This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 03-31-2022 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION | Provider CCN: 15-1324 Worksheet S Peri od: From 01/01/2021 Parts I-III AND SETTLEMENT SUMMARY 12/31/2021 Date/Time Prepared: 5/27/2022 5:01 pm PART I - COST REPORT STATUS Provi der 1. [X] Electronically prepared cost report Date: 5/27/2022 5: 01 pm use only] Manually prepared cost report Ilf this is an amended report enter the number of times the provider resubmitted this cost report [Medicare Utilization. Enter "F" for full or "L" for low. [1] Cost Report Status
[1] As Submitted
[2] Settled without Audit
[3] Settled with Audit
[4] Date Received:
[5] To. NPR Date:
[6] 10. NPR Date:
[7] 11. Contractor's Vendor Code:
[7] 12. [8] Final Report for this Provider CCN
[9] [8] Final Report for this Provider CCN
[10] NPR Date:
[11] 12. Contractor's Vendor Code:
[12] [9] If line 5, column 1 is 4: Enter
[13] NPR Date:
[14] 12. Contractor's Vendor Code:
[15] 13. NPR Date:
[16] 13. NPR Date:
[17] 14. Contractor's Vendor Code:
[18] 15. Contractor's Vendor Code:
[18] 16. NPR Date:
[18] 17. Contractor's Vendor Code:
[18] 17. Contractor's Vendor Code:
[18] 18. Contractor's Vendor Code:
[18] 19. NPR Date:
[18] 19. NPR Date:
[18] 19. NPR Date:
[18] 19. NPR Date:
[19] 19. NPR Date: Contractor use only

number of times reopened = 0-9.

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

(3) Settled with Audit

(4) Reopened (5) Amended

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by FRANCISCAN HEALTH RENSSELAER (15-1324) for the cost reporting period beginning 01/01/2021 and ending 12/31/2021 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINA	NCIAL OFFICER OR ADMINISTRATOR	CHECKBOX		
	1			SI GNATURE STATEMENT	
1				I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name				2
3	Signatory Title	CF0			3
4	Date				4

		Title	XVIII			
Cost Center Description	Title V	Part A	Part B	HIT	Title XIX	
	1.00	2.00	3. 00	4. 00	5. 00	
PART III - SETTLEMENT SUMMARY						
1.00 Hospi tal	0	-59, 514	-2, 298, 440	0	-41	1. 00
2.00 Subprovider - IPF	0	0	0		0	2. 00
3.00 Subprovider - IRF	0	0	0		0	3. 00
5.00 Swing Bed - SNF	0	90, 978	0		0	5. 00
6.00 Swing Bed - NF	0				0	6. 00
9.00 HOME HEALTH AGENCY I	0	0	0		0	9. 00
10.00 RURAL HEALTH CLINIC I	0		-3, 394		0	10.00
10. 01 BROOK RHC II	0		-40, 944		0	10. 01
200. 00 Total	0	31, 464	-2, 342, 778	0	-41	200. 00
The above amounts represent "due to" or "due from"	the applicable	program for th	ne element of t	he above comple	ex 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 01/01/2021 Part I Date/Time Prepared: 12/31/2021 5/27/2022 5:01 pm 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)

/ XVIII XIX 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 Ν 0 0 3.00 RENSSEL AFR Subprovi der - IPF 4.00 4 00 5.00 Subprovider - IRF 5.00 Subprovi der - (Other) 6.00 6.00 Swing Beds - SNF FRANCISCAN HEALTH 157324 99915 N 12/31/2005 N 0 7 00 7.00 RENSSELAER 8.00 Swing Beds - NF 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 15.00 Hospital-Based Health Clinic - RHC WHEATFIELD CLINIC 153990 99915 10/07/1999 Ν 0 Ν 15.00 Hospital-Based Health Clinic - RHC BROOK 158502 99915 01/01/2005 N 0 N 15.01 15.01 Hospital-Based Health Clinic - FQHC 16.00 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) 01/01/2021 12/31/2021 20.00 21.00 Type of Control (see instructions) 21.00 1 3. 00 1. 00 2. 00 Inpatient PPS Information 22. 00 Does this facility qualify and is it currently receiving payments for N N 22. 00 disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. 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 22.02 Ν 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. 22.04 Did this hospital receive a geographic reclassification from urban to rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no Ν Ν Ν 22.04 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.

year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.

GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.

57 00

58 00

59.00

N

57.00 | If line 56 is yes, is this the first cost reporting period during which residents in approved

58.00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.

59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.

· · · · · · · · · · · · · · · · · · ·		TH RENSSELAER	N 45 4004 D		u of Form CMS-2	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	IA	Provi der CC		eriod: rom 01/01/2021 o 12/31/2021	Worksheet S-2 Part I Date/Time Prep	pared:
			NAHE 413. 85	Worksheet A	5/27/2022 5:0° Pass-Through	ı pili
			Y/N	Line #	Qualification Criterion Code	
			1. 00	2. 00	3.00	
60.00 Are you claiming nursing and allied health education any programs that meet the criteria under 42 CFR 413.			N			60.00
instructions) Enter "Y" for yes or "N" for no in col is "Y", are you impacted by CR 11642 (or subsequent C	umn 1. CR) NAHE	If column 1				
adjustement? Enter "Y" for yes or "N" for no in colu	Y/N	IME	Direct GME	I ME	Direct GME	
(4.00 Did years benefits) granity ETF of the years ACA	1.00	2. 00	3. 00	4.00	5.00	(1.00
61.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in	N			0.00	0.00	61. 00
column 1. (see instructions) 61.01 Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see						61. 01
instructions) 61.02 Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of						61. 02
ACA). (see instructions) 61.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see						61. 03
instructions) 61.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the						61. 04
current cost reporting period (see instructions). 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. 05
61.04 minus line 61.03). (see instructions) 61.06 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)						61.06
	Pro	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
/1 10 Of the FTFe in Line /1 OF excels to each new program		1. 00	2. 00	3.00	4.00	(1.10
61.10 Of the FTEs in line 61.05, specify each new program 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.				0.00	0.00	61. 10
61.20 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.				0.00	0.00	61. 20
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.						
the direct one fite dimergified count.	I			1	1.00	
ACA Provisions Affecting the Health Resources and Ser				ad fan wet ek		(2.00
62.00 Enter the number of FTE residents that your hospital your hospital received HRSA PCRE funding (see instruc	tions)					62.00
62.01 Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC program.				your hospital	0.00	62. 01
Teaching Hospitals that Claim Residents in Nonprovide 63.00 Has your facility trained residents in nonprovider se	er Setti	ngs		period? Entor	N	63. 00
"Y" for yes or "N" for no in column 1. If yes, comple			77. (see instru	ictions)		03.00
			Unwei ghted FTEs Nonprovi der	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
			Si te 1.00	·		
Section 5504 of the ACA Base Year FTE Residents in No				is your cost r	3.00 reporting	
period that begins on or after July 1, 2009 and befor 64.00 Enter in column 1, if line 63 is yes, or your facilit			0.00	0.00	0. 000000	64. 00
in the base year period, the number of unweighted nor resident FTEs attributable to rotations occurring in settings. Enter in column 2 the number of unweighted	n-primar all nor I non-pr	ry care nprovider rimary care	3.00	3.00	2. 333330	
resident FTEs that trained in your hospital. Enter in of (column 1 divided by (column 1 + column 2)). (see						
				•		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-1324 Peri od: Worksheet S-2 From 01/01/2021 Part I Date/Time Prepared: 12/31/2021 5/27/2022 5:01 pm 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. 00 0. 00 0.000000 65.00 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)

81.00 1s This a LICH co-located within another hospital for part or all of the cost reporting period? Enter N 81.0 1 1 1 1 1 1 1 1 1	Health Financial Systems FRANCISCAN HEALTH HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der CC	CN: 15-1324	Peri od: From 01/01/2021 To 12/31/2021	u of Form CMS- Worksheet S-2 Part I Date/Time Pro 5/27/2022 5:0	epared:
80.00 St hils a long term care hospital (LTDI)? Enter "Y" for yes and "N" for no. 80.01 St hils a long term care hospital (LTDI)? Enter "Y" for yes and "N" for no. 80.02 St hils a long term care hospital (LTDI)? Enter "Y" for yes or "N" for no. 80.03 Did this racility establish a new Other subprovider (excluded unit) under 42 CFR Section 5413.40(f)(1)(1) EFRA? Enter "Y" for yes or "N" for no. 80.00 Did this racility establish a new Other subprovider (excluded unit) under 42 CFR Section 5413.40(f)(1)(1)(1) Enter "Y" for yes ond "N" for no. 80.00 Did this racility establish a new Other subprovider (excluded unit) under 42 CFR Section 5413.40(f)(1)(1)(1) Enter "Y" for yes ond "N" for no. 80.00 Did this racility establish a new Other subprovider (excluded unit) under 42 CFR Section 5413.40(f)(1)(1)(1) (2)(1) Enter "Y" for yes ond "N" for no. 80.00 Dess this hospital an extended neoplastic disease care hospital classified under section N					1.00	1
85.00 Dist this a new hospital under 42 CFE Section \$413.40(f)(1)(i) TFERAZ Enter "Y" for yes or "N" for no. No. 1813.40(f)(1)(i)? Enter "Y" for yes and "N" for no. No. 1813.40(f)(1)(i)? Enter "Y" for yes and "N" for no. No. 1813.40(f)(1)(i)? Enter "Y" for yes and "N" for no. No. 1813.40(f)(1)(i)? Enter "Y" for yes and "N" for no. No. 1813.40(f)(1)(i)? Enter "Y" for yes and "N" for no. No. 1813.40(f)(1)(i)? Enter "Y" for yes or "N" for no. No. 1813.40(f)(1)(i)? Enter "Y" for yes or "N" for no. No. 2.00 (i) It this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column. No. 1813.40(f)(i) It the XIX MF patients occupying title XVII It the V and/or XIX through the cost report either in No. 1813.40(f)(i) It the XIX MF patients occupying title XVII It She beds (due) certification? (see No. 2.00 (ii) No. 1813.41(f) It the XIX MF patients occupying title XVII It She beds (due) certification? (see No. 2.00 (iii) No. 1813.41(f) It the XIX MF patients occupying title XVII It She beds (due) certification? (see No. 2.00 (iii) No. 1813.41(f) No.	80.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes a 81.00 Is this a LTCH co-located within another hospital for part or			ng period? Enter		80. 00 81. 00
87.00 1s this hospital an extended neoplastic disease care hospital classified under section N 87.6	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 (excluded				N	85. 00 86. 00
	87.00 Is this hospital an extended neoplastic disease care hospital	classified ι	under section	ו	N	87. 00
Title V and XIX Services Proceedings Process Pro	1000(d) (1) (b) (vi) : Eliter 1 101 yes 31 N 101 110.					
yes or "N" for no in the applicable column. 19.00 Is this hospital retimbursed for title V and/or XIX through the cost report either in rull or in part? Enter "Y" for yes or "N" for no in the applicable column. 29.00 Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see Instructions) Enter "Y" for yes or "N" for no in the applicable column. 39.00 Does title V or XIX reduce capital cost? Enter "Y" for yes or "N" for no in the applicable column. 49.00 Does title V or XIX reduce operating cost? Enter "Y" for yes, and "N" for no in the applicable column. 50.00 If I line 94 is "Y". enter the reduction percentage in the applicable column. 50.00 If I line 94 is "Y". enter the reduction percentage in the applicable column. 50.00 If I line 94 is "Y". enter the reduction percentage in the applicable column. 50.00 If I line 96 is "Y". enter the reduction percentage in the applicable column. 50.00 If I line 96 is "Y". enter the reduction percentage in the applicable column. 50.00 If I line 96 is "Y". enter the reduction percentage in the applicable column. 50.00 If I line 96 is "Y". enter the reduction percentage in the applicable column. 50.00 If I line 96 is "Y". enter the reduction percentage in the applicable column. 50.00 I line 96 is "Y". enter the reduction percentage in the applicable column. 50.00 I line 96 is "Y". enter the reduction percentage in the applicable column. 50.00 I line 96 is "Y". enter the reduction percentage in the applicable column. 50.00 I line 96 is "Y". enter the reduction percentage in the applicable column. 50.00 I line 96 is "Y". enter the reduction percentage in the applicable column. 50.00 I line 96 is "Y". enter the reduction percentage in the applicable column. 50.00 I line 96 is "Y". enter the reduction percentage in the applicable column. 50.00 I line 96 is "Y". enter the reduction percentage in the applicable column. 50.00 I line 96 is "Y". enter the reduction percentage in the applicable col						
91.00 [Is this hospital relimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column. 92.00 Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column. 93.00 Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column. 94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column. 95.00 IF line 94 is "Y", enter the reduction percentage in the applicable column. 96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column. 97.00 IF line 94 is "Y", enter the reduction percentage in the applicable column. 97.00 IF line 96 is "Y", enter the reduction percentage in the applicable column. 97.00 IF line 96 is "Y", enter the reduction percentage in the applicable column. 97.00 IF line 96 is "Y", enter the reduction percentage in the applicable column. 97.00 IF line 96 is "Y", enter the reduction percentage in the applicable column. 98.01 Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst B, Pt I, col. 25? Enter "Y" for yes or "N" for no in 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 reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 98.02 Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) relabursed 101% of patients and title V or XIX follow Medicare (title XVIII) for a CAH relabursed 101% of patients and title V or XIX follow Medicare (title XVIII) for a CAH relabursed 101% of patients and title V or XIX follow Medicare (title XVIII) for a CAH relabursed 101% of N N N N N N N N N N N N N N N N N N		services? Er	nter "Y" for	N	Y	90.00
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98.04 Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 98.05 Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 98.06 Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. Rural Providers 105.00 Does this hospital qualify as a CAH? 106.00 If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions) 107.00 Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R 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 approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions) 108.00 Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no. Physical Occupational Speech Respiratory 1.00 2.00 3.00 4.00 109.00 If this hospital qualifies as a CAH or a cost provider, are Y N N N 109.0	98.03 Does title V or XIX follow Medicare (title XVIII) for a critic reimbursed 101% of inpatient services cost? Enter "Y" for yes				N	98. 03
98.05 Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 98.06 Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. Rural Providers 105.00 Does this hospital qualify as a CAH? 106.00 If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions) 107.00 Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R 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 approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions) 108.00 Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no. Physical Occupational Speech Respiratory 1.00 2.00 3.00 4.00 109.00 If this hospital qualifies as a CAH or a cost provider, are Y N N N 109.0	98.04 Does title V or XIX follow Medicare (title XVIII) for a CAH re				N	98. 04
column 2 for title XIX. 98.06 Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. Rural Providers 105.00 Does this hospital qualify as a CAH? 106.00 If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions) 107.00 Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R 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 approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions) 108.00 Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 N 108.00 Physical Occupational Speech Respiratory 1.00 2.00 3.00 4.00 N N 109.00 109.00 If this hospital qualifies as a CAH or a cost provider, are Y N N 109.00	98.05 Does title V or XIX follow Medicare (title XVIII) and add back				Y	98. 05
Rural Providers 105.00 Does this hospital qualify as a CAH? 106.00 If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions) 107.00 Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R 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 approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions) 108.00 Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no. Physical Occupational Speech Respiratory 1.00 2.00 3.00 4.00 109.00 If this hospital qualifies as a CAH or a cost provider, are Y N N N 109.0	98.06 Does title V or XIX follow Medicare (title XVIII) when cost re Pts. I through IV? Enter "Y" for yes or "N" for no in column?			Y	Y	98. 06
106.00 If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions) 107.00 Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for L&R 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 L&Rs in an approved medical education program in the CAH's excluded LPF and/or LRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions) 108.00 Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 N 108.00 CFR Section §412.113(c). Enter "Y" for yes or "N" for no. Physical Occupational Speech Respiratory 1.00 2.00 3.00 4.00 109.00 If this hospital qualifies as a CAH or a cost provider, are Y N N N 109.0	Rural Providers					105.65
for outpatient services? (see instructions) 107.00 Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for L&R 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 L&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions) 108.00 Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 N CFR Section §412.113(c). Enter "Y" for yes or "N" for no. Physical Occupational Speech Respiratory 1.00 2.00 3.00 4.00 109.00 If this hospital qualifies as a CAH or a cost provider, are Y N N N 109.0		nclusive meth	nod of paymen			105. 00 106. 00
Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train L&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions) 108.00 Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 N 108.00 CFR Section §412.113(c). Enter "Y" for yes or "N" for no. Physical Occupational Speech Respiratory 1.00 2.00 3.00 4.00 109.00 If this hospital qualifies as a CAH or a cost provider, are Y N N N 109.0	107.00 Column 1: If line 105 is Y, is this facility eligible for cos			N		107. 00
108.00 Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 N 108.00 CFR Section §412.113(c). Enter "Y" for yes or "N" for no. Physical Occupational Speech Respiratory 1.00 2.00 3.00 4.00 109.00 If this hospital qualifies as a CAH or a cost provider, are Y N N N 109.00 109.00 N N N N N N N N N	Column 2: If column 1 is Y and line 70 or line 75 is Y, do you approved medical education program in the CAH's excluded IPF	ou train I&Rs and/or IRF u	s in an			
1.00 2.00 3.00 4.00 109.00 If this hospital qualifies as a CAH or a cost provider, are Y N N N 109.0	108.00 Is this a rural hospital qualifying for an exception to the CF	RNA fee sched				108. 00
109.00 If this hospital qualifies as a CAH or a cost provider, are Y N N 109.0						+
	109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y"					109. 00
						_

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

140.00

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 (HI)	() inconting in the Ar	mori can Pocovory and	Poi pyos	tmont Act			

165.00 s this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs?

170.00 Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting

1.00

N

2.00

1.00

165.00

170.00

	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.	Υ	167. 00
168.00 f 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)		1
168.01 f this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship		168. 01
exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		
169.00 f this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the	0. 00	169. 00
transition factor. (see instructions)		
Begi nni ng	Endi ng	

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 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		171. 00

Multicampus

	Financial Systems FRANCISCAN HEALT AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	TH RENSSELAER Provider C	CN: 15-1324	Peri od:	u of Form CMS- Worksheet S-2	
	The same state of the same sta			From 01/01/2021 To 12/31/2021	Part II Date/Time Pro 5/27/2022 5:0	epared
				Y/N	Date	
	General Instruction: Enter Y for all YES responses. Enter N	for all NO ro	sponsos Ent	1.00	2. 00	
	mm/dd/yyyy format.	TOT ALL NO TE	sponses. Ente	er arr dates in t	.rie	
	COMPLETED BY ALL HOSPITALS Provider Organization and Operation					
00	Has the provider changed ownership immediately prior to the			N		1.0
	reporting period? If yes, enter the date of the change in c	olumn 2. (see	instructions, Y/N) Date	V/I	
			1.00	2. 00	3. 00	
. 00	Has the provider terminated participation in the Medicare P yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary.		N			2. (
. 00	Is the provider involved in business transactions, includin contracts, with individuals or entities (e.g., chain home o or medical supply companies) that are related to the provid officers, medical staff, management personnel, or members o of directors through ownership, control, or family and othe relationships? (see instructions)	ffices, drug er or its f the board	Y			3. (
			Y/N	Type	Date	
	Financial Data and Reports		1.00	2. 00	3. 00	
. 00	Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" for "R" for Reviewed. Submit complete copy or enter date ava column 3. (see instructions) If no, see instructions. Are the cost report total expenses and total revenues diffe	or Compiled, ilable in	Y	A	05/06/2022	4. (
	those on the filed financial statements? If yes, submit rec					
				Y/N 1. 00	Legal Oper. 2.00	
00	Approved Educational Activities Column 1: Are costs claimed for a nursing program? Column	2: If ves. is	s the provide	r I N I		6. (
	is the legal operator of the program?					
00	Are costs claimed for Allied Health Programs? If "Y" see in Were nursing programs and/or allied health programs approve cost reporting period? If yes, see instructions.		wed during the	e N		7. 8.
00	Are costs claimed for Interns and Residents in an approved		cal education	N		9.
0. 00	program in the current cost report? If yes, see instruction Was an approved Intern and Resident GME program initiated o		the current	N		10.
1. 00	cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	& R in an App	proved	N		11.
					Y/N 1. 00	
	Bad Debts					10
	Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection p period? If yes, submit copy.			ost reporting	Y N	12. (
1. 00	If line 12 is yes, were patient deductibles and/or co-payme Bed Complement	nts waived? If	yes, see ins	structi ons.	N	14.
5. 00	Did total beds available change from the prior cost reporti		yes, see ins [.] -t A	tructions. Par	N + R	15.
		Y/N	Date	Y/N	Date	
	DCAD Data	1. 00	2.00	3. 00	4. 00	
5. 00	PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 (see	N		N		16.
. 00	instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date	Υ	04/08/2022	Y	04/08/2022	17.
3. 00	in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this	N		N		18.
9. 00	cost report? If yes, see instructions.	N		N		19.

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 01/01/2021 To 12/31/2021	Worksheet S-2 Part II Date/Time Pre 5/27/2022 5:0	pared:
			ipti on	Y/N	Y/N	
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R	(0	1. 00 N	3. 00 N	20.00
20.00	Report data for Other? Describe the other adjustments:			IN IN	IV	20.00
		Y/N	Date	Y/N	Date	
	III	1. 00	2. 00	3. 00	4. 00	
21. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21. 00
					1. 00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	PT CHILDRENS H	IOSPI TALS)			
	Capital Related Cost					
22. 00	Have assets been relifed for Medicare purposes? If yes, see				N	22. 00
23. 00	Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.	due to apprais	sais made dui	ing the cost	N	23. 00
24. 00	Were new leases and/or amendments to existing leases entere lf 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 instructions.	the cost repor	ting period?	If yes, see	N	25. 00
26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during th instructions.	e cost reporti	ng period? I	f yes, see	N	26. 00
27. 00	Has the provider's capitalization policy changed during the copy.	cost reportin	ng period? If	yes, submit	N	27. 00
28. 00	<pre>Interest Expense Were new loans, mortgage agreements or letters of credit en period? If yes, see instructions.</pre>	tered into dur	ing the cost	reporti ng	N	28. 00
29. 00	Did the provider have a funded depreciation account and/or treated as a funded depreciation account? If yes, see instructions.		ebt Service R	eserve Fund)	Υ	29. 00
30. 00	Has existing debt been replaced prior to its scheduled matu instructions.		debt? If yes	, see	N	30. 00
31. 00	Has debt been recalled before scheduled maturity without is instructions.	suance of new	debt? If yes	, see	N	31. 00
32. 00	Purchased Services Have changes or new agreements occurred in patient care ser		ed through co	ntractual	Υ	32. 00
33. 00	arrangements with suppliers of services? If yes, see instru If line 32 is yes, were the requirements of Sec. 2135.2 app no, see instructions.		ng to competi	tive bidding? If	N	33. 00
	Provi der-Based Physi ci ans					
34. 00	Are services furnished at the provider facility under an ar If yes, see instructions.	rangement with	n provi der-ba	sed physi ci ans?	Υ	34. 00
35. 00	If line 34 is yes, were there new agreements or amended exiphysicians during the cost reporting period? If yes, see in		nts with the		Υ	35. 00
				Y/N	Date	
	Home Office Costs			1. 00	2. 00	
36. 00	Were home office costs claimed on the cost report?			Υ		36. 00
37. 00	If line 36 is yes, has a home office cost statement been pr If yes, see instructions.	epared by the	home office?			37. 00
38. 00	If line 36 is yes, was the fiscal year end of the home off the provider? If yes, enter in column 2 the fiscal year end			N		38. 00
39. 00	see instructions.		,			39. 00
40. 00	If line 36 is yes, did the provider render services to the instructions.	home office?	If yes, see	N		40. 00
		1	00	2.	00	
	Cost Report Preparer Contact Information	1.		Ζ.		
41. 00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	STEVE		HOWELL		41. 00
42. 00	' ' ' '	FRANCISCAN ALL	I ANCE			42. 00
43. 00	preparer. Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	765-428-5927		STEVEN. HOWELL@I ANCE. ORG	FRANCI SCANALLI	43. 00
	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	1				11

Health Financial Systems	FRANCI SCAN HEAL	TH RENSSELAER	?	In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT	QUESTI ONNAI RE	Provi der		Peri od:	Worksheet S-2	!
				From 01/01/2021 To 12/31/2021	Part II Date/Time Pre 5/27/2022 5:0	pared:
		(3. 00			
Cost Report Preparer Contact Information						
41.00 Enter the first name, last name and the t		MANAGER COST	REPORTI NG			41.00
held by the cost report preparer in colum	ns 1, 2, and 3,					
respecti vel y.						
42.00 Enter the employer/company name of the co	st report					42. 00
preparer.						
43.00 Enter the telephone number and email addr						43. 00
report preparer in columns 1 and 2, respe	cti vel y.					

