Health Financial Systems

FRANCISCAN HEALTH MICHIGAN CITY

In Lieu of Form CMS-2552-10

noar en rinanor			111 21 01	
This report is	required by law (42 USC 1395g; 42 CFR 413.20(b)). Fai	lure to report can resul	t in all interim	FORM APPROVED
payments made	since the beginning of the cost reporting period being	g deemed overpayments (42	2 USC 1395g).	OMB NO. 0938-0050
				EXPIRES 05-31-2019
	OSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION	Provider CCN: 15-0015	Peri od:	Worksheet S
AND SETTLEMENT	SUMMARY		From 01/01/2017 To 12/31/2017	Parts I-III Date/Time Prepared:
			10 12/31/2017	5/31/2018 12:44 pm
PART I - COST	REPORT STATUS			
Provi der	 [X]Electronically filed cost report 		Date: 5/31/20	18 Time: 12:44 pm
use only	2. [] Manually submitted cost report			
	3. [0] If this is an amended report enter the number		esubmitted this co	ost report
	4. [F] Medicare Utilization. Enter "F" for full or "	L" for low.		
Contractor	5. [1] Cost Report Status 6. Date Received:		NPR Date:	
use only	 (1) As Submitted 7. Contractor No. (2) Settled without Audit 8. [N] Initial Report f 		Contractor's Vendo	
	(3) Settled with Audit 9. [N] Final Report for	this Provider CCN		les reopened = 0-9.
	(4) Reopened			
	(5) Amended			
PART II - CERT	I FI CATI ON			
MI SREPRESENTAT	ION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN	THIS COST REPORT MAY BE F	PUNISHABLE BY CRIM	IINAL, CIVIL AND
ADMI NI STRATI VE	ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW.	FURTHERMORE, IF SERVICES	S IDENTIFIED IN TH	IIS REPORT WERE
	OCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A	A KICKBACK OR WERE OTHERW	VISE ILLEGAL, CRIN	IINAL, CIVIL AND
ADMI NI STRATI VE	ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.			
CERTI F	FICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR O	F PROVIDER(S)		

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by FRANCISCAN HEALTH MICHIGAN CITY (15-0015) for the cost reporting period beginning 01/01/2017 and ending 12/31/2017 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.

]I have read and agree with the above certification statement. I certify that I intend my electronic Г signature on this certification statement to be the legally binding equivalent of my original signature.

(Si	gned)

Officer or Administrator of Provider(s)

Title

Date

		1					. <u> </u>
			Title	Title XVIII			
	Cost Center Description	Title V	Part A	Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	132, 293	-64, 552	0	0	1.00
2.00	Subprovider - IPF	0	11, 400	0		0	2.00
3.00	Subprovider - IRF	0	15, 929	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7.00
8.00	NURSING FACILITY	0				0	8.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		0		0	10.00
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
12.00	CMHC I	0		0		0	12.00
200.00	Total	0	159, 622	-64, 552	0	0	200.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The 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.

SPLI	Financial Systems AL AND HOSPITAL HEALTH CARE COMPLEX	FRANCISCAN HEA		der CCN: 1		Period: From 01/01, To 12/31,	/2017	<u>of For</u> Workshe Part I Date/Ti	et S-2 me Pre	parec
	1.00	2.00		2.00				5/30/20		
	1.00 Hospital and Hospital Health Care Co	2.00		3.00			4.00			
00	Street: 301 W. HOMER STREET	PO Box:								1.0
00	City: MICHIGAN CITY	State: IN	Zip Coc	le: 46360	Count	ty:				2.0
		Component Name	CCN	CBSA	Provi der			ent Syst		
			Number	Number	Туре	Certified		, 0, or		-
		1.00	2.00	2.00	1.00	F 00	V	XVIII	XIX	-
	Hospital and Hospital-Based Componen	1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
00	Hospi tal	FRANCI SCAN HEALTH	150015	33140	1	07/01/1966	N	Р	0	3.0
00		MI CHI GAN CI TY	100010	00110						0.
00	Subprovider - IPF	FRANCI SCAN HEALTH	15S015	33140	4	01/01/1998	N N	P	0	4.
		MICHIGAN CITY								
00	Subprovider - IRF	FRANCI SCAN HEALTH	15T015	33140	5	01/01/1997	" N	P	0	5.
~~		MICHIGAN CITY								
00	Subprovider - (Other)									6.
)0)0	Swing Beds - SNF Swing Beds - NF									7. 8.
00	Hospi tal -Based SNF									9.
00	Hospi tal -Based NF									10.
00	Hospi tal -Based OLTC									111.
00	Hospi tal -Based HHA				1		1			12.
00	Separately Certified ASC									13.
00	Hospi tal -Based Hospi ce				1					14.
00	Hospital-Based Health Clinic - RHC									15.
00	Hospital-Based Health Clinic - FQHC									16.
00	Hospital-Based (CMHC) I									17.
10	Hospital-Based (CORF) I									17.
00	Renal Dialysis									18.
00	Other						<u> </u>			19.
						From: 1.00		To 2. (-
00	Cost Reporting Period (mm/dd/yyyy)					01/01/2		12/31/		20.
00	Type of Control (see instructions)					1				21.
	Inpatient PPS Information									1
00	Does this facility qualify and is it	currently receiving	payments fo	r disprop	ortionate	Y		N		22.
	share hospital adjustment, in accord									
	for yes or "N" for no. Is this facil			12.106(c)	(2) (Pi ckl	е				
	amendment hospital?) In column 2, en									
01	Did this hospital receive interim un					Y		Y		22.
	period? Enter in column 1, "Y" for y									
	reporting period occurring prior to									
	for no for the portion of the cost r (see instructions)	eporting period occur			ober 1.					
02	is this a newly merged hospital that	requires final uncom	nensated ca	re navmen	nts to be	N		N		22.
02	determined at cost report settlement									22.
	or "N" for no, for the portion of th	. ,			2	-				
	in column 2, "Y" for yes or "N" for					n				
	or after October 1.									
03	Did this hospital receive a geograph							N		22.
	of the OMB standards for delineating									
	in column 1, "Y" for yes or "N" for									
	prior to October 1. Enter in column cost reporting period occurring on o	∠, ĭ ror yes or "N" r after October 1 (c	FOF NO TOP	ione) Dee	.ion of th	e				
	hospital contain at least 100 but no					h				
	42 CFR 412.105)? Enter in column 3,				dance wit					
00	Which method is used to determine Me			5 below?	In column	1	3	N		23.
-	1, enter 1 if date of admission, 2 i						-			.
	method of identifying the days in th	is cost reporting per	iod differe	nt from t	he method					
	used in the prior cost reporting per	<u>iod? In column 2, en</u>	ter "Y" for	yes or "	N" for no					
					Out-of		Medi cai		ther	
					State		HMO day	- I	li cai d	
		paio				Medicaid		C	lays	
				oaid pa ays	id days	eligible unpaid				
		1		00	3.00	4.00	5.00	6	. 00	-
			444	88	3.00	4.00		121		24.
00	If this provider is an LPPS bosnital	enter the	+++	00	30	51	4,	121	00	∠4.
00	If this provider is an IPPS hospital				1					
00	in-state Medicaid paid days in colum	n 1, in-state								
00	in-state Medicaid paid days in colum Medicaid eligible unpaid days in col	n 1, in-state umn 2,								
00	in-state Medicaid paid days in colum Medicaid eligible unpaid days in col out-of-state Medicaid paid days in c	n 1, in-state umn 2, olumn 3,								
00	in-state Medicaid paid days in colum Medicaid eligible unpaid days in col	n 1, in-state umn 2, olumn 3, d days in column								

	F	eriod: rom 01/01/		Part I	et S-2	
		o 12/31/	2017	Date/Ti 5/30/20)18 6:0	
	Medicaid Medicaid State paid days eligible Medicaid Medic		ledi ca M0 da 5. 00	ys Med	ther li cai d lays . 00	-
5. 00	If this provider is an IRF, enter the in-state 1.00 2.00 3.00 Medicaid paid days in column 1, the in-state 12 12 0 Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state 12 12 0 Medicaid eligible unpaid days in column 4, Medicaid 12 12 0	0		95		25. (
		Urban/Rur 1.00		Date of 2.(<u> </u>	
o. 00 7. 00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural. Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable,	-	1			26. 27.
5. 00	enter the effective date of the geographic reclassification in column 2. If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	Degi ppi	0	Fadi	201	35.
		Begi nni 1. 00		Endi 2. (
. 00 . 00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates. If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in the cost period.		0			36. 37.
. 01	is in effect in the cost reporting period. Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)					37.
. 00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.					38.
		Y/N 1.00		Y/ 2. (
9. 00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412. 101(b)(2)(i) or (ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412. 101(b)(2)(i) or (ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N		N		39.
). 00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N		N		40.
			V 1.00	2.00	XI X 3.00	
. 00	Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital payment for disproportionate share in ac	cordance	N	Y	N	45.
. 00	with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exception for extraordinary circumstan pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I	ces	N	N	N	46.
. 00 . 00	Pt. III. Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no Teaching lucopitals		N N	N N	N N	47. 48.
. 00	Teaching Hospitals Is this a hospital involved in training residents in approved GME programs? Enter "Y" - "N" for pa	for yes	N			56.
. 00	or "N" for no. If line 56 is yes, is this the first cost reporting period during which residents in ap GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If is "Y" did residents start training in the first month of this cost reporting period? for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If colu	column 1 Enter "Y"				57.
. 00	"N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. If line 56 is yes, did this facility elect cost reimbursement for physicians' services defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	as	N			58.
. 00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I. NAHE 413.85 Y/N	Workshee Line	#	Pass-Th Qualifi Criterio	cation	59.
						1

IOSPI 1	TAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	TA	Provider C	F	eriod: rom 01/01/2017 o 12/31/2017	Worksheet S-2 Part I Date/Time Pre 5/30/2018 6:0	pared
		Y/N	IME	Direct GME	IME	Direct GME	
1 00	Did your boositel associus FTF state youlan ACA	1.00	2.00	3.00	4.00	5.00	(1)
1. 00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see linstructions)	N			0.00		61. (
. 02							61. (
I. 03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.0
1. 04							61.0
1. 05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61. (
1. 06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.
		Pro	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
			1.00	2.00	3.00	4.00	
	Of the FTEs in line 61.05, specify each new program special ty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. Of the FTEs in line 61.05, specify each expanded program special ty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00		61.
						1.00	1
	ACA Provisions Affecting the Health Resources and Ser						
2. 00 2. 01	your hospital received HRSA PCRE funding (see instruct Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC prog	ctions) a Teachi gram. (s	ng Health Cen see instruction	ter (THC) into			62. 62.
3. 00	<u>Teaching Hospitals that Claim Residents in Nonprovide</u> Has your facility trained residents in nonprovider se "Y" for yes or "N" for no in column 1. If yes, complete	ettings	during this c			N	63.
				Unweighted FTEs Nonprovider Site	FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
	Section 5504 of the ACA Base Year ETE Decidents in No	opprovila	lar Sattings	1.00	2.00	3.00	
4. 00	Section 5504 of the ACA Base Year FTE Residents in No period that begins on or after July 1, 2009 and befor Enter in column 1, if line 63 is yes, or your facilit in the base year period, the number of unweighted nor resident FTEs attributable to rotations occurring in settings. Enter in column 2 the number of unweighted resident FTEs that trained in your hospital. Enter in of (column 1 divided by (column 1 + column 2)). (see	re June ty train a-primar all non d non-pr n column	30, 2010. The residents by care provider timary care 3 the ratio	0.00			64.

	LEX IDENTIFICATION DA	N HEALTH MICHIGAN CIT	CN: 15-0015 Pe	eri od:	Wor	Form CMS- rksheet S-2	2
			Fr Tc	om 01/01/2 12/31/2	017 Dat	rt I te/Time Pre	
	Program Name	Program Code	Unwei ghted	Unwei ghte	ed Rati	<u>30/2018 6:0</u> io (col. 3/	/
			FTEs Nonprovider	FTEs in Hospital		1.3+col. 4))	
	1.00	2.00	Site				4
5.00 Enter in column 1, if line 63	1.00	2.00	3.00	4.00	D. 00	5.00 0.00000	65.0
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)			Unweighted	Unwei ghte	ed Rati	io (col. 1/	
			FTĔs Nonprovider Site	FTEs in Hospital	ı (col	1 + col. 2))	
Section 5504 of the ACA Current	Year FTE Residents i	n Nonprovider Settind	1.00 gsEffective fo	2.00 r cost rep	orting p	<u>3.00</u> Deriods	-
beginning on or after July 1, 20 5.00 Enter in column 1 the number of		rv care resident	0.00		0. 00	0. 000000	66.
FTEs attributable to rotations o Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 +	unweighted non-prima al. Enter in column _column 2)). (see in	ry care resident 3 the ratio of structions)	Unweighted	llousi abt	ad Dati		/
	Program Name	Program Code	Unweighted FTEs	Unweighte FTEs in	ı (col	io (col. 3/ I. 3 + col.	
			Nonprovider Site	Hospi tal		4))	
	1.00	2.00		4.00	D. 00	4)) 5.00 0.000000) 67. (
7.00 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)	1.00	2.00	Si te 3. 00	4.00		5.00	67. (
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)		2.00	Si te 3. 00	4.00	0.00	5.00	67. (
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)	PS		Si te 3.00 0.00	4.00	0.00	5.00	
<pre>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)</pre>	PS ychiatric Facility (the facility have a efore November 15, 20 lumn 2: Did this fac R 412.424 (d)(1)(iii cate which program y	IPF), or does it cont n approved GME teachi 204? Enter "Y" for y 11 ty train residents)(D)? Enter "Y" for y	Si te 3.00 0.00 cain an IPF subp ng program in t yes or "N" for n s in a new teach yes or "N" for n	4.00 4.00 rovi der? he most o. (see i ng o.	D. 00 1. 00 2	5.00	70.0
<pre>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)</pre>	PS ychiatric Facility (the facility have a efore November 15, 2 lumn 2: Did this fac R 412.424 (d)(1)(iii) cate which program y y PPS habilitation Facilit	IPF), or does it cont n approved GME teachi 204? Enter "Y" for y ility train residents)(D)? Enter "Y" for y ear began during this	Site 3.00 0.00 0.00 	4.00 4.00 rovi der? he most o. (see i ng o.	D. 00	5.00 0.000000 2.00 3.00	70. (71. (75. (

Health Financial Systems FRANCISCAN HEALTH				u of Form CMS	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider C		Period: From 01/01/2017	Worksheet S- Part I	2
			To 12/31/2017	Date/Time Pr 5/30/2018 6:	
Long Term Care Hospital PPS				1.00	
80.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes	and "N" for	no.		N	80.00
81.00 Is this a LTCH co-located within another hospital for part or	all of the	cost reporting	g period? Enter	N	81.00
"Y" for yes and "N" for no. TEFRA Providers					_
85.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i)				N	85.00
86.00 Did this facility establish a new Other subprovider (excluded §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.	l unit) under	42 CFR Sectio	on		86.00
87.00 Is this hospital an extended neoplastic disease care hospital	cl assi fi ed	under section		Ν	87.00
1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.			V	VIV	
			1.00	XI X 2.00	-
Title V and XIX Services					
90.00 Does this facility have title V and/or XIX inpatient hospital yes or "N" for no in the applicable column.	servi ces? E	nter "Y" for	N	Y	90.00
91.00 Is this hospital reimbursed for title V and/or XIX through th	ne cost repor	t either in	N	Y	91.00
full or in part? Enter "Y" for yes or "N" for no in the appli					
92.00 Are title XIX NF patients occupying title XVIII SNF beds (dua instructions) Enter "Y" for yes or "N" for no in the applicab		ion)? (see		N	92.00
93.00 Does this facility operate an ICF/IID facility for purposes of		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, a	and "N" for n	o in the	N	N	94.00
applicable column.			IN IN	IN	94.00
95.00 If line 94 is "Y", enter the reduction percentage in the appl			0.00	0.00	95.00
96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes applicable column.	or "N" for n	o in the	N	N	96.00
97.00 If line 96 is "Y", enter the reduction percentage in the appl			0.00	0.00	97.00
98.00 Does title V or XIX follow Medicare (title XVIII) for the int			N	N	98.00
stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" fo column 1 for title V, and in column 2 for title XIX.	J yes of N				
98.01 Does title V or XIX follow Medicare (title XVIII) for the rep			N	N	98. 01
C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for tit title XIX.	te V, and in	column 2 for			
98.02 Does title V or XIX follow Medicare (title XVIII) for the cal			N	N	98. 02
bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or for title V, and in column 2 for title XIX.	"N" for no	in column 1			
98.03 Does title V or XIX follow Medicare (title XVIII) for a criti	cal access h	ospital (CAH)	N	N	98.03
reimbursed 101% of inpatient services cost? Enter "Y" for yes	s or "N" for i	no in column '	1		
for title V, and in column 2 for title XIX. 98.04 Does title V or XIX follow Medicare (title XVIII) for a CAH r	eimbursed 10	1% of	N	N	98.04
outpatient services cost? Enter "Y" for yes or "N" for no in					
in column 2 for title XIX. 98.05 Does title V or XIX follow Medicare (title XVIII) and add bac	k the RCE di	sallowance on	N	N	98.05
Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in co					/0.00
column 2 for title XIX. 98.06 Does title V or XIX follow Medicare (title XVIII) when cost r	aimburgad fa	r Wkat D	N	N	98.06
Pts. I through IV? Enter "Y" for yes or "N" for no in column			IN IN	IN	90.00
column 2 for title XIX.					_
Rural Providers 105.00Does this hospital gualify as a CAH?			N		105.00
106.00 If this facility qualifies as a CAH, has it elected the all-i	nclusive met	hod of paymen ⁻			106.00
for outpatient services? (see instructions) 107.00 If this facility qualifies as a CAH, is it eligible for cost	reimbursemen	t for L&R			107.00
training programs? Enter "Y" for yes or "N" for no in column					107.00
yes, the GME elimination is not made on Wkst. B, Pt. I, col.	25 and the p	rogram is cos	t		
reimbursed. If yes complete Wkst. D-2, Pt. II. 108.00 Is this a rural hospital qualifying for an exception to the C	RNA fee sche	dul e? See 42	N		108.00
CFR Section §412.113(c). Enter "Y" for yes or "N" for no.					_
-	Physi cal 1.00	Occupational 2.00	Speech 3.00	Respi ratory 4.00	_
109.00 If this hospital qualifies as a CAH or a cost provider, are	1.00	2.00	0.00	1.00	109.00
therapy services provided by outside supplier? Enter "Y"					
for yes or "N" for no for each therapy.		I			
				1.00	110
110.00 Did this hospital participate in the Rural Community Hospital Demonstration) for the current cost reporting period? Enter "Y				Ν	110.00
complete Worksheet E, Part A, lines 200 through 218, and Work					
applicable.					

Health Financial Systems FRANCISCAN HEALTH MICHIGAN CIT HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider C	Y CN: 15-0015	l Period: From 01/01, To 12/31,	/2017		et S-2	2
		10 12/31/	2017	5/30/20		
		1.00	1	2.0	0	-
111.00 If this facility qualifies as a CAH, did it participate in the Frontier C Health Integration Project (FCHIP) demonstration for this cost reporting "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, integration prong of the FCHIP demo in which this CAH is participating in Enter all that apply: "A" for Ambulance services; "B" for additional beds for tele-health services.	period? Enter enter the column 2.	N	1	2.0		111. OC
			1.00	2.00	3.00	
Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no i is yes, enter the method used (A, B, or E only) in column 2. If column 2 3 either "93" percent for short term hospital or "98" percent for long te psychiatric, rehabilitation and long term hospitals providers) based on t Pub.15-1, chapter 22, §2208.1.	is "E", enter erm care (incl che definition	in column udes	N		0	115. 00
116.00 Is this facility classified as a referral center? Enter "Y" for yes or "N 117.00 Is this facility legally-required to carry malpractice insurance? Enter " no.		"N" for	Y Y			116. 00 117. 00
118.00 Is the malpractice insurance a claims-made or occurrence policy? Enter 1 claim-made. Enter 2 if the policy is occurrence.	if the policy	/is	2			118.00
jeranni-made. Enter 2 m the porrey is decurrence.	Premi ums	Losse	s	Insura	ance	
	1.00	2.00)	3.0	00	-
118.01 List amounts of malpractice premiums and paid losses:	828, 6	03 37	4, 001		(0 118. 01
		1.00)	2.0	0	-
118. 02 Are malpractice premiums and paid losses reported in a cost center other Administrative and General? If yes, submit supporting schedule listing c and amounts contained therein. 119. 00 DO NOT USE THIS LINE		N				118.02
119.0000 Not use find that [110,000] [120,0	(" for yes or he Outpatient			N		120. 00
121.00Did this facility incur and report costs for high cost implantable device	es charged to	Y				121.00
patients? Enter "Y" for yes or "N" for no. 122.00 Does the cost report contain healthcare related taxes as defined in §1903 Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter the Worksheet A line number where these taxes are included.						122.00
Transplant Center Information 125.00Does this facility operate a transplant center? Enter "Y" for yes and "N"	for no lf	N				125.00
yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, enter the certi in column 1 and termination date, if applicable, in column 2.						126. 00
127.00 If this is a Medicare certified heart transplant center, enter the certif in column 1 and termination date, if applicable, in column 2.	ication date					127.00
128.00 If this is a Medicare certified liver transplant center, enter the certified liver transplant center, enter the certified liver transplant center.	ication date					128.00
129.00 If this is a Medicare certified lung transplant center, enter the certificolumn 1 and termination date, if applicable, in column 2.	cation date i	n				129.00
130.00 If this is a Medicare certified pancreas transplant center, enter the cer date in column 1 and termination date, if applicable, in column 2.	ti ficati on					130. 00
131.00 If this is a Medicare certified intestinal transplant center, enter the c date in column 1 and termination date, if applicable, in column 2.	certification					131.00
132.00 If this is a Medicare certified islet transplant center, enter the certif in column 1 and termination date, if applicable, in column 2.	ication date					132.00
I33.00 If this is a Medicare certified other transplant center, enter the certif in column 1 and termination date, if applicable, in column 2.						133.00
134.00 If this is an organ procurement organization (OPO), enter the OPO number and termination date, if applicable, in column 2.	in column 1					134.00
All Providers 140.00 Are there any related organization or home office costs as defined in CMS chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home are claimed, enter in column 2 the home office chain number. (see instruct	e office costs	у 5		15HC)14	140. 00

IUSFITAL AND HUSFITAL HEALTH CARE COWFLE	EX IDENTIFICATION DATA	A Provi der	CCN: 15-0015	Peri od		Worksheet S-2	-2552-1 2
					1/01/2017 2/31/2017	Part I Date/Time Pre	epared:
1.00		2.00			3.00	5/30/2018 6:0	06 pm
If this facility is part of a cha	in organization, ente		rough 143 the	e name and		of the	
home office and enter the home of							
41.00 Name: FRANCISCAN ALLIANCE 42.00 Street: 1515 DRAGOON TRAIL	Contractor's Na PO Box:	me: WPS	Contra	ctor's Nu	mber: 8001		141.0
43. 00 Ci ty: MI SHAWAKA	State:	IN	Zip Co	de:	4654	16	143.0
			· · ·				
44.00 Are provider based physicial and	sta included in Werka	boot A2				1.00 Y	144. C
44.00 Are provider based physicians' co	Sts Included III works	neet A?				T	144. 0
					1.00	2.00	
45.00 If costs for renal services are c inpatient services only? Enter "Y							145. C
no, does the dialysis facility in							
period? Enter "Y" for yes or "N"	for no in column 2.						
46.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no i				l f	N		146. C
yes, enter the approval date (mm/		Pub. 15-2, chapter	40, 94020)				
47.00Was there a change in the statist	ical basis? Enter "V"	for ves or "N" f	or no			1.00 N	147.0
48.00 Was there a change in the order of						N	147.0
49.00 Was there a change to the simplif		od? Enter "Y" for	yes or "N" f			N	149.0
		Part A	Part B	Т	itle V	Title XIX	-
Does this facility contain a prov	ider that qualifies f	1.00	2.00	cation of	3.00 the Lowe	4.00	
or charges? Enter "Y" for yes or							
55.00Hospi tal		N	N		N	N	155. 0
56.00 Subprovider - IPF 57.00 Subprovider - IRF		N	N		N	N	156.0
57. 00 SUBPROVI DER		N	N		N	N	157. C
59. 00 SNF		Ν	N		Ν	N	159.0
60.00 HOME HEALTH AGENCY		N	N		Ν	N	160. C
61. 00 CMHC 61. 10 CORF			N N		N N	N N	161. C
			N			IN IN	101.1
						1.00	
Multicampus	ampus hasnital that h	as one or more car	muses in dif	forent (P	SAc2	N	165.0
165 MMLs this bosnital nart of a Multic			iipuses in un	Terent of	543:	IN IN	105.0
165.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.	ampus nospitai that n						
	Name	County		Zip Code	CBSA	FTE/Campus	_
Enter "Y" for yes or "N" for no.	· · ·		State 2.00	Zip Code 3.00	CBSA 4.00	5.00	0.166_0
	Name	County				5.00	0 166. C
Enter "Y" for yes or "N" for no. 66.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in	Name	County				5.00	0 166. 0
Enter "Y" for yes or "N" for no. 66.00 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,	Name	County				5.00	 D 166. C
Enter "Y" for yes or "N" for no. 66.00 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	Name	County				5.00	 0 166. C
Enter "Y" for yes or "N" for no. 66.00 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,	Name	County				5.00	0 166. C
Enter "Y" for yes or "N" for no. 66.00 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)	Name 0	County 1.00	2.00	3.00		5.00	 D 166. C
Enter "Y" for yes or "N" for no. 66.00 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) Health Information Technology (HI	Name 0 T) incentive in the A	County 1.00 merican Recovery	2.00	3.00		5.00	_
Enter "Y" for yes or "N" for no. 66.00 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) Health Information Technology (HI 67.00 Is this provider a meaningful use 68.00 If this provider is a CAH (line 10	Name 0 T) incentive in the A r under §1886(n)? En D5 is "Y") and is a m	County 1.00 merican Recovery ter "Y" for yes o eaningful user (li	and Rei nvestm r "N" for no.	3.00	4.00	5.00 0.00 1.00 Y	167. 0
Enter "Y" for yes or "N" for no. 66.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Heal th Information Technology (HI 67.00 Is this provider a meaningful use 68.00 If this provider is a CAH (line 10 reasonable cost incurred for the l	Name 0 T) incentive in the A r under §1886(n)? En D5 is "Y") and is a m HIT assets (see instr	County 1.00 merican Recovery ter "Y" for yes or eaningful user (li uctions)	and Reinvestm "N" for no. ne 167 is "Y	3.00 nent Act "), enter	4.00	5.00 0.00 1.00 Y	- 167. (0168. (
Enter "Y" for yes or "N" for no. 66.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Heal th Information Technology (HI 67.00 Is this provider a meaningful use 68.00 If this provider is a CAH (line 10 reasonable cost incurred for the 68.01 If this provider is a CAH and is not 68.01 If this provider is a CAH and is not column 5 (see instructions)	Name 0 T) incentive in the A r under §1886(n)? En D5 is "Y") and is a m HIT assets (see instr not a meaningful user	County 1.00 merican Recovery ter "Y" for yes or eaningful user (Li uctions) , does this provid	2.00 and Reinvestm "N" for no. ne 167 is "Y der qualify f	3.00 nent Act "), enter	4.00	5.00 0.00 1.00 Y	- 167. C 0168. C
Enter "Y" for yes or "N" for no. 66.00 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) Health Information Technology (HI 67.00 Is this provider a meaningful use 68.00 If this provider is a CAH (line 1) reasonable cost incurred for the l exception under §413.70(a) (6) (ii) 69.00 If this provider is a meaningful	Name O T) incentive in the A r under §1886(n)? En D5 is "Y") and is a m HIT assets (see instr not a meaningful user ? Enter "Y" for yes o user (line 167 is "Y"	County 1.00 merican Recovery ter "Y" for yes or eaningful user (li uctions) , does this provio r "N" for no. (see	2.00 and Reinvestm - "N" for no. ne 167 is "Y der qualify f e instruction	3.00 hent Act "), enter for a harc s)	4.00	5.00 0.00 1.00 Y	167. C 0168. C 168. C
Enter "Y" for yes or "N" for no. 66.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Heal th Information Technology (HI 67.00 Is this provider a meaningful use 68.00 If this provider is a CAH (line 11) reasonable cost incurred for the 11 68.01 If this provider is a CAH and is 12 exception under §413.70(a)(6)(ii)	Name O T) incentive in the A r under §1886(n)? En D5 is "Y") and is a m HIT assets (see instr not a meaningful user ? Enter "Y" for yes o user (line 167 is "Y"	County 1.00 merican Recovery ter "Y" for yes or eaningful user (li uctions) , does this provio r "N" for no. (see	2.00 and Reinvestm - "N" for no. ne 167 is "Y der qualify f e instruction	3.00 <u>aent Act</u> "), enter for a harc s) s "N"), e	4.00 • the Ishi p	5.00 0.00 1.00 Y 0.0	167. C 0168. C 168. C
Enter "Y" for yes or "N" for no. 66.00 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) Health Information Technology (HI 67.00 Is this provider a meaningful use 68.00 If this provider is a CAH (line 1) reasonable cost incurred for the l exception under §413.70(a) (6) (ii) 69.00 If this provider is a meaningful	Name O T) incentive in the A r under §1886(n)? En D5 is "Y") and is a m HIT assets (see instr not a meaningful user ? Enter "Y" for yes o user (line 167 is "Y"	County 1.00 merican Recovery ter "Y" for yes or eaningful user (li uctions) , does this provio r "N" for no. (see	2.00 and Reinvestm - "N" for no. ne 167 is "Y der qualify f e instruction	3.00 nent Act "), enter or a harco s) s "N"), e Be	4.00 the ship nter the ginning	5. 00 0. 00 1. 00 Y 0. 0 Endi ng	167. C 0168. C 168. C
Enter "Y" for yes or "N" for no. 66.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Heal th Information Technology (HI 67.00 Is this provider a meaningful use 68.00 If this provider is a CAH (line 10 reasonable cost incurred for the 1 68.01 If this provider is a CAH and is i exception under §413.70(a)(6)(ii) 69.00 If this provider is a meaningful use transition factor. (see instruction	Name 0 T) incentive in the A r under §1886(n)? En D5 is "Y") and is a m HIT assets (see instr not a meaningful user ? Enter "Y" for yes o user (line 167 is "Y" pns)	County 1.00 merican Recovery ter "Y" for yes of eaningful user (li uctions) , does this provid r "N" for no. (see) and is not a CA	2.00 and Reinvestm "N" for no. ne 167 is "Y der qualify f e instruction t (line 105 i	3.00 nent Act "), enter or a harc s) s "N"), e Be	4.00 • the Ishi p	5.00 0.00 1.00 Y 0.0	167. C 0168. C 168. C 0169. C
Enter "Y" for yes or "N" for no. Enter "Y" for yes or "N" for each Enter "Y" for yes, for each Enter "Y" for y	Name 0 T) incentive in the A r under §1886(n)? En D5 is "Y") and is a m HIT assets (see instr not a meaningful user ? Enter "Y" for yes o user (line 167 is "Y" pns)	County 1.00 merican Recovery ter "Y" for yes of eaningful user (li uctions) , does this provid r "N" for no. (see) and is not a CA	2.00 and Reinvestm "N" for no. ne 167 is "Y der qualify f e instruction t (line 105 i	3.00 nent Act "), enter or a harc s) s "N"), e Be	4.00 • the Iship Inter the ginning 1.00	5. 00 0. 00 1. 00 Y 0. 0 Endi ng 2. 00	167. C 0168. C 168. C 0169. C
Enter "Y" for yes or "N" for no. Enter "Y" for yes or "N" for no. Enter "Y" for yes or "N" for no. Enter the name in column O, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Heal th Information Technology (HI 167.00 Is this provider a meaningful use 168.00 If this provider is a CAH (line 11 reasonable cost incurred for the I exception under §413.70(a) (6) (ii) 169.00 If this provider is a meaningful use transition factor. (see instruction 170.00 Enter in columns 1 and 2 the EHR	Name 0 T) incentive in the A r under §1886(n)? En D5 is "Y") and is a m HIT assets (see instr not a meaningful user ? Enter "Y" for yes o user (line 167 is "Y" pns)	County 1.00 merican Recovery ter "Y" for yes of eaningful user (li uctions) , does this provid r "N" for no. (see) and is not a CA	2.00 and Reinvestm "N" for no. ne 167 is "Y der qualify f e instruction t (line 105 i	3.00 <u>aent Act</u> "), enter for a harc s) s "N"), e <u>Be</u> 08/	4.00 • the Ishi p enter the <u>gi nni ng</u> 1.00 (05/2017	5.00 0.00 1.00 Y 0.0 Endi ng 2.00 11/03/2017	167. C 0168. C 168. C 0169. C
Enter "Y" for yes or "N" for no. Enter "Y" for yes or "N" for each Enter "Y"	Name O T) incentive in the A r under §1886(n)? En D5 is "Y") and is a m HIT assets (see instr not a meaningful user ? Enter "Y" for yes o user (line 167 is "Y" ons) beginning date and en	County 1.00 1.00 merican Recovery ter "Y" for yes or eaningful user (li uctions) ; does this provid r "N" for no. (see) and is not a CAI ding date for the	2.00 and Reinvestm - "N" for no. ne 167 is "Y der qualify f e instruction d (line 105 i reporting	3.00 <u>aent Act</u> "), enter for a harc s) s "N"), e <u>Be</u> 08/	4.00 • the Iship Inter the ginning 1.00	5. 00 0. 00 1. 00 Y 0. 0 Endi ng 2. 00 11/03/2017 2. 00	166. 0 166. 0 167. 0 168. 0 168. 0 169. 0 170. 0 171. 0
Enter "Y" for yes or "N" for no. Enter "Y" for yes or "N" for no. Enter "Y" for yes or "N" for no. Enter the name in column O, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Heal th Information Technology (HI 167.00 Is this provider a meaningful use 168.00 If this provider is a CAH (line 11 reasonable cost incurred for the I exception under §413.70(a) (6) (ii) 169.00 If this provider is a meaningful use transition factor. (see instruction 170.00 Enter in columns 1 and 2 the EHR	Name 0 T) incentive in the A r under \$1886(n)? En 05 is "Y") and is a m HIT assets (see instr not a meaningful user ? Enter "Y" for yes o user (line 167 is "Y" ons) beginning date and en vider have any days fr	County 1.00 merican Recovery ter "Y" for yes or eaningful user (li uctions) , does this provid r "N" for no. (see) and is not a CAI ding date for the for individuals emi , Pt. I, line 2, o	2.00 and Reinvestm - "N" for no. ne 167 is "Y der qualify f e instruction t (line 105 i reporting	3.00 nent Act "), enter or a harc s) s "N"), e Be 08/	4.00 • the Iship enter the <u>ginning</u> 1.00 (05/2017 •	5. 00 0. 00 1. 00 Y 0. 0 Endi ng 2. 00 11/03/2017 2. 00	- 167. C 0168. C 168. C 0169. C - 170. C

Health Financial Syste

FRANCISCAN HEALTH MICHIGAN CITY

Health Fin	ancial Systems FRANCISCAN HEALT	H MICHIGAN CIT	Y	In Lie	eu of Form CMS	-2552-10
	AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		CN: 15-0015	Period: From 01/01/2017 To 12/31/2017	Worksheet S- Part II Date/Time Pr	2 epared:
				Y/N	5/30/2018 6: Date	06 pm
				1.00	2.00	
mm/o COMI	eral Instruction: Enter Y for all YES responses. Enter M dd/yyyy format. PLETED BY ALL HOSPITALS	l for all NO r∈	esponses. Enter	r all dates in t	the	_
1 00 Has	vider Organization and Operation s the provider changed ownership immediately prior to the	boginning of	the east	N		1 1 00
1.00 Has	porting period? If yes, enter the date of the change in a	column 2. (see	instructions)	IN		1.00
· ·			Y/N	Date	V/I	
2.00 Has	s the provider terminated participation in the Medicare F	Decemper 2 lf	1.00 N	2.00	3.00	2.00
yes	s, enter in column 2 the date of termination and in colum untary or "I" for involuntary.		N IN			2.00
con or off of	the provider involved in business transactions, includin tracts, with individuals or entities (e.g., chain home of medical supply companies) that are related to the provid ficers, medical staff, management personnel, or members of directors through ownership, control, or family and othe ationships? (see instructions)	offices, drug der or its of the board	N			3.00
1101			Y/N	Туре	Date	
			1.00	2.00	3.00	
4.00 Col Acc	ancial Data and Reports umn 1: Were the financial statements prepared by a Cert countant? Column 2: If yes, enter "A" for Audited, "C" f "R" for Reviewed. Submit complete copy or enter date ava	For Compiled,	Y	A	04/18/2018	4.00
5.00 Are	umn 3. (see instructions) If no, see instructions. the cost report total expenses and total revenues diffence the filed financial statements? If yes, submit rec		N			5.00
1110			1	Y/N	Legal Oper.	
				1.00	2.00	
6.00 Col	roved Educational Activities umn 1: Are costs claimed for nursing school? Column 2: e legal operator of the program?	lfyes, is th	ne provider is	N		6.00
7.00 Are 8.00 Wer	costs claimed for Allied Health Programs? If "Y" see in e nursing school and/or allied health programs approved treporting period? If yes, see instructions.		d during the	N N		7.00 8.00
9.00 Are pro	e costs claimed for Interns and Residents in an approved ogram in the current cost report? If yes, see instruction	is.		Ν		9.00
cos	an approved Intern and Resident GME program initiated of trapporting period? If yes, see instructions.			N		10.00
	e GME cost directly assigned to cost centers other than I aching Program on Worksheet A? If yes, see instructions.	актпапар	broved	N		11.00
1.22					Y/N	
Ded	Dahta				1.00	_
	Debts the provider seeking reimbursement for bad debts? If yes	s. see instruct	tions.		Y	12.00
13.00 If per	line 12 is yes, did the provider's bad debt collection priod? If yes, submit copy.	oolicy change o	during this cos		N	13.00
Bed	line 12 is yes, were patient deductibles and/or co-payme Complement I total beds available change from the prior cost reporti		*		N N	14.00
13.00 IDIU			rt A		T B	15.00
		Y/N	Date	Y/N	Date	
200		1.00	2.00	3.00	4.00	
16.00 Was	<u>R Data</u> s the cost report prepared using the PS&R Report only? either column 1 or 3 is yes, enter the paid-through se of the PS&R Report used in columns 2 and 4 .(see	N		N		16.00
17.00 Was tot	structions) the cost report prepared using the PS&R Report for als and the provider's records for allocation? If ther column 1 or 3 is yes, enter the paid-through date	Y	04/03/2018	Y	04/03/2018	17.00
18.00 in Rep	columns 2 and 4. (see instructions) line 16 or 17 is yes, were adjustments made to PS&R port data for additional claims that have been billed are not included on the PS&R Report used to file this	Ν		Ν		18.00
19.00 Cos	to the formation of the second	Ν		Ν		19.00

Health Financial Systems

FRANCISCAN HEALTH MICHIGAN CITY

In Lieu of Form CMS-2552-10

<u>Heal th</u>	Financial Systems FRANCISCAN HEALT	<u>'H MICHIGAN CIT</u>	Y	<u> </u>	eu of Form CMS-	<u>2552-10</u>
	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider (F	Period: From 01/01/2017 Fo 12/31/2017	Date/Time Pre	epared:
	· · · · · · · · · · · · · · · · · · ·)/ /N	5/30/2018 6:0	06 pm
			<u>ription</u> 0	Y/N 1.00	Y/N 3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		0	N	N N	20.00
	Report data for other bescribe the other adjustments.	Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's	N		N		21.00
	records? If yes, see instructions.					
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCI	EPT CHILDRENS I	HOSPITALS)			-
22.00	Capital Related Cost	- ! + + !			N	222.00
22.00 23.00	Have assets been relifed for Medicare purposes? If yes, see Have changes occurred in the Medicare depreciation expense			na the cost	N N	22.00
	reporting period? If yes, see instructions.			0	N	
24.00	Were new leases and/or amendments to existing leases enter If yes, see instructions	0		0.1		24.00
25.00	Have there been new capitalized leases entered into during instructions.	the cost repo	rting period? I	f yes, see	N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the instructions.	he cost report	ing period? If	yes, see	N	26.00
27.00	Has the provider's capitalization policy changed during the	e cost reporti	ng period?lfy	yes, submit	N	27.00
	copy. Interest Expense					
28. 00	Were new loans, mortgage agreements or letters of credit en period? If yes, see instructions.	ntered into du	ring the cost r	reporting	N	28.00
29.00	Did the provider have a funded depreciation account and/or treated as a funded depreciation account? If yes, see inst		ebt Service Res	serve Fund)	N	29.00
30.00	Has existing debt been replaced prior to its scheduled mati instructions.		debt? If yes,	see	N	30.00
31. 00	Has debt been recalled before scheduled maturity without is	ssuance of new	debt? If yes,	see	N	31.00
	instructions. Purchased Services					
32.00	Have changes or new agreements occurred in patient care se arrangements with suppliers of services? If yes, see instru		ed through cont	tractual	N	32.00
33. 00	If line 32 is yes, were the requirements of Sec. 2135.2 ap no, see instructions.		ng to competiti	ve bidding? If		33.00
	Provi der-Based Physi ci ans					
34.00	Are services furnished at the provider facility under an a	rrangement wit	h provider-base	ed physicians?	Y	34.00
35.00	If yes, see instructions. If line 34 is yes, were there new agreements or amended ex		nts with the pr	rovi der-based	N	35.00
	physicians during the cost reporting period? If yes, see in	nstructions.		Y/N	Date	
				1.00	2.00	
	Home Office Costs			1.00	2.00	
36.00 37.00	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been p	renared by the	home office?	Y Y		36.00 37.00
	lf yes, see instructions.					
	If line 36 is yes, was the fiscal year end of the home of the provider? If yes, enter in column 2 the fiscal year end	d of the home	offi ce.	N		38.00
39. 00	If line 36 is yes, did the provider render services to othe see instructions.	er chain compo	nents? If yes,	Ν		39.00
40.00	If line 36 is yes, did the provider render services to the instructions.	home office?	lf yes, see	Ν		40.00
		1	. 00	2.	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,	SCOTT		CLAYTON		41.00
42.00	respectively. Enter the employer/company name of the cost report	FRANCI SCAN ALI	LI ANCE			42.00
	preparer.	219 932 2300	X32580	SCOTT CLAYTON@	FRANCI SCANALL	43.00
10.00	report preparer in columns 1 and 2, respectively.			ANCE. ORG		
41. 00 42. 00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. Enter the employer/company name of the cost report preparer. Enter the telephone number and email address of the cost			SCOTT. CLAYTON@	FRANCI SCANALLI	42.

Heal th	Financial Systems FRA	NCISCAN HEALTH	H MICHIGAN CITY		In Lie	u of Form CMS-	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUES	TI ONNAI RE	Provider CCN:		Period: From 01/01/2017	Worksheet S-2 Part II	
							pared: <u>6 pm</u>
					_		
			3.00				
	Cost Report Preparer Contact Information						
41.00	Enter the first name, last name and the title,	/position	FINANCIAL ANALYS	- SENIOR			41.00
	held by the cost report preparer in columns 1,	, 2, and 3,					
	respecti vel y.						
42.00	Enter the employer/company name of the cost re	eport					42.00
	preparer.						
	Enter the telephone number and email address o						43.00
	report preparer in columns 1 and 2, respective	el y.					

^{5/30/2018 6:06} pm

	Financial Systems FR. TAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC.	AL DATA	Provider CC		Peri od:	u of Form CMS-2 Worksheet S-3	
					From 01/01/2017 To 12/31/2017		
						I/P Days / 0/P	
	Component	Worksheet A Line Number	No. of Beds	Bed Days Avai I abl e	CAH Hours	<u>Visits / Trips</u> Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00 2.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds) HMO and other (see instructions)	30. 00	135	49, 27	.00	0	1.00 2.00
3.00 4.00 5.00 6.00	HMO IPF Subprovider HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF					0	3.00 4.00 5.00 6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		135	49, 27	0.00	0	7.00
8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00 20.00 21.00	INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY) NURSERY Total (see instructions) CAH visits SUBPROVIDER - IPF SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE	31.00 32.00 33.00 34.00 43.00 40.00 41.00 44.00 45.00 46.00	14 0 0 149 18 16 0 0 0 0	54, 38 6, 57 5, 84	0 0.00 0 0.00 0 0.00 35 0.00	0 0 0	8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00 20.00 21.00
22.00 23.00 24.00 24.10 25.00 25.10 26.00 26.25 27.00 28.00 29.00 30.00 31.00	HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D.P.) HOSPICE HOSPICE (non-distinct part) CMHC - CMHC CMHC - CORF RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days Ambulance Trips Employee discount days (see instruction) Employee discount days - IRF	101. 00 115. 00 116. 00 99. 00 99. 00 99. 10 88. 00 89. 00	0 183		0	0 0 0 0 0	22. 00 23. 00 24. 00 25. 00 25. 10 26. 00 26. 25 27. 00 28. 00 29. 00 30. 00 31. 00
32. 00 32. 01 33. 00 33. 01	Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions) LTCH non-covered days LTCH site neutral days and discharges		O		0		32. 00 32. 01 33. 00 33. 01

IOSPI ⁻	FAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC		Provider CC		Period: From 01/01/2017 To 12/31/2017	Worksheet S-3 Part I Date/Time Pre 5/30/2018 6:0	parec
		I/P Days	/ O/P Visits	/ Trips	Full Time E	Equi val ents	
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
. 00 2. 00 3. 00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds) HMO and other (see instructions) HMO IPF Subprovider	9, 312 1, 818 41	456 4, 121 0	16, 48	34		1. (2. (3. (
. 00	HMO IRF Subprovider	163	0				4.
. 00	Hospital Adults & Peds. Swing Bed SNF	0	0		0		5.
. 00 . 00	Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions)	9, 312	0 456	16, 48	0 34		6. 7.
. 00	INTENSIVE CARE UNIT	1, 121	85	2, 59	94		8.
00	CORONARY CARE UNIT	0	0		0		9.
). 00	BURN INTENSIVE CARE UNIT	0	0		0		10
. 00	SURGICAL INTENSIVE CARE UNIT	0	0		0		11
2.00	OTHER SPECIAL CARE (SPECIFY)						12
3.00	NURSERY		77	1, 03			13
1.00	Total (see instructions)	10, 433	618	20, 11		710.69	
5.00	CAH visits	0	0		0		15
5.00	SUBPROVIDER - IPF	842	1, 457	3, 17			
. 00	SUBPROVIDER - IRF	1, 718	119	2,60	0.00	19.36	
3.00					0 0 00	0.00	18
9.00).00	SKILLED NURSING FACILITY NURSING FACILITY	0	0		0 0.00 0 0.00		
1.00	OTHER LONG TERM CARE		0		0 0.00		
2.00	HOME HEALTH AGENCY	0	0		0 0.00	0.00	
3.00	AMBULATORY SURGICAL CENTER (D. P.)	0	0		0.00		
1.00	HOSPICE	0	0		0 0.00	0.00	
I. 10	HOSPICE (non-distinct part)	0	0		0 0.00	0.00	24
5.00	CMHC - CMHC	0	0		0 0.00	0.00	
5. 10	CMHC - CORF	0	o		0 0.00		
5.00	RURAL HEALTH CLINIC	0	ō		0 0.00		
6. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0.00		26
7.00	Total (sum of lines 14-26)				0.00	747.61	27
3. 00	Observation Bed Days		1, 146	4, 01	8		28
9. 00	Ambul ance Trips	0					29
0. 00	Employee discount days (see instruction)				0		30
I. 00	Employee discount days - IRF				0		31
2.00	Labor & delivery days (see instructions)	0	60	1, 12	24		32
2. 01	Total ancillary labor & delivery room				0		32
	outpatient days (see instructions)						
3.00	LTCH non-covered days	0					33
3. 01	LTCH site neutral days and discharges	0					33

HOSPIT	FAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CO	CN: 15-0015	Period: From 01/01/2017 To 12/31/2017	Worksheet S-3 Part I Date/Time Pre 5/30/2018 6:0	pared:
		Full Time Equivalents		Di s	scharges		
	Component	Nonpai d Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 15.00 15.00 20.00 21.00 21.00 22.00 23.00 24.00 25.10 25.00 25.10 26.05 27.00 28.00 29.00 30.00 21.00 21.00 21.00 21.00 22.00 23.00 24.00 23.00 24.00 25.00 25.00 26.00 27.00 28.00 20.00 21.00 21.00 21.00 22.00 23.00 24.00 25.00 25.00 26.00 25.00 26.00 27.00 28.00 20.00 21.00 21.00 21.00 22.00 23.00 24.00 25.00 25.00 26.00 26.00 27.00 28.00 20.00 21.00 20.00 21.00 22.00 23.00 24.00 25.00 26.00 25.00 26.00 26.00 27.00 28.00 20.00 20.00 20.00 20.00 20.00 21.00 22.00 23.00 24.00 25.00 25.00 26.00 26.00 26.00 27.00 27.00 28.00 29.00 20.00 21.00 20.00 21.00 20.00 21.00 20.00 21.00 25.00 26.00 27.00 28.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 20.00 29.00 20.00 29.00 20.00 29.00 29.00 20.00 29.00 20.00 29.00 20.00 29.00 20.00 29.00 20.00 20.00 29.00 20.0	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) HMO and other (see instructions) HMO IPF Subprovider HMO IRF Subprovider HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed SNF Total Adults and Peds. (exclude observation beds) (see instructions) INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY) NURSERY Total (see instructions) CAH visits SUBPROVIDER - IPF SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D.P.) HOSPICE HOSPICE (non-distinct part) CMHC - CORF RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days Ambulance Trips Employee discount days (see instruction) Employee discount days - IRF	0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.0	12.00 0 0 0	2, 5	68 1, 398 02 0 0 0	5, 374 5, 374 463	1.00 2.00 3.00 4.00 5.00 7.00 8.00 9.00 11.00 12.00 13.00 14.00 13.00 14.00 15.00 20.00 21.00 23.00 24.00 25.10 25.10 25.10 25.00 25.10 26.00 27.00 28.00 21.
32.00 32.01 33.00	Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions) LTCH non-covered days LTCH site neutral days and discharges				0		32.00 32.01 33.00 33.01

PI T.	AL WAGE INDEX INFORMATION			Provider C	F	eriod: rom 01/01/2017 o 12/31/2017		pared
		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)			Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA SALARIES							
0	Total salaries (see	200. 00	48, 741, 26	6 C	48, 741, 266	1, 555, 025. 14	31.34	1.0
0	instructions) Non-physician anesthetist Part			o c	0	0.00	0.00	2.0
0	A Non-physician anesthetist Part			o c	0	0.00	0.00	3. (
0	B Physician-Part A -			o c	0	0.00	0.00	4. (
1	Administrative Physicians - Part A - Teaching			0 0	0	0.00	0.00	4.0
0	Physician and Non			0 0	-			
0	Physician-Part B Non-physician-Part B for hospital-based RHC and FOHC services			o c	0	0.00	0.00	6.
0	Interns & residents (in an approved program)	21.00		o c	0	0.00	0.00	7. (
1	Contracted interns and residents (in an approved programs)		1	o c	0	0.00	0.00	7.(
0	Home office and/or related organization personnel			o c	0	0.00	0.00	8. (
0 00	SNF Excluded area salaries (see	44.00	3, 988, 92		-	0.00 137,834.85		
00	instructions) OTHER WAGES & RELATED COSTS				0, 700, 720	107,001.00	20.71	10.1
00	Contract Labor: Direct Patient Care		879, 87	4 C	879, 874	16, 920. 00	52.00	11.0
00	Contract labor: Top level management and other management and administrative			o c	0	0.00	0.00	12.
00	services Contract Labor: Physician-Part		495, 51	5 C	495, 515	3, 702. 19	133. 84	13.
00	A - Administrative Home office and/or related orgainzation salaries and wage-related costs			o c	0	0.00	0. 00	14. (
01	Home office salaries		8, 758, 82	з с	8, 758, 823	285, 366. 00	30. 69	14. (
02 00	Related organization salaries Home office: Physician Part A				0	0.00 0.00		
	- Administrative					0.00	0.00	15.0
00	Home office and Contract Physicians Part A - Teaching WAGE-RELATED COSTS			0 0	0	0.00	0.00	16.
00	Wage-related costs (core) (see instructions)		13, 584, 52	1 C	13, 584, 521			17.0
00	Wage-related costs (other) (see instructions)			о с	0			18.
00	Excluded areas		1, 111, 73	9 0	1, 111, 739			19. (
00	Non-physician anesthetist Part A			C	0			20. (
	Non-physician anesthetist Part B			o c	0			21.
	Physician Part A - Administrative		1		_			22. (
01 00	Physician Part A - Teaching Physician Part B							22. (23. (
00	Wage-related costs (RHC/FQHC)			0 0	0			24.0
	Interns & residents (in an approved program)			o c	0			25. (
	Home office wage-related (core)		3, 823, 17	6 C	3, 823, 176			25. !
51	Related organization wage-related (core)		1	0 0	0			25. !
52	Home office: Physician Part A - Administrative - wage-related (core)			o c	0			25. 5
53	Home office & Contract Physicians Part A - Teaching - wage-related (core)			o c	0			25. !
	OVERHEAD COSTS - DIRECT SALARIE				I	I	I	
00	Employee Benefits Department Administrative & General	4.00 5.00	846, 70 4, 809, 77					

Heal th	Financial Systems	FRA	ANCISCAN HEALTH	H MICHIGAN CITY	(In Lie	u of Form CMS-2	2552-10
HOSPI T	AL WAGE INDEX INFORMATION			Provider C		eri od:	Worksheet S-3	
						rom 01/01/2017		
					T	o 12/31/2017	Date/Time Pre 5/30/2018 6:0	pared:
		Wkst. A Line	Amount	Reclassi fi cati	Adj usted	Paid Hours	Average Hourly	
		Number		on of Salaries			Wage (col. 4 ÷	
		Number	Reported	(from Wkst.	$(col.2 \pm col.$	Salaries in	col. 5)	
				A-6)	3)	col. 4	001.0)	
		1.00	2.00	3.00	4,00	5.00	6, 00	
28.00	Administrative & General under		385, 593		385, 593	3, 220. 00	119. 75	28.00
	contract (see inst.)							
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	2, 355, 525	0	2, 355, 525	81, 190. 01	29.01	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeepi ng	9.00	1, 194, 556	0	1, 194, 556	83, 062. 98	14.38	32.00
33.00	Housekeeping under contract		0	0	0	0.00	0.00	33.00
	(see instructions)							
34.00	Dietary	10.00	1, 245, 543	-903, 134	342, 409	19, 465. 00	17.59	34.00
35.00	Dietary under contract (see		0	0	0	0.00	0.00	35.00
	instructions)							
36.00	Cafeteri a	11.00	0	903, 134	903, 134	51, 342. 00		36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	2, 176, 945	0	2, 176, 945	63, 351. 85	34.36	38.00
39.00	Central Services and Supply	14.00	114, 620	0	114, 620	6, 384. 75	17.95	39.00
40.00	Pharmacy	15.00	2, 198, 815	0	2, 198, 815	53, 362. 93	41.20	40.00
41.00	Medical Records & Medical	16.00	9, 807	0	9, 807	416.00	23. 57	41.00
	Records Library							
	Soci al Servi ce	17.00	0	0	0	0.00		42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

^{5/30/2018 6:06} pm

Heal th	Financial Systems	FR/	ANCISCAN HEALTH	H MICHIGAN CITY	/	In Lie	eu of Form CMS-2	2552-10
HOSPI	TAL WAGE INDEX INFORMATION			Provider CO		Period: From 01/01/2017 To 12/31/2017		
		Worksheet A		Recl assi fi cati	, J		Average Hourly	
		Line Number	Reported	on of Salaries			Wage (col. 4 ÷	
				(from	(col.2 ± col.		col. 5)	
				Worksheet A-6)	3)	col. 4		
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		49, 126, 859	0	49, 126, 85	9 1, 558, 245. 14	31.53	1.00
	instructions)							
2.00	Excluded area salaries (see instructions)		3, 988, 920	0	3, 988, 92	0 137, 834. 85	28. 94	2.00
3.00	Subtotal salaries (line 1 minus line 2)		45, 137, 939	0	45, 137, 93	9 1, 420, 410. 29	31. 78	3.00
4.00	Subtotal other wages & related costs (see inst.)		10, 134, 212	0	10, 134, 21	2 305, 988. 19	33. 12	4.00
5.00	Subtotal wage-related costs (see inst.)		17, 407, 697	0	17, 407, 69	7 0.00	38. 57	5.00
6.00	Total (sum of lines 3 thru 5)		72, 679, 848	0	72, 679, 84	8 1, 726, 398. 48	42. 10	6.00
7.00	Total overhead cost (see instructions)		15, 337, 883	0	15, 337, 88	3 514, 171. 59	29. 83	7.00

^{5/30/2018 6:06} pm

	Financial Systems FRANCISCAN HEALTH AL WAGE RELATED COSTS	MICHIGAN CITY Provider CCN: 15-0015	Period:	u of Form CMS-2 Worksheet S-3	
позрт	AL WAGE RELATED COSTS	Provider CCN. 15-0015	From 01/01/2017		
			To 12/31/2017		pared:
				5/30/2018 6:0	6 pm
				Amount	
				Reported	
				1.00	
	PART IV - WAGE RELATED COSTS				
	Part A - Core List				
1 00	RETIREMENT COST			(25 505	1 1 0
1.00	401K Employer Contributions			635, 505	1.0
2.00	Tax Sheltered Annuity (TSA) Employer Contribution			0	2.0
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)			0	3.0
4.00	Qualified Defined Benefit Plan Cost (see instructions)			2, 443, 333	4.0
- 00	PLAN ADMINISTRATIVE COSTS (Paid to External Organization) 401K/TSA Plan Administration fees			0	
5.00				0	5.0
5.00	Legal /Accounting/Management Fees-Pension Plan			0	6.0
7.00	Employee Managed Care Program Administration Fees			0	7.0
3. 00	HEALTH AND INSURANCE COST Health Insurance (Purchased or Self Funded)			5, 045, 874	8. C
	Health Insurance (Self Funded without a Third Party Administ	- matan)		5,045,874	
. 01				0	8.0
8. 02 8. 03	Health Insurance (Self Funded with a Third Party Administrat Health Insurance (Purchased)	.01)		0	8. C
9.03 9.00	Prescription Drug Plan			0	9.0
				-	
0.00	Dental, Hearing and Vision Plan			501, 416	
1.00	Life Insurance (If employee is owner or beneficiary)			26, 800	
2.00	Accident Insurance (If employee is owner or beneficiary)			0 476, 402	
	Disability Insurance (If employee is owner or beneficiary)				
4.00	Long-Term Care Insurance (If employee is owner or beneficiar	·y)		889, 358	
15.00	'Workers' Compensation Insurance Retirement Health Care Cost (Only current year, not the extr		L L FACD 10/	0	15.0
16.00	Non cumulative portion)	aordinary accruai require	ed by FASB 106.	0	16.0
	TAXES				
7.00	FICA-Employers Portion Only			3, 362, 433	17 0
8.00	Medicare Taxes - Employers Portion Only			0, 302, 433	
9.00	Unemployment Insurance			11, 847	
	State or Federal Unemployment Taxes			047	
0.00	OTHER			0	20.0
1 00	Executive Deferred Compensation (Other Than Retirement Cost	Reported on lines 1 throu	igh 4 above (see	0	21.0
00	instructions))		.g 00000. (300	0	20
2.00	Day Care Cost and Allowances			0	22. C
	Tuition Reimbursement			102, 729	
	Total Wage Related cost (Sum of lines 1 -23)			13, 495, 697	
	Part B - Other than Core Related Cost			,,,	0
25 00	OTHER WAGE RELATED COSTS (SPECIFY)			0	25.0

Health Financ	cial Systems	FRANCISCAN HEALTH N	II CHI GAN CI TY	In Lie	u of Form CMS-2	2552-10
HOSPI TAL CON	TRACT LABOR AND BENEFIT COST		Provider CCN: 15-0015	Peri od:	Worksheet S-3	
				From 01/01/2017	Part V	
				To 12/31/2017	Date/Time Pre 5/30/2018 6:0	
	Cost Center Description			Contract Labor		
	best benter bescription			1.00	2.00	
PART V	/ - Contract Labor and Benefit Cost					
Hospi t	tal and Hospital-Based Component Id	enti fi cati on:				
1.00 Total	facility's contract labor and bene	fit cost		0	0	1.00
2.00 Hospi	tal			0	0	2.00
3.00 Subpro	ovider – IPF			0	0	3.00
4.00 Subpro	ovider – IRF			0	0	4.00
5.00 Subpro	ovider – (Other)			0	0	5.00
6.00 Swing	Beds - SNF			0	0	6.00
7.00 Swing	Beds - NF			0	0	7.00
8.00 Hospi	tal-Based SNF			0	0	8.00
9.00 Hospi	tal-Based NF			0	0	9.00
10.00 Hospi	tal-Based OLTC					10.00
11.00 Hospi	tal-Based HHA			0	0	11.00
12.00 Separa	ately Certified ASC			0	0	12.00
13.00 Hospi	tal -Based Hospice			0	0	13.00
14.00 Hospi	tal-Based Health Clinic RHC			0	0	14.00
15.00 Hospi	tal-Based Health Clinic FQHC			0	0	15.00
16.00 Hospi	tal-Based-CMHC			0	0	16.00
16.10 Hospi	tal-Based-CMHC 10			0	0	16. 10
17.00 Renal	Di al ysi s			0	0	17.00
18.00 Other				0	0	18.00

Heal th	Financial Systems FRANCISCAN HEALTH MICHIGAN CITY In Lieu of Form CMS-2552-10								
HOSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CC	CN: 15-0015	Peri od:	Worksheet S-1)			
				From 01/01/2017 To 12/31/2017	Date/Time Pre 5/30/2018 6:0				
					1.00				
	Uncompensated and indigent care cost computation				1.00				
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 div	ided by li	ne 202 column	8)	0. 229721	1.00			
1.00	Medicaid (see instructions for each line)	rucu by rri			0.227721	1.00			
2.00	Net revenue from Medicaid				24, 812, 070	2.00			
3.00	Did you receive DSH or supplemental payments from Medicaid?				N	3.00			
4.00	If line 3 is yes, does line 2 include all DSH and/or supplement			i d?	N	4.00			
5.00	If line 4 is no, then enter DSH and/or supplemental payments from the second se	om Medicai	d		0	5.00			
6.00 7.00	Medicaid charges Medicaid cost (line 1 times line 6)				137, 919, 594 31, 683, 027	6.00 7.00			
7.00 8.00	Difference between net revenue and costs for Medicaid program (line 7 min	us sum of lir	es 2 and 5 [.] if	6, 870, 957	7.00 8.00			
0.00	<pre>< zero then enter zero)</pre>		0,070,737	0.00					
	Children's Health Insurance Program (CHIP) (see instructions for	r each line	e)						
9.00	Net revenue from stand-alone CHIP				0	9.00			
10.00	Stand-al one CHIP charges				0	10.00			
11.00	Stand-alone CHIP cost (line 1 times line 10)			£	0	11.00			
12.00	Difference between net revenue and costs for stand-alone CHIP (enter zero)	line ii mi	nus line 9; i	r < zero then	0	12.00			
	Other state or local government indigent care program (see insti	ructions fo	or each line)						
13.00	Net revenue from state or local indigent care program (Not incl	uded on li	nes 2, 5 or 9)	0	13.00			
14.00	Charges for patients covered under state or local indigent care	program (I	Not included	in lines 6 or	0	14.00			
45 00	10)					45 00			
15.00 16.00	State or local indigent care program cost (line 1 times line 14) Difference between net revenue and costs for state or local ind		program (Lin	o 15 minuo lino	0	15. 00 16. 00			
10.00	13; if < zero then enter zero)	igent care	program (TT		0	10.00			
	Grants, donations and total unreimbursed cost for Medicaid, CHII	and state	e/local indig	ent care program	ns (see				
	instructions for each line)								
	Private grants, donations, or endowment income restricted to fu				0	17.00			
18.00 19.00	Government grants, appropriations or transfers for support of h				0 6, 870, 957	18. 00 19. 00			
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local 8, 12 and 16)	That gent	care programs	(sum of times	0, 870, 957	19.00			
			Uni nsured	Insured	Total (col. 1				
			patients	patients	+ col. 2)				
			1.00	2.00	3.00				
20.00	Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire fac	i l i ty	9, 285, 44	3 2, 085, 175	11, 370, 618	20.00			
20.00	(see instructions)	iiity	7, 203, 44	2,000,170	11, 370, 010	20.00			
21.00	Cost of patients approved for charity care and uninsured discou	nts (see	2, 133, 06	2, 085, 175	4, 218, 236	21.00			
	instructions)								
22.00	Payments received from patients for amounts previously written	off as		0 0	0	22.00			
23.00	charity care Cost of charity care (line 21 minus line 22)		2, 133, 06	2, 085, 175	4, 218, 236	22.00			
23.00			2, 133, 00	2,005,175	4, 210, 230	23.00			
					1.00				
24.00	Does the amount on line 20 column 2, include charges for patien		ond a length	of stay limit	Ν	24.00			
25.00	imposed on patients covered by Medicaid or other indigent care If line 24 is yes, enter the charges for patient days beyond the		care program	's length of	0	25.00			
23.00	stay limit	e murgent		3 rength of	0	23.00			
26.00	Total bad debt expense for the entire hospital complex (see ins				15, 460, 145				
27.00	Medicare reimbursable bad debts for the entire hospital complex				684, 370				
27.01	Medicare allowable bad debts for the entire hospital complex (se	ee instruc	tions)		1, 052, 876 14, 407, 269				
28. 00 29. 00									
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	6136 (366			3, 678, 158 7, 896, 394				
	Total unreimbursed and uncompensated care cost (line 19 plus lin	ne 30)			14, 767, 351				
	· · · · · · · ·								

