N N N N N N N N N N N N	r no. s or "N" f Part E 2.00 n the appli and Part I N N N N N N Sess in dif	3 T ication o B. (See 4.	3.00 F the I owe 2 CFR §413 N N N N N N SSAS? CBSA	N N Title XIX 4.00 r of costs .13) N N N N N N N N N N N N T.00	148.0 149.0 155.0 156.0 157.0 158.0 159.0 160.0 161.0
9.00 Was there a change to the simplified Does this facility contain a provide or charges? Enter "Y" for yes or "N" 5.00 Hospital 6.00 Subprovider - IPF 7.00 Subprovider - IRF 8.00 SUBPROVIDER 9.00 SNF 0.00 HOME HEALTH AGENCY 1.00 CMHC Multicampus 5.00 Is this hospital part of a Multicamp Enter "Y" for yes or "N" for no.	llocation? Enter "Y" cost finding method r that qualifies for for no for each com us hospital that has	for yes or "N" fo ? Enter "Y" for ye Part A 1.00 an exemption from ponent for Part A N N N N N N N N N N	r no. s or "N" f Part E 2.00 n the appli n the appli N N N N N N N N Sess in dif	3 T ication o B. (See 4.	3.00 f the Iowe 2 CFR §413 N N N N N N SSAS?	N N Title XIX 4.00 r of costs .13) N N N N N N N N N N N N TI.00 TI.00 FTE/Campus 5.00	148. 149. 155. 156. 157. 158. 159. 160. 161. 161.
9.00 Was there a change to the simplified Does this facility contain a provide or charges? Enter "Y" for yes or "N" 5.00 Hospital 6.00 Subprovider - IPF 7.00 Subprovider - IRF 8.00 SUBPROVIDER 9.00 SNF 0.00 HOME HEALTH AGENCY 1.00 CMHC Multicampus 5.00 Is this hospital part of a Multicamp Enter "Y" for yes or "N" for no. 6.00 If line 165 is yes, for each campus enter the name in column	llocation? Enter "Y" cost finding method r that qualifies for for no for each com us hospital that has Name	for yes or "N" fo ? Enter "Y" for ye Part A 1.00 an exemption from ponent for Part A N N N N N N N N N N N N N	r no. s or "N" f Part E 2.00 n the appli and Part I N N N N N N Sess in dif	3 T ication o B. (See 4.	3.00 F the I owe 2 CFR §413 N N N N N N SSAs? CBSA	N N Title XIX 4.00 r of costs .13) N N N N N N N N N N N N TI.00 TI.00 FTE/Campus 5.00	148. 149. 155. 156. 157. 158. 159. 160. 161. 161.
9.00 Was there a change to the simplified Does this facility contain a provide or charges? Enter "Y" for yes or "N" 5.00 Hospital 6.00 Subprovider - IPF 7.00 Subprovider - IRF 8.00 SUBPROVIDER 9.00 SNF 0.00 HOME HEALTH AGENCY 1.00 CMHC Multicampus 5.00 Is this hospital part of a Multicamp Enter "Y" for yes or "N" for no. 6.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in	llocation? Enter "Y" cost finding method r that qualifies for for no for each com us hospital that has Name	for yes or "N" fo ? Enter "Y" for ye Part A 1.00 an exemption from ponent for Part A N N N N N N N N N N N N N	r no. s or "N" f Part E 2.00 n the appli and Part I N N N N N N Sess in dif	3 T ication o B. (See 4.	3.00 F the I owe 2 CFR §413 N N N N N N SSAs? CBSA	N N Title XIX 4.00 r of costs .13) N N N N N N N N N N N N TI.00 TI.00 FTE/Campus 5.00	148. 149. 155. 156. 157. 158. 159. 160. 161. 161.
9.00 Was there a change to the simplified Does this facility contain a provide or charges? Enter "Y" for yes or "N" 5.00 Hospital 6.00 Subprovider - IPF 7.00 Subprovider - IRF 8.00 SUBPROVIDER 9.00 SNF 0.00 HOME HEALTH AGENCY 1.00 CMHC Multicampus 5.00 Is this hospital part of a Multicamp Enter "Y" for yes or "N" for no. 6.00 If line 165 is yes, for each campus enter the name in column	llocation? Enter "Y" cost finding method r that qualifies for for no for each com us hospital that has Name	for yes or "N" fo ? Enter "Y" for ye Part A 1.00 an exemption from ponent for Part A N N N N N N N N N N N N N	r no. s or "N" f Part E 2.00 n the appli and Part I N N N N N N Sess in dif	3 T ication o B. (See 4.	3.00 F the I owe 2 CFR §413 N N N N N N SSAs? CBSA	N N Title XIX 4.00 r of costs .13) N N N N N N N N N N N N TI.00 TI.00 FTE/Campus 5.00	148.0 149.0 155.0 155.0 157.0 158.0 157.0 158.0 160.0 161.0 165.0
9.00 Was there a change to the simplified Does this facility contain a provide or charges? Enter "Y" for yes or "N" 5.00 Hospital 6.00 Subprovider - IPF 7.00 Subprovider - IRF 8.00 SUBPROVIDER 9.00 SNF 0.00 HOME HEALTH AGENCY 1.00 CMHC Multicampus 5.00 Is this hospital part of a Multicamp Enter "Y" for yes or "N" for no. 6.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3,	llocation? Enter "Y" cost finding method r that qualifies for for no for each com us hospital that has Name	for yes or "N" fo ? Enter "Y" for ye Part A 1.00 an exemption from ponent for Part A N N N N N N N N N N N N N	r no. s or "N" f Part E 2.00 n the appli and Part I N N N N N N Sess in dif	3 T ication o B. (See 4.	3.00 F the I owe 2 CFR §413 N N N N N N SSAs? CBSA	N N Title XIX 4.00 r of costs .13) N N N N N N N N N N N N TI.00 TI.00 FTE/Campus 5.00	148.0 149.0 155.0 155.0 157.0 158.0 157.0 158.0 160.0 161.0 165.0
9.00 Was there a change to the simplified Does this facility contain a provide or charges? Enter "Y" for yes or "N" 5.00 Hospital 6.00 Subprovider - IPF 7.00 Subprovider - IRF 8.00 SUBPROVIDER 9.00 SNF 0.00 HOME HEALTH AGENCY 1.00 CMHC Multicampus 5.00 Is this hospital part of a Multicamp Enter "Y" for yes or "N" for no. 6.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in	llocation? Enter "Y" cost finding method r that qualifies for for no for each com us hospital that has Name	for yes or "N" fo ? Enter "Y" for ye Part A 1.00 an exemption from ponent for Part A N N N N N N N N N N N N N	r no. s or "N" f Part E 2.00 n the appli and Part I N N N N N N Sess in dif	3 T ication o B. (See 4.	3.00 F the I owe 2 CFR §413 N N N N N N SSAs? CBSA	N N Title XIX 4.00 r of costs .13) N N N N N N N N N N N N S TE/Campus 5.00 0.00	148.0 149.0 155.0 155.0 157.0 158.0 157.0 158.0 160.0 161.0 165.0
9.00 Was there a change to the simplified Does this facility contain a provide or charges? Enter "Y" for yes or "N" 5.00 Hospital 6.00 Subprovider - IPF 7.00 Subprovider - IRF 8.00 SUBPROVIDER 9.00 SNF 0.00 HOME HEALTH AGENCY 1.00 CMHC Multicampus 5.00 Is this hospital part of a Multicamp Enter "Y" for yes or "N" for no. 6.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)	Ilocation? Enter "Y" cost finding method' r that qualifies for for no for each com us hospital that has Name 0 incentive in the Ame	for yes or "N" fo ? Enter "Y" for ye Part A 1.00 an exemption from ponent for Part A N N N N N N N N N N N N N	r no. s or "N" f Part E 2.00 n the appli n the appli N N N N N N N N N Sess in dif State 2.00 A State A State 2.00 A State 2.00 A State State St	3 T ication or B. (See 4: See 4: Ferent CE Zip Code 3.00	3.00 F the I owe 2 CFR §413 N N N N N N SSAs? CBSA	N N N Title XIX 4.00 r of costs .13) N N N N N N N N N N N N N N N S TE/Campus 5.00 0.00	148.0 149.0 155.0 155.0 157.0 158.0 157.0 158.0 160.0 161.0 165.0
9.00 Was there a change to the simplified Does this facility contain a provide or charges? Enter "Y" for yes or "N" 5.00 Hospital 6.00 Subprovider - IPF 7.00 Subprovider - IRF 8.00 SUBPROVIDER 9.00 SNF 0.00 HOME HEALTH AGENCY 1.00 CMHC Multicampus 5.00 Is this hospital part of a Multicamp Enter "Y" for yes or "N" for no. 6.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Heal th Information Technology (HIT) 7.00 Is this provider a meaningful user u	Ilocation? Enter "Y" cost finding method' r that qualifies for for no for each com us hospital that has Name 0 incentive in the Ame nder §1886(n)? Enter	for yes or "N" fo ? Enter "Y" for ye Part A 1.00 an exemption from ponent for Part A N N N N N N N N N N N N N	r no. s or "N" f Part E 2.00 n the appli and Part I N N N N N N N N Sees in dif State 2.00 A State A State State A State A State A State A State St	3 T ication o B. (See 4: See 4: Cip Code 3.00	3.00 f the I owe 2 CFR §413 N N N N N N N SSAS? CBSA 4.00	N N Title XIX 4.00 r of costs .13) N N N N N N N N N N N N S TE/Campus 5.00 0.00	148.0 149.0 155.0 155.0 157.0 157.0 157.0 160.0 161.0 165.0 165.0 166.0
9.00 Was there a change to the simplified Does this facility contain a provide or charges? Enter "Y" for yes or "N" 5.00 Hospital 6.00 Subprovider - IPF 7.00 Subprovider - IRF 8.00 SUBPROVIDER 9.00 SNF 0.00 HOME HEALTH AGENCY 1.00 CMHC Multicampus 5.00 Is this hospital part of a Multicamp Enter "Y" for yes or "N" for no. 6.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Heal th Information Technology (HIT) 7.00 Is this provider a meaningful user u 8.00 If this provider is a CAH (line 105	Ilocation? Enter "Y" cost finding method' r that qualifies for for no for each com us hospital that has Name 0 incentive in the Ame nder §1886(n)? Enter is "Y") and is a mean	for yes or "N" fo ? Enter "Y" for ye Part A 1.00 an exemption from ponent for Part A N N N N N N N N N N N N N	r no. s or "N" f Part E 2.00 n the appli and Part I N N N N N N N N Sees in dif State 2.00 A State A State State A State A State A State A State St	3 T ication o B. (See 4: See 4: Cip Code 3.00	3.00 f the I owe 2 CFR §413 N N N N N N N SSAS? CBSA 4.00	N N N Title XIX 4.00 r of costs .13) N N N N N N N N N N N N N N N S TE/Campus 5.00 0.00	148. (149. (149. (155. (156. (157. (157. (159. (161. (161. (161. (161. (165. (165. (165. (166. (166. (167. (167. (167. (167. (
9.00 Was there a change to the simplified Does this facility contain a provide or charges? Enter "Y" for yes or "N" 5.00 Hospital 6.00 Subprovider - IPF 7.00 Subprovider - IRF 8.00 SUBPROVIDER 9.00 SNF 0.00 HOME HEALTH AGENCY 1.00 CMHC Multicampus 5.00 Is this hospital part of a Multicamp Enter "Y" for yes or "N" for no. 6.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Heal th Information Technology (HIT) 7.00 Is this provider a meaningful user u 8.00 If this provider is a CAH (line 105 reasonable cost incurred for the HIT 8.01 If this provider is a CAH and is not	Ilocation? Enter "Y" cost finding method r that qualifies for for no for each com us hospital that has Name 0 incentive in the Ame nder §1886(n)? Enter is "Y") and is a mear assets (see instructioningful user, of a meaningful user, of a mea	for yes or "N" fo ? Enter "Y" for ye Part A 1.00 an exemption from ponent for Part A N N N N N N N N N N N N N	r no. s or "N" f Part E 2.00 n the appli and Part I N N N N N N N N N N N N N	3 T ication or B. (See 4: S. (See 4: Ferent CE Zip Code 3.00 ment Act ("), enter	3.00 f the I owe 2 CFR §413 N N N N N N SSAS? CBSA 4.00 - the	N N N Title XIX 4.00 r of costs .13) N N N N N N N N N N N N N N N S TE/Campus 5.00 0.00	148. (149. (149. (155. (156. (157. (158. (159. (160. (
9.00 Was there a change to the simplified Does this facility contain a provide or charges? Enter "Y" for yes or "N" 5.00 Hospital 6.00 Subprovider - IPF 7.00 Subprovider - IRF 8.00 SUBPROVIDER 9.00 SNF 0.00 HOME HEALTH AGENCY 1.00 CMHC Multicampus 5.00 Is this hospital part of a Multicamp Enter "Y" for yes or "N" for no. 6.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Heal th Information Technology (HIT) 7.00 Is this provider a meaningful user u 8.00 If this provider is a CAH (line 105 reasonable cost incurred for the HIT	Ilocation? Enter "Y" cost finding method' r that qualifies for for no for each com us hospital that has Name 0 incentive in the Ame nder §1886(n)? Enter is "Y") and is a mear assets (see instruct a meaningful user, of nter "Y" for yes or 10 10 10 10 10 10 10 10 10 10	for yes or "N" fo ? Enter "Y" for ye Part A 1.00 an exemption from ponent for Part A N N N N N N N N N N N N N	r no. s or "N" f Part E 2.00 n the appli and Part I N N N N N N N N N N N N N	3 T ication or B. (See 4: S. (See 4: Ferent CE Zip Code 3.00 ment Act ("), enter For a harce is)	3.00 F the I owe 2 CFR §413 N N N N N N N N N N SSAS? CBSA 4.00 - the dship	N N 1 i t l e XI X 4.00 r of costs .13) N N N N N N N N N N N T.00 T.00 O.00 O.00 O.00 Y	148. 149. 155. 156. 157. 158. 159. 160. 161. 165. 0 166. 165.

Health Financial Systems	FRANCI SCAN HEALTH	I NDI ANAPOLI S	In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX	IDENTIFICATION DATA		Period:	Worksheet S-2	
			From 01/01/2023		
			To 12/31/2023	Date/Time Pre	
				3/28/2024 2:2	1 pm
			Begi nni ng	Endi ng	
			1.00	2.00	
170.00 Enter in columns 1 and 2 the EHR be			170.00		
period respectively (mm/dd/yyyy)					
			1.00	2.00	1
171.00 If line 167 is "Y", does this provi	der have any days for indi-	viduals enrolled in	N	C	171.00
section 1876 Medicare cost plans re	eported on Wkst. S-3, Pt. I	, line 2, col. 6? Enter			
"Y" for yes and "N" for no in colum	n 1. If column 1 is yes, e	nter the number of section	1		
1876 Medicare days in column 2. (se	e instructions)				

Heal th	Fi nanci al	Systems	
- modil till	i i marioi ai	0,000	

Heal th	Financial Systems FRANCISCAN HEALT	TH INDIANAPOLIS	i	In Lie	u of Form CMS-	2552-10
	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		CN: 15-0162	Period: From 01/01/2023 Fo 12/31/2023	Worksheet S-2 Part II	2 epared:
				Y/N	Date	
	PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURSE			1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N m/dd/yyyy format. COMPLETED BY ALL HOSPITALS			all dates in t	the	-
	Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the reporting period? If yes, enter the date of the change in c			N Date	V/I	1.00
			1.00	2.00	3.00	-
2.00	Has the provider terminated participation in the Medicare F yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary.	Program? If nn 3, "V" for	N			2.00
3.00	Is the provider involved in business transactions, includin contracts, with individuals or entities (e.g., chain home of or medical supply companies) that are related to the provid officers, medical staff, management personnel, or members of of directors through ownership, control, or family and othe relationships? (see instructions)	offices, drug der or its of the board	Y			3.00
			Y/N	Туре	Date	
	Financial Data and Demanta		1.00	2.00	3.00	
4.00	Financial Data and Reports Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" f or "R" for Reviewed. Submit complete copy or enter date ava column 3. (see instructions) If no, see instructions.	for Compiled,	Y	A	05/31/2024	4.00
5.00	Are the cost report total expenses and total revenues diffe those on the filed financial statements? If yes, submit rec		Ν			5.00
				Y/N	Legal Oper.	
	Approved Educational Activities			1.00	2.00	
6.00	Column 1: Are costs claimed for a nursing program? Column the legal operator of the program?	5	s the provider	N		6.00
7.00 8.00	Are costs claimed for Allied Health Programs? If "Y" see in Were nursing programs and/or allied health programs approve cost reporting period? If yes, see instructions.		wed during the	Y Y		7.00 8.00
9.00	Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction		al education	Y		9.00
	Was an approved Intern and Resident GME program initiated c cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I			N		10.00
	Teaching Program on Worksheet A? If yes, see instructions.					11.00
	Ded Debte				Y/N 1.00	
	Bad Debts Is the provider seeking reimbursement for bad debts? If yes				Y	12.00
	If line 12 is yes, did the provider's bad debt collection p period? If yes, submit copy.	5 5	5		N	13.00
14.00	If line 12 is yes, were patient deductibles and/or coinsura instructions. Bed Complement	ance amounts wa	il veu ? TT yes,	See	N	14.00
15.00	Did total beds available change from the prior cost reporti	ng period? If	yes, see instr		Y	15.00
			rt A		t B	
		Y/N 1.00	Date 2.00	Y/N 3.00	Date 4.00	
	PS&R Data	1.00	2.00	3.00	4.00	-
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 the PS&R Report used in columns 2 and 4. (see instructions)	N		N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date	Y	03/04/2024	Y	03/04/2024	17.00
18.00	in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If was not included on the PS&R Report used to file this	N		Ν		18.00
19. 00	cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		Ν		19.00

Health Financial Systems

FRANCISCAN HEALTH INDIANAPOLIS

In Lieu of Form CMS-2552-10

	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C	CN: 15-0162	Period: From 01/01/2023	Worksheet S-2	
		_		To 12/31/2023	Date/Time Pre 3/28/2024 2:2	
		Descri		Y/N	Y/N	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R	()	1.00 N	3.00 N	20.00
20.00	Report data for Other? Describe the other adjustments:					20.00
		Y/N 1.00	Date 2.00	Y/N 3.00	Date 4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N	2.00	N	4.00	21.00
		1				
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	EPT CHILDRENS H	OSPI TALS)			-
22.00	Capital Related Cost Have assets been relifed for Medicare purposes? If yes, see	e instructions			N	22.00
23.00	Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.		als made duri	ng the cost	N	23.00
24.00	Were new leases and/or amendments to existing leases entero If yes, see instructions	ed into during	this cost rep	porting period?	Ν	24.00
25.00	Have there been new capitalized leases entered into during instructions.	lf yes, see	Ν	25.00		
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the instructions.	f yes, see	Ν	26.00		
27.00	Has the provider's capitalization policy changed during the copy.	e cost reportin	g period? If	yes, submit	Ν	27.00
	Interest Expense					
	Were new loans, mortgage agreements or letters of credit en period? If yes, see instructions.	. 0	Ν	28.00		
	Did the provider have a funded depreciation account and/or treated as a funded depreciation account? If yes, see inst	ructions		,	Ν	29.00
30. 00	Has existing debt been replaced prior to its scheduled matu instructions.	5	5		Ν	30.00
31.00	Has debt been recalled before scheduled maturity without is instructions.	ssuance of new	debt? If yes,	see	N	31.00
32 00	Purchased Services Have changes or new agreements occurred in patient care ser	rvices furnishe	d through cor	atractual	N	32.00
	arrangements with suppliers of services? If yes, see instru If line 32 is yes, were the requirements of Sec. 2135.2 app	uctions.	0		N	33.00
00.00	no, see instructions.	pri ou por curini	g to comport	ar to braaring. Th		00100
	Provi der-Based Physi ci ans					
34.00	Were services furnished at the provider facility under an a If yes, see instructions.	arrangement wit	h provider-ba	ased physicians?	Y	34.00
35.00	If line 34 is yes, were there new agreements or amended exi physicians during the cost reporting period? If yes, see in		ts with the p	provi der-based	Ν	35.00
	physicians during the cost reporting period? It yes, see th	istructions.		Y/N	Date	
				1.00	2.00	
	Home Office Costs					
	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been pu	repared by the	home office?	Y N		36.00 37.00
38.00	If yes, see instructions. If line 36 is yes , was the fiscal year end of the home of			Ν		38.00
39. 00	the provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to othe			Y		39.00
40.00	see instructions. If line 36 is yes, did the provider render services to the	home office?	lf yes, see	Y		40.00
	instructions					
	Cast Demant Deserver Contact Information	1.	00	2.	00	
41.00	Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	NEIL		GRAFF		41.00
42.00	respectively. Enter the employer/company name of the cost report	FRANCI SCAN ALL	LANCE			42.00
	preparer. Enter the telephone number and email address of the cost	2625106359		NEI L. GRAFF@FRA		43.00
+3.00	report preparer in columns 1 and 2, respectively.	2020100007		E. ORG	NOT JUNINALLI ANU	+5.00

Heal th	Financial Systems	FRANCI SCAN HEALT	H INDIANAPOLIS		In Lie	u of Form CMS-	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT	Provider CCN: 15-		Period:	Worksheet S-2		
					rom 01/01/2023 o 12/31/2023		pared: <u>1 pm</u>
			3.00				
	Cost Report Preparer Contact Information						
41.00	Enter the first name, last name and the t	itle/position	REIMBURSEMENT DI RECT	OR			41.00
	held by the cost report preparer in colum	ns 1, 2, and 3,					
	respecti vel y.						
42.00	Enter the employer/company name of the co	st report					42.00
	preparer.						
43.00	Enter the telephone number and email addr	ess of the cost					43.00
	report preparer in columns 1 and 2, respe						

	Financial Systems FR AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	ANCISCAN HEALT	Provider C	N. 15-0162	Peri od:	u of Form CMS-2 Worksheet S-3	
1105111	AL AND HOSTITAL HEALTH CARE COMPLEX STATISTIC			5N. 13-0102	From 01/01/2023	Part I	
					To 12/31/2023	Date/Time Pre 3/28/2024 2:2	
						I/P Days / O/P	
						Visits / Trips	
	Component	Worksheet A	No. of Beds	Bed Days	CAH/REH Hours	Title V	
		Line No. 1.00	2.00	Available 3.00	4.00	5.00	
	PART I – STATISTICAL DATA	1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30.00	272	99, 28	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	
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		272	99, 28		0	7.00
8.00	INTENSIVE CARE UNIT	31.00	30	10, 95		0	8.00
8.01	NEONATAL INTENSIVE CARE UNIT	31.01	31	11, 31		0	8. 01
9.00	CORONARY CARE UNIT	32.00	46	16, 79	0.00	0	9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT	34.00	31	11, 31	0.00	0	11.00
12.00	OTHER SPECIAL CARE (SPECIFY)	10.00					12.00
13.00	NURSERY	43.00	110	140.45		0	13.00
14.00	Total (see instructions)		410	149, 65	0.00	0	14.00
15.00	CAH visits				0.00	0	15.00 15.10
15. 10 16. 00	REH hours and visits SUBPROVIDER - IPF				0.00	0	16.00
17.00	SUBPROVIDER - IRF	41.00	22	8, 03	20	0	17.00
18.00	SUBPROVI DER	41.00	22	0, 0.	50	0	18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23.00
24.00	HOSPI CE	116.00	0		0		24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		432				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambul ance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0		0		32.00
32. 01	Total ancillary labor & delivery room						32.01
	outpatient days (see instructions)						
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges		_			_	33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care	30.00	0		0	0	34.00

)SPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CC		Period: From 01/01/2023 To 12/31/2023	Worksheet S-3 Part I Date/Time Pre 3/28/2024 2:2	pare
		I/P Days	/ O/P Visits	/ Trips	Full Time E		
	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						
00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	20, 630	715	71, 03	9		1
00	HMO and other (see instructions)	32, 208	23, 105				2
00	HMO IPF Subprovider	0	0				3
00	HMO IRF Subprovider	1, 354	342				4
00	Hospital Adults & Peds. Swing Bed SNF	0	0		0		5
00	Hospital Adults & Peds. Swing Bed NF		0		0		6
00	Total Adults and Peds. (exclude observation beds) (see instructions)	20, 630	715	71, 03			7
00	INTENSIVE CARE UNIT	2, 880	100	9, 95			8
01	NEONATAL INTENSIVE CARE UNIT	0	68	6, 79			8
00	CORONARY CARE UNIT	4, 685	136	13, 51	/		10
. 00	BURN INTENSIVE CARE UNIT	2 422	80	0.00	11		10
. 00	SURGI CAL I NTENSI VE CARE UNI T OTHER SPECI AL CARE (SPECI FY)	2, 432	80	8,00			12
3.00	NURSERY		35	3, 45	0		13
I. 00	Total (see instructions)	30, 627	1, 134	112, 76		2, 346. 64	
5.00	CAH vi si ts	0	0	112,70	0	2, 340. 04	15
5. 10	REH hours and visits	0	0		0		15
. 00	SUBPROVIDER - IPF	-	-		-		16
. 00	SUBPROVIDER - IRF	3, 180	21	5, 98	0.00	41.61	
. 00	SUBPROVI DER						18
. 00	SKILLED NURSING FACILITY						19
. 00	NURSING FACILITY						20
. 00	OTHER LONG TERM CARE						21
2. 00	HOME HEALTH AGENCY	0	0		0 0.00	0.00	22
. 00	AMBULATORY SURGICAL CENTER (D. P.)						23
. 00	HOSPI CE	0	0		0 0.00	66.01	24
. 10	HOSPICE (non-distinct part)				0		24
. 00	CMHC - CMHC						25
. 00	RURAL HEALTH CLINIC		_		_		26
. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0.00	0.00	
. 00	Total (sum of lines 14-26)				25.99	2, 454. 26	
. 00	Observation Bed Days		1, 677	9, 71	5		28
. 00	Ambulance Trips	0					29
0.00	Employee discount days (see instruction)				0		30
. 00	Employee discount days - IRF		2/0	27	0		31
2.00 2.01	Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions)	0	368	36	0		32 32
3. 00	LTCH non-covered days	0					33
3. 00 3. 01	LTCH non-covered days LTCH site neutral days and discharges	0					33
J. UT	Temporary Expansi on COVID-19 PHE Acute Care	0	О		0		34

OSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider C	CN: 15-0162	Period: From 01/01/2023 To 12/31/2023	Worksheet S-3 Part I Date/Time Pre 3/28/2024 2:2	pare
		Full Time		Di se	charges		
	Component	Equi val ents Nonpai d Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
	PART I – STATISTICAL DATA						
. 00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		С	5, 74	16 200	19, 924	1.
00	HMO and other (see instructions)			5, 05	51 4, 497		2
00	HMO IPF Subprovider				0		3
00	HMO IRF Subprovider				29		4
00	Hospital Adults & Peds. Swing Bed SNF						5
00 00	Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions)						6
00	INTENSIVE CARE UNIT						8
01	NEONATAL INTENSIVE CARE UNIT						8
00	CORONARY CARE UNIT						9
. 00	BURN INTENSIVE CARE UNIT						10
. 00	SURGICAL INTENSIVE CARE UNIT						11
. 00	OTHER SPECIAL CARE (SPECIFY)						12
. 00	NURSERY						13
. 00	Total (see instructions)	0.00	C	5, 74	16 200	19, 924	14
. 00	CAH visits						15
. 10	REH hours and visits						15
. 00	SUBPROVIDER – IPF						16
. 00	SUBPROVIDER – IRF	0.00	C	27	77 1	487	17
. 00	SUBPROVI DER						18
. 00	SKILLED NURSING FACILITY						19
. 00	NURSING FACILITY						20
. 00	OTHER LONG TERM CARE						21
. 00	HOME HEALTH AGENCY	0.00					22
. 00	AMBULATORY SURGICAL CENTER (D. P.)						23
. 00	HOSPI CE	0.00					24
. 10	HOSPICE (non-distinct part)						24
. 00	CMHC - CMHC						25
o. 00	RURAL HEALTH CLINIC						26
. 25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26
. 00	Total (sum of lines 14-26)	0.00					27
. 00	Observation Bed Days						28
00	Ambul ance Trips						29
00 .	Employee discount days (see instruction)						30
. 00	Employee discount days - IRF						31
2.00	Labor & delivery days (see instructions)						32
2. 01	Total ancillary labor & delivery room						32
3. 00	outpatient days (see instructions) LTCH non-covered days				0		33
3.00 3.01	LTCH non-covered days LTCH site neutral days and discharges				0		33
J. UI	LETON SELE HEULTAL UAYS AND ULSUNALYES			1	VI		1 33

	inancial Systems WAGE INDEX INFORMATION	1 1	ANCISCAN HEALTH	Provi der C	CN: 15-0162	Period: From 01/01/2023	worksheet S-3	
						To 12/31/2023		
		Wkst. A Line Number		Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col 3)	Related to	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
PA	ART II - WAGE DATA	1.00	2.00	0.00	1.00	0.00	0.00	
	ALARI ES							1
	otal salaries (see nstructions)	200. 00	205, 922, 580	0	205, 922, 58	0 5, 104, 870. 00	40. 34	1.
DO N	on-physician anesthetist Part		0	0		0 0.00	0.00	2
00 N	on-physician anesthetist Part		0	0		0 0.00	0.00	3
	, hysician-Part A - dministrative		0	0		0 0.00	0.00	4
	hysicians - Part A - Teaching		1, 665, 294	0	1, 665, 29	4 12, 980. 00	128.30	4
00 P	hysician and Non hysician-Part B		2, 988, 164	0	2, 988, 16			
00 N h	lon-physician-Part B for ospital-based RHC and FQHC ervices		0	0		0 0.00	0. 00	6
00 1	nterns & residents (in an pproved program)	21.00	5, 800, 692	-3, 567, 849	2, 232, 84	.3 66, 985. 00	33. 33	7
01 C	iontracted interns and esidents (in an approved rograms)		0	0		0 0.00	0. 00	7
о н	lome office and/or related Irganization personnel		0	0		0 0.00	0.00	8
	NF	44.00	0	0		0 0.00	0.00	9
00 E	xcluded area salaries (see nstructions)	11.00	19, 346, 963	1, 603, 275	20, 950, 23			
	THER WAGES & RELATED COSTS				1			
00 C	contract labor: Direct Patient		32, 182, 741	0	32, 182, 74	1 306, 134. 00	105.13	11
00 C	are contract Labor: Top Level		0	0		0 0.00	0.00	12
m	anagement and other anagement and administrative ervices							
00 C	contract Labor: Physician-Part - Administrative		317, 445	0	317, 44	5 2, 357. 50	134.65	13
00 H	lome office and/or related organization salaries and		О	0		0 0.00	0.00	14
	age-related costs							
	ome office salaries		76, 907, 516	0	76, 907, 51			
02 R 00 H	elated organization salaries Iome office: Physician Part A		0	0		0 0.00 0 0.00		
	Administrative		0	0		0.00	0.00	15
оо н	ome office and Contract		0	0		0 0.00	0.00	16
01 H	hysicians Part A - Teaching Iome office Physicians Part A		0	0		0 0.00	0.00	16
02 H	Teaching Iome office contract		0	0		0 0.00	0.00	16
	hysicians Part A - Teaching							
00 W	AGE-RELATED COSTS lage-related costs (core) (see		42, 345, 949	-329, 698	42, 016, 25	1		17
00 W	nstructions) lage-related costs (other)							18
	see instructions)		4 004 504	220 (22				10
	xcluded areas Ion-physician anesthetist Part		4, 821, 531 0	329, 698 0	5, 151, 22	0		19 20
00 N	on-physician anesthetist Part		0	0		0		21
	hysician Part A - dministrative		0	0		0		22
	dministrative hysician Part A – Teaching		263, 918	0	263, 91	8		22
	hysician Part B		455 872	0	455 87			23

455, 872

578, 131

20, 920, 426

0

0

0

0

0

0

0

0

0

455, 872

578, 131

20, 920, 426

0

0

0

23.00

24.00

25.00

25.50

25.51

25.52

23.00 Physician Part B

(core)

25.00

25.50

25.51

25.52

24.00 Wage-related costs (RHC/FQHC)

approved program)

wage-related (core)

Interns & residents (in an

Related organization wage-related (core) Home office: Physician Part A - Administrative -

Home office wage-related

Heal th	Financial Systems	FR	ANCISCAN HEALT	H INDIANAPOLIS		In Lie	u of Form CMS-2	2552-10
HOSPI 1	AL WAGE INDEX INFORMATION			Provider C		Period: From 01/01/2023 To 12/31/2023		pared:
		Wkst. A Line Number		Reclassificati on of Salaries (from Wkst. A-6)		Related to	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A - Teaching - wage-related (core)		0	0		0		25. 53
	OVERHEAD COSTS - DI RECT SALARI I			4 (00.075			15.10	
26.00	Employee Benefits Department	4.00	2, 230, 115					
27.00	Administrative & General	5.00	5, 763, 335		5, 763, 33			
28.00	Administrative & General under contract (see inst.)		840, 660	0	840, 66	0 8, 189. 82	102.65	28.00
29.00	Maintenance & Repairs	6.00	0	0	1	0 0.00	0.00	29.00
30.00	Operation of Plant	7.00	3, 334, 956	0	3, 334, 95	6 104, 633.00	31.87	30.00
31.00	Laundry & Linen Service	8.00	188, 512	0	188, 51	2 8, 833.00	21.34	31.00
32.00	Housekeepi ng	9.00	3, 877, 925	0	3, 877, 92	5 191, 812.00	20. 22	32.00
33.00	Housekeeping under contract (see instructions)		2, 341, 339	0	2, 341, 33	9 71, 176. 44	32. 89	33.00
34.00	Dietary	10.00	2, 953, 633	-1, 710, 385	1, 243, 24	8 60, 235. 00	20.64	34.00
35.00	Dietary under contract (see instructions)		48, 118		48, 11			
36.00	Cafeteri a	11.00	717, 546	1, 710, 385	2, 427, 93	1 119, 803.00	20. 27	36.00
37.00	Maintenance of Personnel	12.00	0	0		0 0.00		37.00
38.00	Nursing Administration	13.00	3, 940, 356	0	3, 940, 35	6 94, 169. 00		
39.00	Central Services and Supply	14.00	803, 556		803, 55			
40.00	Pharmacy	15.00	6, 455, 666		6, 455, 66			40.00
41.00	Medi cal Records & Medi cal Records Library	16.00	0	0		0 0.00		41.00
42.00	Soci al Servi ce	17.00	0	0		0 0.00	0.00	42.00
43.00	Other General Service	18.00	0	0		0 0.00		43.00

Heal th	Financial Systems	FR	ANCI SCAN HEALT	TH INDIANAPOLIS		In Lie	eu of Form CMS-2	2552-10
HOSPITAL WAGE INDEX INFORMATION				Provider CC		Period: From 01/01/2023 To 12/31/2023		
		Worksheet A		Recl assi fi cati			Average Hourly	
		Line Number	Reported	on of Salaries			Wage (col. 4 ÷	
				(from	(col.2 ± col.		col. 5)	
				Worksheet A-6)	/	col. 4		
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY				_		
1.00	Net salaries (see		198, 698, 547	3, 567, 849	202, 266, 39	6 5, 086, 367. 51	39.77	1.00
	instructions)							
2.00	Excluded area salaries (see instructions)		19, 346, 963	1, 603, 275	20, 950, 23	8 495, 205. 00	42. 31	2.00
3.00	Subtotal salaries (line 1		179, 351, 584	1, 964, 574	181, 316, 15	8 4, 591, 162. 51	39. 49	3.00
	minus line 2)							
4.00	Subtotal other wages & related costs (see inst.)		109, 407, 702	0	109, 407, 70	2 2, 300, 387. 50	47.56	4.00
5.00	Subtotal wage-related costs (see inst.)		63, 266, 375	-329, 698	62, 936, 67	7 0.00	34. 71	5.00
6.00	Total (sum of lines 3 thru 5)		352, 025, 661	1, 634, 876	353, 660, 53	7 6, 891, 550. 01	51.32	6,00
7.00	Total overhead cost (see instructions)		33, 495, 717					

	Financial Systems FRANCISCAN HEALTH AL WAGE RELATED COSTS	INDIANAPOLIS Provider CCN: 15-0162	Peri od:	u of Form CMS-2 Worksheet S-3	
			From 01/01/2023	Part IV	
			To 12/31/2023		
				3/28/2024 2:2	<u>1 pm</u>
				Amount	
				Reported	
	PART IV - WAGE RELATED COSTS			1.00	
	Part A - Core List				-
	RETIREMENT COST				+
00	401K Employer Contributions			5, 671, 516	1 1.
00	Tax Sheltered Annuity (TSA) Employer Contribution			3, 071, 310	
00	Nonqualified Defined Benefit Plan Cost (see instructions)			0	
00	Qualified Defined Benefit Plan Cost (see instructions)			7, 918, 874	
00	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)			7, 910, 074	4.
00	401K/TSA Plan Administration fees			0	1 5.
00	Legal /Accounting/Management Fees-Pension Plan			0	
00	Employee Managed Care Program Administration Fees			0	
00	HEALTH AND INSURANCE COST			0	· · ·
00	Health Insurance (Purchased or Self Funded)			0	8.
)1	Health Insurance (Self Funded without a Third Party Administ	rator)		0	-
02	Health Insurance (Self Funded with a Third Party Administrat			20, 734, 090	
)2)3	Heal th Insurance (Purchased)			20, 734, 070	
00	Prescription Drug Plan			0	
. 00	Dental, Hearing and Vision Plan			630, 452	
	Life Insurance (If employee is owner or beneficiary)			56, 368	
. 00	Accident Insurance (If employee is owner or beneficiary)			0	
	Disability Insurance (If employee is owner or beneficiary)			684, 051	
	Long-Term Care Insurance (If employee is owner or beneficiar	w)		004,001	
. 00	'Workers' Compensation Insurance	<i>y)</i>		985, 294	
	Retirement Health Care Cost (Only current year, not the extr	aordinary accrual require	d by FASB 106	903, 294	
. 00	Noncumulative portion)	abititially accidati require	a by 1855-100.	0	
	TAXES				
00	FICA-Employers Portion Only			11, 784, 758	1 17
	Medicare Taxes - Employers Portion Only			0	
	Unemployment Insurance			0	
	State or Federal Unemployment Taxes			0	
	OTHER				1
. 00	Executive Deferred Compensation (Other Than Retirement Cost	Reported on lines 1 throu	igh 4 above. (see	0	21.
	instructions))	•		-	
. 00	Day Care Cost and Allowances			0	22
. 00	Tuition Reimbursement			0	23
. 00	Total Wage Related cost (Sum of lines 1 -23)			48, 465, 403	24.
	Part B - Other than Core Related Cost				1
00	OTHER WAGE RELATED COSTS (SPECIFY)				1 25.

Heal th	Financial Systems	FRANCI SCAN HEALTH I NDI ANAPOLI S	In Lie	u of Form CMS-2	2552-10
HOSPI T	AL CONTRACT LABOR AND BENEFIT COST	Provider CCN: 15-0162	Peri od:	Worksheet S-3	
			From 01/01/2023	Part V	
			To 12/31/2023	Date/Time Pre 3/28/2024 2:2	
	Cost Center Description		Contract Labor		i piii
			1.00	2.00	
	PART V - Contract Labor and Benefit Cost			2100	
	Hospital and Hospital-Based Component Ide	nti fi cati on:			
1.00	Total facility's contract labor and benef		32, 182, 741	48, 465, 403	1.00
2.00	Hospi tal		32, 182, 741	48, 465, 403	2.00
3.00	SUBPROVIDER - IPF				3.00
4.00	SUBPROVIDER - IRF		0	0	4.00
5.00	Subprovider - (Other)		0	0	5.00
6.00	Swing Beds - SNF		0	0	6.00
7.00	Swing Beds - NF		0	0	7.00
8.00	SKILLED NURSING FACILITY				8.00
9.00	NURSING FACILITY				9.00
10.00	OTHER LONG TERM CARE I				10.00
11.00	Hospital-Based HHA		0	0	11.00
12.00	AMBULATORY SURGICAL CENTER (D. P.) I				12.00
13.00	Hospi tal -Based Hospi ce		0	0	13.00
14.00	Hospital-Based Health Clinic RHC				14.00
15.00	Hospital-Based Health Clinic FQHC				15.00
16.00	Hospi tal -Based-CMHC				16.00
17.00	RENAL DIALYSIS I		0	0	
18.00	Other		0	0	18.00

HOSPI T	AL-BASED HOSPICE IDENTIFICATION	DATA		Provider CO Hospice CCI	CN: 15-0162 N: 15-1523	Period: From 01/01/2023 To 12/31/2023		GH IV pared:
						Hospi ce I		
		Unduplicated						
		Days						
		Title XVIII	Title XIX	Title XVIII	Title XIX	All Other	Total (sum of	
				Skilled	Nursi ng		cols. 1, 2 &	
				Nursi ng	Facility		5)	
				Facility				
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART I - ENROLLMENT DAYS FOR CO	OST REPORTING F	PERIODS BEGINNI	NG BEFORE OCTO	BER 1, 2015			
1.00	Hospice Continuous Home Care							1.00
2.00	Hospice Routine Home Care							2.0
3.00	Hospice Inpatient Respite Care							3.0
1.00	Hospice General Inpatient Care							4.0
5.00	Total Hospice Days							5.0
	Part II - CENSUS DATA FOR COST	REPORTING PERI	ODS BEGI NNI NG	BEFORE OCTOBER	1, 2015			
5.00	Number of patients receiving							6.00
	hospice care							
7.00	Total number of unduplicated							7.0
	Continuous Care hours billable							
	to Medicare							
3.00	Average Length of Stay (line 5							8.0
9.00	/ line 6) Unduplicated census count							9.0
								9.00
UTE:	Parts I and II, columns 1 and 2	also include	the days report	ted in columns	3 and 4.			
				Title XVIII	Title XIX	Other	Total (sum of	
							col s. 1	
							through 3)	
				1.00	2.00	3.00	4.00	
	PART III - ENROLLMENT DAYS FOR	COST REPORTING	S PERIODS BEGIN			2015		
	Hospice Continuous Home Care			0		0 0		10.0
	Hospice Routine Home Care			15, 475		75 2, 001	17, 951	•
	Hospice Inpatient Respite Care			416		5 45		12.0
13.00	Hospice General Inpatient Care			12		3 0		13.00
14.00	Total Hospice Days			15, 903	49	33 2,046	18, 432	1110

0 15.00 0 16.00

 PART IV - CONTRACTED STATISTICAL DATA FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015

 15.00
 Hospice Inpatient Respite Care
 0
 0
 0

 16.00
 Hospice General Inpatient Care
 0
 0
 0

0

Heal th	Financial Systems FRANCISCAN HEALTH IN	DI ANAPOLI S		In Lie	eu of Form CMS-2	2552-10
HOSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CC	N: 15-0162	Peri od: From 01/01/2023 To 12/31/2023	Date/Time Pre	pared:
	· · · · ·				3/28/2024 2:2	1 pm
					1.00	
	PART I - HOSPITAL AND HOSPITAL COMPLEX DATA				1.00	
	Uncompensated and Indigent Care Cost-to-Charge Ratio					1
1.00	Cost to charge ratio (see instructions)				0. 175122	1 1.00
	Medicaid (see instructions for each line)				01110122	1
2.00	Net revenue from Medicaid				118, 059, 017	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?				N	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplement	al payments	s from Medica	ai d?	1	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments fr	om Medicaio	b		0	5.00
6.00	Medi cai d charges				564, 037, 714	6.00
7.00	Medicaid cost (line 1 times line 6)				98, 775, 413	7.00
8.00	Difference between net revenue and costs for Medicaid program (see instruc	ctions)		0	8.00
	Children's Health Insurance Program (CHIP) (see instructions fo	r each line	e)			
9.00	Net revenue from stand-alone CHIP				0	
10.00	Stand-alone CHIP charges				0	
11.00	Stand-alone CHIP cost (line 1 times line 10)				0	
12.00	Difference between net revenue and costs for stand-alone CHIP (0	12.00
	Other state or local government indigent care program (see inst					
13.00	Net revenue from state or local indigent care program (Not incl				0	
14.00	Charges for patients covered under state or local indigent care	e program (N	Not included	in lines 6 or	0	14.00
						15 00
15.00	State or local indigent care program cost (line 1 times line 14				0	
16.00	Difference between net revenue and costs for state or local inc				0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHI instructions for each line)	P and state		jent care progran	is (see	
17.00	Private grants, donations, or endowment income restricted to fu	indi na chari	ty care		0	17.00
18.00	Government grants, appropriations or transfers for support of h	0	2		0	
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local			s (sum of lines	0	
17.00	8, 12 and 16)	indigent e			Ĭ	17.00
			Uni nsured	Insured	Total (col. 1	
			patients	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)		50, 360, 59			•
21.00	Cost of patients approved for charity care and uninsured discou	ints (see	8, 819, 2	11, 877, 019	20, 696, 267	21.00
~~ ~~	instructions)	66				
22.00	Payments received from patients for amounts previously written	off as		0 0	0	22.00
22.00	charity care		0 010 0	11 077 010		0.00
23.00	Cost of charity care (see instructions)		8, 819, 2	11, 877, 019	20, 696, 267	23.00
					1.00	
24.00	Does the amount on line 20 col. 2, include charges for patient	dave boyon	ha longth of	² ctav limit	N 1.00	24.00
24.00	imposed on patients covered by Medicaid or other indigent care			Stay Trimit		24.00
25.00	If line 24 is yes, enter the charges for patient days beyond th		care program	's length of	0	25.00
25.00	stay limit	ie margent	care progra	i s rength of	Ĭ	20.00
25.01	Charges for insured patients' liability (see instructions)				0	25.01
26.00	5					
27.00						
27.01						
28.00 Non-Medicare bad debt amount (see instructions) 18,597,8						•
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amo	ounts (see i	nstructions?	1	3, 530, 690	•
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)				24, 226, 957	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus li	ne 30)			24, 226, 957	31.00

In Lieu of Form CMS-2552-10

N: 15-0162 Period From (To 1	01/01/2023	Worksheet S Parts I & I Date/Time F 3/28/2024 2	l Prepared:
		1.00	

				1.00		
	PART II – HOSPITAL DATA					
	Uncompensated and Indigent Care Cost-to-Charge Ratio					
1.00	Cost to charge ratio (see instructions)			0. 172025	1.00	
	Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid				2.00	
3.00	Did you receive DSH or supplemental payments from Medicaid?				3.00	
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payment		1?		4.00	
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicai	d			5.00	
6.00	Medi cai d charges				6.00	
7.00	Medicaid cost (line 1 times line 6)				7.00	
8.00	Difference between net revenue and costs for Medicaid program (see instru				8.00	
	Children's Health Insurance Program (CHIP) (see instructions for each lin	ie)				
9.00	Net revenue from stand-al one CHIP				9.00	
10.00	Stand-al one CHIP charges				10.00	
11.00					11.00	
12.00	Difference between net revenue and costs for stand-alone CHIP (see instru				12.00	
13.00	Other state or local government indigent care program (see instructions f Net revenue from state or local indigent care program (Not included on li				13.00	
14.00	Charges for patients covered under state or local indigent care program (Not included on in		lines 4 or		14.00	
14.00	(10)				14.00	
15.00	State or local indigent care program cost (line 1 times line 14)				15.00	
16.00	Difference between net revenue and costs for state or local indigent care	nstructions)		16.00		
10.00	Grants, donations and total unreimbursed cost for Medicaid, CHIP and stat		,	ns (see	10.00	
	instructions for each line)					
17.00	Private grants, donations, or endowment income restricted to funding char		17.00			
18.00	00 Government grants, appropriations or transfers for support of hospital operations					
19.00					19.00	
	8, 12 and 16)					
		Uni nsured	Insured	Total (col. 1		
		patients	patients	+ col . 2)		
		1.00	2.00	3.00		
20.00	Uncompensated care cost (see instructions for each line) Charity care charges and uninsured discounts (see instructions)	49, 748, 438	11, 835, 730	61, 584, 168	20.00	
20.00	Cost of patients approved for charity care and uninsured discounts (see	8, 557, 975	11, 835, 730			
21.00	instructions)	0, 337, 773	11,000,700	20, 373, 703	21.00	
22.00	Payments received from patients for amounts previously written off as	0	0	0	22.00	
	charity care		-	_		
23.00	Cost of charity care (see instructions)	8, 557, 975	11, 835, 730	20, 393, 705	23.00	
				1.00		
24.00	Does the amount on line 20 col. 2, include charges for patient days beyor	nd a length of s	stay limit	N	24.00	
	imposed on patients covered by Medicaid or other indigent care program?					
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent	care program's	length of	0	25.00	
	stay limit					
25.01	Charges for insured patients' liability (see instructions)	0				
26.00	Bad debt amount (see instructions)	19, 329, 762				
27.00	Medicare reimbursable bad debts (see instructions)	508, 475	•			
27.01	Medicare allowable bad debts (see instructions)	782, 269				
20 00			18, 547, 493			
		I potrouot!>		2 4/ 4 40/		
	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see	instructions)		3, 464, 426		
29. 00 30. 00		instructions)		3, 464, 426 23, 858, 131 23, 858, 131	30.00	

LASSIFI	ICATION AND ADJUSTMENTS OF TRIAL BALANCE OF	EXPENSES	Provider CO	F	eriod: rom 01/01/2023 o 12/31/2023	Worksheet A	nor
	Cost Center Description	Sal ari es	Other		o 12/31/2023 Reclassificati ons (See A-6)	Date/Time Pre 3/28/2024 2:2 Reclassified Trial Balance	
				1 001. 2)		(col. 3 +-	
	-	1.00	2.00	3.00	4.00	col. 4) 5.00	
GEN	ERAL SERVICE COST CENTERS	1.00	2.00	3.00	4.00	3.00	
	00 CAP REL COSTS-BLDG & FIXT		0				
	COD CAP REL COSTS-MVBLE EQUIP		0	-			2
	OO EMPLOYEE BENEFITS DEPARTMENT	2, 230, 115	1, 792, 790				
		0	-9	-9	-	-19	5
	80 CASHI ERI NG/ACCOUNTS RECEI VABLE 90 OTHER ADMIN & GENERAL	0 E 742 22E	0	0 80, 897, 096		0	5
	00 OPERATION OF PLANT	5, 763, 335 3, 334, 956	75, 133, 761 12, 647, 213			77, 391, 826 12, 304, 340	
	00 LAUNDRY & LINEN SERVICE	188, 512	1, 738, 710			1, 923, 371	8
	DOO HOUSEKEEPI NG	3, 877, 925	4, 915, 376			8, 723, 876	
00 010	00 DI ETARY	2, 953, 633	2, 564, 704	5, 518, 337	-3, 056, 045	2, 462, 292	10
	00 CAFETERI A	717, 546	1, 555, 273				
	00 NURSING ADMINISTRATION	3, 940, 356	259, 428			4, 104, 957	13
	00 CENTRAL SERVICES & SUPPLY	803, 556	2, 986, 541			3, 180, 756	
	00 PHARMACY 00 MEDI CAL RECORDS & LI BRARY	6, 455, 666 0	26, 419, 623 28, 593			6, 643, 684 28, 593	
	00 I &R SERVICES-SALARY & FRINGES APPRV	5, 800, 692	1, 174, 987			2, 373, 984	
	00 I &R SERVICES-OTHER PRGM COSTS APPRV	0,000,072	0				
	00 MEDICAL LABORATORY SCIENTIST PRGM	42, 889	5, 423			46, 698	
01 023	02 PHARMACY PRGM	308, 439	17, 889			326, 328	23
	01 EMERGENCY MEDICAL SERVICES	699, 285	91, 052				
	03 PARAMEDI C PRGM	0	0	0			
	SURGICAL TECH PROGRAM	149, 725	45, 747	195, 472	-3, 649	191, 823	23
	ATI ENT ROUTI NE SERVI CE COST CENTERS	36, 073, 813	27, 227, 740	63, 301, 553	-15, 388, 283	47, 913, 270	30
	00 I NTENSI VE CARE UNI T	8, 905, 417	3, 016, 538			10, 240, 234	
	60 NEONATAL INTENSIVE CARE UNIT	4, 303, 614	2, 277, 377			6, 077, 168	
	COO CORONARY CARE UNI T	10, 170, 615	3, 951, 759				
	OO SURGICAL INTENSIVE CARE UNIT	8, 061, 098	1, 886, 735		-703,063	9, 244, 770	34
	00 SUBPROVIDER - IRF	3, 689, 952	775, 810				
	NURSERY	0	0	0	1, 366, 964	1, 366, 964	43
	ILLARY SERVICE COST CENTERS	13, 690, 878	51, 928, 567	65, 619, 445	-39, 541, 950	26, 077, 495	50
	OO DELIVERY ROOM & LABOR ROOM	3, 237, 597	937, 780				
00 054	00 RADI OLOGY-DI AGNOSTI C	9, 530, 999	14, 619, 513	24, 150, 512	-8, 097, 262		
	600 RADI OLOGY-THERAPEUTI C	1, 330, 442	11, 096, 751				
	00 RADI OI SOTOPE	239, 528	765, 627				
	000 CARDI AC CATHETERI ZATI ON 000 LABORATORY	2,833,072	24, 823, 161 28, 122, 679				
	00 I NTRAVENOUS THERAPY	566, 405 4, 358, 225	48, 158, 988				
	00 RESPIRATORY THERAPY	8, 949, 731	3, 677, 459				
	000 PHYSI CAL THERAPY	5, 885, 546	1, 171, 528				
	OO OCCUPATIONAL THERAPY	2, 684, 953	175, 102			2, 707, 444	
	BOO SPEECH PATHOLOGY	1, 215, 101	366, 930			1, 361, 144	
	00 ELECTROCARDI OLOGY	1, 279, 937	706, 317			1, 494, 256	
	00 ELECTROENCEPHALOGRAPHY	1, 922, 666	677, 062				
	00 MEDICAL SUPPLIES CHARGED TO PATIENT 200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0		51, 448, 323 31, 441, 379	
	00 DRUGS CHARGED TO PATIENTS	0	0	0	83, 985, 983	83, 985, 983	
	00 RENAL DIALYSIS	0	1, 450, 211	1, 450, 211		1, 398, 317	74
	97 CARDI AC REHABI LI TATI ON	549, 755	162, 300	712, 055		560, 919	
	OO ALLOGENEIC HSCT ACQUISITION	0	0	0	1, 505, 398	1, 505, 398	77
	CAR T-CELL IMMUNOTHERAPY	0	0	0	6, 117, 348	6, 117, 348	78
	PATIENT SERVICE COST CENTERS	E 404 044	1.0/0.40/	(107 152	1 000 000	7 504 050	
	000 CLINIC 001 IBMT JOINT VENTURE	5, 134, 044 1, 696, 268	1, 063, 106 5, 874, 928			7, 526, 958 2, 167, 324	90
	02 MOORESVILLE INFUSION CLINIC	28, 209	5, 874, 928 407, 813			2, 167, 324 30, 242	
	05 CV DI AGNOSTI C SERVICES	9, 116, 121	3, 659, 821	12, 775, 942		9, 723, 646	
	00 EMERGENCY	8, 745, 291	5, 478, 519				
	00 OBSERVATION BEDS (NON-DISTINCT PART						92
	ER REIMBURSABLE COST CENTERS						1.
	00 HOME HEALTH AGENCY	0	6				101
	200 OPI OI D TREATMENT PROGRAM CIAL PURPOSE COST CENTERS	0	0	0	0	0	102
	00 INTEREST EXPENSE		0	0	0	0	113
	00 HOSPI CE	6, 157, 987	1, 792, 734		-610, 705	7, 340, 016	
. 00	SUBTOTALS (SUM OF LINES 1 through 117)	197, 623, 894	377, 629, 962				
	REIMBURSABLE COST CENTERS			-	1		
	000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	407, 309	377, 404				
	200 PHYSICIANS' PRIVATE OFFICES 255 MARKETING & COMMUNITY RELATIONS	6, 010, 910 60, 713	1, 305, 008 136			9, 196, 256 60, 849	
001070							

Health Financial Systems F	RANCISCAN HEALT	H INDIANAPOLIS		In Lie	u of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE (OF EXPENSES	Provider CC		Period:	Worksheet A	
				From 01/01/2023 To 12/31/2023	Date/Time Pre 3/28/2024 2:2	
Cost Center Description	Sal ari es	0ther	Total (col. 1	Reclassi fi cati	Recl assi fi ed	
			+ col. 2)	ons (See A-6)	Trial Balance	
					(col. 3 +-	
					col. 4)	
	1.00	2.00	3.00	4.00	5.00	
194.0207950 OTHER NONREIMBURSABLE COST CENTERS	0	0		0 0	0	194.02
194.04 07954 OTHER NRCC	1, 819, 754	66, 331, 506	68, 151, 26	0 -15, 242, 498	52, 908, 762	194.04
194. 05 07956 FOUNDATI ON	0	0		0 0	0	194.05
200.00 TOTAL (SUM OF LINES 118 through 199)	205, 922, 580	445, 644, 016	651, 566, 59	6 0	651, 566, 596	200. 00

ECLAS	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE	OF EXPENSES	Provider CCN: 15-01	62 Period: From 01/01/2023	Worksheet A
				To 12/31/2023	Date/Time Prepare 3/28/2024 2:21 pm
	Cost Center Description	Adjustments	Net Expenses	I	
		(See A-8) 6.00	For Allocation 7.00		
	GENERAL SERVICE COST CENTERS	0.00	7.00		
. 00	00100 CAP REL COSTS-BLDG & FIXT	11, 279, 224	39, 949, 429		1.
00	00200 CAP REL COSTS-MVBLE EQUIP	6, 013, 630	16, 068, 747		2
. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	-582, 584	619, 948		4
01	00570 ADMI TTI NG	0	-19		5
02	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	0	0		5
03	00590 OTHER ADMIN & GENERAL	123, 454, 202	200, 846, 028		5
00 00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	6, 808, 978 -3, 490	19, 113, 318 1, 919, 881		7.
00	00900 HOUSEKEEPING	-3,490	8, 723, 876		9
0.00	01000 DI ETARY	-23, 951	2, 438, 341		10
. 00	01100 CAFETERIA	-2, 606, 399	2, 229, 603		11
	01300 NURSI NG ADMI NI STRATI ON	348, 441	4, 453, 398		13
	01400 CENTRAL SERVICES & SUPPLY	-200, 037	2, 980, 719		14
	01500 PHARMACY	1, 530, 419	8, 174, 103		15
. 00	01600 MEDI CAL RECORDS & LI BRARY	3, 881, 273	3, 909, 866		16
. 00	02100 I &R SERVICES-SALARY & FRINGES APPRV	-98, 061	2, 275, 923		21
	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	-781, 489	1, 046, 751		22
8.00	02300 MEDICAL LABORATORY SCIENTIST PRGM	-10, 749	35, 949		23
	02302 PHARMACY PRGM	-283	326, 045		23
	02301 EMERGENCY MEDICAL SERVICES	-534, 472	144, 837		23
. 03	02303 PARAMEDI C PRGM	0	100,000		23
8. 04	02305 SURGI CAL TECH PROGRAM	-31, 182	160, 641		23
. 00	03000 ADULTS & PEDI ATRI CS	-12, 567	47, 900, 703		30
. 00	03100 I NTENSI VE CARE UNI T	-35, 625	10, 204, 609		31
	02060 NEONATAL INTENSIVE CARE UNIT	-394, 851	5, 682, 317		31
	03200 CORONARY CARE UNI T	0	12, 954, 862		32
	03400 SURGICAL INTENSIVE CARE UNIT	-48	9, 244, 722		34
I. 00	04100 SUBPROVIDER - IRF	-6, 700	4, 326, 909		41
3.00	04300 NURSERY	0	1, 366, 964		43
	ANCI LLARY SERVICE COST CENTERS				
	05000 OPERATING ROOM	-6, 340, 692	19, 736, 803		50
2.00	05200 DELIVERY ROOM & LABOR ROOM	-154	3, 486, 984		52
. 00 5. 00	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	-71, 979	15, 981, 271		54
b. 00	05600 RADI OLOGI - THERAPEUTI C	-3, 010, 384 0	8, 817, 201 280, 020		56
9.00 9.00	05900 CARDI AC CATHETERI ZATI ON	-322, 801	2, 754, 019		59
. 00	06000 LABORATORY	-31,050	23, 985, 565		60
. 00	06400 I NTRAVENOUS THERAPY	-1, 145, 001	4,069,728		64
5.00	06500 RESPI RATORY THERAPY	-31,871	9, 775, 709		65
. 00	06600 PHYSI CAL THERAPY	-14, 716	5, 917, 060		66.
. 00	06700 OCCUPATI ONAL THERAPY	-49, 905	2, 657, 539		67
	06800 SPEECH PATHOLOGY	-17, 348			68
	06900 ELECTROCARDI OLOGY	-178, 970	1, 315, 286		69
	07000 ELECTROENCEPHALOGRAPHY	-187, 316	1, 922, 913		70
	07100 MEDI CAL SUPPLIES CHARGED TO PATIENT	-1, 952, 631	49, 495, 692		71
. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	-1, 140, 594	30, 300, 785		72
. 00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DI ALYSI S	0	83, 985, 983 1, 398, 317		73.
. 00	07400 RENAL DIALYSIS 07697 CARDIAC REHABILITATION	0	560, 919		74
. 97 . 00	07700 ALLOGENEIC HSCT ACQUISITION	0	1, 505, 398		77
. 00	07800 CAR T-CELL IMMUNOTHERAPY	0	6, 117, 348		78
	OUTPATIENT SERVICE COST CENTERS				
. 00	09000 CLINIC	-1, 165, 941	6, 361, 017		90
. 01	09001 I BMT JOINT VENTURE	-724, 305	1, 443, 019		90
. 02	09002 MOORESVILLE INFUSION CLINIC	0	30, 242		90
. 05	09005 CV DIAGNOSTIC SERVICES	-847, 831	8, 875, 815		90
. 00	09100 EMERGENCY	-108, 686	12, 627, 758		91
2.00	09200 OBSERVATION BEDS (NON-DISTINCT PART				92
	OTHER REIMBURSABLE COST CENTERS	0	0		101
	10100 HOME HEALTH AGENCY				

90. 00 09000 CLINIC	-1, 165, 941	6, 361, 017	9	0.00
90.01 09001 IBMT JOINT VENTURE	-724, 305	1, 443, 019	9	0. 01
90.02 09002 MOORESVILLE INFUSION CLINIC	0	30, 242	9	0. 02
90. 05 09005 CV DIAGNOSTIC SERVICES	-847, 831	8, 875, 815	9	0. 05
91.00 09100 EMERGENCY	-108, 686	12, 627, 758	9	1.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART			9	2.00
OTHER REIMBURSABLE COST CENTERS				
101.00 10100 HOME HEALTH AGENCY	0	0	10	1.00
102.00 10200 OPI OI D TREATMENT PROGRAM	0	0	10	2.00
SPECIAL PURPOSE COST CENTERS				
113.00 11300 INTEREST EXPENSE	0	0	11	3.00
116. 00 11600 H0SPI CE	-762, 687	6, 577, 329	11	6.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	129, 888, 817	718, 521, 986	11	8.00
NONREI MBURSABLE COST CENTERS				
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	767, 560	19	0.00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	-1, 777, 733	7, 418, 523	19	2.00
194.0007955 MARKETING & COMMUNITY RELATIONS	-2, 924	57, 925	19	4.00
194.0107952 WOMEN'S CENTER	0	0	19	4.01
194.0207950 OTHER NONREIMBURSABLE COST CENTERS	0	0	19	4. 02
194.04 07954 0THER NRCC	29, 216, 259	82, 125, 021	19	4.04
-				

Health Financial Systems Fi	RANCISCAN HEALTH	I INDI ANAPOLI S	In Lieu of Form CMS-2552-10		
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provider CCN: 15-0162	Period: From 01/01/2023	Worksheet A	
				Date/Time Prepared: 3/28/2024 2:21 pm	
Cost Center Description	Adjustments	Net Expenses	_		
	(See A-8) F	For Allocation			
	6.00	7.00			
194. 05 07956 FOUNDATI ON	14, 987	14, 987		194.05	
200.00 TOTAL (SUM OF LINES 118 through 199)	157, 339, 406	808, 906, 002		200.00	

RECLASSI FI CATI ONS Provider CCN: 15-0162 Peri od: Worksheet A-6 From 01/01/2023 То 12/31/2023 Date/Time Prepared: 3/28/2024 2:21 pm Increases Cost Center Line # Sal ary 0ther 2.00 3.00 4.00 5.00 - MEDICAL SUPPLIES 1.00 MEDICAL SUPPLIES CHARGED TO 71.00 0 51, 448, 323 1.00 PATI ENT 2.00 IMPL. DEV. CHARGED TO 72.00 0 31, 441, 379 2.00 PATI ENTS 3.00 0.00 0 0 3.00 4.00 0.00 0 0 4.00 5.00 0.00 0 0 5.00 0 0.00 0 6.00 6.00 0 0 7.00 0.00 7.00 8.00 0.00 0 0 8.00 9.00 0.00 0 0 9.00 0 0 10.00 0.00 10.00 0 11.00 0.00 0 11.00 12.00 0.00 0 0 12.00 0 13.00 0.00 0 0 0 13.00 0 0.00 14.00 14.00 15.00 0.00 0 15.00 0.00 0 16.00 0 0 0 16.00 0 17 00 0 00 17 00 18.00 0.00 18.00 19.00 0.00 0 0 19.00 0 0 20.00 0.00 20.00 0 0 0.00 21 00 21.00 22.00 0.00 0 22.00 0 0 23.00 0.00 23.00 0 0 24 00 0.00 24 00 0 25.00 0.00 25.00 0 26.00 0.00 0 26.00 0 27.00 0.00 0 0 0 27.00 0 28 00 0 00 28 00 0 29.00 0.00 29.00 30.00 0.00 0 0 30.00 0 0 31.00 0.00 31.00 0 32.00 0.00 32.00 33.00 0.00 0 33.00 34.00 0.00 0 0 34.00 0 0 0 35.00 0.00 35.00 36.00 0.00 36.00 37.00 0.00 0 0 37.00 38.00 0.00 0 0 38.00 0 0 39.00 0.00 39.00 0 0 40.00 0.00 40.00 41.00 0.00 0 0 41.00 TOTALS 82, 889, 702 B - DRUG 1.00 DRUGS CHARGED TO PATIENTS 83, 985, 983 73.00 0 1.00 2.00 0.00 0 0 2.00 0 3.00 0.00 0 3.00 0.00 0 0 4.00 4.00 5.00 0.00 0 0 5.00 0 0 6.00 0.00 6.00 0 0 0 7.00 0.00 7.00 8.00 0.00 0 8.00 0 0 9.00 0.00 0 9.00 0 10.00 0.00 10.00 0 0 11.00 0.00 11.00 0 12.00 0.00 0 12.00 0.00 0 0 13.00 13.00 0 0 14.00 0.00 14.00 0.00 0 15.00 15.00 0 16.00 0.00 0 16.00 0.00 0 17.00 0 0 0 17.00 0 18 00 0 00 18 00 19.00 0.00 19.00 20.00 0.00 0 0 20.00 0 0 21.00 0.00 21.00 0 0 0.00 22.00 22.00 23.00 0.00 0 23.00 24.00 0.00 0 0 24.00 0 0 0 0 25.00 0.00 25.00 0.00 26.00 26.00 0 27.00 0.00 0 27.00

0.00

0

0

FRANCI SCAN HEALTH INDIANAPOLIS

In Lieu of Form CMS-2552-10

28.00

28.00

Health Financial Systems

	Financial Systems	FF	RANCI SCAN HEALTH	INDIANAPOLIS Provider CCN: 15-0		worksheet A-6
					From 01/01/2023 To 12/31/2023	
	Cost Center	I ncreases Li ne #	Salary	Other		
29.00	2. 00	3.00	4.00 00	5.00 0 83,985,983		29.00
$\begin{array}{c} 1. \ 00\\ 2. \ 00\\ 3. \ 00\\ 4. \ 00\\ 5. \ 00\\ 7. \ 00\\ 8. \ 00\\ 9. \ 00\\ 10. \ 00\\ 11. \ 00\\ 12. \ 00\\ 12. \ 00\\ 13. \ 00\\ 14. \ 00\\ 15. \ 00\\ 14. \ 00\\ 15. \ 00\\ 17. \ 00\\ 21. \ 00\\ 22. \ 00\\ 21. \ 00\\ 22. \ 00\\ 23. \ 00\\ 24. \ 00\\ 25. \ 00\\ 25. \ 00\\ 27. \ 00\\ 27. \ 00\\ \end{array}$	C - EQUI PMENT LEASE CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUI P SPEECH PATHOLOGY	1.00 2.00 68.00 0.00 0.00 0.00 0.00 0.00 0.00		8, 013, 890 605, 088 104, 043 0 0 0 0 0 0 0 0 0 0 0 0 0		$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ 20.\ 00\\ 21.\ 00\\ 22.\ 00\\ 23.\ 00\\ 23.\ 00\\ 24.\ 00\\ 25.\ 00\\ 24.\ 00\\ 25.\ 00\\ 26.\ 00\\ 27.\ 00\\ \end{array}$
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 17.\ 00\\ 18.\ 00\\ 22.\ 00\\ 23.\ 00\\ 24.\ 00\\ 25.\ 00\\ 26.\ 00\\ 27.\ 00\\ 28.\ 00\\ 27.\ 00\\ 28.\ 00\\ 33.\ 00\\ 31.\ 00\\ 33.\ 00\\ 33.\ 00\\ 33.\ 00\\ 34.\ 00\\ 35.\ 00\\ 36.\ 00\\ 37.\ 00\\ 38.\ 00\\ 39.\ 00\\ 40.\ 00\\ 41.\ 00\\ 42.\ 00\\ 22.\ 00\\ 20.\ 00\\ 20.\ 00\\ 39.\ 00\\ 40.\ 00\\ 41.\ 00\\ 42.\ 00\\ 20.\ 00\\ 20.\ 00\\ 20.\ 00\\ 00\\ 00\\ 00\\ 00\\ 00\\ 00\\ 00\\ 00\\ 00$	TOTALS D - DEPRECIATION CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP			8, 723, 021 20, 656, 315 9, 450, 029 0 <td></td> <td>1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00 20.00 23.00 24.00 25.00 26.00 26.00 27.00 28.00 29.00 30.00 31.00 32.00 34.00 35.00 36.00 37.00 38.00 39.00 40.00 31.00 34.00 </td>		1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00 20.00 23.00 24.00 25.00 26.00 26.00 27.00 28.00 29.00 30.00 31.00 32.00 34.00 35.00 36.00 37.00 38.00 39.00 40.00 31.00 34.00

th Financial Systems LASSIFICATIONS	FR	ANCISCAN HEALTH	Provider CCN: 15-016	2 Period: From 01/01/2023	u of Form CMS-2552-10 Worksheet A-6
				To 12/31/2023	Date/Time Prepared: 3/28/2024 2:21 pm
Cost Center	Li ne #	Salary	Other		
2. 00	3.00	4.00	5.00		
00	0. 00 0. 00	0	0		43.00 44.00
TOTALS		0	30, 106, 344		44.00
E - CAFETERIA		4 740 005	1 004 (00		
0 <u>CAFETERI</u> A	<u>11.00</u>	<u>1, 710, 385</u> 1, 710, 385	<u>1,034,602</u> <u>1,034,602</u>		1.00
F - PARAMEDICAL ED		1, 110, 000	1,001,002		
		0	<u>0</u>		1.00
TOTALS G - INTERNS AND RESIDENT		U	0		
0 I &R SERVICES-OTHER PRGM	22.00	1, 719, 545	108, 695		1.00
COSTS APPRV	90.00	1 040 204	226 417		2.00
0 <u>CLINIC</u>		<u>1, 848, 304</u> 3, 567, 849	<u>326, 4</u> 17 435, 112		2.00
H - EMPLOYEE BENEFITS		£			
0 EMPLOYEE BENEFITS DEPARTM 0 MOORESVILLE INFUSION CLIN		0	367, 774 144		1.00 2.00
	0.00	0	0		3.00
0	0.00	0	0		4.00
0	0. 00 0. 00	0	0		5.00
0	0.00	0	Ő		7.00
0	0.00	0	0		8.00
0 00	0.00 0.00	0	0		9. 00 10. 00
00	0.00	0	Ö		11.00
00	0.00	0	0		12.00
00	0.00 0.00	0	0		13.00
00	0.00	0	0		14.00
00	0.00	0	0		16.00
00	0.00 0.00	0	0		17.00
00	0.00	0	0		18. 00 19. 00
00	0.00	0	0		20.00
00	0.00	0	0		21.00
00	0.00 0.00	0	0		22.00
00	0.00	Ō	0		24.00
00	0.00	0	0		25.00
00	0.00 0.00	0	0		26.00 27.00
00	0.00	Ö	Ö		28.00
00	0.00	0	0		29.00
00	0. 00 0. 00	0	0		30. 00 31. 00
00	0.00	õ	ō		32.00
00	0.00	0	0		33. 00 34. 00
00	0. 00 0. 00	0	0		34.00
00	0.00	O	0		36.00
00	0.00 0.00	0	0		37. 00 38. 00
00	0.00	0	0		38.00
TOTALS			367, 918		
I - PHARMACY RESIDENCY	0.00	0	0		1.00
TOTALS		0	<u>0</u>		
J - EMS & PARAMEDIC RECLA			100,000		
0 PARAMEDI C_PRGM	<u>23.03</u>	0	100,000		1.00
K - HOME HEALTH RECLASS		0	100,000		
O OTHER NRCC	194.04	0	<u>6</u> 6		1.00
TOTALS L - NURSERY		0	6		
0 NURSERY	43.00	1, 339, 934	27,030		1.00
0 <u>DELIVERY ROOM & LABOR</u> ROOM		180, 538	3, 642		2.00
TOTALS		1, 520, 472	30, 672		
N - ALLOGENEIC STEM CELL O ALLOGENEIC HSCT ACQUISITI	ON 77.00	0	1, 505, 398		1.00
	0.00	0	1,000,070		2.00
0	0.00	0	1, 505, 398		2.00

Heal th	Fi nanci al	Systems
DECLAS	SIELCATION	c

FRANCISCAN HEALTH INDIANAPOLIS

In Lieu of Form CMS-2552-10

RECLAS	SI FI CATI ONS			Provider (CCN: 15-0162	Period: From 01/01/2023 To 12/31/2023	Worksheet A- Date/Time Pr 3/28/2024 2:	epared:
		Increases						
	Cost Center	Line #	Sal ary	0ther				
	2.00	3.00	4.00	5.00				
	0 - T-CELL IMMUNOTHERAPY							
1.00	CAR T-CELL IMMUNOTHERAPY	78.00	2, 943, 330	3, 174, 018				1.00
2.00		0.00	0	0				2.00
	TOTALS		2, 943, 330	3, 174, 018				
	P - WORKING WELL							
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	1, 603, 275	530, 825				1.00
	TOTALS		1, 603, 275	530, 825				
500.00	Grand Total: Increases		11, 345, 311	212, 883, 601				500.00

Health Financial Systems RECLASSIFICATIONS

FRANCISCAN HEALTH INDIANAPOLIS

In Lieu of Form CMS-2552-10

Provider CCN: 15-0162

 Period:
 Worksheet A-6

 From 01/01/2023
 Date/Time Prepared:

 3/28/2024
 2:21 pm

Image: Solid Program Distor Distor Distor Distor A AMEDICAL SUPPLIS 0.00 0.00 0.00 1.00 1 A MEDICAL SUPPLIS 0.00 1.00 0.00 1.00 1 0.00 0.00 3.02 0 3.02 0 1.00 1 0.00 0.00 3.02 0 3.02 0 1.00 0.00 0.00 0.00 0.00 3.02 0 1.00 <							3/28/2024	
e.o.o. 7.00 8.00 9.00 10.00 AN ULL INSCREDUPTION 4.00 9.00 10.00 100 2.00 AUNI INSCREDUPTION 4.00 0.00 100 1.00 2.00 AUNI INSCREDUPTION 4.00 0.00 3.54 0 4.00 4.00 DELAR ION & CRAREN 7.00 0 3.54 0 4.00 4.00 DELAR ION & CRAREN 7.00 0 2.97 0 4.00 0.00 CALE ENA 10.00 0 2.97 0 0 2.07 0 3.00 0 4.00 10.00 CALE INAL SERVICES SERVICY 15.00 0 7.42,03 0 10.00							1	
A. A.<							-	
1.00 DIRUCYEE BEREFITS OLEMANIMENT 4.00 0 33.829 9 1 0 3.00 PREFATION OF FUNCTION 5.00 0 1.376 0 1.00 3.00 PREFATION OF FUNCTION 5.00 0 1.376 0 1.00 3.00 PREFATION OF FUNCTION 5.00 0 2.939 0 6.00 0.00 DELEXALPING 9.00 0 2.939 0 6.00 0.00 DELEXALPING 1.00 0 2.939 0 6.00 0.00 DELEXALPING 1.00 0 2.939 0 1.00 0.00 DELEXALPING 1.00 0 2.939 0 1.00 1.00 DEREXALPING 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 DEREXALPING 1.00 1.00 1.00 1.00 1.00 1.00 1.00 DEREXALPING 1.00 1.00 1.00 1.00			7.00	0.00	9.00	10.00		
3.00 THER ADMIA & GRUERAM 5.03 0 4.3, 392 0 4.5, 392 0 4.5, 392 0 4.5, 392 0 4.5, 392 0 4.5, 392 0 4.5, 392 0 4.5, 392 0 5.00 4.5, 392 0 5.00 4.5, 392 0 5.00 4.5, 392 0 5.00 4.5, 392 0 5.00 4.5, 392 0 5.00 4.5, 392 0 7.00	1.00		4.00	C	33, 829	9		1.00
4 00 DEPENTION OF FLINT 7.00 0 3.547 0 4.00 5.00 MARROY N. LITAY, STANCE 0.00 2.90 0 6.00 6.00 MARROY N. LITAY, STANCE 0.00 2.90 0 6.00 6.00 MARSING, ALLAN, STANCE 1.00 0 2.90 0 6.00 0.00 MARSING, ALDAN, STANCE 1.00 0 1.00 0 0.00 0.00 MARSING, SA SUPPLY 1.00 0 3.0.77 0 1.00 1.00 MARSING, SA SUPPLY 1.00 3.0.77 0 1.00 1.00 1.00 MARSING, SA SUPPLY 3.10 0 3.1.77 0 1.00 1.00 MARSING, SA SUPPLY 3.1.00 0 3.1.77 0 1.00 1.00 MARSING, SA SUPPLY 3.1.00 0 3.1.77 0 1.00 1.00 MARSING, SA SUPPLY 3.1.00 1.0.77 0 1.0.0 1.00 MARSING, CALALAND, SERVICE	2.00	ADMI TTI NG		C				2.00
5.00 LAURENY & LINER SLEVICE 8.00 0 39e 0 6.00 7.00 DELRAY 10.00 0 219.16/ 0 7.00 7.00 DELRAY 10.00 0 219.16/ 0 7.00 7.00 DELRAY 11.00 0 319.978 0 10.00 7.00 DENTRAL SERVICES ASIPPLY 14.00 0 733.875 0 11.00 7.00 DENTRAL SERVICES 25.02 0 8.668 0 11.00 7.00 DENTRAL SERVICES 25.02 0 8.668 0 11.00 7.00 DENTRAL INTROS 33.00 0 2.04/478 0 14.00 7.00 DENTRAL INTROS 33.00 0 2.04/478 0 14.00 7.00 DENTRAL INTROS 33.00 0 7.07 16.00 17.00 7.00 DENTRAL INTROS 33.00 0 7.03 17.00 17.00 7.00							•	
0.00 POUSENCEPINO 9.00 0.2995 0 6.00 2.00 0.00 CHETERA PAIN INTERTION 11.00 0.122.367 0 8.00 0.00 CHETERA PAIN INTERTION 11.00 0.122.367 0 8.00 0.00 CENTRAL SERVICES SALENY & 12.00 740.333 0 11.00 1.00 PARAMACY 15.00 0 740.333 0 11.00 1.00 PARAMACY 15.00 0 740.333 0 11.00 1.00 PARAMACY 21.00 0 38.76 0 12.00 1.10 PARAMACY 21.00 13.00 1.37.74 0 13.00 1.00 INTERTICAT PARTICS 30.00 1.37.74 0 13.00 1.00 SARENO DER - IFR 41.00 0 40.00 20.00 2.00 3.63.37 0 22.00 20.00 20.00 20.00 2.00 3.64.43.47 0 22.00 20.00 <				-		-		
7.00 DUETARY 10.00 0 219, 167 0 7.00 0.00 MURSING ADMINISTICS ADMALY 13.00 0 18, 111 0 0 0.00 1.00 MURSING ADMINISTICS ADMALY 15.00 0 34, 111 0 0 0.00 1.00 MURSING ADMINISTICS ADMALY 15.00 0 34, 413 0 11.00 1.00 DERRENCY INSING ALL, SERVICES 23.00 0 8, 636 0 13.00 1.00 DERRENCY INSING ALL, SERVICES 23.00 0 2, 7, 184 0 14.00 1.00 DERRENCY INSING CARE UNIT 33.00 0 1, 370, 177 0 16.00 1.00 DERRENCY INSING CARE UNIT 33.00 0 47, 03 18.00 18.00 1.00 DERRENCY INSING CARE UNIT 32.00 46, 31, 677 0 22.00 1.00 DERRENCY INSING CARE UNIT 32.00 46, 31, 677 0 22.00 1.00 DERRENCY INSING CARE UNIT 32.00 <t< td=""><td></td><td></td><td></td><td>-</td><td></td><td></td><td>•</td><td></td></t<>				-			•	
LOD CATTINA A 11 C0 152,365 0 8.0 0.0 CENTRAL SERVICES 5,9FPLY 14 00 0 319,978 0 100 10.0 CENTRAL SERVICES 5,0FPLY 14 00 0 319,978 0 100 11.00 Headmann 5,00 70,853 0 11.00 12.00 11.00 BURICAL TECH PROBAM 20.00 0 33,975 0 13.00 11.00 BURICAL TECH PROBAM 23.04 0 3,196 0 14.00 11.00 BURICAL TECH PROBAM 23.04 0 7,317,245 0 18.00 12.00 BURICAL INTERSIVE CARE UNIT 31.00 0 47.06,631 0 19.00 10.00 SURGICAL INTERSIVE CARE UNIT 34.00 0 470.6631 0 23.00 10.00 SURGICAL INTERSIVE CARE UNIT 34.00 0 70.188 0 23.00 10.00 SURGICAL INTERSIVE CARE UNIT 34.00 0 70.00						-		
10.00 CNITRAL SERVICES & SUPPLY 14.00 0 319.978 0 10.00 12.00 LAR SERVICES & SUPPLY 15.00 0 74.98.83 0 11.00 12.00 LAR SERVICES 21.00 D 73.975 0 12.00 14.00 SURCICAL TECH PROCEAN 23.07 0 R.456 0 13.00 14.00 SURCICAL TECH PROCEAN 23.04 0 3.196 0 14.00 10.00 INTERS VF CARE UNIT 31.00 0 1.200.177 10.00 15.00 10.00 INTERS VF CARE UNIT 31.00 0 1.72.01.77 10.00 17.00 10.00 MORTAL INTERSIVE CARE UNIT 34.00 0 470.081 0 10.00 10.00 DELIVERY ROW & LADOR DOM 52.00 0 75.53.33 0 22.00 20.00 DELIVERY ROW & LADOR DOM 55.00 0 7.00 70.00 22.00 21.00 DELIVERY ROW & LADOR DOM 50.00 0 2.0				C		-		
11.00 PARAMACY 15.00 0 740,833 0 11.00 12.00 PAR SYN CES-SALENCK 21.00 0 33.875 0 12.00 13.00 PAR SYN CES-SALENCK 22.00 0 33.875 0 13.00 14.00 PERING'S APPRO 13.00 0 5.194 0 13.00 15.00 ADULTS & FEDIATRICS 30.00 0 2.404,748 0 15.00 16.00 INTENC CARE UNIT 31.00 0 1,31.245 0 15.00 17.00 REMATAL INTENSIVE CARE UNIT 34.00 0 463.311 0 17.00 18.00 BORTICAL UNTENSIVE CARE UNIT 34.00 0 453.533 0 22.00 22.00 DELIVERY NORN & LABOR ROW 52.00 7.832.00 22.00 22.00 22.00 24.00 RADI OLCY-THERAPEUTIC 55.00 0 7.832.00 22.00 23.00 24.00 RADI OLCY-THERAPEUTIC 55.00 0 24.04.740	9.00	NURSING ADMINISTRATION	13.00	C	8, 111	0		9.00
12.00 LAR SERVICES-SALARY & FINESSAPPRY 21.00 33.875 0 12.00 13.00 DEFINESKY IEFJ CAL, SERVICES 23.20 0 8.636 0 13.00 14.00 SIRECLECH TECH PROFEMAL 23.04 0 2.3176 0 14.00 16.00 INTENSIVE CALE TECH PROFEMAL 23.04 0 2.32177 0 15.00 16.00 INTENSIVE CALE UNIT 31.00 0 2.32311 0 17.00 18.00 CORONARY CALE UNIT 22.00 0 663.311 0 17.00 19.00 SURFROUTER - TER 41.00 0 101.056 0 20.00 20.00 SURFINITION FORM ADDR ROUTER - TER 56.00 0 7.832 0 22.00 21.00 SURFINITION FORM ADDR ROUTER - TER 56.00 0 2.81.462 0 22.00 23.00 21.00 SURFINITION FORM PERAPY 66.00 0 2.02.160 0 22.00 23.00 21.00 SURFINITION FORM PERAPY				-			•	
FIN INSES APPRIV Image: Constraint of the co				-		-		
13.00 PERFERENCY MEDICAL SERVICES 23.00 8.636 0 13.00 14.00 SUBJECAL TECH PROCEAU 23.04 0 3.196 0 14.00 15.00 APULTS & FEDIATRICS 30.00 0 2.047.78 0 15.00 16.00 INTERVICARL UNIT 30.00 0 2.047.78 0 15.00 17.00 SURGICAL INTERSIVE CARE UNIT 32.00 0 663.311 0 16.00 18.00 CORDINARY CARE UNIT 32.00 0 663.311 0 170.00 20.00 SURFORDINER - INF 41.00 0 101.086 0 20.00 21.00 DELIVERY ROUN & LABOR ROUN 52.00 0 7.35.33 0 22.00 22.00 DELIVERY ROUN & LABOR ROUN 55.00 0 2.41.462 0 22.00 23.00 RADISTORY THERMONI DICK - S5.00 0 2.44.42 0 22.00 23.00 24.00 LABORTORY CARE CATHERER LATION 65.00 0	12.00		21.00	Ľ	33,8/5	0		12.00
14.00 SUREICAL TECH PROGRAM 23.04 0 3.196 0 14.00 15.00 AULTS & PEDLATECS 30.00 0 2.604,748 0 15.00 16.00 INTENSIVE CARE UNIT 31.00 0 1,220,177 16.00 17.00 17.00 REMARKI LITENSIVE CARE UNIT 31.01 0 172,245 0 170.00 18.00 SURBICAL INTENSIVE CARE UNIT 34.00 0 90.041 0 20.00 20.00 SURBYROW FER - INF 44.00 0 64.13,497 0 22.00 21.00 DELEVER ROM A LABOR ROM 50.00 0 7.832,167 22.00 24.00 22.00 DARDI ALCORT-TRERAPEUTIC 55.00 0 2.3.41.462 24.00 20.00 24.00 DARDI ALCORT-TRERAPEUTIC 50.00 0 2.3.41.462 20.00 27.00 2.80.02 25.00 DARDI ALCORT-TRERAPEUTIC 50.00 0 2.02.51.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00	13 00		23 02	C	8 636	0		13 00
16.00 INTERNIVE CARE UNIT 31.00 1,320,177 0 16.00 18.00 CORONARY CARE UNIT 32.00 0 663,311 0 17.00 18.00 SURFACUL INTENSIVE CARE UNIT 32.00 0 663,311 0 19.00 10.00 SURFACUL INTENSIVE CARE UNIT 32.00 0 663,311 0 10.056 20.00 20.00 SURFACUL INTERSIVE CARE UNIT 34.00 0 101.056 20.00 23.00 23.00 PADID IOGY- INARDESTIC 54.00 0 5.387,167 0 22.00 24.00 OUCOY- THERAPTICE 56.00 0 7.632 0 27.00 25.00 RADID IOGY- INARDESTATION 59.00 0 2.36.81.462 0 28.00 20.00 RESHRATORY THERAPY 66.00 0 34.67.40 28.00 33.00 21.00 UABORATORY 66.00 0 34.67.40 33.00 33.00 33.00 33.00 33.00 33.00 34.67.40				-				
17.00 NOMARLAL INTENSIVE CARE UNIT 31.01 0 317.245 0 17.00 18.00 CORRANY CARE UNIT 32.00 0 963.311 0 18.00 19.00 SURGUCAL INTENSIVE CARE UNIT 34.00 0 470.681 0 20.00 21.00 DEPRATINE ROUMER - IRE 54.00 0 36.413.673 0 22.00 22.00 RADIOLOGY - INARMOR NOM 52.00 0 36.413.673 0 22.00 23.00 RADIOLOGY - INARMOR NOM 59.00 0 7.832.00 22.00 24.00 24.00 CARDIAC CATHERN LATION 59.00 0 23.681.462 0 22.00 26.00 CARDIAC CATHERN LATION 59.00 0 34.674.00 23.00 33.00 31.00 CARDIAC CATHERN LATION 60.00 0 4.02.740 0 33.00 32.00 CARDIAC CATHERN LATION 60.00 0 34.6740 0 33.00 31.00 CARDIAC CATHERN LATION 60.00 0 45.200 33.00 34.00 34.00 34.00 34.00	15.00	ADULTS & PEDIATRICS	30.00	C	2, 604, 748	0		15.00
18. 00 CREMARY CARE UNIT 32.00 0 963.311 0 18. 00 19. 00 19.00 SUBEROVIDER - IRF 11.00 0 101, 056 0 20. 00 10.00 DELIVERY ROAM & LABOR ROAM 50. 00 0 66, 613, 497 0 21. 00 20.00 DELIVERY ROAM & LABOR ROAM 50. 00 0 763, 533 0 23. 00 21.00 DELIVERY ROAM & LABOR ROAM 50. 00 0 763, 533 0 23. 00 25.00 RADID SOTOPE 56. 00 0 9, 916 0 25. 00 26.00 RADID SOTOPE 60. 00 0 4, 664. 00 28. 00 27. 00 28. 00 27.00 LABORATORY 66. 00 0 62, 742. 0 30. 00 31. 00 0 33. 00 27. 00 33. 00 33. 00 33. 00 33. 00 33. 00 33. 00 33. 00 33. 00 33. 00 33. 00 33. 00 33. 00 33. 00 33. 00 33. 00 33. 00 33. 00<				C	1, 320, 177		•	
19.00 SURGICAL INTENSIVE CARE UNIT 34.00 0 470.081 0 90.00 21.00 SUBBROW IDER - IFE 41.00 0 101.056 0 21.00 21.00 DELAYTING ROOM 50.00 0 36.613.497 0 21.00 22.00 DELAYTER ROOM & LABOR ROOM 52.00 0 743.533 0 22.00 23.00 RADIOLOGY - INERAPEUTIC 55.00 0 7.33.20 0 24.00 24.00 RADIOLOGY - INERAPEUTIC 55.00 0 23.61.462 0 27.00 25.00 DARODIAC, GATTEERR ATON 66.00 0 24.02 27.00 28.00 17.00 24.00 24.00 27.00 28.00 13.00 31.00 32.00 33.00 31.00 32.00 33.00 31.00 32.00 33.00 32.00 33.00 33.00 33.00 33.00 33.00 34.00 35.00 32.00 33.00 34.00 35.00 35.00 35.00 35.00 35.00 </td <td></td> <td></td> <td></td> <td>C</td> <td></td> <td>-</td> <td></td> <td></td>				C		-		
20.00 SUBPROVIDER - IRF 41.00 0 101.056 0 20.00 22.00 23.00							•	
21.00 DEFEATING ROOM 50.00 36.613.497 0 21.00 22.00 DELIVERY ROOM & LADOR ROOM 52.00 0 753.533 0 22.00 23.00 RADIDLOCY-LHEARPEUTIC 56.00 0 783.533 0 22.00 25.00 RADIDLOCY-LHEARPEUTIC 56.00 0 9.916 0 24.00 25.00 RADIDLOCY-LHEARPEUTIC 56.00 0 9.461.40 0 25.00 20.00 RESPLATCRY 60.00 0 4.688.102 0 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00 36.01 27.00 36.00 30.00 31.00 31.00 31.00 33.00 31.00 31.00 33.00 32.00 27.00 33.00 34.00 34.00 34.00 34.00 34.00 34.00				-		-		
22.00 DELLYERY BOOM & LABOR BOOM 52.00 O 779.5.533 C 22.00 RADIOLOSY-DIAGNOSTIC 54.00 0 5.382.167 O 23.00 RADIOLOSY-DIAGNOSTIC 55.00 0 7.832 O 23.00 RADIOLOSY-DIAGNOSTIC 55.00 0 7.832 O 23.00 RADIOLOSY-DIAGNOSTIC 55.00 0 7.832 O 23.00 24.00 24.00 24.00 24.00 24.00 24.00 25.00 25.00 25.00 25.00 25.00 26.00 27.00 26.00 27.00 26.00 27.00 28.00 1NTRAVENOUS THERAPY 64.00 0 3.46.740 D 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 33.00 22.00 28.00 33.00 22.00 28.00 33.00 33.00 22.00 28.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 35.00 33.00 35.00 33.00				-			•	
23.00 RADIOLOGY-DIAGNOSTIC 54.00 0 5.00 RADIOLOGY-DIAGNOSTIC 23.00 24.00 24.00 RADIOLOGY-THERAPEUTIC 55.00 0 7.332 0 24.00 25.00 RADIOLOGY-THERAPEUTIC 55.00 0 9.916 0 25.00 26.00 27.00 28.00 27.00 28.00 27.00 28.00 27.00 28.00 27.00 28.00 27.00 28.00 27.00 28.00 27.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 29.00 RESPIRATORY THERAPY 66.00 0 62.742 0 30.00 29.00 33.00 29.00 33.00 29.00 33.00 29.00 33.00 20.00 33.00 20.00 33.00 20.00 33.00 20.00 33.00 20.00 20.00 33.00 20.00 33.00 20.00 20.00 33.00 20.00 20.00 33.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 <				-		-		
25.00 RADIO ISOTOPE 56.00 0 9,916 0 25.00 26.00 27.00 26.00 27.00 26.00 27.00 28.00 17.00 28.00 17.00 28.00 17.00 28.00 17.00 28.00 17.00 28.00 0 28.00 0 28.00 0 28.00 0 28.00 0 28.00 0 28.00 0 28.00 0 28.00 0 28.00 0 28.00 0 28.00 0 28.00 0 28.00 0 0 28.00 0 0 28.00 0 30.00 31.00 32.00 31.00 32.00 34.00 21.00 35.00 36.00 34.00 35.00 36.00 37.00 36.00 37.00 36.00 37.00 36.00 38.00 38.00 38.00 38.00 38.00 38.00 38.00 39.00 40.00 2.00 30.00 39.00 40.00 40.00 40.00 40.00 40.	23.00	RADI OLOGY-DI AGNOSTI C	54.00	C				23.00
26.00 CARDIAC CATHETERIZATION 59.00 0 23.61.462 0 26.00 27.00 LABOATDEY 60.00 0 4.08.102 0 27.00 LABOATDEY 60.00 0 346,740 0 28.00 28.00 29.00 PSIFINATIONT THERAPY 65.00 0 20.00 13.00 00 346,740 0 30.00 13.00 00 33.00 0 27.00 0 46.68 0 31.00 0 32.00 33.00 0 13.00 0 14.00 34.00 35.00 14.00 35.00 14.00 35.00 14.00 35.00 36.00 14.575 0 36.00 38.00 39.00 14.00 37.00 14.00 37.00 38.00 39.00 30.00 14.00 14.00	24.00	RADI OLOGY-THERAPEUTI C	55.00	C				24.00
27. 00 LABORATORY 60. 00 0 4.008, 102 0 27. 00 28. 00 INTRAVENUS THERAPY 66. 00 0 2.025, 106 0 29. 00 30. 00 PHST RATORY THERAPY 66. 00 0 62. 742 0 30. 00 31. 00 0CCUPATI ONAL THERAPY 66. 00 0 84. 658 0 31. 00 32. 00 SPECH PATHOLOGY 68. 00 0 18. 955 0 32. 00 33. 00 ELECTROCARDIOLOGY 69. 00 0 45. 756 0 33. 00 34. 00 ELECTROCARDIAL CERHAPI 74. 00 0 36. 310 0 36. 00 37. 00 36. 310 36. 00 39. 00 39. 00 NOORESVILE LINUSION CLINIC 90. 02 0 27. 905 0 40. 00 39. 00 41. 00 41. 00 41. 00 41. 00 41. 00 42. 00 39. 00 40. 00 39. 00 40. 00 39. 00 40. 00 39. 00 40. 00 39. 00 40. 00 39. 00 40. 00 39. 00 40. 00 39. 00 40. 00 39. 00 <td< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></td<>								
28.00 INTRAVENUS THERAPY 64.00 0 346.740 0 28.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 30.00 20.025.106 0 30.00 30.00 30.00 30.00 31.00 31.00 31.00 31.00 31.00 32.00 33.00 31.00 32.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 34.00 0 46.310 0 35.00 33.00 34.00 0 35.00 34.00 36.00 38.00 38.00 38				-		-		
99 00 PESPIRATORY THERAPY 65.00 0 2.025,106 0 29.00 99.00 31.00 00 06.27,742 00 31.00 00 07.00 0 34.658 0 32.00 00 07.00 0 34.658 0 32.00 00 07.00 0 44.52.302 0 33.00 33.00 33.00 33.00 33.00 34.00 34.00 34.00 35.00 07.00 0 45.75 0 35.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>								
0.0.00 PHYSICAL THERAPY 66.00 0 62.742 0 30.00 1.0.00 COURDATIONAL THERAPY 67.00 0 43.658 0 32.00 30.00 ELECTROCARDIOLOGY 68.00 0 18.955 0 33.00 30.00 ELECTROCARDIOLOGY 69.00 0 45.2302 0 33.00 30.00 ELECTROENCEPHALDGRAPHY 70.00 0 66.310 0 35.00 35.00 RAAL DIALYSIS 74.00 0 36.310 0 37.00 36.00 LECTROENCEPHALDGRAPHY 70.00 0 24.7431 0 37.00 37.00 CLARDIAC BERHABILITATION 76.97 0 4.77.739 0 38.00 39.00 NORDESVILLE INVISION CLIN C 90.02 0 2.905 0 39.00 40.00 CV DIAGNSTIC SERVICES 90.05 0 32.717.319 0 1.00 1.00 EMPGOTESVILLE INVISION CLIN C 90.05 0 23.731 1.						-		
11 00 OCCUPATI ONAL THERAPY 67.00 0 34.658 0 31.00 200 SPECE PATHOLOGY 66.00 0 48.955 0 32.00 33.00 ELECTROCADENDIOLOGY 69.00 0 45.302 0 33.00 33.00 40.00 ELECTROCADENDIAL ORGAPHY 70.00 0 64.172.00 34.603 35.00 36.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 30.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 <				0				
33.00 ELECTROCADED LOGY 69.00 0 452.302 0 33.00 41.00 ELECTROCADEPHALORGRAPHY 70.00 0 36.126 0 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 36.00 37.00 37.00 37.00 38.00 36.00 37.00 38.00 38.00 38.00 38.00 38.00 38.00 39.00 39.00 39.00 40.00 37.07.00 39.00 40.00 41.00 41.00 41.00 41.00 41.00 41.00 41.00 41.00 41.00 41.00 41.00 41.00 40.00 32.00 30.00 42.00 30.00 40.00 50.00<				C		-		
34.00 ELECTROBUCEPHALOGRAPHY 70.00 96,126 0 34.00 35.00 RENAL DI ALYSIS 74.00 0 36,310 0 35.00 76.97 0 4,575 0 36.00 37.00 CLINIC 90.00 0 237.431 0 37.00 39.00 41.00 41.00 41.00 41.00 41.00 41.00 41.00 41.00 40.00 3.00 37.00 42.60 3.00 30.00 40.00 3.00 <t< td=""><td>32.00</td><td>SPEECH PATHOLOGY</td><td>68.00</td><td>C</td><td>18, 955</td><td>0</td><td></td><td>32.00</td></t<>	32.00	SPEECH PATHOLOGY	68.00	C	18, 955	0		32.00
35.00 RENAL DIALYSIS 74.00 0 35.10 0 36.00 CARDIAC REHBILITATION 76.97 0 4.575 0 36.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 38.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 38.00 37.00 37.00 37.00 37.00 37.00 39.00 0000ESVILLE INVESTOR CLINIC 90.05 0 37.00,060 0 41.00 41.00 41.00 41.00 41.00 41.00 0 22.887,702 0 3.00 40.00 41.00 40.00 41.00 40.00 41.00 40.00 41.00 40.00 41.00 40.00 41.00 40.00 41.00 40.00 41.00 40.00 41.00 40.00 41.00 40.00 41.00 40.00 41.00 40.00 41.00 40.00 41.00 40.00 41.00 40.00 41.00 40.00 41.00 40.00 41.00 40.				-		-		
36 00 CARDIAC REHABILITATION 76 97 0 4.575 0 36.00 37.00 37.00 CLINIC 90.00 0 237.431 0 38.00 38.00 39.00 MODRESVILLE INFUSION CLINIC 90.01 0 74,626 0 38.00 39.00 40.00 VDIARNOSTIC SERVICES 90.05 0 376,906 0 40.00 41.00 EMERGENCY 91.00 0 1.217,319 0 41.00 8 DRUG 0 2.2889,702 0 3.00 40.00 9.00 0 0 2.17,319 0 1.00 2.00 9.00 0 0 2.31,781 0 2.00 3.00 0.00 OPERTION OF PLANT 7.00 0 2.00 3.00 4.00 5.03 0 4.00 5.03 0 4.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00<				C				
37.00 CLINIC 90.00 0 237.431 0 37.00 37.00 38.00 1BMT JOINT VENTURE 90.01 0 74.626 0 38.00 39.00 41.00 41.00 41.00 41.00 41.00 41.00 41.00 41.00 41.00 41.00 41.00 41.00 40.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 <t< td=""><td></td><td></td><td></td><td>C</td><td></td><td>-</td><td></td><td></td></t<>				C		-		
3B CO IBAT JOINT VENTURE 90 OT 0 74,626 0 38.00 39.00 MORESVILLE INFUSION CLINIC 90.02 0 2,905 0 39.00 40.00 CV DIAGNOSTIC SERVICES 90.05 0 1,77,319 0 41.00 TOTALS - 0 82,897,702 41.00 41.00 00 OTHER ADMIN & GENERAL 5.03 0 849 0 2.00 1.00 CMERATION OF PLANT 7.00 0 2.0 3.00 4.00 2.00 OTHER ADMIN & GENERAL 5.03 0 849 0 2.00 3.00 NUESING ADMINISTRATION 13.00 0 6.41 0 4.00 5.00 CO 15.060 0 25.26,328 0 6.00 7.00 FRINCES APRV 15.00 0 24.695 0 7.00 8.00 ADULTS & PEDIATRICS 30.00 0 8.13,243 0 9.00 10.00 CONA								
99 000 MOORESVILLE INFUSION CLINIC 90.02 0 2.905 0 39.00 40.00 CV DIAGNOSTIC SERVICES 90.05 0 376.906 0 40.00 41.00 TOTALS 0 0 1.217.319 0 40.00 41.00 TOTALS 0 82.889.702 0 52.089.702 0 2.00 1.00 EMPLOYEE BENFFITS DEPARTMENT 4.00 0 23.00 0 84.90 0 2.00 3.00 OPERATION OF PLANT 7.00 0 2 0 3.00 4.00 DENTRAL SERVICES & SUPPLY 14.00 0 15.060 0 5.00 6.00 PHARNACY 15.00 0 224.695 0 7.00 8.00 9.00 1.000 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00<				0		-		
41.00 EMERGENCY 91.00 0 1.217.319 0 B DRUG 30.00 231.781 0 1.00 20.00 THER ADMIN & GENERAL 5.03 0 849 0 2.00 3.00 DPERATION OF PLANT 7.00 0 2.0 3.00 4.00 3.00 4.00 NURSING ADMINISTRATION 13.00 0 641 0 4.00 5.00 CENTRAL SERVICES & SUPPLY 14.00 0 15.060 5.00 6.00 PHARMACY 15.00 0 25.226.328 0 6.00 7.00 FRINGES APPRV 8.00 0 144.355 0 7.00 8.00 ADULTS & PEDIATRICS 30.00 0 8.613.243 0 8.00 10.00 NORNARY CARE UNIT 13.01 0 1.034 0 11.00 11.00 NUTRSIVE CARE UNIT 31.00 0 42.314 0 13.00 10.00 DRONARY CARE UNIT <td< td=""><td></td><td></td><td></td><td>C</td><td></td><td></td><td></td><td></td></td<>				C				
TOTALS O 82,889,702 O O B - DRUG 1.00 EMPLOYEE BENEFITS DEPARTMENT 4.00 0 231,781 0 1.00 2.00 OTHER ADMIN & GENERAL 5.03 0 849 0 2.00 3.00 OPERATION OF PLANT 7.00 0 2 0 3.00 4.00 NURSING ADMIN STRATION 13.00 0 641 0 4.00 5.00 CENTRAL SERVICES & SUPPLY 14.00 0 15.060 0 5.00 6.00 PHARMACY 15.00 0 25.226.328 0 6.00 7.00 IRS SERVICES-SALARY & 21.00 0 324.695 0 7.00 8.00 ADULTS & PEDIATRICS 30.00 0 8.43.243 0 8.00 9.00 INTENSIVE CARE UNIT 11.01 0 1,034 0 10.00 11.00 CRNOARY CARE UNIT 32.00 0 6.2,314 0 11.00 12.00 SUBPROVI	40.00	CV DIAGNOSTIC SERVICES	90.05	C	376, 906	0		40.00
B - DRUG 1.00 EMPLOYEE BENEFITS DEPARTMENT 4.00 0 231,781 0 2.00 OTHER ADMIN & GENERAL 5.03 0 849 0 3.00 3.00 OPERATION OF PLANT 7.00 0 2 0 3.00 4.00 NURSI NG ADMI NI STRATION 13.00 0 641 0 4.00 5.00 CENTRAL SERVICES & SUPPLY 14.00 0 15.060 0 5.00 6.00 PHARMACY 15.00 0 25,226,328 0 7.00 7.00 INTENSIVE CARE UNIT 31.00 0 144,355 0 9.00 10.00 NORONARY CARE UNIT 31.00 0 144,355 0 9.00 11.00 CORONARY CARE UNIT 31.00 0 12.00 322,60 328 0 11.00 12.00 SURGI CAL INTENSI VE CARE UNIT 31.00 0 46.037 0 12.00 13.00 SURGI CAL INTENSI VE CARE UNI T <td< td=""><td>41.00</td><td></td><td><u> </u></td><td></td><td></td><td></td><td>-</td><td>41.00</td></td<>	41.00		<u> </u>				-	41.00
1.00 EMPLOYEE BENEFITS DEPARTMENT 4.00 0 231,781 0 1.00 2.00 OTHER ADMIN & GENERAL 5.03 0 849 0 2.00 3.00 OPERATION OF PLANT 7.00 0 2 0 3.00 4.00 NURSI NG ADMI NI STRATI ON 13.00 0 641 0 4.00 5.00 CENTRAL SERVI CES & SUPPLY 14.00 0 15.060 0 6.00 7.00 I&R SERVI CES-SALARY & 21.00 0 226,226,328 0 7.00 8.00 ADULTS & PEDI ATRI CS 30.00 0 8.613,243 0 8.00 9.00 INTENSI VE CARE UNI T 31.00 0 144,355 0 10.00 10.00 NEONATAL INTENSI VE CARE UNI T 32.00 0 62,314 0 10.00 11.00 COROMARY CARE UNI T 32.00 0 46,037 12.00 12.00 12.00 SUBPROVI DER - INF 41.00 328 0 13.00 14.00 12.00 12.00 13.00 DERATLI INTENSI VE CAR				C	82,889,702			_
2.00 OTHER ADMIN & GENERAL 5.03 0 849 0 2.00 3.00 OPERATION OF PLANT 7.00 0 2 0 3.00 4.00 NURSI NG ADMINISTRATION 13.00 0 641 0 4.00 5.00 CENTRAL SERVICES & SUPPLY 14.00 0 15.060 0 5.00 6.00 PHARMACY TIS.00 0 25,226,328 0 6.00 7.00 IAR SERVICES-SALARY & 21.00 0 324,695 0 7.00 8.00 ADULTS & PEDIATRICS 30.00 0 8.613,243 0 8.00 9.00 INTENSIVE CARE UNIT 31.00 0 144,355 0 10.00 11.00 CORONARY CARE UNIT 32.00 0 62,314 0 10.00 12.00 SURGICAL INTENSI VE CARE UNIT 34.00 0 46.037 0 13.00 14.00 OPERATING ROOM 50.00 0 167,283 0 14.00	1 00		4 00		231 781	0		1 00
3.00 OPERATION OF PLANT 7.00 0 2 0 3.00 4.00 NURSI NG ADMI NI STRATI ON 13.00 0 641 0 4.00 5.00 CENTRAL SERVICES & SUPPLY 14.00 0 15.060 0 5.00 6.00 5.00 6.00 PHARMACY 15.00 0 25,226,328 0 6.00 7.00 I&R SERVI CES - SALARY & 21.00 0 324,695 0 7.00 8.00 ADULTS & PEDI ATRI CS 30.00 0 8.613,243 0 8.00 9.00 INTENSI VE CARE UNI T 31.01 0 1,43,355 0 9.00 10.00 NEONATAL INTENSI VE CARE UNI T 31.01 0 1,034 0 10.00 11.00 COROMARY CARE UNI T 34.00 0 46,037 0 12.00 13.00 SUBPROVI DER - IRF 41.00 0 22.84 0 13.00 14.00 DEL VERY ROM & LABOR ROOM 52.00 2,584 0								
4.00 NURSI NG ADMI NI STRATI ON 13.00 0 641 0 4.00 5.00 CENTRAL SERVI CES & SUPPLY 14.00 0 15,060 0 5.00 6.00 PHARMACY 15.00 0 25,226,328 0 6.00 7.00 I&R SERVI CES - SALARY & 21.00 0 324,695 0 7.00 8.00 ADULTS & PEDI ATRICS 30.00 0 8.613,243 0 8.00 9.00 INTENSI VE CARE UNI T 31.01 0 144,355 0 9.00 10.00 NEONAATAL INTENSI VE CARE UNI T 31.01 0 144,355 0 11.00 12.00 SURGI CAL INTENSI VE CARE UNI T 32.00 0 62.314 0 11.00 13.00 SUBPROVI DER - IRF 41.00 328 0 13.00 144.00 14.00 DERATI IN GOM 52.00 0 167.283 0 14.00 15.00 DELI VERY ROOM & LABOR ROOM 52.00 0 77.078.679 16.00 16.00 16.00 RADI OLOGY-DI AGNOSTI C 54.00		OPERATION OF PLANT		C				
6.00 PHARMACY 15.00 0 25,226,328 0 6.00 7.00 I&R SERVICES-SALARY & 21.00 0 324,695 0 7.00 8.00 ADULTS & PEDIATRICS 30.00 0 8,613,243 0 8.00 9.00 INTENSIVE CARE UNIT 31.00 0 144,355 0 9.00 10.00 NEONATAL INTENSIVE CARE UNIT 31.01 0 1,034 0 10.00 11.00 CORONARY CARE UNIT 32.00 0 62,314 0 11.00 12.00 SUBROVI DER - IRF 41.00 0 328 0 13.00 14.00 OPERATING ROOM 50.00 0 167,283 0 14.00 15.00 DELIVERY ROOM & LABOR ROOM 52.00 0 77.00 77.00 16.00 17.00 RADIOLOGY-DIAGNOSTIC 54.00 0 77.00 16.00 17.00 18.00 CARDIAC CATHETERIZATION 59.00 0 22,584 0 18.00 19.00 LABORATORY 60.00 0 0 20	4.00		13.00	C				4.00
7. 00 I&R SERVICES-SALARY & 21.00 0 324,695 0 7.00 8. 00 ADULTS & PEDI ATRICS 30.00 0 8,613,243 0 8.00 9.00 INTENSIVE CARE UNIT 31.00 0 144,355 0 9.00 10.00 NEONATAL INTENSIVE CARE UNIT 31.01 0 1,034 0 10.00 11.00 CORONARY CARE UNIT 32.00 0 62,314 0 12.00 12.00 SURGICAL INTENSIVE CARE UNIT 34.00 0 328 0 13.00 14.00 OPENATING ROOM 50.00 0 167,283 0 14.00 15.00 DELIVERY ROOM & LABOR ROOM 52.00 0 7,8679 16.00 17.00 16.00 RADI OLGY-DI AGNOSTIC 54.00 0 32,882 0 18.00 19.00 LABORATORY 60.00 0 20,501 18.00 19.00 20.00 INTRAVENOUS THERAPY 64.00 0 46,710,653 0 20.00 21.00 RESPI RATORY THERAPY 65.00 0 28.00 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>								
FRI NGES APPRV FRI NGES APPRV 8.00 ADULTS & PEDI ATRICS 30.00 0 8,613,243 0 9.00 INTENSI VE CARE UNI T 31.00 0 144,355 0 9.00 10.00 NEONATAL INTENSI VE CARE UNI T 31.01 0 1,034 0 10.00 11.00 CORONARY CARE UNI T 32.00 0 62,314 0 11.00 12.00 SUBPROVI DER - IRF 41.00 0 328 0 13.00 14.00 OPERATI NG ROM 50.00 0 167,283 0 14.00 15.00 DELI VERY ROM & LABOR ROM 52.00 0 78,679 0 16.00 17.00 RADI OLOGY-DI AGNOSTI C 54.00 0 778,679 0 16.00 17.00 RADI OLOGY-DI AGNOSTI C 56.00 0 608,434 0 17.00 18.00 CARDI AC CATHETREI ZATI ON 59.00 0 32.282 0 18.00 19.00 LABORATORY 60.00				-				
8.00 ADULTS & PEDIATRICS 30.00 0 8,613,243 0 8.00 9.00 INTENSIVE CARE UNIT 31.00 0 144,355 0 9.00 10.00 NEONATAL INTENSIVE CARE UNIT 31.01 0 1,034 0 10.00 11.00 CORONARY CARE UNIT 32.00 0 62,314 0 11.00 12.00 SURGICAL INTENSIVE CARE UNIT 34.00 0 46,037 0 13.00 13.00 SUBPROVIDER - IRF 41.00 0 328 0 13.00 14.00 DELIVERY ROOM LABOR ROOM 50.00 0 167,283 0 14.00 15.00 DELIVERY ROOM & LABOR ROOM 52.00 0 25,584 0 15.00 16.00 RADI OLGGY-DI AGNOSTIC 54.00 0 32,282 0 18.00 19.00 LABORATORY 60.00 0 20,551 19.00 19.00 20.00 CCUPATI NOR.THERAPY 65.00 0 280,400 21.00 22.00 21.00 CCUPATI NOAL THERAPY 65.00	7.00		21.00	Ĺ	324, 095	0		7.00
9.00 INTENSI VE CARE UNI T 31.00 0 144,355 0 9.00 10.00 NEONATAL INTENSI VE CARE UNI T 31.01 0 1,034 0 10.00 11.00 CORONARY CARE UNI T 32.00 0 62,314 0 11.00 12.00 SUBGI CAL INTENSI VE CARE UNI T 34.00 0 46,037 0 12.00 13.00 SUBPROVI DER - IRF 41.00 0 328 0 13.00 14.00 OPERATING ROOM 50.00 0 167,283 0 14.00 15.00 DELI VERY ROOM & LABOR ROOM 52.00 0 2,584 0 15.00 16.00 RADI OLGY-DI AGNOSTI C 54.00 0 778,679 0 16.00 17.00 RADI OLSOTOPE 56.00 0 68,434 0 17.00 18.00 CARDI AC CATHETERI ZATI ON 59.00 0 32,282 0 18.00 19.00 LABORATORY 60.00 0 20,501 0 20.00 21.00 22.00 INTRAVENOUS THERAPY 65.00	8.00		30, 00	C	8, 613, 243	0		8, 00
11.00 CORONARY CARE UNIT 32.00 0 62,314 0 11.00 12.00 SURGI CAL INTENSIVE CARE UNIT 34.00 0 46,037 0 12.00 13.00 SUBPROVI DER - IRF 41.00 0 328 0 13.00 14.00 OPERATING ROOM 50.00 0 167,283 0 14.00 15.00 DELIVERY ROM & LABOR ROOM 52.00 0 2,584 0 15.00 16.00 RADI OLOGY-DI AGNOSTI C 54.00 0 778,679 0 16.00 17.00 RADI OL SOTOPE 56.00 0 608,434 0 17.00 18.00 CARDI AC CATHETERI ZATI ON 59.00 0 32,282 0 18.00 19.00 LABORATORY 60.00 0 20,501 0 20.00 21.00 21.00 RESPI RATORY THERAPY 65.00 0 280,400 0 21.00 22.00 OCCUPATI ONAL THERAPY 65.00 0 280,400 0 22.00 23.00 ELECTROCARDI OLOGY 69.00 0 <td></td> <td></td> <td></td> <td>C</td> <td></td> <td></td> <td>•</td> <td></td>				C			•	
12.00 SURGI CAL INTENSI VE CARE UNIT 34.00 0 46,037 0 13.00 SUBPROVI DER - IRF 41.00 0 328 0 13.00 14.00 OPERATI NG ROOM 50.00 0 167,283 0 14.00 15.00 DELI VERY ROOM & LABOR ROOM 52.00 0 2,584 0 15.00 16.00 RADI OLOGY-DI AGNOSTI C 54.00 0 778,679 0 16.00 17.00 RADI OL SOTOPE 56.00 0 608,434 0 17.00 18.00 CARDI AC CATHETERI ZATI ON 59.00 0 32,282 0 18.00 19.00 LABORATORY 60.00 0 20,551 0 19.00 20.00 INTRAVENOUS THERAPY 64.00 0 46,710,653 0 20.00 21.00 RESPI RATORY THERAPY 67.00 990 0 22.00 22.00 23.00 ELECTROCARDI OLOGY 69.00 0 117 0 23.00 24.00 RENAL DI ALYSI S 74.00 0,7,202 0 24.00 </td <td>10.00</td> <td>NEONATAL INTENSIVE CARE UNIT</td> <td>31.01</td> <td>C</td> <td>1, 034</td> <td></td> <td></td> <td>10.00</td>	10.00	NEONATAL INTENSIVE CARE UNIT	31.01	C	1, 034			10.00
13.00 SUBPROVIDER - IRF 41.00 0 328 0 13.00 14.00 OPERATING ROOM 50.00 0 167,283 0 14.00 15.00 DELIVERY ROOM & LABOR ROOM 52.00 0 2,584 0 15.00 16.00 RADIOLOGY-DIAGNOSTIC 54.00 0 778,679 0 16.00 17.00 RADIOLOSOTOPE 56.00 0 608,434 0 17.00 18.00 CARDIAC CATHETERIZATION 59.00 0 32,282 0 18.00 19.00 LABORATORY 60.00 0 20,501 0 19.00 20.00 INTRAVENOUS THERAPY 64.00 0 46,710,653 0 20.00 21.00 RESPI RATORY THERAPY 65.00 0 280,400 0 21.00 22.00 OCCUPATI ONAL THERAPY 67.00 0 990 0 22.00 23.00 ELECTROCARDIOLOGY 69.00 0 117 0 23.00 24.00 RENAL DI ALYSIS 74.00 0 7,202 0				C			•	
14.00 OPERATING ROOM 50.00 0 167,283 0 14.00 15.00 DELIVERY ROOM & LABOR ROOM 52.00 0 2,584 0 15.00 16.00 RADI OLGGY-DI AGNOSTI C 54.00 0 778,679 0 16.00 17.00 RADI OLSOTOPE 56.00 0 608,434 0 17.00 18.00 CARDI AC CATHETERI ZATI ON 59.00 0 32,282 0 18.00 19.00 LABORATORY 60.00 0 20,501 0 19.00 20.00 INTRAVENOUS THERAPY 64.00 0 46,710,653 0 20.00 21.00 RESPI RATORY THERAPY 65.00 0 280,400 0 21.00 22.00 OCCUPATI ONAL THERAPY 67.00 0 990 0 22.00 23.00 ELECTROCARDI OLOGY 69.00 0 117 0 23.00 24.00 RENAL DI ALYSIS 74.00 0 7,202 0 24.00 25.00 CLI NI C 90.01 0 2,365 0				-		-		
15.00 DELI VERY ROOM & LABOR ROOM 52.00 0 2,584 0 15.00 16.00 RADI OLOGY-DI AGNOSTI C 54.00 0 778,679 0 16.00 17.00 RADI OLSOTOPE 56.00 0 608,434 0 17.00 18.00 CARDI AC CATHETERI ZATI ON 59.00 0 32,282 0 18.00 19.00 LABORATORY 60.00 0 20,501 0 19.00 19.00 20.00 INTRAVENOUS THERAPY 64.00 0 46,710,653 0 20.00 21.00 RESPI RATORY THERAPY 65.00 0 280,400 0 21.00 22.00 OCCUPATI ONAL THERAPY 67.00 0 990 0 22.00 23.00 ELECTROCARDI OLOGY 69.00 0 117 0 23.00 24.00 RENAL DI ALYSIS 74.00 0 7,202 0 24.00 25.00 CLI NI C 90.01 0 2,365 0 25.00 25.00 26.00 IBMT JOI NT VENTURE 90.02 0 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>•</td> <td></td>							•	
16.00 RADI OLOGY-DI AGNOSTI C 54.00 0 778,679 0 16.00 17.00 RADI OL SOTOPE 56.00 0 608,434 0 17.00 18.00 CARDI AC CATHETERI ZATI ON 59.00 0 32,282 0 18.00 19.00 LABORATORY 60.00 0 20,501 0 19.00 20.00 INTRAVENOUS THERAPY 64.00 0 46,710,653 0 20.00 21.00 RESPI RATORY THERAPY 65.00 0 280,400 0 21.00 22.00 OCCUPATI ONAL THERAPY 67.00 0 990 0 22.00 23.00 ELECTROCARDI OLOGY 69.00 0 117 0 23.00 24.00 24.00 24.00 25.00 CLI NI C 90.00 0 2,365 0 25.00 25.00 25.00 25.00 26.00 26.00 26.00 27.00 26.00 27.00 26.00 27.00 26.00 27.00 26.00 27.00 27.00 27.00 27.00 27.00 27.00 27.00<				-		-		
17. 00 RADI OI SOTOPE 56. 00 0 608, 434 0 17. 00 18. 00 CARDI AC CATHETERI ZATI ON 59. 00 0 32, 282 0 18. 00 19. 00 LABORATORY 60. 00 0 20, 501 0 19. 00 20. 00 INTRAVENOUS THERAPY 64. 00 0 46, 710, 653 0 20. 00 21. 00 RESPI RATORY THERAPY 65. 00 0 280, 400 0 21. 00 22. 00 OCCUPATI ONAL THERAPY 67. 00 0 990 0 22. 00 23. 00 ELECTROCARDI OLOGY 69. 00 0 117 0 23. 00 24. 00 RENAL DI ALYSI S 74. 00 0 7, 202 0 24. 00 25. 00 CLI NI C 90. 01 0 2, 365 0 25. 00 25. 00 26. 00 26. 00 27. 00 MOORESVI LLE INFUSI ON CLI NI C 90. 02 0 403, 019 0 27. 00				-				
19.00 LABORATORY 60.00 0 20,501 0 19.00 20.00 INTRAVENOUS THERAPY 64.00 0 46,710,653 0 20.00 21.00 RESPI RATORY THERAPY 65.00 0 280,400 0 21.00 22.00 OCCUPATI ONAL THERAPY 67.00 0 990 0 22.00 23.00 ELECTROCARDI OLOGY 69.00 0 1117 0 23.00 24.00 RENAL DI ALYSI S 74.00 0 7,202 0 24.00 25.00 CLI NI C 90.01 0 2,365 0 25.00 25.00 26.00 IBMT JOI NT VENTURE 90.01 0 2,292 0 26.00 27.00 MOORESVI LLE INFUSION CLINIC 90.02 0 403,019 0 27.00				C		-		
20.00 INTRAVENOUS THERAPY 64.00 0 46,710,653 0 20.00 21.00 RESPI RATORY THERAPY 65.00 0 280,400 0 21.00 22.00 OCCUPATI ONAL THERAPY 67.00 0 990 0 22.00 23.00 ELECTROCARDIOLOGY 69.00 0 1117 0 23.00 24.00 RENAL DI ALYSI S 74.00 0 7,202 0 24.00 25.00 CLI NI C 90.01 0 2,365 0 25.00 25.00 25.00 26.00 27.00 26.00 27.00 27.00 26.00			59.00	C	32, 282	0		18.00
21.00 RESPIRATORY THERAPY 65.00 0 280,400 0 21.00 22.00 OCCUPATI ONAL THERAPY 67.00 0 990 0 22.00 23.00 ELECTROCARDI OLOGY 69.00 0 117 0 23.00 24.00 RENAL DI ALYSIS 74.00 0 7,202 0 24.00 25.00 CLI NI C 90.00 0 2,365 0 25.00 26.00 26.00 IBMT JOI NT VENTURE 90.01 0 2,292 0 26.00 27.00 MOORESVI LLE INFUSION CLINIC 90.02 0 403,019 0 27.00				-		-		
22.00 OCCUPATIONAL THERAPY 67.00 0 990 0 22.00 23.00 ELECTROCARDIOLOGY 69.00 0 117 0 23.00 24.00 RENAL DI ALYSIS 74.00 0 7,202 0 24.00 25.00 CLINIC 90.00 0 2,365 0 25.00 26.00 IBMT JOINT VENTURE 90.01 0 2,292 0 26.00 27.00 MOORESVILLE INFUSION CLINIC 90.02 0 403,019 0 27.00				C				
23.00 ELECTROCARDIOLOGY 69.00 0 117 0 23.00 24.00 RENAL DI ALYSIS 74.00 0 7,202 0 24.00 25.00 CLINIC 90.00 0 2,365 0 25.00 26.00 IBMT JOINT VENTURE 90.01 0 2,292 0 26.00 27.00 MOORESVILLE INFUSION CLINIC 90.02 0 403,019 0 27.00				C				
24.00 RENAL DI ALYSI S 74.00 0 7,202 0 24.00 25.00 CLI NI C 90.00 0 2,365 0 25.00 25.00 26.00 1BMT JOI NT VENTURE 90.01 0 2,292 0 26.00 26.00 27.00 20.02 0 403,019 0 27.00								
25.00 CLINIC 90.00 0 2,365 0 25.00 26.00 IBMT JOINT VENTURE 90.01 0 2,292 0 26.00 26.00 26.00 26.00 27.00 20.00 27.00 20.01 27.00				-		-		
26.00 I BMT_JOI NT_VENTURE 90.01 0 2,292 0 26.00 26.00 27.00 403,019 0 27.00 20.01				C		-		
				C		-		
28.00 CV DI AGNOSTI C SERVI CES 90.05 0 214, 274 0 28.00								
	28.00	CV DI AGNOSTI C SERVI CES	90.05	C	214, 274	0		28.00

FRANCI SCAN HEALTH I NDI ANAPOLI S Provi der CCN: 15-0162

	In Lieu	u of Form CMS-2552-10
	Peri od:	Worksheet A-6 Date/Time Prepared: 3/28/2024 2:21 pm
	From 01/01/2023	
	To 12/31/2023	Date/Time Prepared:
_		3/28/2024 2:21 pm

					ļ.,	3/28/2024 2	:21 pm
		Decreases					
	Cost Center	Line #	Sal ary	Other	Wkst. A-7 Ref.		
	6. 00	7.00	8.00	9.00	10.00		
29.00	EMERGENCY	<u>91.</u> 00	0	8 <u>8, 2</u> 41	0		29.00
	TOTALS		0	83, 985, 983			
	C - EQUIPMENT LEASE				· · · · · ·		
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0		10		1.00
2.00	OTHER ADMIN & GENERAL	5.03	0		10		2.00
3.00	OPERATION OF PLANT	7.00	0	2, 432, 804	0		3.00
4.00	HOUSEKEEPI NG	9.00	0	7, 766	0		4.00
5.00	DI ETARY	10.00	0	27, 659	0		5.00
6.00	CENTRAL SERVICES & SUPPLY	14.00	0	8, 228	0		6.00
7.00	PHARMACY	15.00	0	136, 878	0		7.00
8.00	I &R SERVICES-SALARY &	21.00	0	585	0		8.00
	FRINGES APPRV						
9.00	ADULTS & PEDIATRICS	30.00	0	18, 883	0		9.00
10.00	INTENSIVE CARE UNIT	31.00	0	7,638	0		10.00
11.00	CORONARY CARE UNIT	32.00	0	1, 695	o		11.00
12.00	SURGICAL INTENSIVE CARE UNIT	34.00	0	1, 391	0		12.00
13.00	SUBPROVIDER - IRF	41.00	0	447	0		13.00
14.00	OPERATING ROOM	50.00	0		0		14.00
15.00	RADI OLOGY-DI AGNOSTI C	54.00	0	203, 796	0		15.00
16.00	LABORATORY	60.00	0	17, 044	0		16.00
17.00	INTRAVENOUS THERAPY	64.00	0		0		17.00
17.00			0	7,850	0		1
	RESPIRATORY THERAPY	65.00	-	234, 226	0		18.00
19.00	PHYSICAL THERAPY	66.00	0	1, 017, 939	0		19.00
20.00	OCCUPATIONAL THERAPY	67.00	0	109, 156	0		20.00
21.00	ELECTROENCEPHALOGRAPHY	70.00	0	168, 975	0		21.00
22.00	CARDIAC REHABILITATION	76.97	0	127, 211	0		22.00
23.00	CLINIC	90.00	0	195, 769	0		23.00
24.00	CV DIAGNOSTIC SERVICES	90.05	0	2, 331, 501	0		24.00
25.00	EMERGENCY	91.00	0	3, 473	0		25.00
26.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	235, 334	0		26.00
27.00	OTHER NRCC	194.04	0	760, 143	0		27.00
	TOTALS		0	8, 723, 021	1		
	D - DEPRECIATION						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	66, 652	9		1.00
2.00	OTHER ADMIN & GENERAL	5.03	0	3, 264, 400	9		2.00
3.00	OPERATION OF PLANT	7.00	0	1, 241, 472	0		3.00
4.00	LAUNDRY & LINEN SERVICE	8.00	0	3, 455	0		4.00
5.00	HOUSEKEEPING	9.00	0	53, 501	0		5.00
6.00	DI ETARY	10.00	0	64, 229	0		6.00
7.00	CAFETERIA	11.00	0	29, 438	0		7.00
8.00	NURSI NG ADMI NI STRATI ON	13.00	0	86, 067	0		8.00
9.00	CENTRAL SERVICES & SUPPLY	13.00	0	266, 074	0		9.00
10.00	PHARMACY	15.00	0		0		10.00
			0	110, 895	0		
11.00	I&R SERVICES-SALARY &	21.00	0	239, 572	0		11.00
12 00	FRINGES APPRV	22.00	0	1 / 1 /	0		12.00
12.00	MEDICAL LABORATORY SCIENTIST	23.00	0	1, 614	0		12.00
10.00	PRGM	22.02	0	0 001	0		10.00
13.00	EMERGENCY MEDICAL SERVICES	23.02	0		0		13.00
14.00	SURGICAL TECH PROGRAM	23.04	0		0		14.00
15.00	ADULTS & PEDIATRICS	30.00	0	462, 346	0		15.00
16.00	INTENSIVE CARE UNIT	31.00	0	197, 377	0		16.00
17.00	NEONATAL INTENSIVE CARE UNIT	31.01	0	181, 270	0		17.00
18.00	CORONARY CARE UNIT	32.00	0	137, 453	0		18.00
19.00	SURGICAL INTENSIVE CARE UNIT	34.00	0	180, 356	0		19.00
20.00	SUBPROVIDER - IRF	41.00	0	30, 318	0		20.00
21.00	OPERATING ROOM	50.00	0	2, 723, 188	0		21.00
22.00	DELIVERY ROOM & LABOR ROOM	52.00	0	104, 306	0		22.00
23.00	RADI OLOGY-DI AGNOSTI C	54.00	0	1, 716, 347	0		23.00
24.00	RADI OLOGY-THERAPEUTI C	55.00	0	591, 774	0		24.00
25,00	RADI OI SOTOPE	56.00	0	106, 785	0		25.00
26.00	CARDIAC CATHETERIZATION	59.00	0	865, 666	0		26.00
27.00	LABORATORY	60.00	0	374, 008	0		27.00
27.00	I NTRAVENOUS THERAPY	64.00	0	235, 173	-		27.00
28.00 29.00	RESPIRATORY THERAPY	65.00	0	235, 173 279, 870			28.00
					0		
30.00	PHYSICAL THERAPY	66.00	0	34, 672	-		30.00
31.00	OCCUPATIONAL THERAPY	67.00	0	6, 963	0		31.00
32.00	SPEECH PATHOLOGY	68.00	0	305, 974	0		32.00
33.00	ELECTROCARDI OLOGY	69.00	0	39, 577	0		33.00
34.00	ELECTROENCEPHALOGRAPHY	70.00	0	224, 396	0		34.00
35.00	RENAL DI ALYSI S	74.00	0	8, 382	0		35.00
36.00	CARDIAC REHABILITATION	76.97	0	19, 349	0		36.00
37.00	CLINIC	90.00	0	407, 740	0		37.00
38.00	IBMT JOINT VENTURE	90.01	0	11, 620	0		38.00
39.00	CV DIAGNOSTIC SERVICES	90.05	0	125, 988	0		39.00
		•			,		

ASS.	I FI CATI ONS			Provider (CCN: 15-0162	Peri od:	Worksheet A-6
						From 01/01/2023 To 12/31/2023	Date/Time Prepa
		Decreases					3/28/2024 2:21
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref		
0	6.00 EMERGENCY	7.00	8.00	<u>9.00</u> 178,327	10.00	0	
	HOSPICE	116.00	0	608, 975		0	
	GIFT, FLOWER, COFFEE SHOP &	190.00	o	17, 152		0	
	CANTEEN						
	PHYSICIANS' PRIVATE OFFICES	192.00	0	18, 420		0	4
	OTHER NRCC	1 <u>94.</u> 04	0	<u>14, 482, 359</u> 30, 106, 344		0	4
L 1	E - CAFETERIA		0	30, 106, 344	<u> </u>		
	DI ETARY	10.00	1, 710, 385	1,034,602		0	
	TOTALS		1, 710, 385	1,034,602			
- P	F - PARAMEDICAL ED						
)		0.00	º_	0	'	<u>o</u>	
	TOTALS G - INTERNS AND RESIDENT		0	0			
	I&R SERVICES-SALARY &	21.00	3, 567, 849	435, 112		0	
	FRINGES APPRV	21100	0,00,,01,	1007 112			
		0.00	0	0		o	
	TOTALS		3, 567, 849	435, 112			
	H - EMPLOYEE BENEFITS EMPLOYEE BENEFITS DEPARTMENT	4.00	0	240.220		0	
	OTHER ADMIN & GENERAL	4.00 5.03	0	240, 328 47, 134		o	
	OPERATION OF PLANT	7.00	0	4		0	
	HOUSEKEEPI NG	9.00	0	5, 219		0	
	DI ETARY	10.00	0	3		0	
	CAFETERI A	11.00	0	1		0	
	NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY	13.00 14.00	0	8		0	
	PHARMACY	14.00	0	7, 671		0	
	I&R SERVICES-SALARY &	21.00	0	7,071		0	
	FRINGES APPRV						
	EMERGENCY MEDI CAL SERVI CES	23.02	0	1		0	
	ADULTS & PEDIATRICS	30.00	0	3, 318		0	
	INTENSIVE CARE UNIT NEONATAL INTENSIVE CARE UNIT	31.00 31.01	0	12, 174 4, 274		0	
	CORONARY CARE UNIT	32.00	0	2, 739		0	
00	SURGICAL INTENSIVE CARE UNIT	34.00	О	4, 598		0	
	SUBPROVIDER - IRF	41.00	0	4		0	
	OPERATING ROOM	50.00	0	2, 304		0	
	DELIVERY ROOM & LABOR ROOM	52.00	0	1, 996		0	
	RADI OLOGY-DI AGNOSTI C RADI OLOGY-THERAPEUTI C	54.00 55.00	0	16, 273 2		0	
	CARDIAC CATHETERIZATION	59.00	0	3		0	
	LABORATORY	60.00	0	1		0	
	INTRAVENOUS THERAPY	64.00	0	2, 068		0	
	RESPIRATORY THERAPY	65.00	0	8		0	
	PHYSI CAL THERAPY OCCUPATI ONAL THERAPY	66.00 67.00	0	9, 945		0	
	SPEECH PATHOLOGY	68.00	0	844 1		o	
	ELECTROCARDI OLOGY	69.00	õ	2		0	
0	ELECTROENCEPHALOGRAPHY	70.00	0	2		0	
	CARDIAC REHABILITATION	76.97	0	1		0	
		90.00	0	1,608		0	
	IBMT JOINT VENTURE CV DIAGNOSTIC SERVICES	90. 01 90. 05	U O	2 3, 627			
	EMERGENCY	90.05	0	3, 027		ŏ	
	HOSPI CE	116.00	õ	1, 730		o	
	GIFT, FLOWER, COFFEE SHOP &	190.00	0	1		0	
	CANTEEN	400.00		-			
	PHYSICIANS' PRIVATE OFFICES	192.00	0	8		0	
- E	OTHER_NRCC	1 <u>94.04</u>	0	2 <u></u> 2 367, 918			
	I - PHARMACY RESIDENCY		<u> </u>				
) [0.00	0	0		0	
	TOTALS		0	0			
	J - EMS & PARAMEDIC RECLASS	22.00		100,000			
	EMERGENCY MEDICAL SERVICES	<u>23.02</u>	0	10 <u>0,000</u> 100,000		0	
- H	K - HOME HEALTH RECLASS		U	100,000			
- F	HOME HEALTH AGENCY	101.00	ol	6		0	
Ē	TOTALS			6		1	
- E	L - NURSERY					1	
	ADULTS & PEDIATRICS	30.00	1, 520, 472	30, 672		0	
)		0.00	0			0	

Health Financial Systems FRANCISCAN HEALTH				H INDIANAPOLIS	S	In Lieu of Form CMS-2552		-2552-10
RECLAS	RECLASSI FI CATI ONS			Provider (CCN: 15-0162	Period:	Worksheet A-	6
						From 01/01/2023 To 12/31/2023	Date/Time Pr 3/28/2024 2:	
		Decreases						
	Cost Center	Line #	Sal ary	0ther	Wkst. A-7 Ref	·		
	6. 00	7.00	8.00	9.00	10.00			
	N - ALLOGENEIC STEM CELL TRAN	ISPLANT						
1.00	I BMT JOINT VENTURE	90.01	0	1, 332, 585		0		1.00
2.00	LABORATORY	60.00	0	17 <u>2, 8</u> 13		0		2.00
	TOTALS		0	1, 505, 398				
	0 - T-CELL IMMUNOTHERAPY							
1.00	ADULTS & PEDIATRICS	30.00	1, 946, 121	188, 480		0		1.00
2.00	IBMT JOINT VENTURE	90.01	997, 209	2, 985, 538		0		2.00
	TOTALS		2, 943, 330	3, 174, 018				
	P - WORKING WELL							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	1, 603, 275	530, 825		0		1.00
	TOTALS		1, 603, 275	530, 825		7		1
500.00	Grand Total: Decreases		11, 345, 311	212, 883, 601				500.00

Heal th Financial	Systems			
RECONCILIATION (OF CAPITAL	COSTS	CENTERS	

FRANCISCAN HEALTH INDIANAPOLIS Provider CCN: 15-0162 From 01 (01

In Lieu of Form CMS-2552-10 Worksheet A-7

					То	01/01/2023 12/31/2023	Part I Date/Time Pre 3/28/2024 2:2	pared: 1 pm
				Acqui si ti on	S			
		Begi nni ng	Purchases	Donati on		Total	Di sposal s and	
		Bal ances					Retirements	
		1.00	2.00	3.00		4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	BALANCES						
1.00	Land	21, 196, 680	0		0	0	0	1.00
2.00	Land Improvements	35, 234, 568	117, 739		0	117, 739	0	2.00
3.00	Buildings and Fixtures	251, 062, 099	9, 195, 934		0	9, 195, 934	0	3.00
4.00	Building Improvements	18, 931, 604	460, 101		0	460, 101	0	4.00
5.00	Fixed Equipment	283, 651, 816	1, 060, 068		0	1, 060, 068	0	5.00
6.00	Movable Equipment	191, 783, 031	6, 342, 862		0	6, 342, 862	0	6.00
7.00	HIT designated Assets	0	0		0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	801, 859, 798	17, 176, 704		0	17, 176, 704	0	8.00
9.00	Reconciling Items	0	8, 582, 507		0	8, 582, 507	0	9.00
10.00	Total (line 8 minus line 9)	801, 859, 798	8, 594, 197		0	8, 594, 197	0	10.00
		Endi ng Bal ance	Fully					
		-	Depreci ated					
			Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	BALANCES		-				
1.00	Land	21, 196, 680	0					1.00
2.00	Land Improvements	35, 352, 307	0					2.00
3.00	Buildings and Fixtures	260, 258, 033	0					3.00
4.00	Building Improvements	19, 391, 705	0					4.00
5.00	Fixed Equipment	284, 711, 884	0					5.00
6.00	Movable Equipment	198, 125, 893	0					6. OC
7.00	HIT designated Assets	0	0					7. OC
8.00	Subtotal (sum of lines 1-7)	819, 036, 502	0					8.00
9.00	Reconciling Items	8, 582, 507	0					9.00
10.00	Total (line 8 minus line 9)	810, 453, 995	0					10.00

Heal th	Financial Systems F	RANCI SCAN HEALT	TH INDIANAPOLIS	S	In Lie	u of Form CMS-2	2552-10
RECONO	ILIATION OF CAPITAL COSTS CENTERS		Provider (CCN: 15-0162	Peri od:	Worksheet A-7	
					From 01/01/2023 To 12/31/2023	Part II Date/Time Pre	narodi
					10 12/31/2023	3/28/2024 2:2	pareu. 1 pm
			S	SUMMARY OF CAF	PI TAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see		
					instructions)		
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUN	IN 2, LINES 1 a	and 2	-	-	
1.00	CAP REL COSTS-BLDG & FIXT	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 0	OF CAPITAL				
				_			
	Cost Center Description		Total (1) (sur	m			
		Capital - Relate					
		d Costs (see	through 14)				
		instructions)	15.00	-			
	DADT IL DECONCLULATION OF ANOUNTS FROM WOD	14.00	15.00				
1 00	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUN	/IN Z, LINES I a	and 2			1 1 00
1.00	CAP REL COSTS-BLDG & FIXT	0					1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	(2.00
3.00	Total (sum of lines 1-2)	0) (U			3.00

Health Financial Systems FR	RANCISCAN HEALT	H INDIANAPOLIS		In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider C	F	Period: From 01/01/2023 Fo 12/31/2023	Date/Time Prep 3/28/2024 2:21	pared: 1 pm
	COM	PUTATION OF RAT	-1 OS	ALLOCATION OF	OTHER CAPITAL	
Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col. 2)		Insurance	
PART III - RECONCILIATION OF CAPITAL COSTS CE	1.00	2.00	3.00	4.00	5.00	
1.00 CAP REL COSTS-BLDG & FIXT 2.00 CAP REL COSTS-BLDG & FIXT 3.00 Total (sum of lines 1-2)	612, 328, 102 198, 125, 893 810, 453, 995	0	198, 125, 893 801, 871, 488	0. 247079	0	1.00 2.00 3.00
Cost Center Description	Taxes	Other Capi tal -Rel ate d Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
	6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE	INTERS			04 400 050	0.010.000	1 00
1.00 CAP REL COSTS-BLDG & FIXT 2.00 CAP REL COSTS-MVBLE EQUIP 3.00 Total (sum of lines 1-2)	0			21, 109, 359 15, 463, 659 36, 573, 018		1.00 2.00 3.00
		SL	IMMARY OF CAPI		0,010,770	0100
Cost Center Description	Interest	Insurance (see instructions)		Other Capital-Relate d Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
	11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE 1.00 CAP REL COSTS-BLDG & FIXT 2.00 CAP REL COSTS-MVBLE EQUIP	NTERS 10, 826, 180 0	0			39, 949, 429 16, 068, 747	1.00 2.00
3.00 Total (sum of lines 1-2)	10, 826, 180	0	(0	56, 018, 176	3.00

	Financial Systems MENTS TO EXPENSES	FR	ANCI SCAN HEALT	H INDIANAPOLIS Provider CCN: 15-0162	In Lie Period:	eu of Form CMS-2 Worksheet A-8	2552-10
100001					From 01/01/2023 To 12/31/2023		
				Expense Classification of To/From Which the Amount i			
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
1.00		1.00	2.00	3.00	4.00	5.00	1.00
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			CAP REL COSTS-BLDG & FIXT	1.00		1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time		0		0.00	0	4.00
5.00	discounts (chapter 8) Refunds and rebates of	В	0		0.00	0	5.00
6.00	expenses (chapter 8) Rental of provider space by		0		0.00	0	6.00
7.00	suppliers (chapter 8) Telephone services (pay		0		0.00		7.00
7.00	stations excluded) (chapter		0		0.00	0	7.00
8.00	21) Television and radio service		0		0.00	0	8.00
9.00	(chapter 21) Parking Lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician	A-8-2	-15, 057, 184			0	10.00
11.00	adjustment Sale of scrap, waste, etc.		0		0.00	0	11.00
12.00	(chapter 23) Related organization	A-8-1	244, 534, 129			0	12.00
13.00	transactions (chapter 10) Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	В	-2, 641, 090	CAFETERI A	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than		0		0.00	0	16.00
17.00	patients Sale of drugs to other than		0		0.00	0	17.00
	patients		0				
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees,		0		0.00	0	19.00
20.00	books, etc.)	P	F2 1F0	CAFETERI A	11.00		20.00
	Vending machines Income from imposition of	В	-52, 150 0		11.00 0.00		20. 00 21. 00
	interest, finance or penalty charges (chapter 21)						
22.00	Interest expense on Medicare overpayments and borrowings to		0		0.00	0	22.00
	repay Medicare overpayments				(5.00		
23.00	Adjustment for respiratory therapy costs in excess of	A-8-3	0	RESPI RATORY THERAPY	65.00		23.00
24.00	limitation (chapter 14) Adjustment for physical	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
	therapy costs in excess of limitation (chapter 14)						
25.00	Utilization review -		0	*** Cost Center Deleted ***	* 114.00		25.00
	physicians' compensation (chapter 21)						
26.00	Depreciation - CAP REL COSTS-BLDG & 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
	Non-physician Anesthetist		0	*** Cost Center Deleted ***			28.00
	Physicians' assistant Adjustment for occupational	A-8-3	0 0	OCCUPATI ONAL THERAPY	0.00 67.00		29.00 30.00
	therapy costs in excess of limitation (chapter 14)						
30. 99	Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30.00		30. 99
31.00	instructions) Adjustment for speech	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
	pathology costs in excess of limitation (chapter 14)						
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	MI SCELLANEOUS I NCOME	В	-254, 015	EMPLOYEE BENEFITS DEPARTMEN	NT 4.00	o	33.00

	Financial Systems MENTS TO EXPENSES	FR	ANUT SUAN HEALT		eriod:	u of Form CMS-2 Worksheet A-8	
				F	rom 01/01/2023 o 12/31/2023	Date/Time Pre	pared:
						3/28/2024 2:2	
				Expense Classification on To/From Which the Amount is			
					·····, ····,		
	Cost Center Description	Basi s/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
	Г	1.00	2.00	3.00	4.00	5.00	
	MI SCELLANEOUS I NCOME	В		OTHER ADMIN & GENERAL	5.03		
	MI SCELLANEOUS I NCOME MI SCELLANEOUS I NCOME	B B		OPERATION OF PLANT	7.00		
	MI SCELLANEOUS I NCOME	В		LAUNDRY & LINEN SERVICE DIETARY	8.00 10.00		
	MI SCELLANEOUS I NCOME	B		CAFETERIA	11.00		
	MI SCELLANEOUS I NCOME	В		NURSING ADMINISTRATION	13.00		
33.07	MI SCELLANEOUS I NCOME	В	-200, 037	CENTRAL SERVICES & SUPPLY	14.00	0	33.0
33. 08	MI SCELLANEOUS I NCOME	В	-26, 459	PHARMACY	15.00	0	33.08
33.09	MI SCELLANEOUS I NCOME	В	-32,445	I&R SERVICES-SALARY &	21.00	0	33.09
22.10		D	10 700	FRINGES APPRV	22.00		22.10
33. 10	MI SCELLANEOUS I NCOME	В	- 10, 700	MEDICAL LABORATORY SCIENTIST PRGM	23.00	0	33.10
33. 11	MI SCELLANEOUS I NCOME	В	-510 472	PRGM 2 EMERGENCY MEDICAL SERVICES	23.02	0	33. 11
	MI SCELLANEOUS I NCOME	B		SURGICAL TECH PROGRAM	23.02	0	
	MI SCELLANEOUS I NCOME	В		SURGICAL INTENSIVE CARE UNIT		0	
	MI SCELLANEOUS I NCOME	В	-154	DELIVERY ROOM & LABOR ROOM	52.00	0	33. 14
	MI SCELLANEOUS I NCOME	В		RADI OLOGY-DI AGNOSTI C	54.00		
	MI SCELLANEOUS I NCOME	В		RADI OLOGY-THERAPEUTI C	55.00		
	MI SCELLANEOUS I NCOME	В		CARDIAC CATHETERIZATION	59.00		
	MI SCELLANEOUS I NCOME	B B		INTRAVENOUS THERAPY	64.00 65.00	0	
	MI SCELLANEOUS I NCOME MI SCELLANEOUS I NCOME	В		RESPI RATORY THERAPY	65.00 66.00	0 0	
	MI SCELLANEOUS I NCOME	В		OCCUPATIONAL THERAPY	67.00		
	MI SCELLANEOUS I NCOME	B		SPEECH PATHOLOGY	68.00		
	MI SCELLANEOUS I NCOME	B		BELECTROENCEPHALOGRAPHY	70.00		
	MI SCELLANEOUS I NCOME	В	-332, 961		90.00	0	
	MI SCELLANEOUS I NCOME	В		I BMT JOI NT VENTURE	90.01	0	
33. 26	MI SCELLANEOUS I NCOME	В	-155, 538	CV DIAGNOSTIC SERVICES	90.05	0	33.26
33. 27	MI SCELLANEOUS I NCOME	В		BEMERGENCY	91.00	0	
33. 28	MI SCELLANEOUS I NCOME	В	-1, 952, 631	MEDICAL SUPPLIES CHARGED TO	71.00	0	33.28
			4 4 40 504	PATIENT	70.00		
33. 29	MI SCELLANEOUS I NCOME	В	-1, 140, 594	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	33. 29
34.00	ADVERTI SI NG	А	-11 247	OTHER ADMIN & GENERAL	5.03	0	34.00
34.00	ADVERTI SI NG	A		OPERATION OF PLANT	7.00		
34.02	ADVERTI SI NG	A		NURSI NG ADMI NI STRATI ON	13.00		
34.03	ADVERTI SI NG	А		I&R SERVICES-SALARY &	21.00	0	
				FRINGES APPRV			
34.04	ADVERTI SI NG	A	-49	MEDICAL LABORATORY SCIENTIST	23.00	0	34.04
				PRGM			
34.05	ADVERTI SI NG	A		PHARMACY PRGM	23.01	0	
34.06	ADVERTI SI NG	A		SURGICAL TECH PROGRAM	23.04	0	
	ADVERTI SI NG ADVERTI SI NG	A A		NEONATAL INTENSIVE CARE UNIT RADIOLOGY-DIAGNOSTIC	31.01 54.00	0	
	ADVERTI SI NG	A		CLINIC	90.00	0	
	ADVERTI SI NG	A		BMT JOINT VENTURE	90.00	0	
34.10	ADVERTI SI NG	A		CV DIAGNOSTIC SERVICES	90.01	0	
34. 12	ADVERTI SI NG	A		EMERGENCY	91.00		
34.13	ADVERTI SI NG	A		BHOSPICE	116.00	0	
35.00	PHYSICIAN RECRUITMENT	A	-62, 305	I&R SERVICES-SALARY &	21.00	0	35.00
				FRINGES APPRV			
36.00	PROVIDER TAX (HIP HAF)	A		OTHER ADMIN & GENERAL	5.03		
37.00	LOBBYING FEES	A		OTHER ADMIN & GENERAL	5.03		
38.00	DONATIONS	A		OTHER ADMIN & GENERAL	5.03		
39. 00 39. 01	NRCC PHYSI CLANS NRCC PHYSI CLANS	A A		HOSPICE PHYSICIANS' PRIVATE OFFICES	116.00 192.00	0	
39.01	NRCC PHYSICIANS	A		MARKETING & COMMUNITY	192.00		
57.02		<u> </u>	2,724	RELATIONS	174.00		
39. 03	NRCC PHYSI CLANS	A	-204, 686	OTHER NRCC	194.04	0	39.03
40.00	PENSION	A		EMPLOYEE BENEFITS DEPARTMENT	4.00		
50.00	TOTAL (sum of lines 1 thru 49)		157, 339, 406				50.00
	(Transfer to Worksheet A,						
	column 6, line 200.)						

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

(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
 Note: See instructions for column 5 referencing to Worksheet A-7.

Heal th	Financial Systems	FRANCI SCAN HEAL	TH INDIANAPOLIS	In Lie	eu of Form CMS-2	2552-10
	ENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HO	ME Provider CCN: 15-0162	Peri od:	Worksheet A-8	-1
OFFICE	COSTS			From 01/01/2023 To 12/31/2023		
	Li ne No.	Cost Center	Expense Items	Amount of	Amount	
				Allowable Cost	Included in	
					Wks. A, column	
					5	
	1.00	2.00	3. 00	4.00	5.00	
	A. COSTS INCURRED AND ADJUST	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED (ORGANIZATIONS OR	CLAI MED	
	HOME OFFICE COSTS:					
1.00		EMPLOYEE BENEFITS DEPARTMENT		575, 717	0	1.00
2.00		OTHER ADMIN & GENERAL	SHARED SERVICES	71, 070, 388	0	2.00
3.00		OPERATION OF PLANT	SHARED SERVICES	6, 890, 201	0	3.00
3.01		NURSING ADMINISTRATION	SHARED SERVICES	359, 023	0	3.01
3.02		MEDICAL RECORDS & LIBRARY	SHARED SERVICES	81, 909		3. 02
3.03	54.00	RADI OLOGY-DI AGNOSTI C	SHARED SERVICES	1, 512, 710	0	3.03
3.04	194.04	OTHER NRCC	SHARED SERVICES	29, 420, 945	0	3.04
3.05	194. 05	FOUNDATION	SHARED SERVICES	14, 987	0	3.05
4.00	1.00	CAP REL COSTS-BLDG & FIXT	FRANCISCAN HOME OFFICE	453, 044	0	4.00
4.01	1.00	CAP REL COSTS-BLDG & FIXT	FRANCISCAN HOME OFFICE	10, 826, 180	0	4.01
4.02	2.00	CAP REL COSTS-MVBLE EQUIP	FRANCISCAN HOME OFFICE	6, 013, 630	0	4.02
4.03	5. 03	OTHER ADMIN & GENERAL	FRANCISCAN HOME OFFICE	111, 946, 553	0	4.03
4.04	15.00	PHARMACY	FRANCISCAN HOME OFFICE	1, 569, 478	0	4.04
4.05	16.00	MEDICAL RECORDS & LIBRARY	FRANCISCAN HOME OFFICE	3, 799, 364	0	4.05
5.00	TOTALS (sum of lines 1-4).			244, 534, 129	0	5.00
	Transfer column 6, line 5 to					
	Worksheet A-8, column 2,					
	line 12.					
* The	amounts on Lines 1-4 (and sub	scripts as appropriate) are t	transferred in detail to Wor	ksheet A column	6 lines as	

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

has not been posted to worksheet A, eordinins i and/or 2, the amount arrowable should be indicated in cordinin 4 or this part.											
				Related Organization(s) and/or Home Office							
	Symbol (1)	Name	Percentage of	Name	Percentage of						
			Ownershi p		Ownership						
	1.00	2.00	3.00	4.00	5.00						
	B. INTERRELATIONSHIP TO RELAT	TED ORGANIZATION(S) AND/OR HO	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:								

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

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

В	SISTERS	100.00	0.	00	6.00
В	APHL	100.00	0.	00	7.00
		0.00	0.	20	8.00
		0.00	0.	20	9.00
		0.00	0.	20	10.00
G. Other (financial or				· ·	100.00
non-financial) specify:					
		B APHL G. Other (financial or	B APHL 100.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00	B APHL 100.00 0.00 0.00 0.00 0.00 0.00 0.00 0.	B APHL 100.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 6. Other (financial or 0.00 0.00 0.00

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

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

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

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

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

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

Health Financial Syste	ms	FRANCI SCAN HEALTH I	NDI ANAPOLI S	u of Form CMS-2552-10	
STATEMENT OF COSTS OF OFFICE COSTS	SERVICES FROM RELATED ORG	ANIZATIONS AND HOME	Provider CCN: 15-0162	Period: From 01/01/2023	Worksheet A-8-1
UTTEL COSTS					Date/Time Prepared: 3/28/2024 2:21 pm
Net Adiustments	Wkst. A-7 Ref.				

	Net	WKST. A-7 Ref.	
	Adjustments		
	(col. 4 minus		
	col. 5)*		
	6.00	7.00	
	A. COSTS INCUR	RED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED	
	HOME OFFICE CO		
1.00	575, 717	0	1.00
2.00	71, 070, 388	0	2.00
3.00	6, 890, 201	0	3.00
3.01	359, 023	0	3.01
3.02	81, 909		3. 02
3.03	1, 512, 710	O	3.03
3.04	29, 420, 945	0	3.04
3.05	14, 987	0	3.05
4.00	453, 044	9	4.00
4.01	10, 826, 180	11	4.01
4.02	6, 013, 630	9	4. 02
4.03	111, 946, 553	O	4.03
4.04	1, 569, 478	O	4.04
4.05	3, 799, 364	0	4.05
5.00	244, 534, 129		5.00

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

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

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

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

6.00	6.00
7.00 SHARED LAB	7.00
8.00	8.00
9.00 10.00	9.00
10.00	10.00
100.00	100.00
(1) Use the fall suitage sumbals to indicate intermediationship	

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

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

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

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

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

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

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

Heal th Financial Systems PROVIDER BASED PHYSICIAN ADJUSTMENT

FRANCI SCAN HEALTH I NDI ANAPOLI S Provi der CCN: 15-0162 Peri od:

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

PROVI DI	ER BASED PHYSIC	IAN ADJUSIMENI		Provider C		Period: From 01/01/2023	Worksheet A-8	3-2
						To 12/31/2023		
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	3/28/2024 2:2 Physi ci an/Prov	
	WRSt. A LINC #	I denti fi er	Remuneration	Component	Component		ider Component	
		i dontri i i or	Remarker are on	oomponont	oomponent		Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	930, 260	930, 260	С	211, 500	0	1.00
2.00	5.03	OTHER ADMIN & GENERAL	2, 376, 832	2, 376, 832	C	211, 500	0	2.00
3.00	15.00	PHARMACY	12, 600	12, 600	C	211, 500	0	3.00
4.00	22.00	I&R SERVICES-OTHER PRGM	1, 898, 518	0	1, 898, 518	179,000	12, 980	4.00
		COSTS APPRV						
5.00	23. 02	EMERGENCY MEDICAL SERVICES	24, 000	24, 000	C	211, 500	0	5.00
6.00	30.00	ADULTS & PEDIATRICS	12, 567	12, 567	C	211, 500	0	6.00
7.00	31.00	INTENSIVE CARE UNIT	35, 625	35, 625	C	211, 500	0	7.00
8.00	31.01	NEONATAL INTENSIVE CARE UNIT	394, 596	394, 596	C	211, 500	0	8.00
9.00	41.00	SUBPROVIDER – IRF	6, 700	6, 700	C	211, 500	0	9.00
10.00	50.00	OPERATING ROOM	6, 340, 692	6, 340, 692	C	246, 400	0	10.00
11.00	54.00	RADI OLOGY-DI AGNOSTI C	1, 361, 819	1, 361, 819	C	271, 900	0	11.00
12.00	59.00	CARDI AC CATHETERI ZATI ON	181, 551	181, 551	C	211, 500	0	12.00
13.00	60.00	LABORATORY	31, 050	31, 050	C	211, 500	0	13.00
14.00	65.00	RESPI RATORY THERAPY	31, 857	31, 857	C	211, 500	0	14.00
15.00	67.00	OCCUPATI ONAL THERAPY	3, 320	3, 320	C	211, 500	0	15.00
16.00	69.00	ELECTROCARDI OLOGY	178, 970	178, 970	C	211, 500	0	16.00
17.00	70.00	ELECTROENCEPHALOGRAPHY	25, 378	25, 378	C	211, 500	0	17.00
18.00	90.00	CLINIC	832, 868	832, 868	C	211, 500	0	18.00
19.00	90.01	IBMT JOINT VENTURE	706, 403	706, 403	C	211, 500	0	19.00
20.00	90.05	CV DIAGNOSTIC SERVICES	680, 103	680, 103	C	211, 500	0	20.00
21.00	91.00	EMERGENCY	108, 504	108, 504	C	211, 500	0	21.00
200.00			16, 174, 213	14, 275, 695	1, 898, 518	8	12, 980	200.00

Heal th	Financial Syste	ems I	FRANCI SCAN HEAL	TH INDIANAPOLI	S	In Lie	eu of Form CMS-	2552-10
PROVI D	ER BASED PHYSIC	I AN ADJUSTMENT		Provi der (Peri od:	Worksheet A-8	-2
			_	_		From 01/01/2023 To 12/31/2023		
	Wkst. A Line #		Unadjusted RCE		Cost of		Physician Cost	
		I denti fi er	Limit	Unadjusted RCE			of Malpractice	
				Limit	Conti nui ng Educati on	Share of col. 12	Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00		EMPLOYEE BENEFITS DEPARTMENT	0	C)	0 0	0	1.00
2.00	5.03	OTHER ADMIN & GENERAL	0	l c		0 0	0	2.00
3.00	15.00	PHARMACY	0	c c		0 0	0	3.00
4.00	22.00	I&R SERVICES-OTHER PRGM	1, 117, 029	55, 851	(0 0	0	4.00
		COSTS APPRV						
5.00		EMERGENCY MEDICAL SERVICES	0	C)	0 0	0	5.00
6.00		ADULTS & PEDIATRICS	0	C)	0 0	0	6.00
7.00		INTENSIVE CARE UNIT	0	C)	0 0	0	7.00
8.00		NEONATAL INTENSIVE CARE UNIT	0	C		0 0	0	8.00
9.00		SUBPROVIDER – IRF	0	C		0 0	0	9.00
10.00		OPERATING ROOM	0	C		0 0	0	10.00
11.00		RADI OLOGY-DI AGNOSTI C	0			0 0	0	11.00
12.00		CARDI AC CATHETERI ZATI ON	0			0 0	0	12.00
13.00			0			0	0	13.00
14.00			0				0	14.00
15.00 16.00		OCCUPATI ONAL THERAPY ELECTROCARDI OLOGY					0	15. 00 16. 00
16.00		ELECTROENCEPHALOGRAPHY					0	17.00
17.00		CLINIC					0	17.00
19.00		IBMT JOINT VENTURE					0	19.00
20.00		CV DI AGNOSTI C SERVI CES					0	20.00
20.00		EMERGENCY					0	20.00
200.00			1, 117, 029	55, 851			0	200.00
		1			1	1		

Heal th	Financial Syste	ems I	RANCI SCAN HEAL	TH INDIANAPOLIS	6	In Lie	u of Form CMS-	2552-10
PROVI D	ER BASED PHYSIC	I AN ADJUSTMENT		Provider (Peri od:	Worksheet A-8	3-2
						From 01/01/2023 To 12/31/2023	Date/Time Pre	epared:
							3/28/2024 2:2	
	Wkst. A Line #		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		
1.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	(930, 260		1.00
2.00	5. 03	OTHER ADMIN & GENERAL	0	0	(2, 376, 832		2.00
3.00	15.00	PHARMACY	0	0	(12,600		3.00
4.00	22.00	I&R SERVICES-OTHER PRGM COSTS APPRV	0	1, 117, 029	781, 489	781, 489		4.00
5.00	23. 02	EMERGENCY MEDICAL SERVICES	0	0	(24,000		5.00
6.00	30.00	ADULTS & PEDIATRICS	0	0	(12, 567		6.00
7.00	31.00	INTENSIVE CARE UNIT	0	0	(35, 625		7.00
8.00	31.01	NEONATAL INTENSIVE CARE UNIT	0	0	(394, 596		8.00
9.00	41.00	SUBPROVIDER – IRF	0	0	(6, 700		9.00
10.00	50.00	OPERATING ROOM	0	0	(6, 340, 692		10.00
11.00		RADI OLOGY-DI AGNOSTI C	0	0	(1, 361, 819		11.00
12.00	59.00	CARDI AC CATHETERI ZATI ON	0	0	(0 181, 551		12.00
13.00		LABORATORY	0	0	(31, 050		13.00
14.00		RESPI RATORY THERAPY	0	0	(31, 857		14.00
15.00		OCCUPATIONAL THERAPY	0	0	(3, 320		15.00
16.00		ELECTROCARDI OLOGY	0	0	(178, 970		16.00
17.00		ELECTROENCEPHALOGRAPHY	0	0	(25, 378		17.00
18.00			0	0	(832, 868		18.00
19.00		I BMT JOI NT VENTURE	0	0	(706, 403		19.00
20.00		CV DI AGNOSTI C SERVI CES	0	0	(680, 103		20.00
21.00		EMERGENCY	0	0 1 117 000	701 400	108, 504		21.00
200.00	1		0	1, 117, 029	781, 489	9 15, 057, 184		200.00

T ALLOCATION - GENERAL SERVICE COSTS		Provider CC	F	Period: From 01/01/2023 To 12/31/2023	u of Form CMS- Worksheet B Part I Date/Time Pre	epare
		CAPI TAL REL	ATED COSTS		3/28/2024 2:2	21 pm
Cost Center Description	Net Expenses for Cost	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFI TS	ADMI TTI NG	
	Allocation			DEPARTMENT		
	(from Wkst A					
	<u>col. 7)</u>	1.00	2.00	4.00	5.01	
GENERAL SERVICE COST CENTERS	0	1.00	2.00	4.00	5.01	
00 00100 CAP REL COSTS-BLDG & FIXT	39, 949, 429	39, 949, 429				1.
00 00200 CAP REL COSTS-MVBLE EQUIP	16, 068, 747		16, 068, 747	,		2
00 00400 EMPLOYEE BENEFITS DEPARTMENT	619, 948		C			4
	-19	106, 414	42, 803		149, 198	
02 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 03 00590 OTHER ADMI N & GENERAL	0 200, 846, 028	43, 704 108, 297	17, 579 43, 560		0	
00 00700 OPERATION OF PLANT	19, 113, 318	5, 262, 123			0	
00 00800 LAUNDRY & LINEN SERVICE	1, 919, 881	362, 274	145, 717		0	
00 00900 HOUSEKEEPI NG	8, 723, 876	299, 116			0	9
00 01000 DI ETARY	2, 438, 341	401, 989			0	
00 01100 CAFETERIA	2, 229, 603	685, 955	275, 910		0	
00 01300 NURSI NG ADMI NI STRATI ON	4, 453, 398	0			0	
00 01400 CENTRAL SERVICES & SUPPLY 00 01500 PHARMACY	2, 980, 719 8, 174, 103	1, 262, 313 547, 267	507, 736 220, 125		0	
00 01600 MEDICAL RECORDS & LIBRARY	3, 909, 866	547,207	220, 125		0	
00 02100 I &R SERVICES-SALARY & FRINGES APPRV	2, 275, 923	41, 553	16, 714	-	0	
00 02200 I &R SERVICES-OTHER PRGM COSTS APPRV	1,046,751	0	C		0	
00 02300 MEDICAL LABORATORY SCIENTIST PRGM	35, 949	0	C	130	0	
01 02302 PHARMACY PRGM	326, 045	0	C		0	
02 02301 EMERGENCY MEDICAL SERVICES	144, 837	0	C		0	
03 02303 PARAMEDIC PRGM 04 02305 SURGICAL TECH PROGRAM	100,000	0		-	0	
INPATIENT ROUTINE SERVICE COST CENTERS	160, 641	0	(452	0	23
00 03000 ADULTS & PEDIATRICS	47, 900, 703	6, 256, 608	2, 516, 575	98, 428	19, 316	30
00 03100 I NTENSI VE CARE UNI T	10, 204, 609				3, 742	
01 02060 NEONATAL INTENSIVE CARE UNIT	5, 682, 317	712, 760			3, 275	
00 03200 CORONARY CARE UNI T	12, 954, 862	2, 174, 678	874, 714	30, 715	3, 677	32
00 03400 SURGI CAL INTENSI VE CARE UNI T	9, 244, 722	1, 098, 612	441, 892		2, 640	
00 04100 SUBPROVIDER - IRF	4, 326, 909	764, 802	307, 624		1, 620	
00 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	1, 366, 964	97, 315	39, 143	4, 047	611	43
00 05000 OPERATING ROOM	19, 736, 803	4, 740, 048	1, 906, 576	41, 346	15, 283	50
00 05200 DELIVERY ROOM & LABOR ROOM	3, 486, 984	1, 229, 859			4,003	
00 05400 RADI OLOGY-DI AGNOSTI C	15, 981, 271	2, 730, 909	1, 098, 446	28, 784	9, 967	54
00 05500 RADI OLOGY-THERAPEUTI C	8, 817, 201	174, 548				
00 05600 RADI OI SOTOPE	280, 020	52, 176	20, 987		246	
00 05900 CARDI AC CATHETERI ZATI ON	2, 754, 019				6, 483 12, 997	
00 06000 LABORATORY 00 06400 I NTRAVENOUS THERAPY	23, 985, 565 4, 069, 728		565, 360 235, 577		641	
00 06500 RESPI RATORY THERAPY	9, 775, 709	186, 202	74, 896		4, 646	
00 06600 PHYSI CAL THERAPY	5, 917, 060	512, 662	206, 207		2, 061	
00 06700 OCCUPATIONAL THERAPY	2, 657, 539	0	C	8, 109	1, 642	67
00 06800 SPEECH PATHOLOGY	1, 343, 796	86, 826	34, 924		610	
00 06900 ELECTROCARDI OLOGY	1, 315, 286	774, 215	311, 410		2, 953	
00 07000 ELECTROENCEPHALOGRAPHY	1, 922, 913	189, 609	76, 266		792	
00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 00 07200 IMPL. DEV. CHARGED TO PATIENTS	49, 495, 692 30, 300, 785	0			14, 093 8, 228	
00 07300 DRUGS CHARGED TO PATIENTS	83, 985, 983	0			8, 228 15, 931	
00 07400 RENAL DI ALYSI S	1, 398, 317	158, 635	63, 807	0	710	
97 07697 CARDI AC REHABI LI TATI ON	560, 919		C		14	
00 07700 ALLOGENEIC HSCT ACQUISITION	1, 505, 398		32, 418	0	0	77
00 07800 CAR T-CELL IMMUNOTHERAPY	6, 117, 348	0	C	8, 889	2, 532	78
OUTPATIENT SERVICE COST CENTERS			054.054	01.007		1
00 09000 CLINIC	6, 361, 017	880, 226	354, 051		80	
01 09001 I BMT JOINT VENTURE 02 09002 MOORESVILLE INFUSION CLINIC	1, 443, 019 30, 242	79, 250 5, 962	31, 877 2, 398		293 0	
05 09005 CV DI AGNOSTI C SERVI CES	8, 875, 815	5, 902 0	2, 390		42	
00 09100 EMERGENCY	12, 627, 758	2, 131, 063	857, 171		9, 575	
00 09200 OBSERVATION BEDS (NON-DISTINCT PART		,			.,	92
OTHER REIMBURSABLE COST CENTERS	1					
. 00 10100 HOME HEALTH AGENCY	0	0				101
2. 00 10200 OPI OI D TREATMENT PROGRAM	0	0	C	0 0	0	102
SPECIAL PURPOSE COST CENTERS 3. 00 11300 I NTEREST EXPENSE						113
0. 00 11600 H0SPI CE	6, 577, 329	0	r c	18, 597	a	113
B. 00 SUBTOTALS (SUM OF LINES 1 through 117)	718, 521, 986		15, 377, 990		7 149, 198	
NONREI MBURSABLE COST CENTERS						
0. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	767, 560	162, 176	65, 232	1, 230	0	190

Health Financial Systems	FRANCI SCAN HEALT	H INDIANAPOLIS		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC		Period: From 01/01/2023 To 12/31/2023		
		CAPI TAL REL	ATED COSTS		372072024 2.2	
Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFI TS DEPARTMENT	ADMI TTI NG	
	0	1.00	2.00	4.00	5. 01	
192.00 19200 PHYSICIANS' PRIVATE OFFICES	7, 418, 523	221, 659	89, 15	7 22, 995	C	192.00
194.0007955 MARKETING & COMMUNITY RELATIONS	57, 925	0		0 183	C	194.00
194.0107952 WOMEN'S CENTER	0	132, 009	53, 09	8 0	C	194.01
194.0207950 OTHER NONREIMBURSABLE COST CENTERS	0	0		0 0	C	194.02
194.0407954 OTHER NRCC	82, 125, 021	1, 201, 485	483, 27	0 5, 496	C	194.04
194.05 07956 FOUNDATION 200.00 Cross Foot Adjustments	14, 987	0		0 0	C	194. 05 200. 00
201.00 Negative Cost Centers		0		0 0	C	201.00
202.00 TOTAL (sum lines 118 through 201)	808, 906, 002	39, 949, 429	16, 068, 74	7 619, 948	149, 198	202.00

	Financial Systems FR ALLOCATION - GENERAL SERVICE COSTS	ANCISCAN HEALT	Provi der CC		eri od:	u of Form CMS-2 Worksheet B	
				Fr	com 01/01/2023 12/31/2023	Part I Date/Time Pre	pared:
	Cost Center Description	Subtotal	CASHI ERI NG/ACC OUNTS	Subtotal	OTHER ADMIN & GENERAL	3/28/2024 2:2 OPERATI ON OF PLANT	1 pm
		5A. 01	RECEIVABLE	5A. 02	E 02	7.00	
	GENERAL SERVICE COST CENTERS	5A. UT	5.02	5A. U2	5.03	7.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00 4.00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT						2.00 4.00
4.00 5.01	00400 EMPLOTEE BENEFITS DEPARTMENT						5.01
5.02	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	61, 283	61, 283				5.02
5.03	00590 OTHER ADMIN & GENERAL	201, 015, 290	15, 087	201, 030, 377	201, 030, 377		5.03
7.00 8.00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	26, 502, 082	2, 014 185	26, 504, 096	8, 765, 170	35, 269, 266	7.00
8.00 9.00	00900 HOUSEKEEPING	2, 428, 441 9, 155, 016	696	2, 428, 626 9, 155, 712	803, 171 3, 027, 886	371, 117 306, 417	9.00
10.00	01000 DI ETARY	3, 005, 776	228	3, 006, 004	994, 116	411, 801	
11.00	01100 CAFETERI A	3, 198, 800	243	3, 199, 043	1, 057, 956	702, 698	
13.00 14.00	01300 NURSI NG ADMI NI STRATI ON	4, 465, 298	339	4, 465, 637	1, 476, 831	1 202 124	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	4, 753, 195 8, 960, 991	361 681	4, 753, 556 8, 961, 672	1, 572, 049 2, 963, 715	1, 293, 124 560, 625	
16.00	01600 MEDI CAL RECORDS & LI BRARY	3, 909, 866	297	3, 910, 163	1, 293, 130	000, 020	
21.00	02100 I &R SERVICES-SALARY & FRINGES APPRV	2, 340, 933	178	2, 341, 111	774, 229	42, 567	21.00
22.00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	1,051,944	80	1, 052, 024	347, 915	0	
23.00 23.01	02300 MEDICAL LABORATORY SCIENTIST PRGM 02302 PHARMACY PRGM	36, 079 326, 976	3 25	36, 082 327, 001	11, 933 108, 143	0	23.00 23.0
23.01	02301 EMERGENCY MEDICAL SERVICES	146, 949	11	146, 960	48, 601	0	23.02
23.03	02303 PARAMEDI C PRGM	100, 000	8	100, 008	33, 074	0	23.03
23.04		161, 093	12	161, 105	53, 279	0	23.04
30.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	56, 791, 630	4, 316	56, 795, 946	18, 782, 987	6, 409, 329	30.00
31.00	03100 I NTENSI VE CARE UNI T	11, 547, 083	4, 318	11, 547, 961	3, 819, 026	0, 409, 329 958, 375	
31.01	02060 NEONATAL INTENSIVE CARE UNIT	6, 698, 040	509	6, 698, 549	2, 215, 277	730, 158	
32.00	03200 CORONARY CARE UNI T	16, 038, 646	1, 219	16, 039, 865	5, 304, 544	2, 227, 759	
34.00	03400 SURGI CAL I NTENSI VE CARE UNI T	10, 812, 211	822	10, 813, 033	3, 575, 978	1, 125, 428	
41.00 43.00	04100 SUBPROVI DER – I RF 04300 NURSERY	5, 412, 099 1, 508, 080	411 115	5, 412, 510 1, 508, 195	1, 789, 971 498, 775	783, 470 99, 690	
45.00	ANCI LLARY SERVICE COST CENTERS	1, 300, 000	115	1, 300, 193	470, 773	77,070	45.00
50.00	05000 OPERATI NG ROOM	26, 440, 056	2, 009	26, 442, 065	8, 744, 655	4, 855, 748	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	5, 225, 852	397	5, 226, 249	1, 728, 373	1, 259, 879	
54.00 55.00	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	19, 849, 377 9, 066, 461	1, 509 689	19, 850, 886 9, 067, 150	6, 564, 887 2, 998, 597	2, 797, 568 178, 809	54.00 55.00
56.00	05600 RADI OLOGI - ITILKAPEOTI C	354, 152	27	354, 179	2, 998, 397	53, 450	
59.00	05900 CARDI AC CATHETERI ZATI ON	4, 264, 873	324	4, 265, 197	1, 410, 543	1, 092, 780	
60.00	06000 LABORATORY	25, 971, 206	1, 974	25, 973, 180	8, 589, 590	1, 439, 881	60.00
64.00	06400 I NTRAVENOUS THERAPY	4, 904, 789	373	4, 905, 162	1, 622, 186	599, 977	64.00
65.00 66.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	10, 068, 481 6, 655, 764	765 506	10, 069, 246 6, 656, 270	3, 330, 000 2, 201, 295	190, 747 525, 175	65.00 66.00
67.00		2, 667, 290	203	2, 667, 493	882, 167	020, 170	
68.00	06800 SPEECH PATHOLOGY	1, 469, 826	112	1, 469, 938	486, 123	88, 945	
69.00	06900 ELECTROCARDI OLOGY	2, 407, 729	183	2, 407, 912	796, 321	793, 113	
70.00 71.00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	2, 195, 386 49, 509, 785	167 3, 763	2, 195, 553 49, 513, 548	726, 091 16, 374, 625	194, 237 0	70.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	30, 309, 013	2, 303	30, 311, 316	10, 024, 255	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	84, 001, 914	6, 384	84, 008, 298	27, 782, 213	0	73.00
74.00	07400 RENAL DI ALYSI S	1, 621, 469	123	1, 621, 592	536, 277	162, 507	74.00
76.97	07697 CARDIAC REHABILITATION	562, 593	43	562, 636	186, 069	0	76.97
77.00 78.00	07700 ALLOGENEIC HSCT ACQUISITION 07800 CAR T-CELL IMMUNOTHERAPY	1, 618, 411 6, 128, 769	123 466	1, 618, 534 6, 129, 235	535, 265 2, 026, 999	82, 562 0	77.00 78.00
70.00	OUTPATIENT SERVICE COST CENTERS	0, 120, 707		0, 127, 233	2,020,777	0	70.00
90.00	09000 CLI NI C	7, 616, 461	579	7, 617, 040	2, 519, 031	901, 711	90.00
90.01	09001 I BMT JOI NT VENTURE	1, 556, 550	118	1, 556, 668	514, 806	81, 185	
90.02 90.05	09002 MOORESVILLE INFUSION CLINIC 09005 CV DIAGNOSTIC SERVICES	38, 687 8, 903, 388	3 677	38, 690 8, 904, 065	12, 795 2, 944, 663	6, 107 0	90.02 90.05
90.05	09003 CV DIAGNOSTIC SERVICES	8, 903, 388 15, 651, 978	1, 190	15, 653, 168	2, 944, 003 5, 176, 659	2, 183, 080	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0,001,00	1, 170	0	0, 170, 007	2, 100, 000	92.00
	OTHER REIMBURSABLE COST CENTERS						
	10100 HOME HEALTH AGENCY	0	0	0	0		101.00
102.00	DIOLOGO OPIOID TREATMENT PROGRAM SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	102.00
113. 00	DI1300 INTEREST EXPENSE						113.00
	11600 HOSPI CE	6, 595, 935	501	6, 596, 436	2, 181, 507	0	116.00
118.00		716, 083, 996	54, 229	716, 076, 942	170, 330, 879	33, 510, 019	118.00
100 0	NONREI MBURSABLE COST CENTERS	004 455	I				100 5-
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSI CLANS' PRI VATE OFFI CES	996, 198 7, 752, 334	76 589	996, 274 7, 752, 923	329, 478	166, 135 227, 069	
	07955 MARKETING & COMMUNITY RELATIONS	7, 752, 334 58, 108	589	7, 752, 923 58, 112	2, 563, 969 19, 218		192. 00 194. 00
		50, 100	4	55, 112	17,210		
	1 07952 WOMEN'S CENTER	185, 107	14	185, 121	61, 221	135, 231	194.01

