] If this is an amended report enter the number of times the provider resubmitted this cost report] Medicare Utilization. Enter "F" for full or "L" for low.

[1] Cost Report Status
[1] As Submitted
[2] Settled without Audit
[3] Settled with Audit
[4] Date Received:
[5] To. NPR Date:
[6] 10. NPR Date:
[7] 11. Contractor's Vendor Code:
[7] 12. [8] Final Report for this Provider CCN
[9] [8] Final Report for this Provider CCN
[10] NPR Date:
[11] 12. Contractor's Vendor Code:
[11] 12. [8] 13. Contractor's Vendor Code:
[12] 13. NPR Date:
[13] 14. Contractor's Vendor Code:
[14] 15. Contractor's Vendor Code:
[15] 16. NPR Date:
[16] 17. Contractor's Vendor Code:
[17] 18. Contractor's Vendor Code:
[18] 19. Contractor's Vendor Code:
[19] 19. Contractor's Vendor Code:
[1

PART II - CERTIFICATION

use only

Contractor use only

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 OFFICER OR ADMINISTRATOR OF PROVIDER(S)

Manually submitted cost report

(3) Settled with Audit

(4) Reopened (5) Amended

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by FRANCISCAN HEALTH RENSSELAER (15-1324) for the cost reporting period beginning 01/01/2016 and ending 12/31/2016 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.

> (Si aned) Officer or Administrator of Provider(s) Title

number of times reopened = 0-9.

Date

		Title XVIII				
Cost Center Description	Title V	Part A	Part B	HI T	Title XIX	
	1.00	2.00	3. 00	4. 00	5. 00	
PART III - SETTLEMENT SUMMARY						
1.00 Hospi tal	0	1, 319, 333	510, 027	0	59, 272	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3. 00
5.00 Swing bed - SNF	0	204, 553	0		0	5. 00
6.00 Swing bed - NF	0				0	6. 00
9. 00 HOME HEALTH AGENCY I	0	0	0		0	9. 00
10.00 RURAL HEALTH CLINIC I	0		4, 126		0	10.00
10.03 RURAL HEALTH CLINIC IV	0		57, 855		0	10. 03
200. 00 Total	0	1, 523, 886	572, 008	0	59, 272	200. 00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-1324 Peri od: Worksheet S-2 From 01/01/2016 Part I Date/Time Prepared: 12/31/2016 8/8/2017 10:19 am 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 1104 EAST GRACE STREET 1.00 PO Box: 1.00 Zip Code: 47978-2.00 City: RENSSELAER State: IN County: **JASPER** 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, 0, or N) Certi fi ed Number Number Type XVIII XIX 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 FRANCISCAN HEALTH 151324 23844 02/03/2005 Ν 0 0 3.00 RENSSEL AFR Subprovider - IPF 4.00 4 00 5.00 Subprovider - IRF 5.00 Subprovi der - (Other) 6.00 6.00 Swing Beds - SNF FRANCISCAN HEALTH 157324 99915 N 12/31/2005 0 7.00 N 7 00 RENSSELAER 8.00 Swing Beds - NF 8.00 9.00 Hospi tal -Based SNF 9.00 Hospi tal -Based NF 10.00 10.00 Hospi tal -Based OLTC 11.00 11.00 12.00 Hospi tal -Based HHA FRANCISCAN HEALTH 157149 99915 05/13/1985 Ν Ρ Ν 12.00 RENSSELAER Separately Certified ASC 13.00 13.00 FRANCISCAN HEALTH 03/12/1993 151519 99915 14.00 Hospi tal -Based Hospi ce 14.00 RENSSELAER 15.00 Hospital-Based Health Clinic - RHC WHEATFIELD CLINIC 153990 99915 10/07/1999 N 0 N 15.00 15.03 Hospital-Based Health Clinic - RHC BROOK 158502 99915 01/01/2005 Ν 0 Ν 15.03 Hospital - Based Health Clinic - FQHC 16 00 16 00 17.00 Hospital -Based (CMHC) I 17.00 18.00 Renal Dialysis 18.00 19.00 Other 19.00 From: To: 1.00 2.00 20.00 Cost Reporting Period (mm/dd/yyyy) 12/31/2016 20.00 01/01/2016 Type of Control (see instructions) 21.00 21.00 1 Inpatient PPS Information Does this facility qualify and is it currently receiving payments for disproportionate N N 22.00 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 uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost 22 01 22 01 Ν Ν 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 final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes 22.02 Ν N 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 rural as a result Ν Ν 22.03 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. 23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 23.00 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 In-State In-State Out-of Out-of Medi cai d 0ther Medi cai d Medi cai d State State HMO days Medi cai d Medi cai d paid days eligible Medi cai d days paid days el i gi bl e unpai d days unpai d 1.00 2. 00 3. 00 4. 00 5. 00 6.00 24.00 If this provider is an IPPS hospital, enter the 24 00 0 0 0 0 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.

Health Financial Systems FRANCISC.	AN HEALTH	RENSSELAER			In Lieu	of Form	n CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA		Provider CC	N: 15-1324	Peri od:	1	Workshe		
				From 01/0 To 12/3	1/2016	Part I Date/Ti 8/8/201		
	In-State		Out-of	Out-of	Medi cai	d Ot	her	
	Medicaid paid days		State Medicaid	State Medi cai d	HMO day		cai d ays	
	paru uays	unpai d	paid days	el i gi bl e		u d	iys	
		days		unpai d				
or so he we have the second of	1.00	2.00	3. 00	4. 00	5. 00		00	05.00
25.00 If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.		0 0	0	0		0		25. 00
				Urban/Ri				
24 00 Enter your standard goographic classification (not we	ago) statu	s at the bes	inning of t	1.0	00	2. 0)	24 00
26.00 Enter your standard geographic classification (not was cost reporting period. Enter "1" for urban or "2" for		s at the beg	jinning or t	ne	2			26. 00
27.00 Enter your standard geographic classification (not wave reporting period. Enter in column 1, "1" for urban or	age) statu: r "2" for	rural. If ap		t	2			27. 00
enter the effective date of the geographic reclassifi 35.00 If this is a sole community hospital (SCH), enter the effect in the cost reporting period.			CH status in		O			35. 00
				Begi nn		Endi r		
36.00 Enter applicable beginning and ending dates of SCH s	tatus, Suh	script line	36 for numh	1. 0 er	JU	2. 0	J	36. 00
of periods in excess of one and enter subsequent date 37.00 If this is a Medicare dependent hospital (MDH), enter	es.	·			O			37. 00
is in effect in the cost reporting period. 37.01 Is this hospital a former MDH that is eligible for the accordance with FY 2016 OPPS final rule? Enter "Y" for				N				37. 01
instructions) 38.00 If line 37 is 1, enter the beginning and ending date:	s of MDH s	tatus. If li	ne 37 is					38. 00
greater than 1, subscript this line for the number or enter subsequent dates.	perrous	in excess of	one and					
,				Y/I		Y/N		
20 00 Deep this facility qualify for the impatient heavite	L normont	adiuatmant f	For Low volu	1. C		2. 0 N)	20, 00
39.00 Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(ii or "N" for no. Does the facility meet the mileage rec CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes 40.00 Is this hospital subject to the HAC program reduction	i)? Enter quirements or "N" fo	in column 1 in accordar r no. (see i	"Y" for yes nce with 42 nstructions)		N N		39. 00 40. 00
"N" for no in column 1, for discharges prior to Octol no in column 2, for discharges on or after October 1.	ber 1. Ent	er "Y" for y			V	XVIII	XI X	40.00
					1.00	2. 00	3. 00	
Prospective Payment System (PPS)-Capital								
45.00 Does this facility qualify and receive Capital paymen with 42 CFR Section §412.320? (see instructions) 46.00 Is this facility eligible for additional payment exce					N N	N N	N N	45. 00 46. 00
pursuant to 42 CFR §412.348(f)? If yes, complete Wks. Pt. III.	t. L, Pt.	III and Wkst	. L-1, Pt.	l through				
47.00 Is this a new hospital under 42 CFR §412.300 PPS capi 48.00 Is the facility electing full federal capital paymen Teaching Hospitals		,			N N	N N	N N	47. 00 48. 00
56.00 Is this a hospital involved in training residents in	approved	GME programs	? Enter "Y	" for yes	N			56. 00
or "N" for no. 57.00 If line 56 is yes, is this the first cost reporting programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first month for yes or "N" for no in column 2. If column 2 is "Y"	r yes or " th of this Y", comple	N" for no ir cost report te Worksheet	n column 1. ing period?	If column 1 Enter "Y"	I			57. 00
"N", complete Wkst. D, Parts III & IV and D-2, Pt. II 58.00 If line 56 is yes, did this facility elect cost reim	bursement	for physicia	ans' service	s as	N			58. 00
defined in CMS Pub. 15-1, chapter 21, §2148? If yes, 59.00 Are costs claimed on line 100 of Worksheet A? If yes			Pt. I.		N			59. 00
60.00 Are you claiming nursing school and/or allied health	costs for	a program t	hat meets t		N			60. 00
provider-operated criteria under §413.85? Enter "Y"	for yes o	<u>r "N" for no</u> IME	o. (see inst Direct GM		F	Di rect	CME	
	TZIN	IWE	Direct GW	E IWI	E	Direct	GIVIE	
	1. 00	2. 00	3. 00	4.0		5. 0		
61.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N				0. 00		0. 00	61.00
61.01 Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see		0. 00	0	. 00				61. 01
i nstructi ons)								

	enter in column 2, the program of						
	3, the IME FTE unweighted count						
	4, direct GME FTE unweighted cou	nt.					
						1.00	
	ACA Provisions Affecting the Hea	Ith Resources and Ser	rvices Administration	(HRSA)			
62.00	Enter the number of FTE resident	s that your hospital	trained in this cost	reporting peri	od for which	0.00	62.00
	your hospital received HRSA PCRE	funding (see instruc	ctions)				
62. 01	Enter the number of FTE resident				your hospital	0.00	62. 01
	during in this cost reporting pe	riod of HRSA THC prog	ıram. (see instruction	ns)			
	Teaching Hospitals that Claim Re	sidents in Nonprovide	er Settings				
3.00	Has your facility trained reside	nts in nonprovider se	ettings during this co	ost reporting p	eriod? Enter	N	63.00
	"Y" for yes or "N" for no in col	umn 1. If yes, comple	ete lines 64-67. (see	instructions)			
				Unwei ghted	Unwei ghted	Ratio (col. 1/	
				FTEs	FTEs in	(col. 1 + col.	
				Nonprovi der	Hospi tal	2))	
				Si te			
				1. 00	2.00	3.00	
	Section 5504 of the ACA Base Yea	r FTE Residents in No	onprovider Settings	This base year	is your cost	reporting	
	period that begins on or after J	uly 1, 2009 and befor	e June 30, 2010.	•	•		
4. 00	Enter in column 1, if line 63 is	yes, or your facilit	y trained residents	0.00	0. 00	0.000000	64.00
	in the base year period, the num						
	resident FTEs attributable to ro	tations occurring in	al I nonprovi der				
	settings. Enter in column 2 the	number of unweighted	I non-primary care				
	resident FTEs that trained in yo						
	of (column 1 divided by (column	1 + column 2)). (see	instructions)				
		Program Name	Program Code	Unwei ghted	Unwei ghted	Ratio (col. 3/	
		-		FTEs	FTEs in	(col. 3 + col.	
				Nonprovi der	Hospi tal	4))	
				Si te			
		1. 00	2.00	3. 00	4.00	5.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-1324 Peri od: Worksheet S-2 From 01/01/2016 Part I Date/Time Prepared: 12/31/2016 8/8/2017 10:19 am Program Code Unwei ghted Unwei ghted Program Name Ratio (col. (col. 3 + col FTEs FTEs in Hospi tal 4)) Nonprovi der Si te 1.00 2.00 3.00 4.00 5.00 0. 00 0. 00 0.000000 65.00 65.00 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code, enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) Unwei ghted Unwei ghted Ratio (col. 1/ FTEs FTEs in (col. 1 + col Nonprovi der Hospi tal 2)) Si te 1.00 2.00 3.00 Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010 Enter in column 1 the number of unweighted non-primary care resident 0.00 0. 00 0.000000 66.00 FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions) Program Name Unwei ghted Ratio (col. 3/ Program Code Unwei ahted FTES FTEs in (col. 3 + col Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3. 00 4.00 5.00 67.00 Enter in column 1, the program 0.000000 67.00 0.00 0.00 name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)) (see instructions) 1.00 2.00 3.00 Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? 70.00 Enter "Y" for yes or "N" for no. 71.00 If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most O 71.00 recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) 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) Inpatient Rehabilitation Facility PPS 75.00 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF N 75.00 subprovider? Enter "Y" for yes and "N" for no. If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the 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)

Health Financial Systems FRANCISCAN HEALTHOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider C	CN: 15-1324	Period: From 01/01/2016 To 12/31/2016		epared:
				1.00	
Long Term Care Hospital PPS				1.00	
80.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes 81.00 Is this a LTCH co-located within another hospital for part of "Y" for yes and "N" for no.			ng period? Enter	N N	80. 00 81. 00
TEFRA Providers 85.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) 86.00 Did this facility establish a new Other subprovider (exclude		,		N	85. 00 86. 00
§413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no. 87.00 Is this hospital a "subclause (II)" LTCH classified under se for yes or "N" for no.	ection 1886(d)	(1)(B)(iv)(I	I)? Enter "Y"	N	87. 00
TOT YES OF IN TOTALO.			V 1,000	XIX	
Title V and XIX Services			1. 00	2.00	
90.00 Does this facility have title V and/or XIX inpatient hospita	al services? E	nter "Y" for	N	Y	90.00
yes or "N" for no in the applicable column. 91.00 Is this hospital reimbursed for title V and/or XIX through t	the cost repor	t either in	N	Υ	91. 00
full or in part? Enter "Y" for yes or "N" for no in the appl 92.00 Are title XIX NF patients occupying title XVIII SNF beds (du		N	92. 00		
instructions) Enter "Y" for yes or "N" for no in the applicate Does this facility operate an ICF/IID facility for purposes		d XIX? Enter	N	N	93. 00
"Y" for yes or "N" for no in the applicable column. 94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes,	and "N" for n	o in the	N	N	94. 00
applicable column. 95.00 If line 94 is "Y", enter the reduction percentage in the app. 96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes	0. 00 N	95. 00 96. 00			
applicable column. 97.00 If line 96 is "Y", enter the reduction percentage in the app	olicable colum	n.	0.00	0.00	97. 00
Rural Providers 105.00 Does this hospital qualify as a critical access hospital (CA 106.00 If this facility qualifies as a CAH, has it elected the all-	nt N		105. 00 106. 00		
for outpatient services? (see instructions) 107.00 If this facility qualifies as a CAH, is it eligible for cost training programs? Enter "Y" for yes or "N" for no in column yes, the GME elimination is not made on Wkst. B, Pt. I, col. reimbursed. If yes complete Wkst. D-2, Pt. II.	n 1. (see inst	ructions) If			107. 00
108.00 Is this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	CRNA fee sche	dul e? See 4	2 N		108. 00
	Physi cal 1.00	Occupation 2.00	al Speech 3.00	Respi ratory 4.00	
109.00 on 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.	Υ	N N	N N	N N	109. 00
110.00 Did this hospital participate in the Rural Community Hospita the current cost reporting period? Enter "Y" for yes or "N"	al Demonstration	on project (410A Demo)for	1. 00 N	110. 00
			1.0	0 2.00 3.00)
Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or is yes, enter the method used (A, B, or E only) in column 2. 3 either "93" percent for short term hospital or "98" percer psychiatric, rehabilitation and long term hospitals provider	If column 2 nt for long te	is "E", ente rm care (inc	r in column Iudes	0	115. 00
Pub. 15-1, chapter 22, §2208.1. 116.00 Is this facility classified as a referral center? Enter "Y" 117.00 Is this facility legally-required to carry malpractice insur	for yes or "N	" for no.	N		116. 00 117. 00
no. 118.00 s the malpractice insurance a claims-made or occurrence pol		,			118. 00
claim-made. Enter 2 if the policy is occurrence.		Premi ums	Losses	Insurance	
		1. 00	2.00	3.00	
118.01 List amounts of malpractice premiums and paid losses:		90,			0118.01

ealth Financial Systems FRANCISCAN HEALT HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	TH RENSSELAER Provider CCN: 1		eri od:	u of Form CM Worksheet S			
			rom 01/01/2016 o 12/31/2016				
				8/8/2017 10): 19 am		
10.00		41	1. 00	2.00	110.0		
18.02 Are mal practice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting schedand amounts contained therein.			N		118. 0		
19. 00 D0 NOT USE THIS LINE 20. 00 s this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in	n column 1, "Y" fo	r yes or	N	N	119. 0 120. 0		
"N" for no. Is this a rural hospital with < 100 beds that que Hold Harmless provision in ACA §3121 and applicable amendmer Enter in column 2, "Y" for yes or "N" for no.	nts? (see instruct	i ons)					
21.00 Did this facility incur and report costs for high cost impla patients? Enter "Y" for yes or "N" for no.		G	Y		121. 0		
22.00 Does the cost report contain state health or similar taxes? for no in column 1. If column 1 is "Y", enter in column 2 the where these taxes are included.			Y	5. 00	122. 0		
Transplant Center Information 25.00 Does this facility operate a transplant center? Enter "Y" for a continuous control of the	or yes and "N" for	no. If	N		125. 0		
	00 If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						
27.00 f this is a Medicare certified heart transplant center, ent in column 1 and termination date, if applicable, in column 2	ter the certificat	ion date			127. 0		
28.00 f this is a Medicare certified liver transplant center, ent in column 1 and termination date, if applicable, in column 2	ter the certificat	ion date			128. 0		
29.00 If this is a Medicare certified lung transplant center, enter column 1 and termination date, if applicable, in column 2.		on date in			129. 0		
30.00 If this is a Medicare certified pancreas transplant center, date in column 1 and termination date, if applicable, in col		cation			130. 0		
31.00 If this is a Medicare certified intestinal transplant center date in column 1 and termination date, if applicable, in col		fi cati on			131. 0		
32.00 If this is a Medicare certified islet transplant center, ent in column 1 and termination date, if applicable, in column 2	2.				132. 0		
33.00 If this is a Medicare certified other transplant center, ent in column 1 and termination date, if applicable, in column 2	2.				133. 0		
34.00 If this is an organ procurement organization (0P0), enter the and termination date, if applicable, in column 2. All Providers	ne OPO number in co	olumn 1			134. 0		
40.00 Are there any related organization or home office costs as chapter 10? Enter "Y" for yes or "N" for no in column 1. If are claimed, enter in column 2 the home office chain number.	yes, and home offi	ice costs	Y		140. 0		
1.00 2.0		142 +	3.00	-6 +1			
If this facility is part of a chain organization, enter on I home office and enter the home office contractor name and contractor and enter the home office contractor name and contractor is Name:			"'s Number:	or the	141. 0		
42.00 Street: PO Box:			3 Number.		142. 0		
43. 00 Ci ty: State:		Zi p Code:			143. 0		
44 00 Are provider board physicians' costs included in Workshoot	12			1.00	144.6		
44.00 Are provider based physicians' costs included in Worksheet A	4 f			Y	144. 0		
			1.00	2.00	<u> </u>		
45.00 If costs for renal services are claimed on Wkst. A, line 74,			N	N	145. C		
inpatient services only? Enter "Y" for yes or "N" for no in no, does the dialysis facility include Medicare utilization period? Enter "Y" for yes or "N" for no in column ?							
no, does the dialysis facility include Medicare utilization period? Enter "Y" for yes or "N" for no in column 2.	for this cost reposit solutions filed cost reposit for the cost reposit	orting port?	N		146. C		
no, does the dialysis facility include Medicare utilization period? Enter "Y" for yes or "N" for no in column 2. 46.00 Has the cost allocation methodology changed from the previouenter "Y" for yes or "N" for no in column 1. (See CMS Pub. 1)	for this cost reposit solutions filed cost reposit for the cost reposit	orting port?	N	1.00	146. C		
no, does the dialysis facility include Medicare utilization period? Enter "Y" for yes or "N" for no in column 2. 46.00 Has the cost allocation methodology changed from the previouenter "Y" for yes or "N" for no in column 1. (See CMS Pub. 1 yes, enter the approval date (mm/dd/yyyy) in column 2.	for this cost repusely filed cost repusely filed cost repusels-2, chapter 40,	orting port?	N	1.00 N			
no, does the dialysis facility include Medicare utilization period? Enter "Y" for yes or "N" for no in column 2. 46.00 Has the cost allocation methodology changed from the previouenter "Y" for yes or "N" for no in column 1. (See CMS Pub. 1 yes, enter the approval date (mm/dd/yyyy) in column 2. 47.00 Was there a change in the statistical basis? Enter "Y" for yes 0.00 Was there a change in the order of allocation? Enter "Y" for	for this cost repusely filed cost repusely filed cost repusels. Contact the formation of th	porting port? §4020) If		N N	147. C 148. C		
no, does the dialysis facility include Medicare utilization period? Enter "Y" for yes or "N" for no in column 2. 46.00 Has the cost allocation methodology changed from the previouenter "Y" for yes or "N" for no in column 1. (See CMS Pub. 1 yes, enter the approval date (mm/dd/yyyy) in column 2. 47.00 Was there a change in the statistical basis? Enter "Y" for 3.00 Was there a change in the order of allocation? Enter "Y" for	for this cost repusely filed cost repusely filed cost repusels. It is a second cost of the	orting port? §4020) If o. r "N" for i	no.	N N N	147. 0 148. 0 149. 0		
no, does the dialysis facility include Medicare utilization period? Enter "Y" for yes or "N" for no in column 2. 46.00 Has the cost allocation methodology changed from the previou Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 1 yes, enter the approval date (mm/dd/yyyy) in column 2. 47.00 Was there a change in the statistical basis? Enter "Y" for y 48.00 Was there a change in the order of allocation? Enter "Y" for 49.00 Was there a change to the simplified cost finding method? Enter "Y" for y 49.00 Was there a change to the simplified cost finding method? Enter "Y" for y 49.00 Was there a change to the simplified cost finding method? Enter "Y" for y 49.00 Was there a change to the simplified cost finding method? Enter "Y" for y 49.00 Was there a change to the simplified cost finding method? Enter "Y" for y 49.00 Was there a change to the simplified cost finding method? Enter "Y" for y 49.00 Was there a change to the simplified cost finding method? Enter "Y" for y 49.00 Was there a change to the simplified cost finding method? Enter "Y" for y 49.00 Was there a change to the simplified cost finding method? Enter "Y" for y 49.00 Was there a change to the simplified cost finding method? Enter "Y" for y 49.00 Was there a change to the simplified cost finding method? Enter "Y" for y 49.00 Was there a change to the simplified cost finding method? Enter "Y" for y 49.00 Was there a change to the simplified cost finding method? Enter "Y" for y 49.00 Was there a change to the simplified cost finding method? Enter "Y" for y 49.00 Was there a change to the simplified cost finding method? Enter "Y" for y 49.00 Was there a change to the simplified cost finding method? Enter "Y" for y 49.00 Was there a change to the simplified cost finding method? Enter "Y" for y 49.00 Was there a change to the simplified cost finding method was the simplified cost finding met	representation of the second s	orting port? §4020) If o. r "N" for I Part B 2.00 e applicat	no. Title V 3.00 ion of the lowe	N N N Title XIX 4.00	147. C 148. C 149. C		
no, does the dialysis facility include Medicare utilization period? Enter "Y" for yes or "N" for no in column 2. 46.00 Has the cost allocation methodology changed from the previou Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 1 yes, enter the approval date (mm/dd/yyyy) in column 2. 47.00 Was there a change in the statistical basis? Enter "Y" for yes. 48.00 Was there a change in the order of allocation? Enter "Y" for yes. 49.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no for each components.	yes or "N" for no.	orting port? §4020) If o. r "N" for I Part B 2.00 e applicat Part B. (no. Title V 3.00 ion of the lowe See 42 CFR §413	N N N Title XIX 4.00 er of costs 3.13)	147. C 148. C		
no, does the dialysis facility include Medicare utilization period? Enter "Y" for yes or "N" for no in column 2. 46.00 Has the cost allocation methodology changed from the previou Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 1 yes, enter the approval date (mm/dd/yyyy) in column 2. 47.00 Was there a change in the statistical basis? Enter "Y" for yes on "N" at the ender of allocation? Enter "Y" for yes on "N" for no for each components on the statistical basis? Enter "Y" for yes on "N" for no for each components on the statistical basis? Enter "Y" for yes on "N" for no for each components on the statistical basis? Enter "Y" for yes or "N" for no for each components on the statistical basis? Enter "Y" for yes or "N" for no for each components on the statistical basis? Enter "Y" for yes or "N" for no for each components on the statistical basis? Enter "Y" for yes or "N" for no for each components of the statistical basis? Enter "Y" for yes or "N" for no for each components of the statistical basis? Enter "Y" for yes or "N" for no for each components of the statistical basis? Enter "Y" for yes or "N" for no for each components of the statistical basis? Enter "Y" for yes or "N" for no for each components of the statistical basis? Enter "Y" for yes or "N" for no for each components of the statistical basis? Enter "Y" for yes or "N" for no for each components of the statistical basis? Enter "Y" for yes or "N" for no for each components of the statistical basis? Enter "Y" for yes or "N" for no for each components of the statistical basis? Enter "Y" for yes or "N" for no for each components of the statistical basis? Enter "Y" for yes or "N" for no for each components of the statistical basis? Enter "Y" for yes or "N" for no for each components of the statistical basis? Enter "Y" for yes or "N" for no for each components of the statistical basis? Enter "Y" for yes or "N" for no for each components of the statistical basis? Enter "Y" for yes or "N" for no for each components of the statistical basis for the	representation of the second s	orting port? §4020) If o. r "N" for I Part B 2.00 e applicat	no. Title V 3.00 ion of the lowe	N N N Title XIX 4.00	147. C 148. C 149. C		
no, does the dialysis facility include Medicare utilization period? Enter "Y" for yes or "N" for no in column 2. 46.00 Has the cost allocation methodology changed from the previou Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 1 yes, enter the approval date (mm/dd/yyyy) in column 2. 47.00 Was there a change in the statistical basis? Enter "Y" for yes, on Was there a change in the order of allocation? Enter "Y" for yes on "N" for no for each component or charges? Enter "Y" for yes or "N" for no for each component of the supprovider of the suppro	yes or "N" for no.	porting port? §4020) If Do. r "N" for r Part B 2.00 e applicat Part B. (N	no. Title V 3.00 ion of the lowe See 42 CFR §413	N N N Title XIX 4.00 er of costs 3.13)	147. C 148. C 149. C		
no, does the dialysis facility include Medicare utilization period? Enter "Y" for yes or "N" for no in column 2. 146.00 Has the cost allocation methodology changed from the previou. Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 1 yes, enter the approval date (mm/dd/yyyy) in column 2. 147.00 Was there a change in the statistical basis? Enter "Y" for yes, enter the approval date (mm/dd/yyyy) in column 2. 149.00 Was there a change in the order of allocation? Enter "Y" for yes on the simplified cost finding method? Enter "Y" for yes or "N" for no for each components. Does this facility contain a provider that qualifies for an or charges? Enter "Y" for yes or "N" for no for each components. 155.00 Hospital Subprovider - IPF 157.00 Subprovider - IRF	yes or "N" for no. Yes or	orting port? §4020) If o. r "N" for pert B 2.00 e applicat Part B. (N N	Title V 3.00 ion of the lowe See 42 CFR §413 N N	N N N Title XIX 4.00 er of costs 3.13) N N	155. 0 156. 0 157. 0 158. 0		
no, does the dialysis facility include Medicare utilization period? Enter "Y" for yes or "N" for no in column 2. 146.00 Has the cost allocation methodology changed from the previou Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 1 yes, enter the approval date (mm/dd/yyyy) in column 2. 147.00 Was there a change in the statistical basis? Enter "Y" for yes. 148.00 Was there a change in the order of allocation? Enter "Y" for yes. 149.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no for each components. 155.00 Hospital 156.00 Subprovider - IPF 157.00 Subprovider - IRF	report this cost report to the cost report to the cost report to the cost report to the cost of the co	porting port? \$4020) If D. T "N" for D Part B 2.00 e applicat Part B. (N	no. Title V 3.00 ion of the lowe See 42 CFR §413 N	N N N Title XIX 4.00 er of costs 3.13) N N	147. 0 148. 0 149. 0 155. 0 156. 0 157. 0		

Health Financial Systems	FRANCI SCAN	HEALTH RENSSELAER			In Lie	u of Form CMS-	-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMP	PLEX IDENTIFICATION DATA	Provi der CC	CN: 15-132	From O	1/01/2016 2/31/2016	Worksheet S-Part I Date/Time Pro 8/8/2017 10:	epared:
						1.00	-
Mul ti campus							
165.00 Is this hospital part of a Mult Enter "Y" for yes or "N" for no		s one or more campu	uses in di	ifferent CE	SSAs?	N	165. 00
	Name	County	State	Zip Code	CBSA	FTE/Campus	
	0	1. 00	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)						0.0	0 166. 00
			<u> </u>	'			
						1.00	
Health Information Technology (
167.00 s this provider a meaningful u 168.00 of this provider is a CAH (line reasonable cost incurred for th	105 is "Y") and is a me	aningful user (line			the	Y	167. 00 0 168. 00
168.01 If this provider is a CAH and i exception under §413.70(a)(6)(i	s not a meaningful user,	does this provider			Ishi p		168. 01
169.00 If this provider is a meaningfu transition factor. (see instruc		and is not a CAH ((line 105				0169. 00
					gi nni ng	Endi ng	
170 00 5	D besieving data and and	!			1. 00 ′01/2016	2.00	170. 00
170.00 Enter in columns 1 and 2 the EH period respectively (mm/dd/yyyy		ing date for the re	eporting	017	70172016	12/31/2016	170.00
					1. 00	2.00	+
171.00 If line 167 is "Y", does this p section 1876 Medicare cost plan "Y" for yes and "N" for no in c 1876 Medicare days in column 2.	s reported on Wkst. S-3, olumn 1. If column 1 is	Pt. I, line 2, col	. 6? Ente		N		0 171. 00

	FRANCISCAN HEAL FAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		CN: 15-1324	Peri od:	worksheet S-2	
				From 01/01/2016 To 12/31/2016		
		-		Y/N	Date	1
	0 1 1 1 1 5 1 V C 11 V5C			1.00	2. 00	-
	General Instruction: Enter Y for all YES responses. Enter N mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS	TOT ALL NU TE	esponses. Ente	er all dates in '	tne	
	Provider Organization and Operation					
00	Has the provider changed ownership immediately prior to the			N		1.
	reporting period? If yes, enter the date of the change in c	column 2. (see	instructions		V/I	
			1.00	2. 00	3. 00	
00	Has the provider terminated participation in the Medicare F	Program? If	N	2.00	0.00	2.
	yes, enter in column 2 the date of termination and in colum	nn 3, "V" for				
00	voluntary or "I" for involuntary. Is the provider involved in business transactions, including	na managomont	Y			3.
00	contracts, with individuals or entities (e.g., chain home of		'			3.
	or medical supply companies) that are related to the provide					
	officers, medical staff, management personnel, or members of					
	of directors through ownership, control, or family and other	er similar				
	relationships? (see instructions)		Y/N	Type	Date	
			1.00	2. 00	3. 00	
	Financial Data and Reports					
00	Column 1: Were the financial statements prepared by a Cert		Y	A		4.
	Accountant? Column 2: If yes, enter "A" for Audited, "C" for "R" for Reviewed. Submit complete copy or enter date ava					
	column 3. (see instructions) If no, see instructions.	irrabre in				
00	Are the cost report total expenses and total revenues diffe	erent from	N			5.
	those on the filed financial statements? If yes, submit rec					
				Y/N	Legal Oper.	
	Approved Educational Activities			1. 00	2. 00	+
00	Column 1: Are costs claimed for nursing school? Column 2:	If ves. is th	ne provider is	s N		6.
	the legal operator of the program?	<i>y</i> ,				
00	Are costs claimed for Allied Health Programs? If "Y" see in			N		7.
00	Were nursing school and/or allied health programs approved	and/or renewed	d during the	N		8.
00	cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved	araduate medic	cal education	N		9.
00	program in the current cost report? If yes, see instruction		car education	IN		7.
0. 00	Was an approved Intern and Resident GME program initiated of		the current	N		10.
	cost reporting period? If yes, see instructions.					1
1. 00	Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	& R in an App	proved	N		11.
	reaching Program on worksheet A? IT yes, see Instructions.				Y/N	
					1. 00	
	Bad Debts					
	Is the provider seeking reimbursement for bad debts? If yes				Y	12.
3. 00	If line 12 is yes, did the provider's bad debt collection period? If yes, submit copy.	orrey change c	during this co	ost reporting	N	13.
4. 00	If line 12 is yes, were patient deductibles and/or co-payme	ents waived? If	yes, see in	structions.	N	14.
	Bed Complement					
5. 00	Did total beds available change from the prior cost reporti				N N	15.
		Y/N	t A Date	Y/N	t B Date	
		1.00	2.00	3. 00	4. 00	
	PS&R Data					
5. 00		N		N		16.
	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)					
7. 00		Υ	05/10/2017	Υ	05/10/2017	17.
	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)	N		N		18.
0.00		I IN		N		18.
3. 00	If line 16 or 17 is yes, were adjustments made to PS&R					
3. 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 cost report? If yes, see instructions.					
	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this	N		N		19.

	Financial Systems FRANCISCAN HEAL				u of Form CM	S-2552-10			
HOSPI T	TAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		CCN: 15-1324	Peri od: From 01/01/2016 To 12/31/2016	Worksheet S Part II Date/Time F 8/8/2017 10	repared:			
			i pti on	Y/N	Y/N				
2000	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:			14	,,	20.00			
		Y/N	Date	Y/N	Date				
04.00	The six and the si	1.00	2.00	3. 00	4. 00	04.00			
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	PT CHILDRENS I	HOSPI TALS)						
	Capital Related Cost								
22. 00	Have assets been relifed for Medicare purposes? If yes, see		aala mada duu	ing the cost	N	22. 00			
23. 00	Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.	ing the cost	N	23. 00					
24. 00	Were new leases and/or amendments to existing leases entered if yes, see instructions	porting period?	N	24. 00					
25. 00	Have there been new capitalized leases entered into during instructions.	the cost repor	rting period?	If yes, see	Y	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 reporti	ng period? If	yes, submit	N	27. 00			
28. 00	Unterest Expense Were new loans, mortgage agreements or letters of credit er	ntered into du	ring the cost	reporti ng	N	28. 00			
29. 00	period? If yes, see instructions. Did the provider have a funded depreciation account and/or treated as a funded depreciation account? If yes, see instr	eserve Fund)	Υ	29. 00					
30. 00	Has existing debt been replaced prior to its scheduled maturinstructions.	N	30. 00						
31. 00									
	Purchased Services								
32. 00	Have changes or new agreements occurred in patient care ser arrangements with suppliers of services? If yes, see instru		ea through co	ntractuai	Y	32. 00			
33. 00	If line 32 is yes, were the requirements of Sec. 2135.2 applino, see instructions.		ng to competi	tive bidding? If	N	33. 00			
	Provi der-Based Physi ci ans								
34. 00	Are services furnished at the provider facility under an ar	rrangement witl	n provi der-ba	sed physicians?	N	34. 00			
35. 00	If yes, see instructions. If line 34 is yes, were there new agreements or amended exists the second of the second		nts with the	provi der-based	N	35. 00			
	physicians during the cost reporting period? If yes, see in	ISTI UCTI OIIS.		Y/N	Date				
				1. 00	2. 00				
	Home Office Costs								
36.00	Were home office costs claimed on the cost report?			Y		36.00			
37. 00	If line 36 is yes, has a home office cost statement been pr If yes, see instructions.	repared by the	home office?	Y		37. 00			
38. 00	If line 36 is yes, was the fiscal year end of the home off the provider? If yes, enter in column 2 the fiscal year end	fice different	from that of	N		38. 00			
39. 00	If line 36 is yes, did the provider render services to other see instructions.			, N		39. 00			
40. 00	If line 36 is yes, did the provider render services to the instructions.	home office?	If yes, see	N		40. 00			
	Cook Donard Donard Control C] 1.	00	2.	00				
41. 00	Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	KYLE		SMI TH		41. 00			
42. 00	respecti vel y.	BLUE & CO				42. 00			
43. 00		317-713-7957		KCSMI TH@BLUEAN	DCO. COM	43. 00			
	report preparer in columns 1 and 2, respectively.			1					

Heal th	Financial Systems	FRANCISCAN HEAL	TH RENSSELAER		In Lie	In Lieu of Form CMS-2552-10			
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT C	QUESTI ONNAI RE	Provi der CCI		Period: From 01/01/2016 To 12/31/2016	Worksheet S-2 Part II Date/Time Pre 8/8/2017 10:1	pared:		
			3.0	00	_				
	Cost Report Preparer Contact Information								
41. 00	Enter the first name, last name and the ti held by the cost report preparer in column respectively.		SENIOR MANAGER				41. 00		
42. 00	Enter the employer/company name of the cos	st report					42. 00		
43. 00	preparer. Enter the telephone number and email addre report preparer in columns 1 and 2, respec						43. 00		

Heal th FinancialSystemsFRANCISCAN HEALTH RENSSELAERHOSPITALAND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATAProvider Complex Statistical Data Provider CCN: 15-1324

| Peri od: | Worksheet S-3 | From 01/01/2016 | Part I | To 12/31/2016 | Date/Time Prepared:

					10	0 12/31/2016	8/8/2017 10:1	
							I/P Days / 0/P	, diii
							Visits / Trips	
	Component	Worksheet A	No	of Beds	Bed Days	CAH Hours	Title V	
	Component	Line Number	110.	or beas	Avai I abl e	oran nodi s	11 110 1	
		1.00		2. 00	3. 00	4. 00	5. 00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	30.00		21	7, 686	50, 544. 00	0	1, 00
	8 exclude Swing Bed, Observation Bed and				,	,		
	Hospice days) (see instructions for col. 2							
	for the portion of LDP room available beds)							
2.00	HMO and other (see instructions)							2.00
3.00	HMO IPF Subprovider							3. 00
4.00	HMO IRF Subprovider							4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						0	5. 00
6.00	Hospital Adults & Peds. Swing Bed NF						0	6.00
7. 00	Total Adults and Peds. (exclude observation			21	7, 686	50, 544. 00	0	7. 00
	beds) (see instructions)				,	,		
8.00	INTENSIVE CARE UNIT	31.00		4	1, 464	7, 752. 00	0	8. 00
9.00	CORONARY CARE UNIT				·	·		9. 00
10.00	BURN INTENSIVE CARE UNIT							10.00
11. 00	SURGICAL INTENSIVE CARE UNIT							11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)							12. 00
13.00	NURSERY							13. 00
14.00	Total (see instructions)			25	9, 150	58, 296. 00	0	14. 00
15.00	CAH visits						0	15. 00
16.00	SUBPROVI DER - I PF							16. 00
17. 00	SUBPROVI DER - I RF							17. 00
18. 00	SUBPROVI DER							18. 00
19.00	SKILLED NURSING FACILITY							19. 00
20.00	NURSING FACILITY							20.00
21. 00	OTHER LONG TERM CARE							21. 00
22. 00	HOME HEALTH AGENCY	101. 00					0	22. 00
23.00	AMBULATORY SURGICAL CENTER (D. P.)							23. 00
24.00	HOSPI CE	116. 00		o	0			24. 00
24. 10	HOSPICE (non-distinct part)	30. 00						24. 10
25.00	CMHC - CMHC							25. 00
26.00	RURAL HEALTH CLINIC	88. 00					0	26. 00
26. 03	RURAL HEALTH CLINIC IV	88. 03					0	26. 03
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00					0	26. 25
27. 00	Total (sum of lines 14-26)			25				27. 00
28. 00	Observation Bed Days						0	28. 00
29. 00	Ambul ance Trips							29. 00
30.00	Employee discount days (see instruction)							30.00
31.00	Employee discount days - IRF							31.00
32.00	Labor & delivery days (see instructions)			0	0			32. 00
32. 01	Total ancillary labor & delivery room							32. 01
	outpatient days (see instructions)							
33. 00	LTCH non-covered days							33. 00

33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

outpatient days (see instructions)

LTCH non-covered days

Provider CCN: 15-1324

Peri od: Worksheet S-3 From 01/01/2016 Part I To 12/31/2016 Date/Time Prepared:

8/8/2017 10:19 am I/P Days / O/P Visits / Trips Full Time Equivalents Title XVIII Component Title XIX Total All Total Interns Employees On Pati ents & Residents Payrol I 7.00 10.00 6.00 8.00 9.00 1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 1,532 23 2, 106 1.00 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) 2 00 HMO and other (see instructions) 2 00 105 3.00 HMO IPF Subprovider 0 3.00 HMO IRF Subprovider 4.00 4.00 5.00 Hospital Adults & Peds. Swing Bed SNF 0 5.00 376 376 Hospital Adults & Peds. Swing Bed NF 6.00 C 6.00 7.00 Total Adults and Peds. (exclude observation 1,908 23 2, 482 7.00 beds) (see instructions) INTENSIVE CARE UNIT 8.00 224 323 8.00 CORONARY CARE UNIT 9.00 9.00 BURN INTENSIVE CARE UNIT 10.00 10.00 11.00 SURGICAL INTENSIVE CARE UNIT 11.00 12.00 OTHER SPECIAL CARE (SPECIFY) 12.00 13.00 NURSERY 13.00 14.00 Total (see instructions) 2, 132 29 2,805 0.00 208.82 14.00 CAH visits 15.00 15.00 SUBPROVIDER - IPF 16.00 16.00 SUBPROVIDER - IRF 17.00 17.00 18.00 SUBPROVI DER 18.00 19.00 SKILLED NURSING FACILITY 19.00 20 00 NURSING FACILITY 20 00 21.00 OTHER LONG TERM CARE 21.00 22.00 HOME HEALTH AGENCY 4,756 2, 554 13, 359 0.00 24.54 22.00 23.00 AMBULATORY SURGICAL CENTER (D. P.) 23.00 HOSPI CE 24 00 2.520 39 4, 565 0.00 6.14 24.00 24. 10 HOSPICE (non-distinct part) 24.10 CMHC - CMHC 25.00 25.00 26, 00 RURAL HEALTH CLINIC 192 719 2, 885 0.00 4.52 26, 00 26. 03 RURAL HEALTH CLINIC IV 4, 821 0.00 4.66 784 714 26.03 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 0.00 0.00 26. 25 27.00 Total (sum of lines 14-26) 0.00 248.68 27.00 Observation Bed Days 893 28.00 0 28.00 29 00 Ambul ance Trips 0 29 00 30.00 Employee discount days (see instruction) 30.00 31.00 Employee discount days - IRF 0 31.00 Labor & delivery days (see instructions) 0 0 32.00 32.00 Ω Total ancillary labor & delivery room 0 32.01

Heal th FinancialSystemsFRANCISCAN HEALTH RENSSELAERHOSPITALAND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATAProvider Complex Statistical Data Provider CCN: 15-1324

				10) 12/31/2016	Date/IIme Prep 8/8/2017 10:19	
		Full Time		Di sch	arges		
		Equi val ents					
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers	40.00	40.00	11.00	Pati ents	
1 00	Hospital Adults & Peds. (columns 5, 6, 7 and	11.00	12. 00	13. 00	14. 00	15. 00 698	1. 00
1. 00 2. 00 3. 00	8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds) HMO and other (see instructions) HMO IPF Subprovider		0	22	0	098	2. 00 3. 00
4.00	HMO IRF Subprovider	·			o		4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF						5. 00
6.00	Hospital Adults & Peds. Swing Bed NF						6. 00
7. 00	Total Adults and Peds. (exclude observation beds) (see instructions)						7. 00
8.00	INTENSIVE CARE UNIT						8. 00
9.00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11. 00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0. 00	0	501	12	698	14.00
15.00	CAH visits						15.00
16.00	SUBPROVI DER - I PF						16.00
17. 00	SUBPROVI DER - I RF						17. 00
18. 00	SUBPROVI DER						18. 00
19. 00	SKILLED NURSING FACILITY						19. 00
20. 00	NURSING FACILITY						20.00
21. 00	OTHER LONG TERM CARE						21. 00
22. 00	HOME HEALTH AGENCY	0. 00					22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24. 00	HOSPI CE	0. 00					24. 00
24. 10	HOSPICE (non-distinct part)						24. 10
25. 00	CMHC - CMHC						25. 00
26. 00	RURAL HEALTH CLINIC	0. 00					26. 00
26. 03	RURAL HEALTH CLINIC IV	0. 00					26. 03
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26. 25
27. 00	Total (sum of lines 14-26)	0. 00					27. 00
28. 00	Observation Bed Days						28. 00
29. 00	Ambulance Trips						29. 00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32. 00
32. 01	Total ancillary labor & delivery room						32. 01
33. 00	outpatient days (see instructions) LTCH non-covered days						33. 00

	<i></i>	FRANCISCAN HEALT		ON 45 4004 D		eu of Form CMS-2	2552-10
HOME I	HEALTH AGENCY STATISTICAL DATA		Provider Component		eriod: rom 01/01/2016 o 12/31/2016	Worksheet S-4 Date/Time Pre	nared·
			- Component		Home Health	8/8/2017 10: 1	
					Agency I		
0.00	County				1. JASPER	00	0.00
0.00	County	Title V	Title XVIII	Title XIX	Other	Total	0.00
	HOME HEALTH AGENCY STATISTICAL DATA	1.00	2. 00	3. 00	4. 00	5. 00	
1.00	Home Health Aide Hours	0	3, 810				1. 00
2.00	Unduplicated Census Count (see instructions)	0.00	159. 00		0.00 oyees (Full Ti		2. 00
		F., t		Ct-FF	0	T-4-1	
		Enter the number your normal		Staff	Contract	Total	
		0		1.00	2. 00	3. 00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES		<u>'</u>	1.00	2.00	3.00	
3. 00 4. 00	Administrator and Assistant Administrator(s) Director(s) and Assistant Director(s)		0. 00	13. 17 0. 00		l e	3. 00 4. 00
5. 00	Other Administrative Personnel			0.00		l e	5. 00
6.00	Direct Nursing Service			3.73			6. 00 7. 00
7. 00 8. 00	Nursi ng Supervi sor Physi cal Therapy Servi ce			0. 00 0. 86			8.00
9.00	Physical Therapy Supervisor			0.00		l e	9. 00
10. 00 11. 00	Occupational Therapy Service Occupational Therapy Supervisor			0. 28 0. 00		l e	10. 00 11. 00
12. 00	Speech Pathology Service			0. 20	0.00	0. 20	12. 00
13. 00 14. 00	Speech Pathology Supervisor Medical Social Service			0. 00 0. 00		l e	
15. 00	Medical Social Service Supervisor			0.00		l	
16.00	Home Heal th Aide Home Heal th Aide Supervisor			2.82	0. 00 0. 00	l .	16. 00 17. 00
17. 00 18. 00	PRIVATE DUTY			0. 00 1. 64		1	18. 00
19. 00	HOME HEALTH AGENCY CBSA CODES Enter in column 1 the number of CBSAs where			3			19. 00
17.00	you provided services during the cost						17.00
20. 00	reporting period. List those CBSA code(s) in column 1 serviced			23844			20. 00
	during this cost reporting period (line 20 contains the first code).						
20. 01	contains the first code).			29200			20. 01
20. 02		Full Ep	i sodes	99915			20. 02
				LUPA Epi sodes	PEP Only Episodes	Total (cols. 1-4)	
		1.00	2. 00	3.00	4. 00	5. 00	
21. 00	PPS ACTIVITY DATA Skilled Nursing Visits	1, 196	107	48	0	1, 351	21. 00
22. 00	Skilled Nursing Visit Charges	366, 342	35, 066	15, 189	0	416, 597	22. 00
23. 00 24. 00	Physical Therapy Visits Physical Therapy Visit Charges	1, 274 423, 395	79 25, 223			1, 368 453, 729	
25. 00	Occupational Therapy Visits	316	53	3	0	372	25. 00
26. 00 27. 00	Occupational Therapy Visit Charges Speech Pathology Visits	106, 113 221	16, 485 45	1			1
28. 00		72, 322	12, 807	1			
29. 00	Medical Social Service Visits	12	2 217	1	0	l	29. 00
30. 00 31. 00	Medical Social Service Visit Charges Home Health Aide Visits	4, 714 1, 011	3, 217 366		0	8, 361 1, 378	30. 00 31. 00
32. 00	Home Health Aide Visit Charges	148, 943	60, 458	173		209, 574	32. 00
33. 00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	4, 030	658	68	0	4, 756	33. 00
34. 00 35. 00	Other Charges	0 1, 121, 829	0 153, 256	· ·		ł	34. 00 35. 00
	30, 32, and 34)		100, 200				
36. 00	Total Number of Episodes (standard/non outlier)	186		25	0	211	36. 00
37. 00 38. 00		93, 696	10 6, 953		0	l e	
50.00	Trotal Non Routine medical Supply cliaiges	73, 070	0, 700	1 03	0	100,712	1 30.00

					From 01/01/2016		
			Component C	CN: 15-3990	To 12/31/2016	Date/Time Pr 8/8/2017 10:	
					RHC I	Cost	
					1	20	_
	Clinic Address and Identification				1.	00	_
	Clinic Address and Identification Street				492 S BI ERMA S	Т	1.0
. 00	Street		Ci t	tv	State	ZIP Code	1.0
			1. 0		2. 00	3. 00	
. 00	City, State, ZIP Code, County		WHEATFI ELD		IN	47978	2. (
							\perp
00	LIOCOLTAL DACED FOLICE ONLY. Decimpation Frag	n "D" for runo	d on "II" for u	mb a n		1.00	0 3.0
. 00	HOSPITAL-BASED FQHCs ONLY: Designation - Ente	r rorrura	i or o ror ur		nt Award	Date	0 3.0
					1. 00	2.00	
	Source of Federal Funds						
. 00	Community Health Center (Section 330(d), PHS						4. (
. 00	Migrant Health Center (Section 329(d), PHS Ac		ļ				5. 0
. 00	Health Services for the Homeless (Section 340	(a), PHS Act)					6. (
. 00	Appalachian Regional Commission Look-Alikes		-				7. 8.
. 00	OTHER (SPECIFY)						9.
. 01							9.
. 02							9.
. 03							9.
. 04							9.
. 05 . 06							9. 9.
. 06 . 07							9.
. 08							9.
. 09							9. (
. 10							9. 1
0. 00	Does this facility operate as other than a ho	enital based B	DUC or EDUC2 End	tor "V" for	1. 00 N	2. 00	0 10.0
0.00	yes or "N" for no in column 1. If yes, indica 2. (Enter in subscripts of line 11 the type of hours.)	te number of o	other operations	s in column	IV.		10.0
	1.04.0.7	Sun	day	M	londay	Tuesday	
		from	to	from	to	from	
		1.00	2. 00	3. 00	4. 00	5. 00	
	Facility hours of operations (1)		<u> </u>	00.00	44.00	00.00	
1.00	Clinic			08: 00	16: 30	08: 00	11. (
					1. 00	2.00	
2. 00	Have you received an approval for an exception	n to the produ	uctivity standar	rd?	N		12. (
3. 00	Is this a consolidated cost report as defined				N		0 13.0
	30.8? Enter "Y" for yes or "N" for no in colu						
	number of providers included in this report. numbers below.	List the names	of all provide	ers and			
	numbers berow.			Provi	ider name	CCN number	
					1. 00	2. 00	
4. 00	RHC/FQHC name, CCN number						14. (
		Y/N	V	XVIII	XIX	Total Visits	Š
F 00	House you provided all are substantially	1. 00	2.00	3. 00	4. 00	5. 00	15 /
5. 00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in						15. (
	column 1. If yes, enter in columns 2, 3 and		1				
	4 the number of program visits performed by		1				
	Intern & Residents for titles V, XVIII, and		1				
	XIX, as applicable. Enter in column 5 the		í l			İ	
	number of total visits for this provider.	ı			1	ļ	

Health Financial Systems					eu of Form CMS-	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 15-1324	Peri od:	Worksheet S-8	
		Component	CCN: 15-3990	From 01/01/2016 To 12/31/2016		
		_		RHC I	Cost	
		County				
		4.	00			
2.00 City, State, ZIP Code, County		JASPER				2. 00
	Tuesday	Wednesday		Thur	sday	
	to	from	to	from	to	
	6. 00	7. 00	8. 00	9. 00	10.00	
Facility hours of operations (1)						
11. 00 Clinic	16: 30	08: 00	12: 00	08: 00	16: 30	11. 00
	Fri	day	Sa	turday		
	from	to	from	to		
	11. 00	12.00	13.00	14. 00		
Facility hours of operations (1)	•			·		
11. 00 Clinic	08: 00	16: 30				11. 00

