This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 09-30-2025 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION | Provider CCN: 15-0193 Worksheet S Peri od: From 01/01/2023 Parts I-III AND SETTLEMENT SUMMARY 12/31/2023 Date/Time Prepared: 5/31/2024 10:50 am PART I - COST REPORT STATUS Provi der 1. [X] Electronically prepared cost report Date: 5/31/2024 Time: 10:50 am use only] Manually prepared cost report Ilf this is an amended report enter the number of times the provider resubmitted this cost report [Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no. [1] Cost Report Status
[1] As Submitted
[2] Settled without Audit
[3] Settled with Audit
[4] Date Received:
[5] To. NPR Date:
[6] 10. NPR Date:
[7] 11. Contractor's Vendor Code:
[7] 12. [8] Initial Report for this Provider CCN
[9] [8] Final Report for this Provider CCN
[10] NPR Date:
[11] 12. NPR Date:
[12] 13. NPR Date:
[13] 14. NPR Date:
[14] 15. NPR Date:
[15] 15. NPR Date:
[16] 16. NPR Date:
[17] 17. NPR Date:
[18] 17. NPR Date:
[18] 18. NPR Date:
[18] 18. NPR Date:
[18] 19. NPR Contractor use only (3) Settled with Audit number of times reopened = 0-9.

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

(4) Reopened (5) Amended

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

CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by FRANCISCAN HEALTH ORTHOPEDIC CARMEL (15-0193) for the cost reporting period beginning 01/01/2023 and ending 12/31/2023 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

			Title XVIII				
		Title V	Part A	Part B	HI T	Title XIX	
		1.00	2.00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPI TAL	0	1, 226, 432	3, 316	0	0	1.00
2.00	SUBPROVI DER - I PF	0	0	0		0	2.00
3.00	SUBPROVI DER - I RF	0	0	0		0	3. 00
5.00	SWING BED - SNF	0	0	0		0	5. 00
6.00	SWING BED - NF	0				0	6.00
200.00	TOTAL	0	1, 226, 432	3, 316	0	0	200. 00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The number for this information collection is OMB 0938-0050 and the number for the Supplement to Form CMS 2552-10, Worksheet N95, is OMB 0938-1425. The time required to complete and review the information collection is estimated 675 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance

Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.
Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

Health Financial Systems FRANCISCAN HEALTH ORTHOPEDIC CARMEL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0193 Peri od: Worksheet S-2 From 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/31/2024 10:50 am 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 10777 ILLINOIS ST 1.00 PO Box: 1.00 State: IN 2.00 City: CARMEL Zip Code: 46032 County 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, 0, or N) Number Number Certi fi ed Type 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 Hospi tal FRANCISCAN HEALTH 150193 26900 05/06/2022 Ν 3.00 ORTHOPEDIC CARMEL Subprovi der - IPF 4.00 4 00 5.00 Subprovider - IRF 5.00 Subprovi der - (Other) 6.00 6.00 Swing Beds - SNF 7 00 7 00 8.00 Swing Beds - NF 8.00 9.00 Hospi tal -Based SNF 9.00 10.00 Hospi tal -Based NF 10.00 11.00 Hospi tal -Based OLTC 11.00 12.00 Hospi tal -Based HHA 12.00 Separately Certified ASC 13.00 13.00 Hospi tal -Based Hospi ce 14.00 14.00 Hospital-Based Health Clinic - RHC 15.00 15 00 16.00 Hospital-Based Health Clinic - FQHC 16.00 17.00 Hospital-Based (CMHC) I 17.00 18.00 Renal Dialysis 18.00 19.00 Other 19.00 From: 2.00 1.00 20.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2023 12/31/2023 20.00 21.00 Type of Control (see instructions) 21.00 1 1. 00 2. 00 3.00 Inpatient PPS Information 22.00 Does this facility qualify and is it currently receiving payments for N N 22.00 disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim UCPs, including supplemental UCPs, for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no 22.01 Ν Ν 22.01 for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) 22.02 Is this a newly merged hospital that requires a final UCP to be Ν Ν 22.02 determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1. 22.03 Did this hospital receive a geographic reclassification from urban to N 22.03 N Ν rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. 22.04 Did this hospital receive a geographic reclassification from urban to 22.04 rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, yes or "N" for no. 23 00 Which method is used to determine Medicaid days on lines 24 and/or 25 23 00 3 N below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.

	•	HEALTH URTH				in Lieu			
HOSPI	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	AIA	Provider CC	CN: 15-0193	Period: From 01/0° To 12/3°		Workshopen Part I Date/Ti 5/31/20		pared:
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medica HMO da	id 0 ys Med	ther di cai d days	
		1.00	2. 00	3. 00	4. 00	5. 00		5. 00	1
24. 00 25. 00	If this provider is an IPPS hospital, enter the in-state Medicaid paid 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				0		0	0	24. 00 25. 00
	Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.								
					Urban/Ru		Date of 2.0		-
26. 00	Enter your standard geographic classification (not w	age) status	at the beg	ginning of t		1			26. 00
27. 00	cost reporting period. Enter "1" for urban or "2" fo Enter your standard geographic classification (not w reporting period. Enter in column 1, "1" for urban o enter the effective date of the geographic reclassif	age) status r "2" for r	ural. If ap		t	1			27. 00
35. 00	If this is a sole community hospital (SCH), enter the effect in the cost reporting period.			CH status in		0			35.00
	errect in the cost reporting perrou.				Begi nn		Endi		
36. 00	Enter applicable beginning and ending dates of SCH s	tatus. Subs	cript line	36 for numb	1.0 er	00	2. (00	36.00
37. 00	of periods in excess of one and enter subsequent dat If this is a Medicare dependent hospital (MDH), ente is in effect in the cost reporting period.		r of period	ds MDH statu	S	0			37. 00
37. 01	Is this hospital a former MDH that is eligible for t accordance with FY 2016 OPPS final rule? Enter "Y" finstructions)								37. 01
38. 00	If line 37 is 1, enter the beginning and ending date greater than 1, subscript this line for the number o enter subsequent dates.								38.00
					Y/I 1. 0		Y/ 2. (
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 accordance with 42 CFR 412.101(b)(2)(i), (ii), or (i or "N" for no. (see instructions)), (ii), or the mileage	(iii)? Ent	er in colum nts in	me N n		N.		39.00
40. 00	Is this hospital subject to the HAC program reductio "N" for no in column 1, for discharges prior to Octo no in column 2, for discharges on or after October 1	ber 1. Ente	r "Y" for y				N	I	40.00
	January State of the State of t	('	V 1. 00	XVI I I	XI X 3. 00	
	Prospective Payment System (PPS)-Capital								
45. 00	Does this facility qualify and receive Capital payme with 42 CFR Section §412.320? (see instructions)	nt for disp	roporti onat	e share in	accordance	N	N	N	45. 00
46. 00	Is this facility eligible for additional payment exc pursuant to 42 CFR §412.348(f)? If yes, complete Wks Pt. III.					N	N	N	46. 00
47. 00 48. 00	Is this a new hospital under 42 CFR §412.300(b) PPS Is the facility electing full federal capital paymen					N N	Y N	N N	47. 00 48. 00
	Teachi ng Hospi tal s							- ''	1
56. 00	Is this a hospital involved in training residents in periods beginning prior to December 27, 2020, enter cost reporting periods beginning on or after Decembe the instructions. For column 2, if the response to c involved in training residents in approved GME progrand are you are impacted by CR 11642 (or applicable "Y" for yes; otherwise, enter "N" for no in column 2	"Y" for yes r 27, 2020, olumn 1 is ams in the CRs) MA dir	or "N" for under 42 ("Y", or if prior year	no in colu CFR 413.78(b this hospit or penultim	mn 1. For)(2), see al was ate year,	N	N		56.00
57. 00 58. 00	For cost reporting periods beginning prior to Decemb is this the first cost reporting period during which at this facility? Enter "Y" for yes or "N" for no i residents start training in the first month of this "N" for no in column 2. If column 2 is "Y", complet complete Wkst. D, Parts III & IV and D-2, Pt. II, if beginning on or after December 27, 2020, under 42 CF which month(s) of the cost report the residents were for yes, enter "Y" for yes in column 1, do not complIf line 56 is yes, did this facility elect cost reim	er 27, 2020 residents n column 1. cost report e Worksheet applicable R 413.77(e on duty, i ete column	in approved If column ing period? E-4. If co . For cost)(1)(iv) ar f the respo	d GME progra 1 is "Y", d 2 Enter "Y" blumn 2 is " reporting p nd (v), rega onse to line blete Worksh	ms trained id for yes or N", eriods rdless of 56 is "Y" eet E-4.	N			57. 00
		complete W		231 11 00		_ ··	1	1	1 30. 0

	instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column					
	3, the IME FTE unweighted count. Enter in column 4,					
	the direct GME FTE unweighted count.					
					1.00	
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)						
62.00	Enter the number of FTE residents that your hospital	trained in this cost	reporting peri	od for which	0.00	62.00
	your hospital received HRSA PCRE funding (see instru	ctions)				
62. 01	Enter the number of FTE residents that rotated from a	a Teaching Health Cente	er (THC) into	your hospital	0.00	62. 01
	during in this cost reporting period of HRSA THC proj	gram. (see instructions	s)			
	Teaching Hospitals that Claim Residents in Nonprovid	er Settings				
63.00	Has your facility trained residents in nonprovider se	ettings during this co	st reporting p	eriod? Enter	N	63. 00
	"Y" for ves or "N" for no in column 1. If ves. comple	ete lines 64 through 6	7. (see instru	ctions)		

0.00 61.20

unweighted count. Enter in column 4, the direct GME

program specialty, if any, and the number of FTE residents for each expanded program. (see

61.20 Of the FTEs in line 61.05, specify each expanded

FTE unweighted count.

Hoal th	Financial Systems	FRANCISCAN H	IENITH ODT	HUDEDIC CVBW	IFI	In Lie	eu of Form CMS-	2552_10
	AL AND HOSPITAL HEALTH CARE COMP			Provi der CC		Peri od: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part I	epared:
					Unwei ghted FTEs Nonprovi de Si te	FTEs in	Ratio (col. 1/ (col. 1 + col. 2))	/
	Section 5504 of the ACA Base Yea	ur ETE Residents in No	onnrovi der	Settings	1.00 This base ve	2.00	3.00	
	period that begins on or after .	luly 1, 2009 and before	re June 30), 2010.				
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 you of (column 1 divided by (column	ber of unweighted nor tations occurring in number of unweighted ur hospital. Enter in	n-primary all nonpr d non-prim n column 3	care rovider nary care the ratio	0.	0.0	0. 000000	5 64.00
		Program Name		ram Code	Unwei ghted FTEs Nonprovi de Si te	FTEs in	Ratio (col. 3/ (col. 3 + col. 4))	
65. 00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)	1.00		2.00	Unwei ghted FTEs Nonprovi dei	FTEs in	Ratio (col. 1/(col. 1 + col. 2))	
					Si te 1.00	2.00	3.00	-
	Section 5504 of the ACA Current		n Nonprovi	der Setting				
66. 00	beginning on or after July 1, 20 Enter in column 1 the number of FTEs attributable to rotations of Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 +	unweighted non-primar ccurring in all nonpr unweighted non-primar al. Enter in column 3	rovider se ry care re 3 the rati	ettings. esident o of		00 0.0		
		Program Name		ram Code	Unwei ghted FTEs Nonprovi de Si te	FTES in Hospital	Ratio (col. 3, (col. 3 + col. 4))	
67. 00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)	1.00		2.00	3.00	4.00 00 0.0	5.00 0 0.000000	67.00

		T	12/31/20	Date/Time P 5/31/2024 1		
				1.00		
	Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-490			1.00		
	For a cost reporting period beginning prior to October 1, 2022, did you ob MAC to apply the new DGME formula in accordance with the FY 2023 IPPS Final (August 10, 2022)?				68.00	
			1	. 00 2. 00 3. 0	0	
70.00	Inpatient Psychiatric Facility PPS					
	Is this facility an Inpatient Psychiatric Facility (IPF), or does it containter "Y" for yes or "N" for no.			N	70.00	
71. 00	If line 70 is yes: Column 1: Did the facility have an approved GME teachir recent cost report filed on or before November 15, 2004? Enter "Y" for ye 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for ye Column 3: If column 2 is Y, indicate which program year began during this (see instructions)	es or "N" for r in a new teach es or "N" for r	io. (see ii ng io.	0	71.00	
75. 00	Inpatient Rehabilitation Facility PPS Is this facility an Inpatient Rehabilitation Facility (IRF), or does it co	ontain an IRF		N	75. 00	
76. 00	subprovider? Enter "Y" for yes and "N" for no. If line 75 is yes: Column 1: Did the facility have an approved GME teachir	na program in t	he most		76. 00	
	recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)					
				1. 00		
30. 00	Long Term Care Hospital PPS Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for r	10.		N	80.00	
81. 00	Is this a LTCH co-located within another hospital for part or all of the ("Y" for yes and "N" for no. TEFRA Providers	er N	81.00			
	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter Did this facility establish a new Other subprovider (excluded unit) under			o. N	85. 00 86. 00	
	§413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no. Is this hospital an extended neoplastic disease care hospital classified u	N	87. 0			
	1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.		Approved for	or Number of		
			Permanent Adjustment (Y/N)			
38. 00	Column 1: Is this hospital approved for a permanent adjustment to the TEFF	2Δ tarmet	1. 00 N	2. 00	0 88.00	
30. 00	amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete of 89. (see instructions) Column 2: Enter the number of approved permanent adjustments.	ol. 2 and line	IV.		0 00.00	
	por unin 2. Effect the number of approved per manerit day astiments.	Wkst. A Line	Effective Da			
		No.		Permanent Adjustment Amount Per		
		1. 00	2. 00	Di scharge 3.00		
89. 00	Column 1: If line 88, column 1 is Y, enter the Worksheet A line number on which the per discharge permanent adjustment approval was based. Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amount per discharge.	1.00		Di scharge		
89. 00	on which the per discharge permanent adjustment approval was based. Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amount			Di scharge		
89. 00	on which the per discharge permanent adjustment approval was based. Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amount per discharge. Column 3: Enter the amount of the approved permanent adjustment to the			Di scharge		
	on which the per discharge permanent adjustment approval was based. Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amount per discharge. Column 3: Enter the amount of the approved permanent adjustment to the TEFRA target amount per discharge. Title V and XIX Services	0. 00	V 1.00	Di scharge 3.00	0 89.00	
90. 00	on which the per discharge permanent adjustment approval was based. Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amount per discharge. Column 3: Enter the amount of the approved permanent adjustment to the TEFRA target amount per discharge. Title V and XIX Services Does this facility have title V and/or XIX inpatient hospital services? Eryes or "N" for no in the applicable column.	0.00 nter "Y" for	V 1.00	Di scharge 3.00 XI X 2.00	90. 00	
90. 00	on which the per discharge permanent adjustment approval was based. Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amount per discharge. Column 3: Enter the amount of the approved permanent adjustment to the TEFRA target amount per discharge. Title V and XIX Services Does this facility have title V and/or XIX inpatient hospital services? Er yes or "N" for no in the applicable column. Is this hospital reimbursed for title V and/or XIX through the cost reportfull or in part? Enter "Y" for yes or "N" for no in the applicable column.	0.00	V 1.00	Di scharge 3.00 XI X 2.00 N	90.00	
90. 00	on which the per discharge permanent adjustment approval was based. Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amount per discharge. Column 3: Enter the amount of the approved permanent adjustment to the TEFRA target amount per discharge. Title V and XIX Services Does this facility have title V and/or XIX inpatient hospital services? Er yes or "N" for no in the applicable column. Is this hospital reimbursed for title V and/or XIX through the cost reportfull or in part? Enter "Y" for yes or "N" for no in the applicable column. Are title XIX NF patients occupying title XVIII SNF beds (dual certificati instructions) Enter "Y" for yes or "N" for no in the applicable column.	0.00 nter "Y" for t either in on)? (see	V 1.00	Di scharge 3.00 XI X 2.00	90. 00	
90. 00	on which the per discharge permanent adjustment approval was based. Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amount per discharge. Column 3: Enter the amount of the approved permanent adjustment to the TEFRA target amount per discharge. Title V and XIX Services Does this facility have title V and/or XIX inpatient hospital services? En yes or "N" for no in the applicable column. Is this hospital reimbursed for title V and/or XIX through the cost reportfull or in part? Enter "Y" for yes or "N" for no in the applicable column. Are title XIX NF patients occupying title XVIII SNF beds (dual certificati instructions) Enter "Y" for yes or "N" for no in the applicable column. Does this facility operate an ICF/IID facility for purposes of title V and Descriptions.	0.00 nter "Y" for t either in on)? (see	V 1.00	Di scharge 3.00 XI X 2.00 N	90. 00	
90. 00 91. 00 92. 00	on which the per discharge permanent adjustment approval was based. Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amount per discharge. Column 3: Enter the amount of the approved permanent adjustment to the TEFRA target amount per discharge. Title V and XIX Services Does this facility have title V and/or XIX inpatient hospital services? En yes or "N" for no in the applicable column. Is this hospital reimbursed for title V and/or XIX through the cost reportfull or in part? Enter "Y" for yes or "N" for no in the applicable column. Are title XIX NF patients occupying title XVIII SNF beds (dual certificati instructions) Enter "Y" for yes or "N" for no in the applicable column. Does this facility operate an ICF/IID facility for purposes of title V and "Y" for yes or "N" for no in the applicable column. Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no	o.oc nter "Y" for t either in on)? (see	V 1.00	Di scharge 3.00 XI X 2.00 N N N	90. 00 91. 00 92. 00 93. 00	
90. 00 91. 00 92. 00 93. 00 94. 00	on which the per discharge permanent adjustment approval was based. Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amount per discharge. Column 3: Enter the amount of the approved permanent adjustment to the TEFRA target amount per discharge. Title V and XIX Services Does this facility have title V and/or XIX inpatient hospital services? En yes or "N" for no in the applicable column. Is this hospital reimbursed for title V and/or XIX through the cost reportfull or in part? Enter "Y" for yes or "N" for no in the applicable column. Are title XIX NF patients occupying title XVIII SNF beds (dual certificati instructions) Enter "Y" for yes or "N" for no in the applicable column. Does this facility operate an ICF/IID facility for purposes of title V and "Y" for yes or "N" for no in the applicable column.	o. oc nter "Y" for t either in on)? (see d XIX? Enter o in the	V 1.00 N N	Di scharge 3.00 XI X 2.00 N N N N		

	Financial Systems FRANCISCAN HEALTH OF	RTHOPEDIC CAR	MEL	In Li∈	eu of Form CMS-	2552-1	
HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der 0		Peri od:	Worksheet S-2	2	
				From 01/01/2023 To 12/31/2023	Part I Date/Time Pre	narod	
				10 12/31/2023	5/31/2024 10:		
		<u> </u>		V	XI X		
				1. 00	2.00		
98. 00	Does title V or XIX follow Medicare (title XVIII) for the in stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" f	terns and res or yes or "N'	sidents post ' for no in	Y	Y	98. 0	
98. 01	column 1 for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for the re C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for ti	porting of ch	narges on Wkst.	. Y	Y	98. 0	
	title XIX. Does title V or XIX follow Medicare (title XVIII) for the ca			Υ	Υ	98. 0	
	bed costs on Wkst. D-1, Pt. IV, line 897 Enter "Y" for yes of for title V, and in column 2 for title XIX.						
	Does title V or XIX follow Medicare (title XVIII) for a crit reimbursed 101% of inpatient services cost? Enter "Y" for ye for title V, and in column 2 for title XIX.			1 N	N	98. 0	
98. 04	Does title V or XIX follow Medicare (title XVIII) for a CAH outpatient services cost? Enter "Y" for yes or "N" for no in		N	N	98. 0		
	in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) and add ba Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in c		Y	98. 0			
	column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) when cost Pts. I through IV? Enter "Y" for yes or "N" for no in column			Y	Y	98. 0	
	column 2 for title XIX. Rural Providers						
105.00	Does this hospital qualify as a CAH?			N		105. 0	
106. 00	If this facility qualifies as a CAH, has it elected the all-	inclusive met	thod of paymen	t		106.0	
	for outpatient services? (see instructions)						
	Column 1: If line 105 is Y, is this facility eligible for co training 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 IP Enter "Y" for yes or "N" for no in column 2. (see instructi	1. (see ins you train I&F F and/or IRF	structions) Rs in an			107. 0	
	If this facility is a REH (line 3, column 4, is "12"), is it reimbursement for I&R training programs? Enter "Y" for yes o	eligible for				107. 0	
	instructions) Is this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	CRNA fee sche	edul e? See 42	N		108. 0	
		Physi cal	Occupati ona		Respi ratory		
		1. 00	2.00	3. 00	4. 00		
	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.					109. C	
109. 00							
109. 00					1.00		
		0.00 Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, Lines 200 through 218, and Worksheet E-2, Lines 200 through 218					
110. 00	Demonstration) for the current cost reporting period? Enter "	Y" for yes or	"N" for no.	lf yes,	N	110. 0	
110. 00	Demonstration) for the current cost reporting period? Enter "complete Worksheet E, Part A, lines 200 through 218, and Wor	Y" for yes or	"N" for no.	lf yes,		110. 0	

		unit(s)?			
Enter "Y" for yes or "N" for no in column 2. (see instruct)		anat .			107.0
07.01 f this facility is a REH (line 3, column 4, is "12"), is in reimbursement for L&R training programs? Enter "Y" for yes					107. 0
instructions)	OI IN TOT TIO.	(See			
08.00 s this a rural hospital qualifying for an exception to the	CRNA fee sche	dul e2 See 42	N		108. 0
CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	CINIA I CC SCIICI	dui C: 300 42	14		100.0
ork doctron grizi ita (d) zintor i ita yad ar in ita ita	Physi cal	Occupati onal	Speech	Respi ratory	
	1.00	2.00	3. 00	4.00	
09.00 f this hospital qualifies as a CAH or a cost provider, are					109. 0
therapy services provided by outside supplier? Enter "Y"					
for yes or "N" for no for each therapy.					
				1.00	
10.00 Did this hospital participate in the Rural Community Hospita				N	110. C
Demonstration) for the current cost reporting period? Enter					
complete Worksheet E, Part A, lines 200 through 218, and Wo	rksheet E-2, I	ines 200 through	215, as		
appl i cabl e.					
		-	1 00	2.00	_
11.00 f this facility qualifies as a CAH, did it participate in	the Frantier C	ommuni tv	1. 00 N	2. 00	111. C
Health Integration Project (FCHIP) demonstration for this co			IN		
"Y" for yes or "N" for no in column 1. If the response to co					
integration prong of the FCHIP demo in which this CAH is pa					
Enter all that apply: "A" for Ambulance services; "B" for a					
for tel e-heal th services.		,			
		1. 00	2. 00	3. 00	
12.00 Did this hospital participate in the Pennsylvania Rural Heal		N			112. C
(PARHM) demonstration for any portion of the current cost re					
period? Enter "Y" for yes or "N" for no in column 1. If co "Y", enter in column 2, the date the hospital began partici					
demonstration. In column 3, enter the date the hospital began participal demonstration.					
quellions tration. The containing, enter the date the hospital ce					
narticination in the demonstration if applicable	asea				
participation in the demonstration, if applicable. Miscellaneous Cost Reporting Information	ased				-
Miscellaneous Cost Reporting Information		N			0115.0
Miscellaneous Cost Reporting Information 15.00 s this an all-inclusive rate provider? Enter "Y" for yes on	r "N" for no	N N			0115. (
Miscellaneous Cost Reporting Information	r "N" for no B, or E only)	N			0115. (
Miscellaneous Cost Reporting Information 15.00 sthis an all-inclusive rate provider? Enter "Y" for yes on in column 1. If column 1 is yes, enter the method used (A, I	r "N" for no B, or E only) 93" percent	N			0115. (
Miscellaneous Cost Reporting Information 15.00 Is this an all-inclusive rate provider? Enter "Y" for yes of in column 1. If column 1 is yes, enter the method used (A, I in column 2. If column 2 is "E", enter in column 3 either "	r "N" for no B, or E only) 93" percent (includes	N			 0 115. (
Miscellaneous Cost Reporting Information 15.00 Is this an all-inclusive rate provider? Enter "Y" for yes on in column 1. If column 1 is yes, enter the method used (A, lin column 2. If column 2 is "E", enter in column 3 either "for short term hospital or "98" percent for long term care psychiatric, rehabilitation and long term hospitals provided the definition in CMS Pub. 15-1, chapter 22, §2208.1.	r "N" for no B, or E only) 93" percent (includes rs) based on	N			
Miscellaneous Cost Reporting Information 15.00 Is this an all-inclusive rate provider? Enter "Y" for yes on in column 1. If column 1 is yes, enter the method used (A, I in column 2. If column 2 is "E", enter in column 3 either "for short term hospital or "98" percent for long term care psychiatric, rehabilitation and long term hospitals provided the definition in CMS Pub. 15-1, chapter 22, §2208. 1. 16.00 Is this facility classified as a referral center? Enter "Y"	r "N" for no B, or E only) 93" percent (includes rs) based on	N N			
Miscellaneous Cost Reporting Information 15.00 Is this an all-inclusive rate provider? Enter "Y" for yes of in column 1. If column 1 is yes, enter the method used (A, I in column 2. If column 2 is "E", enter in column 3 either "I for short term hospital or "98" percent for long term care psychiatric, rehabilitation and long term hospitals provided the definition in CMS Pub. 15-1, chapter 22, §2208. 1. 16.00 Is this facility classified as a referral center? Enter "Y" "N" for no.	r "N" for no B, or E only) 93" percent (includes rs) based on for yes or	N			116. (
Miscellaneous Cost Reporting Information 15.00 Is this an all-inclusive rate provider? Enter "Y" for yes on in column 1. If column 1 is yes, enter the method used (A, I in column 2. If column 2 is "E", enter in column 3 either "for short term hospital or "98" percent for long term care psychiatric, rehabilitation and long term hospitals provided the definition in CMS Pub. 15-1, chapter 22, §2208. 1. 16.00 Is this facility classified as a referral center? Enter "Y" "N" for no. 17.00 Is this facility legally-required to carry malpractice insurance.	r "N" for no B, or E only) 93" percent (includes rs) based on for yes or				116. (
Miscellaneous Cost Reporting Information 15.00 Is this an all-inclusive rate provider? Enter "Y" for yes on in column 1. If column 1 is yes, enter the method used (A, in column 2. If column 2 is "E", enter in column 3 either "for short term hospital or "98" percent for long term care psychiatric, rehabilitation and long term hospitals provided the definition in CMS Pub. 15-1, chapter 22, §2208.1. 16.00 Is this facility classified as a referral center? Enter "Y" "N" for no. 17.00 Is this facility legally-required to carry malpractice insulations.	r "N" for no B, or E only) 93" percent (includes rs) based on for yes or rance? Enter	N N			116. C
Miscellaneous Cost Reporting Information 15.00 Is this an all-inclusive rate provider? Enter "Y" for yes on in column 1. If column 1 is yes, enter the method used (A, lin column 2. If column 2 is "E", enter in column 3 either "for short term hospital or "98" percent for long term care psychiatric, rehabilitation and long term hospitals provided the definition in CMS Pub. 15-1, chapter 22, §2208. 1. 16.00 Is this facility classified as a referral center? Enter "Y" "N" for no. 17.00 Is this facility legally-required to carry malpractice insurance "Y" for yes or "N" for no. 18.00 Is the malpractice insurance a claims-made or occurrence points.	r "N" for no B, or E only) 93" percent (includes rs) based on for yes or rance? Enter	N			116. C
Miscellaneous Cost Reporting Information 15.00 Is this an all-inclusive rate provider? Enter "Y" for yes on in column 1. If column 1 is yes, enter the method used (A, in column 2. If column 2 is "E", enter in column 3 either "for short term hospital or "98" percent for long term care psychiatric, rehabilitation and long term hospitals provided the definition in CMS Pub. 15-1, chapter 22, §2208.1. 16.00 Is this facility classified as a referral center? Enter "Y" "N" for no. 17.00 Is this facility legally-required to carry malpractice insulations.	r "N" for no B, or E only) 93" percent (includes rs) based on for yes or rance? Enter	N N			116. (
Miscellaneous Cost Reporting Information 15.00 Is this an all-inclusive rate provider? Enter "Y" for yes on in column 1. If column 1 is yes, enter the method used (A, lin column 2. If column 2 is "E", enter in column 3 either "for short term hospital or "98" percent for long term care psychiatric, rehabilitation and long term hospitals provided the definition in CMS Pub. 15-1, chapter 22, §2208.1. 16.00 Is this facility classified as a referral center? Enter "Y" "N" for no. 17.00 Is this facility legally-required to carry malpractice insurance "Y" for yes or "N" for no. 18.00 Is the malpractice insurance a claims-made or occurrence points.	r "N" for no B, or E only) 93" percent (includes rs) based on for yes or rance? Enter	N N			116. (
Miscellaneous Cost Reporting Information 5.00 Is this an all-inclusive rate provider? Enter "Y" for yes on in column 1. If column 1 is yes, enter the method used (A, in column 2. If column 2 is "E", enter in column 3 either "for short term hospital or "98" percent for long term care psychiatric, rehabilitation and long term hospitals provided the definition in CMS Pub. 15-1, chapter 22, §2208.1. 6.00 Is this facility classified as a referral center? Enter "Y" "N" for no. 7.00 Is this facility legally-required to carry malpractice insurance are pools to the malpractice insurance a claims-made or occurrence points.	r "N" for no B, or E only) 93" percent (includes rs) based on for yes or rance? Enter	N N			116. (

		To 12/31/2023	Date/Time P	
	Premi ums	Losses	5/31/2024 1 Insurance	
	1.00	2.00	3. 00	
118.01 List amounts of malpractice premiums and paid losses:		0 0	25, 8	321 118. 01
		1. 00	2.00	
118.02 Are mal practice premiums and paid losses reported in a cost center of Administrative and General? If yes, submit supporting schedule list and amounts contained therein.		N		118. 02
119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmles §3121 and applicable amendments? (see instructions) Enter in column "N" for no. Is this a rural hospital with < 100 beds that qualifies Hold Harmless provision in ACA §3121 and applicable amendments? (see Enter in column 2, "Y" for yes or "N" for no.	1, "Y" for yes or for the Outpatient	N	N	119. 00 120. 00
121.00 Did this facility incur and report costs for high cost implantable of	devices charged to	Y		121. 00
patients? Enter "Y" for yes or "N" for no. 122.00 Does the cost report contain healthcare related taxes as defined in Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", the Worksheet A line number where these taxes are included.				122. 00
123.00 Did the facility and/or its subproviders (if applicable) purchase puservices, e.g., legal, accounting, tax preparation, bookkeeping, paymanagement/consulting services, from an unrelated organization? In offor yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., greated professional services expenses, for services purchased from unrelated.	yroll, and/or column 1, enter "Y" r than 50% of total	Y	N	123. 00
"N" for no. Certified Transplant Center Information 125.00 Does this facility operate a Medicare-certified transplant center? I and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) bel 126.00 If this is a Medicare-certified kidney transplant program, enter the in column 1 and termination date, if applicable, in column 2. 127.00 If this is a Medicare-certified heart transplant program, enter the in column 1 and termination date, if applicable, in column 2. 128.00 If this is a Medicare-certified liver transplant program, enter the in column 1 and termination date, if applicable, in column 2. 129.00 If this is a Medicare-certified lung transplant program, enter the order of the column 2.	low. e certification date certification date	N N		125. 00 126. 00 127. 00 128. 00 129. 00
 in column 1 and termination date, if applicable, in column 2. 130.00 If this is a Medicare-certified pancreas transplant program, enter date in column 1 and termination date, if applicable, in column 2. 131.00 If this is a Medicare-certified intestinal transplant program, enter date in column 1 and termination date, if applicable, in column 2. 132.00 If this is a Medicare-certified islet transplant program, enter the in column 1 and termination date, if applicable, in column 2. 	r the certification			130. 00 131. 00 132. 00
133.00 Removed and reserved 134.00 If this is a hospital-based organ procurement organization (OPO), en in column 1 and termination date, if applicable, in column 2. All Providers	nter the OPO number			133. 00
140.00 Are there any related organization or home office costs as defined in chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and are claimed, enter in column 2 the home office chain number. (see in	d home office costs	Y	15H014	140. 00
1.00 2.00 If this facility is part of a chain organization, enter on lines 14	1 through 143 the n	3.00 ame and address	of the	
home office and enter the home office contractor name and contracton 141.00 Name: FRANCISCAN ALLIANCE INC. AND Contractor's Name: WISCONSIN	or number.			141. 00
AFFLI SERVI CES 142. 00 Street: 1515 W DRAGOON TRL PO Box: 1290				142. 00
143.00 City: MISHAWAKA State: IN	Zi p Code:	4654	4	143. 00
			1.00	
144.00 Are provider based physicians' costs included in Worksheet A?			Y Y	144. 00
		1. 00	2.00	
145.00 If costs for renal services are claimed on Wkst. A, line 74, are the inpatient services only? Enter "Y" for yes or "N" for no in column no, does the dialysis facility include Medicare utilization for this	1. If column 1 is	1.00	2.00	145. 00
period? Enter "Y" for yes or "N" for no in column 2. 146.00 Has the cost allocation methodology changed from the previously file Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, cha yes, enter the approval date (mm/dd/yyyy) in column 2.		N		146. 00

Health Financial Systems	FRANCISCAN HEAL	TH ORTHOPE	OLC CARM	EL		In Li	eu of Form CMS	-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DATA	Pro	vider CC	N: 15-0193		riod: om 01/01/2023 12/31/2023		epared:
							1.00	\dashv
147.00 Was there a change in the statisti							N N	147. 00
148.00 Was there a change in the order of					_		N	148. 00
149.00 Was there a change to the simplifi	ed cost finding method		t A	s or "N" Part		o. Title V	N Title XIX	149. 00
			00	2.00		3.00	4.00	
Does this facility contain a provi		r an exempt	ion from	the appl	icati	on of the low	er of costs	
or charges? Enter "Y" for yes or "	N" for no for each cor				B. (S			155.00
155.00 Hospi tal 156.00 Subprovi der - IPF			N N	N N		N N	N N	155. 00 156. 00
157. 00 Subprovi der – TRF		l l	N I	N		N	N N	157. 00
158. 00 SUBPROVI DER				•				158. 00
159. 00 SNF			N	N		N	N	159. 00
160.00 HOME HEALTH AGENCY			N	N		N	N	160. 00
161. 00 CMHC				N		N	N	161. 00
							1.00	\dashv
Multicampus								
165.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.	mpus hospital that has	s one or mo	re campu	ses in di	fferer	nt CBSAs?	N	165. 00
Effect 1 101 yes of 10 10.	Name	Coun	ty	State	Zip (Code CBSA	FTE/Campus	
	0	1. 0)	2. 00	3. (00 4.00	5.00	
166.00 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)							0. (00 166. 00
							1.00	
Health Information Technology (HI)) incentive in the Ame	eri can Reco	verv and	Rei nvest	tment	Act	1.00	
167.00 s this provider a meaningful user 168.00 lf this provider is a CAH (line 10 reasonable cost incurred for the H	5 is "Y") and is a mea IT assets (see instruc	aningful us ctions)	er (line	167 is "	Υ"), θ		Y	167. 00 168. 00
168.01 If this provider is a CAH and is r exception under §413.70(a)(6)(ii)? 169.00 If this provider is a meaningful u	Enter "Y" for yes or	"N" for no	(see i	nstructio	ns)	•	0.0	168. 01 99169. 00
transition factor. (see instruction	,	and 15 not	a CAII (11116 103	15 1), enter the	7.	77 107. 00
						Begi nni ng	Endi ng	
						1. 00	2. 00	
170.00 Enter in columns 1 and 2 the EHR because in	eginning date and endi	ing date fo	r the re	porting				170. 00
						1. 00	2.00	-
171.00 ffline 167 is "Y", does this prov section 1876 Medicare cost plans r "Y" for yes and "N" for no in colu 1876 Medicare days in column 2. (s	eported on Wkst. S-3, mn 1. If column 1 is y	Pt. I, lin	e 2, col	. 6? Ente		N		0 171. 00

3811	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der Co		Peri od: From 01/01/2023 To 12/31/2023		epared:
				1.00	2.00	
	PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURSEME	NT QUESTIONN	AI RE			
	General Instruction: Enter Y for all YES responses. Enter N formm/dd/yyyy format. COMPLETED BY ALL HOSPITALS	or all NO re	sponses. Ente	r all dates in [.]	the	
	Provider Organization and Operation					
00	Has the provider changed ownership immediately prior to the b reporting period? If yes, enter the date of the change in col		instructions)			1.00
			Y/N	Date	V/I	
00	Has the provider terminated participation in the Medicare Pro	arom? If	1.00 N	2. 00	3. 00	2.0
,,	yes, enter in column 2 the date of termination and in column voluntary or "I" for involuntary.		IN IN			2.00
00	Is the provider involved in business transactions, including contracts, with individuals or entities (e.g., chain home off or medical supply companies) that are related to the provider officers, medical staff, management personnel, or members of of directors through ownership, control, or family and other relationships? (see instructions)	ices, drug or its the board	Y			3.00
	Teratronamps: (acc matructions)		Y/N	Туре	Date	
			1.00	2. 00	3. 00	
	Financial Data and Reports					
00	Column 1: Were the financial statements prepared by a Certif Accountant? Column 2: If yes, enter "A" for Audited, "C" for or "R" for Reviewed. Submit complete copy or enter date avail column 3. (see instructions) If no, see instructions.	Compiled, able in	Y	A	04/17/2024	4.00
00	Are the cost report total expenses and total revenues differe		N			5.00
	those on the filed financial statements? If yes, submit recon	CITIALI OII.		Y/N	Legal Oper.	
				1. 00	2. 00	
	Approved Educational Activities					
00	Column 1: Are costs claimed for a nursing program? Column 2:	If yes, is	the provider	N		6.0
_	the legal operator of the program?					
10 10	Are costs claimed for Allied Health Programs? If "Y" see inst Were nursing programs and/or allied health programs approved cost reporting period? If yes, see instructions.		ed during the	N N		7. 00 8. 00
0	Are costs claimed for Interns and Residents in an approved gr program in the current cost report? If yes, see instructions.	aduate medic	al education	N		9. 00
00	Was an approved Intern and Resident GME program initiated or	renewed in t	he current	N		10. 0
00	cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I & Teaching Program on Worksheet A? If yes, see instructions.	R in an App	roved	N		11. 0
					Y/N	
					1.00	
	Bad Debts	 			T	
	Is the provider seeking reimbursement for bad debts? If yes, If line 12 is yes, did the provider's bad debt collection polperiod? If yes, submit copy.			st reporting	Y N	12. 0
00	If line 12 is yes, were patient deductibles and/or coinsuranc instructions.	e amounts wa	ived? If yes,	see	N	14. 00
00	Bed Complement	. 10 1 6				45.0
00	Did total beds available change from the prior cost reporting		yes, see inst t A	ructions.	N N	15. 0
		Y/N	Date	Y/N	Date	
		1.00	2.00	3. 00	4.00	
	PS&R Data					
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. 0
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 in columns 2 and 4. (see instructions)	Υ	03/18/2024	Y	03/18/2024	17. 00
00	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	N		N		18.00
00	cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R	N		N		19.00

	Financial Systems FRANCISCAN HEALTH				u of Form CMS-	
HOSPI T	TAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		CN: 15-0193	Peri od: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part II Date/Time Pre 5/31/2024 10:	epared:
			i pti on	Y/N	Y/N	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R		0	1. 00 N	3. 00 N	20. 00
20.00	Report data for Other? Describe the other adjustments:			IN IN	IN	20.00
		Y/N	Date	Y/N	Date	
		1. 00	2. 00	3. 00	4. 00	
21. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21. 00
					1. 00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	EPT CHILDRENS H	HOSPI TALS)		1.00	
	Capital Related Cost		,			
22. 00	Have assets been relifed for Medicare purposes? If yes, see				N	22. 00
23. 00	Have changes occurred in the Medicare depreciation expense	due to apprais	sals made dur	ing the cost	N	23. 00
24. 00	reporting period? If yes, see instructions. Were new leases and/or amendments to existing leases entered	porting period?	N	24. 00		
	If yes, see instructions					
25. 00	Have there been new capitalized leases entered into during instructions.	the cost repor	rting period?	If yes, see	N	25. 00
26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during the instructions.	ne cost reporti	ng period? I	f yes, see	N	26. 00
27. 00	Has the provider's capitalization policy changed during the copy.	e cost reportir	ng period? If	yes, submit	N	27. 00
	Interest Expense					
28. 00	Were new loans, mortgage agreements or letters of credit er period? If yes, see instructions.	reporti ng	N	28. 00		
29. 00	Did the provider have a funded depreciation account and/or treated as a funded depreciation account? If yes, see instr	eserve Fund)	N	29. 00		
30. 00	Has existing debt been replaced prior to its scheduled maturinstructions.		debt? If yes	, see	N	30. 00
31. 00	Has debt been recalled before scheduled maturity without is instructions.	ssuance of new	debt? If yes	, see	N	31. 00
	Purchased Services					
32. 00	Have changes or new agreements occurred in patient care ser		ed through co	ntractual	N	32. 00
33. 00	arrangements with suppliers of services? If yes, see instruction 32 is yes, were the requirements of Sec. 2135.2 approximately, see instructions.		ng to competi	tive bidding? If	N	33. 00
	Provi der-Based Physi ci ans					
34.00	Were services furnished at the provider facility under an a	arrangement wi	th provider-b	ased physicians?	Y	34. 00
35. 00	If yes, see instructions. If line 34 is yes, were there new agreements or amended exi		nts with the	provi der-based	N	35. 00
	physicians during the cost reporting period? If yes, see in	nstructions.	_	V /N	Do+o	
				Y/N 1. 00	Date 2.00	
	Home Office Costs			1.00	2.00	
36. 00	Were home office costs claimed on the cost report?			Υ		36. 00
37. 00	If line 36 is yes, has a home office cost statement been pr	repared by the	home office?	Υ		37. 00
38. 00	If yes, see instructions. If line 36 is yes, was the fiscal year end of the home off			N		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 other			, Y		39. 00
40. 00	see instructions. If line 36 is yes, did the provider render services to the	home office?	If yes, see	Υ		40. 00
	instructions.					
		1.	00	2.	00	-
	Cost Report Preparer Contact Information					
41. 00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	PAM		MEI SER		41. 00
42. 00	respectively. Enter the employer/company name of the cost report	FRANCISCAN ALL	_I ANCE			42. 00
12 00	preparer. Enter the telephone number and email address of the cost	724 777 7402		DAMELA MELCEDA	EDANCISCANALLI	12 00
43. 00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	734-777-7602		PAMELA. MEI SER@ ANCE. ORG	I NAINCI SCANALLI	43.00

Heal th	Financial Systems	FRANCISCAN HEALTH O	ORTH	OPEDIC CARMEL		In Lieu	u of Form CN	IS-2	552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT	Γ QUESTI ONNAI RE		Provider CCN: 15-0193		i od:	Worksheet S	3-2	
					To		Part II Date/Time I		
							5/31/2024	10: 5	0 am_
				3. 00					
	Cost Report Preparer Contact Information								
41.00	Enter the first name, last name and the	title/position	COST	REPORTING ANALYST					41.00
	held by the cost report preparer in colu	ımns 1, 2, and 3,							
	respectively.								
42.00	Enter the employer/company name of the c	ost report							42.00
	preparer.								
43.00	Enter the telephone number and email add	lress of the cost						l	43.00
	report preparer in columns 1 and 2, resp	ecti vel y.							
		- '							

2.00

3.00

4.00

5.00

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17.00

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19.00

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21.00

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24. 00

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26.00

26. 25

27.00

28 00

29. 00

30.00

31.00 32.00

32.01

33.00

33.01

SUBPROVIDER - IRF

NURSING FACILITY

OTHER LONG TERM CARE

HOME HEALTH AGENCY

RURAL HEALTH CLINIC

Observation Bed Days

LTCH non-covered days

Ambul ance Trips

SKILLED NURSING FACILITY

HOSPICE (non-distinct part)

Total (sum of lines 14-26)

Employee discount days - IRF

AMBULATORY SURGICAL CENTER (D. P.)