Heal th Financial Systems	RANCISCAN HEALT	H INDIANAPOLIS		In Lieu of Form CMS-2552-10		
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CO		eriod: rom 01/01/2023	Worksheet B Part I	
	_	_		o 12/31/2023	Date/Time Pre 3/28/2024 2:2	
Cost Center Description	Subtotal	CASHI ERI NG/ACC	Subtotal	OTHER ADMIN &	OPERATION OF	
		OUNTS		GENERAL	PLANT	
		RECEI VABLE				
	5A. 01	5.02	5A. 02	5.03	7.00	
194.04 07954 OTHER NRCC	83, 815, 272	6, 370	83, 821, 642	27, 720, 655	1, 230, 812	194.04
194. 05 07956 FOUNDATI ON	14, 987	1	14, 988	4, 957	0	194.05
200.00 Cross Foot Adjustments	0		0			200.00
201.00 Negative Cost Centers	0	0	0	0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	808, 906, 002	61, 283	808, 906, 002	201, 030, 377	35, 269, 266	202.00

	Financial Systems F LLOCATION - GENERAL SERVICE COSTS	RANCI SCAN HEALTH	Provider CC		eri od:	Worksheet B	2552-10
				To	rom 01/01/2023 0 12/31/2023	Date/Time Pre	pared:
	Cost Center Description		HOUSEKEEPING	DI ETARY	CAFETERI A	3/28/2024 2:2 NURSI NG	
		LINEN SERVICE 8.00	9.00	10.00	11.00	ADMI NI STRATI ON 13.00	
	GENERAL SERVICE COST CENTERS			10100		10100	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00 4.00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT						2.00 4.00
5.01	00570 ADMI TTI NG						5.01
5.02	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5.02
5.03 7.00	00590 OTHER ADMIN & GENERAL 00700 OPERATI ON OF PLANT						5.03 7.00
8.00	00800 LAUNDRY & LINEN SERVICE	3, 602, 914					8.00
9.00	00900 HOUSEKEEPI NG	0	12, 490, 015				9.00
10.00	01000 DI ETARY	0	148, 689	4, 560, 610			10.00
11.00 13.00	01100 CAFETERIA 01300 NURSING ADMINISTRATION	0	253, 723 0	0	5, 213, 420 98, 834	6, 041, 302	11.00 13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	13, 353	466, 908	0	98, 834 35, 880	0, 041, 302	14.00
15.00	01500 PHARMACY	0	202, 424	0	178, 985	0	
16.00	01600 MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
21.00 22.00	02100 I & SERVI CES-SALARY & FRI NGES APPRV 02200 I & SERVI CES-OTHER PRGM COSTS APPRV	0	15, 370 0	0	117, 994	0	21.00
22.00	02300 MEDICAL LABORATORY SCIENTIST PRGM	0	0	0	742	0	
23.01	02302 PHARMACY PRGM	0	0	0	7, 909	0	23.01
23.02	02301 EMERGENCY MEDICAL SERVICES	0	0	0	27, 931	0	23. 02
23.03	02303 PARAMEDI C PRGM	0	0	0	0	0	23.03
23.04	02305 SURGI CAL TECH PROGRAM	0	0	0	3, 489	0	23.04
30.00	03000 ADULTS & PEDI ATRI CS	1, 452, 570	2, 314, 211	2, 728, 332	1, 245, 749	3, 614, 138	30.00
31.00	03100 I NTENSI VE CARE UNI T	184, 652	346, 040	382, 179	273, 059		31.00
31.01	02060 NEONATAL INTENSIVE CARE UNIT	21,860	263, 638	260, 931	146, 613	345, 648	
32.00 34.00	03200 CORONARY CARE UNIT 03400 SURGICAL INTENSIVE CARE UNIT	264, 921 160, 928	804, 376 406, 358	519, 135 307, 287	302, 425 209, 238	687, 683 407, 054	
41.00	04100 SUBPROVIDER - IRF	81, 624	282, 887	229, 899	112, 359	304, 540	
43.00	04300 NURSERY	0	35, 995	132, 847	0	175, 978	
	ANCI LLARY SERVI CE COST CENTERS	0/7 504	1 750 0/0				
50.00 52.00	05000 OPERATING ROOM 05200 DELIVERY ROOM & LABOR ROOM	267, 521 186, 703	1, 753, 262 454, 904	0	311, 322 107, 801	0	
52.00	05400 RADI OLOGY-DI AGNOSTI C	165, 169	1, 010, 116	0	226, 447	0	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	67	64, 562	0	30, 083	0	55.00
56.00	05600 RADI OI SOTOPE	7, 968	19, 299	0	9, 314	0	56.00
59.00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	57, 303	394, 569	0	75, 790	0	59.00 60.00
60.00 64.00	06400 I NTRAVENOUS THERAPY	1,800	519, 897 216, 633	0	15, 073 87, 718	0	64.00
65.00	06500 RESPI RATORY THERAPY	969	68, 873	0	264, 677	0	65.00
66.00	06600 PHYSI CAL THERAPY	31, 712	189, 625	0	119, 292	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0	0	0	53, 780		
68.00 69.00	06900 ELECTROCARDI OLOGY	3, 153 20, 348	32, 115 286, 369	0	23, 532 37, 728	0	
70.00	07000 ELECTROENCEPHALOGRAPHY	12,042	70, 133	0	55, 389	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 74.00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	14, 867	0 58, 676	0	0	0	73.00
76.97	07697 CARDIAC REHABILITATION	0	50, 070	0	14, 587	0	1
77.00	07700 ALLOGENEIC HSCT ACQUISITION	4, 808	29, 811	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	19, 960	325, 580		134, 351	0	90.00
90.00 90.01	09000 CLINIC 09001 IBMT JOINT VENTURE	7, 818	325, 580 29, 313	0	36, 360	0	
90.02	09002 MOORESVILLE INFUSION CLINIC	0	2, 205	0	0	0	
90.05	09005 CV DI AGNOSTI C SERVI CES	0	0	0	253, 533	0	
91.00	09100 EMERGENCY	564, 479	788, 243	0	255, 195	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS						92.00
101.00	10100 HOME HEALTH AGENCY	0	0	0	0	0	101.00
	10200 OPI OI D TREATMENT PROGRAM	0	0	0	0		102.00
	SPECIAL PURPOSE COST CENTERS	I	1				
	11300 INTEREST EXPENSE		0	0	1/7 /5/		113.00
118.00	11600 HOSPICE SUBTOTALS (SUM OF LINES 1 through 117)	3, 546, 595	0 11, 854, 804	0 4, 560, 610	167, 656 5, 040, 835		116.00
110.00	NONREI MBURSABLE COST CENTERS	3, 340, 375	11,004,004	F, 560, 610	5, 040, 035	5, 041, 302	
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	59, 986	0	18, 828		190. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES	10, 840	81, 988	0	109, 639		192.00
	07955 MARKETING & COMMUNITY RELATIONS 07952 WOMEN'S CENTER	0	0 48, 828	0	1, 754		194.00 194.01
194 111	UNITER O DENTER	1 0	40, 020	0	0		
	07950 OTHER NONREI MBURSABLE COST CENTERS	0	0	0	0	0	194.02

Health Financial Systems	FRANCI SCAN HEALT	H INDIANAPOLIS		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider C		Period:	Worksheet B	
				From 01/01/2023 To 12/31/2023		narod
				10 12/31/2023	3/28/2024 2:2	
Cost Center Description	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	
	LINEN SERVICE				ADMI NI STRATI ON	
	8.00	9.00	10.00	11.00	13.00	
194. 05 07956 FOUNDATI ON	0	0	(0 0	0	194.05
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)	3, 602, 914	12, 490, 015	4, 560, 610	5, 213, 420	6, 041, 302	202.00

	Financial Systems Financial Systems Financial Systems Financial Service COSTS	RANCISCAN HEALTH	I NDI ANAPOLI S Provi der CC	N: 15-0162 P	In Lie eriod:	u of Form CMS-: Worksheet B	2552-10
				F	rom 01/01/2023 o 12/31/2023	Part I Date/Time Pre	pared:
					INTERNS &	3/28/2024 2:2	1 pm
		CENTRAL	DUADMACY				
	Cost Center Description	CENTRAL SERVICES &	PHARMACY	MEDI CAL RECORDS &	SERVI CES-SALAR Y & FRI NGES	PRGM COSTS	
		SUPPLY 14.00	15.00	LI BRARY 16.00	APPRV 21.00	APPRV 22.00	
	GENERAL SERVICE COST CENTERS	14.00	15.00	18.00	21.00	22.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00 4.00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT						2.00
5.01	00570 ADMI TTI NG						5.01
5.02 5.03	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 00590 OTHER ADMIN & GENERAL						5. 02 5. 03
7.00	00700 OPERATION OF PLANT						7.00
8.00 9.00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG						8.00 9.00
9.00 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	8, 134, 870					13.00
15.00	01500 PHARMACY	9, 050	12, 876, 471				15.00
	01600 MEDI CAL RECORDS & LI BRARY	55	0	5, 203, 348			16.00
21.00 22.00	02100 I & R SERVICES-SALARY & FRINGES APPRV 02200 I & R SERVICES-OTHER PRGM COSTS APPRV	3, 250 0	0	0		1, 399, 939	21.00
	02300 MEDICAL LABORATORY SCIENTIST PRGM	15	0	0		., ., ,, ,, ,,	23.00
23. 01 23. 02	02302 PHARMACY PRGM 02301 EMERGENCY MEDICAL SERVICES	19 137	0	0			23.01 23.02
23.02	02303 PARAMEDIC PRGM	0	0	0			23.02
23.04	02305 SURGI CAL TECH PROGRAM	65	0	0			23.04
30. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	26, 731	0	346, 079	1, 259, 286	535, 108	30.00
	03100 I NTENSI VE CARE UNI T	2, 594	0	61, 325		32, 741	
	02060 NEONATAL INTENSIVE CARE UNIT	1,816	0	53, 683		2, 046	
32.00 34.00	03200 CORONARY CARE UNIT 03400 SURGICAL INTENSIVE CARE UNIT	4, 761 2, 377	0	60, 262 43, 270		0	1
41.00	04100 SUBPROVI DER – I RF	1, 435	0	26, 557		0	1
43.00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	0	0	10, 012	0	0	43.00
50.00	05000 OPERATI NG ROOM	44, 950	0	470, 762	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	3,067	0	65, 818		0	
54.00 55.00	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	14, 370 1, 110	0	499, 700 151, 827	0	0	
56.00	05600 RADI OI SOTOPE	114	0	13, 792	0	0	56.00
59.00 60.00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	4, 169 1, 019	0	259, 561 398, 629	0	0	
	06400 I NTRAVENOUS THERAPY	6, 278	0	106, 024	0	0	1
	06500 RESPI RATORY THERAPY	2, 501	0	89, 582		4, 200	
66.00 67.00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	3, 045 628	0	79, 179 38, 946		0	
68.00	06800 SPEECH PATHOLOGY	1, 294	0	18, 334		0	
69.00	06900 ELECTROCARDI OLOGY	3, 392	0	71, 841	87, 568	37, 210	
70. 00 71. 00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 327 4, 993, 550	0	39, 418 380, 774	0	0	1
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	2, 916, 881	0	207, 591	0	0	72.00
73.00 74.00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	0 78	12, 710, 992	970, 661	0	0	
74.00 76.97	07400 RENAL DIALYSIS 07697 CARDIAC REHABILITATION	453	0	12, 337 5, 952		0	1
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0	0	1, 239	0	0	77.00
78.00	07800 CAR T-CELL IMMUNOTHERAPY OUTPATIENT SERVICE COST CENTERS	0	0	53, 960	0	0	78.00
90.00	09000 CLI NI C	1, 834	0	23, 975	0	0	90.00
90.01	09001 I BMT JOI NT VENTURE	975	0	17, 375		0	
90. 02 90. 05	09002 MOORESVILLE INFUSION CLINIC 09005 CV DIAGNOSTIC SERVICES	6, 305	0	773 132, 447		0	
	09100 EMERGENCY	5, 630	0	470, 862		26, 979	
92.00	09200 OBSERVATI ON BEDS (NON-DI STI NCT PART						92.00
101.00	OTHER REIMBURSABLE COST CENTERS 10100 HOME HEALTH AGENCY	0	0	0	0	0	101.00
	10200 OPI OI D TREATMENT PROGRAM	0	0	0	-		102.00
112 00	SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE	I					113.00
	11600 HOSPI CE	17, 857	38, 683	20, 801			116.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	8, 083, 133	12, 749, 675	5, 203, 348		638, 284	
190 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	437	0	0	o	0	190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	3, 580	119, 837	0	-	0	192.00
194.00	07955 MARKETING & COMMUNITY RELATIONS	0	0	0	0	0	194.00

Health Financial Systems F	RANCI SCAN HEALTH	I INDIANAPOLIS		In Lie	u of Form CMS-2	2552-10
COST ALLOCATI ON - GENERAL SERVI CE COSTS		Provider CC		Period: From 01/01/2023 To 12/31/2023		
				INTERNS &	RESI DENTS	
Cost Center Description	CENTRAL SERVI CES &	PHARMACY	MEDICAL RECORDS &	SERVI CES-SALAR Y & FRI NGES	SERVICES-OTHER PRGM COSTS	
	SUPPLY		LIBRARY	APPRV	APPRV	
	14.00	15.00	16.00	21.00	22.00	
194.0107952 WOMEN' S CENTER	0	0		0 0	0	194.01
194.0207950 OTHER NONREIMBURSABLE COST CENTERS	0	0		0 0	0	194.02
194.04079540THER NRCC	47, 720	6, 959		0 1, 792, 426	761, 655	194.04
194. 05 07956 FOUNDATI ON	0	0		0 0	0	194.05
200.00 Cross Foot Adjustments				0	0	200.00
201.00 Negative Cost Centers	0	0		0 0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	8, 134, 870	12, 876, 471	5, 203, 34	8 3, 294, 521	1, 399, 939	202.00

	Financial Systems FF LLOCATION - GENERAL SERVICE COSTS	RANCISCAN HEALT	Provi der CC		Period: From 01/01/2023	u of Form CMS-2 Worksheet B	
					To 12/31/2023		
	Cost Center Description	MEDI CAL	PHARMACY PRGM	EMERGENCY	PARAMEDIC PRGM	3/28/2024 2:2 SURGI CAL TECH	
		LABORATORY SCIENTIST PRGM		MEDI CAL SERVI CES		PROGRAM	
		23.00	23.01	23. 02	23.03	23.04	
1 00	GENERAL SERVICE COST CENTERS						1 1 00
1.00 2.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						1.00 2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570 ADMI TTI NG						5. 01
5.02	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5.02
5.03 7.00	00590 OTHER ADMIN & GENERAL 00700 OPERATION OF PLANT						5.03 7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPI NG						9.00
10.00	01000 DI ETARY						10.00
11. 00 13. 00	01100 CAFETERIA 01300 NURSING ADMINISTRATION						11.00 13.00
14.00	01400 CENTRAL SERVICES & SUPPLY						14.00
	01500 PHARMACY						15.00
	01600 MEDI CAL RECORDS & LI BRARY						16.00
21.00 22.00	02100 I & R SERVI CES-SALARY & FRI NGES APPRV 02200 I & R SERVI CES-OTHER PRGM COSTS APPRV						21.00 22.00
23.00	02300 MEDI CAL LABORATORY SCI ENTI ST PRGM	48, 772					23.00
	02302 PHARMACY PRGM		443, 072				23. 01
23.02	02301 EMERGENCY MEDICAL SERVICES			223, 62			23.02
23. 03 23. 04	02303 PARAMEDIC PRGM 02305 SURGICAL TECH PROGRAM				133, 082	217, 938	23.03 23.04
23.04	INPATIENT ROUTINE SERVICE COST CENTERS				<u> </u>	217, 750	23.04
30.00	03000 ADULTS & PEDI ATRI CS	0	0		0 0	0	30. 00
31.00	03100 I NTENSI VE CARE UNI T	0	0		0 0	0	31.00
31. 01 32. 00	02060 NEONATAL INTENSIVE CARE UNIT 03200 CORONARY CARE UNIT	0	0			0	31.01 32.00
	03400 SURGI CAL I NTENSI VE CARE UNI T	0	0		0 0	0	34.00
41.00	04100 SUBPROVI DER – I RF	0	0		0 0	0	41.00
43.00	04300 NURSERY	0	0		0 0	0	43.00
50.00	ANCI LLARY SERVI CE COST CENTERS	0	0		0 0	217, 938	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	217, 750	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0		0 0	0	55.00
56.00 59.00	05600 RADI OI SOTOPE 05900 CARDI AC CATHETERI ZATI ON	0	0			0	56.00 59.00
60.00	06000 LABORATORY	48, 772	0		0 0	0	60.00
64.00	06400 I NTRAVENOUS THERAPY	0	0		0 0	0	64.00
65.00	06500 RESPI RATORY THERAPY	0	0		0 0	0	65.00
66.00 67.00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	0	0			0	66.00 67.00
68.00	06800 SPEECH PATHOLOGY	0	0		0 0	0	68.00
	06900 ELECTROCARDI OLOGY	0	0		0 0	0	69.00
	07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0	70.00
71.00 72.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	71.00 72.00
	07300 DRUGS CHARGED TO PATIENTS	0	443,072		0 0	0	73.00
	07400 RENAL DIALYSIS	0	0		0 0	0	74.00
76.97	07697 CARDI AC REHABI LI TATI ON	0	0		0 0	0	76.97
	07700 ALLOGENEIC HSCT ACQUISITION 07800 CAR T-CELL IMMUNOTHERAPY	0	0		0 0	0	77.00 78.00
78.00	OUTPATIENT SERVICE COST CENTERS	0	0		0 0	0	78.00
90.00	09000 CLINIC	0	0		0 0	0	90.00
	09001 I BMT JOI NT VENTURE	0	0		0 0	0	90.01
	09002 MOORESVILLE INFUSION CLINIC 09005 CV DIAGNOSTIC SERVICES	0	0			0	90.02 90.05
	09100 EMERGENCY	0	0	223, 62	9 133, 082	0	90.05
	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
464 -	OTHER REIMBURSABLE COST CENTERS						101 -
	10100 HOME HEALTH AGENCY 10200 OPI 0I D TREATMENT PROGRAM	0	0				101.00 102.00
102.00	SPECIAL PURPOSE COST CENTERS	0	<u> </u>		<u> </u>	0	102.00
	11300 I NTEREST EXPENSE						113.00
113.00	11600 HOSPI CE	0	0		0 0		116.00
116.00			443, 072	223, 62	9 133, 082	217, 938	118.00
	SUBTOTALS (SUM OF LINES 1 through 117)	48, 772	443, 072				
116.00 118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	48, 772	<u>++3, 072</u>		0 0		
116.00 118.00	SUBTOTALS (SUM OF LINES 1 through 117)	48, 772	0		0 0 0	0	190. 00
116.00 118.00 190.00 192.00 194.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSI CIANS' PRI VATE OFFICES 07955 MARKETING & COMMUNITY RELATIONS	48, 772 0 0 0	0 0		0 0 0 0 0 0	0 0 0	190. 00 192. 00 194. 00
116.00 118.00 190.00 192.00 194.00 194.01	SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSI CLANS' PRI VATE OFFICES	48, 772	000000000000000000000000000000000000000			0 0 0 0	190. 00 192. 00

Health Financial Systems F	RANCI SCAN HEALT	H INDIANAPOLIS		In Lie	eu of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CO		Period:	Worksheet B	
				From 01/01/2023 To 12/31/2023		narod
				10 12/31/2023	3/28/2024 2:2	
Cost Center Description	MEDI CAL	PHARMACY PRGM	EMERGENCY	PARAMEDIC PRGM	SURGI CAL TECH	
	LABORATORY		MEDI CAL		PROGRAM	
	SCIENTIST PRGM		SERVI CES			
	23.00	23.01	23.02	23.03	23.04	
194.04 07954 OTHER NRCC	0	0		0 0	0	194.04
194. 05 07956 FOUNDATI ON	0	0		0 0	0	194.05
200.00 Cross Foot Adjustments	0	0		0 0	0	200.00
201.00 Negative Cost Centers	0	0		0 0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	48, 772	443, 072	223, 62	133, 082	217, 938	202.00

	Financial Systems FR LOCATION - GENERAL SERVICE COSTS		Provider CCI	N: 15-0162	Period: From 01/01/20	<u>ieu of Form CMS-2552</u> Worksheet B 23 Part I
					To 12/31/20	
	Cost Center Description	Subtotal	Intern &	Total		0,20,2021 2.21 p
			Residents Cost & Post			
			Stepdown			
			Adjustments			
	GENERAL SERVICE COST CENTERS	24.00	25.00	26.00		
	00100 CAP REL COSTS-BLDG & FIXT					1
	00200 CAP REL COSTS-MVBLE EQUIP					2
	00400 EMPLOYEE BENEFITS DEPARTMENT					4
	00570 ADMI TTI NG					5
	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 00590 OTHER ADMI N & GENERAL					5
	00700 OPERATION OF PLANT					7
	00800 LAUNDRY & LINEN SERVICE					8
00	00900 HOUSEKEEPI NG					9
	01000 DI ETARY					10
						11
	01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY					13
	01500 PHARMACY					15
	01600 MEDICAL RECORDS & LIBRARY					16
00	02100 I &R SERVICES-SALARY & FRINGES APPRV					21
	02200 I &R SERVICES-OTHER PRGM COSTS APPRV					22
	02300 MEDICAL LABORATORY SCIENTIST PRGM					23
	02302 PHARMACY PRGM 02301 EMERGENCY MEDICAL SERVICES					23
	02303 PARAMEDIC PRGM					23
	02305 SURGI CAL TECH PROGRAM					23
	INPATIENT ROUTINE SERVICE COST CENTERS		Г. П.		L.	
	03000 ADULTS & PEDI ATRI CS	95, 510, 466		93, 716, 0		30
	03100 I NTENSI VE CARE UNI T	18, 191, 263		18,081,4		31
	02060 NEONATAL INTENSIVE CARE UNIT	10, 745, 035		10, 738, 1		31
	03200 CORONARY CARE UNIT 03400 SURGICAL INTENSIVE CARE UNIT	26, 215, 731 17, 050, 951	0	26, 215, 7 17, 050, 9		32
	04100 SUBPROVI DER – I RF	9, 025, 252		9, 025, 2		41
1	04300 NURSERY	2, 461, 492	0	2, 461, 4		43
	ANCILLARY SERVICE COST CENTERS				-	
	05000 OPERATING ROOM	43, 108, 223		43, 108, 2		50
	05200 DELIVERY ROOM & LABOR ROOM 05400 RADIOLOGY-DIAGNOSTIC	9, 032, 794 31, 129, 143		9, 032, 7 31, 129, 1		52
	05500 RADI OLOGY - DI AGNOSTI C	12, 492, 205		12, 492, 2		55
	05600 RADI OI SOTOPE	575, 247	0	575, 2		56
00	05900 CARDI AC CATHETERI ZATI ON	7, 559, 912	0	7, 559, 9	12	59
	06000 LABORATORY	36, 987, 841		36, 987, 8		60
	06400 I NTRAVENOUS THERAPY	7, 543, 978		7, 543, 9		64
	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	14, 030, 680		14,016,5		65
	06700 OCCUPATI ONAL THERAPY	9, 805, 593 3, 643, 014		9, 805, 5 3, 643, 0		66
	06800 SPEECH PATHOLOGY	2, 123, 434		2, 123, 4		68
00	06900 ELECTROCARDI OLOGY	4, 541, 802		4, 417, 0	24	69
	07000 ELECTROENCEPHALOGRAPHY	3, 294, 190		3, 294, 1		70
	07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT	71, 262, 497		71, 262, 4		71
	07200 I MPL. DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS	43, 460, 043 125, 915, 236		43, 460, 0 125, 915, 2		72
	07400 RENAL DIALYSIS	2, 406, 334		2, 406, 3		74
	07697 CARDI AC REHABI LI TATI ON	769, 697		769, 6		76
	07700 ALLOGENEIC HSCT ACQUISITION	2, 272, 219		2, 272, 2		77
	07800 CAR T-CELL IMMUNOTHERAPY	8, 210, 194	0	8, 210, 1	94	78
	DUTPATIENT SERVICE COST CENTERS	44 545 11		44.815	22	
	09000 CLINIC 09001 IBMT JOINT VENTURE	11, 543, 482		11, 543, 4		90
	09001 IBMI JOINT VENTURE 09002 MOORESVILLE INFUSION CLINIC	2, 244, 500 60, 571		2, 244, 5 60, 5		90
	09002 MOORESVILLE INFOSTOR CLINIC	12, 241, 013		12, 241, 0		90
	09100 EMERGENCY	25, 544, 496		25, 454, 0		91
	09200 OBSERVATION BEDS (NON-DISTINCT PART		0			92
	OTHER REIMBURSABLE COST CENTERS					
	10100 HOME HEALTH AGENCY	0			0	101
	10200 OPI OI D TREATMENT PROGRAM SPECI AL PURPOSE COST CENTERS	0	0		0	102
	11300 INTEREST EXPENSE					113
	11600 HOSPI CE	9, 022, 940	о	9, 022, 9	40	116
3. 00		680, 021, 468		677, 881, 0		118
	NONREI MBURSABLE COST CENTERS					
ົດດໂ	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1, 571, 138		1, 571, 1		190 192
	19200 PHYSICIANS' PRIVATE OFFICES	10, 869, 845	0	10, 869, 8		

Health Financial Systems	FRANCI SCAN HEALTH	I NDI ANAPOLI S		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC	CN: 15-0162	Period: From 01/01/2023 To 12/31/2023		narod
				10 12/31/2023	3/28/2024 2:2	
Cost Center Description	Subtotal	Intern &	Total			
	R	esidents Cost				
		& Post				
		Stepdown				
		Adjustments				
	24.00	25.00	26.00			
194.0107952WOMEN'S CENTER	430, 401	0	430, 40	01		194.01
194.0207950 OTHER NONREIMBURSABLE COST CENTERS	0	0		0		194.02
194.04 07954 OTHER NRCC	115, 914, 121	-2, 554, 081	113, 360, 04	40		194.04
194. 05 07956 FOUNDATI ON	19, 945	0	19, 94	15		194.05
200.00 Cross Foot Adjustments	0	0		0		200.00
201.00 Negative Cost Centers	0	0		0		201.00
202.00 TOTAL (sum lines 118 through 201)	808, 906, 002	-4, 694, 460	804, 211, 54	12		202.00

Health Financial Systems F ALLOCATION OF CAPITAL RELATED COSTS	RANCI SCAN HEALT	H INDIANAPOLIS Provider C	CN: 15-0162 P	eriod:	u of Form CMS-: Worksheet B	2552-10
				rom 01/01/2023 o 12/31/2023	Part II Date/Time Pre 3/28/2024 2:2	
		CAPI TAL REI	LATED COSTS		0,20,2021 2.2	
Cost Center Description	Directly Assigned New Capital	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
	Related Costs O	1.00	2.00	2A	4.00	
GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 5.01 00570 ADMITTING 5.02 00580 CASHI ERING/ACCOUNTS RECEIVABLE 5.03 00590 OTHER ADMIN & GENERAL 7.00 00700 OPERATION OF PLANT 8.00 00800 LAUNDRY & LINEN SERVICE 9.00 00900 HOUSEKEEPING 10.00 01000 DI ETARY 11.00 01100 CAFETERIA 13.00 01300 NURSI NG ADMINI STRATION 14.00 01400 CENTRAL SERVICES & SUPPLY 15.00 01500 PHARMACY 16.00 01600 MEDI CAL RECORDS & LI BRARY 21.00 02100 I & SERVI CES - SALARY & FRINGES APPRV		0 106, 414 43, 704 108, 297 5, 262, 123 362, 274 299, 116 401, 989 685, 955 0 1, 262, 313 547, 267 0 41, 553	17, 579 43, 560 2, 116, 569 145, 717 120, 313 161, 691 275, 910 507, 736 220, 125 0	61, 283 151, 857 7, 378, 692 507, 991 419, 429 563, 680 961, 865 0 1, 770, 049 767, 392 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	$\begin{array}{c} 2.\ 00\\ 4.\ 00\\ 5.\ 01\\ 5.\ 02\\ 5.\ 03\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ \end{array}$
21. 00 102100 1&R SERVICES-SALARY & FRINGES APPRV 22. 00 02200 1 &R SERVICES-OTHER PRGM COSTS APPRV 23. 00 02300 MEDICAL LABORATORY SCIENTIST PRGM 23. 01 02302 PHARMACY PRGM 23. 02 02301 EMERGENCY MEDICAL SERVICES 23. 03 02303 PARAMEDIC PRGM 23. 04 02305 SURGICAL TECH PROGRAM INPATIENT ROUTINE SERVICE COST CENTERS	0 0 0 0 0	41,553 0 0 0 0 0 0	0 0 0 0 0	0 0 0 0	0 0 0 0 0 0 0	22. 00 23. 00 23. 01 23. 02 23. 03
30.00 03000 ADULTS PEDIATRICS 31.00 03100 INTENSIVE CARE UNIT 31.01 02060 NEONATAL INTENSIVE CARE UNIT 32.00 03200 CORNARY CARE UNIT 34.00 03400 SURGI CAL INTENSIVE CARE UNIT 41.00 04100 SUBPROVI DER - IRF 43.00 04300 NURSERY ANCILLARY SERVICE COST CENTERS ANCILLARY	0 0 0 0 0 0 0	6, 256, 608 935, 539 712, 760 2, 174, 678 1, 098, 612 764, 802 97, 315	376, 299 286, 691 874, 714 441, 892 307, 624	1, 311, 838 999, 451 3, 049, 392 1, 540, 504 1, 072, 426	0 0 0 0 0 0 0 0	31.00 31.01 32.00 34.00 41.00
50.00 05000 OPERATING ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM 54.00 05400 RADIOLOGY-DIAGNOSTIC 55.00 05500 RADIOLOGY-THERAPEUTIC 56.00 05600 RADIOLOGY-THERAPEUTIC 59.00 05900 CARDIAC CATHETERIZATION 60.00 06000 LABORATORY 64.00 06400 INTRAVENOUS THERAPY 65.00 06500 RESPIRATORY 64.00 06600 PHYSICAL THERAPY 65.00 06500 RESPIRATORY THERAPY 66.00 066000 PHYSICAL THERAPY 67.00 06700 OCCUPATIONAL THERAPY 68.00 068000 SPEECH PATHOLOGY 69.00 06900 ELECTROCARDIOLOGY 70.00 07000 ELECTROENCEPHALOGRAPHY 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 73.00 07300 DRUGS CHARGED TO PATIENTS 74.00 07400 RENAL DIALYSIS 76.97 CARDIAC REHABILITATION		4, 740, 048 1, 229, 859 2, 730, 909 174, 548 52, 176 1, 066, 742 1, 405, 573 585, 681 186, 202 512, 662 0 86, 826 774, 215 189, 609 0 0 158, 635 0 80, 595	494, 683 1, 098, 446 70, 208 20, 987 429, 073 565, 360 235, 577 74, 896 206, 207 0 34, 924 311, 410 76, 266 0 0 63, 807 0	1, 724, 542 3, 829, 355 244, 756 73, 163 1, 495, 815 1, 970, 933 821, 258 261, 098 718, 869 0 121, 750 1, 085, 625 265, 875 0 0 0 222, 442 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	$\begin{array}{c} 52.\ 00\\ 54.\ 00\\ 55.\ 00\\ 56.\ 00\\ 60.\ 00\\ 64.\ 00\\ 65.\ 00\\ 65.\ 00\\ 66.\ 00\\ 67.\ 00\\ 70.\ 00\\ 71.\ 00\\ 71.\ 00\\ 73.\ 00\\ 74.\ 00\\ 74.\ 00\\ 77.\ 00\\ \end{array}$
78.00 07800 CAR T-CELL IMMUNOTHERAPY OUTPATI ENT SERVICE COST CENTERS 90.00 O9000 CLINIC O9000 CUNIC 90.01 09000 CLINIC O9000 CUNIC 90.02 09000 MORESVILLE INFUSION CLINIC 90.05 09005 CV DIAGNOSTIC SERVICES 91.00 09100 EMERGENCY O9200 OBSERVATION BEDS (NON-DI STINCT PART 0THER REI MBURSABLE COST CENTERS 101.00 HOME HEALTH AGENCY		0 880, 226 79, 250 5, 962 0 2, 131, 063	31, 877 2, 398 0 857, 171	111, 127 8, 360 0 2, 988, 234 0		90.00 90.01 90.02 90.05 91.00 92.00
102.00 OPI OI D TREATMENT PROGRAM SPECI AL PURPOSE COST CENTERS 113.00 11300 I NTEREST EXPENSE 116.00 11600 HOSPI CE	0	0	0	0		102.00 113.00 116.00
118. 00 SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	0	38, 232, 100	15, 377, 990	53, 610, 090		118.00
190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	0	162, 176 221, 659				190. 00 192. 00

Health Financial Systems	FRANCISCAN HEALT	H INDIANAPOLIS		In Lie	eu of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CC		Period: From 01/01/2023 To 12/31/2023	Date/Time Pre	epared:
		CAPI TAL REL	ATED COSTS		3/28/2024 2:2	1 pm
Cost Center Description	Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFI TS DEPARTMENT	
	0	1.00	2.00	2A	4.00	
194.00 07955 MARKETING & COMMUNITY RELATIONS	0	0		0 0	C	194.00
194.0107952WOMEN'S CENTER	0	132, 009	53, 09	8 185, 107	0	194.01
194.0207950 OTHER NONREIMBURSABLE COST CENTERS	0	0		0 0	0	194.02
194.04079540THER NRCC	0	1, 201, 485	483, 27	0 1, 684, 755	C	194.04
194. 05 07956 FOUNDATI ON	0	0		0 0	C	194.05
200.00 Cross Foot Adjustments				0		200.00
201.00 Negative Cost Centers		0		0 0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	0	39, 949, 429	16, 068, 74	56, 018, 176	0	202.00

	Financial Systems FR	RANCI SCAN HEALT	H INDIANAPOLIS Provider CO		In Lie Period:	u of Form CMS-: Worksheet B	2552-10
ALLOCA	THON OF CALLER RELATED COSTS			F	rom 01/01/2023 o 12/31/2023	Part II	pared:
	Cost Center Description	ADMI TTI NG	CASHI ERI NG/ACC OUNTS RECEI VABLE	OTHER ADMIN & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
		5.01	5. 02	5.03	7.00	8.00	
1 00	GENERAL SERVICE COST CENTERS						1 1 00
1.00 2.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						1.00 2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570 ADMI TTI NG	149, 198					5.01
5.02	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	0	61, 283				5.02
5.03	00590 OTHER ADMIN & GENERAL	0	15, 087	166, 944			5.03
7.00	00700 OPERATION OF PLANT	0	2,014	7, 289		50/ 500	7.00
8.00 9.00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	0	185 696	668 2, 518		586, 583 0	1
10.00	01000 DI ETARY	0	228	827		0	1
11.00	01100 CAFETERI A	0	243	880		0	
13.00	01300 NURSING ADMINISTRATION	0	339	1, 228		0	13.00
	01400 CENTRAL SERVICES & SUPPLY	0	361	1, 307		2, 174	•
	01500 PHARMACY	0	681	2, 464		0	
	01600 MEDICAL RECORDS & LIBRARY	0	297	1, 075		0	
	02100 I & R SERVI CES-SALARY & FRI NGES APPRV 02200 I & R SERVI CES-OTHER PRGM COSTS APPRV	0	178 80	644		0	
23.00	02300 MEDI CAL LABORATORY SCI ENTI ST PRGM	0	3	10		0	•
	02302 PHARMACY PRGM	0	25	90		0	
23. 02	02301 EMERGENCY MEDICAL SERVICES	0	11	40	0	0	23.02
	02303 PARAMEDIC PRGM	0	8	28		0	
23.04	02305 SURGI CAL TECH PROGRAM	0	12	44	0	0	23.04
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	10 214	4 214	15 410	1 242 504	224 401	20.00
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 I NTENSI VE CARE UNI T	19, 316 3, 742	4, 316 878			236, 491 30, 063	•
	02060 NEONATAL INTENSIVE CARE UNIT	3, 275	509	1, 842		3, 559	•
32.00	03200 CORONARY CARE UNI T	3, 677	1, 219			43, 131	•
34.00	03400 SURGICAL INTENSIVE CARE UNIT	2,640	822	2, 974	235, 748	26, 200	34.00
41.00	04100 SUBPROVI DER – I RF	1, 620	411	1, 488		13, 289	•
43.00	04300 NURSERY	611	115	415	20, 882	0	43.00
50, 00	ANCI LLARY SERVI CE COST CENTERS 05000 OPERATI NG ROOM	15, 283	2,009	7, 272	1 017 152	43, 554	50.00
50.00 52.00	05200 DELIVERY ROOM & LABOR ROOM	4, 003	2,009	1, 437		43, 554 30, 397	•
54.00	05400 RADI OLOGY-DI AGNOSTI C	9,967	1, 509			26, 891	•
55.00	05500 RADI OLOGY-THERAPEUTI C	486	689	2, 493		11	1
56.00	05600 RADI OI SOTOPE	246	27	97		1, 297	•
59.00	05900 CARDI AC CATHETERI ZATI ON	6, 483	324	1, 173		9, 329	•
60.00		12,997	1, 974			293	•
64.00 65.00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	641 4, 646	373	1, 349 2, 769		0 158	
	06600 PHYSI CAL THERAPY	2, 061	506			5, 163	•
	06700 OCCUPATI ONAL THERAPY	1,642	203			0,100	
	06800 SPEECH PATHOLOGY	610	112	404	18, 632	513	68.00
	06900 ELECTROCARDI OLOGY	2, 953	183			3, 313	
	07000 ELECTROENCEPHALOGRAPHY	792	167			1, 960	•
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	14, 093 8, 228	3, 763			0	
	07200 TMPL. DEV. CHARGED TO PATTENTS	0, 220 15, 931	2, 303 6, 384	8, 336 22, 878		0	1
	07400 RENAL DIALYSIS	710	123	446		2, 420	•
	07697 CARDI AC REHABI LI TATI ON	14	43	155		0	•
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0	123	445	17, 295	783	77.00
78.00	07800 CAR T-CELL IMMUNOTHERAPY	2, 532	466	1, 686	0	0	78.00
~~ ~~	OUTPATIENT SERVICE COST CENTERS		570	0.005	100.005		
		80	579			3, 250	1
	09001 IBMT JOINT VENTURE 09002 MOORESVILLE INFUSION CLINIC	293 0	118	428		1, 273 0	1
	09005 CV DI AGNOSTI C SERVI CES	42	677	2, 449		0	1
	09100 EMERGENCY	9, 575	1, 190			91, 902	•
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
	OTHER REIMBURSABLE COST CENTERS	1					
	10100 HOME HEALTH AGENCY	0	0				101.00
102.00	10200 OPI OLD TREATMENT PROGRAM	0	0	0	0	0	102.00
113 00	SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE						113.00
	11600 HOSPI CE	9	501	1, 814	0	0	116.00
118.00		149, 198					
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	76				190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	589				192.00
	07955 MARKETING & COMMUNITY RELATIONS	0	4	16			194.00
	07952 WOMEN'S CENTER 07950 OTHER NONREIMBURSABLE COST CENTERS		14				194. 01 194. 02
174.02	US / SOLOTIEN NORNET MUDINORDEL COST CENTERS	U	0	ı 0	u U	0	1174.02

Health Financial Systems F	RANCISCAN HEALT	H INDIANAPOLIS		In Lie	u of Form CMS-:	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider C	CN: 15-0162 F	Period:	Worksheet B	
				rom 01/01/2023		
			[]	o 12/31/2023	Date/Time Pre	
					3/28/2024 2:2	1 pm
Cost Center Description	ADMI TTI NG	CASHI ERI NG/ACC	OTHER ADMIN &	OPERATION OF	LAUNDRY &	
		OUNTS	GENERAL	PLANT	LINEN SERVICE	
		RECEI VABLE				
	5.01	5.02	5.03	7.00	8.00	
194.04 07954 OTHER NRCC	0	6, 370	23, 051	257, 823	7, 404	194.04
194. 05 07956 FOUNDATI ON	0	1	4	l 0	0	194.05
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	19	0	(0 0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	149, 217	61, 283	166, 944	7, 387, 995	586, 583	202.00

	Financial Systems Fi FION OF CAPITAL RELATED COSTS	RANCI SCAN HEALTH	Provi der CCN		eriod: rom 01/01/2023	u of Form CMS-2 Worksheet B Part II	2332 10
					0 12/31/2023	Date/Time Pre 3/28/2024 2:2	pared: 1 pm
	Cost Center Description	HOUSEKEEPING	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVICES & SUPPLY	
		9.00	10.00	11.00	13.00	14.00	
	GENERAL SERVICE COST CENTERS						1
	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						1.00 2.00
	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570 ADMI TTI NG						5.01
5.02	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5.02
5.03 7.00	00590 OTHER ADMIN & GENERAL 00700 OPERATION OF PLANT						5.03 7.00
	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPI NG	486, 829					9.00
	01000 DI ETARY	5, 796	656, 793				10.00
	01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON	9, 889	0	1, 120, 074 21, 234			11.00 13.00
	01400 CENTRAL SERVICES & SUPPLY	18, 199	0	7, 709		2, 070, 675	1
15.00	01500 PHARMACY	7, 890	0	38, 454		2, 304	
	01600 MEDI CAL RECORDS & LI BRARY	0	0	0	-	14	1
	02100 I&R SERVICES-SALARY & FRINGES APPRV 02200 I&R SERVICES-OTHER PRGM COSTS APPRV	599 0	0	25, 350 0		827 0	21.00 22.00
	02300 MEDICAL LABORATORY SCIENTIST PRGM	0	0	159	-	4	23.00
23.01	02302 PHARMACY PRGM	0	0	1, 699	0	5	23.01
	02301 EMERGENCY MEDICAL SERVICES	0	0	6, 001	0	35	1
	02303 PARAMEDI C PRGM 02305 SURGI CAL TECH PROGRAM	0	0	0 750	-	0 16	
23.04	INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>		/30	<u> </u>	10	20.04
	03000 ADULTS & PEDI ATRI CS	90, 201	392, 918	267, 641		6, 804	30.00
	03100 I NTENSI VE CARE UNI T	13, 488	55, 039	58, 665		660	1
	02060 NEONATAL INTENSIVE CARE UNIT 03200 CORONARY CARE UNIT	10, 276 31, 353	37, 578 74, 763	31, 499 64, 974		462 1, 212	
	03400 SURGI CAL I NTENSI VE CARE UNI T	15, 839	44, 254	44, 954		605	
	04100 SUBPROVI DER – I RF	11, 026	33, 109	24, 140		365	
		1, 403	19, 132	0	664	0	43.00
	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	68, 338	0	66, 886	ol	11, 442	50.00
	05200 DELIVERY ROOM & LABOR ROOM	17, 731	0	23, 161		781	
	05400 RADI OLOGY-DI AGNOSTI C	39, 372	0	48, 651	0	3, 658	
	05500 RADI OLOGY-THERAPEUTI C	2, 516	0 0	6, 463	0	283	
	05600 RADI OI SOTOPE 05900 CARDI AC CATHETERI ZATI ON	752 15, 379	0	2, 001 16, 283	-	29 1, 061	1
	06000 LABORATORY	20, 264	0	3, 238		259	1
	06400 I NTRAVENOUS THERAPY	8, 444	0	18, 846		1, 598	1
	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	2, 684 7, 391	0 0	56, 864 25, 629		637 775	
	06700 OCCUPATI ONAL THERAPY	0	0	11, 554			67.00
	06800 SPEECH PATHOLOGY	1, 252	0	5, 056			68.00
	06900 ELECTROCARDI OLOGY	11, 162	0	8, 106			69.00
	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	2, 734 0	0	11, 900 0	0	338 1, 271, 074	70.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	742, 473	
	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	
	07400 RENAL DI ALYSI S	2, 287	0	0	0		74.00
	07697 CARDIAC REHABILITATION 07700 ALLOGENEIC HSCT ACQUISITION	0 1, 162	0	3, 134	0	0	76.97 77.00
	07800 CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	1
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLINIC	12, 690	0	28, 865		467	
	09001 IBMT JOINT VENTURE 09002 MOORESVILLE INFUSION CLINIC	1, 143 86	0	7, 812 0		248	90.01 90.02
	09005 CV DI AGNOSTI C SERVI CES	0	0	54, 470		1, 605	
91.00	09100 EMERGENCY	30, 724	0	54, 827			91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	101.00
	10200 OPI OI D TREATMENT PROGRAM	0	0	0			101.00
	SPECIAL PURPOSE COST CENTERS	· 1			·		
113 00	11300 INTEREST EXPENSE		~	0/ 000			113.00
	11600 HOSPI CE	0 462, 070	0 656, 793	36, 020 1, 082, 995		4, 545 2, 057, 506	116.00
116.00	SUBTOTALS (SUM OF LINES 1 through 117)		000, 170	1,002,790	22,001	2,007,000	1.10.00
116. 00 118. 00		462,070					
116.00 118.00 190.00	NONREI MBURSABLE COST CENTERS	2, 338	0	4, 045	0		190.00
116.00 118.00 190.00 192.00	NONREI MBURSABLE COST CENTERS 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSI CI ANS' PRI VATE OFFI CES	2, 338 3, 196		23, 555	0	911	192.00
116.00 118.00 190.00 192.00 194.00	NONREI MBURSABLE COST CENTERS	2, 338			0	911 0	

Health Financial Systems F	RANCISCAN HEALT	H INDIANAPOLIS		In Lie	u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CC	CN: 15-0162	Period:	Worksheet B	
				rom 01/01/2023	Part II	
			-	To 12/31/2023	Date/Time Pre	
				1	3/28/2024 2:2	1 pm
Cost Center Description	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	
				ADMI NI STRATI ON	SERVICES &	
					SUPPLY	
	9.00	10.00	11.00	13.00	14.00	
194.04 07954 OTHER NRCC	17, 322	0	9, 10	2 0	12, 147	194.04
194. 05 07956 FOUNDATI ON	0	0	(0 0	0	194.05
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)	486, 829	656, 793	1, 120, 07	1 22, 801	2, 070, 675	202.00

Heal th	Fi nanc	ial S	Syste	ems	
		CAD			0

	ATION OF CAPITAL RELATED COSTS		Provider C	, F	eriod: rom 01/01/2023 o 12/31/2023		pared: <u>1 pm</u>
				INTERNS &	RESI DENTS		
	Cost Center Description	PHARMACY	RECORDS & LI BRARY	SERVI CES-SALAR Y & FRI NGES APPRV	PRGM COSTS APPRV	LABORATORY SCIENTIST PRGM	
		15.00	16.00	21.00	22.00	23.00	
1 00	GENERAL SERVICE COST CENTERS						1 1 00
1.00 2.00 4.00 5.01 5.02 5.03 7.00 8.00 9.00 10.00 11.00 13.00 13.00 14.00 15.00 14.00 21.00 23.00 23.01 23.01 23.03	01100 CAFETERIA 01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY 02100 I &R SERVI CES-SALARY & FRI NGES APPRV 02200 I &R SERVI CES-OTHER PRGM COSTS APPRV 02300 MEDI CAL LABORATORY SCI ENTI ST PRGM 02301 EMERGENCY MEDI CAL SERVI CES	936, 621 0 0 0 0 0 0 0 0	1, 386 0 0 0 0 0 0 0 0 0 0	94, 782	369	176	1.00 2.00 4.00 5.01 5.02 5.03 7.00 8.00 9.00 10.00 11.00 13.00 14.00 21.00 22.00 23.00 23.01 23.02 23.03
23.03 23.04		0	0				23.03
23.04	INPATIENT ROUTINE SERVICE COST CENTERS	0	0	1			23.04
30. 00		0	0	1			30.00
31.00		0	0				31.00
31.01		0	0				31.01
32.00		0	0				32.00
34.00 41.00		0	0 0				34.00 41.00
43.00		0	0				41.00
10.00	ANCI LLARY SERVI CE COST CENTERS			1			10.00
50.00		0	0)			50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0				52.00
54.00		0	0				54.00
55.00		0	0				55.00
56.00		0	0				56.00
59.00 60.00		0	0				59.00 60.00
64.00		0	0				64.00
65.00		0	0				65.00
66.00		0	0				66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	0				67.00
68.00		0	0				68.00
69.00		0	0				69.00
70.00 71.00		0	0				70.00
72.00		0	0				72.00
73.00		924, 584	1, 386				73.00
74.00		0	0				74.00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0				76.97
77.00		0	0				77.00
78.00		0	0				78.00
00.00	OUTPATIENT SERVICE COST CENTERS		~	1			00.00
90.00 90.01		0	0				90.00
90.01		0	0				90.01
90.02		0	0				90.05
91.00		0	0				91.00
92.00							92.00
	OTHER REIMBURSABLE COST CENTERS				1		
	0 10100 HOME HEALTH AGENCY	0	0				101.00
102.00	0 10200 OPI OI D TREATMENT PROGRAM	0	0	1			102.00
112 0	SPECIAL PURPOSE COST CENTERS	1				l l	112 00
	0 11300 I NTEREST EXPENSE 0 11600 HOSPI CE	2, 814	0				113.00 116.00
116.00 118.00		2, 814 927, 398	1, 386		0	0	118.00
. 10. 0	NONREI MBURSABLE COST CENTERS	721, 370	1, 300	0	0	0	1 10.00
190.00	0 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0				190.00
	0 19200 PHYSI CI ANS' PRI VATE OFFI CES	8, 717	0				192.00
	0 07955 MARKETING & COMMUNITY RELATIONS	0	0	1	1		194.00

Health Financial Systems F	RANCI SCAN HEALTI	H INDIANAPOLIS	i	In Lie	eu of Form CMS-:	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider C		Period: From 01/01/2023		
				To 12/31/2023	Date/Time Pre 3/28/2024 2:2	
			I NTERNS	& RESIDENTS		
Cost Center Description	PHARMACY			RSERVI CES-OTHER		
		RECORDS & LI BRARY	Y & FRINGES APPRV	PRGM COSTS APPRV	LABORATORY	
	15.00	16.00	21.00	22.00	23.00	
194.0107952 WOMEN'S CENTER	0	C				194.01
194.0207950 OTHER NONREIMBURSABLE COST CENTERS	0	C				194.02
194.0407954 OTHER NRCC	506	C				194.04
194. 05 07956 FOUNDATI ON	0	C				194.05
200.00 Cross Foot Adjustments			94, 78	2 369	176	200.00
201.00 Negative Cost Centers	0	C		0 0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	936, 621	1, 386	94, 78	2 369	176	202.00

ALLOCA	TION OF CAPITAL RELATED COSTS		Provider C	CN: 15-0162	Period: From 01/01/2023 To 12/31/2023		
	Cost Center Description	PHARMACY PRGM	EMERGENCY MEDI CAL SERVI CES	PARAMEDIC PF	RGM SURGICAL TECH PROGRAM	<u>3/28/2024 2:2</u> Subtotal	<u>pm</u>
		23.01	23.02	23.03	23.04	24.00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-BEDG & TTXT						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570 ADMI TTI NG						5.01
5.02	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5.02
5.03	00590 OTHER ADMIN & GENERAL						5.03
7.00	00700 OPERATION OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPING						9.00
10.00 11.00	01000 DI ETARY 01100 CAFETERI A						10.00
13.00	01300 NURSI NG ADMI NI STRATI ON						13.00
14.00	01400 CENTRAL SERVICES & SUPPLY						14.00
15.00	01500 PHARMACY						15.00
16.00	01600 MEDICAL RECORDS & LIBRARY						16.00
21.00	02100 I &R SERVICES-SALARY & FRINGES APPRV						21.00
22.00	02200 I &R SERVI CES-OTHER PRGM COSTS APPRV						22.00
23.00	02300 MEDICAL LABORATORY SCIENTIST PRGM	1 010					23.00
23.01	02302 PHARMACY PRGM	1, 819	4 007	7			23.01
23. 02 23. 03	02301 EMERGENCY MEDICAL SERVICES 02303 PARAMEDIC PRGM		6, 087	1	36		23.02 23.03
23.03	02305 SURGI CAL TECH PROGRAM				822		23.04
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS					11, 162, 716	30.00
31.00	03100 I NTENSI VE CARE UNI T					1, 680, 215	
31.01	02060 NEONATAL INTENSIVE CARE UNIT					1, 242, 705	
32.00	03200 CORONARY CARE UNIT					3, 743, 385	
34.00 41.00	03400 SURGI CAL I NTENSI VE CARE UNI T 04100 SUBPROVI DER – I RF					1, 916, 076 1, 323, 140	1
43.00	04300 NURSERY					1, 323, 140	
101.00	ANCI LLARY SERVICE COST CENTERS					1117000	
50.00	05000 OPERATI NG ROOM					7, 878, 561	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM					2, 066, 361	
54.00	05400 RADI OLOGY-DI AGNOSTI C					4, 550, 880	
55.00	05500 RADI OLOGY-THERAPEUTI C					295, 153	
56.00 59.00	05600 RADI OI SOTOPE 05900 CARDI AC CATHETERI ZATI ON					88, 808 1, 774, 756	
60.00	06000 LABORATORY					2, 318, 719	
64.00	06400 I NTRAVENOUS THERAPY					978, 189	
65.00	06500 RESPI RATORY THERAPY					369, 578	65.00
66.00	06600 PHYSI CAL THERAPY					872, 235	
67.00	06700 OCCUPATI ONAL THERAPY					14, 293	
68.00						148,658	1
69.00 70.00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY					1, 279, 003 325, 058	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT					1, 302, 546	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS					761, 340	
	07300 DRUGS CHARGED TO PATIENTS					971, 163	
74.00	07400 RENAL DI ALYSI S					262, 489	
76.97	07697 CARDI AC REHABI LI TATI ON					3, 461	
77.00	07700 ALLOGENEIC HSCT ACQUISITION					132, 821	
78.00	07800 CAR T-CELL IMMUNOTHERAPY OUTPATIENT SERVICE COST CENTERS			I		4, 684	78.00
90.00	09000 CLINIC					1, 471, 188	90.00
90.01	09001 I BMT JOI NT VENTURE					139, 448	
	09002 MOORESVILLE INFUSION CLINIC					9, 739	
90.05	09005 CV DI AGNOSTI C SERVI CES					59, 243	
	09100 EMERGENCY					3, 639, 489	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
101 00	OTHER REIMBURSABLE COST CENTERS			1		0	101.00
	10200 OPI OI D TREATMENT PROGRAM						102.00
	SPECIAL PURPOSE COST CENTERS	1 1		1		-	
113.00	11300 INTEREST EXPENSE						113.00
116.00	11600 HOSPI CE					45, 703	116.00
		0	0	D	0 0	53, 011, 483	118.00
118.00	NONREIMBURSABLE COST CENTERS						
		1			1	0/0 000	100 00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN					269, 053	
190.00 192.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES					399, 246	192.00
190.00 192.00 194.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN					399, 246	192. 00 194. 00

Health Financial Systems	RANCISCAN HEALT	H INDIANAPOLIS		In Lie	u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider C		eriod:	Worksheet B	
				rom 01/01/2023 o 12/31/2023	Part II Date/Time Pre	narod
			1	0 12/31/2023	3/28/2024 2:2	
Cost Center Description	PHARMACY PRGM	EMERGENCY	PARAMEDIC PRGN	SURGI CAL TECH	Subtotal	
		MEDI CAL		PROGRAM		
		SERVI CES				
	23.01	23.02	23.03	23.04	24.00	
194.0407954 OTHER NRCC					2, 018, 480	194.04
194. 05 07956 FOUNDATI ON					5	194.05
200.00 Cross Foot Adjustments	1, 819	6, 087	36	822	104, 091	200.00
201.00 Negative Cost Centers	0	0	C	0	19	201.00
202.00 TOTAL (sum lines 118 through 201)	1, 819	6, 087	36	822	56, 018, 176	202.00

	Financial Systems F ATION OF CAPITAL RELATED COSTS	RANCI SCAN HEALTH	Provi der CCI	N: 15-0162	Peri od: From 01/01/2023 To 12/31/2023	u of Form CMS-25 Worksheet B Part II Date/Time Prepa	ared:
	Cost Center Description	Intern & Residents Cost & Post Stepdown	Total			3/28/2024 2: 21	pm
		Adjustments 25.00	26.00				
	GENERAL SERVICE COST CENTERS	23.00	20.00				
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUI P						2.00
4.00 5.01	00400 EMPLOYEE BENEFITS DEPARTMENT 00570 ADMITTING						4.00 5.01
5.02	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5.02
5.03	00590 OTHER ADMIN & GENERAL						5.03
7.00	00700 OPERATION OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00 10.00	00900 HOUSEKEEPI NG 01000 DI ETARY						9.00 10.00
11.00	01100 CAFETERI A						11.00
13.00	01300 NURSING ADMINISTRATION						13.00
14.00	01400 CENTRAL SERVICES & SUPPLY						14.00
15.00							15.00
16.00 21.00	01600 MEDICAL RECORDS & LIBRARY 02100 I &R SERVICES-SALARY & FRINGES APPRV						16.00 21.00
22.00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV						22.00
23.00							23.00
23.01	02302 PHARMACY PRGM						23.01
23.02							23.02
23.03 23.04	02303 PARAMEDIC PRGM 02305 SURGICAL TECH PROGRAM						23.03 23.04
20101	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	I	I.				20.01
30.00	03000 ADULTS & PEDIATRICS	0	11, 162, 716				30.00
31.00		0	1, 680, 215				31.00
31.01 32.00	02060 NEONATAL INTENSIVE CARE UNIT 03200 CORONARY CARE UNIT	0	1, 242, 705 3, 743, 385				31.01 32.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	0	1, 916, 076				34.00
41.00	04100 SUBPROVIDER - IRF	0	1, 323, 140				41.00
43.00	04300 NURSERY	0	179, 680				43.00
50.00	ANCI LLARY SERVI CE COST CENTERS	0	7, 878, 561				50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	2,066,361				52.00
54.00		0	4, 550, 880				54.00
55.00 56.00	05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE	0	295, 153				55.00 56.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	88, 808 1, 774, 756				59.00
60.00	06000 LABORATORY	0	2, 318, 719				60.00
64.00		0	978, 189				64.00
65.00		0	369, 578				65.00
66.00 67.00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	0	872, 235 14, 293				66.00 67.00
68.00		0	148, 658				68.00
	06900 ELECTROCARDI OLOGY	0	1, 279, 003				69.00
	07000 ELECTROENCEPHALOGRAPHY	0	325, 058				70.00
71.00 72.00		0	1, 302, 546 761, 340				71.00 72.00
	07300 DRUGS CHARGED TO PATIENTS	0	971, 163				73.00
74.00		0	262, 489				74.00
76.97 77.00	07697 CARDIAC REHABILITATION 07700 ALLOGENEIC HSCT ACQUISITION	0	3, 461				76.97 77.00
78.00		0	132, 821 4, 684				78.00
	OUTPATIENT SERVICE COST CENTERS						
90.00		0	1, 471, 188				90.00
	09001 I BMT JOI NT VENTURE 09002 MOORESVILLE I NFUSION CLINIC	0	139, 448 9, 739				90. 01 90. 02
	09002 MOORESVILLE INFOSTOR CLINIC	0	9, 739 59, 243				90.02 90.05
91.00		0	3, 639, 489				91.00
92.00		0					92.00
101 00	OTHER REIMBURSABLE COST CENTERS	0	0			1	101.00
	10200 OPI OI D TREATMENT PROGRAM	0	0				102.00
	SPECIAL PURPOSE COST CENTERS						
	11300 I NTEREST EXPENSE		15 300				113.00
116.00 118.00	D 11600 HOSPICE D SUBTOTALS (SUM OF LINES 1 through 117)	0	45, 703 53, 011, 483				116.00 118.00
110.00	NONREIMBURSABLE COST CENTERS		55, 011, 405			1	10.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	269, 053				190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	0	399, 246				192.00

Health Financial Systems	FRANCI SCAN HEALTH	I NDI ANAPOLI S		In Lieu	u of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CC	CN: 15-0162	Period: From 01/01/2023 To 12/31/2023	Worksheet B Part II Date/Time Prepared: 3/28/2024 2:21 pm
Cost Center Description	Intern & Residents Cost & Post	Total			
	Stepdown				
	Adjustments				
	25.00	26.00			
194.01 07952 WOMEN' S CENTER	0	215, 402			194.01
194.0207950 OTHER NONREIMBURSABLE COST CENTERS	0	0			194.02
194.0407954 OTHER NRCC	0	2,018,480			194.04
194. 05 07956 FOUNDATI ON	0	5			194.05
200.00 Cross Foot Adjustments	0	104, 091			200.00
201.00 Negative Cost Centers	0	19			201.00
202.00 TOTAL (sum lines 118 through 201)	0	56, 018, 176			202.00

Heal th Financial	Systems
COST ALLOCATION	- STATISTICAL BASIS

FRANCI SCAN HEALTH I NDI ANAPOLI S Provi der CCN: 15-0162

 In Lieu of Form CMS-2552-10

 Period:
 Worksheet B-1

 From 01/01/2023
 Date/Time Prepared: 3/28/2024 2:21 pm

				T	o 12/31/2023	Date/Time Pre 3/28/2024 2:2	
		CAPI TAL REI	LATED COSTS			372072024 2.2	
	Cost Center Description	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	ADMI TTI NG	Reconciliation	
	cost center bescription	(SQUARE FEET)		BENEFITS	(INPATIENT	Reconciliation	
				DEPARTMENT	CHARGES)		
				(GROSS SALARI ES)			
		1.00	2.00	4. 00	5. 01	5A. 02	
	GENERAL SERVICE COST CENTERS						
1.00 2.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP	891, 234	891, 234				1.00 2.00
2.00 4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0					4.00
5.01	00570 ADMI TTI NG	2, 374	2, 374				5.01
5.02	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	975			-	-61, 283	5.02
5.03 7.00	00590 OTHER ADMIN & GENERAL 00700 OPERATION OF PLANT	2, 416 117, 393				0	5.03 7.00
8.00	00800 LAUNDRY & LINEN SERVICE	8, 082					8.00
9.00	00900 HOUSEKEEPI NG	6, 673					9.00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	8, 968 15, 303					10.00 11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	15, 303			-		13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	28, 161		803, 556			14.00
15.00	01500 PHARMACY	12, 209					15.00
16. 00 21. 00	01600 MEDICAL RECORDS & LIBRARY 02100 I &R SERVICES-SALARY & FRINGES APPRV	927		(2, 232, 843	-		16.00 21.00
22.00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0			-	-	22.00
23.00	02300 MEDICAL LABORATORY SCIENTIST PRGM	0	-	42, 889		0	23.00
23.01	02302 PHARMACY PRGM	0		308, 439		0	23. 01 23. 02
23. 02 23. 03	02301 EMERGENCY MEDICAL SERVICES 02303 PARAMEDIC PRGM	0				-	23.02
23.04	02305 SURGI CAL TECH PROGRAM	0					23.04
	INPATIENT ROUTINE SERVICE COST CENTERS	400 570	400.570	00 (07 00)	000.054.040		
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	139, 579 20, 871					30.00 31.00
31.01	02060 NEONATAL INTENSIVE CARE UNIT	15, 901				0	31.01
32.00	03200 CORONARY CARE UNI T	48, 515				0	32.00
34.00 41.00	03400 SURGICAL INTENSIVE CARE UNIT 04100 SUBPROVIDER - IRF	24, 509 17, 062				0	34.00 41.00
41.00	04100 SUBPROVIDER - TRF	2, 171					41.00
	ANCILLARY SERVICE COST CENTERS	1	1		1	1	
50.00	05000 OPERATING ROOM	105, 746					
52.00 54.00	05200 DELIVERY ROOM & LABOR ROOM 05400 RADIOLOGY-DIAGNOSTIC	27,437 60,924				0	52.00 54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	3, 894					55.00
56.00	05600 RADI OI SOTOPE	1, 164				0	56.00
59. 00 60. 00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	23, 798 31, 357				0	59.00 60.00
64.00	06400 I NTRAVENOUS THERAPY	13,066				0	64.00
65.00	06500 RESPI RATORY THERAPY	4, 154	4, 154	8, 949, 731	56, 654, 670	0	65.00
66.00 67.00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	11, 437	11, 437			0	
68.00	06800 SPEECH PATHOLOGY	1, 937	1, 937	2, 684, 953 1, 215, 101			67.00 68.00
69.00	06900 ELECTROCARDI OLOGY	17, 272				0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	4, 230				0	70.00
71.00 72.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	0				0	71.00 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	(73.00
74.00	07400 RENAL DI ALYSI S	3, 539	3, 539		-, ,	0	74.00
76. 97 77. 00	07697 CARDIAC REHABILITATION 07700 ALLOGENEIC HSCT ACQUISITION	0 1, 798	0 1, 798	549, 755		0	76. 97 77. 00
78.00	07800 CAR T-CELL IMMUNOTHERAPY	1, 798		2, 943, 330	, s	0	78.00
	OUTPATIENT SERVICE COST CENTERS	1	-				
90.00	09000 CLINIC	19,637				0	90.00
90. 01 90. 02	09001 I BMT JOINT VENTURE 09002 MOORESVILLE INFUSION CLINIC	1, 768				0	90. 01 90. 02
90.05	09005 CV DI AGNOSTI C SERVI CES	0				0	90.05
91.00	09100 EMERGENCY	47, 542	47, 542	8, 745, 291	116, 768, 825	0	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS						92.00
101.00	10100 HOME HEALTH AGENCY	0	0	(0	0	101.00
	10200 OPI OI D TREATMENT PROGRAM	0					102.00
110 00	SPECIAL PURPOSE COST CENTERS						112 00
	11300 I NTEREST EXPENSE 11600 HOSPI CE	0	0	6, 157, 987	110, 173	n –	113. 00 116. 00
118.00		852, 922	-		1, 812, 780, 585		
100 5	NONREI MBURSABLE COST CENTERS	0.415	0.105	107.07		-	100.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	3, 618	3, 618	407, 309	0	1 0	190. 00

COST ALLOCATI	ON - STATISTICAL BASIS		Provider CC		Period: From 01/01/2023 To 12/31/2023		
						3/28/2024 2:2	
		CAPITAL REL	ATED COSTS				
	Cost Center Description	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	ADMI TTI NG	Reconciliation	
		(SQUARE FEET)		BENEFITS	(INPATI ENT		
		· · · ·	` ´	DEPARTMENT	CHARGES)		
				(GROSS			
				SALARI ES)			
		1.00	2.00	4.00	5. 01	5A. 02	
	PHYSI CI ANS' PRI VATE OFFI CES	4, 945	4, 945	7, 614, 18			192.
	MARKETING & COMMUNITY RELATIONS	0	0	60, 71	3 0		194.
	WOMEN'S CENTER	2, 945	2, 945		0 0		194.
	OTHER NONREIMBURSABLE COST CENTERS	0	0		0 0		194.
94.04 07954		26, 804	26, 804	1, 819, 75	4 0		194.
94.0507956		0	0		0 0		194.
	Cross Foot Adjustments						200.
	Negative Cost Centers						201.
	Cost to be allocated (per Wkst. B,	39, 949, 429	16, 068, 747	619, 94	8 149, 198		202.
	Part I) Unit cost multiplier (Wkst. B, Part I)	44. 824848	18. 029773	0, 00302	0 0.000082		203.
	Cost to be allocated (per Wkst. B,	44. 024040	10. 029773	0.00302	0 149, 217		203.
	Part II)				0 147,217		204.
	Unit cost multiplier (Wkst. B, Part			0.00000	0.00082		205.
				0.00000	0.000002		200.
	NAHE adjustment amount to be allocated						206.
	(per Wkst. B-2)						
	NAHE unit cost multiplier (Wkst. D,						207.
	Parts III and IV)						

COST A	Financial Systems F LLOCATION - STATISTICAL BASIS	RANCI SCAN HEALTH	Provider CC	CN: 15-0162 P	eriod: rom 01/01/2023	u of Form CMS-: Worksheet B-1	
					0 12/31/2023	Date/Time Pre 3/28/2024 2:2	pared:
	Cost Center Description	CASHI ERI NG/ACC	Reconciliation			LAUNDRY &	
		OUNTS RECEI VABLE		GENERAL (ACCUM. COST)	PLANT (SQUARE FEET)	LINEN SERVICE (POUNDS OF	
		(ACCUM. COST)		(ACCOM. COST)	(SQUARE ILLI)	LAUNDRY)	
		5.02	5A. 03	5.03	7.00	8.00	
	GENERAL SERVICE COST CENTERS	1 1					
1.00 2.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570 ADMI TTI NG						5.01
5.02	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	808, 844, 719					5.02
5.03	00590 OTHER ADMIN & GENERAL	201, 015, 290	-201, 030, 377	607, 875, 625			5.03
7.00 8.00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	26, 502, 082 2, 428, 441	0	26, 504, 096 2, 428, 626		2, 758, 340	7.00
9.00	00900 HOUSEKEEPING	9, 155, 016	0	9, 155, 712		2,758,540	
	01000 DI ETARY	3, 005, 776	0	3, 006, 004		0	
	01100 CAFETERI A	3, 198, 800	0	3, 199, 043	15, 303	0	
	01300 NURSING ADMINISTRATION	4, 465, 298	0	4, 465, 637	0	0	
	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	4, 753, 195	0	4, 753, 556	28, 161	10, 223	
	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	8, 960, 991 3, 909, 866	0	8, 961, 672 3, 910, 163	12, 209 0	0	
	02100 I &R SERVICES-SALARY & FRINGES APPRV	2, 340, 933	0	2, 341, 111	927	0	
	02200 I&R SERVICES-OTHER PRGM COSTS APPRV	1, 051, 944	0	1, 052, 024	0	0	1
	02300 MEDICAL LABORATORY SCIENTIST PRGM	36, 079	0	36, 082	0	0	
	02302 PHARMACY PRGM	326, 976	0	327, 001	0	0	
	02301 EMERGENCY MEDICAL SERVICES	146, 949	0	146, 960	0	0	
	02303 PARAMEDIC PRGM 02305 SURGICAL TECH PROGRAM	100, 000 161, 093	0	100, 008 161, 105	-	0	
23.04	INPATIENT ROUTINE SERVICE COST CENTERS	101,075	0	101, 103	0	0	23.04
30. 00	03000 ADULTS & PEDI ATRI CS	56, 791, 630	0	56, 795, 946	139, 579	1, 112, 069	30. 00
31.00	03100 I NTENSI VE CARE UNI T	11, 547, 083	0	11, 547, 961	20, 871	141, 367	31.00
	02060 NEONATAL INTENSIVE CARE UNIT	6, 698, 040	0	6, 698, 549		16, 736	
	03200 CORONARY CARE UNIT	16, 038, 646	0	16, 039, 865		202, 820	
	03400 SURGICAL INTENSIVE CARE UNIT 04100 SUBPROVIDER - IRF	10, 812, 211 5, 412, 099	0	10, 813, 033 5, 412, 510		123, 204 62, 490	
	04300 NURSERY	1, 508, 080	0	1, 508, 195		02,490	1
	ANCI LLARY SERVICE COST CENTERS	.,,	-	.,,	_,,	-	
	05000 OPERATI NG ROOM	26, 440, 056	0	26, 442, 065			•
	05200 DELIVERY ROOM & LABOR ROOM	5, 225, 852	0	5, 226, 249		142, 937	
	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	19, 849, 377 9, 066, 461	0	19, 850, 886 9, 067, 150		126, 451 51	
	05600 RADI OLOGI - TILKAPLOTI C	354, 152	0	354, 179			
	05900 CARDI AC CATHETERI ZATI ON	4, 264, 873	0	4, 265, 197	23, 798		
60.00	06000 LABORATORY	25, 971, 206	0	25, 973, 180		1, 378	60.00
	06400 I NTRAVENOUS THERAPY	4, 904, 789	0	4, 905, 162			
	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	10, 068, 481	0	10, 069, 246			65.00
	06700 OCCUPATIONAL THERAPY	6, 655, 764 2, 667, 290	0	6, 656, 270 2, 667, 493	11, 437 0		67.00
	06800 SPEECH PATHOLOGY	1, 469, 826	0	1, 469, 938	-		68.00
69.00	06900 ELECTROCARDI OLOGY	2, 407, 729	0	2, 407, 912	17, 272	15, 578	69.00
	07000 ELECTROENCEPHALOGRAPHY	2, 195, 386	0	2, 195, 553	4, 230		70.00
	07100 MEDI CAL SUPPLIES CHARGED TO PATIENT	49, 509, 785	0	49, 513, 548		0	
	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	30, 309, 013 84, 001, 914	0	30, 311, 316 84, 008, 298		0	
	07400 RENAL DIALYSIS	1, 621, 469	0	1, 621, 592	3, 539		
	07607 CARDI AC REHABI LI TATI ON	562, 593	0	562, 636		0	
	07700 ALLOGENEIC HSCT ACQUISITION	1, 618, 411	0	1, 618, 534		3, 681	77.00
78.00	07800 CAR T-CELL IMMUNOTHERAPY	6, 128, 769	0	6, 129, 235	0	0	78.00
00.00		7 /4/ 4/4	-	7 / 47 010	10 / 07	45 001	
	09000 CLINIC 09001 IBMT JOINT VENTURE	7, 616, 461 1, 556, 550	0	7, 617, 040 1, 556, 668	19, 637 1, 768	15, 281 5 985	90.00 90.01
	09002 MOORESVILLE INFUSION CLINIC	38, 687	0	1, 556, 668 38, 690	1, 768	5, 985	1
	09005 CV DI AGNOSTI C SERVI CES	8, 903, 388	0	8, 904, 065	0	0	
91.00	09100 EMERGENCY	15, 651, 978	0	15, 653, 168	47, 542	432, 157	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
101 00	OTHER REIMBURSABLE COST CENTERS		0	0	0	0	1101 00
	10100 HOME HEALTH AGENCY 10200 OPI OI D TREATMENT PROGRAM	0	0 0	0	0		101.00
	SPECIAL PURPOSE COST CENTERS		0	0	0	0	1.52.00
	11300 INTEREST EXPENSE						113.00
	11600 HOSPI CE	6, 595, 935	0	6, 596, 436			116.00
118.00		716, 022, 713	-201, 030, 377	515, 046, 565	729, 764	2, 715, 223	118.00
100 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	004 100	0	004 274	2 210	0	190. 00
	19000 BIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	996, 198 7, 752, 334	0	996, 274 7, 752, 923			190.00
		58, 108	0	58, 112	-, ,+5		194. 00
194.00	07955 MARKETING & COMMUNITY RELATIONS	50, 1001					

Heal th	Financial Systems F	RANCISCAN HEALT	H INDIANAPOLIS		In Lie	u of Form CMS-:	2552-10
COST A	LLOCATION - STATISTICAL BASIS		Provider C		Peri od:	Worksheet B-1	
					From 01/01/2023		
				-	Fo 12/31/2023		pared:
						3/28/2024 2:2	1 pm
	Cost Center Description	CASHI ERI NG/ACC	Reconciliation			LAUNDRY &	
		OUNTS		GENERAL	PLANT	LINEN SERVICE	
		RECEI VABLE		(ACCUM. COST)	(SQUARE FEET)		
		(ACCUM. COST)				LAUNDRY)	
		5.02	5A. 03	5.03	7.00	8.00	
194.02	07950 OTHER NONREIMBURSABLE COST CENTERS	0	0	(0 0	0	194.02
194.04	07954 OTHER NRCC	83, 815, 272	0	83, 821, 642	2 26, 804	34, 818	194.04
194.05	07956 FOUNDATI ON	14, 987	0	14, 988	3 0	0	194.05
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00		61, 283		201, 030, 37	35, 269, 266	3, 602, 914	202.00
	Part I)					-,,	
203.00		0.000076		0. 330710	45. 918979	1. 306189	203.00
204.00	Cost to be allocated (per Wkst. B,	61, 283		166, 944	1 7, 387, 995	586, 583	204.00
	Part II)					,	
205.00		0.000076		0.00027	9, 618833	0. 212658	205.00
206.00	NAHE adjustment amount to be allocated						206.00
	(per Wkst. B-2)						
207.00							207.00
207.00	Parts III and IV)						
		1	I	1	1	I	I

	Financial Systems Fi LOCATION - STATISTICAL BASIS	RANCI SCAN HEALTH	H INDIANAPOLIS Provider CC		Period:	u of Form CMS-2 Worksheet B-1	
					From 01/01/2023 To 12/31/2023	Date/Time Pre 3/28/2024 2:2	
	Cost Center Description	HOUSEKEEPING (SQUARE FEET)	DI ETARY (TOTAL PATI ENT DAYS)	CAFETERI A (FTES)	NURSI NG ADMI NI STRATI ON (TOTAL PATI	CENTRAL SERVI CES & SUPPLY (COSTED	
		9.00	10.00	11.00	ENT DAYS) 13.00	REQUIS.) 14.00	
	GENERAL SERVICE COST CENTERS						1.00
2.00 4.00 5.01 5.03 5.03 7.00 8.00 9.00 10.00 11.00 13.00 14.00 15.00 14.00 22.00 23.01 23.01 23.01 23.03	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00570 ADMITTING 00580 CASHIERING/ACCOUNTS RECEIVABLE 00590 OTHER ADMIN & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 02100 I&R SERVICES-SALARY & FRINGES APPRV 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 02300 MEDICAL LABORATORY SCIENTIST PRGM 02301 EMERGENCY MEDICAL SERVICES 02303 PARAMEDIC PRGM 02305 SURGICAL TECH PROGRAM	753, 321 8, 968 15, 303 0 28, 161 12, 209 0 927 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	118, 747 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	6, 181, 498 117, 18 42, 54 212, 22 (139, 90 (88(9, 37 33, 11 (4, 13	5 118, 747 3 0 1 0 4 0 5 0 6 0 5 0 7 0 5 0 7 0 5 0 7 0 0 0	88, 207, 578 98, 129 35, 245 0 160 207 1, 486 0 702	15.00 16.00 21.00 22.00 23.01 23.01 23.02 23.03
Ī	INPATIENT ROUTINE SERVICE COST CENTERS	120 570	71 020			200 054	1
31.00 31.01 32.00 34.00 41.00 43.00	03100 I NTENSI VE CARE UNI T 02060 NEONATAL I NTENSI VE CARE UNI T 03200 CORONARY CARE UNI T 03400 SURGI CAL I NTENSI VE CARE UNI T 04100 SUBPROVI DER – I RF 04300 NURSERY	139, 579 20, 871 15, 901 48, 515 24, 509 17, 062 2, 171	71, 039 9, 951 6, 794 13, 517 8, 001 5, 986 3, 459	1, 477, 07(323, 76; 173, 838 358, 58; 248, 09 133, 22;	3 9, 951 3 6, 794 2 13, 517 1 8, 001 3 5, 986	289, 854 28, 124 19, 693 51, 622 25, 770 15, 561 0	31.00 31.01 32.00 34.00 41.00
50.00 52.00 52.00 54.00 55.00 55.00 60.00 64.00 65.00 66.00 67.00 67.00 69.00 67.00 70.00 70.00 71.00 73.00 74.00 74.00 77.00 73.00	ANCI LLARY SERVICE COST CENTERS D5000 OPERATI NG ROOM O5200 DELI VERY ROOM & LABOR ROOM O5400 RADI OLOGY-DI AGNOSTI C O5500 RADI OLOGY-THERAPEUTI C O5600 RADI OLOGY-THERAPEUTI C O5600 CARDI AC CATHETERI ZATI ON O6000 LABORATORY O6400 I NTRAVENOUS THERAPY O6600 PHYSI CAL THERAPY O6600 PHYSI CAL THERAPY O6600 SPEECH PATHOLOGY O6600 SPEECH PATHOLOGY O6600 ELECTROCARDI OLOGY O7000 ELECTROCARDI OLOGY O7100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 07200 INPL. DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS 07400 RENAL DI ALYSI S 07697 CARDI AC REHABI LI TATI ON 07700 ALLOGENEI C HSCT ACQUI SI TI ON 07800 CAR T-CELL I MMUNOTHERAPY 00400 CLI NU C	105, 746 27, 437 60, 924 3, 894 1, 164 23, 798 31, 357 13, 066 4, 154 11, 437 17, 272 4, 230 0 0 0 3, 539 0 1, 798 0		369, 13 127, 81 268, 496 35, 66 11, 044 89, 86 17, 87 104, 00 313, 825 141, 44 63, 76 27, 90 44, 73 65, 67 (((((((((((((2 0 5 0 4 0 3 0 5 0 5 0 5 0 5 0 5 0 5 0 5 0 5 0 5 0 5 0 5 0 5 0 5 0 6 0 0 0 0 0 0 0 0 0 0 0 0 0	487, 403 33, 255 155, 815 12, 038 1, 240 45, 209 11, 052 68, 073 27, 124 33, 015 6, 807 14, 034 36, 782 14, 386 54, 145, 717 31, 628, 225 0 846 4, 907 0 0	52.00 54.00 55.00 59.00 60.00 64.00 65.00 65.00 66.00 67.00 68.00 69.00 70.00 71.00 73.00 74.00 74.00 76.97 77.00 78.00
90. 01 90. 02 90. 05 91. 00	09000 CLINIC 09001 IBMT JOINT VENTURE 09002 MOORESVILLE INFUSION CLINIC 09005 CV DIAGNOSTIC SERVICES 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	19, 637 1, 768 133 0 47, 542	0 0 0 0	159, 299 43, 112 (300, 61 302, 582	2 0 0 0 1 0	19, 881 10, 576 15 68, 364 61, 045	90. 01 90. 02 90. 05
101.00 102.00	DTHER REIMBURSABLE COST CENTERS 10100 HOME HEALTH AGENCY 10200 OPI OI D TREATMENT PROGRAM	0	0	(101. 00 102. 00
113.00 116.00 118.00	SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE 11600 HOSPI CE SUBTOTALS (SUM OF LINES 1 through 117)	0 715, 009	0 118, 747	198, 788 5, 976, 865		193, 622 87, 646, 583	113. 00 116. 00
190.00 192.00	NONREI MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES 07955 MARKETING & COMMUNITY RELATIONS	3, 618 4, 945 0	0 0 0	22, 324 129, 998 2, 080	3 0	38, 818	190. 00 192. 00 194. 00

Health Financial S	Systems FF	RANCI SCAN HEALTI	H INDIANAPOLIS		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION -	STATISTICAL BASIS		Provider CC		Period:	Worksheet B-1	
					From 01/01/2023 To 12/31/2023	Date/Time Pre 3/28/2024 2:2	
Cost	Center Description	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	
		(SQUARE FEET)	(TOTAL PATI	(FTES)	ADMI NI STRATI ON		
			ENT DAYS)		(SUPPLY	
					(TOTAL PATI	(COSTED	
					ENT DAYS)	REQUIS.)	
		9.00	10.00	11.00	13.00	14.00	
194.0107952 WOMEN		2, 945	0		0 0		194.01
	NONREIMBURSABLE COST CENTERS	0	0		0 0		194.02
194.0407954 OTHER		26, 804	0	50, 23	1 0	517, 436	•
194.0507956 FOUND		0	0		0 0	0	194.05
	Foot Adjustments						200.00
	ive Cost Centers						201.00
202.00 Cost Part	to be allocated (per Wkst. B, I)	12, 490, 015	4, 560, 610	5, 213, 42	6, 041, 302	8, 134, 870	202.00
203.00 Uni t	cost multiplier (Wkst. B, Part I)	16. 579937	38. 406107	0.84339	1 50. 875407	0. 092224	203.00
204.00 Cost Part	to be allocated (per Wkst. B, 11)	486, 829	656, 793	1, 120, 07	4 22, 801	2, 070, 675	204.00
205.00 Unit	cost multiplier (Wkst. B, Part	0. 646244	5. 531028	0. 18119	3 0. 192013	0. 023475	205. 00
206.00 NAHE	adjustment amount to be allocated Wkst. B-2)						206. 00
207.00 NAHE	unit cost multiplier (Wkst. D, 5 III and IV)						207. 00

ST ALLOCATION - STATISTICAL BASIS		Provider CO		Period: From 01/01/2023	Worksheet B-1	
				To 12/31/2023	Date/Time Pre 3/28/2024 2:2	
			I NTERNS &	& RESIDENTS		
Cost Center Description	PHARMACY (COSTED REQUI S.)	MEDI CAL RECORDS & LI BRARY (GROSS CHAR GES)	SERVI CES-SALA Y & FRI NGES APPRV (ASSI GNED TI ME)	RSERVICES-OTHER PRGMCOSTS APPRV (ASSIGNED TIME)	MEDICAL LABORATORY SCIENTIST PRGM (ASSIGNED TIME)	1
	15.00	16.00	21.00	22.00	23.00	
GENERAL SERVICE COST CENTERS 00 00100 CAP REL COSTS-BLDG & FIXT 00 00200 CAP REL COSTS-BLDG & FIXT 00 00400 EMPLOYEE BENEFITS DEPARTMENT 00 00570 ADMITTING 00570 ODHER ADMIN 00 00590 OTHER ADMIN & GENERAL 00 00700 OPERATION OF PLANT 00 00900 HOUSEKEEPING 00 00900 HOUSEKEEPING 00 01000 DI ETARY 00 01100 CAFTERIA 00 01300 NURSI NG ADMIN ISTRATION 00 01400 CENTRAL SERVICES & SUPPLY 00 01500 PHARMACY 00 01400 CENTRAL SERVICES - SALARY AFRINGES APPRV 00 02100 I & SERVICES - SALARY AFRINGES APPRV 00 02200 I & R SERVICES - OTHER PRGM COSTS APPRV 00 02300 MEDICAL LABORATORY SCI ENTIST PRGM 00 02300<	85, 079, 358 0 0 0 0 0 0 0 0 0 0	3, 870, 913, 379 0 0 0 0 0 0 0 0 0 0	25, 99	7 25, 997	100	23. 23. 23.
. 04 02305 SURGI CAL TECH PROGRAM I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0	0				23.
.00 03000 ADULTS & PEDIATRICS .00 03100 INTENSIVE CARE UNIT .01 02060 NEONATAL INTENSIVE CARE UNIT .00 03200 CORONARY CARE UNIT .00 03400 SURGICAL INTENSIVE CARE UNIT .00 04100 SUBPROVIDER IRF .00 04300 NURSERY			60 3		0 0 0 0 0) 31.) 31.) 32.) 34.) 41.
ANCI LLARY SERVICE COST CENTERS 00 05000 OPERATING ROOM 00 05200 DELIVERY ROOM & LABOR ROOM 00 05400 RADI OLOGY-DI AGNOSTIC 00 05500 RADI OLOGY-THERAPEUTIC 00 05500 RADI OLOGY-THERAPEUTIC 00 05500 RADI OLOGY-THERAPEUTIC 00 05600 RADI AC CATHETERI ZATION 00 06400 LABORATORY 00 06400 INTRAVENOUS THERAPY 00 06400 INTRAVENOUS THERAPY 00 06600 PHYSI CAL THERAPY 00 06600 PHYSI CAL THERAPY 00 06600 SPEECH PATHOLOGY 00 06600 SPEECH PATHOLOGY 00 06700 CCUPATI ONAL THERAPY 00 06800 SPEECH PATHOLOGY 00 06900 ELECTROCARDI OLOGY 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 00 07200 IMPL. DEV. CHARGED TO PATIENTS 00 07300 RUAGS	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	48, 971, 664 371, 800, 783 112, 966, 617 10, 261, 587 193, 125, 396 296, 599, 274 78, 887, 275 66, 653, 414 58, 913, 287 28, 977, 341 13, 641, 682 53, 453, 217 29, 329, 127 283, 313, 855 154, 457, 585	69	0 0 0 0	0 0 0 100 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	522 544 555 566 59 600 644 655 666 677 688 700 711 722 733 74.4 77.4 77.4
.00 09000 CLINIC .01 09001 IBMT JOINT VENTURE .02 09002 MOORESVILLE INFUSION CLINIC .05 09005 CV DIAGNOSTIC SERVICES .00 09100 EMERGENCY .00 09200 OBSERVATION BEDS (NON-DISTINCT PART		1		0 0 0 0 0 0 0 0 1 501		90 90 90
OTHER REIMBURSABLE COST CENTERS 1.000 10100 HOME HEALTH AGENCY 2.000 00PI 0I D TREATMENT PROGRAM SPECIAL PURPOSE COST CENTERS	0	0		0 0 0 0		101 102
SPECIAL PURPOSE COST CENTERS 3. 00 11300 INTEREST EXPENSE 6. 00 11600 HOSPI CE 8. 00 SUBTOTALS (SUM OF LINES 1 through 117)	255, 590	15, 476, 930 3, 870, 913, 379		3 11, 853		113

Health Financial Systems	FRANCI SCAN HEALT				eu of Form CMS-2	
COST ALLOCATION - STATISTICAL BASIS		Provider C		Period: From 01/01/2023	Worksheet B-1	
				To 12/31/2023		pared.
			_	10 12/01/2020	3/28/2024 2:2	
			I NTERNS	& RESIDENTS		
Cost Center Description	PHARMACY	MEDICAL		RSERVI CES-OTHER		
	(COSTED	RECORDS &	Y & FRINGES	PRGM COSTS	LABORATORY	
	REQUIS.)	LI BRARY	APPRV		SCIENTIST PRGM	
		(GROSS CHAR	(ASSI GNED	(ASSI GNED	(
		GES)	TIME)	TIME)	(ASSI GNED	
					TIME)	
	15.00	16.00	21.00	22.00	23.00	
NONREI MBURSABLE COST CENTERS		-	1	-	-	
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CAN		0)	0 0		190.00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	791, 801	C)	0 0		192.00
194.00 07955 MARKETING & COMMUNITY RELATIONS	0	C)	0 0		194.00
194.0107952WOMEN'S CENTER	0	C)	0 0		194. 01
194.0207950 OTHER NONREIMBURSABLE COST CENT		C)	0 0		194. 02
194.0407954 OTHER NRCC	45, 983	C	14, 14	4 14, 144		194. 04
194. 05 07956 FOUNDATI ON	0	0		0 0	0	194.05
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers						201.00
202.00 Cost to be allocated (per Wkst. Part I)	B, 12, 876, 471	5, 203, 348	3, 294, 52	1, 399, 939	48, 772	202.00
203.00 Unit cost multiplier (Wkst. B,	Part I) 0.151347	0. 001344	126, 72696	53.850021	487, 720000	203.00
204.00 Cost to be allocated (per Wkst.		1, 386				204.00
Part II)	5, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	.,	, , , , , ,	2 007		201100
205.00 Unit cost multiplier (Wkst. B,	Part 0.011009	0. 000000	3. 64588	0. 014194	1. 760000	205.00
206.00 NAHE adjustment amount to be al	located				0	206. 00
(per Wkst. B-2)						
207.00 NAHE unit cost multiplier (Wkst Parts III and IV)	. D,				0.000000	207.00

	Financial Systems FR LLOCATION - STATISTICAL BASIS	RANCI SCAN HEALTI	H INDIANAPOLIS		In Lie Period:	u of Form CMS-2552 Worksheet B-1	2-10
0001 //				1	From 01/01/2023 To 12/31/2023	Date/Time Prepare	
	Cost Center Description	PHARMACY PRGM (ASSIGNED TIME)	EMERGENCY MEDI CAL SERVI CES (ASSI GNED	PARAMEDIC PRGI (ASSIGNED TIME)	M SURGI CAL TECH PROGRAM (ASSI GNED TI ME)	3/28/2024 2:21 pm	<u></u>
		23.01	TIME) 23.02	23.03	23.04		
1 00	GENERAL SERVICE COST CENTERS					1	
$\begin{array}{c} 11.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 21.\ 00\\ 22.\ 00\\ 23.\ 00\\ 23.\ 01\\ 23.\ 02\\ 23.\ 03\\ \end{array}$	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00570 ADMITTING 00580 CASHIERING/ACCOUNTS RECEIVABLE 00590 OTHER ADMIN & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DI ETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 02100 I&R SERVICES-SALARY & FRINGES APPRV 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 02300 MEDICAL LABORATORY SCIENTIST PRGM 02301 EMERGENCY MEDICAL SERVICES 02303 PARAMEDIC PRGM 02305 SURGICAL TECH PROGRAM	100	100	100	0 100	2. 4. 5. 5. 7. 8. 9. 10. 11. 13. 14. 15. 16. 21. 22. 23. 23. 23. 23.	. 00 . 00 . 00 . 01 . 02 . 03 . 00 . 00
30.00	INPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	0	0			30	. 00
31.00 31.01 32.00 34.00 41.00	03100 INTENSIVE CARE UNIT 02060 NEONATAL INTENSIVE CARE UNIT 03200 CORONARY CARE UNIT 03400 SURGICAL INTENSIVE CARE UNIT 04100 SUBPROVIDER - IRF 04300 NURSERY		0 0 0 0 0 0 0 0		0 0 0 0 0 0 0 0 0 0	31. 31. 32. 34. 41.	. 00 . 01 . 00 . 00 . 00 . 00
$\begin{array}{c} 52.\ 00\\ 54.\ 00\\ 55.\ 00\\ 56.\ 00\\ 60.\ 00\\ 64.\ 00\\ 65.\ 00\\ 65.\ 00\\ 66.\ 00\\ 67.\ 00\\ 68.\ 00\\ 70.\ 00\\ 71.\ 00\\ 72.\ 00\\ 73.\ 00\\ 74.\ 00\\ 76.\ 97\\ 77.\ 00\\ 78.\ 00\\ \end{array}$	ANCI LLARY SERVICE COST CENTERS 05000 OPERATI NG ROOM 05200 DELI VERY ROOM & LABOR ROOM 05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C 05600 RADI OLOGY-THERAPEUTI C 05600 CARDI AC CATHETERI ZATI ON 06000 LABORATORY 06400 I NTRAVENOUS THERAPY 06600 PHYSI CAL THERAPY 06600 SPEECH PATHOLOGY 06700 OCCUPATI ONAL THERAPY 06600 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY 07000 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 07200 IMPL. DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS 07400 RENAL DI ALYSI S 07697 CARDI AC REHABI LI TATI ON 07700 ALLOGENEI C HSCT ACQUI SI TI ON 07800 CAR T-CELL I MMUNOTHERAPY 001704 DI NUCL					52. 54. 55. 56. 59. 60. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 74. 76. 77. 78.	. 00 . 00
90. 01 90. 02 90. 05 91. 00	09000 CLINIC 09001 IBMT JOINT VENTURE 09002 MOORESVILLE INFUSION CLINIC 09005 CV DIAGNOSTIC SERVICES 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS	0 0 0 0	0 0 0 100	() () () () () ()	0 0 0 0 0 0 0 0 0 0	90. 90. 90. 91.	. 00 . 01 . 02 . 05 . 00 . 00
	10100 HOME HEALTH AGENCY 10200 OPIOID TREATMENT PROGRAM	0	0		0 0 0 0	101. 102.	
113.00	SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE 11600 HOSPICE SUBTOTALS (SUM OF LINES 1 through 117)	0	0 100	(10)	-	113. 116. 118.	. 00 . 00
192.00	NONREI MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSI CIANS' PRI VATE OFFI CES 07955 MARKETI NG & COMMUNI TY RELATI ONS	0 0 0	0 0 0	(190. 192. 194.	