East 1/201/2018 (a) East 2/2012 (b) East 2		Financial Systems FR SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	ANCI SCAN HEALTH F EXPENSES	MICHIGAN CITY Provider CO	CN: 15-0015 P	eriod:	u of Form CMS-2 Worksheet A	2552-10
Cost Conter Description Sal arise Other Fold Cost Test Besting Test Besting 100 2.00 3.00 4.00 5.00 4.00 5.00 100 0.0000 (AP R1_COST RULE, CATURE FUELD) 1.00 2.00 3.00 4.00 5.00 100 0.0000 (AP R1_COST RULE, FUHT 1.00, 1.000 4.00 5.00 1.00, 0.000 4.00, 1.00 4.00 4.00, 1						rom 01/01/2017 o 12/31/2017	Date/Time Pre	pared:
Image: stand stand Image: stand		Cost Center Description	Salaries	Other	Total (col 1	RecLassi fi cati		6 pm
Index Col Col </td <td></td> <td></td> <td></td> <td>o thoi</td> <td></td> <td></td> <td>Trial Balance</td> <td></td>				o thoi			Trial Balance	
Interval Standie Standie Konge nangelinger in der standie Standie Konge in der standie Konge								
1.00 DOTOD GAP NEL COST S-BLUE & FINI 1.00 DOTOD GAP NEL COST S-BLUE & FUNI 1.00 DOTOD FUNIS & FUNI NEL COST S-BLUE & FUNI N			1.00	2.00	3.00	4.00		
2.00 DOUCOL CAP, REL COS IS-MOBLE EQUIP 0 0 0.12, 22, 230 11, 22, 230 12, 20, 230 14, 25, 262 14, 13, 26, 262 14, 13, 26, 262 14, 13, 26, 262 14, 13, 26, 262 14, 13, 26, 262 14, 13, 26, 262 14, 13, 26, 262 14, 13, 26, 262 14, 13, 26, 262 14, 13, 26, 262 14, 13, 26, 262 14, 13, 26, 262 14, 13, 26, 262 14, 13, 26, 263 16, 14, 14, 26, 263 16, 14, 14, 26, 263 16, 14, 14, 26, 263 16, 14, 14, 26, 263 16, 14, 14, 26, 263 16, 14, 14, 26, 263 16, 14, 14, 26, 263 16, 14, 14, 26, 263 16, 14, 14, 14, 14, 14, 14, 14, 14, 14, 14	1 00		[[10 012 150	10 012 150	0 612 597	0.200 572	1 1 00
3.00 DOUDD (INTEL CP BLE) Set (INTEL CP BLE)<		00200 CAP REL COSTS-BLDG & FIXT		18, 913, 159 0				
5.00 DOBOOD (ARM IN STRATUPL & ELEMENL 4, BOP, 776 S2, 0.62, 014 B4, B52, 485 -7, 60 GAP, 600 B4, B52, 485 -7, 60 GAP, 600 B4, B52, 685 -7, 60 GAP, 600 B4, B52, 685 -7, 600 GAP, 600 B4, B52, 685 -7, 600 GAP, 600 B4, B52, 685 -7, 600 B4, B52, 783 B43, B43, B43, B43, B43, B43, B43, B43,		00300 OTHER CAP REL COSTS		0	-	0	0	
6.00 DORDOL MAIN NITHANCE & REPAIRS 0								
8.00 DOBUD LAUMENY & LITIME STRVICE 0 409, 942 409, 942 409, 942 370 409, 972 8.00 0.00 DOBUD EXERPTING 1, 124, 556 372, 208 1, 566, 824 -15, 569, 373 15, 43, 371 13, 371, 371, 131 13, 371, 371, 131 13, 371, 371, 131 13, 371, 371, 131, 371, 131 13, 371, 371, 131, 371, 131 13, 371, 371, 131, 371, 131 13, 371, 371, 131, 371, 131 13, 371, 371, 131, 371, 131 13, 371, 371, 131, 371, 131 13, 371, 371, 131, 371, 131, 371, 131, 371, 37				32, 042, 919	30, 852, 895	-20, 003		
9.00 00000 HUSENEEPINE METAWY 1.124,558 372,288 1,566,864 1,555,427 1,550,797 1,507 1,557,437 10,00 1,520,737 1,557,437 10,00 1,520,737 1,557,437 1,557,437 10,00 1,520,737 1,557,437 1,557,557 1,557,557 1,557,557 1,557,577 1,55			2, 355, 525					
10.00 DICADO JULETARY 1.245,543 865,227 2,103,770 -1.529,433 15,49,497 10,00 13.00 DICADO JULESTARY 2,176,445 934,407 3,111,442 -228 3,111,241 13,00 13.00 DICADO JULESTARY 2,176,445 934,407 3,111,442 -344,445 -1,442,492 -344,445			0					
13.00 01300 NURSING ADMINISTRATION 2,176,945 934,407 3,111,242 -2-228 3,111,241 13.00 15.00 17.00 15.00 15.00 17.00 15.00 17.00 15.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 11.00 10.00 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>								
14.00 CNTRML SERVICES & SUPPY 114,620 1,707,662 1,622,482 -314,647 1,507,63 15,603,603 16,00 10,003,003 16,00 10,003,003 16,00 0 <td< td=""><td></td><td></td><td>Ŭ</td><td>0</td><td></td><td></td><td></td><td></td></td<>			Ŭ	0				
10. 100 0 101000 PRAMMACY 2, 198, 815 13, 206, 926 15, 705, 801 -74, 996 15, 630, 803 15, 600 10. 00 101000 (SECI AL, SEGURGE & LIBRARY 9, 807 1, 700, 346 1, 710, 153 16, 00 10. 00 101000 (SECI AL, SERVICE, SULATION 0<								
17.00 00 07.00 SCLAL SERVICE 0 0 17.00 18.00 10700 NORMENKS CLAL MARSTHETISTS 0 0 0 0 0 19.00 19.00 10700 NORMENKS CSCHOLATION 0								
18. 00 OTOBE INSERVICE ENDIFIEST 0 </td <td></td> <td></td> <td>9, 807</td> <td>1, 700, 346</td> <td></td> <td>0</td> <td></td> <td></td>			9, 807	1, 700, 346		0		
10. 00 01*000 NOMEN'S ICALAN AMESTHETISTS 0			0	0	0	0		
21 00 20100 LAR SERVICES-SALARY & FRINCES APPRVD 0 0 0 0 22.00 20200 222001 02200 02200 0 0 0 0 0 0 0 0 0 0 0 22.00 22.00 0 </td <td></td> <td></td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td>-</td> <td></td>			0	0	0	0	-	
22.00 D2200 LAR SERVICES-OTHER PROM COSTS APPROV 0 0 0 0 0 23.00 100000 MULTS & PEDNALGS ED FORMACS - </td <td></td> <td></td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td>-</td> <td></td>			0	0	0	0	-	
23.00 D2300 PARAMED EDP PROL-(SPECIFY) O O D 23.0 O O O D PARAMED OS PARAMED OS PARAMED OS PARAMED OS O <td></td> <td></td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td>-</td> <td></td>			0	0	0	0	-	
30. 00 02000 ADULTS & PEDLATIN CS 10.142,998 11,526,274 11,669,172 -1,842,925 9,826,247 30. 00 31. 00 02100 (DITENSIV CARE UNIT 0			0	0	0	0		
31.00 03100 INTENSIVE CARE UNIT 2,063,791 206,458 2,270,249 -188,246 2,082,003 31.00 33.00 03200 03200 0200 OSANAFY CARE UNIT 0 0 0 33.00 33.00 03200 SUBRICAL INTENSIVE CARE UNIT 0 0 0 0 33.00 40.00 04000 SUBRAVID ER - IPF 1,027,742 2267,223 1,249,4965 -5.856 1,289,109 40.00 41.00 04100 SUBRAVID ER - IFF 1,031,352 13.6156 -33.211 1.416,477,333 43.00 44.00 04400 SUBRAVID ER CARE 0 0 0 0 46.00 45.00 04500 NURSING FACILITY 0<				4 50/ 07/		1 0 40 005	0.00/.017	
32:00 0200C COROMARY CARE UNIT 0 <td< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></td<>								
34.00 03400 SURGICAL INTENSIVE CARE LINIT 0 <td></td> <td></td> <td>0</td> <td>200, 400</td> <td>2, 270, 247</td> <td>0</td> <td>0</td> <td></td>			0	200, 400	2, 270, 247	0	0	
40:00 04000 SUBPROV DER - I PF 1,027,742 267,223 1,294,965 -5,856 1,289,109 40.00 41:00 04100 SUBPROV DER - I PF 1,313,525 136,158 1,449,683 -33,211 1,416,472 41.00 41:00 04400 SKILLED NURSI NG FACILITY 0 0 0 0 0 0 44.00 40:00 04500 NURSI NG FACILITY 0 0 0 0 0 45.00 0:00 05000 OFHER LICR NG CARE 0 0 0 0 45.00 0:00 051000 OFHER LICR NG NOM 4,732,832 11,228,279 15,961,111 -8,182,362 7,778,749 50.00 0:00 05100 OFHER LICR NG NOM 4,732,832 11,228,279 15,961,111 -8,182,362 7,778,749 50.00 51.00 50.00 53.00 51.00 6300 ANESTICS ICARE CARE CARE 7,718,749 10.99,946 -1.52.08 1,93.193 50.00 55.00 55.00 55.00 55.00 55.00 55.00 55.00 55.00 55.00 55.00 55.00 55.00 55.00 55.00 55.00 55.00			0	0	0	0	-	
11.00 004100 SUBPROVIDER - I RF 1, 313, 525 13.6, 158 -33, 211 1, 416, 472 41.00 43.00 04300 NURSENK FACILITY 0 0 0 46.00 044.00 04400 NURSINK FACILITY 0 0 0 0 0 46.00 04500 OFFARITNE ROM 0 <				0	0 1 204 065	-5 856	-	
44. 00 00 0 0 0 0 0 44. 00 65. 00 04600 OTHER LONG TERM CARE 0<								
45. 00 04500 NURSING FACILITY 0 0 0 0 45. 00 ANCILLARY SERVICE COST CENTERS			0	0	0	467, 333		
46. 00 04600 01 0 0 0 0 0 0 ANCLLARY SERV CE COST CENTES 50.00 05100 0FECOVERY ROOM 0			0	0	0	0		
50. 00 05000 (DFEATING ROM 4, 732, 832 11, 228, 279 15, 961, 111 -8, 182, 362 7, 778, 749 50. 00 51. 00 05000 RECOVERY ROM 0 0 0 0 837, 989 837, 989 53. 00 53. 00 05300 ANESTHESI OLOGY 37, 838 55, 275 93, 113 0 93, 113 53. 00 54. 01 05400 RADI OLOGY - DI AGNOSTI C 2, 671, 492 1, 022, 524 3, 694, 016 -289, 824 3, 404, 192 54. 01 55. 01 05500 RADI OLOGY - DI AGNOSTI C 711, 066 26, 17, 40 972, 806 -42, 458 930, 348 54. 01 55. 01 05500 RADI OLOGY - DI AGNOSTI C 711, 066 26, 17, 40 972, 806 -42, 458 930, 348 54. 01 55. 01 05500 RADI OLOGY - DI AGNOSTI C 711, 066 26, 17, 740 972, 806 -42, 458 930, 348 55. 00 55. 01 05500 RADI OLOGY - DI AGNOSTI C 711, 710 652, 03 1, 162, 359 -46, 918 1, 115, 441 55. 01 65. 00 0 GO 0			0	0	0	0		
51.00 DS100 RECOVERY ROOM 0	F0 00		4 700 000	11 220 270	15 0/1 111	0 100 0/0	7 770 740	50.00
52. 00 OS200 DEL VERY ROOM & LABOR ROOM 0 0 837,989 837,989 52.00 53. 00 05300 ANESTHESI OLOGY 37,838 55,275 9,3113 0 93,113 53.00 54. 01 05401 RADI OLOGY - DI AGNOSTI C 2,671,492 1,022,527 3,694,016 -289,824 3,404,192 54.00 55. 01 05500 RADI OLOGY - DI AGNOSTI C 711,066 26,1740 972,806 -42,458 930,348 54.01 55. 01 0500 LAND CANCER CARE CTR 709,721 452,638 1,162,359 -46,918 1,115,441 55.01 56. 00 0500 CARDI ACCATHETERI ZATION 871,180 0 0 0 0 58.00 59. 00 S6800 MAGNETI C RESONANCE I MAGING (MRI) 0 1,305,849 -1,931,711 1,542,138 59.00 60. 01 FS6D LAB 0 1,305,849 -2,69 1,305,580 60.01 61. 00 0 0 0 0 0 0 62.00				11, 228, 279	15, 961, 111	-8, 182, 362		
54.00 05400 RADIO LOGY-DIAGNOSTI C 2.671,492 1.022,524 3.694,016 -289,824 3.404,192 54.00 55.00 05500 RADIO LOGY - THERAPEUTI C 711,066 261,740 972,806 -42,458 930,348 54.01 55.00 05501 RADIO LOGY - THERAPEUTI C 618,008 1,372,937 1,990,945 -15,208 1,775,737 55.00 56.00 05500 RADIO TOPE 0 0 0 0 57.00 57.00 05700 CT SCAN 0 0 0 0 58.00 59.00 OSPO0 CARDI AC CATHETERI ZATI ON 871,180 2,602,669 3,473,849 -1,931,711 1,542,138 59.00 60.01 06001 FS ED LAB 0 1,305,849 -2.29 1,305,840 -2.69 1,305,840 -2.69 1,305,840 -0.0 6.00	52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0			52.00
54.01 05401 FSED RADIOLOGY - DIAGNOSTIC 711,066 261,740 972,806 -42,458 930,348 54.01 55.00 05501 WODLAND CANCER CARE CTR 709,721 452,638 1,162,359 -46,918 1,115,41 55.00 56.00 05600 RADIOLOGY-THERAPPEUTIC 0 0 0 0 0 56.00 50.00 05501 WODLAND CANCER CARE CTR 709,721 452,638 1,162,359 -46,918 1,115,41 55.00 57.00 05700 CT SCAN 0 0 0 0 57.00 57.00 59.00 05900 CARDIA C CATHETERIZATION 871,180 2,602,669 3,473,849 -1,931,711 1,542,138 59.00 60.03 60.01 61.00 61.00 60.01 61.00 60.01 61.00 61.00 60.01 61.00 61.00 62.00 62.00 63.00 63.00 63.00 63.00 63.00 63.00 63.00 63.00 63.00 63.00 63.00 63.00 65.00 65.00 65.00 65.00 65.00 65.00 65.00								
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56.00 0500 RADI 0I SOTOPE 0 0 0 0 0 0 0 0 57.00 0<		05500 RADI OLOGY-THERAPEUTI C	618, 008	1, 372, 937	1, 990, 945	-15, 208	1, 975, 737	55.00
57.00 05700 CT SCAN 0			709, 721	452, 638	1, 162, 359	-46, 918		
58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0 0 0 0 0 0 58. 00 59. 00 05900 CARDI AC CATHETERI ZATI ON 871, 180 2, 602, 669 3, 473, 849 -1, 931, 711 1, 542, 138 59. 00 60. 00 06000 LABORATORY 0 6, 037, 612 6, 037, 612 -8, 787 6, 028, 60. 01 61. 00 06100 PBP CLI NI CAL LAB SERVI CES-PRGM ONLY 0 0 0 0 61. 00 62.00 06200 WHOLE BLOOD & PACKED RED BLODD CELLS 0 0 0 0 64. 00 63.00 06400 INTRAVENUS THERAPY 0 0 0 0 64. 00 64.00 06400 INTRAVENUS THERAPY 703, 846 2, 551, 897 3, 255, 743 -37, 959 3, 217, 784 66. 00 67.00 06000 PHYSI CAL THERAPY 703, 846 2, 551, 897 3, 255, 743 -37, 959 3, 217, 784 66. 00 67.00 06000 ELECTROCARDI LOAGY 890, 371 215, 448 1, 105, 819 -25, 152 1, 080, 667 9. 00 <t< td=""><td></td><td></td><td>0</td><td>0</td><td>0</td><td>0</td><td></td><td></td></t<>			0	0	0	0		
60.00 06000 LABORATORY 0 6, 037, 612 6, 037, 612 -8, 787 6, 028, 825 60.00 60.01 06001 FS ED LAB 0 1, 305, 849 1, 305, 849 -269 1, 305, 580 60.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 0 0 0 0 62.00 63.00 D6300 BLOOD STORING, PROCESSING & TRANS. 0 0 0 0 0 64.00 0 0 0 0 0 0 0 0 0 0 0 64.00 0 0 0 0 0 0 0 0 0 0 0 0 0 65.00 66.00 66.00 0600 9PHYSI CAL THERAPY 703, 846 2, 551, 897 3, 255, 743 -37, 959 3, 217, 784 66.00 69.00 06800 SPECH PATHOLOGY 0 0 0 0 0 0 0 0 0 <td></td> <td>05800 MAGNETIC RESONANCE IMAGING (MRI)</td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td></td>		05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	
60.01 06001 FS ED LAB 0 1, 305, 849 -269 1, 305, 580 60.01 61.00 06100 PBP CLINICAL LAB SERVICES-PRGMONLY 0 0 0 0 61.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 0 0 63.00 63.00 06400 JINRAVENOUS THERAPY 0 0 0 0 63.00 65.00 06500 RESPIRATORY THERAPY 888,114 192,876 1,080,990 -63,710 1,017,280 65.00 66.00 06600 PHYSI CAL THERAPY 703,846 2,551,897 3,255,743 -37,959 3,217,784 66.00 67.00 06700 0 0 0 0 67.00 67.00 68.00 06800 PEECTROCARDIOLOGY 890,371 215,448 1,105,819 -25,152 1,080,667 69.00 71.00 07000 ELECTROEARDEPHALOGRAPHY 0 0 0 0 0 70.00 71,046,079 1,046,079 <td></td> <td></td> <td>871, 180</td> <td></td> <td></td> <td></td> <td></td> <td></td>			871, 180					
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 0 0 0 61.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 0 62.00 63.00 06400 INTRAVENOUS THERAPY 0 0 0 64.00 64.00 06400 INTRAVENOUS THERAPY 0 0 0 64.00 65.00 06500 RESPI RATORY THERAPY 888,114 192,876 1,080,990 -63,710 1,017,280 65.00 66.00 06700 0CCUPATI ONAL THERAPY 703,846 2,551,897 3,255,743 -37,959 3,217,784 66.00 67.00 06700 0CUPATI ONAL THERAPY 0 0 0 0 67.00 06500 RESPI RATORY THERAPY 0 0 0 0 0 0 67.00 06700 0CCUPATI ONAL THERAPY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0<			0					
63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 0 0 0 63.00 64.00 06400 INTRAVENOUS THERAPY 0 0 0 0 64.00 65.00 06500 RESPI RATORY THERAPY 888,114 192,876 1,080,990 -63,710 1,017,280 65.00 66.00 06000 PHYSI CAL THERAPY 703,846 2,551,897 3,255,743 -37,959 3,217,784 66.00 67.00 06700 0CCUPATI ONAL THERAPY 0 0 0 0 67.00 68.00 06600 SPEECH PATHOLOGY 0 0 0 0 68.00 69.00 06600 ELECTROCARDI OLOGY 890,371 215,448 1,105,819 -25,152 1,080,667 69.00 71.00 07000 ELECTROCARDI OLOGY 890,371 215,448 1,046,079 1,046,079 71.00 72.00 7300 07300 RUGS CHARGED TO PATI ENTS 0 0 0 73.00 73.00 73.00 74.00 74.00 74.00 73.00 75.00 75.00	61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0	0	0	0	61.00
64.00 06400 INTRAVENOUS THERAPY 0 0 0 0 64.00 65.00 06500 RESPI RATORY THERAPY 888, 114 192, 876 1, 080, 990 -63, 710 1, 017, 280 65.00 66.00 06700 0CCUPATI ONAL THERAPY 703, 846 2, 551, 897 3, 255, 743 -37, 959 3, 217, 784 66.00 67.00 06700 0CCUPATI ONAL THERAPY 0 0 0 0 67.00 68.00 06800 SPEECH PATHOLOGY 0 0 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY 890, 371 215, 448 1, 105, 819 -25, 152 1, 080, 667 69.00 70.00 07000 ELECTROCARDI OLOGY 890, 371 215, 448 1, 105, 819 -25, 152 1, 080, 667 69.00 0			0	0	0	0	-	
65.00 06500 RESPI RATORY THERAPY 888, 114 192, 876 1, 080, 990 -63, 710 1, 017, 280 65.00 66.00 06600 PHYSI CAL THERAPY 703, 846 2, 551, 897 3, 255, 743 -37, 959 3, 217, 784 66.00 67.00 0CCUPATI ONAL THERAPY 0 0 0 0 67.00 68.00 06800 SPEECH PATHOLOGY 0 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY 890, 371 215, 448 1, 105, 819 -25, 152 1, 080, 667 69.00 70.00 07000 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 70.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 71.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 73.00 74.00 07400 REAL DI ALYSI S 0 0 0 0 74.00 75.00 07500 ASC (NON-DI STI NCT PART) 0 0 0 0 75.00 76.00			0	0		0		
67.00 06700 0CCUPATIONAL THERAPY 0 0 0 0 0 67.00 68.00 06800 SPEECH PATHOLOGY 0 0 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY 890, 371 215, 448 1, 105, 819 -25, 152 1, 080, 667 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 0 70.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 0 1, 046, 079 1, 046, 079 71.00 72.00 72.00 07200 I MPL. DEV. CHARGED TO PATIENTS 0 0 0 0 73.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 73.00 74.00 07400 RENAL DI ALYSI S 0 0 0 0 74.00 75.00 07500 ASC (NON-DI STINCT PART) 0 0 0 0 0 76.00 76.00 03202 CV RESOURCE CTR 0 0 0 0 0 0	65.00	06500 RESPI RATORY THERAPY						65.00
68.00 06800 SPEECH PATHOLOGY 0 0 0 0 68.00 69.00 06900 ELECTROCARDIOLOGY 890, 371 215, 448 1, 105, 819 -25, 152 1, 080, 667 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 0 70.00 71.00 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 0 1, 046, 079 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 10, 571, 866 72.00 73.00 07400 RENAL DI ALYSI S 0 0 0 0 73.00 74.00 07500 ASC (NON-DI STINCT PART) 0 0 0 0 74.00 75.00 07500 ASC (NON-DI STINCT PART) 0 0 0 0 75.00 76.00 03020 CV RESOURCE CTR 0 0 0 0 0 76.00 77.00 07700 ALLOGENEI C STEM CELL ACQUI SITION 0 0 0 0 0 76.00 77.00 08800 RURAL HEALT				2, 551, 897	3, 255, 743	-37, 959		
69.00 06900 ELECTROCARDIOLOGY 890, 371 215, 448 1, 105, 819 -25, 152 1, 080, 667 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 0 0 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 1, 046, 079 1, 046, 079 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 10, 571, 866 10, 571, 866 10, 571, 866 73.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 73.00 74.00 07400 RENAL DIALYSIS 0 0 0 0 74.00 75.00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0 76.00 70.00 0700 ALLOGENEI C STEM CELL ACQUISITION 0 0 0 0 0 76.00 70.00 08800 RURAL HEALTH CLINIC 0 0 0 <td< td=""><td></td><td></td><td>0</td><td>0</td><td></td><td>0</td><td></td><td></td></td<>			0	0		0		
71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 1,046,079 1,046,079 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 10,571,866 10,571,866 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 73.00 74.00 07400 RENAL DI ALYSI S 0 0 0 0 74.00 75.00 07500 ASC (NON-DI STINCT PART) 0 0 0 0 75.00 70.00 07400 RENAL DI ALYSI S 0 0 0 0 74.00 75.00 07500 ASC (NON-DI STINCT PART) 0 0 0 0 75.00 70.00 07700 ALLOGENEI C STEM CELL ACOUI SI TI ON 0 0 0 0 77.00 00TPATI ENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0 0 0 88.00 89.00 08900 FEDER	69.00	06900 ELECTROCARDI OLOGY	890, 371	215, 448	1, 105, 819	-25, 152	1, 080, 667	69.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 10, 571, 866 10, 571, 866 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 73.00 74.00 07400 RENAL DI ALYSI S 0 0 0 0 0 74.00 75.00 07500 ASC (NON-DI STINCT PART) 0 0 0 0 75.00 76.00 03020 CV RESOURCE CTR 0 0 0 0 75.00 77.00 07700 ALLOGENEIC STEM CELL ACQUISITION 0 0 0 0 77.00 07700 ALRAL HEALTH CLINIC 0 0 0 0 0 0 77.00 00179ATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0 0 88.00 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 89.00 90.00 09000 CLINI			0	0	0	1 0/6 070	-	
73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 73.00 74.00 07400 RENAL DI ALYSI S 0 0 0 0 0 74.00 75.00 07500 ASC (NON-DI STINCT PART) 0 0 0 0 0 75.00 76.00 03020 CV RESOURCE CTR 0 0 0 0 76.00 76.00 76.00 76.00 77.00 77.00 0 0 0 0 0 76.00 77.00 77.00 77.00 0 0 0 0 76.00 88.00 89.00 89.00 89.00 89.00 89.00 89.00 89.00 89.00 89.00			0	0	0			
75.00 07500 ASC (NON-DI STINCT PART) 0 0 0 0 75.00 76.00 70.00 70.00 70.00 70.00 70.00 70.00 88.00 88.00 89.00 89.00 89.00 89.00 89.00 89.00 89.00 90.00 90.00 90.00 90.00 90.00 90.00	73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00 03020 CV RESOURCE CTR 0 0 0 0 76.00 76.00 76.00 76.00 76.00 76.00 76.00 76.00 76.00 76.00 76.00 76.00 76.00 76.00 76.00 76.00 77.00 00 0 0 0 0 0 0 0 76.00 77.00 00 0 0 0 0 0 0 0 0 0 0 0 0 76.00 77.00 00 0 0 0 0 0 0 0 0 0 0 77.00 0			0	0	0	0		
77.00 07700 ALLOGENEI C STEM CELL ACQUI SI TI ON 0 0 0 0 77.00 OUTPATI ENT SERVI CE COST CENTERS 0 0 0 0 0 0 0 88.00 88.00 88.00 88.00 0 0 0 0 88.00 89.00 90.00 FEDERALLY QUALI FIED HEALTH CENTER 0 0 0 0 89.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.03 1NFUSION OP SERVICES 274, 140 301, 153 575, 293 -16, 548 558, 745 90.03			0	0	0	0		
88. 00 08800 RURAL HEALTH CLINIC 0 0 0 0 88. 00 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 89. 00 90. 00 09000 CLINIC 0 0 0 0 90. 00 90. 03 09003 INFUSION OP SERVICES 274, 140 301, 153 575, 293 -16, 548 558, 745 90. 03		07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	
89.00 08900 FEDERALLY_QUALIFIED_HEALTH_CENTER 0 0 0 0 89.00 90.00 90.00 CLI NI C 0 0 0 0 0 90.00 90.00 90.00 0 0 0 0 90.00 <	22 00			0		0	0	88 00
90. 00 09000 CLI NI C 0 0 0 0 90. 00 90. 03 09003 I NFUSI ON OP SERVICES 274, 140 301, 153 575, 293 -16, 548 558, 745 90. 03			0	0	0	0		
		09000 CLI NI C	0	0	0	0		
			274,140	301, 153	J 575, 293	- 16, 548	558, 745	90.03

Health Financial Systems FR	ANCISCAN HEALTH	MICHIGAN CITY	,	In Lie	u of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O		Provider CO		Peri od:	Worksheet A	
				From 01/01/2017		
				To 12/31/2017	Date/Time Pre 5/30/2018 6:0	
Cost Center Description	Sal ari es	Other	Total (col.	1 Reclassi ficati	Recl assi fi ed	
			+ col. 2)	ons (See A-6)	Trial Balance	
					(col. 3 +-	
					col. 4)	
	1.00	2.00	3.00	4.00	5.00	
91.00 09100 EMERGENCY	3, 273, 404	2, 599, 013	5, 872, 41		5, 579, 084	91.00
91.01 09101 FREE STANDING EMERGENCY DEPT	1, 211, 355	559, 054	1, 770, 40	9 -54, 704	1, 715, 705	91.01
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS						
94. 00 09400 HOME PROGRAM DI ALYSI S	0	0		0 0	0	94.00
95. 00 09500 AMBULANCE SERVICES	0	0		0 0	0	95.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0		0 0	0	96.00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0		0 0	0	97.00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	0		0 0	0	98.00
99. 00 09900 CMHC	0	0		0 0	0	99.00
99. 10 09910 CORF	0	0		0 0	0	99.10
100.00 10000 I &R SERVICES-NOT APPRVD PRGM	0	0		0 0	0	100. 00
101.00 10100 HOME HEALTH AGENCY	0	0		0 0	0	101.00
SPECIAL PURPOSE COST CENTERS						
105.00 10500 KIDNEY ACQUISITION	0	0		0 0	0	105.00
106. 00 10600 HEART ACQUI SI TI ON	0	0		0 0	0	106.00
107.00 10700 LIVER ACQUISITION	0	0		0 0	0	107.00
108.00 10800 LUNG ACQUISITION	0	0		0 0	0	108.00
109.00 10900 PANCREAS ACQUISITION	0	0		0 0	0	109.00
110.00 11000 INTESTINAL ACQUISITION	0	0		0 0	0	110.00
111.00 11100 I SLET ACQUI SI TI ON	0	0		0 0	0	111.00
113.00 11300 INTEREST EXPENSE		0		0 0	0	113.00
114.00 11400 UTI LI ZATI ON REVIEW-SNF	0	0		0 0	0	114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0		0 0	0	115.00
116. 00 11600 HOSPI CE	0	0		0 0	0	116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	47, 093, 613	121, 387, 467	168, 481, 08	0 34, 052	168, 515, 132	118.00
NONREI MBURSABLE COST CENTERS						1
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0	0	190.00
191. 00 19100 RESEARCH	0	0		0 0	0	191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0 0	0	192.00
193. 00 19300 NONPALD WORKERS	0	0		0 0	0	193.00
193. 01 19301 NONPALD WORKERS	0	0		0 0	0	193.01
194.0007950 OTHER NONREIMBURSABLE COST CENTERS	0	0		0 0	0	194.00
194.0107951 WORKING WELL	1, 607, 923	711, 060	2, 318, 98	3 -34, 013	2, 284, 970	194.01
194.03 07953 OTHER NONREIMBURSABLE COST CENTERS	0	72	7	2 0		194.03
194. 10 07960 DUNELAND FI TNESS CTR	0	0		0 0	0	194.10
194.11 07961 OMNI HEALTH & FITNESS CHESTERTOWN	0	-629	-62	9 -39		194. 11
194. 16 07966 PHYSICIAN PRACTICE MD WISW	4,056	-207, 946			-203, 890	1
194. 19 07969 HEALTH PARTNERS	0	-1, 536	-1, 53			194.19
194. 20 07970 CENTER OF HOPE	35,674	900	36, 57			194.20
200.00 TOTAL (SUM OF LINES 118 through 199)	48, 741, 266	121, 889, 388			170, 630, 654	
				1 -		

Heal th Financial	Systems	FRANCISCAN HEALTH MI	CHIGAN CITY
RECLASSI FI CATI O	N AND ADJUSTMENTS OF T	RIAL BALANCE OF EXPENSES	Provider CCN: 15-0015

In Lieu of Form CMS-2552-10 Period: Worksheet A From 01/01/2017

				e Preparec 8 6:06 pm
	Cost Center Description	Adjustments	Net Expenses For Allocation	
		(See A-8) 6.00	7.00	
	GENERAL SERVICE COST CENTERS	050 740	0.044.054	
1.00 2.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP	-352, 718		1.
3.00	00300 OTHER CAP REL COSTS	0	0, 252, 850	3.
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	1, 569, 000	16, 295, 684	4.
5.00	00500 ADMINISTRATIVE & GENERAL	-6, 657, 800	30, 168, 292	5.
5.00	00600 MAI NTENANCE & REPAI RS	0	0	6.
7.00	00700 OPERATION OF PLANT	-23, 814		7.
3.00	00800 LAUNDRY & LINEN SERVICE	0	409, 572	8.
0.00	00900 HOUSEKEEPI NG	-1, 341	1, 550, 456	9.
0.00		-76, 365		10.
1.00 3.00	01100 CAFETERIA 01300 NURSING ADMINISTRATION	-660, 263 -28, 702	865, 165 3, 082, 512	11.
4.00	01400 CENTRAL SERVICES & SUPPLY	-92,087	1, 415, 848	13.
5.00	01500 PHARMACY	14, 613		15.
6.00	01600 MEDI CAL RECORDS & LI BRARY	-649, 426	1, 060, 727	16.
7.00	01700 SOCIAL SERVICE	0	0	17.
8.00	01080 I NSERVI CE EDUCATI ON	0	0	18.
	01900 NONPHYSICIAN ANESTHETISTS	0	0	19.
	02000 NURSI NG SCHOOL	0	0	20.
1.00	02100 I & R SERVI CES-SALARY & FRI NGES APPRVD	0	0	21.
22.00	02200 I & R SERVICES-OTHER PRGM COSTS APPRVD	0	0	22.
23.00	02300 PARAMED ED PRGM-(SPECIFY) I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0	0	23.
30.00	03000 ADULTS & PEDIATRICS	-57, 181	9, 769, 066	30.
31.00	03100 I NTENSI VE CARE UNI T	5,000		31.
32.00	03200 CORONARY CARE UNI T	0	0	32.
33.00	03300 BURN INTENSIVE CARE UNIT	0	0	33.
4.00	03400 SURGI CAL I NTENSI VE CARE UNI T	0	0	34.
0.00	04000 SUBPROVIDER - IPF	-239, 460	1, 049, 649	40.
1.00	04100 SUBPROVIDER - IRF	0	1, 416, 472	41.
3.00	04300 NURSERY	0	467, 333	43.
4.00	04400 SKILLED NURSING FACILITY 04500 NURSING FACILITY	0	0	44. 45.
46.00	04600 OTHER LONG TERM CARE	0	0	45.
	ANCI LLARY SERVICE COST CENTERS			101
50.00	05000 OPERATI NG ROOM	-1, 088, 920	6, 689, 829	50.
51.00	05100 RECOVERY ROOM	0	0	51.
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	837, 989	52.
53.00	05300 ANESTHESI OLOGY	-2, 288		53.
64.00	05400 RADI OLOGY-DI AGNOSTI C	-29, 120	3, 375, 072	54.
4.01 5.00	05401 FSED RADI OLOGY - DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	0	930, 348 1, 971, 077	54. 55.
5.00	05501 WOODLAND CANCER CARE CTR	-4, 660 -30, 382	1, 085, 059	55.
6.00	05600 RADI OI SOTOPE	0	0	56.
57.00	05700 CT SCAN	0	0	57.
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.
		-6, 826	1, 535, 312	59.
0.00		-26, 685		60.
60. 01	06001 FS ED LAB	0	1, 305, 580	60.
	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	61.
2.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	62.
	04200 DLOOD STODLING DDOGESSLING & TDANS			
		0	0	
64.00	06400 I NTRAVENOUS THERAPY	0 0 -5 245	0 0 0	64.
4.00 5.00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	0 0 -5, 245 -38, 640		64. 65.
94.00 95.00 96.00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	0 0 -5, 245 -38, 640 0		64. 65. 66.
4.00 5.00 6.00 7.00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY		3, 179, 144	64. 65. 66. 67.
4.00 5.00 6.00 7.00 8.00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY		3, 179, 144	64. 65. 66. 67. 68.
4.00 5.00 6.00 7.00 8.00 9.00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY		3, 179, 144 0 0	64. 65. 66. 67. 68. 69.
4.00 5.00 6.00 7.00 8.00 9.00 0.00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY		3, 179, 144 0 0 1, 080, 667 0	64. 65. 66. 67. 68. 69. 70. 71.
4.00 5.00 6.00 7.00 8.00 9.00 0.00 1.00 2.00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY 07000 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 07200 IMPL. DEV. CHARGED TO PATI ENTS	-38, 640 0 0 0 0 -155, 094 0	3, 179, 144 0 1, 080, 667 890, 985 10, 571, 866	64. 65. 66. 67. 68. 69. 70. 71. 72.
4.00 5.00 6.00 7.00 8.00 9.00 0.00 1.00 2.00 3.00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06600 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 07200 IMPL. DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS	-38,640 0 0 0 0 0	3, 179, 144 0 1, 080, 667 890, 985 10, 571, 866	64. 65. 66. 67. 68. 69. 70. 71. 72. 73.
4.00 5.00 6.00 7.00 8.00 9.00 0.00 1.00 2.00 3.00 4.00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY 06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY 07000 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 07200 IMPL. DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS 07400 RENAL DI ALYSI S	-38, 640 0 0 0 0 -155, 094 0	3, 179, 144 0 1, 080, 667 890, 985 10, 571, 866	64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74.
94.00 95.00 96.00 97.00 98.00 99.00 90.00 10.00 11.00 12.00 13.00 14.00 15.00	06400 INTRAVENOUS THERAPY 06500 RESPIRATORY THERAPY 06600 PHYSICAL THERAPY 06700 OCCUPATIONAL THERAPY 06700 OCCUPATIONAL THERAPY 06800 SPEECH PATHOLOGY 06900 ELECTROCARDIOLOGY 07000 ELECTROCARDIOLOGY 07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS 07200 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS 07500 ASC (NON-DISTINCT PART)	-38, 640 0 0 0 0 -155, 094 0	3, 179, 144 0 1, 080, 667 890, 985 10, 571, 866 -218, 914 0 0	64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75.
4.00 5.00 6.00 7.00 8.00 9.00 0.00 1.00 2.00 3.00 4.00 5.00 6.00	06400 INTRAVENOUS THERAPY 06500 RESPIRATORY THERAPY 06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 07200 IMPL. DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS 07400 RENAL DI ALYSI S 07500 ASC (NON-DI STINCT PART) 03020 CV RESOURCE CTR	-38, 640 0 0 0 0 -155, 094 0	3, 179, 144 0 1, 080, 667 890, 985 10, 571, 866 -218, 914 0 0	64. 65. 66. 67. 68. 70. 71. 72. 73. 74. 75. 76.
4.00 5.00 6.00 7.00 8.00 9.00 0.00 1.00 2.00 3.00 4.00 5.00 6.00	06400 INTRAVENOUS THERAPY 06500 RESPIRATORY THERAPY 06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 07200 I MPL. DEV. CHARGED TO PATI ENTS 07200 I MPL. DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS 07400 RENAL DI ALYSI S 07500 ASC (NON-DI STI NCT PART) 03020 CV RESOURCE CTR 07700 ALLOGENEI C STEM CELL ACQUI SI TI ON	-38, 640 0 0 0 0 -155, 094 0	3, 179, 144 0 1, 080, 667 890, 985 10, 571, 866 -218, 914 0 0	64. 65. 66. 67. 68. 70. 71. 72. 73. 74. 75. 76.
4.00 5.00 6.00 7.00 8.00 9.00 0.00 1.00 2.00 3.00 4.00 5.00 6.00 7.00	06400 INTRAVENOUS THERAPY 06500 RESPIRATORY THERAPY 06600 PHYSI CAL THERAPY 06600 OCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 07200 IMPL. DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS 07400 RENAL DI ALYSI S 07500 ASC (NON-DI STINCT PART) 03020 CV RESOURCE CTR 07700 ALLOGENEI C STEM CELL ACQUI SI TI ON 0UTPATI ENT SERVI CE COST CENTERS	-38, 640 0 0 0 0 -155, 094 0	3, 179, 144 0 1, 080, 667 890, 985 10, 571, 866 -218, 914 0 0 0	64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77.
44.00 55.00 66.00 77.00 88.00 99.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00	06400 INTRAVENOUS THERAPY 06500 RESPIRATORY THERAPY 06600 PHYSI CAL THERAPY 06600 OCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY 07000 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 07200 IMPL. DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS 07400 RENAL DI ALYSI S 07500 ASC (NON-DI STI NCT PART) 03020 CV RESOURCE CTR 07700 ALLOGENEI C STEM CELL ACQUI SI TI ON 0UTPATI ENT SERVI CE COST CENTERS 08800 RURAL HEALTH CLI NI C	-38, 640 0 0 -155, 094 0 -218, 914 0 0 0 0 0	3, 179, 144 0 1, 080, 667 890, 985 10, 571, 866 -218, 914 0 0 0 0 0	64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 76. 88.
94.00 95.00 95.00 96.00 97.00 98.00 99.00 90.00 90.00 91.00 92.00 93.00 94.00 95.00 97.00 97.00 97.00 97.00 97.00 98.00 99.00 99.00	06400 INTRAVENOUS THERAPY 06500 RESPIRATORY THERAPY 06600 PHYSICAL THERAPY 06600 OCCUPATIONAL THERAPY 06800 SPEECH PATHOLOGY 06900 ELECTROCARDIOLOGY 07000 ELECTROCARDIOLOGY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS 07400 RENAL DIALYSIS 07500 ASC (NON-DISTINCT PART) 03020 CV RESOURCE CTR 07700 ALLOGENEIC STEM CELL ACQUISITION 0UTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER	-38, 640 0 0 -155, 094 0 -218, 914 0 0 0 0 0	3, 179, 144 0 1, 080, 667 890, 985 10, 571, 866 -218, 914 0 0 0	64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 88. 89.
94.00 95.00 95.00 96.00 97.00 98.00 99.00 90.00 91.00 92.00 93.00 94.00 95.00 97.00 98.00 97.00 98.00 99.00 90.00 90.00 90.00 90.00	06400 INTRAVENOUS THERAPY 06500 RESPIRATORY THERAPY 06600 PHYSICAL THERAPY 06700 OCCUPATIONAL THERAPY 06800 SPEECH PATHOLOGY 06900 ELECTROCARDIOLOGY 07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS 07500 ASC (NON-DISTINCT PART) 03020 CV RESOURCE CTR 07700 ALLOGENEIC STEM CELL ACQUISITION 0UTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC	-38, 640 0 0 0 -155, 094 0 -218, 914 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	3, 179, 144 0 1, 080, 667 890, 985 10, 571, 866 -218, 914 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	64. 65. 66. 67. 68. 70. 71. 72. 73. 74. 75. 76. 77. 88. 88. 89. 90.
54.00 55.00 56.00 57.00 59.00 70.00 71.00 72.00 73.00 74.00 75.00 75.00 76.00 77.00 88.00 39.00 90.00 90.00	06400 INTRAVENOUS THERAPY 06500 RESPIRATORY THERAPY 06600 PHYSICAL THERAPY 06600 OCCUPATIONAL THERAPY 06800 SPEECH PATHOLOGY 06900 ELECTROCARDIOLOGY 07000 ELECTROCARDIOLOGY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS 07400 RENAL DIALYSIS 07500 ASC (NON-DISTINCT PART) 03020 CV RESOURCE CTR 07700 ALLOGENEIC STEM CELL ACQUISITION 0UTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER	-38, 640 0 0 -155, 094 0 -218, 914 0 0 0 0 0	3, 179, 144 0 1, 080, 667 0 890, 985 10, 571, 866 -218, 914 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 88. 89. 90. 90. 91.

Heal th	Financial Systems FR	ANCISCAN HEALTH	MICHIGAN CITY	In Lieu of Form CM	S-2552-10
	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O		Provider CCN: 15-0015	Period: Worksheet A	
				From 01/01/2017	
				To 12/31/2017 Date/Time P 5/30/2018 6	
	Cost Center Description	Adjustments	Net Expenses	575072010 0	
			For Allocation		
		6.00	7.00		
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)				92.00
	OTHER REIMBURSABLE COST CENTERS		·		
94.00	09400 HOME PROGRAM DI ALYSI S	0	0		94.00
95.00	09500 AMBULANCE SERVICES	0	0		95.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0		96.00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0	0		97.00
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0	0		98.00
	09900 CMHC	0	0		99.00
	09910 CORF	0	0		99.10
100.00	10000 I&R SERVICES-NOT APPRVD PRGM	0	0		100.00
101.00	10100 HOME HEALTH AGENCY	0	0		101.00
	SPECIAL PURPOSE COST CENTERS				
105.00	10500 KIDNEY ACQUISITION	0	0		105.00
106.00	10600 HEART ACQUI SI TI ON	0	0		106.00
107.00	10700 LIVER ACQUISITION	0	0		107.00
	10800 LUNG ACQUISITION	0	0		108.00
109.00	10900 PANCREAS ACQUISITION	0	0		109.00
110.00	11000 INTESTINAL ACQUISITION	0	0		110.00
111.00	11100 I SLET ACQUI SI TI ON	0	0		111.00
113.00	11300 INTEREST EXPENSE	0	0		113.00
114.00	11400 UTI LI ZATI ON REVI EW-SNF	0	0		114.00
115.00	11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0		115.00
116.00	11600 HOSPI CE	0	0		116.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	-8, 877, 444	159, 637, 688		118.00
	NONREI MBURSABLE COST CENTERS				
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190. 00
	19100 RESEARCH	0	0		191.00
	19200 PHYSICIANS' PRIVATE OFFICES	0	0		192.00
193.00	19300 NONPAI D WORKERS	0	0		193.00
	19301 NONPAID WORKERS	0	0		193. 01
	07950 OTHER NONREI MBURSABLE COST CENTERS	0	0		194.00
	07951 WORKING WELL	0	2, 284, 970		194.01
	07953 OTHER NONREI MBURSABLE COST CENTERS	0	72		194. 03
	07960 DUNELAND FITNESS CTR	0	0		194. 10
	07961 OMNI HEALTH & FITNESS CHESTERTOWN	0	-668		194. 11
	07966 PHYSICIAN PRACTICE MD WISW	0	-203, 890		194. 16
	07969 HEALTH PARTNERS	0	-1, 536		194. 19
	07970 CENTER OF HOPE	0	36, 574		194. 20
200.00	TOTAL (SUM OF LINES 118 through 199)	-8, 877, 444	161, 753, 210		200.00

Ith Financial Systems CLASSIFICATIONS		ANCISCAN HEALTH	Provi der CCN:	15-0015	Peri od:	u of Form CM Worksheet A	
					From 01/01/2017 To 12/31/2017	Date/Time P	
					10 12/31/2017	5/30/2018 6	
Cost Center	Increases	Colora	Other				
2.00	Li ne # 3.00	Salary 4.00	0ther 5.00				
A - CAPITAL							
DO <u>CAP REL</u> C <u>OST</u> S_MVBL <u>E_EQUIP</u> _		0	<u>10, 252, 8</u> 30				1.0
TOTALS			10, 252, 830				_
B - CAFETERIA DO CAFETERIA	11.00	903, 134	622, 294				1.0
TOTALS		903, 134	622, 294				1.0
C - IMPLANTABLE DEVICES	1 1						
00 IMPL. DEV. CHARGED TO	72.00	0	10, 024, 084				1.0
PATI ENTS	++		10,024,084				
D - MEDICAL SUPPLIES		U	10, 024, 064				_
MEDICAL SUPPLIES CHARGED TO	71.00	0	11, 070, 163				1.0
PATI ENTS							
00	0.00	0	0				2.0
00	0.00	0	0				3.0
	0.00 0.00	0	0				4.0 5.0
	0.00	0	0				6.0
00	0.00	0	0				7.0
00	0.00	0	0				8.0
00	0.00	0	0				9.0
00	0.00	0	0				10.0
00 00 00 00 00 00 00 00 00 00 00 00 00	0.00 0.00	0	0				11.0
00	0.00	0	0				13.0
00	0.00	0	0				15.0
00	0.00	0	0				16.0
00	0.00	0	0				17.0
00 00 00 00 00 00 00 00 00 00 00 00 00	0.00 0.00	0	0				18. 0 19. 0
00	0.00	0	0				20.0
00	0.00	0	0				21.0
00	0.00	0	0				22.0
00	0.00	0	0				23.0
00 00 00 00 00 00 00 00 00 00 00 00 00	0.00 0.00	0	0				24.0 25.0
00	0.00	0	0				25.0
00	0.00	0	0				27.0
00	0.00	0	0				28.0
00	0.00	0	0				29.0
		0	0				30.0
TOTALS E – MEDI CAL SUPPLI ES PACEMAK	/FDS	0	11, 070, 163				_
00 IMPL. DEV. CHARGED TO	72.00	0	547, 782				1.0
PATIENTS	12100						
TOTALS		0	547, 782				
F - NURSERY AND L&D	40.00	207 050	00,000				
00 NURSERY 00 <u>DELI VERY ROOM & LABOR</u> ROOM _	43.00	387, 253 694, 395	80, 080				1.0
DO <u>DELIVERY</u> <u>ROOM & LABOR</u> <u>ROOM</u> TOTALS	52.00	<u>694, 395</u> 1, 081, 648	<u>143, 594</u> 223, 674				2.0
G - DEPRECIATION	<u> </u>	1, 001, 010	223, 07 1				
00 CAP_REL_COSTS_BLDG_&_FLXT	1.00	0	<u>629, 2</u> 56				1.0
TOTALS		0	629, 256				
H - INTEREST	4.00		0.007				
00 CAP_REL_COSTS_BLDG_&_FLXT TOTALS	1.00		<u> </u>				1.0
	i	U	7,707				1

LASSI F	FICATIONS			Provider (CCN: 15-0015	Peri od:	Worksheet A-6
						From 01/01/2017 To 12/31/2017	Date/Time Prepare
		Decreases				<u> </u>	5/30/2018 6:06 pr
	Cost Center	Li ne #	Salary	Other	Wkst. A-7 Ref	₽.	
	6.00	7.00	8.00	9.00	10.00		
A	- CAPITAL					-	
	AP REL COSTS-BLDG & FIXT		0	<u>10, 252, 8</u> 30		2	1
	OTALS		0	10, 252, 830			
	- CAFETERIA						
	I ETARY	<u>10.00</u>	90 <u>3, 1</u> 34	<u>622, 2</u> 94		Q	1
	DTALS		903, 134	622, 294			
	- IMPLANTABLE DEVICES	74.00		10.001.001			
	EDI CAL SUPPLI ES CHARGED TO	71.00	0	10, 024, 084		0	1
	ATI ENTS	+		10,024,084		-	
	- MEDI CAL SUPPLI ES		0	10, 024, 064	<u> </u>		
	MPLOYEE BENEFITS DEPARTMENT	4.00	0	4, 138		0	1
	DMI NI STRATI VE & GENERAL	5.00	0	26, 603		0	2
	PERATION OF PLANT	7.00	0	9, 381		0	3
	DUSEKEEPING	9.00	0	15, 067		0	4
	I ETARY	10.00	0	3, 945		0	5
	JRSING ADMINI STRATION	13.00	o	228		0	6
	ENTRAL SERVICES & SUPPLY	14.00	o	314, 547		0	7
	HARMACY	15.00	Ö	74, 998		0	8
	DULTS & PEDIATRICS	30.00	0	537, 603		0	9
	NTENSIVE CARE UNIT	31.00	o	188, 246		0	10
00 SL	JBPROVIDER - IPF	40.00	o	5, 856		0	11
00 SL	JBPROVIDER - IRF	41.00	o	33, 211		0	12
00 OF	PERATING ROOM	50.00	0	7, 543, 119		0	13
	ADI OLOGY-DI AGNOSTI C	54.00	0	289, 824		0	15
	SED RADIOLOGY - DIAGNOSTIC	54.01	0	42, 458		0	16
	ADI OLOGY-THERAPEUTI C	55.00	0	15, 208		0	17
	DODLAND CANCER CARE CTR	55.01	0	46, 918		0	18
	ARDI AC CATHETERI ZATI ON	59.00	0	1, 383, 929		0	19
	ABORATORY	60.00	0	8, 787		0	20
	S ED LAB	60.01	0	269		0	21
		65.00	0	63, 710		0	22
	HYSI CAL THERAPY	66.00	0	37, 959		0	23
		69.00	-	25, 152			
	NFUSION OP SERVICES MERGENCY	90. 03 91. 00	0	16, 548 293, 333		0	25
	REE STANDING EMERGENCY DEPT	91.00	0	293, 333 54, 704			20
	ORKING WELL	194.01	0	34, 013		0	28
	MNI HEALTH & FITNESS	194.01	0	34, 013		õ	20
	HESTERTOWN	177.11	J.	57		~	27
	AUNDRY & LINEN SERVICE	8.00	0	370		0	30
	DTALS	+		11,070,163		1	
E	- MEDICAL SUPPLIES PACEMAKER	RS					
D CA	ARDI AC_CATHETERI ZATI ON	59.00	0	<u>547, 7</u> 82		0	1
	DTALS		0	547, 782			
	- NURSERY AND L&D						
	DULTS & PEDIATRICS	30.00	387, 253	80, 080		0	1
	DULTS & PEDIATRICS		694, 395	143, 594		Q	2
	OTALS		1, 081, 648	223, 674			
	- DEPRECIATION				L		
	PERATING ROOM	<u>50.00</u>	•	62 <u>9, 2</u> 56		9	1
	DTALS		0	629, 256			
	- INTEREST		. 1				
	PERATING_ROOM	50.00	0_	<u> </u>		11	1
110	OTALS		0	9, 987			

Heal th	Financial Systems FR	ANCISCAN HEALTH	H MICHIGAN CITY	(In Lie	u of Form CMS-2	2552-10
RECONC	ILIATION OF CAPITAL COSTS CENTERS		Provider CO	CN: 15-0015		iod: m 01/01/2017 12/31/2017		pared:
				Acqui si ti or	IS			
		Begi nni ng	Purchases	Donati on		Total	Disposals and	
		Bal ances					Retirements	
		1.00	2.00	3.00		4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	BALANCES						
1.00	Land	7, 180, 112	0		0	0	0	1.00
2.00	Land Improvements	4, 044, 462	14, 812		0	14, 812	0	2.00
3.00	Buildings and Fixtures	92, 808, 827	0		0	0	-2, 180	3.00
4.00	Building Improvements	0	0		0	0	0	4.00
5.00	Fixed Equipment	4, 316, 923	0		0	0	0	5.00
6.00	Movable Equipment	112, 118, 284	1, 332, 089		0	1, 332, 089	-44, 284	6.00
7.00	HIT designated Assets	0	0		0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	220, 468, 608	1, 346, 901		0	1, 346, 901	-46, 464	8.00
9.00	Reconciling Items	0	0		0	0	-4,359	9.00
10.00	Total (line 8 minus line 9)	220, 468, 608	1, 346, 901		0	1, 346, 901	-42, 105	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	7, 180, 112						1.00
2.00	Land Improvements	4, 059, 274						2.00
3.00	Buildings and Fixtures	92, 811, 007	15, 631, 762					3.00
4.00	Building Improvements	0	0					4.00
5.00	Fixed Equipment	4, 316, 923	0					5.00
6.00	Movable Equipment	113, 494, 657	29, 415, 920					6.00
7.00	HIT designated Assets	0	0					7.00
8.00	Subtotal (sum of lines 1-7)	221, 861, 973	46, 792, 195					8.00
9.00	Reconciling Items	4, 359	0					9.00
10.00	Total (line 8 minus line 9)	221, 857, 614	46, 792, 195					10.00

Heal th	Financial Systems FR	ANCISCAN HEALTH	I MICHIGAN CITY	(In Lie	u of Form CMS-2	2552-10
RECONC	CILIATION OF CAPITAL COSTS CENTERS		Provider C	CN: 15-0015	Peri od:	Worksheet A-7	
					From 01/01/2017 To 12/31/2017		narod
					10 12/31/2017	5/30/2018 6:0	
			SL	JMMARY OF CAP	I TAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see		
					instructions)		
	1	9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WOR		N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	18, 913, 159	0		0 0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		0 0	0	2.00
3.00	Total (sum of lines 1-2)	18, 913, 159	0		0 0	0	3.00
		SUMMARY O	F CAPITAL				
	Cost Center Description	Other	Total (1) (sum				
		Capi tal -Rel ate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	18, 913, 159				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	18, 913, 159				3.00

CONCILIATION OF CAPITAL COSTS CENTERS		Provider C		Period: From 01/01/2017	Worksheet A-7 Part III	
				To 12/31/2017	Date/Time Prep 5/30/2018 6:06	
	COM	PUTATION OF RAT	TI OS	ALLOCATION OF		5 pm
Cost Center Description	Gross Assets	Capitalized	Gross Assets	Ratio (see	Insurance	
		Leases	for Ratio	instructions)		
			(col. 1 - col.			
	1.00	2.00	2)	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL CO		2.00	3.00	4.00	5.00	
00 CAP REL COSTS-BLDG & FIXT	104, 048, 214	0	104, 048, 214	0. 449433	0	1.
00 CAP REL COSTS-MVBLE EQUIP	127, 461, 754		127, 461, 754		0	2.
00 Total (sum of lines 1-2)	231, 509, 968	0	231, 509, 968	1. 000000	0	3.
	ALLOCA	TION OF OTHER (CAPI TAL	SUMMARY O	F CAPITAL	
Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
		Capi tal -Rel ate				
		d Costs	through 7)			
	6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL CO				10,400,504	0	
00 CAP REL COSTS-BLDG & FIXT 00 CAP REL COSTS-MVBLE EQUIP	0	, s	(0	1.
00 CAP REL COSTS-MVBLE EQUIP 00 Total (sum of lines 1-2)	0	0		0 10, 252, 830 22, 691, 354	0	2. 3.
	0		I JMMARY OF CAPI		0	J.
		50				
Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
		instructions)	instructions)	Capi tal -Rel ate	of cols. 9	
				d Costs (see	through 14)	
	11.00	12.00	10.00	instructions)	15.00	
PART III - RECONCILIATION OF CAPITAL CO	11.00	12.00	13.00	14.00	15.00	
00 CAP REL COSTS-BLDG & FIXT	-3, 195, 279	0	(-296, 391	8, 946, 854	1.
00 CAP REL COSTS-MVBLE EQUIP	0,170,277	0			10, 252, 830	2.
00 Total (sum of lines 1-2)	-3, 195, 279	-			19, 199, 684	3.

Heal th	Fi nanci a	I Systems
AD JUST	MENTS TO	EXPENSES

FRANCISCAN HEALTH MICHIGAN CITY

In Lieu of Form CMS-2552-10

ealth Financial Systems	FRA	NCISCAN HEALT	H MICHIGAN CITY		eu of Form CMS-2	2552-
DJUSTMENTS TO EXPENSES			Provider CCN: 15-0015	Period: From 01/01/2017 To 12/31/2017	Worksheet A-8 Date/Time Pre 5/30/2018 6:00	pareo 6 pm
			Expense Classification c To/From Which the Amount is			o piii
Cost Center Descripti		Amount	Cost Center		Wkst. A-7 Ref.	
.00 Investment income - CAP REL	1.00	2.00	3.00 CAP REL COSTS-BLDG & FIXT	4.00	5.00	1.
COSTS-BLDG & FIXT (chapter .00 Investment income - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.
COSTS-MVBLE EQUIP (chapter	2)					
00 Investment income - other (chapter 2)	В	15, 628	CAP REL COSTS-BLDG & FIXT	1.00	11	3.
00 Trade, quantity, and time		0		0.00	0	4.
discounts (chapter 8) D0 Refunds and rebates of	В	-8, 265	ADMI NI STRATI VE & GENERAL	5.00	0	5
expenses (chapter 8)						
20 Rental of provider space by suppliers (chapter 8)	У	0		0.00	0	6
Tel ephone services (pay stations excluded) (chapter 21)	r	0		0.00	0	7.
D0 Television and radio servio	ce	0		0.00	0	8
(chapter 21) D0 Parking Lot (chapter 21)		0		0.00	0	9
00 Provider-based physician	A-8-2	-3, 191, 559		0.00	0	10
adjustment .00 Sale of scrap, waste, etc.		0		0.00	0	11
(chapter 23) . 00 Related organization	A-8-1	-136, 387			0	12
transactions (chapter 10)	A-0-1	-150, 507				
00 Laundry and linen service 00 Cafeteria-employees and gue	ests B	642 090	CAFETERI A	0.00 11.00		13 14
00 Rental of quarters to emplo		-042, 989	CALLIENTA	0.00		15
and others 00 Sale of medical and surgica supplies to other than	al	0		0.00	0	16
patients 00 Sale of drugs to other than	n	0		0.00	0	17
patients 00 Sale of medical records and	d	0		0.00	0	18
abstracts						
00 Nursing and allied health education (tuition, fees,		0		0.00	0	19
books, etc.) 00 Vending machines	В	-17 274	CAFETERI A	11.00	0	20
00 Income from imposition of	D D	-17,274		0.00		20
interest, finance or penalt charges (chapter 21)	ty					
00 Interest expense on Medicar		0		0.00	0	22
overpayments and borrowings repay Medicare overpayments						
.00 Adjustment for respiratory	A-8-3	0	RESPI RATORY THERAPY	65.00		23
therapy costs in excess of limitation (chapter 14)						
00 Adjustment for physical	A-8-3	0	PHYSI CAL THERAPY	66.00		24
therapy costs in excess of limitation (chapter 14)						
00 Utilization review -		0	UTILIZATION REVIEW-SNF	114.00		25
physicians' compensation (chapter 21)						
00 Depreciation - CAP REL COSTS-BLDG & FLXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26
.00 Depreciation - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27
COSTS-MVBLE EQUIP 00 Non-physician Anesthetist		Ω	NONPHYSICIAN ANESTHETISTS	19.00		28
00 Physicians' assistant		0		0.00	0	29
00 Adjustment for occupational therapy costs in excess of		0	OCCUPATI ONAL THERAPY	67.00		30
limitation (chapter 14) 99 Hospice (non-distinct) (see	e	٥	ADULTS & PEDIATRICS	30.00		30
instructions)						
.00 Adjustment for speech pathology costs in excess of	A-8-3	0	SPEECH PATHOLOGY	68.00		31.
.00 CAH HIT Adjustment for		0		0.00	0	32.
Depreciation and Interest						
. 00 UNCLAI MED PROPERTY	В	-140	ADMI NI STRATI VE & GENERAL	5.00	0	33.

Heal th	Financial Systems	FR/	ANCISCAN HEALT	H MICHIGAN CITY	In Lie	eu of Form CMS-:	2552-10
ADJUST	MENTS TO EXPENSES				Peri od:	Worksheet A-8	
					From 01/01/2017		
					To 12/31/2017		
				Expense Classification or	Worksheet A	5/30/2018 6:0	
				To/From Which the Amount is			
					to be Aujusteu		
	Cost Center Description	Basi s/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
36.00	OB PROGRAM FEES	В	- 300	ADULTS & PEDIATRICS	30.00	0	36.00
37.00	DONATIONS EXPENSE	A	-2,950	ADMINISTRATIVE & GENERAL	5.00	0	37.00
38.00	ADVERTI SI NG EXPENSE	A	-1, 441	ADMINI STRATI VE & GENERAL	5.00	0	38.00
40.00	A&G MISC REVENUE	В	-16, 920	ADMI NI STRATI VE & GENERAL	5.00	0	40.00
41.00	LOBBYI NG	A	-2,130	ADMINISTRATIVE & GENERAL	5.00	0	41.00
43.00	WOODLAND SURGERY BUILDING	В	-23, 814	OPERATION OF PLANT	7.00	0	43.00
	RENTAL INC						
44.00	GOODWI LL	A	-296, 391	CAP REL COSTS-BLDG & FIXT	1.00	14	44.00
45.00	OUTSIDE HOME HEALTH SUPPLIES	A		ADMI NI STRATI VE & GENERAL	5.00	0	45.00
47.00	DI SCOUNTS/REBATES	В		DIETARY	10.00	0	
48.00	DI SCOUNTS/REBATES	В	-218, 914	DRUGS CHARGED TO PATIENTS	73.00	0	48.00
49.00	HAF PROVIDER TAX	A		ADMI NI STRATI VE & GENERAL	5.00		
49.01	PENSION	A	1, 569, 000	EMPLOYEE BENEFITS DEPARTMEN			49.01
49.02	MEDI CAL RECORDS	В	-7, 252	ADMI NI STRATI VE & GENERAL	5.00		
49.03	DI SCOUNTS EARNED/REBATES		C		0.00		
	DI SCOUNTS EARNED/REBATES	В		OPERATING ROOM	50.00		
49.05	DI SCOUNTS EARNED/REBATES	В		OPERATING ROOM	50.00		
49.06	DI SCOUNTS EARNED/REBATES	В		RADI OLOGY-DI AGNOSTI C	54.00		
49.07	RENTAL INCOME	В		WOODLAND CANCER CARE CTR	55.01	0	
49.08	DI SCOUNTS EARNED/REBATES	В		LABORATORY	60.00		
49.09	DI SCOUNTS EARNED/REBATES	В		RESPIRATORY THERAPY	65.00		
49.10	MI SCELLANEOUS - OTHER	В	-1,140	PHYSICAL THERAPY	66.00	0	49.10
10 11	OPERATING		74.000		71.00		10 11
49. 11	DI SCOUNTS EARNED/REBATES	В	-74,888	MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	71.00	0	49.11
49, 12	DI SCOUNTS EARNED/REBATES	В	Q0 204	MEDICAL SUPPLIES CHARGED TO	71.00	0	49.12
49. IZ	DI SCOUNTS EARNED/ REDATES	D	-60, 200	PATIENTS	71.00	0	49.12
49, 13	MI SCELLANEOUS - OTHER		C	-	0.00	0	49.13
47.15	OPERATING		C C		0.00		47.15
49.14	MI SCELLANEOUS - OTHER		C		0.00	0	49.14
17.11	OPERATI NG		0		0.00		
49.15	BH WORKSHOP/SPEAKER INC	В	-1,059	ADMI NI STRATI VE & GENERAL	5.00	0	49.15
49.16	DONATION COMMUNITY BENEFIT	A		ADMI NI STRATI VE & GENERAL	5. OC		•
49.17	RENTAL INCOME	В		ADMI NI STRATI VE & GENERAL	5. OC		•
49.18	MISC. OTHER REV	В		OPERATING ROOM	50. OC		49.18
49.19	MISC. OTHER REV	В	-19	WOODLAND CANCER CARE CTR	55.01	0	49.19
49.20	MISC. LAUNDRY REV	В	-1, 341	HOUSEKEEPI NG	9.00	0	49.20
	TOTAL (E 1: 1 + 10)	1	0 077 444	1	1	1	

-8,877,444

(Transfer to Worksheet A, column 6, line 200.) (1) Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.

50.00 TOTAL (sum of lines 1 thru 49)

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.

50.00

Heal th	Financial Systems	FRANCI SCAN HEAL	TH MICHIGAN CITY	In Lie	eu of Form CMS-:	2552-10
STATEME	ENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HO		Peri od:	Worksheet A-8	-1
OFFICE	COSTS			From 01/01/2017 To 12/31/2017		
	Line 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 ADJUSTN	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED OF	RGANIZATIONS OR	CLAI MED	
	HOME OFFICE COSTS:			1		
1.00	1.00	CAP REL COSTS-BLDG & FIXT	INTEREST	2, 789, 184	6, 010, 078	1.00
2.00	1.00	CAP REL COSTS-BLDG & FIXT	ALLOWABLE NEW CAPITAL COSTS	3, 148, 940	1	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	ADMIN & GENERAL	18, 027, 409	17, 369, 383	3.00
4.00	14.00	CENTRAL SERVICES & SUPPLY	CENTRAL SUPPLY SERVICES & SU	1	92, 088	4.00
4.01	15.00	PHARMACY	COEP PHARMACY	260, 228	241, 173	4.01
4.02	16.00	MEDICAL RECORDS & LIBRARY	нім	1, 039, 463	1, 688, 889	4.02
5.00	TOTALS (sum of lines 1-4).			25, 265, 225	25, 401, 612	5.00
	Transfer column 6, line 5 to					
	Worksheet A-8, column 2,					
	line 12.					
* The	amounts on lines 1-4 (and sub	scripts as appropriate) are t	transferred in detail to Work	sheet A, column	6, lines as	

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

			Related Organization(s) and	/or Home Office
Symbol (1)	Name	Percentage of	Name	Percentage of
5ymbor (1)	Name		Name	
		Ownership		Ownership
1.00	2.00	3.00	4.00	5.00
1.00	2.00	0.00	1.00	0.00

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	100.00	0.0	0 6.00
7.00		0.00	0.0	7.00
8.00		0.00	0.0	0 8.00
9.00		0.00	0.0	9.00
10.00		0.00	0.0	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 organization.

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

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

Health Financial Systems				FRANCISCAN HEALTH MICHIGAN CITY				In Lieu of Form CMS-2552-10				
		SERVICES FROM	I RELATED	ORGANI ZATI ONS	AND HOME	Provi der	CCN:	15-0015	Period: From 01/01/2017	Worksheet	A-8-1	_
OFFICE	COSTS								To 12/31/2017	Date/Time		
										5/30/2018	6:06 pm	_
	Net	Wkst. A-7 Ref										

	Net	Wkst. A-7 Ref.		
	Adjustments			
	(col. 4 minus			
	col. 5)*			
	6.00	7.00		
	A. COSTS INCUR	RED AND ADJUSTM	ENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED	
	HOME OFFICE CO	STS:		
1.00	-3, 220, 894	11		1.00
2.00	3, 148, 939	9		2.00
3.00	658, 026	0		3.00
4.00	-92, 087	0		4.00
4.01	19, 055	0		4.01
4.02	-649, 426	0		4. 02
5.00	-136, 387			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

1105 110	Deen posted to worksheet A,	columns i and/or 2, the amount arrowable should be indicated in column 4 of this part.	
	Rel ated Organi zati on(s)		
	and/or Home Office		
	Type of Business		
	6.00		
	B. INTERRELATIONSHIP TO RELAT	TED ORGANIZATION(S) AND/OR HOME OFFICE:	

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

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

rerinbu			
6.00	FRANCI SCAN ALLI		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10. 00 100. 00			10.00
100.00		1	100.00

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

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

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

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

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

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

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

FRANCISCAN HEALTH MICHIGAN CITY

In Lieu of Form CMS-2552-10

Heal th	Financial Syste	ems F	RANCI SCAN HEAL	TH MICHIO	GAN CIT	Ϋ́	In Lie	eu of Form CMS-	2552-10
	ER BASED PHYSIC			Pro	vider (Period: From 01/01/2017 To 12/31/2017	, Worksheet A-8	3-2 epared:
	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Profess Compo		Provider Component	RCE Amount	Physician/Prov ider Component Hours	
	1.00	2.00	3.00	4.0	00	5.00	6.00	7.00	
1.00	31.00	I NTENSI VE CARE UNI T	-5, 000)	-5,000	C	197, 500	0	1.00
2.00		ADMINISTRATIVE & GENERAL	2, 319, 994		099, 469				2.00
3.00		NURSING ADMINISTRATION	56, 523		19, 897				3.00
4.00		PHARMACY	9, 000		750				4.00
5.00		ADULTS & PEDIATRICS	75, 776		50, 901	24, 875			5.00
6.00 7.00		SUBPROVI DER – I PF SUBPROVI DER – I RF	250, 000	4	236, 187	13, 813	197, 500	111 0	6.00
7.00 8.00		OPERATING ROOM	627, 490		0 512, 765	14, 725	246, 400		7.00 8.00
9.00		ANESTHESI OLOGY	10,000	1	012, 703	10,000			9.00
10.00		PHYSI CAL THERAPY	37, 500	1	37, 500				10.00
11.00		RADI OLOGY - THERAPEUTI C	25, 200		0				
12.00		WOODLAND CANCER CARE CTR	12, 088		9, 838	2, 250	271, 900	18	12.00
13.00		CARDI AC CATHETERI ZATI ON	18, 125	1	3, 250				13.00
14.00		LABORATORY	53, 276		0				14.00
15.00			3,000	1	0				15.00
16. 00 17. 00		INFUSION OP SERVICES EMERGENCY	6, 652	1	0				16. 00 17. 00
17.00		FREE STANDING EMERGENCY DEPT	32, 500 44, 307		0	44, 307			
200.00	71.01		3, 576, 431)65, 557				200.00
200100	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE			Cost of	Provi der	Physician Cost	2001.00
		I denti fi er	Limit			Memberships &	Component	of Mal practi ce	
				Lim	it	Conti nui ng	Share of col.	Insurance	
	1.00	2.00	8.00	9.0	0	Education 12.00	12 13.00	14.00	
1.00		I NTENSI VE CARE UNI T	0.00		0				1.00
2.00		ADMI NI STRATI VE & GENERAL	167, 495		8, 375			-	2.00
3.00		NURSING ADMINISTRATION	27, 821		1, 391	C		0	3.00
4.00	15.00	PHARMACY	4, 558		228	C	0	0	4.00
5.00		ADULTS & PEDIATRICS	18, 895		945			0	5.00
6.00		SUBPROVIDER - IPF	10, 540		527			0	6.00
7.00 8.00		SUBPROVIDER - IRF OPERATING ROOM	0 7 700		0		-	0	7.00 8.00
8.00 9.00		ANESTHESI OLOGY	7, 700	1	385 386			0	8.00 9.00
10.00		PHYSI CAL THERAPY	0	1	000			0	10.00
11.00		RADI OLOGY - THERAPEUTI C	20, 540		1, 027			0	11.00
12.00	55.01	WOODLAND CANCER CARE CTR	2, 353		118	C	0	0	12.00
13.00		CARDIAC CATHETERIZATION	11, 299	1	565		-	0	13.00
14.00			40, 450	1	2,023		-	0	14.00
15. 00 16. 00		RESPIRATORY THERAPY	2, 279 5, 032	1	114 252			0	15. 00 16. 00
17.00		EMERGENCY	24, 688		1, 232			0	17.00
18.00		FREE STANDING EMERGENCY DEPT	33, 613	1	1, 681		-	0	18.00
200.00			384, 975		19, 251	C	0	0	
	Wkst. A Line #		Provi der	Adjuste		RCE	Adjustment		
		I denti fi er	Component	Lim	it	Di sal I owance			
			Share of col. 14						
	1.00	2.00	15.00	16.	00	17.00	18.00		
1.00	31.00	I NTENSI VE CARE UNI T	0		0	C	-5, 000		1.00
2.00		ADMINISTRATIVE & GENERAL	0		167, 495				2.00
3.00		NURSI NG ADMI NI STRATI ON	0		27,821	8,805			3.00
4.00 5.00		PHARMACY ADULTS & PEDIATRICS			4, 558 18, 895				4.00 5.00
6.00		SUBPROVIDER - IPF			10, 540				6.00
7.00		SUBPROVIDER - IRF	0		0	0,2,0	0		7.00
8.00		OPERATING ROOM	0		7,700	7, 025	619, 790		8.00
9.00		ANESTHESI OLOGY	0		7, 712	2, 288	2, 288		9.00
10.00		PHYSI CAL THERAPY	0		0	-	37, 500		10.00
11.00		RADI OLOGY-THERAPEUTI C	0		20, 540				11.00
12.00		WOODLAND CANCER CARE CTR	0	1	2,353		9,838		12.00
13.00 14.00		CARDI AC CATHETERI ZATI ON LABORATORY			11, 299 40, 450				13.00 14.00
14.00		RESPI RATORY THERAPY			2, 279				15.00
16.00		INFUSION OP SERVICES	0)	5,032				16.00
17.00		EMERGENCY	0		24, 688				17.00
18.00		FREE STANDING EMERGENCY DEPT	0		33, 613				18.00
200.00	I	l	0	4 3	384, 975	126, 002	2 3, 191, 559		200.00

ST A	LLOCATION - GENERAL SERVICE COSTS		Provider CO	F	eriod: rom 01/01/2017 o 12/31/2017	Worksheet B Part I Date/Time Pre	parec
			CAPI TAL REL	ATED COSTS		5/30/2018 6:0	b pm
	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFI TS DEPARTMENT	Subtotal	
		col. 7)					
		0	1.00	2.00	4.00	4A	
00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT	8, 946, 854	8, 946, 854				1 1.
00	00200 CAP REL COSTS-BEDG & FIXT		0, 940, 004				2.
00	00400 EMPLOYEE BENEFITS DEPARTMENT	10, 252, 830 16, 295, 684	86, 223	10, 252, 830 12, 380			4.
0	00500 ADMINISTRATIVE & GENERAL	30, 168, 292	1, 290, 803	1, 323, 839		34, 429, 320	4. 5.
0	00600 MAINTENANCE & REPAIRS	30, 100, 292	1, 290, 803	1, 323, 039		34, 429, 320	6.
0	00700 OPERATION OF PLANT	6, 484, 355	1, 125, 873	2, 257, 039	-	10, 673, 563	
0	00800 LAUNDRY & LINEN SERVICE	409, 572	99, 401	2, 237, 037		509, 083	
0	00900 HOUSEKEEPING	1, 550, 456	163, 194	7, 732		2, 130, 279	
00	01000 DI ETARY	498, 032	71, 214	19, 682		706, 135	
00	01100 CAFETERI A	865, 165	168, 902	19,002		1, 343, 210	
00	01300 NURSI NG ADMI NI STRATI ON	3, 082, 512	40, 602	174, 893		4, 043, 175	
00	01400 CENTRAL SERVICES & SUPPLY	1, 415, 848	157,033	88, 465		1, 700, 580	
00	01500 PHARMACY	15, 645, 416	75, 115	2, 546		16, 475, 731	15.
	01600 MEDICAL RECORDS & LI BRARY	1,060,727	69, 549	219, 899		1, 353, 532	
00	01700 SOCIAL SERVICE	1,000,727	07, 347	219,099		1, 333, 332	17.
	01080 I NSERVI CE EDUCATI ON		0	0	-	0	
	01900 NONPHYSI CLAN ANESTHETI STS	0	0	0	-	0	
	02000 NURSI NG SCHOOL	0	0	0	-	0	20.
00	02100 I &R SERVICES-SALARY & FRINGES APPRVD	0	0	0	-	0	
00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	-	0	22.
00	02300 PARAMED ED PRGM-(SPECIFY)	0	0	0		0	
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS						
00	03000 ADULTS & PEDIATRICS	9, 769, 066	1, 563, 174	179, 754	3, 101, 646	14, 613, 640	30.
00	03100 I NTENSI VE CARE UNI T	2,087,003	140, 264	182, 128		3, 115, 831	
00	03200 CORONARY CARE UNIT	0	0	0		0	
00	03300 BURN INTENSIVE CARE UNIT	0	0	0	0	0	
00	03400 SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.
00	04000 SUBPROVIDER - IPF	1,049,649	148, 899	11, 408	351, 796	1, 561, 752	
00	04100 SUBPROVIDER - IRF	1, 416, 472	269, 492	44, 769		2, 180, 353	
00	04300 NURSERY	467, 333	21, 383	327		621, 600	
00	04400 SKILLED NURSING FACILITY	0	0	0		0	44.
00	04500 NURSING FACILITY	0	0	0	0	0	45.
00	04600 OTHER LONG TERM CARE	0	0	0	0	0	46.
	ANCILLARY SERVICE COST CENTERS						
00	05000 OPERATI NG ROOM	6, 689, 829	449, 812	1, 310, 235	1, 620, 048	10, 069, 924	50.
00	05100 RECOVERY ROOM	0	0	0	0	0	51.
	05200 DELIVERY ROOM & LABOR ROOM	837, 989			237, 691	1, 247, 223	52.
00	05300 ANESTHESI OLOGY	90, 825	12, 987	7, 136	12, 952	123, 900	53.
00	05400 RADI OLOGY-DI AGNOSTI C	3, 375, 072	430, 736	820, 217		5, 540, 477	54.
01	05401 FSED RADIOLOGY - DIAGNOSTIC	930, 348	68, 146	996, 067		2, 237, 959	
00	05500 RADI OLOGY-THERAPEUTI C	1, 971, 077	213, 025			2, 657, 081	
01	05501 WOODLAND CANCER CARE CTR	1, 085, 059		962		1, 583, 132	
00	05600 RADI OI SOTOPE	0	0	0	-	0	
00	05700 CT SCAN	0	0	0	-	0	
00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0	0	-	0	58.
00	05900 CARDI AC CATHETERI ZATI ON	1, 535, 312	103, 016			3, 035, 535	
00	06000 LABORATORY	6,002,140	213, 572	7, 451		6, 223, 163	
01	06001 FS ED LAB	1, 305, 580	30, 921	107	0	1, 336, 608	
00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	-	-	_	0	
00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	-	0	
00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	-	0	
00	06400 I NTRAVENOUS THERAPY	0	0	0	-	0	64.
00		1,012,035				1, 393, 488	
00	06600 PHYSI CAL THERAPY	3, 179, 144	32, 824	12, 940	240, 926	3, 465, 834	
00	06700 OCCUPATI ONAL THERAPY	0	0	0	0	0	
00		1 000 (/7	121 (22	152 750	-	1 440 921	68.
00		1, 080, 667	131, 630	152, 750	304, 774	1, 669, 821	
00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	
	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	890, 985	0	0	-	890, 985	
	07200 I MPL. DEV. CHARGED TO PATIENTS	10, 571, 866	0	0	0	10, 571, 866	
00	07300 DRUGS CHARGED TO PATIENTS	-218, 914	0	0	0	-218, 914	
	07400 RENAL DI ALYSI S	0	0	0	-	0	
00	07500 ASC (NON-DI STI NCT PART)	0	0	0	-	0	75.
07	03020 CV RESOURCE CTR	0	0	0	-	0	
	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.
	07700 ALLOGENEIC STEM CELL ACQUISITION OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC	0	0	0		0	

			F	rom 01/01/2017 o 12/31/2017	Part I Date/Time Pre 5/30/2018 6:0	
		CAPI TAL REL	_ATED COSTS			
Cost Center Description	Net Expenses for Cost Allocation (from Wkst A	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFI TS DEPARTMENT	Subtotal	
	<u>col.7)</u>	1.00	2.00	4,00	4A	
90. 00 09000 CLINIC	0	0				90.00
90. 03 09003 INFUSION OP SERVICES	557, 125	33, 134	-	-	686, 853	
91. 00 09100 EMERGENCY	5, 571, 272	477, 903			7, 294, 745	91.00
91. 01 09101 FREE STANDING EMERGENCY DEPT	1, 705, 011	508, 562			3, 165, 706	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1,700,011	000,002		111,017	0, 100, 700	1
OTHER REIMBURSABLE COST CENTERS	II				Ŭ	/2.00
94. 00 09400 HOME PROGRAM DI ALYSI S	0	0	0	0	0	94.00
95. 00 09500 AMBULANCE SERVICES	0	0			0	95.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0			0	96.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0		-	0	97.00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
99. 00 09900 CMHC	0	0	0	0	0	99.00
99. 10 09910 CORF	0	0	0	0	0	
100.00 10000 I &R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00 10100 HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						1
105.00 10500 KIDNEY ACQUISITION	0	0	0	0	0	105.00
106. 00 10600 HEART ACQUI SI TI ON	0	0	0	0	0	106.00
107.00 10700 LIVER ACQUISITION	0	0	0	0	0	107.00
108.00 10800 LUNG ACQUISITION	0	0	0	0	0	108.00
109.00 10900 PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00 11000 INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00 11100 I SLET ACQUI SI TI ON	0	0	0	0	0	111.00
113.00 11300 INTEREST EXPENSE						113.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0		115.00
116. 00 11600 HOSPI CE	0	0	0	0	0	116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	159, 637, 688	8, 670, 749	9, 888, 408	15, 830, 296	158, 433, 170	118.00
NONREI MBURSABLE COST CENTERS	· · · · · · · · · · · · · · · · · · ·					
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	23, 429				190.00
191.00 19100 RESEARCH	0	0	-	-		191.00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0			192.00
193.00 19300 NONPALD WORKERS	0	0	0	0		193.00
193. 01 19301 NONPAI D WORKERS	0	0	0	0		193.01
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	0	0	, °	0		194.00
194.01 07951 WORKING WELL	2, 284, 970	0			2, 942, 268	•
194.03 07953 OTHER NONREI MBURSABLE COST CENTERS	72	144, 617			164, 858	
194. 10 07960 DUNELAND FITNESS CTR	0	108, 059		-	108, 059	
194.11 07961 OMNI HEALTH & FITNESS CHESTERTOWN	-668	0			203, 412	
194.16 07966 PHYSICIAN PRACTICE MD WISW	-203, 890	0	-,		-196, 736	•
194. 19 07969 HEALTH PARTNERS	-1, 536	0			25, 294	•
194. 20 07970 CENTER OF HOPE	36, 574	0	671	12, 211		194.20
200.00 Cross Foot Adjustments		-	_			200.00
201.00 Negative Cost Centers	1/1 750 010	0		14 204 207		201.00
202.00 TOTAL (sum lines 118 through 201)	161, 753, 210	8, 946, 854	10, 252, 830	16, 394, 287	161, 753, 210	1202.00

DST A	ALLOCATION - GENERAL SERVICE COSTS		Provider C	F	eriod: rom 01/01/2017 o 12/31/2017		
	Cost Center Description	ADMI NI STRATI VE	MAINTENANCE &		LAUNDRY &	5/30/2018 6: 0 HOUSEKEEPI NG	
	cost center bescription	& GENERAL	REPAI RS	PLANT	LINEN SERVICE		
	GENERAL SERVICE COST CENTERS	5.00	6.00	7.00	8.00	9.00	
00	00100 CAP REL COSTS-BLDG & FIXT						1.
00	00200 CAP REL COSTS-MVBLE EQUIP						2.
00 00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL	34, 429, 320					4. 5.
00	00600 MAINTENANCE & REPAIRS	34, 429, 320	C				6.
00	00700 OPERATION OF PLANT	2, 876, 824	0	13, 550, 387			7.
00	00800 LAUNDRY & LINEN SERVICE	137, 212	C	209, 020	855, 315		8.
00	00900 HOUSEKEEPI NG	574, 170	0	0.0,.00		3, 047, 614	
0.00	01000 DI ETARY	190, 323	0	149, 750		35, 111	
1.00 3.00	01100 CAFETERIA 01300 NURSI NG ADMINI STRATI ON	362, 033 1, 089, 749	0		0	83, 274 20, 018	
4.00	01400 CENTRAL SERVICES & SUPPLY	458, 354	0		0	77, 423	
5.00		4, 440, 606	0		-	37, 034	
5.00	01600 MEDICAL RECORDS & LIBRARY	364, 815	C	146, 249	0	34, 290	16.
7.00		0	C	0	0	0	
3.00		0	0	0	0	0	
9.00 0.00		0	0	0	0	0	1
1.00	02100 I &R SERVICES-SALARY & FRINGES APPRVD	0		0	0	0	
2.00		0	C	0	0	0	
3.00		0	C	0	0	0	
	INPATIENT ROUTINE SERVICE COST CENTERS	- 1 1		1		1	
0.00		3, 938, 785	0				
1.00		839, 804	0	294, 949			
2.00 3.00	03200 CORONARY CARE UNIT 03300 BURN INTENSIVE CARE UNIT	0		0	0	0	
4.00		0	0	0	0	0	
0. 00	04000 SUBPROVIDER - IPF	420, 936	0	313, 105	94, 084		
. 00	04100 SUBPROVI DER – I RF	587, 666	C	566, 690	34, 212	132, 868	41.
3. 00		167, 539	0	44, 965		10, 543	
4.00		0	0	0	0	0	
5.00		0	0	-	0	0	
5.00	ANCI LLARY SERVICE COST CENTERS		0	y 0	0	0	46.
0. 00	05000 OPERATI NG ROOM	2, 714, 126	C	945, 867	45, 332	221, 772	50.
1.00	05100 RECOVERY ROOM	0	C	0	0	0	51.
2.00	05200 DELIVERY ROOM & LABOR ROOM	336, 162	C	000,721	0	84, 576	
3.00		33, 395	0	27, 309		6, 403	
4.00 4.01	05400 RADI OLOGY-DI AGNOSTI C 05401 FSED RADI OLOGY - DI AGNOSTI C	1, 493, 314 603, 193	0	,,			
5.00	05500 RADI OLOGY - DI AGNOSTI C	716, 158	0			33, 598 105, 028	
5. 01	05501 WOODLAND CANCER CARE CTR	426, 698	C				
o. 00		0	C	0	0		56.
7.00		0	C	0	0	0	57.
3.00		0	0	0	0	0	
2.00		818, 162	0	216, 623		50, 790	
0.00 0.01	06000 LABORATORY 06001 FS ED LAB	1, 677, 317 360, 253	0	449, 100 65, 022		105, 298 15, 245	
. 00		300, 203	0	05,022	0	15, 245	61.
2.00		0	C	0	0	0	
3. 00		0	C	0	0	0	
1.00		0	C	0	0	0	
5.00		375, 584	0	100, 184		23, 489	
b. 00		934, 139	0	69, 023	25, 660		
2.00 3.00		0	0	0	0	0	
	06900 ELECTROCARDI OLOGY	450, 064		276, 793	4, 277	64, 898	
	07000 ELECTROENCEPHALOGRAPHY		0	0	0	04,070	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	240, 145	C	0	0	0	
. 00		2, 849, 414	C	0	0	0	
. 00		0	C	0	0	0	
. 00		0	0	0	0	0	
	07500 ASC (NON-DI STI NCT PART)	0	0	0	0	0	
	03020 CV RESOURCE CTR 07700 ALLOGENEIC STEM CELL ACQUISITION	0	C C	0	0	0	
. 00	OUTPATIENT SERVICE COST CENTERS		U	0	0	0	H ' '
3. 00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	C	0	0	0	
0. 00		0	0	0	0	0	
	09003 I NFUSI ON OP SERVI CES	185, 126	C	69, 673			
1.00	09100 EMERGENCY 09101 FREE STANDING EMERGENCY DEPT	1, 966, 138	0	1,004,936			
01		853, 246		1, 069, 408		250, 738	