FEDERALLY QUALIFIED HEALTH CENTER

Employee discount days (see instruction)

Labor & delivery days (see instructions)

Total ancillary labor & delivery room

LTCH site neutral days and discharges

34.00 Temporary Expansion COVID-19 PHE Acute Care

outpatient days (see instructions)

SUBPROVI DER

HOSPI CE

CMHC - CMHC

Health Financial Systems In Lieu of Form CMS-2552-10 FRANCISCAN HEALTH ORTHOPEDIC CARMEL HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CCN: 15-0193 Peri od: Worksheet S-3 From 01/01/2023 Part I 12/31/2023 Date/Time Prepared: 5/31/2024 10:50 am I/P Days / O/P Visits / Trips Component Worksheet A No. of Beds Bed Days CAH/REH Hours Title V Avai I abl e Line No. 5.00 2.00 4.00 1.00 3.00 PART I - STATISTICAL DATA Hospital Adults & Peds. (columns 5, 6, 7 and 30.00 7, 300 20 0.00 1.00 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) HMO and other (see instructions) 2.00 HMO IPF Subprovider 3.00 HMO IRF Subprovider 4.00 Hospital Adults & Peds. Swing Bed SNF 0 5.00 Hospital Adults & Peds. Swing Bed NF 0 6.00 Total Adults and Peds. (exclude observation 20 7, 300 0.00 7. 00 beds) (see instructions) INTENSIVE CARE UNIT 8.00 CORONARY CARE UNIT 9.00 10.00 BURN INTENSIVE CARE UNIT 10.00 SURGICAL INTENSIVE CARE UNIT 11.00 11.00 OTHER SPECIAL CARE (SPECIFY) 12.00 12.00 13.00 NURSERY 13.00 Total (see instructions) 14.00 14.00 20 7,300 0.00 CAH visits 15.00 15.00 15.10 REH hours and visits 0.00 15. 10 16.00 SUBPROVIDER - IPF 16.00

30.00

89.00

30.00

20

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17.00

18.00

19.00

20.00

21.00

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31 00

32.00

32.01

33.00

33.01

0 34.00

0 26.25

0 28 00

34.00

0

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-0193

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

5/31/2024 10:50 am I/P Days / O/P Visits / Trips Full Time Equivalents Component Title XVIII Title XIX Total All Total Interns Employees On Pati ents & Residents Payrol I 8.00 6.00 7.00 9.00 10.00 PART I - STATISTICAL DATA Hospital Adults & Peds. (columns 5, 6, 7 and 1.00 230 12 576 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) 90 2.00 3.00 HMO IPF Subprovider 3.00 4.00 HMO IRF Subprovider 0 0 4.00 0 Hospital Adults & Peds. Swing Bed SNF 5.00 0 0 5.00 6.00 Hospital Adults & Peds. Swing Bed NF 0 6.00 Total Adults and Peds. (exclude observation 7.00 230 12 576 7.00 beds) (see instructions) INTENSIVE CARE UNIT 8.00 8.00 9.00 CORONARY CARE UNIT 9.00 10.00 BURN INTENSIVE CARE UNIT 10.00 11.00 SURGICAL INTENSIVE CARE UNIT 11.00 OTHER SPECIAL CARE (SPECIFY) 12.00 12.00 13.00 NURSERY 13.00 Total (see instructions) 100.09 14.00 230 12 576 0.00 14.00 CAH visits 15.00 15.00 0 15.10 REH hours and visits 0 15. 10 16.00 SUBPROVIDER - IPF 16.00 SUBPROVIDER - IRF 17.00 17.00 18 00 SUBPROVI DER 18 00 SKILLED NURSING FACILITY 19.00 19.00 20.00 NURSING FACILITY 20.00 OTHER LONG TERM CARE 21.00 21.00 HOME HEALTH AGENCY 22 00 22 00 23.00 AMBULATORY SURGICAL CENTER (D. P.) 23.00 24.00 HOSPI CE 24.00 24. 10 HOSPICE (non-distinct part) 0 24. 10 CMHC - CMHC 25.00 25.00 26.00 RURAL HEALTH CLINIC 26.00 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 0 0.00 0.00 26.25 Total (sum of lines 14-26) 100.09 27.00 27.00 0.00 28 00 Observation Bed Days 17 28 00 29. 00 Ambul ance Trips 29.00 30.00 Employee discount days (see instruction) 30.00 0 Employee discount days - IRF 0 31.00 31.00 32.00 Labor & delivery days (see instructions) 0 0 32.00 Total ancillary labor & delivery room 0 32.01 32.01 outpatient days (see instructions) 33.00 33.00 LTCH non-covered days LTCH site neutral days and discharges

33.01

34.00 Temporary Expansion COVID-19 PHE Acute Care

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

34.00 Temporary Expansion COVID-19 PHE Acute Care

Provider CCN: 15-0193

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

5/31/2024 10:50 am Full Time Di scharges Equi val ents Title XVIII Total All Component Nonpai d Title V Title XIX Workers Pati ents 14.00 15.00 12.00 13.00 11.00 PART I - STATISTICAL DATA Hospital Adults & Peds. (columns 5, 6, 7 and 1.00 123 6 312 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) 56 2.00 3.00 HMO IPF Subprovider 0 3.00 4.00 HMO IRF Subprovider ol 4.00 Hospital Adults & Peds. Swing Bed SNF 5.00 5.00 6.00 Hospital Adults & Peds. Swing Bed NF 6.00 Total Adults and Peds. (exclude observation 7.00 7.00 beds) (see instructions) INTENSIVE CARE UNIT 8.00 8.00 9.00 CORONARY CARE UNIT 9.00 10.00 BURN INTENSIVE CARE UNIT 10.00 SURGICAL INTENSIVE CARE UNIT 11.00 11.00 OTHER SPECIAL CARE (SPECIFY) 12.00 12.00 13.00 NURSERY 13.00 Total (see instructions) 0.00 312 14.00 14.00 123 6 CAH visits 15.00 15.00 REH hours and visits 15. 10 15. 10 16.00 SUBPROVIDER - IPF 16.00 SUBPROVIDER - IRF 17.00 17.00 18 00 SUBPROVI DER 18 00 SKILLED NURSING FACILITY 19.00 19.00 20.00 NURSING FACILITY 20.00 OTHER LONG TERM CARE 21.00 21.00 HOME HEALTH AGENCY 22 00 22 00 23.00 AMBULATORY SURGICAL CENTER (D. P.) 23.00 24.00 HOSPI CE 24.00 24. 10 HOSPICE (non-distinct part) 24. 10 CMHC - CMHC 25.00 25 00 26.00 RURAL HEALTH CLINIC 26.00 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 0.00 26.25 Total (sum of lines 14-26) 0.00 27.00 27.00 28 00 Observation Bed Days 28 00 29. 00 Ambul ance Trips 29.00 30.00 Employee discount days (see instruction) 30.00 Employee discount days - IRF 31.00 31.00 32.00 Labor & delivery days (see instructions) 32.00 Total ancillary labor & delivery room 32.01 32.01 outpatient days (see instructions) 33.00 LTCH non-covered days 33.00 0 33. 01 LTCH site neutral days and discharges 0 33.01

In Lieu of Form CMS-2552-10

Period:	Worksheet S-3
From 01/01/2023	Part II
To 12/31/2023	Date/Time Prepared:
5/31/2024	10:50 am

						12/31/2023	5/31/2024 10:	
		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries	Adj usted Sal ari es		Average Hourly Wage (col. 4 ÷	
		Number	керог геа	(from Wkst.	(col.2 ± col.	Salaries in	col. 5)	
		1.00	0.00	A-6)	3)	col . 4		
	PART II - WAGE DATA	1. 00	2. 00	3.00	4. 00	5. 00	6. 00	
	SALARI ES							1
1. 00	Total salaries (see instructions)	200. 00	7, 806, 406	0	7, 806, 406	208, 184. 00	37. 50	1.00
2.00	Non-physician anesthetist Part		0	О	0	0.00	0. 00	2. 00
3. 00	A Non-physician anesthetist Part		O	0	0	0. 00	0. 00	3.00
	В							
4. 00	Physician-Part A - Administrative		0	0	0	0. 00	0. 00	4. 00
4. 01	Physicians - Part A - Teaching		0	О		0.00	l	
5.00	Physician and Non Physician-Part B		124, 534	0	124, 534	971. 00	128. 25	5. 00
6.00	Non-physician-Part B for		0	О	0	0.00	0. 00	6.00
	hospital-based RHC and FQHC services							
7. 00	Interns & residents (in an	21. 00	0	О	0	0.00	0. 00	7. 00
7. 01	approved program) Contracted interns and		0	0	0	0. 00	0. 00	7. 01
7.01	residents (in an approved		O	٥	0	0.00	0.00	7.01
8. 00	programs) Home office and/or related		0	0	0	0. 00	0. 00	8.00
8.00	organization personnel		O	٥		0.00	0.00	8.00
9. 00 10. 00	SNF Excluded area salaries (see	44. 00	0 114, 406	0 337, 112	0 451, 518	0. 00 7, 754. 00	l	
10.00	instructions)		114, 400	337, 112	431, 310	7, 734. 00	30. 23	10.00
11. 00	OTHER WAGES & RELATED COSTS Contract labor: Direct Patient		1, 564, 501	l 0	1, 564, 501	17, 822. 00	87. 78	11.00
	Care		1, 304, 301		.,,			
12. 00	Contract labor: Top level management and other		0	0	0	0. 00	0. 00	12. 00
	management and administrative							
13. 00	services Contract Labor: Physician-Part		121, 875	0	121, 875	813. 00	149 91	13. 00
	A - Administrative							
14. 00	Home office and/or related organization salaries and		0	0	0	0. 00	0. 00	14. 00
	wage-related costs			_				l
14. 01 14. 02	Home office salaries Related organization salaries		3, 726, 340 0		-, ,	99, 574. 00 0. 00	l e	14. 01 14. 02
15. 00	Home office: Physician Part A		0	1	_	0. 00	l e	
16. 00	- Administrative Home office and Contract		O	0	0	0. 00	0.00	16. 00
	Physicians Part A - Teaching		· ·	_				
16. 01	Home office Physicians Part A - Teaching		0	0	0	0. 00	0. 00	16. 01
16. 02	Home office contract		0	О	0	0.00	0. 00	16. 02
	Physicians Part A - Teaching WAGE-RELATED COSTS							_
17. 00	Wage-related costs (core) (see		1, 791, 964	-77, 384	1, 714, 580			17. 00
18. 00	instructions) Wage-related costs (other)							18. 00
10.00	(see instructions)		12 000	77 204	01 272			10.00
19. 00 20. 00	Excluded areas Non-physician anesthetist Part		13, 888 0	77, 384 0	91, 272			19. 00 20. 00
21 00	A Non physician appathatist Dant		0					21 00
21. 00	Non-physician anesthetist Part B		U		U			21. 00
22. 00	Physician Part A - Administrative		0	0	0			22. 00
22. 01	Physician Part A - Teaching		0	О	0			22. 01
23. 00	Physician Part B		19, 016	0	19, 016			23. 00
24. 00 25. 00	Wage-related costs (RHC/FQHC) Interns & residents (in an		0	0				24. 00 25. 00
	approved program)		1 007 000		1 00/ 000			
25. 50	Home office wage-related (core)		1, 086, 822	0	1, 086, 822			25. 50
25. 51	Related organization wage-related (core)		0	0	0			25. 51
25. 52	Home office: Physician Part A		0	О	О			25. 52
	- Administrative - wage-related (core)							
	wage=rerated (COLE)			l	ı		l	1

Records Library Social Service

43.00 Other General Service

42.00

0.00 42.00

0.00 43.00

HOSPITAL WAGE INDEX INFORMATION Provider CCN: 15-0193 Peri od: Worksheet S-3 From 01/01/2023 Part II 12/31/2023 Date/Time Prepared: 5/31/2024 10:50 am Wkst. A Line Amount Recl assi fi cati Adj usted Paid Hours Average Hourly Number on of Salaries Sal ari es Related to Wage (col. 4 Reported col . 5) (from Wkst. (col.2 ± col. Salaries in A-6)3) col. 4 2.00 1.00 5.00 6.00 3.00 4.00 25.53 Home office: Physicians Part A 0 25.53 - Teaching - wage-related (core) OVERHÉAD COSTS - DIRECT SALARIES 26.00 4 00 629, 678 -337, 112 292, 566 26.00 Employee Benefits Department 6, 679. 00 43.80 27.00 Administrative & General 5.00 1, 265, 245 -789, 009 476, 236 10, 447. 00 45. 59 27.00 28.00 Administrative & General under 172, 035 172, 035 1, 184. 00 145. 30 28.00 contract (see inst.) Maintenance & Repairs 6.00 0.00 29.00 0.00 29.00 C 419, 123 Operation of Plant 419, 123 0 13, 570. 00 30. 89 30.00 7.00 30.00 31.00 Laundry & Linen Service 8.00 5, 345 0 5, 345 350.00 15. 27 31.00 370, 760 19, 904. 00 32.00 Housekeepi ng 9.00 370, 760 0 18. 63 32.00 5, 908. 00 Housekeeping under contract 199, 284 33.00 0 199, 284 33. 73 33.00 (see instructions) 34.00 Di etary 10.00 411, 704 -368, 356 43, 348 2, 109.00 20. 55 34.00 Di etary under contract (see instructions) 38. 59 35.00 8,682 8, 682 225.00 35.00 36.00 368, 356 20. 55 Cafeteri a 11.00 368, 356 17, 921. 00 36.00 0 Maintenance of Personnel 0.00 37.00 12.00 0 0.00 37.00 38.00 Nursing Administration 13.00 0 789,009 789, 009 17, 309. 00 45. 58 38.00 39.00 Central Services and Supply 14.00 486, 880 486, 880 16, 827. 00 28. 93 39.00 8, 555. 00 465, 223 40.00 Pharmacy 15.00 0 465, 223 54. 38 40.00 41.00 Medical Records & Medical 16.00 0 0 0 0.00 0.00 41.00

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0.00

0.00

17.00

18.00

Total overhead cost (see

instructions)

7.00

33.86

7.00

HOSPITAL WAGE INDEX INFORMATION Worksheet S-3 Part III Date/Time Prepared: Provi der CCN: 15-0193 Peri od: From 01/01/2023 To 12/31/2023 5/31/2024 10:50 am Average Hourly Worksheet A Amount Recl assi fi cati Adj usted Pai d Hours Line Number Reported on of Salaries Sal ari es Related to Wage (col. 4 (col . 2 ± col . col. 5) (from Salaries in Works<u>heet A-6)</u> 3) col. 4 1.00 4.00 6.00 2.00 5.00 3.00 PART III - HOSPITAL WAGE INDEX SUMMARY 1.00 Net salaries (see 8, 061, 873 8, 061, 873 214, 530. 00 37. 58 1.00 instructions) 2.00 Excluded area salaries (see 337, 112 451, 518 7, 754. 00 58. 23 2.00 114, 406 instructions) 3.00 Subtotal salaries (line 1 7, 947, 467 -337, 112 7, 610, 355 206, 776. 00 36.80 3.00 minus line 2) 4.00 Subtotal other wages & related 5, 412, 716 5, 412, 716 118, 209. 00 45. 79 4.00 costs (see inst.) Subtotal wage-related costs 5.00 2, 878, 786 -77, 384 2, 801, 402 0.00 36.81 5.00 (see inst.) Total (sum of lines 3 thru 5) 16, 238, 969 6.00 6.00 -414, 496 15, 824, 473 324, 985. 00 48 69

4, 433, 959

-337, 112

4, 096, 847

120, 988. 00

	To 12/31/2023	Date/Time Pre 5/31/2024 10:	
		Amount	
		Reported	
		1. 00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETI REMENT COST		
1.00	401K Employer Contributions	240, 715	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2. 00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3. 00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	179, 801	4. 00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5. 00
6.00	Legal /Accounting/Management Fees-Pension Plan	0	6. 00
7.00	Employee Managed Care Program Administration Fees	0	7. 00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8. 00
8. 01	Health Insurance (Self Funded without a Third Party Administrator)	0	8. 01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	767, 008	8. 02
8. 03	Health Insurance (Purchased)	0	8. 03
9.00	Prescription Drug Plan	0	9. 00
10.00	Dental, Hearing and Vision Plan	27, 416	10.00
11. 00	Life Insurance (If employee is owner or beneficiary)	2, 472	11. 00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	27, 009	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14. 00
15.00	'Workers' Compensation Insurance	70, 496	15. 00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	509, 951	16. 00
	Noncumulative portion)		
	TAXES		
17.00	FICA-Employers Portion Only	0	17. 00
18.00	Medicare Taxes - Employers Portion Only	0	18. 00
19.00	Unempl oyment Insurance	0	19. 00
20.00	State or Federal Unemployment Taxes	0	20. 00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see	0	21. 00
	instructions))		
	Day Care Cost and Allowances	0	22. 00
	Tuition Reimbursement	0	23. 00
24.00	3 3 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4	1, 824, 868	24. 00
	Part B - Other than Core Related Cost		
25. 00	OTHER WAGE RELATED COSTS (SPECIFY)		25. 00

Health Financial Systems	FRANCISCAN HEALTH ORTHOPEDIC CARMEL	In Lieu of Form CMS-2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provider CCN: 15-0193	Peri od: Worksheet S-3 From 01/01/2023 Part V
		11 0 11 0 17 20 20 1 di t

		To 12/31/2023	Date/Time Pre 5/31/2024 10:	
	Cost Center Description	Contract Labor	Benefit Cost	
		1. 00	2. 00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	1, 564, 501	1, 824, 868	1. 00
2.00	Hospi tal	1, 564, 501	1, 824, 868	2. 00
3.00	SUBPROVI DER - I PF			3. 00
4.00	SUBPROVI DER - I RF			4. 00
5.00	Subprovi der - (Other)	0	0	5. 00
6.00	Swing Beds - SNF	0	0	6. 00
7.00	Swing Beds - NF	0	0	7. 00
8.00	SKILLED NURSING FACILITY			8. 00
9.00	NURSING FACILITY			9. 00
10.00	OTHER LONG TERM CARE I			10.00
11. 00	Hospi tal -Based HHA			11. 00
12. 00	AMBULATORY SURGICAL CENTER (D. P.) I			12.00
13. 00	Hospi tal -Based Hospi ce			13. 00
14. 00	Hospital-Based Health Clinic RHC			14. 00
15. 00	Hospital-Based Health Clinic FQHC			15. 00
16. 00	Hospi tal -Based-CMHC			16. 00
17. 00	RENAL DIALYSIS I			17. 00
18. 00	0ther	0	0	18. 00

	Financial Systems	FRANCISCAN HEALTH ORTHO				u of Form CMS-	
HOSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA	. F	Provider CC	:N: 15-0193	Peri od: From 01/01/2023 To 12/31/2023		pared:
						070172021 10.	JO GIII
						1. 00	
	PART I - HOSPITAL AND HOSPITAL COMPLEX						1
	Uncompensated and Indigent Care Cost-to						1
1.00	Cost to charge ratio (see instructions)					0. 411493	1.00
	Medicaid (see instructions for each lir	ne)					
2.00	Net revenue from Medicaid					213, 617	2. 00
3.00	Did you receive DSH or supplemental pay					N	3.00
4.00	If line 3 is yes, does line 2 include a				ai d'?		4. 00
5.00	If line 4 is no, then enter DSH and/or	supplemental payments from	om Medicai	d		0	
6.00	Medicaid charges					1, 036, 658	
7.00	Medicaid cost (line 1 times line 6)	t- 6 M1:: -1 (:	-+!>		426, 578	
8. 00	Difference between net revenue and cost					212, 961	8. 00
9. 00	Children's Health Insurance Program (Children's	HIP) (see Instructions for	r each iine	e)		0	9.00
	Stand-alone CHIP cost (line 1 times lin	20 10)				0	
	Difference between net revenue and cost		eoo inetru	ctions)		0	
12.00	Other state or local government indiger				1		12.00
13 00	Net revenue from state or local indiger					0	13.00
	Charges for patients covered under state					o o	1
00	10)	to or room riim gont our o	program (
15. 00	State or local indigent care program co	ost (line 1 times line 14)			0	15. 00
	Difference between net revenue and cost			program (see	e instructions)	0	1
	Grants, donations and total unreimburse					ns (see	1
	instructions for each line)	·		`	, ,	`	
17.00	Private grants, donations, or endowment	t income restricted to fu	ndi ng chari	ty care		0	17. 00
18.00	Government grants, appropriations or tr	ransfers for support of h	ospital ope	erati ons		0	18.00
19.00	Total unreimbursed cost for Medicaid,	CHIP and state and local	indigent o	care programs	s (sum of lines	212, 961	19. 00
	8, 12 and 16)						
				Uni nsured	Insured	Total (col. 1	
				pati ents	pati ents	+ col. 2)	
				1. 00	2. 00	3. 00	
	Uncompensated care cost (see instruction						
	Charity care charges and uninsured disc			167, 7			
21. 00	Cost of patients approved for charity	care and uninsured discou	nts (see	69, 0	33 0	69, 033	21. 00
22 22	instructions)		-66 -			_	22.00
22. 00	Payments received from patients for amo	bunts previously written	orr as		0 0	0	22. 00
22 00	charity care	`		40.0	33 0	40.022	22 00
∠3.00	Cost of charity care (see instructions))		69, 0	၁၁၂ ပ	69, 033	23.00

	Financial Systems FRANCISCAN HEALTH ORT				u of Form CMS-	
HOSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provi der CO		Period: From 01/01/2023 To 12/31/2023	Worksheet S-1 Parts I & II Date/Time Pre 5/31/2024 10:	pared:
			<u> </u>			
					1. 00	
	PART II - HOSPITAL DATA					
4 00	Uncompensated and Indigent Care Cost-to-Charge Ratio				0.444400	4
1. 00	Cost to charge ratio (see instructions)				0. 411493	1.00
2 00	Medicaid (see instructions for each line)					1 2 00
2.00	Net revenue from Medicaid					2.00
3. 00 4. 00	Did you receive DSH or supplemental payments from Medicaid? If line 3 is yes, does line 2 include all DSH and/or suppleme	ntal naumant	s from Modico	i 42		4.00
4. 00 5. 00	If line 4 is no, then enter DSH and/or supplemental payments			i u ?		5.00
6. 00	Medicaid charges	II olii wedi cai	u			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	ctions)			8.00
0.00	Children's Health Insurance Program (CHIP) (see instructions					0.00
9. 00	Net revenue from stand-alone CHIP		-,			9.00
	Stand-alone CHIP charges					10.00
	Stand-alone CHIP cost (line 1 times line 10)					11. 00
12.00	Difference between net revenue and costs for stand-alone CHIP	(see instru	ctions)			12. 00
	Other state or local government indigent care program (see in					
	Net revenue from state or local indigent care program (Not in					13. 00
14. 00	Charges for patients covered under state or local indigent ca 10)	re program (Not included	in lines 6 or		14. 00
	State or local indigent care program cost (line 1 times line					15. 00
16. 00	Difference between net revenue and costs for state or local i					16. 00
	Grants, donations and total unreimbursed cost for Medicaid, C instructions for each line)			ent care program	ıs (see	
	Private grants, donations, or endowment income restricted to					17. 00
	Government grants, appropriations or transfers for support of					18. 00
19. 00	Total unreimbursed cost for Medicaid , CHIP and state and loc 8, 12 and 16)	al indigent				19. 00
			Uni nsured	Insured	Total (col. 1	
			patients	pati ents	+ col . 2)	
	Uncompensated care cost (see instructions for each line)		1.00	2. 00	3. 00	
20 00	Charity care charges and uninsured discounts (see instruction	e)	6, 99	3 113, 120	120, 113	20.00
21. 00			2, 87			
_ /. 00	instructions)	(500		110, 120	110,770	1 21.00
22. 00		n off as		0 0	0	22. 00
	charity care					
23.00	Cost of charity care (see instructions)		2, 87	8 113, 120	115, 998	23.00

20.00	Charity care charges and uninsured discounts (see instructions)	6, 993	113, 120	120, 113	20.00		
21.00	Cost of patients approved for charity care and uninsured discounts (see	2, 878	113, 120	115, 998	21.00		
	instructions)						
22. 00	Payments received from patients for amounts previously written off as	0	0	0	22. 00		
	chari ty care						
23. 00	Cost of charity care (see instructions)	2, 878	113, 120	115, 998	23. 00		
				1. 00			
24. 00	Does the amount on line 20 col. 2, include charges for patient days beyon	d a Length of s	stay limit	N	24.00		
	imposed on patients covered by Medicaid or other indigent care program?				25. 00		
25. 00	25.00 If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of						
	stay limit						
	Charges for insured patients' liability (see instructions)			0	20.0.		
	Bad debt amount (see instructions)			233, 543			
	Medicare reimbursable bad debts (see instructions)				27.00		
	Medicare allowable bad debts (see instructions)			7, 780 225, 763			
	3.00 Non-Medicare bad debt amount (see instructions)						
29. 00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see	95, 623	29. 00				
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)	211, 621	30.00				
31. 00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			211, 621	31.00		

Health Financial Syst	tems	FRANCISCAN HEALTH ORT	HOPEDIC CARMEL	In Lieu of Form CMS-2552-10	

Cost Center Beacription	Health Financial Systems FRAN	CISCAN HEALTH OF	RTHOPEDIC CARM	1EL	In Lie	eu of Form CMS-2	2552-10
Cost Center Description	RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der CO			Worksheet A	
Cost Center Description					From 01/01/2023	Data /Tima Daa	nanad.
Cost Center Description					10 12/31/2023		
Central Service Cost Centres	Cost Center Description	Sal ari es	Other	Total (col. 1	Reclassi fi cati		OO diii
Centeral Service Cost Centers				,			
Company Comp				ĺ	, ,		
CEMERAL SERVICE COST CENTERS						col . 4)	
1.00		1.00	2. 00	3. 00	4. 00	5. 00	
2.00 00200 CAP REL COSTS-MUBLE EQUIP 0 0 3,688,279 2.00					_		
4.00			0		.,,		ł
5.00			0				ł
7. 00							
B. 00 00800 LAUNDRY & LINEN SERVICE							ł
9.00 00900 HOUSEKEEPING					· ·		
10.0 01000 01ETARY			•		· ·		
11. 00							1
13.00 01300 NURSI NG ADMINI STRATI ON 0 359 359 794, 743 795, 102 13. 00 14.00 01400 CENTRAL SERVI CES & SUPPLY 486, 880 1, 024, 573 1, 511, 453 -320, 267 1, 91, 186 14. 00 15.00 01500 PHARMACY 465, 223 86, 168 551, 391 -78, 628 472, 763 15. 00 16.00 01600 MEDICAL RECORDS & LI BRARY 0 0 0 0 0 0 16.00 NO 0000 NO 0 0 0 0 17.00 07000 O2000 O2000 O2000 O2000 O2000 18.00 O3000 ADULTS & PEDIATRI CS 1, 148, 226 346, 809 1, 495, 035 -110, 477 1, 384, 558 19.00 05000 OPERATI NG ROOM 1, 760, 003 16, 892, 126 18, 652, 129 -14, 547, 365 4, 104, 764 50. 00 19.00 05000 OPERATI NG ROOM 1, 760, 003 16, 892, 126 18, 652, 129 -14, 547, 365 4, 104, 764 50. 00 19.00 05000 OPERATI NG ROOM 1, 760, 003 16, 892, 126 18, 652, 129 -14, 547, 365 4, 104, 764 50. 00 19.00 05000 OPERATI NG ROOM 1, 760, 003 16, 892, 126 18, 652, 129 -14, 547, 365 4, 104, 764 50. 00 19.00 05000 O2000 DELEVERY ROOM & LABOR ROOM 0, 66, 52 66, 452 66, 452 -51, 538 14, 914 60. 00 19.00 050000 05000 05000 05000 050000 050000 050000 050000 050000 050000 050000 050000 050							1
14.00 01400 CENTRAL SERVICES & SUPPLY 486, 880 1,024,573 1,511,453 -320,267 1,191,186 14.00 16.00 01600 MEDICAL RECORDS & LI BRARY 0 0 0 0 0 0 0 1NPATI ENT ROUTINE SERVICE COST CENTERS 0 1,148,226 346,809 1,495,035 -110,477 1,384,558 30.00 3000 ADULTS & PEDI ATRICS 1,148,226 346,809 1,495,035 -110,477 1,384,558 30.00 3000 OPERATI ING ROOM 1,760,003 16,892,126 18,652,129 -14,547,365 4,104,764 50.00 50.00 5000 OPERATINE ROUTINE ROOM 0 0 0 0 0 0 52.00 05200 DELI VERY ROOM & LABOR ROOM 0 0 0 0 0 0 65.00 05000 OPERATINE ROOM 0 0 0 0 0 0 65.00 05000 OPERATINE ROOM		١					•
15. 00 01500 PIARMANCY 16. 00 0 0 0 0 0 0 0 0 0		١					
16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 17. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 1							1
INPATI ENT ROUTINE SERVICE COST CENTERS 3.0.0		· .	•	•		l	1
30.00 03000 ADULTS & PEDIATRICS		l d	U		J 0	0	16.00
ANCILLARY SERVICE COST CENTERS SerVICE CO		1 140 224	244 000	1 405 02	110 477	1 204 550	20 00
50.00		1, 140, 220	340, 609	1, 490, 03	-110,477	1, 304, 336	30.00
52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0 0 0 52.00		1 760 003	16 902 126	18 652 12	14 547 365	4 104 764	50 00
54. 00		1, 700, 003	10, 072, 120	10, 032, 12			
60. 00		87 455	247 093	334 54	0		l
65. 00 06500 RESPIRATORY THERAPY 427,286 112,444 539,730 -33,867 505,863 65. 00 66. 00 06600 PHYSI CAL THERAPY 202,236 352 202,588 -94 202,494 66. 00 67. 00 06700 00 00 0 0 0 0 0 0		07, 433					
66. 00 06600 PHYSI CAL THERAPY 202, 236 352 202, 588 -94 202, 494 66. 00 67. 00 67. 00 06700 0CCUPATI ONAL THERAPY 0 0 0 0 0 0 0 0 0 67. 00 68. 00 06900 0ECEPRATHOLOGY 0 0 0 0 0 0 0 0 0 68. 00 06900 0EPECH PATHOLOGY 12, 836 681 13, 517 -31 13, 486 69. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0 0 0 0 5, 191, 689 5, 191, 689 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 8, 641, 764 8, 641, 764 72. 00 73. 00 07300 DRIGS CHARGED TO PATIENTS 0 0 0 0 0 345, 638 345, 638 73. 00 73. 00 07300 DRIGS CHARGED TO PATIENTS 0 0 0 0 0 0 0 0 0 0 0		427 286	•		· ·	1	
67. 00 06700 OCCUPATIONAL THERAPY O O O O O O O O O							•
68. 00 06800 SPEECH PATHOLOGY 0 0 0 0 0 0 0 0 68. 00 69. 00 06900 ELECTROCARDI OLOGY 12,836 681 13,517 -31 13,486 69. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0 0 0 0 5,191,689 5, 191,689 5, 191,689 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 8,641,764 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 8,641,764 8,641,764 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 345,638 345,638 73. 00 77. 00 07700 ALLOGENEI C HSCT ACQUI SI TI ON 0 0 0 0 0 0 0 77. 00 78. 00 07800 CAR T -CELL I IMMUNOTHERAPY 0 0 0 0 0 0 0 0 78. 00 0UTPATIENT SERVI CE COST CENTERS 90. 00 09000 CLI NI C 0 0 0 0 0 0 0 0 0 91. 00 91. 00 09100 EMERGENCY 0 0 0 0 0 0 0 0 91. 00 92. 00 09200 DBSERVATI ON BEDS (NON-DI STI NCT PART OTHER REI MBURSABLE COST CENTERS 102. 00 10200 OPI OI TREATMENT PROGRAM 0 0 0 0 0 0 0 102. 00 SPECI AL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 0 0 0 0 0 0 0 0 0 113. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN 0 2, 177 0 0 2, 177 190. 00 191. 00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN 0 534 465, 071 465, 605 192. 00 194. 00 07950 OTHER NRCC 114, 406 809, 192 923, 598 1, 957, 764 2, 881, 362 194. 00						1	
69. 00 06900 ELECTROCARDI OLOGY 12,836 681 13,517 -31 13,486 69. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0 0 0 5,191,689 5,191,689 71. 00 72. 00 07200 IMPL DEV. CHARGED TO PATIENTS 0 0 0 8,641,764 8,641,764 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 345,638 345,638 73. 00 77. 00 07700 ALLOGENEI C HSCT ACQUI SITION 0 0 0 0 0 78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 0 79. 00 07900 CLI NI C 0 0 0 0 0 79. 00 09000 CLI NI C 0 0 0 0 0 79. 00 09100 EMERGENCY 0 0 0 0 0 79. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 92. 00 79. 00 09200 OFFICE OST CENTERS 102. 00 010200 OPI OI D TREATMENT PROGRAM 0 0 0 0 70 01300 OTHER REI MBURSABLE COST CENTERS 113. 00 11300 INTEREST EXPENSE 0 0 0 0 71. 00 010200 OFFICE SHOP & CANTEEN 0 0 71. 00 010200 OFFICE SHOP & CANTEEN 0 0 0 71. 00 010200 OFFICE SHOP & CANTEEN 0 0 0 71. 00 010200 OFFICE SHOP & CANTEEN 0 0 0 72. 00 07950 OTHER NRCC 114,406 809,192 923,598 1,957,764 2,881,362 194.00 73. 00 07100 07100 07100 07100 07100 07100 07100 07100 74. 00 07100 07		0	0		0	0	
71. 00		12, 836	681	13, 51	7 -31	13. 486	ı
72. 00	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0				ı
77. 00 07700 ALLOGENEI C HSCT ACQUI SITION 0 0 0 0 0 0 0 0 77. 00 78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 0 0 0 0 78. 00 000 00 0 0 0 0 0 0 0 0 0 0 0 0 0		o	0		8, 641, 764	8, 641, 764	72.00
78. 00	73.00 07300 DRUGS CHARGED TO PATIENTS	O	0		345, 638	345, 638	73. 00
78. 00	77.00 07700 ALLOGENEIC HSCT ACQUISITION	O	0		0	0	77. 00
90. 00		O	0		0 0	0	78. 00
91. 00 09100 EMERGENCY 0 0 0 0 0 0 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 92. 00 071HER REI MBURSABLE COST CENTERS 92. 00 071HER REI MBURSABLE COST CENTERS 92. 00 0 0 0 0 0 0 0 0 0	OUTPATIENT SERVICE COST CENTERS						
92. 00 09200 0BSERVATI ON BEDS (NON-DI STINCT PART	90. 00 09000 CLI NI C	0	0	(0	0	90. 00
OTHER REIMBURSABLE COST CENTERS O O O O O O O O O O O O O O O O O O		0	0		0 0	0	91. 00
102.00 10200 OPI OI D TREATMENT PROGRAM O O O O O O 102.00							92. 00
SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 0 0 0 0 0 0 113.00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 7,692,000 36,958,405 44,650,405 -2,422,835 42,227,570 118.00 NONREI MBURSABLE COST CENTERS 0 2,177 2,177 0 2,177 190.00 19							
113. 00 11300 INTEREST EXPENSE 0 0 0 0 0 113. 00 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 7,692,000 36,958,405 44,650,405 -2,422,835 42,227,570 118. 00 NONREI MBURSABLE COST CENTERS 0 2,177 2,177 0 2,177 190. 00 192. 00 19200 PHYSI CI ANS PRI VATE OFFI CES 0 534 534 465,071 465,605 192. 00 194. 00 07950 OTHER NRCC 114,406 809,192 923,598 1,957,764 2,881,362 194. 00		0	0		0	0	102. 00
118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 7, 692, 000 36, 958, 405 44, 650, 405 -2, 422, 835 42, 227, 570 18. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN 0 2, 177 2, 177 0 2, 177 190. 00 192. 00 19200 PHYSI CI ANS PRI VATE OFFI CES 0 534 465, 071 465, 605 192. 00 194. 00 07950 OTHER NRCC 114, 406 809, 192 923, 598 1, 957, 764 2, 881, 362 194. 00							
NONREI MBURSABLE COST CENTERS 190.00 19000 GI FT FLOWER COFFEE SHOP & CANTEEN 0 2, 177 2, 177 0 2, 177 190.00 192.00 19200 PHYSI CI ANS PRI VATE OFFI CES 0 534 534 465, 071 465, 605 192.00 194.00 07950 0THER NRCC 114, 406 809, 192 923, 598 1, 957, 764 2, 881, 362 194.00 194.0			•		-	1	1
190. 00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN 0 2, 177 2, 177 0 2, 177 190. 00 192. 00 19200 PHYSI CI ANS PRI VATE OFFICES 0 534 534 465, 071 465, 605 192. 00 194. 00 07950 OTHER NRCC 114, 406 809, 192 923, 598 1, 957, 764 2, 881, 362 194. 00	7	7, 692, 000	36, 958, 405	44, 650, 40	5 -2, 422, 835	42, 227, 570	118. 00
192.00 19200 PHYSI CLANS PRI VATE OFFI CES 0 534 465, 071 465, 605 192.00 194.00 07950 OTHER NRCC 114, 406 809, 192 923, 598 1, 957, 764 2, 881, 362 194.00				_	=		
194. 00 07950 OTHER NRCC 114, 406 809, 192 923, 598 1, 957, 764 2, 881, 362 194. 00			•				1
		١					
200.00 TOTAL (SUM OF LINES 118 through 199) 7,806,406 37,770,308 45,576,714 0 45,576,714 200.00	200.00 TOTAL (SUM OF LINES ITS THROUGH 199)	7,806,406	37, 770, 308	45, 5/6, /1	4 0	45, 5/6, /14	J200. 00