Health Financial Systems	FRANCI SCAN HEALT	H INDIANAPOLIS		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider C		Peri od:	Worksheet B-1	
				From 01/01/2023 To 12/31/2023	Date/Time Pre	narod
				12/31/2023	3/28/2024 2:2	
Cost Center Description	PHARMACY PRGM	EMERGENCY	PARAMEDIC PRG	SURGI CAL TECH		
	(ASSI GNED	MEDI CAL		PROGRAM		
	TIME)	SERVI CES	(ASSI GNED	(ASSI GNED		
		(ASSI GNED	TIME)	TIME)		
		TIME)				
	23.01	23.02	23.03	23.04		
194.01 07952 WOMEN' S CENTER	0	0	(0 0		194.01
194.0207950 OTHER NONREIMBURSABLE COST CENTERS	0	0	(0 0		194. 02
194.04079540THER NRCC	0	0	(0 0		194.04
194. 05 07956 FOUNDATI ON	0	0	(0 0		194.05
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers						201.00
202.00 Cost to be allocated (per Wkst. B,	443, 072	223, 629	133, 082	2 217, 938		202.00
Part I)						
203.00 Unit cost multiplier (Wkst. B, Part I						203.00
204.00 Cost to be allocated (per Wkst. B,	1, 819	6, 087	36	6 822		204.00
Part II)						
205.00 Unit cost multiplier (Wkst. B, Part	18. 190000	60. 870000	0.360000	8. 220000		205.00
206.00 NAHE adjustment amount to be allocate	0 1	0	(0 0		206.00
(per Wkst. B-2)						
207.00 NAHE unit cost multiplier (Wkst. D,	0. 000000	0. 000000	0.00000	0. 000000		207.00
Parts III and IV)			I	1		

FRANCISCAN HEALTH INDIANAPOLIS

In Lieu of Form CMS-2552-10

COMPUTATION OF RATIO OF COSTS TO CHARGES	Provider C		Period: From 01/01/2023 To 12/31/2023	Worksheet C Part I Date/Time Pre 3/28/2024 2:2	pared: 1 pm	
		Title	XVIII	Hospi tal	PPS	<u> </u>
				Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I, col.	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
	26)					
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS	02 716 072		02 71/ 07	2 0	02 716 072	20.00
30. 00 03000 ADULTS & PEDIATRICS	93, 716, 072		93, 716, 07			
31. 00 03100 I NTENSI VE CARE UNI T	18,081,472		18, 081, 47			
31. 01 02060 NEONATAL INTENSIVE CARE UNIT	10, 738, 173		10, 738, 17			
32.00 03200 CORONARY CARE UNI T	26, 215, 731		26, 215, 73		26, 215, 731	
34.00 03400 SURGI CAL INTENSI VE CARE UNI T	17, 050, 951		17, 050, 95		17, 050, 951	
41.00 04100 SUBPROVIDER - IRF	9, 025, 252		9, 025, 25		.,	
43. 00 04300 NURSERY	2, 461, 492		2, 461, 49	2 0	2, 461, 492	43.00
ANCI LLARY SERVI CE COST CENTERS	1	1	1			
50.00 05000 OPERATI NG ROOM	43, 108, 223		43, 108, 22			
52.00 05200 DELIVERY ROOM & LABOR ROOM	9, 032, 794		9, 032, 79	4 0	9, 032, 794	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	31, 129, 143		31, 129, 14	3 0	31, 129, 143	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	12, 492, 205		12, 492, 20	5 0	12, 492, 205	55.00
56. 00 05600 RADI OI SOTOPE	575, 247		575, 24	7 0	575, 247	56.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	7, 559, 912		7, 559, 91	2 0	7, 559, 912	59.00
60. 00 06000 LABORATORY	36, 987, 841		36, 987, 84	1 0	36, 987, 841	60.00
64.00 06400 INTRAVENOUS THERAPY	7, 543, 978		7, 543, 97			
65. 00 06500 RESPI RATORY THERAPY	14, 016, 595					
66. 00 06600 PHYSI CAL THERAPY	9, 805, 593				9, 805, 593	
67. 00 06700 OCCUPATI ONAL THERAPY	3, 643, 014				3, 643, 014	
68. 00 06800 SPEECH PATHOLOGY	2, 123, 434		2, 123, 43		2, 123, 434	
69. 00 06900 ELECTROCARDI OLOGY	4, 417, 024		4, 417, 02		4, 417, 024	
70. 00 07000 ELECTROENCEPHALOGRAPHY	3, 294, 190		3, 294, 19		3, 294, 190	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	71, 262, 497		71, 262, 49			
	43, 460, 043		43, 460, 04		43, 460, 043	
73. 00 07300 DRUGS CHARGED TO PATIENTS	125, 915, 236		125, 915, 23		125, 915, 236	
74.00 07400 RENAL DI ALYSI S	2, 406, 334		2, 406, 33		2, 406, 334	
76. 97 07697 CARDI AC REHABI LI TATI ON	769, 697		769, 69		769, 697	
77.00 07700 ALLOGENEIC HSCT ACQUISITION	2, 272, 219		2, 272, 21		2, 272, 219	
78.00 07800 CAR T-CELL IMMUNOTHERAPY	8, 210, 194		8, 210, 19	4 0	8, 210, 194	78.00
OUTPATIENT SERVICE COST CENTERS		1				
90. 00 09000 CLINIC	11, 543, 482		11, 543, 48			
90.01 09001 IBMT JOINT VENTURE	2, 244, 500		2, 244, 50		2, 244, 500	
90.02 09002 MOORESVILLE INFUSION CLINIC	60, 571		60, 57		60, 571	90. 02
90. 05 09005 CV DIAGNOSTIC SERVICES	12, 241, 013		12, 241, 01		12, 241, 013	
91. 00 09100 EMERGENCY	25, 454, 027		25, 454, 02	7 0	25, 454, 027	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	11, 274, 355		11, 274, 35	5	11, 274, 355	92.00
OTHER REIMBURSABLE COST CENTERS	1			- 1		
101.00 10100 HOME HEALTH AGENCY	0			0		101.00
102.00 0PI 0I D TREATMENT PROGRAM	0			0	0	102.00
SPECIAL PURPOSE COST CENTERS		1				440.00
113.00 11300 INTEREST EXPENSE						113.00
116.00 11600 HOSPI CE	9, 022, 940		9, 022, 94		9, 022, 940	
200.00 Subtotal (see instructions)	689, 155, 444					
201.00 Less Observation Beds	11, 274, 355		11, 274, 35		11, 274, 355	
202.00 Total (see instructions)	677, 881, 089	0	677, 881, 08	9 0	677, 881, 089	202.00

Heal th	Fi nan	ci a	I Syst	ems			
COMPLIE	ATLON	OF	PATIO	OF	27200	ΤO	CL

FRANCISCAN HEALTH INDIANAPOLIS

In Lieu of Form CMS-2552-10

	OF RATIO OF COSTS TO CHARGES	RANCI SCAN HEALT	Provi der C	CN: 15-0162	Period: From 01/01/2023 Fo 12/31/2023	Worksheet C Part I Date/Time Pre 3/28/2024 2:2	
			Title	× XVIII	Hospi tal	PPS	
			Charges				
	Cost Center Description	I npati ent	Outpati ent	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
		6.00	7.00	8.00	9.00	10.00	
	FIENT ROUTINE SERVICE COST CENTERS	0.00	7.00	0.00	7.00	10.00	
	ADULTS & PEDIATRICS	211, 775, 236		211, 775, 230	5		30.00
	DINTENSIVE CARE UNIT	45, 628, 948		45, 628, 948			31.00
	D NEONATAL INTENSIVE CARE UNIT	39, 942, 560		39, 942, 560			31.01
	CORONARY CARE UNIT	44, 837, 524		44, 837, 524			32.00
	SURGICAL INTENSIVE CARE UNIT	32, 194, 892		32, 194, 892			34.00
	SUBPROVIDER - IRF	19, 759, 843		19, 759, 843			41.00
	NURSERY	7, 449, 680		7, 449, 680			43.00
	LARY SERVICE COST CENTERS	1 1111000		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	-		101.00
	OPERATING ROOM	186, 378, 478	163, 890, 948	350, 269, 420	0. 123072	0.00000	50.00
	D DELIVERY ROOM & LABOR ROOM	48, 815, 761	155, 903			0.000000	
	RADI OLOGY-DI AGNOSTI C	121, 552, 326	250, 248, 457			0.000000	
	RADI OLOGY-THERAPEUTI C	5, 925, 750	107, 040, 867			0.000000	
	RADI OI SOTOPE	3,005,482	7, 256, 105			0.000000	
	CARDI AC CATHETERI ZATI ON	79, 062, 809	114, 062, 587			0.000000	
	LABORATORY	158, 494, 853	138, 104, 421			0.000000	
	INTRAVENOUS THERAPY	7, 820, 407	71, 066, 868			0.000000	
	RESPIRATORY THERAPY	56, 654, 670	9, 998, 744			0.000000	
	PHYSI CAL THERAPY	25, 139, 318	33, 773, 969			0.000000	
	O OCCUPATIONAL THERAPY	20, 029, 070	8, 948, 271			0.000000	
	SPEECH PATHOLOGY	7, 443, 199	6, 198, 483			0.000000	
	DELECTROCARDIOLOGY	36, 010, 987	17, 442, 230			0.000000	
	ELECTROENCEPHALOGRAPHY	9, 662, 622	19, 666, 505			0.000000	
	MEDICAL SUPPLIES CHARGED TO PATIENT	171, 860, 154	111, 453, 701			0.000000	
	IMPL. DEV. CHARGED TO PATIENTS	100, 335, 879	54, 121, 706			0.000000	
	D DRUGS CHARGED TO PATIENTS	194, 284, 288	527, 307, 260			0.000000	
	RENAL DIALYSIS	8, 659, 635	519, 802			0.000000	
	7 CARDI AC REHABI LI TATI ON	168, 387	4, 260, 180			0. 000000	
	ALLOGENEIC HSCT ACQUISITION	00,007	921, 931			0.000000	
	CAR T-CELL IMMUNOTHERAPY	30, 872, 289	9, 276, 647			0.000000	
	ATIENT SERVICE COST CENTERS	00/0/2/20/	,12,0,01,	107110770	012011/0	0100000	/ 01 00
		970, 577	16, 868, 044	17, 838, 62	0. 647106	0.00000	90.00
	I I BMT JOINT VENTURE	3, 574, 448	9, 353, 361			0.000000	
	2 MOORESVILLE INFUSION CLINIC	0,07,17,110	575, 175			0.000000	
	5 CV DI AGNOSTI C SERVI CES	510, 383	98, 036, 297			0.000000	
	DEMERGENCY	116, 768, 825	233, 574, 901			0.000000	
	OBSERVATION BEDS (NON-DISTINCT PART	17, 081, 132	28, 642, 674			0.000000	
	R REIMBURSABLE COST CENTERS	17,001,102	20,012,071	10, 720, 000	0.210070	0.00000	12.00
	HOME HEALTH AGENCY	0	0	(0		101.00
	OPIOID TREATMENT PROGRAM	0	0				102.00
	AL PURPOSE COST CENTERS	<u>ч</u>	0	· · · · · ·	- 1	L	1
	INTEREST EXPENSE						113.00
116.00 11600		110, 173	15, 366, 757	15, 476, 930	0		116.00
200.00	Subtotal (see instructions)	1, 812, 780, 585					200.00
201.00	Less Observation Beds	., 0.2, ,00,000	_,,, // -				201.00
202.00	Total (see instructions)	1,812,780,585	2, 058, 132, 794	3. 870. 913 379	9		202.00
202.00		1,012,700,000	2,000,102,774	0,0,0,0,0,0,0		I	1-02.00

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCR: 15-0702 Provider CCR: 1	Health Financial Systems	FRANCI SCAN HEALTH	I NDI ANAPOLI S	In Lie	u of Form CMS-	2552-10
Image: Cost Center Description PPS Inpatient Ratio Title XVIII Hospital PPS Image: Cost Center Description PPS Inpatient Ratio 11.00	COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0162	From 01/01/2023	Part I Date/Time Pre	epared:
Cost Center Description PPS Inpatient Ratio Nation INPATIENT ROUTINE SERVICE COST CENTERS 30.00<					3/28/2024 2:2	<u>2'1 pm</u>
Ratio Ratio 11.00 11.00 0 0.00000000000000000000000000000000000			Title XVIII	Hospi tal	PPS	
11.00 11.00 30.00 03000 ADULTS & PEDLATRICS 31.01 31.01 03100 03400 03400 03400 03400 04300 NURSERY 43.00 41.00 04100 040115 05.00 05500 0500 05000 0500 05000 0500 0500 05000 0500 0500 0500 0500 05000 0500 0500 <t< td=""><td>Cost Center Description</td><td></td><td></td><td></td><td></td><td></td></t<>	Cost Center Description					
IMPART LENT ROUTI NE SERVICE COST CENTERS 30.00 10.00 003000 ADULTS & PED NITI C 31.00 31.00 03200 (NORMATL, INTENSIVE CARE UNIT 31.00 32.00 03200 (ORMARY CARE UNIT 32.00 34.00 03200 (ORMOLAR) FURSIVE CARE UNIT 32.00 34.00 03400 (NIRSERY 41.00 41.00 04100 (SUBRACL INTENSIVE CARE UNIT 43.00 35.00 05200 (DERATIL RENSIVE CARE UNIT 43.00 40.00 04200 (NIRSERY 43.00 35.00 05200 (DERATILR ROM 0.123072 50.00 05200 (DERATILR ROMA 0.184449 52.00 05200 (DELIVERY ROM & LABOR ROM 0.184449 52.00 05500 (RADI LOCO'-INERAPETITI C 0.10583 56.00 05600 (RADI LOCO'-INERAPETITI C 0.10583 50.00 05600 (RADI LOCO'-INERAPETITI C 0.10583 50.00 05600 (RADI LOCO'-INERAPY 0.21291 61.00 06000 (SER) RATOR THERAPY 0.122109 62.00 06000 (SER) RATOR THERAPY 0.164411 62.00 06000 (SER) RATO						
30. 00 03000 (ADULTS & PEDLATRICS 31. 00 31. 00 03100 (DTRESNY CARE UNIT 31. 01 32. 00 03200 (DRONARY CARE UNIT 31. 01 32. 00 03400 (DRONARY CARE UNIT 34. 00 34. 00 03400 (DRONARY CARE UNIT 34. 00 43. 00 04300 (UNRSERY 41. 00 43. 00 04300 (DRONARY CARE UNIT 34. 00 43. 00 04300 (UNRSERY 43. 00 44. 00 04100 (DRONARY CARE UNIT 34. 00 45. 00 05000 (DRENTING ROOM 0. 123072 50. 00 05000 (DREND ALLARY SERVICE COST CENTERS 52. 00 50. 00 05600 (RADI OLCOV-1HRAPEUTIC 0. 10832 55. 00 50. 00 05600 (RADI OLCOV-1HRAPEUTIC 0. 134449 55. 00 50. 00 05600 (RADI OLSOV-THRAPEUTIC 0. 134706 64. 00 60. 00 06000 (RADI ALCATHERPETIZITINN 0. 134706 64. 00 60. 00 06000 (RADI OLSOV-THRAPEUTIC 0. 125719 67. 00 60. 00 06000 (CRESTRIATORY THERAPY 0. 125719 67. 00 60. 00 06000 (CRESTRIATORY THERAPY 0. 125719 67.	INPATIENT ROUTINE SERVICE COST CENTERS	11.00				-
31.00 03100 INTENSIVE CARE UNIT 31.00 31.00 02200 CORONATA: INTENSIVE CARE UNIT 32.00 32.00 03200 CORONATY CARE UNIT 32.00 32.00 03200 CORONATA: INTENSIVE CARE UNIT 32.00 32.00 04100 SUBFORO, INTENSIVE CARE UNIT 34.00 30.00 04300 NIRSERY 43.00 30.00 04300 NIRSERY 43.00 30.00 05200 DEFLATING ROM 0.122072 50.00 05200 DEFLATING ROM 0.124072 52.00 05200 DELLISERY PROM & LABOR ROM 0.124479 55.00 05500 RADI OLCY-THERAPEUTIC 0.039145 56.00 05600 RADI OLCY-THERAPEUTIC 0.039145 57.00 0500 CARDI AC CATHETER TATI ON 0.039145 50.00 06000 RESPI RATORY HERAPY 0.124706 64.00 06000 RESPI RATORY HERAPY 0.124716 64.00 0.6000 RESPI RATORY HERAPY 0.124716 65.00 0.6000 RESPI RATORY HERAPY 0.124716 67.00 0.0000 RESPI RATORY HERAPY 0.124711 67.00 0.0000 RESPI RATORY HERAPY 0.124411 66.00 0.6000						30.00
31.01 02000 NEOMATAL INTENSIVE CARE UNIT 31.01 32.00 03300 SURGI CAL INTENSIVE CARE UNIT 32.00 41.00 04000 SURGI CAL INTENSIVE CARE UNIT 34.00 41.00 04000 SURGI CAL INTENSIVE CARE UNIT 41.00 41.00 04300 NURSERPY 41.00 41.01 04300 NURSERPY 50.00 41.01 05000 OPEGATING ROOM 0.184449 50.00 05000 OPEGATING ROOM 0.184449 50.00 05500 RADI LOCY-THERAFEUTIC 0.003725 51.00 05500 RADI LOCY-THERAFEUTIC 0.10583 55.00 05500 CARDI AC CATHETERIZATION 0.039145 50.00 05600 CARDI AC CATHETERIZATION 0.039145 50.00 06500 CESPI RATIONY THERAPY 0.210291 66.00 06600 PHYSI CAL THERAPY 0.155568 66.00 06600 CESPI RATIONY THERAPY 0.122519 67.00 0700 CLETEROCARAHY 0.12318 70.00 07000 CLETEROCARAHY 0.12318 70.00 07000 CLETEROCARAHY 0.12318 70.00 07000 CLETEROCARAHY 0.12318 70.00 07000 CLETEROCARAHY						
32.00 03200 CORONARY CARE UNIT 32.00 40.00 04000 SUBERGIAL INFENSIVE CARE UNIT 34.00 41.00 04100 SUBEROVIDER - INFINSIVE CARE UNIT 41.00 43.00 04300 PRASTING ROM 0.123072 52.00 05200 DEFLATING ROM 0.124072 52.00 05200 DEFLATING ROM 0.124049 52.00 05200 DEFLATING ROM 0.124072 55.00 05500 RADI OLCY-THERAPEUTIC 0.038725 56.00 05600 RADI OLCY-THERAPEUTIC 0.039145 56.00 05600 RADI OLCY-THERAPEUTIC 0.039145 57.00 05600 CARDI AC CATHETERI ZATI ON 0.039145 57.00 06400 INTERAVENUS THERAPY 0.216241 66.00 66000 PHYSI GLAL THERAPY 0.166441 67.00 06000 SPECICI THERAPY 0.125132 67.00 06000 SPECICI PHAID LORY THERAPY 0.125132 71.00 07000 CLIPATI ONAL THERAPY 0.125132 72.00 07000 SPECICARDI AC REPARED TO PATI ENT 0.25132 72.00 07000 LIPL DEV CARGED TO PATI ENT 0.25132 72.00 07000 LIPL DEV CARGED TO PATI ENT 0.244030 <t< td=""><td></td><td></td><td></td><td></td><td></td><td>•</td></t<>						•
34.00 03400 SURGICAL INTENSIVE CARE UNIT 34.00 34.00 34.00 34.00 34.00 34.00 41.00 41.00 04300 NURSERV 41.00 41.00 41.00 41.00 ANULLARY SERVICE COST CENTERS 50.00 05000 OPEATING ROOM 0.182472 50.00 52.00 52.00 05200 DELIVEER NOR & LABOR ROOM 0.184449 52.00 52.00 51.00 05500 RADIOLOGY-THERAPEUTIC 0.083725 56.00 56.00 50.00 05500 RADIOLOGY-THERAPEUTIC 0.105803 56.00 56.00 50.00 05500 RADIOLOGY-THERAPEUTIC 0.039145 56.00 56.00 60.00 06000 CARDIA C CATHETERIZATION 0.039145 56.00 56.00 60.00 06000 PHYSICAL THERAPY 0.126719 66.00 66.00 66.00 60.00 06000 CCARDIA C ATHETERIZATION 0.128719 66.00 66.00 66.00 60.00 06000 CCARDIA C ATHETERIZATION 0.128719 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00<						
43:00 VUSSERY 43:00 MOLLLARY SERVICE COST CENTERS 50:00 05000 OPERATING ROM 0.123072 50:00 50:00 05200 DELIVERY ROM & LABOR ROM 0.124449 52:00 52:00 50:00 05200 DELIVERY ROM & LABOR ROM 0.124449 52:00 54:00 50:00 05000 RADIOLOGY-THERAPEUTIC 0.056058 55:00 55:00 55:00 50:00 05000 LABORATORY 0.124706 60:00 66:00 70:00 70:00 70:00 70:00 70:00 70:00 70:00 70:00 70:00 70:00 70:00						
ANCILLARY SERVICE COST CENTERS	41.00 04100 SUBPROVIDER - IRF					41.00
50. 00 GG000 (PERATI ISC ROM 0.123072 50. 00 50. 00 520.00 DELI VERY PROM & LABOR ROM 0.184449 52. 00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0.083725 54. 00 55. 00 05500 RADI OLOGY-THERAPEUTI C 0.110683 55. 00 56. 00 05600 CATHETERI ZATI ON 0.056058 56. 00 50. 00 05600 LABORATORY 0.124706 66. 00 60. 00 06600 RESPI RATORY THERAPY 0.210291 65. 00 66. 00 06600 RESPI RATORY THERAPY 0.125719 67. 00 67. 00 06700 OCCUPATI NAL THERAPY 0.125719 67. 00 67. 00 06700 CATRORAL THERAPY 0.125719 67. 00 67. 00 06700 OCCUPATI NAL THERAPY 0.125719 77. 00 70. 00 CARDI CALSTRAPY 0.125719 77. 00 77. 00 70. 00 CARDI CALSTRAPY 0.125119 77. 00 77. 00 71. 00 OTADO ICAL SUPPLIES CHARGED TO	43. 00 04300 NURSERY					43.00
52.00 05200 DELIVERY ROOM & LABOR ROOM 0.184449 52.00 54.00 05400 RADI OLOGY-THERAPEUTI C 0.083725 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 0.110583 55.00 56.00 05600 RADI OLOGY-THERAPEUTI C 0.1058058 55.00 50.00 OSGOO RADI AC CATHETERI ZATI ON 0.039145 59.00 60.00 OGGOO LABORATORY 0.124706 66.00 65.00 DESDI PERTERPY 0.125719 66.00 66.00 OFGOO PHYSI CAL THERAPY 0.125719 67.00 66.00 OFGOO PHYSI CAL THERAPY 0.125719 67.00 68.00 OFGOO PHECIAC DEVENT HERAPY 0.125719 67.00 70.00 OFGOO PHECIAC DEVENALOGRAPHY 0.125719 71.00 70.00 DECIAT DEVENT HERAPY 0.125719 68.00 70.00 OFGOO PHYSI CAL THERAPY 0.125719 71.00 70.00 OTGOO ELECTROCARGED TO PATI ENT 0.28233 69.00 70.00 OTGOO ILECTROCAREPHALOGRAPHY 0.124	ANCI LLARY SERVICE COST CENTERS					
54.00 OS400 RADI 0LOGY-DI ASNOSTI C 0.083725 54.00 55.00 56.00 55.00 56.00 50.00 5		0. 123072				50.00
55.00 OS500 RADIO LOGY-THERAPEUTI C 0.110583 55.00 56.00 DS600 RADIO STOPE 0.056058 59.00 59.00 0590 CARDIA C CATHETERI ZATION 0.039145 59.00 60.00 DS600 INTRAVENUS THERAPY 0.124706 60.00 60.00 OS00 INTRAVENUS THERAPY 0.210291 65.00 65.00 OS00 OPENSICAL THERAPY 0.125719 66.00 66.00 OS00 SPECCH PATHOLOGY 0.155658 68.00 69.00 OPODO DELECTROCARDIOLOGY 0.18564441 70.00 70.00 OTODO ELECTROCARDIOLOGY 0.82633 69.00 70.00 OTODO MEDICAL SUPPLIES CHARGED TO PATIENT 0.21532 71.00 71.00 OT200 IMUL, DEV. CHARGED TO PATIENTS 0.24214 74.00 71.00 OT200 ORLOGAL SURGED TO PATIENTS 0.244493 74.00 71.00 OT200 IMUL DEV. CHARGED TO PATIENTS 0.24214 74.00 71.00 OT200 </td <td>52.00 05200 DELIVERY ROOM & LABOR ROOM</td> <td>0. 184449</td> <td></td> <td></td> <td></td> <td>52.00</td>	52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 184449				52.00
56.00 05600 RADI 01 SOTOPE 0.066058 56.00 59.00 05900 CARDI AC CATHETERI ZATI 0N 0.039145 59.00 60.00 06400 IABORATORY 0.095630 64.00 65.00 05000 RESPI RATORY THERAPY 0.0124706 65.00 66.00 06600 PHYSI CAL THERAPY 0.166441 66.00 67.00 06600 CAUTORY THERAPY 0.155658 68.00 68.00 06600 ELECTROCARDI OLAGRAPHY 0.155658 68.00 69.00 0100 DECIPATIONAL THERAPY 0.155658 68.00 00 06000 ELECTROCARDI OLAGRAPHY 0.112318 71.00 00 07000 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0.281372 72.00 073.00 DRUGS CHARGED TO PATI ENTS 0.262144 74.00 77.00 OLICOENCI CHASI CONSTIC SENTOR 78.00 77.00 OLICOENCI C HASI CAUSTICT 0.262144 74.00 70.00 OTADO CAR T-CELI MUNIONTHERAPY 0.2624493 74.00		0. 083725				
59:00 05900 CARDIAC CATHETRIZATION 0.039145 59:00 60:00 06000 LABORATORY 0.124706 60:00 64:00 06400 INTRAVENOUS THERAPY 0.210291 65:00 65:00 06500 PESPI RATORY THERAPY 0.126519 67:00 66:00 06600 PHYSI CAL THERAPY 0.125719 67:00 68:00 06900 SPECCH PATHOLOGY 0.15658 68:00 69:00 06900 ELECTROCARDIOLOGY 0.125719 71:00 70:00 70:00 ELECTROCARDIOLOGY 0.125132 71:00 71:00 07000 RELCETROCARDIOLOGY 0.281372 72:00 73:00 07300 RUGS CHARGED TO PATIENTS 0.281372 72:00 73:00 07300 RUGS CHARGED TO PATIENTS 0.282144 73:00 74:00 07400 RNAL DIALYSIS 0.262144 74:00 70:00 0700 ALCGENET CHST ACOUSI STION 2.464630 76:00 70:00 0700 ALCGENET CHST ACOUSI						
60.00 0.0000 LABORATORY 0.124706 60.00 64.00 0.6400 INTRAVENOUS THERAPY 0.09530 64.00 65.00 06500 RESPI RATORY THERAPY 0.210291 65.00 66.00 0000 CULPATI DNAL THERAPY 0.166441 66.00 67.00 0000 CUCUPATI DNAL THERAPY 0.125719 67.00 68.00 06800 SPECH PATHOLOGY 0.155658 68.00 69.00 06900 ELECTROCARDIOLOGY 0.082633 69.00 0.00 07000 ELECTROCARDIOLOGY 0.21532 71.00 0.00 07000 ELECTROCARDI OLOGRAPHY 0.112318 71.00 0.00 07000 ELECTROCARDI OLOGRAPHY 0.174497 73.00 0.00 07300 DRUGS CHARGED TO PATI ENTS 0.22124 73.00 0.00 07000 CLURIC CARDIA CREHABI LI TATI ON 0.173803 76.97 0.00 07300 CRUC CLI IMMUNDHERAPY 0.240433 78.00 0.00 07000 CLI IC 0.042493 78.00 0.00 07000 CLI IL IMMUNDHERAPY 0.173618 90.01						
64.00 0c400 INTRAVENUUS THERAPY 0.095630 64.00 65.00 0c500 RESPIRATORY THERAPY 0.210291 65.00 66.00 0c500 PHYSICAL THERAPY 0.125719 67.00 67.00 0c700 CUEVATI ONAL THERAPY 0.125719 67.00 68.00 06900 SPECH PATHOLOGY 0.82633 69.00 70.00 00000 ELECTROCARDIOLOGY 0.82633 71.00 71.00 000 MEDI CAL SUPPLIE SCHARGED TO PATI ENT 0.281372 72.00 73.00 07300 DRUSC CHARGED TO PATI ENTS 0.262144 74.00 74.00 70.00 ALLOGEN CHARGED TO PATI ENTS 0.264430 76.97 70.00 07300 ART-GELL I MUNOTHERAPY 0.204493 76.97 70.00 07300 CRT - CELL I MUNOTHERAPY 0.204493 76.97 70.00 07300 CRT - CELL I MUNOTHERAPY 0.204493 76.97 70.00 07300 CLUC RET SERVICE COST CENTERS 90.00 90.00 0.00000 CLUT SERVI						
65:00 06500 PESPI RATORY THERAPY 0.210291 65:00 66:00 06600 PHYSI CAL THERAPY 0.166441 66:00 67:00 06700 0CUPATIONAL THERAPY 0.125719 67:00 68:00 06800 SPECH PATHOLOGY 0.155658 68:00 00:00 06000 ELECTROCARDI OLOGY 0.082633 69:00 00:00 OTOOD ELECTROCARDI OLOGY 0.12318 70:00 01:00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0.251532 71:00 02:00 07200 IPPL. DEV. CHARGED TO PATIENTS 0.262144 74:00 0:73:00 07300 DRUGS CHARGED TO PATIENTS 0.264340 77:00 0:70:07 CARDI AC REHABILITATION 0.173803 76:07 0:70:00 CART AC REHABILITATION 0.204493 78:00 0:70:00 CART -CELL IMMUNOTHERAPY 0.204493 78:00 0:10:00 O7000 CLINIC 0.105309 90:01 0:00:00 OVOOD CLINIC 0.2464575 90:02						
66.00 06600 PHYSICAL THERAPY 0.166441 66.00 67.00 06700 OCCUPATIONAL THERAPY 0.125719 67.00 68.00 06800 SPECT PATHOLOCY 0.55558 68.00 09.00 07000 ELECTROCARDIOLOGY 0.082633 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0.251532 71.00 72.00 07200 INPL. DEV. CHARGED TO PATIENTS 0.281372 72.00 73.00 07300 NUPL. DEV. CHARGED TO PATIENTS 0.262144 74.00 74.00 07400 RENAL DIALYSIS 0.264330 76.97 77.00 07700 ALLOGENEI C HASCT ACOUISTION 2.464630 77.00 00 07800 CART -CELL IMMUNOTHERAPY 0.264493 78.00 00 07900 CART -CELL IMMUNOTHERAPY 0.264716 90.00 90.00 09000 CLINIC 0.173618 90.00 90.01 99000 09005 CV DI AGNOSTI C SERVICES 0.173618 90.00 90.02 90022 MORESTAUTION BLDS (NON-DISTINCT PART 0.246575 90.00 91.00 90100 EMERGENCY 0.1246575 90.00 91.00 09200 OBSERVATION BEDS (NON-DISTINCT						
67.00 06700 OCCUPATIONAL THERAPY 0.125719 67.00 68.00 06800 SPECH PATHOLOGY 0.155658 69.00 07.000 ELECTROENCEPHALOGRAPHY 0.112318 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0.2813372 72.00 73.00 07200 INPL. DEV. CHARGED TO PATIENTS 0.281372 73.00 74.00 07400 RENAL DI ALYSIS 0.173803 74.00 70.00 07400 RENAL DI ALYSIS 0.262144 73.00 71.00 07400 RENAL DI ALYSIS 0.264493 76.97 71.00 07400 RENAL DI ALYSIS 0.2444330 77.00 71.00 07400 RENAL DI ALVSIS 0.647106 90.01 90.01 09000 CLINIC 0.647136 90.01 90.02 90002 MORESVI LE INFUSION CLINIC 0.173803 90.02 90.02 90002 MORESVI LE INFUSION CLINIC 0.173618 90.01 90.01 90001 IMTHERNERVY 0.246575 90.02 90.02 90002 MORESVI LE INFUSI						
68.00 06800 SPEECH PATHOLOGY 0.155658 68.00 69.00 06900 ELECTROCARDIOLOGY 0.082633 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0.251532 71.00 72.00 07300 IMPL. DEV. CHARGED TO PATIENTS 0.281372 72.00 74.00 07400 RENAL DI ALYSI S 0.174497 73.00 74.00 07400 RENAL DI ALYSI S 0.262144 74.00 75.00 0700 ACRDIA C REHABILI TATI ON 0.173803 76.97 76.00 0700 LACGENEIC HSCT ACQUISITION 2.464630 77.00 78.00 0700 CARDIA C REHABILI TATION 0.173618 90.00 0010 09001 CLINIC 0.647106 90.01 90.01 09001 IBMT JOINT VENTURE 0.173618 90.02 90.02 90002 MOORESVI LLE INFUSION CLINIC 0.173618 90.02 90.02 09002 MOORESVI LLE INFUSION CLINIC 0.072654 91.00 91.00 09000 EMERGENCY 0.072654 91.00 92.00 09200 DESERVATI ON BEDS (NON-DI STINCT PART 0.246575 92.00 0110.00 10000 HERGENCY 0.072654 <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td></t<>						
69.00 06900 ELECTROCARDIOLOGY 0.082633 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0.112318 70.00 71.00 7100 MTOLA SUPPLIES CHARGED TO PATIENT 0.251532 71.00 72.00 07300 DRUGS CHARGED TO PATIENTS 0.281372 72.00 73.00 ORGOS CHARGED TO PATIENTS 0.174497 73.00 74.00 OT400 RENAL DIALYSIS 0.173803 74.00 75.00 O7697 CARDIAC REHABILITATION 0.173803 76.97 77.00 OT600 CAR T-CELL IMMUNOTHERAPY 0.204493 78.00 01000 OR000 CLINIC 0.647106 90.00 90.01 09000 CLINIC 0.173618 90.01 90.02 90002 LINIC 0.172651 90.02 90.03 09005 CV DIAGNOSTIC SERVICES 0.124215 90.02 90.04 09000 CU NORESVILLE INFUSION CLINIC 0.072654 91.00 91.00 09100 EMERGENCY 0.072654 91.00 92.00 09200 OBSERVATION B						
70.00 07000 ELECTROENCEPHALOGRAPHY 0.112318 70.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0.281372 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.281372 73.00 73.00 07400 RENAL DI ALYSIS 0.262144 74.00 70.00 07700 ALDGENEIC HSCT ACQUISTION 2.464630 77.00 77.00 07700 CARDI AC REHABILITATION 0.273083 77.00 78.00 07600 CART -CELL IMMUNOTHERAPY 0.204493 78.00 007000 CLN IC 0.647106 90.00 90.00 09000 CLINIC 0.647106 90.00 90.02 90.00 090001 IBMT JOINT VENTURE 0.173618 90.00 90.01 09005 CV DI AGNOSTIC SERVICES 0.124215 90.02 91.00 09000 EBRERGENCY 0.072654 90.02 91.00 09100 EMERGENCY 0.072654 91.00 92.00 07000 OPIOLO BERGENCY 0.072654 91.00 92.00 02000 0						
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0.251532 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.281372 72.00 73.00 07000 REUGS CHARGED TO PATI ENTS 0.262144 74.00 71.00 07697 CARDI AC REHABILI TATI ON 0.173803 76.97 77.00 07697 CARDI AC REHABILI TATI ON 0.173803 76.97 77.00 04LOGENEI C HSCT ACQUI SI TI ON 2.464630 76.00 001700 CLI NIC 0.647106 90.00 90.00 CLI NI C 0.464630 90.00 90.01 09002 CLI NI C 0.647106 90.00 90.02 09002 CUITPATI ENT SERVICE COST CENTERS 90.00 90.01 90.02 09002 CLI NI C 0.105309 90.01 90.02 09005 CV DI AGNOSTI C SERVI CES 0.124215 90.05 91.00 09200 DERREGNCY 0.246575 92.00 01100 HOME HEALTH AGENCY 0.246575 92.00 0112.00 10200 OPI OID TREATHEAGENCY 0.246575 <						
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.281372 72.00 73.00 DRUGS CHARGED TO PATIENTS 0.174497 73.00 74.00 O7400 RENAL DI ALYSI S 0.262144 74.00 77.00 O7700 ALDGENEIC HSCT ACQUISITION 2.464630 77.00 78.00 O7800 CAR T-CELL IMMUNOTHERAPY 0.204493 78.00 00100 CUTPATIENT SERVICE COST CENTERS 90.00 90.00 90.00 00100 DOVOL INT VENTURE 0.647106 90.00 90.01 09000 CLINIC 0.173618 90.02 90.02 09002 KV AGNOSTIC SERVICES 0.124215 90.02 90.03 09000 EMERGENCY 0.072654 91.00 91.00 OP100 EMERGENCY 0.246575 92.00 0110.00 10100 HOME HEALTH AGENCY 0						
73.00 07300 DRUGS CHARGED TO PATIENTS 0.174497 73.00 74.00 07400 RENAL DI ALYSI S 0.262144 74.00 76.97 CARDI AC REHABILITATION 0.173803 76.97 77.00 OT700 ALLOGENEIC HSCT ACQUISITION 2.464630 77.00 00 07800 CAR T-CELL IMMUNOTHERAPY 0.204493 78.00 00 09000 CLINIC 0.647106 90.00 00.01 09001 IBMT JOINT VENTURE 0.173618 90.00 90.02 09002 MORESVILLE INFUSION CLINIC 0.0647106 90.02 90.02 09005 CV JI AGNOSTIC SERVICES 0.124215 90.02 91.00 09200 DEREGENCY 0.072654 90.02 92.00 09200 OBSERVATION BEDS (NON-DI STINCT PART 0.246575 92.00 01100 HOME HEALTH AGENCY 101.00 102.00 101.00 102.00 101.00 102.00 101.00 102.00 102.00 101.00 102.00 102.00 100.00 102.00 101.00 102.00 101.00 102.00 100.00						
74.00 07400 RENAL DI ALYSI S 0.262144 74.00 76.97 07697 CARDI AC REHABI LI TATI ON 0.173803 76.97 77.00 0700 ALLOGENEI C HSCT ACQUI SI TI ON 2.464630 77.00 78.00 07800 CAR T-CELL IMMUNOTHERAPY 0.204493 78.00 0UTPATI ENT SERVICE COST CENTERS 0.647106 90.00 90.01 09001 CLI NI C 0.647106 90.01 90.02 09002 MORESVI LLE I NEUSI ON CLI NI C 0.173618 90.02 90.05 09005 CV DI AGNOSTI C SERVI CES 0.124215 90.02 91.00 09100 EMERGENCY 0.072654 91.00 92.00 09200 (DSERVATI ON BEDS (NON-DI STI NCT PART 0.246575 92.00 01.00 HOME HEALTH AGENCY 0.072654 91.00 92.00 10200 OPI OI D TREATMENT PROGRAM 102.00 101.00 102.00 10200 OPI OI D TREATMENT PROGRAM 102.00 102.00 113.00 11300 INTEREST EXPENSE 113.00 113.00 116.00 INOSPICE 200.00 200.00 2						
76.97 07697 CARDI AC REHABI LI TATI ON 0.173803 76.97 77.00 0700 ALLOGENEI C HSCT ACQUI SI TION 2.464630 77.00 78.00 07800 CAR T-CELL I MMUNOTHERAPY 0.204493 78.00 90.00 09000 CLINI C 0.647106 90.00 90.01 09001 IBMT JOINT VENTURE 0.173618 90.01 90.02 09002 MORESVI LLE INFUSION CLINI C 0.105309 90.02 90.05 09005 CV DI AGNOSTI C SERVI CES 0.124215 90.05 91.00 09100 ERRENCY 0.072654 91.00 92.00 0BSERVATI ON BEDS (NON-DI STINCT PART 0.246575 92.00 01.00 10100 HOME HEALTH AGENCY 0.072654 91.00 92.00 01100 ID100 TREATIMENT PROGRAM 102.00 91.00 102.00 IP101 D TREATENT PROGRAM 102.00 91.00 113.00 11300 INTEREST EXPENSE 113.00 116.00 11600 HOSPICE 200.00 200.00 900.01 Subtotal (see instructions) 200						
77.00 0700 ALLOGENEIC HSCT ACQUISITION 2.464630 77.00 78.00 07800 CAR T-CELL IMMUNOTHERAPY 0.204493 78.00 00100 OUTPATIENT SERVICE COST CENTERS 0.647106 90.00 90.00 09000 CLINIC 0.647106 90.00 90.01 09001 IBMT JOINT VENTURE 0.173618 90.00 90.02 09002 MORESVILLE INFUSION CLINIC 0.105309 90.02 90.05 09005 CV DIAGNOSTIC SERVICES 0.124215 90.05 91.00 09100 EMERGENCY 0.072654 91.00 92.00 OBSERVATION BEDS (NON-DISTINCT PART 0.246575 92.00 011.00 IOMER REIMBURSABLE COST CENTERS 101.00 102.00 101.00 IOMER REIMBURSABLE COST CENTERS 101.00 102.00 101.00 IOMER REIMENT PROGRAM 102.00 102.00 0PIOID TREATMENT PROGRAM 102.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 11300 11300 11300 11300 11300 113.00 116.00 IA600 HO50 FICE 113.00						
78.00 O7800 CAR T - CELL I MMUNOTHERAPY 0.204493 78.00 90.00 09000 CLI NI C 0.647106 90.00 90.01 09001 IBMT JOI NT VENTURE 0.173618 90.01 90.02 09002 MOORESVILLE I NFUSION CLI NI C 0.105309 90.02 90.05 CV DI AGNOSTI C SERVI CES 0.124215 90.02 91.00 09100 BMERGENCY 0.072654 91.00 92.00 0BSERVATI ON BEDS (NON-DI STI NCT PART 0.246575 92.00 011.00 10100 HOME HEALTH AGENCY 92.00 012.00 0PI OI D TREATMENT PROGRAM 101.00 902.01 11300 I TREREST EXPENSE 113.00 113.00 11300 I TREREST EXPENSE 113.00 116.00 HOSPI CE 113.00 Subtotal (see instructions) 200.00 201.00 Less Observation Beds 201.00 201.00						
OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLINIC 0.647106 90.00 90.01 09001 IBMT JOINT VENTURE 0.173618 90.01 90.02 09002 MOORESVILLE INFUSION CLINIC 0.105309 90.02 90.05 09005 CV DIAGNOSTIC SERVICES 0.124215 90.05 91.00 D9100 EMERGENCY 0.072654 91.00 92.00 0955 (NON-DISTINCT PART 0.246575 92.00 0THER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 101.00 102.00 10200 (D1 OID TREATMENT PROGRAM 102.00 10200 (D1 OID TREATMENT PROGRAM 102.00 9FECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 11300 INTEREST EXPENSE 114.00 116.00 HOSPICE 200.00 201.00 200.00 201.00						
90.01 09001 IBMT JOINT VENTURE 0.173618 90.01 90.02 09002 MOORESVILLE INFUSION CLINIC 0.105309 90.02 90.05 09005 CV DIAGNOSTIC SERVICES 0.124215 90.05 91.00 P9100 EMERGENCY 0.072654 91.00 92.00 OBSERVATION BEDS (NON-DISTINCT PART 0.246575 91.00 01.00 ID100 HOME HEALTH AGENCY 101.00 101.00 10100 HOME HEALTH AGENCY 101.00 102.00 0PI OI D TREATMENT PROGRAM 102.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 116.00 HO60H HOSPICE 200.00 200.00 200.00 200.00 201.00 Less Observation Beds 200.00 201.00		· · ·				
90.02 09002 MOORESVILLE INFUSION CLINIC 0.105309 90.02 90.05 09005 CV DIAGNOSTIC SERVICES 0.124215 90.05 91.00 09100 EMERGENCY 0.072654 91.00 92.00 0BSERVATION BEDS (NON-DISTINCT PART 0.246575 92.00 0THER REIMBURSABLE COST CENTERS 92.00 101.00 HOME HEALTH AGENCY 101.00 10200 OPI OID TREATMENT PROGRAM 101.00 SPECI AL PURPOSE COST CENTERS 113.00 113.00 INTEREST EXPENSE 113.00 116.00 10600 HOSPI CE 116.00 200.00 Subtotal (see instructions) 200.00 201.00	90. 00 09000 CLINIC	0. 647106				90.00
90.05 09005 CV DIAGNOSTIC SERVICES 0.124215 90.05 91.00 09100 EMERGENCY 0.072654 91.00 92.00 0BSERVATION BEDS (NON-DISTINCT PART) 0.246575 92.00 0THER REIMBURSABLE COST CENTERS 101.00 101.00 HOME HEALTH AGENCY 101.00 10200 OPI OID TREATMENT PROGRAM 102.00 SPECI AL PURPOSE COST CENTERS 113.00 INTEREST EXPENSE 113.00 116.00 10600 HOSPI CE 116.00 200.00 Subtotal (see instructions) 200.00 200.00 201.00 Less Observation Beds 201.00	90.01 09001 IBMT JOINT VENTURE	0. 173618				90.01
91.00 09100 EMERGENCY 0.072654 91.00 92.00 0BSERVATION BEDS (NON-DISTINCT PART 0.246575 92.00 0THER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 101.00 102.00 0PI 0ID TREATMENT PROGRAM 101.00 102.00 10200 0PI 0ID TREATMENT PROGRAM 102.00 SPECI AL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 113.00 11600 HOSPI CE 116.00 11600 200.00 201.00 200.00 Subtotal (see instructions) 200.00 201.00 201.00 201.00 201.00	90.02 09002 MOORESVILLE INFUSION CLINIC	0. 105309				90.02
92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART 0.246575 92.00 0THER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 101.00 101.00 101.00 101.00 101.00 101.00 101.00 101.00 101.00 101.00 101.00 101.00 101.00 101.00 101.00 102.00 103.00 113.00 113.00 113.00 113.00 114.00 00.00 200.00 200.00 200.00 200.00 200.00 201.00 201.00 201.00 201.00 201.00 201.00 201.		0. 124215				
OTHER REI MBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 101.00 102.00 10200 OPI OI D TREATMENT PROGRAM 102.00 SPECI AL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 116.00 11600 HOSPI CE 116.00 200.00 Subtotal (see instructions) 200.00 201.00 Less Observation 201.00						
101.00 10100 HOME HEALTH AGENCY 101.00 102.00 10200 0PI 0I D TREATMENT PROGRAM 102.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 116.00 H060 H05PI CE 116.00 200.00 Subtotal (see instructions) 200.00 201.00 Less Observation Beds 201.00		0. 246575				92.00
102.00 10200 OPI OI D TREATMENT PROGRAM 102.00 SPECIAL PURPOSE COST CENTERS 113.00 113.00 11300 INTEREST EXPENSE 113.00 116.00 11600 HOSPICE 116.00 200.00 Subtotal (see instructions) 200.00 201.00						
SPECIAL PURPOSE COST CENTERS 113.00 113.00 INTEREST EXPENSE 113.00 116.00 HOSPICE 116.00 200.00 Subtotal (see instructions) 200.00 201.00 Less Observation Beds 201.00						
113.00 11300 INTEREST EXPENSE 113.00 116.00 11600 HOSPICE 116.00 200.00 Subtotal (see instructions) 200.00 201.00 Less Observation Beds 201.00						102.00
116.00 1160 HOSPICE 116.00 200.00 Subtotal (see instructions) 200.00 201.00 Less Observation Beds 201.00		1				112 00
200.00 Subtotal (see instructions) 200.00 201.00 Less Observation Beds 201.00						
201.00 Less Observation Beds 201.00						
		i l				1-02.00

FRANCISCAN HEALTH INDIANAPOLIS

In Lieu of Form CMS-2552-10

COMPUTATI	ON OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-0162	Period: From 01/01/2023 To 12/31/2023		pared: 1 pm
			Titl	e XIX	Hospi tal	PPS	
	Cost Center Description	Total Cost (from Wkst. B, Part I, col.	Therapy Limit Adj.	Total Costs	Costs RCE Di sal I owance	Total Costs	
		26)	2.00	2.00	4.00	F 00	
LNI	PATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	-
	000 ADULTS & PEDIATRICS	93, 716, 072		93, 716, 07	2 0	93, 716, 072	30.00
	100 I NTENSI VE CARE UNI T	18, 081, 472		18, 081, 47			
	060 NEONATAL INTENSIVE CARE UNIT	10, 738, 173		10, 738, 17			
	200 CORONARY CARE UNIT	26, 215, 731		26, 215, 73		26, 215, 731	
	400 SURGICAL INTENSIVE CARE UNIT	17,050,951		17, 050, 95		17, 050, 951	
	100 SUBPROVIDER – IRF	9,025,252		9, 025, 25			
	300 NURSERY	2, 461, 492		2, 461, 49		2, 461, 492	
	CILLARY SERVICE COST CENTERS		1		1 .	1 1 1 1 1 1 1	
	000 OPERATI NG ROOM	43, 108, 223		43, 108, 22	23 0	43, 108, 223	50.00
52.00 05	200 DELIVERY ROOM & LABOR ROOM	9, 032, 794		9, 032, 79	04 0	9, 032, 794	52.00
54.00 05	400 RADI OLOGY-DI AGNOSTI C	31, 129, 143		31, 129, 14	3 0	31, 129, 143	54.00
55.00 05	500 RADI OLOGY-THERAPEUTI C	12, 492, 205		12, 492, 20	05 0	12, 492, 205	55.00
56.00 05	600 RADI OI SOTOPE	575, 247		575, 24	17 0	575, 247	56.00
59.00 05	900 CARDI AC CATHETERI ZATI ON	7, 559, 912		7, 559, 91	2 0	7, 559, 912	59.00
60.00 06	000 LABORATORY	36, 987, 841		36, 987, 84	1 0	36, 987, 841	60.00
	400 I NTRAVENOUS THERAPY	7, 543, 978		7, 543, 97	78 0	7, 543, 978	64.00
	500 RESPI RATORY THERAPY	14, 016, 595	0	14, 016, 59	95 0	14, 016, 595	65.00
	600 PHYSI CAL THERAPY	9, 805, 593				9, 805, 593	
	700 OCCUPATI ONAL THERAPY	3, 643, 014	0			-, ,	
	800 SPEECH PATHOLOGY	2, 123, 434	0	2, 123, 43		2, 123, 434	
	900 ELECTROCARDI OLOGY	4, 417, 024		4, 417, 02		4, 417, 024	
	000 ELECTROENCEPHALOGRAPHY	3, 294, 190		3, 294, 19			
	100 MEDICAL SUPPLIES CHARGED TO PATIENT	71, 262, 497		71, 262, 49		, ===,	
	200 IMPL. DEV. CHARGED TO PATIENTS	43, 460, 043		43, 460, 04			
	300 DRUGS CHARGED TO PATIENTS	125, 915, 236		125, 915, 23		125, 915, 236	
	400 RENAL DIALYSIS	2, 406, 334		2, 406, 33		2, 406, 334	
	697 CARDIAC REHABILITATION	769, 697		769, 69		769, 697	
	700 ALLOGENEIC HSCT ACQUISITION	2, 272, 219		2, 272, 21		_,,	
	800 CAR T-CELL IMMUNOTHERAPY	8, 210, 194		8, 210, 19	04 0	8, 210, 194	78.00
	TPATIENT SERVICE COST CENTERS	11 542 402		11 540 40	32 0	11 542 402	00.00
	000 CLINIC 001 IBMT JOINT VENTURE	11, 543, 482		11, 543, 48			
90.01 09	002 MOORESVILLE INFUSION CLINIC	2, 244, 500		2, 244, 50			
		60, 571		60, 57			•
	005 CV DI AGNOSTI C SERVI CES 100 EMERGENCY	12, 241, 013 25, 454, 027		12, 241, 0		12, 241, 013	
	200 OBSERVATION BEDS (NON-DISTINCT PART	25, 454, 027		25, 454, 02 11, 274, 35		25, 454, 027	
	HER REIMBURSABLE COST CENTERS	11,274,300		11, 274, 30	50	11, 274, 355	92.00
	100 HOME HEALTH AGENCY	0			0	0	101.00
	200 OPI OI D TREATMENT PROGRAM	0			0		101.00
	ECIAL PURPOSE COST CENTERS	0			0	0	102.00
	300 INTEREST EXPENSE						113.00
	600 HOSPI CE	9,022,940		9, 022, 94	10	9, 022, 940	
200.00	Subtotal (see instructions)	689, 155, 444					
201.00	Less Observation Beds	11, 274, 355		11, 274, 35		11, 274, 355	
202.00	Total (see instructions)	677, 881, 089					
		,,,,,				,,,,,	