Heal th	Fi nanci al	Systems	

Health Financial Systems FF	RANCISCAN HEALT	H MICHIGAN CITY	(In Lie	U OT FORM CMS	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider C	CN: 15-0015	Peri od:	Worksheet B	
				From 01/01/2017	Part I	
				To 12/31/2017	Date/Time Pre	pared:
					5/30/2018 6:0	
Cost Center Description	ADMI NI STRATI VE	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
	& GENERAL	REPAI RS	PLANT	LINEN SERVICE		
	5.00	6.00	7.00	8.00	9.00	
OTHER REIMBURSABLE COST CENTERS	5.00	0.00	7.00	0.00	9.00	
	0			0	0	04.00
94. 00 09400 HOME PROGRAM DI ALYSI S	0	0		0 0	0	94.00
95. 00 09500 AMBULANCE SERVI CES	0	0		0 0	0	95.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0		0 0	0	96.00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0		0 0	0	97.00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	0		0 0	0	98.00
99. 00 09900 CMHC	0	0		0 0	0	99.00
99. 10 09910 CORF		0			0	99.10
100.00 10000 I &R SERVICES-NOT APPRVD PRGM				0 0	0	
		0		0 0		
101.00 10100 HOME HEALTH AGENCY	0	0		0 0	0	101.00
SPECIAL PURPOSE COST CENTERS	1	1			1	
105.00 10500 KIDNEY ACQUISITION	0	0		0 0		105.00
106.00 10600 HEART ACQUI SI TI ON	0	0		0 0	0	106.00
107.00 10700 LIVER ACQUISITION	0	0		0 0	0	107.00
108.00 10800 LUNG ACQUISITION	0	0		0 0	0	108.00
109.00 10900 PANCREAS ACQUISITION	0	0		0 0	0	109.00
110.00 11000 INTESTINAL ACQUISITION	0	0		0 0		110.00
111. 00 11100 I SLET ACQUI SI TI ON		0		0 0		111.00
113. 00 11300 I NTEREST EXPENSE				0 0	0	113.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0		0 0		115.00
116. 00 11600 HOSPI CE	0	0		0 0		116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	33, 481, 450	0	12, 969, 79	3 812, 549	2, 911, 486	118.00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	6, 315	0	49, 26	6 0	11, 551	190.00
191. 00 19100 RESEARCH	0	0		0 0	0	191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0 0	0	192.00
193. 00 19300 NONPALD WORKERS	0	0		0 0	0	193.00
193. 01 19301 NONPALD WORKERS	0	0		0 0		193.01
194. 00 07950 OTHER NONREI MBURSABLE COST CENTERS				0 0		194.00
194. 01 07951 WORKING WELL	793, 024			0 0		194.00
			204.10	0 0		
194.03 07953 OTHER NONREI MBURSABLE COST CENTERS	44, 434		304, 10			194.03
194.1007960 DUNELAND FITNESS CTR	29, 125		227, 22	6 0		194. 10
194.1107961 OMNI HEALTH & FITNESS CHESTERTOWN	54, 825			0 0		194. 11
194.1607966 PHYSICIAN PRACTICE MD WISW	0	0		0 0		194. 16
194. 19 07969 HEALTH PARTNERS	6, 817	0		0 42, 766	0	194.19
194.2007970 CENTER OF HOPE	13, 330	0		0 0	0	194. 20
200.00 Cross Foot Adjustments	1					200.00
201.00 Negative Cost Centers	0	0		0 0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	34, 429, 320	0	13, 550, 38	7 855, 315	-	
	1 01, 127, 020		1 10,000,00		1 0,017,014	202.00

COST A	ALLOCATION - GENERAL SERVICE COSTS		Provider C		riod: om 01/01/2017 12/31/2017	Worksheet B Part I Date/Time Pre 5/30/2018 6:0	
	Cost Center Description	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY	
		10.00	11.00	13.00	14.00	15.00	
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 13.\ 00\\ 14.\$	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DI ETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 CAFETERIA	1, 081, 661 0 0	2, 143, 686 118, 405 11, 934	5, 356, 726 0	2, 578, 502	21, 222, 152	1.00 2.00 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 20. 00 21. 00 22. 00 23. 00	01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY 01700 SOCI AL SERVI CE 01080 I NSERVI CE EDUCATI ON 01900 NONPHYSI CI AN ANESTHETI STS 02000 NURSI NG SCHOOL 02100 I &R SERVI CES-SALARY & FRI NGES APPRVD 02200 I &R SERVI CES-OTHER PRGM COSTS APPRVD 02300 PARAMED ED PRGM-(SPECI FY) I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0 0 0 0 0 0 0 0 0 0	99, 746 777 0 0 0 0 0 0 0		18, 080 0 0 0 0 0 0 0 0 0	21, 229, 150 0 0 0 0 0 0 0 0 0 0	16.00 17.00 18.00 19.00 20.00 21.00 22.00
30.00	03000 ADULTS & PEDIATRICS	704, 867	486, 367		129, 602	0	30.00
31.00 32.00	03100 I NTENSI VE CARE UNI T 03200 CORONARY CARE UNI T	103, 837	102, 351 0	543, 950 0	45, 381 0	0	31.00 32.00
32.00 33.00 34.00 40.00 41.00 43.00 44.00 45.00 46.00	03200 EUROWARY CARE UNIT 03300 BURN INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF 04100 SUBPROVIDER - IRF 04300 NURSERY 04400 SKILLED NURSING FACILITY 04500 NURSING FACILITY 04600 OTHER LONG TERM CARE ANCILLARY SERVICE COST CENTERS	0 0 127, 089 104, 359 41, 509 0 0 0	0 0 68, 260 75, 257 18, 853 0 0 0	185, 788	0 0 1, 412 8, 006 0 0 0 0 0	0 0 0 0 0 0 0	33.00 34.00 40.00 41.00 43.00 44.00 45.00
50.00	05000 OPERATING ROOM	0	294, 807	859, 081	1, 818, 453	0	50.00
51.00 52.00 53.00 54.00 54.01 55.00	05100 OPERATING ROOM 05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY - DI AGNOSTI C 05401 FSED RADI OLOGY - DI AGNOSTI C 05500 RADI OLOGY - THERAPEUTI C 05500 RADI OLOGY - THERAPEUTI C 05500 RADI OLOGY - THERAPEUTI C 05600 RADI OLOGY - THERAPEUTI C 05700 CT SCAN		294, 807 0 33, 819 3, 771 163, 186 41, 166 26, 938 38, 445 0	0 163, 261 0 44, 549 0 0	1, 818, 433 0 0 69, 869 10, 236 3, 666 11, 311 0	0 0 0 0 0 0 0 0 0 0 0	51.00 52.00 53.00 54.00 54.01 55.00
58.00 59.00 60.01 61.00 62.00 63.00 64.00 65.00	05800 MAGNETIC RESONANCE I MAGI NG (MRI) 05900 CARDI AC CATHETERI ZATION 06000 LABORATORY 06001 FS ED LAB 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06300 BLOOD STORING, PROCESSING & TRANS. 064000 I NTRAVENOUS THERAPY 06500 RESPIRATORY THERAPY		0 40, 738 0 0 0 0 55, 471	0 0 0 0 0	0 333, 629 2, 118 65 0 0 0 15, 359		58.00 59.00 60.01 61.00 62.00 63.00 64.00 65.00
$\begin{array}{c} 66.\ 00\\ 67.\ 00\\ 68.\ 00\\ 70.\ 00\\ 71.\ 00\\ 72.\ 00\\ 73.\ 00\\ 74.\ 00\\ 75.\ 00\\ 76.\ 00\\ \end{array}$	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 07200 IMPL. DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS 07400 RENAL DI ALYSI S 07500 ASC (NON-DI STINCT PART) 03020 CV RESOURCE CTR 07700 ALLOGENEI C STEM CELL ACQUI SI TI ON		40, 466 0 50, 961 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	8, 353 0 0	9, 151 9, 151 0 0 6, 063 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 21, 229, 150 0 0 0 0 0	66.00 67.00 68.00 69.00 70.00 71.00 72.00 73.00 74.00 75.00 76.00
89.00 90.00 90.03 91.00 91.01	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC 09000 CLINIC 09000 CLINIC 09000 EMERGENCY 09101 FREE STANDING EMERGENCY DEPT 018 6:06 pm	0 0 0 0 0 0	0 0 15, 082 182, 738 60, 058	719, 613	0 0 3, 989 70, 715 13, 188	0 0 0 0 0 0 0	89.00 90.00 90.03 91.00

Health Financial Systems FR	ANCISCAN HEALTH	MICHIGAN CITY	(In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CO	F	Period: From 01/01/2017 Fo 12/31/2017	Worksheet B Part I Date/Time Prep 5/30/2018 6:06	pared: 6 pm
Cost Center Description	DI ETARY		NURSI NG ADMI NI STRATI Of	SUPPLY	PHARMACY	
	10.00	11.00	13.00	14.00	15.00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS	-			-1 -1	-	
94.00 09400 HOME PROGRAM DI ALYSI S	0	0	(0 0	0	94.00
95. 00 09500 AMBULANCE SERVICES	0	0	(0 0	0	95.00
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	(0 0	0	96.00
97.00 09700 DURABLE MEDI CAL EQUI P-SOLD	0	0	(0 0	0	97.00
98.00 09850 OTHER REI MBURSABLE COST CENTERS	0	0	(0 0	0	98.00
99.00 09900 CMHC	0	0	(0 0	0	99.00
99. 10 09910 CORF	0	0	(0 0	0	99.10
100.00 10000 I &R SERVICES-NOT APPRVD PRGM	0	0	(0 0		100.00
101.00 10100 HOME HEALTH AGENCY	0	0	(0 0	0	101.00
SPECIAL PURPOSE COST CENTERS						
105.00 10500 KIDNEY ACQUISITION	0	0				105.00
106.00 10600 HEART ACQUI SI TI ON	0	0	(0 0		106.00
107.00 10700 LIVER ACQUISITION	0	0	(0 0		107.00
108.00 10800 LUNG ACQUI SI TI ON	0	0	(0 0		108.00
109.00 10900 PANCREAS ACQUISITION	0	0	(0 0		109.00
110.00 11000 INTESTINAL ACQUISITION	0	0	(0 0		110.00
111.00 11100 I SLET ACQUI SI TI ON	0	0		0 0		111.00
113.00 11300 INTEREST EXPENSE						113.00
114.00 11400 UTI LI ZATI ON REVIEW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	(0	-	115.00
116.00 11600 HOSPI CE	0	0	(0 570 000		116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	1, 081, 661	2, 029, 596	5, 300, 028	3 2, 570, 293	21, 229, 150	118.00
NONREI MBURSABLE COST CENTERS						100.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 191. 00 19100 RESEARCH	0	0	(0		190.00
	0	0				191.00 192.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES 193.00 19300 NONPALD WORKERS	0	0				192.00
193. 00 19300 NONPALD WORKERS	0	0				
	0	0				193.01
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS 194.01 07951 WORKING WELL	0	112 202	E4 14-			194. 00 194. 01
	0	112, 302	54, 16	7 8, 200		194. 01 194. 03
194.03 07953 OTHER NONREIMBURSABLE COST CENTERS 194.10 07960 DUNELAND FITNESS CTR	0	0				194. 03 194. 10
194. 11 07961 OMNI HEALTH & FITNESS CHESTERTOWN	0	0				194. 10 194. 11
194. 16 07966 PHYSICIAN PRACTICE MD WISW	0	0				194.11
194. 19 07969 HEALTH PARTNERS	0	39				194.10
194. 20 07970 CENTER OF HOPE	0	39 1, 749				194. 19
200.00 Cross Foot Adjustments	0	1, 747	2,00			200.00
201.00 Negative Cost Centers	0	0				200.00
202.00 TOTAL (sum lines 118 through 201)	1, 081, 661	2, 143, 686	5, 356, 726	2, 578, 502		
	1, 001, 001	2, 175, 000	1 0,000,720	2, 570, 502	21,227,100	-02.00

	Financial Systems FF	RANCISCAN HEALT		CN: 15-0015 P	<u>In Lie</u> Period: From 01/01/2017	eu of Form CMS-: Worksheet B Part I	2552-10
					o 12/31/2017		
				OTHER GENERAL			
	Cost Center Description	MEDI CAL	SOCIAL SERVICE	SERVI CE	NONPHYSI CI AN	NURSING SCHOOL	
		RECORDS &		EDUCATI ON	ANESTHETI STS		
		LI BRARY 16. 00	17.00	18.00	19.00	20.00	
	GENERAL SERVICE COST CENTERS			1		1	1 1 00
	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
	00500 ADMI NI STRATI VE & GENERAL 00600 MAI NTENANCE & REPAI RS						5.00
	00700 OPERATION OF PLANT						7.00
	00800 LAUNDRY & LINEN SERVICE						8.00
	00900 HOUSEKEEPI NG 01000 DI ETARY						9.00
	01100 CAFETERIA						11.00
	01300 NURSI NG ADMI NI STRATI ON						13.00
	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY						14.00
	01600 MEDI CAL RECORDS & LI BRARY	1, 899, 663					16.00
	01700 SOCIAL SERVICE	0	0				17.00
	01080 I NSERVI CE EDUCATI ON 01900 NONPHYSI CI AN ANESTHETI STS	0					18.00
20.00	02000 NURSI NG SCHOOL	0	0	C)	0	
	02100 I &R SERVICES-SALARY & FRINGES APPRVD 02200 I &R SERVICES-OTHER PRGM COSTS APPRVD	0	0				21.00
	02300 PARAMED ED PRGM-(SPECIFY)	0	0				22.00
	INPATIENT ROUTINE SERVICE COST CENTERS			1	1	1	
	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	110, 731 16, 828	0		-		
	03200 CORONARY CARE UNIT	0, 020	0		-	-	
	03300 BURN INTENSIVE CARE UNIT	0	0	C	0 0	0	
	03400 SURGICAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF	0 12, 597	0		0	0	
	04100 SUBPROVIDER - IRF	19, 529	0			0	
	04300 NURSERY	3, 296	0	C	0	0	
	04400 SKILLED NURSING FACILITY 04500 NURSING FACILITY	0	0			0	
	04600 OTHER LONG TERM CARE	0	0		-	-	
	ANCI LLARY SERVICE COST CENTERS 05000 OPERATI NG ROOM	339, 869	0	C			
	05100 RECOVERY ROOM	339,009	0		-	-	
	05200 DELIVERY ROOM & LABOR ROOM	5, 910	0	C	0 0	0	
	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	13, 827 249, 981	0		0	0	
	05400 RADI OLOGI - DI AGNOSTI C	52, 883	0	-	-	0	
55.00	05500 RADI OLOGY-THERAPEUTI C	42, 626		C	0 0	0	55.00
	05501 WOODLAND CANCER CARE CTR 05600 RADI OI SOTOPE	8, 237	0	0	0	0	55.01 56.00
	05700 CT SCAN	0	0	c c		0	57.00
	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	C	0	0	
	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	60, 780 160, 144				0	
60.01	06001 FS ED LAB	24, 759		C	0	0	
	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06300 BLOOD STORING, PROCESSING & TRANS.	0				0	62.00 63.00
64.00	06400 I NTRAVENOUS THERAPY	0	0	c c	0	0	64.00
	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	36, 214 60, 969	0	0	0	0	65.00 66.00
	06700 OCCUPATI ONAL THERAPY	00, 969	0			0	
68.00	06800 SPEECH PATHOLOGY	0	0	C	0	0	68.00
	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	51,095				0	69.00 70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	58, 522	0			0	71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	46, 875	0	C	0	0	72.00
	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	344, 754				0	73.00 74.00
	07500 ASC (NON-DI STINCT PART)	0	0			0	
	03020 CV RESOURCE CTR	0	0	C	0	0	
	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	C	00	0	77.00
77.00							
77.00 88.00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC	0	0	C	C	0	
77.00 88.00 89.00	OUTPATIENT SERVICE COST CENTERS	000000000000000000000000000000000000000	000000000000000000000000000000000000000			0	89.00

Health Financial Systems FR	ANCISCAN HEALTH	I MICHIGAN CITY	ſ		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider C		To 1	: 1/01/2017 2/31/2017	Worksheet B Part I Date/Time Pre 5/30/2018 6:0	pared: 6 pm
Cost Center Description	MEDI CAL RECORDS & LI BRARY	SOCI AL SERVI CE	OTHER GENERA SERVI CE I NSERVI CE EDUCATI ON	NONP	HYSI CI AN THETI STS	NURSING SCHOOL	
	16.00	17.00	18.00	1	19.00	20.00	
91. 00 09100 EMERGENCY	140, 903	0		0	0	0	
91.01 09101 FREE STANDING EMERGENCY DEPT	31, 341	0		0	0	0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)							92.00
OTHER REIMBURSABLE COST CENTERS				-			
94.00 09400 HOME PROGRAM DI ALYSI S	0	0		0	0	0	94.00
95. 00 09500 AMBULANCE SERVICES	0	0		0	0	0	95.00
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0		0	0	0	
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0		0	0	0	97.00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	0		0	0	0	
99. 00 09900 CMHC	0	0		0	0	0	
99. 10 09910 CORF	0	0		0	0	0	/ // /0
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0		0	0		100.00
101.0010100HOME HEALTH AGENCY	0	0		0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
105.00 10500 KIDNEY ACQUISITION	0	0		0	0		105.00
106.00 10600 HEART ACQUI SI TI ON	0	0		0	0		106.00
107.00 10700 LI VER ACQUI SI TI ON	0	0		0	0		107.00
108.00 10800 LUNG ACQUISITION	0	0		0	0		108.00
109.00 10900 PANCREAS ACQUISITION	0	0		0	0		109.00
110.00 11000 INTESTINAL ACQUISITION	0	0		0	0		110.00
111.00 11100 I SLET ACQUI SI TI ON	0	0		0	0	0	111.00
113.00 11300 I NTEREST EXPENSE							113.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF						_	114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0		0	0		115.00
116.00 11600 HOSPI CE	0	0		0			116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	1, 899, 663	0		0	0	0	118.00
NONREI MBURSABLE COST CENTERS				0		0	100.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0	0		190.00
191. 00 19100 RESEARCH	0	0		0	0		191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0	0		192.00
193. 00 19300 NONPALD WORKERS	0	0		0	0		193.00
193. 01 19301 NONPALD WORKERS	0	0		0	0		193.01 194.00
194. 00 07950 OTHER NONREI MBURSABLE COST CENTERS	0	0		0	0		194.00
194. 01 07951 WORKING WELL	0	0		0	0		194.01
194. 03 07953 OTHER NONREI MBURSABLE COST CENTERS 194. 10 07960 DUNELAND FI TNESS CTR	0	0		0	0		194.03
194. 11 07961 0MNI HEALTH & FITNESS CHESTERTOWN	0	0		0	0		194.10
194. 16 07966 PHYSICIAN PRACTICE MD WISW	0	0		0	0		194.11
194. 1907969 HEALTH PARTNERS	0	0		0	0		194.16
194. 20 07970 CENTER OF HOPE	0	0		0	0		194.19
200.00 Cross Foot Adjustments	0	0		U	0		200.00
201.00 Negative Cost Centers		^		0	0		200.00
202.00 TOTAL (sum lines 118 through 201)	1, 899, 663	0		0	0		201.00
	1,077,003	0	Т	9	0	0	202.00

COST /	ALLOCATION - GENERAL SERVICE COSTS		Provider C	CN: 15-0015	Peri od:	Worksheet B	
					From 01/01/2017 To 12/31/2017	Date/Time Pre	
		INTERNS &	RESI DENTS			5/30/2018 6:0	06 pm
	Cost Center Description	SERVI CES-SALAR Y & FRI NGES	SERVICES-OTHER PRGMCOSTS	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		21.00	22.00	23.00	24.00	25.00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT					1	1.00
$\begin{array}{c} 2.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ \end{array}$	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY						2.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 13.00 14.00 15.00 16.00
18.00	01900 NONPHYSI CI AN ANESTHETI STS 02000 NURSI NG SCHOOL 02100 I &R SERVI CES-SALARY & FRI NGES APPRVD 02200 I &R SERVI CES-OTHER PRGM COSTS APPRVD 02300 PARAMED ED PRGM-(SPECI FY)	0	0		0		17.00 18.00 19.00 20.00 21.00 22.00 23.00
30. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	0	0		0 26, 174, 047	/ 0	30.00
31.00 32.00 33.00		0	0 0		0 5, 174, 852 0 0	2 0 0 0	32.00
34.00		0	0		0 0		
40.00 41.00		0	0		0 2, 872, 357 0 3, 894, 728		
43.00		0	0		0 999, 684		
44.00		0	0		0 0		
45.00 46.00		0	0				
F0 00	ANCI LLARY SERVICE COST CENTERS				0 17 200 221		
50.00 51.00	05000 OPERATING ROOM 05100 RECOVERY ROOM	0	0 0		0 17, 309, 231 0 0		
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0 2, 231, 672		52.00
	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 208, 605 0 8, 713, 879		
	05401 FSED RADIOLOGY - DIAGNOSTIC	0	0		0 3, 122, 333		
	05500 RADI OLOGY-THERAPEUTI C	0	0		0 3, 999, 875	5 0	
55. 01 56. 00		0	0		0 2, 851, 847		
57.00		0	0		0 0		
58.00		0	0		0 0	0 0	
59.00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	0	0		0 4, 695, 982 0 8, 617, 140		
60.00		0	0		0 1, 801, 952		
	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY				0)	61.00
62.00		0	0		0 0	0	
63.00 64.00		0	0				
65.00		0	0		0 2,000,042		
66.00		0	0		0 4, 629, 778		
67.00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0	0		0 0		
69.00		0	0		0 2, 676, 738		
	07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0	70.00
	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	0		0 1, 189, 652		
72.00 73.00	07200 I MPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	0		0 13, 468, 155 0 21, 354, 990		
74.00		0	0		0 0		
	07500 ASC (NON-DI STI NCT PART)	0	0		0 0	0	
76.00 77.00	03020 CV RESOURCE CTR 07700 ALLOGENEI C STEM CELL ACQUI SI TI ON	0	0 0		0 0		
00.05							
	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0 0		0 0		88.00 89.00

 FRANCI SCAN HEALTH MI CHI GAN CITY
 In Lieu of Form CMS-2552-10

 Provider CCN: 15-0015
 Period: Erom 01/01/2017
 Worksheet B

SUST ALLOONTON SERVICE SERVICE SUSTS			SN. 13 0013	From 01/01/2017 To 12/31/2017		
	INTERNS & F	RESIDENTS				
Cost Center Description	SERVI CES-SALARS	ERVI CES-OTHER	PARAMED ED	Subtotal	Intern &	
	Y & FRINGES	PRGM COSTS	PRGM		Residents Cost	
					& Post	
					Stepdown	
					Adjustments	
	21.00	22.00	23.00	24.00	25.00	
90. 00 09000 CLINIC	0	0		0 0	-	
90. 03 09003 I NFUSI ON OP SERVI CES	0	0		0 1,062,775		90.03
91.00 09100 EMERGENCY	0	0		0 11, 700, 942		91.00
91. 01 09101 FREE STANDING EMERGENCY DEPT	0	0		0 5, 795, 559		91.01
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)					0	92.00
OTHER REI MBURSABLE COST CENTERS		0				0.4.00
94.00 09400 HOME PROGRAM DI ALYSI S	0	0		0 0	-	94.00
95. 00 09500 AMBULANCE SERVICES	0	0		0 0	-	95.00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	0	0		0 0	0	
97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD	0	0		0 0	0	97.00
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0	0		0 0	0	98.00
99. 00 09900 CMHC	0	0			0	
99. 10 09910 CORF	0	0			0	
100.00 10000 I & SERVICES-NOT APPRVD PRGM	0	0				100.00
101.00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	U	0		0 0	0	101.00
105. 00 10500 KI DNEY ACQUI SI TI ON	0	0		0 0	0	105.00
106. 00 10600 HEART ACQUISITION	0	0				105.00
107. 00 10700 LI VER ACQUI SI TI ON	0	0				107.00
108. 00 10800 LUNG ACQUI SI TI ON	0	0				107.00
109. 00 10900 PANCREAS ACQUI SI TI ON	0	0				109.00
110. 00 11000 I NTESTI NAL ACQUI SI TI ON	0	0		0 0		110.00
111. 00 11100 SLET ACQUI SI TI ON	0	0		0 0		111.00
113.00 11300 INTEREST EXPENSE		-		-	-	113.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0		0 0	0	115.00
116. 00 11600 HOSPI CE				0 0	0	116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	0		0 156, 546, 815		118.00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 90, 561	0	190.00
191. 00 19100 RESEARCH	0	0		0 0	0	191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0 0	0	192.00
193.00 19300 NONPALD WORKERS	0	0		0 0	0	193.00
193.01 19301 NONPALD WORKERS	0	0		0 0		193.01
194.00079500THER NONREIMBURSABLE COST CENTERS	0	0		0 0	0	194.00
194.01 07951 WORKING WELL	0	0		0 3, 909, 961		194.01
194.03079530THER NONREIMBURSABLE COST CENTERS	0	0		0 584, 695		194.03
194. 10 07960 DUNELAND FI TNESS CTR	0	0		0 417,686		194. 10
194.11079610MNI HEALTH & FITNESS CHESTERTOWN	0	0		0 258, 246		194. 11
194. 16 07966 PHYSICIAN PRACTICE MD WISW	0	0		0 -196, 736		194.16
194. 19 07969 HEALTH PARTNERS	0	0		0 74, 916		194.19
194. 20 07970 CENTER OF HOPE	0	0		0 67,066		194.20
200.00 Cross Foot Adjustments	0	0		0 0		200.00
201.00 Negative Cost Centers	0	0		0		201.00
202.00 TOTAL (sum lines 118 through 201)		0		0 161, 753, 210	1 O	202.00

Heal t	h Fiı	nanci al	S	ystems	
COST	ALL0	CATI ON	-	GENERAL	SEF

In Lieu of Form CMS-2552-10

	Financial Systems FR	ANCI SCAN HEALTH	MI CHI GAN CI TY Provi der CCN: 15-0015	In Lieu of Form CM Period: Worksheet I From 01/01/2017 Part I To 12/31/2017 Date/Time I 5/30/2018 0	3 Prepared:
	Cost Center Description	Total 26.00		575072018	<u>5.00 pm</u>
	GENERAL SERVICE COST CENTERS	20.00			
1.00 2.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP				1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500 ADMI NI STRATI VE & GENERAL				5.00
6.00	00600 MAI NTENANCE & REPAI RS				6.00
7.00	00700 OPERATION OF PLANT				7.00
8.00 9.00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG				8.00 9.00
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				14.00
15.00 16.00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY				15.00 16.00
17.00	01700 SOCIAL SERVICE				17.00
18.00	01080 I NSERVI CE EDUCATI ON				18.00
19.00	01900 NONPHYSICIAN ANESTHETISTS				19.00
	02000 NURSI NG SCHOOL				20.00
21.00 22.00	02100 I & R SERVI CES-SALARY & FRI NGES APPRVD 02200 I & R SERVI CES-OTHER PRGM COSTS APPRVD				21.00 22.00
	02300 PARAMED ED PRGM-(SPECIFY)				23.00
	INPATIENT ROUTINE SERVICE COST CENTERS	· · · · · · · · · · · · · · · · · · ·			
30.00	03000 ADULTS & PEDIATRICS	26, 174, 047			30.00
31.00 32.00	03100 I NTENSI VE CARE UNI T	5, 174, 852			31.00 32.00
32.00	03200 CORONARY CARE UNIT 03300 BURN INTENSIVE CARE UNIT	0			32.00
34.00	03400 SURGI CAL I NTENSI VE CARE UNI T	0			34.00
40.00	04000 SUBPROVI DER – I PF	2, 872, 357			40.00
41.00	04100 SUBPROVIDER - IRF	3, 894, 728			41.00
43.00 44.00	04300 NURSERY 04400 SKI LLED NURSI NG FACI LI TY	999, 684 0			43.00 44.00
45.00	04500 NURSING FACILITY	0			45.00
46.00	04600 OTHER LONG TERM CARE	0			46.00
50.00	ANCI LLARY SERVICE COST CENTERS	47.000.004			
50.00 51.00	05000 OPERATING ROOM 05100 RECOVERY ROOM	17, 309, 231			50.00 51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	2, 231, 672			52.00
53.00	05300 ANESTHESI OLOGY	208, 605			53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	8, 713, 879			54.00
54. 01 55. 00	05401 FSED RADI OLOGY - DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	3, 122, 333 3, 999, 875			54.01 55.00
55.00	05501 WOODLAND CANCER CARE CTR	2, 851, 847			55.00
56.00	05600 RADI OI SOTOPE	0			56.00
	05700 CT SCAN	0			57.00
	05800 MAGNETIC RESONANCE I MAGI NG (MRI)	0			58.00
59.00 60.00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	4, 695, 982 8, 617, 140			59.00 60.00
60.00	06001 FS ED LAB	1, 801, 952			60.00
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0			61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0			62.00
63.00 64.00	06300 BLOOD STORI NG, PROCESSI NG & TRANS. 06400 I NTRAVENOUS THERAPY	0			63.00 64.00
65.00	06500 RESPIRATORY THERAPY	2,000,042			65.00
66.00	06600 PHYSI CAL THERAPY	4, 629, 778			66.00
67.00	06700 OCCUPATI ONAL THERAPY	0			67.00
68.00	06800 SPEECH PATHOLOGY	0			68.00
69.00 70.00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	2, 676, 738			69.00 70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 189, 652			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	13, 468, 155			72.00
	07300 DRUGS CHARGED TO PATIENTS	21, 354, 990			73.00
74.00 75.00	07400 RENAL DI ALYSI S 07500 ASC (NON-DI STI NCT PART)	0			74.00 75.00
	03020 CV RESOURCE CTR	0			75.00
	07700 ALLOGENEIC STEM CELL ACQUISITION	0			77.00
	OUTPATIENT SERVICE COST CENTERS				
	08800 RURAL HEALTH CLINIC	0			88.00
	08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC	0			89.00 90.00
	09003 I NFUSI ON OP SERVI CES	1, 062, 775			90.03
91.00	09100 EMERGENCY	11, 700, 942			91.00
91.01	09101 FREE STANDING EMERGENCY DEPT	5, 795, 559			91.01

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)

92.00

Health Financial Systems

	FRANCI SCAN	HEALTH	MI CHI GAN	CLTY	
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Health Financial Systems FR	ANCISCAN HEALIH	MICHIGAN CITY	In Lieu of Form (JMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 15-0015	Period: Worksheet	В
			From 01/01/2017 Part I	D
			To 12/31/2017 Date/Time 5/30/2018	
Cost Center Description	Total		57 307 2018	0.00 pili
cost center bescription	26.00			
OTHER REIMBURSABLE COST CENTERS	20.00		· · · · · · · · · · · · · · · · · · ·	
94. 00 09400 HOME PROGRAM DI ALYSI S	0			94.00
95. 00 09500 AMBULANCE SERVICES	0			95.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0			96.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0			97.00
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0			98.00
99. 00 09900 CMHC	0			99.00
99. 10 09910 CORF	0			99.10
100.00 10000 I & SERVICES-NOT APPRVD PRGM	0			100.00
	0			100.00
101.00 10100 HOME HEALTH AGENCY	U U			101.00
SPECIAL PURPOSE COST CENTERS				105 00
105. 00 10500 KI DNEY ACQUI SI TI ON	0			105.00
106. 00 10600 HEART ACQUI SI TI ON	0			106.00
107. 00 10700 LI VER ACQUI SI TI ON	0			107.00
108.00 10800 LUNG ACQUISITION	0			108.00
109. 00 10900 PANCREAS ACQUI SI TI ON	0			109.00
110. 00 11000 I NTESTI NAL ACQUI SI TI ON	0			110.00
111.00 11100 I SLET ACQUI SI TI ON	0			111.00
113.00 11300 I NTEREST EXPENSE				113.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF				114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0			115.00
116.00 11600 HOSPI CE	0			116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	156, 546, 815			118.00
NONREI MBURSABLE COST CENTERS	1			
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	90, 561			190.00
191. 00 19100 RESEARCH	0			191.00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	0			192.00
193.00 19300 NONPALD WORKERS	0			193.00
193.01 19301 NONPALD WORKERS	0			193. 01
194.00079500THER NONREIMBURSABLE COST CENTERS	0			194.00
194.01 07951 WORKING WELL	3, 909, 961			194.01
194.03079530THER NONREIMBURSABLE COST CENTERS	584, 695			194.03
194. 10 07960 DUNELAND FITNESS CTR	417, 686			194.10
194.11079610MNI HEALTH & FITNESS CHESTERTOWN	258, 246			194.11
194.1607966 PHYSICIAN PRACTICE MD WISW	-196, 736			194.16
194.1907969 HEALTH PARTNERS	74, 916			194.19
194.2007970 CENTER OF HOPE	67, 066			194.20
200.00 Cross Foot Adjustments	0			200.00
201.00 Negative Cost Centers	0			201.00
202.00 TOTAL (sum lines 118 through 201)	161, 753, 210			202.00
				-

ALLOCA	Financial Systems Fi TION OF CAPITAL RELATED COSTS	RANCI SCAN HEALTH	Provider C	CN: 15-0015 Pe Fi To	eriod: com 01/01/2017	u of Form CMS-2 Worksheet B Part II Date/Time Pre 5/30/2018 6:0	pared:
			CAPI TAL REI	LATED COSTS			
	Cost Center Description	Directly Assigned New Capital	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		Related Costs 0	1.00	2.00	2A	4.00	
1 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT						1 1 00
1.00 2.00	00200 CAP REL COSTS-BLDG & FIXT						1.00 2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	86, 223	12, 380	98, 603	98, 603	4.00
5.00	00500 ADMI NI STRATI VE & GENERAL	0	1, 290, 803	1, 323, 839	2, 614, 642	9, 903	5.00
5.00	00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT	0	0	0	0	0	
7.00 3.00	00800 LAUNDRY & LINEN SERVICE	0	1, 125, 873 99, 401	2, 257, 039 110	3, 382, 912 99, 511	4, 850 0	
9.00	00900 HOUSEKEEPING	0	163, 194		170, 926	2, 460	
10.00	01000 DI ETARY	0	71, 214		90, 896	705	
11.00		0	168, 902		168, 902	1, 860	
13.00 14.00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	0	40, 602 157, 033		215, 495 245, 498	4, 482 236	
	01500 PHARMACY	0	75, 115		77, 661	4, 527	
16.00	01600 MEDICAL RECORDS & LIBRARY	0	69, 549		289, 448	20	
	01700 SOCIAL SERVICE	0	0	0	0	0	17.00
	01080 I NSERVI CE EDUCATI ON 01900 NONPHYSI CI AN ANESTHETI STS	0	0	0	0	0	18.00 19.00
	02000 NURSI NG SCHOOL	0	0	0	0	0	20.00
21.00	02100 I &R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
23.00	02300 PARAMED ED PRGM-(SPECIFY) I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0	0	0	0	0	23.00
30.00	03000 ADULTS & PEDIATRICS	0	1, 563, 174	179, 754	1, 742, 928	18, 647	30.00
31.00	03100 I NTENSI VE CARE UNI T	0	140, 264	182, 128	322, 392	4, 249	1
32.00	03200 CORONARY CARE UNI T	0	0	0	0	0	
33.00	03300 BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
34.00 10.00	03400 SURGI CAL I NTENSI VE CARE UNI T 04000 SUBPROVI DER – I PF	0	148, 899	11, 408	160, 307	0 2, 116	34.00 40.00
41.00	04100 SUBPROVI DER – I RF	0	269, 492		314, 261	2, 705	1
43.00	04300 NURSERY	0	21, 383		21, 710	797	43.00
44.00	04400 SKI LLED NURSI NG FACI LI TY	0	0	0	0	0	
45.00 46.00	04500 NURSING FACILITY 04600 OTHER LONG TERM CARE	0	0	0	0	0	
+0. 00	ANCI LLARY SERVICE COST CENTERS	0	0	0	0	0	40.00
50.00	05000 OPERATING ROOM	0	449, 812	1, 310, 235	1, 760, 047	9, 745	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
52.00 53.00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY	0	171, 543 12, 987		171, 543 20, 123	1, 430 78	
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	430, 736		1, 250, 953		54.00
54.01	05401 FSED RADIOLOGY - DIAGNOSTIC	0	68, 146		1, 064, 213	1, 464	
55.00	05500 RADI OLOGY-THERAPEUTI C	0	213, 025		474, 460	1, 272	
55.01 56.00	05501 WOODLAND CANCER CARE CTR 05600 RADI OI SOTOPE	0	254, 174	962	255, 136	1, 461 0	55.01 56.00
57.00	05700 CT SCAN	0	0	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	103, 016		1, 202, 018	1, 794	
50.00 50.01	06000 LABORATORY 06001 FS ED LAB	0	213, 572 30, 921		221, 023 31, 028	0	60.00 60.01
51.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	50, 721	107	0 0 0	0	61.00
52.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
53.00	06300 BLOOD STORI NG, PROCESSI NG & TRANS.	0	0	0	0	0	
54.00 55.00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	0	0 47, 643	0 29, 809	0 77, 452	0 1, 829	64.00 65.00
55.00 56.00	06600 PHYSI CAL THERAPY	0	32, 824		45, 764	1, 829	1
57.00	06700 OCCUPATI ONAL THERAPY	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	
59.00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	0	131, 630	152, 750	284, 380	1, 833	
	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	0	
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
	07400 RENAL DI ALYSI S	0	0	0	0	0	74.00
75.00 76.00	07500 ASC (NON-DI STINCT PART) 03020 CV RESOURCE CTR	0	0		0	0	75.00 76.00
	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	
	OUTPATIENT SERVICE COST CENTERS		-	-	-		
	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	-	0	0 0	
n n n				0	0		

leal th Financial Systems FR		MICHIGAN CITY		Peri od:	eu of Form CMS-2 Worksheet B	2002 1
			N. 13 0013	From 01/01/2017 To 12/31/2017	Part II	pared: 6 pm
		CAPI TAL REL	ATED COSTS			
Cost Center Description	Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFI TS DEPARTMENT	
	0	1.00	2.00	2A	4.00	
PO. 03 09003 INFUSION OP SERVICES	0	33, 134	2, 75	56 35, 890	564	90.03
91. 00 09100 EMERGENCY	0	477, 903	125, 08	602, 987	6, 740	91.00
91.01 09101 FREE STANDING EMERGENCY DEPT	0	508, 562	537, 48			91.01
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
OTHER REI MBURSABLE COST CENTERS						
94.00 09400 HOME PROGRAM DI ALYSI S	0	0		0 0	0	94.00
25. 00 09500 AMBULANCE SERVICES	0	0		0 0		95.00
26.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0		0 0	0	96.00
	0	0		0 0	0	97.00 98.00
78.00 09850 OTHER REI MBURSABLE COST CENTERS 79.00 09900 CMHC	0	0		0 0	0	98.00
99. 10 09910 CORF	0	0				99.00
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0		0 0	-	100.00
101.00 10100 HOME HEALTH AGENCY	0	0		0 0		101.00
SPECIAL PURPOSE COST CENTERS	0	0		0 0	0	101.00
105. 00 10500 KI DNEY ACQUI SI TI ON	0	0		0 0	0	105.00
106. 00 10600 HEART ACQUI SI TI ON	0	0		0 0		106.00
107. 00 10700 LIVER ACQUISITION	0	0		0 0		107.00
108.00 10800 LUNG ACQUISITION	0	0		0 0		108.00
109. 00 10900 PANCREAS ACQUI SI TI ON	0	0		0 0		109.00
110.00 11000 INTESTINAL ACQUISITION	0	0		0 0		110.00
111.00 11100 I SLET ACQUI SI TI ON	0	0		0 0	0	111.00
113.00 11300 INTEREST EXPENSE						113.00
114.00 11400 UTILIZATION REVIEW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0		0 0	0	115.00
116. 00 11600 HOSPI CE	0	0		0 0	0	116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	8, 670, 749	9, 888, 40	18, 559, 157	95, 211	118.00
NONREI MBURSABLE COST CENTERS	1					
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	23, 429		0 23, 429		190.00
191. 00 19100 RESEARCH	0	0		0 0		191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0 0		192.00
193. 00 19300 NONPALD WORKERS	0	0		0 0		193.00
193. 01 19301 NONPALD WORKERS	0	0		0 0		193. 0 ⁻
194.00 07950 OTHER NONREI MBURSABLE COST CENTERS	0	0	10/ 00			194.0
194.01 07951 WORKING WELL 194.03 07953 OTHER NONREIMBURSABLE COST CENTERS	0	0 144, 617	106, 90			194. 0 [°] 194. 0
194. 03/07953/0THER NONREIMBURSABLE COST CENTERS	0	144, 617 108, 059	20, 16	59 164, 786 0 108, 059		194. 0.
194. 10 07960 DUNELAND FITNESS CTR 194. 11 07961 OMNI HEALTH & FITNESS CHESTERTOWN	0	108, 059	204, 08			194. 10 194. 1
194. 1607966 PHYSICIAN PRACTICE MD WISW	0	0	204, 08 5, 76			194. 1
194. 19/07969 HEALTH PARTNERS	0	0	26, 83			194. 1
194. 20 07970 CENTER OF HOPE	0	0	20, 03			194. 2
200.00 Cross Foot Adjustments		0	0.	0,1	/ /3	200.00
201.00 Negative Cost Centers		0		0 0	0	200.00
	1	0				

	A Financial Systems F ATION OF CAPITAL RELATED COSTS	RANCI SCAN HEALTH		CCN: 15-0015 F	Period: From 01/01/2017 To 12/31/2017	wu of Form CMS-: Worksheet B Part II Date/Time Pre	
				_		5/30/2018 6:0)6 pm
	Cost Center Description	ADMI NI STRATI VE & GENERAL	REPAI RS	OPERATION OF	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
	GENERAL SERVICE COST CENTERS	5.00	6.00	7.00	8.00	9.00	-
00	00100 CAP REL COSTS-BLDG & FIXT						1 1.0
00	00200 CAP REL COSTS-MVBLE EQUIP						2.
00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. (
00	00500 ADMI NI STRATI VE & GENERAL	2, 624, 545					5.0
00	00600 MAI NTENANCE & REPAI RS 00700 OPERATI ON OF PLANT	219, 299		3, 607, 061			6.
00	00800 LAUNDRY & LINEN SERVICE	10, 460		5, 007, 00			8.
00	00900 HOUSEKEEPI NG	43, 769		91, 349		308, 504	
D. 00	01000 DI ETARY	14, 508		39, 863	3 66	3, 554	10.
1.00	01100 CAFETERI A	27, 598		94, 545		8, 430	
3.00	01300 NURSING ADMINISTRATION	83, 071		22, 727 0 87, 901		2,026	
4.00 5.00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	34, 940 338, 517		0 87,901 0 42,046		7,837 3,749	
5.00		27,810		38, 931		3, 471	
7.00		0				0	17.
3. 00		0		o (-	0	
9.00		0			0	0	
D. 00 1. 00	02000 NURSING SCHOOL 02100 I &R SERVICES-SALARY & FRINGES APPRVD	0				0	
2.00		0			-	0	
3.00		0			0 0	0	
	INPATIENT ROUTINE SERVICE COST CENTERS				1		
0.00	03000 ADULTS & PEDIATRICS	300, 252		875,000			
1.00 2.00		64, 018		2 78, 514 2 0		7,000	
2.00 3.00	03300 BURN INTENSIVE CARE UNIT	0			-	0	
4.00		0			0 0	0	
0. 00	04000 SUBPROVIDER - IPF	32, 088		83, 347	7 18, 217	7, 431	40.
I. 00		44, 798		0 150, 851		13, 450	
3.00	04300 NURSERY	12, 771		0 11,970		1,067	
4.00 5.00	04400 SKILLED NURSING FACILITY 04500 NURSING FACILITY	0			-	0	
5.00		0				0	
	ANCI LLARY SERVI CE COST CENTERS						
0. 00	05000 OPERATING ROOM	206, 897		251, 786		22, 450	
1.00		0				0	
2.00 3.00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY	25, 625 2, 546		0 96, 022 0 7, 270		8, 561 648	
4.00	05400 RADI OLOGY-DI AGNOSTI C	113, 835		241, 108		21, 497	
4. 01	05401 FSED RADIOLOGY - DIAGNOSTIC	45, 981		38, 145		3, 401	
5.00	05500 RADI OLOGY-THERAPEUTI C	54, 592		0 119, 243		10, 632	
5. 01	05501 WOODLAND CANCER CARE CTR	32, 527		D 142, 276			
5.00 7.00		0				0	56. 57.
3. 00		0				0	
9.00		62, 368		57,664	-	-	
0. 00	06000 LABORATORY	127, 861	(0 119, 549		10, 659	60.
). 01		27, 462		D 17, 309	9 0	1, 543	
00		0				0	61.
2.00 3.00		0				0	
I. 00		0			0 0	0	
5.00		28, 631		26, 668	3 0	2, 378	65.
5.00		71, 209		18, 374			
. 00		0			-	0	
3.00 9.00		0 34, 308		0 (0 73,681	0 0 I 828	0 6, 569	
). 00		0,308		0 , 3, 08	0 0	0, 309	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	18, 306			0	0	
. 00		217, 210	(o (0 0	0	
	07300 DRUGS CHARGED TO PATIENTS	0			0	0	
. 00		0				0	
5.00 5.00	07500 ASC (NON-DI STINCT PART) 03020 CV RESOURCE CTR	0				0	
	07700 ALLOGENEIC STEM CELL ACQUISITION	0			-		
	OUTPATIENT SERVICE COST CENTERS						1
3. 00	08800 RURAL HEALTH CLINIC	0		о (0	
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0			0	0	
). 00		0				0	
). 03 1. 00	09003 I NFUSI ON OP SERVI CES 09100 EMERGENCY	14, 112 149, 878		0 18, 547 0 267, 510		1, 654 23, 852	
	09100 EMERGENCY 09101 FREE STANDING EMERGENCY DEPT	65, 043		287, 510			
		00,010			5, 521	1 20,002	1 1 1

Heal th	Fi nanci	ial Syst	ems
ALL 00A		OADL TAL	

Health Financial Systems FF	RANCISCAN HEALIF	I MICHIGAN CIT	ſ	In Lie	U OF FORM CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider C	F	Period: From 01/01/2017 Fo 12/31/2017		epared:
Cast Canton Description	ADMI NI STRATI VE		OPERATION OF	LAUNDRY &	5/30/2018 6:0 HOUSEKEEPI NG	06 pm
Cost Center Description	& GENERAL	REPAIRS	PLANT	LINEN SERVICE	HUUSEKEEPING	
	5.00	6.00	7.00	8.00	9.00	
OTHER REIMBURSABLE COST CENTERS	0.00	0.00	7.00	0.00	7.00	
94. 00 09400 HOME PROGRAM DI ALYSI S	0	0	(0	0	94.00
95. 00 09500 AMBULANCE SERVICES	0	0			0	
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	(0	96.00
97. 00 09700 DURABLE MEDICAL EQUI P-SOLD	0	0	(0	0	97.00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	0	(0	0	98.00
99. 00 09900 CMHC	0	0	(0	0	
99. 10 09910 CORF	0	0	(-	0	
100.00 10000 I &R SERVICES-NOT APPRVD PRGM	0	0		0	0	100.00
101. 00 10100 HOME HEALTH AGENCY	0	0				101.00
SPECIAL PURPOSE COST CENTERS	<u> </u>	0	1			101.00
105. 00 10500 KI DNEY ACQUI SI TI ON	0	C	(0 0	0	105.00
106. 00 10600 HEART ACQUI SI TI ON	0	0	(106.00
107. 00 10700 LI VER ACQUI SI TI ON	0	0	(-		107.00
108. 00 10800 LUNG ACQUISITION	0	0		0		108.00
109. 00 10900 PANCREAS ACQUISITION	0	0	(0		109.00
110. 00 11000 I NTESTI NAL ACQUI SI TI ON	0	0		0		110.00
111. 00 11100 I SLET ACQUI SI TI ON	0	0				111.00
113. 00 11300 I NTEREST EXPENSE	Ű	0		5	0	113.00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF						114.00
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0			0	115.00
116. 00 11600 HOSPI CE	0	0				116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	2, 552, 290	0		157, 330		•
NONREI MBURSABLE COST CENTERS	2, 332, 270	0	J 3, 432, 300	137, 330	274,724	110.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	481	0	13, 115	5 0	1 160	190.00
191. 00 19100 RESEARCH		0	10, 11			191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0				192.00
193. 00 19300 NONPALD WORKERS	0	0				193.00
193. 01 19301 NONPALD WORKERS	0	0				193.01
194. 00 07950 OTHER NONREI MBURSABLE COST CENTERS	0	0				194.00
194. 01/07951 WORKING WELL	60, 452	0		,		194.00
194. 03 07953 OTHER NONREIMBURSABLE COST CENTERS	3, 387	0	80, 95	-		194.01
194. 10 07960 DUNELAND FI TNESS CTR	2, 220	0	60, 48			194.03
194. 11 07961 OMNI HEALTH & FITNESS CHESTERTOWN	4, 179	0	00,40			194.10
194. 16 07966 PHYSICIAN PRACTICE MD WISW	4, 177	0				194.16
194. 19 07969 HEALTH PARTNERS	520	0		8, 281		194.10
194. 20 07970 CENTER OF HOPE	1,016	0		0,201		194.20
200.00 Cross Foot Adjustments	1,010	U			0	200.00
201.00 Negative Cost Centers		C			0	200.00
201.00 TOTAL (sum Lines 118 through 201)	2, 624, 545	0		1 165, 611		
	2, 024, 040	U	J 3,007,00	105,011	500, 504	1202.00

Cost Genter Description DITARY CATTERIA RUGSING CITERIA PRIMINGY ID 00 11.00 13.00 14.00 15.00 15.00 ID 00 00000 2000 15.00 15.00 15.00 ID 00 00000 ENERGIAL SERVICE COST CENTERS 15.00 15.00 15.00 ID 000000 ENERGIAL SERVICE COST CENTERS 15.00 15.00 5.00 ID 000000 ENERGIAL SERVICE COST CENTERS 15.00 5.00 5.00 ID 000000 ENERGIAL SERVICE COST CENTERS 15.00 5.00 5.00 ID 000000 ENERGIAL SERVICE COST CENTERS 15.00 5.00 5.00 ID 000000 ENERGIAL SERVICE COST CENTERS 15.00 5.00 5.00 ID 000000 ENERGIAL SERVICE COST CENTERS 140.02 201.33 201.33 201.33 201.33 201.33 201.33 201.33 201.33 201.33 201.33 201.33 201.33 201		Financial Systems FR TION OF CAPITAL RELATED COSTS	ANCI SCAN HEALTH	Provi der C	CN: 15-0015 Pe	eriod: com 01/01/2017	u of Form CMS-2 Worksheet B Part II Date/Time Pre 5/30/2018 6:0	pared:	
CEREMAL SERVICE COST COST COST COST COST COST COST COST		Cost Center Description	DI ETARY	CAFETERI A		SERVICES &			
100 000000 00000 00000			10.00	11.00	13.00	14.00	15.00		
18. 00 01000 INSERVICE EDUCATION 0 </td <td>$\begin{array}{c} 2.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ \end{array}$</td> <td>00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUI P 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY</td> <td>149, 592 0 0 0 0 0 0 0</td> <td>16, 644 1, 678 14, 021 109</td> <td>344, 445 0 0 0 0</td> <td>2, 651</td> <td>0</td> <td>16.00</td>	$\begin{array}{c} 2.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ \end{array}$	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUI P 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	149, 592 0 0 0 0 0 0 0	16, 644 1, 678 14, 021 109	344, 445 0 0 0 0	2, 651	0	16.00	
90.00 03000 ADULTS & PEDIATRICS 97.481 68.369 111.261 19.004 0 <t< td=""><td>19.00 20.00 21.00 22.00</td><td>01900 NONPHYSICIAN ANESTHETISTS 02000 NURSING SCHOOL 02100 I&R SERVICES-SALARY & FRINGES APPRVD 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD 02300 PARAMED ED PRGM-(SPECIFY)</td><td>0 0 0 0 0</td><td>0 0 0 0 0 0</td><td></td><td>-</td><td>0 0 0 0</td><td></td></t<>	19.00 20.00 21.00 22.00	01900 NONPHYSICIAN ANESTHETISTS 02000 NURSING SCHOOL 02100 I&R SERVICES-SALARY & FRINGES APPRVD 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD 02300 PARAMED ED PRGM-(SPECIFY)	0 0 0 0 0	0 0 0 0 0 0		-	0 0 0 0		
92.00 03200 CORENARY CARE UNIT 0		03000 ADULTS & PEDI ATRI CS	97, 481	68, 369	111, 261		0	30.00	
33 00 03300 00 0<			14, 361					31.00	
94.00 03400 USE 03400 03400 0400 04000 04000 04000 04000 04000 04000 04000 04000 04000 04000 041000 041000 041000 041000 0410000 0410000 0410000 04100000 04100000 041000000 0410000000 04100000000000000000000000000000000000			0	0		0	-		
40.00 Q4000 SUBPROVIDER - I FF 17,576 9,595 12,842 207 0 40.00 41.00 Q4300 SUBPROVIDER - I FF 14,433 10,579 11,174 0 10.00 43.00 Q4300 NURSERY 5,741 2,650 5,859 0 0 0 0 43.00 44.00 Q4400 DFREN IDRE TERM CARE 0 0 0 0 0 0 45.00 64.00 QFENTIES ING FACILITY 0 0 0 0 0 0 0 0 0 0 45.00 64.00 QFENTIES INGOM 0 41.441 55.240 266.01 51.00 55.00			0	0	Ű	0	-	34.00	
43.00 Q4300 NUSSERY 5,741 2,650 5,859 0 0 43.00 44.00 Q4400 SKILLEP NURSING FACILITY 0 0 0 0 0 43.00 44.00 Q4600 SKILLEP NURSING FACILITY 0 0 0 0 0 43.00 46.00 Q4600 OTHER 1006 FRM CARE 0 0 0 0 0 0 0 0 0 0 44.00 50.00 OSD00 OPERATING ROM 0 41.441 55.240 266.641 0 55.00 0 55.00 0 55.00 0 55.00 0 55.00 0 55.00 0 55.00 0 55.00 0 55.00 0 55.00 0 55.00 <td></td> <td></td> <td>17, 576</td> <td>9, 595</td> <td>12, 842</td> <td>207</td> <td></td> <td>40.00</td>			17, 576	9, 595	12, 842	207		40.00	
44 00 0 0 0 0 0 0 44 00 45 00 04600 OWESIN & FACILITY 0	41.00	04100 SUBPROVI DER – I RF	14, 433	10, 579	11, 946	1, 174	0	41.00	
45.00 Description Description <thdescription< th=""> <thd< td=""><td></td><td></td><td>5, 741</td><td>2,650</td><td>5, 859</td><td>0</td><td>0</td><td>43.00</td></thd<></thdescription<>			5, 741	2,650	5, 859	0	0	43.00	
46. CO 0 0 0 0 0 60 ANCILLARY SERVICE COST CENTES			0	0	-	0		44.00	
ANCILLARY SERVICE COST CENTERS Image: Control of Control Control of Control of Control of Co			0	0		0	-	•	
50:00 050000 DEFRATING ROM 0 41.41 55.240 266.641 0 50.0 51:00 05000 RECOVERY ROM 0	46.00		0	U	ין U	U	0	46.00	
51:00 05:00 0 0 0 0 0 0 51:00 52:00 05:200 DELIVERY ROOM & LABOR ROOM 0 75:0 0	50 00		0	41 441	55 240	266 641	0	50 00	
53.00 OS300 ANESTHESI OLOGY 0 53.0 0 0 53.0 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 2,939 2,865 10,245 0 54.0 55.00 05500 RADI OLOGY - THERAPEUTI C 0 3,787 0 53.8 0 55.0 56.00 05500 RADI OLOGY - THERAPEUTI C 0 3,787 0 53.8 0 55.0 56.00 0500 RADI OL SOTOPE 0 0 0 0 0 55.0 57.00 05700 CT SCAN 0 0 0 0 0 57.00 57.00 0 0 0 0 58.00 0 59.00 05900 CARNIA C CATHETRER ZATI ON 0 57.726 8.968 48.921 0 60.0 60.00 </td <td></td> <td></td> <td>0</td> <td></td> <td></td> <td></td> <td>-</td> <td></td>			0				-		
54.00 05400 RADI OLOGY - DI AGNOSTI C 0 52,939 2,865 10,245 0 54.01 54.01 05401 FSED RADI OLOGY - THERAPEUTI C 0 3,787 0 1,501 0 55.00 55.00 55.00 55.00 55.01 055.01 055.01 055.01 055.00 55.00 0 56.00 55.00 0 0 0 0 0 0 0 56.00 55.00 0 0 0 0 0 0 0 0 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 58.00 50.00 50.00 50.00 50.00 50.00	52.00	05200 DELIVERY ROOM & LABOR ROOM	0	4, 754	10, 498	0	0	52.00	
54.01 05401 FSED RADIOLOGY - DIAGNOSTIC 0 57.87 0 1.501 0 54.00 55.00 0500 RADIOLOGY - THERAPEUTIC 0 3.787 0 538 0 55.00 55.01 05501 WOODLAND CANCER CARE CTR 0			0			0	0	53.00	
55:00 PS500 RADIOLOGY-THERAPEUTIC 0 3,787 0 538 0 55.00 55:01 05501 WODDLAND CANCER CARE CTR 0 5.00 7.438 1,659 0 55.00 56:00 05600 RADIOLOGY-THERAPEUTIC 0 0 0 0 0 0 0 55.00 56:00 05600 RADIOLOGY-THERAPEUTIC 0 0 0 0 0 0 0 0 0 55.00 58:00 05500 RADIOLOGY-THERAPEUTIC MAGINA 0			0				0	54.00	
55.01 05501 0000LAND CANCER CARE CTR 0 5.404 7,438 1,659 0 56.00 56.00 05000 RADIOI SOTOPE 0 0 0 0 0 55.00 57.00 05700 CT SCAN 0 0 0 0 0 0 57.00 59.00 05700 CARDAC CATHETERIZATION 0 0 0 0 0 0 60.00 60.00 LABORATORY 0 0 0 0 0 0 60.00 60.01 06000 LABORATORY 0 0 0 0 0 60.00 61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY - - - 61.00 66.00 63.00 63.00 60.00 0 0 0 60.00 63.00 65.00 65.00 65.00 65.00 65.00 65.00 65.00 65.00 65.00 66.00 64.00 0 0 0 0 64.00 64.00 65.00 66.00 66.00 65.00 66.00 6			0				0		
56.00 05600 RXDI 01 SOTOPE 0 0 0 0 0 57.00 57.00 05700 CT SCAN 0 0 0 0 0 0 57.00 58.00 05800 (ARDI AC CATHETERI ZATI 0N 0 57.00 0 0 0 0 0 0 58.00 60.00 6000 (LABORATORY 0 0 0 0 311 0 60.00 60			0					1	
57.00 05700 CT SCAN 0 0 0 0 57.00 58.00 05800 CARDIAC CATHETERIZATION 0 0 0 0 59.00 60.00 06000 LABORATORY 0 0 0 0 0 60.00 60.01 06000 LABORATORY 0 0 0 0 0 60.00 60.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 0 0 0 0 60.00 61.00 06400 INTRAVENOUS THERN PROCESSING & TRANS. 0 0 0 0 63.00 63.00 06400 INTRAVENOUS THERAPY 0 0 0 0 64.00 64.00 06400 INTRAVENOUS THERAPY 0 7.797 16 2,252 65.00 65.00 06500 RESPI RATORY THERAPY 0 0 0 0 67.00 64.00 06400 STECH PATHOLOGY 0 0 0 0 67.00 65.00 06500 RESPI RATORY THERAPY 0 0 0 0 6			0				0	00.01	
59:00 OSYODE CARDIAC CATHETERIZATION 0 5,726 8,968 48,921 0 59:00 60:00 D60:00 LABORATORY 0 0 0 311 0 60:00 60:01 OSODE LABORATORY 0 0 0 311 0 60:00 60:00 D6000 PAP CLINICAL LAB SERVICES-PRGM ONLY 0 0 0 0 60:00 61:00 O6100 PBP CLINICAL LAB SERVICES-PRGM ONLY 0 0 0 0 60:00 62:00 00 0 0 0 62:00 00:000 0 0 0 62:00 00:000 0 0 0 62:00 00:000 0 0 63:00 06:00 0 0 0 64:00 0 64:00 64:00 64:00 64:00 65:00 06:00 PREYI RATORY THERAPY 0 5:68 5:37 1:342 0 66:00 0 67:00 0 0 0 0 0 0 0 0 0 0 0 0 0 <t< td=""><td></td><td></td><td>0</td><td>0</td><td>0</td><td>0</td><td></td><td>1</td></t<>			0	0	0	0		1	
60.00 06000 LABORATORY 0 0 311 0 60.01 60.01 06001 FS ED LAB 0 0 0 0 60.01 61.00 06000 LABORATORY 0 0 0 60.01 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 0 62.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 0 63.00 64.00 06400 INTERAPY 0 0 0 64.00 65.00 06500 RESPI RATORY THERAPY 0 7,797 16 2,252 65.00 66.00 06000 PHYSI CAL THERAPY 0 5,688 533 1,342 66.00 67.00 060700 CUPRTIONAL THERAPY 0 0 0 0 69.00 69.00 06900 ELECTROCARDIOLOGY 0 0 0 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00<	58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	C	0	0	0	58.00	
60.01 06001 FS ED LAB 0			0	5, 726	8, 968		-		
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66.00 06600 PHYSI CAL THERAPY 0 5,688 537 1,342 0 66.00 67.00 0CCUPATI ONAL THERAPY 0 0 0 0 0 67.00 68.00 06800 SPEECH PATHOLOGY 0 0 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0 7,164 6,608 889 0 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 70.00 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 0 0 72.00 72.00 07200 I MPL. DEV. CHARGED TO PATI ENTS 0 0 0 73.00 73.00 7300 DRUGS CHARGED TO PATI ENTS 0 0 0 73.00 73.00 74.00 0 0 0 0 74.00 74.00 74.00 74.00 74.00 74.00 75.00 0 0 0 0 75.00 75.00 75.00 75.00 76.00 0 0 0 76.00 76.00 76.00			0	C		0	0		
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69.00 06900 ELECTROCARDI OLOGY 0 7,164 6,608 889 0 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 0 0 70.00 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 72.00 73.00 07300 RUGS CHARGED TO PATI ENTS 0 0 0 73.00 73.00 74.00 0400 RENAL DI ALYSI S 73.00 74.00 75.00 75.00 0500 ASC (NON-DI STI NCT PART) 0 0 0 0 74.00 76.00 75.00 75.00 00 0 0 0 76.00 76.00 76.00 76.00 76.00 76.00 76.00 77.00 77.00 77.00 77.00 0 0 0 0 0 77.00 77.00 07700 ALLOGENEI C STEM CELL ACOUI SI TI ON 0 0 0 0 0 0 0 <t< td=""><td></td><td></td><td>0</td><td>0</td><td></td><td>0</td><td>-</td><td></td></t<>			0	0		0	-		
70.00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 0 70.00 70			0	7, 164	6, 608	889	0	69.00	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 72.00 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 483,172 73.00 74.00 07400 RENAL DI ALYSIS 0 0 0 0 74.00 75.00 75.00 75.00 75.00 75.00 0 0 0 0 74.00 75.00 75.00 75.00 75.00 75.00 0 0 0 0 0 74.00 75.00 75.00 75.00 75.00 0 0 0 0 75.00 75.00 75.00 75.00 75.00 75.00 75.00 76.00			Ő	0	0	0	0		
73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 483,172 73.00 74.00 07400 RENAL DI ALYSI S 0 0 0 0 74.00 75.00 07500 ASC (NON-DI STINCT PART) 0 0 0 0 75.00 76.00 03020 CV RESOURCE CTR 0 0 0 0 76.00 77.00 0700 ALLOGENEI C STEM CELL ACQUI SI TI ON 0 0 0 0 77.00 00TPATI ENT SERVICE COST CENTERS 0 0 0 0 0 77.00 08800 RURAL HEALTH CLINIC 0 0 0 0 88.00 88.00 08800 FEDERALLY QUALI FIED HEALTH CENTER 0 0 0 89.00 90.00 09000 CLINIC 0 0 0 89.00 90.00 09000 CLINIC 0 0 0 90.00 90.00 09000 CLINIC 0 0 0 90.00 90.00 09000 ON OP SERVICES 0 2,120			0	C	0	0			
74.00 07400 RENAL DI ALYSI S 0 0 0 0 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 75.00 <th 75.0<="" td=""><td></td><td></td><td>0</td><td>0</td><td>0</td><td>0</td><td></td><td></td></th>	<td></td> <td></td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td></td> <td></td>			0	0	0	0		
75.00 07500 ASC (NON-DI STINCT PART) 0 0 0 0 75.00			0	0	0	0			
76.00 03020 CV RESOURCE CTR 0 0 0 0 76.00 77.00 00 0 0 0 0 0 0 77.00 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 77.00 00 0			0						
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION 0 0 0 0 77.00 OUTPATI ENT SERVICE COST CENTERS OUTPATI ENT SERVICE COST CENTERS 0 0 0 0 88.00 08900 RURAL HEALTH CLINIC 0 0 0 0 88.00 90.00 0 0 0 88.00 90.00 90.00 0 0 0 89.00 90.00 90.00 0 0 0 89.00 90.00 90.00 0 0 0 0 0 90.00 90.00 90.00 0			0	0	0	0			
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 89.00 90.00 09000 CLINIC 0 0 0 0 90.00 90.03 09003 INFUSION OP SERVICES 0 2,120 5,046 585 0 90.00 91.00 09100 EMERGENCY 0 25,687 46,272 10,369 0 91.00	77.00	07700 ALLOGENEI C STEM CELL ACQUI SI TI ON OUTPATI ENT SERVI CE COST CENTERS	0	0		0	0	77.00	
90. 00 09000 CLINIC 0 0 0 90. 00 90. 03 09003 INFUSION OP SERVICES 0 2, 120 5, 046 585 0 90. 03 91. 00 09100 EMERGENCY 0 25, 687 46, 272 10, 369 0 91. 00			0	C		0	-		
90. 03 09003 I NFUSI ON OP SERVICES 0 2, 120 5, 046 585 0 90. 03 91. 00 09100 EMERGENCY 0 25, 687 46, 272 10, 369 0 91. 00			0	0	0	0			
91. 00 09100 EMERGENCY 0 25, 687 46, 272 10, 369 0 91. 00			0	0 2 120		0	-		
			0					1	
		09101 FREE STANDING EMERGENCY DEPT	o	8, 442		1, 934			

Health Financial Systems FR	ANCISCAN HEALTH	MICHIGAN CITY	/	Inlie	u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CC	CN: 15-0015 P F	eriod: rom 01/01/2017 o 12/31/2017	Worksheet B Part II	pared:
Cost Center Description	DI ETARY		NURSI NG ADMI NI STRATI ON	SUPPLY	PHARMACY	
	10.00	11.00	13.00	14.00	15.00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS						
94.00 09400 HOME PROGRAM DI ALYSI S	0	0	0	0	0	
95. 00 09500 AMBULANCE SERVI CES	0	0	0	0	0	
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
99.00 09900 CMHC	0	0	0	0	0	99.00
99. 10 09910 CORF	0	0	0	0	0	99.10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00 10100 HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
105.00 10500 KIDNEY ACQUISITION	0	0	0	0	0	105.00
106.00 10600 HEART ACQUI SI TI ON	0	0	0	0	0	106.00
107.00 10700 LIVER ACQUISITION	0	0	0	0	0	107.00
108.00 10800 LUNG ACQUISITION	0	0	0	0	0	108.00
109.00 10900 PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00 11000 INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00 11100 I SLET ACQUI SI TI ON	0	0	0	0	0	111.00
113.00 11300 INTEREST EXPENSE						113.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	0	0	0	115.00
116. 00 11600 HOSPI CE	0	0	0	0	0	116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	149, 592	285, 298	340, 799	376, 887	483, 172	118.00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
191. 00 19100 RESEARCH	0	0	0	0	0	191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	0		192.00
193.00 19300 NONPALD WORKERS	0	0	0	0		193.00
193.01 19301 NONPALD WORKERS	0	0	0	0	0	193. 01
194.0007950 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.0107951 WORKING WELL	0	15, 786	3, 483	1, 202	0	194.01
194.03 07953 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.03
194. 10 07960 DUNELAND FI TNESS CTR	0	0	0	0	0	194.10
194.11079610MNI HEALTH & FITNESS CHESTERTOWN	0	0	0	1	0	194.11
194.16 07966 PHYSICIAN PRACTICE MD WISW	0	0	0	0		194. 16
194. 19 07969 HEALTH PARTNERS	0	5	0	0	0	194.19
194.2007970 CENTER OF HOPE	0	246	163	0	0	194.20
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	0	0	0		201.00
202.00 TOTAL (sum lines 118 through 201)	149, 592	301, 335	344, 445	378, 090	483, 172	202.00

11.00 01100 CAPETERIA 11.00 01100 CAPETERIA 13.00 01400 CENTRAL SERVICES & SUPPLY 11.00	<u>Health Financi</u> ALLOCATION OF	CAPITAL RELATED COSTS	FRANCI SCAN HEALTI		CN: 15-0015 F	Period: From 01/01/2017 To 12/31/2017	Date/Time Pre	pared:
LIBRARY I.O.0 19.00 19.00 29.00 1000 CONT CAP REL COST CENTERS 17.00 18.00 19.00 20.00 1000 CONT CAP REL COST CENTERS 17.00 18.00 19.00 20.00 1000 CARL COST SERVICE COST CENTERS 19.00	C	ost Center Description		SOCI AL SERVI CE	SERVI CE			6 pm
DEREMAL SERVICE COST CONTERS 0.00 00100 CAP REL COSTS-MUBLE EQUIP 0.0000 CAD NITESMUT & & PUBLISAL 0.0000 CAD NITESMUT & & SUPPLY 1.000 CHOOL DEL LERKA 1.000 CHOOL ONERVICE & SUPPLY			LI BRARY	17.00	18,00	19.00	20.00	
2.00 02000 CAP REL COSTS-MUELE FOUP PROVE BREFUTS DEPARTMENT 5 DEPARTM					1	T T	1	
23.00 Q2300 PARAMED ED PROM.(SPECIFY) Q Q Q Q INPARTLENT ROUTLES SERVICE COST CENTERS 30.00 30000 ADULTS & PEDIATRI CS 20.971 0	2.00 00200 C 4.00 00400 E 5.00 00500 A 6.00 00600 M 7.00 00700 0 8.00 00800 L 9.00 00900 H 10.00 01100 C 13.00 01300 N 14.00 01400 C 15.00 01500 P 16.00 01600 M 17.00 01700 S 18.00 01080 I 19.00 01900 N 20.00 02000 N 21.00 02100 I	AP REL COSTS-MVBLE EQUI P MPLOYEE BENEFITS DEPARTMENT DMI NI STRATI VE & GENERAL AI NTENANCE & REPAI RS PERATI ON OF PLANT AUNDRY & LI NEN SERVI CE OUSEKEEPI NG I ETARY AFETERI A URSI NG ADMI NI STRATI ON ENTRAL SERVI CES & SUPPLY HARMACY EDI CAL RECORDS & LI BRARY OCI AL SERVI CE NSERVI CE NSERVI CE NSERVI CE NSERVI CE NSERVI CE AN ANESTHETI STS URSI NG SCHOOL &R SERVI CES-SALARY & FRI NGES APPRVD	359, 789 0 0 0 0 0 0 0 0					21.00
30. 00 03000 ADULTS & PEDIATRICS 20, 971 0 0 31. 00 03000 INTENSIVE CARE UNIT 3, 187 0 0 32. 00 03200 CORONARY CARE UNIT 0 0 0 33. 00 03300 BURN INTENSIVE CARE UNIT 0 0 0 40. 00 04000 SUBGIGAL INTENSIVE CARE UNIT 0 0 0 41. 00 04000 SUBGROVIDER - IPF 2, 386 0 0 43. 00 04000 SUBROVIDER - IPF 2, 386 0 0 43. 00 04000 SUBRING FACILITY 0 0 0 44. 00 04000 SUBREAV FACILITY 0 0 0 45. 00 04600 ONFROVERY ROM 0 0 0 0 46. 00 04600 ONFROVERY ROM 0 0 0 0 50. 00 05000 OPERATING ROM 1.119 0 0 0 51. 00 05000 OPERATING ROMONTIC 10, 015 0 0 1 54. 00 05400 RADI LOGY - DI AGNOSTIC 10, 015 0 0 0 1 1	1 1		0		1			22.00 23.00
50.00 05000 0PERATI NG ROOM 64, 365 0 0 51.00 05100 RECOVERY ROOM & LABOR ROOM 1,119 0 0 52.00 05200 DELI VERY ROOM & LABOR ROOM 1,119 0 0 53.00 05300 ANESTHESI OLOGY 2,619 0 0 54.01 05401 FSED RADI OLOGY - DI AGNOSTI C 10,015 0 0 55.01 05501 RADI OLOGY - DI AGNOSTI C 10,015 0 0 55.01 05501 WODLAND CANCER CARE CTR 1,560 0 0 56.01 05500 GRADI OLOGY - THERAPEUTI C 8,073 0 0 0 57.00 05700 CT SCAN 0 0 0 0 0 58.00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0 0 0 0 0 59.00 05900 CARDI AC CATHETERI ZATI ON 11,511 0 0 0 0 60.00 06000 LABORATORY 30,329 0 0 0 0 0 61.00 06100 PBP CLINI CAL LAB SERVI CES-PRGM ONLY	INPATIE 30.00 03000 A 31.00 03100 I 32.00 03200 C 33.00 03300 B 34.00 03400 S 40.00 04000 S 41.00 04100 S 43.00 04400 S 45.00 04400 S 45.00 04400 S	NT ROUTINE SERVICE COST CENTERS DULTS & PEDIATRICS NTENSIVE CARE UNIT ORONARY CARE UNIT URN INTENSIVE CARE UNIT URGICAL INTENSIVE CARE UNIT UBPROVIDER - IPF UBPROVIDER - IRF URSERY KILLED NURSING FACILITY URSING FACILITY	3, 187 0 0 2, 386 3, 698 624 0 0					30. 00 31. 00 32. 00 33. 00 34. 00 40. 00 41. 00 43. 00 44. 00 45. 00 46. 00
51.00 05100 RECOVERY ROOM 0 0 52.00 05200 DELIVERY ROOM & LABOR ROOM 1,119 0 0 53.00 05300 ANESTHESI OLOGY 2,619 0 0 54.01 05401 RADI OLOGY-DI AGNOSTI C 47,342 0 0 54.01 05401 FSED RADI OLOGY - DI AGNOSTI C 10,015 0 0 55.01 05500 RADI OLOGY - THERAPEUTI C 8,073 0 0 55.01 05501 WODLAND CANCER CARE CTR 1,560 0 0 56.00 05600 RADI OL SOTOPE 0 0 0 2 57.00 05700 CT SCAN 0 0 0 2 58.00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0 0 0 2 59.00 05900 CARDI AC CATHETERI ZATI ON 11,511 0 0 2 60.01 06000 LABORATORY 30,329 0 0 0 2 2 61.00 06100 PBP CLINI CAL LAB SERVI CES-PRGM ONLY 4,689 0	ANCI LLA	RY SERVICE COST CENTERS	(4.2/5					
73.00 07300 DRUGS CHARGED TO PATIENTS 65, 316 0 0 74.00 07400 RENAL DI ALYSI S 0 0 0 75.00 07500 ASC (NON-DI STINCT PART) 0 0 0 76.00 03020 CV RESOURCE CTR 0 0 0 77.00 07700 ALLOGENEI C STEM CELL ACQUI SI TI ON 0 0 0 0UTPATI ENT SERVICE COST CENTERS 0 0 0 0 0	51.00 05100 R 52.00 05200 D 53.00 05400 R 54.01 05401 F 55.00 05500 R 55.01 05500 R 57.00 05500 R 57.00 05700 C 58.00 05800 M 59.00 05900 C 60.00 06000 L 60.01 06001 F 61.00 06400 H 65.00 06500 R 65.00 06400 H 65.00 06400 E 65.00 06400 E 65.00 06400 E 67.00 06400 E 67.00 06400 E 70.00 07000 E 71.00 07100 M 72.00 07200 I 73.00 07300 D 74.00 </td <td>ECOVERY ROOM ELIVERY ROOM & LABOR ROOM NESTHESI OLOGY ADI OLOGY-DI AGNOSTI C SED RADI OLOGY - DI AGNOSTI C ADI OLOGY-THERAPEUTI C OODLAND CANCER CARE CTR ADI OL SOTOPE T SCAN AGNETI C RESONANCE I MAGI NG (MRI) ARDI AC CATHETERI ZATI ON ABORATORY S ED LAB BP CLI NI CAL LAB SERVI CES-PRGM ONLY HOLE BLOOD & PACKED RED BLOOD CELLS LOOD STORI NG, PROCESSI NG & TRANS. NTRAVENOUS THERAPY ESPI RATORY THERAPY ESPI RATORY THERAPY HYSI CAL THERAPY CCUPATI ONAL THERAPY PEECH PATHOLOGY LECTROCARDI OLOGY LECTROCARDI OLOGY LECTROCARDI OLOGY LECTROCARDI OLOGY LECTROCARDI OLOGY LECTROCARDI OLOGY LECTROCARDI OLOGY LECTROCARDI OLOGY LECTROCARDI OLOGY LECTROCARDI THERAPY FOI CAL SUPPLI ES CHARGED TO PATI ENTS MPL. DEV. CHARGED TO PATI ENTS RUGS CHARGED TO PATI ENTS SC (NON-DI STI NCT PART) V RESOURCE CTR LLOGENEI C STEM CELL ACQUI SI TI ON ENT SERVI CE COST CENTERS</td> <td>0 1, 119 2, 619 47, 342 10, 015 8, 073 1, 560 0 0 0 11, 511 30, 329 4, 689 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0</td> <td></td> <td></td> <td></td> <td></td> <td>50.00 51.00 52.00 52.00 53.00 54.00 54.01 55.01 55.01 56.00 57.00 57.00 58.00 59.00 60.00 60.00 60.00 60.00 63.00 64.00 63.00 64.00 64.00 67.00 67.00 70.00 71.00 72.00 73.00 74.00 75.00 74.00 75.00 74.00 77.00 88.00</td>	ECOVERY ROOM ELIVERY ROOM & LABOR ROOM NESTHESI OLOGY ADI OLOGY-DI AGNOSTI C SED RADI OLOGY - DI AGNOSTI C ADI OLOGY-THERAPEUTI C OODLAND CANCER CARE CTR ADI OL SOTOPE T SCAN AGNETI C RESONANCE I MAGI NG (MRI) ARDI AC CATHETERI ZATI ON ABORATORY S ED LAB BP CLI NI CAL LAB SERVI CES-PRGM ONLY HOLE BLOOD & PACKED RED BLOOD CELLS LOOD STORI NG, PROCESSI NG & TRANS. NTRAVENOUS THERAPY ESPI RATORY THERAPY ESPI RATORY THERAPY HYSI CAL THERAPY CCUPATI ONAL THERAPY PEECH PATHOLOGY LECTROCARDI OLOGY LECTROCARDI OLOGY LECTROCARDI OLOGY LECTROCARDI OLOGY LECTROCARDI OLOGY LECTROCARDI OLOGY LECTROCARDI OLOGY LECTROCARDI OLOGY LECTROCARDI OLOGY LECTROCARDI THERAPY FOI CAL SUPPLI ES CHARGED TO PATI ENTS MPL. DEV. CHARGED TO PATI ENTS RUGS CHARGED TO PATI ENTS SC (NON-DI STI NCT PART) V RESOURCE CTR LLOGENEI C STEM CELL ACQUI SI TI ON ENT SERVI CE COST CENTERS	0 1, 119 2, 619 47, 342 10, 015 8, 073 1, 560 0 0 0 11, 511 30, 329 4, 689 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0					50.00 51.00 52.00 52.00 53.00 54.00 54.01 55.01 55.01 56.00 57.00 57.00 58.00 59.00 60.00 60.00 60.00 60.00 63.00 64.00 63.00 64.00 64.00 67.00 67.00 70.00 71.00 72.00 73.00 74.00 75.00 74.00 75.00 74.00 77.00 88.00