TOTAL (SUM OF LINES 118 through 199)

Date/Time Prepared:

200.00

12/31/2023

FRANCISCAN HEALTH ORTHOPEDIC CARMEL RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES Provider CCN: 15-0193 Peri od: Worksheet A From 01/01/2023

5/31/2024 10:50 am Cost Center Description Adjustments Net Expenses (See A-8) For Allocation 6.00 7.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT -1, 489, 972 5, 515, 653 1.00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 110, 652 3, 798, 931 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 1, 978, 155 2, 276, 328 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 4, 996, 373 9, 730, 721 5 00 7.00 00700 OPERATION OF PLANT 92,779 1, 769, 830 7.00 00800 LAUNDRY & LINEN SERVICE 167, 120 8.00 8.00 9.00 00900 HOUSEKEEPI NG -220, 200 676, 484 9.00 01000 DI ETARY 88, 316 10.00 10.00 -8, 999 11.00 01100 CAFETERI A -221, 740 473, 949 11.00 13.00 01300 NURSING ADMINISTRATION 25, 352 820, 454 13.00 01400 CENTRAL SERVICES & SUPPLY 14 00 -720, 312 470.874 14 00 15.00 01500 PHARMACY -193, 924 278, 839 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 86, 367 86, 367 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 30.00 03000 ADULTS & PEDIATRICS -51 1, 384, 507 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM -963, 907 50 00 3, 140, 857 05200 DELIVERY ROOM & LABOR ROOM 52.00 52.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 108, 297 211, 362 54 00 60.00 06000 LABORATORY 14, 914 60.00 65.00 06500 RESPIRATORY THERAPY -5, 678 500, 185 65.00 66.00 06600 PHYSI CAL THERAPY -46, 336 156, 158 66.00 67.00 06700 OCCUPATI ONAL THERAPY Ω 67.00 68.00 06800 SPEECH PATHOLOGY 0 68.00 06900 ELECTROCARDI OLOGY 13, 486 69.00 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT -87, 836 71.00 5, 103, 853 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS -146, 161 8, 495, 603 72.00 07300 DRUGS CHARGED TO PATIENTS 345, 638 73.00 73.00 07700 ALLOGENEIC HSCT ACQUISITION 0 77.00 77.00 0 07800 CAR T-CELL IMMUNOTHERAPY 78.00 0 0 78.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 0 90.00 91 00 09100 EMERGENCY 0 0 91 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 102. 00 10200 OPI OI D TREATMENT PROGRAM 0 0 102.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 0 0 113.00 SUBTOTALS (SUM OF LINES 1 through 117) 3, 292, 859 45, 520, 429 118.00 118.00 NONREI MBURSABLE COST CENTERS

190. 00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN 2, 177 190.00 192.00 19200 PHYSICIANS PRIVATE OFFICES 0 465, 605 192. 00 194.00 07950 OTHER NRCC 2,078,569 4, 959, 931 194.00

5, 371, 428

50, 948, 142

200.00

Health Financial Systems RECLASSIFICATIONS FRANCISCAN HEALTH ORTHOPEDIC CARMEL
Provider CCN: 15-0193 Peri od: From 01/01/2023 To 12/31/2023 Date/Ti me Prepared: 5/31/2024 10:50 am

					5/31/2024 10	: 50 am
		Increases				
	Cost Center	Li ne #	Sal ary	Other		
	2.00	3. 00	4. 00	5. 00		
1 00	A - MEDICAL SUPPLIES	71. 00	0	E 101 (00		1 00
1. 00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	۷	5, 191, 689		1. 00
2.00	IMPL. DEV. CHARGED TO	72. 00	О	8, 641, 764		2. 00
0.00	PATI ENTS	0.00				0.00
3.00		0.00	0	0		3. 00
4.00		0.00	0	0		4. 00
5.00		0. 00 0. 00	0	0		5.00
6. 00 7. 00		0.00	o	0		6. 00 7. 00
8. 00		0.00	0	0		8. 00
9. 00		0.00	o	0		9. 00
10. 00		0.00	o	0		10.00
11. 00		0.00	ol	0		11. 00
12.00		0.00	o	0		12. 00
13.00		0.00	o	0		13. 00
14.00		0.00	0	0		14. 00
15. 00		0.00	0	0		15. 00
	0		0	13, 833, 453		
	B - DRUGS					4
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	345, 638		1.00
2. 00 3. 00		0. 00 0. 00	0	0		2. 00 3. 00
4.00		0.00	0	0		4. 00
5.00		0.00	0	0		5. 00
6.00		0.00	Ö	0		6. 00
7. 00		0.00	ō	0		7. 00
	0			345, 638		
	C - EQUIPMENT LEASE RECLASS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	337, 646		1. 00
2.00	PHARMACY	15. 00	0	190, 448		2. 00
3.00		0.00	0	0		3. 00
4.00		0.00	0	0		4. 00
5. 00 6. 00		0. 00 0. 00	0	0		5. 00 6. 00
0.00				528, 094		8.00
	D - DEPRECIATION		<u> </u>	020, 071		
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	780, 787		1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	o	3, 870, 797		2. 00
3.00		0.00	0	0		3. 00
4.00		0.00	0	0		4. 00
5.00		0. 00	0	0		5. 00
6.00		0.00	0	0		6. 00
7.00		0.00	0	0		7. 00
8. 00 9. 00		0. 00 0. 00	0	0		8. 00 9. 00
10. 00		0.00	o	0		10.00
11. 00		0.00	o	0		11. 00
12. 00		0. 00	o	0		12. 00
13. 00		0.00	o	0		13. 00
14.00		0.00	O	0		14. 00
15.00		0.00	0	0		15. 00
16. 00		0.00	0	0		16. 00
	TOTALS		0	4, 651, 584		_
1 00	E - EMPLOYEE BENEFITS	4 00	ما	FO 1/1		1 00
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	58, 161		1.00
2. 00 3. 00		0. 00 0. 00	0	0		2. 00 3. 00
4.00		0.00	0	0		4. 00
5.00		0.00	0	0		5. 00
6.00		0.00	o	0		6. 00
7.00		0.00	O	0		7. 00
	TOTALS			58, 161		1
	F - CAFETERIA					
1.00	DI ETARY	10.00	0	13, 820		1. 00
2.00	CAFETERI A	<u>11.</u> 00	368, 356	209, 894		2. 00
	TOTALS		368, 356	223, 714		_
1 00	G - WORKING WELL	100.00	227 440	100 00=		1 00
1. 00	PHYSICIANS PRIVATE OFFICES	192.00	337, 112	128, 237		1. 00
	TOTALS H - INSURANCE		337, 112	128, 237		4
1.00	PHYSICIANS PRIVATE OFFICES	192. 00	O	n		1. 00
50	0		— — — — —	$ \frac{0}{0}$		
	'	ı	-1	-1		1

Health Financial Systems	FRANCISCAN HEALTH ORTHOPEDIC CARMEL	_	In Lie	u of Form CMS-2552-10
RECLASSI FI CATI ONS	Provider CCN	: 15-0193	Peri od: From 01/01/2023	Worksheet A-6
				Date/Time Prepared:

							5/31/2024 1	0:50 am_
		Increases						
	Cost Center	Li ne #	Sal ary	0ther				
	2. 00	3.00	4. 00	5. 00				
	I - CAPTALIZED INTEREST							
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	4, 389, 762				1. 00
2.00	OTHER NRCC	194. 00	0	2, 022, 938				2. 00
	TOTALS		0	6, 412, 700				
	J - PRE-ADMIT TESTING							
1.00	NURSING ADMINISTRATION	1300	789, 009	6, 093				1. 00
	TOTALS		789, 009	6, 093				
	K - PROPERTY TAX							
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1, 497, 430				1. 00
2.00		0.00	0	0				2. 00
	TOTALS		0	1, 497, 430				
500.00	Grand Total: Increases		1, 494, 477	27, 685, 104				500.00

Peri od: From 01/01/2023 To 12/31/2023

Date/Time Prepared: 5/31/2024 10:50 am

	Deevenee					5/31/2024 10:	: 50 am
	C+ C+	Decreases	C-1	0+1	 		
	Cost Center 6.00	Li ne # 7.00	Sal ary 8.00	0ther 9.00	Wkst. A-7 Ref. 10.00		
	A - MEDICAL SUPPLIES	7.00	8.00	9.00	10.00		
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	ol	16, 083	0		1.00
2.00	ADMINISTRATIVE & GENERAL	5. 00	0	10, 889			2.00
3.00	OPERATION OF PLANT	7.00	0	2, 164			3.00
		l .	-				1
4.00	HOUSEKEEPI NG	9.00	0	4, 360	1		4. 00
5.00	DIETARY	10.00	0	10, 718	1		5. 00
6. 00	CAFETERI A	11.00	0	13, 260			6. 00
7. 00	NURSING ADMINISTRATION	13. 00	0	359	1		7. 00
8. 00	CENTRAL SERVICES & SUPPLY	14. 00	0	111, 513	1		8. 00
9. 00	PHARMACY	15. 00	0	7, 351	0		9. 00
10. 00	ADULTS & PEDIATRICS	30.00	0	41, 071	0		10.00
11. 00	OPERATING ROOM	50.00	0	13, 555, 012	0		11. 00
12. 00	RADI OLOGY-DI AGNOSTI C	54. 00	0	423	0		12. 00
13. 00	LABORATORY	60.00	0	28, 250	0		13. 00
14.00	RESPIRATORY THERAPY	65.00	0	31, 969	0		14. 00
15.00	ELECTROCARDI OLOGY	69.00	0	31	0		15. 00
	0 — — — — —			13, 833, 453			
	B - DRUGS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	3, 201	0		1.00
2.00	ADMINISTRATIVE & GENERAL	5. 00	0	1, 352	0		2. 00
3.00	CENTRAL SERVICES & SUPPLY	14. 00	o	233			3. 00
4.00	PHARMACY	15. 00	o	258, 909			4. 00
5. 00	ADULTS & PEDIATRICS	30.00	0	5, 294			5. 00
6. 00	OPERATING ROOM	50.00	Ö	68, 845	1		6. 00
7. 00	OTHER NRCC	194.00	Ö	7, 804			7. 00
7.00	0		— — —	345, 638			7.00
	C - EQUIPMENT LEASE RECLASS		<u> </u>	343, 030			
1 00	EMPLOYEE BENEFITS DEPARTMENT	4 00	0	11/ 470	10		1 00
1.00	1	4.00		116, 472			1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	182, 518	1		2.00
3.00	ADMINISTRATIVE & GENERAL	5. 00	0	221, 301	0		3.00
4.00	OPERATION OF PLANT	7.00	0	2, 890	1		4. 00
5. 00	DI ETARY	10.00	0	4, 293	1		5. 00
6. 00	RESPI RATORY THERAPY	<u>65.</u> 00	0	620			6. 00
	0		0	528, 094			_
	D - DEPRECIATION	T			T		
1. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	3, 721	9		1. 00
2.00	OPERATION OF PLANT	7.00	0	48, 459	1		2. 00
3.00	LAUNDRY & LINEN SERVICE	8. 00	0	2, 183	0		3. 00
4.00	HOUSEKEEPI NG	9. 00	0	15, 865	0		4. 00
5.00	DI ETARY	10.00	0	112, 152	0		5. 00
6.00	CAFETERI A	11.00	0	4, 466	0		6. 00
7.00	CENTRAL SERVICES & SUPPLY	14. 00	0	208, 521	0		7. 00
8.00	PHARMACY	15. 00	0	1, 999	0		8. 00
9.00	ADULTS & PEDIATRICS	30.00	0	64, 111	0		9. 00
10.00	OPERATING ROOM	50.00	0	923, 506	0		10.00
11. 00	RADI OLOGY-DI AGNOSTI C	54.00	o	231, 060			11.00
12. 00	LABORATORY	60.00	o	23, 288			12. 00
13. 00	RESPIRATORY THERAPY	65. 00	o	1, 278			13. 00
14. 00	PHYSI CAL THERAPY	66.00	o	94			14. 00
15. 00	ADMINISTRATIVE & GENERAL	5. 00	Ö	3, 010, 603			15. 00
16. 00	PHYSICIANS PRIVATE OFFICES	192.00		278			16. 00
10.00	TOTALS	192.00	— — —	4, 651, 584			10.00
	E - EMPLOYEE BENEFITS		UU	+, 051, 564			1
1.00	ADMINISTRATIVE & GENERAL	5. 00	ol	785	0		1.00
	HOUSEKEEPING	9.00	-	/85	1		
2.00		1	0	1	0		2.00
3.00	DIETARY	10.00	0	1	0		3.00
4.00	PHARMACY	15. 00	0	1	0		4. 00
5.00	ADULTS & PEDIATRICS	30.00	0	I	0		5.00
6. 00	OPERATING ROOM	50.00	0	2	0		6. 00
7. 00	OTHER NRCC	194.00	0_	<u>57, 3</u> 70			7. 00
	TOTALS		0	58, 161			1
_	F - CAFETERI A	,			T		4
1. 00	DI ETARY	10. 00	368, 356	209, 894			1. 00
2.00	CAFETERI A	11.00		1 <u>3, 8</u> 20			2. 00
	TOTALS		368, 356	223, 714]
	G - WORKING WELL						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	337, 112	128, 237	0		1. 00
	TOTALS	\Box \Box \Box \dagger	337, 112	128, 237			
	H - I NSURANCE		· .		·		1
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	0	0		1. 00
		<u> </u>		— — <u> </u>			
	•		-1				•

Health Financial Systems	FRANCISCAN HEALTH ORTHOPEDIC CARMEL	In Lie	u of Form CMS-2552-10
RECLASSI FI CATI ONS	Provi der CCN: 15-0193	Peri od: From 01/01/2023	Worksheet A-6
		To 12/31/2023	Date/Time Prepared:

						5/31/2024 10	:50 am
		Decreases					
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.		
	6. 00	7.00	8. 00	9. 00	10.00		
	I - CAPTALIZED INTEREST						
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	6, 412, 700	11		1. 00
2.00		0.00	0	0)C		2. 00
	TOTALS		0	6, 412, 700			
	J - PRE-ADMIT TESTING						
1.00	ADMINISTRATIVE & GENERAL	5. 00	789, 009	6, 093	C		1. 00
	TOTALS		789, 009	6, 093			
	K - PROPERTY TAX						
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	1, 496, 614	. 13	3	1. 00
2.00	PHARMACY	15. 00	0	816	C		2. 00
	TOTALS — — — — —	$T^- T^- T^-$	0	1, 497, 430)	1	
500.00	Grand Total: Decreases		1, 494, 477	27, 685, 104		1	500.00

Subtotal (sum of lines 1-7)

Reconciling Items

10.00 Total (line 8 minus line 9)

8.00

9.00

8.00

9.00

10.00

RECONCILIATION OF CAPITAL COSTS CENTERS Provider CCN: 15-0193 Peri od: Worksheet A-7 From 01/01/2023 Part I 12/31/2023 Date/Time Prepared: 5/31/2024 10:50 am Acqui si ti ons Begi nni ng Di sposal s and Purchases Donati on Total Bal ances Retirements 2.00 3.00 4. 00 1 00 5 00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 0 1.00 138, 935 0 2.00 Land Improvements 57, 632 57, 632 0 2.00 0 3.00 64, 668, 756 1, 340, 386 1, 340, 386 3.00 Buildings and Fixtures 0 1, 574, 146 0 4.00 Building Improvements 1, 574, 146 4.00 5.00 Fixed Equipment 1, 991, 979 418, 002 0 418, 002 5.00 14, 733, 651 0 5, 995, 173 6.00 Movable Equipment 5, 995, 173 0 6.00 0 7.00 HIT designated Assets 0 7.00 0 8.00 Subtotal (sum of lines 1-7) 83, 107, 467 7, 811, 193 7, 811, 193 1, 574, 146 8.00 9.00 Reconciling Items 0 9.00 83, 107, 467 Total (line 8 minus line 9) 1, 574, 146 10.00 7, 811, 193 0 7, 811, 193 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 0 1.00 2.00 Land Improvements 196, 567 0 2.00 66, 009, 142 3.00 Buildings and Fixtures 0 3.00 0 4.00 Building Improvements 4.00 5.00 Fi xed Equipment 2, 409, 981 0 5.00 Movable Equipment 20, 728, 824 0 6.00 6.00 7. 00 7.00 HIT designated Assets 0

89, 344, 514

89, 344, 514

0

0

Heal th	Financial Systems FRAN	CISCAN HEALTH C	ORTHOPEDIC CA	ARMEL		In Lie	u of Form CMS-2	2552-10
RECONC	ILIATION OF CAPITAL COSTS CENTERS		Provi der	CCN: 1		Peri od: From 01/01/2023	Worksheet A-7 Part II	
							Date/Time Pre	pared:
							5/31/2024 10:	50 am
				SUMMAR	RY OF CAPI	TAL		
	Cost Center Description	Depreciation	Lease	1	nterest	Insurance (see	Taxes (see	
		·				instructions)	instructions)	
		9. 00	10.00		11. 00	12.00	13. 00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM	N 2, LINES 1	and 2				
1.00	CAP REL COSTS-BLDG & FLXT	0		0		0	0	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	0		0		0	0	2.00
3.00	Total (sum of lines 1-2)	0		0		0 0	0	3. 00
		SUMMARY O	F CAPITAL					
	Cost Center Description	Other	Total (1) (s					
		Capi tal -Rel ate	of cols. 9					
		d Costs (see	through 14))				
		instructions)						
		14. 00	15. 00					
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM	N 2, LINES 1	and 2				ļ
1. 00	CAP REL COSTS-BLDG & FLXT	0		0				1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	0		0				2. 00
3.00	Total (sum of lines 1-2)	0		0				3.00

Heal th	Financial Systems FRAN	CISCAN HEALTH (ORTHOPEDIC CARN	ИEL	In Lie	eu of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provider Co		Period: From 01/01/2023 To 12/31/2023		pared: 50 am
		COMI	PUTATION OF RAT	TI 0S	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col	instructions)	Insurance	
		1. 00	2.00	2) 3.00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1. 00	CAP REL COSTS-BLDG & FLXT	68, 615, 691	1	68, 615, 69	1 0. 777266	0	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	20, 728, 824					2. 00
3.00	Total (sum of lines 1-2)	89, 344, 515					3. 00
ALLOCATION OF OTHER CAPITAL						F CAPITAL	<u> </u>
	Cost Center Description	Taxes	Other Capi tal -Relate	Total (sum of cols. 5	Depreciation	Lease	
			d Costs	through 7)			
		6. 00	7. 00	8. 00	9. 00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE	ENTERS					
1.00	CAP REL COSTS-BLDG & FIXT	0	0		0 788, 245		1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		0 3, 981, 449		2. 00
3.00	Total (sum of lines 1-2)	0	0		0 4, 769, 694	155, 128	3. 00
			St	JMMARY OF CAPI	TAL		
	Cost Center Description	Interest	Insurance (see	Taxes (see	0ther	Total (2) (sum	
			instructions)	instructions)	Capi tal -Rel ate		
					d Costs (see instructions)	through 14)	
		11. 00	12.00	13.00	14.00	15. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE	ENTERS					
1.00	CAP REL COSTS-BLDG & FIXT	4, 389, 762	0		0 0	5, 515, 653	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		0 0	3, 798, 931	2. 00

0 4, 389, 762

0 0 0

0 0 0

0 0 0

5, 515, 653 1. 00 3, 798, 931 2. 00 9, 314, 584 3. 00

2.00 CAP REL COSTS-MVBLE EQUIP
3.00 Total (sum of lines 1-2)

				To	0 12/31/2023	Date/Time Prep 5/31/2024 10:5	
	,			Expense Classification on		3/31/2024 10.3	oo alii
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description		Amount 2.00	Cost Center 3.00		Wkst. A-7 Ref.	
1.00	Investment income - CAP REL	1.00		CAP REL COSTS-BLDG & FLXT	4. 00 1. 00	5. 00 0	1. 00
2. 00	COSTS-BLDG & FIXT (chapter 2) Investment income - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	2. 00
	COSTS-MVBLE EQUIP (chapter 2)		O	CAL REE GOSTS MVBEE EGGTT		[
3. 00	Investment income - other (chapter 2)		0		0. 00	0	3. 00
4.00	Trade, quantity, and time		0		0. 00	О	4. 00
5.00	discounts (chapter 8) Refunds and rebates of		0		0.00	0	5. 00
6. 00	expenses (chapter 8) Rental of provider space by		0		0.00	0	6. 00
	suppliers (chapter 8)		O				
7. 00	Telephone services (pay stations excluded) (chapter		0		0. 00	0	7. 00
0.00	21)			ODERATION OF BLANT	7.00		0.00
8. 00	Television and radio service (chapter 21)	A	U	OPERATION OF PLANT	7. 00	0	8. 00
9. 00 10. 00	Parking Lot (chapter 21) Provider-based physician	A-8-2	0 -1, 097, 991		0. 00	0	9. 00 10. 00
	adj ustment	A-0-2					
11. 00	Sale of scrap, waste, etc. (chapter 23)		0		0. 00	0	11. 00
12. 00	Related organization	A-8-1	10, 733, 565			0	12.00
13. 00	transactions (chapter 10) Laundry and linen service		0		0.00	0	13. 00
14. 00 15. 00	Cafeteria-employees and guests Rental of quarters to employee	1	-218, 611	CAFETERI A	11. 00 0. 00	0	14. 00 15. 00
	and others		O				
16. 00	Sale of medical and surgical supplies to other than		0		0. 00	0	16. 00
17.00	pati ents		0		0.00		17. 00
17. 00	Sale of drugs to other than patients		U		0.00	0	17.00
18. 00	Sale of medical records and abstracts		0		0. 00	0	18. 00
19. 00	Nursing and allied health		0		0.00	0	19. 00
	education (tuition, fees, books, etc.)						
20. 00 21. 00	Vending machines Income from imposition of		0		0. 00 0. 00	0	20. 00 21. 00
21.00	interest, finance or penalty		0		0.00		21.00
22. 00	charges (chapter 21) Interest expense on Medicare	1	0		0. 00	0	22. 00
	overpayments and borrowings to		_		2.22		
23. 00	repay Medicare overpayments Adjustment for respiratory	A-8-3	0	RESPI RATORY THERAPY	65. 00		23. 00
	therapy costs in excess of limitation (chapter 14)						
24. 00	Adjustment for physical	A-8-3	0	PHYSI CAL THERAPY	66. 00		24. 00
	therapy costs in excess of limitation (chapter 14)						
25. 00	Utilization review - physicians' compensation		0	*** Cost Center Deleted ***	114. 00		25. 00
	(chapter 21)						
26. 00	Depreciation - CAP REL COSTS-BLDG & FLXT		0	CAP REL COSTS-BLDG & FLXT	1. 00	0	26. 00
27. 00	Depreciation - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	27. 00
28. 00	COSTS-MVBLE EQUIP Non-physician Anesthetist		0	*** Cost Center Deleted ***	19. 00		28. 00
29. 00 30. 00	Physicians' assistant Adjustment for occupational	A-8-3	0	OCCUPATI ONAL THERAPY	0. 00 67. 00	0	29. 00 30. 00
50.00	therapy costs in excess of	n-0-3	U	OCCUPATIONAL THENAFT	67.00		50.00
30. 99	Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30. 00		30. 99
	instructions)	1 400					
31. 00	Adjustment for speech pathology costs in excess of	A-8-3	0	SPEECH PATHOLOGY	68. 00		31. 00
32. 00	limitation (chapter 14) CAH HIT Adjustment for		0		0.00	0	32. 00
-2.00	Depreciation and Interest		Ü		3. 30	l	50

From 01/01/2023 | WUI NOTICE LA-0
From 12/31/2023 | Date/Time Prepared:

				T	o 12/31/2023	Date/Time Pre 5/31/2024 10:	
	,			Expense Classification on	Worksheet A	070172021 10.	OO diii
				To/From Which the Amount is			
					,		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
	,	1.00	2. 00	3.00	4. 00	5. 00	
33.00	MISC INCOME	В		MEDICAL SUPPLIES CHARGED TO	71. 00	0	33. 00
				PATI ENT			
33. 01	MISC INCOME	В	-696, 188	ADMINISTRATIVE & GENERAL	5. 00	0	33. 01
33. 02	MISC INCOME	В	-378, 763	OPERATION OF PLANT	7. 00		33. 02
33. 03	MISC INCOME	В	0		0.00		33. 03
33. 04	MISC INCOME	В		HOUSEKEEPI NG	9. 00	0	33. 04
33. 05	MISC INCOME	В	-8, 999	DI ETARY	10.00	0	33. 05
33.06	MISC INCOME	В	-3, 129	CAFETERI A	11. 00	0	33. 06
33. 07	MISC INCOME	В		IMPL. DEV. CHARGED TO	72. 00	0	33. 07
				PATI ENTS			
	MISC INCOME	В	•	CENTRAL SERVICES & SUPPLY	14. 00		00.00
33. 09	MISC INCOME	В	-193, 924	PHARMACY	15. 00	0	33. 09
33. 10	MISC INCOME	В	-25, 244	OPERATING ROOM	50.00	0	33. 10
33. 11	MISC INCOME	В	1, 480	RADI OLOGY-DI AGNOSTI C	54. 00		
33. 12	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	33. 12
	(3)						
33. 13	MI SC I NCOME	В	•	RESPI RATORY THERAPY	65. 00	0	000
33. 14	MISC INCOME	В		PHYSI CAL THERAPY	66. 00		33. 14
33. 15	ADVERTISING EXPENSE	A		ADULTS & PEDIATRICS	30. 00		33. 15
33. 16	ADVERTISING EXPENSE	A		OPERATION OF PLANT	7. 00	0	33. 16
33. 17	ADVERTISING EXPENSE	A	-515	EMPLOYEE BENEFITS DEPARTMENT	4. 00		33. 17
33. 18	OTHER ADJUSTMENTS (SPECIFY)		0		0. 00	0	33. 18
	(3)						
33. 19	LOBBYING FEES	A		ADMINISTRATIVE & GENERAL	5. 00		00 ,
33. 20	PROPERTY TAX	A		CAP REL COSTS-BLDG & FIXT	1.00	13	
50. 00	TOTAL (sum of lines 1 thru 49)		5, 371, 428				50. 00
	(Transfer to Worksheet A,						
	column 6, line 200.)						

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

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

B. Amount Received - if cost cannot be determined.

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME

Provider CCN: 15-0193

Worksheet A-8-1

From 01/01/2023 To 12/31/2023 Date/Time Prepared: OFFICE COSTS

				_	5/31/2024 10:	50 am		
	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 ADJUSTM	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED O	RGANIZATIONS OR	CLAI MED			
	HOME OFFICE COSTS:							
1.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	SHARED SERVICE ALLOCATION	2, 122, 850	0	1.00		
2.00	1	ADMINISTRATIVE & GENERAL	SHARED SERVICE ALLOCATION	1, 534, 707	0	2. 00		
3.00	7. 00	OPERATION OF PLANT	SHARED SERVICE ALLOCAITON	486, 540	0	3. 00		
4.00	13. 00	NURSING ADMINISTRATION	SHARED SERVICE ALLOCATION	25, 352	0	4. 00		
4.01	16. 00	MEDICAL RECORDS & LIBRARY	SHARED SERVICE ALLOCATION	5, 784	0	4. 01		
4.02	54. 00	RADI OLOGY-DI AGNOSTI C	SHARED SERVICE ALLOCATION	106, 817	0	4. 02		
4.04	194. 00	OTHER NRCC	SHARED SERVICE ALLOCATION	2, 077, 511	0	4. 04		
4.05	194. 00	OTHER NRCC	SHARED SERVICE ALLOCATION	1, 058	0	4. 05		
4.06	1.00	CAP REL COSTS-BLDG & FIXT	FRANCISCAN HOME OFFICE	7, 458	0	4. 06		
4.07	0.00			0	0	4. 07		
4.08	2. 00	CAP REL COSTS-MVBLE EQUIP	FRANCISCAN HOME OFFICE	110, 652	0	4. 08		
4.09	5. 00	ADMINISTRATIVE & GENERAL	FRANCISCAN HOME OFFICE	4, 174, 253	0	4. 09		
4. 10	16. 00	MEDICAL RECORDS & LIBRARY	FRANCISCAN HOME OFFICE	80, 583	0	4. 10		
5.00	TOTALS (sum of lines 1-4).			10, 733, 565	0	5.00		
	Transfer column 6, line 5 to							
	Worksheet A-8, column 2,							
	line 12.							

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

1100 110 0	been posted to norkance h, cordinas i and or 2, the amount arronable should be indicated in cordinar i or this part.							
				Related Organization(s) and/	or Home Office			
	Symbol (1)	Name	Percentage of	Name	Percentage of			
			Ownershi p		Ownershi p			
	1. 00	2.00	3. 00	4. 00	5. 00			
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:							

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

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

6. 00	В	HOME OFFICE	100. 00	FRANC. ALLI ANCE	100.00	6. 00
7.00	G	FH CENTRAL INDY	100.00	FRANC. HEALTH	100.00	7. 00
8. 00			0.00		0.00	8. 00
9. 00			0.00		0.00	9. 00
10. 00			0.00		0.00	10.00
100.00	G. Other (financial or					100.00
	non-financial) specify:					

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

						5/31/2024 10:	50 am
	Net	Wkst. A-7 Ref.					
	Adjustments						
	(col. 4 minus						
	col. 5)*						
	6. 00	7. 00					
			MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED O	RGANIZATIONS OR	CLAI MED	
	HOME OFFICE CO						
1.00	2, 122, 850						1. 00
2.00	1, 534, 707	0					2. 00
3.00	486, 540						3. 00
4.00	25, 352						4.00
4.01	5, 784						4. 01
4.02	106, 817	0					4. 02
4.04	2, 077, 511	0					4. 04
4.05	1, 058	0					4. 05
4.06	7, 458	9					4. 06
4.07	0	0					4. 07
4.08	110, 652	9					4. 08
4.09	4, 174, 253	0					4. 09
4.10	80, 583	0					4. 10
5.00	10, 733, 565						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						
		4				
6. 00						
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:						

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

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

To imbal Somort and the Aviii.								
6.00	HEALTH SYSTEM		6. 00					
7.00	HOSPI TAL		7.00					
8.00			8.00					
9.00			9.00					
10.00			10.00					
100.00			100.00					

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

Period: Worksheet A-8-2 From 01/01/2023 To 12/31/2023 Date/Time Prepared: 5/31/2024 10:50 am

							5/31/2024 10:	50 am_
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remuneration	Component	Component		ider Component	
		1 45111111151	Tromarior a tron	- Component	ooporiorit		Hours	
	1.00	2.00	3.00	4.00	5. 00	6. 00	7. 00	
1.00		EMPLOYEE BENEFITS DEPARTMENT	144, 180					1. 00
2.00		ADMINISTRATIVE & GENERAL	15, 148			,		2. 00
3.00		OPERATING ROOM	938, 663			211, 500		3. 00
4.00	0. 00		0	0	0	0	0	4. 00
5.00	0.00		0	0	0	0	0	5. 00
6.00	0.00		l 0	0	0	0	0	6. 00
7.00	0.00		1 0	l 0	0	l 0	0	7. 00
8. 00	0.00		١	١	0	ĺ	0	8. 00
9. 00	0.00				0	0	0	9. 00
			0		0	0	0	
10.00	0. 00				0	0	0	
200.00			1, 097, 991	1, 097, 991	0		971	
	Wkst. A Line #		Unadjusted RCE		Cost of	Provi der	Physician Cost	
		ldenti fi er	Limit	Unadjusted RCE			of Malpractice	
				Limit	Conti nui ng	Share of col.	Insurance	
					Educati on	12		
	1. 00	2. 00	8. 00	9. 00	12. 00	13. 00	14. 00	
1.00	4. 00	EMPLOYEE BENEFITS DEPARTMENT	98, 734	4, 937	0	0	0	1. 00
2.00	5. 00	ADMINISTRATIVE & GENERAL	l o	0	0	0	0	2. 00
3.00		OPERATING ROOM	0	0	0	0	0	3. 00
4. 00	0.00		١	١	0	l o	0	4. 00
5. 00	0.00		١		0	١	Ö	5. 00
	0.00		0		0	0		
6.00			0	0	0	0	0	6. 00
7.00	0. 00		0	0	0	0	0	7. 00
8. 00	0. 00		0	0	0	0	0	8. 00
9.00	0.00		0	0	0	0	0	9. 00
10.00	0.00		0	0	0	0	0	10.00
200.00			98, 734	4, 937	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		Identi 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		EMPLOYEE BENEFITS DEPARTMENT	10.00	98, 734				1. 00
2.00		ADMINISTRATIVE & GENERAL	١	0,754		· ·		2. 00
3.00		OPERATING ROOM		0	0			3. 00
			0	0	_			
4.00	0. 00		0	0	0	0		4. 00
5.00	0. 00		0	0	0	0		5. 00
6.00	0. 00		0	0	0	0		6. 00
7.00	0. 00		0	0	0	0		7. 00
8.00	0. 00		0	0	0	0		8. 00
9.00	0.00		0	0	0	0		9. 00
10.00	0.00		0	0	0	0		10. 00
200.00			Ö	98, 734	0	1, 097, 991		200. 00
	1	ı	'	1 , , , , ,	'	1 1/=::///	1	

COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0193 Peri od: Worksheet B From 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/31/2024 10:50 am CAPITAL RELATED COSTS Cost Center Description Net Expenses BLDG & FIXT MVBLE EQUIP **EMPLOYEE** Subtotal for Cost **BENEFITS** DEPARTMENT Allocation (from Wkst A col. 7) 1.00 2.00 4. 00 4A GENERAL SERVICE COST CENTERS 1 00 1 00 00100 CAP REL COSTS-BLDG & FLXT 5, 515, 653 5, 515, 653 2.00 00200 CAP REL COSTS-MVBLE EQUIP 3, 798, 931 3, 798, 931 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 2, 276, 328 338, 829 233, 370 2, 848, 527 4.00 00500 ADMINISTRATIVE & GENERAL 240. 684 10, 501, 396 5.00 5 00 9, 730, 721 349, 448 180 543 00700 OPERATION OF PLANT 7.00 1, 769, 830 561, 176 386, 512 158, 891 2, 876, 409 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 167, 120 65, 481 45, 100 2,026 279, 727 8.00 9.00 00900 HOUSEKEEPI NG 676, 484 118, 199 81, 410 140, 557 1,016,650 9.00 01000 DI ETARY 211, 980 43, 734 10 00 88.316 63, 497 10 00 16, 433 11.00 01100 CAFETERI A 473, 949 539, 509 371, 590 139, 645 1, 524, 693 11.00 01300 NURSING ADMINISTRATION 820, 454 369, 934 254, 794 299, 116 1, 744, 298 13.00 13.00 01400 CENTRAL SERVICES & SUPPLY 470, 874 530, 393 365, 310 184, 578 1, 551, 155 14.00 14.00 01500 PHARMACY 674, 740 15.00 15.00 278.839 129, 997 89, 536 176, 368 16.00 01600 MEDICAL RECORDS & LIBRARY 86, 367 86, 367 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 980, 770 435, 297 3, 476, 084 30.00 1, 384, 507 675, 510 30.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 3, 140, 857 5, 700, 922 50.00 1, 120, 850 771, 990 667, 225 52.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 05400 RADI OLOGY-DI AGNOSTI C 188, 639 707, 040 54.00 211, 362 273, 884 54.00 33, 155 06000 LABORATORY 60.00 14, 914 73,686 50, 752 139, 352 60.00 662, 171 06500 RESPIRATORY THERAPY 500, 185 161, 986 65.00 0 65.00 66.00 06600 PHYSI CAL THERAPY 156, 158 0 232, 826 66.00 76, 668 06700 OCCUPATI ONAL THERAPY 67.00 0 0 67.00 0 0 0 68.00 06800 SPEECH PATHOLOGY 0 C 0 Ω 68.00 06900 ELECTROCARDI OLOGY 69.00 13, 486 4,866 18, 352 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 5, 103, 853 0 0 0 5, 103, 853 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72.00 8, 495, 603 0 0 8, 495, 603 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 345, 638 0 0 345, 638 73.00 07700 ALLOGENEIC HSCT ACQUISITION 0 o 77.00 0 0 O 77.00 07800 CAR T-CELL IMMUNOTHERAPY 0 78.00 0 0 78.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 0 0 0 0 90.00 09100 EMERGENCY 0 0 0 91.00 91.00 0 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 0 OTHER REIMBURSABLE COST CENTERS 102.00 10200 OPI OI D TREATMENT PROGRAM 0 0 0 0 0 102. 00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 45, 520, 429 5, 515, 653 3, 798, 931 2, 677, 354 45, 349, 256 118. 00 NONREIMBURSABLE COST CENTERS 190. 00 19000 GLFT FLOWER COFFEE SHOP & CANTEEN 2, 177 190. 00 2, 177 0 192.00 19200 PHYSICIANS PRIVATE OFFICES 465,605 0 0 127, 801 593, 406 192. 00 194.00 07950 OTHER NRCC 4, 959, 931 0 43, 372 5, 003, 303 194. 00 0 200.00 Cross Foot Adjustments 0 200. 00