Heal th	Fi nan	ci a	I Syst	ems			
COMPLIT		0F	PATIO	0F	27200	ΤO	CL

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

From 01/01/2023 Part 1 Date/Time Propared: 37/8/2024 Cost Center Description Impatient Outpatient Total (col)6 Outpatient) Cost Other Ratio Cost Other Ratio Total (col)6 Display Cost Other Ratio Part 1 Impatient 0.00 03000 INPATIENT ROUTINE SERVICE COST CENTERS 0.00 30.00 31.00 30.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 32.00 30200 CR0MARY CARE UNIT 44.837,524 44.837,524 44.837,524 44.802 43.00 0.0 03000 URIGLAL INTENSIVE CARE UNIT 19.799, 843 19.759, 843 19.759, 843 19.759, 843 19.759, 843 19.759, 843 43.00 0.0 05000 DEFRATING ROM 186.378,478 163.890,946 350.269,426 0.123072 0.000000 52.00 50.00 0.000000 DESCO 05200 DEFRATING ROM 186.378,478 163.890,946		RANCI SCAN TILALI					2552-10
Title XIX Hospital 3/28/2024 2:1 pr Cost Center Description Inpatient Outpatient Total (col. 7) Cost or Other Ratio NPX1 ENT ROUTINE SERVICE COST CENTERS Outpatient Total (col. 7) Cost or Other Ratio Impatient 30.00 03000 AUTLS & PEDIATRI CS 211, 775, 236 211, 775, 236 211, 775, 236 30.00 31.00 03200 CROMARY CARE UNIT 45, 628, 948 45, 628, 948 35, 600 31.00 32.00 03200 CROMARY CARE UNIT 44, 837, 524 44, 837, 524 32, 00 32, 00 32.00 03200 CROMARY CARE UNIT 32, 194, 992 32, 194, 992 34, 00 44, 00 30, 00 32.00 03200 CROMARY CARE UNIT 32, 194, 992 32, 194, 992 34, 00 30, 00 32.00 03200 CROMARY CARE UNIT 32, 194, 992 32, 194, 992 34, 00 30, 00 32.00 03200 CROMARY CARE UNIT 32, 194, 992 32, 00 32, 00 32, 00 30, 00 30, 00 30, 00 34, 971, 644 41, 00 30, 00 34, 971, 644 41, 00 <td>COMPUTATION OF RATIO OF COSTS TO CHARGES</td> <td></td> <td>Provider C</td> <td>CN: 15-0162</td> <td>Period:</td> <td>Worksheet C</td> <td></td>	COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-0162	Period:	Worksheet C	
Title XIX Hospital 3/28/2024 2:1 pr Cost Center Description Inpatient Outpatient Total (col. 7) Cost or Other Ratio NPX1 ENT ROUTINE SERVICE COST CENTERS Outpatient Total (col. 7) Cost or Other Ratio Impatient 30.00 03000 AUTLS & PEDIATRI CS 211, 775, 236 211, 775, 236 211, 775, 236 30.00 31.00 03200 CROMARY CARE UNIT 45, 628, 948 45, 628, 948 35, 600 31.00 32.00 03200 CROMARY CARE UNIT 44, 837, 524 44, 837, 524 32, 00 32, 00 32.00 03200 CROMARY CARE UNIT 32, 194, 992 32, 194, 992 34, 00 44, 00 30, 00 32.00 03200 CROMARY CARE UNIT 32, 194, 992 32, 194, 992 34, 00 30, 00 32.00 03200 CROMARY CARE UNIT 32, 194, 992 32, 194, 992 34, 00 30, 00 32.00 03200 CROMARY CARE UNIT 32, 194, 992 32, 00 32, 00 32, 00 30, 00 30, 00 30, 00 34, 971, 644 41, 00 30, 00 34, 971, 644 41, 00 <td></td> <td></td> <td></td> <td>-</td> <td>$\Gamma_0 = \frac{12}{31} \frac{12}{2023}$</td> <td>Date/Time Pre</td> <td>nared</td>				-	$\Gamma_0 = \frac{12}{31} \frac{12}{2023}$	Date/Time Pre	nared
Cost Center Description Title XIX Hospital PPS Linpatient Unpatient Total (col - 6) Cost or Other Ratio Cost or Other Ratio Cost or Other Ratio TEFRA Inpatient 0 0.00 7.00 8.00 9.00 10.00 30.00 0.00 0.00 0.00 7.00 8.00 9.00 10.00 0.00 0.00 0.00 7.00 8.00 9.00 10.00 0.00 0.00 0.00 7.00 8.00 9.00 30.00 0.00 0.00 0.00 30.0					10 12/31/2023	3/28/2024 2:2	1 pm
Cost Center Description Charges Cost Coll Cost of Other Ratio TFERA Inpatient 0.00 7.00 8.00 9.00 10.00 0.00 3000 ADULTS & PEN ATRICS 211,775,236 211,775,236 211,775,236 30.00 0.00 03000 ADULTS & PEN ATRICS 211,775,236 211,775,236 211,775,236 31.00 0.01 03000 CROMAY CARE UNIT 39,942,560 39,942,560 39,942,560 31.00 0.01 03000 SURGICAL INTENSIVE CARE UNIT 32,194,892 32.00 33.00 32.00 32.00 32.00 32.00 32.00 <td< td=""><td></td><td></td><td>Ti †I</td><td>e XIX</td><td>Hospi tal</td><td>PPS</td><td></td></td<>			Ti †I	e XIX	Hospi tal	PPS	
Cost Center Description Inpatient Outpatient Total (col. 6) Cost or Other Ratio TEFRA Inpatient 0.00 03000 AULTS & PEDIATRICS 6.00 7.00 8.00 9.00 10.00 0.01 03000 AULTS & PEDIATRICS 211,775,236 211,775,236 30.00 31.00 0.01 02000 INTERSI VE CARE UNIT 45,628,948 45,628,948 35,942 31.01 31.01 0.01 02060 ORMAL ALTRESIVE CARE UNIT 44,837,524 44,857,554 32.01 32.01 0.01000 INTERSIVE CARE UNIT 44,837,524 44,857,554 44,877,554 44,877,554 44,970,983 45,970,974,970,970,982,990,990,974 0,12372,970,970,982,990,974 0,12372,970,970,982,990,974 0,124706,00,090,055,00 0,00000,95,00 55,00 </td <td></td> <td></td> <td></td> <td>C MIN</td> <td></td> <td>110</td> <td></td>				C MIN		110	
Impart ent Routi NE SERVICE COST CENTERS 211, 775, 236 211, 775, 236 211, 775, 236 211, 775, 236 30.00 9.00 10.00 0.00 030000 AUULTS & PEDIATRICS 211, 775, 236 211, 775, 236 211, 775, 236 30.00 31.00 30.00 31.00 <td>Cost Center Description</td> <td>Innationt</td> <td></td> <td>Total (col 6</td> <td>Cost or Other</td> <td>TEEDA</td> <td></td>	Cost Center Description	Innationt		Total (col 6	Cost or Other	TEEDA	
IMPATIENT ROUTINE SERVICE COST CENTERS 0 Ratio 0.00 0.000 7.00 8.00 9.00 10.00 0.10 0.000 0.000 8.00 9.00 10.00 0.10 0.000 0.000 3.000 4.300 4.400 4.48,37,524 4.48,982 4.40 4.300 0.00 0.000000 DERATINE ROMM 186,378,478 163,890,948 3.00,269,426 0.122072 0.0000000 5.00 5.00 0.5000 DERATINE ROMM 186,378,478 163,890,948 3.00,269,426 0.122072 0.000000 5.00 5.00 5.00 5.000 5.00 5.00 5.00 5.00 5.00 5.00	cost center bescription	inpatrent	outpatrent				
IMPATIENT ROUTINE SERVICE COST CENTERS 7.00 8.00 9.00 10.00 30.00 03000 ADULTS & PEDIATRICS 211,775,236 211,775,236 31.01 33.00 33.01 03000 ADULTS & PEDIATRICS 211,775,236 31.01 33.01 03000 CORNARY CARE UNIT 345,624 445,628,948 45,628,948 45,628,948 31.01 33.01				+ COL. 7)	Katio		
INPART ENT ROUTINE SERVICE COST CENTERS 211, 775, 236 211, 775, 236 31, 00 0.0 03000 DNUTS & PENTRI VE CARE UNIT 45, 628, 948 45, 628, 948 31, 00 31, 00 032000 CORMARI, INTENSI VE CARE UNIT 44, 837, 524 44, 837, 524 32, 00 32, 00 032000 CORMARY CARE UNIT 44, 837, 524 44, 837, 524 32, 194, 992 34, 00 41, 00 04300, UNRSERY TRENSI VE CARE UNIT 44, 837, 524 44, 837, 524 44, 837, 524 44, 837, 524 44, 837, 524 34, 00 41, 00 04300, UNRSERY TRENSI VE CARE UNIT 42, 1492 32, 194, 992 34, 00 41, 00 04300, UNRSERY TRENSI VE CARE UNIT 32, 194, 892 350, 269, 426 0, 123072 0, 0000000 52, 00 50, 00 05200 DELLIVERY ROM & LABOR ROM 48, 815, 761 155, 903 48, 971, 664 0, 136439 0, 80000005 52, 00 50, 00 05500 RADI CLOCY - DRAWOM 48, 815, 761 112, 965, 617 0, 110583 0, 0000000 55, 00 50, 00 50, 00 50, 00 50, 00, 50, 50, 00 50,		6.00	7 00	0.00	0.00		
30.00 03000 ADULTS & PEDLATRICS 211, 775, 236 211, 775, 236 31. 01 31.00 03000 INTENSIVE CARE UNIT 39, 942, 560 31. 01 31.00 03000 CORNARY CARE UNIT 39, 942, 560 31. 01 31.00 03200 DORNARY CARE UNIT 34, 29, 942, 560 31. 01 32.00 03200 DORNARY CARE UNIT 32, 194, 892 32, 194, 892 34. 00 34.00 03400 SURROLOR, LINTENSIVE CARE UNIT 32, 194, 892 34. 00 41. 00 410.00 04300 NURSERY 7, 449, 680 7, 449, 680 41. 00 MACILLARY SERVICE COST CENTERS - - 7, 449, 680 7, 449, 680 50. 00 50.00 05000 DELIVERY ROMM & LABOR ROM 148, 815, 751 155, 903 48, 971, 800, 783 0. 0000005 50. 00 50.00 05000 CARDIOLCOV-HIRAPPY CONDUCION-THERAPY 79, 662, 809 141, 664, 651 0. 112, 956, 6. 661 0. 0000000 50. 00 500 05000 CARDIAC CARHERSENT 0. 005000 50. 00 50. 00 500 05000 CARDIAC CARHERAPY 79, 66, 54, 470 79, 96, 599, 274 0. 124706		0.00	7.00	0.00	9.00	10.00	
31: 00 003:00 INTENSI VE CARE UNIT 45, 628, 948 45, 628, 948 41, 00 31: 00 002:00 (CRONARY CARE UNIT 44, 837, 524 32, 00 34, 00		211 775 224		211 775 22			20.00
31. 01 02000 NEONATAL INTENSIVE CARE UNIT 39, 942, 560 39, 942, 560 31. 01 32. 00 03200 (DROMARY CARE UNIT 44, 837, 524 44, 837, 524 44, 837, 524 32. 04 34. 00 03400 SURGICAL, INTENSIVE CARE UNIT 32, 194, 892 19, 759, 843 19, 759, 843 41, 00 41. 00 04300 NURSERPY 7, 449, 680 7, 449, 680 0 100 0 0100000 50. 00 05000 OPERATING ROOM 48, 817, 761 155, 903 48, 971, 664 0. 123072 0. 0000000 52. 00 52. 00 055000 OPERATING ROOM 48, 817, 521 12, 552, 252 107, 040, 667 112, 966, 617 0. 110583 0. 0000000 52. 00 55. 00 05500 RADI LOCY - THERAPEUTIC 5, 925, 750 107, 040, 667 112, 966, 617 0. 110583 0. 0000000 65. 00 50. 00 05000 CARDI AC CATHETERIZATION 79, 062, 809 114, 062, 587 103, 104, 212, 25, 396 0. 039145 0. 0000000 65. 00 0. 0000000 65. 00 0. 0000000 65. 00 0. 0000000 65. 00 0. 0000000 65. 00 0. 0000000 65. 00 0. 0000000 65. 00 0. 0000000							
32: 00 03200 COROMARY CARE UNIT 44,837,524 44,837,524 32: 00 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>							
34.00 03400_SURGICAL INTENSIVE CARE UNIT 32, 194, 892 32, 194, 892 32, 194, 892 34, 00 41, 00 41.00 04100_SURGICAL INTENSIVE CARE UNIT 19, 759, 843 17, 759, 843 7, 449, 680 7, 449, 680 7, 449, 680 7, 449, 680 7, 449, 680 41, 00 A1.00 05000_OPEARTING ROOM 48, 815, 761 155, 903 48, 971, 664 0, 123072 0, 000000 52, 00 52.00 05200_RADIOLOGY - DIAGNOSTIC 121, 552, 326 250, 248, 457 371, 800, 783 0, 083725 0, 000000 54, 00 55.00 05500_RADIOLOGY - THERAPEUTIC 5, 525, 750 107, 040, 867 112, 966, 617 0, 110583 0, 000000 56, 00 50.00 05600_CARDIA C_ATHETERIZATION 79, 062, 309 114, 062, 587 173, 125, 396 0, 39145 0, 000000 64, 00 0, 000000 64, 00 0, 06000_RESPI RATORY HIERAPY 75, 664, 670 9, 987, 744 66, 653, 414 0, 1000000 65, 00 06, 000 065000_CCUPATIONAL THERAPY 25, 139, 318 33, 773, 900 58, 913, 287 0, 166441 0, 000000 67, 00 0, 000000 64, 00 0, 000000 67, 00 0, 000000							
11:00 04100 SUBPROVIDER - IRF 19, 759, 843 19, 759, 843 19, 759, 843 41.00 00 04300 00, 00000 REXPLICE COST CENTERS 7, 449, 680 7, 449, 680 43.00 00 05200 DELIVERY ROOM L86, 378, 478 163, 890, 948 350, 269, 426 0, 123072 0, 000000 52.00 52.00 05200 DELIVERY ROOM 48, 815, 761 155, 902 371, 800, 783 0, 083725 0, 000000 52.00 50.00 05600 RADIOLOGY- THERAPEUTIC 5, 925, 750 107, 040, 867 112, 966, 617 0, 11658 0, 000000 59.00 50.00 05600 RADIOLOSTOPE 7, 849, 882 78.81 138, 104, 421 29.6599, 274 0, 241706 0, 000000 69.00 60.00 06400 INTRAVENUS THERAPY 7, 520, 407 71, 066, 888 78.87 0, 156568 0, 000000 64.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 68.00							
43:00 04300 NUESERY 7, 449, 680 7, 449, 680 43.00 ANOLLARY SERVICE COST CENTERS	34.00 03400 SURGI CAL INTENSI VE CARE UNI T	32, 194, 892		32, 194, 892	2		34.00
ANCLLARY SERVICE COST CENTERS 1 <th1< td=""><td>41.00 04100 SUBPROVIDER - IRF</td><td>19, 759, 843</td><td></td><td>19, 759, 843</td><td>3</td><td></td><td>41.00</td></th1<>	41.00 04100 SUBPROVIDER - IRF	19, 759, 843		19, 759, 843	3		41.00
50. 00 05000 (DPELIVERY PROM & LABOR ROOM 186, 378, 478 163, 890, 948 350, 249, 426 0.122072 0.000000 50. 00 50. 00 05000 (PELIVERY PROM & LABOR ROOM 48, 815, 761 155, 903 48, 971, 640 0.184449 0.000000 52. 00 55. 00 05500 (RADI OLOGY-DI AGNOSTIC 5, 925, 750 107, 040, 867 112, 966, 617 0.110583 0.000000 55. 00 50. 00 05500 (CADI AC CATHETERI ZATI ON 79, 062, 809 114, 062, 587 193, 125, 396 0.039145 0.000000 65. 00 60. 00 06000 (LABORATORY 158, 494, 853 138, 104, 421 296, 599, 274 0.124706 0.000000 64. 00 06400 (INTRAVENOUS THERAPY 7, 802, 0407 71, 066, 868 78, 887, 275 0.095630 0.000000 65. 00 65. 00 06500 (RESPI RATORY THERAPY 25, 039, 318 33, 733, 699 58, 913, 287 0.166441 0.000000 65. 00 60. 00 06600 PESPI RATORANAL THERAPY 25, 139, 318 33, 733, 699 58, 913, 287 0.166441 0.000000 65. 00 <td< td=""><td>43. 00 04300 NURSERY</td><td>7, 449, 680</td><td></td><td>7, 449, 680</td><td>D</td><td></td><td>43.00</td></td<>	43. 00 04300 NURSERY	7, 449, 680		7, 449, 680	D		43.00
50. 00 05000 (DPELIVERY PROM & LABOR ROOM 186, 378, 478 163, 890, 948 350, 249, 426 0.122072 0.000000 50. 00 50. 00 05000 (PELIVERY PROM & LABOR ROOM 48, 815, 761 155, 903 48, 971, 640 0.184449 0.000000 52. 00 55. 00 05500 (RADI OLOGY-DI AGNOSTIC 5, 925, 750 107, 040, 867 112, 966, 617 0.110583 0.000000 55. 00 50. 00 05500 (CADI AC CATHETERI ZATI ON 79, 062, 809 114, 062, 587 193, 125, 396 0.039145 0.000000 65. 00 60. 00 06000 (LABORATORY 158, 494, 853 138, 104, 421 296, 599, 274 0.124706 0.000000 64. 00 06400 (INTRAVENOUS THERAPY 7, 802, 0407 71, 066, 868 78, 887, 275 0.095630 0.000000 65. 00 65. 00 06500 (RESPI RATORY THERAPY 25, 039, 318 33, 733, 699 58, 913, 287 0.166441 0.000000 65. 00 60. 00 06600 PESPI RATORANAL THERAPY 25, 139, 318 33, 733, 699 58, 913, 287 0.166441 0.000000 65. 00 <td< td=""><td>ANCI LLARY SERVICE COST CENTERS</td><td></td><td></td><td></td><td></td><td></td><td></td></td<>	ANCI LLARY SERVICE COST CENTERS						
52.00 052.00 DELUVERY PROM & LABOR ROOM 48, 815, 761 155, 903 48, 971, 664 0.184449 0.000000 52.00 54.00 05500 RADI OLOGY-THERAPEUTI C 5, 925, 750 107, 040, 867 112, 966, 617 0.110583 0.000000 55.00 55.00 05600 RADI OLOGY-THERAPEUTI C 5, 925, 750 107, 040, 867 112, 966, 617 0.110583 0.000000 55.00 50.00 OSCOO CARDI AC CATHETERI ZATI ON 79, 062, 809 114, 062, 587 103, 104, 421 296, 599, 274 0.124706 0.000000 65.00 60.00 06600 INTRAVENOUS THERAPY 7, 256, 4670 9, 998, 744 66, 653, 414 0.210291 0.000000 65.00 66.00 06600 PHSTACK THERAPY 256, 544, 670 9, 998, 744 66, 653, 414 0.2152719 0.000000 65.00 67.00 06700 OCCUPATI ONAL THERAPY 250, 229, 070 8, 948, 271 28, 977, 341 0.125719 0.000000 65.00 60.00 06900 FECH PATHOLOGY 7, 443, 199 6, 198, 483<		186, 378, 478	163, 890, 948	350, 269, 420	6 0. 123072	0,00000	50.00
54.00 054.00 Robi DLOGY-DI AGNOSTI C 121, 552, 326 250, 248, 457 371, 800, 783 0.083725 0.000000 54.00 55.00 05500 RADI DLOGY-THERAPEUTI C 5, 925, 750 107, 040, 867 112, 966, 817 0.110583 0.000000 55.00 50.00 05600 CARDI AC CATHETERI ZATI ON 79, 062, 809 114, 062, 587 193, 125, 396 0.039145 0.000000 66.00 60.00 OGOO LABORATORY 158, 494, 853 138, 104, 421 296, 599, 274 0.124706 0.000000 66.00 66.00 D6400 INTRAVENUUS THERAPY 7, 665, 654, 670 9.998, 744 66, 638, 414 0.210291 0.000000 65.00 66.00 D6600 PHYSI CAL THERAPY 26, 654, 670 9.998, 744 66, 868, 78, 897, 287 0.166441 0.000000 65.00 66.00 06600 PHYSI CAL THERAPY 20, 029, 070 8, 948, 271 28, 977, 341 0.125719 0.000000 67.00 60.00 D6600 ELECTROCARDI DLOGY 7, 443, 199 6198, 483, 713, 841, 682 0.55658 0.000000 67.00 70.00 07000 ELECTROCARDI DLOGY 36, 610, 977 174, 453,							
55. 00 055.00 RADI DLOGY-THERAPEUTI C 5,925,750 107,400,867 112,966,617 0.110,883 0.00000 55.00 56. 00 05600 RADI DI SOTOPE 3,005,482 7,256,105 10,261,587 0.056058 0.00000 56.00 60. 00 G6000 LABORATORY 179,062,809 114,062,587 193,125,396 0.039145 0.00000 64.00 64.00 06400 INTRAVENUS THERAPY 76,820,407 71,066,867 878,87,275 0.09530 0.00000 64.00 65.00 06500 PHYSI CAL THERAPY 25,639,714 66,653,414 0.210291 0.00000 65.00 66.00 06600 PHYSI CAL THERAPY 20,029,070 8,948,271 28,977,341 0.125719 0.00000 67.00 68.00 06800 SPECH PATHOLOGY 7,443,199 6,198,483 13,641,682 0.155658 0.000000 67.00 71.00 DOTODE LECTROCARDI DLOGY 7,443,199 6,198,483 13,845,527 0.12318 0.000000 70.00 70.00 OTODO IMEDI CAL SHREED TO PATI ENT 171,860,1587 12,931,287 <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td></t<>							
56.00 05600 RADI 01 SOTOPE 3, 005, 482 7, 256, 105 10, 261, 587 0, 05606 0, 000000 56, 00 59.00 05900 CARDI AC CATHETERI ZATION 79, 062, 809 114, 062, 587 193, 125, 396 0, 039145 0, 000000 64, 00 64.00 IABORATORY TERAPY 7, 820, 407 71, 066, 868 78, 887, 275 0, 095630 0, 000000 64, 00 65.00 06500 RESPI RATORY THERAPY 26, 654, 670 9, 998, 744 66, 653, 414 0, 102770 0, 000000 65, 00 66.00 06600 RESPI RATONAL THERAPY 20, 029, 070 8, 948, 271 28, 977, 341 0, 125710 0, 000000 67. 00 0.00000 ELECTROCARDI OLACY 7, 443, 199 6, 198, 483 13, 641, 682 0, 15558 0, 000000 69. 00 0.00000 ELECTROCARDI OLOGY 7, 443, 199 6, 198, 483 13, 641, 682 0, 15558 0, 000000 69. 00 0.00000 ELECTROCARDI OLOGY 7, 443, 199 6, 198, 483 13, 641, 682 0, 15558 0, 000000 70. 00 0.00000 ELECTROCARDI OLOGRAPHY 9, 662,21							
59:00 OS900 CARDIAC CATHETERI ZATION 79:062.809 114.062.587 193.125.396 0.039145 0.000000 69:00 60:00 06000 LABORATORY 158.494.853 1138.104.421 296.599.274 0.124706 0.000000 64:00 64:00 06400 INTRAVENOUS THERAPY 56.654.670 9.998.744 66.653.414 0.210291 0.000000 65:00 65:00 OCCUPATI ONAL THERAPY 25.139.318 33.773.949 58.913.287 0.166441 0.000000 67:00 67:00 06700 OCCUPATI ONAL THERAPY 20.029.070 8.948.271 28.977.341 0.125719 0.000000 67:00 68:00 06900 ELECTROCARDI OLOGY 7.443.199 6.198.483 13.641.682 0.155658 0.000000 69:00 70:00 OTOD MEDI CAL SUPPLIES CHARGED TO PATIENT 171.866.505 29.329.127 0.112318 0.000000 70:00 71:00 OTA00 REVENCEPHALOGRAPHY 9.662.622 19.966.505 29.329.127 0.112318 0.000000 71:00 71:00 OTA00 REVENCEPHALOGRAPHY 9.662.622 19.662.512							
60.00 06000 LABDRATORY 158, 494, 853 138, 104, 421 296, 599, 274 0. 124706 0. 000000 64.00 64.00 06400 INTRAVENOUS THERAPY 7, 820, 407 71, 066, 868 78, 887, 275 0. 095630 0.000000 64.00 65.00 D6500 RESPI RATORY THERAPY 25, 139, 318 33, 773, 969 58, 913, 287 0. 166441 0.000000 65.00 66.00 OCOD OCCUPATIONAL THERAPY 20, 029, 070 8, 948, 271 28, 977, 341 0. 125719 0.000000 65.00 67.00 OF000 CELECTROCARDIOLOGY 7, 443, 199 6, 198, 483 13, 641, 682 0. 155658 0.000000 67.00 67.00 06900 IELECTROCARDIOLOGY 7, 443, 199 6, 662, 655 29, 329, 127 0. 112318 0.000000 70.00 71.00 MEDICAL SUPPLIES CHARGED TO PATIENT 171, 860, 154 111, 453, 701 283, 313, 855 0. 251532 0.000000 72.00 72.00 072000 INCLOSCHARGED TO PATIENTS 100, 358, 879 54, 12, 706 154, 457, 585 <td< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td></td<>							
64.00 06400 INTRAVENOUS THERAPY 7, 820, 407 71, 066, 868 78, 887, 275 0.095630 0.000000 64, 00 65.00 06500 RESPI RATORY THERAPY 56, 654, 670 9, 998, 744 66, 653, 414 0.210291 0.000000 65.00 66.00 06600 PHYSI CAL THERAPY 20, 029, 070 8, 948, 271 28, 977, 341 0.125719 0.000000 65.00 67.00 06000 SPECE HATHOLOCY 7, 443, 199 6, 198, 483 13, 641, 682 0.15658 0.000000 68.00 69.00 06900 ELECTROCARDIOLOGY 7, 443, 199 6, 154, 457, 71 28, 313, 855 0.21532 0.000000 69.00 70.00 07000 MELO DEV CHARGED TO PATI ENT 171, 860, 154 111, 452, 75 0.281372 0.000000 72.00 71.00 07100 MELO DEV CHARGED TO PATI ENTS 100, 335, 879 54, 121, 706 154, 457, 585 0.281372 0.000000 73.00 70.00 07200 RINAL DI ALYSIS 8, 659, 635 519, 802 9, 17							
65:00 06500 RESPI RATORY THERAPY 56, 654, 670 9, 998, 744 66, 653, 414 0. 210291 0. 000000 66. 00 66:00 06600 PHYSI CAL THERAPY 25, 139, 318 33, 773, 969 58, 913, 287 0. 166441 0. 000000 66. 00 67:00 06700 0CCUPATIONAL THERAPY 20, 029, 070 8, 948, 271 28, 977, 341 0. 125719 0. 000000 67. 00 68:00 0EEECT PATHOLOGY 7, 443, 199 6, 198, 483 13, 641, 682 0. 155658 0.000000 69. 00 0:00 06900 ELECTROENCEPHALOGRAPHY 9, 662, 622 19, 666, 505 29, 329, 127 0. 112318 0.000000 70. 00 71:00 07100 ELECTROENCEPHALOGRAPHY 9, 652, 622 19, 666, 505 29, 329, 127 0. 112318 0.000000 71. 00 73:00 07300 DRUGS CHARGED TO PATIENTS 109, 335, 879 54, 121, 706 154, 457, 555 0. 281372 0.000000 72. 00 74:00 07400 RENAL DI ALYSIS 8, 659, 635 519, 802 9, 179, 437 0. 262144 0.000000 74. 00 70:00 0700							
66.00 06600 PHYSI CAL THERAPY 25, 139, 318 33, 773, 969 58, 913, 287 0.166441 0.000000 66.00 67.00 0CCUPATI ONAL THERAPY 20, 029, 070 8, 948, 271 28, 977, 341 0.125719 0.000000 66.00 68.00 06600 SPECET PATHOLOGY 7, 443, 199 6, 198, 482, 271 28, 977, 341 0.125719 0.000000 68.00 69.00 06900 ELECTROCARDIOLOGY 7, 443, 199 6, 66, 605 29, 329, 127 0.112318 0.000000 70.00 71.00 07100 MEL CARSUPPLIE SCHARGED TO PATIENT 171, 860, 154 111, 453, 701 283, 313, 855 0.251532 0.000000 72.00 72.00 07300 RUGS CHARGED TO PATIENTS 194, 284, 288 527, 307, 260 721, 591, 548 0.174497 0.000000 73.00 73.00 07300 RUGS CHARGED TO PATIENTS 194, 284, 288 527, 307, 260 721, 591, 548 0.174497 0.000000 74.00 74.00 07400 RUAS CREABILITATION 168, 387 4, 260, 180 4, 428, 567 0.173803 0.000000 77.07 77.00 0.000000							
67:00 0CCUPATI ONAL THERAPY 20,029,070 8,948,271 28,977,341 0.125719 0.000000 67.00 68:00 06800 SPEECH PATHOLOGY 7,443,199 6,198,483 13,641,682 0.155658 0.000000 68.00 00:00 05900 ELECTROEACEPIDLOGY 36,010,987 17,442,230 53,453,217 0.082633 0.000000 67.00 70:00 0700 MEDICAL SUPPLIES CHARGED TO PATIENT 171,860,154 111,453,701 283,313,855 0.251532 0.000000 72.00 71:00 07200 IMPL DEV. CHARGED TO PATIENTS 100,335,879 54,121,706 154,457,585 0.281372 0.000000 73.00 73:00 07400 RENAL DI ALYSI S 194,284,288 527,307,260 721,591,548 0.174497 0.000000 74.00 70:00 O7400 RENAL DI ALYSI S 8,659,635 519,802 9,179,431 2.464630 0.000000 76.07 70:00 O760 CARDI AC REHABILITATION 168,837 4,260,180 4,428,567 0.173803 0.000000 77.07 0.000000 78.07 0.000000 90.02							
68.00 06800 SPEECH PATHOLOGY 7, 443, 199 6, 198, 483 13, 641, 682 0. 155658 0. 000000 68.00 69.00 06900 ELECTROCARDIOLOGY 36, 010, 987 17, 442, 230 53, 453, 217 0. 082633 0. 000000 69.00 71.00 07000 ELECTROCARDIOLOGY 9, 662, 622 19, 664, 505 29, 329, 127 0. 112318 0. 000000 70.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 171, 860, 154 111, 453, 701 283, 313, 855 0. 251532 0. 000000 73.00 73.00 07300 RURA DI ALYSI S 194, 284, 288 527, 307, 260 721, 591, 548 0. 174497 0. 000000 73.00 74.00 07400 RENAL DI ALYSI S 8, 659, 635 519, 802 9, 179, 437 0. 262144 0. 000000 74.00 75.00 7070 ALJCGENEI C HSCT ACQUI SITION 0 921, 931 924, 931 2. 464630 0.000000 74.00 78.00 09000 CLAN IN 93, 872, 289 9, 276, 647 40, 148, 936 0. 204493 0.000000 78.00 70.00 00000		25, 139, 318	33, 773, 969	58, 913, 28	0. 166441		
69.00 06900 ELECTROCARDIOLOGY 36,010,987 17,442,230 53,453,217 0.082633 0.000000 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 9,662,622 19,666,505 29,329,127 0.112318 0.000000 71.00 71.00 07100 IEDI CAL SUPPLIES CHARGED T0 PATIENT 171,860,154 111,453,701 283,313,855 0.281372 0.000000 72.00 72.00 07200 IMPL. DEV. CHARGED T0 PATIENTS 109,335,879 54,121,706 154,457,585 0.281372 0.000000 73.00 73.00 07300 RENAL DI ALYSI S 8,659,635 519,802 9,179,437 0.262144 0.000000 74.00 74.00 07400 ALLOGENEIC HSCT ACQUI SI TI ON 186,337 4.260,180 4,428,567 0.173803 0.000000 76.97 77.00 07000 ALLOGENEIC HSCT ACQUI SI TI ON 0.921,931 921,931 2.464630 0.000000 77.00 78.00 073000 CR T-CELL IMMUNOTHERAPY 30,872,289 9.276,647 40,148,936 0.204493 0.000000 90.00 90.01 90000 CL NIC	67.00 06700 OCCUPATI ONAL THERAPY	20, 029, 070	8, 948, 271	28, 977, 34	0. 125719	0.000000	67.00
70.00 07000 ELECTROENCEPHALOGRAPHY 9, 662, 622 19, 666, 505 29, 329, 127 0. 112318 0.000000 70.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 171, 860, 154 111, 453, 701 283, 313, 855 0. 251532 0.000000 72.0 73.00 07300 DRUGS CHARGED TO PATIENTS 100, 335, 879 54, 121, 706 154, 457, 585 0. 281372 0.000000 73.00 74.00 07400 RENAL DI ALYSI S 8, 659, 635 519, 802 9, 179, 437 0. 262144 0.000000 74.00 76.97 ORADI AC REHABILITATION 168, 887 4, 260, 180 4, 428, 567 0.173803 0.000000 77.00 78.00 07300 ALOGENEI C HSCT ACQUI SITION 0 921, 931 2.464630 0.000000 78.00 00100 09000 LENT SERVICE COST CENTERS 0.000000 71.00 75.00 0.04008 0.04493 0.000000 90.00 90.01 09001 IBMT JOINT VENTURE 3, 574, 448 9, 353, 361 12, 927, 809 0.173618 0.000000 90.00 90.02 090000 LINC </td <td>68.00 06800 SPEECH PATHOLOGY</td> <td>7, 443, 199</td> <td>6, 198, 483</td> <td>13, 641, 682</td> <td>2 0. 155658</td> <td>0.000000</td> <td>68.00</td>	68.00 06800 SPEECH PATHOLOGY	7, 443, 199	6, 198, 483	13, 641, 682	2 0. 155658	0.000000	68.00
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 171, 860, 154 111, 453, 701 283, 313, 855 0. 251532 0.000000 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 100, 355, 879 54, 121, 706 154, 457, 585 0. 281372 0.000000 72.00 73.00 07400 RENAL DI ALYSIS 194, 284, 288 527, 307, 260 721, 591, 548 0. 174497 0.000000 74.00 74.00 07400 RENAL DI ALYSIS 8, 659, 635 519, 802 9, 179, 437 0. 262144 0.000000 74.00 76.97 CARDI AC REHABILI TATI ON 168, 387 4, 260, 180 4, 428, 567 0. 173803 0.000000 76.97 70.00 O700 CAR T-CELL IMUNOTHERAPY 30, 872, 289 9, 276, 647 40, 148, 936 0. 204493 0.000000 70.07 90.01 09000 CLI NI C 970, 577 16, 868, 044 17, 838, 621 0. 647106 0.000000 90.07 90.02 09002 KORESVI LLE INFUSION CLINIC 0 575, 175 575, 575, 175 0. 105309 0.000000 90.07 90.01 09001 IBMT JOINT VENTURE 510, 383	69. 00 06900 ELECTROCARDI OLOGY	36, 010, 987	17, 442, 230	53, 453, 21	0. 082633	0.000000	69.00
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 171, 860, 154 111, 453, 701 283, 313, 855 0. 251532 0.000000 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 100, 335, 879 54, 121, 706 154, 457, 585 0. 281372 0.000000 72.00 73.00 07400 RENAL DI ALYSI S 194, 284, 288 527, 307, 260 721, 591, 548 0. 174497 0.000000 74.00 76.97 07697 CARDI AC REHABL LI TATI 0N 168, 387 4, 260, 180 4, 428, 567 0. 173803 0.000000 74.00 70.00 O7700 ALLOGENEI C HSCT ACOUI SI TI ON 0 921, 931 921, 931 2. 464630 0.000000 77.00 71.00 0900 CAT T-CELL I MUNOTHERAPY 30, 872, 289 9, 276, 647 40, 148, 936 0. 204493 0.000000 90.00 90.01 09000 CLI NI C 970, 577 16, 868, 044 17, 838, 621 0. 647106 0.000000 90.00 90.02 09002 KORESVI LLE INFUSION CLINIC 0 575, 175 575, 175 0. 105309 0.000000 90.00 90.00 90.00 90.00 90.00 90.0	70.00 07000 ELECTROENCEPHALOGRAPHY	9, 662, 622	19, 666, 505	29, 329, 12	0. 112318	0.000000	70.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 100, 335, 879 54, 121, 706 154, 457, 585 0.281372 0.000000 72.00 73.00 DRUGS CHARGED TO PATIENTS 194, 284, 288 527, 307, 260 721, 591, 548 0.174497 0.000000 73.00 74.00 O7400 RENAL DIALYSI S 8, 659, 635 519, 802 9, 179, 437 0.262144 0.000000 74.00 76.97 ORFO? CARDIAC REHABILITATION 168, 387 4, 260, 180 4, 428, 567 0.173803 0.000000 74.00 77.00 07700 ALLOGENEI C HSCT ACQUI SITION 0 921, 931 921, 931 2.464630 0.000000 77.00 78.00 07800 CAR T-CELL IMMUNOTHERAPY 30, 872, 289 9, 276, 647 40, 148, 936 0.204493 0.0000000 90.00 90.00 09000 CLINIC 970, 577 16, 868, 044 17, 838, 621 0.647106 0.000000 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.01 90.01 90.01 168, 75, 175 575, 175 0.105309 0.000000 90.02	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT						
73.00 07300 DRUGS CHARGED TO PATIENTS 194, 284, 288 527, 307, 260 721, 591, 548 0.174497 0.000000 73.00 74.00 O7400 RENAL DI ALYSI S 8, 659, 635 519, 802 9, 179, 437 0.262144 0.000000 74.00 76.97 OR407 CARDI AC REHABILITATION 168, 387 4, 260, 180 4, 428, 567 0.173803 0.000000 77.00 77.00 O7700 ALLOGENEIC HSCT ACQUISITION 0 921, 931 921, 931 921, 931 0.24443 0.000000 77.00 78.00 07800 CAR T-CELL IMMUNOTHERAPY 30, 872, 289 9, 276, 647 40, 148, 936 0.204493 0.000000 78.00 00000 CLINIC 970, 577 16, 868, 044 17, 838, 621 0.647106 0.000000 90.02 90.01 09000 CLINIC 970, 577 16, 868, 044 17, 838, 621 0.647106 0.000000 90.02 90.02 09002 KORESVILLE INFUSION CLINIC 575, 175 575, 175 0.105309 0.000000 90.02 90.02 09005 CV DI AGNOSTIC SERVICES 510, 383 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>							
74.00 07400 RENAL DI ALYSI S 8, 659, 635 519, 802 9, 179, 437 0. 262144 0. 000000 74.00 76.97 07697 CARDI AC REHABI LI TATI ON 168, 387 4, 260, 180 4, 428, 567 0. 173803 0. 000000 76.97 77.00 07700 ALLOGENEI C HSCT ACQUI SI TI ON 0 921, 931 921, 931 2. 464630 0. 000000 77.00 78.00 OZRT -CELL IMMUNOTHERAPY 30, 872, 289 9, 276, 647 40, 148, 936 0. 204493 0. 000000 78.00 00TPATI ENT SERVICE COST CENTERS 00700 CLI NI C 970, 577 16, 868, 044 17, 838, 621 0. 647106 0. 000000 90.00 90.00 09001 IBMT JOI NT VENTURE 3, 574, 448 9, 353, 361 12, 927, 809 0. 173618 0. 000000 90.00 90.01 09001 IBMT JOI NT VENTURE 3, 574, 448 9, 353, 361 12, 927, 809 0. 173618 0. 000000 90.00 90.05 09002 MORESVI LLE INFUSION CLINIC 0 575, 175 0. 105309 0. 000000 90.02 91.00 09100 EMERGENCY <td< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td></td<>							
76. 97 O7697 CARDI AC REHABI LI TATI ON 168, 387 4, 260, 180 4, 428, 567 0. 173803 0.000000 76. 97 77. 00 O7700 ALL OGENEI C HSCT ACQUI SITION 0 921, 931 921, 931 2. 464630 0.000000 77. 00 78. 00 O7800 CAR T - CELL I MMUNOTHERAPY 30, 872, 289 9, 276, 647 40, 148, 936 0.204493 0.000000 90. 00 0017PATI ENT SERVI CE COST CENTERS 90.00 09000 CLINI C 970, 577 16, 868, 044 17, 838, 621 0. 647106 0.000000 90. 01 90. 01 09001 IBMT JOINT VENTURE 3, 574, 448 9, 353, 361 12, 927, 809 0. 173618 0.000000 90. 01 90. 02 09002 MORESVI LLE INFUSION CLINIC 0 575, 175 575, 175 0.105309 0.000000 90. 02 91. 00 09100 EKREROCY 116, 768, 825 233, 574, 901 350, 343, 726 0.072654 0.000000 91. 02 92. 00 09200 DSERVATI ON BEDS (NON-DI STINCT PART 17, 081, 132 28, 642, 674 45, 723, 806 0.246575 0.000000 92. 00							
77.00 07700 ALLOGENEI C HSCT ACQUI SI TI ON 0 921, 931 921, 931 2.464630 0.000000 77.00 78.00 07800 CAR T-CELL IMMUNOTHERAPY 30, 872, 289 9, 276, 647 40, 148, 936 0.204493 0.000000 78.00 0UTPATIENT SERVICE COST CENTERS 90.00 CLINIC 970, 577 16, 868, 044 17, 838, 621 0.647106 0.00000 90.00 90.00 90.01 09000 CLINIC 970, 577 16, 868, 044 17, 838, 621 0.647106 0.000000 90.00 90.00 90.02 09002 MORESVILLE INFUSION CLINIC 0 575, 175 575, 175 0.105309 0.000000 90.02 90.05 0905 CV DI AGNOSTIC SERVICES 510, 383 98, 036, 297 98, 546, 680 0.124215 0.000000 90.02 91.00 09100 EMERGENCY 116, 768, 825 233, 574, 901 350, 343, 726 0.072654 0.0000000 91.00 92.00 0BSERVATI ON BEDS (NON-DI STI NCT PART 17, 081, 132 28, 642, 674 45, 723, 806 0.246575 0.000000 92.00 92.00							
78.00 07800 CAR T-CELL IMMUNOTHERAPY 30,872,289 9,276,647 40,148,936 0.204493 0.000000 78.00 0UTPATI ENT SERVICE COST CENTERS 970,577 16,868,044 17,838,621 0.647106 0.000000 90.00 90.01 18MT JOINT VENTURE 3,574,448 9,353,361 12,927,809 0.173618 0.000000 90.01 90.02 90002 MORESVILLE INFUSION CLINIC 0 575,175 575,175 0.105309 0.000000 90.02 90.02 9005 CV DI AGNOSTIC SERVICES 510,383 98,036,297 98,546,680 0.124215 0.000000 90.02 90.02 09000 BERVATION BEDS (NON-DISTINCT PART 17,081,132 28,642,674 45,723,806 0.246575 0.000000 91.00 92.00 055EV LLE INFUSABLE COST CENTERS 101.00 101.00 10100 HOME HEALTH AGENCY 0							
OUTPATI ENT SERVICE COST CENTERS 90.00 09000 CLINIC 970, 577 16, 868, 044 17, 838, 621 0. 647106 0. 000000 90. 00 90.01 09001 IBMT JOINT VENTURE 3, 574, 448 9, 353, 361 12, 927, 809 0. 173618 0. 000000 90. 00 90.02 09002 MOORESVILLE INFUSION CLINIC 0 575, 175 575, 175 0. 105309 0. 000000 90. 02 90.05 09005 CV DI AGNOSTI C SERVICES 510, 383 98, 036, 297 98, 546, 680 0. 124215 0. 000000 90. 02 91.00 OP100 EMERGENCY 116, 768, 825 233, 574, 901 350, 343, 726 0. 072654 0. 000000 91. 00 92.00 OBSERVATION BEDS (NON-DI STINCT PART 17, 081, 132 28, 642, 674 45, 723, 806 0. 246575 0. 000000 92. 00 011.00 10100 HOME HEALTH AGENCY 0 0 0 0 101. 00 102.00 01020 0PI 0I D TREATMENT PROGRAM 0 0 0 102. 00		-					
90.00 09000 CLINIC 970, 577 16, 868, 044 17, 838, 621 0. 647106 0. 000000 90. 00 90.01 09001 IBMT JOINT VENTURE 3, 574, 448 9, 353, 361 12, 927, 809 0. 173618 0. 000000 90. 00 90.02 09002 MOORESVILLE INFUSION CLINIC 0 575, 175 575, 175 0. 105309 0. 000000 90. 00 90.05 09005 CV DIAGNOSTIC SERVICES 510, 383 98, 036, 297 98, 546, 680 0. 124215 0. 000000 90. 00 91.00 09100 EMERGENCY 116, 768, 825 233, 574, 901 350, 343, 726 0. 072654 0. 000000 91. 00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 17, 081, 132 28, 642, 674 45, 723, 806 0. 246575 0. 000000 91. 00 011.00 HOME HEALTH AGENCY 0 0 0 0 101. 00 1020 0101 D TREATMENT PROGRAM 0 0 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 10. 00 <td></td> <td>30, 872, 289</td> <td>9, 276, 647</td> <td>40, 148, 930</td> <td>0.204493</td> <td>0.00000</td> <td>/8.00</td>		30, 872, 289	9, 276, 647	40, 148, 930	0.204493	0.00000	/8.00
90.01 09001 IBMT JOINT VENTURE 3, 574, 448 9, 353, 361 12, 927, 809 0. 173618 0. 000000 90. 01 90.02 09002 MOORESVILLE INFUSION CLINIC 0 575, 175 575, 175 0. 105309 0. 000000 90. 02 90.05 09005 CV DIAGNOSTIC SERVICES 510, 383 98, 036, 297 98, 546, 680 0. 124215 0. 000000 90. 02 91.00 09100 EMERGENCY 116, 768, 825 233, 574, 901 350, 343, 726 0. 072654 0. 000000 91. 00 92.00 OBSERVATION BEDS (NON-DISTINCT PART 17, 081, 132 28, 642, 674 45, 723, 806 0. 246575 0. 000000 91. 00 91.00 10100 HOME HEALTH AGENCY 0 0 0 0 101. 00 10100 HOME HEALTH AGENCY 10. 00 101. 00 1020 0 0 102. 00 10200 0PI 0I D TREATMENT PROGRAM 0 0 0 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 102. 00 10		070 577	44 040 044	47.000 (0)	0 (4740 (0.00000	00.00
90.02 09002 MOORESVILLE INFUSION CLINIC 0 575, 175 575, 175 0.105309 0.000000 90.02 90.05 09005 CV DIAGNOSTIC SERVICES 510, 383 98, 036, 297 98, 546, 680 0.124215 0.000000 90.02 91.00 09100 EMERGENCY 116, 768, 825 233, 574, 901 350, 343, 726 0.072654 0.000000 91.00 92.00 OBSERVATION BEDS (NON-DISTINCT PART 17, 081, 132 28, 642, 674 45, 723, 806 0.246575 0.000000 91.00 91.00 THER REIMBURSABLE COST CENTERS 0 0 0 0 0.246575 0.000000 91.00 92.00 OBSERVATION BEDS (NON-DISTINCT PART 17, 081, 132 28, 642, 674 45, 723, 806 0.246575 0.000000 91.00 92.00 I0100 HOME HEALTH AGENCY 0 0 0 0 0 101.00 1020 01010 TREATMENT PROGRAM 0 0 0 102.00 102.00 102.00 102.00 102.00 102.00 <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td></t<>							
90.05 09005 CV DIAGNOSTIC SERVICES 510,383 98,036,297 98,546,680 0.124215 0.000000 90.05 91.00 09100 EMERGENCY 116,768,825 233,574,901 350,343,726 0.072654 0.000000 91.00 92.00 OBSERVATION BEDS (NON-DISTINCT PART 17,081,132 28,642,674 45,723,806 0.246575 0.000000 92.00 91.00 TOTHER REIMBURSABLE COST CENTERS 0 0 0 0 0 92.00 0 0.000000 92.00 101.00 TOTHER REIMBURSABLE COST CENTERS 0 0 0 0 0 0 0 92.00							
91.00 09100 EMERGENCY 116, 769, 825 233, 574, 901 350, 343, 726 0.072654 0.000000 91.00 92.00 OBSERVATION BEDS (NON-DISTINCT PART 17, 081, 132 28, 642, 674 45, 723, 806 0.246575 0.000000 92.00 01.00 HOME HEALTH AGENCY 0 0 0 0 0 101.00 1000 HOME HEALTH AGENCY 0 0 0 102.00 0 0 102.00 0 0 0 102.00 0 0 102.00 0 0 102.00 0 102.00 0 0 0 102.00 0 0 102.00 0 102.00 0 0 102.00 0 102.00 0 102.00 0 102.00 0 102.00 102.00 102.00 102.00 102.00 102.00 102.00 102.00 102.00 102.00 103.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 114.00 16.00 16.00 16.00 20.00 20.00 200.00 200.00		-					
92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART 17,081,132 28,642,674 45,723,806 0.246575 0.000000 92.00 0THER REI MBURSABLE COST CENTERS 0 0 0 0 101.00 10100 HOME HEALTH AGENCY 0 0 0 0 101.00 102.00 0 0 0 0 102.00 0 101.00 102.00 0 0 0 0 0 102.00 102.00 0 101.00 102.00 0 0 0 0 0 0 102.00 103.		510, 383	98, 036, 297	98, 546, 680	0. 124215	0.000000	90.05
OTHER REI MBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 0 0 0 101.00 102.00 10200 OPI OI D TREATMENT PROGRAM 0 0 0 102.00 SPECI AL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 113.00 116.00 HOSPI CE 110, 173 15, 366, 757 15, 476, 930 116.00 116.00 200.00 201.00 Less 0bservation 200.00 201.00 Less 0bservation 201.00	91.00 09100 EMERGENCY	116, 768, 825	233, 574, 901	350, 343, 720	6 0. 072654	0.000000	91.00
101.00 10100 HOME HEALTH AGENCY 0 0 0 101.00 102.00 10200 0PI 0I D TREATMENT PROGRAM 0 0 0 102.00 SPECI AL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 113.00 116.00 1060 HOSPI CE 113.00 116.00 116.00 116.00 200.00 Subtotal (see instructions) 1,812,780,585 2,058,132,794 3,870,913,379 200.00 201.00	92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	17, 081, 132	28, 642, 674	45, 723, 800	6 0. 246575	0.000000	92.00
102.00 10200 OPIOID TREATMENT PROGRAM 0 0 102.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 11300 11600 HOSPICE 110,173 15,366,757 15,476,930 116.00 116.00 100.00 200.00 200.00 2,058,132,794 3,870,913,379 200.00 201.00	OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 110, 173 15, 366, 757 15, 476, 930 116.00 116.00 11600 HOSPICE 110, 173 15, 366, 757 15, 476, 930 116.00 200.00 Subtotal (see instructions) 1, 812, 780, 585 2, 058, 132, 794 3, 870, 913, 379 200.00 201.00 Less Observation Beds 201.00 201.00 201.00 201.00	101.00 10100 HOME HEALTH AGENCY	0	0) (D		101.00
SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 110, 173 15, 366, 757 15, 476, 930 116.00 116.00 11600 HOSPICE 110, 173 15, 366, 757 15, 476, 930 116.00 200.00 Subtotal (see instructions) 1, 812, 780, 585 2, 058, 132, 794 3, 870, 913, 379 200.00 201.00 Less Observation Beds 201.00 201.00 201.00 201.00	102.00 10200 OPI OI D TREATMENT PROGRAM	0	C	(D		102.00
113.00 11300 INTEREST EXPENSE 113.00 116.00 11600 HOSPICE 110,173 15,366,757 15,476,930 116.00 200.00 Subtotal (see instructions) 1,812,780,585 2,058,132,794 3,870,913,379 200.00 201.00							
116.00 1100 HOSPICE 110, 173 15, 366, 757 15, 476, 930 116.00 200.00 Subtotal (see instructions) 1, 812, 780, 585 2, 058, 132, 794 3, 870, 913, 379 200.00 201.00 Less Observation Beds 201.00 201.00 201.00 201.00							1113 00
200.00 Subtotal (see instructions) 1,812,780,585 2,058,132,794 3,870,913,379 200.00 201.00 Less Observation Beds 201.00 201		110 173	15, 366, 757	15, 476 930	0		
201.00 Less Observation Beds 201.00							
		1,012,700,000	2,030,132,794	3,070,713,37			
		1 812 700 505	2 058 122 704	3 870 012 270	0		
		1,012,700,385	2,000,102,794	1 3,010, 713, 3/	7	I	1202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES	FRANCISCAN HEALTH	Provider CCN: 15-0162	Peri od:	Worksheet C
			From 01/01/2023	Part I
			To 12/31/2023	Date/Time Prepared 3/28/2024 2:21 pm
		Title XIX	Hospi tal	PPS
Cost Center Description	PPS Inpatient			
	Rati o 11.00			
INPATIENT ROUTINE SERVICE COST CENTERS	11.00			
30. 00 03000 ADULTS & PEDIATRICS				30.
31.00 03100 INTENSIVE CARE UNIT				31.0
31.01 02060 NEONATAL INTENSIVE CARE UNIT				31.0
32.00 03200 CORONARY CARE UNIT				32.
34.00 03400 SURGICAL INTENSIVE CARE UNIT				34.
41.00 04100 SUBPROVIDER - IRF				41.0
43. 00 04300 NURSERY				43.
ANCILLARY SERVICE COST CENTERS				
50. 00 05000 OPERATI NG ROOM	0. 123072			50.0
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 184449			52.0
54.00 05400 RADI OLOGY-DI AGNOSTI C	0.083725			54.0
55. 00 05500 RADI OLOGY - THERAPEUTI C	0. 110583			55.0
56. 00 05600 RADI OI SOTOPE	0. 056058			56.
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 039145			59.0
60. 00 06000 LABORATORY	0. 124706			60.
64.00 06400 I NTRAVENOUS THERAPY	0.095630			64.0
65. 00 06500 RESPI RATORY THERAPY	0. 210291			65.0
66. 00 06600 PHYSI CAL THERAPY	0. 166441			66.
67. 00 06700 OCCUPATI ONAL THERAPY	0. 125719			67.0
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	0. 155658 0. 082633			68.0
70. 00 07000 ELECTROCARDI OLOGI	0. 112318			70.
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 251532			70.0
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 281372			72.
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 174497			73.
74. 00 07400 RENAL DIALYSIS	0. 262144			74.0
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 173803			76.
77.00 07700 ALLOGENEIC HSCT ACQUISITION	2,464630			77.0
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0. 204493			78.0
OUTPATIENT SERVICE COST CENTERS				
90. 00 09000 CLI NI C	0. 647106			90. (
90.01 09001 IBMT JOINT VENTURE	0. 173618			90.
90.02 09002 MOORESVILLE INFUSION CLINIC	0. 105309			90.
90. 05 09005 CV DIAGNOSTIC SERVICES	0. 124215			90.
91. 00 09100 EMERGENCY	0. 072654			91.0
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 246575			92.
OTHER REIMBURSABLE COST CENTERS				
101.00 10100 HOME HEALTH AGENCY				101.
102.00 0PI 0I D TREATMENT PROGRAM				102.
SPECIAL PURPOSE COST CENTERS				
113.00 11300 INTEREST EXPENSE				113.
116.00 11600 HOSPI CE				116.
200.00 Subtotal (see instructions)				200.
201.00 Less Observation Beds				201.
202.00 Total (see instructions)				202.

	OF OUTPATIENT SERVICE COST TO CHARGE R FOR MEDICAID ONLY	ATTUS NET OF	Provider C	CN: 15-0162	Peri od:	Worksheet C	
	FOR MEDICALD UNLY				From 01/01/2023	Part II	
					To 12/31/2023	Date/Time Pre	nared
					10 12/31/2023	3/28/2024 2:2	21 pm
			Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description	Total Cost	Capital Cost	Operating Co		Operating Cost	
	'	(Wkst. B, Part				Reduction	
		I, col. 26)	II col. 26)	Cost (col. 1	-	Amount	
			,	col. 2)			
		1.00	2.00	3.00	4.00	5.00	
ANCI L	LARY SERVICE COST CENTERS						
0.00 05000	OPERATING ROOM	43, 108, 223	7, 878, 561	35, 229, 6	62 0	0	50.00
2.00 05200	DELIVERY ROOM & LABOR ROOM	9,032,794	2,066,361	6, 966, 4	33 0	0	52.0
4.00 05400	RADI OLOGY-DI AGNOSTI C	31, 129, 143	4, 550, 880	26, 578, 2	63 0	0	54.00
	RADI OLOGY-THERAPEUTI C	12, 492, 205				0	
	RADI OI SOTOPE	575, 247	88, 808			0	
	CARDI AC CATHETERI ZATI ON	7, 559, 912				0	
	LABORATORY	36, 987, 841	2, 318, 719			0	
	INTRAVENOUS THERAPY	7, 543, 978			-	0	
	RESPIRATORY THERAPY	14, 016, 595				0	
	PHYSICAL THERAPY	9, 805, 593				0	
	OCCUPATIONAL THERAPY					0	
		3, 643, 014				0	
	SPEECH PATHOLOGY	2, 123, 434				•	00.0
	ELECTROCARDI OLOGY	4, 417, 024				0	
	ELECTROENCEPHALOGRAPHY	3, 294, 190				0	1
	MEDICAL SUPPLIES CHARGED TO PATIENT	71, 262, 497				0	1
	IMPL. DEV. CHARGED TO PATIENTS	43, 460, 043				0	1 . 2. 0
	DRUGS CHARGED TO PATIENTS	125, 915, 236				0	1
	RENAL DIALYSIS	2, 406, 334				0	1
	CARDIAC REHABILITATION	769, 697				0	1
	ALLOGENEIC HSCT ACQUISITION	2, 272, 219	132, 821	2, 139, 3	98 0	0	77.0
8.00 07800	CAR T-CELL IMMUNOTHERAPY	8, 210, 194	4, 684	8, 205, 5	10 0	0	78.0
OUTPA	TIENT SERVICE COST CENTERS						
0.00 09000	CLINIC	11, 543, 482	1, 471, 188	10, 072, 2	94 0	0	90.0
0.01 09001	I BMT JOINT VENTURE	2, 244, 500	139, 448	2, 105, 0	52 0	0	90.0
0. 02 09002	MOORESVILLE INFUSION CLINIC	60, 571	9, 739		32 0	0	90.0
	CV DIAGNOSTIC SERVICES	12, 241, 013				0	
1.00 09100	EMERGENCY	25, 454, 027				0	91.0
	OBSERVATION BEDS (NON-DISTINCT PART	11, 274, 355				0	
	REIMBURSABLE COST CENTERS		.,	1			1
	HOME HEALTH AGENCY	0	C	1	0 0	0	101.0
	OPIOID TREATMENT PROGRAM	0			0 0		102.0
	AL PURPOSE COST CENTERS	0		1	с <mark>,</mark> 0	0	1.02.0
	INTEREST EXPENSE			1			1113.0
16.0011600		9, 022, 940	45, 703	8, 977, 2	37 0	0	116.0
00.00	Subtotal (sum of lines 50 thru 199)	511, 866, 301					200. 0
00.00	Less Observation Beds	11, 274, 355					200.0
01.00	Total (line 200 minus line 201)	500, 591, 946					201.0

LCULATION OF OUTPATIENT SERVICE COST TO CHARGE	FRANCISCAN HEALT	Provider C		Peri od:	Worksheet C	-2552
DUCTIONS FOR MEDICALD ONLY	KATTUS NET UF	Provider C	CN. 13-0102	From 01/01/2023	Part II	
BOOTTONS FOR WEDTONED ONET				To 12/31/2023	Date/Time Pr	epare
		T: +1		11	3/28/2024 2::	21 pm
Cast Contor Description	Cost Not of	Total Charges	e XIX Outpatient	Hospi tal	PPS	
Cost Center Description		(Worksheet C,				
		Part I, column				
	Reduction	8)	/ col. 7)	0		
	6.00	7.00	8.00	—		
ANCI LLARY SERVI CE COST CENTERS	0.00	7.00	0.00			
00 05000 OPERATING ROOM	43, 108, 223	350, 269, 426	0. 1230	72		50.
00 05200 DELIVERY ROOM & LABOR ROOM	9, 032, 794					52.
00 05400 RADI OLOGY - DI AGNOSTI C	31, 129, 143					54.
00 05500 RADI OLOGY-THERAPEUTI C	12, 492, 205					55.
. 00 05600 RADI 0LOGI - THERAPEOTIC	575, 247					56
00 05900 CARDI AC CATHETERI ZATI ON	7, 559, 912					59
. 00 06000 LABORATORY	36, 987, 841					60
						64
00 06400 I NTRAVENOUS THERAPY	7, 543, 978					
00 06500 RESPIRATORY THERAPY	14, 016, 595					65
00 06600 PHYSI CAL THERAPY	9, 805, 593					66
00 06700 OCCUPATI ONAL THERAPY	3, 643, 014					67
00 06800 SPEECH PATHOLOGY	2, 123, 434					68
00 06900 ELECTROCARDI OLOGY	4, 417, 024					69
00 07000 ELECTROENCEPHALOGRAPHY	3, 294, 190					70
00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	71, 262, 497					71
.00 07200 IMPL. DEV. CHARGED TO PATIENTS	43, 460, 043					72
00 07300 DRUGS CHARGED TO PATIENTS	125, 915, 236					73
00 07400 RENAL DIALYSIS	2, 406, 334					74
. 97 07697 CARDIAC REHABILITATION	769, 697					76
. 00 07700 ALLOGENEIC HSCT ACQUISITION	2, 272, 219					77
. 00 07800 CAR T-CELL IMMUNOTHERAPY	8, 210, 194	40, 148, 936	0. 2044	93		78
OUTPATIENT SERVICE COST CENTERS						
. 00 09000 CLINIC	11, 543, 482	17, 838, 621	0.64710)6		90
. 01 09001 IBMT JOINT VENTURE	2, 244, 500	12, 927, 809	0. 1736	18		90
02 09002 MOORESVILLE INFUSION CLINIC	60, 571	575, 175	0. 10530)9		90
. 05 09005 CV DIAGNOSTIC SERVICES	12, 241, 013	98, 546, 680	0. 1242	15		90
00 09100 EMERGENCY	25, 454, 027	350, 343, 726	0. 0726	54		91
00 09200 OBSERVATION BEDS (NON-DISTINCT PART	11, 274, 355	45, 723, 806	0. 2465	75		92
OTHER REIMBURSABLE COST CENTERS		•	•			
1.00 10100 HOME HEALTH AGENCY	0	0	0.0000	00		101
2.00 10200 OPIOID TREATMENT PROGRAM	0	0	0.0000	00		102
SPECIAL PURPOSE COST CENTERS	· ·	•		· · · · · · · · · · · · · · · · · · ·		
3.00 11300 INTEREST EXPENSE						113
6. 00 11600 HOSPI CE	9, 022, 940	15, 476, 930	0. 58299	93		116
0.00 Subtotal (sum of lines 50 thru 199)		3, 469, 324, 696				200
1.00 Less Observation Beds	11, 274, 355					201
2.00 Total (line 200 minus line 201)		3, 469, 324, 696				202

Health Financial Systems	FRANCI SCAN HEALT	H INDIANAPOLIS		In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CA	PI TAL COSTS	Provider C		Period: From 01/01/2023 Fo 12/31/2023	Date/Time Pre 3/28/2024 2:2	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col. 1 - col			
	26)		2)			
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	11, 162, 716	0	11, 162, 71	6 80, 754	138.23	30.00
31.00 INTENSIVE CARE UNIT	1, 680, 215		1, 680, 21	5 9, 951	168.85	31.00
31.01 NEONATAL INTENSIVE CARE UNIT	1, 242, 705		1, 242, 70	5 6, 794	182.91	31.01
32.00 CORONARY CARE UNIT	3, 743, 385		3, 743, 38	5 13, 517	276.94	32.00
34.00 SURGICAL INTENSIVE CARE UNIT	1, 916, 076		1, 916, 07	6 8, 001	239.48	34.00
41.00 SUBPROVIDER - IRF	1, 323, 140	0	1, 323, 14	5, 986	221.04	41.00
43.00 NURSERY	179, 680		179, 68	3, 459	51.95	43.00
200.00 Total (lines 30 through 199)	21, 247, 917		21, 247, 91	7 128, 462		200.00
Cost Center Description	I npati ent	Inpati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	20, 630					30.00
31.00 INTENSIVE CARE UNIT	2, 880	486, 288				31.00
31.01 NEONATAL INTENSIVE CARE UNIT	0	0				31.01
32.00 CORONARY CARE UNI T	4, 685		•			32.00
34.00 SURGI CAL INTENSI VE CARE UNI T	2, 432					34.00
41.00 SUBPROVIDER – IRF	3, 180	702, 907				41.00
43.00 NURSERY	0	0				43.00
200.00 Total (lines 30 through 199)	33, 807	5, 920, 759	1			200. 00

Health Financial Systems F	RANCI SCAN HEALT	H INDIANAPOLIS		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provider C		Peri od:	Worksheet D	
				From 01/01/2023		
				To 12/31/2023	Date/Time Pre 3/28/2024 2:2	pared:
		Title	XVIII	Hospi tal	372872024 2:2 PPS	грш
Cost Center Description	Capi tal	Total Charges			Capital Costs	
bost benter beschiption		(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,				column 4)	
	Part II, col.	8)	2)	i ondrigoo		
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	7, 878, 561	350, 269, 426	0. 02249	3 52, 363, 550	1, 177, 813	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	2,066,361	48, 971, 664	0. 04219			
54.00 05400 RADI OLOGY-DI AGNOSTI C	4, 550, 880	371, 800, 783	0. 01224	0 38, 349, 173	469, 394	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	295, 153		0. 00261	3 1, 931, 015	5, 046	55.00
56. 00 05600 RADI OI SOTOPE	88, 808	10, 261, 587	0. 00865	4 1, 044, 195	9,036	56.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	1, 774, 756	193, 125, 396	0.00919			59.00
60. 00 06000 LABORATORY	2, 318, 719	296, 599, 274	0. 00781	8 44, 831, 725	350, 494	60.00
64.00 06400 INTRAVENOUS THERAPY	978, 189					
65. 00 06500 RESPI RATORY THERAPY	369, 578	66, 653, 414	0.00554	5 15, 083, 118	83, 636	65.00
66. 00 06600 PHYSI CAL THERAPY	872, 235					
67.00 06700 OCCUPATIONAL THERAPY	14, 293					
68.00 06800 SPEECH PATHOLOGY	148,658					
69. 00 06900 ELECTROCARDI OLOGY	1, 279, 003					
70.00 07000 ELECTROENCEPHALOGRAPHY	325,058					
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 302, 546					•
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	761, 340					•
73.00 07300 DRUGS CHARGED TO PATIENTS	971, 163					•
74.00 07400 RENAL DIALYSIS	262, 489			3, 000, 592	85, 802	74.00
76. 97 07697 CARDI AC REHABI LI TATI ON	3, 461					76.97
77.00 07700 ALLOGENEIC HSCT ACQUISITION	132, 821					77.00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	4, 684	40, 148, 936	0. 00011	7 15, 486, 184	1, 812	78.00
OUTPATIENT SERVICE COST CENTERS	· · · · ·				· · · ·	1
90. 00 09000 CLINIC	1, 471, 188	17, 838, 621	0.08247	2 164, 710	13, 584	90.00
90. 01 09001 I BMT JOINT VENTURE	139, 448					
90.02 09002 MOORESVILLE INFUSION CLINIC	9, 739					•
90. 05 09005 CV DI AGNOSTI C SERVI CES	59, 243			1 195, 328	117	90.05
91.00 09100 EMERGENCY	3, 639, 489		0. 01038			
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 342, 911					92.00
200.00 Total (lines 50 through 199)	33, 060, 774	3, 453, 847, 766		411, 888, 255	3, 920, 220	200.00

lealth Financial Systems	FRANCI SCAN HEALTH				u of Form CMS-	2552-1
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER	R PASS THROUGH COSTS	S Provider C	CN: 15-0162	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part III Date/Time Pre 3/28/2024 2:2	pared: 1 pm
		Title	e XVIII	Hospi tal	PPS	
Cost Center Description	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Healt Post-Stepdow Adjustments	h Allied Health n Cost	All Other Medical Education Cost	
	1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS	17.	1.00	2/1	2.00	0.00	
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT 31. 01 02060 NEONATAL INTENSIVE CARE UNIT	0 0 0	C C C		0 0 0 0 0 0	0 0 0	31. C
32. 00 03200 CORONARY CARE UNIT 34. 00 03400 SURGICAL INTENSIVE CARE UNIT 41. 00 04100 SUBPROVIDER - IRF	0 0 0	0 0 0		0 0 0 0 0 0	0 0 0	34. C
43.00 04300 NURSERY 200.00 Total (lines 30 through 199)	0	0		0 0	0	43.0 200.0
Cost Center Description	Amount (see	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patien Days	t Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	200.0
	4.00	5.00	6.00	7.00	8.00	
INPATI ENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 31.00 03100 INTENSIVE CARE UNIT 31.01 02060 NEONATAL INTENSIVE CARE UNIT 32.00 03200 CORONARY CARE UNIT 34.00 03400 SURGICAL INTENSIVE CARE UNIT 41.00 04100 SUBPROVIDER - IRF 43.00 04300 NURSERY 200.00 Total (lines 30 through 199)	0		80, 75 9, 95 6, 79 13, 51 8, 00 5, 98 3, 45 128, 46	i1 0.00 04 0.00 7 0.00 01 0.00 36 0.00 9 0.00	2, 880 0 4, 685 2, 432 3, 180	31.0 31.0 32.0 34.0 41.0 43.0
Cost Center Description	I npati ent Program Pass-Through Cost (col. 7 x col. 8) 9.00					
INPATI ENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 31.00 03100 INTENSIVE CARE UNIT 31.01 02060 NEONATAL INTENSIVE CARE UNIT 32.00 03200 CORONARY CARE UNIT 34.00 03400 SURGICAL INTENSIVE CARE UNIT 41.00 04100 SUBPROVIDER - IRF 43.00 04300 NURSERY 200.00 Total (lines 30 through 199)						30. 0 31. 0 31. 0 32. 0 34. 0 41. 0 43. 0 200. 0

Health Financial Systems F	RANCISCAN HEALT	H INDIANAPOLIS			In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF THROUGH COSTS	RVICE OTHER PASS					3/28/2024 2:2	pared: 1 pm
		Title	XVIII		Hospi tal	PPS	
Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	F	Allied Health Post-Stepdown Adjustments	Allied Health	
	1.00	2A	2.00		3A	3.00	
ANCI LLARY SERVI CE COST CENTERS							
50. 00 05000 OPERATI NG ROOM	0	0		0	0	217, 938	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	0		Ő	0	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0	0	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0	0	0	55.00
56. 00 05600 RADI OI SOTOPE	0	0		0	0	0	56.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0	0	0	59.00
60. 00 06000 LABORATORY	0	0		0	0	48, 772	
64. 00 06400 I NTRAVENOUS THERAPY	0	0		0	0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0	0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0	0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0		0	0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0	0		0	0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0	0	0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0	0	0	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0	0	0	71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	443,072	
74.00 07400 RENAL DI ALYSI S	0	0		0	0	0	74.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		0	0	0	76.97
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
OUTPATIENT SERVICE COST CENTERS		-			-	-	
90. 00 09000 CLINIC	0	0		0	0	0	90.00
90. 01 09001 I BMT JOINT VENTURE	0	0		Ő	0	0	90.01
90. 02 09002 MOORESVILLE INFUSION CLINIC	0	0		Ō	0	0	90.02
90. 05 09005 CV DI AGNOSTI C SERVI CES	0	0		Ō	0	0	
91. 00 09100 EMERGENCY	0	0		Ō	0	356, 711	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0			Ő	Ŭ	0	92.00
200.00 Total (lines 50 through 199)	0	0		0	0	1, 066, 493	
					- 1		

Health Financial Systems F	RANCI SCAN HEALT	H INDIANAPOLIS		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEI	RVICE OTHER PAS	S Provider C		Peri od:	Worksheet D	
THROUGH COSTS				From 01/01/2023 To 12/31/2023	Part IV Date/Time Pre	narod
				10 12/31/2023	3/28/2024 2:2	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,	to Charges	
	Education Cost	1, 2, 3, and	Cost (sum of		(col. 5 ÷ col.	
		4)	cols. 2, 3,	8)	7)	
			and 4)		(see	
	4.00	F 00	(00	7.00	instructions)	
	4.00	5.00	6.00	7.00	8.00	
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM	0	217 020	217.02	0 250 260 426	0. 000622	50.00
50.00 05000 OPERATING ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM	0	217, 938				
	0	0		0 48, 971, 664 0 371, 800, 783		
54. 00 05400 RADI OLOGY-DI AGNOSTI C 55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0 371,800,783	0.000000	
56. 00 05600 RADI 0LOGY - THERAPEUTI C	0	0		0 112, 966, 617		
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 193, 125, 396		
60. 00 06000 LABORATORY	0	48, 772				60.00
64. 00 06400 I NTRAVENOUS THERAPY	0	40, 772		2 290, 599, 274 0 78, 887, 275		
65. 00 06500 RESPI RATORY THERAPY	0	0		0 66, 653, 414		•
66. 00 06600 PHYSI CAL THERAPY	0	0		0 58, 913, 287	0.000000	•
67. 00 06700 OCCUPATI ONAL THERAPY	0			0 28, 977, 341	0.000000	
68. 00 06800 SPEECH PATHOLOGY	0			0 13, 641, 682		
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 53, 453, 217		•
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 29, 329, 127	0.000000	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 283, 313, 855	0.000000	•
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 154, 457, 585	0. 000000	•
73.00 07300 DRUGS CHARGED TO PATIENTS	0	443,072	443, 07			
74.00 07400 RENAL DIALYSIS	0	0		0 9, 179, 437	0.000000	74.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		0 4, 428, 567	0.000000	76.97
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0		0 921, 931	0.000000	77.00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0	0		0 40, 148, 936	0. 000000	78.00
OUTPATIENT SERVICE COST CENTERS		•				1
90. 00 09000 CLINIC	0	0		0 17, 838, 621	0.00000	90.00
90. 01 09001 IBMT JOINT VENTURE	0	0		0 12, 927, 809	0.000000	90.01
90.02 09002 MOORESVILLE INFUSION CLINIC	0	0		0 575, 175		
90. 05 09005 CV DI AGNOSTI C SERVI CES	0	0		0 98, 546, 680		
91. 00 09100 EMERGENCY	0	356, 711	356, 71			
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		0 45, 723, 806		
200.00 Total (lines 50 through 199)	0	1, 066, 493	1, 066, 49	3 3, 453, 847, 766		200. 00

52.00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 55, 372 0 2, 643 0 52 54.00 05400 RADI 0L0GY-DI AGNOSTI C 0.000000 38, 349, 173 0 48, 564, 441 0 54 55.00 D5500 RADI 0L0GY-THERAPEUTI C 0.000000 1, 931, 015 0 29, 043, 062 0 55 56.00 O5600 RADI 0LSOTOPE 0.000000 1, 931, 015 0 29, 043, 062 0 56 59.00 O5600 CARDI AC CATHETERI ZATI 0N 0.000000 22, 159, 552 0 32, 363, 982 0 59 60.00 06000 LABORATORY 0.000164 44, 831, 725 7, 352 10, 121, 963 1, 666 66 64.00 06400 INTRAVENOUS THERAPY 0.000000 15, 083, 118 0 2, 248, 362 0 65 65.00 06600 PHYSI CAL THERAPY 0.000000 5, 644, 000 0 28, 215 0 67 66.00 06600 PHYSI CAL THERAPY 0.000000 11, 790, 746 0 4, 684, 692 0 69	Health Financial Systems	FRANCI SCAN HEALTH	I NDI ANAPOLI S		In Lie	eu of Form CMS-:	2552-10
And Data Sourds To 12/31/2023 Date/Time Prepart AZ85/2024 2:21 pr 3/28/2024 2:21 pr Post Date/Time Prepart Program	APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY S	ERVICE OTHER PASS	Provider C	CN: 15-0162			
It is the second seco	THROUGH COSTS					Part IV	
Title XUIII Hoppital PPS Cost Center Description Title XUIII Hoppital Program Program Program Program Program Program Program Pass-Through Costs (col. 9 Outpatient Program Pass-Through Costs (col. 9 Not colspan="2">Charges Cost (col. 9 Not colspan="2">Charges Cost (col. 9 Not colspan="2">Outpatient Program Program Program Pass-Through Costs (col. 9 Not colspan="2">Not colspan="2">Not colspan="2">Outpatient Program Pass-Through Costs (col. 9 Not colspan="2">Not colspan="2">Not colspan="2">Outpatient Program Pass-Through Costs (col. 9 Not colspan="2">Not colspan="2">Not colspan="2">Outpatient Program Pass-Through Costs (col. 9 Not colspan="2">Not colspan="2">Not colspan="2">Outpatient Program Pass-Through Costs (col. 9 Not colspan="2">Not colspan="2">Not colspan="2">Outpatient Program Pass-Through Costs (col. 9 Not colspan="2">Not colspan="2">Outpatient Program Pass-Through Costs (col. 9 Not colspan="2">Not colspan="2">Outpatient Program Pass-Through Costs (col. 9 Not colspan="2">Not colspan="2">Not colspan="2">Not colspan="2">Outpatient Program Pass-Through Costs (col. 9 Not colspan="2">Not colspan="2">Outpatient Program Pass-Through Costs (col. 9 Not colspan="2">Not colspan="2" Outpatient Program Pass-Through Costs (col					10 12/31/2023	Date/IIme Pre	pared: 1 pm
Cost Center Description Outpatient Ratio of Cost to Charges (col. 6 + col. 7) inpatient Program Charges Inpatient Program Charges Inpatient Program Charges Outpatient Program Charges 50.00 05000 OPERATING ROOM 0.000622 52,363,550 32,570 31,451,387 19,563 50 52.00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 53,372 0 2,643 0 52 50.00 05500 RADI 01SOTOPE 0.000000 1,931,015 0 29,043,062 0 55 50.00 05500 RADI 01SOTOPE 0.000000 1,44,195 1,642,659 0 66 60.00 06400 INTRAVENUDS THERAPY 0.000000 1,583,118 0 2,248,362 0 66 60.00 06500 RESPI RATORY THERAPY 0.000000 1,790,7			Title	XVIII	Hospi tal		
ANCI LLARY SERVICE COST CENTERS Program (Call set of Cost) Program (Charges) Progra	Cost Center Description	Outpatient					
Image: tool charges Pass-Through Costs (col. 8 (col. 6 + col. 7) Pass-Through Costs (col. 9 (costs (col. 10) Pass-Through Costs (col. 9 (costs (col. 9) NCILLARY SERVICE COST CENTERS 0.000622 52,363,550 32,570 31,451,387 19,563 50 50.00 05000 OPERATING ROOM 0.000000 55,372 0 2,643 0 52 50.00 05500 RADI OLOGY-DI AKNOSTI C 0.000000 18,349,173 0 48,564,441 0 54 55.00 05500 RADI OLOGY-DI AKNOSTI C 0.000000 1,931,015 229,043,062 0 55 50.00 05900 CARDI AL CATHETERI ZATI ON 0.000000 1,931,015 229,043,062 0 56 60.00 06000 LABORATORY 0.000164 44,831,725 7,352 10,121,963 1,660 66 64.00 06400 INTRAVENOUS THERAPY 0.000000 1,559,081 0 15,426,589 6 6 65.00 06500 RESPI RATORY THERAPY 0.000000 1,799,746 0 82,215 6 6 66.00 06600 PEECH PAT							
$ \begin{array}{ c c c c c c c c c c c c c c c c c c c$							
7) x col. 10) x col. 12) 9.00 10.00 11.00 12.00 13.00 50.00 05000 DPERATING ROOM 0.000622 52.363,550 32.570 31.451,387 19.563 50 52.00 05400 PEIAVERY ROOM & LABOR ROOM 0.000000 55,372 0 2.643 0 52 54.00 05500 RADI 0LOGY-DI AGNOSTI C 0.000000 38,349,173 0 48,564,441 0 54 55.00 05500 RADI 0LOGY-THERAPEUTI C 0.000000 1,044,195 0 1,628,962 0 56 50.00 05900 CARDI AC CATHETERIZATI ON 0.000000 1,755,081 0 15,265,59 0 56 56 60.00 06000 LABORATORY 0.000000 1,755,081 0 15,246,59 0 66 61.00 06500 RESPI RATORY THERAPY 0.000000 15,083,118 0 2,248,362 0 65 62.00 06500 RESPI RATORY THERAPY 0.000000 1,399,026 0 23,400 0			g				
ANCI LLARY SERVI CE COST CENTERS 9.00 10.00 11.00 12.00 13.00 50.00 05000 OPERATI NG ROOM 0.000622 52,363,550 32,570 31,451,387 19,563 50 52.00 05200 DELI VERY ROM & LABOR ROOM 0.000000 55,372 0 2,643 0 52 54.00 05500 RADI LOGY - THERAPEUTI C 0.000000 1,044,195 0 1,628,962 0 55 56.00 05600 RADI LOGY - THERAPEUTI C 0.000000 1,044,195 0 1,628,962 0 56 00 05000 CARDI AC CATHETERI ZATI ON 0.000000 1,755,081 0 15,426,589 0 64 00 06400 INTRAVENOUS THERAPY 0.000000 1,755,081 0 15,426,589 0 64 00 06500 RESPI RATORY THERAPY 0.000000 1,399,026 0 2,443,362 0 65 00 06500 PESPI RATORY THERAPY 0.0000000 1,399,026 0							
50.00 05000 OPERATI NG ROOM 0.000622 52, 363, 550 32, 570 31, 451, 387 19, 563 50 52.00 05200 DELI VERY ROOM & LABOR ROOM 0.000000 55, 372 0 2, 643 0 52 54.00 O5400 RADI OLOGY - JHERAPEUTI C 0.000000 1, 931, 015 0 29, 043, 062 0 55 55.00 O5500 RADI OLOGY - THERAPEUTI C 0.000000 1, 931, 015 0 1, 628, 962 0 56 59.00 O5500 CATHETERI ZATI ON 0.000000 1, 044, 195 1, 628, 962 0 59 60.00 O6400 LABORATORY 0.000164 44, 831, 725 7, 352 10, 121, 963 1, 666 64 60.00 O6400 INTRAVENOUS THERAPY 0.000000 1, 755, 081 0 15, 426, 589 0 64 65.00 OE500 RESPI RATORY THERAPY 0.000000 15, 083, 118 0 2, 248, 362 0 65 66.00 O6500 RESPI RATORY THERAPY 0.000000 1, 399, 026 23, 400 0 68			10.00		12.00		
52.00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 55, 372 0 2, 643 0 52 54.00 05400 RADI 0LOGY-DI AGNOSTI C 0.000000 38, 349, 173 0 48, 564, 441 0 54 55.00 RADI 0LOGY-DI AGNOSTI C 0.000000 1, 931, 015 0 29, 043, 062 0 55 56.00 05600 RADI 0LOGY-THERAPEUTI C 0.000000 1, 931, 015 0 29, 043, 062 0 56 59.00 05600 CARDI AC CATHETERI ZATI ON 0.000000 22, 159, 552 0 32, 363, 982 0 59 60.00 06000 LABORATORY 0.000000 1, 755, 081 0 15, 426, 589 0 64 65.00 06500 RESPI RATORY THERAPY 0.000000 1, 755, 081 0 2, 248, 362 0 66 66.00 06600 PHYSI CAL THERAPY 0.000000 5, 644, 000 0 28, 215 0 67 67.00 06700 0CCUPATI ONAL THERAPY 0.000000 1, 399, 026 0 23, 400 0 68	ANCI LLARY SERVI CE COST CENTERS			•		•	
54.00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 38, 349, 173 0 48, 564, 441 0 54 55.00 05500 RADI OLOGY-THERAPEUTI C 0.000000 1, 941, 105 0 29, 043, 062 0 55 56.00 05600 RADI OLOGY-THERAPEUTI ON 0.000000 1, 044, 195 0 1, 628, 962 0 56 59.00 05900 CARDI AC CATHETERI ZATI ON 0.000000 12, 159, 552 0 32, 363, 982 0 59 60.00 06400 INTRAVENOUS THERAPY 0.000164 44, 831, 725 7, 352 10, 121, 963 1, 660 60 64.00 06400 INTRAVENOUS THERAPY 0.000000 15, 083, 118 0 2, 248, 362 0 65 65.00 06500 RESPI RATORY THERAPY 0.000000 6, 657, 216 0 82, 620 0 66 64.00 06600 PHYSI CAL THERAPY 0.000000 1, 790, 746 0 4, 844, 692 0 67 68.00 06800 SPEECH PATHOLOGY 0.000000 1, 790, 746 0 3, 351, 581 0 <td>50. 00 05000 OPERATI NG ROOM</td> <td>0. 000622</td> <td>52, 363, 550</td> <td>32, 5</td> <td>70 31, 451, 387</td> <td>19, 563</td> <td>50.00</td>	50. 00 05000 OPERATI NG ROOM	0. 000622	52, 363, 550	32, 5	70 31, 451, 387	19, 563	50.00
55.00 05500 RADI OLOGY - THERAPEUTI C 0.000000 1,931,015 0 29,043,062 0 55 56.00 05600 RADI OL SOTOPE 0.000000 1,044,195 0 1,628,962 56 59.00 05900 CARDI AC CATHETERI ZATI ON 0.000000 22,159,552 0 32,363,982 0 66 60.00 06400 INTRAVENOUS THERAPY 0.000164 44,831,725 7,352 10,121,963 1,660 60 64.00 06400 INTRAVENOUS THERAPY 0.000000 1,755,081 0 15,426,589 0 64 65.00 06500 RESPI RATORY THERAPY 0.000000 1,583,118 0 2,248,362 0 65 66.00 06600 PHYSI CAL THERAPY 0.000000 5,064,000 0 82,620 0 68 67.00 0CCUPATI ONAL THERAPY 0.000000 1,399,026 0 23,400 0 68 69.00 06900 ELECTROCARDI OLOGY 0.000000 1,790,746 0 4,684,692 0 71 71.00 07100 <	52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	55, 372	1	0 2,643	0	52.00
56.00 05600 RADI OI SOTOPE 0.000000 1.044,195 0 1.628,962 0 56 59.00 05900 CARDI AC CATHETERI ZATI ON 0.000000 22,159,552 0 32,363,982 0 59 60.00 06000 LABORATORY 0.000164 44,831,725 7,352 10,121,963 1,660 60 64.00 06400 INTRAVENOUS THERAPY 0.000000 1,755,081 0 15,426,589 0 64 65.00 06500 RESPI RATORY THERAPY 0.000000 1,044,195 0 82,620 0 66 66.00 06600 PHYSI CAL THERAPY 0.000000 5,064,000 28,215 0 67 67.00 06700 CCUPATI ONAL THERAPY 0.000000 1,399,026 23,400 0 68 69.00 06900 ELECTROCARDI OLOGY 0.000000 1,790,746 0 4,684,692 0 69 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0.000000 27,594,162	54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	38, 349, 173	1	0 48, 564, 441	0	54.00
59.00 05900 CARDI AC CATHETERI ZATI ON 0.000000 22, 159, 552 0 32, 363, 982 0 59 60.00 06000 LABORATORY 0.000164 44, 831, 725 7, 352 10, 121, 963 1, 660 60 64.00 06400 INTRAVENOUS THERAPY 0.000000 1, 755, 081 0 15, 426, 589 0 64 65.00 06500 RESPI RATORY THERAPY 0.000000 15, 083, 118 0 2, 248, 362 0 65 66.00 06600 PHYSI CAL THERAPY 0.000000 6, 657, 216 0 82, 620 0 66 67.00 0C2UPATI ONAL THERAPY 0.000000 5, 064, 000 0 28, 215 0 67 68.00 06800 SPEECH PATHOLOGY 0.000000 11, 790, 746 0 4, 684, 692 0 69 70.00 07000 ELCTROCARDI OLOGY 0.000000 2, 713, 582 0 3, 351, 581 0 71 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0.000000 38, 456, 984 0 15, 599, 522 0 72 </td <td>55. 00 05500 RADI OLOGY-THERAPEUTI C</td> <td>0. 000000</td> <td>1, 931, 015</td> <td>1</td> <td>0 29, 043, 062</td> <td>0</td> <td>55.00</td>	55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000	1, 931, 015	1	0 29, 043, 062	0	55.00
60.00 06000 LABORATORY 0.000164 44, 831, 725 7, 352 10, 121, 963 1, 660 60 64.00 06400 INTRAVENOUS THERAPY 0.000000 1, 755, 081 0 15, 426, 589 0 64 65.00 06500 RESPI RATORY THERAPY 0.000000 15, 083, 118 0 2, 248, 362 0 65 66.00 06600 PHYSI CAL THERAPY 0.000000 6, 657, 216 0 82, 620 0 66 67.00 06700 OCCUPATI ONAL THERAPY 0.000000 5, 064, 000 0 28, 215 0 67 68.00 06800 SPEECH PATHOLOGY 0.000000 1, 399, 026 0 23, 400 0 68 69.00 06900 ELECTROCARDI OLOGY 0.000000 1, 790, 746 0 4, 684, 692 0 70 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0.000000 2, 713, 582 0 3, 351, 581 0 70 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.000000 38, 456, 984 0 15, 599, 522 0	56. 00 05600 RADI OI SOTOPE	0. 000000	1, 044, 195	1	0 1, 628, 962	0	56.00
64.00 06400 INTRAVENOUS THERAPY 0.000000 1,755,081 0 15,426,589 0 64 65.00 06500 RESPI RATORY THERAPY 0.000000 15,083,118 0 2,248,362 0 65 66.00 06600 PHYSI CAL THERAPY 0.000000 6,657,216 0 82,620 0 66 67.00 0CCUPATI ONAL THERAPY 0.000000 5,064,000 0 28,215 0 67 68.00 06800 SPEECH PATHOLOGY 0.000000 1,399,026 0 23,400 0 68 69.00 06900 ELECTROCARDI OLOGY 0.000000 2,713,582 0 3,351,581 0 70 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0.000000 38,456,984 0 15,599,522 0 72 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.000000 3,000,592 0 76,707 0 74 74.00 07400 RENAL DI ALYSI S 0.000000 39,922 0 1,367,591 0 76,707 74 77.00 </td <td>59. 00 05900 CARDI AC CATHETERI ZATI ON</td> <td>0. 000000</td> <td>22, 159, 552</td> <td>1</td> <td>0 32, 363, 982</td> <td>0</td> <td>59.00</td>	59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	22, 159, 552	1	0 32, 363, 982	0	59.00
65.00 06500 RESPI RATORY THERAPY 0.000000 15,083,118 0 2,243,362 0 65 66.00 06600 PHYSI CAL THERAPY 0.000000 6,657,216 0 82,620 0 66 67.00 0CCUPATI ONAL THERAPY 0.000000 5,064,000 0 28,215 0 67 68.00 06800 SPEECH PATHOLOGY 0.000000 1,399,026 0 23,400 0 68 69.00 06900 ELECTROCARDI OLOGY 0.000000 11,790,746 0 4,684,692 0 69 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0.000000 2,713,582 0 3,351,581 0 70 72.00 07200 IMPL DEV. CHARGED TO PATI ENTS 0.000000 38,456,984 0 15,599,522 0 72 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.000000 3,000,592 0 76,707 0 74 74.00 07400 RENAL DI ALYSI S 0.000000 3,000,592 0 76,707 0 76 77.	60. 00 06000 LABORATORY	0. 000164	44, 831, 725	7, 3	52 10, 121, 963	1, 660	60.00
66.00 06600 PHYSI CAL THERAPY 0.000000 6,657,216 0 82,620 0 66 67.00 06700 OCCUPATI ONAL THERAPY 0.000000 5,064,000 0 28,215 0 67 68.00 06800 SPEECH PATHOLOGY 0.000000 1,399,026 0 23,400 0 68 69.00 06900 ELECTROCARDI OLOGY 0.000000 11,790,746 0 4,684,692 0 67 70.00 07000 ELECTROCENCEPHALOGRAPHY 0.000000 2,713,582 0 3,351,581 0 70 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0.000000 49,814,599 0 27,594,162 0 72 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.000000 38,456,984 0 15,599,522 0 74 74.00 07400 RENAL DI ALYSI S 0.000000 3,000,592 0 76,707 0 74 75.97 07697 CARDI AC REHABI LI TATI ON 0.000000 0 0 0 0 76 76	64.00 06400 INTRAVENOUS THERAPY	0. 000000	1, 755, 081		0 15, 426, 589	0	64.00
67.00 06700 0CCUPATIONAL THERAPY 0.000000 5,064,000 0 28,215 0 67 68.00 06800 SPEECH PATHOLOGY 0.000000 1,399,026 0 23,400 0 68 69.00 06900 ELECTROCARDIOLOGY 0.000000 11,790,746 0 4,684,692 0 69 70.00 07000 ELECTROENCEPHALOGRAPHY 0.000000 2,713,582 0 3,351,581 0 70 71.00 O7100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0.000000 49,814,599 0 27,594,162 0 71 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.000000 38,456,984 0 15,599,522 0 72 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.000000 3,000,592 0 76,707 0 74 74.00 07400 RENAL DI ALYSIS 0.000000 39,922 0 1,367,591 0 76 77.00 07697 CARDI AC REHABI LI TATI ON 0.000000 0 0 0 77 78 0 0	65. 00 06500 RESPI RATORY THERAPY	0. 000000	15, 083, 118		0 2, 248, 362	0	65.00
68.00 06800 SPEECH PATHOLOGY 0.000000 1, 399, 026 0 23, 400 0 68 69.00 06900 ELECTROCARDI OLOGY 0.000000 11, 790, 746 0 4, 684, 692 0 69 70.00 07000 ELECTROENCEPHALOGRAPHY 0.000000 2, 713, 582 0 3, 351, 581 0 70 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0.000000 49, 814, 599 0 27, 594, 162 0 71 72.00 07200 IMPL DEV. CHARGED TO PATI ENTS 0.000000 38, 456, 984 0 15, 599, 522 0 72 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.000000 3, 000, 592 0 76, 707 0 74 00 07400 RENAL DI ALYSI S 0.000000 39, 922 0 1, 367, 591 0 76 77 0 76 77 0 77 76 76 77 0 77 0 77 0 77 0 77 0 77 0 76 77 0 77	66. 00 06600 PHYSI CAL THERAPY	0. 000000	6, 657, 216		0 82, 620	0	66.00
69.00 06900 ELECTROCARDI OLOGY 0.000000 11,790,746 0 4,684,692 0 69 70.00 07000 ELECTROENCEPHALOGRAPHY 0.000000 2,713,582 0 3,351,581 0 70 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0.000000 49,814,599 0 27,594,162 0 71 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.000000 38,456,984 0 15,599,522 0 72 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.000000 3,000,592 0 76,707 0 74 74.00 07400 RENAL DI ALYSI S 0.000000 3,000,592 0 76,707 74 76.97 7677 CARDI AC REHABI LI TATI ON 0.000000 39,922 1,367,591 0 77 78.00 07800 CAR T-CELL I MUNOTHERAPY 0.000000 15,486,184 0 3,263,469 0 78 90.00 09000 CLINIC 0.000000 164,710 0 3,936,236 0 90	67.00 06700 OCCUPATI ONAL THERAPY	0. 000000	5,064,000		0 28, 215	0	67.00
70. 00 07000 ELECTROENCEPHALOGRAPHY 0.000000 2,713,582 0 3,351,581 0 70 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0.000000 49,814,599 0 27,594,162 0 71 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.000000 38,456,984 0 15,599,522 0 72 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0.000000 3,000,592 0 76,707 0 74 74. 00 07400 RENAL DI ALYSI S 0.000000 3,000,592 0 76,707 0 74 75. 00 07400 RENAL DI ALYSI S 0.000000 39,922 0 1,367,591 0 74 76. 97 07697 CARDI AC REHABI LI TATI ON 0.000000 0 0 0 77 0 74 77. 00 07800 CAR T -CELL I MUNOTHERAPY 0.000000 0 0 0 78 0 3, 263, 469 0 78	68.00 06800 SPEECH PATHOLOGY	0. 000000	1, 399, 026		0 23, 400	0	68.00
71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0.000000 49, 814, 599 0 27, 594, 162 0 71 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.000000 38, 456, 984 0 15, 599, 522 0 72 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.000000 38, 456, 984 0 15, 599, 522 0 72 74.00 07400 RENAL DI ALYSI S 0.000000 3, 000, 592 0 76, 707 0 74 76.97 07697 CARDI AC REHABI LI TATI ON 0.000000 39, 922 0 1, 367, 591 0 77 78.00 07800 CAR T - CELL I MUNOTHERAPY 0.000000 15, 486, 184 0 3, 263, 469 0 90.00 09000 CLI NI C 0.000000 164, 710 0 3, 936, 236 0 90	69. 00 06900 ELECTROCARDI OLOGY	0. 000000	11, 790, 746		0 4, 684, 692	0	69.00
72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.000000 38, 456, 984 0 15, 599, 522 0 72 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0.0000014 54, 643, 751 33, 551 171, 457, 423 105, 275 73 74. 00 07400 RENAL DI ALYSI S 0.000000 3, 000, 592 0 76, 707 0 74 76. 97 07697 CARDI AC REHABI LI TATI ON 0.000000 39, 922 0 1, 367, 591 0 76 77. 00 07700 ALLOGENEI C HSCT ACQUI SI TI ON 0.000000 0 0 0 77 78. 00 07800 CAR T - CELL I MMUNOTHERAPY 0.000000 15, 486, 184 0 3, 263, 469 0 78 90. 00 09000 CLINI C 0.000000 164, 710 0 3, 936, 236 0 90	70.00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	2, 713, 582		0 3, 351, 581	0	70.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 0.000614 54, 643, 751 33, 551 171, 457, 423 105, 275 73 74. 00 07400 RENAL DI ALYSI S 0.000000 3, 000, 592 0 76, 707 0 74 76. 97 07697 CARDI AC REHABILITATION 0.000000 39, 922 0 1, 367, 591 0 76 77. 00 07700 ALLOGENEIC HSCT ACQUISITION 0.000000 0 0 0 77 78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0.000000 15, 486, 184 0 3, 263, 469 0 78 90. 00 09000 CLINIC 0.000000 164, 710 0 3, 936, 236 0 90	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	49, 814, 599		0 27, 594, 162	0	71.00
74. 00 07400 RENAL DI ALYSI S 0.000000 3,000,592 0 76,707 0 74 76. 97 07697 CARDI AC REHABI LI TATI ON 0.000000 39,922 0 1,367,591 0 76 77. 00 07700 ALLOGENEI C HSCT ACQUI SI TI ON 0.000000 0 0 0 77 78. 00 07800 CAR T-CELL I MMUNOTHERAPY 0.000000 15,486,184 0 3,263,469 0 78 90. 00 09000 CLI NI C 0.000000 164,710 0 3,936,236 0 90	72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	38, 456, 984		0 15, 599, 522	0	72.00
76. 97 07697 CARDI AC REHABI LI TATI ON 0.000000 39, 922 0 1, 367, 591 0 76 77. 00 07700 ALLOGENEI C HSCT ACQUI SI TI ON 0.000000 0 0 0 77 78. 00 07800 CAR T-CELL I MMUNOTHERAPY 0.000000 15, 486, 184 0 3, 263, 469 0 78 90. 00 09000 CLI NI C 0.000000 164, 710 0 3, 936, 236 0 90	73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000614	54, 643, 751	33, 5	51 171, 457, 423	105, 275	73.00
77. 00 07700 ALLOGENEIC HSCT ACQUI SI TI ON 0.000000 0 0 0 77 78. 00 07800 CAR T-CELL I MMUNOTHERAPY 0.000000 15, 486, 184 0 3, 263, 469 0 78 90. 00 09000 CLINIC 0.000000 164, 710 0 3, 936, 236 0 90	74.00 07400 RENAL DIALYSIS	0. 000000	3, 000, 592		0 76, 707	0	74.00
78. 00 07800 CAR_T-CELL IMMUNOTHERAPY 0.000000 15, 486, 184 0 3, 263, 469 0 78 90. 00 09000 CLINIC 0.000000 164, 710 0 3, 936, 236 0 90	76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000	39, 922		0 1, 367, 591	0	76.97
OUTPATI ENT_SERVICE_COST_CENTERS 90. 00 09000 CLINIC 0.000000 164, 710 0 3, 936, 236 0 90	77.00 07700 ALLOGENEIC HSCT ACQUISITION	0. 000000	0		0 0	0	77.00
90. 00 09000 CLINIC 0. 000000 164, 710 0 3, 936, 236 0 90	78.00 07800 CAR T-CELL IMMUNOTHERAPY	0. 000000	15, 486, 184		0 3, 263, 469	0	78.00
	OUTPATIENT SERVICE COST CENTERS						
90. 01 09001 I BMT JOINT VENTURE 0. 00000 434, 138 0 1, 524, 012 0 90	90. 00 09000 CLINIC	0. 000000	164, 710		0 3, 936, 236	0	90.00
	90.01 09001 IBMT JOINT VENTURE	0. 000000	434, 138		0 1, 524, 012	0	90.01
90. 02 09002 MOORESVILLE INFUSION CLINIC 0. 000000 0 129, 175 0 90	90.02 09002 MOORESVILLE INFUSION CLINIC	0. 000000	0		0 129, 175	0	90.02
90. 05 09005 CV DLAGNOSTI C SERVICES 0. 000000 195, 328 0 29, 991, 597 0 90	90.05 09005 CV DIAGNOSTIC SERVICES	0. 000000	195, 328		0 29, 991, 597	0	90.05
		0. 001018	38, 734, 863	39, 43	32 28, 439, 533	28, 951	91.00
	92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	5, 719, 833				92.00
200.00 Total (Lines 50 through 199) 411, 888, 255 112, 905 465, 112, 635 155, 449 200	200.00 Total (lines 50 through 199)		411, 888, 255	112, 90	05 465, 112, 635	155, 449	200.00

Health Financial Systems F	RANCI SCAN HEALT	H INDIANAPOLIS		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	O VACCINE COST	Provider CO	CN: 15-0162	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part V Date/Time Pre 3/28/2024 2:2	epared:
		Title	e XVIII	Hospi tal	PPS	
			Charges		Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
	Ratio From	Services (see	Reimbursed	Rei mbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins			
	1.00	2.00	(see inst.)	(see inst.) 4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
50. 00 05000 OPERATI NG ROOM	0. 123072	31, 451, 387		0 0	3, 870, 785	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0. 123072			0 0	487	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 083725		19		4, 066, 058	
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 110583			0 0	3, 211, 669	
56. 00 05600 RADI OI SOTOPE	0. 056058			0 0	91, 316	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 039145			0 0	1, 266, 888	
60. 00 06000 LABORATORY	0. 124706			0 0	1, 262, 270	
64.00 06400 I NTRAVENOUS THERAPY	0. 095630			0 0	1, 475, 245	
65. 00 06500 RESPI RATORY THERAPY	0. 210291	2, 248, 362		0 0	472, 810	
66. 00 06600 PHYSI CAL THERAPY	0. 166441	82, 620		0 0	13, 751	
67.00 06700 OCCUPATI ONAL THERAPY	0. 125719			0 0	3, 547	
68.00 06800 SPEECH PATHOLOGY	0. 155658			0 0	3, 642	
69. 00 06900 ELECTROCARDI OLOGY	0. 082633	4, 684, 692		0 0	387, 110	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0. 112318			0 0	376, 443	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 251532	27, 594, 162	69	99 0	6, 940, 815	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 281372	15, 599, 522		0 0	4, 389, 269	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 174497	171, 457, 423	2, 39	84, 040	29, 918, 806	73.00
74.00 07400 RENAL DIALYSIS	0. 262144	76, 707		0 0	20, 108	74.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 173803	1, 367, 591		0 0	237, 691	76.97
77.00 07700 ALLOGENEIC HSCT ACQUISITION	2. 464630			0 0	0	
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0. 204493	3, 263, 469		0 0	667, 357	78.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0. 647106			0 0	2, 547, 162	
90. 01 09001 I BMT JOINT VENTURE	0. 173618			0 0	264, 596	
90. 02 09002 MOORESVILLE INFUSION CLINIC	0. 105309			0 0	13, 603	
90. 05 09005 CV DI AGNOSTI C SERVI CES	0. 124215			0	3, 725, 406	
91.00 09100 EMERGENCY	0. 072654			0 0	2,066,246	
92.00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART	0. 246575			0 0	668, 541	
200.00 Subtotal (see instructions)		465, 112, 635	3, 28		67, 961, 621	200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges				0 0		201.00
202.00 Net Charges (line 200 - line 201)		465, 112, 635	3, 28	84, 040	67, 961, 621	202 00
202.00 met charges (The 200 - The 201)	1	400, 112, 000	1 3, 20	04, 040	07, 701, 021	202.00

Health Financial Systems F	RANCI SCAN HEALTH	H INDIANAPOLIS		In Lie	u of Form CMS	-2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AN	D VACCINE COST	Provider C		Period: From 01/01/2023 To 12/31/2023	Worksheet D Part V Date/Time Pr 3/28/2024 2:	repared: 21 pm
		Title	XVIII	Hospi tal	PPS	
	Cos	ts				
Cost Center Description	Cost	Cost				
	Reimbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
		Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7.00				
ANCI LLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0	0				50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0				52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	16	0				54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0				55.00
56. 00 05600 RADI 0I SOTOPE	0	0				56.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0				59.00
60. 00 06000 LABORATORY	0	0				60.00
64.00 06400 INTRAVENOUS THERAPY	0	0				64.00
65. 00 06500 RESPI RATORY THERAPY	0	0				65.00
66. 00 06600 PHYSI CAL THERAPY	0	0				66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0				67.00
68.00 06800 SPEECH PATHOLOGY	0	0				68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0				69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0				70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	176	0				71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0				72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	418	14, 665				73.00
74. 00 07400 RENAL DIALYSIS	0	000				74.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0				76.9
77. 00 07700 ALLOGENEIC HSCT ACQUISITION	0	0	•			77.00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0	0				78.00
OUTPATIENT SERVICE COST CENTERS	0	0	1			/0.00
90. 00 09000 CLINIC	0	0				90.00
90. 00 09000 CEINIC 90. 01 09001 IBMT JOINT VENTURE	0	0				90.00
90.02 09002 MOORESVILLE INFUSION CLINIC	0	0				90.02
90. 02 09002 MODRESVILLE INFOSTOR CLINIC 90. 05 09005 CV DIAGNOSTIC SERVICES	0	0				90.02
	0	0				
91.00 09100 EMERGENCY	0	0				91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	-				92.00
200.00 Subtotal (see instructions)	610	14, 665				200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201.00
Only Charges	(10)	14 // 5				000 00
202.00 Net Charges (line 200 - line 201)	610	14, 665	1			202.00

	FRANCI SCAN HEALT				u of Form CMS-2	2552-1
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT	AL CUSIS	Provider C	JN: 15-0162	Period: From 01/01/2023	Worksheet D Part II	
		Component	CCN: 15-T162	To 12/31/2023		pared: 1 pm
		Title	XVIII	Subprovider - IRF	PPS	•
Cost Center Description	Capi tal	Total Charges	Ratio of Cos		Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,				column 4)	
	Part II, col.	8)	2)	0	,	
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS						
50. 00 05000 OPERATING ROOM	7, 878, 561	350, 269, 426	0. 02249	93 132, 718	2, 985	
52.00 05200 DELIVERY ROOM & LABOR ROOM	2, 066, 361				0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	4, 550, 880				6, 496	
55. 00 05500 RADI OLOGY-THERAPEUTI C	295, 153	112, 966, 617				55.0
56. 00 05600 RADI OI SOTOPE	88, 808		0. 00865			56.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	1, 774, 756				154	
60. 00 06000 LABORATORY	2, 318, 719				6, 261	
64.00 06400 INTRAVENOUS THERAPY	978, 189					
65. 00 06500 RESPI RATORY THERAPY	369, 578					
66. 00 06600 PHYSI CAL THERAPY	872, 235				41, 106	66.00
67.00 06700 OCCUPATI ONAL THERAPY	14, 293					
68.00 06800 SPEECH PATHOLOGY	148, 658					
69. 00 06900 ELECTROCARDI OLOGY	1, 279, 003					
70. 00 07000 ELECTROENCEPHALOGRAPHY	325, 058					
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 302, 546					
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	761, 340					
73.00 07300 DRUGS CHARGED TO PATIENTS	971, 163				1, 126	
74.00 07400 RENAL DIALYSIS	262, 489					
76. 97 07697 CARDI AC REHABI LI TATI ON	3, 461					
77.00 07700 ALLOGENEIC HSCT ACQUISITION	132, 821					77.00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	4, 684	40, 148, 936	0.0001	17 0	0	78.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	1, 471, 188				1	
90. 01 09001 I BMT JOI NT VENTURE	139, 448					
90. 02 09002 MOORESVILLE INFUSION CLINIC	9, 739					
90. 05 09005 CV DIAGNOSTIC SERVICES	59, 243				0	90.0
91. 00 09100 EMERGENCY	3, 639, 489				336	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0					-
200.00 Total (lines 50 through 199)	31, 717, 863	3, 453, 847, 766		10, 296, 077	82, 779	200. 0

Health Financial Systems F	RANCISCAN HEALT	H INDIANAPOLIS			In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PASS	S Provider C	CN: 15-0162	Peri od		Worksheet D	
THROUGH COSTS		Component	CCN: 15-T162		1/01/2023 2/31/2023		nared
		component	CCN. 13-1102		2/ 51/ 2025	3/28/2024 2:2	
		Title	e XVIII		ovider -	PPS	
					IRF		
Cost Center Description	Non Physician	Nursi ng	Nursi ng			Allied Health	
	Anestheti st	Program Post-Stepdown	Program		-Stepdown ustments		
	Cost	Adj ustments		Adji	ustments		
	1.00	2A	2.00		3A	3.00	
ANCI LLARY SERVI CE COST CENTERS							
50. 00 05000 OPERATI NG ROOM	0	0		0	0	217, 938	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0	0	0	52.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0	0	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0	0	0	55.00
56. 00 05600 RADI OI SOTOPE	0	0		0	0	0	56.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0	0	0	59.00
60. 00 06000 LABORATORY	0	0		0	0	48, 772	60.00
64.00 06400 I NTRAVENOUS THERAPY	0	0		0	0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0	0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0	0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0		0	0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0	0		0	0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0	0	0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0	0	0	70.00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT	0	0		0	0	0	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	0	72.00 73.00
73.00 07300 DR0GS CHARGED TO PATTENTS 74.00 07400 RENAL DIALYSIS	0	0		0	0	443, 072 0	73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		0	0		76.97
77. 00 07700 ALLOGENEI C HSCT ACQUISITION	0	0		0	0	0	77.00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0	0		0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS	0	0		0	0	0	70.00
90. 00 09000 CLINIC	0	0		0	0	0	90.00
90. 01 09001 I BMT JOINT VENTURE	0	0		0	0	0	90.01
90. 02 09002 MOORESVILLE INFUSION CLINIC	0	0		0	0	0	90.02
90. 05 09005 CV DI AGNOSTI C SERVI CES	0	0		0	0	0	90.05
91. 00 09100 EMERGENCY	0	0		0	0	356, 711	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0			0		0	92.00
200.00 Total (lines 50 through 199)	0	0		0	0	1, 066, 493	200. 00

	RANCI SCAN HEALT			In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PASS	S Provider C		Peri od:	Worksheet D	
THROUGH COSTS				From 01/01/2023		
		Component	CCN: 15-T162	To 12/31/2023	Date/Time Pre 3/28/2024 2:2	
		Title	XVIII	Subprovider -	PPS	
				I RF		
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,	to Charges	
	Education Cost	1, 2, 3, and	Cost (sum of	Part I, col.	(col. 5 ÷ col.	
		4)	cols. 2, 3,	8)	7)	
			and 4)		(see	
					instructions)	
	4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS	-					
50.00 05000 OPERATI NG ROOM	0	217, 938	217, 93			
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 48, 971, 664	0.000000	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 371, 800, 783	0.000000	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0 112, 966, 617	0.000000	55.00
56. 00 05600 RADI OI SOTOPE	0	0		0 10, 261, 587	0.000000	56.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 193, 125, 396	0. 000000	59.00
60. 00 06000 LABORATORY	0	48, 772	48, 77	2 296, 599, 274	0. 000164	60.00
64.00 06400 INTRAVENOUS THERAPY	0	0	1	0 78, 887, 275	0. 000000	64.00
65. 00 06500 RESPI RATORY THERAPY	0	0	1	0 66, 653, 414	0. 000000	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0	1	0 58, 913, 287	0. 000000	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 28, 977, 341	0. 000000	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0 13, 641, 682	0.000000	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 53, 453, 217	0.000000	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 29, 329, 127	0. 000000	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 283, 313, 855	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 154, 457, 585	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	443, 072	443, 07	2 721, 591, 548	0.000614	73.00
74.00 07400 RENAL DI ALYSI S	0	0		0 9, 179, 437	0. 000000	74.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		0 4, 428, 567	0. 000000	76.97
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0		0 921, 931	0. 000000	77.00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0	0		0 40, 148, 936	0. 000000	78.00
OUTPATIENT SERVICE COST CENTERS						1
90. 00 09000 CLINIC	0	0		0 17, 838, 621	0.00000	90.00
90.01 09001 I BMT JOINT VENTURE	0	0		0 12, 927, 809		•
90.02 09002 MOORESVILLE INFUSION CLINIC	0	0		0 575, 175		
90. 05 09005 CV DIAGNOSTIC SERVICES	0	0		0 98, 546, 680	0. 000000	90.05
91.00 09100 EMERGENCY	0	356, 711	356, 71			
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		0 45, 723, 806		92.00
200.00 Total (lines 50 through 199)	0	1, 066, 493	1, 066, 49	3 3, 453, 847, 766		200.00
		.,,.,.,	.,,		I	

Health Financial Systems	FRANCI SCAN HEALTH	I NDI ANAPOLI S		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PASS	Provider C	CN: 15-0162	Peri od:	Worksheet D	
THROUGH COSTS		Component	CON. 15 T1()	From 01/01/2023 To 12/31/2023	Part IV	norod.
		Component (CCN: 15-T162	To 12/31/2023	Date/Time Pre 3/28/2024 2:2	pared: 1 nm
		Title	× XVIII	Subprovider -	PPS	
				I RF		
Cost Center Description	Outpati ent	Inpati ent	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Throug		Pass-Through	
	(col. 6 ÷ col.		Costs (col.	8	Costs (col. 9	
	7)	10.00	x col. 10)	10.00	x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCI LLARY SERVI CE COST CENTERS	0.000(00)	100 710	1		0	50.00
50. 00 05000 OPERATI NG ROOM	0. 000622	132, 718		83 0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0 0	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	530, 692		0 0	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000	12, 006		0 0	0	55.00
56. 00 05600 RADI OI SOTOPE	0. 000000	8, 674		0 0	0	56.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	16, 768		0 0	0	59.00
60. 00 06000 LABORATORY	0. 000164	800, 884		31 0	0	60.00
64.00 06400 I NTRAVENOUS THERAPY	0. 000000	11, 886		0 0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	515, 752		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	2, 776, 486		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000	2, 490, 040		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	950, 049		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	54, 253		0 0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	5, 257		0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	983, 751		0 0	0	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000	6, 451		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000614	836, 751		14 318		73.00
74.00 07400 RENAL DI ALYSI S	0. 000000	129, 666		0 0	0	74.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000	946		0 0	0	76.97
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0. 000000	0		0 0	0	77.00
78.00 O7800 CAR T-CELL IMMUNOTHERAPY	0. 000000	0		0 0	0	78.00
OUTPATIENT SERVICE COST CENTERS			1	-	-	
90. 00 09000 CLI NI C	0. 000000	7		0 0	0	90.00
90. 01 09001 I BMT JOI NT VENTURE	0. 000000	2		0 0	0	90.01
90. 02 09002 MOORESVILLE INFUSION CLINIC	0. 000000	0		0 0	0	90.02
90. 05 09005 CV DI AGNOSTI C SERVI CES	0. 000000	701		0 0	0	90.05
91.00 09100 EMERGENCY	0. 001018	32, 337		33 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	0	_	0 0	0	92.00
200.00 Total (lines 50 through 199)		10, 296, 077	1 7	61 318	0	200.00

Health Fina	ncial Systems F	RANCISCAN HEALT	H INDIANAPOLIS		In Lie	u of Form CMS-	2552-10
APPORTI ONME	ENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C	CN: 15-0162	Peri od:	Worksheet D	
			Comment	20N 15 T1/2	From 01/01/2023	Part V	
			component	CCN: 15-T162	To 12/31/2023	Date/Time Pre 3/28/2024 2:2	21 nm
			Title	XVIII	Subprovider -	PPS	
					IRF		
				Charges		Costs	
	Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
		Ratio From	Services (see	Reimbursed	Reimbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins			
				(see inst.)	(see inst.)		
		1.00	2.00	3.00	4.00	5.00	
	LLARY SERVICE COST CENTERS	0.100070	-				
	O OPERATING ROOM	0. 123072	0		0 0	C	
	O DELIVERY ROOM & LABOR ROOM	0. 184449	0		0 0	C	
	0 RADI OLOGY-DI AGNOSTI C	0.083725	0		0 0	C	
	0 RADI OLOGY-THERAPEUTI C	0. 110583	0		0 0	C	
	O RADI OI SOTOPE	0. 056058	0		0 0	C	
	O CARDI AC CATHETERI ZATI ON	0. 039145	0		0 0	C	
		0. 124706	0		0 0	C	
	O I NTRAVENOUS THERAPY	0.095630	0		0 0	C	
	O RESPIRATORY THERAPY	0. 210291	0		0 0	C	
	O PHYSI CAL THERAPY	0. 166441	0		0 0	C	1
	0 OCCUPATIONAL THERAPY	0. 125719	0		0 0	C	
	O SPEECH PATHOLOGY	0. 155658	0		0 0	C	
	O ELECTROCARDI OLOGY	0. 082633	0		0 0	C	
		0. 112318	0			C	
	O MEDICAL SUPPLIES CHARGED TO PATIENT O I MPL. DEV. CHARGED TO PATIENTS	0. 251532	0			C	
	O DRUGS CHARGED TO PATIENTS	0. 281372	318		0 0 0 355	C	
	ORENAL DIALYSIS	0. 174497 0. 262144	318		0 355	55	1
	7 CARDIAC REHABILITATION				-	-	
		0. 173803 2. 464630	0		0 0		
	O ALLOGENEIC HSCT ACQUISITION	0. 204493	0		0 0		
	O CAR T-CELL IMMUNOTHERAPY ATIENT SERVICE COST CENTERS	0. 204493	0		0 0	L C	/ /8.00
	O CLINIC	0. 647106	0		0 0	C	90, 00
	1 I BMT JOINT VENTURE	0. 173618	0		0 0	C	
	2 MOORESVILLE INFUSION CLINIC	0. 173018	0		0 0	C	
	5 CV DIAGNOSTIC SERVICES	0. 124215	0		0 0	C	
	0 EMERGENCY	0. 072654	0		0 0		
	O OBSERVATION BEDS (NON-DISTINCT PART	0. 246575	0		0 0		
200.00	Subtotal (see instructions)	0.240070	318		0 355	-	200.00
201.00	Less PBP Clinic Lab. Services-Program		510		0 0		200.00
201.00	Only Charges						
202.00	Net Charges (line 200 - line 201)		318		0 355	55	202.00
•							

	RANCI SCAN HEALT				u of Form CMS-2552
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AN	D VACCINE COST	Provider C	CN: 15-0162	Period: From 01/01/2023	Worksheet D Part V
		Component	CCN: 15-T162	To 12/31/2023	Date/Time Prepare 3/28/2024 2:21 pm
		Title	e XVIII	Subprovider - IRF	PPS
		sts	-	· .	
Cost Center Description	Cost	Cost			
	Reimbursed	Reimbursed			
	Servi ces	Services Not			
	Subject To	Subject To			
		Ded. & Coins.			
	(see inst.)	(see inst.)	-		
ANCI LLARY SERVICE COST CENTERS	6.00	7.00			
50. 00 05000 OPERATI NG ROOM	C	C			50.
2.00 05200 DELIVERY ROOM & LABOR ROOM			•		50.
44. 00 05400 RADI OLOGY-DI AGNOSTI C		-			54.
5. 00 05500 RADI OLOGY-THERAPEUTI C		0			55.
6. 00 05600 RADI OI SOTOPE		0			56.
9.00 05900 CARDI AC CATHETERI ZATI ON		0			59.
		0			60.
4.00 06400 I NTRAVENOUS THERAPY		0			64.
5. 00 06500 RESPI RATORY THERAPY		0			65.
6. 00 06600 PHYSI CAL THERAPY		0			66.
7.00 06700 OCCUPATIONAL THERAPY		0			67.
08.00 06800 SPEECH PATHOLOGY		0			68.
		0			69.
0. 00 07000 ELECTROENCEPHALOGRAPHY		0			70.
1.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT		0			71.
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0			72.
3. 00 07300 DRUGS CHARGED TO PATIENTS		62 0			73.
4. 00 07400 RENAL DIALYSIS					74.
6. 97 07697 CARDI AC REHABI LI TATI ON		0			76.
7. 00 07700 ALLOGENEI C HSCT ACQUI SI TI ON	C	-			77.
8.00 07800 CAR T-CELL IMMUNOTHERAPY OUTPATIENT SERVICE COST CENTERS	C	0 0			78.
0. 00 09000 CLINIC	C				
					90.
					90.
0.02 09002 MOORESVILLE INFUSION CLINIC					90.
0. 05 09005 CV DI AGNOSTI C SERVI CES					90.
1.00 09100 EMERGENCY 2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART			•		91.
			•		
200.00 Subtotal (see instructions)		62			200.
201.00 Less PBP Clinic Lab. Services-Program					201.
0nly Charges 202.00 Net Charges (line 200 - line 201)	C	40			202.
.02.00 INEL CIALGES (THE 200 - THE 201)	I U	62	I.		202.