Health Financial Systems FR	ANCISCAN HEALTH	I MICHIGAN CITY	(In Li	eu of Form CMS-:	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider C		Period: From 01/01/201 To 12/31/201		
Cost Center Description	MEDI CAL RECORDS & LI BRARY	SOCI AL SERVI CE	OTHER GENERA SERVI CE I NSERVI CE EDUCATI ON	NONPHYSI CI AN ANESTHETI STS	NURSING SCHOOL	
	16.00	17.00	18.00	19.00	20.00	
91. 00 09100 EMERGENCY	26, 685	0		0		91.00
91.01 09101 FREE STANDING EMERGENCY DEPT	5, 935	0		0		91.01
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS	r				-	
94.00 09400 HOME PROGRAM DI ALYSI S	0	0		0		94.00
95. 00 09500 AMBULANCE SERVICES	0	0		0		95.00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	0	0		0		96.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0		0		97.00
98.00 09850 OTHER REI MBURSABLE COST CENTERS	0	0		0		98.00
99. 00 09900 CMHC	0	0		0		99.00
99. 10 09910 CORF	0	0		0		99.10
100.00 10000 I &R SERVICES-NOT APPRVD PRGM	0	0		0		100.00
101.00 10100 HOME HEALTH AGENCY	0	0		0		101.00
SPECIAL PURPOSE COST CENTERS					_	
105.00 10500 KIDNEY ACQUISITION	0	0		0		105.00
106.00 10600 HEART ACQUI SI TI ON	0	0		0		106.00
107.00 10700 LIVER ACQUISITION	0	0		0		107.00
108.00 10800 LUNG ACQUISITION	0	0		0		108.00
109.00 10900 PANCREAS ACQUI SI TI ON	0	0		0		109.00
110.00 11000 INTESTINAL ACQUISITION	0	0		0		110.00
111.00 11100 I SLET ACQUI SI TI ON	0	0		0		111.00
113.00 11300 INTEREST EXPENSE						113.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF		_				114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0		0		115.00
116.00 11600 HOSPI CE	0	0		0	_	116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	359, 789	0		0	0 0	118.00
NONREI MBURSABLE COST CENTERS				0	1	100 00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0		190.00
	0	0		0		191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0		192.00
193.00 19300 NONPALD WORKERS	0	-		-		193.00
193.01 19301 NONPALD WORKERS	0	0		0		193.01 194.00
194.00 07950 OTHER NONREI MBURSABLE COST CENTERS	0	-		0		
194. 01 07951 WORKING WELL	0	0		0		194.01
194.0307953 OTHER NONREIMBURSABLE COST CENTERS 194.1007960 DUNELAND FITNESS CTR	0	0		0		194.03 194.10
194. 11 07961 OMNI HEALTH & FITNESS CHESTERTOWN	0	0		0		194.10
194. 16 07966 PHYSICIAN PRACTICE MD WISW	0	0		0		194.11
194. 19 07969 HEALTH PARTNERS	0	0		0		194.10
194. 19 07969 HEALTH PARTNERS	0	0		0		194. 19
200.00 Cross Foot Adjustments	0	0		-	0 0	200.00
201.00 Negative Cost Centers	_	0			-	200.00
202.00 TOTAL (sum lines 118 through 201)	359, 789	0				201.00
202.00 TITL (Sum TITLES TTO THE OUGH 201)	1 337,109	0	I	J.	- U	1202.00

	In Lieu	u of Form CMS-2552-10
15-0015	Period: From 01/01/2017	Worksheet B Part II Date/Time Prepared:
	To 12/31/2017	Date/Time Prepared: 5/30/2018 6:06 pm

					To 12/31/2017		
		INTERNS &	RESI DENTS			5/30/2018 6:0	
	Cost Center Description	Y & FRINGES	SERVICES-OTHER PRGM COSTS	PARAMED ED PRGM	Subtotal	Intern & Residents Cost	
						& Post	
						Stepdown Adjustments	
		21.00	22.00	23.00	24.00	25.00	
	GENERAL SERVICE COST CENTERS						
1.00 2.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						1.00 2.00
2.00 4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMI NI STRATI VE & GENERAL						5.00
6.00 7.00	00600 MAINTENANCE & REPAIRS						6.00 7.00
7.00 8.00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPI NG						9.00
10. 00 11. 00	01000 DI ETARY						10.00 11.00
13.00	01100 CAFETERIA 01300 NURSING ADMINISTRATION						13.00
14.00	01400 CENTRAL SERVICES & SUPPLY						14.00
15.00							15.00
16.00 17.00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE						16.00 17.00
18.00	01080 I NSERVI CE EDUCATI ON						18.00
19.00	01900 NONPHYSI CLAN ANESTHETI STS						19.00
20. 00 21. 00	02000 NURSI NG SCHOOL 02100 I &R SERVI CES-SALARY & FRI NGES APPRVD	0					20.00 21.00
22.00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD		0				22.00
23.00	02300 PARAMED ED PRGM-(SPECIFY)				0		23.00
30.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS				3, 409, 769	0	30.00
31.00	03100 I NTENSI VE CARE UNI T				558, 020		31.00
32.00 33.00	03200 CORONARY CARE UNIT 03300 BURN INTENSIVE CARE UNIT				0	0	32.00 33.00
34.00	03400 SURGI CAL I NTENSI VE CARE UNI T				0	0	34.00
40.00	04000 SUBPROVIDER - IPF				346, 112	0	40.00
41.00 43.00	04100 SUBPROVIDER - IRF 04300 NURSERY				574, 519 63, 239		41.00 43.00
44.00	04400 SKI LLED NURSI NG FACI LI TY				03,237	0	44.00
45.00	04500 NURSING FACILITY				0	0	45.00
46.00	04600 OTHER LONG TERM CARE ANCI LLARY SERVI CE COST CENTERS				0	0	46.00
50.00	05000 OPERATI NG ROOM				2, 687, 389		
51.00 52.00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM				0 319, 552	0	51.00 52.00
53.00	05300 ANESTHESI OLOGY				33, 814		53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C				1, 722, 942		54.00
54. 01 55. 00	05401 FSED RADI OLOGY - DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C				1, 170, 507 672, 680	0	54.01 55.00
55.01	05501 WOODLAND CANCER CARE CTR				461, 803	0	
56.00	05600 RADI OI SOTOPE				0	0	
57.00 58.00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)				0	0	57.00 58.00
59.00	05900 CARDI AC CATHETERI ZATI ON				1, 404, 161	0	59.00
60.00	06000 LABORATORY				509, 732		60.00
60. 01 61. 00	06001 FS ED LAB 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY				82, 041	0	60. 01 61. 00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS				0	0	62.00
63.00 64.00	06300 BLOOD STORING, PROCESSING & TRANS. 06400 INTRAVENOUS THERAPY				0	0	63.00 64.00
65.00	06500 RESPIRATORY THERAPY				153, 881	0	65.00
66.00	06600 PHYSI CAL THERAPY				162, 515	0	66.00
67.00 68.00	06700 OCCUPATIONAL THERAPY 06800 SPEECH PATHOLOGY				0	0	67.00
69.00	06900 ELECTROCARDI OLOGY				425, 937	0	68.00 69.00
70.00	07000 ELECTROENCEPHALOGRAPHY				0	0	70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS				29, 389 226, 087	0	71.00 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS				548, 488	-	73.00
	07400 RENAL DI ALYSI S				0	0	74.00
75.00 76.00	07500 ASC (NON-DI STI NCT PART) 03020 CV RESOURCE CTR					0	75.00 76.00
	07700 ALLOGENEIC STEM CELL ACQUISITION				0	0	
88 00	OUTPATIENT SERVICE COST CENTERS				0	0	88.00
	08900 FEDERALLY QUALIFIED HEALTH CENTER				0		89.00
5/30/2	018 6:06 pm						

	In Lieu	u of Form CMS-2552-10
5	Peri od:	Worksheet B Part II Date/Time Prepared
	From 01/01/2017	Part II
	To 12/31/2017	Date/Time Prenared

				To 12/31/2017	Date/Time Pre	pared:
	INTERNS &	RESI DENTS			5/30/2018 6:0	6 pm
Cost Contor Description	SERVI CES-SALAR		PARAMED ED	Subtotal	Intern &	
Cost Center Description	Y & FRINGES	PRGM COSTS	PARAMEDED	Subtotal	Residents Cost	
					& Post	
					Stepdown	
	21.00	22.00	23.00	24.00	Adjustments 25.00	
90. 00 09000 CLINIC	21.00	22.00	23.00	0		90.00
90. 03 09003 INFUSION OP SERVICES				79, 892	0	90.03
91.00 09100 EMERGENCY				1, 176, 541	0	91.00
91.01 09101 FREE STANDING EMERGENCY DEPT				1, 467, 000	0	91.01
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)					0	92.00
0THER REI MBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DI ALYSI S				0	0	94.00
95. 00 09500 AMBULANCE SERVICES				0		95.00
96. 00 09600 DURABLE MEDICAL EQUI P-RENTED				0	0	96.00
97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD				0	0	97.00
98.00 09850 OTHER REIMBURSABLE COST CENTERS				0	0	98.00
99.00 09900 CMHC				0	0	99.00
99. 10 09910 CORF 100. 00 10000 L&R SERVICES-NOT APPRVD PRGM				0	0	99.10 100.00
101.00/10100 HOME HEALTH AGENCY				0		100.00
SPECIAL PURPOSE COST CENTERS				0	0	101.00
105.00 10500 KIDNEY ACQUISITION				0	0	105.00
106.00 10600 HEART ACQUI SI TI ON				0		106. 00
107.00 10700 LI VER ACQUI SI TI ON				0		107.00
108.00 10800 LUNG ACQUI SI TI ON				0		108.00
109. 00 10900 PANCREAS ACQUI SI TI ON 110. 00 11000 I NTESTI NAL ACQUI SI TI ON				0		109.00 110.00
111. 00 11100 I SLET ACQUI SI TI ON				0		111.00
113.00 11300 INTEREST EXPENSE						113.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)				0		115.00
116.00 11600 HOSPI CE				0		116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	0		0 18, 286, 010	0	118.00
NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN				38, 194	0	190.00
191. 00 19100 RESEARCH				30, 194		190.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES				0		192.00
193.00 19300 NONPALD WORKERS				0		193.00
193. 01 19301 NONPALD WORKERS				0		193. 01
194.00 07950 OTHER NONREI MBURSABLE COST CENTERS				0		194.00
194. 01 07951 WORKI NG WELL				191, 140		194.01
194. 03 07953 OTHER NONREI MBURSABLE COST CENTERS 194. 10 07960 DUNELAND FI TNESS CTR				256, 342 176, 159		194. 03 194. 10
194. 11 07961 OMNI HEALTH & FITNESS CHESTERTOWN				208, 260		194.10
194. 16 07966 PHYSI CI AN PRACTI CE MD WI SW				5, 774		194.16
194. 19 07969 HEALTH PARTNERS				35, 636		194.19
194.2007970 CENTER OF HOPE				2, 169		194. 20
200.00 Cross Foot Adjustments	0	0		0 0		200.00
201.00 Negative Cost Centers	0	0		0 10 100 694		201.00
202.00 TOTAL (sum lines 118 through 201)		0	l	0 19, 199, 684	0	202.00

Health Fina	nci al	Syste	ms	
ALLOCATI ON	OF CA	PI TAL	RELATED	COSTS

In Lieu of Form CMS-2552-10

From 01/01/2017 Pa To 12/31/2017 Da	orksheet B art II ate/Time Prepared: /30/2018 6:06 pm
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			5/30/2018	6:06 pm
	Cost Center Description	Total		
		26.00		
	GENERAL SERVICE COST CENTERS	1		
1.00	00100 CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500 ADMI NI STRATI VE & GENERAL			5.00
6.00	00600 MAINTENANCE & REPAIRS			6.00
7.00				7.00
8.00 9.00	00800 LAUNDRY & LINEN SERVICE			8.00 9.00
9.00 10.00	00900 HOUSEKEEPI NG 01000 DI ETARY			
11.00	01100 CAFETERIA			10.00
13.00				13.00
14.00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY			14.00
	01500 PHARMACY			14.00
16.00				16.00
17.00	01700 SOCIAL SERVICE			17.00
18.00	01080 I NSERVI CE EDUCATI ON			18.00
19.00	01900 NONPHYSICIAN ANESTHETISTS			19.00
20.00				20.00
20.00	02100 I &R SERVICES-SALARY & FRINGES APPRVD			20.00
21.00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD			21.00
	02300 PARAMED ED PRGM-(SPECIFY)			23.00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS			23.00
30.00	03000 ADULTS & PEDIATRICS	3, 409, 769		30.00
30.00	03100 I NTENSI VE CARE UNI T	558, 020		30.00
31.00	03200 CORONARY CARE UNIT	558,020		32.00
32.00	03300 BURN INTENSIVE CARE UNIT	0		32.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	0		34.00
40.00	04000 SUBPROVI DER – I PF	346, 112		40.00
	04100 SUBPROVI DER – I RF	574, 519		41.00
43.00	04300 NURSERY	63, 239		43.00
44.00	04400 SKI LLED NURSI NG FACI LI TY	03,237		44.00
45.00	04500 NURSING FACILITY	0		45.00
46.00	04600 OTHER LONG TERM CARE	0		46.00
40.00	ANCI LLARY SERVICE COST CENTERS	ц 0		40.00
50.00	05000 OPERATI NG ROOM	2, 687, 389		50.00
51.00		2,007,007		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	319, 552		52.00
53.00	05300 ANESTHESI OLOGY	33, 814		53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 722, 942		54.00
54.01	05401 FSED RADIOLOGY - DIAGNOSTIC	1, 170, 507		54.01
55.00	05500 RADI OLOGY-THERAPEUTI C	672, 680		55.00
55.01	05501 WOODLAND CANCER CARE CTR	461, 803		55.01
56.00	05600 RADI OI SOTOPE	0		56.00
57.00	05700 CT SCAN	0		57.00
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0		58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	1, 404, 161		59.00
60.00	06000 LABORATORY	509, 732		60.00
60.01	06001 FS ED LAB	82,041		60.01
61.00				61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0		62.00
63.00	06300 BLOOD STORI NG, PROCESSI NG & TRANS.	0		63.00
64.00		0		64.00
65.00	06500 RESPI RATORY THERAPY	153, 881		65.00
66.00	06600 PHYSI CAL THERAPY	162, 515		66.00
67.00	06700 OCCUPATI ONAL THERAPY	0		67.00
68.00	06800 SPEECH PATHOLOGY	0		68.00
69.00	06900 ELECTROCARDI OLOGY	425, 937		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0		70.00
71.00		29, 389		71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	226, 087		72.00
	07300 DRUGS CHARGED TO PATIENTS	548, 488		73.00
74.00	07400 RENAL DIALYSIS	0		74.00
75.00	07500 ASC (NON-DI STINCT PART)	0		75.00
76.00	03020 CV RESOURCE CTR	0		76.00
77.00	07700 ALLOGENEIC STEM CELL ACQUISITION	0		77.00
	OUTPATIENT SERVICE COST CENTERS			
88.00		0		88.00
89.00		0		89.00
90.00	09000 CLINIC	0		90.00
	09003 INFUSION OP SERVICES	79, 892		90.03
	09100 EMERGENCY	1, 176, 541		91.00
	09101 FREE STANDING EMERGENCY DEPT	1, 467, 000		91.01
	09200 OBSERVATION BEDS (NON-DISTINCT PART)			92.00

Health Financial Systems FR	ANCISCAN HEALTH I	MICHIGAN CITY	In Lieu of Form C	MS_2552_10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der CCN: 15-0015	Period: From 01/01/2017 Part II To 12/31/2017 Date/Time 5/30/2018	B Prepared:
Cost Center Description	Total 26.00			
OTHER REIMBURSABLE COST CENTERS	20100			
94.00 09400 HOME PROGRAM DI ALYSI S	0			94.00
95. 00 09500 AMBULANCE SERVI CES	0			95.00
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0			96.00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0			97.00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0			98.00
99. 00 09900 CMHC	0			99.00
99. 10 09910 CORF	0			99.10
100.00 10000 I &R SERVICES-NOT APPRVD PRGM	0			100.00
101.00 10100 HOME HEALTH AGENCY	0			101.00
SPECIAL PURPOSE COST CENTERS				
105.00 10500 KI DNEY ACQUI SI TI ON	0			105.00
106.00 10600 HEART ACQUI SI TI ON	0			106.00
107.00 10700 LI VER ACQUI SI TI ON	0			107.00
108.00 10800 LUNG ACQUI SI TI ON	0			108.00
109.00 10900 PANCREAS ACQUISITION	0			109.00
110. 00 11000 I NTESTI NAL ACQUI SI TI ON	0			110.00
111.00 11100 I SLET ACQUI SI TI ON 113.00 11300 I NTEREST EXPENSE	0			111. 00 113. 00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF				113.00
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0			115.00
116. 00 11600 HOSPI CE	0			116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	18, 286, 010			118.00
NONREI MBURSABLE COST CENTERS	10, 200, 010			
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	38, 194			190.00
191. 00 19100 RESEARCH	0			191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0			192.00
193.00 19300 NONPALD WORKERS	0			193.00
193. 01 19301 NONPALD WORKERS	0			193.01
194.0007950 OTHER NONREIMBURSABLE COST CENTERS	0			194.00
194.0107951 WORKING WELL	191, 140			194.01
194.0307953 OTHER NONREIMBURSABLE COST CENTERS	256, 342			194.03
194. 10 07960 DUNELAND FI TNESS CTR	176, 159			194.10
194.1107961 OMNI HEALTH & FITNESS CHESTERTOWN	208, 260			194.11
194.16 07966 PHYSICIAN PRACTICE MD WISW	5, 774			194.16
194. 19 07969 HEALTH PARTNERS	35, 636			194. 19
194. 20 07970 CENTER OF HOPE	2, 169			194.20
200.00 Cross Foot Adjustments	0			200.00
201.00 Negative Cost Centers	0			201.00
202.00 TOTAL (sum lines 118 through 201)	19, 199, 684			202.00

Heal th Financial	Systems	
COST ALLOCATION	- STATI STI CAL	BASI S

FRANCI SCAN HEALTH MI CHI GAN CI TY Provi der CCN: 15-0015

In Lieu of Form CMS-2552-10 Period: Worksheet B-1 From 01/01/2017

		1			rom 01/01/2017 o 12/31/2017	Date/Time Pre 5/30/2018 6:0	
		CAPITAL RE	LATED COSTS				
	Cost Center Description	BLDG & FIXT (SOUARE FEFT)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS	Reconciliation	ADMI NI STRATI VE & GENERAL	
				DEPARTMENT		(ACCUM. COST)	
				(GROSS SALARI ES)			
		1.00	2.00	4.00	5A	5.00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT	376, 144					1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	2 (25	13, 787, 072	47 004 542			2.00
4.00 5.00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL	3, 625 54, 268				127, 739, 540	4.00 5.00
6.00	00600 MAI NTENANCE & REPAI RS	0	0	0	0	0	6.00
7.00 8.00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	47, 334 4, 179			0	10, 673, 563 509, 083	7.00 8.00
9.00	00900 HOUSEKEEPI NG	6, 861	10, 397	1, 194, 556		2, 130, 279	9.00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	2, 994 7, 101		342, 409 903, 134		706, 135 1, 343, 210	10.00 11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	1, 707	235, 180	2, 176, 945	0	4, 043, 175	13.00
14.00 15.00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	6, 602 3, 158				1, 700, 580 16, 475, 731	14.00 15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	2, 924				1, 353, 532	16.00
17.00 18.00	01700 SOCIAL SERVICE 01080 INSERVICE EDUCATION	0	0	0	0	0	17.00 18.00
19.00	01900 NONPHYSI CI AN ANESTHETI STS	0	0	0	0	0	19.00
20. 00 21. 00	02000 NURSI NG SCHOOL 02100 I & R SERVI CES-SALARY & FRI NGES APPRVD	0	0	0	0	0	20. 00 21. 00
21.00	02200 I &R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
23.00	02300 PARAMED ED PRGM-(SPECIFY) I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0	0	0	0	0	23.00
30.00	03000 ADULTS & PEDIATRICS	65, 719	241, 717	9, 061, 250	0	14, 613, 640	30.00
31.00	03100 I NTENSI VE CARE UNI T	5, 897		2, 063, 791	0	3, 115, 831	31.00
32.00 33.00	03200 CORONARY CARE UNIT 03300 BURN INTENSIVE CARE UNIT		0	0	0	0	32.00 33.00
34.00	03400 SURGI CAL I NTENSI VE CARE UNI T	0	-	0	0	0	34.00
40.00 41.00	04000 SUBPROVI DER – I PF 04100 SUBPROVI DER – I RF	6, 260 11, 330		1, 027, 742 1, 313, 525		1, 561, 752 2, 180, 353	40.00 41.00
43.00	04300 NURSERY	899	440	387, 253	0	621, 600	43.00
44.00 45.00	04400 SKILLED NURSING FACILITY 04500 NURSING FACILITY		-	0	0	0	44.00 45.00
46.00	04600 OTHER LONG TERM CARE ANCI LLARY SERVI CE COST CENTERS	0	0	0	0	0	46.00
50.00	05000 OPERATING ROOM	18, 911	1, 761, 885	4, 732, 832	0	10, 069, 924	50.00
51.00 52.00	05100 RECOVERY ROOM	0	-	604 205	0	0	51.00
52.00 53.00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY	7, 212		694, 395 37, 838		1, 247, 223 123, 900	
54.00	05400 RADI OLOGY-DI AGNOSTI C	18, 109				5, 540, 477	
54. 01 55. 00	05401 FSED RADI OLOGY - DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	2, 865 8, 956		711, 066 618, 008		2, 237, 959 2, 657, 081	
55.01	05501 WOODLAND CANCER CARE CTR	10, 686	1, 293			1, 583, 132	55.01
56.00 57.00	05600 RADI 0I SOTOPE 05700 CT SCAN		-	0	0	0	56.00 57.00
58.00	05800 MAGNETIC RESONANCE I MAGI NG (MRI)	0	0	0	0	0	58.00
59.00 60.00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	4, 331 8, 979				3, 035, 535 6, 223, 163	
60. 01	06001 FS ED LAB	1, 300			0	1, 336, 608	60. 01
61.00 62.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	61.00 62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00 65.00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	2,003	-	0 888, 114	0	0 1, 393, 488	64.00 65.00
66.00	06600 PHYSI CAL THERAPY	1, 380		703, 846		3, 465, 834	66.00
67.00 68.00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0	-	0	-	0	67.00 68.00
69.00		5, 534	-	-	-	1, 669, 821	
70. 00 71. 00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0 890, 985	70.00 71.00
72.00		0	0	0	0	10, 571, 866	
73.00		0	0	0	218, 914	0	73.00
74.00 75.00	07400 RENAL DIALYSIS 07500 ASC (NON-DISTINCT PART)		0	0	0	0	74.00 75.00
	03020 CV RESOURCE CTR	0	0	0	0	0	
77.00	07700 ALLOGENEI C STEM CELL ACQUI SI TI ON OUTPATI ENT SERVI CE COST CENTERS	0	0	0	0	0	77.00
88.00	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER	0					88.00 89.00
07.00	UNITED TEALT CONCILLED TEALTE CENTER	1 0	<u>ا</u> ا	<u>ا</u>	I U	0	07.00

OST ALLOCATION - STATISTICAL BASIS Provider Col: 15-001 Period: To: 0 Deriod: Deriod	5	ANCISCAN HEALI	H MICHIGAN CITY			eu of Form CMS-	
Cost Center Description CAPITAL RELATED COSTS IMPLOVE USUARE FEED Reconcil I and the cost in Subvinite Accurate Subvinite Subvinite	COST ALLOCATION - STATISTICAL BASIS		Provider CC			Worksheet B-1	
Cost Conter Description CAPITAL RELATED COSTS EMPLOY ALTED COSTS DBCG & FVT (0000 (LUHIC 0							
Cost Center Description BLOG & FIXT (SOURCE FEET) (ODLLAR VALUE) EMPLOYEE BENEFITS SULARIES Reconciliation (ACCOML COST) 0.00 0000 (CLINIC 0.00 0.00 5.00 0.00 5.00 0.00 6.00 <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td></t<>							
CSUMAE FEED (2000/E CODELAR VALUE) (CROSS DEFINITION (ARTINIC) (CROSS S.CENERAL (ACUM, COST) 0.00 00000 (LINIC 1.00 2.00 4.00 5.4 5.00 0 0.00 00000 (LINIC 2.00 4.00 5.4 0 6.60 0 0 1.00 0100 (MIRGENCY 20.092 1.05, 70 1.21, 335 0 0 7, 244, 445 1 7, 244, 445 <		CAPITAL REI	LATED COSTS				
CSUMAE FEED (2000/E CODELAR VALUE) (CROSS DEFINITION (ARTINIC) (CROSS S.CENERAL (ACUM, COST) 0.00 00000 (LINIC 1.00 2.00 4.00 5.4 5.00 0 0.00 00000 (LINIC 2.00 4.00 5.4 0 6.60 0 0 1.00 0100 (MIRGENCY 20.092 1.05, 70 1.21, 335 0 0 7, 244, 445 1 7, 244, 445 <	Cret Creter Deresistion						
DEPARTMENT CACOM CAST 0.00 00001 CLI NIC 1.00 2.00 6.00 5.00 9.00 0.010 00001 CLI NIC 1.00 5.00 9.00 6	Cost Center Description				Reconciliation		
Image: Construction of the second s		(SQUARE FEET)	(DULLAR VALUE)				
NOME SALARLES SALARLES SALARLES 0.00 00000 CLINIC 0 0.00 90.1 0.00 00000 CLINIC 0 0.00 0 0 7.247.744 0.157.766 91.1 0.00 00000 CLINIC 0.00 0 0 0 0 92.1 0.00 00000 CLINIC 0.00 0 0 0 0 94.1 0.00 00000 CLINIC 0.00 0 0 0 0 0 94.1 0.00 00000 CLINIC 0.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0						(ACCUM. CUST)	
I. 000 2.00 4.00 5.00 0.03 9003 INFUSION OF SERVICES 0.33 0.706 27.4140 0.686, 683, 90.1 0.03 00031 INFUSION OF SERVICES 1.333 3.706 27.4140 0 668, 683, 90.1 0.734, 745 91.1 0.00 000101 FREE STANDION EDERGENCY 20.092 1.211, 355 0 3.165, 706 94.1 0.00 000201 INEX RESERVICES 0 0 0 94.1 0.00 00000 0 0 0 0 94.1 94.1 0.00 00000 0 0 0 0 0 94.1 0.00 00000 0 0 0 0 0 0 0 94.1 0.00 00000 0 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>							
0.00 00000 (CLI NIC 0		1 00	2.00		54	5.00	
0.03 0.03 0.03 0.03 0.03 0.04 <th< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td>00.00</td></th<>							00.00
1.00 09100 EDERGENCY 20.092 169.202 3.2.37.404 0 7.2.94,745 91. 2.00 09200 DBSFRWATION BEDS (MON-DISTINCT PART) 21.311 35 0 3.165.766 91. 2.00 09200 DBSFRWATION BEDS (MON-DISTINCT PART) 21.311 35 0		-		-	-		
1.01 09101 FREE STANDING ENERGENCY DEPT 21, 381 722, 762 1, 211, 355 0 3, 165, 706 91, 1 00 00 00 0 0 0 0 0 92, 00 92, 00 92, 00 92, 00 92, 00 92, 00 92, 00 92, 00 92, 00 94, 00 <td< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td></td<>							
2.00 09200 0SERPAYTION BEDS (NON-DISTINCT PART) 92. 4.00 OTHER REMURSABLE COST CENTERS 0 0 0 0 94. 4.00 09400 HOME PRODORAM DIALYSIS 0 0 0 0 94. 6.00 09600 DURABLE MEDICAL EQUP PROL EQUP ANDL 0 0 0 0 0 95. 7.00 09600 DURABLE MEDICAL EQUP PROL 0 0 0 0 0 0 97. 8.00 09650 OTHER RELINDICAL EQUP PROL 0 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>							
DIFER RELIMBURSABLE COST Cost <thcost< th=""> Cost</thcost<>		21, 301	122,102	1, 211, 333	0	3, 103, 700	
4.00 0400 HOME PROCRAM DIALYSIS 0							72.00
5.00 09500 AMBULANCE SERVICES 0 0 0 0 0 0 0 0 9 0 9500 AMBULANCE SERVICES 0 </td <td></td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td></td>		0	0	0	0	0	
6.00 0900D DURABLE MEDICAL EQUIP-RENTED 0		-			0		
7.00 09700 DURABLE MEDICAL EQUIP-SOLD 0 <		0	0	0	0	-	
B. 00 Opesol DTHER REL MEMBRSABLE COST CENTERS 0			0	0	0	-	
9.00 09000 CMM 0		0	0	0	0	-	
9-10 09910 CORF 0.00 10000 (IAR SERVICES-NOT APPRVD PRGM 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.		0	0	0	0	-	
00. 00 IAR SERVICES-NOT APPRVD PRGM 0		0	0	0	0	-	
01.00 DOTOOD HOME HEALTH AGENCY 0 <td></td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td></td> <td></td>		0	0	0	0		
SPECIAL PURPOSE COST CENTERS 06: 0015000 (KINEY ACQUISITION 0 113.0 113.0 113.0 113.0 113.0 113.0 113.0 113.0 113.0 113.0 114.0 0 0 0 0 0 0 114.0 114.0 114.0 114.0 114.0 114.0 114.0 114.0 114.0 114.0 110.0 <t< td=""><td></td><td>0</td><td>-</td><td>0</td><td>0</td><td></td><td></td></t<>		0	-	0	0		
05: 00 [15500 KLDNEY ACQUISITION 0 <		0	0	0	0	0	
06. CO 10600 HEART ACQUISITION 0 <th< td=""><td></td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>105 00</td></th<>		0	0	0	0	0	105 00
07. 00 10700 LIVER ACQUISITION 0 1111 113.1 113.1 113.0 113.0 113.0 113.0 113.0 113.0 113.0 113.0 0							
08. 00 10800 LUNG ACQUIS STION 0 <th< td=""><td></td><td>0</td><td>0</td><td>0</td><td>0</td><td></td><td></td></th<>		0	0	0	0		
09. 00 10900 PANCERAS ACQUISITION 0 <t< td=""><td></td><td>0</td><td>0</td><td>0</td><td>0</td><td></td><td></td></t<>		0	0	0	0		
10.00 INTESTINAL ACQUISITION 0 </td <td></td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td></td> <td></td>		0	0	0	0		
11.100 INTERE ACQUISITION 0 0 0 0 1113.0 13.00 INTEREST EXPENSE 113.0 113.00 114.00 111.00 111.00 111.00 111.00 111.00 111.00 111.00 111.00 111.00 111.00 111.00 111.00 111.00 111.00 111.00 111.00 111.1 113.00 113.00 111.00 111.00 111.1 113.00 113.00 0 <td< td=""><td></td><td>0</td><td>0</td><td>0</td><td>0</td><td></td><td></td></td<>		0	0	0	0		
13:00 11300 INTEREST EXPENSE 113. 14:00 011400 UTLLIZATION REVIEW-SNF 114. 15:00 11500 AMBULATORY SURGICAL CENTER (D, P.) 0 115. 114. 114. 114. 114. 114. 114. 114. 114. 114. 114. 115. 114. 115. 114.		0	0	0	0		
14.00 UTLIZATION REVIEW-SNF 114. 15.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0		0	0	0	0	0	
15:00 ItSD AMBULATORY SURGICAL CENTER (D. P.) 0 0 0 0 0 115.0 16:00 11600 HOSPICE 0							
16.00 11600 HOSPICE 0 0 0 0 0 116.0 18.00 SUBTOTALS (SUM OF LINES 1 through 117) 364, 536 13, 297, 032 46, 246, 910 -34, 210, 406 124, 222, 764 116.0 NONRER MBURSABLE COST CENTERS 90.00 19100 RESEARCH 0 0 0 0 0 116.1 90.00 19100 RESEARCH 0 0 0 0 0 1910 93.00 19301 NONPAI D WORKERS 0 0 0 0 1933 94.00 07550 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 194.1 94.00 07550 OTHER NONREI MBURSABLE COST CENTERS 0 143, 757 1, 607, 923 2, 942, 268 194.1 94.10 07650 OTHER NONREI MBURSABLE COST CENTERS 6,080 27, 121 0 0 168,858 194.1 94.10 07660 DUNELAND FI TNESS CTR 4,543 0 0 108,059 194.1 94.10 07660 PHXSLI AN PRACTICE MD WI SW 0 7,7		0	0	0	0	0	
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90.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 985 0 0 0 23, 429 190. 91.00 19100 RESEARCH 0 <t< td=""><td></td><td>504, 550</td><td>13, 297, 032</td><td>40, 240, 910</td><td>-34, 210, 400</td><td>124, 222, 704</td><td>1110.00</td></t<>		504, 550	13, 297, 032	40, 240, 910	-34, 210, 400	124, 222, 704	1110.00
91.00 19100 RESEARCH 0 0 0 0 191.0 92.00 19200 PHYSI CLANS' PRI VATE OFFICES 0 0 0 192.0 93.01 19301 NONPAID WORKERS 0 0 0 0 193.0 93.01 19301 NONPAID WORKERS 0 0 0 0 193.1 94.00 07950 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 193.1 94.01 07951 WORKING WELL 0 143.757 1,607.923 0 2,942,268 194.1 94.10 07960 DUNELAND FI TNESS CHESTERTOWN 0 274,428 0 0 164,858 194.9 94.10 07960 PHSTICLAN PRACTICE MD WI SW 0 7,753 4,056 196,736 0 194.2 194.1 194.16 194.60 194.50 194.50 194.16 200.4 194.10 194.10 194.10 194.10 194.10 194.10 194.10 194.10 194.10 194.10 194.10 194.10 194.10 194.10 194.10		0.05	Ō	0	0	22 420	1100 00
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93.01 19301 NONPAID WORKERS 0		0	0	0	0		
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200.00 Cross Foot Adjustments 200.0 201.00 Negative Cost Centers 201.0 202.00 Cost to be allocated (per Wkst. B, Part I) 8,946,854 10,252,830 16,394,287 34,429,320 202.0 203.00 Unit cost multiplier (Wkst. B, Part I) 23.785715 0.743655 0.342300 0.269528 203.0 204.00 Cost to be allocated (per Wkst. B, Part I) 23.785715 0.743655 0.342300 0.269528 203.0 205.00 Unit cost multiplier (Wkst. B, Part I) 23.785715 0.743655 0.002059 0.020546 205.0 206.00 Unit cost multiplier (Wkst. B, Part I) 23.785715 0.743655 0.002059 0.020546 205.0 205.00 Unit cost multiplier (Wkst. B, Part I) 0.002059 0.020546 205.0 205.0 206.00 NAHE adjustment amount to be allocated (per Wkst. B, 2) 206.0 206.0 206.0 206.0 207.00 NAHE unit cost multiplier (Wkst. D, 207.0 207.0 207.0 207.0							
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Part I) Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 23.785715 0.743655 0.342300 0.269528 203.0 204.00 Cost to be allocated (per Wkst. B, Part II) 23.785715 0.743655 0.342300 0.269528 203.0 205.00 Unit cost multiplier (Wkst. B, Part II) 0.002059 0.002059 0.020546 205.0 11) 0.000 NAHE adjustment amount to be allocated (per Wkst. B-2) 0.002059 0.020546 206.0 207.00 NAHE unit cost multiplier (Wkst. D, 0.002059 0.020540 206.0			10 353 030	14 204 207		24 420 220	
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204.00 Cost to be allocated (per Wkst. B, Part II) 98,603 2,624,545 204.0 205.00 Unit cost multiplier (Wkst. B, Part II) 0.002059 0.020546 205.0 206.00 NAHE adjustment amount to be allocated (per Wkst. B-2) 0.002059 0.020546 206.0 207.00 NAHE unit cost multiplier (Wkst. D, 0.02054 207.0 207.0		22 705715	0 740/55	0 0 40000		0.0/0500	000 0
Part II)205.00Unit cost multiplier (Wkst. B, Part II)206.00NAHE adjustment amount to be allocated (per Wkst. B-2)207.00NAHE unit cost multiplier (Wkst. D,		23. /85/15	U. /43655				
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11) NAHE adjustment amount to be allocated (per Wkst. B-2) 206.0 NAHE unit cost multiplier (Wkst. D, 207.0				0 000050		0.000547	
NAHE adjustment amount to be allocated (per Wkst. B-2)200.0NAHE unit cost multiplier (Wkst. D,200.0				0.002059		0. 020546	205.00
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207.00 NAHE unit cost multiplier (Wkst. D, 207.0							200.00
							207 0
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	Parts III anu IV)	I	1 1		I	I	I

					eriod: rom 01/01/2017		
		1			o 12/31/2017	Date/Time Pre 5/30/2018 6:0	
	Cost Center Description	MAI NTENANCE & REPAI RS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPI NG (SQUARE FEET)	DI ETARY (MEALS SERVED)	
		6.00	7.00	8.00	9.00	10.00	
1 00	GENERAL SERVICE COST CENTERS			1			1 1 00
13.00 14.00 15.00 16.00 17.00 18.00 19.00 20.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DI ETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE 01900 NONPHYSICIAN ANESTHETISTS 02000 NURSING SCHOOL	318, 251 47, 334 4, 179 6, 861 2, 994 7, 101 1, 707 6, 602 3, 158 2, 924 0 0 0 0 0	270, 917 4, 179 6, 861 2, 994 7, 101 1, 707 6, 602 3, 158 2, 924 0 0 0 0 0	719, 957 0 288 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	259, 877 2, 994 7, 101 1, 707 6, 602 3, 158 2, 924 0 0 0 0	116, 065 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1.00 2.00 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 20.00
	02100 I &R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
	02200 I & SERVI CES-OTHER PRGM COSTS APPRVD 02300 PARAMED ED PRGM-(SPECI FY)	0	0	0	0	0 0	22.00 23.00
	INPATIENT ROUTINE SERVICE COST CENTERS	(5.340	(5.740	000.070	(5.710	75 (04	
	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	65, 719 5, 897	65, 719 5, 897	338, 379 35, 998	65, 719 5, 897	75, 634 11, 142	30.00
32.00	03200 CORONARY CARE UNI T	0	0	0	0	0	32.00
33.00 34.00	03300 BURN INTENSIVE CARE UNIT 03400 SURGICAL INTENSIVE CARE UNIT	0	0		0	0	33.00 34.00
40.00	04000 SUBPROVIDER - IPF	6, 260	6, 260	79, 195	6, 260	13, 637	40.00
41.00 43.00	04100 SUBPROVIDER - IRF 04300 NURSERY	11, 330	11, 330 899	28, 798 216	11, 330 899	11, 198 4, 454	1
44.00	04400 SKILLED NURSING FACILITY	0	0	0	0	0	44.00
	04500 NURSING FACILITY 04600 OTHER LONG TERM CARE	0	0	0	0	0	45.00
	ANCILLARY SERVICE COST CENTERS	,	0	,	-	0	40.00
50. 00 51. 00	05000 OPERATING ROOM 05100 RECOVERY ROOM	18, 911	18, 911	38, 158 0	18, 911 0	0	50.00 51.00
	05200 DELIVERY ROOM & LABOR ROOM	7, 212	7, 212	0	7, 212	0	52.00
53.00 54.00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	546 18, 109	546 18, 109	0 28, 942	546 18, 109	0	53.00 54.00
	05401 FSED RADIOLOGY - DIAGNOSTIC	2, 865	2, 865	0	2, 865	0	54.00
	05500 RADI OLOGY-THERAPEUTI C 05501 WOODLAND CANCER CARE CTR	8, 956			8, 956 10, 686	0	55.00 55.01
56.00	05600 RADI OI SOTOPE	10, 686 0	10, 686 0	7, 200 0	10, 080	0	56.00
	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	57.00 58.00
	05900 CARDI AC CATHETERI ZATI ON	4, 331	4, 331	216	4, 331	0	59.00
60.00	06000 LABORATORY	8,979		0	8, 979	0	60.00
60. 01 61. 00	06001 FS ED LAB 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	1, 300	1, 300	0	1, 300	0	60.01 61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00 63.00
63.00 64.00	06300 BLOOD STORING, PROCESSING & TRANS. 06400 INTRAVENOUS THERAPY	0	0	0	0	0	63.00
65.00	06500 RESPI RATORY THERAPY	2,003	2, 003		2, 003	0	65.00
	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	1, 380	1, 380	21, 599	1, 380 0	0	66.00 67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	5, 534	5, 534	3, 600	5, 534	0	69.00 70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	0	0	0 0	0	0 0	73.00 74.00
75.00	07500 ASC (NON-DI STINCT PART)	0	0	0	0	0	75.00
	03020 CV RESOURCE CTR 07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	76.00 77.00
	OUTPATIENT SERVICE COST CENTERS	,					
	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	88.00 89.00
	09000 CLI NI C	0	0	0	0	0	90.00
	09003 INFUSION OP SERVICES	1, 393	1, 393	216	1, 393	0	90.03

OST ALLOCAT	cial Systems FR ION - STATISTICAL BASIS		Provider C		Period:	Worksheet B-1	
					From 01/01/2017 To 12/31/2017		
	Cost Center Description	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	5/30/2018 6:0 DI ETARY)6 pr
		REPAI RS	PLANT	LINEN SERVICE		(MEALS SERVED)	
		(SQUARE FEET)	(SQUARE FEET)	(POUNDS OF		· · · ·	
				LAUNDRY)			
		6.00	7.00	8.00	9.00	10.00	
	FREE STANDING EMERGENCY DEPT	21, 381	21, 381	28, 798	3 21, 381	0	
	OBSERVATION BEDS (NON-DISTINCT PART)						92
	REI MBURSABLE COST CENTERS	0					1
	HOME PROGRAM DI ALYSI S AMBULANCE SERVI CES	0	0		-	0	
	DURABLE MEDICAL EQUIP-RENTED					0	
1 1	DURABLE MEDICAL EQUIP-SOLD					0	
1 1	OTHER REIMBURSABLE COST CENTERS	0	0		0 0	0	
9.00 09900		0	Ő		0 0	0	
9.10 09910		0	0	(0 0	0	
00.0010000	I&R SERVICES-NOT APPRVD PRGM	0	0		0 0	0	100
01.00 10100	HOME HEALTH AGENCY	0	0	(0 0	0	101
SPECI A	AL PURPOSE COST CENTERS						
	KIDNEY ACQUISITION	0	0	(0 0	0	105
	HEART ACQUISITION	0	0	(0 0		106
	LIVER ACQUISITION	0	0	(0 0		107
	LUNG ACQUISITION	0	0	(0 0	-	108
	PANCREAS ACQUISITION	0	0	(0 0		109
	INTESTINAL ACQUISITION	0	0	(0		110
	I SLET ACQUI SI TI ON	0	0		0	0	111
	INTEREST EXPENSE						113
	UTILIZATION REVIEW-SNF						114
16.0011600	AMBULATORY SURGICAL CENTER (D. P.)		0				116
	SUBTOTALS (SUM OF LINES 1 through 117)	306, 643	259, 309	683, 959	248, 269	116, 065	
	MBURSABLE COST CENTERS	300, 043	237,307	000,70	240,207	110,000	1.10
	GIFT, FLOWER, COFFEE SHOP & CANTEEN	985	985	(985	0	190
91.0019100		0	0	(191
92.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	(0 0	0	192
93.00 19300	NONPAID WORKERS	0	0	(0 0	0	193
93.01 19301	NONPAID WORKERS	0	0	(0 0	0	193
94.0007950	OTHER NONREIMBURSABLE COST CENTERS	0	0	(0 0	0	194
94. 01 07951	WORKING WELL	0	0	(0 0	0	194
	OTHER NONREIMBURSABLE COST CENTERS	6, 080		(6, 080		194
	DUNELAND FITNESS CTR	4, 543	4, 543	(4, 543		194
1 1	OMNI HEALTH & FITNESS CHESTERTOWN	0	0	(0		194
	PHYSICIAN PRACTICE MD WISW	0	0	25.000	0		194
	HEALTH PARTNERS CENTER OF HOPE	0	0	35, 998	3 U		194
1 1	Cross Foot Adjustments	0	0		0	0	200
	Negative Cost Centers						200
	Cost to be allocated (per Wkst. B,	0	13, 550, 387	855, 315	3, 047, 614	1, 081, 661	
	Part I)		10, 000, 007		, , , , , , , , , , , , , , , , , , , ,		
	Unit cost multiplier (Wkst. B, Part I)	0. 000000	50. 016747	1. 188008	11. 727140	9. 319442	203
	Cost to be allocated (per Wkst. B,	0	3, 607, 061	165, 61		149, 592	
	Part II)				, 501		
	Unit cost multiplier (Wkst. B, Part	0. 000000	13. 314266	0. 230029	1. 187115	1. 288864	205
	11)						
06.00	NAHE adjustment amount to be allocated						206
	(per Wkst. B-2) NAHE unit cost multiplier (Wkst. D,						207
07.00							

	Financial Systems F ALLOCATION - STATISTICAL BASIS	RANCI SCAN HEALT	H MICHIGAN CITY Provider CC	N: 15-0015 P	eri od:	u of Form CMS- Worksheet B-1	
					rom 01/01/2017 o 12/31/2017	Date/Time Pre	
	Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	5/30/2018 6:0 MEDI CAL	
		(FTE'S)	ADMI NI STRATI ON	SERVICES & SUPPLY	(COSTED REQUIS.)	RECORDS & LI BRARY	
			(DI RECT NURS.	(COSTED		(GROSS	
		11.00	HRS.) 13.00	REQUIS.) 14.00	15.00	CHARGES) 16.00	
1 00	GENERAL SERVICE COST CENTERS		1				1 00
1.00 2.00 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 20.00 21.00 22.00 23.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE 01080 INSERVICE EDUCATION 01900 NONPHYSICIAN ANESTHETISTS 02000 NURSING SCHOOL 02100 I & SERVICES-SALARY & FRINGES APPRVD 02200 I & SERVICES-OTHER PRGM COSTS APPRVD 02300 PARAMED ED PRGM-(SPECIFY)	55, 147 3, 046 307 2, 566 20 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	21, 163 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	10, 695, 884 74, 998 C C C C C C C C C C C C C C C C C C		681, 464, 005 0 0 0 0 0 0 0 0 0 0 0	17.00 18.00 19.00 20.00 21.00 22.00
23.00	INPATIENT ROUTINE SERVICE COST CENTERS	(vj	U	ij U	0	23.00
30.00	03000 ADULTS & PEDI ATRI CS	12, 512		537, 603		39, 716, 894	
31.00 32.00	03100 I NTENSI VE CARE UNI T 03200 CORONARY CARE UNI T	2,633		188, 246	0	6, 035, 896 0	
33.00	03300 BURN INTENSIVE CARE UNIT	0	0	C	0	0	
34.00	03400 SURGI CAL INTENSI VE CARE UNI T	1 754	0	0	0	0	
40.00 41.00	04000 SUBPROVI DER – I PF 04100 SUBPROVI DER – I RF	1, 756		5, 856 33, 211		4, 518, 415 7, 004, 683	
43.00	04300 NURSERY	485		00, 211 C	0	1, 182, 213	
44.00	04400 SKI LLED NURSI NG FACI LI TY	C	0	C	0	0	
45.00 46.00	04500 NURSING FACILITY 04600 OTHER LONG TERM CARE		-	C	0	0	
40.00	ANCI LLARY SERVICE COST CENTERS		<u>1</u> 0		0	0	40.00
50.00	05000 OPERATING ROOM	7, 584	3, 394	7, 543, 119	0	121, 904, 193	
51.00 52.00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	870	0 645	C	0	0 2, 119, 859	
53.00	05300 ANESTHESI OLOGY	97		C	0	4, 959, 612	
54.00	05400 RADI OLOGY-DI AGNOSTI C	4, 198	176	289, 824	. 0	89, 663, 221	
	05401 FSED RADI OLOGY - DI AGNOSTI C	1,059	1	42, 458		18, 968, 256	
	05500 RADIOLOGY-THERAPEUTIC 05501 WOODLAND CANCER CARE CTR	693		15, 208 46, 918		15, 288, 947 2, 954, 303	
	05600 RADI OI SOTOPE	,0,	437	40, 710	0	2, 754, 505	
	05700 CT SCAN	C	0	C	0	0	
		1.040	0	1 202 020	0	0	
59.00 60.00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	1,048	551	1, 383, 929 8, 787		21, 800, 576 57, 440, 436	
60.01	06001 FS ED LAB	0	0	269		8, 880, 592	
	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0	C	0	0	62.00
	06300 BLOOD STORI NG, PROCESSI NG & TRANS. 06400 I NTRAVENOUS THERAPY					0	
		1, 427	1	63, 710	0	12, 989, 208	
66.00	06600 PHYSI CAL THERAPY	1, 041		37, 959		21, 868, 326	66.00
67.00	06700 OCCUPATIONAL THERAPY		0	C	0	0	
	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	1, 311	0 0 406	C 25, 152	0	0 18, 326, 722	
	07000 ELECTROENCEPHALOGRAPHY	(, 311 (0	23, 132	0	18, 320, 722	
71.00	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	C	0	C	0	20, 990, 525	71.00
	07200 I MPL. DEV. CHARGED TO PATIENTS		0	C	0	16, 813, 251	
	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS		0	C	100	123, 749, 311 0	73.00
	07500 ASC (NON-DI STINCT PART)		0	C	0		75.00
76.00	03020 CV RESOURCE CTR	0	0	C	0	0	
77.00		C	0	C	0	0	77.00
88 00	OUTPATI ENT SERVI CE COST CENTERS 08800 RURAL HEALTH CLINIC			0		0	88.00
	08900 FEDERALLY QUALIFIED HEALTH CENTER		0	C	0	0	1
				0	0	0	
90.00	09000 CLINIC 09003 INFUSION OP SERVICES	388	310	16, 548		2, 508, 402	

Cost Center D					- 04 /04 /0047		
Cost Center D					From 01/01/2017 To 12/31/2017	Date/Time Pre	nared.
Cost Center E						5/30/2018 6:0	
	escription	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDICAL	
		(FTE'S)	ADMI NI STRATI ON	SERVICES & SUPPLY	(COSTED REQUIS.)	RECORDS & LI BRARY	
			(DIRECT NURS.	(COSTED	REQ013.)	(GROSS	
			HRS.)	REQUIS.)		CHARGES)	
		11.00	13.00	14.00	15.00	16.00	
1.00 09100 EMERGENCY		4, 701		293, 333		50, 538, 926	
1. 01 09101 FREE STANDING		1, 545	1, 255	54, 704	4 0	11, 241, 238	
2.00 09200 OBSERVATION E OTHER REIMBURSABLE	EDS (NON-DI STINCT PART)						92.00
4. 00 09400 HOME PROGRAM		0		(0	94.0
5. 00 09500 AMBULANCE SER		0	, v	(0	
6. 00 09600 DURABLE MEDIC		0	Ó	(0	0	
7.00 09700 DURABLE MEDIC		0	0	(0 0	0	
8.00 09850 OTHER REIMBUR	SABLE COST CENTERS	0	0 0	(0 0	0	98.00
9. 00 09900 CMHC		0	0 0	(0 0	0	99.00
9. 10 09910 CORF		0	0 0	(0 0	0	1
00. 00 10000 I &R SERVI CES-		0	0	(0 0		100.00
01.00 10100 HOME HEALTH A		0	0	(0 0	0	101.00
SPECIAL PURPOSE COS 05.00 10500 KI DNEY ACQUIS		0	0			0	105.00
06. 00 10600 HEART ACQUIS		0		(105.00
07. 00 10700 LI VER ACQUI SI		0		(107.00
08. 00 10800 LUNG ACQUISIT		0		(108.00
09. 00 10900 PANCREAS ACQU		0	o o	(0		109.00
10.00 11000 INTESTINAL AC		0	0	(0 0	0	110.00
11.00 11100 I SLET ACQUI SI	TION	0	0 0	(0 0	0	111.00
13.00 11300 INTEREST EXPE	NSE						113.00
14.00 11400 UTILIZATION R							114.00
15.00 11500 AMBULATORY SU	RGICAL CENTER (D. P.)	0	0	(0 0		115.00
16.00 11600 HOSPI CE		0 50.010		10 ((1 0))	0		116.00
18.00 SUBTOTALS (SU NONREI MBURSABLE COS	M OF LINES 1 through 117)	52, 212	20, 939	10, 661, 832	2 100	681, 464, 005	1118.00
90. 00 19000 GI FT, FLOWER,		0		(0 0	0	190. 00
91. 00 19100 RESEARCH	COTTEE SHOT & CANTEEN	0		(191.00
92. 00 19200 PHYSI CI ANS' P	RIVATE OFFICES	0	o o	(0		192.00
93.00 19300 NONPAID WORKE		0	0 0	(0 0	0	193.00
93.01 19301 NONPAID WORKE	RS	0	0 0	(0 0	0	193. 0 [.]
94.00 07950 OTHER NONREIN	BURSABLE COST CENTERS	0	0 0	(0 0		194. 00
94.0107951 WORKING WELL		2, 889	214	34, 013			194. 0
94. 03 07953 OTHER NONRELM		0	0	(0		194.0
94. 10 07960 DUNELAND FITN		0		(194.10
94. 11 07961 OMNI HEALTH &		0		30			194. 1 194. 1
94. 16 07966 PHYSI CI AN PRA 94. 19 07969 HEALTH PARTNE		1		(194.10
94. 20 07970 CENTER OF HOP		45	10	(194. 1
00.00 Cross Foot Ad		45					200. 00
01.00 Negative Cost							201.00
02.00 Cost to be al	located (per Wkst. B,	2, 143, 686	5, 356, 726	2, 578, 502	2 21, 229, 150	1, 899, 663	
Part I)	tiplion (What D Doot 1)	20 070014	DED 11751/	0 04107	1212 201 500000	0 000700	202 0
	tiplier (Wkst. B, Part I) located (per Wkst. B,	38. 872214 301, 335		0. 241074 378, 090	4212, 291. 500000 483, 172	0. 002788 359, 789	
Part II)	iocateu (pei WKSt. D,	301, 335	344, 445	376,090	403, 172	307, 789	204.00
05.00 Unit cost mul	tiplier (Wkst. B, Part	5. 464214	16. 275812	0.035349	9 4, 831. 720000	0.000528	205.0
06.00 NAHE adjustme	nt amount to be allocated						206. 00
07.00 (per Wkst. B- NAHE unit cos	2) t multiplier (Wkst. D,						207.0

OST A	Financial Systems Financial Systems Financial Systems Financial Statistical Basis	RANCI SCAN HEALT	Provi der C	CN: 15-0015 F	Period: From 01/01/2017	worksheet B-1	
					To 12/31/2017	Date/Time Pre 5/30/2018 6:0	
			OTHER GENERAL			INTERNS &	
	Cost Center Description	SOCI AL SERVI CE	SERVI CE	NONPHYSI CI AN	NURSING SCHOOL	RESI DENTS SERVI CES-SALAR	
			EDUCATI ON	ANESTHETI STS		Y & FRINGES	
		(TIME SPENT)	(TIME SPENT)	(ASSIGNED TIME)	(ASSI GNED TI ME)	(ASSIGNED TIME)	
		17.00	18.00	19.00	20.00	21.00	
	GENERAL SERVICE COST CENTERS		- -				
00 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						1.
00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.
00	00500 ADMI NI STRATI VE & GENERAL						5.
00	00600 MAINTENANCE & REPAIRS						6.
00 00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE						7.
00	00900 HOUSEKEEPI NG						9.
. 00	01000 DI ETARY						10.
. 00							11.
. 00 . 00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY						13.
. 00	01500 PHARMACY						15
. 00	01600 MEDI CAL RECORDS & LI BRARY						16.
. 00 . 00	01700 SOCIAL SERVICE 01080 INSERVICE EDUCATION						17
	01900 NONPHYSICIAN ANESTHETISTS				2		19
. 00	02000 NURSI NG SCHOOL	C			0		20
	02100 I &R SERVICES-SALARY & FRINGES APPRVD	C	C			0	
. 00 . 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD 02300 PARAMED ED PRGM-(SPECIFY)			1			22
. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS		<u>/</u>	1		<u> </u>	23.
. 00	03000 ADULTS & PEDI ATRI CS	C) C	(0 0	0	30
	03100 I NTENSI VE CARE UNI T	0			-		
. 00 . 00	03200 CORONARY CARE UNIT 03300 BURN INTENSIVE CARE UNIT					0	
	03400 SURGI CAL I NTENSI VE CARE UNI T	0				0	
. 00	04000 SUBPROVI DER – I PF	C	C		-	0	
. 00	04100 SUBPROVIDER - IRF	0			-	0	
. 00 . 00	04300 NURSERY 04400 SKI LLED NURSI NG FACI LI TY					0	
. 00	04500 NURSING FACILITY	C) C			0	
. 00	04600 OTHER LONG TERM CARE	C) C	(0 0	0	46
. 00	ANCI LLARY SERVI CE COST CENTERS	C			0 0	0	50
. 00	05100 RECOVERY ROOM				0 0		
. 00	05200 DELIVERY ROOM & LABOR ROOM	C) C			0	
. 00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	0		(0	
. 00 . 01	05400 RADIOLOGY - DIAGNOSTIC					0	
. 00	05500 RADI OLOGY-THERAPEUTI C	C		(0 0	0	
. 01	05501 WOODLAND CANCER CARE CTR	0		(0 0	0	
. 00 . 00	05600 RADI 0I SOTOPE 05700 CT SCAN					0	
. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)				0 0	0	
. 00	05900 CARDI AC CATHETERI ZATI ON	C) C	0	0 0	0	
. 00	06000 LABORATORY	0			0 0	0	
. 01	06001 FS ED LAB 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY				0	0	60 61
	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	C) C		o o	0	
	06300 BLOOD STORI NG, PROCESSI NG & TRANS.	C	C		0 0	0	
00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY					0	
. 00	06600 PHYSI CAL THERAPY					0	
00	06700 OCCUPATI ONAL THERAPY	C			0 0	0	67
	06800 SPEECH PATHOLOGY	0) C	0	0	0	68
						0	
	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS					0	
	07200 I MPL. DEV. CHARGED TO PATIENTS	0				0	
	07300 DRUGS CHARGED TO PATIENTS	0	C	0	0 0	0	
	07400 RENAL DIALYSIS 07500 ASC (NON-DISTINCT PART)					0	
. 00 . 00	03020 CV RESOURCE CTR					0	
	07700 ALLOGENEIC STEM CELL ACQUISITION	0			-	0	
00	OUTPATIENT SERVICE COST CENTERS						1
	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER				-		
	100,000 EDERMEET QUALITIED HEALTH VENTER	1		1			90.

	TION - STATISTICAL BASIS		Provider C		Period:	Worksheet B-1	
				F	rom 01/01/2017 o 12/31/2017	Data (Time Dras	
				1	0 12/31/2017	Date/Time Pre 5/30/2018 6:0	
			OTHER GENERAL			INTERNS &	
			SERVI CE			RESI DENTS	
	Cost Center Description	SOCI AL SERVI CE		NONPHYSI CI AN	NURSING SCHOOL	SERVI CES-SALAR	
			EDUCATI ON	ANESTHETI STS		Y & FRINGES	
		(TIME SPENT)	(TIME SPENT)	(ASSI GNED	(ASSI GNED	(ASSI GNED	
		17.00	10.00	TI ME)	TI ME)	TI ME)	
90.03 09003	INFUSION OP SERVICES	17.00	18.00	19.00	20.00	21.00	90.03
	EMERGENCY	0				0	
	FREE STANDING EMERGENCY DEPT	0	0		0	0	
	OBSERVATION BEDS (NON-DISTINCT PART)		-		-	_	92.00
OTHER	REIMBURSABLE COST CENTERS			•			1
94.00 09400	HOME PROGRAM DIALYSIS	0	0	C	0 0	0	94.00
	AMBULANCE SERVICES	0	0 0	C	0 0	0	
	DURABLE MEDICAL EQUIP-RENTED	0	0 0	C	0 0	0	96.00
	DURABLE MEDICAL EQUIP-SOLD	0	0	C	0	0	97.00
	OTHER REIMBURSABLE COST CENTERS	0	0		0	0	
99.00 09900 99.10 09910		0				0	
	I&R SERVICES-NOT APPRVD PRGM	0				-	100.00
	HOME HEALTH AGENCY	0					101.00
	AL PURPOSE COST CENTERS				,	0	101.00
	KIDNEY ACQUISITION	0	0	C	0 0	0	105.00
106.0010600	HEART ACQUISITION	0	0	c	0 0	0	106.00
107.0010700	LIVER ACQUISITION	0	0	C	0 0	0	107.00
108.0010800	LUNG ACQUISITION	0	0 0	C	0 0	0	108.00
	PANCREAS ACQUISITION	0	0	C	0 0		109.00
	INTESTINAL ACQUISITION	0	0	C	0 0		110.00
	I SLET ACQUI SI TI ON	0	0	C	0 0	0	111.00
	INTEREST EXPENSE						113.00
	UTILIZATION REVIEW-SNF AMBULATORY SURGICAL CENTER (D.P.)	0	0		0	0	114. 00 115. 00
116.0011600		0			0	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	0	0	c c	0	0	118.00
	IMBURSABLE COST CENTERS	-	-	-	· <u> </u>		
	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	C	0 0	0	190.00
191.00 19100	RESEARCH	0	0	C	0 0	0	191.00
	PHYSICIANS' PRIVATE OFFICES	0	0	C	0 0		192.00
	NONPAID WORKERS	0	0	C	0 0		193.00
	NONPAID WORKERS	0	0 0	C	0 0		193.01
	OTHER NONREI MBURSABLE COST CENTERS	0	0		0		194.00
	WORKING WELL	0	0		0		194. 01 194. 03
	OTHER NONREIMBURSABLE COST CENTERS DUNELAND FITNESS CTR	0					194.03
	OMNI HEALTH & FITNESS CHESTERTOWN	0					194.10
	PHYSICIAN PRACTICE MD WISW	0	0				194.16
	HEALTH PARTNERS	0	0		0		194.19
	CENTER OF HOPE	0	0	C	0		194.20
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B,	0	0	C	0 0	0	202.00
	Part I)						
203.00	Unit cost multiplier (Wkst. B, Part I)	0. 000000	0. 000000	0.000000	0. 000000		
204.00	Cost to be allocated (per Wkst. B,	0	ין 0	C C	0 וי	0	204.00
205 00	Part II)	0,000000	0,000000	0. 000000	0 000000	0 00000	205 00
205.00	Unit cost multiplier (Wkst. B, Part	0. 000000	0. 000000	0.00000	0. 000000	0.00000	205.00
206.00	NAHE adjustment amount to be allocated				0		206.00
200.00	(per Wkst. B-2)						
207.00	NAHE unit cost multiplier (Wkst. D,	1			0.000000		207.00
	Parts III and IV)	ļ					

	LLOCATION - STATISTICAL BASIS		Provider C		From 01/01/2017	Worksheet B-1
					To 12/31/2017	Date/Time Prepare 5/30/2018 6:06 pt
	Cost Center Description	I NTERNS & RESI DENTS SERVI CES-OTHER PRGM COSTS (ASSI GNED TI ME) 22. 00	PARAMED ED PRGM (ASSI GNED TI ME) 23. 00	_		
	GENERAL SERVICE COST CENTERS			1		
00 00 00 00 00 00 00 00 00 00 00 00 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-WVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DI ETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE 01080 INSERVICE EDUCATION 01900 NONPHYSICIAN ANESTHETISTS 02000 NURSING SCHOOL 02100 I&R SERVICES-SALARY & FRINGES APPRVD 02200 I&R SERVICES-DTHER PRGM COSTS APPRVD	0				1 2 4 5 6 7 7 8 9 10 11 13 14 15 16 17 18 19 20 21 22
. 00	02300 PARAMED ED PRGM-(SPECIFY)		C			23
. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	0	C)		30
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	03100 INTENSIVE CARE UNIT 03200 CORONARY CARE UNIT 03300 BURN INTENSIVE CARE UNIT 03400 SURGICAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF 04100 SUBPROVIDER - IRF 04300 NURSERY 04400 SKILLED NURSING FACILITY 04500 NURSING FACILITY 04600 OTHER LONG TERM CARE					31 32 33 34 40 41 43 44 45 46
	ANCI LLARY SERVICE COST CENTERS	-				
. 00 . 00	05000 OPERATING ROOM 05100 RECOVERY ROOM	0	C			50
00	05200 DELIVERY ROOM & LABOR ROOM	0	C			52
00	05300 ANESTHESI OLOGY	0	C			53
00		0	C			54
01 00	05401 FSED RADI OLOGY - DI AGNOSTI C	0	C			54
00	05500 RADIOLOGY-THERAPEUTIC 05501 WOODLAND CANCER CARE CTR	0		1		55
00	05600 RADI OI SOTOPE	0	C	1		50
00	05700 CT SCAN	0	C			57
00	05800 MAGNETIC RESONANCE I MAGI NG (MRI)	0	C	1		58
00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	0	C	1		59
00	06001 FS ED LAB	0	((60
00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		-			6
. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	C			62
. 00	06300 BLOOD STORI NG, PROCESSI NG & TRANS.	0	C	1		63
00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	0	C			64
00	06600 PHYSI CAL THERAPY	0	C			66
00	06700 OCCUPATI ONAL THERAPY	0	C			67
00	06800 SPEECH PATHOLOGY	0	C	1		68
00 00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	0	C			69
00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0				71
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	C			72
00	07300 DRUGS CHARGED TO PATIENTS	0	C			73
	07400 RENAL DI ALYSI S	0	C			74
. 00	07500 ASC (NON-DI STINCT PART)	0	C			75
. 00 . 00	03020 CV RESOURCE CTR 07700 ALLOGENEI C STEM CELL ACQUI SI TI ON	0	C	1		76
. 00	OUTPATIENT SERVICE COST CENTERS	- U	L. L.	1		//
	08800 RURAL HEALTH CLINIC	0	C			88
. 00		1		1		100

Health Financial Systems F	RANCI SCAN HEALTH	H MICHIGAN CITY		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider CCN:	15-0015	Peri od:	Worksheet B-1	
				From 01/01/2017	Data /Tima Dra	nored.
				To 12/31/2017	Date/Time Pre 5/30/2018 6:0	
	INTERNS &				0/00/2010 0.0	
	RESI DENTS					
Cost Center Description	SERVI CES-OTHER	PARAMED ED				
	PRGM COSTS	PRGM				
	(ASSI GNED	(ASSI GNED				
	TIME)	TIME)				
	22.00	23.00				
90.03 09003 INFUSION OP SERVICES	0	0				90.03
91. 00 09100 EMERGENCY	0	0				91.00
91. 01 09101 FREE STANDING EMERGENCY DEPT	0	0				91.01
92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART)	Ŭ	U				92.00
OTHER REIMBURSABLE COST CENTERS						72.00
94.00 09400 HOME PROGRAM DI ALYSI S	0	0				94.00
95. 00 09500 AMBULANCE SERVICES	0	0				95.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0				96.00
	0	0				97.00
	0	0				
98.00 09850 OTHER REI MBURSABLE COST CENTERS	0	0				98.00
99.00 09900 CMHC	0	0				99.00
99.10 09910 CORF	0	0				99.10
100.00 10000 I &R SERVICES-NOT APPRVD PRGM	0	0				100.00
101.00 10100 HOME HEALTH AGENCY	0	0				101.00
SPECIAL PURPOSE COST CENTERS						105 00
105. 00 10500 KI DNEY ACQUI SI TI ON	0	0				105.00
106.00 10600 HEART ACQUI SI TI ON	0	0				106.00
107. 00 10700 LI VER ACQUI SI TI ON	0	0				107.00
108. 00 10800 LUNG ACQUI SI TI ON	0	0				108.00
109.00 10900 PANCREAS ACQUI SI TI ON	0	0				109.00
110.00 11000 INTESTINAL ACQUISITION	0	0				110.00
111.00 11100 I SLET ACQUI SI TI ON	0	0				111.00
113.00 11300 INTEREST EXPENSE						113.00
114.00 11400 UTI LI ZATI ON REVIEW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0				115.00
116. 00 11600 HOSPI CE		0				116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	0				118.00
NONREI MBURSABLE COST CENTERS						-
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0				190.00
191. 00 19100 RESEARCH	0	0				191.00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0				192.00
193.00 19300 NONPALD WORKERS	0	0				193.00
193.01 19301 NONPALD WORKERS	0	0				193.01
194.00079500THER NONREIMBURSABLE COST CENTERS	0	0				194.00
194.01 07951 WORKING WELL	0	0				194.01
194.03079530THER NONREIMBURSABLE COST CENTERS	0	0				194.03
194.1007960 DUNELAND FITNESS CTR	0	0				194.10
194.1107961 OMNI HEALTH & FITNESS CHESTERTOWN	0	0				194.11
194.1607966 PHYSICIAN PRACTICE MD WISW	0	0				194.16
194.1907969 HEALTH PARTNERS	0	0				194.19
194.2007970 CENTER OF HOPE	0	0				194.20
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers						201.00
202.00 Cost to be allocated (per Wkst. B,	0	0				202.00
Part I)						
203.00 Unit cost multiplier (Wkst. B, Part I)	0. 000000	0. 000000				203.00
204.00 Cost to be allocated (per Wkst. B,	0	0				204.00
Part II)						
205.00 Unit cost multiplier (Wkst. B, Part	0. 000000	0. 000000				205.00
206.00 NAHE adjustment amount to be allocated	l l	0				206.00
(per Wkst. B-2)						
207.00 NAHE unit cost multiplier (Wkst. D,		0. 000000				207.00
Parts III and IV)						
		. !				