50, 948, 142

5, 515, 653

3, 798, 931

2, 848, 527

0 201. 00

50, 948, 142 202. 00

201 00

202.00

Negative Cost Centers

TOTAL (sum lines 118 through 201)

| Peri od: | Worksheet B | From 01/01/2023 | Part | | To 12/31/2023 | Date/Time Prepared: | To 12/31/2023 | Date/Time Prepared: | To 12/31/2024 | To 12/31/202 Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0193

				10	3 12/31/2023	Date/IIme Pre 5/31/2024 10:	
	Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	50 diii
		& GENERAL	PLANT	LINEN SERVICE		_,_,,,,,,	
		5. 00	7. 00	8. 00	9. 00	10.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	10, 501, 396					5. 00
7.00	00700 OPERATION OF PLANT	746, 816	3, 623, 225				7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	72, 627	23, 948	376, 302			8. 00
9.00	00900 HOUSEKEEPI NG	263, 958	43, 228	0	1, 323, 836		9. 00
10.00	01000 DI ETARY	55, 037	0	0	0	267, 017	10.00
11.00	01100 CAFETERI A	395, 864	220, 533	0	82, 099	0	11. 00
13.00	01300 NURSING ADMINISTRATION	452, 881	135, 293	0	50, 367	0	13.00
14. 00	01400 CENTRAL SERVICES & SUPPLY	402, 734	193, 977		72, 213	0	14. 00
15. 00	01500 PHARMACY	175, 186	47, 543	·	17, 699	0	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	22, 424	0	o	O	0	16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS				-1		
30.00	03000 ADULTS & PEDI ATRI CS	902, 513	358, 690	52, 275	133, 532	267, 017	30.00
	ANCILLARY SERVICE COST CENTERS		·		· '		
50.00	05000 OPERATI NG ROOM	1, 480, 159	409, 920	74, 429	152, 604	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0	0	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	183, 572	100, 166	0	37, 289	0	54.00
60.00	06000 LABORATORY	36, 181	26, 949		10, 032	0	60.00
65.00	06500 RESPIRATORY THERAPY	171, 923	0	o	0	0	65.00
66. 00	06600 PHYSI CAL THERAPY	60, 450	0	o	o	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	0	o	o	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0	o	o	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	4, 765	0	o	o	0	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 325, 139	0	0	o	0	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	2, 205, 760	0	0	o	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	89, 740	0	0	o	0	73. 00
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	0	0	o	0	77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0	0	0	o	0	78. 00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	0	0	0	0	90. 00
91.00	09100 EMERGENCY	0	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
	OTHER REIMBURSABLE COST CENTERS						
102.00	10200 OPIOID TREATMENT PROGRAM	0	0	0	0	0	102. 00
	SPECIAL PURPOSE COST CENTERS						
113.00	11300 I NTEREST EXPENSE						113. 00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	9, 047, 729	1, 560, 247	165, 708	555, 835	267, 017	118. 00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT FLOWER COFFEE SHOP & CANTEEN	565	0	0	0	0	190. 00
192.00	19200 PHYSICIANS PRIVATE OFFICES	154, 069	0	0	0	0	192. 00
194.00	07950 OTHER NRCC	1, 299, 033	2, 062, 978	210, 594	768, 001	0	194. 00
200.00	Cross Foot Adjustments						200. 00
201.00	Negative Cost Centers	0	0	0	0		201. 00
202.00	TOTAL (sum lines 118 through 201)	10, 501, 396	3, 623, 225	376, 302	1, 323, 836	267, 017	202. 00

In Lieu of Form CMS-2552-10

Period:	Worksheet B
From 01/01/2023	Part
To 12/31/2023	Date/Time Prepared:
5/31/2024	10:50 am

					5/31/2024 10:	50 am
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		ADMI NI STRATI ON	SERVICES &		RECORDS &	
			SUPPLY		LI BRARY	
	11. 00	13.00	14.00	15. 00	16. 00	
GENERAL SERVICE COST CENTERS						
1.00 O0100 CAP REL COSTS-BLDG & FLXT						1. 00
2.00 O0200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00 00500 ADMINISTRATIVE & GENERAL						5. 00
7.00 00700 OPERATION OF PLANT						7. 00
8.00 00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00 00900 HOUSEKEEPI NG						9. 00
10. 00 01000 DI ETARY						10.00
11. 00 01100 CAFETERI A	2, 223, 189					11. 00
13.00 01300 NURSING ADMINISTRATION	277, 899	2, 660, 738				13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	277, 899		2, 536, 982			14. 00
15. 00 01500 PHARMACY	138, 949	ol ol	420	1, 054, 537		15. 00
16.00 01600 MEDICAL RECORDS & LIBRARY	C	1	0	0	108, 791	16. 00
INPATIENT ROUTINE SERVICE COST CENTERS	<u>'</u>			,		
30. 00 03000 ADULTS & PEDI ATRI CS	451, 585	1, 275, 382	1, 133	0	1, 847	30. 00
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	729, 483	1, 385, 356	27, 681	0	48, 063	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	C	0	0	0	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	34, 737	o o	57	0	1, 028	54.00
60. 00 06000 LABORATORY	C	o	4	0	2, 863	60.00
65. 00 06500 RESPI RATORY THERAPY	173, 687	rl ol	94	0	860	65. 00
66. 00 06600 PHYSI CAL THERAPY	69, 475	ol ol	0	0	1, 603	66.00
67. 00 06700 OCCUPATIONAL THERAPY	C	ol ol	0	0	0	67. 00
68. 00 06800 SPEECH PATHOLOGY		ol ol	0	o	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	C	ol ol	0	0	82	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	г І с	ol ol	940, 080	0	13, 414	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	C	ol ol	1, 564, 320	0	35, 617	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	C	ol ol	0	1, 054, 537	3, 414	73. 00
77.00 07700 ALLOGENEIC HSCT ACQUISITION		ol ol	0	0	0	77. 00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	C	ol ol	Ö	o	0	78. 00
OUTPATIENT SERVICE COST CENTERS				-1		
90. 00 09000 CLI NI C	C	ol ol	0	0	0	90.00
91. 00 09100 EMERGENCY	C	ol ol	0	o	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	r i					92.00
OTHER REIMBURSABLE COST CENTERS	'	'	· · · · · · · · · · · · · · · · · · ·	<u>'</u>		
102.00 10200 OPI OI D TREATMENT PROGRAM	C	ol	0	0	0	102. 00
SPECIAL PURPOSE COST CENTERS	<u> </u>	·		'		
113. 00 11300 INTEREST EXPENSE						113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 1	117) 2, 153, 714	2, 660, 738	2, 533, 789	1, 054, 537	108, 791	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN	l C	0	34	0	0	190. 00
192.00 19200 PHYSICIANS PRIVATE OFFICES	69, 475	ol ol	0	o	0	192. 00
194. 00 07950 OTHER NRCC	C	ol ol	3, 159	o	0	194. 00
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	C	ol ol	0	o	0	201. 00
202.00 TOTAL (sum lines 118 through 201)	2, 223, 189	2, 660, 738	2, 536, 982	1, 054, 537	108, 791	202. 00
	•		'	'		

Provider CCN: 15-0193

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

				То	12/31/2023 Date/Time I 5/31/2024	
	Cost Center Description	Subtotal	Intern &	Total	5/31/2024	10. 50 alli
	oost center bescriptron		Residents Cost	Total		
		ľ	& Post			
			Stepdown			
			Adjustments			
		24.00	25.00	26. 00		
	GENERAL SERVICE COST CENTERS					
1.00	00100 CAP REL COSTS-BLDG & FLXT					1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP					2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT					4. 00
5.00	00500 ADMINISTRATIVE & GENERAL					5. 00
7.00	00700 OPERATION OF PLANT					7. 00
8.00	00800 LAUNDRY & LINEN SERVICE					8. 00
9.00	00900 HOUSEKEEPI NG					9. 00
10.00	01000 DI ETARY					10. 00
11. 00	01100 CAFETERI A					11. 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
	INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00	03000 ADULTS & PEDI ATRI CS	6, 920, 058	0	6, 920, 058		30. 00
F0 00	ANCILLARY SERVICE COST CENTERS	10.000 (17		10 000 (17		- FO 00
50.00	05000 OPERATI NG ROOM	10, 008, 617	0	10, 008, 617		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0		52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 063, 889	0	1, 063, 889		54.00
60.00	06000 LABORATORY	215, 381	0	215, 381		60.00
65.00	06500 RESPI RATORY THERAPY	1, 008, 735	0	1, 008, 735		65. 00
66.00	06600 PHYSI CAL THERAPY	364, 354	0	364, 354		66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	0		67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0	0		68. 00
69. 00	06900 ELECTROCARDI OLOGY	23, 199	0	23, 199		69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	7, 382, 486	0	7, 382, 486		71. 00
	07200 I MPL. DEV. CHARGED TO PATIENTS	12, 301, 300	0	12, 301, 300		72. 00
	07300 DRUGS CHARGED TO PATIENTS	1, 493, 329	0	1, 493, 329		73. 00
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	0	0		77. 00
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0	0	0		78. 00
90. 00	OUTPATIENT SERVICE COST CENTERS	٥	0	0		90.00
90.00	09000 CLI NI C 09100 EMERGENCY	0	0	0		91.00
		٥	0	U		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS		υ			92.00
102.00	10200 OPLOLD TREATMENT PROGRAM	0	0	0		102. 00
102.00	SPECIAL PURPOSE COST CENTERS	<u> </u>	U _I	U		102.00
113 00	11300 I NTEREST EXPENSE					113. 00
118.00	l	40, 781, 348	o	40, 781, 348		118. 00
	NONREI MBURSABLE COST CENTERS	107 70 17 0 10		10, 70., 0.0		
190.00	19000 GIFT FLOWER COFFEE SHOP & CANTEEN	2, 776	0	2, 776		190. 00
	19200 PHYSICIANS PRIVATE OFFICES	816, 950	O	816, 950		192. 00
	07950 OTHER NRCC	9, 347, 068	O	9, 347, 068		194.00
200.00		0	Ö	0		200. 00
201.00	,	ol	Ö	Ö		201. 00
202.00	9	50, 948, 142	o	50, 948, 142		202. 00
		·	•			

| Peri od: | Worksheet B | From 01/01/2023 | Part | I | To | 12/31/2023 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS FRANCISCAN HEALTH ORTHOPEDIC CARMEL
Provider CCN: 15-0193

				То	12/31/2023	Date/Time Pre 5/31/2024 10:	
			CAPI TAL REI	ATED COSTS		373172024 10.	JO alli
	Cost Center Description	Di rectly	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
		Assigned New				BENEFI TS	
		Capi tal				DEPARTMENT	
		Related Costs	4.00	0.00			
	CENEDAL CEDALCE COCT CENTEDO	0	1. 00	2.00	2A	4. 00	
1. 00	GENERAL SERVICE COST CENTERS OO100 CAP REL COSTS-BLDG & FIXT	I			T		1.00
2. 00	00200 CAP REL COSTS-BLDG & FIXT						2.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	338, 829	233, 370	572, 199	572, 199	4. 00
5. 00	00500 ADMI NI STRATI VE & GENERAL	0	349, 448		590, 132	36, 267	5.00
7. 00	00700 OPERATION OF PLANT	0	561, 176		947, 688	31, 917	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	65, 481	45, 100	110, 581	407	8.00
9. 00	00900 HOUSEKEEPI NG	0	118, 199	· ·	199, 609	28, 234	9. 00
10.00	01000 DI ETARY	0	63, 497		107, 231	3, 301	10.00
11. 00	01100 CAFETERI A	0	539, 509		911, 099	28, 051	11. 00
13.00	01300 NURSING ADMINISTRATION	0	369, 934		624, 728	60, 085	13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	530, 393	365, 310	895, 703	37, 077	14. 00
15.00	01500 PHARMACY	0	129, 997	89, 536	219, 533	35, 428	15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	0	980, 770	675, 510	1, 656, 280	87, 441	30. 00
	ANCILLARY SERVICE COST CENTERS						
50. 00	05000 OPERATI NG ROOM	0	1, 120, 850	· ·	1, 892, 840	134, 030	50. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0	-	0	0	52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	273, 884		462, 523	6, 660	54.00
60. 00 65. 00	06000 LABORATORY 06500 RESPI RATORY THERAPY	0	73, 686 0		124, 438 0	0 32, 539	60. 00 65. 00
66. 00	06600 PHYSI CAL THERAPY	0	0		0	15, 401	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0		0	15, 401	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0	-	o	0	68.00
69. 00	06900 ELECTROCARDI OLOGY	0	0		Ö	977	69.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	ol	0	71.00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	Ö	ol	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	o	0	73. 00
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0	0	0	o	0	77. 00
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78. 00
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLI NI C	0	0		0	0	90. 00
91.00	09100 EMERGENCY	0	0	0	0	0	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART				0		92. 00
	OTHER REIMBURSABLE COST CENTERS	_	_		_1		
102.00	10200 OPI OI D TREATMENT PROGRAM	0	0	0	0	0	102. 00
112 00	SPECIAL PURPOSE COST CENTERS				1		1112 00
	11300 INTEREST EXPENSE		E E1E (E2	2 700 021	0 214 504	E27 01E	113.00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	0	5, 515, 653	3, 798, 931	9, 314, 584	537, 815	1118.00
100 00	19000 GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	ol	0	190. 00
	19200 PHYSICIANS PRIVATE OFFICES	0	0		o	25, 672	
	07950 OTHER NRCC		0	0	0		194. 00
200.00			0		ol	0, 712	200. 00
201.00			0	o	ol	0	201. 00
202.00	9	0	5, 515, 653	3, 798, 931	9, 314, 584	572, 199	
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Health Financial Systems FRANCISCAN HEALTH ORTHOPEDIC CARMEL In Lieu of Form CMS-2552-10

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0193 | Period: From 01/01/2023 | Part II | To 12/31/2023 | Date/Time Prepared: 5/31/2024 10: 50 am

COST CENTER DESCRIPTION ADMINISTRATIVE DEPARTION OF LAUNDRY SIZE DISCRIPTING					10	12/31/2023	5/31/2024 10:	
CENERAL SERVICE COST CENTERS S.00 7.00 8.00 9.00 10.00		Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG		00 (
CEMBERAL SERVICE COST CENTERS			-					
GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLYT 2.00 00200 CAP REL COSTS-BLDG & FLYT 3.00 00200 CAP REL COSTS-BLDG & FLYT 5.00 00200 CAP REL COSTS-MARGE EQUIP 9 4.00 00400 CAP DEL COSTS-MARGE EQUIP 9 5.00 00500 CAP REL COSTS-MARGE EQUIP 9 5.00 00500 CAP REL COSTS-MARGE EQUIP 9 6.00 00500 CAP REL COSTS-MARGE EQUIP 9 6.00 00500 CAP REL COSTS-MARGE EQUIP 9 7.00 00700 OPERATION OF PLANT 44, 547 1, 024, 152 7.00 0.00 0.00 0000 CHAUMORY & LINEN SERVICE 4, 332 6, 769 122, 009 8 8.00 00600 LAUMORY & LINEN SERVICE 4, 332 6, 769 122, 009 0 8.00 00000 CHOUSEKEEPIN 2 8.00 010000 DISTARY 3, 283 0 0 0 113, 815 10.00 11.00 1100 CAPTERIA SERVICE 3, 283 0 0 0 113, 815 10.00 11.00 1100 CAPTERIA SERVICE 3, 283 0 0 0 113, 815 10.00 11.00 1100 CAPTERIA SERVICES & SUPPLY 2, 023 54, 830 12, 655 13, 954 0 14.00 15.00 1500 CAPTERIA SERVICES & SUPPLY 24, 023 54, 830 12, 655 13, 954 0 14.00 15.00 1500 CAPTERIA SERVICES & SUPPLY 3, 383 0 0 3, 420 0 15.00 1500 CAPTERIA SERVICES & SUPPLY 3, 383 0 0 3, 420 0 15.00 1500 CAPTERIA SERVICES & SUPPLY 3, 383 0 0 3, 420 0 15.00 1500 CAPTERIA SERVICES & SUPPLY 3, 383 0 0 3, 420 0 15.00 1500 CAPTERIA SERVICES & SUPPLY 3, 383 0 0 3, 420 0 15.00 1500 CAPTERIA SERVICES & SUPPLY 3, 383 0 0 0 3, 420 0 15.00 1500 CAPTERIA SERVICES & SUPPLY 3, 383 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				7. 00		9. 00	10.00	
1.00		GENERAL SERVICE COST CENTERS						
4. 00 0.0400 CMPLOYEE BENEFITS DEPARTMENT	1.00							1.00
4. 00 0.0400 CMPLOYEE BENEFITS DEPARTMENT	2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
5.00 00500 ADMINISTRATIVE & GENERAL 6.26, 399	4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
7. 00 7.			626, 399					
8.00 00800 LANINDRY & LINEN SERVICE				1, 024, 152				
9. 00 0. 00000 00000 00000 00000 00000 00000 00000 000000								
10.00 01000 015TARY 3, 283 0 0 0 113, 815 10.00 11.00 11.00 11.00 11.00 CAFETERI A 23, 613 62, 337 0 15, 864 0 11.00 11.00 11.00 11.00 CAFETERI A 23, 613 62, 337 0 15, 864 0 11.00 11.00 11.00 11.00 CAFETERI A 24, 023 54, 830 12, 655 13, 954 0 14, 00 14.00 14.00 CENTRAL SERVICES & SUPPLY 24, 023 54, 830 12, 655 13, 954 0 14, 00 14.00 1					· ·	255 807		
11. 00 0100 0100 0100 0200 0200 0200 0200 0100 0200							113 815	
13. 00 01300 NURSI NG ADMINISTRATION 27, 014 38, 242 0 9, 732 0 13. 00 14. 00 11400 CENTRAL SERVICES & SUPPLY 24, 023 54, 803 12, 655 13, 954 0 14, 00 16. 00 01500 PHARMACY 10, 450 13, 439 0 0 0 0 0 16. 00 10500 PHARMACY 10, 450 13, 439 0 0 0 0 0 10. 00 10500 PHARMACY 10, 450 13, 439 0 0 0 0 0 10. 00 10500 PHARMACY 10, 450 13, 439 0 0 0 0 0 0 10. 00 10500 PHARMACY 1, 338 0 0 0 0 0 0 10. 00 10500 PHARMACY 1, 338 0 0 0 0 0 0 10. 00 10500 PHARMACY 1, 338 0 0 0 0 0 10. 00 10500 PHARMACY 1, 338 0 0 0 0 0 10. 00 10500 PHARMACY 1, 338 0 0 0 0 0 10. 00 10500 PHARMACY 1, 338 0 0 0 0 0 10. 00 10500 PHARMACY 1, 338 0 0 0 0 0 10. 00 10500 PHARMACY 1, 338 0 0 0 0 0 10. 00 10500 PHARMACY 1, 338 0 0 0 0 0 10. 00 10500 PHARMACY 1, 338 0 0 0 0 0 10. 00 10. 00 1, 348 1, 348 0 0 0 0 0 10. 00 10. 00 1, 348 0 0 0 0 0 10. 00 10. 00 1, 348 0 0 0 0 0 10. 00 10. 00 1, 348 0 0 0 0 0 10. 00 10. 00 1, 348 0 0 0 0 0 10. 00 10. 00 1, 348 0 0 0 0 0 10. 00 10. 00 1, 348 0 0 0 0 0 0 10. 00 10. 00 1, 348 0 0 0 0 0 0 10. 00 10. 00 1, 348 0 0 0 0 0 0 10. 00 10. 00 1, 348 0 0 0 0 0 0 10. 00 10. 00 1, 348 0 0 0 0 0 0 10. 00 10. 00 10. 00 10. 00 0 0 0 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 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				_	-	15 864	· ·	
14. 00		l l					-	
15.00 01500 PHARMACY								
16.00 16.00 16.00 16.00 16.00 16.00 16.00							-	
INPATIENT ROUTI NE SERVICE COST CENTERS		1						1
30.00 03000 ADULTS & PEDI ATRICS 53,834 101,388 16,960 25,803 113,815 30.00	10.00		1, 330	U	U	<u> </u>	0	10.00
ANCI LLARY SERVICE COST CENTERS	20 00		F2 024	101 200	16 060	25 003	112 015	20 00
50.00	30.00		33, 634	101, 300	10, 700	25, 603	113, 013	30.00
52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0 0 0 0 52.00	50 00		99 200	115 060	24 140	20 400	0	50 00
54. 00		1	00, 290					
60. 00 06000 LABORATORY 2, 158 7, 617 0 1, 939 0 60. 00 65. 00 06500 06500 RESPI RATORY THERAPY 10, 255 0 0 0 0 0 65. 00 66. 00 06600 PHYSI CAL THERAPY 3, 606 0 0 0 0 0 0 67. 00 06700 0CCUPATI ONAL THERAPY 0 0 0 0 0 0 0 68. 00 06800 SPEECH PATHOLOGY 0 0 0 0 0 0 0 69. 00 06900 ELECTROCARDI OLOGY 284 0 0 0 0 0 0 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 79, 043 0 0 0 0 0 0 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 131, 571 0 0 0 0 0 0 73. 00 07300 DRUGS CHARGED TO PATIENTS 5, 353 0 0 0 0 0 0 74. 00 07300 DRUGS CHARGED TO PATIENTS 5, 353 0 0 0 0 0 0 75. 00 07300 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 0 0 0 76. 00 09000 CLINIC 0 0 0 0 0 0 77. 00 07000 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 0 0 78. 00 09000 CLINIC 0 0 0 0 0 0 79. 00 09000 CLINIC 0 0 0 0 0 0 79. 00 09000 CLINIC 0 0 0 0 0 79. 00 09000 CLINIC 0 0 0 0 0 79. 00 09000 CLINIC 0 0 0 0 0 70. 00 09000 00 0 0 0 70. 00 00 00 0 0 0 70. 00 00 00 0 0 70. 00 00 00 0 0 70. 00 00 00 0 70. 00 00 00 0 0 70. 00 00 00 0 70. 00 00 00 0 70. 00 00 00 0 0 70. 00 00 00 00 0 70. 00 00 00 00 0 70. 00 00 00 00 00 70. 00 00 00 00 70. 00 00 00 00 70. 00 00 00 00 70. 00 00 00			10.050	_	_	٩		02.00
65. 00							-	
66. 00							-	
67. 00 06700 0CCUPATIONAL THERAPY 0 0 0 0 0 0 67. 00 68. 00 06800 SPEECH PATHOLOGY 0 0 0 0 0 0 68. 00 69. 00 06900 ELECTROCARDIOLOGY 284 0 0 0 0 0 69. 00 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 79,043 0 0 0 0 0 0 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 131,571 0 0 0 0 0 0 73. 00 07300 DRUGS CHARGED TO PATIENTS 5,353 0 0 0 0 0 0 77. 00 07700 ALLOGENEIC HSCT ACQUISITION 0 0 0 0 0 0 78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 0 0 78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 0 79. 00 09000 CLINIC 0 0 0 0 0 0 79. 00 09000 CLINIC 0 0 0 0 0 79. 00 09000 DINIC 0 0 0 0 0 79. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 0 0 0 0 70HER REIMBURSABLE COST CENTERS 0 0 0 0 0 70HORD REPORT OF THE NEW SABLE COST CENTERS 0 0 0 0 0 70HORD REPORT OF THE NEW COFFEE SHOP & CANTEEN 34 0 0 0 0 0 70HORD REPORT OF THE NEW COFFEE SHOP & CANTEEN 34 0 0 0 0 70HORD REPORT OF THE NEW COFFEE SHOP & CANTEEN 34 0 0 0 0 70HORD REPORT OF THE NEW COFFEE SHOP & CANTEEN 34 0 0 0 0 70HORD REPORT OF THE NECC 77,486 583,129 68,326 148,402 0 194.00 70HORD REPORT OF THE NECC 77,486 583,129 68,326 148,402 0 194.00 70HORD REPORT OF THE NECC 77,486 583,129 68,326 148,402 0 194.00 70HORD REPORT OF THE NECC 77,486 583,129 68,326 148,402 0 194.00 70HORD REPORT OF THE NECC 77,486 583,129 68,326 148,402 0 194.00 70HORD REPORT OF THE NECC 77,486 583,129 68,326 148,402 0 194.00 70HORD REPORT OF THE NECC 77,486 583,129 68,326 148,402 0 194.00 70HORD REPORT OF THE NECC 77,486 583,129 68,326 148,402 0 194.00 70HORD REPORT OF THE NECC 77,486 783,129 783,129 783,129 783,129 783,129 783,129 783,129 783,129 783,129 7		1				O O		
68. 00 06800 SPEECH PATHOLOGY 0 0 0 0 0 68. 00 69. 00 06900 ELECTROCARDI OLOGY 284 0 0 0 0 0 69. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 79, 043 0 0 0 0 0 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 131, 571 0 0 0 0 0 73. 00 07300 DRUGS CHARGED TO PATIENTS 5, 353 0 0 0 0 0 77. 00 07700 ALLOGENEI C HSCT ACQUISITION 0 0 0 0 0 78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 0 0 79. 00 07900 CLINIC 0 0 0 0 0 0 79. 00 09000 CLINIC 0 0 0 0 0 79. 00 09000 CLINIC 0 0 0 0 79. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92. 00 79. 00 09200 OPIOLO IN TEATMENT PROGRAM 0 0 0 0 70. 00 09200 OPIOLO IN TEATMENT PROGRAM 0 0 0 0 70. 00 09200 OPIOLO IN TEATMENT PROGRAM 0 0 0 0 70. 00 09200 OPIOLO IN TEATMENT PROGRAM 0 0 0 0 70. 00 09000 OPIOLO IN TEATMENT PROGRAM 0 0 0 0 70. 00 09000 OPIOLO IN TEATMENT PROGRAM 0 0 0 0 70. 00 09000 OPIOLO IN TEATMENT PROGRAM 0 0 0 0 70. 00 09000 OPIOLO IN TEATMENT PROGRAM 0 0 0 0 70. 00 09000 OPIOLO IN TEATMENT PROGRAM 0 0 0 0 70. 00 09000 OPIOLO IN TEATMENT PROGRAM 0 0 0 0 70. 00 09000 OPIOLO IN TEATMENT PROGRAM 0 0 0 0 70. 00 09000 OPIOLO IN TEATMENT PROGRAM 0 0 0 0 70. 00 09000 OPIOLO IN TEATMENT PROGRAM 0 0 0 0 70. 00 09000 OPIOLO IN TEATMENT PROGRAM 0 0 0 0 70. 00 09000 OPIOLO IN TEATMENT PROGRAM 0 0 0 0 70. 00 09000 OPIOLO IN TEATMENT PROGRAM 0 0 0 0 70. 00 09000 OPIOLO IN TEATMENT PROGRAM 0 0 0 0 70. 00 09000 09000 09000 09000 09000 09000 09000 09000 09000 70. 00 09000		1	3,000	0		o o	-	
69. 00 06900 ELECTROCARDI OLOGY 284 0 0 0 0 0 0 0 0 69. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 79, 043 0 0 0 0 0 0 0 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 131, 571 0 0 0 0 0 0 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 5, 353 0 0 0 0 0 0 0 73. 00 77. 00 07700 ALLOGENEI C HSCT ACQUISITION 0 0 0 0 0 0 0 0 77. 00 78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 0 0 0 0 0 0 79. 00 0000 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 0 0 0 0 0 0 0 0 0 79. 00 09000 CLINIC 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1	0	0	0	U O	-	
71. 00		1	204	0	0	U O	-	1
72. 00		1		0	0	U O		1
73. 00				0	0	U		
77. 00				0	0	U		
78. 00				_	_	U	-	
OUTPATIENT SERVICE COST CENTERS O			_	_	_	٩	-	
90. 00	78.00		0	0	U	U	0	/8.00
91. 00	00.00			0		ما	0	00 00
92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART 92. 00 0THER REIMBURSABLE COST CENTERS 92. 00 0 0 0 0 0 0 0 0 0			0	_		-		
OTHER REIMBURSABLE COST CENTERS 102.00 10200 OPI OI D TREATMENT PROGRAM O O O O O O 102.00			0	0	0	٩	0	
102. 00 10200 OPI OI D TREATMENT PROGRAM O O O O O O O O O	92.00							92.00
SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 11300 INTEREST EXPENSE 113.00 11300 INTEREST EXPENSE 113.00 11300 SUBTOTALS (SUM OF LINES 1 through 117) 539,689 441,023 53,763 107,405 113,815 118.00 113	400.00					ام		
113. 00 118. 00 118. 00 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) S39, 689 441, 023 53, 763 107, 405 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19200 PHYSI CI ANS PRI VATE OFFICES 9, 190 00 194. 00 19700 OTHER NRCC 77, 486 583, 129 68, 326 148, 402 0194. 00 200. 00 Regative Cost Centers 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	102.00		0	0	0	0	0	102.00
118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 539, 689 441, 023 53, 763 107, 405 113, 815 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN 34 0 0 0 0 0 190. 00 192. 00 19200 PHYSI CI ANS PRI VATE OFFICES 9, 190 0 0 0 0 192. 00 194. 00 07950 OTHER NRCC 77, 486 583, 129 68, 326 148, 402 0 194. 00 200. 00 201. 00 Negative Cost Centers 0 0 0 0 0 0 201. 00					1	1		
NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN 34 0 0 0 0 190. 00 192. 00 19200 PHYSI CI ANS PRI VATE OFFICES 9, 190 0 0 0 0 194. 00 07950 OTHER NRCC 77, 486 583, 129 68, 326 148, 402 0 200. 00 Cross Foot Adjustments 200. 00 201. 00 Negative Cost Centers 0 0 0 0 0 201. 00 0 201. 00								
190. 00	118.00		539, 689	441, 023	53, 763	107, 405	113, 815]118. 00
192. 00 19200 PHYSICIANS PRIVATE OFFICES 9, 190 0 0 0 0 192. 00 194. 00 07950 OTHER NRCC 77, 486 583, 129 68, 326 148, 402 0 194. 00 200. 00 Cross Foot Adjustments 0 0 0 0 0 0 0 200. 00 201. 00 Negative Cost Centers 0 0 0 0 0 0 201. 00				_	-	_1		
194. 00 07950 OTHER NRCC 77, 486 583, 129 68, 326 148, 402 0 194. 00 200. 00 Cross Foot Adjustments 201. 00 0 0 0 0 0 0 201. 00						O		
200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 0 0 0 0 0 0 201.00				_	_	0		
201.00 Negative Cost Centers 0 0 0 0 201.00		1	77, 486	583, 129	68, 326	148, 402	0	
		1 1						
202.00 101AL (sum lines 118 through 201) 626,399 1,024,152 122,089 255,807 113,815 202.00			0	J		0		
	202. 00		626, 399	1, 024, 152	122, 089	255, 807	113, 815	J202. 00

FRANCISCAN HEALTH ORTHOPEDIC CARMEL
Provider CCN: 15-0193 | Period: | Worksheet B | From 01/01/2023 | Part II | To | 12/31/2023 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

				To	12/31/2023	Date/Time Pre 5/31/2024 10:	
	Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
			ADMI NI STRATI ON			RECORDS &	
				SUPPLY		LI BRARY	
		11. 00	13. 00	14. 00	15. 00	16. 00	
	GENERAL SERVICE COST CENTERS		1				
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINISTRATIVE & GENERAL						5. 00
7.00	00700 OPERATION OF PLANT						7. 00
8.00	00800 LAUNDRY & LINEN SERVICE						8. 00
9.00	00900 HOUSEKEEPI NG						9.00
10.00	01000 DI ETARY	1 040 074					10.00
11. 00	01100 CAFETERI A	1, 040, 964	000 000				11.00
13. 00 14. 00	01300 NURSI NG ADMI NI STRATI ON	130, 121	889, 922	1 1/0 2/2			13. 00 14. 00
	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	130, 121	0		247 524		
15. 00 16. 00	01600 MEDICAL RECORDS & LIBRARY	65, 060 0		194 0	347, 524 0	1 220	15. 00
16.00	I NPATIENT ROUTINE SERVICE COST CENTERS	U	l d	U	υĮ	1, 338	16. 00
30. 00	03000 ADULTS & PEDIATRICS	211, 446	426, 570	522	0	24	30.00
30.00	ANCI LLARY SERVI CE COST CENTERS	211, 440	420, 370	322	<u> </u>		30.00
50.00	05000 OPERATING ROOM	341, 566	463, 352	12, 748	ol	563	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0 11,7 000	0	0	o	0	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	16, 265	l ol	26	o	13	1
60.00	06000 LABORATORY	0	l ol	2	o	37	
65. 00	06500 RESPIRATORY THERAPY	81, 325	l ol	44	o	11	65. 00
66.00	06600 PHYSI CAL THERAPY	32, 530		0	o	20	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	ol	0	o	0	67. 00
68.00	06800 SPEECH PATHOLOGY	0	o	0	o	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	0	o	0	0	1	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	o	432, 939	0	171	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	o	720, 417	0	454	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	o	0	347, 524	44	73. 00
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0	o	0	0	0	77. 00
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78. 00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	0	0	0	0	90.00
91. 00	09100 EMERGENCY	0	0	0	0	0	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
	OTHER REIMBURSABLE COST CENTERS						
102.00	10200 OPI OI D TREATMENT PROGRAM	0	0	0	0	0	102. 00
	SPECIAL PURPOSE COST CENTERS		1		1		
	11300 INTEREST EXPENSE	4 000 404	000 000	4.44.000	0.47 50.4	4 000	113.00
118. 00	1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	1, 008, 434	889, 922	1, 166, 892	347, 524	1, 338	118. 00
100.00	NONREI MBURSABLE COST CENTERS	0	1 0	1/	٥١		100 00
	19000 GIFT FLOWER COFFEE SHOP & CANTEEN	22 520	0	16 0	0		190.00
	19200 PHYSICIANS PRIVATE OFFICES 07950 OTHER NRCC	32, 530	0	1, 455	0		192. 00 194. 00
200.00		0		1, 455	Ч	Ü	200. 00
200.00	,	0		0		0	200.00
201.00		1, 040, 964	889, 922	1, 168, 363	347, 524		201.00
202.00	1 1017/2 (Suil 111103 110 till ougil 201)	1,040,704	1 007, 722	1, 100, 303	347, 324	1, 330	1202.00

In Lieu of Form CMS-2552-10
Period: Worksheet B
From 01/01/2023 Part II
To 1/21/2022 Part/Time Propagate Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0193

Subtotal Intern & Total Residents Cost & Post Stepdown Adjustments Stepdown Adjustments Stepdown Adjustments Stepdown Adjustments Stepdown
Resi dents Cost & Post Stepdown Adj ustments 24.00 25.00 26.00
Stepdown Adj ustments 24.00 25.00 26.00
Adj ustments 24.00 25.00 26.00
24.00 25.00 26.00
GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 00700 OPERATION OF PLANT 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 00900 HOUSEKEEPING 9.00 10.00 01000 DIETARY 10.00 11.00 01100 CAFETERIA 11.00 11.0
1. 00
2. 00
4. 00
5. 00
7. 00
8. 00 00800 LAUNDRY & LI NEN SERVI CE
9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY 10. 00 11. 00 01100 CAFETERI A 11. 00
10. 00 01000 DI ETARY 10. 00 11. 00 01100 CAFETERI A 11. 00
11. 00 01100 CAFETERI A
13.00 01300 NURSI NG ADMI NI STRATI ON
14.00 01400 CENTRAL SERVICES & SUPPLY 14.00
15. 00 01500 PHARMACY 15. 00
16. 00 01600 MEDICAL RECORDS & LIBRARY 16. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS
30. 00 03000 ADULTS & PEDIATRICS 2, 694, 083 0 2, 694, 083 30. 00
ANCI LLARY SERVI CE COST CENTERS
50. 00 05000 0PERATI NG ROOM 3, 102, 894 0 3, 102, 894 50. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0 52.00
54. 00 05400 RADI 0LOGY-DI AGNOSTI C 531, 955 0 531, 955 54. 00
60. 00 06000 LABORATORY 136, 191 0 136, 191 60. 00
65. 00 06500 RESPI RATORY THERAPY 124, 174 0 124, 174 65. 00
66. 00 06600 PHYSI CAL THERAPY 51, 557 0 51, 557 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 1, 262 0 1, 262 69. 00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 512, 153 0 512, 153 71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 852, 442 0 852, 442 72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS 352, 921 0 352, 921 73. 00
77. 00 07700 ALLOGENEI C HSCT ACQUI SI TI ON 0 0 0 0 77. 00 07700 07
78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 78. 00 0 78. 00 0 0 78. 00
90. 00 09000 CLINI C 0 0 90. 00
91. 00 09100 EMERGENCY
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0 92. 00
OTHER REI MBURSABLE COST CENTERS
102. 00 10200 OPI 01 D TREATMENT PROGRAM 0 0 0 1 102. 00
SPECIAL PURPOSE COST CENTERS
113. 00 11300 I NTEREST EXPENSE 113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) 8,359,632 0 8,359,632 118.00
NONREI MBURSABLE COST CENTERS
190. 00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN 50 0 50 190. 00
192. 00 19200 PHYSI CI ANS PRI VATE OFFI CES 67, 392 0 67, 392 192. 00
194. 00 07950 OTHER NRCC 887, 510 0 887, 510 194. 00
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) 9,314,584 0 9,314,584 202.00

