AND SETTLEMEN	I SUMMARY	To 12/31/2017 Date/Time Prepared: 5/31/2018 3:08 am
PART I - COST	REPORT STATUS	
Provi der	1.[X]Electronically filed cost report	Date: 5/31/2018 Time: 3:08 am
use only	2. [] Manually submitted cost report	
	3. [0] If this is an amended report enter the number 4. [F] Medicare Utilization. Enter "F" for full or "L	
Contractor use only	5. [1]Cost Report Status6. Date Received:(1) As Submitted7. Contractor No.(2) Settled without Audit8. [N]Initial Report fo(3) Settled with Audit9. [N]Final Report for(4) Reopened(5) Amended	10. NPR Date: 11. Contractor's Vendor Code: 4 11. Contractor's Vendor Code: 4 12. [0]If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by FRANCISCAN HEALTH RENSSELAER (15-1324) 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 signature on this certification statement to be the legally binding equivalent of my original signature.

(Si aned)

Officer or Administrator of Provider(s)

Peri od.

From 01/01/2017

In Lieu of Form CMS-2552-10

Worksheet S

Parts I-III

OMB NO. 0938-0050 EXPIRES 05-31-2019

Title

Date

		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	461, 460	-3, 001, 680	0	0	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
5.00 Swing bed - SNF	0	34, 787	0		0	5.00
6.00 Swing bed - NF	0				0	6.00
9.00 HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00 RURAL HEALTH CLINIC I	0		6, 872		0	10.00
10.03 RURAL HEALTH CLINIC IV	0		46, 497		0	10.03
_200. 00 Total	0	496, 247	-2, 948, 311	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.

10521	Financial Systems FAL AND HOSPITAL HEALTH CARE COMPLEX	FRANCI SCAN HEAI		ler CCN: 1		Period: From 01/01/ To 12/31/	2017	of For Workshe Part I Date/Ti	et S-2	
	1.00	2.00		3.00		/	1.00	5/31/20	18 2:4	6 am
	Hospital and Hospital Health Care Co			3.00			F. 00			
. 00	Street: 1104 EAST GRACE STREET	P0 Box:								1.00
2.00	City: RENSSELAER	State: IN	Zip Cod CCN	e: 47978- CBSA	Count Provi der	y: JASPER Date	Dayma	nt Syst	om (D	2.00
		Component Name	Number	Number	Type	Certified		0, or		
					51		V	XVIII	XIX	1
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
8.00	Hospital and Hospital-Based Componen Hospital	FRANCI SCAN HEALTH	151324	23844	1	02/03/2005	N	0	0	3.00
		RENSSELAER	101021	20011		02,00,2000			Ū	
. 00 . 00	Subprovider - IPF Subprovider - IRF									4.00
5.00 5.00	Subprovider - (Other)									6.00
. 00	Swing Beds - SNF	FRANCI SCAN HEALTH	15Z324	99915		12/31/2005	Ν	0	Ν	7.0
00	Swing Dodo NE	RENSSELAER								
. 00 . 00	Swing Beds - NF Hospital-Based SNF									8.0
0.00	Hospi tal -Based NF									10.0
1.00	Hospital-Based OLTC		4574.40	00045						11.0
2.00	Hospital-Based HHA	FRANCI SCAN HEALTH RENSSELAER	157149	99915		05/13/1985	Ν	P	N	12.0
3. 00	Separately Certified ASC	RENJJELAER								13.0
4.00	Hospi tal -Based Hospi ce	FRANCI SCAN HEALTH	151519	99915		03/12/1993				14.00
5 00	Hospital-Based Health Clinic - RHC	RENSSELAER WHEATFIELD CLINIC	153990	99915		10/07/1999	Ν	0	N	15.00
5.03	Hospital -Based Health Clinic - RHC	BROOK	158502	99915		01/01/2005	N	0	N	15.03
(00										1.0
6.00 7.00	Hospital-Based Health Clinic - FQHC Hospital-Based (CMHC) I									16.00
8.00	Renal Dialysis									18.0
9.00	Other									19.0
						From: 1.00				-
0.00	Cost Reporting Period (mm/dd/yyyy)					01/01/20	017	12/31/		20.00
1. 00						1				21.00
2.00	Inpatient PPS Information Does this facility qualify and is it	currently receiving pa	wments for	di sprop	ortionate	N		N		22.00
2.00	share hospital adjustment, in accord									22.0
	for yes or "N" for no. Is this facil			2.106(c)	(2) (Pi ckl e	9				
2. 01	amendment hospital?) In column 2, en Did this hospital receive interim un			s cost re	eportina	N		N		22.0
2.0.	period? Enter in column 1, "Y" for y									22.0
	reporting period occurring prior to									
	for no for the portion of the cost r (see instructions)	eporting period occurri	ng on or a	arter octo	Juer I.					
2. 02	Is this a newly merged hospital that					N		Ν		22.0
	determined at cost report settlement or "N" for no, for the portion of th					5				
	in column 2, "Y" for yes or "N" for					1				
	or after October 1.			1 5						
2.03	Did this hospital receive a geograph of the OMB standards for delineating					T N		N		22.0
	in column 1, "Y" for yes or "N" for									
		2, "Y" for yes or "N" f				e				
	prior to October 1. Enter in column			ons) Does	stnis					
	cost reporting period occurring on o					1				
	cost reporting period occurring on o hospital contain at least 100 but no 42 CFR 412.105)? Enter in column 3,	t more than 499 beds (a "Y" for yes or "N" for	ns counted no.	in accord	dance with	1				23.0
3. 00	cost reporting period occurring on o hospital contain at least 100 but no 42 CFR 412.105)? Enter in column 3, Which method is used to determine Me	t more than 499 beds (a "Y" for yes or "N" for dicaid days on lines 24	ns counted no. and/or 25	in accord 5 below? I	dance with In column	1	0			20.0
3. 00	cost reporting period occurring on o hospital contain at least 100 but no 42 CFR 412.105)? Enter in column 3, Which method is used to determine Me 1, enter 1 if date of admission, 2 i	t more than 499 beds (a "Y" for yes or "N" for dicaid days on lines 24 f census days, or 3 if	ns counted no. and/or 25 date of di	in accord 5 below? I scharge.	dance with In column Is the	1	0			20.0
3. 00	cost reporting period occurring on o hospital contain at least 100 but no 42 CFR 412.105)? Enter in column 3, Which method is used to determine Me	t more than 499 beds (a "Y" for yes or "N" for dicaid days on lines 24 f census days, or 3 if is cost reporting peric iod? In column 2, ente	as counted no. and/or 25 date of di od differer er "Y" for	in accord below? I scharge. ht from th yes or "N	dance with In column Is the ne method <u>V" for no.</u>		0			23.0
3. 00	cost reporting period occurring on o hospital contain at least 100 but no 42 CFR 412.105)? Enter in column 3, Which method is used to determine Me 1, enter 1 if date of admission, 2 i method of identifying the days in th	t more than 499 beds (a "Y" for yes or "N" for dicaid days on lines 24 f census days, or 3 if is cost reporting perio iod? In column 2, ente In-St	as counted no. and/or 25 date of di od differer er "Y" for rate In-S	in accord below? I scharge. It from th yes or "N tate 0	dance with In column Is the ne method <u>V" for no.</u> ut-of	Out-of M	0 edicai M0 day		ther i cai d	20.0
3. 00	cost reporting period occurring on o hospital contain at least 100 but no 42 CFR 412.105)? Enter in column 3, Which method is used to determine Me 1, enter 1 if date of admission, 2 i method of identifying the days in th	t more than 499 beds (a "Y" for yes or "N" for dicaid days on lines 24 f census days, or 3 if is cost reporting peric iod? In column 2, ente	as counted no. 4 and/or 25 date of di od differer er "Y" for rate In-S cate Medi	in accord below? I scharge. It from th yes or "N tate 0 caid 5	dance with In column Is the ne method <u>V" for no.</u> ut-of State dicaid M	Out-of M State H Medicaid	0 edicai MO day	/s Med	ther i cai d ays	23.0
3. 00	cost reporting period occurring on o hospital contain at least 100 but no 42 CFR 412.105)? Enter in column 3, Which method is used to determine Me 1, enter 1 if date of admission, 2 i method of identifying the days in th	t more than 499 beds (a "Y" for yes or "N" for dicaid days on lines 24 f census days, or 3 if is cost reporting perio iod? In column 2, ente In-St Medic	as counted no. and/or 25 date of di od differer er "Y" for ate In-S aid Medi days elig unp	in accord below? I scharge. nt from th yes or "I tate O caid S ible Me aid pai	dance with In column Is the ne method <u>V" for no.</u> ut-of State dicaid M d days e	Out-of M State H ledicaid eligible		/s Med	i cai d	20.0
3. 00	cost reporting period occurring on o hospital contain at least 100 but no 42 CFR 412.105)? Enter in column 3, Which method is used to determine Me 1, enter 1 if date of admission, 2 i method of identifying the days in th	t more than 499 beds (a "Y" for yes or "N" for dicaid days on lines 22 f census days, or 3 if is cost reporting perio iod? In column 2, enter In-St Medio paid	as counted no. date of di od differer er "Y" for ate In-S aid Medi days elig unp da	in accord below? I scharge. ht from th yes or "h tate 0 caid S ible Me aid pai ys	dance with In column Is the ne method <u>N" for no.</u> ut-of State dicaid d days e	Out-of M State H ledicaid eligible unpaid	MO day	/s Med d	i cai d ays	20.0
	cost reporting period occurring on o hospital contain at least 100 but no 42 CFR 412.105)? Enter in column 3, Which method is used to determine Me 1, enter 1 if date of admission, 2 i method of identifying the days in th used in the prior cost reporting per	t more than 499 beds (a "Y" for yes or "N" for dicaid days on lines 24 f census days, or 3 if is cost reporting perio iod? In column 2, ente In-St Medic paid	as counted no. date of di od differer er "Y" for ate In-S aid Medi days elig unp da	in accord below? I scharge. ht from th yes or "h tate 0 caid S ible Me aid pai ys	dance with In column Is the ne method <u>V" for no.</u> ut-of State dicaid M d days e	Out-of M State H ledicaid eligible		/s Med d	i cai d ays . 00	-
	cost reporting period occurring on o hospital contain at least 100 but no 42 CFR 412.105)? Enter in column 3, Which method is used to determine Me 1, enter 1 if date of admission, 2 i method of identifying the days in the used in the prior cost reporting per	t more than 499 beds (a "Y" for yes or "N" for dicaid days on lines 24 f census days, or 3 if is cost reporting period iod? In column 2, enter In-St Mediod paid of 1.0 , enter the n 1, in-state	as counted no. and/or 25 date of di dd differer er "Y" for ate In-S aid Medi el ig unp da 00 2.	in accord below? I scharge. t from th yes or "N tate 0 caid S ible Me aid pai ys	dance with In column Is the ne method <u>N" for no.</u> ut-of State dicaid M d days e <u>3.00</u>	Out-of M State H ledi cai d el i gi bl e unpai d 4. 00	MO day	vs Med d	i cai d ays . 00	-
	cost reporting period occurring on o hospital contain at least 100 but no 42 CFR 412.105)? Enter in column 3, Which method is used to determine Me 1, enter 1 if date of admission, 2 i method of identifying the days in th used in the prior cost reporting per lif this provider is an IPPS hospital in-state Medicaid paid days in colum Medicaid eligible unpaid days in col	t more than 499 beds (a "Y" for yes or "N" for dicaid days on lines 24 f census days, or 3 if is cost reporting period iod? In column 2, enter In-S1 Medic paid 1.0 , enter the n 1, in-state umn 2,	as counted no. and/or 25 date of di dd differer er "Y" for ate In-S aid Medi el ig unp da 00 2.	in accord below? I scharge. t from th yes or "N tate 0 caid S ible Me aid pai ys	dance with In column Is the ne method <u>N" for no.</u> ut-of State dicaid M d days e <u>3.00</u>	Out-of M State H ledi cai d el i gi bl e unpai d 4. 00	MO day	vs Med d	i cai d ays . 00	24.00
	cost reporting period occurring on o hospital contain at least 100 but no 42 CFR 412.105)? Enter in column 3, Which method is used to determine Me 1, enter 1 if date of admission, 2 i method of identifying the days in the used in the prior cost reporting per	t more than 499 beds (a "Y" for yes or "N" for dicaid days on lines 24 f census days, or 3 if is cost reporting period iod? In column 2, enter In-St Medic paid 1.0 , enter the n 1, in-state umn 2, olumn 3,	as counted no. and/or 25 date of di dd differer er "Y" for ate In-S aid Medi el ig unp da 00 2.	in accord below? I scharge. t from th yes or "N tate 0 caid S ible Me aid pai ys	dance with In column Is the ne method <u>N" for no.</u> ut-of State dicaid M d days e <u>3.00</u>	Out-of M State H ledi cai d el i gi bl e unpai d 4. 00	MO day	vs Med d	i cai d ays . 00	-
	cost reporting period occurring on o hospital contain at least 100 but no 42 CFR 412.105)? Enter in column 3, Which method is used to determine Me 1, enter 1 if date of admission, 2 i method of identifying the days in th used in the prior cost reporting per lif this provider is an IPPS hospital in-state Medicaid paid days in colum Medicaid eligible unpaid days in col out-of-state Medicaid paid days in col	t more than 499 beds (a "Y" for yes or "N" for dicaid days on lines 24 f census days, or 3 if is cost reporting perio iod? In column 2, enter In-St Medic paid 1.C , enter the n 1, in-state umn 2, olumn 3, d days in column t unpaid days in	as counted no. and/or 25 date of di dd differer er "Y" for ate In-S aid Medi el ig unp da 00 2.	in accord below? I scharge. t from th yes or "N tate 0 caid S ible Me aid pai ys	dance with In column Is the ne method <u>N" for no.</u> ut-of State dicaid M d days e <u>3.00</u>	Out-of M State H ledi cai d el i gi bl e unpai d 4. 00	MO day	vs Med d	i cai d ays . 00	_

SPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DAT	TA I	Provider CC	N: 15-1324	Peri		4 /0047			t S-2	
				To		1/2017 1/2017	Dat	e/Tin	e Pre 8 2:4	
	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out- Sta Medic eligi unpa	te caid ble	Medic HMO d	aid	Ot Medi	ner cai d ys	
	1.00	2.00	3.00	4. C		5.0		6.	00	0.5
.00 If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0		0 ban/R	ural S	O	- of	Geogr	25.
					1. (Dur	2.00		
 .00 Enter your standard geographic classification (not way cost reporting period. Enter "1" for urban or "2" for .00 Enter your standard geographic classification (not way reporting period. Enter in column 1, "1" for urban or enter the effective date of the geographic reclassification. .00 If this is a sole community hospital (SCH), enter the effect in the cost reporting period. 	rural. ige) status "2" for r cation in i	at the end ural. If ap column 2.	l of the cos pplicable,	t		:	2 2 0			26. 27. 35.
errect in the cost reporting perrod.				E	Begi nr	ni ng:		Endi n	g:	
.00 Enter applicable beginning and ending dates of SCH st.	atus Suba	crint line	36 for numb	or	1. (00		2.00)	36.
of periods in excess of one and enter subsequent dates		si pt i ne								30.
.00 If this is a Medicare dependent hospital (MDH), enter is in effect in the cost reporting period.	the numbe	r of period	ls MDH statu	IS		(C			37.
.01 Is this hospital a former MDH that is eligible for the accordance with FY 2016 OPPS final rule? Enter "Y" fo instructions)					N					37.
.00 If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of										38.
enter subsequent dates.					Y/	N		Y/N		
00 Deep this facility and if for the impetiant benefited					1. C N			2.00)	39.
 .00 Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(i) for yes or "N" for no. Does the facility meet the mill with 42 CFR 412.101(b)(2)(i) or (ii)? Enter in column instructions) .00 Is this hospital subject to the HAC program reduction 	or (ii)? eage requi 2 "Y" for	Enter in co rements in yes or "N"	olumn 1 "Y" accordance for no. (s	ee	N			N		40.
"N" for no in column 1, for discharges prior to Octob no in column 2, for discharges on or after October 1.	er 1. Ente	r "Y" for y				V		111	XIX	
						1.0			3.00	
Prospective Payment System (PPS)-Capital .00 Does this facility qualify and receive Capital paymen with 42 CFB Satism 5412 2022 (casi patruations)	nt for disp	roporti onat	e share in	accord	lance	N		N	N	45.
 with 42 CFR Section §412.320? (see instructions) .00 Is this facility eligible for additional payment exce pursuant to 42 CFR §412.348(f)? If yes, complete Wkst Pt. III. 					bugh	N		N	Ν	46.
.00 Is this a new hospital under 42 CFR §412.300(b) PPS c			2		ıo.	N N		N N	N N	47. 48.
.00 Is the facility electing full federal capital payment	56.00 Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes N									56.
.00 <u>Is the facility electing full federal capital payment</u> <u>Teaching Hospitals</u> .00 Is this a hospital involved in training residents in a	approved G	ME programs	? Enter "Y	TOP	-					57.
.00 Is the facility electing full federal capital payment Teaching Hospitals	eriod duri yes or "N h of this (", complet	ng which re " for no in cost report e Worksheet	esidents in 1 column 1. ing period?	approv If col ' Ente	umn 1 er "Y"					
 .00 Is the facility electing full federal capital payment' Teaching Hospitals .00 Is this a hospital involved in training residents in a or "N" for no. .00 If line 56 is yes, is this the first cost reporting p GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first month for yes or "N" for no in column 2. If column 2 is "Y 	eriod durin yes or "N h of this (", complet , if applic pursement fo	ng which re " for no in cost report e Worksheet cable. or physicia	esidents in column 1. ing period? E-4. If co	approv If col 2 Ente 0 umn 2	umn 1 er "Y"					58.
 .00 Is the facility electing full federal capital payment' Teaching Hospitals .00 Is this a hospital involved in training residents in a or "N" for no. .00 If line 56 is yes, is this the first cost reporting p GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mont for yes or "N" for no in column 2. If column 2 is "Y "N", complete Wkst. D, Parts III & IV and D-2, Pt. II .00 If line 56 is yes, did this facility elect cost reimb 	period durin yes or "N h of this (", complete , if appli complete W	ng which re 'for no in cost report e Worksheet cable. or physicia kst. D-5.	esidents in a column 1. ing period? : E-4. If co ans' service Pt. I.	approv If col 2 Ente 1 umn 2 es as	umn 1 er "Y" 2 is	N				
 .00 Is the facility electing full federal capital payment' Teaching Hospitals .00 Is this a hospital involved in training residents in a or "N" for no. .00 If line 56 is yes, is this the first cost reporting p GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first monti for yes or "N" for no in column 2. If column 2 is "Y "N", complete Wkst. D, Parts III & IV and D-2, Pt. II .00 If line 56 is yes, did this facility elect cost reimbi defined in CMS Pub. 15-1, chapter 21, §2148? If yes, or 	period durin yes or "N h of this (", complete , if appli complete W	ng which re 'for no in cost report e Worksheet cable. or physicia kst. D-5.	esidents in a column 1. ing period? E-4. If co ans' service	approv If col 2 Ente 1 umn 2 es as	umn 1 er "Y" 2 is	N N eet A	Pas Qual	i fi c	rough ati on 1 Code	58. 59.
 .00 Is the facility electing full federal capital payment' Teaching Hospitals .00 Is this a hospital involved in training residents in a or "N" for no. .00 If line 56 is yes, is this the first cost reporting p GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first monti for yes or "N" for no in column 2. If column 2 is "Y "N", complete Wkst. D, Parts III & IV and D-2, Pt. II .00 If line 56 is yes, did this facility elect cost reimbi defined in CMS Pub. 15-1, chapter 21, §2148? If yes, or 	period durin yes or "N h of this (", complete , if appli complete W	ng which re 'for no in cost report e Worksheet cable. or physicia kst. D-5.	esidents in a column 1. ing period? : E-4. If co ans' service Pt. I. NAHE 413.8	approv If col 2 Ente 1 umn 2 es as	umn 1 er "Y" 2 is /orksh	N eet A e #	Pas Qual	i fi c	ation Code	59.

	Financial Systems FRANCISCA FAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	TA	Provider CC		eriod: rom 01/01/2017 o 12/31/2017		pared:
		Y/N	IME	Direct GME	IME	5/31/2018 2:4 Direct GME	6 am
	1	1.00	2.00	3.00	4.00	5.00	
	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 instructions)	N			0. 00) O. OC	61.0
1. 02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.0
1. 03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.0
1. 04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).						61. C
	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)						61.0
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. C
		Pro	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
			1.00	2.00	3.00	4.00	1
1. 10	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
						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 Cent see instruction	ter (THC) into			62. C
3. 00	Teaching Hospitals that Claim Residents in Nonprovide Has your facility trained residents in nonprovider se "Y" for yes or "N" for no in column 1. If yes, complete	ettings	during this co	67. (see instru	ictions)	N	63. 0
				Unwei ghted FTEs Nonprovi der Si te	FTES in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
	Section 5504 of the ACA Base Year FTE Residents in No	onprovi	der Settings	1.00 This base vear	2.00 is vour cost r	<u> </u>	
4.00	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 non 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	<u>re June</u> y trair a-primar all nor l non-pr n columr	30, 2010. med residents y care provider imary care n 3 the ratio	0. OC	-		64.0

OSPITAL AND HOSPITAL HEALTH CARE COMPLI	EX IDENTIFICATION DA	TA Provider (Fi	eriod: rom 01/01/2017		
			To	b 12/31/2017	Date/Time Pre 5/31/2018 2:4	pared: 6 am
	Program Name	Program Code	Unwei ghted	Unwei ghted	Ratio (col. 3/	
			FTEs Nonprovider Site	FTEs in Hospital	(col. 3 + col. 4))	
-	1.00	2.00	3.00	4.00	5.00	1
5.00 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care			0.00	0. 00	0. 000000	65. C
FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3						
divided by (column 3 + column 4)). (see instructions)			Unwei ghted	Unweighted	Ratio (col. 1/	
			FTEs Nonprovi der Si te	FTEs in Hospital	(col . 1 + col . 2))	
			1.00	2.00	3.00	1
Section 5504 of the ACA Current Y	ear FTE Residents ir	n Nonprovider Settin				
b.00 Enter in column 1 the number of u FTEs attributable to rotations oc Enter in column 2 the number of u FTEs that trained in your hospita (column 1 divided by (column 1 4)	curring in all nonpr nweighted non-primar I. Enter in column 3	rovider settings. Ty care resident 3 the ratio of	0.00	0.00 Unweighted	0.000000 Ratio (col. 3/	
-	Ŭ		FTĔs Nonprovider Site	FTES in Hospital	(col. 3 + col. 4))	
00 Entor in column 1 the program	1.00	2.00	3.00	4.00	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)						07.0
				1.00	0 2.00 3.00	
Inpatient Psychiatric Facility PP 0.00 Is this facility an Inpatient Psy		PF), or does it con	tain an IPF subp	provider? N		70. 0
Enter "Y" for yes or "N" for no. .00 If line 70 is yes: Column 1: Did recent cost report filed on or be 42 CFR 412.424(d)(1)(iii)(c)) Col program in accordance with 42 CFR Column 3: If column 2 is Y, indic (see instructions)	fore November 15, 20 umn 2: Did this faci 412.424 (d)(1)(iii) ate which program ye	004? Enter "Y" for lity train residents (D)? Enter "Y" for	yes or "N" for n s in a new teach yes or "N" for n	io. (see ii ng io.	0	71.0
	PPS					 75. (
5.00 Is this facility an Inpatient Rehability an Inpatient Rehability and Inpatient Rehability a	abilitation Facility	(IRF), or does it o	contain an IRF	N		/ 5.0

Heal th	Financial Systems FRANCISCAN HEALTH RENSSELAER	In Lie	u of Form CMS-	2552-10		
HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-1324	Peri od: From 01/01/2017 To 12/31/2017	Worksheet S-2 Part I Date/Time Pre	epared:		
			5/31/2018 2:4			
81.00	Long Term Care Hospital PPS Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no. Is this a LTCH co-located within another hospital for part or all of the cost reporti "Y" for yes and "N" for no.	ng period? Enter	N N	80. 00 81. 00		
85. 00 86. 00	TEFRA Providers Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for ye Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Sect §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.		N	85.00 86.00		
87.00	Is this hospital an extended neoplastic disease care hospital classified under section [86(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	on	Ν	87.00		
		V	XI X	_		
	Title V and XIX Services	1.00	2.00	-		
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	- N	Y	90.00		
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	Ν	Y	91.00		
	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00		
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	- N	N	93.00		
	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	Ν	N	94.00		
96.00	If line 94 is "Y", enter the reduction percentage in the applicable column. Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column	0. 00 N	0. 00 N	95.00 96.00		
97. 00 98. 00	applicable column. 0.00 7.00 If line 96 is "Y", enter the reduction percentage in the applicable column. 0.00 8.00 Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in Y					
98. 01	column 1 for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wks C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 fo title XIX.		Y	98. 01		
98. 02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1	Y	Y	98.02		
98. 03	for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAF reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column		Ν	98. 03		
98.04	for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, ar	N	N	98.04		
98.05	in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance o Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and		Y	98. 05		
	column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Υ	Y	98.06		
	Rural Providers Does this hospital qualify as a CAH?	Y		105.00		
	If this facility qualifies as a CAH, has it elected the all-inclusive method of paymet for outpatient services? (see instructions)			106.00		
	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is co			107.00		
108.00	reimbursed. If yes complete Wkst. D-2, Pt. II. Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 4 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	12 N		108.00		
	Physical Occupation		Respi ratory			
	1.002.00If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.Y	3.00 N	4.00 N	109.00		
			1.00	-		
	Did this hospital participate in the Rural Community Hospital Demonstration project (Demonstration)for the current cost reporting period? Enter "Y" for yes or "N" for no. complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 thr applicable.	If yes,	N	110.00		

leal th Financial Systems FRANCISCAN HEALTH HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der CCN: 15-1324	Period: From 01/01		u of For Workshe Part I Date/Ti 5/31/20	et S-2 me Pre	2 epared:
		1.0	C	2.0	00	1
111.00 If this facility qualifies as a CAH, did it participate in the Health Integration Project (FCHIP) demonstration for this cost "Y" for yes or "N" for no in column 1. If the response to colu integration prong of the FCHIP demo in which this CAH is parti Enter all that apply: "A" for Ambulance services; "B" for addi for tele-health services.	er N	_			111.00	
			1.00	2.00	3.00	1
Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or " is yes, enter the method used (A, B, or E only) in column 2. I 3 either "93" percent for short term hospital or "98" percent psychiatric, rehabilitation and long term hospitals providers) Pub. 15-1, chapter 22, §2208.1. 116.00 Is this facility classified as a referral center? Enter "Y" for 117.00 Is this facility legally-required to carry malpractice insurar	f column 2 is "E", ent for long term care (in based on the definiti or yes or "N" for no.	er in column cludes on in CMS	N		0	115. 00 116. 00 117. 00
no. 118.00 s the malpractice insurance a claims-made or occurrence polic	5		1			118.00
claim-made. Enter 2 if the policy is occurrence.				Laour	0000	
	Premi um	S LUSS	25	Insur	ance	
	1.00	2.0		3. (
18.01 List amounts of malpractice premiums and paid losses:	141	, 168	0		(0 118. 0'
18.02 Are malpractice premiums and paid losses reported in a cost ce		1.0 N	C	2.0	00	118.02
Administrative and General? If yes, submit supporting schedul and amounts contained therein. 119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold H §3121 and applicable amendments? (see instructions) Enter in c "N" for no. Is this a rural hospital with < 100 beds that qual Hold Harmless provision in ACA §3121 and applicable amendments Enter in column 2, "Y" for yes or "N" for no.	Harmless provision in A column 1, "Y" for yes o ifies for the Outpatie	CA N		Ν		119. 00 120. 00
21.00 Did this facility incur and report costs for high cost implant patients? Enter "Y" for yes or "N" for no.	table devices charged t	o Y				121.00
22.00 Does the cost report contain healthcare related taxes as defir Act?Enter "Y" for yes or "N" for no in column 1. If column 1 i the Worksheet A line number where these taxes are included.	ned in §1903(w)(3) of t s "Y", enter in column	he Y 2		5.0	00	122. 0
Transplant Center Information 25.00Does this facility operate a transplant center? Enter "Y" for	yes and "N" for no. If	N				125. 0
yes, enter certification date(s) (mm/dd/yyyy) below. 26.00 f this is a Medicare certified kidney transplant center, enter	er the certification da	te				126. 0
in column 1 and termination date, if applicable, in column 2. 27.00 If this is a Medicare certified heart transplant center, enter in column 1 and termination date, if applicable, in column 2.		e				127.0
28.00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 2.	the certification dat	e				128. 0
29.00 If this is a Medicare certified lung transplant center, enter column 1 and termination date, if applicable, in column 2.	the certification date	in				129. 0
30.00 If this is a Medicare certified pancreas transplant center, er date in column 1 and termination date, if applicable, in colum	nn 2.					130.0
31.00 If this is a Medicare certified intestinal transplant center, date in column 1 and termination date, if applicable, in colum	nn 2.					131.0
32.00/If this is a Medicare certified islet transplant center, enter in column 1 and termination date, if applicable, in column 2.						132.0
33.00 If this is a Medicare certified other transplant center, enter in column 1 and termination date, if applicable, in column 2. 34.00 If this is an organ procurement organization (OPO), enter the						133. 0 134. 0
and termination date, if applicable, in column 2. All Providers						-
40.00 Are there any related organization or home office costs as def chapter 10? Enter "Y" for yes or "N" for no in column 1. If ye are claimed, enter in column 2 the home office chain number. (es, and home office cos	ts Y		1580	014	140. 0

	EX IDENTIFICATION DATA	A Provi de	r CCN: 15	-1324	Peri od	: 1/01/2017	Worksheet S- Part I	2
						2/31/2017	Date/Time Pr	
1.00		2.00				3.00	5/31/2018 2:	46 am
If this facility is part of a cha	ín organization, ente		hrough 1	43 the	name an		of the	
home office and enter the home of				<u> </u>				
1.00Name: FRANCISCAN ALLIANCE, INC. 12.00Street: 1515 DRAGOON TRAIL	Contractor's Nar PO Box:	me: WPS 1290	C	Contrac	tor's Nu	mber: 0810)1	141.
13. 00 City: MISHAWAKA	State:	1290 I N	z	Zip Cod	e:	4654	46-1290	142.
							1.00	
44.00 Are provider based physicians' co	sts included in Worksh	heet A?					Y	144.
						1.00	2.00	-
15.00 If costs for renal services are c	aimed on Wkst. A, lir	ne 74, are the c	osts for					145.
inpatient services only? Enter "Y								
no, does the dialysis facility in period? Enter "Y" for yes or "N"		ation for this c	ost repor	rting				
46.00 Has the cost allocation methodolog		reviously filed	cost repo	ort?		Ν		146.
Enter "Y" for yes or "N" for no i	n column 1. (See CMS F				f			
yes, enter the approval date (mm/	dd/yyyy) in column 2.							_
							1.00	-
47.00 Was there a change in the statist	cal basis? Enter "Y"	for yes or "N"	for no.				N N	147.
48.00 Was there a change in the order o	f allocation? Enter "\	Y" for yes or "N	" for no.				N	148.
49.00Was there a change to the simplif	ed cost finding metho						N	149.
		Part A 1.00	F	Part <u>B</u> 2.00	1	<u>itle V</u> 3.00	Title XIX 4.00	-
Does this facility contain a prov	ider that qualifies f		from the		cation o			
or charges? Enter "Y" for yes or								
55.00Hospi tal		N		Ν		N	N	155.
56.00 Subprovider - IPF		N		N		N	N	156.
57. 00 Subprovider - TRF 58. 00 SUBPROVIDER	7.00 Subprovider - IRF N N N						N	157. 158.
59. 00 SNF		N		Ν		Ν	N	159.
60.00 HOME HEALTH AGENCY		N		Ν		Ν	N	160.
61.00 CMHC				N		N	N	161.
							1.00	-
Multicampus							1.00	
65.00 Is this hospital part of a Multica	ampus hospital that ha	as one or more c	ampuses i	in diff	èrent CE	BSAs?	N	165. (
Enter "Y" for yes or "N" for no.	News		C+	ate Z	la Carla			_
				are /				
	Name	County			ip Code	CBSA 4 00	FTE/Campus	
66.00 fline 165 is ves, for each		County 1.00		. 00	3.00	CBSA 4.00	5.00	0166.0
66.00 If line 165 is yes, for each campus enter the name in column					-		5.00	0166.
campus enter the name in column O, county in column 1, state in					-		5.00	0166.
campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3,					-		5.00	0 166.
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					-		5.00	0 166.
campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3,					-		5.00	0 166.
campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)	0	1.00	2.	. 00	3.00		5.00	0 166.
campus 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) Health Information Technology (HI	0 T) incentive in the A	1.00	2.	nvestme	3.00		5.00 0.0	
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	0 T) incentive in the An r under §1886(n)? Ent	1.00 merican Recovery ter "Y" for yes	2. v and Rei i or "N" fc	nvestme pr no.	3.00 ent Act	4.00	5.00 0.0 1.00	167.
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	0 T) incentive in the Ar r under §1886(n)? En D5 is "Y") and is a me HIT assets (see instru	1.00 merican Recovery ter "Y" for yes eaningful user (uctions)	2. and Rein or "N" fc line 167	nvestme pr no. is "Y"	3.00 ent Act), enter	4.00	5.00 0.0 1.00	
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 reasonable cost incurred for the 68.01 If this provider is a CAH and is not	0 T) incentive in the An r under §1886(n)? Ent D5 is "Y") and is a me HIT assets (see instru- not a meaningful user,	1.00 merican Recovery ter "Y" for yes eaningful user (uctions) , does this prov	v and Rein or "N" fc line 167 ider qual	nvestme pr no. is "Y"	3.00 ent Act), enter	4.00	5.00 0.0 1.00	
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 reasonable cost incurred for the 68.01 If this provider is a CAH and is in exception under §413.70(a)(6)(ii)	0 T) incentive in the Au r under §1886(n)? En D5 is "Y") and is a me HIT assets (see instru- not a meaningful user, ? Enter "Y" for yes of	1.00 I.00 Inter "Y" for yes eaningful user (uctions) , does this prov r "N" for no. (s	<u>/ and Rei</u> i or "N" fc line 167 ider qual ee instru	nvestme pr no. is "Y" lify fouctions	3.00 ent Act), enter or a harc	4.00	5.00 0.0 1.00 Y	167. 0168. 168.
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 reasonable cost incurred for the 68.01 If this provider is a CAH and is in exception under §413.70(a)(6)(ii)	0 T) incentive in the Ar r under §1886(n)? En 05 is "Y") and is a me HIT assets (see instru- not a meaningful user, ? Enter "Y" for yes or user (line 167 is "Y")	1.00 I.00 Inter an Recovery ter "Y" for yes eaningful user (uctions) , does this prov r "N" for no. (s	<u>/ and Rei</u> i or "N" fc line 167 ider qual ee instru	nvestme pr no. is "Y" lify fouctions	3.00 ent Act), enter or a harc	4.00	5.00 0.0 1.00 Y	167. 0168. 168.
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 11 reasonable cost incurred for the 16 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	0 T) incentive in the Ar r under §1886(n)? En 05 is "Y") and is a me HIT assets (see instru- not a meaningful user, ? Enter "Y" for yes or user (line 167 is "Y")	1.00 I.00 Inter an Recovery ter "Y" for yes eaningful user (uctions) , does this prov r "N" for no. (s	<u>/ and Rei</u> i or "N" fc line 167 ider qual ee instru	nvestme pr no. is "Y" lify fouctions	3.00 ent Act), enter), enter ;; "N"), e	4.00 - the dship ginning	5. 00 0. 0 1. 00 Y 0. 0 Endi ng	167. (0168. (168. (
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 exception under §413.70(a) (6) (ii) 69.00 If this provider is a meaningful to transition factor. (see instruction	0 T) incentive in the Ar r under §1886(n)? Ent D5 is "Y") and is a me HIT assets (see instru- not a meaningful user, ? Enter "Y" for yes or user (line 167 is "Y") ons)	1.00 merican Recovery ter "Y" for yes eaningful user (uctions) , does this prov r "N" for no. (s) and is not a C	2. v and Rein or "N" fc line 167 ider qual ee instru AH (line	nvestme pr no. i s "Y" li fy fo ucti ons 105 i s	3.00 ent Act), enter or a harc ; "N"), e Be	4.00 - the dship enter the ginning 1.00	5. 00 0. 0 1. 00 Y 0. 0 Endi ng 2. 00	
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 reasonable cost incurred for the 68.01 If this provider is a CAH and is exception under §413.70(a)(6)(ii) 69.00 If this provider is a meaningful of transition factor. (see instruction 70.00 Enter in columns 1 and 2 the EHR	0 T) incentive in the Ar r under §1886(n)? Ent D5 is "Y") and is a me HIT assets (see instru- not a meaningful user, ? Enter "Y" for yes or user (line 167 is "Y") ons)	1.00 merican Recovery ter "Y" for yes eaningful user (uctions) , does this prov r "N" for no. (s) and is not a C	2. v and Rein or "N" fc line 167 ider qual ee instru AH (line	nvestme pr no. i s "Y" li fy fo ucti ons 105 i s	3.00 ent Act), enter or a harc ; "N"), e Be	4.00 - the dship ginning	5. 00 0. 0 1. 00 Y 0. 0 Endi ng	
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 exception under §413.70(a) (6) (ii) 69.00 If this provider is a meaningful to transition factor. (see instruction	0 T) incentive in the Ar r under §1886(n)? Ent D5 is "Y") and is a me HIT assets (see instru- not a meaningful user, ? Enter "Y" for yes or user (line 167 is "Y") ons)	1.00 merican Recovery ter "Y" for yes eaningful user (uctions) , does this prov r "N" for no. (s) and is not a C	2. v and Rein or "N" fc line 167 ider qual ee instru AH (line	nvestme pr no. i s "Y" li fy fo ucti ons 105 i s	3.00 ent Act), enter or a harc ; "N"), e Be	4.00 - the dship enter the ginning 1.00	5. 00 0. 0 1. 00 Y 0. 0 Endi ng 2. 00	- 0167. 0168. 168. 100169.
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 (88.00 If this provider is a CAH (line 10 reasonable cost incurred for the exception under §413.70(a) (6) (ii) 69.00 If this provider is a meaningful of transition factor. (see instruction 70.00 Enter in columns 1 and 2 the EHR	0 T) incentive in the Ar r under §1886(n)? Ent D5 is "Y") and is a me HIT assets (see instru- not a meaningful user, ? Enter "Y" for yes or user (line 167 is "Y") ons)	1.00 merican Recovery ter "Y" for yes eaningful user (uctions) , does this prov r "N" for no. (s) and is not a C	2. v and Rein or "N" fc line 167 ider qual ee instru AH (line	nvestme pr no. i s "Y" li fy fo ucti ons 105 i s	3.00 ent Act), enter or a harc ; "N"), e Be	4.00 - the dship enter the ginning 1.00	5. 00 0. 0 1. 00 Y 0. 0 Endi ng 2. 00	0 166. 1 167. 0 168. 1 168. 1 168. 1 168. 1 170. 1 -
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 exception under \$413.70(a) (6) (ii) 69.00 if this provider is a meaningful transition factor. (see instruction 70.00 Enter in columns 1 and 2 the EHR I period respectively (mm/dd/yyyy) 71.00 if line 167 is "Y", does this provider	0 T) incentive in the Ar r under §1886(n)? En 05 is "Y") and is a me HIT assets (see instru- not a meaningful user, ? Enter "Y" for yes or user (line 167 is "Y") ons) beginning date and end vider have any days fo	1.00 merican Recovery ter "Y" for yes eaningful user (uctions) , does this prov r "N" for no. (s) and is not a C ding date for th	2. and Rein or "N" fc line 167 ider qual ee instru AH (line e reporti nrolled i	nvestme pr no. i s "Y" li fy fo ucti ons 105 i s	3.00 ent Act), enter or a harc ; "N"), e Be	4.00 - the dship enter the <u>gi nni ng</u> 1.00 /05/2017	5.00 0.0 1.00 Y 0.0 Endi ng 2.00 11/03/2017 2.00	
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 1) reasonable cost incurred for the I 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 transition factor. (see instruction 70.00 Enter in columns 1 and 2 the EHR I period respectively (mm/dd/yyyy)	0 T) incentive in the Ar r under §1886(n)? Ent D5 is "Y") and is a me HIT assets (see instru- not a meaningful user, ? Enter "Y" for yes or user (line 167 is "Y") ons) beginning date and end vider have any days for reported on Wkst. S-3,	1.00 merican Recovery ter "Y" for yes eaningful user (uctions) , does this prov r "N" for no. (s) and is not a C ding date for th or individuals e , Pt. I, line 2,	2. and Rein or "N" fc line 167 ider qual ee instru AH (line e reporti nrolled i col. 6?	nvestme pr no. is "Y" ify fo uctions 105 is	3.00 ent Act), enter or a harc); "N"), e Be 08, 08,	4.00 4.00 4.00 5.00 5.00 5.00 1.00 1.00	5.00 0.0 1.00 Y 0.0 Endi ng 2.00 11/03/2017 2.00	- 167. 0168. 168. 10169. - 170.

)SPI T	Financial Systems FRANCISCAN HEAL	Provider C	CN: 15-1324	Period: From 01/01/2017 To 12/31/2017		2 epared:
				¥ /N	5/31/2018 2:4	46 am
				Y/N 1.00	Date 2.00	
	General Instruction: Enter Y for all YES responses. Enter N	for all NO re	snonses Ente			_
	mm/dd/yyyy format.		Sponsos. Ente			
	COMPLETED BY ALL HOSPITALS					
	Provider Organization and Operation					
00	Has the provider changed ownership immediately prior to the			N		1.0
	reporting period? If yes, enter the date of the change in c	olumn 2. (see	Y/N) Date	V/I	
			1.00	2.00	3.00	
00	Has the provider terminated participation in the Medicare P	rogram? If	N	2100	0100	2.0
00	yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary. Is the provider involved in business transactions, includin contracts, with individuals or entities (e.g., chain home o	n 3, "V" for g management	Y			3. 0
	or medical supply companies) that are related to the provid officers, medical staff, management personnel, or members o of directors through ownership, control, or family and othe relationships? (see instructions)	er or its f the board				
			Y/N	Туре	Date	
			1.00	2.00	3.00	
00	Financial Data and Reports Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" f or "R" for Reviewed. Submit complete copy or enter date ava	or Compiled,	Y	A		4.0
00	column 3. (see instructions) If no, see instructions. Are the cost report total expenses and total revenues diffe those on the filed financial statements? If yes, submit rec		N			5.0
				Y/N	Legal Oper.	
				1.00	2.00	_
00	Approved Educational Activities Column 1: Are costs claimed for nursing school? Column 2: the legal operator of the program?	lfyes, is th	ne provider is	s N		6.0
00 00	Are costs claimed for Allied Health Programs? If "Y" see in Were nursing school and/or allied health programs approved cost reporting period? If yes, see instructions.		l during the	N N		7.0
00	Are costs claimed for Interns and Residents in an approved	graduate medic	al education	Ν		9.0
0. 00	program in the current cost report? If yes, see instruction Was an approved Intern and Resident GME program initiated o		he current	Ν		10.0
I. 00	cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	& R in an App	proved	N		11. (
					Y/N 1.00	
	Bad Debts				1.00	
	Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection p			ost reporting	Y N	12. 0 13. 0
1. 00	period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or co-payme Bed Complement	nts waived? If	yes, see ins	structions.	N	14. (
5.00	Did total beds available change from the prior cost reporti	<u>v</u> 1			N + P	15. (
		Y/N	t A Date	Par Y/N	<u>тв</u> Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
b. 00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Ν		N		16. (
7.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date	Y	04/10/2018	Y	04/10/2018	17. (
8. 00	in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this	Ν		N		18.0
9.00	cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R	Ν		N		19.

Health Financial Systems

FRANCI SCAN	HEALTH	RENSSELAER

In Lieu of Form CMS-2552-10

HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-1324	Peri od:	Worksheet S-2	
				From 01/01/2017 To 12/31/2017	Part II Date/Time Pre	narod
				10 12/31/2017	5/31/2018 2:4	6 am
		Descri	ption	Y/N	Y/N	
		()	1.00	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:			N	N	20.00
		Y/N 1.00	Date 2.00	Y/N 3.00	Date 4.00	
21.00	Was the cost report prepared only using the provider's	N 1.00	2.00	N	4.00	21.00
	records? If yes, see instructions.					
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXC	EPT CHILDRENS H	OSPI TALS)		1.00	
	Capital Related Cost				-	
	Have assets been relifed for Medicare purposes? If yes, see				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.	due to apprais	als made dur	ing the cost	N	23.00
24.00	Were new leases and/or amendments to existing leases enter	ed into during	this cost re	porting period?	N	24.00
25.00	If yes, see instructions Have there been new capitalized leases entered into during	the cost repor	ting period?	lf yes, see	Y	25.00
26.00	instructions. Were assets subject to Sec.2314 of DEFRA acquired during t	he cost reporti	ng period? I	f yes, see	N	26.00
27.00	instructions. Has the provider's capitalization policy changed during the	t reportin		vec cubmit	N	27.00
27.00	copy.	e cost reportin	y periou? II	yes, subiii t	IN I	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit en period? If yes, see instructions.	reporting	N	28.00		
29.00	Did the provider have a funded depreciation account and/or	eserve Fund)	Y	29.00		
30.00	treated as a funded depreciation account? If yes, see inst Has existing debt been replaced prior to its scheduled mate	, see	N	30.00		
31.00	instructions. Has debt been recalled before scheduled maturity without is	ssuance of new	debt? If ves	see	N	31.00
	instructions.					
22 00	Purchased Services Have changes or new agreements occurred in patient care se	rvi cos furni sho	d through co	ntractual	Y	32.00
	arrangements with suppliers of services? If yes, see instru	uctions.	0			
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 app no, see instructions.	plied pertainin	g to competi	tive bidding? If	N	33.00
	Provi der-Based Physi ci ans				I	
34.00	Are services furnished at the provider facility under an a	rrangement with	provi der-ba	sed physi ci ans?	N	34.00
	If yes, see instructions.					
35.00	If line 34 is yes, were there new agreements or amended exi physicians during the cost reporting period? If yes, see in		ts with the	provi der-based	N	35.00
				Y/N	Date	
	Home Office Costs			1.00	2.00	
36.00	Were home office costs claimed on the cost report?			Y		36.00
	If line 36 is yes, has a home office cost statement been p	repared by the	home office?			37.00
38.00	If yes, see instructions. If line 36 is yes , was the fiscal year end of the home of	fice different	from that of	N		38.00
39 00	the provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to othe			, N		39.00
	see instructions.		5			
40.00	If line 36 is yes, did the provider render services to the instructions.	home office?	If yes, see	N		40.00
						_
	Cost Report Preparer Contact Information	1.	00	2.	00	
41.00	Enter the first name, last name and the title/position	STEVE		HOWELL		41.00
	held by the cost report preparer in columns 1, 2, and 3,					
42.00	respectively. Enter the employer/company name of the cost report	FRANCI SCAN ALL	I ANCE			42.00
43 00	preparer. Enter the telephone number and email address of the cost	765-428-5927		STEVEN. HOWELL@	FRANCISCANALL	43.00
	report preparer in columns 1 and 2, respectively.			ANCE. ORG		

Heal th	Financial Systems	FRANCI SCAN HEALT	TH RENSSELAER	In Lie	u of Form CMS-:	2552-10
H0SPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT	QUESTI ONNAI RE	Provider CCN: 15-1324	Peri od:	Worksheet S-2	
				From 01/01/2017 To 12/31/2017		pared: <u>6 am</u>
			3.00			
	Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the t	itle/position 🛛 🕅	MANAGER REIMBURSEMENT			41.00
	held by the cost report preparer in colum	ns 1, 2, and 3,				
	respecti vel y.					
42.00	Enter the employer/company name of the co	st report				42.00
	preparer.					
43.00	Enter the telephone number and email addr	ess of the cost				43.00
	report preparer in columns 1 and 2, respe					

	Financial Systems F TAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	RANCISCAN HEALT	Provi der CC	N: 15-1324	Peri od:	u of Form CMS-2 Worksheet S-3	
100111				N. 13 1324	From 01/01/2017 To 12/31/2017	Part I Date/Time Pre	pared:
						5/31/2018 2:4 I/P Days / 0/P	
						Visits / Trips	
	Component	Worksheet A Line Number	No. of Beds	Bed Days Avai I abl e	CAH Hours	Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30.00	21	7,60		0	1.00
	8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2						
2.00	for the portion of LDP room available beds) HMO and other (see instructions)						2.00
3.00	HMO I PF Subprovi der						3.00
4.00	HMO I RF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		21	7,60		0	7.00
8.00	INTENSIVE CARE UNIT	31.00	4	1, 40	60 4, 632. 00	0	8.00
9.00 10.00	CORONARY CARE UNIT						9.00
11.00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						10.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		25	9, 12	25 35, 328. 00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVI DER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00 21.00	NURSING FACILITY OTHER LONG TERM CARE						20.00
21.00	HOME HEALTH AGENCY	101.00				0	21.00
22.00	AMBULATORY SURGICAL CENTER (D. P.)	101.00				0	22.00
24.00	HOSPI CE	116.00	0		0		24.00
24.10	HOSPICE (non-distinct part)	30.00	-		-		24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.03	RURAL HEALTH CLINIC IV	88. 03				0	26.03
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26. 25
27.00	Total (sum of lines 14-26)		25				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00 31.00	Employee discount days (see instruction) Employee discount days - IRF						30.00 31.00
32.00	Labor & delivery days (see instructions)		0		0		31.00
32.00	Total ancillary labor & delivery room		0				32.00
52.01	outpatient days (see instructions)						02.01
33.00	LTCH non-covered days						33.00
33 01	LTCH site neutral days and discharges						33.01

OSPI 1	TAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CC		Period: From 01/01/2017 To 12/31/2017	Worksheet S-3 Part I Date/Time Pre 5/31/2018 2:4	parec
		I/P Days	/ O/P Visits	/ Trips	Full Time E		
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
. 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)	763	123	1, 27	9		1. (
. 00	HMO and other (see instructions)	30	0				2. (
. 00	HMO I PF Subprovi der	0	0				3. (
. 00	HMO I RF Subprovider	0	0	20			4.0
. 00 . 00	Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF	209	0	20	3		5. 6.
. 00	Total Adults and Peds. (exclude observation beds) (see instructions)	972	123	1, 50	-		7.
. 00	INTENSIVE CARE UNIT	108	18	19	3		8.
00	CORONARY CARE UNIT						9.
0. 00	BURN INTENSIVE CARE UNIT						10.
. 00	SURGI CAL INTENSI VE CARE UNI T						11.
2.00	OTHER SPECIAL CARE (SPECIFY)						12.
8.00	NURSERY	1 000	1.4.1	1 / 0	0.00	177 /0	13.
. 00	Total (see instructions)	1, 080 0	141 0	1, 69	4 0.00 0	177.60	14.
. 00	CAH visits SUBPROVIDER - IPF	0	0		0		16
. 00	SUBPROVIDER - I RF						17
. 00	SUBPROVI DER						18
. 00	SKILLED NURSING FACILITY						19
. 00	NURSING FACILITY						20
. 00	OTHER LONG TERM CARE						21
. 00	HOME HEALTH AGENCY	2, 656	0	6, 43	2 0.00	15.80	22
. 00	AMBULATORY SURGICAL CENTER (D. P.)						23
. 00	HOSPI CE	3, 082	90	3, 37	8 0.00	5.37	24
. 10	HOSPICE (non-distinct part)	0	0		0		24
. 00	CMHC - CMHC						25
. 00	RURAL HEALTH CLINIC	300	1, 449	3, 00			
. 03	RURAL HEALTH CLINIC IV	905	1, 605	4, 55			
. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0.00		
. 00	Total (sum of lines 14-26)		89	61	0.00	207.66	27
. 00	Observation Bed Days Ambulance Trips	0	09	01	1		20
. 00	Employee discount days (see instruction)	0			0		30
. 00	Employee discount days - IRF				0		31
. 00	Labor & delivery days (see instructions)	0	0		0		32
2. 01	Total ancillary labor & delivery room	0	0		0		32
	outpatient days (see instructions)				-		
3. 00	LTCH non-covered days	0					33
3. 01	LTCH site neutral days and discharges	0					33

SPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICA	AL DATA	Provider C	CN: 15-1324	Period: From 01/01/2017 To 12/31/2017	Worksheet S-3 Part I Date/Time Pre 5/31/2018 2:4	parec
	Full Time		Di s	charges		
Component	Equi val ents Nonpai d Workers	Title V	Title XVIII	Title XIX	Total All Patients	
-		12.00	13.00	14.00		
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) 00 HMO and other (see instructions) 00 HMO and other (see instructions) 00 HMO and other (see instructions) 00 HMO IRF Subprovider 00 Hospital Adults & Peds. Swing Bed SNF 00 Hospital Adults & Peds. Swing Bed NF 00 Hospital Adults and Peds. (exclude observation beds) (see instructions) 00 INTENSI VE CARE UNIT 00 BURN INTENSI VE CARE UNIT 00 BURN INTENSI VE CARE UNIT 00 SURGI CAL INTENSI VE CARE UNIT 00 NURSERY 00 Total (see instructions) 00 Total (see instructions) 00 SUBPROVI DER - IPF 00 SUBPROVI DER - IRF 00 SUBPROVI DER 0	11.00	12.00 (14.00 62 44 8 0 0 0 62 44	15.00 433 433	2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13.
 OO NURSING FACILITY OO NURSING FACILITY OO THER LONG TERM CARE OO HOME HEALTH AGENCY OO AMBULATORY SURGICAL CENTER (D. P.) HOSPICE HOSPICE (non-distinct part) OO CMHC - CMHC OO RURAL HEALTH CLINIC IN RURAL HEALTH CLINIC IV FEDERALLY QUALIFIED HEALTH CENTER OO Total (sum of lines 14-26) OO Observation Bed Days Ambulance Trips OO Employee discount days (see instruction) OE Employee discount days - IRF OO Labor & delivery days (see instructions) IT Total ancillary labor & delivery room outpatient days (see instructions) LTCH non-covered days And discharges 	0.00 0.00 0.00 0.00 0.00 0.00			0 0		200 21. 22. 23. 24. 25. 26. 26. 26. 26. 27. 28. 29. 30. 31. 32. 33. 33.