In Lieu of Form CMS-2552-10

		RANCI SCAN HEALT				u of Form CMS-2	2552-10
COMPUT	ATION OF RATIO OF COSTS TO CHARGES		Provider C	F	Period: From 01/01/2017 To 12/31/2017	Worksheet C Part I Date/Time Pre 5/30/2018 6:0	pared:
			Title	e XVIII	Hospi tal	PPS	o pili
					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	1	1	1			
30.00	03000 ADULTS & PEDI ATRI CS	26, 174, 047		26, 174, 047		26, 180, 027	
31.00	03100 I NTENSI VE CARE UNI T	5, 174, 852		5, 174, 852	0	5, 174, 852	
	03200 CORONARY CARE UNIT	0			0	0	32.00
33.00	03300 BURN I NTENSI VE CARE UNI T	0			0	0	33.00
34.00 40.00	03400 SURGI CAL INTENSI VE CARE UNI T 04000 SUBPROVI DER - I PF	2, 872, 357		2, 872, 357	3, 273	0 2, 875, 630	34.00 40.00
40.00	04100 SUBPROVIDER - IPF	3, 894, 728		3, 894, 728		3, 894, 728	
43.00	04300 NURSERY	999, 684		999, 684		999, 684	
44.00	04400 SKILLED NURSING FACILITY	0		(0	44.00
45.00	04500 NURSING FACILITY	0			0 0	0	45.00
46.00	04600 OTHER LONG TERM CARE	0		0	0 0	0	46.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	17, 309, 231		17, 309, 231	7, 025	17, 316, 256	
51.00	05100 RECOVERY ROOM	0			0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	2, 231, 672		2, 231, 672		2, 231, 672	
53.00	05300 ANESTHESI OLOGY	208,605		208, 605			
54.00 54.01	05400 RADI OLOGY-DI AGNOSTI C 05401 FSED RADI OLOGY - DI AGNOSTI C	8, 713, 879 3, 122, 333		8, 713, 879 3, 122, 333		8, 713, 879 3, 122, 333	
55.00	05500 RADI OLOGY - THERAPEUTI C	3, 999, 875		3, 999, 875		4, 004, 535	1
55. 00 55. 01	05501 WOODLAND CANCER CARE CTR	2, 851, 847		2, 851, 847		2, 851, 847	55.01
56.00	05600 RADI OI SOTOPE	2,001,017		2,001,011	0	2,001,017	56.00
57.00	05700 CT SCAN	0			0 0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0		0	0 0	0	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	4, 695, 982		4, 695, 982	3, 576	4, 699, 558	59.00
60.00	06000 LABORATORY	8, 617, 140		8, 617, 140	12, 826	8, 629, 966	60.00
60. 01	06001 FS ED LAB	1, 801, 952		1, 801, 952	2 0	1, 801, 952	
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0		0	0 0	0	61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0			0	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0			0	0	63.00
64.00 65.00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	2,000,042	c	2,000,042	0 0	0 2, 000, 763	64.00 65.00
66. 00	06600 PHYSI CAL THERAPY	4, 629, 778		4, 629, 778		4, 629, 778	
67.00	06700 OCCUPATI ONAL THERAPY	0				0	67.00
68.00	06800 SPEECH PATHOLOGY	0	C C		0	0	68.00
69.00	06900 ELECTROCARDI OLOGY	2, 676, 738		2, 676, 738	3 0	2, 676, 738	1
70.00	07000 ELECTROENCEPHALOGRAPHY	0		c	0 0	0	70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 189, 652		1, 189, 652		1, 189, 652	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	13, 468, 155		13, 468, 155		13, 468, 155	
	07300 DRUGS CHARGED TO PATIENTS	21, 354, 990		21, 354, 990		21, 354, 990	
	07400 RENAL DIALYSIS 07500 ASC (NON-DISTINCT PART)	0			-	0	
76.00	03020 CV RESOURCE CTR	0				0	
	07700 ALLOGENEIC STEM CELL ACQUISITION	0				0	77.00
	OUTPATIENT SERVICE COST CENTERS		1		1		
88.00	08800 RURAL HEALTH CLINIC	0		0	0 0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0		0	0 0	0	89.00
90.00	09000 CLINIC	0		0	0	0	90.00
	09003 I NFUSI ON OP SERVI CES	1, 062, 775		1, 062, 775		1,064,395	
91.00	09100 EMERGENCY	11, 700, 942		11, 700, 942		11, 708, 754	
	09101 FREE STANDING EMERGENCY DEPT 09200 OBSERVATION BEDS (NON-DISTINCT PART)	5, 795, 559		5, 795, 559		5, 806, 253 5, 130, 785	
72. UU	OTHER REIMBURSABLE COST CENTERS	5, 130, 785	1	5, 130, 785	'I	5, 130, 785	_ 7∠.00
94.00	09400 HOME PROGRAM DI ALYSI S	0) 0	0	94.00
95.00	09500 AMBULANCE SERVICES	0			-	0	95.00
	09600 DURABLE MEDICAL EQUIP-RENTED	0		0	0	0	96.00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0		0	0 0	0	97.00
	09850 OTHER REIMBURSABLE COST CENTERS	0		0	0 0	0	98.00
	09900 CMHC	0		0		0	99.00
	09910 CORF	0				0	99.10
	10000 I &R SERVICES-NOT APPRVD PRGM	0					100.00
101.00	10100 HOME HEALTH AGENCY	0	1		л <u></u>	0	101.00
105 00	SPECIAL PURPOSE COST CENTERS 10500 KIDNEY ACQUISITION	0			ป	0	105.00
	10600 HEART ACQUISITION						105.00
	10700 LIVER ACQUISITION	0		(107.00
	10800 LUNG ACQUISITION	0		0	D		108.00
	10900 PANCREAS ACQUISITION	0		0			109.00
	11000 INTESTINAL ACQUISITION	0		0)		110.00
111.00	11100 I SLET ACQUI SI TI ON	0		0)	0	111.00
E /20 /20	018 6 06 pm						

Health Financial Systems	FRANCI SCAN HEALTH	H MICHIGAN CITY	(In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 01/01/2017 To 12/31/2017	Worksheet C Part I Date/Time Pre 5/30/2018 6:0	
		Title	XVIII	Hospi tal	PPS	
				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	
113.00 11300 INTEREST EXPENSE 114.00 11400 UTI LI ZATI ON REVIEW-SNF 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 116.00 11600 HOSPICE 200.00 Subtotal (see instructions) 201.00 Less Observation Beds 202.00 Total (see instructions)	0 0 161, 677, 600 5, 130, 785 156, 546, 815		161, 677, 60 5, 130, 78 156, 546, 81	5	0 161, 738, 075 5, 130, 785	201.00

^{5/30/2018 6:06} pm

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COMPLIT		0F	PATIO	OF	27200	ΤO	C

	Financial Systems FR ATION OF RATIO OF COSTS TO CHARGES	ANCI SCAN HEALTH		CN: 15-0015	In Lie Period: From 01/01/2017 To 12/31/2017	Date/Time Pre 5/30/2018 6:0	pared:
				e XVIII	Hospi tal	PPS	
	Cost Center Description	I npati ent	Charges Outpati ent	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA I npati ent Rati o	
		6.00	7.00	8.00	9.00	10.00	
30.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	34,007,365		34, 007, 36	-		30.00
31.00	03100 I NTENSI VE CARE UNI T	6, 035, 896		6, 035, 89			31.00
32.00	03200 CORONARY CARE UNIT	0,000,070		0,000,07	5		32.00
33.00	03300 BURN INTENSIVE CARE UNIT	0			D		33.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	0			C		34.00
40.00	04000 SUBPROVIDER - IPF	4, 518, 415		4, 518, 41			40.00
41.00 43.00	04100 SUBPROVIDER - IRF 04300 NURSERY	7, 004, 683 1, 182, 213		7, 004, 68			41.00 43.00
43.00	04400 SKILLED NURSING FACILITY	1, 102, 213		1, 102, 21	2		43.00
45.00	04500 NURSING FACILITY	0					45.00
46.00	04600 OTHER LONG TERM CARE	0			D		46.00
	ANCI LLARY SERVI CE COST CENTERS	I		I	1	1	
50.00	05000 OPERATING ROOM	28, 948, 393					
51.00 52.00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	0 1, 910, 298	209, 561		0.000000 0.000000 0.052745		
52.00	05300 ANESTHESI OLOGY	1, 910, 298	3, 183, 228	1 1 1		0. 000000	
54.00	05400 RADI OLOGY-DI AGNOSTI C	19, 733, 462	69, 929, 759				
54.01	05401 FSED RADI OLOGY - DI AGNOSTI C	995, 361	17, 972, 895			0. 000000	
55.00	05500 RADI OLOGY-THERAPEUTI C	1, 443, 557	13, 845, 390	15, 288, 94		0. 000000	55.00
55.01	05501 WOODLAND CANCER CARE CTR	34, 225	2, 920, 078	2, 954, 30			
56.00	05600 RADI OI SOTOPE	0	C		0. 000000		
57.00 58.00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	0			0. 000000 0. 000000		
59.00	05900 CARDI AC CATHETERI ZATI ON	9, 931, 491	11, 869, 085	21, 800, 57			
60.00	06000 LABORATORY	21, 640, 148	35, 800, 288			0. 000000	
60. 01	06001 FS ED LAB	60, 174	8, 820, 418				
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	C		0. 000000	0. 000000	61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	C		0. 00000	0.000000	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0			0.00000		
64.00 65.00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	11, 435, 888	1, 553, 320	12, 989, 20	0. 000000 0. 153977	0. 000000 0. 000000	
66.00	06600 PHYSI CAL THERAPY	4, 539, 150	17, 329, 176			0. 000000	
67.00	06700 OCCUPATIONAL THERAPY	0	C		0. 000000		
68.00	06800 SPEECH PATHOLOGY	0	C		0. 000000	0. 000000	
69.00	06900 ELECTROCARDI OLOGY	6, 345, 960	11, 980, 762	18, 326, 72		0.000000	
70.00 71.00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	9, 788, 377	11, 202, 148	20, 990, 52	0. 000000 0. 056676		
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	9, 768, 377	5, 544, 334				
73.00	07300 DRUGS CHARGED TO PATIENTS	34, 346, 266	89, 403, 045			0. 000000	
74.00	07400 RENAL DIALYSIS	0	C		0. 000000	0. 000000	74.00
	07500 ASC (NON-DISTINCT PART)	0	C		0. 000000		
76.00	03020 CV RESOURCE CTR	0	C		0. 000000		
77.00	07700 ALLOGENEIC STEM CELL ACQUISITION OUTPATIENT SERVICE COST CENTERS	0	C		0.00000	0. 000000	77.00
88.00	08800 RURAL HEALTH CLINIC	0	C		D		88.00
89.00	08900 FEDERALLY QUALI FIED HEALTH CENTER	0	C		D		89.00
90.00	09000 CLINIC	0	C		0. 000000		1
90.03	09003 I NFUSI ON OP SERVI CES	15, 523	2, 492, 879				
91.00 91.01	09100 EMERGENCY	10, 370, 203 1, 096, 887					
91.01 92.00	09101 FREE STANDING EMERGENCY DEPT 09200 OBSERVATION BEDS (NON-DISTINCT PART)	722, 110	10, 144, 351 4, 987, 419			0.000000	
72.00	OTHER REIMBURSABLE COST CENTERS	722,110	1, 707, 117	0,707,02	0.070000	0.00000	72.00
94.00	09400 HOME PROGRAM DI ALYSI S	0	C) (0. 000000	0.00000	94.00
95.00	09500 AMBULANCE SERVICES	0	C		0. 000000	0. 000000	95.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	C) (0. 000000		
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0			0. 000000		
98.00 99.00	09850 OTHER REIMBURSABLE COST CENTERS 09900 CMHC				0. 000000	0.000000	98.00 99.00
	09910 CORF	0			2		99.10
	10000 I &R SERVICES-NOT APPRVD PRGM	0	C		D		100.00
101.00	10100 HOME HEALTH AGENCY	0	C		2		101.00
405 -	SPECIAL PURPOSE COST CENTERS			N.		[105
	10500 KIDNEY ACQUISITION	0	C				105.00
	10600 HEART ACQUISITION 10700 LIVER ACQUISITION						106.00 107.00
	10800 LUNG ACQUISITION	0					107.00
	10900 PANCREAS ACQUISITION	0	C C		D		109.00
110.00	11000 INTESTINAL ACQUISITION	0	C		D		110.00
	11100 I SLET ACQUI SI TI ON	0	C)			111.00
113.00	11300 INTEREST EXPENSE						113.00

Health Financial Systems FF	RANCI SCAN HEALTH	H MICHIGAN CITY	/	In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CO		Period: From 01/01/2017 To 12/31/2017		epared: 06 pm
		Title	XVIII	Hospi tal	PPS	
		Charges				
Cost Center Description	Inpati 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	
114.00 11400 UTI LI ZATI ON REVI EW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0		0		115.00
116. 00 11600 HOSPI CE	0	0		0		116.00
200.00 Subtotal (see instructions)	229, 151, 346	452, 312, 659	681, 464, 00	5		200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	229, 151, 346	452, 312, 659	681, 464, 00	5		202.00

^{5/30/2018 6:06} pm

	5	FRANCI SCAN HEALTH		In Lie	u of Form CMS-2552-1
COMPUT	TATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0015	Period: From 01/01/2017 To 12/31/2017	Worksheet C Part I Date/Time Prepared: 5/30/2018 6:06 pm
			Title XVIII	Hospi tal	PPS
	Cost Center Description	PPS Inpatient Ratio 11.00			
	INPATIENT ROUTINE SERVICE COST CENTERS	11.00			
30.00	03000 ADULTS & PEDIATRICS				30.00
31.00	03100 I NTENSI VE CARE UNI T				31.00
32.00	03200 CORONARY CARE UNIT				32.00
33.00	03300 BURN INTENSIVE CARE UNIT				33.00
34.00	03400 SURGI CAL INTENSI VE CARE UNI T 04000 SUBPROVI DER - I PF				34.00
40.00	04000 SUBPROVIDER - TPF				40.00
43.00	04300 NURSERY				43.00
44.00	04400 SKILLED NURSING FACILITY				44.00
45.00	04500 NURSING FACILITY				45.00
46.00	04600 OTHER LONG TERM CARE				46.00
	ANCI LLARY SERVICE COST CENTERS				
50.00	05000 OPERATI NG ROOM	0. 142048			50.00
51.00	05100 RECOVERY ROOM	0. 000000			51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1. 052745			52.00
53.00	05300 ANESTHESI OLOGY	0. 042522			53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 097185			54.00
54.01	05401 FSED RADI OLOGY - DI AGNOSTI C	0. 164608			54.01
55.00	05500 RADI OLOGY-THERAPEUTI C	0. 261924			55.00
55.01	05501 WOODLAND CANCER CARE CTR	0. 965320			55.01
56.00	05600 RADI OI SOTOPE	0.00000			56.00
57.00	05700 CT SCAN	0.000000			57.00
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0.000000			58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0. 215570			59.00
50.00 50.01	06000 LABORATORY 06001 FS ED LAB	0. 150242 0. 202909			60. 00 60. 01
50. 01 51. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0. 202909			61.00
51.00 52.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000			62.00
53.00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000			63.00
54. 00	06400 I NTRAVENOUS THERAPY	0. 000000			64.00
65.00	06500 RESPI RATORY THERAPY	0. 154033			65.00
66.00	06600 PHYSI CAL THERAPY	0. 211712			66.00
67.00	06700 OCCUPATIONAL THERAPY	0. 000000			67.00
68.00	06800 SPEECH PATHOLOGY	0. 000000			68.00
69.00	06900 ELECTROCARDI OLOGY	0. 146057			69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 000000			70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 056676			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 801044			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 172567			73.00
74.00	07400 RENAL DI ALYSI S	0. 000000			74.00
75.00	07500 ASC (NON-DISTINCT PART)	0. 000000			75.00
76.00	03020 CV RESOURCE CTR	0. 000000			76.00
77.00		0.000000			77.00
00 00					
88.00 89.00	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER				88. 00 89. 00
90.00	09000 CLINIC	0. 000000			90.00
90.00		0. 424332			90.03
91.00	09100 EMERGENCY	0. 231678			91.00
91.00	09101 FREE STANDING EMERGENCY DEPT	0. 516514			91.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 898635			92.00
	OTHER REIMBURSABLE COST CENTERS				
94.00	09400 HOME PROGRAM DI ALYSI S	0. 000000			94.00
95.00	09500 AMBULANCE SERVICES	0. 000000			95.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000			96.00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0. 000000			97.00
98.00		0. 000000			98.00
99.00					99.00
	09910 CORF				99.10
	10000 I & R SERVI CES-NOT APPRVD PRGM				100.00
101.00	10100 HOME HEALTH AGENCY				101.00
	SPECIAL PURPOSE COST CENTERS				
	10500 KI DNEY ACQUI SI TI ON				105.00
	10600 HEART ACQUI SI TI ON				106.00
	10700 LIVER ACQUISITION				107.00
	10800 LUNG ACQUI SI TI ON				108.00
	10900 PANCREAS ACQUISITION				109.00
	11000 INTESTINAL ACQUISITION				110.00
	11100 I SLET ACQUI SI TI ON				111.00
	11300 INTEREST EXPENSE				113.00
) 11400 UTILIZATION REVIEW-SNF) 11500 AMBULATORY SURGICAL CENTER (D.P.)				114.00
	ILISUUAMBULATURY SURGICAL (ENTER (1) P)				115.00

5/30/2018 6:06 pm

Health Fina	ncial Systems	FRANCI SCAN HEALTH	MICHIGAN CITY	In Lieu of Form CMS-2552-10			
COMPUTATI ON	I OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0015	Period:	Worksheet C		
				From 01/01/2017	Part I		
				To 12/31/2017	Date/Time Pre		
					5/30/2018 6:0	6 pm	
			Title XVIII	Hospi tal	PPS		
	Cost Center Description	PPS Inpatient					
		Ratio					
		11.00					
116.0011600	0 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	

^{5/30/2018 6:06} pm

	RANCISCAN HEALI				eu of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C	F	eriod: rom 01/01/2017	Worksheet C Part I	
			T	0 12/31/2017	Date/Time Pre 5/30/2018 6:0	epared: 06 pm
	1	Titl	e XIX	Hospi tal	Cost	
	.			Costs		
Cost Center Description	Total Cost (from Wkst. B,	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
	Part I, col.	Adj .		Disarrowance		
	26)					
	1.00	2.00	3.00	4.00	5.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS	26, 174, 047		26, 174, 047	0	0	30.00
31. 00 03100 I NTENSI VE CARE UNI T	5, 174, 852		5, 174, 852			
32. 00 03200 CORONARY CARE UNI T	0		0	0	0	
33. 00 03300 BURN INTENSIVE CARE UNIT	0		0	0	0	
34. 00 03400 SURGI CAL I NTENSI VE CARE UNI T 40. 00 04000 SUBPROVI DER – I PF	2, 872, 357		2, 872, 357	0		
41. 00 04100 SUBPROVI DER - I RF	3, 894, 728		3, 894, 728		0	
43. 00 04300 NURSERY	999, 684	- -	999, 684	0	0	
44. 00 04400 SKI LLED NURSI NG FACI LI TY	0		0	0	0	
45. 00 04500 NURSING FACILITY 46. 00 04600 OTHER LONG TERM CARE	0			0		
ANCI LLARY SERVICE COST CENTERS						10.00
50. 00 05000 OPERATI NG ROOM	17, 309, 231		17, 309, 231			
51.00 05100 RECOVERY ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM	0		0	-		
52. 00 05200 DELI VERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESI OLOGY	2, 231, 672 208, 605		2, 231, 672 208, 605	-	-	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	8, 713, 879		8, 713, 879		-	
54. 01 05401 FSED RADIOLOGY - DIAGNOSTIC	3, 122, 333	- -	3, 122, 333		0	
55. 00 05500 RADI OLOGY-THERAPEUTI C	3, 999, 875		3, 999, 875		0	
55. 01 05501 WOODLAND CANCER CARE CTR 56. 00 05600 RADI 0I SOTOPE	2, 851, 847		2, 851, 847	0	0	
57. 00 05700 CT SCAN	0		0	0	0	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0		0	0	0	
59. 00 05900 CARDI AC CATHETERI ZATI ON	4, 695, 982		4, 695, 982		0	
60. 00 06000 LABORATORY 60. 01 06001 FS ED LAB	8, 617, 140 1, 801, 952		8, 617, 140 1, 801, 952		0	
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	1,001,932		1,001,732	0	0	
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0		0	0	0	62.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0		0	0	0	
64. 00 06400 I NTRAVENOUS THERAPY 65. 00 06500 RESPI RATORY THERAPY	2,000,042	0	2, 000, 042	0	0	
66. 00 06600 PHYSI CAL THERAPY	4, 629, 778		4, 629, 778		0	
67.00 06700 OCCUPATI ONAL THERAPY	0	C	0	0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0	O	0	0	0	
69. 00 06900 ELECTROCARDI OLOGY 70. 00 07000 ELECTROENCEPHALOGRAPHY	2, 676, 738		2, 676, 738	0	0	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 189, 652		1, 189, 652	0	0	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	13, 468, 155		13, 468, 155		0	
73. 00 07300 DRUGS CHARGED TO PATIENTS	21, 354, 990		21, 354, 990		0	
74.00 07400 RENAL DIALYSIS 75.00 07500 ASC (NON-DISTINCT PART)	0					
76.00 03020 CV RESOURCE CTR	0		0	-		
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0		0	0	0	77.00
88.00 08800 RURAL HEALTH CLINIC 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0			0	0	
90. 00 09000 CLINIC	0		0	0	0	
90. 03 09003 I NFUSI ON OP SERVI CES	1,062,775		1, 062, 775		0	
91.00 09100 EMERGENCY 91.01 09101 FREE STANDING EMERGENCY DEPT	11, 700, 942 5, 795, 559		11, 700, 942		0	
91.01 09101 FREE STANDING EMERGENCY DEPT 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	5, 795, 559		5, 795, 559			
OTHER REI MBURSABLE COST CENTERS	-		-		-	
94.00 09400 HOME PROGRAM DI ALYSI S	0		0	0	0	
95. 00 09500 AMBULANCE SERVICES 96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0		0	0	0	
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED 97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0			0		
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0		0	0	0	
99. 00 09900 CMHC	0		0		0	
99.10 09910 CORF	0		0		0	
100.00100001&R SERVICES-NOT APPRVD PRGM 101.0010100 HOME HEALTH AGENCY	0					100. 00 101. 00
SPECIAL PURPOSE COST CENTERS	0		. 0		. 0	101.00
105.00 10500 KI DNEY ACQUI SI TI ON	0		0			105.00
106. 00 10600 HEART ACQUI SI TI ON	0		0			106.00
107. 00 10700 LIVER ACQUISITION 108. 00 10800 LUNG ACQUISITION						107.00 108.00
109. 00 10900 PANCREAS ACQUISITION	0		0			109.00
110.00 11000 INTESTINAL ACQUISITION	0		0			110.00
111.00 11100 ISLET ACQUISITION	0		0		0	111.00
5/30/2018 6 06 pm						

5/30/2018 6:06 pm

Health Financial Systems FF	ANCISCAN HEALTH MICHIGAN CITY			In Lieu of Form CMS-2552-10			
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CO	CN: 15-0015	Period: From 01/01/2017 To 12/31/2017	Worksheet C Part I Date/Time Pre 5/30/2018 6:0		
		Titl	e XIX	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		
113.00 11300 INTEREST EXPENSE 114.00 11400 UTILIZATION REVIEW-SNF 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 116.00 11600 HOSPICE 200.00 Subtotal (see instructions) 201.00 Less Observation Beds 202.00 Total (see instructions)	0 0 156, 546, 815 0 156, 546, 815		156, 546, 8′ 156, 546, 8′	0	0 0 0	113.00 114.00 115.00 116.00 200.00 201.00 202.00	

MPUTAT	TION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-0015		riod: om 01/01/2017	Worksheet C Part I	
					To		Date/Time Pre 5/30/2018 6:0	epare)6 pm
		-		e XIX		Hospi tal	Cost	1
	Cost Center Description	I npati ent	Charges Outpatient	Total (col. + col. 7)	6 0	Cost or Other Ratio	TEFRA I npati ent Rati o	
		6.00	7.00	8.00		9.00	10.00	
	NPATIENT ROUTINE SERVICE COST CENTERS	0	1	1	0			1 20
	3000 ADULTS & PEDIATRICS 3100 INTENSIVE CARE UNIT				0			30.
1	3200 CORONARY CARE UNI T				0			32.
1	3300 BURN INTENSIVE CARE UNIT	C			0			33.
	3400 SURGICAL INTENSIVE CARE UNIT	C			0			34.
	4000 SUBPROVIDER - IPF	C			0			40.
	4100 SUBPROVIDER - IRF	C			0			41.
	4300 NURSERY	C			0			43.
	4400 SKILLED NURSING FACILITY 4500 NURSING FACILITY				0			44.
	4600 OTHER LONG TERM CARE				0			40.
	NCI LLARY SERVI CE COST CENTERS		<u>'</u>	1	0			40.
	5000 OPERATING ROOM	C) (0	0.00000	0.00000	50.
	5100 RECOVERY ROOM	C		D	0	0.000000	0.000000	
	5200 DELIVERY ROOM & LABOR ROOM	C			0	0. 000000	0.000000	
	5300 ANESTHESI OLOGY	C) (-	0	0.00000	0.00000	
	5400 RADI OLOGY-DI AGNOSTI C	C		-	0	0.000000	0.000000	
	5401 FSED RADI OLOGY - DI AGNOSTI C			-	0	0.000000	0.000000	
	5500 RADIOLOGY-THERAPEUTIC 5501 WOODLAND CANCER CARE CTR			-	0	0.000000 0.000000	0. 000000 0. 000000	
	5600 RADI OI SOTOPE				0	0.000000	0.000000	
	5700 CT SCAN			-	0	0.000000	0. 000000	
	5800 MAGNETIC RESONANCE I MAGING (MRI)	C C			0	0.000000	0.000000	
	5900 CARDI AC CATHETERI ZATI ON	C) (b	0	0.000000	0.000000	
	6000 LABORATORY	C) (D	0	0.00000	0.00000	60
	6001 FS ED LAB	C) (-	0	0.00000	0.00000	
	6100 PBP CLINICAL LAB SERVICES-PRGM ONLY	C		-	0	0.00000	0.00000	
	6200 WHOLE BLOOD & PACKED RED BLOOD CELLS	C		-	0	0.000000	0.000000	
	6300 BLOOD STORING, PROCESSING & TRANS.	C			0	0.000000	0.000000	
	6400 I NTRAVENOUS THERAPY 6500 RESPI RATORY THERAPY				0	0.000000	0. 000000 0. 000000	
	6600 PHYSI CAL THERAPY				0	0.000000	0.000000	
	6700 OCCUPATI ONAL THERAPY				0	0.000000	0. 000000	
	6800 SPEECH PATHOLOGY	C			0	0.000000	0.000000	
00 0	6900 ELECTROCARDI OLOGY	C) (D	0	0.00000	0.000000	69
	7000 ELECTROENCEPHALOGRAPHY	C) (D	0	0.00000	0.000000	
	7100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	C			0	0.00000	0.000000	
	7200 IMPL. DEV. CHARGED TO PATIENTS				0	0.000000	0.000000	
	7300 DRUGS CHARGED TO PATIENTS 7400 RENAL DIALYSIS				0	0.000000 0.000000	0. 000000 0. 000000	
	7500 ASC (NON-DISTINCT PART)				0	0.000000	0.000000	
	3020 CV RESOURCE CTR				0	0.000000	0. 000000	
	7700 ALLOGENEIC STEM CELL ACQUISITION	C			0	0.000000	0.000000	
0	UTPATIENT SERVICE COST CENTERS							
	8800 RURAL HEALTH CLINIC	C) (D	0	0.00000	0.00000	
	8900 FEDERALLY QUALIFIED HEALTH CENTER	C		2	0	0.000000	0.000000	
	9000 CLINIC 9003 INFUSION OP SERVICES				0	0.000000	0.000000	
	9003 INFUSION OP SERVICES 9100 EMERGENCY			Ś.	0	0.000000	0. 000000 0. 000000	
	9100 EMERGENCY 9101 FREE STANDING EMERGENCY DEPT			ő	0	0.000000	0.000000	
	9200 OBSERVATION BEDS (NON-DISTINCT PART)				0	0.000000	0.000000	
	THER REIMBURSABLE COST CENTERS							
00 0	9400 HOME PROGRAM DI ALYSI S	C) (<u></u>	0	0.00000	0.00000	
	9500 AMBULANCE SERVICES	C) (0	0.00000	0.00000	
	9600 DURABLE MEDICAL EQUIP-RENTED			2	0	0.000000	0.000000	
	9700 DURABLE MEDICAL EQUIP-SOLD 9850 OTHER REIMBURSABLE COST CENTERS				0	0.000000	0. 000000 0. 000000	
	9900 CMHC			-	0	0.000000	0.000000	98
	9900 CMRC 9910 CORF			ő	0			99
	0000 I & R SERVICES-NOT APPRVD PRGM			b	õ			100
	0100 HOME HEALTH AGENCY	C			0			101
	PECIAL PURPOSE COST CENTERS	·	·	·				
5. 00 1	0500 KIDNEY ACQUISITION	C) (0			105
	0600 HEART ACQUI SI TI ON	C) (0			106
	0700 LIVER ACQUISITION	C		2	0			107
	0800 LUNG ACQUISITION			2	0			108
	0900 PANCREAS ACQUISITION			2	0			109
	1000 INTESTINAL ACQUISITION 1100 ISLET ACQUISITION			Ś.	0			111
	TIOUTISET ACCUISTION	, U	1 (1	U			1111

113.00|11300|INTEREST_EXPENSE 5/30/2018_6:06_pm

Health Financial Systems F	RANCISCAN HEALTH	H MICHIGAN CITY	(In Lieu of Form CMS-2552-10			
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C			Period: Worksheet C From 01/01/2017 Part I To 12/31/2017 Date/Time Pr 5/30/2018		
	Title XIX			Hospi tal	Cost		
		Charges					
Cost Center Description	I npati ent	Outpati ent		Cost or Other	TEFRA		
			+ col. 7)	Rati o	Inpati ent		
					Ratio		
	6.00	7.00	8.00	9.00	10.00		
114.00 11400 UTI LI ZATI ON REVI EW-SNF						114.00	
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0		0		115.00	
116. 00 11600 HOSPI CE	0	0		0		116.00	
200.00 Subtotal (see instructions)	0	0		0		200.00	
201.00 Less Observation Beds						201.00	
202.00 Total (see instructions)	0	0		0		202.00	

^{5/30/2018 6:06} pm

JOIWI U	TATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0015	Period: From 01/01/2017 To 12/31/2017	
			Title XIX	Hospi tal	Cost
	Cost Center Description	PPS Inpatient			
		Rati o 11.00			
	INPATIENT ROUTINE SERVICE COST CENTERS	11100			
30.00	03000 ADULTS & PEDIATRICS				30. (
31.00	03100 I NTENSI VE CARE UNI T				31. (
32.00	03200 CORONARY CARE UNI T				32.0
33.00	03300 BURN INTENSIVE CARE UNIT				33. (
34.00	03400 SURGI CAL I NTENSI VE CARE UNI T				34.0
40.00	04000 SUBPROVIDER - IPF				40.0
41.00 43.00	04100 SUBPROVI DER – I RF				41. (
43.00 44.00					43. (
	04400 SKILLED NURSING FACILITY				
45.00 46.00	04500 NURSING FACILITY 04600 OTHER LONG TERM CARE				45.0
+0. 00	ANCI LLARY SERVICE COST CENTERS				40.0
50.00	05000 OPERATING ROOM	0.000000			50.0
51.00	05100 RECOVERY ROOM	0. 000000			51.0
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000			52.0
53.00	05300 ANESTHESI OLOGY	0. 000000			53.0
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000			54.0
54.01	05401 FSED RADIOLOGY - DIAGNOSTIC	0. 000000			54.0
55.00	05500 RADI OLOGY-THERAPEUTI C	0. 000000			55.0
55.01	05501 WOODLAND CANCER CARE CTR	0. 000000			55.0
56.00	05600 RADI OI SOTOPE	0. 000000			56. (
57.00	05700 CT SCAN	0. 000000			57. (
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000			58.0
9.00	05900 CARDI AC CATHETERI ZATI ON	0. 000000			59.0
0.00	06000 LABORATORY	0. 000000			60. (
0. 01	06001 FS ED LAB	0. 000000			60.0
1. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0. 000000			61.0
2.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000			62.0
3.00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000			63.0
4.00	06400 I NTRAVENOUS THERAPY	0. 000000			64.0
5.00	06500 RESPI RATORY THERAPY	0. 000000			65.0
56.00	06600 PHYSI CAL THERAPY	0. 000000			66.0
57.00	06700 OCCUPATIONAL THERAPY	0. 000000			67.0
58.00	06800 SPEECH PATHOLOGY	0. 000000			68.0
59.00	06900 ELECTROCARDI OLOGY	0. 000000			69.0
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 000000			70.0
71.00	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0. 000000			71.0
2.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000			72. (
3.00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	0.000000			73.0
4.00	07500 ASC (NON-DISTINCT PART)	0.000000			74. (
5.00	03020 CV RESOURCE CTR	0.000000			75.0
	07700 ALLOGENEIC STEM CELL ACQUISITION	0. 000000			70.0
7.00	OUTPATIENT SERVICE COST CENTERS	0.000000			
38.00	08800 RURAL HEALTH CLINIC	0.000000			88. (
9.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000			89.0
0.00	09000 CLINIC	0. 000000			90.0
0.03		0. 000000			90.0
91.00	09100 EMERGENCY	0. 000000			91. (
1.01	09101 FREE STANDING EMERGENCY DEPT	0. 000000			91. (
2.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000			92. (
	OTHER REIMBURSABLE COST CENTERS	· · · · · · · · · · · · · · · · · · ·			
4.00	09400 HOME PROGRAM DI ALYSI S	0. 000000			94.0
5.00	09500 AMBULANCE SERVICES	0. 000000			95.0
6. 00		0. 000000			96. (
7.00		0. 000000			97. (
8.00		0. 000000			98. (
	09900 CMHC				99. (
	09910 CORF				99. ⁻
	0 10000 I &R SERVICES-NOT APPRVD PRGM				100. (
01.00	0 10100 HOME HEALTH AGENCY				101. (
	SPECIAL PURPOSE COST CENTERS	1 .			
	10500 KIDNEY ACQUISITION				105. (
	10600 HEART ACQUI SI TI ON				106. (
	10700 LIVER ACQUISITION				107. (
	0 10800 LUNG ACQUISITION				108. (
	0 10900 PANCREAS ACQUISITION				109. (
	11000 INTESTINAL ACQUISITION				110. (
	11100 I SLET ACQUI SI TI ON				111. (
	11300 INTEREST EXPENSE				113. (
	11400 UTILIZATION REVIEW-SNF				114. (
	D 11500 AMBULATORY SURGICAL CENTER (D. P.)	1			115. (

5/30/2018 6:06 pm

Heal th Fina	ncial Systems	FRANCISCAN HEALTH N	ICHIGAN CITY	In Lieu of Form CMS-2552-10			
COMPUTATI ON	OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0015	Peri od:	Worksheet C		
				From 01/01/2017	Part I		
				To 12/31/2017	Date/Time Pre 5/30/2018 6:0	pared:	
						5 pm	
			Title XIX	Hospi tal	Cost		
	Cost Center Description	PPS Inpatient					
		Ratio					
		11.00					
116.0011600	D 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	

^{5/30/2018 6:06} pm

Health Financial Systems	FRANCISCAN HEALTH	I MICHIGAN CIT	ſ	In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPI	TAL COSTS	Provider C		Period: From 01/01/2017 To 12/31/2017		
		Title	XVIII	Hospi tal	PPS	<u>o p</u>
Cost Center Description	Capi tal	Swing Bed	Reduced		Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,	· , · · · · ·	Related Cost			
	Part II, col.		(col. 1 - col			
	26)		2)			
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	3, 409, 769	C	3, 409, 76	9 20, 502	166.31	30.00
31.00 INTENSIVE CARE UNIT	558, 020		558, 02	2, 594	215.12	31.00
32.00 CORONARY CARE UNI T	0			0 0	0.00	32.00
33.00 BURN INTENSIVE CARE UNIT	0			0 0	0.00	33.00
34.00 SURGICAL INTENSIVE CARE UNIT	0			0 0	0.00	34.00
40.00 SUBPROVIDER - IPF	346, 112	C	346, 11	2 3, 175	109.01	40.00
41.00 SUBPROVIDER - IRF	574, 519	C	574, 51	9 2,607	220. 38	41.00
43.00 NURSERY	63, 239		63, 23			43.00
44.00 SKILLED NURSING FACILITY	0			0 0	0.00	44.00
45.00 NURSING FACILITY	0			0 0	0.00	45.00
200.00 Total (lines 30 through 199)	4, 951, 659		4, 951, 65	29, 915		200.00
Cost Center Description	I npati ent	Inpati ent				
	Program days	Program				
	Û Ĵ	Capital Cost				
		(col. 5 x col.				
		6)				
	6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	9, 312	1, 548, 679				30.00
31.00 INTENSIVE CARE UNIT	1, 121	241, 150				31.00
32.00 CORONARY CARE UNI T	0	C				32.00
33.00 BURN INTENSIVE CARE UNIT	0	C)			33.00
34.00 SURGICAL INTENSIVE CARE UNIT	0	0				34.00
40. 00 SUBPROVIDER - IPF	842	91, 786	,			40.00
41.00 SUBPROVIDER - IRF	1, 718	378, 613				41.00
43.00 NURSERY	0	0				43.00
44.00 SKILLED NURSING FACILITY	0	0				44.00
45.00 NURSING FACILITY	0	C				45.00
200.00 Total (lines 30 through 199)	12, 993	2, 260, 228				200. 00

	Financial Systems FF		H MICHIGAN CIT		Period:	u of Form CMS-: Worksheet D	2552-10
APPUR	TUNMENT OF INPATIENT ANGILLARY SERVICE CAPITA	AL COSTS	Provider C	CN: 15-0015	From 01/01/2017 To 12/31/2017	Part II Date/Time Pre 5/30/2018 6:0	pared:
			Title	e XVIII	Hospi tal	PPS	o pili
	Cost Center Description	Capi tal	Total Charges			Capital Costs	
		Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
		(from Wkst. B,	Part I, col.	(col. 1 ÷ col		column 4)	
		Part II, col.	8)	2)			
		26)	,	, í			
		1.00	2.00	3.00	4.00	5.00	
	ANCI LLARY SERVI CE COST CENTERS						
50.00	05000 OPERATING ROOM	2, 687, 389	121, 904, 193	0. 02204	45 13, 141, 287	289, 700	50.00
51.00	05100 RECOVERY ROOM	0	0	0.0000	0 00	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	319, 552	2, 119, 859	0. 15074	42 4, 063	612	52.00
53.00	05300 ANESTHESI OLOGY	33, 814	4, 959, 612	0. 0068	18 745, 530	5, 083	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 722, 942	89, 663, 221	0. 0192	16 10, 866, 276	208, 806	54.00
54.01	05401 FSED RADIOLOGY - DIAGNOSTIC	1, 170, 507	18, 968, 256	0.06170	0 0	0	54.01
55.00	05500 RADI OLOGY-THERAPEUTI C	672, 680	15, 288, 947	0.0439	98 952, 672	41, 916	55.00
55.01	05501 WOODLAND CANCER CARE CTR	461, 803	2, 954, 303			0	55.01
56.00	05600 RADI OI SOTOPE	0	0	0.00000		0	56.00
57.00	05700 CT SCAN	0	0			0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.0000		0	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	1, 404, 161	21, 800, 576	0.06440	3, 084, 312	198, 657	
60.00	06000 LABORATORY	509, 732	57, 440, 436	0.0088	74 11, 164, 874	99, 077	60.00
60. 01	06001 FS ED LAB	82, 041	8, 880, 592	0.00923	38 0	0	60.01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0.0000	0 00	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0.0000	0 00	0	63.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0.0000	0 00	0	64.00
65.00	06500 RESPI RATORY THERAPY	153, 881	12, 989, 208	0. 01184	47 6, 371, 846	75, 487	65.00
66.00	06600 PHYSI CAL THERAPY	162, 515	21, 868, 326	0.00743	32 2, 095, 328	15, 572	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	0	0.0000	0 00	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0.0000	0 00	0	68.00
69.00	06900 ELECTROCARDI OLOGY	425, 937	18, 326, 722	0. 02324	41 3, 404, 986	79, 135	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0.0000	0 00	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	29, 389	20, 990, 525	0.00140	3, 742, 310	5, 239	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	226, 087	16, 813, 251	0. 01344	47 5, 112, 560	68, 749	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	548, 488	123, 749, 311	0.00443	32 18, 060, 879	80, 046	73.00
74.00	07400 RENAL DI ALYSI S	0	0	0.0000	0 00	0	74.00
75.00	07500 ASC (NON-DI STI NCT PART)	0	0	0.0000	0 00	0	75.00
76.00	03020 CV RESOURCE CTR	0	0	0.0000	0 00	0	76.00
77.00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	0.0000	0 00	0	77.00
	OUTPATIENT SERVICE COST CENTERS	_	-				
88.00	08800 RURAL HEALTH CLINIC	0	0	0.0000	0 00	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.0000	0 00	0	89.00
90.00	09000 CLI NI C	0	0	0.0000	0 00	0	90.00
90.03	09003 INFUSION OP SERVICES	79, 892	2, 508, 402	0. 0318	50 13, 656	435	90.03
91.00	09100 EMERGENCY	1, 176, 541			30 4, 584, 572	106, 729	91.00
91.01	09101 FREE STANDING EMERGENCY DEPT	1, 467, 000	11, 241, 238	0. 13050	02 0	0	91.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	668, 249	5, 709, 529	0. 11704	41 0	0	92.00
	OTHER REIMBURSABLE COST CENTERS						
94.00	09400 HOME PROGRAM DI ALYSI S	0	C	0.0000	0 00	0	94.00
95.00	09500 AMBULANCE SERVICES						95.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0.0000	0 00	0	96.00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0	0			0	97.00
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0	0	0.0000	0 00	0	98.00
70.00							

Health Financial Systems	FRANCI SCAN HEALTH			In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER	R PASS THROUGH COST		F	eriod: rom 01/01/2017 o 12/31/2017	Date/Time Pre 5/30/2018 6:0	
			e XVIII	Hospi tal	PPS	
Cost Center Description	Nursing School	Nursing School			All Other	
	Post-Stepdown		Post-Stepdown	Cost	Medi cal	
	Adjustments		Adjustments		Education Cost	
	1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS	· · · ·					
30. 00 03000 ADULTS & PEDI ATRI CS	0	0	0	0	0	30.00
31. 00 03100 I NTENSI VE CARE UNI T	0	0			0	
32. 00 03200 CORONARY CARE UNI T	0	0		0	0	
		0	í í			
33. 00 03300 BURN INTENSIVE CARE UNIT	0	0	0	0	0	
34.00 03400 SURGICAL INTENSIVE CARE UNIT	0	Û	0 0	0	0	
40. 00 04000 SUBPROVIDER - IPF	0	C	0	0	0	
41.00 04100 SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00 04300 NURSERY	0	0	0	0	0	43.00
44.00 04400 SKILLED NURSING FACILITY	o	C	0	0		44.00
45.00 04500 NURSING FACILITY	0	0		0		45.00
200.00 Total (lines 30 through 199)	0	0		0	0	200.00
Cost Center Description	Swing-Bed	Total Costs	Total Patient	Per Diem (col	Inpati ent	200.00
cost center bescription	Adjustment	(sum of cols.	Days	$5 \div col. 6$	Program Days	
	Amount (see	1 through 3,	Days	J + COI. U)	riogram bays	
		0				
	instructions) 4.00	<u>minus col. 4)</u> 5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS	4.00	5.00	0.00	7.00	0.00	
	0	0	20 502	0.00	0.212	30.00
	0	-			9, 312	
31.00 03100 INTENSIVE CARE UNIT		C	2,071		1, 121	
32. 00 03200 CORONARY CARE UNI T		C	0		0	
33.00 03300 BURN INTENSIVE CARE UNIT		C	0	0.00	0	33.00
34.00 03400 SURGICAL INTENSIVE CARE UNIT		0	0	0.00	0	34.00
40. 00 04000 SUBPROVIDER - IPF	0	0	3, 175	0.00	842	40.00
41.00 04100 SUBPROVIDER - IRF	0	0	2,607	0.00	1, 718	41.00
43. 00 04300 NURSERY		0	1,037		0	
44. 00 04400 SKILLED NURSING FACILITY		0	0		0	
45. 00 04500 NURSING FACILITY		0			0	
		0	-			200.00
200.00 Total (lines 30 through 199) Cost Center Description	I npati ent	0	29,910		12, 993	200.00
cost center bescription	Program					
	Pass-Through					
	Cost (col. 7 x					
	<u>col . 8)</u>					
INDATIENT DOUTINE SEDVICE COST CENTERS	9.00					
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS	0					30.00
						•
31. 00 03100 I NTENSI VE CARE UNI T	0					31.00
32.00 03200 CORONARY CARE UNI T	0					32.00
33.00 03300 BURN INTENSIVE CARE UNIT	0					33.00
34.00 03400 SURGI CAL INTENSI VE CARE UNIT	0					34.00
40. 00 04000 SUBPROVIDER - IPF	0					40.00
41.00 04100 SUBPROVIDER - IRF	0					41.00
43. 00 04300 NURSERY	0					43.00
44. 00 04400 SKILLED NURSING FACILITY	0					44.00
45. 00 04500 NURSING FACILITY	0					44.00
	0					
200.00 Total (lines 30 through 199)	l O					200.00

		RANCI SCAN HEALTH				u of Form CMS-2	2552-10
	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF H COSTS	RVICE OTHER PASS		F	Period: From 01/01/2017 To 12/31/2017	Date/Time Pre 5/30/2018 6:0	
				e XVIII	Hospi tal	PPS	
	Cost Center Description			Nursing School	Allied Health	Allied Health	
			Post-Stepdown		Post-Stepdown		
		Cost	Adjustments	0.00	Adjustments	0.00	
		1.00	2A	2.00	3A	3.00	
50.00	ANCI LLARY SERVI CE COST CENTERS	0	0) 0	0	50.00
		0	0				50.00
51.00	05100 RECOVERY ROOM	-	-	-		-	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0			-	52.00
53.00	05300 ANESTHESI OLOGY	0	U		, o	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		-	-	54.00
54.01	05401 FSED RADI OLOGY - DI AGNOSTI C	0	0	-		-	54.01
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0	-	-	-	55.00
55.01	05501 WOODLAND CANCER CARE CTR	0	0		, 0	0	55.01
56.00	05600 RADI OI SOTOPE	0	0			-	56.00
57.00	05700 CT SCAN	0	0				57.00
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0			-	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0		-	-	59.00
60.00	06000 LABORATORY	0	0		-	-	60.00
60.01	06001 FS ED LAB	0	0	0 0	0 0	0	60.01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		-	-	62.00
63.00	06300 BLOOD STORI NG, PROCESSI NG & TRANS.	0	0			-	63.00
64.00	06400 I NTRAVENOUS THERAPY	0	0		-	-	64.00
65.00	06500 RESPI RATORY THERAPY	0	0	0	-	0	65.00
66.00	06600 PHYSI CAL THERAPY	0	0		-	-	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	C		-	U U	67.00
68.00	06800 SPEECH PATHOLOGY	0	C				68.00
	06900 ELECTROCARDI OLOGY	0	C			-	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	C		-	-	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	C		-	0	71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	C		-	-	72.00
	07300 DRUGS CHARGED TO PATIENTS	0	C		, i	0	73.00
74.00	07400 RENAL DIALYSIS	0	C		, e	0	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0	C		-	-	75.00
	03020 CV RESOURCE CTR	0	C				76.00
77.00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0) (0 0	0	77.00
	OUTPATIENT SERVICE COST CENTERS			-	-	-	
	08800 RURAL HEALTH CLINIC	0	C				88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	C				89.00
90.00	09000 CLI NI C	0	C	0 0	0 0	-	90.00
90.03	09003 INFUSION OP SERVICES	0	C		0 0	0	90.03
91.00	09100 EMERGENCY	0	C		-	0	91.00
91.01	09101 FREE STANDING EMERGENCY DEPT	0	C		-	-	91.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0)	0	92.00
	OTHER REIMBURSABLE COST CENTERS	1 1		1	. [1	
94.00	09400 HOME PROGRAM DI ALYSI S	0	C	0 0	0 0	0	94.00
95.00	09500 AMBULANCE SERVICES						95.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0				96.00
	09700 DURABLE MEDI CAL EQUI P-SOLD	0	0		-	0	97.00
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0	0		-	-	
200.00	Total (lines 50 through 199)	0	C) (0 0	0	200.00

	Financial Systems F TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE		H MICHIGAN CIT S Provider C		Peri od:	eu of Form CMS-: Worksheet D	2552-10
	H COSTS	RVICE UTHER PAS:	S Provider C	UN: 15-0015	From 01/01/2017 To 12/31/2017	Part IV Date/Time Pre	pared:
						5/30/2018 6:0	6 pm
	Cast Caster Description			XVIII	Hospi tal	PPS	
	Cost Center Description	All Other Medical	Total Cost (sum of col 1	Total Outpatient		Ratio of Cost to Charges	
		Education Cost		Cost (sum o			
		Luucation cost	4)	col. 2, 3 an		7)	
			.,	4)		.,	
		4.00	5.00	6.00	7.00	8.00	
	ANCI LLARY SERVI CE COST CENTERS		•	•			
50.00	05000 OPERATI NG ROOM	0	-		0 121, 904, 193	0. 000000	50.00
51.00	05100 RECOVERY ROOM	0			0 0	0. 000000	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0			0 2, 119, 859		
53.00	05300 ANESTHESI OLOGY	0			0 4, 959, 612		
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	-		0 89, 663, 221		
54.01	05401 FSED RADIOLOGY - DIAGNOSTIC	0			0 18, 968, 256		
55.00	05500 RADI OLOGY-THERAPEUTI C	0			0 15, 288, 947		
55.01	05501 WOODLAND CANCER CARE CTR	0	-		0 2, 954, 303		
56.00	05600 RADI OI SOTOPE	0			0 0	0.000000	
57.00	05700 CT SCAN	0	-		0 0		
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0			0 0	0.000000	
59.00	05900 CARDI AC CATHETERI ZATI ON	0	-		0 21, 800, 576		
60.00	06000 LABORATORY	0	-		0 57, 440, 436		1
60.01	06001 FS ED LAB	0	0		0 8, 880, 592	0.00000	
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	-		0 0		
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	-		0 0		
64.00	06400 I NTRAVENOUS THERAPY	0	-		0 0	0.000000	
65.00	06500 RESPI RATORY THERAPY	0			0 12, 989, 208		
66.00	06600 PHYSI CAL THERAPY	0	-		0 21, 868, 326		
67.00	06700 OCCUPATIONAL THERAPY	0	-		0 0		
68.00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	0			0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		
69.00 70.00	07000 ELECTROENCEPHALOGRAPHY	0	-		0 18, 326, 722 0 0	0.000000	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0			0 20, 990, 525		
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0			0 20, 990, 525		
73.00	07300 DRUGS CHARGED TO PATIENTS	0	-		0 123, 749, 311		
	07400 RENAL DIALYSIS	0	-		0 123, 747, 311		
	07500 ASC (NON-DI STINCT PART)	0			0 0		
76.00	03020 CV RESOURCE CTR	0	-		0 0		
	07700 ALLOGENEIC STEM CELL ACQUISITION	0			0 0		
	OUTPATIENT SERVICE COST CENTERS		-	1			
88.00	08800 RURAL HEALTH CLINIC	0	C		0 0	0.000000	1 88. 00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	C)	0 0		
90.00	09000 CLI NI C	0	C)	0 0		
90.03	09003 INFUSION OP SERVICES	0	C)	0 2, 508, 402		
91.00	09100 EMERGENCY	0	C		0 50, 538, 926		
91.01	09101 FREE STANDING EMERGENCY DEPT	0	C		0 11, 241, 238	0. 000000	91.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	C		0 5, 709, 529		92.00
	OTHER REIMBURSABLE COST CENTERS		·	•			1
94.00	09400 HOME PROGRAM DI ALYSI S	0	C		0 0	0.000000	94.00
95.00	09500 AMBULANCE SERVICES						95.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0		0 0	0. 000000	96.00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0	C		0 0		
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0	0)	0 0	0. 000000	98.00
200.00	Total (lines 50 through 199)	0	c c	1	0 628, 715, 433		200.00

	OF INPATIENT/OUTPATIENT ANCILLARY SE	DVICE OTHER DACC	Provider C	CN. 1E 001E	Peri	i odi	Worksheet D	2552-10
THROUGH COSTS	OF INPATIENT/OUTPATIENT ANGILLARY SE	RVICE UTHER PASS	Provider C	UN: 15-0015		m 01/01/2017 12/31/2017	Part IV Date/Time Prep 5/30/2018 6:00	
			Title	× XVIII		Hospi tal	PPS	o pii
C	ost Center Description	Outpatient	Inpati ent	Inpatient		Outpati ent	Outpati ent	
	•	Ratio of Cost	Program	Program		Program	Program	
		to Charges	Charges	Pass-Throug	h	Charges	Pass-Through	
		(col. 6 ÷ col.	-	Costs (col.	8	, e	Costs (col. 9	
		7)		x col. 10)			x col. 12)	
		9.00	10.00	11.00		12.00	13.00	
	RY SERVICE COST CENTERS	- I		1				
	PERATING ROOM	0. 000000	13, 141, 287		0	31, 399, 450	0	
	ECOVERY ROOM	0. 000000	0		0	0	0	51.00
	ELIVERY ROOM & LABOR ROOM	0. 000000	4, 063		0	0	0	52.00
	NESTHESI OLOGY	0. 000000	745, 530		0	1, 263, 389	0	53.00
	ADI OLOGY-DI AGNOSTI C	0. 000000	10, 866, 276		0	25, 104, 324	0	54.00
	SED RADIOLOGY – DIAGNOSTIC	0. 000000	0		0	0	0	54.01
55.00 05500 R	ADI OLOGY-THERAPEUTI C	0. 000000	952, 672		0	7, 422, 941	0	55.00
55.01 05501 W	OODLAND CANCER CARE CTR	0. 000000	0		0	0	0	55.01
56.00 05600 R	ADI OI SOTOPE	0. 000000	0		0	0	0	56.00
57.00 05700 C	T SCAN	0. 000000	0		0	0	0	57.00
58.00 05800 M	AGNETIC RESONANCE IMAGING (MRI)	0. 000000	0		0	0	0	58.00
59.00 05900 C	ARDI AC CATHETERI ZATI ON	0. 000000	3, 084, 312		0	3, 280, 184	0	59.00
60.00 06000 L	ABORATORY	0. 000000	11, 164, 874		0	6, 891, 951	0	60.00
60.01 06001 F	S ED LAB	0. 000000	0		0	0	0	60.01
	BP CLINICAL LAB SERVICES-PRGM ONLY							61.00
	HOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000	0		0	0	0	62.00
	LOOD STORING, PROCESSING & TRANS.	0. 000000	0		0	0	0	63.00
	NTRAVENOUS THERAPY	0. 000000	0		0	0	0	64.00
	ESPI RATORY THERAPY	0. 000000	6, 371, 846		0	526, 673	0	65.00
	HYSI CAL THERAPY	0. 000000	2,095,328		0	114, 658	0	66.00
	CCUPATIONAL THERAPY	0. 000000	0		0	0	0	67.00
	PEECH PATHOLOGY	0. 000000	0		0	Ő	0	68.00
	LECTROCARDI OLOGY	0. 000000	3, 404, 986		0	4, 479, 495	0	69.00
	LECTROENCEPHALOGRAPHY	0. 000000	0, 101, 200		0	0,11,11,10	0	70.00
	EDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	3, 742, 310		0	2, 332, 534	0	71.00
	MPL. DEV. CHARGED TO PATIENTS	0. 000000	5, 112, 560		0	2, 212, 622	0	72.00
	RUGS CHARGED TO PATIENTS	0. 000000	18, 060, 879		0	45, 247, 838	0	73.00
	ENAL DIALYSIS	0. 000000	0		0	000	0	74.00
	SC (NON-DISTINCT PART)	0. 000000	0		0	Ő	0	75.00
	V RESOURCE CTR	0. 000000	0		0	Ő	0	76.00
	LLOGENEIC STEM CELL ACQUISITION	0. 000000	0		0	0	0	
	ENT SERVICE COST CENTERS	0.000000		1	-			1 1 1 00
	URAL HEALTH CLINIC	0.000000	0		0	0	0	88.00
	EDERALLY QUALIFIED HEALTH CENTER	0. 000000	0		0	0	0	89.00
90.00 09000 C		0. 000000	0		0	0	0	90.00
	NFUSION OP SERVICES	0. 000000	13, 656		0	985, 960	0	90.03
	MERGENCY	0. 000000	4, 584, 572		0	7, 642, 250	0	91.00
	REE STANDING EMERGENCY DEPT	0. 000000	0		0	,, 012, 200	0	91.01
	BSERVATION BEDS (NON-DISTINCT PART)	0. 000000	0		0	1, 348, 038	0	•
	EIMBURSABLE COST CENTERS	0.000000	0	1		1, 818, 880	0	/2.00
	OME PROGRAM DI ALYSI S	0. 000000	0		0	0	0	94.00
	MBULANCE SERVICES	0.00000	0		Ĭ	Ŭ	Ű	95.00
	URABLE MEDICAL EQUIP-RENTED	0. 000000	0		0	0	0	96.00
	URABLE MEDICAL EQUIP-SOLD	0. 000000	0		0	0	0	97.00
			-			-	0	•
98.00 09850 0	THER REIMBURSABLE COST CENTERS	0.000000	0		0	0		1 98 110

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCHE COST Provider COX. 15-0013 Period Instruction For 01/201201 Worksheet D For 01/201201 Worksheet D For 01/201201 Cost Center Description Cost To Charge PFS Reletures Worksheet C, Part I, ed. , Part I, ed. ,	Health Financial S	ystems FF	RANCISCAN HEALT	H MICHIGAN CIT	(In Lie	u of Form CMS-2	2552-10
To 12/31/207 Data Critice Prepared Cost Center Description Cost to Charge PSE Inturned Ratio From Barkenet C, Part I, col. Charges Services (see inst.) Cost to Services (sevice (sevice) (sevice (sevice) (s	APPORTIONMENT OF M	IEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C				
Cost Center Description This AVIII Hoggital PPS Cost Center Description Destrogeneration of the pression of the							Date/Time Pre	
Cost Center Description Ost to Charges Baltio From Baltio From Baltio From Baltio From Baltio From Services (see inst.) Cost Relimbursa Ded & Coins Services (see inst.) Cost Baltio From Services (see inst.) MCLILARY SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00 50.00 05000 (PERALING ROM Services (see inst.) 0.00 4.00 5.00 5.00 50.00 05000 (PERALING ROM Services (see inst.) 0.00 4.00 5.00 5.00 50.00 05000 (PERALING ROM Services (see inst.) 0.00000 0.00000 0.0000 6.0000 0.00000 50.00 05000 (PERALING ROM Services (see inst.) 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.000000 0.000000 0.000000 0.000000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.000000 0.0000				Title	xviii	Hospi tal		o pili
Relit is Front Services Part I, col. Services Inst. Relimbursed Subject To bed & Colns Relimbursed Subject To bed & Colns Relimbursed Subject To bed & Colns 0 2.00 4.05 5.00 5.00 5.00 0 0.0000 (PFRATING ROW 0.00000 (PFRATING ROW 0.000000 (PFRATING ROW 0.00000 (PFRATING ROW 0.00000 (PFRATING ROW 0.00000 (PFRATING ROW 0.000000 (PFRATING ROW 0.00000 (PFRATING ROW 0.000000 (PFRATING ROW 0.00000 (PFRATING ROW 0.00000 (PFRAT					Charges			
Burch Leep L , Part I, col. 9 Inst.) Services Not Deck & Coll science ANCILLARY SERVICE COST ENTERS 1.00 2.00 3.00 4.00 5.00 50.00 05000 (PERATINE ROW 0.141990 (see inst.) 3.00 4.00 5.00 51.00 05000 (PERATINE ROW 0.141990 (see inst.) 3.00 4.00 5.00 51.00 05000 (sec OVER NOM 0.042061 (see inst.) 5.00 5.00 5.00 51.00 05300 (ANESTHERS NOM 0.042061 (see inst.) 5.03.00 5.00 5.00 51.00 05401 (see inst.) 0.00 0.0141990 (see inst.) 5.00 5.00 51.00 05401 (see inst.) 0.00 0.014190 (see inst.) 5.00 5.00 50.00 05300 (ANESTHER) OLGOV - DLANOSTIC 0.164608 (see inst.) 0.00 0.014190 (see inst.) 5.00 50.00 05600 (ADULOC) - HARCHER LINCI (see inst.) 0.00000 (see inst.) 0.00 5.00 5.00 50.00 05600 (ADULOC) - HARCHER LINCI (see inst.) 0.00000 (see inst.) 0.00 5.00 50.00	Cost C	Center Description	5					
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55. 01 05501 WODLAND CANCER CARE CTR 0.96520 0 0 0 55. 00 56. 00 65600 RADI 01 STOPE 0.000000 0 0 0 57. 00 0 0 0 0 57. 00 0 0 0 57. 00 0 0 0 0 0 0 0 0 0 0 57. 00 0					C	0 0	0	54.01
56.00 OSGOO OSGOO O O O S7.00					C	0 0		
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90. 00 09000 CLINIC 0.000000 0 0 0 0 0 0 0 0 90. 00 90. 00 90. 00 90. 00 90. 00 90. 00 90. 00 90. 00 90. 00 90. 00 90. 00 90. 00 90. 00 90. 00 90. 00 90. 00 90. 00 91. 00 91. 00 91. 01 90. 01 FREE STANDI NG EMERGENCY 0. 231523 7, 642, 250 0 0 1, 769, 357 91. 00 91. 01 92. 00 90200 005ERVATI ON BEDS (NON-DI STINCT PART) 0. 898635 1, 348, 038 0 0 1, 211, 394 92. 00 91. 01 92. 00 92. 00 95. 00 94. 00 94. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 96. 00								
90. 03 09003 INFUSION OP SERVICES 0. 423686 985,960 0 417,737 90. 03 91. 00 09100 EMERGENCY 0. 231523 7,642,250 0 0 1,769,357 91. 00 91. 01 09100 FREE STANDING EMERGENCY DEPT 0. 515562 0 0 0 0 1,769,357 91. 01 92. 00 09200 0BSERVATION BEDS (NON-DI STINCT PART) 0. 898635 1,348,038 0 0 1,211,394 92. 00 07HER REI MBURSABLE COST CENTERS 0. 000000 0 0 94.00 95.00 9500 AMBULANCE SERVICES 0. 000000 0 95.00 95.00 96.00 96.00 96.00 96.00 96.00 96.00 96.00 96.00 96.00 96.00 96.00 97.00 97.00 97.00 98.00 98.00 98.00 98.00 98.00 98.00 98.00 98.00 98.00 98.00 98.00 98.00 98.00 98.00 98.00 98.00 <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></t<>								
91.00 09100 EMERGENCY 0.231523 7,642,250 0 0 1,769,357 91.00 91.01 09101 FREE STANDI NG EMERGENCY DEPT 0.515562 0 0 0 0 91.01 92.00 09200 0BSERVATI ON BEDS (NON-DI STINCT PART) 0.898635 1,348,038 0 0 1,211,394 92.00 07HER REI MBUSABLE COST CENTERS 0 0 0 94.00 9600 AMBULANCE SERVICES 91.00 92.00 95.00 09500 AMBULANCE SERVICES 0.000000 0 0 95.00 95.00 95.00 96.00 96.00 96.00 96.00 96.00 96.00 96.00 96.00 97.00 98.00 9850 0.000000 0 0 97.00 98.00 90.00								
91.01 09101 FREE STANDING EMERGENCY DEPT 0.515562 0 0 0 0 91.01 92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 0.898635 1,348,038 0 0 1,211,394 92.00 0THER REI MBURSABLE COST CENTERS 0.000000 0 0 94.00 94.00 95.00 09600 MMBULANCE SERVICES 94.00 95.00 95.00 96.00 0 0 95.00 96.00 0 0 95.00 95.00 96.00 97.00 97.00 97.00 0 0 0 95.00 96.00 96.00 96.00 96.00 96.00 96.00 96.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 98.00 0 0 0 0 97.00 97.00 98.00 9850 01HER REI MBURSABLE COST CENTERS 0.000000 0 0 0 98.00 98.00 98.00 98.00 98.00 98.00 98.00 98.00 98.00 98.00 98.00 98.00 98.00 98.00 98.00 <td< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></td<>								
92. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 0.898635 1,348,038 0 0 1,211,394 92.00 0THER REI MBURSABLE COST CENTERS 0 0 1,211,394 94.00 94.00 94.00 94.00 94.00 95.00 09500 AMBULANCE SERVICES 0.000000 0 0 95.00 95.00 95.00 96.00 0 0 0 95.00 95.00 96.00 0 0 0 95.00 95.00 96.00 0 0 0 96.00 97.00 97.00 0 0 0 96.00 97.00 97.00 98.00 0 0 0 97.00 97.00 98.00 0 0 0 0 98.00 <td>1 1</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>., ,</td> <td></td>	1 1						., ,	
OTHER REI MBURSABLE COST CENTERS 94. 00 09400 HOME PROGRAM DI ALYSI S 0.000000 0 94. 00 95. 00 09500 AMBULANCE SERVI CES 0.000000 0 95. 00 95. 00 96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0.000000 0 0 0 96. 00 97. 00 09700 DURABLE MEDI CAL EQUI P-RENTED 0.000000 0 0 0 97. 00 98. 00 09850 OTHER REI MBURSABLE COST CENTERS 0.000000 0 0 0 98. 00 200. 00 Subtotal (see instructions) 140, 252, 307 0 32, 694 24, 504, 799 200. 00 201. 00 Less PBP Clinic Lab. Services-Program 0 0 201. 00								
95. 00 09500 AMBULANCE SERVICES 0.000000 0 0 95. 00 95. 00 96. 00 09600 DURABLE MEDICAL EQUIP-RENTED 0.000000 0 0 0 96. 00 96. 00 96. 00 96. 00 96. 00 96. 00 96. 00 96. 00 96. 00 97. 00 98. 00 0 0 0 97. 00 98. 00 98. 00 98. 00 98. 00 98. 00 98. 00 98. 00 98. 00 98. 00 98. 00 98. 00 98. 00 98. 00 90. 00 0 0 0 98. 00 98. 00 98. 00 98. 00 98. 00 98. 00 98. 00 98. 00 98. 00 98. 00 90. 00 98. 00<								
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0.000000 0 0 0 96. 00 96. 00 97. 00 97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0.000000 0 0 0 0 97. 00 98. 00 09850 OTHER REI MBURSABLE COST CENTERS 0.000000 0 0 0 98. 00	1 1							
97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0.000000 0 0 0 97. 00 97. 00 98. 00 98. 00 98. 00 09850 0THER REI MBURSABLE COST CENTERS 0.000000 0 0 0 98. 00	1 1						-	
98.00 09850 OTHER REI MBURSABLE COST CENTERS 0.000000 0 0 0 98.00 200.00 Subtotal (see instructions) 140,252,307 0 32,694 24,504,799 200.00 201.00 Less PBP Clinic Lab. Services-Program Only Charges 0 0 0 0 201.00	1 1							
200.00 Subtotal (see instructions) 140, 252, 307 0 32, 694 24, 504, 799 200.00 201.00 Less PBP Clinic Lab. Services-Program Only Charges 0 0 0 201.00						-		97.00
201.00 Less PBP Clinic Lab. Services-Program 0 0 201.00 Only Charges 0 0 201.00			0.00000					
Only Charges				, 202, 307		0	,, , , , , , ,	
202. 00 Net Charges (line 200 - line 201) 140, 252, 307 0 32, 694 24, 504, 799 202. 00	Only C	Charges						
	202.00 Net Ch	narges (line 200 – line 201)		140, 252, 307	C	32, 694	24, 504, 799	202.00

Health Financ	cial Systems FR	ANCISCAN HEALTH	I MICHIGAN CITY		In Lie	u of Form CMS-2	2552-10
	T OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider CC	N: 15-0015	Period: From 01/01/2017	Worksheet D Part V	
					To 12/31/2017	Date/Time Pre	
			Title	XV/111	Hospi tal	5/30/2018 6:0 PPS	6 pm
		Cos			nospi tai		
(Cost Center Description	Cost	Cost				
		Reimbursed	Reimbursed				
		Servi ces Subj ect To	Services Not Subject To				
		Ded. & Coins.	Ded. & Coins.				
		(see inst.)	(see inst.)				
		6.00	7.00				
	ARY SERVICE COST CENTERS		0				50.00
	RECOVERY ROOM	0	0				50.00 51.00
1 1	DELIVERY ROOM & LABOR ROOM	0	0				52.00
	ANESTHESI OLOGY	0	0				53.00
	RADI OLOGY-DI AGNOSTI C	0	0				54.00
1 1	FSED RADIOLOGY - DIAGNOSTIC	0	0				54.01
1 1	RADIOLOGY-THERAPEUTIC	0	0				55.00
1 1	WOODLAND CANCER CARE CTR RADIOISOTOPE	0	0				55.01 56.00
	CT SCAN	0	0				57.00
	MAGNETIC RESONANCE IMAGING (MRI)	0	0				58.00
59.00 05900	CARDI AC CATHETERI ZATI ON	0	0				59.00
	LABORATORY	0	0				60.00
	FS ED LAB	0	0				60.01
1 1	PBP CLINICAL LAB SERVICES-PRGM ONLY WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0				61.00 62.00
1 1	BLOOD STORING, PROCESSING & TRANS.	0	0				63.00
1 1	INTRAVENOUS THERAPY	0	0				64.00
	RESPI RATORY THERAPY	0	0				65.00
1 1	PHYSI CAL THERAPY	0	0				66.00
	OCCUPATIONAL THERAPY	0	0				67.00
1 1	SPEECH PATHOLOGY ELECTROCARDI OLOGY	0	0				68.00 69.00
	ELECTROENCEPHALOGRAPHY	0	0				70.00
	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				71.00
	IMPL. DEV. CHARGED TO PATIENTS	0	0				72.00
	DRUGS CHARGED TO PATIENTS	0	5, 642				73.00
	RENAL DIALYSIS	0	0				74.00
	ASC (NON-DI STINCT PART) CV RESOURCE CTR	0	0				75.00
	ALLOGENEIC STEM CELL ACQUISITION	0	0				77.00
	IENT SERVICE COST CENTERS						1
1 1	RURAL HEALTH CLINIC	0	0				88.00
	FEDERALLY QUALIFIED HEALTH CENTER	0	0				89.00
90.00 09000	CLINIC INFUSION OP SERVICES	0	0				90.00
90. 03 09003 91. 00 09100		0	0				90.03 91.00
	FREE STANDING EMERGENCY DEPT	0	0				91.00
	OBSERVATION BEDS (NON-DISTINCT PART)	0	0				92.00
OTHER	REIMBURSABLE COST CENTERS	· · · ·					
1 1	HOME PROGRAM DI ALYSI S	0	0				94.00
	AMBULANCE SERVICES DURABLE MEDICAL EQUIP-RENTED	0	0				95.00 96.00
	DURABLE MEDICAL EQUIP-RENTED DURABLE MEDICAL EQUIP-SOLD	0	0				96.00
	OTHER REIMBURSABLE COST CENTERS	0	0				98.00
1 1	Subtotal (see instructions)	0	5, 642				200.00
201.00	Less PBP Clinic Lab. Services-Program	0					201.00
1 1	Only Charges		F (10				202.00
202.00 1	Net Charges (line 200 - line 201)	0	5, 642				202.00

ORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT.	AL COSTS	Provider C	CN: 15-0015	Peri od:	Worksheet D	
		Component	CCN: 15-S015	From 01/01/2017 To 12/31/2017	Part II Date/Time Pre 5/30/2018 6:0	
		Title	e XVIII	Subprovider - IPF	PPS	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
		(from Wkst. C,		U U	(column 3 x	
	(from Wkst. B,			I. Charges	column 4)	
	Part II, col. 26)	8)	2)			
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	1.00	2.00	0.00	1.00	0.00	
00 05000 OPERATING ROOM	2, 687, 389	121, 904, 193	0. 0220	45 27, 012	595	50.0
DO 05100 RECOVERY ROOM	0				0	
00 05200 DELIVERY ROOM & LABOR ROOM	319, 552	2, 119, 859			0	
00 05300 ANESTHESI OLOGY	33, 814			18 0	0	53.0
00 05400 RADI OLOGY-DI AGNOSTI C	1, 722, 942				651	54.0
01 05401 FSED RADIOLOGY - DIAGNOSTIC	1, 170, 507	18, 968, 256	0. 0617	09 0	0	54.
00 05500 RADI OLOGY-THERAPEUTI C	672, 680	15, 288, 947	0. 0439	98 0	0	55.
01 05501 WOODLAND CANCER CARE CTR	461, 803	2, 954, 303	0. 1563	15 0	0	55.
00 05600 RADI OI SOTOPE	0	C	0. 0000	00 00	0	56.
DO 05700 CT SCAN	0	c c			0	57.
DO 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	c c	0. 0000	00 00	0	58.
00 05900 CARDI AC CATHETERI ZATI ON	1, 404, 161	21, 800, 576	0. 0644	09 0	0	59.
00 06000 LABORATORY	509, 732	57, 440, 436	0. 0088	74 122, 007	1, 083	60.
01 06001 FS ED LAB	82, 041	8, 880, 592	0.0092	38 0	0	60.
00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.
00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	C	0.0000	00 0	0	62.
00 06300 BLOOD STORING, PROCESSING & TRANS.	0	C			0	63.
00 06400 INTRAVENOUS THERAPY	0	-			0	64.
00 06500 RESPI RATORY THERAPY	153, 881	12, 989, 208			157	65.
00 06600 PHYSI CAL THERAPY	162, 515	21, 868, 326			67	66.
00 06700 OCCUPATI ONAL THERAPY	0	-			0	
00 06800 SPEECH PATHOLOGY	0	C			0	
00 06900 ELECTROCARDI OLOGY	425, 937	18, 326, 722			196	
00 07000 ELECTROENCEPHALOGRAPHY	0	-	0.0000		0	
00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	29, 389				13	
00 07200 IMPL. DEV. CHARGED TO PATIENTS	226, 087				0	
00 07300 DRUGS CHARGED TO PATIENTS	548, 488				1, 143	
00 07400 RENAL DIALYSIS	0				0	
00 07500 ASC (NON-DI STINCT PART)	0	-			0	
00 03020 CV RESOURCE CTR	0				0	
00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	C	0.0000	00 0	0	77.
			0.0000	00 0	0	1
00 08800 RURAL HEALTH CLINIC	0					
00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	-			0	
00 09000 CLINIC 03 09003 INFUSION OP SERVICES	0	-				
03 09003 I NFUSI ON OP SERVI CES 00 09100 EMERGENCY	79,892				0	
	1, 176, 541				2, 112	
01 09101 FREE STANDING EMERGENCY DEPT 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 467, 000				Ũ	
OTHER REIMBURSABLE COST CENTERS	0	0,709,529	0.0000	00 0	0	92.
00 09400 HOME PROGRAM DI ALYSI S			0.0000	0 00	0	94.
00 09500 AMBULANCE SERVICES			0.0000	00 0	0	94. 95.
00 09600 DURABLE MEDICAL EQUIP-RENTED		c	0.0000	0	0	
00 09700 DURABLE MEDICAL EQUIP-RENTED	0				0	
00 09850 OTHER REIMBURSABLE COST CENTERS	0				0	
.00 Total (lines 50 through 199)	0	628, 715, 433	0.0000	571, 542		200.