HOSPI	TAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 15-1324	Peri od:	Worksheet S-	8
				CCN: 15-8502	From 01/01/2016 To 12/31/2016	Date/Time Pr	epared:
					RHC IV	8/8/2017 10: Cost	19 alli
						3001	
					1.	00	
. 00	Clinic Address and Identification Street				420 E MAIN ST		1.00
1.00			Ci	ty	State	ZIP Code	1.00
				00	2. 00	3. 00	
2. 00	City, State, ZIP Code, County		BROOK		I N	47922	2.00
						1. 00	+
3. 00	HOSPITAL-BASED FQHCs ONLY: Designation - Ente	er "R" for rura	al or "U" for u	ırban			0 3.00
					nt Award	Date	
					1. 00	2. 00	
1. 00	Source of Federal Funds Community Health Center (Section 330(d), PHS	Acti		T			4.00
5. 00	Migrant Health Center (Section 329(d), PHS Ac						5.00
5. 00	Heal th Services for the Homeless (Section 340						6. 00
. 00	Appal achi an Regi onal Commissi on	. ,					7. 0
3. 00	Look-Al i kes						8. 0
. 00	OTHER (SPECIFY)						9. 0
. 01							9.0
. 02 . 03							9. 0.
. 03							9.0
. 05							9.0
. 06							9. 0
. 07							9. 0
. 08							9. 08
0.09							9.09
9. 10							9. 10
					1. 00	2.00	
0. 00	Does this facility operate as other than a ho yes or "N" for no in column 1. If yes, indica 2. (Enter in subscripts of line 11 the type of hours.)	ite number of a	other operation	ns in column	N		0 10.00
	Tiour S.)	Sur	iday	I	Monday	Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4. 00	5. 00	
4 00	Facility hours of operations (1)		T	loo 00	44.00	loo 00	
1. 00	Clinic			08: 00	16: 30	08: 00	11. 00
					1. 00	2.00	
12. 00	Have you received an approval for an exception	n to the produ	uctivity standa	ard?	N		12. 00
13. 00	Is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in colunumber of providers included in this report. numbers below.	ımn 1. If yes,	enter in colum	nn 2 the	N		0 13.00
				Prov	ider name	CCN number	
	1				1. 00	2. 00	
4. 00	RHC/FQHC name, CCN number) / /N	1 ,,	20011	N/A	-	14.00
		Y/N 1.00	V 2. 00	3. 00	XI X 4. 00	Total Visits 5.00	
5. 00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the	1.00	2.00	3.00	4. 00	5.00	15. 00

Health Financial Systems	FRANCISCAN HEALTH RENSSELAER In Lieu				u of Form CMS-	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 15-1324	Peri od:	Worksheet S-8	
			2011 45 0500	From 01/01/2016		
		Component	CCN: 15-8502	To 12/31/2016	Date/Time Pre 8/8/2017 10:1	
				RHC IV	Cost	,
		Cou	nty			
		4.	00			
2.00 City, State, ZIP Code, County		JASPER				2. 00
	Tuesday	Wednesday		Thur	sday	
	to	from	to	from	to	
	6. 00	7. 00	8. 00	9. 00	10.00	
Facility hours of operations (1)						
11. 00 Cl i ni c	16: 30	08: 00	16: 30	08: 00	16: 30	11. 00
	Fri	day	Sa	turday		
	from	to	from	to		
	11.00	12. 00	13. 00	14. 00		
Facility hours of operations (1)						
11. 00 Cl i ni c	08: 00	12: 00				11. 00

Heal th	Financial Systems	F	FRANCISCAN HEAL	TH RENSSELAER		In Lie	u of Form CMS-2	2552-10
	TAL-BASED HOSPICE IDENTIFICATION		TO BE TO SERVICE A SERVICE	Provi der C		Peri od: From 01/01/2016	Worksheet S-9 PARTS I THROU	GH IV
				Hospi ce CCI	N: 15-1519	To 12/31/2016	Date/Time Prep 8/8/2017 10:19	
						Hospi ce I	0,0,201, 10.1	7 diii
		Unduplicated						
		Days	T: 11 VIV	T: 11 \0.011	T T' 11 VIV	411 011	T 1 1 6	
		Title XVIII	Title XIX	Title XVIII Skilled	Title XIX Nursing	All Other	Total (sum of cols. 1, 2 &	
				Nursi ng	Facility		5)	
				Facility	laciiity		3)	
		1.00	2.00	3.00	4.00	5. 00	6. 00	
	PART I - ENROLLMENT DAYS FOR CO	OST REPORTING F	PERI ODS BEGINNI	NG BEFORE OCTO	BER 1, 2015			
1.00	Hospice Continuous Home Care							1. 00
2.00	Hospice Routine Home Care							2.00
3. 00 4. 00	Hospice Inpatient Respite Care Hospice General Inpatient Care							3. 00 4. 00
5.00	Total Hospice Days							5.00
3.00	Part II - CENSUS DATA FOR COST	REPORTING PERI	ODS BEGLNNING	BEFORE OCTOBER	1 2015			3.00
6.00	Number of patients receiving				,			6.00
	hospi ce care							
7.00	Total number of unduplicated							7. 00
	Continuous Care hours billable							
8. 00	to Medicare Average Length of Stay (line 5							8. 00
8.00	/ line 6)							0.00
9.00	Unduplicated census count							9. 00
NOTE:	Parts I and II, columns 1 and 2	also include	the days repor	ted in columns	3 and 4.			
				Title XVIII	Title XIX	Other	Total (sum of	
							col s. 1	
				4.00	0.00	2.00	through 3)	
	PART III - ENROLLMENT DAYS FOR	COST DEDODTING	C DEDIADS DECLA	1. 00	2.00	3. 00	4. 00	
10. 00		COST REPORTING	J PERIODS DEGIN	INTING ON OR AFT	ER OCTOBER I	, <u>2013</u>	0	10.00
11. 00	Hospice Routine Home Care			2, 514		0 2,045		11. 00
12. 00	Hospice Inpatient Respite Care			6	1	0 0	6	
13.00	Hospice General Inpatient Care			0		0 0	0	ı
14. 00	Total Hospice Days			2, 520		0 2, 045		14. 00
	PART IV - CONTRACTED STATISTICA	AL DATA FOR COS	ST REPORTING PE					
15. 00	Hospice Inpatient Respite Care			0		0 0		
16. 00	Hospice General Inpatient Care			0	1	0 0	0	16. 00

Hool +h	Financial Customs	EDANCI COAN LIEALTII	DENCCEL AED		العالما	of Form CMC 1	DEE2 10		
	Financial Systems TAL UNCOMPENSATED AND INDIGENT CARE DATA	FRANCISCAN HEALTH	Provi der CC	N. 1E 1224	Peri od:	u of Form CMS-2 Worksheet S-10			
HUSPI I	AL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CC	N: 15-1324	From 01/01/2016	worksneet 3-10	J		
					To 12/31/2016	Date/Time Pre	oared:		
						8/8/2017 10: 1			
	1					1. 00			
4 00	Uncompensated and indigent care cost comp			200	0)	0 (0(470	4 00		
1. 00	Cost to charge ratio (Worksheet C, Part I	Tine 202 column 3 d	IVI ded by III	ne 202 column	า 8)	0. 686479	1. 00		
2 00	Medicaid (see instructions for each line)					0	2.00		
2. 00 3. 00	Net revenue from Medicaid Did you receive DSH or supplemental payme	nts from Modicaid?				U	2. 00 3. 00		
4. 00	If line 3 is "yes", does line 2 include a	12		4. 00					
5. 00	If line 4 is "no", then enter DSH or supp	• • •	1 2	irolli wedicare	<i>i</i> :	0	5. 00		
6. 00	Medicaid charges	remerrear paymerres rr	om weareara			0	6. 00		
7. 00	Medicaid cost (line 1 times line 6)					0	7. 00		
8. 00	Difference between net revenue and costs	for Medicaid program	(line 7 minu	us sum of lir	nes 2 and 5: if	0	8. 00		
	< zero then enter zero)	1 1 1 1 1 1 1 1 1			,				
	Children's Health Insurance Program (CHIP) (see instructions	for each line	e)					
9.00	Net revenue from stand-alone CHIP					0	9. 00		
10.00	Stand-alone CHIP charges					0	10.00		
11. 00	Stand-alone CHIP cost (line 1 times line					0			
12. 00	Difference between net revenue and costs	for stand-alone CHIP	(line 11 mi	nus line 9; i	f < zero then	0	12. 00		
	enter zero)								
12.00	Other state or local government indigent					0	13. 00		
13. 00 14. 00									
14.00	4.00 Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)								
15. 00									
16. 00				nrogram (Lir	ne 15 minus line	0	15. 00 16. 00		
10.00	13; if < zero then enter zero)	To: State of Todai T	nargent care	program (iii	10 10 1111103 11110	o l	10.00		
	Uncompensated care (see instructions for	each line)							
17.00	Private grants, donations, or endowment i	ncome restricted to	fundi ng chari	ity care		0	17.00		
18. 00	1 1 1					-	18. 00		
19. 00		IIP and state and Loc	al indigent o	care programs	s (sum of lines	0	19. 00		
	8, 12 and 16)								
				Uni nsured	Insured	Total (col. 1			
				pati ents 1.00	pati ents 2.00	+ col . 2) 3.00			
20.00	Charity care charges for the entire facil	ity (see instruction	6)	1.00	0 0	3.00	20. 00		
21. 00	Cost of patients approved for charity car	3 1	,		0 0	0	21. 00		
22. 00	1 11	•	20)		0 0	0	22. 00		
23. 00					0 0	0			
		,	'						
						1. 00			
24. 00	Does the amount in line 20 column 2 inclu			nd a Length o	of stay limit		24. 00		
	imposed on patients covered by Medicaid o								
25. 00				ogram's Leng	th of stay limit	0	25. 00		
26. 00						0	26. 00		
27. 00			,	073		252, 671			
28. 00	Non-Medicare and non-reimbursable Medicar				00)	-252, 671			
29. 00			xpense (IIne	i times iine	28)	-173, 453			
30.00	Cost of uncompensated care (line 23 colum Total unreimbursed and uncompensated care	'	lino 20)			-173, 453 -173, 453			
31.00	Trotal uniterimonised and uncompensated care	cost (Tine 19 pius	11110 30)			-1/3, 453	31.00		

	Financial Systems	FRANCI SCAN HEALTH RENSSELAER			In Lieu of Form CMS-2552-1		
RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE (OF EXPENSES	Provi der Co		Peri od:	Worksheet A	
					From 01/01/2016 Fo 12/31/2016	Date/Time Pre 8/8/2017 10:1	
	Cost Center Description	Sal ari es	0ther		Reclassificati	Reclassi fi ed	
				+ col . 2)	ons (See A-6)	Trial Balance (col. 3 +-	
						col . 4)	
		1.00	2. 00	3. 00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT		3, 172, 410			3, 365, 985	
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	106, 330	4, 500, 735			4, 607, 065	4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	1, 331, 302	7, 053, 821			8, 191, 548	
7. 00 8. 00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	259, 525 67, 292	1, 078, 564 29, 065			1, 338, 089 96, 357	1
9. 00	00900 HOUSEKEEPING	463, 218	90, 780	1		526, 198	
10. 00	01000 DI ETARY	365, 203	196, 275			265, 077	
11. 00	01100 CAFETERI A	0	0		296, 401	296, 401	
13.00	01300 NURSING ADMINISTRATION	183, 731	23, 426	207, 15		207, 157	13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	28, 054	410, 384	438, 438	0	438, 438	14. 00
15. 00	01500 PHARMACY	390, 882	2, 362, 317			2, 753, 199	
16. 00	01600 MEDICAL RECORDS & LIBRARY	900	41, 728			42, 628	1
17. 00	01700 SOCIAL SERVICE	0	0	(0	0	17. 00
30. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	918, 593	25, 050	943, 643	3 27, 800	971, 443	30.00
31. 00	03100 I NTENSI VE CARE UNI T	639, 887	7, 181				1
31.00	ANCI LLARY SERVI CE COST CENTERS	037,007	7, 101	047,000	9 9	047,000	31.00
50.00	05000 OPERATING ROOM	444, 795	582, 121	1, 026, 910	5 0	1, 026, 916	50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	799, 547	837, 771	1, 637, 318	0	1, 637, 318	54.00
60.00	06000 LABORATORY	0	2, 155, 590	2, 155, 590	0	2, 155, 590	60. 00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	63, 688			63, 688	1
65. 00	06500 RESPI RATORY THERAPY	701, 197	75, 675			776, 872	
66. 00	06600 PHYSI CAL THERAPY	900, 811	79, 130			493, 899	1
66. 01 67. 00	06601 WHEATFIELD PT	221, 281 91, 709	1, 994			384, 580	
67. 00	06700 OCCUPATI ONAL THERAPY 06701 WHEATFI ELD OT	47, 583	85 2, 358	1		209, 901 85, 613	
68. 00	06800 SPEECH PATHOLOGY	53, 017	2, 330			121, 913	1
68. 01	06801 WHEATFI ELD ST	30, 877	1, 005			54, 655	1
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	0	(o	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	743, 447	743, 44	7 0	743, 447	71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENT	0	107, 507			107, 507	
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0	(0	0	73. 00
00.00	OUTPATIENT SERVICE COST CENTERS	2/5 7/4	(4.20/	220.1//		220 1/0	00.00
88. 00 88. 03	08800 RURAL HEALTH CLINIC 08801 RURAL HEALTH CLINIC IV	265, 764 306, 241	64, 396 80, 660			330, 160 386, 901	
90. 00	09000 CLINIC	1, 106, 811	74, 390			1, 181, 201	
91. 00	09100 EMERGENCY	953, 627	930, 978			1, 884, 605	1
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)			, ,		, ,	92.00
	OTHER REIMBURSABLE COST CENTERS						
101.00	10100 HOME HEALTH AGENCY	1, 048, 766	196, 483	1, 245, 249	158, 176	1, 403, 425	101. 00
44/ 0/	SPECIAL PURPOSE COST CENTERS	204 205	000 540	T 544 000	-1 -1	E44 00E	144 00
116.00	11600 HOSPICE SUBTOTALS (SUM OF LINES 1-117)	324, 325	220, 510				
110.00	NONREI MBURSABLE COST CENTERS	12, 051, 268	25, 209, 818	37, 261, 08	5 78, 593	37, 339, 079	1116.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0	0	190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	0	0		o		192. 00
192. 01	19201 RENSSELAER HEALTH CENTER	0	0		o	0	192. 01
	19300 NONPALD WORKERS	0	0		0		193. 00
	07950 ALTERNACARE	561, 872	21, 958	583, 830	이	583, 830	
	07951 DME EQUI PMENT	0	0	(40.00)	0		194. 01
	207952 WHEATFIELD FITNESS	469, 408 386, 125	172, 987				
	07957 JOHNSON FITNESS 07953 FOUNDATION	380, 125	28, 163 4, 670			555, 445 4, 670	194. 03
	07954 MEALS ON WHEELS		4, 570 N	4,070			194. 04
	07955 WATER LAB		0				194. 06
	7 07956 ADVERTI SI NG	0	50	1			194. 07
200.00	TOTAL (SUM OF LINES 118-199)	13, 468, 673	25, 437, 646	38, 906, 319	e o	38, 906, 319	200. 00

Provider CCN: 15-1324

Peri od: From 01/01/2016 To 12/31/2016 Date/Ti me Prepared: 8/8/2017 10:19 am

			8/8/2017 10: 1	9 am
Cost Center Description	Adjustments	Net Expenses		
	(See A-8)	For Allocation		
	6.00	7. 00		
GENERAL SERVICE COST CENTERS				
1.00 O0100 NEW CAP REL COSTS-BLDG & FLXT	1, 267, 368	4, 633, 353		1. 00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	274, 711	4, 881, 776		4. 00
5.00 00500 ADMINISTRATIVE & GENERAL	5, 017, 553	13, 209, 101		5. 00
7.00 00700 OPERATION OF PLANT	-95			7. 00
8.00 00800 LAUNDRY & LINEN SERVICE	0			8. 00
9. 00 00900 HOUSEKEEPI NG	-580			9. 00
10. 00 01000 DI ETARY	-23, 990			10.00
11. 00 01100 CAFETERI A	-35, 247			11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	138, 893			13. 00
14. 00 01400 CENTRAL SERVICES & SUPPLY				14. 00
	-354, 427			
15. 00 01500 PHARMACY	32, 753			15.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	126, 308			16. 00
17. 00 01700 SOCIAL SERVICE	0	0		17. 00
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS	-8, 175			30. 00
31. 00 03100 I NTENSI VE CARE UNIT	-1, 750	645, 318		31.00
ANCILLARY SERVICE COST CENTERS				
50. 00 05000 OPERATI NG ROOM	-430, 337	596, 579		50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	-8, 847	1, 628, 471		54.00
60. 00 06000 LABORATORY	-31, 354	2, 124, 236		60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	63, 688		63. 00
65. 00 06500 RESPIRATORY THERAPY	-486	l ·	·	65. 00
66. 00 06600 PHYSI CAL THERAPY	-30	l ·	·	66. 00
66. 01 06601 WHEATFI ELD PT	0			66. 01
67. 00 06700 OCCUPATI ONAL THERAPY	0			67. 00
67. 01 06701 WHEATFI ELD OT		1		67. 01
68. 00 06800 SPEECH PATHOLOGY			l .	68. 00
		, , , , , , , , , , , , , , , , , , , ,		
68. 01 06801 WHEATFIELD ST	0			68. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY	0		l .	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0			71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0			72. 00
73.00 O7300 DRUGS CHARGED TO PATIENTS	0	0		73. 00
OUTPATIENT SERVICE COST CENTERS	_			
88.00 08800 RURAL HEALTH CLINIC	0			88. 00
88.03 08801 RURAL HEALTH CLINIC IV	0	386, 901		88. 03
90. 00 09000 CLI NI C	-950	1, 180, 251		90.00
91. 00 09100 EMERGENCY	-490	1, 884, 115		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)				92.00
OTHER REIMBURSABLE COST CENTERS				
101.00 10100 HOME HEALTH AGENCY	0	1, 403, 425		101. 00
SPECIAL PURPOSE COST CENTERS		,		
116. 00 11600 HOSPI CE	0	544, 835		116. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	5, 960, 828			118. 00
NONREI MBURSABLE COST CENTERS	0,700,020	10,000,007		110.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190. 00
	1		•	1
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	0		l .	192. 00
192. 01 19201 RENSSELAER HEALTH CENTER	0	0		192. 01
193. 00 19300 NONPAI D WORKERS	0	0		193. 00
194. 00 07950 ALTERNACARE	0			194. 00
194. 01 07951 DME EQUI PMENT	0	l .		194. 01
194. 02 07952 WHEATFI ELD FITNESS	0	,		194. 02
194.03 07957 JOHNSON FITNESS	0	555, 445		194. 03
194. 04 07953 FOUNDATI ON	0	4, 670		194. 04
194.05 07954 MEALS ON WHEELS	0	0		194. 05
194.06 07955 WATER LAB	0	0		194. 06
194. 07 07956 ADVERTI SI NG	0	50		194. 07
200.00 TOTAL (SUM OF LINES 118-199)	5, 960, 828			200. 00
1 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2			ı	,

Health Financial Systems	FRANCI SCAN HEALTH RENSSELAER	In Lieu of Form CMS-2552-10
RECLASSI FI CATI ONS	Provi der CCN: 15-1324	Period: Worksheet A-6
		From 01/01/2016 Date/Time Prepared:

					To 12/31/2016 Date/Time Pr 8/8/2017 10:	epared: 19 am
		Increases				
	Cost Center	Li ne #	Sal ary	Other		
	2. 00	3.00	4. 00	5. 00		
	A - CAFETERIA					
1.00	CAFETERI A	11. 00	192, 789	103, 612		1. 00
	0		192, 789	103, 612		
	B - PROPERTY INSURANCE					
1.00	NEW CAP REL COSTS-BLDG &	1.00	0	193, 575		1. 00
	FIXT					
	0		0	193, 575		_
	D - WHEATFIELD RECLASS					
1.00	WHEATFIELD PT	66. 01	158, 058	3, 247		1. 00
2.00	WHEATFIELD OT	67. 01	33, 988	1, 684		2. 00
3.00	WHEATFIELD ST	68. 01	22, 055	718		3. 00
	0		214, 101	5, 649		
	E - REHAB RECLASS					
1.00	OCCUPATI ONAL THERAPY	67.00	118, 043	64		1. 00
2.00	SPEECH PATHOLOGY	68.00	68, 240	362		2. 00
3.00	HOME HEALTH AGENCY	101.00	135, 731	22, 445		3. 00
4.00	JOHNSON FITNESS	194.03	130, 636	1 <u>0, 5</u> 21		4. 00
	0		452, 650	33, 392		
	H - HOUSEKEEPING					
1.00	ADULTS & PEDIATRICS	30.00	27, 800	0		1. 00
	TOTALS		27, 800	0		
500.00	Grand Total: Increases		887, 340	336, 228		500.00

Health Financial Systems		FRANCI SCAN HEALTH RENSSELAER			In Lieu of Form CMS-2552-10			
RECLASS	SIFICATIONS			Provi der (Peri od: From 01/01/2016 To 12/31/2016	Date/Time Pre	pared:
							8/8/2017 10: 1	<u>9 am </u>
		Decreases						
	Cost Center	Li ne #	Sal ary	Other	Wkst. A-7 Ref	· .		
	6.00	7 00	8 00	9 00	10.00			

						8/8/201/ 10:	19 am
		Decreases					
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10.00		
	A - CAFETERIA						
1.00	DI ETARY	10.00	192, 789	103, 612	0		1. 00
	0		192, 789	103, 612			
	B - PROPERTY INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	193, 575	12		1. 00
	0		0	193, 575			
	D - WHEATFIELD RECLASS						
1.00	WHEATFIELD FITNESS	194. 02	214, 101	5, 649	0		1. 00
2.00		0.00	0	0	0		2. 00
3.00		0.00	0	0	0		3. 00
	0		214, 101	5, 649			
	E - REHAB RECLASS						
1.00	PHYSI CAL THERAPY	66.00	452, 650	33, 392	0		1. 00
2.00		0.00	0	0	0		2. 00
3.00		0.00	0	0	0		3. 00
4.00		0.00	0	0	0		4. 00
	0		452, 650	33, 392			
	H - HOUSEKEEPING						
1.00	HOUSEKEEPI NG	9. 00	27, 800	0	0		1. 00
	TOTALS		27, 800	— — — _ō			
500.00	Grand Total: Decreases		887, 340	336, 228			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS Provider CCN: 15-1324 Peri od: Worksheet A-7 From 01/01/2016 Part I Date/Time Prepared: 12/31/2016 8/8/2017 10:19 am Acqui si ti ons Begi nni ng Purchases Total Di sposal s and Donati on Bal ances Retirements 2.00 3.00 4. 00 5.00 1 00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 675, 791 1.00 1.00 0 2.00 Land Improvements 509, 925 0 0 0 25, 499 2.00 3.00 3.00 Buildings and Fixtures Ω 4.00 Building Improvements 16, 723, 913 0 252, 567 4.00 5.00 Fixed Equipment 0 5.00 0 6.00 Movable Equipment 4, 475, 276 2, 572, 811 2, 572, 811 0 6.00 0 7.00 HIT designated Assets 0 7.00 0 8.00 Subtotal (sum of lines 1-7) 22, 384, 905 2, 572, 811 2, 572, 811 278, 066 8.00 9.00 Reconciling Items 0 9.00 <u>22, 384</u>, 905 Total (line 8 minus line 9) 2, 572, 811 278, 066 10.00 0 2, 572, 811 10.00 Endi ng Bal ance Fully Depreciated Assets 6.00 7. 00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 Land 675, 791 0 1.00 2.00 Land Improvements 484, 426 0 2.00 3.00 Buildings and Fixtures 0 3.00 0 4.00 Building Improvements 16, 471, 346 4.00

7,048,087

24, 679, 650

24, 679, 650

0

0

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0

5.00

6.00

7.00

8.00

9.00

10.00

5.00

6.00

7.00

8.00

9.00

Fi xed Equipment

Movable Equipment

Reconciling Items

HIT designated Assets

10.00 Total (line 8 minus line 9)

Subtotal (sum of lines 1-7)

Heal th	Financial Systems	FRANCI SCAN HEAL	TH RENSSELAER		In Lie	u of Form CMS-2	2552-10
RECONG	CILIATION OF CAPITAL COSTS CENTERS		Provi der CO		Peri od:	Worksheet A-7	
					From 01/01/2016 To 12/31/2016		pared:
						8/8/2017 10:1	9 am
			SU	JMMARY OF CAPI	TAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see		
					instructions)		
		9. 00	10.00	11. 00	12. 00	13. 00	
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	2, 336, 844	0	18, 29	0 8	0	1. 00
3.00	Total (sum of lines 1-2)	2, 336, 844	0	18, 29	0 8	0	3. 00
		SUMMARY O	F CAPITAL				
	Cost Center Description	Other	Total (1) (sum				
	· ·	Capi tal -Relate	of cols. 9				
		d Costs (see	through 14)				
		instructions)	Ů,				
		14.00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WOR		N 2. LINES 1 a	nd 2			
1.00	NEW CAP REL COSTS-BLDG & FLXT	817, 268					1.00
3.00	Total (sum of lines 1-2)	817, 268					3. 00

Health Financial Systems	RANCISCAN HEAL	TH RENSSELAER		In Lie	u of Form CMS-2	552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der Co		Peri od:	Worksheet A-7	
				From 01/01/2016 Fo 12/31/2016	Part III Date/Time Prep	arod.
				10 12/31/2016	8/8/2017 10: 19	oareu: 9 am
	COM	PUTATION OF RAT	TLOS	ALLOCATION OF	OTHER CAPITAL	, am
Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets	Ratio (see	Insurance	
		Leases	for Ratio	instructions)		
			(col. 1 - col.			
			2)			
	1.00	2. 00	3. 00	4. 00	5. 00	
PART III - RECONCILIATION OF CAPITAL COSTS CI		ı	1			
1.00 NEW CAP REL COSTS-BLDG & FLXT	24, 679, 650		24, 679, 650		0	1. 00
3.00 Total (sum of lines 1-2)	24, 679, 650		2 1/ 07 7/ 00			3. 00
	ALLOCA	TION OF OTHER (CAPI TAL	SUMMARY 0	F CAPITAL	
Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
		Capi tal -Relate				
		d Costs	through 7)			
	6.00	7. 00	8. 00	9. 00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CI	ENTERS					
1.00 NEW CAP REL COSTS-BLDG & FLXT	0	0	(2, 309, 485	0	1.00
3.00 Total (sum of lines 1-2)	0	0	(2, 309, 485	0	3.00
		Sl	JMMARY OF CAPI	TAL		
Cost Center Description	Interest	Insurance (see			Total (2) (sum	
		instructions)	instructions)	Capi tal -Rel ate		
				d Costs (see	through 14)	
				instructions)		
	11. 00	12. 00	13. 00	14. 00	15. 00	
PART III - RECONCILIATION OF CAPITAL COSTS CI			1			
1.00 NEW CAP REL COSTS-BLDG & FLXT	-750, 518			2, 880, 811		1. 00
3.00 Total (sum of lines 1-2)	-750, 518	193, 575	(2, 880, 811	4, 633, 353	3. 00

ADJUSTMENTS TO EXPENSES Provider CCN: 15-1324 Peri od: Worksheet A-8 From 01/01/2016 12/31/2016 Date/Time Prepared: 8/8/2017 10:19 am Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted Cost Center Description Basis/Code (2) Cost Center Line # Wkst. A-7 Ref. Amount 1.00 2.00 3.00 4.00 5.00 1.00 ONEW CAP REL COSTS-BLDG & 1. 00 Investment income - NEW CAP 1.00 REL COSTS-BLDG & FLXT (chapter IFI XT 2.00 Investment income - CAP REL 0 *** Cost Center Deleted *** 2.00 2.00 COSTS-MVBLE EQUIP (chapter 2) 3.00 Investment income - other 3.00 0.00 (chapter 2) Trade, quantity, and time 4.00 0 00 4.00 discounts (chapter 8) 5.00 Refunds and rebates of 0.00 5.00 expenses (chapter 8) Rental of provider space by suppliers (chapter 8) 6.00 0.00 6.00 7 00 7.00 Tel ephone servi ces (pay 0.00 stations excluded) (chapter 8.00 Television and radio service 0.00 8.00 (chapter 21) 9.00 Parking Lot (chapter 21) 0.00 9.00 10.00 Provi der-based physician A-8-2 10.00 adj ustment Sale of scrap, waste, etc. 11.00 0.00 11.00 (chapter 23) Related organization A-8-1 7, 616, 206 12.00 12.00 transactions (chapter 10) 13 00 Laundry and linen service 0 0 00 13 00 Cafeteria-employees and guests 0 0.00 14.00 14.00 15.00 Rental of quarters to employee 0 0.00 15.00 and others 16 00 Sale of medical and surgical O 0 00 16 00 supplies to other than pati ents Sale of drugs to other than 17.00 17.00 0.00 0 pati ents Sale of medical records and -9, 330 MEDICAL RECORDS & LIBRARY 18.00 18.00 В 16.00 abstracts 19.00 Nursing school (tuition, fees, 0 19.00 0.00 books, etc.) 20.00 Vending machines 0.00 20.00 21.00 Income from imposition of 0.00 21.00 interest, finance or penalty charges (chapter 21) 22.00 Interest expense on Medicare 0.00 22.00 overpayments and borrowings to repay Medicare overpayments Adjustment for respiratory A-8-3 ORESPIRATORY THERAPY 65.00 23.00 23.00 therapy costs in excess of limitation (chapter 14) 24.00 Adjustment for physical A-8-3 OPHYSICAL THERAPY 66.00 24 00 therapy costs in excess of limitation (chapter 14) 25.00 Utilization review 0 *** Cost Center Deleted *** 114.00 25.00 physicians' compensation (chapter 21) Depreciation - NEW CAP REL ONEW CAP REL COSTS-BLDG & 26.00 1.00 26.00 COSTS-BLDG & FLXT FI XT 0 *** Cost Center Deleted *** 27.00 Depreciation - CAP REL 2.00 27.00 COSTS-MVBLE EQUIP 28.00 0 *** Cost Center Deleted *** 19.00 28.00 Non-physician Anesthetist Physicians' assistant 29 00 29.00 0.00 30.00 Adjustment for occupational A-8-3 O OCCUPATIONAL THERAPY 67.00 30.00 therapy costs in excess of limitation (chapter 14) 30.99 Hospice (non-distinct) (see OADULTS & PEDIATRICS 30.00 30.99 instructions) 31.00 Adjustment for speech A-8-3 OSPEECH PATHOLOGY 68.00 31.00 pathology costs in excess of limitation (chapter 14) 32.00 CAH HIT Adjustment for -17, 196 NEW CAP REL COSTS-BLDG & 32.00 Α 1.00 Depreciation and Interest IFT XT 33.00 HAF OFFSET -1, 002, 301 ADMI NI STRATI VE & GENERAL 5.00 Α 0 33.00

Heal th	Financial Systems	F	RANCISCAN HEAL	TH RENSSELAER	In Li€	eu of Form CMS-2	2552-10
ADJUST	TMENTS TO EXPENSES			Provider CCN: 15-1324	Peri od:	Worksheet A-8	
					From 01/01/2016		
					To 12/31/2016	Date/Time Pre 8/8/2017 10:1	
				Expense Classification o	n Worksheet A	07 07 20 17 101 1	, <u>u</u>
				To/From Which the Amount is	s to be Adjusted		
					·		
	Cook Cooker December	D:- (CI- (2)	A +	Cook Cooks	1: "	WI+ A 7 D-6	
	Cost Center Description	Basi s/Code (2) 1.00	Amount 2.00	Cost Center 3.00	Li ne #	Wkst. A-7 Ref. 5.00	
20.00	OTHER REVENUE			NEW CAP REL COSTS-BLDG &	4.00		39.00
39. 00	OTHER REVENUE	В		FIXT	1.00	9	39.00
40. 00	OTHER REVENUE	В		ADMINISTRATIVE & GENERAL	5.00	0	40.00
40. 01	OTHER REVENUE	В	· ·	OPERATION OF PLANT	7. 00		1
40. 01	OTHER REVENUE	В		HOUSEKEEPI NG	9.00		1
40. 02	OTHER REVENUE	В		DI ETARY	10.00		1
44. 00	OTHER REVENUE	В	· ·	CAFETERI A	11. 00		1
44. 01	OTHER REVENUE	B		NURSING ADMINISTRATION	13.00		1
44. 02	OTHER REVENUE	B	· ·	CENTRAL SERVICES & SUPPLY	14. 00		1
44. 03	OTHER REVENUE	В		PHARMACY	15. 00		
44. 04	OTHER REVENUE	В	· ·	OPERATING ROOM	50.00		
44. 05	OTHER REVENUE	В		RADI OLOGY-DI AGNOSTI C	54.00		44. 05
44. 06	OTHER REVENUE	В		LABORATORY	60.00		1
44. 07	OTHER REVENUE	В	· ·	RESPIRATORY THERAPY	65.00		1
44. 08	OTHER REVENUE	В		PHYSI CAL THERAPY	66.00		1
44. 09	OTHER REVENUE	В		EMERGENCY	91.00		
44. 10	OTHER REVENUE	В	-9, 330	MEDICAL RECORDS & LIBRARY	16.00	9	44. 10
44. 11	MI SELLANEOUS ADMIN	В	-631	ADMINISTRATIVE & GENERAL	5. 00	0	44. 11
44. 12	MI SCELLANEOUS CAFETERIA	В	-57	CAFETERI A	11. 00	0	44. 12
44. 14	MI SCELLANEOUS I NCOME PHARMACY	В	-3, 766	PHARMACY	15. 00	0	44. 14
44. 16	MI SCELLANEOUS MEDICAL RECORDS	В	-1, 794	MEDICAL RECORDS & LIBRARY	16.00	0	44. 16
44. 17	LOBBYING EXPENSE	Α	-755	ADMINISTRATIVE & GENERAL	5. 00	0	44. 17
44. 18	ANESTHESI A OFFSET	Α	-8, 175	ADULTS & PEDIATRICS	30.00	0	44. 18
44. 19	ANESTHESIA OFFSET	Α	-1, 750	INTENSIVE CARE UNIT	31.00	0	44. 19
44. 20	ANESTHESIA OFFSET	Α	-416, 892	OPERATING ROOM	50.00	0	44. 20
44. 21	ANESTHESIA OFFSET	A	-950	CLINIC	90.00	0	44. 21
44. 22	ANESTHESIA OFFSET	A	-400	EMERGENCY	91.00	0	44. 22
44. 23	DEPRECIATION CARRYFORWARD	A	8, 439	ADMINISTRATIVE & GENERAL	5.00	0	= -
44 24	1	1		d	0.00		11 21

5, 960, 828

0.00

44. 24

50.00

column 6, line 200.) (1) Description - all chapter references in this column pertain to CMS Pub. 15-1.

(2) Basis for adjustment (see instructions).

TOTAL (sum of lines 1 thru 49)

(Transfer to Worksheet A,

44. 24

50.00

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: 15-1324 Peri od: From 01/01/2016 | Date/Time Prepared: OFFICE COSTS

					8/8/2017 10: 1	<u>9 am</u>
	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 OR	GANIZATIONS OR	CLAI MED	
	HOME OFFICE COSTS:					
1.00	1.00	NEW CAP REL COSTS-BLDG & FIX	ALLOWABLE NEW CAPITAL COSTS	2, 063, 543	0	1. 00
2.00	1.00	NEW CAP REL COSTS-BLDG & FIX	I NTEREST	28, 352	797, 168	2. 00
3.00	5. 00	ADMINISTRATIVE & GENERAL	ADMINISTRATIVE & GENERAL	8, 764, 253	3, 555, 842	3. 00
4.00	14. 00	CENTRAL SERVICES & SUPPLY	CENTRAL SUPPLY	0	346, 092	4. 00
4.01	15. 00	PHARMACY	COVP / PHARMACY	4, 953	0	4. 01
4.02	16. 00	MEDICAL RECORDS & LIBRARY	ні м	146, 762	0	4. 02
4.03	4. 00	EMPLOYEE BENEFITS DEPARTMENT	SHARED SERVICES	274, 711	0	4. 03
4.04	5. 00	ADMINISTRATIVE & GENERAL	SHARED SERVICES	827, 023	0	4. 04
4.06	13. 00	NURSING ADMINISTRATION	SHARED SERVICES	150, 473	0	4. 06
4.07	15. 00	PHARMACY	SHARED SERVICES	55, 238	0	4. 07
4.08	0.00			0	0	4. 08
5.00	TOTALS (sum of lines 1-4).			12, 315, 308	4, 699, 102	5. 00
	Transfer column 6, line 5 to					
	Worksheet A-8, column 2,					
	line 12					

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

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

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

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

6.00	В	FRANCISCAN ALLI	100.00	0.00	6. 00
7.00			0.00	0.00	7. 00
8.00			0.00	0.00	8. 00
9.00			0.00	0.00	9. 00
10.00			0.00	0.00	10.00
100.00	G. Other (financial or				100.00
	non-financial) specify:				

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

Heal th	Financial Syste	ems			FRANCI SCA	N HEALTH	RENSSELAE	R		In Lie	u of Form CMS-	2552-10
STATEME OFFICE	INT OF COSTS OF COSTS	SERVICES I	ROM	RELATED ORGANI	ZATIONS AN	ND HOME	Provi der	CCN:	15-1324	Peri od: From 01/01/2016 To 12/31/2016	Worksheet A-8 Date/Time Pre 8/8/2017 10:1	pared:
	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7	Ref.									
	6. 00	7. 00										
	A. COSTS INCURI		JUSTN	MENTS REQUIRED	AS A RESUI	LT OF TRA	NSACTI ONS	WI TH	RELATED C	ORGANIZATIONS OR (CLAI MED	
1.00	2, 063, 543		14									1. 00
2.00	-768, 816		11									2. 00
3.00	5, 208, 411		0									3. 00
4.00	-346, 092		0									4. 00
4. 01	4, 953		0									4. 01
4.02	146, 762		0									4. 02
4.03	274, 711		0									4. 03
4.04	827, 023		0									4. 04
4.06	150, 473		0									4. 06
4.07	55, 238		0									4. 07

5.00 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.

4.08

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

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

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

6.00	6. 00
7. 00	7. 00
8. 00	8. 00
9. 00	9. 00
10.00	10.00
6. 00 7. 00 8. 00 9. 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.
- Provider has financial interest in corporation, partnership, or other organization.
- D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organi zati on.
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in

7, 616, 206

4.08

0

| Period: | Worksheet A-8-2 | From 01/01/2016 | To 12/31/2016 | Date/Time Prepared: Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT Provider CCN: 15-1324

					-	To 12/31/201	6 Date/Time Pre 8/8/2017 10:	epared: 19 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	
							Hours	
	1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	7. 00	
1. 00		ADMINISTRATIVE & GENERAL	115, 650					
2.00		LABORATORY	10, 000				1	
3.00		RESPI RATORY THERAPY	2, 080		_, -,		ή	
4.00		EMERGENCY	773, 337			1	0	
5.00	0. 00		0		0		0	
6.00	0.00		0	(0		0	
7. 00	0.00		0	(0		0	
8. 00	0.00		0	() 0		0	
9. 00	0.00		0	() 0		0	/ // 00
10. 00	0.00		0	(0		0	
200.00		0 1 0 1 (8)	901, 067		901, 067		0	
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of	Provi der	Physician Cost	
		l denti fi er	Limit	Limit	Memberships &		of Malpractice Insurance	
				LIMIL	Conti nui ng Educati on	Share of col.	Trisurance	
	1. 00	2.00	8. 00	9. 00	12. 00	13. 00	14. 00	
1.00		ADMINISTRATIVE & GENERAL	0.00					1. 00
2. 00		LABORATORY	0		-	1		
3. 00		RESPI RATORY THERAPY	0		1		ol o	1
4.00		EMERGENCY	0					1
5. 00	0.00		0				ol o	
6. 00	0.00		0					1
7. 00	0.00		0	ĺ			ol o	
8. 00	0.00		0				ol o	1
9. 00	0.00		0	d	0		o	1
10.00	0.00		0		0		ol o	10.00
200.00			0		0		o	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		l denti fi er	Component	Limit	Di sal I owance	_		
			Share of col.					
			14					
	1. 00	2. 00	15. 00	16. 00	17. 00	18. 00		
1. 00		ADMINISTRATIVE & GENERAL	0		_	1	1	1. 00
2.00		LABORATORY	0		-	1	1	2. 00
3.00		RESPI RATORY THERAPY	0	C	ή	(1	3. 00
4.00		EMERGENCY	0	(0			4. 00
5.00	0. 00		0	(0) ()	5. 00
6.00	0. 00		0	(0) ()	6. 00
7. 00	0.00		0	(0) ()	7. 00
8. 00	0.00		0	[C	0	١)	8. 00
9. 00	0. 00		0) c	0	9)	9. 00
10. 00	0.00		0	[C	0		1	10.00
200.00			0	() C) ()	200.00

Heal th	Financial Systems	FRANCI SCAN HEAL	TH RENSSELAER		In Lie	eu of Form CMS-2	2552-10
	ABLE COST DETERMINATION FOR THERAPY SERVICES	FURNI SHED BY	Provi der CC		Peri od: From 01/01/2016	Worksheet A-8 Parts I-VI	-3
001510	E SUPPLI ERS				To 12/31/2016	Date/Time Pre	
					Physical Therapy	8/8/2017 10:1 Cost	9 am
					rnysical merapy	Cost	
	DADT I OFNEDAL INFORMATION					1. 00	
1. 00	PART I - GENERAL INFORMATION Total number of weeks worked (excluding aide:	s) (see instruc	tions)			52	1.00
2. 00	Line 1 multiplied by 15 hours per week	3) (See Thisti de	. (1 0113)			780	
3.00	Number of unduplicated days in which supervi					0	
4. 00	Number of unduplicated days in which therapy nor therapist was on provider site (see inst		on provider si	te but neithe	r supervisor	0	4. 00
5.00	Number of unduplicated offsite visits - supe	rvisors or ther	apists (see in	structions)		0	5. 00
6.00	Number of unduplicated offsite visits - there					0	6. 00
	assistant and on which supervisor and/or the instructions)	rapist was not	present during	the visit(s)) (see		
7.00	Standard travel expense rate					5. 51	7. 00
8.00	Optional travel expense rate per mile					0.00	8. 00
		Supervi sors 1.00	Therapists 2.00	Assistants 3.00	Ai des 4. 00	Trai nees 5.00	
9. 00	Total hours worked	0. 00	897. 00	0.0	0.00	0.00	
10.00	AHSEA (see instructions)	0.00				0.00	
11. 00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3,	39. 99	39. 99	0.0	U		11. 00
	one-half of column 3, line 10)						
12. 00	Number of travel hours (provider site)	0	0		0		12. 00 12. 01
12. 01 13. 00	Number of travel hours (offsite) Number of miles driven (provider site)	0	0		0		13. 00
13. 01	Number of miles driven (offsite)	0	0		0		13. 01
						1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION					1.00	
14.00	Supervisors (column 1, line 9 times column 1,	, line 10)				0	14. 00
15.00	Therapists (column 2, line 9 times column 2,					71, 742	1
16. 00 17. 00	Assistants (column 3, line 9 times column 3, Subtotal allowance amount (sum of lines 14 a		ratory therapy	or lines 14-	16 for all	0 71, 742	
17.00	others)	na ro roi respi	ratory therapy	01 111103 11	10 101 411	, , , , , , ,	17.00
18. 00	Aides (column 4, line 9 times column 4, line	,				0	18. 00 19. 00
19. 00 20. 00	Trainees (column 5, line 9 times column 5, li Total allowance amount (sum of lines 17-19 fo		therapy or lin	es 17 and 18	for all others)	_	1
	If the sum of columns 1 and 2 for respiratory	therapy or co	lumns 1-3 for	physical ther	apy, speech path	hology or	
	occupational therapy, line 9, is greater than the amount from line 20. Otherwise complete		no entries on	lines 21 and	22 and enter on	line 23	
21. 00	Weighted average rate excluding aides and tra		divided by su	m of columns	1 and 2, line 9	0.00	21. 00
	for respiratory therapy or columns 1 thru 3,					_	
22. 00	Weighted allowance excluding aides and train Total salary equivalency (see instructions)		es line 21)			0 71 742	22. 00
23.00	PART III - STANDARD AND OPTIONAL TRAVEL ALLOW		L EXPENSE COMP	UTATION - PRO	VIDER SITE	/1,742	23.00
0.4.00	Standard Travel Allowance					1	
24. 00 25. 00	Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11)					0	24. 00 25. 00
26. 00	Subtotal (line 24 for respiratory therapy or	sum of lines 2	4 and 25 for a	II others)		Ö	1
27. 00	Standard travel expense (line 7 times line 3	for respirator	y therapy or s	um of lines 3	and 4 for all	0	27. 00
28. 00	others) Total standard travel allowance and standard	travel expense	at the provid	er site (sum	of lines 26 and	0	28. 00
	27)	·]
29. 00	Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of the su		d 2 line 12)			T 0	20.00
30.00	Assistants (column 3, line 10 times the sum 3		iu z, Title 12)			0	
31.00	Subtotal (line 29 for respiratory therapy or	sum of lines 2		,		0	1
32. 00	Optional travel expense (line 8 times columns columns 1-3, line 13 for all others)	s 1 and 2, line	13 for respir	atory therapy	or sum of	0	32. 00
33. 00	Standard travel allowance and standard travel	l expense (line	28)			0	33. 00
34.00	Optional travel allowance and standard trave	l expense (sum	of lines 27 an			0	34. 00
35. 00	Optional travel allowance and optional travel				ICES OUTSIDE DO	OWIDED SITE	35. 00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWA Standard Travel Expense	ANCE AND TRAVEL	EXPENSE COMPU	IAIIUN - SERV	I CES UUTSTDE PRO	UNIDER SITE	1
36. 00	Therapists (line 5 times column 2, line 11)					0	
37.00	Assistants (line 6 times column 3, line 11)					0	1
38. 00 39. 00	Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the sum	m of lines 5 an	d 6)			0 0	
	Optional Travel Allowance and Optional Travel		,				1

EASONABLE COST DETERMINATI JTSIDE SUPPLIERS	ON FOR THERAPY SERVICES F	FURNI SHED BY	Provider CC	N: 15-1324	Period: From 01/01/2016 To 12/31/2016		pared:	
					Physical Therapy	Cost		
						1. 00		
6.00 Optional travel allo	wance and optional travel		f lines 42 and	d 43 – see in	structions)		46. 0	
		Therapi sts	Assistants	Ai des	Trai nees	Total		
PART V - OVERTIME COI	MPHTATI ON	1.00	2. 00	3. 00	4. 00	5. 00		
7.00 Overtime hours worke period (if column 5, equal to or greater	d during reporting line 47, is zero or	0. 00	0.00	0. 0	0.00	0.00	47. 0	
3.00 Overtime rate (see i 7.00 Total overtime (incl allowance) (multiply	nstructions) uding base and overtime line 47 times line 48)	0. 00 0. 00	0. 00 0. 00	0. C 0. C			48. 0 49. 0	
O. 00 CALCULATION OF LIMIT Percentage of overti (divide the hours in by the total overtim line 47)	each column on line 47	0. 00	0.00	0.0	0.00	0.00	50.0	
1.00 Allocation of provid for one full-time em	50) (see instructions)	0. 00	0.00	0.0	0.00	0.00	51. (
	ry equi val ency amount	79. 98	0.00	0.0	0.00		52.0	
	tion (line 51 times line	0	0		0 0		53.	
	t (enter the Lesser of	0	0		0 0		54.	
5.00 Portion of overtime	t the AHSEA (multiply	0	О		0 0		55. (
5.00 Overtime allowance (if negative enter ze the sum of columns 1	líne 54 minus line 55 - ro) (Enter in column 5	0	0		0 0	0	56.	
D. J. M. GOMBUTATION		ND EVAFOR ASST	D. WOTHERT			1. 00		
Part VI - COMPUTATION 7.00 Salary equivalency a	N OF THERAPY LIMITATION A	ND EXCESS COST A	ADJUSTMENT			71, 742	57.	
Travel allowance and Travel allowance and D.00 Travel allowance and Overtime allowance (Equipment cost (see Supplies (see instrumum 1.00 Total allowance (sumum 1.00 Total cost of outside D.00 Total cost of outs	expense - provider site expense - Offsite servic from column 5, line 56) instructions) ctions)	es (from lines	44, 45, or 46))		0 0 0 0 0 71, 742 49, 636	58. 59. 60. 61. 62. 63.	
00.01 Line 27 = line 7 tim	0.00 Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others 0.01 Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others 0.02 Line 33 = line 28 = sum of lines 26 and 27							
01.00 Line 27 = line 7 tim 01.01 Line 31 = line 29 fo 01.02 Line 34 = sum of lin LINE 35 CALCULATION	r respiratory therapy or es 27 and 31	sum of lines 29	and 30 for al	I others	others	0	101. (101. (101. (
02.00 Line 31 = line 29 fo 02.01 Line 32 = line 8 tim					mns 1-3, line		102. 102.	
13 for all others		•				i	1	

COST ALLOCATION - GENERAL SERVICE COSTS				CN: 15-1324 P	eri od:	Worksheet B	
					rom 01/01/2016	Part I	
				1	o 12/31/2016	Date/Time Pre 8/8/2017 10:1	oarea:
			CAPI TAL			0/0/2017 10. 1	7 alli
			RELATED COSTS				
	Cost Center Description	Net Expenses	NEW BLDG &	EMPLOYEE	Subtotal	ADMI NI STRATI VE	
	cost center bescription	for Cost	FIXT	BENEFITS	Subtotal	& GENERAL	
			FIAI			& GENERAL	
		Allocation		DEPARTMENT			
		(from Wkst A					
		col . 7)	1 00	4.00	4.0	F 00	
	CENEDAL CEDALCE COCT CENTEDO	0	1.00	4. 00	4A	5. 00	
1 00	GENERAL SERVI CE COST CENTERS	4 (22 252	4 (22 252	1	1		1 00
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT	4, 633, 353					1. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	4, 881, 776	l	4, 881, 776			4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	13, 209, 101	489, 826			14, 185, 309	5. 00
7.00	00700 OPERATION OF PLANT	1, 337, 994	81, 558	94, 814	1, 514, 366	700, 146	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	96, 357	70, 674	24, 584	191, 615	88, 591	8. 00
9.00	00900 HOUSEKEEPI NG	525, 618	83, 656	159, 075	768, 349	355, 235	9. 00
10.00	01000 DI ETARY	241, 087	78, 454	62, 989	382, 530	176, 857	10.00
11.00	01100 CAFETERI A	261, 154	87, 720	70, 433	419, 307	193, 861	11.00
13.00	01300 NURSING ADMINISTRATION	346, 050	17, 614	67, 124	430, 788	199, 169	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	84, 011	0	10, 249		43, 580	14. 00
15.00	01500 PHARMACY	2, 785, 952	44, 057			1, 374, 427	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	168, 936				105, 840	16. 00
17. 00	01700 SOCI AL SERVI CE	0	l .	0		0	17. 00
17.00	INPATIENT ROUTINE SERVICE COST CENTERS				<u> </u>	0	17.00
20.00	03000 ADULTS & PEDIATRICS	963, 268	446, 075	345, 753	1 755 00/	011 444	30. 00
30.00						811, 444	
31. 00	03100 NTENSI VE CARE UNI T	645, 318	33, 043	233, 775	912, 136	421, 713	31. 00
F0 00	ANCILLARY SERVICE COST CENTERS	F0/ F70	F04 000	4/0 504	4 0/0 400	F00 700	F0 00
50.00	05000 OPERATING ROOM	596, 579	l			582, 729	50. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	1, 628, 471	420, 638			1, 082, 428	54.00
60.00	06000 LABORATORY	2, 124, 236	l			1, 031, 902	60. 00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	63, 688	8, 741	0	72, 429	33, 487	63. 00
65.00	06500 RESPI RATORY THERAPY	776, 386	141, 524	256, 174	1, 174, 084	542, 821	65. 00
66.00	06600 PHYSI CAL THERAPY	493, 869	105, 291	163, 730	762, 890	352, 712	66.00
66. 01	06601 WHEATFI ELD PT	384, 580	400, 401	138, 587	923, 568	426, 999	66. 01
67.00	06700 OCCUPATI ONAL THERAPY	209, 901	43, 489	76, 630	330, 020	152, 580	67.00
67. 01	06701 WHEATFI ELD OT	85, 613	86, 103	29, 801	201, 517	93, 169	67. 01
68. 00	06800 SPEECH PATHOLOGY	121, 913	l			88, 466	68. 00
68. 01	06801 WHEATFI ELD ST	54, 655				60, 035	68. 01
70. 00	07000 ELECTROENCEPHALOGRAPHY	0.7555	00,000	0		0	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	743, 447	49, 083			366, 415	71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENT	107, 507	7, 124			52, 998	72. 00
	07300 DRUGS CHARGED TO PATIENTS	107, 307	l		.,	0	73. 00
73.00	OUTPATIENT SERVICE COST CENTERS			1	ı o	0	73.00
00 00	08800 RURAL HEALTH CLINIC	220 1/0	_	07.004	427.254	107 525	00 00
88. 00	· ·	330, 160	ł	97, 094		197, 535	88. 00
88. 03	08801 RURAL HEALTH CLINIC IV	386, 901	115, 824			284, 154	88. 03
90.00	09000 CLI NI C	1, 180, 251	196, 114			823, 293	90.00
91. 00	09100 EMERGENCY	1, 884, 115	195, 109	348, 396		1, 122, 376	91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)				0		92. 00
	OTHER REIMBURSABLE COST CENTERS						
101.00	10100 HOME HEALTH AGENCY	1, 403, 425	134, 880	432, 742	1, 971, 047	911, 286	101. 00
	SPECIAL PURPOSE COST CENTERS						
	11600 H0SPI CE	544, 835	10, 883	118, 488	674, 206	311, 710	116. 00
118.00	SUBTOTALS (SUM OF LINES 1-117)	43, 300, 507	4, 097, 547	4, 394, 438	42, 277, 363	12, 987, 958	118.00
	NONREI MBURSABLE COST CENTERS						
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	10, 053	0	10, 053	4, 648	190. 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	0	l	Ö			192. 00
	1 19201 RENSSELAER HEALTH CENTER	0		0			192. 01
	19300 NONPALD WORKERS	0	1				193. 00
	07950 ALTERNACARE	583, 830	1	205, 273	1, 154, 582	533, 805	
	07951 DME EQUIPMENT	303, 030	303,477	203, 273	1, 134, 302	·	194. 00
		422 (45	121 502	02 272	(27 511		
	2 07952 WHEATFIELD FITNESS	422, 645				294, 744	
	3 07957 JOHNSON FITNESS	555, 445		188, 792		344, 088	
	107953 FOUNDATION	4, 670	l	0	.,		194. 04
	07954 MEALS ON WHEELS	0		0			194. 05
	07955 WATER LAB	0		0		11, 195	
	7 07956 ADVERTI SI NG	50	14, 467	0	14, 517	6, 712	194. 07
200.00	Cross Foot Adjustments				0		200. 00
201.00	Negative Cost Centers		0	0	0	0	201. 00
202.00	TOTAL (sum lines 118-201)	44, 867, 147	4, 633, 353	4, 881, 776	44, 867, 147	14, 185, 309	202. 00
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Provider CCN: 15-1324