Health Financial Systems	FRANCI SCAN HEALT	H INDIANAPOLIS	i	In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAP	ITAL COSTS	Provider C		Period: From 01/01/2023 Fo 12/31/2023	Date/Time Pre 3/28/2024 2:2	pared: 1 pm
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col. 1 - col			
	26)		2)			
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	11, 162, 716	0	11, 162, 71	6 80, 754	138.23	30.00
31.00 INTENSIVE CARE UNIT	1, 680, 215		1, 680, 21	5 9, 951	168.85	31.00
31.01 NEONATAL INTENSIVE CARE UNIT	1, 242, 705		1, 242, 70	5 6, 794	182. 91	31.01
32.00 CORONARY CARE UNIT	3, 743, 385		3, 743, 38	5 13, 517	276.94	32.00
34.00 SURGICAL INTENSIVE CARE UNIT	1, 916, 076		1, 916, 07	6 8, 001	239.48	34.00
41.00 SUBPROVIDER – IRF	1, 323, 140	0	1, 323, 14	5, 986	221.04	41.00
43.00 NURSERY	179, 680		179, 68	3, 459	51.95	43.00
200.00 Total (lines 30 through 199)	21, 247, 917		21, 247, 91	7 128, 462		200.00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	715					30.00
31.00 INTENSIVE CARE UNIT	100					31.00
31.01 NEONATAL INTENSIVE CARE UNIT	68					31.01
32.00 CORONARY CARE UNI T	136					32.00
34.00 SURGICAL INTENSIVE CARE UNIT	80					34.00
41.00 SUBPROVIDER - IRF	21	4, 642				41.00
43.00 NURSERY	35					43.00
200.00 Total (lines 30 through 199)	1, 155	191, 439	1			200.00

Health Financial Systems F	RANCI SCAN HEALT	H INDIANAPOLIS		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT.	AL COSTS	Provider C		Period: From 01/01/2023	Worksheet D Part II	
				To 12/31/2023	Date/Time Pre 3/28/2024 2:2	pared: 1 pm
			e XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,			. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	1		1		-	
50.00 05000 OPERATING ROOM	7, 878, 561					•
52.00 05200 DELIVERY ROOM & LABOR ROOM	2, 066, 361					•
54.00 05400 RADI OLOGY-DI AGNOSTI C	4, 550, 880					
55. 00 05500 RADI OLOGY-THERAPEUTI C	295, 153					
56. 00 05600 RADI OI SOTOPE	88, 808					
59. 00 05900 CARDI AC CATHETERI ZATI ON	1, 774, 756					
60. 00 06000 LABORATORY	2, 318, 719	296, 599, 274	0. 00781	8 25, 171, 994	196, 795	60.00
64.00 06400 INTRAVENOUS THERAPY	978, 189	78, 887, 275	0. 01240	0 1, 105, 336	13, 706	64.00
65. 00 06500 RESPI RATORY THERAPY	369, 578	66, 653, 414	0. 00554	5 9, 146, 231	50, 716	65.00
66. 00 06600 PHYSI CAL THERAPY	872, 235	58, 913, 287	0. 01480	2, 307, 340	34, 160	66.00
67.00 06700 OCCUPATI ONAL THERAPY	14, 293	28, 977, 341	0. 00049	3 2, 044, 112	1, 008	67.00
68.00 06800 SPEECH PATHOLOGY	148, 658	13, 641, 682	0. 01089	7 1, 223, 909	13, 337	68.00
69. 00 06900 ELECTROCARDI OLOGY	1, 279, 003	53, 453, 217	0. 02392	4, 530, 720	108, 411	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	325, 058	29, 329, 127	0. 01108	3 2, 138, 111	23, 697	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 302, 546	283, 313, 855	0. 00459	22, 709, 267	104, 417	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	761, 340	154, 457, 585	0. 00492	9 6, 667, 088	32, 862	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	971, 163	721, 591, 548	0. 00134	6 29, 080, 542	39, 142	73.00
74.00 07400 RENAL DI ALYSI S	262, 489	9, 179, 437	0. 02859	5 1, 273, 780	36, 424	74.00
76. 97 07697 CARDIAC REHABILITATION	3, 461	4, 428, 567	0. 00078	2 19, 319		
77.00 07700 ALLOGENEIC HSCT ACQUISITION	132, 821					77.00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	4,684	40, 148, 936	0. 00011	7 0	0	78.00
OUTPATIENT SERVICE COST CENTERS	· · · ·		•			1
90. 00 09000 CLI NI C	1, 471, 188	17, 838, 621	0. 08247	2 289, 102	23, 843	90.00
90. 01 09001 I BMT JOINT VENTURE	139, 448					
90.02 09002 MOORESVILLE INFUSION CLINIC	9, 739					
90. 05 09005 CV DI AGNOSTI C SERVI CES	59, 243				21	90.05
91. 00 09100 EMERGENCY	3, 639, 489					
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 342, 911					92.00
200.00 Total (lines 50 through 199)		3, 453, 847, 766		192, 214, 190		•
			•			1

Health Financial Systems	FRANCI SCAN HEALTH				eu of Form CMS-	2552-1
APPORTIONMENT OF INPATIENT ROUTINE SERVICE O	THER PASS THROUGH COST			Period: From 01/01/2023 To 12/31/2023		epared: 21 pm
			e XIX	Hospi tal	PPS	
Cost Center Description	Nursi ng	Nursi ng		h Allied Health	All Other	
	Program	Program	Post-Stepdow		Medi cal	
	Post-Stepdown		Adjustments		Education Cost	
	Adjustments					
	1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS			1	-		
30. 00 03000 ADULTS & PEDI ATRI CS	0	C		0 0	-	
31.00 03100 INTENSIVE CARE UNIT	0	C)	0 0	-	
31.01 02060 NEONATAL INTENSIVE CARE UNIT	0	C)	0 0	0	00
32.00 03200 CORONARY CARE UNI T	0	C)	0 0	0	02.00
34.00 03400 SURGICAL INTENSIVE CARE UNIT	0	C)	0 0	0	000
41.00 04100 SUBPROVIDER - IRF	0	C		0 0	0	1
43.00 04300 NURSERY	0	C		0 0	0	
200.00 Total (lines 30 through 199)	0	C)	0 0		200.00
Cost Center Description	Swi ng-Bed	Total Costs		t Per Diem (col.	Inpati ent	
	Adj ustment	(sum of cols.	Days	5 ÷ col. 6)	Program Days	
	Amount (see	1 through 3,				
		minus col. 4)				
	4.00	5.00	6.00	7.00	8.00	-
INPATIENT ROUTINE SERVICE COST CENTERS						1
30. 00 03000 ADULTS & PEDI ATRI CS	0	C				
31.00 03100 I NTENSI VE CARE UNI T		C	9, 9			
31.01 02060 NEONATAL INTENSIVE CARE UNIT		C	6, 79			
32.00 03200 CORONARY CARE UNIT		C	13, 5			
34.00 03400 SURGICAL INTENSIVE CARE UNIT		C	8,00			
41.00 04100 SUBPROVIDER - IRF	0	C	5, 98			
43.00 04300 NURSERY		C	3, 45			
200.00 Total (lines 30 through 199)		C	128, 40	52	1, 155	200.00
Cost Center Description	Inpati ent					
	Program					
	Pass-Through					
	Cost (col. 7 x					
	<u>col. 8)</u> 9.00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0					30.00
31. 00 03100 I NTENSI VE CARE UNI T	0					31.00
31. 01 02060 NEONATAL INTENSIVE CARE UNIT	0					31.00
	0					
32. 00 03200 CORONARY CARE UNIT	0					32.00
34. 00 03400 SURGI CAL I NTENSI VE CARE UNI T	-					34.00
41. 00 04100 SUBPROVIDER - IRF	0					41.00
43.00 04300 NURSERY	0					43.00
200.00 Total (lines 30 through 199)	0					200.00

Health Financial Systems FF	RANCISCAN HEALT	H INDIANAPOLIS			In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER THROUGH COSTS	VICE OTHER PASS	6 Provider CC	CN: 15-0162		riod: om 01/01/2023 12/31/2023	Worksheet D Part IV Date/Time Pre 3/28/2024 2:2	pared: 1 pm
		Ti tl	e XIX		Hospi tal	PPS	
Cost Center Description	Non Physician Anesthetist	Nursing Program	Nursi ng Program		Allied Health Post-Stepdown	Allied Health	
	Cost	Post-Stepdown Adjustments	-		Adjustments		
	1.00	2A	2.00		3A	3.00	
ANCI LLARY SERVI CE COST CENTERS							
50. 00 05000 OPERATI NG ROOM	0	0		0	0	217, 938	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0	0	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0	0	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0	1	0	0	0	55.00
56. 00 05600 RADI OI SOTOPE	0	0		0	0	0	56.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0	0	0	59.00
60. 00 06000 LABORATORY	0	0		0	0	48, 772	60.00
64. 00 06400 I NTRAVENOUS THERAPY	0	0		0	0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0	0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0	0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0	0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0	0	0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0	0	0	70.00
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	443, 072	73.00
74.00 07400 RENAL DIALYSIS	0	0		0	0	0	74.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		0	0	0	76. 97
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
OUTPATIENT SERVICE COST CENTERS			1				
90. 00 09000 CLINIC	0	0		0	0	0	90.00
90. 01 09001 I BMT JOI NT VENTURE	0	0		0	0	0	90.01
90. 02 09002 MOORESVILLE INFUSION CLINIC	0	0		0	0	0	90. 02
90. 05 09005 CV DI AGNOSTI C SERVI CES	0	0		0	0	0	90.05
91. 00 09100 EMERGENCY	0	0		0	0	356, 711	91.00
92.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART	0	-		0	_	0	92.00
200.00 Total (lines 50 through 199)	0	0		0	0	1, 066, 493	200.00

Health Financial Systems F	RANCI SCAN HEALT	H INDIANAPOLIS		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS		S Provider C	Provider CCN: 15-0162		Worksheet D	
THROUGH COSTS				From 01/01/2023 To 12/31/2023	Part IV	narod:
				10 12/31/2023	Date/Time Prepared: 3/28/2024 2:21 pm	
		Titl	Title XIX		PPS	
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,	to Charges	
	Education Cost	1, 2, 3, and	Cost (sum of		(col. 5 ÷ col.	
		4)	cols. 2, 3,	8)	7)	
			and 4)		(see	
	4.00	F 00	(00	7.00	instructions)	
	4.00	5.00	6.00	7.00	8.00	
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM	0	217 020	217.02	0 250 260 426	0. 000622	50.00
50.00 05000 OPERATING ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM	0	217, 938				
	0	0		0 48, 971, 664 0 371, 800, 783		
54. 00 05400 RADI OLOGY-DI AGNOSTI C 55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0 371,800,783	0.000000	
56. 00 05600 RADIOLOGY-THERAPEUTIC	0	0		0 112, 966, 617		
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 193, 125, 396		
60. 00 06000 LABORATORY	0	48, 772				60.00
64. 00 06400 INTRAVENOUS THERAPY	0	40, 772		2 290, 599, 274 0 78, 887, 275		
65. 00 06500 RESPIRATORY THERAPY	0	0		0 66, 653, 414		•
66. 00 06600 PHYSI CAL THERAPY	0	0		0 58, 913, 287	0.000000	•
67. 00 06700 OCCUPATI ONAL THERAPY	0			0 28, 977, 341	0.000000	
68. 00 06800 SPEECH PATHOLOGY	0			0 13, 641, 682		
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 53, 453, 217		•
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 29, 329, 127	0.000000	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 283, 313, 855	0.000000	•
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 154, 457, 585	0. 000000	•
73.00 07300 DRUGS CHARGED TO PATIENTS	0	443,072	443, 07			
74.00 07400 RENAL DIALYSIS	0	0		0 9, 179, 437	0.000000	74.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		0 4, 428, 567	0.000000	76.97
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0		0 921, 931	0.000000	77.00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0	0		0 40, 148, 936	0. 000000	78.00
OUTPATIENT SERVICE COST CENTERS		•				1
90. 00 09000 CLI NI C	0	0		0 17, 838, 621	0.000000	90.00
90. 01 09001 IBMT JOINT VENTURE	0	0		0 12, 927, 809	0.000000	90.01
90.02 09002 MOORESVILLE INFUSION CLINIC	0	0		0 575, 175		
90. 05 09005 CV DI AGNOSTI C SERVI CES	0	0		0 98, 546, 680		
91. 00 09100 EMERGENCY	0	356, 711	356, 71			
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		0 45, 723, 806		
200.00 Total (lines 50 through 199)	0	1, 066, 493	1, 066, 49	3 3, 453, 847, 766		200. 00

Health Financial Systems F	RANCI SCAN HEALTH	I NDI ANAPOLI S		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS		Provider CCN: 15-0162		Peri od:	Worksheet D	
THROUGH COSTS				From 01/01/2023	Part IV	
				To 12/31/2023	Date/Time Pre 3/28/2024 2:2	pared:
		Title XIX		Hospi tal PPS		трш
Cost Center Description	Outpatient	Inpatient	Inpati ent	Outpati ent	Outpati ent	
Cost Center Description	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through		Pass-Through	
	$(col. 6 \div col.)$	ondrigeo	Costs (col.		Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9,00	10,00	11.00	12.00	13.00	
ANCI LLARY SERVI CE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0.000622	24, 555, 234	15, 2	73 0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	16, 554, 780		0 0	0	52.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	16, 209, 234		0 0	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000	232, 151		0 0	0	55.00
56. 00 05600 RADI 0I SOTOPE	0. 000000	346, 125		0 0	0	56.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	8, 227, 533		0 0	0	59.00
60. 00 06000 LABORATORY	0.000164	25, 171, 994		28 0	0	60.00
64.00 06400 INTRAVENOUS THERAPY	0.000000	1, 105, 336		0 0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0.000000	9, 146, 231		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0.000000	2, 307, 340		0 0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0.000000	2,044,112		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0.000000	1, 223, 909		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0.000000	4, 530, 720		0 0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0,000000	2, 138, 111		0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	22, 709, 267		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0, 000000	6, 667, 088		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.000614	29, 080, 542		55 0	0	73.00
74.00 07400 RENAL DI ALYSI S	0,000000	1, 273, 780		0 0	0	74.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0.000000	19, 319		0 0	0	76.97
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			1			
90. 00 09000 CLI NI C	0.000000	289, 102		0 0	0	90.00
90. 01 09001 I BMT JOINT VENTURE	0.000000	9, 673		0 0	0	90.01
90.02 09002 MOORESVILLE INFUSION CLINIC	0.000000	0		0 0	0	90.02
90. 05 09005 CV DI AGNOSTI C SERVI CES	0.000000	34, 928		0 0	0	90.05
91.00 09100 EMERGENCY	0.001018	16, 655, 020	16, 9	55 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000	1, 682, 661		0 0	0	92.00
200.00 Total (lines 50 through 199)		192, 214, 190	54, 2	11 0	0	200.00

	RANCI SCAN HEALT				u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	D VACCINE COST	Provider C		Period: From 01/01/2023	Worksheet D Part V	
				To 12/31/2023	Date/Time Pre	pared:
					3/28/2024 2:2	1 pm
		Ti tl	e XIX	Hospi tal	PPS	
			Charges	0.1	Costs	
Cost Center Description	Cost to Charge			Cost	PPS Services	
	Ratio From Worksheet C,	Services (see inst.)	Reimbursed Services	Reimbursed Services Not	(see inst.)	
	Part I, col. 9		Subject To	Subject To		
	Fait I, COI. 7		Ded. & Coins			
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS		2100	0.00		0100	
50. 00 05000 OPERATI NG ROOM	0. 123072	0	23, 627, 05	5 0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 184449				0	52.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0.083725				0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 110583	0			0	55.00
56. 00 05600 RADI OI SOTOPE	0. 056058	0	947, 07	0 0	0	56.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 039145	0	7, 194, 33	8 0	0	59.00
60. 00 06000 LABORATORY	0. 124706				0	60.00
64.00 06400 INTRAVENOUS THERAPY	0. 095630	0	9, 779, 80	09 0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0. 210291	0	1, 732, 28	35 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 166441	0			0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0. 125719	0	2, 993, 93	31 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 155658	0	2, 504, 95	57 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 082633	0			0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0. 112318		4, 155, 17	0 /2	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 251532	0	12, 749, 42	25 0	0	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0. 281372	0	4, 699, 48	31 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 174497	0	50, 288, 39	03 0	0	73.00
74.00 07400 RENAL DIALYSIS	0. 262144	0	97, 27	2 0	0	74.00
76. 97 07697 CARDIAC REHABILITATION	0. 173803	0	210, 36	0	0	76.97
77.00 07700 ALLOGENEIC HSCT ACQUISITION	2.464630	0		0 0	0	77.00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0. 204493	0		0 0	0	78.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0. 647106				0	
90. 01 09001 I BMT JOINT VENTURE	0. 173618				0	
90.02 09002 MOORESVILLE INFUSION CLINIC	0. 105309				0	
90. 05 09005 CV DI AGNOSTI C SERVI CES	0. 124215				0	
91.00 09100 EMERGENCY	0. 072654				0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 246575	0			0	
200.00 Subtotal (see instructions)		0	308, 194, 25		0	200.00
201.00 Less PBP Clinic Lab. Services-Program				0 0		201.00
Only Charges		_	000 404 0		-	000 00
202.00 Net Charges (line 200 - line 201)	1	0	308, 194, 25	51 0	0	202.00

5	RANCI SCAN HEALT				u of Form CMS	-2552-1
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AN	D VACCINE COST	Provider CC	CN: 15-0162	Peri od: From 01/01/2023 To 12/31/2023	Worksheet D Part V Date/Time Pr 3/28/2024 2:	epared: 21 pm
		Titl	e XIX	Hospi tal	PPS	
	Cos					
Cost Center Description	Cost	Cost				
	Reimbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
		Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7.00				
ANCI LLARY SERVICE COST CENTERS		_				
50. 00 05000 OPERATI NG ROOM	2, 907, 829					50.0
2.00 05200 DELIVERY ROOM & LABOR ROOM	14, 331	0				52.0
4.00 05400 RADI OLOGY-DI AGNOSTI C	3, 602, 102	0				54.0
5. 00 05500 RADI OLOGY-THERAPEUTI C	1, 423, 522	0				55. C
6. 00 05600 RADI OI SOTOPE	53, 091	0				56. C
9. 00 05900 CARDI AC CATHETERI ZATI ON	281, 622					59.0
0. 00 06000 LABORATORY	3, 081, 994					60.0
4.00 06400 INTRAVENOUS THERAPY	935, 243	0				64.0
5. 00 06500 RESPI RATORY THERAPY	364, 284	0				65. C
6. 00 06600 PHYSI CAL THERAPY	1, 118, 507	0				66.0
7.00 06700 OCCUPATI ONAL THERAPY	376, 394	0				67.0
8.00 06800 SPEECH PATHOLOGY	389, 917	0				68.0
9. 00 06900 ELECTROCARDI OLOGY	176, 074	0				69.0
0.00 07000 ELECTROENCEPHALOGRAPHY	466, 701	0				70.0
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	3, 206, 888	0				71. (
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS	1, 322, 302	0				72. (
3.00 07300 DRUGS CHARGED TO PATIENTS	8, 775, 174	0				73. (
4.00 07400 RENAL DIALYSIS	25, 499	0				74. (
6. 97 07697 CARDI AC REHABI LI TATI ON	36, 561	0				76. 9
7.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0				77. (
8.00 07800 CAR T-CELL IMMUNOTHERAPY	0	0				78. (
OUTPATIENT SERVICE COST CENTERS						
0. 00 09000 CLINIC	2, 235, 841	0				90. (
0.01 09001 IBMT JOINT VENTURE	104, 565	0				90. (
0. 02 09002 MOORESVILLE INFUSION CLINIC	8, 480	0				90. (
0. 05 09005 CV DI AGNOSTI C SERVI CES	982, 180	0				90.0
1.00 09100 EMERGENCY	5, 847, 467	0				91.0
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 269, 195	0				92.0
00.00 Subtotal (see instructions)	39, 005, 763	0				200.0
01.00 Less PBP Clinic Lab. Services-Program	0					201.0
Only Charges						
02.00 Net Charges (line 200 - line 201)	39, 005, 763	0				202.0

	FRANCI SCAN HEALT				u of Form CMS-2	2552-1
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT	TAL COSTS	Provider C		Period: From 01/01/2023	Worksheet D Part II	
			CCN: 15-T162	To 12/31/2023	Date/Time Pre 3/28/2024 2:2	pared: 1 pm
		Ti tl	e XIX	Subprovider - IRF	PPS	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,			. Charges	column 4)	
	Part II, col.	8)	2)			
	26)	0.00	0.00	1.00	F 00	
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	7 070 5/4	050 0/0 40/	0.0004		47	1 50 0
50.00 05000 OPERATING ROOM	7, 878, 561					
52. 00 05200 DELIVERY ROOM & LABOR ROOM	2, 066, 361				0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	4, 550, 880				0	
55. 00 05500 RADI OLOGY-THERAPEUTI C	295, 153				0	55.0
56. 00 05600 RADI OI SOTOPE	88, 808				0	
9.00 05900 CARDI AC CATHETERI ZATI ON	1, 774, 756				0	59.0
0.00 06000 LABORATORY	2, 318, 719				33	
4.00 06400 INTRAVENOUS THERAPY	978, 189				0	64.0
5. 00 06500 RESPI RATORY THERAPY	369, 578				0	
66.00 06600 PHYSI CAL THERAPY	872, 235				3, 745	
57.00 06700 OCCUPATI ONAL THERAPY	14, 293				114	
8.00 06800 SPEECH PATHOLOGY	148, 658				1, 070	
9.00 06900 ELECTROCARDI OLOGY	1, 279, 003				0	
0.00 07000 ELECTROENCEPHALOGRAPHY	325, 058				0	70.0
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 302, 546				8	71.0
22.00 07200 I MPL. DEV. CHARGED TO PATIENTS	761, 340				0	
73.00 07300 DRUGS CHARGED TO PATIENTS	971, 163				0	73.0
4.00 07400 RENAL DI ALYSI S	262, 489				0	
6. 97 07697 CARDI AC REHABI LI TATI ON	3, 461				0	
77.00 07700 ALLOGENEIC HSCT ACQUISITION	132, 821				0	77.0
78.00 07800 CAR T-CELL IMMUNOTHERAPY OUTPATI ENT SERVI CE COST CENTERS	4, 684	40, 148, 936	0.00011	0	0	78.0
0. 00 09000 CLINIC	1, 471, 188	17, 838, 621	0.08247	72 0	0	90.0
0. 01 09001 I BMT JOINT VENTURE	139, 448				0	
0.02 09002 MOORESVILLE INFUSION CLINIC	9, 739				0	
0.05 09005 CV DI AGNOSTI C SERVI CES	59, 243				0	90.0
21. 00 09100 EMERGENCY	3, 639, 489				0	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0				0	
200.00 Total (lines 50 through 199)		3, 453, 847, 766		591, 499	5,017	

Health Financial Systems F	RANCISCAN HEALT	H INDIANAPOLIS		In	_ieu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PASS	S Provider C	CN: 15-0162	Peri od:	Worksheet D	
THROUGH COSTS		Component	CCN: 15-T162	From 01/01/20 To 12/31/20		nared
		component	CCN. 13-1102	10 12/31/20	3/28/2024 2:2	
		Ti tl	e XIX	Subprovi der	- PPS	
				IRF		
Cost Center Description	Non Physician	Nursi ng	Nursi ng		th Allied Health	
	Anestheti st	Program Post-Stepdown	Program	Post-Stepdo Adjustment		
	Cost	Adj ustments		Adj us tillen t	>	
	1.00	2A	2.00	3A	3.00	
ANCI LLARY SERVI CE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0	0		0	0 217, 938	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0	0 0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0	0 0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0	0 0	
56. 00 05600 RADI OI SOTOPE	0	0		0	0 0	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0	0 0	
60. 00 06000 LABORATORY	0	0		0	0 48, 772	
64.00 06400 INTRAVENOUS THERAPY	0	0		0	0 0	
65. 00 06500 RESPI RATORY THERAPY	0	0		0	0 0	
66. 00 06600 PHYSI CAL THERAPY	0	0		0	0 0	
67. 00 06700 OCCUPATI ONAL THERAPY	0	0		0	0 0	
68. 00 06800 SPEECH PATHOLOGY	0	0		0	0 0	
69. 00 06900 ELECTROCARDI OLOGY	0	0		0	0 0	
70. 00 07000 ELECTROENCEPHALOGRAPHY 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0	0		0		
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0		
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0		0	0 443,072	
74. 00 07400 RENAL DIALYSIS	0	0		0	0 443,072	
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		0		1
77. 00 07700 ALLOGENEI CHSCT ACQUI SI TI ON	0	0		0	0 0	
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0	0		0	0 0	1
OUTPATIENT SERVICE COST CENTERS					- <u>-</u>	
90. 00 09000 CLINIC	0	0		0	0 0	90.00
90. 01 09001 IBMT JOINT VENTURE	0	0		0	0 0	90.01
90.02 09002 MOORESVILLE INFUSION CLINIC	0	0		0	0 0	90.02
90. 05 09005 CV DI AGNOSTI C SERVI CES	0	0		0	0 0	90.05
91. 00 09100 EMERGENCY	0	0		0	0 356, 711	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0			0	C	
200.00 Total (lines 50 through 199)	0	0	1	0	0 1, 066, 493	200. 00

Health Financial Systems F	RANCISCAN HEALT	H INDIANAPOLIS		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PASS	S Provider C		Peri od:	Worksheet D	
THROUGH COSTS				From 01/01/2023		
		Component (CCN: 15-T162	To 12/31/2023	Date/Time Pre 3/28/2024 2:2	
		Titl	e XIX	Subprovider -	PPS	
				IRF		
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,	to Charges	
	Education Cost	1, 2, 3, and	Cost (sum of	Part I, col.	(col. 5 ÷ col.	
		4)	cols. 2, 3,	8)	7)	
			and 4)		(see	
					instructions)	
	4.00	5.00	6.00	7.00	8.00	
ANCI LLARY SERVI CE COST CENTERS	1			1		
50.00 05000 OPERATI NG ROOM	0	217, 938	217, 93			•
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 48, 971, 664		
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 371, 800, 783	0.000000	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0 112, 966, 617	0.00000	55.00
56. 00 05600 RADI OI SOTOPE	0	0		0 10, 261, 587	0.00000	56.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 193, 125, 396	0.000000	59.00
60. 00 06000 LABORATORY	0	48, 772	48, 77	2 296, 599, 274	0. 000164	60.00
64.00 06400 INTRAVENOUS THERAPY	0	0		0 78, 887, 275	0.000000	64.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0 66, 653, 414	0.000000	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0	1	0 58, 913, 287	0. 000000	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0	1	0 28, 977, 341	0. 000000	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0 13, 641, 682	0. 000000	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 53, 453, 217	0. 000000	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 29, 329, 127	0. 000000	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 283, 313, 855	0. 000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 154, 457, 585	0. 000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	443, 072	443, 07	2 721, 591, 548	0.000614	73.00
74.00 07400 RENAL DIALYSIS	0	0		0 9, 179, 437	0.000000	74.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		0 4, 428, 567	0.000000	76.97
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0		0 921, 931	0.000000	77.00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0	0		0 40, 148, 936	0.000000	78.00
OUTPATIENT SERVICE COST CENTERS			•			1
90. 00 09000 CLINIC	0	0		0 17, 838, 621	0.00000	90.00
90.01 09001 IBMT JOINT VENTURE	0	0		0 12, 927, 809	0. 000000	90.01
90.02 09002 MOORESVILLE INFUSION CLINIC	0	0		0 575, 175	0.000000	90.02
90. 05 09005 CV DI AGNOSTI C SERVI CES	0	0		0 98, 546, 680	0. 000000	90.05
91.00 09100 EMERGENCY	0	356, 711	356, 71	1 350, 343, 726	0. 001018	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		0 45, 723, 806	0. 000000	92.00
200.00 Total (lines 50 through 199)	0	1, 066, 493	1, 066, 49	3 3, 453, 847, 766		200.00
						-

Health Financial Systems	FRANCI SCAN HEALTH	I NDI ANAPOLI S		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PASS	Provider C	CN: 15-0162	Period:	Worksheet D	
THROUGH COSTS		Component	CCN: 15-T162	From 01/01/2023 To 12/31/2023	Part IV Date/Time Pre	nared
		•			3/28/2024 2:2	1 pm
		Titl	e XIX	Subprovider -	PPS	
				I RF		
Cost Center Description	Outpatient	Inpati ent	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program Charges	Program Pass-Throug	Program Charges	Program Pass-Through	
	to Charges (col. 6 ÷ col.	charges	Costs (col.		Costs (col. 9	
	7)		x col. 10)	0	x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCI LLARY SERVI CE COST CENTERS	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	10100	11100	12100	101.00	
50. 00 05000 OPERATI NG ROOM	0.000622	2, 088		1 0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0 0	0	52.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	0)	0 0	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000	0)	0 0	0	55.00
56. 00 05600 RADI OI SOTOPE	0. 000000	0)	0 0	0	56.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	0)	0 0	0	59.00
60. 00 06000 LABORATORY	0. 000164	4, 158		1 0	0	60.00
64. 00 06400 I NTRAVENOUS THERAPY	0. 000000	0)	0 0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	0)	0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	252, 975	i i	0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000	232, 242		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	98, 186		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	0		0 0	0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	0		0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	1, 704		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000614	146		0 0	0	73.00
74.00 07400 RENAL DIALYSIS	0. 000000	0		0 0	0	74.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000	0		0 0	0	76.97
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0. 000000	0		0 0	0	77.00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0.000000	0	9	0 0	0	78.00
90. 00 09000 CLINIC	0.000000			0		00.00
	0.00000	0		0 0		90.00
90. 01 09001 IBMT JOINT VENTURE 90. 02 09002 MOORESVILLE INFUSION CLINIC	0. 000000 0. 000000	0		0 0	0	90.01
90. 02 09002 MOORESVILLE INFUSION CLINIC 90. 05 09005 CV DIAGNOSTIC SERVICES	0. 000000	0			0	90.02 90.05
90: 05 09005 CV DIAGNOSTIC SERVICES 91. 00 09100 EMERGENCY	0.00000	0			0	90.05
91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0.00000	0			0	91.00
200.00 Total (lines 50 through 199)	0.000000	591, 499		2 0	-	200.00
	1 1	571,477	1	-1 0	0	1200.00

Health Financial Systems F	RANCI SCAN HEALTI	H INDIANAPOLIS		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AN	D VACCINE COST	Provider C		Period:	Worksheet D	
		Component	CCN: 15-T162	From 01/01/2023 To 12/31/2023	Part V Date/Time Pre	narod
		component	JUN. 13-1102	10 12/31/2023	3/28/2024 2:2	pareu. 1 pm
		Titl	e XIX	Subprovider -	PPS	<u> </u>
			-	I RF		
			Charges		Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
		Services (see	Reimbursed	Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins			
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVICE COST CENTERS	0 100070		1		0	
50.00 05000 OPERATING ROOM	0. 123072	0		0 0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 184449	0		0 0	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 55. 00 05500 RADI OLOGY-THERAPEUTI C	0.083725	0		0	-	54.00
	0. 110583	0		0 0	0	55.00
56. 00 05600 RADI 0I SOTOPE 59. 00 05900 CARDI AC_CATHETERI ZATI 0N	0. 056058 0. 039145	0		0 0	0	56.00 59.00
60. 00 06000 LABORATORY	0. 039145	0		0 0	0	60.00
64. 00 06400 INTRAVENOUS THERAPY	0. 124708	0		0 0	0	64.00
65. 00 06500 RESPIRATORY THERAPY	0. 095830	0		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 210291	0		0 0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 100441	0		0 0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0. 125719	0			0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 082633	0	02	0 0	0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 112318	0		0 0	0	70.00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT	0. 251532	0		0 0	0	71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0. 281372	0		0 0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 174497	0		0 0	0	73.00
74. 00 07400 RENAL DI ALYSI S	0. 262144	0		0 0	0	74.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 173803	0		0 0	0	76.97
77. 00 07700 ALLOGENEIC HSCT ACQUISITION	2. 464630	0		0 0	0	77.00
78. 00 07800 CAR T-CELL IMMUNOTHERAPY	0. 204493	0		0 0	0	78.00
OUTPATIENT SERVICE COST CENTERS	01201170					10100
90. 00 09000 CLINIC	0. 647106	0		0 0	0	90.00
90.01 09001 IBMT JOINT VENTURE	0. 173618	0		0 0	0	90.01
90. 02 09002 MOORESVILLE INFUSION CLINIC	0. 105309	0		0 0	0	90. 02
90. 05 09005 CV DI AGNOSTI C SERVI CES	0. 124215	0		0 0	0	90.05
91.00 09100 EMERGENCY	0. 072654	0		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 246575	0	1	0 0	0	92.00
200.00 Subtotal (see instructions)		0	62	2 0	0	200. 00
201.00 Less PBP Clinic Lab. Services-Program				0 0		201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)		0	62	2 0	0	202.00

Heal th Financi	al Systems Fi	RANCISCAN HEALT	H INDIANAPOLIS		In Lie	u of Form CMS-2552-
APPORTI ONMENT	OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C	CN: 15-0162	Peri od:	Worksheet D
			Component	CCN: 15-T162	From 01/01/2023 To 12/31/2023	Part V Date/Time Prepared
			•			3/28/2024 2:21 pm
			Titl	e XIX	Subprovider - IRF	PPS
		Cos	sts			
C	ost Center Description	Cost	Cost			
		Reimbursed	Reimbursed			
		Servi ces	Services Not			
		Subject To	Subject To			
			Ded. & Coins.			
		(see inst.)	(see inst.)	-		
	RY SERVICE COST CENTERS	6.00	7.00			
	PERATING ROOM	0	0			50.0
	ELIVERY ROOM & LABOR ROOM	0	0			52.0
	ADI OLOGY-DI AGNOSTI C	0	0			54.0
	ADI OLOGY-THERAPEUTI C	0	0			55.0
	ADI OLOGI - THEKAPEOTI C	0	0			56.0
	ADI OF SOTOFE ARDI AC CATHETERI ZATI ON	0				59.0
	ABORATORY	0	0			60.0
	NTRAVENOUS THERAPY	0				64.
1 1	ESPIRATORY THERAPY	0	0			65.0
1 1	HYSICAL THERAPY	0	0			66.0
	CCUPATIONAL THERAPY	0				67.
	PEECH PATHOLOGY	97				68.0
	LECTROCARDI OLOGY	0				69.
	LECTROENCEPHALOGRAPHY	0				70.0
	EDICAL SUPPLIES CHARGED TO PATIENT	0				71.0
	MPL. DEV. CHARGED TO PATIENTS	0				72.0
	RUGS CHARGED TO PATIENTS	0				73.0
	ENAL DIALYSIS	0				74.0
	ARDI AC REHABI LI TATI ON	0	0			74.
	LLOGENEIC HSCT ACQUISITION	0	0			77.0
	AR T-CELL IMMUNOTHERAPY	0	0			78.0
	ENT SERVICE COST CENTERS	0	0	1		70.
90.00 09000 C		0	0			90. (
	BMT JOINT VENTURE	0	0			90.0
	OORESVILLE INFUSION CLINIC	0	0			90.
	V DI AGNOSTI C SERVI CES	0	0			90.
	MERGENCY	0	0			91.0
	BSERVATION BEDS (NON-DISTINCT PART	0	0			92.
	ubtotal (see instructions)	97	0			200.
	ess PBP Clinic Lab. Services-Program	0	U U			201.
		U U		1		201.
	nly Charges					

FRANCISCAN HEALTH INDIANAPOLIS

In Lieu of Form CMS-2552-10

	FINANCIAL SYSTEMS FRANCISCAN HEALTH	I NDI ANAPOLI S Provi der CCN: 15-0162	In Lie Period:	u of Form CMS-2 Worksheet D-1	2552-10
JUMPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0162	From 01/01/2023	worksneet D-I	
			To 12/31/2023		
		Title XVIII	Hospi tal	3/28/2024 2: 2 PPS	I pm
	Cost Center Description		nospi tui	115	
				1.00	
	PART I - ALL PROVIDER COMPONENTS				
	INPATIENT DAYS			00.754	1 00
	Inpatient days (including private room days and swing-bed day Inpatient days (including private room days, excluding swing-			80, 754	1.00 2.00
	Private room days (excluding swing-bed and observation bed days)		rivate room days	80, 754 0	3.00
5.00	do not complete this line.	iya). Ti you have only pi	rvate room days,	0	5.00
4.00	Semi-private room days (excluding swing-bed and observation b	oed days)		71, 039	4.00
5.00	Total swing-bed SNF type inpatient days (including private ro	oom days) through Decembe	er 31 of the cost	0	5.00
6.00	reporting period Total swing-bed SNF type inpatient days (including private re	and davic) after December	21 of the cost	0	6.00
5.00	reporting period (if calendar year, enter 0 on this line)	Join days) al ter becenber	ST OF THE COST	0	0.00
7.00	Total swing-bed NF type inpatient days (including private roo	om days) through December	- 31 of the cost	0	7.00
	reporting period				
8.00	Total swing-bed NF type inpatient days (including private roo	om 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 Brogram (aveluding	r cwing bod and	20 420	9.00
9.00	newborn days) (see instructions)	to the Program (excluding	y swifty-bed allu	20, 630	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII of	only (including private i	room days)	0	10.00
	through December 31 of the cost reporting period (see instruct				
11.00	Swing-bed SNF type inpatient days applicable to title XVIII of		room days) after	0	11.00
12.00	December 31 of the cost reporting period (if calendar year, of Swing-bed NF type inpatient days applicable to titles V or XI		te room dave)	0	12.00
12.00	through December 31 of the cost reporting period	The during privation	te room days)	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XI	X only (including privat	te room days)	0	13.00
	after December 31 of the cost reporting period (if calendar y				
	Medically necessary private room days applicable to the Progr	ram (excluding swing-bed	days)	0	14.00
	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			0	15.00 16.00
	SWING BED ADJUSTMENT			0	10.00
	Medicare rate for swing-bed SNF services applicable to service	ces through December 31 d	of the cost	0.00	17.00
ļ	reporting period				
18.00	Medicare rate for swing-bed SNF services applicable to servic	ces after December 31 of	the cost	0.00	18.00
19.00	reporting period Medicaid rate for swing-bed NF services applicable to service	es through December 31 of	^e the cost	0.00	19.00
17.00	reporting period			0.00	17.00
20. 00	Medicaid rate for swing-bed NF services applicable to service	es after December 31 of t	the cost	0.00	20.00
21 00	reporting period	>		00 71/ 070	01 00
	Total general inpatient routine service cost (see instruction Swing-bed cost applicable to SNF type services through Decemb		ting period (line	93, 716, 072 0	21.00
22.00	5 x line 17)		ing period (inic	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December	r 31 of the cost reportin	ng period (line 6	0	23.00
	x line 18)				
24.00	Swing-bed cost applicable to NF type services through December 7 x line 19)	er 31 of the cost reporti	ng period (line	0	24.00
25.00	Swing-bed cost applicable to NF type services after December	31 of the cost reporting	period (line 8	0	25.00
	x line 20)				
	Total swing-bed cost (see instructions)			0	
	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		93, 716, 072	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-be	ed and observation bed ch	varges)	0	28.00
	Private room charges (excluding swing-bed charges)		lai ges)	0	29.00
	Semi-private room charges (excluding swing-bed charges)			0	30.00
	General inpatient routine service cost/charge ratio (line 27	÷line 28)		0.000000	
	Average private room per diem charge (line 29 ÷ line 3)			0.00	
	Average semi-private room per diem charge (line 30 ÷ line 4)		+:>		33.00
		nue line 22) (con inctour			34.00
35.00 1	Average per diem private room charge differential (line 32 mi		ctions)		35.00
			ctions)		35.00 36.00
36.00	Average per diem private room charge differential (line 32 mi Average per diem private room cost differential (line 34 x li Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost	ne 31)		0.00	36.00
36. 00 37. 00	Average per diem private room charge differential (line 32 mi Average per diem private room cost differential (line 34 x li Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost 27 minus line 36)	ne 31)		0. 00 0	36.00
36. 00 37. 00	Average per diem private room charge differential (line 32 mi Average per diem private room cost differential (line 34 x li Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY	ne 31) and private room cost di		0. 00 0	36.00
36.00 37.00	Average per diem private room charge differential (line 32 mi Average per diem private room cost differential (line 34 x li Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AD.	ne 31) and private room cost di JUSTMENTS		0. 00 0 93, 716, 072	36. 00 37. 00
36. 00 37. 00 38. 00	Average per diem private room charge differential (line 32 mi Average per diem private room cost differential (line 34 x li Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY	and private room cost di JUSTMENTS e instructions)		0. 00 0	36. 00 37. 00 38. 00
36. 00 37. 00 38. 00 39. 00 40. 00	Average per diem private room charge differential (line 32 mi Average per diem private room cost differential (line 34 x li Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AD. Adjusted general inpatient routine service cost per diem (see	and private room cost di JUSTMENTS e instructions) = 38) ram (line 14 x line 35)		0. 00 0 93, 716, 072 	36. 00 37. 00 38. 00 39. 00 40. 00

	ATION OF INPATIENT OPERATING COST		Provider C		eri od:	worksheet D-1	
					rom 01/01/2023 o 12/31/2023		
				XVIII	Hospi tal	PPS	
	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)	0					42.00
	Intensive Care Type Inpatient Hospital Units						
43.00 43.01	INTENSIVE CARE UNIT NEONATAL INTENSIVE CARE UNIT	18,081,472		1, 817. 05 1, 580. 54			
44.00	CORONARY CARE UNIT	10, 738, 173 26, 215, 731		1, 939. 46			
45.00	BURN INTENSIVE CARE UNIT	20, 213, 731	10,017	1, 757.40	4,000	7,000,370	45.00
46.00	SURGI CAL INTENSI VE CARE UNI T	17, 050, 951	8, 001	2, 131. 10	2, 432	5, 182, 835	
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
	Cost Center Description					1.00	
48.00	Program inpatient ancillary service cost (Wks	st. D-3, col. 3	3, line 200)			64, 254, 025	48.00
48. 01	Program inpatient cellular therapy acquisitio			III, line 10,	column 1)	0	
49.00	Total Program inpatient costs (sum of lines 4	41 through 48.0	01)(see instruc	tions)		107, 697, 655	49.00
50.00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inpa	tiont routing	convigos (from	Wkct D cum	of Dorte L and	5, 217, 852	50.00
50.00	111)		Services (IIOII	WKSL. D, SUII	UI PAILS I ANU	5, 217, 652	50.00
51.00	Pass through costs applicable to Program inpa and IV)	atient ancillar	ry services (fr	om Wkst. D, su	m of Parts II	4, 033, 125	51.00
52.00	Total Program excludable cost (sum of lines !	50 and 51)				9, 250, 977	52.00
53.00	Total Program inpatient operating cost exclud medical education costs (line 49 minus line 5		elated, non-phy	sician anesthe	tist, and	98, 446, 678	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION					1	
54.00	Program di scharges					0	54.00 55.00
55.00 55.01	Target amount per discharge Permanent adjustment amount per discharge					0.00	
55.02	Adjustment amount per discharge (contractor u	use only)				0.00	
56.00	Target amount (line 54 x sum of lines 55, 55.					0	56.0
57.00	Difference between adjusted inpatient operati	ng cost and ta	arget amount (I	ine 56 minus I	ine 53)	0	
58.00	Bonus payment (see instructions)	n line FF from	the east rang	sting posied o	nding 100/	0	
59.00	Trended costs (lesser of line 53 ÷ line 54, or updated and compounded by the market basket)	or time so troit	i the cost repo	rting period e	nui ng 1996,	0.00	59.0
50.00	Expected costs (lesser of line 53 ÷ line 54, market basket)	or line 55 fro	om prior year c	ost report, up	dated by the	0.00	60.00
61.00	Continuous improvement bonus payment (if line 55.01, or line 59, or line 60, enter the less 53) are less than expected costs (lines 54 x	ser of 50% of t	he amount by w	hich operating	costs (İine	0	61.0
	enter zero. (see instructions) Relief payment (see instructions)					0	
53.00	Allowable Inpatient cost plus incentive payme PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instru	ictions)			0	63.0
54.00	Medicare swing-bed SNF inpatient routine cost	ts through Dece	ember 31 of the	cost reportin	a period (See	0	64.00
	instructions)(title XVIII only)	5		·	51 (
5.00	Medicare swing-bed SNF inpatient routine cost	ts after Decemb	per 31 of the c	ost reporting	period (See	0	65.0
56.00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routin	ne costs (line	64 nlus line 6	5)(title XVIII	only) for	0	66.0
0.00	CAH, see instructions			5)((11)	oniy), ioi	"	00.0
57.00	Title V or XIX swing-bed NF inpatient routine (line 12 x line 19)	e costs through	n December 31 o	f the cost rep	orting period	0	67.0
58. 00	Title V or XIX swing-bed NF inpatient routine (line 13 x line 20)	e costs after D	ecember 31 of	the cost repor	ting period	0	68.00
69. 00	Total title V or XIX swing-bed NF inpatient i PART III - SKILLED NURSING FACILITY, OTHER NU					0	69.00
70.00	Skilled nursing facility/other nursing facili						70.00
1.00	Adjusted general inpatient routine service co		ine 70 ÷ line	2)			71.0
72.00 73.00	Program routine service cost (line 9 x line 7		(lipo 14 v !!	no 25)			72.0
3.00 4.00	Medically necessary private room cost applica Total Program general inpatient routine servi			ne 55)			74.0
5.00	Capital-related cost allocated to inpatient i	•		orksheet B, Pa	rt II, column		75.0
6. 00	26, line 45) Per diem capital-related costs (line 75 ÷ lin	ne 2)					76.0
7.00	Program capital -related costs (line 9 x line						77.0
8.00	Inpatient routine service cost (line 74 minus						78.0
9.00	Aggregate charges to beneficiaries for excess						79.0
0.00	Total Program routine service costs for compa		cost limitation	(line 78 minu	s line 79)		80.0
1.00	Inpatient routine service cost per diem limit Inpatient routine service cost limitation (li)				81.0
32.00 33.00	Reasonable inpatient routine service cost limitation (i)		· .				82.0
34. 00 34. 00	Program inpatient ancillary services (see ins						84.0
35.00	Utilization review - physician compensation	(see instructio					85.0
36. 00	Total Program inpatient operating costs (sum		nrough 85)				86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS					0.715	87.0
37.00	Total observation bed days (see instructions))				9 / 1/1	10/ 0

COMPUTATION OF INPATIENT OPERATING COST Provider CCN: 15-0162 Period: Worksheet D-1 From 01/01/2023	
To 12/31/2023 Date/Time Prepa 3/28/2024 2:21	red: pm
Cost Center Description	
1.00	
89.00 Observation bed cost (line 87 x line 88) (see instructions) 11, 274, 355	39.00
Cost Center Description Cost Routine Cost column 1 ÷ Total Observation	
(from line 21) column 2 Observation Bed Pass	
Bed Cost (from Through Cost	
line 89) (col. 3 x col.	
4) (see	
i nstructi ons)	
1.00 2.00 3.00 4.00 5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST	
90. 00 Capital -related cost 11, 162, 716 93, 716, 072 0. 119112 11, 274, 355 1, 342, 911	90.00
91.00 Nursing Program cost 0 93,716,072 0.00000 11,274,355 0	91.00
92. 00 Allied health cost 0 93, 716, 072 0. 000000 11, 274, 355 0	92.00
93.00 All other Medical Education 0 93,716,072 0.000000 11,274,355 0	93.00

WPUT	TION OF INPATIENT OPERATING COST	Provider CCN: 15-0162 Component CCN: 15-T162	Peri od: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Pre 3/28/2024 2:2	pare
		Title XVIII	Subprovider - IRF	PPS	
	Cost Center Description		-	1.00	
	PART I - ALL PROVIDER COMPONENTS				
	INPATIENT DAYS Inpatient days (including private room days and swing-bed day	vs excluding newborn)		5, 986	1 1
	Inpatient days (including private room days, excluding swing			5, 986	2
00	Private room days (excluding swing-bed and observation bed da	ays). If you have only pr	ivate room days,	0	3
	do not complete this line.		-		
	Semi-private room days (excluding swing-bed and observation I		- 01 -6 +6+	5, 986	4
	Total swing-bed SNF type inpatient days (including private ro reporting period	bom days) through Decembe	er 31 of the cost	0	5
	Total swing-bed SNF type inpatient days (including private ro	oom days) after December	31 of the cost	0	6
	reporting period (if calendar year, enter 0 on this line)				
	Total swing-bed NF type inpatient days (including private roo	om days) through December	31 of the cost	0	7
	reporting period	am dava) aftar Dacambar (1 of the east	0	8
	Total swing-bed NF type inpatient days (including private roor reporting period (if calendar year, enter 0 on this line)	on days) at ter becenber 3	I OI LINE COST	0	
	Total inpatient days including private room days applicable .	to the Program (excluding	swing-bed and	3, 180	9
	newborn days) (see instructions)		-		
. 00	Swing-bed SNF type inpatient days applicable to title XVIII of		oom days)	0	10
00	through December 31 of the cost reporting period (see instruc Swing-bed SNF type inpatient days applicable to title XVIII of		nom davs) after	0	11
	December 31 of the cost reporting period (if calendar year, o		oom days) arter	0	''
	Swing-bed NF type inpatient days applicable to titles V or XI		e room days)	0	12
	through December 31 of the cost reporting period			_	
	Swing-bed NF type inpatient days applicable to titles V or XI			0	13
	after December 31 of the cost reporting period (if calendar y Medically necessary private room days applicable to the Prog			0	14
	Total nursery days (title V or XIX only)	tam (exertaining swring bea	uuys)	0	
. 00	Nursery days (title V or XIX only)			0	16
	SWING BED ADJUSTMENT		<u> </u>	0.00	
. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	ces through December 31 c	or the cost	0.00	
. 00	Medicare rate for swing-bed SNF services applicable to servic	ces after December 31 of	the cost	0.00	18
	reporting period				
	Medicaid rate for swing-bed NF services applicable to service reporting period	es through December 31 of	the cost	0.00	19
	Medicaid rate for swing-bed NF services applicable to service	es after December 31 of t	he cost	0.00	20
	reporting period				
	Total general inpatient routine service cost (see instruction			9, 025, 252	
	Swing-bed cost applicable to SNF type services through Decemb	ber 31 of the cost report	ing period (line	0	22
	5 x line 17) Swing-bed cost applicable to SNF type services after Decembe	r 31 of the cost reportir	a period (line 6	0	23
	x line 18)		g por ou (rino o	0	
. 00	Swing-bed cost applicable to NF type services through December	er 31 of the cost reporti	ng period (line	0	24
. 00	7 x line 19) Swing-bed cost applicable to NF type services after December	21 of the cost reporting	pariod (line 9	0	25
. 00	x line 20)	ST OF THE COST TEPOT THE		0	20
. 00	Total swing-bed cost (see instructions)			0	26
	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		9, 025, 252	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-be	ad and obconvation had a	argos)	0	28
	Private room charges (excluding swing-bed charges)	ed and observation bed ci		0	29
	Semi - pri vate room charges (excluding sming bed charges)			0	30
. 00	General inpatient routine service cost/charge ratio (line 27	÷line 28)		0.000000	31
	Average private room per diem charge (line 29 ÷ line 3)			0.00	
	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 mi	inus line 22) (coo inctrus	tions)	0.00	
	Average per diem private room cost differential (line 34 x li			0.00 0.00	
	Private room cost differential adjustment (line 3 x line 35)	/		0.00	36
. 00	General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line	9, 025, 252	37
5	27 minus line 36)				
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AD.	JUSTMENTS			
	Adjusted general inpatient routine service cost per diem (see			1, 507. 73	38
	Program general inpatient routine service cost (line 9 x line			4, 794, 581	
	Medically necessary private room cost applicable to the Prog				40
00	Total Program general inpatient routine service cost (line 39	9 + line 40)		4, 794, 581	41

Health Financial Systems FRANCISCAN HEALT COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0162 Period: From 01/01/2023 Component CCN: 15-T162 To 12/31/2023	B Date/Time Pre 3/28/2024 2:2	pared:
	Title XVIII Subprovider -	PPS	
	Total Average Per Program Days Inpatient Days Col. 2)	Program Cost (col. 3 x col. 4)	
1.00 42.00 NURSERY (title V & XIX only) 0	2.00 3.00 4.00 0 0.00	5.00	42.00
Intensive Care Type Inpatient Hospital Units		1	
43. 00 INTENSI VE CARE UNI T 0 43. 01 NEONATAL INTENSI VE CARE UNI T 0			1
43. 01 NEONATAL INTENSIVE CARE UNIT 0 44. 00 CORONARY CARE UNIT 0			
45.00 BURN INTENSIVE CARE UNIT			45.00
46.00 SURGICAL INTENSIVE CARE UNIT 0	0 0.00	0 0	46.00
47.00 OTHER SPECIAL CARE (SPECIFY) Cost Center Description			47.00
·		1.00	
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3		1, 632, 695	
48.01 Program inpatient cellular therapy acquisition cost (Worksh 49.00 Total Program inpatient costs (sum of lines 41 through 48.0		0 6, 427, 276	
PASS THROUGH COST ADJUSTMENTS		0, 127, 270	17.00
50.00 Pass through costs applicable to Program inpatient routine	services (from Wkst. D, sum of Parts I and	702, 907	50.00
) 51.00 Pass through costs applicable to Program inpatient ancillar	ry services (from Wkst D sum of Parts II	83, 540	51.00
and IV)	J Sections (from more b, Sum of fulls fr	03, 340	
52.00 Total Program excludable cost (sum of lines 50 and 51)		786, 447	52.00
53.00 Total Program inpatient operating cost excluding capital re medical education costs (line 49 minus line 52)	elated, non-physician anesthetist, and	5, 640, 829	53.00
TARGET AMOUNT AND LIMIT COMPUTATION			
54.00 Program discharges		0	
55.00 Target amount per discharge 55.01 Permanent adjustment amount per discharge		0.00	
55.02 Adjustment amount per discharge (contractor use only)		0.00	1
56.00 Target amount (line 54 x sum of lines 55, 55.01, and 55.02)		0	
57.00 Difference between adjusted inpatient operating cost and ta 58.00 Bonus payment (see instructions)	arget amount (line 56 minus line 53)	0	57.00 58.00
59.00 Trended costs (lesser of line 53 ÷ line 54, or line 55 from	n the cost reporting period ending 1996,	0.00	1
updated and compounded by the market basket)			
60.00 Expected costs (lesser of line 53 ÷ line 54, or line 55 from market basket)	om prior year cost report, updated by the	0.00	60.00
61.00 Continuous improvement bonus payment (if line 53 ÷ line 54 55.01, or line 59, or line 60, enter the lesser of 50% of t 53) are less than expected costs (lines 54 x 60), or 1 % of enter zero. (see instructions)	the amount by which operating costs (line	0	61.00
62.00 Relief payment (see instructions)		0	
63.00 Allowable Inpatient cost plus incentive payment (see instru PROGRAM INPATIENT ROUTINE SWING BED COST	uctions)	0	63.00
64.00 Medicare swing-bed SNF inpatient routine costs through Dece instructions)(title XVIII only)	ember 31 of the cost reporting period (See	0	64.00
55.00 Medicare swing-bed SNF inpatient routine costs after Decemb	per 31 of the cost reporting period (See	0	65.00
 instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routine costs (line CAH, see instructions 	64 plus line 65)(title XVIII only); for	0	66.00
57.00 Title V or XIX swing-bed NF inpatient routine costs through (line 12 x line 19)	December 31 of the cost reporting period	0	67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after D (line 13 x line 20)		0	
69.00 Total title V or XIX swing-bed NF inpatient routine costs (PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY		0	69.00
70.00 Skilled nursing facility/other nursing facility/ICF/IID rou	·		70.00
71.00 Adjusted general inpatient routine service cost per diem (I			71.00
72.00 Program routine service cost (line 9 x line 71) 73.00 Medically necessary private room cost applicable to Program	n (line 14 x line 35)		72.00
74.00 Total Program general inpatient routine service costs (line			74.00
75.00 Capital-related cost allocated to inpatient routine service 26, line 45)			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 76) 78.00 Inpatient routine service cost (line 74 minus line 77)			77.00
79.00 Aggregate charges to beneficiaries for excess costs (from p			79.00
80.00 Total Program routine service costs for comparison to the c	cost limitation (line 78 minus line 79)		80.00
81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81			81.00 82.00
83.00 Reasonable inpatient routine service costs (see instruction			83.00
84.00 Program inpatient ancillary services (see instructions)	>		84.00
85.00 Utilization review - physician compensation (see instruction) 86.00 Total Program inpatient operating costs (sum of lines 83 th			85.00 86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		ı	00.00
87.00 Total observation bed days (see instructions)		0	87.00

Health Financial Systems FR	ANCISCAN HEALT	H INDIANAPOLIS		In Lie	u of Form CMS-2	2552-1
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period:	Worksheet D-1	
		Component C		From 01/01/2023 To 12/31/2023		
		Title	XVIII	Subprovider - IRF	PPS	
Cost Center Description		· · ·	÷			
					1.00	
38.00 Adjusted general inpatient routine cost per d	liem (line 27 ÷	line 2)			0.00	88.00
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 C	OST			÷		
90.00 Capital-related cost	1, 323, 140	9, 025, 252	0. 14660	4 0	0	90.0
91.00 Nursing Program cost	0	9, 025, 252	0.00000	0 0	0	91.0
92.00 Allied health cost	0	9,025,252		0 0	0	92.00
93.00 All other Medical Education		9, 025, 252				93.00

Health Financial System

FRANCI SCAN	HEALTH	I NDI ANAPOLI S

In Lieu of Form CMS-2552-10

Heal th	Financial Systems FRANCISCAN HEALTH	NDI ANAPOLI S	In Lie	u of Form CMS-2	2552-1
	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0162	Peri od:	Worksheet D-1	
			From 01/01/2023 To 12/31/2023	Date/Time Pre	nared
			10 12/31/2023	3/28/2024 2:2	1 pm
		Title XIX	Hospi tal	PPS	
	Cost Center Description				
				1.00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS				+
1.00	Inpatient days (including private room days and swing-bed day	s. excluding newborn)		80, 754	1.0
2.00	Inpatient days (including private room days, excluding swing-			80, 754	2.0
3.00	Private room days (excluding swing-bed and observation bed da		ivate room days,	0	3.0
	do not complete this line.		-		
4.00	Semi-private room days (excluding swing-bed and observation b			71, 039	
5.00	Total swing-bed SNF type inpatient days (including private ro	om days) through Decembe	r 31 of the cost	0	5.0
6.00	reporting period Total swing-bed SNF type inpatient days (including private ro	om dave) after Decomber	21 of the cost	0	6.0
0.00	reporting period (if calendar year, enter 0 on this line)	on days) after becenber	ST OF THE COST	0	0.0
7.00	Total swing-bed NF type inpatient days (including private roo	m days) through December	31 of the cost	0	7.0
	reporting period				
8.00	Total swing-bed NF type inpatient days (including private roo	m days) after December 3	1 of the cost	0	8.0
	reporting period (if calendar year, enter 0 on this line)				
9.00	Total inpatient days including private room days applicable t	o the Program (excluding	swing-bed and	715	9.0
10.00	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII o	ply (including privato r	noom davic)	0	10.0
10.00	through December 31 of the cost reporting period (see instruc	tions)	uays)	0	10.0
11.00	Swing-bed SNF type inpatient days applicable to title XVIII o		oom davs) after	0	11.0
	December 31 of the cost reporting period (if calendar year, e			-	
12.00	Swing-bed NF type inpatient days applicable to titles V or XI.		e room days)	0	12.0
	through December 31 of the cost reporting period				
13.00	Swing-bed NF type inpatient days applicable to titles V or XI.			0	13.0
14.00	after December 31 of the cost reporting period (if calendar y Medically necessary private room days applicable to the Progr	ear, enter 0 on this lin	e) davc)	0	14.0
	Total nursery days (title V or XIX only)	an (excluding swing-bed	uays)	3, 459	
16.00	Nursery days (title V or XIX only)				16.0
	SWING BED ADJUSTMENT				1 101 0
17.00	Medicare rate for swing-bed SNF services applicable to servic	es through December 31 o	f the cost	0.00	17.0
	reporting period				
18.00	Medicare rate for swing-bed SNF services applicable to servic	es after December 31 of	the cost	0.00	18.0
10 00	reporting period	a through December 21 of	the east	0.00	10.0
19.00	Medicaid rate for swing-bed NF services applicable to service reporting period	s thi ough beceniber 31 of	the cost	0.00	19.0
20.00	Medicaid rate for swing-bed NF services applicable to service	s after December 31 of t	he cost	0.00	20.0
	reporting period				
21.00				93, 716, 072	
22.00	Swing-bed cost applicable to SNF type services through Decemb	er 31 of the cost report	ing period (line	0	22.0
23.00	5 x line 17) Swing-bed cost applicable to SNF type services after December	21 of the cost reportin	a pariod (lipa 6	0	23.0
23.00	x line 18)	ST OF THE COST TEPOLITI	g period (Title 6	0	23.0
24.00	Swing-bed cost applicable to NF type services through Decembe	r 31 of the cost reporti	na period (line	0	24.0
	7 x line 19)	· · · · · · · · · · · · · · · · · · ·		-	
25.00	Swing-bed cost applicable to NF type services after December	31 of the cost reporting	period (line 8	0	25.0
	x line 20)				
26.00	Total swing-bed cost (see instructions)			0	26.0
27.00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		93, 716, 072	27.0
28.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-be	d and observation bed ch	arges)	0	28.0
29.00	Private room charges (excluding swing-bed charges)		ai ges)	0	29.0
30.00	Semi-private room charges (excluding swing bed charges)			0	30.0
31.00	General inpatient routine service cost/charge ratio (line 27	÷line 28)		0.00000	
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	32.0
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 mi	, ,	tions)	0.00	
35.00	Average per diem private room cost differential (line 34 x li	ne 31)		0.00	
36.00	Private room cost differential adjustment (line 3 x line 35)	and private ream east d	fforontial (line	02 716 072	36.0
37.00	General inpatient routine service cost net of swing-bed cost 27 minus line 36)	and private room cost di	inerential (IINe	93, 716, 072	37.0
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				ł
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ	JSTMENTS			1
38.00	Adjusted general inpatient routine service cost per diem (see			1, 160. 51	38.0
39.00	Program general inpatient routine service cost (line 9 x line	· · · · · · · · · · · · · · · · · · ·		829, 765	
40.00	Medically necessary private room cost applicable to the Progra			0	
41.00	Total Program general inpatient routine service cost (line 39	$\pm \text{line}(10)$		829, 765	1 11 0

	Financial Systems FF	RANCISCAN HEALT	H INDIANAPOLIS	CN: 15-0162	Period:	eu of Form CMS-: Worksheet D-1	
					From 01/01/2023 To 12/31/2023		
		1		e XIX	Hospi tal	PPS	
	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)	2, 461, 492	3, 459	711.62	2 35	24, 907	42.00
43.00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	18, 081, 472	9, 951	1, 817. 0	5 100	181, 705	43.00
43.00	NEONATAL INTENSIVE CARE UNIT	10, 738, 173					
44.00	CORONARY CARE UNIT	26, 215, 731				263, 767	
45.00	BURN INTENSIVE CARE UNIT	17 050 051	0.001	2 1 2 1 1		170 400	45.00
46.00 47.00	SURGI CAL I NTENSI VE CARE UNI T OTHER SPECI AL CARE (SPECI FY)	17, 050, 951	8, 001	2, 131. 10	80	170, 488	46.00
11100	Cost Center Description						11100
10.00						1.00	10.00
48. 00 48. 01	Program inpatient ancillary service cost (Wks Program inpatient cellular therapy acquisition			III line 10	column 1)	29, 231, 905	48.00 48.01
49.00	Total Program inpatient costs (sum of lines					30, 810, 014	
	PASS THROUGH COST ADJUSTMENTS	~~~~~~				1	
50.00	Pass through costs applicable to Program inpa	atient routine	services (from	Wkst. D, sum	of Parts I and	186, 797	50.00
51.00	<pre>III) Pass through costs applicable to Program inpa cost by</pre>	atient ancillar	ry services (fr	om Wkst. D, su	um of Parts II	2, 483, 765	51.00
52.00	and IV) Total Program excludable cost (sum of lines !	50 and 51)				2, 670, 562	52.00
53.00	Total Program inpatient operating cost exclud medical education costs (line 49 minus line 5	ding capital re	elated, non-phy	sician anesthe	etist, and	28, 139, 452	
54.00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54.00
55.00	Target amount per discharge					0.00	
55.01	Permanent adjustment amount per discharge					0.00	
55.02	Adjustment amount per discharge (contractor u					0.00	
56.00 57.00	Target amount (line 54 x sum of lines 55, 55. Difference between adjusted inpatient operati			ine 56 minus l	ine 53)	0	56.00 57.00
58.00	Bonus payment (see instructions)		inger amount (i			0	
59.00	Trended costs (lesser of line 53 ÷ line 54, o	or line 55 from	n the cost repo	rting period e	endi ng 1996,	0.00	59.00
60. 00	updated and compounded by the market basket) Expected costs (lesser of line 53 ÷ line 54,	or line 55 fro	om prior year c	ost report, up	odated by the	0.00	60.00
61.00	market basket) Continuous improvement bonus payment (if line 55.01, or line 59, or line 60, enter the less	ser of 50% of t	the amount by w	hich operating	g costs (line	0	61.00
62.00	53) are less than expected costs (lines 54 x enter zero. (see instructions) Relief payment (see instructions)	60), or 1 % of	f the target am	ount (line 56)), otherwise	0	62.00
63.00	Allowable Inpatient cost plus incentive payme PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instru	uctions)			0	
64.00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	ember 31 of the	cost reportir	ng period (See	0	64.00
65.00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	ts after Decemb	per 31 of the c	ost reporting	period (See	0	65.00
66.00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routin	ne costs (line	64 plus line 6	5)(title XVIII	only); for	0	66.00
67.00	CAH, see instructions Title V or XIX swing-bed NF inpatient routing	e costs through	n December 31 o	f the cost rep	porting period	0	67.00
68.00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routine (line 13 x line 20)	e costs after D	December 31 of	the cost repor	rting period	0	68.00
69.00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient N PART III - SKILLED NURSING FACILITY, OTHER NU					0	69.00
70.00	Skilled nursing facility/other nursing facili						70.00
71.00	Adjusted general inpatient routine service co	ost per diem (l					71.00
72.00	Program routine service cost (line 9 x line)			no 2E)			72.00
73.00 74.00	Medically necessary private room cost applica Total Program general inpatient routine servi						73.00
75.00	Capital -related cost allocated to inpatient (26, line 45)	•			art II, column		75.00
76.00	Per diem capital-related costs (line 75 ÷ lin	ne 2)					76.00
77.00	Program capital-related costs (line 9 x line						77.00
78.00 79.00	Inpatient routine service cost (line 74 minus Aggregate charges to beneficiaries for excess		rovider record	c)			78.00
80.00	Total Program routine service costs for compa			· · ·	us line 79)		80.00
81.00	Inpatient routine service cost per diem limi						81.00
82.00	Inpatient routine service cost limitation (I						82.00
83.00 84.00	Reasonable inpatient routine service costs (Program inpatient ancillary services (see ins		is)				83.00 84.00
84.00 85.00	Utilization review - physician compensation		ons)				84.00
86.00	Total Program inpatient operating costs (sum	of lines 83 th					86.00
07 00	PART IV - COMPUTATION OF OBSERVATION BED PASS					0.745	07 00
87.00 88.00	Total observation bed days (see instructions) Adjusted general inpatient routine cost per o		line 2)			9, 715	87.00 88.00
	juite general impactione roactino cost por t	(1110 27 1				1, 700.01	

Health Financial Systems Fi	RANCISCAN HEALT	H INDIANAPOLIS		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period: From 01/01/2023	Worksheet D-1	
				To 12/31/2023	Date/Time Pre 3/28/2024 2:2	pared: 1 pm
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description						
					1.00	
89.00 Observation bed cost (line 87 x line 88) (se	e instructions)				11, 274, 355	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	11, 162, 716	93, 716, 072	0. 11911	2 11, 274, 355	1, 342, 911	90.00
91.00 Nursing Program cost	0	93, 716, 072	0.00000	0 11, 274, 355	0	91.00
92.00 Allied health cost	0	93, 716, 072	0.00000	0 11, 274, 355	0	92.00
93.00 All other Medical Education	0	93, 716, 072	0.00000	0 11, 274, 355	0	93.00

JMPUT	ATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0162 Component CCN: 15-T162	Peri od: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Pre 3/28/2024 2:2	pare
	Cost Costor Description	Title XIX	Subprovider - IRF	PPS	
	Cost Center Description			1.00	
	PART I – ALL PROVIDER COMPONENTS INPATIENT DAYS				-
	Inpatient days (including private room days and swing-bed da	ys, excluding newborn)		5, 986	1 1
00	Inpatient days (including private room days, excluding swing			5, 986	2
00	Private room days (excluding swing-bed and observation bed d	ays). If you have only pr	ivate room days,	0	3
00	do not complete this line. Semi-private room days (excluding swing-bed and observation	bed days)		5, 986	4
00	Total swing-bed SNF type inpatient days (including private r		r 31 of the cost	0	
	reporting period				
00	Total swing-bed SNF type inpatient days (including private r reporting period (if calendar year, enter 0 on this line)	oom days) after December	31 of the cost	0	6
00	Total swing-bed NF type inpatient days (including private ro	om days) through December	31 of the cost	0	7
	reporting period				
00	Total swing-bed NF type inpatient days (including private ro	om days) after December 3	1 of the cost	0	8
00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable	to the Program (excluding	swing-bed and	21	9
	newborn days) (see instructions)	······································			
0. 00	Swing-bed SNF type inpatient days applicable to title XVIII		oom days)	0	10
1.00	through December 31 of the cost reporting period (see instru Swing-bed SNF type inpatient days applicable to title XVIII		oom days) after	0	11
	December 31 of the cost reporting period (if calendar year,		com days) arter	0	
2.00	Swing-bed NF type inpatient days applicable to titles V or X	IX only (including privat	e room days)	0	12
3. 00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or X	IX only (including privat	a room davic)	0	13
5.00	after December 31 of the cost reporting period (if calendar			0	
1.00	Medically necessary private room days applicable to the Prog	ram (excluding swing-bed	days)	0	14
	Total nursery days (title V or XIX only)			3, 459	
	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			35	16
	Medicare rate for swing-bed SNF services applicable to servi	ces through December 31 o	f the cost	0.00	17
	reporting period	-			
3.00	Medicare rate for swing-bed SNF services applicable to servi reporting period	ces after December 31 of	the cost	0.00	18
9.00	Medicaid rate for swing-bed NF services applicable to servic	es through December 31 of	the cost	0.00	19
	reporting period	C C			
0.00	Medicaid rate for swing-bed NF services applicable to servic reporting period	es after December 31 of t	he cost	0.00	20
1.00	Total general inpatient routine service cost (see instructio	ns)		9, 025, 252	21
	Swing-bed cost applicable to SNF type services through Decem		ing period (line	0	
	5 x line 17)				
3.00	Swing-bed cost applicable to SNF type services after Decembe x line 18)	r 31 of the cost reportin	g period (line 6	0	23
1.00	Swing-bed cost applicable to NF type services through Decemb	er 31 of the cost reporti	ng period (line	0	24
	7 x line 19)				
5.00	Swing-bed cost applicable to NF type services after December x line 20)	31 of the cost reporting	period (line 8	0	25
5.00	Total swing-bed cost (see instructions)			0	26
7.00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		9, 025, 252	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
	General inpatient routine service charges (excluding swing-b Private room charges (excluding swing-bed charges)	ed and observation bed ch	arges)	0	28
	Semi -private room charges (excluding swing-bed charges)			0	30
I. 00	General inpatient routine service cost/charge ratio (line 27	÷line 28)		0. 000000	31
	Average private room per diem charge (line 29 ÷ line 3)			0.00	
	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 m		tions)	0.00 0.00	
	Average per diem private room cost differential (line 34 x l			0.00	
5.00	Private room cost differential adjustment (line 3 x line 35)			0	36
7.00	General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line	9, 025, 252	37
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				1
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AD.	JUSTMENTS			1
	Adjusted general inpatient routine service cost per diem (se			1, 507. 73	
	Program general inpatient routine service cost (line 9 x lin Medically necessary private room cost applicable to the Proq			31, 662	
	Medically necessary private room cost applicable to the Prod	iam (IIIIE 14 X IIIIE 35)		0	40

OMPUT	Financial Systems FF ATION OF INPATIENT OPERATING COST	RANCI SCAN HEALTH		CN: 15-0162	Peri od:	worksheet D-1	
			Component	CCN: 15-T162	From 01/01/2023 To 12/31/2023		
			Ti t	e XIX	Subprovider -	PPS	трш
	Cost Center Description	Total Inpatient Costl	Total npatient Days	Average Per Diem (col. 1 col. 2)		Program Cost (col. 3 x col. 4)	
2 00	NUDSEDV (title V & VIV entv)	1.00	2.00	3.00 0 0.	4.00	5.00	42.0
2.00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	(J 0.		ų <u> </u>	42.0
3.00	INTENSIVE CARE UNIT	0	(
3.01	NEONATAL INTENSIVE CARE UNIT CORONARY CARE UNIT	0	(0. 0.			
5.00	BURN INTENSIVE CARE UNIT	5	· · · · · · · · · · · · · · · · · · ·				45.0
6.00	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)	0	(0.	00 0	0	46.0 47.0
7.00	Cost Center Description						47.0
0.00			11 2002			1.00	40.0
8.00 8.01	Program inpatient ancillary service cost (Wks Program inpatient cellular therapy acquisitio			III. line 10	column 1)	87, 815 0	1
9.00	Total Program inpatient costs (sum of lines 4	•				119, 477	
0.00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inpa	ationt routing s	ervices (fro	m Wkst D su	m of Parts I and	4, 642	50. C
0.00	()	attent foutthe s	ervices (110	n wkst. D, Su		4, 042	50.0
1. 00	Pass through costs applicable to Program inpa	atient ancillary	services (f	rom Wkst. D,	sum of Parts II	5, 019	51.0
2.00	and IV) Total Program excludable cost (sum of lines !	50 and 51)				9, 661	52.0
3.00	Total Program inpatient operating cost exclude	ding capital rel	ated, non-ph	ysician anestl	netist, and	109, 816	
	medical education costs (line 49 minus line ! TARGET AMOUNT AND LIMIT COMPUTATION	52)					
4.00	Program di scharges					0	54.0
5.00 5.01	Target amount per discharge Permanent adjustment amount per discharge					0.00	
5. 01	Adjustment amount per discharge (contractor u	use only)				0.00	
6. 00	Target amount (line 54 x sum of lines 55, 55.	01, and 55.02)				0	56.
7.00 8.00	Difference between adjusted inpatient operati Bonus payment (see instructions)	ng cost and tar	get amount (ine 56 minus	line 53)	0	
9.00	Trended costs (lesser of line 53 ÷ line 54, (or line 55 from	the cost rep	orting period	endi ng 1996,	0.00	
0. 00	updated and compounded by the market basket) Expected costs (lesser of line 53 ÷ line 54,	or line 55 from	prior year o	cost report, i	updated by the	0.00	60. (
1.00	market basket)	E2 Lipo E4 i	c locc than	the lowest of	Lines EE plus	0	61. (
1.00	Continuous improvement bonus payment (if line 55.01, or line 59, or line 60, enter the less 53) are less than expected costs (lines 54 x enter zero. (see instructions)	ser of 50% of th	e amount by v	which operati	ng costs (line		01.0
2.00	Relief payment (see instructions)					0	
3.00	Allowable Inpatient cost plus incentive payme PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instruc	tions)			0	63.0
4.00	Medicare swing-bed SNF inpatient routine cos	ts through Decem	ber 31 of the	e cost report	ng period (See	0	64. (
5.00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	ts after Decembe	r 31 of the (cost reportin	a period (See	0	65. (
	instructions)(title XVIII only)						
6. 00	Total Medicare swing-bed SNF inpatient routin CAH, see instructions	ne costs (line 6	4 plus line (65)(title XVI	ll only); for	0	66.0
7.00	Title V or XIX swing-bed NF inpatient routine	e costs through	December 31 (of the cost r	eporting period	0	67.0
8. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routing	e costs after De	cember 31 of	the cost rep	orting period	0	68. (
9. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient (0	69.
D. 00	PART III - SKILLED NURSING FACILITY, OTHER NU Skilled nursing facility/other nursing facili)		70.0
1.00	Adjusted general inpatient routine service of				,		71.
2.00	Program routine service cost (line 9 x line)		(line 14	PO 25)			72.
3.00 4.00	Medically necessary private room cost applica Total Program general inpatient routine servi	0	•				73.0
5.00	Capital-related cost allocated to inpatient (26, line 45)				Part II, column		75.
5.00	Per diem capital-related costs (line 75 ÷ lin						76.
7.00 3.00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minus						77.
9.00	Aggregate charges to beneficiaries for excess	s costs (from pr					79.
0.00	Total Program routine service costs for compa		st limitatio	n (line 78 mi	nus line 79)		80.
1.00 2.00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (li						81. 82.
3.00	Reasonable inpatient routine service costs (,)				83.
	Program inpatient ancillary services (see ins						84.
4.00	litilization moulou physicic company i						
4.00 5.00 6.00	Utilization review - physician compensation Total Program inpatient operating costs (sum						85. 0 86. 0

lealth Financial Systems FR	ANCISCAN HEALT	H INDIANAPOLIS		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period: From 01/01/2023	Worksheet D-1	
		Component C		To 12/31/2023		
		Title	e XIX	Subprovider - IRF	PPS	
Cost Center Description						
					1.00	
38.00 Adjusted general inpatient routine cost per d	diem (line 27 ÷	line 2)			0.00	88.00
39.00 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 C	OST			·		
90.00 Capital-related cost	1, 323, 140	9, 025, 252	0. 14660	4 0	0	90.00
91.00 Nursing Program cost	0	9,025,252	0.00000	0 0	0	91.00
92.00 Allied health cost	0	9,025,252		o o	0	92.00
93.00 All other Medical Education	_	9,025,252			1	93.00

	Financial Systems ENT ANCILLARY SERVICE COST APPORTIONMENT	FRANCISCAN HEALTH INDIANAPOLIS Provider C		Peri od:	eu of Form CMS- Worksheet D-3	
				From 01/01/2023 To 12/31/2023	Date/Time Pre 3/28/2024 2:2	
-		Title	XVIII	Hospi tal	PPS	
	Cost Center Description		Ratio of Cos To Charges	t Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
	INPATIENT ROUTINE SERVICE COST CENTERS		1		1	_
	03000 ADULTS & PEDIATRICS			61, 268, 366		30.00
	03100 I NTENSI VE CARE UNI T			13, 010, 819		31.00
	02060 NEONATAL INTENSIVE CARE UNIT			0		31.01
	03200 CORONARY CARE UNIT			14, 712, 099		32.00
	03400 SURGI CAL INTENSI VE CARE UNI T			9, 631, 723		34.00
	04100 SUBPROVI DER – I RF 04300 NURSERY			0	1	41.00
	ANCI LLARY SERVICE COST CENTERS					43.00
	05000 OPERATI NG ROOM		0. 1230	72 52, 363, 550	6, 444, 487	50.00
	05200 DELIVERY ROOM & LABOR ROOM		0. 1230			
	05400 RADI OLOGY-DI AGNOSTI C		0. 0837			
	05500 RADI OLOGY-THERAPEUTI C		0. 1105			
	05600 RADI OI SOTOPE		0. 0560			
	05900 CARDI AC CATHETERI ZATI ON		0. 0391			
	06000 LABORATORY		0. 12470			
	06400 INTRAVENOUS THERAPY		0.0956			
	06500 RESPI RATORY THERAPY		0. 2102			
66.00	06600 PHYSI CAL THERAPY		0. 1664			66.00
67.00	06700 OCCUPATI ONAL THERAPY		0. 1257	19 5, 064, 000	636, 641	67.00
	06800 SPEECH PATHOLOGY		0. 1556	58 1, 399, 026	217, 770	68.00
69.00	06900 ELECTROCARDI OLOGY		0. 0826	33 11, 790, 746	974, 305	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY		0. 1123	18 2, 713, 582	304, 784	1 70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIEN	Т	0. 2515	32 49, 814, 599	12, 529, 966	5 71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS		0. 2813	72 38, 456, 984	10, 820, 719	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		0. 1744	97 54, 643, 751	9, 535, 171	73.00
74.00	07400 RENAL DIALYSIS		0. 2621	44 3, 000, 592	786, 587	74.00
76.97	07697 CARDI AC REHABI LI TATI ON		0. 1738	03 39, 922	6, 939	76.97
	07700 ALLOGENEIC HSCT ACQUISITION		2.4646		0 0	
	07800 CAR T-CELL IMMUNOTHERAPY		0. 2044	93 15, 486, 184	3, 166, 816	5 78.00
	OUTPATIENT SERVICE COST CENTERS				1	
	09000 CLINIC		0. 64710			
	09001 IBMT JOINT VENTURE		0. 1736			
	09002 MOORESVILLE INFUSION CLINIC		0. 10530			
	09005 CV DIAGNOSTIC SERVICES		0. 1242			
	09100 EMERGENCY	-	0.0726			
	09200 OBSERVATION BEDS (NON-DISTINCT PAR		0. 2465			
200.00	Total (sum of lines 50 through 94			411, 888, 255		
201.00	Less PBP Clinic Laboratory Service			411 000 255		201.00
202.00	Net charges (line 200 minus line 2	01)	1	411, 888, 255		202.00

Heal th	Fin	anci al	Sys	tems	
		ANCLL			COCT

FRANCISCAN HEALTH INDIANAPOLIS

In Lieu of Form CMS-2552-10

Health Financial Systems FRANCISCAN HEALTH	H INDIANAPOLIS	<u> </u>	In Lie	eu of Form CMS-	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0162	Peri od:	Worksheet D-3	
	Component	CCN: 15-T162	From 01/01/2023 To 12/31/2023	Date/Time Pre 3/28/2024 2:2	pared: 1 pm
	Title	e XVIII	Subprovider - IRF	PPS	
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		1		I	
30. 00 03000 ADULTS & PEDI ATRI CS					30.00
31. 00 03100 I NTENSI VE CARE UNI T					31.00
31.01 02060 NEONATAL INTENSIVE CARE UNIT					31.01
32.00 03200 CORONARY CARE UNIT					32.00
34.00 03400 SURGI CAL I NTENSI VE CARE UNI T					34.00
41. 00 O4100 SUBPROVIDER - IRF			10, 445, 770		41.00
43. 00 04300 NURSERY					43.00
ANCI LLARY SERVI CE COST CENTERS					
50.00 05000 OPERATING ROOM		0. 1230			50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 1844		0	52.00
54.00 05400 RADI OLOGY-DI AGNOSTI C		0. 08372			
55. 00 05500 RADI OLOGY-THERAPEUTI C		0. 1105			
56. 00 05600 RADI OI SOTOPE		0. 0560			
59. 00 05900 CARDI AC CATHETERI ZATI ON		0. 03914	16, 768	656	•
60. 00 06000 LABORATORY		0. 12470	06 800, 884	99, 875	60.00
64.00 06400 INTRAVENOUS THERAPY		0. 0956			64.00
65. 00 06500 RESPI RATORY THERAPY		0. 2102	91 515, 752		65.00
66. 00 06600 PHYSI CAL THERAPY		0. 1664			66.00
67. 00 06700 OCCUPATI ONAL THERAPY		0. 1257			
68.00 06800 SPEECH PATHOLOGY		0. 1556			•
69. 00 06900 ELECTROCARDI OLOGY		0. 0826			•
70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 1123			•
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 2515		247, 445	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 2813		1, 815	
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 1744		146, 011	73.00
74.00 07400 RENAL DIALYSIS		0. 2621			74.00
76. 97 07697 CARDI AC REHABI LI TATI ON		0. 1738			
77.00 07700 ALLOGENEIC HSCT ACQUISITION		2.4646			77.00
78.00 07800 CAR T-CELL IMMUNOTHERAPY		0. 2044	93 0	0	78.00
OUTPATI ENT SERVICE COST CENTERS					
90. 00 09000 CLINIC		0.64710		5	90.00
90. 01 09001 I BMT JOI NT VENTURE		0. 1736		0	90.01
90. 02 09002 MOORESVILLE INFUSION CLINIC		0. 10530		-	90.02
90. 05 09005 CV DI AGNOSTI C SERVI CES		0. 1242			90.05
91.00 09100 EMERGENCY		0.0726			1
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 2465		0	
200.00 Total (sum of lines 50 through 94 and 96 through 98)			10, 296, 077	1, 632, 695	
201.00 Less PBP Clinic Laboratory Services-Program only charg	jes (line 61)		0		201.00
202.00 Net charges (line 200 minus line 201)		1	10, 296, 077	l	202.00

NPATI	ENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0162	Period: From 01/01/2023 To 12/31/2023		epared
		Titl	e XIX	Hospi tal	PPS	
	Cost Center Description		Ratio of Cos To Charges	t Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS		1		1	
	03000 ADULTS & PEDI ATRI CS			31, 970, 862		30.
	03100 I NTENSI VE CARE UNI T			8, 032, 560		31.
	02060 NEONATAL INTENSIVE CARE UNIT			20, 909, 560		31.
	03200 CORONARY CARE UNI T			5, 031, 078		32.
	03400 SURGI CAL I NTENSI VE CARE UNI T			4, 588, 895		34.
	04100 SUBPROVI DER – I RF			0		41.
3.00	04300 NURSERY			3, 006, 160		43.
	ANCI LLARY SERVI CE COST CENTERS		1		1	
	05000 OPERATING ROOM		0. 1230			
	05200 DELIVERY ROOM & LABOR ROOM		0. 1844			
	05400 RADI OLOGY-DI AGNOSTI C		0. 08372			
	05500 RADI OLOGY-THERAPEUTI C		0. 1105			
	05600 RADI OI SOTOPE		0. 0560			
	05900 CARDI AC CATHETERI ZATI ON		0. 0391			
	06000 LABORATORY		0. 12470			
	06400 I NTRAVENOUS THERAPY		0. 0956		105, 703	
	06500 RESPI RATORY THERAPY		0. 2102			
	06600 PHYSI CAL THERAPY		0. 1664		384, 036	66.
	06700 OCCUPATI ONAL THERAPY		0. 1257			
	06800 SPEECH PATHOLOGY		0. 1556		190, 511	68.
	06900 ELECTROCARDI OLOGY		0. 0826	33 4, 530, 720	374, 387	69.
	07000 ELECTROENCEPHALOGRAPHY		0. 1123	18 2, 138, 111	240, 148	3 70.
1.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 2515	32 22, 709, 267	5, 712, 107	71.
	07200 I MPL. DEV. CHARGED TO PATIENTS		0. 2813		1, 875, 932	2 72.
	07300 DRUGS CHARGED TO PATIENTS		0. 1744	97 29, 080, 542	5, 074, 467	73.
	07400 RENAL DI ALYSI S		0. 2621	44 1, 273, 780	333, 914	74.
	07697 CARDI AC REHABI LI TATI ON		0. 1738	03 19, 319	3, 358	8 76.
	07700 ALLOGENEIC HSCT ACQUISITION		2. 4646	30 0	0) 77.
8.00	07800 CAR T-CELL IMMUNOTHERAPY		0. 2044	93 0	0	78.
	OUTPATIENT SERVICE COST CENTERS				1	
	09000 CLI NI C		0. 64710	289, 102	187, 080	90.
	09001 I BMT JOINT VENTURE		0. 1736		1, 679	
0. 02	09002 MOORESVILLE INFUSION CLINIC		0. 1053	0 0	0	90.
	09005 CV DI AGNOSTI C SERVI CES		0. 1242	15 34, 928	4, 339	90.
1.00	09100 EMERGENCY		0. 0726	54 16, 655, 020	1, 210, 054	91.
2.00	09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 2465	75 1, 682, 661	414, 902	92.
00.00	Total (sum of lines 50 through 94 and 96 through 98)			192, 214, 190	29, 231, 905	200.
01.00		es (line 61)		0		201
02.00	Net charges (line 200 minus line 201)		1	192, 214, 190		202.