Heal th	Financial Systems	FRANCI SCAN HEAL	TH RENSSELAER		In Lie	eu of Form CMS-:	2552-10
	IEALTH AGENCY STATI STI CAL DATA		Provider C	CN: 15-1324	Peri od:	Worksheet S-4	
			Component	CCN: 15-7149	From 01/01/2017 To 12/31/2017		
					Home Health	5/31/2018 2:4 PPS	
					Agency I		
					1	00	-
0.00	County				JASPER	00	0.00
		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
1.00	HOME HEALTH AGENCY STATISTICAL DATA Home Health Aide Hours	0	1, 974	1	0 5, 287	7, 261	1.00
2.00	Unduplicated Census Count (see instructions)	0.00					1
				Number of Em	ployees (Full Ti	me Equivalent)	
			er of hours in	Staff	Contract	Total	
		your normal	l work week				
		(0	1.00	2.00	3.00	
3.00	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES Administrator and Assistant Administrator(s)	1	0.00	0.	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)		0.00	1.			1
5.00	Other Administrative Personnel			5.			
6.00	Direct Nursing Service			4.			1
7.00 8.00	Nursi ng Supervi sor Physi cal Therapy Servi ce			0. 0.			1
9.00	Physical Therapy Supervisor			0.			1
10.00	Occupational Therapy Service			0.			
11.00	Occupational Therapy Supervisor			0.			1
12.00 13.00	Speech Pathol ogy Servi ce Speech Pathol ogy Supervi sor			0. 0.			1
14.00	Medical Social Service			0.			
15.00	Medical Social Service Supervisor			0.			
16.00	Home Health Aide			3.			
17.00 18.00	Home Health Aide Supervisor PRIVATE DUTY			0. 0.			
10.00	HOME HEALTH AGENCY CBSA CODES			0.	0.00	0.10	10.00
19.00	Enter in column 1 the number of CBSAs where				3		19.00
	you provided services during the cost reporting period.						
20.00	List those CBSA code(s) in column 1 serviced			23844			20.00
	during this cost reporting period (line 20						
00.01	contains the first code).						00.01
20. 01 20. 02				29200 99915			20.01
20.02	<u> </u>	Full Ep	pi sodes	////0			20.02
		Wi thout	With Outliers	LUPA Epi sode	-	Total (cols.	
		0utliers 1.00	2.00	3.00	Epi sodes 4. 00	1-4) 5.00	
	PPS ACTIVITY DATA	1.00	2.00	3.00	4.00	5.00	
21.00	Skilled Nursing Visits	609			34 48		
22.00	Skilled Nursing Visit Charges	220, 504					
23.00 24.00	Physical Therapy Visits Physical Therapy Visit Charges	779 292, 650			16 25 05 9,689		
25.00	Occupational Therapy Visits	213			2 8	248	
26.00	Occupational Therapy Visit Charges	79, 667			42 2, 968		
27.00	Speech Pathology Visits	49			0 0	83	
28.00 29.00	Speech Pathology Visit Charges Medical Social Service Visits	18, 754	13, 143	1	0 0	31, 897	
30.00	Medical Social Service Visits	3, 036	-		0 0		
31.00	Home Health Aide Visits	457	95		1 43	596	31.00
32.00	Home Health Aide Visit Charges	80, 356			84 7, 824		
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	2, 114	365		53 124	2, 656	33.00
34.00	Other Charges	0	C		0 0	0	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28,	694, 967	117, 674	19, 1	69 38, 443	870, 253	
26 00	30, 32, and 34) Total Number of Episodes (standard/pop	2 114			50 F	0 170	26 00
36.00	Total Number of Episodes (standard/non outlier)	2, 114			53 5	2, 172	36.00
37.00	Total Number of Outlier Episodes		365		0		
38.00	Total Non-Routine Medical Supply Charges	2, 227	13, 233		0 395	15, 855	38.00

Heal th	Financial Systems F	RANCI SCAN HEAL	TH RENSSELAER		In Lie	eu of Form CMS-:	2552-10
HOSPI T	AL-BASED RHC/FQHC STATISTICAL DATA		Provider C		Period: From 01/01/2017	Worksheet S-8	3
			Component		To 12/31/2017		
	· · · · · · · · · · · · · · · · · · ·				RHC I	Cost	
					1.	00	
1 00	Clinic Address and Identification				400 0 0 5040 0		1 00
1.00	Street		Ci	ty	492 S BIERMA S State	ZIP Code	1.00
				00	2.00	3.00	
2.00	City, State, ZIP Code, County		WHEATFIELD		IN	47978	2.00
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Ente	pr "P" for rur	al or "II" for i	Irban		1.00	3.00
5.00	Those the based rules over besignation - enter				t Award	Date	3.00
					. 00	2.00	
	Source of Federal Funds			1		1	
4.00 5.00	Community Health Center (Section 330(d), PHS Migrant Health Center (Section 329(d), PHS Ac						4.00
5.00 6.00	Health Services for the Homeless (Section 340						6.00
7.00	Appal achi an Regi onal Commi ssi on						7.00
8.00	Look-Alikes						8.00
9.00	OTHER (SPECIFY)						9.00
					1.00	2.00	
10.00	Does this facility operate as other than a ho	ospital-based F	RHC or FQHC? Er	ter "Y" for	N	0	10.00
	yes or "N" for no in column 1. If yes, indica 2. (Enter in subscripts of line 11 the type of hours.)						
		Sur	nday	Mc	nday	Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
11 00	Facility hours of operations (1) CLINIC		1	08:00	16: 30	08:00	1 11 00
11.00				08:00	10:30	08:00	11.00
					1.00	2.00	
	Have you received an approval for an exception				N		12.00
13.00	Is this a consolidated cost report as defined				N	0	13.00
	30.8? Enter "Y" for yes or "N" for no in colunumber of providers included in this report.						
	numbers below.		: -: p: -				
					der name	CCN number	
14.00	RHC/FQHC name, CCN number			1	. 00	2.00	14.00
14.00		Y/N	V	XVIII	XIX	Total Visits	14.00
		1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all						15.00
	GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and						
	4 the number of program visits performed by						
	Intern & Residents for titles V, XVIII, and						
	XIX, as applicable. Enter in column 5 the						
	number of total visits for this provider. (see instructions)						
			Cou	Inty			
				00			
2.00	City, State, ZIP Code, County	·	JASPER				2.00
		Tuesday to	from Wedne	esday to		rsday to	
		6.00	7.00	to 8.00	from 9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	16: 30	08: 00	12:00	08: 00	16: 30	11.00

Health Financial Systems	FRANCI SCAN HEAL	TH RENSSELAER		In Lie	u of Form CMS-2	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider C	CN: 15-1324	Peri od:	Worksheet S-8	
		Component	CCN: 15-3990	From 01/01/2017 To 12/31/2017	Date/Time Pre 5/31/2018 2:4	
			-	RHC I	Cost	
	Fri	day	Sa	turday		
	from	to	from	to		
	11.00	12.00	13.00	14.00		
Facility hours of operations (1)						
11. 00 CLINIC	08: 00	16: 30				11.00

Heal th	Financial Systems	RANCI SCAN HEAL	LTH RENSSELAER		In Lie	eu of Form CMS-	2552-10
HOSPI T	AL-BASED RHC/FQHC STATISTICAL DATA		Provider C		Period: From 01/01/2017	Worksheet S-8	3
_			Component		To 12/31/2017		
					RHC IV	Cost	
					1.	. 00	
1.00	Clinic Address and Identification Street				420 E MAIN ST		1.00
1.00			Ci	ty	State	ZIP Code	1.00
				00	2.00	3.00	
2.00	City, State, ZIP Code, County		BROOK		IN	47922	2.00
2.00	HOCDITAL DACED FOLICE ONLY Destimation Fat			under eine		1.00	2 00
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Ente	er "R" for rura	al or "U" for l		t Award	Date	3.00
				-	1. 00	2.00	
	Source of Federal Funds					2.00	
4.00	Community Health Center (Section 330(d), PHS	Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS A						5.00
6.00	Health Services for the Homeless (Section 340	D(d), PHS Act)					6.00
7.00	Appalachian Regional Commission						7.00
8.00 9.00	Look-Alikes OTHER (SPECIFY)						8.00 9.00
9.00							9.00
					1.00	2.00	
10.00	Does this facility operate as other than a hory yes or "N" for no in column 1. If yes, indica 2. (Enter in subscripts of line 11 the type of the summer of t	ate number of (other operatior	ns in column	N	C	10.00
	hours.)	Sur	nday	Mc	onday	Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00				08: 00	16: 30	08:00	11.00
					1.00	2.00	
12.00	Have you received an approval for an exception		uctivity stand	ard?	1.00 N	2.00	12.00
	Is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in colu	d in CMS Pub. umn 1. If yes,	100-04, chapter enter in colur	r 9, section mn 2 the	N	C	
	number of providers included in this report. numbers below.	LIST THE NAMES	s or all provid	dens and			
				Provi	der name	CCN number	
				1	I. 00	2.00	
14.00	RHC/FQHC name, CCN number			2011-1		.	14.00
		Y/N 1.00	V 2.00	XVIII 3.00	4. 00	Total Visits	
15 00	Have you provided all or substantially all	1.00	2.00	3.00	4.00	5.00	15.00
15.00	GME cost? Enter "Y" for yes or "N" for no in						15.00
	column 1. If yes, enter in columns 2, 3 and						
	4 the number of program visits performed by						
	Intern & Residents for titles V, XVIII, and						
	XIX, as applicable. Enter in column 5 the number of total visits for this provider.						
	(see instructions)						
		1	Сог	unty		1	
				00			
2.00	City, State, ZIP Code, County	T	JASPER				2.00
		Tuesday		esday +o		rsday tota	
		to 6.00	from 7.00	to 8.00	from 9.00	to 10.00	
	Facility hours of operations (1)	0.00	7.00	0.00	7.00	10.00	
11.00		16: 30	08:00	16: 30	08: 00	16: 30	11.00

Health Financial Systems	FRANCI SCAN HEAL	TH RENSSELAER		In Lie	u of Form CMS-2	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider C	CN: 15-1324	Period: From 01/01/2017	Worksheet S-8	
		Component	CCN: 15-8502	To 12/31/2017	Date/Time Pre 5/31/2018 2:4	
				RHC IV	Cost	
	Fri	day	Sa	turday		
	from	to	from	to		
	11.00	12.00	13.00	14.00		
Facility hours of operations (1)						
11.00 CLINIC	08: 00	12:00				11.00

	Financial Systems		RANCI SCAN HEAL				eu of Form CMS-2	
10SPI 1	FAL-BASED HOSPICE IDENTIFICATION	DATA		Provider CC Hospice CC	CN: 15-1324 N: 15-1519	Period: From 01/01/2017 To 12/31/2017		GH IV pared:
						Hospi ce I	0,01,2010 211	<u> </u>
		Unduplicated						
		Days						
		Title XVIII	Title XIX	Title XVIII	Title XIX	All Other	Total (sum of	
				Skilled	Nursi ng		cols. 1, 2 &	
				Nursi ng	Facility		5)	
				Facility				
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART I - ENROLLMENT DAYS FOR CO	OST REPORTING P	PERIODS BEGINNI	NG BEFORE OCTO	BER 1, 2015			
. 00	Hospice Continuous Home Care							1.00
2.00	Hospice Routine Home Care							2.00
3.00	Hospice Inpatient Respite Care							3.00
1.00	Hospice General Inpatient Care							4.00
. 00	Total Hospice Days Part II - CENSUS DATA FOR COST				1 2015			5.00
00		REPORTING PERI	ODS BEGINNING	BEFORE OCTOBER	1, 2015		1	
. 00	Number of patients receiving hospice care							6.00
7.00	Total number of unduplicated							7.00
. 00	Continuous Care hours billable							/.00
	to Medicare							
8. 00	Average Length of Stay (line 5							8.00
	/line 6)							
. 00	Unduplicated census count							9.00
OTE:	Parts I and II, columns 1 and 2	also include t	the days report	ted in columns	3 and 4.			
				Title XVIII	Title XIX	Other	Total (sum of	
							cols. 1	
							through 3)	
				1.00	2.00	3.00	4.00	
	PART III - ENROLLMENT DAYS FOR	COST REPORTING	F PERIODS BEGIN	NING ON OR AFT	ER OCTOBER 1	, 2015		
0.00				0		0 0		1 .0.00
1.00				3, 074		90 238		11.00
2.00				7		0 6		12.00
3.00	The second			1		0 52		13.00
4.00				3, 082		90 296		14.00
F 00	PART IV - CONTRACTED STATISTICA	AL DATA FOR COS	I REPORTING PE					45 00
5.00	The second secon			0		0 0		
	Hospice General Inpatient Care			0		0 0)I O	16.00

Heal th	Financial Systems FRANCISCAN HEALTH R	RENSSELAER		In Lie	eu of Form CMS-2	2552-10
		Provider CC	N: 15-1324	Period: From 01/01/2017	Worksheet S-1	
				To 12/31/2017		
					1.00	
	Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 div	/ided by lin	e 202 column	18)	0. 514612	1.00
	Medicaid (see instructions for each line)				1	
2.00	Net revenue from Medicaid				0	
3.00	Did you receive DSH or supplemental payments from Medicaid?		с н н			3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplement			11 d'?		4.00
5.00 6.00	If line 4 is no, then enter DSH and/or supplemental payments fr Medicaid charges	om medicald			0	5.00 6.00
7.00	Medicaid cost (line 1 times line 6)				0	7.00
8.00	Difference between net revenue and costs for Medicaid program (ling 7 minu	s sum of lir	los 2 and 5 if	0	
0.00	<pre>< zero then enter zero)</pre>		S Sum Of TH		0	0.00
	Children's Health Insurance Program (CHIP) (see instructions fo	or each line)			
9.00	Net revenue from stand-alone CHIP		/		0	9.00
10.00	Stand-alone CHIP charges				0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)				0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP ((line 11 min	us line 9; i	f < zero then	0	12.00
	enter zero)					
	Other state or local government indigent care program (see inst					1 4 9 9 9
13.00	Net revenue from state or local indigent care program (Not incl				0	
14.00	Charges for patients covered under state or local indigent care	e program (N	ot included	In lines 6 or	0	14.00
15.00	10) State or local indigent care program cost (line 1 times line 14	1)			0	15.00
16.00	Difference between net revenue and costs for state or local ind		nrogram (lir	e 15 minus line	-	
10.00	13; if < zero then enter zero)	argent care			0	10.00
	Grants, donations and total unreimbursed cost for Medicaid, CHI	P and state	/local indig	ent care progra	ms (see	1
	instructions for each line)		-			
17.00	Private grants, donations, or endowment income restricted to fu					17.00
18.00	Government grants, appropriations or transfers for support of h				0	
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local 8, 12 and 16)	indigent c	are programs	s (sum of lines	0	19.00
			Uni nsured	Insured	Total (col. 1	
		-	patients	patients	+ col . 2)	
	Uncomponented Core (and instructions for each line)		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	sility		0 0	0	20.00
20.00	(see instructions)	JIILY			0	20.00
21.00	Cost of patients approved for charity care and uninsured discou	ints (see		0 0	0	21.00
211 00	instructions)					2
22.00	Payments received from patients for amounts previously written	off as		0 0	0 0	22.00
	charity care					
23.00	Cost of charity care (line 21 minus line 22)			0 0	0 0	23.00
0.4.00				<u> </u>	1.00	0.4.00
24.00	Does the amount on line 20 column 2, include charges for patien imposed on patients covered by Medicaid or other indigent care		nd a rength	or stay limit		24.00
25.00	If line 24 is yes, enter the charges for patient days beyond th		care program	's length of	0	25.00
20.00	stav limit	ie margent		i s rength of	0	20.00
26.00	Total bad debt expense for the entire hospital complex (see ins	structions)			566, 902	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex	(see instr	uctions)		353, 587	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (s	see instruct	ions)		543, 980	27.01
28.00					22, 922	
29.00		oense (see i	nstructions)		202, 189	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)				202, 189	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus li	ne 30)			202, 189	31.00

EULAS	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF	F EXPENSES	Provider CO	CN: 15-1324	Peri od:	Worksheet A	2552-1
					From 01/01/2017 To 12/31/2017	Date/Time Pre 5/31/2018 2:4	
	Cost Center Description	Sal ari es	Other	Total (col. + col. 2)	1 Reclassificati ons (See A-6)		
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS		2.00	0100		0100	
. 00	00100 CAP REL COSTS-BLDG & FIXT		3, 492, 206	3, 492, 2	06 54, 326	3, 546, 532	1.00
. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	3, 881, 597	3, 881, 5	97 0	3, 881, 597	4.0
. 00	00500 ADMINISTRATIVE & GENERAL	666, 706	9, 958, 576	10, 625, 2	82 -54, 326	10, 570, 956	5.0
. 00	00700 OPERATION OF PLANT	275, 076	1, 278, 206	1, 553, 2	82 0	1, 553, 282	7.0
. 00	00800 LAUNDRY & LINEN SERVICE	72, 299	23, 513		12 0	95, 812	
. 00	00900 HOUSEKEEPI NG	503, 227	99, 016				
0.00	01000 DI ETARY	293, 571	158, 749				
	01100 CAFETERI A	0	0		0 235, 663		
3.00	01300 NURSING ADMINISTRATION	282, 802	7,642				
4.00	01400 CENTRAL SERVICES & SUPPLY	36, 837	380, 559				
	01500 PHARMACY	390, 646	1, 822, 908				
6.00	01600 MEDI CAL RECORDS & LI BRARY	0	834, 946	834, 9	46 0	834, 946	16.0
	INPATIENT ROUTINE SERVICE COST CENTERS	074 040	0.05/	000.1	20	000.400	1
0.00	03000 ADULTS & PEDIATRICS	871, 943	8, 256				
1.00		574, 764	7, 139	581, 9	03 0	581, 903	31.0
0.00	ANCI LLARY SERVI CE COST CENTERS	425, 917	559, 603	985, 5	20 31, 470	1, 016, 990	50.0
4.00	05400 RADI OLOGY-DI AGNOSTI C		613, 421				
0.00	06000 LABORATORY	761, 109 0	1, 526, 662				
3.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	50, 118			50, 118	
5.00	06500 RESPIRATORY THERAPY	668, 267	84, 400			752, 667	
6.00	06600 PHYSI CAL THERAPY	748, 881	51, 935				
6. 01	06601 WHEATFI ELD PT	275, 078	7, 526				
7.00	06700 OCCUPATI ONAL THERAPY	150, 016	436			150, 452	
7.01	06701 WHEATFI ELD OT	80, 162	5, 077				
8.00	06800 SPEECH PATHOLOGY	96, 735	491	97, 2			
8.01	06801 WHEATFI ELD ST	59,039	777	59,8			
1.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	389, 161	389, 1			
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	187, 490				
	07300 DRUGS CHARGED TO PATIENTS	0	0		0 0		
	OUTPATIENT SERVICE COST CENTERS				L		1
8.00	08800 RURAL HEALTH CLINIC	271, 322	53, 969	325, 2	91 0	325, 291	88.0
8. 03	08801 RURAL HEALTH CLINIC IV	341, 724	57, 570	399, 2	94 0	399, 294	88.0
0.00	09000 CLI NI C	1, 007, 936	109, 472	1, 117, 4	08 0	1, 117, 408	90.0
1.00	09100 EMERGENCY	949, 341	1, 086, 449	2, 035, 7	90 0	2, 035, 790	91.0
2.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.0
	OTHER REIMBURSABLE COST CENTERS	I					
01.00	10100 HOME HEALTH AGENCY	794, 142	376, 696	1, 170, 8	38 0	1, 170, 838	101. 0
	SPECIAL PURPOSE COST CENTERS						
	11600 HOSPI CE	320, 248	231,002				
18.00		10, 917, 788	27, 345, 568	38, 263, 3	56 0	38, 263, 356	118.0
~ ~	NONREI MBURSABLE COST CENTERS	0			0	0	1100 0
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	0	0		0 0		190.0
		0	0		0 0		192.0
	19201 RENSSELAER HEALTH CENTER 07950 ALTERNACARE		U 17 100	404 0		686, 955	192.0
	07950 ALTERNACARE 07951 DME EQUIPMENT	669, 765	17, 190	686, 9			
	07951 DME EQUIPMENT 07952 WHEATFIELD FITNESS	214 045	04 433	011 F		311, 598	194.0
	07952 WHEATFIELD FITNESS 07957 JOHNSON FITNESS	216, 965 381, 697	94, 633			403, 832	
	07957 JOHNSON FITNESS 07953 FOUNDATION	301,07/	22, 135	403,8	32 U 0 0		194.0
	07953 FOUNDATION 07954 MEALS ON WHEELS	0	0		0 0		194.0
	07954 MEALS ON WHEELS 07955 WATER LAB	0	0				194.0
		U	0		J 0		
	07956 ADVERTI SI NG		0		0 0	∩	194.0

Health Financial Systems	FRANCI SCAN HEALT	TH RENSSELAER	In Lie	u of Form CMS-2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE		Provider CCN: 15-132	24 Period:	Worksheet A
			From 01/01/2017 To 12/31/2017	Data /Tima Dranaradi
			To 12/31/2017	Date/Time Prepared: 5/31/2018 2:46 am
Cost Center Description	Adjustments	Net Expenses		
	· · · · · · · · · · · · · · · · · · ·	For Allocation		
	6.00	7.00		
GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT	520, 659	4,067,191		1.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	630, 970	4, 512, 567		4.00
5. 00 00500 ADMINI STRATI VE & GENERAL	-2, 779, 170	7, 791, 786		5.00
7.00 00700 OPERATION OF PLANT	2, 777, 170	1, 553, 282		7.00
8.00 00800 LAUNDRY & LINEN SERVICE	0	95, 812		8.00
9. 00 00900 HOUSEKEEPI NG	-929	569, 844		9.00
10. 00 01000 DI ETARY	-37,669	178, 988		10.00
11. 00 01100 CAFETERI A	-57, 126	178, 537		11.00
13.00 01300 NURSING ADMINISTRATION	142, 242	432, 686		13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	-293, 057	124, 339		14.00
15. 00 01500 PHARMACY	-18, 420	2, 195, 134		15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	-432, 419	402, 527		16.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS	0	880, 199		30.00
31. 00 03100 I NTENSI VE CARE UNI T	0	581, 903		31.00
ANCI LLARY SERVI CE COST CENTERS	104 540	500 444		F0.00
50. 00 05000 OPERATING ROOM	-426, 549	590, 441		50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 60. 00 06000 LABORATORY	-3, 693 -5, 490	1, 370, 837		54.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	-5, 490	1, 521, 172 50, 118		60. 00 63. 00
65. 00 06500 RESPI RATORY THERAPY	-4, 923	747, 744		65.00
66. 00 06600 PHYSI CAL THERAPY	-4, 723	800, 816		66.00
66. 01 06601 WHEATFI ELD PT	0	282, 604		66. 01
67. 00 06700 OCCUPATI ONAL THERAPY	0	150, 452		67.00
67. 01 06701 WHEATFIELD OT	0	85, 239		67.01
68.00 06800 SPEECH PATHOLOGY	0	97, 226		68.00
68. 01 06801 WHEATFI ELD ST	0	59, 816		68. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	389, 161		71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	187, 490		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		73.00
OUTPATIENT SERVICE COST CENTERS				
88.00 08800 RURAL HEALTH CLINIC	0	325, 291		88.00
88.03 08801 RURAL HEALTH CLINIC IV	0	399, 294		88.03
90. 00 09000 CLINIC	0	1, 117, 408		90.00
91.00 09100 EMERGENCY	-150	2,035,640		91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART				92.00
OTHER REIMBURSABLE COST CENTERS	0	1, 170, 838		101.00
SPECIAL PURPOSE COST CENTERS	0	1, 170, 838		101.00
116. 00 11600 HOSPI CE	0	551, 250		116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)		35, 497, 632		118.00
NONREI MBURSABLE COST CENTERS				
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	o		192.00
192.01 19201 RENSSELAER HEALTH CENTER	0	o		192.01
194. 00 07950 ALTERNACARE	0	686, 955		194.00
194. 01 07951 DME EQUI PMENT	0	0		194.01
194. 02 07952 WHEATFI ELD FI TNESS	0	311, 598		194.02
194.0307957 JOHNSON FITNESS	0	403, 832		194.03
194. 04 07953 FOUNDATI ON	0	0		194.04
194.05 07954 MEALS ON WHEELS	0	0		194.05
194. 06 07955 WATER LAB	0	0		194.06
194. 07 07956 ADVERTI SI NG	0	0		194.07
200.00 TOTAL (SUM OF LINES 118 through 199)	-2, 765, 724	36, 900, 017		200.00

Heal th	Financial Systems		FRANCI SCAN HEAL	TH RENSSELAER		In Lieu	u of Form CMS	-2552-10
RECLASS	SI FI CATI ONS			Provider (CCN: 15-1324	Period: From 01/01/2017 To 12/31/2017	Worksheet A- Date/Time Pr	
						10 12/31/2017	5/31/2018 2:	<u>46 am</u>
		Increases						
	Cost Center	Li ne #	Sal ary	0ther				
	2.00	3.00	4.00	5.00				
	A – CAFETERIA							
1.00	CAFETERI A	11.00	152, 953	82, 710				1.00
	0 — — — — — — —		152, 953	82, 710				
	B - PROPERTY INSURANCE							1
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	54, 326				1.00
	0 — — — — — —		0	54, 326				1
	C - HOUSEKEEPING							1
1.00	OPERATING ROOM	50.00	31, 470	0				1.00
	0		31, 470	0				1
500.00	Grand Total: Increases		184, 423	137, 036				500.00

Heal th	Financial Systems		FRANCI SCAN HEAL	TH RENSSELAER		In Lie	u of Form CMS	2552-10
RECLAS	SIFICATIONS			Provider (CCN: 15-1324	Period: From 01/01/2017	Worksheet A-	6
						To 12/31/2017	Date/Time Pro 5/31/2018 2:	epared: 46 am
		Decreases						
	Cost Center	Line #	Sal ary	0ther	Wkst. A-7 Ref	,		
	6.00	7.00	8.00	9.00	10.00			
	A – CAFETERIA							
1.00	DI ETARY	10.00	152, 953	82, 710)	0		1.00
	0 — — — — — — —		152, 953	82, 710				
	B - PROPERTY INSURANCE							1
1.00	ADMI NI STRATI VE & GENERAL	5.00	0	54, 326	1	2		1.00
	0 — — — — — — — —		0	54, 326	,	7		
	C - HOUSEKEEPING		•					1
1.00	HOUSEKEEPI NG	9.00	31, 470	0)	0		1.00
	0 — — — — — — —		31, 470	0		7		
500.00	Grand Total: Decreases		184, 423	137, 036				500.00

RECONCILIATION OF CAPITAL COSTS CENTERS Provider CCN: 15-1324 Period: From 01/01/2017 To 12/31/2018 Worksheet A-7 Pat / I me Prepa 5/31/2018 Worksheet A-7 Pat / I me Prepa 5/31/2018 Period: Pat / I me Prepa 5/31/2018 Worksheet A-7 Pat / I me Prepa 5/31/2018 PRT I - Acquisitions Donation Total Disposal s and Retirements 1.00 2.00 3.00 4.00 5.00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 0 0 0 1.00 Land 675,791 0 0 0 0 2.00 Buildings and Fixtures 0 0 0 0 0 3.00 Building Improvements 16,471,346 474,634 0 474,634 0 5.00 Fixed Equipment 7,048,087 3,794,715 3,794,715 0 0 0 6.00 Morable Equipment 7,048,087 3,794,715 0 0 0 7.00 HIT designated Assets 0 0 0 0 0 0 8.00 Subtotal (sum o	52-10
PART I Analysis <	
$\begin{tabular}{ c c c c c c c c c c c c c c c c c c c$	
Beginning Balances Purchases Donation Total Disposal s and Retirements 1.00 2.00 3.00 4.00 5.00 7.00 PART 1 - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 675,791 0 0 0 0 1.00 Land 675,791 0 0 0 0 0 2.00 Buildings and Fixtures 0 0 0 0 0 0 0 3.00 Building Improvements 16,471,346 474,634 0 474,634 0	
Bal ances Retirements 1.00 2.00 3.00 4.00 5.00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 0 <th< td=""><td></td></th<>	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 Land 675,791 0 0 0 2.00 Land Improvements 484,426 0 0 0 0 3.00 Buildings and Fixtures 0 0 0 0 0 0 4.00 Building Improvements 16,471,346 474,634 0	
1.00 Land 675,791 0 0 0 0 2.00 Land Improvements 484,426 0 0 0 0 3.00 Buildings and Fixtures 0 0 0 0 0 4.00 Building Improvements 16,471,346 474,634 0 474,634 0 5.00 Fixed Equipment 0 0 0 0 0 0 6.00 Movable Equipment 7,048,087 3,794,715 0 3,794,715 0 7.00 HIT designated Assets 0 0 0 0 0 0 8.00 Subtotal (sum of lines 1-7) 24,679,650 4,269,349 0 4,269,349 0	
2.00 Land Improvements 484,426 0 0 0 0 3.00 Buildings and Fixtures 0 0 0 0 0 4.00 Building Improvements 16,471,346 474,634 0 474,634 0 5.00 Fixed Equipment 0 0 0 0 0 6.00 Movable Equipment 7,048,087 3,794,715 0 0 0 7.00 HIT designated Assets 0 0 0 0 0 0 8.00 Subtotal (sum of lines 1-7) 24,679,650 4,269,349 0 4,269,349 0	
3.00 Buildings and Fixtures 0 0 0 0 4.00 Building Improvements 16,471,346 474,634 0 474,634 0 5.00 Fixed Equipment 0 0 0 0 0 0 6.00 Movable Equipment 7,048,087 3,794,715 0 3,794,715 0 7.00 HIT designated Assets 0 0 0 0 0 8.00 Subtotal (sum of lines 1-7) 24,679,650 4,269,349 0 4,269,349 0	1.00
4.00 Building Improvements 16,471,346 474,634 0 474,634 0 5.00 Fixed Equipment 0 0 0 0 0 0 6.00 Movable Equipment 7,048,087 3,794,715 0 3,794,715 0 7.00 HIT designated Assets 0 0 0 0 0 8.00 Subtotal (sum of lines 1-7) 24,679,650 4,269,349 0 4,269,349 0	2.00
5.00 Fixed Equipment 0	3.00
6.00 Movable Equipment 7,048,087 3,794,715 0 3,794,715 0 7.00 HIT designated Assets 0 0 0 0 0 8.00 Subtotal (sum of lines 1-7) 24,679,650 4,269,349 0 4,269,349 0	4.00
7.00 HIT designated Assets 0 <td>5.00</td>	5.00
8.00 Subtotal (sum of lines 1-7) 24,679,650 4,269,349 0 4,269,349 0	6.00
	7.00
9.00 Reconciling Items 0 0 0 0	8.00
	9.00
10.00 Total (line 8 minus line 9) 24,679,650 4,269,349 0 4,269,349 0	0.00
Ending Balance Fully	
Depreciated	
Assets	
6.00 7.00	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES	
1.00 Land 675,791 0	1.00
2.00 Land Improvements 484,426 0	2.00
3.00 Buildings and Fixtures 0 0	3.00
4.00 Building Improvements 16,945,980 0	4.00
5.00 Fixed Equipment 0 0	5.00
6.00 Movable Equipment 10, 842, 802 0	6.00
7.00 HIT designated Assets 0 0	7.00
8.00 Subtotal (sum of lines 1-7) 28,948,999 0	8.00
9.00 Reconciling Items 0 0	9.00
10.00 Total (line 8 minus line 9) 28,948,999 0	0.00

Heal th	Financial Systems	FRANCI SCAN HEAL	TH RENSSELAER		In Lie	u of Form CMS-:	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provider CO		Period: From 01/01/2017 To 12/31/2017		pared:
			SL	IMMARY OF CAPI	TAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WO	RKSHEET A, COLUN	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	2, 680, 566	0	811, 64	0 0	0	1.00
3.00	Total (sum of lines 1-2)	2, 680, 566	0	811, 64	0 0	0	3.00
		SUMMARY C	OF CAPITAL				
	Cost Center Description	0ther	Total (1) (sum				
		Capi tal -Rel ate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WC	RKSHEET A, COLUN	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	3, 492, 206				1.00
3.00	Total (sum of lines 1-2)	0	3, 492, 206				3.00

Health Financial Systems	RANCI SCAN HEAL	TH RENSSELAER		In Lie	eu of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider CO		Period: From 01/01/2017 To 12/31/2017		hared:
				10 12/01/2017	5/31/2018 2:46	5 am
	COM	PUTATION OF RAT	FI OS	ALLOCATION OF	OTHER CAPITAL	
Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets	Ratio (see	Insurance	
		Leases	for Ratio	instructions)		
			(col. 1 - col			
			2)			
	1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CI						
1.00 CAP REL COSTS-BLDG & FLXT	28, 948, 999		28, 948, 99			1.00
3.00 Total (sum of lines 1-2)	28, 948, 999		28, 948, 99			3.00
	ALLOCA	FION OF OTHER C	CAPI TAL	SUMMARY C	OF 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 COSTS CI				1		
1.00 CAP REL COSTS-BLDG & FIXT	0	-		0 2, 618, 138		1.00
3.00 Total (sum of lines 1-2)	0	0		0 2, 618, 138	0	3.00
		SL	JMMARY OF CAPI			
Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
		instructions)	instructions)	Capital-Relate		
				d Costs (see	through 14)	
				instructions)		
	11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CI			1			
1.00 CAP REL COSTS-BLDG & FIXT	780, 295			0 614, 432		1.00
3.00 Total (sum of lines 1-2)	780, 295	54, 326	1	0 614, 432	4, 067, 191	3.00

	Heal t	h Financial	Systems	
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FRANCISCAN HEALTH RENSSELAER

Heal th	Financial Systems	F	RANCI SCAN HEALT	H RENSSELAER	In Lie	u of Form CMS-2	2552-10
ADJUST	MENTS TO EXPENSES			Provider CCN: 15-1324	Period: From 01/01/2017	Worksheet A-8	
					To 12/31/2017	Date/Time Pre	
				Evenence Classification a	Waskabaat A	5/31/2018 2:4	6 am
				Expense Classification on Fo/From Which the Amount is			
				To Thom will car the Amount 13	to be haj astea		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL	В	-40, 2890	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	COSTS-BLDG & FIXT (chapter 2) Investment income - CAP REL		0.*	*** Cost Center Deleted ***	2.00	0	2.00
2.00	COSTS-MVBLE EQUIP (chapter 2)		0	cost center bereted	2.00	0	2.00
3.00	Investment income - other		0		0.00	0	3.00
	(chapter 2)						
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of		О		0.00	0	5.00
	expenses (chapter 8)						
6.00	Rental of provider space by		0		0.00	0	6.00
7.00	suppliers (chapter 8) Telephone services (pay		0		0.00	0	7.00
7.00	stations excluded) (chapter		0		0.00	0	7.00
	21)						
8.00	Tel evi si on and radio servi ce		0		0.00	0	8.00
9.00	(chapter 21) Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provi der-based physi ci an	A-8-2	-4, 388		0.00	0	
	adjustment						
11.00	Sale of scrap, waste, etc.		0		0.00	0	11.00
12.00	(chapter 23) Related organization	A-8-1	-579, 181			0	12.00
12.00	transactions (chapter 10)	A O I	377, 101			0	12.00
	Laundry and linen service		0		0.00	0	
	Cafeteria-employees and guests		0		0.00		
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical		О		0.00	0	16.00
	supplies to other than						
17 00	patients				0.00		17 00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and	В	-698 M	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
	abstracts						
19.00	Nursing and allied health		0		0.00	0	19.00
	education (tuition, fees, books, etc.)						
20.00	Vending machines		О		0.00	0	20.00
21.00	Income from imposition of		0		0.00	0	21.00
	interest, finance or penal ty						
22.00	charges (chapter 21) Interest expense on Medicare		0		0.00	0	22.00
22.00	overpayments and borrowings to		0		0.00	0	22.00
	repay Medicare overpayments						
23.00	Adjustment for respiratory	A-8-3	OF	RESPI RATORY THERAPY	65.00		23.00
	therapy costs in excess of limitation (chapter 14)						
24.00	Adjustment for physical	A-8-3	OF	PHYSICAL THERAPY	66.00		24.00
	therapy costs in excess of						
25 00	limitation (chapter 14)		0*	*** Cost Center Deleted ***	114 00		25.00
25.00	Utilization review - physicians' compensation		0	cost center bereted	114.00		25.00
	(chapter 21)						
26.00	Depreciation - CAP REL		00	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27 00	COSTS-BLDG & FIXT Depreciation - CAP REL		0.*	*** Cost Center Deleted ***	2.00	0	27.00
27.00	COSTS-MVBLE EQUIP		0	cost center bereted	2.00	0	27.00
28.00	Non-physician Anesthetist		0 *	*** Cost Center Deleted ***	19.00		28.00
	Physicians' assistant		0		0.00		
30.00	Adjustment for occupational	A-8-3	00	OCCUPATIONAL THERAPY	67.00		30.00
	therapy costs in excess of limitation (chapter 14)						
30. 99	Hospice (non-distinct) (see		OA	ADULTS & PEDIATRICS	30.00		30. 99
04 55	instructions)						04 55
31.00	Adjustment for speech pathology costs in excess of	A-8-3	05	SPEECH PATHOLOGY	68.00		31.00
	limitation (chapter 14)						
32.00	CAH HIT Adjustment for	A	-13,6000	CAP REL COSTS-BLDG & FIXT	1.00	9	32.00
00.00	Depreciation and Interest		1 454 30			_	22.02
33.00	HAF OFFSET	A	-1,456,724A	ADMI NI STRATI VE & GENERAL	5.00	0	33.00

Heal th	Financial Systems	F	RANCI SCAN HEAL	TH RENSSELAER	In Lie	u of Form CMS-2	2552-10
ADJUST	MENTS TO EXPENSES			Provider CCN: 15-1324	Peri od:	Worksheet A-8	
					From 01/01/2017 To 12/31/2017	Date/Time Pre 5/31/2018 2:4	
				Expense Classification of			
				To/From Which the Amount i	s to be Adjusted		
	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	
39.00	OTHER REVENUE	В	-57, 267	CAP REL COSTS-BLDG & FIXT	1.00	9	39.00
40.00	OTHER REVENUE	В	-48, 897	ADMI NI STRATI VE & GENERAL	5.00	0	40.00
40.01	OTHER REVENUE	В	-929	HOUSEKEEPI NG	9.00	0	40.01
40.02	OTHER REVENUE	В	-37,669	DI ETARY	10.00	0	40.02
40.03	OTHER REVENUE	В	-57, 126	CAFETERI A	11.00	0	40.03
40.04	OTHER REVENUE	В		NURSING ADMINISTRATION	13.00	0	40.04
40.05	OTHER REVENUE	В	-3, 137	CENTRAL SERVICES & SUPPLY	14.00	0	40.05
40.06	OTHER REVENUE	В	-25, 211	PHARMACY	15.00	0	40.06
40.07	OTHER REVENUE	В	-6, 214	OPERATING ROOM	50.00	0	40.07
40.08	OTHER REVENUE	В	-3, 693	RADI OLOGY-DI AGNOSTI C	54.00	0	40.08
40.09	OTHER REVENUE	В	-5, 490	LABORATORY	60.00	0	40.09
40. 10	OTHER REVENUE	В	-1, 535	RESPI RATORY THERAPY	65.00	0	40.10
40. 11	OTHER REVENUE	В	-150	EMERGENCY	91.00	0	40.11
41.00	LOBBYI NG	A	-738	ADMI NI STRATI VE & GENERAL	5.00	0	41.00
42.00	ANESTHESI A	A		OPERATING ROOM	50.00	0	42.00
43.00	DEPRECIATION CARRY FORWARD	A		CAP REL COSTS-BLDG & FIXT	1.00	9	10.00
50.00	TOTAL (sum of lines 1 thru 49)		-2, 765, 724				50.00
	(Transfer to Worksheet A,						
	column 6, line 200.)						

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
Note: See instructions for column 5 referencing to Worksheet A-7.

Heal th	Financial Systems	FRANCI SCAN HEA	ALTH RENSSELAER	In Lie	eu of Form CMS-:	2552-10
STATEM	ENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HO		Peri od:	Worksheet A-8	-1
OFFI CE	COSTS			From 01/01/2017		
				To 12/31/2017	Date/Time Pre 5/31/2018 2:4	
	Line No.	Cost Center	Expense Items	Amount of	Amount	
				Allowable Cost		
					Wks. A, column	
					5	
	1.00	2.00	3.00	4.00	5.00	
		MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED O	RGANIZATIONS OR	CLAI MED	
	HOME OFFICE COSTS:	1	1	1		
1.00			ALLOWABLE NEW CAPITAL COSTS	614, 432		1.00
2.00			INTEREST	8, 944		2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	ADMI NI STRATI VE & GENERAL	4, 989, 814	6, 770, 278	3.00
4.00		NURSING ADMINISTRATION	NURSING ADMIN	0	1, 330	4.00
4.01	14.00	CENTRAL SERVICES & SUPPLY	CENTRAL SUPPLY	0	289, 920	4.01
4.02	15.00	PHARMACY	COVP / PHARMACY	17, 913	66, 360	4.02
4.03	16.00	MEDICAL RECORDS & LIBRARY	HIM	364, 634	796, 355	4.03
4.04	1.00	CAP REL COSTS-BLDG & FIXT	INTEREST	799, 703	799, 703	4.04
4.05	4.00	EMPLOYEE BENEFITS DEPARTMENT	SHARED SERVICES	630, 970	0	4.05
4.06	5.00	ADMINISTRATIVE & GENERAL	SHARED SERVICES	507, 653	0	4.06
4.07	13.00	NURSING ADMINISTRATION	SHARED SERVICES	155, 464	0	4.07
4.08	15.00	PHARMACY	SHARED SERVICES	55, 238	0	4.08
5.00	TOTALS (sum of lines 1-4).			8, 144, 765	8, 723, 946	5.00
	Transfer column 6, line 5 to					
	Worksheet A-8, column 2,					
	line 12.					

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

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	
		Symbol (1)	Nume	, v	Name	Ŭ I	
				Ownership		Ownershi p	
		1.00	2.00	3.00	4.00	5.00	
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:							

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

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

i oi mour				
6.00	В	FRANCI SCAN ALLI	100.00	0.00 6.00
7.00			0.00	0.00 7.00
8.00			0.00	0.00 8.00
9.00			0.00	0.00 9.00
10.00			0.00	0.00 10.00
100.00	G. Other (financial or			100.00
	non-financial) specify:			

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

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

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

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

D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related 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	FRANCI SCAN HEALTH	RENSSELAER	In Lie	u of Form CMS-2552-10
STATEMENT OF COSTS OF SERVICES FROM	M RELATED ORGANIZATIONS AND HOME	Provider CCN: 15-1324	Period: From 01/01/2017	Worksheet A-8-1
			To 12/31/2017	Date/Time Prepared:

			5/31/2018 2:4	46 am
	Net	Wkst. A-7 Ref.		
	Adjustments			
	(col. 4 minus			
	col. 5)*			
	6.00	7.00		
	A. COSTS INCUR	RED AND ADJUSTN	IENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED	
	HOME OFFICE CO	STS:		
1.00	614, 432	14		1.00
2.00	8, 944	11		2.00
3.00	-1, 780, 464	0		3.00
4.00	-1, 330	0		4.00
4.01	-289, 920	0		4.01
4.02	-48, 447	0		4.02
4.03	-431, 721	0		4.03
4.04	0	11		4.04
4.05	630, 970	0		4.05
4.06	507, 653			4.06
4.07	155, 464			4.07
4.08	55, 238			4.08
5.00	-579, 181			5.00

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

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

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

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

6.00	6.00
7.00	7.00
8.00	8.00
9.00	9.00
10.00	10.00
6. 00 7. 00 8. 00 9. 00 10. 00 100. 00	100.00

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

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

- B. Corporation, partnership, or other organization has financial interest in provider.
 C. Provider has financial interest in corporation, partnership, or other organization.

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

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

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

Heal th	Financial Syste	ems	FRANCI SCAN HEA	LTH RENSSELAER		In Lie	eu of Form CMS-	2552-10
	R BASED PHYSIC				CCN: 15-1324	Period: From 01/01/2017 To 12/31/2017	Worksheet A-8 7 7 Date/Time Pre	3-2 epared:
	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	5/31/2018 2:4 Physician/Prov ider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMI NI STRATI VE & GENERAL	164, 109	0	164, 109	9 0	0	1.00
2.00	50.00	OPERATING ROOM	1,000	1,000	(0 0	0	2.00
3.00		LABORATORY	32, 850		32, 850	0 0	0	3.00
4.00		RESPI RATORY THERAPY	17, 898	3, 388	14, 510	0 0	0	4.00
5.00		EMERGENCY	1, 036, 212	0	1, 036, 212	2 0	0	5.00
6.00	0.00		0	0	(0	
7.00	0.00		0	0	(0 0	0	
8.00	0.00		0	0	(0 0	0	
9.00	0.00		0	0	(0 0	0	
10.00	0.00		0	0	(0 0	0	
200.00			1, 252, 069				0	
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE		Cost of	Provi der	Physician Cost	
		rdentrirer	Limit	Unadjusted RCE Limit	Continuing	Component Share of col.	of Malpractice Insurance	
					Education	12	Thisui ance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00		ADMI NI STRATI VE & GENERAL	0.00			0 0		1.00
2.00		OPERATI NG ROOM	0		(
3.00		LABORATORY	0		(0	
4.00	65.00	RESPI RATORY THERAPY	0	0	(0 0	0	
5.00	91.00	EMERGENCY	0	0	(o o	0	5.00
6.00	0.00		0	0	(o o	0	6.00
7.00	0.00		0	0	(o o	0	7.00
8.00	0.00		0	0	(o o	0	8.00
9.00	0.00		0	0	(0 0	0	9.00
10.00	0.00		0	0	(0 0	0	10.00
200.00			0	0	(°	0	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		ldentifier	Component	Limit	Di sal I owance			
			Share of col.					
	1.00	2.00	14 15. 00	16.00	17.00	18.00	-	
1.00		ADMI NI STRATI VE & GENERAL	0		17.00			1.00
2.00		OPERATI NG ROOM	0			1,000		2.00
3.00		LABORATORY	0		(3.00
4.00		RESPI RATORY THERAPY	0	0	(°		4.00
5.00		EMERGENCY	0	0	(5.00
6.00	0.00		0	0	(-		6.00
7.00	0.00		0	0	(7.00
8.00	0.00		0	0	(8.00
9.00	0.00		0	0	(n n		9.00
10.00	0.00		0	0	(10.00
200.00			0	0	(4, 388		200.00

	NABLE COST DETERMINATION FOR THERAPY SERVICES DE SUPPLIERS	FURNI SHED BY	Provider CC	CN: 15-1324	Period: From 01/01/2017 To 12/31/2017		pared:			
					Physical Therapy	5/31/2018 2:46 Cost				
						1.00				
	PART I - GENERAL INFORMATION					1.00				
1.00	Total number of weeks worked (excluding aides	s) (see instruc	ti ons)			31	1.00			
2.00 3.00	Line 1 multiplied by 15 hours per week Number of unduplicated days in which supervis	or or thoranic	t was on provid	dor cito (c	o instructions)	465 140	2.00 3.00			
4.00	Number of unduplicated days in which therapy					0	4.00			
	nor therapist was on provider site (see insti	ructions)								
5.00	Number of unduplicated offsite visits - super				by thereasy	0	5.00 6.00			
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy 0 assistant and on which supervisor and/or therapist was not present during the visit(s)) (see									
	instructions)									
7.00	Standard travel expense rate					0.00	7.00			
8.00	Optional travel expense rate per mile	Supervi sors	Therapi sts	Assi stants	s Ai des	0.00 Trai nees	8.00			
		1.00	2.00	3.00	4.00	5.00				
9.00	Total hours worked	0.00	1, 136. 00		. 00 0. 00		9.00			
10.00 11.00		0. 00 40. 52	81. 04 40. 52		. 00 0. 00 . 00	0.00	10.00 11.00			
11.00	one-half of column 2, line 10; column 3,	10. 02	10. 02	0.						
	one-half of column 3, line 10)						10.00			
12.00 12.01	Number of travel hours (provider site) Number of travel hours (offsite)	0	0		0		12.00 12.01			
13.00		0	0		0		13.00			
13.01	Number of miles driven (offsite)	0	7, 267		0		13.01			
						1.00				
	Part II - SALARY EQUIVALENCY COMPUTATION					1.00				
14.00	Supervisors (column 1, line 9 times column 1,	line 10)				0	14.00			
15.00						92, 061	15.00			
16.00 17.00			catory therapy	or lines 14	1-16 for all	0 92, 061	16.00 17.00			
17.00	others)		atory therapy	or rines r		72,001	17.00			
18.00						0	18.00			
19.00 20.00			thorapy or lin	ac 17 and 10	for all others)	0 92, 061	19.00 20.00			
20.00	If the sum of columns 1 and 2 for respiratory						20.00			
	occupational therapy, line 9, is greater than	line 2, make r								
21.00	the amount from line 20. Otherwise complete Weighted average rate excluding aides and tra		divided by su	m of columns	a 1 and 2 line 9	0.00	21.00			
21.00	for respiratory therapy or columns 1 thru 3,					0.00	21.00			
22.00	Weighted allowance excluding aides and traine					0	22.00			
23.00	Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW					92, 061	23.00			
	Standard Travel Allowance	ANCE AND TRAVEL	LAFLINGE COMPO	JIATION - Fr	OVIDER SITE					
24.00	Therapists (line 3 times column 2, line 11)						24.00			
25.00										
26.00										
27 00	Standard travel expense (line 7 times line 3				3 and 4 for all	0 5, 673	25.00 26.00			
27.00	Standard travel expense (line 7 times line 3 others)				3 and 4 for all	0	25.00 26.00			
27. 00 28. 00	others) Total standard travel allowance and standard	for respiratory	y therapy or s	um of lines		0 5, 673	25.00 26.00 27.00			
	others) Total standard travel allowance and standard 27)	for respiratory	y therapy or s	um of lines		0 5, 673 0	25.00 26.00 27.00			
	others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of	for respiratory travel expense Expense of columns 1 and	y therapy or so at the provide	um of lines		0 5, 673 0	25. 00 26. 00 27. 00 28. 00 29. 00			
28. 00 29. 00 30. 00	others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3,	for respiratory travel expense Expense of columns 1 and line 12)	y therapy or si at the provide d 2, line 12)	um of lines er site (sur		0 5, 673 0 5, 673 0 0 0	25.00 26.00 27.00 28.00 29.00 30.00			
28.00 29.00 30.00 31.00	others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or	for respiratory travel expense Expense of columns 1 and line 12) sum of lines 24	y therapy or si at the provide d 2, line 12) 9 and 30 for a	um of lines er site (sur	n of lines 26 and	0 5, 673 0 5, 673 0 0 0 0 0	25.00 26.00 27.00 28.00 29.00 30.00 31.00			
28. 00 29. 00 30. 00	others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or	for respiratory travel expense Expense of columns 1 and line 12) sum of lines 24	y therapy or si at the provide d 2, line 12) 9 and 30 for a	um of lines er site (sur	n of lines 26 and	0 5, 673 0 5, 673 0 0 0	25.00 26.00 27.00 28.00 29.00 30.00 31.00			
28.00 29.00 30.00 31.00 32.00 33.00	others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum 0 Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel	for respiratory travel expense Expense of columns 1 and line 12) sum of lines 20 s 1 and 2, line expense (line	y therapy or si at the provide d 2, line 12) 9 and 30 for a 13 for respire 28)	um of lines er site (sur ll others) atory therap	n of lines 26 and	0 5, 673 0 5, 673 0 0 0 0 0 0 0 0 0	25. 00 26. 00 27. 00 28. 00 30. 00 31. 00 32. 00 33. 00			
28.00 29.00 30.00 31.00 32.00 33.00 34.00	others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel	for respiratory travel expense <u>Expense</u> of columns 1 and line 12) sum of lines 2 ⁴ s 1 and 2, line expense (line expense (sum of	y therapy or si at the provide d 2, line 12) 9 and 30 for a 13 for respire 28) of lines 27 and	um of lines er site (sur ll others) atory thera d 31)	n of lines 26 and	0 5, 673 0 5, 673 0 0 0 0 0 0 0 0 0 0 0	25. 00 26. 00 27. 00 28. 00 30. 00 31. 00 32. 00 33. 00 34. 00			
28.00 29.00 30.00 31.00 32.00 33.00	others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and optional travel	for respiratory travel expense Expense of columns 1 and line 12) sum of lines 20 s 1 and 2, line expense (line expense (sum of expense (sum of	y therapy or si at the provide d 2, line 12) 9 and 30 for a 13 for respir: 28) of lines 27 and of lines 31 and	um of lines er site (sur Il others) atory therap d 31) d 32)	n of lines 26 and	0 5, 673 0 5, 673 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	25. 00 26. 00 27. 00 28. 00 30. 00 31. 00 32. 00 33. 00 34. 00			
28.00 29.00 30.00 31.00 32.00 33.00 34.00	others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and optional travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWA Standard Travel Expense	for respiratory travel expense Expense of columns 1 and line 12) sum of lines 20 s 1 and 2, line expense (line expense (sum of expense (sum of	y therapy or si at the provide d 2, line 12) 9 and 30 for a 13 for respir: 28) of lines 27 and of lines 31 and	um of lines er site (sur Il others) atory therap d 31) d 32)	n of lines 26 and	0 5, 673 0 5, 673 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	25. 00 26. 00 27. 00 28. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00			
28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00	others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and optional travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWE Standard Travel Expense Therapists (line 5 times column 2, line 11)	for respiratory travel expense Expense of columns 1 and line 12) sum of lines 20 s 1 and 2, line expense (line expense (sum of expense (sum of	y therapy or si at the provide d 2, line 12) 9 and 30 for a 13 for respir: 28) of lines 27 and of lines 31 and	um of lines er site (sur Il others) atory therap d 31) d 32)	n of lines 26 and	0 5, 673 0 5, 673 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	25. 00 26. 00 27. 00 28. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00			
28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00	others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum 0 Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and optional travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWA Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11)	for respiratory travel expense Expense of columns 1 and line 12) sum of lines 20 s 1 and 2, line expense (line expense (sum of expense (sum of	y therapy or si at the provide d 2, line 12) 9 and 30 for a 13 for respir: 28) of lines 27 and of lines 31 and	um of lines er site (sur Il others) atory therap d 31) d 32)	n of lines 26 and	0 5, 673 0 5, 673 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	25. 00 26. 00 27. 00 28. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00			
28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00	others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum 3, Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and standard travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW/ Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37)	for respiratory travel expense <u>Expense</u> of columns 1 and line 12) sum of lines 2 ⁴ s 1 and 2, line expense (line expense (sum of NCE AND TRAVEL	y therapy or si at the provide d 2, line 12) 9 and 30 for a 13 for respire 28) of lines 27 and of lines 31 and EXPENSE COMPU	um of lines er site (sur Il others) atory therap d 31) d 32)	n of lines 26 and	0 5, 673 0 5, 673 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	25. 00 26. 00 27. 00 28. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00			
28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00	others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and optional travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW/ Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the sum Optional Travel Allowance and Optional Travel	for respiratory travel expense Expense of columns 1 and line 12) sum of lines 24 s 1 and 2, line expense (line expense (sum of NCE AND TRAVEL	y therapy or si at the provide d 2, line 12) 9 and 30 for a 13 for respira 28) of lines 27 and of lines 31 and EXPENSE COMPUT	um of lines er site (sur Il others) atory therap d 31) d 32)	n of lines 26 and	0 5, 673 0 5, 673 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	25. 00 26. 00 27. 00 28. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00			
28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00	others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and optional travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWA Standard Travel Expense Therapists (line 5 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel Allowance and Optional Travel Therapists (sum of columns 1 and 2, line 12.000000000000000000000000000000000000	for respiratory travel expense <u>Expense</u> of columns 1 and line 12) sum of lines 24 a 1 and 2, line expense (line expense (sum of expense (sum of NCE AND TRAVEL	y therapy or si at the provide d 2, line 12) 9 and 30 for a 13 for respira 28) of lines 27 and of lines 31 and EXPENSE COMPUT	um of lines er site (sur Il others) atory therap d 31) d 32)	n of lines 26 and	0 5, 673 0 5, 673 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	25. 00 26. 00 27. 00 28. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00			
28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00 41. 00	others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and optional travel Optional travel allowance and optional travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWA Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel Allowance and Optional Travel Therapists (sum of columns 1 and 2, line 12.0 Assistants (column 3, line 12.01 times column	for respiratory travel expense <u>Expense</u> of columns 1 and line 12) sum of lines 24 a 1 and 2, line expense (line expense (sum of expense (sum of NCE AND TRAVEL	y therapy or si at the provide d 2, line 12) 9 and 30 for a 13 for respira 28) of lines 27 and of lines 31 and EXPENSE COMPUT	um of lines er site (sur Il others) atory therap d 31) d 32)	n of lines 26 and	0 5, 673 0 5, 673 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	25. 00 26. 00 27. 00 28. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00 41. 00			
28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00	others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and optional travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWA Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel Allowance and Optional Travel Therapists (sum of columns 1 and 2, line 12. Assistants (column 3, line 12.01 times column Subtotal (sum of lines 40 and 41)	for respiratory travel expense Expense of columns 1 and line 12) sum of lines 24 s 1 and 2, line expense (line expense (sum of expense (sum of NCE AND TRAVEL n of lines 5 and Expense 1 times column n 3, line 10)	y therapy or si at the provide d 2, line 12) 9 and 30 for a 13 for respire 28) of lines 27 and of lines 31 and EXPENSE COMPU d 6) 2, line 10)	um of lines er site (sur Il others) atory therap d 31) d 32)	n of lines 26 and	0 5, 673 0 5, 673 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	25. 00 26. 00 27. 00 28. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00			
28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00 41. 00 42. 00	others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and optional travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWA Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the sum Optional Travel Allowance and Optional Travel Therapists (column 3, line 12.01 times column Subtotal (sum of lines 40 and 41) Optional travel expense (line 8 times the sum Total Travel Allowance and Travel Expense - C	for respiratory travel expense Expense of columns 1 and line 12) sum of lines 24 s 1 and 2, line expense (line expense (sum of expense (sum of NCE AND TRAVEL n of lines 5 and Expense 1 times column a 3, line 10) n of columns 1-3	y therapy or si at the provide d 2, line 12) 9 and 30 for a 13 for respire 28) of lines 27 and of lines 31 and EXPENSE COMPU d 6) 2, line 10) 3, line 13.01)	um of lines er site (sur ll others) atory therap d 31) d 32) TATION - SEF	n of lines 26 and by or sum of RVICES OUTSIDE PRO	0 5, 673 0 5, 673 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	25. 00 26. 00 27. 00 28. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00 41. 00 42. 00			
28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00 41. 00 42. 00	others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and optional travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW/ Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the sur Optional Travel Allowance and Optional Travel Therapists (sum of columns 1 and 2, line 12.0 Assistants (column 3, line 12.01 times column Subtotal (sum of lines 40 and 41) Optional travel expense (line 8 times the sur Total Travel Allowance and Travel Expense - C or 46, as appropriate.	for respiratory travel expense Expense of columns 1 and line 12) sum of lines 24 s 1 and 2, line expense (line expense (sum of expense (sum of NCE AND TRAVEL n of lines 5 and Expense 1 times column n 3, line 10) n of columns 1-3 offsite Services	y therapy or si at the provide d 2, line 12) 9 and 30 for a 13 for respira 28) of lines 27 and of lines 31 and EXPENSE COMPUT d 6) 2, line 10) 3, line 13.01) 5; Complete one	um of lines er site (sur ll others) atory therap d 31) d 32) TATION - SEF	n of lines 26 and by or sum of RVICES OUTSIDE PRO	0 5, 673 0 5, 673 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	25. 00 26. 00 27. 00 28. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00 41. 00 42. 00			

	Financial Systems F ABLE COST DETERMINATION FOR THERAPY SERVICES I E SUPPLIERS	FURNI SHED BY	Provider CC		Period: From 01/01/2017 To 12/31/2017		pared:
					Physical Therapy	Cost	
						1.00	
6. 00	Optional travel allowance and optional travel						46.00
		Therapi sts	Assistants	Aides	Trai nees	Total	
	PART V - OVERTIME COMPUTATION	1.00	2.00	3.00	4.00	5.00	
7.00	Overtime hours worked during reporting	0.00	0.00	0.0	0.00	0.00	47.0
	period (if column 5, line 47, is zero or	0.00	0100	0.10	0100	0.00	
	equal to or greater than 2,080, do not						
	complete lines 48-55 and enter zero in each						
0 00	column of line 56)	0.00	0.00	0.0			40.0
8.00 9.00	Overtime rate (see instructions) Total overtime (including base and overtime	0. 00 0. 00	0.00 0.00	0. C 0. C			48.0 49.0
9.00	allowance) (multiply line 47 times line 48)	0.00	0.00	0.0	0.00		49.0
	CALCULATION OF LIMIT						
0. 00	Percentage of overtime hours by category	0.00	0.00	0. C	0.00	0.00	50.0
	(divide the hours in each column on line 47						
	by the total overtime worked - column 5,						
1 00	line 47) Allocation of provider's standard work year	0.00	0.00	0.0		0.00	51.0
1.00	for one full-time employee times the	0.00	0.00	0.0	0.00	0.00	51.0
	percentages on line 50) (see instructions)						
	DETERMINATION OF OVERTIME ALLOWANCE		I				
2.00	Adjusted hourly salary equivalency amount	81.04	0.00	0. C	0.00		52. C
	(see instructions)						
3.00	Overtime cost limitation (line 51 times line	0	0		0 0		53. C
4.00	52) Maximum overtime cost (enter the lesser of	0	0		0 0		54. C
4.00	line 49 or line 53)	0	0		0 0		34.0
5.00	Portion of overtime already included in	0	0		0 0		55.0
	hourly computation at the AHSEA (multiply						
	line 47 times line 52)						
6.00	Overtime allowance (line 54 minus line 55 -	0	0		0 0	0	56.0
	if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for						
	respiratory therapy and columns 1 through 3						
	for all others.)						
						1.00	
7.00	Part VI - COMPUTATION OF THERAPY LIMITATION A Salary equivalency amount (from line 23)	IND EXCESS COST A	ADJUSTMENT			92, 061	57.0
8.00	Travel allowance and expense - provider site	(from lines 33	34 or 35))			92,001	
9.00	Travel allowance and expense - Offsite service)		0	
0.00	Overtime allowance (from column 5, line 56)			·		0	
1.00	Equipment cost (see instructions)					0	61.0
2.00	Supplies (see instructions)					0	
	Total allowance (sum of lines 57-62)					92, 061	
	Total cost of outside supplier services (from					86, 128	
5.00	Excess over limitation (line 64 minus line 63 LINE 33 CALCULATION	s - IT negative,	enter zero)			0	65.0
00 00	Line 26 = line 24 for respiratory therapy or	sum of lines 24	and 25 for a	LL others		5, 673	100 0
	Line 27 = line 7 times line 3 for respiratory				others		100.0
	Line 33 = line 28 = sum of lines 26 and 27					5, 673	100.0
	LINE 34 CALCULATION						
01 00	Line 27 = line 7 times line 3 for respiratory	1.5			others		101. C
	Line 31 = line 29 for respiratory therapy or	sum of lines 29	and 30 for al	II others			101. C
01.01	Line 34 = sum of lines 27 and 31					0	101. C
01.01							1
01. 01 01. 02	LINE 35 CALCULATION	sum of Lince 20	and 20 for al	II othors		<u>^</u>	1100 0
01. 01 01. 02 02. 00	Line 31 = line 29 for respiratory therapy or				mms 1_3 line		102.0
01. 01 01. 02 02. 00					mns 1-3, line		102. (102. (