			10	12/31/2016	8/8/2017 10:1	
Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	, dill
· ·	PLANT	LINEN SERVICE				
	7. 00	8. 00	9. 00	10.00	11. 00	
GENERAL SERVICE COST CENTERS						
1.00 00100 NEW CAP REL COSTS-BLDG & FLXT						1.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 00 00500 ADMI NI STRATI VE & GENERAL	0.044.540					5. 00
7. 00 00700 OPERATION OF PLANT	2, 214, 512	040 704				7. 00
8. 00 00800 LAUNDRY & LINEN SERVICE	38, 530					8.00
9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY	45, 607	22, 344 3, 582		(00 127		9. 00 10. 00
	42, 772	3, 382		609, 137	441 E02	
11. 00 01100 CAFETERI A 13. 00 01300 NURSI NG ADMI NI STRATI ON	47, 824	0	591 0	0	661, 583	
14. 00 01400 CENTRAL SERVICES & SUPPLY	9, 603	0	0	0	13, 062 3, 649	1
15. 00 01500 PHARMACY	24, 019	0	17, 202	0	25, 212	1
16. 00 01600 MEDI CAL RECORDS & LI BRARY	32, 526	0	17, 202	0	25, 212	16.00
17. 00 01700 SOCIAL SERVICE	32, 320	0	0	0	0	17. 00
I NPATIENT ROUTINE SERVICE COST CENTERS	0	0		<u> </u>		17.00
30. 00 03000 ADULTS & PEDIATRICS	243, 192	185, 194	345, 818	181, 873	77, 409	30.00
31. 00 03100 NTENSI VE CARE UNI T	18, 014	1, 354	31, 894	20, 785	40, 961	1
ANCI LLARY SERVICE COST CENTERS	10,011	1,001	01,071	20, 700	10, 701	01.00
50. 00 05000 OPERATING ROOM	273, 311	16, 161	0	0	41, 791	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	229, 324	4, 182	137, 914	o	65, 137	1
60. 00 06000 LABORATORY	58, 713	0	50, 056	o	0	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	4, 766	0	0	O	0	63.00
65. 00 06500 RESPIRATORY THERAPY	77, 156	8, 757	28, 203	O	63, 574	
66. 00 06600 PHYSI CAL THERAPY	57, 403	21, 327	55, 786	o	52, 105	66. 00
66. 01 06601 WHEATFI ELD PT	218, 292	0	0	o	27, 246	
67. 00 06700 OCCUPATI ONAL THERAPY	23, 709	0	23, 035	О	14, 668	67. 00
67. 01 06701 WHEATFI ELD OT	46, 942	0	0	0	3, 585	67. 01
68.00 06800 SPEECH PATHOLOGY	13, 701	0	13, 319	0	6, 414	68. 00
68. 01 06801 WHEATFI ELD ST	30, 453	0	0	0	3, 289	68. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	26, 759	0	0	0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	3, 884	0	0	0	0	72. 00
73.00 O7300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73. 00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	0	0	0	0	88. 00
88.03 08801 RURAL HEALTH CLINIC IV	63, 145	0	0	0	0	88. 03
90. 00 09000 CLI NI C	106, 918	4, 047		7, 764	82, 324	1
91. 00 09100 EMERGENCY	106, 370	7, 154	102, 328	0	72, 312	1
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS	70.504		00.400	اه		
101. 00 10100 HOME HEALTH AGENCY	73, 534	0	92, 139	0	0	101. 00
SPECIAL PURPOSE COST CENTERS	5. 933	0		ما	0	11/ 00
116. 00 11600 HOSPI CE			1 022 279	0 210, 422		116.00
118. 00 SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS	1, 922, 400	274, 102	1, 023, 278	210, 422	592, 802	1118.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	5, 481		295	0	^	190. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0,401	0	1	0		192.00
192. 01 19201 RENSSELAER HEALTH CENTER	0	0	0	0		192. 00
193. 00 19300 NONPALD WORKERS	0	0	0	0		193. 00
194. 00 07950 ALTERNACARE	199, 253	44, 634	155, 928	318, 813		194. 00
194. 01 07951 DME EQUI PMENT	177, 233	1 44, 034	133, 720	310, 013		194. 01
194. 02 07952 WHEATFI ELD FITNESS	66, 290	0	o o	Ö		194. 02
194. 03 07957 JOHNSON FITNESS	00,270	l n		ol O		194. 03
194. 04 07953 FOUNDATION	0	0	0	ő		194. 04
194. 05 07954 MEALS ON WHEELS	0	0	o o	79, 902		194. 05
194. 06 07955 WATER LAB	13, 201	Ö	12, 034	0		194. 06
194. 07 07956 ADVERTI SI NG	7, 887	Ō	0	ol		194. 07
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	0	0	0	o	0	201. 00
202.00 TOTAL (sum lines 118-201)	2, 214, 512	318, 736	1, 191, 535	609, 137	661, 583	202. 00
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Provider CCN: 15-1324

			10	12/31/2010	8/8/2017 10:1	
Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCI AL SERVI CE	
	ADMI NI STRATI ON	SERVICES &		RECORDS &		
		SUPPLY		LI BRARY		
OFFICE ALL OFFICE OF CONT. OFFITEED	13. 00	14. 00	15. 00	16. 00	17. 00	
GENERAL SERVI CE COST CENTERS						1 00
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						1. 00 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 NURSING ADMINISTRATION	652, 622					13. 00
14.00 01400 CENTRAL SERVICES & SUPPLY	0	141, 489				14. 00
15. 00 01500 PHARMACY	0	O	4, 413, 673			15. 00
16.00 01600 MEDICAL RECORDS & LIBRARY	0	0	0	367, 355		16. 00
17. 00 01700 SOCIAL SERVICE	0	0	0	0	0	17. 00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	132, 968	0	0	96, 278	l	
31. 00 03100 INTENSIVE CARE UNIT	70, 359	0	0	14, 769	0	31.00
ANCILLARY SERVICE COST CENTERS	71 705	ما	0	27 024		F0 00
50. 00 05000 0PERATING ROOM 54. 00 05400 RADIOLOGY-DIAGNOSTIC	71, 785 111, 887	0	0	36, 934 48, 110	l e	
60. 00 06000 LABORATORY	111, 887	0	0	9, 362	0	
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.		0	0	7, 302 0	0	
65. 00 06500 RESPIRATORY THERAPY	0	0	0	0	0	
66. 00 06600 PHYSI CAL THERAPY	0	0	0	0	l ő	
66. 01 06601 WHEATFI ELD PT	0	o	0	0	Ö	
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	0	0	0	1
67. 01 06701 WHEATFIELD OT	0	0	0	0	0	67. 01
68.00 06800 SPEECH PATHOLOGY	0	0	0	0	0	68. 00
68. 01 06801 WHEATFI ELD ST	0	0	0	0	0	68. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	141, 489	0	0	0	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	
73. 00 O7300 DRUGS CHARGED TO PATIENTS	0	0	4, 413, 673	0	0	73. 00
OUTPATIENT SERVICE COST CENTERS		ام				00.00
88. 00 08800 RURAL HEALTH CLINIC 88. 03 08801 RURAL HEALTH CLINIC IV	0	U	0	0	0	1
88. 03 08801 RURAL HEALTH CLINIC IV 90. 00 09000 CLINIC	141, 412	0	0	113, 939		
91. 00 09100 EMERGENCY	124, 211	0	0	47, 963	0	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	124, 211	ĭ	J	47, 703		92.00
OTHER REIMBURSABLE COST CENTERS						72.00
101.00 10100 HOME HEALTH AGENCY	0	0	0	0	0	101. 00
SPECIAL PURPOSE COST CENTERS						
116. 00 11600 HOSPI CE	0	0	0	0		116. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	652, 622	141, 489	4, 413, 673	367, 355	0	118. 00
NONREI MBURSABLE COST CENTERS						
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190. 00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	0	0	0	0		192.00
192. 01 19201 RENSSELAER HEALTH CENTER	0	0	0	0		192. 01
193. 00 19300 NONPALD WORKERS 194. 00 07950 ALTERNACARE	0	U	0	0		193. 00 194. 00
194. 01 07951 DME EQUI PMENT		0	0	0		194. 00
194. 02 07952 WHEATFI ELD FI TNESS	0	0	0	0		194. 02
194. 03 07957 JOHNSON FITNESS	0	0	0	0		194. 03
194. 04 07953 FOUNDATION	0	ő	0	0	l .	194. 04
194. 05 07954 MEALS ON WHEELS	0	ol	0	0		194. 05
194. 06 07955 WATER LAB		o	o	0		194. 06
194. 07 07956 ADVERTI SI NG	o	o	0	0		194. 07
200.00 Cross Foot Adjustments		ļ				200. 00
201.00 Negative Cost Centers	0	0	0	0		201. 00
202.00 TOTAL (sum lines 118-201)	652, 622	141, 489	4, 413, 673	367, 355	0	202. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-1324

					From 01/01/2016 To 12/31/2016	Date/Time Prepared:
	Cost Center Description	Subtotal	Intern &	Total		8/8/2017 10:19 am
		R	Residents Cost & Post			
			Stepdown			
		04.00	Adjustments	0/ 00	_	
	GENERAL SERVICE COST CENTERS	24. 00	25. 00	26. 00		
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT					1. 00
	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL					4. 00 5. 00
	00700 OPERATION OF PLANT					7. 00
	00800 LAUNDRY & LINEN SERVICE					8. 00
	00900 HOUSEKEEPI NG 01000 DI ETARY					9.00
	01100 CAFETERI A					11. 00
	01300 NURSING ADMINISTRATION					13. 00
	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY					14. 00 15. 00
	01600 MEDICAL RECORDS & LIBRARY					16. 00
17. 00	01700 SOCI AL SERVI CE					17. 00
30. 00	O3000 ADULTS & PEDIATRICS	3, 829, 272	0	3, 829, 27	2	30.00
31. 00	03100 INTENSIVE CARE UNIT	1, 531, 985	Ö	1, 531, 98		31. 00
	ANCI LLARY SERVI CE COST CENTERS 05000 OPERATI NG ROOM	2 202 112	ol	2 202 11	2	F0.00
	05400 RADI OLOGY-DI AGNOSTI C	2, 283, 113 4, 020, 196	0	2, 283, 11: 4, 020, 19		50. 00 54. 00
60.00	06000 LABORATORY	3, 381, 963	0	3, 381, 96		60.00
	06300 BLOOD STORING, PROCESSING & TRANS. 06500 RESPIRATORY THERAPY	110, 682 1, 894, 595	0	110, 68: 1, 894, 59!		63. 00 65. 00
	06600 PHYSI CAL THERAPY	1, 302, 223	o	1, 302, 22		66.00
	06601 WHEATFIELD PT	1, 596, 105	o	1, 596, 10		66. 01
	06700 OCCUPATIONAL THERAPY 06701 WHEATFIELD OT	544, 012 345, 213	0	544, 01: 345, 21:		67. 00 67. 01
	06800 SPEECH PATHOLOGY	313, 245	o	313, 24		68. 00
	06801 WHEATFIELD ST	223, 628	0	223, 62		68. 01
	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 327, 193	0	1, 327, 19) 3	70. 00 71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENT	171, 513	0	171, 51	3	72. 00
	07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS	4, 413, 673	0	4, 413, 67	3	73. 00
	08800 RURAL HEALTH CLINIC	624, 789	0	624, 78	9	88. 00
	08801 RURAL HEALTH CLINIC IV	961, 905	O	961, 90		88. 03
	09000 CLI NI C 09100 EMERGENCY	3, 182, 019 4, 010, 334	0	3, 182, 01 ⁹ 4, 010, 33 ⁹		90.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	4,010,334	o	4, 010, 33	1	92. 00
	OTHER REIMBURSABLE COST CENTERS	2 040 00/	0	2 242 22	,	101 00
101.00	10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	3, 048, 006	0	3, 048, 00	5	101. 00
	11600 H0SPI CE	991, 849	0	991, 84		116. 00
118. 00		40, 107, 513	0	40, 107, 51	3	118. 00
	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	20, 477	0	20, 47	7	190. 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	0	o		o O	192. 00
	19201 RENSSELAER HEALTH CENTER 19300 NONPALD WORKERS	0	0	() 1	192. 01 193. 00
	07950 ALTERNACARE	2, 475, 765	o	2, 475, 76	5	194. 00
	07951 DME EQUI PMENT	0	0	000 54	0	194. 01
	07952 WHEATFIELD FITNESS 07957 JOHNSON FITNESS	998, 545 1, 088, 325	0	998, 54! 1, 088, 32!		194. 02 194. 03
194. 04	07953 FOUNDATI ON	6, 829	Ö	6, 82	9	194. 04
	07954 MEALS ON WHEELS 07955 WATER LAB	79, 902	O	79, 90:		194. 05 194. 06
	07956 ADVERTI SI NG	60, 644 29, 147	0	60, 64 29, 14		194. 06
200.00	Cross Foot Adjustments	0	ō	(O	200. 00
201. 00 202. 00		0 44, 867, 147	0	44, 867, 14 ⁻) 7	201. 00 202. 00
202.00	1017L (3011 111103 110-201)	1 77,007,147	Ч	77,007,14	' I	1202.00

ALLOCA	ATION C	OF CAPITAL RELATED COSTS		Provi der CC		Period: From 01/01/2016 To 12/31/2016		
		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	Subtotal	EMPLOYEE BENEFI TS DEPARTMENT	ADMI NI STRATI VE & GENERAL	
			0	1. 00	2A	4. 00	5. 00	
1 00		AL SERVICE COST CENTERS						1 00
1. 00 4. 00		NEW CAP REL COSTS-BLDG & FIXT EMPLOYEE BENEFITS DEPARTMENT	0	0		0 0		1. 00 4. 00
5. 00		ADMINISTRATIVE & GENERAL	0	489, 826	489, 82		489, 826	5. 00
7. 00	1	OPERATION OF PLANT		81, 558	81, 55		24, 177	7. 00
8.00		LAUNDRY & LINEN SERVICE	0	70, 674	70, 67		3, 059	8. 00
9.00	00900	HOUSEKEEPI NG	0	83, 656	83, 65	6 0	12, 267	9. 00
10. 00	1	DI ETARY	0	78, 454	78, 45		6, 107	10. 00
11. 00		CAFETERI A	0	87, 720	87, 72		6, 694	11. 00
13.00		NURSING ADMINISTRATION	0	17, 614	17, 61		6, 878	13.00
14. 00 15. 00		CENTRAL SERVICES & SUPPLY PHARMACY	0	0 44, 057	44, 05	0 7 0	1, 505 47, 450	14. 00 15. 00
16. 00	4	MEDICAL RECORDS & LIBRARY	0	59, 660	59, 66		3, 655	16. 00
17. 00		SOCIAL SERVICE		0 7, 000		o o	l	17. 00
		IENT ROUTINE SERVICE COST CENTERS	-1	-,		-, -		
30.00		ADULTS & PEDI ATRI CS	0	446, 075	446, 07		28, 020	30. 00
31. 00		INTENSIVE CARE UNIT	0	33, 043	33, 04	3 0	14, 562	31. 00
		LARY SERVICE COST CENTERS		= 0.0 ooo	504.00	al .	00.400	
50. 00 54. 00		OPERATING ROOM RADIOLOGY-DIAGNOSTIC	0	501, 322	501, 32 420, 63		20, 122 37, 377	50.00
60.00		LABORATORY	0	420, 638 107, 694	420, 63 107, 69		35, 633	54. 00 60. 00
63. 00		BLOOD STORING, PROCESSING & TRANS.	0	8, 741	8, 74		1, 156	63. 00
65. 00		RESPI RATORY THERAPY	l o	141, 524	141, 52		18, 744	65. 00
66. 00	06600	PHYSI CAL THERAPY	O	105, 291	105, 29		12, 180	66. 00
66. 01		WHEATFIELD PT	0	400, 401	400, 40		14, 745	66. 01
67. 00		OCCUPATI ONAL THERAPY	0	43, 489	43, 48		5, 269	67. 00
67. 01		WHEATFI ELD OT	0	86, 103	86, 10		3, 217	67. 01
68. 00 68. 01		SPEECH PATHOLOGY WHEATFIELD ST	0	25, 132 55, 858	25, 13 55, 85		3, 055 2, 073	68. 00 68. 01
70. 00	1	ELECTROENCEPHALOGRAPHY	0	აა, იაი ი		0 0	2,0/3	70.00
71. 00	1	MEDICAL SUPPLIES CHARGED TO PATIENTS		49, 083	49, 08	-	12, 653	71.00
72. 00		IMPL. DEV. CHARGED TO PATIENT	0	7, 124	7, 12		1, 830	72.00
73.00		DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73. 00
		TIENT SERVICE COST CENTERS						
88. 00		RURAL HEALTH CLINIC	0	0		0 0	6, 821	88. 00
88. 03		RURAL HEALTH CLINIC IV	0	115, 824	115, 82		9, 812	88. 03
90. 00 91. 00		CLINIC EMERGENCY	0	196, 114 195, 109	196, 11 195, 10		28, 429 38, 757	90. 00 91. 00
92. 00		OBSERVATION BEDS (NON-DISTINCT PART)		175, 107		0	30,737	92.00
,2.00		REIMBURSABLE COST CENTERS	<u> </u>			<u> </u>		72.00
101.00		HOME HEALTH AGENCY	0	134, 880	134, 88	0 0	31, 468	101. 00
		AL PURPOSE COST CENTERS						
		HOSPI CE	0	10, 883	10, 88		10, 764	
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	4, 097, 547	4, 097, 54	7 0	448, 479	118. 00
100 00		IMBURSABLE COST CENTERS GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	10, 053	10, 05	3 0	160	190. 00
		PHYSICIANS' PRIVATE OFFICES	0	10, 033		0 0	l e	190.00
		RENSSELAER HEALTH CENTER		Ö		o o		192. 01
	4	NONPALD WORKERS	O	0		0 0	0	193. 00
		ALTERNACARE	0	365, 479	365, 47	9 0	18, 433	
		DME EQUIPMENT	0	0	_	0	l e	194. 01
		WHEATFIELD FITNESS	0	121, 593	121, 59	3 0	10, 178	
		JOHNSON FITNESS FOUNDATION		0			11, 882	194. 03 194. 04
		MEALS ON WHEELS		O O				194. 04
		WATER LAB		24, 214	24, 21	4 0	l	194. 06
		ADVERTI SI NG		14, 467	14, 46			194. 07
200.00		Cross Foot Adjustments				О		200. 00
201.00		Negative Cost Centers		. 0	_	0		201. 00
202.00	ון	TOTAL (sum lines 118-201)	0	4, 633, 353	4, 633, 35	3 0	489, 826	202.00

| Period: | Worksheet B | From 01/01/2016 | Part II | To | 12/31/2016 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-1324

				To	12/31/2016	Date/Time Pre	
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	8/8/2017 10: 1 CAFETERI A	9 am
	oost denter bescription	PLANT	LINEN SERVICE		DIEIAKI	ONIETEKTA	
		7. 00	8. 00	9. 00	10. 00	11. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
4. 00 5. 00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL						4. 00 5. 00
7.00	00700 OPERATION OF PLANT	105, 735					7.00
8. 00	00800 LAUNDRY & LINEN SERVICE	1, 840					8.00
9. 00	00900 HOUSEKEEPI NG	2, 178					9. 00
10.00	01000 DI ETARY	2, 042	849		87, 747		10.00
11.00	01100 CAFETERI A	2, 283	0	51	0	96, 748	11. 00
13.00	01300 NURSING ADMINISTRATION	459	0	0	0	1, 910	
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	0		0	534	1
15.00	01500 PHARMACY	1, 147	0	,	0	3, 687	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	1, 553	0	- 1	0	9	16.00
17. 00	INPATIENT ROUTINE SERVICE COST CENTERS		0	l o	U _I	U	17. 00
30. 00	03000 ADULTS & PEDI ATRI CS	11, 612	43, 910	30, 008	26, 199	11, 320	30.00
31. 00	03100 INTENSIVE CARE UNIT	860			2, 994	5, 990	1
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	13, 048	3, 832		0	6, 111	50. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	10, 949			0	9, 525	1
60.00	06000 LABORATORY	2, 803 228	0		0	0	60. 00 63. 00
63. 00 65. 00	06300 BLOOD STORING, PROCESSING & TRANS. 06500 RESPIRATORY THERAPY	3, 684	2, 076	-	0	9, 297	65.00
66. 00	06600 PHYSI CAL THERAPY	2, 741	5, 057		0	7, 620	•
66. 01	06601 WHEATFIELD PT	10, 423	0,007		o	3, 984	1
67. 00	06700 OCCUPATI ONAL THERAPY	1, 132	Ō		o	2, 145	1
67. 01	06701 WHEATFIELD OT	2, 241	0	0	0	524	67. 01
68. 00	06800 SPEECH PATHOLOGY	654	0	1, 156	0	938	ł
68. 01	06801 WHEATFI ELD ST	1, 454	0	0	0	481	68. 01
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	1, 278		0	0	0	71.00
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENT 07300 DRUGS CHARGED TO PATIENTS	185 0			0	0	72. 00 73. 00
73.00	OUTPATIENT SERVICE COST CENTERS			١	<u> </u>		73.00
88. 00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88. 00
88. 03	08801 RURAL HEALTH CLINIC IV	3, 015	0	0	0	0	88. 03
90.00	09000 CLI NI C	5, 105	959	10, 552	1, 118	12, 039	90. 00
91. 00	09100 EMERGENCY	5, 079	1, 696	8, 880	0	10, 575	
92. 00	09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)						92. 00
101 00	OTHER REIMBURSABLE COST CENTERS 10100 HOME HEALTH AGENCY	3, 511	0	7, 996	ol	0	101. 00
101.00	SPECIAL PURPOSE COST CENTERS	3,511	0	7, 770	υį	0	101.00
116.00	11600 HOSPI CE	283	0	0	0	0	116. 00
118.00	SUBTOTALS (SUM OF LINES 1-117)	91, 787	64, 990	88, 798	30, 311	86, 689	118. 00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	262	0		0		190. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	0		192. 00
	19201 RENSSELAER HEALTH CENTER 19300 NONPAI D WORKERS	0	0	0	0		192. 01 193. 00
	07950 ALTERNACARE	9, 514	10, 583	- 1	45, 926		194. 00
	07951 DME EQUI PMENT	0	0	0	0		194. 01
	07952 WHEATFIELD FITNESS	3, 165	0	0	0		194. 02
	07957 JOHNSON FITNESS	0	0	0	0		194. 03
	07953 FOUNDATI ON	0	0	-	0		194. 04
	07954 MEALS ON WHEELS	0	0	١	11, 510		194. 05
	07955 WATER LAB	630	0	1, 044	0		194. 06
200.00	O7956 ADVERTISING Cross Foot Adjustments	377	0		٥	5	194. 07 200. 00
200.00		n	n	0	n	n	200.00
202.00		105, 735	75, 573	103, 399	87, 747		202.00
		•	•				•

| Period: | Worksheet B | From 01/01/2016 | Part II | To | 12/31/2016 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-1324

				To	12/31/2016		
	Cost Contor Description	MIDSING	CENTRAL	DHADMACV	MEDICAL	8/8/2017 10: 1 SOCIAL SERVICE	9 am
	Cost Center Description	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	SUCIAL SERVICE	
		13.00	14.00	15. 00	16. 00	17. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1. 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 01000 DI ETARY						9.00
10. 00 11. 00	01100 CAFETERI A						10. 00 11. 00
13. 00	01300 NURSING ADMINISTRATION	26, 861					13.00
14. 00	01400 CENTRAL SERVICES & SUPPLY	20,001	2, 039				14. 00
15. 00	01500 PHARMACY	o	2,007				15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	O	0	1	64, 877	•	16. 00
17.00	01700 SOCIAL SERVICE	0	0	0	0	0	17. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	5, 473	0		17, 003	0	30. 00
31. 00	03100 I NTENSI VE CARE UNI T	2, 896	0	0	2, 608	0	31. 00
	ANCILLARY SERVICE COST CENTERS	T					
50.00	05000 OPERATING ROOM	2, 955	0		6, 523	0	50.00
54. 00	05400 RADI OLOGY - DI AGNOSTI C	4, 605	0	·	8, 496		54.00
60.00	06000 LABORATORY	0	0	0	1, 653		60.00
63. 00 65. 00	06300 BLOOD STORING, PROCESSING & TRANS. 06500 RESPIRATORY THERAPY		0	0	0	0	63. 00 65. 00
66. 00	06600 PHYSI CAL THERAPY		0	0	0	0	66.00
66. 01	06601 WHEATFIELD PT		0	Ö	0	0	66. 01
67. 00	06700 OCCUPATI ONAL THERAPY		0	Ö	0	0	67. 00
67. 01	06701 WHEATFI ELD OT	o	0	0	0	0	67. 01
68. 00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68. 00
68. 01	06801 WHEATFI ELD ST	0	0	0	0	0	68. 01
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2, 039	1	0	0	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENT	0	0		0	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0	97, 834	0	0	73. 00
00 00	OUTPATIENT SERVICE COST CENTERS	O			0	0	00.00
88. 00 88. 03	08800 RURAL HEALTH CLINIC 08801 RURAL HEALTH CLINIC IV		0	0	0	0	88. 00 88. 03
90. 00	09000 CLINIC	5, 820	0	0	20, 124	0	90.00
91. 00	09100 EMERGENCY	5, 112	0	ĺ	8, 470	-	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0,2	· ·		0,	Ĭ	92. 00
	OTHER REIMBURSABLE COST CENTERS	'					
101.00	10100 HOME HEALTH AGENCY	0	0	0	0	0	101. 00
	SPECIAL PURPOSE COST CENTERS						
	11600 HOSPI CE	0	0		0	-	116. 00
118. 00	SUBTOTALS (SUM OF LINES 1-117) NONREIMBURSABLE COST CENTERS	26, 861	2, 039	97, 834	64, 877	0	118. 00
100 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	O	0	0	0		190. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES		0		0		190.00
	19201 RENSSELAER HEALTH CENTER	0	0		0		192. 01
	19300 NONPAI D WORKERS		0		0		193. 00
	07950 ALTERNACARE	o	0		0		194. 00
	07951 DME EQUI PMENT	0	0	0	0		194. 01
194. 02	07952 WHEATFIELD FITNESS	0	0	0	0		194. 02
194. 03	07957 JOHNSON FITNESS	0	0	0	0		194. 03
	07953 FOUNDATI ON	0	0	0	0		194. 04
	07954 MEALS ON WHEELS	0	0	0	0		194. 05
	07955 WATER LAB	0	0	· -	0		194. 06
	07956 ADVERTI SI NG	0	0	0	0	0	194. 07
200. 00 201. 00	1 1		^		0	_	200. 00 201. 00
201.00		26, 861	2, 039	97, 834	64, 877		201.00
202.00		20,001	2, 039	1 77,034	04, 077	ı	1202.00

Health Financial Systems FRANCISCAN HEALTH RENSSELAER In Lieu of Form CMS-2552-10 ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-1324 Peri od: Worksheet B From 01/01/2016 Part II Date/Time Prepared: 12/31/2016 8/8/2017 10:19 am Cost Center Description Subtotal Intern & Total Residents Cost & Post Stepdown Adjustments 24.00 25.00 26.00 GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 00700 OPERATION OF PLANT 7.00 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 00900 HOUSEKEEPI NG 9.00 9 00 10.00 01000 DI ETARY 10.00 11.00 01100 CAFETERI A 11.00 01300 NURSING ADMINISTRATION 13.00 13 00 01400 CENTRAL SERVICES & SUPPLY 14.00 14.00 15.00 01500 PHARMACY 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 16.00 01700 SOCIAL SERVICE 17.00 17 00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 619, 620 619, 620 30.00 03100 INTENSIVE CARE UNIT 0 66, 042 31 00 66,042 31 00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 553, 913 0 553, 913 50.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 504, 550 0 504, 550 54.00 06000 LABORATORY 152, 127 60 00 152, 127 0 60 00 06300 BLOOD STORING, PROCESSING & TRANS. 63.00 10, 125 0 10, 125 63.00 06500 RESPIRATORY THERAPY 177, 772 177, 772 65.00 66.00 06600 PHYSI CAL THERAPY 137, 730 0 137, 730 66.00 429, 553 06601 WHEATFIELD PT 0 429, 553 66.01 66.01 06700 OCCUPATIONAL THERAPY 67.00 54,034 0 54,034 67.00 92, 085 06701 WHEATFIELD OT 92, 085 67.01 67.01 06800 SPEECH PATHOLOGY 30, 935 0 30, 935 68.00 68.00 06801 WHEATFIELD ST 0 68.01 59,866 59, 866 68.01 70.00 07000 ELECTROENCEPHALOGRAPHY 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 65.053 71.00 65,053 71.00 07200 IMPL. DEV. CHARGED TO PATIENT 07300 DRUGS CHARGED TO PATIENTS 72.00 9, 139 0 9, 139 72.00 97,834 97, 834 73.00 0 73.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 6, 821 0 6, 821 88.00 08801 RURAL HEALTH CLINIC IV 88.03 128,651 0 128, 651 88.03 90.00 09000 CLI NI C 280, 260 0 280, 260 90.00 91.00 09100 EMERGENCY 273, 678 0 273, 678 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 177, 855 0 177, 855 101.00 SPECIAL PURPOSE COST CENTERS 116. 00 11600 HOSPI CE 21.930 0 21, 930 116,00 SUBTOTALS (SUM OF LINES 1-117) 118.00 3, 949, 573 0 3, 949, 573 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 192.00 19200 PHYSICIANS' PRIVATE OFFICES 10, 501 10, 501 190. 00 0 192.00 0 C 192. 01 19201 RENSSELAER HEALTH CENTER 0 0 0 192. 01 193. 00 19300 NONPALD WORKERS 0 193. 00 0 194. 00 07950 ALTERNACARE 0 194. 00 473.520 473, 520 194. 01 07951 DME EQUI PMENT 0 \cap 194.01 194. 02 07952 WHEATFIELD FITNESS 134, 936 0 134, 936 194. 02 194. 03 07957 JOHNSON FITNESS 11,882 11, 882 194.03 194. 04 07953 FOUNDATION 75 0 75 194. 04 194.05 07954 MEALS ON WHEELS 0 11,510 11, 510 194.05 194.06 07955 WATER LAB 26, 275 26, 275 194.06 194. 07 07956 ADVERTI SI NG 15,081 15,081 194.07 200 00 Cross Foot Adjustments 0 200 00 0 C

4, 633, 353

4, 633, 353

201.00

202.00

Negative Cost Centers

TOTAL (sum lines 118-201)

201.00

202.00

	Financial Systems	FRANCISCAN HEAL	IH KENSSELAEK		III LI E	u of Form CMS-2	2552-10
	ALLOCATION - STATISTICAL BASIS		Provi der C	F	eriod: rom 01/01/2016 o 12/31/2016	Worksheet B-1 Date/Time Pre 8/8/2017 10:1	pared:
	Cost Center Description	CAPITAL RELATED COSTS NEW BLDG & FIXT (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)		ADMINISTRATIVE & GENERAL (ACCUM. COST)	PLANT (SQUARE FEET)	
	OFNEDAL OFDILLOS COOT OFNEDO	1.00	4. 00	5A	5. 00	7. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT	106, 009					1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	13, 362, 343	1	00 (04 000		4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	11, 207	1, 331, 302				5. 00
7.00	00700 OPERATION OF PLANT	1, 866	259, 525	1	.,,	92, 936	
8.00	00800 LAUNDRY & LINEN SERVICE	1, 617	67, 292	1	191, 615	1, 617	
9.00	00900 HOUSEKEEPI NG	1, 914	435, 418	1	768, 349	1, 914	
10.00	01000 DI ETARY 01100 CAFETERI A	1, 795	172, 414	1	382, 530	1, 795	
11. 00 13. 00	01300 NURSING ADMINISTRATION	2, 007 403	192, 789 183, 731	1	419, 307 430, 788	2, 007 403	1
14. 00	01400 CENTRAL SERVICES & SUPPLY	403	28, 054	1		403	
15. 00	01500 PHARMACY	1, 008	390, 882			1, 008	
16.00	01600 MEDICAL RECORDS & LIBRARY	1, 365	900	•		1, 365	1
17. 00	01700 SOCIAL SERVICE	0	0	1		0	
17.00	I NPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>		,ı	<u>ا</u>		17.00
30. 00	03000 ADULTS & PEDIATRICS	10, 206	946, 393	8 0	1, 755, 096	10, 206	30.00
31.00	03100 INTENSIVE CARE UNIT	756	639, 887	•		756	1
	ANCILLARY SERVICE COST CENTERS			-			1
50.00	05000 OPERATING ROOM	11, 470	444, 795	0	1, 260, 402	11, 470	50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	9, 624	799, 547	0		9, 624	
60.00	06000 LABORATORY	2, 464	. 0	0		2, 464	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	200	O	0	72, 429	200	63.00
65.00	06500 RESPI RATORY THERAPY	3, 238	701, 197	0	1, 174, 084	3, 238	65. 00
66.00	06600 PHYSI CAL THERAPY	2, 409	448, 161	0	762, 890	2, 409	66.00
66.01	06601 WHEATFIELD PT	9, 161	379, 339	0	923, 568	9, 161	66. 01
67.00	06700 OCCUPATI ONAL THERAPY	995	209, 752	0	330, 020	995	67.00
67.01	06701 WHEATFI ELD OT	1, 970	81, 571	0	201, 517	1, 970	67. 01
68.00	06800 SPEECH PATHOLOGY	575	121, 257	0	191, 345	575	68.00
68. 01	06801 WHEATFIELD ST	1, 278	52, 932	2 0	129, 851	1, 278	68. 01
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 123	0	0	792, 530	1, 123	
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	163	0	0	114, 631	163	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0) 0	0	0	73.00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0	265, 764	1		0	
88. 03	08801 RURAL HEALTH CLINIC IV	2, 650	306, 241	•		2, 650	
90.00	09000 CLI NI C	4, 487	1, 106, 811	1		4, 487	
91.00	09100 EMERGENCY	4, 464	953, 627	0	2, 427, 620	4, 464	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
101 0	OTHER REIMBURSABLE COST CENTERS	2.00/	1 104 407	, ,	1 071 047	2.00/	101 00
101.00	D10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	3, 086	1, 184, 497	<u>'</u> 0	1, 971, 047	3, 086	101.00
116 0	11600 HOSPI CE	249	324, 325	5 0	674, 206	2/10	116. 00
118.00		93, 750	12, 028, 403			80, 677	
110.0	NONREI MBURSABLE COST CENTERS	75, 750	12,020, 400	14, 103, 307	20, 072, 034	00,077	1110.00
190 0	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	230	0	0	10, 053	230	190. 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	0	0				192. 00
	1 19201 RENSSELAER HEALTH CENTER	o	Ö	1	Ö		192. 01
	19300 NONPALD WORKERS		n	o o	0		193. 00
	07950 ALTERNACARE	8, 362	561, 872	1	1, 154, 582		194. 00
	1 07951 DME EQUI PMENT	0	0	o o			194. 01
	207952 WHEATFIELD FITNESS	2, 782	255, 307	' o	637, 511		194. 02
	3 07957 JOHNSON FITNESS	0	516, 761	0			194. 03
	4 07953 FOUNDATI ON	o	0	o o	4, 670		194. 04
	07954 MEALS ON WHEELS	0	0) 0	o		194. 05
	07955 WATER LAB	554	0) o	24, 214		194. 06
	7 07956 ADVERTI SI NG	331	0) 0	14, 517	331	194. 07
200.00							200. 00
201.00	1 1 0						201. 00
202.00		4, 633, 353	4, 881, 776	o	14, 185, 309	2, 214, 512	202.00
	Part I)						
	Unit cost multiplier (Wkst. B, Part I)	43. 707166	0. 365338	3	0. 462336	23. 828355	
203.00			_)I	489, 826	105, 735	204.00
	Cost to be allocated (per Wkst. B,		U	1	, , , , ,	•	
203. 00 204. 00	Cost to be allocated (per Wkst. B, Part II)		0.000000				205 22
203.00	Cost to be allocated (per Wkst. B, Part II)		0. 000000		0. 015965	1. 137718	205. 00

Cost Genter Description	-	LLOCATION - STATISTICAL BASIS	TRANSPORTER TIERE	Provi der Co	CN: 15-1324 F	eri od:	Worksheet B-1	
CAMPRION LAWRENCE LIFER SERVICE COST CENTERS						rom 01/01/2016	Dato/Timo Bro	narod:
COLUMN C					'	0 12/31/2010		
ODULAR SERVICE COST CENTERS COULDED CO		Cost Center Description						
							ADMI NI STRATI ON	
CEREMAL SERVICE COST CENTERS			,	SERVICE)	SERVED)	HOURS)	(MAN	
CHERAL SERVICE COST CENTERS			VALUE					
1.00			8.00	9. 00	10.00	11.00		
4.00 004000 EMPLOYME BERKET IS DEPARTMENT 7.00 004000 MIN ISTRATIVE & CEMERAL 7.00 005000 MIN ISTRATIVE MIN 7.00 00500 MIN ISTRATIVE MIN 7.00 0050						1		
0.0000 DOSON DAMINISTRATIVE & CENERAL								
0.0000 0.0000 DERATINO OF PLANT								
8.00 0.05000 LAUNDRY & LINEN SERVICE 256.375 80.605 9.904 9.00 10.00 0.005 ETRAPY 2.881 230 9.904 10.00 10								
10.00 01000 DETARY 2.881 230 9.964 10.00 17.00			256, 375					
11.00 01100 CAFETERIA 0 40 0 279,019 11.00 14.00 14.00 0 0 5.509 16.235 13.00 13		l e			1			
13.00 01300 MURSING ADMINISTRATION 0 0 0 5,509 160,235 33.00 15.00 01500 PHARMACY 0 0 1.165 0 10,633 0 15.00 15.00 01500 PHARMACY 0 0 0 0 0 0 0 17.00 01700 SICHAL SERVICE COST CENTERS 0 0 0 0 0 0 17.00 01700 SICHAL SERVICE COST CENTERS 0 0 0 0 0 0 17.00 01700 SICHAL SERVICE COST CENTERS 0 0 0 0 0 0 17.00 01700 SICHAL SERVICE COST CENTERS 0 0 0 0 0 0 18.00 01700 SICHAL SERVICE COST CENTERS 0 0 0 0 0 0 19.00 01700 MIRCHARD SICHAL SERVICE COST CENTERS 0 0 0 0 0 0 0 19.00 01700 MIRCHARD SICHAL SERVICE COST CENTERS 0 0 0 0 0 0 0 19.00 01700 MIRCHARD SICHAL SERVICE COST CENTERS 0 0 0 0 0 0 0 0 19.00 01700 MIRCHARD SICHAL SERVICE COST CENTERS 0 0 0 0 0 0 0 0 19.00 01700 MIRCHARD SICHAL SERVICE COST CENTERS 0 0 0 0 0 0 0 0 0			1		1			
14.00 01400 PARISMACY 0 1.165 0 1.633 0 15.0		l e e e e e e e e e e e e e e e e e e e	0	40		1	1/0 225	1
15.00 0 1500 [PHARMACY] 17.00 0 1500 [PHARMACY] 18.00 0 1600 [PHARMACY] 18.00 0 10 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0	0	1	-,		•
16.00 16.00		l e e e e e e e e e e e e e e e e e e e	0	1, 165			-	1
IMPATIENT ROUTINE SERVICE COST CENTERS 148, 962 23, 470 2, 975 32, 647 32, 647 30. 00 30. 00 30.00 AUITS & PEROLECOST CENTERS 1, 089 2, 160 340 17, 275 17, 275 31. 00 30. 00 30. 00 17, 625 17, 625 17, 625 50. 00 60.0			0				0	16. 00
30.00 3000 ADULT'S & PEDIATRICS 148, 962 23, 420 2.975 32, 647 32, 647 30.00 3000 INTENSIVE CASE UNIT 1.08 92 2.160 340 17, 275 17, 275 31.00 3000 INTENSIVE CASE UNIT 1.08 92 2.160 340 17, 275 17, 275 31.00 3000 DISTRICT COST CENTERS 0 0 0 17, 625 17, 625 50.00 5000 DISTRICT COST CENTERS 0 0.400 ADULT CASE 17, 625 50.00 5000 DISTRICT COST CENTERS 0 0 0 0 0 0 0 0 0	17. 00		0	0) c	0	0	17. 00
31.0	00.00		140.040	00.400	0.075	00 (47	20 / 47	
## MICLILARY SERVICE COST CENTERS 50.00 05000 0FEART INR ROWM 12, 999 0 0 17, 625 17, 625 50.00 54.00 05000 0FEART INR ROWM 0 3, 364 9, 340 0 27, 471 54.00 63.00 05000 06500 05000 0 0 0 0 0 0 0					1			
50.00	31.00		1,007	2, 100	7 340	17,273	17,273	31.00
60.00	50.00		12, 999	0) C	17, 625	17, 625	50.00
63.00 06500 BLOOD STORING, PROCESSING & TRANS. 0 0 0 0 0 0 0 0 0		l e e e e e e e e e e e e e e e e e e e	3, 364		1	1	27, 471	1
65.00 06500 PHSTORA THERAPY 17.154 1.7			0	3, 390	1			1
66.00 06600 PHYSICAL THERAPY 17, 154 3,778 0 21, 975 0 66.00		·	7 044	1 010	1		Ŭ	
66.01		l e e e e e e e e e e e e e e e e e e e					0	1
67.00 06700 06700 06700 06700 06700 06700 06700 06700 06700 06700 06700 06700 06700 06700 06700 06700 0680		l e e e e e e e e e e e e e e e e e e e	1	3,770		,	0	1
68. 00 06800 SPECCH PATHOLOGY 0 902 0 2,705 0 68. 00		l e e e e e e e e e e e e e e e e e e e	0	1, 560	1	1	0	1
68. 01 06801 WHEATFIELD ST 0 0 0 0 1,387 0 68. 01 070. 00 070. 00 070. 00 070. 00 0 0 0 0 0 0 0 0		· ·	0	0			0	
10. 00 07000 07000 07000 07000 07000 07000 071000 071000 071000 071000 071000 071000 071000 0710		· ·	0	902	1	,	0	1
17.00		· ·	0	0			Ŭ	1
12.00 07200 IMPL DEV. CHARGED TO PATIENT 0 0 0 0 0 0 72.00			0	0			Ŭ	1
13.00 O7300 DRUGS CHARGED TO PATIENTS O O O O O O O O O			0	Ö			0	
88. 00 08800 RURAL HEALTH CLINIC 0 0 0 0 0 0 0 88. 00	73.00		0	0) c	0	0	73. 00
88. 03 08801 RURAL HEALTH CLINIC IV 0 0 0 0 0 0 88. 03 90. 00 09000 CLINIC 3,255 8,235 127 34,720 34,720 90. 00 91. 00 09100 EMERGENCY 5,754 6,930 0 30,497 30,497 91. 00 92. 00 09200 085ERVATI ON BEDS (NON-DISTINCT PART) 92. 00 09100 EMERGENCY 0 6,240 0 0 0 0 09100 THER REI MBURSABLE COST CENTERS 92. 00 09100 HOSPI CE 0 0 0 0 0 0 0 09100 HOSPI CE 0 0 0 0 0 0 09100 HOSPI CE 0 0 0 0 0 0 0 09100 HOSPI CE 0 0 0 0 0 0 0 0 09100 HOSPI CE 0 0 0 0 0 0 0 0 0 09100 HOSPI CE 0 0 0 0 0 0 0 0 0								
90.00 09000 CLINIC 3,255 8,235 127 34,720 34,720 91.00 91.00 91.00 91.00 92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 92.00 92.			-	0			_	
91.00 09100 EMERGENCY 92.00 09200 OSERVATION BEDS (NON-DISTINCT PART) 101.00 10100 HOME HEALTH AGENCY 0 6,240 0 0 0 101.00 101			_	8 235			-	1
92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 0 6,240 0 0 0 0 101.00								•
101.00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS O O O O O O O O O	92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
SPECIAL PURPOSE COST CENTERS 0 0 0 0 0 0 0 0 0								1
116. 00 11600 HOSPI CE SUBTOTALS (SUM OF LINES 1-117) 220, 474 69, 300 3, 442 250, 011 160, 235 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 190.00 190.00 191.00 190.00 190.00 190.00 190.00 191.00	101. 00		0	6, 240) <u> </u>	0	0	101.00
118.00 SUBTOTALS (SUM OF LINES 1-117) 220,474 69,300 3,442 250,011 160,235 118.00	116 00		1 0	0		0	0	116 00
NONREL IMBURSABLE COST CENTERS 190.00 191.		SUBTOTALS (SUM OF LINES 1-117)	220, 474	69. 300	3. 442	250, 011		
192.00 19200 19200 RENSSELAER HEALTH CENTER								
192.01 19201 RENSSELAER HEALTH CENTER 0 0 0 0 0 0 0 0 0 192.01			1		1			1
193.00 19300 NONPAID WORKERS 194.00 07950 ALTERNACARE 35,901 10,560 5,215 28,995 0 194.00 194.01 07951 DME EQUI PMENT 0 0 0 0 0 0 0 194.01 194.02 07952 WHEATFIELD FITNESS 0 0 0 0 0 0 0 194.02 194.04 07953 FOUNDATION 0 0 0 0 0 0 194.04 194.05 07954 MEALS ON WHEELS 0 0 0 0 0 0 0 194.04 194.06 07955 WATER LAB 0 0 815 0 0 0 0 194.07 194.07 07956 ADVERTISING 0 0 0 0 194.07 194.07 07956 Cross Foot Adjustments 200.00 Negative Cost Centers 202.00 Cost to be allocated (per Wkst. B, Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 205.00 Unit cost multiplier (Wkst. B, Part I) 2075.00 Unit cost multiplier (Wkst. B, Part II) 2075.00 Unit cost multiplier (Wkst. B, Part III) 2075.00 Unit cost multiplier (Wkst. B, Part III)		l e e e e e e e e e e e e e e e e e e e	1	0	1			1
194. 00 07950 ALTERNACARE 35, 901 10, 560 5, 215 28, 995 0 194. 00 194. 01 194. 02 07952 MHEATFI ELD FITNESS 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0	0		0		
194. 01 07951 DME EQUI PMENT 0 0 0 0 0 0 194. 01 194. 02 194. 03 07957 DME EQUI PMENT 0 0 0 0 0 0 194. 02 194. 03 07957 DMEALS ON WHEATE LED FITNESS 0 0 0 0 0 0 0 194. 03 194. 04 07953 FOUNDATION 0 0 0 0 0 194. 05 194. 05 07954 DMEALS ON WHEELS 0 0 0 0 1, 307 0 0 194. 05 194. 06 07955 DMEALS ON WHEELS 0 0 815 0 0 0 194. 05 194. 06 07955 DMEALS ON WHEELS 0 0 815 0 0 0 194. 05 194. 06 07955 DMEALS ON WHEELS 0 0 815 0 0 0 194. 05 194. 05 194. 06 07955 DMEALS ON WHEELS 0 0 815 0 0 0 194. 05 194. 05 194. 06 07955 DMEALS ON WHEELS 0 0 815 0 0 0 194. 05 194. 05 194. 07 197956 DMEALS ON WHEELS 0 0 0 0 194. 05 194. 05 194. 07 197956 DMEALS ON WHEELS 0 0 0 0 194. 05 194. 05 194. 07 197956 DMEALS ON WHEELS 0 0 0 0 194. 05 194. 05 194. 07 197956 DMEALS ON WHEELS 0 0 0 0 194. 05 194.			35. 901	10. 560	5, 215	28. 995		
194. 03 07957 JOHNSON FITNESS 0 0 0 0 0 0 194. 03 194. 04 07953 FOUNDATION 0 0 0 0 0 194. 04 194. 05 07954 MEALS ON WHEELS 0 0 0 194. 05 194. 06 07955 WATER LAB 0 815 0 0 0 194. 06 194. 06 200. 00 Cross Foot Adjustments 202. 00 Reart I)			0	0		0		
194. 04 07953 FOUNDATION 0 0 0 0 194. 04 194. 05 07954 MEALS ON WHEELS 0 0 0 1, 307 0 0 194. 05 194. 06 07955 WATER LAB 0 815 0 0 0 194. 06 194. 07 07956 ADVERTISING 0 0 0 13 0 194. 07 200. 00 Cross Foot Adjustments 202. 00 Negative Cost Centers 202. 00 Cost to be allocated (per Wkst. B, Part I) 203. 00 Unit cost multiplier (Wkst. B, Part I) 204. 00 Cost to be allocated (per Wkst. B, Part II) 205. 00 Unit cost multiplier (Wkst. B, Part II) 205. 00 Unit cost multiplier (Wkst. B, Part II) 205. 00 Unit cost multiplier (Wkst. B, Part III) 205. 00 Unit cost multiplier (Wkst. B, Part IIII) 205. 00 Unit cost multiplier (Wkst. B, Part IIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII			0	0) c	0		
194. 05 07954 MEALS ON WHEELS 194. 06 07955 WATER LAB 194. 07 07956 ADVERTISING 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 194. 05 194. 05 00 00 1, 307 00 00 1, 307 00 00 1, 307 00 00 1, 307 00 00 13 0194. 05 200. 00 201. 00 202. 00 Cost fo be allocated (per Wkst. B, Part I) 203. 00 204. 00 205. 00 Unit cost multiplier (Wkst. B, Part I) 205. 00 Unit cost multiplier (Wkst. B, Part I) 205. 00 Unit cost multiplier (Wkst. B, Part I) Unit cost multiplier (Wkst. B, Part I) 205. 00 Unit cost multiplier (Wkst. B, Part I) 10. 294775 11. 281356 11. 307 0 0 0 194. 05 0 194. 05 0 0 0 0 194. 05 0 194. 05 0 194. 06 0 194. 05 0 194. 05 0 194. 06 0 194. 05 0 194. 05 0 194. 05 0 194. 06 0 0 0 0 0 0 13 0 194. 06 194. 0			0	0) C	0		
194.06 07955 WATER LAB 0 815 0 0 0 194.06 194.07 07956 ADVERTISING 0 0 0 13 0 194.07 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 202.00 Cost to be allocated (per Wkst. B, Part I) 1.243241 14.765909 61.133782 2.371104 4.072905 203.00 204.00 Cost to be allocated (per Wkst. B, Part II) 1.243241 14.765909 61.133782 2.371104 4.072905 203.00 204.00 Cost to be allocated (per Wkst. B, Part II) 1.243241 103,399 87,747 96,748 26,861 204.00 205.00 Unit cost multiplier (Wkst. B, Part II) 205.00 Unit cost multiplier (Wkst. B, Part II) 205.00			0	0	1 207	0		
194. 07 07956 ADVERTISING 0 0 0 13 0 194. 07 200. 00 201. 00 Negative Cost Centers 202. 00 Cost to be allocated (per Wkst. B, Part I) Unit cost multiplier (Wkst. B, Part II) 1. 243241 14. 765909 61. 133782 2. 371104 4. 072905 203. 00 204. 00 Cost to be allocated (per Wkst. B, Part II) 1. 243241 103, 399 87, 747 96, 748 26, 861 204. 00 Part II) 205. 00 Unit cost multiplier (Wkst. B, Part III) 205. 00 Unit cost multiplier (Wkst. B, Part IIII) 205. 00 Unit cost multiplier (Wkst. B, Part IIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII			0	815		0		
200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 202.00 Cost to be allocated (per Wkst. B, Part I) 318,736 1,191,535 609,137 661,583 652,622 202.00 203.00 Unit cost multiplier (Wkst. B, Part I) 1.243241 14.765909 61.133782 2.371104 4.072905 203.00 204.00 Cost to be allocated (per Wkst. B, Part II) 75,573 103,399 87,747 96,748 26,861 204.00 205.00 Unit cost multiplier (Wkst. B, Part 0.294775 1.281356 8.806403 0.346743 0.167635 205.00			0	0		13		
202.00 Cost to be allocated (per Wkst. B, Part I) 318,736 1,191,535 609,137 661,583 652,622 202.00 203.00 Unit cost multiplier (Wkst. B, Part I) 1.243241 14.765909 61.133782 2.371104 4.072905 203.00 204.00 Cost to be allocated (per Wkst. B, Part II) 75,573 103,399 87,747 96,748 26,861 204.00 205.00 Unit cost multiplier (Wkst. B, Part 0.294775 1.281356 8.806403 0.346743 0.167635 205.00	200.00	Cross Foot Adjustments						200. 00
Part I) Unit cost multiplier (Wkst. B, Part I) 203.00 Cost to be allocated (per Wkst. B, Part II) Cost to be allocated (per Wkst. B, Part III) Unit cost multiplier (Wkst. B, Part III) Unit cost multiplier (Wkst. B, Part IIII) 205.00 Part II) 1. 243241 14. 765909 61. 133782 2. 371104 4. 072905 203. 00 96, 748 26, 861 204. 00 205. 00 1. 281356 205. 00 1. 281356 206. 00 1. 281356 206. 00 1. 281356 207. 00 1. 281356 208. 00 1. 281356 208. 00 1. 281356 209. 00								1
203.00 Unit cost multiplier (Wkst. B, Part I) 1.243241 14.765909 61.133782 2.371104 4.072905 203.00	202. 00	,,,	318, 736	1, 191, 535	609, 137	661, 583	652, 622	202. 00
204.00 Cost to be allocated (per Wkst. B, Part II) 205.00 Unit cost multiplier (Wkst. B, Part 0.294775 1.281356 8.806403 0.346743 0.167635 205.00	203 00		1 243241	14 765909	61 133783	2 371104	4 072905	203 00
Part II) 205.00 Unit cost multiplier (Wkst. B, Part 0.294775 1.281356 8.806403 0.346743 0.167635 205.00					1			1
		Part II)						
	205. 00		0. 294775	1. 281356	8. 806403	0. 346743	0. 167635	205. 00
		· · · /	I	I	I	I	I	I

