payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g).

OMB NO. 0938-0050

EXPRES 03-31-2022

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION Provider CCN: 15-1324 Period: From 01/01/2020 To 12/31/2020 To 12/31/2020 Prepared: 8/2/2021 9:26 am

							8/2/202	:1 9:2	:6 am
PART I - COST	REPORT	STATUS							
Provi der	1. [X] Electronically prepar	red cost report			Date: 8/2/2	2021 T	ime:	9: 26 an
use only	2. [] Manually prepared cos	st report						
			l report enter the number Enter "F" for full or "L		er resub	omitted this	s cost repo	rt	
Contractor use only	(1) (2) (3) (4)	Ás Submitted	6. Date Received: 7. Contractor No. 8. [N] Initial Report fo 9. [N] Final Report for	r this Provider CCN		ractor's Ve	column 1 i		

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 OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by FRANCISCAN HEALTH RENSSELAER (15-1324) for the cost reporting period beginning 01/01/2020 and ending 12/31/2020 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 gned)	
	Officer or Administrator of Provider(s)
Title	
Date	

			Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	HI T	Title XIX	
		1.00	2.00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	-156, 555	-1, 251, 937	0	16, 868	1. 00
2.00	Subprovi der - IPF	0	0	0		0	2. 00
3.00	Subprovi der - IRF	0	0	0		0	3. 00
5.00	Swing Bed - SNF	0	-313, 538	0		0	5. 00
6.00	Swing Bed - NF	0				0	6. 00
10.00	RURAL HEALTH CLINIC I	0		17, 543		0	10.00
10. 03	RURAL HEALTH CLINIC IV	0		-6, 113		0	10. 03
200.00	Total	0	-470, 093	-1, 240, 507	0	16, 868	200. 00

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

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-1324 Peri od: Worksheet S-2 From 01/01/2020 Part I Date/Time Prepared: 12/31/2020 8/2/2021 9: 26 am 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 1104 EAST GRACE STREET 1.00 PO Box: 1.00 State: IN Zi p Code: 47978-2.00 City: RENSSELAER County: **JASPER** 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, 0, or N) Certi fi ed Number Number Type 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 FRANCISCAN HEALTH 151324 23844 02/03/2005 N 0 0 3.00 RENSSEL AFR Subprovi der - IPF 4.00 4 00 5.00 Subprovider - IRF 5.00 6.00 Subprovi der - (Other) 6.00 Swing Beds - SNF FRANCISCAN HEALTH 157324 99915 N 7.00 12/31/2005 N 0 7 00 RENSSELAER Swing Beds - NF 8.00 8.00 9.00 Hospi tal -Based SNF 9.00 10.00 Hospi tal -Based NF 10.00 Hospi tal -Based OLTC 11.00 11 00 12.00 Hospi tal -Based HHA 12.00 Separately Certified ASC 13.00 13.00 Hospi tal -Based Hospi ce 14.00 14 00 153990 15.00 Hospital-Based Health Clinic - RHC WHEATELELD CLINIC 99915 10/07/1999 Ν 0 Ν 15.00 15. 03 Hospital-Based Health Clinic - RHC BROOK 158502 99915 01/01/2005 N N 15.03 0 16.00 Hospital-Based Health Clinic - FQHC 16.00 Hospital-Based (CMHC) I 17.00 17 00 18.00 Renal Dialysis 18.00 19.00 Other 19.00 From: To: 1.00 2.00 20.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2020 12/31/2020 20.00 21.00 Type of Control (see instructions) 21.00 1 3.00 1. 00 2. 00 Inpatient PPS Information Does this facility qualify and is it currently receiving payments for 22. 00 N N 22.00 disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. 22 01 Did this hospital receive interim uncompensated care payments for this N N 22.01 cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Is this a newly merged hospital that requires final uncompensated care Ν 22.02 Ν payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1 22.03 Did this hospital receive a geographic reclassification from urban to 22.03 Ν Ν Ν rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.

23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 0 23.00 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.

			H RENSSELAER	ON: 1E 1204		u of Form CMS-2	
OSPI I	TAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DAT	IA	Provi der CC	JN: 15-1324	Peri od: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part I Date/Time Pre 8/2/2021 9:26	pared
				NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
				1.00	2.00	3.00	
0. 00	Are you claiming nursing and allied health education any programs that meet the criteria under 42 CFR 413. instructions) Enter "Y" for yes or "N" for no in colis "Y", are you impacted by CR 11642 (or subsequent C	85? (s∈ umn 1. R) NAHE	ee If column 1	N			60.
	adjustement? Enter "Y" for yes or "N" for no in colu	mn 2. Y/N	IME	Direct GME	IME	Direct GME	
		1. 00	2. 00	3. 00	4.00	5.00	
1. 00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N	2.00	0.00	0.00		61.
1. 01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see						61.
1. 02	instructions) Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of						61.
1. 03	ACA). (see instructions) Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see						61.
1. 04	<pre>instructions) Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period (see instructions).</pre>						61.
. 05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.
1. 06	Enter the amount of ACA \$5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.
		Pro	gram Name	Program Cod		Unweighted Direct GME FTE Count	
. 10	Of the FTEs in line 61.05, specify each new program		1.00	2. 00	3.00	4.00	61.
	specialty, 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.						
. 20	Of the FTEs in line 61.05, specify each expanded program specialty, 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	0.00	61.
						1.00	
00	ACA Provisions Affecting the Health Resources and Ser Enter the number of FTE residents that your hospital				riod for which	0.00	62
	your hospital received HRSA PCRE funding (see instruc	ti ons) Teachi r	ng Health Cen	ter (THC) int		0.00	
. 00	Teaching Hospitals that Claim Residents in Nonprovide Has your facility trained residents in nonprovider se	r Settir ttings o	ngs during this co	ost reporting		N	63.
	"Y" for yes or "N" for no in column 1. If yes, comple	te iines	s o4 inrough (Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
	Section 5504 of the ACA Base Year FTE Residents in No			1.00 This base yea	2.00 ar is your cost r	3.00 reporting	
1. 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	y traine -primary all nonp	ed residents / care provider	0.	0. 00	0. 000000	64.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-1324 Peri od: Worksheet S-2 From 01/01/2020 Part I Date/Time Prepared: 12/31/2020 8/2/2021 9: 26 am Program Code Unwei ghted Unwei ghted Program Name Ratio (col. (col. 3 + col FTEs FTEs in Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3.00 4.00 5.00 65.00 Enter in column 1, if line 63 is yes, or your facility 0.000000 65.00 0. 00 0. 00 trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) Unwei ghted Unwei ghted Ratio (col. 1/ FTEs FTEs in (col. 1 + col. Nonprovi der Hospi tal 2)) Si te 1.00 2.00 3.00 Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010 Enter in column 1 the number of unweighted non-primary care resident 0.00 0. 00 0.000000 66.00 FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions) Program Name Unwei ghted Ratio (col. 3/ Program Code Unwei ahted FTES FTEs in (col. 3 + col Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3. 00 4.00 5.00 67.00 Enter in column 1, the program 0.000000 67.00 0.00 0.00 name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)) (see instructions) 1.00 2.00 3.00 Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? 70.00 Enter "Y" for yes or "N" for no. 71.00 If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most O 71.00 recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) Inpatient Rehabilitation Facility PPS 75.00 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF N 75.00 subprovider? Enter "Y" for yes and "N" for no. If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most 76.00 recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)

Health Financial Systems FRANCISCAN HEALTHOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	TH RENSSELAER Provider CC	CN: 15-1324	In Lie Period: From 01/01/2020 To 12/31/2020	u of Form CMS- Worksheet S-2 Part I Date/Time Pro 8/2/2021 9:20	epared:
				1.00	+
Long Term Care Hospital PPS 80.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes	and "N" for			N	80.00
81.00 Is this a LTCH co-located within another hospital for part of "Y" for yes and "N" for no. TEFRA Providers	or all of the o	cost reportin	g period? Enter	N N	81. 00
85.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) 86.00 Did this facility establish a new Other subprovider (exclude				N	85. 00 86. 00
\$413. 40(f)(1)(ii)? Enter "Y" for yes and "N" for no. 87. 00 Is this hospital an extended neoplastic disease care hospital	al classified ι	under section		N	87. 00
1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.			V	XIX	
			1. 00	2.00	
Title V and XIX Services					
90.00 Does this facility have title V and/or XIX inpatient hospital yes or "N" for no in the applicable column.	al services? Er	nter "Y" for	N	Y	90.00
91.00 Is this hospital reimbursed for title V and/or XIX through			N	Y	91. 00
full or in part? Enter "Y" for yes or "N" for no in the appl 92.00 Are title XIX NF patients occupying title XVIII SNF beds (du				N	92. 00
instructions) Enter "Y" for yes or "N" for no in the applica 93.00 Does this facility operate an ICF/IID facility for purposes "Y" for yes or "N" for no in the applicable column.		d XIX? Enter	N	N	93. 00
94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes,	and "N" for no	o in the	N	N	94. 00
applicable column. 95.00 If line 94 is "Y", enter the reduction percentage in the app	olicable column	٦.	0. 00	0.00	95. 00
96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes applicable column.			N	N	96. 00
97.00 If line 96 is "Y", enter the reduction percentage in the app	olicable column	า.	0. 00	0.00	97. 00
98.00 Does title V or XIX follow Medicare (title XVIII) for the instepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" 1	Y	Y	98. 00		
column 1 for title V, and in column 2 for title XIX. 98.01 Does title V or XIX follow Medicare (title XVIII) for the re C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for ti title XIX.				Y	98. 01
98.02 Does title V or XIX follow Medicare (title XVIII) for the cabed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes of for title V, and in column 2 for title XIX.			Y	Y	98. 02
98.03 Does title V or XIX follow Medicare (title XVIII) for a critre imbursed 101% of inpatient services cost? Enter "Y" for ye for title V, and in column 2 for title XIX.				N	98. 03
98.04 Does title V or XIX follow Medicare (title XVIII) for a CAH outpatient services cost? Enter "Y" for yes or "N" for no in			N	N	98. 04
in column 2 for title XIX. 98.05 Does title V or XIX follow Medicare (title XVIII) and add bawkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in a				Y	98. 05
column 2 for title XIX. 98.06 Does title V or XIX follow Medicare (title XVIII) when cost Pts. I through IV? Enter "Y" for yes or "N" for no in column			Y	Y	98. 06
column 2 for title XIX. Rural Providers					-
105.00 Does this hospital qualify as a CAH?			Y		105. 00
106.00 If this facility qualifies as a CAH, has it elected the all-	-inclusive meth	nod of paymen	t N		106. 00
for outpatient services? (see instructions) 107.00 Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R N training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an					107. 00
approved medical education program in the CAH's excluded IF	PF and/or LRF ι				
Enter "Y" for yes or "N" for no in column 2. (see instructi 108.00 Is this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.		dul e? See 42	N		108. 00
12 000 train 3.1.2. 1.10(0), Entor 1 101 you of 14 101 110.	Physi cal	Occupati ona	I Speech	Respi ratory	
100 00 16 111 1 111 111 111 111 111 111 111 11	1. 00	2.00	3.00	4.00	100.00
109.00 f 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	N	N	N	109. 00

	1.00	
110.00 Did this hospital participate in the Rural Community Hospital Demonstration project (§410A	N	110. 00
Demonstration)for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes,		
complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as		
appl i cabl e.		

158014

140.00

ALL Providers

140.00 Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs

are claimed, enter in column 2 the home office chain number. (see instructions)

From 01/01/2020 Part I Date/Time Prepared: 12/31/2020 8/2/2021 9: 26 am 3.00 If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number Contractor's Number: 08101 141. 00 Name: FRANCISCAN ALLIANCE, INC. Contractor's Name: WPS 141 00 142.00 Street: 1515 DRAGOON TRAIL PO Box: 1290 142.00 143.00 Ci ty: MI SHAWAKA 46546-1290 143. 00 State: ΙN Zip Code: 1.00 144.00 Are provider based physicians' costs included in Worksheet A? 144. 00 1. 00 2.00 145.00|If costs for renal services are claimed on Wkst. A, line 74, are the costs for 145 00 inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2. 146.00 Has the cost allocation methodology changed from the previously filed cost report? 146.00 Ν Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2. 1.00 147.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no. 148.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no. 147. 00 Ν 148 00 N 149.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no Ν 149.00 Part A Part B Title V Title XIX 1.00 2.00 3.00 4.00 Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13) 155.00 Hospi tal 155.00 Ν N 156.00 Subprovi der - IPF Ν Ν Ν Ν 156.00 157.00 Subprovi der - IRF 157 00 N Ν Ν N 158. 00 SUBPROVI DER 158. 00 159.00 SNF Ν Ν Ν 159. 00 Ν 160.00 HOME HEALTH AGENCY 160.00 Ν Ν Ν Ν 161.00 CMHC Ν Ν N 161. 00 1.00 Multicampus 165.00 s this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? N 165.00 Enter "Y" for yes or "N" for no. Name County State Zip Code CBSA FTE/Campus 0 1.00 2.00 3.00 4.00 5.00 166.00 If line 165 is yes, for each 0.00 166.00 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) 1.00 Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act 167.00 s this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no. 167 00 168.00 of this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the 168.00 reasonable cost incurred for the HIT assets (see instructions) 168.01 If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions) 168.01 169.00 If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the 0.00169.00 transition factor. (see instructions) Begi nni ng Endi ng 1.00 2.00 170.00 Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting 170. 00 period respectively (mm/dd/yyyy) 1.00 2.00 171.00|If line 167 is "Y", does this provider have any days for individuals enrolled in 0171.00 N section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)

N

19.00

Ν

Report data for additional claims that have been billed but are not included on the PS&R Report used to file this

If line 16 or 17 is yes, were adjustments made to PS&R

Report data for corrections of other PS&R Report

cost report? If yes, see instructions.

information? If yes, see instructions.

Heal th	Financial Systems FRANCISCAN HEAL	TH RENSSELAER		In Lie	u of Form CMS-	2552-10		
	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C	CN: 15-1324	Peri od: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part II Date/Time Pre 8/2/2021 9:26	pared:		
			i pti on	Y/N	Y/N			
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R		0	1. 00 N	3. 00 N	20. 00		
	Report data for Other? Describe the other adjustments:					20.00		
		Y/N 1.00	2. 00	Y/N 3. 00	<u>Date</u> 4.00			
21. 00	Was the cost report prepared only using the provider's	N N	2.00	N N	4.00	21. 00		
	records? If yes, see instructions.							
					1. 00			
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	PT CHILDRENS H	IOSPI TALS)	-				
22. 00	Capital Related Cost Have assets been relifed for Medicare purposes? If yes, see	Instructions			N	22. 00		
23. 00	Have changes occurred in the Medicare depreciation expense		als made dur	ing the cost	N N	23. 00		
	reporting period? If yes, see instructions.	• • •						
24. 00	Were new leases and/or amendments to existing leases entere If yes, see instructions	d into during	this cost re	porting period?	N	24. 00		
25. 00	Have there been new capitalized leases entered into during	the cost repor	ting period?	If yes, see	N	25. 00		
0/ 00	instructions.		. 10 1			04.00		
26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during th instructions.	e cost reporti	ng period?i	r yes, see	N	26. 00		
27. 00	Has the provider's capitalization policy changed during the	cost reportir	ng period? If	yes, submit	N	27. 00		
	copy. Interest Expense							
28. 00	Were new loans, mortgage agreements or letters of credit en	N	28. 00					
29. 00	period? If yes, see instructions. Did the provider have a funded depreciation account and/or	Υ	29. 00					
29.00	treated as a funded depreciation account? If yes, see instr	,	29.00					
30. 00	Has existing debt been replaced prior to its scheduled matu	N	30. 00					
31. 00	instructions. Has debt been recalled before scheduled maturity without is	N	31. 00					
	instructions.							
32. 00	Purchased Services Have changes or new agreements occurred in patient care ser	vices furnishe	ed through co	ntractual	Υ	32. 00		
	arrangements with suppliers of services? If yes, see instru	icti ons.						
33. 00	If line 32 is yes, were the requirements of Sec. 2135.2 app no, see instructions.	lied pertainir	ng to competi	tive bidding? If	N	33. 00		
	Provi der-Based Physi ci ans							
34. 00	Are services furnished at the provider facility under an ar	rangement with	n provi der-ba	sed physi ci ans?	Υ	34. 00		
35. 00	If yes, see instructions. If line 34 is yes, were there new agreements or amended exi	sting agreemer	nts with the	provi der-based	Υ	35. 00		
	physicians during the cost reporting period? If yes, see in							
				Y/N 1. 00	Date 2.00			
	Home Office Costs			1.00	2.00			
36. 00	Were home office costs claimed on the cost report?			Y		36.00		
37. 00	If line 36 is yes, has a home office cost statement been pr If yes, see instructions.	epared by the	nome office?	Y		37. 00		
38. 00	If line 36 is yes , was the fiscal year end of the home off			N		38. 00		
39. 00	the provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to othe			, N		39. 00		
37.00	see instructions.	. Chari Compor	ionita: II yes	, 14		37.00		
40. 00	If line 36 is yes, did the provider render services to the instructions.	home office?	If yes, see	N		40. 00		
	THISTI UCTI OHS.							
	1.00 2.00							
41. 00	Cost Report Preparer Contact Information OD Enter the first name, last name and the title/position STEVE HOWELL							
11.00	held by the cost report preparer in columns 1, 2, and 3,	J. 2 V L		. IOWELL		41. 00		
42. 00	respectively. Enter the employer/company name of the cost report	FRANCISCAN ALL	LANCE			42. 00		
42.00	preparer.	I NANGI JUAN ALL	IANGE			42.00		
43. 00	Enter the telephone number and email address of the cost	765-428-5927		STEVEN. HOWELL@F	FRANCI SCANALLI	43. 00		
	report preparer in columns 1 and 2, respectively.			ANCE. ORG		II		

Health Financial Systems	FRANCI SCAN F	HEALTH RENSSELAER		In Lieu of Form CMS-2552-10			
HOSPITAL AND HOSPITAL HEAL	TH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN:		Period: From 01/01/2020	Worksheet S-2		
					Date/Time Pre 8/2/2021 9:26	pared: am	
		3. 00					
Cost Report Preparer	Contact Information						
	e, last name and the title/position	MANAGER REIMBURSE	MENT			41. 00	
	port preparer in columns 1, 2, and 3,	,					
respecti vel y.							
42.00 Enter the employer/	company name of the cost report					42. 00	
preparer.							
	number and email address of the cost	t				43.00	
report preparer in	columns 1 and 2, respectively.						

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

				'	0 12/31/2020	8/2/2021 9: 26	
						I/P Days / 0/P	
						Visits / Trips	
	Component	Worksheet A	No. of Beds	Bed Days	CAH Hours	Title V	
	· · · · ·	Line Number		Avai I abl e			
		1.00	2.00	3.00	4. 00	5. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00	21	7, 686	24, 000. 00	0	1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)						2. 00
3.00	HMO I PF Subprovi der						3. 00
4.00	HMO I RF Subprovi der					_ !	4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0.4	7 (0)	04 000 00	0	
7.00	Total Adults and Peds. (exclude observation		21	7, 686	24, 000. 00	0	7. 00
8. 00	beds) (see instructions) INTENSIVE CARE UNIT	31. 00	4	1, 464	0.00	o	8. 00
9. 00	CORONARY CARE UNIT	31.00	4	1, 404	0.00	١	9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11.00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12.00
13. 00	NURSERY						13.00
14. 00	Total (see instructions)		25	9, 150	24, 000. 00	o	•
15. 00	CAH visits		23	7, 150	24,000.00		15. 00
16. 00	SUBPROVI DER - I PF					١	16.00
17. 00	SUBPROVI DER - I RF						17. 00
18. 00	SUBPROVI DER						18. 00
19. 00	SKILLED NURSING FACILITY						19. 00
20.00	NURSING FACILITY						20. 00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22. 00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24.00	HOSPI CE						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. 03	RURAL HEALTH CLINIC IV	88. 03				0	26. 03
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00				0	26. 25
27. 00	Total (sum of lines 14-26)		25				27. 00
28. 00	Observation Bed Days					0	28. 00
29. 00	Ambul ance Tri ps						29. 00
30. 00	Employee discount days (see instruction)						30. 00
31. 00	Employee discount days - IRF						31. 00
32. 00	Labor & delivery days (see instructions)		0	C			32. 00
32. 01	Total ancillary labor & delivery room						32. 01
22.00	outpatient days (see instructions)						22.00
33.00	LTCH non-covered days						33.00
33. UI	LTCH site neutral days and discharges			I	l		33. 01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-1324

Peri od: Worksheet S-3 From 01/01/2020 Part I To 12/31/2020 Date/Time Prepared:

8/2/2021 9: 26 am I/P Days / O/P Visits / Trips Full Time Equivalents Title XVIII Component Title XIX Total All Total Interns Employees On Pati ents & Residents Payrol I 10.00 7.00 6.00 8.00 9.00 1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 675 1, 000 1.00 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) 2 00 HMO and other (see instructions) 2 00 88 141 3.00 HMO IPF Subprovider C 3.00 HMO IRF Subprovider 4.00 4.00 5.00 Hospital Adults & Peds. Swing Bed SNF 0 896 5.00 896 Hospital Adults & Peds. Swing Bed NF 6.00 0 319 6.00 7.00 Total Adults and Peds. (exclude observation 1,571 8 2, 215 7.00 beds) (see instructions) INTENSIVE CARE UNIT 8.00 51 113 8.00 CORONARY CARE UNIT 9.00 9.00 BURN INTENSIVE CARE UNIT 10.00 10.00 11.00 SURGICAL INTENSIVE CARE UNIT 11.00 12.00 OTHER SPECIAL CARE (SPECIFY) 12.00 13.00 NURSERY 13.00 172.00 14.00 Total (see instructions) 1,622 14 2, 328 0.00 14.00 CAH visits 15.00 15.00 SUBPROVIDER - IPF 16.00 16.00 SUBPROVIDER - IRF 17.00 17.00 18.00 SUBPROVI DER 18.00 19.00 SKILLED NURSING FACILITY 19.00 20 00 NURSING FACILITY 20 00 21.00 OTHER LONG TERM CARE 21.00 22.00 HOME HEALTH AGENCY 22.00 AMBULATORY SURGICAL CENTER (D. P.) 23.00 23.00 HOSPI CE 24 00 24 00 24. 10 HOSPICE (non-distinct part) 0 24. 10 CMHC - CMHC 25.00 25.00 26, 00 RURAL HEALTH CLINIC 385 731 1, 590 0.00 3.53 26, 00 RURAL HEALTH CLINIC IV 26. 03 26.03 2, 947 0.00 3.68 1, 221 744 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 0.00 0.00 26. 25 C 27.00 Total (sum of lines 14-26) 0.00 179. 21 27.00 Observation Bed Days 28.00 158 685 28.00 29 00 Ambul ance Trips 0 29 00 30.00 Employee discount days (see instruction) 30.00 31.00 Employee discount days - IRF 0 31.00 Labor & delivery days (see instructions) 0 0 32.00 32.00 C Total ancillary labor & delivery room 0 32.01 outpatient days (see instructions) LTCH non-covered days 33.00 0 33.01 LTCH site neutral days and discharges 33.01

Heal th FinancialSystemsFRANCISCAN HEALTH RENSSELAERHOSPITALAND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATAProvider Complex Statistical Data In Lieu of Form CMS-2552-10 Provider CCN: 15-1324

					J 12/31/2020	8/2/2021 9: 26	
		Full Time		Di sch	arges		
		Equi val ents					
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Pati ents	
		11.00	12.00	13. 00	14. 00	15. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and		0	269	4	411	1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)			42	31		2. 00
3.00	HMO I PF Subprovi der				0		3. 00
4.00	HMO IRF Subprovider				0		4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF						5. 00
6.00	Hospital Adults & Peds. Swing Bed NF						6. 00
7. 00	Total Adults and Peds. (exclude observation						7. 00
0.00	beds) (see instructions)						0 00
8.00	INTENSIVE CARE UNIT						8. 00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	0. 00	0	240	4	411	13.00
14. 00 15. 00	Total (see instructions) CAH visits	0.00	U	269	4	411	14. 00 15. 00
16. 00	SUBPROVIDER - IPF						16.00
17. 00	SUBPROVIDER - I RF						17. 00
18. 00	SUBPROVI DER						18. 00
19. 00	SKILLED NURSING FACILITY						19. 00
20. 00	NURSING FACILITY						20.00
21. 00	OTHER LONG TERM CARE						21. 00
22. 00	HOME HEALTH AGENCY						22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24. 00	HOSPI CE						24. 00
24. 10	HOSPICE (non-distinct part)						24. 10
25. 00	CMHC - CMHC						25. 00
26.00	RURAL HEALTH CLINIC	0.00					26. 00
26. 03	RURAL HEALTH CLINIC IV	0. 00					26. 03
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0. 00					26. 25
27.00	Total (sum of lines 14-26)	0. 00					27. 00
28.00	Observation Bed Days						28. 00
29. 00	Ambul ance Tri ps						29. 00
30.00	Employee discount days (see instruction)						30. 00
31.00	Employee discount days - IRF						31. 00
32.00	Labor & delivery days (see instructions)						32. 00
32. 01	Total ancillary labor & delivery room						32. 01
	outpatient days (see instructions)						
33. 00	LTCH non-covered days			0			33. 00
33. 01	LTCH site neutral days and discharges			0			33. 01

til	n Financial Systems F	RANCISCAN HEAL	TH RENSSELAER		In Lie	eu of Form CMS	-2552-1
	TAL-BASED RHC/FQHC STATISTICAL DATA		Provider C	CN: 15-1324	Peri od:	Worksheet S-	-8
			Component	CCN: 15-3990	From 01/01/2020 To 12/31/2020		
					RHC I	Cost	
	01:::- Add: 1 d-:::4::6:				1.	00	
1. 00	Clinic Address and Identification Street				492 S BI ERMA S	T	1.0
1.00	Street		Ci	ty	State	ZIP Code	1.0
				00	2.00	3.00	
2.00	City, State, ZIP Code, County		WHEATFI ELD		IN	47978	2.0
						1.00	
3. 00	HOSPITAL-BASED FQHCs ONLY: Designation - Ente	r "R" for rura	al or "II" for i	ırhan		1. 00	0 3.0
3.00	THOSE TRE-DASED TORICS ONET. Designation - Ente	a K TOLTULA	11 01 0 101 0		nt Award	Date	0 3.0
					1. 00	2.00	
	Source of Federal Funds						
4.00	Community Health Center (Section 330(d), PHS						4. 0
5.00	Migrant Health Center (Section 329(d), PHS Ad						5.0
6. 00 7. 00	Health Services for the Homeless (Section 340 Appalachian Regional Commission	o(u), PHS ACT)		1			6. 0 7. 0
8.00	Look-Alikes						8.0
9. 00	OTHER (SPECIFY)			<u> </u>			9. 0
10.00			501100 5	. ""	1.00	2. 00	0 10 0
10. 00	Does this facility operate as other than a hoyes or "N" for no in column 1. If yes, indica 2. (Enter in subscripts of line 11 the type of hours.)	ite number of a	other operation	ns in column	N		0 10.0
		Sun	day	N	londay	Tuesday	
		from	to	from	to	from	
		1. 00	2. 00	3. 00	4. 00	5. 00	
11 00	Facility hours of operations (1)			08: 00	16: 30	08: 00	11 0
11.00	CLINIC			06.00	10. 30	08.00	11.0
					1. 00	2.00	
12. 00 13. 00	Have you received an approval for an exception is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in columber of providers included in this report.	in CMS Pub. 1 umn 1. If yes,	100-04, chapter enter in colum	9, section nn 2 the	Y N		12. 0 0 13. 0
	numbers below.			Provi	ider name	CCN number	
					1.00	2.00	
14. 00	RHC/FQHC name, CCN number				1. 00	2. 00	14.0
14. 00	RHC/FQHC name, CCN number	Y/N	V	XVIII	XIX	Total Visits	
		Y/N 1.00	V 2.00				;
	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider.		-	XVIII	XIX	Total Visits	
14. 00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the		2.00	XVIII	XIX	Total Visits	;
	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider.		2.00 Cou	XVIII 3.00	XIX	Total Visits	;
	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider.	1.00	2.00 Cot 4. JASPER	XVIII 3.00	XI X 4. 00	Total Visits	;
15. 00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)	1.00 Tuesday	2.00 Cou JASPER Wedn	XVIII 3.00 3.00 inty 00 esday	XI X 4. 00	Total Visits 5.00	15.0
15. 00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)	1.00 Tuesday	2.00 Cou 4. JASPER Wedn from	XVIII 3.00 Inty 00 esday to	XIX 4.00 Thur	Total Visits 5.00	15.0
15. 00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)	1.00 Tuesday	2.00 Cou JASPER Wedn	XVIII 3.00 3.00 inty 00 esday	XI X 4. 00	Total Visits 5.00	15.0

Health Financial Systems	FRANCISCAN HEAL	TH RENSSELAER		In Lie	u of Form CMS-	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 15-1324	Peri od:	Worksheet S-8	1
				From 01/01/2020		
		Component	CCN: 15-3990	To 12/31/2020	Date/Time Pre	pared:
		·			8/2/2021 9: 26	am
			_	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 F	RANCI SCAN HEAL	TH RENSSELAER		. In Li∈	eu of Form CMS-	2552-10
HOSPI T	AL-BASED RHC/FQHC STATISTICAL DATA			CCN: 15-1324 CCN: 15-8502	Period: From 01/01/2020 To 12/31/2020	Date/Time Pre	epared:
					RHC IV	8/2/2021 9: 26 Cost	am
					KIIC I V	COST	
	To a contract of the contract				1.	00	
1 00	Clinic Address and Identification Street				1104 E GRACE S	·T	1.00
1.00	Street		С	i ty	State	ZIP Code	1.00
				. 00	2. 00	3. 00	
2.00	City, State, ZIP Code, County		RENSSELAER		I N	47922	2.00
						1.00	
3. 00	HOSPITAL-BASED FQHCs ONLY: Designation - Ente	er "R" for rura	al or "U" for	urban		0	3.00
					nt Award	Date	
	Source of Federal Funds				1. 00	2. 00	-
4. 00	Community Health Center (Section 330(d), PHS	Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Ad						5.00
6.00	Health Services for the Homeless (Section 340	O(d), PHS Act)					6. 00 7. 00
7. 00 8. 00	Appalachian Regional Commission Look-Alikes						8.00
9. 00	OTHER (SPECIFY)						9. 00
					4.00	0.00	
10.00	Does this facility operate as other than a ho	snital_hased F	RHC or ENHC2 F	nter "V" for	1. 00 N	2. 00	10.00
10.00	yes or "N" for no in column 1. If yes, indica 2. (Enter in subscripts of line 11 the type of hours.)	ite number of d	other operation	ns in column	N		10.00
		Sun	day	M	onday	Tuesday	
		from	to	from	to	from	-
	Facility hours of operations (1)	1.00	2. 00	3. 00	4. 00	5. 00	
11. 00	CLINIC			08: 00	16: 30	08: 00	11. 00
					1.00		
12. 00	Have you received an approval for an exception	n to the produ	ictivity stand	ard?	1. 00 Y	2. 00	12. 00
	Is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in colunumber of providers included in this report. numbers below.	in CMS Pub. 1 umn 1. If yes,	100-04, chapte enter in colu	r 9, section mn 2 the	N	C	•
	Trainber 3 berow.			Provi	der name	CCN number	
	T				1. 00	2. 00	
14.00	RHC/FQHC name, CCN number	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 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						15. 00
	number of total visits for this provider.						
	(see instructions)		Co	unty			
	(See Instructions)		4				
2. 00			JASPER	. 00			2. 00
2. 00	City, State, ZIP Code, County	Tuesday	JASPER	. 00 nesday	Thur	rsday	2. 00
2.00		to	JASPER Wedr from	nesday to	from	to	2.00
2.00			JASPER Wedr	nesday			2.00

Health Financial Systems	FRANCISCAN HEAL	TH RENSSELAER		In Lie	u of Form CMS-	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 15-1324	Peri od:	Worksheet S-8	1
				From 01/01/2020		
		Component	CCN: 15-8502	To 12/31/2020		
					8/2/2021 9: 26	am
				RHC I V	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

OSPI T	Financial Systems FRANCISCAN HEALTH REI AL UNCOMPENSATED AND INDIGENT CARE DATA Pr	rovi der CCN: 15-1324	Peri od:	u of Form CMS-2 Worksheet S-1					
03111	AL UNCOMI ENSATED AND THOUGHT CARE DATA	OVI del CCN. 13-1324	From 01/01/2020	WOLKSHEET 3-1	U				
			To 12/31/2020	Date/Time Pre 8/2/2021 9:26	parec am				
				1. 00					
	Uncompensated and indigent care cost computation								
. 00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divi	ded by line 202 colum	nn 8)	0. 391075	1. (
	Medicaid (see instructions for each line)								
. 00	Net revenue from Medicaid			0	I				
00	Did you receive DSH or supplemental payments from Medicaid?	l Madi	-: -!		3.				
. 00	If line 3 is yes, does line 2 include all DSH and/or supplementa If line 4 is no, then enter DSH and/or supplemental payments fro		ai u r	0	4. 5.				
. 00	Medicaid charges	iii wearcara		0					
. 00	Medicaid cost (line 1 times line 6)			0					
. 00	Difference between net revenue and costs for Medicaid program (I	ine 7 minus sum of li	nes 2 and 5; if	0	1				
	< zero then enter zero)								
	Children's Health Insurance Program (CHIP) (see instructions for	each line)							
00	Net revenue from stand-alone CHIP			0					
0. 00 1. 00	Stand-alone CHIP charges Stand-alone CHIP cost (line 1 times line 10)			0					
2. 00		Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero the							
2. 00	enter zero)	THE TI III HUS TITIE 7,	TT \ Zero then	O	12.				
	Other state or local government indigent care program (see instr	uctions for each line	e)						
3. 00	Net revenue from state or local indigent care program (Not inclu			0	13.				
4. 00	Charges for patients covered under state or local indigent care	program (Not included	d in lines 6 or	0	14.				
- 00	[10]				4.5				
5.00	State or local indigent care program cost (line 1 times line 14) Difference between net revenue and costs for state or local indi	aont ooro program (li	no 15 minuo lino	0	15. 16.				
6. 00	13; if < zero then enter zero)	gent care program (11	ne is minus iine	U	10.				
	Grants, donations and total unreimbursed cost for Medicaid, CHIP	and state/local indi	gent care program	ns (see					
	instructions for each line)								
7. 00	1				17.				
8.00	Government grants, appropriations or transfers for support of ho		no (oum of lines	0					
9. 00	Total unreimbursed cost for Medicaid , CHIP and state and local 8, 12 and 16)	indigent care program	is (sum of fines	U	19.				
		Uni nsured	Insured	Total (col. 1					
		pati ents	pati ents	+ col . 2)					
		1.00	2. 00	3. 00					
0. 00	Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire faci	1 ! +	0 0	0	20.				
). 00	(see instructions)	iity		U	20.				
1. 00	Cost of patients approved for charity care and uninsured discoun	ts (see	o o	0	21.				
	instructions)	`							
2. 00	Payments received from patients for amounts previously written o	ff as	0 0	0	22.				
	charity care								
3. 00	Cost of charity care (line 21 minus line 22)		0 0	0	23.				
				1. 00					
4. 00	Does the amount on line 20 column 2, include charges for patient	days beyond a Length	n of stay limit	N N	24.				
	imposed on patients covered by Medicaid or other indigent care p								
5. 00	If line 24 is yes, enter the charges for patient days beyond the stay limit	indigent care progra	am's length of	0	25.				
5. 00	Total bad debt expense for the entire hospital complex (see inst			3, 070, 109	26.				
7. 00	Medicare reimbursable bad debts for the entire hospital complex	` '		426, 532	1				
7. 01	Medicare allowable bad debts for the entire hospital complex (se	e instructions)		656, 203	1				
8. 00	Non-Medicare bad debt expense (see instructions)	, , , , , , , , , , , , , , , , , , , ,	,	2, 413, 906					
	Cost of non-Medicare and non-reimbursable Medicare bad debt expe	nse (see instructions	5)	1, 173, 689	29.				
9. 00	· ·		ı	1 170 /00	20				
0. 00	Cost of uncompensated care (line 23 column 3 plus line 29) Total unreimbursed and uncompensated care cost (line 19 plus lin	0. 20)		1, 173, 689 1, 173, 689					