Heal th F	inancial Systems	FRANCI SCAN HEAL	TH RENSSELAER		In Lie	eu of Form CMS-:	2552-10
COST ALL	OCATION - GENERAL SERVICE COSTS		Provider CC		Period: From 01/01/2017 To 12/31/2017		
	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPI TAL <u>RELATED COSTS</u> BLDG & FI XT	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMI NI STRATI VE & GENERAL	
		0	1.00	4.00	4A	5.00	
	ENERAL SERVICE COST CENTERS 0100 CAP REL COSTS-BLDG & FIXT	4, 067, 191	4, 067, 191				1.00
	0400 EMPLOYEE BENEFITS DEPARTMENT	4, 512, 567	4,007,191	4, 512, 56	7		4.00
	0500 ADMI NI STRATI VE & GENERAL	7, 791, 786	-			8, 468, 641	5.00
	0700 OPERATION OF PLANT	1, 553, 282					•
	0800 LAUNDRY & LINEN SERVICE	95, 812					•
	0900 HOUSEKEEPI NG	569, 844	73, 433				•
10.00 0 ⁻	1000 DI ETARY	178, 988					•
11.00 0	1100 CAFETERI A	178, 537	76, 004	56, 63	9 311, 180	92, 689	11.00
13.00 0	1300 NURSI NG ADMI NI STRATI ON	432, 686	15, 462	104, 72	2 552, 870	164, 680	13.00
	1400 CENTRAL SERVICES & SUPPLY	124, 339		13, 64			
	1500 PHARMACY	2, 195, 134					
	1600 MEDI CAL RECORDS & LI BRARY	402, 527	52, 370		0 454, 897	135, 497	16.00
	NPATIENT ROUTINE SERVICE COST CENTERS	000.400	001 540			1 174 007	
	3000 ADULTS & PEDIATRICS	880, 199					•
	3100 I NTENSI VE CARE UNI T NCI LLARY SERVI CE COST CENTERS	581, 903	29, 005	212, 83	6 823, 744	245, 363	31.00
	5000 OPERATING ROOM	590, 441	440, 064	169, 37	1 1, 199, 876	357, 399	50.00
	5400 RADI OLOGY-DI AGNOSTI C	1, 370, 837					
	6000 LABORATORY	1, 521, 172			0 1, 615, 707		
	6300 BLOOD STORING, PROCESSING & TRANS.	50, 118			0 57, 791		•
	6500 RESPI RATORY THERAPY	747, 744		247, 46			•
66.00 00	6600 PHYSI CAL THERAPY	800, 816	92, 425	277, 31	1 1, 170, 552	348, 664	66.00
66.01 00	6601 WHEATFIELD PT	282, 604	351, 475	101, 86	2 735, 941	219, 210	66. 01
	6700 OCCUPATI ONAL THERAPY	150, 452	38, 175	55, 55	1 244, 178	72, 732	67.00
	6701 WHEATFI ELD OT	85, 239					•
	6800 SPEECH PATHOLOGY	97, 226		35, 82			•
	6801 WHEATFI ELD ST	59, 816					1
	7100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	389, 161	43, 086		0 432, 247		1
	7200 IMPL. DEV. CHARGED TO PATIENTS 7300 DRUGS CHARGED TO PATIENTS	187, 490 0			0 193, 744 0 0		1
	JTPATIENT SERVICE COST CENTERS	0	0			0	1 / 3. 00
	8800 RURAL HEALTH CLINIC	325, 291	0	100, 47	1 425, 762	126, 819	88.00
	8801 RURAL HEALTH CLINIC IV	399, 294	101, 671	126, 54			•
	9000 CLINIC	1, 117, 408					•
91.00 0	9100 EMERGENCY	2, 035, 640	171, 268	351, 54	2 2, 558, 450	762, 055	91.00
92.00 0	9200 OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
	THER REIMBURSABLE COST CENTERS	1		-		1	
	0100 HOME HEALTH AGENCY	1, 170, 838	119, 588	294, 07	2 1, 584, 498	471, 963	101.00
	PECIAL PURPOSE COST CENTERS	554.050	0.044	440.50		000.011	111 (00
	1600 HOSPICE	551, 250					116.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117) DNREIMBURSABLE COST CENTERS	35, 497, 632	3, 596, 857	4, 042, 86	7 34, 557, 598	1, 110, 922	1118.00
	9000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	8, 824		0 8, 824	2 628	190.00
	9200 PHYSI CLANS' PRI VATE OFFI CES	0	0, 024		0 0, 024		192.00
	9201 RENSSELAER HEALTH CENTER	0	0		0 0		192.01
	7950 ALTERNACARE	686, 955	320, 820	248, 01	5 1, 255, 790		•
	7951 DME EQUI PMENT	0	0		0 0		194.01
	7952 WHEATFIELD FITNESS	311, 598	106, 736	80, 34	2 498, 676		
	7957 JOHNSON FITNESS	403, 832	0	141, 34	3 545, 175		
	7953 FOUNDATI ON	0	0		0 0		194.04
	7954 MEALS ON WHEELS	0	0		0 0		194.05
	7955 WATER LAB	0	21, 255		0 21, 255		194.06
	7956 ADVERTI SI NG	0	12, 699		0 12, 699	3, 783	194.07
200.00	Cross Foot Adjustments				0		200.00
201.00	Negative Cost Centers	24 000 017		1 510 51			201.00
202.00	TOTAL (sum lines 118 through 201)	36, 900, 017	4, 067, 191	4, 512, 56	7 36, 900, 017	8, 468, 641	1202. UU

Health Financial Systems	FRANCI SCAN HEALT	H RENSSELAER		In Lieu	u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider C		eri od:	Worksheet B	
				rom 01/01/2017 0 12/31/2017	Part I Date/Time Prep	bared:
					5/31/2018 2:46	
Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
	PLANT 7.00	LINEN SERVICE 8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	0.00	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	10100		
1.00 00100 CAP REL COSTS-BLDG & FIXT						1.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00 00500 ADMINI STRATI VE & GENERAL						5.00
7.00 00700 OPERATION OF PLANT	2, 241, 065					7.00
8.00 00800 LAUNDRY & LINEN SERVICE	38, 992	278, 607				8.00
9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY	46, 154 43, 912	19, 531 3, 131		440, 814		9.00 10.00
11. 00 01100 CAFETERIA	47, 770	3, 131		440, 014	452, 198	11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	9, 718	0	0	0	16, 699	13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	0	0	0	0	2, 175	14.00
15. 00 01500 PHARMACY	24, 307	0	16, 275	0	23, 067	15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	32, 916	0	0	0	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS	11					
30. 00 03000 ADULTS & PEDI ATRI CS	246, 108	161, 879		125, 743	51, 486	30.00
31. 00 03100 I NTENSI VE CARE UNI T	18, 230	1, 183	30, 175	14, 373	33, 939	31.00
ANCI LLARY SERVICE COST CENTERS 50. 00 05000 OPERATI NG ROOM	276, 588	14, 126	0	ol	26, 518	
50. 00 05000 OPERATI NG ROOM 54. 00 05400 RADI OLOGY-DI AGNOSTI C	276, 588	3, 656		0	44, 942	50.00 54.00
60. 00 06000 LABORATORY	59, 417	3, 030		0	44, 942	60.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	4, 823	0		0	0	63.00
65. 00 06500 RESPI RATORY THERAPY	78, 081	7,655	-	0	39, 460	65.00
66.00 06600 PHYSI CAL THERAPY	58, 091	18, 641		0	44, 220	66.00
66.01 06601 WHEATFI ELD PT	220, 909	0		0	0	66. 01
67.00 06700 OCCUPATI ONAL THERAPY	23, 993	0	21, 793	0	8, 858	67.00
67.01 06701 WHEATFI ELD OT	47, 505	0	0	0	0	67.01
68.00 06800 SPEECH PATHOLOGY	13, 866	0	12, 601	0	5, 712	68.00
68. 01 06801 WHEATFI ELD ST	30, 818	0	0	0	0	68.01
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	27,080	0	0	0	0	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	3, 931	0		0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATI ENTS OUTPATI ENT SERVI CE COST CENTERS	0	0	0	0	0	73.00
88.00 08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88. 03 08801 RURAL HEALTH CLINIC IV	63, 902	0	-	0	0	88.03
90. 00 09000 CLINIC	108, 200	3, 537		0	59, 517	90.00
91.00 09100 EMERGENCY	107, 645	6, 253		0	56, 057	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS						
101.0010100HOME HEALTH AGENCY	75, 164	0	87, 172	0	0	101. 00
SPECIAL PURPOSE COST CENTERS			-	-	-	
116. 00 11600 HOSPI CE	5, 257	0		0		116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	1, 945, 451	239, 592	968, 111	140, 116	412, 650	118.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	5, 546	0	279	0	0	190. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFICES	0, 540	0	0	0		192.00
192. 01 19201 RENSSELAER HEALTH CENTER	0	0	0	0		192.00
194. 00 07950 ALTERNACARE	201, 642	39, 015	147, 522	220, 434	39, 548	
194. 01 07951 DME EQUI PMENT	0	0	0	0		194.01
194. 02 07952 WHEATFI ELD FI TNESS	67, 085	0	0	0		194.02
194.0307957 JOHNSON FITNESS	0	0	0	0		194. 03
194. 04 07953 FOUNDATI ON	0	0	0	0		194.04
194.05 07954 MEALS ON WHEELS	0	0	0	80, 264		194. 05
194. 06 07955 WATER LAB	13, 359	0	11, 385	0		194.06
194. 07 07956 ADVERTI SI NG	7, 982	0	0	0		194.07
200.00 Cross Foot Adjustments		~		~		200.00
201.00Negative Cost Centers202.00TOTAL (sum lines 118 through 201)	2 241 065	0 278, 607	0 1, 127, 297	0 110 011	0 452, 198	201.00
202.00 TOTAL (sum lines 118 through 201)	2, 241, 065	270,007	1, 127, 297	440, 814	402, 198	202.00

COST /	ALLOCATION - GENERAL SERVICE COSTS		Provider CC	CN: 15-1324	Period: From 01/01/2017	Worksheet B Part I	
					To 12/31/2017	Date/Time Pre 5/31/2018 2:4	
	Cost Center Description	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES &	PHARMACY	MEDI CAL RECORDS &	Subtotal	
		13.00	SUPPLY 14.00	15.00	LI BRARY 16.00	24.00	
	GENERAL SERVICE COST CENTERS	13.00	14.00	15.00	10.00	24.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINI STRATI VE & GENERAL						5.00
7.00	00700 OPERATION OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPI NG						9.00
10.00	01000 DI ETARY						10.00
11.00	01100 CAFETERI A						11.00
13.00	01300 NURSING ADMINISTRATION	743, 967					13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	181, 254				14.00
15.00	01500 PHARMACY	0	6, 560	3, 157, 12	29		15. OC
16.00	01600 MEDI CAL RECORDS & LI BRARY	0	442		0 623, 752		16.00
	INPATIENT ROUTINE SERVICE COST CENTERS				· · ·		1
30.00	03000 ADULTS & PEDI ATRI CS	150, 639	514	14	45 163, 476	3, 296, 799	30.00
31.00	03100 I NTENSI VE CARE UNI T	99, 297	175		0 25, 077	1, 291, 556	31.00
	ANCI LLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	77, 585	2, 099	5, 1	13 62, 712	2, 022, 016	50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	82, 028	9, 347	75	55 81, 688	3, 209, 137	54.00
60.00	06000 LABORATORY	0	55	1.	18 15, 897	2, 219, 811	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	8, 653		0 0	88, 481	63.00
65.00	06500 RESPI RATORY THERAPY	0	5, 587		0 0	1, 610, 338	65.00
66.00	06600 PHYSI CAL THERAPY	0	1, 243	90	05 0	1, 695, 094	66.00
66. 01	06601 WHEATFI ELD PT	0	486		0 0	1, 176, 546	66.01
67.00	06700 OCCUPATI ONAL THERAPY	0	24		0 0	371, 578	67.00
67.01	06701 WHEATFIELD OT	0	178		0 0	294, 932	67.01
68.00	06800 SPEECH PATHOLOGY	0	2		0 0	233, 490	68.00
68. 01	06801 WHEATFIELD ST	0	51		0 0	200, 513	68.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	85, 565		0 0	673, 642	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	35, 534		0 0	290, 918	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	2, 969, 10	68 0	2, 969, 168	73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0	717	28, 88	32 0	582, 180	88.00
88. 03	08801 RURAL HEALTH CLINIC IV	0	693	55, 33	33 0	934, 345	88.03
90.00	09000 CLI NI C	170, 408	2, 994	3, 59	92 193, 463	2, 814, 834	90.00
91.00	09100 EMERGENCY	164, 010	2, 025	52	22 81, 439	3, 835, 267	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
	OTHER REIMBURSABLE COST CENTERS	1 1					
101.00	0 10100 HOME HEALTH AGENCY	0	6, 963		0 0	2, 225, 760	101.00
	SPECIAL PURPOSE COST CENTERS						
116.00	D 11600 HOSPI CE	0	5, 057	91, 68		982, 208	
118.00		743, 967	174, 964	3, 156, 21	14 623, 752	33, 018, 613	118.00
	NONREI MBURSABLE COST CENTERS	т. – г					
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0	17, 277	
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0 0		192.00
	19201 RENSSELAER HEALTH CENTER	0	0		0 0	0	192. 01
	07950 ALTERNACARE	0	2, 194		4 0	2, 280, 202	
	07951 DME EQUI PMENT	0	0		0 0		194.01
	2 07952 WHEATFIELD FITNESS	0	3, 298		41 0	718, 137	
	3 07957 JOHNSON FITNESS	0	798	3	70 0	708, 730	
	4 07953 FOUNDATI ON	0	0		0 0		194. 04
	07954 MEALS ON WHEELS	0	0		0 0	80, 264	194. 05
194.00	07955 WATER LAB	0	0		0 0	52, 330	
	07956 ADVERTI SI NG	0	0		0 0	24, 464	
							1
200.00							200.00
	Negative Cost Centers	0	0	3, 157, 12	0 0		201.00

Health Financial Systems FRANCI SCAN HEALTH RENSSELAER In Lieu of	Form CMS-2552-10
From 01/01/2017 Part To 12/31/2017 Date	e/Time Prepared:
Cost Center Description Intern & Total Residents Cost & Post Stepdown Adjustments	1/2018 2:46 am
25.00 26.00	
GENERAL SERVICE COST CENTERS	
1.00 00100 CAP REL COSTS-BLDG & FLXT 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 5.00 00500 ADMI NI STRATI VE & GENERAL 7.00 00700 OPERATI ON OF PLANT 8.00 00800 LAUNDRY & LI NEN SERVI CE 9.00 00900 HOUSEKEEPI NG 10.00 01000 DI ETARY 11.00 01100 CAFETERIA	1.00 4.00 5.00 7.00 8.00 9.00 10.00 11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON 14. 00 01400 CENTRAL SERVI CES & SUPPLY	13.00 14.00
15. 00 01500 PHARMACY	15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	16.00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	
30. 00 03000 ADULTS & PEDI ATRI CS 0 3, 296, 799	30.00
31. 00 03100 I NTENSI VE CARE UNI T 0 1, 291, 556 ANCI LLARY SERVI CE COST CENTERS	31.00
50. 00 05000 OPERATING ROOM 0 2, 022, 016	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 3, 209, 137	54.00
60. 00 06000 LABORATORY 0 2, 219, 811	60.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS. 0 88, 481	63.00
65. 00 06500 RESPI RATORY THERAPY 0 1, 610, 338	65.00
66. 00 06600 PHYSI CAL THERAPY 0 1, 695, 094 66. 01 06601 WHEATFI ELD PT 0 1, 176, 546	66. 00 66. 01
67. 00 06700 OCCUPATI ONAL THERAPY 0 371, 578	67.00
67. 01 06701 WHEATFI ELD OT 0 294, 932	67.01
68. 00 06800 SPEECH PATHOLOGY 0 233, 490	68.00
68.01 06801 WHEATFI ELD ST 0 200, 513	68.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 673, 642 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 290, 918	71.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 0 2, 969, 168	72.00
OUTPATIENT SERVICE COST CENTERS	70.00
88. 00 08800 RURAL HEALTH CLINIC 0 582, 180	88.00
88. 03 08801 RURAL HEALTH CLINIC IV 0 934, 345	88.03
90. 00 09000 CLINIC 0 2,814,834	90.00
91. 00 09100 EMERGENCY 0 3, 835, 267 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0	91.00 92.00
OTHER REIMBURSABLE COST CENTERS	72.00
101.00 10100 HOME HEALTH AGENCY 0 2,225,760	101.00
SPECIAL PURPOSE COST CENTERS	
116. 00 11600 HOSPI CE 0 982, 208	116.00
SUBTOTALS SUB OF LINES 1 through 117) 0 33,018,613 NONREI MBURSABLE COST CENTERS	118.00
190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 17, 277	190.00
192. OOI 19200 PHYSI CLANS' PRI VATE OFFI CES 0 0	192.00
192. 01 19201 RENSSELAER HEALTH CENTER 0 0	192.01
194. 00 07950 ALTERNACARE 0 2, 280, 202	194.00
194. 01 07951 DME EQUI PMENT 0 0 0	194.01
194. 02 07952 WHEATFI ELD_FI TNESS 0 718, 137 194. 03 07957 JOHNSON_FI TNESS 0 708, 730	194. 02 194. 03
194. 04 07953 FOUNDATI ON	194.03
194. 05 07954 MEALS 0N WHEELS 0 80, 264	194.05
194. 06 07955 WATER LAB 0 52, 330	194.06
194. 07 07956 ADVERTI SI NG 0 24, 464	194.07
200.00 Cross Foot Adjustments 0 0	200.00
201.00 Negative Cost Centers 0 0 202.00 TOTAL (sum Lines 118 through 201) 0 36,900,017	201.00 202.00
	1202.00

Heal th	Financial Systems	FRANCI SCAN HEAL	TH RENSSELAER		In Lie	eu of Form CMS-2	2552-10
	TION OF CAPITAL RELATED COSTS		Provider CC		eriod: rom 01/01/2017	Worksheet B	
					o 12/31/2017	Date/Time Pre 5/31/2018 2:4	pared:
			CAPI TAL			373172010 2.4	
	Cost Center Description	Di rectl y	RELATED COSTS BLDG & FI XT	Subtotal	EMPLOYEE	ADMI NI STRATI VE	
		Assigned New Capital			BENEFI TS DEPARTMENT	& GENERAL	
		Related Costs	1.00	24		F 00	
	GENERAL SERVICE COST CENTERS	0	1.00	2A	4.00	5.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	0	0	C		4.00
5.00 7.00	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT	0	429, 973 71, 592			.=.,	5.00 7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	62, 039		-		8.00
9.00	00900 HOUSEKEEPING	0	73, 433				9.00
10.00	01000 DI ETARY	0	69, 865	69, 865	C	4, 551	10.00
11.00	01100 CAFETERI A	0	76, 004		C	.,	11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	0	15, 462		C	-,	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	0	0	0	C		14.00
15.00 16.00	01600 MEDICAL RECORDS & LIBRARY	0	38, 673 52, 370				15.00 16.00
10.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0	52, 570	52, 570		0,077	10.00
30.00	03000 ADULTS & PEDIATRICS	0	391, 568	391, 568	C	24, 116	30.00
31.00	03100 I NTENSI VE CARE UNI T	0	29, 005	29, 005	C	12, 457	31.00
	ANCI LLARY SERVI CE COST CENTERS						
50.00 54.00	05000 OPERATI NG ROOM 05400 RADI OLOGY-DI AGNOSTI C	0					50.00 54.00
60. 00	06000 LABORATORY	0	369, 239 94, 535				60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	7, 673				63.00
65.00	06500 RESPI RATORY THERAPY	0	124, 231		C		65.00
66.00	06600 PHYSI CAL THERAPY	0	92, 425		C		66.00
66. 01	06601 WHEATFI ELD PT	0	351, 475	351, 475	C	11, 130	66. 01
67.00	06700 OCCUPATI ONAL THERAPY	0	38, 175		C		67.00
67.01	06701 WHEATFI ELD OT	0	75, 582		C	_,	67.01
68. 00 68. 01	06800 SPEECH PATHOLOGY 06801 WHEATFI ELD ST	0	22, 061 49, 032			_/ = / = / =	68. 00 68. 01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	43, 086		-		71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	6, 254		C		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0		0	C		73.00
	OUTPATIENT SERVICE COST CENTERS			1	1	-	
88.00	08800 RURAL HEALTH CLINIC	0			C		88.00
88.03	08801 RURAL HEALTH CLINIC IV	0			C		88.03
90.00 91.00	09000 CLINIC 09100 EMERGENCY	0					90.00 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	171,200	0		50,077	92.00
	OTHER REIMBURSABLE COST CENTERS			-			
101.00	10100 HOME HEALTH AGENCY	0	119, 588	119, 588	C	23, 962	101.00
444 00	SPECIAL PURPOSE COST CENTERS		0.0(1	0.0(4		40.05(11/ 00
116.00 118.00	SUBTOTALS (SUM OF LINES 1 through 117)	0					
116.00	NONREI MBURSABLE COST CENTERS	0	5, 590, 657	3, 590, 657	L	<u> </u>	116.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	8, 824	8, 824	C	133	190. 00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	C		192.00
	19201 RENSSELAER HEALTH CENTER	0	0	0	C		192. 01
	07950 ALTERNACARE	0	320, 820	320, 820	C	18, 991	
	07951 DME EQUI PMENT	0	0	0	C		194.01
	07952 WHEATFI ELD FI TNESS	0	106, 736	106, 736			194.02
	07957 JOHNSON FITNESS 07953 FOUNDATION	0	0				194. 03 194. 04
	07954 MEALS ON WHEELS	0	0	0			194.04 194.05
	07955 WATER LAB	0	21, 255	21, 255	C		194.06
194.07	07956 ADVERTI SI NG	0	12, 699				194. 07
200.00	5			0			200. 00
201.00			0	0	C		201.00
202.00	TOTAL (sum lines 118 through 201)	0	4, 067, 191	4, 067, 191	C	429, 973	202.00

		FRANCI SCAN HEAL				u of Form CMS-	2552-10
ALLOCA	FION OF CAPITAL RELATED COSTS		Provider C		Period: From 01/01/2017	Worksheet B Part II	
					To 12/31/2017	Date/Time Pre 5/31/2018 2:4	pared:
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
		PLANT	LINEN SERVICE				
		7.00	8.00	9.00	10.00	11.00	<u> </u>
	GENERAL SERVICE COST CENTERS			1			1 4 00
	00100 CAP REL COSTS-BLDG & FLXT 00400 EMPLOYEE BENEFLTS DEPARTMENT						1.00
	00500 ADMINI STRATI VE & GENERAL						5.00
	00700 OPERATION OF PLANT	97, 705					7.00
	00800 LAUNDRY & LINEN SERVICE	1,700	66, 531				8.00
	00900 HOUSEKEEPING	2,012	4, 664		9		9.00
	01000 DI ETARY	1, 914	748				10.00
11.00	01100 CAFETERI A	2, 083	0	4	6 0	82, 839	11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	424	0		0 0	3, 059	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	0		0 0	398	14.00
	01500 PHARMACY	1,060	0			4, 226	1
	01600 MEDI CAL RECORDS & LI BRARY	1, 435	0		0 0	0	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
	03000 ADULTS & PEDIATRICS	10, 730	38, 656			9, 432	
	03100 I NTENSI VE CARE UNI T	795	283	2, 47	5 2, 522	6, 217	31.00
	ANCI LLARY SERVI CE COST CENTERS	12.050	2 222			4.050	
	05400 RADI OLOGY-DI AGNOSTI C	12, 058 10, 118	3, 373 873		0 0	4, 858 8, 233	
	06000 LABORATORY	2, 590	0/3			0, 233	1
	06300 BLOOD STORING, PROCESSING & TRANS.	2, 370	0		0 0	0	
	06500 RESPI RATORY THERAPY	3, 404	1, 828		-	7, 229	
	06600 PHYSI CAL THERAPY	2, 533	4, 451			8, 101	
	06601 WHEATFI ELD PT	9,631	0		0 0	0	
67.00	06700 OCCUPATI ONAL THERAPY	1,046	0	1, 78	8 0	1, 623	67.00
67.01	06701 WHEATFI ELD OT	2,071	0		0 0	0	67.01
68.00	06800 SPEECH PATHOLOGY	605	0	1, 03	4 0	1, 046	68.00
	06801 WHEATFI ELD ST	1, 344	0		0 0	0	68.01
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 181	0		0 0	0	
	07200 I MPL. DEV. CHARGED TO PATIENTS	171	0	1	0 0	0	
	07300 DRUGS CHARGED TO PATIENTS	0	0	1	0 0	0	73.00
	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC	0	0			0	00 00
	08800 RURAL HEALTH CLINIC IV	2, 786	0		0 0 0 0	0	
	09000 CLINIC	4, 717	845		-	10, 903	
	09100 EMERGENCY	4, 693	1, 493			10, 269	
	09200 OBSERVATION BEDS (NON-DISTINCT PART	1,070	1, 170		-	10,207	92.00
	OTHER REIMBURSABLE COST CENTERS	I		1	I		
	10100 HOME HEALTH AGENCY	3, 277	0	7, 15	1 0	0	101.00
	SPECIAL PURPOSE COST CENTERS						
116.00	11600 HOSPI CE	229	0		0 0	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	84, 817	57, 214	79, 42	0 24, 584	75, 594	118.00
	NONREI MBURSABLE COST CENTERS	1		1			
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	242	0		3 0	0	190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0 0		192.00
	19201 RENSSELAER HEALTH CENTER	0	0	10.10	0 0		192.01
	07950 ALTERNACARE	8, 791	9, 317	12, 10	2 38, 675		194.00
	07951 DME EQUIPMENT 07952 WHEATFIELD FITNESS	2, 925	0				194.01
	07952 WHEATFIELD FITNESS 07957 JOHNSON FITNESS	2, 725	0				194.02
	07953 FOUNDATION		0				194.03
		0	0		0 14,083		194.05
194.04	07954 MEALS ON WHEELS					0	1.2.1.00
194. 04 194. 05	07954 MEALS ON WHEELS 07955 WATER LAB	582	0	93	4 0	0	194.06
194.04 194.05 194.06	07954 MEALS ON WHEELS 07955 WATER LAB 07956 ADVERTI SI NG	582 348	0	93	4 0 0 0		194.06
194.04 194.05 194.06	07955 WATER LAB 07956 ADVERTI SI NG		0	93	4 0 0 0	0	194. 07 200. 00
194.04 194.05 194.06 194.07	07955 WATER LAB 07956 ADVERTISING Cross Foot Adjustments Negative Cost Centers		000000000000000000000000000000000000000	93 92, 47	o o o o	0	194. 07

Heal th	Financial Systems	FRANCI SCAN HEALT	TH RENSSELAER		In Lie	u of Form CMS-	2552-10
ALLOCA	TION OF CAPITAL RELATED COSTS		Provider CO	CN: 15-1324	Period: From 01/01/2017 To 12/31/2017	Worksheet B Part II Date/Time Pre	
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	5/31/2018 2:4 Subtotal	16 am
		ADMI NI STRATI ON	SERVICES & SUPPLY		RECORDS & LI BRARY		
		13.00	14.00	15.00	16.00	24.00	
	GENERAL SERVICE COST CENTERS	1 1					
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINI STRATI VE & GENERAL						5.00
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
9.00 10.00	01000 DI ETARY						10.00
11.00	01100 CAFETERI A						11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	27, 306					13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	2, 485				14.00
15.00	01500 PHARMACY	0	90	81, 3	54		15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	6		0 60, 690		16.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	5, 529	7		4 15, 906	544, 849	
31.00	03100 I NTENSI VE CARE UNI T	3, 645	2		0 2,440	59, 841	31.00
	ANCI LLARY SERVICE COST CENTERS			-			
50.00	05000 OPERATING ROOM	2,848	29		32 6, 102	487, 610	
54.00	05400 RADI OLOGY-DI AGNOSTI C	3, 011	128		19 7, 948	440, 850	
60.00	06000 LABORATORY	0	1 119		3 1, 547 0 0	126, 995 8, 876	
63.00 65.00	06300 BLOOD STORI NG, PROCESSI NG & TRANS. 06500 RESPI RATORY THERAPY	0	77		0 0 0 0	155, 887	
66. 00	06600 PHYSI CAL THERAPY	0	17		23 0	129, 582	
66. 01	06601 WHEATFI ELD PT	0	7		0 0	372, 243	
67.00	06700 OCCUPATI ONAL THERAPY	0	0		0 0	46, 325	
67.01	06701 WHEATFI ELD OT	0	2		0 0	80, 536	
68.00	06800 SPEECH PATHOLOGY	0	0		0 0	27, 092	
68.01	06801 WHEATFI ELD ST	0	1		0 0	52, 354	68.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	1, 174		0 0	51, 978	3 71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	487		0 0	9, 842	2 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	76, 5	11 0	76, 511	73.00
~~ ~~	OUTPATIENT SERVICE COST CENTERS			-		7 400	
88.00	08800 RURAL HEALTH CLINIC	0	10		44 0	7, 193	
88.03	08801 RURAL HEALTH CLINIC IV	0	9	1, 4		115, 382	
90.00 91.00	09000 CLINIC 09100 EMERGENCY	6, 253 6, 020	41 28		93 18, 823 13 7, 924	248, 409 248, 349	
91.00 92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0, 020	20		13 7,924	240, 349	91.00
72.00	OTHER REIMBURSABLE COST CENTERS						72.00
101.00	10100 HOME HEALTH AGENCY	0	95		0 0	154, 073	101.00
	SPECIAL PURPOSE COST CENTERS	1 1					
116.00	11600 HOSPI CE	0	69	2, 3	62 0	21, 280	116.00
118.00		27, 306	2, 399	81, 3	30 60, 690	3, 466, 057	118.00
	NONREI MBURSABLE COST CENTERS	r					
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0		190.00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	0	0		0 0		192.00
	19201 RENSSELAER HEALTH CENTER	0	0		0 0		192.01
		0	30		0 0	415, 971	
	07951 DME EQUIPMENT 07952 WHEATFIELD FITNESS	0	0 45		0 0 14 0	0 117, 261	194.01
	07952 WHEATFIELD FITNESS	0	45 11		14 0 10 0		194.02
	07953 FOUNDATION	0	0				194.03
	07954 MEALS ON WHEELS	0	0		0 0		194.04
	07955 WATER LAB	0	0		0 0	23.092	194.06
	07956 ADVERTI SI NG	0	0		0 0		194.07
200.00			-			0	200.00
201.00	Negative Cost Centers	0	0		0 0		201.00
202.00	TOTAL (sum lines 118 through 201)	27, 306	2, 485	81, 3	54 60, 690	4, 067, 191	202.00

	5	FRANCI SCAN HEALTH			m CMS-2552-10
ALLUCAT	ION OF CAPITAL RELATED COSTS		Provider CCN: 15-	From 01/01/2017 Part II To 12/31/2017 Date/Tin	егв me Prepared: 18 2:46 am
	Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
		25.00	26.00		
C	GENERAL SERVICE COST CENTERS				
4.00 0 5.00 0	DO100 CAP REL COSTS-BLDG & FIXT DO400 EMPLOYEE BENEFITS DEPARTMENT DO500 ADMINISTRATIVE & GENERAL DO700 OPERATION OF PLANT				1.00 4.00 5.00 7.00
	DO800 LAUNDRY & LINEN SERVICE				8.00
	DO900 HOUSEKEEPING				9.00
	D1000 DI ETARY				10.00
	D1100 CAFETERIA				11.00
	D1300 NURSI NG ADMI NI STRATI ON				13.00
	01400 CENTRAL SERVICES & SUPPLY				14.00
	D1500 PHARMACY				15.00
	D1600 MEDICAL RECORDS & LIBRARY				16.00
	NPATIENT ROUTINE SERVICE COST CENTERS	I			
30.00	D3000 ADULTS & PEDIATRICS	0	544, 849		30.00
31.00	D3100 I NTENSI VE CARE UNI T	0	59, 841		31.00
A	ANCILLARY SERVICE COST CENTERS				
50.00	D5000 OPERATI NG ROOM	0	487, 610		50.00
54.00 0	05400 RADI OLOGY-DI AGNOSTI C	0	440, 850		54.00
60.00	D6000 LABORATORY	0	126, 995		60.00
63.00	D6300 BLOOD STORING, PROCESSING & TRANS.	0	8, 876		63.00
65.00 0	D6500 RESPI RATORY THERAPY	0	155, 887		65.00
66.00 (D6600 PHYSI CAL THERAPY	0	129, 582		66.00
66.01 (D6601 WHEATFI ELD PT	0	372, 243		66. 01
	06700 OCCUPATI ONAL THERAPY	0	46, 325		67.00
	D6701 WHEATFI ELD OT	0	80, 536		67.01
	D6800 SPEECH PATHOLOGY	0	27, 092		68.00
	06801 WHEATFI ELD ST	0	52, 354		68.01
	07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT	0	51, 978		71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	9,842		72.00
	D7300 DRUGS CHARGED TO PATIENTS	0	76, 511		73.00
	DUTPATIENT SERVICE COST CENTERS	0	7 100		00 00
	08800 RURAL HEALTH CLINIC	0	7, 193		88.00
	D8801 RURAL HEALTH CLINIC IV	0	115, 382		88.03
	D9100 EMERGENCY	0	248, 409 248, 349		90.00 91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	248, 349		92.00
	THER REIMBURSABLE COST CENTERS	9			72.00
	10100 HOME HEALTH AGENCY	0	154,073		101.00
	SPECIAL PURPOSE COST CENTERS	0	134, 073		
	11600 HOSPI CE	0	21, 280		116. 00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	0	3, 466, 057		118.00
	NONREI MBURSABLE COST CENTERS		07 1007 007		
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	9, 222		190. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		192.00
	19201 RENSSELAER HEALTH CENTER	0	o		192.01
	07950 ALTERNACARE	0	415, 971		194.00
	07951 DME EQUI PMENT	0	o		194.01
	07952 WHEATFIELD FITNESS	0	117, 261		194. 02
194.03	D7957 JOHNSON FITNESS	0	8, 266		194. 03
	D7953 FOUNDATI ON	0	o		194.04
	D7954 MEALS ON WHEELS	0	14, 083		194. 05
	D7955 WATER LAB	0	23, 092		194.06
194.07	D7956 ADVERTI SI NG	0	13, 239		194.07
	Croce Foot Adjustments		o		200.00
200.00	Cross Foot Adjustments	0	U		1200.00
200.00 201.00 202.00	Negative Cost Centers TOTAL (sum lines 118 through 201)	0	0		201. 00 202. 00

SI ALL	OCATION - STATISTICAL BASIS		Provider C		eriod:	Worksheet B-1	_
					rom 01/01/2017 o 12/31/2017		pare
		CAPI TAL				5/31/2018 2:4	<u>6 an</u>
		RELATED COSTS					
	Cost Center Description	BLDG & FIXT	EMPLOYEE	Reconciliation	ADMI NI STRATI VE		
		(SQUARE FEET)	BENEFI TS		& GENERAL	PLANT	
			DEPARTMENT		(ACCUM. COST)	(SQUARE FEET)	
			(GROSS				
		1.00	SALARI ES) 4. 00	5A	5.00	7.00	
	ENERAL SERVICE COST CENTERS	10(000					
	D100 CAP REL COSTS-BLDG & FLXT	106, 009	10 10/ 015				
	D400 EMPLOYEE BENEFITS DEPARTMENT	0	12, 186, 215	0 4/0 / 41	20 421 274		
	D500 ADMINISTRATIVE & GENERAL D700 OPERATION OF PLANT	11, 207 1, 866	666, 706 275, 076	-8, 468, 641	28, 431, 376 1, 726, 735		
	D800 LAUNDRY & LINEN SERVICE	1,617	72, 299	0	1, 720, 735		
	0900 HOUSEKEEPING	1, 914	471, 757		817, 969		
	1000 DI ETARY	1, 821	140, 618	0	300, 924		
	1100 CAFETERIA	1, 981	152, 953	0	311, 180		
	1300 NURSING ADMINISTRATION	403	282, 802	o o	552, 870	403	
	1400 CENTRAL SERVICES & SUPPLY	0	36, 837	0	137, 980	0	14
00 01	1500 PHARMACY	1,008	390, 646	0	2, 378, 464	1,008	15
	1600 MEDI CAL RECORDS & LI BRARY	1, 365	0	0	454, 897	1, 365	16
	NPATIENT ROUTINE SERVICE COST CENTERS			1			
	3000 ADULTS & PEDIATRICS	10, 206	871, 943				
	3100 I NTENSI VE CARE UNI T	756	574, 764	0	823, 744	756	31
	VCI LLARY SERVI CE COST CENTERS	11 470	457,007	^	1 100 07/	11, 470	_ /
	5400 RADI OLOGY-DI AGNOSTI C	11, 470	457, 387	0	1, 199, 876		
	6000 LABORATORY	9, 624 2, 464	761, 109 0	0	2, 021, 915 1, 615, 707	9,624 2,464	
	6300 BLOOD STORING, PROCESSING & TRANS.	2,404	0		57, 791	2,404	
	5500 RESPIRATORY THERAPY	3, 238	668, 267	0	1, 119, 435	3, 238	
	6600 PHYSI CAL THERAPY	2, 409	748, 881	0	1, 170, 552	2, 409	
	6601 WHEATFI ELD PT	9, 161	275, 078	0	735, 941	9, 161	
	5700 OCCUPATI ONAL THERAPY	995	150, 016	0	244, 178	995	
	6701 WHEATFI ELD OT	1, 970	80, 162	0	190, 505	1, 970	
	5800 SPEECH PATHOLOGY	575	96, 735	0	155, 108	575	
	5801 WHEATFI ELD ST	1, 278	59, 039	0	130, 710		
	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 123	0	0	432, 247	1, 123	
	7200 I MPL. DEV. CHARGED TO PATIENTS	163	0	0	193, 744	163	
	7300 DRUGS CHARGED TO PATIENTS	0	0	0		0	73
	JTPATIENT SERVICE COST CENTERS						
	B800 RURAL HEALTH CLINIC	0	271, 322	0	425, 762		
	3801 RURAL HEALTH CLINIC IV	2,650	341, 724	0	627, 506	2, 650	
	9000 CLINIC	4, 487	1,007,936	0	1, 662, 796		
	9100 EMERGENCY	4, 464	949, 341	0	2, 558, 450	4, 464	
	9200 OBSERVATION BEDS (NON-DISTINCT PART						92
	THER REIMBURSABLE COST CENTERS	3, 117	794, 142	0	1, 584, 498	2 117	110
	D100 HOME HEALTH AGENCY PECIAL PURPOSE COST CENTERS	3, 11/	/94, 142	0	1, 304, 490	3, 117	10
	1600 HOSPI CE	218	320, 248	0	678, 202	218	1116
3. 00	SUBTOTALS (SUM OF LINES 1 through 117)	93, 750	10, 917, 788				
	ONREIMBURSABLE COST CENTERS			1			
	9000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	230	0	0	8, 824	230	
	9200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	0		192
	9201 RENSSELAER HEALTH CENTER	0	0	0	0		192
		8, 362	669, 765	0	1, 255, 790		
	7951 DME EQUI PMENT	0	0		400 (7)		194
	7952 WHEATFIELD FITNESS 7957 JOHNSON FITNESS	2, 782	216, 965		498, 676 545, 175		
		0	381, 697		545, 175		194 194
	7953 FOUNDATION 7954 MEALS ON WHEELS	0	0		0		194
	7954 MEALS ON WHEELS 7955 WATER LAB	554	0		0 21, 255	554	
	7955 WATER LAB 7956 ADVERTISING	331	0		21, 255 12, 699		
). 00	Cross Foot Adjustments	331	0		12,079	551	200
. 00	Negative Cost Centers					1	200
2.00	Cost to be allocated (per Wkst. B,	4, 067, 191	4, 512, 567		8, 468, 641	2, 241, 065	
	Part I)						
3.00	Unit cost multiplier (Wkst. B, Part I)	38. 366469	0. 370301		0. 297863	24. 114068	203
I. 00	Cost to be allocated (per Wkst. B,		0		429, 973	97, 705	204
	Part II)						
5.00	Unit cost multiplier (Wkst. B, Part		0. 000000		0. 015123	1.051315	205
00	NAME adjustment amount to be allocated					1	201
5.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206
	NAHE unit cost multiplier (Wkst. D,					1	207
7.00							

	Financial Systems F LLOCATION - STATISTICAL BASIS	RANCI SCAN HEAL	TH RENSSELAER	N: 15-1324 Pe	In Lie eriod:	u of Form CMS-2 Worksheet B-1	2552-1
0001 /					om 01/01/2017	Date/Time Pre	
	Cost Center Description	LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY)	HOUSEKEEPI NG (HOURS OF SERVI C)	DI ETARY (MEALS SERVED)	CAFETERI A (SALARI ES)	5/31/2018 2:40 NURSI NG ADMI NI STRATI ON (NURSI NG SALARI ES)	<u>6 am</u>
		8.00	9.00	10.00	11.00	13.00	
1 00	GENERAL SERVICE COST CENTERS						1.0
1.00 4.00 5.00 7.00 8.00 9.00 10.00 11.00 13.00 14.00	00100 CAP REL COSTS-BLDG & FIXT 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DI ETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY	278, 110 19, 496 3, 125 0 0	80, 695 230 40 0	32, 694 0 0	7, 658, 126 282, 802 36, 837	4, 306, 300 0	1.0 4.0 5.0 7.0 8.0 9.0 10.0 11.0 13.0 14.0
	01500 PHARMACY	0	1, 165	0	390, 646	0	15.0
	01600 MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16. 0
30.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	161, 591	23, 420	9, 326	871, 943	871, 943	30. 0
31.00	03100 I NTENSI VE CARE UNI T	1, 181	2, 160	1, 066	574, 764	574, 764	31.0
	ANCI LLARY SERVI CE COST CENTERS		-			110.001	
50.00 54.00 60.00 63.00	05000 OPERATI NG ROOM 05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY 06300 BLOOD STORI NG, PROCESSI NG & TRANS.	14, 101 3, 649 0 0	0 9, 340 3, 390 0	0 0 0 0	449, 084 761, 109 0 0	449, 084 474, 803 0 0	50. 0 54. 0 60. 0 63. 0
65.00	06500 RESPI RATORY THERAPY	7,641	1, 910	0	668, 267	0	65.0
66. 00 66. 01	06600 PHYSI CAL THERAPY 06601 WHEATFI ELD PT	18, 608 0	3, 778 0	0	748, 881 0	0	66. 0 66. 0
67.00	06700 OCCUPATI ONAL THERAPY	Ō	1, 560	0	150, 016	0	67.0
67.01	06701 WHEATFI ELD OT	0	0	0	0	0	67.0
68. 00 68. 01	06800 SPEECH PATHOLOGY 06801 WHEATFI ELD ST	0	902 0	0	96, 735 0	0	68. 0 68. 0
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.0
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.0
73.00	07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS	0	0	0	0	0	73.0
88.00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88. 0
88. 03 90. 00	08801 RURAL HEALTH CLINIC IV 09000 CLINIC	0	0	0 0	0 1, 007, 936	004 245	88. 0 90. 0
90.00	09100 EMERGENCY	3, 531 6, 242	8, 235 6, 930	0	949, 341	986, 365 949, 341	90.0
	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.0
101 00	OTHER REIMBURSABLE COST CENTERS	0	(240	0	0	0	101 0
101.00	SPECIAL PURPOSE COST CENTERS	0	6, 240	0	0	0	101. 0
116.00 118.00	11600 HOSPI CE	0 239, 165	0 69, 300	U	0 6, 988, 361	0 4, 306, 300	116. 0 118. 0
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	20	0	0	0	190. 0
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	0		192.0
	19201 RENSSELAER HEALTH CENTER	0 38, 945	0 10, 560	0 16, 349	0 669, 765		192. 0 194. 0
	07951 DME EQUI PMENT	0	0	0	0		194.0
	07952 WHEATFIELD FITNESS	0	0	0	0		194.0
	07957 JOHNSON FITNESS 07953 FOUNDATION	0	0	0	0		194. 0 194. 0
		0	0	5, 953	0		194. 0
	07954 MEALS ON WHEELS	0	0	5, 755			
194. 05 194. 06	07955 WATER LAB	0	0 815		0		
194. 05 194. 06 194. 07	07955 WATER LAB 07956 ADVERTI SI NG	0 0 0	0 815 0		0 0	0	194. 0 194. 0 200. 0
194. 05 194. 06	07955 WATER LAB 07956 ADVERTISING Cross Foot Adjustments	0 0 0	0 815 0		0 0	0	
194. 05 194. 06 194. 07 200. 00 201. 00 202. 00	07955 WATER LAB 07956 ADVERTISING Cross Foot Adjustments Negative Cost Centers Cost to be allocated (per Wkst. B, Part I)	0 0 278, 607 1, 001787	0 1, 127, 297	0 0 440, 814	0 0 452, 198 0, 059048	0 743, 967	194. 0 200. 0 201. 0 202. 0
194. 05 194. 06 194. 07 200. 00 201. 00 202. 00 203. 00 203. 00	07955 WATER LAB 07956 ADVERTISING Cross Foot Adjustments Negative Cost Centers Cost to be allocated (per Wkst. B, Part I) Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B, Part II)	1. 001787 66, 531	0 1, 127, 297 13. 969849 92, 479	0 0 440, 814 13. 483024 77, 342	0. 059048 82, 839	0 743, 967 0. 172762 27, 306	194. 0 200. 0 201. 0 202. 0 203. 0 203. 0
194.05 194.06 194.07 200.00	07955 WATER LAB 07956 ADVERTISING Cross Foot Adjustments Negative Cost Centers Cost to be allocated (per Wkst. B, Part I) Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B, Part II) Unit cost multiplier (Wkst. B, Part	1. 001787	0 1, 127, 297 13. 969849	0 0 440, 814 13. 483024 77, 342	0. 059048	0 743, 967 0. 172762	194. 0 200. 0 201. 0 202. 0 203. 0 203. 0
194. 05 194. 06 194. 07 200. 00 201. 00 202. 00 203. 00 203. 00	07955 WATER LAB 07956 ADVERTISING Cross Foot Adjustments Negative Cost Centers Cost to be allocated (per Wkst. B, Part I) Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B, Part II) Unit cost multiplier (Wkst. B, Part II) NAHE adjustment amount to be allocated (per Wkst. B-2)	1. 001787 66, 531	0 1, 127, 297 13. 969849 92, 479	0 0 440, 814 13. 483024 77, 342	0. 059048 82, 839	0 743, 967 0. 172762 27, 306 0. 006341	194. 0 200. 0 201. 0 202. 0 203. 0 203. 0

	Financial Systems LOCATION - STATISTICAL BASIS	FRANCI SCAN HEAL	TH RENSSELAER Provider CO	CN: 15-1324	In Lie Period:	u of Form CMS-25 Worksheet B-1	<u>552-1</u>
JOOT NE					From 01/01/2017 To 12/31/2017	Date/Time Prepa	arod
					10 12/31/2017	5/31/2018 2:46	
	Cost Center Description	CENTRAL SERVI CES & SUPPLY (COSTED	PHARMACY (COSTED REQUI SI TI ONS)	MEDI CAL RECORDS & LI BRARY (TI ME SPENT)			
		REQUISITIONS)					
		14.00	15.00	16.00			
	ENERAL SERVICE COST CENTERS						1.0
	00400 EMPLOYEE BENEFITS DEPARTMENT						4.0
5. OO 0	00500 ADMINI STRATI VE & GENERAL						5.0
. 00 0	00700 OPERATION OF PLANT						7.C
	00800 LAUNDRY & LINEN SERVICE						8. C
	00900 HOUSEKEEPING						9.0
	01000 DI ETARY 01100 CAFETERI A						10. C
	01300 NURSING ADMINI STRATI ON						13.0
	01400 CENTRAL SERVICES & SUPPLY	953, 711					14. C
	01500 PHARMACY	34, 518	1, 680, 656				15. C
	01600 MEDICAL RECORDS & LIBRARY	2, 327	0	74, 94	5		16. C
	NPATIENT ROUTINE SERVICE COST CENTERS	0.700		40.77			20.0
	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	2, 703 919		19, 64: 3, 01:			30. C 31. C
	NCI LLARY SERVICE COST CENTERS	919	0	3,01	<u>)</u>		31.0
	D5000 OPERATI NG ROOM	11, 045	2, 722	7, 53	5		50.0
	05400 RADI OLOGY-DI AGNOSTI C	49, 181	402	9, 81			54.C
	06000 LABORATORY	291	63	1, 910			60. C
	06300 BLOOD STORING, PROCESSING & TRANS.	45, 528			0		63.0
	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	29, 398					65. 0 66. 0
	06601 WHEATFI ELD PT	6, 542 2, 559			0		66. (
	06700 OCCUPATI ONAL THERAPY	124			0		67.0
	06701 WHEATFIELD OT	939		(0		67.0
8. OO 🛛	06800 SPEECH PATHOLOGY	11	0	(C		68.0
	06801 WHEATFI ELD ST	268			0		68. (
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	450, 209					71.0
	07200 I MPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	186, 970 0					72. C 73. C
	UTPATIENT SERVICE COST CENTERS		1,000,077		5		70.0
	08800 RURAL HEALTH CLINIC	3, 775	15, 375		C		88. C
	08801 RURAL HEALTH CLINIC IV	3, 645			C		88. C
	09000 CLI NI C 09100 EMERGENCY	15, 755 10, 656		23, 24 9, 78			90. C 91. C
	09200 OBSERVATION BEDS (NON-DISTINCT PART	10, 050	270	7, 70.	5		92. C
	THER REIMBURSABLE COST CENTERS	1	I				
	0100 HOME HEALTH AGENCY	36, 636	0	(C	1	101. 0
	PECIAL PURPOSE COST CENTERS	07 (11	40.005			1	11/ 0
18.001	1600 HOSPICE SUBTOTALS (SUM OF LINES 1 through 117)	26, 611 920, 610			0		116. C 118. C
	IONREI MBURSABLE COST CENTERS	720,010	1,000,107	71,71			110. \
	9000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0			C		190. (
	9200 PHYSI CI ANS' PRI VATE OFFI CES	0	-		0		192. (
	9201 RENSSELAER HEALTH CENTER	11 545	0				192. (194. (
	07950 ALTERNACARE 07951 DME EQUI PMENT	11, 545	0				194. (194. (
	07952 WHEATFIELD FITNESS	17, 355	-		D D		194. (
94.030	07957 JOHNSON FITNESS	4, 201		(С		194. (
	07953 FOUNDATI ON	0	0	(C		194. (
	07954 MEALS ON WHEELS	0	0		0		194. (
)7955 WATER LAB)7956 ADVERTI SI NG	0	0				194. (194. (
01 07 0 00. 00	Cross Foot Adjustments						200. (
01.00	Negative Cost Centers						201. (
02.00	Cost to be allocated (per Wkst. B,	181, 254	3, 157, 129	623, 75	2	2	202. (
22.00	Part I)	0 100051	1 070510	0 22270	7		202 (
03.00 04.00	Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B,	0. 190051 2, 485					203.0 204.0
	Part II)	2,400	01, 334	00, 09		2	-04.0
05.00	Unit cost multiplier (Wkst. B, Part	0. 002606	0. 048406	0.80979	4	2	205.0
)						
06.00	NAHE adjustment amount to be allocated (per Wkst. B-2)					2	206. C
07.00	NAHE unit cost multiplier (Wkst. D,					2	207. C
		1	1		1		

Health Financial Systems	FRANCI SCAN HEAL	TH RENSSELAER		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 5/31/2018 2:4	
		Title	XVIII	Hospi tal	Cost	
				Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	3, 296, 799		3, 296, 79	9 0	0	30.00
31. 00 03100 I NTENSI VE CARE UNI T	1, 291, 556		1, 291, 55	6 0	0	31.00
ANCI LLARY SERVI CE COST CENTERS		•	•			1
50. 00 05000 OPERATI NG ROOM	2, 022, 016		2, 022, 01	6 0	0	50.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	3, 209, 137		3, 209, 13	7 0	0	54.00
60. 00 06000 LABORATORY	2, 219, 811		2, 219, 81	1 0	0	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	88, 481		88, 48	1 0	0	63.00
65. 00 06500 RESPI RATORY THERAPY	1, 610, 338	0	1, 610, 33	8 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	1, 695, 094	0	1, 695, 09	4 0	0	66.00
66. 01 06601 WHEATFI ELD PT	1, 176, 546	0	1, 176, 54	6 0	0	66.01
67.00 06700 OCCUPATI ONAL THERAPY	371, 578	0	371, 57	8 0	0	67.00
67.01 06701 WHEATFI ELD OT	294, 932	0	294, 93	2 0	0	67.01
68.00 06800 SPEECH PATHOLOGY	233, 490	0	233, 49	0 0	0	68.00
68. 01 06801 WHEATFI ELD ST	200, 513	0	200, 51	3 0	0	68.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	673, 642		673, 64	2 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	290, 918		290, 91	8 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	2, 969, 168		2, 969, 16	8 0	0	73.00
OUTPATIENT SERVICE COST CENTERS			•			1
88.00 08800 RURAL HEALTH CLINIC	582, 180		582, 18	0 0	0	88.00
88.03 08801 RURAL HEALTH CLINIC IV	934, 345		934, 34	5 0	0	88.03
90. 00 09000 CLINIC	2, 814, 834		2, 814, 83	4 0	0	90.00
91.00 09100 EMERGENCY	3, 835, 267		3, 835, 26	7 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	959, 160		959, 16	0	0	92.00
OTHER REIMBURSABLE COST CENTERS			· · · ·			1
101.00 10100 HOME HEALTH AGENCY	2, 225, 760		2, 225, 76	0	0	101.00
SPECIAL PURPOSE COST CENTERS		I				
116. 00 11600 HOSPI CE	982, 208		982, 20	8	0	116.00
200.00 Subtotal (see instructions)	33, 977, 773					200.00
201.00 Less Observation Beds	959, 160		959, 16			201.00
202.00 Total (see instructions)	33, 018, 613					202.00
		•	•			•

Heal th	Financial Systems	FRANCI SCAN HEALT	TH RENSSELAER		In Lie	u of Form CMS-:	2552-10
COMPUTA	ATION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-1324	Peri od:	Worksheet C	
					From 01/01/2017 To 12/31/2017		pared:
						5/31/2018 2:4	
				e XVIII	Hospi tal	Cost	
			Charges				
	Cost Center Description	Inpati ent	Outpati ent		6 Cost or Other	TEFRA	
				+ col. 7)	Rati o	Inpati ent	
		6.00	7.00	8.00	9,00	Rati o 10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS	0.00	7.00	8.00	9.00	10.00	
	03000 ADULTS & PEDIATRICS	1, 331, 552		1, 331, 5	52		30,00
	03100 I NTENSI VE CARE UNI T	253, 624		253, 62			31.00
	ANCI LLARY SERVICE COST CENTERS	233, 024		233, 02	- 4		51.00
	05000 OPERATING ROOM	307, 229	2, 850, 801	3, 158, 03	0. 640278	0.00000	50.00
	05400 RADI OLOGY-DI AGNOSTI C	274, 789	8, 794, 349			0. 000000	
	06000 LABORATORY	644, 819	6, 315, 087			0, 000000	
	06300 BLOOD STORING, PROCESSING & TRANS.	37, 201	159, 801			0. 000000	
	06500 RESPI RATORY THERAPY	375, 831	1, 848, 282			0. 000000	
66.00	06600 PHYSI CAL THERAPY	70, 742	1, 901, 074			0.000000	•
66. 01	06601 WHEATFI ELD PT	0	1, 232, 059			0.000000	
67.00	06700 OCCUPATI ONAL THERAPY	44, 103	319, 851			0.000000	67.00
67.01	06701 WHEATFI ELD OT	0	143, 484	143, 48	2. 055504	0.000000	67.01
68.00	06800 SPEECH PATHOLOGY	5, 348	148, 748	154, 04	1. 515224	0. 000000	68.00
68. 01	06801 WHEATFI ELD ST	0	99, 120	99, 12	2. 022932	0. 000000	68. 01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	861, 715	3, 827, 185	4, 688, 90	0. 143667	0.000000	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	518, 449	988, 354	1, 506, 80	0. 193070	0.000000	72.00
	07300 DRUGS CHARGED TO PATIENTS	1, 470, 950	13, 733, 497	15, 204, 44	0. 195283	0.00000	73.00
	OUTPATIENT SERVICE COST CENTERS						
	08800 RURAL HEALTH CLINIC	0	251, 708				88.00
	08801 RURAL HEALTH CLINIC IV	0	417, 363				88. 03
	09000 CLI NI C	98, 785	3, 586, 340			0. 000000	
	09100 EMERGENCY	228, 174	5, 644, 296			0. 000000	•
	09200 OBSERVATION BEDS (NON-DISTINCT PART	77, 245	1, 358, 531	1, 435, 7	0. 668043	0.00000	92.00
	OTHER REIMBURSABLE COST CENTERS	-					
	10100 HOME HEALTH AGENCY	0	2, 021, 637	2, 021, 63	37		101.00
	SPECIAL PURPOSE COST CENTERS		1 000 040	1 000 0			111 00
	11600 HOSPI CE		1, 920, 040				116.00
200.00 201.00	Subtotal (see instructions) Less Observation Beds	6, 600, 556	57, 561, 607	64, 162, 10	03		200. 00 201. 00
201.00	Total (see instructions)	6, 600, 556	57, 561, 607	64, 162, 10	2		201.00
202.00		0, 000, 550	57, 501, 607	04, 102, 10	10		202.00

Health Financial Systems	FRANCI SCAN HEALTH	RENSSELAER	In Lie	u of Form CMS-2552	2-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1324	Peri od: From 01/01/2017 To 12/31/2017	Worksheet C Part I Date/Time Prepare 5/31/2018 2:46 am	ed:
		Title XVIII	Hospi tal	Cost	
Cost Center Description	PPS Inpatient		· · · ·		
	Ratio				
	11.00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS				30	0. 00
31.00 03100 INTENSIVE CARE UNIT				31	I. 00
ANCI LLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	0. 000000			50	0. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000			54	4.00
60. 00 06000 LABORATORY	0. 000000			60	0. 00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000			63	3.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000			65	5.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000			66	5.00
66. 01 06601 WHEATFI ELD PT	0. 000000			66	5. 01
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000			67	7.00
67. 01 06701 WHEATFI ELD OT	0. 000000			67	7.01
68.00 06800 SPEECH PATHOLOGY	0. 000000			68	3. 00
68. 01 06801 WHEATFI ELD ST	0. 000000			68	3. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000			71	I. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000			72	2.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73	3.00
OUTPATIENT SERVICE COST CENTERS					
88.00 08800 RURAL HEALTH CLINIC				88	3. 00
88.03 08801 RURAL HEALTH CLINIC IV				88	3. 03
90. 00 09000 CLINIC	0. 000000			90	0. 00
91. 00 09100 EMERGENCY	0. 000000				1.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0, 000000				2.00
OTHER REIMBURSABLE COST CENTERS	1				
101.00 10100 HOME HEALTH AGENCY				101	I. 00
SPECIAL PURPOSE COST CENTERS					
116. 00 11600 HOSPI CE				116	5.00
200.00 Subtotal (see instructions)). 00
201.00 Less Observation Beds					1.00
202.00 Total (see instructions)				202	
	i i			1202	