Health Financial Systems	RANCISCAN HEALTH	MICHIGAN CIT	Y	In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PASS	Provider C	CN: 15-0015	Peri od:	Worksheet D	
THROUGH COSTS		Component	CCN: 15-S015	From 01/01/2017 To 12/31/2017		pared:
		Title	e XVIII	Subprovider -	PPS	<u>o piii</u>
Cost Center Description	Non Physician N	lursi ng School	Nursing Schoo	Allied Health	Allied Health	
		Post-Stepdown		Post-Stepdown		
	<u>Cost</u> 1.00	Adjustments 2A	2.00	Adjustments 3A	3.00	
ANCI LLARY SERVI CE COST CENTERS	1.00	ZA	2.00	3A	3.00	
50. 00 05000 OPERATING ROOM	0	(0 0	0	50.00
51.00 05100 RECOVERY ROOM	0	C		0 0		
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	C		0 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0	C		0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	C		0 0	0	54.00
54.01 05401 FSED RADIOLOGY - DIAGNOSTIC	0	C		0 0	0	
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	C	D	0 0	0	
55.01 05501 WOODLAND CANCER CARE CTR	0	C	0	0 0	0	
56. 00 05600 RADI OI SOTOPE	0	(0	0 0	0	
57.00 05700 CT SCAN	0	(0	
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI) 59. 00 05900 CARDIAC CATHETERIZATION	0	(0	
60. 00 06000 LABORATORY	0			0 0	0	1
60. 01 06001 FS ED LAB	0				0	
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	C	, 	0		61.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	C		0 0	0	
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	C		0 0	o o	1
64.00 06400 INTRAVENOUS THERAPY	0	C	þ	0 0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0	C		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	C		0 0	0	
67.00 06700 OCCUPATI ONAL THERAPY	0	C		0 0	0	
68.00 06800 SPEECH PATHOLOGY	0	C	D	0 0	0	
69.00 06900 ELECTROCARDI OLOGY	0	C	0	0 0	-	1
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	(0	0 0	0	
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	(0 0	0	
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS 73.00 07300 DRUGS CHARGED TO PATIENTS	0			0 0	0	
74. 00 07400 RENAL DIALYSIS	0				0	1
75. 00 07500 ASC (NON-DI STINCT PART)	0	(0 0	0	
76. 00 03020 CV RESOURCE CTR	0	0		0 0	-	
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	C		0 0	0	1
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	C)	0 0	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	C		0 0	-	
90. 00 09000 CLINIC	0	C	D	0 0	, o	
90. 03 09003 INFUSION OP SERVICES	0	0	0	0 0	0	
91. 00 09100 EMERGENCY	0	(0 0	0	
91. 01 09101 FREE STANDING EMERGENCY DEPT	0	Ĺ		0 0	-	1
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0		1	U	0	92.00
94. 00 09400 HOME PROGRAM DI ALYSI S	0	(0 0	0	94.00
95. 00 09500 AMBULANCE SERVICES		C	1			95.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	C		0 0	0	1
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	C	þ	0 0	-	
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	C	þ	0 0	0	1
200.00 Total (lines 50 through 199)	0	C		0 0	0	200.00

APPORTI ONMENT	AI Systems F OF INPATIENT/OUTPATIENT ANCILLARY SE		MICHIGAN CIT		Peri od:	eu of Form CMS-: Worksheet D	-
HROUGH COSTS				CCN: 15-S015	From 01/01/2017 To 12/31/2017	7 Part IV	
			Title	e XVIII	Subprovider - IPF	PPS	0 pm
C	cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
		Medi cal	(sum of col 1				
		Education Cost		Cost (sum o		(col. 5 ÷ col.	
			4)	col. 2, 3 ar	nd 8)	7)	
		4.00	5.00	4) 6.00	7.00	8.00	
ANCI LLA	ARY SERVICE COST CENTERS		0100	0.00	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	0,00	
50.00 05000 C	PERATING ROOM	0	C		0 121, 904, 193	3 0. 000000	50.00
51.00 05100 R	ECOVERY ROOM	0	C		0 0	0. 000000	51.00
52.00 05200 D	ELIVERY ROOM & LABOR ROOM	0	C		0 2, 119, 859	9 0. 000000	52.00
53.00 05300 A	NESTHESI OLOGY	0	C		0 4, 959, 612	0. 000000	53.00
4.00 05400 R	ADI OLOGY-DI AGNOSTI C	0	C		0 89, 663, 22	0. 000000	54.00
	SED RADIOLOGY - DIAGNOSTIC	0	0		0 18, 968, 250		
5.00 05500 R	ADI OLOGY-THERAPEUTI C	0	0		0 15, 288, 94	0. 000000	55.00
	OODLAND CANCER CARE CTR	0	0		0 2, 954, 303	0. 000000	55.01
6.00 05600 R	ADI OI SOTOPE	0	0		0 0	0. 000000	56.00
7.00 05700 0		0	0		0 0		•
1 1	AGNETIC RESONANCE IMAGING (MRI)	0	0		-	0. 000000	
	ARDI AC CATHETERI ZATI ON	0	0		0 21, 800, 576		
	ABORATORY	0	C		0 57, 440, 430		
	S ED LAB	0	C		0 8, 880, 592	0. 000000	
	BP CLINICAL LAB SERVICES-PRGM ONLY						61.00
	HOLE BLOOD & PACKED RED BLOOD CELLS	0	C			0. 000000	
	LOOD STORING, PROCESSING & TRANS.	0	C		-	0. 000000	
	NTRAVENOUS THERAPY	0	C		-	0. 000000	
	ESPI RATORY THERAPY	0	C		0 12, 989, 208		
	HYSI CAL THERAPY	0	C		0 21, 868, 320		
	CCUPATIONAL THERAPY	0	0		-	0. 000000	
	PEECH PATHOLOGY	0	0		-	0. 000000	
	LECTROCARDI OLOGY	0	0		0 18, 326, 72		
	LECTROENCEPHALOGRAPHY	0	0		-	0. 000000	
	IEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	0		0 20, 990, 52		
	MPL. DEV. CHARGED TO PATIENTS	0	0		0 16, 813, 25		
	RUGS CHARGED TO PATIENTS	0	0		0 123, 749, 31		
	ENAL DIALYSIS	0	0		-	0. 000000	
	SC (NON-DI STI NCT PART)	0	0			0. 000000	
	V RESOURCE CTR	0	0			0. 000000	
	LLOGENEIC STEM CELL ACQUISITION	0	0		0	0. 000000	77.00
	ENT SERVICE COST CENTERS	0	C		0		
1 1	URAL HEALTH CLINIC	0	0			0.000000	
90.00 09000 C	EDERALLY QUALIFIED HEALTH CENTER	0	0		-		
	NFUSION OP SERVICES	0	0		0 2, 508, 402		
	MERGENCY	0	0		0 50, 538, 920		
	REE STANDING EMERGENCY DEPT	0	0		0 11, 241, 23		
	BSERVATION BEDS (NON-DISTINCT PART)	0	0		0 11, 241, 230		
	REIMBURSABLE COST CENTERS	0	0	1	5, 707, 52	0.00000	72.00
	IOME PROGRAM DI ALYSI S	0	0		0 (0. 000000	94.00
	MBULANCE SERVICES						95.00
	URABLE MEDICAL EQUIP-RENTED	0	C		0	0. 000000	
	URABLE MEDICAL EQUIP-SOLD	0	C		0 (0. 000000	
	THER REIMBURSABLE COST CENTERS	0	C			0. 000000	

Health Financial Systems F	RANCISCAN HEALTH	MICHIGAN CITY	ſ	In Li	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE THROUGH COSTS	RVICE OTHER PASS	Provider Component	CN: 15-0015 CCN: 15-S015	Period: From 01/01/201 To 12/31/201		pared:
					5/30/2018 6:0	
		Title	e XVIII	Subprovider - IPF	PPS	
Cost Center Description	Outpati ent	Inpati ent	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through		Pass-Through	
	(col. 6 ÷ col.		Costs (col.	8	Costs (col. 9	
	7) 9.00	10.00	x col. 10) 11.00	12.00	x col. 12) 13.00	
ANCI LLARY SERVI CE COST CENTERS	9.00	10.00	11.00	12.00	13.00	
50. 00 05000 OPERATING ROOM	0. 000000	27, 012		0 27, 01	2 0	50.00
51. 00 05100 RECOVERY ROOM	0. 000000	27,012			0 0	1
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0	0 0	
53. 00 05300 ANESTHESI OLOGY	0. 000000	0		0	0 0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	33, 899		0 29, 51	-	
54. 01 05401 FSED RADIOLOGY - DIAGNOSTIC	0. 000000	00,077	1	0	0 0	54.01
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000	0		0	0 0	55.00
55. 01 05501 WOODLAND CANCER CARE CTR	0. 000000	0		0	0 0	
56. 00 05600 RADI OI SOTOPE	0, 000000	0		0	0 0	1
57.00 05700 CT SCAN	0.000000	0)	0	0 0	1
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	0		0	0 0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	0		0	0 0	59.00
60. 00 06000 LABORATORY	0. 000000	122, 007		0 122,00	7 0	60.00
60. 01 06001 FS ED LAB	0. 000000	0		0	0 0	60.01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000	0)	0	0 0	62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	0		0	0 0	63.00
64.00 06400 INTRAVENOUS THERAPY	0. 000000	0)	0	0 0	64.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	13, 219		0 13, 21	9 0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	9, 033		0 9, 03	3 0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	0		0	0 0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	0		0	0 0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	8, 431		0 12, 81	4 0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	0		0	0 0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	9, 246		0 9, 24		
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0		0	0 0	1
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	257, 954		0 257, 95		
74.00 07400 RENAL DIALYSIS	0. 000000	0		0	0 0	
75.00 07500 ASC (NON-DI STI NCT PART)	0. 000000	0		0	0 0	
76.00 03020 CV RESOURCE CTR	0. 000000	0		0	0 0	1
77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION	0. 000000	0		0	0 0	77.00
	0.000000	0		0	0	00.00
88.00 08800 RURAL HEALTH CLINIC	0. 000000	0			0 0	1
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000	0		0	0 0	
90. 00 09000 CLINIC 90. 03 09003 INFUSION OP SERVICES	0. 000000	0		0		
	0. 000000	00 741		0		
91. 00 09100 EMERGENCY 91. 01 09101 FREE STANDING EMERGENCY DEPT	0. 000000 0. 000000	90, 741 0		0 97, 17 0	0 0	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0		0		1
0THER REIMBURSABLE COST CENTERS	0.000000	0	1	U	<u>vi</u> 0	92.00
94. 00 09400 HOME PROGRAM DI ALYSI S	0. 000000	0	1	0	0 0	94.00
95. 00 09500 AMBULANCE SERVICES	0.000000	0				94.00
95. 00 09500 AMBOLANCE SERVICES 96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000	0		0	0 0	
97. 00 09700 DURABLE MEDICAL EQUIP-RENTED	0.000000	0		0		
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0.000000	0		0		
200.00 Total (lines 50 through 199)	0.000000	571, 542		0 577,97		200.00
	I I	571, 542	1	-1 0,1,77		

PPORTI	ONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	O VACCINE COST	Provider C		Period: From 01/01/2017 To 12/31/2017	Worksheet D Part V Date/Time Pre	nared.
			component	CCN. 13-3013	10 12/31/2017	5/30/2018 6:0	
			Titl€	× XVIII	Subprovider -	PPS	
				Charges	I PF	Costs	
	Cost Center Description	Cost to Charge	PPS Reimbursed		Cost	PPS Services	
	•		Services (see	Reimbursed	Reimbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To Ded. & Coins.	Subject To Ded. & Coins.		
				(see inst.)	(see inst.)		
		1.00	2.00	3.00	4.00	5.00	
	ANCI LLARY SERVICE COST CENTERS	1 1		1	1		
	D5000 OPERATING ROOM	0. 141990	27, 012		0 0	3, 835	
	D5100 RECOVERY ROOM D5200 DELIVERY ROOM & LABOR ROOM	0. 000000 1. 052745	0		0 0 0 0	0	
	D5300 ANESTHESI OLOGY	0. 042061	0		0 0	0	
	05400 RADI OLOGY-DI AGNOSTI C	0. 097185	29, 516		0 0	2, 869	
	D5401 FSED RADIOLOGY - DIAGNOSTIC	0. 164608	2,,010		0 0	0	1
	05500 RADI OLOGY-THERAPEUTI C	0. 261619	C		0 0	0	55.00
	05501 WOODLAND CANCER CARE CTR	0. 965320	C		0 0	0	55. Oʻ
	D5600 RADI OI SOTOPE	0. 000000	C		0 0	0	
	05700 CT SCAN	0. 000000	0		0 0	0	
	D5800 MAGNETIC RESONANCE I MAGING (MRI)	0.000000	0		0 0 0 0	0	
	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	0. 215406 0. 150019	122, 007		0 0	0 18, 303	
	D6001 FS ED LAB	0. 202909	122,007		0 0	10, 505	
	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0. 000000			0 0	0	61.0
2.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000	C		0 0	0	62.0
	06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	C		0 0	0	63.00
	06400 I NTRAVENOUS THERAPY	0. 000000	C		0 0	0	
	06500 RESPI RATORY THERAPY	0. 153977	13, 219		0 0	2,035	
	06600 PHYSI CAL THERAPY	0. 211712	9, 033		0 0	1, 912	
1	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0. 000000 0. 000000	0		0 0	0	
1	06900 ELECTROCARDI OLOGY	0. 146057	12, 814		0 0	1, 872	
	D7000 ELECTROENCEPHALOGRAPHY	0. 000000	12,011		0 0	0	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 056676	9, 246		0 0	524	
2.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 801044	C		0 0	0	72.0
	07300 DRUGS CHARGED TO PATIENTS	0. 172567	257, 954		0 0	44, 514	
	07400 RENAL DI ALYSI S	0. 000000	0		0 0	0	
	07500 ASC (NON-DI STINCT PART) 03020 CV RESOURCE CTR	0. 000000 0. 000000	0		0 0	0	
	D7700 ALLOGENEIC STEM CELL ACQUISITION	0. 000000	0		0 0	0	
-	DUTPATIENT SERVICE COST CENTERS	0.000000			0 0	0	17.00
	08800 RURAL HEALTH CLINIC	0. 000000				0	88.00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000				0	89.00
	09000 CLI NI C	0. 000000	C		0 0	0	
	09003 I NFUSI ON OP SERVI CES	0. 423686	0		0 0	0	
	09100 EMERGENCY 09101 FREE STANDING EMERGENCY DEPT	0. 231523	97, 170		0 0	22, 497	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 515562 0. 898635	0		0 0 0 0	0	
	THER REIMBURSABLE COST CENTERS	0. 070033		1	0 0	0	72.00
	09400 HOME PROGRAM DI ALYSI S	0. 000000			0		94.00
5.00 0	09500 AMBULANCE SERVICES	0. 000000			0		95.00
	09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000	0		0 0	0	
	09700 DURABLE MEDICAL EQUIP-SOLD	0. 000000	C		0 0	0	
	09850 OTHER REIMBURSABLE COST CENTERS	0. 000000	0		0 0	0	
00.00 01.00	Subtotal (see instructions)		577, 971		0 0	98, 361	
	Less PBP Clinic Lab. Services-Program			1	0 0		201.00
01.00	Only Charges						

	nl Systems FF DF MEDICAL, OTHER HEALTH SERVICES AND	RANCISCAN HEALTH		CN: 15-0015	Peri od:	u of Form CMS-25 Worksheet D	
			Component	CCN: 15-S015	From 01/01/2017 To 12/31/2017	Part V Date/Time Prepa 5/30/2018 6:06	
			Title	e XVIII	Subprovider -	PPS	
		Cost	· c		I PF		
Co	st Center Description	Cost	Cost	-			
		Reimbursed	Reimbursed				
		Servi ces	Services Not				
		Subject To	Subject To				
			ed. & Coins.				
		(see inst.)	(see inst.)	_			
	V SEDVICE COST CENTERS	6.00	7.00				
	Y SERVICE COST CENTERS ERATING ROOM	0					50.
	COVERY ROOM	0	0				50. 51.
	LIVERY ROOM & LABOR ROOM	0	(1			52.
	ESTHESI OLOGY	0	(1			53.
	DI OLOGY-DI AGNOSTI C	0	C				54.
	ED RADIOLOGY - DIAGNOSTIC	0	C				54.
	DI OLOGY-THERAPEUTI C	0	C				55.
5.01 05501 WO	ODLAND CANCER CARE CTR	0	C				55.
5. 00 05600 RA	DI OI SOTOPE	0	C			!	56.
7.00 05700 CT	SCAN	0	C	p			57.
	GNETIC RESONANCE IMAGING (MRI)	0	C				58.
	RDI AC CATHETERI ZATI ON	0	C				59.
0.00 06000 LA		0	C				60.
. 01 06001 FS		0	C				60.
	P CLINICAL LAB SERVICES-PRGM ONLY	0					61.
	OLE BLOOD & PACKED RED BLOOD CELLS OOD STORING, PROCESSING & TRANS.	0	0				62. 63.
	TRAVENOUS THERAPY	0	0				64.
	SPI RATORY THERAPY	0	0				65.
	YSI CAL THERAPY	0	C				66.
	CUPATIONAL THERAPY	0	C				67.
	EECH PATHOLOGY	0	C				68.
9. 00 06900 EL	ECTROCARDI OLOGY	0	C				69.
0. 00 07000 EL	ECTROENCEPHALOGRAPHY	0	C				70.
	DICAL SUPPLIES CHARGED TO PATIENTS	0	C				71.
	PL. DEV. CHARGED TO PATIENTS	0	C	1			72.
	UGS CHARGED TO PATIENTS	0	C	1			73.
	NAL DIALYSIS	0	0				74.
	C (NON-DISTINCT PART) RESOURCE CTR	0	0				75. 76.
	LOGENEIC STEM CELL ACQUISITION	0	0				70.
	NT SERVICE COST CENTERS	<u>ч</u>	(/			11.
	RAL HEALTH CLINIC	0	(88.
	DERALLY QUALIFIED HEALTH CENTER	0	C				89.
0.00 09000 CL		0	C				90.
D. 03 09003 I N	FUSION OP SERVICES	0	C				90.
I. 00 09100 EM	ERGENCY	0	C				91.
	EE STANDING EMERGENCY DEPT	0	C				91.
	SERVATION BEDS (NON-DISTINCT PART)	0					92.
	I MBURSABLE COST CENTERS						
	ME PROGRAM DI ALYSI S	0	C	1			94. 05
	BULANCE SERVICES	0	~				95. 04
	RABLE MEDICAL EQUIP-RENTED	0	(96. 07
	RABLE MEDICAL EQUIP-SOLD	0	0				97.
	HER REIMBURSABLE COST CENTERS btotal (see instructions)	0					98. 200.
	ss PBP Clinic Lab. Services-Program	0	Ĺ				200. 201.
	ly Charges					2	-01.
	t Charges (line 200 - line 201)	0	C	1			202.

ORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT.	AL COSTS	Provider C	CN: 15-0015	Peri od:	Worksheet D	
		Component	CCN: 15-T015	From 01/01/2017 To 12/31/2017		
		Title	e XVIII	Subprovider - IRF	PPS	<u>o p</u>
Cost Center Description	Capi tal	Total Charges			Capital Costs	
		(from Wkst. C,		U U	(column 3 x	
	(from Wkst. B,			I. Charges	column 4)	
	Part II, col.	8)	2)			
	<u>26)</u> 1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
00 05000 OPERATING ROOM	2, 687, 389	121, 904, 193	0. 0220	45 43, 749	964	50.
00 05100 RECOVERY ROOM	2,007,007					
00 05200 DELIVERY ROOM & LABOR ROOM	319, 552	-			0	
00 05300 ANESTHESI OLOGY	33, 814				0	
00 05400 RADI OLOGY-DI AGNOSTI C	1, 722, 942				-	
01 05401 FSED RADIOLOGY - DIAGNOSTIC	1, 170, 507				2,070	
00 05500 RADI OLOGY - DI AGNOSTI C	672, 680					
01 05501 WOODLAND CANCER CARE CTR	461, 803				0	
00 05600 RADI OI SOTOPE	401, 803					
00 05700 CT SCAN	0	-			0	
00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	-			-	
	-	-				
	1, 404, 161		•			
00 06000 LABORATORY 01 06001 FS ED LAB	509, 732					
	82, 041	8, 880, 592	0. 0092	38 0	0	
00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY			0.0000	~ ~ ~		61
00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	-			0	
00 06300 BLOOD STORING, PROCESSING & TRANS.	0	-			0	
00 06400 I NTRAVENOUS THERAPY	0	-			0	
00 06500 RESPI RATORY THERAPY	153, 881					
00 06600 PHYSI CAL THERAPY	162, 515					
00 06700 OCCUPATI ONAL THERAPY	0	-			0	
00 06800 SPEECH PATHOLOGY	0	0			-	
00 06900 ELECTROCARDI OLOGY	425, 937					
00 07000 ELECTROENCEPHALOGRAPHY	0	-	0.0000		0	
00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	29, 389					
00 07200 IMPL. DEV. CHARGED TO PATIENTS	226, 087					
00 07300 DRUGS CHARGED TO PATIENTS	548, 488					
00 07400 RENAL DIALYSIS	0				-	
00 07500 ASC (NON-DISTINCT PART)	0	-			-	
00 03020 CV RESOURCE CTR	0					
00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	C	0.0000	00 00	0	77
OUTPATIENT SERVICE COST CENTERS			0.0000	20		
00 08800 RURAL HEALTH CLINIC	0					
00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	-				
00 09000 CLINIC	0	-				
03 09003 I NFUSI ON OP SERVI CES	79, 892					
00 09100 EMERGENCY	1, 176, 541					
01 09101 FREE STANDING EMERGENCY DEPT	1, 467, 000				-	
00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)	0	5, 709, 529	0.0000	00 0	0	92
OTHER REIMBURSABLE COST CENTERS		-	0.0000	20		۰ ا
00 09400 HOME PROGRAM DI ALYSI S	0	C	0.0000	00 0	0	
00 09500 AMBULANCE SERVICES	_	_	0.0000	~ ~	_	95
00 09600 DURABLE MEDICAL EQUIP-RENTED	0	C			0	
00 09700 DURABLE MEDICAL EQUIP-SOLD	0				0	
00 09850 OTHER REIMBURSABLE COST CENTERS	0				0	
0.00 Total (lines 50 through 199)	13, 334, 351	628, 715, 433	5	4, 110, 832	33, 044	1200

Health Financial Systems F	RANCI SCAN HEALTH	MICHIGAN CIT	Y	In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PASS	Provider C	CN: 15-0015	Period:	Worksheet D	
THROUGH COSTS		Component	CCN: 15-T015	From 01/01/2017 To 12/31/2017		pared:
		Title	e XVIII	Subprovider -	PPS	
Cost Center Description	Non Physician N	lursi ng School	Nursing Schoo	Allied Health	Allied Health	
		Post-Stepdown		Post-Stepdown		
	<u>Cost</u> 1.00	Adjustments 2A	2.00	Adjustments 3A	3.00	
ANCI LLARY SERVI CE COST CENTERS	1.00	ZA	2.00	3A	3.00	
50. 00 05000 OPERATING ROOM	0	(0 0	0	50.00
51.00 05100 RECOVERY ROOM	0	C		0 0		
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	C		0 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0	C		0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	C		0 0	0	54.00
54. 01 05401 FSED RADIOLOGY - DIAGNOSTIC	0	C	D	0 0	0	
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	C		0 0	0	
55.01 05501 WOODLAND CANCER CARE CTR	0	C	D	0 0	0	
56. 00 05600 RADI OI SOTOPE	0	(2	0 0	0	
57.00 05700 CT SCAN	0	(2		0	
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI) 59. 00 05900 CARDIAC CATHETERIZATION	0	(0	
60. 00 06000 LABORATORY	0			0 0	0	1
60. 01 06001 FS ED LAB	0				0	
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		C		0		61.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	C		0 0	0	
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	Ő	0		0 0	0	1
64.00 06400 I NTRAVENOUS THERAPY	0	C		0 0	0	
65. 00 06500 RESPI RATORY THERAPY	0	C		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	C		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	C		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	C		0 0	0	
69.00 06900 ELECTROCARDI OLOGY	0	C		0 0	-	1
70.00 07000 ELECTROENCEPHALOGRAPHY	0	C	D .	0 0	0	
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	0	2	0 0	0	
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS 73. 00 07300 DRUGS CHARGED TO PATIENTS	0	(0 0	0	
74. 00 07400 RENAL DIALYSIS	0	(0 0		1
75. 00 07500 ASC (NON-DI STINCT PART)	0				0	
76. 00 03020 CV RESOURCE CTR	0	(0 0	-	
77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION	o	0		0 0	-	
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	C	D	0 0	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	C	D	0 0	0	89.00
90. 00 09000 CLINIC	0	C	D	0 0	, o	
90. 03 09003 I NFUSI ON OP SERVI CES	0	C		0 0	0	
91.00 09100 EMERGENCY	0	0	2	0 0	0	
91. 01 09101 FREE STANDING EMERGENCY DEPT	0	Ĺ		0 0	-	
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)	0			0	0	92.00
94. 00 09400 HOME PROGRAM DI ALYSI S	0	C		0 0	0	94.00
95. 00 09500 AMBULANCE SERVICES	0	L. L.		0		94.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	C		0 0	0	1
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	ſ		0 0	-	
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0	C	þ	0 0	0	
200.00 Total (lines 50 through 199)	0	C	þ	0 0		200.00
U				•		-

APPORTI	ONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEP	RVICE OTHER PASS	H MICHIGAN CITY Provider C		Pe	eri od:	Worksheet D	2552-10
THROUGH				CCN: 15-T015		om 01/01/2017	Part IV Date/Time Pre 5/30/2018 6:0	pared: 6 pm
			Title	e XVIII	S	Subprovider - IRF	PPS	
	Cost Center Description	AII Other	Total Cost	Total		Total Charges	Ratio of Cost	
		Medi cal	(sum of col 1			(from Wkst. C,		
		Education Cost		Cost (sum o			(col. 5 ÷ col.	
			4)	col. 2, 3 ar	nd	8)	7)	
		4.00	5.00	4) 6.00		7.00	8.00	
ŀ	NCILLARY SERVICE COST CENTERS		0.00	0.00		1100	0100	
50.00	D5000 OPERATING ROOM	0	0		0	121, 904, 193	0. 000000	50.00
51.00 0	D5100 RECOVERY ROOM	0	0		0	0	0.00000	51.00
52.00	D5200 DELIVERY ROOM & LABOR ROOM	0	0		0	2, 119, 859	0.00000	52.00
	05300 ANESTHESI OLOGY	0	0		0	4, 959, 612	0.00000	
	05400 RADI OLOGY-DI AGNOSTI C	0	0		0	89, 663, 221	0. 000000	54.00
	05401 FSED RADIOLOGY - DIAGNOSTIC	0	0		0	18, 968, 256	0.00000	
	05500 RADI OLOGY-THERAPEUTI C	0	0		0	15, 288, 947	0.00000	
	05501 WOODLAND CANCER CARE CTR	0	0		0	2, 954, 303	0.00000	
	05600 RADI OI SOTOPE	0	0		0	0	0.00000	•
	05700 CT SCAN	0	0		0	0	0.000000	
	D5800 MAGNETIC RESONANCE I MAGING (MRI)	0	0		0	0	0.00000	
	05900 CARDI AC CATHETERI ZATI ON	0	0		0	21, 800, 576	0.00000	
	06000 LABORATORY	0	0		0	57, 440, 436	0.000000	
	06001 FS ED LAB	0	0		0	8, 880, 592	0. 000000	
	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY				~	0	0,000000	61.00
	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0	0	0.000000	
	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0	0	0.00000	
	06400 I NTRAVENOUS THERAPY	0	0		0	12 000 200	0.000000	
		0	0		0	12, 989, 208	0.000000	
	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	0			0	21, 868, 326	0. 000000 0. 000000	
	06800 SPEECH PATHOLOGY	0			0 0	0		•
	06900 ELECTROCARDI OLOGY	0	0		0	18, 326, 722	0.00000 0.000000	
	07000 ELECTROENCEPHALOGRAPHY	0	0		0	10, 320, 722	0.000000	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	20, 990, 525	0.000000	
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0	16, 813, 251	0.000000	•
	07300 DRUGS CHARGED TO PATIENTS	0	0		0	123, 749, 311	0. 000000	
	07400 RENAL DI ALYSI S	0	0		0	0	0.000000	
	07500 ASC (NON-DI STI NCT PART)	0	0		0	0	0. 000000	
	03020 CV RESOURCE CTR	0	0		0	0	0. 000000	
1	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0		0	0	0. 000000	
	DUTPATIENT SERVICE COST CENTERS					-		
88.00	08800 RURAL HEALTH CLINIC	0	0		0	0	0.00000	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0	0	0. 000000	89.00
90.00	09000 CLINIC	0	0		0	0	0. 000000	90.00
90.03	09003 INFUSION OP SERVICES	0	0		0	2, 508, 402	0. 000000	90.03
	09100 EMERGENCY	0	0		0	50, 538, 926	0. 000000	
	09101 FREE STANDING EMERGENCY DEPT	0	0		0	11, 241, 238		
	09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS	0	0		0	5, 709, 529	0.000000	92.00
	09400 HOME PROGRAM DI ALYSI S	0	0		0	0	0. 000000	94.00
	09500 AMBULANCE SERVICES		0		Ŭ	0	0.00000	95.00
	09600 DURABLE MEDICAL EQUIP-RENTED	0	0		0	0	0. 000000	•
	09700 DURABLE MEDICAL EQUIP-SOLD	0	0		0	0	0.000000	
97.00 1				1	-		2.000000	
	09850 OTHER REIMBURSABLE COST CENTERS	0	0		0	0	0.000000	98.00

	RANCISCAN HEALTH				eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE THROUGH COSTS	RVICE OTHER PASS	Provider C		Period: From 01/01/2017	Worksheet D Part IV	
		Component	CCN: 15-T015	To 12/31/2017	Date/Time Pre 5/30/2018 6:0	
		Title	e XVIII	Subprovider - IRF	PPS	
Cost Center Description	Outpati ent	Inpati ent	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through		Pass-Through Costs (col. 9	
	(col. 6 ÷ col. 7)		Costs (col. x col. 10)	0	x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCI LLARY SERVI CE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0. 000000	43, 749		0 43, 749	0	50.00
51.00 05100 RECOVERY ROOM	0. 000000	0		0 0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0. 000000	0		0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	140, 281		0 144, 744	0	54.00
54. 01 05401 FSED RADI OLOGY - DI AGNOSTI C	0. 000000	0		0 0	0	54.01
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000	2, 846	1	0 2,846	0	55.00
55. 01 05501 WOODLAND CANCER CARE CTR 56. 00 05600 RADI 0I SOTOPE	0. 000000 0. 000000	0		0 0	0	55.01
56. 00 05600 RADI 0I SOTOPE 57. 00 05700 CT_SCAN	0.000000	0			0	56.00 57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0			0	57.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0.000000	4, 232		0 0	0	59.00
60. 00 06000 LABORATORY	0. 000000	300, 240		0 300, 240	0	60.00
60. 01 06001 FS ED LAB	0. 000000	000, 240	1	0 0	0	60.01
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000	0		0		61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000	0		0 0	0	62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0.000000	0)	0 0	0	63.00
64.00 06400 INTRAVENOUS THERAPY	0. 000000	0)	0 0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	366, 049		0 366, 049	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	2, 410, 288		0 2, 410, 288	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000	0		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	0		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	36, 735	1	0 33, 504	0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	0		0 0	0	70.00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0. 000000	122, 663		0 122, 663	0	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000	1, 385		0 1, 385	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	682, 280	1	0 682, 280	0	73.00
74.00 07400 RENAL DIALYSIS 75.00 07500 ASC (NON-DISTINCT PART)	0. 000000 0. 000000	0		0 0	0	74.00 75.00
76. 00 03020 CV RESOURCE CTR	0.000000	0		0 0	0	76.00
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0. 000000	0		0 0	0	77.00
OUTPATIENT SERVICE COST CENTERS	0.000000	0		0		11.00
88.00 08800 RURAL HEALTH CLINIC	0. 000000	0)	0 0	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000	0	1	0 0	0	89.00
90. 00 09000 CLINIC	0. 000000	0		0 0	0	90.00
90. 03 09003 INFUSION OP SERVICES	0. 000000	84		0 0	0	90.03
91. 00 09100 EMERGENCY	0. 000000	0		0 0	0	91.00
91.01 09101 FREE STANDING EMERGENCY DEPT	0. 000000	0		0 0	, e	91.01
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	0		0 0	0	92.00
OTHER REIMBURSABLE COST CENTERS	0.000000		1			04.00
94. 00 09400 HOME PROGRAM DI ALYSI S	0. 000000	0		0 0	0	
95. 00 09500 AMBULANCE SERVICES 96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0 00000	~		0	0	95.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED 97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0. 000000 0. 000000	0			0	
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0.000000	0				97.00
200.00 Total (lines 50 through 199)	0.00000	4, 110, 832		0 4, 107, 748		200.00
	I I	7, 110, 032	1	J 7, 107, 740	0	1200.00

	RANCISCAN HEALTH				u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AN	D VACCINE COST		CN: 15-0015 CCN: 15-T015	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part V Date/Time Pre	narod
		component	CCN: 15-1015		5/30/2018 6:0	
		Titl€	e XVIII	Subprovider - IRF	PPS	
			Charges		Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed		Cost	PPS Services	
	Ratio From	Services (see		Reimbursed	(see inst.)	
	Worksheet C, Part I, col. 9	inst.)	Services Subject To	Services Not Subject To		
			Ded. & Coi ns			
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVICE COST CENTERS 50. 00 05000 OPERATI NG ROOM	0. 141990	43, 749		0 0	6, 212	50.00
51. 00 05100 RECOVERY ROOM	0. 141990	43,749 C		0 0	0, 212	1
52.00 05200 DELIVERY ROOM & LABOR ROOM	1. 052745	C		0 0	0	
53. 00 05300 ANESTHESI OLOGY	0. 042061	C		0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 097185			0 0	14, 067	
54. 01 05401 FSED RADI OLOGY - DI AGNOSTI C 55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 164608			0 0	0	
55. 00 05500 RADI OLOGY-THERAPEUTI C 55. 01 05501 WOODLAND CANCER CARE CTR	0. 261619 0. 965320	2, 846 C		0 0	745 0	
56. 00 05600 RADI 0I SOTOPE	0. 000000	l c		0 0	0	1
57.00 05700 CT SCAN	0. 000000	C		0 0	0	
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 000000	C		0 0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 215406	C		0 0	0	1
60. 00 06000 LABORATORY	0. 150019	300, 240		0 0	45, 042	
60. 01 06001 FS ED LAB 61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0. 202909 0. 000000	C	1	0 0	0	60.01 61.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000	C		0 0	0	1
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	C		0 0	0	
64. 00 06400 I NTRAVENOUS THERAPY	0. 000000	C		0 0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0. 153977	366, 049		0 0	56, 363	
66. 00 06600 PHYSI CAL THERAPY	0. 211712	2, 410, 288		0 0	510, 287	
67. 00 06700 OCCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY	0.000000			0 0	0	
69. 00 06900 ELECTROCARDI OLOGY	0. 146057	33, 504		0 0	4, 893	
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	C		0 0	0	1
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 056676	122, 663		0 0	6, 952	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0. 801044	1, 385		0 0	1, 109	
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 172567	682, 280		0 0	117, 739	
74. 00 07400 RENAL DI ALYSI S 75. 00 07500 ASC (NON-DI STINCT PART)	0. 000000 0. 000000			0 0	0	
76. 00 03020 CV RESOURCE CTR	0. 000000		1	0 0	0	
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0. 000000	C		0 0	0	1
OUTPATIENT SERVICE COST CENTERS			1			
88. 00 08800 RURAL HEALTH CLINIC	0. 000000				0	1
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 90. 00 09000 CLINIC	0. 000000 0. 000000	C		0 0	0	
90. 03 09003 INFUSION OP SERVICES	0. 423686			0 0		
91. 00 09100 EMERGENCY	0. 231523			0 0	0	
91. 01 09101 FREE STANDING EMERGENCY DEPT	0. 515562	C		0 0	0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 898635	C		0 0	0	92.00
	0,000000			0		1 0 4 00
94. 00 09400 HOME PROGRAM DI ALYSI S 95. 00 09500 AMBULANCE SERVI CES	0. 000000 0. 000000			0		94.00 95.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000	C		0 0	0	
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0. 000000	C		0 0	0	
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0. 000000			0 0	0	98.00
200.00 Subtotal (see instructions)		4, 107, 748	8	0 0	763, 409	
201.00 Less PBP Clinic Lab. Services-Program				0 0		201.00
Only Charges202.00Net Charges (line 200 - line 201)		4, 107, 748		0 0	763, 409	202 00
	1	.,,	Т	-1 0	,,	

PORTI ONMENT	ial Systems FF OF MEDICAL, OTHER HEALTH SERVICES AND	RANCISCAN HEALTH	Provider C	CN: 15-0015	Peri od:	Worksheet D	2552-1
				CCN: 15-T015	From 01/01/2017 To 12/31/2017	Part V Date/Time Prep 5/30/2018 6:06	
			Titl	e XVIII	Subprovider -	PPS	
		Cost			I RF		
(Cost Center Description	Cost	Cost	-			
	·	Reimbursed	Reimbursed				
			Services Not				
		Subject To	Subject To				
			Ded. & Coins.				
		(see inst.) 6.00	<u>(see inst.)</u> 7.00	-			
ANCILL	ARY SERVICE COST CENTERS	0.00	7.00				
	DPERATING ROOM	0	(50.0
. 00 05100 F	RECOVERY ROOM	0	(o			51.0
	DELIVERY ROOM & LABOR ROOM	0	(D			52.0
	ANESTHESI OLOGY	0	(-			53.0
	RADI OLOGY-DI AGNOSTI C	0					54.0
	SED RADIOLOGY - DIAGNOSTIC	0					54.0
	RADI OLOGY-THERAPEUTI C	0					55.0
	VOODLAND CANCER CARE CTR RADI OI SOTOPE	0					55. 56.
	CT SCAN	0					50. 57.
	MAGNETIC RESONANCE IMAGING (MRI)	0					58.
	CARDI AC CATHETERI ZATI ON	0					50. 59.
	ABORATORY	0					60.
	S ED LAB	0					60.
	PBP CLINICAL LAB SERVICES-PRGM ONLY	0					61.
. 00 06200 1	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	(62.
. 00 06300 E	BLOOD STORING, PROCESSING & TRANS.	0	(b			63.
. 00 06400 I	NTRAVENOUS THERAPY	0	(64.0
	RESPI RATORY THERAPY	0		D			65.0
	PHYSI CAL THERAPY	0		D D			66. (
	OCCUPATIONAL THERAPY	0					67.0
	SPEECH PATHOLOGY	0					68.
	ELECTROCARDI OLOGY ELECTROENCEPHALOGRAPHY	0					69. 70.
	MEDICAL SUPPLIES CHARGED TO PATIENTS	0					70.
	MPL. DEV. CHARGED TO PATIENTS	0					72.
	DRUGS CHARGED TO PATIENTS	0					73.
	RENAL DIALYSIS	0	(74.
. 00 07500	ASC (NON-DISTINCT PART)	0	(o			75.
	CV RESOURCE CTR	0					76.
	ALLOGENEIC STEM CELL ACQUISITION	0	(77.
	ENT SERVICE COST CENTERS						
	RURAL HEALTH CLINIC	0					88.
0.00 08900 F 0.00 09000 0	EDERALLY QUALIFIED HEALTH CENTER	0					89. 90.
	NFUSION OP SERVICES	0					90. 90.
	EMERGENCY	0					91.
	REE STANDING EMERGENCY DEPT	0					91.
	DESERVATION BEDS (NON-DISTINCT PART)	0					92.
	REIMBURSABLE COST CENTERS	•					
	HOME PROGRAM DI ALYSI S	0	(94.
	AMBULANCE SERVICES	0					95.
	DURABLE MEDICAL EQUIP-RENTED	0	(96.
	DURABLE MEDICAL EQUIP-SOLD	0		D			97.
	THER REIMBURSABLE COST CENTERS	0	(98.
	Subtotal (see instructions)	0	(ון			200.
	Less PBP Clinic Lab. Services-Program Dnly Charges	0				1	201.

Health Financial Systems	FRANCI SCAN HEALTH	MICHIGAN CIT	Y	In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CA	API TAL COSTS	Provider C		Period: From 01/01/2017 To 12/31/2017		
		Titl	e XIX	Hospi tal	Cost	· · · ·
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col. 1 - col			
	26)		2)			
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS					•	
30. 00 ADULTS & PEDI ATRI CS	3, 409, 769	C	3, 409, 76	9 20, 502	166. 31	30.00
31.00 INTENSIVE CARE UNIT	558, 020		558, 02	2, 594	215.12	31.00
32.00 CORONARY CARE UNIT	0			0 0	0.00	32.00
33.00 BURN INTENSIVE CARE UNIT	0			0 0	0.00	33.00
34.00 SURGICAL INTENSIVE CARE UNIT	o			0 0	0.00	34.00
40.00 SUBPROVIDER - IPF	346, 112	C	346, 11	2 3, 175		•
41.00 SUBPROVIDER - IRF	574, 519	0	574, 51			•
43.00 NURSERY	63, 239		63, 23			
44.00 SKILLED NURSING FACILITY	0			0 0		
45.00 NURSING FACILITY	0			0 0		45.00
200.00 Total (lines 30 through 199)	4, 951, 659		4, 951, 65	i9 29, 915		200.00
Cost Center Description	I npati ent	Inpati ent	1, 701, 00	27,710		200.00
	Program days	Program				
	rrogram days	Capital Cost				
		(col. 5 x col.				
		6)				
	6.00	7.00	1			
INPATIENT ROUTINE SERVICE COST CENTERS		7.00	1			
30. 00 ADULTS & PEDIATRICS	456	75, 837	7			30.00
31. 00 INTENSIVE CARE UNIT	85	18, 285				31.00
32. 00 CORONARY CARE UNI T	0	10, 200	1			32.00
33. 00 BURN INTENSIVE CARE UNIT	0	0				33.00
34. 00 SURGI CAL I NTENSI VE CARE UNI T	0	0				34.00
40. 00 SUBPROVIDER - IPF	1,457	158, 828				40.00
40. 00 SUBPROVIDER - TPF 41. 00 SUBPROVIDER - TRF	1, 457		•			40.00
		26, 225				
43.00 NURSERY	77	4, 695	1			43.00
44.00 SKILLED NURSING FACILITY	0	0				
45.00 NURSING FACILITY	0	0				45.00
200.00 Total (lines 30 through 199)	2, 194	283, 870	1			200.00

		RANCI SCAN HEALTI				u of Form CMS-	2552-10
APPORI	IONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSIS	Provider C	CN: 15-0015	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part II Date/Time Pre 5/30/2018 6:0	pared:
			Ti †I	e XIX	Hospi tal	Cost	
	Cost Center Description	Capi tal	Total Charges			Capital Costs	
			(from Wkst. C,		Program	(column 3 x	
		(from Wkst. B,	Part I, col.			column 4)	
		Part II, col.	8)	2)	J		
		26)	, í	, í			
		1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	2, 687, 389	0	0.0000	00 8, 903, 141	0	50.00
51.00	05100 RECOVERY ROOM	0	0	0.0000	0 00	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	319, 552	0	0.0000	0 00	0	52.00
53.00	05300 ANESTHESI OLOGY	33, 814	0	0.0000	393, 139	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 722, 942	0	0.0000	3, 521, 475	0	54.00
54.01	05401 FSED RADIOLOGY - DIAGNOSTIC	1, 170, 507	0	0.0000	102, 783	0	54.01
55.00	05500 RADI OLOGY-THERAPEUTI C	672, 680	0	0.0000	295, 851	0	55.00
55.01	05501 WOODLAND CANCER CARE CTR	461, 803	0	0.00000	00 831	0	55.01
56.00	05600 RADI OI SOTOPE	0	0	0.0000	0 00	0	56.00
57.00	05700 CT SCAN	0	0	0.0000	0 00	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.0000	0 00	0	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	1, 404, 161	0	0. 00000	1, 327, 235	0	59.00
60.00	06000 LABORATORY	509, 732	0			0	60,00
60.01	06001 FS ED LAB	82, 041	0			0	60.01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		-		.,	_	61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0. 00000	0 00	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0			-	63.00
64.00	06400 I NTRAVENOUS THERAPY	0	0			0	64.00
65.00	06500 RESPI RATORY THERAPY	153, 881	0				65.00
66.00	06600 PHYSI CAL THERAPY	162, 515	0			0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	0				67.00
68.00	06800 SPEECH PATHOLOGY	0	0			0	68.00
69.00	06900 ELECTROCARDI OLOGY	425, 937	0	0. 00000			69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0. 00000		0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	29, 389	0				71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	226, 087	0			0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	548, 488	0	0. 00000		0	•
	07400 RENAL DIALYSIS	0 10, 100	0			0	74.00
75.00	07500 ASC (NON-DI STINCT PART)	0	0				•
76.00	03020 CV RESOURCE CTR	0	0				76.00
77.00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0				
,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	OUTPATIENT SERVICE COST CENTERS			0.00000			1 1 1 00
88.00	08800 RURAL HEALTH CLINIC	0	0	0.0000	0 00	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0				89.00
90.00	09000 CLINIC	0	0	0.00000		0	90.00
90.03	09003 I NFUSI ON OP SERVI CES	79, 892	0	0. 00000		0	90.03
91.00	09100 EMERGENCY	1, 176, 541	0			0	91.00
91.01	09101 FREE STANDING EMERGENCY DEPT	1, 467, 000	0			0	91.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0				•
72.00	OTHER REIMBURSABLE COST CENTERS			0100000			12.00
94.00	09400 HOME PROGRAM DI ALYSI S	0	0	0.0000	0 00	0	94.00
95.00	09500 AMBULANCE SERVICES						95.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0. 00000	0 00	0	96.00
						0	97.00
97.00	1097001DURABLE MEDICAL EUULP-SULD	0	0				
	09700 DURABLE MEDICAL EQUIP-SOLD 09850 OTHER REIMBURSABLE COST CENTERS	0	0			0	98.00

Health Financial Systems	FRANCI SCAN HEALTH	H MICHIGAN CIT	(In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER	PASS THROUGH COS		F	Period: From 01/01/2017 To 12/31/2017		pared: 6 pm
			e XIX	Hospi tal	Cost	
Cost Center Description		Nursing School		Allied Health	All Other	
	Post-Stepdown		Post-Stepdown	Cost	Medi cal	
	Adjustments		Adjustments		Education Cost	
	1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	C	0	0 0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	0	l a		0	0	31.00
32. 00 03200 CORONARY CARE UNI T	0	0				
33. 00 03300 BURN INTENSIVE CARE UNIT	0			-	0	
	0			, O	0	
	0			, e	-	
40. 00 04000 SUBPROVIDER - IPF	0		0	, O	0	
41.00 04100 SUBPROVIDER - IRF	0	0	C	, O	0	
43. 00 04300 NURSERY	0	0	0	0 0	0	43.00
44.00 04400 SKILLED NURSING FACILITY	0	0	0	0 0		44.00
45.00 04500 NURSING FACILITY	0	0	0	0 0		45.00
200.00 Total (lines 30 through 199)	0	l o		0 0	0	200.00
Cost Center Description	Swing-Bed	Total Costs	Total Patient	Per Diem (col.	Inpati ent	
p	Adjustment	(sum of cols.	Days	$5 \div col. 6)$	Program Days	
	Amount (see	1 through 3,	buys			
	instructions)	minus col. 4)				
	4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS	4.00	5.00	0.00	7.00	0.00	
	0	C	20 502	0.00	456	30.00
	0					•
31.00 03100 INTENSIVE CARE UNIT		0	2, 594			•
32.00 03200 CORONARY CARE UNI T		0	0			
33.00 03300 BURN INTENSIVE CARE UNIT		0	0			
34.00 03400 SURGICAL INTENSIVE CARE UNIT		0	0	0.00	0	34.00
40. 00 04000 SUBPROVIDER - IPF	0	0	3, 175	0.00	1, 457	40.00
41.00 04100 SUBPROVIDER - IRF	0	l o	2, 607	0.00	119	41.00
43. 00 04300 NURSERY			1, 037		77	43.00
44. 00 04400 SKI LLED NURSI NG FACI LI TY			(
45. 00 04500 NURSING FACILITY						
			-			
200.00 Total (lines 30 through 199)	1	0	29, 915		2, 194	200.00
Cost Center Description	Inpati ent					
	Program					
	Pass-Through					
	Cost (col. 7 x					
	col. 8)					
	9.00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0					30.00
31.00 03100 INTENSIVE CARE UNIT	0					31.00
32.00 03200 CORONARY CARE UNI T	0					32.00
33. 00 03300 BURN INTENSIVE CARE UNIT	1 0					33.00
34. 00 03400 SURGI CAL I NTENSI VE CARE UNI T						34.00
40. 00 04000 SUBPROVIDER - IPF						
	0					40.00
41. 00 O4100 SUBPROVIDER - IRF	0					41.00
43.00 04300 NURSERY	0					43.00
44.00 04400 SKILLED NURSING FACILITY	0					44.00
45.00 04500 NURSING FACILITY	0					45.00
200.00 Total (lines 30 through 199)	0					200.00
	·					•

Health Financial Systems Fi	RANCI SCAN HEALTI	H MICHIGAN CIT	Y	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SET THROUGH COSTS	RVICE OTHER PASS		F	Period: From 01/01/2017 Fo 12/31/2017	Worksheet D Part IV Date/Time Pre 5/30/2018 6:0	
			e XIX	Hospi tal	Cost	
Cost Center Description	Non Physician Anesthetist	Nursing School Post-Stepdown	Nursing School	Allied Health Post-Stepdown	Allied Health	
	Cost	Adjustments		Adjustments		
	1.00	2A	2.00	3A	3.00	
ANCI LLARY SERVI CE COST CENTERS					0	
50.00 05000 OPERATING ROOM 51.00 05100 RECOVERY ROOM	0			-		50.00 51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0			-	-	52.00
53. 00 05300 ANESTHESI OLOGY	0				0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0				0	54.00
54. 01 05401 FSED RADI OLOGY - DI AGNOSTI C	0				0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0				0	55.00
55. 01 05501 WOODLAND CANCER CARE CTR	0			0 0	0	55.01
56. 00 05600 RADI OI SOTOPE	0			0 0	0	56.00
57. 00 05700 CT SCAN	0			0 0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0			0 0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	c c		0 0	0	59.00
60. 00 06000 LABORATORY	0	c c		0 0	0	60.00
60. 01 06001 FS ED LAB	0	c c) (0 0	0	60.01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	c c		0 0	0	62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	c c) (0 0	0	63.00
64.00 06400 INTRAVENOUS THERAPY	0	c c) (0 0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0	c c) (0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	C) (0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	C) (0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	C) (0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	C) (0 0	0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	C) (0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	C) (0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	C) (0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	C		0 0	0	73.00
74.00 07400 RENAL DIALYSIS	0	C) (0 0	0	74.00
75.00 07500 ASC (NON-DI STI NCT PART)	0	C		0 0	0	75.00
76.00 03020 CV RESOURCE CTR	0	C		0	0	76.00
77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	C) (0 0	0	77.00
	0	C		0	0	00.00
88.00 08800 RURAL HEALTH CLINIC 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0			-	-	88.00 89.00
90. 00 09000 CLINIC	0			0	0	90.00
90. 03 09000 CEINIC 90. 03 09003 INFUSION OP SERVICES	0				0	90.00
91. 00 09100 EMERGENCY	0				0	90.03
91. 01 09101 FREE STANDING EMERGENCY DEPT	0				0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0	0	
OTHER REIMBURSABLE COST CENTERS	0				0	72.00
94. 00 09400 HOME PROGRAM DI ALYSI S	0	C		0 0	0	94.00
95. 00 09500 AMBULANCE SERVICES					0	95.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	l c		o o	0	96.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0				0	97.00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0			0 0	0	
200.00 Total (lines 50 through 199)	0) (0 0	0	200.00

	Financial Systems Financia Systems Financial Systems Financial Systems Financial Sys			CN. 1E 001E	Period:	Worksheet D	2552-10
	H COSTS	RVICE UTHER PAS:	S Provider C	UN: 15-0015	From 01/01/2017 To 12/31/2017	Part IV Date/Time Pre	pared:
						5/30/2018 6:0	6 pm
	Cast Canton Decarintian	All Other		e XIX Total	Hospital	Cost	
	Cost Center Description	Medi cal	Total Cost (sum of col 1	Outpatient	(from Wkst. C,	Ratio of Cost to Charges	
		Education Cost		Cost (sum of		$(col. 5 \div col.$	
			4)	col. 2, 3 an		7)	
				4)		, í	
		4.00	5.00	6.00	7.00	8.00	
	ANCI LLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	-		0 0		
51.00	05100 RECOVERY ROOM	0			0 0		
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	-		0 0		
53.00	05300 ANESTHESI OLOGY	0	-		0 0		
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	-		0 0		
54.01	05401 FSED RADI OLOGY - DI AGNOSTI C	0	-		0 0		
55.00	05500 RADI OLOGY-THERAPEUTI C	0			0 0		
55.01	05501 WOODLAND CANCER CARE CTR	0			0 0		
56.00	05600 RADI OI SOTOPE 05700 CT SCAN	0	-		0 0 0 0		
57.00 58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	-		0 0		
59.00	05900 CARDI AC CATHETERI ZATI ON	0	-		0 0		
60.00	06000 LABORATORY	0	-		0 0		
60.00	06001 FS ED LAB	0	-		0 0		1
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0		0	0.000000	61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0 0	0. 000000	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	-		0 0		
64.00	06400 I NTRAVENOUS THERAPY	0	-		0 0		
65.00	06500 RESPI RATORY THERAPY	0	-		0 0		
66.00	06600 PHYSI CAL THERAPY	0	-		0 0		
67.00	06700 OCCUPATI ONAL THERAPY	0	0		0 0		
68.00	06800 SPEECH PATHOLOGY	0	0		0 0	0. 000000	68.00
69.00	06900 ELECTROCARDI OLOGY	0	0		0 0		
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0. 000000	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0. 000000	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0.000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0.000000	73.00
	07400 RENAL DIALYSIS	0	-		0 0		
	07500 ASC (NON-DISTINCT PART)	0	-		0 0		
	03020 CV RESOURCE CTR	0			0 0		
77.00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0		0 0	0.000000	77.00
~~ ~~	OUTPATIENT SERVICE COST CENTERS	1		1			
88.00	08800 RURAL HEALTH CLINIC	0	-		0 0		
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	-		0 0		
90.00		0	-		0 0		
90.03	09003 I NFUSI ON OP SERVI CES	0	-		0 0		
91.00 91.01	09100 EMERGENCY 09101 FREE STANDING EMERGENCY DEPT	0	-		0 0		
		0					
92.00	09200 OBSERVATI ON BEDS (NON-DI STINCT PART) OTHER REIMBURSABLE COST CENTERS	0	0	1	0 0	0.000000	92.00
94.00	09400 HOME PROGRAM DI ALYSI S	0	0		0 0	0. 000000	94.00
	09500 AMBULANCE SERVICES	0				0.00000	95.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0		0 0	0. 000000	
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0			0 0		
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0	-		0 0		
90. UU							

		RANCISCAN HEALTH				eu of Form CMS-2	2552-10
	I ONMENT OF I NPATI ENT/OUTPATI ENT ANCI LLARY SEI H COSTS	RVI CE OTHER PASS	Provider CC	CN: 15-0015	Period: From 01/01/2017 To 12/31/2017		
			Titl	e XIX	Hospi tal	Cost	
	Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col.	Inpatient Program Charges	Inpatient Program Pass-Throug Costs (col.		Outpatient Program Pass-Through Costs (col. 9	
		7)		x col. 10)		x col. 12)	
		9.00	10.00	11.00	12.00	13.00	
	ANCI LLARY SERVI CE COST CENTERS					1	
	05000 OPERATI NG ROOM	0. 000000	8, 903, 141		0 (
	05100 RECOVERY ROOM	0. 000000	0			0 0	
	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0			0 0	1
	05300 ANESTHESI OLOGY	0. 000000	393, 139		0 0	0 0	
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	3, 521, 475		0 (0 0	54.00
54.01	05401 FSED RADIOLOGY - DIAGNOSTIC	0. 000000	102, 783		0 (0 0	54.01
55.00	05500 RADI OLOGY-THERAPEUTI C	0. 000000	295, 851		0 (0 0	55.00
55.01	05501 WOODLAND CANCER CARE CTR	0. 000000	831		0 (o o	55.01
56.00	05600 RADI OI SOTOPE	0. 000000	0		0 (0 0	56.00
	05700 CT SCAN	0. 000000	0		0 (o l	57.00
	05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 000000	0				
	05900 CARDI AC CATHETERI ZATI ON	0. 000000	1, 327, 235				
	06000 LABORATORY	0. 000000	4, 575, 808				
	06001 FS ED LAB	0. 000000	4, 373, 888		0 0		
	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000	4, 447		0		61.00
		0,000000	0		0	0	
	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	0		0 0		62.00
	06300 BLOOD STORING, PROCESSING & TRANS.	0.000000	0			0 0	
	06400 I NTRAVENOUS THERAPY	0. 000000	0			0	
	06500 RESPI RATORY THERAPY	0. 000000	1, 939, 684			0	
	06600 PHYSI CAL THERAPY	0. 000000	0			0 0	
	06700 OCCUPATI ONAL THERAPY	0. 000000	0			0 0	
	06800 SPEECH PATHOLOGY	0. 000000	0			0 0	
	06900 ELECTROCARDI OLOGY	0. 000000	1, 030, 130			0 0	
	07000 ELECTROENCEPHALOGRAPHY	0. 000000	0			0 0	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	0		0 (0 0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0		0 (0 0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	0		0 (0 0	73.00
74.00	07400 RENAL DIALYSIS	0. 000000	0		0 (0 0	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0. 000000	0		0 0	0 0	75.00
76.00	03020 CV RESOURCE CTR	0. 000000	0		0 (o o	76.00
	07700 ALLOGENEIC STEM CELL ACQUISITION	0. 000000	0		0 (o l	77.00
	OUTPATIENT SERVICE COST CENTERS			I		· · · · · ·	
	08800 RURAL HEALTH CLINIC	0. 000000	0		0 (0 0	88.00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000	0				
	09000 CLINIC	0. 000000	0				
	09003 INFUSION OP SERVICES	0. 000000	0		0 0		
	09100 EMERGENCY	0. 000000	1, 962, 779		0 0		
	09101 FREE STANDING EMERGENCY DEPT	0. 000000	1, 902, 779				
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	0		0 (0 0	92.00
	OTHER REIMBURSABLE COST CENTERS	0.000000					04.00
	09400 HOME PROGRAM DI ALYSI S	0. 000000	0		0 0	0 0	
	09500 AMBULANCE SERVICES						95.00
	09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000	0		0 0	0 0	96.00
96.00			-		-		
96. 00 97. 00	09700 DURABLE MEDICAL EQUIP-SOLD	0. 000000	0			0 0	
96. 00 97. 00	09700 DURABLE MEDI CAL EQUI P-SOLD 09850 OTHER REI MBURSABLE COST CENTERS		-		0 0	0	

ORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT,	AL COSTS	Provider C	CN: 15-0015	Peri od:	Worksheet D	
		Component	CCN: 15-S015	From 01/01/2017 To 12/31/2017	Part II Date/Time Pre 5/30/2018 6:0	pare 6 pm
		Titl	e XIX	Subprovider - IPF	Cost	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
		(from Wkst. C,	U U	U U	(column 3 x	
	(from Wkst. B,			I. Charges	column 4)	
	Part II, col. 26)	8)	2)			
	1.00	2.00	3.00	4.00	5.00	-
ANCI LLARY SERVI CE COST CENTERS		2.00	0.00		0100	
00 05000 OPERATI NG ROOM	2, 687, 389	C	0.0000	00 00	0	50.
00 05100 RECOVERY ROOM	0	c c	0.0000	00 00	0	51
00 05200 DELIVERY ROOM & LABOR ROOM	319, 552	C	0.0000	00 00	0	52
00 05300 ANESTHESI OLOGY	33, 814	C C	0.0000	00 00	0	53
00 05400 RADI OLOGY-DI AGNOSTI C	1, 722, 942	c c	0.0000	00 00	0	54
01 05401 FSED RADIOLOGY - DIAGNOSTIC	1, 170, 507	C C	0.0000	00 00	0	54
00 05500 RADI OLOGY-THERAPEUTI C	672, 680	C C	0.0000	00 00	0	55
01 05501 WOODLAND CANCER CARE CTR	461, 803	C C	0.0000	00 00	0	55
00 05600 RADI 0I SOTOPE	0	C	0.0000	00 00	0	56
00 05700 CT SCAN	0	C C	0.0000	00 00	0	57
00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	C	0.0000	00 00	0	58
00 05900 CARDI AC CATHETERI ZATI ON	1, 404, 161	C C	0.0000	00 00	0	59
00 06000 LABORATORY	509, 732	C C	0.0000	00 00	0	60
01 06001 FS ED LAB	82, 041	C C	0.0000	00 00	0	60
00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61
00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	c c	0.0000	00 00	0	62
00 06300 BLOOD STORING, PROCESSING & TRANS.	0	c c	0.0000	00 00	0	63
00 06400 INTRAVENOUS THERAPY	0	c c	0.0000	00 00	0	64
00 06500 RESPI RATORY THERAPY	153, 881	C	0.0000	00 0	0	65
00 06600 PHYSI CAL THERAPY	162, 515	C	0.0000	00 0	0	66
00 06700 OCCUPATI ONAL THERAPY	0	C	0.0000	00 0	0	67
00 06800 SPEECH PATHOLOGY	0	C	0.0000	00 0	0	68
00 06900 ELECTROCARDI OLOGY	425, 937	C	0.0000	00 0	0	69
00 07000 ELECTROENCEPHALOGRAPHY	0	C	0.0000	00 0	0	70
00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	29, 389	C	0.0000	00 0	0	71
00 07200 IMPL. DEV. CHARGED TO PATIENTS	226, 087	C	0.0000	00 0	0	72
00 07300 DRUGS CHARGED TO PATIENTS	548, 488	C	0.0000	00 0	0	73
00 07400 RENAL DIALYSIS	0	C	0.0000	00 0	0	74
00 07500 ASC (NON-DISTINCT PART)	0	-			0	
00 03020 CV RESOURCE CTR	0				0	
00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	C	0.0000	00 00	0	77
OUTPATIENT SERVICE COST CENTERS	-		1			
00 08800 RURAL HEALTH CLINIC	0					
00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	-			0	
	0	-			0	
03 09003 INFUSION OP SERVICES	79, 892				0	
00 09100 EMERGENCY	1, 176, 541				0	
01 09101 FREE STANDING EMERGENCY DEPT	1, 467, 000				-	
00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)	0	C	0.0000	00 0	0	92
OTHER REIMBURSABLE COST CENTERS			0.0000			
00 09400 HOME PROGRAM DI ALYSI S	0	C	0.0000	00 00	0	
00 09500 AMBULANCE SERVICES			0.0000			95
00 09600 DURABLE MEDICAL EQUIP-RENTED	0				0	
00 09700 DURABLE MEDICAL EQUIP-SOLD	0				0	
00 09850 OTHER REIMBURSABLE COST CENTERS	0	C	0.0000		0	

Health Financial Systems FI	RANCISCAN HEALTH	MICHIGAN CIT	Y	In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PASS	Provider C	CN: 15-0015	Period:	Worksheet D	
THROUGH COSTS		Component	CCN: 15-S015	From 01/01/2017 To 12/31/2017		pared: 6 pm
		Ti tl	e XIX	Subprovider - IPF	Cost	
Cost Center Description	Non Physician N	lursi ng School	Nursing Schoo	Allied Health	Allied Health	
		Post-Stepdown		Post-Stepdown		
	<u>Cost</u> 1.00	Adjustments 2A	2.00	Adjustments 3A	3.00	
ANCI LLARY SERVI CE COST CENTERS	1.00	28	2.00	JA	3.00	
50. 00 05000 OPERATI NG ROOM	0	(0 0	0	50.00
51.00 05100 RECOVERY ROOM	0	C		0 0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	C		0 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0	C		0 0	0	
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	C	0	0 0	0	
54. 01 05401 FSED RADI OLOGY - DI AGNOSTI C	0	0		0 0	0	
55. 00 05500 RADI OLOGY-THERAPEUTI C	0			0 0	0	
55. 01 05501 WOODLAND CANCER CARE CTR 56. 00 05600 RADI 0I SOTOPE	0					
57. 00 05700 CT SCAN	0				0	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	(0 0	-	1
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	C		0 0	-	
60. 00 06000 LABORATORY	0	C	þ	0 0	0	1
60. 01 06001 FS ED LAB	0	C		0 0	0	60. 01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	C		0 0	0	
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	C	D	0 0	0	
64.00 06400 I NTRAVENOUS THERAPY	0	C		0 0	-	
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	0			0 0	0	
67. 00 06700 OCCUPATI ONAL THERAPY	0	(
68. 00 06800 SPEECH PATHOLOGY	0				0	
69. 00 06900 ELECTROCARDI OLOGY	0	(0 0	-	1
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	C		0 0	0	1
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	C	þ	0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	C		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	C		0 0	0	
74.00 07400 RENAL DIALYSIS	0	C	D	0 0	0	
75.00 07500 ASC (NON-DISTINCT PART)	0	0	0	0 0	0	
76.00 03020 CV RESOURCE CTR	0	(0 0	-	
77. 00 07700 ALLOGENEI C STEM CELL ACQUI SI TI ON OUTPATI ENT SERVI CE COST CENTERS	0	Ĺ	<u>и</u>	0 0	0	77.00
88. 00 08800 RURAL HEALTH CLINIC	0	(0 0	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0	-	
90. 00 09000 CLINIC	0	C		0 0	-	
90. 03 09003 INFUSION OP SERVICES	0	C		0 0	0	90.03
91. 00 09100 EMERGENCY	0	C		0 0	0	91.00
91. 01 09101 FREE STANDING EMERGENCY DEPT	0	C		0 0	-	
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)	0			0	0	92.00
OTHER REI MBURSABLE COST CENTERS				0		04.00
94.00 09400 HOME PROGRAM DI ALYSI S	0	C	י 	0 0	0	
95. 00 09500 AMBULANCE SERVICES 96. 00 09600 DURABLE MEDICAL EQUIP-RENTED		r		0 0	0	95.00 96.00
97. 00 09700 DURABLE MEDICAL EQUIP-RENTED	0	r c	Ś		-	
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0	(0 0	0	
200.00 Total (lines 50 through 199)	0	0		0 0		200.00
	-1		·			

Health Financial Systems F APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE		H MICHIGAN CITY			eu of Form CMS-2 Worksheet D	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCIELARY SE THROUGH COSTS	RVICE UTHER PAS:		CCN: 15-0015	Period: From 01/01/2017 To 12/31/2017	Part IV Date/Time Pre	
		Titl	e XIX	Subprovider - IPF	5/30/2018 6:0 Cost	o pili
Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
	Medi cal	(sum of col 1	Outpati ent	(from Wkst. C,		
	Education Cost	5	Cost (sum of		(col. 5 ÷ col.	
		4)	col. 2, 3 an 4)	d 8)	7)	
	4.00	5.00	6.00	7.00	8.00	
ANCI LLARY SERVI CE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0			0 0		•
51.00 05100 RECOVERY ROOM	0			0 0		•
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0			0 0		•
53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0.000000	•
54. 01 05401 FSED RADI OLOGY - DI AGNOSTI C	0	0		0 0	0.000000	
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0 0	0. 000000	•
55.01 05501 WOODLAND CANCER CARE CTR	0	0		0 0		•
56. 00 05600 RADI 0I SOTOPE	0	0		0 0	0. 000000	•
57.00 05700 CT SCAN	0	0		0 0	0. 000000	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 0	0. 000000	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 0	0.000000	
60. 00 06000 LABORATORY	0	0		0 0	0.000000	
60.01 06001 FS ED LAB	0	0		0 0	0. 000000	
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0 0	0. 000000	61.00 62.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0 0	0.000000	
64. 00 06400 I NTRAVENOUS THERAPY	0	0		0 0	0. 000000	
65. 00 06500 RESPI RATORY THERAPY	0	0		0 0	0. 000000	•
66. 00 06600 PHYSI CAL THERAPY	0	0		0 0	0. 000000	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 0	0. 000000	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0 0	0. 000000	•
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 0	0.000000	•
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0.000000	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0.000000	
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0.000000	
74. 00 07400 RENAL DI ALYSI S	0	0		0 0	0. 000000	
75.00 07500 ASC (NON-DISTINCT PART)	0	0		0 0	0. 000000	
76.00 03020 CV RESOURCE CTR	0	0		0 0	0. 000000	76.00
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	0		0 0	0.00000	77.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0			0 0		•
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 90. 00 09000 CLINIC	0	0		0 0	0.000000	
90. 03 09003 INFUSION OP SERVICES	0	0		0 0	0.000000	
91. 00 09100 EMERGENCY	0	0		0 0		•
91. 01 09101 FREE STANDING EMERGENCY DEPT	0	0		0 0		
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) OTHER REI MBURSABLE COST CENTERS	0	0		0 0		
94.00 09400 HOME PROGRAM DI ALYSI S	0	0		0 0	0.000000	94.00
95. 00 09500 AMBULANCE SERVICES		0			0.000000	95.00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	0	0		0 0	0. 000000	
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	-		0 0		
97. 00 U9700 DURABLE MEDICAL EQUIP-SOLD						
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0			0 0		98.00

			MICHIGAN CIT		D		u of Form CMS-2	2552-10
	I ONMENT OF I NPATI ENT/OUTPATI ENT ANCI LLARY SEA H COSTS	RVICE UTHER PASS	Provider C Component	CN: 15-0015 CCN: 15-S015		riod: om 01/01/2017 12/31/2017	Worksheet D Part IV Date/Time Pre	
			Titl	e XIX	S	ubprovider -	5/30/2018 6:0 Cost	6 pm
						IPF		
	Cost Center Description	Outpatient Ratio of Cost	Inpatient Program	Inpatient Program		Outpatient Program	Outpatient Program	
		to Charges	Charges	Pass-Throug	1h	Charges	Pass-Through	
		$(col \cdot 6 \div col \cdot$	onar ges	Costs (col.		ondriges	Costs (col. 9	
		7)		x col. 10)			x col. 12)	
		9.00	10.00	11.00		12.00	13.00	
	ANCI LLARY SERVICE COST CENTERS	0.000000		1				
	05000 OPERATING ROOM	0.000000	0		0	0	0	50.00
51.00	05100 RECOVERY ROOM	0.000000	0		0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0		0	0	0	52.00
53.00	05300 ANESTHESI OLOGY	0. 000000 0. 000000	0		0	0	0	53.00 54.00
54.00 54.01	05400 RADI OLOGY-DI AGNOSTI C 05401 FSED RADI OLOGY - DI AGNOSTI C	0. 000000	0		0	0	0	54.00
	05500 RADI OLOGY - DI AGNOSTI C	0. 000000	0		0	0	0	55.00
55.00 55.01	05501 WOODLAND CANCER CARE CTR	0. 000000	0		0	0	0	55.00
55. 01 56. 00	05600 RADI OI SOTOPE	0. 000000	0		0	0	0	56.00
57.00	05700 CT SCAN	0. 000000	0		0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	0		0	0	0	58.00
59.00 59.00	05900 CARDI AC CATHETERI ZATI ON	0.000000	0		0	0	0	59.00
60.00	06000 LABORATORY	0. 000000	0		0	0	0	60.00
	06001 FS ED LAB	0. 000000	0		0	0	0	60.00
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000	0		Ŭ	0	0	61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000	C		0	o	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	Ő		Ő	0	0	63.00
64.00	06400 I NTRAVENOUS THERAPY	0. 000000	0		0	o	0	64.00
65.00	06500 RESPIRATORY THERAPY	0, 000000	0		0	o	0	65.00
66.00	06600 PHYSI CAL THERAPY	0. 000000	C		0	0	0	66.00
	06700 OCCUPATI ONAL THERAPY	0. 000000	C		0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0. 000000	C		0	0	0	68.00
69.00	06900 ELECTROCARDI OLOGY	0. 000000	C)	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 000000	0)	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	0		0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	C		0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	0		0	0	0	73.00
	07400 RENAL DIALYSIS	0. 000000	C		0	0	0	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0. 000000	C		0	0	0	75.00
76.00	03020 CV RESOURCE CTR	0. 000000	0		0	0	0	76.00
77.00	07700 ALLOGENEIC STEM CELL ACQUISITION	0. 000000	0		0	0	0	77.00
	OUTPATIENT SERVICE COST CENTERS			1		-		
	08800 RURAL HEALTH CLINIC	0.000000	0		0	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0		0	0	0	89.00
	09000 CLINIC	0.000000	0	1	0	0	0	90.00
90.03	09003 I NFUSI ON OP SERVI CES	0.000000	0		0	0	0	90.03
	09100 EMERGENCY	0.000000	0		0 0	0	0	91.00
	09101 FREE STANDING EMERGENCY DEPT 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	0		0	0	0	91.01 92.00
	OTHER REIMBURSABLE COST CENTERS	0.000000	0	1	U	0	0	72.00
	09400 HOME PROGRAM DI ALYSI S	0. 000000	0		0	0	0	94.00
	09500 AMBULANCE SERVICES	0.000000	0		Ŭ	0	0	95.00
	09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000	C		0	o	0	
	09700 DURABLE MEDICAL EQUIP-SOLD	0. 000000	0		0	0	0	
97.00								
	09850 OTHER REIMBURSABLE COST CENTERS	0. 000000	C		0	0	0	98.00

PORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT	AL COSTS	Provider C	CN: 15-0015	Peri od:	Worksheet D	
		Component	CCN: 15-T015	From 01/01/2017 To 12/31/2017	Part II Date/Time Pre 5/30/2018 6:0	pare 6 pm
		Titl	e XIX	Subprovider - IRF	Cost	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
		(from Wkst. C,	U U	U	(column 3 x	
	(from Wkst. B,			I. Charges	column 4)	
	Part II, col. 26)	8)	2)			
	1.00	2.00	3.00	4.00	5.00	<u> </u>
ANCI LLARY SERVICE COST CENTERS	1.00	2.00	0.00	1.00	0.00	-
00 05000 OPERATI NG ROOM	2, 687, 389	C	0.0000	00 0	0	50.
00 05100 RECOVERY ROOM	0		1		0	
00 05200 DELIVERY ROOM & LABOR ROOM	319, 552	c c	1		0	
00 05300 ANESTHESI OLOGY	33, 814				0	
00 05400 RADI OLOGY-DI AGNOSTI C	1, 722, 942		1		0	
01 05401 FSED RADIOLOGY - DIAGNOSTIC	1, 170, 507	l c	1		0	54
00 05500 RADI OLOGY-THERAPEUTI C	672, 680		1		0	
01 05501 WOODLAND CANCER CARE CTR	461, 803		1		0	
00 05600 RADI OI SOTOPE	0				0	
00 05700 CT SCAN	0		1		0	
00 05800 MAGNETIC RESONANCE I MAGI NG (MRI)	0		1		0	
00 05900 CARDI AC CATHETERI ZATI ON	1, 404, 161				0	
00 06000 LABORATORY	509, 732				0	
01 06001 FS ED LAB	82, 041		1		0	
00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		-			-	61
00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	l c	0, 0000	00 0	0	
00 06300 BLOOD STORING, PROCESSING & TRANS.	0				0	
00 06400 I NTRAVENOUS THERAPY	0		1		0	
00 06500 RESPIRATORY THERAPY	153, 881		1		0	
00 06600 PHYSI CAL THERAPY	162, 515				0	66
00 06700 OCCUPATI ONAL THERAPY	0				0	
00 06800 SPEECH PATHOLOGY	0	-			0	
00 06900 ELECTROCARDI OLOGY	425, 937				0	
00 07000 ELECTROENCEPHALOGRAPHY	0				0	
00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	29, 389				0	
00 07200 IMPL. DEV. CHARGED TO PATIENTS	226, 087	C			0	
00 07300 DRUGS CHARGED TO PATIENTS	548, 488		1		0	
00 07400 RENAL DIALYSIS	0		1		0	
00 07500 ASC (NON-DISTINCT PART)	0				0	
00 03020 CV RESOURCE CTR	0	l c			0	
00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	c c	1		0	
OUTPATIENT SERVICE COST CENTERS						
00 08800 RURAL HEALTH CLINIC	0	C	0.0000	00 0	0	88
00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	c c	0.0000	00 0	0	89
00 09000 CLINIC	0	c c	0.0000	00 0	0	90
03 09003 I NEUSI ON OP SERVI CES	79, 892	c c	0.0000	00 0	0	90
00 09100 EMERGENCY	1, 176, 541	c	0. 0000	00 0	0	91
01 09101 FREE STANDING EMERGENCY DEPT	1, 467, 000		0.0000	00 0	0	91
00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0		0.0000	00 0	0	
OTHER REIMBURSABLE COST CENTERS						
00 09400 HOME PROGRAM DI ALYSI S	0	C	0.0000	00 0	0	94
00 09500 AMBULANCE SERVICES						95
00 09600 DURABLE MEDICAL EQUIP-RENTED	0	c c	0.0000	00 0	0	96
00 09700 DURABLE MEDICAL EQUIP-SOLD	0	c c	1		0	97
00 09850 OTHER REIMBURSABLE COST CENTERS	0				0	
D.00 Total (lines 50 through 199)	13, 334, 351	l c		0	0	200

Health Financial Systems F	RANCISCAN HEALTH	MICHIGAN CIT	Y	In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PASS	Provider C	CN: 15-0015	Period:	Worksheet D	
THROUGH COSTS		Component	CCN: 15-T015	From 01/01/2017 To 12/31/2017		pared: 6 pm
		Titl	e XIX	Subprovider -	Cost	
Cost Center Description	Non Physician N	lursi ng School	Nursing Schoo	Allied Health	Allied Health	
		Post-Stepdown		Post-Stepdown		
	<u>Cost</u> 1.00	Adjustments 2A	2.00	Adjustments 3A	3.00	
ANCI LLARY SERVI CE COST CENTERS	1.00	ZA	2.00	3A	3.00	
50. 00 05000 OPERATING ROOM	0	(0 0	0	50.00
51.00 05100 RECOVERY ROOM	0	C		0 0		
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	C		0 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0	C		0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	C		0 0	0	54.00
54. 01 05401 FSED RADIOLOGY - DIAGNOSTIC	0	C		0 0	0	
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	C	D	0 0	0	
55.01 05501 WOODLAND CANCER CARE CTR	0	C	0	0 0	0	
56. 00 05600 RADI OI SOTOPE	0	(0	0 0	0	
57.00 05700 CT SCAN	0	(0 0	0	
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI) 59. 00 05900 CARDIAC CATHETERIZATION	0	(0	
60. 00 06000 LABORATORY	0			0 0	0	1
60. 01 06001 FS ED LAB	0				0	
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	C	,	0		61.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	C		0 0	0	
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0 0	0	1
64.00 06400 I NTRAVENOUS THERAPY	0	C		0 0	0	
65. 00 06500 RESPI RATORY THERAPY	0	C	þ	0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	C		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	C		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	C		0 0	0	
69.00 06900 ELECTROCARDI OLOGY	0	C	D	0 0	-	1
70.00 07000 ELECTROENCEPHALOGRAPHY	0	C	0	0 0	0	
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0 0	0	
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS 73. 00 07300 DRUGS CHARGED TO PATIENTS	0	(0 0	0	
74. 00 07400 RENAL DIALYSIS	0	(0 0		1
75. 00 07500 ASC (NON-DI STINCT PART)	0				0	
76. 00 03020 CV RESOURCE CTR	0	(0 0	-	
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	C		0 0	-	
OUTPATIENT SERVICE COST CENTERS	- · · ·					
88.00 08800 RURAL HEALTH CLINIC	0	C)	0 0	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	C	D	0 0	0	89.00
90. 00 09000 CLINIC	0	C		0 0	, o	
90. 03 09003 I NFUSI ON OP SERVI CES	0	C	0	0 0	0	
91.00 09100 EMERGENCY	0	0	0	0 0	0	
91. 01 09101 FREE STANDING EMERGENCY DEPT	0	Ĺ		0 0	-	
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)	0			0	0	92.00
OTHER REI MBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DI ALYSI S	0	0		0 0	0	94.00
95. 00 09500 AMBULANCE SERVICES	0	Ĺ	, 	0		94.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	C		0 0	0	1
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	ſ		0 0	-	
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0	C	þ	0 0	0	
200.00 Total (lines 50 through 199)	0	C	þ	0 0		200.00
U				•		-