Hear th Financial Systems	FRANCI SCAN HEAL		N 45 4004 D		U 01 F01111 CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der CO		eriod: rom 01/01/2016	Worksheet B-1
				0 12/31/2016	
	OFNEDAL	DUADUA OV	11501.041	000111 0501105	8/8/2017 10:19 am
Cost Center Description	CENTRAL	PHARMACY		SOCIAL SERVICE	
	SERVICES & SUPPLY	(100% ALLOCATION)	RECORDS & LI BRARY	(TIME	
	(100%	ALLUCATION)	(TIME	SPENT)	
	ALLOCATION)		SPENT)	SI LIVI)	
	14. 00	15. 00	16.00	17. 00	
GENERAL SERVICE COST CENTERS	<u>'</u>				
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT					1.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT					4. 00
5. 00 00500 ADMI NI STRATI VE & GENERAL					5. 00
7. 00 00700 OPERATION OF PLANT					7.00
8.00 00800 LAUNDRY & LINEN SERVICE 9.00 00900 HOUSEKEEPING					8. 00 9. 00
9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY					10.00
11. 00 01100 CAFETERI A					11. 00
13. 00 01300 NURSING ADMINISTRATION					13. 00
14. 00 01400 CENTRAL SERVICES & SUPPLY	100				14.00
15. 00 01500 PHARMACY	0	100			15. 00
16.00 01600 MEDICAL RECORDS & LIBRARY	0	0	74, 945		16. 00
17. 00 01700 SOCIAL SERVICE	0	0	0	0	17. 00
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS	0		19, 642		
31. 00 03100 I NTENSI VE CARE UNIT	0	0	3, 013	0	31.00
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 0PERATI NG ROOM		0	7 525	0	F0.00
50. 00 05000 OPERATI NG ROOM 54. 00 05400 RADI OLOGY-DI AGNOSTI C	0 0		7, 535 9, 815		50. 00 54. 00
60. 00 06000 LABORATORY			1, 910		60.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	Ö	1	1, 710	l .	63.00
65. 00 06500 RESPIRATORY THERAPY	o o	o o	Ö	o	65. 00
66. 00 06600 PHYSI CAL THERAPY	0	0	Ö	0	66.00
66. 01 06601 WHEATFIELD PT	0	0	0	0	66. 01
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	0	0	67. 00
67. 01 06701 WHEATFIELD OT	0	0	0	0	67. 01
68. 00 06800 SPEECH PATHOLOGY	0	0	0	0	68. 00
68. 01 06801 WHEATFI ELD ST	0		0	0	68. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY	0		0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 MPL. DEV. CHARGED TO PATIENT	100		0		71. 00 72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS				1	73.00
OUTPATIENT SERVICE COST CENTERS		100		0	73.00
88. 00 08800 RURAL HEALTH CLINIC	0	0	0	0	88. 00
88.03 08801 RURAL HEALTH CLINIC IV	0	0	0	0	88. 03
90. 00 09000 CLI NI C	0	0	23, 245	0	90.00
91. 00 09100 EMERGENCY	0	0	9, 785	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS					101.00
101.00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0	0	0	0	101.00
116. 00 11600 HOSPI CE	0	0	0	0	116. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	100				
NONREI MBURSABLE COST CENTERS	100	100	71,710	<u> </u>	110.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192. 00
192.01 19201 RENSSELAER HEALTH CENTER	0	0	0	0	192. 01
193.00 19300 NONPALD WORKERS	0	0	0		193. 00
194. 00 07950 ALTERNACARE	0	0	0	0	194. 00
194. 01 07951 DME EQUI PMENT	0	0	0	0	194. 01
194. 02 07952 WHEATFIELD FITNESS 194. 03 07957 JOHNSON FITNESS	0	0	0	0	194. 02 194. 03
194. 04 07953 FOUNDATION		0	0	0	194. 03
194. 05 07954 MEALS ON WHEELS	0	0	0	0	194. 05
194. 06 07955 WATER LAB	0	l ő	0	ő	194. 06
194. 07 07956 ADVERTI SI NG	0	0	Ö	0	194. 07
200.00 Cross Foot Adjustments					200. 00
201.00 Negative Cost Centers					201. 00
202.00 Cost to be allocated (per Wkst. B,	141, 489	4, 413, 673	367, 355	o	202.00
Part I)					
203.00 Unit cost multiplier (Wkst. B, Part I)				l .	203. 00
204.00 Cost to be allocated (per Wkst. B,	2, 039	97, 834	64, 877	0	204. 00
Part II) 205.00 Unit cost multiplier (Wkst. B, Part	20. 390000	978. 340000	0. 865661	0. 000000	205. 00
II)	20. 370000	770. 340000	0.003001	3.000000	203.00
	1		•	'	1

Heal th	Financial Systems	FRANCI SCAN HEAL	TH RENSSELAER		In Lie	u of Form CMS-:	2552-10
COMPUT	ATION OF RATIO OF COSTS TO CHARGES		Provider CO		Period: From 01/01/2016 To 12/31/2016		
			Title	XVIII	Hospi tal	Cost	
					Costs		
	Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
		1.00	2.00	3.00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS			•			
30.00	03000 ADULTS & PEDIATRICS	3, 829, 272		3, 829, 27	2 0	0	30.00
31.00	03100 INTENSIVE CARE UNIT	1, 531, 985		1, 531, 98	5 0	0	31.00
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	2, 283, 113		2, 283, 11		0	
	05400 RADI OLOGY-DI AGNOSTI C	4, 020, 196		4, 020, 19		0	
60.00	06000 LABORATORY	3, 381, 963		3, 381, 96		0	00.00
	06300 BLOOD STORING, PROCESSING & TRANS.	110, 682		110, 68		0	63. 00
	06500 RESPI RATORY THERAPY	1, 894, 595		1, 894, 59		0	00.00
	06600 PHYSI CAL THERAPY	1, 302, 223		1, 302, 22		0	00.00
66. 01	06601 WHEATFI ELD PT	1, 596, 105		1, 596, 10		0	00.0.
	06700 OCCUPATI ONAL THERAPY	544, 012		544, 01		0	67. 00
	06701 WHEATFI ELD OT	345, 213		345, 21		0	07.0.
	06800 SPEECH PATHOLOGY	313, 245		313, 24		0	
	06801 WHEATFI ELD ST	223, 628	0	223, 62	8 0	0	00.0.
	07000 ELECTROENCEPHALOGRAPHY	0		4 007 40	0	0	, 0. 00
	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	1, 327, 193		1, 327, 19		0	
	07200 I MPL. DEV. CHARGED TO PATIENT	171, 513		171, 51		0	
/3.00	07300 DRUGS CHARGED TO PATIENTS	4, 413, 673		4, 413, 67	3 0	0	73. 00

624, 789

961, 905 3, 182, 019

4,010,334

1, 013, 198

3, 048, 006

41, 120, 711 1, 013, 198

40, 107, 513

991, 849

624, 789

961, 905

3, 182, 019

4, 010, 334

1, 013, 198

3, 048, 006

41, 120, 711

1, 013, 198

40, 107, 513

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991, 849

90.00

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MCRI F32 - 10.8.161.0

88.00

88. 03

91.00

200.00

201.00

202.00

90. 00 09000 CLI NI C

116. 00 11600 HOSPI CE

09100 EMERGENCY

101. 00 10100 HOME HEALTH AGENCY

92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)

Subtotal (see instructions)

OTHER REIMBURSABLE COST CENTERS

Less Observation Beds

Total (see instructions)

SPECIAL PURPOSE COST CENTERS

OUTPATIENT SERVICE COST CENTERS

08800 RURAL HEALTH CLINIC

08801 RURAL HEALTH CLINIC IV

Health Financial Systems	FRANCI SCAN HEALTH RENSSELAER	In Lieu of Form CMS-2552-			
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-1324	Peri od: From 01/01/2016 To 12/31/2016	Worksheet C Part I Date/Time Prepared: 8/8/2017 10:19 am		
	T: +1 o V/// 1 I	Heeni tel	Coot		

				Т	o 12/31/2016	Date/Time Pre 8/8/2017 10:1	
			Title	XVIII	Hospi tal	Cost	
			Charges				
	Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
				+ col. 7)	Ratio	I npati ent	
						Ratio	
		6. 00	7. 00	8. 00	9. 00	10. 00	
	PATIENT ROUTINE SERVICE COST CENTERS						1
	DOO ADULTS & PEDIATRICS	1, 958, 858		1, 958, 858			30. 00
	100 INTENSIVE CARE UNIT	446, 269		446, 269			31. 00
	CILLARY SERVICE COST CENTERS						1
	OOO OPERATING ROOM	503, 740	3, 617, 041			0. 000000	
	400 RADI OLOGY-DI AGNOSTI C	565, 098	9, 665, 353			0. 000000	
	DOO LABORATORY	1, 069, 082	7, 860, 203			0. 000000	1
	BOO BLOOD STORING, PROCESSING & TRANS.	75, 490	100, 395	·		0. 000000	
	500 RESPI RATORY THERAPY	898, 521	1, 974, 266		1	0.000000	
	600 PHYSI CAL THERAPY	187, 499	1, 060, 629			0.000000	
	601 WHEATFIELD PT	0	1, 283, 228		1	0.000000	
	700 OCCUPATIONAL THERAPY	99, 088	260, 168	359, 256		0. 000000	
	701 WHEATFIELD OT	0	157, 676	·		0.000000	
	BOO SPEECH PATHOLOGY	19, 156	131, 480	150, 636	2. 079483	0.000000	
	BO1 WHEATFIELD ST	0	100, 944	100, 944	2. 215367	0.000000	68. 01
	DOO ELECTROENCEPHALOGRAPHY	0	0	C	0. 000000	0.000000	
	100 MEDICAL SUPPLIES CHARGED TO PATIENTS	368, 564	2, 134, 882	2, 503, 446	0. 530146	0.000000	
	200 IMPL. DEV. CHARGED TO PATIENT	58, 069	216, 899	274, 968	0. 623756	0.000000	
	300 DRUGS CHARGED TO PATIENTS	2, 107, 807	6, 910, 058	9, 017, 865	0. 489437	0. 000000	73. 00
	FPATIENT SERVICE COST CENTERS						
	BOO RURAL HEALTH CLINIC	0	231, 944				88. 00
	BO1 RURAL HEALTH CLINIC IV	0	410, 218	410, 218			88. 03
	DOO CLI NI C	106, 462	3, 202, 700	3, 309, 162	0. 961578	0.000000	90.00
91.00 091	100 EMERGENCY	88, 162	4, 402, 077	4, 490, 239	0. 893123	0.000000	91.00
92.00 092	200 OBSERVATION BEDS (NON-DISTINCT PART)	35, 913	1, 727, 055	1, 762, 968	0. 574712	0. 000000	92.00
OTH	HER REIMBURSABLE COST CENTERS						
101. 00 101	100 HOME HEALTH AGENCY	0	3, 335, 373	3, 335, 373			101. 00
SPE	ECLAL PURPOSE COST CENTERS						
	600 HOSPI CE	0	1, 054, 587	1, 054, 587			116. 00
200. 00	Subtotal (see instructions)	8, 587, 778	49, 837, 176	58, 424, 954			200. 00
201. 00	Less Observation Beds						201. 00
202. 00	Total (see instructions)	8, 587, 778	49, 837, 176	58, 424, 954	.		202. 00

		U DENOCEL AED		6.5. 040.4	
Health Financial Systems	FRANCI SCAN HEALTH	H RENSSELAER	In Lieu of Form CMS-2		2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1324	From 01/01/2016	Worksheet C 2016 Part I 2016 Date/Time Prepar 8/8/2017 10:19 a	
		Title XVIII	Hospi tal	Cost	
Cost Center Description	PPS Inpatient Ratio 11.00				

		litle XVIII	Hospi tal	Cost
Cost Center Description	PPS Inpatient			
	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDIATRICS				30.00
31.00 03100 INTENSIVE CARE UNIT				31.00
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0. 000000			50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000			54.00
60. 00 06000 LABORATORY	0. 000000			60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000			63. 00
65. 00 06500 RESPIRATORY THERAPY	0. 000000			65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 000000			66. 00
66. 01 06601 WHEATFI ELD PT	0. 000000			66. 01
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000			67. 00
67. 01 06701 WHEATFLELD OT	0. 000000			67. 01
68. 00 06800 SPEECH PATHOLOGY	0. 000000			68. 00
68. 01 06801 WHEATFI ELD ST	0. 000000			68. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000			70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000			72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73. 00
OUTPATIENT SERVICE COST CENTERS	<u>'</u>			
88. 00 08800 RURAL HEALTH CLINIC				88. 00
88.03 08801 RURAL HEALTH CLINIC IV				88. 03
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)	0. 000000			92. 00
OTHER REIMBURSABLE COST CENTERS	<u>'</u>			
101.00 10100 HOME HEALTH AGENCY				101. 00
SPECIAL PURPOSE COST CENTERS	<u>'</u>			
116. 00 11600 HOSPI CE				116. 00
200.00 Subtotal (see instructions)				200. 00
201.00 Less Observation Beds				201. 00
202.00 Total (see instructions)				202. 00
	1			1

Heal th	Financial Systems	FRANCI SCAN HEAL	TH RENSSELAER		In lie	eu of Form CMS-2	2552-10
	ATION OF RATIO OF COSTS TO CHARGES		Provi der CC		Period: From 01/01/2016 To 12/31/2016	Worksheet C Part I Date/Time Pre 8/8/2017 10:1	pared:
			Titl	e XIX	Hospi tal	Cost	
	Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	Costs RCE Di sal I owance	Total Costs	
		1.00	2. 00	3. 00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
	03000 ADULTS & PEDIATRICS	3, 829, 272		3, 829, 27		3, 829, 272	
31. 00	03100 INTENSIVE CARE UNIT	1, 531, 985		1, 531, 98	5 0	1, 531, 985	31. 00
	ANCILLARY SERVICE COST CENTERS				_		
	05000 OPERATING ROOM	2, 283, 113		2, 283, 11		2, 283, 113	
	05400 RADI OLOGY-DI AGNOSTI C	4, 020, 196		4, 020, 19		4, 020, 196	
	06000 LABORATORY	3, 381, 963		3, 381, 96		3, 381, 963	
	06300 BLOOD STORING, PROCESSING & TRANS.	110, 682		110, 68		110, 682	1
65. 00	06500 RESPI RATORY THERAPY	1, 894, 595		1, 894, 59		1, 894, 595	1
	06600 PHYSI CAL THERAPY	1, 302, 223		1, 302, 22		1, 302, 223	1
	06601 WHEATFI ELD PT	1, 596, 105		1, 596, 10		1, 596, 105	1
	06700 OCCUPATI ONAL THERAPY	544, 012		544, 01		544, 012	1
	06701 WHEATFI ELD OT	345, 213		345, 21		345, 213	1
	06800 SPEECH PATHOLOGY	313, 245	0	313, 24		313, 245	1
68. 01	06801 WHEATFIELD ST	223, 628	0	223, 62	8 0	223, 628	1
	07000 ELECTROENCEPHALOGRAPHY	0		4 007 10		0	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 327, 193		1, 327, 19		1, 327, 193	1
72. 00	07200 I MPL. DEV. CHARGED TO PATIENT	171, 513		171, 51	3	171, 513	72. 00

4, 413, 673

624, 789

961, 905

3, 182, 019

4,010,334

1, 013, 198

3, 048, 006

991, 849

41, 120, 711

1, 013, 198

40, 107, 513

4, 413, 673

624, 789

961, 905

3, 182, 019

4, 010, 334

1, 013, 198

3, 048, 006

41, 120, 711

1, 013, 198

40, 107, 513

0

0

991, 849

0

0

0

0

4, 413, 673

624, 789

961, 905

3, 182, 019

4, 010, 334

1, 013, 198

3, 048, 006 101. 00

41, 120, 711 200. 00

1, 013, 198 201. 00

40, 107, 513 202. 00

991, 849 116. 00

73.00

88.00

88. 03

90.00

91.00

92.00

73. 00 07300 DRUGS CHARGED TO PATIENTS

88.00 08800 RURAL HEALTH CLINIC

09100 EMERGENCY

101. 00 10100 HOME HEALTH AGENCY

90. 00 09000 CLINIC

116. 00 11600 HOSPI CE

91.00

200.00

201.00

202.00

88. 03 08801 RURAL HEALTH CLINIC IV

OUTPATIENT SERVICE COST CENTERS

92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)

Subtotal (see instructions)

OTHER REIMBURSABLE COST CENTERS

Less Observation Beds

Total (see instructions)

SPECIAL PURPOSE COST CENTERS

Health Financial Systems	FRANCISCAN HEALTH RENSSELAER	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-1324	Peri od: From 01/01/2016 To 12/31/2016	Worksheet C Part I Date/Time Prepared: 8/8/2017 10:19 am
	Ti +l o VI V	Hospi tal	Cost

						0 12/31/2016	8/8/2017 10:1	
				Titl	e XIX	Hospi tal	Cost	
				Charges				
	Cost Center Des	scri pti on	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
					+ col. 7)	Ratio	Inpati ent	
							Ratio	
			6. 00	7. 00	8. 00	9. 00	10. 00	
	INPATIENT ROUTINE SE							
30.00	03000 ADULTS & PEDIA		1, 958, 858		1, 958, 858	I I		30. 00
31. 00	03100 INTENSIVE CARE		446, 269		446, 269			31. 00
	ANCILLARY SERVICE CO	ST CENTERS						
50.00	05000 OPERATING ROOM		503, 740	3, 617, 041			0. 000000	
54.00	05400 RADI OLOGY-DI AGI	NOSTI C	565, 098	9, 665, 353		I I	0. 000000	
60.00	06000 LABORATORY		1, 069, 082	7, 860, 203			0. 000000	
63.00	06300 BLOOD STORING,		75, 490	100, 395		· •	0. 000000	1
65.00	06500 RESPIRATORY THI		898, 521	1, 974, 266			0. 000000	
66. 00	06600 PHYSI CAL THERAI	ΡΥ	187, 499	1, 060, 629			0.000000	
66. 01	06601 WHEATFI ELD PT		0	1, 283, 228			0.000000	
67. 00	06700 OCCUPATI ONAL TI	HERAPY	99, 088	260, 168		I I	0.000000	
67. 01	06701 WHEATFI ELD OT		0	157, 676		· •	0. 000000	
68. 00	06800 SPEECH PATHOLOG	GY	19, 156	131, 480			0.000000	
68. 01	06801 WHEATFI ELD ST		0	100, 944	100, 944	· •	0.000000	
70.00	07000 ELECTROENCEPHAI		0	0	(0. 000000	0.000000	
71. 00		ES CHARGED TO PATIENTS	368, 564	2, 134, 882			0.000000	71.00
72.00	07200 I MPL. DEV. CHAI		58, 069	216, 899			0.000000	
73.00	07300 DRUGS CHARGED		2, 107, 807	6, 910, 058	9, 017, 865	0. 489437	0.000000	73. 00
	OUTPATIENT SERVICE C							
88. 00	08800 RURAL HEALTH CI		0	231, 944		I	0. 000000	
88. 03	08801 RURAL HEALTH CI	LINIC IV	0	410, 218		l l	0. 000000	
90.00	09000 CLI NI C		106, 462	3, 202, 700			0.000000	
91. 00	09100 EMERGENCY		88, 162	4, 402, 077	4, 490, 239	0. 893123	0.000000	
92.00		OS (NON-DISTINCT PART)	35, 913	1, 727, 055	1, 762, 968	0. 574712	0.000000	92. 00
	OTHER REIMBURSABLE C							
101.00	10100 HOME HEALTH AGI		0	3, 335, 373	3, 335, 373			101. 00
	SPECIAL PURPOSE COST	CENTERS						
	11600 HOSPI CE		0	1, 054, 587		I I		116. 00
200.00			8, 587, 778	49, 837, 176	58, 424, 954			200. 00
201.00								201. 00
202.00	Total (see ins	tructions)	8, 587, 778	49, 837, 176	58, 424, 954			202. 00

Health Financial Systems	FRANCI SCAN HEALTH	I RENSSELAER	In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1324	Peri od: From 01/01/2016 To 12/31/2016	Worksheet C Part I Date/Time Pre 8/8/2017 10:1	pared:
		Title XIX	Hospi tal	Cost	
Cost Center Description	PPS Inpatient Ratio 11.00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS 31. 00 03100 INTENSI VE CARE UNI T					30. 00 31. 00
ANCILLARY SERVICE COST CENTERS					41

	cost center bescription	[PPS TIIPATTEIIT]	
		Ratio	
		11.00	
	INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000 ADULTS & PEDIATRICS		30. 00
31.00	03100 INTENSIVE CARE UNIT		31. 00
	ANCILLARY SERVICE COST CENTERS		
50.00	05000 OPERATING ROOM	0. 000000	50. 00
54.00	-	0. 000000	54.00
60.00	06000 LABORATORY	0. 000000	60.00
63.00		0. 000000	63. 00
65.00		0. 000000	65. 00
66.00		0. 000000	66. 00
66. 0´		0. 000000	66. 01
67.00	0 06700 OCCUPATI ONAL THERAPY	0. 000000	67. 00
67. 01	1 06701 WHEATFIELD OT	0. 000000	67. 01
68. 00	06800 SPEECH PATHOLOGY	0. 000000	68. 00
68. Oʻ	1 06801 WHEATFIELD ST	0. 000000	68. 01
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 000000	70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	71. 00
72.00		0. 000000	72. 00
73.00		0. 000000	73. 00
	OUTPATIENT SERVICE COST CENTERS		
88. 00	08800 RURAL HEALTH CLINIC	0. 000000	88. 00
88. 03	3 08801 RURAL HEALTH CLINIC IV	0. 000000	88. 03
90.00		0. 000000	90.00
91.00	O 09100 EMERGENCY	0. 000000	91.00
92.00		0. 000000	92. 00
	OTHER REIMBURSABLE COST CENTERS		
101. 0	DO 10100 HOME HEALTH AGENCY		101. 00
	SPECIAL PURPOSE COST CENTERS		
	00 11600 H0SPI CE		116. 00
200.0	, ,		200. 00
201. 0			201. 00
202. 0	Total (see instructions)		202. 00

Health Financial Systems	FRANCI SCAN HEALTH	FRANCISCAN HEALTH RENSSELAER		
APPORTIONMENT OF INPATIENT	ANCILLARY SERVICE CAPITAL COSTS	Provider CCN: 15-1324	Peri od:	Worksheet D

Heal th	Financial Systems	FRANCI SCAN HEAL	TH RENSSELAER		In Lie	u of Form CMS-2	2552-10
APPORT	IONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der C		Period: From 01/01/2016 To 12/31/2016	Worksheet D Part II Date/Time Pre 8/8/2017 10:1	
			Titl∈	XVIII	Hospi tal	Cost	
	Cost Center Description	Capi tal	Total Charges			Capital Costs	
			(from Wkst. C,		Program	(column 3 x	
		(from Wkst. B,	· ·	1	. Charges	column 4)	
		Part II, col.	8)	2)			
		26)					
		1. 00	2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS				a 457 005	04 004	
	05000 OPERATING ROOM	553, 913				21, 021	
	05400 RADI OLOGY-DI AGNOSTI C	504, 550		1		-	
	06000 LABORATORY	152, 127	•	1		-	
	06300 BLOOD STORING, PROCESSING & TRANS.	10, 125		1	·	-	1
	06500 RESPI RATORY THERAPY	177, 772				-	
	06600 PHYSI CAL THERAPY	137, 730				· ·	
	06601 WHEATFI ELD PT	429, 553		1		0	66. 01
	06700 OCCUPATI ONAL THERAPY	54, 034		1		8, 341	67.00
	06701 WHEATFI ELD OT	92, 085				0	67. 01
	06800 SPEECH PATHOLOGY	30, 935				3, 284	
	06801 WHEATFIELD ST	59, 866	1			0	00.0.
	07000 ELECTROENCEPHALOGRAPHY	(5.050	0 500 111	0.0000		0	70.00
	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	65, 053	1				71.00
	07200 I MPL. DEV. CHARGED TO PATIENT	9, 139				260	
73. 00	07300 DRUGS CHARGED TO PATIENTS	97, 834	9, 017, 865	0. 01084	9 1, 122, 125	12, 174	73. 00
00.00	OUTPATIENT SERVICE COST CENTERS	(004	004 044	0.00046	.0	-	00.00
	08800 RURAL HEALTH CLINIC	6, 821		1		0	88. 00
	08801 RURAL HEALTH CLINIC IV	128, 651		1		0	88. 03
	09000 CLINIC	280, 260		1		-	
	09100 EMERGENCY	273, 678		1		-	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	163, 947					92.00
200.00	Total (lines 50-199)	3, 228, 073	51, 629, 867	1	3, 939, 406	159, 072	1200. 00

Health Financial Systems	FRANCI SCAN HEALTH	RENSSELAER	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-1324	Peri od:	Worksheet D
THROUGH COSTS			From 01/01/2016	

INKOUGH COSTS				o 12/31/2016		
		Title	xVIII	Hospi tal	8/8/2017 10: 1 Cost	9 am
Cost Center Description	Non Physician Nu				Total Cost	
oost conten bescription	Anesthetist	ii si iig school	The road thouse the	Medi cal	(sum of col 1	
	Cost			Education Cost	•	
					4)	
	1.00	2.00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0	C	0	0	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0	C	0	0	54. 00
60. 00 06000 LABORATORY	0	0	C	0	0	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	C	0	0	63. 00
65. 00 06500 RESPI RATORY THERAPY	0	0	C	0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0	0	C	0	0	66. 00
66. 01 06601 WHEATFIELD PT	0	0	C	0	0	66. 01
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	C	0	0	67. 00
67. 01 06701 WHEATFIELD OT	0	0	C	0	0	67. 01
68. 00 06800 SPEECH PATHOLOGY	0	0	C	0	0	68. 00
68. 01 06801 WHEATFI ELD ST	0	0	C	0	0	68. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	C	0	0	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	C	0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	C	0	0	72. 00
73. 00 O7300 DRUGS CHARGED TO PATIENTS	0	0	C	0	0	73. 00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	0	C	0	0	88. 00
88. 03 08801 RURAL HEALTH CLINIC IV	0	0	C	0	0	88. 03
90. 00 09000 CLI NI C	0	0	C	0	0	90. 00
91. 00 09100 EMERGENCY	0	0	C	0	0	91. 00
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	(C	0	0	92. 00
200.00 Total (lines 50-199)	0	0	(C	0	0	200. 00

Health Financial Systems	FRANCI SCAN HEALTH	RENSSELAER	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-1324	Peri od: From 01/01/2016 To 12/31/2016	Worksheet D Part IV Date/Time Prepared: 8/8/2017 10:19 am

Title XVIII	
Outpatient Cost (sum of Source))))	
Cost (sum of Part I, col. (col. 5 ÷ col. to Charges (col. 2, 3 and 8) 7) (col. 6 ÷ col. 4) (col. 6 + col. 7)	
col . 2, 3 and 8) 7) (col . 6 ÷ col . 4) 7)	
4) 7)	
6.00 7.00 8.00 9.00 10.00	
ANCILLARY SERVICE COST CENTERS	
50. 00 05000 0PERATI NG ROOM 0 4, 120, 781 0. 000000 0. 000000 156, 38	
54. 00 05400 RADI 0LOGY-DI AGNOSTI C 0 10, 230, 451 0. 000000 0. 000000 434, 10	
60. 00 06000 LABORATORY 0 8, 929, 285 0. 000000 0. 000000 771, 50	
63. 00 06300 BLOOD STORING, PROCESSING & TRANS. 0 175, 885 0.000000 0.000000 69, 60	
65. 00 06500 RESPI RATORY THERAPY 0 2, 872, 787 0. 000000 0. 000000 758, 70	•
66. 00 06600 PHYSI CAL THERAPY 0 1, 248, 128 0. 000000 0. 000000 81, 4	
66. 01 06601 WHEATFI ELD PT 0 1, 283, 228 0. 000000 0. 000000	0 66. 01
67. 00 06700 0CCUPATI ONAL THERAPY 0 359, 256 0. 000000 0. 000000 55, 49	
67. 01 06701 WHEATFI ELD 0T 0 157, 676 0. 000000 0. 000000	0 67. 01
68. 00 06800 SPEECH PATHOLOGY 0 150, 636 0. 000000 0. 000000 15, 94	
68. 01 06801 WHEATFI ELD ST 0 100, 944 0. 000000 0. 000000	0 68. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0. 000000 0. 000000	0 70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 2,503,446 0.000000 0.000000 329,66	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT 0 274,968 0.000000 0.000000 7,8	7 72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS 0 9, 017, 865 0. 000000 0. 000000 1, 122, 13	5 73.00
OUTPATIENT SERVICE COST CENTERS	
88. 00 08800 RURAL HEALTH CLINIC 0 231, 944 0. 000000 0. 000000	0 88. 00
88. 03 08801 RURAL HEALTH CLINIC IV 0 410, 218 0. 000000 0. 000000	0 88. 03
90. 00 09000 CLI NI C 0 3, 309, 162 0. 000000 0. 000000 65, 1°	6 90.00
91. 00 09100 EMERGENCY 0 4, 490, 239 0. 000000 0. 000000 38, 1°	
92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 0 1,762,968 0.000000 0.000000 33,16	
200.00 Total (lines 50-199) 0 51,629,867 3,939,40	6 200. 00

Health Financial Systems	FRANCI SCAN HEALTH	RENSSELAER	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-1324	Peri od:	Worksheet D
THROUGH COSTS			From 01/01/2016	Part IV

					lo 12/31/2016	Date/lime Pro 8/8/2017 10:	
			Ti tl e	e XVIII	Hospi tal	Cost	17 4111
	Cost Center Description	Inpatient	Outpati ent	Outpati ent			
	·	Program	Program	Program			
		Pass-Through	Charges	Pass-Through			
		Costs (col. 8		Costs (col. 9			
		x col. 10)		x col. 12)			
		11.00	12.00	13. 00			
	ANCILLARY SERVICE COST CENTERS				_		
	05000 OPERATING ROOM	0	C)			50. 00
	05400 RADI OLOGY-DI AGNOSTI C	0	C)			54. 00
60.00	06000 LABORATORY	0	C)			60. 00
	06300 BLOOD STORING, PROCESSING & TRANS.	0	C)			63. 00
65. 00	06500 RESPI RATORY THERAPY	0	C)			65. 00
66. 00	06600 PHYSI CAL THERAPY	0	C)			66. 00
	06601 WHEATFI ELD PT	0	C)			66. 01
67. 00	06700 OCCUPATI ONAL THERAPY	0	C)			67. 00
67. 01	06701 WHEATFI ELD OT	0	C)			67. 01
	06800 SPEECH PATHOLOGY	0	C)			68. 00
	06801 WHEATFI ELD ST	0	C)			68. 01
	07000 ELECTROENCEPHALOGRAPHY	0	C)			70. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	C)			71. 00
	07200 I MPL. DEV. CHARGED TO PATIENT	0	C)	O		72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	C)			73. 00
	OUTPATIENT SERVICE COST CENTERS						
	08800 RURAL HEALTH CLINIC	0	C)			88. 00
	08801 RURAL HEALTH CLINIC IV	0	C)			88. 03
	09000 CLI NI C	0	C)			90. 00
	09100 EMERGENCY	0	C)			91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	C)			92. 00
200.00	Total (lines 50-199)	0	C))		200. 00

Health Financial Systems	FRANCI SCAN HEALTH RENSSELAER			u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provi der CCN: 15-1324	Peri od:	Worksheet D

From 01/01/2016 | Part V To 12/31/2016 | Date/Time Prepared: 8/8/2017 10:19 am Title XVIII Hospi tal Cost Charges Costs Cost to Charge PPS Reimbursed PPS Services Cost Center Description Cost Cost Services (see Ratio From Rei mbursed Rei mbursed (see inst.) Worksheet C, inst.) Servi ces Services Not Part I, col. 9 Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) 3.00 (see inst.) 1. 00 2.00 5. 00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 554049 1, 220, 188 0 50.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0. 392964 3, 195, 223 0 0 0 0 0 0 0 0 54.00 06000 LABORATORY 0. 378750 2, 998, 253 60 00 0 60 00 0 06300 BLOOD STORING, PROCESSING & TRANS. 63.00 0.629286 0 63, 845 0 63.00 65.00 06500 RESPIRATORY THERAPY 0.659497 791, 998 0 65.00 66.00 06600 PHYSI CAL THERAPY 1.043341 506, 378 0 66.00 413, 910 06601 WHEATFIELD PT 66. 01 1.243820 0 66.01 67.00 06700 OCCUPATIONAL THERAPY 1.514274 59, 704 0 67.00 06701 WHEATFIELD OT 67.01 2.189382 23, 380 0 67.01 06800 SPEECH PATHOLOGY 2. 079483 68.00 68 00 24, 517 0 68.01 06801 WHEATFIELD ST 2. 215367 0 4, 177 0 68.01 70.00 07000 ELECTROENCEPHALOGRAPHY 0.000000 0 0 70.00 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.530146 0 713, 548 71.00 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENT Ω 163, 370 0.623756 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.489437 0 3, 356, 500 550 0 73.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0.000000 0 88. 00 08801 RURAL HEALTH CLINIC IV 0.000000 88.03 88.03 0 90.00 09000 CLI NI C 0. 961578 1, 326, 274 240 0 90.00 09100 EMERGENCY 0.893123 1, 258, 626 91.00 91.00 0 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 0.574712 0 694.071 0 0 0 200. 00 200.00 Subtotal (see instructions) Ω 16, 813, 962 790 201.00 Less PBP Clinic Lab. Services-Program 201.00 0 Only Charges 0 202.00 202.00 Net Charges (line 200 +/- line 201) 16, 813, 962 790

Health Financial Systems		FRANCI SCAN	N HEALTH	RENSSELAER		In Lieu	u of Form CMS-2552-10	
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES	AND VACCINE	COST	Provider CCN:	15-1324	Peri od: From 01/01/2016	Worksheet D	
							Date/Time Prepared	

				From 01/01/2016 To 12/31/2016	Part V Date/Time Pre 8/8/2017 10:	
		Title	XVIII	Hospi tal	Cost	
	Cos	sts				
Cost Center Description	Cost	Cost				
	Rei mbursed	Reimbursed				
	Servi ces	Servi ces Not				
	Subject To	Subj ect To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
	6. 00	7. 00				
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	676, 044		1			50. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 255, 608)			54. 00
60. 00 06000 LABORATORY	1, 135, 588	0)			60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	40, 177	0)			63. 00
65. 00 06500 RESPI RATORY THERAPY	522, 320	0)			65. 00
66. 00 06600 PHYSI CAL THERAPY	528, 325)			66. 00
66. 01 06601 WHEATFI ELD PT	514, 830	0)			66. 01
67. 00 06700 OCCUPATI ONAL THERAPY	90, 408	0)			67. 00
67. 01 06701 WHEATFI ELD OT	51, 188	0)			67. 01
68.00 06800 SPEECH PATHOLOGY	50, 983	0)			68. 00
68. 01 06801 WHEATFI ELD ST	9, 254	0)			68. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0)			70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	378, 285	0				71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	101, 903	0				72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	1, 642, 795	269				73. 00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	0				88. 00
88.03 08801 RURAL HEALTH CLINIC IV	0	0				88. 03
90. 00 09000 CLI NI C	1, 275, 316	231				90. 00
91. 00 09100 EMERGENCY	1, 124, 108	0				91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	398, 891	0				92. 00
200.00 Subtotal (see instructions)	9, 796, 023	500				200. 00
201.00 Less PBP Clinic Lab. Services-Program	0					201. 00
Only Charges						
202.00 Net Charges (line 200 +/- line 201)	9, 796, 023	500	o			202. 00

Health Financial Systems	FRANCI SCAN HEALTH	RENSSELAER	In Lie	u of Form CMS-2552-10
APPORTI ONMENT OF MEDICAL, OT	HER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-1324	Period: From 01/01/2016	Worksheet D Part V
		Component CCN: 15-Z324		

		Component	CCN: 15-Z324	To 12/31/2016		
		Title	XVIII	Swing Beds - SNF		
			Charges		Costs	
Cost Center Description	Cost to Charge			Cost	PPS Services	
		Services (see	Reimbursed	Rei mbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins			
	1.00	0.00	(see inst.)	(see inst.)	F 00	
ANOULL ADV. CEDVILOE, COCT, CENTEDO	1.00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS	0 554040					FO 00
50. 00 05000 OPERATING ROOM	0. 554049	0		0	0	00.00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	0. 392964	0		0	0	0 00
60. 00 06000 LABORATORY	0. 378750	0		0	0	00.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 629286	0		0	0	00.00
65. 00 06500 RESPI RATORY THERAPY	0. 659497	0		0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	1. 043341	0		0	0	66. 00
66. 01 06601 WHEATFI ELD PT	1. 243820	0		0	0	66. 01
67. 00 06700 0CCUPATI ONAL THERAPY 67. 01 06701 WHEATFI ELD OT	1. 514274	0		0	0	67.00
	2. 189382 2. 079483	0		0	0	67. 01
		0		0	0	68. 00
	2. 215367	0		0	0	68. 01
70.00 07000 ELECTROENCEPHALOGRAPHY 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0		0	0	70. 00 71. 00
72. 00 07700 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 530146 0. 623756	0		0	0	1
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 623756	0	•	0	0 0	
OUTPATIENT SERVICE COST CENTERS	0. 489437	U		0 0	U	73.00
88. 00 08800 RURAL HEALTH CLINIC	0. 000000		I		0	88. 00
88. 03 08801 RURAL HEALTH CLINIC IV	0. 000000				0	88. 03
90. 00 09000 CLI NI C	0. 961578	0		0	0	90.00
91. 00 09100 EMERGENCY	0. 893123	0			0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 574712	0			0	92. 00
200.00 Subtotal (see instructions)	0. 374712	0			·	200. 00
201.00 Less PBP Clinic Lab. Services-Program		0			0	201. 00
Only Charges						201.00
202.00 Net Charges (line 200 +/- line 201)		0		0 0	0	202. 00
	1 1	O	1	-1	ı	1=32.00

Health Financial Systems	FRANCI SCAN HEAL	TH RENSSELAER		In Lie	u of Form CMS-2	552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICE	S AND VACCINE COST	Provi der CO	CN: 15-1324	Peri od: From 01/01/2016	Worksheet D Part V	
		Component (CCN: 15-Z324	To 12/31/2016	Date/Time Prep 8/8/2017 10:19	oared: am
		Title	XVIII	Swing Beds - SNF	Cost	
	Со	sts				
Cost Center Description	Cost	Cost				
	Rei mbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst)	(see inst)				

		Subject To	Subject To	
		Ded. & Coins.	Ded. & Coins.	
		(see inst.)	(see inst.)	
		6. 00	7. 00	
	ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATI NG ROOM	0	0	50. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0	54. 00
60.00	06000 LABORATORY	0	0	60. 00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	63. 00
65.00	06500 RESPI RATORY THERAPY	0	0	65. 00
66.00	06600 PHYSI CAL THERAPY	0	0	66. 00
66. 01	06601 WHEATFI ELD PT	0	0	66. 01
67.00	06700 OCCUPATI ONAL THERAPY	0	0	67. 00
67. 01	06701 WHEATFI ELD OT	0	0	67. 01
68.00	06800 SPEECH PATHOLOGY	0	0	68. 00
68. 01	06801 WHEATFI ELD ST	0	0	68. 01
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	73. 00
	OUTPATIENT SERVICE COST CENTERS	1		
88. 00	08800 RURAL HEALTH CLINIC	0	0	88. 00
	08801 RURAL HEALTH CLINIC IV	0	0	88. 03
	09000 CLI NI C	0	0	90. 00
	09100 EMERGENCY	0	0	91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92. 00
200.00		0	0	200. 00
201.00		0		201. 00
	Only Charges			
202.00	Net Charges (line 200 +/- line 201)	0	0	202. 00

Health Financial Systems	FRANCISCAN HEAL	TH RENSSELAER		In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	SS THROUGH COST	rs Provider C		Period: From 01/01/2016 To 12/31/2016		epared: 9 am
		Titl	e XIX	Hospi tal	Cost	
Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cos		Total Costs (sum of cols. 1 through 3, minus col. 4)	
	1.00	2. 00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS			•			
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT 200. 00 Total (lines 30-199)	0	0		0 0 0	0 0	30. 00 31. 00 200. 00
Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
INPATIENT ROUTINE SERVICE COST CENTERS	0.00	7.00	0.00	7. 00		
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT 200. 00 Total (Lines 30-199)	2, 999 323 3, 322	0.00	1	3 0 6 0 9 0		30. 00 31. 00 200. 00

Health Financial Systems	FRANCI SCAN HEALTH	RENSSELAER	In Lieu	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-1324	Peri od:	Worksheet D
THROUGH COSTS			From 01/01/2016	Part IV

11111000				Ť	o 12/31/2016	Date/Time Pre 8/8/2017 10:1	pared: 9 am
			Titl	e XIX	Hospi tal	Cost	
	Cost Center Description	Non Physician Nu	rsing School	Allied Health	All Other	Total Cost	
		Anestheti st			Medi cal	(sum of col 1	
		Cost			Education Cost	through col.	
						4)	
	[1.00	2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS			_			
	05000 OPERATING ROOM	0	0		0	0	50.00
	05400 RADI OLOGY-DI AGNOSTI C	0	0		0	0	54.00
	06000 LABORATORY	0	0		0	0	60.00
	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0	0	63.00
65. 00	06500 RESPI RATORY THERAPY	0	0		0	0	65.00
	06600 PHYSI CAL THERAPY	0	0		0	0	66.00
	06601 WHEATFIELD PT	0	0		0	0	66. 01
	06700 OCCUPATI ONAL THERAPY	0	0		0	0	67.00
	06701 WHEATFI ELD OT	0	0		0	0	67. 01
	06800 SPEECH PATHOLOGY	0	0		0	0	68. 00
	06801 WHEATFIELD ST	0	0			0	68. 01
	07000 ELECTROENCEPHALOGRAPHY	0	0			0	70.00
	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	0			0	71.00
	07200 I MPL. DEV. CHARGED TO PATIENT	0	0			0	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	U U	0) 0	0	73. 00
00.00	OUTPATIENT SERVICE COST CENTERS						00.00
	08800 RURAL HEALTH CLINIC	0	0			0	88. 00
	08801 RURAL HEALTH CLINIC IV	0	0			0	88. 03
	09000 CLI NI C	0	0			0	90.00
	09100 EMERGENCY	0	0			0	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0			0	92.00
200.00	Total (lines 50-199)	[0	0	[C	이 이	0	200. 00

Health Financial Systems	FRANCI SCAN HEALTH	RENSSELAER	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	ERVICE OTHER PASS	Provider CCN: 15	-1324 Period: From 01/01/2016	Worksheet D	
THROUGH COSTS				Date/Time Prep	
		Title XIX	Hospi tal	8/8/2017 10: 19 Cost	9 am
Cost Center Description		otal Charges Ratio	o of Cost Outpatient	Inpati ent	

			'	0 12/31/2010	8/8/2017 10: 1	
		Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description	Total		Ratio of Cost		I npati ent	
		(from Wkst. C,		Ratio of Cost	Program	
	Cost (sum of		$(col. 5 \div col.$		Charges	
	col. 2, 3 and	8)	7)	(col. 6 ÷ col.		
	4)			7)		
	6. 00	7. 00	8. 00	9. 00	10. 00	
ANCI LLARY SERVI CE COST CENTERS		1 400 704			0.10	
50. 00 05000 OPERATI NG ROOM	0	4, 120, 781	l .		963	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	10, 230, 451	l .		•	1
60. 00 06000 LABORATORY	0	8, 929, 285	1		15, 921	60.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	175, 885	1		•	1
65. 00 06500 RESPI RATORY THERAPY	0	2, 872, 787	l .		•	65.00
66. 00 06600 PHYSI CAL THERAPY	0	1, 248, 128	1		3, 350	1
66. 01 06601 WHEATFI ELD PT	0	1, 283, 228	1		0	66. 01
67. 00 06700 OCCUPATI ONAL THERAPY	0	359, 256	1		0	67.00
67. 01 06701 WHEATFI ELD OT	0	157, 676	1		0	67. 01
68. 00 06800 SPEECH PATHOLOGY	0	150, 636	1		0	68. 00
68. 01 06801 WHEATFI ELD ST	0	100, 944	1		0	68. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0.500.44	0.000000		0	70.00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	2, 503, 446			895	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT	0	274, 968			0	72.00
73. 00 O7300 DRUGS CHARGED TO PATIENTS	0	9, 017, 865	0.000000	0.000000	26, 625	73. 00
OUTPATIENT SERVICE COST CENTERS		004.04	1 0 00000	0.00000	0	00.00
88. 00 08800 RURAL HEALTH CLINIC	0	231, 944	1		0	88. 00
88. 03 08801 RURAL HEALTH CLINIC IV	0	410, 218	1			88. 03
90. 00 09000 CLI NI C	0	3, 309, 162	1		2, 098	ı
91. 00 09100 EMERGENCY	0	4, 490, 239	1		1, 041	1
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	1, 762, 968	1	0. 000000		, ,
200.00 Total (lines 50-199)	1 0	51, 629, 867	Ί	1	76, 319	J200. 00

Health Financial Systems	FRANCI SCAN HEALTH	RENSSELAER	In Lieu	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-1324		Worksheet D Part IV Date/Time Prepared:

					lo 12/31/2016	Date/lime Pro 8/8/2017 10:	
			Ti tI	e XIX	Hospi tal	Cost	17 4111
	Cost Center Description	Inpatient	Outpati ent	Outpati ent			
	·	Program	Program	Program			
		Pass-Through	Charges	Pass-Through			
		Costs (col. 8		Costs (col. 9			
		x col. 10)		x col. 12)			
		11.00	12.00	13. 00			
	ANCILLARY SERVICE COST CENTERS				_		
	05000 OPERATING ROOM	0	C) (50. 00
	05400 RADI OLOGY-DI AGNOSTI C	0	C				54. 00
60.00	06000 LABORATORY	0	C) (60. 00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	C) (O		63. 00
65. 00	06500 RESPI RATORY THERAPY	0	C				65. 00
66. 00	06600 PHYSI CAL THERAPY	0	C				66. 00
	06601 WHEATFI ELD PT	0	C				66. 01
67. 00	06700 OCCUPATI ONAL THERAPY	0	C				67. 00
67. 01	06701 WHEATFI ELD OT	0	C				67. 01
	06800 SPEECH PATHOLOGY	0	C				68. 00
	06801 WHEATFI ELD ST	0	C				68. 01
	07000 ELECTROENCEPHALOGRAPHY	0	C				70. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	C) (71. 00
	07200 IMPL. DEV. CHARGED TO PATIENT	0	C) (72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	C	(73. 00
	OUTPATIENT SERVICE COST CENTERS						
	08800 RURAL HEALTH CLINIC	0	C) (O		88. 00
	08801 RURAL HEALTH CLINIC IV	0	C) (O		88. 03
	09000 CLI NI C	0	C) (O		90. 00
	09100 EMERGENCY	0	C	(91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	C	(92. 00
200.00	Total (lines 50-199)	0	C	(0		200. 00

Health Financial Systems	FRANCISCAN HEALTH RENSSELAER	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-1324	Peri od: From 01/01/2016	Worksheet D-1	
		To 12/31/2016	Date/Time Pre 8/8/2017 10:1	
	Title XVIII	Hospi tal	Cost	
Cost Center Description				
			1. 00	
DART I _ ALL PROVIDER COMPONENTS				

		Title XVIII	Hospi tal	Cost	<i>y</i> diii
	Cost Center Description				
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days	s, excluding newborn)		3, 375	1. 00
2.00	Inpatient days (including private room days, excluding swing-			2, 999	2. 00
3.00	Private room days (excluding swing-bed and observation bed day do not complete this line.	ys). If you have only pri	vate room days,	0	3. 00
4.00	Semi-private room days (excluding swing-bed and observation be	ed davs)		2, 106	4. 00
5.00	Total swing-bed SNF type inpatient days (including private roo		r 31 of the cost	376	5. 00
	reporting period		24 6 11		, 00
6. 00	Total swing-bed SNF type inpatient days (including private roof reporting period (if calendar year, enter 0 on this line)	om days) after December .	31 of the cost	0	6. 00
7.00	Total swing-bed NF type inpatient days (including private room	m days) through December	31 of the cost	0	7. 00
	reporting period				
8. 00	Total swing-bed NF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	m days) after December 3	1 of the cost	0	8. 00
9. 00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	1, 532	9. 00
7.00	newborn days)	o the trogram (exertaining	Sin rig 200 and	., 552	7. 00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII or		oom days)	376	10. 00
11. 00	through December 31 of the cost reporting period (see instructions). Swing-bed SNF type inpatient days applicable to title XVIII or		nom dave) after	0	11. 00
11.00	December 31 of the cost reporting period (if calendar year, en		Join days) arter	O	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX	X only (including private	e room days)	0	12. 00
13. 00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XIX	V only (including private	a room days)	0	13. 00
13.00	after December 31 of the cost reporting period (if calendar ye			U	13.00
14.00	Medically necessary private room days applicable to the Progra			0	14. 00
15. 00	Total nursery days (title V or XIX only)			0	15. 00
16. 00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			0	16. 00
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 of	f the cost		17. 00
	reporting period	3			
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost		18. 00
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	s through December 31 of	the cost	129. 14	19 00
17.00	reporting period	3 through becomber 31 of	the cost	127. 17	17.00
20. 00	Medicaid rate for swing-bed NF services applicable to services	s after December 31 of th	ne cost	0. 00	20. 00
21. 00	reporting period Total general inpatient routine service cost (see instructions	-)		3, 829, 272	21. 00
21.00	Swing-bed cost applicable to SNF type services through December		na period (line	3, 629, 272	22. 00
	5 x line 17)	·			
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reporting	g period (line 6	0	23. 00
24. 00	x line 18) Swing-bed cost applicable to NF type services through December	r 31 of the cost reportio	na period (line	0	24. 00
21.00	7 x line 19)	or or the cost reportin	ig perrod (Trile	G	21.00
25. 00	Swing-bed cost applicable to NF type services after December :	31 of the cost reporting	period (line 8	0	25. 00
26. 00	x line 20) Total swing-bed cost (see instructions)			426, 610	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		3, 402, 662	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	,			
	General inpatient routine service charges (excluding swing-bed	d and observation bed cha	arges)	0	
29. 00 30. 00	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	29. 00 30. 00
31. 00	General inpatient routine service cost/charge ratio (line 27	÷ line 28)		0. 000000	
32.00	Average private room per diem charge (line 29 ÷ line 3)	,		0.00	32. 00
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)	1: 00) (0.00	
34. 00 35. 00	Average per diem private room charge differential (line 32 mil Average per diem private room cost differential (line 34 x li		tions)	0. 00 0. 00	
36. 00	Private room cost differential adjustment (line 3 x line 35)	16 31)		0.00	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line	3, 402, 662	
	27 minus line 36)				
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	ISTMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see			1, 134. 60	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line			1, 738, 207	
	Medically necessary private room cost applicable to the Progra	,		0	40.00
41.00	Total Program general inpatient routine service cost (line 39	+ IINE 40)	l	1, 738, 207	41.00