Health Financial Systems FRANCISCAN INPATIENT ANCILLARY SERVICE COST APPORTIONMENT FRANCISCAN	Provider C	CN: 15-0162	Peri od:	u of Form CMS-2 Worksheet D-3	
			From 01/01/2023		
	Component	CCN: 15-T162	To 12/31/2023	Date/Time Prep 3/28/2024 2:2	
	Titl	e XIX	Subprovider -	PPS	i pii
			I RF		
Cost Center Description		Ratio of Cos		Inpatient	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
		1.00	2.00	2)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
30. 00 03000 ADULTS & PEDIATRICS					30.00
31. 00 03100 I NTENSI VE CARE UNI T					31.00
31. 01 02060 NEONATAL INTENSIVE CARE UNIT					31.01
32. 00 03200 CORONARY CARE UNI T					32.00
34. 00 03400 SURGI CAL I NTENSI VE CARE UNI T					34.00
41. 00 04100 SUBPROVIDER - IRF			975, 942		41.00
43.00 04300 NURSERY					43.00
ANCILLARY SERVICE COST CENTERS					
50. 00 05000 OPERATING ROOM		0. 12307	2 2, 088	257	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 18444	9 0	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 08372		0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C		0. 11058		0	55.00
56. 00 05600 RADI 0I SOTOPE		0. 05605		0	56.00
59. 00 05900 CARDI AC CATHETERI ZATI ON		0. 03914		0	59.00
60. 00 06000 LABORATORY		0. 12470			60.00
64.00 06400 I NTRAVENOUS THERAPY		0. 09563		0	64.00
65. 00 06500 RESPI RATORY THERAPY		0. 21029		0	65.00
66. 00 06600 PHYSI CAL THERAPY		0. 16644			
67. 00 06700 OCCUPATI ONAL THERAPY		0. 12571			67.00
68. 00 06800 SPEECH PATHOLOGY		0. 15565			68.00
69. 00 06900 ELECTROCARDI OLOGY		0. 08263		0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 11231		0	70.00
71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT		0. 25153		429	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS		0. 28137	2 0	0	72.00

73.00

74.00

77.00

90.02

90.05

91.00

201.00

202.00

25

0

0 76.97

0

0 78.00

0 90.00

0 90.01

0

0

0

0 92.00

87, 815 200. 00

146

0 0 0

0

0 0

0 0 0

0

0

591, 499

591, 499

0.174497

0.262144

0.173803

2.464630

0.204493

0.647106

0.173618

0.105309

0.124215

0.072654

0.246575

73.00 07300 DRUGS CHARGED TO PATIENTS

09001 IBMT JOINT VENTURE

90.05 09005 CV DIAGNOSTIC SERVICES

07697 CARDI AC REHABI LI TATI ON

07800 CAR T-CELL IMMUNOTHERAPY

OUTPATIENT SERVICE COST CENTERS

09002 MOORESVILLE INFUSION CLINIC

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART

Net charges (line 200 minus line 201)

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

Less PBP Clinic Laboratory Services-Program only charges (line 61)

07700 ALLOGENEIC HSCT ACQUISITION

74.00 07400 RENAL DIALYSIS

09000 CLI NI C

91.00 09100 EMERGENCY

76.97

77.00

78.00

90.00

90.01

90.02

200.00

201.00

202.00

	Financial Systems Fi ATION OF CELLULAR THERAPY ACQUISITION COSTS	RANCISCAN HEALT	TH INDIANAPOLIS Provider C	CN: 15-0162 Pe	eriod: rom 01/01/2023	eu of Form CMS-: Worksheet D-6 Parts I - IV Date/Time Pre	
	Inpatient Routine Services Acquisition Costs	D-1	Routi ne Servi ces	Per Diem Costs (see	Inpatient Acquisition	3/28/2024 2:2 Acqui si ti on Costs (col. 2	1 pm
			Acqui si ti on Charges	instructions)	Days	x col. 3)	
	PART I - INPATIENT ROUTINE AND ANCILLARY SERV			2.00	3.00	4.00	
1.00	ADULTS & PEDIATRICS	38.00			0	0	1.00
2.00	INTENSIVE CARE UNIT	43.00	C		0		2.00
2.01 3.00	NEONATAL INTENSIVE CARE UNIT CORONARY CARE UNIT	43.01 44.00	C	1, 580. 54	0	0	2.01 3.00
4.00	BURN INTENSIVE CARE UNIT	45.00					4.00
5.00	SURGICAL INTENSIVE CARE UNIT	46.00	C	_,	0	0	5.00
6.00 7.00	OTHER SPECIAL CARE (SPECIFY) TOTAL (sum of lines 1 through 6)	47.00		0.00	0	0	6.00 7.00
7.00	Ancillary Services Acquisition Costs	С	Ratio of Cost	Inpatient	Outpati ent	Inpatient	7.00
			to Charges	Ancillary	Ancillary	Ancillary	
			(from Wkst. C, Pt. I, col. 9)	Services Acquistion	Services Acquistion	Services Acquistion	
			. ,	Charges	Charges	Cost	
8.00	OPERATI NG ROOM	0	1.00	2.00	3.00	4.00	8.00
8.00 9.00	RECOVERY ROOM	51.00	0. 123072	-	0		9.00
10.00	DELIVERY ROOM & LABOR ROOM	52.00					10.00
11.00 12.00	ANESTHESI OLOGY RADI OLOGY-DI AGNOSTI C	53.00 54.00	0. 000000		0	0 69, 275	11.00
13.00	RADI OLOGY-THERAPEUTI C	55.00	0. 110583		0	07,275	13.00
14.00	RADI OI SOTOPE	56.00	0. 056058		0	0	14.00
15.00 16.00	CT SCAN MAGNETIC RESONANCE IMAGING (MRI)	57.00 58.00	0. 000000		0	0	15.00 16.00
17.00	CARDI AC CATHETERI ZATI ON	59.00	0. 039145		0	0	
18.00	LABORATORY	60.00	0. 124706		0	40, 862	18.00
19.00 20.00	PBP CLINICAL LAB SERVICES-PRGM ONLY WHOLE BLOOD & PACKED RED BLOOD CELLS	61.00 62.00	0. 000000		0	0	19.00 20.00
21.00	BLOOD STORING, PROCESSING & TRANS.	63.00	0. 000000		0	0	21.00
22.00	INTRAVENOUS THERAPY	64.00	0.095630		0	115	1
23.00 24.00	ELECTROCARDI OLOGY MEDI CAL SUPPLI ES CHARGED TO PATI ENT	69.00 71.00	0. 082633 0. 251532		0	0 50	
25.00	DRUGS CHARGED TO PATIENTS	73.00	0. 174497	17, 903	0	3, 124	1
26.00	ASC (NON-DI STI NCT PART)	75.00 76.00	0.00000		0	0	26.00
27.00 27.97	OTHER ANCILLARY SERVICE COST CENTERS CARDIAC REHABILITATION	76.97	0. 000000		0	0	27.00 27.97
28.00	CLINIC	90.00	0. 647106	0	0	0	28.00
28. 01 28. 02	IBMT JOINT VENTURE MOORESVILLE INFUSION CLINIC	90.01 90.02	0. 173618		0	2, 596 1, 486	
28.02	CV DI AGNOSTI C SERVI CES	90.02	0. 124215		0		28.02
30.00	TOTAL (sum of lines 8 through 28)			1, 203, 450	0	117, 508	30.00
	Ancillary Services Acquisition Costs	Outpatient Ancillary					
		Servi ces					
		Acquistion Cost					
		5.00	-				
8.00	OPERATING ROOM	C	-				8.00
9.00 10.00	RECOVERY ROOM DELIVERY ROOM & LABOR ROOM	C					9.00 10.00
11.00	ANESTHESI OLOGY	C					11.00
12.00 13.00	RADI OLOGY-DI AGNOSTI C RADI OLOGY-THERAPEUTI C						12.00 13.00
14.00	RADI OI SOTOPE						14.00
15.00	CT SCAN	C	-				15.00
16.00 17.00	MAGNETIC RESONANCE IMAGING (MRI) CARDIAC CATHETERIZATION		-				16.00 17.00
18.00	LABORATORY	0	-				18.00
19.00	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	-				19.00
20. 00 21. 00	WHOLE BLOOD & PACKED RED BLOOD CELLS BLOOD STORING, PROCESSING & TRANS.						20.00
22.00	INTRAVENOUS THERAPY	C					22.00
23.00 24.00	ELECTROCARDI OLOGY MEDI CAL SUPPLI ES CHARGED TO PATI ENT		-				23.00 24.00
24.00 25.00	DRUGS CHARGED TO PATIENT						24.00
26.00	ASC (NON-DISTINCT PART)	C	-				26.00
27.00 27.97	OTHER ANCILLARY SERVICE COST CENTERS CARDIAC REHABILITATION						27.00 27.97
27.97 28.00	CLINIC		-				27.97
28.01	I BMT JOINT VENTURE	C					28.01
	MOORESVILLE INFUSION CLINIC CV DIAGNOSTIC SERVICES						28.02 28.05
20.00			1				20.00

Health Financial Systems	FRANCI SCAN HEALTH	I NDI ANAPOLI S	In Lieu	u of Form CMS-2552-10
COMPUTATION OF CELLULAR THERAPY ACQUISITION COSTS		Provider CCN: 15-0162	Period: From 01/01/2023 To 12/31/2023	Worksheet D-6 Parts I - IV Date/Time Prepared: 3/28/2024 2:21 pm
Ancillary Services Acquisition Costs	Outpatient Ancillary Services Acquistion <u>Cost</u> 5.00			
30.00 TOTAL (sum of lines 8 through 28)	0			30.00

2.00 INTENSIVE CARE UNIT 3.00 0.00 0 2.01 NEONATAL INTENSIVE CARE UNIT 3.01 0.00 0 3.00 CORONARY CARE UNIT 4.00 0 0 4.00 BURN INTENSIVE CARE UNIT 4.00 0 0 5.00 SURGICAL INTENSIVE CARE UNIT 6.00 0.00 0 6.00 OTHER SPECIAL CARE (SPECIFY) 0 0 0 7.00 TOTAL (sum of lines 1 through 6) 0 0 0 Amount 1.00	
Program Acquisition Costs Per Day (from Wkst. D-2, Pt. I, col. 4) Acquisition Days B Acquisition Costs (col. x col. 2) 0 1.00 2.00 3.00 PART 11 - INTERNS AND RESIDENTS NOT IN AN APPROVED TEACHING PROGRAM CELLULAR THERAPY ACOULSITION COSTS 1.00 ADULTS & PEDIATRICS 2.00 0 0.00 0 2.00 INTENSIVE CARE UNIT 3.00 0.00 0 0 2.01 NEONATAL INTENSIVE CARE UNIT 3.01 0.00 0 0 3.00 CORONARY CARE UNIT 4.00 0 0 0 4.00 BURN INTENSIVE CARE UNIT 6.00 0.00 0 0 5.00 SURGICAL INTENSIVE CARE UNIT 6.00 0.00 0 0 7.00 TOTAL (sum of lines 1 through 6) 0 0 0 0 PART 111 - SUMMARY OF CELLULAR THERAPY ACQUISITION COSTS	epared: 21 pm
PART 11 - INTERNS AND RESIDENTS NOT IN AN APPROVED TEACHING PROGRAM CELLULAR THERAPY ACQUISITION COSTS 1.00 ADULTS & PEDIATRICS 2.00 0.00 0 2.00 INTENSIVE CARE UNIT 2.00 0.00 0 2.01 NEONATAL INTENSIVE CARE UNIT 3.01 0.00 0 3.00 CORONARY CARE UNIT 4.00 0 0 4.00 BURN INTENSIVE CARE UNIT 6.00 0.00 0 5.00 SURGICAL INTENSIVE CARE UNIT 6.00 0.00 0 7.00 TOTAL (sum of lines 1 through 6) 0 0 0 SUMMARY OF CELLULAR THERAPY ACQUISITION COSTS 0 0	1
PART II INTERNS AND RESIDENTS NOT IN AN APPROVED TEACHING PROGRAM CELLULAR THERAPY ACQUISITION COSTS 1.00 ADULTS & PEDIATRICS 2.00 0.00 0 2.00 INTENSIVE CARE UNIT 3.00 0.00 0 2.01 NEONATAL INTENSIVE CARE UNIT 3.01 0.00 0 3.00 CORONARY CARE UNIT 4.00 0 0 4.00 BURN INTENSIVE CARE UNIT 6.00 0.00 0 5.00 SURGICAL INTENSIVE CARE UNIT 6.00 0 0 7.00 TOTAL (Sum of Lines 1 through 6) 0 0 0 Amount PART III - SUMMARY OF CELLULAR THERAPY ACQUISITION COSTS	
1.00 ADULTS & PEDIATRICS 2.00 0.00 0 2.00 INTENSIVE CARE UNIT 3.00 0.00 0 2.01 NEONATAL INTENSIVE CARE UNIT 3.01 0.00 0 3.00 CORONARY CARE UNIT 4.00 0 0 4.00 BURN INTENSIVE CARE UNIT 6.00 0.00 0 5.00 SURGICAL INTENSIVE CARE UNIT 6.00 0.00 0 6.00 OTHER SPECIAL CARE (SPECIFY) 0 0 0 7.00 TOTAL (sum of lines 1 through 6) 0 0 0 Amount PART 111 - SUMMARY OF CELLULAR THERAPY ACQUI SITION COSTS	
2.00 INTENSIVE CARE UNIT 3.00 0.00 0 2.01 NEONATAL INTENSIVE CARE UNIT 3.01 0.00 0 3.00 CORONARY CARE UNIT 4.00 0 0 4.00 BURN INTENSIVE CARE UNIT 4.00 0 0 5.00 SURGICAL INTENSIVE CARE UNIT 6.00 0.00 0 6.00 OTHER SPECIAL CARE (SPECIFY) 0 0 0 7.00 TOTAL (sum of lines 1 through 6) 0 0 0 Amount PART 111 - SUMMARY OF CELLULAR THERAPY ACQUI SITION COSTS	
2.01 NEONATAL INTENSIVE CARE UNIT 3.01 0.00 0 3.00 CORONARY CARE UNIT 4.00 4.00 6.00 0 4.00 BURN INTENSIVE CARE UNIT 6.00 0.00 0 5.00 SURGICAL INTENSIVE CARE UNIT 6.00 0.00 0 6.00 OTHER SPECIAL CARE (SPECIFY) 6.00 0.00 0 7.00 TOTAL (sum of lines 1 through 6) 0 0 Amount PART 111 - SUMMARY OF CELLULAR THERAPY ACQUI SITION COSTS	0 1.00
3.00 CORONARY CARE UNIT 4.00 4.00 BURN INTENSIVE CARE UNIT 6.00 5.00 SURGICAL INTENSIVE CARE UNIT 6.00 6.00 OTHER SPECIAL CARE (SPECIFY) 6.00 7.00 TOTAL (sum of lines 1 through 6) 0 Amount 1.00	0 2.00
4.00 BURN INTENSIVE CARE UNIT 5.00 SURGICAL INTENSIVE CARE UNIT 6.00 OTHER SPECIAL CARE (SPECIFY) 7.00 TOTAL (sum of lines 1 through 6) 6.00 O PART 111 - SUMMARY OF CELLULAR THERAPY ACQUISITION COSTS	0 2.01
5.00 SURGICAL INTENSIVE CARE UNIT 6.00 0.00 0 6.00 OTHER SPECIAL CARE (SPECIFY) 0 0 7.00 TOTAL (sum of lines 1 through 6) 0 0 Amount PART III - SUMMARY OF CELLULAR THERAPY ACQUISITION COSTS	3.00
6.00 OTHER SPECIAL CARE (SPECIFY) 7.00 TOTAL (sum of lines 1 through 6) 0 Amount 1.00 PART III - SUMMARY OF CELLULAR THERAPY ACQUISITION COSTS	4.00
7.00 TOTAL (sum of lines 1 through 6) 0 PART III - SUMMARY OF CELLULAR THERAPY ACQUISITION COSTS Amount	6.00
PART III - SUMMARY OF CELLULAR THERAPY ACQUISITION COSTS	0 7.00
PART III - SUMMARY OF CELLULAR THERAPY ACQUISITION COSTS	7.00
1.00 Acquisition cost from Worksheet B, col. 26 (see instructions) 2,272,21	9 1.00
Acquisition Services Total Costs Inpatient Outpatient	
1.00 2.00	
	0 2.00
	0 3.00
	0 4.00
	0 5.00
	0 6.00
Determine Ratio of Medicare Transplants to Total Transplants Inpatient Outpatient Total	
1.00 2.00 3.00	
7.00Total transplants (see instructions)2402	
8.00 Medicare transplants (see instructions) 6 0	8.00
9.00 Medicare ratio (line 8 ÷ line 7) 0.250000 0.000000	9.00
10.00 Medicare cost (see instructions) 597, 432 0	10.00
<u>Amount</u> 1.00	
PART IV - STATISTICS	
	0 1.00

	ATION OF REIMBURSEMENT SETTLEMENT Provider CCN: 15-0162 Period: From 01/01/2023 To 12/31/2023	Date/Time Pre 3/28/2024 2:2	pared:
	Ti tle XVIII Hospi tal	PPS	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS	1.00	
1.00	DRG Amounts Other than Outlier Payments	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see	55, 317, 679	1. 01
1.02	instructions) DRG amounts other than outlier payments for discharges occurring on or after October 1 (see	20, 157, 856	1. 02
1 00	instructions)		
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)	0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after	0	1.04
2.00	October 1 (see instructions) Outlier payments for discharges. (see instructions)		2.00
2.01	Outlier reconciliation amount	0	2.01
2.02 2.03	Outlier payment for discharges for Model 4 BPCI (see instructions) Outlier payments for discharges occurring prior to October 1 (see instructions)	0 3, 425, 329	2.02 2.03
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	1, 158, 223	
3.00	Managed Care Simulated Payments	70, 884, 874	
4.00	Bed days available divided by number of days in the cost reporting period (see instructions) Indirect Medical Education Adjustment	383.38	4.00
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on	21. 78	5.00
5.01	or before 12/31/1996.(see instructions) FTE cap adjustment for qualifing hospitals under §131 of the CAA 2021 (see instructions)	0.00	5. 01
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for	0.00	1
6.26	new programs in accordance with 42 CFR 413.79(e) Rural track program FTE cap limitation adjustment after the cap-building window closed under §127 of	0.00	6.26
	the CAA 2021 (see instructions)		
7.00 7.01	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1) ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the	0.32 0.00	7.00 7.01
7.01	cost report straddles July 1, 2011 then see instructions.	0.00	7.01
7.02	Adjustment (increase or decrease) to the hospital's rural track program FTE limitation(s) for rural track programs with a rural track for Medicare GME affiliated programs in accordance with 413.75(b)	0.00	7.02
	and 87 FR 49075 (August 10, 2022) (see instructions)		
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for	0.00	8.00
	affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost	0. 81	8. 01
8.02	report straddles July 1, 2011, see instructions. The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital	0.00	8. 02
0.01	under § 5506 of ACA. (see instructions)	0.00	0.01
8. 21	The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see instructions)	0.00	8. 21
9.00	Sum of lines 5 and 5.01, plus line 6, plus lines 6.26 through 6.49, minus lines 7 and 7.01, plus or	22.27	9.00
10.00	minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.27 (see instructions) FTE count for allopathic and osteopathic programs in the current year from your records	25.99	10.00
11.00	FTE count for residents in dental and podiatric programs.	0.00	11.00
	Current year allowable FTE (see instructions) Total allowable FTE count for the prior year.	22. 27 22. 27	12.00 13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997,	22.27	
15.00	otherwise enter zero. Sum of lines 12 through 14 divided by 3.	22.27	15.00
16.00	Adjustment for residents in initial years of the program (see instructions)	0.00	
17.00	Adjustment for residents displaced by program or hospital closure	0.00	
18.00 19.00	Adjusted rolling average FTE count Current year resident to bed ratio (line 18 divided by line 4).	22. 27 0. 058089	18.00 19.00
20.00	Prior year resident to bed ratio (see instructions)	0. 047599	20.00
21.00 22.00	Enter the lesser of lines 19 or 20 (see instructions) IME payment adjustment (see instructions)	0. 047599 1, 937, 080	
22.00	IME payment adjustment - Managed Care (see instructions)	1, 819, 260	
22.00	Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA	0.00	22.00
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).	0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	3.72	
25.00	If the amount on line 24 is greater than -O-, then enter the lower of line 23 or line 24 (see instructions)	0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0. 000000	
27.00 28.00	IME payments adjustment factor. (see instructions) IME add-on adjustment amount (see instructions)	0. 000000 0	27.00 28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)	0	28.01
29. 00 29. 01	Total IME payment (sum of lines 22 and 28) Total IME payment – Managed Care (sum of lines 22.01 and 28.01)	1, 937, 080 1, 819, 260	
∠7. UI	Disproportionate Share Adjustment	1, 019, 200	27.01
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	3.04	
31.00 32.00	Percentage of Medicaid patient days (see instructions) Sum of lines 30 and 31	21.75 24.79	
33.00	Allowable disproportionate share percentage (see instructions)	9.67	33.00
34.00	Disproportionate share adjustment (see instructions)	1, 824, 621	34.00

	Financial Systems FRANCISCAN HEALTH ATI ON OF REI MBURSEMENT SETTLEMENT FRANCISCAN HEALTH	Provider CCN: 15-0162	Peri od:	u of Form CMS-2 Worksheet E	
			From 01/01/2023 To 12/31/2023	Part A Date/Time Pre	
		T: +1 - \/// + 1		3/28/2024 2:2	1 pm
		Title XVIII	Hospital Prior to 10/1	PPS	
			1.00	2.00	
	Uncompensated Care Payment Adjustment				
5.00	Total uncompensated care amount (see instructions)		0	0	
5. 01	Factor 3 (see instructions)		0. 00000000	0.00000000	
5. 02	Hospital UCP, including supplemental UCP (If line 34 is zero,	enter zero on this line) 7, 673, 313	5, 838, 991	35.
- 02	(see instructions)		F 700 01/	1 4/7 704	25
5.03 5.00	Pro rata share of the hospital UCP, including supplemental UC Total UCP adjustment (sum of columns 1 and 2 on line 35.03)	CP (see instructions)	5, 739, 216 7, 206, 940	1, 467, 724	35. 36.
3. 00	Additional payment for high percentage of ESRD beneficiary di	scharges (Lines 40 throu			30.
0. 00	Total Medicare discharges (see instructions)	Scharges (Tries 40 throu	0		40.
1.00	Total ESRD Medicare discharges (see instructions)		0		41.
I. 01	Total ESRD Medicare covered and paid discharges (see instruct	tions)	0		41.
2.00	Divide line 41 by line 40 (if less than 10%, you do not quali	fy for adjustment)	0.00		42.
3.00	Total Medicare ESRD inpatient days (see instructions)		0		43.
1.00	Ratio of average length of stay to one week (line 43 divided	by line 41 divided by 7	0. 000000		44.
- 00	days)	- >	0.00		45
5.00	Average weekly cost for dialysis treatments (see instructions Total additional payment (line 45 times line 44 times line 41		0.00		45. 46.
7.00	Subtotal (see instructions)	1.01)	91, 027, 728		40.
3.00	Hospital specific payments (to be completed by SCH and MDH, s	small rural hospitals	91, 027, 720		48.
	only. (see instructions)		0		
				Amount 1.00	
9.00	Total payment for inpatient operating costs (see instructions	3)		92, 846, 988	49.
). 00	Payment for inpatient program capital (from Wkst. L, Pt. I an			6, 252, 583	
. 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).		936, 883	52.
3. 00	Nursing and Allied Health Managed Care payment			241, 525	
. 00	Special add-on payments for new technologies			81, 026	
. 01	Islet isolation add-on payment			0	54.
5.00 5.01	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 6 Cellular therapy acquisition cost (see instructions)	59)		0 597, 432	55. 55.
5. 00	Cost of physicians' services in a teaching hospital (see intr	cuctions)		0 397, 432	56.
. 00	Routine service other pass through costs (from Wkst. D, Pt. I		hrough 35)	0	57
. 00	Ancillary service other pass through costs from Wkst. D, Pt.		in ough ooy!	112, 905	
. 00	Total (sum of amounts on lines 49 through 58)			101, 069, 342	
. 00	Primary payer payments			20, 282	60
. 00	Total amount payable for program beneficiaries (line 59 minus	s line 60)		101, 049, 060	61
. 00	Deductibles billed to program beneficiaries			6, 346, 600	
. 00	Coinsurance billed to program beneficiaries			268, 367	
. 00	Allowable bad debts (see instructions)			231, 517	
. 00 . 00	Adjusted reimbursable bad debts (see instructions)	tructions)		150, 486 72, 059	
. 00	Allowable bad debts for dual eligible beneficiaries (see inst Subtotal (line 61 plus line 65 minus lines 62 and 63)			72,059 94,584,579	
	Credits received from manufacturers for replaced devices for	applicable to MS_DRGs (s	ee instructions)	94, 384, 379	
. 00	Outlier payments reconciliation (sum of lines 93, 95 and 96).			0	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	70
. 00	Rural Community Hospital Demonstration Project (§410A Demonst	tration) adjustment (see	instructions)	0	70
	N95 respirator payment adjustment amount (see instructions)			0	70
. 50				0	70
. 50 . 75 . 87	Demonstration payment adjustment amount before sequestration			0	70
. 50 . 75 . 87 . 88	SCH or MDH volume decrease adjustment (contractor use only)				70
. 50 . 75 . 87 . 88 . 89	SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see inst	tructions)		_	
. 50 . 75 . 87 . 88 . 89 . 90	SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see inst HSP bonus payment HVBP adjustment amount (see instructions)	tructions)		0	70
. 50 . 75 . 87 . 88 . 89 . 90 . 91	SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see inst HSP bonus payment HVBP adjustment amount (see instructions) HSP bonus payment HRR adjustment amount (see instructions)	tructions)		0	70 70
), 50), 75), 87), 88), 89), 90), 91), 92	SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see inst HSP bonus payment HVBP adjustment amount (see instructions) HSP bonus payment HRR adjustment amount (see instructions) Bundled Model 1 discount amount (see instructions)	tructions)		0 0	70 70 70
). 00). 50). 75). 87). 88). 89). 90). 90). 91). 92). 93). 94	SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see inst HSP bonus payment HVBP adjustment amount (see instructions) HSP bonus payment HRR adjustment amount (see instructions)	tructions)		0	70. 70. 70. 70.

	TION OF REIMBURSEMENT SETTLEMENT	I NDI ANAPOLI S Provi der Co		Period: From 01/01/2023 To 12/31/2023 Hospital	Worksheet E Part A	2552- pared 1 pm
		iiie		(yyyy)	Amount	
				0	1.00	
'0.96 L	ow volume adjustment for federal fiscal year (yyyy) (Enter i	n column O		0	0	70. 9
	he corresponding federal year for the period prior to 10/1)					
	ow volume adjustment for federal fiscal year (yyyy) (Enter in			0	0	70. 9
	the corresponding federal year for the period ending on or af	ter 10/1)		0	0	70.0
	.ow Volume Payment-3 IAC adjustment amount (see instructions)			0	0 255, 641	
	Mount due provider (line 67 minus lines 68 plus/minus lines o	60 8 70)			93, 793, 411	
	Sequestration adjustment (see instructions)	07 & 70)			1, 875, 868	
1	Demonstration payment adjustment amount after sequestration				0	71.0
	Sequestration adjustment-PARHM pass-throughs					71. (
2.00 1	nterim payments				91, 791, 293	72.0
2.01 I	nterim payments-PARHM					72. (
	entative settlement (for contractor use only)				0	
	entative settlement-PARHM (for contractor use only)	0 70 .				73.0
	Balance due provider/program (line 71 minus lines 71.01, 71.0)	2, 72, and			126, 250	74.(
	'3) Balance due provider/program-PARHM (see instructions)					74.0
	Protested amounts (nonallowable cost report items) in accorda	nce with			1, 830, 317	
	MS Pub. 15-2, chapter 1, §115.2	nce with			1,030,317	75.0
Т	0 BE COMPLETED BY CONTRACTOR (lines 90 through 96)		1			
)perating outlier amount from Wkst. E, Pt. A, line 2, or sum (of 2.03			0	90. (
p	olus 2.04 (see instructions)					
	Capital outlier from Wkst. L, Pt. I, line 2				0	91.
	perating outlier reconciliation adjustment amount (see instru				0	92.
	Capital outlier reconciliation adjustment amount (see instruc				0	93.
	The rate used to calculate the time value of money (see instructions)				0. 00 0	94. (95. (
1	ime value of money for operating expenses (see instructions) ime value of money for capital related expenses (see instructions).				0	
0.00 1			1	Prior to 10/1		70.0
				1.00	2.00	
	SP Bonus Payment Amount					
	ISP bonus amount (see instructions)			0	0	100. (
	VBP Adjustment for HSP Bonus Payment					
01.00IF				0.000000000	0 000000000	101
	IVBP adjustment factor (see instructions)	c)		0.000000000	0.000000000	
02. 00 <u> </u>	IVBP adjustment amount for HSP bonus payment (see instruction	s)		0.0000000000000000000000000000000000000		
02.00 ⊢ H	IVBP adjustment amount for HSP bonus payment (see instruction: RR Adjustment for HSP Bonus Payment	s)		0	0	102. (
02.00 ⊦ H 03.00 ⊦	IVBP adjustment amount for HSP bonus payment (see instruction: RR Adjustment for HSP Bonus Payment IRR adjustment factor (see instructions)				0. 0000	102. 103.
02.00 + H 03.00 + 04.00 +	IVBP adjustment amount for HSP bonus payment (see instruction: RR Adjustment for HSP Bonus Payment IRR adjustment factor (see instructions) IRR adjustment amount for HSP bonus payment (see instructions))	stment	0.0000	0. 0000	102.
02.00 H H 03.00 H 04.00 H R	IVBP adjustment amount for HSP bonus payment (see instruction: RR Adjustment for HSP Bonus Payment IRR adjustment factor (see instructions)) ration) Adju		0.0000	0.0000 0	102. 103. 104.
02.00 H H 03.00 H 04.00 H R 00.00 I C	IVBP adjustment amount for HSP bonus payment (see instructions RR Adjustment for HSP Bonus Payment IRR adjustment factor (see instructions) IRR adjustment amount for HSP bonus payment (see instructions) ural Community Hospital Demonstration Project (§410A Demonstr s this the first year of the current 5-year demonstration pe century Cures Act? Enter "Y" for yes or "N" for no.) ration) Adju		0.0000	0.0000 0	102. 103. 104.
02.00 + H 03.00 + 04.00 + R 00.00 1 C	IVBP adjustment amount for HSP bonus payment (see instructions RR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) ural Community Hospital Demonstration Project (§410A Demonstr s this the first year of the current 5-year demonstration per century Cures Act? Enter "Y" for yes or "N" for no. ost Reimbursement) ration) Adju riod under t		0.0000	0.0000 0	102. 103. 104. 200.
02.00 H H 03.00 H 04.00 H 00.00 H C 00.00 H C 01.00 M	IVBP adjustment amount for HSP bonus payment (see instructions RR Adjustment for HSP Bonus Payment IRR adjustment factor (see instructions) IRR adjustment amount for HSP bonus payment (see instructions) ural Community Hospital Demonstration Project (§410A Demonstr s this the first year of the current 5-year demonstration per century Cures Act? Enter "Y" for yes or "N" for no. ost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line) ration) Adju riod under t		0.0000	0.0000 0	 102. 103. 104. 200. 201.
02.00 H H 03.00 H 04.00 H 00.00 H C C 01.00 M 02.00 M	IVBP adjustment amount for HSP bonus payment (see instructions) RR Adjustment for HSP Bonus Payment IRR adjustment factor (see instructions) IRR adjustment amount for HSP bonus payment (see instructions) IRR adjustment amount for HSP bonus payment (see instructions) IRR adjustment amount for HSP bonus payment (see instructions) IRR adjustment amount for HSP bonus payment (see instructions) IRR adjustment amount for HSP bonus payment (see instructions) IRR adjustment amount for HSP bonus payment (see instructions) IRR adjustment amount for HSP bonus payment (see instructions) IRR adjustment amount for HSP bonus payment (see instructions) IRR adjustment amount for HSP bonus payment (see instructions) IRR adjustment amount for HSP bonus payment (see instructions)) ration) Adju riod under t		0.0000	0.0000 0	 102. 103. 104. 200. 201. 202.
02.00 03.00 04.00 00.00 00.00 00.00 00.00 01.00 02.00 03.00	IVBP adjustment amount for HSP bonus payment (see instructions) RR Adjustment for HSP Bonus Payment IRR adjustment factor (see instructions) IRR adjustment amount for HSP bonus payment (see instructions) IRR adjustment amount for HSP bonus payment (see instructions) IRR adjustment amount for HSP bonus payment (see instructions) IRR adjustment amount for HSP bonus payment (see instructions) Irrad Community Hospital Demonstration Project (§410A Demonstration percently Cures Act? Enter "Y" for yes or "N" for no. Sentury Cures Act? Enter "Y" for yes or "N" for no. ost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Idedicare discharges (see instructions) Case-mix adjustment factor (see instructions)) ration) Adju riod under t e 49)	he 21st	0.0000	0.0000	102. 103. 104. 200. 201. 202.
02.00 + H 03.00 + 04.00 + R 00.00 I C 01.00 M 02.00 M 03.00 C	IVBP adjustment amount for HSP bonus payment (see instruction: RR Adjustment for HSP Bonus Payment IRR adjustment factor (see instructions) IRR adjustment amount for HSP bonus payment (see instructions) IRR adjustment amount for HSP bonus payment (see instructions) IRR adjustment amount for HSP bonus payment (see instructions) IRR adjustment amount for HSP bonus payment (see instructions) IRR adjustment amount for HSP bonus payment (see instructions) s this the first year of the current 5-year demonstration percentury Cures Act? Enter "Y" for yes or "N" for no. ost Reimbursement Iedicare inpatient service costs (from Wkst. D-1, Pt. II, line Iedicare di scharges (see instructions) Case-mix adjustment factor (see instructions) omputation of Demonstration Target Amount Limitation (N/A in) ration) Adju riod under t e 49)	he 21st	0.0000	0.0000	 102. 103. 104. 200. 201. 202.
02.00 + + 03.00 + 04.00 + R 00.00 1 C 01.00 M 02.00 M 03.00 C C p	IVBP adjustment amount for HSP bonus payment (see instructions) RR Adjustment for HSP Bonus Payment IRR adjustment factor (see instructions) IRR adjustment amount for HSP bonus payment (see instructions) IRR adjustment amount for HSP bonus payment (see instructions) IRR adjustment amount for HSP bonus payment (see instructions) IRR adjustment amount for HSP bonus payment (see instructions) ural Community Hospital Demonstration Project (§410A Demonstration percentury Cures Act? Enter "Y" for yes or "N" for no. ost Reimbursement Iedicare inpatient service costs (from Wkst. D-1, Pt. II, line Iedicare di scharges (see instructions) Case-mix adjustment factor (see instructions) omputation of Demonstration Target Amount Limitation (N/A in eriod)) ration) Adju riod under t e 49)	he 21st	0.0000	0.0000 0	 102. 103. 104. 200. 201. 202. 203.
02.00	IVBP adjustment amount for HSP bonus payment (see instruction: RR Adjustment for HSP Bonus Payment IRR adjustment factor (see instructions) IRR adjustment amount for HSP bonus payment (see instructions) IRR adjustment amount for HSP bonus payment (see instructions) IRR adjustment amount for HSP bonus payment (see instructions) IRR adjustment amount for HSP bonus payment (see instructions) IRR adjustment amount for HSP bonus payment (see instructions) s this the first year of the current 5-year demonstration percentury Cures Act? Enter "Y" for yes or "N" for no. ost Reimbursement Iedicare inpatient service costs (from Wkst. D-1, Pt. II, line Iedicare di scharges (see instructions) Case-mix adjustment factor (see instructions) omputation of Demonstration Target Amount Limitation (N/A in) ration) Adju riod under t e 49)	he 21st	0.0000	0 0.0000 0	 102. 103. 104. 200. 201. 202. 203. 204.
22. 00	IVBP adjustment amount for HSP bonus payment (see instructions) RR Adjustment for HSP Bonus Payment IRR adjustment factor (see instructions) IRR adjustment amount for HSP bonus payment (see instructions) IRR adjustment amount for HSP bonus payment (see instructions) IRR adjustment amount for HSP bonus payment (see instructions) IRR adjustment amount for HSP bonus payment (see instructions) ural Community Hospital Demonstration Project (§410A Demonstration percentury Cures Act? Enter "Y" for yes or "N" for no. cost Reimbursement ledicare inpatient service costs (from Wkst. D-1, Pt. II, line ledicare discharges (see instructions) case-mix adjustment factor (see instructions) omputation of Demonstration Target Amount Limitation (N/A in eriod) ledicare target amount) ration) Adju riod under t e 49)	he 21st	0.0000	0 0.0000 0	 102. 103. 104. 200. 201. 202. 203. 204. 205.
22. 00 H 33. 00 04. 00 R R 00. 00 C C C C C C C C C C C C C	IVBP adjustment amount for HSP bonus payment (see instructions) RR Adjustment for HSP Bonus Payment IRR adjustment factor (see instructions) IRR adjustment amount for HSP bonus payment (see instructions) IRR adjustment amount for HSP bonus payment (see instructions) IRR adjustment amount for HSP bonus payment (see instructions) Irr adjustment amount for HSP bonus payment (see instructions) Irr adjustment amount for HSP bonus payment (see instructions) s this the first year of the current 5-year demonstration percently Cures Act? Enter "Y" for yes or "N" for no. ost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Idedicare discharges (see instructions) case-mix adjustment factor (see instructions) omputation of Demonstration Target Amount Limitation (N/A in eriod) Iedicare target amount (ase-mix adjusted target amount (line 203 times line 204) Iedicare inpatient routine cost cap (line 202 times line 204) Iedicare inpatient routine cost cap (line 202 times line 205)) ration) Adju riod under t e 49) first year	he 21st	0.0000	0 0.0000 0	 102. 103. 104. 200. 201. 202. 203. 204. 205. 206.
22.00 H H H D3.00 H D4.00 H R C D0.00 I D1.00 M D2.00 M D3.00 C D1.00 M D2.00 M D3.00 C D4.00 M D5.00 C D6.00 M D7.00 F	IVBP adjustment amount for HSP bonus payment (see instructions) RR Adjustment for HSP Bonus Payment IRR adjustment factor (see instructions) IRR adjustment factor (see instructions) IRR adjustment amount for HSP bonus payment (see instructions) IRR adjustment amount for HSP bonus payment (see instructions) IRR adjustment amount for HSP bonus payment (see instructions) ural Community Hospital Demonstration Project (§410A Demonstristion project (§410A Demonstristion percentry Cures Act? Enter "Y" for yes or "N" for no. ost Reimbursement Hedicare inpatient service costs (from Wkst. D-1, Pt. II, line Ideicare discharges (see instructions) case-mix adjustment factor (see instructions) omputation of Demonstration Target Amount Limitation (N/A in eriod) Hedicare target amount Case mix adjusted target amount (line 203 times line 204) Hedicare inpatient routine cost cap (line 202 times line 205) djustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions)) ration) Adju riod under t e 49) first year ructions)	he 21st	0.0000	0.0000 0	 102. 103. 104. 200. 201. 202. 203. 204. 205. 206. 207.
D2.00 H H H D3.00 H D4.00 H D0.00 H D0.00 C D1.00 M D2.00 M D3.00 C D1.00 M D2.00 M D3.00 C D4.00 M D5.00 C D6.00 M D7.00 F D8.00 M	IVBP adjustment amount for HSP bonus payment (see instructions) RR Adjustment for HSP Bonus Payment IRR adjustment factor (see instructions) IRR adjustment factor (see instructions) IRR adjustment amount for HSP bonus payment (see instructions) IRR adjustment amount for HSP bonus payment (see instructions) IRR adjustment amount for HSP bonus payment (see instructions) ural Community Hospital Demonstration Project (§410A Demonstration percent) s this the first year of the current 5-year demonstration percently Cures Act? Enter "Y" for yes or "N" for no. ost Reimbursement ledicare inpatient service costs (from Wkst. D-1, Pt. II, line ledicare discharges (see instructions) case-mix adjustment factor (see instructions) computation of Demonstration Target Amount Limitation (N/A in eriod) ledicare target amount care inpatient routine cost cap (line 203 times line 204) ledicare inpatient routine cost cap (line 202 times line 205) djustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instidedicare Part A inpatient service costs (from Wkst. E, Pt. A,) ration) Adju riod under t e 49) first year ructions)	he 21st	0.0000	0.0000 0	 102. 103. 104. 200. 201. 202. 203. 204. 205. 206. 207. 208.
022.00	IVBP adjustment amount for HSP bonus payment (see instructions) RR Adjustment for HSP Bonus Payment IRR adjustment factor (see instructions) IRR adjustment amount for HSP bonus payment (see instructions) IRR adjustment amount for HSP bonus payment (see instructions) IRR adjustment amount for HSP bonus payment (see instructions) IRR adjustment amount for HSP bonus payment (see instructions) ural Community Hospital Demonstration Project (§410A Demonstration percentry Cures Act? Enter "Y" for yes or "N" for no. ost Reimbursement ledicare inpatient service costs (from Wkst. D-1, Pt. II, line ledicare discharges (see instructions) case-mix adjustment factor (see instructions) omputation of Demonstration Target Amount Limitation (N/A in eriod) ledicare target amount lase-mix adjusted target amount (line 203 times line 204) ledicare inpatient routine cost cap (line 202 times line 205) djustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions) ledicare Part A inpatient service costs (from Wkst. E, Pt. A, kdjustment to Medicare IPPS payments (see instructions)) ration) Adju riod under t e 49) first year ructions)	he 21st	0.0000	0.0000 0	 102. 103. 104. 200. 201. 202. 203. 204. 205. 206. 206. 207. 208. 209.
22.00 H 11 H 12.00 M 10.00 M 10.00 F	IVBP adjustment amount for HSP bonus payment (see instructions) RR Adjustment for HSP Bonus Payment IRR adjustment factor (see instructions) IRR adjustment factor (see instructions) IRR adjustment amount for HSP bonus payment (see instructions) IRR adjustment amount for HSP bonus payment (see instructions) IRR adjustment amount for HSP bonus payment (see instructions) ural Community Hospital Demonstration Project (§410A Demonstration percentury Cures Act? Enter "Y" for yes or "N" for no. ost Reimbursement ledicare inpatient service costs (from Wkst. D-1, Pt. II, line redicare discharges (see instructions) case-mix adjustment factor (see instructions) omputation of Demonstration Target Amount Limitation (N/A in eriod) ledicare target amount case-mix adjusted target amount (line 203 times line 204) ledicare inpatient routine cost cap (line 202 times line 205) djustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions) Redicare IPPS payments (see instructions) Redicare IPPS payments (see instructions)) ration) Adju riod under t e 49) first year ructions)	he 21st	0.0000	0.0000 0	 102. 103. 104. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209. 210.
02.00	IVBP adjustment amount for HSP bonus payment (see instructions) RR Adjustment for HSP Bonus Payment IRR adjustment factor (see instructions) IRR adjustment amount for HSP bonus payment (see instructions) IRR adjustment amount for HSP bonus payment (see instructions) IRR adjustment amount for HSP bonus payment (see instructions) ural Community Hospital Demonstration Project (§410A Demonstration (N/A in eriod) Iedicare target amount Sase-mix adjusted target amount (line 203 times line 204) Iedicare inpatient routine cost cap (line 202 times line 205) Idjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions) Rei instructions) Redicare Part A inpatient service costs (from Wkst. E, Pt. A, djustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions)) ration) Adju riod under t e 49) first year ructions)	he 21st	0.0000	0.0000 0	102. 103.
22.00 H H H D3.00 H D4.00 H R C D0.00 I D1.00 M D2.00 M D2.00 M D3.00 C D4.00 M D5.00 C D6.00 M D7.00 F D8.00 M D9.00 F 11.00 T C C	IVBP adjustment amount for HSP bonus payment (see instructions) RR Adjustment for HSP Bonus Payment IRR adjustment factor (see instructions) IRR adjustment factor (see instructions) IRR adjustment amount for HSP bonus payment (see instructions) IRR adjustment amount for HSP bonus payment (see instructions) IRR adjustment amount for HSP bonus payment (see instructions) ural Community Hospital Demonstration Project (§410A Demonstristion project (§410A Demonstristion percenter) S this the first year of the current 5-year demonstration percenter Century Cures Act? Enter "Y" for yes or "N" for no. ost Reimbursement Hedicare inpatient service costs (from Wkst. D-1, Pt. II, limited Icare discharges (see instructions) case-mix adjustment factor (see instructions) omputation of Demonstration Target Amount Limitation (N/A in eriod) Hedicare target amount Care target amount Care inpatient routine cost cap (line 202 times line 204) Hedicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions) Reserved for future use Oral adjustment to Medicare IPPS payments (see instructions) Reserved for future use Otal adjustment to Medicare IPPS payments (see instructions)) ration) Adju riod under t e 49) first year ructions) line 59)	he 21st	0.0000	0.0000 0	 102. 103. 104. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209. 210. 211.
D2.00 H D3.00 H D4.00 H D0.00 R D0.00 C D1.00 M D2.00 M D2.00 M D3.00 C D4.00 M D5.00 C D4.00 M D5.00 C D6.00 M D7.00 F D8.00 M D9.00 A 11.00 T 12.00 T	IVBP adjustment amount for HSP bonus payment (see instructions) RR Adjustment for HSP Bonus Payment IRR adjustment factor (see instructions) IRR adjustment factor (see instructions) IRR adjustment amount for HSP bonus payment (see instructions) IRR adjustment amount for HSP bonus payment (see instructions) IRR adjustment amount for HSP bonus payment (see instructions) IRR adjustment amount for HSP bonus payment (see instructions) ural Community Hospital Demonstration Project (§410A Demonstration percenter) Century Cures Act? Enter "Y" for yes or "N" for no. ost Reimbursement Hedicare inpatient service costs (from Wkst. D-1, Pt. II, line Iedicare discharges (see instructions) case-mix adjustment factor (see instructions) omputation of Demonstration Target Amount Limitation (N/A in eriod) Iedicare target amount Care target amount Care inpatient routine cost cap (line 202 times line 204) Iedicare to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions) omparision of PPS versus Cost Reimbursement Total adjustment to Medicare Part A IPPS payments (from line 1000)) ration) Adju riod under t e 49) first year ructions) line 59)	he 21st	0.0000	0.0000 0	 102. 103. 104. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209. 210. 211. 212.
22.00 H 13.00 H 14.00 H 14.00 H 104.00 H 101.00 N 102.00 N 103.00 C 100.00 N 101.00 N 102.00 N 103.00 C 104.00 N 105.00 C 106.00 N 107.00 F 108.00 N 109.00 A 11.00 T 12.00 T 13.00 L	IVBP adjustment amount for HSP bonus payment (see instructions) RR Adjustment for HSP Bonus Payment IRR adjustment factor (see instructions) IRR adjustment factor (see instructions) IRR adjustment amount for HSP bonus payment (see instructions) IRR adjustment amount for HSP bonus payment (see instructions) IRR adjustment amount for HSP bonus payment (see instructions) ural Community Hospital Demonstration Project (§410A Demonstristion project (§410A Demonstristion percenter) S this the first year of the current 5-year demonstration percenter Century Cures Act? Enter "Y" for yes or "N" for no. ost Reimbursement Hedicare inpatient service costs (from Wkst. D-1, Pt. II, limited Icare discharges (see instructions) case-mix adjustment factor (see instructions) omputation of Demonstration Target Amount Limitation (N/A in eriod) Hedicare target amount Care target amount Care inpatient routine cost cap (line 202 times line 204) Hedicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions) Reserved for future use Oral adjustment to Medicare IPPS payments (see instructions) Reserved for future use Otal adjustment to Medicare IPPS payments (see instructions)) ration) Adju riod under t e 49) first year ructions) line 59) 211)	he 21st	0.0000	0.0000 0	 102. 103. 104. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209. 210. 211.

	Financial Systems LUME CALCULATION EXHIBIT 4	F	RANCI SCAN HEALT	Provider C	CN: 15-0162 Pe	eriod: rom 01/01/2023	u of Form CMS-2 Worksheet E Part A Exhibi Date/Time Prep 3/28/2024 2:2	t 4 pared:
		W/S E, Part A line	Amounts (from E, Part A)	Title Pre/Post Entitlement	XVIII Period Prior to 10/01	Hospital Period On/After 10/01	PPS Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges	1.01	55, 317, 679	0	55, 317, 679		55, 317, 679	1. 01
1.02	occurring prior to October 1 DRG amounts other than outlier payments for discharges occurring on or after October	1. 02	20, 157, 856	0		20, 157, 856	20, 157, 856	1. 02
1.03	T DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	Ο		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1. 04
2.00	Outlier payments for	2.00						2.00
	di scharges (see instructions)							
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2. 01
2. 02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	3, 425, 329	0	3, 425, 329		3, 425, 329	2. 02
2. 03	Outlier payments for discharges occurring on or after October 1 (see	2.04	1, 158, 223	0		1, 158, 223	1, 158, 223	2. 03
	instructions)							
3.00	Operating outlier	2. 01	0	0	0	0	0	3.00
4.00	reconciliation Managed care simulated payments	3.00	70, 884, 874	0	54, 358, 430	16, 526, 444	70, 884, 874	4.00
- 00	Indirect Medical Education Adju		0.047500	0.047500	0.047500	0.047500		Го
5.00 6.00	Amount from Worksheet E, Part A, line 21 (see instructions) IME payment adjustment (see	21.00 22.00	0. 047599 1, 937, 080				1, 937, 080	5. 00 6. 00
5. 01	instructions) IME payment adjustment for	22.01	1, 819, 260				1, 819, 260	
	managed care (see instructions) Indirect Medical Education Adju	ictment for the	Add on for Co	ation 100 of t	be MMA			
7.00	IME payment adjustment factor (see instructions)	27.00	0. 000000			0. 000000		7.00
3.00	IME adjustment (see instructions)	28.00	0		0		0	
3. 01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8. 0'
9.00	Total IME payment (sum of lines 6 and 8)	29.00	1, 937, 080	0	1, 419, 729	517, 351	1, 937, 080	9.00
9. 01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	1, 819, 260	0	1, 395, 109	424, 151	1, 819, 260	9.01
	Disproportionate Share Adjustme	ent						
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0. 0967	0. 0967	0. 0967	0. 0967		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	1, 824, 621	0	1, 337, 305	487, 316	1, 824, 621	11.00
1.01	Uncompensated care payments Additional payment for high per	36.00	7, 206, 940		5, 739, 216	1, 467, 724	7, 206, 940	11.0
2.00	Total ESRD additional payment (see instructions)	46.00	0 Denerricial y	0 O	0	0	0	12.00
3.00 4.00	Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH, small rural hospitals only.)	47.00 48.00	91, 027, 728 0	0	67, 239, 258 0	23, 788, 470 0	91, 027, 728 0	13.00 14.00
5.00	(see instructions) Total payment for inpatient operating costs (see	49.00	92, 846, 988	0	68, 634, 367	24, 212, 621	92, 846, 988	15.00
16. 00	instructions) Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	6, 252, 583	0	4, 634, 858	1, 617, 725	6, 252, 583	16.00

	Financial Systems	Fr	RANCISCAN HEALT			Period:	eu of Form CMS-2 Worksheet E	2552-11
LUW VU	LUME CALCULATION EXHIBIT 4			Provider CC	JN: 15-0162	From 01/01/2023 To 12/31/2023	Part A Exhibi	pared:
					XVIII	Hospi tal	PPS	
		line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prion to 10/01	On/After 10/01		
		0	1.00	2.00	3.00	4.00	5.00	
17.00	Special add-on payments for new technologies	54.00	81, 026	0	72, 08	36 8, 941	81, 027	
17. 01 17. 02	Net organ aquisition cost Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0		0 0	0	17.01 17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)		0	0		0 0	0	18.00
19.00	SUBTOTAL			0	73, 341, 31	11 25, 839, 287	99, 180, 598	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20. 00 20. 01	Capital DRG other than outlier Model 4 BPCI Capital DRG other than outlier	1. 00 1. 01	5, 736, 762 0	0 0		78 1, 557, 684 0 0		
21. 00 21. 01	Capital DRG outlier payments Model 4 BPCI Capital DRG outlier payments	2. 00 2. 01	394, 775 0	0 0	001/01	01 27, 174 0 0	394, 775 0	
22.00	Indirect medical education percentage (see instructions)	5.00	0. 0211	0. 0211	0. 02	0. 0211		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	121, 046	0	88, 1	79 32, 867	121, 046	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0. 0000	0. 0000	0.000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0		0 0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	6, 252, 583	0	4, 634, 8	58 1, 617, 725	6, 252, 583	26.00
			(Amounts to E,					
		line 0	Part A) 1.00	2.00	3.00	4,00	5.00	
27.00	Low volume adjustment factor	0	1.00	2.00	0.0000			27.0
28.00	Low volume adjustment fuctor Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70. 96			0.00000	0	0	
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				0	0	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100. 00

			H INDIANAPOLIS			u of Form CMS-:	2552-10
HOSPI T	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	TION EXHIBIT 5	Provider CC		Period: From 01/01/2023 To 12/31/2023		
						3/28/2024 2:2	
		Wkst. E, Pt.	Amt. from	XVIII Period to	Hospital Period on	PPS Total (cols. 2	
		A, line	Wkst. E, Pt. A)	10/01	after 10/01	and 3)	
		0	1.00	2.00	3.00	4.00	
1. 00 1. 01	DRG amounts other than outlier payments DRG amounts other than outlier payments for discharges occurring prior to October 1	1.00 1.01	55, 317, 679	55, 317, 67	9	55, 317, 679	1.00 1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	20, 157, 856		20, 157, 856	20, 157, 856	1. 02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October	1.03	0		0	0	1. 03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1. 04
2.00	Outlier payments for discharges (see instructions)	2.00					2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0		0 0	0	2. 01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	3, 425, 329	3, 425, 32	.9	3, 425, 329	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	1, 158, 223		1, 158, 223	1, 158, 223	2.03
3.00 4.00	Operating outlier reconciliation Managed care simulated payments	2.01 3.00	0 70, 884, 874		0 0 0 16, 526, 444	-	3.00 4.00
	Indirect Medical Education Adjustment						
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0. 047599	0. 04759	0. 047599		5.00
5. 00 5. 01	IME payment adjustment (see instructions) IME payment adjustment for managed care (see	22.00 22.01	1, 937, 080 1, 819, 260			1, 937, 080 1, 819, 260	
	instructions) Indirect Medical Education Adjustment for the	Add_on for Se	action 422 of t	he MMA			
7.00	IME payment adjustment factor (see instructions)	27.00	0. 000000		0 0.00000		7.00
3. 00 3. 01	IME adjustment (see instructions) IME payment adjustment add on for managed care (see instructions)	28.00 28.01	0		0 0 0 0		
9. 00 9. 01	Total IME payment (sum of lines 6 and 8) Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.00 29.01	1, 937, 080 1, 819, 260			1, 937, 080 1, 819, 260	
	Di sproporti onate Share Adjustment					I	
0. 00	Allowable disproportionate share percentage (see instructions)	33.00	0. 0967	0. 096	0. 0967		10.00
1.00	Disproportionate share adjustment (see instructions)	34.00	1, 824, 621	1, 337, 30	487, 316	1, 824, 621	11.00
11.01	Uncompensated care payments Additional payment for high percentage of ESR	36.00	7, 206, 940	5, 739, 21	6 1, 467, 724	7, 206, 940	11.01
2.00	Total ESRD additional payment (see instructions)	46.00	0		0 0	0	12.00
3.00 4.00	Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see	47.00 48.00	91, 027, 728 0	67, 239, 25	8 23, 788, 470 0 0	91, 027, 728 0	
5.00	instructions) Total payment for inpatient operating costs (see instructions)	49.00	92, 846, 988	68, 634, 36	7 24, 212, 621	92, 846, 988	15.00
6. 00	(see instructions) Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	6, 252, 583	4, 634, 85	8 1, 617, 725	6, 252, 583	16. OC
17.00 17.01	Special add-on payments for new technologies Net organ acquisition cost	54.00	81, 026	72, 08	5 8, 941	81, 026	17. 00 17. 01
7. 02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0		0 0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0		0 0	0	18.00
19. 00	SUBTOTAL			73, 341, 31	0 25, 839, 287	99, 180, 597	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	TION EXHIBIT 5	Provider CO		Period: From 01/01/2023 To 12/31/2023		pared:
		Title	XVIII	Hospi tal	PPS	
	Wkst. L, line	(Amt. from Wkst. L)				
	0	1.00	2.00	3.00	4.00	
20.00 Capital DRG other than outlier	1.00	5, 736, 762	4, 179, 07	8 1, 557, 684	5, 736, 762	20.00
20.01 Model 4 BPCI Capital DRG other than outlier	1.01	0		0 0	0	20.01
21.00 Capital DRG outlier payments	2.00	394, 775	367, 60	27, 174	394, 775	21.00
21.01 Model 4 BPCI Capital DRG outlier payments	2.01	0		0 0	0	21.01
22.00 Indirect medical education percentage (see instructions)	5.00	0. 0211	0. 021	1 0.0211		22.00
23.00 Indirect medical education adjustment (see instructions)	6.00	121, 046	88, 17	32, 867	121, 046	23.00
24.00 Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.000	0.0000		24.00
25.00 Disproportionate share adjustment (see instructions)	11.00	0		0 0	0	25.00
26.00 Total prospective capital payments (see instructions)	12.00	6, 252, 583	4, 634, 85	1, 617, 725	6, 252, 583	26.00
	Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
	0	1.00	2.00	3.00	4.00	
27.00						27.00
28.00 Low volume adjustment prior to October 1	70.96	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	-148, 144		0 -148, 144	-148, 144	30.00
30.01 HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0		0 0	0	30. 01
31.00 HRR adjustment (see instructions)	70.94	-387, 383	-260, 33	-127, 051	-387,383	31.00
31.01 HRR adjustment for HSP bonus payment (see instructions)	70. 91	0		0 0	0	31.01
					(Amt. to Wkst. E, Pt. A)	
	0	1.00	2.00	3.00	4.00	
32.00 HAC Reduction Program adjustment (see instructions)	70. 99			0 255, 641	255, 641	32.00
100.00 Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100. 00

	Financial Systems FRANCISCAN HEALTH IND ATION OF REIMBURSEMENT SETTLEMENT P	DIANAPOLIS Provider CCN: 15-0162	In Lie Period:	u of Form CMS-2 Worksheet E	2552-10
UNEOUL			From 01/01/2023 To 12/31/2023	Part B Date/Time Pre	
	Title XVIII Hospital				1 pm
				1.00	
	PART B - MEDI CAL AND OTHER HEALTH SERVI CES				
1.00 2.00	Medical and other services (see instructions) Medical and other services reimbursed under OPPS (see instruction	ons)		15, 275 67, 806, 172	1.00
3.00	OPPS or REH payments	5113)		53, 228, 623	
4.00	Outlier payment (see instructions)	140, 825	4.00		
4.01 5.00	Outlier reconciliation amount (see instructions) Enter the hospital specific payment to cost ratio (see instructi	0.000	4.01 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	•		
8.00 9.00	Transitional corridor payment (see instructions) Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200				8.00 9.00
10.00	Organ acqui si ti ons			155, 449 0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			15, 275	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges				
12.00	Ancillary service charges			87, 325	
13.00 14.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line Total reasonable charges (sum of lines 12 and 13)	e 69)		0 87, 325	13.00
14.00	Customary charges			07, 323	14.00
15.00	Aggregate amount actually collected from patients liable for pay		0	0	
16.00	Amounts that would have been realized from patients liable for phad such payment been made in accordance with 42 CFR §413.13(e)	payment for services o	n a chargebasis	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0. 000000	17.00
18.00	Total customary charges (see instructions)			87, 325	
19.00	Excess of customary charges over reasonable cost (complete only instructions)	IT line 18 exceeds li	ne 11) (see	72, 050	19.00
20.00	Excess of reasonable cost over customary charges (complete only	if line 11 exceeds li	ne 18) (see	0	20.00
21 00	instructions)			15 075	21 00
21.00 22.00	Lesser of cost or charges (see instructions) Interns and residents (see instructions)			15, 275	
23.00	Cost of physicians' services in a teaching hospital (see instruc	ctions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) COMPUTATION OF REIMBURSEMENT SETTLEMENT	53, 524, 897	24.00		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)			178	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 2	-		8, 870, 895	
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plu instructions)	us the sum of lines 22	and 23] (see	44, 669, 099	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line	e 50)		555, 201	28.00
28.50	REH facility payment amount				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 45, 224, 300	
31.00	Primary payer payments			4, 040	
32.00	Subtotal (line 30 minus line 31)	2		45, 220, 260	32.00
33.00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES Composite rate ESRD (from Wkst. I-5, line 11)	5)		0	33.00
34.00	Allowable bad debts (see instructions)			550, 752	34.00
35.00 36.00	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instruc	ctions)		357, 989 357, 149	
37.00	Subtotal (see instructions)			45, 578, 249	
38.00	MSP-LCC reconciliation amount from PS&R			-14	
39.00 39.50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions)			0	39.00 39.50
39. 30 39. 75	N95 respirator payment adjustment amount (see instructions)			0	
39. 97	Demonstration payment adjustment amount before sequestration			0	39.97
39. 98 39. 99	Partial or full credits received from manufacturers for replaced RECOVERY OF ACCELERATED DEPRECIATION	d devices (see instruc	tions)	0	39.98 39.99
40.00	Subtotal (see instructions)			45, 578, 263	
40.01	Sequestration adjustment (see instructions)			911, 565	
40. 02 40. 03	Demonstration payment adjustment amount after sequestration Sequestration adjustment-PARHM pass-throughs			0	40.02
41.00	Interim payments			44, 577, 734	1
41.01	Interim payments-PARHM			0	41.01
42.00 42.01	Tentative settlement (for contractors use only) Tentative settlement-PARHM (for contractor use only)				42.00 42.01
43.00	Balance due provider/program (see instructions)				43.00
43.01	Balance due provider/program-PARHM (see instructions) Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,				43.01
44.00	§115.2	e with CMS PUD. 15-2,	chapter I,	0	44.00
	TO BE COMPLETED BY CONTRACTOR			1	
90.00 91.00	Original outlier amount (see instructions) Outlier reconciliation adjustment amount (see instructions)			0	90.00 91.00
91.00 92.00	The rate used to calculate the Time Value of Money			0.00	
93.00	Time Value of Money (see instructions)			0	
94.00	Total (sum of lines 91 and 93)			0	94.00

Health Financial Systems	FRANCISCAN HEALTH I	NCISCAN HEALTH INDIANAPOLIS		In Lieu of Form CMS-2552-10			
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0162	Period:	od: Worksheet E 01/01/2023 Part B			
				Date/Time Pre			
				3/28/2024 2:2	1 pm		
		Title XVIII	Hospi tal	PPS			
				1.00			
MEDICARE PART B ANCILLARY COSTS							
200.00 Part B Combined Billed Days	0	200. 00					

	Financial Systems FRANCI SCAN HEALTH			u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0162	Period: From 01/01/2023	Worksheet E Part B	
		Component CCN: 15-T162	To 12/31/2023	Date/Time Prep 3/28/2024 2:2	
		Title XVIII	Subprovider - IRF	PPS	•
				1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00 2.00	Medical and other services (see instructions) Medical and other services reimbursed under OPPS (see instruc	tions)		62 55	1.00 2.00
3.00	OPPS or REH payments			83	3.00
4.00	Outlier payment (see instructions)			0	4.00
4.01 5.00	Outlier reconciliation amount (see instructions) Enter the hospital specific payment to cost ratio (see instru	uctions)		0 0. 000	4.01 5.00
6.00	Line 2 times line 5			0.000	
7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	
8.00 9.00	Transitional corridor payment (see instructions) Ancillary service other pass through costs from Wkst. D, Pt.	IV col 13 line 200		0	8.00 9.00
10.00	Organ acqui si ti ons	11, 601. 10, 11116 200		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			62	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges				-
12.00	Ancillary service charges			355	
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, I	ine 69)		0	
14.00	Total reasonable charges (sum of lines 12 and 13) Customary charges			355	14.00
15.00	Aggregate amount actually collected from patients liable for			0	
16.00	Amounts that would have been realized from patients liable for had such payment been made in accordance with 42 CFR §413.13(1 5	n a chargebasis	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0. 000000	17.00
18.00	Total customary charges (see instructions)			355	
19.00	Excess of customary charges over reasonable cost (complete on instructions)	nly if line 18 exceeds li	ne 11) (see	293	19.00
20.00	Excess of reasonable cost over customary charges (complete on	nlyifline 11 exceeds li	ne 18) (see	0	20.00
21 00	instructions)			(2)	21 00
21.00 22.00	Lesser of cost or charges (see instructions) Interns and residents (see instructions)			62 0	21.00 22.00
23.00	Cost of physicians' services in a teaching hospital (see inst	tructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) COMPUTATION OF REIMBURSEMENT SETTLEMENT			83	24.00
25.00	Deductibles and coinsurance amounts (for CAH, see instruction	าร)		0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on lin	•		0	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) instructions)	plus the sum of lines 22	and 23] (see	145	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, I	ine 50)		0	28.00
28.50	REH facility payment amount				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)			0 145	
31.00	Primary payer payments			0	31.00
32.00	Subtotal (line 30 minus line 31)	(25)		145	32.00
33.00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVI Composite rate ESRD (from Wkst. I-5, line 11)	(E3)		0	33.00
34.00	Allowable bad debts (see instructions)			0	34.00
35.00 36.00	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see inst	tructions)		0	35.00 36.00
37.00	Subtotal (see instructions)			145	
38.00	MSP-LCC reconciliation amount from PS&R			0	38.00
39.00 39.50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instruction	าร)		0	39.00 39.50
39. 50 39. 75	N95 respirator payment adjustment amount (see instructions)	,		0	39. 50
39.97	Demonstration payment adjustment amount before sequestration		+:)	0	39.97
39. 98 39. 99	Partial or full credits received from manufacturers for repla RECOVERY OF ACCELERATED DEPRECIATION	acea aevices (see instruc	tions)	0	39.98 39.99
40.00	Subtotal (see instructions)			145	40.00
40.01	Sequestration adjustment (see instructions)			3	
40. 02 40. 03	Demonstration payment adjustment amount after sequestration Sequestration adjustment-PARHM pass-throughs			0	40.02
41.00	Interim payments			151	41.00
41.01	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
43.00	Bal ance due provi der/program (see instructions)			-9	43.00
43.01	Balance due provider/program-PARHM (see instructions)	and with ONC Dut 45 C	abortor 1		43.01
44.00	Protested amounts (nonallowable cost report items) in accorda §115.2	ance with CMS Pub. 15-2,	chapter I,	0	44.00
	TO BE COMPLETED BY CONTRACTOR				1
90.00	Original outlier amount (see instructions) Outlier reconciliation adjustment amount (see instructions)			0	
91.00	parties reconcitration aujustillent allount (see thistructions)				
92.00	The rate used to calculate the Time Value of Money		i	0.00	92.00

Health Financial Systems	FRANCI SCAN HEALTH I NDI ANAPOLI S	In Lie	u of Form CMS	-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0162	Peri od:	Worksheet E	
	Component CCN: 15-T162	From 01/01/2023 To 12/31/2023	Date/Time Pr	epared:
			3/28/2024 2:	21 pm
	Title XVIII	Subprovider -	PPS	
		I RF		
			1.00	
94.00 Total (sum of lines 91 and 93)			(94.00
			1.00	
MEDICARE PART B ANCILLARY COSTS				
200.00 Part B Combined Billed Days				200. 00

ANALY	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC		Period: From 01/01/2023 To 12/31/2023		
		Title	XVIII	Hospi tal	PPS	1
		I npati en	t Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		90, 073, 89	93	44, 577, 734	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for			0	0	2.00
	services rendered in the cost reporting period. If none, write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3.00
0.00	amount based on subsequent revision of the interim rate					0.00
	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 3.02	ADJUSTMENTS TO PROVIDER	01/03/2024	1, 717, 40		0	3. 01 3. 02
3.02 3.03				0	0	3.02
3.03				0	0	3.04
3.05				0	0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM			0	0	3.50
3.51				0	0	3.51
3.52				0	0	3.52
3.53 3.54				0	0	3.53 3.54
3.94 3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		1, 717, 40		0	3.99
0. , ,	3. 50-3. 98)		1, 717, 10		Ŭ	0. 7
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		91, 791, 29	93	44, 577, 734	4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropriate) TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5.00
0.00	desk review. Also show date of each payment. If none,					0.00
	write "NONE" or enter a zero. (1)					
	Program to Provider				1	
5.01	TENTATI VE TO PROVI DER			0	0	5.01
5.02 5.03				0	0	5.02 5.03
5.05	Provider to Program			0	0	5.03
5.50	TENTATI VE TO PROGRAM			0	0	5.50
5.51				0	0	5.51
5.52				0	0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	5.99
	5.50-5.98)					(0)
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6. 01	SETTLEMENT TO PROVIDER		126, 25	50	88, 964	6. 01
6.02	SETTLEMENT TO PROGRAM		.20,20	0	00, 701	6. 02
7.00	Total Medicare program liability (see instructions)		91, 917, 54	13	44, 666, 698	7.00
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
		()	1.00	2.00	

ALYS	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC Component (CN: 15-0162 CCN: 15-T162	Period: From 01/01/20 To 12/31/20		pared
		Title	XVIII	Subprovi der I RF		
		Inpatien	t Part A		art B	
		mm/dd/yyyy	Amount	mm/dd/yyyy		
		1.00	2.00	3.00	4.00	
00 00 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)		6, 157, 0	0	151 0	1. (2. (3. (
	Program to Provider					-
01	ADJUSTMENTS TO PROVIDER			0	0	3.
02				0	0	3.
03				0 0	0	
04 05				0	0	3.
	Provider to Program			0		
50	ADJUSTMENTS TO PROGRAM			0	0	
51				0	0	3
52 53				0	0	3
53 54				0	0	3
9 9	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0	0	3
	3. 50-3. 98)					
00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		6, 157, 0	89	151	4
	TO BE COMPLETED BY CONTRACTOR		-			
00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.
	Program to Provider					
)1	TENTATI VE TO PROVI DER			0	0	
)2)3				0 0	0	5
,5	Provider to Program			0		
0	TENTATI VE TO PROGRAM			0	0	5
51				0	0	5
52 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	5
	5. 50-5. 98)			0	0	
00	Determined net settlement amount (balance due) based on the cost report. (1)					6
)1)2	SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM		117, 6	0	0	6
)2)0	Total Medicare program liability (see instructions)		6, 039, 4		142	
			0,007,4	Contractor		
				Number	(Mo/Day/Yr)	
	Name of Contractor	()	1.00	2.00	8

Heal th	Financial Systems FRANCISCAN HEALTH	I NDI ANAPOLI S	In Lie	u of Form CMS-	2552-10
CALCUI	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0162	Period: From 01/01/2023	Worksheet E-1 Part II	
			To 12/31/2023		
		Title XVIII	Hospi tal	PPS	
				1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				-
1 00	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATIO		4.4		1 1 00
1.00	Total hospital discharges as defined in AARA §4102 from Wkst	. S-3, Pt. I COI. 15 IINE	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	11			5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3				6.00
7.00	CAH only - The reasonable cost incurred for the purchase of line 168	certified HII technology	WKST. 5-2, 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	n (see instructions)			10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)				30.00
31.00	Other Adjustment (specify)				31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and	line 31) (see instruction	ns)		32.00

ALCUI	LATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0162	Period: From 01/01/2023	Worksheet E-3 Part III	
		Component CCN: 15-T162	To 12/31/2023	Date/Time Pre 3/28/2024 2:2	
		Title XVIII	Subprovider - IRF	PPS	<u>, bi</u>
				1.00	
	PART III - MEDICARE PART A SERVICES - IRF PPS				
00	Net Federal PPS Payment (see instructions)			5, 995, 296] 1
00	Medicare SSI ratio (IRF PPS only) (see instructions)			0.0097	2
00	Inpatient Rehabilitation LIP Payments (see instructions)			130, 697	3
00	Outlier Payments			98, 201	4
00	Unweighted intern and resident FTE count in the most recent of November 15, 2004 (see instructions)		0	0.00	5
01	Cap increases for the unweighted intern and resident FTE coprogram or hospital closure, that would not be counted with CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00	5
00	New Teaching program adjustment. (see instructions)			0.00	6
00	Current year's unweighted FTE count of I&R excluding FTEs	in the new program growth p	eriod of a "new	0.00	7
00	teaching program" (see instructions) Current year's unweighted I&R FTE count for residents with	in the new program growth p	eriod of a "new	0.00	8
00	teaching program" (see instructions)	····		0.00	
00	Intern and resident count for IRF PPS medical education ad	justment (see instructions)		0.00	
00 00	Average Daily Census (see instructions)			16. 400000	
00	Teaching Adjustment Factor (see instructions) Teaching Adjustment (see instructions)			0.000000	
00	5 5			6, 224, 194	
00	Nursing and Allied Health Managed Care payments (see instru	uction)		0, 224, 194	
00	Organ acquisition (DO NOT USE THIS LINE)			0	1
00	Cost of physicians' services in a teaching hospital (see in	nstructions)		0	
00	Subtotal (see instructions)	,		6, 224, 194	1
00	Primary payer payments			0	1
00	Subtotal (line 17 less line 18).			6, 224, 194	1
00				51, 068	
00				6, 173, 126	
00				11, 200	
00				6, 161, 926	
00	Allowable bad debts (exclude bad debts for professional se	rvices) (see instructions)		0	2
00 00		nstructions)		0	2
00	Subtotal (sum of lines 23 and 25)	listi ucti olis)		6, 161, 926	
00	Direct graduate medical education payments (from Wkst. E-4	line 49)		0, 101, 420	2
00		, , , , , , , , , , , , , , , , , , , ,		761	
00				0	3
00				0	3
50		i ons)		0	3
98	Recovery of accelerated depreciation.			0	3
99		on		0	
00				6, 162, 687	
01				123, 254	
02	Demonstration payment adjustment amount after sequestration	n		0	
00	1 5			6, 157, 089	
00 00	Tentative settlement (for contractor use only) Balance due provider/program (line 32 minus lines 32.01, 3.	20233 and 34		0 -117, 656	
00	Protested amounts (nonallowable cost report items) in acco		chapter 1,	0	3
	§115.2 TO BE COMPLETED BY CONTRACTOR				1
00	Original outlier amount from Wkst. E-3, Pt. III, line 4		1	98, 201	5
00	5)		98, 201	5
00	The rate used to calculate the Time Value of Money	/		0.00	
00	3			0.00	
-	FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 / THE COVID-19 PHE)	AND BEGINNING ON OR BEFORE	MAY 11, 2023 (THE		1
00	Teaching Adjustment Factor for the cost reporting period in	mmediately preceding Februa	iry 29, 2020.	0.000000	9
	Calculated Teaching Adjustment Factor for the current year	31	-	0.000000	

LCUI	ATION OF REIMBURSEMENT SETTLEMENT	I NDI ANAPOLI S Provi der CCN: 15-0162	Peri od:	u of Form CMS-2 Worksheet E-3	
			From 01/01/2023 To 12/31/2023	Part VII Date/Time Prej 3/28/2024 2:2	pare
		Title XIX	Hospi tal	PPS	i pii
			I npati ent	Outpati ent	
			1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SE	ERVICES FOR TITLES V OR >	KIX SERVICES		-
00	COMPUTATION OF NET COST OF COVERED SERVICES		0		1 1
00 00	Inpatient hospital/SNF/NF services Medical and other services		0	39, 005, 763	1
00	Organ acquisition (certified transplant programs only)		0	37,003,703	3
00	Subtotal (sum of lines 1, 2 and 3)		0	39, 005, 763	
00	Inpatient primary payer payments		0		5
00	Outpatient primary payer payments			0	6
00	Subtotal (line 4 less sum of lines 5 and 6)		0	39, 005, 763	7
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonabl e Charges				
00	Routine service charges		0	000 404 054	8
00	Ancillary service charges		192, 214, 190	308, 194, 251	9
	Organ acquisition charges, net of revenue Incentive from target amount computation		0		10 11
	Total reasonable charges (sum of lines 8 through 11)		192, 214, 190	308, 194, 251	
. 00	CUSTOMARY CHARGES		172, 214, 170	500, 194, 251	1 12
. 00	Amount actually collected from patients liable for payment for	or services on a charge	0	0	13
	basi s	3			
. 00	Amounts that would have been realized from patients liable for	or payment for services (on 0	0	14
	a charge basis had such payment been made in accordance with	42 CFR §413.13(e)			
. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0. 000000	0.00000	
	Total customary charges (see instructions)		192, 214, 190	308, 194, 251	16
. 00	Excess of customary charges over reasonable cost (complete or	nly if line 16 exceeds	192, 214, 190	269, 188, 488	17
. 00	line 4) (see instructions) Excess of reasonable cost over customary charges (complete or	alvifling 4 avecade li	ne O	0	18
. 00	16) (see instructions)	illy II IIIle 4 exceeds III	0	0	
. 00	Interns and Residents (see instructions)		0	0	19
	Cost of physicians' services in a teaching hospital (see inst	tructions)	0	0	20
. 00	Cost of covered services (enter the lesser of line 4 or line	16)	0	39, 005, 763	21
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be	e completed for PPS provi	ders.		
	Other than outlier payments		0	0	22
	Outlier payments		0	0	23
	Program capital payments		0		24
	Capital exception payments (see instructions)		U E4 011	0	25
. 00 . 00	Routine and Ancillary service other pass through costs Subtotal (sum of lines 22 through 26)		54, 211 54, 211	0	26
. 00	Customary charges (title V or XIX PPS covered services only)		54, 211	0	28
	Titles V or XIX (sum of lines 21 and 27)		54, 211	39, 005, 763	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		01/211	07,000,700	1 - 1
. 00	Excess of reasonable cost (from line 18)		0	0	30
. 00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6	6)	54, 211	39, 005, 763	31
. 00	Deducti bl es		0	0	32
. 00	Coinsurance		0	0	33
	Allowable bad debts (see instructions)		0	0	
. 00	Utilization review		0		35
	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 ar	nd 33)	54, 211	39, 005, 763	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 20 005 742	37
	Subtotal (line 36 ± line 37)		54, 211	39, 005, 763	
	Direct graduate medical education payments (from Wkst. E-4) Total amount payable to the provider (sum of lines 38 and 39)		0 54, 211	39, 005, 763	39
	Interim payments	,	55, 057	39, 005, 783 38, 780, 343	
. 00	Balance due provider/program (line 40 minus line 41)		-846	225, 420	
. 00	Protested amounts (nonallowable cost report items) in accorda	ance with CMS Pub 15-2	-340	225, 420	
		100 m cm ond rub 10^{-2}	0	0	1 7

LCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0162	Period: From 01/01/2023	Worksheet E-3 Part VII	
		Component CCN: 15-T162	To 12/31/2023	Date/Time Pre 3/28/2024 2:2	
		Title XIX	Subprovi der – I RF	PPS	•
			Inpati ent 1.00	Outpatient 2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SE	RVICES FOR TITLES V OR X		2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES				1
00	Inpatient hospital/SNF/NF services		0		1
00	Medical and other services			97	
00	Organ acquisition (certified transplant programs only)		0	97	
00 00	Subtotal (sum of lines 1, 2 and 3) Inpatient primary payer payments		0	97	
00	Outpatient primary payer payments		0	0	
00	Subtotal (line 4 less sum of lines 5 and 6)		0	97	
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonable Charges				1
00	Routine service charges		0		18
00	Ancillary service charges		591, 499	622	9
. 00	Organ acquisition charges, net of revenue		0		10
. 00	Incentive from target amount computation		0		1
. 00	Total reasonable charges (sum of lines 8 through 11)		591, 499	622	1:
~~	CUSTOMARY CHARGES		0	0	1
. 00	Amount actually collected from patients liable for payment for basis	or services on a charge	0	0	13
00	Amounts that would have been realized from patients liable for	or navment for services o	n O	0	14
00	a charge basis had such payment been made in accordance with			0	Ι.
00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0. 000000	0.000000	1
. 00	Total customary charges (see instructions)		591, 499	622	1
00	Excess of customary charges over reasonable cost (complete on	nly if line 16 exceeds	591, 499	525	1
	line 4) (see instructions)				
. 00	5 5 1	nly if line 4 exceeds lin	e 0	0	18
00	16) (see instructions)		0	0	10
. 00	Interns and Residents (see instructions) Cost of physicians' services in a teaching hospital (see inst	ructions)	0	0	
. 00	Cost of covered services (enter the lesser of line 4 or line		0	97	
00	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be			71	2
. 00			0	0	2
. 00	Outlier payments		0	0	2
00	Program capital payments		0		24
00	Capital exception payments (see instructions)		0		2
00	Routine and Ancillary service other pass through costs		2	0	
00	Subtotal (sum of lines 22 through 26)		2	0	
. 00	Customary charges (title V or XIX PPS covered services only)		0	0	
. 00	Titles V or XIX (sum of lines 21 and 27)		2	97	20
. 00	COMPUTATION OF REIMBURSEMENT SETTLEMENT Excess of reasonable cost (from line 18)		0	0	30
	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6	2)	2	97	
	Deductibles	·)	0	0	
00			0	0	
00	Allowable bad debts (see instructions)		0	0	
00	Utilization review		0		35
. 00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 an	nd 33)	2	97	36
. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	
. 00	Subtotal (line 36 ± line 37)		2	97	
00			0		39
. 00	Total amount payable to the provider (sum of lines 38 and 39)	1	2	97	
. 00	Interim payments		2	95	
. 00 . 00			0	2	
	Protested amounts (nonallowable cost report items) in accorda	ance with UMS Pub 15-2,	0	0	43