Health Financial Systems	FRANCI SCAN HEAL	TH RENSSELAER		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	pared:
		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	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	3, 296, 799		3, 296, 79	9 0	3, 296, 799	30.00
31.00 03100 INTENSIVE CARE UNIT	1, 291, 556		1, 291, 55	6 0	1, 291, 556	31.00
ANCI LLARY SERVICE COST CENTERS						
50.00 05000 OPERATI NG ROOM	2, 022, 016		2, 022, 01	6 0	2, 022, 016	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	3, 209, 137		3, 209, 13	7 0	3, 209, 137	54.00
60. 00 06000 LABORATORY	2, 219, 811		2, 219, 81	1 0	2, 219, 811	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	88, 481		88, 48	1 0	88, 481	63.00
65. 00 06500 RESPI RATORY THERAPY	1, 610, 338	0	1, 610, 33	8 0	1, 610, 338	65.00
66. 00 06600 PHYSI CAL THERAPY	1, 695, 094	0	1, 695, 09	4 0	1, 695, 094	66.00
66. 01 06601 WHEATFIELD PT	1, 176, 546	0	1, 176, 54	6 0	1, 176, 546	66.01
67.00 06700 OCCUPATI ONAL THERAPY	371, 578	0	371, 57	8 0	371, 578	67.00
67.01 06701 WHEATFIELD OT	294, 932	0	294, 93	2 0	294, 932	67.01
68.00 06800 SPEECH PATHOLOGY	233, 490	0	233, 49	0 0	233, 490	68.00
68. 01 06801 WHEATFIELD ST	200, 513	0	200, 51	3 0	200, 513	68.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	673, 642		673, 64	2 0	673, 642	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	290, 918		290, 91	8 0	290, 918	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	2, 969, 168		2, 969, 16	8 0	2, 969, 168	73.00
OUTPATIENT SERVICE COST CENTERS				· ·		1
88.00 08800 RURAL HEALTH CLINIC	582, 180		582, 18	0 0	582, 180	88.00
88.03 08801 RURAL HEALTH CLINIC IV	934, 345		934, 34	5 0	934, 345	88.03
90. 00 09000 CLINIC	2, 814, 834		2, 814, 83	4 0	2, 814, 834	90.00
91.00 09100 EMERGENCY	3, 835, 267		3, 835, 26	7 0	3, 835, 267	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	959, 160		959, 16	0	959, 160	92.00
OTHER REIMBURSABLE COST CENTERS						
101.00 10100 HOME HEALTH AGENCY	2, 225, 760		2, 225, 76	0	2, 225, 760	101.00
SPECIAL PURPOSE COST CENTERS		_	_			
116. 00 11600 HOSPI CE	982, 208		982, 20		982, 208	
200.00 Subtotal (see instructions)	33, 977, 773	0	33, 977, 77	3 0		
201.00 Less Observation Beds	959, 160		959, 16		959, 160	
202.00 Total (see instructions)	33, 018, 613	0	33, 018, 61	3 0	33, 018, 613	202.00

Health Fi	nancial Systems	FRANCI SCAN HEALT	TH RENSSELAER		In Lie	u of Form CMS-	2552-10
COMPUTATI	ON OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 01/01/2017 To 12/31/2017	Date/Time Pre 5/31/2018 2:4	
				e XIX	Hospi tal	Cost	
	Cost Center Description	I npati ent	Charges Outpatient	+ col. 7)	6 Cost or Other Ratio	TEFRA I npati ent Rati o	
		6.00	7.00	8.00	9.00	10.00	
	PATIENT ROUTINE SERVICE COST CENTERS						
	000 ADULTS & PEDIATRICS	1, 331, 552		1, 331, 55	2		30.00
31.00 03	100 INTENSIVE CARE UNIT	253, 624		253, 62	4		31.00
AN	CILLARY SERVICE COST CENTERS			-			
50.00 05	000 OPERATING ROOM	307, 229	2, 850, 801	3, 158, 03	0. 640278	0. 000000	50.00
54.00 05	400 RADI OLOGY-DI AGNOSTI C	274, 789	8, 794, 349	9, 069, 13	8 0. 353852	0. 000000	54.00
60.00 06	000 LABORATORY	644, 819	6, 315, 087	6, 959, 90	6 0. 318943	0. 000000	60.00
	300 BLOOD STORING, PROCESSING & TRANS.	37, 201	159, 801	197, 00	0. 449138	0. 000000	63.00
65.00 06	500 RESPI RATORY THERAPY	375, 831	1, 848, 282	2, 224, 11	3 0.724036	0. 000000	65.00
66.00 06	600 PHYSI CAL THERAPY	70, 742	1, 901, 074	1, 971, 81	6 0.859661	0. 000000	66.00
66.01 06	601 WHEATFIELD PT	0	1, 232, 059	1, 232, 05	0. 954943	0. 000000	66.01
67.00 06	700 OCCUPATI ONAL THERAPY	44, 103	319, 851	363, 95	4 1.020948	0. 000000	67.00
67.01 06	701 WHEATFIELD OT	0	143, 484	143, 48	2. 055504	0. 000000	67.01
68.00 06	800 SPEECH PATHOLOGY	5, 348	148, 748	154, 09	6 1.515224	0. 000000	68.00
68.01 06	801 WHEATFIELD ST	0	99, 120	99, 12	2. 022932	0. 000000	68.01
71.00 07	100 MEDICAL SUPPLIES CHARGED TO PATIENT	861, 715	3, 827, 185	4, 688, 90	0. 143667	0. 000000	71.00
72.00 07	200 IMPL. DEV. CHARGED TO PATIENTS	518, 449	988, 354	1, 506, 80	0. 193070	0. 000000	72.00
73.00 07	300 DRUGS CHARGED TO PATIENTS	1, 470, 950	13, 733, 497	15, 204, 44	0. 195283	0. 000000	73.00
OU	TPATIENT SERVICE COST CENTERS						1
88.00 08	800 RURAL HEALTH CLINIC	0	251, 708	251, 70	2. 312918	0. 000000	88.00
88. 03 08	801 RURAL HEALTH CLINIC IV	0	417, 363	417, 36	3 2.238687	0. 000000	88.03
	000 CLINIC	98, 785	3, 586, 340	3, 685, 12	0. 763837	0. 000000	90.00
	100 EMERGENCY	228, 174	5, 644, 296	5, 872, 47	0 0.653093	0. 000000	91.00
92.00 09	200 OBSERVATION BEDS (NON-DISTINCT PART	77, 245	1, 358, 531	1, 435, 77	6 0.668043	0. 000000	92.00
ОТ	HER REIMBURSABLE COST CENTERS						1
	100 HOME HEALTH AGENCY	0	2, 021, 637	2, 021, 63	7		101.00
	ECIAL PURPOSE COST CENTERS						
116.0011	600 HOSPI CE	0	1, 920, 040	1, 920, 04	0		116.00
200.00	Subtotal (see instructions)	6, 600, 556	57, 561, 607	64, 162, 16	3		200. 00
201.00	Less Observation Beds						201.00
202.00	Total (see instructions)	6, 600, 556	57, 561, 607	64, 162, 16	3		202.00

Health Financial Systems	FRANCI SCAN HEALTH	RENSSELAER	In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1324	Peri od: From 01/01/2017 To 12/31/2017	Worksheet C Part I Date/Time Pre 5/31/2018 2:4	epared: 16 am
		Title XIX	Hospi tal	Cost	
Cost Center Description	PPS Inpatient				
	Ratio				
	11.00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS					30.00
31.00 03100 INTENSIVE CARE UNIT					31.00
ANCI LLARY SERVI CE COST CENTERS					
50.00 05000 OPERATING ROOM	0. 000000				50.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000				54.00
60.00 06000 LABORATORY	0. 000000				60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000				63.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000				65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000				66.00
66.01 06601 WHEATFIELD PT	0. 000000				66.01
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000				67.00
67.01 06701 WHEATFIELD OT	0. 000000				67.01
68.00 06800 SPEECH PATHOLOGY	0. 000000				68.00
68.01 06801 WHEATFIELD ST	0. 000000				68.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000				73.00
OUTPATIENT SERVICE COST CENTERS					
88.00 08800 RURAL HEALTH CLINIC	0.000000				88.00
88.03 08801 RURAL HEALTH CLINIC IV	0. 000000				88.03
90. 00 09000 CLINIC	0. 000000				90.00
91.00 09100 EMERGENCY	0. 000000				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000				92.00
OTHER REIMBURSABLE COST CENTERS					
101.00 10100 HOME HEALTH AGENCY					101.00
SPECIAL PURPOSE COST CENTERS					
116.00 11600 HOSPI CE					116.00
200.00 Subtotal (see instructions)					200.00
201.00 Less Observation Beds					201.00
202.00 Total (see instructions)					202.00
					•

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPI					u of Form CMS-2	2002-10
	TAL COSTS	Provider CO		Period: From 01/01/2017 To 12/31/2017	Worksheet D Part II Date/Time Pre 5/31/2018 2:4	
			XVIII	Hospi tal	Cost	
Cost Center Description	Capi tal	Total Charges	Ratio of Cost		Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,			. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS	- 1			-	-	
50. 00 05000 OPERATI NG ROOM	487, 610					
54. 00 05400 RADI OLOGY-DI AGNOSTI C	440, 850					
60. 00 06000 LABORATORY	126, 995					
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	8, 876					63.00
65. 00 06500 RESPI RATORY THERAPY	155, 887	2, 224, 113	0. 07009	0 226, 921	15, 905	65.00
66. 00 06600 PHYSI CAL THERAPY	129, 582	1, 971, 816	0.06571	7 29, 197	1, 919	66.00
66.01 06601 WHEATFIELD PT	372, 243	1, 232, 059	0. 30213	1 0	0	66.01
67.00 06700 OCCUPATI ONAL THERAPY	46, 325	363, 954	0. 12728	3 13, 830	1, 760	67.00
67.01 06701 WHEATFIELD OT	80, 536	143, 484	0. 56128	9 0	0	67.01
68.00 06800 SPEECH PATHOLOGY	27, 092	154, 096	0. 17581	2 2, 185	384	68.00
68. 01 06801 WHEATFI ELD ST	52, 354	99, 120	0. 52818	8 0	0	68.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	51, 978	4, 688, 900	0. 01108	5 620, 498	6, 878	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	9,842	1, 506, 803	0.00653	2 379, 463	2, 479	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	76, 511	15, 204, 447	0.00503	2 853, 954	4, 297	73.00
OUTPATIENT SERVICE COST CENTERS					· · · · · ·	1
88.00 08800 RURAL HEALTH CLINIC	7, 193	251, 708	0. 02857	7 0	0	88.00
88.03 08801 RURAL HEALTH CLINIC IV	115, 382	417, 363	0, 27645	5 0	0	88.03
90. 00 09000 CLINIC	248, 409			9 50, 477	3, 403	90.00
91. 00 09100 EMERGENCY	248, 349					
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	158, 517					
200.00 Total (lines 50 through 199)	2, 844, 531			3, 193, 281		

Health Financial Systems	FRANCI SCAN HEAL	TH RENSSELAER		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE THROUGH COSTS	ERVICE OTHER PAS			Period: From 01/01/2017 To 12/31/2017		pared: 6 am
	-		XVIII	Hospi tal	Cost	
Cost Center Description				Allied Health	Allied Health	
	Anesthetist	Post-Stepdown		Post-Stepdown		
	Cost	Adjustments		Adjustments		
	1.00	2A	2.00	3A	3.00	
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0		0 0	0	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	54.00
60. 00 06000 LABORATORY	0	0		0 0	0	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0 0	0	63.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 0	0	66.00
66.01 06601 WHEATFIELD PT	0	C		0 0	0	66. 01
67.00 06700 OCCUPATI ONAL THERAPY	0	C		0 0	0	67.00
67.01 06701 WHEATFIELD OT	0	0		0 0	0	67.01
68.00 06800 SPEECH PATHOLOGY	0	0		0 0	0	68.00
68.01 06801 WHEATFIELD ST	0	C		0 0	0	68. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		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
OUTPATIENT SERVICE COST CENTERS		_				
88.00 08800 RURAL HEALTH CLINIC	0	C		0 0	0	88.00
88.03 08801 RURAL HEALTH CLINIC IV	0	C)	0 0	0	88.03
90. 00 09000 CLINIC	0	C)	0 0	0	90.00
91. 00 09100 EMERGENCY	0	0)	0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0			0	0	92.00
200.00 Total (lines 50 through 199)	0	c	1	0 0	0	200. 00

Health Financial Systems	FRANCI SCAN HEAL	TH RENSSELAER		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEI THROUGH COSTS	RVICE OTHER PASS	6 Provider C		Period: From 01/01/2017 To 12/31/2017		
	_	Title	XVIII	Hospi tal	Cost	
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	Medi cal	(sum of col 1	Outpati ent	(from Wkst. C,		
	Education Cost	through col.	Cost (sum of	Part I, col.	(col. 5 ÷ col.	
		4)	col. 2, 3 and	l 8)	7)	
			4)			
	4.00	5.00	6.00	7.00	8.00	
ANCI LLARY SERVI CE COST CENTERS				- F	-	
50.00 05000 OPERATI NG ROOM	0	0		3, 158, 030		1
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		9, 069, 138		
60. 00 06000 LABORATORY	0	0		0 6, 959, 906		
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0 197, 002	0. 000000	63.00
65. 00 06500 RESPI RATORY THERAPY	0	0		2, 224, 113		
66. 00 06600 PHYSI CAL THERAPY	0	0		0 1, 971, 816		
66. 01 06601 WHEATFI ELD PT	0	0		0 1, 232, 059	0.000000	66. 01
67.00 06700 OCCUPATI ONAL THERAPY	0	0		363, 954	0.000000	67.00
67.01 06701 WHEATFIELD OT	0	0		0 143, 484	0.000000	67.01
68.00 06800 SPEECH PATHOLOGY	0	0		0 154, 096	0. 000000	68.00
68. 01 06801 WHEATFI ELD ST	0	0		99, 120	0. 000000	68.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		4, 688, 900	0. 000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		1, 506, 803	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 15, 204, 447	0. 000000	73.00
OUTPATIENT SERVICE COST CENTERS						1
88.00 08800 RURAL HEALTH CLINIC	0	0		251, 708	0.000000	88.00
88.03 08801 RURAL HEALTH CLINIC IV	0	0		0 417, 363	0.000000	88.03
90. 00 09000 CLINIC	0	0		3, 685, 125	0.000000	90.00
91.00 09100 EMERGENCY	0	0		5, 872, 470	0.000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		1, 435, 776		92.00
200.00 Total (lines 50 through 199)	0	0		58, 635, 310		200.00
			•	,	•	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS Provider CCN: 15-1324 Period: From 01/01/2017 To Worksheet D Part IV Date/TIme Prepared: 5/31/2018 2: 46 an Program Cost Center Description Outpatient Ratio of Cost to Charges (Col. 6 + col. 7) Title XVIII Hospital Outpatient Program Dass-Through Costs (col. 8 x col. 10) Outpatient Program Charges Outpatient Program Costs (col. 9 x col. 10) Outpatient Program Pass-Through Costs (col. 9 x col. 10) Outpatient Program Charges Outpatient Program Charges <td< th=""><th>Health Financial Systems</th><th>FRANCI SCAN HEALTH</th><th>I RENSSELAER</th><th></th><th>In Lie</th><th>u of Form CMS-2</th><th>2552-10</th></td<>	Health Financial Systems	FRANCI SCAN HEALTH	I RENSSELAER		In Lie	u of Form CMS-2	2552-10
Cost Center Description Outpatient Ratio of Cost to Charges (col. 6 + col. 7) Inpatient Program (col. 6 + col. 7) Inpatient Program (col. 6 + col. 7) Outpatient Program (col. 8 x col. 10) Outpatient Program (costs (col. 8 x col. 10) Outpatient Program (costs (col. 9 x col. 12) ANCI LLARY SERVICE COST CENTERS 0 10.00 11.00 12.00 13.00 55.00 05500 (OPERATING ROM 05500 (DERATING ROM 60.00 LABORATORY 0.000000 216.253 0 0 0 50.00 65.00 05000 (DERATING ROM 0000 LABORATORY 0.000000 216.253 0 0 0 64.00 63.00 06300 BLODD STORING, PROCESSING & TRANS. 0.000000 27.156 0 0 65.00 65.00 66.01 66.		RVICE OTHER PASS	Provider CO		From 01/01/2017	Part IV Date/Time Pre	
Ratio of Cost Program to Charges (col. 6 + col. 7) Program (Charges) Program (Char			Title	XVIII	Hospi tal	Cost	
Image: tool constraints tool charges (col. 6 + col. 7) Charges (col. 6) Pass-Through (costs (col. 8) Pass-Through (costs (col. 9) Pass-Through (costs (col. 10)) Pass-Through (costs (cost) (costs (col 1	Cost Center Description		Inpati ent		Outpati ent	Outpati ent	
ANCI LLARY SERVICE COST CENTERS Costs (col. 8 7) Costs (col. 9 x col. 10) Costs (col. 9 x col. 12) 50.00 0PERATI NG ROOM 0.000000 216,253 0 0 0 54.00 54.00 05400 RADI OLOGY - DI AGNOSTI C 0.000000 134,611 0 0 54.00 66.00 06000 LABORATORY 0.000000 27,156 0 0 66.00 65.00 06500 RESPI RATORY THERAPY 0.000000 226,921 0 0 65.00 66.01 67.01 67.01 <td< td=""><td></td><td></td><td>Program</td><td>Program</td><td>Program</td><td></td><td></td></td<>			Program	Program	Program		
T) x col. 10) x col. 12) 9.00 10.00 11.00 12.00 13.00 50.00 05000 OPERATI NG ROOM 0.000000 216,253 0 0 50.00 54.00 05400 RADI LLGRY SERVICE COST CENTERS 0 0 50.00 50.00 64.00 06000 LABORATORY 0.000000 216,253 0 0 60.00 63.00 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 0.000000 27,156 0 0 65.00 66.00 RESPI RATORY THERAPY 0.000000 226,921 0 0 66.00 66.01 MEATHERAPY 0.000000 29,197 0 0 66.00 67.01 06701 WHEATFI ELD PT 0.000000 0 0 67.01 67.01 06701 WHEATFI ELD OT 0.000000 2,185 0 0 68.01 68.01 06800 SPECH PATHOLOGY 0.000000 0 0 71.00 71.00 <td< td=""><td></td><td>to Charges</td><td>Charges</td><td></td><td></td><td></td><td></td></td<>		to Charges	Charges				
P.00 10.00 11.00 12.00 13.00 ANCI LLARY SERVICE COST CENTERS 0 <t< td=""><td></td><td>(col. 6 ÷ col.</td><td></td><td>Costs (col.</td><td>8</td><td>Costs (col. 9</td><td></td></t<>		(col. 6 ÷ col.		Costs (col.	8	Costs (col. 9	
ANCI LLARY SERVICE COST CENTERS 50. 00 05000 OPERATING ROOM 0.000000 216,253 0 0 0 50.00 54. 00 05000 RADIOLOGY-DI AGNOSTI C 0.000000 134,611 0 0 0 54.00 60. 00 06300 BLOOD STORING, PROCESSING & TRANS. 0.000000 27,156 0 0 0 63.00 65. 00 06500 RESPI RATORY THERAPY 0.000000 26,921 0 0 0 66.00 66. 01 06600 PHYSI CAL THERAPY 0.000000 29,197 0 0 0 66.00 66. 01 06601 WHEATFI ELD PT 0.000000 0 0 0 66.01 67. 01 06701 WHEATFI ELD OT 0.000000 0 0 0 67.01 68. 00 06800 SPECH PATHOLOGY 0.000000 0 0 0 68.00 71. 00 07100 MEATFI ELD ST 0.000000 0 0 0 68		7)		x col. 10)		x col. 12)	
50.00 05000 0PERATING ROOM 0.000000 216,253 0 0 50.00 54.00 05400 RADIOLOGY-DLAGNOSTIC 0.000000 134,611 0 0 54.00 60.00 06000 LABORATORY 0.000000 134,611 0 0 0 60.00 63.00 06300 BLODD STORING, PROCESSING & TRANS. 0.000000 27,156 0 0 0 63.00 66.01 06600 PHYSI CAL THERAPY 0.000000 29,197 0 0 0 66.00 66.01 06601 WHEATFI ELD PT 0.000000 0 0 66.01 66.01 67.00 06700 0 0 0 0 67.00 0 0 67.01 68.01 06801 WHEATFI ELD OT 0.000000 0 0 0 67.01 68.01 06800 SPEECH PATHOLGGY 0.000000 0 0 0 68.01 71.00 07100 MEDICAL SUPPLIES CHARGED TO P		9.00	10.00	11.00	12.00	13.00	
54.00 05400 RADIOLOGY-DIAGNOSTIC 0.000000 134, 611 0 0 54.00 60.00 06000 LABORATORY 0.000000 446, 335 0 0 0 60.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0.000000 27, 156 0 0 0 63.00 65.00 06500 RESPIRATORY THERAPY 0.000000 226, 921 0 0 0 65.00 66.01 06600 PHYSI CAL THERAPY 0.000000 29, 197 0 0 0 66.01 67.01 06701 WHEATFI ELD PT 0.000000 0 0 0 66.01 67.01 06701 WHEATFI ELD OT 0.000000 0 0 0 67.00 68.00 06800 SPECH PATHOLOGY 0.000000 2, 185 0 0 68.00 68.01 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0.000000 620, 498 0 0 71.00 72.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 853, 954 0 <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td></t<>							
60.00 06000 LABORATORY 0.000000 446,335 0 0 60.00 63.00 06300 BLODD STORING, PROCESSING & TRANS. 0.000000 27,156 0 0 0 63.00 65.00 06500 RESPIRATORY THERAPY 0.000000 226,921 0 0 0 65.00 66.00 06600 PHYSICAL THERAPY 0.000000 29,197 0 0 0 66.00 66.01 06601 WHEATFIELD PT 0.000000 0 0 0 0 66.01 67.01 06700 0CCUPATI ONAL THERAPY 0.000000 0 0 0 67.00 68.00 06800 SPEECH PATHOLOGY 0.000000 2,185 0 0 68.01 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0.000000 0 0 0 68.01 72.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 379,463 0 0 0 72.00 73.00<	50.00 05000 OPERATING ROOM		216, 253		0 0	0	50.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0.000000 27,156 0 0 63.00 65.00 06500 RESPIRATORY THERAPY 0.000000 226,921 0 0 0 65.00 66.01 06601 WHEATFIELD PT 0.000000 29,197 0 0 0 66.00 66.01 06601 WHEATFIELD PT 0.000000 0 0 0 66.01 67.00 06700 0CCUPATIONAL THERAPY 0.000000 13,830 0 0 0 67.01 67.01 06701 WHEATFIELD OT 0.000000 0 0 0 67.01 68.00 06800 SPEECH PATHOLOGY 0.000000 2,185 0 0 0 68.01 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0.000000 379,463 0 0 0 71.00 72.00 07300 DRUSS CHARGED TO PATI ENTS 0.000000 379,463 0 0 0 0 73	54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	134, 611		0 0	0	54.00
65.00 06500 RESPIRATORY THERAPY 0.000000 226,921 0 0 0 65.00 66.00 06600 PHYSI CAL THERAPY 0.000000 29,197 0 0 0 66.00 66.01 06600 WHEATFI ELD PT 0.000000 0 0 0 0 0 66.01 67.01 06700 0CCUPATI ONAL THERAPY 0.000000 13,830 0 0 0 67.01 67.01 06701 WHEATFI ELD OT 0.000000 0 0 0 0 67.01 68.00 06800 SPECH PATHOLOGY 0.000000 2,185 0 0 0 68.00 68.01 06801 WHEATFI ELD ST 0.000000 0 0 0 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.000000 379,463 0 0 0 72.00 0 0 72.00 07300 DUES CHARGED TO PATI ENTS 0.000000	60. 00 06000 LABORATORY	0. 000000	446, 335		0 0	0	60.00
66.00 06600 PHYSI CAL THERAPY 0.000000 29, 197 0 0 0 66.00 66.01 06601 WHEATFI ELD PT 0.000000 0 0 0 0 66.01 67.00 06700 0CCUPATI ONAL THERAPY 0.000000 13, 830 0 0 0 67.00 67.01 06701 WHEATFI ELD OT 0.000000 0 0 0 0 0 0 67.01 68.01 06800 SPEECH PATHOLOGY 0.000000 2, 185 0 0 68.01 0 046801 WHEATFI ELD ST 0.000000 0 0 0 68.01 0 046801 WHEATFI ELD ST 0.000000 0 0 0 68.00 68.01 06801 WHEATFI ELD ST 0.000000 620, 498 0 0 0 0 71.00 71.00 07100 MEL CAL SUPPLI ES CHARGED TO PATI ENTS 0.000000 379, 463 0 0 0 0	63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	27, 156		0 0	0	63.00
66.01 06601 WHEATFIELD PT 0.000000 0 0 0 66.01 67.00 06700 OCCUPATIONAL THERAPY 0.000000 13,830 0 0 0 67.00 67.01 06701 WHEATFIELD OT 0.000000 0 0 0 0 67.01 68.00 06800 SPEECH PATHOLOGY 0.000000 2,185 0 0 0 68.00 68.01 06801 WHEATFIELD ST 0.000000 0 0 0 68.01 71.00 O7100 MEDICAL SUPPLIES CHARGED TO PATIENT 0.000000 379,463 0 0 0 72.00 72.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 379,463 0 0 0 73.00 0UTPATIENT SERVICE COST CENTERS 0.000000 0 0 0 0 88.03 88.00 08800 RURAL HEALTH CLINIC IV 0.000000 0 0 0 88.03 90.00 09000 <td< td=""><td>65. 00 06500 RESPI RATORY THERAPY</td><td>0. 000000</td><td>226, 921</td><td></td><td>0 0</td><td>0</td><td>65.00</td></td<>	65. 00 06500 RESPI RATORY THERAPY	0. 000000	226, 921		0 0	0	65.00
67.00 06700 OCCUPATI ONAL THERAPY 0.000000 13,830 0 0 67.00 67.01 06701 WHEATFI ELD OT 0.000000 0 0 0 0 67.01 68.00 06800 SPEECH PATHOLOGY 0.000000 0 0 0 68.00 68.01 06801 WHEATFI ELD ST 0.000000 0 0 0 68.00 68.01 06801 WHEATFI ELD ST 0.000000 0 0 0 68.01 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0.000000 620,498 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.000000 379,463 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.000000 0 0 0 73.00 0HTPATI ENT SERVICE COST CENTERS	66. 00 06600 PHYSI CAL THERAPY	0. 000000	29, 197		0 0	0	66.00
67.01 06701 WHEATFIELD OT 0.000000 0 0 0 67.01 68.00 06800 SPEECH PATHOLOGY 0.000000 2,185 0 0 0 68.00 68.01 06801 WHEATFIELD ST 0.000000 0 0 0 0 68.01 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0.000000 620,498 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 379,463 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 853,954 0 0 0 73.00 0 08800 RURAL HEALTH CLINIC 0.000000 0 0 0 88.00 88.00 08800 RURAL HEALTH CLINIC IV 0.000000 0 0 0 88.03 90.00 09000 CLINIC 0.000000 50,477 0 0 90.00 91.00 09100 EMERGENCY 0.000000 115,156 0 0	66. 01 06601 WHEATFI ELD PT	0. 000000	0		0 0	0	66. 01
68.00 06800 SPEECH PATHOLOGY 0.000000 2,185 0 0 68.00 68.01 06801 WHEATFIELD ST 0.000000 0 0 0 0 68.01 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0.000000 620,498 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 379,463 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 853,954 0 0 0 73.00 0UTPATIENT SERVICE COST CENTERS 0.000000 0 0 0 0 88.00 88.00 08800 RURAL HEALTH CLINIC 0.000000 0 0 0 88.00 88.03 08801 RURAL HEALTH CLINIC IV 0.000000 0 0 0 88.00 90.00 09000 CLINIC 0.000000 0 0 0 90.00 91.00 09100	67.00 06700 OCCUPATI ONAL THERAPY	0. 000000	13, 830		0 0	0	67.00
68. 01 06801 WHEATFIELD ST 0.000000 0 0 0 68. 01 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0.000000 620, 498 0 0 0 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 379, 463 0 0 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0.000000 853, 954 0 0 0 73. 00 0UTPATIENT SERVICE COST CENTERS 0.000000 0 0 0 0 88. 00 88. 00 08800 RURAL HEALTH CLINIC 0.000000 0 0 0 88. 00 90. 00 09000 CLINIC 0.000000 0 0 0 88. 03 90. 00 09000 CLINIC 0.000000 50, 477 0 0 0 90. 00 91. 00 09100 EMERGENCY 0.000000 115, 156 0 0 0 91.00 92. 00 09200 DBSERVATI ON BEDS (NON-DI STINCT PART 0.000000 77, 245 0 <td< td=""><td>67. 01 06701 WHEATFI ELD OT</td><td>0. 000000</td><td>0</td><td></td><td>0 0</td><td>0</td><td>67.01</td></td<>	67. 01 06701 WHEATFI ELD OT	0. 000000	0		0 0	0	67.01
71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0.000000 620, 498 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.000000 379, 463 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.000000 853, 954 0 0 0 73.00 OUTPATI ENT SERVICE COST CENTERS 0.000000 0 0 0 0 88.00 08800 RURAL HEALTH CLINIC IV 0.000000 0 0 0 88.03 90.00 09000 CLINIC 0.000000 50, 477 0 0 0 90.00 9100 EMERGENCY 0.000000 115, 156 0 0 91.00 91.00 91.00 92.00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART 0.000000 77, 245 0 0 0 92.00	68.00 06800 SPEECH PATHOLOGY	0. 000000	2, 185		0 0	0	68.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 379,463 0 0 72.00 72.00 73.00 DRUGS CHARGED TO PATIENTS 0.000000 853,954 0 0 0 73.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0.000000 0 0 0 88.00 88.00 0 0 0 88.00 0 0 0 88.00 0 0 0 0 88.00 88.00 0 0 0 0 0 88.00 0 88.00 0 90.00 0 0 0 0 88.00 88.00 90.00 0 0 0 0 88.00 88.00 90.00 90.00 0 0 0 88.00 90.00 91.00 90.00 90.00 91.00 90.00 91.00 91.00 90.00 91.00 91.00 91.00 92.00 92.00 92.00 92.00 92.00	68. 01 06801 WHEATFI ELD ST	0. 000000	0		0 0	0	68.01
73.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 853,954 0 0 73.00 OUTPATIENT SERVICE COST CENTERS 0.000000 0 0 0 0 88.00 88.00 0.000000 0 0 0 88.00 88.00 88.00 0.000000 0 0 0 88.00 88.00 90.00 0 0 0 88.00 88.00 90.00 0 0 0 88.00 88.03 90.00 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 90.00 91.00 91.00 92.00 92.00 0 0 0 92.00 0 0 0 92.00 0 0 0 92.00 0 0 0 92.00 0 0 0 92.00 0 0 0 0 92.00	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	620, 498		0 0	0	71.00
OUTPATI ENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0.000000 0 0 0 88.00 88.03 08801 RURAL HEALTH CLINIC IV 0.000000 0 0 0 88.03 90.00 09000 CLINIC 0.000000 50,477 0 0 90.00 91.00 09100 EMERGENCY 0.000000 115,156 0 0 91.00 92.00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART 0.000000 77,245 0 0 92.00	72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	379, 463		0 0	0	72.00
88.00 08800 RURAL HEALTH CLINIC 0.000000 0 0 0 0 88.00 88.03 08801 RURAL HEALTH CLINIC V 0.000000 0 0 0 0 88.03 90.00 09000 CLINIC 0.000000 50,477 0 0 0 90.00 91.00 09100 EMERGENCY 0.000000 115,156 0 0 91.00 92.00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART 0.000000 77,245 0 0 0 92.00	73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	853, 954		0 0	0	73.00
88.03 08801 RURAL HEALTH CLINICIV 0.000000 0 0 0 88.03 90.00 09000 CLINIC 0.000000 50,477 0 0 90.00 91.00 09100 EMERGENCY 0.000000 115,156 0 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0.000000 77,245 0 0 0 92.00	OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C 0. 00000 50, 477 0 0 90. 00 90. 00 91. 00 91. 00 991. 00 991. 00 991. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART 0. 000000 115, 156 0 0 0 92. 00 92.00 0 92.00 77, 245 0 0 92. 00 92.00	88.00 08800 RURAL HEALTH CLINIC	0.000000	0		0 0	0	88.00
91.00 09100 EMERGENCY 0.000000 115,156 0 0 91.00 91.00 92.00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART 0.000000 77,245 0 0 0 92.00 92.00 0 92.00 0 0 92.00 0 0 92.00 0 0 0 92.00 0 0 0 92.00 0 0 0 92.00 0 0 0 92.00 0 0 0 92.00 0 0 0 0 92.00 0 0 0 0 92.00 0 0 0 92.00 0 0 0 92.00 0 0 0 92.00 0 0 0 92.00 0 <td>88.03 08801 RURAL HEALTH CLINIC IV</td> <td>0. 000000</td> <td>0</td> <td></td> <td>0 0</td> <td>0</td> <td>88.03</td>	88.03 08801 RURAL HEALTH CLINIC IV	0. 000000	0		0 0	0	88.03
91.00 09100 EMERGENCY 0.000000 115,156 0 0 91.00 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0.000000 77,245 0 0 0 92.00 92.00 0 92.00 0 0 92.00 0 0 92.00 0 0 0 92.00 0 0 0 92.00 0 0 0 92.00 0 0 92.00 0 0 0 92.00 0 0 0 92.00 0 0 0 0 92.00 0 0 0 0 0 92.00 0 0 0 0 92.00 0	90. 00 09000 CLINIC	0. 000000	50, 477		0 0	0	90.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART 0. 000000 77, 245 0 0 0 0 92. 00					0 0	0	91.00
	92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART				0 0	0	92.00
	200.00 Total (lines 50 through 199)		3, 193, 281		0 0	0	•

Health Financial Systems F	RANCI SCAN HEAL	TH RENSSELAER		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C	CN: 15-1324	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part V Date/Time Pre 5/31/2018 2:4	pared: 6 am
		Title	e XVIII	Hospi tal	Cost	
			Charges		Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
	Ratio From	Services (see	Reimbursed	Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins			
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS		-				
50. 00 05000 OPERATI NG ROOM	0. 640278		.,		0	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 353852		2, 908, 99		0	
60. 00 06000 LABORATORY	0. 318943	0	1, 628, 30	01 0	0	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 449138	0	124, 81	11 0	0	63.00
65. 00 06500 RESPI RATORY THERAPY	0. 724036	0	761, 68	35 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 859661	0	676, 74	12 0	0	66.00
66.01 06601 WHEATFIELD PT	0. 954943	0	388, 34	41 0	0	66.01
67.00 06700 OCCUPATI ONAL THERAPY	1. 020948	0	62, 43	32 0	0	67.00
67.01 06701 WHEATFI ELD OT	2.055504	0	21, 65	54 0	0	67.01
68.00 06800 SPEECH PATHOLOGY	1. 515224	0	17, 54	14 0	0	68.00
68.01 06801 WHEATFI ELD ST	2. 022932	0	5, 84	42 0	0	68.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 143667	0	1, 277, 0	55 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 193070	0	437,60	01 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 195283	0	5, 986, 04	40 0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0. 000000				0	88.00
88.03 08801 RURAL HEALTH CLINIC IV	0. 000000				0	88.03
90. 00 09000 CLINIC	0. 763837	0	1, 440, 0	58 0	0	90.00
91.00 09100 EMERGENCY	0. 653093	0	1, 454, 02	24 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 668043	0	670, 53		0	92.00
200.00 Subtotal (see instructions)		0	18, 964, 19		0	200.00
201.00 Less PBP Clinic Lab. Services-Program				0 0		201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)		0	18, 964, 19	95 0	0	202.00

Health Financia	al Systems F	RANCI SCAN HEAL	TH RENSSELAER		In Lie	u of Form CMS	-2552-10
APPORTI ONMENT (OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C		Period: From 01/01/2017 To 12/31/2017	Worksheet D Part V Date/Time Pr 5/31/2018 2:	
			Title	XVIII	Hospi tal	Cost	
		Cos					
Co	ost Center Description	Cost	Cost				
		Reimbursed	Reimbursed				
		Servi ces	Services Not				
		Subject To	Subject To				
		Ded. & Coins.	Ded. & Coins.				
		(see inst.)	(see inst.)	-			
		6.00	7.00				
	RY SERVICE COST CENTERS	705 000		1			-
	PERATING ROOM	705, 933					50.00
	DI OLOGY-DI AGNOSTI C	1, 029, 352					54.00
60.00 06000 LA		519, 335	0				60.00
	OOD STORING, PROCESSING & TRANS.	56, 057	0				63.00
	SPI RATORY THERAPY	551, 487	0				65.00
	IYSI CAL THERAPY	581, 769	0				66.00
	IEATFI ELD PT	370, 844	0				66. 01
	CUPATIONAL THERAPY	63, 740	0				67.00
	IEATFI ELD OT	44, 510	0				67.01
	PEECH PATHOLOGY	26, 583					68.00
	IEATFI ELD ST	11, 818	0				68. 01
	DICAL SUPPLIES CHARGED TO PATIENT	183, 471	0				71.00
	IPL. DEV. CHARGED TO PATIENTS	84, 488	0				72.00
	RUGS CHARGED TO PATIENTS	1, 168, 972	0)			73.00
	ENT SERVICE COST CENTERS						
	IRAL HEALTH CLINIC	0	0				88.00
	IRAL HEALTH CLINIC IV	0	0				88.03
90.00 09000 CL		1, 099, 970	0				90.00
91.00 09100 EM	IERGENCY	949, 613	0				91.00
92.00 09200 OB	SERVATION BEDS (NON-DISTINCT PART	447, 945	0				92.00
200. 00 Su	ıbtotal (see instructions)	7, 895, 887	0				200.00
	ess PBP Clinic Lab. Services-Program	0					201.00
	nly Charges						
202.00 Ne	et Charges (line 200 - line 201)	7, 895, 887	0				202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CON: 15-1324 Period: To 12/31/2017 Worksheet D For 01/01/2017 Cost center Description Cost to Charge Worksheet C, Part I, col. 9 Swing Beds - SNF Cost Cost Cost Cost Period: To 12/31/2017 Period: Ded. 4: Coins, Cost Period: Ded. 4: Coins, Cost Period: Ded. 4: Coins, Cost Vorksheet D Part V Period: To 12/31/2017 Worksheet D Part V Period: Ded. 4: Coins, Cost Worksheet D Part V Period: Ded. 4: Coins, Cost Period: Ded. 4: Coins, Cost	Health Financial Systems	RANCI SCAN HEAL	TH RENSSELAER		In Lie	eu of Form CMS-	2552-10
Image: construct construction Component CCN: 15-2324 To 12/31/2017 Date/Time Prepared: Cost Cost Center Description Cost to Charge PPS Reimbursed Ratio From Worksheet C, Part I, col. 9 Cost (Cost Center Sources) Cost (Cost Center Ces Not Sources) PPS Services (Cost Ces Not Sources) PPS Services (Cost (See Inst.)) PPS Services (Cost Ces Not Sources) PPS Services (Cost Ces Not Sources) Services Not Sources) Services Not Sources (Cost Ces Not Sources) Services Not Sources) Services Not Sources (Cost Ces Not Sources) Services Not Sources) Services Not Sources (Cost Ces Not Sources) Services Not Sources) Services Not Sources) Services Not Sources Not Source	APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C	CN: 15-1324			
ANCILLARY SERVICE COST CENTERS Cost to Charges Cost Reimbursed Services (see inst.) Soving Beds - SNF Cost Cost st Cost st Cost to Charges Cost Cost Reimbursed Services (see inst.) PPS Services Services (see inst.) Cost Services (see inst.) Cost Services (see inst.) Cost Cost Services (see inst.) Service (sevices (see inst.) Serv			Component (CCN: 15-7324			nared
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200.00Subtotal (see instructions)0000200.00201.00Less PBP Clinic Lab. Services-Program000201.00Only Charges					0 0		
201.00Less PBP Clinic Lab. Services-Program00201.00Only Charges00201.00		0. 668043	0		0 0		
Only Charges			0		0 0	0	
					0 0		201.00
202.00 Net Charges (line 200 - line 201) 0							
	202.00 Net Charges (line 200 - line 201)		0		0 0	0	202.00

Health Financial Systems	FRANCI SCAN HEAL	TH RENSSELAER		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C Component	CN: 15-1324 CCN: 15-Z324	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part V Date/Time Pre	
		T: +1 -		Culture Dada - CNE	5/31/2018 2:4	16 am
	Ca	sts	XVIII	Swing Beds - SNF	Cost	
Cost Center Description	Cost	Cost	-			
cost center bescription	Reimbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
		Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7.00	1			
ANCI LLARY SERVI CE COST CENTERS			1			
50. 00 05000 OPERATI NG ROOM	0	C)			50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	C				54.00
60. 00 06000 LABORATORY	0	C				60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	C				63.00
65. 00 06500 RESPI RATORY THERAPY	0	C				65.00
66. 00 06600 PHYSI CAL THERAPY	0	c c				66,00
66.01 06601 WHEATFI ELD PT	0	c c				66, 01
67.00 06700 OCCUPATI ONAL THERAPY	0	c				67.00
67.01 06701 WHEATFI ELD OT	0	c c				67.01
68.00 06800 SPEECH PATHOLOGY	0	c c				68.00
68. 01 06801 WHEATFI ELD ST	0	c				68.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	c				71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	c				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	c				73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	0)			88.00
88.03 08801 RURAL HEALTH CLINIC IV	0	0				88.03
90. 00 09000 CLINIC	0	0				90.00
91.00 09100 EMERGENCY	0	0				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0				92.00
200.00 Subtotal (see instructions)	0	0				200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)	0	C				202.00

Health Financial Systems F	RANCI SCAN HEAL	TH RENSSELAER		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCI NE COST	Provider C	CN: 15-1324	Period:	Worksheet D	
				From 01/01/2017 To 12/31/2017	Part V Date/Time Pre	pared:
					5/31/2018 2:4	6 am
		Titl	e XIX	Hospi tal	Cost	
			Charges		Costs	
Cost Center Description		PPS Reimbursed		Cost	PPS Services	
	Ratio From	Services (see	Rei mbursed	Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins			
	1 00	0.00	(see inst.)	(see inst.)	F 00	
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	0. 640278	0	22, 98		0	50.00
					-	
54. 00 05400 RADI OLOGY-DI AGNOSTI C 60. 00 06000 LABORATORY	0. 353852 0. 318943		89, 64		0	
			71, 38		0	
63. 00 06300 BLOOD STORI NG, PROCESSI NG & TRANS.	0. 449138		0.00	0 0	0	
65. 00 06500 RESPI RATORY THERAPY	0. 724036		9, 98		0	65.00
66. 00 06600 PHYSI CAL THERAPY	0.859661		11, 10		0	66.00
66. 01 06601 WHEATFIELD PT	0. 954943		13, 09		0	66.01
67. 00 06700 OCCUPATI ONAL THERAPY	1. 020948		12, 15		0	67.00
67. 01 06701 WHEATFI ELD OT	2.055504		9, 94		0	67.01
68.00 06800 SPEECH PATHOLOGY	1. 515224		5, 6		0	68.00
68.01 06801 WHEATFIELD ST	2. 022932		9, 7		0	68. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 143667		19, 35		0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 193070			-	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 195283	0	172, 43	37 0	0	73.00
OUTPATIENT SERVICE COST CENTERS			1		-	
88.00 08800 RURAL HEALTH CLINIC	2. 312918				0	
88.03 08801 RURAL HEALTH CLINIC IV	2. 238687				0	
90. 00 09000 CLINIC	0. 763837		21, 8		0	
91.00 09100 EMERGENCY	0. 653093		99, 79		0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 668043	0	22, 08		0	1 2.00
200.00 Subtotal (see instructions)		0	591, 9		0	200. 00
201.00 Less PBP Clinic Lab. Services-Program				0 0		201.00
Only Charges		_		-	-	
202.00 Net Charges (line 200 - line 201)		0	591, 9	53 0	0	202.00

Health Financial Systems	FRANCI SCAN HEAL	TH RENSSELAER		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND) VACCINE COST	Provider CC	:N: 15-1324	Peri od: From 01/01/2017 To 12/31/2017	Worksheet D Part V Date/Time Pre 5/31/2018 2:4	
		Title	e XIX	Hospi tal	Cost	
		sts				
Cost Center Description	Cost	Cost				
	Rei mbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7.00				
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM	14, 714	0				50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	31, 722					54.00
60. 00 06000 LABORATORY	22, 768					60.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	22,700					63.00
65. 00 06500 RESPIRATORY THERAPY	7,230	Ű				65.00
66. 00 06600 PHYSI CAL THERAPY	9, 549					66.00
66. 01 06601 WHEATFI ELD PT	12, 503					66.01
67. 00 06700 OCCUPATIONAL THERAPY	12, 503					67.00
67. 01 06701 WHEATFI ELD OT	20, 450					67.00
68. 00 06800 SPEECH PATHOLOGY	8, 502					68.00
68. 01 06801 WHEATFIELD ST	19,659					68.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	2, 781					71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	154					72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	33, 674					73.00
OUTPATIENT SERVICE COST CENTERS	55,074	0				/ 3. 00
88. 00 08800 RURAL HEALTH CLINIC	0	0				88.00
88. 03 08801 RURAL HEALTH CLINIC IV	0					88.03
90. 00 09000 CLINIC	16, 695	Ű				90.00
91. 00 09100 EMERGENCY	65, 174					91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	14, 752					92.00
200.00 Subtotal (see instructions)	292, 732					200.00
201.00 Less PBP Clinic Lab. Services-Program	0	, i i i i i i i i i i i i i i i i i i i				201.00
Only Charges	Ĭ					
202.00 Net Charges (line 200 - line 201)	292, 732	0				202.00
	, , , , , , , , , , , , , , , , , , , ,	-1				

	Financial Systems FRANCISCAN HEALTH			u of Form CMS-2	
COMPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-1324	Period: From 01/01/2017 To 12/31/2017	Worksheet D-1 Date/Time Pre 5/31/2018 2:40	pared:
		Title XVIII	Hospi tal	Cost	
	Cost Center Description			1.00	
	PART I - ALL PROVIDER COMPONENTS				
1.00	INPATIENT DAYS Inpatient days (including private room days and swing-bed day	s excluding newborn)		2, 112	1.00
2.00	Inpatient days (including private room days and swing-bed day Inpatient days (including private room days, excluding swing-			1, 890	
3.00	Private room days (excluding swing-bed and observation bed da		rivate room days,	0	1
4.00	do not complete this line. Semi-private room days (excluding swing-bed and observation b	od dave)		1, 279	4.00
4.00 5.00	Total swing-bed SNF type inpatient days (including private ro		er 31 of the cost	209	
	reporting period				
6.00	Total swing-bed SNF type inpatient days (including private ro reporting period (if calendar year, enter 0 on this line)	om days) after December	31 of the cost	0	6.00
7.00	Total swing-bed NF type inpatient days (including private roo	m days) through Decembe	r 31 of the cost	13	7.00
	reporting period				
8.00	Total swing-bed NF type inpatient days (including private roo reporting period (if calendar year, enter 0 on this line)	m days) after December 3	31 of the cost	0	8.00
9.00	Total inpatient days including private room days applicable t	o the Program (excluding	g swing-bed and	763	9.00
10.00	newborn days)	nly (including private)		200	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		oom uays)	209	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII o	nly (including private)	room days) after	0	11.00
12.00	December 31 of the cost reporting period (if calendar year, e Swing-bed NF type inpatient days applicable to titles V or XI		te room dave)	0	12.00
12.00	through December 31 of the cost reporting period	x only (including priva	te room days)	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XI			0	13.00
14.00	after December 31 of the cost reporting period (if calendar y Medically necessary private room days applicable to the Progr			0	14.00
15.00	Total nursery days (title V or XIX only)	am (exer during swring bed	uuys)	0	
16.00	Nursery days (title V or XIX only)			0	16.00
17.00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to servic	es through December 31 (of the cost		17.00
	reporting period	0			
18.00	Medicare rate for swing-bed SNF services applicable to servic reporting period	es after December 31 of	the cost		18.00
19.00	Medicaid rate for swing-bed NF services applicable to service	s through December 31 o	f the cost	134.09	19.00
20.00	reporting period			0.00	20.00
20.00	Medicaid rate for swing-bed NF services applicable to service reporting period	s after December 31 of	the cost	0.00	20.00
21.00	Total general inpatient routine service cost (see instruction			3, 296, 799	
22.00	Swing-bed cost applicable to SNF type services through Decemb 5 x line 17)	er 31 of the cost repor	ting period (line	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December	31 of the cost reportion	ng period (line 6	0	23.00
	x line 18)				
24.00	Swing-bed cost applicable to NF type services through Decembe 7×1 (ine 19)	r 31 of the cost report	ng period (line	1, 743	24.00
25.00	Swing-bed cost applicable to NF type services after December	31 of the cost reporting	g period (line 8	0	25.00
26.00	x line 20) Total swing-bed cost (see instructions)			329, 835	26.00
28.00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		2, 966, 964	
	PRI VATE ROOM DI FFERENTI AL ADJUSTMENT	· · · · · · · · · · · · · · · · · · ·			
28.00 29.00	General inpatient routine service charges (excluding swing-be	d and observation bed c	narges)	0	1
29.00 30.00	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	
31.00	General inpatient routine service cost/charge ratio (line 27	÷line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)				32.00
33.00 34.00	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 mi	nus line 33)(see instru	ctions)	0.00 0.00	
35.00	Average per diem private room cost differential (line 34 x li		·	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	and private room cost d	fforontial (line	0	
37.00	General inpatient routine service cost net of swing-bed cost 27 minus line 36)	anu private room cost d	inerential (IINe	2, 966, 964	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
38.00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ Adjusted general inpatient routine service cost per diem (see			1, 569. 82	30 00
38.00 39.00	Program general inpatient routine service cost per drem (see			1, 569. 82	
40.00	Medically necessary private room cost applicable to the Progr	am (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39	+ line 40)		1, 197, 773	41.00

MPUTATION OF INPATIENT OPERATING COST		Provider C	CN: 15-1324	Peri od:	Worksheet D-1	
				From 01/01/2017 To 12/31/2017	Date/Time Pre	epare
			XVIII	Hospi tal	5/31/2018 2:4 Cost	16 am
Cost Center Description	Total	Total	Average Per		Program Cost	
	npatient Cost	Inpatient Days		÷	(col. 3 x col.	
-	1.00	2.00	col. 2) 3.00	4.00	4) 5.00	
2.00 NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00	3.00	42.
Intensive Care Type Inpatient Hospital Units						
. OO INTENSIVE CARE UNIT . OO CORONARY CARE UNIT	1, 291, 556	193	6, 692. (108	722, 736	43
5. 00 BURN INTENSIVE CARE UNIT						44
0. 00 SURGI CAL I NTENSI VE CARE UNI T						46
7. 00 OTHER SPECIAL CARE (SPECIFY)						47.
Cost Center Description					1.00	
.00 Program inpatient ancillary service cost (Wks	t. D-3, col. 3	, line 200)			1,042,014	48
0.00 Total Program inpatient costs (sum of lines 4	1 through 48)(see instructio	ns)		2, 962, 523	49.
PASS THROUGH COST ADJUSTMENTS 0.00 Pass through costs applicable to Program inpa	tiont routing	anniaca (from	What D arm	of Donto L and	0	50.
	trent routine	Services (ITOI	WKSL. D, SU	I UI PALLS I ANU	0	50.
00 Pass through costs applicable to Program inpa	tient ancillar	y services (fr	om Wkst. D, s	sum of Parts II	0	51.
and IV) 2.00 Total Program excludable cost (sum of lines 5	hand E1				0	52
2.00 Total Program excludable cost (sum of lines 5 3.00 Total Program inpatient operating cost exclud		lated non-phy	sician anesth	netist and		
medical education costs (line 49 minus line 5					_	
TARGET AMOUNT AND LIMIT COMPUTATION						
.00 Program discharges .00 Target amount per discharge					0.00	
. 00 Target amount (line 54 x line 55)					0.00	
. 00 Difference between adjusted inpatient operati	ng cost and ta	rget amount (I	ine 56 minus	line 53)	0	
B. 00 Bonus payment (see instructions)	arting pariod	anding 1004	ndated and a	manundad by the	0	
0.00 Lesser of lines 53/54 or 55 from the cost rep market basket	bring period	ending 1996, u	puated and co	inpounded by the	0.00	59
0.00 Lesser of lines 53/54 or 55 from prior year c					0.00	60
1.00 If line 53/54 is less than the lower of lines					0	61
which operating costs (line 53) are less than amount (line 56), otherwise enter zero (see i		s (TTHES 54 X	60), OF 1% OF	the target		
2.00 Relief payment (see instructions)	,				0	
8.00 Allowable Inpatient cost plus incentive payme	nt (see instru	ctions)			0	63
PROGRAM INPATIENT ROUTINE SWING BED COST 4.00 Medicare swing-bed SNF inpatient routine cost	s through Dece	mber 31 of the	cost reporti	na period (See	328, 092	64.
instructions)(title XVIII only)	0			0 1 1		
5.00 Medicare swing-bed SNF inpatient routine cost	s after Decemb	er 31 of the c	ost reportino	g period (See	0	65.
instructions)(title XVIII only) 5.00 Total Medicare swing-bed SNF inpatient routin	e costs (line	64 plus line 6	5)(title XVII	l only). For	328, 092	66
CAH (see instructions)				•		
7.00 Title V or XIX swing-bed NF inpatient routine	costs through	December 31 o	f the cost re	eporting period	0	67.
(line 12 x line 19) B.OO Title V or XIX swing-bed NF inpatient routine	costs after D	ecember 31 of	the cost repo	orting period	0	68.
(line 13 x line 20)			the boot ropt	, thig point ou		
0.00 Total title V or XIX swing-bed NF inpatient r					0	69.
PART III - SKILLED NURSING FACILITY, OTHER NU 0.00 Skilled nursing facility/other nursing facili				1		70
1.00 Adjusted general inpatient routine service co	5					71.
2.00 Program routine service cost (line 9 x line 7		<i>(</i>),	0.51			72
8.00 Medically necessary private room cost applica 9.00 Total Program general inpatient routine servi						73
5.00 Capital-related cost allocated to inpatient ro				Part II, column		75
26, line 45)		`				
0.00 Per diem capital-related costs (line 75 ÷ lin						76
.00 Program capital-related costs (line 9 x line .00 Inpatient routine service cost (line 74 minus	· ·					77
. 00 Aggregate charges to beneficiaries for excess	,	rovi der record	s)			79
.00 Total Program routine service costs for compa		ost limitation	(line 78 mir	nus line 79)		80
.00 Inpatient routine service cost per diem limit. .00 Inpatient routine service cost limitation (li)				81
. 00 Reasonable inpatient routine service cost film tation (if		•				82
00 Program inpatient ancillary services (see ins						84
0.00 Utilization review - physician compensation (85
D. 00 Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS		rough 85)				86
7.00 Total observation bed days (see instructions)	11100011 0031				611	87
3.00 Adjusted general inpatient routine cost per d		line 2)			1, 569. 82	88
0.00 Observation bed cost (line 87 x line 88) (see					959, 160	

Health Financial Systems	FRANCI SCAN HEAL	TH RENSSELAER		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period:	Worksheet D-1	
				From 01/01/2017 To 12/31/2017	Date/Time Pre 5/31/2018 2:4	
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	544, 849	3, 296, 799	0. 16526	6 959, 160	158, 517	90.00
91.00 Nursing School cost	0	3, 296, 799	0.00000	959, 160	0	91.00
92.00 Allied health cost	0	3, 296, 799	0.00000	0 959, 160	0	92.00
93.00 All other Medical Education	0	3, 296, 799	0.00000	959, 160	0	93.00

	FINANCI SCAN HEALTH ATION OF INPATIENT OPERATING COST	Provider CCN: 15-1324	Period:	u of Form CMS-2 Worksheet D-1	
			From 01/01/2017 To 12/31/2017	Date/Time Pre	pared:
		Title XIX	Hospi tal	5/31/2018 2:40 Cost	υam
	Cost Center Description			1.00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
	INPATIENT DAYS			0.110]
1.00 2.00	Inpatient days (including private room days and swing-bed day Inpatient days (including private room days, excluding swing-			2, 112 1, 890	
3.00	Private room days (excluding swing-bed and observation bed da		rivate room days,	0	1
1 00	do not complete this line.		-	1 070	1 00
4.00 5.00	Semi-private room days (excluding swing-bed and observation b Total swing-bed SNF type inpatient days (including private ro		er 31 of the cost	1, 279 209	
	reporting period				
6.00	Total swing-bed SNF type inpatient days (including private ro reporting period (if calendar year, enter 0 on this line)	om days) after December	31 of the cost	0	6.00
7.00	Total swing-bed NF type inpatient days (including private roc	m days) through December	- 31 of the cost	13	7.00
0.00	reporting period				
8.00	Total swing-bed NF type inpatient days (including private roo reporting period (if calendar year, enter 0 on this line)	m days) arter December (31 OF THE COST	0	8.00
9.00	Total inpatient days including private room days applicable t	o the Program (excluding	g swing-bed and	123	9.00
10. 00	newborn days) Swing-bed SNF type inpatient days applicable to title XVIII c	nly (including private :	coom dave)	0	10.00
10.00	through December 31 of the cost reporting period (see instruc		oom days)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII o		room days) after	0	11.00
12.00	December 31 of the cost reporting period (if calendar year, e Swing-bed NF type inpatient days applicable to titles V or XI		te room days)	0	12.00
	through December 31 of the cost reporting period		5 .		
13.00	Swing-bed NF type inpatient days applicable to titles V or XI after December 31 of the cost reporting period (if calendar y			0	13.00
14.00	Medically necessary private room days applicable to the Progr			0	14.00
15.00	Total nursery days (title V or XIX only)		5	0	
16.00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			0	16.00
17.00	Medicare rate for swing-bed SNF services applicable to servic	es through December 31 d	of the cost		17.00
18.00	reporting period Medicare rate for swing-bed SNF services applicable to servic	ac after December 21 of	the cost		18.00
18.00	reporting period	es arter December 31 01	the cost		18.00
19.00	Medicaid rate for swing-bed NF services applicable to service	es through December 31 of	f the cost	134.09	19.00
20.00	reporting period Medicaid rate for swing-bed NF services applicable to service	s after December 31 of 1	the cost	0.00	20.00
	reporting period				
21.00 22.00	Total general inpatient routine service cost (see instruction Swing-bed cost applicable to SNF type services through Decemb		ting period (line)	3, 296, 799 0	
22.00	5 x line 17)	er 51 of the cost report	ting period (inne	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December	31 of the cost reportir	ng period (line 6	0	23.00
24.00	x line 18) Swing-bed cost applicable to NF type services through Decembe	r 31 of the cost reporti	ng period (line	1, 743	24.00
	7 x line 19)				
25.00	Swing-bed cost applicable to NF type services after December x line 20)	31 of the cost reporting	g period (line 8	0	25.00
26.00	Total swing-bed cost (see instructions)			329, 835	26.00
27.00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		2, 966, 964	27.00
28.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-be	d and observation bed ch	narges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)		g,	0	
30.00	Semi-private room charges (excluding swing-bed charges)			0	
31.00	General inpatient routine service cost/charge ratio (line 27	÷line 28)		0.00000	
32.00 33.00	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)			0.00 0.00	
34.00	Average per diem private room charge differential (line 32 mi	nus line 33)(see instruc	rtions)	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	1
37.00	General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line	2, 966, 964	37.00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				1
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ				1
		· · · · ·		1 5/0 00	38.00
38.00	Adjusted general inpatient routine service cost per diem (see			1, 569. 82	
38.00 39.00 40.00	Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Progr	: 38)		1, 569, 82 193, 088 0	39.00

MPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-1324 Period: Worksheet D-7	1
	To 12/31/2017 Date/Time Pro 5/31/2018 2:4	
	Title XIX Hospital Cost	
Cost Center Description T Inpati	Total Average Per Program Days Program Cost Cost Inpatient Days Diem (col. 1 ÷ (col. 3 x col.	
	col. 2) 4) 2.00 3.00 4.00 5.00	+
.00 NURSERY (title V & XIX only)		42.
Intensive Care Type Inpatient Hospital Units		
. OO INTENSIVE CARE UNIT	, 556 193 6, 692. 00 18 120, 456	5 43 44
. OO BURN INTENSIVE CARE UNIT		44
. 00 SURGI CAL I NTENSI VE CARE UNI T		46
. 00 OTHER SPECIAL CARE (SPECIFY)		47
Cost Center Description	1.00	-
. 00 Program inpatient ancillary service cost (Wkst. D-	DI. 3, line 200) 11,571	1 48
0.00 Total Program inpatient costs (sum of lines 41 thr		
PASS THROUGH COST ADJUSTMENTS		
0.00 Pass through costs applicable to Program inpatient	tine services (from Wkst. D, sum of Parts I and C	50
) 1.00 Pass through costs applicable to Program inpatient	Ilary services (from Wkst. D. sum of Parts II	51.
and IV)		
2.00 Total Program excludable cost (sum of lines 50 and	(52
3.00 Total Program inpatient operating cost excluding c	al related, non-physician anesthetist, and 0	53
medical education costs (line 49 minus line 52)		-
TARGET AMOUNT AND LIMIT COMPUTATION 4.00 Program discharges		54
0.00 Target amount per discharge		55
0.00 Target amount (line 54 x line 55)	(56 0
7.00 Difference between adjusted inpatient operating co		
8.00 Bonus payment (see instructions) 9.00 Lesser of lines 53/54 or 55 from the cost reportin	iod ending 1996, updated and compounded by the 0.00	
market basket	tion ending 1998, updated and compounded by the	J 59
0.00 Lesser of lines 53/54 or 55 from prior year cost r	t, updated by the market basket 0.00	0 60
.00 If line 53/54 is less than the lower of lines 55,) 61
which operating costs (line 53) are less than expe		
amount (line 56), otherwise enter zero (see instru 2.00 Relief payment (see instructions)	15)	62
8.00 Allowable Inpatient cost plus incentive payment (s		63
PROGRAM INPATIENT ROUTINE SWING BED COST		
4.00 Medicare swing-bed SNF inpatient routine costs thr	December 31 of the cost reporting period (See	64
instructions)(title XVIII only) 5.00 Medicare swing-bed SNF inpatient routine costs aft	ecember 31 of the cost reporting period (See	65
instructions)(title XVIII only)		/ 00
5.00 Total Medicare swing-bed SNF inpatient routine cos	ine 64 plus line 65)(title XVIII only). For) 66
CAH (see instructions)	and December 21 of the cost momentian and a	
7.00 Title V or XIX swing-bed NF inpatient routine cost (line 12 x line 19)	rough December 31 of the cost reporting period	67
3.00 Title V or XIX swing-bed NF inpatient routine cost	ter December 31 of the cost reporting period	68
(line 13 x line 20)		
2.00 Total title V or XIX swing-bed NF inpatient routin	• • • •	0 69
PART III - SKILLED NURSING FACILITY, OTHER NURSING 0.00 Skilled nursing facility/other nursing facility/IC		70
.00 Adjusted general inpatient routine service cost pe		71
2.00 Program routine service cost (line 9 x line 71)		72
6.00 Medically necessary private room cost applicable t		73
I. 00 Total Program general inpatient routine service co 5.00 Capital-related cost allocated to inpatient routin	· · ·	74
26, line 45)		75
b. 00 Per diem capital-related costs (line 75 ÷ line 2)		76
.00 Program capital-related costs (line 9 x line 76)		77
.00 Inpatient routine service cost (line 74 minus line	som provider records)	78
.00 Aggregate charges to beneficiaries for excess cost .00 Total Program routine service costs for comparison		80
.00 Inpatient routine service costs for comparison		81
.00 Inpatient routine service cost limitation (line 9	ne 81)	82
.00 Reasonable inpatient routine service costs (see in	-	83
. 00 Program inpatient ancillary services (see instruct		84
 00 Utilization review - physician compensation (see i 00 Total Program inpatient operating costs (sum of li 		85
PART IV - COMPUTATION OF OBSERVATION BED PASS THRO		- 00
7.00 Total observation bed days (see instructions)	611	1 87
3.00 Adjusted general inpatient routine cost per diem (
.00 Observation bed cost (line 87 x line 88) (see inst		D 89

Health Financial Systems	FRANCI SCAN HEAL	TH RENSSELAER		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period:	Worksheet D-1	
				From 01/01/2017 To 12/31/2017	Date/Time Pre 5/31/2018 2:4	
		Titl	e XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	544, 849	3, 296, 799	0. 16526	6 959, 160	158, 517	90.00
91.00 Nursing School cost	0	3, 296, 799	0.00000	959, 160	0	91.00
92.00 Allied health cost	0	3, 296, 799	0.00000	959, 160	0	92.00
93.00 All other Medical Education	0	3, 296, 799	0.00000	959, 160	0	93.00

Health Financial Systems	FRANCI SCAN HEALTH RENSSELAER		In Lie	eu of Form CMS-	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der (CCN: 15-1324	Period: From 01/01/2017	Worksheet D-3	;
			To 12/31/2017		pared:
				5/31/2018 2:4	6 am
	Ti tl	e XVIII	Hospi tal	Cost	
Cost Center Description		Ratio of Cos		Inpatient	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
		1.00	2.00	2)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
30. 00 03000 ADULTS & PEDIATRICS			746, 191	[30.00
31. 00 03100 I NTENSI VE CARE UNI T			149, 040		31.00
ANCI LLARY SERVICE COST CENTERS			117,010		01.00
50. 00 05000 OPERATI NG ROOM		0. 6402	78 216, 253	138, 462	50.00
54.00 05400 RADI OLOGY-DI AGNOSTI C		0.3538			
60. 00 06000 LABORATORY		0. 3189			
63.00 06300 BLOOD STORING, PROCESSING & TRANS.		0. 4491			
65. 00 06500 RESPI RATORY THERAPY		0. 7240	36 226, 921	164, 299	65.00
66. 00 06600 PHYSI CAL THERAPY		0.8596	61 29, 197	25, 100	66.00
66. 01 06601 WHEATFI ELD PT		0.9549	43 0	0	66. 01
67.00 06700 OCCUPATI ONAL THERAPY		1.0209	48 13, 830	14, 120	67.00
67. 01 06701 WHEATFI ELD OT		2.0555		0	
68.00 06800 SPEECH PATHOLOGY		1. 5152		3, 311	
68. 01 06801 WHEATFI ELD ST		2.0229		0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 1436			
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS		0. 1930			
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 1952	83 853, 954	166, 763	73.00
OUTPATIENT SERVICE COST CENTERS		0.0000	20		
88.00 08800 RURAL HEALTH CLINIC 88.03 08801 RURAL HEALTH CLINIC IV		0.0000		0	00.00
		0.0000		s	
90. 00 09000 CLINIC 91. 00 09100 EMERGENCY		0. 7638			
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 6680			91.00 92.00
200.00 Total (sum of lines 50 through 94 and	06 through 00	0.0080	43 77, 245 3, 193, 281		
201.00 Less PBP Clinic Laboratory Services-P			3, 173, 201	1, 042, 014	200.00
202.00 Net charges (line 200 minus line 201)			3, 193, 281		201.00
		1	0, 170, 201	I	1-02.00

Health Financial Systems	FRANCI SCAN HEALTH	RENSSELAER		In Lie	eu of Form CMS-	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider C		Peri od:	Worksheet D-3	;
		Component		From 01/01/2017	Data /Tima Dra	norod.
		Component	CCN: 15-Z324	To 12/31/2017	Date/Time Pre 5/31/2018 2:4	
		Title	XVIII	Swing Beds - SNF		
Cost Center Description			Ratio of Cos	t Inpatient	Inpati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
					2)	
			1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS				1		
30. 00 03000 ADULTS & PEDI ATRI CS				0		30.00
31. 00 03100 I NTENSI VE CARE UNI T				0		31.00
ANCI LLARY SERVI CE COST CENTERS			0. 64027	78 0	0	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C			0. 35385		-	
60. 00 06000 LABORATORY			0. 31894			
63. 00 06300 EABORATORT 63. 00 06300 BLOOD STORING, PROCESSING & TRANS.			0. 31892			•
65. 00 06500 RESPIRATORY THERAPY			0. 72403			
66. 00 06600 PHYSI CAL THERAPY			0. 85966			
66. 01 06601 WHEATFI ELD PT			0. 95494			
67. 00 06700 OCCUPATI ONAL THERAPY			1. 02094			
67. 01 06701 WHEATFI ELD OT			2. 05550		0	
68. 00 06800 SPEECH PATHOLOGY			1. 51522			
68. 01 06801 WHEATFI ELD ST			2.02293		0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT			0. 14366		2, 155	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS			0. 19307	0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS			0. 19528	159, 808	31, 208	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC			0.0000		0	00.00
88.03 08801 RURAL HEALTH CLINIC IV			0.00000	00	0	88.03
90. 00 09000 CLINIC			0. 76383	37 0	0	90.00
91.00 09100 EMERGENCY			0.65309	93 0	0	1 / 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART			0. 66804	13 0	0	
200.00 Total (sum of lines 50 through 94 and				273, 667	111, 296	
201.00 Less PBP Clinic Laboratory Services-F		5 (line 61)		0		201.00
202.00 Net charges (line 200 minus line 201)				273, 667		202.00

54.00 05400 RADI OLOGY-DI AGNOSTI C 0.353852 4,667 1,651 54.0 60.00 06000 LABORATORY 0.318943 4,878 1,556 60.0 63.00 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 0.449138 0 0 63.0 65.00 06500 RESPI RATORY THERAPY 0.859661 0 0 66.0 66.01 06601 WHEATFI ELD PT 0.954943 0 0 66.0 67.00 06700 OCCUPATI ONAL THERAPY 0.859661 0 0 66.0 67.01 06601 WHEATFI ELD DT 0.954943 0 0 67.0 67.01 06700 OCCUPATI ONAL THERAPY 1.020948 0 0 67.0 68.01 06800 SPEECH PATHOLOGY 1.515224 0 0 68.0 68.01 06801 WHEATFI ELD ST 2.022932 0 68.0 68.0 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0.193070 0 0 72.0 72.00 07200 IMPL. DEV. CHARGED TO P	Health Financial Systems FRANCIS	SCAN HEALTH RENSSELAER		In Lie	u of Form CMS-	2552-10
To 12/31/2017 Date/Time Prepared 5/31/2018 2:46 am Cost Center Description Title XIX Hospital Cost 1npatient Program Costs (col. 1 x col. 2) Inpatient Program Costs (col. 1 x col. 2) Inpatient Program Costs (col. 1 x col. 2) Inpatient Program Costs (col. 1 x col. 2) 30.00 03000 ADULTS & PEDIATRICS 1.00 2.00 3.00 31.00 03100 INTENSIVE CARE UNIT 0 3.00 31.0 ANCILLARY SERVICE COST CENTERS 0 0.54.00 54.00 0.5400 RADIOLOGY-DI AGNOSTIC 31.0 50.00 05000 OPERATING ROOM 0.640278 0 0 50.0 50.00 065000 RESPIRATING ROOM 0.338952 4.667 1.651 54.00 60.00 0.6600 RESPIRATORY THERAPY 0.124036 832 662.00 66.00 66.00 0.6600 RESPIRATORY THERAPY 0.224034 0 63.00 66.00 66.00 0.6600 RESPIRATORY THERAPY 0.240436 0 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00	INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 15-13			Worksheet D-3	
Impart entropy Title XIX Hospital Cost Cost Center Description Title XIX Hospital Cost To Charges Inpatient Program Charges Inpatient Prog					Data/Tima Pro	narod
Cost Center Description Ratio of Cost To Charges Inpatient Program Charges Inpatient Program (cl 1 x col . 2) 30.00 03000 ADULTS & PEDIATRICS 1.00 2.00 3.00 31.00 03000 ADULTS & PEDIATRICS 6,483 30.0 31.00 03000 INTENVE CARE UNIT 0 31.0 ANCILLARY SERVICE COST CENTERS 0 31.0 50.00 05400 RADILOGY-DIAGNOSTIC 0.318943 4,878 50.00 054000 RADILOGY-DIAGNOSTIC 0.318943 4,878 6.00 065000 RESPIRATORY 0.724036 832 602 6.01 0.6600 PHYSICAL THERAPY 0.954943 0 0 6.00 06000 UCCUPATIONAL THERAPY 0.954943 0 0 67.0 6.01 06601 WHEATFIELD PT 2.055504 0 0 67.0 68.0 6.8.00 06800 SPEECE NATHOLOGY 1.515224 0 0 68.0 6.8.00 06800 SPEECE NATHOLOGY 1.515224 0 0 68.0 7.00 07200 IMPL. DEV. CH			'	0 12/31/2017		
Instruction To Charges Program Costs (cl. 1 x col. 2) 1.00 2.00 3.00 30.00 03000 ADULTS & PEDIATRICS 6,483 30.0 31.00 03000 ADULTS & PEDIATRICS 6,483 30.0 30.00 05000 PERATI ENT ROUTI NE SERVICE COST CENTERS 6,483 30.0 50.00 05000 PERATI NG ROOM 0.640278 0 50.0 50.00 05000 PERATI NG ROOM 0.338943 4,878 1,566 60.0 60.00 LABORATORY 0.318943 4,878 1,556 60.0 63.0 61.00 06300 BLOOD STORING, PROCESSING & TRANS. 0.449138 0 0 63.0 65.00 06500 RESPI RATORY THERAPY 0.353952 4,667 6.6 66.0 66.00 66.00 65.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00					Cost	
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INPATI ENT ROUTI NE SERVI CE COST CENTERS 0.00 03000 ADULTS & PEDI ATRI CS 6, 483 30.0 31.00 03100 INTENSI VE CARE UNI T 0 31.0 31.0 ANCI LLARY SERVI CE COST CENTERS 0 50.00 05400 RADI OLOGY -DI AGNOSTI C 0.50.0 05000 OPERATI NG ROOM 0.640278 0 50.00 54.00 05400 RADI OLOGY -DI AGNOSTI C 0.353852 4, 667 1, 651 54.0 63.00 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 0.449138 0 63.00 65.00 06500 RESPI RATORY 0.724036 832 602 65.00 66.00 06600 PHYSI CAL THERAPY 0.724036 832 602 65.00 66.01 06601 WHEATFI ELD PT 0.954943 0 66.00 66.01 66.01 06600 SPECH PATHORY 1.020948 0 67.00 67.00 68.01 68.01 68.01 68.01 06800 WHEATFI ELD DT 2.022932 0 68.0 68.01 68.01 68.01 68.01 68.01 68.01				Charges		
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31.00 03100 INTENSIVE CARE UNIT 0 31.00 ANCILLARY SERVICE COST CENTERS				4 402		20.00
ANCI LLARY SERVICE COST CENTERS 50. 00 05000 OPERATING ROM 0.640278 0 0 50.0 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0.353852 4,667 1,651 54.0 60. 00 06000 LABORATORY 0.318943 4,878 1,556 60.0 63. 00 06300 BLOOD STORING, PROCESSING & TRANS. 0.449138 0 63.0 65. 00 06600 PHYSI CAL THERAPY 0.724036 832 602 65.0 66. 01 06601 WHEATFI ELD PT 0.859661 0 0 66.0 67. 01 06700 OCCUPATI ONAL THERAPY 0.2055504 0 67.0 67.0 68. 00 06800 SPEECH PATHOLOGY 1.515224 0 68.0 68.0 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0.193070 0 67.0 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.193070 0 72.0 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0.195283 11,997 2,343 73.0 00TPATI ENT SERVICE COST CENTERS 0<						
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54.00 05400 RADI OLOGY-DI AGNOSTI C 0.353852 4,667 1,651 54.0 60.00 06000 LABORATORY 0.318943 4,878 1,556 60.0 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0.449138 0 0 63.0 65.00 06500 RESPI RATORY THERAPY 0.859661 0 0 65.0 66.01 06601 WHEATFI ELD PT 0.954943 0 0 66.0 67.00 06700 OCCUPATI ONAL THERAPY 0.859661 0 0 66.0 67.01 06600 WHEATFI ELD DT 2.055504 0 0 67.0 67.01 06701 WHEATFI ELD ST 2.02932 0 0 68.0 68.01 06801 WHEATFI ELD ST 0.143667 1,954 28.0 71.0 68.0 73.0 73.0 0 0 68.0 73.0 0.193070 0 0 73.0 71.00 07300 DRUGS CHARGED TO PATI ENTS 0.193070 0 0 73.0 0.7300 DRUGS CHARGED TO PATI ENTS		0	640278	0	0	50.00
60.00 06000 LABORATORY 0.318943 4,878 1,556 60.0 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0.449138 0 0 63.0 65.00 06500 RESPIRATORY THERAPY 0.724036 8322 602 65.0 66.00 06600 PHYSI CAL THERAPY 0.859661 0 0 66.0 66.01 06601 WHEATFI ELD PT 0.954943 0 0 66.0 67.00 06700 OCCUPATI ONAL THERAPY 1.020948 0 0 67.0 67.01 06701 WHEATFI ELD OT 2.055504 0 0 67.0 68.00 68.01 68.01 68.01 06800 SPECH PATHOLOGY 1.515224 0 0 68.0 68.01 06801 WHEATFI ELD ST 2.022932 0 0 68.0 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0.143667 1,954 281 71.0 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.193070 0 72.0 72.0 73.00 07300					-	
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65.00 06500 RESPIRATORY THERAPY 0.724036 832 602 65.00 66.00 06600 PHYSI CAL THERAPY 0.859661 0 0 66.01 66.01 06601 WHEATFI ELD PT 0.954943 0 0 66.01 67.00 06700 0CCUPATI ONAL THERAPY 1.020948 0 0 67.01 67.01 06701 WHEATFI ELD OT 2.055504 0 0 67.01 68.00 06800 SPEECH PATHOLOGY 1.515224 0 0 68.01 68.01 06801 WHEATFI ELD ST 2.022932 0 0 68.01 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0.143667 1,954 28.17 71.00 72.00 07200 I MPL. DEV. CHARGED TO PATI ENTS 0.193070 0 72.01 72.02 007300 DRUES CHARGED TO PATI ENTS 0.195283 11,997 2,343 73.01 00TPATI ENT SERVICE COST CENTERS 2.312918 0 0 88.00 08800 RURAL HEALTH CLINIC V 2.238687 0 0						1
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68.00 06800 SPEECH PATHOLOGY 1.515224 0 068.0 68.0 68.01 06801 WHEATFI ELD ST 2.022932 0 0 68.0 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0.143667 1,954 281 71.0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.193070 0 72.0 07300 DRUGS CHARGED TO PATIENTS 0.195283 11,997 2,343 73.0 0UTPATIENT SERVICE COST CENTERS 0 0 0 88.03 08801 RURAL HEALTH CLINIC 2.312918 0 0 88.03 08801 RURAL HEALTH CLINIC IV 2.238687 0 0 88.0 90.00 09000 CLINIC 0.763837 5,024 3,838 90.0	67.00 06700 OCCUPATI ONAL THERAPY	1.	020948	8 0	0	67.00
68.01 06801 WHEATFIELD ST 2.022932 0 68.01 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0.143667 1,954 281 71.0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.193070 0 72.0 07300 DRUGS CHARGED TO PATIENTS 0.195283 11,997 2,343 73.0 0UTPATIENT SERVICE COST CENTERS 0 08800 RURAL HEALTH CLINIC 2.312918 0 0 88.00 88.03 08801 RURAL HEALTH CLINIC IV 2.238687 0 0 88.0 90.00 09000 CLINIC 0.763837 5,024 3,838 90.0	67.01 06701 WHEATFIELD OT	2.	055504	0	0	67.01
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0.143667 1,954 281 71.0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.193070 0 72.0 73.00 DRUGS CHARGED TO PATIENTS 0.195283 11,997 2,343 73.0 0UTPATIENT SERVICE COST CENTERS 0 0.195283 11,997 2,343 73.0 88.00 08800 RURAL HEALTH CLINIC 2.312918 0 0 88.0 90.00 09000 CLINIC 10.763837 5,024 3,838 90.0					0	00.00
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73. 00 07300 DRUGS CHARGED TO PATIENTS 0.195283 11,997 2,343 73.0 0UTPATIENT SERVICE COST CENTERS 0 0.195283 0.195283 0 0 88.0 88. 00 08800 RURAL HEALTH CLINIC 2.312918 0 0 88.0 88. 03 08801 RURAL HEALTH CLINIC IV 2.238687 0 0 88.0 90. 00 09000 CLINIC 0.763837 5,024 3,838 90.0						71.00
OUTPATI ENT_SERVICE_COST_CENTERS 88.00 08800 RURAL_HEALTH_CLINIC 2.312918 0 0 88.0 88.03 08801 RURAL_HEALTH_CLINIC_IV 2.238687 0 0 88.0 90.00 09000 CLINIC 0.763837 5,024 3,838 90.0						
88.00 08800 RURAL HEALTH CLINIC 2.312918 0 0 88.0 88.03 08801 RURAL HEALTH CLINIC V 2.238687 0 0 88.0 90.00 09000 CLINIC V 0.763837 5,024 3,838 90.0		0.	195283	11, 997	2, 343	73.00
88.03 08801 RURAL HEALTH CLINICIV 2.238687 0 88.03 90.00 09000 CLINIC 0.763837 5,024 3,838 90.00			040040			0.00
90. 00 09000 CLINIC 0. 763837 5, 024 3, 838 90. 0					-	
		-				
91. 00 09100 EMERGENCY 0. 653093 1, 991 1, 300 91. 0 92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART 0. 668043 0 0 92. 0						1
200.00 Total (sum of lines 50 through 94 and 96 through 98) 0.608043 0 0 92.0			000043	-	-	
				51, 343 N	11, 371	200.00
				31 343		201.00
		I		51, 545	I	1202.00

CALCUL	Financial Systems FRANCISCAN HEALTI ATION OF REIMBURSEMENT SETTLEMENT FRANCISCAN HEALTI	Provi der CCN: 15-1324	Peri od: From 01/01/2017	eu of Form CMS-2 Worksheet E Part B	
			To 12/31/2017		
		Title XVIII	Hospi tal	Cost	
				1.00	
1 00	PART B - MEDICAL AND OTHER HEALTH SERVICES			7 005 007	1.00
1.00 2.00	Medical and other services (see instructions) Medical and other services reimbursed under OPPS (see instru	uctions)		7, 895, 887	1.00 2.00
3.00	OPPS payments			0	
4.00	Outlier payment (see instructions)			0	
4.01 5.00	Outlier reconciliation amount (see instructions) Enter the hospital specific payment to cost ratio (see instr	uctions)		0.000	
6.00	Line 2 times line 5			0.000	
7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	
8.00 9.00	Transitional corridor payment (see instructions)	IV col 12 Lino 200		0	
9.00	Ancillary service other pass through costs from Wkst. D, Pt. Organ acquisitions	TV, COL. 13, TTHE 200			
11.00	Total cost (sum of lines 1 and 10) (see instructions)			7, 895, 887	
	COMPUTATION OF LESSER OF COST OR CHARGES				-
12.00	Reasonable charges Ancillary service charges			0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4,	line 69)		0	1
14.00	Total reasonable charges (sum of lines 12 and 13)			0	14.00
15.00	Customary charges Aggregate amount actually collected from patients liable for	payment for services on	a charge basi s	0	15.00
16.00	Amounts that would have been realized from patients liable f			0	
	had such payment been made in accordance with 42 CFR §413.13	(e)			17.00
17.00 18.00	Ratio of line 15 to line 16 (not to exceed 1.000000) Total customary charges (see instructions)			0.000000	
19.00	Excess of customary charges over reasonable cost (complete o	nlyifline 18 exceeds li	ne 11) (see	0	
	instructions)	-			
20.00	Excess of reasonable cost over customary charges (complete o instructions)	nly if line 11 exceeds li	ne 18) (see	0	20.00
21.00	Lesser of cost or charges (see instructions)			7, 974, 846	21.00
	Interns and residents (see instructions)			0	
23.00	Cost of physicians' services in a teaching hospital (see ins			0	
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) COMPUTATION OF REIMBURSEMENT SETTLEMENT			0	24.00
25.00	Deductibles and coinsurance (for CAH, see instructions)			82, 277	
26.00	Deductibles and Coinsurance relating to amount on line 24 (f			3, 471, 848	
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) instructions)	prus the sum of rifles 22		4, 420, 721	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4,			0	
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	
30.00 31.00	Subtotal (sum of lines 27 through 29) Primary payer payments			4, 420, 721 4, 504	1
32.00	Subtotal (line 30 minus line 31)			4, 416, 217	
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERV	I CES)			
33.00 34.00	Composite rate ESRD (from Wkst. I-5, line 11) Allowable bad debts (see instructions)			0 515, 214	33.00 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			334, 889	
36.00	Allowable bad debts for dual eligible beneficiaries (see ins	tructions)		459, 420	
	Subtotal (see instructions)			4, 751, 106	
37.00				0	
38.00	MSP-LCC reconciliation amount from PS&R				37.00
38. 00 39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	uns)		, i i i i i i i i i i i i i i i i i i i	39.50
38.00				0	
38.00 39.00 39.50 39.97 39.98	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instruction Demonstration payment adjustment amount before sequestration Partial or full credits received from manufacturers for repl		ctions)	0	39. 97 39. 98
38.00 39.00 39.50 39.97 39.98 39.99	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructio Demonstration payment adjustment amount before sequestration Partial or full credits received from manufacturers for repl RECOVERY OF ACCELERATED DEPRECIATION		ctions)	0 0 0	39. 97 39. 98 39. 99
38.00 39.00 39.50 39.97 39.98 39.99 40.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instruction Demonstration payment adjustment amount before sequestration Partial or full credits received from manufacturers for repl RECOVERY OF ACCELERATED DEPRECIATION Subtotal (see instructions)		ctions)	0 0 4, 751, 106	39. 97 39. 98 39. 99 40. 00
38.00 39.00 39.50 39.97 39.98 39.99	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instruction Demonstration payment adjustment amount before sequestration Partial or full credits received from manufacturers for repl RECOVERY OF ACCELERATED DEPRECIATION Subtotal (see instructions) Sequestration adjustment (see instructions)		ctions)	0 0 0	39.97 39.98 39.99 40.00 40.01
38.00 39.00 39.50 39.97 39.98 39.99 40.00 40.01 40.02 41.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instruction Demonstration payment adjustment amount before sequestration Partial or full credits received from manufacturers for repl RECOVERY OF ACCELERATED DEPRECIATION Subtotal (see instructions) Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration Interim payments		ctions)	0 0 4, 751, 106 95, 022 0 7, 657, 764	39. 97 39. 98 39. 99 40. 00 40. 01 40. 02 41. 00
38.00 39.00 39.50 39.97 39.98 39.99 40.00 40.01 40.02 41.00 42.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instruction Demonstration payment adjustment amount before sequestration Partial or full credits received from manufacturers for repl RECOVERY OF ACCELERATED DEPRECIATION Subtotal (see instructions) Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration Interim payments Tentative settlement (for contractors use only)		ctions)	0 0 4, 751, 106 95, 022 0 7, 657, 764 0	39.98 39.99 40.00 40.01 40.02 41.00 42.00
38. 00 39. 00 39. 50 39. 97 39. 98 39. 99 40. 00 40. 01 40. 02 41. 00 42. 00 43. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instruction Demonstration payment adjustment amount before sequestration Partial or full credits received from manufacturers for repl RECOVERY OF ACCELERATED DEPRECIATION Subtotal (see instructions) Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration Interim payments Tentative settlement (for contractors use only) Balance due provider/program (see instructions)	aced devices (see instruc		0 0 4, 751, 106 95, 022 0 7, 657, 764	39.97 39.98 39.99 40.00 40.01 40.02 41.00 42.00 43.00
38.00 39.00 39.50 39.97 39.98 39.99 40.00 40.01 40.02 41.00 42.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instruction Demonstration payment adjustment amount before sequestration Partial or full credits received from manufacturers for repl RECOVERY OF ACCELERATED DEPRECIATION Subtotal (see instructions) Sequestration adjustment (see instructions) 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 accord §115.2	aced devices (see instruc		0 0 4, 751, 106 95, 022 0 7, 657, 764 0 -3, 001, 680	39.97 39.98 39.99 40.00 40.01 40.02 41.00 42.00 43.00
38. 00 39. 00 39. 50 39. 97 39. 98 39. 99 40. 00 40. 01 40. 02 41. 00 42. 00 43. 00 44. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instruction Demonstration payment adjustment amount before sequestration Partial or full credits received from manufacturers for repl RECOVERY OF ACCELERATED DEPRECIATION Subtotal (see instructions) Sequestration adjustment (see instructions) 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 accord §115.2 TO BE COMPLETED BY CONTRACTOR	aced devices (see instruc		0 0 4, 751, 106 95, 022 0 7, 657, 764 0 -3, 001, 680 0	39.97 39.98 39.99 40.00 40.01 40.02 41.00 42.00 43.00 44.00
38. 00 39. 00 39. 50 39. 97 39. 98 39. 99 40. 00 40. 01 40. 02 41. 00 42. 00 43. 00 44. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instruction Demonstration payment adjustment amount before sequestration Partial or full credits received from manufacturers for repl RECOVERY OF ACCELERATED DEPRECIATION Subtotal (see instructions) Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration Interim payments Tentative settlement (for contractors use only) Balance due provider/program (see instructions) Protested amounts (nonal lowable cost report items) in accord §115.2 TO BE COMPLETED BY CONTRACTOR Original outlier amount (see instructions)	aced devices (see instruc		0 0 4, 751, 106 95, 022 0 7, 657, 764 0 -3, 001, 680 0	39. 97 39. 98 39. 99 40. 00 40. 01 40. 02 41. 00 42. 00 43. 00 44. 00
38. 00 39. 00 39. 50 39. 97 39. 98 39. 99 40. 00 40. 01 40. 02 41. 00 42. 00 43. 00 44. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instruction Demonstration payment adjustment amount before sequestration Partial or full credits received from manufacturers for repl RECOVERY OF ACCELERATED DEPRECIATION Subtotal (see instructions) Sequestration adjustment (see instructions) 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 accord §115.2 TO BE COMPLETED BY CONTRACTOR	aced devices (see instruc		0 0 4, 751, 106 95, 022 0 7, 657, 764 0 -3, 001, 680 0	39. 97 39. 98 39. 99 40. 00 40. 01 40. 02 41. 00 42. 00 43. 00 44. 00

	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 5/31/2018 2:46	
		Title		Hospi tal	Cost	
		Inpatient	t Part A	Par	tВ	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1, 655, 94	3	7, 385, 964	1. C
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero			0	0	2. (
. 00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3. (
	Program to Provider					
. 01 . 02 . 03 . 04 . 05	ADJUSTMENTS TO PROVIDER	08/18/2017 09/27/2017			107, 900 163, 900 0 0 0	3. (3. (3. (3. (3. (
. 05	Provider to Program			0	0	3.0
. 50	ADJUSTMENTS TO PROGRAM			0	0	3.
. 51				0	0	3.
. 52				0	0	3.
. 53				0	Ő	3.
. 54				0	0	3.
. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		581,40	-	271, 800	3.
. 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, 237, 34	3	7, 657, 764	4.
	TO BE COMPLETED BY CONTRACTOR	<u>г</u>				
. 00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.
	Program to Provider			-		
. 01	TENTATI VE TO PROVIDER			0	0	5.
02				0	0	5.
. 03	Danu dalar da Danaman			0	0	5.
50	Provider to Program TENTATIVE TO PROGRAM			0	0	5.
50 51	I ENTATIVE TU PRUGRAM			0	0	5. 5.
51 52				0	0	5. 5.
52 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	5.
77	5. 50-5. 98)				U	0.
00	Determined net settlement amount (balance due) based on the cost report. (1)					6.
01	SETTLEMENT TO PROVIDER		461, 46	0	0	6.
02	SETTLEMENT TO PROGRAM			0	3, 001, 680	6.
00	Total Medicare program liability (see instructions)		2, 698, 80	3	4, 656, 084	7.
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	

IALY:	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CO		Period: From 01/01/2017 To 12/31/2017		pared
		Title	XVIII	Swing Beds - SNI		<u>o am</u>
		I npati en	t Part A		rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
00	Total interim payments paid to provider		315, 39		0	1. (
00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero			0	0	
00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3. (
	Program to Provider					
01	ADJUSTMENTS TO PROVIDER	08/21/2017	48, 60		0	
02		09/27/2017	35, 00		0	
03 04				0	0	
04				0	0	
	Provider to Program			-		
50	ADJUSTMENTS TO PROGRAM			0	0	
51				0	0	
52				0	0	
53 54				0	0	
99 99	Subtotal (sum of lines 3.01–3.49 minus sum of lines		83, 60	-	0	
	3. 50-3. 98)					
00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		398, 99	90	0	4.
	TO BE COMPLETED BY CONTRACTOR				1	
00	List separately each tentative settlement payment after					5.
	desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					
01	TENTATI VE TO PROVIDER			0	0	5.
22				0	0	
03				0	0	5.
_	Provider to Program			-		
50	TENTATI VE TO PROGRAM			0	0	
51 52				0	0	
∍∠ 99	Subtotal (sum of lines 5.01–5.49 minus sum of lines			0	0	
	5. 50-5. 98)			-	j ű	.
00	Determined net settlement amount (balance due) based on the cost report. (1)					6.
01	SETTLEMENT TO PROVIDER		34, 78		0	
)2	SETTLEMENT TO PROGRAM			0	0	
00	Total Medicare program liability (see instructions)		433, 77		0	7.
)	Contractor Number 1.00	NPR Date (Mo/Day/Yr) 2.00	
00	Name of Contractor			1.00	2.00	8.

Heal th	Financial Systems FRANCISCAN HEALTH	I RENSSELAER	In Lie	u of Form CMS-	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-1324	Period: From 01/01/2017		
			To 12/31/2017	Date/Time Pre 5/31/2018 2:4	
		Title XVIII	Hospi tal	Cost	
	TO BE CONDUCTED BY CONTRACTOR FOR NONCTANRARD COST REPORTS			1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION	1			-
1.00	Total hospital discharges as defined in AARA §4102 from Wkst.		1/		1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8		. 14		2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. Line 2	5 12			3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8	3-12			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	ine 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of c line 168	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	Calculation of the HIT incentive payment after sequestration	(see instructions)			10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
	Initial/interim HIT payment adjustment (see instructions)				30.00
	Other Adjustment (specify)				31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and l	ine 31) (see instruction	is)		32.00

ALCUL	ATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 15-1324	Period:	Worksheet E-2	
		Component CCN: 15-Z324	From 01/01/2017 To 12/31/2017	Date/Time Pre	pare
				5/31/2018 2:4	
		Title XVIII	Swing Beds - SNF		
			Part A 1.00	<u>Part B</u> 2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES		1.00	2.00	
00	Inpatient routine services - swing bed-SNF (see instructions)		331, 373	0	1 1
00	Inpatient routine services - swing bed-NF (see instructions)		001,070		2
00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Par-	t A, and sum of Wkst. D,	112, 409	0	3
	Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see ins	structions)			
00	Per diem cost for interns and residents not in approved teach	ing program (see		0.00	4
~~	instructions)		200	0	
00	Program days	netructione)	209	0	5
00 00	Interns and residents not in approved teaching program (see in Utilization review - physician compensation - SNF optional me		0	0	0
00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	thou only	443, 782	0	8
00	Primary payer payments (see instructions)		0	0	
. 00	Subtotal (line 8 minus line 9)		443, 782	0	10
00	Deductibles billed to program patients (exclude amounts applic	cable to physician	0	0	11
	professional services)				
. 00	Subtotal (line 10 minus line 11)		443, 782	0	12
. 00	Coinsurance billed to program patients (from provider records)) (excl ude coi nsurance	1, 152	0	13
00	for physician professional services)			0	11
. 00 . 00	80% of Part B costs (line 12 x 80%) Subtotal (enter the lesser of line 12 minus line 13, or line 1	14)	442, 630	0	
. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	14)	442, 030	0	16
. 50	Pioneer ACO demonstration payment adjustment (see instructions	s)	0	0	16
. 55	Rural community hospital demonstration project (§410A Demonstr		0		16
	adjustment (see instructions)		-		
. 99	Demonstration payment adjustment amount before sequestration		0	0	16
. 00	Allowable bad debts (see instructions)		0	0	
. 01	Adjusted reimbursable bad debts (see instructions)		0	0	
00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)	0	0	18
00	Total (see instructions)		442, 630	0	19
. 01 . 02	Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration)		8, 853 0	0	19
. 02	Interim payments		398, 990	0	20
00	Tentative settlement (for contractor use only)		0	0	21
00	Balance due provider/program (line 19 minus lines 19.01, 20, a	and 21)	34, 787	0	22
. 00	Protested amounts (nonallowable cost report items) in accordan		0	0	23
	chapter 1, §115.2				
	Rural Community Hospital Demonstration Project (§410A Demonstr				
0.00	Is this the first year of the current 5-year demonstration per	riod under the 21st			200
	Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement				
1 00	Medicare swing-bed SNF inpatient routine service costs (from)	Wkst D-1 Pt II line			201
1. 00	66 (title XVIII hospital))				201
2.00	Medicare swing-bed SNF inpatient ancillary service costs (from	m Wkst. D-3, col. 3, lin	e		202
	200 (title XVIII swing-bed SNF))				
	Total (sum of lines 201 and 202)				203
1. 00	Medicare swing-bed SNF discharges (see instructions)				204
	Computation of Demonstration Target Amount Limitation (N/A in	first year of the curre	nt 5-year demonst	ration	
: 00	period) Medicare swing-bed SNF target amount				205
	Medicare swing bed SNF inpatient routine cost cap (line 205 ti	imes line 204)			206
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimburs	,			
7.00	Program reimbursement under the §410A Demonstration (see inst				207
3. 00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2	2, col. 1, sum of lines	1		208
	and 3)				
	Adjustment to Medicare swing-bed SNF PPS payments (see instruc	ctions)			209
0. 00	Reserved for future use				210
	Comparision of PPS versus Cost Reimbursement				215
15.00	Total adjustment to Medicare swing-bed SNF PPS payment (line : instructions)	209 plus line 210) (see			

		ALTH RENSSELAER		u of Form CMS-2	
ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1324	Period: From 01/01/2017	Worksheet E-3 Part V	
			To 12/31/2017	Date/Time Pre 5/31/2018 2:4	
		Title XVIII	Hospi tal	Cost	
				1.00	
. 00	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDIC Inpatient services	ARE PART A SERVICES - CUST	RETINBURGEMENT	2, 962, 523	1 1.
. 00	Nursing and Allied Health Managed Care payment (see instru	uctions)		2, 702, 525	
. 00	Organ acqui si ti on			0	
. 00	Subtotal (sum of lines 1 through 3)			2, 962, 523	
. 00	Primary payer payments			4,650	5.
. 00	Total cost (line 4 less line 5). For CAH (see instructions	5)		2, 987, 498	6.
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonable charges				
. 00	Routine service charges			0	7.
00	Ancillary service charges Organ acquisition charges, net of revenue			0	
D. 00	Total reasonable charges			0	
J. 00	Customary charges			0	
I. 00	Aggregate amount actually collected from patients liable f	for payment for services on	a charge basis	0	11
2.00	Amounts that would have been realized from patients liable	1 5	5	0	
	had such payment been made in accordance with 42 CFR 413.1	13(e)	5		
. 00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0.00000	13
. 00	Total customary charges (see instructions)			0	
5.00	Excess of customary charges over reasonable cost (complete	e only if line 14 exceeds li	ne 6) (see	0	15
	instructions)				
5. 00	Excess of reasonable cost over customary charges (complete instructions)	e only if line 6 exceeds lin	e 14) (see	0	16
7.00	Cost of physicians' services in a teaching hospital (see i	nstructions)		0	17
. 00	COMPUTATION OF REIMBURSEMENT SETTLEMENT			0	1 ''
3. 00	Direct graduate medical education payments (from Worksheet	t E-4, line 49)		0	118
9.00	Cost of covered services (sum of lines 6, 17 and 18)	. ,		2, 987, 498	19
0. 00	Deductibles (exclude professional component)			250, 012	20
. 00	Excess reasonable cost (from line 16)			0	21
2.00	Subtotal (line 19 minus line 20 and 21)			2, 737, 486	
8. 00	Coinsurance			2, 303	
. 00	Subtotal (line 22 minus line 23)			2, 735, 183	
5.00	Allowable bad debts (exclude bad debts for professional se	ervices) (see instructions)		28, 766	
00	Adjusted reimbursable bad debts (see instructions)	netructione)		18, 698	
2.00 3.00	Allowable bad debts for dual eligible beneficiaries (see i Subtotal (sum of lines 24 and 25, or line 26)	nstructions)		24, 010 2, 753, 881	
00 0.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			2, 755, 661	
. 50	Pioneer ACO demonstration payment adjustment (see instruct	tions)		0	
. 99	Demonstration payment adjustment adjustment (see instruct			0	
. 00	Subtotal (see instructions)			2, 753, 881	
0. 01	Sequestration adjustment (see instructions)			55, 078	
). 02	Demonstration payment adjustment amount after sequestratio	วท		0	30
. 00	Interim payments			2, 237, 343	31
2.00	Tentative settlement (for contractor use only)			0	32
3.00	Balance due provider/program (line 30 minus lines 30.01, 3			461, 460	
4.00	Protested amounts (nonallowable cost report items) in acco	ordance with CMS Pub. 15-2,	chapter 1,	0	34

ALCULA	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1324	Peri od:	Worksheet E-3	
			From 01/01/2017 To 12/31/2017	Part VII Date/Time Pre 5/31/2018 2:4	
		Title XIX	Hospi tal	Cost	0 am
			I npati ent	Outpati ent	
r			1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERV	VICES FOR TITLES V OR X	IX SERVICES		
- F	COMPUTATION OF NET COST OF COVERED SERVICES		005 445		
. 00 . 00	Inpatient hospital/SNF/NF services		325, 115	202 722	1.0
	Medical and other services Organ acquisition (certified transplant centers only)		0	292, 732	3. (
.00	Subtotal (sum of lines 1, 2 and 3)		325, 115	292, 732	
	Inpatient primary payer payments		020, 110	272,702	5.
	Outpatient primary payer payments			0	
	Subtotal (line 4 less sum of lines 5 and 6)		325, 115	292, 732	7.
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonabl e Charges				
	Routine service charges		0		8.
	Ancillary service charges		31, 343	591, 953	
	Organ acquisition charges, net of revenue	0		10.	
	Incentive from target amount computation Total reasonable charges (sum of lines 8 through 11)	31, 343	591, 953	11.	
2.00	CUSTOMARY CHARGES		51, 545	571, 755	12.
3.00	Amount actually collected from patients liable for payment for	services on a charge	0	0	13.
	Amounts that would have been realized from patients liable for	C		0	
	a charge basis had such payment been made in accordance with 42	0	0	14.	
	Ratio of line 13 to line 14 (not to exceed 1.000000)	0. 000000	0.000000	15.	
	Total customary charges (see instructions)	31, 343	591, 953		
	Excess of customary charges over reasonable cost (complete only	0	299, 221		
	line 4) (see instructions)				
8.00	Excess of reasonable cost over customary charges (complete only	y if line 4 exceeds lin	e 293, 772	0	18.
0.00	16) (see instructions)			0	10
	Interns and Residents (see instructions) Cost of physicians' services in a teaching hospital (see instru	usti spo)	0	0	19. 20.
	Cost of physicians services in a teaching hospital (see institution of covered services (enter the lesser of line 4 or line 10	-	325, 115	292, 732	
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be of			272, 132	21.
- F	Other than outlier payments		0	0	22.
	Outlier payments		0	0	23.
	Program capital payments		0		24.
5.00	Capital exception payments (see instructions)		0		25.
	Routine and Ancillary service other pass through costs		0	0	26.
	Subtotal (sum of lines 22 through 26)		0	0	
	Customary charges (title V or XIX PPS covered services only)		0	0	28.
	Titles V or XIX (sum of lines 21 and 27)		325, 115	292, 732	29.
H	COMPUTATION OF REIMBURSEMENT SETTLEMENT		202 772	0	20
	Excess of reasonable cost (from line 18) Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		293, 772 325, 115	0 292, 732	30. 31.
	Deductiblies		525, 115	292, 732	
	Coi nsurance		0	0	
	Allowable bad debts (see instructions)		0	0	
1	Utilization review		0	-	35.
	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	33)	325, 115	292, 732	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.
	Subtotal (line 36 ± line 37)		325, 115	292, 732	
	Direct graduate medical education payments (from Wkst. E-4)		0		39.
	Total amount payable to the provider (sum of lines 38 and 39)		325, 115	292, 732	
	Interim payments		325, 115	292, 732	
	Balance due provider/program (line 40 minus line 41)	as with CNC Dub 15 C	0	0	
3.00	Protested amounts (nonallowable cost report items) in accordance	CE WITH UMS PUB 15-2,	0	0	43.

CLU 00 Call 00 Call 00 Call 00 No 00 All 00 All 00 All 00 All 00 All 00 All 00 Tr 00 All 00	During records, complete the General Fund column JURENT ASSETS ash on hand in banks emporary investments otes receivable ccounts receivable ther receivable llowances for uncollectible notes and accounts receivable nventory repaid expenses ther current assets ue from other funds otal current assets (sum of lines 1-10) INED ASSETS and and improvements ccumulated depreciation uildings ccumulated depreciation easehold improvements ccumulated depreciation ixed equipment ccumulated depreciation ixed equipment ccumulated depreciation utomobiles and trucks	General Fund 1.00 164, 782 928, 580 0 6, 412, 747 0 -2, 730, 788 908, 924 0 145, 056 0 5, 829, 301 675, 791 484, 426 0 16, 945, 980 0 663, 147 0 0 0 0 0 0 0 0 0 0 0 0 0	Speci fi c Purpose Fund 2.00	From 01/01/2017 To 12/31/2017 Endowment Fund 3.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	5/31/2018 2: 4 Pl ant Fund 4.00 0 0 0 0 0 0 0 0 0 0 0 0	46 a 00 1 1 00 2 00 2 0 00 2 00 2 0
DO C2 DO Te DO Na DO Aa DO Da DO Da DO Da DO Da OO Da OO La OO La OO Aa OO <	ash on hand in banks emporary investments otes receivable ccounts receivable ther receivable Ilowances for uncollectible notes and accounts receivable nventory repaid expenses ther current assets ue from other funds otal current assets (sum of lines 1-10) IXED ASSETS and and improvements ccumulated depreciation uildings ccumulated depreciation easehold improvements ccumulated depreciation ixed equipment ccumulated depreciation	1.00 164,782 928,580 0 6,412,747 0 -2,730,788 908,924 0 145,056 0 5,829,301 675,791 484,426 0 16,945,980 0	Purpose Fund 2.00	3.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0	PI ant Fund 4.00 0 0 0 0 0 0 0 0 0 0 0 0	0 1 1 0 2 2 0 0 3 2 2 0 0 4 2 0 0 5 6 0 0 6 6 0 7 7 0 0 8 6 0 0 7 7 0 0 8 6 0 0 1 1 1 0 0 1 1 2 0 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
DO C2 DO Te DO Na DO Aa DO Da DO Da DO Da DO Da OO Da OO La OO La OO Aa OO <	ash on hand in banks emporary investments otes receivable ccounts receivable ther receivable Ilowances for uncollectible notes and accounts receivable nventory repaid expenses ther current assets ue from other funds otal current assets (sum of lines 1-10) IXED ASSETS and and improvements ccumulated depreciation uildings ccumulated depreciation easehold improvements ccumulated depreciation ixed equipment ccumulated depreciation	164, 782 928, 580 0 6, 412, 747 0 -2, 730, 788 908, 924 0 145, 056 0 5, 829, 301 675, 791 484, 426 0 16, 945, 980				0 2 0 3 0 4 0 5 0 5 0 6 0 7 0 6 0 7 0 6 0 10 0 12 0 13
00 C2 00 Te 00 Na 00 Aa 00 Da 00 Aa 00 <	ash on hand in banks emporary investments otes receivable ccounts receivable ther receivable Ilowances for uncollectible notes and accounts receivable nventory repaid expenses ther current assets ue from other funds otal current assets (sum of lines 1-10) IXED ASSETS and and improvements ccumulated depreciation uildings ccumulated depreciation easehold improvements ccumulated depreciation ixed equipment ccumulated depreciation	928, 580 0 6, 412, 747 -2, 730, 788 908, 924 0 145, 056 0 5, 829, 301 675, 791 484, 426 0 16, 945, 980 0				0 2 0 3 0 4 0 5 0 5 0 6 0 7 0 6 0 7 0 6 0 10 0 12 0 13
DO Te DO AC DO Pr DO DL DO DL DO L2 DO L2 DO AC DO L6 DO AC DO <	emporary investments otes receivable ccounts receivable ther receivable llowances for uncollectible notes and accounts receivable nventory repaid expenses ther current assets ue from other funds otal current assets (sum of lines 1-10) IXED ASSETS and and improvements ccumulated depreciation uildings ccumulated depreciation easehold improvements ccumulated depreciation ixed equipment ccumulated depreciation	928, 580 0 6, 412, 747 -2, 730, 788 908, 924 0 145, 056 0 5, 829, 301 675, 791 484, 426 0 16, 945, 980 0				0 2 0 3 0 4 0 5 0 5 0 6 0 7 0 6 0 7 0 6 0 10 0 12 0 13
00 Act 00 01 00 1 00 1 00 1 00 0 00 0 00 0 00 0 00 1 00 0 00 0 00 1 00 1 00 1 00 1 00 1 00 Act 00	ccounts receivable ther receivable llowances for uncollectible notes and accounts receivable nventory repaid expenses ther current assets ue from other funds otal current assets (sum of lines 1-10) IXED ASSETS and and improvements ccumulated depreciation uildings ccumulated depreciation easehold improvements ccumulated depreciation i xed equipment ccumulated depreciation	0 -2, 730, 788 908, 924 0 145, 056 0 5, 829, 301 675, 791 484, 426 0 16, 945, 980 0				0 2 0 5 0 5 0 6 0 7 0 8 0 9 0 10 0 11 0 12 0 13
00 01 00 AI 00 Ir 00 Ir 00 O 00 D 00 D 00 D 00 D 00 La 00 La 00 Ac	ther receivable Ilowances for uncollectible notes and accounts receivable nventory repaid expenses ther current assets ue from other funds otal current assets (sum of lines 1-10) IXED ASSETS and and improvements ccumulated depreciation uildings ccumulated depreciation easehold improvements ccumulated depreciation i xed equipment ccumulated depreciation	0 -2, 730, 788 908, 924 0 145, 056 0 5, 829, 301 675, 791 484, 426 0 16, 945, 980 0				0 5 0 6 0 7 0 8 0 8 0 9 0 10 0 11 0 12 0 13
OO AI DO Ir DO Ir DO Pr DO O OO To OO To OO To OO To OO La OO La OO Ac OO <t< td=""><td><pre>Ilowances for uncollectible notes and accounts receivable nventory repaid expenses ther current assets ue from other funds otal current assets (sum of lines 1-10) IXED ASSETS and and improvements ccumulated depreciation uildings ccumulated depreciation easehold improvements ccumulated depreciation ixed equipment ccumulated depreciation</pre></td><td>908, 924 0 145, 056 0 5, 829, 301 675, 791 484, 426 0 16, 945, 980 0</td><td></td><td></td><td></td><td>0 6 0 7 0 8 0 9 0 10 0 11 0 12 0 13</td></t<>	<pre>Ilowances for uncollectible notes and accounts receivable nventory repaid expenses ther current assets ue from other funds otal current assets (sum of lines 1-10) IXED ASSETS and and improvements ccumulated depreciation uildings ccumulated depreciation easehold improvements ccumulated depreciation ixed equipment ccumulated depreciation</pre>	908, 924 0 145, 056 0 5, 829, 301 675, 791 484, 426 0 16, 945, 980 0				0 6 0 7 0 8 0 9 0 10 0 11 0 12 0 13
DO I r DO Pr DO O DO DL OO DL OO La OO La OO La OO La OO Ac OO Ma OO Ma OO Ac OO Ma OO Ma OO Ma	nventory repaid expenses ther current assets ue from other funds otal current assets (sum of lines 1-10) IXED ASSETS and and improvements ccumul ated depreciation uil dings ccumul ated depreciation easehold improvements ccumul ated depreciation ixed equipment ccumul ated depreciation	908, 924 0 145, 056 0 5, 829, 301 675, 791 484, 426 0 16, 945, 980 0				0 7 0 8 0 9 0 10 0 11 0 12 0 13
DO Pr DO DQ OO DQ OO DQ OO DQ OO L2 OO L2 OO L2 OO L2 OO L2 OO L4 OO L4 OO AC OO AC OO AC OO AC OO AC OO M2 OO M2	repaid expenses ther current assets ue from other funds otal current assets (sum of lines 1-10) IXED ASSETS and and improvements ccumulated depreciation uildings ccumulated depreciation easehold improvements ccumulated depreciation ixed equipment ccumulated depreciation	0 145, 056 0 5, 829, 301 675, 791 484, 426 0 16, 945, 980 0			0 0 0 0	0 8 0 10 0 11 0 12 0 12
DO O1 00 DL 00 T 00 L 00 L 00 L 00 L 00 A	ther current assets ue from other funds otal current assets (sum of lines 1-10) IXED ASSETS and and improvements ccumulated depreciation uildings ccumulated depreciation easehold improvements ccumulated depreciation ixed equipment ccumulated depreciation	0 5, 829, 301 675, 791 484, 426 16, 945, 980 0			0 0 0 0 0 0 0	0 10 0 10 0 11 0 12 0 12
OO Du 00 Tc 00 La 00 La 00 La 00 Ac 00 Bu 00 Ac 00 La 00 Ac 00 Ac 00 Fil 00 Ac 00 Ma 00 Ac 00 Ma 00 Ma 00 Ma	ue from other funds otal current assets (sum of lines 1-10) IXED ASSETS and and improvements ccumulated depreciation uildings ccumulated depreciation easehold improvements ccumulated depreciation ixed equipment ccumulated depreciation	0 5, 829, 301 675, 791 484, 426 16, 945, 980 0			0 0 0 0 0	0 10 0 1 ⁻ 0 12 0 13
OO Tc FI 00 La 00 La 00 00 La 00 00 Bu 00 00 La 00 00 Ac 00 00 Ma 00	otal current assets (sum of lines 1-10) IXED ASSETS and and improvements ccumulated depreciation uildings ccumulated depreciation easehold improvements ccumulated depreciation ixed equipment ccumulated depreciation	675, 791 484, 426 0 16, 945, 980 0		0 0 0 0 0 0	000000000000000000000000000000000000000	0 11 0 12 0 13
FI 00 La 00 La 00 Aa 00 Bu 00 Aa 00 La 00 Aa 00 Ma 00 Aa 00 Ma 00 Ma 00 Ma	IXED ASSETS and and improvements ccumulated depreciation uildings ccumulated depreciation easehold improvements ccumulated depreciation ixed equipment ccumulated depreciation	675, 791 484, 426 0 16, 945, 980 0		0 0 0 0	000000000000000000000000000000000000000	0 12 0 13
00 Lá 00 Lá 00 Ad 00 Bu 00 Ad 00 Ma 00 Ma	and and improvements ccumulated depreciation uildings ccumulated depreciation easehold improvements ccumulated depreciation ixed equipment ccumulated depreciation	484, 426 C 16, 945, 980 C		0 0	0	0 13
00 La 00 Ac 00 Bu 00 Ac 00 Ma 00 Ma 00 Ma	and improvements ccumulated depreciation uildings ccumulated depreciation easehold improvements ccumulated depreciation ixed equipment ccumulated depreciation	484, 426 C 16, 945, 980 C			0	0 13
00 But 00 Act 00 Let 00 Act 00 Fi 00 Act 00 Mat 00 Act 00 Mat 00 Mat	uildings ccumulated depreciation easehold improvements ccumulated depreciation ixed equipment ccumulated depreciation	0 16, 945, 980 0				1 -
OO Ad OO Lee OO Ad OO Fi OO Ad	ccumulated depreciation easehold improvements ccumulated depreciation ixed equipment ccumulated depreciation	0		0 0	0	0 14
00 Let 00 Add 00 Fi 00 Add 00 Materia 00 Materia 00 Materia	easehold improvements ccumulated depreciation ixed equipment ccumulated depreciation	0 663, 147 0 0			0	0 15
OO Ad OO Fi OO Ad	ccumulated depreciation ixed equipment ccumulated depreciation	663, 147 0		u 0	0	
00 Fi 00 Addition	ixed equipment ccumulated depreciation			0 0	0	
00 Ac 00 Ac 00 Ac 00 Ma 00 Ac 00 Mi	ccumulated depreciation			0 0	0	
00 Au 00 Ao 00 Ma 00 Ao 00 Ao				0 0	0	
00 Ac 00 Ma 00 Ac 00 Mi	UTOMODILES AND TRUCKS	0		0 0	0	
00 Ma 00 Ac 00 Mi	ccumulated depreciation			0 0 0 0	0	
. 00 Ac . 00 Mi	ajor movable equipment	10, 842, 802			0	
00 Mi	ccumul ated depreciation	-6, 151, 625			0	
	i nor equipment depreciable	0, 101, 020		0 0	0	
	ccumulated depreciation	0		0 0	0	
	IT designated Assets	C		0 0	0	0 27
00 Ad	ccumulated depreciation	0		0 0	0	0 28
00 Mi	i nor equi pment-nondepreci abl e	0		0 0	0	0 29
	otal fixed assets (sum of lines 12-29)	23, 460, 521		0 0	0	0 30
	THER ASSETS					
	nvestments	0				
	eposits on leases ue from owners/officers			0 0 0 0	0	
	ther assets	83, 413		0 0	0	
	otal other assets (sum of lines 31-34)	83, 413		0 0		
1	otal assets (sum of lines 11, 30, and 35)	29, 373, 235		0 0		
	URRENT LI ABI LI TI ES	27,070,200				1 .
	ccounts payable	2,044,748		0 0	0	0 37
00 Sa	al ari es, wages, and fees payable	928, 459		0 0	0	0 38
	ayroll taxes payable	0		0 0	0	
	otes and loans payable (short term)	64, 854		0 0	0	
1	eferred income	0		0 0	0	
	ccelerated payments	0			_	42
	ue to other funds	2, 994, 730		0 0	0	
	ther current liabilities	14, 345, 638		0 0	-	
	otal current liabilities (sum of lines 37 thru 44)	20, 378, 429		0 0	0	0 45
	DNG TERM LIABILITIES			0 0	0	0 46
	otes payable	20, 900, 616		0 0	0	
	nsecured Loans			0 0	0	
	ther long term liabilities	77, 124		0 0	0	
00 To	otal long term liabilities (sum of lines 46 thru 49)	20, 977, 740		0 0	0	0 50
00 To	otal liabilities (sum of lines 45 and 50)	41, 356, 169		0 0	0	0 51
	API TAL ACCOUNTS					
	eneral fund balance	-11, 982, 934				52
	pecific purpose fund			0		53
	onor created - endowment fund balance - restricted			0		54
	onor created - endowment fund balance - unrestricted			0		55
1	overning body created - endowment fund balance			0	0	56
	lant fund balance – invested in plant lant fund balance – reserve for plant improvement,				0	
	eplacement, and expansion				0	1 36
	otal fund balances (sum of lines 52 thru 58)	-11, 982, 934		0 0	0	0 59
	otal liabilities and fund balances (sum of lines 51 and	29, 373, 235		0 0	0	