	Financial Systems ATION OF INPATIENT OPERATING COST	FRANCI SCAN HEALT	H RENSSELAER Provi der C	°N: 15_1224	In Lie	u of Form CMS-2 Worksheet D-1	
COMPUT	ATTON OF INPATTENT OPERATING COST		Provider C	JN. 13-1324	From 01/01/2016 To 12/31/2016		
						8/8/2017 10: 1	
	Cost Center Description	Total	Ti tl e Total	XVIII Average Per	Hospital Program Days	Cost Program Cost	
	oost senter bescription	Inpatient Cost				(col. 3 x col. 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	1, 531, 985	323	4, 742.	99 224	1, 062, 430	43.00
44. 00	CORONARY CARE UNIT	, , , , , ,				, ,	44. 00
45.00	BURN INTENSIVE CARE UNIT						45. 00
46. 00 47. 00	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						46. 00 47. 00
	Cost Center Description			1			
48. 00	Program inpatient ancillary service cost (W	/kst D-3 col 3	line 200)			1. 00 2, 140, 464	48. 00
	Total Program inpatient costs (sum of lines		,	ns)		4, 941, 101	1
50. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program in	notiont routing	and and (from	Wka+ D aum	n of Donto L and	0	50.00
30.00	Hass through costs appricable to Program in	ipatrent routine s	services (IIOII	WKSt. D, Sui	ii Oi Pai tS i aiiu	0	30.00
51. 00	Pass through costs applicable to Program in	npatient ancillary	y services (fr	om Wkst. D, s	sum of Parts II	0	51.00
52. 00	and IV) Total Program excludable cost (sum of lines	s 50 and 51)				0	52. 00
53. 00	Total Program inpatient operating cost excl	uding capital rel	ated, non-phy	sician anesth	netist, and	0	53. 00
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	9 52)					1
	Program di scharges						54. 00
	Target amount per discharge						55.00
56. 00 57. 00	Target amount (line 54 x line 55) Difference between adjusted inpatient opera	nting cost and tai	aet amount (I	ine 56 minus	line 53)	0	56. 00 57. 00
58. 00	Bonus payment (see instructions)	Ü			ŕ	0	58. 00
59. 00	Lesser of lines 53/54 or 55 from the cost r market basket	reporting period (endi ng 1996, u	pdated and co	ompounded by the	0. 00	59. 00
60.00	Lesser of lines 53/54 or 55 from prior year	cost report, upo	dated by the m	arket basket		0.00	60.00
61. 00	If line 53/54 is less than the lower of lin					0	61.00
	which operating costs (line 53) are less the amount (line 56), otherwise enter zero (see		s (Tines 54 X	60), OF 1% O	the target		
	Relief payment (see instructions)	•				0	
63. 00	Allowable Inpatient cost plus incentive pay PROGRAM INPATIENT ROUTINE SWING BED COST	ment (see instru	ctions)			0	63. 00
64. 00	Medicare swing-bed SNF inpatient routine co	sts through Dece	mber 31 of the	cost reporti	ng period (See	426, 610	64. 00
65. 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine co	osts after Decembe	er 31 of the c	ost reporting	a period (See	0	65.00
	instructions)(title XVIII only)			,			
66. 00	Total Medicare swing-bed SNF inpatient rout CAH (see instructions)	ine costs (line o	64 plus line 6	5)(title XVII	I only). For	426, 610	66.00
67. 00	Title V or XIX swing-bed NF inpatient routi	ne costs through	December 31 c	f the cost re	eporting period	0	67. 00
68 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routi	ne costs after De	ecember 31 of	the cost repo	orting period	0	68. 00
	(line 13 x line 20)			•	or tring porrou		
69. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER	•				0	69.00
70.00	Skilled nursing facility/other nursing faci	lity/ICF/IID rou	tine service c	ost (line 37))		70.00
71. 00 72. 00	Adjusted general inpatient routine service Program routine service cost (line 9 x line		ne 70 ÷ line	2)			71. 00
73. 00	Medically necessary private room cost appli		(line 14 x li	ne 35)			73. 00
74. 00	Total Program general inpatient routine ser	•					74. 00
75. 00	Capital-related cost allocated to inpatient 26. line 45)	routine service	costs (from W	orksheet B, F	Part II, column		75. 00
76. 00	Per diem capital-related costs (line 75 ÷ l						76. 00
77. 00 78. 00	Program capital-related costs (line 9 x lir Inpatient routine service cost (line 74 mir						77. 00 78. 00
79. 00	Aggregate charges to beneficiaries for exce	,	rovi der record	s)			79.00
80.00	Total Program routine service costs for com	nparison to the co		*	nus line 79)		80.00
81. 00 82. 00	Inpatient routine service cost per diem lim Inpatient routine service cost limitation (1				81. 00 82. 00
83. 00	Reasonable inpatient routine service cost	•					83.00
84.00	Program inpatient ancillary services (see i	nstructions)					84. 00
85. 00	Utilization review - physician compensatior Total Program inpatient operating costs (su						85. 00 86. 00
86 NN			ough 00)			<u> </u>	1 00.00
86. 00	PART IV - COMPUTATION OF OBSERVATION BED PA	SS THROUGH COST					
86. 00 87. 00 88. 00	Total observation bed days (see instruction Adjusted general inpatient routine cost per	ns)	Line 2)			893 1, 134. 60	1

Health Financial Systems	FRANCI SCAN HEAL	TH RENSSELAER		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2016 To 12/31/2016		
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	619, 620	3, 829, 272	0. 16181	1 1, 013, 198	163, 947	90.00
91.00 Nursing School cost	0	3, 829, 272	0.00000	1, 013, 198	0	91.00
92.00 Allied health cost	0	3, 829, 272	0.00000	1, 013, 198	0	92.00
93.00 All other Medical Education	0	3, 829, 272	0.00000	1, 013, 198	0	93.00

Health Financial Systems	FRANCISCAN HEALTH RENSSELAER	In Lie	u of Form CMS-:	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-1324	Peri od: From 01/01/2016 To 12/31/2016	Worksheet D-1 Date/Time Pre 8/8/2017 10:1	pared:
	Title XIX	Hospi tal	Cost	
Cost Center Description				
			1. 00	
PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS				

		Title XIX	Hospi tal	Cost	
	Cost Center Description		-	1 00	
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days	s, excluding newborn)		3, 375	1. 00
2.00	Inpatient days (including private room days, excluding swing-	bed and newborn days)		2, 999	2. 00
3.00	Private room days (excluding swing-bed and observation bed day	ys). If you have only pr	vate room days,	0	3. 00
4.00	do not complete this line. Semi-private room days (excluding swing-bed and observation by	ad days)		2, 106	4. 00
5.00	Total swing-bed SNF type inpatient days (including private ro		r 31 of the cost	2, 100	5. 00
0.00	reporting period	om dayo, em ougn boodinbo	0. 0. 1 0001	١	0.00
6.00	Total swing-bed SNF type inpatient days (including private ro	om days) after December :	31 of the cost	0	6. 00
7.00	reporting period (if calendar year, enter 0 on this line)		24 6 11		7.00
7. 00	Total swing-bed NF type inpatient days (including private room reporting period	m days) through December	31 of the cost	0	7. 00
8.00	Total swing-bed NF type inpatient days (including private room	m davs) after December 3	1 of the cost	0	8. 00
	reporting period (if calendar year, enter 0 on this line)	3 7			
9. 00	Total inpatient days including private room days applicable to	o the Program (excluding	swi ng-bed and	23	9. 00
10. 00	newborn days) Swing-bed SNF type inpatient days applicable to title XVIII o	nly (including private r	nom dave)	0	10. 00
10.00	through December 31 of the cost reporting period (see instruc		Join days)	١	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII o		oom days) after	0	11. 00
40.00	December 31 of the cost reporting period (if calendar year, e			ا	40.00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XI through December 31 of the cost reporting period	X only (including private	e room days)	0	12. 00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI	X only (including private	e room days)	0	13. 00
	after December 31 of the cost reporting period (if calendar ye	ear, enter O on this line	e) ,		
14. 00	Medically necessary private room days applicable to the Progra	am (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			U	16.00
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 o	f the cost		17. 00
	reporting period				
18. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es after December 31 of	the cost		18. 00
19. 00	Medicaid rate for swing-bed NF services applicable to services	s through December 31 of	the cost	0.00	19. 00
	reporting period	3			
20. 00	Medicaid rate for swing-bed NF services applicable to services	s after December 31 of t	ne cost	0. 00	20. 00
21. 00	reporting period Total general inpatient routine service cost (see instructions	5)		3, 829, 272	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December		ing period (line	0	22. 00
	5 x line 17)				
23. 00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reporting	g period (line 6	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December	r 31 of the cost reporti	na period (line	0	24. 00
21.00	7 x line 19)		.g po ou (١	2 00
25. 00	Swing-bed cost applicable to NF type services after December	31 of the cost reporting	period (line 8	0	25. 00
26. 00	x line 20) Total swing-bed cost (see instructions)			0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		3, 829, 272	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		1		
	General inpatient routine service charges (excluding swing-be	d and observation bed ch	arges)	0	
	Private room charges (excluding swing-bed charges)			0	
30.00	Semi-private room charges (excluding swing-bed charges)	. line 20)		0 000000	
31. 00 32. 00	General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 ÷ line 3)	- IIIIC 20 <i>)</i>		0. 000000 0. 00	
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)				
		nus lino 22)/sss instant	tions)	0.00	
34. 00	Average per diem private room charge differential (line 32 min	, ,	11 0115)	0.00	
35. 00	Average per diem private room cost differential (line 34 x li	ne 31)		0.00	
36. 00	Private room cost differential adjustment (line 3 x line 35)			0	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line	3, 829, 272	37. 00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	JSTMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see			1, 276. 85	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line			29, 368	
40. 00	Medically necessary private room cost applicable to the Progra	•		0	40. 00
	Total Program general inpatient routine service cost (line 39	,		29, 368	
				•	

	Total Swing-bed Cost (See Instructions)	0
27. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3, 829, 272
	PRI VATE ROOM DI FFERENTI AL ADJUSTMENT	
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0
29.00	Pri vate room charges (excluding swing-bed charges)	0
30.00	Semi -pri vate room charges (excluding swing-bed charges)	0
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	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
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line	3, 829, 272
	27 minus line 36)	
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS	
38. 00	Adjusted general inpatient routine service cost per diem (see instructions)	1, 276. 85
39. 00	Program general inpatient routine service cost (line 9 x line 38)	29, 368
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	29, 368

(,()[()()))	Financial Systems ATION OF INPATIENT OPERATING COST	FRANCI SCAN HEALT	Provider C	°N: 15_1224	In Lie Period:	u of Form CMS-2 Worksheet D-1	
COMPUT	ATTON OF INPATTENT OPERATING COST		Provider C	JN. 15-1324	From 01/01/2016 To 12/31/2016		
				VIV		8/8/2017 10: 1	
	Cost Center Description	Total	Total	e XIX Average Per	Hospital Program Days	Cost Program Cost	
	oost conton bood (pt. o.)	Inpatient Cost				(col. 3 x col.	
		1.00	0.00	col . 2)	4.00	4)	
42 00	NURSERY (title V & XIX only)	1.00	2. 00	3. 00	4. 00	5. 00	42. 00
42.00	Intensive Care Type Inpatient Hospital Unit	S					42.00
43.00	INTENSIVE CARE UNIT	1, 531, 985	323	4, 742.	99 6	28, 458	1
44.00	CORONARY CARE UNIT						44.00
45. 00 46. 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						45. 00 46. 00
	OTHER SPECIAL CARE (SPECIFY)						47. 00
	Cost Center Description						
48. 00	Program inpatient ancillary service cost (W	lkst D 2 col 2	Line 200)			1. 00 41, 004	48. 00
	Total Program inpatient costs (sum of lines		,	ns)		98, 830	1
	PASS THROUGH COST ADJUSTMENTS	· · · · · · · · · · · · · · · · · · ·		,		10,000]
50.00	Pass through costs applicable to Program in	patient routine s	services (from	Wkst. D, sun	n of Parts I and	0	50.00
51. 00	<pre> </pre>	natient ancillary	, services (fr	om Wkst D s	sum of Parts II	0	51.00
51.00	and IV)	patront unorridiy	, 30, 7, 603 (11	o moc. D, 3	Jun Or Full to 11		51.00
52. 00	Total Program excludable cost (sum of lines					0	
53. 00	Total Program inpatient operating cost excl medical education costs (line 49 minus line		ated, non-phy	sician anesth	netist, and	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION	; 52)					1
	Program di scharges						54. 00
	Target amount per discharge						55.00
56. 00 57. 00	, ,	ating cost and tag	caet amount (1	ine 56 minus	line 53)	0	56. 00 57. 00
58. 00	Bonus payment (see instructions)	iting cost and tai	get amount (i	THE 50 III HUS	11110 33)	ő	
59. 00	Lesser of lines 53/54 or 55 from the cost r	reporting period o	endi ng 1996, u	pdated and co	ompounded by the	0.00	59. 00
40.00	market basket	cost roport un	datad by the m	arkat backat		0.00	60.00
60. 00 61. 00	Lesser of lines 53/54 or 55 from prior year If line 53/54 is less than the lower of lin				the amount by	0.00	1
	which operating costs (line 53) are less th						
(2.00	amount (line 56), otherwise enter zero (see		(2.00				
	Relief payment (see instructions) Allowable Inpatient cost plus incentive pay		0 0				
00.00	PROGRAM INPATIENT ROUTINE SWING BED COST		, , , , , , , , , , , , , , , , , , ,]
64. 00		sts through Decer	mber 31 of the	cost reporti	ng period (See	0	64. 00
65. 00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine co</pre>	sts after Decembe	er 31 of the c	ost reporting	neriod (See	0	65.00
00.00	instructions) (title XVIII only)	oto di tei becembe		ost roportrii	g perrou (occ		00.00
66. 00	Total Medicare swing-bed SNF inpatient rout	ine costs (line 6	64 plus line 6	5)(title XVII	I only). For	0	66. 00
67. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routi	ne costs through	December 31 o	f the cost re	enorting period	0	67. 00
07.00	(line 12 x line 19)	ne costs till ough	December 51 c	THE COST TO	sporting period		07.00
68. 00	Title V or XIX swing-bed NF inpatient routi	ne costs after De	ecember 31 of	the cost repo	orting period	0	68. 00
69 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient	routine costs (ine 67 ± line	. 68)		0	69. 00
07.00	PART III - SKILLED NURSING FACILITY, OTHER						07.00
70. 00	Skilled nursing facility/other nursing faci)		70. 00
71. 00 72. 00	Adjusted general inpatient routine service Program routine service cost (line 9 x line		ne 70 ÷ line	2)			71. 00
73.00	Medically necessary private room cost appli		(line 14 x li	ne 35)			73.00
74. 00	Total Program general inpatient routine ser						74. 00
75. 00	Capital-related cost allocated to inpatient	routine service	costs (from ${\tt W}$	orksheet B, F	Part II, column		75. 00
76. 00	26, line 45) Per diem capital-related costs (line 75 ÷ l	ine 2)					76. 00
77. 00	Program capital -related costs (line 9 x lin	. *					77. 00
78.00	,						78. 00
79.00	Aggregate charges to beneficiaries for exce Total Program routine service costs for com				nus line 70)		79. 00 80. 00
81. 00	Inpatient routine service costs for com	•	ost iriiii tati Uli	CITIE 10 IIII I	143 TIHE 11)		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)					82. 00
83.00	Reasonable inpatient routine service costs		s)				83.00
84. 00	Program inpatient ancillary services (see i Utilization review - physician compensation		ns)				84. 00 85. 00
85 NO							86.00
85. 00 86. 00							
86. 00	PART IV - COMPUTATION OF OBSERVATION BED PA		, , , , , , , , , , , , , , , , , , ,				1_
		is)				893 1, 276. 85	87.00

Health Financial Systems	FRANCI SCAN HEAL	TH RENSSELAER		In Lie	eu of Form CMS-2	2552-10	
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1		
				From 01/01/2016 To 12/31/2016			
		Ti tl	e XIX	Hospi tal	Cost		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on		
		(from line 21)	column 2	Observati on	Bed Pass		
				Bed Cost (from	Through Cost		
				line 89)	(col. 3 x col.		
					4) (see		
					instructions)		
	1.00	2.00	3. 00	4. 00	5. 00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00 Capital -related cost	619, 620	3, 829, 272	0. 16181	1 1, 140, 227	184, 501	90. 00	
91.00 Nursing School cost	0	3, 829, 272	0.00000	1, 140, 227	0	91.00	
92.00 Allied health cost	0	3, 829, 272	0. 00000	1, 140, 227	0	92.00	
93 00 All other Medical Education	0	3 829 272	0 00000	1 140 227	0	93 00	

Health Financial Systems FRANCISCAN HEALTH RE INPATIENT ANCILLARY SERVICE COST APPORTIONMENT P		Provi der CCN: 15-1324		Peri od:	eu of Form CMS-2552- Worksheet D-3	
				From 01/01/2016		
				To 12/31/2016	Date/Time Pre 8/8/2017 10:1	
		Titl∈	XVIII	Hospi tal	Cost	
	Cost Center Description		Ratio of Cos	t Inpatient	I npati ent	
			To Charges		Program Costs	
				Charges	(col. 1 x col.	
					2)	
			1.00	2. 00	3. 00	
	ENT ROUTINE SERVICE COST CENTERS			4 054 000		
	ADULTS & PEDIATRICS			1, 254, 833		30.00
	INTENSIVE CARE UNIT LARY SERVICE COST CENTERS			304, 160		31. 00
	OPERATING ROOM		0. 55404	9 156, 385	86, 645	50.00
	RADI OLOGY-DI AGNOSTI C		0. 39296		170, 613	
	LABORATORY		0.37270		292, 228	
	BLOOD STORING, PROCESSING & TRANS.		0. 62928		43, 836	
	RESPI RATORY THERAPY		0. 65949		500, 360	
	PHYSI CAL THERAPY		1. 04334		84, 943	
	WHEATFI ELD PT		1. 24382		0	
	OCCUPATI ONAL THERAPY		1. 51427	4 55, 457	83, 977	67.00
67. 01 06701	WHEATFI ELD OT		2. 18938	32 0	0	67. 01
68. 00 06800	SPEECH PATHOLOGY		2. 07948	15, 992	33, 255	68. 00
	WHEATFI ELD ST		2. 21536		0	
	ELECTROENCEPHALOGRAPHY		0.00000		0	
	MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 53014		174, 783	
	IMPL. DEV. CHARGED TO PATIENT		0. 62375		4, 888	
	DRUGS CHARGED TO PATIENTS		0. 48943	1, 122, 125	549, 209	73. 00
	TIENT SERVICE COST CENTERS					
	RURAL HEALTH CLINIC		0.00000		0	
	RURAL HEALTH CLINIC IV		0.00000		0	88. 03
	CLINIC		0. 96157		62, 614	
	EMERGENCY OBSERVATION BEDS (NON-DISTINCT PART)		0. 89312 0. 57471		34, 037 19, 076	
200.00	Total (sum of lines 50-94 and 96-98)		0.5/4/1	3, 939, 406	2, 140, 464	
200.00	Less PBP Clinic Laboratory Services-Program only charges	(Line 61)	-	3, 939, 406		200.00
201.00	Net Charges (line 200 minus line 201)	(TIME OI)	1	ı V		1201.00

Health Financial Systems FRANCISCAN HEALTH	RENSSELAER		In Lie	eu of Form CMS-:	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT Provider C		CN: 15-1324	Peri od:	Worksheet D-3	
	Component		From 01/01/2016 To 12/31/2016		
	Ti tl e	: XVIII	Swing Beds - SNF		9 4111
Cost Center Description	11110	Ratio of Cos		Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
			,	2)	
		1. 00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS			C	1	30. 00
31. 00 03100 I NTENSI VE CARE UNI T			C)	31.00
ANCI LLARY SERVI CE COST CENTERS		ı			
50. 00 05000 OPERATING ROOM		0. 55404			
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 39296			1
60. 00 06000 LABORATORY		0. 37875			
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.		0. 62928			
65. 00 06500 RESPIRATORY THERAPY		0. 65949			
66. 00 06600 PHYSI CAL THERAPY 66. 01 06601 WHEATFI ELD PT		1. 04334 1. 24382		1	
67. 00 06700 OCCUPATI ONAL THERAPY		1. 51427		0 62, 785	
67. 01 06701 WHEATFI ELD OT		2. 18938		02, 785	1
68. 00 06800 SPEECH PATHOLOGY		2. 07948			
68. 01 06801 WHEATFI ELD ST		2. 21536		3, 3//	1
70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 00000			70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 53014			
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT		0. 62375		0,070	1
73. 00 O7300 DRUGS CHARGED TO PATIENTS		0. 48943			1
OUTPATIENT SERVICE COST CENTERS				,	1
88. 00 08800 RURAL HEALTH CLINIC		0.00000	00	0	88. 00
88. 03 08801 RURAL HEALTH CLINIC IV		0. 00000	00	0	88. 03
90. 00 09000 CLI NI C		0. 96157	78 100	96	90.00
91. 00 09100 EMERGENCY		0. 89312	23 C	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 57471	2 0	0	92.00
200.00 Total (sum of lines 50-94 and 96-98)			411, 383	287, 082	
201.00 Less PBP Clinic Laboratory Services-Program only charges	s (line 61)		C	1	201. 00
202.00 Net Charges (line 200 minus line 201)		l	411, 383		202. 00

Health Financial Systems FRANCISCAN HEALTH R				u of Form CMS-2	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C		Peri od:	Worksheet D-3	
			From 01/01/2016 To 12/31/2016	Date/Time Pre	nared:
			10 12/31/2010	8/8/2017 10: 1	
	Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description		Ratio of Cos	t Inpatient	I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS					1
30. 00 03000 ADULTS & PEDI ATRI CS			21, 480	l e	30.00
31. 00 03100 I NTENSI VE CARE UNI T			8, 040		31.00
ANCI LLARY SERVI CE COST CENTERS		1			
50. 00 05000 OPERATI NG ROOM		0. 55404			
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 39296	•		
60. 00 06000 LABORATORY		0. 37875	•	6, 030	
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.		0. 62928	•	l	
65. 00 06500 RESPI RATORY THERAPY		0. 65949			
66. 00 06600 PHYSI CAL THERAPY		1. 04334	•		
66. 01 06601 WHEATFI ELD PT		1. 24382		0	
67. 00 06700 OCCUPATI ONAL THERAPY		1. 51427		0	67.00
67. 01 06701 WHEATFI ELD OT		2. 18938		0	67. 01
68. 00 06800 SPEECH PATHOLOGY		2. 07948		0	00.00
68. 01 06801 WHEATFI ELD ST		2. 21536		0	
70. 00 07000 ELECTROENCEPHALOGRAPHY		0.00000		0	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 53014		1	
72. 00 07200 I MPL. DEV. CHARGED TO PATIENT		0. 62375		0	
73. 00 O7300 DRUGS CHARGED TO PATIENTS		0. 48943	37 26, 625	13, 031	73.00
OUTPATIENT SERVICE COST CENTERS		2 (0270	V 0		
88. 00 08800 RURAL HEALTH CLINIC		2. 69370		0	
88. 03 08801 RURAL HEALTH CLINIC IV		2. 34486		0	88. 03
90. 00 09000 CLI NI C		0. 96157	•		
91. 00 09100 EMERGENCY		0. 89312		930	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 57471		0	92.00
200.00 Total (sum of lines 50-94 and 96-98) 201.00 Less PBP Clinic Laboratory Services-Program only charges	(1: (1)		76, 319		200. 00 201. 00
201.00 Less PBP Clinic Laboratory Services-Program only charges	(TIME 61)	I	0	I	1/01 ()(

201. 00 202. 00

76, 319

201.00 202.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) Net Charges (line 200 minus line 201)

Health Financial Systems	FRANCI SCAN HEALTH	RENSSELAER	In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-1324	From 01/01/2016 To 12/31/2016	Worksheet E Part B Date/Time Prepared: 8/8/2017 10:19 am
		Title XVIII	Hospi tal	Cost

			To 12/31/2016	Date/Time Pre 8/8/2017 10:1	
	Title XVIII Hospital				, uiii
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1. 00	
1. 00	Medical and other services (see instructions)			9, 796, 523	1. 00
2.00	Medical and other services reimbursed under OPPS (see instruct	ti ons)		0	2. 00
3.00	PPS payments			0	3. 00
4.00	Outlier payment (see instructions)			0	4. 00
5.00	Enter the hospital specific payment to cost ratio (see instruc	ctions)		0. 000	
6. 00 7. 00	Line 2 times line 5			0 0. 00	6. 00 7. 00
8.00	Sum of line 3 plus line 4 divided by line 6 Transitional corridor payment (see instructions)			0.00	8.00
9. 00	Ancillary service other pass through costs from Wkst. D, Pt. I	V. col. 13. Line 200		0	9. 00
10.00	Organ acqui si ti ons	,		0	10.00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			9, 796, 523	11. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
12 00	Reasonable charges			0	12. 00
12. 00 13. 00	Ancillary service charges Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, Ii	ne 69)		0	13.00
14. 00	Total reasonable charges (sum of lines 12 and 13)	116 07)		0	14. 00
	Customary charges				
15. 00	Aggregate amount actually collected from patients liable for p			0	15. 00
16. 00	Amounts that would have been realized from patients liable for	1 3	n a chargebasis	0	16. 00
17 00	had such payment been made in accordance with 42 CFR §413.13(6	e)		0.000000	17.00
17. 00 18. 00	Ratio of line 15 to line 16 (not to exceed 1.000000) Total customary charges (see instructions)			0.000000	17. 00 18. 00
19. 00	Excess of customary charges over reasonable cost (complete onl	vifline 18 exceeds Li	ne 11) (see	0	19. 00
. ,	instructions)	y	, (555	· ·	17.00
20. 00	Excess of reasonable cost over customary charges (complete onl	y if line 11 exceeds li	ne 18) (see	0	20. 00
21. 00	instructions) Lesser of cost or charges (line 11 minus line 20) (for CAH see	instructions)		9, 894, 488	21. 00
22. 00	Interns and residents (see instructions)	e matructions)		9, 094, 400	22. 00
23. 00	Cost of physicians' services in a teaching hospital (see instr	ructions)		0	
24. 00	Total prospective payment (sum of lines 3, 4, 8 and 9)	,		0	24. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25. 00	Deductibles and coinsurance (for CAH, see instructions)	c CAH coo i netructione)		59, 406	
26. 00 27. 00	Deductibles and Coinsurance relating to amount on line 24 (for Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26);			2, 796, 071 7, 039, 011	
27.00	instructions)	or do the sam of fines 22	ana 20] (300	7,037,011	27.00
28. 00	Direct graduate medical education payments (from Wkst. E-4, li	ne 50)		0	28. 00
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	29. 00
30.00	Subtotal (sum of lines 27 through 29)			7, 039, 011	
31. 00 32. 00	Primary payer payments Subtotal (line 30 minus line 31)			9, 222 7, 029, 789	
32.00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE	CES)		7,027,707	32.00
33. 00	Composite rate ESRD (from Wkst. I-5, line 11)	,		0	33. 00
34.00	Allowable bad debts (see instructions)			337, 430	
35. 00	Adjusted reimbursable bad debts (see instructions)			219, 330	
36. 00	Allowable bad debts for dual eligible beneficiaries (see insti	ructions)		328, 593	
37. 00 38. 00	Subtotal (see instructions) MSP-LCC reconciliation amount from PS&R			7, 249, 119 0	38.00
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
39. 50	Pioneer ACO demonstration payment adjustment (see instructions	5)		0	39. 50
39. 98	Partial or full credits received from manufacturers for replace	ced devices (see instruc	tions)	0	39. 98
39. 99	RECOVERY OF ACCELERATED DEPRECIATION			0	39. 99
40.00	Subtotal (see instructions)			7, 249, 119 144, 982	
40. 01	, , , , , , , , , , , , , , , , , , , ,				
41. 00 42. 00					41. 00 42. 00
43. 00				0 510, 027	
44. 00				0	1
	§115. 2	<u> </u>	•		
00.00	TO BE COMPLETED BY CONTRACTOR				00.00
90.00	Original outlier amount (see instructions) Outlier reconciliation adjustment amount (see instructions)			0	
91. 00 92. 00	The rate used to calculate the Time Value of Money				91.00
93. 00	Time Value of Money (see instructions)			0.00	
	Total (sum of lines 91 and 93)			0	
			,		

| Period: | Worksheet E-1 | From 01/01/2016 | Part | To 12/31/2016 | Date/Time Prepared: | 8/8/2017 10:19 am Health Financial Systems FRANC ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provider CCN: 15-1324

					8/8/2017 10: 19	9 am
			XVIII	Hospi tal	Cost	
		Inpatien	it Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2.00	3. 00	4.00	
1.00	Total interim payments paid to provider		2, 954, 966		6, 244, 010	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	04/01/2016	34, 500	07/27/2016	350, 100	3. 01
3. 02	ABSOSTWENTS TO TROVIDER	07/27/2016	169, 500		0	3. 02
3. 02		0772772010	107, 300			3. 02
3. 04						3. 04
3. 05					l ol	3. 05
3.03	Provider to Program			1		5. 05
3.50	ADJUSTMENTS TO PROGRAM		C		0	3. 50
3. 51					l ol	3. 51
3. 52					o	3. 52
3. 53					0	3. 53
3.54			l c		o	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		204, 000		350, 100	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		3, 158, 966		6, 594, 110	4. 00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR	ı	ı	ı	1	
5. 00	List separately each tentative settlement payment after					5. 00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
5. 01	Program to Provider TENTATIVE TO PROVIDER				0	5. 01
5. 01	TENTATIVE TO PROVIDER					5. 01
5. 02						5. 02
5.05	Provider to Program				0	5. 05
5. 50	TENTATI VE TO PROGRAM				0	5. 50
5. 51	TENTITY TO THOUSE MIN		l d		0	5. 51
5. 52			1		0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines				l ol	5. 99
	5. 50-5. 98)					
6.00	Determined net settlement amount (balance due) based on					6.00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVIDER		1, 319, 333		510, 027	6. 01
6.02	SETTLEMENT TO PROGRAM		[c		0	6. 02
7.00	Total Medicare program liability (see instructions)		4, 478, 299		7, 104, 137	7. 00
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
	Turn Caracter State Control	()	1. 00	2. 00	
8.00	Name of Contractor					8. 00

Health Financial Systems FRANC ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

		'			8/8/2017 10:1	9 am
				ving Beds - SNF		
		Inpatier	it Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3. 00	4. 00	
1.00	Total interim payments paid to provider		471, 113		0	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	07/07/004/				
3. 01	ADJUSTMENTS TO PROVIDER	07/27/2016	29, 800		0	3. 01
3. 02			0		0	3. 02
3. 03			0		0	3. 03
3.04			0		0	3. 04
3. 05	Describber to Describe		0		0	3. 05
2 50	Provider to Program ADJUSTMENTS TO PROGRAM	I	0		0] 3. 50
3. 50 3. 51	ADJUSTMENTS TO PROGRAM				0	3. 50
3. 51						3.51
3. 52					0	3. 52
3. 54			0		0	3.54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		29, 800		0	3. 99
J. 77	3. 50-3. 98)		27,000			J. 77
4. 00	Total interim payments (sum of lines 1, 2, and 3.99)		500, 913		0	4.00
00	(transfer to Wkst. E or Wkst. E-3, line and column as		000,7.0			
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR		•		•	ĺ
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)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER		0		0	5. 01
5.02			0		0	5. 02
5. 03			0		0	5. 03
	Provi der to Program	T	_		T -	
5. 50	TENTATI VE TO PROGRAM		0		0	5. 50
5. 51			0		0	5. 51
5. 52	Cultural (0		0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		0		0	5. 99
4 00	5.50-5.98) Determined net settlement amount (balance due) based on					4 00
6. 00	the cost report. (1)					6. 00
6. 01	SETTLEMENT TO PROVIDER		204, 553		0	6. 01
6. 02	SETTLEMENT TO PROGRAM		204, 333		0	6. 02
7. 00	Total Medicare program liability (see instructions)		705, 466		0	7. 00
7.00	Trotal mode ode o program trability (ode thotal detroils)		, , , , , , , , , , , , , , , , , , , ,	Contractor	NPR Date	7.30
				Number	(Mo/Day/Yr)	
)	1. 00	2.00	
8. 00	Name of Contractor					8. 00
	•	•		,	•	•

Heal th	Financial Systems FRANCISCAN HEALT	TH RENSSELAER	In Lie	u of Form CMS-2	2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 15-1324 Period: From 01/01/2016 Part II To 12/31/2016 Period: From 01/01/2016 Perio						
		Title XVIII	Hospi tal	Cost		
				1. 00		
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS					
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				1. 00	
1.00	1.00 Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14 698					
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1,	8-12		1, 756	2. 00	
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			105	3. 00	
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1,	8-12		2, 429	4. 00	
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			58, 424, 954	5. 00	
6.00	Total hospital charity care charges from Wkst. S-10, col. 3	line 20		0	6. 00	
7. 00	CAH only - The reasonable cost incurred for the purchase of line 168	certified HIT technology	Wkst. S-2, Pt. I	0	7. 00	
8.00	Calculation of the HIT incentive payment (see instructions)			0	8. 00	
9.00	Sequestration adjustment amount (see instructions)			ol	9. 00	
10.00	Calculation of the HIT incentive payment after sequestration	n (see instructions)		0	10.00	
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH					
30.00	Initial/interim HIT payment adjustment (see instructions)			0	30. 00	
31.00	Other Adjustment (specify)			ol	31. 00	
22 00	100 Palance due provider (line 9 (or line 10) minus line 30 and line 31) (see instructions)					

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

0 30.00 0 31.00 0 32.00

Health Financial Systems	FRANCI SCAN HEALTH	RENSSELAER	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT -	SWING BEDS			Worksheet E-2
			From 01/01/2016	
		Component CCN: 15-Z324	10 12/31/2016	8/8/2017 10:19 am
•		Ti tlo YVIII	Swing Rods - SNE	Cost

				8/8/2017 10: 19	9 am_
		Title XVIII	Swing Beds - SNF	Cost	
	<u> </u>		Part A	Part B	
			1. 00	2. 00	
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient routine services - swing bed-SNF (see instructions)		430, 876	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)				2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part	A, and sum of Wkst. D	, 289, 953	0	3.00
	Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see ins				
4.00	Per diem cost for interns and residents not in approved teachi	ng program (see		0. 00	4.00
	instructions)				
5. 00	Program days		376	0	5. 00
6. 00	Interns and residents not in approved teaching program (see in	,		0	6. 00
7. 00	Utilization review - physician compensation - SNF optional met	hod only	0		7. 00
8. 00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		720, 829	0	8. 00
9. 00	Primary payer payments (see instructions)		0	0	9. 00
10. 00	Subtotal (line 8 minus line 9)		720, 829	0	10.00
11. 00	Deductibles billed to program patients (exclude amounts applic	able to physician	0	0	11. 00
	professional services)				
12. 00			720, 829	0	12.00
13. 00	Coinsurance billed to program patients (from provider records)	(excl ude coi nsurance	966	0	13.00
	for physician professional services)				
	80% of Part B costs (line 12 x 80%)		740.040	0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 1	4)	719, 863	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	16.00
16. 50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	16. 50
16. 55	410A RURAL DEMONSTRATION PROJECT		0	0	16. 55
17.00	Allowable bad debts (see instructions)		0	0	17.00
17. 01	Adjusted reimbursable bad debts (see instructions)		0	0	17. 0° 18. 00
18.00	Allowable bad debts for dual eligible beneficiaries (see instr	uctions)	710 0/3	0	
19.00	Total (see instructions)		719, 863	0	19.00
19. 01	Sequestration adjustment (see instructions)		14, 397	0	19. 01
20.00			500, 913	0	20.00
21. 00	,	nd 21)	204 552	0	21.00
22. 00			204, 553	0	22. 00
23. 00	Protested amounts (nonallowable cost report items) in accordan chapter 1, §115.2	ce with CMS Pub. 15-2,	0	0	23. 00

Heal th	Financial Systems	FRANCI SCAN HEALTH	RENSSELAER	In Lie	u of Form CMS-2	2552-10
CALCULA	TION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-1324	Peri od: From 01/01/2016 To 12/31/2016	Worksheet E-3 Part V Date/Time Prep 8/8/2017 10:10	pared:
			Title XVIII	Hospi tal	Cost	
	·					
					1. 00	
F	PART V - CALCULATION OF REIMBURSEMENT SETT	LEMENT FOR MEDICARE	PART A SERVICES - COST	REIMBURSEMENT		
1.00	Inpatient services				4, 941, 101	1. 00
2.00	Nursing and Allied Health Managed Care pay	yment (see instructio	ons)		0	2. 00
2 00	Organ acquisition	,	•		0	2 00

2.00 Nursing and Allied Health Managed Care payment (see instructions) 0 2.6				
Inpatient services			1. 00	
2.00 Nursing and Allied Health Managed Care payment (see instructions) 0 2.0				
3.00 Organ acquisition 0.3.6		Inpatient services	4, 941, 101	1. 00
				2. 00
Primary payer payments				3. 00
A 2007 Total Cost Cline A 1 1 1 1 1 1 1 1 1			4, 941, 101	4. 00
COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges Reasonable charges				5. 00
Reasonable charges	6.00		4, 979, 317	6. 00
Routine service charges				
Ancillary service charges 0 8.6				
9.00 Organ acquisition charges, net of revenue 9.0 9.0 Total reasonable charges 0 10.0 Total reasonable charges 0 10.0 10.0				7. 00
10.00 Total reasonable charges 0 10.00 Coustomary charges 0 10.00 10.00 Coustomary charges 0 10.00 Coustomary 0 10.				8. 00
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15.00 Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions) 16.00 Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions) 17.00 Cost of physicians' services in a teaching hospital (see instructions) 17.00 Cost of physicians' services in a teaching hospital (see instructions) 17.00 Cost of complete medical education payments (from Worksheet E-4, line 49) 18.01 18.01 18.01 18.02				
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COMPUTATION OF REIMBURSEMENT SETTLEMENT 18.00 Direct graduate medical education payments (from Worksheet E-4, line 49) 19.00 Cost of covered services (sum of lines 6, 17 and 18) 20.00 Deductibles (exclude professional component) 21.00 Excess reasonable cost (from line 16) 22.00 Subtotal (line 19 minus line 20 and 21) 23.00 Coinsurance 24.00 Subtotal (line 22 minus line 23) 25.00 Allowable bad debts (exclude bad debts for professional services) (see instructions) 27.00 Allowable bad debts (exclude bad debts for professional services) (see instructions) 27.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 28.00 Subtotal (sum of lines 24 and 25, or line 26) 29.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 29.50 Pioneer ACO demonstration payment adjustment (see instructions) 30.00 Subtotal (see instructions) 31.00 Interim payments 32.00 Tentative settlement (for contractor use only) 33.00 Bal ance due provider/program (line 30 minus lines 30.01, 31, and 32) 4, 51, 52, 52, 63, 71, 71, 71, 72, 73, 73, 73, 74, 74, 74, 74, 74, 74, 74, 74, 74, 74	17 00		٥	17 0
18.00 Direct graduate medical education payments (from Worksheet E-4, line 49) 0 18.00 19.00 Cost of covered services (sum of lines 6, 17 and 18) 4,979,317 19.0 20.00 Deductibles (exclude professional component) 437,813 20.0 21.00 Excess reasonable cost (from line 16) 0 21.0 22.00 Subtotal (line 19 minus line 20 and 21) 4,541,504 22.0 23.00 Coinsurance 5,152 23.0 24.00 Subtotal (line 22 minus line 23) 4,536,352 24.0 25.00 Allowable bad debts (exclude bad debts for professional services) (see instructions) 51,294 25.0 26.00 Adjusted reimbursable bad debts (see instructions) 33,341 26.0 27.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 46,342 27.0 28.00 Subtotal (sum of lines 24 and 25, or line 26) 4,569,693 28.0 29.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0.29.5 29.50 Pioneer ACO demonstration payment adjustment (see instructions) 4,569,693 30.01 Sequestration adjustment (see instructions) 91,394 30.01 <td>17.00</td> <td></td> <td>U U</td> <td>17.0</td>	17.00		U U	17.0
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23. 00 Coinsurance 5, 152 23. 0 24. 00 Subtotal (line 22 minus line 23) 4, 536, 352 24. 0 25. 00 Allowable bad debts (exclude bad debts for professional services) (see instructions) 51, 294 25. 0 26. 00 Adjusted reimbursable bad debts (see instructions) 33, 341 26. 0 27. 00 Allowable bad debts for dual eligible beneficiaries (see instructions) 46, 342 27. 0 28. 00 Subtotal (sum of lines 24 and 25, or line 26) 4, 569, 693 28. 0 29. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 29. 0 29. 50 Pioneer ACO demonstration payment adjustment (see instructions) 0 29. 5 29. 99 Recovery of Accelerated Depreciation 0 29. 5 30. 00 Subtotal (see instructions) 4, 569, 693 30. 0 30. 01 Sequestration adjustment (see instructions) 91, 394 30. 0 31. 00 Interim payments 3, 158, 966 31. 0 32. 00 Tentative settlement (for contractor use only) 33. 00 Balance due provider/program (line 30 minus lines 30.01, 31, and 32) 1, 319, 333 33. 0 34. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	22. 00		4, 541, 504	22. 0
25. 00 Allowable bad debts (exclude bad debts for professional services) (see instructions) 26. 00 Adjusted reimbursable bad debts (see instructions) 27. 00 Allowable bad debts for dual eligible beneficiaries (see instructions) 28. 00 Subtotal (sum of lines 24 and 25, or line 26) 29. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 29. 50 Pioneer ACO demonstration payment adjustment (see instructions) 29. 99 Recovery of Accelerated Depreciation 30. 00 Subtotal (see instructions) 30. 01 Sequestration adjustment (see instructions) 31. 00 Interim payments 32. 00 Tentative settlement (for contractor use only) 33. 00 Balance due provider/program (line 30 minus lines 30.01, 31, and 32) 34. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	23. 00			23. 0
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26. 00 Adjusted reimbursable bad debts (see instructions) 27. 00 Allowable bad debts for dual eligible beneficiaries (see instructions) 28. 00 Subtotal (sum of lines 24 and 25, or line 26) 29. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 29. 50 Pioneer ACO demonstration payment adjustment (see instructions) 29. 99 Recovery of Accelerated Depreciation 30. 00 Subtotal (see instructions) 30. 01 Sequestration adjustment (see instructions) 31. 00 Interim payments 32. 00 Tentative settlement (for contractor use only) 33. 00 Balance due provider/program (line 30 minus lines 30.01, 31, and 32) 34. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	51, 294	25. 0
28.00 Subtotal (sum of lines 24 and 25, or line 26) 29.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 29.50 Pioneer ACO demonstration payment adjustment (see instructions) 29.99 Recovery of Accelerated Depreciation 30.00 Subtotal (see instructions) 30.01 Sequestration adjustment (see instructions) 31.00 Interim payments 32.00 Tentative settlement (for contractor use only) 33.00 Balance due provider/program (line 30 minus lines 30.01, 31, and 32) 34.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	26.00		33, 341	26. 0
29.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 29.50 Pi oneer ACO demonstration payment adjustment (see instructions) 29.99 Recovery of Accelerated Depreciation 30.00 Subtotal (see instructions) 30.01 Sequestration adjustment (see instructions) 31.00 Interim payments 32.00 Tentative settlement (for contractor use only) 33.00 Balance due provider/program (line 30 minus lines 30.01, 31, and 32) 34.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	46, 342	27. 0
29. 50 Pi oneer ACO demonstration payment adjustment (see instructions) 29. 99 Recovery of Accelerated Depreciation 30. 00 Subtotal (see instructions) 30. 01 Sequestration adjustment (see instructions) 31. 00 Interim payments 32. 00 Tentative settlement (for contractor use only) 33. 00 Balance due provider/program (line 30 minus lines 30.01, 31, and 32) 34. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	28. 00	Subtotal (sum of lines 24 and 25, or line 26)	4, 569, 693	28. 0
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29. 99 Recovery of Accelerated Depreciation 30. 00 Subtotal (see instructions) 30. 01 Sequestration adjustment (see instructions) 31. 00 Interim payments 32. 00 Tentative settlement (for contractor use only) 33. 00 Balance due provider/program (line 30 minus lines 30.01, 31, and 32) 34. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	29. 50	Pioneer ACO demonstration payment adjustment (see instructions)	o	29. 5
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31.00 Interim payments 3, 158, 966 31.0 32.00 Tentative settlement (for contractor use only) 33.00 Balance due provider/program (line 30 minus lines 30.01, 31, and 32) 34.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 34.00	30.00	Subtotal (see instructions)	4, 569, 693	30. 0
31.00 Interim payments 3, 158, 966 31.0 32.00 Tentative settlement (for contractor use only) 33.00 Balance due provider/program (line 30 minus lines 30.01, 31, and 32) 34.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 34.00	30. 01	Sequestration adjustment (see instructions)	91, 394	30. 0
32.00 Tentative settlement (for contractor use only) 33.00 Balance due provider/program (line 30 minus lines 30.01, 31, and 32) 34.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 34.00				
33.00 Balance due provider/program (line 30 minus lines 30.01, 31, and 32) 34.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 34.00				32. 0
34.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 34.0				
				34.00

Health Financial Systems	FRANCISCAN HEALTH RENSSELAER	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-1324	Peri od: From 01/01/2016 To 12/31/2016	Worksheet E-3 Part VII Date/Time Prepared: 8/8/2017 10:19 am

				8/8/2017 10:1	9 am
		Title XIX	Hospi tal	Cost	
			Inpati ent	Outpati ent	
			1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SEF	RVICES FOR TITLES V OR XIX	SERVI CES		
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services		98, 830		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		o		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		98, 830	0	4. 00
5.00	Inpatient primary payer payments		o		5. 00
6.00	Outpati ent pri mary payer payments			0	6. 00
7. 00	Subtotal (line 4 less sum of lines 5 and 6)		98, 830	0	7. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonable Charges				
8.00	Routi ne servi ce charges		29, 520		8. 00
9. 00	Ancillary service charges		76, 319	0	9. 00
10.00	Organ acquisition charges, net of revenue		o		10.00
11. 00	Incentive from target amount computation		o		11. 00
12. 00	Total reasonable charges (sum of lines 8 through 11)		105, 839	0	12. 00
.2.00	CUSTOMARY CHARGES		1007007		.2.00
13. 00	Amount actually collected from patients liable for payment for	services on a charge	O	0	13. 00
	basis	g-		_	
14.00	Amounts that would have been realized from patients liable for	payment for services on	ol	0	14. 00
	a charge basis had such payment been made in accordance with				
15. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0. 000000	0.000000	15. 00
16. 00	Total customary charges (see instructions)		105, 839	0	16. 00
17. 00	Excess of customary charges over reasonable cost (complete onl	y if line 16 exceeds	7, 009	0	17. 00
	line 4) (see instructions)				
18. 00	Excess of reasonable cost over customary charges (complete onl	y if line 4 exceeds line	o	0	18.00
	16) (see instructions)				
19. 00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instr	ructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 1	16)	98, 830	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be	completed for PPS provide	rs.		
22. 00	Other than outlier payments		0	0	22. 00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27. 00	Subtotal (sum of lines 22 through 26)		o	0	27. 00
28. 00	Customary charges (title V or XIX PPS covered services only)		o	0	28. 00
29. 00	Titles V or XIX (sum of lines 21 and 27)		98, 830	0	29. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6))	98, 830	0	31.00
32.00	Deducti bl es		o	0	32.00
33.00	Coinsurance		o	0	33. 00
34.00	Allowable bad debts (see instructions)		o	0	34.00
35. 00	Utilization review		o		35. 00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	1 33)	98, 830	0	36. 00
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	, ,	o	0	37. 00
	Subtotal (line 36 ± line 37)		98, 830	0	38. 00
	Direct graduate medical education payments (from Wkst. E-4)		0	Ü	39. 00
	Total amount payable to the provider (sum of lines 38 and 39)		98, 830	0	40. 00
41. 00	Interim payments		39, 558	0	41. 00
42. 00	Balance due provider/program (line 40 minus line 41)		59, 272	0	42. 00
43. 00	Protested amounts (nonallowable cost report items) in accordan	nce with CMS Pub 15-2	0	0	43. 00
10.00	chapter 1, §115.2	.55 (II SMO 1 GD 10 Z,		O	10.00
	Landeran of Oriona		ı		1

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

Provider CCN: 15-1324

Peri od: Worksheet G
From 01/01/2016
To 12/31/2016 Date/Ti me Prepared: 8/8/2017 10: 19 am

——————————————————————————————————————					8/8/2017 10:1	9 am
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2. 00	3. 00	4. 00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	2, 024, 641		_	_	
2.00	Temporary investments	0	0			1
3. 00 4. 00	Notes recei vabl e Accounts recei vabl e	9, 472, 868	0	0	0	3. 00 4. 00
5.00	Other receivable	9,472,600		0	0	5. 00
6. 00	Allowances for uncollectible notes and accounts receivable	-4, 369, 732	Ó	Ö	ő	6. 00
7.00	Inventory	976, 241		0	0	
8.00	Prepai d expenses	0	0	0	0	
9.00	Other current assets	147, 530		_	0	
10.00	Due from other funds	0 054 540	0	_	0	10.00
11. 00	Total current assets (sum of lines 1-10) FIXED ASSETS	8, 251, 548	0	0	0	11. 00
12. 00	Land	675, 791	T 0	0	0	12.00
13. 00	Land improvements	484, 426			_	13. 00
14.00	Accumulated depreciation	0	0	0	0	14. 00
15.00	Bui I di ngs	16, 471, 346	0	0		15. 00
16.00	Accumulated depreciation	0	0	0	0	16.00
17. 00 18. 00	Leasehold improvements Accumulated depreciation	3, 814, 172	0	_	0	17. 00
19. 00	Fi xed equi pment			_	0	18. 00 19. 00
20.00	Accumul ated depreciation			0	ő	20.00
21. 00	Automobiles and trucks	0	Ö	0	Ō	21. 00
22. 00	Accumul ated depreciation	0	0	0	0	22. 00
23. 00	Major movable equipment	7, 048, 087		0	0	23. 00
24. 00	Accumulated depreciation	-3, 471, 059	0	0	0	24. 00
25. 00 26. 00	Minor equipment depreciable Accumulated depreciation			0	0	25. 00 26. 00
27. 00	HIT designated Assets			0	0	27. 00
28. 00	Accumulated depreciation		o o	Ö	ő	28. 00
29. 00	Mi nor equi pment-nondepreci abl e	0	Ö	0		29. 00
30.00	Total fixed assets (sum of lines 12-29)	25, 022, 763	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	_	_	
32. 00 33. 00	Deposits on Leases		0	_	0	32. 00 33. 00
34. 00	Due from owners/officers Other assets	84,000	1	_	0	34. 00
35. 00	Total other assets (sum of lines 31-34)	84, 000			0	35. 00
36. 00	Total assets (sum of lines 11, 30, and 35)	33, 358, 311	1	_		36.00
	CURRENT LIABILITIES					
37. 00	Accounts payable	1, 804, 991	1		_	37. 00
38. 00	Salaries, wages, and fees payable	953, 109	0	0		38. 00
39. 00 40. 00	Payroll taxes payable Notes and Loans payable (short term)	8, 967) '	0	0	
41. 00	Deferred income	8, 707		0	0	41.00
42. 00	Accel erated payments					42. 00
43.00	Due to other funds	1, 585, 381	0	0	0	43.00
44.00	Other current liabilities	9, 942, 076	0	0	0	44. 00
45.00	Total current liabilities (sum of lines 37 thru 44)	14, 294, 524	0	0	0	45. 00
47 00	LONG TERM LIABILITIES					47 00
46. 00 47. 00	Mortgage payable Notes payable	20, 100, 912	0		_	
48. 00	Unsecured Loans	580, 340	1			
49. 00	Other long term liabilities	22, 354				49. 00
50.00	Total long term liabilities (sum of lines 46 thru 49)	20, 703, 606		0		
51.00	Total liabilities (sum of lines 45 and 50)	34, 998, 130	0	0	0	51.00
	CAPITAL ACCOUNTS		,			
52. 00	General fund balance	-1, 639, 819	1			52. 00
53.00	Specific purpose fund		0			53. 00 54. 00
54. 00 55. 00	Donor created - endowment fund balance - restricted Donor created - endowment fund balance - unrestricted			0		55. 00
56. 00	Governing body created - endowment fund balance			0		56.00
57. 00	Plant fund balance - invested in plant				0	57.00
58. 00	Plant fund balance - reserve for plant improvement,				0	58. 00
	repl acement, and expansi on					
59. 00	Total fund balances (sum of lines 52 thru 58)	-1, 639, 819		0	0	1
60. 00	Total liabilities and fund balances (sum of lines 51 and 59)	33, 358, 311	0	0	0	60.00
	· · /	I	I	I	I	I