Health Financial Systems FRANCISCA
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Peri od: | Worksheet S-3 | From 01/01/2021 | Part | To 12/31/2021 | Date/Time Prepared: Provi der CCN: 15-1324

					[1	o 12/31/2021	Date/Time Prep	
							5/27/2022 5:0° I/P Days / 0/P	ı pili
							Visits / Trips	
	Component	Worksheet A	No	of Beds	Bed Days	CAH Hours	Title V	
	omponent	Line Number	1.0.	or beas	Avai I abl e	oran nour s	11 110 1	
		1. 00		2. 00	3.00	4. 00	5. 00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00		21	7, 665	29, 472. 00	0	1. 00
	8 exclude Swing Bed, Observation Bed and							
	Hospice days) (see instructions for col. 2							
	for the portion of LDP room available beds)							
2.00	HMO and other (see instructions)							2. 00
3.00	HMO IPF Subprovider							3. 00
4.00	HMO 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	6. 00
7. 00	Total Adults and Peds. (exclude observation			21	7, 665	29, 472. 00	0	7. 00
0.00	beds) (see instructions)	31. 00		4	1 4//	104 00	o	8. 00
8. 00 9. 00	INTENSIVE CARE UNIT	31. 00 32. 00		4	,			
10.00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT	32.00		U	1	0.00	U	9. 00 10. 00
11. 00	SURGICAL INTENSIVE CARE UNIT							11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)							12. 00
13. 00	NURSERY							13. 00
14. 00	Total (see instructions)			25	9, 125	29, 668. 00	o	14. 00
15. 00	CAH visits			25	7, 120	27,000.00	0	15. 00
16. 00	SUBPROVI DER - I PF							16. 00
17. 00	SUBPROVI DER - I RF							17. 00
18. 00	SUBPROVI DER							18. 00
19. 00	SKILLED NURSING FACILITY							19.00
20.00	NURSING FACILITY							20.00
21.00	OTHER LONG TERM CARE							21.00
22.00	HOME HEALTH AGENCY	101. 00					0	22.00
23.00	AMBULATORY SURGICAL CENTER (D. P.)	115. 00						23.00
24.00	HOSPI CE	116. 00		0	()		24.00
24. 10	HOSPICE (non-distinct part)	30. 00						24. 10
25.00	CMHC - CMHC							25.00
26. 00	RURAL HEALTH CLINIC	88. 00					0	26.00
26. 01	BROOK RHC	88. 01					0	26. 01
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	(7		32. 00
32. 01	Total ancillary labor & delivery room outpatient days (see instructions)							32. 01
33. 00	LTCH non-covered days							33. 00
	LTCH site neutral days and discharges							33. 00
30. 01	12.5. 5. to floati ai days and ai sonai ges		ı		I	1	ı	50.01

Heal th FinancialSystemsFRANCISCAN HEALTH RENSSELAERHOSPITALAND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATAProvider Complex Statistical Data

Provider CCN: 15-1324

In Lieu of Form CMS-2552-10

Period:	Worksheet S-3
From 01/01/2021	Part
To 12/31/2021	Date/Time Prepared:
5/27/2022 5:01 pm	

						5/27/2022 5:0	1 pm
		I/P Days	o/P Visits	/ Trips	Full Time I	Equi val ents	
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7. 00	8. 00	9. 00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)	626	31	1, 228			1.00
2.00	HMO and other (see instructions)	271	103				2.00
3.00	HMO I PF Subprovi der	o	0				3.00
4.00	HMO IRF Subprovider	o	0				4.00
5. 00	Hospital Adults & Peds. Swing Bed SNF	506	0	506			5. 00
6.00	Hospital Adults & Peds. Swing Bed NF		0	365			6.00
7. 00	Total Adults and Peds. (exclude observation beds) (see instructions)	1, 132	31	2, 099			7. 00
8. 00	INTENSIVE CARE UNIT	12	4	49			8.00
9. 00	CORONARY CARE UNIT	0	0	.,			9. 00
10. 00	BURN INTENSIVE CARE UNIT	Ĭ	J				10.00
11. 00	SURGI CAL INTENSI VE CARE UNI T						11.00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12.00
13. 00	NURSERY						13. 00
14. 00	Total (see instructions)	1, 144	35	2, 148	0.00	123. 00	14. 00
15. 00	CAH visits	0	0	2,	0.00	120100	15. 00
16. 00	SUBPROVI DER - I PF		_	_			16. 00
17. 00	SUBPROVI DER - I RF						17. 00
18. 00	SUBPROVI DER						18. 00
19. 00	SKILLED NURSING FACILITY						19.00
20. 00	NURSING FACILITY						20. 00
21. 00	OTHER LONG TERM CARE						21. 00
22. 00	HOME HEALTH AGENCY	ol	0	C	0.00	0.00	22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)				0.00		23. 00
24.00	HOSPI CE	o	0	C	0.00	0.00	24. 00
24. 10	HOSPICE (non-distinct part)			C			24. 10
25. 00	CMHC - CMHC						25. 00
26.00	RURAL HEALTH CLINIC	187	737	1, 344	0.00	4. 50	26. 00
26. 01	BROOK RHC	450	670	1, 833	0.00	4. 50	26. 01
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	o	0	C	0.00	0.00	26. 25
27.00	Total (sum of lines 14-26)				0.00	132. 00	27. 00
28.00	Observation Bed Days		162	601			28. 00
29.00	Ambul ance Tri ps	O					29. 00
30.00	Employee discount days (see instruction)			C			30.00
31.00	Employee discount days - IRF			C			31.00
32.00	Labor & delivery days (see instructions)	О	0	C			32. 00
32. 01	Total ancillary labor & delivery room			C			32. 01
	outpatient days (see instructions)						
33.00	LTCH non-covered days	o					33. 00
33. 01	LTCH site neutral days and discharges	o					33. 01

Heal th FinancialSystemsFRANCISCAN HEALTH RENSSELAERHOSPITALAND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATAProvider Complex Statistical Data In Lieu of Form CMS-2552-10 | Peri od: | Worksheet S-3 | From 01/01/2021 | Part I | Date/Time Prepared: | Provider CCN: 15-1324

				''	0 12/31/2021	5/27/2022 5:0	
		Full Time	_	Di sch	arges		
		Equi val ents			3		
	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		(52	453	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)			0	0		2. 00
3.00	HMO IPF Subprovider				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
7.00	beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8. 00
9.00	CORONARY CARE UNIT						9. 00
10. 00	BURN INTENSIVE CARE UNIT						10. 00
11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12. 00
13. 00	NURSERY						13. 00
14. 00	Total (see instructions)	0. 00	(227	52	453	
15. 00	CAH visits	0.00		227	32	433	15. 00
16. 00	SUBPROVI DER - I PF						16. 00
17. 00	SUBPROVI DER - I RF						17. 00
18. 00	SUBPROVI DER						18. 00
19. 00	SKILLED NURSING FACILITY						19. 00
20. 00	NURSING FACILITY						20.00
21. 00	OTHER LONG TERM CARE						21. 00
22. 00	HOME HEALTH AGENCY	0. 00					22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)	0.00					23. 00
24. 00	HOSPI CE	0.00					24. 00
24. 10	HOSPICE (non-distinct part)	0.00					24. 10
25. 00	CMHC - CMHC						25. 00
26. 00	RURAL HEALTH CLINIC	0. 00					26. 00
26. 01	BROOK RHC	0.00					26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26. 25
27. 00	Total (sum of lines 14-26)	0.00					20. 23
28. 00	· ·	0.00					28. 00
29. 00	Observation Bed Days Ambulance Trips						29. 00
							30.00
30.00	Employee discount days (see instruction)						
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
22.00	outpatient days (see instructions)						22.00
33.00	LTCH non-covered days			0			33. 00
33. UI	LTCH site neutral days and discharges			0			33. 01

HOSPITAL-BASED RHC/FORC STATISTICAL DATA	Heal th	Financial Systems F	RANCISCAN HEALT	TH RENSSELAER		In Lie	eu of Form CMS-	2552-10
Component CRX: 15-3990 To 12/31/2021 State Tree Prepare					CN: 15-1324		Worksheet S-8	3
Clinic Address and Identification				Component	CCN: 15-3990			
Clinic Address: and Identification						RHC I)ı pm
Clinic Address and Identification						KIIC I	COST	
Street						1.	00	
City State ZIP Code Co		Clinic Address and Identification						
1.00 2.00 3.00 1.017778 2.00 3.00 1.017778 2.00 3.00 1.017778 2.00 1.017778 2.00 1.007778 2.00 1.00 2.00 3.00 1.007778 3.00 1.007778 3.00 1.007778 3.00 1.00 3.00 1.00 3.00 3.00 1.00 3.0	1.00	Street						1.00
2.00 City, State, ZIP Code, County MHEATFIELD IN 47978 2								-
1.00 1.00 1.00 1.00 3.00 1.00 1.00 3.00 1.00 3.00 1.00 3.00 3.00 1.00 3.00	2.00	City Ctata 7LD Cada County	v		00			2.00
	2.00	crity, State, ZIP code, county	IV	MEATFIELD		IN	4/9/8	2. 00
							1 00	
Source of Federal Funds 1.00 2.00	3. 00	HOSPITAL-BASED FQHCs ONLY: Designation - Ente	er "R" for rural	l or "U" for u	ırban			3.00
Source of Federal Funds						nt Award	Date	
Community Heal th Center (Section 330(d), PHS Act) 5						1. 00	2. 00	
Migrant Heal th Center (Section 329(d), PHS Act)								_
Health Services for the Honeless (Section 340(d), PHS Act)								4.00
Appal achian Regional Commission								5.00
10.00			J(d), PHS ACT)					6. 00 7. 00
9.00 OTHER (SPECIFY)		1 1 1						8.00
10.00 Does this Facility operate as other than a hospital-based RHC or FOHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operation(s) and the operations in column 2. (Enter in subscripts of line 11 the type of other operation(s) and the operation in the production of the properation of the operation in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operation(s) and the operation in column 1. If you have you from to from the productivity standard? 12.00 Have you received an approval for an exception to the productivity standard? 13.00 Is this a consol dated cost report as defined in CMS Pub. 100-04, chapter 9, section N								9.00
10.00 Does this facility operate as other than a hospital -based RRC or F0K/C Enter "\" for yes or "\" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operation(s) and the operating hours.) Sunday	7.00	To MERC (OF EOTH 1)						7. 50
ves or "N" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operation(s) and the operating hours.) Sunday						1. 00	2.00	
Sunday Monday Tuesday From to to From to to to to to to to	10. 00	yes or "N" for no in column 1. If yes, indica 2. (Enter in subscripts of line 11 the type of	ate number of o	ther operation	s in column	N	0	10.00
From to To To To To To To		TIOUI 3,	Suno	Tuesday				
Facility hours of operations (1)								
11.00 CLINIC			1.00	2.00	3.00	4. 00	5. 00	
12.00 Have you received an approval for an exception to the productivity standard? 13.00 Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30. 8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below. Provider name CCN number 1.00 2.00 14.00 RHC/FOHC name, CCN number Y/N V XVIII XIX Total Visits 1.00 2.00 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 number of total visits for this provider. (see instructions) County 4.00 County 1 Tuesday Wednesday Thursday Total Visits County 4.00 Facility hours of operations (1)								
12.00 Have you received an approval for an exception to the productivity standard? 13.00 Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below. Provider name CCN number 1.00 2.00	11. 00	CLI NI C			07: 00	16: 30	07: 00	11.00
12.00 Have you received an approval for an exception to the productivity standard? 13.00 15 this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section N						1 00	2.00	-
13.00 Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below. Provider name	12 00	Have you received an approval for an exception	on to the produc	rtivity standa	ırd?		2.00	12. 00
14.00 RHC/FOHC name, CCN number 1.00 2.00 14.00 RHC/FOHC name, CCN number 1.00 2.00 14.00 14.00 14.00 14.00 15.00		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.	d in CMS Pub. 10 umn 1. If yes, e	00-04, chapter enter in colum	9, section n 2 the	**	0	13.00
14.00 RHC/FQHC name, CCN number		Traineer of Seriour			Provi	ider name	CCN number	
Y/N V XVIII XIX Total Visits						1. 00	2. 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 number of total visits for this provider. (see instructions) County	14.00	RHC/FQHC name, CCN number						14.00
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 number of total visits for this provider. (see instructions) 2.00 City, State, ZIP Code, County Tuesday Wednesday Thursday To from to from to from to Facility hours of operations (1)								
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) County 4.00 2.00 City, State, ZIP Code, County Tuesday Wednesday Thursday to from to from to 6.00 7.00 8.00 9.00 10.00 Facility hours of operations (1)	15 00	House you provided all as substantially	1.00	2. 00	3.00	4. 00	5. 00	15 00
County 4.00	15.00	GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider.						15. 00
A.00 City, State, ZIP Code, County 2 2 2 2 2 2 2 2 2		1 (300 mari deti ona)		Cou	intv			
2.00 City, State, ZIP Code, County Tuesday Wednesday Thursday								
Tuesday Wednesday Thursday to from	2. 00	City, State, ZIP Code, County						2.00
to from to from to 6.00 7.00 8.00 9.00 10.00 Facility hours of operations (1)			Tuesday	Wedne	esday	Thur	sday	
Facility hours of operations (1)			_	from	to			
			6. 00	7. 00	8.00	9. 00	10.00	
11. 00 CLINIC 16: 30 07: 00 16: 30 11								11. 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	
				From 01/01/2021		
		Component	CCN: 15-3990	To 12/31/2021	Date/Time Pre	pared:
		· ·			5/27/2022 5:0	1 pm
			_	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	FRANCISCAN HEALT	TH RENSSELAER		In Lie	eu of Form CMS-	2552-10
	AL-BASED RHC/FQHC STATISTICAL DATA			CN: 15-1324	Peri od:	Worksheet S-8	3
			Component	CCN: 15-8502	From 01/01/2021 To 12/31/2021	Date/Time Pre	
					RHC II	5/27/2022 5:0 Cost	и рш
					I IIIO II	0031	
					1.	00	
	Clinic Address and Identification						
1.00	Street				1104 E GRACE S		1. 00
				ty	State	ZIP Code	
0.00	0.1 0.1 710.0 1			00	2. 00	3.00	0.00
2.00	City, State, ZIP Code, County	k	RENSSELAER		I IN	47978	2.00
						1.00	
3. 00	HOSPITAL-BASED FQHCs ONLY: Designation - Ente	er "R" for rural	l or "U" for i	ırban		0	3.00
0.00	THOSE TIME BROEF FERIOS ONET. BOST GREAT OF LETTER	or it for furdi	01 0 101 0		nt Award	Date	0.00
					1. 00	2.00	
	Source of Federal Funds						
4.00	Community Health Center (Section 330(d), PHS						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	Appalachian Regional Commission						7.00
8.00	Look-Alikes OTHER (SPECIFY)						8.00
9. 00	OTHER (SPECIFY)						9.00
					1. 00	2.00	
10. 00	Does this facility operate as other than a ho	ospital-based RE	HC or FOHC? Fr	iter "Y" for	N N		10.00
	yes or "N" for no in column 1. If yes, indica 2. (Enter in subscripts of line 11 the type of hours.)	ate number of ot	ther operation	s in column			
	Thou of y	Sund	Tuesday				
		from	to	from	Monday to	from	
		1.00	2. 00	3. 00	4. 00	5. 00	
	Facility hours of operations (1)						_
11. 00	CLINIC			07: 00	16: 30	07: 00	11.00
					1.00	2.00	
12. 00	Have you received an approval for an exception	on to the produc	ctivity standa	urd?	1. 00 N	2.00	12.00
13. 00	Is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in columbne of providers included in this report. numbers below.	d in CMS Pub. 10 umn 1. If yes, e	00-04, chapter enter in colum	9, section nn 2 the	N	0	13.00
				Prov	ider name	CCN number	
					1. 00	2. 00	
14.00	RHC/FQHC name, CCN number						14. 00
		Y/N	V	XVIII	XI X	Total Visits	
	I	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 number of total visits for this provider.						15.00
	(see instructions)			1			
			Cou	inty			
				00			
2.00	City, State, ZIP Code, County						2. 00
		Tuesday		esday		sday	
		to	from	to	from	to	
		6. 00	7. 00	8. 00	9. 00	10. 00	
	Facility hours of operations (1)	4.00		l	07.00	la / 00	
11.00	CLI NI C	16: 30 C	07: 00	16: 30	07: 00	16: 30	11.0

Health Financial Systems F	FRANCISCAN HEAL	TH RENSSELAER		In Lie	u of Form CMS-2	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der CO	CN: 15-1324	Peri od:	Worksheet S-8	
				From 01/01/2021		
		Component (CCN: 15-8502	To 12/31/2021	Date/Time Pre	pared:
		·			5/27/2022 5:0	1 pm
				RHC II	Cost	
	Frid	day	Sa	turday		
	from	to	from	to		
	11. 00	12.00	13. 00	14. 00		
Facility hours of operations (1)						
11. 00 CLINIC						11. 00

Heal th	Financial Systems FRANCISCAN HEA	ALTH RENSSELAER		In Lie	u of Form CMS-2	2552-10			
	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 15-1		od:	Worksheet S-1				
			From To	01/01/2021 12/31/2021	Date/Time Pre	pared:			
					5/27/2022 5:0				
					1. 00				
	Uncompensated and indigent care cost computation	0 11 1 1 1 1 1 000			0.050000				
1. 00	Cost to charge ratio (Worksheet C, Part I line 202 column Medicaid (see instructions for each line)	3 divided by line 202	column 8)		0. 359330	1.00			
2.00	Net revenue from Medicaid				0	2. 00			
3. 00	Did you receive DSH or supplemental payments from Medicai	d?				3. 00			
4.00	If line 3 is yes, does line 2 include all DSH and/or supp		Medi cai d?			4. 00 5. 00			
5.00									
6. 00 7. 00	Medicaid charges Medicaid cost (line 1 times line 6)				0 0				
8. 00	Difference between net revenue and costs for Medicaid pro	gram (line 7 minus sum	of lines 2	and 5; if	0				
	< zero then enter zero)								
0.00	Children's Health Insurance Program (CHIP) (see instruction	ons for each line)				0.00			
9. 00 10. 00	Net revenue from stand-alone CHIP Stand-alone CHIP charges				0	9. 00 10. 00			
11. 00	Stand-alone CHIP cost (line 1 times line 10)					11.00			
12.00	Difference between net revenue and costs for stand-alone	CHIP (line 11 minus lin	ne 9; if < 2	zero then		12.00			
	enter zero)								
13. 00	Other state or local government indigent care program (See				0	13. 00			
14. 00									
	10)								
15. 00									
16. 00									
	13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see								
	instructions for each line)				,				
17. 00	Private grants, donations, or endowment income restricted	9				17. 00			
18. 00 19. 00	Government grants, appropriations or transfers for suppor Total unreimbursed cost for Medicaid, CHIP and state and			n of lines	0 0	18. 00 19. 00			
	8, 12 and 16)	- Todar Thangert dare pr	ograms (sur			17.00			
			sured ents	Insured patients	Total (col. 1 + col. 2)				
			00	2. 00	3.00				
	Uncompensated Care (see instructions for each line)								
20. 00	Charity care charges and uninsured discounts for the enti (see instructions)	re facility	0	0	0	20. 00			
21. 00	Cost of patients approved for charity care and uninsured	discounts (see	0	0	0	21. 00			
22. 00	instructions) Payments received from patients for amounts previously wr	itten off as	0	0	0	22. 00			
	charity care								
23. 00	Cost of charity care (line 21 minus line 22)		0	0	0	23. 00			
					1. 00				
24. 00	Does the amount on line 20 column 2, include charges for		ength of st	tay limit	N	24. 00			
25. 00	imposed on patients covered by Medicaid or other indigent If line 24 is yes, enter the charges for patient days bey		orogram's le	ength of	0	25. 00			
26. 00	stay limit Total bad debt expense for the entire hospital complex (s	aa instructions)			1 270 100	26.00			
26.00	Medicare reimbursable bad debts for the entire hospital c		ns)		1, 279, 199 493, 811				
27. 00	Medicare allowable bad debts for the entire hospital comp	. ,	,		759, 709				
28. 00	Non-Medicare bad debt expense (see instructions)	·			519, 490				
29. 00	Cost of non-Medicare and non-reimbursable Medicare bad de		ctions)		452, 566				
	Cost of uncompensated care (line 23 column 3 plus line 29				452, 566				
31.00	Total unreimbursed and uncompensated care cost (line 19 p	ius iille 30)			452, 566	J 31.00			

Health Financial Systems F	FRANCI SCAN HEALTH RENSSELAER			In Lieu of Form CMS-2552-10			
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provider CCN: 15-1324		Period: From 01/01/2021	Worksheet A		
				o 12/31/2021	Date/Time Pre	oared:	
	0.1		T 1 1 1 1	D 1 'C' 1'	5/27/2022 5:0	1 pm	
Cost Center Description	Sal ari es	Other	+ col . 2)	Reclassifications (See A-6)	Reclassified Trial Balance		
			+ (01. 2)	ons (see A-o)	(col . 3 +-		
					col . 4)		
	1.00	2. 00	3. 00	4. 00	5. 00		
GENERAL SERVICE COST CENTERS							
1.00 O0100 CAP REL COSTS-BLDG & FLXT		1, 226, 926	1, 226, 926	39, 431	1, 266, 357	1.00	
2.00 O0200 CAP REL COSTS-MVBLE EQUIP 3.00 O0300 OTHER CAP REL COSTS		0			0	2. 00 3. 00	
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT	0	3, 367, 623	3, 367, 623	3	3, 367, 623	4. 00	
5. 00 00500 ADMINISTRATIVE & GENERAL	3, 639, 291	7, 347, 585			11, 009, 435	5. 00	
7.00 00700 OPERATION OF PLANT	303, 478	1, 084, 658			1, 388, 136	7. 00	
8.00 00800 LAUNDRY & LINEN SERVICE	26, 297	55, 719	82, 016	0	82, 016	8. 00	
9. 00 00900 HOUSEKEEPI NG	377, 917	109, 003			450, 118	9. 00	
10. 00 01000 DI ETARY	241, 528	134, 034			134, 027	10.00	
11. 00 01100 CAFETERI A	210, 270	124 277	244.454	,	241, 535	11.00	
13. 00 O1300 NURSI NG ADMINI STRATI ON 14. 00 O1400 CENTRAL SERVI CES & SUPPLY	210, 279 32, 254	134, 377 134, 888			344, 656 167, 142	13. 00 14. 00	
15. 00 01500 PHARMACY	317, 885	2, 756, 019			389, 466	15. 00	
16. 00 01600 MEDI CAL RECORDS & LI BRARY	388	2, 730, 017			388	16. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	,			·, ·			
30. 00 03000 ADULTS & PEDIATRICS	1, 797, 581	75, 590	1, 873, 171	-280	1, 872, 891	30. 00	
31.00 03100 INTENSIVE CARE UNIT	512, 792	1, 062			513, 854	31. 00	
32. 00 03200 CORONARY CARE UNIT	0	0	C	0	0	32. 00	
ANCILLARY SERVICE COST CENTERS 50. 00 05000 OPERATING ROOM	(70, 200	450 (24	1 120 022	24 055	1 172 007	FO 00	
50. 00 05000 OPERATI NG ROOM 54. 00 05400 RADI OLOGY-DI AGNOSTI C	679, 308 933, 536	459, 624 459, 397			1, 172, 987 1, 372, 954	50. 00 54. 00	
60. 00 06000 LABORATORY	933, 330	2, 256, 430			2, 256, 146	60.00	
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.		6, 200			6, 200	63. 00	
65. 00 06500 RESPIRATORY THERAPY	673, 435	56, 146			729, 581	65. 00	
66. 00 06600 PHYSI CAL THERAPY	493, 852	30, 357	524, 209	-150	524, 059	66.00	
66. 01 06601 PHYSI CAL THERAPY- WHEATFIELD	440, 562	34, 312			474, 571	66. 01	
67. 00 06700 OCCUPATI ONAL THERAPY	89, 892	5, 186			95, 078	67. 00	
67. 01 06701 OCCUPATIONAL THERAPY- WHEATFIELD	107, 946	1, 795			109, 741	67. 01	
68. 00 06800 SPEECH PATHOLOGY 68. 01 06801 SPEECH PATHOLOGY - WHEATFIELD	93, 708 107, 979	1, 012 2, 195			94, 720 110, 174	68. 00 68. 01	
69. 00 06900 ELECTROCARDI OLOGY	107, 979	2, 193 O	110, 172		110, 174	69. 00	
70. 00 07000 ELECTROENCEPHALOGRAPHY		0			Ö	70. 00	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	o	632, 299	632, 299	o	632, 299	71. 00	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	o	193, 163			193, 163	72.00	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	C	2, 677, 219	2, 677, 219	73. 00	
74. 00 07400 RENAL DI ALYSI S	0	0	C	0	0	74. 00	
OUTPATIENT SERVICE COST CENTERS	277 022	121 027	100 (70	12 420	207 222	00.00	
88. 00 08800 RURAL HEALTH CLINIC 88. 01 08801 BROOK RHC	277, 833 311, 027	131, 837 106, 007				88. 00 88. 01	
90. 00 09000 CLI NI C	811, 757	321, 684			1, 133, 386	90.00	
90. 01 09001 WOUND CARE	27, 491	84, 374			109, 794		
91. 00 09100 EMERGENCY	1, 134, 192	1, 000, 037			2, 133, 795		
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)					, ,	92.00	
OTHER REIMBURSABLE COST CENTERS							
95. 00 09500 AMBULANCE SERVICES	0	0	C	0	0	95. 00	
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0	0			0	98. 00	
101. 00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0	0	C	0	0	101. 00	
113. 00 11300 INTEREST EXPENSE		0		0	0	113. 00	
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0				115. 00	
116. 00 11600 H0SPI CE	o	0		o o		116. 00	
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	13, 642, 208	22, 209, 539	35, 851, 747	0	35, 851, 747	118. 00	
NONREI MBURSABLE COST CENTERS							
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2, 042	2, 042	0		190. 00	
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	(0		192.00	
194. 00 07950 ALTERNACARE 194. 01 07951 SPORTS MEDI CI NE	36, 124	457 540			36, 581		
194. 01 07951 SPORTS MEDICINE 194. 02 07952 UNUSED SPACE	31, 025	540 0			31, 565 0	194. 01 194. 02	
194. 03 07953 LAFAYETTE HHA BRANCH	100	2, 456	`	,		194. 02	
200.00 TOTAL (SUM OF LINES 118 through 199)	13, 709, 457	22, 215, 034					
				·			

Provider CCN: 15-1324

| Period: | Worksheet A | From 01/01/2021 | To 12/31/2021 | Date/Time Prepared: 5/27/2022 5:01 pm

				5/27/2022 5: 0	1 pm
	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 & FIXT	316, 995	1, 583, 352		1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	0	0		2.00
3.00	00300 OTHER CAP REL COSTS	0	0		3.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	-712, 932	2, 654, 691		4.00
5.00	00500 ADMINISTRATIVE & GENERAL	-1, 702, 167	9, 307, 268		5. 00
7.00	00700 OPERATION OF PLANT	-6, 954	1, 381, 182		7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	82, 016		8. 00
9.00	00900 HOUSEKEEPI NG	0	450, 118		9. 00
10.00	01000 DI ETARY	0	134, 027	l e e e e e e e e e e e e e e e e e e e	10.00
11. 00	01100 CAFETERI A	-52, 626			11. 00
13. 00	01300 NURSING ADMINISTRATION	228, 899		l	13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	-77, 191			14. 00
15. 00	01500 PHARMACY	54, 756			15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	458, 348			16. 00
10.00	INPATIENT ROUTINE SERVICE COST CENTERS	430, 340	1 430, 730		10.00
30. 00	03000 ADULTS & PEDIATRICS	-503, 110	1, 369, 781		30. 00
31. 00	03100 NTENSIVE CARE UNIT	-303, 110			31. 00
32. 00	1 1	0			
32.00	03200 CORONARY CARE UNIT ANCILLARY SERVICE COST CENTERS	U			32. 00
FO 00	05000 OPERATING ROOM	1/1 272	1 011 /14		50. 00
50.00		-161, 373			
54.00	05400 RADI OLOGY-DI AGNOSTI C	-10, 191		l l	54.00
60.00	06000 LABORATORY	0			60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	-,		63. 00
65. 00	06500 RESPI RATORY THERAPY	-14, 996		· · · · · · · · · · · · · · · · · · ·	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	524, 059		66. 00
66. 01	06601 PHYSICAL THERAPY- WHEATFIELD	0			66. 01
67. 00	06700 OCCUPATI ONAL THERAPY	0			67. 00
67. 01	06701 OCCUPATIONAL THERAPY- WHEATFIELD	0			67. 01
68. 00	06800 SPEECH PATHOLOGY	0		l l	68. 00
68. 01	06801 SPEECH PATHOLOGY- WHEATFIELD	0	110, 174		68. 01
69. 00	06900 ELECTROCARDI OLOGY	0	0		69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	632, 299		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	193, 163		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	2, 677, 219		73.00
74.00	07400 RENAL DIALYSIS	0	0		74.00
	OUTPATIENT SERVICE COST CENTERS				
88. 00	08800 RURAL HEALTH CLINIC	-61, 483	335, 749		88. 00
88. 01	08801 BROOK RHC	-53, 362			88. 01
90.00	09000 CLI NI C	-225, 000			90.00
90. 01	09001 WOUND CARE	-81, 000			90. 01
91. 00	09100 EMERGENCY	0			91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		_,,		92. 00
72.00	OTHER REIMBURSABLE COST CENTERS				,2.00
95. 00	09500 AMBULANCE SERVICES	0	0		95. 00
	09850 OTHER REIMBURSABLE COST CENTERS	0			98. 00
	10100 HOME HEALTH AGENCY	0		l l	101. 00
101.00	SPECIAL PURPOSE COST CENTERS	0	0		101.00
112 00	11300 I NTEREST EXPENSE	0	1		113. 00
	1 1	0	0	· · · · · · · · · · · · · · · · · · ·	115. 00
	11500 AMBULATORY SURGICAL CENTER (D. P.) 11600 HOSPICE	0	0		
	1 1	2 (02 207	22 240 240		116.00
118.00		-2, 603, 387	33, 248, 360		118. 00
100.00	NONREI MBURSABLE COST CENTERS		0.040		400 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0			190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	0			192. 00
	07950 ALTERNACARE	0	36, 581	l	194. 00
	07951 SPORTS MEDICINE	0	31, 565	l e e e e e e e e e e e e e e e e e e e	194. 01
	07952 UNUSED SPACE	0	0	l e e e e e e e e e e e e e e e e e e e	194. 02
	07953 LAFAYETTE HHA BRANCH	0	2, 556		194. 03
200.00	TOTAL (SUM OF LINES 118 through 199)	-2, 603, 387	33, 321, 104		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