Health Financial Systems	FRANCISCAN HEALTI	H RENSSELAER		In Lie	u of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE C	F EXPENSES	Provider CCN: 15-1324		Peri od:	Worksheet A	
				From 01/01/2020 To 12/31/2020	Date/Time Pre	nared:
				. 12/31/2020	8/2/2021 9: 26	
Cost Center Description	Sal ari es	0ther		Recl assi fi cati	Recl assi fi ed	
			+ col . 2)	ons (See A-6)	Trial Balance	
					(col. 3 +-	
	1.00	2.00	3. 00	4. 00	col . 4) 5.00	
GENERAL SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
1. 00 O0100 CAP REL COSTS-BLDG & FLXT		3, 624, 370	3, 624, 370	18, 698	3, 643, 068	1. 00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	61, 543	2, 832, 480			2, 894, 023	4. 00
5.00 00500 ADMINISTRATIVE & GENERAL	3, 311, 801	5, 765, 642			8, 996, 745	5. 00
7.00 00700 OPERATION OF PLANT	290, 867	1, 056, 432	1, 347, 299	o	1, 347, 299	7. 00
8.00 00800 LAUNDRY & LINEN SERVICE	76, 467	32, 445	108, 912	0	108, 912	8. 00
9. 00 00900 HOUSEKEEPI NG	361, 868	79, 567	441, 435	-32, 158	409, 277	9. 00
10. 00 01000 DI ETARY	266, 774	153, 555	420, 329		180, 532	10.00
11. 00 01100 CAFETERI A	0	0			239, 797	11. 00
13. 00 O1300 NURSING ADMINISTRATION	236, 133	3, 191	239, 324		239, 324	13. 00
14. 00 01400 CENTRAL SERVI CES & SUPPLY	31, 266	34, 853			66, 119	14. 00
15. 00 01500 PHARMACY	277, 421	2, 537, 371	2, 814, 792		370, 365	15. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	0	0	(0	0	16. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS	1 4/5 /0/	471 440	1 027 151	702	1 02/ 452	20.00
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT	1, 465, 686 466, 557	471, 469 1, 222			1, 936, 453 467, 779	30. 00 31. 00
ANCI LLARY SERVI CE COST CENTERS	400, 337	1, 222	407,77	/ 0	407,777	31.00
50. 00 05000 OPERATI NG ROOM	664, 842	384, 334	1, 049, 176	28, 590	1, 077, 766	50. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	852, 269	98, 284			950, 400	54. 00
60. 00 06000 LABORATORY	0	2, 028, 057			2, 027, 513	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	26, 278			26, 278	63.00
65. 00 06500 RESPIRATORY THERAPY	571, 271	47, 898			619, 169	65. 00
66. 00 06600 PHYSI CAL THERAPY	732, 033	34, 525	766, 558	-79	766, 479	66. 00
66. 01 06601 WHEATFI ELD PT	266, 731	3, 105	269, 836	-146	269, 690	66. 01
67. 00 06700 OCCUPATI ONAL THERAPY	131, 500	420			131, 920	67. 00
67. 01 06701 WHEATFI ELD OT	85, 376	4, 290			89, 666	67. 01
68. 00 06800 SPEECH PATHOLOGY	94, 572	591	95, 163		95, 163	68. 00
68. 01 06801 WHEATFI ELD ST	79, 272	593	·		79, 865	68. 01
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0	599, 286			599, 286	71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	181, 781	181, 781		181, 781	72.00
73. 00 O7300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS	0	19	19	2, 534, 963	2, 534, 982	73. 00
88. 00 08800 RURAL HEALTH CLINIC	274, 189	57, 505	331, 694	-15, 027	316, 667	88. 00
88. 03 08801 RURAL HEALTH CLINIC IV	294, 718	33, 985	·		314, 437	88. 03
90. 00 09000 CLI NI C	891, 125	192, 869			1, 083, 934	90.00
90. 01 09001 WOUND CARE	28, 845	119, 897			148, 288	90. 01
91. 00 09100 EMERGENCY	1, 006, 742	1, 349, 118			2, 355, 537	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
SPECIAL PURPOSE COST CENTERS						
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	12, 819, 868	21, 755, 432	34, 575, 300	-6, 786	34, 568, 514	118. 00
NONREI MBURSABLE COST CENTERS						
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	5, 506	5, 50	0		190. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	9	0		192.00
192. 01 19201 RENSSELAER HEALTH CENTER	0	0	(,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	0		192. 01
194. 00 07950 ALTERNACARE	630, 744	38, 424	669, 168	6, 786		
194. 01 07951 DME EQUI PMENT	0	0				194. 01 194. 02
194. 02 07952 WHEATFIELD FITNESS		0				
194. 03 07957 JOHNSON FITNESS 194. 04 07953 FOUNDATION		0				194. 03 194. 04
194.05 07954 MEALS ON WHEELS		0				194. 04
194.06 07955 WATER LAB		0				194. 05
194. 07 07956 ADVERTI SI NG		0				194. 07
194. 08 07958 UNOCCUPI ED SPACE		0				194. 07
194. 09 07959 LAFAYETTE HHA BRANCH		0		ol ől		194. 09
200.00 TOTAL (SUM OF LINES 118 through 199)	13, 450, 612	21, 799, 362	35, 249, 97	i o	35, 249, 974	
			•	. '		-

| Peri od: | From 01/01/2020 | To 12/31/2020 | Date/Ti me Prepared: | 8/2/2021 9: 26 am

			8/2/2021 9: 26	am
Cost Center Description	Adjustments	Net Expenses		
	(See A-8)	For Allocation		
	6. 00	7. 00		
GENERAL SERVICE COST CENTERS				
1.00 00100 CAP REL COSTS-BLDG & FLXT	404, 288	4, 047, 356		1. 00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	243, 001	3, 137, 024		4. 00
5.00 00500 ADMINISTRATIVE & GENERAL	-925, 169	8, 071, 576		5. 00
7.00 00700 OPERATION OF PLANT	0	1, 347, 299		7. 00
8.00 00800 LAUNDRY & LINEN SERVICE	0	108, 912		8. 00
9. 00 00900 HOUSEKEEPI NG	-1, 347	407, 930		9. 00
10. 00 01000 DI ETARY	-18, 439	162, 093		10.00
11. 00 01100 CAFETERI A	-59, 890	179, 907		11. 00
13.00 O1300 NURSING ADMINISTRATION	160, 725	400, 049		13. 00
14.00 01400 CENTRAL SERVICES & SUPPLY	231, 564	297, 683		14.00
15. 00 01500 PHARMACY	18, 225	388, 590		15. 00
16. 00 01600 MEDICAL RECORDS & LIBRARY	388, 216	388, 216		16. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	000/2:0	000/210		1 .0.00
30. 00 03000 ADULTS & PEDIATRICS	-825, 085	1, 111, 368		30.00
31. 00 03100 I NTENSI VE CARE UNI T	0	467, 779		31. 00
ANCI LLARY SERVI CE COST CENTERS	٥,	1077 777		1 0 00
50. 00 05000 OPERATING ROOM	-649, 510	428, 256		50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	-24, 287	926, 113		54. 00
60. 00 06000 LABORATORY	-6, 522	2, 020, 991		60.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0, 022	26, 278		63. 00
65. 00 06500 RESPI RATORY THERAPY	-653	618, 516		65. 00
66. 00 06600 PHYSI CAL THERAPY	0	766, 479		66. 00
66. 01 06601 WHEATFI ELD PT	o	269, 690		66. 01
67. 00 06700 OCCUPATI ONAL THERAPY	o	131, 920		67. 00
67. 01 06700 0CC0FATTONAL THEKAFT	o	89, 666		67. 01
68. 00 06800 SPEECH PATHOLOGY	o	95, 163		68. 00
68. 01 06800 SPEECH PATHOLOGY 68. 01 06801 WHEATFI ELD ST	0	79, 865		68. 01
	0			71. 00
		599, 286		
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	181, 781		72.00
73. 00 O7300 DRUGS CHARGED TO PATIENTS	0	2, 534, 982		73. 00
OUTPATIENT SERVICE COST CENTERS	E2 EE0	244 100		00.00
88. 00 08800 RURAL HEALTH CLINIC	-52, 559	264, 108		88. 00
88. 03 08801 RURAL HEALTH CLINIC IV	-49, 417	265, 020		88. 03
90. 00 09000 CLI NI C	-150, 000	933, 934		90.00
90. 01 09001 WOUND CARE	-118, 900	29, 388		90. 01
91. 00 09100 EMERGENCY	0	2, 355, 537		91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART				92. 00
SPECIAL PURPOSE COST CENTERS	4 405 750	20 100 755		4
118. 00 SUBTOTALS (SUM OF LINES 1 through 117)	-1, 435, 759	33, 132, 755		118. 00
NONREI MBURSABLE COST CENTERS		F F0/		1,00,00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	5, 506		190. 00
192. 00 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	675, 954		194. 00
194. 01 07951 DME EQUI PMENT	0	0		194. 01
194. 02 07952 WHEATFIELD FITNESS	0	0		194. 02
194. 03 07957 JOHNSON FITNESS	0	0		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
194. 08 07958 UNOCCUPI ED SPACE	0	0		194. 08
194.09 07959 LAFAYETTE HHA BRANCH	o	o		194. 09
200.00 TOTAL (SUM OF LINES 118 through 199)	-1, 435, 759	33, 814, 215		200. 00
		·		-

Health Financial Systems	FRANCISCAN HEALTH RENSSELAER	In Lieu of Form CMS-2552-10		
RECLASSI FI CATI ONS	Provi der CCN: 15-1324	Peri od: Worksheet A-6		
		From 01/01/2020		

					From 01/01/2020		
					To 12/31/2020	Date/Time Pr 8/2/2021 9:2	repared: 26 am
		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, 194	87, 603			1. 00
	0		152, 194	87, 603			
	B - PROPERTY INSURANCE						
1.00	CAP REL COSTS-BLDG & FIXT	1. 00	0	18, 698			1. 00
	0		0	18, 698			
	C - HOUSEKEEPING						
1.00	OPERATING ROOM	50.00	32, 158	0			1. 00
	0		32, 158	0			
	D - DRUGS						
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	2, 534, 963			1. 00
2.00	ALTERNACARE	194.00	0	6, 786			2. 00
3.00		0.00	0	0			3. 00
4.00		0.00	0	0			4. 00
5.00		0.00	0	0			5. 00
6.00		0.00	0	0			6. 00
7.00		0.00	0	0			7. 00
8.00		0.00	0	0			8. 00
9.00		0.00	0	0			9. 00
10.00		0.00	0	0			10.00
11.00		0.00	0	0			11. 00
12.00		0.00	0	0			12.00
13.00		0.00	0	0			13. 00
	0		0	2, 541, 749			
500.00	Grand Total: Increases		184, 352	2, 648, 050			500.00

Peri od: Worksheet A-6 From 01/01/2020 To 12/31/2020 Date/Time Prepared:

					Т	To 12/31/2020 Date/Ti 8/2/202	me Prepared: 21 9:26 am
		Decreases				0, 2, 202	7, 20 diii
	Cost Center	Li ne #	Sal ary	Other	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10.00		
	A - CAFETERIA						
1.00	DI ETARY	10. 00	152, 194	87, 603	0		1. 00
	0		152, 194	87, 603			
	B - PROPERTY INSURANCE						
1.00	ADMI NI STRATI VE & GENERAL	5. 00	0	1 <u>8, 6</u> 98	12		1. 00
	0		0	18, 698			
	C - HOUSEKEEPING						
1.00	HOUSEKEEPI NG	9. 00	32, 158	0	0		1. 00
	0		32, 158	0			
	D - DRUGS						
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	62, 000	0		1. 00
2.00	PHARMACY	15. 00	0	2, 444, 427	0		2. 00
3.00	ADULTS & PEDIATRICS	30.00	0	702	0		3. 00
4.00	OPERATING ROOM	50.00	0	3, 568	0		4. 00
5.00	RADI OLOGY-DI AGNOSTI C	54.00	0	153	0		5. 00
6.00	LABORATORY	60.00	0	544	0		6. 00
7.00	PHYSI CAL THERAPY	66. 00	0	79	0		7. 00
8.00	WHEATFIELD PT	66. 01	0	146	0		8. 00
9.00	RURAL HEALTH CLINIC	88. 00	0	15, 027	0		9. 00
10.00	RURAL HEALTH CLINIC IV	88. 03	0	14, 266	0		10. 00
11.00	CLINIC	90.00	0	60	0		11. 00
12.00	WOUND CARE	90. 01	0	454	0		12. 00
13.00	EMERGENCY	91. 00	0	323	0		13. 00
	0		0	2, 541, 749			
500.00	Grand Total: Decreases		184, 352	2, 648, 050			500.00

				To	12/31/2020	Date/Time Prep 8/2/2021 9:26	pared:
				Acqui si ti ons		0/2/2021 7.20	aiii
		Begi nni ng	Purchases	Donati on	Total	Di sposal s and	
		Bal ances				Retirements	
		1.00	2.00	3. 00	4. 00	5. 00	
•	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	Γ BALANCES					
1.00	Land	675, 791	0	0	0	0	1. 00
2.00	Land Improvements	484, 426	0	0	0	0	2. 00
3.00	Buildings and Fixtures	17, 314, 748	89, 039	0	89, 039	0	3. 00
4.00	Building Improvements	1, 692, 153	116, 733	0	116, 733	0	4. 00
5.00	Fi xed Equipment	0	0	0	0	0	5. 00
6.00	Movable Equipment	12, 107, 051	829, 530	0	829, 530	214, 523	6. 00
7.00	HIT designated Assets	0	0	0	0	0	7. 00
8.00	Subtotal (sum of lines 1-7)	32, 274, 169	1, 035, 302	0	1, 035, 302	214, 523	8. 00
9.00	Reconciling Items	0	0	0	0	0	9. 00
10.00	Total (line 8 minus line 9)	32, 274, 169	1, 035, 302	0	1, 035, 302	214, 523	10.00
		Endi ng Bal ance	Fully				
			Depreci ated				
			Assets				
		6.00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET						
1.00	Land	675, 791	0				1. 00
2.00	Land Improvements	484, 426	0				2. 00
3.00	Buildings and Fixtures	17, 403, 787	0				3. 00
4.00	Building Improvements	1, 808, 886	0				4. 00
5.00	Fixed Equipment	0	0				5. 00
6.00	Movable Equipment	12, 722, 058	0				6. 00
7.00	HIT designated Assets	0	0				7. 00
8.00	Subtotal (sum of lines 1-7)	33, 094, 948	0				8. 00
9.00	Reconciling Items	0	0				9. 00
10. 00	Total (line 8 minus line 9)	33, 094, 948	0				10.00

Heal th	Financial Systems	FRANCI SCAN HEAL	TH RENSSELAER		In Lie	u of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der CO		Peri od: From 01/01/2020	Worksheet A-7 Part II	
					To 12/31/2020		pared:
	,					8/2/2021 9: 26	am
		SUMMARY OF CAPITAL					
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see		
					instructions)		
		9. 00	10.00	11. 00	12. 00	13. 00	
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUMI	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	2, 821, 514	0	802, 85	6 0	0	1.00
3.00	Total (sum of lines 1-2)	2, 821, 514	0	802, 85	6 0	0	3. 00
		SUMMARY OF	F CAPITAL				
	Cost Center Description	0ther	Total (1) (sum				
	, , , , , , , , , , , , , , , , , , ,	Capi tal -Relate	` ' '				
		d Costs (see	through 14)				
		instructions)	3 ,				
		14.00	15. 00				İ
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A. COLUMI	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FLXT	0	3, 624, 370				1.00
3. 00	Total (sum of lines 1-2)	0	3, 624, 370				3. 00
		•					

Health Financial Systems	RANCISCAN HEAL	TH RENSSELAER		In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der CO		Peri od:	Worksheet A-7	
				From 01/01/2020 To 12/31/2020		arod:
				10 12/31/2020	8/2/2021 9: 26	am
	COME	PUTATION OF RAT	TI OS	ALLOCATION OF	OTHER CAPITAL	
Cost Center Description	Gross Assets	Capitalized	Gross Assets	Ratio (see	Insurance	
		Leases	for Ratio	instructions)		
			(col. 1 - col.	,		
	4 00	0.00	2)	4.00	F 00	
PART III - RECONCILIATION OF CAPITAL COSTS CE	1. 00	2.00	3. 00	4. 00	5. 00	
1.00 CAP REL COSTS-BLDG & FIXT	INTERS	0	Ι ,	1. 000000	0	1. 00
3.00 Total (sum of lines 1-2)	0	0		1.000000	-	3. 00
3.00 Total (Suill Of Titles 1-2)					F CAPITAL	3.00
	ALLOCATION OF OTHER CALLIAL SUMMARY OF CALLIAL					
Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
		Capi tal -Relate	col s. 5			
		d Costs	through 7)			
	6. 00	7. 00	8. 00	9. 00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE	NTERS					
1.00 CAP REL COSTS-BLDG & FLXT	0	0		2, 829, 953		1. 00
3.00 Total (sum of lines 1-2)	0	0	(2, 829, 953	0	3. 00
		SL	JMMARY OF CAPI	TAL		
Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
		instructions)	instructions)	Capi tal -Rel ate		
				d Costs (see	through 14)	
				instructions)		
DART III DECONOLILIATION OF CARLTY COOTS OF	11.00	12. 00	13. 00	14. 00	15. 00	
PART III - RECONCILIATION OF CAPITAL COSTS CE				al .a l		
1.00 CAP REL COSTS-BLDG & FLXT	797, 551			0 401, 154		1.00
3.00 Total (sum of lines 1-2)	797, 551	18, 698	l (0 401, 154	4, 047, 356	3. 00

Pagement Cressed Figuration on Worksheet A Forest Which the Animal is to be Alijusted					To	12/31/2020	Date/Time Prep 8/2/2021 9:26	
Cast Center Description Sesis/Code (2) Amount Cast Center Line # Missi A.7 Bot							07272021 7.20	Cilii
1.00 Investment Income - CAP RPT 8 -0.850CAP RPT COSTS. BIG A FIXT 1.00 11 1.00					To/From Which the Amount is ¹	to be Adjusted		
1.00 Investment Income - CAP RPT 8 -0.850CAP RPT COSTS. BIG A FIXT 1.00 11 1.00								
1.00 Investment Income - CAP RPT 8 -0.850CAP RPT COSTS. BIG A FIXT 1.00 11 1.00								
1.00 Investment income - CAP REL 0015-ENLD & FIXT 1.00 11 1.00 12 10 10 10 10 10 10		Cost Center Description	Basis/Code (2)					
COSTS-BUBLE & FIXT (Chapter 2) 0	1 00	Investment income CAD DEL						1 00
OSTS-MALE EQUIP (chapter 2) 0	1.00	II	В	-8, 355	CAP REL COSTS-BLDG & FIXT	1.00	''	1.00
Investment income - other	2.00			0	*** Cost Center Deleted ***	2. 00	0	2. 00
Trade, quantity, and time 0 0.00 0.00 0.4.00 0.5.00	3. 00			0		0.00	0	3. 00
discounts (chapter 8)								
ReFunds and rebates of 0 0.00 0.50 0.00 0.50 0.00	4.00			O		0.00	U	4.00
Sental of provi der space by 0 0.00 0.6.00 0.00	5.00	Refunds and rebates of		0		0. 00	0	5. 00
Supplier's (chapter 8)	6. 00			0		0. 00	0	6. 00
Stations excluded) (Chapter 27)		suppliers (chapter 8)		_				
8. 00 Television and radio service	7. 00			O		0.00	0	7. 00
Chapter 21) 0 0 0 0 0 0 0 0 0		21)						
9.00 Parking lot (chapter 21) 0 0.00 0.00 0.00 0.00 1.00	8. 00	II		0		0. 00	0	8. 00
adjustment (chapter 23) 1.00 Sale of scrap, waste, etc. (chapter 23) 2.00 Related organization 1.717, 632 2.00 Related organization 1.717, 632 3.00 Laudry and Linea servicus 3.00 Laudry		Parking Lot (chapter 21)		0		0.00	0	
11.00 Safe of scrap, waste, etc. (chapter 23) 12.00 Related organization (target 23) 13.00 Laundry and Linen service 0 0 0.00 0.00 0.13.00 13.00 Laundry and Linen service 0 0 0.00 0.00 0.13.00 15.00 Gental of quarters to employee and dustream of the content of	10. 00	1 3	A-8-2	-1, 665, 804			0	10. 00
12.00 Related organization charactions (chapter 10) 13.00 Laundry and I linen service 0 0.00 0.00 0.13.00 15.00	11. 00			0		0.00	0	11. 00
transactions (chapter 10) 14. 00 Careteria-employees and guests 0 0 0.00 0.00 0.13. 00 14. 00 Careteria-employees and guests 0 0.00 0.00 0.14. 00 14. 00 Careteria-employees and guests 0 0.00 0.00 0.15. 00 15. 00 Rental of quarters to employee and others 16. 00 Sale of medical and surgical supplies to other than patients 17. 00 Sale of drugs to other than patients 18. 00 Sale of drugs to other than patients 18. 00 Sale of medical records and B 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0	12 00		Λ_8_1	1 717 632			0	12 00
14.00 Caffeteria-employees and guests 0 0.00 0.14.00	12.00		A-0-1	1, 717, 032				12.00
15.00 Rental of quarters to employee and others 0 0 0 15.00 0 16.00 0 16.00 0 16.00 0 16.00 0 16.00 0 17.00 0 17.00 0 17.00 0 17.00 0 17.00 0 18.00 0 19.00 0		1		0				
16.00 Sale of medical and surgical supplies to other than patients 0 0.00 0.00 0.00 0.17.00			1	0			-	
Suppl set to other than patients	1/ 00	1		0		0.00		17.00
17. 00 Sale of drugs to other than patients 0 0.00	16.00			U		0.00	U	16.00
Batlents	17.00			0		0.00		17.00
abstracts	17.00			Ü		0.00	U	17.00
19.00 Nursing and allied heal the education (tuition, fees, books, etc.) 20.00 Vending machines 0 0.00	18. 00	II	В	-162	MEDICAL RECORDS & LIBRARY	16. 00	0	18. 00
education (tuition, fees, books, etc.) 20.00 Vending machines 0 0.00	19. 00	1		0		0.00	0	19. 00
20.00 Vending machines 0 0.00 0.00 0.20.00		education (tuition, fees,						
21.00	20. 00			0		0.00	0	20. 00
Charges (chapter 21) Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments O		Income from imposition of		0		0. 00	0	21. 00
Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments and borrowings to repay Medicare overpayments ORESPIRATORY THERAPY								
Page Medicare overpayments Adjustment for respiratory A-8-3 ORESPIRATORY THERAPY 65.00 23.00	22. 00	Interest expense on Medicare		0		0.00	0	22. 00
23.00 Adj ustment for respiratory therapy costs in excess of limitation (chapter 14) 24.00 Adj ustment for physical therapy costs in excess of limitation (chapter 14) 25.00 Utilization review - physicians' compensation (chapter 21) 26.00 Depreciation - CAP REL COSTS-BLDG & FIXT								
I imitation (chapter 14)	23. 00	Adjustment for respiratory	A-8-3	0	RESPIRATORY THERAPY	65. 00		23. 00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14) 25.00 Utilization review - physicians' compensation (chapter 21) 26.00 Depreciation - CAP REL COSTS-BLDG & FIXT 27.00 Depreciation - CAP REL COSTS-BLDG & FIXT 28.00 Non-physician Anesthetist COSTS-MVBLE EQUIP COSTS and Anesthetist COSTS and Anesthetis								
limitation (chapter 14)	24. 00	Adjustment for physical	A-8-3	0	PHYSICAL THERAPY	66. 00		24. 00
25.00 Utilization review - physicians' compensation (chapter 21) 26.00 Depreciation - CAP REL COSTS-BLDG & FIXT 1.00 0.26.00 0.0								
Chapter 21) Depreciation - CAP REL OCAP REL COSTS-BLDG & FIXT 1.00 0 26.00	25. 00	Utilization review -		0	*** Cost Center Deleted ***	114.00		25. 00
26. 00 Depreciation - CAP REL COSTS-BLDG & FIXT 1.00 0 26. 00 COSTS-BLDG & FIXT 1.00 0 26. 00 Depreciation - CAP REL COSTS-BLDG & FIXT 1.00 0 27. 00 Depreciation - CAP REL COSTS-BLDG & FIXT 1.00 0 27. 00 Depreciation - CAP REL COSTS-BLDG & FIXT 1.00 0 27. 00 Depreciation - CAP REL COSTS-BLDG & FIXT 1.00 0 27. 00 Depreciation - CAP REL COSTS-BLDG & FIXT 1.00 0 27. 00 Depreciation - CAP REL COSTS-BLDG & FIXT 1.00 0 27. 00 Depreciation - CAP REL COSTS-BLDG & FIXT 1.00 0 27. 00 Depreciation - CAP REL COSTS-BLDG & FIXT 1.00 0 27. 00 Depreciation - CAP REL COSTS-BLDG & FIXT 1.00 0 26. 00 Depreciation - CAP REL COSTS-BLDG & FIXT 1.00 0 Depreciation - CAP REL COSTS & FIXT 1.00 Depre								
27. 00 Depreciation - CAP REL COSTS-MVBLE EQUIP 28. 00 Non-physician Anesthetist 29. 00 Physicians' assistant 30. 00 Adjustment for occupational therapy costs in excess of limitation (chapter 14) 30. 99 Hospice (non-distinct) (see instructions) 31. 00 Adjustment for speech pathology costs in excess of limitation (chapter 14) 32. 00 CAH HIT Adjustment for Depreciation and Interest 0 **** Cost Center Deleted **** 19. 00 28. 00 0	26. 00			0	CAP REL COSTS-BLDG & FIXT	1.00	0	26. 00
COSTS-MVBLE EQUIP Non-physician Anesthetist Physicians' assistant Adjustment for occupational therapy costs in excess of limitation (chapter 14) 30. 99 Hospice (non-distinct) (see instructions) 31. 00 Adjustment for speech pathology costs in excess of limitation (chapter 14) 32. 00 CAH HIT Adjustment for Depreciation and Interest O **** Cost Center Deleted **** 19. 00 28. 00 29. 00 30. 00 67. 00 30. 00 30. 00 30. 00 30. 99 31. 00 30. 00 30. 99 31. 00 31. 00 32. 00 32. 00 33. 00 33. 00 30.	27.00	1		0	*** Cost Contor Doloted ***	2 00	0	27.00
29. 00 Physicians' assistant 30. 00 Adjustment for occupational therapy costs in excess of limitation (chapter 14) Hospice (non-distinct) (see instructions) 31. 00 Adjustment for speech pathology costs in excess of limitation (chapter 14) 32. 00 CAH HIT Adjustment for Depreciation and Interest	27.00					2.00		27.00
30. 00 Adj ustment for occupational therapy costs in excess of limitation (chapter 14) 30. 99 Hospice (non-distinct) (see instructions) 31. 00 Adj ustment for speech pathology costs in excess of limitation (chapter 14) 32. 00 CAH HIT Adj ustment for Depreciation and Interest A-8-3 OCCUPATIONAL THERAPY 67. 00 30. 00 A-8-3 OSPEECH PATHOLOGY 68. 00 31. 00 9 32. 00				0	*** Cost Center Deleted ***			
limitation (chapter 14) 30. 99 Hospice (non-distinct) (see instructions) 31. 00 Adjustment for speech pathology costs in excess of limitation (chapter 14) 32. 00 CAH HIT Adjustment for Depreciation and Interest OADULTS & PEDIATRICS 30. 00 31. 00 31. 00 32. 00 OADULTS & PEDIATRICS 30. 00 30. 99 31. 00 31. 00 9 32. 00			A-8-3	0	OCCUPATI ONAL THERAPY		U	
30. 99 Hospice (non-distinct) (see instructions) 31. 00 Adjustment for speech pathology costs in excess of limitation (chapter 14) 32. 00 CAH HIT Adjustment for Depreciation and Interest OADULTS & PEDIATRICS 30. 00 30. 99 31. 00 SPEECH PATHOLOGY 68. 00 31. 00 9 32. 00								
instructions) 31.00 Adjustment for speech A-8-3 OSPEECH PATHOLOGY 68.00 31.00 pathology costs in excess of limitation (chapter 14) 32.00 CAH HIT Adjustment for Depreciation and Interest	30. 99			0	ADULTS & PEDIATRICS	30. 00		30. 99
pathology costs in excess of limitation (chapter 14) 32.00 CAH HIT Adjustment for Depreciation and Interest		instructions)	1 4 6 6					
I imitation (chapter 14) 32.00 CAH HIT Adjustment for 0 0.00 9 32.00 Depreciation and Interest	31.00		A-8-3	O	SPEECH PATHULUGY	68. 00		31.00
Depreciation and Interest	22.00	limitation (chapter 14)		_		2.22	_	22.00
	32.00			O		0.00	9	32.00
	33. 00		A	-1, 077, 307	ADMINISTRATIVE & GENERAL	5. 00	o	33. 00

				o 12/31/2020	Date/Time Prep 8/2/2021 9:26	
			Expense Classification on	Worksheet A		
			To/From Which the Amount is	to be Adjusted		
	D 1 (0 1 (0)			"		
Cost Center Description						
OTHER REVENUE					5.00	20.00
	1	· ·	1		9	39. 00
					0	39. 01
					0	40. 00
	1	· ·	1		0	40. 01
		· ·	1		0	40. 02
			l T		0	40. 03
OTHER REVENUE	В	· ·	1	13. 00	0	40. 04
OTHER REVENUE	В	-4, 418	CENTRAL SERVICES & SUPPLY	14.00	0	40. 05
OTHER REVENUE	В	-42, 731	PHARMACY	15. 00	0	40. 06
OTHER REVENUE	В	-28, 872	OPERATING ROOM	50.00	0	40. 07
OTHER REVENUE	В	-8, 833	RADI OLOGY-DI AGNOSTI C	54.00	0	40. 08
OTHER REVENUE	В	-6, 522	LABORATORY	60.00	0	40. 09
OTHER REVENUE	В	-653	RESPIRATORY THERAPY	65.00	0	40. 10
LOBBYI NG	A	-734	ADMINISTRATIVE & GENERAL	5. 00	0	41.00
ANESTHESI A	A	-60, 134	OPERATING ROOM	50.00	0	42. 00
DEPRECIATION CARRY FORWARD	A	8, 439	CAP REL COSTS-BLDG & FIXT	1.00	9	43. 00
MARKETING / ADVERTISING	A	-4, 203	RADI OLOGY-DI AGNOSTI C	54.00	0	43. 01
MARKETING / ADVERTISING	A	-1, 562	ADMINISTRATIVE & GENERAL	5. 00	0	43. 02
PHYSICIAN SALARIES	l A 1	-46, 619	RURAL HEALTH CLINIC	88. 00	0	43. 03
PHYSICIAN SALARIES	A	· ·	1	88. 03	0	43. 04
		· ·	i e			50.00
(Transfer to Worksheet A,		,,				
	OTHER REVENUE LOBBYING ANESTHESIA DEPRECIATION CARRY FORWARD MARKETING / ADVERTISING MARKETING / ADVERTISING PHYSICIAN SALARIES TOTAL (sum of lines 1 thru 49)	OTHER REVENUE B OTHER REVENUE OTHER REVENUE B OTHER REVENUE OTHER REVENUE B OTHER REVENUE B OTHER REVENUE B OTHER REVENUE B OTHER REVENUE A OTHER REVENUE B OTHER REVENUE B OTHER REVENUE A A ANESTHESI A A DEPRECIATION CARRY FORWARD A MARKETING / ADVERTISING A MARKETING / ADVERTISING A PHYSICIAN SALARIES A TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A,	1.00 2.00	Cost Center Description Cost Center Description	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted To/From Which the Amount is to be Adjusted

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

⁽²⁾ Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

Provider CCN: 15-1324

Worksheet A-8-1

From 01/01/2020 | Date/Time Prepared:

					8/2/2021 9: 26				
	Li ne No.	Cost Center	Expense Items	Amount of	Amount				
				Allowable Cost	Included in				
					Wks. A, column				
					5				
	1. 00	2.00	3. 00	4. 00	5. 00				
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED								
	HOME OFFICE COSTS:		<u>, </u>						
1. 00	l .	l .	ALLOWABLE NEW CAPITAL COSTS	401, 154		1. 00			
2.00	l control of the cont	CAP REL COSTS-BLDG & FIXT	I NTEREST	3, 050		2. 00			
3.00			ADMINISTRATIVE & GENERAL	4, 745, 533	5, 284, 223	3.00			
4.00	14. 00	CENTRAL SERVICES & SUPPLY	CENTRAL SUPPLY	235, 982	0	4. 00			
4.01	15. 00	PHARMACY	CPVP / PHARMACY	41, 384	0	4. 01			
4.02	16. 00	MEDICAL RECORDS & LIBRARY	Н М	388, 378	0	4. 02			
4.03	1.00	CAP REL COSTS-BLDG & FIXT	I NTEREST	799, 703	799, 703	4. 03			
4.04	4. 00	EMPLOYEE BENEFITS DEPARTMENT	SHARED SERVICES	243, 001	0	4.04			
4.05	5. 00	ADMINISTRATIVE & GENERAL	SHARED SERVICES	722, 024	0	4. 05			
4.06	13.00	NURSING ADMINISTRATION	SHARED SERVICES	201, 777	0	4.06			
4.07	15. 00	PHARMACY	SHARED SERVICES	19, 572	0	4. 07			
5.00	TOTALS (sum of lines 1-4).			7, 801, 558	6, 083, 926	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.