Heal th	Financial Systems	FRANCI SCAN HEALT	H RENSSELAER		In Lie	u of Form CMS-2	2552-10
	IENT OF CHANGES IN FUND BALANCES		Provider CC	CN: 15-1324	Period: From 01/01/2017 To 12/31/2017	Worksheet G-1 Date/Time Pre 5/31/2018 2:4	pared:
		General	Fund	Speci al	Purpose Fund	Endowment Fund	
		1.00	2.00	2.00	4.00	F. 00	
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ \end{array}$	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) EQUITY TRANSFERS TO/ FROM AFFILIATES	1.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2.00 -1,640,406 -7,622,940 -9,263,346 -9,263,346 -9,263,346	3.00	4.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	5.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ \end{array}$
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)		2, 719, 588 -11, 982, 934		0		18. 00 19. 00
		Endowment Fund	PI ant	Fund	_		
		6.00	7.00	8.00	_		
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) 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 18. 00 19. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) EQUITY TRANSFERS TO/ FROM AFFILIATES Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0 0 0 0	0 0 0 0 0 0		0 0 0 0		10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00

CTATE		RENSSELAER	CN. 1E 1004	D-		u of Form CMS-2	
STATE	IENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provider C		Fro To	iod: m 01/01/2017 12/31/2017	Worksheet G-2 Parts I & II Date/Time Pre 5/31/2018 2:4	pared:
	Cost Center Description		Inpati ent		Outpatient	Total	
			1.00		2.00	3.00	
	PART I - PATIENT REVENUES						-
1.00	General Inpatient Routine Services Hospital		1, 331, 5	52	I	1, 331, 552	1.00
2.00	SUBPROVI DER – I PF		1, 331, 3	52		1, 331, 332	2.00
3.00	SUBPROVIDER - IRF						3.00
4.00	SUBPROVI DER						4.00
5.00	Swing bed - SNF			0		0	5.00
6.00	Swing bed - NF			0		0	
7.00	SKILLED NURSING FACILITY			-		-	7.00
8.00	NURSING FACILITY						8.00
9.00	OTHER LONG TERM CARE						9.00
10.00	Total general inpatient care services (sum of lines 1-9)		1, 331, 5	52		1, 331, 552	10.00
	Intensive Care Type Inpatient Hospital Services						
11.00	INTENSIVE CARE UNIT		253, 6	24		253, 624	
12.00	CORONARY CARE UNIT						12.00
13.00	BURN INTENSIVE CARE UNIT						13.00
14.00	SURGI CAL I NTENSI VE CARE UNI T						14.00
15.00	OTHER SPECIAL CARE (SPECIFY)	<u></u>		~ .			15.00
16.00	Total intensive care type inpatient hospital services (sum o	r lines	253, 6	24		253, 624	16.00
17.00	11-15) Total inpatient routine care services (sum of lines 10 and 10	۷)	1, 585, 1	74		1, 585, 176	17.00
18.00	Ancillary services	5)	4, 611, 1		42, 361, 692	46, 972, 868	
19.00	Outpati ent services		326, 9		10, 666, 412	10, 993, 371	
20.00	RURAL HEALTH CLINIC		020, 7	0	251, 708	251, 708	
20.03	RURAL HEALTH CLINIC IV			0	417, 363	417, 363	
21.00	FEDERALLY QUALIFIED HEALTH CENTER			0	0	0	
22.00	HOME HEALTH AGENCY				2,021,637	2,021,637	22.00
23.00	AMBULANCE SERVICES						23.00
24.00	СМНС						24.00
25.00	AMBULATORY SURGICAL CENTER (D. P.)						25.00
26.00	HOSPI CE			0	1, 920, 040	1, 920, 040	
27.00	NRCC REVENUE		889, 4		64, 131	953, 565	
27.01	CRNA PROFESSIONAL FEES		26, 7		135, 528	162, 313	
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3	3 to Wkst.	7, 439, 5	30	57, 838, 511	65, 278, 041	28.00
	G-3, line 1) PART II - OPERATING EXPENSES		1		I		-
29.00	Operating expenses (per Wkst. A, column 3, line 200)				39, 665, 741		29.00
30.00	ADD (SPECIFY)			0	07,000,711		30.00
31.00				0			31.00
32.00				0			32.00
33.00				0			33.00
34.00				0			34.00
35.00				0			35.00
36.00	Total additions (sum of lines 30-35)				0		36.00
37.00	DEDUCT (SPECI FY)			0			37.00
38.00				0			38.00
39.00				0			39.00
40.00				0			40.00
41.00	Tatal deductions (sum of lines 27 41)			U	0		41.00
42.00 43.00	Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line -	12) (transfor			U		42.00 43.00
	TIOLAI OPERALITY EXPENSES (SUIL OF TIMES 29 AND 30 III MUS TIME 4	+z)(LI dHSI el	1		39, 665, 741		43.UU

Heal th	Financial Systems	FRANCI SCAN HEALTH	RENSSELAER	In Lie	u of Form CMS-2	2552-10
STATEM	ENT OF REVENUES AND EXPENSES		Provider CCN: 15-1324	Period: From 01/01/2017 To 12/31/2017	Worksheet G-3 Date/Time Pre	pared:
					5/31/2018 2:40	6 am
					1.00	
1.00	Total patient revenues (from Wkst. G-2	Part column 3 line	28)		65, 278, 041	1.00
2.00	Less contractual allowances and discou				34, 062, 926	2.00
3.00	Net patient revenues (line 1 minus lir				31, 215, 115	3.00
4.00	Less total operating expenses (from W		43)		39, 665, 741	4.00
5.00	Net income from service to patients (I				-8, 450, 626	
	OTHER INCOME					
6.00	Contributions, donations, bequests, et	с			0	6.00
7.00	Income from investments				0	7.00
8.00	Revenues from telephone and other misc	ellaneous communication	servi ces		0	8.00
9.00	Revenue from television and radio serv	i 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 a				0	14.00
15.00	Revenue from rental of living quarters				0	15.00
16.00	Revenue from sale of medical and surgi		nan patients		0	16.00
17.00	Revenue from sale of drugs to other th				0	17.00
18.00	Revenue from sale of medical records a				0	18.00
19.00	Tuition (fees, sale of textbooks, unif				0	19.00
20.00	Revenue from gifts, flowers, coffee sh	ops, and canteen			0	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				639, 424	
24.01	OTHER NON-OPERATING REVENUE				188, 262	
25.00	Total other income (sum of lines 6-24)				827, 686	
26.00	Total (line 5 plus line 25)				-7, 622, 940	
	OTHER EXPENSES (SPECIFY)				0	27.00
28.00	Total other expenses (sum of line 27 a	1 2			0	28.00
29.00	Net income (or loss) for the period (I	ine 26 minus line 28)			-7, 622, 940	29.00

	i Financial Systems SIS OF HOSPITAL-BASED HOME HEALT		RANCI SCAN HEAL	Provi der C	CN: 15-1324	Peri od:	u of Form CMS-2 Worksheet H	2002-
				HHA CCN:	15-7149	From 01/01/2017 To 12/31/2017	Date/Time Pre	nared
					13 7147		5/31/2018 2:4	6 am
						Home Health Agency I	PPS	
		Sal ari es	Empl oyee	Transportati on			Total (sum of	
			Benefits	(see	chased		cols. 1 thru	
		1.00	2.00	<u>instructions)</u> 3.00	Services 4.00	5.00	5) 6. 00	
	GENERAL SERVICE COST CENTERS							
. 00	Capital Related - Bldg. &			0		0	0	1.0
. 00	Fixtures Capital Related - Movable			0		0	0	2.0
	Equi pment			Ū				
. 00	Plant Operation & Maintenance	0	0	0		0 0	0	
. 00 . 00	Transportation Administrative and General	0 300, 099	0	0 4, 036	152, 28	0 0 31 19, 425	0 475, 841	
. 00	HHA REIMBURSABLE SERVICES	300, 077	0	4,030	152,20	17,423	475,041	J J. 1
. 00	Skilled Nursing Care	283, 609	0	18, 724		0 0	302, 333	
. 00	Physical Therapy	66, 111	0	6, 241		14 0	188, 496	
. 00 . 00	Occupational Therapy Speech Pathology	43, 066 12, 752	0	4, 874 1, 933		0 0	47, 940 14, 685	
D. 00	Medical Social Services	0	0	1, 933		0 335	335	
1.00	Home Heal th Aide	88, 128	0	20, 623		0 0	108, 751	
2.00	Supplies (see instructions)	0	0	0		0 31, 912	31, 912	
3.00	Drugs	0	0	0		0 0	0	
4.00	DME HHA NONREI MBURSABLE SERVI CES	0	0	0		0 0	0	14.
5.00	Home Dialysis Aide Services	0	0	0		0 0	0	15.
6.00	Respiratory Therapy	0	0	0		0 0	0	
7.00	Private Duty Nursing	377	0	168		0 0	545	
3.00	Clinic	0	0	0		0 0	0	-
9.00 0.00	Health Promotion Activities Day Care Program	0	0	0			0	
1.00	Home Delivered Meals Program	0	0	0		0 0	0	
2.00	Homemaker Service	0	0	0		0 0	0	22.
3.00		0	0	0		0 0	0	23.
3.50	Telemedicine Total (sum of lines 1–23)	0 794, 142	0	0 56, 599	268, 42	0 0 25 51,672	0 1, 170, 838	23.
4.00		Recl assi fi cati	Recl assi fi ed	Adjustments	Net Expenses		1, 170, 030	27.1
		on	Trial Balance	2	for Allocatio			
			(col. 6 + col.7)		(col. 8 + col 9)			
		7.00	8.00	9.00	10.00			1
	GENERAL SERVICE COST CENTERS				1			
00	Capital Related - Bldg. &	0	0	0		0		1.
. 00	Fixtures Capital Related - Movable	0	0	0		0		2.
	Equipment		Ū	Ū.				
. 00	Plant Operation & Maintenance	0	0	0		0		3.
. 00	Transportation	0		0		0		4.
. 00	Administrative and General HHA REIMBURSABLE SERVICES	0	475, 841	0	475, 84	+ 1		5.
. 00	Skilled Nursing Care	0	302, 333	0	302, 33	33		6.
. 00	Physical Therapy	0	188, 496	0	188, 49	96		7.
. 00	Occupational Therapy	0	47, 940	0	47, 94			8.
. 00	Speech Pathology	0	14, 685	0				9.
0 00	Medical Social Services	0	335 108, 751	0	33 108, 75			10.
	HOME Health Aide	0		0				12.
1. 00	Home Health Aide Supplies (see instructions)	0	31,912			0		13.
1.00 2.00 3.00	Supplies (see instructions) Drugs	0	31, 912 0	0				1 1 4
1.00 2.00 3.00	Supplies (see instructions) Drugs DME			0		0		14.
1.00 2.00 3.00 4.00	Supplies (see instructions) Drugs DME HHA NONREIMBURSABLE SERVICES	0	0	0		0		
1.00 2.00 3.00 4.00	Supplies (see instructions) Drugs DME HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services	000000000000000000000000000000000000000	0 0	0		0		15.
1.00 2.00 3.00 4.00 5.00 5.00	Supplies (see instructions) Drugs DME HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services Respiratory Therapy	0	0	0		0		15. 16.
1.00 2.00 3.00 4.00 5.00 5.00 7.00 3.00	Supplies (see instructions) Drugs DME HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic	0 0 0 0 0 0	0 0 0 0 545 0	0 0 0 0 0 0	54	0 0 15 0		15. 16. 17. 18.
1.00 2.00 3.00 4.00 5.00 5.00 7.00 3.00 9.00	Supplies (see instructions) Drugs DME HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities	0 0 0 0 0 0 0 0 0	0 0 0 545 0 0	0 0 0 0 0 0 0 0	54	0 0 15 0 0		15. 16. 17. 18. 19.
1.00 2.00 3.00 4.00 5.00 6.00 7.00 3.00 9.00 0.00	Supplies (see instructions) Drugs DME HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program	0 0 0 0 0 0 0 0 0 0	0 0 0 545 0 0 0 0		54	0 0 15 0 0 0		15. 16. 17. 18. 19. 20.
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 0.00 1.00	Supplies (see instructions) Drugs DME HHA NONREI MBURSABLE SERVICES Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program		0 0 0 545 0 0 0 0 0 0	0 0 0 0 0 0 0 0	54	0 0 15 0 0 0 0 0 0		15. 16. 17. 18. 19. 20. 21.
2.00	Supplies (see instructions) Drugs DME HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program	0 0 0 0 0 0 0 0 0 0	0 0 0 545 0 0 0 0		54	0 0 15 0 0 0		15. 16. 17. 18. 19. 20.
1.00 2.00 3.00 4.00 5.00 5.00 7.00 3.00 7.00 3.00 9.00 1.00 2.00	Supplies (see instructions) Drugs DME HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify)		0 0 0 545 0 0 0 0 0 0 0		54	0 0 0 15 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		15. 16. 17. 18. 19. 20. 21. 22.

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

	Financial Systems ALLOCATION - HHA GENERAL SERVICE		RANCI SCAN HEALT	H RENSSELAER	N· 15_1324	Period:	eu of Form CMS- Worksheet H-1	
CU31 P	LEUCATION - THA GENERAL SERVICE	_ 0031		HHA CCN:	15-7149	From 01/01/2017 To 12/31/2017	Part I	epared:
						Home Health	PPS	40 dili
			Capital Rela	ated Costs		Agency I		
		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	BI dgs & Fixtures	Movable Equipment	Pl ant Operati on a Mai ntenance		Subtotal (col s. 0-4)	
	OFNERAL CERVICE COST OFNER	0	1.00	2.00	3.00	4.00	4A. 00	
1.00	GENERAL SERVICE COST CENTERS Capital Related - Bldg. &	0	0				(1.00
2.00	Fixtures Capital Related - Movable	0		0				2.00
	Equi pment	_		0				
3.00 4.00	Plant Operation & Maintenance Transportation	0	0	0		0 0		3.00
5.00	Administrative and General	475, 841	0	0		0 (475, 841	5.00
6.00	HHA REIMBURSABLE SERVICES Skilled Nursing Care	302, 333	0	0		0 0	302, 333	6.00
7.00 8.00	Physical Therapy Occupational Therapy	188, 496 47, 940	0	0		0 0		
9.00 9.00	Speech Pathol ogy	14, 685	0	0		0 0		
10.00 11.00	Medical Social Services Home Health Aide	335 108, 751	0	0		0 0		
12.00	Supplies (see instructions)	31, 912	0	0		0 0		
13.00 14.00	Drugs DME	0	0	0		0		
14.00	HHA NONREI MBURSABLE SERVI CES	0	0	0			<u>,</u>	14.00
15.00 16.00	Home Dialysis Aide Services Respiratory Therapy	0	0	0		0 0		
17.00	Private Duty Nursing	545	0	0		0 0		
18.00 19.00	Clinic Health Promotion Activities	0	0	0		0 0		
20.00	Day Care Program	0	0	0		0 0		
21.00 22.00	Home Delivered Meals Program Homemaker Service	0	0	0		0 0		
23.00	All Others (specify)	0	0	0		0 0		
23.50 24.00	Telemedicine Total (sum of lines 1-23)	0 1, 170, 838	0	0		0 0) (1, 170, 838	
21100		Admi ni strati ve					1,170,000	2110
		& General 5.00	4A + 5) 6.00					-
1 00	GENERAL SERVICE COST CENTERS							1.0
1.00	Capital Related - Bldg. & Fixtures							1.00
2.00	Capital Related - Movable Equipment							2.00
3. 00	Plant Operation & Maintenance							3.00
4.00 5.00	Transportation Administrative and General	475, 841						4.00
	HHA REIMBURSABLE SERVICES	· · · ·						
6.00 7.00	Skilled Nursing Care Physical Therapy	206, 998 129, 057	509, 331 317, 553					6.00
3.00	Occupational Therapy	32, 823	80, 763					8.0
9.00 10.00	Speech Pathology Medical Social Services	10, 054 229	24, 739 564					9.0
11.00	Home Health Aide	74, 458	183, 209					11.0
12.00 13.00	Supplies (see instructions) Drugs	21, 849 0	53, 761 0					12.0
14.00	DME	0	0					14. 0
15.00	HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services	0	0					15.00
16.00	Respiratory Therapy	0	0					16.00
17.00 18.00	Private Duty Nursing Clinic	373 0	918 0					17.0
19. 00	Health Promotion Activities	0	0					19.0
20.00 21.00	Day Care Program Home Delivered Meals Program	0	0					20.00
22.00	Homemaker Service	0	О					22.00
23.00	All Others (specify) Telemedicine	0	0					23.00
23.50								

	Financial Systems		RANCI SCAN HEAL			1	u of Form CMS-2	2552-10
COST A	LLOCATION - HHA STATISTICAL BAS	IS		Provider CC HHA CCN:	CN: 15-1324 15-7149	Period: From 01/01/2017 To 12/31/2017	Worksheet H-1 Part II Date/Time Prep 5/31/2018 2:40	
						Home Health Agency I	PPS	
		Capital Rel	ated Costs					
		BIdgs &	Movabl e	PI ant	Transportati	onReconciliation	Admi ni strati ve	
		Fixtures (SOUARE FEFT)	Equipment (DOLLAR VALUE)	Operation & Maintenance	(MI LEAGE)		& General (ACCUM. COST)	
		· · ·	,	(SQUARE FEET)			. ,	
		1.00	2.00	3.00	4.00	5A. 00	5.00	
1 00	GENERAL SERVICE COST CENTERS	-						1 00
1.00	Capital Related - Bldg. & Fixtures	0				0		1.00
2.00	Capital Related - Movable		0			0		2.00
2.00	Equipment		0			0		2.00
3.00	Plant Operation & Maintenance	0	0	0		0		3.00
4.00	Transportation (see	0	0	0		0		4.00
	instructions)							
5.00	Administrative and General HHA REIMBURSABLE SERVICES	0	0	0		0 -475, 841	694, 997	5.00
6.00	Skilled Nursing Care	0	0	0		0 0	302, 333	6.00
7.00	Physical Therapy	0	-	0		0 0	188, 496	
8.00	Occupational Therapy	0	0	0		0 0	47, 940	
9.00	Speech Pathology	0	0	0		0 0	14, 685	9.00
10.00	Medical Social Services	0	0	0		0 0	335	
11.00	Home Health Aide	0	0	0		0 0	108, 751	
12.00	Supplies (see instructions)	0	0	0		0 0	31, 912	
13.00 14.00	Drugs DME	0	0	0		0 0	0	
14.00	HHA NONREI MBURSABLE SERVI CES	0	0	0		0 0	0	14.00
15.00	Home Dialysis Aide Services	0	0	0		0 0	0	15.00
16.00	Respiratory Therapy	0	0	0		0 0	0	16.00
17.00	Private Duty Nursing	0	0	0		0 0	545	
18.00	Clinic	0	0	0		0 0	0	18.00
19.00	Health Promotion Activities	0	0	0		0 0	0	
20. 00 21. 00	Day Care Program Home Delivered Meals Program	0	0	0		0 0	0	20.00 21.00
21.00	Homemaker Service	0	0	0		0 0	0	21.00
22.00	All Others (specify)	0	0	0		0 0	0	22.00
23.50	Tel emedi ci ne	0	0	0		0 0	0	23.50
24.00	Total (sum of lines 1-23)	0	0	0		0 -475, 841	694, 997	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0		0	475, 841	25.00
2/ 00	Unit Cost Multiplier	0. 000000	0. 000000	0. 000000	0.0000	00	0. 684666	26 00

ALLOC	n Financial Systems ATION OF GENERAL SERVICE COSTS 1	O HHA COST CEN	TERS	Provider CC	CN: 15-1324	Peri od:	Worksheet H-2	
				HHA CCN:	15-7149	From 01/01/2017 To 12/31/2017	Part I Date/Time Pre 5/31/2018 2:4	pared: 6 am
						Home Health Agency I	PPS	
			CAPI TAL			Agency		
	Cost Center Description	HHA Trial Balance (1)	RELATED COSTS BLDG & FIXT	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMI NI STRATI VE & GENERAL	OPERATION OF PLANT	-
		0	1.00	4.00	4A	5.00	7.00	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 11. 00 11. 00 12. 00 13. 00 14. 00 15. 00 14. 00 19. 00 19. 00 19. 00 21. 00	Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine	0 509, 331 317, 553 80, 763 24, 739 564 183, 209 53, 761 0 0 0 0 918 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		294, 072 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	183, 20 53, 70	$\begin{array}{cccccccccccccccccccccccccccccccccccc$	75, 164 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2.00 3.00 4.000 5.00 5.00 7.000 8.00 9.00 10.000 11.00 12.00 13.00 14.00 15.00 16.00 17.00 19.00 19.00 19.00 19.00 19.00 10.00 10.00 10.00 11.00 12.00 13.00 14.00 14.00 15.00 14.00 15.00 14.00 15.00 14.00 15.00 14.00 14.00 15.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 15.00 14.00 14.00 15.00 14.00 15.00 14.00 15.00 16.00 17.00
	6 decimal places. Cost Center Description	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES &	
		8.00	9.00	10.00	11.00	13.00	SUPPLY 14.00	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 11. 00 12. 00 13. 00 14. 00 15. 00 15. 00 16. 00 17. 00 19. 00 19. 00 21. 00	Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2)		87, 172 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	6,963 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.50

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

LLOCATION OF GENERAL SERVICE COSTS T	O HHA COST CEN	TERS	Provider C	CN: 15-1324		eri od:	Worksheet H-2	
			HHA CCN:	15-7149	То		5/31/2018 2:40	
						Home Health	PPS	
Cost Center Description	PHARMACY	MEDI CAL	Subtotal	Intern &		Agency I Subtotal	Allocated HHA	
		RECORDS &		Residents Co	st		A&G (see Part	
		LI BRARY		& Post			11)	
				Stepdown Adjustments	<u>د</u>			
	15.00	16.00	24.00	25.00	3	26.00	27.00	
.00 Administrative and General	0	0	706, 173		0	706, 173		1. 0
. 00 Skilled Nursing Care	0	0	661, 043		0	661, 043		2.0
00 Physical Therapy 00 Occupational Therapy	0	0	412, 140 104, 819		0 0	412, 140 104, 819		3.0 4.0
. 00 Speech Pathol ogy	0	0	32, 108		0	32, 108		5.0
. 00 Medical Social Services	0	0	732		0	732		6.0
. 00 Home Heal th Ai de	0	0	237, 780		0	237, 780		7.0
00 Supplies (see instructions) 00 Drugs	0	0	69, 774 C		0 0	69, 774 0		8. 0 9. 0
0.00 DME	0	0	0		0	0	0	10.0
1.00 Home Dialysis Aide Services	0	0	C		0	0	0	11. 0
2.00 Respiratory Therapy	0	0	0		0	0		12.0
3.00 Private Duty Nursing 4.00 Clinic	0	0	1, 191 C		0 0	1, 191 0		13.0 14.0
5.00 Health Promotion Activities	0	0	0		0	0	0	15.0
6.00 Day Care Program	0	0	C		0	0	0	16. 0
7.00 Home Delivered Meals Program	0	0	0		0	0	0	17.0
8.00 Homemaker Service 9.00 All Others (specify)	0	0	0		0 0	0	0	18. 0 19. 0
9. 50 Tel emedi ci ne	0	0	0		0	0	0	19.5
0.00 Total (sum of lines 1-19) (2)	0	0	2, 225, 760		0	2, 225, 760	706, 173	20. 0
1.00 Unit Cost Multiplier: column							0. 464714	21. 0
26, line 1 divided by the sum of column 26, line 20 minus								
column 26, line 1, rounded to								
6 decimal places.	T							
Cost Center Description	Total HHA Costs							
	28.00							
.00 Administrative and General								1.0
2.00 Skilled Nursing Care 3.00 Physical Therapy	968, 239 603, 667							2.0 3.0
. 00 Occupational Therapy	153, 530							4.0
00 Speech Pathol ogy	47, 029							5.0
.00 Medical Social Services	1,072							6.0
.00 Home Health Aide .00 Supplies (see instructions)	348, 280 102, 199							7.0 8.0
0.00 Drugs	102, 199							9.0
0. OO DME	0							10.0
1.00 Home Dialysis Aide Services	0							11. 0
2.00 Respiratory Therapy	0							12.0
3.00 Private Duty Nursing 4.00 Clinic	1, 744 0							13.0 14.0
5.00 Health Promotion Activities	0							15.0
6.00 Day Care Program	0							16. 0
7.00 Home Delivered Meals Program	0							17.0
8.00 Homemaker Service9.00 All Others (specify)	0							18. 0 19. 0
9. 50 Tel emedi ci ne	0							19.5
0.00 Total (sum of lines 1-19) (2)	2, 225, 760							20. 0
1.00 Unit Cost Multiplier: column								21.0
26, line 1 divided by the sum of column 26, line 20 minus								
column 26, line 1, rounded to								
6 decimal places.								

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

Ith Financial Systems _OCATION OF GENERAL SERVICE COSTS ⁻	TO HHA COST CEN	TERS STATISTICA	L Provider C	CN: 15-1324	Period:	Worksheet H-2	
SI S			HHA CCN:	15-7149	From 01/01/2017 To 12/31/2017	Part II Date/Time Pre 5/31/2018 2:4	
					Home Health	PPS	
	CAPI TAL				Agency I		
Cost Center Description	RELATED COSTS BLDG & FI XT (SQUARE FEET)	BENEFI TS DEPARTMENT (GROSS	Reconciliation	ADMI NI STRATI & GENERAL (ACCUM. COST	PLANT	LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY)	-
	1.00	SALARIES) 4.00	5A	5.00	7.00	8.00	
00 Administrative and General	3, 117	794, 142	0			0	1.
00 Skilled Nursing Care 00 Physical Therapy 00 Occupational Therapy	0 0 0	0 0 0	0 0 0	317, 5 80, 7	53 0 53 0	0	3. 4.
00 Speech Pathology 00 Medical Social Services	0	0	0	24, 7	39 0 54 0	0	
DO Home Health Aide	0	0	0			-	
00 Supplies (see instructions)	0	0	0	53, 70		0	
00 Drugs	0	0	0		0 0	-	
00 DME 00 Home Dialysis Aide Services	0	0	0		0 0	-	
00 Respiratory Therapy	0	0	0		0 0		
00 Private Duty Nursing	0	0	0	9	18 0	0	13
00 Clinic	0	0	0		0 0	0	
00 Health Promotion Activities 00 Day Care Program	0	0	0		0 0	0	
00 Home Delivered Meals Program	0	0	0		0 0	0	
00 Homemaker Service	0	0	0		0 0	0	
00 All Others (specify)	0	0	0		0 0	0	
50 Telemedicine 00 Total (sum of lines 1-19)	3, 117	0 794, 142	0	1, 584, 4	0 0 98 3, 117	0	1
00 Total cost to be allocated	119, 588	294, 072		471, 90		-	
00 Unit cost multiplier	38. 366378	0. 370302		0. 2978			22
Cost Center Description	HOUSEKEEPI NG (HOURS OF SERVI C)	DI ETARY (MEALS SERVED)	CAFETERI A (SALARI ES)	NURSI NG ADMI NI STRATI (SUPPLY	PHARMACY (COSTED REQUI SI TI ONS)	
				(NURSI NG SALARI ES)	(COSTED REQUI SI TI ONS)		
	9.00	10.00	11.00	13.00	14.00	15.00	
00 Administrative and General	6, 240	0	0		0 36, 636		
0 Skilled Nursing Care 0 Physical Therapy	0	0	0		0 0	0	
00 Occupational Therapy	0	0	0		0 0	0	
0 Speech Pathol ogy	0	0	0		0 0	0	
0 Medical Social Services 0 Home Health Aide	0	0	0		0 0	0	
00 Supplies (see instructions)	0	0	0				
0 Drugs	0	0	0		0 0	0	
OO DME	0	0	0		0 0		
00 Home Dialysis Aide Services00 Respiratory Therapy	0	0	0		0 0	-	
00 Private Duty Nursing	0	0	0		0 0	-	
00 Clinic	0	Ō	0		0 0	0	14
00 Health Promotion Activities	0	0	0		0 0	-	
00 Day Care Program00 Home Delivered Meals Program	0	0	0		0 0	0	
00 Homemaker Service	0	0	0		0 0	0	
00 All Others (specify)	0	0	0		0 0	0	19
50 Telemedicine	0	0	0		0 0	0	
00 Total (sum of lines 1-19)	6, 240	0	0		0 36, 636		
00 Total cost to be allocated	87, 172	0	∩		0 6,963	0	21

Heal th	Financial Systems	F	RANCI SCAN HEALTH	RENSSELAER		In Lie	u of Form CMS-:	2552-10
	TION OF GENERAL SERVICE COSTS 1	O HHA COST CEN	TERS STATI STI CAL	Provider CCN:	15-1324	Peri od:	Worksheet H-2	
BASI S				HHA CCN:	15-7149	From 01/01/2017 To 12/31/2017	Part II Date/Time Pre	narod
					13-7149	10 12/31/2017	5/31/2018 2:4	
						Home Health	PPS	
						Agency I		
	Cost Center Description	MEDI CAL						
		RECORDS &						
		LI BRARY (TI ME SPENT)						
		16. 00				-		
1.00	Administrative and General	0						1.00
2.00	Skilled Nursing Care	0						2.00
3.00	Physical Therapy	0						3.00
4.00	Occupational Therapy	0						4.00
5.00	Speech Pathology	0						5.00
6.00	Medical Social Services	0						6.00
7.00	Home Health Aide	0						7.00
8.00	Supplies (see instructions)	0						8.00
9.00	Drugs	0						9.00
10.00	DME	0						10.00
11.00	Home Dialysis Aide Services	0						11.00
12.00	Respiratory Therapy	0						12.00
13.00	Private Duty Nursing	0						13.00
14.00	Clinic	0						14.00 15.00
16.00	Health Promotion Activities Day Care Program	0						16.00
17.00		0						17.00
18.00	Homemaker Service	0						18.00
19.00	All Others (specify)	0						19.00
19.50		0						19.50
20.00		0						20.00
21.00	Total cost to be allocated	0						21.00
22.00	Unit cost multiplier	0. 000000						22.00

Heal th	Financial Systems	F	RANCI SCAN HEAL	TH RENSSELAER		In Lie	eu of Form CMS-2	2552-10
APPORT	IONMENT OF PATIENT SERVICE COST	S		Provider C	CN: 15-1324	Period: From 01/01/2017	Worksheet H-3 Part I	
				HHA CCN:	15-7149	To 12/31/2017		pared: 6 am
				Title	e XVIII	Home Health Agency I	PPS	
	Cost Center Description		Facility Costs		Total HHA	Total Visits	Average Cost	
		H-2, Part I, col. 28, line	(from Wkst. H-2, Part I)	Ancillary Costs (from	Costs (cols. + 2)	1	Per Visit (col. 3 ÷ col.	
			1.00	Part II)	2.00	4.00	4) 5.00	
	PART I - COMPUTATION OF LESSER	OF AGGREGATE F	1.00 PROGRAM COST, A	2.00 GGREGATE OF TH	3.00 E PROGRAM LIN	4.00		
	BENEFICIARY COST LIMITATION							
1.00	Cost Per Visit Computation Skilled Nursing Care	2.00	968, 239		968, 23	2, 344	413.07	1.00
2.00	Physical Therapy	3.00	603, 667	C	603, 66	1, 334	452. 52	
3.00	Occupational Therapy	4.00		C				
4.00 5.00	Speech Pathology Medical Social Services	5. 00 6. 00		C) 47,02 1,07			
5.00 6.00	Home Health Aide	7.00			348, 28			5.00 6.00
7.00	Total (sum of lines 1-6)	/.00	2, 121, 817	C				7.00
			I		Program Visit			
	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Not Subject 1	art B o Subject to		
	cost center bescription	COST LINITIS	CDSA NO. (T)	Fait A	Deducti bl es			
					Coi nsurance			
	Limitation Cost Computation	0	1.00	2.00	3.00	4.00	5.00	
8.00	Skilled Nursing Care		23844	C	76	5		8.00
8.01	Skilled Nursing Care		29200	C		1		8. 01
8.02	Skilled Nursing Care		99915	C		3		8.02
9.00 9.01	Physical Therapy Physical Therapy		23844 29200	C		1		9.00 9.01
9.02	Physical Therapy		99915	C		18		9.02
10.00	Occupational Therapy		23844	C	22	27		10.00
10.01	Occupational Therapy		29200	C		7		10.01
10. 02 11. 00	Occupational Therapy Speech Pathology		99915 23844	C		4		10. 02 11. 00
11.00	Speech Pathology		29200	C		0		11.00
11.02	Speech Pathol ogy		99915	C		0		11.02
12.00	Medical Social Services		23844	C		6		12.00
12.01	Medical Social Services		29200	C		0		12.01
12. 02 13. 00	Medical Social Services Home Health Aide		99915 23844	C		1		12.02 13.00
13.00	Home Heal th Aide		29200			34		13.00
13.02	Home Health Aide		99915	C		0		13.02
14.00				Chausad				14.00
	Cost Center Description	From WKST. H-2 Part I, col.	Facility Costs (from Wkst.	Shared Ancillary	Total HHA Costs (cols.	Total Charges 1 (from HHA	Ratio (col. 3 ÷ col. 4)	
		28, line	H-2, Part I)	Costs (from	+ 2)	Records)		
			1.00	Part II)	0.00	4.00	5.00	
	Supplies and Drugs Cost Compute	0 ations	1.00	2.00	3.00	4.00	5.00	
15.00	Cost of Medical Supplies	8.00						
16.00	Cost of Drugs	9.00	0 Program Visits		Cost of	0 0	0. 000000	16.00
			Par	t B	Servi ces	Part B		
	Cost Center Description	Part A	Not Subject to		Part A	Not Subject to	Subject to	
			Deductibles &			Deductibles &	Deductibles &	
		6.00	Coi nsurance 7.00	Coi nsurance 8.00	9.00	Coi nsurance 10.00	Coi nsurance 11.00	
	PART I - COMPUTATION OF LESSER BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation	1				1		
1.00	Skilled Nursing Care	0				0 334, 174		1.00
2.00 3.00	Physical Therapy Occupational Therapy	0				0 413, 151 0 92, 640		2.00 3.00
3.00 4.00	Speech Pathol ogy	0				0 92, 840		4.00
5.00	Medical Social Services	0				0 469		5.00
6.00	Home Health Aide	0				0 94, 651		6.00
7.00	Total (sum of lines 1-6)	0	2, 656		I	0 964, 215	I	7.00

				CN: 15-1324	Period: From 01/01/2017	Part I	}
			HHA CCN:	15-7149	To 12/31/2017	Date/Time Pre 5/31/2018 2:4	
			Title	XVIII	Home Health Agency I	PPS	
Cost Center Description	(00	7.00	0.00	0.00		11 00	
Limitation Cost Computation	0.00	7.00	8.00	9.00	10.00	11.00	
Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Physical Therapy Physical Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Speech Pathology Speech Pathology Speech Pathology Medical Social Services Medical Social Services Home Health Aide							$\begin{array}{c} 8.00\\ 8.01\\ 8.02\\ 9.00\\ 9.01\\ 9.02\\ 10.00\\ 10.01\\ 10.02\\ 11.00\\ 11.01\\ 11.02\\ 12.00\\ 12.01\\ 12.02\\ 13.00\\ 0.01\\ 0$
							13.01 13.02
Total (sum of lines 8-13)							14.00
	Progi	ram Covered Cha	rges				
		-	_	00.11000			
Cost Center Description	Part A	Not Subject to Deductibles &	Subject to Deductibles &	Part A	Not Subject to Deductibles &	Deductibles &	
	6.00	7.00	8.00	9.00	10.00	11.00	
Cost of Medical Supplies		0	0		0 0	C	15.00
Cost of Drugs	T I I D	0	0		0	C	16.00
Cost center bescription	Cost (sum of cols. 9-10)						
PART L - COMPUTATION OF LESSER		PROGRAM COST A	GGREGATE OF TH	F PROGRAM LI	MITATION COST OF	2	
BENEFICIARY COST LIMITATION							
	224 174						1.00
Physical Therapy	413, 151						2.00
Occupational Therapy							3.00
							4.00
							5.00 6.00
Total (sum of lines 1-6)							7.00
Cost Center Description							
Limitation Cost Computation	12.00						
Skilled Nursing Care							8.00
Skilled Nursing Care Skilled Nursing Care Physical Therapy Physical Therapy Physical Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Speech Pathology Speech Pathology Speech Pathology Medical Social Services Medical Social Services Home Health Aide							$\begin{array}{c} 8. \ 01 \\ 8. \ 02 \\ 9. \ 00 \\ 9. \ 01 \\ 9. \ 02 \\ 10. \ 00 \\ 10. \ 01 \\ 10. \ 02 \\ 11. \ 00 \\ 11. \ 01 \\ 11. \ 02 \\ 12. \ 00 \\ 12. \ 01 \\ 12. \ 02 \\ 13. \ 00 \\ 13. \ 01 \end{array}$
	Limitation Cost Computation Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Physical Therapy Physical Therapy Physical Therapy Occupational Therapy Occupational Therapy Occupational Therapy Speech Pathology Speech Pathology Speech Pathology Medical Social Services Medical Social Services Medical Social Services Home Heal th Aide Home Heal th Aide Home Heal th Aide Total (sum of lines 8-13) Cost Center Description Supplies and Drugs Cost Computa Cost of Medical Supplies Cost Center Description Supplies and Drugs Cost Computa Cost Center Description Supplies and Drugs Cost Computa Cost Center Description PART I - COMPUTATION OF LESSER BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Heal th Aide Total (sum of lines 1-6) Cost Center Description Limitation Cost Computation Skilled Nursing Care Skilled Nursing Care	6.00 Limitation Cost Computation Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Physical Therapy Physical Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Speech Pathology Speech Pathol ogy Speech Pathol agy Speech Pathol agy Speech Pathol agy Speech Pathol agy Medical Social Services Medical Social Services Home Heal th Aide Home Heal th Aide Home Heal th Aide Total (sum of Lines 8-13) Prog Cost Center Description Cost of Drugs Cost Center Description Skilled Nursing Care BENEFICIARY COST LIMITATION Cost Center Description Skilled Nursing Care Medical Social Services Medical Social Services Medical Social Services Home Health Aide	6.00 7.00 Limitation Cost Computation 5.00 Skilled Nursing Care 5.00 Skilled Nursing Care 5.00 Skilled Nursing Care Physical Therapy Physical Therapy Physical Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Speech Pathology Speech Pathology Speech Pathology Speech Pathol Gay Speech Pathol Services Medical Social Services Medical Social Services Part A Medical Social Services 0 Medical Social Services 0 Medical Social Services 0 Medical Social Services 0 Cost Center Description Part A Cost of Medical Supplies 0 Cost Center Description Total Program Skilled Nursing Care 334, 174 Physical Therapy 413, 151 Occupational Therapy 92, 64	6.00 7.00 8.00 Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Physical Therapy Prysical Therapy Cocupational Therapy Occupational Therapy Cocupational Therapy Speech Pathol ogy Speech Pathol ogy Cost Center Description Part A Cost Center Description Part A Cost of Medical Supplies 0 Cost Center Description Total Program Co	6.00 7.00 8.00 9.00 Ski I led Nursing Care Ski I led Nursing Care Ski I led Nursing Care Ski I led Nursing Care Ski I led Nursing Care Ski I led Nursing Care Ski I led Nursing Care Ski I led Nursing Care Ski I led Nursing Care Physical Therapy Physica Therapy Spech Pathol Ogy Occupational Therapy Occupational Therapy Spech Pathol Ogy Speech Pathol Ogy Spech Pathol Ogy Spech Pathol Ogy Medical Social Services Nof Subject to Subject to Nof Subject to Subject to Deductibles & Cost of Services Medical Social Services 6.00 7.00 8.00 9.00 Supplies and Drugs Cost Computations 0 0 0 0 Cost Center Description Total Program Covered Charges Cost of Nedical Supplies 0 0 Cost Center Description Total Program Covered Charges Scolinsurance 9.00 Cost Center Description Total Program Covered Charges Cost of Services Modical Social Services 0 0 0 Cost Center Description Total Program Covered Charges 9.00 Cost Center Description 12.00 0 0 Cost Center Description Scoling Care 94.651 Descriptional Th	6.00 7.00 8.00 9.00 10.00 Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Physical Therapy Physical Therapy Decupational Therapy Decupational Therapy Speech Pathol agy Speech Pathol agy Sp	Linit Ratio Cost Computation 6.00 7.00 8.00 9.00 10.00 11.00 Skill et Mursing Care Skill et Mursing Care <

Heal th	n Financial Systems	F	RANCI SCAN HEAL	TH RENSSELAER		In Lie	u of Form CMS-2	2552-10
APPOR	TIONMENT OF PATIENT SERVICE COST	S		Provider C	CN: 15-1324	Peri od:	Worksheet H-3	
				HHA CCN:	15-7149	From 01/01/2017 To 12/31/2017		pared:
							5/31/2018 2:4	6 am
				Title	XVIII	Home Health	PPS	
						Agency I		
	Cost Center Description		Cost to Charge		HHA Shared			
		Part I, col.	Ratio	Charge (from	Ancillary	Part I as		
		9, line			Costs (col.	1 Indicated		
				records)	x col. 2)			
		0	1.00	2.00	3.00	4.00		
	PART II - APPORTIONMENT OF COS	T OF HHA SERVI	CES FURNI SHED B	Y SHARED HOSPI	TAL DEPARTMEN	NTS		
1.00	Physical Therapy	66.00	0. 859661	0		0 col. 2, line 2	. 00	1.00
1.01	Physical Therapy 1	66. 01	0. 954943	0		0 col. 2, line 2	. 01	1.01
2.00	Occupational Therapy	67.00	1. 020948	0		0 col. 2, line 3	. 00	2.00
2.01	Occupational Therapy 1	67.01	2. 055504	0		Ocol. 2, line 3	. 01	2.01
3.00	Speech Pathology	68.00	1. 515224	0		Ocol. 2, line 4	. 00	3.00
3.01	Speech Pathology 1	68.01	2. 022932	0		0col. 2, line 4	. 01	3. 01
4.00	Cost of Medical Supplies	71.00	0. 143667	0		0 col. 2, line 1	5.00	4.00
5.00	Cost of Drugs	73.00	0. 195283	0		0 col. 2, line 1	6. 00	5.00

LCUL	Financial Systems FRANCISCAN HEALTH I ATION OF HHA REIMBURSEMENT SETTLEMENT	Provider CCN	: 15-1324	Peri o		Worksheet H-4	2552
		HHA CCN:	15-7149		01/01/2017 12/31/2017	Part I-II Date/Time Pre 5/31/2018 2:4	
		Title >	(VIII	Hom	e Health	PPS	0 4
				Ac	gency I Par	+ P	1
			Part A	Not		Subject to	-
						Deductibles &	
		-	1.00	Coi	nsurance 2.00	Coi nsurance 3.00	-
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTO	MARY CHARGES	1.00		2.00	0.00	
	Reasonable Cost of Part A & Part B Services						Ι.
0	Reasonable cost of services (see instructions) Total charges			0 0	0	0 0	
0	Customary Charges				0		1
0	Amount actually collected from patients liable for payment for	servi ces		0	0	0] :
0	on a charge basis (from your records) Amount that would have been realized from patients liable for	navmont		0	0	0	
0	with 42 CFR \S 413.13(b)			0	0	0	
)	Ratio of line 3 to line 4 (not to exceed 1.000000)		0.0000	00	0. 000000	0.000000	1
0	Total customary charges (see instructions)			0	0	0	
)	Excess of total customary charges over total reasonable cost (only if line 6 exceeds line 1)	complete		0	0	0	
0	Excess of reasonable cost over customary charges (complete onl)	yifline		0	0	0	
)	1 exceeds line 6) Primary payer amounts			0	0	0	
					Part A	Part B	
				S	ervices 1.00	Services 2.00	-
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT				1.00	2.00	
	Total reasonable cost (see instructions)				0		1
00	Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers				0	379, 617 36, 591	
00	Total PPS Reimbursement - LUPA Episodes				0	8, 855	
00	Total PPS Reimbursement - PEP Episodes				0	7, 817	
00	Total PPS Outlier Reimbursement - Full Episodes with Outliers				0	9, 150	1
00	Total PPS Outlier Reimbursement - PEP Episodes				0	4, 143	1
00	Total Other Payments				0	0	1
	DME Payments				0	0	
00	Oxygen Payments				0	0	
	Prosthetic and Orthotic Payments				0	0	
	Part B deductibles billed to Medicare patients (exclude coinsu	rance)			-	0	
	Subtotal (sum of lines 10 thru 20 minus line 21)				0	446, 173	
	Excess reasonable cost (from line 8)				0	0	
00	Subtotal (line 22 minus line 23)				0	446, 173	
	Coinsurance billed to program patients (from your records)				0	0	
00	Net cost (line 24 minus line 25)				0	446, 173	
	Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see in						2
-	5	,			0	114 172	2
	Total costs - current cost reporting period (line 26 plus line	27)			0	446, 173	
00 50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions)			0	0	
	Demonstration payment adjustment amount before sequestration	/			0	0	
00	Subtotal (see instructions)				0	446, 173	
00	Sequestration adjustment (see instructions)				0	440, 173	
02	Demonstration payment adjustment amount after sequestration				0	0	
00	Interim payments (see instructions)				0	446, 173	
00	Tentative settlement (for contractor use only)				0	0	
				1	0		
00	Balance due provider/program (line 31 minus lines 31.01, 32, a	nd 33)			0	0	34

	IS OF PAYMENTS TO HOSPITAL-BASED HHAS FOR SERVICES RENDERED	Provider CC	CN: 15-1324		eriod:	Worksheet H-5	
PRC	IGRAM BENEFI CI ARI ES	HHA CCN:	15-7149	FI To	rom 01/01/2017 5 12/31/2017	Date/Time Prep 5/31/2018 2:46	
					Home Health Agency I	PPS	J am
		Inpatien	t Part A			t B	
		mm/dd/yyyy	Amount		mm/dd/yyyy	Amount	
00	Tatal interim novemente neid te provider	1.00	2.00	0	3.00	4.00	1
00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero			0		446, 173 0	2
0	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						3
	Program to Provider						
1				0		0	3
2 3				0		0	3
)4				0		0	3
5				0		0	3
	Provider to Program						
0				0		0	3
1 2				0		0	3
3				0		0	3
64				0		0	3
9	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0		0	З
0	3.50-3.98) Total interim payments (sum of lines 1, 2, and 3.99)			0		446, 173	4
0	(transfer to Wkst. H-4, Part II, column as appropriate, line 32)			U		440, 173	4
	TO BE COMPLETED BY CONTRACTOR						
00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						5
	Program to Provider						
1				0		0	5
)2)3				0		0	5
5	Provider to Program		I	U		0	
0				0		0	5
1				0		0	5
2	Subtotal (sum of lines 5.01–5.49 minus sum of lines			0		0	5
0	5.50-5.98) Determined net settlement amount (balance due) based on			U		0	6
5	the cost report. (1)						0
)1	SETTLEMENT TO PROVIDER			0		0	6
)2	SETTLEMENT TO PROGRAM			0		0	6
00	Total Medicare program liability (see instructions)			0	Contractor	446,173 NPR Date	7
					Number	(Mo/Day/Yr)	
		()		1.00	2.00	

	Financial Systems SIS OF HOSPITAL-BASED HOSPICE COSTS	FRANCI SCAN HEALT	Provider C	CN: 15-1324	Peri od:	u of Form CMS-: Worksheet O	
			Hospi ce CC	N: 15-1519	From 01/01/2017 To 12/31/2017	Date/Time Pre 5/31/2018 2:4	
		SALARI ES	OTHER	SUBTOTAL (co	Hospi ce I	SUBTOTAL	
				1 plus col.	2) CATIONS		
	GENERAL SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
1.00	CAP REL COSTS-BLDG & FIXT*		C		0 0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP*		C		0 0	0	
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	C		0 0	0	
4.00	ADMI NI STRATI VE & GENERAL*	146, 261	34, 434	180, 6	95 0	180, 695	4.0
5.00	PLANT OPERATION & MAINTENANCE*	0	C		0 0	0	5.00
6.00	LAUNDRY & LINEN SERVICE*	0	C		0 0	0	6.0
7.00	HOUSEKEEPI NG*	0	C		0 0	0	
8.00	DI ETARY*	0	C		0 0	0	
9.00	NURSING ADMINISTRATION*	0	C		0 0	0	
10.00	ROUTINE MEDICAL SUPPLIES*	0	C		0 0	0	10.00
11.00	MEDI CAL RECORDS*	0	C	0	0 0	0	11.00
12.00	STAFF TRANSPORTATION*	0	0)	0 0	0	
13.00	VOLUNTEER SERVICE COORDINATION*	0	()	0 0	0	
14.00		0	0		0 0	0	
15.00	PHYSICIAN ADMINISTRATIVE SERVICES* OTHER GENERAL SERVICE*	0	(0 0	0	
16.00 17.00	PATI ENT/RESI DENTI AL CARE SERVI CES	0	C		0 0	U U	17.00
17.00	DIRECT PATIENT CARE SERVICE COST CENTERS						17.00
25.00	INPATIENT CARE-CONTRACTED**		C		0 0	0	25.00
26.00	PHYSI CI AN SERVI CES**	0	C	1	0 0	0	
27.00	NURSE PRACTITIONER**	0	(1	0 0	0	
28.00	REGI STERED NURSE**	173, 987	331		-	174, 318	
29.00	LPN/LVN**	0	0		0 0	0	1
30.00	PHYSI CAL THERAPY**	0	C		0 0	0	
31.00	OCCUPATIONAL THERAPY**	0	C		0 0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	C		0 0	0	32.00
33.00	MEDICAL SOCIAL SERVICES**	0	C		0 0	0	33.00
34.00	SPI RI TUAL COUNSELI NG**	0	C		0 0	0	34.00
35.00	DI ETARY COUNSELI NG**	0	821	8	21 0	821	35.00
36.00	COUNSELING - OTHER**	0	C		0 0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES**	0	C		0 0	0	
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	36, 469			36, 469	
39.00	PATIENT TRANSPORTATION**	0	22, 046			22, 046	
40.00	I MAGI NG SERVI CES**	0	0)	0 0	0	
41.00	LABS & DI AGNOSTI CS**	0	(0 0	0	41.0
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	1, 787			1, 787	
42.50 43.00	DRUGS CHARGED TO PATI ENTS** OUTPATI ENT SERVICES**	0	45, 533			45, 533	
43.00	PALLIATIVE RADIATION THERAPY**	0	89, 581 (0 0	89, 581 0	
45.00	PALLIATIVE CHEMOTHERAPY**	0	0		0 0	0	
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	0		0 0	0	
40.00	NONREI MBURSABLE COST CENTERS	Ч. Ч.	,	1	0 0	0	0. 00
60.00		0	(0 0	0	60.00
61.00	VOLUNTEER PROGRAM *	0	C		0 0	0	
62.00	FUNDRAI SI NG*	0	C		0 0	0	
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	C		0 0	0	
64.00		0	C		0 0	0	
65.00	OTHER PHYSICIAN SERVICES*	0	C		0 0	0	65.0
66.00	RESI DENTI AL CARE*	0	C		0 0	0	66.0
67.00	ADVERTI SI NG*	0	C		0 0	0	
8. 00		0	C		0 0	0	
69.00		0	C		0 0	0	
70.00	NURSING FACILITY ROOM & BOARD*	0	C		0 0	0	
	OTHER NONREIMBURSABLE (SPECIFY)*	0	C		0 0	0	
100 00	DITOTAL	320, 248	231, 002	551, 2	50 0	551, 250	1100 0

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

IALYS	SIS OF HOSPITAL-BASED HOSPICE COSTS		Provider CCN	: 15-1324	Peri od:	Worksheet O	
			Hospice CCN:	15-1519	From 01/01/2017 To 12/31/2017	Date/Time Prep	pare
					Hocni co. I	5/31/2018 2:40	6 ar
		ADJUSTMENTS	TOTAL (col. 5		Hospi ce I		
		6.00	± col. 6) 7.00				
	GENERAL SERVICE COST CENTERS	0.00	7.00				
00	CAP REL COSTS-BLDG & FIXT*	0	0				1 1
00	CAP REL COSTS-MVBLE EQUIP*	0	0				2
00	EMPLOYEE BENEFITS DEPARTMENT*	0	0				3
00	ADMI NI STRATI VE & GENERAL*	0	180, 695				4
00	PLANT OPERATION & MAINTENANCE*	0	0				5
00	LAUNDRY & LINEN SERVICE*	0	0				6
00	HOUSEKEEPI NG*	0	0				7
00	DI ETARY*	0	0				8
00	NURSING ADMINISTRATION*	0	0				9
00	ROUTI NE MEDI CAL SUPPLI ES*	0	0				10
00	MEDI CAL RECORDS*	0	0				11
00	STAFF TRANSPORTATI ON*	0	0				12
00	VOLUNTEER SERVICE COORDINATION*	0	0				13
. 00	PHARMACY*	0	0				14
00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0				15
00	OTHER GENERAL SERVICE*	0	0				16
00	PATIENT/RESIDENTIAL CARE SERVICES						17
~ ~	DI RECT PATI ENT CARE SERVI CE COST CENTERS						
00	INPATIENT CARE-CONTRACTED**	0	0				25
00	PHYSI CI AN SERVI CES**	0	0				26
00	NURSE PRACTITIONER**	0	0				27
00	REGI STERED NURSE**	0	174, 318				28
00		0	0				29
00	PHYSICAL THERAPY**	0	0				30
00 00	OCCUPATIONAL THERAPY**		0				3
00	SPEECH/LANGUAGE PATHOLOGY** MEDI CAL SOCI AL SERVI CES**		0				33
00	SPIRITUAL COUNSELING**	0	0				34
00	DI ETARY COUNSELING**		821				35
00	COUNSELING - OTHER**		021				36
00	HOSPICE AIDE & HOMEMAKER SERVICES**	0	0				37
00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	36, 469				38
00	PATI ENT TRANSPORTATI ON**	0	22, 046				39
00	I MAGI NG SERVI CES**	0	0				40
00	LABS & DI AGNOSTI CS**	0	0				4
00	MEDICAL SUPPLIES-NON-ROUTINE**	0	1, 787				42
50	DRUGS CHARGED TO PATIENTS**	0	45, 533				42
00	OUTPATIENT SERVICES**	0	89, 581				43
00	PALLIATIVE RADIATION THERAPY**	0	0				44
00	PALLIATIVE CHEMOTHERAPY**	0	0				45
00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	0				46
	NONREI MBURSABLE COST CENTERS		· · ·				
00	BEREAVEMENT PROGRAM *	0	0				60
00	VOLUNTEER PROGRAM *	0	0				61
00	FUNDRAI SI NG*	0	0				62
00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0				63
00	PALLIATIVE CARE PROGRAM*	0	0				64
00	OTHER PHYSI CI AN SERVI CES*	0	0				65
00	RESI DENTI AL CARE*	0	0				66
00	ADVERTI SI NG*	0	0				6
00	TELEHEALTH/TELEMONI TORI NG*	0	0				68
00	THRI FT STORE*	0	0				69
00		0	0				70
00		0	0				71
). 00	TOTAL	0	551, 250				100

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

ealth Financial Systems NALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSP	FRANCI SCAN HEALT	Provider C	NI 15 1224	Peri od:	u of Form CMS-2 Worksheet 0-2	
ARE	ICE ROUTINE HOME	Provider Co		From 01/01/2017	worksneet 0-2	
AKE		Hospi ce CCI		To 12/31/2017	Date/Time Pre	pared:
					5/31/2018 2:4	6 am
				Hospi ce I		
	SALARI ES	OTHER	SUBTOTAL (COL		SUBTOTAL	
	1.00	2.00	$1 + col \cdot 2$	CATIONS	F 00	
DIRECT PATIENT CARE SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
25.00 INPATIENT CARE-CONTRACTED						25.0
26.00 PHYSICIAN SERVICES		0		0	0	
27. 00 NURSE PRACTITIONER	0	0		0 0	0	20.0
28.00 REGISTERED NURSE	172, 580	0	172, 58	0 0	172, 580	
9.00 LPN/LVN	172, 580	0	1/2, 58		172, 580	28.0
0.00 PHYSICAL THERAPY	0	0		0 0	0	30. (
1. 00 OCCUPATIONAL THERAPY	0	0		0 0	0	31.
22.00 SPEECH/LANGUAGE PATHOLOGY	0	0		0 0	0	32.
3. 00 MEDICAL SOCIAL SERVICES	0	0			0	33.0
44. 00 SPIRITUAL COUNSELING	0	0		0 0	0	34.
5. 00 DIETARY COUNSELING	0	821	82	1 0	821	35.
6. 00 COUNSELING - OTHER	0	021	02	0 0	021	36.
7. 00 HOSPICE ALDE & HOMEMAKER SERVICES	0	0		0 0	0	30.
8. 00 DURABLE MEDICAL EQUIPMENT/OXYGEN	0	36, 469	36, 46	0 0	36, 469	
9. 00 PATIENT TRANSPORTATION	0	22,046			22, 046	
0.00 I MAGI NG SERVI CES	0	22, 040	22,04	0 0	22,040	40.
1.00 LABS & DIAGNOSTICS	0	0		0 0	0	41.
2. 00 MEDICAL SUPPLIES-NON-ROUTINE	0	1, 787	1, 78	7 0	1, 787	42.
2. 50 DRUGS CHARGED TO PATIENTS	0	45, 533			45, 533	
3. 00 OUTPATIENT SERVICES	0	89, 581	89, 58		89, 581	
4. 00 PALLIATIVE RADIATION THERAPY	0	0		0 0	0	1
5. 00 PALLI ATI VE CHEMOTHERAPY	0	0		0 0	0	45.
6.00 OTHER PATIENT CARE SERVICES (SPECIFY)	0	0		0 0	0	
00. 00 TOTAL *	172, 580	196, 237	368, 81	7 0	368, 817	

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

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	
		6.00	7.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS			
25.00	INPATIENT CARE-CONTRACTED			25.00
26.00	PHYSI CI AN SERVI CES	0	0	26.00
27.00	NURSE PRACTITIONER	0	0	27.00
28.00	REGI STERED NURSE	0	172, 580	28.00
29.00	LPN/LVN	0	0	29.00
30.00	PHYSI CAL THERAPY	0	0	30.00
31.00	OCCUPATI ONAL THERAPY	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	0	33.00
34.00	SPI RI TUAL COUNSELI NG	0	0	34.00
35.00	DI ETARY COUNSELI NG	0	821	35.00
36.00	COUNSELING - OTHER	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	0	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	36, 469	38.00
39.00	PATI ENT TRANSPORTATI ON	0	22, 046	39.00
40.00	I MAGI NG SERVI CES	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	1, 787	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	45, 533	42.50
43.00	OUTPATI ENT SERVICES	0	89, 581	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	46.00
100.00	TOTAL *	0	368, 817	100.00
* Tran	sfer the amount in column 7 to Wkst. 0-5, col	umn 1, line 51.		