					To 12/31/2021 Date/Time Pr 5/27/2022 5:	epared: 01 pm
		Increases				
	Cost Center	Li ne #	Sal ary	0ther		
	2. 00	3. 00	4. 00	5. 00		
	A - CAFETERIA					
1.00	CAFETERI A	1100	15 <u>5, 3</u> 34	8 <u>6, 2</u> 01		1. 00
	TOTALS		155, 334	86, 201		
	B - PROPERTY INSURANCE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	39, 431		1. 00
	TOTALS		0	39, 431		
	C - HOUSEKEEPING					
1.00	OPERATING ROOM	50.00	36, 802	0		1. 00
	TOTALS		36, 802	0		
	D - DRUGS					
1.00	DRUGS CHARGED TO PATIENTS	73. 00	0	2, 677, 219		1. 00
2.00	ADMINISTRATIVE & GENERAL	5. 00	0	61, 990		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
	TOTALS			2, 739, 209		
500.00	Grand Total: Increases		192, 136	2, 864, 841		500.00

Peri od: Worksheet A-6 From 01/01/2021 Date/Time Prepared: 5/27/2022 5:01 pm

					10	5/27/2021 Date/11 me Pr	
		Decreases		<u>.</u>			
	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	15 <u>5, 3</u> 34	8 <u>6, 2</u> 01	0		1. 00
	TOTALS		155, 334	86, 201			
	B - PROPERTY INSURANCE						
1.00	ADMI NI STRATI VE & GENERAL	5. 00	0	3 <u>9, 4</u> 31			1. 00
	TOTALS		0	39, 431			
	C - HOUSEKEEPING						
1.00	HOUSEKEEPI NG	9.00	<u>36, 8</u> 02	0	0		1. 00
	TOTALS		36, 802	0			
	D - DRUGS						
1.00		0.00	0	0	9		1. 00
2.00	PHARMACY	15. 00	0	2, 684, 438			2. 00
3.00	ADULTS & PEDIATRICS	30.00	0	280	0		3. 00
4.00	OPERATING ROOM	50.00	0	2, 747			4. 00
5.00	RADI OLOGY-DI AGNOSTI C	54.00	0	19, 979	0		5. 00
6.00	LABORATORY	60.00	0	284	0		6. 00
7.00	PHYSI CAL THERAPY	66.00	0	150	0		7. 00
8.00	PHYSICAL THERAPY- WHEATFIELD	66. 01	0	303	0		8. 00
9.00	RURAL HEALTH CLINIC	88. 00	0	12, 438	0		9. 00
10.00	BROOK RHC	88. 01	0	16, 030	0		10. 00
11.00	CLINIC	90.00	0	55	0		11. 00
12.00	WOUND CARE	90. 01	0	2, 071	0		12. 00
13.00	EMERGENCY	91.00	0	434	0		13. 00
	TOTALS		0	2, 739, 209			
500.00	Grand Total: Decreases		192, 136	2, 864, 841			500.00

Subtotal (sum of lines 1-7)

Reconciling Items

10.00 Total (line 8 minus line 9)

8.00

9.00

8.00

9.00

10.00

RECONCILIATION OF CAPITAL COSTS CENTERS Provi der CCN: 15-1324 Peri od: Worksheet A-7 From 01/01/2021 Part I Date/Time Prepared: 12/31/2021 5/27/2022 5:01 pm Acqui si ti ons Begi nni ng Di sposal s and Purchases Donati on Total Bal ances Retirements 2.00 3.00 4. 00 1 00 5 00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 675, 791 1.00 0 1.00 484, 426 0 2.00 Land Improvements 0 2.00 0 3.00 17, 403, 786 3.00 Buildings and Fixtures 39, 361 39, 361 0 0 4.00 Building Improvements 1, 808, 886 0 4.00 5.00 Fixed Equipment 0 5.00 0 6.00 Movable Equipment 12, 722, 058 623, 698 623, 698 1, 419, 452 6.00 0 7.00 HIT designated Assets 0 7.00 0 8.00 Subtotal (sum of lines 1-7) 33, 094, 947 663, 059 663, 059 1, 419, 452 8.00 9.00 Reconciling Items 0 9.00 <u>33, 0</u>94, 947 663, <u>0</u>59 1<u>, 419, 452</u> Total (line 8 minus line 9) 10.00 0 663, 059 10.00 Endi ng Bal ance Fully Depreciated Assets 6.00 7. 00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 Land 675, 791 1.00 2.00 Land Improvements 484, 426 0 2.00 3.00 Buildings and Fixtures 17, 443, 147 3.00 0 4.00 Building Improvements 1, 808, 886 4.00 5.00 Fi xed Equipment 5.00 Movable Equipment 6.00 11, 926, 304 1, 976, 778 6.00 7.00 HIT designated Assets 7.00

32, 338, 554

32, 338, 554

1, 976, 778

1, 976, 778

Heal th	n Financial Systems	FRANCI SCAN HEAL	TH RENSSELAER		In Lie	u of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der C	CN: 15-1324	Peri od:	Worksheet A-7	
					From 01/01/2021	Part II	
					To 12/31/2021	Date/Time Pre	pared:
			CI	LIMMADY OF CAD	1 TAI	5/27/2022 5:0	1 pm
		SUMMARY OF CAPITAL					
	Cook Cooks Decoristics	D		I 1	1	T /	
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see	,	
		0.00	10.00	11.00		instructions)	
	DART II. BEGONGLILLATION OF ANGUNTO FROM NO	9.00	10.00	11.00	12. 00	13. 00	
	PART II - RECONCILIATION OF AMOUNTS FROM WO			and 2		_	
1. 00	CAP REL COSTS-BLDG & FLXT	1, 226, 926	0)	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		0	0	2. 00
3.00	Total (sum of lines 1-2)	1, 226, 926			0 0	. 0	3. 00
		SUMMARY 0	F CAPITAL				
	Cost Center Description	Other	Total (1) (sum	n			
		Capi tal -Rel ate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14. 00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WO	RKSHEET A, COLUM	IN 2, LINES 1 a	and 2			
1.00	CAP REL COSTS-BLDG & FLXT	0	1, 226, 926	5			1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2. 00
2 00	T-+-1 (6 1: 1 2)		1 22/ 22/	.			1 2 00

0 0 0

1, 226, 926

1. 00 2. 00 3. 00

1.00 CAP REL COSTS-BLDG & FLX1
2.00 CAP REL COSTS-MVBLE EQUIP
3.00 Total (sum of lines 1-2)

Heal th	n Financial Systems	FRANCISCAN HEAL	TH RENSSELAER		In Lie	eu of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der C		Period: From 01/01/2021	Worksheet A-7 Part III	
					To 12/31/2021	Date/Time Prep 5/27/2022 5:0	
		COMI	COMPUTATION OF RATIOS ALLOCATION OF OTH				
	Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets		Insurance	
			Leases	for Ratio (col. 1 - col	instructions)		
				2)	•		
		1.00	2.00	3. 00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS					
1.00	CAP REL COSTS-BLDG & FLXT	0	0		0 1. 000000	0	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		0. 000000		2. 00
3.00	Total (sum of lines 1-2)	0	0		0 1.000000		3. 00
		ALLOCA	TION OF OTHER (CAPITAL	SUMMARY C	F CAPITAL	
	Cost Center Description	Taxes	0ther	Total (sum of	Depreciation	Lease	
			Capi tal -Relate				
		/ 00	d Costs 7.00	through 7)	9, 00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS C	6. 00	7.00	8. 00	9.00	10.00	
1. 00	CAP REL COSTS-BLDG & FIXT	LIVIERS			0 1, 235, 365	0	1. 00
2.00	CAP REL COSTS-BEDG & TTAT	0			0 1, 233, 303 0 0		2. 00
3.00	Total (sum of lines 1-2)	0			0 1, 235, 365	"	3. 00
0.00	Trotal (sam of trilles t 2)		Sl	JMMARY OF CAPI		J	0.00
	Cost Center Description	Interest	Insurance (see			Total (2) (sum	
			instructions)	instructions)	Capi tal -Relate		
					d Costs (see	through 14)	
		11.00	10.00	10.00	instructions)	45.00	
	PART III - RECONCILIATION OF CAPITAL COSTS C	11.00	12.00	13.00	14. 00	15. 00	
1. 00	CAP REL COSTS-BLDG & FIXT	594	39, 431		0 307, 962	1, 583, 352	1. 00
2.00	CAP REL COSTS-BLDG & FTXT	094	37, 431	•	0 307, 962	1, 363, 332	2. 00
3.00	Total (sum of lines 1-2)	594	39, 431		0 307, 962	"	3. 00
0.00	1.1.1. (1.1.1.00 1.2)	1 071	0,, 101	1	-1 33., 702	., 555, 552	0.00

| Period: | Worksheet A-8 | From 01/01/2021 | To 12/31/2021 | Date/Time Prepared: Health Financial Systems
ADJUSTMENTS TO EXPENSES Provider CCN: 15-1324

				To	12/31/2021	Date/Time Prep 5/27/2022 5:00	
				Expense Classification on		3/2//2022 5.0	Грііі
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basi s/Code (2) 1.00	Amount 2.00	Cost Center 3.00	Li ne # 4. 00	Wkst. A-7 Ref. 5.00	
1. 00	Investment income - CAP REL	1.00		CAP REL COSTS-BLDG & FIXT	1. 00	0.00	1. 00
2. 00	COSTS-BLDG & FIXT (chapter 2) Investment income - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	2. 00
3. 00	COSTS-MVBLE EQUIP (chapter 2) Investment income - other		0		0.00	0	3. 00
	(chapter 2)		-				
4. 00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4. 00
5. 00	Refunds and rebates of expenses (chapter 8)	В	-77, 163	CENTRAL SERVICES & SUPPLY	14. 00	0	5. 00
6.00	Rental of provider space by		0		0. 00	0	6. 00
7. 00	suppliers (chapter 8) Telephone services (pay		0		0.00	0	7. 00
	stations excluded) (chapter 21)						
8.00	Television and radio service		0		0. 00	О	8. 00
9. 00	(chapter 21) Parking Lot (chapter 21)		0		0. 00	0	9. 00
10. 00	Provider-based physician adjustment	A-8-2	-1, 010, 002			0	10. 00
11. 00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	o	11. 00
12. 00	Related organization	A-8-1	937, 973			0	12.00
13. 00	transactions (chapter 10) Laundry and linen service		0		0. 00	0	13. 00
14. 00 15. 00	Cafeteria-employees and guests Rental of quarters to employee		-49, 198	CAFETERI A	11. 00 0. 00	0	14. 00 15. 00
	and others		0				
16. 00	Sale of medical and surgical supplies to other than		0		0.00	0	16. 00
17. 00	patients Sale of drugs to other than		0		0.00	0	17. 00
	pati ents	В	17/	MEDICAL DECODDS & LIDDADY			
18. 00	Sale of medical records and abstracts	В		MEDICAL RECORDS & LIBRARY	16. 00		
19. 00	Nursing and allied health education (tuition, fees,		0		0. 00	0	19. 00
19. 01	books, etc.) Nursing and allied health		0		0.00	0	19. 01
17.01	education (tuition, fees,		O		0.00	J	17.01
19. 02	books, etc.) Nursing and allied health		0		0.00	0	19. 02
	education (tuition, fees, books, etc.)						
20.00	Vending machines		0		0.00	0	20.00
21. 00	Income from imposition of interest, finance or penalty		0		0.00	0	21. 00
22. 00	charges (chapter 21) Interest expense on Medicare	1	0		0. 00	0	22. 00
	overpayments and borrowings to repay Medicare overpayments						
23. 00	Adjustment for respiratory	A-8-3	0	RESPI RATORY THERAPY	65. 00		23. 00
	therapy costs in excess of limitation (chapter 14)						
24. 00	Adjustment for physical therapy costs in excess of	A-8-3	0	PHYSI CAL THERAPY	66. 00		24. 00
25 00	limitation (chapter 14)		0	*** Coot Conton Doloted ***	114 00		25 00
25. 00	Utilization review - physicians' compensation		U	*** Cost Center Deleted ***	114. 00		25. 00
26. 00	(chapter 21) Depreciation - CAP REL		0	CAP REL COSTS-BLDG & FIXT	1. 00	0	26. 00
27. 00	COSTS-BLDG & FLXT Depreciation - CAP REL			CAP REL COSTS-MVBLE EQUIP	2. 00	0	
	COSTS-MVBLE EQUIP						
28. 00 29. 00	Non-physician Anesthetist Physicians' assistant		0	*** Cost Center Deleted ***	19. 00 0. 00	О	28. 00 29. 00
30. 00	Adjustment for occupational therapy costs in excess of	A-8-3	0	OCCUPATI ONAL THERAPY	67. 00		30. 00
20. 22	limitation (chapter 14)		=	ADULTO A DEDLATOLOG	20.5		20.00
30. 99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30. 00		30. 99
		<u> </u>			<u> </u>	<u> </u>	

-28 CENTRAL SERVICES & SUPPLY

-8,000 RURAL HEALTH CLINIC

-46, 619 RURAL HEALTH CLINIC

-49, 362 BROOK RHC

-2, 603, 387

14.00

88.00

88.00

88.01

ol

38 03

38.04

39.00

39.01

50.00

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

Α

Α

Α

Α

(2) Basis for adjustment (see instructions)

TOTAL (sum of lines 1 thru 49)

(Transfer to Worksheet A, column 6, line 200.)

PHYSICIAN RHC SALARY

PHYSICIAN RHC SALARY

38 03

38.04

39. 00

39.01

50.00

- A. Costs if cost, including applicable overhead, can be determined.
- B. Amount Received if cost cannot be determined.
- (3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
- 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 Period: From 01/01/2021 To 12/31/2021 Date/Time Prepared: 5/27/2022 5:01 pm

					5/27/2022 5:0	1 pm
	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	
		MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED OF	RGANIZATIONS OR	CLAI MED	
	HOME OFFICE COSTS:					
1.00			ALLOWABLE NEW CAPITAL COSTS	307, 962		1. 00
2.00	1.00	CAP REL COSTS-BLDG & FIXT	I NTEREST	594	0	2. 00
3.00	4. 00	EMPLOYEE BENEFITS DEPARTMENT	EMPLYEE BENEFITS	0	807, 310	3.00
3.02	5. 00	ADMINISTRATIVE & GENERAL	ADMIN & GENERAL	4, 906, 380	4, 868, 428	3. 02
3.03	0.00			0	0	3. 03
3.04	15. 00	PHARMACY	COVP / PHARMACY	35, 184	0	3.04
3.05	16. 00	MEDICAL RECORDS & LIBRARY	ні м	458, 524	0	3. 05
3.06	1. 00	CAP REL COSTS-BLDG & FIXT	INTEREST	799, 713	799, 713	3.06
3.07	4. 00	EMPLOYEE BENEFITS DEPARTMENT	SHARED SERVICES	94, 378	0	3. 07
3.09	5. 00	ADMINISTRATIVE & GENERAL	SHARED SERVICES	562, 218	0	3. 09
4.00	13. 00	NURSING ADMINISTRATION	SHARED SERVICES	228, 899	0	4. 00
4.01	15. 00	PHARMACY	SHARED SERVICES	19, 572	o	4. 01
5.00	TOTALS (sum of lines 1-4).			7, 413, 424	6, 475, 451	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.

nas n	be been posted to worksheet A, cordinas i and/or 2, the amount arrowable should be rindreated in cordinar 4 or this part.					
				Related Organization(s) and/	or Home Office	
	Symbol (1)	Name	Percentage of	Name	Percentage of	
			Ownershi p		Ownershi p	
	1. 00	2.00	3.00	4. 00	5. 00	
·	B. INTERRELATIONSHIP TO RELAT	TED ORGANIZATION(S) AND/OR HO	ME OFFICE:			

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

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

6.00	В	FRANCI SCAN ALLI	100.00	0.00	6. 00
7.00			0.00	0.00	7.00
8.00			0.00	0.00	8.00
9.00			0.00	0.00	9.00
10.00			0.00	0.00 10	10.00
100.00	G. Other (financial or			100	00.00
	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.
- $\hbox{B. Corporation, partnership, or other organization has financial interest in provider}.$
- C. Provider has financial interest in corporation, partnership, or other organization.
- D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

				5/27/2022 5:0	01 pm
	Net	Wkst. A-7 Ref.			
	Adjustments				
	(col. 4 minus				
	col. 5)*				
	6. 00	7. 00			
	A. COSTS INCUR	RED AND ADJUSTN	MENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR	CLAI MED	
	HOME OFFICE CO	STS:			
1.00	307, 962	14			1.00
2.00	594	11			2.00
3.00	-807, 310	0			3.00
3.02	37, 952	0			3. 02
3.03	0	0			3. 03
3.04	35, 184	0			3. 04
3.05	458, 524	0			3.05
3.06	0	11			3.06
3.07	94, 378	0			3. 07
3.09	562, 218	0			3. 09
4.00	228, 899				4.00
4. 01	19, 572				4. 01
5. 00	937, 973				5. 00

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

Related Organization(s)		
and/or Home Office		
Type of Business		
1,760 01 240111000		
6. 00		
B. INTERRELATIONSHIP TO RELAT	TED ORGANIZATION(S) AND/OR HOME OFFICE:	

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

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

6.00
7. 00
8.00
9.00
10.00
100.00

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

| Period: | Worksheet A-8-2 | From 01/01/2021 | To 12/21/2021 Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT Provider CCN: 15-1324

							Γο 12/31/2021		
	Wkst. A Line #	Cost Center/Physician	Total	Professi on	al	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remuneration	Component		Component		ider Component	
								Hours	
	1. 00	2.00	3.00	4.00		5. 00	6. 00	7. 00	
1. 00	5. 00	ADMINISTRATIVE & GENERAL	66, 701	66,	701	0	0	0	1. 00
2.00	30.00	ADULTS & PEDIATRICS	500, 397	500,	397	0	0	0	2. 00
3.00	50. 00	OPERATING ROOM	109, 400	109,	400	0	0	0	3. 00
4.00	54. 00	RADI OLOGY-DI AGNOSTI C	12, 508	12,	508	0	0	0	4. 00
5.00	65. 00	RESPI RATORY THERAPY	14, 996	14,	996	0	0	0	5. 00
6.00		CLI NI C	225, 000	225,	000	0	0	0	6. 00
7.00	90. 01	WOUND CARE	81, 000	81,	000	0	0	0	7. 00
8.00	91. 00	EMERGENCY	991, 767		0	991, 767	0	0	8. 00
9.00	0.00		0		0	0		0	9. 00
10.00	0.00		0		0	0	0	0	10. 00
200.00			2, 001, 769	1, 010,	002	991, 767		0	200. 00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE	5 Percent	of	Cost of	Provi der	Physician Cost	
		ldentifier	Limit	Unadj usted	RCE	Memberships &		of Malpractice	
				Limit		Conti nui ng	Share of col.	Insurance	
						Educati on	12		
	1. 00	2. 00	8.00	9. 00		12. 00	13. 00	14. 00	
1.00		ADMINISTRATIVE & GENERAL	0		0	_	0		
2.00		ADULTS & PEDIATRICS	0		0	_	0	0	2. 00
3.00		OPERATING ROOM	0		0	0	0	0	3. 00
4.00		RADI OLOGY-DI AGNOSTI C	0		0	0	0	0	4. 00
5.00		RESPI RATORY THERAPY	0		0	0	0	0	5. 00
6.00		CLINIC	0		0	0	0	0	6. 00
7.00		WOUND CARE	0		0	0	0	0	7. 00
8.00		EMERGENCY	0		0	0	0	0	8. 00
9.00	0.00		0		0	0	0	0	9. 00
10.00	0. 00		0		0	0	0	0	10.00
200.00	WI+ A I : //	Cost Center/Physician	Provi der	Adjusted R	0	RCE	0 0	0	200. 00
	Wkst. A Line #	I denti fi er	Component	Limit	CE	Di sal I owance	Adjustment		
		rdentiffer	Share of col.	LIIIII		DI Sai i Owance			
			14						
	1. 00	2. 00	15. 00	16, 00		17. 00	18. 00		
1.00		ADMINISTRATIVE & GENERAL	0		0				1. 00
2.00		ADULTS & PEDIATRICS	0		0	0			2. 00
3.00	50. 00	OPERATING ROOM	0		0	0	109, 400		3. 00
4.00		RADI OLOGY-DI AGNOSTI C	0		0	0	12, 508		4. 00
5. 00		RESPI RATORY THERAPY	l		0	0	14, 996		5. 00
6.00		CLI NI C	0		0	0	225, 000		6. 00
7. 00	90. 01	WOUND CARE	0		0	0	81, 000		7. 00
8. 00		EMERGENCY	0		0	0	0		8. 00
9. 00	0.00		0		0	0	0		9. 00
10.00	0.00		0		0	0	0		10.00
200.00			0		0	0	1, 010, 002		200. 00

REASO!			u of Form CMS-2 Worksheet A-8 Parts I-VI Date/Time Pre 5/27/2022 5:0	-3 pared:
	Physi ca	I Therapy		
			1. 00	
	PART I - GENERAL INFORMATION			
1. 00 2. 00	Total number of weeks worked (excluding aides) (see instructions) Line 1 multiplied by 15 hours per week		9 135	1. 00 2. 00
3. 00	Number of unduplicated days in which supervisor or therapist was on provider site (see instru	ıctions)	41	3. 00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither super		0	4. 00
5. 00	nor therapist was on provider site (see instructions) Number of unduplicated offsite visits - supervisors or therapists (see instructions)		0	5. 00
6. 00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy	іру	0	6. 00
	assistant and on which supervisor and/or therapist was not present during the visit(s)) (see			
7. 00	instructions) Standard travel expense rate		0. 00	7. 00
8. 00	Optional travel expense rate per mile		0. 00	8. 00
		i des	Trai nees	
9. 00	1.00 2.00 3.00 4 Total hours worked 0.00 355.25 0.00	4. 00 0. 00	5. 00	9. 00
10.00	AHSEA (see instructions) 0.00 82.91 0.00	0.00	0.00	10. 00
11. 00	Standard travel allowance (columns 1 and 2, description one-half of column 2, line 10; column 3, description one-half of column 2, line 10; column 3, description one-half of column 2, line 10; column 3, description one-half of column 2, line 10; column 3, description one-half of column 2, line 10; column 3, description one-half of column 2, line 10; column 3, description one-half of column 2, line 10; column 3, description one-half of column 2, line 10; column 3, description one-half of column 2, line 10; column 3, description one-half of column 2, line 10; column 3, description one-half of column 2, line 10; column 3, description one-half of column 2, line 10; column 3, description one-half of column 2, line 10; column 3, description one-half of column 2, line 10; column 3, description one-half of column 2, line 10; column 3, description one-half of column 2, line 10; column 3, description one-half of column 2, line 10; column 3, description one-half of column 3, description o			11. 00
	one-half of column 3, line 10)			
12. 00				12. 00
12. 01 13. 00				12. 01 13. 00
13. 01				13. 01
			1 00	
	Part II - SALARY EQUIVALENCY COMPUTATION		1. 00	
14.00			0	14. 00
15.00			29, 454	15.00
16. 00 17. 00		all	0 29, 454	16. 00 17. 00
	others)		27, 101	
18. 00 19. 00			0	18. 00 19. 00
20. 00		others)	29, 454	20. 00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, sp	eech path		
	occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and the amount from line 20. Otherwise complete lines 21-23.	enter on	line 23	
21. 00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2	line 9	0.00	21. 00
22. 00	for respiratory therapy or columns 1 thru 3, line 9 for all others) Weighted allowance excluding aides and trainees (line 2 times line 21)		0	22. 00
	Total salary equivalency (see instructions)		29, 454	
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER S	I TE		
24. 00	Standard Travel Allowance Therapists (line 3 times column 2, line 11)		1 700	24. 00
25. 00			0	25. 00
26.00		£!!	1, 700	26. 00
27. 00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 others)	TOT all	0	27. 00
28. 00	Total standard travel allowance and standard travel expense at the provider site (sum of line	s 26 and	1, 700	28. 00
	27) Optional Travel Allowance and Optional Travel Expense			
29. 00	•		0	29. 00
30.00			0	30.00
31. 00 32. 00		n of	0	31. 00 32. 00
02.00	columns 1-3, line 13 for all others)			02.00
33.00			0	33.00
34. 00 35. 00			0	34. 00 35. 00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OU	ITSI DE PRO		
26 00	Standard Travel Expense Therapists (line 5 times column 2, line 11)		0	26 00
36. 00 37. 00			0	36. 00 37. 00
38. 00	Subtotal (sum of lines 36 and 37)		0	38. 00
39. 00	Standard travel expense (line 7 times the sum of lines 5 and 6) Optional Travel Allowance and Optional Travel Expense		0	39. 00
40. 00	•		0	40. 00
41 00	Assistants (column 2 line 12 01 times column 2 line 10)			41 00

43.00 Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)

Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.