 	001 411110 1 41147 01 27 1110 4111041						
			Related Organization(s) and/	or Home Office			
Symbol (1)	Name	Percentage of	Name	Percentage of			
		Ownershi p		Ownershi p			
1. 00	2.00	3. 00	4. 00	5. 00			
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:							

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

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

6. 00	В	FRANCISCAN ALLI	100.00	0. 00	6. 00
7.00			0.00	0. 00	7. 00
8.00			0.00	0. 00	8. 00
9.00			0.00	0. 00	9. 00
10.00			0.00	0. 00	10.00
100.00	G. Other (financial or				100.00
	non-financial) specify:				

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

Heal th I	Financial Syste	ems		FRANCI SCAN	N HEALTH	RENSSELAE	R		In Lie	u of Form CMS-	2552-10
STATEME OFFICE		SERVICES F	ROM RE	ELATED ORGANIZATIONS AN	D HOME	Provi der	CCN:	15-1324	Period: From 01/01/2020	Worksheet A-8	-1
									To 12/31/2020	Date/Time Pre 8/2/2021 9:26	
	Net	Wkst. A-7 F	Ref.								
	Adjustments										
	(col. 4 minus										
	col. 5)*										
	6. 00	7. 00									
	A. COSTS INCUR	RED AND ADJ	USTMEN	NTS REQUIRED AS A RESUL	T OF TRA	NSACTI ONS	WI TH	RELATED 0	RGANIZATIONS OR (CLAI MED	
	HOME OFFICE CO										
1.00	401, 154		14								1.00
2.00	3, 050		11								2.00
3.00	-538, 690		0								3.00
4.00	235, 982		0								4.00
4.01	41, 384		0								4. 01
4.02	388, 378		0								4.02
4.03	0		11								4.03
4.04	243, 001		O								4. 04
4. 05	722, 024		0								4.05

5.00 5.00 The amounts on lines 1-4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropriate. Positive amounts increase cost and negative amounts decrease cost. For related organization or home office cost which has not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

4.06

4.07

1100 110 0	Boot postou to normanost m	001 amin 0 1 ama, 01 2, 1	the amount arremable	modia bo imaroatoa im oc	ramin i or emo parer	
	Related Organization(s)					
	and/or Home Office					
	Type of Business					
	6. 00					
	B. INTERRELATIONSHIP TO RELA	TED ORGANIZATION(S) A	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	10	100.00

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

0

4.06

4.07

201, 777

1, 717, 632

19, 572

- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- B. Corporation, partnership, or other organization has financial interest in provider.
- Provider has financial interest in corporation, partnership, or other organization.
- D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organi zati on.
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 15-1324

Peri od: Worksheet A-8-2 From 01/01/2020 To 12/31/2020 Date/Time Prepared:

8/2/2021 9: 26 am Wkst. A Line # Cost Center/Physician Total Professi onal Provi der RCE Amount Physi ci an/Prov Identi fi er ider Component Remuneration Component Component Hours 1. 00 2.00 3. 00 4.00 5. 00 6. 00 7. 00 5. OO ADMI NI STRATI VE & GENERAL 92, 748 1. 00 1.00 64 92.684 0 0 2.00 30.00 ADULTS & PEDIATRICS 825, 085 825, 085 0 2.00 3.00 50. 00 OPERATING ROOM 572, 878 560, 504 12, 374 0 3.00 11, 251 4.00 54. 00 RADI OLOGY-DI AGNOSTI C 11, 251 0 0 4.00 60. 00 LABORATORY 5.00 27,000 27,000 0 5.00 6.00 65. 00 RESPIRATORY THERAPY 11, 375 6.00 11, 375 0 7.00 90. 00 CLI NI C 150,000 150,000 0 7.00 90. 01 WOUND CARE 8.00 118, 900 118, 900 0 8.00 0 9.00 91. 00 EMERGENCY 1, 313, 104 1, 313, 104 9.00 10.00 0.00 0 10.00 3, 122, 341 1, 665, 804 200.00 200.00 1, 456, 537 Wkst. A Line # Cost Center/Physician Unadjusted RCE 5 Percent of Provi der Physician Cost Cost of I denti fi er Limit Unadjusted RCE Memberships & Component of Malpractice Limit Conti nui ng Share of col. Insurance Educati on 12 1. 00 2.00 8.00 9.00 12. 00 13.00 14.00 5. 00 ADMINISTRATIVE & GENERAL 1. 00 1.00 0 2.00 30.00 ADULTS & PEDIATRICS 0 0 0 0 0 2.00 3.00 50. 00 OPERATING ROOM o 0 0 0 3.00 0 4.00 54. 00 RADI OLOGY-DI AGNOSTI C 0 0 0 0 4.00 0 60. 00 LABORATORY 5.00 0 5 00 6.00 65. 00 RESPIRATORY THERAPY 0 6.00 7.00 90. 00 CLI NI C o 0 0 0 0 0 7.00 90. 01 WOUND CARE 0 0 8.00 0 8.00 91. 00 EMERGENCY 0 0 9.00 9.00 10.00 0.00 10.00 200.00 200.00 Wkst. A Line # Cost Center/Physician Provi der Adjusted RCE RCE Adjustment I denti fi er Component Limit Di sal I owance Share of col. 14 1. 00 2.00 15. 00 16. 00 17. 00 18. 00 5. OO ADMINISTRATIVE & GENERAL 1. 00 1.00 0 0 0 0 825, 085 2.00 30.00 ADULTS & PEDIATRICS 0 0 2.00 3.00 50. 00 OPERATING ROOM 0 0 560, 504 3.00 4.00 54. 00 RADI OLOGY-DI AGNOSTI C 0 0 0 11, 251 4.00 60. 00 LABORATORY 5.00 0 0 0 5 00 65. 00 RESPIRATORY THERAPY 6.00 0 0 6.00 7.00 90. 00 CLI NI C 0 0 0 150,000 7.00 90. 01 WOUND CARE 0 0 8.00 0 118,900 8.00 91. 00 EMERGENCY 9.00 0 9.00 10.00 0.00 0 10.00 200.00 1, 665, 804 200.00

REASON	Financial Systems IABLE COST DETERMINATION FOR THERAPY SERVICES DE SUPPLIERS	FRANCI SCAN HEALT FURNI SHED BY	Provider CC	CN: 15-1324	Peri od: From 01/01/2020 To 12/31/2020		-3 pared:
					Physical Therapy		
						1. 00	
1 00	PART I - GENERAL INFORMATION	a) (aaa i matmust	ti ono)			9	1 00
1. 00 2. 00	Total number of weeks worked (excluding aide: Line 1 multiplied by 15 hours per week	s) (see instruct	ti ons)			135	1. 00 2. 00
3. 00 4. 00	Number of unduplicated days in which supervi: Number of unduplicated days in which therapy nor therapist was on provider site (see inst	assistant was d ructions)	on provider si	te but neithe		33	3. 00 4. 00 5. 00
5. 00 6. 00	Number of unduplicated offsite visits - supervisors or therapists (see instructions) Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy						
	assistant and on which supervisor and/or the instructions)	rapıst was not p	oresent during	the visit(s)) (see		
7. 00	Standard travel expense rate					0.00	7. 00
8. 00	Optional travel expense rate per mile	Supervi sors	Therapi sts	Assi stants	Ai des	0.00 Trai nees	8. 00
		1.00	2.00	3. 00	4. 00	5. 00	
9. 00 10. 00	Total hours worked AHSEA (see instructions)	0. 00 0. 00	325. 00 82. 91	0. (0. (l e	9. 00 10. 00
11. 00	Standard travel allowance (columns 1 and 2,	41. 46	41. 46	0. (0.00	11. 00
	one-half of column 2, line 10; column 3,						
12. 00	one-half of column 3, line 10) Number of travel hours (provider site)	0	o		0		12. 00
12. 01	Number of travel hours (offsite)	0	0		0		12. 01
13. 00 13. 01	Number of miles driven (provider site) Number of miles driven (offsite)	0	0		0		13. 00 13. 01
13.01	Number of infres driven (offsite)	<u> </u>	<u> </u>			4.00	13.01
	Part II - SALARY EQUIVALENCY COMPUTATION					1. 00	
14. 00	Supervisors (column 1, line 9 times column 1,					0	14. 00
15. 00 16. 00	Therapists (column 2, line 9 times column 2, Assistants (column 3, line 9 times column 3,					26, 946 0	15. 00 16. 00
17. 00	Subtotal allowance amount (sum of lines 14 allothers)		ratory therapy	or lines 14-	-16 for all	26, 946	
18. 00	Aides (column 4, line 9 times column 4, line	10)				0	18. 00
19. 00 20. 00	Trainees (column 5, line 9 times column 5, l Total allowance amount (sum of lines 17–19 fo		thanany an lin	oo 17 and 10	for all athora)	0 26, 946	19. 00 20. 00
20.00	If the sum of columns 1 and 2 for respiratory	therapy or col	umns 1-3 for	ohysical ther	apy, speech path		20.00
	occupational therapy, line 9, is greater than	n 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	1 and 2. Line 9	0.00	21. 00
	for respiratory therapy or columns 1 thru 3,	line 9 for all	others)	0. 00. 4	. and 2,		
22. 00	Weighted allowance excluding aides and trained Total salary equivalency (see instructions)	ees (line 2 time	es line 21)			0 26, 946	22. 00 23. 00
23.00	PART III - STANDARD AND OPTIONAL TRAVEL ALLOW	VANCE AND TRAVEL	EXPENSE COMPL	JTATION - PRO	VIDER SITE	20, 740	23.00
04.00	Standard Travel Allowance					1 0/0	04.00
24. 00 25. 00	Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11)					1, 368	24. 00 25. 00
26. 00	Subtotal (line 24 for respiratory therapy or	sum of lines 24	4 and 25 for a	II others)		1, 368	1
27. 00	Standard travel expense (line 7 times line 3 others)	for respiratory	y therapy or s	um of lines 3	and 4 for all	0	27. 00
28. 00	Total standard travel allowance and standard 27)	<u>'</u>	at the provide	er site (sum	of lines 26 and	1, 368	28. 00
29. 00	Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of		d 2 line 12)			0	29. 00
30.00	Assistants (column 3, line 10 times column 3		3 2, 11110 12)			Ö	30.00
31.00	Subtotal (line 29 for respiratory therapy or				, as aum af	0	31.00
32. 00	Optional travel expense (line 8 times columns columns 1-3, line 13 for all others)	s ranu z, rrne	13 for respira	atory therapy	/ Of Sulli Of	0	32. 00
33. 00							
34. 00 35. 00	Optional travel allowance and standard travel Optional travel allowance and optional travel			,		0	34. 00 35. 00
55. 00	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWA				ICES OUTSIDE PRO		33.00
36. 00	Standard Travel Expense Therapists (line 5 times column 2, line 11)					0	36. 00
37. 00	Assistants (line 6 times column 3, line 11)					0	37. 00
38. 00	Subtotal (sum of lines 36 and 37)		4 7			0	38. 00
39. 00	Standard travel expense (line 7 times the sur Optional Travel Allowance and Optional Travel		ı 6)			0	39. 00
40.00	Thomasista (sum of solumno 1 and 2 11 == 12	01 +:	2 11 10)			_	1 40 00

	IABLE COST DETERMINATION FOR THERAPY SERVICES I	FURNI SHED BY	Provider CCM		Period: From 01/01/2020 To 12/31/2020	Date/Time Prep 8/2/2021 9:26	pared:
					Physical Therapy	Cost	
						1. 00	
46. 00	Optional travel allowance and optional travel						46. 00
		Therapists 1.00	Assi stants 2.00	Ai des 3. 00	Trai nees 4.00	Total 5.00	
	PART V - OVERTIME COMPUTATION	1.00	2.00	0.00	1. 00	0.00	
47. 00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each	0.00	0. 00	0.0	0.00	0.00	47. 00
	column of line 56)						
48. 00	Overtime rate (see instructions)	0. 00	0.00	0.0			48.00
49. 00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48) CALCULATION OF LIMIT	0. 00	0.00	0.0	0.00		49. 00
50. 00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0. 00	0.00	0. 0	0.00	0.00	50. 00
51. 00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0. 00	0.00	0.0	0.00	0.00	51.00
52. 00	DETERMINATION OF OVERTIME ALLOWANCE Adjusted hourly salary equivalency amount	82. 91	0.00	0.0	0.00		52. OC
53. 00	(see instructions) Overtime cost limitation (line 51 times line	0	0.00		0 0		53. 00
54. 00	52) Maximum overtime cost (enter the lesser of	0	0		0 0		54. 00
55. 00	line 49 or line 53) Portion of overtime already included in hourly computation at the AHSEA (multiply	0	0		0 0		55. 00
56. 00	line 47 times line 52) Overtime allowance (line 54 minus line 55 - 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.)	0	0		0 0	0	56. 00
						1. 00	
	Part VI - COMPUTATION OF THERAPY LIMITATION A	ND EXCESS COST A	ADJUSTMENT				
57. 00 Salary equivalency amount (from line 23) 58. 00 Travel allowance and expense - provider site (from lines 33, 34, or 35)) 59. 00 Travel allowance and expense - Offsite services (from lines 44, 45, or 46) 60. 00 Overtime allowance (from column 5, line 56) 61. 00 Equipment cost (see instructions) 62. 00 Supplies (see instructions) 63. 00 Total allowance (sum of lines 57-62) 64. 00 Total cost of outside supplier services (from your records) 65. 00 Excess over limitation (line 64 minus line 63 - if negative, enter zero)						26, 946 0 0 0 0 0 26, 946 5, 719	58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00
LINE 33 CALCULATION 100.00 Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others 100.01 Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others 100.02 Line 33 = line 28 = sum of lines 26 and 27							100. 00 100. 01 100. 02
	LINE 34 CALCULATION 101.00 Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others 101.01 Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others 101.02 Line 34 = sum of lines 27 and 31						
100. 02 101. 00 101. 01	Line 27 = line 7 times line 3 for respiratory Line 31 = line 29 for respiratory therapy or Line 34 = sum of lines 27 and 31				other 3		101. 01 101. 02
100. 02 101. 00 101. 01 101. 02	Line 27 = line 7 times line 3 for respiratory Line 31 = line 29 for respiratory therapy or	sum of lines 29	and 30 for al	l others		0	101. 01

| Peri od: | Worksheet B | From 01/01/2020 | Part | | To | 12/31/2020 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-1324

				То	12/31/2020		
	Cost Center Description	Net Expenses for Cost Allocation	CAPITAL RELATED COSTS BLDG & FIXT	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	8/2/2021 9: 26 ADMI NI STRATI VE & GENERAL	alli
		(from Wkst A col. 7)					
		0	1. 00	4.00	4A	5. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT	4, 047, 356	4, 047, 356				1. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	3, 137, 024	77, 775				4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	8, 071, 576	407, 092		9, 273, 855		5.00
7. 00 8. 00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	1, 347, 299 108, 912	462, 210 49, 388		1, 879, 348 176, 660		7. 00 8. 00
9. 00	00900 HOUSEKEEPI NG	407, 930	55, 429		542, 524		9. 00
10.00		162, 093	54, 740		244, 344		
11. 00		179, 907	72, 736		289, 186		11. 00
13.00	01300 NURSING ADMINISTRATION	400, 049	12, 488	56, 697	469, 234	177, 324	13. 00
14. 00	1	297, 683	134, 487		439, 677		
15.00		388, 590	34, 271		489, 471	184, 972	15. 00
16. 00		388, 216	50, 358	0	438, 574	165, 738	16. 00
30. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	1, 111, 368	270, 133	351, 920	1, 733, 421	655, 063	30. 00
31. 00		467, 779	23, 567		603, 369	228, 014	31.00
01.00	ANCI LLARY SERVI CE COST CENTERS	107,777	20,007	112,020	000,007	220,011	01.00
50.00		428, 256	286, 157	167, 354	881, 767	333, 222	50. 00
54.00		926, 113	162, 468	204, 635	1, 293, 216		54.00
60.00		2, 020, 991	88, 511		2, 109, 502		
63. 00		26, 278	3, 192		29, 470		63. 00
65. 00 66. 00		618, 516	118, 025 66, 539		873, 707 1, 008, 784	330, 176	65. 00 66. 00
66. 01		766, 479 269, 690	295, 421		629, 155		66. 01
67. 00		131, 920	13, 489		176, 983		
67. 01		89, 666	61, 657		171, 822	64, 932	67. 01
68. 00	06800 SPEECH PATHOLOGY	95, 163	11, 424		129, 294		68. 00
68. 01		79, 865	39, 999	19, 034	138, 898	52, 490	68. 01
71. 00		1	0		599, 286		71. 00
72.00		181, 781	0		181, 781		
73. 00	07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS	2, 534, 982	0	0	2, 534, 982	957, 975	73. 00
88. 00		264, 108	0	65, 834	329, 942	124, 686	88. 00
88. 03		265, 020	80, 498		416, 282	157, 314	
90.00		933, 934	404, 557		1, 552, 455		90.00
90. 01	09001 WOUND CARE	29, 388	30, 954	6, 926	67, 268	25, 421	90. 01
91. 00	l l	2, 355, 537	244, 969	241, 725	2, 842, 231	1, 074, 090	
92. 00	,				0		92. 00
118. 00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 1	117) 33, 132, 755	3, 612, 534	3, 063, 354	32, 546, 488	8, 794, 779	110 00
110.00	NONREI MBURSABLE COST CENTERS	117) 33, 132, 733	3,012,534	3,003,334	32, 340, 400	0, 174, 117	110.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	V 5, 506	8, 607	0	14, 113	5, 333	190. 00
	00 19200 PHYSICIANS' PRIVATE OFFICES	0	0		0	0	192. 00
	1 19201 RENSSELAER HEALTH CENTER	0	0	0	0	0	192. 01
	00 07950 ALTERNACARE	675, 954	195, 612	151, 445	1, 023, 011	386, 598	
	01 07951 DME EQUI PMENT	0	0	0	0		194. 01
	02 07952 WHEATFIELD FITNESS	0	65, 600	0	65, 600	24, 790	
	13 07957 JOHNSON FITNESS 14 07953 FOUNDATION	0	0		0		194. 03 194. 04
	15 07954 MEALS ON WHEELS		0	0	0		194. 05
194.06	06 07955 WATER LAB	o	0	Ö	0		194. 06
	07 07956 ADVERTI SI NG	0	0	0	0		194. 07
	08 07958 UNOCCUPI ED SPACE	0	72, 048		72, 048		
	09 07959 LAFAYETTE HHA BRANCH	0	92, 955	0	92, 955		
200.00	1 1		_	_	0		200. 00
201.00	1 9	22 014 215	4 047 354	2 214 700	22 014 215		201. 00
202.00	TOTAL (sum lines 118 through 201)	33, 814, 215	4, 047, 356	3, 214, 799	33, 814, 215	7, 2/3, 000	₁ 202.00

In Lieu of Form CMS-2552-10

Period:	Worksheet B
From 01/01/2020	Part
To 12/31/2020	Date/Time Prepared:
8/2/2021 9:26 am	

				' '	3 12/31/2020	8/2/2021 9: 26	
	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	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMINISTRATIVE & GENERAL						5. 00
7.00	00700 OPERATION OF PLANT	2, 589, 557					7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	41, 252	284, 672				8. 00
9.00	00900 HOUSEKEEPI NG	46, 298	0	793, 843			9. 00
10.00	01000 DI ETARY	45, 723	2, 462	23, 967	408, 834		10.00
11. 00	01100 CAFETERI A	60, 754	0	31, 847	0	491, 071	11. 00
13.00	01300 NURSI NG ADMI NI STRATI ON	10, 431	0	5, 468	0	14, 293	13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	112, 333	0	0	0	1, 892	14. 00
15.00	01500 PHARMACY	28, 626	0	15, 005	0	16, 792	15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	42, 063	0	0	0	0	16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	225, 632	73, 073	118, 275	193, 410	88, 713	30. 00
31.00	03100 INTENSIVE CARE UNIT	19, 685	25, 990	10, 319	9, 874	28, 240	31. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	239, 017	26, 385	0	0	42, 188	50. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	135, 704	23, 189	71, 135	0	51, 586	54. 00
60.00	06000 LABORATORY	73, 930	0	38, 753	0	0	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	2, 666	0	0	0	0	63. 00
65.00	06500 RESPI RATORY THERAPY	98, 582	2, 260	51, 676	0	34, 578	65. 00
66.00	06600 PHYSI CAL THERAPY	55, 578	23, 754	29, 134	0	44, 308	66. 00
66. 01	06601 WHEATFI ELD PT	246, 755	0	0	0	0	66. 01
67.00	06700 OCCUPATI ONAL THERAPY	11, 267	0	5, 906	0	7, 959	67. 00
67. 01	06701 WHEATFI ELD OT	51, 500	0	0	0	0	67. 01
68.00	06800 SPEECH PATHOLOGY	9, 542	0	5, 002	0	5, 724	68. 00
68. 01	06801 WHEATFI ELD ST	33, 410	0	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	0	0	0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73. 00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88. 00
88. 03	08801 RURAL HEALTH CLINIC IV	67, 237	0		0	0	88. 03
90.00	09000 CLI NI C	337, 911	14, 379	177, 131	0	53, 938	90.00
90. 01	09001 WOUND CARE	25, 855	2, 448	13, 553	0	1, 746	90. 01
91.00	09100 EMERGENCY	204, 614	33, 587	107, 257	0	60, 936	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
	SPECIAL PURPOSE COST CENTERS						
118.00		2, 226, 365	227, 527	704, 428	203, 284	452, 893	118. 00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	7, 189	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
	07950 ALTERNACARE	163, 388	57, 145	85, 647	205, 550		194. 00
	07951 DME EQUI PMENT	0	0	0	0		194. 01
	07952 WHEATFIELD FITNESS	54, 794	0	0	0		194. 02
	07957 JOHNSON FITNESS	0	0	1	0		194. 03
	07953 FOUNDATION	0	0		0		194. 04
	07954 MEALS ON WHEELS	0	0		0		194. 05
	07955 WATER LAB	0	0	0	0		194. 06
	07956 ADVERTI SI NG	0	0	0	0		194. 07
	07958 UNOCCUPI ED SPACE	60, 179	0	0	0		194. 08
	07959 LAFAYETTE HHA BRANCH	77, 642	0	0	0	0	194. 09
200.00							200. 00
201.00		0	0	0	0		201.00
202.00	TOTAL (sum lines 118 through 201)	2, 589, 557	284, 672	793, 843	408, 834	491, 071	J202. 00

Peri od: Worksheet B From 01/01/2020 Part I To 12/31/2020 Date/Time Prepared:

				10	12/31/2020	8/2/2021 9: 26	pared: am
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	Subtotal	Cili
	cost contor boson per on	ADMI NI STRATI ON	SERVICES &		RECORDS &	oub to tu.	
			SUPPLY		LI BRARY		
		13.00	14.00	15. 00	16.00	24. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FLXT						1. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMINISTRATIVE & GENERAL						5. 00
7. 00	00700 OPERATION OF PLANT						7. 00
8.00	00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00	00900 HOUSEKEEPI NG						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	676, 750					13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	720, 057				14. 00
15. 00	01500 PHARMACY		4, 147	739, 013			15. 00
16. 00	01600 MEDI CAL RECORDS & LI BRARY		7, 147	737, 013	646, 375		16. 00
10.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	<u> </u>	0	0	040, 373		10.00
30. 00	03000 ADULTS & PEDIATRICS	177, 419	3, 947	209	34, 486	3, 303, 648	30. 00
31. 00	03100 I NTENSI VE CARE UNI T	76, 448	561	0	1, 449	1, 003, 949	31. 00
31.00	ANCI LLARY SERVI CE COST CENTERS	70, 440	301	0	1, 447	1,003,747	31.00
50. 00	05000 OPERATING ROOM	56, 279	2, 004	1, 063	22, 718	1, 604, 643	50. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	60, 312	26, 137	46	87, 926	2, 237, 960	54. 00
60. 00	06000 LABORATORY	00, 312	1, 311	162	87, 731	3, 108, 574	60.00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.		20, 258		657	64, 188	63. 00
65. 00	06500 RESPIRATORY THERAPY		20, 236		19, 155	1, 430, 470	65. 00
66. 00	06600 PHYSI CAL THERAPY		4, 824	24	18, 775	1, 566, 402	66. 00
66. 01	06601 WHEATFIELD PT				11, 975		66. 01
67. 00	06700 OCCUPATI ONAL THERAPY		1, 436 8	44		1, 127, 124 273, 551	67. 00
			o e	1 1	4, 546		
67. 01	06701 WHEATFIELD OT 06800 SPEECH PATHOLOGY		108	1	1, 685	290, 047	67. 01
68. 00			224	0	1, 702	200, 348	68. 00
68. 01	06801 WHEATFI ELD ST	0	46		2, 741	227, 585	68. 01
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	466, 637	0	47, 824	1, 340, 218	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	140, 136		12, 914	403, 526	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0	728, 486	203, 929	4, 425, 372	73. 00
	OUTPATIENT SERVICE COST CENTERS		4 500		4 000	4/4 707	
88. 00	08800 RURAL HEALTH CLINIC	0	1, 592		1, 009	461, 707	88. 00
88. 03	08801 RURAL HEALTH CLINIC IV	0	1, 327		1, 493	647, 905	88. 03
90.00	09000 CLI NI C	141, 332	12, 938		27, 786	2, 904, 564	90.00
90. 01	09001 WOUND CARE	0	419	135	2, 132	138, 977	90. 01
91.00	09100 EMERGENCY	164, 960	4, 881	96	53, 742	4, 546, 394	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
440.04	SPECIAL PURPOSE COST CENTERS	(7, 750	740 077	700.040	(4(075	04 007 450	440.00
118. 00		676, 750	713, 277	739, 013	646, 375	31, 307, 152	118.00
100.00	NONREI MBURSABLE COST CENTERS		4 225		ما	24 (20	100.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	4, 225	0	0	34, 628	
192.00	19200 PHYSI CI ANS' PRI VATE OFFI CES	0	0	0	0		192.00
	1 19201 RENSSELAER HEALTH CENTER	0	0 555	0	0		192. 01
	07950 ALTERNACARE	0	2, 555	0	0	1, 962, 072	
	1 07951 DME EQUI PMENT	0	0		0		194. 01
	2 07952 WHEATFI ELD FI TNESS	0	0	0	0	145, 184	
	3 07957 JOHNSON FITNESS	0	0	0	0		194. 03
	4 07953 FOUNDATI ON	0	0	0	0		194. 04
	5 07954 MEALS ON WHEELS	0	0	0	0		194. 05
	07955 WATER LAB	0	0	0	0		194. 06
	7 07956 ADVERTI SI NG	0	0	0	0		194. 07
	B 07958 UNOCCUPI ED SPACE	0	0	0	0	159, 454	
	07959 LAFAYETTE HHA BRANCH	0	0	0	0	205, 725	
200.00							200. 00
201.00		0	0	0	0		201. 00
202.00	TOTAL (sum lines 118 through 201)	676, 750	720, 057	739, 013	646, 375	33, 814, 215	202. 00

COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-1324 Peri od: Worksheet B From 01/01/2020 Part I 12/31/2020 Date/Time Prepared: 8/2/2021 9: 26 am Cost Center Description Intern & Total Residents Cost & Post Stepdown Adj ustments 25.00 26.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 00700 OPERATION OF PLANT 7.00 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 00900 HOUSEKEEPI NG 9.00 9 00 10.00 01000 DI ETARY 10.00 11.00 01100 CAFETERI A 11.00 13.00 01300 NURSING ADMINISTRATION 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 14.00 15. 00 01500 PHARMACY 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 3, 303, 648 30.00 03100 INTENSIVE CARE UNIT 31.00 1,003,949 31.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATI NG ROOM 1,604,643 50.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 2, 237, 960 54.00 3, 108, 574 60.00 06000 LABORATORY 00000000000 60.00 63. 00 06300 BLOOD STORING, PROCESSING & TRANS. 64, 188 63 00 06500 RESPIRATORY THERAPY 65.00 1, 430, 470 65.00 06600 PHYSI CAL THERAPY 1, 566, 402 66.00 66.00 66.01 06601 WHEATFIELD PT 1, 127, 124 66.01 06700 OCCUPATIONAL THERAPY 273, 551 67 00 67.00 06701 WHEATFIELD OT 67.01 290, 047 67.01 06800 SPEECH PATHOLOGY 200, 348 68.00 68.00 06801 WHEATFIELD ST 68. 01 68. 01 227, 585 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 1, 340, 218 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 403, 526 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 4, 425, 372 73.00 OUTPATIENT SERVICE COST CENTERS 88.00 0 88.00 08800 RURAL HEALTH CLINIC 461, 707 88. 03 08801 RURAL HEALTH CLINIC IV 0 0 0 647, 905 88.03 09000 CLI NI C 90.00 2, 904, 564 90.00 09001 WOUND CARE 90.01 138, 977 90.01 09100 EMERGENCY 91.00 4, 546, 394 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 118.00 0 31, 307, 152 118.00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 34, 628 190.00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 000000000000000 192.00 0 192. 01 19201 RENSSELAER HEALTH CENTER Λ 192. 01 194. 00 07950 ALTERNACARE 1, 962, 072 194. 00 194. 01 07951 DME EQUI PMENT 194. 01 C 194. 02 07952 WHEATFIELD FITNESS 145, 184 194 02 194.03 07957 JOHNSON FITNESS 0 194. 03 194. 04 07953 FOUNDATION 194. 04 0 194.05 07954 MEALS ON WHEELS 194. 05 0 194.06 07955 WATER LAB 194. 06 0 194. 07 07956 ADVERTI SI NG Ω 194.07 194. 08 07958 UNOCCUPI ED SPACE 194. 08 159, 454 194. 09 07959 LAFAYETTE HHA BRANCH 205, 725 194. 09 200.00 Cross Foot Adjustments C 200.00 201.00 Negative Cost Centers 201. 00 202.00 TOTAL (sum lines 118 through 201) 33, 814, 215 202.00

| Period: | Worksheet B | From 01/01/2020 | Part II | To | 12/31/2020 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-1324

					To	12/31/2020	Date/Time Pre	
				CAPI TAL			8/2/2021 9: 26	am
				RELATED COSTS				
	Cos	t Center Description	Di rectly	BLDG & FIXT	Subtotal		ADMI NI STRATI VE	
			Assigned New			BENEFITS	& GENERAL	
			Capi tal Rel ated Costs			DEPARTMENT		
			0	1. 00	2A	4. 00	5. 00	
	GENERAL S	ERVICE COST CENTERS						
		REL COSTS-BLDG & FIXT						1. 00
		LOYEE BENEFITS DEPARTMENT	0	77, 775		77, 775	427 227	4. 00
		INISTRATIVE & GENERAL RATION OF PLANT	0	407, 092 462, 210		19, 235 1, 690	426, 327 32, 648	5. 00 7. 00
		NDRY & LINEN SERVICE	0	49, 388		444	3, 069	8. 00
	00900 HOUS		0	55, 429	· ·	1, 915	9, 425	9. 00
10.00	01000 DI E	TARY	0	54, 740	54, 740	666	4, 245	10. 00
	01100 CAFI	1	0	72, 736		884	5, 024	
		SING ADMINISTRATION	0	12, 488		1, 372	8, 152	13.00
	01400 CEN 01500 PHAI	TRAL SERVICES & SUPPLY	0	134, 487 34, 271		182 1, 612	7, 638 8, 503	
	1 1	I CAL RECORDS & LI BRARY	0	50, 358		1, 012	7, 619	•
		ROUTINE SERVICE COST CENTERS	<u>_</u>	30,000	00,000	<u> </u>	,,,,,,	10.00
30.00		LTS & PEDIATRICS	0			8, 514	30, 113	30. 00
		ENSIVE CARE UNIT	0	23, 567	23, 567	2, 710	10, 482	31. 00
		SERVICE COST CENTERS	0	00/ 457	00/ 457	4 040	45.040	F0 00
		RATING ROOM IOLOGY-DIAGNOSTIC	0	286, 157 162, 468		4, 049 4, 951	15, 318 22, 466	
	06000 LAB		0	88, 511		4, 731	36, 646	
	1 1	OD STORING, PROCESSING & TRANS.	0	3, 192		Ö	512	
65.00	06500 RESI	PI RATORY THERAPY	0	118, 025	118, 025	3, 319	15, 178	65. 00
		SI CAL THERAPY	0	66, 539		4, 252	17, 525	
66. 01		ATFIELD PT	0	295, 421		1, 549	10, 930	
		UPATIONAL THERAPY ATFIELD OT	0	13, 489 61, 657	· ·	764 496	3, 075 2, 985	
		ECH PATHOLOGY	0	11, 424		549	2, 246	
		ATFI ELD ST	0	39, 999		460	2, 413	
		ICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	10, 411	71. 00
		L. DEV. CHARGED TO PATIENTS	0	0		0	3, 158	
73. 00		GS CHARGED TO PATIENTS	0	0	0	0	44, 038	73. 00
88. 00		IT SERVICE COST CENTERS AL HEALTH CLINIC	0	0	O	1, 593	5, 732	88. 00
	1 1	AL HEALTH CLINIC IV	0	80, 498		1, 712	7, 232	
90.00	09000 CLII		0	404, 557		5, 177	26, 969	90.00
	09001 WOUI		0	30, 954		168	1, 169	90. 01
	09100 EMEI		0	244, 969		5, 848	49, 382	91. 00
92. 00		ERVATION BEDS (NON-DISTINCT PART PURPOSE COST CENTERS			0			92. 00
118. 00		TOTALS (SUM OF LINES 1 through 117)	0	3, 612, 534	3, 612, 534	74, 111	404, 303	118. 00
		RSABLE COST CENTERS		0,0.2,001	0,012,001	, ,, , , , ,	10 17 000	
190.00	19000 GI F	T, FLOWER, COFFEE SHOP & CANTEEN	0	8, 607	8, 607	0	245	190. 00
	1 1	SICIANS' PRIVATE OFFICES	0	0	0	0		192. 00
		SSELAER HEALTH CENTER	0	0	0	0	0	192. 01
	07950 ALTI	EQUI PMENT	0	195, 612	195, 612	3, 664	17, 772	194. 00 194. 01
		ATFIELD FITNESS	0	65, 600	65, 600	0		194. 01
		NSON FITNESS	0	0	0	0		194. 03
	07953 F0UI		0	0	0	0		194. 04
		LS ON WHEELS	0	0	0	0		194. 05
	07955 WATI		0	0	0	0		194. 06
	07956 ADVI	CCUPLED SPACE	0	72, 048	72, 048	O O		194. 07 194. 08
		AYETTE HHA BRANCH	0	92, 955		ol		194. 08
200.00		ss Foot Adjustments		, , , , ,	0	Ĭ	.,	200. 00
201.00		ative Cost Centers		0	· ·	o		201. 00
202. 00	TOT	AL (sum lines 118 through 201)	0	4, 047, 356	4, 047, 356	77, 775	426, 327	202. 00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-1324

Peri od: Worksheet B From 01/01/2020 Part II To 12/31/2020 Date/Time Prepared:

8/2/2021 9:26 am Cost Center Description OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY CAFETERI A LINEN SERVICE **PLANT** 7. 00 9.00 10.00 11.00 8.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT 1.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 7 00 00700 OPERATION OF PLANT 496, 548 7 00 00800 LAUNDRY & LINEN SERVICE 8.00 7, 910 60, 811 8.00 00900 HOUSEKEEPI NG 8,878 9.00 75, 647 9.00 10.00 01000 DI ETARY 8, 767 526 2, 284 71, 228 10.00 01100 CAFETERI A 11, 650 93, 329 11.00 C 3.035 11.00 13.00 01300 NURSING ADMINISTRATION 2,000 521 2, 716 13.00 0 14.00 01400 CENTRAL SERVICES & SUPPLY 21,540 C C 0 360 14.00 01500 PHARMACY 15 00 5.489 1, 430 3, 191 15.00 C 0 01600 MEDICAL RECORDS & LIBRARY 16.00 8,066 0 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 30. 00 03000 ADULTS & PEDIATRICS 43, 265 16, 861 30.00 15, 609 11, 271 33, 696 03100 INTENSIVE CARE UNIT 31.00 3, 775 5, 552 983 1.720 5, 367 31.00 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM 45, 832 8 018 5, 636 50 00 0 05400 RADI OLOGY-DI AGNOSTI C 26, 021 4, 954 9, 804 54.00 6.779 54.00 06000 LABORATORY 60.00 14, 176 r 3,693 Λ 60.00 06300 BLOOD STORING, PROCESSING & TRANS. 511 0 63.00 0 63.00 06500 RESPIRATORY THERAPY 18, 903 65.00 483 4, 924 0 0 6, 571 65.00 06600 PHYSI CAL THERAPY 66.00 10,657 5,074 2,776 8, 421 66.00 66.01 06601 WHEATFIELD PT 47, 315 O Λ 66.01 67.00 06700 OCCUPATIONAL THERAPY 2, 160 0 563 1,513 67.00 0 0 0 06701 WHEATFIELD OT 9,875 67.01 0 67.01 C 0 06800 SPEECH PATHOLOGY 1, 830 68.00 C 477 1,088 68.00 68.01 06801 WHEATFIELD ST 6,406 C 0 0 68.01 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 0 0 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 72.00 72.00 0 07300 DRUGS CHARGED TO PATIENTS 0 73.00 0 C 0 0 73.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0 88.00 08801 RURAL HEALTH CLINIC IV 88 03 12.893 0 0 0 88 03 C 09000 CLI NI C 0 90.00 64, 793 3,072 16, 879 10, 251 90.00 90.01 09001 WOUND CARE 4, 958 523 1, 291 0 332 90.01 91.00 09100 EMERGENCY 39, 235 7, 175 10, 221 ol 11, 581 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 86, 074 118. 00 118.00 426, 905 48, 604 67, 127 35, 416 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190. 00 1,379 359 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 192.00 192. 01 19201 RENSSELAER HEALTH CENTER 0 0 192. 01 194. 00 07950 ALTERNACARE 12, 207 35, 812 7, 255 194. 00 31, 330 8, 161 0 194. 01 194. 01 07951 DME EQUIPMENT C 194.02 07952 WHEATFIELD FITNESS 10, 507 0 0 0 0 194. 02 194.03 07957 JOHNSON FITNESS 0 0 0 194. 03 0 194. 04 07953 FOUNDATI ON 0 0 194 04 Ω 0 0 194.05 07954 MEALS ON WHEELS 0 0 0 0 194. 05 194.06 07955 WATER LAB 0 0 0 194.06 0 194. 07 07956 ADVERTI SI NG 0 0 0 194. 07 0 194. 08 07958 UNOCCUPIED SPACE 11 539 C 0 0 0 194 08 194. 09 07959 LAFAYETTE HHA BRANCH 14,888 0 0 0 194. 09 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 0 201, 00 0 202.00 TOTAL (sum lines 118 through 201) 496, 548 60, 811 75, 647 71, 228 93, 329 202. 00

| Peri od: | Worksheet B | From 01/01/2020 | Part | I | To 12/31/2020 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-1324

				To	12/31/2020	Date/Time Pre 8/2/2021 9:26	
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	Subtotal	alli
	coot contor boson per on	ADMI NI STRATI ON	SERVICES &		RECORDS &	oub to tu.	
			SUPPLY		LI BRARY		
		13.00	14. 00	15. 00	16. 00	24. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FLXT						1. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMINISTRATIVE & GENERAL						5. 00
7. 00	00700 OPERATION OF PLANT						7. 00
8.00	00800 LAUNDRY & LINEN SERVICE						8. 00
9.00	00900 HOUSEKEEPI NG						9. 00
10. 00	01000 DI ETARY						10. 00
11. 00	01100 CAFETERI A						11. 00
13. 00	01300 NURSING ADMINISTRATION	27, 249					13. 00
14. 00	01400 CENTRAL SERVI CES & SUPPLY	0	164, 207				14. 00
15. 00	01500 PHARMACY	0	946				15. 00
16. 00	01600 MEDI CAL RECORDS & LI BRARY	0	0	0	66, 043		16. 00
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS				0.504		
30.00	03000 ADULTS & PEDI ATRI CS	7, 143	900		3, 524	441, 045	1
31. 00	03100 I NTENSI VE CARE UNI T	3, 078	128	0	148	57, 510	31. 00
F0 00	ANCILLARY SERVICE COST CENTERS	0.044	457	0.0	0.004	070 404	
50.00	05000 OPERATING ROOM	2, 266	457		2, 321	370, 134	1
54. 00	05400 RADI OLOGY-DI AGNOSTI C	2, 429	5, 961	3	8, 984	254, 820	1
60.00	06000 LABORATORY	0	299		8, 964	152, 301	60.00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	4, 620		67	8, 902	1
65. 00	06500 RESPI RATORY THERAPY	0	4, 638		1, 957	173, 998	1
66. 00	06600 PHYSI CAL THERAPY	0	1, 100		1, 918	118, 264	1
66. 01	06601 WHEATFIELD PT	0	328		1, 224	356, 770	1
67. 00	O6700 OCCUPATI ONAL THERAPY O6701 WHEATFI ELD OT	0	2		465	22, 031	1
67. 01 68. 00	06800 SPEECH PATHOLOGY	0	25 E1	0	172	75, 210	
68. 00	06801 WHEATFI ELD ST	0	51 11	0	174 280	17, 839 49, 569	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	106, 413		4, 887	121, 711	1
71.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	31, 957			36, 435	1
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	31, 937		1, 320 20, 834	119, 525	1
73.00	OUTPATIENT SERVICE COST CENTERS	l o		54, 055	20, 034	117, 323	73.00
88. 00	08800 RURAL HEALTH CLINIC	O	363	336	103	8, 127	88. 00
88. 03	08801 RURAL HEALTH CLINIC IV		303		153	103, 110	1
90.00	09000 CLI NI C	5, 691	2, 950		2, 839	543, 179	1
90. 01	09001 WOUND CARE	0,071	95		218	39, 718	1
91. 00	09100 EMERGENCY	6, 642	1, 113		5, 491	381, 664	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1	.,	·	-,		92. 00
	SPECIAL PURPOSE COST CENTERS	'			'		
118.00		27, 249	162, 660	55, 442	66, 043	3, 451, 862	118. 00
	NONREI MBURSABLE COST CENTERS						1
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	964	0	0	11, 554	190. 00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192. 00
192. 01	19201 RENSSELAER HEALTH CENTER	0	0	0	0	0	192. 01
194.00	07950 ALTERNACARE	0	583	0	0	312, 396	194. 00
	07951 DME EQUIPMENT	0	0	0	0		194. 01
194. 02	07952 WHEATFIELD FITNESS	0	0	0	0	77, 247	194. 02
	07957 JOHNSON FITNESS	0	0		0		194. 03
	07953 FOUNDATION	0	0		0		194. 04
	07954 MEALS ON WHEELS	0	0		0		194. 05
	07955 WATER LAB	0	0	0	0		194. 06
	07956 ADVERTI SI NG	0	0	0	0		194. 07
	07958 UNOCCUPI ED SPACE	0	0	0	0		194. 08
	07959 LAFAYETTE HHA BRANCH	0	0	0	0	109, 458	1
200.00							200. 00
201.00		0	0	0	0		201. 00
202. 00	TOTAL (sum lines 118 through 201)	27, 249	164, 207	55, 442	66, 043	4, 047, 356	J202. 00

ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-1324 Peri od: Worksheet B From 01/01/2020 Part II Date/Time Prepared: 12/31/2020 8/2/2021 9: 26 am Cost Center Description Intern & Total Residents Cost & Post Stepdown Adj ustments 25.00 26.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 00700 OPERATION OF PLANT 7.00 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 00900 HOUSEKEEPI NG 9.00 9 00 10.00 01000 DI ETARY 10.00 11.00 01100 CAFETERI A 11.00 13.00 01300 NURSING ADMINISTRATION 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 14.00 15. 00 01500 PHARMACY 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 441, 045 30.00 03100 INTENSIVE CARE UNIT 31.00 0 57, 510 31.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATI NG ROOM 0 0 370, 134 50.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 254, 820 54.00 06000 LABORATORY 60.00 000000000000 152, 301 60.00 63. 00 06300 BLOOD STORING, PROCESSING & TRANS. 8, 902 63 00 06500 RESPIRATORY THERAPY 65.00 173, 998 65.00 06600 PHYSI CAL THERAPY 118, 264 66.00 66.00 66.01 06601 WHEATFIELD PT 356, 770 66.01 06700 OCCUPATIONAL THERAPY 22.031 67 00 67.00 06701 WHEATFIELD OT 67.01 75, 210 67.01 06800 SPEECH PATHOLOGY 17, 839 68.00 68.00 06801 WHEATFIELD ST 49, 569 68. 01 68.01 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 121, 711 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 36, 435 72.00 07300 DRUGS CHARGED TO PATIENTS 0 119, 525 73.00 73.00 OUTPATIENT SERVICE COST CENTERS 88.00 0 88.00 08800 RURAL HEALTH CLINIC 8, 127 88. 03 08801 RURAL HEALTH CLINIC IV 103, 110 88.03 0 0 0 09000 CLI NI C 90.00 543, 179 90.00 09001 WOUND CARE 39, 718 90.01 90.01 09100 EMERGENCY 91.00 381, 664 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 118.00 0 3, 451, 862 118.00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 11, 554 190.00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 000000000000000 192. 00 0 192. 01 19201 RENSSELAER HEALTH CENTER Λ 192. 01 194. 00 07950 ALTERNACARE 312, 396 194. 00 194. 01 07951 DME EQUI PMENT 194. 01 C 194. 02 07952 WHEATFIELD FITNESS 194 02 77, 247 194.03 07957 JOHNSON FITNESS C 194. 03 194. 04 07953 FOUNDATION 194. 04 0 194.05 07954 MEALS ON WHEELS 194. 05 0 194.06 07955 WATER LAB 194. 06 0 194. 07 07956 ADVERTI SI NG Ω 194.07 194. 08 07958 UNOCCUPI ED SPACE 194. 08 84, 839 194. 09 07959 LAFAYETTE HHA BRANCH 109 458 194. 09 200.00 Cross Foot Adjustments C 200.00 201.00 Negative Cost Centers 201. 00 202.00 TOTAL (sum lines 118 through 201) 4, 047, 356 202.00

Cost Center Description	CUST	ILLUCATION - STATISTICAL BASIS		Provider C	F	Period: From 01/01/2020 To 12/31/2020	Worksheet B-1 Date/Time Pre 8/2/2021 9:26	pared:
Company Control Co		Cost Center Description	RELATED COSTS BLDG & FIXT	BENEFITS DEPARTMENT (GROSS	Reconciliation	& GENERAL	PLANT	
00000 CAP REL COSTS-BLDG & FIXT 129-317 1-0.0 00000 AURILY COSTS-BLDG & FIXT 1.5 0.0 00000 AURILY COSTS DEPARTMENT 2.485 13,889.099 -9,273,855 24,540.366 9-7,000 1.979.046 9-7,000 1.979.046 9-7,000 1.979.046 9-7,000 1.979.046 9-7,000 1.979.046 9-7,000 1.979.046 9-7,000 1.979.046 9-7,000 1.979.046 9-7,000 1.979.046 9-7,000 1.979.046 9-7,000 1.979.046 9-7,000 1.979.046 9-7,000 9-7,00			1. 00		5A	5. 00	7. 00	
4.00 0.0000 EMPLOYEE BENEFITS DEPARTMENT 2, 488 13, 389, 069 5.00 0.0000 ADMINISTRATUS ECHRSAL 13, 007 3, 318, 801 - 0, 273, 805 24, 540, 360 94, 077 7.00 0.0000 DEPART (0.00 PLANII OR PLANII 14, 768 799, 867 0.00 18, 797, 340 1, 879, 348 1, 749 10, 00 10, 000 0.000 DEPART (0.00 PLANII OR PLANII								
5.00 00SQQ AMUNINISTRATIVE & GENERAL 13,007 3,311,801 -9,273,855 24,540,306 5,57 7.		1 1						1.00
2.00 0.0700 OPFRATION OF PLANT					1			4. 00
8.00 00800 LANINDRY & LINEN SERVICE 1,578 70,467 0 176,660 1,578 1,571 10,00 1000 01000 0151ARY 1,749 114,189 0 244,344 1,749 110,00 1100 011000 011000 011000 011000 011000 011000 011000 011000 011000 011000			1				00.057	5.00
9.00 0.0900 0.0150EEPING 1,771 329,710 0 542,524 1,771 71 10 0 10100 15100 0.15					1			7. 00 8. 00
10.00 01000 DETARY 1,749 11.4,890 0 244,344 1,749 13.00 01300 MURSING ADMINISTRATION 399 230,133 0 469,234 399 13.1 14.00 01400 01400 01400 01400 01400 01400 01400 01400 01400 01400 01400 01400 01400 01400 01400 01400 01400 01500 01400 01400 01400 01400 01500 01400 01400 01500 01400 01400 01500 01400 01400 01500 01500 01400 01500		1 1	1		1			1
11.00 01.00 CAFETERIA 2,324 15.2,194 0 299,186 2,324 11.30 01.300 MRSIN GAMINISTRATION 399 236,133 30 460,234 399 13.1 14.00 01.400 CENTRAL SERVICES & SUPPLY 4,297 31,266 0 439,677 4,297 14.1 15.00 15.00 01.00 MRSIN GAMINISTRATION 1.095 577,421 0 499,471 1,695 15.1 15.00 01.00 MEDI CAL RECORDS & LIBRARY 1.095 577,421 0 499,471 1,695 15.1 1.095 15.00 01.00 MEDI CAL RECORDS & LIBRARY 1.095 577,421 0 499,471 1,695 15.1 1.095 15.00 1.00 MRSIN GAMINISTRATION 1.095 1.00 MRSIN GAMINISTRATION 1.00 MRSIN GAMINISTRATION 1.095 1.00 MRSIN GAMINISTRATION 1.00 MRSIN GAM			1					1
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63.00 06300 BLOOD STORING, PROCESSING & TRANS. 102 0 0 29, 470 102 63.					l .			1
65.00 06500 RESPIRATORY THERAPY 3,771 571,271 0 873,707 3,771 66.6				-	1			1
66.00 06-600 PHYSICAL THERAPY 2,126 732,033 0 1,008,784 2,126 66.6 0 06-60 WHEATFILED PT 9,439 266,731 0 629,155 9,439 66.67 00 06-700			1	•	1			1
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68. 01 06801 WHEATFIELD ST 1,278 79,272 0 138,898 1,278 68.	67. 01		1, 970		l .		1, 970	67. 01
17.00	68. 00	06800 SPEECH PATHOLOGY	365	94, 572	C	129, 294	365	68. 00
12 00 07200 IMPL DEV. CHARGED TO PATIENTS 0 0 0 181, 781 0 72.			1	79, 272	1			
73.00 O7300 DRUGS CHARGED TO PATIENTS 0 0 0 2,534,982 0 73.			1	-	1			
BR. 00 BBSO RURAL HEALTH CLINIC IV 2,572 294,718 0 416,282 2,572 88.			1					
88. 03 08801 RURAL HEALTH CLINIC 0 274, 189 0 329, 942 0 88. 88. 88. 88. 98801 RURAL HEALTH CLINIC IV 2,572 294,718 0 416, 282 2,572 88. 99. 90. 00 09000 CLINIC 12,926 891, 125 0 1,552,455 12,926 99. 90. 01 09000 CLINIC 7,827 1,006,742 0 2,842,231 7,827 90. 01 09000 CLINIC 1,552,455 12,926 99. 90. 01 09000 EMERGENCY 7,827 1,006,742 0 2,842,231 7,827 90. 01 09000 EMERGENCY 7,827 1,006,742 0 2,842,231 7,827 90. 01 09000 FERRICAL PURPOSE COST CENTERS	73.00		l ol			2, 554, 962	0	73.00
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194. 00 07950 ALTERNACARE 6, 250 630, 744 0 1, 023, 011 6, 250 194. 01 07951 DME EQUI PMENT 0 0 0 0 0 0 194. 01 07952 194. 03 07957 JOHNSON FITNESS 2, 096 0 0 0 0 0 0 194. 03 07957 JOHNSON FITNESS 0 0 0 0 0 0 0 194. 04 07953 194. 05 07954 MEALS ON WHEELS 0 0 0 0 0 0 194. 04 07955 07954 MEALS ON WHEELS 0 0 0 0 0 0 194. 04 07955 07954 MEALS ON WHEELS 0 0 0 0 0 0 0 0 0			0	0	C	0		192. 00
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194. 02 07952 WHEATFIELD FITNESS 2,096 0 0 65,600 2,096 194.03 07957 JOHNSON FITNESS 0 0 0 0 194.03 07957 JOHNSON FITNESS 0 0 0 0 0 194.04 07953 FOUNDATION 0 0 0 0 0 0 194.04 07953 FOUNDATION 0 0 0 0 0 0 194.04 07958 WALES ON WHEELS 0 0 0 0 0 0 194.05 07955 WATER LAB 0 0 0 0 0 0 0 194.05 07955 WATER LAB 0 0 0 0 0 0 194.05 07958 UNDOCCUPIED SPACE 2,302 0 0 72,048 2,302 194.05 194.09 07959 LAFAYETTE HHA BRANCH 2,970 0 0 92,955 2,970 194.05 194.09 07959 LAFAYETTE HHA BRANCH 2,970 0 0 92,955 2,970 194.05 19			6, 250	630, /44	ı	.,		
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206.00 NAHE adjustment amount to be allocated 206.0	∠∪5. 00			0. 005809		0.01/3/2	5.012/50	205.00
	206.00							206. 00
		(per Wkst. B-2)]					
	207. 00							207. 00
Parts III and IV)			1 I		I			I

In Lieu of Form CMS-2552-10 Health Financial Systems FRANCISCAN HEALTH RENSSELAER COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-1324 Peri od: Worksheet B-1 From 01/01/2020 12/31/2020 Date/Time Prepared: 8/2/2021 9: 26 am Cost Center Description LAUNDRY & HOUSEKEEPI NG DI ETARY CAFETERI A NURSI NG LINEN SERVICE (SQUARE FEET) (MEALS SERVED) (SALARIES) ADMI NI STRATI ON (POUNDS OF (NURSING SA LAUNDRY) LARI ES) 8.00 9.00 10.00 11.00 13.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 00700 OPERATION OF PLANT 7.00 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 142, 587 8.00 00900 HOUSEKEEPI NG 9.00 57, 930 9 00 10.00 01000 DI ETARY 1, 233 1,749 21,821 10.00 11.00 01100 CAFETERI A 2, 324 8, 113, 164 11.00 0 C 01300 NURSING ADMINISTRATION 0 399 0 4, 130, 180 13 00 236, 133 13 00 14.00 01400 CENTRAL SERVICES & SUPPLY 0 0 31, 266 0 14.00 15.00 01500 PHARMACY 0 1, 095 0 277, 421 0 15.00 01600 MEDICAL RECORDS & LIBRARY 0 0 0 16.00 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 36, 601 8, 631 10, 323 1, 465, 686 1, 082, 791 30.00 03100 INTENSIVE CARE UNIT 31.00 13,018 753 527 466, 557 466, 557 31.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 13, 216 697,000 343, 467 50.00 05400 RADI OLOGY-DI AGNOSTI C 11, 615 5, 191 0 852, 269 368, 082 54.00 54.00 2, 828 60.00 06000 LABORATORY 0 60.00 0 0 06300 BLOOD STORING, PROCESSING & TRANS. 0 63.00 0 0 63 00 06500 RESPIRATORY THERAPY 65.00 1, 132 3, 771 0 571, 271 0 65.00 06600 PHYSI CAL THERAPY 66.00 11, 898 2, 126 732, 033 66.00 66, 01 06601 WHEATFIELD PT 0 0 66.01 0 06700 OCCUPATIONAL THERAPY 0 431 0 67.00 131, 500 0 67.00 67.01 06701 WHEATFIELD OT 0 0 67.01 06800 SPEECH PATHOLOGY 0 0 68.00 365 94.572 0 68.00 0 06801 WHEATFIELD ST 0 68.01 0 68.01 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 71.00 Ω 0 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 72.00 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 0 0 0 73.00 OUTPATIENT SERVICE COST CENTERS 88 00 88.00 08800 RURAL HEALTH CLINIC 0 0 0 0 0 08801 RURAL HEALTH CLINIC IV 0 88.03 88.03 0 90.00 09000 CLI NI C 7, 202 12, 926 891, 125 862, 541 90.00 09001 WOUND CARE 90.01 989 0 28, 845 90.01 1.226 0 0 91.00 09100 EMERGENCY 16,823 7,827 1, 006, 742 1,006,742 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 113, 964 51, 405 10, 850 7, 482, 420 4, 130, 180 118. 00 118.00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 275 0 190. 00 0 192.00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 C 0 192. 01 19201 RENSSELAER HEALTH CENTER 0 0 0 0 192. 01 194. 00 07950 ALTERNACARE 28, 623 6, 250 10, 971 630, 744 0 194.00 194. 01 07951 DME EQUIPMENT 0 0 194. 01 0 C 0 194. 02 07952 WHEATFIELD FITNESS 0 194 02 0 0 C 0 194.03 07957 JOHNSON FITNESS 0 C 0 0 0 194. 03 194. 04 07953 FOUNDATION 0 0 194. 04 0 0 0 0 194.05 07954 MEALS ON WHEELS 0 0 194.05 194.06 07955 WATER LAB 0 194.06 C 0 194. 07 07956 ADVERTI SI NG 0 0 0 0 194. 07 194. 08 07958 UNOCCUPI ED SPACE 0 0 0 194. 08 0 194. 09 07959 LAFAYETTE HHA BRANCH 0 O 0 194.09 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201.00 Cost to be allocated (per Wkst. B, 202.00 284, 672 793, 843 408, 834 491, 071 676, 750 202. 00 Part I) 0. 163855 203. 00 203 00 Unit cost multiplier (Wkst. B, Part I) 1.996479 13.703487 18.735805 0.060528 204.00 Cost to be allocated (per Wkst. B, 71, 228 93, 329 27, 249 204. 00 60,811 75, 647 Part II) 205.00 Unit cost multiplier (Wkst. B, Part 0. 426483 1.305835 3. 264195 0.011503 0.006598 205.00

206. 00

207. 00

II)

(per Wkst. B-2)

Parts III and IV)

NAHE adjustment amount to be allocated

NAHE unit cost multiplier (Wkst. D,

206.00

207.00

| Period: | Worksheet B-1 | From 01/01/2020 | To 12/31/2020 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-1324

					To 12/31/2020 Date/Time Pr 8/2/2021 9:2	
	Cost Center Description	CENTRAL SERVI CES & SUPPLY (COSTED REQ UISITIONS)	PHARMACY (COSTED REQ UI SI TI ONS)	MEDI CAL RECORDS & LI BRARY (GROSS CHARGES)	672/2021 9.2	20 dili
	GENERAL SERVICE COST CENTERS	14. 00	15. 00	16. 00		
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 DIETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	934, 043 5, 379	2, 479, 768			1. 00 4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00
	01600 MEDI CAL RECORDS & LI BRARY	0	0	80, 054, 188	3	16. 00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	5, 120	702	4, 271, 206		30.00
	03100 INTENSIVE CARE UNIT ANCILLARY SERVICE COST CENTERS	728	0	179, 410	J	31. 00
50. 00 54. 00 60. 00 63. 00 65. 00 66. 01 67. 00 67. 01 68. 00 68. 01 71. 00 72. 00 73. 00	05000 OPERATING ROOM 05400 RADIOLOGY-DIAGNOSTIC 06000 LABORATORY 06300 BLOOD STORING, PROCESSING & TRANS. 06500 RESPIRATORY THERAPY 06600 PHYSICAL THERAPY 06600 WHEATFIELD PT 06700 OCCUPATIONAL THERAPY 06701 WHEATFIELD OT 06800 SPEECH PATHOLOGY 06801 WHEATFIELD ST 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 0UTPATIENT SERVICE COST CENTERS	2, 600 33, 905 1, 700 26, 278 26, 380 6, 257 1, 863 10 440 290 60 605, 313 181, 781	3, 568 153 544 0 0 79 146 0 0 0 0 0 0	2, 813, 691 10, 889, 978 10, 865, 841 81, 354 2, 372, 379 2, 325, 308 1, 483, 209 563, 043 208, 644 210, 788 339, 460 5, 923, 176 1, 599, 446 25, 255, 819		50. 00 54. 00 60. 00 63. 00 65. 00 66. 01 67. 00 67. 01 68. 00 68. 01 71. 00 72. 00 73. 00
	08800 RURAL HEALTH CLINIC	2, 065	15, 027	124, 977	7	88. 00
90. 00 90. 01 91. 00 92. 00	08801 RURAL HEALTH CLINIC IV 09000 CLINIC 09001 WOUND CARE 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 722 16, 783 543 6, 331	14, 266 60 454 323	184, 891 3, 441, 360 264, 087 6, 656, 121	7	88. 03 90. 00 90. 01 91. 00 92. 00
118. 00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	925, 248	2, 479, 768	80, 054, 188	3	118. 00
	NONREI MBURSABLE COST CENTERS	E 401	ما			100.00
192. 00 192. 01 194. 00 194. 01 194. 02 194. 03 194. 04 194. 05 194. 06 194. 07	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES 19201 RENSSELAER HEALTH CENTER 07950 ALTERNACARE 07951 DME EQUIPMENT 07952 WHEATFIELD FITNESS 07953 FOUNDATION 07954 WATER LAB 07956 ADVERTISING 07958 UNOCCUPIED SPACE 07959 LAFAYETTE HHA BRANCH Cross Foot Adjustments Negative Cost Centers Cost to be allocated (per Wkst. B, Part I)	5, 481 0 0 3, 314 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0	646, 375		190. 00 192. 00 192. 01 194. 00 194. 01 194. 02 194. 03 194. 04 194. 05 194. 06 194. 07 194. 08 194. 09 200. 00 201. 00 202. 00
203. 00 204. 00	Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B,	0. 770903 164, 207	0. 298017 55, 442	0. 008074 66, 043		203. 00 204. 00
205. 00	Part II) Unit cost multiplier (Wkst. B, Part II)	0. 175802	0. 022358	0. 000825	5	205. 00
206. 00	NAHE adjustment amount to be allocated (per Wkst. B-2)					206. 00
207. 00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)					207. 00

Health Financial Systems	FRANCI SCAN HEALTH RENSSELAER	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-1324	Peri od: Worksheet C
		From 01/01/2020 Part I
		To 12/21/2020 Doto/Time December

				To 12/31/2020	Part I Date/Time Pre 8/2/2021 9:26	
		Title	XVIII	Hospi tal	Cost	
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	(from Wkst. B,	Adj .		Di sal I owance		
	Part I, col.					
	26)	0.00	0.00			
INDATIENT DOUTINE CEDVICE COST CENTEDS	1.00	2. 00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS 30.00 O3000 ADULTS & PEDIATRICS	3, 303, 648		3, 303, 64	اه ام	0	30.00
31. 00 03000 ADULTS & PEDITATRICS	1, 003, 949		1, 003, 94		0	
ANCILLARY SERVICE COST CENTERS	1,003,949		1, 003, 94	9 0	0	31.00
50. 00 05000 0PERATI NG ROOM	1, 604, 643		1, 604, 64	3 0	0	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 237, 960		2, 237, 96		0	
60. 00 06000 LABORATORY	3, 108, 574		3, 108, 57		0	
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	64, 188		64, 18		0	63.00
65. 00 06500 RESPIRATORY THERAPY	1, 430, 470	0	1, 430, 47		0	65.00
66. 00 06600 PHYSI CAL THERAPY	1, 566, 402	0	1, 566, 40	2 0	0	66. 00
66. 01 06601 WHEATFI ELD PT	1, 127, 124	0	1, 127, 12	4 0	0	66. 01
67. 00 06700 OCCUPATI ONAL THERAPY	273, 551	0	273, 55	1 0	0	67. 00
67. 01 06701 WHEATFI ELD OT	290, 047	0	290, 04	7 0	0	
68.00 06800 SPEECH PATHOLOGY	200, 348	0	200, 34		0	
68. 01 06801 WHEATFI ELD ST	227, 585	0	227, 58		0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 340, 218		1, 340, 21		0	1
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	403, 526		403, 52		0	1
73. 00 O7300 DRUGS CHARGED TO PATIENTS	4, 425, 372		4, 425, 37	2 0	0	73. 00
OUTPATIENT SERVICE COST CENTERS						
88. 00 08800 RURAL HEALTH CLINIC	461, 707		461, 70		0	
88. 03 08801 RURAL HEALTH CLINIC IV	647, 905		647, 90		0	00.00
90. 00 09000 CLI NI C	2, 904, 564		2, 904, 56		0	1 ,0.00
90. 01 09001 WOUND CARE	138, 977		138, 97		0	1 ,0.0.
91. 00 09100 EMERGENCY	4, 546, 394		4, 546, 39		0	1 / 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 200.00 Subtotal (see instructions)	863, 669 32, 170, 821	_	863, 66 32, 170, 82		0	92. 00 200. 00
201.00 Less Observation Beds	863, 669	U	863, 66			200.00
202. 00 Total (see instructions)	31, 307, 152	0				201.00
202.00 10tal (366 1113t1 46t1 0113)	31,307,132	U	1 31,307,13	<u>-</u> 1	ı o	1202.00

Health Financial Systems	FRANCI SCAN HEALTH RENSSELAER	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-1324	Peri od: Worksheet C
		From 01/01/2020 Part I
		To 12/21/2020 Doto/Time December

					o 12/31/2020	Date/Time Pre 8/2/2021 9:26	
			Title	XVIII	Hospi tal	Cost	
			Charges				
	Cost Center Description	Inpati ent	Outpati ent	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient	
				1 001. 7)	Ratio	Ratio	
		6. 00	7. 00	8.00	9. 00	10. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	2, 583, 206		2, 583, 206			30. 00
31.00	03100 INTENSIVE CARE UNIT	179, 410		179, 410)		31. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	208, 803	2, 604, 888	2, 813, 691	0. 570298	0.000000	50. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	473, 501	10, 416, 477			0.000000	
60.00	06000 LABORATORY	1, 074, 791	9, 791, 050			0.000000	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	17, 709	63, 645			0.000000	
65. 00	06500 RESPI RATORY THERAPY	390, 449	1, 981, 930			0.000000	
66. 00	06600 PHYSI CAL THERAPY	273, 201	2, 052, 107			0. 000000	
66. 01	06601 WHEATFI ELD PT	23, 787	1, 459, 422			0. 000000	
67. 00	06700 OCCUPATI ONAL THERAPY	277, 057	285, 986			0. 000000	
67. 01	06701 WHEATFI ELD OT	6, 588	202, 056	·		0. 000000	
68. 00	06800 SPEECH PATHOLOGY	28, 900	181, 888	·		0. 000000	
68. 01	06801 WHEATFI ELD ST	0	339, 460			0. 000000	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	595, 982	5, 327, 194			0. 000000	
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	474, 796	1, 124, 650			0. 000000	
73. 00	07300 DRUGS CHARGED TO PATIENTS	1, 326, 845	23, 928, 974	25, 255, 819	0. 175222	0. 000000	73. 00
	OUTPATIENT SERVICE COST CENTERS	T					
88. 00	08800 RURAL HEALTH CLINIC	0	124, 977	·			88. 00
88. 03	08801 RURAL HEALTH CLINIC IV	0	184, 891	·			88. 03
90.00	09000 CLI NI C	26, 752	3, 414, 608			0. 000000	
90. 01	09001 WOUND CARE	0	264, 087	·		0. 000000	90. 01
91.00	09100 EMERGENCY	253, 792	6, 402, 329				91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	33, 140	1, 654, 860			0. 000000	
200.00		8, 248, 709	71, 805, 479	80, 054, 188	5		200. 00
201.00		0.040.700	74 005 170	00.054.100			201. 00
202.00	Total (see instructions)	8, 248, 709	71, 805, 479	80, 054, 188	§		202. 00

Health Financial Systems	FRANCISCAN HEALTH RENSSELAER	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-1324	Peri od: From 01/01/2020 To 12/31/2020	Worksheet C Part I Date/Time Prepared: 8/2/2021 9:26 am
	Title XVIII	Hospi tal	Cost

			10 12/31/2020	8/2/2021 9: 26 am
		Title XVIII	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 I NTENSI VE CARE UNIT				31.00
ANCILLARY SERVICE COST CENTERS				
50. 00 05000 OPERATI NG 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 WHEATFI ELD PT	0. 000000			66. 01
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000			67. 00
67. 01 06701 WHEATFI ELD OT	0. 000000			67. 01
68. 00 06800 SPEECH PATHOLOGY	0. 000000			68. 00
68. 01 06801 WHEATFI ELD ST	0. 000000			68. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000			71. 00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000			72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73. 00
OUTPATIENT SERVICE COST CENTERS	T T			
88. 00 08800 RURAL HEALTH CLINIC				88. 00
88. 03 08801 RURAL HEALTH CLINIC IV				88. 03
90. 00 09000 CLI NI C	0. 000000			90.00
90. 01 09001 WOUND CARE	0. 000000			90. 01
91. 00 09100 EMERGENCY	0. 000000			91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000			92. 00
200.00 Subtotal (see instructions)				200. 00
201.00 Less Observation Beds				201. 00
202.00 Total (see instructions)				202. 00

Health Financial Systems	FRANCISCAN HEALTH RENSSELAER	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-1324	Period: Worksheet C
		From 01/01/2020 Part I
		To 12/21/2020 Doto/Time Dropared

					To 12/31/2020	Date/Time Pre	
			Ti +I	e XIX	Hospi tal	8/2/2021 9: 26 Cost	am
			11 (1	C ALA	Costs	0031	
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	, , , , , , , , , , , , , , , , , , ,	(from Wkst. B,	Adj .		Di sal I owance		
		Part I, col.	,				
		26)					
		1.00	2. 00	3. 00	4. 00	5. 00	
	IPATIENT ROUTINE SERVICE COST CENTERS						
	3000 ADULTS & PEDIATRICS	3, 303, 648		3, 303, 648	0	3, 303, 648	30. 00
31.00 03	3100 INTENSIVE CARE UNIT	1, 003, 949		1, 003, 949	9 0	1, 003, 949	31. 00
	CILLARY SERVICE COST CENTERS						
	5000 OPERATING ROOM	1, 604, 643		1, 604, 643		1, 604, 643	
	6400 RADI OLOGY-DI AGNOSTI C	2, 237, 960		2, 237, 960		2, 237, 960	
	0000 LABORATORY	3, 108, 574		3, 108, 574		3, 108, 574	
	300 BLOOD STORING, PROCESSING & TRANS.	64, 188		64, 188		64, 188	
	500 RESPI RATORY THERAPY	1, 430, 470	0	1, 430, 470	0	1, 430, 470	
	600 PHYSI CAL THERAPY	1, 566, 402	0	1, 566, 402	2 0	1, 566, 402	
	601 WHEATFIELD PT	1, 127, 124	0	1, 127, 124	1 0	1, 127, 124	
	700 OCCUPATI ONAL THERAPY	273, 551	0	273, 551		273, 551	
	701 WHEATFIELD OT	290, 047	0	290, 047		290, 047	
	800 SPEECH PATHOLOGY	200, 348	l .	200, 348		200, 348	
	801 WHEATFIELD ST	227, 585	l .	227, 585		227, 585	
	100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 340, 218		1, 340, 218	0	1, 340, 218	
	200 IMPL. DEV. CHARGED TO PATIENTS	403, 526	l .	403, 526		403, 526	
	300 DRUGS CHARGED TO PATIENTS	4, 425, 372		4, 425, 372	2 0	4, 425, 372	73. 00
	ITPATIENT SERVICE COST CENTERS						
	8800 RURAL HEALTH CLINIC	461, 707	l .	461, 707		461, 707	1
	8801 RURAL HEALTH CLINIC IV	647, 905	l .	647, 905		647, 905	
	2000 CLI NI C	2, 904, 564		2, 904, 564		2, 904, 564	
	0001 WOUND CARE	138, 977	l e	138, 977		138, 977	
	2100 EMERGENCY	4, 546, 394	l e	4, 546, 394		4, 546, 394	
	0200 OBSERVATION BEDS (NON-DISTINCT PART	863, 669	l e	863, 669		863, 669	
200.00	Subtotal (see instructions)	32, 170, 821		02/1/0/02		32, 170, 821	
201.00	Less Observation Beds	863, 669	l e	863, 669		863, 669	
202.00	Total (see instructions)	31, 307, 152	0	31, 307, 152	2 0	31, 307, 152	202. 00