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES Provider CCN: 15-1324

					To 12/31/2016		
		General	Fund	Special F	Purpose Fund	Endowment Fund	
		1.00	2.00	3. 00	4. 00	5. 00	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) EQUITY TRANSFER TO AFFILIATES Total deductions (sum of lines 12-17) Fund balance at end of period per balance	1.00 0 0 0 0 0 0 141, 231 0 0 0	2.00 5, 232, 115 -6, 730, 703 -1, 498, 588 0 -1, 498, 588 141, 231 -1, 639, 819		4.00 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 17. 00 18. 00
19.00	sheet (line 11 minus line 18)	Endowment Fund	-1, 037, 017 Pl ant		0		19.00
		6. 00	7.00	8. 00			
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2)	0	0 0 0	0.00	0		1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) EQUITY TRANSFER TO AFFILIATES Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0 0	0 0 0 0 0		0 0 0		10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00

Health Financial Systems FRASTATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provi der CCN: 15-1324

			Т	o 12/31/2016	Date/Time Prep 8/8/2017 10:19	
	Cost Center Description		Inpatient	Outpati ent	Total	
			1. 00	2. 00	3. 00	
	PART I - PATIENT REVENUES				0.00	
	General Inpatient Routine Services					
1.00	Hospi tal		1, 958, 858		1, 958, 858	1. 00
2.00	SUBPROVIDER - I PF		.,		.,,	2. 00
3. 00	SUBPROVIDER - IRF					3. 00
4. 00	SUBPROVI DER					4. 00
5. 00	Swing bed - SNF		C		0	5. 00
6. 00	Swing bed - NF		C		0	6. 00
7. 00	SKILLED NURSING FACILITY		· ·		ŭ.	7. 00
8.00	NURSING FACILITY					8. 00
9. 00	OTHER LONG TERM CARE					9. 00
10. 00	Total general inpatient care services (sum of lines 1-9)		1, 958, 858		1, 958, 858	
	Intensive Care Type Inpatient Hospital Services		., ,,,,,,		177007000	10.00
11. 00	INTENSIVE CARE UNIT		446, 269		446, 269	11. 00
12. 00	CORONARY CARE UNIT				110,207	12. 00
13. 00	BURN INTENSIVE CARE UNIT					13. 00
14. 00	SURGI CAL INTENSI VE CARE UNI T					14. 00
15. 00	OTHER SPECIAL CARE (SPECIFY)					15. 00
16. 00	Total intensive care type inpatient hospital services (sum of I	ines	446, 269		446, 269	16. 00
	11-15)				110,207	
17. 00	Total inpatient routine care services (sum of lines 10 and 16)		2, 405, 127		2, 405, 127	17. 00
18. 00	Ancillary services		5, 839, 754	35, 194, 938	41, 034, 692	18. 00
19. 00	Outpatient services		185, 537	9, 376, 833	9, 562, 370	19. 00
20. 00	RURAL HEALTH CLINIC		0	231, 944	231, 944	
20. 03	RURAL HEALTH CLINIC IV		C	410, 218	410, 218	
21. 00	FEDERALLY QUALIFIED HEALTH CENTER		C	0	0	21. 00
22. 00	HOME HEALTH AGENCY		· ·	2, 611, 486	2, 611, 486	
23. 00	AMBULANCE SERVICES			2,011,100	2,011,100	23. 00
24. 00	CMHC					24. 00
25. 00	AMBULATORY SURGICAL CENTER (D.P.)					25. 00
26. 00	HOSPI CE		C	1, 054, 587	1, 054, 587	26. 00
27. 00	ALTERNACARE AND KV		717, 522	1, 737, 185	2, 454, 707	27. 00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 t	to Wkst	9, 147, 940	50, 617, 191	59, 765, 131	28. 00
20.00	G-3, line 1)	io iikst.	7, 117, 710	00,017,171	07, 700, 101	20.00
	PART II - OPERATING EXPENSES					
29. 00	Operating expenses (per Wkst. A, column 3, line 200)			38, 906, 319		29. 00
30. 00	ADD (SPECIFY)		C			30. 00
31. 00	(O			31. 00
32. 00			O			32. 00
33. 00			O			33. 00
34. 00			O			34. 00
35. 00			O			35. 00
36. 00	Total additions (sum of lines 30-35)		_	ol		36. 00
37. 00	DEDUCT (SPECIFY)		O	Ĭ		37. 00
38. 00			O			38. 00
39. 00			O			39. 00
40. 00			Ö			40. 00
41. 00			Ö			41. 00
42. 00	Total deductions (sum of lines 37-41)		·	n		42. 00
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)	(transfer		38, 906, 319		43. 00
	to Wkst. G-3, line 4)	(1. 0		55, 755, 617		.0.00
		1		'	!	1

Heal th	Financial Systems FRANCISCAN HEALTH	RENSSELAER	In Lie	u of Form CMS-2	2552-10
	IENT OF REVENUES AND EXPENSES	Provider CCN: 15-1324	Peri od:	Worksheet G-3	
			From 01/01/2016 To 12/31/2016	Date/Time Pre 8/8/2017 10:19	
1 00	(0. 111) 0.0 0.1	00)		1.00	1 00
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, lin			59, 765, 131	1.00
2.00	Less contractual allowances and discounts on patients' accoun	ts		28, 032, 691	2. 00
3.00	Net patient revenues (line 1 minus line 2)	40)		31, 732, 440	
4.00	Less total operating expenses (from Wkst. G-2, Part II, line	43)		38, 906, 319	4. 00
5. 00	Net income from service to patients (line 3 minus line 4)			-7, 173, 879	5. 00
/ 00	OTHER INCOME			0	/ 00
6. 00 7. 00	Contributions, donations, bequests, etc Income from investments			0	6. 00 7. 00
7. 00 8. 00	Revenues from telephone and other miscellaneous communication	00714 000		0	
9. 00	Revenue from television and radio service	ser vi ces		0	
10. 00	Purchase di scounts			0	10.00
11. 00	Rebates and refunds of expenses			0	10.00
12. 00	Parking lot receipts			0	12.00
13. 00	Revenue from Laundry and Linen service			0	
14. 00	Revenue from meals sold to employees and guests			- 1	14. 00
15. 00	Revenue from rental of living quarters				15. 00
16. 00	Revenue from sale of medical and surgical supplies to other t	han natients			16. 00
17. 00	Revenue from sale of drugs to other than patients	nan patrents			17. 00
18. 00	Revenue from sale of medical records and abstracts			0	
19. 00	Tuition (fees, sale of textbooks, uniforms, etc.)			0	
20. 00	Revenue from gifts, flowers, coffee shops, and canteen			0	20. 00
21. 00	Rental of vending machines			0	
22. 00	Rental of hospital space			0	
23. 00	Governmental appropriations			0	
24. 00	OTHER OPERATING REVENUE			443, 132	
24. 01	OHTER NONOPERATING REVENUE				24. 01
25. 00	Total other income (sum of lines 6-24)			443, 176	25. 00
	Total (line 5 plus line 25)			-6, 730, 703	
27. 00	OTHER EXPENSES (SPECIFY)			0	
	Total other expenses (sum of line 27 and subscripts)			0	28. 00
29. 00	Net income (or loss) for the period (line 26 minus line 28)			-6, 730, 703	29. 00
			•	•	

Column, 6 line 24 should agree with the Worksheet A, column 3, line 101, or subscript as applicable.

0

0

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158, 176

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1, 403, 425

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0

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0

1, 403, 425

22.00

23 00

23.50

24.00

Homemaker Service

Tel emedi ci ne

All Others (specify)

24.00 Total (sum of lines 1-23)

22.00

23. 00 23. 50

Heal th	Financial Systems	F	RANCI SCAN HEALT	H RENSSELAER		In Lie	u of Form CMS-2	2552-10
	LLOCATION - HHA GENERAL SERVICE			Provi der Co	CN: 15-1324	Peri od: From 01/01/2016	Worksheet H-1	
				HHA CCN:	15-7149	To 12/31/2016		pared:
-						Home Health	PPS	9 4111
			Capital Rela	ated Costs		Agency I		
		Net Expenses for Cost	Bldgs & Fixtures	Movable Equipment	Plant Operation &	Transportation	Subtotal (cols. 0-4)	
		Allocation	TTAtures	Equi pilierre	Mai ntenance		(0013. 0-4)	
		(from Wkst. H, col. 10)						
		0	1.00	2.00	3. 00	4. 00	4A. 00	
1. 00	GENERAL SERVICE COST CENTERS Capital Related - Bldg. &	0	0		T		0	1.00
1.00	Fixtures							1.00
2.00	Capital Related - Movable Equipment	0		0			0	2. 00
3. 00	Plant Operation & Maintenance	0	О	0		0	0	3. 00
4.00	Transportation	0	0	0		0 0	/// 072	4.00
5. 00	Administrative and General HHA REIMBURSABLE SERVICES	664, 072	υ	0		0 0	664, 072	5. 00
6.00	Skilled Nursing Care	243, 786	0	0	•	0 0	243, 786	
7. 00 8. 00	Physical Therapy Occupational Therapy	200, 269 51, 680	0	0	1	0 0	200, 269 51, 680	
9.00	Speech Pathology	38, 490	O	0		0 0	38, 490	9. 00
10. 00 11. 00	Medical Social Services Home Health Aide	93, 309	0	0		0 0	0 93, 309	
12. 00	Supplies (see instructions)	50, 828	o	0		0 0	50, 828	1
13.00	Drugs	2, 009	O	0		0 0	2,009	1
14. 00	DME HHA NONREI MBURSABLE SERVI CES	0	0	0		0 0	0	14. 00
15.00	Home Dialysis Aide Services	0	0	0	•	0 0	0	
16. 00 17. 00	Respiratory Therapy Private Duty Nursing	0 58, 982	0	0		0 0	0 58, 982	
18. 00	Clinic	0	O	0		0 0	0	18. 00
19. 00 20. 00	Health Promotion Activities Day Care Program	0	0	0		0 0	0	19. 00 20. 00
21. 00		0	Ö	Ö		0 0	Ö	1
22. 00 23. 00	Homemaker Service All Others (specify)	0	0	0		0 0	0	22. 00 23. 00
23. 50	Tel emedi ci ne	0	Ö	0		0 0	0	
24. 00	Total (sum of lines 1-23)	1, 403, 425 Admi ni strati ve	O Total (col.s	0		0 0	1, 403, 425	24. 00
		& General	4A + 5)					
	GENERAL SERVICE COST CENTERS	5. 00	6. 00					
1. 00	Capital Related - Bldg. &							1. 00
2 00	Fixtures							2.00
2. 00	Capital Related - Movable Equipment							2. 00
3.00	Plant Operation & Maintenance							3.00
4. 00 5. 00	Transportation Administrative and General	664, 072						4. 00 5. 00
	HHA REIMBURSABLE SERVICES		750					
6. 00 7. 00	Skilled Nursing Care Physical Therapy	218, 964 179, 878	462, 750 380, 147					6. 00 7. 00
8.00	Occupational Therapy	46, 418	98, 098					8. 00
9. 00 10. 00	Speech Pathology Medical Social Services	34, 571	73, 061					9. 00 10. 00
11. 00	Home Health Aide	83, 808	177, 117					11. 00
12. 00 13. 00	Supplies (see instructions) Drugs	45, 653 1, 804	96, 481 3, 813					12. 00 13. 00
14. 00	DME	0	3, 813					14. 00
15 00	HHA NONREI MBURSABLE SERVI CES							1E 00
15. 00 16. 00	Home Dialysis Aide Services Respiratory Therapy	0 0	0					15. 00 16. 00
17.00	Private Duty Nursing	52, 976	111, 958					17. 00
18. 00 19. 00	Clinic Health Promotion Activities	0	0					18. 00 19. 00
20. 00	Day Care Program	0	О					20. 00
21. 00 22. 00	Home Delivered Meals Program Homemaker Service	0	0					21. 00 22. 00
	All Others (specify)	0	О					23. 00
23. 50	Tel emedi ci ne	0	1 402 425					23. 50 24. 00
∠4. UU	Total (sum of lines 1-23)	1	1, 403, 425					24. UU

Heal th	Financial Systems	F	RANCISCAN HEAL	TH RENSSELAER		In Lie	eu of Form CMS-2	2552-10
	LLOCATION - HHA STATISTICAL BAS	SIS		Provi der Co	CN: 15-1324	Peri od:	Worksheet H-1	
				HHA CCN:	15-7149	From 01/01/2016 To 12/31/2016	Part II	pared:
						Home Health Agency I	PPS	
		Capital Rel	ated Costs			Agency I		
		Capital Kei	ateu costs					
		BI dgs &	Movabl e	PI ant	Transportati	onReconciliation	Admi ni strati ve	
		Fixtures	Equi pment	Operation &	(MI LEAGE)		& General	
		(SQUARE FEET)	(DOLLAR VALUE)	Mai ntenance			(ACCUM. COST)	
				(SQUARE FEET)				
		1. 00	2. 00	3. 00	4.00	5A. 00	5. 00	
	GENERAL SERVICE COST CENTERS							_
1.00	Capital Related - Bldg. &	0				0		1. 00
	Fixtures		_			_		
2. 00	Capital Related - Movable		0			0		2. 00
0.00	Equi pment							0.00
3.00	Plant Operation & Maintenance	0	0	0		0		3.00
4. 00	Transportation (see instructions)	0	0	0		0		4. 00
5. 00	Administrative and General	0	0	0		0 -664, 072	739, 353	5. 00
5.00	HHA REIMBURSABLE SERVICES					0 004, 072	137, 333	3.00
6. 00	Skilled Nursing Care	0	0	0		0 0	243, 786	6.00
7. 00	Physical Therapy	0	0	0		0 0	200, 269	1
8. 00	Occupational Therapy	0	0	0		0 0	51, 680	•
9. 00	Speech Pathology	0	0	Ö		0 0	38, 490	
10.00	Medical Social Services	0	0	0		0 0	0	10.00
11. 00	Home Health Aide	0	0	0		0 0	93, 309	
12.00	Supplies (see instructions)	0	0	0		0 0	50, 828	12. 00
13.00	Drugs	0	0	0		0	2,009	13. 00
14.00	DME	0	0	0		0 0	0	14. 00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0		0 0	0	15. 00
16.00	Respiratory Therapy	0	0	0		0 0	0	
17.00	Private Duty Nursing	0	0	0		0 0	58, 982	17. 00
18. 00	Clinic	0	0	0		0	0	
19. 00	Health Promotion Activities	0	0	0		0 0	0	1 . ,
20.00	Day Care Program	0	0	0		0 0	0	1 20.00
21. 00	Home Delivered Meals Program	0	0	0		0	0	1 = 00
22. 00	Homemaker Service	0	0	0		0 0	0	
	All Others (specify)	0	0	0	1	0 0	0	
23. 50	Tel emedi ci ne	0	0	0	1	0 0	0	
24. 00	Total (sum of lines 1-23)	0	0	0		0 -664, 072	739, 353	
25. 00	Cost To Be Allocated (per	0	0	0	1	0	664, 072	25. 00
26 00	Worksheet H-1, Part I) Unit Cost Multiplier	0. 000000	0. 000000	0. 000000	0. 0000	00	0. 898180	26 00
∠0. 00	Torrit cost murtiprier	1 0.000000	0. 000000	0.00000	I 0.0000	00	0.090180	J 20. 00

Health Financial Systems FRANC ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS Worksheet H-2 Part I Date/Time Prepared: 8/8/2017 10:19 am Provi der CCN: 15-1324 Peri od: From 01/01/2016 To 12/31/2016 HHA CCN: 15-7149 Home Health

						Agency I	PP5	
			CAPI TAL			/igeney i		
			RELATED COSTS					
	Cost Center Description	HHA Trial	NEW BLDG &	EMPLOYEE	Subtotal	ADMI NI STRATI VE	OPERATION OF	
		Bal ance (1)	FLXT	BENEFITS		& GENERAL	PLANT	
			1.00	DEPARTMENT			7.00	
1 00	Administratives and Consent	0	1.00	4. 00	4A	5. 00	7. 00	1 00
1. 00 2. 00	Administrative and General	0	134, 880 0	432, 742	567, 622 462, 750		73, 534 0	1. 00 2. 00
3.00	Skilled Nursing Care Physical Therapy	462, 750 380, 147	0	0	380, 147		0	3. 00
4. 00	Occupati onal Therapy	98, 098	0	0	98, 098	•	0	4. 00
5. 00	Speech Pathology	73, 061	0	0	73, 061		0	5. 00
6. 00	Medical Social Services	73,001	0	0	73,001	33, 777	0	6. 00
7. 00	Home Heal th Aide	177, 117	Ö	0	177, 117	81, 888	Ö	7. 00
8.00	Supplies (see instructions)	96, 481	0	0	96, 481		0	8. 00
9.00	Drugs	3, 813	0	0	3, 813	1, 763	0	9. 00
10.00	DME	0	0	0	C	0	0	10.00
11. 00	Home Dialysis Aide Services	0	0	0	C	0	0	11. 00
12. 00	Respiratory Therapy	0	0	0	C	0	0	12. 00
13.00	Private Duty Nursing	111, 958	0	0	111, 958	51, 762	0	13.00
14. 00 15. 00	Clinic Health Promotion Activities	0	0	0			0	14. 00 15. 00
16. 00	Day Care Program		0	0			0	16. 00
17. 00	Home Delivered Meals Program		0	0			0	17. 00
18. 00	Homemaker Service	0	o	0		o o	Ö	18. 00
19. 00	All Others (specify)	0	0	0	C	0	0	19.00
19. 50	Tel emedi ci ne	0	0	0	C	0	0	19. 50
20. 00	Total (sum of lines 1-19) (2)	1, 403, 425	134, 880	432, 742			73, 534	20.00
21. 00	Unit Cost Multiplier: column				0. 000000)		21. 00
	26, line 1 divided by the sum							
	of column 26, line 20 minus column 26, line 1, rounded to							
	16 decimal places							
	6 decimal places. Cost Center Description	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	
	Cost Center Description	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVICES &	
		LINEN SERVICE				ADMI NI STRATI ON	SERVI CES & SUPPLY	
1.00	Cost Center Description	LINEN SERVICE 8.00	9.00	10. 00	11. 00	ADMI NI STRATI ON 13. 00	SERVI CES & SUPPLY 14.00	1.00
1.00	Cost Center Description Administrative and General	LINEN SERVICE	9. 00 92, 139		11. 00 C	ADMINI STRATI ON 13. 00 0 0	SERVI CES & SUPPLY 14.00	1.00
2.00	Cost Center Description Administrative and General Skilled Nursing Care	LINEN SERVICE 8.00	9. 00 92, 139 0	10. 00	11. 00	ADMINI STRATI ON 13. 00 0 0	SERVI CES & SUPPLY 14.00 0	2. 00
2. 00 3. 00	Cost Center Description Administrative and General Skilled Nursing Care Physical Therapy	LINEN SERVICE 8.00	9. 00 92, 139	10. 00	11. 00 C	ADMINI STRATI ON 13. 00 0 0	SERVI CES & SUPPLY 14. 00 0 0 0	2. 00 3. 00
2. 00 3. 00 4. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy	LINEN SERVICE 8.00	9. 00 92, 139 0	10. 00	11. 00 C	ADMINI STRATI ON 13. 00 0 0	SERVI CES & SUPPLY 14.00 0	2. 00 3. 00 4. 00
2. 00 3. 00	Cost Center Description Administrative and General Skilled Nursing Care Physical Therapy	LINEN SERVICE 8.00	9. 00 92, 139 0	10. 00	11. 00 C	13. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0	SERVI CES & SUPPLY 14. 00 0 0 0 0 0 0	2. 00 3. 00
2. 00 3. 00 4. 00 5. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology	LINEN SERVICE 8.00	9. 00 92, 139 0 0 0	10.00	11. 00 C C C	13. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0	SERVI CES & SUPPLY 14. 00 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions)	LINEN SERVICE 8.00	9.00 92,139 0 0 0 0 0	10.00	11.00 C C C C C C	13. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	SERVI CES & SUPPLY 14. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs	LINEN SERVICE 8.00	9.00 92,139 0 0 0 0 0 0	10.00	11.00 C C C C C C C	13. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	SERVI CES & SUPPLY 14. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME	LINEN SERVICE 8.00	9.00 92,139 0 0 0 0 0 0	10.00	11.00 C C C C C C	13. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	SERVI CES & SUPPLY 14. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services	LINEN SERVICE 8.00	9.00 92,139 0 0 0 0 0 0	10.00	11.00 C C C C C C C	13. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	SERVI CES & SUPPLY 14. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy	LINEN SERVICE 8.00	9.00 92,139 0 0 0 0 0 0 0	10.00	11.00 C C C C C C C	13. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	SERVI CES & SUPPLY 14. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing	LINEN SERVICE 8.00	9.00 92,139 0 0 0 0 0 0 0 0	10.00	11.00 C C C C C C C	13. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	SERVI CES & SUPPLY 14.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic	LINEN SERVICE 8.00	9.00 92,139 0 0 0 0 0 0 0	10.00	11.00 C C C C C C C	13. 00 13. 00 0 0 0 0 0 0 0 0 0 0 0 0	SERVI CES & SUPPLY 14. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing	8. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	9.00 92,139 0 0 0 0 0 0 0 0 0 0 0 0 0	10.00	11.00 CC CC CC CC CC CC CC CC CC	13. 00 13. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	SERVI CES & SUPPLY 14.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities	8. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	9.00 92,139 0 0 0 0 0 0 0 0 0 0	10.00	11. 00	13. 00 13. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	SERVI CES & SUPPLY 14. 00 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program	8. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	9.00 92,139 0 0 0 0 0 0 0 0 0 0	10.00 0 0 0 0 0 0 0 0 0 0 0	11. 00	13. 00 13. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	SERVI CES & SUPPLY 14. 00 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify)	8. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	9.00 92,139 0 0 0 0 0 0 0 0 0 0	10.00 0 0 0 0 0 0 0 0 0 0 0	11. 00	13. 00 13. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	SERVI CES & SUPPLY 14. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 17. 00 18. 00 19. 00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine	8. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	9.00 92,139 0 0 0 0 0 0 0 0 0 0 0 0 0	10.00 0 0 0 0 0 0 0 0 0 0 0	11. 00	13. 00 13. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	SERVI CES & SUPPLY 14.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 17. 00 18. 00 19. 00 19. 50
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 19. 50 20. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2)	8. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	9.00 92,139 0 0 0 0 0 0 0 0 0 0	10.00 0 0 0 0 0 0 0 0 0 0 0	11. 00	13. 00 13. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	SERVI CES & SUPPLY 14.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 17. 00 18. 00 19. 50 20. 00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2) Unit Cost Multiplier: column	8. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	9.00 92,139 0 0 0 0 0 0 0 0 0 0 0 0 0	10.00 0 0 0 0 0 0 0 0 0 0 0	11. 00	13. 00 13. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	SERVI CES & SUPPLY 14.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 17. 00 18. 00 19. 00 19. 50
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 19. 50 20. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum	8. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	9.00 92,139 0 0 0 0 0 0 0 0 0 0 0 0 0	10.00 0 0 0 0 0 0 0 0 0 0 0	11. 00	13. 00 13. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	SERVI CES & SUPPLY 14.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 17. 00 18. 00 19. 50 20. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 19. 50 20. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus	8. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	9.00 92,139 0 0 0 0 0 0 0 0 0 0 0 0 0	10.00 0 0 0 0 0 0 0 0 0 0 0	11. 00	13. 00 13. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	SERVI CES & SUPPLY 14.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 17. 00 18. 00 19. 50 20. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 19. 50 20. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum	8. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	9.00 92,139 0 0 0 0 0 0 0 0 0 0 0 0 0	10.00 0 0 0 0 0 0 0 0 0 0 0	11. 00	13. 00 13. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	SERVI CES & SUPPLY 14.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 17. 00 18. 00 19. 00 19. 50 20. 00

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

From 01/01/2016 Part I HHA CCN: 15-7149 То 12/31/2016 Date/Time Prepared: 8/8/2017 10:19 am Home Health **PPS** Agency I Cost Center Description PHARMACY MEDI CAL SOCIAL SERVICE Subtotal Intern & Subtotal Residents Cost RECORDS & LI BRARY & Post Stepdown Adjustments 15. 00 16.00 17. 00 24.00 25. 00 26.00 1.00 Administrative and General 0 0 995, 726 995, 726 1.00 0 o 2 00 2 00 Skilled Nursing Care C 676, 696 676, 696 3.00 Physical Therapy 0 0 555, 903 0 555, 903 3.00 0000000000000000000 4.00 Occupational Therapy 0 0 143, 452 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 143, 452 4.00 Speech Pathology 0 5 00 106, 840 106, 840 5 00 6.00 Medical Social Services 0 6.00 0 7.00 Home Heal th Aide 0 259, 005 259,005 7.00 0 8.00 Supplies (see instructions) 0 141,088 141,088 8.00 0 9.00 0 5,576 9 00 Drugs 5, 576 10.00 DMF 0 0 10.00 Home Dialysis Aide Services 0 11.00 0 11.00 Respiratory Therapy 0 12.00 12.00 0 0 0 0 13.00 Private Duty Nursing 0 163, 720 163, 720 13.00 14.00 Clinic 0 14.00 C Health Promotion Activities 15.00 0 15.00 Day Care Program 0 0 0 0 0 16, 00 16.00 0 17.00 Home Delivered Meals Program 0 0 17 00 18.00 Homemaker Service 0 18.00 19.00 All Others (specify) 0 0 0 19.00 0 19.50 Tel emedi ci ne 0 19.50 0 3, 048, 006 20.00 Total (sum of lines 1-19) (2) 3, 048, 006 20.00 Unit Cost Multiplier: column 21.00 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places. Cost Center Description Allocated HHA Total HHA A&G (see Part Costs II) 27. 00 28. 00 1.00 Administrative and General 1.00 1, 005, 016 2.00 Skilled Nursing Care 328, 320 2.00 3.00 Physical Therapy 269, 713 825, 616 3.00 213, 052 4 00 Occupational Therapy 69,600 4 00 5.00 Speech Pathology 51,837 158, 677 5.00 Medical Social Services 6.00 6.00 7.00 Home Health Aide 125, 664 384, 669 7.00 209, 541 8.00 Supplies (see instructions) 68, 453 8.00 9.00 Drugs 2,705 8, 281 9.00 10.00 0 10.00 Home Dialysis Aide Services 11.00 11.00 0 0 12.00 Respiratory Therapy 0 0 12.00 13.00 Private Duty Nursing 79, 434 243, 154 13.00 14.00 Clinic 0 0 14.00 0 Health Promotion Activities 0 15.00 15.00 0 16.00 Day Care Program 16.00 Home Delivered Meals Program 0 0 17.00 17.00 Homemaker Service All Others (specify) 0 0 18.00 18.00 0 19.00 19.00 0 19.50 Tel emedi ci ne 0 19.50 20.00 Total (sum of lines 1-19) (2) 995, 726 3, 048, 006 20.00

21.00

Unit Cost Multiplier: column

6 decimal places.

26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to

0. 485180

21.00

⁽¹⁾ Column O, line 20 must agree with Wkst. A, column 7, line 101.

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

| In Lieu of Form CMS-2552-10 | Period: | Worksheet H-2 | From 01/01/2016 | Part II | To 12/31/2016 | Date/Time Prepared: | 8/8/2017 10:19 am BASIS HHA CCN: 15-7149 Home Health

						Home Health Agency I	PPS	
		CAPI TAL				7,90,107		
		RELATED COSTS	511D1 0\155			005047101105	I ALINDRY A	
	Cost Center Description	NEW BLDG & FLXT	EMPLOYEE BENEFITS	Reconciliation	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
		(SQUARE	DEPARTMENT		(ACCUM.	(SQUARE	(DOLLAR	
		FEET)	(GROSS		COST)	FEET)	VALUE)	
		,	SALARI ES)		,	ŕ	ŕ	
1 00	Administrative and Consumb	1.00	4.00	5A	5. 00	7. 00	8. 00	1 00
1. 00 2. 00	Administrative and General Skilled Nursing Care	3, 086	1, 184, 497 C	1	567, 622 462, 750	3, 086	0	1. 00 2. 00
3. 00	Physical Therapy		C	1	1	0	Ö	3. 00
4. 00	Occupational Therapy	Ö	C	1	98, 098	0	Ō	4. 00
5.00	Speech Pathology	0	C) c	73, 061	0	0	5. 00
6.00	Medical Social Services	0	C	1	0	0	0	6. 00
7. 00	Home Heal th Aide	0	C		177, 117	0	0	7. 00
8.00	Supplies (see instructions)	0	C		96, 481	0	0	8. 00
9. 00 10. 00	Drugs DME	0	C	1	3, 813	0	0	9. 00 10. 00
11. 00	Home Dialysis Aide Services		C			0	0	11. 00
12. 00	Respiratory Therapy	l o	C		ol o	0	Ö	12. 00
13.00	Private Duty Nursing	0	C	o c	111, 958	0	0	13. 00
14.00	Clinic	0	C) c	0	0	0	14. 00
15. 00	Health Promotion Activities	0	C) C	0	0	0	15. 00
16.00	Day Care Program	0	C		0	0	0	16.00
17. 00 18. 00	Home Delivered Meals Program Homemaker Service		C			0	0	17. 00 18. 00
19. 00	All Others (specify)		C			0	0	19. 00
19. 50	Tel emedi ci ne	l o	C	o c	o o	0	Ö	19. 50
20.00	Total (sum of lines 1-19)	3, 086	1, 184, 497	1	1, 971, 047	3, 086	0	20. 00
21. 00	Total cost to be allocated	134, 880	432, 742		911, 286		0	21. 00
22. 00	Unit cost multiplier	43. 707064	0. 365338		0. 462336		0.000000	22. 00
	Cost Center Description	HOUSEKEEPING (HOURS OF	DI ETARY (MEALS	CAFETERIA (MAN	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES &	PHARMACY (100%	
		SERVICE)	SERVED)	HOURS)	ADMINI STRATION	SUPPLY	ALLOCATION)	
		ŕ			(MAN	(100%	ŕ	
		0.00	10.00	44.00	HOURS)	ALLOCATION)	45.00	
1. 00	Administrative and General	9. 00	10. 00	11. 00	13.00	14. 00	15. 00 0	1. 00
2. 00	Skilled Nursing Care	0,210	C		ol ö	0	1	2. 00
3.00	Physi cal Therapy	0	C) c	0	0	0	3. 00
4.00	Occupational Therapy	0	C	1	0	0	0	4. 00
5.00	Speech Pathology	0	C	_	0	0	0	5. 00
6.00	Medical Social Services	0	C	1	0	0	0	6. 00
7. 00 8. 00	Home Health Aide Supplies (see instructions)		C	-	0	0	0	7. 00 8. 00
9. 00	Drugs		C	1		0	0	9. 00
10.00	DME	Ö	C		o o	0	Ō	10.00
11. 00	Home Dialysis Aide Services	o	C) c	0	0	0	11. 00
12.00	Respi ratory Therapy	0	C		0	0	0	12. 00
13. 00	Private Duty Nursing	0	C		0	0	0	13. 00
14.00		0	C		0	0	0	
15. 00 16. 00	Health Promotion Activities Day Care Program		C			0	0	15. 00 16. 00
17. 00	Home Delivered Meals Program		C	1		0	0	17. 00
18. 00	Homemaker Service	l o	C	-	o o	0	Ö	18. 00
19. 00	All Others (specify)	0	C) c	o o	0	0	19. 00
19. 50	Tel emedi ci ne	0	C	1	0	0	0	19. 50
20.00	Total (sum of lines 1-19)	6, 240	C) C	0	0	0	20.00
21. 00	Total cost to be allocated	92, 139	0.00000	0.00000	0 000000	0 000000	0 000000	21.00
22. 00	Unit cost multiplier	14. 765865	0. 000000	0.000000	0.000000	0. 000000	0. 000000	ZZ. UU

	_Financial_Systems ATION OF GENERAL SERVICE COSTS T		FRANCISCAN HEALTH ITERS STATISTICAL	Provi der CCN:	15-1324	Peri od:	u of Form CMS-: Worksheet H-2	
BASIS	or or cenerale central coord	0 000. 02				From 01/01/2016	Part II	
				HHA CCN:	15-7149	To 12/31/2016		
						Home Health	8/8/2017 10: 1 PPS	9 alli
						Agency I	113	
	Cost Center Description	MEDI CAL	SOCIAL SERVICE			7.901.07	ll.	
	'	RECORDS &						
		LI BRARY	(TIME					
		(TIME	SPENT)					
		SPENT)						
	,	16. 00	17. 00					
1.00	Administrative and General	C	0					1. 00
2.00	Skilled Nursing Care	C	0					2. 00
3.00	Physi cal Therapy	C	0					3. 00
4.00	Occupational Therapy	C	0					4. 00
5.00	Speech Pathology	C	0					5. 00
6.00	Medical Social Services	C	0					6. 00
7.00	Home Health Aide	C	0					7. 00
8.00	Supplies (see instructions)	C	0					8. 00
9.00	Drugs	C	0					9. 00
10.00	DME	C	0					10.00
11. 00	Home Dialysis Aide Services	C	0					11. 00
12. 00	Respiratory Therapy	C	0					12. 00
13.00	Private Duty Nursing	C	0					13. 00
14. 00	Clinic	C	0					14. 00
15. 00	Health Promotion Activities	C	0					15. 00
16.00	Day Care Program	C	0					16. 00
17. 00	Home Delivered Meals Program	C	0					17. 00
18. 00	Homemaker Service	C	0					18. 00
19. 00	All Others (specify)	C	0					19. 00
19. 50	Tel emedi ci ne	C	0					19. 50
20.00	Total (sum of lines 1-19)	C	0					20.00
21. 00	Total cost to be allocated	C	0					21. 00
22.00	Unit cost multiplier	0. 000000	0. 000000					22. 00

Hoal th	Financial Systems		FRANCISCAN HEAL	TU DENCCEI AED		In Lie	eu of Form CMS-2	2552 10
	TONMENT OF PATIENT SERVICE COST		KANCI SCAN TILAL	Provi der C	CN: 15-1324	Peri od:	Worksheet H-3	
				HHA CCN:		From 01/01/2016 To 12/31/2016		
				Title	e XVIII	Home Health Agency I	PPS	<u> </u>
	Cost Center Description	From, Wkst.	Facility Costs	Shared	Total HHA	Total Visits	Average Cost	
		H-2, Part I,	(from Wkst.	Ancillary	Costs (cols.	1	Per Visit	
		col. 28, line	H-2, Part I)	Costs (from	+ 2)		(col. 3 ÷ col.	
		0	1.00	Part II) 2.00	3.00	4. 00	4) 5. 00	
	PART I - COMPUTATION OF LESSER							
	BENEFICIARY COST LIMITATION Cost Per Visit Computation							
1. 00	Skilled Nursing Care	2. 00	1, 005, 016		1, 005, 01	6 3, 070	327. 37	1.00
2.00	Physical Therapy	3. 00					l e	
3.00	Occupational Therapy	4. 00						
4.00	Speech Pathology	5. 00	158, 677	C	158, 67	7 295	537. 89	4. 00
5.00	Medical Social Services	6. 00				0 0	0. 00	5. 00
6.00	Home Health Aide	7. 00			384, 66			
7. 00	Total (sum of lines 1-6)		2, 587, 030	С				7. 00
					Program Visit	s ırt B		-
	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Not Subject t			
	cost center bescription	COST LIMITES	CBSA NO. (1)	raitA	Deductibles			
					Coi nsurance	beddeti bi es		
		0	1.00	2.00	3. 00	4. 00	5. 00	
0.00	Limitation Cost Computation		00044					0.00
8.00	Skilled Nursing Care		23844 29200	C	•			8. 00 8. 01
8. 01 8. 02	Skilled Nursing Care Skilled Nursing Care		99915	C	•	9		8. 01
9. 00	Physical Therapy		23844	C				9. 00
9. 01	Physical Therapy		29200	Č		7		9. 01
9. 02	Physical Therapy		99915	C	8	2		9. 02
10.00	Occupational Therapy		23844	C	33	9		10. 00
10. 01	Occupational Therapy		29200	C	l	0		10. 01
10. 02	Occupational Therapy		99915	C		3		10. 02
11.00	Speech Pathology		23844	C				11.00
11. 01 11. 02	Speech Pathology Speech Pathology		29200 99915	C	l .	0 4		11. 01 11. 02
12. 00	Medical Social Services		23844			5		12.00
12. 00	Medical Social Services		29200		•	0		12. 00
12. 02	Medical Social Services		99915	Č	1	6		12. 02
13.00	Home Health Aide		23844	C	1, 29	4		13. 00
13.01	Home Health Aide		29200	C		0		13. 01
13. 02	Home Health Aide		99915	C	•	4		13. 02
14. 00	Total (sum of lines 8-13)	- "		C	-,,		D 11 (1 0	14. 00
	Cost Center Description		Facility Costs		Total HHA	9	Ratio (col. 3	
		Part I, col. 28, line	(from Wkst. H-2, Part I)	Ancillary Costs (from	Costs (cols. + 2)	1 (from HHA Records)	÷ col. 4)	
		20, 11110	11 2, 141 (1)	Part II)	' -/	i i i i i i i i i i i i i i i i i i i		
		0	1.00	2.00	3. 00	4. 00	5. 00	
45.00	Supplies and Drugs Cost Computa		000 544		000 54	4	0.00000	45.00
15. 00 16. 00	Cost of Medical Supplies Cost of Drugs	8. 00 9. 00			•			
16.00	Cost of brugs		8,281 Program Vi si ts		8, 28 Cost of	0	0. 000000	16. 00
			11 Ogram VI 31 t3		Servi ces			
			Par	t B		Part B		
	Cost Center Description	Part A	Not Subject to		Part A	Not Subject to		
			Deductibles &			Deductibles &	Deductibles &	
		4 00	Coi nsurance	Coi nsurance	0.00	Coi nsurance 10, 00	Coi nsurance	
	PART I - COMPUTATION OF LESSER	6.00 OF AGGREGATE F	7.00 PROGRAM COST A	8.00 GGREGATE OF TH	9.00		11.00	
	BENEFICIARY COST LIMITATION	or AGGREGATE F		SSILEONIE OF TI	I NOONAW LIW			
	Cost Per Visit Computation]
1.00	Skilled Nursing Care	0	.,			0 442, 277		1.00
2.00	Physi cal Therapy	0	.,		1	0 537, 569	l e	2. 00
3.00	Occupational Therapy	0	372		1	0 151, 542		3. 00
4.00	Speech Pathology	0	266		•	0 143, 079		4.00
5. 00 6. 00	Medical Social Services Home Health Aide	0	21 1, 378		•	0 0 71, 918		5. 00 6. 00
7. 00	Total (sum of lines 1-6)				l	0 1, 346, 385		7.00
		1	1 7,750	l	1	1, 540, 303	I	, , , , ,

APPORT	FIONMENT OF PATIENT SERVICE COST	S		Provider CC	15-7149	Peri od: From 01/01/2016 To 12/31/2016	Date/Time Pre 8/8/2017 10:1	pared:
				Title	XVIII	Home Health Agency I	PPS	
	Cost Center Description	4.00	7.00	0.00	0.00		11 00	
	Limitation Cost Computation	6. 00	7.00	8. 00	9. 00	10.00	11.00	
8. 00 8. 01 8. 02 9. 00 9. 01 9. 02 10. 00 10. 01 11. 00 11. 01 11. 02 12. 00 12. 01 12. 02 13. 00 13. 01 13. 02 14. 00	Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Physical Therapy Physical Therapy Physical Therapy Occupational Therapy Occupational Therapy Occupational Therapy Speech Pathology Speech Pathology Speech Pathology Medical Social Services Medical Social Services Medical Social Services Home Health Aide Home Health Aide Total (sum of lines 8-13)							8. 00 8. 01 8. 02 9. 00 9. 01 9. 02 10. 00 10. 01 11. 01 11. 02 12. 00 12. 01 12. 02 13. 00 13. 01 13. 02 14. 00
14.00	Tretar (sum of Trines 6 15)	Prog	ram Covered Cha	rges	Cost of			14.00
					Servi ces			
	Cost Center Description	Part A	Part Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	Part B Not Subject to Deductibles & Coinsurance	Deductibles & Coinsurance	
	Supplies and Drugs Cost Computa	6.00 ations	7. 00	8. 00	9. 00	10.00	11. 00	
	Cost of Medical Supplies	C		0		0 0		
16. 00	Cost Center Description	Total Program Cost (sum of cols. 9-10) 12.00	O	0		0	C	16.00
	PART I - COMPUTATION OF LESSER	OF AGGREGATE I	PROGRAM COST, AC	GGREGATE OF TH	E PROGRAM LI	MITATION COST, OF	?	
	BENEFICIARY COST LIMITATION Cost Per Visit Computation							1
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6) Cost Center Description	442, 277 537, 569 151, 542 143, 079 0 71, 918 1, 346, 385						1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00
	11:::	12. 00						
8. 00 8. 01 8. 02 9. 00 9. 01 9. 02 10. 00 10. 01 11. 00 11. 01 11. 02 12. 00 12. 01 12. 02 13. 00 13. 01 13. 01	Speech Pathology Speech Pathology Speech Pathology Medical Social Services Medical Social Services Medical Social Services							8. 00 8. 01 8. 02 9. 00 9. 01 9. 02 10. 00 10. 01 11. 00 11. 01 11. 02 12. 00 12. 01 12. 02 13. 00 13. 01 13. 01

Heal th	Financial Systems	F	FRANCISCAN HEAL	TH RENSSELAER				2552-10
APP0R1	TIONMENT OF PATIENT SERVICE COST	S		Provi der Co	CN: 15-1324	Peri od:	Worksheet H-3	
				HHA CCN:	15-7149	From 01/01/2016 To 12/31/2016		
			Title	: XVIII	Home Health Agency I	PPS		
	Cost Center Description	From Wkst. C,	Cost to Charge	Total HHA	HHA Shared			
	·	Part I, col.	Ratio	Charge (from	Ancillary	Part I as		
		9, line		provi der	Costs (col.	1 Indicated		
				records)	x col. 2)			
		0	1.00	2.00	3. 00	4. 00		
	PART II - APPORTIONMENT OF COST	T OF HHA SERVIO	ES FURNISHED B	Y SHARED HOSPI	TAL DEPARTMEN	NTS		
1.00	Physical Therapy	66. 00	1. 043341	0		0 col. 2, line 2	. 00	1. 00
1. 01	Physical Therapy 1	66. 01	1. 243820	0		0 col. 2, line 2	. 01	1. 01
2.00	Occupational Therapy	67. 00	1. 514274	0		0 col. 2, line 3	. 00	2. 00
2.01	Occupational Therapy 1	67. 01	2. 189382	0		0 col. 2, line 3	. 01	2. 01
3.00	Speech Pathology	68. 00	2. 079483	0		0 col. 2, line 4	. 00	3. 00
3.01	Speech Pathology 1	68. 01	2. 215367	0		0 col. 2, line 4	. 01	3. 01
4.00	Cost of Medical Supplies	71. 00	0. 530146	0		0 col. 2, line 1	5. 00	4. 00
5.00	Cost of Drugs	73. 00	0. 489437	0		0 col. 2, line 1	6. 00	5. 00

th Financial Systems FRANCISCAN HEALT CULATION OF HHA REIMBURSEMENT SETTLEMENT	Provider CO	`N: 15_1324	Peri od:	u of Form CMS-2 Worksheet H-4	
SULATION OF THE REIMBURSEMENT SETTLEMENT			From 01/01/2016	Part I-II	
	HHA CCN:	15-7149	To 12/31/2016	Date/Time Prep 8/8/2017 10:19	
	Title	XVIII	Home Health Agency I	PPS	
				t B	
		Part A	Not Subject to		
				Deductibles &	
		1 00	Coi nsurance	Coi nsurance	
PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUS	TOMARY CHARGE	1.00	2. 00	3. 00	
Reasonable Cost of Part A & Part B Services	TOWART CHARGE	5			1
Reasonable cost of services (see instructions)			0 0	0	1 -
Total charges			0 0		
Customary Charges					
Amount actually collected from patients liable for payment f	or services		0 0	0	:
on a charge basis (from your records)					
Amount that would have been realized from patients liable for for services on a charge basis had such payment been made in			0 0	0	4
with 42 CFR §413.13(b)	accordance				1
Ratio of line 3 to line 4 (not to exceed 1.000000)		0. 0000	0. 000000	0. 000000	
Total customary charges (see instructions)			0 0	0	1
Excess of total customary charges over total reasonable cost	(complete		0 0	0	.
only if line 6 exceeds line 1)			-	_	1
Excess of reasonable cost over customary charges (complete o	only if line		0 0	0	1
1 exceeds line 6) Primary payer amounts			0 0	0	
7 Titimary payor amounts			Part A	Part B	
			Servi ces	Servi ces	
			1. 00	2. 00	
PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT					1.
00 Total reasonable cost (see instructions) 00 Total PPS Reimbursement - Full Episodes without Outliers			0	0 607, 101	
00 Total PPS Reimbursement - Full Episodes without outliers			0	39, 955	
00 Total PPS Reimbursement - LUPA Episodes			0	11, 280	
00 Total PPS Reimbursement - PEP Episodes			0	0	
70 Total PPS Outlier Reimbursement - Full Episodes with Outlier	`S		0	7, 294	
OO Total PPS Outlier Reimbursement - PEP Episodes			0	0	1
Total Other Payments			0	0	
DO DME Payments			0	0	
ON Oxygen Payments			0	0	
00 Prosthetic and Orthotic Payments 00 Part B deductibles billed to Medicare patients (exclude coin	elleance)		0	0	
00 Subtotal (sum of lines 10 thru 20 minus line 21)	isui aiice)		0	665, 630	
00 Excess reasonable cost (from line 8)			0	005, 030	1 -
OD Subtotal (line 22 minus line 23)			0	665, 630	
OO Coinsurance billed to program patients (from your records)				0	1
Net cost (line 24 minus line 25)			0	665, 630	
Reimbursable bad debts (from your records)					2
Reimbursable bad debts for dual eligible beneficiaries (see				//= /22	2
Total costs - current cost reporting period (line 26 plus li	ne 2/)		0	665, 630	
DO OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 50 Pioneer ACO demonstration payment adjustment (see instructio	ine)		0	0	1
00 Subtotal (see instructions)	113)		0	665, 630	
Of Subtotal (see First detroits) Of Seguestration adjustment (see instructions)			0	13, 313	
			0	652, 317	
00 Interim payments (see instructions)					
00 Interim payments (see instructions) 00 Tentative settlement (for contractor use only)			0	0	3.
			0	0	34

Health Financial Systems FRANCISCAN HEALTH RENSSELAER

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED HHAS FOR SERVICES RENDERED Provider C Peri od: From 01/01/2016 To 12/31/2016 Date/Ti me Prepared: 8/8/2017 10:19 am PPS Provider CCN: 15-1324 TO PROGRAM BENEFICIARIES HHA CCN: 15-7149

				Home Health Agency I	PPS	
		Inpatien	t Part A		t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
1.00		1. 00	2. 00	3. 00	4.00	1 00
1. 00 2. 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero			0	652, 317 0	1. 00 2. 00
3. 00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					3. 00
3. 01				0	0	3. 01
3. 02				0	0	3. 02
3. 03 3. 04				0		3. 03 3. 04
3. 05				0	l ől	3. 05
	Provider to Program					
3.50				0	0	3. 50
3.51				0	0	3. 51
3. 52 3. 53				0	0	3. 52 3. 53
3. 54				0		3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			Ö	o	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)		1	0	652, 317	4. 00
	TO BE COMPLETED BY CONTRACTOR					
5. 00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5. 00
5. 01	Program to Provider			0	0	5. 01
5. 01				0	0	5. 01
5. 03				0	ان	5. 03
	Provider to Program					
5. 50				0	0	5. 50
5. 51				0	0	5. 51
5. 52 5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0		5. 52 5. 99
6. 00	5.50-5.98) Determined net settlement amount (balance due) based on		'	O		6. 00
	the cost report. (1)				_	
6. 01 6. 02	SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM			0 0	0	6. 01 6. 02
6. 02 7. 00	Total Medicare program liability (see instructions)			0	652, 317	6. 02 7. 00
7.00	install mean odi o program i rability (see i iisti detions)			Contractor Number	NPR Date (Mo/Day/Yr)	7.00
		()	1. 00	2.00	
8.00	Name of Contractor					8. 00

						8/8/2017 10: 1	9 am
		041.451.50	0.71150	OUDTOTAL (Hospi ce I	OURTOTAL	
		SALARI ES	OTHER	SUBTOTAL (col.	RECLASSIFI -	SUBTOTAL	
		4.00	0.00	1 plus col. 2)	CATIONS	F 00	
	OFNEDAL CERVI OF COCT CENTERS	1.00	2. 00	3. 00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT*		0	C		0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP*		0	C	0	0	2. 00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	0	l c	0	0	3. 00
4.00	ADMINISTRATIVE & GENERAL*	198, 317	168, 246	366, 563	0	366, 563	4. 00
5.00	PLANT OPERATION & MAINTENANCE*	0	0	0	0	0	5. 00
6.00	LAUNDRY & LINEN SERVICE*	0	0	0	0	0	6. 00
7.00	HOUSEKEEPI NG*	0	0	C	0	0	7. 00
8.00	DI ETARY*	0	0	O.	0	0	8. 00
9.00	NURSI NG ADMI NI STRATI ON*	0	0	C	0	0	9. 00
10.00	ROUTINE MEDICAL SUPPLIES*	0	0	ol c	0	0	10.00
11. 00	MEDI CAL RECORDS*	o	0		0	0	11. 00
12.00	STAFF TRANSPORTATION*	o	0		0	0	12.00
13.00	VOLUNTEER SERVICE COORDINATION*	ol	0		0	0	13.00
14. 00	PHARMACY*	0	0		0	0	14.00
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES*		0		0	0	15. 00
16. 00	OTHER GENERAL SERVI CE*		0		0	0	16. 00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES		· ·	Ĭ		Ŭ	17. 00
17.00	DIRECT PATIENT CARE SERVICE COST CENTERS			1			17.00
25. 00	INPATIENT CARE-CONTRACTED**	O	0	0	0	0	25. 00
26. 00	PHYSI CI AN SERVI CES**		0			0	26.00
27. 00	NURSE PRACTITIONER**		0		0	0	27.00
28. 00	REGISTERED NURSE**	124 000	E 7.2	12/ 501	0	126, 581	28.00
29. 00	LPN/LVN**	126, 008	573	126, 581	0		29.00
	PHYSI CAL THERAPY**	0	U		0	0	
30.00		0	U		0	0	30.00
31. 00	OCCUPATIONAL THERAPY**	0	U		0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	U		0	0	32.00
33. 00	MEDICAL SOCIAL SERVICES**	0	Ü		0	0	33. 00
34.00	SPIRITUAL COUNSELING**	0	Ü			0	34.00
35. 00	DI ETARY COUNSELI NG**	0	0	C	0	0	35. 00
36. 00	COUNSELING - OTHER**	0	0		0	0	36. 00
37. 00	HOSPICE AIDE & HOMEMAKER SERVICES**	0	0	0	0	0	37. 00
38. 00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	0	l c	0	0	38. 00
39. 00	PATI ENT TRANSPORTATI ON**	0	14, 368	14, 368	0	14, 368	39. 00
40.00	I MAGI NG SERVI CES**	0	0	C	0	0	40. 00
41. 00	LABS & DI AGNOSTI CS**	0	0	0	0	0	41. 00
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	36, 810	36, 810	0	36, 810	42. 00
43.00	OUTPATIENT SERVICES**	0	513	513	0	513	43.00
44.00	PALLIATIVE RADIATION THERAPY**	0	0	C	0	0	44. 00
45.00	PALLIATIVE CHEMOTHERAPY**	0	0	O C	0	0	45. 00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY) **	o	0	o c	0	0	46.00
	NONREI MBURSABLE COST CENTERS			•			
60.00	BEREAVEMENT PROGRAM *	0	C	C	0	0	60.00
61.00	VOLUNTEER PROGRAM *	o	0	l c	0	0	61.00
62. 00	FUNDRAI SI NG*	o	0		0	0	62.00
63. 00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	O	0		0	0	63.00
64. 00	PALLIATIVE CARE PROGRAM*		0		0	0	64.00
65. 00	OTHER PHYSI CI AN SERVI CES*		0		0	0	65. 00
66. 00	RESI DENTI AL CARE*		0		0	0	66.00
67. 00	ADVERTI SI NG*		0		0	0	67.00
68. 00	TELEHEALTH/TELEMONI TORI NG*		0		0	0	68. 00
69. 00	THRIFT STORE*		0		0	0	69.00
70. 00	NURSING FACILITY ROOM & BOARD*		0		0	0	70.00
71. 00	OTHER NONREIMBURSABLE (SPECIFY)*		0	,	0	0	71.00
	TOTAL	324, 325	220, 510	544, 835		544, 835	
-	ofer the amounts in column 7 to Wkst O.E. co		appropri ata	1 344, 033		344, 033	1.00.00