	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	VICE OTHER PASS	H MICHIGAN CITY	°N· 15_0015	Period:	Worksheet D	2552-10
	H COSTS				From 01/01/2017 To 12/31/2017	Part IV Date/Time Pre 5/30/2018 6:0	
			Titl	e XIX	Subprovider - IRF	Cost	
	Cost Center Description	AII Other	Total Cost	Total	Total Charges	Ratio of Cost	
		Medi cal	(sum of col 1	Outpati ent	(from Wkst. C,	U U	
		Education Cost	5	Cost (sum of		(col. 5 ÷ col.	
			4)	col. 2, 3 and	(8	7)	
		4.00	5.00	4)	7.00	8.00	
	ANCI LLARY SERVI CE COST CENTERS	4.00	3.00	0.00	7.00	0.00	
50.00	05000 OPERATI NG ROOM	0	0		0 0	0.00000	50.00
51.00	05100 RECOVERY ROOM	0	0		0 0	0.000000	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0. 000000	52.00
53.00	05300 ANESTHESI OLOGY	0	0		0 0	0. 000000	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0.00000	54.00
54.01	05401 FSED RADIOLOGY - DIAGNOSTIC	0	0		0 0	0.00000	54.01
	05500 RADI OLOGY-THERAPEUTI C	0	0		0 0	0. 000000	•
55. 01	05501 WOODLAND CANCER CARE CTR	0	0		0 0	0. 000000	•
	05600 RADI OI SOTOPE	0	0		0 0	0.00000	•
57.00	05700 CT SCAN	0			0 0	0.000000	
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 0	0.00000	•
	05900 CARDI AC CATHETERI ZATI ON	0			0 0	0.00000	•
60.00	06000 LABORATORY	0	0		0 0	0.000000	•
	06001 FS ED LAB	0	0		0 0	0.000000	•
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY					0 000000	61.00
	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0 0	0.000000	•
63.00 64.00	06300 BLOOD STORING, PROCESSING & TRANS. 06400 INTRAVENOUS THERAPY	0	0		0 0 0 0	0.000000 0.000000	•
65.00	06500 RESPI RATORY THERAPY	0	0		0 0	0.000000	•
66.00	06600 PHYSI CAL THERAPY	0	0		0 0	0.000000	•
	06700 OCCUPATI ONAL THERAPY	0	0		0 0	0.000000	•
68.00	06800 SPEECH PATHOLOGY	0	0		0 0	0.000000	•
	06900 ELECTROCARDI OLOGY	0	0		0 0	0.000000	
	07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0.000000	•
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0.000000	•
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0.000000	
	07300 DRUGS CHARGED TO PATIENTS	0	0		o o	0.000000	•
74.00	07400 RENAL DI ALYSI S	0	0		0 0	0.000000	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0		0 0	0. 000000	75.00
76.00	03020 CV RESOURCE CTR	0	0		0 0	0.00000	76.00
77.00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0		0 0	0.00000	77.00
	OUTPATIENT SERVICE COST CENTERS	1					
	08800 RURAL HEALTH CLINIC	0			0 0	0. 000000	•
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0			0 0	0. 000000	•
	09000 CLI NI C	0	0		0 0	0.00000	
90.03	09003 INFUSION OP SERVICES	0	0		0 0	0.00000	•
	09100 EMERGENCY	0			0 0	0.00000	•
	09101 FREE STANDING EMERGENCY DEPT	0	e e e e e e e e e e e e e e e e e e e		0 0	0.000000	•
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 0	0.000000	92.00
04 00	OTHER REIMBURSABLE COST CENTERS				0	0,000000	04.00
	09400 HOME PROGRAM DI ALYSI S	0	0		0 0	0. 000000	•
	09500 AMBULANCE SERVI CES 09600 DURABLE MEDI CAL EQUI P-RENTED	0	0		0	0 000000	95.00 96.00
		-	-		0 0	0.000000	
	100700 DURABLE MEDICAL FOULD SOLD	^					
97.00	09700 DURABLE MEDICAL EQUIP-SOLD 09850 OTHER REIMBURSABLE COST CENTERS	0			0 0 0 0	0. 000000 0. 000000	

	Financial Systems FF ONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	SALUE UTHED DV66	Provider C		Peri		Worksheet D	2552-10
	I CONTRACT OF THE ATTENT OF PATTENT ANGILLARY SEP 1 COSTS	VILL UTILL FASS		CCN: 15-T015		n 01/01/2017 12/31/2017	Part IV Date/Time Pre	
			Titl	e XIX	Sul	bprovider - IRF	5/30/2018 6:00 Cost	o pili
	Cost Center Description	Outpati ent	Inpati ent	Inpati ent		Outpati ent	Outpati ent	
		Ratio of Cost	Program	Program		Program	Program	
		to Charges	Charges	Pass-Throug		Charges	Pass-Through	
		(col. 6 ÷ col.		Costs (col.			Costs (col. 9	
		7) 9.00	10.00	x col. 10) 11.00		12.00	x col. 12) 13.00	
	ANCI LLARY SERVI CE COST CENTERS	7.00	10.00	11.00		12.00	13.00	
	05000 OPERATING ROOM	0. 000000	C		0	0	0	50.00
51.00	05100 RECOVERY ROOM	0. 000000	C		0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0	0	0	52.00
53.00	05300 ANESTHESI OLOGY	0. 000000	C		0	0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	C		0	0	0	54.00
	05401 FSED RADIOLOGY - DIAGNOSTIC	0. 000000	0		0	0	0	54.01
	05500 RADI OLOGY-THERAPEUTI C	0. 000000	C		0	0	0	55.00
	05501 WOODLAND CANCER CARE CTR	0. 000000	C		0	0	0	55.01
	05600 RADI OI SOTOPE	0. 000000	0		0	0	0	56.00
	05700 CT SCAN	0. 000000	0		0	0	0	57.00
	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	0		0	0	0	58.00
	05900 CARDI AC CATHETERI ZATI ON	0. 000000	0		0	0	0	59.00
	06000 LABORATORY 06001 FS ED LAB	0. 000000 0. 000000	0		0 0	0	0	60.00 60.01
	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000	U		0	0	0	61.00
	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000	C		0	0	0	62.00
	06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	C		0	0	0	63.00
	06400 I NTRAVENOUS THERAPY	0. 000000	C		0	0	0	64.00
	06500 RESPI RATORY THERAPY	0. 000000	C		0	Ő	0	65.00
	06600 PHYSI CAL THERAPY	0. 000000	0		0	0	0	66.00
	06700 OCCUPATI ONAL THERAPY	0. 000000	C		0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0. 000000	0		0	0	0	68.00
69.00	06900 ELECTROCARDI OLOGY	0. 000000	C		0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 000000	C		0	0	0	70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	0		0	0	0	71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	C		0	0	0	72.00
	07300 DRUGS CHARGED TO PATIENTS	0. 000000	C		0	0	0	73.00
	07400 RENAL DI ALYSI S	0. 000000	0		0	0	0	74.00
	07500 ASC (NON-DI STI NCT PART)	0. 000000	0		0	0	0	75.00
	03020 CV RESOURCE CTR 07700 ALLOGENEIC STEM CELL ACQUISITION	0. 000000 0. 000000	0		0 0	0	0	76.00 77.00
	OUTPATIENT SERVICE COST CENTERS	0.000000				0	0	//.00
	08800 RURAL HEALTH CLINIC	0. 000000	C		0	0	0	88.00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0, 000000	C		0	o	0	89.00
	09000 CLINIC	0. 000000	0		0	0	0	90.00
	09003 INFUSION OP SERVICES	0. 000000	C		0	0	0	90.03
91.00	09100 EMERGENCY	0. 000000	C		0	0	0	91.00
	09101 FREE STANDING EMERGENCY DEPT	0. 000000	C		0	0	0	91.01
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	0		0	0	0	92.00
	OTHER REIMBURSABLE COST CENTERS	0.00000-			0	-1		04.07
	09400 HOME PROGRAM DI ALYSI S	0. 000000	C		0	0	0	
	09500 AMBULANCE SERVICES 09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000	~		0	~	0	95.00
	09600 DURABLE MEDICAL EQUIP-RENTED 09700 DURABLE MEDICAL EQUIP-SOLD	0.000000	0		0	0	0	
	09700 DURABLE MEDICAL EQUIP-SOLD 09850 OTHER REIMBURSABLE COST CENTERS	0. 000000	0		0	0	0	
98.00								

FRANCI SCAN HEALTH MI CHI GAN CI TY

In Lieu of Form CMS-2552-10

	Financial Systems FRANCISCAN HEALTH N		In Lie	u of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0015	Peri od:	Worksheet D-1	
			From 01/01/2017 To 12/31/2017	Date/Time Pre	narod
			10 12/31/2017	5/30/2018 6:0	
		Title XVIII	Hospi tal	PPS	
	Cost Center Description				
				1.00	
	PART I - ALL PROVIDER COMPONENTS				
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed day			20, 502	1.00
2.00	Inpatient days (including private room days, excluding swing-			20, 502	2.00
3.00	Private room days (excluding swing-bed and observation bed da	ays). If you have only p	rivate room days,	0	3.00
4 00	do not complete this line. Semi-private room days (excluding swing-bed and observation b			14 404	4.00
4.00 5.00	Total swing-bed SNF type inpatient days (including private ro	5 /	or 21 of the cost	16, 484 0	4.00 5.00
5.00	reporting period	olii days) thi odgri becellib		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private ro	oom days) after December	31 of the cost	0	6.00
0.00	reporting period (if calendar year, enter 0 on this line)			Ū	0.00
7.00	Total swing-bed NF type inpatient days (including private roo	om days) through Decembe	~ 31 of the cost	0	7.00
	reporting period				
8.00	Total swing-bed NF type inpatient days (including private roo	om days) after December :	31 of the cost	0	8.00
	reporting period (if calendar year, enter 0 on this line)				
9.00	Total inpatient days including private room days applicable t	the Program (excluding	g swing-bed and	9, 312	9.00
10.00	newborn days) Swing had SNE type inputient days applies to title XV/LL s	alv (including arivete)	and and	0	10.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII o through December 31 of the cost reporting period (see instruc		com days)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII o		room days) after	0	11.00
11.00	December 31 of the cost reporting period (if calendar year, e		com days) arter	0	
12.00	Swing-bed NF type inpatient days applicable to titles V or XI	X only (including priva	te room days)	0	12.00
	through December 31 of the cost reporting period		-		
13.00	Swing-bed NF type inpatient days applicable to titles V or XI			0	13.00
4.4.00	after December 31 of the cost reporting period (if calendar y				44.00
14.00	Medically necessary private room days applicable to the Progr	ram (excluding swing-bed	days)	0	14.00 15.00
15.00 16.00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			0	
10.00	SWING BED ADJUSTMENT			0	10.00
17.00	Medicare rate for swing-bed SNF services applicable to servic	es through December 31 (of the cost	0.00	17.00
	reporting period	5			
18.00	Medicare rate for swing-bed SNF services applicable to servic	ces after December 31 of	the cost	0.00	18.00
	reporting period				
19.00	Medicaid rate for swing-bed NF services applicable to service	es through December 31 of	the cost	0.00	19.00
20.00	reporting period Medicaid rate for swing-bed NF services applicable to service	s after December 31 of	the cost	0.00	20.00
20.00	reporting period			0.00	20.00
21.00	Total general inpatient routine service cost (see instruction	าร)		26, 180, 027	21.00
22.00	Swing-bed cost applicable to SNF type services through Decemb	per 31 of the cost repor	ting period (line	0	22.00
	5 x line 17)				
23.00	Swing-bed cost applicable to SNF type services after December	31 of the cost reportin	ng period (line 6	0	23.00
24.00	x line 18)		an and dime		24.00
24.00	Swing-bed cost applicable to NF type services through Decembe 7×10^{-1} x line 19)	er 31 of the cost report	ng period (line	0	24.00
25.00	Swing-bed cost applicable to NF type services after December	31 of the cost reporting	n period (line 8	0	25.00
	x line 20)		5 p - · · · · · (· · · · · ·	-	
26.00	Total swing-bed cost (see instructions)			0	26.00
27.00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		26, 180, 027	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-be	ed and observation bed cl	narges)	0	•
29.00	Private room charges (excluding swing-bed charges)			0	29.00 30.00
30.00 31.00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27	÷ line 28)		0 0. 000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	÷ Trhe 20)		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 mi	nus line 33)(see instruc	ctions)	0.00	
35.00	Average per diem private room cost differential (line 34 x li	, ,		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	26, 180, 027	37.00
	27 minus line 36)				l
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	UNCTMENTS			
20 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ			1 274 05	38.00
38.00 39.00	Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line			1, 276. 95 11, 890, 958	
40.00	Medically necessary private room cost applicable to the Progr	-		0	40.00
	Total Program general inpatient routine service cost (line 39	, , ,		11, 890, 958	
		/		, ,	

Ith Financial Systems MPUTATION OF INPATIENT OPERATING COST	FRANCISCAN HEALTH MICHIGAN CITY In Lie Provider CCN: 15-0015 Period:	eu of Form CMS-: Worksheet D-1	
	From 01/01/2017 To 12/31/2017		pare
		5/30/2018 6:0	
Cost Center Description	Title XVIII Hospital Total Total Average Per Program Days	PPS Program Cost	
	Inpatient CostInpatient DaysDiem (col. 1 ÷	(col. 3 x col.	
	col. 2) 1.00 2.00 3.00 4.00	4) 5.00	
00 NURSERY (title V & XIX only)	0 0 0.00 0		42.
Intensive Care Type Inpatient Hospital U		0.00/.017	
00 INTENSIVE CARE UNIT 00 CORONARY CARE UNIT	5, 174, 852 0 0 0, 00 0		
00 BURN INTENSIVE CARE UNIT			
00 SURGICAL INTENSIVE CARE UNIT	0 0 0.00 0	0	
00 OTHER SPECIAL CARE (SPECIFY) Cost Center Description			47.
Cost center bescription		1.00	
00 Program inpatient ancillary service cost		15, 965, 096	
00 Total Program inpatient costs (sum of li PASS THROUGH COST ADJUSTMENTS	nes 41 through 48)(see instructions)	30, 092, 371	49
	inpatient routine services (from Wkst. D, sum of Parts I and	1, 789, 829	50
		4 075 040	54
00 Pass through costs applicable to Program and IV)	inpatient ancillary services (from Wkst. D, sum of Parts II	1, 275, 243	51
00 Total Program excludable cost (sum of li	nes 50 and 51)	3, 065, 072	52
	xcluding capital related, non-physician anesthetist, and	27, 027, 299	53
medical education costs (line 49 minus I TARGET AMOUNT AND LIMIT COMPUTATION	The 52)		
00 Program di scharges		0	
00 Target amount per discharge		0.00	
00 Target amount (line 54 x line 55) 00 Difference between adjusted inpatient op	erating cost and target amount (line 56 minus line 53)	0	
00 Bonus payment (see instructions)		0	
	t reporting period ending 1996, updated and compounded by the	0.00	59
market basket 00 Lesser of lines 53/54 or 55 from prior y	ear cost report, updated by the market basket	0.00	60
00 If line 53/54 is less than the lower of	lines 55, 59 or 60 enter the lesser of 50% of the amount by	0	
	than expected costs (lines 54 x 60), or 1% of the target		
amount (line 56), otherwise enter zero (00 Relief payment (see instructions)		0	62
00 Allowable Inpatient cost plus incentive		0	63
PROGRAM INPATIENT ROUTINE SWING BED COST 00 Medicare swing-bed SNF inpatient routine	costs through December 31 of the cost reporting period (See	0	64
instructions) (title XVIII only)	costs through becember 31 of the cost reporting period (see	0	04
	costs after December 31 of the cost reporting period (See	0	65
instructions)(title XVIII only) 00 Total Medicare swing-bed SNF inpatient r	outine costs (line 64 plus line 65)(title XVIII only). For	0	66
CAH (see instructions)		0	
	utine costs through December 31 of the cost reporting period	0	67
(line 12 x line 19) 00 Title V or XIX swing-bed NF inpatient ro	utine costs after December 31 of the cost reporting period	0	68
(line 13 x line 20)			
00 Total title V or XIX swing-bed NF inpati PART III - SKILLED NURSING FACILITY, OTH		0	69
· · · · · · · · · · · · · · · · · · ·	acility/ICF/IID routine service cost (line 37)		70
00 Adjusted general inpatient routine servi			71
00 Program routine service cost (line 9 x l			72
00 Medically necessary private room cost ap 00 Total Program general inpatient routine			73
5 5 1	ent routine service costs (from Worksheet B, Part II, column		75
26, line 45) 00 Per diem capital-related costs (line 75	÷line 2)		76
00 Program capital -related costs (line 9 x			77
00 Inpatient routine service cost (line 74			78
00 Aggregate charges to beneficiaries for e			79
00 Total Program routine service costs for 00 Inpatient routine service cost per diem	comparison to the cost limitation (line 78 minus line 79) limitation		80
00 Inpatient routine service cost limitatio	n (line 9 x line 81)		82
00 Reasonable inpatient routine service cos	•		83
00 Program inpatient ancillary services (se 00 Utilization review - physician compensat			84
00 Total Program inpatient operating costs			86
PART IV - COMPUTATION OF OBSERVATION BED			1
00 Total observation bed days (see instruct 00 Adjusted general inpatient routine cost		4, 018 1, 276. 95	
	(····· L/ · ···· L/	1 1, 2, 0. 75	1 50

Health Financial Systems FR	,					2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period: From 01/01/2017	Worksheet D-1	
				To 12/31/2017		
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST					
90.00 Capital-related cost	3, 409, 769	26, 180, 027	0. 13024	3 5, 130, 785	668, 249	90.00
91.00 Nursing School cost	0	26, 180, 027	0.00000	0 5, 130, 785	0	91.00
92.00 Allied health cost	0	26, 180, 027	0.00000	0 5, 130, 785	0	92.00
93.00 All other Medical Education	0	26, 180, 027	0. 00000	0 5, 130, 785	0	93.00

^{5/30/2018 6:06} pm

	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0015 Component CCN: 15-S015 Title XVIII	Peri od: From 01/01/2017 To 12/31/2017 Subprovi der -	Worksheet D-1 Date/Time Prep 5/30/2018 6:00 PPS	pare
	Cost Center Description		IPF	ггэ	
				1.00	
H	PART I - ALL PROVIDER COMPONENTS				-
	INPATIENT DAYS Inpatient days (including private room days and swing-bed da	vs. excluding newborn)		3, 175	1 1.
	Inpatient days (including private room days, excluding swing			3, 175	
00	Private room days (excluding swing-bed and observation bed d	ays). If you have only pr	ivate room days,	0	3.
00	do not complete this line. Semi-private room days (excluding swing-bed and observation	had days)		3, 175	4.
	Total swing-bed SNF type inpatient days (including private r		r 31 of the cost	3, 175	
	reporting period			C C	
	Total swing-bed SNF type inpatient days (including private r	oom days) after December	31 of the cost	0	6.
	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private ro	om dave) through December	21 of the cost	0	7.
	reporting period	on days) through becenber	ST OF THE COST	0	^{/.}
	Total swing-bed NF type inpatient days (including private ro	om days) after December 3	1 of the cost	0	8.
	reporting period (if calendar year, enter 0 on this line)			0.40	
	Total inpatient days including private room days applicable newborn days)	to the Program (excluding	swing-bed and	842	9
	Swing-bed SNF type inpatient days applicable to title XVIII	only (including private r	oom days)	0	10
	through December 31 of the cost reporting period (see instru	ctions)	•		
	Swing-bed SNF type inpatient days applicable to title XVIII December 31 of the cost reporting period (if calendar year,		oom days) after	0	11
	Swing-bed NF type inpatient days applicable to titles V or X		e room days)	0	12
	through December 31 of the cost reporting period		o room dago)	C C	
	Swing-bed NF type inpatient days applicable to titles V or X			0	13
	after December 31 of the cost reporting period (if calendar Medically necessary private room days applicable to the Prog			0	14
	Total nursery days (title V or XIX only)	Tam (excluding swing-bed	uays)	0	
	Nursery days (title V or XIX only)			0	
	SWING BED ADJUSTMENT				
. 00	Medicare rate for swing-bed SNF services applicable to servi reporting period	ces through December 31 o	f the cost	0.00	17
. 00	Medicare rate for swing-bed SNF services applicable to servi	ces after December 31 of	the cost	0.00	18
	reporting period				
0. 00	Medicaid rate for swing-bed NF services applicable to servic	es through December 31 of	the cost	0.00	19
. 00	reporting period Medicaid rate for swing-bed NF services applicable to servic	es after December 31 of t	he cost	0.00	20
	reporting period			0.00	20
	Total general inpatient routine service cost (see instructio			2, 875, 630	
	Swing-bed cost applicable to SNF type services through Decem	ber 31 of the cost report	ing period (line	0	22
	5 x line 17) Swing-bed cost applicable to SNF type services after Decembe	r 31 of the cost reportin	a period (line 6	0	23
	x line 18)		g per lou (i i i e e	0	20
. 00	Swing-bed cost applicable to NF type services through Decemb	er 31 of the cost reporti	ng period (line	0	24
. 00	7 x line 19) Swing-bed cost applicable to NF type services after December	31 of the cost reporting	period (line 8	0	25
. 00	x line 20)	ST OF the cost reporting	period (inne o	0	23
	Total swing-bed cost (see instructions)			0	
	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		2, 875, 630	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-b	ed and observation bed ch	arges)	0	28
	Private room charges (excluding swing-bed charges)		al gooy	0	
	Semi-private room charges (excluding swing-bed charges)			0	
	General inpatient routine service cost/charge ratio (line 27	÷line 28)		0.00000	
	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)			0.00 0.00	
	Average per diem private room charge differential (line 32 m		tions)	0.00	
	Average per diem private room cost differential (line 34 x l	-		0.00	
	Private room cost differential adjustment (line 3 x line 35)		fforontial (11-	0	
. 00	General inpatient routine service cost net of swing-bed cost 27 minus line 36)	anu private room cost di	TTEPENTIAL (LINE	2, 875, 630	37
ł	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AD				
	Adjusted general inpatient routine service cost per diem (se			905.71	
	Program general inpatient routine service cost (line 9 x lin Medically necessary private room cost applicable to the Prog			762, 608 0	
. 00					

COMPUTA	Financial Systems FR	ANCI SCAN HEALTH		CN: 15-0015	Period:	worksheet D-1	
					From 01/01/2017 To 12/31/2017		
			Title	e XVIII	Subprovider -	5/30/2018 6:0 PPS	6 pm
					. I PF		
	Cost Center Description	Total Inpatient Costl	Total npatient Days	Average Per Diem (col. 1 col. 2)	<pre>Program Days </pre>	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	NURSERY (title V & XIX only)	0	0	0.0	0 0	0	42.
	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	o	C	0.0	0 0	0	43.
	CORONARY CARE UNIT	0	C				
	BURN INTENSIVE CARE UNIT	0	C				
	SURGECAL ENTENSIVE CARE UNIT	0	C	0.0	0 0	0	
7.00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description			1			47.
2 00		+ D 2 2	11			1.00	10
	Program inpatient ancillary service cost (Wks Total Program inpatient costs (sum of lines 4			ons)		96, 702 859, 310	
	PASS THROUGH COST ADJUSTMENTS			513)			/.
	Pass through costs applicable to Program inpa	atient routine s	ervices (from	n Wkst. D, sum	of Parts I and	91, 786	50.
1	III) Pass through costs applicable to Program inpa	atient ancillary	services (fr	rom Wkst. D, s	um of Parts II	6, 017	51.
	and IV)					07.000	-
	Total Program excludable cost (sum of lines ! Total Program inpatient operating cost exclud		ated non-nh	isician anosth	etist and	97, 803 761, 507	
	medical education costs (line 49 minus line !					701, 307] 33.
H H	TARGET AMOUNT AND LIMIT COMPUTATION						1 - 4
	Program discharges Target amount per discharge					0.00	
	Target amount (line 54 x line 55)					0	
	Difference between adjusted inpatient operati	ing cost and tar	get amount (I	ine 56 minus	line 53)	0	
	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost rep	porting poriod a	nding 1004	indated and co	mounded by the	0.00	
	market basket	Soluting period e	inunny 1990, t		inpounded by the	0.00	09.
	Lesser of lines 53/54 or 55 from prior year of					0.00	
	If line 53/54 is less than the lower of lines which operating costs (line 53) are less than					0	61
	amount (line 56), otherwise enter zero (see i		(THES 54 X	00), 01 1/8 01	the target		
	Relief payment (see instructions)					0	
	Allowable Inpatient cost plus incentive payme PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instruc	tions)			0	63.
	Medicare swing-bed SNF inpatient routine cos	ts through Decem	ber 31 of the	e cost reporti	ng period (See	0	64.
	instructions)(title XVIII only)		04 6 11				
	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts arter Decembe	er 31 of the c	cost reporting	period (See	0	65.
5.00	Total Medicare swing-bed SNF inpatient routin	ne costs (line é	4 plus line 6	5)(title XVII	l only). For	0	66.
	CAH (see instructions)	a costs through	December 21	f the cost re	porting poriod	0	67.
7.00	Title V or XIX swing-bed NF inpatient routine (line 12 x line 19)	e costs through	December 31 C	on the cost re	portring period	0	07.
3. 00	Title V or XIX swing-bed NF inpatient routine	e costs after De	ecember 31 of	the cost repo	rting period	0	68.
9.00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient n	coutine costs (l	ine 67 + line	e 68)		0	69.
	PART III - SKILLED NURSING FACILITY, OTHER NU						
	Skilled nursing facility/other nursing facili						70.
	Adjusted general inpatient routine service of Program routine service cost (line 9 x line		ne /0 ÷ line	2)			71.
	Medically necessary private room cost applica	,	(line 14 x li	ne 35)			73.
	Total Program general inpatient routine servi						74.
	Capital-related cost allocated to inpatient 1 26, line 45)	routine service	costs (from V	vorksheet B, P	arτ II, column		75.
5.00	Per diem capital-related costs (line 75 ÷ lin						76.
	Program capital -related costs (line 9 x line						77.
	Inpatient routine service cost (line 74 minus Aggregate charges to beneficiaries for excess		ovider record	ts)			78.
	Total Program routine service costs for compa				us line 79)		80.
	Inpatient routine service cost per diem limi						81.
	Inpatient routine service cost limitation (li Reasonable inpatient routine service costs (s	,					82.
	Program inpatient ancillary services (see ins		·/				84.
5. 00	Utilization review - physician compensation	(see instruction					85.
	Total Program inpatient operating costs (sum		ough 85)				86.
	PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions)					0	87.
	Adjusted general inpatient routine cost per o		line 2)			0.00	
۱ OO	Observation bed cost (line 87 x line 88) (see	e instructions)				0	89.

Health Financial Systems FF	RANCISCAN HEALTH MICHIGAN CITY In Lie				eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period: From 01/01/2017	Worksheet D-1	
		Component (CCN: 15-S015	To 12/31/2017		pared: 6 pm
		Title	XVIII	Subprovider -	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	346, 112	2, 875, 630	0. 12036	0 0	0	90.00
91.00 Nursing School cost	0	2, 875, 630	0. 00000	0 0	0	91.00
92.00 Allied health cost	0	2, 875, 630	0. 00000	0 0	0	92.00
93.00 All other Medical Education	0	2, 875, 630	0.00000	00 0	0	93.00

^{5/30/2018 6:06} pm

JMPU I A	TION OF INPATIENT OPERATING COST	Provider CCN: 15-0015 Component CCN: 15-T015	Period: From 01/01/2017 To 12/31/2017	Worksheet D-1 Date/Time Prep 5/30/2018 6:00	pare
	Cost Contor Description	Title XVIII	Subprovider - IRF	PPS	
	Cost Center Description		-	1.00	
	PART I - ALL PROVIDER COMPONENTS				
	NPATIENT DAYS Inpatient days (including private room days and swing-bed day	(s excluding newborn)		2,607	1 1
	Inpatient days (including private room days and swing bed day Inpatient days (including private room days, excluding swing-			2,607	2
	Private room days (excluding swing-bed and observation bed da		ivate room days,	0	3
	do not complete this line.		-		
	Semi-private room days (excluding swing-bed and observation b			2, 607	4
00	Total swing-bed SNF type inpatient days (including private ro reporting period	oom days) through Decembe	r 31 of the cost	0	5
00	Total swing-bed SNF type inpatient days (including private ro	oom days) after December	31 of the cost	0	6
	reporting period (if calendar year, enter 0 on this line)			-	-
	Total swing-bed NF type inpatient days (including private roo	om days) through December	31 of the cost	0	7
	reporting period				
00	Total swing-bed NF type inpatient days (including private roc reporting period (if calendar year, enter 0 on this line)	om days) after December 3	1 of the cost	0	8
00	Total inpatient days including private room days applicable t	to the Program (excluding	swing-bed and	1, 718	9
	newborn days)		5		
. 00	Swing-bed SNF type inpatient days applicable to title XVIII o		oom days)	0	10
00	through December 31 of the cost reporting period (see instruc		and dave) after	0	11
	Swing-bed SNF type inpatient days applicable to title XVIII o December 31 of the cost reporting period (if calendar year, e		oom days) arter	0	11
	Swing-bed NF type inpatient days applicable to titles V or XI		e room days)	0	12
	through December 31 of the cost reporting period		3 ,		
	Swing-bed NF type inpatient days applicable to titles V or XI			0	13
	after December 31 of the cost reporting period (if calendar y Medically necessary private room days applicable to the Progr			0	14
	Total nursery days (title V or XIX only)	all (excluding swing-bed	uays)	0	
	Nursery days (title V or XIX only)			0	
	SWING BED ADJUSTMENT				
. 00	Medicare rate for swing-bed SNF services applicable to servic	ces through December 31 o	f the cost	0.00	17
. 00	reporting period Medicare rate for swing-bed SNF services applicable to servic	res after December 31 of	the cost	0.00	18
	reporting period			0100	
	Medicaid rate for swing-bed NF services applicable to service	es through December 31 of	the cost	0.00	19
	reporting period		h	0.00	0
	Medicaid rate for swing-bed NF services applicable to service reporting period	es after December 31 of t	ne cost	0.00	20
	Total general inpatient routine service cost (see instruction	าร)		3, 894, 728	21
	Swing-bed cost applicable to SNF type services through Decemb		ing period (line	0	
	5 x line 17)				
	Swing-bed cost applicable to SNF type services after December x line 18)	r 31 of the cost reportin	g period (line 6	0	23
	Swing-bed cost applicable to NF type services through Decembe	er 31 of the cost reporti	ng period (line	0	24
	7 x line 19)		3	0	- '
. 00	Swing-bed cost applicable to NF type services after December	31 of the cost reporting	period (line 8	0	25
00	x line 20) Total swing-bed cost (see instructions)			0	2/
	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		0 3, 894, 728	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			2, 37.1, 120	1 - '
. 00 [General inpatient routine service charges (excluding swing-be	ed and observation bed ch	arges)	0	
	Private room charges (excluding swing-bed charges)			0	
	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27	÷ line 28)		0 0. 000000	
	Average private room per diem charge (line 29 ÷ line 3)	· · · · · · · · 20)		0.000000	
	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
00	Average per diem private room charge differential (line 32 mi		tions)	0.00	34
	Average per diem private room cost differential (line 34 x li	ne 31)		0.00	
	Private room cost differential adjustment (line 3 x line 35)	and private seet "	fforonticl (1)	0	
. 00	General inpatient routine service cost net of swing-bed cost 27 minus line 36)	and private room cost di	rrerential (line	3, 894, 728	37
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ	IUSTMENTS			1
00	Adjusted general inpatient routine service cost per diem (see			1, 493. 95	
					1 20
. 00	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Progr			2, 566, 606 0	

	Financial Systems FR TATION OF INPATIENT OPERATING COST	ANCISCAN HEALTH			Period:	eu of Form CMS- Worksheet D-1	
					From 01/01/2017 To 12/31/2017		
				e XVIII	Subprovider -	5/30/2018 6:0 PPS) <mark>6 pm</mark>
		1			I RF	-	
	Cost Center Description	Total Inpatient Costl	Total npatient Days	Average Per Diem (col. 1 col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
2.00	NURSERY (title V & XIX only)	0	C	0.0	0 0	0	42.
3. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	0	(0.0	0 0	0	43.
4.00	CORONARY CARE UNIT	0	(
5.00	BURN INTENSIVE CARE UNIT	0	C	0.0	0 0	0	45.
6.00	SURGICAL INTENSIVE CARE UNIT	0	C	0.0	0 0	0	
7.00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47.
						1.00	
	Program inpatient ancillary service cost (Wks			>		764, 485	
9.00	Total Program inpatient costs (sum of lines - PASS THROUGH COST ADJUSTMENTS	41 through 48)(s	see instructio	ons)		3, 331, 091	49.
D. 00	Pass through costs applicable to Program inpa	atient routine s	services (from	n Wkst. D, sum	of Parts I and	378, 613	50.
1 00)	ationt and llar		oom Wkot Doo	um of Dorto II	22.044	E1
1. 00	Pass through costs applicable to Program inpa and IV)	attent and trans	services (II	UNI WKSL. D, S	um of Parts II	33, 044	51.
2.00	Total Program excludable cost (sum of lines					411, 657	
3.00	Total Program inpatient operating cost exclu- medical education costs (line 49 minus line 4		ated, non-phy	ysician anesth	etist, and	2, 919, 434	53.
	TARGET AMOUNT AND LIMIT COMPUTATION	52)					
4.00	Program di scharges					0	
5.00	Target amount per discharge					0.00	
b. 00 7. 00	Target amount (line 54 x line 55) Difference between adjusted inpatient operat	ing cost and tar	rget amount (l	ine 56 minus	line 53)	0	
3. 00	Bonus payment (see instructions)	ing obser and tai	got anount (i			0	
9.00	Lesser of lines 53/54 or 55 from the cost re	porting period e	ending 1996, ι	updated and co	mpounded by the	0.00	59.
0. 00	market basket Lesser of lines 53/54 or 55 from prior year	cost report upp	lated by the m	narket basket		0.00	60.
1.00	If line 53/54 is less than the lower of line				the amount by	0.00	
	which operating costs (line 53) are less than		s (lines 54 x	60), or 1% of	the target		
2.00	amount (line 56), otherwise enter zero (see Relief payment (see instructions)	nstructions)				0	62.
3.00	Allowable Inpatient cost plus incentive payme	ent (see instruc	ctions)			0	
	PROGRAM INPATIENT ROUTINE SWING BED COST						
4. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts through Decem	iber 31 of the	e cost reporti	ng period (See	0	64.
5.00	Medicare swing-bed SNF inpatient routine cos	ts after Decembe	er 31 of the d	cost reporting	period (See	0	65.
,	instructions)(title XVIII only)						
5.00	Total Medicare swing-bed SNF inpatient routin CAH (see instructions)	ne costs (line é	54 plus line 6	55)(TITIE XVII	i oniy). For	0	66.
7.00	Title V or XIX swing-bed NF inpatient routine	e costs through	December 31 d	of the cost re	porting period	0	67.
0 00	(line 12 x line 19)	a coste after De	combor 21 of	the cost rope	rting pariod	0	40
3. 00	Title V or XIX swing-bed NF inpatient routing (line 13 x line 20)	e costs arter De	cember 31 01	the cost repo	rting period	0	68.
9.00	Total title V or XIX swing-bed NF inpatient					0	69.
D. 00	PART III - SKILLED NURSING FACILITY, OTHER NU Skilled nursing facility/other nursing facil					1	70.
1.00	Adjusted general inpatient routine service of						71.
2. 00	Program routine service cost (line 9 x line	71)		,			72.
3.00	Medically necessary private room cost applicated						73.
4.00 5.00	Total Program general inpatient routine servi Capital-related cost allocated to inpatient				art II, column		74.
	26, line 45)						
5.00 7.00	Per diem capital-related costs (line 75 ÷ lin Program capital-related costs (line 9 × line						76.
3.00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minu:	· · · · · · · · · · · · · · · · · · ·					78.
. 00	Aggregate charges to beneficiaries for excess		ovider record	(st			79.
0. 00	Total Program routine service costs for compa		ost limitation	n (line 78 min	us line 79)		80.
. 00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (I						81.
. 00 . 00	Reasonable inpatient routine service costs (83.
4. 00	Program inpatient ancillary services (see in	structions)					84.
5.00	Utilization review - physician compensation						85.
6. 00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS		ougn 85)				86.
7.00	Total observation bed days (see instructions)					0	87.
8.00	Adjusted general inpatient routine cost per	•	line 2)			0.00	
1. ()()	Observation bed cost (line 87 x line 88) (see	e instructions)				0	89.

Health Financial Systems FR	ANCISCAN HEALTH	H MICHIGAN CITY	/	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period: From 01/01/2017	Worksheet D-1	
		Component (CCN: 15-T015	To 12/31/2017		
		Title	XVIII	Subprovider -	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	574, 519	3, 894, 728	0. 14751	2 0	0	90.00
91.00 Nursing School cost	0	3, 894, 728	0. 00000	0 0	0	91.00
92.00 Allied health cost	0	3, 894, 728	0.0000	0 0	0	92.00
93.00 All other Medical Education	0	3, 894, 728	0.00000	0 00	0	93.00

^{5/30/2018 6:06} pm

	ancial Systems FRANCISCAN HEALT ANCILLARY SERVICE COST APPORTIONMENT		CN: 15-0015	Peri od:	worksheet D-3	
				From 01/01/2017 To 12/31/2017		
		T: +1	- \/////		5/30/2018 6:0	6 pr
	Cost Center Description		e XVIII Ratio of Cos	Hospital st Inpatient	PPS Inpatient	
	cost center bescription		To Charges		Program Costs	
			J	Charges	(col. 1 x col.	
					2)	
			1.00	2.00	3.00	
	ATLENT ROUTINE SERVICE COST CENTERS			15, 871, 391		30
	DO I NTENSI VE CARE UNI T			2, 823, 087		31
	DO CORONARY CARE UNI T			0		32
	DO BURN INTENSIVE CARE UNIT			0		33
	DO SURGICAL INTENSIVE CARE UNIT			0		34
	DO SUBPROVIDER - IPF			0		40
	DO SUBPROVIDER - IRF DO NURSERY			0		41
	LLARY SERVICE COST CENTERS					43
	DO OPERATI NG ROOM		0. 1420	48 13, 141, 287	1, 866, 694	50
	DO RECOVERY ROOM		0.0000			51
	DO DELIVERY ROOM & LABOR ROOM		1.0527			52
	DO ANESTHESI OLOGY		0.0425			
	DO RADI OLOGY-DI AGNOSTI C		0.0971			54
	D1 FSED RADI OLOGY - DI AGNOSTI C D0 RADI OLOGY-THERAPEUTI C		0. 1646		0 249, 528	54 55
	DI WOODLAND CANCER CARE CTR		0.9653			55
	DO RADI OI SOTOPE		0.0000			56
	DO CT SCAN		0.0000		0	57
. 00 0580	DO MAGNETIC RESONANCE IMAGING (MRI)		0.0000	00 0	0	58
	DO CARDI AC CATHETERI ZATI ON		0. 2155			
	DO LABORATORY		0. 1502			60
	D1 FS ED LAB		0. 2029			60
	DO PBP CLINICAL LAB SERVICES-PRGM ONLY DO WHOLE BLOOD & PACKED RED BLOOD CELLS		0.0000			61
	DO BLOOD STORING, PROCESSING & TRANS.		0.0000			63
	DO I NTRAVENOUS THERAPY		0.0000			64
	DO RESPI RATORY THERAPY		0. 1540		981, 475	65
	DO PHYSI CAL THERAPY		0. 2117		443, 606	66
	DO OCCUPATIONAL THERAPY		0.0000			67
	DO SPEECH PATHOLOGY		0.0000		-	68
1	DO ELECTROCARDI OLOGY DO ELECTROENCEPHALOGRAPHY		0. 1460 0. 0000		497, 322	69 70
	DO MEDICAL SUPPLIES CHARGED TO PATIENTS		0.0566		-	
	DO IMPL. DEV. CHARGED TO PATIENTS		0.8010			
	DO DRUGS CHARGED TO PATIENTS		0. 1725	67 18, 060, 879	3, 116, 712	73
	DO RENAL DI ALYSI S		0.0000			74
	DO ASC (NON-DI STINCT PART)		0.0000			
	20 CV RESOURCE CTR DO ALLOGENEIC STEM CELL ACQUISITION		0.0000			
	PATIENT SERVICE COST CENTERS		0.0000	00 0	0	1 ''
	DO RURAL HEALTH CLINIC		0.0000	00	0	88
	DO FEDERALLY QUALI FI ED HEALTH CENTER		0.0000		0	89
			0.0000		0	90
	03 I NFUSI ON OP SERVI CES		0. 4243			
	DO EMERGENCY		0. 2316			
	D1 FREE STANDING EMERGENCY DEPT D0 OBSERVATION BEDS (NON-DISTINCT PART)		0. 5165			91 92
	ER REIMBURSABLE COST CENTERS		0.0700	0	U	72
	DO HOME PROGRAM DI ALYSI S		0.0000	00 0	0	94
	DO AMBULANCE SERVICES					95
. 00 0960	DO DURABLE MEDI CAL EQUI P-RENTED		0.0000		0	96
	DO DURABLE MEDICAL EQUIP-SOLD		0.0000			
	50 OTHER REIMBURSABLE COST CENTERS		0.0000		-	98
0.00	Total (sum of lines 50 through 94 and 96 through 98)	and (line (1)		83, 345, 151	15, 965, 096	
)1.00)2.00	Less PBP Clinic Laboratory Services-Program only chan Net charges (line 200 minus line 201)	yes (ITTHE OT)		83, 345, 151		201 202

	Financial Systems FRANCISCAN HEALTH MI				n Lie	u of Form CMS-	
INPAILE	ENT ANCILLARY SERVICE COST APPORTIONMENT	Provider (CCN: 15-0015	Period: From 01/01/	2017	Worksheet D-3	5
		Component	CCN: 15-S015	To 12/31/		Date/Time Pre	
		Ti tl	e XVIII	Subprovi de	r -	5/30/2018 6:0 PPS	o pili
				I PF			
	Cost Center Description		Ratio of Cos			Inpatient	
			To Charges	Program Charges		Program Costs (col. 1 x col.	
				charge.	5	2)	
			1.00	2.00		3.00	
-	INPATIENT ROUTINE SERVICE COST CENTERS		1				
	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT				0		30.00
	03200 CORONARY CARE UNIT				0		32.00
	03300 BURN INTENSIVE CARE UNIT				Ő		33.00
	03400 SURGI CAL I NTENSI VE CARE UNI T				0		34.00
	04000 SUBPROVI DER – I PF			1, 204	, 595		40.00
	04100 SUBPROVIDER - IRF				0		41.00
							43.00
	ANCILLARY SERVICE COST CENTERS		0. 1420	48 27	, 012	3, 837	50.00
	05100 RECOVERY ROOM		0. 1420		, 012	3, 837	
	05200 DELIVERY ROOM & LABOR ROOM		1. 0527		Ő	0	
53.00	05300 ANESTHESI OLOGY		0.0425	22	0	0	53.00
	05400 RADI OLOGY-DI AGNOSTI C		0. 0971		, 899	3, 294	
	05401 FSED RADI OLOGY - DI AGNOSTI C		0. 1646		0	0	
	05500 RADI OLOGY-THERAPEUTI C		0. 2619		0	0	
	05501 WOODLAND CANCER CARE CTR 05600 RADI 0I SOTOPE		0. 9653		0	0	
	05700 CT SCAN		0.0000		0	0	
	05800 MAGNETIC RESONANCE IMAGING (MRI)		0.0000		0	0	
	05900 CARDI AC CATHETERI ZATI ON		0. 2155		0	0	59.00
	06000 LABORATORY		0. 1502		, 007	18, 331	
	06001 FS ED LAB		0. 2029		0	0	
	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0.0000		0	0	
	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06300 BLOOD STORING, PROCESSING & TRANS.		0.0000		0	0	
	06400 I NTRAVENOUS THERAPY		0.0000		0	0	
	06500 RESPI RATORY THERAPY		0. 1540		, 219	2,036	
	06600 PHYSI CAL THERAPY		0. 2117	12 9	, 033	1, 912	66.00
	06700 OCCUPATI ONAL THERAPY		0.0000		0	0	
			0.0000		421	0	
	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY		0. 1460		, 431 0	1, 231 0	
	07000 ELECTROLINGERTIALOGRAFIT		0. 0566		, 246	524	
	07200 I MPL. DEV. CHARGED TO PATIENTS		0.8010		0	0	
	07300 DRUGS CHARGED TO PATIENTS		0. 1725	67 257	, 954	44, 514	
	07400 RENAL DI ALYSI S		0.0000		0	0	
	07500 ASC (NON-DI STI NCT PART)		0.0000		0	0	
	03020 CV RESOURCE CTR 07700 ALLOGENEI C STEM CELL ACQUI SI TI ON		0.0000		0	-	
	DUTPATIENT SERVICE COST CENTERS		0.0000	00	0	0	17.00
88.00	08800 RURAL HEALTH CLINIC		0.0000	00		0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER		0.0000	00		0	89.00
	09000 CLINIC		0.0000		0	0	
	09003 I NFUSI ON OP SERVI CES		0. 4243		0	0	
	09100 EMERGENCY 09101 FREE STANDING EMERGENCY DEPT		0. 2316		, 741	21, 023 0	1
	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 8986		0		
	OTHER REIMBURSABLE COST CENTERS						1
94.00	09400 HOME PROGRAM DI ALYSI S		0.0000	00	0	0	
	09500 AMBULANCE SERVI CES						95.00
	09600 DURABLE MEDICAL EQUIP-RENTED		0.0000		0	0	
	09700 DURABLE MEDICAL EQUIP-SOLD		0.0000		0	0	
98.00 200.00	09850 OTHER REIMBURSABLE COST CENTERS Total (sum of lines 50 through 94 and 96 through 98)		0.0000		0 , 542	0 96 702	98.00 200.00
	Less PBP Clinic Laboratory Services-Program only charges	(line 61)		571	, 542 0	70,702	200.00
201.00				1	5		202.00

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

	Financial Systems FRANCISCAN HEA ENT ANCILLARY SERVICE COST APPORTIONMENT	ALTH MICHIGAN CIT Provider C	CN: 15-0015	Peri od:	worksheet D-3	
			CCN: 15-T015	From 01/01/2017 To 12/31/2017		pared:
		Title	e XVIII	Subprovider - IRF	PPS	o piii
	Cost Center Description		Ratio of Cos		Inpatient	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
			1.00	2.00	2) 3.00	
	INPATIENT ROUTINE SERVICE COST CENTERS			2100	0.00	
30.00	03000 ADULTS & PEDI ATRI CS			0		30.00
31.00	03100 I NTENSI VE CARE UNI T			0		31.00
32.00	03200 CORONARY CARE UNIT			0		32.00
33.00	03300 BURN INTENSIVE CARE UNIT			0		33.00
34.00	03400 SURGI CAL I NTENSI VE CARE UNI T			0		34.00
40.00	04000 SUBPROVI DER - I PF			0 252 (10		40.00
41.00	04100 SUBPROVIDER - IRF			2, 252, 618		41.00
43.00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS					43.00
50.00	05000 OPERATING ROOM		0. 14204	43, 749	6, 214	50.00
51.00	05100 RECOVERY ROOM		0. 00000		0,211	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM		1. 05274		0	52.00
53.00	05300 ANESTHESI OLOGY		0.04252		0	•
54.00	05400 RADI OLOGY-DI AGNOSTI C		0. 09718		13, 633	54.00
54.01	05401 FSED RADIOLOGY - DIAGNOSTIC		0. 16460	0 8	0	54.01
55.00	05500 RADI OLOGY-THERAPEUTI C		0. 26192	2, 846	745	55.00
55.01	05501 WOODLAND CANCER CARE CTR		0. 96532	20 0	0	55.01
56.00	05600 RADI OI SOTOPE		0.0000	0 0	0	56.00
57.00	05700 CT SCAN		0.00000		0	57.00
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)		0.00000		0	
59.00	05900 CARDI AC CATHETERI ZATI ON		0. 21557		912	
60.00	06000 LABORATORY		0. 15024			
60.01	06001 FS ED LAB		0. 20290		0	
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0.00000		0	
62.00 63.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06300 BLOOD STORI NG, PROCESSI NG & TRANS.		0.00000		0	62.00 63.00
64.00	06400 INTRAVENOUS THERAPY		0.00000			64.00
65.00	06500 RESPI RATORY THERAPY		0. 15403			
66.00	06600 PHYSI CAL THERAPY		0. 21171		510, 287	
67.00	06700 OCCUPATI ONAL THERAPY		0. 00000		0	
68.00	06800 SPEECH PATHOLOGY		0.00000		0	68.00
69.00	06900 ELECTROCARDI OLOGY		0. 14605		5, 365	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY		0.00000	0 0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0.05667	76 122, 663	6, 952	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS		0. 80104	4 1, 385	1, 109	
	07300 DRUGS CHARGED TO PATIENTS		0. 17256		117, 739	
74.00	07400 RENAL DI ALYSI S		0.00000		0	
75.00	07500 ASC (NON-DI STINCT PART)		0.00000		0	
	03020 CV RESOURCE CTR		0.00000			
77.00	07700 ALLOGENEI C STEM CELL ACQUI SI TI ON OUTPATI ENT SERVI CE COST CENTERS		0.00000	0 0	0	77.00
88.00	08800 RURAL HEALTH CLINIC		0.0000	00	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER		0.0000		0	
90.00	09000 CLI NI C		0.00000	0 0	0	
	09003 I NFUSI ON OP SERVI CES		0. 42433		36	
91.00	09100 EMERGENCY		0. 23167		0	
	09101 FREE STANDING EMERGENCY DEPT		0. 51651		0	
92.00	09200 OBSERVATI ON BEDS (NON-DI STINCT PART)		0. 89863	35 0	0	92.00
04.05	OTHER REIMBURSABLE COST CENTERS		0.005	-	-	04.07
94.00	09400 HOME PROGRAM DI ALYSI S		0.00000	00 0	0	
	09500 AMBULANCE SERVICES 09600 DURABLE MEDICAL EQUIP-RENTED		0.00000	0 0	_	95.00 96.00
20.00	107000 DOMADLE WEDTOAL EQUITERENTED		. 0.0000	0	. 0	1 70.00

0
0
4, 110, 832
0
4, 110, 832

96.00 97.00 0

201.00 202.00

0 98.00

764, 485 200. 00

	ancial Systems FRANCISCAN HEAL ANCILLARY SERVICE COST APPORTIONMENT	TH MICHIGAN CIT Provider C	CN: 15-0015	Peri od:	wof Form CMS-2 Worksheet D-3	
				From 01/01/2017		
				To 12/31/2017	Date/Time Pre 5/30/2018 6:0	
		Ti tl	e XIX	Hospi tal	Cost	
	Cost Center Description		Ratio of Cos		Inpatient	
			To Charges	Program Charges	Program Costs (col. 1 x col.	
				onar ges	2)	
			1.00	2.00	3.00	
	TI ENT ROUTI NE SERVI CE COST CENTERS		T		r	
	0 ADULTS & PEDIATRICS			6, 439, 923		30
	00 I NTENSI VE CARE UNI T 00 CORONARY CARE UNI T			1, 215, 903		31
	00 BURN INTENSIVE CARE UNIT			0		33
	00 SURGI CAL I NTENSI VE CARE UNI T			0		34
	00 SUBPROVIDER - IPF			2, 073, 441		40
	00 SUBPROVI DER – I RF			417, 861		41
	00 NURSERY			829, 106		43
	LLARY SERVICE COST CENTERS		0.0000	00 9 002 141	0	50
	00 OPERATING ROOM 00 RECOVERY ROOM		0.0000			50
	DO DELIVERY ROOM & LABOR ROOM		0.0000			52
. 00 0530	00 ANESTHESI OLOGY		0.0000		0	53
	00 RADI OLOGY-DI AGNOSTI C		0.0000			54
	1 FSED RADI OLOGY - DI AGNOSTI C		0.0000			54
	00 RADI OLOGY-THERAPEUTI C		0.0000		0	55
	01 WOODLAND CANCER CARE CTR 00 RADI 0I SOTOPE		0.0000		0	55 56
	DO CT SCAN		0.0000		-	57
	00 MAGNETIC RESONANCE IMAGING (MRI)		0.0000		-	58
	00 CARDI AC CATHETERI ZATI ON		0.0000		-	59
	DO LABORATORY		0.0000			60
	1 FS ED LAB		0.0000		0	60
	00 PBP CLINICAL LAB SERVICES-PRGM ONLY		0.0000			61
	00 WHOLE BLOOD & PACKED RED BLOOD CELLS		0.0000			62
	00 BLOOD STORI NG, PROCESSI NG & TRANS. 00 I NTRAVENOUS THERAPY		0.0000		-	63 64
	00 RESPIRATORY THERAPY		0.0000			65
	00 PHYSI CAL THERAPY		0.0000			66
. 00 0670	OO OCCUPATI ONAL THERAPY		0.0000	00 0	0	67
	00 SPEECH PATHOLOGY		0.0000			68
1	00 ELECTROCARDI OLOGY		0.0000			69
	00 ELECTROENCEPHALOGRAPHY 00 MEDICAL SUPPLIES CHARGED TO PATIENTS		0.0000		-	70 71
	00 IMPL. DEV. CHARGED TO PATIENTS		0.0000			72
	DO DRUGS CHARGED TO PATIENTS		0.0000		-	73
	DO RENAL DI ALYSI S		0.0000		0	74
	00 ASC (NON-DISTINCT PART)		0.0000			75
	20 CV RESOURCE CTR		0.0000			
	00 ALLOGENEIC STEM CELL ACQUISITION		0.0000	00 0	0	77
	ATIENT SERVICE COST CENTERS		0.0000	00 0	0	88
	0 FEDERALLY QUALIFIED HEALTH CENTER		0.0000			
	DO CLINIC		0.0000			90
	3 INFUSION OP SERVICES		0.0000		-	90
	DO EMERGENCY		0.0000			91
	1 FREE STANDING EMERGENCY DEPT		0.0000			91
	00 OBSERVATION BEDS (NON-DISTINCT PART)		0.0000	00 0	0	92
	R REIMBURSABLE COST CENTERS		0.0000	00 0	0	94
	0 AMBULANCE SERVICES		0.0000			95
	00 DURABLE MEDICAL EQUIP-RENTED		0.0000	00 0	0	96
	DO DURABLE MEDI CAL EQUI P-SOLD		0.0000	00 0	0	
	0 OTHER REIMBURSABLE COST CENTERS		0.0000		-	
0.00	Total (sum of lines 50 through 94 and 96 through 98)			24, 163, 192		200
01.00 02.00	Less PBP Clinic Laboratory Services-Program only cha Net charges (line 200 minus line 201)	arges (line 61)		0 24, 163, 192		201 202

ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0015	Period: From 01/01/2017 To 12/31/2017	Worksheet E Part A Date/Time Pre 5/30/2018 6:0	
		Title XVIII	Hospi tal	PPS	- piii
				1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS			1.00	
. 00	DRG Amounts Other than Outlier Payments		,	0	
. 01	DRG amounts other than outlier payments for discharges occurrininstructions)	ng prior to October 1	(see	15, 635, 304	1.0
. 02	DRG amounts other than outlier payments for discharges occurrin	ng on or after October	1 (see	5, 441, 097	1.0
. 03	instructions) DRG for federal specific operating payment for Model 4 BPCI fo	r discharges occurring	nrior to October	0	1.0
. 00	1 (see instructions)			0	1.0
. 04	DRG for federal specific operating payment for Model 4 BPCI for	r discharges occurring	on or after	0	1.0
. 00	October 1 (see instructions) Outlier payments for discharges. (see instructions)			197, 440	2.0
. 01	Outlier reconciliation amount			0	
. 02	Outlier payment for discharges for Model 4 BPCI (see instruction	ons)		0	-
. 00 . 00	Managed Care Simulated Payments Bed days available divided by number of days in the cost repor	ting period (see instru	uctions)	0 137. 99	
. 00	Indirect Medical Education Adjustment	ting period (see motio		107.77	
. 00	FTE count for allopathic and osteopathic programs for the most	recent cost reporting	period ending on	0.00	5. C
. 00	or before 12/31/1996. (see instructions) FTE count for allopathic and osteopathic programs which meet th	he criteria for an add	on to the cap	0.00	6.0
	for new programs in accordance with 42 CFR 413.79(e)				
. 00	MMA Section 422 reduction amount to the IME cap as specified u			0.00	
. 01	ACA § 5503 reduction amount to the IME cap as specified under - cost report straddles July 1, 2011 then see instructions.	42 CFR §412.105(T)(1)(1	V)(B)(2) IT the	0.00	7.0
. 00	Adjustment (increase or decrease) to the FTE count for allopat	hic and osteopathic pro	ograms for	0.00	8.0
	affiliated programs in accordance with 42 CFR 413.75(b), 413.7	9(c)(2)(iv), 64 FR 263	40 (May 12,		
01	1998), and 67 FR 50069 (August 1, 2002). The amount of increase if the hospital was awarded FTE cap slo	ts under § 5503 of the	ACA If the cost	0.00	8.
01	report straddles July 1, 2011, see instructions.		Non. IT the cost	0.00	0. (
02	The amount of increase if the hospital was awarded FTE cap slo	ts from a closed teachi	ng hospital	0.00	8.
00	under § 5506 of ACA. (see instructions) Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus line:	s (8, 8,01 and 8,02)	(see	0.00	9. (
	instructions)				
). 00 I. 00	FTE count for allopathic and osteopathic programs in the current FTE count for residents in dental and podiatric programs.	nt year from your reco	rds	0. 00 0. 00	10.
2.00	Current year allowable FTE (see instructions)				12.
3.00	Total allowable FTE count for the prior year.			0.00	
4.00	Total allowable FTE count for the penultimate year if that year	r ended on or after Se	otember 30, 1997,	0.00	14.
5.00	otherwise enter zero. Sum of lines 12 through 14 divided by 3.			0.00	15.
5.00	Adjustment for residents in initial years of the program				16.
7.00	Adjustment for residents displaced by program or hospital close	ure		0.00	
8.00	Adjusted rolling average FTE count			0.00	
9.00).00	Current year resident to bed ratio (line 18 divided by line 4) Prior year resident to bed ratio (see instructions)	<u>.</u>		0. 000000 0. 000000	
. 00	Enter the lesser of lines 19 or 20 (see instructions)			0. 000000	
2.00	IME payment adjustment (see instructions)			0	
2. 01	IME payment adjustment - Managed Care (see instructions) Indirect Medical Education Adjustment for the Add-on for § 422	of the MMA		0	22.
. 00	Number of additional allopathic and osteopathic IME FTE reside		CFR 412.105	0.00	23.
	(f)(1)(iv)(C).			0.00	24
. 00 5. 00	IME FTE Resident Count Over Cap (see instructions) If the amount on line 24 is greater than -O-, then enter the lo	ower of line 23 or line	- 24 (see	0. 00 0. 00	1
. 00	instructions)		24 (300	0.00	20.
. 00	Resident to bed ratio (divide line 25 by line 4)			0. 000000	
. 00	IME payments adjustment factor. (see instructions)			0. 000000	
. 00 . 01	IME add-on adjustment amount (see instructions) IME add-on adjustment amount - Managed Care (see instructions)			0	
. 00	Total IME payment (sum of lines 22 and 28)			0	
. 01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0	29.
00	Disproportionate Share Adjustment	tiont dave (and instant	ations)	(10	20
. 00 . 00	Percentage of SSI recipient patient days to Medicare Part A pa Percentage of Medicaid patient days (see instructions)	trent uays (see instruc	.uuus <i>)</i>	6. 12 22. 60	
. 00	Sum of Lines 30 and 31			22.00	
8.00	Allowable disproportionate share percentage (see instructions)			12.91	33.
	Disproportionate share adjustment (see instructions)			680, 242	3/

ALCUL	Financial Systems FRANCISCAN HEAL ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0015	Peri od:	u of Form CMS-2 Worksheet E	
			From 01/01/2017 To 12/31/2017	Part A Date/Time Pre	
		Title XVIII	Hospi tal	5/30/2018 6: 00 PPS	io pi
			Prior to 10/1		
			1.00	2.00	
- 00	Uncompensated Care Adjustment		E 077 400 447	4 744 405 444	1
5.00 5.01	Total uncompensated care amount (see instructions) Factor 3 (see instructions)		5, 977, 483, 147	6, 766, 695, 164	
5. 02	Hospital uncompensated care payment (If line 34 is zero, e	antar zaro on this line) (se		0. 000175215 1, 185, 627	35
). UZ	instructions)			1, 105, 027	33
5. 03	Pro rata share of the hospital uncompensated care payment	amount (see instructions)	662, 462	298, 843	35
. 00	Total uncompensated care (sum of columns 1 and 2 on line 3		961, 305		36
	Additional payment for high percentage of ESRD beneficiary				
0. 00	Total Medicare discharges on Worksheet S-3, Part I excludi	ing discharges for MS-DRGs	0		40
	652, 682, 683, 684 and 685 (see instructions)				
I. 00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682 instructions)	2, 683, 684 an 685. (see	0		41
1. 01	Total ESRD Medicare covered and paid discharges excluding	MS-DRGs 652 682 683 684	ч о		41
	an 685. (see instructions)		. 0		''
2.00	Divide line 41 by line 40 (if less than 10%, you do not qu	ualify for adjustment)	0.00		42
3.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652,	, 682, 683, 684 an 685. (see	e 0		43
	instructions)				
1.00	Ratio of average length of stay to one week (line 43 divid	ded by line 41 divided by 7	0.00000		44
5.00	days) Average weekly cost for dialysis treatments (see instructi	(and	0.00		45
5.00	Total additional payment (line 45 times line 44 times line		0.00		46
7.00	Subtotal (see instructions)		22, 915, 388		47
3.00	Hospital specific payments (to be completed by SCH and MDH	H, small rural hospitals	0		48
	only. (see instructions)				
				Amount	-
9.00	Total payment for inpatient operating costs (see instructi	ions)		1.00 22,915,388	49
). 00). 00	Payment for inpatient program capital (from Wkst. L, Pt. I		1	1, 826, 818	
1.00	Exception payment for inpatient program capital (Wkst. L,			0	51
2.00	Direct graduate medical education payment (from Wkst. E-4,	line 49 see instructions).		0	52
8.00	Nursing and Allied Health Managed Care payment			0	53
1.00	Special add-on payments for new technologies			0	54
. 01	Islet isolation add-on payment			0	54
5.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, lir			0	55
5.00 7.00	Cost of physicians' services in a teaching hospital (see i	-	hrough 2E)	0	56
3. 00	Routine service other pass through costs (from Wkst. D, P1 Ancillary service other pass through costs from Wkst. D, F		. mough 35).	0	58
9.00	Total (sum of amounts on lines 49 through 58)			24, 742, 206	
). 00	Primary payer payments			1, 452	
. 00	Total amount payable for program beneficiaries (line 59 mi	inus line 60)		24, 740, 754	6
2.00	Deductibles billed to program beneficiaries			2, 373, 392	62
3.00	Coinsurance billed to program beneficiaries			59, 808	
1.00	Allowable bad debts (see instructions)			368, 135	
5.00	Adjusted reimbursable bad debts (see instructions)			239, 288	
5.00	Allowable bad debts for dual eligible beneficiaries (see i	nstructions)		112,005	
7.00 8.00	Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices f	for applicable to MS_DPCs ((an instructions)	22, 546, 842 0	
	Outlier payments reconciliation (sum of lines 93, 95 and 9			0	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	70
	Rural Community Hospital Demonstration Project (§410A Demo	onstration) adjustment (see	instructions)	0	70
0. 00				0	70
). 00). 50	Demonstration payment adjustment amount before sequestrati			0	70
). 00). 50). 87). 88	SCH or MDH volume decrease adjustment (contractor use only				
). 00). 50). 87). 88). 89	SCH or MDH volume decrease adjustment (contractor use only Pioneer ACO demonstration payment adjustment amount (see i	nstructions)			
). 00). 50). 87). 88). 89). 90	SCH or MDH volume decrease adjustment (contractor use only Pioneer ACO demonstration payment adjustment amount (see i HSP bonus payment HVBP adjustment amount (see instructions	nstructions) s)		0	70
 O. 00 S0 S0 87 88 89 89 90 91 	SCH or MDH volume decrease adjustment (contractor use only Pioneer ACO demonstration payment adjustment amount (see i HSP bonus payment HVBP adjustment amount (see instructions) HSP bonus payment HRR adjustment amount (see instructions)	nstructions) s)		0	70
 O. 00 S0 S0 87 88 89 90 91 92 	SCH or MDH volume decrease adjustment (contractor use only Pioneer ACO demonstration payment adjustment amount (see i HSP bonus payment HVBP adjustment amount (see instructions) HSP bonus payment HRR adjustment amount (see instructions) Bundled Model 1 discount amount (see instructions)	nstructions) s)		0 0	70 70 70
9.00 0.00 0.50 0.87 0.88 0.90 0.91 0.91 0.92 0.93 0.94	SCH or MDH volume decrease adjustment (contractor use only Pioneer ACO demonstration payment adjustment amount (see i HSP bonus payment HVBP adjustment amount (see instructions) HSP bonus payment HRR adjustment amount (see instructions)	nstructions) s)		0	70 70 70 70

	TION OF REIMBURSEMENT SETTLEMENT	Provider C		Period: From 01/01/2017 To 12/31/2017	Worksheet E Part A Date/Time Pre 5/30/2018 6:0	
		litle	XVIII	Hospi tal	PPS	
				′ (<u>yyyy</u>)	Amount	
	and and and the find and find and (man) (Fature i			0	1.00	70
	ow volume adjustment for federal fiscal year (yyyy) (Enter i	n corumn o		0	0	70.
0.97 L	the corresponding federal year for the period prior to 10/1) Low volume adjustment for federal fiscal year (yyyy) (Enter i The corresponding federal year for the period ending on or af			0	0	70.
	Low Volume Payment-3				0	70.
	HAC adjustment amount (see instructions)				0	
	Amount due provider (line 67 minus lines 68 plus/minus lines	69 & 70)			22, 353, 620	
	Sequestration adjustment (see instructions)	o, a ,o)			447,072	
	Demonstration payment adjustment amount after sequestration				0	
	nterim payments				21, 774, 255	
	Fentative settlement (for contractor use only)				21, 774, 200	73
. 00 E	Balance due provider/program (line 71 minus lines 71.01, 71.0 3)	2, 72, and			132, 293	
. 00 F	?rotested amounts (nonallowable cost report items) in accorda DNS Pub. 15–2, chapter 1, §115.2	nce with			488, 811	75
	0 BE COMPLETED BY CONTRACTOR (lines 90 through 96)					1
	Operating outlier amount from Wkst. E, Pt. A, line 2 (see ins	tructions)			0	90
	Capital outlier from Wkst. L, Pt. I, line 2				0	
	Operating outlier reconciliation adjustment amount (see instr	uctions)			0	
	Capital outlier reconciliation adjustment amount (see instruc				0	
	The rate used to calculate the time value of money (see instr				0.00	
	Fime value of money for operating expenses (see instructions)				0,00	
	Fime value of money for capital related expenses (see instruc	tions)			0	
				Prior to 10/1	On/After 10/1	
				1.00	2.00	
Н	SP Bonus Payment Amount					
D. 00 F	ISP bonus amount (see instructions)			0	0	100
				0	0	100
н 1.00 н	ISP bonus amount (see instructions) VBP Adjustment for HSP Bonus Payment IVBP adjustment factor (see instructions)			0.000000000	0.000000000	
н 1.00 F	HSP bonus amount (see instructions) VBP Adjustment for HSP Bonus Payment	s)			0.000000000	101
H 1.00 F 2.00 F	ISP bonus amount (see instructions) VBP Adjustment for HSP Bonus Payment IVBP adjustment factor (see instructions)	s)		0. 000000000	0.000000000	101
H 1.00 F 2.00 F H	ISP bonus amount (see instructions) VBP Adjustment for HSP Bonus Payment IVBP adjustment factor (see instructions) IVBP adjustment amount for HSP bonus payment (see instruction	s)		0. 000000000	0.000000000	101 102
H 1.00 F 2.00 F H 3.00 F	ISP bonus amount (see instructions) VBP Adjustment for HSP Bonus Payment IVBP adjustment factor (see instructions) IVBP adjustment amount for HSP bonus payment (see instruction RR Adjustment for HSP Bonus Payment			0.000000000	0. 000000000 0 0. 0000	101 102 103
H 1.00 F 2.00 F H 3.00 F 4.00 F	ISP bonus amount (see instructions) VBP Adjustment for HSP Bonus Payment IVBP adjustment factor (see instructions) IVBP adjustment amount for HSP bonus payment (see instruction RR Adjustment for HSP Bonus Payment IRR adjustment factor (see instructions))	stment	0. 000000000000000000000000000000000000	0. 000000000 0 0. 0000	101 102 103
H 1.00 F 2.00 F 4.00 F 4.00 F R 0.00 I	ISP bonus amount (see instructions) VBP Adjustment for HSP Bonus Payment IVBP adjustment factor (see instructions) IVBP adjustment amount for HSP bonus payment (see instruction RR Adjustment for HSP Bonus Payment IRR adjustment factor (see instructions) IRR adjustment amount for HSP bonus payment (see instructions ural Community Hospital Demonstration Project (§410A Demonst s this the first year of the current 5-year demonstration pe) ration) Adju		0. 000000000000000000000000000000000000	0. 000000000 0 0. 0000 0. 0000 0	101 102 103 104
H 1. 00 F 2. 00 F H 3. 00 F 4. 00 F R 0. 00 I C	ISP bonus amount (see instructions) VBP Adjustment for HSP Bonus Payment IVBP adjustment factor (see instructions) IVBP adjustment amount for HSP bonus payment (see instruction RR Adjustment for HSP Bonus Payment IRR adjustment factor (see instructions) IRR adjustment amount for HSP bonus payment (see instructions ural Community Hospital Demonstration Project (§410A Demonst s this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no.) ration) Adju		0. 000000000000000000000000000000000000	0. 000000000 0 0. 0000 0. 0000 0	101 102 103 104
H 1. 00 F 2. 00 F 3. 00 F 4. 00 F 4. 00 F C C	ISP bonus amount (see instructions) VBP Adjustment for HSP Bonus Payment IVBP adjustment factor (see instructions) IVBP adjustment amount for HSP bonus payment (see instruction RR Adjustment for HSP Bonus Payment IRR adjustment factor (see instructions) IRR adjustment amount for HSP bonus payment (see instructions) IRR adjustment factor (see instructions) IRR adjustment for HSP bonus payment (see instructions) IRR adjustment factor (see instructions) IRR adjustment (see instructions) IRR adjustment factor (see instructions) IRR adjustment (see instructions) IRR adju) ration) Adju riod under t		0. 000000000000000000000000000000000000	0. 000000000 0 0. 0000 0. 0000 0	101 102 103 104 200
H 1. 00 F 2. 00 F H 3. 00 F 4. 00 F 0. 00 I C 1. 00 M	ISP bonus amount (see instructions) VBP Adjustment for HSP Bonus Payment VBP adjustment factor (see instructions) IVBP adjustment amount for HSP bonus payment (see instruction RR Adjustment for HSP Bonus Payment IRR adjustment factor (see instructions) IRR adjustment amount for HSP bonus payment (see instructions) IRR adjustment factor (see instruct) ration) Adju riod under t		0. 000000000000000000000000000000000000	0. 000000000 0 0. 0000 0. 0000 0	101 102 103 104 200
H 2. 00 F 2. 00 F 3. 00 F 4. 00 F 4. 00 F 0. 00 I C C C C C C C C C C C C C C C C C C C	ISP bonus amount (see instructions) VBP Adjustment for HSP Bonus Payment VBP adjustment factor (see instructions) IVBP adjustment amount for HSP bonus payment (see instruction RR Adjustment for HSP Bonus Payment IRR adjustment factor (see instructions) IRR adjustment amount for HSP bonus payment (see instructions) IRR adjustment factor (see instructions) IRR adjustment factor (see instructions) IRR adjustment factor (see instructions) IRR adjustment factor (see instructions)) ration) Adju riod under t		0. 000000000000000000000000000000000000	0. 000000000 0 0. 0000 0. 0000 0	101 102 103 104 200
H 1. 00 F 2. 00 F 3. 00 F 4. 00 F R R C C 1. 00 M 2. 00 M 3. 00 C	ISP bonus amount (see instructions) VBP Adjustment for HSP Bonus Payment IVBP adjustment factor (see instructions) IVBP adjustment amount for HSP bonus payment (see instruction RR Adjustment factor (see instructions) IRR adjustment factor (see instructions) IRR adjustment amount for HSP bonus payment (see instructions) IRR adjustment factor (see instructions) Community Hospital Demonstration Project (§410A Demonst s this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. ost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions)) ration) Adju riod under t e 49)	he 21st	0.0000000000000000000000000000000000000	0.000000000 0 0.0000 0	101 102 103 104 200
H 1. 00 F 2. 00 F 4. 00 F 7. 00 I C 1. 00 M 2. 00 M 3. 00 C	ISP bonus amount (see instructions) VBP Adjustment for HSP Bonus Payment IVBP adjustment factor (see instructions) IVBP adjustment amount for HSP bonus payment (see instruction RR Adjustment factor (see instructions) IRR adjustment factor (see instructions) IRR adjustment amount for HSP bonus payment (see instructions) IRR adjustment factor (see instructions) Adjustment first year of the current 5-year demonstration pe Sentury Cures Act? Enter "Y" for yes or "N" for no. Ost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) omputation of Demonstration Target Amount Limitation (N/A in) ration) Adju riod under t e 49)	he 21st	0.0000000000000000000000000000000000000	0.000000000 0 0.0000 0	101 102 103 104 200
H 1. 00 H 2. 00 H 3. 00 H 4. 00 H 1. 00 M 2. 00 M 2. 00 M 3. 00 C 0 D	ISP bonus amount (see instructions) VBP Adjustment for HSP Bonus Payment IVBP adjustment factor (see instructions) IVBP adjustment factor (see instructions) IVBP adjustment for HSP Bonus Payment IRR adjustment factor (see instructions) IRR adjustment factor (see instructions) IRR adjustment amount for HSP bonus payment (see instructions) IRR adjustment factor (see instructions) IRR adjustment service costs (from Wsst. D-1, Pt. II, lin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) omputation of Demonstration Target Amount Limitation (N/A in eriod)) ration) Adju riod under t e 49)	he 21st	0.0000000000000000000000000000000000000	0.000000000 0 0.0000 0	101 102 103 104 200 201 202 203
H 1. 00 + 2. 00 + H 3. 00 + H 4. 00 + R R C C 1. 00 M 2. 00 M 3. 00 C P 4. 00 M	ISP bonus amount (see instructions) VBP Adjustment for HSP Bonus Payment IVBP adjustment factor (see instructions) IVBP adjustment factor (see instructions) IVBP adjustment for HSP Bonus Payment IRR adjustment factor (see instructions) IRR adjustment factor (see instructions) IRR adjustment amount for HSP bonus payment (see instructions) this the first year of the current 5-year demonstration pe Contury Cures Act? Enter "Y" for yes or "N" for no. ost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) computation of Demonstration Target Amount Limitation (N/A in eriod) Medicare target amount) ration) Adju riod under t e 49)	he 21st	0.0000000000000000000000000000000000000	0.000000000 0 0.0000 0	101 102 103 104 200 201 202 203
H 1. 00 F 2. 00 F 4. 00 F 4. 00 F 1. 00 M 2. 00 M 2. 00 M 3. 00 C 0 M 4. 00 M 5. 00 C	ISP bonus amount (see instructions) VBP Adjustment for HSP Bonus Payment VBP adjustment factor (see instructions) IVBP adjustment amount for HSP bonus payment (see instruction RR Adjustment factor (see instructions) IRR adjustment factor (see instructions) IRR adjustment amount for HSP bonus payment (see instruction pe Century Cures Act? Enter "Y" for yes or "N" for no. ost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Medicare target amount Case-mix adjusted target amount (line 203 times line 204)) ration) Adju riod under t e 49)	he 21st	0.0000000000000000000000000000000000000	0.000000000 0 0.0000 0	101 102 103 104 200 201 203 203 204 204 205
H 1. 00 F 2. 00 F 4. 00 F 4. 00 F 1. 00 M 2. 00 M 2. 00 M 3. 00 C C 0 M 5. 00 C 0 M 0 M 0 M 0 M 0 M 0 M 0 M 0 M	ISP bonus amount (see instructions) VBP Adjustment for HSP Bonus Payment VBP adjustment factor (see instructions) IVBP adjustment amount for HSP bonus payment (see instruction RR Adjustment factor (see instructions) IRR adjustment factor (see instructions) IRR adjustment amount for HSP bonus payment (see instructions) URR adjustment factor (see instruction Project (§410A Demonst s this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. ost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) omputation of Demonstration Target Amount Limitation (N/A in eri od) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205)) ration) Adju riod under t e 49)	he 21st	0.0000000000000000000000000000000000000	0.000000000 0 0.0000 0	101 102 103 104 200 201 203 203 204 204 205
H 1. 00 F 2. 00 F 4. 00 F 1. 00 F 1. 00 M 2. 00 M 3. 00 C 5. 00 M 5. 00 M A	ISP bonus amount (see instructions) VBP Adjustment for HSP Bonus Payment VBP adjustment factor (see instructions) IVBP adjustment factor (see instructions) IVBP adjustment factor (see instructions) RR Adjustment factor (see instructions) IRR adjustment factor (see instructions) IRR adjustment amount for HSP bonus payment (see instructions) IRR adjustment factor (see instruction Project (§410A Demonst s this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. ost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) omputation of Demonstration Target Amount Limitation (N/A in eriod) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) djustment to Medicare Part A Inpatient Reimbursement) ration) Adju riod under t e 49) first year	he 21st	0.0000000000000000000000000000000000000	0.000000000 0 0.0000 0	102 103 104 200 201 202 203 204 205 206
H 1. 00 F 2. 00 F 4. 00 F 1. 00 M 2. 00 M 2. 00 M 3. 00 C 0 M 4. 00 M 5. 00 C 5. 00 C 5. 00 F 4. 00 F	ISP bonus amount (see instructions) VBP Adjustment for HSP Bonus Payment VBP adjustment factor (see instructions) IVBP adjustment amount for HSP bonus payment (see instruction RR Adjustment factor (see instructions) IRR adjustment factor (see instructions) IRR adjustment amount for HSP bonus payment (see instructions) IRR adjustment factor (see instructions) IRR adjustment first year of the current 5-year demonstration pe Community Hospital Demonstration Project (§410A Demonst s this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. ost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) omputation of Demonstration Target Amount Limitation (N/A in eriod) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) djustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst) ration) Adju riod under t e 49) first year ructions)	he 21st	0.0000000000000000000000000000000000000	0.000000000 0 0.0000 0	101 102 103 104 200 201 202 203 204 205 206 206
H 1. 00 F 2. 00 F 4. 00 F 4. 00 F 7. 00 F 4. 00 M 0. 00 C 0. 00 C 0. 00 C 0. 00 M 0. 00 F 0. 00 F	ISP bonus amount (see instructions) VBP Adjustment for HSP Bonus Payment VBP adjustment factor (see instructions) IVBP adjustment for HSP Bonus Payment (see instruction RR Adjustment for HSP Bonus Payment IRR adjustment for HSP Bonus Payment (see instructions) IRR adjustment amount for HSP bonus payment (see instructions) IRR adjustment factor (see instructions) Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. ost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) omputation of Demonstration Target Amount Limitation (N/A in eriod) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) djustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst Medicare Part A inpatient service costs (from Wkst. E, Pt. A,) ration) Adju riod under t e 49) first year ructions)	he 21st	0.0000000000000000000000000000000000000	0.000000000 0 0.0000 0	101 102 103 104 200 201 202 203 204 205 206 207 208
H H 1.00 F H H H N S.00 F C C C C S.00 I C C S.00 I C C S.00 N S.00	ISP bonus amount (see instructions) VBP Adjustment for HSP Bonus Payment VBP adjustment factor (see instructions) VBP adjustment factor (see instructions) IVBP adjustment for HSP Bonus Payment RR Adjustment for HSP Bonus Payment IRR adjustment for HSP bonus payment (see instructions) IRR adjustment amount for HSP bonus payment (see instructions) contury Cures Act? Enter "Y" for yes or "N" for no. ost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin Medicare discharges (see instructions) case-mix adjustment factor (see instructions) omputation of Demonstration Target Amount Limitation (N/A in eriod) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) djustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions)) ration) Adju riod under t e 49) first year ructions)	he 21st	0.0000000000000000000000000000000000000	0.000000000 0 0.0000 0	101 102 103 104 200 201 202 203 204 205 206 207 208 207 208 209
H 1.00 H 3.00 H 4.00 H 4.00 H 7.00 H 4.00 H 7.00 H 7.00 M 4.00 H 7.00 M 7.00 M 7.000 M 7.00 M 7.	ISP bonus amount (see instructions) VBP Adjustment for HSP Bonus Payment VBP adjustment factor (see instructions) IVBP adjustment amount for HSP bonus payment (see instruction RR Adjustment factor (see instructions) IRR adjustment factor (see instructions) IRR adjustment amount for HSP bonus payment (see instructions) ural Community Hospital Demonstration Project (§410A Demonst s this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. ost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) omputation of Demonstration Target Amount Limitation (N/A in eriod) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) djustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst Medicare IPAT A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions) Reserved for future use) ration) Adju riod under t e 49) first year ructions)	he 21st	0.0000000000000000000000000000000000000	0.000000000 0 0.0000 0	101 102 103 104 200 201 202 203 204 205 206 207 208 207 208 209 210
H 1. 00 H 3. 00 H 4. 00 H 7. 00 H 4. 00 H 7. 00 H 4. 00 H 7. 00 H	ISP bonus amount (see instructions) VBP Adjustment for HSP Bonus Payment VBP adjustment factor (see instructions) IVBP adjustment amount for HSP bonus payment (see instruction RR Adjustment factor (see instructions) IRR adjustment factor (see instructions) IRR adjustment amount for HSP bonus payment (see instructions) ural Community Hospital Demonstration Project (§410A Demonst s this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. ost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) omputation of Demonstration Target Amount Limitation (N/A in eri od) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) djustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions) Test adjustment to Medicare IPPS payments (see instructions) Test adjustment to Medicare IPPS payments (see instructions)) ration) Adju riod under t e 49) first year ructions)	he 21st	0.0000000000000000000000000000000000000	0.000000000 0 0.0000 0	101 102 103 104 200 201 202 203 204 205 206 207 208 207 208 209 210
H H 1.00 H 3.00 H 4.00 H 7 O 4.00 H 7 O 7 O 7 O 7 O 1.00 H 1.00 H 1.00 H 1.00 H 1.00 H 1.00 T	ISP bonus amount (see instructions) VBP Adjustment for HSP Bonus Payment VBP adjustment factor (see instructions) AVBP adjustment factor (see instructions) RR Adjustment factor (see instructions) RR Adjustment factor (see instructions) IRR adjustment factor (see instructions) IRR adjustment amount for HSP bonus payment (see instructions) ural Community Hospital Demonstration Project (§410A Demonst s this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. ost Reimbursement Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) case-mix adjustment factor (see instructions) omputation of Demonstration Target Amount Limitation (N/A in eriod) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) djustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions) omparision of PPS versus Cost Reimbursement) ration) Adju riod under t e 49) first year ructions) line 59)	he 21st	0.0000000000000000000000000000000000000	0.000000000 0 0.0000 0	101 102 103 104 200 201 202 203 204 205 206 207 208 209 210 211
H 1. 00 F 2. 00 F 3. 00 F 4. 00 F 0. 00 C 1. 00 M 3. 00 C 0. 00 M 3. 00 C 0. 00 F 1. 00 F 3. 00 F 0. 00 F 1. 00 F 1. 00 F 2. 00 K 1. 00 F 2. 00 T 2. 00 T	ISP bonus amount (see instructions) VBP Adjustment for HSP Bonus Payment VBP adjustment factor (see instructions) AVBP adjustment factor (see instructions) RR Adjustment factor (see instructions) RR Adjustment factor (see instructions) IRR adjustment factor (see instructions) IRR adjustment amount for HSP bonus payment (see instructions) ural Community Hospital Demonstration Project (§410A Demonst s this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. ost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) omputation of Demonstration Target Amount Limitation (N/A in eriod) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) djustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions) omparision of PPS versus Cost Reimbursement Total adjustment to Medicare Part A IPPS payments (from line) ration) Adju riod under t e 49) first year ructions) line 59)	he 21st	0.0000000000000000000000000000000000000	0.000000000 0 0.0000 0	101 102 103 200 201 202 203 204 205 206 207 208 209 210 211 212
H 1. 00 F 2. 00 F 4. 00 F 4. 00 C 0. 00 C 1. 00 M 3. 00 C 1. 00 M 5. 00 M 5. 00 M 6. 00 M 7. 00 F 8. 00 M 9. 00 A 7. 00 F 8. 00 M 1. 00 T 2. 00 T 3. 00 L	ISP bonus amount (see instructions) VBP Adjustment for HSP Bonus Payment VBP adjustment factor (see instructions) AVBP adjustment factor (see instructions) RR Adjustment factor (see instructions) RR Adjustment factor (see instructions) IRR adjustment factor (see instructions) IRR adjustment amount for HSP bonus payment (see instructions) ural Community Hospital Demonstration Project (§410A Demonst s this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. ost Reimbursement Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) case-mix adjustment factor (see instructions) omputation of Demonstration Target Amount Limitation (N/A in eriod) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) djustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions) omparision of PPS versus Cost Reimbursement) ration) Adju riod under t e 49) first year ructions) line 59) 211)	he 21st	0.0000000000000000000000000000000000000	0.000000000 0 0.0000 0 	101 102 103 104 200 201 202 203 204 205 206 207 208 209 210 211