Health Financial Systems	FRANCISCAN HEALTH RENSSELAER	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-1324	Peri od:	Worksheet C
		From 01/01/2020	
		To 12/21/2020	Data/Timo Droparod

			1	To 12/31/2020	Date/Time Pre 8/2/2021 9:26	
			e XIX	Hospi tal	Cost	
		Charges				
Cost Center Description	Inpati ent	Outpati ent		Cost or Other	TEFRA	
			+ col . 7)	Ratio	Inpatient	
	4 00	7.00	0.00	0.00	Ratio	
INDATIENT DOUTING CEDAL CE COCT CENTEDO	6. 00	7. 00	8. 00	9. 00	10. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	2 502 204		2 502 204			20.00
30. 00 03000 ADULTS & PEDI ATRI CS	2, 583, 206		2, 583, 206			30.00
31. 00 03100 I NTENSI VE CARE UNI T	179, 410		179, 410)]		31. 00
ANCILLARY SERVICE COST CENTERS 50.00 OPERATING ROOM	200 002	2 (04 000	2 012 (01	0, 570298	0.000000	50.00
50. 00 05000 OPERATI NG ROOM 54. 00 05400 RADI OLOGY-DI AGNOSTI C	208, 803	2, 604, 888			0. 000000 0. 000000	54.00
60. 00 06000 LABORATORY	473, 501 1, 074, 791	10, 416, 477 9, 791, 050			0.000000	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	1, 074, 791				0. 000000	63.00
65. 00 06500 RESPIRATORY THERAPY	390, 449	63, 645 1, 981, 930			0.000000	65. 00
66. 00 06600 PHYSI CAL THERAPY	273, 201	2, 052, 107			0.000000	66.00
66. 01 06601 WHEATFI ELD PT	23, 787	1, 459, 422			0.000000	66. 01
67. 00 06700 OCCUPATI ONAL THERAPY	277, 057	285, 986			0. 000000	67. 00
67. 01 06701 WHEATFIELD OT	6, 588	202, 056			0. 000000	67. 01
68. 00 06800 SPEECH PATHOLOGY	28, 900	181, 888			0. 000000	68. 00
68. 01 06801 WHEATFI ELD ST	20, 700	339, 460			0. 000000	68. 01
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	595, 982	5, 327, 194			0. 000000	71. 00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	474, 796	1, 124, 650			0. 000000	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	1, 326, 845	23, 928, 974			0. 000000	73. 00
OUTPATIENT SERVICE COST CENTERS	.,					
88. 00 08800 RURAL HEALTH CLINIC	0	124, 977	124, 977	3. 694336	0.000000	88. 00
88.03 08801 RURAL HEALTH CLINIC IV	0	184, 891	184, 891	3. 504254	0.000000	88. 03
90. 00 09000 CLI NI C	26, 752	3, 414, 608	3, 441, 360	0. 844016	0.000000	90.00
90. 01 09001 WOUND CARE	0	264, 087	264, 087	0. 526255	0.000000	90. 01
91. 00 09100 EMERGENCY	253, 792	6, 402, 329	6, 656, 121	0. 683040	0.000000	91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	33, 140	1, 654, 860	1, 688, 000	0. 511652	0.000000	92. 00
200.00 Subtotal (see instructions)	8, 248, 709	71, 805, 479	80, 054, 188	3		200. 00
201.00 Less Observation Beds						201. 00
202.00 Total (see instructions)	8, 248, 709	71, 805, 479	80, 054, 188	3		202. 00

Health Financial Systems	Health Financial Systems FRANCISCAN HEALTH F				2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1324	From 01/01/2020 To 12/31/2020	Worksheet C Part I Date/Time Prep 8/2/2021 9:26	
		Title XIX	Hospi tal	Cost	aiii
Cost Center Description	PPS Inpatient Ratio				

				8/2/2021 9: 26 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 I NTENSI VE CARE UNI T				31. 00
ANCILLARY SERVICE COST CENTERS				
50. 00 05000 OPERATI NG 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 WHEATFI ELD 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 WHEATFI ELD 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 CLI NI C	0. 000000			90.00
90. 01 09001 WOUND CARE	0. 000000			90. 01
91. 00 09100 EMERGENCY	0. 000000			91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000			92. 00
200.00 Subtotal (see instructions)				200. 00
201.00 Less Observation Beds				201. 00
202.00 Total (see instructions)				202. 00

Health Financial Systems	FRANCI SCAN HEALTH	RENSSELAER	In Lie	u of Form CMS-2552-10
ADDODITIONMENT OF INDATIENT ANGLE	LADV CEDVICE CADITAL COCTO	Drovi don CCN, 1E 1224	Dori od:	Workshoot D

Health Financial Systems	FRANCI SCAN HEAL	TH RENSSELAER		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT	TAL COSTS			Period: From 01/01/2020 To 12/31/2020	Worksheet D Part II Date/Time Pre 8/2/2021 9:26	
		Ti tl e	e XVIII	Hospi tal	Cost	
Cost Center Description	Capi tal	Total Charges		t Inpatient	Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,	Part I, col.	(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3. 00	4. 00	5. 00	
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATING ROOM	370, 134					
54. 00 05400 RADI OLOGY-DI AGNOSTI C	254, 820		1		-	
60. 00 06000 LABORATORY	152, 301		1		-	
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	8, 902				0	63. 00
65. 00 06500 RESPI RATORY THERAPY	173, 998				-	
66. 00 06600 PHYSI CAL THERAPY	118, 264				-	
66. 01 06601 WHEATFI ELD PT	356, 770					
67. 00 06700 OCCUPATI ONAL THERAPY	22, 031		1		931	
67. 01 06701 WHEATFI ELD OT	75, 210		1		1, 326	
68. 00 06800 SPEECH PATHOLOGY	17, 839	210, 788	0. 08463	0 6, 588	558	
68. 01 06801 WHEATFI ELD ST	49, 569	339, 460	0. 14602		0	68. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	121, 711	5, 923, 176	0. 02054	8 270, 829		
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	36, 435	1, 599, 446	0. 02278	374, 879	8, 540	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	119, 525	25, 255, 819	0.00473	3 573, 932	2, 716	73. 00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	8, 127	124, 977	0. 06502	.8	0	88. 00
88.03 08801 RURAL HEALTH CLINIC IV	103, 110	184, 891	0. 55768	0 0	0	88. 03
90. 00 09000 CLI NI C	543, 179	3, 441, 360	0. 15783	8 16, 269	2, 568	90. 00
90. 01 09001 WOUND CARE	39, 718	264, 087	0. 15039	7 0	0	90. 01
91. 00 09100 EMERGENCY	381, 664	6, 656, 121	0. 05734	0 94, 334	5, 409	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	115, 302	1, 688, 000	0. 06830	7, 696	526	92. 00
200.00 Total (lines 50 through 199)	3, 068, 609	77, 291, 572	2	2, 460, 985	72, 690	200. 00

Hea	th Financial Systems	FRAN	CISCAN HEALTH	RENSSELAER	In Lie	u of Form CMS-2552-10
	ORTIONMENT OF INPATIENT/OUTPATIENT DUGH COSTS	ANCILLARY SERVICE	OTHER PASS	Provider CCN: 15-1324	Peri od: From 01/01/2020 To 12/31/2020	Worksheet D Part IV Date/Time Prepared:

					0 12/31/2020	8/2/2021 9: 26	
			Title	XVIII	Hospi tal	Cost	
	Cost Center Description	Non Physician	Nursing School	Nursing School	Allied Health	Allied Health	
		Anesthetist	Post-Stepdown		Post-Stepdown		
		Cost	Adjustments		Adjustments		
		1.00	2A	2.00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATI NG ROOM	0	0	(0	0	50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0	(0	0	54.00
60.00	06000 LABORATORY	0	0	(0	0	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	(0	0	63. 00
65.00	06500 RESPI RATORY THERAPY	0	0	(0	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	0	(0	0	66. 00
66. 01	06601 WHEATFIELD PT	0	0	(0	0	66. 01
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	(0	0	67. 00
	06701 WHEATFIELD OT	0	0	(0	0	67. 01
68. 00	06800 SPEECH PATHOLOGY	0	0	(0	0	68. 00
68. 01	06801 WHEATFIELD ST	0	0	(0	0	68. 01
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	(0	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	(0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	(0	0	73. 00
	OUTPATIENT SERVICE COST CENTERS						
	08800 RURAL HEALTH CLINIC	0	0	(0	0	88. 00
	08801 RURAL HEALTH CLINIC IV	0	0	(0	0	88. 03
	09000 CLI NI C	0	0	(0	0	90.00
	09001 WOUND CARE	0	0	(0	0	90. 01
	09100 EMERGENCY	0	0	(0	0	91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0)	(0	92. 00
200.00	Total (lines 50 through 199)	0) 0	(0	0	200. 00

Health Financial Systems	FRANCISCAN HEALTH	RENSSELAER	In Lieu	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-1324		Worksheet D
THROUGH COSTS			From 01/01/2020	Part IV

THROUGH COSTS				Γο 12/31/2020		
			XVIII	Hospi tal	Cost	
Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,		
	Education Cost		Cost (sum of	· ·	(col. 5 ÷ col.	
		4)	col s. 2, 3,	8)	7)	
			and 4)		(see	
	4.00			7.00	instructions)	
ANOULLA DV. OF DV. OF COOT OF NTERO	4. 00	5. 00	6. 00	7. 00	8. 00	
ANCILLARY SERVICE COST CENTERS			.1	0.010.404		
50. 00 05000 OPERATING ROOM	0	0		2, 813, 691	0.000000	
54. 00 05400 RADI OLOGY - DI AGNOSTI C	0	0		10, 889, 978		
60. 00 06000 LABORATORY	0	0		10, 865, 841		
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		81, 354		
65. 00 06500 RESPIRATORY THERAPY	0	0		2, 372, 379		65. 00
66. 00 06600 PHYSI CAL THERAPY	0	0		2, 325, 308		66. 00
66. 01 06601 WHEATFI ELD PT	0	0		1, 483, 209		
67. 00 06700 0CCUPATI ONAL THERAPY	0	0		563, 043		
67. 01 06701 WHEATFI ELD OT	0	0		208, 644		
68. 00 06800 SPEECH PATHOLOGY	0	0		210, 788		
68. 01 06801 WHEATFI ELD ST	0	0)	339, 460		
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0)	5, 923, 176		
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0)	1, 599, 446		72. 00
73.00 O7300 DRUGS CHARGED TO PATIENTS	0	0) (25, 255, 819	0. 000000	73. 00
OUTPATIENT SERVICE COST CENTERS	_	_				
88.00 08800 RURAL HEALTH CLINIC	0	0)	124, 977		
88.03 08801 RURAL HEALTH CLINIC IV	0	0)	184, 891	0. 000000	
90. 00 09000 CLI NI C	0	0)	3, 441, 360		
90. 01 09001 WOUND CARE	0	0)	264, 087		
91. 00 09100 EMERGENCY	0	0)	6, 656, 121		
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0)	1, 688, 000		
200.00 Total (lines 50 through 199)	0	0) (77, 291, 572		200. 00

Health Financial Systems	FRANCI SCAN HEAL	TH RENSSELAER		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLA THROUGH COSTS	RY SERVICE OTHER PASS	Provider C		Period: From 01/01/2020 To 12/31/2020		
		Title	: XVIII	Hospi tal	Cost	
Cost Center Description	Outpatient Ratio of Cost	Inpatient Program	Inpatient Program	Outpatient Program	Outpatient Program	
	to Charges (col. 6 ÷ col.	Charges	Pass-Through	Charges	Pass-Through Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13. 00	

	Cost Center Description	Outpati ent	I npati ent	I npati ent	Outpati ent	Outpati ent	
		Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through	Charges	Pass-Through	
		(col. 6 ÷ col.		Costs (col. 8		Costs (col. 9	
		7)		x col. 10)		x col. 12)	
		9.00	10.00	11.00	12.00	13. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	0. 000000	126, 402	0	0	0	50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	209, 088	0	0	0	54.00
60.00	06000 LABORATORY	0. 000000	543, 166	0	0	0	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	0	0	0	0	63.00
65.00	06500 RESPI RATORY THERAPY	0. 000000	175, 395	0	0	0	65.00
66. 00	06600 PHYSI CAL THERAPY	0. 000000	30, 845	0	0	0	66. 00
66. 01	06601 WHEATFI ELD PT	0. 000000	4, 096	0	0	0	66. 01
67. 00	06700 OCCUPATI ONAL THERAPY	0. 000000	23, 787	0	0	0	67.00
67. 01	06701 WHEATFI ELD OT	0. 000000	3, 679	0	0	0	67. 01
68. 00	06800 SPEECH PATHOLOGY	0. 000000	6, 588	0	0	0	68. 00
68. 01	06801 WHEATFI ELD ST	0. 000000	0	0	0	0	68. 01
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	270, 829	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	374, 879	0	0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	573, 932	0	0	0	73. 00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0.000000	0	0	0	0	88. 00
88. 03	08801 RURAL HEALTH CLINIC IV	0. 000000	0	0	0	0	88. 03
90.00	09000 CLI NI C	0. 000000	16, 269	0	0	0	90. 00
90. 01	09001 WOUND CARE	0. 000000	0	0	0	0	90. 01
91.00	09100 EMERGENCY	0. 000000	94, 334	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	7, 696	0	0	0	92.00
200.00			2, 460, 985	0	0	0	200. 00

In Lieu of Form CMS-2552-10
Worksheet D
01/2020 Part V
01/2020 Date/Time Prepared:
8/2/2021 9: 26 am
tal Cost Provider CCN: 15-1324 Peri od: From 01/01/2020 To 12/31/2020 Title XVIII Hospi tal

				Charges		Costs	
	Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
		Ratio From	Services (see	Reimbursed	Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins.	Ded. & Coins.		
				(see inst.)	(see inst.)		
- In		1.00	2. 00	3. 00	4. 00	5. 00	
	NCILLARY SERVICE COST CENTERS		1			I	
	05000 OPERATING ROOM	0. 570298		730, 062		0	50.00
	05400 RADI OLOGY-DI AGNOSTI C	0. 205506	0	3, 559, 164		0	54. 00
	06000 LABORATORY	0. 286087	0	1, 543, 670		0	60.00
	06300 BLOOD STORING, PROCESSING & TRANS.	0. 788996		34, 860		0	63. 00
	06500 RESPI RATORY THERAPY	0. 602969		859, 310		0	65. 00
	06600 PHYSI CAL THERAPY	0. 673632		1, 348, 972		0	66. 00
	06601 WHEATFI ELD PT	0. 759923		15, 994		0	66. 01
	06700 OCCUPATI ONAL THERAPY	0. 485844		89, 654		0	67. 00
	06701 WHEATFIELD OT	1. 390153		707	0	0	67. 01
	06800 SPEECH PATHOLOGY	0. 950472		33, 256	0	0	68. 00
68. 01 0	06801 WHEATFIELD ST	0. 670432	0	191	0	0	68. 01
71.00 0	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 226267	0	1, 366, 860	0	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 252291	0	364, 621	0	0	72. 00
	07300 DRUGS CHARGED TO PATIENTS	0. 175222	0	11, 708, 573	0	0	73. 00
0	OUTPATIENT SERVICE COST CENTERS						
88.00 0	08800 RURAL HEALTH CLINIC						88. 00
88. 03 0	08801 RURAL HEALTH CLINIC IV						88. 03
90.00	09000 CLI NI C	0. 844016	0	1, 482, 521	0	0	90. 00
90. 01 0	09001 WOUND CARE	0. 526255	0	67, 975	0	0	90. 01
91.00	99100 EMERGENCY	0. 683040	0	1, 863, 393	0	0	91.00
92.00 0	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 511652	0	928, 319	0	0	92.00
200.00	Subtotal (see instructions)		0	25, 998, 102	0	0	200. 00
201.00	Less PBP Clinic Lab. Services-Program			0	0		201. 00
	Only Charges						
202. 00	Net Charges (line 200 - line 201)		o	25, 998, 102	0	0	202. 00

Health Financial Systems	FRANCI SCAN HEALTH	RENSSELAER	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-1324	From 01/01/2020	Worksheet D Part V Date/Time Prepared:

				To 12/31/2020	Date/Time Pre 8/2/2021 9:26	
		Title	XVIII	Hospi tal	Cost	
	Cos	sts				
Cost Center Description	Cost	Cost				
	Rei mbursed	Rei mbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
	6. 00	7. 00				
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	416, 353	l .)			50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	731, 430)			54. 00
60. 00 06000 LABORATORY	441, 624	l .)			60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	27, 504	0)			63. 00
65. 00 06500 RESPI RATORY THERAPY	518, 137	0)			65. 00
66. 00 06600 PHYSI CAL THERAPY	908, 711	0)			66. 00
66. 01 06601 WHEATFI ELD PT	12, 154	l .)			66. 01
67. 00 06700 OCCUPATI ONAL THERAPY	43, 558)			67. 00
67. 01 06701 WHEATFI ELD OT	983)			67. 01
68.00 06800 SPEECH PATHOLOGY	31, 609	l e)			68. 00
68. 01 06801 WHEATFI ELD ST	128	l e)			68. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	309, 275	0)			71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	91, 991	0)			72. 00
73.00 O7300 DRUGS CHARGED TO PATIENTS	2, 051, 600	0)			73. 00
OUTPAȚIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC						88. 00
88.03 08801 RURAL HEALTH CLINIC IV						88. 03
90. 00 09000 CLI NI C	1, 251, 271	0)			90.00
90. 01 09001 WOUND CARE	35, 772	0)			90. 01
91. 00 09100 EMERGENCY	1, 272, 772	0)			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	474, 976	0)			92.00
200.00 Subtotal (see instructions)	8, 619, 848	0)			200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201. 00
Only Charges						
202.00 Net Charges (line 200 - line 201)	8, 619, 848	0)			202. 00

Provider CCN: 15-1324 Worksheet D From 01/01/2020 Part V 12/31/2020 Date/Time Prepared: 8/2/2021 9: 26 am Title XIX Hospi tal Cost Charges Costs Cost to Charge PPS Reimbursed PPS Services Cost Center Description Cost Cost Services (see Rei mbursed Ratio From Rei mbursed (see inst.) Worksheet C, inst.) Servi ces Services Not Part I, col. 9 Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) 3.00 (see inst.) 1. 00 2.00 5. 00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 570298 417, 548 0 50.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0. 205506 0 1, 580, 446 54.00 0 60. 00 06000 LABORATORY 0. 286087 0 0 60.00 1, 503, 809 0 06300 BLOOD STORING, PROCESSING & TRANS. 0 63.00 0.788996 0 7, 427 0 63.00 65. 00 06500 RESPIRATORY THERAPY 0.602969 263, 482 0 65.00 66.00 06600 PHYSI CAL THERAPY 0.673632 0 0 439, 797 0 66.00 06601 WHEATFIELD PT 0.759923 0 0 66. 01 0 0 66.01 67.00 06700 OCCUPATIONAL THERAPY 0. 485844 0 0 67.00 06701 WHEATFIELD OT 1. 390153 0 0 67.01 0 0 67.01 0 06800 SPEECH PATHOLOGY 0. 950472 68.00 0 68, 459 68 00 0 68.01 06801 WHEATFIELD ST 0.670432 0 2, 324 0 68.01 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0. 226267 0 0 738, 459 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 0. 252291 0 0 208, 407 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 0. 175222 0 0 1, 214, 525 73.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 88.00 08801 RURAL HEALTH CLINIC IV 88. 03 88.03 09000 CLI NI C 0.844016 0 313, 493 0 90.00 90.00 0 90.01 09001 WOUND CARE 0. 526255 50, 329 0 90.01 09100 EMERGENCY 0.683040 0 1, 318, 614 91.00 91.00 0 0 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 92.00 0.511652 0 248, 160 0 200.00 8, 375, 279 0 200. 00 Subtotal (see instructions) Ω 201.00 Less PBP Clinic Lab. Services-Program 0 201. 00 Only Charges

0

0

8, 375, 279

0 202.00

202.00

Net Charges (line 200 - line 201)

				To 12/31/2020	Part V Date/Time Pre 8/2/2021 9:26	
		Titl	e XIX	Hospi tal	Cost	
	Cos	sts				
Cost Center Description	Cost	Cost				
	Rei mbursed	Rei mbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coi ns.	Ded. & Coins.				
	(see inst.) 6.00	(see inst.) 7.00	-			
ANCI LLARY SERVI CE COST CENTERS	6.00	7.00				
50. 00 05000 OPERATING ROOM		238, 127	,			50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		324, 791				54.00
60. 00 06000 LABORATORY		430, 220	1			60.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.		5, 860				63.00
65. 00 06500 RESPIRATORY THERAPY		158, 871				65. 00
66. 00 06600 PHYSI CAL THERAPY		296, 261	1			66.00
66. 01 06601 WHEATFI ELD PT		2,0,201				66. 01
67. 00 06700 OCCUPATI ONAL THERAPY		0				67. 00
67. 01 06701 WHEATFI ELD OT	0	Ō				67. 01
68.00 06800 SPEECH PATHOLOGY	0	65, 068				68. 00
68. 01 06801 WHEATFI ELD ST	0	1, 558	8			68. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	167, 089				71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	52, 579				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	212, 811				73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC						88. 00
88.03 08801 RURAL HEALTH CLINIC IV						88. 03
90. 00 09000 CLI NI C	0	264, 593	•			90.00
90. 01 09001 WOUND CARE	0	26, 486				90. 01
91. 00 09100 EMERGENCY	0	900, 666				91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	126, 972	•			92. 00
200.00 Subtotal (see instructions)	0	3, 271, 952	2			200. 00
201.00 Less PBP Clinic Lab. Services-Program	0					201. 00
Only Charges		2 271 052	,			202 00
202.00 Net Charges (line 200 - line 201)	0	3, 271, 952	[202. 00

Health Financial Systems	FRANCI SCAN HEALTH RENSSELAER	SELAER In Lieu of Form CMS-2552-10			
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-	-1324 Peri od: From 01/01/2020	Worksheet D-1		
		To 12/31/2020	Date/Time Pre 8/2/2021 9:26		
	Title XVIII	Hospi tal	Cost		
Cost Center Description		-			

Dietr 1. M. 1900/1907 to Compension Dietr 1. M. 1900/1907 to Compension			Title XVIII	Hospi tal	Cost	
INPATITION DAYS Impatient days (Including private room days and saing-bed days, excluding newborn) 2,000 1,000		Cost Center Description			1 00	
Imparition Todays 1.00 Impartion days (including private room days and swing-bed days, excluding newborn) 2,00 1.00 Impation days (including private room days, excluding swing-bed and newborn days) 3,00 2,00 1.00		PART I - ALL PROVIDER COMPONENTS			1.00	
Inpatient days (including private room days, excluding saing-bed and newborn days) 1,668 2,00						
Private room days (excluding seing-bed and observation bed days) If you have only private room days. 0 3.00						
do not complete this line. 4.00 Selli-private room days (excluding swing-bed and observation bod days) 1.000 Intal swing-bod SW type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 7.00 Total swing-bod SW type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 7.00 Total swing-bod SW type inpatient days (including private room days) after December 31 of the cost of calendar year, enter 0 on this line) 8.00 Total swing-bod SW type inputient days (including private room days) after December 31 of the cost on the cost of the cost reporting period (if calendar year, enter 0 on this line) 9.00 Total swing-bod SW type inputient days (including private room days) after December 31 of the cost on the swing-bod swing-bod and provide on the swing-bod swing-bod swing-bod and provide on the swing-bod swi						
Semi_private room days (excluding swing-bed and observation bed days) 1,000 4,00	3.00		(S). If you have only pri	vate room days,	U	3.00
Total saring bed SW Type Inpatient days (Including private room days) after December 31 of the cost	4.00		ed days)		1, 000	4. 00
Total swing-bed SNF type inpatient days (including private room days) after becember 31 of the cost reporting period (if cal endar year, enter 0 on this line) 7.00	5.00	Total swing-bed SNF type inpatient days (including private roo		31 of the cost	896	5. 00
reporting period (if calendar year, enter 0 on this line) 7.00 Total swing-bed Nr type inpatient days (including private room days) after December 31 of the cost reporting period 8.00 Total sing bed Nr type inpatient days (including private room days) after December 31 of the cost 7.00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newton days) including private room days applicable to the Program (excluding swing-bed and newton days) including private room days applicable to the Program (excluding swing-bed and horse) instructions) 10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after through December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including days) after December 31 of the cost reporting period (including days) after December 31 of the cost reporting period (including days						,
Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost of lotal swing-bed NF type inpatient days (including private room days) after December 31 of the cost of reporting period (if calendar year, enter 0 on this line) 1.00 principal period (if calendar year, enter 0 on t	6.00	lotal swing-bed SNF type inpatient days (including private roo	om days) after December 3	31 of the cost	0	6.00
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24. 00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 49, 451	23. 00		31 of the cost reporting	g period (line 6	0	23. 00
7 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 vine 20) 26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 27.00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 + line 28) 32.00 Average private room per diem charge (line 29 + line 3) 33.00 Average semi-private room per diem charge (line 30 + line 4) 34.00 Average per diem private room cost differential (line 32 x line 31) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 124, 493) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 124, 493) 37.00 Private room cost differential adjustment (line 3 x line 35) 38.00 Algusted general inpatient routine service cost per diem (see instructions) 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 40.00 Value (line 14 x line 35)	24.00		21 of the cost managetin	na ported (Line	40.451	24.00
x line 20) 26. 00 Total swing-bed cost (see instructions) 27. 00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 27. 00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28. 00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 28. 00 Private room charges (excluding swing-bed charges) 30. 00 Semi-private room charges (excluding swing-bed charges) 31. 00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32. 00 Average private room per diem charge (line 29 ÷ line 3) 33. 00 Average semi-private room per diem charge (line 30 ÷ line 4) 34. 00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35. 00 Average per diem private room cost differential (line 34 x line 31) 36. 00 Private room cost differential adjustment (line 3 x line 35) 37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 124, 493) 38. 00 Adjusted general inpatient routine service cost per diem (see instructions) 38. 00 Adjusted general inpatient routine service cost (line 9 x line 38) 40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 40. 00 40. 00	24.00		31 of the cost reportin	ig perrou (Trile	49, 451	24.00
Total swing-bed cost (see instructions) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERNTIAL ADJUSTMENT Ceneral inpatient routine service charges (excluding swing-bed and observation bed charges) Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) Ceneral inpatient routine service cost/charge ratio (line 27 ÷ line 28) Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 minus line 33)(see instructions) Average per diem private room cost differential (line 34 x line 31) Average per diem private room cost differential (line 3 x line 35) Private room cost differential adjustment (line 3 x line 35) Ceneral inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 124, 493) Adjusted general inpatient routine service cost (line 9 x line 38) Program general inpatient routine service cost (line 9 x line 38) Medically necessary private room cost applicable to the Program (line 14 x line 35) O 40.00 Average per diem private room cost applicable to the Program (line 14 x line 35) O 40.00	25. 00	Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	period (line 8	0	25. 00
27. 00 Common	27.00				1 170 155	27 00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) O 28.00 29.00 Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) O 29.00 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) Average private room per diem charge (line 29 + line 3) Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 minus line 33) (see instructions) Average per diem private room cost differential (line 34 x line 31) Average per diem private room cost differential (line 3 x line 31) O 00 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 124, 493) The program inpatient routine service cost per diem (see instructions) Adjusted general inpatient routine service cost per diem (see instructions) Adjusted general inpatient routine service cost per diem (see instructions) Program general inpatient routine service cost (line 9 x line 38) 851,060 Medically necessary private room cost applicable to the Program (line 14 x line 35) O 28.00 29.00 29.00 0 29.00 0 20.00 0 30.00 0 .0000003 0 .0000003 0 .000 0 .0000003 0 .000 0 .0000003 0 .000 0 .0000003 0 .000 0 .0000003 0 .000 2 .000 3 .000			line 21 minus line 26)			
29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 124, 493) 37.00 PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 29.00 30.00 30.00 30.00 30.00 30.00 31.00 31.00 32.00 32.00 33.00 34.00 35.00 36.00 37.00 Frogram general inpatient routine service cost and private room cost differential (line 2, 124, 493) 37.00 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 38.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00		PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			2, 121, 170	27.00
30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 124, 493) 37.00 PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0			and observation bed cha	arges)	-	
31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 124, 493) 37.00 PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0.00 0.00 32.00 32.00 0.00 32.00 32.00 0.00 33.00 32.00 0.00 33.00 33.00 0.00 34.00 34.00 0.00 34.00 35.00 0.00 35.00 37.00 2.00 0.00 35.00 37.00 2.00 0.00 35.00 37.00 2.00 0.00 0.00 35.00 38.00 0.00 0.00 0.00 0.00 0.00 0.00 37.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00						1
32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 124, 493) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS Adjusted general inpatient routine service cost (line 9 x line 38) Program general inpatient routine service cost (line 9 x line 38) Medically necessary private room cost applicable to the Program (line 14 x line 35) 0.00 32.00 0.00 33.00 0.00 34.00 0.00 35.00 0.00 36.00 0.00 36.00 0.00 36.00 0.00 37.00 0.00 37.00 0.00 38.00 0.00 39.00 0.00 39.00 0.00 40.00			Line 20)		-	
33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 124, 493) Adjusted general inpatient routine service cost per diem (see instructions) 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) Program general inpatient routine service cost (line 9 x line 38) Medically necessary private room cost applicable to the Program (line 14 x line 35) 0.00 34.00 0.00 35.00 0.00 36.00 0.0			- Tine 28)			
34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 124, 493) 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 00 34.00 35.00 36.00 37.00 36						
35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 124, 493 and 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		, , , , , , , , , , , , , , , , , , , ,	nus lina 33)(saa instruc	tions)		
36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 124, 493 37.00 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 36.00 2, 124, 493 37.00 2, 124, 493 2, 1				11 0113)		
37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 124, 493 and 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) and 1, 260.83 and 2, 00 Program general inpatient routine service cost (line 9 x line 38) and 39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) and 40.00		, , ,	:= 2.7			ı
27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1, 260.83 38.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00		, , , , , , , , , , , , , , , , , , ,	and private room cost di	fferential (line	-	
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1, 260.83 38.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00		27 minus line 36)	,	(, .,	
38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1,260.83 38.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 1,260.83 38.00 851,060 39.00			ICTMENTS			
39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 851,060 39.00 40.00	20 00			T	1 240 02	20 00
40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00					·	
		,	•			1
		, , , , , , , , , , , , , , , , , , , ,	•			1

Heal th	Financial Systems	FRANCISCAN HEALT	ΓΗ RENSSELAER		In Lie	u of Form CMS-2	2552-10	
	TATION OF INPATIENT OPERATING COST			CCN: 15-1324	Peri od:	Worksheet D-1		
					From 01/01/2020 To 12/31/2020	Date/Time Pre	pared:	
			Ti +I	e XVIII	Hospi tal	8/2/2021 9: 26 Cost	am	
	Cost Center Description	Total	Total	Average Per		Program Cost		
	·	Inpatient Cost	npatient Days		÷	(col. 3 x col.		
		1.00	2. 00	col . 2) 3.00	4. 00	4) 5. 00		
42. 00	NURSERY (title V & XIX only)		2.00	0.00	11 00	0.00	42. 00	
42.00	Intensive Care Type Inpatient Hospital Units		111	0.004	FO F1	452 110	1 42 00	
43. 00 44. 00	INTENSIVE CARE UNIT	1, 003, 949	11:	8, 884.	50 51	453, 110	43. 00 44. 00	
45. 00							45. 00	
46. 00							46. 00	
47.00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47. 00	
	·					1. 00		
48. 00	Program inpatient ancillary service cost (Wk Total Program inpatient costs (sum of lines			one)		761, 559		
49.00	PASS THROUGH COST ADJUSTMENTS	41 till ough 40) (see mstructi	uris)		2, 065, 729	49.00	
50. 00	Pass through costs applicable to Program inp	atient routine s	services (fro	m Wkst. D, sur	m of Parts I and	0	50. 00	
51. 00		atient ancillary	v services (f	rom Wkst D «	sum of Parts II	0	51. 00	
31.00	and IV)	attent anertrary	y services (i	TOIL WKSt. D,	Juli Of Tarts II		31.00	
52. 00	Total Program excludable cost (sum of lines		loted - '	vol al : ''	antint	0		
53. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line	J 1	ι aτeα, non-pn	ysıcıan anesti	netist, and	0	53. 00	
	TARGET AMOUNT AND LIMIT COMPUTATION	- /						
54. 00 55. 00	Program discharges Target amount per discharge					0	54. 00 55. 00	
56. 00						0.00	1	
57. 00	Difference between adjusted inpatient operat	ing cost and tar	rget amount (line 56 minus	line 53)	0	57. 00	
58. 00 59. 00	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost re	porting ported	anding 1006	undated and co	ampounded by the	0	58. 00 59. 00	
39.00	market basket	portring perrou e	ending 1996,	upuateu anu c	onipounded by the	0.00	39.00	
60.00						0.00	•	
61. 00	If line 53/54 is less than the lower of line which operating costs (line 53) are less that					0	61. 00	
	amount (line 56), otherwise enter zero (see instructions)							
62. 00 63. 00	0 0							
03.00	0	03.00						
64. 00		ts through Decer	mber 31 of th	e cost reporti	ng period (See	1, 129, 704	64. 00	
65. 00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos</pre>	ts after Decembe	er 31 of the	cost renortino	neriod (See	0	65. 00	
00.00	instructions)(title XVIII only)							
66. 00	Total Medicare swing-bed SNF inpatient routi CAH (see instructions)	ne costs (line 6	64 plus line	65)(title XVII	I only). For	1, 129, 704	66. 00	
67. 00	, ,	e costs through	December 31	of the cost re	eporting period	0	67. 00	
	(line 12 x line 19)		. 04 6				,,,,,,,	
68. 00	Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)	e costs arter De	ecember 31 or	the cost repo	orting period	0	68. 00	
69. 00	Total title V or XIX swing-bed NF inpatient					0	69. 00	
70. 00	PART III - SKILLED NURSING FACILITY, OTHER N				.		70.00	
70.00	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service of	-			,		70. 00 71. 00	
72.00	Program routine service cost (line 9 x line	71)		•			72. 00	
73. 00 74. 00	Medically necessary private room cost applic Total Program general inpatient routine serv						73. 00 74. 00	
75. 00	Capital -related cost allocated to inpatient	•		•	Part II, column		75. 00	
7/ 00	26, line 45)	2)					7/ 00	
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line						76. 00 77. 00	
78. 00	Inpatient routine service cost (line 74 minu	s line 77)					78. 00	
79. 00 80. 00	Aggregate charges to beneficiaries for exces			*.	aus Lino 70)		79.00	
80.00	Total Program routine service costs for comp Inpatient routine service cost per diem limi		ost iiiiii tatiO	(11116 /0 11111	143 11110 <i>17)</i>		80. 00 81. 00	
82. 00	Inpatient routine service cost limitation (I	ine 9 x line 81)					82. 00	
83. 00 84. 00	Reasonable inpatient routine service costs (Program inpatient ancillary services (see in		s)				83. 00 84. 00	
85. 00	Utilization review - physician compensation		ns)				85. 00	
86. 00	Total Program inpatient operating costs (sum	of lines 83 th					86. 00	
87. 00	PART IV - COMPUTATION OF OBSERVATION BED PAS Total observation bed days (see instructions					685	87. 00	
88. 00	3 .	•	line 2)			1, 260. 83	•	
89. 00	Observation bed cost (line 87 x line 88) (se	e instructions)				863, 669	89. 00	