Health Financial Systems	FRANCI SCAN HEA	LTH RENSSELAER		In Lie	u of Form CMS-	2552-10
ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS	FOR HOSPICE INPATIENT	Provider C		Peri od:	Worksheet 0-3	
RESPI TE CARE		Hospi ce CC	CN: 15-1519	From 01/01/2017 To 12/31/2017	Date/Time Pre 5/31/2018 2:4	
				Hospi ce I		
	SALARI ES	OTHER	SUBTOTAL (col	. RECLASSI FI -	SUBTOTAL	
			1 + col. 2)	CATIONS		
	1.00	2.00	3.00	4.00	5.00	
DIRECT PATIENT CARE SERVICE COST C	ENTERS	-1	1			
25.00 INPATIENT CARE-CONTRACTED		(D	0 0	0	25.00
26.00 PHYSICIAN SERVICES		0 0	D	0 0	0	26.00
27.00 NURSE PRACTITIONER		0 0	D	0 0	0	27.00
28.00 REGI STERED NURSE	1, 23	1 290	0 1,52	21 0	1, 521	28.00
29.00 LPN/LVN		0 (D	0 0	0	29.00
30. 00 PHYSI CAL THERAPY		0 0	D	0 0	0	30.00
31.00 OCCUPATIONAL THERAPY		0 0	D	0 0	0	31.00
32.00 SPEECH/LANGUAGE PATHOLOGY		0 0	D	0 0	0	32.00
33.00 MEDICAL SOCIAL SERVICES		0 0	D	0 0	0	33.00
34.00 SPIRITUAL COUNSELING		0 0	D	0 0	0	34.00
35. 00 DI ETARY COUNSELI NG		0 0	D	0 0	0	35.00
36.00 COUNSELING - OTHER		0 (D	0 0	0	36.00
37.00 HOSPICE AIDE & HOMEMAKER SERVICES		0 0	D	0 0	0	37.00
38.00 DURABLE MEDICAL EQUIPMENT/OXYGEN		0 (D	0 0	0	38.00
39.00 PATIENT TRANSPORTATION		0 0	D	0 0	0	39.00
40.00 I MAGI NG SERVI CES		0 0	D	0 0	0	40.00
41.00 LABS & DIAGNOSTICS		0 0	D	0 0	0	41.00
42.00 MEDICAL SUPPLIES-NON-ROUTINE		0 0	D	0 0	0	42.00
42.50 DRUGS CHARGED TO PATIENTS		0 0	D	0 0	0	42.50
43.00 OUTPATIENT SERVICES		0 0	D	0 0	0	43.00
44.00 PALLIATIVE RADIATION THERAPY		0 0	D	0 0	0	44.00
45.00 PALLIATIVE CHEMOTHERAPY		0 (D	0 0	0	45.00
46.00 OTHER PATIENT CARE SERVICES (SPECI		0 (D	0 0	0	46.00
100.00 TOTAL *	1,23	1 290	0 1,52	21 0	1, 521	100.00

 100.00
 TOTAL *
 1,231

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

± col. 6) ± col. 6) 01 RECT PATIENT CARE SERVICE COST CENTERS 0 7.00 25.00 INPATIENT CARE-CONTRACTED 0 0 26.00 PHYSICIAN SERVICES 0 0 27.00 NURSE PRACTITIONER 0 0 28.00 REGISTERED NURSE 0 1,521 28.00 29.00 LPN/LW 0 0 29.00 20.00 PHYSICAL THERAPY 0 0 31.00 31.00 OCCUPATIONAL THERAPY 0 0 32.00 32.00 SPECH/LANGUAGE PATHOLOGY 0 0 33.00 34.00 SPIRITUAL COUNSELING 0 0 34.00 35.00 DIETARY COUNSELING 0 0 35.00 38.00 DURSELING 0 0 37.00 38.00 DURSELING 0 0 38.00 39.00 PATIENT CARE SERVICES 0 0 38.00 39.00 DURABLE MEDICAL EQUI PMENT/OXYGEN 0 0					
DI RECT PATI ENT CARE SERVICE COST CENTERS 25.00 INPATI ENT CARE-CONTRACTED 0 0 25.00 26.00 PHYSI CI AN SERVI CES 0 0 26.00 26.00 27.00 NURSE PRACTI TI ONER 0 0 27.00 28.00 REGI STERED NURSE 0 1, 521 28.00 29.00 LPN/LWN 0 0 0 29.00 29.00 29.00 29.00 29.00 30.00 31.00 0 OCUPATI ONAL THERAPY 0 0 0 31.00 32.00 SPECH/LANGUAGE PATHOLOGY 0 0 33.00 33.00 33.00 MEDI CAL SOCI AL SERVI CES 0 0 33.00 34.00 35.00 0 35.00 35.00 35.00 36.00 37.00			ADJUSTMENTS	TOTAL (col. 5	
DI RECT PATI ENT CARE SERVICE COST CENTERS 25.00 INPATI ENT CARE-CONTRACTED 0 0 25.00 26.00 PHYSI CI AN SERVI CES 0 0 26.00 26.00 NURSE PRACTI TI ONER 0 0 27.00 27.00 NURSE PRACTI TI ONER 0 0 27.00 28.00 REGI STERED NURSE 0 1,521 28.00 29.00 LPN/LVN 0 0 0 29.00 30.00 PHYSI CAL THERAPY 0 0 30.00 29.00 31.00 OCCUPATI ONAL THERAPY 0 0 31.00 32.00 32.00 SPEECH/LANGUAGE PATHOLOGY 0 0 32.00 32.00 33.00 MEDI CAL SOCIAL SERVI CES 0 0 34.00 34.00 35.00 DI EARY COUNSELI NG 0 0 35.00 36.00 36.00 36.00 DURABLE MEDI CAL EQUI PMENT/OXYGEN 0 0 38.00 39.00 37.00 HOE & HOMEMAKER SERVI CES					
25.00 INPATIENT CARE-CONTRACTED 0 0 25.00 26.00 PHYSI CIAN SERVICES 0 0 26.00 27.00 NURSE PRACTITIONER 0 0 27.00 28.00 REGISTERED NURSE 0 1,521 28.00 29.00 LPN/LVN 0 0 29.00 30.00 PHYSICAL THERAPY 0 0 30.00 31.00 OCCUPATIONAL THERAPY 0 0 31.00 32.00 SPEECH/LANGUAGE PATHOLOGY 0 0 31.00 32.00 SPEECH/LANGUAGE PATHOLOGY 0 0 33.00 33.00 MEDICAL SOCIAL SERVICES 0 0 33.00 35.00 DI ETARY COUNSELING 0 0 34.00 36.00 COUNSELING - OTHER 0 0 37.00 38.00 DURABLE MEDICAL EQUIPMENT/OXYGEN 0 0 38.00 39.00 PATHENT TRANSPORTATION 0 0 39.00 40.00 IMAGING SERVICES<			6.00	7.00	
26.00 PHYSICIAN SERVICES 0 0 27.00 NURSE PRACTITIONER 0 0 28.00 REGISTERED NURSE 0 1,521 28.00 29.00 LPV/LVN 0 0 29.00 10.00 CCUPATIONAL THERAPY 0 0 29.00 30.00 PHYSICAL THERAPY 0 0 30.00 31.00 OCCUPATIONAL THERAPY 0 0 32.00 32.00 SPECH/LANGUAGE PATHOLOGY 0 0 33.00 33.00 MEDI CAL SOCIAL SERVICES 0 0 33.00 34.00 SPI RI TUAL COUNSELING 0 0 34.00 35.00 DI ETARY COUNSELING 0 0 35.00 36.00 DURABLE MEDI CAL EQUI PMENT/OXYGEN 0 0 36.00 37.00 HOSPI CE AI DE & HOMEMAKER SERVI CES 0 0 38.00 39.00 PATI ENT TRANSPORTATION 0 0 40.00 40.00 HAGING SERVI CES 0 0 40.00 41.00 LABS & DI AGNOSTI CS 0 0<			1		
27.00 NURSE PRACTITIONER 0 0 27.00 28.00 REGISTERED NURSE 0 1,521 28.00 29.00 LPN/LVN 0 0 29.00 30.00 PHYSICAL THERAPY 0 0 30.00 31.00 OCCUPATIONAL THERAPY 0 0 31.00 32.00 SPEECH/LANGUAGE PATHOLOGY 0 0 32.00 33.00 MEDI CAL SOCIAL SERVICES 0 0 33.00 34.00 SPI RI TUAL COUNSELING 0 0 35.00 35.00 DE TARY COUNSELING 0 0 35.00 36.00 COUNSELING - OTHER 0 0 35.00 37.00 HOSPI CE AL DE & HOMEMAKER SERVICES 0 0 37.00 38.00 DURABLE MEDI CAL EQUI PMENT/OXYGEN 0 0 38.00 39.00 PATI ENT TRANSPORTATION 0 0 39.00 40.00 IMAGI NG SERVI CES 0 0 40.00 41.00 LABS & DI AGNOSTICS 0 0 41.00 42.00 MEDI CAL SUP			0	0	
28.00 REGI STERED NURSE 0 1, 521 28.00 29.00 LPN/LVN 0 0 0 30.00 PHYSI CAL THERAPY 0 0 30.00 31.00 OCCUPATI ONAL THERAPY 0 0 31.00 32.00 SPEECH/LANGUAGE PATHOLOGY 0 0 31.00 33.00 MEDI CAL SOCI AL SERVI CES 0 0 33.00 34.00 SPI RI TUAL COUNSELI NG 0 0 34.00 35.00 DI ETARY COUNSELI NG 0 0 35.00 36.00 COUNSELI NG - OTHER 0 0 36.00 37.00 HOSPI CE AI DE & HOMEMAKER SERVI CES 0 0 37.00 38.00 DURABLE MEDI CAL EQUI PMENT/OXYGEN 0 0 38.00 39.00 PATI ENT TRANSPORTATI ON 0 0 39.00 40.00 I MAGI NG SERVI CES 0 0 40.00 41.00 LABS & DI AGNOSTI CS 0 0 41.00 42.00 MEDI CAL SUPPLI ES-NON-ROUTI NE 0 0 42.00 42.00			0	0	
29.00 LPN/LVN 0 0 29.00 30.00 PHYSI CAL THERAPY 0 0 30.00 31.00 OCCUPATI ONAL THERAPY 0 0 31.00 32.00 SPEECH/LANGUAGE PATHOLOGY 0 0 32.00 33.00 MEDI CAL SOCI AL SERVI CES 0 0 33.00 34.00 SPI RI TUAL COUNSELI NG 0 0 34.00 35.00 DI ETARY COUNSELI NG 0 0 35.00 36.00 COUNSELI NG - OTHER 0 0 36.00 37.00 HOSPI CE AI DE & HOMEMAKER SERVI CES 0 0 37.00 38.00 DURABLE MEDI CAL EQUI PMENT/OXYGEN 0 0 38.00 39.00 PATI ENT TRANSPORTATI ON 0 0 39.00 40.00 IMAGI NG SERVI CES 0 0 40.00 41.00 LABS & DI AGNOSTI CS 0 0 40.00 42.50 DRUGS CHARGED TO PATI ENTS 0 0 42.50 43.00 OUTPATI ENT SERVI CES 0 0 42.50	27.00		0	0	
30.00 PHYSI CAL THERAPY 0 0 30.00 31.00 OCCUPATI ONAL THERAPY 0 0 31.00 32.00 SPEECH/LANGUAGE PATHOLOGY 0 0 32.00 33.00 MEDI CAL SOCI AL SERVICES 0 0 33.00 34.00 SPI RI TUAL COUNSELI NG 0 0 34.00 35.00 DI ETARY COUNSELI NG 0 0 34.00 36.00 COUNSELI NG - OTHER 0 0 35.00 37.00 HOSPI CE AI DE & HOMEMAKER SERVICES 0 0 36.00 37.00 HOSPI CE AI DE & HOMEMAKER SERVICES 0 0 38.00 38.00 DURABLE MEDI CAL EQUI PMENT/0XYGEN 0 0 38.00 39.00 PATI ENT TRANSPORTATI ON 0 0 39.00 40.00 I MAGI NG SERVI CES 0 0 41.00 42.00 KEDI CAL SUPPLIES-NON-ROUTI NE 0 0 42.50 43.00 OUTPATI ENT SERVICES 0 0 42.50 43.00 OUTPATI ENT SERVICES 0 0 42.50		REGI STERED NURSE	0	1, 521	28.00
31.00 OCCUPATIONAL THERAPY 0 0 31.00 32.00 SPEECH/LANGUAGE PATHOLOGY 0 0 32.00 33.00 MEDI CAL SOCI AL SERVI CES 0 0 33.00 34.00 SPI TIVAL COUNSELI NG 0 0 34.00 35.00 DI ETARY COUNSELI NG 0 0 35.00 36.00 COUNSELI NG - OTHER 0 0 35.00 37.00 HOSPI CE AI DE & HOMEMAKER SERVI CES 0 0 36.00 38.00 DURABLE MEDI CAL EQUI PMENT/OXYGEN 0 0 38.00 39.00 PATI ENT TRANSPORTATI ON 0 0 39.00 40.00 IMAGI NG SERVI CES 0 0 40.00 41.00 LABS & DI AGNOSTI CS 0 0 41.00 42.00 MEDI CAL SUPPLI ES-NON-ROUTI NE 0 0 42.00 43.00 OUTPATI ENT SERVI CES 0 0 42.00 44.00 PALLI ATI VE RADI ATI ON THERAPY 0 0 42.00	29.00	LPN/LVN	0	0	29.00
32.00 SPEECH/LANGUAGE PATHOLOGY 0 32.00 33.00 MEDI CAL SOCI AL SERVI CES 0 0 34.00 SPI RI TUAL COUNSELI NG 0 0 35.00 DI ETARY COUNSELI NG 0 0 36.00 COUNSELI NG - OTHER 0 0 37.00 HOSPI CE AI DE & HOMEMAKER SERVI CES 0 0 38.00 DURABLE MEDI CAL EQUI PMENT/OXYGEN 0 0 39.00 PATI ENT TRANSPORTATI ON 0 0 40.00 IMAGI NG SERVI CES 0 0 41.00 LABS & DI AGNOSTI CS 0 0 42.50 DRUGS CHARGED TO PATI ENTS 0 0 43.00 OUTPATI ENT SERVI CES 0 0 44.00 PALLI ATI VE RADI ATI ON THERAPY 0 0	30.00	PHYSI CAL THERAPY	0	0	30.00
33.00 MEDI CAL SOCI AL SERVICES 0 0 33.00 34.00 SPI RI TUAL COUNSELI NG 0 0 34.00 35.00 DI ETARY COUNSELI NG 0 0 35.00 36.00 COUNSELI NG - OTHER 0 0 36.00 37.00 HOSPI CE AI DE & HOMEMAKER SERVI CES 0 0 36.00 38.00 DURABLE MEDI CAL EQUI PMENT/OXYGEN 0 0 38.00 39.00 PATI ENT TRANSPORTATI ON 0 0 39.00 40.00 IMAGI NG SERVI CES 0 0 39.00 41.00 LABS & DI AGNOSTI CS 0 0 40.00 42.00 MEDI CAL SUPPLI ES-NON-ROUTI NE 0 0 42.00 42.50 DRUGS CHARGED TO PATI ENTS 0 0 42.50 43.00 OUTPATI ENT SERVI CES 0 0 42.50 44.00 PALLI ATI VE RADI ATI ON THERAPY 0 0 44.00	31.00	OCCUPATIONAL THERAPY	0	0	31.00
34.00 SPI RI TUAL COUNSELI NG 0 0 34.00 35.00 DI ETARY COUNSELI NG 0 0 35.00 36.00 COUNSELI NG - OTHER 0 0 36.00 37.00 HOSPI CE AI DE & HOMEMAKER SERVI CES 0 0 37.00 38.00 DURABLE MEDI CAL EQUI PMENT/OXYGEN 0 0 38.00 39.00 PATI ENT TRANSPORTATI ON 0 0 39.00 40.00 IMAGI NG SERVI CES 0 0 40.00 41.00 LABS & DI AGNOSTI CS 0 0 41.00 42.00 MEDI CAL SUPPLI ES-NON-ROUTI NE 0 0 42.00 42.50 DRUGS CHARGED TO PATI ENTS 0 0 42.50 43.00 OUTPATI ENT SERVI CES 0 0 43.00 44.00 PALLI ATI VE RADI ATI ON THERAPY 0 0 44.00	32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	32.00
35.00 DI ETARY COUNSELING 0 0 35.00 36.00 COUNSELING - OTHER 0 0 36.00 37.00 HOSPICE AIDE & HOMEMAKER SERVICES 0 0 37.00 38.00 DURABLE MEDICAL EQUIPMENT/OXYGEN 0 0 38.00 39.00 PATI ENT TRANSPORTATION 0 0 39.00 40.00 IMAGING SERVICES 0 0 40.00 41.00 LABS & DI AGNOSTICS 0 0 41.00 42.00 MEDICAL SUPPLIES-NON-ROUTINE 0 0 42.00 43.00 OUTPATIENT SERVICES 0 0 42.50 43.00 PALLIATIVE RADIATION THERAPY 0 0 44.00	33.00	MEDICAL SOCIAL SERVICES	0	0	33.00
36.00 COUNSELING - OTHER 0 0 36.00 37.00 HOSPICE AIDE & HOMEMAKER SERVICES 0 0 37.00 38.00 DURABLE MEDICAL EQUIPMENT/OXYGEN 0 0 38.00 39.00 PATIENT TRANSPORTATION 0 0 39.00 40.00 IMAGING SERVICES 0 0 40.00 41.00 LABS & DI AGNOSTICS 0 0 41.00 42.00 MEDICAL SUPPLIES-NON-ROUTINE 0 0 42.00 42.50 DRUGS CHARGED TO PATIENTS 0 0 42.50 43.00 OUTPATIENT SERVICES 0 0 43.00 44.00 PALLIATIVE RADIATION THERAPY 0 0 44.00	34.00	SPI RI TUAL COUNSELI NG	0	0	34.00
37.00 HOSPICE AIDE & HOMEMAKER SERVICES 0 0 37.00 38.00 DURABLE MEDICAL EQUIPMENT/OXYGEN 0 0 38.00 39.00 PATIENT TRANSPORTATION 0 0 39.00 40.00 IMAGING SERVICES 0 0 0 41.00 LABS & DI AGNOSTICS 0 0 41.00 42.00 MEDICAL SUPPLIES-NON-ROUTINE 0 0 42.00 43.00 OUTPATIENT SERVICES 0 0 42.00 44.00 PALLIATIVE RADIATION THERAPY 0 0 44.00	35.00	DI ETARY COUNSELI NG	0	0	35.00
38.00 DURABLE MEDICAL EQUIPMENT/OXYGEN 0 0 38.00 39.00 PATIENT TRANSPORTATION 0 0 39.00 40.00 IMAGING SERVICES 0 0 40.00 41.00 LABS & DI AGNOSTICS 0 0 41.00 42.00 MEDICAL SUPPLIES-NON-ROUTINE 0 0 42.00 42.50 DRUGS CHARGED TO PATIENTS 0 0 42.50 43.00 OUTPATIENT SERVICES 0 0 43.00 44.00 PALLIATIVE RADIATION THERAPY 0 0 44.00	36.00	COUNSELING - OTHER	0	0	36.00
39. 00 PATI ENT TRANSPORTATION 0 0 39. 00 40. 00 I MAGI NG SERVI CES 0 0 40. 00 41. 00 LABS & DI AGNOSTI CS 0 0 41. 00 42. 00 MEDI CAL SUPPLI ES-NON-ROUTI NE 0 0 42. 00 42. 50 DRUGS CHARGED TO PATI ENTS 0 0 42. 50 43. 00 OUTPATI ENT SERVI CES 0 0 43. 00 44. 00 PALLI ATI VE RADI ATI ON THERAPY 0 0 44. 00	37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	0	37.00
40. 00 I MAGI NG SERVI CES 0 0 40. 00 41. 00 LABS & DI AGNOSTI CS 0 0 41. 00 42. 00 MEDI CAL SUPPLI ES-NON-ROUTI NE 0 0 42. 00 42. 50 DRUGS CHARGED TO PATI ENTS 0 0 42. 50 43. 00 OUTPATI ENT SERVI CES 0 0 43. 00 44. 00 PALLI ATI VE RADI ATI ON THERAPY 0 0 44. 00	38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	38.00
41.00 LABS & DI AGNOSTICS 0 0 41.00 42.00 MEDI CAL SUPPLI ES-NON-ROUTINE 0 0 42.00 42.50 DRUGS CHARGED TO PATIENTS 0 0 42.50 43.00 OUTPATIENT SERVICES 0 0 43.00 44.00 PALLIATIVE RADIATION THERAPY 0 0 44.00	39.00	PATI ENT TRANSPORTATI ON	0	0	39.00
42.00 MEDI CAL SUPPLI ES-NON-ROUTI NE 0 0 42.00 42.50 DRUGS CHARGED TO PATI ENTS 0 0 42.50 43.00 OUTPATI ENT SERVICES 0 0 43.00 44.00 PALLI ATI VE RADI ATI ON THERAPY 0 0 44.00	40.00	I MAGI NG SERVI CES	0	0	40.00
42. 50 DRUGS CHARGED TO PATIENTS 0 0 42. 50 43. 00 OUTPATIENT SERVICES 0 0 43. 00 44. 00 PALLIATIVE RADIATION THERAPY 0 0 44. 00	41.00	LABS & DI AGNOSTI CS	0	0	41.00
43.00 OUTPATIENT SERVICES 0 0 43.00 44.00 PALLIATIVE RADIATION THERAPY 0 0 44.00	42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	42.00
44. 00 PALLIATIVE RADIATION THERAPY 0 0 0 44. 00	42.50	DRUGS CHARGED TO PATIENTS	0	0	42.50
	43.00	OUTPATI ENT SERVICES	0	0	43.00
	44.00	PALLIATIVE RADIATION THERAPY	0	0	44.00
			0	0	45.00
46. 00 OTHER PATI ENT CARE SERVICES (SPECIFY) 0 0 46. 00			0	0	
100.00 TOTAL * 0 1.521 100.00			l o	1, 521	
* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 52.			umn 1 line 52		

Health Financial Systems	FRANCI SCAN HEALTH	RENSSELAER		In Lie	u of Form CMS-:	2552-10
ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSP	PICE GENERAL	Provider CO	CN: 15-1324	Period:	Worksheet 0-4	
INPATIENT CARE		Hospice CCM	N: 15-1519	From 01/01/2017 To 12/31/2017	Date/Time Pre	
				Hospi ce I	5/31/2018 2:4	6 am
	SALARI ES	OTHER	SUBTOTAL (co		SUBTOTAL	
	SALARIES	OTTIER	1 + col . 2		SOBIOTAL	
	1.00	2.00	3.00	4.00	5.00	
DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00 INPATIENT CARE-CONTRACTED		0		0 0	0	25.00
26. 00 PHYSI CI AN SERVI CES	0	0	1	0 0	0	26.00
27.00 NURSE PRACTITIONER	0	0		0 0	0	27.00
28.00 REGI STERED NURSE	176	41	2	17 0	217	28.00
29.00 LPN/LVN	0	0		0 0	0	29.00
30. 00 PHYSI CAL THERAPY	0	0		0 0	0	30.00
31.00 OCCUPATIONAL THERAPY	0	0		0 0	0	31.00
32.00 SPEECH/LANGUAGE PATHOLOGY	0	0		0 0	0	32.00
33.00 MEDICAL SOCIAL SERVICES	0	0		0 0	0	33.00
34.00 SPIRITUAL COUNSELING	0	0		0 0	0	34.00
35. 00 DI ETARY COUNSELI NG	0	0		0 0	0	35.00
36.00 COUNSELING - OTHER	0	0		0 0	0	36.00
37.00 HOSPICE AIDE & HOMEMAKER SERVICES	0	0		0 0	0	37.00
38.00 DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0		0 0	0	38.00
39.00 PATIENT TRANSPORTATION	0	0		0 0	0	39.00
40.00 I MAGI NG SERVI CES	0	0		0 0	0	40.00
41.00 LABS & DIAGNOSTICS	0	0		0 0	0	41.00
42.00 MEDI CAL SUPPLI ES-NON-ROUTI NE	0	0		0 0	0	42.00
42.50 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	42.50
43.00 OUTPATIENT SERVICES	0	0		0 0	0	43.00
44.00 PALLIATIVE RADIATION THERAPY	0	0		0 0	0	44.00
45.00 PALLIATIVE CHEMOTHERAPY	0	0		0 0	0	45.00
46.00 OTHER PATIENT CARE SERVICES (SPECIFY)	0	0		0 0	0	46.00
100.00 TOTAL *	176	41	2	17 0	217	100.00

 100.00
 TOTAL *
 176

 * Transfer the amount in column 7 to Wkst. 0-5, column 1, line 53.

		ADJUSTMENTS	TOTAL (col. 5		
		(00	± col. 6)		
		6.00	7.00		
	DI RECT PATIENT CARE SERVICE COST CENTERS	1	1		
25.00	INPATIENT CARE-CONTRACTED	0	0		25.00
	PHYSI CI AN SERVI CES	0	0		26.00
	NURSE PRACTITIONER	0	0		27.00
28.00	REGI STERED NURSE	0	217		28.00
29.00	LPN/LVN	0	0		29.00
30.00	PHYSI CAL THERAPY	0	0		30.00
31.00	OCCUPATIONAL THERAPY	0	0		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0		32.00
33.00	MEDICAL SOCIAL SERVICES	0	0		33.00
34.00	SPI RI TUAL COUNSELI NG	0	0		34.00
35.00	DI ETARY COUNSELI NG	0	0		35.00
36.00	COUNSELING - OTHER	0	0		36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	0		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0		38.00
39.00	PATIENT TRANSPORTATION	0	0		39.00
40.00	I MAGI NG SERVI CES	0	0		40.00
41.00	LABS & DI AGNOSTI CS	0	0		41.00
	MEDICAL SUPPLIES-NON-ROUTINE	0	0		42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0		42.50
	OUTPATI ENT SERVICES	0	0		43.00
	PALLIATIVE RADIATION THERAPY	0	0		44.00
	PALLI ATI VE CHEMOTHERAPY		0		45.00
	OTHER PATIENT CARE SERVICES (SPECIFY)		0		46.00
	TOTAL *		217		00.00
		U U U U U U U U U U U U U U U U U U U	217	۱ <u> </u>	00.00
° Iran	sfer the amount in column 7 to Wkst. 0-5, col	umn I, IIne 53.			

Heal th	Financial Systems FRANCI SCAN HEALTH	I RENSSELAER		In Lie	eu of Form CMS-2	2552-10
COST A	LLOCATION - DETERMINATION OF HOSPITAL-BASED HOSPICE NET	Provider C		Peri od:	Worksheet 0-5	
EXPENS	ES FOR ALLOCATION			From 01/01/2017		
		Hospi ce CC	N: 15-1519	To 12/31/2017	Date/Time Pre 5/31/2018 2:4	
				Hospi ce I	5/51/2016 2.4	
	Descriptions		HOSPICE DI REC		TOTAL EXPENSES	
			EXPENSES (se		(sum of cols.	
			i nstructi ons		1 + 2)	
				WKST B PART I		
				(see		
				instructions)		
			1.00	2.00	3.00	
	GENERAL SERVICE COST CENTERS					
1.00	CAP REL COSTS-BLDG & FIXT			0 8, 364	8, 364	1.00
2.00	CAP REL COSTS-MVBLE EQUIP			0 0	0	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT			0 118, 588	118, 588	3.00
4.00	ADMI NI STRATI VE & GENERAL		180, 69	5 202, 011	382, 706	4.00
5.00	PLANT OPERATION & MAINTENANCE			0 5, 257	5, 257	5.00
6.00	LAUNDRY & LINEN SERVICE			0 0	0	6.00
7.00	HOUSEKEEPING			0 0	0	7.00
8.00	DI ETARY			0 0	0	8.00
9.00	NURSI NG ADMI NI STRATI ON			0 0	0	9.00
10.00	ROUTI NE MEDI CAL SUPPLI ES			0 5, 057	5, 057	10.00
11.00	MEDI CAL RECORDS			0 0	0	11.00
12.00	STAFF TRANSPORTATION			0	0	12.00
13.00	VOLUNTEER SERVICE COORDINATION			0	0	13.00
14.00	PHARMACY			0 91, 681	91, 681	14.00
15.00	PHYSI CI AN ADMI NI STRATI VE SERVI CES			0	0	15.00
16.00	OTHER GENERAL SERVICE			0 0		16.00
17.00	PATI ENT/RESI DENTI AL CARE SERVI CES			0	0	17.00
	LEVEL OF CARE		1			
50.00	HOSPICE CONTINUOUS HOME CARE			0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE		368, 81		368, 817	51.00
52.00	HOSPICE INPATIENT RESPITE CARE		1, 52		1, 521	52.00
53.00	HOSPICE GENERAL INPATIENT CARE		21	/	217	53.00
(0.00	NONREI MBURSABLE COST CENTERS		1		0	(0.00
60.00	BEREAVEMENT PROGRAM			0	0	60.00
61.00	VOLUNTEER PROGRAM			0	0	61.00
62.00 63.00				0	0	62.00 63.00
63.00 64.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS PALLIATIVE CARE PROGRAM			0	0	63.00 64.00
65.00	OTHER PHYSICIAN SERVICES			0	0	65.00
66.00	RESIDENTIAL CARE			0	0	66.00
67.00	ADVERTI SI NG			0	0	67.00
68.00				0	0	68.00
69.00	TELEHEALTH/TELEMONI TORI NG THRI FT STORE			0	0	68.00 69.00
70.00	NURSING FACILITY ROOM & BOARD			0	0	70.00
70.00	OTHER NONREIMBURSABLE (SPECIFY)			0	0	70.00
99.00	NEGATIVE COST CENTER			0		99.00
	TOTAL		551, 25	0 430, 958	-	
	·-··-		1 001,20		, , , , , , , , , , , , , , , , , , , ,	1.20.00

	Financial Systems	FRANCI SCAN HEALT				u of Form CMS-2	
COST A	LLOCATION - HOSPITAL-BASED HOSPICE GENERAL	SERVICE COSTS	Provider CC Hospice CC		Period: From 01/01/2017 To 12/31/2017	Worksheet 0-6 Part I Date/Time Pre 5/31/2018 2:4	pared:
					Hospi ce I		
	Descriptions	TOTAL EXPENSES	CAP REL BLDG & FIX	CAP REL MVBL EQUI P		SUBTOTAL	
		0	1.00	2.00	3.00	3A	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	8, 364	8, 364				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0			0		2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	118, 588	0		0 118, 588		3.00
4.00	ADMINISTRATIVE & GENERAL	382, 706	8, 364		0 118, 588	509, 658	4.00
5.00	PLANT OPERATION & MAINTENANCE	5, 257	0		0 0	5, 257	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0		0 0	0	6.00
7.00	HOUSEKEEPING	0	0		0 0	0	7.00
8.00	DI ETARY	0	0		0 0	0	8.00
9.00	NURSI NG ADMI NI STRATI ON	0	0		0 0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	5,057	0		0 0	5,057	10.00
11.00	MEDI CAL RECORDS	0	0		0 0	0	11.00
12.00	STAFF TRANSPORTATION	0	0		0 0	0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0		0 0	0	
14.00	PHARMACY	91, 681	0		0 0	91, 681	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0		0 0	0	
	OTHER GENERAL SERVICE	0	0		0 0	0	
	PATIENT/RESIDENTIAL CARE SERVICES	-	0		0	0	17.00
	LEVEL OF CARE				0		
50.00	HOSPICE CONTINUOUS HOME CARE	0			0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	368, 817			0	368, 817	
52.00	HOSPICE INPATIENT RESPITE CARE	1, 521	0		0 0	1, 521	
53.00	HOSPICE GENERAL INPATIENT CARE	217	0		0 0	217	
00.00	NONREI MBURSABLE COST CENTERS	2.7		<u> </u>	0	2.17	00.00
60, 00	BEREAVEMENT PROGRAM	0	0		0 0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0		0 0	0	61.00
62.00	FUNDRAI SI NG	0	0		0 0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0		0 0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0		0 0	0	64.00
65.00	OTHER PHYSI CI AN SERVI CES	0	0		0 0	0	65.00
66.00	RESI DENTI AL CARE	0	0		0 0	0	66.00
67.00	ADVERTI SI NG	0	0			0	67.00
68.00	TELEHEALTH/TELEMONI TORI NG	0	0		0 0	0	68.00
69.00	THRIFT STORE	0	0			0	69.00
	NURSING FACILITY ROOM & BOARD	0	0		0	0	70.00
	OTHER NONREIMBURSABLE (SPECIFY)	0	0		0	0	71.00
<i>9</i> 9.00	NEGATIVE COST CENTER		0		0 0	0	99.00
100.00		002 200	-		-	002 200	
100.00	TUTAL	982, 208	8, 364		0 118, 588	982, 208	1100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS Provider CON: 15-1324 (hospice CON: 15-1319) Pron 01/2017 (To 12/31/2017) Prepart 0-6 (Part 1) Descriptions ADMINISTRATIVE & GENERAL SERVICE PLANT OPERATION & GENERAL SERVICE Hospice CON: 15-1324 (MINTENANCE Hospice CON: 15-1324 (MINTENANCE DIETARY Descriptions ADMINISTRATIVE & GENERAL SERVICE PLANT OPERATION & GENERAL SERVICE LIANNDRY & MINTENANCE Hospice CON: 15-1324 (MINTENANCE DIETARY 1:00 CAP REL COSTS-BUDG & FIXT CONTRACTOR 4.00 6.00 7.00 8.00 1:00 CAP REL COSTS-MUBLE EQUIP 3:00 BUNINTENANCE 5:07 10,927 0 3.00 0:00 PLANT OPERATION 4:00 BUNINTSTRATIVE 0:00 S.070 0 0 0 3.00 0:00 NUMEN ALINEN SERVICE 0 0 0 0 1.00 0:00 NUMEN ALINEN SERVICE 0 0 0 0 1.00 1:00 DEARCOSTS-MUBLE EQUIP 3:00 S.454 0 0 1.00 0:00 PLANT REL COSTS-MUBLE EQUIP 4:00 0 0	Heal th	Financial Systems	FRANCI SCAN HEAL	TH RENSSELAER			In Lie	u of Form CMS	S-2	552-10
Descriptions ADM IN STRATUR PEANT & GENERAL CAUNDRY & LAUNDRY & MAINTENANCE HOUSEKEEPING DIETARY CENERAL SERVICE COST CENTERS 4.00 5.00 7.00 8.00 1.00 CAP REL COSTS-MUBLE EQUIP 3.00 6.00 7.00 8.00 2.00 CAP REL COSTS-MUBLE EQUIP 3.00 6.00 7.00 8.00 3.00 EMPLACTS DEPARTMENT 4.00 509,658 0 0 4.00 0.00 LAUNDRY & LINEN SERVICE 5.670 10.927 0 4.00 0.00 LAUNDRY & LINEN SERVICE 5.670 0 0 6.00 7.00 0.00 LAUNDRY & LINEN SERVICE 5.670 0 0 6.00 7.00 0.00 NOTTHEW MEDICAL SUPPLIES 5.454 0 0 11.00 1.00 CAL RECORDS 0 0 12.00 12.00 1.00 STAFT TRATIVE SERVICES 0 0 12.00 12.00 1.00 STAFT TRATIVE SERVICE 0 0 10.00 10.00	COST A	ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL	SERVICE COSTS			Fr	rom 01/01/2017	Part I Date/Time Pr	rep	
Image: Constraint of the service of the ser							Hospi ce I			
GENERAL SERVICE COST CENTERS 1 1.00 CAP REL COSTS-MUBLE EQUIP 1.00 2.00 CAP REL COSTS-MUBLE EQUIP 3.00 3.00 EMPLOYEE BENEFITS DEPARTMENT 509.658 4.00 ADMINISTRATIVE & CENERAL 509.658 5.00 PLANT OPERATION & MAINTENANCE 5.670 10.927 6.00 LAURDPY & LINEN SERVICE 0 0 7.00 HOUSEKEEPING 0 0 0 9.00 NURSING ADMINISTRATION 0 0 0 0 9.00 NURSING ADMINISTRATION 0 0 0 0 0 11.00 MEDICAL RECORDS 5.454 0 0 10.00 11.00 12.00 STAFT TRANSPORTATION 0 0 0 11.00 12.00 12.00 TAFT TRANSPORTATION 0 0 0 11.00 12.00 13.00 PHYSICIAN ADMINISTRATIVE SERVICES 98.880 0 0 14.00 14.00 PHARMACY 98.880		Descriptions		OPERATION &			HOUSEKEEPI NG	DI ETARY		
1.00 CAP REL COSTS-BLOG & FLXT 1.00 2.00 CAP REL COSTS-PUBLE GUIP 1.00 3.00 EMPLOYEE BENEFITS DEPARTMENT 509,658 6.00 ADM INISTRATIVE & GENERAL 509,658 5.00 PLANT OPERATION & MAINTENANCE 5.670 6.00 LAUNDRY & LINEN SERVICE 0 0 7.00 HOUSEKEEPING 0 0 6.00 8.00 DI ETARY 0 0 0 8.00 9.00 NURSING ADMINISTRATION 0 0 0 8.00 10.00 10.00 ROUTINE MEDICAL SUPPLIES 5.454 0 0 10.00 10.00 11.00 REL COSTS-MERSENICE 0 0 0 12.00 13.00 11.00 REARMACY 98,880 0 0 12.00 13.00 11.00 PARMACY 98,880 0 0 14.00 15.00 11.00 PARMACY 98,880 0 0 0 15.00 10.00			4.00	5.00	6.00		7.00	8.00		
2.00 CAP REL COSTS-MVBLE EQUIP 2.00 3.00 EMPLOYEE BENEFITS DEPARTMENT 5.00 4.00 ADMINI STRATIVE & GENERAL 509,658 5.00 PLANT OPERATION & MAINTENNANCE 5.670 6.00 LAUNDRY & LINEN SERVICE 0 0 6.00 HOUNDRY & LINEN SERVICE 0 0 0 7.00 HOUSEKEEPING 0 0 0 7.00 9.00 NURSING ADMINI STRATION 0 0 0 0 0 9.00 NURSING ADMINI STRATION 0 0 0 0 0 0 0 11.00 MEDI CAL RECORDS 0 0 0 0 11.00 12.00 STAFF TRANSPORTATION 0 0 0 12.00 13.00 14.00 PHARMACY SERVICES 0 0 14.00 15.00 15.00 THEY RESIDERTAL CARE SERVICES 0 0 0 15.00 10.00 OULINTER SERVICE COORDINATION 0		GENERAL SERVICE COST CENTERS								
3.00 EMPLOYEE BENEFITS DEPARTMENT 3.00 4.00 ADMINISTRATIVE & GENERAL 509, 658 5.00 PLANT OPERATION & MAINTENANCE 5.07 6.00 LAUNDRY & LINEN SERVICE 0 0 6.00 LAUNDRY & LINEN SERVICE 0 0 6.00 7.00 HOUSEKEEPINS 0 0 0 8.00 9.00 NURSING ADMINISTRATION 0 0 0 8.00 9.00 RUSSING ADMINISTRATION 0 0 0 9.00 10.00 ROLICAL RECORDS 0 0 0 10.00 11.00 CAL, RECORDS 0 0 11.00 12.00 STAFF TRANSPORTATION 0 0 12.00 13.00 PHARMACY 98,880 0 0 14.00 15.00 PHARMACY 98,880 0 0 14.00 16.00 PHARMACY 98,880 0 0 14.00 15.00 HOSPICE CONTINUOUS NOME CARE 0	1.00	CAP REL COSTS-BLDG & FIXT								1.00
4.00 ADMINI STRATIVE & GENERAL 509, 658 4.00 5.00 PLANT OPERATION & MAINTENANCE 5, 670 10, 927 5.00 6.00 LAUNDRY & LINEN SERVICE 0 0 0 5.00 0.00 HOUSEKEEPING 0 0 0 0 7.00 9.00 NURSING ADMINISTRATION 0 0 0 0 9.00 10.00 ROUTINE MEDICAL SUPPLIES 5.454 0 0 10.00 11.00 MEDICAL RECORDS 0 0 0 11.00 12.00 STAFF TRANSPORTATION 0 0 0 11.00 13.00 VOLUNTEER SERVICE COORDINATION 0 0 0 11.00 14.00 PHARMACY 98, 880 0 0 11.00 11.00 15.00 THER GENERAL SERVICE 0 0 0 11.00 11.00 16.00 OTHER GENERAL SERVICE 0 0 0 0 11.00 17.00 PATIENT	2.00	CAP REL COSTS-MVBLE EQUIP								2.00
5.00 PLANT OPERATION & MAINTENANCE 5.670 10,927 5.00 6.00 LAUNDRY & LINEN SERVICE 0 0 0 7.00 HOUSEKEEPING 0 0 0 7.00 8.00 DI ETARY 0 0 0 0 8.00 9.00 NURSI NG ADMIN ISTRATION 0 0 0 9.00 11.00 MEDI CAL SUPPLIES 5.454 0 0 10.00 11.00 REICAL RECORDS 0 0 0 11.00 12.00 STAFF TRANSPORTATION 0 0 12.00 13.00 14.00 PHARMACY 98.80 0 0 14.00 15.00 PHYSI CI AN ADMIN INSTRATI VE SERVI CES 0 0 0 15.00 16.00 PHYSI CI AN ADMIN INSTRATI VE SERVI CES 0 0 0 15.00 16.00 PHYSI CI AN ADMIN INSTRATI VE SERVI CES 0 0 0 50.00 15.00 HOSPI CE COUTI NUOUS HOME CARE 377.780 <td>3.00</td> <td>EMPLOYEE BENEFITS DEPARTMENT</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>3.00</td>	3.00	EMPLOYEE BENEFITS DEPARTMENT								3.00
5.00 PLANT OPERATION & MAINTENANCE 5.670 10,927 5.00 6.00 LAUNDRY & LINEN SERVICE 0 0 0 7.00 HOUSEKEEPING 0 0 0 7.00 8.00 DI ETARY 0 0 0 0 8.00 9.00 NURSI NG ADMIN ISTRATION 0 0 0 9.00 11.00 MEDI CAL SUPPLIES 5.454 0 0 10.00 11.00 REICAL RECORDS 0 0 0 11.00 12.00 STAFF TRANSPORTATION 0 0 12.00 13.00 14.00 PHARMACY 98.80 0 0 14.00 15.00 PHYSI CI AN ADMIN INSTRATI VE SERVI CES 0 0 0 15.00 16.00 PHYSI CI AN ADMIN INSTRATI VE SERVI CES 0 0 0 15.00 16.00 PHYSI CI AN ADMIN INSTRATI VE SERVI CES 0 0 0 50.00 15.00 HOSPI CE COUTI NUOUS HOME CARE 377.780 <td>4.00</td> <td>ADMINISTRATIVE & GENERAL</td> <td>509,658</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>4.00</td>	4.00	ADMINISTRATIVE & GENERAL	509,658							4.00
6.00 LAUNDRY & LI NEN SERVICE 0 0 6.00 7.00 HOUSEKEEPI NG 0 0 0 7.00 8.00 DIETARY 0 0 0 8.00 9.00 NURSING ADMI NI STRATI ON 0 0 0 9.00 10.00 ROUTI NE MEDI CAL SUPPLIES 5.454 0 0 10.00 11.00 MEDI CAL RECORDS 0 0 0 11.00 12.00 STAFF TRANSPORTATI ON 0 0 0 11.00 13.00 VOLUNTERS ENEROL CE CORDINATI ON 0 0 13.00 14.00 14.00 PHARMACY 98,880 0 0 15.00 16.00 17.00 PATIENT/RESI DENTIAL CARE SERVICES 0 0 0 15.00 16.00 17.00 PATIENT/RESI DENTIAL CARE 397.780 51.00 52.00 52.00 51.00 PSPICE ENPATI ENT RESPITE CARE 1,640 0 0 52.00 52.00 PSPICE EN					,					
7.00 HOUSEKEEPI NG 0 0 7.00 8.00 DI ETARY 0 0 0 8.00 9.00 NURSI NG ADMINI STRATI ON 0 0 0 8.00 10.00 ROUTI NE MEDI CAL SUPPLIES 5.454 0 0 10.00 11.00 MEDI CAL RECORDS 0 0 11.00 12.00 STAFF TRANSPORTATI ON 0 0 0 11.00 12.00 TAFF TRANSPORTATI ON 0 0 13.00 14.00 14.00 PHARMACY 98.880 0 0 14.00 15.00 PHARMACY 98.880 0 0 15.00 16.00 THER GENERAL SERVICE 0 0 15.00 15.00 16.00 PATLENT/RESI DENTI AL CARE 397.780 51.00 51.00 52.00 50.00 HOSPI CE CONTI NUOUS HOME CARE 0 0 0 52.00 50.00 DSPI CE ELOPECALL TENT CESPI TE CARE 2344 <			0		1	0				
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53.00 HOSPICE GENERAL INPATIENT CARE 234 10,927 0 0 0 53.00 NONREI MBURSABLE COST CENTERS						0	0			
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61.00 VOLUNTEER PROGRAM 0 0 61.00 62.00 FUNDRAISING 0 0 0 62.00 63.00 HOSPICE/PALLIATIVE MEDICINE FELLOWS 0 0 0 63.00 64.00 PALLIATIVE CARE PROGRAM 0 0 0 64.00 65.00 OTHER PHYSICIAN SERVICES 0 0 0 65.00 66.00 RESIDENTIAL CARE 0 0 0 65.00 66.00 RESIDENTIAL CARE 0 0 0 66.00 67.00 ADVERTISING 0 0 0 66.00 67.00 68.00 TELEHEALTH/TELEMONITORING 0 0 0 68.00 69.00 69.00 THRIFT STORE 0 0 0 69.00 69.00 70.00 NURSING FACILITY ROOM & BOARD 70.00 0 0 0 71.00 71.00 OTHER NONREIMBURSABLE (SPECIFY) 0 0 0 0 99.00 99.00 NEGATIVE COST CENTER 0 0 0 0 99.00	60 00		0		1		0		_	60 00
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63.00 HOSPI CE/PALLI ATI VE MEDI CI NE FELLOWS 0 0 63.00 64.00 PALLI ATI VE CARE PROGRAM 0 0 0 64.00 65.00 OTHER PHYSI CI AN SERVI CES 0 0 0 65.00 65.00 66.00 RESI DENTI AL CARE 0 0 0 0 65.00 66.00 RESI DENTI AL CARE 0 0 0 66.00 66.00 67.00 ADVERTI SI NG 0 0 0 67.00 68.00 TELEHEALTH/TELEMONI TORI NG 0 0 68.00 69.00 69.00 THRI FT STORE 0 0 0 68.00 69.00 70.00 NURSI NG FACI LI TY ROOM & BOARD 70.00 71.00 0 0 0 0 71.00 99.00 NEGATI VE COST CENTER 0 0 0 0 99.00			0				0			
64.00 PALLI ATI VE CARE PROGRAM 0 0 64.00 65.00 OTHER PHYSI CI AN SERVI CES 0 0 0 65.00 66.00 RESI DENTI AL CARE 0 0 0 0 65.00 66.00 RESI DENTI AL CARE 0 0 0 0 66.00 67.00 ADVERTI SI NG 0 0 0 67.00 68.00 TELEHEALTH/TELEMONI TORI NG 0 0 68.00 69.00 69.00 THRI FT STORE 0 0 69.00 69.00 70.00 NURSI NG FACI LI TY ROOM & BOARD 70.00 0 0 70.00 71.00 OTHER NONREI MBURSABLE (SPECI FY) 0 0 0 0 99.00 99.00 NEGATI VE COST CENTER 0 0 0 0 99.00			0				0			
65.00 OTHER PHYSI CI AN SERVI CES 0 0 0 65.00 66.00 RESI DENTI AL CARE 0 0 0 0 66.00 67.00 ADVERTI SI NG 0 0 0 67.00 67.00 68.00 TELEHEALTH/TELEMONI TORI NG 0 0 0 68.00 69.00 69.00 THRI FT STORE 0 0 0 69.00 69.00 70.00 NURSI NG FACI LI TY ROOM & BOARD			0				0			
66.00 RESI DENTI AL CARE 0 0 0 0 66.00 67.00 ADVERTI SI NG 0 0 0 67.00 68.00 TELEHEALTH/TELEMONI TORI NG 0 0 0 68.00 69.00 THRI FT STORE 0 0 0 69.00 70.00 NURSI NG FACI LI TY ROOM & BOARD 70.00 0 0 0 70.00 71.00 OTHER NONREI MBURSABLE (SPECI FY) 0 0 0 0 0 71.00 99.00 NEGATI VE COST CENTER 0 0 0 0 0 99.00			0				0			
67.00 ADVERTISING 0 0 67.00 68.00 TELEHEALTH/TELEMONITORING 0 0 0 68.00 69.00 THRIFT STORE 0 0 0 69.00 69.00 70.00 NURSING FACILITY ROOM & BOARD 0 0 0 70.00 70.00 71.00 OTHER NONREIMBURSABLE (SPECIFY) 0 0 0 0 71.00 99.00 NEGATIVE COST CENTER 0 0 0 0 99.00			0			~	0			
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69.00 THRI FT STORE 0 0 69.00 70.00 NURSI NG FACILITY ROOM & BOARD 70.00 70.00 71.00 OTHER NONREI MBURSABLE (SPECI FY) 0 0 0 0 71.00 99.00 NEGATI VE COST CENTER 0 0 0 0 99.00			0)		0			
70.00 NURSI NG FACILITY ROOM & BOARD 70.00 71.00 OTHER NONREIMBURSABLE (SPECIFY) 0 0 0 0 71.00 99.00 NEGATI VE COST CENTER 0 0 0 0 99.00			0)		0			
71.00 OTHER NONREIMBURSABLE (SPECIFY) 0 0 0 0 71.00 99.00 NEGATI VE COST CENTER 0 0 0 0 99.00			0	Ĺ			0			
99.00 NEGATIVE COST CENTER 0 0 0 0 99.00				-			_			
			0	L C		0	0		-	
100.00/101AL 509,658 10,927 0 0 0 100.00			0	C		0	0		-	
	100.00	DI TOTAL	509, 658	10, 927	1	0	0		0	100.00

	Financial Systems LLOCATION - HOSPITAL-BASED HOSPICE GENERAL	FRANCI SCAN HEALT	Provider C	°N+ 15 1224	Period:	u of Form CMS- Worksheet 0-6	
CUST F	LLUCATION - HUSPITAL-DASED HUSPICE GENERAL	_ SERVICE CUSIS	Provider Co	UN. 10-1524	From 01/01/2017	Part I	
			Hospi ce CCI	N: 15-1519	To 12/31/2017	Date/Time Pre	pared:
					Hospi ce I	5/31/2018 2:4	6 am
	Descriptions	NURSI NG	ROUTI NE	MEDI CAL	STAFF	VOLUNTEER	
		ADMI NI STRATI ON	MEDICAL	RECORDS	TRANSPORTATI ON		
			SUPPLI ES			COORDI NATI ON	
		9.00	10.00	11.00	12.00	13.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.0
2.00	CAP REL COSTS-MVBLE EQUIP						2.0
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.0
4.00	ADMI NI STRATI VE & GENERAL						4.0
5.00	PLANT OPERATION & MAINTENANCE						5.0
6.00	LAUNDRY & LINEN SERVICE						6.0
7.00	HOUSEKEEPING						7.0
8.00	DI ETARY						8.0
9.00	NURSI NG ADMI NI STRATI ON	0					9.0
10. 00	ROUTI NE MEDI CAL SUPPLI ES	0	10, 511				10.0
11.00	MEDI CAL RECORDS	0			0		11.0
	STAFF TRANSPORTATION	0			0		12.0
13.00	VOLUNTEER SERVICE COORDINATION	0			0	0	
14.00	PHARMACY	0			0	0	1
	PHYSI CI AN ADMI NI STRATI VE SERVI CES	0			0	0	
	OTHER GENERAL SERVICE	0			0	0	
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17. C
50.00	LEVEL OF CARE HOSPICE CONTINUOUS HOME CARE	0	0		0 0	0	1 50 0
	HOSPICE CONTINUOUS HOME CARE	0	10, 311		0 0 0 0	0	
	HOSPICE ROUTINE HOME CARE	0	39		0 0	0	
	HOSPICE GENERAL INPATIENT CARE	0	161		0 0		
0.00	NONREI MBURSABLE COST CENTERS		101	1	0 0	0	00.0
0.00	BEREAVEMENT PROGRAM	0			0	0	60.0
51.00	VOLUNTEER PROGRAM	0			0	0	
	FUNDRAI SI NG	0			0	0	62.0
3.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0			0	0	63.0
	PALLIATIVE CARE PROGRAM	0			0	0	64.0
5.00	OTHER PHYSICIAN SERVICES	0			0	0	65.0
6. 00	RESI DENTI AL CARE	0			0	0	66.0
	ADVERTI SI NG	0			0	0	67.0
	TELEHEALTH/TELEMONI TORI NG	0			0	0	68.0
9.00	THRI FT STORE	0			0	0	69. (
0. 00	NURSING FACILITY ROOM & BOARD						70. (
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0			0	0	71. (
? 9. 00	NEGATI VE COST CENTER	0	0		0 0	0	99.0
100.00	TOTAL	o	10, 511		0 0	0	100.0