W VC	LUME CALCULATION EXHIBIT 4			Provi der C	Fi Ti		Worksheet E Part A Exhibi Date/Time Pre 5/30/2018 6:0	pared
		W/S E, Part A line O	Amounts (from E, Part A)	Pre/Post Entitlement		Hospital Period On/After 10/01	PPS Total (Col 2 through 4)	
00	DRG amounts other than outlier	1.00	1.00	2.00	3.00	4.00	5.00	1.
01	payments DRG amounts other than outlier payments for discharges	1. 01	15, 635, 304	0	15, 635, 304		15, 635, 304	1.
02	occurring prior to October 1 DRG amounts other than outlier payments for discharges occurring on or after October	1. 02	5, 441, 097	0		5, 441, 097	5, 441, 097	1.
03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1. 03	0	0	0		0	1.
04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	Ο	0		0	0	1.
00	Outlier payments for	2.00	197, 440	0	175, 163	22, 278	197, 441	2.
01	discharges (see instructions) Outlier payments for	2.02	О	0	0	0	0	2.
00	discharges for Model 4 BPCI Operating outlier	2. 01	0	0	0	0	0	3.
00	reconciliation Managed care simulated payments	3.00	0	0	0	0	0	4.
00	Indirect Medical Education Adju Amount from Worksheet E, Part	ustment 21.00	0. 000000	0. 000000	0. 000000	0. 000000		5.
00	A, line 21 (see instructions) IME payment adjustment (see	22.00	0.000000	0.000000	0		0	
01	instructions) IME payment adjustment for managed care (see	22.01	Ο	0	0	0	0	6.
	instructions) Indirect Medical Education Adju	ustment for the	e Add-on for Se	ction 422 of t	he MMA			
00	IME payment adjustment factor (see instructions)	27.00	0. 000000	0. 000000	0.00000	0. 000000		7.
00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8
1	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8
0	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9
1	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9
00	Disproportionate Share Adjustme Allowable disproportionate	ant 33.00	0. 1291	0. 1291	0. 1291	0. 1291		10
00	share percentage (see instructions)	00.00	0.1271	0.1271	0.1271	0.1271		
00	Disproportionate share adjustment (see instructions)	34.00	680, 242	0	504, 630	175, 612	680, 242	11
01	Uncompensated care payments Additional payment for high per	36.00	961, 305	0	662, 462	298, 843	961, 305	11
00	Total ESRD additional payment	46.00	0 Denericiary	of scharges 0	0	0	0	12
00 00	(see instructions) Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH, small rural hospitals only.)	47.00 48.00	22, 915, 388 0	0 0	16, 977, 558 0	5, 937, 830 0	22, 915, 388 0	13 14
00	(see instructions) Total payment for inpatient operating costs (see	49.00	22, 915, 388	0	16, 977, 558	5, 937, 830	22, 915, 388	15
00	instructions) Payment for inpatient program capital (from Wkst. L, Pt. I,	50.00	1, 826, 818	0	-471, 162	2, 297, 980	1, 826, 818	16
00	if applicable) Special add-on payments for new technologies	54.00	0	0	0	0	0	17
01 02	Net organ aquisition cost Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	O	0	O	0	0	17 17

5/30/2018 6:06 pm

Heal th	Financial Systems	FR	ANCISCAN HEALTH	H MICHIGAN CITY	(In Lie	eu of Form CMS-2	2552-10
LOW VO	LUME CALCULATION EXHIBIT 4			Provider C		Period: From 01/01/2017 To 12/31/2017	5/30/2018 6:0	pared:
				Title	XVIII	Hospi tal	PPS	
		W/S E, Part A	Amounts (from	Pre/Post	Period Prior	Period	Total (Col 2	
		line	E, Part A)	Entitlement	to 10/01	On/After 10/01	through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0		0 0	0	18.00
10 00	SUBTOTAL			0	16, 506, 39	8, 235, 810	24, 742, 206	10 00
19.00	JOBIOTAL	W/S L, line	(Amounts from	0	10, 500, 5	0,233,010	24, 742, 200	19.00
		W/SL, THE	L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	1, 704, 736	0	-442, 18	2, 146, 920	1, 704, 736	20.00
20. 01	Model 4 BPCI Capital DRG other than outlier	1. 01	0	0		0 0	0	20. 01
21.00	Capital DRG outlier payments	2.00	19, 968	0	-2, 49	22, 459	19, 968	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2. 01	0	0		0 0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0. 0000	0.0000	0.000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0		0 0	0	23.00
24.00	Al lowable di sproporti onate share percentage (see i nstructi ons)	10.00	0. 0599	0. 0599	0. 059	0. 0599		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	102, 114	0	-26, 48	128, 601	102, 114	25.00
26.00	Total prospective capital payments (see instructions)	12.00	1, 826, 818	0	-471, 16	2, 297, 980	1, 826, 818	26.00
		W/S E, Part A	(Amounts to E,					
		line	Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.0000	0. 000000		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96				0	0	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70. 97				0	0	29.00
100.00	Pt. A, IIne) Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100. 00

HOSPI T	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	TION EXHIBIT 5			Period: From 01/01/2017 To 12/31/2017	5/30/2018 6:0	pared:
				XVIII	Hospi tal	PPS	
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1. 01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	15, 635, 304	15, 635, 30)4	15, 635, 304	1. 01
1. 02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	5, 441, 097		5, 441, 097	5, 441, 097	1. 02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0		0	0	1. 03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1. 04
2.00	Outlier payments for discharges (see instructions)	2.00	197, 440	175, 16	22, 278	197, 441	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0		0 0	0	2. 01
3.00	Operating outlier reconciliation	2.01	0		0 0	0	3.00
4.00	Managed care simulated payments	3.00	0		0 0	0	4.00
	Indirect Medical Education Adjustment						
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0. 000000	0.00000			5.00
6.00	IME payment adjustment (see instructions)	22.00	0		0 0	-	6.00
6. 01	IME payment adjustment for managed care (see instructions)		0		0 0	0	6. 01
7 00	Indirect Medical Education Adjustment for the				0 00000		7 00
7.00	IME payment adjustment factor (see instructions)	27.00	0. 000000	0.00000	0.00000		7.00
8.00	IME adjustment (see instructions)	28.00	0		0 0	0	8.00
8. 01	IME payment adjustment add on for managed care (see instructions)	28.01	0		0 0	0	8. 01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0		0 0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0		0 0	0	9. 01
	Disproportionate Share Adjustment						
10.00	Allowable disproportionate share percentage	33.00	0. 1291	0. 129	0. 1291		10.00
11.00	(see instructions) Disproportionate share adjustment (see instructions)	34.00	680, 242	504, 63	175, 612	680, 242	11.00
11.01	Uncompensated care payments	36.00	961, 305	662, 46	2 298, 843	961, 305	11.01
	Additional payment for high percentage of ESF			002, 10	2,3,010	, , , , , , , , , , , , , , , , , , , ,	
12.00	Total ESRD additional payment (see instructions)	46.00	0		0 0	0	12.00
13.00	Subtotal (see instructions)	47.00	22, 915, 388	16, 977, 55	5, 937, 830	22, 915, 388	13.00
	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see	48.00	0		0 0	0	14.00
15.00	instructions) Total payment for inpatient operating costs (see instructions)	49.00	22, 915, 388	16, 977, 55	5, 937, 830	22, 915, 388	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	1, 826, 818	-471, 16	2, 297, 980	1, 826, 818	16.00
17. 00 17. 01	Special add-on payments for new technologies Net organ acquisition cost	54.00	0		0 0	0	17.00 17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0		0 0	0	1
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0		0 0	0	18.00
19.00	SUBTOTAL			16, 506, 39	8, 235, 810	24, 742, 206	19.00

	Financial Systems FR AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	TION EXHIBIT 5	Provider CC		Period: From 01/01/2017 To 12/31/2017	Date/Time Pre 5/30/2018 6:0	pared:
			Title	XVIII	Hospi tal	PPS	
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	1, 704, 736	-442, 18	2, 146, 920	1, 704, 736	20.00
20. 01	Model 4 BPCI Capital DRG other than outlier	1.01	0		0 0	0	20.01
21.00	Capital DRG outlier payments	2.00	19, 968	-2, 49	22, 459	19, 968	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0		0 0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0		0 0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0. 0599	0. 059	0. 0599		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	102, 114	-26, 48	128, 601	102, 114	25.00
26. 00	Total prospective capital payments (see instructions)	12.00	1, 826, 818	-471, 16	2, 297, 980	1, 826, 818	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70. 96	0		0	0	28.00
29.00	Low volume adjustment on or after October 1	70. 97	0		0	0	29.00
30.00	HVBP payment adjustment (see instructions)	70. 93	-148, 548	-119, 01	-29, 537	-148, 548	30.00
30. 01	HVBP payment adjustment for HSP bonus payment (see instructions)	70. 90	0		0 0	0	30. 01
31.00	HRR adjustment (see instructions)	70.94	-44, 674	-23, 45	-21, 221	-44, 674	31.00
31. 01	HRR adjustment for HSP bonus payment (see instructions)	70. 91	0		0 0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
	HAC Reduction Program adjustment (see instructions)	70. 99			0 0	0	
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100. 00

	Financial Systems FRANCISCAN HEALTH N ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0015	Period: From 01/01/2017 To 12/31/2017	u of Form CMS-2 Worksheet E Part B Date/Time Pre 5/30/2018 6:00	pared:
		Title XVIII	Hospi tal	PPS	
				1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES				
. 00	Medical and other services (see instructions)			5, 642	1.00
. 00 . 00	Medical and other services reimbursed under OPPS (see instruc OPPS payments	ctions)		24, 504, 799 20, 774, 743	2.00 3.00
. 00	Outlier payment (see instructions)			72, 330	
. 01	Outlier reconciliation amount (see instructions)			0	4. 01
. 00	Enter the hospital specific payment to cost ratio (see instru	uctions)		0.000	5.00
. 00 . 00	Line 2 times line 5 Sum of lines 3, 4, and 4.01, divided by line 6			0 0. 00	6.00 7.00
. 00	Transitional corridor payment (see instructions)			0.00	8.00
. 00	Ancillary service other pass through costs from Wkst. D, Pt.	IV, col. 13, line 200		0	9.00
0.00	Organ acqui si ti ons			0	10.00
1. 00	Total cost (sum of lines 1 and 10) (see instructions) COMPUTATION OF LESSER OF COST OR CHARGES			5, 642	11.00
	Reasonable charges				
2.00	Ancillary service charges			32, 694	12.00
3.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, I	line 69)		0	13.00
4.00	Total reasonable charges (sum of lines 12 and 13) Customary charges			32, 694	14.00
5.00	Aggregate amount actually collected from patients liable for	payment for services on	a charge basis	0	15.00
6. 00	Amounts that would have been realized from patients liable for	or payment for services o		0	16.00
	had such payment been made in accordance with 42 CFR §413.13((e)		0,000000	17.00
7.00 8.00	Ratio of line 15 to line 16 (not to exceed 1.000000) Total customary charges (see instructions)			0. 000000 32, 694	
9.00	Excess of customary charges over reasonable cost (complete or	nlyifline 18 exceeds li	ne 11) (see	27,052	
	instructions)	,			
0. 00	Excess of reasonable cost over customary charges (complete or	nly if line 11 exceeds li	ne 18) (see	0	20.00
1. 00	instructions) Lesser of cost or charges (see instructions)			5 642	21.00
2.00	Interns and residents (see instructions)			0,042	22.00
3.00	Cost of physicians' services in a teaching hospital (see inst	tructions)		0	23.00
4.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			20, 847, 073	24.00
5.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT Deductibles and coinsurance (for CAH, see instructions)			0	25.00
6.00	Deductibles and Coinsurance relating to amount on line 24 (for	or CAH, see instructions)		4, 027, 830	
7.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26)			16, 824, 885	
8. 00	instructions)	Line EO)		0	28.00
9.00	Direct graduate medical education payments (from Wkst. E-4, I ESRD direct medical education costs (from Wkst. E-4, line 36)			0	28.00
0.00	Subtotal (sum of lines 27 through 29)	, ,		16, 824, 885	
1. 00	Primary payer payments			6, 375	
2.00	Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVI	(ES)		16, 818, 510	32.00
3. 00	Composite rate ESRD (from Wkst. I-5, line 11)	CES)		0	33.00
4.00	Allowable bad debts (see instructions)			660, 853	
5.00	Adjusted reimbursable bad debts (see instructions)			429, 554	35.00
6.00 7.00	Allowable bad debts for dual eligible beneficiaries (see inst Subtotal (see instructions)	tructions)		354, 867 17, 248, 064	
8.00	MSP-LCC reconciliation amount from PS&R			238	38.00
9.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39.00
9. 50	Pioneer ACO demonstration payment adjustment (see instruction				39.50
9.97	Demonstration payment adjustment amount before sequestration		+:>	0	39.97
	Partial or full credits received from manufacturers for repla RECOVERY OF ACCELERATED DEPRECIATION	aced devices (see Instruc	ctions)	0	39.98 39.99
9.98 9.99	Subtotal (see instructions)			17, 247, 826	40.00
9.90 9.99 0.00				344, 957	40. 01
9. 99 0. 00 0. 01	Sequestration adjustment (see instructions)			0	40.02
9. 99 0. 00 0. 01 0. 02	Demonstration payment adjustment amount after sequestration			16 067 404	
9. 99 0. 00 0. 01 0. 02 1. 00	Demonstration payment adjustment amount after sequestration Interim payments			16, 967, 421 0	
9. 99 0. 00 0. 01 0. 02	Demonstration payment adjustment amount after sequestration			16, 967, 421 0 -64, 552	41.00 42.00 43.00
9. 99 0. 00 0. 01 0. 02 1. 00 2. 00	Demonstration payment adjustment amount after sequestration Interim payments Tentative settlement (for contractors use only) Balance due provider/program (see instructions) Protested amounts (nonallowable cost report items) in accorda	ance with CMS Pub. 15-2,	chapter 1,	0	42.00
9. 99 0. 00 0. 01 0. 02 1. 00 2. 00 3. 00	Demonstration payment adjustment amount after sequestration Interim payments Tentative settlement (for contractors use only) Balance due provider/program (see instructions) Protested amounts (nonallowable cost report items) in accorda \$115.2	ance with CMS Pub. 15-2,	chapter 1,	0 -64, 552	42.00 43.00
9. 99 0. 00 0. 01 0. 02 1. 00 2. 00 3. 00 4. 00	Demonstration payment adjustment amount after sequestration Interim payments Tentative settlement (for contractors use only) Balance due provider/program (see instructions) Protested amounts (nonallowable cost report items) in accorda §115.2 TO BE COMPLETED BY CONTRACTOR	ance with CMS Pub. 15-2,	chapter 1,	0 -64, 552 0	42.00 43.00 44.00
9. 99 0. 00 0. 01 0. 02 1. 00 2. 00 3. 00	Demonstration payment adjustment amount after sequestration Interim payments Tentative settlement (for contractors use only) Balance due provider/program (see instructions) Protested amounts (nonallowable cost report items) in accorda \$115.2	ance with CMS Pub. 15-2,	chapter 1,	0 -64, 552	42.00 43.00
9.99 0.00 0.01 0.02 1.00 2.00 3.00 4.00	Demonstration payment adjustment amount after sequestration Interim payments Tentative settlement (for contractors use only) Balance due provider/program (see instructions) Protested amounts (nonallowable cost report items) in accorda §115.2 TO BE COMPLETED BY CONTRACTOR Original outlier amount (see instructions)	ance with CMS Pub. 15-2,	chapter 1,	0 -64, 552 0 0 0	42.00 43.00 44.00 90.00 91.00 92.00

ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0015	Peri od:	Worksheet E	2552-
		Component CCN: 15-SO15	From 01/01/2017 To 12/31/2017	Part B Date/Time Pre 5/30/2018 6:0	
		Title XVIII	Subprovider -	PPS	o piii
				1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES				
. 00 . 00	Medical and other services (see instructions) Medical and other services reimbursed under OPPS (see instru	uctions)		0 98, 361	1.0
. 00	OPPS payments			0, 301	
. 00	Outlier payment (see instructions)			0	4.0
. 01 . 00	Outlier reconciliation amount (see instructions) Enter the hospital specific payment to cost ratio (see instr	ructions)		0 0. 000	4. 5.
. 00	Line 2 times line 5			0.000	6.
. 00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	
. 00 . 00	Transitional corridor payment (see instructions) Ancillary service other pass through costs from Wkst. D, Pt.	IV col 12 Lino 200		0	
0.00	Organ acquisitions	. TV, COL. 13, TTHE 200		0	10.
1.00	Total cost (sum of lines 1 and 10) (see instructions)			0	11.0
	COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges				-
2.00	Ancillary service charges			0	12.0
3.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4,	line 69)		0	
4.00	Total reasonable charges (sum of lines 12 and 13)			0	14.
5.00	Customary charges Aggregate amount actually collected from patients liable for	r payment for services on	a charge basis	0	15.
6.00	Amounts that would have been realized from patients liable 1			0	
7 00	had such payment been made in accordance with 42 CFR §413.13	3(e)		0. 000000	17
7.00 8.00	Ratio of line 15 to line 16 (not to exceed 1.000000) Total customary charges (see instructions)			0.000000	
9.00	Excess of customary charges over reasonable cost (complete o	only if line 18 exceeds li	ne 11) (see	0	
	instructions)		10) (0	
20.00	Excess of reasonable cost over customary charges (complete or instructions)	only if line ii exceeds ii	ne 18) (see	0	20.
21.00	Lesser of cost or charges (see instructions)			0	21.
22.00	Interns and residents (see instructions)			0	
23.00	Cost of physicians' services in a teaching hospital (see ins Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			0	
4.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT)		0	27.
25.00	Deductibles and coinsurance (for CAH, see instructions)			0	25.
26.00 27.00	Deductibles and Coinsurance relating to amount on line 24 (1 Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26)			0	26. 27.
7.00	instructions)	prus the sum of trifles 22		0	27.
28.00	Direct graduate medical education payments (from Wkst. E-4,	-		0	28.
29.00 30.00	ESRD direct medical education costs (from Wkst. E-4, line 36 Subtotal (sum of lines 27 through 29)	6)		0	29. 30.
31.00	Primary payer payments			0	31.
32.00	Subtotal (line 30 minus line 31)			0	32.
3. 00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERV Composite rate ESRD (from Wkst. I-5, line 11)	/I CES)		0	33.
3.00	Allowable bad debts (see instructions)			0	34.
35.00	Adjusted reimbursable bad debts (see instructions)			0	35.
36.00 37.00	Allowable bad debts for dual eligible beneficiaries (see ins Subtotal (see instructions)	structions)		0	36. 37.
8.00	MSP-LCC reconciliation amount from PS&R			0	37.
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39.
39.50	Pioneer ACO demonstration payment adjustment (see instruction			0	39.
9. 97 9. 98	Demonstration payment adjustment amount before sequestration Partial or full credits received from manufacturers for repl		tions)	0	39. 39.
9.99	RECOVERY OF ACCELERATED DEPRECIATION			0	39.
0.00	Subtotal (see instructions)			0	40.
0. 01 0. 02	Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration			0	40. 40.
1.00	Interim payments			0	41.
2.00	Tentative settlement (for contractors use only)			0	42.
3.00	Balance due provider/program (see instructions)	danco with CMS Dub 15 2	chaptor 1	0	43.
4.00	Protested amounts (nonallowable cost report items) in accord §115.2	uance with two PUD. 10-2,	chapter I,	0	44.
	TO BE COMPLETED BY CONTRACTOR				1
90.00	Original outlier amount (see instructions)			0	90.
91.00 92.00	Outlier reconciliation adjustment amount (see instructions) The rate used to calculate the Time Value of Money)		0 0.00	
			0.00		

LCULA	Financial Systems FRANCISCAN HEALTH N TION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0015	Peri od:	u of Form CMS- Worksheet E	
		Component CCN: 15-T015	From 01/01/2017 To 12/31/2017	Part B Date/Time Pre 5/30/2018 6:0	
		Title XVIII	Subprovider -	PPS	<u>o pii</u>
				1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES				1
	Medical and other services (see instructions) Medical and other services reimbursed under OPPS (see instruc	tions)		0 763, 409	
	OPPS payments			0	
	Outlier payment (see instructions)			0	
	Outlier reconciliation amount (see instructions) Enter the hospital specific payment to cost ratio (see instru	ctions)		0 0. 000	4.
	Line 2 times line 5			0.000	
	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	
	Transitional corridor payment (see instructions)	LV and 12 Line 200		0	
	Ancillary service other pass through costs from Wkst. D, Pt. Organ acquisitions	TV, COL. 13, TTHE 200		0	
	Total cost (sum of lines 1 and 10) (see instructions)			0	
(COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonable charges			0	12.
	Ancillary service charges Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, I	ine 69)		0	
	Total reasonable charges (sum of lines 12 and 13)				14
	Customary charges		· · ·		
	Aggregate amount actually collected from patients liable for Amounts that would have been realized from patients liable fo			0	
	had such payment been made in accordance with 42 CFR §413.13(in a chargebasis	0	
	Ratio of line 15 to line 16 (not to exceed 1.000000)			0. 000000	
	Total customary charges (see instructions)			0	
	Excess of customary charges over reasonable cost (complete on instructions)	I y IT I I ne 18 exceeds I I	ne II) (see	0	19
	Excess of reasonable cost over customary charges (complete on	ly if line 11 exceeds li	ne 18) (see	0	20
	instructions)	5			
	Lesser of cost or charges (see instructions)			0	
	Interns and residents (see instructions) Cost of physicians' services in a teaching hospital (see inst	ructions)		0	
	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			0	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
	Deductibles and coinsurance (for CAH, see instructions) Deductibles and Coinsurance relating to amount on line 24 (fo	r CAH soo instructions)		0	
	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26)			0	
	instructions)				
	Direct graduate medical education payments (from Wkst. E-4, I			0	
	ESRD direct medical education costs (from Wkst. E-4, line 36) Subtotal (sum of lines 27 through 29)			0	
	Primary payer payments			0	31
. 00	Subtotal (line 30 minus line 31)			0	32
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVI	CES)		0	1
1	Composite rate ESRD (from Wkst. 1-5, line 11) Allowable bad debts (see instructions)			0	
	Adjusted reimbursable bad debts (see instructions)			0	
	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		0	
	Subtotal (see instructions)			0	
	MSP-LCC reconciliation amount from PS&R OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
	Pioneer ACO demonstration payment adjustment (see instruction	s)		-	39
	Demonstration payment adjustment amount before sequestration			0	
	Partial or full credits received from manufacturers for repla	ced devices (see instruc	ctions)	0	
	RECOVERY OF ACCELERATED DEPRECIATION Subtotal (see instructions)			0	
. 01	Sequestration adjustment (see instructions)			0	40
	Demonstration payment adjustment amount after sequestration			0	
	Interim payments Tentative settlement (for contractors use only)			0	
	Balance due provider/program (see instructions)			0	
. 00	Protested amounts (nonallowable cost report items) in accorda	nce with CMS Pub. 15-2,	chapter 1,	0	
					1
-	TO BE COMPLETED BY CONTRACTOR Original outlier amount (see instructions)			0	90
	Outlier reconciliation adjustment amount (see instructions)			0	
. 00	The rate used to calculate the Time Value of Money			0.00	92
. 00	Time Value of Money (see instructions)			0	93

ANALY	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC		Period: From 01/01/2017 To 12/31/2017	Worksheet E-1 Part I Date/Time Prep 5/30/2018 6:06	bared: 5 pm
		Title	XVIII	Hospi tal	PPS	
		I npati en	t Part A	Par	tВ	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00 2.00	Total interim payments paid to provider Interim payments payable on individual bills, either		21, 774, 25	55	16, 967, 421	1.00 2.00
2.00	submitted or to be submitted to the contractor for			0	0	2.00
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3.00
	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)					
0 01	Program to Provider			0	0	3. 01
3.01 3.02	ADJUSTMENTS TO PROVIDER			0	0	3.01
3.02				0	0	3.02
3.03				0	0	3.04
3.05				0	Ő	3.05
0.00	Provider to Program			<u> </u>		0.00
3.50	ADJUSTMENTS TO PROGRAM			0	0	3.50
3.51				0	0	3. 51
3.52				0	0	3.52
3.53				0	0	3.53
3.54				0	0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			0	0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		21, 774, 25	5	16, 967, 421	4.00
4.00	(transfer to Wkst. E or Wkst. E-3, line and column as		21, 774, 20		10, 707, 421	4.00
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5.00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1) Program to Provider					
5. 01	TENTATI VE TO PROVIDER			0	0	5. 0 ⁻
5. 02				0	0	5.02
5.03				0	0	5.03
	Provider to Program					
5.50	TENTATI VE TO PROGRAM			0	0	5.50
5. 51				0	0	5.51
5.52				0	0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	5.99
6.00	5.50-5.98) Determined net settlement amount (balance due) based on					6.00
5.00	the cost report. (1)					0.00
6. 01	SETTLEMENT TO PROVIDER		132, 29	93	0	6. 01
6. 02	SETTLEMENT TO PROGRAM			0	64, 552	6. 02
7.00	Total Medicare program liability (see instructions)		21, 906, 54	8	16, 902, 869	7.00
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
		C	``````````````````````````````````````	1.00	2.00	

VALY:	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC Component C	CN: 15-0015 CCN: 15-S015	Period: From 01/01/2017 To 12/31/2017	Worksheet E-1 Part I Date/Time Pre 5/30/2018 6:0	pare
		Ti tl e	XVIII	Subprovider -	PPS	
		Inpatien	t Part A		t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
00	Tatal interim assuments with the survivier	1.00	2.00	3.00	4.00	1
00 00 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each		611, 2	0	0 0	1
	payment. If none, write "NONE" or enter a zero. (1)					
01	Program to Provider ADJUSTMENTS TO PROVIDER			0	0	3.
)2)3)4	ADJUSTMENTS TU PROVIDER			0 0 0	0 0 0	3
05				0	0	3
	Provider to Program					
50	ADJUSTMENTS TO PROGRAM			0	0	
51 52				0	0	
5∠ 53				0	0	
54 99	Subtotal (sum of lines 3.01–3.49 minus sum of lines 3.50–3.98)			0	0	
00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		611, 2	70	0	4
	TO BE COMPLETED BY CONTRACTOR			-		1 .
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
11	Program to Provider TENTATIVE TO PROVIDER			0	0	
)1)2	ILIVIAII VE TO PROVIDER			0	0	
)2)3				0	0	
	Provider to Program			V I	0	1 7
50	TENTATI VE TO PROGRAM			0	0	5
51				0	0	
52				0	0	
9	Subtotal (sum of lines 5.01–5.49 minus sum of lines			0	0	
00	5.50-5.98) Determined net settlement amount (balance due) based on					6
	the cost report. (1)				_	
)1	SETTLEMENT TO PROVIDER		11, 4	00	0	-
02	SETTLEMENT TO PROGRAM			0	0	
00	Total Medicare program liability (see instructions)		622, 6		0	7
				Contractor Number	NPR Date (Mo/Day/Yr)	
		(1,00	2.00	-

VALY:	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC Component C	CN: 15-0015 CCN: 15-T015	Period: From 01/01/2017 To 12/31/2017		parec
		Ti tl e	XVIII	Subprovider -	PPS	<u>o p</u>
		Inpatien	t Part A		t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
00 00 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each		2, 684, 0	0 0	0 0	
	payment. If none, write "NONE" or enter a zero. (1)					
0.4	Program to Provider					
01 02	ADJUSTMENTS TO PROVIDER			0	0	
02				0	0	
04				0	0	
05				0	0	3
	Provider to Program				1	
50	ADJUSTMENTS TO PROGRAM			0	0	
51 52				0	0	
52 53				0		
53 54				0	0	
99	Subtotal (sum of lines 3.01–3.49 minus sum of lines 3.50–3.98)			0	0	
00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2, 684, 0	174	0	4
	TO BE COMPLETED BY CONTRACTOR					
00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5
01	Program to Provider TENTATIVE TO PROVIDER			0	0	5
02				0	0	
03				0	0	
	Provider to Program					
50	TENTATI VE TO PROGRAM			0	0	
51 52				0	0	
52 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0		
)))0	5. 50-5. 98) Determined net settlement amount (balance due) based on			Ŭ		6
	the cost report. (1)					
01	SETTLEMENT TO PROVIDER		15, 9	29	0	
02	SETTLEMENT TO PROGRAM			0	0	
00	Total Medicare program liability (see instructions)		2, 700, 0		0	7
				Contractor Number	NPR Date (Mo/Day/Yr)	
		()	1.00	2.00	

2.00Medicare days from Wkst. S-3, Pt. 1, col. 6 sum of lines 1, 8-122.003.00Medicare HMO days from Wkst. S-3, Pt. 1, col. 6. line 23.004.00Total inpatient days from S-3, Pt. 1 col. 8 sum of lines 1, 8-123.005.00Total hospital charges from Wkst C, Pt. 1, col. 8 line 2004.006.00Total hospital charity care charges from Wkst. S-10, col. 3 line 205.007.00CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I7.008.00Calculation of the HIT incentive payment (see instructions)8.009.00Sequestration adjustment amount (see instructions)9.0010.00Calculation of the HIT incentive payment after sequestration (see instructions)9.0010.00Initial/interim HIT payment adjustment (see instructions)10.0030.00Initial/interim HIT payment adjustment (see instructions)30.00	Heal th	Financial Systems FRANCISCAN HEALTH N	11 CHI GAN CI TY	In Lie	u of Form CMS-	2552-10
To 12/31/2017 Date/Time Prepared: 5/30/2018 6:06 pm Title XVIII Hospital PPS To Date/Time Prepared: 5/30/2018 6:06 pm To Total hospital PPS Incorr Provide the prepared: 5/30/2018 6:06 pm To BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION 1.00 Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14 2.00 Medicare days from Wkst. S-3, Pt. I, col. 6 une 2 3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 8 um of lines 1, 8-12 3.00 S.00 Total hospital charges from Wkst C, Pt. I, col. 8 line 200 5.00 S.00 Total hospital charity care charges from Wkst. S-10, col. 3 line 20 5.00 S.00 Total hospital charity care charges from Wkst. S-10, col. 3 line 20 5.00 S.00 Calculation of the HIT incentive payment (see instructions) 8.00 9.00 Sequestration adjustment amount (see instructions) 9.00 10.01 Intent HOSPITAL SERVICES UNDER THE IPPS & CAH 10.00 30.00 Initial/interim HIT payment adjustment (see instru	CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0015			
Title XVIII Hospital PPS 1.00 1.00 TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION 1.00 Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14 2.00 Medicare days from Wkst. S-3, Pt. I, col. 6 um of lines 1, 8-12 3.00 Medicare function days from Wst. S-3, Pt. I, col. 6. line 2 4.00 Total hospital charges from Wkst C, Pt. I, col. 8 line 200 6.00 Total hospital charges from Wkst C, Pt. I, col. 8 line 200 7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I 1.100 8.00 Calculation of the HIT incentive payment (see instructions) 9.00 Sequestration adj ustment amount (see instructions) 10.00 INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH 30.00 Initial/interim HIT payment adjustment (see instructions)					Date/Time Pre	
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION1.00Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 141.002.00Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-122.003.00Medicare HMO days from S-3, Pt. I, col. 6. line 23.004.00Total hospital charges from Wst. S-3, Pt. I, col. 8 sum of lines 1, 8-123.005.00Total hospital charges from Wst. C, Pt. I, col. 8 line 2005.006.00Total hospital charity care charges from Wkst. S-10, col. 3 line 205.007.00CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 1687.008.00Calculation of the HIT incentive payment (see instructions)8.009.00Sequestration adjustment amount (see instructions)9.0010.00INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH10.0030.00Initial/interim HIT payment adjustment (see instructions)30.00			Title XVIII	Hospi tal		
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION1.00Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 141.002.00Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-122.003.00Medicare HMO days from S-3, Pt. I, col. 6. line 23.004.00Total hospital charges from Wkst. S-3, Pt. I, col. 8 sum of lines 1, 8-123.005.00Total hospital charges from Wkst. C, Pt. I, col. 8 line 2005.006.00Total hospital charity care charges from Wkst. S-10, col. 3 line 205.007.00CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 1687.008.00Calculation of the HIT incentive payment (see instructions)8.009.00Sequestration adjustment amount (see instructions)9.0010.00INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH10.0030.00Initial/interim HIT payment adjustment (see instructions)30.00						
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1.00 Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14 1.00 2.00 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12 2.00 3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6 line 2 3.00 4.00 Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12 3.00 5.00 Total hospital charges from Wkst C, Pt. I, col. 8 line 200 4.00 6.00 Total hospital charges from Wkst S-10, col. 3 line 200 5.00 7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I 7.00 8.00 Calculation of the HIT incentive payment (see instructions) 8.00 9.00 Sequestration adjustment amount (see instructions) 9.00 10.00 INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH 10.00 30.00 Initial/interim HIT payment adjustment (see instructions) 30.00						
2.00Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-122.003.00Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 23.004.00Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-124.005.00Total hospital charges from Wkst C, Pt. I, col. 8 line 2005.006.00Total hospital charity care charges from Wkst. S-10, col. 3 line 205.007.00CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I7.001 line 1688.00Calculation of the HIT incentive payment (see instructions)8.009.00Sequestration adjustment amount (see instructions)9.0010.00INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH0.0030.00Initial/interim HIT payment adjustment (see instructions)30.00						
3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2 3.00 4.00 Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12 4.00 5.00 Total hospital charges from Wkst C, Pt. I, col. 8 line 200 5.00 6.00 Total hospital charity care charges from Wkst. S-10, col. 3 line 20 5.00 7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168 7.00 8.00 Calculation of the HIT incentive payment (see instructions) 9.00 9.00 Sequestration adjustment amount (see instructions) 9.00 10.00 Calculation of the HIT incentive payment after sequestration (see instructions) 10.00 10.00 Initial/interim HIT payment adjustment (see instructions) 30.00				e 14		1.00
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5.00 Total hospital charges from Wkst C, Pt. I, col. 8 line 200 5.00 6.00 Total hospital charity care charges from Wkst. S-10, col. 3 line 20 6.00 7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I 7.00 1 ine 168 8.00 Calculation of the HIT incentive payment (see instructions) 8.00 9.00 Sequestration adjustment amount (see instructions) 9.00 10.00 Calculation of the HIT incentive payment after sequestration (see instructions) 10.00 10.01 INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH 30.00	3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3.00
6.00 Total hospital charity care charges from Wkst. S-10, col. 3 line 20 6.00 7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168 7.00 8.00 Calculation of the HIT incentive payment (see instructions) 8.00 9.00 Sequestration adjustment amount (see instructions) 9.00 10.00 Calculation of the HIT incentive payment after sequestration (see instructions) 10.00 10.101 INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH 30.00 30.00 Initial/interim HIT payment adjustment (see instructions) 30.00	4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8	-12			4.00
7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I 7.00 1 ine 168 8.00 Calculation of the HIT incentive payment (see instructions) 8.00 9.00 Sequestration adjustment amount (see instructions) 9.00 10.00 Calculation of the HIT incentive payment after sequestration (see instructions) 9.00 10.00 INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH 0.00 30.00 Initial/interim HIT payment adjustment (see instructions) 30.00	5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5.00
I ine 168 I ine 168 8.00 Cal culation of the HIT incentive payment (see instructions) 9.00 Sequestration adjustment amount (see instructions) 10.00 Cal culation of the HIT incentive payment after sequestration (see instructions) 10.00 INPATI ENT HOSPITAL SERVICES UNDER THE IPPS & CAH 30.00 Initial /interim HIT payment adjustment (see instructions)	6.00	Total hospital charity care charges from Wkst. S-10, col. 3 l	ine 20			6.00
8.00 Calculation of the HIT incentive payment (see instructions) 8.00 9.00 Sequestration adjustment amount (see instructions) 9.00 10.00 Calculation of the HIT incentive payment after sequestration (see instructions) 10.00 1NPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH 30.00 30.00 Initial /interim HIT payment adjustment (see instructions) 30.00	7.00	CAH only - The reasonable cost incurred for the purchase of c	ertified HIT technology	Wkst. S-2, Pt. I		7.00
9.00 Sequestration adjustment amount (see instructions) 9.00 10.00 Calculation of the HIT incentive payment after sequestration (see instructions) 10.00 1NPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH 30.00 30.00 Initial /interim HIT payment adjustment (see instructions) 30.00		line 168				
10.00 Calculation of the HIT incentive payment after sequestration (see instructions) 10.00 INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH 30.00 Initial /interim HIT payment adjustment (see instructions) 30.00	8.00	Calculation of the HIT incentive payment (see instructions)				8.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH 30.00 Initial/interim HIT payment adjustment (see instructions) 30.00	9.00	Sequestration adjustment amount (see instructions)				9.00
30.00 Initial/interim HIT payment adjustment (see instructions) 30.00	10.00	Calculation of the HIT incentive payment after sequestration	(see instructions)			10.00
		INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
31.00 Other Adjustment (specify) 31.00	30.00	Initial/interim HIT payment adjustment (see instructions)				30.00
	31.00	Other Adjustment (specify)				31.00
32.00 Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions) 32.00	32.00	Balance due provider (line 8 (or line 10) minus line 30 and l	ine 31) (see instruction	is)		32.00

^{5/30/2018 6:06} pm

	Financial Systems FRANCISCAN HEAL'	TH MICHIGAN CITY Provider CCN: 15-0015	Peri od:	u of Form CMS-2 Worksheet E-3	
		Component CCN: 15-S015	From 01/01/2017 To 12/31/2017	Part II Date/Time Pre 5/30/2018 6:0	
		Title XVIII	Subprovider -	PPS	
				1.00	
	PART II - MEDICARE PART A SERVICES - IPF PPS			1.00	
00	Net Federal IPF PPS Payments (excluding outlier, ECT, and	medical education payments)		681, 622	1
00	Net IPF PPS Outlier Payments			31, 619	2
00	Net IPF PPS ECT Payments			0	3
00	Unweighted intern and resident FTE count in the most recer 15, 2004. (see instructions)	nt cost report filed on or b	efore November	0.00	4
01	Cap increases for the unweighted intern and resident FTE c program or hospital closure, that would not be counted wit			0.00	4
	CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)				
	New Teaching program adjustment. (see instructions)			0.00	5
00	Current year's unweighted FTE count of I&R excluding FTEs	in the new program growth p	eriod of a "new	0.00	
00	teaching program" (see instuctions) Current year's unweighted I&R FTE count for residents with	nin the new program growth p	eriod of a "new	0.00	
00	teaching program" (see instuctions) Intern and resident count for IPF PPS medical education ac	diustmont (soo instructions)		0.00	
00	Average Daily Census (see instructions)			8. 698630	
	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised	to the power of .5150 -1}.		0.000000	
	Teaching Adjustment (line 1 multiplied by line 10).			0	1
	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 1	11)		713, 241	1
00	Nursing and Allied Health Managed Care payment (see instru	uction)		0	1
00	Organ acquisition (DO NOT USE THIS LINE)				1
	Cost of physicians' services in a teaching hospital (see i	nstructions)		0	
	Subtotal (see instructions)			713, 241	
	Primary payer payments			712 241	1
	Subtotal (line 16 less line 17). Deductibles			713, 241 72, 380	
	Subtotal (line 18 minus line 19)			640, 861	
	Coinsurance			17, 108	
	Subtotal (line 20 minus line 21)			623, 753	
00	Allowable bad debts (exclude bad debts for professional se	ervices) (see instructions)		17, 884	2
00	Adjusted reimbursable bad debts (see instructions)			11, 625	2
00	Allowable bad debts for dual eligible beneficiaries (see i	nstructions)		3, 008	2
	Subtotal (sum of lines 22 and 24)			635, 378	
	Direct graduate medical education payments (from Wkst. E-4	4, line 49)		0	2
	Other pass through costs (see instructions)			0	2
	Outlier payments reconciliation OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	2
	Pioneer ACO demonstration payment adjustment (see instruct	tions)		0	3
	Demonstration payment adjustment amount before sequestrati			0	3
	Total amount payable to the provider (see instructions)	-		635, 378	
	Sequestration adjustment (see instructions)			12, 708	
02	Demonstration payment adjustment amount after sequestration	n		0	
	Interim payments			611, 270	
	Tentative settlement (for contractor use only)			0	
	Balance due provider/program (line 31 minus lines 31.01, 3			11, 400	
	Protested amounts (nonallowable cost report items) in acco §115.2	proance with CMS Pub. 15-2,	cnapter I,	0	3
	TO BE COMPLETED BY CONTRACTOR Original outlier amount from Worksheet E-3, Part II, line	2		31, 619	5
	Outlier reconciliation adjustment amount (see instructions			01,017	5
	The rate used to calculate the Time Value of Money	-		0.00	
	Time Value of Money (see instructions)			0	5

ALCUI	LATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0015	Peri od:	Worksheet E-3	
		Component CCN: 15-T015	From 01/01/2017 To 12/31/2017	Part Date/Time Pre 5/30/2018 6:00	
		Title XVIII	Subprovider - IRF	PPS	
				1.00	
	PART III - MEDICARE PART A SERVICES - IRF PPS				
. 00	Net Federal PPS Payment (see instructions)			2, 466, 062	1
00	Medicare SSI ratio (IRF PPS only) (see instructions)			0.0302	2
00	Inpatient Rehabilitation LIP Payments (see instructions)			57, 952	3
00 00	Outlier Payments Unweighted intern and resident FTE count in the most rec	cont cost reporting poriod on	ding on or prior	231, 794 0. 00	4 5
	to November 15, 2004 (see instructions)		0 1		
01	Cap increases for the unweighted intern and resident FTE program or hospital closure, that would not be counted w CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	ithout a temporary cap adjust		0.00	5
00	New Teaching program adjustment. (see instructions)			0.00	6
00	Current year's unweighted FTE count of I&R excluding FTE	in the new program growth p	eriod of a "new	0.00	7
	teaching program" (see instructions)				
00	Current year's unweighted I&R FTE count for residents wi teaching program" (see instructions)	thin the new program growth p	eriod of a new	0.00	8
00	Intern and resident count for IRF PPS medical education	adjustment (see instructions)		0.00	ç
. 00	Average Daily Census (see instructions)	,		7.142466	10
. 00	Teaching Adjustment Factor (see instructions)			0.00000	11
. 00	Teaching Adjustment (see instructions)			0	12
. 00	Total PPS Payment (see instructions)			2, 755, 808	1:
. 00	Nursing and Allied Health Managed Care payments (see ins	struction)		0	14
. 00	Organ acquisition (DO NOT USE THIS LINE)				1!
. 00	Cost of physicians' services in a teaching hospital (see Subtotal (see instructions)	e instructions)		0	16
. 00				2, 755, 808 0	17 18
0.00	Subtotal (line 17 less line 18).			2, 755, 808	19
. 00	Deducti bl es			2, 733, 000	20
. 00	Subtotal (line 19 minus line 20)			2, 755, 808	
. 00	Coinsurance			4, 606	
. 00	Subtotal (line 21 minus line 22)			2, 751, 202	23
. 00	Allowable bad debts (exclude bad debts for professional	services) (see instructions)		6, 004	24
. 00	Adjusted reimbursable bad debts (see instructions)			3, 903	25
. 00	Allowable bad debts for dual eligible beneficiaries (see	e instructions)		314	26
. 00	Subtotal (sum of lines 23 and 25)			2, 755, 105	27
3.00	Direct graduate medical education payments (from Wkst. E	-4, line 49)		0	28
. 00	Other pass through costs (see instructions)			0	29
. 00	Outlier payments reconciliation			0	30 31
. 50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instru	ictions)		0	31 31
1. 99	Demonstration payment adjustment amount before sequestra			0	31
2.00	Total amount payable to the provider (see instructions)			2, 755, 105	
. 01	Sequestration adjustment (see instructions)			55, 102	
. 02		i on			32
. 00				2, 684, 074	
. 00	Tentative settlement (for contractor use only)			0	34
5.00	Balance due provider/program (line 32 minus lines 32.01,			15, 929	35
6. 00	Protested amounts (nonallowable cost report items) in ac §115.2	cordance with CMS Pub. 15-2,	chapter 1,	0	36
	TO BE COMPLETED BY CONTRACTOR			004 704	
). 00	5			231, 794	
. 00	Outlier reconciliation adjustment amount (see instruction	JIIS)		0	51
2.00	The rate used to calculate the Time Value of Money			0. 00 0	

ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0015	Period: From 01/01/2017 To 12/31/2017	Worksheet E-3 Part VII Date/Time Pre 5/30/2018 6:0	pare
		Title XIX	Hospi tal	Cost	- p
			Inpati ent	Outpati ent	
			1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH S COMPUTATION OF NET COST OF COVERED SERVICES	ERVICES FOR TITLES V OR X	IX SERVICES		+
00	Inpatient hospital/SNF/NF services		0		1 1.
00	Medical and other services		0	0	
00	Organ acquisition (certified transplant centers only)		0	-	3
00	Subtotal (sum of lines 1, 2 and 3)		0	0	4
00	Inpatient primary payer payments		0		5
00	Outpatient primary payer payments			0	6
00	Subtotal (line 4 less sum of lines 5 and 6)		0	0	7
	COMPUTATION OF LESSER OF COST OR CHARGES				-
~~	Reasonable Charges				1.
00 00	Routine service charges Ancillary service charges		0 24, 163, 192	0	8
00	Organ acquisition charges, net of revenue		24, 103, 192	0	10
. 00	Incentive from target amount computation		0		11
	Total reasonable charges (sum of lines 8 through 11)		24, 163, 192	0	
	CUSTOMARY CHARGES		21,100,172		1
. 00	Amount actually collected from patients liable for payment f	or services on a charge	0	0	13
. 00	basis Amounts that would have been realized from patients liable f	for payment for services o	in O	0	14
	a charge basis had such payment been made in accordance with			Ū	·
. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15
. 00	Total customary charges (see instructions)		24, 163, 192	0	16
. 00	Excess of customary charges over reasonable cost (complete o	nly if line 16 exceeds	24, 163, 192	0	17
	line 4) (see instructions)				
3. 00	Excess of reasonable cost over customary charges (complete o	only if line 4 exceeds lin	ie 0	0	18
00	16) (see instructions)		0	0	10
	Interns and Residents (see instructions) Cost of physicians' services in a teaching hospital (see ins	tructions)	0	0	
. 00	Cost of covered services (enter the lesser of line 4 or line		0	0	
. 00	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only b		-	0	1 - '
2.00	Other than outlier payments		0	0	22
3.00	Outlier payments		0	0	
	Program capital payments		0		24
5.00	Capital exception payments (see instructions)		0		25
. 00	Routine and Ancillary service other pass through costs		0	0	26
. 00	Subtotal (sum of lines 22 through 26)		0	0	
3. 00	Customary charges (title V or XIX PPS covered services only)		0	0	
9.00	Titles V or XIX (sum of lines 21 and 27)		0	0	29
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			0	1 20
	Excess of reasonable cost (from line 18)		0	0	30
. 00 2. 00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and Deductibles	0)	0	0	
	Coi nsurance		0	0	
	Allowable bad debts (see instructions)		0	0	
. 00	Utilization review		0	0	35
b. 00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 a	ind 33)	0	0	
. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	- /	0	0	
3.00	Subtotal (line 36 ± line 37)		0	0	
9.00	Direct graduate medical education payments (from Wkst. E-4)		0		39
	Total amount payable to the provider (sum of lines 38 and 39)	0	0	40
. 00	Interim payments		0	0	41
2.00	Balance due provider/program (line 40 minus line 41)		0	0	42
3.00	Protested amounts (nonallowable cost report items) in accord	ance with CMS Pub 15-2.	0	0	43

LCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0015 Component CCN: 15-S015	Period: From 01/01/2017 To 12/31/2017	Worksheet E-3 Part VII Date/Time Pre	
		•		5/30/2018 6:0	
		Title XIX	Subprovider -	Cost	
			Inpatient 1.00	Outpatient 2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH S	FRVICES FOR TITLES V OR X		2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES				1
00	Inpatient hospital/SNF/NF services		0		1 1
00	Medical and other services			0	2
00	Organ acquisition (certified transplant centers only)		0		3
00	Subtotal (sum of lines 1, 2 and 3)		0	0	4
00	Inpatient primary payer payments		0		5
00	Outpatient primary payer payments			0	6
00	Subtotal (line 4 less sum of lines 5 and 6)		0	0	7
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonable Charges				
00	Routi ne servi ce charges		0	-	8
00	Ancillary service charges		0	0	
. 00	Organ acquisition charges, net of revenue		0		10
. 00 . 00	Incentive from target amount computation		0	0	
. 00	Total reasonable charges (sum of lines 8 through 11) CUSTOMARY CHARGES		0	0	1''
. 00	Amount actually collected from patients liable for payment f	or services on a charge	0	0	13
. 00	basis	or services on a charge	0	0	
. 00	Amounts that would have been realized from patients liable f	for payment for services o	n 0	0	14
	a charge basis had such payment been made in accordance with			0	1.
. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)	15		0.000000	15
. 00	Total customary charges (see instructions)		0. 000000 0	0	
. 00	Excess of customary charges over reasonable cost (complete o			0	1
	line 4) (see instructions)	5			
. 00	Excess of reasonable cost over customary charges (complete o	nly if line 4 exceeds lin	ie 0	0	18
	16) (see instructions)				
. 00	Interns and Residents (see instructions)		0	0	
. 00	Cost of physicians' services in a teaching hospital (see ins		0	0	20
. 00	Cost of covered services (enter the lesser of line 4 or line		0	0	21
~ ~	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only b	e completed for PPS provi			
. 00	Other than outlier payments		0	0	
. 00	Outlier payments		0	0	
. 00	Program capital payments		0		24
. 00 . 00	Capital exception payments (see instructions) Routine and Ancillary service other pass through costs		0	0	2!
. 00	Subtotal (sum of lines 22 through 26)		0	0	20
. 00	Customary charges (title V or XIX PPS covered services only)		0	0	28
	Titles V or XIX (sum of lines 21 and 27)		0	0	
. 00	COMPUTATION OF REIMBURSEMENT SETTLEMENT		V	0	2
. 00	Excess of reasonable cost (from line 18)		0	0	30
	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and	6)	0	0	
	Deductibles		0	0	
. 00	Coinsurance		0	0	
.00	Allowable bad debts (see instructions)		0	0	
. 00	Utilization review		0		35
. 00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 a	ind 33)	0	0	30
. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	3
. 00	Subtotal (line 36 ± line 37)		0	0	38
. 00	Direct graduate medical education payments (from Wkst. E-4)		0		39
. 00	Total amount payable to the provider (sum of lines 38 and 39)	0	0	
. 00	Interim payments		0	0	
. 00	Balance due provider/program (line 40 minus line 41)		0	0	
. 00	Protested amounts (nonallowable cost report items) in accord	lance with CMS Pub 15-2,	0	0	43

LCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0015 Component CCN: 15-T015	Period: From 01/01/2017 To 12/31/2017	Worksheet E-3 Part VII Date/Time Pre	
		•		5/30/2018 6:0	
		Title XIX	Subprovider - IRF	Cost	
			Inpatient	Outpatient	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SE	RVICES FOR TITLES V OR X	1.00	2.00	-
	COMPUTATION OF NET COST OF COVERED SERVICES				1
00	Inpatient hospital/SNF/NF services		0		1 1
00	Medical and other services			0	2
00	Organ acquisition (certified transplant centers only)		0		3
00	Subtotal (sum of lines 1, 2 and 3)		0	0	
00	Inpatient primary payer payments		0	0	5
00	Outpatient primary payer payments		0	0	
00	Subtotal (line 4 less sum of lines 5 and 6) COMPUTATION OF LESSER OF COST OR CHARGES		0	0	7
	Reasonable Charges				1
00	Routi ne servi ce charges		0		1 8
00	Ancillary service charges		0	0	
.00	Organ acquisition charges, net of revenue		0		10
. 00	Incentive from target amount computation		0		1
. 00	Total reasonable charges (sum of lines 8 through 11)		0	0	12
	CUSTOMARY CHARGES				
. 00	Amount actually collected from patients liable for payment for	or services on a charge	0	0	13
00	basis	n normant for condision o		0	1
. 00	Amounts that would have been realized from patients liable for a charge basis had such payment been made in accordance with		n 0	0	14
. 00	5	atio of line 13 to line 14 (not to exceed 1.000000)			
. 00	Total customary charges (see instructions)		0.000000	0. 000000 0	
. 00	Excess of customary charges over reasonable cost (complete or	nlvifline 16 exceeds	0	0	
	line 4) (see instructions)			-	
. 00	Excess of reasonable cost over customary charges (complete or	nly if line 4 exceeds lin	e 0	0	18
	16) (see instructions)				
. 00	Interns and Residents (see instructions)		0	0	
. 00	Cost of physicians' services in a teaching hospital (see inst		0	0	
. 00	Cost of covered services (enter the lesser of line 4 or line		0	0	2'
. 00	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be Other than outlier payments	e compreted for PPS provi	olers.	0	22
. 00	Outlier payments		0	0	
. 00	Program capital payments		0	0	24
. 00	Capital exception payments (see instructions)		0		2!
.00	Routine and Ancillary service other pass through costs		0	0	
. 00	Subtotal (sum of lines 22 through 26)		0	0	2
. 00	Customary charges (title V or XIX PPS covered services only)		0	0	
. 00	Titles V or XIX (sum of lines 21 and 27)		0	0	20
a -	COMPUTATION OF REIMBURSEMENT SETTLEMENT				١.
	Excess of reasonable cost (from line 18)		0	0	
	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	0	0	
. 00	Deducti bl es Coi nsurance		0	0	
00	Allowable bad debts (see instructions)		0	0	
00	Utilization review		0	0	35
. 00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 ar	nd 33)	0	0	
. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	<i>,</i>	0	0	
. 00	Subtotal (line 36 ± line 37)		0	0	
00	Direct graduate medical education payments (from Wkst. E-4)		0		30
00	Total amount payable to the provider (sum of lines 38 and 39))	0	0	
. 00	Interim payments		0	0	
	Balance due provider/program (line 40 minus line 41)		0	0	
. 00	Protested amounts (nonallowable cost report items) in accorda	ance with CMS Pub 15-2,	0	0	43

ALANC	<u>Financial Systems</u> E SHEET (If you are nonproprietary and do not maintain ype accounting records, complete the General Fund column	Provi der C		Period: From 01/01/2017	u of Form CMS-2 Worksheet G	
nly)	ype accounting records, comprete the general rund cordmin			To 12/31/2017	Date/Time Pre 5/30/2018 6:0	pare 6 pm
		General Fund	Specific Purpose Func			
	CURRENT ASSETS	1.00	2.00	3.00	4.00	
. 00	Cash on hand in banks	128, 670, 540		0 0	0	1.
. 00	Temporary investments	10, 783, 954		0 0	0	2.
. 00	Notes receivable	0		0 0	0	3
. 00	Accounts receivable	30, 754, 452		0 0	0	4
. 00	Other receivable	0		0 0	0	5
. 00	Allowances for uncollectible notes and accounts receivable	-6, 464, 978		0 0	0	6
. 00	Inventory	3, 514, 254		0 0	0	7
. 00	Prepaid expenses	0		0 0	0	8
. 00	Other current assets	1, 820, 645		0 0	0	9
0.00	Due from other funds	0		0 0	0	10
1. 00	Total current assets (sum of lines 1-10)	169, 078, 867		0 0	0	11
	FIXED ASSETS					
2.00	Land	7, 180, 112		0 0	0	
3.00	Land improvements	4, 059, 275		0 0	0	13
4.00	Accumulated depreciation	-2, 469, 310		0 0	0	14
	Buildings	92, 806, 647		0 0	0	15
6.00	Accumulated depreciation	-54, 248, 994		0 0	0	16
7.00	Leasehold improvements	0		0 0	0	17
8.00	Accumulated depreciation	0		0 0	0	18
	Fixed equipment			0 0	0	19
	Accumulated depreciation Automobiles and trucks			0 0	0	20
	Accumulated depreciation			0 0	0	21
	Major movable equipment	226, 669, 703		0 0	0	22
	Accumulated depreciation	-68, 891, 172		0 0	0	23
	Mi nor equipment depreciable	-00,091,172		0 0	0	25
	Accumulated depreciation			0 0	0	26
	HIT designated Assets			0 0	0	27
	Accumulated depreciation			0 0	0	
	Mi nor equi pment-nondepreci abl e			0 0	0	
	Total fixed assets (sum of lines 12-29)	205, 106, 261		0 0	0	
0.00	OTHER ASSETS	200, 100, 201		0 0	Ŭ	
1.00	Investments	116, 300		0 0	0	31
2.00	Deposits on Leases	0		0 0	0	32
3.00	Due from owners/officers	0		0 0	0	33
4.00	Other assets	2, 388, 493		0 0	0	34
5.00	Total other assets (sum of lines 31-34)	2, 504, 793		0 0	0	35
6.00	Total assets (sum of lines 11, 30, and 35)	376, 689, 921		0 0	0	
	CURRENT LI ABI LI TI ES					
7.00	Accounts payable	23, 894, 214		0 0	0	37
	Salaries, wages, and fees payable	4, 570, 566		0 0	0	38
9.00	Payroll taxes payable	0		0 0	0	39
0.00	Notes and Loans payable (short term)	0	1	0 0	0	40
1.00	Deferred income	0		0 0	0	41
2.00	Accelerated payments	0				42
3.00	Due to other funds	948, 446		0 0	0	43
4.00	Other current liabilities	1, 959, 271		0 0	0	44
5.00	Total current liabilities (sum of lines 37 thru 44)	31, 372, 497		0 0	0	45
	LONG TERM LIABILITIES					
6.00	Mortgage payable	0		0 0	0	
7.00	Notes payable	0		0 0	0	47
8.00	Unsecured Loans	0		0 0	0	
9.00	Other long term liabilities	-1, 953, 313		0 0	0	
	Total long term liabilities (sum of lines 46 thru 49)	-1, 953, 313		0 0	0	
1.00	Total liabilities (sum of lines 45 and 50)	29, 419, 184		0 0	0	51
~ ~~	CAPI TAL ACCOUNTS	0.47.070.70/		-		1 - 0
2.00	General fund balance	347, 270, 736		0		52
3.00	Specific purpose fund			0		53
4.00	Donor created - endowment fund balance - restricted			0		54
5.00	Donor created - endowment fund balance - unrestricted			0		55
6.00	Governing body created - endowment fund balance			0	_	56
7.00	Plant fund balance - invested in plant				0	
8.00	Plant fund balance - reserve for plant improvement,				0	58
0 00	replacement, and expansion Total fund balances (cum of Lines 52 thru 58)	247 770 774		0 0	0	=
9.00 0.00	Total fund balances (sum of lines 52 thru 58) Total liabilities and fund balances (sum of lines 51 and	347, 270, 736 376, 689, 920		0 0	0	

	Financial Systems FR ENT OF CHANGES IN FUND BALANCES	ANCI SCAN HEALTH	Provi der CC			i od: m 01/01/2017 12/31/2017	u of Form CMS-: Worksheet G-1 Date/Time Pre	pared:
		General	Fund	Speci al	Purp	oose Fund	5/30/2018 6:0 Endowment Fund	
		1.00	2.00	3.00		4.00	5.00	
$\begin{array}{c} 1. \ 00\\ 2. \ 00\\ 3. \ 00\\ 4. \ 00\\ 5. \ 00\\ 6. \ 00\\ 7. \ 00\\ 8. \ 00\\ 9. \ 00\\ 10. \ 00\\ 11. \ 00\\ 12. \ 00\\ 13. \ 00\\ 14. \ 00\\ 15. \ 00\\ 16. \ 00\\ 17. \ 00\\ 18. \ 00\\ 19. \ 00\\ \end{array}$	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) FUND BALANCE ADJUSTMENT 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 0 0 0 0 0 0	248, 813, 782 15, 835, 095 264, 648, 877 0 264, 648, 877 -83, 147, 437 347, 796, 314			0 0 0 0 0 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 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
		Endowment Fund	PI ant					
1.00	Fund balances at beginning of period	6.00	7.00	8.00	0			1.00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	0	0 0 0 0 0		0			1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00
10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) FUND BALANCE ADJUSTMENT	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	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			18.00 19.00

Heal th	Financial Systems FRANCISCAN HEALTH N	II CHI GAN CI TY	(In Lie	eu of Form CMS-2	2552-10
STATEM	IENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provider CC	CN: 15-0015	Period: From 01/01/2017 To 12/31/2017	Date/Time Pre 5/30/2018 6:0	pared:
	Cost Center Description		Inpatient	Outpatient	Total	
	PART I - PATIENT REVENUES		1.00	2.00	3.00	
	General Inpatient Routine Services					1
1.00	Hospi tal		32, 467, 2	14	32, 467, 214	1.00
2.00	SUBPROVIDER - IPF		4, 518, 4		4, 518, 415	
3.00	SUBPROVIDER - IRF		6, 971, 7	65	6, 971, 765	
4.00 5.00	SUBPROVIDER Swing bed - SNF			0	0	4.00 5.00
6.00	Swing bed - NF			0	0	•
7.00	SKILLED NURSING FACILITY			0	0	
8.00	NURSING FACILITY			0	0	
9.00	OTHER LONG TERM CARE			0	0	9.00
10.00	Total general inpatient care services (sum of lines 1-9)		43, 957, 39	94	43, 957, 394	10.00
	Intensive Care Type Inpatient Hospital Services		(/ aaa aaa	1
11.00 12.00	I NTENSI VE CARE UNI T CORONARY CARE UNI T		6, 022, 30	0	6, 022, 300 0	
12.00	BURN INTENSIVE CARE UNIT			0	0	
14.00	SURGI CAL I NTENSI VE CARE UNI T			0	0	
15.00	OTHER SPECIAL CARE (SPECIFY)			0		15.00
16.00	Total intensive care type inpatient hospital services (sum of	lines	6, 022, 30	00	6, 022, 300	16.00
	11-15)					
17.00	Total inpatient routine care services (sum of lines 10 and 16)	49, 979, 6		49, 979, 694	•
18.00	Ancillary services		160, 866, 1			
19.00 20.00	Outpatient services RURAL HEALTH CLINIC		11, 841, 2	75 52, 892, 534 0 0		19.00 20.00
20.00	FEDERALLY QUALIFIED HEALTH CENTER				-	
22.00	HOME HEALTH AGENCY					
23.00	AMBULANCE SERVICES			0 0		
24.00	СМНС			(0	24.00
24.10	CORF			0 0	-	
25.00	AMBULATORY SURGICAL CENTER (D. P.)			0 0	-	
26.00	HOSPICE			0 (°	
27.00 28.00	NON REIMBURSABLE	to Wkot	222 (07 1)	0 3, 023, 095		
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 G-3, line 1)	LO WKSL.	222, 687, 1	57 461, 793, 669	684, 480, 826	28.00
	PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)			170, 630, 654	ł	29.00
30.00	ADD (SPECIFY)			0		30.00
31.00				0		31.00
32.00				0		32.00
33.00 34.00				0		33.00 34.00
34.00				0		35.00
36.00	Total additions (sum of lines 30-35)			0		36.00
37.00	DEDUCT (SPECIFY)			0		37.00
38.00				0		38.00
39.00				0		39.00
40.00				0		40.00
41.00				0		41.00
42.00	Total deductions (sum of lines 37-41)) (transform) I	42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 4 to Wkst. G-3, line 4)	z) (transfer		170, 630, 654	+	43.00
	10 WKSt. 0-5, 1110 4)		I	I	1	1

Heal th	Financial Systems	FRANCI SCAN HEALTH MI	CHIGAN CITY	In Lie	u of Form CMS-2	2552-10
	IENT OF REVENUES AND EXPENSES		Provider CCN: 15-0015	Peri od:	Worksheet G-3	
				From 01/01/2017 To 12/31/2017	Date/Time Pre	hared.
					5/30/2018 6:0	
1 00	Tatal nations revenues (from What C 2	Dort L. column 2 Line	20)		1.00	1 00
1.00 2.00	Total patient revenues (from Wkst. G-2, Less contractual allowances and discount				684, 480, 826 502, 837, 347	1.00 2.00
3.00	Net patient revenues (line 1 minus line	•	5		181, 643, 479	3.00
4.00	Less total operating expenses (from Wkst	<i>·</i>	3)		170, 630, 654	4.00
5.00	Net income from service to patients (lin				11, 012, 825	5.00
	OTHER I NCOME					
6.00	Contributions, donations, bequests, etc				0	6.00
7.00	Income from investments				0	7.00
8.00	Revenues from telephone and other miscel		servi ces		0	8.00
9.00	Revenue from television and radio servic	ce			0	9.00
10.00	Purchase di scounts				0	10.00
11.00	Rebates and refunds of expenses				0	11.00
12.00	Parking lot receipts				0	12.00
13.00	Revenue from Laundry and Linen service				0	13.00
14.00	Revenue from meals sold to employees and	guests			0	14.00
15.00 16.00	Revenue from rental of living quarters Revenue from sale of medical and surgica	al supplies to other th	an nationts		0	15.00 16.00
17.00	Revenue from sale of drugs to other than				0	17.00
18.00	Revenue from sale of medical records and	•			0	18.00
19.00	Tuition (fees, sale of textbooks, unifor				0	19.00
20.00	Revenue from gifts, flowers, coffee shop				Ő	20.00
21.00	Rental of vending machines				0	21.00
22.00	Rental of hospital space				0	22.00
23.00	Governmental appropriations				0	23.00
24.00	OTHER OPERATING REVENUE				2, 243, 572	24.00
24.01	PREMI UM REVENUE				549, 996	24.01
24.02	BAD DEBT				888, 906	
24.03	OTHER (SPECIFY)				0	24.03
24.04	NON OPERATING REVENUE				1, 139, 796	
25.00	Total other income (sum of lines 6-24)				4, 822, 270	
26.00	Total (line 5 plus line 25)				15, 835, 095	
27.00 27.01	BAD DEBT EQUITY TRANSFERS				0	27.00 27.01
27.01	TOTAL NON-OPERATING REVENUE				0	27.01
27.02					0	27.02
27.03					0	27.03
28.00	Total other expenses (sum of line 27 and	subscripts)			0	28.00
	Net income (or loss) for the period (lin				15, 835, 095	
				I		

	ATION OF CAPITAL PAYMENT	Provider CCN: 15-0015	Peri od:	Worksheet L	
			From 01/01/2017 To 12/31/2017	Parts I-III Date/Time Pre	narod
			10 12/31/2017	5/30/2018 6:0	
		Title XVIII	Hospi tal	PPS	
				1.00	
	PART I - FULLY PROSPECTIVE METHOD			1.00	
	CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier			1, 704, 736	
1.01	Model 4 BPCI Capital DRG other than outlier			0	1
2.00	Capital DRG outlier payments			19, 968	
2. 01	Model 4 BPCI Capital DRG outlier payments			0	
3.00	Total inpatient days divided by number of days in the cost r	reporting period (see inst	ructions)	55.35	
4.00	Number of interns & residents (see instructions)			0.00	
5.00	Indirect medical education percentage (see instructions)			0.00	
5.00	Indirect medical education adjustment (multiply line 5 by th 1.01) (see instructions)	ne sum of lines 1 and 1.01	, columns 1 and	0	6.0
7.00	Percentage of SSI recipient patient days to Medicare Part A 30) (see instructions)	patient days (Worksheet E	, part A line	6. 12	7.0
3. 00	Percentage of Medicaid patient days to total days (see instr	ructions)		22.60	8.0
9.00	Sum of lines 7 and 8			28.72	9.0
0.00	Allowable disproportionate share percentage (see instruction	าร)		5.99	10.0
11.00	Disproportionate share adjustment (see instructions)			102, 114	11.0
2.00	Total prospective capital payments (see instructions)			1, 826, 818	12.0
				1.00	
	PART II - PAYMENT UNDER REASONABLE COST			1.00	
1.00	Program inpatient routine capital cost (see instructions)			0	1.0
2.00	Program inpatient ancillary capital cost (see instructions)			0	2.0
3.00	Total inpatient program capital cost (line 1 plus line 2)			0	3.0
4.00	Capital cost payment factor (see instructions)			0	4.0
5.00	Total inpatient program capital cost (line 3 x line 4)			0	5.0
				1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS				
. 00	Program inpatient capital costs (see instructions)			0	
. 00	Program inpatient capital costs for extraordinary circumstar	nces (see instructions)		0	
. 00	Net program inpatient capital costs (line 1 minus line 2)			0	
. 00	Applicable exception percentage (see instructions)			0.00	
	Capital cost for comparison to payments (line 3 x line 4)			0	
. 00				0.00	
. 00 . 00	Percentage adjustment for extraordinary circumstances (see i			-	7.0
. 00 . 00 . 00	Adjustment to capital minimum payment level for extraordinar		(line 6)	0	
. 00 . 00 . 00 . 00	Adjustment to capital minimum payment level for extraordinar Capital minimum payment level (line 5 plus line 7)	ry circumstances (line 2 ×	cline 6)	0	8. (
. 00 . 00 . 00 . 00 . 00	Adjustment to capital minimum payment level for extraordinar Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as appl	ry circumstances (line 2 × icable)		0	8. 0 9. 0
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