Health Financial Systems	FRANCI SCAN HEAL	TH RENSSELAER		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Period: From 01/01/2020	Worksheet D-1	
				To 12/31/2020	Date/Time Pre 8/2/2021 9:26	
		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	441, 045	3, 303, 648	0. 13350.	2 863, 669	115, 302	90.00
91.00 Nursing School cost	0	3, 303, 648	0.00000	863, 669	0	91.00
92.00 Allied health cost	0	3, 303, 648	0.00000	863, 669	0	92.00
93.00 All other Medical Education	0	3, 303, 648	0.00000	863, 669	0	93. 00

Health Financial Systems	FRANCISCAN HEALTH RENSSELAER	In Lie	ieu of Form CMS-2552-10		
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-1324	Peri od: From 01/01/2020	Worksheet D-1		
			Date/Time Pre 8/2/2021 9:26		
	Title XIX	Hospi tal	Cost		
Cost Center Description					

		Title XIX	Hospi tal	8/2/2021 9: 26 Cost	am
	Cost Center Description	THE ALL	nesp. ta.	'	
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	I NPATI ENT DAYS				
1. 00 2. 00 3. 00	Inpatient days (including private room days and swing-bed days, excluding newborn) Inpatient days (including private room days, excluding swing-bed and newborn days) Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.				
4. 00 5. 00	Semi-private room days (excluding swing-bed and observation be Total swing-bed SNF type inpatient days (including private room reporting period		r 31 of the cost	1, 000 896	4. 00 5. 00
6. 00	Total swing-bed SNF type inpatient days (including private roo reporting period (if calendar year, enter 0 on this line)	om days) after December	31 of the cost	0	6. 00
7. 00	Total swing-bed NF type inpatient days (including private room reporting period	n days) through December	31 of the cost	319	7. 00
8.00	Total swing-bed NF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	n days) after December 3	1 of the cost	0	8. 00
9. 00	Total inpatient days including private room days applicable to newborn days) (see instructions)	the Program (excluding	swi ng-bed and	8	9. 00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or through December 31 of the cost reporting period (see instruct	i ons)		896	10. 00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or December 31 of the cost reporting period (if calendar year, er	nter O on this line)	,	0	11. 00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XI) through December 31 of the cost reporting period	3 .	,	0	12.00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX after December 31 of the cost reporting period (if calendar ye	ear, enter O on this lin	e)	0	13.00
14. 00 15. 00	Medically necessary private room days applicable to the Progra Total nursery days (title V or XIX only)	ım (excluding swing-bed	days)	0	14. 00 15. 00
16. 00	Nursery days (title V or XLX only) SWING BED ADJUSTMENT			0	16. 00
17. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es through December 31 o	f the cost		17. 00
18. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es after December 31 of	the cost		18. 00
19. 00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			0.00	19. 00
20. 00	Medicaid rate for swing-bed NF services applicable to services reporting period		he cost		20. 00
21. 00 22. 00	Total general inpatient routine service cost (see instructions Swing-bed cost applicable to SNF type services through Decembe		ing period (line	3, 303, 648 0	21. 00 22. 00
23. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reporting	g period (line 6	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December (7×1) ine 19)	31 of the cost reporti	ng period (line	0	24. 00
25. 00	Swing-bed cost applicable to NF type services after December 3 x line 20)	31 of the cost reporting	period (line 8	0	25. 00
26. 00 27. 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (Tine 21 minus line 26)		1, 146, 871 2, 156, 777	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed		arnes)	0	
29. 00	Private room charges (excluding swing-bed charges)	and observation bed en	ui gcs)	0	29. 00
30.00	Semi-private room charges (excluding swing-bed charges)			0	30. 00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷	line 28)		0.000000	
32. 00	Average private room per diem charge (line 29 ÷ line 3)			0.00	
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
34. 00	Average per diem private room charge differential (line 32 mir		tions)	0.00	
35. 00	Average per diem private room cost differential (line 34 x lin	ne 31)		0.00	
36.00	Private room cost differential adjustment (line 3 x line 35)	and private room cost di	fforontial (lima) 1E4 777	36.00
37. 00	General inpatient routine service cost net of swing-bed cost a 27 minus line 36)	ina private room cost di	rrenential (Time	2, 156, 777	37. 00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	STMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see			1, 279. 99	38. 00
39. 00	Program general inpatient routine service cost per drem (see	•		1, 279. 99	
40. 00	Medically necessary private room cost applicable to the Progra	-		0	40.00
	Total Program general inpatient routine service cost (line 39	•	İ	10, 240	

	Financial Systems	FRANCISCAN HEAL		CN: 1E 1224		eu of Form CMS-2	
COMPUI	ATION OF INPATIENT OPERATING COST		Provider C	CN: 15-1324	Peri od: From 01/01/2020		
					To 12/31/2020	Date/Time Pre 8/2/2021 9:26	
				e XIX	Hospi tal	Cost	
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per		Program Cost (col. 3 x col.	
		·		col . 2)		4)	
42.00	NURSERY (title V & XIX only)	1.00	2. 00	3.00	4. 00	5. 00	42. 00
42.00	Intensive Care Type Inpatient Hospital Units	5					42.00
43.00	INTENSIVE CARE UNIT	1, 003, 949	113	8, 884.	50 6	53, 307	43. 00
44. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						44. 00 45. 00
45. 00 46. 00	4						46.00
	OTHER SPECIAL CARE (SPECIFY)						47. 00
	Cost Center Description					1.00	
48. 00	Program inpatient ancillary service cost (W	kst. D-3, col. 3	I, line 200)			139, 362	48. 00
49. 00	Total Program inpatient costs (sum of lines			ons)		202, 909	
50. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inp	nationt routing	sorvices (from	Wkst D su	m of Parts I and	0	50.00
30.00	[111]	Datrent routine	services (110	ii wkst. D, Sui	ii Oi Faits i aliu		30.00
51. 00	Pass through costs applicable to Program in	oatient ancillar	y services (fr	om Wkst. D,	sum of Parts II	0	51.00
52. 00	and IV) Total Program excludable cost (sum of lines	50 and 51)				0	52.00
53. 00	Total Program inpatient operating cost exclu	uding capital re	lated, non-phy	sician anest	netist, and	Ö	
	medical education costs (line 49 minus line	52)					
54. 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54.00
	Target amount per discharge					0.00	
56. 00 57. 00	Target amount (line 54 x line 55)	ting cost and to	rgot omount (ino E4 minus	lino E2)	0	
58.00	Difference between adjusted inpatient operations payment (see instructions)	tring cost and ta	irget amount (i	The 50 minus	11 ne 53)	0	
59. 00	Lesser of lines 53/54 or 55 from the cost re	eporting period	endi ng 1996, เ	updated and co	ompounded by the	0.00	59. 00
60. 00	market basket Lesser of lines 53/54 or 55 from prior year	cost report un	ndated by the m	markat haskat		0.00	60.00
61. 00	If line 53/54 is less than the lower of line					0.00	
	which operating costs (line 53) are less that		s (lines 54 x	60), or 1% o	f the target		
62 00	amount (line 56), otherwise enter zero (see Relief payment (see instructions)	instructions)				0	62.00
	Allowable Inpatient cost plus incentive payr	ment (see instru	ıcti ons)			0	
44.00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ata thealigh Daga	mbox 21 of the	anat manant	ing ported (Coo	1 14/ 071	(4.00
64. 00	instructions)(title XVIII only)	sts till ough bece	aliber 31 of the	e cost report	ing perrod (see	1, 146, 871	64. 00
65. 00	Medicare swing-bed SNF inpatient routine cos	sts after Decemb	er 31 of the d	cost reportin	g period (See	0	65. 00
66. 00	<pre>instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi</pre>	ne costs (line	64 plus line 6	55)(title XVI	II only) For	1, 146, 871	66 00
00.00	CAH (see instructions)	·	·	, ,	3,	1,110,071	00.00
67. 00	Title V or XIX swing-bed NF inpatient routing (line 12 x line 19)	ne costs through	December 31 o	of the cost r	eporting period	0	67. 00
68. 00	Title V or XIX swing-bed NF inpatient routing	ne costs after D	ecember 31 of	the cost rep	orting period	0	68. 00
	(line 13 x line 20)						
69.00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N					0	69.00
70. 00	Skilled nursing facility/other nursing facil		•)		70. 00
71. 00	Adjusted general inpatient routine service of		ine 70 ÷ line	2)			71.00
72. 00 73. 00	Program routine service cost (line 9 x line Medically necessary private room cost applic		ı(line 14 x li	ne 35)			72. 00 73. 00
74. 00	Total Program general inpatient routine serv	vice costs (line	2 + line 73)				74. 00
75. 00	Capital-related cost allocated to inpatient 26. line 45)	routine service	costs (from V	Vorksheet B, I	Part II, column		75. 00
76. 00	Per diem capital-related costs (line 75 ÷ li	ne 2)					76. 00
77. 00	Program capital -related costs (line 9 x line						77. 00
78. 00 79. 00	Inpatient routine service cost (line 74 minu Aggregate charges to beneficiaries for exces		rovi der record	15)			78. 00 79. 00
	Total Program routine service costs for comp				nus line 79)		80.00
81.00	Inpatient routine service cost per diem limi		`				81.00
82. 00 83. 00	Inpatient routine service cost limitation (I Reasonable inpatient routine service costs		* .				82. 00 83. 00
84. 00	Program inpatient ancillary services (see in	•	-,				84. 00
85.00	Utilization review - physician compensation						85.00
80. UU	Total Program inpatient operating costs (sur PART IV - COMPUTATION OF OBSERVATION BED PAS		ii ougii 85)				86. 00
87. 00	Total observation bed days (see instructions	s)				685	
88. 00	Adjusted general inpatient routine cost per Observation bed cost (line 87 x line 88) (se	•				1, 279. 99 876, 793	1
07.00	longer sation ned cost (Time of X Time 88) (Se	ee manuchums)				010, 193	J 07. UU

Health Financial Systems	FRANCI SCAN HEAL	TH RENSSELAER		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Period: From 01/01/2020	Worksheet D-1	
				To 12/31/2020	Date/Time Pre 8/2/2021 9:26	
		Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	441, 045	3, 303, 648	0. 13350.	2 876, 793	117, 054	90.00
91.00 Nursing School cost	0	3, 303, 648	0.00000	876, 793	0	91.00
92.00 Allied health cost	0	3, 303, 648	0.00000	876, 793	0	92.00
93.00 All other Medical Education	0	3, 303, 648	0.00000	876, 793	0	93. 00

Heal th Financial Systems FRANCISCAN HEAL		CN. 1E 1224		eu of Form CMS-1	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-1324	Peri od: From 01/01/2020	Worksheet D-3	i
			To 12/31/2020	Date/Time Pre 8/2/2021 9:26	
	Title	e XVIII	Hospi tal	Cost	
Cost Center Description		Ratio of Cos	t Inpatient	Inpati ent	
		To Charges		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			817, 613		30.00
31. 00 03100 I NTENSI VE CARE UNI T			96, 216		31.00
ANCILLARY SERVICE COST CENTERS					
50. 00 05000 OPERATING ROOM		0. 57029			
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 20550			
60. 00 06000 LABORATORY		0. 28608			
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.		0. 78899		1	
65. 00 06500 RESPI RATORY THERAPY		0. 60296			
66. 00 06600 PHYSI CAL THERAPY		0. 67363			
66. 01 06601 WHEATFI ELD PT		0. 75992			
67. 00 06700 OCCUPATI ONAL THERAPY		0. 48584			
67. 01 06701 WHEATFI ELD 0T		1. 39015			
68. 00 06800 SPEECH PATHOLOGY		0. 95047			
68. 01 06801 WHEATFI ELD ST		0. 67043			
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 22626			
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS		0. 25229			
73. 00 O7300 DRUGS CHARGED TO PATIENTS		0. 17522	22 573, 932	100, 566	73. 00
OUTPATIENT SERVICE COST CENTERS					
88. 00 08800 RURAL HEALTH CLINIC		0.00000		0	00.00
88. 03 08801 RURAL HEALTH CLINIC IV		0.00000		0	88. 03
90. 00 09000 CLI NI C		0. 84401		13, 731	
90. 01 09001 WOUND CARE		0. 52625		0	
91. 00 09100 EMERGENCY		0. 68304			
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 51165			
200 00 Total (sum of Lines 50 through 04 and 06 through 08)		1	2 460 085	761 550	1200 00

Total (sum of lines 50 through 94 and 96 through 98)
Less PBP Clinic Laboratory Services-Program only charges (line 61)
Net charges (line 200 minus line 201)

2, 460, 985

2, 460, 985

761, 559 200. 00

201. 00 202. 00

200.00

201.00 202.00

Health Financial Systems FRANCISCA	NN HEALTH RENSSELAER		In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der CCN		Peri od:	Worksheet D-3	
	Component CC		From 01/01/2020 To 12/31/2020	Date/Time Prep 8/2/2021 9:26	
	Title X	(VIII S	wing Beds - SNF	Cost	
Cost Center Description	R	atio of Cost To Charges	Program	Inpatient Program Costs (col. 1 x col. 2)	
		1. 00	2. 00	3. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS		1.00	2.00	0.00	
30. 00 03000 ADULTS & PEDI ATRI CS			0		30.00
31. 00 03100 I NTENSI VE CARE UNI T ANCI LLARY SERVI CE COST CENTERS			0		31. 00
50. 00 O5000 OPERATING ROOM		0. 570298	0	0	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 205506			54. 00
60. 00 06000 LABORATORY		0. 286087		28, 095	
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.		0. 788996		20, 070	63.00
65. 00 06500 RESPIRATORY THERAPY		0. 602969		41, 476	
66. 00 06600 PHYSI CAL THERAPY		0. 673632		112, 125	
66. 01 06601 WHEATFIELD PT		0. 759923		. 0	66, 01
67. 00 06700 OCCUPATI ONAL THERAPY		0. 485844		87, 211	67. 00
67. 01 06701 WHEATFI ELD OT		1. 390153		0	67. 01
68. 00 06800 SPEECH PATHOLOGY		0. 950472	9, 411	8, 945	68. 00
68. 01 06801 WHEATFI ELD ST		0. 670432	2 0	0	68. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 226267	61, 829	13, 990	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 252291	1 0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 175222	155, 240	27, 201	73. 00
OUTPATIENT SERVICE COST CENTERS					
88. 00 08800 RURAL HEALTH CLINIC		0.000000	O	0	88. 00
88.03 08801 RURAL HEALTH CLINIC IV		0.000000		0	88. 03
90. 00 09000 CLI NI C		0.844016	300	253	90. 00
90. 01 09001 WOUND CARE		0. 526255	5 0	0	90. 01
91. 00 09100 EMERGENCY		0. 683040		0	91. 00
92 ON O9200 ORSERVATION REDS (NON-DISTINCT PART		0 51165	0	0	92 00

201. 00 202. 00

0 92.00

321, 655 200. 00

0. 511652

751, 204

200.00

201.00 202.00

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART

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

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

Health Financial Systems FRANCISCAN HEA				u of Form CMS-	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C		Peri od: From 01/01/2020	Worksheet D-3	
			To 12/31/2020	Date/Time Pre	
	Ti +I	e XIX	Hospi tal	8/2/2021 9: 26 Cost	am
Cost Center Description	11 (1	Ratio of Cos		Inpati ent	
cost center bescription		To Charges	Program	Program Costs	
		10 onar ges	Charges	(col. 1 x col.	
			onal goo	2)	
		1.00	2. 00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS			87, 929		30. 00
31. 00 03100 INTENSIVE CARE UNIT			23, 559		31. 00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM		0. 57029			
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 20550			
60. 00 06000 LABORATORY		0. 28608		27, 359	
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.		0. 78899		0	
65. 00 06500 RESPI RATORY THERAPY		0. 60296			
66. 00 06600 PHYSI CAL THERAPY		0. 67363			
66. 01 06601 WHEATFI ELD PT		0. 75992		0	
67. 00 06700 OCCUPATI ONAL THERAPY		0. 48584		0	
67. 01 06701 WHEATFI ELD OT		1. 39015		0	
68. 00 06800 SPEECH PATHOLOGY		0. 95047		260	
68. 01 06801 WHEATFI ELD ST		0. 67043		0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 22626			
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 25229			
73.00 O7300 DRUGS CHARGED TO PATIENTS		0. 17522	22 131, 201	22, 989	73. 00
OUTPATIENT SERVICE COST CENTERS					
88. 00 08800 RURAL HEALTH CLINIC		3. 69433		0	
88. 03 08801 RURAL HEALTH CLINIC IV		3. 50425		0	00.00
90. 00 09000 CLI NI C		0. 84401		95	
90. 01 09001 WOUND CARE		0. 52625		0	
91. 00 09100 EMERGENCY		0. 68304			
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 51165			92. 00
200.00 Total (sum of Lines 50 through 94 and 96 through 98)			441. 546	139 362	1200 00

441, 546

441, 546

139, 362 200. 00

201. 00 202. 00

200.00

201.00 202.00 Total (sum of lines 50 through 94 and 96 through 98)

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

Health Financial Systems	FRANCISCAN HEALTH RENSSELAER	In Lie	eu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-1	From 01/01/2020	Worksheet E Part B Date/Time Prepared: 8/2/2021 9:26 am

		Ti +Lo W/LLI	Hooni tal	8/2/2021 9: 26	am
		Title XVIII	Hospi tal	Cost	
				1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
1.00	Medical and other services (see instructions)			8, 619, 848	1. 00
2.00	Medical and other services reimbursed under OPPS (see instruc-	tions)		0	
3.00	OPPS payments			0	3.00
4. 00 4. 01	Outlier payment (see instructions) Outlier reconciliation amount (see instructions)			0	4. 00 4. 01
5.00	Enter the hospital specific payment to cost ratio (see instruc	ctions)		0.000	1
6. 00	Line 2 times line 5	31. 33)		0	ı
7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	7. 00
8.00	Transitional corridor payment (see instructions)			0	1
9.00	Ancillary service other pass through costs from Wkst. D, Pt.	V, col. 13, line 200		0	9.00
10. 00 11. 00	Organ acquisitions			0 (10 040	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions) COMPUTATION OF LESSER OF COST OR CHARGES			8, 619, 848	11. 00
	Reasonable charges				
12.00	Ancillary service charges			0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, Ii	ne 69)		0	13. 00
14. 00	Total reasonable charges (sum of lines 12 and 13)			0	14. 00
15 00	Customary charges	normant for condition on a	ahanga basi s		15 00
15. 00 16. 00	Aggregate amount actually collected from patients liable for patients that would have been realized from patients liable for			0	15. 00 16. 00
10.00	had such payment been made in accordance with 42 CFR §413.13(a chargebasi s	Ĭ	10.00
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000	17. 00
18. 00	Total customary charges (see instructions)			0	1
19. 00	Excess of customary charges over reasonable cost (complete only	y if line 18 exceeds lin	e 11) (see	0	19. 00
20.00	instructions) Excess of reasonable cost ever sustanary charges (complete on	vifling 11 avecade lin	0 10) (600	0	20. 00
20. 00	Excess of reasonable cost over customary charges (complete onlinstructions)	y IT TITLE IT exceeds ITTL	e 16) (See	0	20.00
21. 00	Lesser of cost or charges (see instructions)			8, 706, 046	21. 00
22. 00	Interns and residents (see instructions)			0	22. 00
23. 00	Cost of physicians' services in a teaching hospital (see inst	ructions)		0	
24. 00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			0	24. 00
25. 00	COMPUTATION OF REIMBURSEMENT SETTLEMENT Deductibles and coinsurance amounts (for CAH, see instructions)	2)		80, 416	25. 00
26. 00	Deductibles and Coinsurance amounts relating to amount on line	•	ctions)	4, 866, 366	•
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26)]			3, 759, 264	•
	instructions)				
28. 00	Direct graduate medical education payments (from Wkst. E-4, Ii	ne 50)		0	•
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	29. 00
30. 00 31. 00	Subtotal (sum of lines 27 through 29) Primary payer payments			3, 759, 264 38, 557	1
32. 00	Subtotal (line 30 minus line 31)			3, 720, 707	1
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE	CES)			
33. 00				0	
34. 00	Allowable bad debts (see instructions)			610, 560	
35. 00 36. 00	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see insti	ructions)		396, 864 366, 045	•
37. 00	Subtotal (see instructions)	uctions)		4, 117, 571	1
	MSP-LCC reconciliation amount from PS&R				38. 00
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39. 00
39. 50	Pioneer ACO demonstration payment adjustment (see instructions	5)			39. 50
39. 97	Demonstration payment adjustment amount before sequestration			0	
39. 98 39. 99	Partial or full credits received from manufacturers for replace RECOVERY OF ACCELERATED DEPRECIATION	ced devices (see instruct	ions)	0	
40.00	Subtotal (see instructions)			4, 117, 571	1
40. 01	Sequestration adjustment (see instructions)			27, 176	
40. 02	Demonstration payment adjustment amount after sequestration			0	1
40. 03	Sequestration adjustment-PARHM pass-throughs				40. 03
41.00	Interim payments			5, 342, 332	1
41. 01	Interim payments-PARHM Tentative settlement (for contractors use only)			0	41. 01
42. 00 42. 01	Tentative settlement (for contractors use only)			0	42. 00 42. 01
43. 00	Balance due provider/program (see instructions)			-1, 251, 937	1
43. 01	Balance due provider/program-PARHM (see instructions)			, , ,	43. 01
44.00	Protested amounts (nonallowable cost report items) in accordan	nce with CMS Pub. 15-2, c	hapter 1,	0	44. 00
	§115. 2			L	
00.00	TO BE COMPLETED BY CONTRACTOR			_	00.00
90. 00 91. 00	Original outlier amount (see instructions) Outlier reconciliation adjustment amount (see instructions)			0	90. 00 91. 00
92.00	The rate used to calculate the Time Value of Money				92.00
93. 00	Time Value of Money (see instructions)			0	1
94. 00	Total (sum of lines 91 and 93)			0	94. 00

Health Financial Systems FRANC ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Peri od: Worksheet E-1
From 01/01/2020 Part I
To 12/31/2020 Date/Time Prepared: 8/2/2021 9: 26 am Provider CCN: 15-1324

					8/2/2021 9: 26	am
			XVIII	Hospi tal	Cost	
		Inpatien	t Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3. 00	4.00	
1.00	Total interim payments paid to provider		1, 975, 05!	5	5, 342, 332	1.00
2.00	Interim payments payable on individual bills, either				0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3.00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER		(3. 01
3.02			(3. 02
3.03				D		3. 03
3.04			(3. 04
3.05			(0	3. 05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		(3. 50
3. 51			(3. 51
3.52			(3. 52
				D		3. 53
				D		3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		(0	3. 99
	3. 50-3. 98)		4 075 05			
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		1, 975, 05!		5, 342, 332	4. 00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
F 00	TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after		Ι			5. 00
5.00	desk review. Also show date of each payment. If none,					5.00
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5 01	TENTATI VE TO PROVI DER				1	5. 01
	TENTATI VE TO TROVIDER			-		5. 02
						5. 02
5.05	Provider to Program	L	<u>'</u>	2		5. 05
5 50	TENTATI VE TO PROGRAM				0	5. 50
	TEITH VE TO TROOTS III					5. 51
						5. 52
	Subtotal (sum of lines 5.01-5.49 minus sum of lines			ol .		5. 99
0. , ,	5. 50-5. 98)		· ·			0. ,,
6.00	Determined net settlement amount (balance due) based on					6. 00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVIDER				0	6. 01
6.02	SETTLEMENT TO PROGRAM		156, 55!	5	1, 251, 937	6. 02
7.00	Total Medicare program liability (see instructions)		1, 818, 500		4, 090, 395	7. 00
				Contractor	Cost Part B Amount 4.00 5,342,332 0 0 0 0 0 0 0 0 0 0 0 0 0	
6. 01 6. 02				Number		
		()	1. 00	2.00	
8.00	Name of Contractor					8. 00

Title XVIII Swing Beds - 5NF Cost Inpatient Part A Part B Part B						8/2/2021 9: 26	am
1.00							
1.00			Inpatien	t Part A	Par	t B	
1.00			mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
Interfim payments Dayable 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 neter a zero.				2.00		4. 00	
Submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NoNE" or enter a zero	1.00	Total interim payments paid to provider		1, 744, 73	4	0	1. 00
Services rendered in the cost reporting period. If none, write "NONE" or netre a zero 200	2.00	Interim payments payable on individual bills, either			o	0	2. 00
write "NONE" or enter a zero .0 U Ist 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) .0		submitted or to be submitted to the contractor for					
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)		services rendered in the cost reporting period. If none,					
amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 3.01 3.02 3.03 3.04 3.05 Provider to Program 3.50 ADJUSTMENTS TO PROVIDER 0 0 0 3.03 3.05 Provider to Program 3.51 3.52 0 0 0 3.55 3.53 3.54 0 0 0 0 3.55 3.53 3.54 0 0 0 0 3.55 3.59 3.50 3.50 3.50 3.50 4.00 Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR write "NONE" or enter a zero. (1) Program to Provider TENTATIVE TO PROGRAM 5.00 Total interim payments (settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider TENTATIVE TO PROGRAM 5.00 Determined net settlement amount (balance due) based on the cost report. (1) SETTLEMENT TO PROGRAM 313,538 0 0 0 5.50 SETTLEMENT TO PROGRAM 313,538 0 0 0 5.99 Contractor Number (Wo/Day/Yrr) SETTLEMENT TO PROGRAM 313,538 0 0.00 Contractor Number (Wo/Day/Yrr) SETTLEMENT TO PROGRAM 313,538 0 0.00 Contractor Number (Wo/Day/Yrr) SETTLEMENT TO PROGRAM 313,538 0 0.00 Contractor Number (Wo/Day/Yrr) SETTLEMENT TO PROGRAM 313,538 0 0.00 Contractor Number (Wo/Day/Yrr) SETTLEMENT TO PROGRAM 313,538 0 0.00 Contractor Number (Wo/Day/Yrr)							
For the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider NONE" or enter a zero. (1) Program to Provider NONE" or enter a zero. (1) NONE	3.00						3. 00
Dayment. If none, write "NONE" or enter a zero. (1) Program to Provider							
Program to Provider ADJUSTMENTS TO PROVIDER							
ADJUSTMENTS TO PROVIDER							
3.02 0	2 01					0	2 01
3.03 3.04 3.05 Provider to Program 3.50 3.51 3.51 3.52 3.53 3.54 3.94 3.05 3.54 3.97 3.50 3.50 3.50 3.51 3.51 3.52 3.53 3.54 3.99 3.50-3.98) 3.50-3.98) 3.50-3.98) 3.50-3.98 3.		ADJUSTIMENTS TO PROVIDER					
3.04						- 1	
3.05							
Provider to Program ADJUSTMENTS TO PROGRAM 0 0 3.50 3.51 3.52 0 0 0 3.51 3.52 0 0 0 3.51 3.52 0 0 0 3.53 3.54 0 0 0 3.53 3.54 0 0 0 3.53 3.54 0 0 0 3.53 3.54 0 0 0 3.53 3.54 0 0 0 3.53 3.54 0 0 0 3.53 3.54 0 0 0 3.53 3.54 0 0 0 3.53 3.54 0 0 0 3.59 3.59 3.50-3.99 0 0 3.99 0 0 0 0 3.99 0 0 0 0 0 0 0 0 0							
ADJUSTMENTS TO PROGRAM	0.00	Provider to Program			<u> </u>	0	0.00
3.51 0	3.50				0	0	3. 50
3.53 3.54 0 0 0 0 3.53 3.54 0 0 0 0 3.53 3.50 3.99 3.50 3.99 3.50 3.593 3.50 3.99 3.50 3.593 3.50 3.99 3.50 3.593 3.50 3.99 3.50 3.50 3.593 3.50 3.593 3.50 3.50 3.593 3.50					Ö	0	
3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) 0 0 3.54 3.99 3.50-3.98) 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 1,744,734 0 4.00 4.00 (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR	3.52				o	0	3. 52
Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.09) 3.99 3.50-3.98) 4.00 Tentral managements (sum of lines 1, 2, and 3.99) 1,744,734 0 4.00	3.53				o	0	3. 53
3.50-3.98 Total interim payments (sum of lines 1, 2, and 3.99) 1,744,734 0 4.00 4.00 (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) To BE COMPLETED BY CONTRACTOR	3.54				o	0	3. 54
Total inferim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR	3. 99				0	0	3. 99
Cransfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR							
appropriate TO BE COMPLETED BY CONTRACTOR	4.00			1, 744, 73	4	0	4. 00
TO BE COMPLÉTED BY CONTRACTOR							
5.00							
desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider	5 00	List songrately each tentative settlement nayment after					5 00
Write "NONE" or enter a zero. (1) Program to Provider	5.00	desk review. Also show date of each navment. If none					3.00
Program to Provider							
TENTATI VE TO PROVIDER				I.			
Solution Settlement to Program Solution Settlement amount (balance due) based on the cost report. (1) Settlement to PROGRAM Settlement amount (balance due) based on the cost report. (1) Settlement to PROGRAM Settlement amount (balance due) based on the cost report. (1) Settlement to PROGRAM Settlement amount (balance due) based on the cost report. (1) Settlement to PROGRAM Settlement to	5. 01				0	0	5. 01
Provider to Program	5.02				0	0	5. 02
TENTATI VE TO PROGRAM 0	5.03				o	0	5. 03
5.51 0							
Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) Subtotal (sum of lines 5.01-5.49 minus sum of lines 6.09		TENTATI VE TO PROGRAM					
5. 99 Subtotal (sum of lines 5. 01-5. 49 minus sum of lines 5. 50-5. 98) 6. 00 Determined net settlement amount (balance due) based on the cost report. (1) 6. 01 SETTLEMENT TO PROVIDER 0 0 6. 01 6. 02 SETTLEMENT TO PROGRAM 313, 538 0 6. 02 7. 00 Total Medicare program liability (see instructions) 1, 431, 196 Contractor NPR Date (Mo/Day/Yr) 0 1. 00 2. 00							
5.50-5.98) 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00					-	- 1	
6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00	5. 99				0	0	5. 99
the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00							/ 00
6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00	6.00						6.00
6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor Number (Mo/Day/Yr) 0 1.00 2.00	6 01					0	6.01
7.00 Total Medicare program liability (see instructions) 1,431,196 Contractor Number (Mo/Day/Yr) 0 1.00 2.00					~	-	
Contractor NPR Date						-	
Number (Mo/Day/Yr) 0 1.00 2.00		in the second of		.,, .,			7.50
0 1.00 2.00							
8.00 Name of Contractor 8.00			()	t A		
	8.00	Name of Contractor					8. 00

Heal th	Financial Systems FRANCISCAN	HEALTH RENSSELAER	In Lie	u of Form CMS-	2552-10
	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provi der CCN: 15-1324	Peri od: From 01/01/2020 To 12/31/2020	Worksheet E-	1 epared:
		Title XVIII	Hospi tal	Cost	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPO				
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCU				
1. 00	Total hospital discharges as defined in AARA §4102 from		e 14		1. 00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of line				2. 00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3. 00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of line				4. 00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line				5. 00
6.00	Total hospital charity care charges from Wkst. S-10, co		W . C O D		6. 00
7. 00	CAH only - The reasonable cost incurred for the purchas	e of certified HII technology	WKST. S-2, PT. I		7. 00
8. 00	Calculation of the HIT incentive payment (see instructi	ons)			8. 00
9. 00	Sequestration adjustment amount (see instructions)				9. 00
10.00	Calculation of the HIT incentive payment after sequestr	ation (see instructions)			10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instruction	s)			30.00
31.00	Other Adjustment (specify)				31. 00
32. 00	Balance due provider (line 8 (or line 10) minus line 30	and line 31) (see instruction	ns)		32. 00

Health Financial Systems	FRANCISCAN HEALTH	RENSSELAER	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT -	SWING BEDS	Provider CCN: 15-1324	Peri od: From 01/01/2020	Worksheet E-2
		Component CCN: 15-Z324	To 12/31/2020	Date/Time Prepared: 8/2/2021 9:26 am

		Component CCN: 15-Z324	To 12/31/2020	Date/Time Pre 8/2/2021 9:26	
		Title XVIII	Swing Beds - SNF	Cost	<i>y</i>
			Part A	Part B	
-			1. 00	2. 00	
	COMPUTATION OF NET COST OF COVERED SERVICES		1 141 001	0	1
	<pre>npatient routine services - swing bed-SNF (see instructions) npatient routine services - swing bed-NF (see instructions)</pre>		1, 141, 001	0	1.
	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part	· A and sum of Wkst D	324, 872	0	
	Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swin	· ·		U	'l 3.
	nstructions)	ig bed pass till oagil, see			
1	Nursing and allied health payment-PARHM (see instructions)				3.
	Per diem cost for interns and residents not in approved teachi	ng program (see		0.00	
i	nstructions)				
	Program days		896	0	
	nterns and residents not in approved teaching program (see in			0	1
1	Jtilization review - physician compensation - SNF optional met	thod only	0		7.
1	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		1, 465, 873	0	
	Primary payer payments (see instructions) Subtotal (line 8 minus line 9)		1, 465, 873	0	
1	Deductibles billed to program patients (exclude amounts applic	able to physician	1, 400, 673	0	
	professional services)	able to physician	ď	U	Ί '''
	Subtotal (line 10 minus line 11)		1, 465, 873	0	12.
	Coinsurance billed to program patients (from provider records)	(excl ude coi nsurance	25, 168	0	13.
f	for physician professional services)	•			
	30% of Part B costs (line 12 x 80%)			0	
1	Subtotal (see instructions)		1, 440, 705	0	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	16.
	Pioneer ACO demonstration payment adjustment (see instructions				16.
	Rural community hospital demonstration project (§410A Demonstr	ration) payment	0		16.
1	adjustment (see instructions) Demonstration payment adjustment amount before sequestration			0	16.
1	Allowable bad debts (see instructions)			0	
	Adjusted reimbursable bad debts (see instructions)		Ö	0	1
	Allowable bad debts for dual eligible beneficiaries (see instr	ructions)	o	0	1
4	Total (see instructions)	,	1, 440, 705	0	
9. 01	Sequestration adjustment (see instructions)		9, 509	0	19.
9. 02	Demonstration payment adjustment amount after sequestration)		0	0	19.
9. 03	Sequestration adjustment-PARHM pass-throughs				19
	nterim payments		1, 744, 734	0	
1	nterim payments-PARHM			_	20
	Fentative settlement (for contractor use only)		0	0	
	Fentative settlement-PARHM (for contractor use only)	and 21)	212 520	0	21
	Balance due provider/program (line 19 minus lines 19.01, 20, a Balance due provider/program-PARHM (see instructions)	ind 21)	-313, 538	U	22
	Protested amounts (nonallowable cost report items) in accordan	nce with CMS Pub 15-2	o	0	1
	chapter 1, §115.2	ice with one rub. 10 2,		Ü	7 -0
	ural Community Hospital Demonstration Project (§410A Demonstr	ation) Adjustment			
00. 00 I	s this the first year of the current 5-year demonstration per	iod under the 21st			200
	Century Cures Act? Enter "Y" for yes or "N" for no.				
	ost Reimbursement				١
	Medicare swing-bed SNF inpatient routine service costs (from W	/kst. D-1, Pt. II, line			201
	66 (title XVIII hospital))	Wkst D 2 col 2 lin			202
	Medicare swing-bed SNF inpatient ancillary service costs (from 200 (title XVIII swing-bed SNF))	I WKSt. D-3, COI. 3, IIII	e		202
- 1	Fotal (sum of lines 201 and 202)				203
	Medicare swing-bed SNF discharges (see instructions)				204
C	computation of Demonstration Target Amount Limitation (N/A in	first year of the curre	nt 5-year demonst	rati on	1
	eri od)				
5. 00 N	Medicare swing-bed SNF target amount				205
	Medicare swing-bed SNF inpatient routine cost cap (line 205 ti				206
	djustment to Medicare Part A Swing-Bed SNF Inpatient Reimburs				
	Program reimbursement under the §410A Demonstration (see instr				207
	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2	2, col. 1, sum of lines	1		208
	and 3)	ations)			200
	Adjustment to Medicare swing-bed SNF PPS payments (see instruc	ELLONS)			209
	Reserved for future use cost Reimbursement				210
	Total adjustment to Medicare swing-bed SNF PPS payment (line 2	200 plus line 210) (see			215
5. OOL	iotal adjustillent to medicare swind-bed sweeps bavillent cithe 2	109 0105 11116 7101 1566			