COST A	Financial Systems NLLOCATION - HOSPITAL-BASED HOSPICE GENERAL S	SERVICE COSTS	Provider C		Period: From 01/01/2017 To 12/31/2017	Worksheet 0-6 Part I Date/Time Pre 5/31/2018 2:4	epared:
	Descriptions	PHARMACY	PHYSI CI AN ADMI NI STRATI VE SERVI CES	OTHER GENERA SERVI CE	Hospi ce I AL PATI ENT/ RESI DENTI AL CARE SERVI CES	TOTAL	
		14.00	15.00	16.00	17.00	18.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMI NI STRATI VE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DI ETARY						8.00
9.00	NURSI NG ADMI NI STRATI ON						9.00
10.00	ROUTI NE MEDI CAL SUPPLI ES						10.00
11.00	MEDI CAL RECORDS						11.00
12.00	STAFF TRANSPORTATION						12.00
13.00	VOLUNTEER SERVICE COORDINATION						13.00
14.00	PHARMACY	190, 561	_				14.00
15.00	PHYSI CI AN ADMI NI STRATI VE SERVI CES	0	0				15.00
16.00	OTHER GENERAL SERVICE	0			0		16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES				0		17.00
50.00	LEVEL OF CARE HOSPICE CONTINUOUS HOME CARE	0	0		0	0	50.00
50.00	HOSPICE CONTINUOUS HOME CARE	186, 836	0		0	963, 744	
52.00	HOSPICE INPATIENT RESPITE CARE	734	0		0 0	3, 934	
53.00	HOSPICE GENERAL INPATIENT CARE	2, 991	0		0 0	14, 530	
55.00	NONREI MBURSABLE COST CENTERS	2,771	0	1	0 0	14, 550	33.00
60.00	BEREAVEMENT PROGRAM	0			0	0	60.00
61.00	VOLUNTEER PROGRAM	0			0	0	
62.00	FUNDRALSING	0			0	0	
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0			0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0			0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0			0	0	65.00
66.00	RESI DENTI AL CARE	0	0		0 0	0	66.00
67.00	ADVERTI SI NG	0			0	0	67.00
68.00	TELEHEALTH/TELEMONI TORI NG	0			0	0	68.00
69.00	THRI FT STORE	0			0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD					0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0		0 0	0	71.00
99.00	NEGATI VE COST CENTER	0	0		0 0	0	99.00
100 00	TOTAL	190, 561	0		0 0	982, 208	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS Provider CCN: 15.132.1 Provider CCN: 15.132.0 Part II For 01/07/2017 Worksheet 0-6 For 01/07/2017 STATISTICAL BASIS Cost Center Descriptions CAP PEL BLDG & CAP REL MVBLE FLX EAP PEL BLDG & CAP REL MVBLE EQUIP EVENTS (GROSS SALARES) Worksheet 0-6 Part II Descriptions Cost Center Descriptions CAP PEL BLDG & CAP REL MVBLE FLX CAP REL MVBLE EQUIP EVENTS (GROSS SALARES) ECONCILIATION/MON INSTRATIVE (COULAR VALUE) CONCILIATION (CROSS SALARES) CONCILIATION (CROSS SALARES) 0	Heal th	Financial Systems	FRANCI SCAN HEALTH	H RENSSELAER		In Lie	u of Form CMS-:	2552-10
Despice CCR: 15-1519 To 12/31/2017 Date/Time Prepared: 5/31/2017 Cost Center Descriptions CAP REL BLDG & CAP REL MUBLE FLX (SUMRE FEET) EMPLOYE (DULKR VALUE) EMPLOYE EVENT EMPLOYE (COSTS) KCONCLILATION/ADMINISTRATIVE (ACCOMPLICATION/ADMINISTRATIVE SALARIES) KCONCLILATION/ADMINISTRATIVE (ACCOMPLICATION/ADMINISTRATIVE (ACCOMPLICATION/ADMINISTRATIVE SALARIES) KCONCLILATION/ADMINISTRATIVE (ACCOMPLICATIVE (ACCOMPLICATIVE (ACCOMPLICATIVE (ACCOMPLICATIVE (ACCOMPLICATIVE (ACCOMPLICATIVE (ACCOMPLICATIVE (ACCOMPLICATIVE (ACCOMPLICATIVE (ACCOMPLICATIVE (ACCOMPLICATION/ADMINISTRATIVE (ACCOMPLICATIVE (ACCOMPLICATIVE (ACCOMPLICA	COST A	LLOCATION - HOSPITAL-BASED HOSPICE GENERAL	SERVICE COSTS	Provider CC				
Cost Center Descriptions CAP REL BLDG & CAP REL MUBLE FIX (SOUARE FEET) EMPLOYEE (DOLLAR VALUE) EMPLOYEE BENEFITS DEPARTMENT (GROSS Hospicol & GENERAL SCOULAR VALUE) 0 CAP REL OSTS-BLDC & FIXT 2.00 1.00 2.00 3.00 4A 4.00 1.00 2.00 3.00 4A 4.00 0.00 0.00 4A 4.00 1.00 2.00 3.00 4A 4.00 0.00 0.00 4A 4.00 1.00 2.00 3.00 4A 4.00 0.00 2.00 3.00 4A 4.00 1.00 2.00 0.00 1.00 2.00 0.00 4A 4.00 0.00 <td< td=""><td>STATI S</td><td>TI CAL BASI S</td><td></td><td></td><td></td><td></td><td></td><td></td></td<>	STATI S	TI CAL BASI S						
Cost Center Descriptions CAP REL BLDG (S CAP REL MURE) FLX (SUUARE FEET) EMPLOYE (SUUAR VALUE) EMPLOYE (BEONS (S) SALARIES) EMPLOYE (ACCUMULATED (CACCIMULATED) (COSTS) 1.00 2.00 3.00 4A 4.00 1.00 2.00 0 0 0 0 2.00 3.00 MAINTERLIVE & COSTS-MURE TO EPARIMENT 0 </td <td></td> <td></td> <td></td> <td>Hospi ce cui</td> <td>1: 15-1519</td> <td>10 12/31/2017</td> <td></td> <td></td>				Hospi ce cui	1: 15-1519	10 12/31/2017		
Cost Center Descriptions CAP RLL BLDG & CAP RLL MVELE FLX CAP RLL MVELE (SOUARE FEET) REMCUYE I (ODLLAR VALUE) REMCUYE I BENETIS RECONCILIATION & OLIFICAL (ACCUMULATED COSTS) 0 CAP REL COSTS-BLDG & FIXT 2.00 3.00 4A 4.00 1.00 CAP REL COSTS-MUSE EQUIP 2.00 3.00 4A 4.00 2.00 CAP REL COSTS-MUSE EQUIP 0 3.00 4A 4.00 2.00 CAP REL COSTS-MUSE EQUIP 0 3.00 4A 4.00 0.00 CAP REL COSTS-MUSE EQUIP 0 3.00 3.00 4A 4.00 0.00 LAINDRY & LINEN SERVICE 0 0 3.00 5.257 5.00 0.00 LAINDRY & LINEN SERVICE 0 0 0 0 0.00 0.00 LAINDRY & LINEN SERVICE 0 0 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 <td></td> <td></td> <td></td> <td></td> <td></td> <td>Hospi ce I</td> <td>3/31/2010 2.4</td> <td></td>						Hospi ce I	3/31/2010 2.4	
FIX (SOUARE FEET) EDU P (DOLLAR VALUE) DEPARTMENT (CROSS SALARIES) & GENERAL (CROSS) 1.00 2.00 3.00 4A 4.00 0.00 CAP REL COSTS-MUDG & FIXT 249 0 3.00 4A 4.00 0.00 CAP REL COSTS-MUDG & FIXT 249 0 3.00 4A 4.00 3.00 DEMACINE E COULP 0 3.00 4A 4.00 3.00 3.00 DEMACINE E COULP 0 3.00 4A 4.00 3.00 3.00 DEMACINE E COULP 0 3.00 4A 4.00 3.00 3.00 DEMACINE E COULP 0 3.00 4A 4.00 3.00 4.00 AMIN INSTRATIVE & GENERAL 249 0 320.248 -509.658 472.557 5.00 0.00 DEMARY & LINEN SCHUCE 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 </td <td></td> <td>Cost Center Descriptions</td> <td>CAP REL BLDG & C</td> <td>AP REL MVBLE</td> <td>EMPLOYEE</td> <td></td> <td>ADMI NI STRATI VE</td> <td></td>		Cost Center Descriptions	CAP REL BLDG & C	AP REL MVBLE	EMPLOYEE		ADMI NI STRATI VE	
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GENERAL SERVICE COST CENTERS 1					SALARI ES)			
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4.00 ADMINISTRATIVE & GENERAL 249 0 320,248 -509,658 472,550 4.00 5.00 LAUNDRY & LINEN SERVICE 0 0 0 5.00 6.00 LAUNDRY & LINEN SERVICE 0 0 0 6.00 7.00 HOUSEKEPING 0 <td>2.00</td> <td>CAP REL COSTS-MVBLE EQUIP</td> <td></td> <td>0</td> <td></td> <td></td> <td></td> <td>2.00</td>	2.00	CAP REL COSTS-MVBLE EQUIP		0				2.00
5.00 PLANT OPERATION & MAINTENANCE 0 0 0 5.257 5.00 6.00 LAUNDRY & LINEN SERVICE 0 </td <td>3.00</td> <td>EMPLOYEE BENEFITS DEPARTMENT</td> <td>0</td> <td>0</td> <td>320, 24</td> <td>8</td> <td></td> <td>3.00</td>	3.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	320, 24	8		3.00
6.00 LAUNDRY & LINEN SERVICE 0 </td <td>4.00</td> <td>ADMI NI STRATI VE & GENERAL</td> <td>249</td> <td>0</td> <td>320, 24</td> <td>8 -509, 658</td> <td>472, 550</td> <td>4.00</td>	4.00	ADMI NI STRATI VE & GENERAL	249	0	320, 24	8 -509, 658	472, 550	4.00
7.00 HOUSEKEEPING 0 0 0 0 7.00 8.00 DIETARY 0 0 0 0 0 0 8.00 9.00 NURSING ADMINISTRATION 0 0 0 0 0 9.00 10.00 ROUTINE MEDICAL SUPPLIES 0 0 0 0 0 0 11.00 12.00 STAFF TRANSPORTATION 0 0 0 0 11.00 13.00 VOLUNTEER SERVICE COORDINATION 0 0 0 0 13.00 14.00 PHARMACY 0 0 0 0 0 13.00 15.00 PHYSI CI AN ADMINI STRATI VE SERVICES 0 0 0 0 16.00 16.00 PATIE MT/RESIDENTIAL CARE SERVICES 0 0 0 0 17.00 LEVEL OF CARE 0 0 0 0 0 0 15.00 51.00 HOSPI CE COUTI NUOUS HOME CARE 0 0	5.00	PLANT OPERATION & MAINTENANCE	0	0		0 0	5, 257	5.00
8.00 DIETARY 0	6.00	LAUNDRY & LINEN SERVICE	0	0		0 0	0	6.00
9.00 NURSI NG ADMI NI STRATION 0	7.00	HOUSEKEEPING	0	0		0 0	0	7.00
10.00 ROUTI NE MEDI CAL SUPPLIES 0 <th< td=""><td>8.00</td><td>DI ETARY</td><td>0</td><td>0</td><td></td><td>0 0</td><td>0</td><td>8.00</td></th<>	8.00	DI ETARY	0	0		0 0	0	8.00
11.00 MEDI CAL RECORDS 0 0 0 0 11.00 12.00 STAFF TRANSPORTATION 0 0 0 0 0 0 11.00 13.00 VOLUNTEER SERVICE CORDINATION 0 0 0 0 0 13.00 14.00 PHARMACY 0 0 0 0 0 14.00 15.00 PHARMACY 0 0 0 0 0 14.00 15.00 PHARMACY 0 0 0 0 0 15.00 16.00 OTHER GENERAL SERVICES 0 0 0 0 16.00 17.00 PATI ENT/RESI DENTI AL CARE SERVICES 0 0 0 15.00 16.00 HOSPICE CONTI NUOUS HOME CARE 0 0 0 50.00 51.00 HOSPICE ROUTI NE HOME CARE 0 0 0 15.20 52.00 HOSPICE ROUTI NE HOME CARE 0 0 0 15.02 53.00 <td>9.00</td> <td>NURSING ADMINISTRATION</td> <td>0</td> <td>0</td> <td></td> <td>0 0</td> <td>0</td> <td>9.00</td>	9.00	NURSING ADMINISTRATION	0	0		0 0	0	9.00
12.00 STAFF TRANSPORTATION 0 0 0 12.00 13.00 VOLUNTEER SERVICE COORDINATION 0 0 0 0 13.00 14.00 PHARMACY 0 0 0 0 13.00 15.00 PHYSICIAN ADMINISTRATIVE SERVICES 0 0 0 15.00 16.00 OTHER GENERAL SERVICE 0 0 0 16.00 17.00 PATIENT/RESIDENTIAL CARE SERVICES 0 0 0 17.00 17.00 PATIENT/RESIDENTIAL CARE SERVICES 0 0 0 17.00 10.01 HOSPICE CONTINUOUS HOME CARE 0 0 0 0 0 51.00 HOSPICE CONTINUOUS HOME CARE 0 0 0 15.00 0 0 15.00 52.00 HOSPICE CENAL INPATIENT CARE 0 0 0 0 21.7 53.00 MONREI MBURSABLE COST CENTERS 0 0 0 0 61.00 64.00 60.00 ERERAVENENT PROGRAM 0 0 0 0 64.00 64.00	10.00	ROUTINE MEDICAL SUPPLIES	0	0		0 0	5, 057	10.00
13.00 VOLUNTEER SERVICE COORDINATION 0 0 0 0 13.00 14.00 PHARMACY 0 0 0 91,681 14.00 15.00 PHYSICIAN ADMINISTRATIVE SERVICES 0 0 0 0 0 15.00 16.00 OTHER GENERAL SERVICE 0 0 0 0 16.00 17.00 PATIENT/RESIDENTIAL CARE SERVICES 0 0 0 0 16.00 17.00 PATIENT/RESIDENTIAL CARE SERVICES 0 0 0 0 17.00 50.00 HOSPICE CONTINUOUS HOME CARE 0 0 0 50.00 51.00 HOSPICE ROUTINE HOME CARE 0 0 0 17.00 52.00 HOSPICE GENERAL INPATIENT CARE 0 0 0 17.50 60.00 BEREAVEMENT PROGRAM 0 0 0 17.53.00 70 MONRELIMBURSABLE COST CENTERS 0 0 0 61.00 61.00 VOLUNTEER PROGRAM <t< td=""><td>11.00</td><td>MEDI CAL RECORDS</td><td>0</td><td>0</td><td></td><td>0 0</td><td>0</td><td>11.00</td></t<>	11.00	MEDI CAL RECORDS	0	0		0 0	0	11.00
14.00 PHARMACY 0 0 0 91,681 14.00 15.00 PHYSI CLAN ADMI NI STRATI VE SERVI CES 0 0 0 0 15.00 16.00 OTHER GENERAL SERVI CE 0 0 0 0 0 16.00 17.00 PATI ENT/RESIDENTI AL CARE SERVI CES 0 0 0 0 17.00 LEVEL OF CARE 0 0 0 0 0 50.00 HOSPI CE CONTI NUOUS HOME CARE 0 0 0 50.00 17.00 52.00 HOSPI CE CONTI NUOUS HOME CARE 0 0 0 368,817 51.00 52.00 HOSPI CE CONTINUT REPRIAL INPATI ENT CARE 0 0 0 22.17 52.00 NONREL MBURSABLE COST CENTERS 0 0 0 0 21.7 53.00 HOSPI CE CRUAL INATI ENT CARE 0 0 0 0 60.00 64.00 60.00 BERAVEMENT PROGRAM 0 0 0 0 64.00 65.00 61.00 VUINTER PROGRAM 0 0 0 0	12.00	STAFF TRANSPORTATION	0	0		0 0	0	12.00
15.00 PHYSICIAN ADMINISTRATIVE SERVICES 0	13.00	VOLUNTEER SERVICE COORDINATION	0	0		0 0	0	13.00
16.00 OTHER GENERAL SERVICE 0 0 0 0 0 16.00 17.00 PATIENT/RESIDENTIAL CARE SERVICES 0	14.00	PHARMACY	0	0		0 0	91, 681	14.00
17.00 PATI ENT/RESI DENTI AL CARE SERVI CES 0 0 0 0 17.00 LEVEL OF CARE	15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0		0 0	0	15.00
LEVEL OF CARE 0 <	16.00	OTHER GENERAL SERVICE	0	0		0 0	0	16.00
50.00 HOSPICE CONTINUOUS HOME CARE 0 0 0 0 0 0 368,817 51.00 51.00 HOSPICE ROUTINE HOME CARE 0 0 0 368,817 51.00 52.00 HOSPICE INPATIENT RESPITE CARE 0 0 0 1,521 0 53.00 HOSPICE GENERAL INPATIENT CARE 0 0 0 217 53.00 NONREI MBURSABLE COST CENTERS 0 0 0 0 0 60.00 60.00 BEREAVEMENT PROGRAM 0 0 0 0 61.00 62.00 FUNDRAI SING 0 0 0 0 62.00 63.00 HOSPI CE PALLIATIVE MEDI CINE FELLOWS 0 0 0 63.00 64.00 PALLI ATI VE CARE PROGRAM 0 0 0 64.00 65.00 OTHER PHYSICIAN SERVICES 0 0 0 65.00 66.00 RESI DENTI AL CARE 0 0 0 66.00 67.00 ADVERTI SING 0 0 0 66.00 68.00	17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0		0	0	17.00
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53.00 HOSPICE GENERAL INPATIENT CARE 0 0 217 53.00 NORREL MBURSABLE COST CENTERS NORREL MBURSABLE COST CENTERS 60.00 BEREAVEMENT PROGRAM 0 0 0 0 60.00 61.00 VOLUNTEER PROGRAM 0 0 0 0 61.00 62.00 FUNDRAI SI NG 0 0 0 0 62.00 63.00 HOSPICE/PALLI ATI VE MEDICINE FELLOWS 0 0 0 63.00 64.00 64.00 64.00 65.00 64.00 65.00 65.00 65.00 65.00 65.00 66.00 65.00 66.00 65.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 67.00 0 0 0 66.00 67.00 68.00 69.00 70.00 68.00 69.00 70.00 68.00 69.00 70.00 70.00 70.00 70.00 70.00 70.00	51.00						368, 817	51.00
NONREI MBURSABLE COST CENTERS 60.00 BERAVEMENT PROGRAM 0 <t< td=""><td>52.00</td><td>HOSPICE INPATIENT RESPITE CARE</td><td></td><td></td><td></td><td></td><td>1, 521</td><td>52.00</td></t<>	52.00	HOSPICE INPATIENT RESPITE CARE					1, 521	52.00
60.00 BEREAVEMENT PROGRAM 0 <td>53.00</td> <td></td> <td>0</td> <td>0</td> <td></td> <td>0 0</td> <td>217</td> <td>53.00</td>	53.00		0	0		0 0	217	53.00
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69.00 THRIFT STORE 0 0 0 69.00 70.00 NURSING FACILITY ROOM & BOARD 0 0 70.00 71.00 OTHER NONREIMBURSABLE (SPECIFY) 0 0 0 71.00 99.00 NEGATIVE COST CENTER 0 118,588 509,658 100.00			0	0		0 0	-	
70. 00 NURSING FACILITY ROOM & BOARD 0 70. 00			0	0		<u> </u>		
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100.00 COST TO BE ALLOCATED (per Wkst. 0-6, Part I) 8,364 0 118,588 509,658 100.00			0	0		0	0	
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	101.00	UNIT COST MULTIPLIER	33. 390301	0. 000000	0. 37030	''I I	1.076527	101.00

Heal th	Financial Systems	FRANCI SCAN HEAL	TH RENSSELAER			u of Form CMS-2	2552-10
	LLOCATION - HOSPITAL-BASED HOSPICE GENERAL SE TICAL BASIS	ERVICE COSTS	Provider Co Hospice CC		Period: From 01/01/2017 To 12/31/2017	Date/Time Pre	pared:
					llooni oo l	5/31/2018 2:4	<u>6 am</u>
	Cost Center Descriptions	PLANT	LAUNDRY &	HOUSEKEEPIN	Hospice I G DIETARY	NURSI NG	
	cost center bescriptions	OPERATION &				ADMI NI STRATI ON	
		MAINTENANCE	LINEN SERVICE	SQUARE FEET			
			(IN-FACILITY DAYS)		DAYS)	(DI RECT NURS.	
		(SQUARE FEET)	DATS)				
		5.00	6.00	7.00	8.00	HRS.) 9. 00	
	GENERAL SERVICE COST CENTERS	5.00	0.00	7.00	0.00	7.00	
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMI NI STRATI VE & GENERAL						4.00
4.00 5.00	PLANT OPERATION & MAINTENANCE	249					5.00
			0				
6.00	LAUNDRY & LINEN SERVICE	0	0		0		6.00
7.00	HOUSEKEEPING	0			0		7.00
8.00	DI ETARY	0			0 0		8.00
9.00	NURSING ADMINISTRATION	0			0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0			0	0	10.00
11.00	MEDI CAL RECORDS	0			0	0	11.00
12.00	STAFF TRANSPORTATION	0			0	0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0			0	0	13.00
14.00	PHARMACY	0			0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0			0	0	15.00
16.00	OTHER GENERAL SERVICE	0			0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0			0		17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE					0	50.00
51.00	HOSPICE ROUTINE HOME CARE					0	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0		0 0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	249	0		0 0	0	53.00
	NONREIMBURSABLE COST CENTERS	·					
60.00	BEREAVEMENT PROGRAM	0			0	0	60.00
61.00	VOLUNTEER PROGRAM	0			0	0	61.00
62.00	FUNDRAI SI NG	0			0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0			0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0			0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0			0	0	65.00
66.00	RESI DENTI AL CARE	0	0		0 0	-	66.00
67.00	ADVERTI SI NG	0	0		0	0	67.00
68.00	TELEHEALTH/TELEMONI TORI NG	0			0	0	68.00
69.00	THRI FT STORE	0			0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0			5		70.00
	OTHER NONREIMBURSABLE (SPECIFY)	0	0		0	0	
71.00		0	0		0	0	71.00
	NEGATIVE COST CENTER	10.007	_				99.00
	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)		0. 000000	0.0000			100.00
101.00	UNIT COST MULTIPLIER	43.883534	0.00000	0.0000	0. 000000	0.000000	101.00

Heal th	Financial Systems	FRANCI SCAN HEALT	H RENSSELAER		In Lie	eu of Form CMS-	2552-10
	ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SE STICAL BASIS	RVICE COSTS	Provider C Hospice CC		Period: From 01/01/2017 To 12/31/2017		pared:
					Hospi ce I		
	Cost Center Descriptions	ROUTI NE MEDI CAL SUPPLI ES (PATI ENT DAYS)	MEDI CAL RECORDS PATI ENT DAYS)	STAFF TRANSPORTATI (MI LEAGE)	VOLUNTEER ON SERVI CE COORDI NATI ON (HOURS OF SERVI CE)	PHARMACY (CHARGES)	
		10.00	11.00	12.00	13.00	14.00	
	GENERAL SERVICE COST CENTERS	10.00	11.00	12.00	13.00	14.00	
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ \end{array}$	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL PLANT OPERATION & MAINTENANCE LAUNDRY & LINEN SERVICE HOUSEKEEPING DI ETARY NURSING ADMINISTRATION ROUTINE MEDICAL SUPPLIES MEDICAL RECORDS STAFF TRANSPORTATION VOLUNTEER SERVICE COORDINATION PHARMACY PHYSICIAN ADMINISTRATIVE SERVICES OTHER GENERAL SERVICE PATIENT/RESIDENTIAL CARE SERVICES	3, 468	0		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0	15.00
50.00	LEVEL OF CARE HOSPICE CONTINUOUS HOME CARE	0	0		0 0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	3, 402	0		0 0		
52.00	HOSPICE INPATIENT RESPITE CARE	13	0		0 0	188	52.00
53.00	HOSPICE GENERAL INPATIENT CARE NONREIMBURSABLE COST CENTERS	53	0	1	0 0	766	53.00
100.0		10, 511 3. 030854	0.000000	0. 0000	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	61.00 62.00 63.00 64.00 65.00 66.00 67.00 68.00 69.00 70.00 71.00 99.00 100.00

Heal th Financial Systems FRANCISCAN HEALTH COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS			Provider C	CN: 15-1324	Peri od:	Worksheet 0-6	
STATI STI CAL BASI S			Hospi ce CC	N: 15-1519	From 01/01/2017 To 12/31/2017	Part II Date/Time Pr 5/31/2018 2:	
					Hospi ce I		
	Cost Center Descriptions		OTHER GENERAL	PATI ENT/			
		ADMI NI STRATI VE		RESI DENTI AL			
		SERVICES	(SPECI FY	CARE SERVICE			
		(PATIENT DAYS)	BASI S)	(IN-FACILIT	Y		
		15.00	16.00	DAYS) 17.00			
	GENERAL SERVICE COST CENTERS	15.00	10.00	17.00			
1.00	CAP REL COSTS-BLDG & FIXT			1			1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMI NI STRATI VE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
5.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
B. 00	DI ETARY						8.00
9.00	NURSI NG ADMI NI STRATI ON						9.00
10.00	ROUTINE MEDICAL SUPPLIES						10.00
11.00	MEDI CAL RECORDS						11.00
12.00	STAFF TRANSPORTATION						12.00
13.00	VOLUNTEER SERVICE COORDINATION						13.00
14.00	PHARMACY						14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0					15.00
16.00	OTHER GENERAL SERVICE		0				16.00
17.00	PATI ENT/RESI DENTI AL CARE SERVI CES				0		17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0)			50.00
51.00	HOSPICE ROUTINE HOME CARE	0	0				51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0)	0		52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0		0		53.00
	NONREI MBURSABLE COST CENTERS	-1					
60.00	BEREAVEMENT PROGRAM		0				60.00
61.00	VOLUNTEER PROGRAM		0				61.00
62.00	FUNDRAI SI NG		0				62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS		0				63.00
64.00	PALLIATIVE CARE PROGRAM		0				64.00
65.00	OTHER PHYSI CI AN SERVI CES	_	0	1			65.00
66.00	RESIDENTIAL CARE	0	0		0		66.00
67.00	ADVERTI SI NG						67.00
68.00	TELEHEALTH/TELEMONI TORI NG						68.00
69.00	THRIFT STORE		0				69.00
70.00	NURSING FACILITY ROOM & BOARD				0		70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0		0		71.00
99.00 100.00	NEGATIVE COST CENTER				0		99.00
	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)			0,0000	0		100.00
111111	UNIT COST MULTIPLIER	0. 000000	0. 000000	0.0000	00		101.0

Health Financial Systems	FRANCI SCAN HEALTH	RENSSELAER		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF HOSPITAL-BASED HOSPICE SHARED	SERVICE COSTS BY	Provider C	CN: 15-1324	Peri od:	Worksheet 0-7	
LEVEL OF CARE		Hospi ce CC	N: 15-1519	From 01/01/2017 To 12/31/2017		
				Hospi ce I	575172010 2.4	
			Charges by	LOC (from Provi	der Records)	
Cost Center Descriptions	From Wkst. C, Co	st to Charge	НСНС	HRHC	HI RC	
	Part I, Col. 9	Ratio				
	line					
	0	1.00	2.00	3.00	4.00	
ANCI LLARY SERVICE COST CENTERS			1			
1. 00 PHYSI CAL THERAPY	66.00	0.859661		0 0	, v	1.00
1. 01 WHEATFIELD PT	66.01	0. 954943		0 0	0	1.01
2. 00 OCCUPATI ONAL THERAPY	67.00	1. 020948		0 0	0	2.00
2.01 WHEATFI ELD OT	67.01	2.055504		0 0	0	2.01
3.00 SPEECH PATHOLOGY	68.00	1. 515224		0 0	0	3.00
3. 01 WHEATFI ELD ST	68.01	2. 022932		0 0	0	3. 01
4.00 DRUGS CHARGED TO PATIENTS	73.00	0. 195283		0 0	0	4.00
5.00 DURABLE MEDICAL EQUIP-RENTED	96.00					5.00
6.00 LABORATORY	60.00	0. 318943		0 0	0	6.00
7.00 MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0. 143667		0 0	0	7.00
8.00 OTHER OUTPATIENT SERVICE COST CENTER	93.00					8.00
9. 00 RADI OLOGY-THERAPEUTI C	55.00					9.00
10.00 OTHER ANCILLARY SERVICE COST CENTERS	76.00					10.00
11.00 Totals (sum of lines 1-11)						11.00
	Charges by LOC		Shared Serv	ice Costs by LOC		
	(from Provider					
	Records)					
Cost Center Descriptions	HGI P HC			xHIRC (col. 1 x		
		col. 2)	col. 3)	col. 4)	col. 5)	
	5.00	6.00	7.00	8.00	9.00	
ANCI LLARY SERVI CE COST CENTERS						
1.00 PHYSI CAL THERAPY	0	0		0 0	, v	
1.01 WHEATFIELD PT	0	0		0 0	0	1.01
2.00 OCCUPATIONAL THERAPY	0	0		0 0	0	2.00
2.01 WHEATFIELD OT	0	0		0 0	0	2.01
3.00 SPEECH PATHOLOGY	0	0		0 0	0	3.00
3. 01 WHEATFI ELD ST	0	0		0 0	0	3. 01
4.00 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	4.00
5. 00 DURABLE MEDICAL EQUIP-RENTED						5.00
6. 00 LABORATORY	0	0		0 0	0	6.00
7.00 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 0	0	7.00
8.00 OTHER OUTPATIENT SERVICE COST CENTER						8.00
9. 00 RADI OLOGY-THERAPEUTI C						9.00
10.00 OTHER ANCILLARY SERVICE COST CENTERS						10.00
11.00 Totals (sum of lines 1-11)		0)	0 0	0	11.00

	Financial Systems FRANCISCAN HEALT				u of Form CMS-2	
CALCUL	ATION OF HOSPITAL-BASED HOSPICE PER DIEM COST	Provi der C	CN: 15-1324	Peri od:	Worksheet 0-8	
		Hospi ce CC	N: 15-1519	From 01/01/2017 To 12/31/2017	Date/Time Pre	nared
		1030100 00	N. 15 1517	10 12/31/2017	5/31/2018 2:4	
				Hospi ce I		
			TITLE XVIII	TITLE XIX	TOTAL	
			MEDI CARE	MEDI CAI D		
			1.00	2.00	3.00	
	HOSPICE CONTINUOUS HOME CARE					
	Total cost (Wkst. 0-6, Part I, col. 18, line 50 plus Wkst. 0	D-7, col. 6,			0	1. (
	line 11)					
	Total unduplicated days (Wkst. S-9, col. 4, line 10)				0	2.
. 00	Total average cost per diem (line 1 divided by line 2)				0.00	3.
	Unduplicated program days (Wkst. S-9 col. as appropriate, li	ne 10)		0 0		4.
	Program cost (line 3 times line 4)			0 0		5.
	HOSPICE ROUTINE HOME CARE		1			
00	Total cost (Wkst. 0-6, Part I, col. 18, line 51 plus Wkst. 0	D-7, col. 7,			963, 744	6.
	line 11)					_
	Total unduplicated days (Wkst. S-9, col. 4, line 11)				3, 402	7.
	Total average cost per diem (line 6 divided by line 7)				283.29	8.
	Unduplicated program days (Wkst. S-9, col. as appropriate, I	ine 11)	3, 0			9.
	Program cost (line 8 times line 9)		870, 8	33 25, 496		10.
	HOSPICE INPATIENT RESPITE CARE		1			
	Total cost (Wkst. 0-6, Part I, col. 18, line 52 plus Wkst. 0	D-7, col. 8,			3, 934	11.
	line 11)				10	10
	Total unduplicated days (Wkst. S-9, col. 4, line 12)					12.
	Total average cost per diem (line 11 divided by line 12)			-	302.62	-
	Unduplicated program days (Wkst. S-9, col. as appropriate, I	ine 12)		7 0		14.
	Program cost (line 13 times line 14)		2, 1	18 0		15.
	HOSPICE GENERAL INPATIENT CARE Total cost (Wkst. 0-6, Part I, col. 18, line 53 plus Wkst. 0		1		14 520	11/
5.00		J-7, COL. 9,			14, 530	16.
7.00	line 11) Total unduplicated days (Wkst. S-9, col. 4, line 13)				53	17.
	Total average cost per diem (line 16 divided by line 17)				274.15	
		ing 12)		1 0		18.
	Unduplicated program days (Wkst. S-9, col. as appropriate, I Program cost (line 18 times line 19)	1110 13)		1 0 74 0		20.
	TOTAL HOSPICE CARE		2	/4 0		20.
	Total cost (sum of line 1 + line 6 + line 11 + line 16)		1		982, 208	21
	Total unduplicated days (Wkst. S-9, col. 4, line 14)				982, 208 3, 468	
					3,468 283.22	
ן טט .נ	Average cost per diem (line 21 divided by line 22)		I	1	283.22	23.

	J		TH RENSSELAER			u of Form CMS-2	
ANALYS	IS OF HOSPITAL-BASED RHC/FQHC COSTS		Provider C		Peri od:	Worksheet M-1	
			Component		From 01/01/2017 To 12/31/2017	Date/Time Pre 5/31/2018 2:4	
					RHC I	Cost	
		Compensation	Other Costs	Total (col.	1 Reclassificati	Reclassi fied	
				+ col. 2)	ons	Trial Balance	
						(col. 3 + col.	
						4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physi ci an	56, 154	0	56, 15	4 0	56, 154	1.00
2.00	Physician Assistant	0	0		0 0	e e	2.00
3.00	Nurse Practitioner	108, 751	0	108, 75	1 0	108, 751	3.00
4.00	Visiting Nurse	0	0		0 0	0	4.00
5.00	Other Nurse	75, 172	0	75, 17	2 0	75, 172	5.00
6.00	Clinical Psychologist	0	0		0 0	0	6.00
7.00	Clinical Social Worker	0	0		0 0	0	7.00
8.00	Laboratory Techni ci an	0	0		0 0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0		0 0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	240, 077	0	240, 07	7 0	240, 077	10.00
11.00	Physician Services Under Agreement	0	0		0 0	0	11.00
12.00	Physician Supervision Under Agreement	0	0		0 0	0	12.00
13.00	Other Costs Under Agreement	0	0		0 0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		0 0	0	14.00
15.00	Medical Supplies	0	15, 838	15, 83	8 0	15, 838	15.00
16.00	Transportation (Health Care Staff)	0	0		0 0	0	16.00
17.00	Depreciation-Medical Equipment	0	0		0 0	0	17.00
18.00	Professional Liability Insurance	0	0		0 0	0	18.00
19.00	Other Health Care Costs	0	0		0 0	0	
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	15, 838			15, 838	
22.00	Total Cost of Health Care Services (sum of	240, 077	15, 838	255, 91	5 0	255, 915	22.00
	lines 10, 14, and 21)						
	COSTS OTHER THAN RHC/FQHC SERVICES	-	-	1		-	
	Pharmacy	0	0		0 0	0	
24.00	Dental	0	0		0 0	0	
25.00	Optometry	0	0		0 0	0	
25.01	Tel eheal th	0	0		0 0	0	
25.02	Chronic Care Management	0	0		0 0	0	
26.00	All other nonreimbursable costs	0	0		0 0	0	
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23	0	0		0 0	0	28.00
	through 27)						-
20.00	FACILITY OVERHEAD		0	1	0 0		29.00
29.00	Facility Costs	21 245	0 101			0	
30.00	Administrative Costs	31, 245	38, 131			0,1010	
31.00	Total Facility Overhead (sum of lines 29 and 30)	31, 245	38, 131	69, 37	6 0	69, 376	31.00
32.00	Total facility costs (sum of lines 22, 28	271, 322	53, 969	325, 29	1 0	325, 291	32.00
	TIVIAL TACITLY CUSIS (SUIL UT TITLES 22, 20	211, 322	່ ວວ, 909	J کے J	1 U	J 320, 291	J J∠. UU

		RANCI SCAN HEAL	TH RENSSELAER		In Lie	u of Form CMS	-2552-1
ANALYS	IS OF HOSPITAL-BASED RHC/FQHC COSTS		Provider C	CN: 15-1324	Peri od:	Worksheet M-	1
			Component (CCN: 15-3990	From 01/01/2017 To 12/31/2017	Date/Time Pr 5/31/2018 2:	
					RHC I	Cost	
		Adjustments	Net Expenses				
			for Allocation				
			(col. 5 + col.				
		6.00	<u> </u>				
	FACILITY HEALTH CARE STAFF COSTS	0.00	7.00				
1.00	Physi ci an	0	56, 154				1.0
2.00	Physi ci an Assi stant	0	0	1			2.0
3.00	Nurse Practitioner	0	108, 751				3.0
4.00	Visiting Nurse	0	0				4.0
5.00	Other Nurse	0	75, 172				5.0
6.00	Clinical Psychologist	0	0				6.0
7.00	Clinical Social Worker	0	0				7.0
B. 00	Laboratory Techni ci an	0	0				8.0
7.00	Other Facility Health Care Staff Costs	0	0				9.0
10.00	Subtotal (sum of lines 1 through 9)	0	240, 077				10.0
11.00	Physician Services Under Agreement	0	0				11.0
2.00	Physician Supervision Under Agreement	0	0				12.0
3.00	Other Costs Under Agreement	0	0				13.0
4.00	Subtotal (sum of lines 11 through 13)	0	0				14.0
15.00	Medical Supplies	0	15, 838				15.0
16.00	Transportation (Health Care Staff)	0	0				16.0
17.00	Depreciation-Medical Equipment	0	0				17.0
18.00	Professional Liability Insurance	0	0				18.0
19.00	Other Heal th Care Costs	0	0				19.0
20.00	Allowable GME Costs	-	-				20.0
21.00	Subtotal (sum of lines 15 through 20)	0	15, 838				21.0
22.00	Total Cost of Health Care Services (sum of	0	255, 915				22.0
22.00	lines 10, 14, and 21)	0	200, 710				22.0
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0				23.0
24.00	Dental	0	0				24.0
25.00	Optometry	0	0				25.0
5. 01	Tel eheal th	0	0				25.0
5. 02	Chronic Care Management	0	0				25.0
26.00	All other nonreimbursable costs	0	0				26.0
27.00	Nonallowable GME costs						27.0
28.00	Total Nonreimbursable Costs (sum of lines 23	0	0				28. C
	through 27)	-					
	FACILITY OVERHEAD						
29.00	Facility Costs	0	0				29.0
30.00	Administrative Costs	0	69, 376				30.0
31.00	Total Facility Overhead (sum of lines 29 and	0	69, 376				31.0
	30)						
32.00	Total facility costs (sum of lines 22, 28	0	325, 291				32.0
	and 31)						

Heal th	Financial Systems F	RANCI SCAN HEAL	TH RENSSELAER		In Lie	eu of Form CMS-2	2552-10
ANALYS	IS OF HOSPITAL-BASED RHC/FQHC COSTS		Provider C		Period:	Worksheet M-1	
			Component		From 01/01/2017 To 12/31/2017	Date/Time Pre 5/31/2018 2:4	
					RHC IV	Cost	
		Compensation	Other Costs	Total (col.	I Reclassificati	Recl assi fi ed	
				+ col. 2)	ons	Trial Balance	
						(col. 3 + col.	
						4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physi ci an	56, 154	C	56, 15	4 0	56, 154	1.00
2.00	Physician Assistant	0	C		0 0	0	2.00
3.00	Nurse Practitioner	148, 831	0	148, 83	1 0	148, 831	3.00
4.00	Visiting Nurse	0	0		0 0	0	4.00
5.00	Other Nurse	116, 440	C	116, 44	0 0	116, 440	5.00
6.00	Clinical Psychologist	0	C		0 0	0	6.00
7.00	Clinical Social Worker	0	C		0 0	0	7.00
8.00	Laboratory Techni ci an	0	C		0 0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	C		0 0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	321, 425	C	321, 42	5 0	321, 425	10.00
11.00	Physician Services Under Agreement	0	0		0 0	0	11.00
12.00	Physician Supervision Under Agreement	0	0		0 0	0	12.00
13.00	Other Costs Under Agreement	0	0		0 0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		0 0	0	14.00
15.00	Medical Supplies	0	36	2	6 0	36	15.00
16.00	Transportation (Health Care Staff)	0	0	-	0 0	0	16.00
	Depreciation-Medical Equipment	0	0			0	17.00
18.00	Professional Liability Insurance	0	0			0	18.00
19.00	Other Health Care Costs	0	0			0	19.00
20.00	Allowable GME Costs	0	0		0	0	20.00
20.00	Subtotal (sum of lines 15 through 20)	0	24		(24	20.00
21.00	Total Cost of Health Care Services (sum of	221 425	36		6 0 1 0	36	
22.00	lines 10, 14, and 21)	321, 425	30	321, 46	0	321, 461	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0		0 0	0	23.00
24.00	Dental	0	0		0 0	-	24.00
25.00	Optometry	0				0	25.00
25.00	Tel eheal th	0	0			0	25.00
25.01	Chronic Care Management	0	0			0	25.01
26.02	All other nonreimbursable costs	0	0		0 0	0	26.02
27.00	Nonallowable GME costs	0	U		0	0	27.00
27.00	Total Nonreimbursable Costs (sum of lines 23	0	0		0 0	0	27.00
20.00	through 27)	0	U		0	0	20.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	0		0 0	0	29.00
29.00 30.00	Administrative Costs	20, 299	57, 534		0		30.00
30.00	Total Facility Overhead (sum of lines 29 and	20, 299 20, 299	57, 534				•
31.00	30)	20, 299	57,534	//,83	3	11,833	31.00
32.00	Total facility costs (sum of lines 22, 28	341, 724	57, 570	399, 29	4 0	399, 294	32.00
52.00	and 31)	571,724	57, 570	377,27		377,274	02.00
	1	I I		1	I	1	1

	· · · · · · · · · · · · · · · · · · ·	RANCI SCAN HEAL				u of Form CMS-	
ANALYS	IS OF HOSPITAL-BASED RHC/FQHC COSTS		Provider CO	CN: 15-1324	Period: From 01/01/2017	Worksheet M-1	1
			Component (CCN: 15-8502	To 12/31/2017	Date/Time Pre 5/31/2018 2:4	
				_	RHC IV	Cost	
		Adjustments	Net Expenses				
			for Allocation				
			(col. 5 + col.				
		6.00	<u> </u>				
	FACILITY HEALTH CARE STAFF COSTS	0.00	7.00				
1.00	Physi ci an	0	56, 154				1.00
2.00	Physician Assistant	0	0				2.00
3.00	Nurse Practitioner	0	148, 831				3.00
4.00	Visiting Nurse	0	0				4.00
5.00	Other Nurse	0	116, 440				5.00
6.00	Clinical Psychologist	0	0				6.00
7.00	Clinical Social Worker	0	0				7.00
8.00	Laboratory Techni ci an	0	0				8.0
9.00	Other Facility Health Care Staff Costs	0	0				9.0
10.00	Subtotal (sum of lines 1 through 9)	0	321, 425				10.0
11.00	Physician Services Under Agreement	0	0				11.0
12.00	Physician Supervision Under Agreement	0	0				12.0
13.00	Other Costs Under Agreement	0	0				13.0
14.00	Subtotal (sum of lines 11 through 13)	0	0				14.0
15.00	Medical Supplies	0	36				15.0
16.00	Transportation (Health Care Staff)	0	0				16.0
17.00	Depreciation-Medical Equipment	0	0				17.0
18.00	Professional Liability Insurance	0	0				18.0
19.00	Other Health Care Costs	0	0				19.0
20.00	Allowable GME Costs						20.0
21.00	Subtotal (sum of lines 15 through 20)	0	36				21.0
22.00	Total Cost of Health Care Services (sum of	0	321, 461				22.0
	lines 10, 14, and 21) COSTS OTHER THAN RHC/FQHC SERVICES						-
23.00	Pharmacy	0	0				23.0
24.00	Dental	0	0				24.0
25.00	Optometry	0	0				25.0
25.01	Tel eheal th	0	0				25.0
25.02	Chronic Care Management	0	0				25.0
26.00	All other nonreimbursable costs	0	0				26.0
27.00	Nonallowable GME costs						27.0
28.00	Total Nonreimbursable Costs (sum of lines 23	0	0				28.0
	through 27)						
	FACILITY OVERHEAD						
29.00	Facility Costs	0	0				29.0
30.00	Administrative Costs	0	77, 833				30.0
31.00	Total Facility Overhead (sum of lines 29 and	0	77, 833				31.0
	30)						
32.00	Total facility costs (sum of lines 22, 28	0	399, 294				32.00
	and 31)						

Health Financial Systems	FRAM	NCI SCAN HEAL	TH RENSSELAER		In Lie	u of Form CMS-2	2552-1
ALLOCATION OF OVERHEAD TO HOSPITAL-	BASED RHC/FQHC SERV	'I CES	Provider C		Period:	Worksheet M-2	
			Component (From 01/01/2017 To 12/31/2017	Date/Time Pre	nared
			oomponente v		10 12/01/2017	5/31/2018 2:4	
					RHC I	Cost	
			Total Visits		Minimum Visits		
	F	Personnel		Standard (1)	(col. 1 x col.		
					3)	4	
		1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY							-
Positions				1.00			
00 Physi ci an		0. 29	526				1.0
.00 Physician Assistant		0.00	0	2, 10			2.0
.00 Nurse Practitioner		1.09	2, 476				3. (
.00 Subtotal (sum of lines 1 thro	bugh 3)	1.38	3, 002		3, 507		4.0
00 Visiting Nurse		0.00	0			0	5.0
00 Clinical Psychologist		0.00	0			0	6. (
.00 Clinical Social Worker		0.00	0			0	7.0
.01 Medical Nutrition Therapist		0.00	0			0	7.0
. 02 Diabetes Self Management Trai	ning (FQHC	0.00	0			0	7.0
only)	5 1 t	1 20	2,002			2 507	
.00 Total FTEs and Visits (sum of	Flines 4	1. 38	3, 002			3, 507	8.0
through 7)	amanto		0			0	9.0
.00 Physician Services Under Agre	ements		0			0	9.0
						1.00	
DETERMINATION OF ALLOWABLE CO	ST APPLICABLE TO HO	OSPI TAL-BASE	D RHC/FQHC SER	VICES			
0.00 Total costs of health care se	ervices (from Wkst.	M-1, col. 7	, line 22)			255, 915	10.0
1.00 Total nonreimbursable costs	(from Wkst. M-1, col	I. 7, line 2	8)			0	11. (
2.00 Cost of all services (excludi	ng overhead) (sum o	of lines 10	and 11)			255, 915	12. (
3.00 Ratio of hospital-based RHC/	QHC services (line	10 di vi ded	by line 12)			1.000000	13.0
4.00 Total hospital-based RHC/FQH0	Coverhead - (from W	Worksheet. M	-1, col. 7, li	ne 31)		69, 376	14.0
5.00 Parent provider overhead allo	cated to facility ((see instruc	tions)			256, 889	15. (
6.00 Total overhead (sum of lines	14 and 15)					326, 265	16.0
7.00 Allowable GME overhead (see i						0	17.0
8.00 Enter the amount from line 10						326, 265	18.0
9.00 Overhead applicable to hospit	al-based RHC/FQHC s	services (li	ne 13 x line 1	8)		326, 265	19.1
0 00 Total allowable cost of best						E02 100	

 20.00
 Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)
 582, 180
 20.00

Heal th	Financial Systems	FRANCI SCAN HEAL	TH RENSSELAER		In Lie	eu of Form CMS-2	2552-10
ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC	SERVI CES	Provi der		Period:	Worksheet M-2	
			Component	CCN: 15-8502	From 01/01/2017 To 12/31/2017	Date/Time Pre	pared [.]
			oomponent	0000. 10 0002	10 12/01/2011	5/31/2018 2:4	
					RHC IV	Cost	
		Number of FTE	Total Visits		Minimum Visits		
		Personnel		Standard (1)	(col. 1 x col.		
					3)	4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						-
	Positions		1				
1.00	Physi ci an	0. 29					1.00
2.00	Physician Assistant	0.00		0 2,10			2.00
3.00	Nurse Practitioner	1.40					3.00
1.00	Subtotal (sum of lines 1 through 3)	1.69			4, 158		
5.00	Visiting Nurse	0.00		0		0	
o. 00	Clinical Psychologist	0.00		0		0	
. 00	Clinical Social Worker	0.00		0		0	1 1.0
7.01	Medical Nutrition Therapist (FQHC only)	0.00		0		0	1 1.0
7.02	Diabetes Self Management Training (FQHC	0.00		0		0	7.02
	only)						
3.00	Total FTEs and Visits (sum of lines 4	1.69	4, 55	3		4, 553	8.00
	through 7)						
9.00	Physician Services Under Agreements			0		0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE	TO HOSPITAL-BASE	D RHC/FOHC SE	RVLCES		1.00	
	Total costs of health care services (from V					321, 461	10.00
	Total nonreimbursable costs (from Wkst. M-1						11.00
	Cost of all services (excluding overhead) (321, 461	
3.00	Ratio of hospital-based RHC/FQHC services (1,000000	
4.00	Total hospital-based RHC/FQHC overhead - (f		77,833				
5.00	Parent provider overhead allocated to facil					535, 051	
6.00	Total overhead (sum of lines 14 and 15)	., (612, 884	
	Allowable GME overhead (see instructions)					0	
8.00	Enter the amount from line 16					612, 884	
	Overhead applicable to hospital-based RHC/F	QHC services (li	ne 13 x line	18)		612, 884	
20.00						004 045	

 20. 00
 Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)
 934, 345
 20. 00

ALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC	RENSSELAER Provi der CCN: 15-1324	Peri od:	u of Form CMS-2 Worksheet M-3	
ERVI CES		From 01/01/2017		
	Component CCN: 15-3990	To 12/31/2017	Date/Time Pre 5/31/2018 2:4	
	Title XVIII	RHC I	Cost	
			1.00	
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			1.00	
.00 Total Allowable Cost of hospital-based RHC/FQHC Services (from	m Wkst. M-2, line 20)		582, 180	1.0
.00 Cost of vaccines and their administration (from Wkst. M-4, lin	ne 15)		11, 977	
.00 Total allowable cost excluding vaccine (line 1 minus line 2)			570, 203	
.00 Total Visits (from Wkst. M-2, column 5, line 8)			3, 507	
.00 Physicians visits under agreement (from Wkst. M-2, column 5, I	line 9)		0	
.00 Total adjusted visits (line 4 plus line 5) .00 Adjusted cost per visit (line 3 divided by line 6)			3, 507 162, 59	
The survived by the of		Cal cul ati on		/.
		Prior to Jan.	On or After	
		1 (Rate Period	•	
		1)	Period 2) 2.00	
.00 Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.	.6 or your contractor)	0.00	0.00	8.
.00 Rate for Program covered visits (see instructions)		162.59	162.59	
CALCULATION OF SETTLEMENT				
0.00 Program covered visits excluding mental health services (from		0	300	10.
1.00 Program cost excluding costs for mental health services (line		0	48, 777	
2.00 Program covered visits for mental health services (from contra		0	0	
3.00 Program covered cost from mental health services (line 9 x lin 4.00 Limit adjustment for mental health services (see instructions)		0	0	
4.00 Limit adjustment for mental health services (see instructions) 5.00 Graduate Medical Education Pass Through Cost (see instructions)		0	0	14.
6.00 Total Program cost (sum of lines 11, 14, and 15, columns 1, 2		0	48, 777	
6.01 Total program charges (see instructions)(from contractor's red		Ŭ	23, 825	
6.02 Total program preventive charges (see instructions)(from provi			1, 425	
6.03 Total program preventive costs ((line 16.02/line 16.01) times	line 16)		2, 917	16.
6.04 Total Program non-preventive costs ((line 16 minus lines 16.03	3 and 18) times .80)		34, 781	16.
(Titles V and XIX see instructions.)				
6.05 Total program cost (see instructions)		0	37, 698	
7.00 Primary payer amounts 8.00 Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		0 2, 384	
records)			2, 304	10.
9.00 Beneficiary coinsurance for RHC/FQHC services (see instruction	ns) (from contractor		4,003	19.
records)	,			
0.00 Net Medicare cost excluding vaccines (see instructions)			37, 698	
1.00 Program cost of vaccines and their administration (from Wkst.	M-4, line 16)		5, 597	
2.00 Total reimbursable Program cost (line 20 plus line 21)			43, 295	
3.00 Allowable bad debts (see instructions)3.01 Adjusted reimbursable bad debts (see instructions)			0	
4.00 Allowable bad debts for dual eligible beneficiaries (see instructions)	ructions)		0	
5.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
5.50 Pioneer ACO demonstration payment adjustment (see instructions	s)		0	
5.99 Demonstration payment adjustment amount before sequestration	-		0	
6.00 Net reimbursable amount (see instructions)			43, 295	26.
6.01 Sequestration adjustment (see instructions)			866	
6.02 Demonstration payment adjustment amount after sequestration			0	
7.00 Interim payments			35, 557	
8.00 Tentative settlement (for contractor use only)	02 27 and 20)		0	
9.00 Balance due component/program (line 26 minus lines 26.01, 26.0 0.00 Protested amounts (nonallowable cost report items) in accordar			6, 872	
	NUC WILLIUWS PUD. 13-11.		0	1 30.

Palth Financial Systems FRANCISCAN HEALTH ALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FOHC	RENSSELAER Provider CCN: 15-1324	Peri od:	u of Form CMS-2 Worksheet M-3	
ERVI CES		From 01/01/2017		
	Component CCN: 15-8502	To 12/31/2017	Date/Time Pre 5/31/2018 2:4	
	Title XVIII	RHC I V	Cost	
			1.00	
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			1.00	
.00 Total Allowable Cost of hospital-based RHC/FQHC Services (from	m Wkst. M-2, line 20)		934, 345	1.0
.00 Cost of vaccines and their administration (from Wkst. M-4, lin	ne 15)		30, 798	
.00 Total allowable cost excluding vaccine (line 1 minus line 2)			903, 547	
.00 Total Visits (from Wkst. M-2, column 5, line 8)			4, 553	
.00 Physicians visits under agreement (from Wkst. M-2, column 5, I	line 9)		0	
.00 Total adjusted visits (line 4 plus line 5) .00 Adjusted cost per visit (line 3 divided by line 6)			4, 553 198, 45	
, oo jaajusted cost per visit (inne 3 divided by inne o)		Cal cul ati on		7.
			01 21 111 (1)	
		Prior to Jan.	On or After	
		1 (Rate Period	•	
		1)	Period 2) 2.00	
.00 Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.	6 or your contractor)	0.00	0.00	8.
.00 Rate for Program covered visits (see instructions)		198.45	198.45	
CALCULATION OF SETTLEMENT				
0.00 Program covered visits excluding mental health services (from		0	905	
1.00 Program cost excluding costs for mental health services (line		0	179, 597	
2.00 Program covered visits for mental health services (from contra		0	0	
3.00 Program covered cost from mental health services (line 9 x line)		0	0	
4.00 Limit adjustment for mental health services (see instructions) 5.00 Graduate Medical Education Pass Through Cost (see instructions)		0	0	14. 15.
6.00 Total Program cost (sum of lines 11, 14, and 15, columns 1, 2		0	179, 597	
6.01 Total program charges (see instructions)(from contractor's red		0	69, 205	
6.02 Total program preventive charges (see instructions)(from provi			5, 105	
6.03 Total program preventive costs ((line 16.02/line 16.01) times	line 16)		13, 248	16.
6.04 Total Program non-preventive costs ((line 16 minus lines 16.03	3 and 18) times .80)		125, 596	16.
(Titles V and XIX see instructions.)				
6.05 Total program cost (see instructions)		0	138, 844	
7.00 Primary payer amounts 8.00 Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		0 254	
8.00 Less: Beneficiary deductible for RHC only (see instructions) records)			9, 354	18.
9.00 Beneficiary coinsurance for RHC/FQHC services (see instruction	ns) (from contractor		10, 949	19.
records)				
0.00 Net Medicare cost excluding vaccines (see instructions)			138, 844	20.
1.00 Program cost of vaccines and their administration (from Wkst.	M-4, line 16)		20, 133	
2.00 Total reimbursable Program cost (line 20 plus line 21)			158, 977	
3.00 Allowable bad debts (see instructions)			0	
3.01 Adjusted reimbursable bad debts (see instructions) 4.00 Allowable bad debts for dual eligible beneficiaries (see instr	ructions)		0	
5.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
5.50 Pioneer ACO demonstration payment adjustment (see instructions	s)		0	
5.99 Demonstration payment adjustment amount before sequestration			0	
6.00 Net reimbursable amount (see instructions)			158, 977	26.
6.01 Sequestration adjustment (see instructions)			3, 180	
6.02 Demonstration payment adjustment amount after sequestration			0	
7.00 Interim payments			109, 300	
8.00 Tentative settlement (for contractor use only)	02 27 and 20)		0	
9.00 Balance due component/program (line 26 minus lines 26.01, 26.0 0.00 Protested amounts (nonallowable cost report items) in accordar			46, 497 0	
			0	1 .30

Heal th	Financial Systems FRANCI SCAN HEALTH	RENSSELAER	In Lie	eu of Form CMS-2	2552-10
	ATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA	Provider CCN: 15-1324	Period:	Worksheet M-4	
VACCIN	IE COST	Component CCN: 15-3990	From 01/01/2017 To 12/31/2017		
		Title XVIII	RHC I	Cost	
			Pneumococcal	I nfl uenza	
			1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		240, 077		1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to tota				
3.00	Pneumococcal and influenza vaccine health care staff cost (lin	,	211		3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (fi		2, 478		
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus		2, 689		
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksho				
7.00	Total overhead (from Wkst. M-2, line 19)	326, 265			
8.00	Ratio of pneumococcal and influenza vaccine direct cost to to	0. 010507	0. 010066	8.00	
	divided by line 6)				
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x l		3, 428		
10.00	Total pneumococcal and influenza vaccine cost and its (their) lines 5 and 9)	administration (sum of	6, 117	5, 860	10.00
11.00	Total number of pneumococcal and influenza vaccine injections	(from your records)	31	110	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10	D/line 11)	197.32	53.27	12.00
13.00	Number of pneumococcal and influenza vaccine injections admini beneficiaries	stered to Program	20	31	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (the (line 12 x line 13)	neir) administration	3, 946	1, 651	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (the		11, 977	15.00	
16. 00	of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2) 16.00 Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)				

Heal th	Financial Systems FRANCISCAN HEALTH	RENSSELAER	In Li	eu of Form CMS-2	2552-10
	ATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA	Provider CCN: 15-1324	Peri od:	Worksheet M-4	
VACCIN	E COST	Component CCN: 15-8502	From 01/01/2017 To 12/31/2017		
		Title XVIII	RHC IV	Cost	
			Pneumococcal	I nfl uenza	
			1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		321, 425		1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to tota				
3.00	Pneumococcal and influenza vaccine health care staff cost (lin		830	.,	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (fi		5, 356		
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus		6, 186		
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksho	· ·		6.00	
7.00	Total overhead (from Wkst. M-2, line 19)	612, 884			
8.00	Ratio of pneumococcal and influenza vaccine direct cost to to	0. 019243	0. 013719	8.00	
	divided by line 6)				
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x l		11, 794		
10.00	Total pneumococcal and influenza vaccine cost and its (their) lines 5 and 9)	administration (sum of	17, 980	12, 818	10. 00
11.00	Total number of pneumococcal and influenza vaccine injections	(from your records)	6	152	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10	D/line 11)	268.30	84.33	12.00
13.00	Number of pneumococcal and influenza vaccine injections admini beneficiaries	stered to Program	48	86	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (the (line 12 x line 13)	neir) administration	12, 881	7, 252	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (the		30, 798	15.00	
16.00	of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2) 16.00 Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)				

Health Financial Systems FRANCISCAN HEAL	LTH RENSSELAER	In Lie	u of Form CMS-2	2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FOHC PROVIDER FOR	Provider CCN: 15-1324	Peri od:	Worksheet M-5	
SERVICES RENDERED TO PROGRAM BENEFICIARIES	Component CCN: 15-3990	From 01/01/2017 To 12/31/2017	Date/Time Prep 5/31/2018 2:46	
		RHC I	Cost	
			t B	
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00 Total interim payments paid to hospital-based RHC/FQHC			35, 557	1.00
2.00 Interim payments payable on individual bills, either submithe contractor for services rendered in the cost reporting "NONE" or enter a zero			0	2.00
3.00 List separately each retroactive lump sum adjustment amoun revision of the interim rate for the cost reporting period. payment. If none, write "NONE" or enter a zero. (1)				3. 00
Program to Provider				
3. 01			0	3. 01
3. 02			0	3. 02
3. 03			0	3.03
3.04			0	3.04
3. 05			0	3.05
Provider to Program				
3. 50			0	3.50
3. 51 3. 52			0	3. 51 3. 52
3. 52			0	3.52 3.53
3. 54			0	3.53 3.54
3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.	98)		0	3.99
4.00 Total interim payments (sum of lines 1, 2, and 3.99) (trans 27)			35, 557	4.00
TO BE COMPLETED BY CONTRACTOR		- 1		
5.00 List separately each tentative settlement payment after des each payment. If none, write "NONE" or enter a zero. (1)	sk review. Also show date o	f		5.00
Program to Provider				
5. 01			0	5.01
5. 02			0	5.02
5.03			0	5.03
Provider to Program 5.50			0	5.50
5. 50			0	5.50 5.51
5. 52			0	5.51
5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.	. 98)		0	5.99
6.00 Determined net settlement amount (balance due) based on the	2		Ŭ	6,00
6.01 SETTLEMENT TO PROVIDER			6, 872	6. 01
6.02 SETTLEMENT TO PROGRAM			0	6. 02
7.00 Total Medicare program liability (see instructions)			42, 429	7.00
		Contractor Number	NPR Date (Mo/Day/Yr)	
	0	1.00	2.00	
8.00 Name of Contractor				8,00

ANALYSI	Financial Systems FRANCISCAN HEAL IS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR	Provider CCN: 15-1324	Peri od:	eu of Form CMS-2	
			Perrou.	Worksheet M-5	
	ES RENDERED TO PROGRAM BENEFICIARIES	Component CCN: 15-8502	From 01/01/2017 To 12/31/2017	Date/Time Prep 5/31/2018 2:46	
			RHC IV	Cost	
				Part B	
			mm/dd/yyyy	Amount	
			1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC			109, 300	1.00
	Interim payments payable on individual bills, either submit	ted or to be submitted to		0	2.00
	the contractor for services rendered in the cost reporting				
	"NONE" or enter a zero				
3.00					3.00
	payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider				
3.01				0	3. 01
3.02				0	3. 02
3.03				0	3.03
3.04				0	3.04
3.05				0	3.05
	Provider to Program				
3.50				0	3.50
3.51				0	3. 51
3.52				0	3. 52
3.53				0	3. 53
3.54				0	3. 54
	99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)				3.99
	Total interim payments (sum of lines 1, 2, and 3.99) (trans	fer to Worksheet M-3, line		109, 300	4.00
	27)				
	TO BE COMPLETED BY CONTRACTOR				
5.00	List separately each tentative settlement payment after des	k review. Also show date of	T _		5.00
	each payment. If none, write "NONE" or enter a zero. (1)				
t i i i i i i i i i i i i i i i i i i i	Program to Provider			0	F 01
5.01 5.02				0	5.01 5.02
5.02				0	5.02
+	Provider to Program			0	5.05
5.50				0	5.50
5.50				0	5.50
5.51				0	5.51
5.92	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.	98)		0	5.99
	Determined net settlement amount (balance due) based on the	·		0	6.00
	SETTLEMENT TO PROVIDER			46, 497	6.01
	SETTLEMENT TO PROGRAM			40, 477	6. 02
7.00	Total Medicare program liability (see instructions)			155, 797	7.00
			Contractor	NPR Date	7.00
			Number	(Mo/Day/Yr)	
				(
		0	1.00	2.00	