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

ADJUSTMENTS					Hospi ce I	
CAP REL COSTS -MBLE CONST -M			ADJUSTMENTS	TOTAL (col. 5		
ENREAL SERVICE COST CENTERS 1.00						
1.00 CAP REL COSTS-RELIG & FIXT* 0 0 0 2.2 0 0 0 0 0 0 0 0 0		DENERAL DERIVER DOOT DENTERO	6. 00	7.00		
2 00 CAP REL COSTS WINELE EQUIP" 0 0 0 3.00	4 00					1.00
EMPLOYCE BENEFIT'S DEPARTMENT" 0 0 0 3.00						
4.00 AMM IN STRATIVE & GENERAL* 5.00 PLAND OF PLANT OF GENERAL* 5.00 PLANT OF G						•
DANT OPERATION & MAINTERANCE" 0			_	۱		•
AUNDRY & LINEN SERVICE" 0 0 0 7.00			_			
NOUSEKEEPING*			_	Ĭ		•
B. 00 OLTARY* 0 0 0 0 0 0 0 0 0		I and the second		_		•
9.00 MURSING ADMINISTRATION* 0 0 0 10.00 11.00				۱		
10.00 Count No. Member Count				_		
11.00 MEDICAL RECORDS* 0 0 0 12.00 13.00 VOLUNTEER SERVI CE COORDINATION* 0 0 0 12.00 13.00 VOLUNTEER SERVI CE COORDINATION* 0 0 0 0 13.00 15.00 PHYSICI AN ADMINISTRATIVE SERVI CES* 0 0 0 16.00 16.00 OTHER GENERAL SERVI CE* 0 0 0 0 16.00 17.00 PHYSICI AN ADMINISTRATIVE SERVI CES* 0 0 0 0 16.00 17.00 PHYSICI AN ADMINISTRATIVE SERVI CES* 0 0 0 0 16.00 17.00 PHYSICI AN ADMINISTRATIVE SERVI CES* 0 0 0 0 16.00 17.00 PATIENT/RESI DENTIAL CARE SERVI CES SERVI CES 0 0 0 0 0 16.00 17.00 PATIENT/RESI DENTIAL CARE- CONTRACTED** 0 0 0 0 2.00 18.00 PATIENT/RESI DENTIAL CARE- CONTRACTED** 0 0 0 0 2.00 18.00 PHYSICI AN SERVI CES** 0 0 0 0 0 2.00 18.00 PHYSICI AN SERVI CES** 0 0 0 0 0 2.00 18.00 PHYSICI AN SERVI CES** 0 0 0 0 0 2.00 19.00 PHYSICI AN SERVI CES** 0 0 0 0 0 2.00 19.00 PHYSICI AN SERVI CES** 0 0 0 0 0 2.00 19.00 PHYSICI AN SERVI CES** 0 0 0 0 0 2.00 19.00 PHYSICI AN SERVI CES** 0 0 0 0 0 2.00 19.00 PHYSICIAL THERAPY** 0 0 0 0 0 2.00 19.00 PHYSICIAL THERAPY** 0 0 0 0 0 2.00 19.00 PHYSICIAL THERAPY** 0 0 0 0 0 2.00 19.00 PHYSICIAL THERAPY** 0 0 0 0 0 2.00 19.00 PHYSICIAL THERAPY** 0 0 0 0 0 2.00 19.00 PHYSICIAL THERAPY** 0 0 0 0 0 3.00 19.00 PHYSICIAL THERAPY** 0 0 0 0 0 3.00 19.00 PHYSICIAL THERAPY** 0 0 0 0 0 3.00 19.00 PHYSICIAL THERAPY** 0 0 0 0 0 3.00 19.00 PHYSICIAL THERAPY** 0 0 0 0 0 3.00 19.00 PHYSICIAL THERAPY** 0 0 0 0 0 3.00 19.00 PHYSICIAL THERAPY** 0 0 0 0 0 3.00 10.00 PHYSICIAL THERAPY** 0 0 0 0 0 3.00 10.00 PHYSICIAL THERAPY** 0 0 0 0 0 3.00 10.00 PHYSICIAL THERAPY** 0 0 0 0 0 3.00 10.00 PHYSICIAL THERAPY** 0 0 0 0 0 3.00 10.00 PHYSICIAL THERAPY** 0 0 0 0 0 3.00 10.00 PHYSICIAL THERAPY** 0 0 0 0 0 0 3.00 10.00 PHYSICIAL THERAPY** 0 0 0 0 0 0 3.00 10.00 PHYSICIAL THERAPY** 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		· ·		_		•
12.00 STAFF TRANSPORTATION*				_		
13.00 VOLUNTEER SERVI CE COORDINATION* 0 0 0 13.00 15.00 PHYSI CI AM ADMIN ISTRATI VE SERVI CES* 0 0 0 16.00 16.00 OTHER CEMERAL SERVI CE* 0 0 0 0 16.00 17.00 PHYSI CI AM ADMIN ISTRATI VE SERVI CES* 0 0 0 16.00 17.00 PATI ENT/RESI DENTI AL CARE SERVI CES 17.00 DIECET PATI ENT CARE SERVI CE COST CENTERS		· ·		_		•
14.00 PHARMACY* 0 0 0 15.0				-		
15.00 PHYSICIAN ADMINISTRATIVE SERVICES* 0 0 0 16.00 17.00 16.00 17.00 16.00 17.00 16.00 17.				Ĭ		•
16. 00 OTHER GENERAL SERVICE* 0 0 0 16. 00 17. 00		y control of the cont		-		
17. 00 PATI ENT/RESIDENTIAL CARE SERVICES				Ĭ		
DIRECT PATIENT CARE SERVICE COST CENTERS 0 0 0 0 25,00			U	U		
25.00 INPATIENT CARE-CONTRACTED**	17.00					17.00
26. 00 PHYSICIAN SERVICES** 0 0 0 27. 00 NURSE PRACTITIONE** 0 0 0 27. 00 NURSE PRACTITIONE** 0 0 126, 581 28. 00 27. 00 28. 00 REGISTRED NURSE** 0 126, 581 28. 00 29. 00 LPN/LVN** 0 0 0 0 0 30. 00 PHYSICIAL THERAPY** 0 0 0 0 30. 00 PHYSICIAL THERAPY** 0 0 0 0 31. 00 0 COUPATIONAL THERAPY** 0 0 0 0 31. 00 0 COUPATIONAL THERAPY** 0 0 0 0 31. 00 0 SPIRITUAL COUNSELING** 0 0 0 0 33. 00 MEDICAL SOCIAL SERVICES** 0 0 0 0 33. 00 SPIRITUAL COUNSELING** 0 0 0 0 33. 00 31. 00 SPIRITUAL COUNSELING** 0 0 0 0 33. 00 35. 00 DURSELING - 0THER** 0 0 0 0 0 33. 00 35. 00 DURSELING - 0THER** 0 0 0 0 0 33. 00 36. 00 DURSELING - 0THER** 0 0 0 0 0 33. 00 36. 00 DURSELING - 0THER** 0 0 0 0 0 33. 00 37. 00 HOSPICE AIDE & HOMEMAKER SERVICES** 0 0 0 0 33. 00 37. 00 HOSPICE AIDE & HOMEMAKER SERVICES** 0 0 0 0 33. 00 40. 0	25 00		0			3F 00
27.00						
28. 00 REGISTERED NURSE**				0		
29, 00 LPN/LVN* 30, 00 PHYSICAL THERAPY* 0 0 0 0 0 0 0 0 0				124 501		
30. 00 PHYSICAL THERAPY** 0 0 0 0 0 0 0 0 0				120, 581		
31.00 CCUPATI ONAL THERAPY** 0 0 0 32.00 SPECH/LANGUAGE PATHOLOGY** 0 0 0 0 32.00 32.00 SPECH/LANGUAGE PATHOLOGY** 0 0 0 0 33.00 32.00 33.00 MEDI CAL SOCI AL SERVI CES** 0 0 0 0 33.00 33.00 34.00 SPIRI TUAL COUNSELI NG** 0 0 0 0 35.00 0 5TARY COUNSELI NG** 0 0 0 0 35.00 0 5TARY COUNSELI NG** 36.00 37.00 HOSPI CE AI DE & HOMEMAKER SERVI CES** 0 0 0 0 37.00 38.00 MEDI CAL EQUI PMENT/OXYGEN** 0 0 0 0 38.00 39.00 PATI ENT TRANSPORTATI ON** 0 14,368 39.00 PATI ENT TRANSPORTATI ON** 0 14,368 39.00 40.00 1MAGI NG SERVI CES** 0 0 0 0 0 0 0 0 0				0		
32.00 SPEECH/LANGUAGE PATHOLOGY** 0 0 0 0 33.00 33.00 MEDI CAL SCRI LA SERVI CES** 0 0 0 0 33.00 33.00 MEDI CAL SCRI SERVI CES** 0 0 0 0 34.00 35.00 DI ETARY COUNSELI NG** 0 0 0 0 35.00 36.00 COUNSELI NG - OTHER** 0 0 0 0 36.00 37.00 HOSPI CE AI DE & HOMEMAKER SERVI CES** 0 0 0 38.00 38.00 DURABLE MEDI CAL EQUI PMENT/OXYGEN** 0 0 0 38.00 40.00 IMAGI NG SERVI CES** 0 0 0 14, 368 39.00 40.00 IMAGI NG SERVI CES** 0 0 0 40.00 41.00 LABS & DI AGNOSTI CS** 0 0 0 41.00 42.00 MEDI CAL SUPULI ES-NON-ROUTI NE** 0 0 513 42.00 43.00 OUTPATI ENT SERVI CES** 0 0 0 45.00 44.00 PALLI ATI VE RADI ATI ON THERAPY** 0 0 0 45.00 46.00 OTHER PATI ENT CARE SERVI CES (SPECI FY)** 0 0 0 46.00 OTHER PATI ENT CARE SERVI CES (SPECI FY)** 0 0 0 60.00 BEREAVEMENT PROGRAM * 0 0 0 65.00 64.00 PALLI ATI VE CARE PROGRAM * 0 0 0 66.00 65.00 OTHER PATI ENT CARE SERVI CES* 0 0 0 66.00 66.00 RESIDENTI AL CARE * MOREMANE* 0 0 0 66.00 66.00 RESIDENTI AL CARE * MOREMANE* 0 0 0 66.00 66.00 RESIDENTI AL CARE * MOREMANE* 0 0 0 66.00 66.00 RESIDENTI AL CARE * MOREMANE* 0 0 0 66.00 66.00 THER PHYSI CLAN SERVI CES* 0 0 0 66.00 66.00 THER FISTORE* 0 0 0 66.00 66.00 THER FISTORE* 0 0 0 0 0 66.00 THER FISTORE* 0 0 0 0 0 66.00 THER FISTORE* 0 0 0 0 66.00 THER FOREIL INTOROM & BOARD * 0 0 0 66.00 THER FOREIL INTOROM & BOARD * 0 0 0 67.00 OTHER NONREI MBURSABLE (SPECI FY) * 0 0 0 67.00 OTHER NONREI MBURSABLE (SPECI FY) * 0 0 0 67.00 OTHER NONREI MBURSABLE (SPECI FY) * 0 0 0 67.00 OTHER NONREI MBURSABLE (SPECI FY) * 0 0 0 67.00 OTHER NONREI MBURSABLE (SPECI FY) * 0 0 0 67.00 OTHER NONREI MBURSABLE (SPECI FY) * 0 0 0 67.00 OTHER NONREI MBURSABLE (SPECI FY) * 0 0 0 67.00 OTHER NONREI MBURSABLE (SPECI FY) * 0 0 0 67.00 OTHE				-		
33. 00 MEDI CAL SOCI AL SERVI CES** 0 0 0 0 34. 00 34. 00 37. 00 0 0 0 0 0 0 0 0 0				Ĭ		
34. 00 SPIRITUAL COUNSELING** 0 0 0 35. 00 0 15TARY COUNSELING** 0 0 0 0 0 35. 00 0 0 0 0 35. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				Ĭ		
35.00 DIETARY COUNSELING** 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				Ĭ		
36. 00 COUNSELING - OTHER** 0 0 0 0 37. 00 HOSPICE AID & & HOMEMAKER SERVICES** 0 0 0 0 38. 00 39. 00 PATLENT TRANSPORTATION** 0 0 0 0 38. 00 39. 00 PATLENT TRANSPORTATION** 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				-		
37. 00 HOSPICE AIDE & HOMEMAKER SERVICES** 0 0 0 0 33. 00 38. 00 DURABLE MEDICAL EQUIPMENT/OXYGEN** 0 0 0 0 33. 00 39. 00 PATI ENT TRANSPORTATI 0** 0 14, 368 39. 00 40. 00 IMAGI NG SERVICES** 0 0 0 0 41. 00 LABS & DI AGNOSTI CS** 0 0 0 0 42. 00 MEDICAL SUPPLIES-NON-ROUTINE** 0 36, 810 42. 00 MEDICAL SUPPLIES-NON-ROUTINE** 0 36, 810 43. 00 OUTPATI ENT SERVICES** 0 0 0 44. 00 PALLI ATI VE RADI ATI ON THERAPY** 0 0 0 45. 00 PALLI ATI VE CHEMOTHERAPY** 0 0 0 66. 00 OTHER PATI ENT CARE SERVICES (SPECI FY)** 0 0 70 NONREI MBURSABLE COST CENTERS 60 OUTPATI ENT SERVICES* 0 0 0 61. 00 OUTPATI ENT SERVICES (SPECI FY)** 0 0 0 70 OUTPATI ENT CARE SERVICES (SPECI FY)** 0 0 0 71 OUTPATI ENT CARE SERVICES (SPECI FY)** 0 0 0 71 OUTPATI ENT CARE SERVICES (SPECI FY)** 0 0 0 71 OUTPATI ENT CARE SERVICES (SPECI FY)** 0 0 0 71 OUTPATI ENT CARE SERVICES (SPECI FY)** 0 0 0 71 OUTPATI ENT CARE SERVICES (SPECI FY)** 0 0 0 71 OUTPATI ENT CARE SERVICES (SPECI FY)** 0 0 0 71 OUTPATI ENT CARE SERVICES (SPECI FY)** 0 0 0 71 OUTPATI ENT CARE SERVICES (SPECI FY)** 0 0 0 71 OUTPATI ENT CARE SERVICES (SPECI FY)** 0 0 0 71 OUTPATI ENT CARE SERVICES (SPECI FY)* 0 0 0 71 OUTPATI ENT CARE SERVICES (SPECI FY)* 0 0 0 71 OUTPATI ENT CARE SERVICES (SPECI FY)* 0 0 0 71 OUTPATI ENT CARE SERVICES (SPECI FY)* 0 0 0 71 OUTPATI ENT SON CARE SERVICES (SPECI FY)* 0 0 0 71 OUTPATI ENT SON ENTRE SERVICES (SPECI FY)* 0 0 0 71 OUTPATI ENTRE SERVICES* 0 0 0 0 71 OUTPATION SERVICES* 0 0 0 0 71 OUTPATION SERVICES* 0 0 0 0 71 OUTPATION SERVICES* 0 0 0 0 72 OUTPATION SERVICES* 0 0 0 0				_		
38. 00 DURABLE MEDI CAL EQUI PMENT/OXYGEN** 0 0 0 38. 00 39. 00 PATI ENT TRANSPORTATI ON** 0 14. 368 39. 00 40. 00 1Magi Ng SERVI CES** 0 0 0 0 41. 00 41. 00 42. 00 41. 00 42. 00 41. 00 42. 00 43. 00 44. 00 44. 00 44. 00 44. 00 44. 00 44. 00 44. 00 44. 00 44. 00 44. 00 44. 00 44. 00 44. 00 45. 00 45. 00 45. 00 46. 0				_		
39.00 PATI ENT TRANSPORTATION** 0 14,368 39.00 40.00 IMAGI NG SERVI CES** 0 0 0 0 0 0 0 0 0				0		
40.00				14 368		
41. 00						
42. 00 MEDI CAL SUPPLI ES-NON-ROUTI NE** 0 36, 810 42. 00 43. 00 0UTPATI ENT SERVI CES** 0 513 43. 00 44. 00 44. 00 A4. 00		· ·	_	0		
43. 00 OUTPATI ENT SERVI CES** 0 513 43. 00 44. 00 PALLI ATI VE RADI ATI ON THERAPY** 0 0 45. 00 PALLI ATI VE CHEMOTHERAPY** 0 0 46. 00 OTHER PATI ENT CARE SERVI CES (SPECI FY)** 0 0 46. 00 OTHER PATI ENT CARE SERVI CES (SPECI FY)** 0 0 46. 00 OTHER PATI ENT CARE SERVI CES (SPECI FY)** 0 0 46. 00 OTHER PATI ENT CARE SERVI CES (SPECI FY)** 0 0 46. 00 OTHER PATI ENT CARE SERVI CES (SPECI FY)** 0 0 46. 00 OTHER PATI ENT CARE SERVI CES (SPECI FY)** 0 0 46. 00 OTHER PROGRAM * 0 0 46. 00 OTHER PROGRAM * 0 0 46. 00 OTHER PROGRAM * 0 0 46. 00 OTHER PHYSI CI AN SERVI CES* 0 0 46. 00 OTHER PHYSI CI AN SERVI CES* 0 0 46. 00 OTHER PHYSI CI AN SERVI CES* 0 0 46. 00 OTHER PHYSI CI AN SERVI CES* 0 0 46. 00 OTHER PHYSI CI AN SERVI CES* 0 0 46. 00 OTHER PHYSI CI AN SERVI CES* 0 0 46. 00 OTHER PHYSI CI AN SERVI CES* 0 0 46. 00 OTHER PHYSI CI AN SERVI CES* 0 0 46. 00 OTHER PHYSI CI AN SERVI CES* 0 0 46. 00 OTHER PHYSI CI AN SERVI CES* 0 0 46. 00 OTHER PHYSI CI AN SERVI CES* 0 0 46. 00 OTHER PHYSI CI AN SERVI CES* 0 0 46. 00 OTHER PHYSI CI AN SERVI CES* 0 0 46. 00 OTHER PHYSI CI AN SERVI CES* 0 0 46. 00 OTHER PHYSI CI AN SERVI CES* 0 0 47. 00 OTHER PHYSI CI AN SERVI CES* 0 0 48. 00 OTHER PHYSI CI AN SERVI CES* 0 0 49. 00 OTHER PHYSI CI AN SERVI CES* 0 0 49. 00 OTHER PHYSI CI AN SERVI CES* 0 0 49. 00 OTHER PHYSI CI AN SERVI CES* 0 0 49. 00 OTHER PHYSI CI AN SERVI CES* 0 0 49. 00 OTHER PHYSI CI AN SERVI CES* 0 0 49. 00 OTHER PHYSI CI AN SERVI CES* 0 0 49. 00 OTHER PHYSI CI AN SERVI CES* 0 0 49. 00 OTHER PHYSI CI AN SERVI CES* 0 0 49. 00 OTHER PHYSI CI AN SERVI CES* 0 0 49. 00 OTHER PHYSI CI AN SERVI CES* 0 0 49. 00 OTHER PHYSI CI AN SERVI CES* 0 0 49. 00 OTHER PHYSI CI AN SERVI CES* 0 0 49. 00 OTHER PHYSI C		· ·		36 810		•
44. 00 PALLI ATI VE RADI ATI ON THERAPY** 0 0 44. 00 45. 00 PALLI ATI VE CHEMOTHERAPY** 0 0 0 45. 00 46. 00 OTHER PATIENT CARE SERVICES (SPECI FY)** 0 0 0 46. 00 NONNEI MBURSABLE COST CENTERS 60. 00 BEREAVEMENT PROGRAM * 0 0 60. 00 61. 00 61. 00 VOLUNTEER PROGRAM * 0 0 61. 00 62. 00 62. 00 FUNDRAI SI NG* 0 0 62. 00 63. 00 63. 00 HOSPI CE/PALLI ATI VE MEDI CI NE FELLOWS* 0 0 63. 00 64. 00 64. 00 PALLI ATI VE CARE PROGRAM* 0 0 64. 00 65. 00 65. 00 OTHER PHYSI CI AN SERVI CES* 0 0 65. 00 65. 00 66. 00 RESI DENTI AL CARE* 0 0 66. 00 67. 00 66. 00 67. 00 ADVERTI SI NG* 0 0 67. 00 68. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 70. 00 70. 00						
45. 00 PALLIATIVE CHEMOTHERAPY** 0 0 0 0 46. 00 THER PATIENT CARE SERVICES (SPECIFY)** 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0						
46. 00 OTHER PATIENT CARE SERVICES (SPECIFY)** 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		y control of the cont		o		
NONREI MBURSABLE COST CENTERS 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		y and the second		-		
61. 00						
61. 00	60.00		0	0		60.00
62. 00 FUNDRAI SI NG* 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0						
64. 00 PALLI ATI VE CARE PROGRAM* 0 0 0 65. 00 65. 00 0 0 65. 00 65. 00 0 0 65. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 67. 00 68. 00 1 68. 00 1 68. 00 1 69. 00				ol		
65. 00 OTHER PHYSICIAN SERVICES* 0 0 0 66. 00 66. 00 RESIDENTIAL CARE* 0 0 0 66. 00 67. 00 ADVERTISING* 0 0 67. 00 68. 00 TELEHEALTH/TELEMONITORING* 0 0 68. 00 70. 00 NURSING FACILITY ROOM & BOARD* 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	ol		63. 00
66. 00 RESI DENTI AL CARE* 0 0 0 67. 00 ADVERTI SI NG* 0 0 68. 00 67. 00 68. 00 TELEHEALTH/TELEMONI TORI NG* 0 0 0 68. 00 69. 00 THRI FT STORE* 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	64.00	PALLIATIVE CARE PROGRAM*	0	ol		64. 00
67. 00 ADVERTI SI NG* 0 0 0 68. 00 68. 00 7ELEHEALTH/TELEMONI TORI NG* 0 0 0 68. 00 69. 00 70. 00 NURSI NG FACI LI TY ROOM & BOARD* 0 0 0 71. 00 OTHER NONREI MBURSABLE (SPECI FY)* 0 0 0 0 0 0 0 0 0 0	65.00	OTHER PHYSICIAN SERVICES*	0	o		65.00
68. 00 TELEHEALTH/TELEMONI TORI NG* 0 0 68. 00 69. 00 THRI FT STORE* 0 0 69. 00 70. 00 NURSI NG FACI LITY ROOM & BOARD* 0 0 70. 00 71. 00 OTHER NONREI MBURSABLE (SPECI FY)* 0 0 71. 00	66. 00	RESI DENTI AL CARE*	0	o		66.00
69. 00 THRIFT STORE* 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	67. 00	ADVERTI SI NG*	0	o		67. 00
70. 00 NURSING FACILITY ROOM & BOARD* 0 0 0 70. 00 71. 00 0 71. 00 0 71. 00 71. 00 0	68.00	TELEHEALTH/TELEMONI TORI NG*	0	o		68.00
71. 00 OTHER NONREI MBURSABLE (SPECI FY)* 0 0 71. 00	69. 00		0	o		69. 00
	70.00	NURSING FACILITY ROOM & BOARD*	0	o		70.00
100. 00 TOTAL 0 544, 835 100. 00				0		
	100.00	TOTAL	0	544, 835		100. 00

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

Health Financial Systems FRANCISCAN HEAL ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE ROUTINE HOME Provider CCN: 15-1324 Peri od: Worksheet 0-2 From 01/01/2016 To 12/31/2016 CARE Date/Time Prepared: 8/8/2017 10:19 am Hospi ce CCN: 15-1519

					Hospi ce I		
		SALARI ES	OTHER	SUBTOTAL (col.	RECLASSIFI -	SUBTOTAL	
				1 + col . 2)	CATI ONS		
		1.00	2.00	3.00	4. 00	5. 00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED						25. 00
26.00	PHYSI CI AN SERVI CES	0	0	0	0	0	26. 00
27. 00	NURSE PRACTITIONER	0	0	0	0	0	27. 00
28. 00	REGI STERED NURSE	125, 332	0	125, 332	0	125, 332	28. 00
29. 00	LPN/LVN	0	0	0	0	0	29. 00
30.00	PHYSI CAL THERAPY	0	0	0	0	0	30. 00
31.00	OCCUPATI ONAL THERAPY	0	0	0	0	0	31. 00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32. 00
33.00	MEDICAL SOCIAL SERVICES	0	0	0	0	0	33. 00
34.00	SPIRITUAL COUNSELING	0	0	0	0	0	34.00
35.00	DI ETARY COUNSELING	0	0	0	0	0	35. 00
36.00	COUNSELING - OTHER	0	0	0	0	0	36. 00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	0	0	0	0	37. 00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38. 00
39.00	PATIENT TRANSPORTATION	0	14, 368	14, 368	0	14, 368	39. 00
40.00	I MAGING SERVICES	0	0	0	0	0	40. 00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	36, 810	36, 810	0	36, 810	42. 00
43.00	OUTPATIENT SERVICES	0	513	513	0	513	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44. 00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45. 00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46. 00
100.00	TOTAL *	125, 332	51, 691	177, 023	0	177, 023	100. 00

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

		ADJUSTMENTS	TOTAL (col. 5	
		ADJUSTINIENTS	± col. 6)	
		6. 00	7.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS	0.00	7.00	
25. 00	I NPATI ENT CARE-CONTRACTED			25. 00
26, 00	PHYSI CI AN SERVI CES	0	ol ol	26. 00
27. 00	NURSE PRACTITIONER	0		27. 00
28. 00	REGI STERED NURSE	0	125, 332	28. 00
29. 00	LPN/LVN	0	o	29. 00
30.00	PHYSI CAL THERAPY	0	ol ol	30.00
31.00	OCCUPATI ONAL THERAPY	0	ol ol	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	ol ol	32. 00
33.00	MEDICAL SOCIAL SERVICES	0	ol	33. 00
34.00	SPI RI TUAL COUNSELI NG	0	ol	34.00
35.00	DI ETARY COUNSELING	0	ol ol	35. 00
36.00	COUNSELING - OTHER	0	ol ol	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	ol	37. 00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	ol ol	38. 00
39.00	PATI ENT TRANSPORTATION	0	14, 368	39. 00
40.00	I MAGI NG SERVI CES	0	o	40.00
41.00	LABS & DIAGNOSTICS	0	o	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	36, 810	42.00
43.00	OUTPATIENT SERVICES	0	513	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	o o	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	o o	45. 00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	o	46. 00
100.00	TOTAL *	0	177, 023	100.00

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

Peri od: Worksheet 0-3

Provider CCN: 15-1324 From 01/01/2016 To 12/31/2016 RESPITE CARE Date/Time Prepared: 8/8/2017 10:19 am Hospi ce CCN: 15-1519 Hospi ce I

		SALARI ES	OTHER	SUBTOTAL (col.	RECLASSIFI -	SUBTOTAL			
				1 + col . 2)	CATI ONS				
		1.00	2. 00	3. 00	4. 00	5. 00			
	DIRECT PATIENT CARE SERVICE COST CENTERS								
25. 00	I NPATIENT CARE-CONTRACTED	0	0	0	0	0	25. 00		
26. 00	PHYSI CI AN SERVI CES	0	0	0	0	0	26. 00		
27. 00	NURSE PRACTITIONER	0	0	0	0	0	27. 00		
28. 00	REGI STERED NURSE	676	573	1, 249	0	1, 249	28. 00		
29.00	LPN/LVN	0	0	0	0	0	29. 00		
30.00	PHYSI CAL THERAPY	0	0	0	0	0	30.00		
31.00	OCCUPATI ONAL THERAPY	0	0	0	0	0	31.00		
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00		
33.00	MEDICAL SOCIAL SERVICES	0	0	0	0	0	33.00		
34.00	SPIRITUAL COUNSELING	0	0	0	0	0	34.00		
35.00	DI ETARY COUNSELI NG	0	0	0	0	0	35.00		
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00		
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	0	0	0	0	37.00		
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN						38. 00		
39.00	PATI ENT TRANSPORTATION	o	0	0	0	0	39. 00		
40.00	I MAGI NG SERVI CES	o	0	0	0	0	40.00		
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00		
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	0	0	42.00		
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00		
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00		
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00		
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	o	0	0	0	0	46.00		
100.00	TOTAL *	676	573	1, 249	0	1, 249	100. 00		
* Tran	* Transfer the amount in column 7 to West 0.5 column 1 line 52								

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

		ADJUSTMENTS	TOTAL (col. 5	
			± col. 6)	
		6. 00	7. 00	
	DIRECT PATIENT CARE SERVICE COST CENTERS			
25.00	INPATIENT CARE-CONTRACTED	0	0	25. 00
26.00	PHYSI CI AN SERVI CES	0	0	26. 00
27.00	NURSE PRACTITIONER	0	0	27. 00
28.00	REGI STERED NURSE	0	1, 249	28. 00
29.00	LPN/LVN	0	0	29. 00
30.00	PHYSI CAL THERAPY	0	0	30. 00
31.00	OCCUPATI ONAL THERAPY	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	32. 00
33.00	MEDICAL SOCIAL SERVICES	0	0	33. 00
34.00	SPIRITUAL COUNSELING	0	0	34.00
35.00	DI ETARY COUNSELING	0	0	35. 00
36.00	COUNSELING - OTHER	0	0	36. 00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	0	37. 00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN			38. 00
39.00	PATI ENT TRANSPORTATION	0	0	39. 00
40.00	I MAGING SERVICES	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	41. 00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	42. 00
43.00	OUTPATI ENT SERVI CES	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	44. 00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	45. 00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	46. 00
100.00	TOTAL *	0	1, 249	100.00

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

	FINANCISCAN HEAL ALLOCATION - DETERMINATION OF HOSPITAL-BASED HOSPICE NET	Provi der C	CN: 15-1324	Peri od:	wof Form CMS-2 Worksheet 0-5	
EXPEN:	SES FOR ALLOCATION	Hospi ce CCI	N: 15-1519	From 01/01/2016 To 12/31/2016	Date/Time Prep 8/8/2017 10:10	
-				Hospi ce I	0/0/2017 10.1	7 diii
	Descriptions		HOSPICE DIRE		TOTAL EXPENSES	
			EXPENSES (se	ee SERVI CE	(sum of cols.	
			i nstructi ons	s) EXPENSES FROM	1 + 2)	
				WKST B PART I		
				(see		
			4.00	instructions)	0.00	
	CENEDAL CEDVICE COST CENTEDS		1.00	2. 00	3. 00	
1.00	GENERAL SERVICE COST CENTERS CAP REL COSTS-BLDG & FLXT		I	0 10, 883	10, 883	1.00
2.00	CAP REL COSTS-BLDG & FIXT			0 10, 883	10, 883	
3.00	EMPLOYEE BENEFITS DEPARTMENT			0 118, 488	118, 488	
4. 00	ADMINISTRATIVE & GENERAL		366, 5		678, 273	
5.00	PLANT OPERATION & MAINTENANCE		300, 3	0 5, 933	5, 933	
6. 00	LAUNDRY & LINEN SERVICE			0 0,700	0, 700	
7. 00	HOUSEKEEPI NG			0	o	1
8. 00	DI ETARY			0 0	0	
9. 00	NURSI NG ADMI NI STRATI ON			o o	Ö	
10.00	ROUTI NE MEDI CAL SUPPLI ES			o o	Ö	
11.00	MEDI CAL RECORDS			0 0	0	
12.00	STAFF TRANSPORTATION			0	0	12. 00
13.00	VOLUNTEER SERVICE COORDINATION			0	0	13. 00
14.00	PHARMACY			0 0	0	14. 00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES			0	0	15. 00
16.00	OTHER GENERAL SERVICE			0	0	
17. 00				0	0	17. 00
	LEVEL OF CARE					
50.00	HOSPI CE CONTI NUOUS HOME CARE			0	0	
51.00	HOSPI CE ROUTI NE HOME CARE		177, 0		177, 023	
52.00	HOSPICE INPATIENT RESPITE CARE		1, 2		1, 249	
53. 00	HOSPI CE GENERAL I NPATI ENT CARE			0	0	53. 00
60. 00	NONREI MBURSABLE COST CENTERS BEREAVEMENT PROGRAM		I	0	0	60.00
	VOLUNTEER PROGRAM			0	0	
61. 00 62. 00	FUNDRALSING			0	0	
63.00	HOSPI CE/PALLI ATI VE MEDI CI NE FELLOWS			0	0	
64. 00	PALLIATIVE CARE PROGRAM			0	0	
65.00	OTHER PHYSI CI AN SERVI CES			0	0	65.00
66.00	RESI DENTI AL CARE			0	0	66.00
67. 00	ADVERTI SI NG			o	Ö	67. 00
68. 00	TELEHEALTH/TELEMONI TORI NG			ō	o	68. 00
69. 00	THRI FT STORE			ō	Ö	
70. 00	NURSING FACILITY ROOM & BOARD			O	0	
71.00	OTHER NONREIMBURSABLE (SPECIFY)			0	0	71. 00
99.00	NEGATI VE COST CENTER			ol	0	99. 00
, ,			1	-		

near tii	Fillancial Systems	FRANCISCAN HEALT	1 KENSSELAER		III LI E	u or Form CM3	2332-10
COST A	ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SI	ERVICE COSTS	Provi der CO	CN: 15-1324	Peri od:	Worksheet 0-6	
			Hospi ce CCN	N: 15-1519	From 01/01/2016 To 12/31/2016		narod:
			nospi ce cci	v. 15-1517	10 12/31/2010	8/8/2017 10: 1	9 am
					Hospi ce I		
	Descriptions	TOTAL EXPENSES CA	AP REL BLDG &	CAP REL MVBL	E EMPLOYEE	SUBTOTAL	
			FIX	EQUI P	BENEFITS		
					DEPARTMENT		
		0	1. 00	2. 00	3. 00	3A	
	GENERAL SERVICE COST CENTERS						
1. 00	CAP REL COSTS-BLDG & FLXT	10, 883	10, 883				1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	0			0		2. 00
3.00	EMPLOYEE BENEFITS DEPARTMENT	118, 488	0		0 118, 488	l	3. 00
4.00	ADMINISTRATIVE & GENERAL	678, 273	10, 883		0 118, 488		1
5.00	PLANT OPERATION & MAINTENANCE	5, 933	0		0	5, 933	5. 00
6.00	LAUNDRY & LINEN SERVICE	0	0		0	0	6. 00
7.00	HOUSEKEEPING	0	0		0	0	7. 00
8.00	DI ETARY	0	0		0	0	8. 00
9.00	NURSING ADMINISTRATION	0	0		0	0	9. 00
10.00	ROUTINE MEDICAL SUPPLIES	0	0		0	0	10.00
11. 00	MEDI CAL RECORDS	0	0		0 0	0	11. 00
12.00	STAFF TRANSPORTATION	0	0		0 0	0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0		0 0	0	13.00
14.00	PHARMACY	O	0		0 0	0	14. 00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	O	0		0 0	0	15. 00
16.00	OTHER GENERAL SERVICE	O	0		0 0	0	16. 00
17.00	PATIENT/RESIDENTIAL CARE SERVICES		0		0	0	17. 00
	LEVEL OF CARE						1
50.00	HOSPICE CONTINUOUS HOME CARE	0			0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	177, 023			0	177, 023	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	1, 249	0		0 0	1, 249	52. 00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0		0 0	0	53. 00
	NONREI MBURSABLE COST CENTERS						1
60.00	BEREAVEMENT PROGRAM	0	0		0 0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0		0	0	61. 00
62.00	FUNDRAI SI NG	0	0		0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0		0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0		0 0	0	64. 00
65.00	OTHER PHYSICIAN SERVICES	0	0		0 0	0	65. 00
66.00	RESI DENTI AL CARE	0	0		0 0	0	66. 00
67.00	ADVERTI SI NG	0	0		0 0	0	67. 00
68.00	TELEHEALTH/TELEMONI TORI NG	0	0		0 0	0	68. 00
69.00	THRI FT STORE	0	0		0 0	0	69. 00
70.00	NURSING FACILITY ROOM & BOARD	0				0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	o	0		0 0	0	71. 00
99. 00	1	o	0		0 0		99. 00
100.00	TOTAL	991, 849	10, 883		0 118, 488	991, 849	1
	,			•		•	•

Health Financial Systems	FRANCI SCAN HEALTH RENSSELAER			In Lieu of Form CMS-2552-10			
COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL	SERVICE COSTS	Provi der C	CN: 15-1324	Peri od:	Worksheet 0-6	5	
				From 01/01/2016			
		Hospi ce CC	N: 15-1519	To 12/31/2016	Date/Time Pre	epared:	
					8/8/2017 10: 1	19 am	
D 1.11	1.5	DI ANIT	1.411110001/	Hospi ce I	DI ETABLE		
Descriptions	ADMI NI STRATI VE	PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY		
	& GENERAL	OPERATION &	LINEN SERVIC	E			
		MAI NTENANCE					
	4.00	5. 00	6. 00	7. 00	8. 00		
GENERAL SERVICE COST CENTERS							
1.00 CAP REL COSTS-BLDG & FLXT						1.00	
2.00 CAP REL COSTS-MVBLE EQUIP						2. 00	
3.00 EMPLOYEE BENEFITS DEPARTMENT						3. 00	
4.00 ADMINISTRATIVE & GENERAL	807, 644					4. 00	
5. OO PLANT OPERATION & MAINTENANCE	26, 013	31, 946	5			5. 00	
6.00 LAUNDRY & LINEN SERVICE	l ol			0		6.00	
7. 00 HOUSEKEEPI NG	ام	Ċ		0		7. 00	
8. 00 DI ETARY		Č		0	0	1	
9. 00 NURSING ADMINISTRATION				0	٥	9.00	
10. 00 ROUTINE MEDICAL SUPPLIES	0			0		10.00	
		C		0			
11. 00 MEDI CAL RECORDS	0	C		0		11.00	
12. 00 STAFF TRANSPORTATION	0	C		0		12.00	
13. 00 VOLUNTEER SERVICE COORDINATION	0	C)	0		13. 00	
14.00 PHARMACY	0	C)	0		14. 00	
15.00 PHYSICIAN ADMINISTRATIVE SERVICES	0	C		0		15. 00	
16.00 OTHER GENERAL SERVICE	0	C		0		16. 00	
17.00 PATIENT/RESIDENTIAL CARE SERVICES	0	C)	0		17. 00	
LEVEL OF CARE							
50.00 HOSPICE CONTINUOUS HOME CARE	0					50.00	
51.00 HOSPICE ROUTINE HOME CARE	776, 155					51.00	
52.00 HOSPICE INPATIENT RESPITE CARE	5, 476	31, 946	5	0 0	0	52.00	
53.00 HOSPICE GENERAL INPATIENT CARE	O	C	ol	0 0		53.00	
NONREI MBURSABLE COST CENTERS			•	<u> </u>	•		
60. 00 BEREAVEMENT PROGRAM	0	C		0		60.00	
61. 00 VOLUNTEER PROGRAM	o	C	ol	0		61. 00	
62. 00 FUNDRAI SI NG	o	C		0		62.00	
63.00 HOSPICE/PALLIATIVE MEDICINE FELLOWS	0			0		63. 00	
64. 00 PALLIATIVE CARE PROGRAM	0	Č		0		64. 00	
65. 00 OTHER PHYSICIAN SERVICES				0		65. 00	
66. 00 RESI DENTI AL CARE				0 0	0		
67. 00 ADVERTI SI NG	0				·	67. 00	
· · · · · · · · · · · · · · · · · · ·	0			0			
68. 00 TELEHEALTH/TELEMONI TORI NG						68. 00	
69. 00 THRIFT STORE	ا	C	ή	0		69.00	
70. 00 NURSING FACILITY ROOM & BOARD	_	_		_	_	70.00	
71.00 OTHER NONREIMBURSABLE (SPECIFY)	0	C	וי	0	0		
99. 00 NEGATIVE COST CENTER	0	C	P	0	0		
100. 00 TOTAL	807, 644	31, 946	þ	0 0] 0	100. 00	

Heal th Financial	Systems		FRANCI SCAN HEALTH	RENSSELAER		In Lieu of Form CMS-2552-10
COST ALLOCATION	HUCDITAL BACED	HUCDI CE CENEDVI	SEDVICE COSTS	Provider CCN: 15-1324	Pari ad:	Workshoot 0 6

Heal th	Financial Systems	FRANCI SCAN HEALTH	H RENSSELAER		In Lie	u of Form CMS-2	2552-10
	ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL	SERVI CE COSTS	Provi der CC	CN: 15-1324	Peri od:	Worksheet 0-6	
					From 01/01/2016	Part I	
			Hospi ce CCN	N: 15-1519	To 12/31/2016	Date/Time Pre 8/8/2017 10:1	pared:
					Hospi ce I	6/6/2017 10.1	7 alli
	Descriptions	NURSI NG	ROUTI NE	MEDI CAL	STAFF	VOLUNTEER	
	200011 p 11 0110	ADMI NI STRATI ON	MEDI CAL	RECORDS	TRANSPORTATI ON		
			SUPPLI ES			COORDI NATI ON	
		9.00	10.00	11. 00	12.00	13. 00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FLXT						1. 00
2.00	CAP REL COSTS-MVBLE EQUIP						2. 00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3. 00
4.00	ADMINISTRATIVE & GENERAL						4. 00
5.00	PLANT OPERATION & MAINTENANCE						5. 00
6.00	LAUNDRY & LINEN SERVICE						6. 00
7.00	HOUSEKEEPI NG						7. 00
8.00	DI ETARY						8. 00
9.00	NURSING ADMINISTRATION	O					9. 00
10.00	ROUTINE MEDICAL SUPPLIES	O	0				10.00
11.00	MEDI CAL RECORDS	O			0		11. 00
12.00	STAFF TRANSPORTATION	O			0		12. 00
13.00	VOLUNTEER SERVICE COORDINATION	O			0	0	13. 00
14.00	PHARMACY	O			0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0			0	0	15. 00
16.00	OTHER GENERAL SERVICE	o			o	0	16. 00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17. 00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0		0 0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	0	0		0 0	0	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0		0 0	0	52. 00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0		0 0	0	53. 00
	NONREI MBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0			0	0	60.00
61.00	VOLUNTEER PROGRAM	0			0	0	61. 00
62.00	FUNDRAI SI NG	0			0	0	62. 00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0			0	0	63. 00
64.00	PALLIATIVE CARE PROGRAM	0			0	0	64. 00
65.00	OTHER PHYSICIAN SERVICES	0			0	0	65. 00
66.00	RESI DENTI AL CARE	0			0	0	66. 00
67.00	ADVERTI SI NG	0			0	0	67. 00
68.00	TELEHEALTH/TELEMONI TORI NG	0			0	0	68. 00
69. 00	THRI FT STORE	0			0	0	
70.00	NURSING FACILITY ROOM & BOARD						70. 00
71. 00	OTHER NONREIMBURSABLE (SPECIFY)	0			0	0	
99. 00	NEGATI VE COST CENTER	0	0		0 0	0	99. 00
100.00	TOTAL	0	0		0 0	0	100. 00

He	alth Financial Systems F	RANCISCAN HEAL	TH RENSSELAER		In Lie	eu of Form CMS-:	2552-10
CC	ST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SE	RVICE COSTS	Provi der C	CN: 15-1324	Peri od:	Worksheet 0-6	,
					From 01/01/2016	Part I	
			Hospi ce CC	N: 15-1519	To 12/31/2016	Date/Time Pre	pared:
			· ·			8/8/2017 10:1	9 am
					Hospi ce I		_
	Descriptions	PHARMACY	PHYSI CI AN	OTHER GENERAL	_ PATI ENT/	TOTAL	
	50001 Pt. 0.10		ADMI NI STRATI VE		RESI DENTI AL		
			SERVI CES	JERVI OL	CARE SERVICES		
		14.00		1/ 00		10.00	
	OFNERAL OFRILLOS COOT OFNERO	14. 00	15. 00	16. 00	17. 00	18. 00	
	GENERAL SERVICE COST CENTERS		1				
	OO CAP REL COSTS-BLDG & FLXT					İ	1. 00
2.	OO CAP REL COSTS-MVBLE EQUIP						2. 00
3.	OO EMPLOYEE BENEFITS DEPARTMENT					ĺ	3. 00
	OO ADMINISTRATIVE & GENERAL						4. 00
	OO PLANT OPERATION & MAINTENANCE						5. 00
	1						6. 00
	OO LAUNDRY & LI NEN SERVI CE						1
	00 HOUSEKEEPI NG						7. 00
	00 DI ETARY						8. 00
9.	OO NURSING ADMINISTRATION						9. 00
10	. 00 ROUTINE MEDICAL SUPPLIES					ĺ	10.00
11	. OO MEDICAL RECORDS					ĺ	11.00
	. OO STAFF TRANSPORTATION					İ	12. 00
	. OO VOLUNTEER SERVICE COORDINATION						13. 00
		^					
	. OO PHARMACY	0					14. 00
15	. 00 PHYSICIAN ADMINISTRATIVE SERVICES	0	0)			15. 00
16	. 00 OTHER GENERAL SERVICE	0			0		16. 00
17	. 00 PATIENT/RESIDENTIAL CARE SERVICES				0		17. 00
	LEVEL OF CARE				<u> </u>		
50	. OO HOSPICE CONTINUOUS HOME CARE	0	0		0	0	50.00
	OO HOSPICE ROUTINE HOME CARE	0			0	953, 178	
	. 00 HOSPICE INPATIENT RESPITE CARE	0		1	o o		1
		0		l .			1
53	. 00 HOSPICE GENERAL INPATIENT CARE	0	0	7	0 0	0	53. 00
	NONREI MBURSABLE COST CENTERS						4
60	OO BEREAVEMENT PROGRAM	0			0	0	60.00
61	. 00 VOLUNTEER PROGRAM	0			0	0	61. 00
62	. OO FUNDRAI SI NG	0			0	0	62.00
63	. OO HOSPICE/PALLIATIVE MEDICINE FELLOWS	0			0	0	63. 00
	. OO PALLIATIVE CARE PROGRAM	0			0	0	1
	. 00 OTHER PHYSI CI AN SERVI CES	0			0	0	65. 00
		0					1
	. 00 RESI DENTI AL CARE	U	C	'	0		66. 00
	. 00 ADVERTI SI NG	0	1		U	0	67. 00
68	. OO TELEHEALTH/TELEMONI TORI NG	0			0	0	68. 00
69	. 00 THRIFT STORE	0			0	0	69. 00
70	.00 NURSING FACILITY ROOM & BOARD					0	70.00
71	. OO OTHER NONREIMBURSABLE (SPECIFY)	0	0	ol	0	0	71. 00
	. OO NEGATIVE COST CENTER	0	,		o o	· -	99.00
	0. 00 TOTAL	0			0 0		
10	U. 00 TOTAL	U	'I '	1	υ υ	771,049	1100.00

Health Financial Systems	FRANCI SCAN HEALTH	RENSSELAER	In Lie	u of Form CMS-2552-10
COST ALLOCATION - HOSPITAL-BASED HOSPIC STATISTICAL BASIS	E GENERAL SERVICE COSTS	Provi der CCN: 15- Hospi ce CCN: 15	Period: From 01/01/2016 To 12/31/2016	Worksheet 0-6 Part II Date/Time Prepared: 8/8/2017 10:19 am

			Hospi ce cci	: 15-1519 1	0 12/31/2016	8/8/2017 10:1	pared: 9 am
					Hospi ce I	0,0,201,1011	, u
	Cost Center Descriptions	CAP REL BLDG & CA	AP REL MVBLE	EMPLOYEE	RECONCI LI ATI ON	ADMI NI STRATI VE	
		FLX	EQUI P	BENEFITS		& GENERAL	
		(SQUARE FEET) (D	OLLAR VALUE)	DEPARTMENT		(ACCUMULATED	
		(, , , , , , , , , , , , , , , , , , , ,	(GROSS		COSTS)	
				SALARI ES)		,	
		1.00	2. 00	3. 00	4A	4. 00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FLXT	1					1.00
2.00	CAP REL COSTS-MVBLE EQUIP		0				2.00
3. 00	EMPLOYEE BENEFITS DEPARTMENT	0	0	324, 325			3. 00
4. 00	ADMINISTRATIVE & GENERAL	1	0	324, 325		184, 205	4. 00
5. 00	PLANT OPERATION & MAINTENANCE		o o	021, 020	007, 011	5, 933	5. 00
6. 00	LAUNDRY & LINEN SERVICE		0	0	0	0,733	6.00
7. 00	HOUSEKEEPI NG		0	0	0	0	7. 00
8. 00	DI ETARY		0	0	0	0	
9.00	NURSING ADMINISTRATION		0	0	0	0	1
		0	0	0	U	-	
10.00	ROUTINE MEDICAL SUPPLIES	0	0	0	0	0	10.00
11.00	MEDI CAL RECORDS	0	0	0	0	0	11.00
12. 00	STAFF TRANSPORTATION	0	0	0	0	0	12. 00
13. 00	VOLUNTEER SERVICE COORDINATION	O	0	0	0	0	13. 00
14. 00	PHARMACY	0	0	0	0	0	14. 00
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0	0	15. 00
16. 00	OTHER GENERAL SERVICE	0	0	0	0	0	16. 00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES	0	0		0	0	17. 00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE			0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE			0	0	177, 023	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	O	0	0	0	1, 249	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	o	o	0	0	0	53.00
	NONREI MBURSABLE COST CENTERS						1
60.00	BEREAVEMENT PROGRAM	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM	o	0	0	0	0	61.00
62.00	FUNDRAI SI NG	l	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	o	o	0	0	0	63.00
64. 00	PALLIATIVE CARE PROGRAM	l ol	o	0	0	0	64.00
65. 00	OTHER PHYSICIAN SERVICES	ol	0	0	0	0	65. 00
66. 00	RESI DENTI AL CARE		0	0	0	Ō	66. 00
67. 00	ADVERTI SI NG		0	0	0	Ö	67. 00
68. 00	TELEHEALTH/TELEMONI TORI NG		o o	0	0	Ö	68.00
69. 00	THRI FT STORE		0	0		0	69.00
70. 00	NURSING FACILITY ROOM & BOARD		O ₁	0	0		70.00
71. 00	OTHER NONREIMBURSABLE (SPECIFY)			0		0	71.00
99. 00		١	٩	U	١		99.00
	NEGATIVE COST CENTER	10 000		110 400		007 / 4 4	
	COST TO BE ALLOCATED (per Wkst. 0-6, Part		0 000000	118, 488		807, 644	
101.00	UNIT COST MULTIPLIER	10, 883. 000000	0. 000000	0. 365337	l l	4. 384485	1101.00