Health Financial Systems	th Financial Systems FRANCISCAN HEALTH RENSSELAER			2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-1324	Period: From 01/01/2020 To 12/31/2020	Worksheet E-3 Part V Date/Time Pre 8/2/2021 9:26	pared:
	Title XVIII	Hospi tal	Cost	
			1 00	

		Title XVIII	Hospi tal	Cost	diii	
	DART V. CALCULATION OF RELABURCHENT CETTLEMENT FOR MEDICARE DAR	OT 4 CEDIU OEC 000T	DELMBURGEMENT	1. 00		
1 00	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PAR	RI A SERVICES - COST	KET MBUKSEMENT	2.045.720	1. 00	
1. 00 2. 00	Inpatient services Nursing and Allied Health Managed Care payment (see instructions)	•		2, 065, 729 0	2. 00	
3.00	Organ acquisition	1		0	3. 00	
4.00	Subtotal (sum of lines 1 through 3)			2, 065, 729	4. 00	
5.00	Primary payer payments			2,005,729	5. 00	
6. 00						
0.00	COMPUTATION OF LESSER OF COST OR CHARGES			2, 086, 386	6. 00	
	Reasonabl e charges					
7.00	Routi ne servi ce charges			0	7. 00	
8.00	Ancillary service charges			0	8. 00	
9.00	Organ acquisition charges, net of revenue			0	9. 00	
10.00	Total reasonable charges			0	10.00	
	Customary charges					
11. 00	Aggregate amount actually collected from patients liable for paym			0	11. 00	
12. 00	Amounts that would have been realized from patients liable for pa	ayment for services on	n a charge basis	0	12.00	
	had such payment been made in accordance with 42 CFR 413.13(e)					
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0. 000000	13.00	
14. 00	Total customary charges (see instructions)	61: 44	() (0	14.00	
15. 00	Excess of customary charges over reasonable cost (complete only i instructions)	T line 14 exceeds lin	ne 6) (see	0	15. 00	
16. 00	Excess of reasonable cost over customary charges (complete only i	fling 6 avende line	14) (600	0	16, 00	
10.00	linstructions)	Title o exceeds Title	(366	U	10.00	
17. 00	Cost of physicians' services in a teaching hospital (see instruct	tions)		0	17. 00	
17.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT					
18. 00	Direct graduate medical education payments (from Worksheet E-4, I	ine 49)		0	18. 00	
19. 00	Cost of covered services (sum of lines 6, 17 and 18)	,		2, 086, 386	19. 00	
20.00	Deductibles (exclude professional component)			277, 376	20.00	
21.00	Excess reasonable cost (from line 16)			0	21. 00	
22. 00	Subtotal (line 19 minus line 20 and 21)			1, 809, 010	22. 00	
23. 00	Coi nsurance			8, 096	23. 00	
24. 00	Subtotal (line 22 minus line 23)			1, 800, 914		
25. 00	Allowable bad debts (exclude bad debts for professional services)	(see instructions)		45, 643		
26. 00	Adjusted reimbursable bad debts (see instructions)			29, 668		
27. 00	Allowable bad debts for dual eligible beneficiaries (see instruct	tions)		12, 058		
28. 00	Subtotal (sum of lines 24 and 25, or line 26)			1, 830, 582		
29. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	29. 00	
29. 50	Pioneer ACO demonstration payment adjustment (see instructions)			0	29. 50	
29. 99	Demonstration payment adjustment amount before sequestration			1 020 502	29. 99	
30. 00 30. 01	Subtotal (see instructions)			1, 830, 582 12, 082	30.00	
30. 01	Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration			12, 082	30. 01 30. 02	
30. 02	Sequestration adjustment-PARHM			U	30. 02	
31. 00	Interim payments			1, 975, 055		
31. 00	Interim payments Interim payments-PARHM			1, 775, 055	31.00	
32. 00	Tentative settlement (for contractor use only)			0	32. 00	
32. 01	Tentative settlement-PARHM (for contractor use only)				32. 01	
33. 00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 3	31, and 32)		-156, 555		
33. 01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus		and 32.01)	,	33. 01	
34.00	Protested amounts (nonallowable cost report items) in accordance			0	34.00	
	§115. 2					

Health Financial Systems	FRANCISCAN HEALTH RENSSELAER	In Lieu of Form CMS-2552-			
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-1324	Peri od: From 01/01/2020 To 12/31/2020	Worksheet E-3 Part VII Date/Time Prepared: 8/2/2021 9:26 am		

			10 12/31/2020	8/2/2021 9: 26	
		Title XIX	Hospi tal	Cost	
			Inpati ent	Outpati ent	
			1. 00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SEF	RVICES FOR TITLES V OR XIX			
	COMPUTATION OF NET COST OF COVERED SERVICES				1
1.00	Inpatient hospital/SNF/NF services		202, 909		1.00
2.00	Medical and other services		, , , , , , ,	3, 271, 952	1
3.00	Organ acquisition (certified transplant centers only)		o	21 11	3. 00
4. 00	Subtotal (sum of lines 1, 2 and 3)		202, 909	3, 271, 952	
5. 00	Inpatient primary payer payments	202, 707	0/2/1/702	5.00	
6. 00	Outpatient primary payer payments			0	6. 00
7. 00	Subtotal (line 4 less sum of lines 5 and 6)		202, 909	3, 271, 952	
7.00	COMPUTATION OF LESSER OF COST OR CHARGES		202, 707	0, 271, 702	7.00
	Reasonable Charges				1
8. 00	Routine service charges				8.00
9. 00	Ancillary service charges		441, 546	8, 375, 279	1
10.00	Organ acquisition charges, net of revenue		441, 340	0, 373, 277	10.00
11. 00	Incentive from target amount computation				11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		441, 546	8, 375, 279	
12.00	CUSTOMARY CHARGES		441, 340	0, 373, 279	12.00
13. 00	Amount actually collected from patients liable for payment for	r convices on a charge	0	0	12 00
13.00	basis	i services on a charge	٩	U	13. 00
14. 00	Amounts that would have been realized from patients liable for	r navment for services on	0	0	14. 00
14.00	a charge basis had such payment been made in accordance with		٩	U	14.00
15. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)	42 CIR 9413. 13(e)	0. 000000	0. 000000	15. 00
16. 00	Total customary charges (see instructions)		441, 546	8, 375, 279	
17. 00	Excess of customary charges over reasonable cost (complete only	Ly if line 14 eyecods	238, 637	5, 103, 327	
17.00	line 4) (see instructions)	ry it fille to exceeds	230, 037	5, 105, 527	17.00
18. 00	Excess of reasonable cost over customary charges (complete onl	Ly if line 4 exceeds line	0	0	18. 00
10.00	16) (see instructions)	ry it title 4 exceeds title	٩	U	16.00
19. 00	Interns and Residents (see instructions)		0	0	19. 00
	Cost of physicians' services in a teaching hospital (see insti	ructions)	0	0	20.00
21. 00	Cost of covered services (enter the lesser of line 4 or line		202, 909	3, 271, 952	
21.00	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be			3, 211, 732	21.00
22 00	Other than outlier payments	compreted for 113 provide	0	0	22. 00
	Outlier payments		o o	0	
	Program capital payments			O	24. 00
25. 00	Capital exception payments (see instructions)				25. 00
26. 00	Routine and Ancillary service other pass through costs			0	1
27. 00	Subtotal (sum of lines 22 through 26)			0	1
28. 00	Customary charges (title V or XIX PPS covered services only)			0	1
29. 00	Titles V or XIX (sum of lines 21 and 27)		202, 909	3, 271, 952	
29.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT		202, 909	3, 211, 732	29.00
30. 00	Excess of reasonable cost (from line 18)		0	0	30.00
	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6))	202, 909	3, 271, 952	
32. 00	Deductibles)	202, 909	3, 271, 432	1
33. 00	Coinsurance			0	
34. 00	Allowable bad debts (see instructions)		0	0	1
	Utilization review		0	U	35.00
		4 33)	202, 909	2 271 052	
36. 00			202, 909	3, 271, 952	37.00
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		202 000	2 271 052	
	Subtotal (line 36 ± line 37)		202, 909	3, 271, 952	38. 00 39. 00
	Direct graduate medical education payments (from Wkst. E-4)		202 000	2 271 052	
40.00	' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' '		202, 909	3, 271, 952	
41.00	Interim payments		204, 150	3, 253, 843	
42.00	Balance due provider/program (line 40 minus line 41)		-1, 241	18, 109	
43. 00	Protested amounts (nonallowable cost report items) in accordan	nce with CMS Pub 15-2,	0	0	43. 00
	chapter 1, §115.2		1		I

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

Provider CCN: 15-1324

Peri od: Worksheet G From 01/01/2020 To 12/31/2020 Date/Ti me Prepared: 8/2/2021 9:26 am

					8/2/2021 9: 26	am
		General Fund	Speci fi c	Endowment Fund	Plant Fund	
		1.00	Purpose Fund	2.00	4.00	
	CHDDENT ACCETS	1.00	2. 00	3. 00	4. 00	
1. 00	CURRENT ASSETS Cash on hand in banks	19, 835		O	0	1.00
2.00	Temporary investments	733, 522		0	0	2.00
3.00	Notes receivable	/33, 322		-	0	3. 00
4. 00	Accounts receivable	5, 710, 278		0	0	4.00
5.00	Other receivable	3,710,276		0	0	5. 00
6. 00	Allowances for uncollectible notes and accounts receivable	-1, 339, 113	1	0	0	6.00
7. 00	Inventory	893, 459		0	0	7. 00
8. 00	Prepai d expenses	392, 806		0	0	8. 00
9. 00	Other current assets	83, 413		0	0	9. 00
10. 00	Due from other funds	03, 413		0	0	10.00
11. 00	Total current assets (sum of lines 1-10)	6, 494, 200	1	-	0	11. 00
11.00	FIXED ASSETS	0,474,200		<u> </u>	0	11.00
12. 00	Land	675, 791		0	0	12.00
13. 00	Land improvements	484, 426			0	13. 00
14. 00	Accumulated depreciation	1 404, 420			0	14. 00
15. 00	Buildings	19, 162, 169	1	0	0	15. 00
16. 00	Accumulated depreciation	17, 102, 107		0	0	16. 00
17. 00	Leasehold improvements	0		0	0	17. 00
18. 00	Accumulated depreciation	0		0	0	18. 00
19. 00	Fi xed equipment	0		0	0	19.00
20. 00	Accumulated depreciation	0	Ö	0	0	20.00
21. 00	Automobiles and trucks	0		0	0	21. 00
22. 00	Accumulated depreciation	0		0	0	22. 00
23. 00	Major movable equipment	12, 772, 561		0	0	23. 00
24. 00	Accumulated depreciation	-13, 977, 727		0	0	24. 00
25. 00	Mi nor equi pment depreci abl e	-13, 7/1, /2/		0	0	25. 00
26. 00	Accumulated depreciation	0		0	0	26.00
27. 00	HIT desi gnated Assets	0		0	0	27. 00
28. 00	Accumulated depreciation	0		0	0	28.00
29. 00	Mi nor equi pment-nondepreci abl e	0		0	0	29. 00
30. 00		10 117 220			0	30.00
30.00	Total fixed assets (sum of lines 12-29) OTHER ASSETS	19, 117, 220		U U	U	30.00
31. 00	Investments		0		0	31. 00
32. 00	Deposits on Leases	0			0	32.00
33. 00	Due from owners/officers	0		0	0	33. 00
34. 00	Other assets	432, 957		0	0	34.00
35. 00	Total other assets (sum of lines 31-34)	432, 957		0	0	35. 00
36. 00	Total assets (sum of lines 11, 30, and 35)	26, 044, 377			0	36.00
30.00	CURRENT LIABILITIES	20,044,377		<u> </u>	0	30.00
37. 00	Accounts payable	1, 594, 926	0	0	0	37. 00
38. 00	Salaries, wages, and fees payable	1, 274, 350		-	0	38. 00
39. 00	Payroll taxes payable	1,274,330		0	0	39. 00
40. 00	Notes and Loans payable (short term)	0		0	0	40.00
41. 00	Deferred income	0		0	0	41.00
42. 00	Accel erated payments	0	1	U	U	42.00
43. 00	Due to other funds	6, 609, 589	,	0	0	43. 00
44. 00	Other current liabilities	14, 477, 744		0	0	44.00
45. 00	Total current liabilities (sum of lines 37 thru 44)	23, 956, 609	1		_	45. 00
43.00		23, 930, 009	[0	U	45.00
46. 00	LONG TERM LIABILITIES Mortgage payable	_	0	ما	0	46. 00
47. 00	Notes payable	0		0	0	47. 00
48. 00	1	0			0	1
	Unsecured Loans Other Long term Linkilities	0 24 241 20E	1	-		48. 00
49. 00 50. 00	Other long term liabilities Total long term liabilities (sum of lines 46 thru 49)	24, 361, 385			0	49. 00 50. 00
	Total liabilities (sum of lines 45 and 50)	24, 361, 385		-		51.00
51. 00	,	48, 317, 994		ı U	U	51.00
E2 00	CAPITAL ACCOUNTS	22 272 /17	I			F2 00
52.00	General fund balance Specific purpose fund	-22, 273, 617				52.00
53. 00 54. 00	Donor created - endowment fund balance - restricted			0		53. 00 54. 00
				0		•
55. 00	Donor created - endowment fund balance - unrestricted			0		55.00
56. 00 57. 00	Governing body created - endowment fund balance			ا	_	56.00
57.00	Plant fund balance - invested in plant				0	57.00
58. 00	Plant fund balance - reserve for plant improvement,				0	58. 00
59. 00	replacement, and expansion Total fund balances (sum of lines 52 thru 58)	-22, 273, 617			0	59. 00
60. 00	Total liabilities and fund balances (sum of lines 51 and	26, 044, 377			0	60.00
UU. UU	Total Trabilities and rund barances (sum of Tries 51 and	20,044,3//		"		00.00
	l~·/	I	I	1		ı

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

					From 01/01/2020 To 12/31/2020		
		Genera	l Fund	Special P	urpose Fund	Endowment Fund	
		1.00	2.00	3.00	4. 00	5. 00	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 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) EQUITY TRANSFERS Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) ROUNDING Total deductions (sum of lines 12-17) Fund balance at end of period per balance	0 196, 708 0 0 0 0 0	-21, 062, 415 -1, 313, 503 -22, 375, 918		4.00 C C C C C C C C C C C C C C C C C C		1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00
	sheet (line 11 minus line 18)	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) EQUITY TRANSFERS	0	0 0 0 0 0		0		1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) ROUNDING	0	0 0 0 0 0		0		10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00
18. 00 19. 00	Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0		1	0		18. 00 19. 00

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

PART I - PATIENT REVENUES 1.00 2.00 3.00				10	12/31/2020	8/2/2021 9: 26	
PART I - PATIENT REVENUES Concernal Inpatient Routine Services 2,584,212 2,584,212 1.00 Concernal Inpatient Routine Services 2,584,212 1.00 Concernal Inpatient Care Services (sum of lines 1-9) 2,584,212 2,584,212 1.00 Concernal Inpatient Routine Services 2,584,212 2,584,212 1.00 Concernal Inpatient Routine Services 2,584,212 2,584,212 1.00 Concernal Inpatient Care Services (sum of lines 1-9) 2,584,212 2,584,212 1.00 Concernal Inpatient Routine Services 2,584,212 2,584,212 1.00 Concernal Inpatient Routine Services 2,584,212 2,584,212 1.00 Concernal Inpatient Care Inpatient Routine Services 2,584,212 2,584,212 1.00 Concernal Inpatient Routine Services 2,783,622 2,783,62		Cost Center Description		Inpatient	Outpati ent		
Centeral Impatient Routine Services 1.00 Hospital 2, 584, 212 2, 584, 212 2, 584, 212 2. 00 2. 00 3.							
Mospital		PART I - PATIENT REVENUES					
SUBPROVIDER IFIF		General Inpatient Routine Services					
SUBPROVIDER TRF	1.00	Hospi tal		2, 584, 212		2, 584, 212	1.00
SUBPROVIDER							
5.00 Swing bed SNF 0 0 0 0 0 0 0 0 0							
Swing bed = NF Swin							
Total case SKILLED NURSING FACILITY Solution SKILLED NURSING FACILITY Solution Skilled Number				-			
8.00				0		0	
OTHER LONG TERM CARE							
10.00							
Intensive Care Type Inpatient Hospital Services 179, 410 180, 400 190, 400, 400 190, 400, 400, 400 400, 400, 400 400, 400,				2 504 212		2 504 212	
11.00 INTENSIVE CARE UNIT 179, 410 179, 410 120, 00 120, 00 13.00 140, 00 140, 00 140, 00 150,	10.00			2, 584, 212		2, 584, 212	10.00
12.00 CORONARY CARE UNIT 12.00 13.00	11 00			170 /10		170 /10	11 00
13. 00 BURN INTENSIVE CARE UNIT				177, 410		177, 410	
14. 00 SURGICAL INTENSIVE CARE UNIT 14. 00 16. 00							
15. 00 OTHER SPECIAL CARE (SPECIFY) Total intensive care type inpatient hospital services (sum of lines 179, 410 179, 410 170, 00 171-15) Total inpatient routine care services (sum of lines 10 and 16) 2, 763, 622 2, 763, 622 2, 763, 622 17. 00 17.							
Total intensive care type inpatient hospital services (sum of lines 179,410 179,							
11-15		· · · · · ·	lines	179, 410		179, 410	
17. 00				, , ,		, , ,	
19.00 0	17.00			2, 763, 622		2, 763, 622	17.00
20. 00 RURÂL HEALTH CLINIC 0 111, 365 111, 365 20. 00	18.00	Ancillary services		5, 142, 034	60, 397, 652	65, 539, 686	18.00
20.03 RURAL HEALTH CLINIC IV FEDERALLY QUALIFIED HEALTH CENTER 0 168,839 20.03 21.00 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 21.00 0 0 22.00 0 0 0 0 0 0 0 0 0	19.00	Outpati ent servi ces		280, 544	12, 474, 978	12, 755, 522	19.00
21.00 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 22.00 100 140 140 100 120 100 120 100 120 100 120 100 120 100 120 100 120 100 120 100 120 100 12	20.00	RURAL HEALTH CLINIC		0	111, 365	111, 365	20.00
22.00 HOME HEALTH AGENCY 23.00 AMBULANCE SERVICES 24.00 23.00 24.00 24.00 25.00 24.00 25.00 25.00 26.00 26.00 26.00 27.00 27.00 28	20. 03	RURAL HEALTH CLINIC IV		0	168, 839	168, 839	
23. 00				0	0	0	
24. 00 CMHC 25. 00 AMBULATORY SURGICAL CENTER (D.P.) 26. 00 HOSPI CE 27. 00 NRCC AND OTHER REVENUE 28. 00 Total patient revenues (sum of lines 17-27) (transfer column 3 to Wkst. 8, 651, 586 73, 154, 106 81, 805, 692 700							
25. 00							
26. 00							
27. 00 NRCC AND OTHER REVENUE 465, 386 1, 272 466, 658 27. 00							
28.00 Total patient revenues (sum of lines 17-27) (transfer column 3 to Wkst. 8, 651, 586 73, 154, 106 81, 805, 692 6-3, line 1) PART II - OPERATING EXPENSES Operating expenses (per Wkst. A, column 3, line 200) ADD (SPECIFY) ADD (SPECIFY) O 35, 249, 974 29.00 30.00 31.00 32.00 33.00 34.00 35.00 36.00 Total additions (sum of lines 30-35) DEDUCT (SPECIFY) O 37.00 38.00 39.00 40.00 41.00 42.00 Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer) Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer) 73, 154, 106 81, 805, 692 73, 154, 106 81, 805, 692 84, 651, 586 73, 154, 106 81, 805, 692 84, 651, 586 73, 154, 106 81, 805, 692 84, 805, 692 84, 805, 586 73, 154, 106 81, 805, 692 84, 651, 586 73, 154, 106 81, 805, 692 84, 651, 586 73, 154, 106 81, 805, 692 84, 651, 586 73, 154, 106 81, 805, 692 84, 805, 692 84, 651, 586 73, 154, 106 81, 805, 692 84, 651, 586 73, 154, 106 81, 805, 692 84, 651, 586 73, 154, 106 81, 805, 692 84, 805, 692 84, 805, 692 84, 805, 692 84, 805, 692 84, 651, 586 84, 805, 692 84, 651, 586 84, 651, 586 84, 805, 692 84, 651, 586 84, 805, 692 84, 651, 586 84, 805, 692 84, 605 84, 651, 586 84, 651, 586 84, 651, 586 84, 651, 586 84, 651, 586 84, 651, 586 84, 805, 692 84, 605 84, 651, 586 84, 651, 586 84, 651, 586 84, 651, 586 84, 651, 586 84, 651, 586 84, 805, 692 84, 605 84, 651, 586 84, 651, 586 84, 651, 586 84, 651, 586 84, 651, 586 84, 651, 586 84, 651, 586 84, 651, 586 84, 651, 586 84, 651, 586 84, 651, 586 84, 651, 586 84, 651, 586 84, 651, 586 84, 651, 586 84, 651, 586 84, 805, 692 84, 651, 586 84, 651, 586 84, 651, 586 84, 651, 586 84, 651, 586 84, 651, 586 84, 651, 586 84, 651, 586 84, 651, 586 84, 651, 586 84, 651, 586 84, 651, 586 84, 651, 586 84, 651, 586 84, 651, 586 84, 651, 686 84, 651, 686 84, 651, 686 84, 651, 686 84, 651, 686 84, 651, 686 84, 651, 686 84, 651, 686 84, 651, 686 84, 651, 686 84, 651, 686 84, 651				4/5 00/	4 070	4// /50	
G-3, line 1) PART II - OPERATING EXPENSES 29.00 Operating expenses (per Wkst. A, column 3, line 200) 35, 249, 974 29.00 30.00 31.00 32.00 33.00 33.00 34.00 35.00 36.00 36.00 36.00 36.00 36.00 37.00 36.00 37.00 38.00 38.00 39.00 40.00 41.00 42.00 Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer 35, 249, 974 43.00 43.00 43.00 43.00 43.00 44.			+- 111+	·	•		
PART II - OPERATING EXPENSES 29. 00	28.00	, , , , , , , , , , , , , , , , , , , ,	to WKST.	8, 651, 586	73, 154, 106	81, 805, 692	28.00
29.00 30.00 30.00 31.00 31.00 32.00 33.00 34.00 35.00 36.00 37.00 38.00 37.00 38.00 39.00 40.00 40.00 41.00 42.00 Total deductions (sum of lines 37-41) Total operating expenses (per Wkst. A, column 3, line 200) 30.00 31.00 30.00 31.00 31.00 32.00 32.00 33.00 34.00 0 0 0 0 0 0 35.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0							
30.00 ADD (SPECIFY) 0 30.00 31.00 32.00 32.00 32.00 33.00 34.00 35.00 35.00 35.00 35.00 35.00 36.00 35.00 36.00 36.00 37.00 36.00 37.00 38.00 39.00 40.00 41.00 42.00 Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer 35,249,974 43.00	29 00				35 249 974		29 00
31.00 32.00 33.00 33.00 34.00 35.00 36.00 Total additions (sum of lines 30-35) DEDUCT (SPECIFY) 0 36.00 37.00 38.00 39.00 40.00 41.00 42.00 Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer) 31.00 31.00 32.00 31.00 32.00 33.00 33.00 33.00 34.00 35.00 0 0 0 0 0 0 0 0 0 40.00 41.00 42.00 Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer) 35.249,974				0	00, 217, 771		
32.00 33.00 33.00 34.00 35.00 36.00 Total additions (sum of lines 30-35) DEDUCT (SPECIFY) 0 37.00 38.00 39.00 40.00 41.00 42.00 Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer) 32.00 32.00 33.00 33.00 34.00 35.00 36.00 37.00 37.00 38.00 39.00 40.00 41.00 42.00 39.00 41.00		(SI ESTITY)					
33.00 34.00 35.00 36.00 Total additions (sum of lines 30-35) DEDUCT (SPECIFY) 0 37.00 38.00 39.00 40.00 41.00 42.00 Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer 0 33.00 34.00 35.00 36.00 37.00 38.00 39.00 40.00 41.00 42.00 39.00 41.00 42.00 35.249,974				-			
34.00 35.00 36.00 Total additions (sum of lines 30-35) DEDUCT (SPECIFY) DEDUCT (SPECIFY) O 38.00 39.00 40.00 41.00 Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer) O 34.00 35.00 35.00 36.00 37.00 37.00 38.00 39.00 40.00 41.00 42.00 39.00 41.00 42.00 35.249,974				-			
35.00 36.00 Total additions (sum of lines 30-35) DEDUCT (SPECIFY) 0 37.00 38.00 39.00 40.00 41.00 42.00 Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer) 35.00 36.00 37.00 37.00 37.00 38.00 39.00 0 0 0 41.00 0 42.00 35.249,974				0			34.00
37. 00 DEDUCT (SPECIFY) 0 37. 00 38. 00 39. 00 40. 00 41. 00 42. 00 Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer 35, 249, 974 43. 00 37. 00 38. 00 0 39. 00 0 40. 00 0 41. 00 42. 00 42. 00 43. 00 43. 00 0 43. 00 44. 0	35.00			0			35.00
38.00 39.00 0 0 38.00 0 0 39.00 0 0 0 40.00 0 0 41.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	36.00	Total additions (sum of lines 30-35)			0		36.00
39.00 40.00 41.00 42.00 Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer 35, 249, 974 33.00	37.00	DEDUCT (SPECIFY)		0			37.00
40.00	38. 00			0			38.00
41.00 42.00 Total deductions (sum of lines 37-41) 43.00 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer 35, 249, 974 43.00	39. 00			0			
42.00 Total deductions (sum of lines 37-41) 0 42.00 43.00 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer 35,249,974 43.00							
43.00 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer 35, 249, 974 43.00				0			
		,			0		
TO WKST. G-3, TINE 4)	43. 00		(transfer		35, 249, 974		43. 00
		LU WKSL. U-3, TIME 4)				l	

		FRANCISCAN HEALTH RE		_	u of Form CMS-2	
STATE	MENT OF REVENUES AND EXPENSES	F	Provider CCN: 15-1324	Peri od: From 01/01/2020	Worksheet G-3	
				To 12/31/2020	Date/Time Pre	pared:
					8/2/2021 9: 26	
					1.00	
1. 00	Total patient revenues (from Wkst. G-2, Part	L column 2 line	20)		1. 00 81, 805, 692	1. 00
2.00	Less contractual allowances and discounts on	•			50, 223, 018	1
3. 00	Net patient revenues (line 1 minus line 2)	patrents accounts			31, 582, 674	
4. 00	Less total operating expenses (from Wkst. G-2	2 Part II lino 42	`		35, 249, 974	1
5.00	Net income from service to patients (line 3 r)		-3, 667, 300	
3.00	OTHER INCOME	illi ilus TTTIE 4)			-3,007,300	3.00
6. 00	Contributions, donations, bequests, etc				0	6.00
7. 00	Income from investments				Ö	1
8.00	Revenues from telephone and other miscellaneo	ous communication s	ervi ces		Ö	
9. 00	Revenue from television and radio service				0	
10.00	Purchase di scounts				0	1
11. 00	Rebates and refunds of expenses				0	11. 00
12.00	Parking lot receipts				0	12. 00
13.00	Revenue from Laundry and Linen service				0	13. 00
14.00	Revenue from meals sold to employees and gues	sts			0	14. 00
15.00	Revenue from rental of living quarters				0	15. 00
16.00	Revenue from sale of medical and surgical sup	pplies to other tha	n patients		0	16. 00
17.00	Revenue from sale of drugs to other than pati	ients			0	17. 00
18.00	Revenue from sale of medical records and abs	tracts			0	18. 00
19.00	Tuition (fees, sale of textbooks, uniforms, e	etc.)			0	19. 00
20.00	Revenue from gifts, flowers, coffee shops, ar	nd 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 REVENUE				290, 772	24. 00
24. 01	OTHER NON-OPERATING				159, 692	24. 01
	COVI D-19 PHE Fundi ng				1, 903, 332	
	Total other income (sum of lines 6-24)				2, 353, 796	
26 00	Total (line 5 plus line 25)				1 212 504	1 24 00

-1, 313, 504

-1, 313, 503 29. 00

504 26.00 -1 27.00 -1 28.00

24. 50 COVID-19 PHE Funding
25. 00 Total other income (sum of lines 6-24)
26. 00 Total (line 5 plus line 25)
27. 00 ROUNDING
28. 00 Total other expenses (sum of line 27 and subscripts)
29. 00 Net income (or loss) for the period (line 26 minus line 28)

	Financial Systems F SIS OF HOSPITAL-BASED RHC/FQHC COSTS	FRANCISCAN HEALT	Provider C	°N: 15_1324	Peri od:	u of Form CMS-2 Worksheet M-1	2552-10
ANALIS	113 OF HOSELTAL-BASED KITC/T QUE COSTS				From 01/01/2020		
			Component	CCN: 15-3990	To 12/31/2020	Date/Time Pre 8/2/2021 9:26	pared:
					RHC I	Cost	uiii
		Compensation	Other Costs		1 Reclassificati	Recl assi fi ed	
				+ col . 2)	ons	Trial Balance	
						(col. 3 + col.	
		1.00		0.00		4)	
	FACILITY HEALTH CARE CTAFE COCTO	1.00	2. 00	3. 00	4. 00	5. 00	
1 00	FACILITY HEALTH CARE STAFF COSTS Physician	68, 558	13, 712	82, 27	0 0	82, 270	1.00
1. 00 2. 00	Physician Assistant	08, 558	13, /12	82, 27	0 0	82, 270	2.00
3.00	Nurse Practitioner	113, 250	0	113, 25	٥	113, 250	
4.00	Visiting Nurse	113, 230	0	113, 20	0 0	113, 230	1
5. 00	Other Nurse	32, 495	0	32, 49	٥	32, 495	
6.00	Clinical Psychologist	02, 170	0	02, 17	0 0	02, 170	6. 00
7. 00	Clinical Social Worker	o	0		o o	0	1
8.00	Laboratory Techni ci an	O	0		0 0	0	8. 00
9.00	Other Facility Health Care Staff Costs	59, 886	0	59, 88	86 0	59, 886	9. 00
10.00	Subtotal (sum of lines 1 through 9)	274, 189	13, 712	287, 90	0	287, 901	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	13. 00
14.00	Subtotal (sum of lines 11 through 13)	0	0		0	0	14. 00
15. 00	Medical Supplies	0	671	67	[1] 0	671	15. 00
16. 00	Transportation (Health Care Staff)	0	0		0	0	16. 00
17. 00	Depreciation-Medical Equipment	0	0		0	0	
18.00	Professional Liability Insurance	0	42 122	40.40	0 0	20,005	18.00
19. 00 20. 00	Other Health Care Costs Allowable GME Costs	U	43, 122	43, 12	-15, 027	28, 095	19. 00 20. 00
21. 00	Subtotal (sum of lines 15 through 20)	0	43, 793	43. 79	-15, 027	28, 766	1
22. 00	Total Cost of Health Care Services (sum of	274, 189	57, 505			316, 667	22.00
22.00	lines 10, 14, and 21)	274, 109	57, 505	331,09	-15,027	310,007	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23. 00	Pharmacy	0	0		0 0	0	23. 00
24. 00	Dental	o	0		0 0	0	24. 00
25.00	Optometry	o	0		0 0	0	25. 00
25. 01	Tel eheal th	0	0		0 0	0	25. 01
25. 02	Chronic Care Management	0	0		0	0	25. 02
26. 00	All other nonreimbursable costs	0	0		0	0	26. 00
27. 00	Nonallowable GME costs						27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	0		0	0	28. 00
	through 27)	1			1		1

0

0

57, 505

274, 189

0

331, 694

0

-15, 027

29.00

32.00

0 30.00

0 31.00

316, 667

through 27)
FACILITY OVERHEAD
29.00 Facility Costs
30.00 Administrative Costs

and 31)

31.00 Total Facility Overhead (sum of lines 29 and

32.00 Total facility costs (sum of lines 22, 28

Health Financial Systems	FRANCISCAN HEALTH RENSSELAER	In Lie	u of Form CMS-2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS		Peri od: From 01/01/2020	Worksheet M-1
	Component CCN: 15-3990	To 12/31/2020	Date/Ti me Prepared: 8/2/2021 9:26 am
		DHC I	Cost