Health Financial Systems FRANCISCAN HEALTH ORTHOPEDIC CARMEL In Lieu of Form CMS-2552-10 COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0193 Peri od: Worksheet B-1 From 01/01/2023 12/31/2023 Date/Time Prepared: 5/31/2024 10:50 am CAPITAL RELATED COSTS Cost Center Description BLDG & FIXT MVBLE EQUIP **EMPLOYEE** Reconciliation ADMINISTRATIVE (SOUARE FEET) (SOUARE FEET) BENEFITS & GENERAL (ACCUM. COST) DEPARTMENT (GROSS SALARI ES) 1.00 2.00 5A 5. 00 GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS-BLDG & FLXT 102 848 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 102, 848 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 6, 318 6, 318 7, 513, 840 4.00 00500 ADMINISTRATIVE & GENERAL 5 00 6, 516 476, 236 -10, 501, 396 40, 446, 746 5 00 6 516 7.00 00700 OPERATION OF PLANT 10, 464 10, 464 419, 123 2, 876, 409 7.00 1, 221 8.00 00800 LAUNDRY & LINEN SERVICE 1, 221 5, 345 279, 727 8.00 0 9.00 00900 HOUSEKEEPI NG 2, 204 2, 204 370, 760 1,016,650 9.00 01000 DI ETARY 10.00 211, 980 1.184 10 00 1 184 43.348 11.00 01100 CAFETERI A 10,060 10,060 368, 356 0 1, 524, 693 11.00 01300 NURSING ADMINISTRATION 6,898 6, 898 789, 009 0 1, 744, 298 13.00 13.00 0 01400 CENTRAL SERVICES & SUPPLY 9,890 9, 890 486, 880 1, 551, 155 14.00 14.00 674, 740 15.00 01500 PHARMACY 2, 424 2, 424 465, 223 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 86, 367 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 30.00 18, 288 18, 288 1, 148, 226 0 3, 476, 084 30.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 20, 900 5, 700, 922 50.00 20, 900 1, 760, 003 0 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 05400 RADI OLOGY-DI AGNOSTI C 0 707, 040 54.00 5.107 5, 107 54.00 87, 455 06000 LABORATORY 60.00 1, 374 1, 374 139, 352 60.00 662, 171 06500 RESPIRATORY THERAPY 0 65.00 0 427, 286 65.00 0 66.00 06600 PHYSI CAL THERAPY 0 202, 236 232, 826 66.00 0 06700 OCCUPATI ONAL THERAPY 67.00 67.00 C 0 0 0 68.00 06800 SPEECH PATHOLOGY 0 C 0 Ω 68.00 06900 ELECTROCARDI OLOGY 69.00 0 0 12,836 0 0 18, 352 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 5, 103, 853 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 C 0 8, 495, 603 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 345, 638 73.00 07700 ALLOGENEIC HSCT ACQUISITION 0 o 77.00 C 0 Ω 77.00 07800 CAR T-CELL IMMUNOTHERAPY 78.00 0 0 0 78.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 0 0 90.00 09100 EMERGENCY 0 0 91.00 91.00 0 0 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 102.00 10200 OPI OI D TREATMENT PROGRAM 0 0 0 0 0 102. 00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 102, 848 102, 848 7, 062, 322 -10, 501, 396 34, 847, 860 118. 00 NONREIMBURSABLE COST CENTERS 190. 00 19000 GLFT FLOWER COFFEE SHOP & CANTEEN 2, 177 190. 00 0 192.00 19200 PHYSICIANS PRIVATE OFFICES 0 0 337, 112 0 593, 406 192. 00 194.00 07950 OTHER NRCC 0 0 5, 003, 303 194. 00 114, 406 200.00 Cross Foot Adjustments 200.00 Negative Cost Centers l201. 00 201 00 202.00 Cost to be allocated (per Wkst. B, 5, 515, 653 3, 798, 931 2, 848, 527 10, 501, 396 202. 00 Part I) 0. 259635 203. 00 203.00 Unit cost multiplier (Wkst. B, Part I) 53. 629171 36. 937335 0 379104 204.00 Cost to be allocated (per Wkst. B, 626, 399 204. 00 572, 199 Part II)

0.076153

0. 015487 205. 00

206.00

207.00

205.00

206.00

207.00

II)

(per Wkst. B-2)

Parts III and IV)

Unit cost multiplier (Wkst. B, Part

NAHE unit cost multiplier (Wkst. D,

NAHE adjustment amount to be allocated

Health Financial Systems FRANCISCAN HEALTH ORTHOPEDIC CARMEL In Lieu of Form CMS-2552-10 COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0193 Peri od: Worksheet B-1 From 01/01/2023 12/31/2023 Date/Time Prepared: 5/31/2024 10:50 am Cost Center Description OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY CAFETERI A LINEN SERVICE (TOTAL PATI PLANT (SQUARE FEET) (FTES) (SQUARE FEET) (POUNDS OF ENT DAYS) LAUNDRY) 10.00 7.00 9.00 11.00 8.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4 00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 00700 OPERATION OF PLANT 7.00 184, 732 7.00 00800 LAUNDRY & LINEN SERVICE 161, 059 8.00 1.221 8.00 00900 HOUSEKEEPI NG 9.00 2, 204 181, 307 9.00 10.00 01000 DI ETARY 576 10.00 11.00 01100 CAFETERI A 11, 244 11, 244 64 11.00 0 01300 NURSING ADMINISTRATION 6, 898 13.00 6,898 0 13.00 8 14.00 01400 CENTRAL SERVICES & SUPPLY 9,890 16, 694 9,890 0 8 14.00 15.00 01500 PHARMACY 2, 424 2, 424 0 15.00 01600 MEDICAL RECORDS & LIBRARY 0 16.00 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 18, 288 22, 374 18, 288 576 13 30.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 21 20, 900 31, 856 20, 900 50 00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 52.00 05400 RADI OLOGY-DI AGNOSTI C 5, 107 5, 107 0 54.00 54.00 C 60.00 06000 LABORATORY 1, 374 1, 374 0 0 60.00 0 06500 RESPIRATORY THERAPY O 65 00 0 Ω 5 65 00 66.00 06600 PHYSI CAL THERAPY 0 0 0 2 66.00 06700 OCCUPATIONAL THERAPY 67.00 0 0 0 0 0 0 0 0 67.00 68 00 06800 SPEECH PATHOLOGY 0 0 68 00 0 69.00 06900 ELECTROCARDI OLOGY C 0 0 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 71.00 71.00 0 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 0 0 0 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 73 00 Ω 0 0 73 00 07700 ALLOGENEIC HSCT ACQUISITION 0 0 77.00 0 0 77.00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 78.00 78.00 0 OUTPATIENT SERVICE COST CENTERS 90 00 90 00 0 Ω O 09000 CLI NI C 0 0 91.00 09100 EMERGENCY 0 C 0 0 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 102. 00 10200 OPI OI D TREATMENT PROGRAM 0 0 0 0 102, 00 0 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1 through 117) 70, 924 79, 550 76, 125 576 62 118. 00 118.00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN 0 190. 00 192.00 19200 PHYSICIANS PRIVATE OFFICES 0 2 192.00 0 194.00 07950 OTHER NRCC 0 194.00 105, 182 105, 182 90, 135 0

3, 623, 225

19.613413

1,024,152

5. 543988

376, 302

2. 336423

122, 089

0.758039

1, 323, 836

7.301627

255, 807

1.410905

267, 017

113, 815

200.00

201.00

206. 00

207.00

2, 223, 189 202. 00

1, 040, 964 204. 00

463. 571181 34, 737. 328125 203. 00

197. 595486 16, 265. 062500 205. 00

200.00

201.00

202.00

203.00

204.00

205.00

206.00

207.00

Cross Foot Adjustments

Cost to be allocated (per Wkst. B,

Cost to be allocated (per Wkst. B,

Unit cost multiplier (Wkst. B, Part

NAHE unit cost multiplier (Wkst. D,

Unit cost multiplier (Wkst. B, Part I)

NAHE adjustment amount to be allocated

Negative Cost Centers

Part I)

Part II)

(per Wkst. B-2)

Parts III and IV)

II)

Health Financial Systems	FRANCISCAN HEALTH ORTHOPEDIC CARMEL	In Lieu of Form CMS-2552-10
COCT ALLOCATION CTATICTICAL DACIC	D	David and Warehaland D 4

Cost Center Description	MS-2552-10
Cost Center Description	B-1
Cost Center Description	
Cost Center Description	
ADMINISTRATION SERVICES & SUPPLY (COSTED SUPPLY (CROSS & SUPPLY (CROSS SUPPLY (CRO	10: 50 am
CONTROL CONT	
CONTECT NUM	
SING) REDUIS CHARGES	
SEMERAL SERVICE COST CENTERS	
SEMERAL SERVICE COST CENTERS	
1.00	
2.00 00200 CAP REL COSTS-MYBLE EQUIP	—
1.00	1. 00
5.00	2. 00
7. 0.0 00700	4. 00
8. 00	5. 00
9.00 00900 HOUSEKEEPI NG 11.00 01100 CAFETERI NA 11.00 C	7. 00
10. 00 0.00000 0.00000 0.00000 0.00000 0.00000 0.000000 0.00000000	8. 00
11. 00	9. 00
13.00 01300 NURSI NG ADMINISTRATION 44, 493 14, 015, 057 15.00 01500 PHARMACY 0 14, 015, 057 15.00 01500 PHARMACY 0 0 0 0 0 0 0 0 0	10.00
14.00	11. 00
15.00 01500 PHARMACY 0 2,322 345,708 0 99,105,794 1000	13.00
15.00 01500 PHARMACY 0 2,322 345,708 0 99,105,794 1000	14. 00
16.00 0 0 0 0 0 0 0 99, 105, 794	15. 00
INPATIENT ROUTINE SERVICE COST CENTERS 21, 327 6, 258 0 1, 682, 343	16. 00
30.00 03000 ADULTS & PEDIATRICS 21,327 6,258 0 1,682,343 ANCILLARY SERVICE COST CENTERS	
ANCI LLARY SERVICE COST CENTERS	30.00
50.00 050000 050000 050000 050000 050000 050000 050000 050000 0500000 0500000 0500000	
52.00 05200 DELLIYERY ROOM & LABDR ROOM 0 0 0 0 0 0 0 0 0	— FO 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 315 0 936, 213 60. 00 06000 LABORATORY 0 23 0 2,607,378 65. 00 06500 RESPI RATORY THERAPY 0 522 0 783,290 66. 00 06600 PHYSI CAL THERAPY 0 0 0 0 1,459,900 67. 00 06700 OCCUPATI ONAL THERAPY 0 0 0 0 0 68. 00 06600 SPEECH PATHOLOGY 0 0 0 0 0 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 67. 00 06700 CCUPATI ONAL THERAPY 0 0 0 0 0 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 69. 00 07700 MEDICAL SUPPLIES CHARGED TO PATI ENT 0 5,193,294 0 12,216,469 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 8,641,764 0 32,437,870 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 345,708 3,109,325 77. 00 07700 ALLOGENEI C HSCT ACQUI SITION 0 0 0 0 78. 00 07800 CAR T-CELL I IMMUNOTHERAPY 0 0 0 0 0 79. 00 09000 CLI NI C 0 0 0 0 0 79. 00 09000 CLI NI C 0 0 0 0 79. 00 09000 CLI NI C 0 0 0 0 79. 00 09000 CLI NI C 0 0 0 0 79. 00 09000 DISTROMENTIAL ORDER OF THE ORDER ORDER OF THE ORDER	50.00
60. 00 06000 LABORATORY 0 23 0 2,607,378 65. 00 06500 RESPI RATORY THERAPY 0 0 522 0 783,290 66. 00 06600 PHYSI CAL THERAPY 0 0 0 0 1,459,900 67. 00 06700 0CCUPATI ONAL THERAPY 0 0 0 0 0 68. 00 06800 SPEECH PATHOLOGY 0 0 0 0 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 0 70. 00 0700 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0 5,193,294 0 12,216,469 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 8,641,764 0 32,437,870 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 8,641,764 0 32,437,870 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 345,708 3,109,325 77. 00 07700 ALLOGENEI C HSCT ACQUI SITION 0 0 0 0 78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 79. 00 09000 CLINIC 0 0 0 0 79. 00 09000 CLINIC 0 0 0 79. 00 09000 CLINIC 0 0 0 79. 00 09000 OSERVATI ON BEDS (NON-DISTINCT PART OTHER REI MBURSABLE COST CENTERS 113. 00 11300 INTEREST EXPENSE 113. 00 11300 INTEREST EXPENSE 113. 00 SUBTOTALS (SUM OF LINES 1 through 117) 44,493 13,997,417 345,708 99,105,794 NONREI MBURSABLE COST CENTERS 0 0 0 0 194. 00 07950 OTHER NRCC 0 17,451 0 0 194. 00 07950 OTHER NRCC 0 0 0 200. 00 Cross Foot Adjustments 0 0 0 0 201. 00 OCOST to be allocated (per Wkst. B, 2,660,738 2,536,982 1,054,537 108,791 203. 00 Unit cost multiplier (Wkst. B, Part I) 59. 801272 0 181018 3.050369 0.001098	52.00
65.00 06500 RESPIRATORY THERAPY 0 522 0 783,290 66.00 06600 PHYSI CAL THERAPY 0 0 0 0 0 67.00 06700 0CCUPATI ONAL THERAPY 0 0 0 0 68.00 06800 SPECH PATHOLOGY 0 0 0 0 69.00 06900 ELECTROCARDIOLOGY 0 0 0 0 67.10 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0 5, 193, 294 0 12, 216, 469 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 8, 641, 764 0 32, 437, 870 73.00 07300 DRUSS CHARGED TO PATI ENTS 0 8, 641, 764 0 32, 437, 870 75.00 07300 DRUSS CHARGED TO PATI ENTS 0 0 0 0 76.00 07700 ALLOGENEI C HSCT ACQUI SI TI ON 0 0 0 0 78.00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 0 79.00 07900 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 79.00 09900 CLI NI C 0 79.00 09900 EMERGENCY 0 0 0 0 0 79.00 09900 EMERGENCY 0 0 0 0 70 09100 DERROGENCY 0 0 0 0 70 09200 DRESERVATI ON BEDS (NON-DI STI NCT PART OTHER REI MBURSABLE COST CENTERS 113.00 1300 INTEREST EXPENSE 113.00 1300 INTEREST EXPENSE 113.00 10200 OPI OI D TREATMENT PROGRAM 0 0 0 70 0 0 0 0 70 0 0 0 70 0 0 0 70 0 0 0 70 0 0 0 70 0 0 0 70 0 0 0 70 0 0 0 70 0 0 0 70 0 0 0 70 0 0 0 71 0 0 0 72 0 0 0 0 73 0 0 0 74 625 0 0 0 74 625 0 0 75 0 0 0 0 76 0 0 0 77 0 0 0 0 77 0 0 0 0 78 0 0 0 0 79 0 0 0 0 79 0 0 0 0 79 0 0 0 0 70 0 0 0 0 70 0 0 0 71 0 0 0 0 75 0 0 0 0 76 0 0 0 0 77 0 0 0 0 78 0 0 0 0 79 0 0 0 0 79 0 0 0 0 70 0 0 0 0 70 0 0 0 0 70 0 0 0 70 0 0 0 0 70 0 0 0 0 70 0 0 0 70 0 0 0 0 70 0 0 0 0 70 0 0 0 0 70 0 0 0 0 70 0 0 0 0 71 0 0 0	54. 00
66.00 06600 PHYSI CAL THERAPY 0 0 0 0 1,459,900 67.00 0 0 0 0 0 0 0 0 0	60. 00
67. 00	65. 00
68. 00	66. 00
69. 00 06900 ELECTROCARDIOLOGY 0 0 74, 625 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0 5, 193, 294 0 12, 216, 469 72. 00 07200 MPL. DEV. CHARGED TO PATIENTS 0 8, 641, 764 0 32, 437, 870 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 345, 708 3, 109, 325 77. 00 07500 ALLOGENEI C HSCT ACQUISITION 0 0 0 0 0 0 0 0 0	67. 00
71. 00	68. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 8,641,764 0 32,437,870 37.00 773.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 345,708 3,109,325 077.00 07700 ALLOGENEIC NSCT ACQUISITION 0 0 0 0 0 0 0 0 0	69. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 8,641,764 0 32,437,870 37.00 773.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 345,708 3,109,325 077.00 07700 ALLOGENEIC NSCT ACQUISITION 0 0 0 0 0 0 0 0 0	71. 00
73. 00	72. 00
77. 00	73. 00
78. 00	77. 00
OUTPATI ENT SERVICE COST CENTERS O	78. 00
90. 00	70.00
91. 00	90.00
92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS 102. 00 10200 OPI OI D TREATMENT PROGRAM O O O O SPECI AL PURPOSE COST CENTERS 113. 00 1NTEREST EXPENSE 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 44, 493 13, 997, 417 345, 708 99, 105, 794 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN O 189 O O 192. 00 19200 PHYSI CI ANS PRI VATE OFFICES O O O 194. 00 07950 OTHER NRCC O 17, 451 O O 200. 00 Cross Foot Adjustments 201. 00 Negative Cost Centers 202. 00 Cost to be allocated (per Wkst. B, 2, 660, 738 2, 536, 982 1, 054, 537 108, 791 Part I) 203. 00 Unit cost multiplier (Wkst. B, Part I) 59. 801272 O. 181018 3. 050369 O. 001098	91.00
OTHER REIMBURSABLE COST CENTERS 102.00 10200 OPI 0I D TREATMENT PROGRAM O O O O O O O O O	
102.00 10200 OPI OI D TREATMENT PROGRAM O O O O O SPECIAL PURPOSE COST CENTERS 113.00 1 NTEREST EXPENSE SUBTOTALS (SUM OF LINES 1 through 117) 44, 493 13, 997, 417 345, 708 99, 105, 794 NONREI MBURSABLE COST CENTERS O O O O 190.00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN O 189 O O 192.00 19200 PHYSI CI ANS PRI VATE OFFICES O O O O 194.00 07950 OTHER NRCC O 17, 451 O O 200.00 Cross Foot Adjustments Negative Cost Centers 202.00 Cost to be allocated (per Wkst. B, Part I) 59, 801272 O. 181018 3. 050369 O. 001098	92. 00
SPECIAL PURPOSE COST CENTERS	—,,,,,,,,
113.00 118.00 11	102. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) 44,493 13,997,417 345,708 99,105,794	
NONREIMBURSABLE COST CENTERS 190. 00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN 0 189 0 0 0 192. 00 19200 PHYSI CI ANS PRI VATE OFFICES 0 0 0 0 0 0 0 0 0	113. 00
190.00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN 0 189 0 0 0 189 0 0 0 192.00	118. 00
192.00 19200 PHYSICIANS PRIVATE OFFICES	
194.00 07950 OTHER NRCC 0 17, 451 0 0 200.00 Cross Foot Adjustments Negative Cost Centers 202.00 Cost to be allocated (per Wkst. B, Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 59.801272 0.181018 3.050369 0.001098	190. 00
200.00 Cross Foot Adjustments Negative Cost Centers Cost to be allocated (per Wkst. B, Part I) Unit cost multiplier (Wkst. B, Part I) 59.801272 0.181018 3.050369 0.001098	192. 00
201.00 Negative Cost Centers 202.00 Cost to be allocated (per Wkst. B, Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 59.801272 0.181018 3.050369 0.001098	194. 00
201.00 Negative Cost Centers 202.00 Cost to be allocated (per Wkst. B, Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 59.801272 0.181018 3.050369 0.001098	200. 00
202.00 Cost to be allocated (per Wkst. B, Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 59.801272 0.181018 3.050369 0.001098	201. 00
Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 59.801272 0.181018 3.050369 0.001098	202. 00
203.00 Unit cost multiplier (Wkst. B, Part I) 59.801272 0.181018 3.050369 0.001098	202.00
	203. 00
204.00 0031 to be directed (per wikst. b, 007,722 1,100,300 347,324 1,330	204. 00
Part II)	204.00
	205. 00
205.00 Unit cost multiplier (Wkst. B, Part 20.001393 0.083365 1.005253 0.000014	205.00
	204 00
206.00 NAHE adjustment amount to be allocated	206. 00
(per Wkst. B-2)	207.00
207.00 NAHE unit cost multiplier (Wkst. D,	207. 00
Parts III and IV)	I

FRANCISCAN HEALTH ORTHOPEDIC CARMEL	In Lieu	u of Form CMS-2552-10
Provi der CCN: 15-0193		Worksheet C

				From 01/01/2023 To 12/31/2023	Part Date/Time Pre	narod:
				10 12/31/2023	5/31/2024 10:	
		Title	XVIII	Hospi tal	PPS	
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	(from Wkst. B,	Adj .		Di sal I owance		
	Part I, col.					
	26)					
INDATIONE DOUTING CERVILOE COST CENTERS	1.00	2. 00	3. 00	4. 00	5. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS	4 020 0E0		4 000 OF		4 020 0E0	20.00
30. 00 03000 ADULTS & PEDIATRICS ANCILLARY SERVICE COST CENTERS	6, 920, 058		6, 920, 05	8 0	6, 920, 058	30. 00
50. 00 05000 OPERATING ROOM	10, 008, 617		10, 008, 61	7 0	10, 008, 617	50.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM	10,000,017		10, 006, 61) 0	10,008,817	52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 063, 889		1, 063, 88		1, 063, 889	1
60. 00 06000 LABORATORY	215, 381		215, 38		215, 381	60.00
65. 00 06500 RESPIRATORY THERAPY	1, 008, 735	0	1, 008, 73		1, 008, 735	
66. 00 06600 PHYSI CAL THERAPY	364, 354	0	364, 35		364, 354	1
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	331,33	0	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0	0		0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	23, 199		23, 19	9 0	23, 199	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	7, 382, 486		7, 382, 48	6 0	7, 382, 486	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	12, 301, 300		12, 301, 30	0	12, 301, 300	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	1, 493, 329		1, 493, 32	9 0	1, 493, 329	73. 00
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0			0 0	0	77. 00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0			0 (C	0	78. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0			0	0	
91. 00 09100 EMERGENCY	0		,	0	0	,
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	198, 383		198, 38	3	198, 383	92. 00
OTHER REIMBURSABLE COST CENTERS			1			
102. 00 10200 OPI OI D TREATMENT PROGRAM	0			O	0	102. 00
SPECIAL PURPOSE COST CENTERS				_		
113. 00 11300 INTEREST EXPENSE	40.070.701		40.070.70		40.070.701	113.00
200.00 Subtotal (see instructions)	40, 979, 731	0			40, 979, 731	
201.00 Less Observation Beds	198, 383	0	198, 38		198, 383	
202.00 Total (see instructions)	40, 781, 348	0	40, 781, 34	8 0	40, 781, 348	1202.00

Health Financial Systems FRAN	ICISCAN HEALTH C	ORTHOPEDIC CARM	ИEL	In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider Co	CN: 15-0193	Peri od:	Worksheet C	
				From 01/01/2023 To 12/31/2023	Part I Date/Time Pre	narod:
				10 12/31/2023	5/31/2024 10:	
		Title	: XVIII	Hospi tal	PPS	
		Charges				
Cost Center Description	Inpati ent	Outpati ent		6 Cost or Other	TEFRA	
			+ col . 7)	Ratio	I npati ent	
	/ 00	7.00	0.00	0.00	Ratio	
INDATIENT DOUTINE CEDVICE COST CENTERS	6.00	7. 00	8. 00	9. 00	10.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS	1, 626, 561		1, 626, 5	۷1		30.00
ANCI LLARY SERVICE COST CENTERS	1, 020, 301		1, 626, 5	01		30.00
50. 00 05000 OPERATI NG ROOM	10, 357, 217	33, 441, 164	43, 798, 3	0. 228516	0.000000	50.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM	10, 337, 217	03, 441, 104		0. 000000		
54. 00 05400 RADI OLOGY - DI AGNOSTI C	320, 231	615, 982				
60. 00 06000 LABORATORY	729, 956	1, 877, 422				1
65. 00 06500 RESPIRATORY THERAPY	311, 934	471, 356				
66. 00 06600 PHYSI CAL THERAPY	507, 456	952, 444				
67. 00 06700 OCCUPATI ONAL THERAPY	O	0	, , .	0.000000		ł
68. 00 06800 SPEECH PATHOLOGY	O	0		0.000000	0. 000000	68. 00
69. 00 06900 ELECTROCARDI OLOGY	46, 593	28, 032	74, 6	0. 310874	0.000000	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	3, 663, 814	8, 552, 655	12, 216, 4	0. 604306	0.000000	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	10, 973, 154	21, 464, 716	32, 437, 8	70 0. 379227	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	1, 272, 288	1, 837, 037	3, 109, 3	0. 480274	0.000000	73. 00
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0		0. 000000	0.000000	77. 00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0	0		0.000000	0.000000	78. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	0		0. 000000		
91. 00 09100 EMERGENCY	0	0		0.000000		1
92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART	2, 512	53, 270	55, 7	3. 556398	0. 000000	92. 00
OTHER REIMBURSABLE COST CENTERS			I			1400 00
102. 00 10200 OPI OI D TREATMENT PROGRAM	0	0		0		102. 00
SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE			I			113. 00
200.00 Subtotal (see instructions)	29, 811, 716	69, 294, 078	99, 105, 7	24		200. 00
201. 00 Less Observation Beds	29,011,/10	07, 274, 078	79, 105, 7	74		200.00
202.00 Total (see instructions)	29, 811, 716	69, 294, 078	99, 105, 7	24		201.00
202.00 10101 (366 111311 0611 0113)	27,011,710	07, 274, 070	1 77, 105, 7	/ T		1202.00

Health Financial Systems	FRANCISCAN HEALTH ORTHOPEDIC CARMEL	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0193	From 01/01/2023	Worksheet C Part I Date/Time Prepared:

			10 12/31/2023	5/31/2024 10:50 am
		Title XVIII	Hospi tal	PPS
Cost Center Description	PPS Inpatient			
	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS				30.00
ANCILLARY SERVICE COST CENTERS				
50. 00 05000 OPERATI NG ROOM	0. 228516			50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000			52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1. 136375			54.00
60. 00 06000 LABORATORY	0. 082604			60.00
65. 00 06500 RESPI RATORY THERAPY	1. 287818			65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 249575			66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000			67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 000000			68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 310874			69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 604306			71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 379227			72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 480274			73. 00
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0. 000000			77. 00
78.00 O7800 CAR T-CELL IMMUNOTHERAPY	0. 000000			78. 00
OUTPATIENT SERVICE COST CENTERS				
90. 00 09000 CLI NI C	0. 000000			90. 00
91. 00 09100 EMERGENCY	0. 000000			91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	3. 556398			92. 00
OTHER REIMBURSABLE COST CENTERS				
102.00 10200 OPI OI D TREATMENT PROGRAM				102. 00
SPECIAL PURPOSE COST CENTERS				
113. 00 11300 I NTEREST EXPENSE				113. 00
200.00 Subtotal (see instructions)				200. 00
201.00 Less Observation Beds				201. 00
202.00 Total (see instructions)				202. 00

Health Financial Systems	FRANCISCAN HEALTH ORTHOPEDIC CARMEL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0193	Period: Worksheet C From 01/01/2023 Part I

					From 01/01/2023 To 12/31/2023	Part I Date/Time Pre 5/31/2024 10:	pared: 50 am
			Ti tl	e XIX	Hospi tal	PPS	
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst. B,	Adj .		Di sal I owance		
		Part I, col.					
		26)	2.00	3.00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
30. 00	03000 ADULTS & PEDI ATRI CS	6, 920, 058		6, 920, 058	3 0	6, 920, 058	30. 00
	ANCILLARY SERVICE COST CENTERS	<u> </u>	<u> </u>		'		
50.00	05000 OPERATING ROOM	10, 008, 617		10, 008, 617	7 0	10, 008, 617	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0		(0	0	52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 063, 889		1, 063, 889	9 0	1, 063, 889	54.00
60.00	06000 LABORATORY	215, 381		215, 381	0	215, 381	60.00
65.00	06500 RESPI RATORY THERAPY	1, 008, 735	0	1, 008, 735	0	1, 008, 735	65. 00
66.00	06600 PHYSI CAL THERAPY	364, 354	0	364, 354	1 0	364, 354	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	(0	0	67. 00
	06800 SPEECH PATHOLOGY	0	0	(0	0	68. 00
	06900 ELECTROCARDI OLOGY	23, 199		23, 199	9 0	23, 199	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	7, 382, 486		7, 382, 486	6 0	7, 382, 486	71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS	12, 301, 300		12, 301, 300	0	12, 301, 300	72. 00
	07300 DRUGS CHARGED TO PATIENTS	1, 493, 329		1, 493, 329	9 0	1, 493, 329	73. 00
	07700 ALLOGENEIC HSCT ACQUISITION	0		(0	0	77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0		(0	0	78. 00
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLI NI C	0		(0	0	70.00
	09100 EMERGENCY	0		(0	0	91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	198, 383		198, 383	3	198, 383	92. 00
	OTHER REIMBURSABLE COST CENTERS		ı	1			
102. 00	10200 OPI OI D TREATMENT PROGRAM	0)	0	102. 00
440.00	SPECIAL PURPOSE COST CENTERS						110 00
	11300 INTEREST EXPENSE	40.070.704		40.070.70		40 070 704	113. 00
200.00	Subtotal (see instructions)	40, 979, 731		40, 979, 731		40, 979, 731	
201.00	Less Observation Beds	198, 383		198, 383		198, 383	
202.00	Total (see instructions)	40, 781, 348	0	40, 781, 348	3 0	40, 781, 348	1202.00

Health Financial Systems FRAN	CISCAN HEALTH O	RTHOPEDIC CAR	MEL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der C		Peri od:	Worksheet C	
				From 01/01/2023 To 12/31/2023	Part I Date/Time Pre	namad.
				To 12/31/2023	5/31/2024 10:	pareu: 50 am
		Ti tl	e XIX	Hospi tal	PPS	<u> </u>
		Charges				
Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
			+ col. 7)	Ratio	Inpati ent	
					Rati o	
	6. 00	7. 00	8. 00	9. 00	10. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS				-		
30. 00 03000 ADULTS & PEDIATRICS	1, 626, 561		1, 626, 56	1		30. 00
ANCILLARY SERVICE COST CENTERS	40.057.047	00 444 444	10.700.00		2 22222	
50. 00 05000 OPERATING ROOM	10, 357, 217	33, 441, 164			0. 000000	50.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM	0	0		0. 000000	0. 000000	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	320, 231	615, 982			0. 000000	54.00
60. 00 06000 LABORATORY	729, 956	1, 877, 422			0. 000000	60.00
65. 00 06500 RESPIRATORY THERAPY	311, 934	471, 356			0. 000000	65. 00
66. 00 06600 PHYSI CAL THERAPY	507, 456	952, 444	1, 459, 90		0. 000000	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	Ü		0.000000	0. 000000	67.00
68. 00 06800 SPEECH PATHOLOGY	47 500	00.000	74.70	0.000000	0. 000000	68. 00
69. 00 06900 ELECTROCARDI OLOGY	46, 593	28, 032			0.000000	69.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	3, 663, 814	8, 552, 655			0. 000000	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	10, 973, 154	21, 464, 716			0.000000	72.00
73.00 O7300 DRUGS CHARGED TO PATIENTS 77.00 O7700 ALLOGENEIC HSCT ACQUISITION	1, 272, 288	1, 837, 037	1		0. 000000 0. 000000	73. 00 77. 00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0	0			0. 000000	78.00
OUTPATIENT SERVICE COST CENTERS	l O	U	'	0. 000000	0.000000	78.00
90. 00 09000 CLINIC	O		l .	0. 000000	0. 000000	90.00
91. 00 09100 EMERGENCY	0	0		0.00000	0. 000000	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	2, 512	53, 270	55, 78		0. 000000	92.00
OTHER REIMBURSABLE COST CENTERS	2,512	55, 270	1 55, 76.	2 3. 550570	0.000000	72.00
102. 00 10200 OPI OI D TREATMENT PROGRAM	O	0	ı .	0		102. 00
SPECIAL PURPOSE COST CENTERS	<u> </u>		1	ا		102.00
113. 00 11300 NTEREST EXPENSE						113. 00
200.00 Subtotal (see instructions)	29, 811, 716	69, 294, 078	99, 105, 79	4		200. 00
201.00 Less Observation Beds	2,,5,,10	0., 2, 0.0	,,,,,,,,,			201. 00
202.00 Total (see instructions)	29, 811, 716	69, 294, 078	99, 105, 79	4		202. 00
		2., 2, 0, 0		1	!	

Health Financial Systems	FRANCISCAN HEALTH ORTH	HOPEDIC CARMEL	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0193	Peri od: From 01/01/2023	Worksheet C Part I Date/Time Prepared:
			10 12/31/2023	E /21 /2024 10: E0 om

				10 12/31/2023	5/31/2024 10: 50 am
			Title XIX	Hospi tal	PPS
Cost Cen	ter Description	PPS Inpatient			
		Ratio			
		11. 00			
	INE SERVICE COST CENTERS				
30. 00 03000 ADULTS &					30.00
	ICE COST CENTERS				
50. 00 05000 OPERATI NO	G ROOM	0. 228516			50.00
52. 00 05200 DELI VERY	ROOM & LABOR ROOM	0. 000000			52.00
54. 00 05400 RADI OLOG	Y-DI AGNOSTI C	1. 136375			54.00
60. 00 06000 LABORATOF	RY	0. 082604			60.00
65. 00 06500 RESPI RATO	ORY THERAPY	1. 287818			65. 00
66. 00 06600 PHYSI CAL		0. 249575			66. 00
67. 00 06700 OCCUPATION	ONAL THERAPY	0. 000000			67. 00
68. 00 06800 SPEECH PA	ATHOLOGY	0. 000000			68. 00
69. 00 06900 ELECTROCA	ARDI OLOGY	0. 310874			69. 00
71.00 07100 MEDICAL S	SUPPLIES CHARGED TO PATIENT	0. 604306			71. 00
72. 00 07200 I MPL. DE	V. CHARGED TO PATIENTS	0. 379227			72. 00
73.00 07300 DRUGS CHA	ARGED TO PATIENTS	0. 480274			73. 00
77. 00 07700 ALLOGENEI	IC HSCT ACQUISITION	0. 000000			77. 00
78. 00 07800 CAR T-CEI	LL IMMUNOTHERAPY	0. 000000			78. 00
	VICE COST CENTERS				
90. 00 09000 CLI NI C		0. 000000			90.00
91. 00 09100 EMERGENC	Y	0. 000000			91.00
92. 00 09200 OBSERVATI	ON BEDS (NON-DISTINCT PART	3. 556398			92. 00
	ABLE COST CENTERS				
102. 00 10200 OPI 0I D TE					102. 00
SPECIAL PURPOS					
113. 00 11300 I NTEREST	EXPENSE				113. 00
	(see instructions)				200. 00
	ervation Beds				201. 00
202.00 Total (se	ee instructions)				202. 00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet C | From 01/01/2023 | Part II | To 12/31/2023 | Date/Time Prepared: | To 12/31/2024 | Part II | Prepared: | Part II | Part I

			'	0 12/31/2023	5/31/2024 10:	
			e XIX	Hospi tal	PPS	
Cost Center Description	Total Cost		Operating Cost		Operating Cost	
	(Wkst. B, Part				Reduction	
	I, col. 26)	II col. 26)	Cost (col. 1 -		Amount	
			col . 2)			
ANOUGH ARM REPUMPS ROOT RENTERS	1.00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS	40,000,747	2 400 004	/ 005 700			F0 00
50. 00 05000 OPERATI NG ROOM	10, 008, 617	3, 102, 894	6, 905, 723	0	0	50.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM	1 0/2 000	U 531 OFF	F21 024	0	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 063, 889	531, 955			0	54.00
60. 00 06000 LABORATORY	215, 381	136, 191			0	60.00
65. 00 06500 RESPIRATORY THERAPY	1, 008, 735	124, 174			0	65. 00
66. 00 06600 PHYSI CAL THERAPY	364, 354	51, 557	312, 797		0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0			0	67.00
68. 00 06800 SPEECH PATHOLOGY	22 100	1 2/2	21 027	0	0	68. 00
69.00 06900 ELECTROCARDIOLOGY 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	23, 199	1, 262			0	69. 00 71. 00
	7, 382, 486	512, 153			0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 73.00 07300 DRUGS CHARGED TO PATIENTS	12, 301, 300	852, 442			· ·	•
73. 00 07300 DRUGS CHARGED TO PATTENTS 77. 00 07700 ALLOGENEI C HSCT ACQUISITION	1, 493, 329	352, 921	1, 140, 408		0	73. 00 77. 00
78. 00 07700 ALLOGENETC HSCT ACQUISITION 78. 00 07800 CAR T-CELL IMMUNOTHERAPY		0			0	78.00
OUTPATIENT SERVICE COST CENTERS	U	U		J U	U	76.00
90. 00 09000 CLINIC		0		0	0	90.00
91. 00 09100 EMERGENCY		0		0	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	198, 383	77, 233	121, 150	o o	0	92. 00
OTHER REIMBURSABLE COST CENTERS	1,70,000	7.7,200	12.7.00			72.00
102. 00 10200 OPI OI D TREATMENT PROGRAM	0	0	C	0	0	102.00
SPECIAL PURPOSE COST CENTERS	·					
113. 00 11300 I NTEREST EXPENSE						113. 00
200.00 Subtotal (sum of lines 50 thru 199)	34, 059, 673	5, 742, 782	28, 316, 891	0	0	200. 00
201.00 Less Observation Beds	198, 383	77, 233	121, 150	0	0	201. 00
202.00 Total (line 200 minus line 201)	33, 861, 290	5, 665, 549	28, 195, 741	0	0	202. 00

REDUCT	TONS FOR MEDICALD ONLY				To 12/31/2023	Date/Time Pro 5/31/2024 10:	
			Ti tl	e XIX	Hospi tal	PPS	00 am
	Cost Center Description	Cost Net of	Total Charges	Outpati ent			
	·	Capital and	(Worksheet C,		je		
		Operating Cost	Part I, column	Ratio (col.	6		
		Reducti on	8)	/ col . 7)			
		6.00	7. 00	8. 00			
	ANCILLARY SERVICE COST CENTERS						
50.00	O5000 OPERATI NG ROOM	10, 008, 617	43, 798, 381	0. 22851	6		50. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0.00000	00		52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 063, 889	936, 213	1. 13637	'5		54.00
60.00	06000 LABORATORY	215, 381	2, 607, 378	0. 08260	04		60.00
65.00	06500 RESPI RATORY THERAPY	1, 008, 735	783, 290	1. 28781	8		65. 00
66.00	06600 PHYSI CAL THERAPY	364, 354	1, 459, 900	0. 24957	'5		66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	0	0.00000	00		67. 00
68.00	06800 SPEECH PATHOLOGY	0	0	0.00000	00		68. 00
69. 00	06900 ELECTROCARDI OLOGY	23, 199	74, 625	0. 31087	'4		69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	7, 382, 486	12, 216, 469	0. 60430	06		71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	12, 301, 300	32, 437, 870	0. 37922	27		72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	1, 493, 329	3, 109, 325	0. 48027	4		73. 00
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0	0	0.00000	00		77. 00
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0	0	0.00000	00		78. 00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	0	0.00000	00		90. 00
91.00	09100 EMERGENCY	0	0	0.00000	00		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	198, 383	55, 782	3. 55639	8		92.00
	OTHER REIMBURSABLE COST CENTERS						
102.00	10200 OPI OI D TREATMENT PROGRAM	0	0	0.00000	00		102. 00
	SPECIAL PURPOSE COST CENTERS						
113.00	11300 I NTEREST EXPENSE						113. 00
200.00	Subtotal (sum of lines 50 thru 199)	34, 059, 673	97, 479, 233				200. 00
201.00	Less Observation Beds	198, 383	0				201. 00
202.00	Total (line 200 minus line 201)	33, 861, 290	97, 479, 233				202. 00