44.00 Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)

45.00 Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)

0 41.00

0 44.00 0 45.00

0 42.00

0 43.00

41.00 Assistants (column 3, line 12.01 times column 3, line 10)

Subtotal (sum of lines 40 and 41)

Health Financial Systems F	FRANCISCAN HEALT	H RENSSELAER		In Lie	eu of Form CMS-2	2552-10
REASONABLE COST DETERMINATION FOR THERAPY SERVICES OUTSIDE SUPPLIERS		Provi der Co	CN: 15-1324	Period: From 01/01/2021 To 12/31/2021	Worksheet A-8 Parts I-VI Date/Time Pre 5/27/2022 5:0	-3 pared:
				Physical Therapy		
					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				_		
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 column of line 56)	0.00	0. 00	0.0	0.00	0.00	47. 00
48.00 Overtime rate (see instructions)	0.00	0.00	0.0	0.00		48. 00
49.00 Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.0	0.00		49. 00
CALCULATION OF LIMIT	0.00	0.00	0.0	0.00	0.00	
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) DETERMINATION OF OVERTIME ALLOWANCE	0.00	0.00	0.0	0.00	0.00	51.00
52.00 Adjusted hourly salary equivalency amount	82. 91	0.00	0.0	0.00		52.00
(see instructions) 53.00 Overtime cost limitation (line 51 times line		0		0 0		53. 00
52) 54.00 Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0		0 0		54.00
55.00 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) 0vertime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for	0	0		0 0	0	56. 00
respiratory therapy and columns 1 through 3 for all others.)						
D. J. W. COMPUTATION OF THE PARK LIMITATION OF	IND EVOCOS OOST	AD IIICTMENT			1. 00	
Part VI - COMPUTATION OF THERAPY LIMITATION A	AND EXCESS COST	ADJUSTMENT			29, 454	 E7 00
57.00 Salary equivalency amount (from line 23) 58.00 Travel allowance and expense - provider site 59.00 Travel allowance and expense - Offsite service 60.00 Overtime allowance (from column 5, line 56) 61.00 Equipment cost (see instructions)	•	. , ,)		29, 454 0 0 0	58. 00 59. 00 60. 00
62.00 Supplies (see instructions)					0	
63.00 Total allowance (sum of lines 57-62)					29, 454	1
64.00 Total cost of outside supplier services (from 65.00 Excess over limitation (line 64 minus line 63 LINE 33 CALCULATION	,	enter zero)			0	
100.00 Line 26 = line 24 for respiratory therapy or	sum of lines 24	and 25 for a	II others		1 700	100.00
100.01 Line 27 = line 7 times line 3 for respiratory 100.02 Line 33 = line 28 = sum of lines 26 and 27 LINE 34 CALCULATION				others	0	100. 01
101.00 Line 27 = line 7 times line 3 for respiratory 101.01 Line 31 = line 29 for respiratory therapy or 101.02 Line 34 = sum of lines 27 and 31				others	0	101. 00 101. 01 101. 02
LINE 35 CALCULATION 102.00 Line 31 = line 29 for respiratory therapy or 102.01 Line 32 = line 8 times columns 1 and 2, line				ımns 1-3. Line		102. 00 102. 01
13 for all others 102.02 Line 35 = sum of lines 31 and 32		, chapy o				102. 02

	•	FRANCI SCAN HEAL				u or Form CM3-2	2552-10
COST A	NLLOCATION - GENERAL SERVICE COSTS		Provi der CC		Period: From 01/01/2021 Fo 12/31/2021	Worksheet B Part I Date/Time Pre	pared:
			0451741 551	1755 00070		5/27/2022 5:0	1 pm
			CAPITAL REL	LATED COSTS			
	Cost Center Description	Net Expenses	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Subtotal	
	cost center bescription	for Cost	DLUG & FIXI	WVDLE EQUIP	BENEFITS	Subtotal	
		Allocation			DEPARTMENT		
		(from Wkst A			DEPARTMENT		
		col. 7)					
		0	1. 00	2. 00	4. 00	4A	
	GENERAL SERVICE COST CENTERS	0	1.00	2.00	4.00	44	
1. 00	00100 CAP REL COSTS-BLDG & FIXT	1, 583, 352	1, 583, 352				1.00
2. 00	00200 CAP REL COSTS-BEDG & TTXT	1, 363, 352	1, 303, 332	,		1	2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	1 -1	20 424			1	4. 00
	00500 ADMINISTRATIVE & GENERAL	2, 654, 691	30, 426		,	10 170 200	
5.00	I I	9, 307, 268	159, 257		,	10, 179, 309	5. 00
7.00	00700 OPERATION OF PLANT	1, 381, 182	180, 819				
8. 00 9. 00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	82, 016	19, 321			106, 488	
	I I	450, 118	21, 684				
10.00	01000 DI ETARY	134, 027	21, 415		16, 882	172, 324	
11.00	01100 CAFETERI A	188, 909	28, 455		30, 424 41, 185	247, 788	
13.00	01300 NURSI NG ADMI NI STRATI ON	573, 555	4, 885		,	619, 625	
14.00	01400 CENTRAL SERVICES & SUPPLY	89, 951	52, 612		6, 317	148, 880	
15. 00	01500 PHARMACY	444, 222	13, 407		62, 261	519, 890	
16. 00	01600 MEDI CAL RECORDS & LI BRARY	458, 736	19, 701	(76	478, 513	16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS			T	1		
30. 00	03000 ADULTS & PEDIATRICS	1, 369, 781	105, 678		352, 072	1, 827, 531	
31. 00	03100 INTENSIVE CARE UNIT	513, 854	9, 220		100, 435	623, 509	
32. 00	03200 CORONARY CARE UNIT	0	0	(0	0	32. 00
	ANCILLARY SERVICE COST CENTERS				,		
50. 00	05000 OPERATING ROOM	1, 011, 614	111, 947		140, 257	1, 263, 818	1
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 362, 763	63, 558		182, 841	1, 609, 162	
60.00	06000 LABORATORY	2, 256, 146	34, 626		0	2, 290, 772	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	6, 200	1, 249	(0	7, 449	
65.00	06500 RESPI RATORY THERAPY	714, 585	46, 172	(131, 898	892, 655	
66.00	06600 PHYSI CAL THERAPY	524, 059	26, 031	(96, 725	646, 815	66. 00
66. 01	06601 PHYSICAL THERAPY- WHEATFIELD	474, 571	115, 571	(86, 288	676, 430	66. 01
67.00	06700 OCCUPATI ONAL THERAPY	95, 078	5, 277	(17, 606	117, 961	67. 00
67. 01	06701 OCCUPATIONAL THERAPY- WHEATFIELD	109, 741	24, 121	(21, 142	155, 004	67. 01
68.00	06800 SPEECH PATHOLOGY	94, 720	4, 469	(18, 354	117, 543	68. 00
68. 01	06801 SPEECH PATHOLOGY- WHEATFIELD	110, 174	15, 648		21, 149	146, 971	68. 01
69.00	06900 ELECTROCARDI OLOGY	o	0		ol	0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	o	0		ol ol	0	70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	632, 299	0	(ol ol	632, 299	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	193, 163	0		ol ol	193, 163	
73.00	07300 DRUGS CHARGED TO PATIENTS	2, 677, 219	0		ol ol	2, 677, 219	73. 00
74. 00	07400 RENAL DIALYSIS	0	0	(o	0	1
	OUTPATIENT SERVICE COST CENTERS						
88. 00		335, 749	0	(54, 416	390, 165	88. 00
88. 01	08801 BROOK RHC	347, 642	31, 491		60, 917	440, 050	
	09000 CLI NI C	908, 386			158, 990		
	09001 WOUND CARE	28, 794	12, 109		5, 384		90. 01
	09100 EMERGENCY	2, 133, 795	95, 833		222, 142	2, 451, 770	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	2, 100, 770	70,000	· `	222, 112		92.00
72.00	OTHER REIMBURSABLE COST CENTERS						72.00
95 00	09500 AMBULANCE SERVICES	0	0		0	0	95. 00
	09850 OTHER REIMBURSABLE COST CENTERS		0			0	
	10100 HOME HEALTH AGENCY		0				101.00
101.00	SPECIAL PURPOSE COST CENTERS	<u> </u>	0	<u> </u>	<u> </u>		101.00
113 00	11300 I NTEREST EXPENSE						113. 00
	11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	,	o	0	115. 00
116.00	11600 HOSPI CE	0	0				116.00
118. 00	I I	33, 248, 360	1, 413, 247		2, 671, 945	33, 065, 083	
110.00		33, 246, 300	1,413,247		2,071,945	33,003,003	1110.00
100 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,042	3, 367	,	ol	E 400	190. 00
	19000 BIFT, FLOWER, COFFEE SHOP & CANTEEN	2,042	3, 307				
	I I	24 501	0				192.00
	07950 ALTERNACARE	36, 581	0		7, 075		194. 00
	07951 SPORTS MEDI CI NE	31, 565	1// 700		6, 077	37,042	194. 01
	07952 UNUSED SPACE	0	166, 738		0	166, 738	
	07953 LAFAYETTE HHA BRANCH	2, 556	O	·	20		194. 03
200.00			_		_		200.00
201.00		22 224 421	1 500 350	(0 (05 4.5)		201. 00
202.00	TOTAL (sum lines 118 through 201)	33, 321, 104	1, 583, 352	l (2, 685, 117	33, 321, 104	1202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-1324

Peri od: Worksheet B From 01/01/2021 Part I To 12/31/2021 Date/Ti me Prepared:

5/27/2022 5:01 pm Cost Center Description ADMINISTRATIVE OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY & GENERAL PLANT LINEN SERVICE 9.00 10.00 5.00 7.00 8.00 GENERAL SERVICE COST CENTERS 1.00 1.00 00100 CAP REL COSTS-BLDG & FLXT 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 10, 179, 309 5 00 5 00 7.00 00700 OPERATION OF PLANT 713, 218 2, 334, 658 7.00 00800 LAUNDRY & LINEN SERVICE 46, 841 190, 521 8.00 37, 192 8.00 9.00 00900 HOUSEKEEPI NG 236, 918 41, 740 6, 821 824, 091 9.00 01000 DI ETARY 75.800 15,060 304, 406 10.00 10.00 41, 222 11.00 01100 CAFETERI A 108, 994 54, 774 2, 144 20, 011 0 11.00 13 00 01300 NURSING ADMINISTRATION 272, 553 9, 404 0 3, 436 0 13.00 01400 CENTRAL SERVICES & SUPPLY 36, 999 14.00 14 00 65.487 101, 275 0 0 15.00 01500 PHARMACY 228, 682 25, 808 0 9, 428 0 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 210, 482 37, 922 0 13,854 0 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 30.00 38.796 03000 ADULTS & PEDIATRICS 803 871 203, 423 74.317 292, 731 6, 484 31.00 03100 INTENSIVE CARE UNIT 274, 261 17, 747 11, 675 31.00 03200 CORONARY CARE UNIT 32 00 32.00 ANCILLARY SERVICE COST CENTERS 50 00 555, 912 78, 726 50.00 05000 OPERATING ROOM 215, 490 8, 980 0 05400 RADI OLOGY-DI AGNOSTI C 707, 817 122, 346 27, 693 44, 697 54.00 54.00 60.00 06000 LABORATORY 1,007,635 66, 653 0 24, 350 0 60.00 06300 BLOOD STORING, PROCESSING & TRANS. 63.00 63.00 3.277 2.404 0 878 0 65.00 06500 RESPIRATORY THERAPY 392, 649 88, 878 6,848 32, 470 0 65.00 66, 00 06600 PHYSI CAL THERAPY 284.513 50. 107 8, 986 18, 306 0 66.00 06601 PHYSICAL THERAPY- WHEATFIELD 297, 539 222, 466 81, 274 66.01 0 0 66.01 06700 OCCUPATI ONAL THERAPY 3, 711 67.00 51.887 10, 158 0 Λ 67.00 67.01 06701 OCCUPATIONAL THERAPY- WHEATFIELD 68, 181 46, 431 0 16, 963 0 67.01 06800 SPEECH PATHOLOGY 51, 703 3, 143 68.00 8, 603 0 0 68.00 11, 004 06801 SPEECH PATHOLOGY- WHEATFIELD 0 68.01 64.648 30, 121 0 68.01 06900 ELECTROCARDI OLOGY 0 69.00 0 0 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY C 0 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS o 71.00 278, 127 0 0 0 71.00 0 72 00 07200 IMPL. DEV. CHARGED TO PATIENTS 84 966 Ω 0 0 72 00 0 07300 DRUGS CHARGED TO PATIENTS 73.00 1, 177, 617 0 0 0 73.00 07400 RENAL DIALYSIS 0 0 74.00 74.00 OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 88.00 88.00 171,621 21, 200 0 193, 563 88. 01 08801 BROOK RHC 60, 619 22, 146 0 88.01 90.00 09000 CLI NI C 539, 119 304, 651 11, 998 111, 299 0 90.00 90 01 09001 WOUND CARE 20, 360 23, 310 8 516 90.01 0 C 91.00 09100 EMERGENCY 1,078,453 184, 473 57,055 67, 394 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 95 00 95 00 09500 AMBULANCE SERVICES 0 0 0 0 98. 00 09850 OTHER REIMBURSABLE COST CENTERS 0 C 0 0 0 98.00 101.00 10100 HOME HEALTH AGENCY 0 0 0 0 0 101.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113 00 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 0 0 0 115.00 116. 00 11600 HOSPI CE 0 0 116.00 SUBTOTALS (SUM OF LINES 1 through 117)
NONREI MBURSABLE COST CENTERS 190, 521 10, 066, 694 2,007,217 704, 466 304, 406 118. 00 118.00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 2, 379 0 190. 00 6, 481 0 2, 368 192.00 19200 PHYSICIANS' PRIVATE OFFICES C 0 0 192. 00 0 194. 00 07950 ALTERNACARE 0 194. 00 19.203 0 0 0 194. 01 07951 SPORTS MEDICINE 0 0 194. 01 16, 557 194. 02 07952 UNUSED SPACE 73, 343 320, 960 0 0 194. 02 117, 257 194. 03 07953 LAFAYETTE HHA BRANCH 0 0 194. 03 1.133 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 0 0 201.00 202.00 TOTAL (sum lines 118 through 201) 10, 179, 309 2, 334, 658 190, 521 824 091 304, 406 202. 00

Provider CCN: 15-1324

			10	12/31/2021	5/27/2022 5:0	pareu. 1 nm
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	, p
		ADMI NI STRATI ON	SERVICES &		RECORDS &	
			SUPPLY		LI BRARY	
OFFICE OFFICE COOT OFFITTED	11.00	13. 00	14. 00	15. 00	16. 00	
GENERAL SERVICE COST CENTERS 1.00 O0100 CAP REL COSTS-BLDG & FLXT	1					1 00
1.00 00100 CAP REL COSTS-BLDG & FLXT 2.00 00200 CAP REL COSTS-MVBLE EQUIP						1. 00 2. 00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 00 00500 ADMINISTRATIVE & GENERAL						5. 00
7. 00 00700 OPERATION OF PLANT						7. 00
8. 00 00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00 O0900 HOUSEKEEPING						9. 00
10. 00 01000 DI ETARY						10.00
11. 00 01100 CAFETERI A	433, 711					11. 00
13. 00 01300 NURSING ADMINISTRATION	11, 182					13. 00
14.00 01400 CENTRAL SERVICES & SUPPLY	1, 715		354, 356			14. 00
15. 00 01500 PHARMACY	16, 904	. 0	12, 652	813, 364		15. 00
16.00 01600 MEDICAL RECORDS & LIBRARY	0	0	0	O	740, 771	16. 00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	95, 595	258, 591	0	83	154, 889	30. 00
31.00 03100 INTENSIVE CARE UNIT	27, 269	107, 472	0	0	44, 186	31. 00
32. 00 03200 CORONARY CARE UNIT	0	0	0	0	0	32. 00
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATING ROOM	38, 081	1	0	816	61, 705	50. 00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	49, 644	1	0	5, 932	80, 440	54.00
60. 00 06000 LABORATORY	0	0	0	84	0	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	25 012	12 274	0	0	0	63.00
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	35, 812	1	0	45	58, 028	65. 00
66. 00 06600 PHYSI CAL THERAPY 66. 01 06601 PHYSI CAL THERAPY - WHEATFI ELD	26, 262		0	45 90	42, 554 37, 962	66. 00 66. 01
67. 00 06700 OCCUPATIONAL THERAPY	4, 780	_	0	90	7, 746	
67. 01 06701 OCCUPATIONAL THERAPY- WHEATFIELD	4, 780		0	0	9, 301	67. 00
68. 00 06800 SPEECH PATHOLOGY	4, 983	1	0	0	8, 075	68. 00
68. 01 06801 SPEECH PATHOLOGY- WHEATFIELD	1, 700	1	0	o o	9, 304	68. 01
69. 00 06900 ELECTROCARDI OLOGY		o o	0	0	0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	o	0	o	0	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	o	272, 482	0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	68, 889	0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	797, 095	0	73. 00
74. 00 07400 RENAL DIALYSIS	0	0	0	0	0	74. 00
OUTPATIENT SERVICE COST CENTERS						
88. 00 08800 RURAL HEALTH CLINIC	0		0	3, 693	23, 940	88. 00
88. 01 08801 BROOK RHC	16, 540		0	4, 760	26, 800	88. 01
90. 00 09000 CLI NI C	43, 168		0	16	69, 947	90.00
90. 01 09001 WOUND CARE	1, 462		0	615	2, 369	90. 01
91. 00 09100 EMERGENCY 92. 00 09200 0BSERVATI ON BEDS (NON-DI STINCT PART)	60, 314	376, 117	U	129	97, 730	91. 00 92. 00
OTHER REIMBURSABLE COST CENTERS						72.00
95. 00 09500 AMBULANCE SERVICES	1 0	0	0	0	0	95. 00
98. 00 09850 OTHER REIMBURSABLE COST CENTERS			0	o	0	98. 00
101.00 10100 HOME HEALTH AGENCY	0	1	0	o		101. 00
SPECIAL PURPOSE COST CENTERS			· · · · · · · · · · · · · · · · · · ·	-1		
113. 00 11300 INTEREST EXPENSE						113. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	0	0	0	115. 00
116. 00 11600 HOSPI CE	0	0	0	0		116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	433, 711	916, 200	354, 023	813, 358	734, 976	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		0	0		190. 00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	-	333	6		192. 00
194. 00 07950 ALTERNACARE	0	0	0	0		194. 00
194. 01 07951 SPORTS MEDICINE	0		0	0	· ·	194. 01
194. 02 07952 UNUSED SPACE			0	0		194. 02
194. 03 07953 LAFAYETTE HHA BRANCH		ή Θ	O	O	9	194. 03
200.00 Cross Foot Adjustments 201.00 Negative Cost Centers			0		0	200. 00 201. 00
202.00 TOTAL (sum lines 118 through 201)	433, 711	916, 200	354, 356	813, 364	740, 771	
202. 00 Trome (Sum Trios Tro through 201)	1 400,711	710, 200	354, 350	313, 304	140, 111	1-02.00

| Period: | Worksheet B | From 01/01/2021 | Part | To | 12/31/2021 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-1324

					To 12/31/2021	Date/Time Prepared:
	Cost Center Description	Subtotal	Intern &	Total		5/27/2022 5: 01 pm
	, , , , , , , , , , , , , , , , , , ,		Residents Cost			
			& Post Stepdown			
			Adjustments			
		24. 00	25. 00	26. 00		
	SENERAL SERVICE COST CENTERS				T	4.00
1	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP					1.00
1	00400 EMPLOYEE BENEFITS DEPARTMENT					4.00
	00500 ADMINISTRATIVE & GENERAL					5. 00
1	00700 OPERATION OF PLANT					7. 00
	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING					8. 00 9. 00
	01000 DI ETARY					10.00
	01100 CAFETERI A					11. 00
	01300 NURSING ADMINISTRATION					13. 00
	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY					14.00
1	01600 MEDICAL RECORDS & LIBRARY					15. 00 16. 00
_	NPATIENT ROUTINE SERVICE COST CENTERS					10.00
	03000 ADULTS & PEDIATRICS	3, 749, 827	0	3, 749, 82	7	30.00
	03100 INTENSIVE CARE UNIT	1, 112, 603	0	1, 112, 60		31.00
	03200 CORONARY CARE UNIT INCILLARY SERVICE COST CENTERS	0	0		0	32. 00
	05000 OPERATING ROOM	2, 244, 065	ol	2, 244, 06	5	50.00
	05400 RADI OLOGY-DI AGNOSTI C	2, 647, 731	Ö	2, 647, 73		54. 00
60.00	06000 LABORATORY	3, 389, 494	0	3, 389, 49	4	60. 00
1	06300 BLOOD STORING, PROCESSING & TRANS.	14, 008	0	14, 00		63.00
	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	1, 519, 614 1, 077, 588	O	1, 519, 61 1, 077, 58		65. 00 66. 00
	06601 PHYSICAL THERAPY- WHEATFIELD	1, 315, 761	ol Ol	1, 315, 76		66. 01
	06700 OCCUPATI ONAL THERAPY	196, 243	o	196, 24		67. 00
1	06701 OCCUPATIONAL THERAPY- WHEATFIELD	295, 880	0	295, 88		67. 01
	06800 SPEECH PATHOLOGY	194, 050	0	194, 05		68.00
	06801 SPEECH PATHOLOGY- WHEATFIELD 06900 ELECTROCARDIOLOGY	262, 048	O O	262, 04	0	68. 01 69. 00
	07000 ELECTROENCEPHALOGRAPHY	o o	Ö		Ö	70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 182, 908	0	1, 182, 90	8	71. 00
	07200 I MPL. DEV. CHARGED TO PATIENTS	347, 018	0	347, 01		72.00
	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	4, 651, 931 0	0	4, 651, 93	0	73. 00 74. 00
<u> </u>	DUTPATIENT SERVICE COST CENTERS	l U	U U		<u>u</u>	74.00
	08800 RURAL HEALTH CLINIC	610, 619	0	610, 61	9	88. 00
	D8801 BROOK RHC	764, 892	0	764, 89		88. 01
	09000 CLINIC	2, 441, 967	0	2, 441, 96		90.00
	09001 WOUND CARE 09100 EMERGENCY	107, 586 4, 373, 435	0	107, 58 4, 373, 43		90. 01
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1,070,100	o	1,070,10		92.00
C	THER REIMBURSABLE COST CENTERS					
	09500 AMBULANCE SERVICES	0	0		0	95. 00
	09850 OTHER REIMBURSABLE COST CENTERS	0	0		0	98. 00 101. 00
_	SPECIAL PURPOSE COST CENTERS	<u> </u>	<u> </u>		<u> </u>	101.00
	1300 I NTEREST EXPENSE					113. 00
	1500 AMBULATORY SURGICAL CENTER (D. P.)	0	0		0	115. 00
116. 00 1 118. 00	1600 HOSPI CE	0 32, 499, 268	0	32, 499, 26	0	116. 00 118. 00
_	SUBTOTALS (SUM OF LINES 1 through 117) IONREI MBURSABLE COST CENTERS	32, 477, 200	<u> </u>	32, 499, 20	O	110.00
	9000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	16, 637	0	16, 63	7	190. 00
	9200 PHYSI CI ANS' PRI VATE OFFI CES	339	o	33		192. 00
	07950 ALTERNACARE 07951 SPORTS MEDICINE	65, 972 56, 972	0	65, 97		194. 00 194. 01
	07951 SPORTS MEDICINE 07952 UNUSED SPACE	56, 872 678, 298	0	56, 87 678, 29		194. 01
	07953 LAFAYETTE HHA BRANCH	3, 718	Ö	3, 71		194. 03
200.00	Cross Foot Adjustments	0	О		0	200. 00
201.00	Negative Cost Centers	0	0		0	201. 00
202. 00	TOTAL (sum lines 118 through 201)	33, 321, 104	0	33, 321, 10	4	202. 00

ALLOCA	TION OF CAPITAL RELATED COSTS		Provi der CO	CN: 15-1324	Period: From 01/01/2021	Worksheet B Part II	
					To 12/31/2021	Date/Time Pre 5/27/2022 5:0	pared:
			CAPI TAL REI	ATED COSTS		5/2//2022 5:0	I DIII
	Cost Center Description	Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
	CENEDAL CEDILLOS COCT CENTEDO	0	1. 00	2. 00	2A	4. 00	
1. 00	GENERAL SERVICE COST CENTERS O0100 CAP REL COSTS-BLDG & FIXT						1.00
2. 00 4. 00 5. 00 7. 00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT	0 0	30, 426 159, 257 180, 819		0 30, 426 0 159, 257 0 180, 819 0 19, 321	8, 079 673	2. 00 4. 00 5. 00 7. 00
8. 00 9. 00	O0800 LAUNDRY & LINEN SERVICE O0900 HOUSEKEEPING	0	19, 321 21, 684		0 19, 321 0 21, 684	58 757	8. 00 9. 00
10.00	01000 DI ETARY	0	21, 415		0 21, 415	191	10. 00
11.00	01100 CAFETERI A	0	28, 455		0 28, 455	345	11.00
13. 00 14. 00	01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY	0	4, 885 52, 612	1	0 4, 885 0 52, 612	467 72	13. 00 14. 00
15. 00	01500 PHARMACY	O	13, 407		0 13, 407	705	1
16. 00	01600 MEDI CAL RECORDS & LI BRARY	0	19, 701		0 19, 701	1	16. 00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	0	105, 678		0 105, 678	3, 989	30.00
31. 00	03100 I NTENSI VE CARE UNI T	Ö	9, 220		0 9, 220	1, 138	1
32. 00	03200 CORONARY CARE UNIT	0	0		0 0	0	32. 00
50. 00	ANCI LLARY SERVI CE COST CENTERS 05000 OPERATI NG ROOM	0	111, 947		0 111, 947	1, 589	50.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	o	63, 558		0 63, 558	2, 072	1
60.00	06000 LABORATORY	0	34, 626		0 34, 626	0	60.00
63. 00 65. 00	06300 BLOOD STORING, PROCESSING & TRANS. 06500 RESPIRATORY THERAPY	0	1, 249 46, 172		0 1, 249 0 46, 172	0 1, 494	63. 00 65. 00
66. 00	06600 PHYSI CAL THERAPY	o	26, 031		0 26, 031	1, 096	1
66. 01	06601 PHYSI CAL THERAPY- WHEATFI ELD	0	115, 571		0 115, 571	978	1
67. 00 67. 01	06700 OCCUPATIONAL THERAPY 06701 OCCUPATIONAL THERAPY WHEATFIELD	0	5, 277 24, 121		0 5, 277 0 24, 121	199 240	67. 00 67. 01
68. 00	06800 SPEECH PATHOLOGY	o	4, 469		0 4, 469	208	68. 00
68. 01	06801 SPEECH PATHOLOGY- WHEATFIELD	0	15, 648		0 15, 648	240	1
69. 00 70. 00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	0	0		0 0 0	0	69. 00 70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	Ö	0		0 0	ő	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	72. 00
73. 00 74. 00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	0	0		0 0 0	0	73. 00 74. 00
74.00	OUTPATIENT SERVICE COST CENTERS	<u> </u>	- U		0 0		74.00
88. 00	08800 RURAL HEALTH CLINIC	0	0		0 0	617	88. 00
88. 01 90. 00	08801 BROOK RHC 09000 CLI NI C	0	31, 491 158, 265		0 31, 491 0 158, 265	690 1, 801	1
90. 01	09001 WOUND CARE	Ö	12, 109		0 12, 109	61	
	09100 EMERGENCY	0	95, 833		95, 833	2, 517	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS				0		92.00
	09500 AMBULANCE SERVICES	0	0		0 0	0	95. 00
	09850 OTHER REIMBURSABLE COST CENTERS	0	0		0	0	
101.00	10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0	0		0 0	0	101. 00
	11300 INTEREST EXPENSE						113. 00
	11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0		0 0		115.00
118.00	11600 HOSPICE SUBTOTALS (SUM OF LINES 1 through 117)	0	1, 413, 247		0 0 1, 413, 247		116. 00 118. 00
	NONREI MBURSABLE COST CENTERS	-1			., ., ., .,		
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3, 367		0 3, 367	l	190.00
	19200 PHYSI CI ANS' PRI VATE OFFI CES 07950 ALTERNACARE		0		0 0		192. 00 194. 00
194. 01	07951 SPORTS MEDICINE	0	0		0	69	194. 01
	07952 UNUSED SPACE	0	166, 738		0 166, 738	l	194. 02
200.00	07953 LAFAYETTE HHA BRANCH Cross Foot Adjustments		0		0		194. 03 200. 00
201.00	Negative Cost Centers		0		0 0		201. 00
202.00	TOTAL (sum lines 118 through 201)	0	1, 583, 352		0 1, 583, 352	30, 426	202. 00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-1324

Peri od: Worksheet B From 01/01/2021 Part II To 12/31/2021 Date/Time Prepared:

5/27/2022 5:01 pm Cost Center Description ADMINISTRATIVE OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY & GENERAL PLANT LINEN SERVICE 9.00 10.00 5.00 7.00 8.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5 00 167, 336 5 00 7.00 00700 OPERATION OF PLANT 11, 725 193, 217 7.00 00800 LAUNDRY & LINEN SERVICE 770 3,078 8.00 23, 227 8.00 9.00 00900 HOUSEKEEPI NG 3, 895 3, 454 832 30, 622 9.00 01000 DI ETARY 26,824 10.00 10.00 1.246 3.412 C 560 4, 533 11.00 01100 CAFETERI A 1, 792 261 744 0 11.00 13 00 01300 NURSING ADMINISTRATION 4, 481 778 0 128 0 13.00 01400 CENTRAL SERVICES & SUPPLY 1, 375 14 00 1.077 8.382 14.00 0 0 15.00 01500 PHARMACY 3, 759 2, 136 0 350 0 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 3,460 3, 138 0 515 0 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 30.00 03000 ADULTS & PEDIATRICS 13, 215 16, 835 4.730 2.762 25.795 31.00 03100 INTENSIVE CARE UNIT 4,509 1, 469 241 1,029 31.00 03200 CORONARY CARE UNIT 32 00 32.00 0 ANCILLARY SERVICE COST CENTERS 50 00 9, 139 50.00 05000 OPERATING ROOM 17, 834 1.095 2.925 0 05400 RADI OLOGY-DI AGNOSTI C 11,636 10, 125 54.00 54.00 3, 376 1,661 06000 LABORATORY 60.00 16, 565 5, 516 0 905 0 60.00 06300 BLOOD STORING, PROCESSING & TRANS. 63.00 63.00 54 199 0 33 0 65.00 06500 RESPIRATORY THERAPY 6.455 7, 356 835 1, 207 0 65.00 4,677 66, 00 06600 PHYSI CAL THERAPY 4.147 1,096 680 0 66.00 06601 PHYSICAL THERAPY- WHEATFIELD 4,891 18, 411 66.01 3.020 0 66.01 C 06700 OCCUPATI ONAL THERAPY 67.00 853 841 0 138 Λ 67.00 67.01 06701 OCCUPATIONAL THERAPY- WHEATFIELD 1, 121 3,843 0 630 0 67.01 06800 SPEECH PATHOLOGY 117 68.00 850 712 0 0 68.00 06801 SPEECH PATHOLOGY- WHEATFIELD 0 409 68.01 1.063 2.493 0 68.01 06900 ELECTROCARDI OLOGY 0 69.00 0 C 0 0 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0 C 0 0 0 70.00 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 4,572 0 0 0 71.00 72 00 07200 IMPL. DEV. CHARGED TO PATIENTS 1 397 Ω 0 0 72 00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 19, 352 0 0 0 73.00 07400 RENAL DIALYSIS 0 0 74.00 74.00 OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 88.00 88.00 2,821 2, 585 0 88. 01 08801 BROOK RHC 3, 182 5,017 823 0 88.01 90.00 09000 CLI NI C 8,863 25, 213 1, 463 4, 136 0 90.00 90 01 09001 WOUND CARE 335 1, 929 90.01 316 0 C 91.00 09100 EMERGENCY 17,729 15, 267 6,954 2,504 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 95 00 0 95 00 0 0 0 98. 00 09850 OTHER REIMBURSABLE COST CENTERS 0 C 0 0 0 98.00 101.00 10100 HOME HEALTH AGENCY 0 0 0 0 0 101.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113 00 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 0 0 0 0 115. 00 116. 00 11600 HOSPI CE 0 0 116.00 SUBTOTALS (SUM OF LINES 1 through 117)
NONREI MBURSABLE COST CENTERS 165, 484 26, 179 26, 824 118. 00 118.00 166, 118 23, 227 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 39 0 190. 00 536 0 88 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 0 0 192. 00 C 194. 00 07950 ALTERNACARE 0 194. 00 0 316 C 0 0 0 194. 01 194. 01 07951 SPORTS MEDICINE 272 0 194. 02 07952 UNUSED SPACE 1, 206 0 0 194. 02 26, 563 4, 355 194. 03 07953 LAFAYETTE HHA BRANCH 0 0 194. 03 19 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers C 0 201.00 202.00 TOTAL (sum lines 118 through 201) 167, 336 193, 217 23, 227 30, 622 26, 824 202. 00

| Peri od: | Worksheet B | From 01/01/2021 | Part | I | To | 12/31/2021 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-1324

				То	12/31/2021	Date/Time Pre 5/27/2022 5:0	
	Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	Dill
			ADMI NI STRATI ON			RECORDS &	
		11. 00	13.00	SUPPLY 14.00	15. 00	16. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1. 00
2. 00 4. 00	OO200 CAP REL COSTS-MVBLE EQUIP OO400 EMPLOYEE BENEFITS DEPARTMENT						2. 00 4. 00
5.00	00500 ADMINISTRATIVE & GENERAL						5. 00
7. 00	00700 OPERATION OF PLANT						7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE						8. 00
9.00	00900 HOUSEKEEPI NG						9.00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	36, 130					10. 00 11. 00
13. 00	01300 NURSING ADMINISTRATION	932	1				13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	143	1				14. 00
	01500 PHARMACY	1, 408			24, 038	0/ 045	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY INPATIENT ROUTINE SERVICE COST CENTERS	C	0	0	0	26, 815	16. 00
30. 00	03000 ADULTS & PEDIATRICS	7, 963	3, 294	0	2	5, 607	30. 00
31.00	03100 INTENSIVE CARE UNIT	2, 272		1	0	1, 599	
32. 00	03200 CORONARY CARE UNIT	C	0	0	0	0	32. 00
50. 00	ANCI LLARY SERVI CE COST CENTERS O5000 OPERATI NG ROOM	3, 172	262	0	24	2, 234	50. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	4, 136	1	1	175	2, 912	
60.00	06000 LABORATORY	, , , , , , , , , , , , , , , , , , ,	i .		2	0	60.00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	C	0		0	0	63. 00
65. 00	06500 RESPIRATORY THERAPY	2, 983		1	0	2, 100	65. 00
66. 00 66. 01	06600 PHYSI CAL THERAPY 06601 PHYSI CAL THERAPY- WHEATFI ELD	2, 188	1	-	3	1, 540 1, 374	66. 00 66. 01
67. 00	06700 OCCUPATI ONAL THERAPY	398			Ö	280	67. 00
67. 01	06701 OCCUPATIONAL THERAPY- WHEATFIELD	C	_	0	0	337	67. 01
68. 00	06800 SPEECH PATHOLOGY	415	0	0	0	292	68. 00
68. 01 69. 00	06801 SPEECH PATHOLOGY - WHEATFIELD 06900 ELECTROCARDIOLOGY		0	0	0	337 0	68. 01 69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY				o	0	70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	C	0	48, 952	0	0	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	C	0	12, 376	0	0	72. 00
73. 00 74. 00	07300 DRUGS CHARGED TO PATIENTS	C	0		23, 559 0	0	73. 00 74. 00
74.00	07400 RENAL DIALYSIS OUTPATIENT SERVICE COST CENTERS		, <u>j</u> 0	<u> </u>	U _I	0	74.00
88. 00	08800 RURAL HEALTH CLINIC	C	0	0	109	867	88. 00
88. 01	08801 BROOK RHC	1, 378			141	970	
	09000 CLINIC	3, 596			0	2, 532	90.00
90. 01 91. 00	O9001 WOUND CARE O9100 EMERGENCY	122 5, 024		1	18 4	86 3, 538	90. 01 91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	3,52.	.,,,,,		·	0,000	92. 00
	OTHER REIMBURSABLE COST CENTERS	1					
95. 00 98. 00	09500 AMBULANCE SERVICES 09850 OTHER REIMBURSABLE COST CENTERS	C			0	0	95. 00 98. 00
	10100 HOME HEALTH AGENCY	C	ا.		0		101. 00
	SPECIAL PURPOSE COST CENTERS			<u> </u>	<u> </u>		
	11300 NTEREST EXPENSE						113. 00
	11500 AMBULATORY SURGICAL CENTER (D. P.)	C	0	-	0		115. 00
118.00	11600 HOSPICE SUBTOTALS (SUM OF LINES 1 through 117)	36, 130	0 11, 671	1	24, 038	26, 605	116. 00 118. 00
	NONREI MBURSABLE COST CENTERS	30, 100	11,071	00,001	21,000	20,000	1110.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	C	0	0	0		190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	C	0	60	0		192. 00
	07950 ALTERNACARE 07951 SPORTS MEDICINE		0	0	0		194. 00 194. 01
	07951 SPORTS MEDICINE				ol		194. 01
194. 03	07953 LAFAYETTE HHA BRANCH	c	o	O	o		194. 03
200.00	1 1	_	_		_	_	200. 00
201. 00 202. 00	1 1 5	36, 130	0 11, 671	63, 661	0 24, 038	0 26, 815	201. 00
202.00	1 1017L (Sum 111103 110 till bugit 201)	1 30, 130	1 11,0/1	1 03,001	24, 030	20, 013	1202.00

| Peri od: | Worksheet B | From 01/01/2021 | Part | I | To 12/31/2021 | Date/Time Prepared: | From 12/31/2021 | Part | I | Prepared: | Pre Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS FRANCI SCAN HEALTH RENSSELAER Provider CCN: 15-1324

				To	o 12/31/2021 Date/Time F 5/27/2022 5	
	Cost Center Description	Subtotal	Intern &	Total	072772022	5. 61 piii
			Residents Cost			
			& Post			
			Stepdown Adjustments			
		24. 00	25. 00	26. 00		
	NERAL SERVICE COST CENTERS					
1	100 CAP REL COSTS-BLDG & FIXT					1.00
1	200 CAP REL COSTS-MVBLE EQUIP 400 EMPLOYEE BENEFITS DEPARTMENT					2. 00 4. 00
1	500 ADMINISTRATIVE & GENERAL					5. 00
	700 OPERATION OF PLANT					7. 00
	800 LAUNDRY & LINEN SERVICE					8. 00
1	900 HOUSEKEEPI NG 000 DI ETARY					9. 00 10. 00
	100 CAFETERI A					11.00
1	300 NURSING ADMINISTRATION					13. 00
	400 CENTRAL SERVICES & SUPPLY					14. 00
	500 PHARMACY					15.00
	600 MEDICAL RECORDS & LIBRARY PATIENT ROUTINE SERVICE COST CENTERS					16. 00
	000 ADULTS & PEDIATRICS	189, 870	0	189, 870		30.00
31. 00 03	100 INTENSIVE CARE UNIT	22, 846	0	22, 846		31. 00
	200 CORONARY CARE UNIT	0	0	0		32. 00
	CILLARY SERVICE COST CENTERS OOO OPERATING ROOM	150 221	0	150 221		F0.00
1	400 RADI OLOGY-DI AGNOSTI C	150, 221 99, 651	0			50. 00 54. 00
1	000 LABORATORY	57, 614	0			60.00
63. 00 06	300 BLOOD STORING, PROCESSING & TRANS.	1, 535	0	1, 535		63. 00
	500 RESPI RATORY THERAPY	68, 758	0	68, 758		65. 00
	600 PHYSICAL THERAPY 601 PHYSICAL THERAPY- WHEATFIELD	41, 456 144, 248	0	41, 456 144, 248		66. 00 66. 01
1	700 OCCUPATIONAL THERAPY	7, 986	0	7, 986		67. 00
1	701 OCCUPATIONAL THERAPY- WHEATFIELD	30, 292	0			67. 01
1	800 SPEECH PATHOLOGY	7, 063	0	.,		68. 00
	801 SPEECH PATHOLOGY- WHEATFIELD 900 ELECTROCARDIOLOGY	20, 190 0	0	20, 190 0		68. 01 69. 00
1	000 ELECTROCARDI OLOGI 000 ELECTROENCEPHALOGRAPHY	0	0	0		70.00
	100 MEDICAL SUPPLIES CHARGED TO PATIENTS	53, 524	0	53, 524		71. 00
	200 IMPL. DEV. CHARGED TO PATIENTS	13, 773	0	13, 773		72. 00
1	300 DRUGS CHARGED TO PATIENTS	42, 911	0			73.00
	400 RENAL DIALYSIS TPATIENT SERVICE COST CENTERS	0	0	0		74. 00
	800 RURAL HEALTH CLINIC	6, 999	0	6, 999		88. 00
	801 BROOK RHC	43, 697	0			88. 01
	000 CLINIC	207, 603	0	,		90.00
	001 WOUND CARE 100 EMERGENCY	15, 035 154, 162	0	15, 035 154, 162		90. 01 91. 00
	200 OBSERVATION BEDS (NON-DISTINCT PART)	154, 102	0			92.00
OT	HER REIMBURSABLE COST CENTERS					
	500 AMBULANCE SERVICES	0	0	-		95. 00
	850 OTHER REIMBURSABLE COST CENTERS 100 HOME HEALTH AGENCY	0	0			98. 00 101. 00
	ECIAL PURPOSE COST CENTERS	U _I	0	<u> </u>		101.00
	300 I NTEREST EXPENSE					113. 00
	500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	0		115. 00
	600 HOSPI CE	1 270 424	0	0		116.00
118. 00 NO	SUBTOTALS (SUM OF LINES 1 through 117) NREIMBURSABLE COST CENTERS	1, 379, 434	0	1, 379, 434		118. 00
	000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	4, 030	0	4, 030		190. 00
	200 PHYSICIANS' PRIVATE OFFICES	60	0			192. 00
	950 ALTERNACARE	509	0	509		194. 00
	951 SPORTS MEDICINE 952 UNUSED SPACE	438 198, 862	0	438 198, 862		194. 01 194. 02
	953 LAFAYETTE HHA BRANCH	198, 862	0	198, 802		194. 02
200.00	Cross Foot Adjustments	Ó	0	Ó		200. 00
201.00	Negative Cost Centers	0	0	0		201. 00
202. 00	TOTAL (sum lines 118 through 201)	1, 583, 352	0	1, 583, 352		202. 00

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-1324 Peri od: Worksheet B-1 From 01/01/2021 12/31/2021 Date/Time Prepared: 5/27/2022 5:01 pm CAPITAL RELATED COSTS Cost Center Description BLDG & FIXT MVBLE EQUIP **EMPLOYEE** Reconciliation ADMINISTRATIVE (SQUARE FEET) (SQUARE FEET) BENEFITS & GENERAL (ACCUM. COST) DEPARTMENT (GROSS SALARI ES) 1.00 2.00 5A 5. 00 GENERAL SERVICE COST CENTERS 1 00 129 317 00100 CAP REL COSTS-BLDG & FLXT 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 129, 317 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 2, 485 2, 485 13, 709, 457 4.00 00500 ADMINISTRATIVE & GENERAL 13, 007 13, 007 3, 639, 291 -10, 179, 309 23, 141, 795 5 00 5 00 7.00 00700 OPERATION OF PLANT 14, 768 14, 768 303, 478 1, 621, 440 7.00 1, 578 8.00 00800 LAUNDRY & LINEN SERVICE 1,578 26, 297 106, 488 8.00 1, 771 0 00900 HOUSEKEEPI NG 1,771 341, 115 538, 612 9.00 9.00 01000 DI ETARY 10.00 172, 324 1,749 1,749 86, 194 10 00 11.00 01100 CAFETERI A 2, 324 2, 324 155, 334 0 247, 788 11.00 01300 NURSING ADMINISTRATION 399 399 210, 279 0 619, 625 13.00 13.00 0 01400 CENTRAL SERVICES & SUPPLY 4, 297 4, 297 14.00 32. 254 148.880 14.00 1, 095 317, 885 519, 890 15.00 01500 PHARMACY 1,095 15.00 01600 MEDICAL RECORDS & LIBRARY 1,609 388 478, 513 16.00 16.00 1,609 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 1, 797, 581 1, 827, 531 8,631 8, 631 30.00 31.00 03100 INTENSIVE CARE UNIT 753 753 512, 792 0 623, 509 31 00 03200 CORONARY CARE UNIT 32.00 32.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 9, 143 9, 143 716, 110 1, 263, 818 50.00 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 5, 191 5, 191 933, 536 1, 609, 162 54 00 2, 828 06000 LABORATORY 2,828 2, 290, 772 60.00 0 0 0 60.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 102 7, 449 102 63.00 65.00 06500 RESPIRATORY THERAPY 3.771 3, 771 673.435 892, 655 65.00 66.00 06600 PHYSI CAL THERAPY 2, 126 2, 126 493, 852 646, 815 66.00 06601 PHYSICAL THERAPY- WHEATFIELD 440, 562 66.01 9, 439 9, 439 0 0 676, 430 66.01 67.00 06700 OCCUPATIONAL THERAPY 431 431 89, 892 117, 961 67.00 06701 OCCUPATIONAL THERAPY- WHEATFIELD 67.01 1,970 1, 970 107, 946 155, 004 67.01 06800 SPEECH PATHOLOGY 93, 708 0 0 0 117, 543 68.00 365 365 68.00 146, 971 68.01 06801 SPEECH PATHOLOGY- WHEATFIELD 1, 278 1, 278 107, 979 68.01 06900 ELECTROCARDI OLOGY 69 00 0 \cap 69 00 70.00 07000 ELECTROENCEPHALOGRAPHY 0 C 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 71.00 0 0 632, 299 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 193, 163 72.00 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 0 2, 677, 219 73.00 Ω 73.00 74.00 07400 RENAL DIALYSIS 0 0 74.00 OUTPATIENT SERVICE COST CENTERS 88 00 08800 RURAL HEALTH CLINIC 0 277 833 0 390 165 88 00 0 88.01 08801 BROOK RHC 2,572 2,572 311, 027 440,050 88.01 90.00 09000 CLI NI C 12, 926 12, 926 811, 757 0 1, 225, 641 90.00 09001 WOUND CARE 0 90. 01 989 989 27, 491 46, 287 90.01 09100 EMERGENCY o 7, 827 91 00 91 00 7.827 1, 134, 192 2, 451, 770 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES C 0 0 95.00 98. 00 09850 OTHER REIMBURSABLE COST CENTERS O 0 Ω 0 0 98.00 101.00 10100 HOME HEALTH AGENCY 0 0 0 0 0 101.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | I NTEREST EXPENSE 113.00 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 Ω 0 0 0 115.00 116. 00 11600 HOSPI CE 0 116.00 -10, 179, 309 22, 885, 774 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 115, 424 115, 424 13, 642, 208 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 275 275 5, 409 190. 00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 192.00 0 C C 0 194. 00 07950 ALTERNACARE 43, 656 194. 00 0 0 36, 124 37, 642 194. 01 194. 01 07951 SPORTS MEDICINE 31,025 194. 02 07952 UNUSED SPACE 13, 618 13, 618 166, 738 194. 02 194. 03 07953 LAFAYETTE HHA BRANCH 100 2, 576 194. 03 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201. 00 202.00 Cost to be allocated (per Wkst. B, 2, 685, 117 10, 179, 309 202. 00 1, 583, 352 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 12. 243959 0.000000 0.195859 0. 439867 203. 00 Cost to be allocated (per Wkst. B, 167, 336 204. 00 204.00 30, 426 Part II) 205.00 Unit cost multiplier (Wkst. B, Part 0.002219 0.007231 205.00 II)

Heal th Finar	ncial Systems F	FRANCISCAN HEAL	TH RENSSELAER		In Lie	u of Form CMS-2	2552-10
COST ALLOCA	TION - STATISTICAL BASIS		Provi der CO		Peri od:	Worksheet B-1	
					From 01/01/2021 To 12/31/2021	Date/Time Pre 5/27/2022 5:0	
		CAPITAL REL	LATED COSTS				
	Cost Center Description	BLDG & FLXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		1.00	2. 00	4. 00	5A	5. 00	
206. 00	NAHE adjustment amount to be allocated						206. 00
207. 00	(per Wkst. B-2) NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00

COST A	ALLOCATION - STATISTICAL BASIS		Provi der Co	CN: 15-1324 F	Peri od:	Worksheet B-1	
					rom 01/01/2021 o 12/31/2021	5/27/2022 5:0	pared:
	Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LI NEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DI ETARY (MEALS SERVED)	CAFETERI A (SALARI ES)	
		7.00	8. 00	9. 00	10.00	11. 00	
1. 00	GENERAL SERVICE COST CENTERS O0100 CAP REL COSTS-BLDG & FIXT		I	1			1.00
2.00	00200 CAP REL COSTS-BEDG & TTAT						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMINISTRATIVE & GENERAL						5. 00
7. 00 8. 00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	99, 057 1, 578	l .				7. 00 8. 00
9. 00	00900 HOUSEKEEPI NG	1, 771			3		9.00
10.00	1	1, 749	l .	.,			10.00
11. 00 13. 00		2, 324 399		2, 324 399		8, 155, 791	
14. 00	1	4, 297	l .			210, 279 32, 254	
15.00	01500 PHARMACY	1, 095	l .	1, 095		317, 885	
16. 00		1, 609	0	1, 609	0	0	16. 00
30 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	8, 631	12, 559	8, 631	13, 239	1, 797, 581	30.00
31.00		753				512, 792	
32.00		0	0	(0	0	32.00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	9. 143	2, 907	9, 143	ol l	716, 110	50.00
54. 00	1	5, 191				933, 536	
60.00		2, 828				0	1
63. 00	•			102		0	
65. 00 66. 00	1	3, 771 2, 126				673, 435 493, 852	
66. 01	1	9, 439				473, 032	1
67. 00	06700 OCCUPATI ONAL THERAPY	431	0	431	0	89, 892	67.00
67. 01	06701 OCCUPATIONAL THERAPY- WHEATFIELD	1, 970	l .	1, 970		0 700	
68. 00 68. 01	1	365 1, 278	l .	365 1, 278		93, 708 0	
69. 00		0	Ö	., 2,		0	1
	07000 ELECTROENCEPHALOGRAPHY	0	0	(0	0	1
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIE 07200 IMPL. DEV. CHARGED TO PATIENTS	NIS 0	0		1	0	1
73. 00	1 1		Ö		_	0	1
74. 00		0	0	(0	0	74.00
88. 00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC	0	6, 863	Ι	ol ol	0	88. 00
88. 01		2, 572	-,			311, 027	
90.00		12, 926				811, 757	
90. 01 91. 00	1	989 7, 827		989 7, 827		27, 491 1, 134, 192	
	09200 OBSERVATION BEDS (NON-DISTINCT PA		10, 470	7,027	ı	1, 134, 172	92.00
	OTHER REIMBURSABLE COST CENTERS		1				4
	09500 AMBULANCE SERVICES 09850 OTHER REIMBURSABLE COST CENTERS	0		0		0	
	0 10100 HOME HEALTH AGENCY					_	101.00
	SPECIAL PURPOSE COST CENTERS				-1		
	0 11300 INTEREST EXPENSE					0	113. 00
	0 11500 AMBULATORY SURGICAL CENTER (D.P.) 0 11600 HOSPICE	0	0				115. 00 116. 00
118.00		117) 85, 164	61, 676	81, 815	13, 767		
	NONREI MBURSABLE COST CENTERS						
	0 19000 GIFT, FLOWER, COFFEE SHOP & CANTE 0 19200 PHYSICIANS' PRIVATE OFFICES	EN 275					190. 00 192. 00
	0 07950 ALTERNACARE		0				194. 00
194.01	1 07951 SPORTS MEDICINE	0	0	C	o	0	194. 0°
	2 07952 UNUSED SPACE	13, 618	0	13, 618	0		194. 0
200.00	3 07953 LAFAYETTE HHA BRANCH 0 Cross Foot Adjustments	0	0		,	0	194. 0: 200. 0
201.00							201. 0
202.00		2, 334, 658	190, 521	824, 091	304, 406	433, 711	202. 0
203.00	Part I) Unit cost multiplier (Wkst. B, Pa	rt I) 23.568834	3. 089062	8. 610471	22. 111281	0. 053178	203 0
204. 00			l .			36, 130	
	Part II)						
205.00	O Unit cost multiplier (Wkst. B, Pa	rt 1. 950564	0. 376597	0. 319952	1. 948427	0. 004430	205.00
206.00		cated					206. 00
	(per Wkst. B-2)						
207.00	NAHE unit cost multiplier (Wkst. Parts III and IV)	υ,					207. 00
	liairs iii anu iv <i>j</i>	ſ	I	I	ı		1

	ILLUCA	TUN - STATISTICAL BASIS		Provider CC	<u>-</u>	From 01/01/2021 To 12/31/2021	Date/Time Prepared: 5/27/2022 5:01 pm
		Cost Center Description	NURSI NG ADMI NI STRATI ON (DI RECT NURS. HRS.) 13.00	CENTRAL SERVI CES & SUPPLY (COSTED REQUI S.) 14.00	PHARMACY (COSTED REQUIS.)	MEDI CAL RECORDS & LI BRARY (GROSS SALARI ES) 16. 00	
		AL SERVICE COST CENTERS					
1.00		CAP REL COSTS-BLDG & FIXT					1.00
2. 00 4. 00		CAP REL COSTS-MVBLE EQUIP EMPLOYEE BENEFITS DEPARTMENT					2.00
5. 00		ADMINISTRATIVE & GENERAL					5. 00
7. 00		OPERATION OF PLANT					7. 00
8. 00		LAUNDRY & LINEN SERVICE					8.00
9. 00	00900	HOUSEKEEPI NG					9. 00
10. 00		DI ETARY					10.00
11.00	1	CAFETERI A	120 500				11.00
13. 00 14. 00		NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY	139, 589	993, 608			13. 00 14. 00
15. 00		PHARMACY		35, 477	2, 739, 228	3	15. 00
	1	MEDICAL RECORDS & LIBRARY		0	2,707,220		16. 00
		ENT ROUTINE SERVICE COST CENTERS					
		ADULTS & PEDIATRICS	39, 398	0	280		30.00
31.00		INTENSIVE CARE UNIT	16, 374	0	(31.00
32. 00		CORONARY CARE UNIT LARY SERVICE COST CENTERS	0	0		0	32.00
50. 00		OPERATING ROOM	3, 129	ol	2, 74	716, 110	50.00
54. 00		RADI OLOGY-DI AGNOSTI C	0	Ö	19, 979		54. 00
60. 00		LABORATORY	0	0	284	4 O	60. 00
63. 00	1	BLOOD STORING, PROCESSING & TRANS.	0	0	(63. 00
65. 00		RESPI RATORY THERAPY	1, 870	0	(65. 00
66. 00 66. 01		PHYSI CAL THERAPY PHYSI CAL THERAPY- WHEATFI ELD	0	0	150 300		66. 00 66. 01
67. 00		OCCUPATIONAL THERAPY		0	30.		67. 00
67. 01	1	OCCUPATIONAL THERAPY- WHEATFIELD	Ö	Ö		107, 946	67. 01
68. 00	06800	SPEECH PATHOLOGY	0	0	(93, 708	68. 00
68. 01		SPEECH PATHOLOGY- WHEATFIELD	0	0		107, 979	68. 01
69.00		ELECTROCARDI OLOGY	0	0			69.00
70. 00 71. 00		ELECTROENCEPHALOGRAPHY MEDICAL SUPPLIES CHARGED TO PATIENTS		764, 035		0 0	70. 00 71. 00
72.00		IMPL. DEV. CHARGED TO PATIENTS		193, 163			72.00
73. 00		DRUGS CHARGED TO PATIENTS	O	0	2, 684, 438	3 o	73.00
74. 00		RENAL DIALYSIS	0	0		0	74.00
88. 00		TIENT SERVICE COST CENTERS RURAL HEALTH CLINIC	O	ol	12, 438	3 277, 833	88. 00
88. 01	1	BROOK RHC	63	0	16, 030		88. 01
90.00		CLINIC	20, 740	O	5!		90.00
90. 01	09001	WOUND CARE	711	0	2, 07	27, 491	90. 01
91. 00	1	EMERGENCY	57, 304	0	434	1, 134, 192	91.00
92. 00		OBSERVATION BEDS (NON-DISTINCT PART)					92.00
95. 00		REIMBURSABLE COST CENTERS AMBULANCE SERVICES	0	ol	(o l	95. 00
		OTHER REIMBURSABLE COST CENTERS	o	0	(98.00
101. 00		HOME HEALTH AGENCY	0	0	(0	101.00
112 00		AL PURPOSE COST CENTERS INTEREST EXPENSE					113. 00
		AMBULATORY SURGICAL CENTER (D. P.)	0	0	(ol ol	115. 00
	1	HOSPI CE	o	Ō	(o o	116. 00
118. 00		SUBTOTALS (SUM OF LINES 1 through 117)	139, 589	992, 675	2, 739, 209	8, 529, 693	118. 00
400 00		MBURSABLE COST CENTERS	I al	٥		J 6	100.00
		GIFT, FLOWER, COFFEE SHOP & CANTEEN PHYSICIANS' PRIVATE OFFICES	0	0 933	19		190. 00 192. 00
		ALTERNACARE		759		36, 124	194. 00
	1	SPORTS MEDICINE	O	0	(31, 025	194. 01
		UNUSED SPACE	0	0	(o o	194. 02
		LAFAYETTE HHA BRANCH	0	0	(100	194. 03
200. 00 201. 00	1	Cross Foot Adjustments Negative Cost Centers					200. 00 201. 00
201. 00 202. 00	1	Cost to be allocated (per Wkst. B,	916, 200	354, 356	813, 364	740, 771	202.00
		Part I)	,	22., 222	2.2,22		
203. 00		Unit cost multiplier (Wkst. B, Part I)	6. 563554	0. 356636	0. 296932		203. 00
204. 00	1	Cost to be allocated (per Wkst. B,	11, 671	63, 661	24, 038	26, 815	204. 00
205. 00		Part II) Unit cost multiplier (Wkst. B, Part	0. 083610	0. 064071	0. 00877!	0. 003119	205. 00
_00.00		II)	0.000010	0. 004071	0.00077	0.003117	203.00
	d	NAHE adjustment amount to be allocated					206. 00
206. 00		(per Wkst. B-2)	l I				1