		FRANCISCAN HEAL				eu of Form CMS-	
	NLLOCATION - HOSPITAL-BASED HOSPICE GENERAL SE STICAL BASIS	RVICE COSTS	Provi der C		Peri od: From 01/01/2016	Worksheet 0-6 Part II	
			Hospi ce CC	N: 15-1519	To 12/31/2016	Date/Time Pre 8/8/2017 10:1	pared: 9 am
					Hospi ce I		
	Cost Center Descriptions	PLANT OPERATION &	LAUNDRY & LINEN SERVICE	HOUSEKEEPING (SQUARE FEET		NURSI NG ADMI NI STRATI ON	
		MAI NTENANCE	(IN-FACILITY	(SQUARE TEET	DAYS)	ADMINISTRATION	
		(SQUARE FEET)	DAYS)			(DI RECT NURS.	
		,	ŕ			HRS.)	
		5. 00	6. 00	7. 00	8. 00	9. 00	
	GENERAL SERVICE COST CENTERS	T.	T	T		T	
1.00	CAP REL COSTS-BLDG & FLXT						1.00
2. 00 3. 00	CAP REL COSTS-MVBLE EQUIP EMPLOYEE BENEFITS DEPARTMENT						2. 00 3. 00
4. 00	ADMINISTRATIVE & GENERAL					+	4. 00
5.00	PLANT OPERATION & MAINTENANCE	1					5. 00
6. 00	LAUNDRY & LINEN SERVICE	0	0	,			6.00
7. 00	HOUSEKEEPI NG	0	Ĭ		0		7. 00
8.00	DI ETARY	0			o o)	8. 00
9.00	NURSING ADMINISTRATION	0			0	0	9. 00
10.00	ROUTINE MEDICAL SUPPLIES	0			0	0	10. 00
11. 00	MEDI CAL RECORDS	0			0	0	11. 00
12.00	STAFF TRANSPORTATION	0			0	0	12. 00
13. 00	VOLUNTEER SERVICE COORDINATION	0			0	0	13. 00
14. 00	PHARMACY	0	l .		0	0	14. 00
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES	0			0	0	15. 00
16.00	OTHER GENERAL SERVICE	0			0	0	16.00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES LEVEL OF CARE	0			0		17. 00
50. 00	HOSPICE CONTINUOUS HOME CARE			I		0	50.00
51. 00	HOSPICE ROUTINE HOME CARE					0	51.00
52. 00	HOSPICE INPATIENT RESPITE CARE	1		,	0		52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	i c)	0 0	0	53.00
	NONREI MBURSABLE COST CENTERS			•			
60.00	BEREAVEMENT PROGRAM	0			0	0	60.00
61. 00	VOLUNTEER PROGRAM	0			0	0	61. 00
62. 00	FUNDRAI SI NG	0	1		0	0	62. 00
63. 00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	•		0	0	63. 00
64. 00	PALLIATIVE CARE PROGRAM	0			O	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0			0	65.00
66. 00 67. 00	RESI DENTI AL CARE ADVERTI SI NG			1		0	66. 00 67. 00
68. 00	TELEHEALTH/TELEMONI TORI NG					0	68.00
69. 00	THRIFT STORE	0			o o	0	69.00
70.00	NUDSING FACILITY DOOM & DOADD				-1		70.00

31, 946

0.000000

31, 946. 000000

0

0.000000

0.000000

69. 00 70.00

71.00

99.00

0 100.00 0. 000000 101. 00

69.00 THRIFT STORE
70.00 NURSING FACILITY ROOM & BOARD
71.00 OTHER NONREIMBURSABLE (SPECIFY)

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

99.00 NEGATIVE COST CENTER

Health Financial Systems F	TH RENSSELAER		In Lie	u of Form CMS-2	2552-10	
COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SEI STATISTICAL BASIS	RVICE COSTS	Provi der Co		Period: From 01/01/2016	Worksheet 0-6 Part II	
I I		Hospi ce CCI	N: 15-1519	To 12/31/2016	Date/Time Prep 8/8/2017 10:19	
				Hospi ce I		
Cost Center Descriptions	ROUTI NE	MEDI CAL	STAFF	VOLUNTEER	PHARMACY	
	MEDI CAL	RECORDS	TRANSPORTATI O	N SERVICE	(CHARGES)	
	SUPPLI ES	(PATIENT DAYS)		COORDI NATI ON		
	(PATIENT DAYS)		(MI LEAGE)	(HOURS OF		

					Hospi ce I		
	Cost Center Descriptions	ROUTI NE	MEDI CAL	STAFF	VOLUNTEER	PHARMACY	
	·	MEDI CAL	RECORDS	TRANSPORTATION	SERVI CE	(CHARGES)	
		SUPPLI ES	(PATIENT DAYS)		COORDI NATI ON		
		(PATIENT DAYS)	ĺ	(MI LEAGE)	(HOURS OF		
					SERVICE)		
		10.00	11.00	12.00	13. 00	14. 00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FLXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2. 00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3. 00
4. 00	ADMI NI STRATI VE & GENERAL						4. 00
5.00	PLANT OPERATION & MAINTENANCE						5.00
	•						1
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPI NG						7. 00
8. 00	DI ETARY						8. 00
9.00	NURSING ADMINISTRATION						9. 00
10. 00	ROUTINE MEDICAL SUPPLIES	0					10. 00
11. 00	MEDI CAL RECORDS		[C)			11. 00
12. 00	STAFF TRANSPORTATION			0			12. 00
13.00	VOLUNTEER SERVICE COORDINATION			0	0		13. 00
14.00	PHARMACY			0	0	0	14. 00
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES			0	o	0	15. 00
16. 00	OTHER GENERAL SERVICE			0	ol	0	16. 00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17. 00
	LEVEL OF CARE	'		1			
50.00	HOSPICE CONTINUOUS HOME CARE	0	C	0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	0		ol o	ol	0	51.00
52. 00	HOSPICE INPATIENT RESPITE CARE	0	l c	ol o	0	0	52.00
53. 00	HOSPICE GENERAL INPATIENT CARE	0			o	0	
	NONREI MBURSABLE COST CENTERS	-	· · · · · · · · · · · · · · · · · · ·		-1		1
60.00	BEREAVEMENT PROGRAM			0	0	0	60.00
61.00	VOLUNTEER PROGRAM			0	0	0	61.00
62.00	FUNDRAI SI NG			0	0	0	1
63. 00	HOSPICE/PALLIATIVE MEDICINE FELLOWS			0	ol	0	
64. 00	PALLIATIVE CARE PROGRAM			0	0	0	
65. 00	OTHER PHYSICIAN SERVICES			١	0	0	
66. 00	RESI DENTI AL CARE				0	0	
67. 00	ADVERTI SI NG				0	0	
68. 00	TELEHEALTH/TELEMONI TORI NG				0	0	
69. 00	THRIFT STORE				0	0	
				0	U	U	
70.00	NURSING FACILITY ROOM & BOARD						70.00
71. 00	OTHER NONREIMBURSABLE (SPECIFY)			0	O	0	
	NEGATI VE COST CENTER	_	_	_	_	-	99. 00
	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	0	0	0	0		100.00
101. 00	UNIT COST MULTIPLIER	0. 000000	0. 000000	0. 000000	0. 000000	0. 000000	[101. 00

Health Financial Systems	FRANCISCAN HEAL	LTH RENSSELAER		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SE	RVICE COSTS	Provi der CCN:		Peri od: From 01/01/2016	Worksheet 0-6	
STATISTICAL BASIS		Hospi ce CCN:		To 12/31/2016		
				Hospi ce I		
Cost Center Descriptions	PHYSI CI AN	OTHER GENERAL	PATI ENT/			

			·			8/8/2017 10:	19 am
					Hospi ce I		
	Cost Center Descriptions	PHYSI CI AN	OTHER GENERAL	PATI ENT/			
		ADMI NI STRATI VE		RESI DENTI AL	_		
		SERVI CES	(SPECI FY	CARE SERVICES			
		(PATIENT DAYS)	BASIS)	(IN-FACILITY			
				DAYS)			
	OFWERN OF BUILDE ORDER OFWERN	15. 00	16. 00	17. 00			
	GENERAL SERVICE COST CENTERS		Ī	T			
1.00	CAP REL COSTS-BLDG & FLXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3. 00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5. 00
6. 00	LAUNDRY & LINEN SERVICE						6. 00
7. 00	HOUSEKEEPI NG						7. 00
8.00	DI ETARY						8. 00
9.00	NURSING ADMINISTRATION						9. 00
10. 00	ROUTINE MEDICAL SUPPLIES						10.00
11. 00	MEDI CAL RECORDS						11.00
12. 00	STAFF TRANSPORTATION						12.00
13.00	VOLUNTEER SERVICE COORDINATION						13.00
14.00	PHARMACY						14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	C)				15. 00
16.00	OTHER GENERAL SERVICE		C				16. 00
17.00	PATIENT/RESIDENTIAL CARE SERVICES				0		17. 00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	C					50.00
51.00	HOSPICE ROUTINE HOME CARE	C) C				51.00
52.00	HOSPICE INPATIENT RESPITE CARE	C) C		0		52. 00
53.00	HOSPICE GENERAL INPATIENT CARE	C	0)	0		53.00
	NONREI MBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM		C)			60.00
61.00	VOLUNTEER PROGRAM		C				61.00
62.00	FUNDRAI SI NG		C				62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS		C				63.00
64.00	PALLIATIVE CARE PROGRAM		C				64. 00
65.00	OTHER PHYSICIAN SERVICES		C				65.00
66.00	RESI DENTI AL CARE	C) C		0		66.00
67. 00	ADVERTI SI NG		C				67.00
68. 00	TELEHEALTH/TELEMONI TORI NG		C				68. 00
69. 00	THRIFT STORE						69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71. 00	OTHER NONREIMBURSABLE (SPECIFY)	C	ol c		0		71.00
	NEGATI VE COST CENTER		1				99.00
	COST TO BE ALLOCATED (per Wkst. 0-6, Part	1)			0		100.00
100.00				1	1		

	FIONMENT OF HOSPITAL-BASED HOSPICE SHARED S OF CARE	ERVICE COSTS BY	Provider CC Hospice CCN	CN: 15-1324 N: 15-1519	Peri od: From 01/01/2016 To 12/31/2016		epared:
					Hospi ce I		
				Charges by	/ LOC (from Provi	ider Records)	
	Cost Center Descriptions	From Wkst. C, Part I, Col. 9 line	Cost to Charge Ratio	НСНС	HRHC	HI RC	
		0	1. 00	2. 00	3. 00	4. 00	
	ANCILLARY SERVICE COST CENTERS						
1.00	PHYSI CAL THERAPY	66. 00	1. 043341		-	0	
1. 01	WHEATFI ELD PT	66. 01	1. 243820		-	0	
2. 00	OCCUPATI ONAL THERAPY	67. 00	1. 514274		0	0 0	
2. 01	WHEATFI ELD OT	67. 01	2. 189382		0	0 0	
3. 00	SPEECH PATHOLOGY	68. 00	2. 079483		0	0 0	3.00
3. 01	WHEATFI ELD ST	68. 01	2. 215367		0	0 0	3. 01
4. 00	DRUGS CHARGED TO PATIENTS	73. 00	0. 489437		0 (0	4.00
5. 00	DURABLE MEDICAL EQUIP-RENTED	96. 00					5. 00
6. 00	LABORATORY	60. 00	0. 378750		0 (0	6.00
7. 00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71. 00	0. 530146		0 (0	7.00
3. 00	FAMILY PRACTICE	93. 00					8. 00
9. 00	RADI OLOGY-THERAPEUTI C	55. 00					9. 00
10.00	OTHER ANCILLARY SERVICE COST CENTERS	76. 00					10.00
11. 00	Totals (sum of lines 1-11)						11. 00
		Charges by LOC		Shared Serv	ice Costs by LOC		
		(from Provider					
		Records)					
	Cost Center Descriptions	HGI P			xHIRC (col. 1)		
			col . 2)	col . 3)	col . 4)	col . 5)	
	ANOLILIA DIVI OF DIVI OF COOT OFFITEDO	5. 00	6. 00	7. 00	8. 00	9. 00	
1. 00	ANCILLARY SERVICE COST CENTERS		0				1 00
	PHYSI CAL THERAPY	0	0		١ ٠	0	
			0		0	0	
1. 01	WHEATFI ELD PT		ام		0	าl ^	1 2 00
1. 01 2. 00	OCCUPATI ONAL THERAPY	0	0		0 0	0	
1. 01 2. 00 2. 01	OCCUPATIONAL THERAPY WHEATFIELD OT	0	0		0	o o	2. 01
1. 01 2. 00 2. 01 3. 00	OCCUPATIONAL THERAPY WHEATFIELD OT SPEECH PATHOLOGY	0	0		0 0		2. 01 3. 00
1. 01 2. 00 2. 01	OCCUPATIONAL THERAPY WHEATFIELD OT	0	0 0		0	o o	2. 01 3. 00 3. 01

0

0

5.00

6.00

7. 00

8.00

9. 00

10.00 0 11.00

5.00

6.00

7.00

8.00

9.00

RADI OLOGY-THERAPEUTI C

LABORATORY

DURABLE MEDICAL EQUIP-RENTED

10.00 OTHER ANCILLARY SERVICE COST CENTERS
11.00 Totals (sum of lines 1-11)

MEDICAL SUPPLIES CHARGED TO PATIENTS
FAMILY PRACTICE

Health Financial Systems	FRANCI SCAN HE	EALTH RENSSELAER	In Li€	eu of Form CMS-2552-10
CALCULATION OF HOSPITAL-BASED HOSPI	CE PER DIEM COST	Provider CCN: 15-1324	Peri od: From 01/01/2016	Worksheet 0-8
		Hospi ce CCN: 15-151		Date/Time Prepared:

		HOSPICE CON:	15-1519 1	0 12/31/2016	8/8/2017 10:19	
				Hospi ce I		
			TITLE XVIII	TITLE XIX	TOTAL	
			MEDI CARE	MEDI CAI D		
			1. 00	2. 00	3. 00	
	HOSPICE CONTINUOUS HOME CARE					
1.00	Total cost (Wkst. 0-6, Part I, col. 18, line 50 plus Wkst. 0-7,	col. 6,			0	1. 00
	line 11)					
2.00	Total unduplicated days (Wkst. S-9, col. 4, line 10)				0	2. 00
3.00					0. 00	3. 00
	4.00 Unduplicated program days (Wkst. S-9 col. as appropriate, line 10)			이		4. 00
5. 00	5.00 Program cost (line 3 times line 4)			0		5. 00
	HOSPICE ROUTINE HOME CARE			1		
6. 00	Total cost (Wkst. 0-6, Part I, col. 18, line 51 plus Wkst. 0-7,	col . 7,			953, 178	6. 00
7.00	line 11)				4 550	7 00
7.00	Total unduplicated days (Wkst. S-9, col. 4, line 11)				4, 559	7. 00
8.00	Total average cost per diem (line 6 divided by line 7)	. 11)	2 514		209. 08	
9.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line	9 11)	2, 514			9. 00
10. 00	Program cost (line 8 times line 9) HOSPICE INPATIENT RESPITE CARE		525, 627	0		10. 00
11 00	Total cost (Wkst. 0-6, Part I, col. 18, line 52 plus Wkst. 0-7,	001 0			20 (71	11 00
11. 00		COI . 8,			38, 671	11. 00
12. 00	Total unduplicated days (Wkst. S-9, col. 4, line 12)				6	12. 00
13. 00	Total average cost per diem (line 11 divided by line 12)				6, 445. 17	
14. 00	Unduplicated program days (Wkst. S-9, col. as appropriate, line	12)	6		0, 443. 17	14. 00
	Program cost (line 13 times line 14)	, 12)	38, 671	1 "1		15. 00
13.00	HOSPICE GENERAL INPATIENT CARE		30, 07 1	<u> </u>		13.00
16. 00	Total cost (Wkst. 0-6, Part I, col. 18, line 53 plus Wkst. 0-7,	col 9			0	16. 00
	line 11)	001.77			ŭ.	
17. 00	Total unduplicated days (Wkst. S-9, col. 4, line 13)				0	17. 00
	Total average cost per diem (line 16 divided by line 17)				0.00	18. 00
19. 00	Unduplicated program days (Wkst. S-9, col. as appropriate, line	9 13)	C	o		19. 00
20.00	Program cost (line 18 times line 19)	ĺ	C	ol		20. 00
	TOTAL HOSPICE CARE					
21. 00	Total cost (sum of line 1 + line 6 + line 11 + line 16)				991, 849	21. 00
22. 00	Total unduplicated days (Wkst. S-9, col. 4, line 14)	l			4, 565	22. 00
23.00	Average cost per diem (line 21 divided by line 22)	l			217. 27	23. 00
	•				·	•

		RANCI SCAN HEAL				eu of Form CMS-2	2552-10
ANALYS	SIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provi der CC		Period: From 01/01/2016	Worksheet M-1	
			Component (To 12/31/2016		
					RHC I	Cost	
		Compensation	Other Costs	•	Recl assi fi cati		
				+ col. 2)	ons	Trial Balance	
						(col. 3 + col.	
		1 00	2.00	2.00	4.00	4)	
	FACILITY HEALTH CARE STAFF COSTS	1. 00	2. 00	3. 00	4. 00	5. 00	
1. 00	Physician	55, 539	0	55, 53	9 0	55, 539	1. 00
2. 00	Physician Assistant	33, 337 O	0		o o	,	
3.00	Nurse Practitioner	123, 021	0	123, 02	-	123, 021	3.00
4. 00	Visiting Nurse	0	0	120, 02	0 0	120, 021	
5. 00	Other Nurse	65, 292	0	65, 29	2 0	65, 292	
6.00	Clinical Psychologist	0	0	,	0 0	0	6.00
7.00	Clinical Social Worker	0	0		0 0	0	7. 00
8.00	Laboratory Techni ci an	0	0		0 0	0	8. 00
9.00	Other Facility Health Care Staff Costs	0	0		0 0	0	9. 00
10.00	Subtotal (sum of lines 1 through 9)	243, 852	0	243, 85	2 0	243, 852	10.00
11. 00	Physician Services Under Agreement	0	0		0	0	
12. 00	Physician Supervision Under Agreement	0	0		0	0	
13. 00	Other Costs Under Agreement	0	0		0	0	
14.00	Subtotal (sum of lines 11 through 13)	0	0		0	0	14.00
15.00	Medical Supplies	0	16, 964	16, 96	4 0	16, 964	1
16. 00 17. 00	Transportation (Health Care Staff)	0	0		0	0	16. 00 17. 00
18. 00	Depreciation-Medical Equipment Professional Liability Insurance	0	0		0 0	0	18.00
19. 00	1	0	0		0 0	0	19.00
20. 00	Allowable GME Costs	O	O		0		20.00
21. 00	Subtotal (sum of lines 15 through 20)	0	16, 964	16, 96	4 0	16, 964	ı
22. 00	Total Cost of Health Care Services (sum of	243, 852	16, 964	260, 81			•
	lines 10, 14, and 21)	,			1		
	COSTS OTHER THAN RHC/FQHC SERVICES						
23. 00	Pharmacy	0	0		0 0	0	23. 00
24.00	Dental	0	0		0		24. 00
25.00	Optometry	0	0		0	0	25. 00
25. 01	Tel eheal th	0	0		0	0	25. 01
25. 02	Chronic Care Management	0	0		0	0	25. 02
26. 00	All other nonreimbursable costs	0	0		0	0	26. 00
27. 00	Nonallowable GME costs	0	0		0	0	27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	U	U		U U	0	28. 00
	through 27) FACILITY OVERHEAD						
29. 00	Facility Costs	0	0		0 0	0	29. 00
30.00	Administrative Costs	21, 912	47, 432	69, 34	-	69, 344	30.00
31. 00	Total Facility Overhead (sum of lines 29 and	21, 912	47, 432	69, 34			
	30)	–					

265, 764

64, 396

330, 160

32.00

330, 160

32.00 Total facility costs (sum of lines 22, 28 and 31)

Health Financial Systems	FRANCISCAN HEAL	TH RENSSELAER		In Lie	u of Form CMS-2	552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provi der CO	CN: 15-1324	Peri od: From 01/01/2016	Worksheet M-1	
		Component (CCN: 15-3990	To 12/31/2016	Date/Time Prep 8/8/2017 10:19	
				RHC I	Cost	
	Adjustments	Net Expenses				
	_	for Allocation				
		(col. 5 + col.				
		6)				
	6 00	7 00				

				KHC I COST	
		Adjustments	Net Expenses		
		•	for Allocation		
			(col. 5 + col.		
			6)		
		6. 00	7. 00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physi ci an	0	55, 539		1.00
2.00	Physici an Assistant	0	0	•	2.00
3.00	Nurse Practitioner	0	123, 021	l .	3. 00
4.00	Visiting Nurse	0	0	•	4. 00
5.00	Other Nurse	0	65, 292	1	5. 00
6. 00	Clinical Psychologist	0	05, 292	l .	6.00
7. 00	Clinical Social Worker	0		l .	
	4	0	1	l .	7. 00
8.00	Laboratory Techni ci an	0	0	l .	8. 00
9.00	Other Facility Health Care Staff Costs	0	0		9. 00
10. 00	Subtotal (sum of lines 1 through 9)	0	243, 852	l .	10. 00
11. 00	Physician Services Under Agreement	0	0	l .	11. 00
12. 00	Physician Supervision Under Agreement	0	0		12. 00
13.00	Other Costs Under Agreement	0	0		13. 00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15.00	Medical Supplies	0	16, 964		15. 00
16.00	Transportation (Health Care Staff)	0	0		16. 00
17.00	Depreciation-Medical Equipment	0	0		17. 00
18.00	Professional Liability Insurance	0	0		18. 00
19.00	Other Health Care Costs	0	0		19.00
20. 00	Allowable GME Costs				20.00
21. 00	Subtotal (sum of lines 15 through 20)	0	16, 964		21. 00
22. 00	Total Cost of Health Care Services (sum of	0	260, 816		22. 00
22.00	lines 10, 14, and 21)	O	200,010		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				1
23. 00	Pharmacy	0	0		23. 00
24. 00	Dental	0	0		24. 00
25. 00	Optometry	0	0		25. 00
25. 01	Tel eheal th	0	0		25. 01
25. 02	Chronic Care Management	0	0	l .	25. 02
26. 00	All other nonreimbursable costs	0	0	l control of the cont	26. 00
27. 00	Nonal Lowable GME costs	0	0		27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	0		28. 00
26.00	`	U	0		20.00
	through 27)				-
20.00	FACILITY OVERHEAD				20.00
29. 00	Facility Costs	0	0	1	29. 00
30.00	Administrative Costs	0	69, 344		30.00
31. 00	Total Facility Overhead (sum of lines 29 and	0	69, 344		31. 00
	30)	_			
32. 00	Total facility costs (sum of lines 22, 28	0	330, 160		32. 00
	and 31)		l		1

	Financial Systems F SIS OF HOSPITAL-BASED RHC/FQHC COSTS	RANCI SCAN HEAL		CN: 15-1324	Peri od:	wof Form CMS-2 Worksheet M-1	2552-10
			Component	CCN: 15-8502	From 01/01/2016 To 12/31/2016		
					RHC IV	Cost	9 3111
		Compensation	Other Costs	Total (col	1 Reclassi fi cati	Recl assi fi ed	
		oomponout. on	011.01 00010	+ col . 2)	ons	Trial Balance	
						(col. 3 + col.	
						4)	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physi ci an	55, 539	0	55, 53	39 0		1. 00
2.00	Physi ci an Assi stant	0	0	1	0	1	2. 00
3.00	Nurse Practitioner	118, 677	0	118, 67	77 0	1 ,	3. 00
4.00	Visiting Nurse	0	0		0	0	4. 00
5.00	Other Nurse	106, 835	0	106, 83		100,000	5. 00
6.00	Clinical Psychologist	0	0)	0	0	6. 00
7.00	Clinical Social Worker	0	0)	0		7. 00
8.00	Laboratory Techni ci an	0	Ü)	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	201 0	0 0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	281, 051	U	281, 05	0	281, 051	
11.00	Physician Services Under Agreement	0	0		0	0	11.00
12. 00 13. 00	Physician Supervision Under Agreement Other Costs Under Agreement	0	0		0	0	12. 00 13. 00
14. 00	Subtotal (sum of lines 11 through 13)	0	0		0 0		14.00
15. 00	Medical Supplies	0	36	1	36 0	36	15. 00
16. 00	Transportation (Health Care Staff)	0	0		0 0	0	16.00
17. 00	Depreciation-Medical Equipment	0	0	1		Ö	17. 00
18. 00	Professional Liability Insurance	0	0		0 0	Ö	18.00
19. 00	Other Health Care Costs	0	0		0 0	0	19.00
20. 00	Allowable GME Costs						20.00
21. 00	Subtotal (sum of lines 15 through 20)	o	36		36 0	36	21. 00
22. 00	Total Cost of Health Care Services (sum of	281, 051	36	•		281, 087	22. 00
	lines 10, 14, and 21)					·	
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0)	0		23. 00
24. 00	Dental	0	0		0		24. 00
25. 00	Optometry	0	0		0		25. 00
25. 01	Tel eheal th	0	0		0	0	25. 01
25. 02	Chronic Care Management	0	0)	0	0	25. 02
26. 00	All other nonreimbursable costs	O	0)	0	0	26. 00
27. 00	Nonallowable GME costs						27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	Ü)	0	0	28. 00
	through 27) FACILITY OVERHEAD						
29. 00	Facility OverHead Facility Costs	ol	0	1	0 0	0	29. 00
30.00	Administrative Costs	25, 190	80, 624	105, 8	-		30.00
31. 00	Total Facility Overhead (sum of lines 29 and	25, 190 25, 190	80, 624 80, 624			105, 814	31.00
51.00	30)	23, 170	00, 024	100, 0		100,014	51.00
				1			l

306, 241

80, 660

386, 901

32.00

386, 901

32.00

Total facility costs (sum of lines 22, 28 and 31)

Health Financial Systems	FRANCISCAN HEALTH	RENSSELAER	In Lie	u of Form CMS-2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provider CCN: 15-1324	Peri od: From 01/01/2016	Worksheet M-1
		Component CCN: 15-8502	To 12/31/2016	Date/Time Prepared: 8/8/2017 10:19 am
			RHC IV	Cost
	Adiustments N	et Exnenses		

							8/8/2017 10: 1	9 am
						RHC IV	Cost	
		Adjustments	Ne	t Expenses				
		,	for	· Allocation				
				ol. 5 + col.				
			100	6)				
		6, 00		7.00				
	FACILITY HEALTH CARE STAFF COSTS	0.00		7.00				_
1. 00	Physi ci an			55, 539				1.00
		0	1					
2.00	Physician Assistant	Ü	2	0				2. 00
3.00	Nurse Practitioner	0)	118, 677				3. 00
4.00	Visiting Nurse	0		0				4. 00
5.00	Other Nurse	0		106, 835				5. 00
6.00	Clinical Psychologist	0		0				6.00
7.00	Clinical Social Worker	0		0				7. 00
8.00	Laboratory Techni ci an	0		0				8.00
9. 00	Other Facility Health Care Staff Costs	0		0				9. 00
10.00	Subtotal (sum of lines 1 through 9)	0	()	281, 051				10.00
		0	1					
11. 00	Physician Services Under Agreement	Ü	2	0				11. 00
12. 00	Physician Supervision Under Agreement	0	9	0				12. 00
13. 00	Other Costs Under Agreement	0		0				13. 00
14.00	Subtotal (sum of lines 11 through 13)	0		0				14. 00
15.00	Medical Supplies	0		36				15. 00
16.00	Transportation (Health Care Staff)	0	ol	0				16. 00
17. 00	Depreciation-Medical Equipment	0		0				17. 00
18. 00	Professional Liability Insurance	0		0				18. 00
19. 00	Other Health Care Costs	0		0				19. 00
20. 00	Allowable GME Costs	O	Ί	O				20. 00
	l e			0.4				1
21. 00	Subtotal (sum of lines 15 through 20)	Ü	2	36				21. 00
22. 00	Total Cost of Health Care Services (sum of	0	9	281, 087				22. 00
	lines 10, 14, and 21)							
	COSTS OTHER THAN RHC/FQHC SERVICES							
23. 00	Pharmacy	0		0				23. 00
24.00	Dental	0		0				24. 00
25.00	Optometry	0		0				25. 00
25. 01	Tel eheal th	0		0				25. 01
25. 02	Chronic Care Management	0	ol .	0				25. 02
26. 00	All other nonreimbursable costs	0		0				26. 00
27. 00	Nonallowable GME costs	O	1	Ü				27. 00
		0		0				1
28. 00	Total Nonreimbursable Costs (sum of lines 23	U	Ί	U				28. 00
	through 27)							-
	FACILITY OVERHEAD							4
29. 00	Facility Costs	0)	0				29. 00
30.00	Administrative Costs	0)	105, 814				30. 00
31.00	Total Facility Overhead (sum of lines 29 and	0)	105, 814				31.00
	30)							1
32.00	Total facility costs (sum of lines 22, 28	0		386, 901				32. 00
	and 31)							1
	, .		•		'			

Heal th	Financial Systems	FRANCI SCAN HEAL	TH RENSSELAER		In Lie	u of Form CMS-2	2552-10
ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC	SERVI CES	Provi der Co		Period: From 01/01/2016	Worksheet M-2	
			Component	CCN: 15-3990	Го 12/31/2016	8/8/2017 10: 1	
					RHC I	Cost	
		Number of FTE	Total Visits		Minimum Visits		
		Personnel		Standard (1)	(col. 1 x col. 3)	col. 2 or col. 4	
		1.00	2. 00	3. 00	4. 00	5. 00	
	VISITS AND PRODUCTIVITY						
	Posi ti ons						
1.00	Physi ci an	0. 38			1		1. 00
2.00	Physician Assistant	0.00		_,			2. 00
3.00	Nurse Practitioner	1. 26	1, 273	2, 100	2, 646		3. 00
4.00	Subtotal (sum of lines 1 through 3)	1. 64			4, 242	4, 242	
5.00	Visiting Nurse	0. 00				0	
6.00	Clinical Psychologist	0. 00				0	6. 00
7.00	Clinical Social Worker	0. 00	l .			0	7. 00
7. 01	Medical Nutrition Therapist (FQHC only)	0. 00				0	
7. 02	Diabetes Self Management Training (FQHC only)	0. 00	0			0	7. 02
8.00	Total FTEs and Visits (sum of lines 4	1. 64	2, 885			4, 242	8. 00
9. 00	through 7) Physician Services Under Agreements		0			0	9. 00
9.00	Priysi ci aii sei vi ces under Agreements					U	9.00
						1. 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE			VICES			
10.00	Total costs of health care services (from W					260, 816	
11.00	Total nonreimbursable costs (from Wkst. M-1					0	
12.00	Cost of all services (excluding overhead) (260, 816	
13.00	Ratio of hospital-based RHC/FQHC services (1. 000000	
14.00	Total hospital-based RHC/FQHC overhead - (f			ne 31)		69, 344	
15. 00	Parent provider overhead allocated to facil	ity (see instrud	ctions)			294, 629	
16. 00	Total overhead (sum of lines 14 and 15)					363, 973	
17. 00	Allowable GME overhead (see instructions)					0	
	Enter the amount from line 16			>		363, 973	
	Overhead applicable to hospital-based RHC/F					363, 973	
20.00	Total allowable cost of hospital-based RHC/	FUHC services (s	sum or lines 10	and 19)		624, 789	20.00

Heal th	Financial Systems	FRANCI SCAN HEAL	TH RENSSELAER		In lie	u of Form CMS-2	2552-10
	ATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC		Provi der Co		Peri od:	Worksheet M-2	
			Component (From 01/01/2016 To 12/31/2016	Date/Time Pre	nared:
			Component	3011. 10 0002		8/8/2017 10: 1	
					RHC IV	Cost	
		Number of FTE	Total Visits		Minimum Visits		
		Personnel		Standard (1)	(col. 1 x col. 3)		
		1.00	2.00	3.00	4. 00	5. 00	
	VISITS AND PRODUCTIVITY	11.55			1		
	Posi ti ons						
1.00	Physi ci an	0. 38	929	4, 20	0 1, 596		1. 00
2.00	Physician Assistant	0. 00		_,			2. 00
3.00	Nurse Practitioner	1. 09	3, 892	2, 10			3. 00
4.00	Subtotal (sum of lines 1 through 3)	1. 47			3, 885	4, 821	4. 00
5.00	Visiting Nurse	0. 00	l e			0	5. 00
6.00	Clinical Psychologist	0. 00				0	6. 00
7.00	Clinical Social Worker	0. 00				0	7. 00
7. 01	Medical Nutrition Therapist (FQHC only)	0.00	l e			0	
7. 02	Diabetes Self Management Training (FQHC	0. 00	0			0	7. 02
0.00	only)	1 47	4 001			4 021	0.00
8. 00	Total FTEs and Visits (sum of lines 4 through 7)	1. 47	4, 821			4, 821	8. 00
9. 00	Physician Services Under Agreements		0			0	9. 00
9.00	Frilysi Crair Servi Ces Under Agreements		0			U	9.00
						1. 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE	TO HOSPI TAL-BASE	D RHC/FQHC SER	VI CES			
10.00	Total costs of health care services (from W	kst. M-1, col. 7	', line 22)			281, 087	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1	, col. 7, line 2	28)			0	11. 00
12.00	Cost of all services (excluding overhead) (sum of lines 10	and 11)			281, 087	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided	by line 12)			1. 000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (f			ne 31)		105, 814	14. 00
15. 00	Parent provider overhead allocated to facil	ity (see instruc	ctions)			575, 004	
16. 00	Total overhead (sum of lines 14 and 15)					680, 818	
17. 00	()					0	
	Enter the amount from line 16					680, 818	
	Overhead applicable to hospital-based RHC/F	•		,		680, 818	
20. 00	Total allowable cost of hospital-based RHC/	FQHC services (s	sum of lines 10	and 19)		961, 905	20.00

TION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC S	Provider CCN: 15-1324	Peri od:	Worksheet M-3	
S			WOLKSHEET M-3	
	Component CCN: 15-3990	From 01/01/2016 To 12/31/2016	Date/Time Prep 8/8/2017 10:19	
	Title XVIII	RHC I	Cost	
DETERMINATION OF DATE FOR MOSDITAL BASED BUC/FOUR SERVICES			1. 00	
	m Wkst M-2 line 20)		624 789	1.00
· · · · · · · · · · · · · · · · · · ·				
Total Visits (from Wkst. M-2, column 5, line 8)			4, 242	4. 00
Physicians visits under agreement (from Wkst. M-2, column 5, I	line 9)		0	5. 00
Total adjusted visits (line 4 plus line 5)			4, 242	6. 00
Adjusted cost per visit (line 3 divided by line 6)			146. 74	7. 00
		Cal cul ati on	of Limit (1)	
		Prior to Jan.	On or After	
		1 (Rate Period		
		1)		
	.6 or your contractor)			8. 00
		146. 74	146. 74	9. 00
	contractor records)	٥	102	10.00
· ·	*			11.00
				12.00
				13.00
· ·	,			14.00
,	,		J.	15. 00
· · · · · · · · · · · · · · · · · · ·	•	O	28, 174	16.00
Total program charges (see instructions)(from contractor's rec	cords)		13, 660	16. 01
			880	16. 02
			1, 815	
Total Program non-preventive costs ((line 16 minus lines 16.0% (Titles V and XIX see instructions.)	3 and 18) times .80)		19, 666	16. 04
Total program cost (see instructions)		0	21, 481	16. 05
Primary payer amounts			0	17. 00
	(from contractor		1, 777	18. 00
Beneficiary coinsurance for RHC/FQHC services (see instruction	ns) (from contractor		2, 201	19. 00
,			21 /01	20.00
	M-4 line 16)			21.00
			22, 030	23. 00
Adjusted reimbursable bad debts (see instructions)			Ö	
	ructions)		0	24. 00
OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	•		0	25. 00
Pioneer ACO demonstration payment adjustment (see instructions	s)		0	25. 50
Net reimbursable amount (see instructions)				
Sequestration adjustment (see instructions)			441	26. 01
1 3				
				28. 00
				1
	nice with CMS Pub. 15-11,		O	30. 00
C F F F F F F F F F F F F F F F F F F F	Cost of vaccines and their administration (from Wkst. M-4, li Total allowable cost excluding vaccine (line 1 minus line 2) Total Visits (from Wkst. M-2, column 5, line 8) Physicians visits under agreement (from Wkst. M-2, column 5, Total adjusted visits (line 4 plus line 5) Adjusted cost per visit (line 4 plus line 5) Adjusted cost per visit (line 3 divided by line 6) Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20 Rate for Program covered visits (see instructions) CALCULATION OF SETTLEMENT Program covered visits excluding mental health services (from Program covered visits for mental health services (from contr. Program covered visits for mental health services (line 9 x lit limit adjustment for mental health services (see instructions Graduate Medical Education Pass Through Cost (see instructions Graduate Medical Education Pass Through Cost (see instructions Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 Total program preventive charges (see instructions) (from prov Total program preventive costs ((line 16.02/line 16.01) times Total Program non-preventive costs ((line 16.02/line 16.01) times Total Program non-preventive costs ((line 16 minus lines 16.0 (Titles V and XIX see instructions.) Primary payer amounts Less: Beneficiary deductible for RHC only (see instructions) Program cost (see instructions) Program cost of vaccines and their administration (from Wkst. Total reimbursable Program cost (line 20 plus line 21) Allowable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instruction Program cost of vaccines and their administration (from Wkst. Total reimbursable amount (see instructions) Prioneer ACO demonstration payment adjustment (see instruction Net reimbursable amount (see instructions) Sequestration adjustment (see instructions) Balance due component/program (line 26 minus lines 26.01, 27, 27, 27, 27, 27, 27, 27, 27, 27, 27	Total Allowable Cost of hospital-based RHC/FOHC Services (from Wkst. M-2, line 20) Cost of vaccines and their administration (from Wkst. M-4, line 15) Total allowable cost excluding vaccine (line 1 minus line 2) Total visits (from Wkst. M-2, column 5, line 8) Physicians visits under agreement (from Wkst. M-2, column 5, line 9) Physicians visits under agreement (from Wkst. M-2, column 5, line 9) Total adjusted visits (line 4 plus line 5) Adjusted cost per visit (line 3 divided by line 6) Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor) Rate for Program covered visits (see instructions) ALCULATION OF SETTLEMENT Program covered visits excluding mental health services (from contractor records) Program covered visits for mental health services (line 9 x line 10) Program covered visits for mental health services (line 9 x line 10) Program covered visits for mental health services (line 9 x line 12) Limit adjustment for mental health services (see instructions) Graduate Medical Education Pass Through Cost (see instructions) Graduate Medical Education Pass Through Cost (see instructions) Total program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) * Total program charges (see instructions)(from contractor's records) Total program preventive charges (see instructions)(from provider's records) Total program preventive costs ((line 16 minus lines 16.03 and 18) times .80) Total program preventive costs ((line 16 minus lines 16.03 and 18) times .80) Total program program cost (see instructions) Primary payer amounts Less: Beneficiary deductible for RHC only (see instructions) (from contractor records) Beneficiary coinsurance for RHC/FQHC services (see instructions) Primary payer amounts Less: Beneficiary deductible for RHC only (see instructions) Allowable bad debts (see instructions) Allowable bad debts (see instructions) Allowable bad debts (see instructions) Note of the program cost (line 20 plus line 21) Allowable bad debts (see instructions) Note of the program cost (see inst	Total Allowable Cost of hospital-based RHC/FOHC Services (from Wkst. M-2, line 20) Cost of vaccines and their administration (from Wkst. M-4, line 15) Total allowable cost excluding vaccine (line 1 minus line 2) Total Visits (from Wkst. M-2, column 5, line 8) Physicians visits under agreement (from Wkst. M-2, column 5, line 9) Total adjusted visits (line 4 plus line 5) Adjusted cost per visit (line 3 divided by line 6) Calculation Prior to Jan. 1 (Rate Period 1) 1.00 Per visit payment limit (from CMS Pub. 100-04, chapter 9, \$20.6 or your contractor) Rate for Program covered visits (see instructions) ALCULATION OF SETTLEMENT Program covered visits excluding mental health services (from contractor records) Program covered visits for mental health services (line 9 x line 10) Program covered visits from mental health services (line 9 x line 10) OPProgram covered visits from mental health services (line 9 x line 10) Intil adjustment for mental health services (line 9 x line 10) OF Graduate Medical Education Pass Through Cost (see instructions) Graduate Medical Education Pass Through Cost (see instructions) Total program covered visits (see instructions) Fotal program preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions) Total program preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions) Primary payer amounts Less: Beneficiary deductible for RHC only (see instructions) (from contractor records) Rotal program cost (see instructions) Program cost of vaccines and their administration (from Wkst. M-4, line 16) Total program monopreventive costs ((line 16 minus lines 16.03 and 18) times .80) OTHER ADUSTNENTS (SEE INSTRUCTIONS) Program cost of vaccines and their administration (from Wkst. M-4, line 16) Total reimbursable Program cost (line 20 minus lines (see instructions) Note the dicare cost excluding vaccines (see instructions) All owable bad debts (see instructions) Note the multiple of the program of the p	Total All Jowable Cost of hospital -based RRC/FGHC Services (from Wkst. M-2, line 20) 624,789

111 41-	FINANCIA CONTRACTOR	DENICCEL AED	111-	£ F OMC /	2552 40
	Financial Systems FRANCISCAN HEALTH ATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FOHC	Provider CCN: 15-1324	Peri od:	u of Form CMS-2 Worksheet M-3	
SERVI (Component CCN: 15-8502	From 01/01/2016 To 12/31/2016	Date/Time Pre 8/8/2017 10:1	pared:
		Title XVIII	RHC IV	Cost	, <u></u>
	DETERMINATION OF DATE FOR HOCKLIAL DACED DUC/FOLIC CERVILORS			1. 00	
1. 00	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES Total Allowable Cost of hospital-based RHC/FQHC Services (fro	m Wkst M-2 line 20)		961, 905	1. 00
2. 00	Cost of vaccines and their administration (from Wkst. M-4, li			12, 562	2.00
3. 00	Total allowable cost excluding vaccine (line 1 minus line 2)			949, 343	•
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			4, 821	4. 00
5. 00	Physicians visits under agreement (from Wkst. M-2, column 5,	line 9)		0	5. 00
6. 00	Total adjusted visits (line 4 plus line 5)			4, 821	6. 00
7. 00	Adjusted cost per visit (line 3 divided by line 6)		C-11 -+:	196. 92	7. 00
			Cal cul ati on		
			Prior to Jan.	On or After	
			1 (Rate Period 1)	Jan. 1 (Rate Period 2)	
			1.00	2. 00	
8. 00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20	, 6 or vour contractor)	81. 32	81. 32	8. 00
9.00	Rate for Program covered visits (see instructions)	,	196. 92	196. 92	l
	CALCULATION OF SETTLEMENT				
10. 00	Program covered visits excluding mental health services (from	,	0	784	10. 00
11. 00	Program cost excluding costs for mental health services (line		0	154, 385	1
12. 00 13. 00	Program covered visits for mental health services (from contr Program covered cost from mental health services (line 9 x li		0	0	12. 00 13. 00
14. 00	Limit adjustment for mental health services (see instructions		0	0	14.00
15. 00	Graduate Medical Education Pass Through Cost (see instruction	•	ď	O	15. 00
16. 00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2	*	0	154, 385	1
16. 01	Total program charges (see instructions) (from contractor's re	cords)		56, 130	16. 01
16. 02	Total program preventive charges (see instructions)(from prov			2, 920	16. 02
16. 03	Total program preventive costs ((line 16.02/line 16.01) times			8, 031	16. 03
16. 04	Total Program non-preventive costs ((line 16 minus lines 16.0	3 and 18) times .80)		108, 713	16. 04
16. 05	(Titles V and XIX see instructions.) Total program cost (see instructions)		0	116, 744	16. 05
17. 00	Primary payer amounts			0	17. 00
18. 00	Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		10, 463	•
	records)				
19. 00	Beneficiary coinsurance for RHC/FQHC services (see instruction records)	ns) (from contractor		8, 549	19. 00
20. 00	Net Medicare cost excluding vaccines (see instructions)			116, 744	20. 00
21. 00	Program cost of vaccines and their administration (from Wkst.	M-4, line 16)		10, 879	21. 00
22. 00				127, 623	
23. 00	Allowable bad debts (see instructions)			0	•
23. 01	Adjusted reimbursable bad debts (see instructions)			0	
24. 00 25. 00	Allowable bad debts for dual eligible beneficiaries (see inst OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	ructions)		0	
25. 50	Pioneer ACO demonstration payment adjustment (see instruction	ıs)		0	
26. 00	Net reimbursable amount (see instructions)			127, 623	
26. 01	Sequestration adjustment (see instructions)			2, 552	26. 01
27. 00				67, 216	
28. 00	Tentative settlement (for contractor use only)			0	28. 00
29. 00 30. 00	Balance due component/program (line 26 minus lines 26.01, 27, Protested amounts (nonallowable cost report items) in accorda			57, 855 0	29. 00 30. 00
30.00	chapter I, §115.2	ince with two Pub. 15-11,		Ü	30.00
	10.00p.co. 1, 3110.2		ı I		I

Health Financial Systems	FRANCI SCAN HEALTH	RENSSELAER	In Lie	u of Form CMS-2552-10
COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST	PNEUMOCOCCAL AND INFLUENZA	Provider CCN: 15-1324	Peri od: From 01/01/2016	Worksheet M-4
VACCINE COST		Component CCN: 15-3990	To 12/31/2016	Date/Time Prepared: 8/8/2017 10:19 am
		Title XVIII	RHC I	Cost

				0/0/201/ 10. 1	9 alli
		Title XVIII	RHC I	Cost	
			Pneumococcal	I nfl uenza	
			1. 00	2. 00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		243, 852	243, 852	1. 00
2.00	Ratio of pneumococcal and influenza vaccine staff time to tota	al health care staff time	0. 000038	0. 001285	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (lin	ne 1 x line 2)	9	313	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (fi	rom your records)	80	565	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus	s line 4)	89	878	5. 00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksho	eet M-1, col. 7, line 22)	260, 816	260, 816	6. 00
7.00	Total overhead (from Wkst. M-2, line 19)		363, 973	363, 973	7. 00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to to	tal direct cost (line 5	0. 000341	0. 003366	8. 00
	divided by line 6)				
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x l	ine 8)	124	1, 225	9. 00
10.00	Total pneumococcal and influenza vaccine cost and its (their)	administration (sum of	213	2, 103	10.00
	lines 5 and 9)				
11. 00	Total number of pneumococcal and influenza vaccine injections	(from your records)	1	34	11. 00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10	D/line 11)	213. 00	61. 85	12.00
13.00	Number of pneumococcal and influenza vaccine injections admini	stered to Program	0	9	13.00
	benefi ci ari es				
14.00	Program cost of pneumococcal and influenza vaccine and its (the	neir) administration	0	557	14.00
	(line 12 x line 13)				
15. 00				2, 316	15. 00
	of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3,	•			
16. 00	Total Program cost of pneumococcal and influenza vaccine and i	. ,		557	16. 00
	administration (sum of cols. 1 and 2, line 14) (transfer this	amount to Wkst. M-3,			
	line 21)				

Health Financial Systems	FRANCI SCAN HEALTH	RENSSELAER	In Lie	u of Form CMS-2552-10
COMPUTATION OF HOSPITAL-BASED RHC/FQHC	PNEUMOCOCCAL AND INFLUENZA	1	Peri od: From 01/01/2016	Worksheet M-4
VACCINE COST		Component CCN: 15-8502		
		Title XVIII	RHC I.V	Cost

				0/0/201/ 10.1:	<i>7</i> aiii
		Title XVIII	RHC IV	Cost	
			Pneumococcal	I nfl uenza	
			1. 00	2. 00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		281, 051	281, 051	1. 00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total	al health care staff time	0. 001348	0. 000693	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (li	ne 1 x line 2)	379	195	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (fi	rom your records)	2, 798	299	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus	s line 4)	3, 177	494	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksho	eet M-1, col. 7, line 22)	281, 087	281, 087	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		680, 818	680, 818	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to to	tal direct cost (line 5	0. 011303	0. 001757	8.00
	divided by line 6)				
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x l	line 8)	7, 695	1, 196	9. 00
10.00	Total pneumococcal and influenza vaccine cost and its (their)	administration (sum of	10, 872	1, 690	10.00
	lines 5 and 9)				
11. 00	Total number of pneumococcal and influenza vaccine injections	(from your records)	35	18	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10	0/line 11)	310. 63	93. 89	12.00
13.00	Number of pneumococcal and influenza vaccine injections admini	istered to Program	32	10	13.00
	benefi ci ari es				
14. 00		heir) administration	9, 940	939	14.00
	(line 12 x line 13)				
15. 00				12, 562	15. 00
	of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3,				
16. 00	Total Program cost of pneumococcal and influenza vaccine and i	,		10, 879	16. 00
	administration (sum of cols. 1 and 2, line 14) (transfer this	amount to Wkst. M-3,			
	line 21)				

Health Financial Systems	FRANCI SCAN HEALTH	RENSSELAER	In Lie	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASEI SERVICES RENDERED TO PROGRAM BENEFICIA	ARLES	Provider CCN: 15-1324 Component CCN: 15-3990	From 01/01/2016	
			DUIG I	-

		Component Con. 13-3770	10 12/31/2010	8/8/2017 10: 19	
			RHC I	Cost	
			Par	t B	
			mm/dd/yyyy	Amount	
			1, 00	2, 00	
1. 00	Total interim payments paid to hospital-based RHC/FQHC			17, 471	1. 00
2.00	Interim payments payable on individual bills, either submitte	ed or to be submitted to		0	2. 00
	the contractor for services rendered in the cost reporting pe				
	"NONE" or enter a zero				
3.00	List separately each retroactive lump sum adjustment amount by	based on subsequent			3.00
	revision of the interim rate for the cost reporting period. A				
	payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider				
3.01				0	3. 01
3.02				o	3. 02
3.03				o	3. 03
3.04				l ol	3. 04
3. 05				0	3. 05
	Provider to Program			_	
3.50				0	3. 50
3. 51				0	3. 51
3. 52				l ol	3. 52
3. 53				0	3. 53
3. 54				l ol	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98	18)		ا	3. 99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer			17, 471	4. 00
00	27)	er te mer nerieet iii e, i i i i			00
	TO BE COMPLETED BY CONTRACTOR				
5.00	List separately each tentative settlement payment after desk	review. Also show date of	f		5. 00
	each payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider				
5.01				0	5. 01
5.02				l ol	5. 02
5.03				l ol	5. 03
	Provider to Program		- '		
5.50				0	5. 50
5. 51				o	5. 51
5. 52				l ol	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98	18)		l ol	5. 99
6.00	Determined net settlement amount (balance due) based on the	*			6. 00
6. 01	SETTLEMENT TO PROVIDER			4, 126	6. 01
6. 02	SETTLEMENT TO PROGRAM			0	6. 02
7. 00	Total Medicare program liability (see instructions)			21, 597	7. 00
			Contractor	NPR Date	
			Number	I (Mo/Dav/Yr) ∣	
		0	Number 1.00	(Mo/Day/Yr) 2.00	

Health Financial Systems	FRANCI SCAN HEALTH	RENSSELAER	In Lie	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASE SERVICES RENDERED TO PROGRAM BENEFICE		Provider CCN: 15-1324 Component CCN: 15-8502	Peri od: From 01/01/2016 To 12/31/2016	
-			-	2. 2. 22

		Component CCN: 15-8502	10 12/31/2016	8/8/2017 10: 19	
			RHC I V	Cost	
			Par	t B	
			mm/dd/yyyy	Amount	
			1. 00	2.00	
00	Total interim payments paid to hospital-based RHC/FQHC			67, 216	1.
00	Interim payments payable on individual bills, either submitte the contractor for services rendered in the cost reporting pe			0	2
	"NONE" or enter a zero				
0	List separately each retroactive lump sum adjustment amount be revision of the interim rate for the cost reporting period. A				3
	payment. If none, write "NONE" or enter a zero. (1)				
_	Program to Provider				١.
11				0	3
12				0	3
3				0	3
4				0	3
15	Description to Discourse			0	3
0	Provider to Program			0	3
1				0	3
2					3
3					3
4		->		0	3
9	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98			0	3
0	Total interim payments (sum of lines 1, 2, and 3.99) (transfe	er to Worksheet M-3, line		67, 216	4
	27)				
	TO BE COMPLETED BY CONTRACTOR		<u> </u>		5
0	List separately each tentative settlement payment after desk each payment. If none, write "NONE" or enter a zero. (1)	review. Also show date of	Т		
.1	Program to Provider			0	١,
11				- 1	5
2				0	5
3	Provider to Program			U	١
0	110vider to 110gi am			0	5
1				ا	5
2				0	5
9	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)				5
0	Determined net settlement amount (balance due) based on the cost report. (1)			l "l	6
1	SETTLEMENT TO PROVIDER			57, 855	6
2	SETTLEMENT TO PROGRAM			37, 833	6
12	Total Medicare program liability (see instructions)			125, 071	7
·U	Total medicale program frability (see Instructions)		Contract	NPR Date	-
			Contractor Number	(Mo/Day/Yr)	
				1 (WO/DAV/YE)	
		0	1. 00	2.00	