Health Financial Systems FRAM	ICISCAN HEALTH (ORTHOPEDIC CARM	ΛEL	In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provider Co		Period: From 01/01/2023 To 12/31/2023		pared: 50 am
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Capital Related Cost (from Wkst. B,	Swing Bed Adjustment	Reduced Capi tal Related Cost	Days	Per Diem (col. 3 / col. 4)	
	Part II, col.		(col. 1 - col 2)			
	1.00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	2, 694, 083	0	2, 694, 08	3 593	4, 543. 14	30.00
200.00 Total (lines 30 through 199)	2, 694, 083		2, 694, 08	3 593		200. 00
Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost				
		(col. 5 x col. 6)				
	6.00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS	,					
30. 00 ADULTS & PEDI ATRI CS	230					30.00
200.00 Total (lines 30 through 199)	230	1, 044, 922				200. 00

Health Financial Systems	FRANCISCAN HEALTH ORTH	In Lieu	u of Form CMS-2552-10	
APPORTIONMENT OF INPATIENT	ANCILLARY SERVICE CAPITAL COSTS	Provi der CCN: 15-0193	Peri od: From 01/01/2023 To 12/31/2023	Worksheet D Part II Date/Time Prepared: 5/31/2024 10:50 am

	00010			From 01/01/2023 To 12/31/2023	Part II Date/Time Pre	
		Ti +l c	xVIII	Hospi tal	5/31/2024 10: PPS	50 am_
Cost Center Description	Capi tal	Total Charges			Capital Costs	
5051 501161 50501 Pt1 611		(from Wkst. C,			(column 3 x	
	(from Wkst. B,				column 4)	
	Part II, col.	8)	2)			
	26)	·				
	1. 00	2.00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	3, 102, 894	43, 798, 381	0. 07084	5 4, 228, 813	299, 590	50. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0.00000		0	52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	531, 955				·	
60. 00 06000 LABORATORY	136, 191		1		17, 118	
65. 00 06500 RESPIRATORY THERAPY	124, 174		1		·	
66. 00 06600 PHYSI CAL THERAPY	51, 557	1, 459, 900	1		7, 523	
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	0.00000		01	67. 00
68.00 06800 SPEECH PATHOLOGY	0	0	0.00000		01	68. 00
69. 00 06900 ELECTROCARDI OLOGY	1, 262		1			69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	512, 153				·	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	852, 442					72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	352, 921	3, 109, 325			60, 755	
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0	0.00000		0	77. 00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0	0	0.00000	0 0	0	78. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	0	0.00000		0	90. 00
91. 00 09100 EMERGENCY	0	0	0.00000		01	91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	77, 233		1		0	92. 00
200.00 Total (lines 50 through 199)	5, 742, 782	97, 479, 233	1	11, 004, 445	697, 080	200. 00

Health Financ	ial Systems	FRANCISCAN HEALTH O	RTHOPEDIC CARM	MEL	In Lie	u of Form CMS-	2552-10
APPORTI ONMENT	T OF INPATIENT ROUTINE SERVICE O	THER PASS THROUGH COST		<u> </u>	Period: From 01/01/2023 Fo 12/31/2023	Worksheet D Part III Date/Time Pre 5/31/2024 10:	
				XVIII	Hospi tal	PPS	
(Cost Center Description	Nursi ng Program Post-Stepdown Adj ustments	Nursi ng Program	Allied Health Post-Stepdown Adjustments		All Other Medical Education Cost	
		1A	1. 00	2A	2. 00	3. 00	
I NPATI	ENT ROUTINE SERVICE COST CENTERS						
	ADULTS & PEDIATRICS	0	0	(0	0	
	Total (lines 30 through 199)	0	0	(0		200. 00
(Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
		4.00	5. 00	6. 00	7. 00	8. 00	
INPATI	ENT ROUTINE SERVICE COST CENTERS						
	ADULTS & PEDIATRICS Total (lines 30 through 199)	0	0	593 593			30. 00 200. 00
	Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00					
	ENT ROUTINE SERVICE COST CENTERS						
	ADULTS & PEDIATRICS Total (lines 30 through 199)	0 0					30. 00 200. 00

Health Financial Systems	FRANCISCAN HEALTH ORT	HOPEDIC CARMEL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0193	Peri od: From 01/01/2023	Worksheet D Part IV
111100011 00313				Dato/Timo Propared:

				1	o 12/31/2023	Date/Time Prep 5/31/2024 10:	
			Title	XVIII	Hospi tal	PPS	
	Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
		Anestheti st	Program	Program	Post-Stepdown		
		Cost	Post-Stepdown		Adjustments		
		1.00	Adjustments	0.00		0.00	
	ANOLULARY OFRICAS COOT OFFITTED	1.00	2A	2.00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0	(0	0	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0	(0	0	52. 00
54.00	05400 RADI OLOGY - DI AGNOSTI C	0	0		0	0	54.00
60.00	06000 LABORATORY	0	0		0	0	60.00
65. 00	06500 RESPIRATORY THERAPY	0	0		0	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	0		0	0	66. 00
67. 00	06700 OCCUPATIONAL THERAPY	0	0		0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0			0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0			0	69. 00
71. 00	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0	0			0	71. 00
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0	0	72. 00
	07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	73. 00
	07700 ALLOGENEIC HSCT ACQUISITION	0	0			0	77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY OUTPATIENT SERVICE COST CENTERS	0	0) 0	0	78. 00
90. 00	09000 CLINIC			1	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	0	90. 00
	09100 EMERGENCY	0	0			0	
91.00		0	U			0	91. 00
92. 00 200. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART		_		ĺ		92.00
200.00	Total (lines 50 through 199)	1	ı	1	ار	ا	200. 00

		ANCISCAN HEALTH (eu of Form CMS-	2552-10
	TIONMENT OF INPATIENT/OUTPATIENT ANCILLARY S	ERVICE OTHER PASS	S Provi der C		Peri od:	Worksheet D	
THROUG	SH COSTS				From 01/01/2023 To 12/31/2023		narod:
					10 12/31/2023	5/31/2024 10:	
			Ti tl e	XVIII	Hospi tal	PPS	
	Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
		Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,	to Charges	
		Education Cost	1, 2, 3, and	Cost (sum of	Part I, col.	(col. 5 ÷ col.	
			4)	col s. 2, 3,	8)	7)	
				and 4)		(see	
						instructions)	
		4. 00	5. 00	6. 00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	0	C)	0 43, 798, 381		
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	C)	0	0.000000	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	C)	0 936, 213		1
60.00	06000 LABORATORY	0	C)	0 2, 607, 378		
65.00	06500 RESPI RATORY THERAPY	0	C)	0 783, 290		
66. 00	06600 PHYSI CAL THERAPY	0	C)	0 1, 459, 900	0.000000	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	C)	0	0.000000	67. 00
68.00	06800 SPEECH PATHOLOGY	0	C)	0	0.000000	68. 00
69.00	06900 ELECTROCARDI OLOGY	0	C		0 74, 625	0.000000	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	C		0 12, 216, 469	0.000000	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	C)	0 32, 437, 870	0.000000	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	C		0 3, 109, 325	0.000000	73. 00
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	C		0	0.000000	77. 00
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0	C		0 0	0.000000	78. 00
	OUTPATIENT SERVICE COST CENTERS						
00 00	00000 CLINIC	0		J	0	0 000000	00 00

0 0 0

0 0 0

0 0 0

55, 782 97, 479, 233

90.00

91.00

92. 00 200. 00

0. 000000 0. 000000

0.000000

90. 00 09000 CLI NI C

91. 00 09100 EMERGENCY

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

	5		DT. 100 FD. 10 04 D.	•=:		6.5	
APPORT	FINANCIAL SYSTEMS FRA IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE H COSTS	NCISCAN HEALTH O RVICE OTHER PASS			Period: From 01/01/2023 To 12/31/2023		pared:
			Title	XVIII	Hospi tal	PPS	
	Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col.	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. x col. 10)		Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		9. 00	10.00	11.00	12.00	13.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0. 000000	4, 228, 813		0 18, 940, 070	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	227, 093		0 147, 704	0	54.00
60.00	06000 LABORATORY	0. 000000	327, 717		0 24, 407	0	60.00
65.00	06500 RESPI RATORY THERAPY	0. 000000	123, 156		0 249, 161	0	65. 00
66.00	06600 PHYSI CAL THERAPY	0. 000000	213, 027		0 316, 092	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0. 000000	0		0	0	67. 00
68.00	06800 SPEECH PATHOLOGY	0. 000000	0		0 0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	0. 000000	19, 949		0 14, 211	0	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	1, 479, 582		0 4, 930, 478	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	3, 849, 838		0 12, 323, 369	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	535, 270		0 1, 047, 190	0	73. 00
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0. 000000	0		0 0	0	77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0. 000000	0		0 0	0	78. 00
	OUTPATIENT SERVICE COST CENTERS						
90 00	DOUDO CLINIC	0.000000	0		0 0	0	l on nn

0. 000000 0. 000000

0. 000000

11, 004, 445

0

12, 326 38, 005, 008

0 0 0 90.00

0

0 91.00 0 92.00 0 200.00

90. 00 09000 CLI NI C

Health Financial Systems	FRANCI SCAN HEALTH ORTI	HOPEDIC CARMEL	In Lie	u of Form CMS-2552-10
ADDODEL ONMENT OF MEDICAL	OTHER HEALTH CERVILORS AND MAGOLINE COST	D ' I OON 45 0400	D : 1	W 1 1 1 D

Health Financial Systems FRAN	CISCAN HEALTH	ORTHOPEDIC CARM	MEL	In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der Co		Period: From 01/01/2023 To 12/31/2023	Date/Time Pre 5/31/2024 10:	pared: 50 am
		Title	XVIII	Hospi tal	PPS	
			Charges		Costs	
Cost Center Description		PPS Reimbursed		Cost	PPS Services	
	Ratio From	Services (see	Reimbursed	Rei mbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins.			
			(see inst.)	(see inst.)		
	1. 00	2.00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS		1	·			
50.00 05000 OPERATI NG ROOM	0. 228516			0	4, 328, 109	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	1		0	0	52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1. 136375			0 0	167, 847	
60. 00 06000 LABORATORY	0. 082604			0	2, 016	
65. 00 06500 RESPI RATORY THERAPY	1. 287818	1		0	320, 874	1
66. 00 06600 PHYSI CAL THERAPY	0. 249575			0	78, 889	•
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000			0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0. 000000			0 0	0	
69. 00 06900 ELECTROCARDI OLOGY	0. 310874	14, 211		0 0	4, 418	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 604306	4, 930, 478		0 0	2, 979, 517	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 379227	12, 323, 369		0 0	4, 673, 354	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 480274	1, 047, 190		0 3, 252	502, 938	73. 00
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0. 000000	0		0 0	0	77. 00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0. 000000	0		0 0	0	78. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0. 000000	0		0	0	90.00
91. 00 09100 EMERGENCY	0. 000000	0		0 0	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	3. 556398	12, 326		0 0	43, 836	92.00
200.00 Subtotal (see instructions)		38, 005, 008		0 3, 252	13, 101, 798	200.00
201.00 Less PBP Clinic Lab. Services-Program				0 0		201. 00
Only Charges 202.00 Net Charges (line 200 - line 201)		38, 005, 008		0 3, 252	13, 101, 798	202. 00

ATTORTIONNENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Trovider c		From 01/01/2023 To 12/31/2023	Date/Time Pre 5/31/2024 10:	epared: 50 am
			XVIII	Hospi tal	PPS	
		sts				
Cost Center Description	Cost	Cost				
	Rei mbursed	Rei mbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)	-			
ANCI LLARY SERVI CE COST CENTERS	6. 00	7. 00				
50. 00 05000 OPERATING ROOM	1		\			50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM						52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C						54. 00
60. 00 06000 LABORATORY						60.00
65. 00 06500 RESPI RATORY THERAPY						65. 00
66. 00 06600 PHYSI CAL THERAPY						66.00
67. 00 06700 OCCUPATI ONAL THERAPY						67. 00
68. 00 06800 SPEECH PATHOLOGY	0					68. 00
69. 00 06900 ELECTROCARDI OLOGY	0					69.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0					71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0					72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	1, 562				73. 00
77. 00 07700 ALLOGENEIC HSCT ACQUISITION	0	1,002				77. 00
78. 00 07800 CAR T-CELL IMMUNOTHERAPY	0	Ö				78. 00
OUTPATIENT SERVICE COST CENTERS			1			70.00
90. 00 09000 CLI NI C	0	0				90.00
91. 00 09100 EMERGENCY	0					91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	l	o			92. 00
200.00 Subtotal (see instructions)	0	1, 562				200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)	0	1, 562	2			202. 00

Health Financial Systems FRAM	ICISCAN HEALTH (ORTHOPEDIC CARM	MEL	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provider Co	F	Period: From 01/01/2023 To 12/31/2023		
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col.	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col.	Days	Per Diem (col. 3 / col. 4)	
	26)		2)			
	1.00	2. 00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDI ATRI CS	2, 694, 083	0	2, 694, 083	593	4, 543. 14	30. 00
200.00 Total (lines 30 through 199)	2, 694, 083		2, 694, 083	593		200. 00
Cost Center Description		Inpatient Program Capital Cost (col. 5 x col. 6)				
	6. 00	7. 00				
I NPATI ENT ROUTI NE SERVI CE COST CENTERS						
30. 00 ADULTS & PEDI ATRI CS	12	54, 518	1			30. 00
200.00 Total (lines 30 through 199)	12	54, 518				200. 00

Heal th Financial	Systems	FRANCISCAN HEALTH ORTHOPEDIC CARMEL					In Lieu of Form CMS-2552-10		
APPORTI ONMENT OF	INPATIENT ANCILLARY	SERVI CE	CAPI TAL	COSTS	Provider CCN:		From 01/01/2023	Worksheet D Part II Date/Time Prepared	

7 7 0		.2 000.0			From 01/01/2023 To 12/31/2023	Part II Date/Time Pre	pared:
						5/31/2024 10:	
				e XIX	Hospi tal	PPS	
	Cost Center Description	Capi tal	Total Charges			Capital Costs	
			(from Wkst. C,		Program	(column 3 x	
		(from Wkst. B,		(col. 1 ÷ col.	Charges	column 4)	
		Part II, col.	8)	2)			
		26)					
	I	1.00	2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS	0 400 004	10 700 001			20.011	
50. 00	05000 OPERATI NG ROOM	3, 102, 894	43, 798, 381		· ·	20, 944	1
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0.00000		0	52.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	531, 955	· ·				54.00
60.00	06000 LABORATORY	136, 191					
65. 00	06500 RESPI RATORY THERAPY	124, 174	· ·		, ,		
66. 00	06600 PHYSI CAL THERAPY	51, 557	1, 459, 900			389	
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	0. 00000		0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0	0. 00000		0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	1, 262					69. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	512, 153					71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS	852, 442			· ·		1
	07300 DRUGS CHARGED TO PATIENTS	352, 921	3, 109, 325			4, 148	•
	07700 ALLOGENEIC HSCT ACQUISITION	0	0	0. 00000		0	77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0	0	0. 00000	0	0	78. 00
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLI NI C	0	0	0. 00000		0	90. 00
	09100 EMERGENCY	0	0	0. 000000		0	91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	77, 233				0	92. 00
200.00	Total (lines 50 through 199)	5, 742, 782	97, 479, 233		978, 245	50, 098	200. 00

Health Financ	cial Systems	FRANCISCAN HEALTH O	RTHOPEDIC CARM	MEL	In Lie	u of Form CMS-	2552-10
APPORTI ONMEN	IT OF INPATIENT ROUTINE SERVICE O	THER PASS THROUGH COST		!	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part III Date/Time Pre 5/31/2024 10:	
				e XIX	Hospi tal	PPS	
	Cost Center Description	Nursi ng Program Post-Stepdown Adj ustments	Nursi ng Program	Allied Health Post-Stepdown Adjustments		All Other Medical Education Cost	
		1A	1. 00	2A	2. 00	3. 00	
INPATI	ENT ROUTINE SERVICE COST CENTERS						
	ADULTS & PEDIATRICS	0	0	(0	0	
200. 00	Total (lines 30 through 199)	0	0		0		200. 00
	Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
		4.00	5. 00	6. 00	7. 00	8. 00	
I NPATI	ENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 200. 00	ADULTS & PEDIATRICS Total (lines 30 through 199)	0	0	59: 59:			30. 00 200. 00
	Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00					
	ENT ROUTINE SERVICE COST CENTERS						
	ADULTS & PEDIATRICS Total (lines 30 through 199)	0 0					30. 00 200. 00

Health Financial Systems	FRANCISCAN HEALTH ORT	HOPEDIC CARMEL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0193	Peri od: From 01/01/2023	Worksheet D Part IV Date/Time Prepared:

				10 12/31/2023	5/31/2024 10:	
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
	Anesthetist	Program	Program	Post-Stepdown		
	Cost	Post-Stepdown		Adjustments		
		Adjustments				
	1. 00	2A	2. 00	3A	3. 00	
ANCILLARY SERVICE COST CENTERS		1	1	1		
50.00 05000 OPERATING ROOM	0	0	(0	0	50. 00
52.00 O5200 DELIVERY ROOM & LABOR ROOM	0	0	(0	0	52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0	(0	0	54. 00
60. 00 06000 LABORATORY	0	0	(0	0	60. 00
65. 00 06500 RESPI RATORY THERAPY	0	0	(0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0	0	(0	0	66. 00
67. 00 06700 0CCUPATI ONAL THERAPY	0	0	(0	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0	0	(0	01	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0	(0	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	(0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	(0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	(0	0	73. 00
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0	(0	0	77. 00
78.00 O7800 CAR T-CELL IMMUNOTHERAPY	0	0	(0 0	0	78. 00
OUTPATIENT SERVICE COST CENTERS		1	1			
90. 00 09000 CLI NI C	0	0	(0	0	90. 00
91. 00 09100 EMERGENCY	0	0	(0	0	91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0)	0	92. 00
200.00 Total (lines 50 through 199)	0	0	(0	j 01	200. 00

	NCISCAN HEALTH (eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	RVICE OTHER PASS	Provider Co		Peri od:	Worksheet D	
THROUGH COSTS				From 01/01/2023 To 12/31/2023		nanad.
				To 12/31/2023	Date/Time Prep 5/31/2024 10:	
		Ti tl	e XIX	Hospi tal	PPS	50 diii
Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
'	Medi cal	(sum of cols.	Outpatient	(from Wkst. C,		
	Education Cost	1, 2, 3, and	Cost (sum of	Part I, col.	(col. 5 ÷ col.	
		4)	col s. 2, 3,	8)	7)	
			and 4)		(see	
					instructions)	
	4.00	5. 00	6. 00	7. 00	8. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATI NG ROOM	0	0		0 43, 798, 381	0.000000	50. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0	0.000000	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		936, 213		54.00
60. 00 06000 LABORATORY	0	0		0 2, 607, 378	0.000000	60.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0 783, 290	0.000000	65. 00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 1, 459, 900	0.000000	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0		0 0	0.000000	67. 00
68. 00 06800 SPEECH PATHOLOGY	0	0		0 0	0.000000	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 74, 625	0.000000	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 12, 216, 469	0.000000	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 32, 437, 870	0.000000	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 3, 109, 325	0.000000	73. 00
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0		0	0. 000000	77. 00
78. 00 07800 CAR T-CELL IMMUNOTHERAPY	0	0		0 0	0.000000	78. 00

0 0 0

0 0

55, 782 97, 479, 233

0 0 0

0.000000

0.000000

0.000000

90.00

91.00

92.00 200.00

OUTPATIENT SERVICE COST CENTERS

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 200.00 Total (lines 50 through 199)

90. 00 09000 CLI NI C

91. 00 09100 EMERGENCY

<u> </u>	NCISCAN HEALTH O				u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PASS	Provi der Co		Peri od:	Worksheet D	
THROUGH COSTS				From 01/01/2023 To 12/31/2023	Part IV Date/Time Pre	naradi
				10 12/31/2023	5/31/2024 10:	
		Ti tl	e XIX	Hospi tal	PPS	00 uiii
Cost Center Description	Outpati ent	Inpatient	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through	Charges	Pass-Through	
	(col. 6 ÷ col.		Costs (col. 8	3	Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9. 00	10.00	11.00	12.00	13. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0. 000000	295, 632		0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0	0	52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	8, 094		0	0	54. 00
60. 00 06000 LABORATORY	0. 000000	3, 369		0	0	60.00
65. 00 06500 RESPIRATORY THERAPY	0. 000000	9, 827		0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	11, 009		0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	0		0	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 000000	0		0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	6, 314		0	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	141, 497		0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	465, 958		0 0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	36, 545		0 0	0	73. 00
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0. 000000	0		0 0	0	77. 00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0. 000000	0		0	0	78. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0. 000000	0		0 0	0	90.00
01 00 00100 EMEDIENCY	0.000000	0	I			01 00

0. 000000 0. 000000 0. 000000

978, 245

0 0 0

0 0 0

0 91.00 0 92.00 0 200.00

Health Financial Systems FRAN	CISCAN HEALTH	ORTHOPEDIC CARM	MEL	In Li€	eu of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider Co		Period: From 01/01/2023 To 12/31/2023	Worksheet D Part V Date/Time Pre 5/31/2024 10:	
		Titl	e XIX	Hospi tal	PPS	
			Charges		Costs	
Cost Center Description		PPS Reimbursed		Cost	PPS Services	
	Ratio From	Services (see	Reimbursed	Rei mbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins			
			(see inst.)	(see inst.)		
	1. 00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	0. 228516		348, 05	8 0	0	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	-		0	0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1. 136375		10, 79		0	
60. 00 06000 LABORATORY	0. 082604		17, 04		0	
65. 00 06500 RESPI RATORY THERAPY	1. 287818	0	4, 20	8 0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 249575	0	2, 48	2 0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	0		0 0	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 000000	0		0 0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 310874	0		0 0	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 604306	0	64, 95	2 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 379227	0	74, 81	1 0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 480274	0	19, 34	8 0	0	73. 00
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0. 000000	0		0 0	0	77. 00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0. 000000	0		0 0	0	78. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0. 000000	0		0 0	0	90.00
91. 00 09100 EMERGENCY	0. 000000	0		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	3. 556398	0	5, 36	2 0	0	92.00
200.00 Subtotal (see instructions)		0	547, 05	8 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	547, 05	8 0	0	202. 00

				Т	o 12/31/2023	Date/Time Pro 5/31/2024 10:	epared: ·50 am
			Ti tl	e XIX	Hospi tal	PPS	. 00 am
		Cos					
	Cost Center Description	Cost	Cost				
	·	Rei mbursed	Reimbursed				
		Servi ces	Services Not				
		Subject To	Subject To				
		Ded. & Coins.	Ded. & Coins.				
		(see inst.)	(see inst.)				
		6. 00	7. 00				
	CILLARY SERVICE COST CENTERS			1			
	OOO OPERATING ROOM	79, 537	0				50. 00
	200 DELIVERY ROOM & LABOR ROOM	0	0				52. 00
	400 RADI OLOGY-DI AGNOSTI C	12, 264	0				54.00
	DOO LABORATORY	1, 408	0				60.00
	500 RESPI RATORY THERAPY	5, 419	0				65. 00
	600 PHYSI CAL THERAPY	619	0				66. 00
	700 OCCUPATI ONAL THERAPY	0	0				67. 00
	BOO SPEECH PATHOLOGY	0	0				68. 00
	900 ELECTROCARDI OLOGY	0	0				69. 00
	100 MEDICAL SUPPLIES CHARGED TO PATIENT	39, 251	0				71. 00
	200 IMPL. DEV. CHARGED TO PATIENTS	28, 370	0				72. 00
	BOO DRUGS CHARGED TO PATIENTS	9, 292	0				73. 00
	700 ALLOGENEIC HSCT ACQUISITION	0	0				77. 00
	BOO CAR T-CELL IMMUNOTHERAPY	0	0				78. 00
	FPATIENT SERVICE COST CENTERS		0	1			
	DOO CLINIC	0	0				90.00
	100 EMERGENCY	10.000	0				91.00
	200 OBSERVATION BEDS (NON-DISTINCT PART	19, 069	0				92.00
200.00	Subtotal (see instructions)	195, 229	0				200. 00
201. 00	Less PBP Clinic Lab. Services-Program Only Charges	0					201. 00
202. 00	Net Charges (line 200 - line 201)	195, 229	0				202. 00
202.00	fiver charges (Title 200 - Title 201)	190, 229	0	1			1202. UU

Health Financial Systems	FRANCISCAN HEALTH ORTHO	OPEDIC CARMEL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST	-	Provider CCN: 15-0193	Peri od: From 01/01/2023	Worksheet D-1	
			To 12/31/2023	Date/Time Prep 5/31/2024 10:	
		Title XVIII	Hospi tal	PPS	
Cost Center Description					
· ·				1. 00	
PART I - ALL PROVIDER COMPONENTS					
I NPATI ENT DAYS					
1.00 Inpatient days (including private room days and swing-bed days, excluding newborn)					1. 00
				F00	

	Cost Center Description	113	
	PART I - ALL PROVIDER COMPONENTS	1. 00	
	I NPATI ENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	593	1. 00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	593	2. 00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days,	0	3. 00
4. 00	do not complete this line. Semi-private room days (excluding swing-bed and observation bed days)	576	4. 00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost	0	5. 00
0.00	report in a peri od	Ĭ	0.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	0	6. 00
7.00	reporting period (if calendar year, enter 0 on this line)		7 00
7. 00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7. 00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	0	8. 00
	reporting period (if calendar year, enter 0 on this line)		
9. 00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and	230	9. 00
10. 00	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	o	10. 00
10.00	through December 31 of the cost reporting period (see instructions)	٥	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after	0	11. 00
	December 31 of the cost reporting period (if calendar year, enter 0 on this line)	_	
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12. 00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	13. 00
.0.00	after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	Ĭ	
14. 00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14. 00
15.00	Total nursery days (title V or XIX only)	0	15.00
16. 00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT	0	16. 00
17. 00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost	0.00	17. 00
	reporting period		
18. 00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost	0. 00	18. 00
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost	0.00	19. 00
17.00	reporting period	0.00	17.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost	0.00	20. 00
04.00	reporting period	, ,,,,,	04 00
21. 00 22. 00	Total general inpatient routine service cost (see instructions) Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line)	6, 920, 058 0	21. 00 22. 00
22.00	5x Line 17)	٥	22.00
23. 00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6	0	23. 00
04.00	x line 18)		0.4.00
24. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	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)		
26. 00	Total swing-bed cost (see instructions)	(020 050	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	6, 920, 058	27. 00
28. 00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28. 00
29. 00		0	29. 00
30. 00	Semi-private room charges (excluding swing-bed charges)	0	30. 00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0. 000000	31.00
32. 00 33. 00	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)	0. 00 0. 00	32. 00 33. 00
34. 00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34. 00
35. 00	Average per diem private room cost differential (line 34 x line 31)	0.00	35. 00
36. 00	Private room cost differential adjustment (line 3 x line 35)	0	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line	6, 920, 058	37. 00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38. 00	Adjusted general inpatient routine service cost per diem (see instructions)	11, 669. 58	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line 38)	2, 684, 003	39. 00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	2 694 003	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	2, 684, 003	41.00

Heal th	Financial Systems FRAN	ICISCAN HEALTH (ORTHOPEDIC CAR	RMFL	In Lie	eu of Form CMS-2	2552-10
	ATION OF INPATIENT OPERATING COST			CCN: 15-0193	Peri od: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Pre	pared:
			Ti tl	e XVIII	Hospi tal	5/31/2024 10: PPS	50 am
	Cost Center Description	Total Inpatient Cost	Total	Average Pe	r Program Days	Program Cost (col. 3 x col.	
		1.00	2. 00	3.00	4. 00	4) 5. 00	
42. 00	NURSERY (title V & XIX only)						42. 00
43. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT			1			43.00
44. 00	CORONARY CARE UNIT						44.00
45. 00	BURN INTENSIVE CARE UNIT						45. 00
46.00	SURGICAL INTENSIVE CARE UNIT						46. 00
47. 00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47. 00
	cost center bescription					1.00	
48. 00	Program inpatient ancillary service cost (Wk	st. D-3, col. 3	, line 200)			4, 080, 615	48. 00
48. 01	Program inpatient cellular therapy acquisiti				, column 1)	0	48. 01
49. 00	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS	41 through 48.0	1)(see instru	ctions)		6, 764, 618	49. 00
50.00	Pass through costs applicable to Program inp	atient routine	services (fro	m Wkst. D, su	m of Parts I and	1, 044, 922	50.00
51. 00	Pass through costs applicable to Program inp	atient ancillar	y services (f	rom Wkst. D,	sum of Parts II	697, 080	51.00
52. 00	and IV) Total Program excludable cost (sum of lines	50 and 51)				1, 742, 002	52. 00
53. 00	Total Program inpatient operating cost exclu		lated, non-ph	ysi ci an anest	hetist, and	5, 022, 616	
	medical education costs (line 49 minus line	52)					
54. 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54.00
55. 00	Target amount per discharge						55.00
55. 01	Permanent adjustment amount per discharge					0.00	55. 01
55. 02	Adjustment amount per discharge (contractor					0.00	
56. 00 57. 00	Target amount (line 54 x sum of lines 55, 55 Difference between adjusted inpatient operat			line 56 minus	line 53)	0	56. 00 57. 00
58. 00	Bonus payment (see instructions)	ring cost and to	inger amount (Title 50 millias	11116 33)	Ö	58.00
59.00	Trended costs (lesser of line 53 ÷ line 54,	or line 55 from	the cost rep	orting period	endi ng 1996,	0.00	59. 00
60. 00	updated and compounded by the market basket)	or line EE fro	m prior year	cost report	undated by the	0.00	60.00
60.00	O Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)						80.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise						61. 00
62. 00	enter zero. (see instructions) Relief payment (see instructions)					0	62. 00
63.00	Allowable Inpatient cost plus incentive paym	ent (see instru	ctions)			0	
	PROGRAM I NPATIENT ROUTI NE SWI NG BED COST		1 04 6 11				
64. 00	Medicare swing-bed SNF inpatient routine cos instructions) (title XVIII only)	ts through Dece	ember 31 of th	e cost report	ing period (See	0	64. 00
65.00	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	er 31 of the	cost reportin	g period (See	0	65. 00
	instructions)(title XVIII only)			(E) (III) \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \			
66. 00	Total Medicare swing-bed SNF inpatient routi CAH, see instructions	ne costs (Tine	64 prus rine	65)(title XVI	ii oniy); ror	0	66.00
67. 00	Title V or XIX swing-bed NF inpatient routin	e costs through	December 31	of the cost r	eporting period	0	67.00
40.00	(line 12 x line 19)	o ocato often D	looombor 21 of	the east wan	onting ported		40.00
68. 00	Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)	e costs after L	ecember 31 OT	the cost rep	orting period	0	68. 00
69. 00	Total title V or XIX swing-bed NF inpatient					0	69. 00
70.00	PART III - SKILLED NURSING FACILITY, OTHER N		•		1		70 00
70. 00 71. 00	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service c)		70.00
72. 00	Program routine service cost (line 9 x line			-/			72.00
73.00	Medically necessary private room cost applic	, ,	•				73. 00
74. 00 75. 00	Total Program general inpatient routine serv			•	Dort II column		74. 00 75. 00
75.00	Capital-related cost allocated to inpatient 26, line 45)	routine service	COSTS (110III	worksneet B,	Part II, Corumn		/5.00
76. 00	Per diem capital-related costs (line 75 ÷ li	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 minu Aggregate charges to beneficiaries for exces		rovi den recon	ds)			78. 00 79. 00
80.00	Total Program routine service costs for comp			*.	nus line 79)		80.00
81.00	Inpatient routine service cost per diem limi				•		81.00
82. 00 83. 00	Inpatient routine service cost limitation (I		* .				82. 00 83. 00
84. 00	Reasonable inpatient routine service costs (Program inpatient ancillary services (see in		13)				84.00
85. 00	Utilization review - physician compensation		ins)				85. 00
86. 00	Total Program inpatient operating costs (sum	of lines 83 th					86. 00
87. 00	PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions					17	87. 00
88. 00	Adjusted general inpatient routine cost per	•	line 2)			11, 669. 58	1
	Observation bed cost (line 87 x line 88) (se	•	•			198, 383	

Health Financial Systems FRAN	ICISCAN HEALTH (ORTHOPEDIC CARM	IEL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Period: From 01/01/2023	Worksheet D-1	
				Γο 12/31/2023	Date/Time Prep 5/31/2024 10:	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST					
90.00 Capital -related cost	2, 694, 083	6, 920, 058	0. 38931	198, 383	77, 233	90.00
91.00 Nursing Program cost	0	6, 920, 058	0.00000	198, 383	0	91.00
92.00 Allied health cost	0	6, 920, 058	0.000000	198, 383	0	92.00
93.00 All other Medical Education	0	6, 920, 058	0.000000	198, 383	0	93. 00

	FINANCI SCAN HEALTH ORT ATION OF INPATIENT OPERATING COST FRANCISCAN HEALTH ORT	Provider CCN: 15-0193	Period:	u of Form CMS-2 Worksheet D-1		
COMPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0193	From 01/01/2023	worksneet D-1		
	To 12/31/2023 Date/Ti me 5/31/2024 5/31/2024					
		Title XIX	Hospi tal	PPS	00 4	
	Cost Center Description					
				1. 00		
	PART I - ALL PROVIDER COMPONENTS					
	I NPATI ENT DAYS					
1.00	Inpatient days (including private room days and swing-bed days			593		
2.00	Inpatient days (including private room days, excluding swing-			593		
3. 00	Private room days (excluding swing-bed and observation bed day do not complete this line.	/s). IT you have only pr	rivate room days,	0	3. 00	
4.00	Semi-private room days (excluding swing-bed and observation be	ad days)		576	4. 00	
5.00	Total swing-bed SNF type inpatient days (including private room		or 31 of the cost	0	5.00	
0.00	reporting period	om days) trii oagri becembe	01 01 110 0031		0.00	
6.00	Total swing-bed SNF type inpatient days (including private roo	om davs) after December	31 of the cost	0	6.00	
	reporting period (if calendar year, enter 0 on this line)			_		
7.00						
	reporting period					
8.00						
	reporting period (if calendar year, enter 0 on this line)					
9. 00	Total inpatient days including private room days applicable to	o the Program (excluding	swing-bed and	12	9. 00	
10.00	newborn days) (see instructions)			0	10. 00	
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII on through December 31 of the cost reporting period (see instruc-		oom days)	U	10.00	
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		coom days) after	0	11. 00	
11.00	December 31 of the cost reporting period (if calendar year, en		oom days) arter	l o	11.00	
12.00			e room days)	0	12. 00	
	through December 31 of the cost reporting period	(,	_		
13.00	Swing-bed NF type inpatient days applicable to titles V or XI)	only (including privat	e room days)	0	13.00	
	after December 31 of the cost reporting period (if calendar ye	ear, enter O on this lir	ne)			
	Medically necessary private room days applicable to the Progra	am (excluding swing-bed	days)	0	1	
	Total nursery days (title V or XIX only)			0	15. 00	
16. 00	Nursery days (title V or XIX only)			0	16. 00	
	SWING BED ADJUSTMENT					
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 c	of the cost	0.00	17. 00	
40.00	reporting period	CL D L 21 C			40.00	
18.00	Medicare rate for swing-bed SNF services applicable to service	es arter December 31 of	tne cost	0.00	18. 00	
10.00	reporting period	through Docombor 21 of	the cost	0.00	10 00	
	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost 0.00 19.					
19.00	reporting period	s till dagit bedember of or	1110 0031	0.00	17.00	

	Cost Center Description	1 00	
	PART I - ALL PROVIDER COMPONENTS	1. 00	
	I NPATI ENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	593	1. 00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	593	2.00
3. 00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3. 00
4. 00	Semi-private room days (excluding swing-bed and observation bed days)	576	4.00
5. 00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost	0	5. 00
	reporting period		1
6. 00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	0	6. 00
7. 00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost	0	7. 00
7.00	reporting period		7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	0	8. 00
	reporting period (if calendar year, enter 0 on this line)		
9. 00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	12	9. 00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	0	10.00
	through December 31 of the cost reporting period (see instructions)		ł
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after	0	11. 00
12. 00	December 31 of the cost reporting period (if calendar year, enter 0 on this line) Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	12. 00
12.00	through December 31 of the cost reporting period	o l	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	13.00
	after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		1
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15. 00 16. 00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)	0	15. 00 16. 00
10.00	SWING BED ADJUSTMENT		10.00
17. 00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost	0.00	17. 00
	reporting period		
18. 00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost	0. 00	18. 00
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost	0. 00	19. 00
17.00	report in a peri od	0.00	17.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost	0.00	20.00
21 00	reporting period	/ 020 050	21 00
21. 00 22. 00	Total general inpatient routine service cost (see instructions) Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line)	6, 920, 058 0	21. 00 22. 00
22.00	5x Line 17)	٥	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6	0	23. 00
	x line 18)	ا	
24. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	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)		ł
26. 00	Total swing-bed cost (see instructions)	0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	6, 920, 058	27. 00
28. 00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28. 00
	Pri vate room charges (excluding swing-bed charges)	0	29. 00
30.00	Semi -pri vate room charges (excluding swing-bed charges)	0	30. 00
31. 00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0. 000000	ł
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33. 00 34. 00	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0. 00 0. 00	•
35. 00	Average per diem private room cost differential (line 34 x line 31)	0.00	•
36. 00	Private room cost differential adjustment (line 3 x line 35)	0	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line	6, 920, 058	37. 00
	27 minus line 36)		
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38. 00	Adjusted general inpatient routine service cost per diem (see instructions)	11, 669. 58	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line 38)	140, 035	
40. 00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40. 00