Health Financial Systems	FRANCI SCAN HEAL	TH RENSSELAER		In Lie	eu of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider Co	CN: 15-1324	Peri od:	Worksheet B-1	
				From 01/01/2021 To 12/31/2021	Date/Time Pre 5/27/2022 5:0	
Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL		
	ADMI NI STRATI ON	SERVICES &	(COSTED	RECORDS &		
		SUPPLY	REQUIS.)	LI BRARY		
	(DI RECT NURS.	(COSTED		(GROSS		
	HRS.)	REQUIS.)		SALARI ES)		
	13.00	14. 00	15. 00	16. 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	Period: Worksheet C From 01/01/2021 Part I

12/31/2021 Date/Time Prepared: To 5/27/2022 5:01 pm Title XVIII Hospi tal Cost Costs Total Cost Therapy Limit Cost Center Description Total Costs RCF Total Costs from Wkst. B, Adj Di sal I owance Part I, col. 26) 2.00 4. 00 5. 00 1.00 3.00 INPATIENT ROUTINE SERVICE COST CENTERS 30 00 3, 749, 827 30 00 03000 ADULTS & PEDIATRICS 3, 749, 827 0 Ω 31.00 03100 INTENSIVE CARE UNIT 1, 112, 603 1, 112, 603 0 0 31.00 03200 CORONARY CARE UNIT o 32.00 32.00 ANCILLARY SERVICE COST CENTERS 50.00 50.00 05000 OPERATING ROOM 2, 244, 065 2, 244, 065 0 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 2, 647, 731 2, 647, 731 0 0 0 0 0 0 0 0 0 0 0 0 0 54.00 60.00 06000 LABORATORY 3, 389, 494 3, 389, 494 60.00 06300 BLOOD STORING, PROCESSING & TRANS. 14, 008 63.00 14.008 63.00 Λ 65.00 06500 RESPIRATORY THERAPY 1, 519, 614 1, 519, 614 0 65.00 66.00 06600 PHYSI CAL THERAPY 1, 077, 588 1, 077, 588 0 66.00 1, 315, 761 06601 PHYSICAL THERAPY- WHEATFIELD 1, 315, 761 66.01 0 66.01 06700 OCCUPATI ONAL THERAPY 196, 243 67.00 196, 243 0 67.00 67.01 06701 OCCUPATIONAL THERAPY- WHEATFIELD 295,880 295, 880 0 67.01 06800 SPEECH PATHOLOGY 194, 050 194, 050 68.00 0 68.00 06801 SPEECH PATHOLOGY- WHEATFIELD 68 01 262,048 262, 048 0 68 01 69.00 06900 ELECTROCARDI OLOGY 0 0 0 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 1, 182, 908 1, 182, 908 0 71.00 07200 I MPL. DEV. CHARGED TO PATIENTS 72 00 347 018 347, 018 72 00 Ω 0 73.00 07300 DRUGS CHARGED TO PATIENTS 4, 651, 931 4, 651, 931 0 73.00 07400 RENAL DIALYSIS 0 74.00 0 74.00 OUTPATIENT SERVICE COST CENTERS 0 88.00 08800 RURAL HEALTH CLINIC 610, 619 610, 619 0 88.00 88. 01 08801 BROOK RHC 764, 892 764, 892 0 0 88.01 0 90.00 09000 CLI NI C 2, 441, 967 2, 441, 967 0 90.00 09001 WOUND CARE 107, 586 90. 01 90 01 107, 586 0 0 91.00 09100 EMERGENCY 4, 373, 435 4, 373, 435 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 950, 596 950, 596 0 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 95 00 95 00 09500 AMBULANCE SERVICES 0 0 0 0 98. 00 09850 OTHER REIMBURSABLE COST CENTERS 0 0 0 0 98.00 101.00 10100 HOME HEALTH AGENCY 0 0 101.00 0 SPECIAL PURPOSE COST CENTERS 1113.00 113. 00 11300 INTEREST EXPENSE 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 0 115.00 116. 00 11600 HOSPI CE 0 0 116.00 33, 449, 864 33, 449, 864 0 200. 00 200.00 Subtotal (see instructions) 0 0 201.00 Less Observation Beds 950, 596 950, 596 0 201.00 202.00 Total (see instructions) 32, 499, 268 32, 499, 268 0 202.00

Health Financial Systems	FRANCI SCAN HEALTH RENSSELAER	In Lieu	ı of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-1324	Peri od: From 01/01/2021	Worksheet C Part I

To 12/31/2021 Date/Time Prepared: 5/27/2022 5:01 pm Title XVIII Hospi tal Cost Charges Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other **TFFRA** + col . 7) Ratio Inpati ent Ratio 6.00 7.00 8.00 9. 00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 3, 471, 882 3, 471, 882 30.00 30.00 31.00 03100 INTENSIVE CARE UNIT 160, 986 160, 986 31.00 03200 CORONARY CARE UNIT 32.00 32.00 ANCILLARY SERVICE COST CENTERS 50.00 2.758.851 2, 897, 035 0.774607 0.000000 50.00 05000 OPERATING ROOM 138, 184 54.00 05400 RADI OLOGY-DI AGNOSTI C 569, 408 13, 438, 857 14, 008, 265 0.189012 0.000000 54.00 60.00 06000 LABORATORY 1, 316, 185 11, 991, 398 13, 307, 583 0. 254704 0.000000 60 00 06300 BLOOD STORING, PROCESSING & TRANS. 20, 606 27. 434 0.510607 0.000000 63.00 6, 828 63.00 2, 483, 047 0.000000 65.00 06500 RESPIRATORY THERAPY 420, 204 2, 903, 251 0.523418 65 00 66.00 06600 PHYSI CAL THERAPY 133, 564 1, 516, 637 1, 650, 201 0.653004 0.000000 66.00 66.01 06601 PHYSICAL THERAPY- WHEATFIELD 229, 728 2, 319, 375 2, 549, 103 0.516166 0.000000 66.01 06700 OCCUPATIONAL THERAPY 245, 190 472, 887 67.00 67.00 227, 697 0.414989 0.000000 67.01 06701 OCCUPATIONAL THERAPY- WHEATFIELD Ω 263, 942 263, 942 1.121004 0.000000 67.01 06800 SPEECH PATHOLOGY 16, 593 210, 851 227, 444 0.853177 0.000000 68.00 68.00 06801 SPEECH PATHOLOGY- WHEATFIELD 88 461, 631 461, 719 0.567549 0.000000 68.01 68.01 06900 FLECTROCARDI OLOGY 0.000000 69 00 0 \cap 0.000000 69 00 70.00 07000 ELECTROENCEPHALOGRAPHY 0 0.000000 0.000000 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 5, 484, 226 0. 196946 0.000000 71.00 522, 043 6, 006, 269 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 1, 834, 952 0.189116 72.00 72.00 268, 262 1, 566, 690 0.000000 73.00 07300 DRUGS CHARGED TO PATIENTS 1, 570, 632 24, 481, 644 26, 052, 276 0.178561 0.000000 73.00 74.00 07400 RENAL DIALYSIS 0.000000 0.000000 74.00 OUTPATIENT SERVICE COST CENTERS 176, 925 88.00 08800 RURAL HEALTH CLINIC O 176 925 88 00 88.01 08801 BROOK RHC 0 244, 221 244, 221 88.01 90.00 09000 CLI NI C 136, 482 4, 295, 398 4, 431, 880 0.551000 0.000000 90.00 90.01 09001 WOUND CARE 2, 264 305, 450 307, 714 0.349630 0.000000 90.01 09100 EMERGENCY 7, 959, 970 0.549429 91.00 332, 358 7, 627, 612 0.000000 91.00 91, 202 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 936, 962 1, 028, 164 0.924557 0.000000 92.00 OTHER REIMBURSABLE COST CENTERS 95 00 09500 AMBULANCE SERVICES 0 0 0.000000 0.000000 95.00 0 98. 00 09850 OTHER REIMBURSABLE COST CENTERS 0 0 0.000000 0.000000 98.00 101.00 10100 HOME HEALTH AGENCY 0 0 0 101.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | INTEREST EXPENSE 113 00 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 0 0 115.00 116. 00 11600 HOSPI CE 116. 00 200.00 Subtotal (see instructions) 9, 628, 368 80, 815, 735 90, 444, 103 200. 00 201.00 Less Observation Beds 201 00 202.00 Total (see instructions) 9, 628, 368 80, 815, 735 90, 444, 103 202.00

Health Financial Systems	FRANCI SCAN HEALTH RENSSELAER	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provider CCN: 15-1324	From 01/01/2021	Worksheet C Part I Date/Time Prepared:

				To 12/31/2021	Date/Time Prepared: 5/27/2022 5:01 pm
			Title XVIII	Hospi tal	Cost
Cost Center Descriptio	n	PPS Inpatient			
·		Ratio			
		11. 00			
INPATIENT ROUTINE SERVICE CO	ST CENTERS				
30.00 03000 ADULTS & PEDIATRICS					30.00
31.00 03100 INTENSIVE CARE UNIT					31.00
32. 00 03200 CORONARY CARE UNIT					32. 00
ANCILLARY SERVICE COST CENTE	RS				
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, PROCESS	ING & 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 PHYSI CAL THERAPY - WHEA	TFIELD	0. 000000			66. 01
67. 00 06700 OCCUPATI ONAL THERAPY		0. 000000			67. 00
67. 01 06701 OCCUPATI ONAL THERAPY-	WHEATFI ELD	0. 000000			67. 01
68.00 06800 SPEECH PATHOLOGY		0. 000000			68. 00
68. 01 06801 SPEECH PATHOLOGY- WHEA	TFIELD	0. 000000			68. 01
69. 00 06900 ELECTROCARDI OLOGY		0. 000000			69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 000000			70.00
71.00 07100 MEDICAL SUPPLIES CHARG		0. 000000			71. 00
72.00 07200 I MPL. DEV. CHARGED TO		0. 000000			72. 00
73.00 07300 DRUGS CHARGED TO PATIE	NTS	0. 000000			73. 00
74. 00 07400 RENAL DIALYSIS		0. 000000			74. 00
OUTPATIENT SERVICE COST CENT	ERS				
88.00 08800 RURAL HEALTH CLINIC					88. 00
88. 01 08801 BROOK RHC					88. 01
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 0BSERVATI ON BEDS (NON-		0. 000000			92. 00
OTHER REIMBURSABLE COST CENT	ERS	0.00000			05.00
95. 00 09500 AMBULANCE SERVICES	T 05NT500	0. 000000			95.00
98. 00 09850 OTHER REI MBURSABLE COS	I CENTERS	0. 000000			98. 00
101. 00 10100 HOME HEALTH AGENCY					101. 00
SPECIAL PURPOSE COST CENTERS					110.00
113. 00 11300 NTEREST EXPENSE	UTED (D.D.)				113. 00
115. 00 11500 AMBULATORY SURGICAL CE	NIER (D. P.)				115. 00
116. 00 11600 H0SPI CE					116. 00
200.00 Subtotal (see instruct	ons)				200.00
201.00 Less Observation Beds	- \				201. 00
202.00 Total (see instruction	5)				202. 00

Health Financial Systems	FRANCI SCAN HEALTH RENSSELAER	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Period: Worksheet C From 01/01/2021 Part I

					From 01/01/2021 To 12/31/2021	Part I Date/Time Pre 5/27/2022 5:0	
			Ti tl	e XIX	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)					
	LNDATLENT DOUTLINE CEDIU OF OOCT OFNITEDO	1.00	2. 00	3. 00	4. 00	5. 00	
00.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0.740.007		0.740.00	17	0.740.007	00.00
30.00	03000 ADULTS & PEDIATRICS	3, 749, 827		3, 749, 82			30.00
31. 00	03100 INTENSIVE CARE UNIT	1, 112, 603		1, 112, 60		1, 112, 603	31.00
32. 00		0			0 0	0	32. 00
F0 00	ANCILLARY SERVICE COST CENTERS	0.044.045		0.044.04		0.044.075	F0 00
50.00	05000 OPERATING ROOM	2, 244, 065		2, 244, 06		2, 244, 065	50.00
54.00	05400 RADI OLOGY - DI AGNOSTI C	2, 647, 731		2, 647, 73		2, 647, 731	54. 00
60.00	06000 LABORATORY	3, 389, 494		3, 389, 49		3, 389, 494	1
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	14, 008		14, 00		14, 008	ł
65. 00	06500 RESPI RATORY THERAPY	1, 519, 614	0	., ,		1, 519, 614	ł
66.00	06600 PHYSI CAL THERAPY	1, 077, 588	0	1,0,,,00		1, 077, 588	ł
66. 01	06601 PHYSI CAL THERAPY - WHEATFI ELD	1, 315, 761	0	.,		1, 315, 761	66. 01
67. 00	06700 OCCUPATI ONAL THERAPY	196, 243	0	196, 24		196, 243	
67. 01	06701 OCCUPATIONAL THERAPY- WHEATFIELD	295, 880	0	295, 88		295, 880	ł
68. 00	06800 SPEECH PATHOLOGY	194, 050	0	194, 05		194, 050	ı
68. 01	06801 SPEECH PATHOLOGY- WHEATFIELD	262, 048	0	262, 04		262, 048	l
69. 00	06900 ELECTROCARDI OLOGY	0			0	0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	4 400 000		4 400 00	0 0	0	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 182, 908		1, 182, 90		1, 182, 908	1
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	347, 018		347, 01		347, 018	•
73.00	07300 DRUGS CHARGED TO PATIENTS	4, 651, 931		4, 651, 93		4, 651, 931	73. 00
74. 00	07400 RENAL DIALYSIS	0			0 0	0	74. 00
00 00	OUTPATIENT SERVICE COST CENTERS	(10 (10		/10 /1		(10, (10	00.00
88. 00	08800 RURAL HEALTH CLINIC	610, 619		610, 61			•
88. 01	08801 BROOK RHC	764, 892		764, 89		764, 892	ł
90.00	09000 CLI NI C 09001 WOUND CARE	2, 441, 967		2, 441, 96		2, 441, 967	90.00
90. 01		107, 586		107, 58		107, 586	
91.00	09100 EMERGENCY	4, 373, 435		4, 373, 43		4, 373, 435	1
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS	950, 596		950, 59	['] 0	950, 596	92. 00
95. 00		0		I	0 0	0	95. 00
	09850 OTHER REIMBURSABLE COST CENTERS	0			0 0	0	
	10100 HOME HEALTH AGENCY	0			0		101. 00
101.00	SPECIAL PURPOSE COST CENTERS	l o			U _I	U	1101.00
112 00	11300 I NTEREST EXPENSE						1 113. 00
	11500 AMBULATORY SURGICAL CENTER (D. P.)	0			0	0	115. 00
	11600 HOSPICE				0		116. 00
200.00		33, 449, 864	0	33, 449, 86	~		
200.00		950, 596	U	950, 59		950, 596	
201.00		32, 499, 268	0	1			
202.00	Total (See That detroins)	32, 477, 200	O	J		52, 477, 200	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 01/01/2021 To 12/31/2021	Part I Date/Time Pre 5/27/2022 5:0	pared: 1 pm
	_		e XIX	Hospi tal	Cost	
		Charges	1			
Cost Center Description	I npati ent	Outpati ent	,	Cost or Other	TEFRA	
			+ col . 7)	Ratio	Inpati ent	
	(00	7.00	0.00	0.00	Ratio	
INDATI ENT. DOUTLINE CERVILOE COCT. CENTERO	6. 00	7. 00	8. 00	9. 00	10. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0 474 000					
30. 00 03000 ADULTS & PEDIATRICS	3, 471, 882		3, 471, 88			30. 00
31. 00 03100 I NTENSI VE CARE UNI T	160, 986		160, 98			31.00
32. 00 03200 CORONARY CARE UNIT	0			0		32. 00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	138, 184	2, 758, 851			0. 000000	50. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	569, 408	13, 438, 857			0. 000000	54.00
60. 00 06000 LABORATORY	1, 316, 185	11, 991, 398	13, 307, 58	0. 254704	0. 000000	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	20, 606	6, 828	27, 43	4 0. 510607	0.000000	63. 00
65. 00 06500 RESPIRATORY THERAPY	420, 204	2, 483, 047	2, 903, 25	0. 523418	0.000000	65. 00
66. 00 06600 PHYSI CAL THERAPY	133, 564	1, 516, 637	1, 650, 20	0. 653004	0.000000	66.00
66. 01 06601 PHYSI CAL THERAPY- WHEATFIELD	229, 728	2, 319, 375	2, 549, 10	0. 516166	0.000000	66. 01
67. 00 06700 OCCUPATI ONAL THERAPY	227, 697	245, 190	472, 88	7 0. 414989	0.000000	67. 00
67. 01 06701 OCCUPATIONAL THERAPY- WHEATFIELD	O	263, 942	263, 94	2 1. 121004	0.000000	67. 01
68.00 06800 SPEECH PATHOLOGY	16, 593	210, 851			0.000000	68. 00
68.01 06801 SPEECH PATHOLOGY- WHEATFIELD	88	461, 631			0.000000	68. 01
69. 00 06900 ELECTROCARDI OLOGY	O	0	i .	0. 000000	0.000000	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	,	0. 000000	0.000000	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	522, 043	5, 484, 226	6, 006, 26		0. 000000	71. 00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	268, 262	1, 566, 690			0. 000000	72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	1, 570, 632	24, 481, 644			0. 000000	73.00
74. 00 07400 RENAL DI ALYSI S	1,370,032	24, 401, 044	1	0. 000000	0. 000000	74.00
OUTPATIENT SERVICE COST CENTERS	<u> </u>		1	0. 000000	0.000000	74.00
88. 00 08800 RURAL HEALTH CLINIC	O	176, 925	176, 92	5 3. 451287	0. 000000	88. 00
88. 01 08801 BROOK RHC	0	244, 221	244, 22		0. 000000	88. 01
90. 00 09000 CLI NI C	136, 482	4, 295, 398			0. 000000	90.00
90. 01 09001 WOUND CARE	2, 264	4, 295, 396 305, 450			0. 000000	90.00
	1		1			
91. 00 09100 EMERGENCY	332, 358	7, 627, 612			0.000000	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	91, 202	936, 962	1, 028, 16	4 0. 924557	0. 000000	92. 00
OTHER REIMBURSABLE COST CENTERS			1	0 000000	0.00000	05.00
95. 00 09500 AMBULANCE SERVICES	0	0		0. 000000	0. 000000	95. 00
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0	0		0. 000000	0. 000000	98. 00
101.00 10100 HOME HEALTH AGENCY	0	0		0		101. 00
SPECIAL PURPOSE COST CENTERS	1		1			
113. 00 11300 I NTEREST EXPENSE						113. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0		0		115. 00
116. 00 11600 HOSPI CE	0	0	1	0		116. 00
200.00 Subtotal (see instructions)	9, 628, 368	80, 815, 735	90, 444, 10	3		200. 00
201.00 Less Observation Beds						201. 00
202.00 Total (see instructions)	9, 628, 368	80, 815, 735	90, 444, 10	3		202. 00

Health Financial Systems	FRANCI SCAN HEALTH RENSSELAER	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provider CCN: 15-1324	From 01/01/2021	Worksheet C Part I Date/Time Prepared:

			To 12/31/2021	Date/Time Prepared: 5/27/2022 5:01 pm
		Title XIX	Hospi tal	Cost
Cost Center Description	PPS Inpatient			
· ·	Ratio			
	11.00			
INPATIENT ROUTINE SERVICE COST CEN	ITERS			
30. 00 03000 ADULTS & PEDIATRICS				30.00
31.00 03100 INTENSIVE CARE UNIT				31.00
32. 00 03200 CORONARY CARE UNIT				32. 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 &				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 PHYSI CAL THERAPY- WHEATFI ELD				66. 01
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000			67.00
67. 01 06701 OCCUPATI ONAL THERAPY- WHEATF				67. 01
68. 00 06800 SPEECH PATHOLOGY	0. 000000			68. 00
68.01 06801 SPEECH PATHOLOGY - WHEATFIELD				68. 01
69. 00 06900 ELECTROCARDI OLOGY	0. 000000			69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000			70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIEN	TS 0. 000000			72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73. 00
74.00 07400 RENAL DIALYSIS	0. 000000			74. 00
OUTPATIENT SERVICE COST CENTERS				
88.00 08800 RURAL HEALTH CLINIC	0. 000000			88. 00
88. 01 08801 BROOK RHC	0. 000000			88. 01
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-DISTIN	CT PART) 0. 000000			92. 00
OTHER REI MBURSABLE COST CENTERS				
95. 00 09500 AMBULANCE SERVICES	0. 000000			95. 00
98. 00 09850 OTHER REIMBURSABLE COST CENT	ERS 0. 000000			98. 00
101.00 10100 HOME HEALTH AGENCY				101. 00
SPECIAL PURPOSE COST CENTERS				110.00
113. 00 11300 NTEREST EXPENSE				113. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)			115. 00
116. 00 11600 HOSPI CE				116. 00
200.00 Subtotal (see instructions)				200. 00
201.00 Less Observation Beds				201. 00
202.00 Total (see instructions)				202. 00

Health Financial Systems	FRANCI SCAN HEA	_TH_RENSSELAER		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVI	CE CAPITAL COSTS	Provi der C		Period: From 01/01/2021 To 12/31/2021	Worksheet D Part II Date/Time Pre 5/27/2022 5:0	
		Ti tl e	e XVIII	Hospi tal	Cost	
Cost Center Description	Capi tal	Total Charges	Ratio of Cost	Inpati ent	Capital Costs	
	Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,	Part I, col.	(col . 1 ÷ col	. Charges	column 4)	

						5/27/2022 5:0	1 pm
				XVIII	Hospi tal	Cost	
	Cost Center Description	Capi tal		Ratio of Cost	I npati ent	Capital Costs	
		Related Cost	(from Wkst. C,	to Charges	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	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	150, 221	2, 897, 035	0. 051853	52, 886	2, 742	50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	99, 651	14, 008, 265	0.007114	158, 721	1, 129	54.00
60.00	06000 LABORATORY	57, 614	13, 307, 583	0.004329	527, 316	2, 283	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	1, 535	27, 434	0.055952	0	0	63.00
65.00	06500 RESPI RATORY THERAPY	68, 758	2, 903, 251	0. 023683	139, 917	3, 314	65. 00
66.00	06600 PHYSI CAL THERAPY	41, 456	1, 650, 201	0. 025122	37, 536	943	66. 00
66. 01	06601 PHYSICAL THERAPY- WHEATFIELD	144, 248	2, 549, 103	0. 056588	0	0	66. 01
67.00	06700 OCCUPATI ONAL THERAPY	7, 986	472, 887	0. 016888	36, 313	613	67. 00
67. 01	06701 OCCUPATIONAL THERAPY- WHEATFIELD	30, 292	263, 942	0. 114768	0	0	67. 01
68. 00	06800 SPEECH PATHOLOGY	7, 063		0. 031054	6, 036	187	68. 00
68. 01	06801 SPEECH PATHOLOGY- WHEATFIELD	20, 190		0. 043728	88		68. 01
69. 00	06900 ELECTROCARDI OLOGY	0	0	1	0	0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0. 000000	0	0	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	53, 524	6, 006, 269	0.008911	106, 536	949	71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	13, 773		1	105, 041	788	72. 00
	07300 DRUGS CHARGED TO PATIENTS	42, 911			440, 092	725	73. 00
	07400 RENAL DIALYSIS	0		1	·	l e	74. 00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	6, 999	176, 925	0. 039559	0	0	88. 00
	08801 BROOK RHC	43, 697		1	0	0	88. 01
90.00	09000 CLI NI C	207, 603		0.046843	5, 537	259	90.00
	09001 WOUND CARE	15, 035		1	0	l e	90. 01
	09100 EMERGENCY	154, 162			76, 565	1, 483	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	48, 132			2, 689		
,2,00	OTHER REIMBURSABLE COST CENTERS	107 102	1,020,101	0.0.00.1	2,007	120	72.00
95.00	09500 AMBULANCE SERVICES						95. 00
	09850 OTHER REIMBURSABLE COST CENTERS	0	0	0. 000000	0	0	
200.00	l l	1, 214, 850		1	1, 695, 273		1
200.00	Total (Tries so through 177)	1,214,000	1 00,011,200	T	1,075,275	10,040	1200.00