					2552-10
	GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT Provide . EDUCATION COSTS Provide COMPUTATION OF TOTAL DIRECT GME AMOUNT Provide Unweighted resident FTE count for allopathic and osteopathic programing on or before becember 31, 1996. FTE cap adjustment under \$131 of the CAA 2021 (see instructions) Unweighted FTE resident cap add-on for new programs per 42 CFR 413 Rural track program FTE cap limitation adjustment after the cap-but the CAA 2021 (see instructions) Amount of reduction to Direct GME cap under section 422 of MMA Direct GME cap reduction amount under ACA \$5503 in accordance with h instructions for cost reporting periods straddling 7/1/2011) Adjustment (plus or minus) to the FTE cap for allopathic and osteoment in 49075 (August 10, 2022) (see instructions) Adjustment (plus or minus) to the FTE cap for allopathic and osteoment in 49075 (August 10, 2022) (see instructions) Adjustment (plus or minus) to the FTE cap (see instructi straddling 7/1/2011) ACA Section 5506 number of additional direct GME FTE cap slots (speriods straddling 7/1/2011) ACA Section 5506 number of additional direct GME FTE cap slots (speriods straddling 7/1/2011) ACA Section 5506 number of additional direct GME FTE cap slots (speriods straddling 7/1/2011) ACA Section 5506 number of additional direct GME FTE cap slots (speriods straddling 7/1/2011) ACA Section 5506 number of additional direct GME FTE cap slots (speriods straddling 7/1/2011) <td< td=""><td>ovider CCN: 15-0162</td><td>From 01/01/2023</td><td></td><td></td></td<>	ovider CCN: 15-0162	From 01/01/2023		
			To 12/31/2023		
		Title XVIII	Hospi tal	PPS	
				1.00	
1.00	COMPUTATION OF TOTAL DIRECT GME AMOUNT	arams for cost reno	rting periods	19.50	1.00
1.00	ending on or before December 31, 1996.		rting perious	17.30	1.00
1.01	FTE cap adjustment under §131 of the CAA 2021 (see instructions)	10 70(-)(1) (:	-+	0.00	
2.00 2.26			,		
2.20	the CAA 2021 (see instructions)		300 under 3127 of	0.00	2.20
3.00	Amount of reduction to Direct GME cap under section 422 of MMA			0.94	
3.01		IN 42 CFR §413.79 (1	m). (see	0.00	3. 01
3.02		TE limitation(s) f	or rural track	0.00	3. 02
		n accordance with 4	13.75(b) and 87 FR		
4.00		eopathic programs d	ue to a Medicare	0.00	4.00
	GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))			0100	
4.01		tions for cost repo	rting periods	0.00	4. 01
4.02		(see instructions f	or cost reporting	0,00	4. 02
	periods straddling 7/1/2011)	•	1 3		
4.21		under §126 of the	CAA 2021 (see	0.00	4. 21
5.00		2.26 through 2.49.	minus lines 3 and	18, 56	5.00
	3.01, plus or minus line 3.02, plus or minus line 4, plus lines	4.01 through 4.27			
6.00		grams for the curre	nt year from your	25.99	6.00
7.00				18 56	7.00
1100		Primary C	are Other	Total	1100
		1.00	2.00	3.00	0.00
8.00		C 2	5. 74 0. 00	25.74	8.00
9.00	If line 6 is less than 5 enter the amount from line 8, otherwise	1	8. 56 0. 00	18.56	9.00
		J22, OF			
10.00	Weighted dental and podiatric resident FTE count for the current				10.00
10.01	0	2)	10.01
11.00	LIOTAL WEIGHTED FIE COUNT				
12 (10)	Total weighted resident FTE count for the prior cost reporting w				11.00
12.00	Total weighted resident FTE count for the prior cost reporting yeinstructions)				11.00
12.00 13.00	instructions) Total weighted resident FTE count for the penultimate cost repor	ear (see 1	8.56 0.00		11. 00 12. 00
13.00	instructions) Total weighted resident FTE count for the penultimate cost repor year (see instructions)	ear (see 1 ting 1	8. 56 0. 00 8. 56 0. 00		11. 00 12. 00 13. 00
	instructions) Total weighted resident FTE count for the penultimate cost repor year (see instructions)	ear (see 1 ting 1 3). 1	8. 56 0. 00 8. 56 0. 00 8. 56 0. 00		11. 00 12. 00 13. 00 14. 00
13.00 14.00 15.00 15.01	instructions) Total weighted resident FTE count for the penultimate cost repor- year (see instructions) Rolling average FTE count (sum of lines 11 through 13 divided by Adjustment for residents in initial years of new programs Unweighted adjustment for residents in initial years of new programs	ear (see 1 ting 1 3). 1 rams	8.56 0.00 8.56 0.00 8.56 0.00 0.00 0.00 0.00 0.00 0.00 0.00		11.00 12.00 13.00 14.00 15.00 15.01
13.00 14.00 15.00 15.01 16.00	instructions) Total weighted resident FTE count for the penultimate cost repor- year (see instructions) Rolling average FTE count (sum of lines 11 through 13 divided by Adjustment for residents in initial years of new programs Unweighted adjustment for residents in initial years of new programs Adjustment for residents displaced by program or hospital closure	ear (see 1 ting 1 3). 1 rams	8.56 0.00 8.56 0.00 8.56 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00		11. 00 12. 00 13. 00 14. 00 15. 00 15. 01 16. 00
13.00 14.00 15.00 15.01	instructions) Total weighted resident FTE count for the penultimate cost repor- year (see instructions) Rolling average FTE count (sum of lines 11 through 13 divided by Adjustment for residents in initial years of new programs Unweighted adjustment for residents in initial years of new progr Adjustment for residents displaced by program or hospital closure Unweighted adjustment for residents displaced by program or hospital	ear (see 1 ting 1 3). 1 rams	8.56 0.00 8.56 0.00 8.56 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00		11. 00 12. 00 13. 00 14. 00 15. 00 15. 01
13.00 14.00 15.00 15.01 16.00 16.01 17.00	instructions) Total weighted resident FTE count for the penultimate cost repor- year (see instructions) Rolling average FTE count (sum of lines 11 through 13 divided by Adjustment for residents in initial years of new programs Unweighted adjustment for residents in initial years of new programs Adjustment for residents displaced by program or hospital closure	ear (see 1 ting 1 3). 1 rams tal	8.56 0.00 8.56 0.00 8.56 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 8.56 0.00		11. 00 12. 00 13. 00 14. 00 15. 00 15. 01 16. 00 16. 01
13.00 14.00 15.00 15.01 16.00 16.01 17.00 18.00	instructions) Total weighted resident FTE count for the penultimate cost repor- year (see instructions) Rolling average FTE count (sum of lines 11 through 13 divided by Adjustment for residents in initial years of new programs Unweighted adjustment for residents in initial years of new program Adjustment for residents displaced by program or hospital closure Unweighted adjustment for residents displaced by program or hospital closure Adjusted rolling average FTE count Per resident amount	FF MFD CAL FORCATION (CMF) & FSRD OUTPATIENT DIRECT Provider CCR: 15-0162 Period: From 10/07/02/3 Worksheet F-4 I NON COSTS Title XVIII Hospital PPS TITLE XVIII Hospital PPS TION OF TOTAL DIRECT CMF AMOUNT 1.00 1.00 TION OF TOTAL DIRECT CMF AMOUNT 1.00 1.00 TION OF TOTAL DIRECT CMF AMOUNT 1.00 0.00 Table of resident FIE court for all opathic and osteopathic programs for cost reporting periods 19.50 adjustment under SI3 of the CAA 2021 (see instructions) 0.00 0.00 adjustment under SI3 of the CAA 2021 (see instructions) 0.00 0.00 adjustment under SI3 of the CAA 2021 (see instructions) 0.00 0.00 Call Cape reduction amount under AAA 5500 in accordance with 42 CFR \$413.79 (n). (see 0.00 0.00 Call Cape reduction SID of the CAA 2021 (see instructions for cost reporting periods 0.00 0.00 0.00 Call Cape reduction SID interact SID inte	11. 00 12. 00 13. 00 14. 00 15. 00 15. 01 16. 00 16. 01 17. 00 18. 00		
13.00 14.00 15.00 15.01 16.00 16.01 17.00 18.00 18.01	instructions) Total weighted resident FTE count for the penultimate cost repor- year (see instructions) Rolling average FTE count (sum of lines 11 through 13 divided by Adjustment for residents in initial years of new programs Unweighted adjustment for residents in initial years of new program Adjustment for residents displaced by program or hospital closure Unweighted adjustment for residents displaced by program or hospital closure Adjusted rolling average FTE count Per resident amount Per resident amount under §131 of the CAA 2021	ear (see 1 ting 1 3). 1 rams tal 1 140, 29	8.56 0.00 8.56 0.00 8.56 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 8.56 0.00 9.66 140, 299.66 0.00 0.00		11. 00 12. 00 13. 00 14. 00 15. 00 15. 01 16. 00 16. 01 17. 00 18. 00 18. 01
13.00 14.00 15.00 15.01 16.00 16.01 17.00 18.00	instructions) Total weighted resident FTE count for the penultimate cost repor- year (see instructions) Rolling average FTE count (sum of lines 11 through 13 divided by Adjustment for residents in initial years of new programs Unweighted adjustment for residents in initial years of new program Adjustment for residents displaced by program or hospital closure Unweighted adjustment for residents displaced by program or hospital closure Adjusted rolling average FTE count Per resident amount	ear (see 1 ting 1 3). 1 rams tal 1 140, 29	8.56 0.00 8.56 0.00 8.56 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 8.56 0.00 9.66 140, 299.66 0.00 0.00		11. 00 12. 00 13. 00 14. 00 15. 00 15. 01 16. 00
13.00 14.00 15.01 16.00 16.01 17.00 18.00 18.01 19.00	instructions) Total weighted resident FTE count for the penultimate cost repor- year (see instructions) Rolling average FTE count (sum of lines 11 through 13 divided by Adjustment for residents in initial years of new programs Unweighted adjustment for residents in initial years of new progr Adjustment for residents displaced by program or hospital closure Unweighted adjustment for residents displaced by program or hospital closure Adjusted rolling average FTE count Per resident amount Per resident amount under §131 of the CAA 2021 Approved amount for resident costs	ear (see 1 ting 1 3). 1 rams tal 1 140, 29 2, 603	8. 56 0. 00 8. 56 0. 00 8. 56 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 8. 56 0. 00 9. 66 140, 299. 66 0. 00 0. 00	2, 603, 962	11. 00 12. 00 13. 00 14. 00 15. 01 15. 01 16. 00 16. 01 17. 00 18. 00 18. 01 19. 00
13.00 14.00 15.00 15.01 16.00 16.01 17.00 18.00 18.01	instructions) Total weighted resident FTE count for the penultimate cost repor- year (see instructions) Rolling average FTE count (sum of lines 11 through 13 divided by Adjustment for residents in initial years of new programs Unweighted adjustment for residents in initial years of new program Adjustment for residents displaced by program or hospital closure Unweighted adjustment for residents displaced by program or hospital closure Adjusted rolling average FTE count Per resident amount under §131 of the CAA 2021 Approved amount for resident costs Additional unweighted allopathic and osteopathic direct GME FTE of	ear (see 1 ting 1 3). 1 rams tal 1 140, 29 2, 603	8. 56 0. 00 8. 56 0. 00 8. 56 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 8. 56 0. 00 9. 66 140, 299. 66 0. 00 0. 00	2, 603, 962	11. 00 12. 00 13. 00 14. 00 15. 01 15. 01 16. 00 16. 01 17. 00 18. 00 18. 01 19. 00
13.00 14.00 15.01 16.00 16.01 17.00 18.00 18.01 19.00	instructions) Total weighted resident FTE count for the penultimate cost repor- year (see instructions) Rolling average FTE count (sum of lines 11 through 13 divided by Adjustment for residents in initial years of new programs Unweighted adjustment for residents in initial years of new progr Adjustment for residents displaced by program or hospital closure Unweighted adjustment for residents displaced by program or hospital closure Adjusted rolling average FTE count Per resident amount Per resident amount under §131 of the CAA 2021 Approved amount for resident costs	ear (see 1 ting 1 3). 1 rams tal 1 tal 1 tal 2,603	8. 56 0. 00 8. 56 0. 00 8. 56 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 8. 56 0. 00 9. 66 140, 299. 66 0. 00 0. 00	2, 603, 962 1. 00 0. 00	11. 00 12. 00 13. 00 14. 00 15. 00 15. 01 16. 00 16. 01 17. 00 18. 00 18. 01 19. 00
13. 00 14. 00 15. 00 15. 01 16. 00 16. 01 17. 00 18. 00 18. 01 19. 00 20. 00 21. 00 22. 00	<pre>instructions) Total weighted resident FTE count for the penultimate cost report year (see instructions) Rolling average FTE count (sum of lines 11 through 13 divided by Adjustment for residents in initial years of new programs Unweighted adjustment for residents in initial years of new program Adjustment for residents displaced by program or hospital closure Adjusted rolling average FTE count Per resident amount Per resident amount under §131 of the CAA 2021 Approved amount for resident costs Additional unweighted allopathic and osteopathic direct GME FTE in Sec. 413.79(c)(4) Direct GME FTE unweighted resident count over cap (see instruction Allowable additional direct GME FTE Resident Count (see instruction </pre>	ear (see 1 ting 1 3). 1 rams tal 1 140, 29 2, 603 resident cap slots ons)	8.56 0.00 8.56 0.00 8.56 0.00 8.56 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 8.56 0.00 9.66 140, 299.66 0.00 0.00 recei ved under 42	2, 603, 962 1.00 0.00 7.43 0.00	11. 00 12. 00 13. 00 14. 00 15. 00 15. 01 16. 00 16. 01 17. 00 18. 00 18. 01 19. 00 20. 00 21. 00 22. 00
13. 00 14. 00 15. 00 15. 01 16. 00 16. 01 17. 00 18. 00 18. 01 19. 00 20. 00 21. 00 22. 00 23. 00	<pre>instructions) Total weighted resident FTE count for the penultimate cost report year (see instructions) Rolling average FTE count (sum of lines 11 through 13 divided by Adjustment for residents in initial years of new programs Unweighted adjustment for residents in initial years of new program or hospital closure Adjustment for residents displaced by program or hospital closure Adjusted rolling average FTE count Per resident amount Per resident amount under §131 of the CAA 2021 Approved amount for resident costs Additional unweighted allopathic and osteopathic direct GME FTE in Sec. 413.79(c)(4) Direct GME FTE unweighted resident count over cap (see instruction Allowable additional direct GME FTE Resident Count (see instruction Enter the locality adjustment national average per resident amount </pre>	ear (see 1 ting 1 3). 1 rams tal 1 140, 29 2, 603 resident cap slots ons)	8.56 0.00 8.56 0.00 8.56 0.00 8.56 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 8.56 0.00 9.66 140, 299.66 0.00 0.00 recei ved under 42	2, 603, 962 1.00 0.00 7.43 0.00 121, 911.43	11. 00 12. 00 13. 00 14. 00 15. 00 15. 01 16. 00 16. 01 17. 00 18. 00 18. 00 18. 01 19. 00 20. 00 21. 00 22. 00 23. 00

lealth Financial Systems FRANCISCAN HEALTH DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT	Provider C		Peri od:	u of Form CMS-2 Worksheet E-4	
IEDI CAL EDUCATI ON COSTS			From 01/01/2023 To 12/31/2023	Date/Time Prep 3/28/2024 2:2	
	Title	XVIII	Hospi tal	PPS	
			rt Managed Care	Total	
		A 1.00	2.00	3.00	
COMPUTATION OF PROGRAM PATIENT LOAD					
26.00 Inpatient Days (see instructions) (Title XIX - see S-2 Part I 3.02, column 2)	X, line	33, 80	33, 562		26.00
27.00 Total Inpatient Days (see instructions)		115, 6	56 115, 656		27.00
28.00 Ratio of inpatient days to total inpatient days		0. 29230	0. 290188		28.00
29.00 Program direct GME amount		761, 1	54 755, 639	1, 516, 793	29.00
29.01 Percent reduction for MA DGME			3. 27		29.01
30.00 Reduction for direct GME payments for Medicare Advantage			24, 709	24, 709	
31.00 Net Program direct GME amount				1, 492, 084	31.00
				1.00	
DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITL	E XVIII ONLY	(NURSING PRO	GRAM AND PARAMED		
EDUCATION COSTS)		C			
32.00 Renal dialysis direct medical education costs (from Wkst. B, and 94)	Pt. I, sum c	of col. 20 and	1 23, lines 74	0	32.00
33.00 Renal dialysis and home dialysis total charges (Wkst. C, Pt.	I, col. 8, s	um of lines 1	74 and 94)	9, 179, 437	33. OC
34.00 Ratio of direct medical education costs to total charges (lir	ne 32 ÷ line	33)		0.00000	34.00
35.00 Medicare outpatient ESRD charges (see instructions)				0	35.00
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	ONLY				
B7. 00 Reasonable cost (see instructions)				114, 124, 931	27 00
88.00 Organ acquisition and HSCT acquisition costs (see instruction	26)			597, 432	
39.00 Cost of physicians' services in a teaching hospital (see inst				0	39.00
10.00 Primary payer payments (see instructions)	(i uc ti ons)			20, 282	
41.00 Total Part A reasonable cost (sum of lines 37 through 39 minu	is line 40)			114, 702, 081	
Part B Reasonable Cost				114, 702, 001	41.00
12.00 Reasonable cost (see instructions)				67, 977, 013	42.00
13.00 Primary payer payments (see instructions)				4,040	
44.00 Total Part B reasonable cost (line 42 minus line 43)				67, 972, 973	
15.00 Total reasonable cost (sum of lines 41 and 44)				182, 675, 054	
16.00 Ratio of Part A reasonable cost to total reasonable cost (lir	ne 41 ÷ line	45)		0. 627902	
47.00 Ratio of Part B reasonable cost to total reasonable cost (lir		45)		0. 372098	47.00
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PA	ART B				
18.00 Total program GME payment (line 31)				1, 492, 084	
19.00 Part A Medicare GME payment (line 46 x 48) (title XVIII only)) (see instru	ictions)		936, 883	49.00
50.00 Part B Medicare GME payment (line 40 x 40) (title XVIII only)			1	555, 201	

Health Financial Systems	FRANCISCAN HEALTH I	NDI ANAPOLI S	In Lie	u of Form CMS-2	552-10
OUTLIER RECONCILIATION AT TENTATIVE SETTLEMENT		Provider CCN: 15-0162	Period: From 01/01/2023	Worksheet E-5	
			To 12/31/2023	Date/Time Prep 3/28/2024 2:21	
		Title XVIII		PPS	
				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 adjustmen	t amount (see instr	uctions)		0	3.00
4.00 Capital outlier reconciliation adjustment	amount (see instruc	ti ons)		0	4.00
5.00 The rate used to calculate the time value	of money (see instr	uctions)		0.00	5.00
6.00 Time value of money for operating expenses	(see instructions)			0	6.00
7.00 Time value of money for capital related ex	penses (see instruc	tions)		0	7.00

nd-t	Financial Systems FRANCISCAN HEALT E SHEET (If you are nonproprietary and do not maintain ype accounting records, complete the General Fund column	Provider C	CN: 15-0162	Period: From 01/01/2023 To 12/31/2023	u of Form CMS-2 Worksheet G Date/Time Pre	
ly)		General Fund	Specific Purpose Fund	Endowment Fund	3/28/2024 2:2	1 pr
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
00	Cash on hand in banks	443, 665, 947		0 0	0	
00	Temporary investments	0		0 0	0	
00 00	Notes receivable Accounts receivable	642, 286, 140		0 0	0	
00	Other receivable	-23, 067, 789		0 0	0	
00 00	Allowances for uncollectible notes and accounts receivable	-457, 619, 089		0 0	0	
00	Inventory	13, 237, 859		0 0	0	
00	Prepaid expenses	2, 489, 819		0 0	0 0	
00	Other current assets	0		0 0	0	
. 00	Due from other funds	0		0 0	0	10
. 00	Total current assets (sum of lines 1-10)	620, 992, 887		0 0	0	11
	FI XED ASSETS					
. 00	Land	8, 660, 206		0 0	0	12
. 00	Land improvements	35, 352, 307		0 0	0	13
. 00	Accumulated depreciation	-33, 654, 711		0 0	0	14
. 00	Bui I di ngs	251, 675, 526		0 0	0	
. 00	Accumulated depreciation	-147, 161, 877		0 0	0	
. 00	Leasehold improvements	19, 391, 705		0 0	0	
. 00	Accumulated depreciation	-18, 452, 983		0 0	0	
	Fixed equipment	284, 711, 884		0 0	0	
	Accumulated depreciation	-179, 786, 381		0 0	0	
	Automobiles and trucks	0		0 0	0	
	Accumulated depreciation	0		0 0	0	
	Major movable equipment	206, 708, 400		0 0	0	
	Accumulated depreciation	-107, 305, 816		0 0	0	
	Minor equipment depreciable Accumulated depreciation	0		0 0		
	HIT designated Assets	0		0 0	0	
	Accumulated depreciation			0 0	0	
	Mi nor equi pment-nondepreci abl e			0 0		
	Total fixed assets (sum of lines 12-29)	320, 138, 260		0 0		
	OTHER ASSETS					
. 00	Investments	23, 626, 864		0 0	0	31
. 00	Deposits on Leases	0		0 0	0	32
. 00	Due from owners/officers	0		0 0	0	33
. 00	Other assets	139, 879, 891		0 0	0	34
. 00	Total other assets (sum of lines 31-34)	163, 506, 755		0 0	0	35
. 00	Total assets (sum of lines 11, 30, and 35)	1, 104, 637, 902		0 0	0	36
	CURRENT LIABILITIES					
	Accounts payable	93, 422, 896		0 0	0	
	Salaries, wages, and fees payable	10, 787, 971		0 0		
. 00	Payroll taxes payable	14, 161, 627		0 0	0	
. 00	Notes and loans payable (short term)	600, 461		0 0	0	
	Deferred income	40, 373		0 0	0	
	Accel erated payments			0		42
	Due to other funds	3, 594, 788		0 0	0	
	Other current liabilities	6, 745, 234 129, 353, 350		0 0 0 0		
. 00	Total current liabilities (sum of lines 37 thru 44)	127, 303, 350	I	<u> </u>	0	45
. 00	Mortgage payable	2, 725, 940		0 0	0	46
. 00	Notes payable	21, 594, 851			0	
. 00	Unsecured Loans	2, 124, 460		0 0	0	
	Other long term liabilities	1, 765, 120		0 0	0	
	Total long term liabilities (sum of lines 46 thru 49)	28, 210, 371		0 0	0	
	Total liabilities (sum of lines 45 and 50)	157, 563, 721		0 0		
-	CAPI TAL ACCOUNTS					1
. 00	General fund balance	947, 074, 181				52
. 00	Specific purpose fund			0	1	53
. 00	Donor created - endowment fund balance - restricted			0	l	54
. 00	Donor created - endowment fund balance - unrestricted			0	1	55
	Governing body created - endowment fund balance			0	l	56
. 00	Plant fund balance - invested in plant				0	57
			1	1	0	58
. 00	Plant fund balance - reserve for plant improvement,				i U	1 00
. 00 . 00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	
. 00 . 00		947, 074, 181		0 0		

	Financial Systems FF ENT OF CHANGES IN FUND BALANCES	RANCI SCAN HEALTH	Provi der CC		Period: From 01/01/2023 To 12/31/2023	Date/Time Pre	pared:
		General	Fund	Speci al	Purpose Fund	3/28/2024 2:2 Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ \end{array}$	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) OTHER Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	5, 042, 547 0 0 0 0 0 0 0 0 0 0 0 0 0	855, 095, 303 86, 936, 331 942, 031, 634 5, 042, 547 947, 074, 181 0 947, 074, 181				$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ \end{array}$
		Endowment Fund	Pl ant				
1.00	Fund balances at beginning of period	6.00	7.00	8.00	0		1.00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	Total (sum of line 1 and line 2) OTHER	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	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		0		10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00
19.00 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		19.00

Heal th	Financial Systems FRANCI SCAN HEALTH	I NDI ANAPOLI S		In Lie	eu of Form CMS-2	2552-10
	IENT OF PATIENT REVENUES AND OPERATING EXPENSES		CN: 15-0162	Period: From 01/01/2023 To 12/31/2023	Worksheet G-2 Parts I & II Date/Time Pre 3/28/2024 2:2	pared:
	Cost Center Description		Inpati ent	Outpatient	Total	
	PART I - PATIENT REVENUES		1.00	2.00	3.00	
	General Inpatient Routine Services					
1.00	Hospi tal		219, 224, 9	16	219, 224, 916	1.00
2.00	SUBPROVIDER - IPF					2.00
3.00	SUBPROVIDER - IRF		19, 759, 8	43	19, 759, 843	3.00
4.00	SUBPROVIDER					4.00
5.00	Swing bed - SNF			0	0	5.00
6.00	Swing bed - NF			0	0	6.00
7.00 8.00	SKILLED NURSING FACILITY NURSING FACILITY					7.00 8.00
8.00 9.00	OTHER LONG TERM CARE					9.00
10.00	Total general inpatient care services (sum of lines 1-9)		238, 984, 7	59	238, 984, 759	
101.00	Intensive Care Type Inpatient Hospital Services		200,701,71		20077017707	10100
11.00	I NTENSI VE CARE UNI T		45, 628, 94	48	45, 628, 948	11.00
11.01	NEONATAL INTENSIVE CARE UNIT		39, 942, 50	50	39, 942, 560	11.01
12.00	CORONARY CARE UNI T		44, 837, 52	24	44, 837, 524	
13.00	BURN INTENSIVE CARE UNIT					13.00
14.00	SURGI CAL INTENSI VE CARE UNI T		32, 194, 8	92	32, 194, 892	
15.00	OTHER SPECIAL CARE (SPECIFY)		1(2,(02,0)		142 402 024	15.00
16.00	Total intensive care type inpatient hospital services (sum of 11-15)	TTNES	162, 603, 93	24	162, 603, 924	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16	.)	401, 588, 68	33	401, 588, 683	17.00
18.00	Ancillary services	· /		54 1, 655, 715, 585		
19.00	Outpatient services		138, 905, 3			
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			0	0	22.00
23.00	AMBULANCE SERVICES					23.00
24.00						24.00
25.00 26.00	AMBULATORY SURGICAL CENTER (D. P.) HOSPICE		110, 1	73 15, 366, 757	15, 476, 930	25.00 26.00
20.00	PROFESSIONAL FEES		110, 1	0 21, 608, 121		
27.00	NRCC PATIENT CHARGES		307, 5			
27.02	OTHER PATIENT CHARGES			0 683, 686		
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3	8 to Wkst.	1, 813, 088, 12	23 2, 226, 331, 377	4, 039, 419, 500	28.00
	G-3, line 1)					
	PART II - OPERATING EXPENSES		1			
29.00	Operating expenses (per Wkst. A, column 3, line 200)		201 504 0	651, 566, 596		29.00
30. 00 31. 00	TRANSFER TO RHO AND MOORESVILLE		291, 504, 08	0		30.00 31.00
31.00				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)			291, 504, 087		36.00
37.00	DEDUCT (SPECI FY)			0		37.00
38.00				0		38.00
39.00				0		39.00
40. 00 41. 00				0		40.00
41.00	Total deductions (sum of lines 37-41)			́		41.00 42.00
42.00	Total operating expenses (sum of lines 29 and 36 minus line 4	2)(transfer		943, 070, 683		42.00
	to Wkst. G-3, line 4)	, , ,				

	Financial Systems FRANCI SCAN HEALTH			u of Form CMS-2	
STATEM	ENT OF REVENUES AND EXPENSES	Provider CCN: 15-0162	Period: From 01/01/2023	Worksheet G-3	
			To 12/31/2023	Date/Time Pre	nared
			10 12/01/2020	3/28/2024 2:2	
				1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, lin			4, 039, 419, 500	1.0
2.00	Less contractual allowances and discounts on patients' accoun	ts		3, 069, 403, 315	
3.00	Net patient revenues (line 1 minus line 2)			970, 016, 185	
4.00	Less total operating expenses (from Wkst. G-2, Part II, line	43)		943, 070, 683	
5.00	Net income from service to patients (line 3 minus line 4)			26, 945, 502	5.0
	OTHER INCOME				
6.00	Contributions, donations, bequests, etc			597, 048	
7.00	Income from investments			0	7.0
8.00	Revenues from telephone and other miscellaneous communication	servi ces		0	8.0
9.00	Revenue from television and radio service			0	9.0
10.00	Purchase di scounts			0	10.0
11.00	Rebates and refunds of expenses			4, 644, 801	11.0
12.00	Parking lot receipts			0	12.0
13.00	Revenue from Laundry and Linen service			0	13.0
14.00	Revenue from meals sold to employees and guests			0	14.0
15.00	Revenue from rental of living quarters			0	15.0
16.00	Revenue from sale of medical and surgical supplies to other t	han patients		0	16.0
17.00	Revenue from sale of drugs to other than patients			0	17.0
18.00	Revenue from sale of medical records and abstracts			0	18.0
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19.0
20.00	Revenue from gifts, flowers, coffee shops, and canteen			0	20.0
21.00	Rental of vending machines			52, 150	21.0
22.00	Rental of hospital space			4, 691, 758	22.0
23.00	Governmental appropriations			0	23.0
24.00	MISC REV			50, 004, 672	24.0
24.50	COVID-19 PHE Funding			0	24.5
24. 51	ROUNDING			400	24.5
25.00	Total other income (sum of lines 6-24)			59, 990, 829	25.0
26.00	Total (line 5 plus line 25)			86, 936, 331	26.0
27.00	NON-OPERATI NG REVENUE			0	27.0
28.00	Total other expenses (sum of line 27 and subscripts)			0	28.0
29.00	Net income (or loss) for the period (line 26 minus line 28)			86, 936, 331	20 0

	I Financial Systems SIS OF HOSPITAL-BASED HOSPICE COSTS	FRANCI SCAN HEALTH	Provi der C		Period:	u of Form CMS- Worksheet O	2552-1
			Hospi ce CC		From 01/01/2023 To 12/31/2023	Date/Time Pre 3/28/2024 2:2	pared:
					Hospi ce I		1
		SALARI ES	OTHER	SUBTOTAL (col 1 plus col. 2		SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS			1		-	
1.00	CAP REL COSTS-BLDG & FIXT*		0	1	0 0	0	
2.00	CAP REL COSTS-MVBLE EQUIP*		0		0 0	0	
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	1, 730				
4.00	ADMI NI STRATI VE & GENERAL*	422, 813	1, 230, 328	1, 653, 14		1, 044, 166	
5.00	PLANT OPERATION & MAINTENANCE*	0	I	(4.47	1 0	I (1 170	5.0
5.00	LAUNDRY & LINEN SERVICE*	61, 170	0	61, 17		61, 170	
7.00	HOUSEKEEPI NG*	0	10		0 0	10	
3.00	DI ETARY*	0	0		0 0	0	
9.00	NURSI NG ADMI NI STRATI ON*	0	0)	0 0	0	
10.00	ROUTINE MEDICAL SUPPLIES*	0	0)	0 0	0	
11.00	MEDI CAL RECORDS*	0	0	0 07 00	0 0	0	
12.00	STAFF TRANSPORTATION*	0	37, 391			37, 391	
13.00	VOLUNTEER SERVICE COORDINATION*	212, 637	0	212, 63		212, 637	
14.00	PHARMACY*	4, 968	255, 590			260, 558	
15.00	PHYSI CI AN ADMI NI STRATI VE SERVI CES*	0	0		0 0	0	
16.00	OTHER GENERAL SERVICE*	0	C)	0 0	0	
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.0
	DIRECT PATIENT CARE SERVICE COST CENTERS			J		0	1 05 0
25.00	INPATIENT CARE-CONTRACTED**		0	1	0 0	0	
26.00	PHYSI CI AN SERVI CES**	0	0)	0 0	0	
27.00	NURSE PRACTITIONER**	0	0		0 0	0	
28.00	REGI STERED NURSE**	1, 890, 343	0	1, 890, 34	3 0	1, 890, 343	
29.00	LPN/LVN**	0	0)	0 0	0	
30.00	PHYSICAL THERAPY**	0	0)	0 0	0	
31.00	OCCUPATIONAL THERAPY**	0	0)	0 0	0	
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0		0 0	0	
33.00	MEDICAL SOCIAL SERVICES**	328, 279	0	328, 27		328, 279	
34.00	SPIRITUAL COUNSELING**	171, 899	0	171, 89	9 0	171, 899	
35.00	DI ETARY COUNSELI NG**	0	0)	0 0	0	
36.00	COUNSELING - OTHER**	0	0		0 0	0	
37.00	HOSPICE AIDE & HOMEMAKER SERVICES**	563, 940	0	563, 94		563, 940	
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	67, 381		-	67, 381	
39.00	PATIENT TRANSPORTATION**	0	0)	0 0	0	
10.00	I MAGI NG SERVI CES**	0	0		0 0	0	
11.00	LABS & DI AGNOSTI CS**	0	474 570	474 57	0	1	41.0
2.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	171, 572	171, 57	2 0	171, 572	
12.50	DRUGS CHARGED TO PATIENTS**	0	0)	0 0	0	
13.00	OUTPATIENT SERVICES**	0	0		0 0	0	
44.00	PALLIATIVE RADIATION THERAPY**	0	0)	0 0	0	1
15.00	PALLIATIVE CHEMOTHERAPY**	0	0)	0 0	0	
16.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	C)	0 0	0	46.0
	NONREI MBURSABLE COST CENTERS	(0.40)		(0.10	4	(0.42)	1 (0 0
50.00		69, 134	0	69, 13	4 0		
51.00	VOLUNTEER PROGRAM *	0	0		0	0	
52.00	FUNDRALSING*	0	0		0	0	
53.00		0	0 700	0 4/4 -0	0	0	
4.00	PALLIATIVE CARE PROGRAM*	2, 432, 804	28, 730	2, 461, 53	4 0	2, 461, 534	
5.00	OTHER PHYSICIAN SERVICES*	0	0		0	0	
6.00		0	0		0	0	
7.00		0	0		0	0	
8.00		0	C		0 0	0	
9.00		0	C		0 0	0	
70.00		0	C		0 0	0	
71.00		0	0		0 0	0	
100 00	D TOTAL	6, 157, 987	1, 792, 734	7, 950, 72	1 -610, 705	7, 340, 016	1100.0

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

NALYSIS	OF HOSPITAL-BASED HOSPICE COSTS		Provider CCN	: 15-0162	Period: From 01/01/2023	Worksheet O	
			Hospi ce CCN:	15-1523	To 12/31/2023	Date/Time P 3/28/2024 2	
					Hospi ce I		
		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)				
		6.00	7.00				
	VERAL SERVICE COST CENTERS						_
	P REL COSTS-BLDG & FIXT*	0	0				1
	P REL COSTS-MVBLE EQUIP*	0	0				2
	PLOYEE BENEFITS DEPARTMENT*	0	1 0 1 1 (0				3
	MINISTRATIVE & GENERAL* ANT OPERATION & MAINTENANCE*	-2, 698	1, 041, 468				4
		0	61, 170				5
	UNDRY & LINEN SERVICE* USEKEEPING*	0					7
	ETARY*	0	10				8
	RSING ADMINI STRATI ON*	0	0				9
		0	0				10
	UTINE MEDICAL SUPPLIES* DICAL RECORDS*	0	0				11
	AFF TRANSPORTATION*	0	37, 391				12
	LUNTEER SERVICE COORDINATION*	0	212, 637				13
1	ARMACY*	0	260, 558				14
	YSICIAN ADMINISTRATIVE SERVICES*	0	200, 558				15
	HER GENERAL SERVICE*	0	0				16
	TI ENT/RESI DENTI AL CARE SERVI CES	0	0				17
	RECT PATIENT CARE SERVICE COST CENTERS						- ''
	PATIENT CARE-CONTRACTED**	0	0				25
	YSI CI AN SERVI CES**	0	0				20
	RSE_PRACTITIONER**	0	0				27
	GI STERED NURSE**	0	1, 890, 343				28
	N/LVN**	0	0				29
	YSI CAL THERAPY**	0	0				30
	CUPATIONAL THERAPY**	0	0				31
	EECH/LANGUAGE PATHOLOGY**	0	0				32
	DI CAL SOCI AL SERVI CES**	0	328, 279				33
	I RI TUAL COUNSELI NG**	0	171, 899				34
	ETARY COUNSELING**	0	0				35
	UNSELING - OTHER**	0	0				36
	SPICE AIDE & HOMEMAKER SERVICES**	0	563, 940				3
	RABLE MEDICAL EQUIPMENT/OXYGEN**	0	67, 381				38
	TI ENT TRANSPORTATI ON**	0	0				39
	AGING SERVICES**	0	0				40
00 LAI	BS & DIAGNOSTICS**	0	1				4
1	DI CAL SUPPLI ES-NON-ROUTI NE**	0	171, 572				42
	UGS CHARGED TO PATI ENTS**	0	0				42
00 00	TPATI ENT SERVI CES**	0	0				43
. 00 PA	LLIATIVE RADIATION THERAPY**	0	0				44
	LLIATIVE CHEMOTHERAPY**	0	0				45
1	HER PATIENT CARE SERVICES (SPECIFY)**	0	0				46
NOM	NREI MBURSABLE COST CENTERS						
. 00 BEI	REAVEMENT PROGRAM *	0	69, 134				60
	LUNTEER PROGRAM *	0	0				61
	NDRAI SI NG*	0	0				62
	SPICE/PALLIATIVE MEDICINE FELLOWS*	0	0				63
	LLIATIVE CARE PROGRAM*	-759, 989	1, 701, 545				64
	HER PHYSICIAN SERVICES*	0	0				65
	SI DENTI AL CARE*	0	0				66
00 AD'	VERTI SI NG*	0	0				67
00 TE	LEHEALTH/TELEMONI TORI NG*	0	0				68
00 TH	RIFT STORE*	0	0				69
	RSING FACILITY ROOM & BOARD*	0	0				70
. 00 OTI	HER NONREIMBURSABLE (SPECIFY)*	0	0				71
0. 00 TO	TAL	-762,687	6, 577, 329				100

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

	RANCISCAN HEALTH		·		eu of Form CMS-	
ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPI	CE CONTINUOUS	Provider (CCN: 15-0162	Peri od:	Worksheet 0-1	
HOME CARE		Hocpi co. C	CN: 15-1523	From 01/01/2023 To 12/31/2023		narad
		nospi ce co	JN. 10-1025	10 12/31/2023	3/28/2024 2:2	
				Hospi ce I	0,20,2021212	- p
	SALARI ES	OTHER	SUBTOTAL (co	I. RECLASSI FI -	SUBTOTAL	
			1 + col . 2)	CATI ONS		
	1.00	2.00	3.00	4.00	5.00	
DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00 INPATIENT CARE-CONTRACTED						25.00
26. 00 PHYSI CI AN SERVI CES	0		0	0 0	0	26.00
27.00 NURSE PRACTITIONER	0		0	0 0	0	27.00
28.00 REGI STERED NURSE	0		0	0 0	0	28.00
29.00 LPN/LVN	0		0	0 0	0	29.00
30. 00 PHYSI CAL THERAPY	0		0	0 0	0	30.00
31.00 OCCUPATIONAL THERAPY	0		0	0 0	0	31.00
32.00 SPEECH/LANGUAGE PATHOLOGY	0		0	0 0	0	32.00
33.00 MEDICAL SOCIAL SERVICES	0		0	0 0	0	33.00
34. 00 SPI RI TUAL COUNSELI NG	0		0	0 0	0	34.00
35. 00 DI ETARY COUNSELI NG	0		0	0 0	0	00.00
36.00 COUNSELING - OTHER	0		0	0 0	0	00.00
37.00 HOSPICE AIDE & HOMEMAKER SERVICES	0		0	0 0	0	37.00
38.00 DURABLE MEDICAL EQUIPMENT/OXYGEN	0		0	0 0	0	38.00
39.00 PATIENT TRANSPORTATION	0		0	0 0	0	39.00
40.00 I MAGI NG SERVI CES	0		0	0 0	0	101.00
41.00 LABS & DI AGNOSTI CS	0		0	0 0	0	1 00
42.00 MEDI CAL SUPPLI ES-NON-ROUTI NE	0		0	0 0	0	12.00
42.50 DRUGS CHARGED TO PATIENTS	0		0	0 0	0	12.00
43.00 OUTPATIENT SERVICES	0		0	0 0	0	43.00
44.00 PALLIATIVE RADIATION THERAPY	0		0	0 0	0	44.00
45.00 PALLIATIVE CHEMOTHERAPY	0		0	0 0	0	45.00
46.00 OTHER PATIENT CARE SERVICES (SPECIFY)	0		0	0 0	0	10.00
100.00 TOTAL *	0		0	0 0	0 0	100.00

 45.00
 PALLIATIVE CHEMOTHERAPY
 0

 46.00
 OTHER PATIENT CARE SERVICES (SPECIFY)
 0

 100.00
 TOTAL *
 0

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

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

Health Financial Systems	FRANCI SCAN HEALTH				u of Form CMS-	
ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HO	SPICE ROUTINE HOME	Provider CC	CN: 15-0162	Peri od:	Worksheet 0-2	
CARE		Hospi ce CCN	N: 15-1523	From 01/01/2023 To 12/31/2023	Date/Time Pre 3/28/2024 2:2	
				Hospi ce I		
	SALARI ES	OTHER	SUBTOTAL (col 1 + col. 2)		SUBTOTAL	
	1.00	2.00	3.00	4.00	5.00	
DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00 INPATIENT CARE-CONTRACTED						25.00
26. 00 PHYSI CI AN SERVI CES	0	0		0 0	0	26.00
27.00 NURSE PRACTITIONER	0	0		0 0	0	27.00
28.00 REGI STERED NURSE	1, 890, 343	0	1, 890, 34	43 0	1, 890, 343	28.00
29.00 LPN/LVN	0	0		0 0	0	29.00
30. 00 PHYSI CAL THERAPY	0	0		0 0	0	30.00
31.00 OCCUPATIONAL THERAPY	0	0		0 0	0	31.00
32.00 SPEECH/LANGUAGE PATHOLOGY	0	0		0 0	0	32.00
33.00 MEDICAL SOCIAL SERVICES	328, 279	0	328, 2	79 0	328, 279	33.00
34.00 SPI RI TUAL COUNSELI NG	171, 899	0	171, 89	99 0	171, 899	34.00
35.00 DI ETARY COUNSELI NG	0	0		0 0	0	35.00
36.00 COUNSELING - OTHER	0	0		0 0	0	36.00
37.00 HOSPICE AIDE & HOMEMAKER SERVICES	563, 940	0	563, 94	40 0	563, 940	37.00
38.00 DURABLE MEDICAL EQUIPMENT/OXYGEN	0	65, 622	65, 62	22 0	65, 622	38.00
39.00 PATIENT TRANSPORTATION	0	0		0 0	0	39.00
40.00 I MAGI NG SERVI CES	0	0		0 0	0	40.00
41.00 LABS & DIAGNOSTICS	0	0		0 0	0	41.00
42.00 MEDICAL SUPPLIES-NON-ROUTINE	0	167, 094	167, 04	94 0	167, 094	42.00
42.50 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	42.50
43.00 OUTPATIENT SERVICES	0	0		0 0	0	43.00
44.00 PALLIATIVE RADIATION THERAPY	0	0		0 0	0	44.00
45.00 PALLIATIVE CHEMOTHERAPY	0	0		0 0	0	45.00
46.00 OTHER PATIENT CARE SERVICES (SPECIFY)	0	0		0 0	0	46.00
100. 00 TOTAL *	2, 954, 461	232, 716	3, 187, 1	77 0	3, 187, 177	100.00

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

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)		
		6.00	7.00		
	DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED			25.	5.00
26.00	PHYSI CI AN SERVI CES	C	0	26.	b. 00
27.00	NURSE PRACTITIONER	C	0	27.	7.00
28.00	REGI STERED NURSE	C	1, 890, 343	28.	3. 00
29.00	LPN/LVN	C	0	29.	9.00
30.00	PHYSI CAL THERAPY	C	0	30.	0. 00
31.00	OCCUPATI ONAL THERAPY	C	0	31.	. 00
32.00	SPEECH/LANGUAGE PATHOLOGY	C	0	32.	2.00
33.00	MEDICAL SOCIAL SERVICES	C	328, 279	33.	3.00
34.00	SPI RI TUAL COUNSELI NG	C	171, 899		l. 00
35.00	DI ETARY COUNSELI NG	C	0	35.	5.00
36.00	COUNSELING - OTHER	C	0	36.	6.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	C	563, 940	37.	7.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	C	65, 622	38.	3.00
39.00	PATI ENT TRANSPORTATI ON	C	0	39.	9.00
40.00	I MAGI NG SERVI CES	C	0	40.). 00
41.00	LABS & DIAGNOSTICS	C	0	41.	. 00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	C	167, 094	42.	2.00
42.50	DRUGS CHARGED TO PATIENTS	C	0	42.	2.50
43.00	OUTPATI ENT SERVICES	C	0	43.	3.00
44.00	PALLIATIVE RADIATION THERAPY	C	0	44.	1.00
45.00	PALLIATIVE CHEMOTHERAPY	C	0		5.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	C	0		b. 00
100.00	TOTAL *	C	3, 187, 177	100.	0. 00
* Tran	sfer the amount in column 7 to Wkst. 0-5, col	umn 1, line 51.			

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

Health Financial Systems FF	ANCISCAN HEALTH	I NDI ANAPOLI S		In Lie	u of Form CMS-2	2552-10
ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPIC	E INPATIENT	Provider CC	CN: 15-0162	Peri od:	Worksheet 0-3	
RESPI TE CARE		Hospice CCN	I: 15-1523	From 01/01/2023 To 12/31/2023	Date/Time Pre	nared
		1030100 001	1. 10 1020	10 12/31/2023	3/28/2024 2:2	
				Hospi ce I		
	SALARI ES	OTHER	SUBTOTAL (col	. RECLASSI FI -	SUBTOTAL	
			1 + col. 2)			
	1.00	2.00	3.00	4.00	5.00	
DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00 INPATIENT CARE-CONTRACTED		0		0 0	0	
26. 00 PHYSI CI AN SERVI CES	0	0		0 0	0	26.00
27.00 NURSE PRACTITIONER	0	0		0 0	0	27.00
28.00 REGI STERED NURSE	0	0		0 0	0	28.00
29.00 LPN/LVN	0	0		0 0	0	29.00
30. 00 PHYSI CAL THERAPY	0	0		0 0	0	30.00
31.00 OCCUPATIONAL THERAPY	0	0		0 0	0	31.00
32.00 SPEECH/LANGUAGE PATHOLOGY	0	0		0 0	0	02.00
33.00 MEDICAL SOCIAL SERVICES	0	0		0 0	0	33.00
34.00 SPI RI TUAL COUNSELI NG	0	0		0 0	0	34.00
35. 00 DI ETARY COUNSELI NG	0	0		0 0	0	35.00
36.00 COUNSELING - OTHER	0	0		0 0	0	36.00
37.00 HOSPICE AIDE & HOMEMAKER SERVICES	0	0		0 0	0	37.00
38.00 DURABLE MEDICAL EQUIPMENT/OXYGEN	0	1, 704	1, 70	04 0	1, 704	
39.00 PATIENT TRANSPORTATION	0	0		0 0	0	39.00
40. 00 I MAGI NG SERVI CES	0	0		0 0	0	40.00
41.00 LABS & DI AGNOSTI CS	0	0		0 0	0	41.00
42.00 MEDI CAL SUPPLI ES-NON-ROUTI NE	0	4, 338	4, 3	38 0	4, 338	
42.50 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	
43.00 OUTPATI ENT SERVICES	0	0		0 0	0	10.00
44.00 PALLIATIVE RADIATION THERAPY	0	0		0 0	0	44.00
45.00 PALLIATIVE CHEMOTHERAPY	0	0		0 0	0	45.00
46.00 OTHER PATIENT CARE SERVICES (SPECIFY)	0	0		0 0	0	1 101 00
100.00 TOTAL *	0	6, 042	6, 04	42 0	6, 042	100.00

 40.00
 OTHER PATIENT CARE SERVICES (SECTOR)

 100.00
 TOTAL *

 0

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

		ADJUSTMENTS	TOTAL (col. 5	
			± col. 6)	
		6.00	7.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS			
25.00	INPATIENT CARE-CONTRACTED	0	0	25.00
26.00	PHYSI CLAN SERVI CES	0	0	26.00
27.00	NURSE PRACTITIONER	0	0	27.00
28.00	REGI STERED NURSE	0	0	28.00
29.00	LPN/LVN	0	0	29.00
30.00	PHYSI CAL THERAPY	0	0	30.00
31.00	OCCUPATI ONAL THERAPY	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	0	33.00
34.00	SPI RI TUAL COUNSELI NG	0	0	34.00
35.00	DI ETARY COUNSELI NG	0	0	35.00
36.00	COUNSELING - OTHER	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	0	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	1, 704	38.00
39.00	PATI ENT TRANSPORTATI ON	0	0	39.00
40.00	I MAGI NG SERVI CES	0	0	40.00
41.00	LABS & DI AGNOSTI CS	0	0	41.00
42.00	MEDI CAL SUPPLI ES-NON-ROUTI NE	0	4, 338	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	42.50
43.00	OUTPATI ENT SERVICES	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	46.00
100.00	D TOTAL *	0	6, 042	100.00
* Trar	nsfer the amount in column 7 to Wkst. 0-5, col	umn 1, line 52.		

Health Financial Systems		RANCI SCAN HEALTH				u of Form CMS-	
	ED HOSPICE COSTS FOR HOSPIC	E GENERAL	Provider C	CN: 15-0162	Period: From 01/01/2023	Worksheet 0-4	
INPATIENT CARE			Hospi ce. CC	N: 15-1523	To 12/31/2023	Date/Time Pre	nared
				10 1020	10 12/01/2020	3/28/2024 2:2	
					Hospi ce I		
		SALARI ES	OTHER	SUBTOTAL (co	I. RECLASSI FI -	SUBTOTAL	
				1 + col. 2)			
		1.00	2.00	3.00	4.00	5.00	
	E SERVICE COST CENTERS						
25.00 INPATIENT CARE-CON			(0 0	0	1 201 00
26.00 PHYSI CI AN SERVI CES		0	(0 0	0	26.00
27.00 NURSE PRACTITIONER		0	(0 0	0	27.00
28.00 REGI STERED NURSE		0	(D	0 0	0	28.00
29.00 LPN/LVN		0	(D	0 0	0	29.00
30. 00 PHYSI CAL THERAPY		0	(D	0 0	0	30.00
31.00 OCCUPATIONAL THERA	PY	0	(D	0 0	0	31.00
32.00 SPEECH/LANGUAGE PA	THOLOGY	0	(D	0 0	0	32.00
33.00 MEDICAL SOCIAL SER	VICES	0	(D	0 0	0	33.00
34.00 SPI RI TUAL COUNSELI	NG	0	(D	0 0	0	34.00
35.00 DI ETARY COUNSELING		0	(0 0	0	35.00
36.00 COUNSELING - OTHER		0	(0 0	0	36.00
37.00 HOSPICE AIDE & HOM	EMAKER SERVICES	0	(0 0	0	37.00
38.00 DURABLE MEDICAL EC	UI PMENT/OXYGEN	0	55	5	55 0	55	38.00
39.00 PATIENT TRANSPORTA	TION	0	(0 0	0	39.00
40.00 I MAGI NG SERVI CES		0	(0 0	0	40.00
41.00 LABS & DIAGNOSTICS		0		1	1 0	1	41.00
42.00 MEDICAL SUPPLIES-N	ON-ROUTI NE	0	140) 1	40 0	140	42.00
42.50 DRUGS CHARGED TO F	ATI ENTS	0	(0 0	0	42.50
43.00 OUTPATIENT SERVICE	S	0	(0 0	0	43.00
44.00 PALLIATIVE RADIATI	ON THERAPY	0	(0 0	0	44.00
45.00 PALLIATIVE CHEMOTH	ERAPY	0	(0 0	0	45.00
46.00 OTHER PATIENT CARE	SERVICES (SPECIFY)	0	(0 0	0	46.00
100.00 TOTAL *		0	196	5 1	96 0	196	100.00

* Transfer the amount in column 7 to Wkst. 0-5, co			
	ADJUSTMENTS	TOTAL (col. 5	
		± col. 6)	
	6.00	7.00	
DIRECT PATIENT CARE SERVICE COST CENTERS			
25.00 INPATIENT CARE-CONTRACTED	0	0	25.0
26.00 PHYSI CI AN SERVI CES	0	0	26.0
27.00 NURSE PRACTITIONER	0	0	27.0
28.00 REGI STERED NURSE	0	0	28.0
29.00 LPN/LVN	0	0	29.0
30. 00 PHYSI CAL THERAPY	0	0	30.0
31. 00 OCCUPATI ONAL THERAPY	0	0	31.0
32.00 SPEECH/LANGUAGE PATHOLOGY	0	0	32.0
33.00 MEDICAL SOCIAL SERVICES	0	0	33.0
34.00 SPIRITUAL COUNSELING	0	0	34.0
35. 00 DI ETARY COUNSELI NG	0	0	35.0
36.00 COUNSELING - OTHER	0	0	36.0
37.00 HOSPICE AIDE & HOMEMAKER SERVICES	0	0	37.0
38.00 DURABLE MEDICAL EQUIPMENT/OXYGEN	0	55	38.0
39.00 PATIENT TRANSPORTATION	0	0	39.0
40.00 I MAGI NG SERVI CES	0	0	40.0
41.00 LABS & DIAGNOSTICS	0	1	41.0
42.00 MEDICAL SUPPLIES-NON-ROUTINE	0	140	42.0
42.50 DRUGS CHARGED TO PATIENTS	0	0	42.5
43.00 OUTPATIENT SERVICES	0	0	43.0
44.00 PALLIATIVE RADIATION THERAPY	0	0	44.0
45.00 PALLIATIVE CHEMOTHERAPY	0	0	45.0
46.00 OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	46.0
100.00 TOTAL *	0	196	100.0
* Transfer the amount in column 7 to Wkst. 0-5, co	olumn 1, line 53.		

Heal th	Financial Systems FRANCI SCAN HEALTH	I INDIANAPOLIS	5	In Lie	eu of Form CMS-2	2552-10
COST A	LLOCATION - DETERMINATION OF HOSPITAL-BASED HOSPICE NET	Provider C	CN: 15-0162	Peri od:	Worksheet 0-5	
EXPENS	ES FOR ALLOCATION			From 01/01/2023		
		Hospi ce CC	N: 15-1523	To 12/31/2023	Date/Time Pre 3/28/2024 2:2	
				Hospi ce I	372072024 2.2	
	Descriptions		HOSPICE DIRE		TOTAL EXPENSES	
			EXPENSES (se		(sum of cols.	
) EXPENSES FROM	1 + 2)	
				WKST B PART I	,	
				(see		
				instructions)		
			1.00	2.00	3.00	
	GENERAL SERVICE COST CENTERS					
1.00	CAP REL COSTS-BLDG & FIXT			0 0		1.00
2.00	CAP REL COSTS-MVBLE EQUIP			0 0	-	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT			0 18, 597		3.00
4.00	ADMI NI STRATI VE & GENERAL		1, 041, 4	2, 349, 673	3, 391, 141	4.00
5.00	PLANT OPERATION & MAINTENANCE			1 0	1	5.00
6.00	LAUNDRY & LINEN SERVICE		61, 1		61, 170	6.00
7.00	HOUSEKEEPING			0 0	10	7.00
8.00	DI ETARY			0 0	-	8.00
9.00	NURSING ADMINISTRATION			0 0	-	9.00
10.00	ROUTINE MEDICAL SUPPLIES			0 17,857		10.00
11.00	MEDI CAL RECORDS			0 20, 801	20, 801	11.00
12.00	STAFF TRANSPORTATION		37, 39		37, 391	12.00
13.00	VOLUNTEER SERVICE COORDINATION		212, 6		212, 637	13.00
14.00	PHARMACY		260, 5			14.00
15.00	PHYSI CI AN ADMI NI STRATI VE SERVI CES			0	0	15.00
16.00	OTHER GENERAL SERVICE			0 0		16.00
17.00	PATI ENT/RESI DENTI AL CARE SERVI CES			0	0	17.00
50.00	LEVEL OF CARE		1			50.00
50.00	HOSPICE CONTINUOUS HOME CARE		0 407 4	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE		3, 187, 1		3, 187, 177	51.00
52.00	HOSPICE INPATIENT RESPITE CARE		6, 0,		6,042	
53.00	HOSPICE GENERAL INPATIENT CARE			96	196	53.00
60.00	NONREIMBURSABLE COST CENTERS BEREAVEMENT PROGRAM		69, 1	24	69, 134	60.00
61.00	VOLUNTEER PROGRAM		07, 1.	0	09,134	61.00
62.00	FUNDRAI SI NG			0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS			0	0	63.00
64.00	PALLI ATI VE CARE PROGRAM		1, 701, 54	-	1, 701, 545	64.00
65.00	OTHER PHYSI CI AN SERVI CES		1,701,5	0	0	65.00
66.00	RESI DENTI AL CARE			0	0	66.00
67.00	ADVERTI SI NG			0	0	67.00
68.00	TELEHEALTH/TELEMONI TORI NG			0	0	68.00
69.00	THRI FT STORE			0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD			0	0	70.00
71.00	OTHER NONREI MBURSABLE (SPECI FY)			0	0	71.00
99.00	NEGATI VE COST CENTER			0	0	99.00
	TOTAL		6, 577, 32	-	-	

	Financial Systems LLOCATION - HOSPITAL-BASED HOSPICE GENERAL	FRANCI SCAN HEALTH		CN: 15-0162	Dor	In Lie riod:	u of Form CMS-2 Worksheet 0-6	
CUST	LLUCATION - HUSPITAL-BASED HUSPICE GENERAL	SERVICE CUSIS	Provider C	CN: 15-0162		om 01/01/2023	Part I	
			Hospi ce CC	N: 15-1523	То			pared:
						Hospi ce I	3/28/2024 2:2	1 pm
	Descriptions	TOTAL EXPENSES	AP REL BLDG &	CAP REL MVB		EMPLOYEE	SUBTOTAL	
			FIX	EQUI P		BENEFI TS	SOBTOTILE	
		0	1.00	2.00		DEPARTMENT 3.00	3A	
	GENERAL SERVICE COST CENTERS	0	1.00	2.00		3.00	38	
1.00	CAP REL COSTS-BLDG & FIXT	0	0					1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0			0			2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	18, 597	0		0	18, 597		3.00
4.00	ADMI NI STRATI VE & GENERAL	3, 391, 141	0		0	1, 277	3, 392, 418	4.00
5.00	PLANT OPERATION & MAINTENANCE	1	0		0	0	1	5.00
6.00	LAUNDRY & LINEN SERVICE	61, 170	0		0	185	61, 355	6.00
7.00	HOUSEKEEPING	10	0		0	0	10	7.00
8.00	DI ETARY	0	0		0	0	0	8.00
9.00	NURSING ADMINISTRATION	0	0		0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	17, 857	0		0	0	17, 857	10.00
11.00	MEDI CAL RECORDS	20, 801	0		0	0	20, 801	11.00
12.00	STAFF TRANSPORTATION	37, 391	0		0	0	37, 391	12.00
13.00	VOLUNTEER SERVICE COORDINATION	212, 637	0		0	642	213, 279	13.00
14.00	PHARMACY	299, 241	0		0	15	299, 256	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0		0	0	0	15.00
16.00	OTHER GENERAL SERVICE	0	0		0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES		0		0		0	17.00
	LEVEL OF CARE			1				
50.00	HOSPICE CONTINUOUS HOME CARE	0				0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	3, 187, 177				3, 097	3, 190, 274	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	6, 042	0		0	583	6, 625	
53.00	HOSPICE GENERAL INPATIENT CARE	196	0		0	5, 243	5, 439	53.00
	NONREI MBURSABLE COST CENTERS			1			(0.040	
60.00	BEREAVEMENT PROGRAM	69, 134	0		0	209	69, 343	60.00
61.00	VOLUNTEER PROGRAM	0	0		0	0	0	61.00
62.00	FUNDRALSING	0	0		0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0		0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	1, 701, 545	0		0	7, 346	1, 708, 891	64.00
65.00	OTHER PHYSI CI AN SERVI CES	0	0		0	0	0	65.00
66.00	RESIDENTIAL CARE	0	0		0	0	0	66.00
67.00	ADVERTI SI NG	0	0		0	0	0	67.00
68.00	TELEHEALTH/TELEMONI TORI NG	0	0		0	0	0	68.00
69.00	THRIFT STORE	0	0		U	0	0	69.00 70.00
70.00 71.00	NURSING FACILITY ROOM & BOARD OTHER NONREIMBURSABLE (SPECIFY)	0	0		0	_	0	70.00
71.00 99.00	NEGATIVE COST CENTER	0	0		0	0	0	99.00
	TOTAL	9,022,940	0		0	18, 597	9, 022, 940	
100.00	TIOINE	7,022,740	0	1	U	10, 597	7, 022, 740	100.00

	Financial Systems LLOCATION - HOSPITAL-BASED HOSPICE GENERA	L SERVICE COSTS	Provider C Hospice CC	CN: 15-0162 N: 15-1523	Period: From 01/01/2023 To 12/31/2023		repared:
	Descriptions	ADMI NI STRATI VE & GENERAL	PLANT OPERATION & MAINTENANCE	LAUNDRY & LINEN SERVIO	Hospi ce I HOUSEKEEPI NG	DI ETARY	
		4.00	5.00	6.00	7.00	8.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL	3, 392, 418					4.00
5.00	PLANT OPERATION & MAINTENANCE	1	2				5.00
6.00	LAUNDRY & LINEN SERVICE	36, 967	C	98, 3	22		6.00
7.00	HOUSEKEEPING	6	C		1	6	7.00
8.00	DI ETARY	0	C			c	0 8.00
9.00	NURSING ADMINISTRATION	0	C			D	9.00
10.00	ROUTI NE MEDI CAL SUPPLI ES	10, 759	C			D	10.00
11.00	MEDI CAL RECORDS	12, 533	C			D	11.00
12.00	STAFF TRANSPORTATION	22, 528	C			D	12.00
13.00	VOLUNTEER SERVICE COORDINATION	128, 502	C			D	13.00
14.00	PHARMACY	180, 303	C)		b	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	C)		b	15.00
16.00	OTHER GENERAL SERVICE	0	C			D	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	C			D	17.00
	LEVEL OF CARE					•	
50.00	HOSPICE CONTINUOUS HOME CARE	0					50.00
51.00	HOSPICE ROUTINE HOME CARE	1, 922, 155					51.00
52.00	HOSPICE INPATIENT RESPITE CARE	3, 992	2	95, 2	56 1	5	0 52.00
53.00	HOSPICE GENERAL INPATIENT CARE	3, 277	C	3, 0	66	1	0 53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	41, 780	C)	(0	60.00
61.00	VOLUNTEER PROGRAM	0	C		(D	61.00
62.00	FUNDRAI SI NG	0	C		(D	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	C		(D	63.00
64.00	PALLIATIVE CARE PROGRAM	1, 029, 615	C			c	64.00
65.00	OTHER PHYSICIAN SERVICES	0	C			D	65.00
66.00	RESI DENTI AL CARE	0	C		0	D	0 66.00
67.00	ADVERTI SI NG	0	C			D	67.00
68.00	TELEHEALTH/TELEMONI TORI NG	0	C		(C	68.00
69.00	THRI FT STORE	0	C			D	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	C		0	D	0 71.00
99.00	NEGATI VE COST CENTER	0	C		0	D	0 99.00
100 00	TOTAL	3, 392, 418	2	98, 3	22 1		0 100.00

Heal th	Financial Systems F	RANCI SCAN HEALTH	I NDI ANAPOLI S		In Lie	u of Form CMS-2	2552-10
	ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SI		Provider CO Hospice CC	CN: 15-0162	Peri od: From 01/01/2023 To 12/31/2023	Worksheet 0-6 Part I Date/Time Pre 3/28/2024 2:2	pared:
					Hospi ce I	372072024 2.2	
	Descriptions	NURSI NG ADMI NI STRATI ON	ROUTI NE MEDI CAL SUPPLI ES	MEDI CAL RECORDS	STAFF TRANSPORTATION	VOLUNTEER SERVI CE COORDI NATI ON	
		9.00	10.00	11.00	12.00	13.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMI NI STRATI VE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DI ETARY						8.00
9.00	NURSING ADMINISTRATION	0					9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	28, 616				10.00
11.00	MEDI CAL RECORDS	0		33, 3			11.00
12.00	STAFF TRANSPORTATION	0			59, 919		12.00
13.00	VOLUNTEER SERVICE COORDINATION	0			0	341, 781	13.00
14.00	PHARMACY	0			0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0			0	0	15.00
16.00	OTHER GENERAL SERVICE	0			0	0	16.00
17.00	PATI ENT/RESI DENTI AL CARE SERVI CES						17.00
	LEVEL OF CARE	-		1	-		
50.00	HOSPICE CONTINUOUS HOME CARE	0	0		0 0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	0	27, 870			332, 862	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	723		43 608	8, 641	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	23		27 5	278	53.00
(0.00	NONREI MBURSABLE COST CENTERS					0	(0.00
60.00	BEREAVEMENT PROGRAM	0			0	0	60.00
61.00	VOLUNTEER PROGRAM	0			0	0	61.00
62.00 63.00	FUNDRAI SI NG HOSPI CE/PALLI ATI VE MEDI CI NE FELLOWS	0			0	0	62.00 63.00
		0			0	-	
64.00	PALLIATIVE CARE PROGRAM	0			0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0			0	0	65.00
66.00 67.00	RESI DENTI AL CARE	0			0	0	66.00 67.00
67.00 68.00	ADVERTI SI NG TELEHEALTH/TELEMONI TORI NG	0			0	0	67.00 68.00
69.00	THRIFT STORE	0			0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0			0	0	70.00
70.00	OTHER NONREIMBURSABLE (SPECIFY)	0			0	0	70.00
99.00	NEGATIVE COST CENTER	0	0		0 0	0	99.00
	TOTAL	0	28, 616	33, 3	34 59, 919	341, 781	
100.00		, oj	20,010	1 55, 5	57, 717	541,701	1.00.00

COST A	LLOCATION - HOSPITAL-BASED HOSPICE GENERAL S	ERVICE COSTS	Provider C Hospice CC		Period: From 01/01/2023 To 12/31/2023	Worksheet 0-6 Part I Date/Time Pre 3/28/2024 2:2	epared:
					Hospi ce I		
	Descriptions	PHARMACY	PHYSI CI AN ADMI NI STRATI VE SERVI CES	OTHER GENER/ SERVI CE	AL PATIENT/ RESIDENTIAL CARE SERVICES	TOTAL	
		14.00	15.00	16.00	17.00	18.00	
	GENERAL SERVICE COST CENTERS	· · · · ·		•			
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMI NI STRATI VE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DI ETARY						8.00
9.00	NURSING ADMINISTRATION						9.00
10.00	ROUTINE MEDICAL SUPPLIES						10.00
11.00	MEDI CAL RECORDS						11.00
12.00	STAFF TRANSPORTATION						12.00
13.00 14.00	VOLUNTEER SERVICE COORDINATION PHARMACY	479, 559					13.00
14.00	PHARMACT PHYSICIAN ADMINISTRATIVE SERVICES	479, 559	0				14.00
16.00	OTHER GENERAL SERVICE	0	0	'	0		16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0			0		17.00
17.00	LEVEL OF CARE	1 1		I	0		17.00
50.00	HOSPICE CONTINUOUS HOME CARE	0	0		0	C	50.00
51.00	HOSPICE ROUTINE HOME CARE	467, 045	0		0	6, 031, 976	
52.00	HOSPICE INPATIENT RESPITE CARE	12, 124	0		0 0	128, 829	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	390	0)	0 0	12, 506	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0			0	111, 123	60.00
61.00	VOLUNTEER PROGRAM	0			0	C	61.00
62.00	FUNDRAI SI NG	0			0	C	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0			0	C	
64.00	PALLIATIVE CARE PROGRAM	0			0	2, 738, 506	
65.00	OTHER PHYSICIAN SERVICES	0			0	C	
66.00	RESI DENTI AL CARE	0	0		0 0	C	
67.00	ADVERTI SI NG	0			0	C	
68.00	TELEHEALTH/TELEMONI TORI NG	0			0	C	
69.00	THRIFT STORE	0			U	C	
70.00	NURSING FACILITY ROOM & BOARD		-		-	C	
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0		0 0	C	
99.00	NEGATI VE COST CENTER	470 550	0		0 0	0 000 040	
100.00	IUTAL	479, 559	0	1	0 0	9, 022, 940	1100.00

	Financial Systems LLOCATION - HOSPITAL-BASED HOSPICE GENERA	FRANCI SCAN HEALTH		N. 1E 01/0		u of Form CMS-2	
	TICAL BASIS	L SERVICE CUSIS	Provider CC	N: 15-0162	Period: From 01/01/2023	Worksheet 0-6 Part II	
JIAIL	TICAL BASIS		Hospi ce CCN	l: 15-1523	To 12/31/2023	Date/Time Pre	
						3/28/2024 2:2	1 pm
					Hospi ce I		
	Cost Center Descriptions	CAP REL BLDG & C		EMPLOYEE	RECONCI LI ATI ON		
		FIX	EQUI P	BENEFITS		& GENERAL	
		(SQUARE FEET) (I	OLLAR VALUE)	DEPARTMENT		(ACCUMULATED	
				(GROSS		COSTS)	
		1.00	2.00	SALARI ES) 3.00	4A	4.00	
	GENERAL SERVICE COST CENTERS	1.00	2.00	3.00	4A	4.00	
. 00	CAP REL COSTS-BLDG & FIXT	0					1.0
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.0
. 00	EMPLOYEE BENEFITS DEPARTMENT	0	0	6, 157, 98	35		3.0
. 00	ADMI NI STRATI VE & GENERAL	0	0	422, 8		5, 630, 522	4.0
. 00	PLANT OPERATION & MAINTENANCE	0	0	122, 0	0 0,072,110	0,000,022	5.0
. 00 . 00	LAUNDRY & LINEN SERVICE	0	0	61, 17	-	61, 355	6.
. 00	HOUSEKEEPING	0	0	01, 11	0 0	10	7.
. 00 3. 00	DIFTARY	0	0			0	8.
. 00	NURSI NG ADMI NI STRATI ON	0	0			0	9.
0.00	ROUTINE MEDICAL SUPPLIES	0	0		0 0	17, 857	10.
1.00	MEDI CAL RECORDS	0	0		0 0	20, 801	11.
2.00	STAFF TRANSPORTATION	0	0		0 0	37, 391	12.
3.00	VOLUNTEER SERVICE COORDINATION	0	0	212, 63	-	213, 279	
4.00	PHARMACY	0	0	4, 96		299, 256	14.
5.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	4, 70	0 0	277, 230	15.
6.00	OTHER GENERAL SERVICE	0	0		0 0	0	16.
7.00	PATI ENT/RESI DENTI AL CARE SERVI CES	0	0		0	0	17.
7.00	LEVEL OF CARE		V		V	0	1
0.00	HOSPICE CONTINUOUS HOME CARE				0 0	0	50.
1.00	HOSPICE ROUTINE HOME CARE			1, 025, 39		3, 190, 274	
2.00	HOSPICE INPATIENT RESPITE CARE	0	о	193, 12		6, 625	52.
3.00	HOSPICE GENERAL INPATIENT CARE	0	0	1, 735, 93		5, 439	
	NONREI MBURSABLE COST CENTERS			.,,		-,	
0. 00	BEREAVEMENT PROGRAM	0	0	69, 13	34 0	69, 343	60.
1.00	VOLUNTEER PROGRAM	0	0		0 0	0	61.
2.00	FUNDRAI SI NG	0	0		0 0	0	62.
3.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0		0 0	0	63.
4.00	PALLIATIVE CARE PROGRAM	0	0	2, 432, 80	04 0	1, 708, 891	64.
5.00	OTHER PHYSICIAN SERVICES	0	0		0 0	0	65.
6.00	RESI DENTI AL CARE	0	0		0 0	0	66.
7.00	ADVERTI SI NG	0	0		0 0	0	67.
8.00	TELEHEALTH/TELEMONI TORI NG	0	0		0 0	0	68.
9.00	THRI FT STORE	0	0		0 0	0	69.
0. 00	NURSING FACILITY ROOM & BOARD				0		70.
1.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0		0 0	0	71.
	NEGATIVE COST CENTER						99.
00.00	COST TO BE ALLOCATED (per Wkst. 0-6, Par	t I) 0	0	18, 59	97	3, 392, 418	100.
	UNIT COST MULTIPLIER	0, 000000	0. 000000	0.00302		0.602505	101

STATI S	LLOCATION - HOSPITAL-BASED HOSPICE GENERAL TICAL BASIS	SERVICE CUSIS	Provider C Hospice CC		Period: From 01/01/2023 To 12/31/2023	Worksheet 0-6 Part II Date/Time Prep 3/28/2024 2:2	pared:
					Hospi ce I		
	Cost Center Descriptions	PLANT OPERATI ON & MAI NTENANCE (SQUARE FEET)	LAUNDRY & LINEN SERVICE (IN-FACILITY DAYS)	HOUSEKEEPING (SQUARE FEET		NURSI NG ADMI NI STRATI ON (DI RECT NURS.	
			bittoj			HRS.)	
		5.00	6.00	7.00	8.00	9.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.0
2.00	CAP REL COSTS-MVBLE EQUIP						2.0
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.0
4.00	ADMINISTRATIVE & GENERAL						4.0
5.00	PLANT OPERATION & MAINTENANCE	329					5.0
5.00	LAUNDRY & LINEN SERVICE	0	481				6.0
7.00	HOUSEKEEPING	0	101		29		7.0
3.00	DI ETARY	0			0 0		8.0
9.00	NURSI NG ADMI NI STRATI ON	0			0	0	9.0
		0			0	0	
0.00	ROUTINE MEDICAL SUPPLIES	0			0		10.0
1.00	MEDICAL RECORDS	0			0	0	11.0
2.00	STAFF TRANSPORTATION	0			0	0	12.0
3.00	VOLUNTEER SERVICE COORDINATION	0			0	0	13.0
4.00	PHARMACY	0			0	0	14. C
5.00	PHYSICIAN ADMINISTRATIVE SERVICES	0			0	0	15.0
6.00	OTHER GENERAL SERVICE	0			0	0	16.0
7.00	PATIENT/RESIDENTIAL CARE SERVICES	0			0		17.0
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE					0	50.0
51.00	HOSPICE ROUTINE HOME CARE					0	51.0
52.00	HOSPICE INPATIENT RESPITE CARE	311	466		11 0	0	52.0
3.00	HOSPICE GENERAL INPATIENT CARE	18	15		18 0	0	53.0
	NONREIMBURSABLE COST CENTERS			1			
0.00	BEREAVEMENT PROGRAM	0			0	0	60. (
1.00	VOLUNTEER PROGRAM	0			0	0	61.0
2.00	FUNDRAI SI NG	0			0	0	62. (
3.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0			0	0	63.
4.00	PALLIATIVE CARE PROGRAM	0			0	0	64.0
5.00	OTHER PHYSI CLAN SERVI CES	0			0	0	65.
6.00	RESIDENTIAL CARE	0	0		0 0	0	66.
7.00	ADVERTI SI NG	0			0	0	67.0
8.00	TELEHEALTH/TELEMONI TORI NG	0			0	0	68. (
9.00	THRI FT STORE	0			0	0	69. (
0.00	NURSING FACILITY ROOM & BOARD					-	70.
1.00	OTHER NONREI MBURSABLE (SPECIFY)	0	0		0 0	0	71.
	NEGATI VE COST CENTER		0				99.
	COST TO BE ALLOCATED (per Wkst. 0-6, Part	2	98, 322	.	16 0	0	100. 0
()() ()()							

Heal th	Financial Systems Fi	RANCI SCAN HEALT	H INDIANAPOLIS		In Lie	u of Form CMS-	2552-10
	LLOCATION - HOSPITAL-BASED HOSPICE GENERAL SE	RVICE COSTS	Provider C	CN: 15-0162	Peri od:	Worksheet 0-6)
STATI S	TICAL BASIS		Hospi ce CC	N: 15-1523	From 01/01/2023 To 12/31/2023	Part II Date/Time Pre	pared.
			110001100 00	10 1020	10 12/01/2020	3/28/2024 2:2	
					Hospi ce I		
	Cost Center Descriptions	ROUTI NE	MEDI CAL	STAFF	VOLUNTEER	PHARMACY	
		MEDI CAL	RECORDS	TRANSPORTATIO		(CHARGES)	
			(PATIENT DAYS)		COORDI NATI ON		
		(PATIENT DAYS)		(MI LEAGE)	(HOURS OF		
		10.00	11.00	12.00	SERVICE) 13.00	14.00	
	GENERAL SERVICE COST CENTERS	10.00	11.00	12.00	13.00	14.00	
1.00	CAP REL COSTS-BLDG & FIXT						1 1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMI NI STRATI VE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DI ETARY						8.00
9.00	NURSING ADMINISTRATION						9.00
10.00	ROUTINE MEDICAL SUPPLIES	18, 432					10.00
11.00	MEDI CAL RECORDS		18, 432				11.00
12.00	STAFF TRANSPORTATION			101, 10)4		12.00
13.00	VOLUNTEER SERVICE COORDINATION				0 18, 432		13.00
14.00	PHARMACY				0 0	18, 432	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES				0 0	0	15.00
16.00	OTHER GENERAL SERVICE				0 0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
	LEVEL OF CARE	1		1			-
50.00	HOSPICE CONTINUOUS HOME CARE	0	0		0 0	0	
51.00	HOSPICE ROUTINE HOME CARE	17, 951	17, 951			17, 951	
52.00	HOSPICE INPATIENT RESPITE CARE	466	466			466	
53.00		15	15		9 15	15	53.00
(0.00	NONREI MBURSABLE COST CENTERS				0 0	0	1 (0 00
60.00 61.00	BEREAVEMENT PROGRAM VOLUNTEER PROGRAM				0 0	0	
61.00	FUNDRALSING				0 0	0	
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS				0 0	0	
64.00	PALLIATIVE CARE PROGRAM				0 0	0	
65.00	OTHER PHYSICIAN SERVICES					0	
66. 00	RESIDENTIAL CARE				0 0	0	
67.00	ADVERTI SI NG					0	
68.00	TELEHEALTH/TELEMONI TORI NG				0 0	0	
69.00	THRI FT STORE				0 0	0	
70.00	NURSING FACILITY ROOM & BOARD				- 0		70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)				0 0	0	
99.00	NEGATI VE COST CENTER	1			J J		99.00
	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	28, 616	33, 334	59, 91	9 341, 781	479, 559	
	UNIT COST MULTIPLIER	1. 552517					
					1		

	Financial Systems F LLOCATION - HOSPITAL-BASED HOSPICE GENERAL SU TICAL BASIS	ERVICE COSTS	Provider C Hospice CC	CN: 15-0162 N: 15-1523	Period: From 01/01/2023 To 12/31/2023	Worksheet O- Part II Date/Time Pr 3/28/2024 2:	repared:
		-			Hospi ce I		
	Cost Center Descriptions	PHYSI CI AN ADMI NI STRATI VE	OTHER GENERAL SERVI CE	PATI ENT/ RESI DENTI AI	L		
		SERVICES (PATIENT DAYS)	(SPECI FY BASI S)	CARE SERVICI (IN-FACILIT DAYS)			
		15.00	16.00	17.00			
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DI ETARY						8.00
9.00	NURSI NG ADMI NI STRATI ON						9.00
10.00	ROUTINE MEDICAL SUPPLIES						10.00
11.00	MEDI CAL RECORDS						11.00
12.00	STAFF TRANSPORTATION						12.00
13.00	VOLUNTEER SERVICE COORDINATION						13.00
14.00	PHARMACY						14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0					15.00
16.00	OTHER GENERAL SERVICE		0		0		16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES				0		17.00
50.00	HOSPICE CONTINUOUS HOME CARE	0	C				50.00
51.00	HOSPICE CONTINUOUS HOME CARE	0					51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0			0		52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0			0		53.00
00.00	NONREI MBURSABLE COST CENTERS		<u> </u>		0		00.00
60.00	BEREAVEMENT PROGRAM		C				60.00
61.00	VOLUNTEER PROGRAM		c c				61.00
62.00	FUNDRAI SI NG		c c)			62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS		c)			63.00
64.00	PALLIATIVE CARE PROGRAM		0)			64.00
65.00	OTHER PHYSI CLAN SERVI CES		0)			65.00
66.00	RESIDENTIAL CARE	0	0		0		66.00
67.00	ADVERTI SI NG		0				67.00
68.00	TELEHEALTH/TELEMONI TORI NG		0				68.00
69.00	THRI FT STORE		0				69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0		0		71.00
99.00	NEGATIVE COST CENTER						99.00
	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)		0		0		100.00
101.00	UNIT COST MULTIPLIER	0. 000000	0. 000000	0.0000	000		101.00

Heal th	Financial Systems F	RANCI SCAN HEALT	H INDIANAPOLIS		In Lie	eu of Form CMS-2	2552-10
APPORT	IONMENT OF HOSPITAL-BASED HOSPICE SHARED SERV	ICE COSTS BY	Provider C	CN: 15-0162	Peri od:	Worksheet 0-7	
LEVEL	OF CARE		Hospi ce CCI	N: 15-1523	From 01/01/2023 To 12/31/2023		
					Hospi ce I	0,20,2021 212	
				Charges by	LOC (from Provi	der Records)	
	Cost Center Descriptions	From Wkst. C, Part I, Col. 9 line		НСНС	HRHC	HI RC	
		0	1.00	2.00	3.00	4.00	
	ANCILLARY SERVICE COST CENTERS						
1.00	PHYSI CAL THERAPY	66.00			0 0	-	
2.00	OCCUPATIONAL THERAPY	67.00			0 0	Ű	2.00
3.00	SPEECH PATHOLOGY	68.00			0 0	0	
4.00	DRUGS CHARGED TO PATIENTS	73.00			0 0	0	
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00					5.00
6.00	LABORATORY	60.00			0 0	0	
7.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00			0 0	0	1.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER	93.00					8.00
9.00	RADI OLOGY-THERAPEUTI C	55.00			0 0	0	
10.97	CARDI AC REHABI LI TATI ON	76. 97	0. 173803		0 0	0	
11.00	Totals (sum of lines 1–11)						11.00
		Charges by LOC (from Provider		Shared Servi	ce Costs by LOC		
		Records)					
	Cost Center Descriptions		HCHC (col 1 x	HRHC (col 1	xHIRC (col. 1 x	HGLP (col 1 x	
	Cost center beschiptrons	norr	col. 2)	col . 3)	col . 4)	col. 5)	
		5.00	6.00	7.00	8.00	9.00	
	ANCILLARY SERVICE COST CENTERS			•		•	
1.00	PHYSI CAL THERAPY	0	0		0 0	0	1.00
2.00	OCCUPATIONAL THERAPY	0	0		0 0	0	2.00
3.00	SPEECH PATHOLOGY	0	0		0 0	0	0.00
4.00	DRUGS CHARGED TO PATIENTS	0	0		0 0	0	
5.00	DURABLE MEDICAL EQUIP-RENTED						5.00
6.00	LABORATORY	0	0		0 0	0	
7.00	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 0	0	1.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER						8.00
9.00	RADI OLOGY-THERAPEUTI C	0	0		0 0	-	
10. 97	CARDIAC REHABILITATION	0	0		0 0	0	
11.00	Totals (sum of lines 1–11)		0		0 0	0	11.00

	FINANCI SCAN HEALTH	Provider C		Period:	u of Form CMS-2	2002-1
ALCUL	ATTUN OF HUSPITAL-BASED HUSPICE PER DIEM CUST	Provider C	UN: 15-0162	From 01/01/2023	Worksheet 0-8	
		Hospi ce CC	N: 15-1523	To 12/31/2023	Date/Time Prep	
		-			3/28/2024 2:2	1 pm
				Hospi ce I		
			TITLE XVIII		TOTAL	
			MEDICARE	MEDI CAI D	2.00	
	HOCOLOG CONTINUOUS HONE CADE		1.00	2.00	3.00	
	HOSPICE CONTINUOUS HOME CARE	7	1		0	1.0
. 00	Total cost (Wkst. 0-6, Part I, col. 18, line 50 plus Wkst. 0- line 11)	-7, COL. 6,			0	1.0
. 00	Total unduplicated days (Wkst. S-9, col. 4, line 10)				0	2.0
. 00	Total average cost per diem (line 1 divided by line 2)				0.00	2. C 3. C
. 00	Unduplicated program days (Wkst. S-9 col. as appropriate, lir	10)		0 0	0.00	4. C
. 00	Program cost (line 3 times line 4)			0 0		4. C 5. C
. 00	HOSPICE ROUTINE HOME CARE			0 0		5.0
. 00	Total cost (Wkst. 0-6, Part I, col. 18, line 51 plus Wkst. 0-	7 col 7	1		6, 031, 976	6.0
. 00	line 11)	7, COL. 7,			0,031,770	0.1
00	Total unduplicated days (Wkst. S-9, col. 4, line 11)				17, 951	7. (
. 00	Total average cost per diem (line 6 divided by line 7)				336.02	8. (
. 00	Unduplicated program days (Wkst. S-9, col. as appropriate, li	ne 11)	15, 4	75 475	000102	9.0
0.00	Program cost (line 8 times line 9)		5, 199, 9			10.0
	HOSPICE INPATIENT RESPITE CARE					
1.00	Total cost (Wkst. 0-6, Part I, col. 18, line 52 plus Wkst. 0-	-7, col. 8,			128, 829	11. (
	line 11)					
2.00	Total unduplicated days (Wkst. S-9, col. 4, line 12)				466	12. (
3.00	Total average cost per diem (line 11 divided by line 12)				276.46	13. (
4.00	Unduplicated program days (Wkst. S-9, col. as appropriate, li	ne 12)	4	16 5		14. (
5.00	Program cost (line 13 times line 14)		115, 0	07 1, 382		15.0
	HOSPICE GENERAL INPATIENT CARE		_			
6.00	Total cost (Wkst. 0-6, Part I, col. 18, line 53 plus Wkst. 0-	-7, col. 9,			12, 506	16. (
	line 11)					
7.00	Total unduplicated days (Wkst. S-9, col. 4, line 13)					
3.00	Total average cost per diem (line 16 divided by line 17)				833. 73	-
9.00	Unduplicated program days (Wkst. S-9, col. as appropriate, li	ne 13)		12 3		19. (
0. 00	Program cost (line 18 times line 19)		10, 0	05 2, 501		20. (
	TOTAL HOSPICE CARE					
1.00	Total cost (sum of line 1 + line 6 + line 11 + line 16)				6, 173, 311	
2.00	Total unduplicated days (Wkst. S-9, col. 4, line 14)				18, 432	
3.00	Average cost per diem (line 21 divided by line 22)				334.92	23.0

Health Financial Systems	FRANCISCAN HEALTH INDIANAPOLIS	In Lie	u of Form CMS-2	2552-10
CALCULATION OF CAPITAL PAYMENT	Provider CCN: 15-0162	Peri od:	Worksheet L	
		From 01/01/2023	Parts I-III	
		To 12/31/2023	Date/Time Pre	pared:
			3/28/2024 2:2	
	Title XVIII	Hospi tal	PPS	
			1.00	
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1 00 Conital DDC athen than outling			E 704 740	1 00

	CAPI TAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	5, 736, 762	1.
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.
2.00	Capital DRG outlier payments	394, 775	2.
2.01	Model 4 BPCI Capital DRG outlier payments	0	2.
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)	300.47	3.
4.00	Number of interns & residents (see instructions)	22.27	4
5.00	Indirect medical education percentage (see instructions)	2.11	5
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01) (see instructions)	121, 046	
. 00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	0.00	7.
8.00	Percentage of Medicaid patient days to total days (see instructions)	0.00	8
. 00	Sum of Lines 7 and 8	0.00	9
0.00		0,00	10
1.00	Disproportionate share adjustment (see instructions)	0	
2.00	Total prospective capital payments (see instructions)	6, 252, 583	
2.00		0,202,000	
		1.00	
	PART II - PAYMENT UNDER REASONABLE COST		
. 00	Program inpatient routine capital cost (see instructions)	0	1
. 00	Program inpatient ancillary capital cost (see instructions)	0	2
. 00	Total inpatient program capital cost (line 1 plus line 2)	0	3
. 00	Capital cost payment factor (see instructions)	0	4
			1 7
5.00 5.00	Total inpatient program capital cost (line 3 x line 4)	0	
			5
	Total inpatient program capital cost (line 3 x line 4)	0	
. 00	Total inpatient program capital cost (line 3 x line 4) PART III - COMPUTATION OF EXCEPTION PAYMENTS	1.00	5
. 00	Total inpatient program capital cost (line 3 x line 4) PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions)	1.00	5
. 00 . 00 . 00	PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstances (see instructions)	1.00 0 0	5 1 2
. 00 . 00 . 00 . 00	PART 111 - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstances (see instructions) Net program inpatient capital costs (line 1 minus line 2)	1.00 0 0 0	5 1 2 3
. 00 . 00 . 00 . 00 . 00	PART 111 - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstances (see instructions) Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions)	1.00 0 0 0 0 0 0.00	5 1 2 3 4
. 00 . 00 . 00 . 00 . 00 . 00 . 00	PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstances (see instructions) Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4)	1.00 0 0 0 0.00 0.00 0	5 1 2 3 4 5
. 00 . 00 . 00 . 00 . 00 . 00 . 00	PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstances (see instructions) Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see instructions)	1.00 0 0 0 0.00 0.00 0.00	5 1 2 3 4 5 6
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Total inpatient program capital cost (line 3 x line 4) PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstances (see instructions) Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see instructions) Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)	1.00 0 0 0.00 0.00 0.00 0.00 0	5 1 2 3 4 5 6 7
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Total inpatient program capital cost (line 3 x line 4) PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstances (see instructions) Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see instructions) Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6) Capital minimum payment level (line 5 plus line 7)	1.00 0 0 0.00 0.00 0.00 0 0.00 0 0	5 1 2 3 4 5 6 7 8
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Total inpatient program capital cost (line 3 x line 4) PART 111 - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstances (see instructions) Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see instructions) Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6) Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as applicable)	1.00 0 0 0.00 0.00 0.00 0 0.00 0 0.00 0 0 0 0 0 0 0 0 0	5 1 2 3 4 5 6 7 8 9
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Total inpatient program capital cost (line 3 x line 4) PART 111 - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstances (see instructions) Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see instructions) Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6) Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as applicable) Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)	1.00 0 0 0.00 0.00 0.00 0 0.00 0 0	5 1 2 3 4 5 6 7 8 9
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Total inpatient program capital cost (line 3 x line 4) PART 111 - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstances (see instructions) Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see instructions) Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6) Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as applicable) Current year comparison of capital minimum payment level to capital payments (line 8 less line 9) Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)	1.00 0 0 0.00 0.00 0.00 0 0.00 0 0 0 0 0	5 1 2 3 4 5 6 7 8 9 10 11
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Total inpatient program capital cost (line 3 x line 4) PART 111 - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstances (see instructions) Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see instructions) Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6) Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as applicable) Current year comparison of capital minimum payment level to capital payments (line 8 less line 9) Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)	1.00 0 0.00 0.00 0.00 0.00 0 0.00 0 0 0	5 1 2 3 4 5 6 7 8 9 10 11
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Total inpatient program capital cost (line 3 x line 4) PART 111 - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstances (see instructions) Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see instructions) Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6) Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as applicable) Current year comparison of capital minimum payment level to capital payments (line 8 less line 9) Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)	1.00 0 0 0.00 0.00 0.00 0 0.00 0 0 0 0 0	5 1 2 3 4 5 6 7 8 9 10 11 11 2
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	PART 111 - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstances (see instructions) Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see instructions) Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6) Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as applicable) Current year comparison of capital minimum payment level to capital payments (line 8 less line 9) Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital payments (line 10 plus line 11) Current year exception payment (if line 12 is positive, enter the amount on this line)	1.00 0 0 0.00 0 0.00 0 0 0 0 0 0 0 0 0 0	5 1 2 3 4 5 6 7 8 9 10 11 11 12 13
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Total inpatient program capital cost (line 3 x line 4) PART 111 - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstances (see instructions) Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see instructions) Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6) Capital minimum payment level (line 5 plus line 7) Current year comparison of capital minimum payment level to capital payments (line 8 less line 9) Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital payments (line 10 plus line 11) Current year exception payment (if line 12 is positive, enter the amount on this line) 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)	1.00 0 0 0.00 0.00 0 0.00 0 0 0 0 0 0 0	5 1 2 3 4 5 6 7 8 9 10 11 11 12 13 14
	Total inpatient program capital cost (line 3 x line 4) PART 111 - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstances (see instructions) Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see instructions) Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6) Capital minimum payment level (line 5 plus line 7) Current year comparison of capital minimum payment level to capital payments (line 8 less line 9) Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital payments (line 10 plus line 11) Current year exception payment (if line 12 is positive, enter the amount on this line) 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)	1.00 0 0 0.00 0.00 0 0.00 0 0 0 0 0 0 0	5 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15