COMPUT	Financial Systems FR ATION OF INPATIENT OPERATING COST	ANCISCAN HEALTH		CCN: 15-0193	Peri od:	wof Form CMS-2 Worksheet D-1	
					From 01/01/2023 To 12/31/2023	Date/Time Pre 5/31/2024 10:	
				le XIX	Hospi tal	PPS	
	Cost Center Description	Total Inpatient Cost	Total	Average Per	3	Program Cost (col. 3 x col.	
		Impatrent cost	Impatrent bay	col . 2)		4)	
		1.00	2.00	3.00	4. 00	5. 00	
42. 00	NURSERY (title V & XIX only)						42.00
43. 00	Intensive Care Type Inpatient Hospital Unit INTENSIVE CARE UNIT	TS					43.00
43. 00 44. 00	CORONARY CARE UNIT						44. 00
45. 00	BURN INTENSIVE CARE UNIT						45. 00
46. 00	SURGICAL INTENSIVE CARE UNIT						46.00
47. 00	OTHER SPECIAL CARE (SPECIFY)						47. 00
	Cost Center Description					1.00	
48. 00	Program inpatient ancillary service cost (Mkst D-3 col 3	line 200)			1. 00 374, 162	48. 0
48. 01	Program inpatient cellular therapy acquisi-			III. line 10	column 1)	0	48. 0
49. 00	Total Program inpatient costs (sum of lines				,	514, 197	
	PASS THROUGH COST ADJUSTMENTS						
50. 00	Pass through costs applicable to Program in	npatient routine	services (fro	m Wkst. D, su	m of Parts I and	54, 518	50. 0
51. 00		nnatient ancillar	v services (f	rom Wkst D	sum of Parts II	50, 098	51.0
	and IV)	ipationt andirial	y 301 V1 063 (1	I OII WKST. D, .	Jam Or ruits II	30,090	31.0
52. 00	Total Program excludable cost (sum of lines					104, 616	
53. 00	Total Program inpatient operating cost excl		elated, non-ph	ysician anestl	netist, and	409, 581	53. 0
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	e 52)					
54. 00	Program discharges					0	54. 0
55. 00	Target amount per discharge					0.00	
55. 01	Permanent adjustment amount per discharge					0.00	55.0
55. 02	Adjustment amount per discharge (contractor					0.00	1
56. 00	Target amount (line 54 x sum of lines 55, !				50)	0	
57. 00 58. 00	Difference between adjusted inpatient opera Bonus payment (see instructions)	ating cost and ta	irget amount (line 56 minus	line 53)	0 0	57. 0 58. 0
59. 00	Trended costs (lesser of line 53 ÷ line 54,	or line 55 from	the cost ren	orting period	endina 1996	0.00	1
37.00	updated and compounded by the market basker		THE COST TOP	or tring period	charing 1770,	0.00	07.0
50.00	Expected costs (lesser of line 53 ÷ line 54		om prior year	cost report,	updated by the	0. 00	60.00
	market basket)				== .	0	
51. 00	55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise						61.00
52. 00	enter zero. (see instructions) 00 Relief payment (see instructions)						
53. 00	Allowable Inpatient cost plus incentive pay	yment (see instru	ıcti ons)			0	
	PROGRAM INPATIENT ROUTINE SWING BED COST	•	,				
54. 00	Medicare swing-bed SNF inpatient routine co	osts through Dece	ember 31 of th	e cost report	ng period (See	0	64. 0
55. 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine co	nete after Necemb	oer 31 of the	cost reporting	a period (See	0	65. 0
55. 00	instructions)(title XVIII only)	J3t3 arter Decemb	del 31 di the	cost reporting	g perrou (see		05.0
66.00	Total Medicare swing-bed SNF inpatient rou	tine costs (line	64 plus line	65)(title XVI	ll only); for	0	66.00
	CAH, see instructions			6.11			
57. 00	Title V or XIX swing-bed NF inpatient routi	ine costs through	December 31	of the cost r	eporting period	0	67.00
58. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routi	ine costs after [ecember 31 of	the cost ren	orting period	0	68. 00
	(line 13 x line 20)				3 1 3		
59. 00	Total title V or XIX swing-bed NF inpatien					0	69.00
70 00	PART III - SKILLED NURSING FACILITY, OTHER		•		<u> </u>		70.00
70. 00 71. 00	Skilled nursing facility/other nursing faci Adjusted general inpatient routine service	-)		70.00
72.00	Program routine service cost (line 9 x line		75 . 11116	-/			72. 0
73. 00	Medically necessary private room cost appli		n (line 14 x l	i ne 35)			73. 0
74. 00	Total Program general inpatient routine se	•		•			74. 0
75. 00	Capital-related cost allocated to inpatien	t routine service	costs (from	worksheet B, I	Part II, column		75. 0
76. 00	26, line 45) Per diem capital-related costs (line 75 ÷ l	line 2)					76. 0
77. 00	Program capital related costs (line 9 x line)						77. 0
78. 00	Inpatient routine service cost (line 74 mi)	nus line 77)					78. 0
79. 00	Aggregate charges to beneficiaries for exce			•	11- 70		79.0
30. 00 31. 00	Total Program routine service costs for con	•	ost ilmitatio	n (iine 78 mii	nus iine 79)		80. 0 81. 0
31.00	Inpatient routine service cost per diem lin Inpatient routine service cost limitation)				82.0
33. 00	Reasonable inpatient routine service costs	•	•				83. 0
34. 00	Program inpatient ancillary services (see i	instructions)	•				84. 0
35. 00	Utilization review - physician compensation						85. 0
36. 00	Total Program inpatient operating costs (su		rough 85)				86. 0
37. 00	PART IV - COMPUTATION OF OBSERVATION BED PA Total observation bed days (see instruction					17	 87. 0
	Adjusted general inpatient routine cost per		· line 2)			11, 669. 58	1
38. 00	That as to a general impatient routine come in						

Health Financial Systems FRAN	CISCAN HEALTH (ORTHOPEDIC CARM	IEL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2023 Fo 12/31/2023	Date/Time Pre 5/31/2024 10:	
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(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	2, 694, 083	6, 920, 058	0. 38931	5 198, 383	77, 233	90.00
91.00 Nursing Program cost	0	6, 920, 058	0.00000	198, 383	0	91.00
92.00 Allied health cost	0	6, 920, 058	0.00000	198, 383	0	92.00
93.00 All other Medical Education	0	6, 920, 058	0. 000000	198, 383	0	93. 00

Health Finar	ncial Systems FRANCISCAN HEALTH ORT	HOPEDIC CARM	ИEL	In Lie	eu of Form CMS-2	2552-10
INPATIENT A	NCILLARY SERVICE COST APPORTIONMENT	Provi der Co		Peri od:	Worksheet D-3	
				From 01/01/2023 To 12/31/2023	Date/Time Pre 5/31/2024 10:	
		Title	XVIII	Hospi tal	PPS	
	Cost Center Description		Ratio of Cos		I npati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
			1.00	2. 00	2) 3. 00	
ΙΝΡΔΤ	TENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
	ADULTS & PEDIATRICS			635, 152		30.00
	LARY SERVICE COST CENTERS			000,102		00.00
	OPERATING ROOM		0. 22851	6 4, 228, 813	966, 351	50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM		0.00000		0	52. 00
54. 00 05400	RADI OLOGY-DI AGNOSTI C		1. 13637	75 227, 093	258, 063	54.00
60.00 06000	LABORATORY		0. 08260	327, 717	27, 071	60.00
	RESPI RATORY THERAPY		1. 28781			65. 00
	PHYSI CAL THERAPY		0. 24957		53, 166	
	OCCUPATI ONAL THERAPY		0.00000		0	67. 00
	SPEECH PATHOLOGY		0. 00000		0	68. 00
	ELECTROCARDI OLOGY		0. 31087			
	MEDICAL SUPPLIES CHARGED TO PATIENT		0. 60430			
	IMPL. DEV. CHARGED TO PATIENTS		0. 37922			
	DRUGS CHARGED TO PATIENTS		0. 48027			
	ALLOGENEIC HSCT ACQUISITION CAR T-CELL IMMUNOTHERAPY		0. 00000 0. 00000		0	77. 00 78. 00
	ITIENT SERVICE COST CENTERS		0.00000	0	0	78.00
90. 00 09000			0.00000	0	0	90.00
91. 00 09100			0. 00000		0	
	OBSERVATION BEDS (NON-DISTINCT PART		3. 55639		0	
200.00	Total (sum of lines 50 through 94 and 96 through 98)		0.0000	11, 004, 445	1	
201.00	Less PBP Clinic Laboratory Services-Program only charges	(line 61)		0	1, 555, 616	201.00
202. 00	Net charges (line 200 minus line 201)	()		11, 004, 445		202. 00
			•	*	•	•

Health Financial Systems FRANCISCAN HEALTH OR	THOPEDIC CAR	MEL	In Li∈	eu of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C		Peri od:	Worksheet D-3	
			From 01/01/2023 To 12/31/2023	Date/Time Pre 5/31/2024 10:	
	Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description		Ratio of Cos		I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
LAIDATI ENT DOUTING CEDALOG COCT CENTEDO		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS			22.072		20.00
30. 00 03000 ADULTS & PEDI ATRI CS ANCI LLARY SERVI CE COST CENTERS			33, 072		30.00
50, 00 05000 OPERATING ROOM		0. 22851	6 295, 632	67, 557	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM		0. 00000		07,337	1
54. 00 05400 RADI OLOGY - DI AGNOSTI C		1. 13637		1	
60. 00 06000 LABORATORY		0. 08260			
65. 00 06500 RESPIRATORY THERAPY		1. 28781			
66. 00 06600 PHYSI CAL THERAPY		0. 24957			1
67. 00 06700 OCCUPATI ONAL THERAPY		0.00000		0	67. 00
68. 00 06800 SPEECH PATHOLOGY		0.00000	0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY		0. 31087	4 6, 314	1, 963	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 60430	141, 497	85, 507	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 37922	7 465, 958		
73.00 O7300 DRUGS CHARGED TO PATIENTS		0. 48027	4 36, 545	17, 552	73. 00
77.00 O7700 ALLOGENEIC HSCT ACQUISITION		0.00000		0	
78.00 O7800 CAR T-CELL IMMUNOTHERAPY		0.00000	0	0	78. 00
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLI NI C		0.00000		0	70.00
91. 00 09100 EMERGENCY		0.00000		0	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART		3. 55639		0	
Total (sum of lines 50 through 94 and 96 through 98)	(1)		978, 245	374, 162	1
201.00 Less PBP Clinic Laboratory Services-Program only charge	s (line 61)		070.045		201. 00
202.00 Net charges (line 200 minus line 201)		I	978, 245	I	202. 00

Health Financial Systems	FRANCISCAN HEALTH ORTHOPEDIC CARMEL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0193	Peri od: From 01/01/2023 To 12/31/2023	Worksheet E Part A Date/Time Prepared: 5/31/2024 10:50 am

			10 12/31/2023	5/31/2024 10:	
		Title XVIII	Hospi tal	PPS	
				1. 00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1.00	DRG Amounts Other than Outlier Payments			0	1.00
1. 01	DRG amounts other than outlier payments for discharges occurri	ng prior to October 1 (s	see	1, 437, 849	1. 01
1 00	instructions)	na on or often October :	1 (000	700 000	1 00
1. 02	DRG amounts other than outlier payments for discharges occurring instructions)	ng on or after october	i (see	790, 899	1. 02
1.03	DRG for federal specific operating payment for Model 4 BPCL fo	or discharges occurring i	orior to October	0	1. 03
1.03	1 (see instructions)	or discharges occurring p	Jiroi to octobei	0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCL fo	or discharges occurring o	on or after	0	1. 04
1.01	October 1 (see instructions)	or ar serial ges decar i ring v	511 61 41 (61	١	1.01
2.00	Outlier payments for discharges. (see instructions)				2. 00
2. 01	Outlier reconciliation amount			0	2. 01
2. 02	Outlier payment for discharges for Model 4 BPCI (see instructi	ons)		0	2. 02
2. 03	Outlier payments for discharges occurring prior to October 1	*		25, 085	2. 03
2. 04	Outlier payments for discharges occurring on or after October			274, 367	2. 04
3.00	Managed Care Simulated Payments	(300 111311 4011 0113)		271,007	3. 00
4. 00	Bed days available divided by number of days in the cost repo	sting pariod (see instru	ctions)	19. 95	4. 00
4.00	Indirect Medical Education Adjustment	tring period (see riistru	511 0113)	17. 73	4.00
5. 00	FTE count for allopathic and osteopathic programs for the most	t recent cost reporting	period ending on	0.00	5. 00
3.00	or before 12/31/1996. (see instructions)	r recent cost reporting p	berroa enaring on	0.00	3.00
5. 01	FTE cap adjustment for qualifing hospitals under §131 of the	CAA 2021 (see instruction	ne)	0. 00	5. 01
6. 00	FTE count for allopathic and osteopathic programs that meet the			0.00	6. 00
0.00	new programs in accordance with 42 CFR 413.79(e)	le cirterra for all add-or	1 to the cap for	0.00	0.00
6. 26	Rural track program FTE cap limitation adjustment after the ca	an huilding window close	d under \$127 of	0.00	6. 26
0. 20	the CAA 2021 (see instructions)	ap-building window crosed	under 9127 of	0.00	0. 20
7. 00	MMA Section 422 reduction amount to the IME cap as specified u	under 42 CED \$412 10E(f)	(1) (i v) (D) (1)	0. 00	7. 00
7. 01	ACA § 5503 reduction amount to the IME cap as specified under	42 CFR 9412. 105(T)(1)(I)	V)(B)(2) IT the	0. 00	7. 01
7 00	cost report straddles July 1, 2011 then see instructions.	ok naganom ETE limitation	(a) far rural	0.00	7 00
7. 02	Adjustment (increase or decrease) to the hospital's rural trad			0. 00	7. 02
	track programs with a rural track for Medicare GME affiliated	programs in accordance	with 413.75(b)		
	and 87 FR 49075 (August 10, 2022) (see instructions)		6		
8.00	Adjustment (increase or decrease) to the FTE count for allopa			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 slo	ots under § 5503 of the <i>i</i>	ACA. If the cost	0. 00	8. 01
	report straddles July 1, 2011, see instructions.				
8. 02	The amount of increase if the hospital was awarded FTE cap slo	ots from a closed teachi	ng hospital	0. 00	8. 02
	under § 5506 of ACA. (see instructions)				
8. 21	The amount of increase if the hospital was awarded FTE cap slo	ots under §126 of the CA	A 2021 (see	0. 00	8. 21
	instructions)				
9.00	Sum of lines 5 and 5.01, plus line 6, plus lines 6.26 through		7.01, plus or	0. 00	9. 00
	minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.				
10. 00	FTE count for allopathic and osteopathic programs in the curre	ent year from your record	ds	0. 00	
11. 00	FTE count for residents in dental and podiatric programs.				11. 00
12. 00	Current year allowable FTE (see instructions)			0. 00	
13. 00	Total allowable FTE count for the prior year.			0. 00	13. 00
14. 00	Total allowable FTE count for the penultimate year if that yes	ar ended on or after Sep [.]	tember 30, 1997,	0. 00	14. 00
	otherwise enter zero.				
15. 00	Sum of lines 12 through 14 divided by 3.			0. 00	15. 00
16.00	Adjustment for residents in initial years of the program (see	i nstructi ons)		0.00	16. 00
17.00	Adjustment for residents displaced by program or hospital clos	sure		0. 00	17. 00
18.00	Adjusted rolling average FTE count			0.00	18. 00
	Current year resident to bed ratio (line 18 divided by line 4)).		0. 000000	
20. 00	Prior year resident to bed ratio (see instructions)			0. 000000	
	Enter the lesser of lines 19 or 20 (see instructions)			0. 000000	
22. 00	IME payment adjustment (see instructions)			0.000000	22. 00
22. 01	IME payment adjustment - Managed Care (see instructions)			0	
22.01	Indirect Medical Education Adjustment for the Add-on for § 422	of the MMA		U	22.01
23. 00			ED 412 10E	0.00	22.00
23.00	Number of additional allopathic and osteopathic IME FTE reside	ent cap stots under 42 ci	FR 412. 103	0. 00	23. 00
24. 00	(f)(1)(iv)(C).			0.00	24 00
	IME FTE Resident Count Over Cap (see instructions)		24 (0.00	
25. 00	If the amount on line 24 is greater than -0-, then enter the	ower of line 23 of line	24 (See	0. 00	25. 00
04 00	instructions)			0.000000	04 00
26. 00	Resident to bed ratio (divide line 25 by line 4)			0.000000	
27. 00	IME payments adjustment factor. (see instructions)			0. 000000	1
28. 00	IME add-on adjustment amount (see instructions)			0	28. 00
28. 01	IME add-on adjustment amount - Managed Care (see instructions))		0	28. 01
29. 00	Total IME payment (sum of lines 22 and 28)			0	29. 00
29. 01	Total IME payment - Managed Care (sum of lines 22.01 and 28.0	1)		0	29. 01
	Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A pa	atient days (see instruc	tions)	0.00	30.00
31.00	Percentage of Medicaid patient days (see instructions)			0.00	31.00
32.00	Sum of lines 30 and 31			0.00	32. 00
33.00	Allowable disproportionate share percentage (see instructions))		0.00	
	Di sproporti onate share adjustment (see instructions)				34.00
	• • • • • • • • • • • • • • • • • • • •		ı		

	nancial Systems FRANCISCAN HEALTH ORTH	HOPEDIC CARMEL Provider CCN: 15-0193		u of Form CMS-2	2552-10
CALCULATIO	ON OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0193	Peri od: From 01/01/2023	Worksheet E Part A	
			To 12/31/2023	Date/Time Pre	
		Title XVIII	Hospi tal	5/31/2024 10: PPS	50 alli
			Prior to 10/1		
			1. 00	2. 00	
	ompensated Care Payment Adjustment				
	tal uncompensated care amount (see instructions)		0	0. 000000000	
	ctor 3 (see instructions) spital UCP, including supplemental UCP (see instructions)		0. 000000000	0. 000000000	35. 01 35. 02
	o rata share of the hospital UCP, including supplemental UCF	(see instructions)	0	0	35. 02
	tal UCP adjustment (sum of columns 1 and 2 on line 35.03)	(,	0	_	36. 00
Add	itional payment for high percentage of ESRD beneficiary dis	scharges (lines 40 throug			
	tal Medicare discharges (see instructions)		0		40.00
	tal ESRD Medicare discharges (see instructions)	anal	0		41. 00 41. 01
1	tal ESRD Medicare covered and paid discharges (see instructi vide line 41 by line 40 (if less than 10%, you do not qualif	•	0.00		42.00
	tal Medicare ESRD inpatient days (see instructions)	y ror day astmerre	0.00		43. 00
	tio of average length of stay to one week (line 43 divided b	by line 41 divided by 7	0. 000000		44.00
day					
	erage weekly cost for dialysis treatments (see instructions)		0.00		45. 00
	tal additional payment (line 45 times line 44 times line 41. ototal (see instructions)	01)	2, 528, 200		46. 00 47. 00
	spital specific payments (to be completed by SCH and MDH, sm	nall rural hospitals	2, 526, 200		48.00
	y. (see instructions)	iiai i i i i i i i i i i i i i i i i i			40.00
				Amount	
40.00 T.				1.00	40.00
	tal payment for inpatient operating costs (see instructions) yment for inpatient program capital (from Wkst. L, Pt. I and			2, 528, 200 1, 480, 702	•
, ,	ception payment for inpatient program capital (Wkst. L, Pt.)			1, 480, 702	1
	rect graduate medical education payment (from Wkst. E-4, lir			0	52. 00
1	rsing and Allied Health Managed Care payment	•		0	53. 00
	ecial add-on payments for new technologies			0	54.00
1	et isolation add-on payment			0	54. 01
	t organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69 Iular therapy acquisition cost (see instructions)))		0	55. 00 55. 01
	st of physicians' services in a teaching hospital (see intru	uctions)		0	1
1	utine service other pass through costs (from Wkst. D, Pt. II	•	rough 35).	0	57. 00
58. 00 And	cillary service other pass through costs from Wkst. D, Pt. I	V, col. 11 line 200)		0	58. 00
	tal (sum of amounts on lines 49 through 58)			4, 008, 902	1
	mary payer payments	line (O)		4 000 003	60.00
	tal amount payable for program beneficiaries (line 59 minus ductibles billed to program beneficiaries	Tine 60)		4, 008, 902 177, 600	1
	nsurance billed to program beneficiaries			0	63.00
1	owable bad debts (see instructions)			4, 668	ı
	usted reimbursable bad debts (see instructions)			3, 034	1
	owable bad debts for dual eligible beneficiaries (see instr	ructions)		3, 112	ł
i i	ototal (line 61 plus line 65 minus lines 62 and 63)	applicable to MS DDCs (sa	o instructions)	3, 834, 336	1
	edits received from manufacturers for replaced devices for a Hier payments reconciliation (sum of lines 93, 95 and 96).(0	68. 00 69. 00
	HER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	C. S. Son See That delibra	'	0	70. 00
	ral Community Hospital Demonstration Project (§410A Demonstr	ration) adjustment (see i	nstructions)	0	70. 50
1	5 respirator payment adjustment amount (see instructions)			0	70. 75
1	monstration payment adjustment amount before sequestration			0	70. 87
1	H or MDH volume decrease adjustment (contractor use only) oneer ACO demonstration payment adjustment amount (see instr	cuctions)		0	70. 88 70. 89
	P bonus payment HVBP adjustment amount (see instructions)	ucti ulisj		0	1
	bonus payment HRR adjustment amount (see instructions)			0	70. 91
1	ndled Model 1 discount amount (see instructions)			0	70. 92
1	BP payment adjustment amount (see instructions)			0	70. 93
1	R adjustment amount (see instructions)			0	•
70. 95 Rec	covery of accelerated depreciation			0	70. 95

Health Financial Systems	FRANCISCAN HEALTH ORTHOPEDIC CARMEL	In Lieu of Form CMS	-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0193	Period: Worksheet E From 01/01/2023 Part A	

To 12/31/2023 | Date/Time Prepared: 5/31/2024 10:50 am Hospi tal Title XVIII PPS FFY (yyyy) Amount 1.00 0 70.96 Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 0 70.96 the corresponding federal year for the period prior to 10/1) Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 0 70.97 70.97 0 the corresponding federal year for the period ending on or after 10/1) 70.98 0 70.98 Low Volume Payment-3 0 70 99 HAC adjustment amount (see instructions) 0 70 99 Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70) 3, 834, 336 71.00 71.00 71. 01 Sequestration adjustment (see instructions) 76, 687 71.01 Demonstration payment adjustment amount after sequestration 71. 02 71. 02 71. 03 Sequestration adjustment-PARHM pass-throughs 71.03 72.00 Interim payments 2, 531, 217 72.00 72. 01 Interim payments-PARHM 72.01 73.00 Tentative settlement (for contractor use only) Ω 73.00 73.01 Tentative settlement-PARHM (for contractor use only) 73.01 74.00 Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 1, 226, 432 74.00 73) Balance due provider/program-PARHM (see instructions) 74 01 74 01 75.00 Protested amounts (nonallowable cost report items) in accordance with 50, 303 75.00 CMS Pub. 15-2, chapter 1, §115.2 TO BE COMPLETED BY CONTRACTOR (lines 90 through 96) 90.00 Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 0 90.00 plus 2.04 (see instructions) Capital outlier from Wkst. L, Pt. I, line 2 91.00 Ω 91.00 92.00 Operating outlier reconciliation adjustment amount (see instructions) 0 92.00 93.00 Capital outlier reconciliation adjustment amount (see instructions) 93.00 0 94 00 The rate used to calculate the time value of money (see instructions) 0 00 94 00 95.00 Time value of money for operating expenses (see instructions) 0 95.00 96.00 Time value of money for capital related expenses (see instructions) 96.00 0 Prior to 10/1 On/After 10/1 2 00 1 00 HSP Bonus Payment Amount 0 100. 00 100.00 HSP bonus amount (see instructions) 0 HVBP Adjustment for HSP Bonus Payment 0.0000000000 101.00 0.0000000000 101.00 HVBP adjustment factor (see instructions) 102.00 HVBP adjustment amount for HSP bonus payment (see instructions) 0 102.00 HRR Adjustment for HSP Bonus Payment 0.0000 103.00 103.00 HRR adjustment factor (see instructions) 0.0000 104.00 HRR adjustment amount for HSP bonus payment (see instructions) 0 104.00 Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no. 200.00 Cost Reimbursement 201.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) 201.00 202.00 Medicare discharges (see instructions) 202. 00 203.00 203.00 Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration peri od) 204.00 Medicare target amount 204.00 205.00 Case-mix adjusted target amount (line 203 times line 204) 205. 00 206.00 Medicare inpatient routine cost cap (line 202 times line 205) 206. 00 Adjustment to Medicare Part A Inpatient Reimbursement 207.00 Program reimbursement under the §410A Demonstration (see instructions) 207.00 208.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59) 208. 00 209.00 Adjustment to Medicare IPPS payments (see instructions) 209. 00 210.00 Reserved for future use 210. 00 211.00 Total adjustment to Medicare IPPS payments (see instructions) 211. 00 Comparision of PPS versus Cost Reimbursement 212.00 Total adjustment to Medicare Part A IPPS payments (from line 211) 212.00 213. 00 218. 00 213.00 Low-volume adjustment (see instructions) 218.00 Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)

| In Lieu of Form CMS-2552-10 | Period: | Worksheet E | From 01/01/2023 | Part A Exhibit 4 | To 12/31/2023 | Date/Time Prepared: | 5/31/2024 | 10: 50 am Health Financial Systems

LOW VOLUME CALCULATION EXHIBIT 4 FRANCISCAN HEALTH ORTHOPEDIC CARMEL
Provider CCN: 15-0193

N/S Part A Assumit (from Part A As							0 12/31/2023	5/31/2024 10:	
1.00 BBC assemble than outline 0.0					Title	XVIII	Hospi tal	PPS	
1.00 SS anounts other than outlier 1.00 0 0 0 0 0 0 0 0 0			W/S E, Part A	Amounts (from		Period Prior		Total (Col 2	
1.00 DRG measures other than outlier 1.00 0 0 0 0 0 0 0 0 0									
1.01 100 1.02 1.03 1.03 1.03 1.03 1.437,849 0 1.437,849 0 1.437,849 1.01 1.437,849 1.01 1.437,849 1.01 1.437,849 1.01 1.437,849 1.02 1.437,849 1.02 1.437,849 1.02		<u>, </u>							
1.01 1.02 1.03	1.00		1. 00	0	0	0	0	0	1. 00
Description									
1.00	1. 01		1. 01	1, 437, 849	0	1, 437, 849		1, 437, 849	1. 01
1.02 PGC unconfits other than outlier 1.02 790,899 0 790,899 790,899 1.02		payments for discharges							
Degree D		occurring prior to October 1							
1.03 Courting on or after October	1.02	DRG amounts other than outlier	1. 02	790, 899	0		790, 899	790, 899	1. 02
1.00 80 For Federal specific 1.03 0 0 0 0 0 0 0 1.03 0 0 0 0 0 0 0 0 0		payments for discharges							
Operating payment for Model 4 BPCI occurring prior to Cotober 1 Cotober		occurring on or after October							
Operating payment for Model 4 BPCI occurring prior to Cotober 1 Cotober		1							
BPC occurring prior to	1.03	·	1. 03	0	0	0		0	1. 03
October 1 October 2 October 3 October 3 October 4 October 4 October 5 October 6 October 6 October 6 October 6 October 7 October 7 October 7 October 7 October 7 October 8 October 9 Octo		operating payment for Model 4							
1.04 DRC for Federal Specific 1.04 0 0 0 0 0 0 0 0 0		BPCI occurring prior to							
operating payment for Model 4 BRCI occurring on a after October Outlier payments for after October Outlier payments for control of the managements for control of the management for the management for control of t		October 1							
BPC occurring on or after	1.04	DRG for Federal specific	1. 04	0	0		0	0	1. 04
October 1									
2.00 Outlier payments for 2.00 2.00 2.00 2.00 2.00 2.00		BPCI occurring on or after							
discharges (see Instructions) 0 0 0 0 0 0 0 0 0		October 1							
2.01 Outlier payments for 2.02 0 0 0 0 0 0 2.01	2.00	Outlier payments for	2. 00						2.00
discharges for Model 4 BPC 2. 03 25,085 0 25,085 2.02 0 0 0 0 0 0 0 0 0		discharges (see instructions)							
2.02 Outlier payments for 2.03 25,085 0 25,085 25,085 2.02	2.01	Outlier payments for	2. 02	0	0	0	0	0	2. 01
di scharges occurring prior to 0		discharges for Model 4 BPCI							
October 1 (see instructions) 2.04 274,367 0 274,367 274,367 2.03 274,367 2.03 2.	2. 02		2. 03	25, 085	0	25, 085		25, 085	2. 02
2.03 Outs care payments for disknesses occurring on or after October 1 (see instructions) 3.00 0 0 0 0 0 0 0 0 0									
discharges occurring on or after October 1 (see 1)									
after October 1 (see	2.03	Outlier payments for	2. 04	274, 367	0		274, 367	274, 367	2.03
Instructions 0									
3.00 Operating outlier		after October 1 (see							
Perfect Perf		instructions)							
A. 00 Managed care s imulated 3. 00 0 0 0 0 0 0 0 0 0	3.00	Operating outlier	2. 01	0	0	0	0	0	3.00
Dayments		reconciliation							
Indi rect Medical Education Adjustment S.00 Anunt from Worksheet E. Part 21.00 0.00000 0.00000 0.00000 0.000000 0.000000 0.000000 0.000000 0.000000 0.00000000	4.00	Managed care simulated	3. 00	0	0	0	0	0	4.00
5.00 Amount from Worksheet E, Part 21.00 0.00000 0.000000 0.00000000		payments							
A. line 21 (see instructions) Colorable Colora		Indirect Medical Education Adj	ustment						
Section IME payment adjustment (see 22.00 0 0 0 0 0 0 0 0 0	5.00	Amount from Worksheet E, Part	21.00	0. 000000	0. 000000	0.000000	0.000000		5.00
Instructions		A, line 21 (see instructions)							
IME payment adjustment for	6.00	IME payment adjustment (see	22. 00	0	0	0	0	0	6.00
managed care (see		instructions)							
Instructions	6.01	IME payment adjustment for	22. 01	o	0	0	o	o	6. 01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA		managed care (see							
The payment adjustment factor See instructions See in structions See in struct									
The payment adjustment factor See instructions See in structions See in struct		Indirect Medical Education Adj	ustment for the	Add-on for Se	ction 422 of t	he MMA			
8.00 IME adjustment (see 28.00 0 0 0 0 0 0 8.00	7.00						0.000000		7.00
Instructions IME payment add on		(see instructions)							
ME payment adjustment add on commanaged care (see instructions) 9.00 Total IME payment (sum of care (see instructions) 29.00 0 0 0 0 0 0 0 0 0	8.00	IME adjustment (see	28. 00	0	0	0	o	0	8.00
For managed care (see instructions) 9.00 Total IME payment (sum of 29.00 0 0 0 0 0 0 0 0 0		instructions)							
Instructions Figure Figu	8.01		28. 01	0	0	0	o	0	8. 01
Instructions Figure Figu		for managed care (see							
I ines 6 and 8 Total IME payment for managed care (sum of lines 6.01 and 8.01) Disproportionate Share Adjustment									
I ines 6 and 8 Total IME payment for managed care (sum of lines 6.01 and 8.01) Disproportionate Share Adjustment	9.00	Total IME payment (sum of	29. 00	0	0	0	o	0	9.00
Total IME payment for managed care (sum of lines 6.01 and 8.01)				٦]]		
Care (sum of lines 6.01 and 8.01) Di sproporti onate Share Adjustment Share Adjustment Share Adjustment Di sproporti onate share percentage (see instructions) Share percentage (see instructions) Share percentage (see instructions) Di sproporti onate share Share Adjustment (see instructions) Share Percentage (see instructions) Share Percentage (see instructions) Share Percentage (see instructions) Share Percentage Share	9. 01		29. 01	О	0	0	l ol	o	9. 01
8.01) Disproportionate Share Adjustment 33.00 0.0000 0.0000 0.0000 0.0000 10.000 10.000 10.000 10.000 11.00									
10.00 Allowable disproportionate 33.00 0.0000 0.0000 0.0000 0.0000 0.0000 10.0000 10.0000 11.00									
Share percentage (see instructions) 11.00 Disproportionate share 34.00 0 0 0 0 0 0 0 0 11.00		Di sproporti onate Share Adjustm	ent						
Share percentage (see instructions) 11.00 Disproportionate share 34.00 0 0 0 0 0 0 0 0 11.00	10.00		33.00	0. 0000	0.0000	0.0000	0.0000		10.00
11. 00 Disproportionate share adjustment (see instructions) 11. 01 Uncompensated care payments 12. 00 Total ESRD additional payment (see instructions) 13. 00 Subtotal (see instructions) 14. 00 Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions) 15. 00 Total payment for inpatient 49. 00 16. 00 17. 00 18. 00 19. 0 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 12. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 462, 934 17. 065, 266 18. 2, 528, 200 19. 10									
adjustment (see instructions) 36.00 0 0 0 0 0 0 0 0 0		instructions)							
11.01 Uncompensated care payments 36.00 0 0 0 0 0 0 11.01	11.00	Di sproporti onate share	34.00	0	0	0	o	o	11.00
Additional payment for high percentage of ESRD beneficiary discharges 12.00 Total ESRD additional payment		adjustment (see instructions)							
12.00 Total ESRD additional payment (see instructions) 13.00 Subtotal (see instructions) 14.00 Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions) 15.00 Total payment for inpatient operating costs (see instructions) 16.00 Payment for inpatient program capital (from Wkst. L, Pt. I,	11. 01			0		0	0	0	11. 01
12.00 Total ESRD additional payment (see instructions) 13.00 Subtotal (see instructions) 14.00 Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions) 15.00 Total payment for inpatient operating costs (see instructions) 16.00 Payment for inpatient program capital (from Wkst. L, Pt. I,		Additional payment for high pe	rcentage of ESF	D beneficiary	di scharges				
(see instructions) Subtotal (see instructions) 13.00 Subtotal (see instructions) 14.00 Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions) 15.00 Total payment for inpatient operating costs (see instructions) 16.00 Payment for inpatient program capital (from Wkst. L, Pt. I,	12.00			0		0	0	0	12.00
13.00 Subtotal (see instructions)									
14.00 Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions) 15.00 Total payment for inpatient operating costs (see instructions) 16.00 Payment for inpatient program capital (from Wkst. L, Pt. I,	13.00		47. 00	2, 528, 200	0	1, 462, 934	1, 065, 266	2, 528, 200	13.00
(completed by SCH and MDH, small rural hospitals only.) (see instructions) 15.00 Total payment for inpatient operating costs (see instructions) 16.00 Payment for inpatient program capital (from Wkst. L, Pt. I,	14.00		48. 00	o	0	0	o	o	
small rural hospitals only.) (see instructions) Total payment for inpatient operating costs (see instructions) Payment for inpatient program capital (from Wkst. L, Pt. I,									
(see instructions) Total payment for inpatient 49.00 2,528,200 0 1,462,934 1,065,266 2,528,200 15.00 operating costs (see instructions) Payment for inpatient program 50.00 0 0 0 0 0 16.00 capital (from Wkst. L, Pt. I,									
15.00 Total payment for inpatient operating costs (see instructions) 16.00 Payment for inpatient program capital (from Wkst. L, Pt. I,									
operating costs (see instructions) 16.00 Payment for inpatient program 50.00 0 0 0 0 16.00 capital (from Wkst. L, Pt. I,	15. 00		49. 00	2, 528, 200	0	1, 462, 934	1, 065, 266	2, 528, 200	15.00
instructions) 16.00 Payment for inpatient program 50.00 0 0 0 0 16.00 capital (from Wkst. L, Pt. I,				,			, ., .,		
16.00 Payment for inpatient program 50.00 0 0 0 16.00 capital (from Wkst. L, Pt. I,									
capital (from Wkst. L, Pt. I,	16. 00		50.00	n	Ω	n	n	n	16. 00
				٦	· ·				
						•	. '		

LOW VO	LUME CALCULATION EXHIBIT 4			Provider CC		Period: From 01/01/2023 To 12/31/2023	Worksheet E Part A Exhibi Date/Time Pre 5/31/2024 10:	pared:
				Title	XVIII	Hospi tal	PPS	
		W/S E, Part A	Amounts (from	Pre/Post	Period Prior	Peri od	Total (Col 2	
		line	E, Part A)	Entitlement	to 10/01	On/After 10/01	through 4)	
		0	1.00	2.00	3. 00	4. 00	5. 00	
17. 00	Special add-on payments for new technologies	54. 00	0	0		0	0	17. 00
17. 01	Net organ aquisition cost							17. 01
	Credits received from manufacturers for replaced	68. 00	0	0	(0	0	
18. 00	devices for applicable MS-DRGs Capital outlier reconciliation	93. 00	0	0		0 0	0	18. 00
	adjustment amount (see instructions)						-	
19.00	SUBTOTAL			0	1, 462, 93	4 1, 065, 266	2, 528, 200	19. 00
		W/S L, line	(Amounts from					
			L)					
		0	1.00	2.00	3. 00	4. 00	5. 00	
20. 00	Capital DRG other than outlier	1. 00	0	0	-61, 04	61, 046	0	20.00
20. 01	Model 4 BPCI Capital DRG other than outlier	1. 01	0	0	1	0	0	20. 01
21.00	Capital DRG outlier payments	2. 00	0	0	(0	0	21. 00
21. 01	Model 4 BPCI Capital DRG outlier payments	2. 01	0	0		0	0	21. 01
22. 00	Indirect medical education percentage (see instructions)	5. 00	0. 0000	0. 0000	0.000	0.0000		22. 00
23. 00	Indirect medical education adjustment (see instructions)	6. 00	0	0	1	0	0	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	25. 00
26. 00	Total prospective capital payments (see instructions)	12. 00	0	0	-61, 04	61, 046	0	26. 00
		W/S E, Part A	(Amounts to E.					
		line	Part A)					
		0	1.00	2.00	3. 00	4. 00	5. 00	
27. 00	Low volume adjustment factor				0.00000	0.000000		27. 00
28. 00	Low volume adjustment (transfer amount to Wkst. E,	70. 96			(D .	0	28. 00
29. 00	Pt. A, line) Low volume adjustment (transfer amount to Wkst. E,	70. 97				0	0	29. 00
100 00	Pt. A, line) Transfer low volume		Υ					100. 00
100.00	adjustments to Wkst. E, Pt. A.		'					1.50. 55