			Component	0011. 10 077	0 10	12/31/2020	8/2/2021 9: 26	
						RHC I	Cost	
		Adjustments	Net Expenses					
			for Allocation					
			(col. 5 + col.					
			6)					
		6.00	7. 00					
	FACILITY HEALTH CARE STAFF COSTS							_
1.00	Physi ci an	-46, 619	35, 651					1. 00
2.00	Physician Assistant	0	0	1				2. 00
3.00	Nurse Practitioner	0	113, 250					3. 00
4.00	Visiting Nurse	0	0					4. 00
5.00	Other Nurse	0	32, 495					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	1				8. 00
9.00	Other Facility Health Care Staff Costs	0	59, 886					9. 00
10.00	Subtotal (sum of lines 1 through 9)	-46, 619	241, 282					10.00
11. 00	Physician Services Under Agreement	0	0					11. 00
12.00	Physician Supervision Under Agreement	0	0	1				12. 00
13.00	Other Costs Under Agreement	0	0	1				13. 00
14.00	Subtotal (sum of lines 11 through 13)	0	0	1				14. 00
15. 00	Medical Supplies	0	671					15. 00
16. 00	Transportation (Health Care Staff)	0	0					16. 00
17. 00	Depreciation-Medical Equipment	0	0					17. 00
18. 00	Professional Liability Insurance	0	0					18. 00
19. 00	Other Health Care Costs	-5, 940	22, 155					19. 00
20.00	Allowable GME Costs							20. 00
21. 00	Subtotal (sum of lines 15 through 20)	-5, 940	22, 826	1				21. 00
22. 00	Total Cost of Health Care Services (sum of	-52, 559	264, 108					22. 00
	lines 10, 14, and 21)							_
	COSTS OTHER THAN RHC/FQHC SERVICES	ما		1				
23. 00	Pharmacy	0	0					23. 00
24. 00	Dental	0	0	1				24. 00
25. 00	Optometry	0	0	1				25. 00
25. 01	Tel eheal th	0	0	1				25. 01
25. 02	Chronic Care Management	0	0	1				25. 02
26. 00	All other nonreimbursable costs	0	0					26. 00
27. 00	Nonallowable GME costs	_	_					27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	0					28. 00
	through 27)							1
20.00	FACILITY OVERHEAD							20.00
29. 00	Facility Costs	0	0	1				29. 00
30.00	Administrative Costs	0	0	1				30.00
31. 00	Total Facility Overhead (sum of lines 29 and	O	0					31. 00
22.00	30)	E2 EE0	244 100					22.00
32. 00	Total facility costs (sum of lines 22, 28 and 31)	-52, 559	264, 108					32. 00
	and 31)	ı		I				ı

		RANCISCAN HEAL				eu of Form CMS-	
ANALYS	SIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provi der C	CN: 15-1324	Peri od:	Worksheet M-1	
			Component		From 01/01/2020 To 12/31/2020		pared:
					RHC IV	Cost	
		Compensation	Other Costs	Total (col. '	Reclassi fi cati	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	(0.550					
1.00	Physi ci an	68, 558	13, 712	82, 27			1
2.00	Physician Assistant	0	0	44, 40	0	1	
3.00	Nurse Practitioner	116, 621	0	116, 62	0	116, 621	3.00
4.00	Visiting Nurse	47.245	0	47.04	0	0	
5. 00 6. 00	Other Nurse	47, 365	0	47, 36	5	47, 365 0	1
7. 00	Clinical Psychologist Clinical Social Worker	0	0		0	0	0.00
7. 00 8. 00	Laboratory Techni ci an	0	0		0	0	8.00
9. 00	Other Facility Health Care Staff Costs	62, 174	0	62, 17	4	62, 174	1
10.00	Subtotal (sum of lines 1 through 9)	294, 718		308, 43		308, 430	
11. 00	Physician Services Under Agreement	274, / 10	13, 712	300, 43	0	0 300, 430	1
12. 00	Physician Supervision Under Agreement	0			0 0	0	1
13. 00	Other Costs Under Agreement	0	0		0	0	13.00
14. 00	Subtotal (sum of lines 11 through 13)	0	١		0 0	0	
15. 00	Medical Supplies	0	895	89	-	895	
16. 00	Transportation (Health Care Staff)	0	423	42		423	1
17. 00		0	0		0 0	0	1
18. 00	Professional Liability Insurance	0	0		0 0	0	18. 00
19.00	Other Health Care Costs	0	18, 955	18, 95	5 -14, 266	4, 689	19. 00
20.00	Allowable GME Costs						20.00
21. 00	Subtotal (sum of lines 15 through 20)	0	20, 273	20, 27	3 -14, 266	6, 007	21.00
22.00	Total Cost of Health Care Services (sum of	294, 718	33, 985	328, 70	3 -14, 266	314, 437	22. 00
	lines 10, 14, and 21)]
	COSTS OTHER THAN RHC/FQHC SERVICES						
23. 00	Pharmacy	0	0		0		0.00
24. 00	Dental	0	0		0	0	24. 00
25. 00	Optometry	0	0		0	0	
25. 01	Tel eheal th	0	0		0	0	25. 01
25. 02	Chronic Care Management	0	0		0		25. 02
26. 00	All other nonreimbursable costs	0	0		0	0	20.00
27. 00	Nonallowable GME costs	_	_		-	_	27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	"		0	0	28. 00

0

33, 985

294, 718

0

328, 703

0

-14, 266

29.00

32.00

0 30.00

0 31.00

314, 437

through 27)
FACILITY OVERHEAD
29.00 Facility Costs
30.00 Administrative Costs

and 31)

31.00

Total Facility Overhead (sum of lines 29 and

32.00 Total facility costs (sum of lines 22, 28

			u of Form CMS-2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS	Provider CCN: 15-1324	Peri od: From 01/01/2020	Worksheet M-1
	Component CCN: 15-8502	To 12/31/2020	

			Component	CCN. 13-030.	2 10	12/31/2020	8/2/2021 9: 26	
					R	RHC IV	Cost	
		Adjustments	Net Expenses					
			for Allocation					
			(col. 5 + col.					
			6)					
		6.00	7. 00					
	FACILITY HEALTH CARE STAFF COSTS							
1.00	Physi ci an	-49, 362	32, 908					1.00
2.00	Physician Assistant	0	0)				2. 00
3.00	Nurse Practitioner	0	116, 621					3. 00
4.00	Visiting Nurse	0	0					4. 00
5.00	Other Nurse	0	47, 365					5. 00
6.00	Clinical Psychologist	0	0					6. 00
7.00	Clinical Social Worker	0	0					7. 00
8.00	Laboratory Techni ci an	0	0					8. 00
9.00	Other Facility Health Care Staff Costs	0	62, 174					9. 00
10.00	Subtotal (sum of lines 1 through 9)	-49, 362	259, 068					10.00
11.00	Physician Services Under Agreement	0	0					11. 00
12.00	Physician Supervision Under Agreement	0	0					12.00
13.00	Other Costs Under Agreement	0	0					13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0					14. 00
15.00	Medical Supplies	0	895					15. 00
16.00	Transportation (Health Care Staff)	0	423					16. 00
17.00	Depreciation-Medical Equipment	0	0					17. 00
18.00	Professional Liability Insurance	0	0					18. 00
19.00	Other Health Care Costs	-55	4, 634					19. 00
20.00	Allowable GME Costs							20. 00
21.00	Subtotal (sum of lines 15 through 20)	-55	5, 952					21. 00
22.00	Total Cost of Health Care Services (sum of	-49, 417	265, 020					22. 00
	lines 10, 14, and 21)							
	COSTS OTHER THAN RHC/FQHC SERVICES			,				
23.00	Pharmacy	0	0)				23. 00
24.00	Dental	0	0)				24. 00
25.00	Optometry	0	0)				25. 00
25. 01	Tel eheal th	0	0					25. 01
25. 02	Chronic Care Management	0	0					25. 02
26.00	All other nonreimbursable costs	0	0					26. 00
27.00	Nonallowable GME costs							27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	0					28. 00
	through 27)							
	FACILITY OVERHEAD							
29. 00	Facility Costs	0	0					29. 00
30.00	Administrative Costs	0	0					30. 00
31.00	Total Facility Overhead (sum of lines 29 and	0	0	1				31. 00
	30)							
32. 00	Total facility costs (sum of lines 22, 28	-49, 417	265, 020	1				32. 00
	and 31)			I				1

Number of FTE Personnel Total Visits Productivity Minimum Visits Greater of 8/2/2021 9:26 am Ric 1 Cost	Heal th	Financial Systems	FRANCI SCAN HEAL	TH RENSSELAER		In Lie	eu of Form CMS-2	2552-10
Number of FTE Total Visits Productivity Minimum Visits Greater of col. 2 or col. 4 4 4 4 4 4 4 4 4 4			SERVI CES			From 01/01/2020	Date/Time Pre	pared:
Number of FTE Personnel						RHC. I		aiii
Note			Number of FTE	Total Visits	Producti vi tv			
NESTER AND PRODUCTIVITY Post tions			Personnel			(col. 1 x col.	col. 2 or col.	
Desirations Physician Services Servi			1.00	2.00	3.00	4. 00	5. 00	
1.00		VISITS AND PRODUCTIVITY						
2.00 Physician Assistant		Posi ti ons						
3.00 Nurse Practitioner	1.00	Physi ci an	0. 06	168				1. 00
4.00 Subtotal (sum of lines 1 through 3)								
5.00 Visiting Nurse								
6.00 Clinical Psychologist 0.00 0 0 0 0 0 0 7.0			1			1, 404		
7. 00 Clinical Social Worker 0. 00 0 0 7. 00 7. 00 7. 01 Medical Nutrition Therapist (FOHC only) 0. 00 0 0 7. 01 7. 02 01 iabetes Self Management Training (FOHC 0. 00 0 0 0 0 0 0 0 0								
7. 01 Medical Nutrition Therapist (FOHC only)			1	l .				
7. 02 Diabetes Self Management Training (FOHC 0.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			1	l .			1	
8. 00 Total FTEs and Visits (sum of lines 4 1. 04 1,590 1,590 1,590 8. 00 through 7) 9. 00 Physician Services Under Agreements 0 0 0 9. 00 DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FOHC SERVICES 10. 00 Total costs of health care services (from Wkst. M-1, col. 7, line 22) 264, 108 10. 00 11. 00 Cost of all services (excluding overhead) (sum of lines 10 and 11) 264, 108 11. 00 13. 00 Ratio of hospital-based RHC/FOHC services (line 10 divided by line 12) 1. 0000000 13. 00 14. 00 Total hospital-based RHC/FOHC overhead - (from Worksheet. M-1, col. 7, line 31) 0 14. 00 Parent provider overhead allocated to facility (see instructions) 197, 599 15. 00 17. 00 Allowable GME overhead (see instructions) 197, 599 18. 00 17. 00 Enter the amount from line 16 197, 599 19. 00 197, 599 19. 00 197, 599 19. 00								
8.00 Total FTEs and Visits (sum of lines 4 1.04 1,590 1,590 1,590 8.00 through 7) 9.00 Physician Services Under Agreements 0 9.00 1.00 1.00 1.00 1.00 1.00 1.00 1.	7. 02		0.00	0			0	7.02
9.00 Physician Services Under Agreements 0 0 9.00 DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FOHC SERVICES 1.00	8.00	Total FTEs and Visits (sum of lines 4	1. 04	1, 590			1, 590	8. 00
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FOHC SERVICES 1.00				_			_	
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FOHC SERVICES 10.00 Total costs of health care services (from Wkst. M-1, col. 7, line 22) 264, 108 10.00 11.00 Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28) 0 11.00 12.00 Cost of all services (excluding overhead) (sum of lines 10 and 11) 264, 108 12.00 13.00 Ratio of hospital-based RHC/FOHC services (line 10 divided by line 12) 1.000000 13.00 14.00 Total hospital-based RHC/FOHC overhead - (from Worksheet. M-1, col. 7, line 31) 0 14.00 15.00 Parent provider overhead allocated to facility (see instructions) 197, 599 15.00 15.00 17.00 Allowable GME overhead (see instructions) 0 17.00 17.00 Allowable GME overhead (see instructions) 0 17.00 17.00 Center the amount from line 16 197, 599 19.00 197, 599 19	9. 00	Physician Services Under Agreements		0			0	9. 00
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FOHC SERVICES 10.00 Total costs of health care services (from Wkst. M-1, col. 7, line 22) 264, 108 10.00 11.00 Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28) 0 11.00 12.00 Cost of all services (excluding overhead) (sum of lines 10 and 11) 264, 108 12.00 13.00 Ratio of hospital-based RHC/FOHC services (line 10 divided by line 12) 1.000000 13.00 14.00 Total hospital-based RHC/FOHC overhead - (from Worksheet. M-1, col. 7, line 31) 0 14.00 15.00 Parent provider overhead allocated to facility (see instructions) 197, 599 15.00 15.00 17.00 Allowable GME overhead (see instructions) 0 17.00 17.00 Allowable GME overhead (see instructions) 0 17.00 17.00 Center the amount from line 16 197, 599 19.00 197, 599 19							1.00	
10.00 Total costs of health care services (from Wkst. M-1, col. 7, line 22) 264, 108 10.00 11.00 10.00 1		DETERMINATION OF ALLOWARIE COST ADDITIONE	TO HOSDITAL DASS	ED DUC/EOUC SED	VII CES		1.00	
11.00 Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28) 12.00 Cost of all services (excluding overhead) (sum of lines 10 and 11) 13.00 Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12) 14.00 Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31) 15.00 Parent provider overhead allocated to facility (see instructions) 16.00 Total overhead (sum of lines 14 and 15) 17.00 Allowable GME overhead (see instructions) 18.00 Enter the amount from line 16 19.00 Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18) 0 11.00 10.00000 13.00 11.00 12.00 12.00 13.00 14.00 197,599 15.00 197,599 16.00 197,599 18.00	10 00				VICES		26/ 108	10 00
12.00 Cost of all services (excluding overhead) (sum of lines 10 and 11) 13.00 Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12) 14.00 Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31) 15.00 Parent provider overhead allocated to facility (see instructions) 16.00 Total overhead (sum of lines 14 and 15) 17.00 Allowable GME overhead (see instructions) 18.00 Enter the amount from line 16 19.00 Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18) 264, 108								1
13.00 Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12) 14.00 Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31) 15.00 Parent provider overhead allocated to facility (see instructions) 16.00 Total overhead (sum of lines 14 and 15) 17.00 Allowable GME overhead (see instructions) 18.00 Enter the amount from line 16 19.00 Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18) 11.000000 12.00 14.00 197,599 15.00 197,599 16.00 197,599 18.00								
Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31) 15.00 Parent provider overhead allocated to facility (see instructions) 16.00 Total overhead (sum of lines 14 and 15) 17.00 Allowable GME overhead (see instructions) 18.00 Enter the amount from line 16 19.00 Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18) 10 14.00 197,599 15.00 197,599 16.00 197,599 18.00								1
Parent provider overhead allocated to facility (see instructions) 197, 599 15.00 16.00 17.00 18.00 197, 599 16.00 17.00 18.00 197, 599 18.00 197, 599 18.00 197, 599 18.00 197, 599 18.00 197, 599 19.00 1					ne 31)		l	
16.00 Total overhead (sum of lines 14 and 15) 197,599 16.00 17.00 Allowable GME overhead (see instructions) 0 17.00 18.00 Enter the amount from line 16 197,599 18.00 19.00 Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18) 197,599 19.00								
18.00 Enter the amount from line 16 19.00 Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18) 19.00 Enter the amount from line 16 197,599 18.00 197,599 19.00	16.00		.5 (,				1
19.00 Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18) 197,599 19.00	17.00	Allowable GME overhead (see instructions)					0	17. 00
	18.00						197, 599	18. 00
20.00 Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19) 461,707 20.00	19. 00	Overhead applicable to hospital-based RHC/F	QHC services (li	ne 13 x line 1	8)		197, 599	19. 00
	20. 00	Total allowable cost of hospital-based RHC/	FQHC services (s	sum of lines 10	and 19)		461, 707	20. 00

	Financial Systems	FRANCI SCAN HEAL	TH RENSSELAER		In Lie	u of Form CMS-2	2552-10
ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC	SERVI CES	Provi der CC		Period: From 01/01/2020	Worksheet M-2	
			Component	CCN: 15-8502	To 12/31/2020	Date/Time Pre 8/2/2021 9:26	
		_			RHC IV	Cost	
		Number of FTE	Total Visits		Minimum Visits		
		Personnel		Standard (1)	(col. 1 x col. 3)	col. 2 or col. 4	
		1.00	2.00	3.00	4. 00	5. 00	
	VISITS AND PRODUCTIVITY						
	Posi ti ons						
1.00	Physi ci an	0. 06	128	128	8 8		1. 00
2.00	Physi ci an Assi stant	0.00	0	10	0		2. 00
3.00	Nurse Practitioner	0. 98	2, 819	2, 81	9 2, 763		3. 00
4.00	Subtotal (sum of lines 1 through 3)	1. 04	2, 947		2, 771	2, 947	4. 00
5.00	Visiting Nurse	0. 00				0	5. 00
6.00	Clinical Psychologist	0. 00				0	6. 00
7.00	Clinical Social Worker	0. 00				0	7. 00
7. 01	Medical Nutrition Therapist (FQHC only)	0. 00				0	7. 01
7. 02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7. 02
8.00	Total FTEs and Visits (sum of lines 4	1. 04	2, 947			2, 947	8. 00
	through 7)						
9.00	Physician Services Under Agreements		0			0	9. 00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE	TO HOSDITAL BASE	D DUC/EOUC SED	VII CES		1. 00	
	Total costs of health care services (from W			VICES		265, 020	10 00
11. 00	Total nonreimbursable costs (from Wkst. M-1					203, 020	
12.00	Cost of all services (excluding overhead) (265, 020	
13. 00	Ratio of hospital -based RHC/FQHC services (1. 000000	
14. 00	Total hospital-based RHC/FQHC overhead - (f			ne 31)		0	14. 00
15. 00	Parent provider overhead allocated to facil					382, 885	
16. 00	Total overhead (sum of lines 14 and 15)	J (-,			382, 885	
17.00	Allowable GME overhead (see instructions)					0	17. 00
18.00	Enter the amount from line 16					382, 885	18. 00
19.00	Overhead applicable to hospital-based RHC/F	QHC services (li	ne 13 x line 1	8)		382, 885	19. 00
20 00	Total allowable cost of hospital-based RHC/	FQHC services (s	sum of lines 10	and 19)		647, 905	20.00

		RENSSELAER	In Lie	u of Form CMS-2	2552-1
	ATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC	Provider CCN: 15-1324	Peri od:	Worksheet M-3	
SERVI (EES	Component CCN: 15-3990	From 01/01/2020 To 12/31/2020	Date/Time Prep 8/2/2021 9:26	
		Title XVIII	RHC I	Cost	
				1. 00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			1.00	
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from	m Wkst. M-2, line 20)		461, 707	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, li	ne 15)		12, 963	
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			448, 744	
4. 00 5. 00	Total Visits (from Wkst. M-2, column 5, line 8) Physicians visits under agreement (from Wkst. M-2, column 5,	Lino (1)		1, 590 0	4. 00 5. 00
6. 00	Total adjusted visits (line 4 plus line 5)	1111e 7)		1, 590	
7. 00	Adjusted cost per visit (line 3 divided by line 6)			282. 23	l .
			Cal cul ati on	of Limit (1)	
			Prior to Jan.	On or After	
			1 (Rate Period		
			1)	Peri od 2)	
0.00	Don visit normant limit (from CMC Dub. 100 04 shorter 0, 520	(or your contractor)	1.00	2. 00	0.00
8. 00 9. 00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20. Rate for Program covered visits (see instructions)	. 6 or your contractor)	0. 00 282. 23	0. 00 282. 23	l
7. 00	CALCULATION OF SETTLEMENT		202.20	202. 23	/. 00
10. 00	Program covered visits excluding mental health services (from	contractor records)	0	126	10.00
11. 00	Program cost excluding costs for mental health services (line	9 x line 10)	0	35, 561	11. 0
12. 00	Program covered visits for mental health services (from contra		0	0	12. 0
13.00	Program covered cost from mental health services (line 9 x line 1)		0	0	13.0
14. 00 15. 00	Limit adjustment for mental health services (see instructions) Graduate Medical Education Pass Through Cost (see instructions		0	0	14. 00 15. 00
16. 00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2	•	0	35, 561	16.00
16. 01	Total program charges (see instructions) (from contractor's rea	•		9, 856	
16. 02	Total program preventive charges (see instructions) (from provi	•		5, 523	
16. 03	Total program preventive costs ((line 16.02/line 16.01) times			19, 927	16. 0
16. 04	Total Program non-preventive costs ((line 16 minus lines 16.03	3 and 18) times .80)		9, 854	16. 04
16. 05	(Titles V and XIX see instructions.) Total program cost (see instructions)		0	29, 781	16. 0!
17. 00	Primary payer amounts			27, 701	17. 00
18. 00	Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		3, 316	l .
	records)				
19. 00	Beneficiary coinsurance for RHC/FQHC services (see instruction records)	ns) (from contractor		1, 308	19. 00
20. 00	Net Medicare cost excluding vaccines (see instructions)			29, 781	20.0
21. 00	Program cost of vaccines and their administration (from Wkst.	M-4, line 16)		4, 684	
22. 00	Total reimbursable Program cost (line 20 plus line 21)			34, 465	
23. 00 23. 01	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			0	
24. 00	Allowable bad debts for dual eligible beneficiaries (see insti	ructions)		0	24.0
25. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	1 40 (1 0113)		0	25. 0
25. 50		s)		0	25. 50
	Demonstration payment adjustment amount before sequestration			0	
26. 00	1			34, 465	
26. 01 26. 02	Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration			227 0	26. 0° 26. 0°
27. 00	, , , , , , , , , , , , , , , , , , , ,			16, 695	
28. 00	1 ' 3			10, 075	1
	,	02, 27, and 28)		17, 543	
29. 00					30.00

Heal th	Financial Systems FRANCISCAN HEALTH	RENSSELAER	In Lie	u of Form CMS-2	2552-10
	ATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC	Provider CCN: 15-1324	Peri od:	Worksheet M-3	
SERVIC	ES	Component CCN: 15-8502	From 01/01/2020 To 12/31/2020	Date/Time Prep 8/2/2021 9:26	
		Title XVIII	RHC IV	Cost	
				1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			1. 00	
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (fro	m Wkst. M-2. line 20)		647, 905	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, li			18, 622	2. 00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			629, 283	3. 00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			2, 947	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5,	line 9)		2 047	5.00
6. 00 7. 00	Total adjusted visits (line 4 plus line 5) Adjusted cost per visit (line 3 divided by line 6)			2, 947 213. 53	6. 00 7. 00
7.00	That district cost per visit (Time 3 divided by Time 6)		Cal cul ati on		7.00
			Prior to Jan.	On or After	
			1 (Rate Period 1)	Peri od 2)	
			1.00	2.00	
8. 00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20	.6 or your contractor)	0.00	0.00	8. 00
9.00	Rate for Program covered visits (see instructions)		213. 53	213. 53	9. 00
10 00	CALCULATION OF SETTLEMENT	contractor records)		245	10.00
10. 00 11. 00	Program covered visits excluding mental health services (from Program cost excluding costs for mental health services (line		0	345 73, 668	l
12. 00	Program covered visits for mental health services (from contr	*	0	73,008	1
13. 00	Program covered cost from mental health services (line 9 x li	•	o	0	13. 00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14. 00
15. 00	Graduate Medical Education Pass Through Cost (see instruction				15. 00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2	,	0	73, 668	•
16. 01 16. 02	Total program charges (see instructions)(from contractor's re Total program preventive charges (see instructions)(from prov	•		25, 896 6, 501	16. 01 16. 02
16. 02	Total program preventive costs ((line 16.02/line 16.01) times	•		18, 494	
16.04	Total Program non-preventive costs ((line 16 minus lines 16.0			37, 455	
	(Titles V and XIX see instructions.)				
16. 05	Total program cost (see instructions)		0	55, 949	
17. 00 18. 00	Primary payer amounts Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		0 8, 355	17. 00 18. 00
10.00	records)	(11 om contractor		0, 333	10.00
19. 00	Beneficiary coinsurance for RHC/FQHC services (see instruction records)	ns) (from contractor		3, 508	19. 00
20. 00	Net Medicare cost excluding vaccines (see instructions)			55, 949	20. 00
21.00	Program cost of vaccines and their administration (from Wkst.	M-4, line 16)		12, 622	•
22. 00	Total reimbursable Program cost (line 20 plus line 21)			68, 571	•
23. 00 23. 01	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			0	ł
24. 00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		0	24.00
25. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	,		0	25. 00
25. 50	Pioneer ACO demonstration payment adjustment (see instruction	s)		0	
	Demonstration payment adjustment amount before sequestration			0 40 E71	
26. 00 26. 01	Net reimbursable amount (see instructions) Sequestration adjustment (see instructions)			68, 571 453	
26. 02	Demonstration adjustment amount after sequestration			0	ı
27. 00				74, 231	
28. 00	,			0	
29. 00	Balance due component/program (line 26 minus lines 26.01, 26.			-6, 113	
30.00	Protested amounts (nonallowable cost report items) in accorda	nce with CMS Pub. 15-II,		0	30.00

Health Financial Systems	FRANCISCAN HEALTH	RENSSELAER	In Lie	u of Form CMS-2552-10
COMPUTATION OF HOSPITAL-BASED RHC/FQH	C PNEUMOCOCCAL AND INFLUENZA	Provider CCN: 15-1324	Peri od: From 01/01/2020	Worksheet M-4
MOSTINE GOOT		Component CCN: 15-3990	To 12/31/2020	Date/Time Prepared: 8/2/2021 9:26 am
		Ti +Lo VVIII	DUC I	Cost

				0/2/2021 7.20	uiii
		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)		241, 282	241, 282	1. 00
2.00	Ratio of pneumococcal and influenza vaccine staff time to tota	al health care staff time	0. 001362	0. 005399	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (lir	ne 1 x line 2)	329	1, 303	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (fr	rom your records)	2, 863	2, 920	4. 00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus	s line 4)	3, 192	4, 223	5. 00
6.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4) Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22 Total overhead (from Wkst. M-2, line 19) Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6) Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8) Total pneumococcal and influenza vaccine cost and its (their) administration (sum of		264, 108	264, 108	6. 00
7.00	Total overhead (from Wkst. M-2, line 19)		197, 599	197, 599	7. 00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to tot	tal direct cost (line 5	0. 012086	0. 015990	8. 00
9.00	00 Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		2, 388	3, 160	9. 00
10.00		administration (sum of	5, 580	7, 383	10.00
	lines 5 and 9)				
11. 00	Total number of pneumococcal and influenza vaccine injections		29		11. 00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10		192. 41	64. 20	12.00
13.00	Number of pneumococcal and influenza vaccine injections admini	stered to Program	13	34	13.00
	benefi ci ari es				
14. 00	Program cost of pneumococcal and influenza vaccine and its (th	neir) administration	2, 501	2, 183	14. 00
	(line 12 x line 13)				
15. 00	Total cost of pneumococcal and influenza vaccine and its (thei			12, 963	15. 00
	of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3,				
16. 00	Total Program cost of pneumococcal and influenza vaccine and i	` ,		4, 684	16. 00
	administration (sum of cols. 1 and 2, line 14) (transfer this	amount to Wkst. M-3,			
	line 21)				

Health Financial Systems	FRANCI SCAN HEALTH	RENSSELAER	In Lie	u of Form CMS-2552-10
COMPUTATION OF HOSPITAL-BASED RHC/FQHC	PNEUMOCOCCAL AND INFLUENZA	Provider CCN: 15-1324	Peri od: From 01/01/2020	Worksheet M-4
VACCINE COST		Component CCN: 15-8502	To 12/31/2020	Date/Time Prepared: 8/2/2021 9:26 am
		Title XVIII	RHC IV	Cost

			0/2/2021 7.20	aiii
	Title XVIII	RHC IV	Cost	
		Pneumococcal	I nfl uenza	
		1. 00	2. 00	
Health care staff cost (from Wkst. M-1, col. 7, line 10)		259, 068	259, 068	1.00
Ratio of pneumococcal and influenza vaccine staff time to total	al health care staff time	0. 001412	0. 005207	2.00
Pneumococcal and influenza vaccine health care staff cost (li	ne 1 x line 2)	366	1, 349	3.00
Medical supplies cost - pneumococcal and influenza vaccine (fi	rom your records)	3, 160	2, 742	4.00
Direct cost of pneumococcal and influenza vaccine (line 3 plus	s line 4)	3, 526	4, 091	5. 00
Total direct cost of the hospital-based RHC/FQHC (from Worksho	eet M-1, col. 7, line 22)	265, 020	265, 020	6.00
Total overhead (from Wkst. M-2, line 19)		382, 885	382, 885	7. 00
Ratio of pneumococcal and influenza vaccine direct cost to to	tal direct cost (line 5	0. 013305	0. 015437	8. 00
divided by line 6)				
Overhead cost - pneumococcal and influenza vaccine (line 7 x l	ine 8)	5, 094	5, 911	9. 00
Total pneumococcal and influenza vaccine cost and its (their)	administration (sum of	8, 620	10, 002	10.00
lines 5 and 9)				
Total number of pneumococcal and influenza vaccine injections	(from your records)			11. 00
Cost per pneumococcal and influenza vaccine injection (line 10	D/line 11)	269. 38	84. 76	12.00
Number of pneumococcal and influenza vaccine injections admini	stered to Program	22	79	13.00
benefi ci ari es				
	neir) administration	5, 926	6, 696	14.00
			18, 622	15. 00
1	,		12, 622	16. 00
	amount to Wkst. M-3,			
[line 21)				
	Ratio of pneumococcal and influenza vaccine staff time to total Pneumococcal and influenza vaccine health care staff cost (limedical supplies cost - pneumococcal and influenza vaccine (find Direct cost of pneumococcal and influenza vaccine (line 3 plus Total direct cost of the hospital-based RHC/FQHC (from Workshot Total overhead (from Wkst. M-2, line 19) Ratio of pneumococcal and influenza vaccine direct cost to total divided by line 6) Overhead cost - pneumococcal and influenza vaccine (line 7 x lotal pneumococcal and influenza vaccine cost and its (their) lines 5 and 9) Total number of pneumococcal and influenza vaccine injections Cost per pneumococcal and influenza vaccine injection (line 10 Number of pneumococcal and influenza vaccine injections adminibeneficiaries Program cost of pneumococcal and influenza vaccine and its (their line 12 x line 13) Total cost of pneumococcal and influenza vaccine and its (their cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, Total Program cost of pneumococcal and influenza vaccine and its (their cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, Total Program cost of pneumococcal and influenza vaccine and its (their cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, Total Program cost of pneumococcal and influenza vaccine and its (their cols. 1 and 2, line 10)	Health care staff cost (from Wkst. M-1, col. 7, line 10) Ratio of pneumococcal and influenza vaccine staff time to total health care staff time Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2) Medical supplies cost - pneumococcal and influenza vaccine (from your records) Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4) Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22) Total overhead (from Wkst. M-2, line 19) Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6) Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8) Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9) Total number of pneumococcal and influenza vaccine injections (from your records) Cost per pneumococcal and influenza vaccine injections (dine 10/line 11) Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13) Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2) Total Program cost of pneumococcal and influenza vaccine and its (their)	Health care staff cost (from Wkst. M-1, col. 7, line 10) Ratio of pneumococcal and influenza vaccine staff time to total health care staff time Pneumococcal and influenza vaccine health care staff tost (line 1 x line 2) Medical supplies cost - pneumococcal and influenza vaccine (from your records) Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4) Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22) Total overhead (from Wkst. M-2, line 19) Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6) Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8) Total pneumococcal and influenza vaccine cost and its (their) administration (sum of 8, 620 lines 5 and 9) Total number of pneumococcal and influenza vaccine injections (from your records) Cost per pneumococcal and influenza vaccine injections administered to Program beneficiaries Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of 1, 926, 38) Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of 2, line 13) Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of 2, line 10) (transfer this amount to Wkst. M-3, line 2) Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3,	Title XVIII RHC IV Cost Pneumococccal Influenza 1.00 2.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FOHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES Provider CCN: 15-1324 Period: From 01/01/2020 Worksheet M-5	Health Financial Systems	FRANCISCAN HEALTH	RENSSELAER	In Lie	u of Form CMS-2552-10
8/2/2021 9:26 am				From 01/01/2020	Date/Time Prepared:

		Component CCN: 15-3990	10 12/31/2020	8/2/2021 9: 26	
			RHC I	Cost	
	·		Par	rt B	
			mm/dd/yyyy	Amount	
			1. 00	2.00	
1. 00 2. 00	Total interim payments paid to hospital-based RHC/FQHC Interim payments payable on individual bills, either submit the contractor for services rendered in the cost reporting "NONE" or enter a zero	period. If none, write		16, 695 0	2. 00
3.00	List separately each retroactive lump sum adjustment amount revision of the interim rate for the cost reporting period. payment. If none, write "NONE" or enter a zero. (1) Program to Provider				3.00
3.01				0	
3. 02			ļ ļ	0	
3. 03			ļ	0	
3.04			ļ ļ	0	
3. 05				0	3. 05
0 50	Provider to Program				
3. 50 3. 51			ļ	0 0	
3. 51			ļ		
3. 52			ļ		
3. 54			ļ		
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.	98)	ļ		
4. 00	Total interim payments (sum of lines 1, 2, and 3.99) (trans		ļ	16, 695	
	27)				
	TO BE COMPLETED BY CONTRACTOR				4
5. 00	List separately each tentative settlement payment after des	sk review. Also show date of	·		5.00
	each payment. If none, write "NONE" or enter a zero. (1) Program to Provider				ł
5. 01	i rogram to rrovider			0	5. 01
5. 02			ļ	l ől	
5. 03			ļ	l ől	
	Provider to Program			_	1
5.50			1	0	5.50
5. 51			ļ	0	5. 51
5.52				0	
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.			0	5. 99
6.00	Determined net settlement amount (balance due) based on the	e cost report. (1)			6. 00
6. 01	SETTLEMENT TO PROVIDER			17, 543	
6. 02	SETTLEMENT TO PROGRAM			0	
7. 00	Total Medicare program liability (see instructions)			34, 238	7. 00
			Contractor	NPR Date	
			Number	(Mo/Day/Yr)	
		0	1. 00	2.00	

Health Financial Systems	FRANCISCAN HEALTH	RENSSELAER	In Lie	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED SERVICES RENDERED TO PROGRAM BENEFICIAR	IES	Provider CCN: 15-1324 Component CCN: 15-8502	From 01/01/2020	

				8/2/2021 9: 26	am
			RHC IV	Cost	
			Part B		
			mm/dd/yyyy	Amount	
			1. 00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC			74, 231	1. 00
2.00				0	2. 00
	the contractor for services rendered in the cost reporting period. If none, write				
	"NONE" or enter a zero	,			
3.00					3.00
	revision of the interim rate for the cost reporting period.				
	payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider		•		
3.01				0	3.0
3. 02				0	3. 02
3. 03				l ol	3. 03
3. 04				0	3. 04
3. 05					3. 0!
3.03	Provider to Program			0	3.0
3. 50	Trovider to rrogiam			0	3. 5
3. 51					3. 5
3. 52					3. 5
3. 53					3. 5.
3. 54					3. 5.
	Cultural (00)			
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.		1 "	3. 9	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (trans 27)	rer to worksneet M-3, line		74, 231	4. 00
	TO BE COMPLETED BY CONTRACTOR				
5.00	List separately each tentative settlement payment after des	k rovi ou. Al oo obou doto of			5. 00
5.00	each payment. If none, write "NONE" or enter a zero. (1)	k review. Also show date of			5.00
	Program to Provider				
5. 01	Program to Provider			1 0	5. 0°
5. 02					5. 0
5. 03	Danisi dana da Danamana			0	5. 03
F F0	Provider to Program				
5. 50				0	5. 50
5. 51				0	5. 5
5. 52				0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	5. 9
6. 00	,				6. 00
6. 01	SETTLEMENT TO PROVIDER			0	6. 0
6. 02				6, 113	6. 0
7.00	Total Medicare program liability (see instructions)			68, 118	7. 00
			Contractor	NPR Date	
			Number	(Mo/Day/Yr)	
		0	1. 00	2.00	
8.00	Name of Contractor				8. 00