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

From 01/01/2021 Part IV To 12/31/2021 Date/Time Prepared: THROUGH COSTS 5/27/2022 5:01 pm Title XVIII Hospi tal Cost Nursi ng Cost Center Description Non Physician Nursi ng Allied Health Allied Health Anestheti st Post-Stepdown Program Program Post-Stepdown Cost Adjustments Adjustments 1.00 ЗА 3. 00 2A 2.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 50.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 05400 RADI OLOGY-DI AGNOSTI C 54.00 0 54.00 0 60.00 06000 LABORATORY 0 60.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 63.00 63.00 0 06500 RESPIRATORY THERAPY 65.00 0 0 65.00 0 06600 PHYSI CAL THERAPY 66.00 0 66.00 66.01 06601 PHYSICAL THERAPY- WHEATFIELD 0 0 0 66.01 67.00 06700 OCCUPATI ONAL THERAPY 0 67.00 Oi 06701 OCCUPATIONAL THERAPY- WHEATFIELD 0 67.01 0 67.01 06800 SPEECH PATHOLOGY 68.00 0 0 68.00 68. 01 06801 SPEECH PATHOLOGY- WHEATFIELD 68. 01 06900 ELECTROCARDI OLOGY 0 0 69.00 0 69.00 07000 ELECTROENCEPHALOGRAPHY 0 70.00 70.00 0 0 71.00 |07100 | MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 72.00 72.00 07300 DRUGS CHARGED TO PATIENTS 0 0 73.00 73 00 0 07400 RENAL DIALYSIS 0 0 74.00 0 74.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 88.00 0 0 0 0 0 0 0 08801 BROOK RHC 0 0 88. 01 88. 01 C 09000 CLI NI C 0 90.00 0 0 90.00 09001 WOUND CARE 0 0 90. 01 90.01 0 0 o 91.00 09100 EMERGENCY C Ω 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 92.00 0 92.00 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 95.00 95.00 98. 00 09850 OTHER REIMBURSABLE COST CENTERS 0 0 0 98.00 0 οl Total (lines 50 through 199) 0 200. 00

200.00

Hoal th	Einancial Systoms	EDANCISCAN HEAL	TU DENCCEI AED		In Lie	eu of Form CMS-2	2552 10
Health Financial Systems FRANCISCAN HEALTH RENSSEL/ APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS Provide					Period: From 01/01/2021 To 12/31/2021	Worksheet D Part IV	pared:
				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,	to Charges	
		Education Cost	1, 2, 3, and	Cost (sum of	Part I, col.	(col. 5 ÷ col.	
			4)	col s. 2, 3,	8)	7)	
				and 4)		(see	
						instructions)	
		4. 00	5. 00	6. 00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATI NG ROOM	0	0		0 2, 897, 035		
	05400 RADI OLOGY-DI AGNOSTI C	0	0		0 14, 008, 265	l	1
	06000 LABORATORY	0	0		0 13, 307, 583		
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0 27, 434		
65.00	06500 RESPI RATORY THERAPY	0	0		0 2, 903, 251	0.000000	
66.00	06600 PHYSI CAL THERAPY	0	0		0 1, 650, 201	0. 000000	66. 00
66. 01	06601 PHYSICAL THERAPY- WHEATFIELD	0	0		0 2, 549, 103	0.000000	66. 01
67.00	06700 OCCUPATI ONAL THERAPY	0	0		0 472, 887	0.000000	67. 00
67. 01	06701 OCCUPATIONAL THERAPY- WHEATFIELD	0	0		0 263, 942	0.000000	67. 01
68.00	06800 SPEECH PATHOLOGY	0	0		0 227, 444	0.000000	68. 00
68. 01	06801 SPEECH PATHOLOGY- WHEATFIELD	0	0		0 461, 719	0.000000	68. 01
69.00	06900 ELECTROCARDI OLOGY	0	0		0	0.000000	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		0	0.000000	70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	o	0		0 6, 006, 269	0.000000	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	o	0		0 1, 834, 952	0.000000	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	o	0		0 26, 052, 276	0.000000	73. 00
74.00	07400 RENAL DIALYSIS	o	0		0	0.000000	74.00
	OUTPATIENT SERVICE COST CENTERS				•		
88.00	08800 RURAL HEALTH CLINIC	0	0		0 176, 925	0.000000	88. 00
88. 01	08801 BROOK RHC	o	0		0 244, 221	0.000000	88. 01
00 00	loogood CLINIC	ا ما	0	I	4 424 000	0 000000	1 00 00

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4, 431, 880 307, 714 7, 959, 970 1, 028, 164

86, 811, 235

0.000000

0.000000

0.000000

0.000000

95. 00 0. 000000 98. 00

90. 01 91. 00

92.00

200. 00

90. 00 | 09000 | CLI NI C 90. 01 | 09001 | WOUND CARE

91. 00 09100 EMERGENCY

91. 00 | 09100 | EMERGENCY 92. 00 | 09200 | OBSERVATI ON BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS 95. 00 | 09850 | OPB50 | OTHER REIMBURSABLE COST CENTERS 200. 00 | Total (Lines 50 through 199)

Heal th	Financial Systems	FRANCI SCAN HEALTI	H DENSSELΔED		In Lie	eu of Form CMS-2	2552_10
APPORT	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER H COSTS		Provider CO		Peri od: From 01/01/2021 To 12/31/2021	Worksheet D Part IV	pared:
				XVIII	Hospi tal	Cost	
	Cost Center Description	Outpati ent	I npati ent	Inpati ent	Outpati ent	Outpati ent	
		Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through		Pass-Through	
		(col. 6 ÷ col.		Costs (col.	8	Costs (col. 9	
		7)		x col. 10)		x col. 12)	
		9. 00	10. 00	11. 00	12. 00	13. 00	
	ANCILLARY SERVICE COST CENTERS			T			
50.00	05000 OPERATING ROOM	0. 000000	52, 886		0	0	50.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	158, 721		0	0	54. 00
60.00	06000 LABORATORY	0. 000000	527, 316		0	0	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	0		0	0	63. 00
65.00	06500 RESPI RATORY THERAPY	0. 000000	139, 917		0	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	0. 000000	37, 536		0	0	66. 00
66. 01	06601 PHYSI CAL THERAPY- WHEATFI ELD	0. 000000	0		0	0	66. 01
67.00	06700 OCCUPATI ONAL THERAPY	0. 000000	36, 313		0	0	67. 00
67. 01	06701 OCCUPATIONAL THERAPY- WHEATFIELD	0. 000000	0		0	0	67. 01
68.00	06800 SPEECH PATHOLOGY	0. 000000	6, 036		0	0	68. 00
68. 01	06801 SPEECH PATHOLOGY- WHEATFIELD	0. 000000	88		0	0	68. 01
69.00	06900 ELECTROCARDI OLOGY	0. 000000	0		0	0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 000000	0		0	0	70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	106, 536		0	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	105, 041		0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	440, 092		0	0	73. 00
74.00	07400 RENAL DIALYSIS	0. 000000	0		0	0	74. 00
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0. 000000	0		0 0	0	88. 00
88. 01	08801 BROOK RHC	0. 000000	0		0 0	0	88. 01
90.00	09000 CLI NI C	0. 000000	5, 537		0	0	90.00
90. 01	09001 WOUND CARE	0. 000000	0		0	0	90. 01
91.00	09100 EMERGENCY	0. 000000	76, 565		0	0	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	2, 689		0 0	0	92. 00

0. 000000

1, 695, 273

0

0

95. 00 0 98. 00

0 200. 00

Health Financial Systems	FRANCI SCAN HEALTH RENSSELAER			In Lieu of Form CMS-2552-10
ADDODTIONMENT OF MEDICAL	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-1324	Dari ad:	Workshoot D

From 01/01/2021 Part V 12/31/2021 Date/Time Prepared: 5/27/2022 5:01 pm Title XVIII Hospi tal Cost Charges Costs Cost to Charge PPS Reimbursed Cost Center Description Cost Cost PPS Services Services (see Ratio From Rei mbursed Rei mbursed (see inst.) Worksheet C, inst.) Servi ces Services Not Part I, col. 9 Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 1. 00 2.00 5. 00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 774607 743, 922 0 50.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0. 189012 4, 176, 260 0 0 0 0 0 0 0 0 54.00 06000 LABORATORY 60 00 0 254704 0 1, 669, 719 60 00 06300 BLOOD STORING, PROCESSING & TRANS. 63.00 0.510607 0 0 63.00 65.00 06500 RESPIRATORY THERAPY 0. 523418 839, 107 65.00 816, 630 66.00 06600 PHYSI CAL THERAPY 66.00 0.653004 0 06601 PHYSICAL THERAPY- WHEATFIELD 66.01 0.516166 556, 211 0 66.01 67.00 06700 OCCUPATI ONAL THERAPY 0.414989 55, 487 67.00 06701 OCCUPATIONAL THERAPY- WHEATFIELD 30, 778 67.01 1. 121004 0 67.01 32, 947 06800 SPEECH PATHOLOGY 68 00 68 00 0.853177 68.01 06801 SPEECH PATHOLOGY- WHEATFIELD 0.567549 9, 998 0 68.01 69.00 06900 ELECTROCARDI OLOGY 0.000000 0 0 0 69.00 0 70.00 07000 ELECTROENCEPHALOGRAPHY 0.000000 70.00 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71 00 0.196946 0 1, 265, 607 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0. 189116 0 634, 017 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0. 178561 14, 961, 723 399 0 73.00 73.00 07400 RENAL DIALYSIS 0. 000000 0 74.00 74.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 88.00 08801 BROOK RHC 88.01 88. 01 09000 CLI NI C 90.00 0.551000 0 1, 298, 388 15, 655 0 90.00 09001 WOUND CARE 90.01 90.01 0.349630 Ω 92, 729 0 49, 462 91.00 09100 EMERGENCY 0.549429 0 1, 335, 158 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 0. 924557 500, 966 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0.000000 95.00 98. 00 09850 OTHER REIMBURSABLE COST CENTERS 0.000000 98.00 0 200.00 200.00 Subtotal (see instructions) 29, 019, 647 65, 516 Less PBP Clinic Lab. Services-Program 201.00 201.00 Only Charges 202.00 Net Charges (line 200 - line 201) 29, 019, 647 65, 516 0 202.00

			10 12/31/2021	5/27/2022 5:01 pm
		Title XVII	II Hospital	Cost
·	Cos	ts		
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 OPERATI NG ROOM	576, 247	0		50. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	789, 363	0		54.00
60. 00 06000 LABORATORY	425, 284	0		60.00
63. 00 06300 BLOOD STORING, PROCESSING	& TRANS. 0	0		63. 00
65. 00 06500 RESPIRATORY THERAPY	439, 204	0		65. 00
66. 00 06600 PHYSI CAL THERAPY	533, 263	0		66. 00
66. 01 06601 PHYSICAL THERAPY- WHEATFIE	LD 287, 097	0		66. 01
67. 00 06700 OCCUPATI ONAL THERAPY	23, 026	0		67. 00
67. 01 06701 OCCUPATIONAL THERAPY- WHEA	TFI ELD 34, 502	0		67. 01
68.00 06800 SPEECH PATHOLOGY	28, 110	0		68. 00
68. 01 06801 SPEECH PATHOLOGY- WHEATFIE	LD 5, 674	0		68. 01
69. 00 06900 ELECTROCARDI OLOGY	0	0		69. 00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED T	O PATIENTS 249, 256	0		71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATI	ENTS 119, 903	0		72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	2, 671, 580	71		73. 00
74.00 07400 RENAL DIALYSIS	0	0		74. 00
OUTPATIENT SERVICE COST CENTERS				
88.00 08800 RURAL HEALTH CLINIC				88. 00
88. 01 08801 BROOK RHC				88. 01
90. 00 09000 CLI NI C	715, 412	8, 626		90.00
90. 01 09001 WOUND CARE	32, 421	0		90. 01
91. 00 09100 EMERGENCY	733, 575	27, 176		91.00
92. 00 09200 OBSERVATION BEDS (NON-DIST	I NCT PART) 463, 172	0		92. 00
OTHER REIMBURSABLE COST CENTERS				
95. 00 09500 AMBULANCE SERVICES	0			95. 00
98. 00 09850 OTHER REIMBURSABLE COST CE	l l	0		98. 00
200.00 Subtotal (see instructions		35, 873		200. 00
201.00 Less PBP Clinic Lab. Servi	ces-Program 0			201. 00
Only Charges				
202.00 Net Charges (line 200 - li	ne 201) 8, 127, 089	35, 873		202. 00

Health Financial Systems	FRANCI SCAN HEALTH	RENSSELAER	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-1324	Peri od: From 01/01/2021	Worksheet D-1	
			To 12/31/2021	Date/Time Prep 5/27/2022 5:0	
		Title XVIII	Hospi tal	Cost	
Cost Center Description					
				1. 00	
PART I - ALL PROVIDER COMPONENTS					
I NPATI ENT DAYS					
1.00 Inpatient days (including private room days	and swing-bed days	, excluding newborn)		2, 700	1.00

	Cook Contan Description Hospital	Cost	
	Cost Center Description	1. 00	
	PART I - ALL PROVIDER COMPONENTS	1.00	
	I NPATI ENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2, 700	1. 00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1, 829	2.00
3. 00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3. 00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1, 228	4. 00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost	506	5. 00
	reporting period		
6. 00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	0	6. 00
7. 00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost	365	7. 00
7.00	reporting period	300	7.00
8. 00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	0	8. 00
	reporting period (if calendar year, enter 0 on this line)	 -	
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and	626	9. 00
10. 00	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	506	10.00
10.00	through December 31 of the cost reporting period (see instructions)	500	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after	0	11. 00
	December 31 of the cost reporting period (if calendar year, enter 0 on this line)	 -	
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	12. 00
12 00	through December 31 of the cost reporting period	0	12 00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XLX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	U	13. 00
14. 00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14. 00
15.00	Total nursery days (title V or XIX only)	0	15. 00
16. 00	Nursery days (title V or XIX only)	0	16. 00
47.00	SWING BED ADJUSTMENT		1 47 00
17. 00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	 -	17. 00
18. 00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost	ļ	18. 00
	reporting period	 -	
19. 00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost	155. 02	19. 00
20.00	reporting period	0.00	20.00
20. 00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21. 00	Total general inpatient routine service cost (see instructions)	3, 749, 827	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line	0	22. 00
	5 x line 17)		
23. 00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	56, 582	24 00
2 00	7 x line 19)	00,002	00
25. 00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	0	25. 00
27, 00	x line 20)	05/ 017	24 00
26. 00 27. 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	856, 917 2, 892, 910	
27.00	PRIVATE ROOM DI FFERENTI AL ADJUSTMENT	2,072,710	27.00
28. 00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)	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	1
32. 00 33. 00	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)	0. 00 0. 00	ı
34. 00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35. 00	Average per diem private room cost differential (line 34 x line 31)	0.00	35. 00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line	2, 892, 910	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)	1, 581. 69	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line 38)	990, 138	39. 00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40. 00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	990, 138	41.00

9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and	626	9. 00
	newborn days) (see instructions)		
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	506	10. 00
	through December 31 of the cost reporting period (see instructions)		
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after	0	11. 00
	December 31 of the cost reporting period (if calendar year, enter 0 on this line)		
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	12. 00
	through December 31 of the cost reporting period		
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	13. 00
	after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		
14. 00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	
15. 00	Total nursery days (title V or XIX only)	0	15. 00
16.00	Nursery days (title V or XIX only)	0	16. 00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost		17. 00
	reporting period		
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost		18. 00
	reporting period		
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost	155. 02	19. 00
	reporting period		
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost	0.00	20.00
	reporting period		
21.00	Total general inpatient routine service cost (see instructions)	3, 749, 827	21. 00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line	0	22. 00
	5 x line 17)		
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6	0	23. 00
	x line 18)		
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	56, 582	24. 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	0	25. 00
	x line 20)		
26.00	Total swing-bed cost (see instructions)	856, 917	26. 00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2, 892, 910	27. 00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28. 00
29.00	Private room charges (excluding swing-bed charges)	0	29. 00
30.00	Semi - pri vate room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32. 00	Average private room per diem charge (line 29 ÷ line 3)	0.00	
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)	0. 00	
34. 00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	
35. 00	Average per diem private room cost differential (line 34 x line 31)	0.00	
36. 00	Private room cost differential adjustment (line 3 x line 35)	0.00	
37. 00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line	2, 892, 910	
37.00	27 minus line 36)	2, 072, 710	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)	1, 581. 69	38. 00
	Program general inpatient routine service cost (line 9 x line 38)	990, 138	
40. 00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	990, 138	
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	990, 138	41.00

COMPUT	Financial Systems	FRANCISCAN HEALT	Provi der CCN		Peri od:	worksheet D-1		
					From 01/01/2021 To 12/31/2021	Date/Time Prep 5/27/2022 5:0		
			Title	XVIII	Hospi tal	Cost	трш	
	Cost Center Description	Total Inpatient Costl		Average Per iem (col. 1 col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
		1.00	2. 00	3.00	4. 00	5. 00		
42. 00	NURSERY (title V & XIX only)						42. 0	
	Intensive Care Type Inpatient Hospital Units		, al	00 70/ 1		070 171		
43. 00 44. 00	INTENSIVE CARE UNIT CORONARY CARE UNIT	1, 112, 603	49	22, 706. 1 0. 0		272, 474	1	
45. 00	BURN INTENSIVE CARE UNIT		U .	0.0	0	١	45.0	
	SURGICAL INTENSIVE CARE UNIT						46. 0	
47. 00	OTHER SPECIAL CARE (SPECIFY)						47. 0	
	Cost Center Description					1.00		
48. 00	Program inpatient ancillary service cost (W	kst D-3 col 3	line 200)			1. 00 490, 324	48. 0	
49. 00	,			s)		1, 752, 936		
	PASS THROUGH COST ADJUSTMENTS	9 , ,						
50. 00	Pass through costs applicable to Program in	patient routine s	ervices (from	Wkst. D, sum	of Parts I and	0	50.0	
51. 00		nationt ancillary	sorvices (fro	m Wkst D si	m of Darte II	ol	51.0	
31.00	and IV)	patrent and mary	services (III)	II WKSt. D, SI	uiii Oi Faits II	ا	31.0	
52. 00	Total Program excludable cost (sum of lines	50 and 51)				0	52.0	
53. 00	Total Program inpatient operating cost excl		ated, non-phys	cian anesth	etist, and	0	53.0	
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)						
54. 00						0	54.0	
55. 00						l .	55. 0	
56. 00	,					0		
57. 00	Difference between adjusted inpatient opera	ting cost and tar	get amount (li	ne 56 minus l	line 53)	0		
58. 00 59. 00	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost re	enorting period e	andina 1996 un	dated and co	mnounded by the	0.00		
37.00	market basket	cportring period c	maring 1770, up	dated and con	iipodriaca by the	0.00	37.0	
60. 00	Lesser of lines 53/54 or 55 from prior year					0.00	1	
61. 00	If line 53/54 is less than the lower of line					0	61.0	
	which operating costs (line 53) are less the amount (line 56), otherwise enter zero (see		(Tines 54 x 6	J), OF 1% OF	the target			
62. 00		Thisti dott ons)				0	62.0	
63. 00	00 Allowable Inpatient cost plus incentive payment (see instructions)							
<i>(</i>	PROGRAM INPATIENT ROUTINE SWING BED COST	ata thealigh Dagom	han 21 of the	anat manamti	na naniad (Caa	000 225	1,,,	
64. 00	Medicare swing-bed SNF inpatient routine con instructions) (title XVIII only)	sts through becen	iber 31 of the	cost reportin	ng period (see	800, 335	64.0	
65. 00	Medicare swing-bed SNF inpatient routine co	sts after Decembe	er 31 of the co	st reporting	period (See	o	65.0	
	instructions)(title XVIII only)						l	
66. 00	Total Medicare swing-bed SNF inpatient rout CAH (see instructions)	ine costs (line 6	4 plus line 65	(title XVII	only). For	800, 335	66. 0	
67. 00	1 '	ne costs through	December 31 of	the cost re	portina period	o	67.0	
	(line 12 x line 19)	3			5 1			
68. 00	Title V or XIX swing-bed NF inpatient routi	ne costs after De	cember 31 of t	ne cost repo	rting period	0	68. 0	
69 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient	routine costs (I	ine 67 ± line	48)			69.0	
07.00	PART III - SKILLED NURSING FACILITY, OTHER] 07.0	
70. 00	Skilled nursing facility/other nursing faci	-		• •			70. 0	
71.00	Adjusted general inpatient routine service		ne 70 ÷ line 2)			71.0	
72. 00 73. 00	Program routine service cost (line 9 x line Medically necessary private room cost appli		(line 14 x lin	e 35)			72. 0	
74. 00	Total Program general inpatient routine ser			3 00)			74. 0	
75. 00	Capital -related cost allocated to inpatient			rksheet B, Pa	art II, column		75. 0	
7/ 00	26, line 45)						7, 0	
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ 1 Program capital-related costs (line 9 x line						76. 0 77. 0	
78. 00	,						78.0	
79. 00	Aggregate charges to beneficiaries for exce	ss costs (from pr	ovi der records)			79. C	
30.00	Total Program routine service costs for com		st limitation	(line 78 min	us line 79)		80.0	
31. 00 32. 00	Inpatient routine service cost per diem lim						81. C	
32.00	Inpatient routine service cost limitation (Reasonable inpatient routine service costs						83.0	
34. 00	Program inpatient ancillary services (see in	•	,				84. 0	
85. 00	Utilization review - physician compensation	(see instruction					85.0	
	Total Program inpatient operating costs (su		ough 85)				86.0	
86. 00	PART IV - COMPUTATION OF OBSERVATION BED PAS	S THROUGH COST					I	
						601	87 0	
86. 00 87. 00 88. 00	Total observation bed days (see instruction Adjusted general inpatient routine cost per	s)	line 2)			601 1, 581. 69	•	

Health Financial Systems	FRANCI SCAN HEAL	TH RENSSELAER		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Period: From 01/01/2021	Worksheet D-1	
				To 12/31/2021	Date/Time Prep 5/27/2022 5:0	
		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			<u> </u>		
90.00 Capital -related cost	189, 870	3, 749, 827	0. 05063	4 950, 596	48, 132	90.00
91.00 Nursing Program cost	0	3, 749, 827	0.00000	950, 596	0	91.00
92.00 Allied health cost	0	3, 749, 827	0.00000	950, 596	0	92.00
93.00 All other Medical Education	0	3, 749, 827	0.00000	950, 596	0	93.00

Health Financial Systems	FRANCI SCAN HEALTH	RENSSELAER	In Lie	u of Form CMS-:	2552-10	
COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-1324	Peri od: From 01/01/2021	Worksheet D-1		
			To 12/31/2021	Date/Time Pre 5/27/2022 5:0		
		Title XIX	Hospi tal	Cost		
Cost Center Description						
				1. 00		
PART I - ALL PROVIDER COMPONENTS						
I NPATI ENT DAYS						
1.00 Inpatient days (including private r	1.00 Inpatient days (including private room days and swing-bed days, excluding newborn)					
2 00 Inpatient days (including private r	room days excluding swing-	bed and newborn days)		1 829	2 00	

	Cost Center Description	Cost	
		1. 00	
	PART I - ALL PROVIDER COMPONENTS		-
1	INPATIENT DAYS On Inpatient days (including private room days and swing-bed days, excluding newborn)	2, 700	1.00
	On Inpatient days (including private room days, excluding swing-bed and newborn days)	1, 829	
3.	00 Private room days (excluding swing-bed and observation bed days). If you have only private room days,	0	3. 00
	do not complete this line.		
4.	00 Semi-private room days (excluding swing-bed and observation bed days) 00 Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost	1, 228 506	4. 00 5. 00
J.	reporting period	300	3.00
6.		0	6. 00
_	reporting period (if calendar year, enter 0 on this line)	0.5	7 00
7.	OD Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	365	7. 00
8.		0	8. 00
	reporting period (if calendar year, enter 0 on this line)		
9.		31	9. 00
10	newborn days) (see instructions) .00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	0	10.00
10	through December 31 of the cost reporting period (see instructions)		10.00
11	.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after	0	11. 00
	December 31 of the cost reporting period (if calendar year, enter 0 on this line)		
12	.00 Swing-bed NF type inpatient days applicable to titles V or XLX only (including private room days) through December 31 of the cost reporting period	0	12. 00
13	.00 Swing-bed NF type inpatient days applicable to titles V or XLX only (including private room days)	0	13. 00
	after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		10.00
	.00 Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	
	.00 Total nursery days (title V or XIX only)	0	
16	.00 Nursery days (title V or XIX only) SWING BED ADJUSTMENT	0	16. 00
17	.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost		17. 00
	reporting period		
18	.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost		18. 00
10	reporting period .00 Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost	0.00	19. 00
17	reporting period	0.00	19.00
20	.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost	0.00	20. 00
	reporting period		
	.00 Total general inpatient routine service cost (see instructions) .00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line	3, 749, 827	21.00
22	5 x line 17)		22.00
23	.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6	0	23. 00
	x line 18)		
24	.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24. 00
25	.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	0	25. 00
	x line 20)		
	.00 Total swing-bed cost (see instructions)	812, 596	
27	.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	2, 937, 231	27. 00
28	.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28. 00
	.00 Private room charges (excluding swing-bed charges)	0	
	.00 Semi-private room charges (excluding swing-bed charges)	0	1
	.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	1
	.00 Average private room per diem charge (line 29 ÷ line 3) .00 Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	1
	.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	1
	.00 Average per diem private room cost differential (line 34 x line 31)	0.00	1
	.00 Private room cost differential adjustment (line 3 x line 35)	0	36. 00
37	.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line	2, 937, 231	37. 00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY		1
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		İ
38	.00 Adjusted general inpatient routine service cost per diem (see instructions)	1, 605. 92	38. 00
	.00 Program general inpatient routine service cost (line 9 x line 38)	49, 784	
	.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) .00 Total Program general inpatient routine service cost (line 39 + line 40)	0 49, 784	40. 00 41. 00
41	. oo Total Trogram general Tripatrent Toutine Service COSt (TITIE 37 + TITIE 40)	1 49, /84	J 4 I. UU

31. 00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line	2, 937, 231	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)	1, 605. 92	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line 38)	49, 784	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	49, 784	41.00

Name		Financial Systems ATION OF INPATIENT OPERATING COST	FRANCI SCAN HEALT	Provi der CCN	l: 15-1324	Peri od:	worksheet D-1		
Cost Center Description									
Inpatient Cast Opported to Day				Title	XIX	Hospi tal		т рііі	
1.00 2.00 3.00 4.00 5.00		Cost Center Description			iem (col. 1		(col. 3 x col.		
2.00 MRSSEY (CITLE V. & N.X. only)			1.00	2.00		4. 00			
1.00 CORDINATE CARE UNIT	42. 00			2.00	0.00	11.00	0.00	42. 0	
Company Carle UNIT 0 0 0 0 0 0 0 0 0									
5.00 SURRICA INTERSIVE CARE UNIT 46.	43.00		1, 112, 603	1					
2.00 SMRCICAL INTERSIVE CARE UNIT				٥	0. (0	U		
2,00 DIFFERSPEIAL CARE (SPEIPY)								46. 0	
1.00	47. 00	OTHER SPECIAL CARE (SPECIFY)						47.0	
		Cost Center Description					1.00		
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Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	67. 00		ne costs through	December 31 of	the cost re	eporting period	0	67.0	
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	87. 00	Total observation bed days (see instructions	5)				l		
9.00 Jubservation bed cost (Time 87 x Time 88) (see instructions) 965, 158 89.	88. 00			line 2)			l '		
	J7. UU	Jobservation bed Cost (Time 87 x Time 88) (Se	e mstructions)				J 905, 158	09.0	