From 01/01/2023 Part A Exhibit 5 Date/Time Prepared: 12/31/2023 5/31/2024 10:50 am Hospi tal Title XVIII PPS Period to Total (cols. 2 Wkst. E, Pt. Amt. from Peri od on 10/01 A. line Wkst. E, Pt. after 10/01 and 3) A) 2.00 3. 00 0 4.00 1.00 1.00 DRG amounts other than outlier payments 1.00 1. 00 DRG amounts other than outlier payments for 1.01 1.01 1, 437, 849 1, 437, 849 1, 437, 849 1.01 discharges occurring prior to October 1 1.02 DRG amounts other than outlier payments for 790.899 790, 899 790.899 1.02 1.02 discharges occurring on or after October 1 1.03 DRG for Federal specific operating payment 1.03 С 1.03 0 for Model 4 BPCI occurring prior to October DRG for Federal specific operating payment 1.04 1.04 0 1.04 for Model 4 BPCI occurring on or after October 1 2.00 Outlier payments for discharges (see 2.00 2.00 instructions) 2.01 Outlier payments for discharges for Model 4 2.02 2.01 **BPCI** 2 02 Outlier payments for discharges occurring 2 03 25, 085 25 085 25 085 2 02 prior to October 1 (see instructions) Outlier payments for discharges occurring on 2.03 2.04 274, 367 274, 367 274, 367 2.03 or after October 1 (see instructions) 3.00 Operating outlier reconciliation 2.01 0 3.00 Managed care simulated payments 4.00 3.00 0 4.00 Indirect Medical Education Adjustment 5.00 Amount from Worksheet E, Part A, line 21 21.00 0.000000 0.000000 0.000000 5.00 (see instructions) IME payment adjustment (see instructions) 6.00 22.00 0 0 6.00 0 IME payment adjustment for managed care (see 0 6.01 22.01 0 0 6.01 instructions) Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA 7.00 IME payment adjustment factor (see 27. 00 0.000000 0.000000 0.000000 7.00 instructions) 8 00 IME adjustment (see instructions) 28 00 8 00 0 0 0 0 8.01 IME payment adjustment add on for managed 28.01 0 0 8.01 care (see instructions) Total IME payment (sum of lines 6 and 8) 29.00 9.00 0 0 9.00 Total IME payment for managed care (sum of 9.01 29.01 C 0 9.01 lines 6.01 and 8.01) Disproportionate Share Adjustment 10.00 Allowable disproportionate share percentage 33.00 0.0000 0.0000 0.0000 10.00 (see instructions) 11.00 Disproportionate share adjustment (see 34.00 0 0 11.00 0 instructions) 11.01 Uncompensated care payments 36 00 0 0 0 11.01 Additional payment for high percentage of ESRD beneficiary discharges 12.00 Total ESRD additional payment (see 46. 00 12.00 instructions) 47.00 1, 462, 934 13 00 2, 528, 200 Subtotal (see instructions) 2, 528, 200 1, 065, 266 13 00 14.00 Hospital specific payments (completed by SCH 48.00 14.00 and MDH, small rural hospitals only.) (see instructions) Total payment for inpatient operating costs 49.00 2, 528, 200 1, 462, 934 2, 528, 200 15.00 15.00 1, 065, 266 (see instructions) 16.00 Payment for inpatient program capital (from 50 00 16.00 0 0 0 Wkst. L, Pt. I, if applicable) 17.00 Special add-on payments for new technologies 54.00 C 17.00 0 17.01 Net organ acquisition cost 17.01 Credits received from manufacturers for 68.00 0 17.02 17.02 0 replaced devices for applicable MS-DRGs 18.00 Capital outlier reconciliation adjustment 93.00 0 18.00 amount (see instructions)

Provider CCN: 15-0193

Peri od:

1, 462, 934

1, 065, 266

2, 528, 200 19. 00

19.00

SUBTOTAL

Health Financial Systems	FRANCISCAN HEALTH ORT	HOPEDIC CARMEL	In Lie	J of ∣

Heal th	Financial Systems FRAN	CISCAN HEALTH (ORTHOPEDIC CARM	ΛEL	In Lie	eu of Form CMS-2	2552-10
HOSPI TA	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	TION EXHIBIT 5	Provi der C		Period: From 01/01/2023 To 12/31/2023		epared:
			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	0	-61, 04	6 61, 046	0	20.00
20. 01	Model 4 BPCI Capital DRG other than outlier	1. 01	0		0 0	0	20. 01
	Capital DRG outlier payments	2. 00	0		0 0	0	21.00
	Model 4 BPCI Capital DRG outlier payments	2. 01	l o		0 0	0	21. 01
	Indirect medical education percentage (see instructions)	5. 00	0.0000	0.000	0.0000		22. 00
23. 00	Indirect medical education adjustment (see instructions)	6. 00	0		0 0	0	23. 00
24. 00	(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	0	-61, 04	61, 046	0	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	0		0 0	0	30.00
	HVBP payment adjustment for HSP bonus payment (see instructions)	70. 90	O		0 0	0	30. 01
31. 00	HRR adjustment (see instructions)	70. 94	l o		0 0	0	31.00
	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	
	HAC Reduction Program adjustment (see instructions)	70. 99			0 0		32. 00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E. Pt. A.		N				100.00

Health Financial Systems	FRANCISCAN HEALTH ORT	HOPEDIC CARMEL	In Lieu of Form CMS-2552-10		
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0193	From 01/01/2023	Worksheet E Part B Date/Time Prepared: 5/31/2024 10:50 am	
		Title YVIII	Hospi tal	DDC	

		Title XVIII	Hospi tal	5/31/2024 10: PPS	50 am
				1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)	one)		1, 562	1.00
2. 00 3. 00	Medical and other services reimbursed under OPPS (see instruction OPPS or REH payments	JIIS)		13, 101, 798 7, 060, 287	2. 00 3. 00
4. 00	Outlier payment (see instructions)			1	4. 00
4. 01	Outlier reconciliation amount (see instructions)			0	4. 01
5.00	Enter the hospital specific payment to cost ratio (see instruction)	ons)		0. 000	5. 00
6. 00 7. 00	Line 2 times line 5 Sum of lines 3, 4, and 4.01, divided by line 6			0. 00	6. 00 7. 00
8. 00	Transitional corridor payment (see instructions)			0.00	8. 00
9.00	Ancillary service other pass through costs including REH direct	graduate medical educa	ation costs from	0	9. 00
	Wkst. D, Pt. IV, col. 13, line 200			_	
10. 00 11. 00	Organ acquisitions Total cost (sum of Lines 1 and 10) (see instructions)			0 1, 562	10. 00 11. 00
11.00	Total cost (sum of lines 1 and 10) (see instructions) COMPUTATION OF LESSER OF COST OR CHARGES			1, 502	11.00
	Reasonabl e charges				
12. 00	Ancillary service charges				12. 00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line	e 69)		0	13.00
14. 00	Total reasonable charges (sum of lines 12 and 13) Customary charges			3, 252	14. 00
15. 00	Aggregate amount actually collected from patients liable for par	yment for services on a	charge basis	0	15. 00
16.00	Amounts that would have been realized from patients liable for			0	16. 00
47.00	had such payment been made in accordance with 42 CFR §413.13(e)			0.000000	47.00
17. 00 18. 00	Ratio of line 15 to line 16 (not to exceed 1.000000) Total customary charges (see instructions)			0. 000000 3, 252	17. 00 18. 00
19. 00	Excess of customary charges over reasonable cost (complete only	if line 18 exceeds lir	ne 11) (see	1, 690	
	instructions)		, (,, 2.12	
20. 00	Excess of reasonable cost over customary charges (complete only	if line 11 exceeds lir	ne 18) (see	0	20. 00
21. 00	<pre>instructions) Lesser of cost or charges (see instructions)</pre>			1, 562	21. 00
22. 00	Interns and residents (see instructions)			1, 302	22. 00
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)			7, 060, 288	24. 00
25. 00	COMPUTATION OF REIMBURSEMENT SETTLEMENT			0	25. 00
26. 00	Deductibles and coinsurance amounts (for CAH, see instructions) Deductibles and Coinsurance amounts relating to amount on line:	24 (for CAH, see instru	uctions)	868, 588	
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plu	•	'	6, 193, 262	27. 00
00.00	instructions)	50)			00.00
28. 00 28. 50	Direct graduate medical education payments (from Wkst. E-4, line REH facility payment amount (see instructions)	e 50)		0	28. 00 28. 50
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	29. 00
30.00	Subtotal (sum of lines 27, 28, 28.50 and 29)			6, 193, 262	
31. 00	Pri mary payer payments			3, 559	
32. 00	Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES	2)		6, 189, 703	32. 00
33. 00	•))		0	33. 00
	Allowable bad debts (see instructions)			3, 112	
35. 00	Adjusted reimbursable bad debts (see instructions)			2, 023	
36.00		ctions)			36.00
37. 00 38. 00	Subtotal (see instructions) MSP-LCC reconciliation amount from PS&R			6, 191, 726 0	37. 00 38. 00
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39. 00
39. 50	Pioneer ACO demonstration payment adjustment (see instructions)				39. 50
39. 75	N95 respirator payment adjustment amount (see instructions)			0	39. 75
39. 97 39. 98	Demonstration payment adjustment amount before sequestration Partial or full credits received from manufacturers for replaced	d devices (see instruct	ions)	0	39. 97 39. 98
39. 90	RECOVERY OF ACCELERATED DEPRECIATION	A GOVERGO (SEE THISTING)	.1 5113)	0	39. 99
40. 00	Subtotal (see instructions)			6, 191, 726	1
40. 01	Sequestration adjustment (see instructions)			123, 835	
40. 02	Demonstration payment adjustment amount after sequestration			0	40. 02
40. 03 41. 00	Sequestration adjustment-PARHM pass-throughs Interim payments			6, 064, 575	40. 03 41. 00
41. 01	Interim payments-PARHM			0, 00 1, 070	41. 01
42.00	Tentative settlement (for contractors use only)			0	42. 00
42. 01	Tentative settlement-PARHM (for contractor use only)				42. 01
43.00	Balance due provider/program (see instructions)			3, 316	1
43. 01 44. 00	Balance due provider/program-PARHM (see instructions) Protested amounts (nonallowable cost report items) in accordance	e with CMS Pub 15-2 o	chapter 1	0	43. 01 44. 00
1 1. 00	§115. 2				11.00
0	TO BE COMPLETED BY CONTRACTOR				
	Original outlier amount (see instructions)			0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions) The rate used to calculate the Time Value of Money			0 0. 00	91. 00 92. 00
	Time Value of Money (see instructions)				93. 00
			<u> </u>		

Health Financial Systems	FRANCISCAN HEALTH ORTHOPEDIC CARMEL	In Lie	u of Form CMS-	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0193	Peri od:	Worksheet E	
		From 01/01/2023 To 12/31/2023	Date/Time Pre	narod:
		10 12/31/2023	5/31/2024 10:	50 am
	Title XVIII	Hospi tal	PPS	
			1. 00	
94.00 Total (sum of lines 91 and 93)			0	94.00
			1.00	
MEDICARE PART B ANCILLARY COSTS				
200.00 Part B Combined Billed Days			0	200. 00

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 Financial
 Systems
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 ANALYSIS
 OF
 PAYMENTS
 TO
 PROVIDERS
 FOR
 SERVICES
 RENDERED
 Provider CCN: 15-0193

					5/31/2024 10: 5	50 am
		Title	XVIII	Hospi tal	PPS	
		Inpatien	t Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2.00	3. 00	4.00	
1.00	Total interim payments paid to provider		2, 389, 01		6, 064, 575	1. 00
2.00	Interim payments payable on individual bills, either			0	0	2. 00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3.00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	09/06/2023	142, 20	00	0	3. 01
3.02				0	0	3. 02
3.03				0	0	3. 03
3.04				0	0	3.04
3.05				0	0	3. 05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM			0	0	3. 50
3.51				0	0	3. 51
3.52				0	0	3. 52
3.53				0	0	3. 53
3.54				0	0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		142, 20	00	0	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		2, 531, 21	7	6, 064, 575	4. 00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR		·			
5.00	List separately each tentative settlement payment after					5. 00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
F 01	Program to Provider		Γ			г 01
5. 01	TENTATI VE TO PROVI DER			0	0 0	5. 01
5. 02				-	0	5. 02
5. 03	Dravi dan ta Dragnam			0	0	5. 03
5. 50	Provider to Program TENTATIVE TO PROGRAM			0	0	5. 50
5. 51	TENTATIVE TO TROOKAW			0		5. 51
5. 52				0		5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	١	5. 99
3. 77	5. 50-5. 98)				Ĭ	5. //
6. 00	Determined net settlement amount (balance due) based on					6. 00
5. 00	the cost report. (1)					0.00
6. 01	SETTLEMENT TO PROVIDER		1, 226, 43	32	3, 316	6. 01
6. 02	SETTLEMENT TO PROGRAM			0	0	6. 02
7. 00	Total Medicare program liability (see instructions)		3, 757, 64	-	6, 067, 891	7. 00
	,		27.2770	Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
		()	1. 00	2.00	
8. 00	Name of Contractor					8. 00
	•	•		•		

Heal th	Financial Systems FRANCISCAN HEALTH ORT	HOPEDIC CARMEL	In Lie	u of Form CMS-	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 15-0193 Period: From 01/01/2023 To 12/31/2023 Part II Date/Time 5/31/2024					epared:
		Title XVIII	Hospi tal	PPS	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	.00 Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14				
2.00	2.00 Medicare days (see instructions)				
3.00	3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				
4.00	Total inpatient days (see instructions)				4. 00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5. 00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 l	ine 20			6. 00
7. 00	CAH only - The reasonable cost incurred for the purchase of cline 168	ertified HIT technology	Wkst. S-2, Pt. I		7. 00
8.00	Calculation of the HIT incentive payment (see instructions)				8.00
9. 00	Sequestration adjustment amount (see instructions)				9. 00
10.00	Calculation of the HIT incentive payment after sequestration	(see instructions)			10.00
	I NPATI ENT HOSPI TAL SERVI CES UNDER THE I PPS & CAH	(222 2322 2227 2000)			1
30.00	Initial/interim HIT payment adjustment (see instructions)				30.00
	Other Adjustment (specify)				31. 00
	00 Delegand due provider (line 9 (or line 10) minus line 20 and line 21) (see instructions)				

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

30. 00 31. 00 32. 00

Health Financial Systems FRANCISCAN HEALTH ORTHOPEDIC CARMEL In Lieu					552-10
OUTLIE	OUTLIER RECONCILIATION AT TENTATIVE SETTLEMENT Provider CCN: 15-0193 Period: W				
			From 01/01/2023 To 12/31/2023	Date/Time Prep 5/31/2024 10:5	
		Title XVIII		PPS	
				1. 00	
TO BE COMPLETED BY CONTRACTOR					
1.00	1.00 Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)				
2.00	Capital outlier from Wkst. L, Pt. I, line 2			0	2.00
3.00 Operating outlier reconciliation adjustment amount (see instructions)				0	3.00
4.00 Capital outlier reconciliation adjustment amount (see instructions)				0	4.00
5.00 The rate used to calculate the time value of money (see instructions)				0.00	5.00
6.00 Time value of money for operating expenses (see instructions)					6.00
7.00 Time value of money for capital related expenses (see instructions)					7.00

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

Provider CCN: 15-0193 Period: From 01/

Peri od: Worksheet G From 01/01/2023 To 12/31/2023 Date/Time Prepared: 5/31/2024 10:50 am

College Not Asserts 1.00 2.00 3.00 4.00	ıy)				127 017 2020	5/31/2024 10:	50 am
CUBRINT ASSITS Label Cubrin Cub			General Fund		Endowment Fund	Plant Fund	
Cosh on hand in banks			1.00		3. 00	4. 00	
Tongorary investments	- +						
Notes refer valle 0			-49, 690, 303		0	0	
Accounts receivable		. ,	0			0	
Other receivable 7, 139, 158			13 764 793	`	,	0	
All owances for uncell ectible notes and accounts receivable					o o	0	
Proposite of expenses	00	Allowances for uncollectible notes and accounts receivable			0	0	6. 00
Other current assets			702, 582	C	0	0	
10.00 Due from other Funds					0	0	
Total current assets (sum of lines 1-10)			-11, 682, 551	`	<u> </u>	0	
FixED_ASSETS	- 1		50 504 526			0	
12.00 Land			-50, 574, 550) 0	0	11.00
13.00 Land Improvements			0		0	0	12. 00
15.00 Buildings 66,009,142 0 0 0 17.00 Leasehold Improvements 0 0 0 0 0 0 0 0 0	1	Land improvements	1, 165, 218		0	0	
16.00 Accumul ated depreciation -2,869,232 0 0 0 0 0 0 0 0 0	. 00	Accumulated depreciation	-725, 518	C	0	0	14. 00
17.00 Leasehold Improvements 0 0 0 0 0 0 0 0 0					-	0	
18.00 Accumulated depreciation			-2, 869, 232	1	-	0	
19.00 Fixed equipment	1	·	0		0	0	
2.00		•	2 400 002			0	
21.00	- 1			1		0	
22.00 Accumulated depreciation 0 0 0 0 24.00 Accumulated depreciation 19, 760, 173 0 0 0 24.00 Accumulated depreciation -4, 323, 608 0 0 0 0 26.00 Accumulated depreciation 0 0 0 0 0 26.00 Accumulated depreciation 0 0 0 0 0 26.00 Accumulated depreciation 0 0 0 0 0 27.00 HT designated Assets 0 0 0 0 0 27.00 HT designated Assets 0 0 0 0 0 27.00 HT designated Assets 0 0 0 0 0 27.00 HT designated Assets 0 0 0 0 0 0 0 0 0	- 1	·	0	1	o o	0	
24.00 Accumulated depreciation 26.00 Minor equipment depreciable 0 0 0 0 26.00 Accumulated depreciation 27.00 HIT designated Assets 0 0 0 0 28.00 Accumulated depreciation 28.00 Accumulated depreciation 38.00 Accumulated depreciation 39.00 Total resignated Assets 0 0 0 0 39.00 Total resignated Assets 0 0 0 0 0 39.00 Total resignated Assets (sum of lines 12-29) 39.00 Total resignated Assets (sum of lines 31-34) 39.00 Total resignated Assets (sum of lines 45 and 50) 39.00 Total resignated Assets (sum of lines 45 and 50) 39.00 Total resignated Assets (sum of lines 51 and 87,006,636) 39.00 Total resignated Assets (sum of lines 51 and 87,006,636) 39.00 Total resignated Assets (sum of lines 51 and 87,006,636) 39.00 Total resignated Assets (sum of lines 51 and 87,006,636) 39.00 Total resignated Assets (sum of lines 51 and 87,006,636) 39.00 Total resignated Assets (sum of lines 51 and 87,006,636) 39.00 Total resignated Assets (sum of lines 51 and 87,006,636) 39.00 Total	- 1		0	C	0	0	
25.00 Minor equipment depreciable 0 0 0 0 0 0 0 0 0	. 00	Major movable equipment	19, 760, 173	(0	0	23. 00
26. 00 Accumulated depreciation		•	-4, 323, 608	C	0	0	
27. 00			0	C	0	0	
Accumulated depreciation		•	0		0	0	
29. 00		<u> </u>	0			0	
30. 00 Total fixed assets (sum of lines 12-29) 81,193,324 0 0 OTHER ASSETS		•			-	0	
OTHER ASSETS 1 1 1 1 1 1 1 1 1		· ·	81, 193, 324	-	_	-	
32.00 Deposits on leases 0 0 0 0 0 0 0 0 0			, , , , , , , , , , , , , , , , , , , ,		,		
33.00 Due from owners/officers 0 0 0 0 0 0 0 0 0	. 00	Investments	9, 765, 340	C	0		
34, 00 Other assets		•	0		-	0	
35.00 Total other assets (sum of lines 31-34) 56.407, 848 0 0 0 0 0 0 0 0 0	- 1		0			0	1
Total assets (sum of lines 11, 30, and 35) 87,006,636 0 0	1				,	0	
CURRENT LIABILITIES	1	· · · · · · · · · · · · · · · · · · ·			,		
37.00 Accounts payable 3, 307, 071 0 0 0 38.00 Salaries, wages, and fees payable 531, 965 0 0 0 0 0 0 0 0 0			07,000,030		,	0	30.00
39.00 Payroll taxes payable 97, 932 0 0 0 0 0 0 0 0 0			3, 307, 071	C	0	0	37. 00
40.00 Notes and Loans payable (short term) 0 0 0 0 0 0 0 0 0			531, 965	(0	0	38. 00
41.00 Deferred income 42.00 Accelerated payments 0 0 0 0 42.00 Accelerated payments 0 0 0 0 43.00 Due to other funds 0 0 0 0 44.00 Other current liabilities 45.00 Total current liabilities (sum of lines 37 thru 44) 4,879,449 0 46.00 Mortgage payable 46.00 Mortgage payable 47.00 Notes payable 48.00 Unsecured loans 48.00 Unsecured loans 49.00 Other long term liabilities 49.00 Other long term liabilities 49.00 Other long term liabilities 40.00 Total long term liabilities (sum of lines 46 thru 49) 49.00 Total liabilities (sum of lines 46 thru 49) 49.4346,044 0 0 51.00 Total liabilities (sum of lines 45 and 50) 52.00 General fund balance 53.00 Specific purpose fund 54.00 Donor created - endowment fund balance - restricted 55.00 Donor created - endowment fund balance 57.00 Plant fund balance - invested in plant 58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 59.00 Total liabilities and fund balances (sum of lines 52 thru 58) 57.00 Total liabilities and fund balances (sum of lines 51 and 87,006,636			97, 932	(0	0	
42.00 Accelerated payments 0 0 43.00 Due to other funds 0 0 44.00 Other current liabilities 942, 481 0 45.00 Total current liabilities (sum of lines 37 thru 44) 4,879, 449 0 46.00 Mortgage payable 0 0 47.00 Notes payable 0 0 47.00 Unsecured loans 0 0 49.00 Other long term liabilities 93,510,327 0 50.00 Total long term liabilities (sum of lines 46 thru 49) 94,346,044 0 51.00 Total liabilities (sum of lines 45 and 50) 99,225,493 0 62.00 General fund balance -12,218,857 53.00 Specific purpose fund 0 54.00 Donor created - endowment fund balance - restricted 0 55.00 Donor created - endowment fund balance 0 60.00 Plant fund balance - invested in plant 0 79.00 Plant fund balance - reserve for plant improvement, replacement, and expansion -12,218,857 0 79.00 Total liabilities and fund balances (sum of lines			0	(0	0	
43.00 Due to other Tunds 0 0 0 0 0 0 0 0 0			0	() O	0	
44.00 Other current liabilities Total current liabilities (sum of lines 37 thru 44) LONG TERM LIABILITIES 46.00 Mortgage payable ONOTERM LIABILITIES 47.00 Notes payable ONOTERM LIABILITIES 48.00 Unsecured loans ONOTERM LIABILITIES 49.00 Other long term liabilities ONOTERM LIABILITIES 40.00 Other long term liabilities ONOTERM LIABILITIES ONOTERM LIABILITES ONOTERM LIABILITE	1	. ,	0	,		0	42. 00 43. 00
Total current liabilities (sum of lines 37 thru 44) 4,879,449 0 0 0			942. 481				
LONG TERM LIABILITIES			1	•	o o		
47. 00 Notes payable							
48.00 Unsecured Loans 49.00 Other Long term Liabilities 50.00 Total Long term Liabilities (sum of Lines 46 thru 49) 51.00 Total Liabilities (sum of Lines 45 and 50) 52.00 General Fund balance 52.00 General Fund balance 53.00 Donor created - endowment fund balance - restricted 54.00 Donor created - endowment fund balance - unrestricted 55.00 Governing body created - endowment fund balance 57.00 Plant fund balance - invested in plant 58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 59.00 Total Liabilities and fund balances (sum of Lines 51 and 87,006,636) 50 O O O O O O O O O O O O O O O O O O O			0	`	,	0	
49.00 Other long term liabilities 93,510,327 0 0 50.00 Total long term liabilities (sum of lines 46 thru 49) 94,346,044 0 0 51.00 Total liabilities (sum of lines 45 and 50) 99,225,493 0 0 CAPITAL ACCOUNTS 52.00 General fund balance 53.00 Specific purpose fund 0 54.00 Donor created - endowment fund balance - restricted 0 55.00 Donor created - endowment fund balance - unrestricted 0 56.00 Governing body created - endowment fund balance 0 57.00 Plant fund balance - invested in plant 0 58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 0 59.00 Total liabilities and fund balances (sum of lines 51 and 0 57.00 Total liabilities and fund balances (sum of lines 51 and 0 58.00 Total liabilities and fund balances (sum of lines 51 and 0 59.00 Total liabilities and fund balances (sum of lines 51 and 0 50 Total liabilities and fund balances (sum of lines 51 and 0 50 Total liabilities and fund balances (sum of lines 51 and 0 50 Total liabilities and fund balances (sum of lines 51 and 0 50 Total liabilities and fund balances (sum of lines 51 and 0 50 Total liabilities and fund balances (sum of lines 51 and 0 50 Total liabilities and fund balances (sum of lines 51 and 0 50 Total liabilities (sum of lines 45 thru 49) 94, 346, 044 0 50 Total liabilities (sum of lines 45 thru 49) 94, 346, 044 0 50 Total liabilities (sum of lines 45 thru 49) 94, 346, 044 0 51.00 Total liabilities (sum of lines 45 thru 49) 94, 346, 044 0 51.00 Total liabilities (sum of lines 45 thru 49) 94, 346, 044 0 51.00 Total liabilities (sum of lines 45 thru 49) 94, 346, 044 0 51.00 Total liabilities (sum of lines 45 thru 49) 94, 346, 044	1	. 3	0			-	
50.00 Total long term liabilities (sum of lines 46 thru 49) 94, 346, 044 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0						0	
51.00 Total liabilities (sum of lines 45 and 50) 99, 225, 493 0 0 CAPITAL ACCOUNTS 52.00 General fund balance 53.00 Specific purpose fund 54.00 Donor created - endowment fund balance - restricted 55.00 Donor created - endowment fund balance - unrestricted 60 Governing body created - endowment fund balance 77.00 Flant fund balance - invested in plant 78.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 79.00 Total fund balances (sum of lines 52 thru 58) 70 Total liabilities and fund balances (sum of lines 51 and 87,006,636)		9					
CAPITAL ACCOUNTS 52.00 General fund balance 53.00 Specific purpose fund 54.00 Donor created - endowment fund balance - restricted 55.00 Donor created - endowment fund balance - unrestricted 60 Governing body created - endowment fund balance 60 Plant fund balance - invested in plant 60 Plant fund balance - reserve for plant improvement, replacement, and expansion 60 Total fund balances (sum of lines 52 thru 58) 60 Total liabilities and fund balances (sum of lines 51 and 60 Total liabilities and fund balances (sum of lines 51 and 60 Total fund balances (sum of lines 51 and	1						
53.00 Specific purpose fund 54.00 Donor created - endowment fund balance - restricted 55.00 Donor created - endowment fund balance - unrestricted 66.00 Governing body created - endowment fund balance 57.00 Plant fund balance - invested in plant 58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 59.00 Total fund balances (sum of lines 52 thru 58) 60.00 Total liabilities and fund balances (sum of lines 51 and 70 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			117===7				1
54.00 Donor created - endowment fund balance - restricted 55.00 Donor created - endowment fund balance - unrestricted 66.00 Governing body created - endowment fund balance 77.00 Plant fund balance - invested in plant 78.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 79.00 Total fund balances (sum of lines 52 thru 58) 70 Total liabilities and fund balances (sum of lines 51 and 70 Total liabilities and fund balances (sum of lines 51 and 70 Donor created - endowment fund balance - restricted 70 Donor created - endowment fund balance	. 00	General fund balance	-12, 218, 857				52. 00
55.00 Donor created - endowment fund balance - unrestricted Governing body created - endowment fund balance 57.00 Plant fund balance - invested in plant 58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 59.00 Total fund balances (sum of lines 52 thru 58) Total liabilities and fund balances (sum of lines 51 and 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				C			53. 00
56.00 Governing body created - endowment fund balance 57.00 Plant fund balance - invested in plant 58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 59.00 Total fund balances (sum of lines 52 thru 58) 60.00 Total liabilities and fund balances (sum of lines 51 and 87,006,636 0 0					0		54.00
57.00 Plant fund balance - invested in plant 58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 59.00 Total fund balances (sum of lines 52 thru 58) -12,218,857 0 0 0 10 Total liabilities and fund balances (sum of lines 51 and 87,006,636)	- 1				0		55. 00
58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 59.00 Total fund balances (sum of lines 52 thru 58) 60.00 Total liabilities and fund balances (sum of lines 51 and 87,006,636 0 0					0	_	56.00
replacement, and expansion 59.00 Total fund balances (sum of lines 52 thru 58) 60.00 Total liabilities and fund balances (sum of lines 51 and 87,006,636 0 0		·				0	
59.00 Total fund balances (sum of lines 52 thru 58) -12, 218, 857 0 60.00 Total liabilities and fund balances (sum of lines 51 and 87,006, 636) 0 0							30.00
60.00 Total liabilities and fund balances (sum of lines 51 and 87,006,636 0 0			-12, 218, 857		o	0	59. 00
[50]	. 00	Total liabilities and fund balances (sum of lines 51 and	87, 006, 636	(0	0	60.00
		59)	l				1

1.00

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7.00

8.00

9.00

Health Financial Systems FRANCISCAN HEALTH ORTHOPEDIC CARMEL In Lieu of Form CMS-2552-10 STATEMENT OF CHANGES IN FUND BALANCES Provi der CCN: 15-0193 Peri od: Worksheet G-1 From 01/01/2023 To 12/31/2023 Date/Time Prepared: 5/31/2024 10:50 am General Fund Special Purpose Fund Endowment Fund 1.00 2.00 3.00 4. 00 5. 00 Fund balances at beginning of period 2, 215, 284 0 1.00 Net income (loss) (from Wkst. G-3, line 29) -5, 288, 106 2.00 Total (sum of line 1 and line 2) -3, 072, 822 0 3.00 DISTRIBUTION IN CONSOLIDATED AFFIL -9, 146, 035 4.00 0 0 5.00 0 0 0 0 6.00 0 0 0 0 7.00 8.00 0 9. 00 10.00 Total additions (sum of line 4-9) -9, 146, 035 10.00 Subtotal (line 3 plus line 10) -12, 218, 857 11.00 11.00 0 Deductions (debit adjustments) (specify) 12.00 12.00 0 0 0 0 0 13.00 13.00 14.00 14.00 0 15.00 0 15.00 16.00 16.00 17.00 17.00 18.00 Total deductions (sum of lines 12-17) 18.00 Fund balance at end of period per balance -12, 218, 857 19.00 19.00 sheet (line 11 minus line 18) Endowment Fund Plant Fund

		6. 00	7. 00	8. 00	
1.00	Fund balances at beginning of period	0		0	1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)				2.00
3.00	Total (sum of line 1 and line 2)	0		0	3. 00
4.00	DISTRIBUTION IN CONSOLIDATED AFFIL		0		4. 00
5.00			0		5. 00
6.00			0		6. 00
7.00			0		7. 00
8.00			0		8. 00
9.00			0		9. 00
10.00	Total additions (sum of line 4-9)	0		0	10.00
11. 00	Subtotal (line 3 plus line 10)	0		0	11. 00
12.00	Deductions (debit adjustments) (specify)		0		12. 00
13.00			0		13. 00
14.00			0		14. 00
15.00			0		15. 00
16.00			0		16. 00
17.00			0		17. 00
18. 00	Total deductions (sum of lines 12-17)	0		0	18. 00
19.00	Fund balance at end of period per balance	0		0	19. 00

sheet (line 11 minus line 18)

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 STATEMENT
 OF
 PATIENT REVENUES
 AND
 OPERATING
 EXPENSES
 Provider CCN: 15-0193

			0 12/31/2023	5/31/2024 10:	
	Cost Center Description	Inpati ent	Outpati ent	Total	
	<u>.</u>	1, 00	2. 00	3. 00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospi tal	1, 626, 56		1, 626, 561	1.00
2.00	SUBPROVI DER - I PF	,		,	2. 00
3. 00	SUBPROVI DER - I RF				3. 00
4.00	SUBPROVI DER				4. 00
5. 00	Swing bed - SNF			o	5. 00
6.00	Swing bed - NF		1	0	6. 00
7. 00	SKILLED NURSING FACILITY	`	,	0	7. 00
8. 00	NURSING FACILITY				8. 00
9. 00	OTHER LONG TERM CARE				9. 00
10.00		1 424 54		1 494 E41	10. 00
10.00	Total general inpatient care services (sum of lines 1-9)	1, 626, 56	l L	1, 626, 561	10.00
11 00	Intensive Care Type Inpatient Hospital Services INTENSIVE CARE UNIT				11 00
11.00					11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14. 00	SURGI CAL INTENSI VE CARE UNIT				14.00
15. 00	OTHER SPECIAL CARE (SPECIFY)			_	15. 00
16. 00	Total intensive care type inpatient hospital services (sum of lines)	0	16. 00
	11-15)				
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	1, 626, 56		1, 626, 561	17. 00
18. 00	Ancillary services	28, 182, 642			18. 00
19. 00	Outpati ent servi ces	2, 512			19. 00
20.00	RURAL HEALTH CLINIC		-	0	20.00
21. 00	FEDERALLY QUALIFIED HEALTH CENTER	(0	0	21.00
22. 00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D. P.)				25.00
26.00	HOSPI CE				26.00
27.00	PROFESSI ONAL FEES		1, 582, 624	1, 582, 624	27.00
27. 01	NRCC	1, 429	0	1, 429	27. 01
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst.	29, 813, 144	70, 876, 702	100, 689, 846	28.00
	G-3, line 1)				
	PART II - OPERATING EXPENSES	•			
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		45, 576, 714		29.00
30.00	TRANSFER TO RHO	1, 583, 22			30.00
31. 00		(31. 00
32. 00					32. 00
33. 00			1		33. 00
34. 00					34. 00
35. 00					35. 00
36. 00	Total additions (sum of lines 30-35)	`	1, 583, 221		36. 00
37. 00	DEDUCT (SPECIFY)				37. 00
38. 00	DEDUCT (SPECIFI)				38. 00
39. 00					39. 00
40.00		(40.00
41. 00	T + 1 + 1 + 1 (C1' 07 44)	(7		41.00
42. 00	Total deductions (sum of lines 37-41)		0		42.00
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer	r	47, 159, 935		43.00
	to Wkst. G-3, line 4)	1	1		

Не	al th	Financial Systems FRANCISCAN HEALTH ORT	HOPEDIC CARMEL	In Lie	eu of Form CMS-2	2552-10
ST	ГАТЕМ	ENT OF REVENUES AND EXPENSES	Provider CCN: 15-0193	Peri od:	Worksheet G-3	
				From 01/01/2023		
				To 12/31/2023	Date/Time Pre 5/31/2024 10:	
					3/31/2024 10.	JU alli
					1.00	
1.	00	Total patient revenues (from Wkst. G-2, Part I, column 3, line	28)		100, 689, 846	1. 00
	00	Less contractual allowances and discounts on patients' accoun-	,		76, 665, 929	
3.	00	· ·			24, 023, 917	1
4.	00	, , , , , , , , , , , , , , , , , , , ,			47, 159, 935	
5.	00	Net income from service to patients (line 3 minus line 4)	•		-23, 136, 018	5. 00
		OTHER I NCOME				
6.	00	Contributions, donations, bequests, etc			209, 671	6. 00
7.	00	Income from investments			0	7. 00
8.	00	Revenues from telephone and other miscellaneous communication	servi ces		0	8. 00
9.	00	Revenue from television and radio service			0	9. 00
10	0. 00	Purchase di scounts			0	10.00
11	1.00	Rebates and refunds of expenses			237, 042	11. 00
12	2. 00	Parking lot receipts			0	12.00
13	3. 00	Revenue from Laundry and Linen service			0	13. 00
14	1. 00	Revenue from meals sold to employees and guests			227, 025	14. 00
15	5. 00	Revenue from rental of living quarters			0	15. 00
16	5. 00	Revenue from sale of medical and surgical supplies to other the	nan patients		0	16. 00
17	7. 00	Revenue from sale of drugs to other than patients			0	17. 00
18	3. 00	Revenue from sale of medical records and abstracts			0	18. 00
19	9. 00	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19. 00
20	0. 00	Revenue from gifts, flowers, coffee shops, and canteen			0	20. 00
21		Rental of vending machines			0	1
		Rental of hospital space			7, 128, 033	22. 00
23		Governmental appropriations			0	20.00
24	4. 00	OTHER OPERATING REVENUE			10, 046, 141	24. 00

0 24.50

-5, 288, 106 26. 00

25. 00

0 27. 00 0 28. 00 -5, 288, 106 29. 00

17, 847, 912

24.00 OTHER OPERATING REVENUE
24.50 COVID-19 PHE Funding
25.00 Total other income (sum of lines 6-24)
26.00 Total (line 5 plus line 25)
27.00 OTHER EXPENSES (SPECIFY)
28.00 Total other expenses (sum of line 27 and subscripts)
29.00 Net income (or loss) for the period (line 26 minus line 28)

	FINANCI SCAN FANCI SCAN FANCI SCAN FATION OF CAPITAL PAYMENT	Provi der CCN: 15-0193	Peri od:	u of Form CMS-2 Worksheet L	
			From 01/01/2023 To 12/31/2023		
		Ti tl a WILL	Hooni tol	5/31/2024 10: PPS	50 am
		Title XVIII	Hospi tal	PPS	
				1. 00	
	PART I - FULLY PROSPECTIVE METHOD				
	CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier			0	1.00
1.01	Model 4 BPCI Capital DRG other than outlier			0	1.0
2.00	Capital DRG outlier payments			0	2.00
2.01	Model 4 BPCI Capital DRG outlier payments			0	2. 01
3.00	Total inpatient days divided by number of days in th	e cost reporting period (see inst	tructions)	0.00	3.00
4.00	Number of interns & residents (see instructions)			0.00	4.00
5.00	Indirect medical education percentage (see instructi			0.00	
6.00	Indirect medical education adjustment (multiply line	5 by the sum of lines 1 and 1.0	1, columns 1 and	0	6. 00
	1.01)(see instructions)				
7. 00	Percentage of SSI recipient patient days to Medicare	Part A patient days (Worksheet E	E, part A line	0. 00	7.00
	30) (see instructions)				
8.00	Percentage of Medicaid patient days to total days (see instructions)			0.00	
9.00	Sum of lines 7 and 8			0.00	
10.00	Allowable disproportionate share percentage (see ins	tructions)		0.00	
11. 00 12. 00	Disproportionate share adjustment (see instructions)	`		0	
12.00	Total prospective capital payments (see instructions)		0	12. 00
				1. 00	
	PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instruct			1, 044, 922	1.00
2.00	Program inpatient ancillary capital cost (see instru			697, 080	2. 00
3. 00	Total inpatient program capital cost (line 1 plus li	ne 2)		1, 742, 002	3. 00
4.00	Capital cost payment factor (see instructions)			85	4.00
5.00	Total inpatient program capital cost (line 3 x line	4)		1, 480, 702	5. 00
				1. 00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instructions)			0	
2.00	Program inpatient capital costs for extraordinary ci			0	2.00
3.00	Net program inpatient capital costs (line 1 minus li	ne 2)		0	3.00
4.00	Applicable exception percentage (see instructions)			0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x li			0	5.00
6. 00	Percentage adjustment for extraordinary circumstance			0.00	
7.00	Adjustment to capital minimum payment level for extr	aordinary circumstances (line 2)	x line 6)	0	7. 00
8. 00	Capital minimum payment level (line 5 plus line 7)			0	8.00
9.00	Current year capital payments (from Part I, line 12,			0	
10.00	Current year comparison of capital minimum payment I			0	
11. 00	Carryover of accumulated capital minimum payment lev	eı over capital payment (from pri	or year	0	11.00
12. 00	Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to c	anital navments (line 10 plus lie	ne 11)	0	12. 0

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

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

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

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

15.00 Current year allowable operating and capital payment (see instructions)
16.00 Current year operating and capital costs (see instructions)
17.00 Current year exception offset amount (see instructions)

0 13.00 14.00 0

12.00

15.00 0 16.00 0 17.00