Health Financial Systems	FRANCISCAN HEAL	TH RENSSELAER		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2021 To 12/31/2021	Date/Time Prep 5/27/2022 5:0	
		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	189, 870	3, 749, 827	0. 05063	4 965, 158	48, 870	90.00
91.00 Nursing Program cost	0	3, 749, 827	0.00000	0 965, 158	0	91.00
92.00 Allied health cost	0	3, 749, 827	0.00000	0 965, 158	0	92.00
93.00 All other Medical Education	0	3, 749, 827	0. 00000	965, 158	0	93. 00

	Financial Systems	FRANCI SCAN HEALTH				eu of Form CMS-	
I NPATI	ENT ANCILLARY SERVICE COST APPORTIONMENT		Provi der C	CN: 15-1324	Peri od: From 01/01/2021	Worksheet D-3	
					To 12/31/2021		
			Title	XVIII	Hospi tal	Cost	
	Cost Center Description			Ratio of Cos		I npati ent	
				To Charges		Program Costs	
					Charges	(col. 1 x col.	
				1.00	2.00	2)	
	INPATIENT ROUTINE SERVICE COST CENTERS			1.00	2. 00	3. 00	
30. 00	03000 ADULTS & PEDIATRICS				890, 608	ol	30.00
31. 00	03100 NTENSI VE CARE UNIT				27, 132		31. 00
32. 00	03200 CORONARY CARE UNIT				27, 132		32.00
32.00	ANCI LLARY SERVI CE COST CENTERS			l		1	32.00
50.00	05000 OPERATING ROOM			0. 7746	07 52, 886	40, 966	50.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C			0. 1890		1	
60.00	06000 LABORATORY			0. 2547	•	1	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.			0. 5106	07	0	63. 00
65.00	06500 RESPIRATORY THERAPY			0. 5234	18 139, 917	73, 235	65. 00
66.00	06600 PHYSI CAL THERAPY			0. 6530	04 37, 536	24, 511	66. 00
66. 01	06601 PHYSI CAL THERAPY- WHEATFIELD			0. 5161	66 (0	66. 01
67. 00	06700 OCCUPATI ONAL THERAPY			0. 4149		15, 069	1
67. 01	06701 OCCUPATIONAL THERAPY- WHEATFIELD			1. 1210		0	
68. 00	06800 SPEECH PATHOLOGY			0. 8531			
68. 01	06801 SPEECH PATHOLOGY- WHEATFIELD			0. 5675		1	1
69. 00	06900 ELECTROCARDI OLOGY			0.0000		1	
70.00	07000 ELECTROENCEPHALOGRAPHY			0.0000		0	70.00
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS			0. 1969			1
72.00	07300 DRUGS CHARGED TO PATIENTS			0. 1891 0. 1785			1
	07400 RENAL DIALYSIS			0. 1783		1	1
74.00	OUTPATIENT SERVICE COST CENTERS			0.0000	00	<u> </u>	74.00
88. 00	08800 RURAL HEALTH CLINIC			0.0000	nn	0	88. 00
88. 01	08801 BROOK RHC			0.0000		0	1
90.00	09000 CLI NI C			0. 5510		_	90.00
90. 01	09001 WOUND CARE			0. 3496		1	1
91. 00	09100 EMERGENCY			0. 5494		1	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)			0. 9245		1	1
	OTHER REIMBURSABLE COST CENTERS			•			1
95.00	09500 AMBULANCE SERVI CES						95. 00
98.00	09850 OTHER REIMBURSABLE COST CENTERS			0.0000		0	
200.00					1, 695, 273	490, 324	
201.00	Less PBP Clinic Laboratory Services-P	rogram only charges	(Line 61)			ol .	201. 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)

1, 695, 273

201. 00

202. 00

200.00 201.00

202.00

INPAII	ENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-1324	Peri od:	Worksheet D-3	}
		Component	CCN: 15-Z324	From 01/01/2021 To 12/31/2021		pared:
		·			5/27/2022 5:0	
	Coot Contan Decemintion	litle	Ratio of Cos	Swing Beds - SN	F Cost Inpatient	
	Cost Center Description		To Charges	Inpatient Program	Program Costs	
			10 Charges	Charges	(col. 1 x col.	
				orial ges	2)	
			1.00	2. 00	3. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00	03000 ADULTS & PEDI ATRI CS					30.00
31. 00	03100 INTENSIVE CARE UNIT					31.00
32. 00	03200 CORONARY CARE UNIT					32.00
	ANCILLARY SERVICE COST CENTERS				•	
50.00	05000 OPERATING ROOM		0. 77460	07	0	50.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C		0. 1890 ⁻	12 17, 48 ⁻	1 3, 304	54.00
60.00	06000 LABORATORY		0. 25470	04 47, 20 ⁻	7 12, 024	60.00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.		0. 51060	07	0	63.00
65. 00	06500 RESPI RATORY THERAPY		0. 5234	18 51, 09:	26, 742	65.00
66. 00	06600 PHYSI CAL THERAPY		0. 65300	04 96, 028	62, 707	66.00
66. 01	06601 PHYSI CAL THERAPY- WHEATFI ELD		0. 5161		-	
67. 00	06700 OCCUPATI ONAL THERAPY		0. 41498	89 98, 03	40, 683	67.00
67. 01	06701 OCCUPATIONAL THERAPY- WHEATFIELD		1. 12100	04	0	67. 01
68. 00	06800 SPEECH PATHOLOGY		0. 8531	77 546	466	68. 00
68. 01	06801 SPEECH PATHOLOGY- WHEATFIELD		0. 5675		0	68. 01
69. 00	06900 ELECTROCARDI OLOGY		0.0000	00	0	69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY		0.0000		0	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 1969		6, 997	
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS		0. 1891		0	
73. 00	07300 DRUGS CHARGED TO PATIENTS		0. 1785		23, 015	1
74. 00	07400 RENAL DIALYSIS		0.0000	00	0	74. 00
	OUTPATIENT SERVICE COST CENTERS					
88. 00	08800 RURAL HEALTH CLINIC		0.0000		0	
88. 01	08801 BROOK RHC		0.0000		0	
90. 00	09000 CLI NI C		0. 55100		0	
90. 01	09001 WOUND CARE		0. 3496		l .	
91. 00	09100 EMERGENCY		0. 54942			
92. 00	09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)		0. 9245	57 (0	92.00
05 00	OTHER REIMBURSABLE COST CENTERS		T		T	1 05 00
95.00	09500 AMBULANCE SERVI CES		0.0000	20		95.00
98. 00	09850 OTHER REIMBURSABLE COST CENTERS		0. 00000		0	
200. 00 201. 00		(1: (1)		477, 07	176, 730	200.00
	THESS PRE CLINIC LABORATORY SERVICES-PROGRAM ONLY CHARG	25 (TINE 61)	1	1 (II .	1201 ()()

Health Financial Systems FRANCISCAN HEALT INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	_	CN: 15-1324	Peri od:	u of Form CMS-2 Worksheet D-3	
THE THE PROPERTY SERVICE GOST THE ORTHORNERT	Trovider o		From 01/01/2021		
			To 12/31/2021	Date/Time Pre 5/27/2022 5:0	
	Ti tl	e XIX	Hospi tal	Cost	трш
Cost Center Description		Ratio of Cos		I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1.00	2. 00	3. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS			162, 745		30.00
31. 00 03100 I NTENSI VE CARE UNIT			38, 946		31.00
32. 00 03200 CORONARY CARE UNIT			0		32.00
ANCI LLARY SERVI CE COST CENTERS		1			
50. 00 05000 0PERATI NG ROOM		0. 77460		29, 109	
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 18901		25, 006	
60. 00 06000 LABORATORY		0. 25470		44, 012	
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.		0. 51060		0	
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY		0. 52341			
		0.65300		0	
66. 01 06601 PHYSI CAL THERAPY - WHEATFI ELD 67. 00 06700 OCCUPATI ONAL THERAPY		0. 51616 0. 41498		259	
67. 00 06700 OCCUPATI ONAL THERAPY WHEATFI ELD		1. 12100		259	
68. 00 06800 SPEECH PATHOLOGY		0. 85317		0	
68. 01 06801 SPEECH PATHOLOGY WHEATFIELD		0. 56754		0	
69. 00 06900 ELECTROCARDI OLOGY		0. 00000		0	
70. 00 07000 ELECTROENCEPHALOGRAPHY		0.00000		0	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 19694		_	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 18911			
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 17856	·		
74. 00 07400 RENAL DI ALYSI S		0.00000		0	
OUTPATIENT SERVICE COST CENTERS					1
88. 00 08800 RURAL HEALTH CLINIC		3. 45128	37 0	0	88. 00
88. 01 08801 BROOK RHC		3. 13196		0	
90. 00 09000 CLI NI C		0. 55100		72, 151	
90. 01 09001 WOUND CARE		0. 34963	0 0	0	90. 01
91. 00 09100 EMERGENCY		0. 54942	29 89, 173	48, 994	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 92455	40, 638	37, 572	92.00
OTHER REIMBURSABLE COST CENTERS					
95. 00 09500 AMBULANCE SERVI CES					95. 00
98. 00 09850 OTHER REIMBURSABLE COST CENTERS		0.00000		0	
200 00 Total (sum of lines 50 through 94 and 96 through 98)		1	916 541	327 318	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)

95. 00 98. 00 327, 318 200. 00 201. 00 202. 00

916, 541

916, 541

200. 00 201. 00

202.00

Health Financial Systems	FRANCISCAN HEALTH RENSSELAER	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-1324	Peri od: From 01/01/2021 To 12/31/2021	Worksheet E Part B Date/Time Prepared: 5/27/2022 5:01 pm

		Title XVIII	Hospi tal	5/27/2022 5: 0 Cost	1 pm
			110061 (41		
	DADT D. HEDLOAL AND OTHER HEALTH CERVILORS			1. 00	
1. 00	PART B - MEDICAL AND OTHER HEALTH SERVICES Medical and other services (see instructions)			8, 162, 962	1.00
2. 00	Medical and other services (see Firstructions) Medical and other services reimbursed under OPPS (see instructions)		0, 102, 702	2.00
3. 00	OPPS payments	,		0	3. 00
4.00	Outlier payment (see instructions)			0	4. 00
4.01	Outlier reconciliation amount (see instructions)			0	4. 01
5.00	Enter the hospital specific payment to cost ratio (see instruction	s)		0.000	5.00
6. 00 7. 00	Line 2 times line 5 Sum of lines 3, 4, and 4.01, divided by line 6			0.00	6. 00 7. 00
8. 00	Transitional corridor payment (see instructions)			0.00	8. 00
9. 00	Ancillary service other pass through costs from Wkst. D, Pt. IV, c	ol. 13, line 200		Ō	9. 00
10.00	Organ acqui si ti ons			0	10.00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			8, 162, 962	11. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
12. 00	Reasonable charges Ancillary service charges			0	12. 00
13. 00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 6	9)		ا	
14.00	Total reasonable charges (sum of lines 12 and 13)	,		0	14. 00
	Customary charges				
15. 00	Aggregate amount actually collected from patients liable for payme			0	
16. 00	Amounts that would have been realized from patients liable for pay had such payment been made in accordance with 42 CFR §413.13(e)	ment for services or	n a chargebasis	0	16. 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	18. 00
19. 00	Excess of customary charges over reasonable cost (complete only if	line 18 exceeds lir	ne 11) (see	0	19. 00
	instructions)				
20. 00	Excess of reasonable cost over customary charges (complete only if instructions)	line 11 exceeds lir	ne 18) (see	0	20. 00
21. 00	Lesser of cost or charges (see instructions)			8, 244, 592	21. 00
	Interns and residents (see instructions)			0	22. 00
23. 00	Cost of physicians' services in a teaching hospital (see instructi	ons)		0	23. 00
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)			62, 884	25. 00
26. 00	Deductibles and Coinsurance amounts relating to amount on line 24	(for CAH, see instru	uctions)	5, 410, 458	
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus			2, 771, 250	
	instructions)				
28. 00	Direct graduate medical education payments (from Wkst. E-4, line 5	0)		0	28. 00
	ESRD direct medical education costs (from Wkst. E-4, line 36) Subtotal (sum of lines 27 through 29)			2, 771, 250	29. 00 30. 00
31. 00	Primary payer payments			15, 721	
32. 00	Subtotal (line 30 minus line 31)			2, 755, 529	1
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
	Composite rate ESRD (from Wkst. I-5, line 11)			720 400	33.00
	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			730, 480 474, 812	
	Allowable bad debts for dual eligible beneficiaries (see instructi	ons)		500, 587	
37. 00	Subtotal (see instructions)	,		3, 230, 341	
38. 00	MSP-LCC reconciliation amount from PS&R			0	38. 00
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
39. 50	Pioneer ACO demonstration payment adjustment (see instructions)				39. 50
39. 97 39. 98	Demonstration payment adjustment amount before sequestration Partial or full credits received from manufacturers for replaced d	evices (see instruct	ions)	0	39. 97 39. 98
39. 90 39. 99	RECOVERY OF ACCELERATED DEPRECIATION	CVICCO (SEE THISTIUCE	.1 5113)	0	39. 90
	Subtotal (see instructions)			3, 230, 341	•
40. 01	Sequestration adjustment (see instructions)			0	40. 01
40. 02	Demonstration payment adjustment amount after sequestration			0	40. 02
40. 03	Sequestration adjustment-PARHM pass-throughs			5 520 701	40.03
	Interim payments Interim payments-PARHM			5, 528, 781	41. 00 41. 01
42. 00	Tentative settlement (for contractors use only)			0	
42. 01	Tentative settlement-PARHM (for contractor use only)				42. 01
43.00	Balance due provider/program (see instructions)			-2, 298, 440	•
43. 01	Balance due provider/program-PARHM (see instructions)	i +b CMC Dul- 4F 0	hantan 1		43. 01
44. 00	Protested amounts (nonallowable cost report items) in accordance w §115.2	rtn CMS Pub. 15-2, c	cnapter I,	0	44. 00
	TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)			0	90.00
	Outlier reconciliation adjustment amount (see instructions)			0	
	The rate used to calculate the Time Value of Money				92.00
93.00	Time Value of Money (see instructions) Total (sum of lines 91 and 93)			0	93. 00 94. 00
, 4. 00	1.000. Common trinos /1 and /0/			١	, 7.00

	FRANCISCAN HEAL SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provi der CO	CN: 15-1324	Peri od:	eu of Form CMS-2 Worksheet E-1	2002 10
AWALT	TO THE MENT OF THE TOTAL TON SERVICES RENDERED	Trovider of		From 01/01/2021 To 12/31/2021	Part I	
		Title	XVIII	Hospi tal	Cost	. р
		Inpatien			rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2. 00	3. 00	4. 00	
1. 00 2. 00	Total interim payments paid to provider Interim payments payable on individual bills, either 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, 589, 43	0	5, 528, 781 0	1. 00 2. 00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					3. 00
3. 01	ADJUSTMENTS TO PROVIDER			0	0	3. 01
3. 02	ABSOSTWENTS TO TROVIDER			0	0	3. 02
3. 02				0		3. 03
3. 04				0		3.04
3. 05				0	0	3.05
0.00	Provider to Program			<u> </u>		0.00
3.50	ADJUSTMENTS TO PROGRAM			0	0	3. 50
3. 51				o	0	3. 51
3. 52				ō	0	3. 52
3. 53				ō	0	3. 53
3. 54				0	0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			0	0	3. 99
4. 00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1, 589, 43	0	5, 528, 781	4. 00
	TO BE COMPLETED BY CONTRACTOR	1				
5. 00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5. 00
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER			0	0	5. 01
5. 02				0	0	5. 02
5. 03				0	0	5. 03
E = 5	Provi der to Program	1				
5. 50	TENTATI VE TO PROGRAM			0	0	5. 50
5. 51				0	0	5. 51
5. 52				0	0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	5. 99

2, 298, 440 3, 230, 341

NPR Date (Mo/Day/Yr) 2.00

59, 514 1, 529, 916

0

Contractor

Number 1.00

6.00

6. 01

6. 02

7. 00

8. 00

6.00

6.01

6. 02

7.00

5. 50-5. 98)

8.00 Name of Contractor

the cost report. (1)
SETTLEMENT TO PROVIDER

SETTLEMENT TO PROGRAM

Total Medicare program liability (see instructions)

Determined net settlement amount (balance due) based on

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provider CCN: 15-1324 Peri od: Worksheet E-1 From 01/01/2021 To 12/31/2021 Part I Component CCN: 15-Z324 Date/Time Prepared: 5/27/2022 5:01 pm Title XVIII Swing Beds - SNF Cost Part B Inpatient Part A mm/dd/yyyy mm/dd/yyyy Amount Amount 1.00 2.00 3.00 4.00 1.00 Total interim payments paid to provider 884, 541 1. 00 0 2.00 Interim payments payable on individual bills, either 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 0 0 3.01 0 0 3.02 3.02 3.03 0 3.03 0 3.04 0 0 3.04 3.05 0 0 3.05 Provider to Program 3.50 ADJUSTMENTS TO PROGRAM 0 0 3.50 0 3.51 0 3.51 0 0 3.52 3.52 0 3.53 0 3.53 0 3.54 0 3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 0 0 3.99 3.50-3.98) 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 884, 541 0 4.00 (transfer to Wkst. E or Wkst. E-3, line and column as appropri ate) TO BE COMPLETED BY CONTRACTOR 5.00 List separately each tentative settlement payment after 5.00 desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 5.01 TENTATIVE TO PROVIDER 0 0 5.01 5.02 0 0 5.02 0 5.03 0 5.03 Provider to Program 5.50 TENTATI VE TO PROGRAM 0 0 5.50 5.51 0 0 5. 51 0 5.52 0 5.52 5. 99 0 Subtotal (sum of lines 5.01-5.49 minus sum of lines 0 5. 99 5.50-5.98) 6.00 Determined net settlement amount (balance due) based on 6.00 the cost report. (1) SETTLEMENT TO PROVIDER 6.01 90, 978 0 6.01

0

NPR Date (Mo/Day/Yr)

2 00

975, 519

0

Contractor

Number

1 00

6.02

7.00

8.00

6 02

7.00

SETTLEMENT TO PROGRAM

8.00 Name of Contractor

Total Medicare program liability (see instructions)

Heal th	Financial Systems FRANCISCAN HEALTH	RENSSEL AER	Inlie	u of Form CMS-	2552_10
	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provi der CCN: 15-1324	Period: From 01/01/2021 To 12/31/2021	Worksheet E-1 Part II Date/Time Pre 5/27/2022 5:0	pared:
		Title XVIII	Hospi tal	Cost	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst.				1. 00
2.00	Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, and	8 through 12, and plus f	or cost		2. 00
	reporting periods beginning on or after 10/01/2013, line 32)				
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3. 00
4.00	Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines	1, and 8 through 12, and	plus for cost		4. 00
	reporting periods beginning on or after 10/01/2013, line 32)				
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5. 00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 I				6. 00
7. 00	CAH only - The reasonable cost incurred for the purchase of c	ertified HIT technology	Wkst. S-2, Pt. I		7. 00
	line 168				
8. 00	Calculation of the HIT incentive payment (see instructions)				8. 00
9. 00	Sequestration adjustment amount (see instructions)				9. 00
10. 00		(see instructions)			10. 00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
	Initial/interim HIT payment adjustment (see instructions)				30. 00
31. 00	Other Adjustment (specify)				31. 00
32. 00	Balance due provider (line 8 (or line 10) minus line 30 and l	ine 31) (see instruction	s)		32. 00

Health Financial Systems	FRANCI SCAN HEALTH	RENSSELAER	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT -	SWI NG BEDS	Provider CCN: 15-1324		Worksheet E-2
			From 01/01/2021	
		Component CCN: 15-Z324	To 12/31/2021	
				5/27/2022 5:01 pm
		Ti +1 o V\/I I I	Cwing Bode CNE	Coct

			5/27/2022 5:0	pared: 1 pm
	Title XVIII	Swing Beds - SNF		
		Part A	Part B	
		1. 00	2. 00	
	COMPUTATION OF NET COST OF COVERED SERVICES	000 220	0	1
00	Inpatient routine services - swing bed-SNF (see instructions) Inpatient routine services - swing bed-NF (see instructions)	808, 338	0	1.0
	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D.	178, 497	0	3.0
	Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-bed pass-through, see	170, 477	O] 3.0
	instructions)			
1	Nursing and allied health payment-PARHM (see instructions)			3.0
00	Per diem cost for interns and residents not in approved teaching program (see		0.00	4. (
	instructions)			
1	Program days	506	0	
	Interns and residents not in approved teaching program (see instructions)		0	
	Utilization review - physician compensation - SNF optional method only	00/ 025	0	7.0
	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	986, 835	0	
	Primary payer payments (see instructions) Subtotal (line 8 minus line 9)	986, 835	0	
	Deductibles billed to program patients (exclude amounts applicable to physician	700, 033	0	11. (
	professional services)		· ·	' ' ' '
1 '	Subtotal (line 10 minus line 11)	986, 835	0	12. (
	Coinsurance billed to program patients (from provider records) (exclude coinsurance	11, 316	0	13.0
-	for physician professional services)			
	80% of Part B costs (line 12 x 80%)		0	
1	Subtotal (see instructions)	975, 519	0	
1	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	1
	Pioneer ACO demonstration payment adjustment (see instructions)			16.
	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)	٥		16. 5
	Demonstration payment adjustment amount before sequestration	0	0	16.
	Allowable bad debts (see instructions)	Ö	0	
	Adjusted reimbursable bad debts (see instructions)	O	0	1
3. 00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18. (
	Total (see instructions)	975, 519	0	1
	Sequestration adjustment (see instructions)	0	0	
	Demonstration payment adjustment amount after sequestration)	0	0	1
1	Sequestration adjustment-PARHM pass-throughs			19. (
	Sequestration for non-claims based amounts (see instructions)	004 541	0	
1	Interim payments Interim payments-PARHM	884, 541	0	20. (
	Tentative settlement (for contractor use only)	0	0	1
	Tentative settlement-PARHM (for contractor use only)		· ·	21. (
	Balance due provider/program (line 19 minus lines 19.01, 19.02, 19.25, 20, and 21)	90, 978	0	1
	Balance due provider/program-PARHM (see instructions)			22. (
3. 00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2,	0	0	23. 0
	chapter 1, §115.2			
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200. 0
	Cost Reimbursement			ł
-	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line			201. (
	66 (title XVIII hospital))			201.
	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line			202. (
	200 (title XVIII swing-bed SNF))			
	Total (sum of lines 201 and 202)			203. (
	Medicare swing-bed SNF discharges (see instructions)			204. (
	Computation of Demonstration Target Amount Limitation (N/A in first year of the currer	nt 5-year demonst	rati on	
μ.	period)			120E /
	Medicare swing-bed SNF target amount Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			205. (206. (
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement			J206. 1
	Program reimbursement under the §410A Demonstration (see instructions)			207.
	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1			208.
	and 3)			
	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209. (
19.00		1		210. (
10. 00	Reserved for future use			-
10. 00 0	Comparision of PPS versus Cost Reimbursement Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see			215. (

Health Financial Systems	FRANCISCAN HEALTH RENSSELAER In Lieu c				
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-1324	Peri od: From 01/01/2021 To 12/31/2021	Worksheet E-3 Part V Date/Time Prep 5/27/2022 5:0	pared:	
	Title XVIII	Hospi tal	Cost		
			1. 00		

	Ti tl e X	VIII	Hospi tal	5/2//2022 5:0 Cost	ı pm
	The state of the s		110001 141	5551	
				1. 00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVI	CES - COST	REIMBURSEMENT		
1.00	Inpatient services			1, 752, 936	1. 00
2.00	Nursing and Allied Health Managed Care payment (see instructions)			0	2. 00
3.00	Organ acqui si ti on			0	3. 00
4.00	Subtotal (sum of lines 1 through 3)			1, 752, 936	4. 00
5. 00	Primary payer payments				5. 00
6. 00	Total cost (line 4 less line 5). For CAH (see instructions)			1, 770, 465	6. 00
	COMPUTATION OF LESSER OF COST OR CHARGES Reasonable 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				10.00
11.00	Aggregate amount actually collected from patients liable for payment for se	rvi ces on	a charge basis	0	11. 00
12.00	Amounts that would have been realized from patients liable for payment for			0	12.00
	had such payment been made in accordance with 42 CFR 413.13(e)		J		
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)			0	14. 00
15.00	Excess of customary charges over reasonable cost (complete only if line 14	exceeds li	ne 6) (see	0	15. 00
	instructions)				
16. 00	Excess of reasonable cost over customary charges (complete only if line 6 e	xceeds lin	e 14) (see	0	16. 00
47.00	instructions)				47.00
17. 00	Cost of physicians' services in a teaching hospital (see instructions)			0	17. 00
18. 00	COMPUTATION OF REIMBURSEMENT SETTLEMENT Direct graduate medical education payments (from Worksheet E-4, line 49)			0	18. 00
19. 00	Cost of covered services (sum of lines 6, 17 and 18)			1, 770, 465	
20. 00	Deductibles (exclude professional component)			259, 548	
21. 00	Excess reasonable cost (from line 16)			0	21.00
22. 00	Subtotal (line 19 minus line 20 and 21)			1, 510, 917	22. 00
23. 00	Coinsurance			0	23. 00
24.00	Subtotal (line 22 minus line 23)			1, 510, 917	24. 00
25.00	Allowable bad debts (exclude bad debts for professional services) (see inst	ructions)		29, 229	25. 00
26.00	Adjusted reimbursable bad debts (see instructions)			18, 999	26. 00
27. 00	Allowable bad debts for dual eligible beneficiaries (see instructions)			6, 765	27. 00
28. 00	Subtotal (sum of lines 24 and 25, or line 26)			1, 529, 916	
29. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	29. 00
29. 50	Pioneer ACO demonstration payment adjustment (see instructions)			0	29. 50
29. 98	Recovery of accelerated depreciation.			0	29. 98
29. 99	Demonstration payment adjustment amount before sequestration			0	29. 99
30.00	Subtotal (see instructions)			1, 529, 916	
30. 01	Sequestration adjustment (see instructions)			0	30. 01
30. 02	Demonstration payment adjustment amount after sequestration			0	30. 02
30. 03 31. 00	Sequestration adjustment-PARHM			1, 589, 430	30. 03 31. 00
31.00	Interim payments Interim payments-PARHM			1, 389, 430	31.00
31.01	Tentative settlement (for contractor use only)			0	31.01
32. 00	Tentative settlement (for contractor use only)			ا	32. 00
33. 00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)			-59, 514	
33. 01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.	03 31 01	and 32 01)	37, 314	33. 01
34. 00	Protested amounts (nonallowable cost report items) in accordance with CMS P			0	34. 00
	§115. 2	,	' '	-	

Health Financial Systems	FRANCISCAN HEALTH RENSSELAER	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-1324	From 01/01/2021 To 12/31/2021	Worksheet E-3 Part VII Date/Time Prepared: 5/27/2022 5:01 pm

			Го 12/31/2021	Date/Time Pre 5/27/2022 5:0	
		Title XIX	Hospi tal	Cost	ГРШ
		THE MA	Inpatient	Outpati ent	
			1. 00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERV	ICES FOR TITLES V OR XIX			
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services		467, 927		1.00
2.00	Medical and other services		,	0	
3.00	Organ acquisition (certified transplant centers only)		0		3. 00
4.00	Subtotal (sum of lines 1, 2 and 3)		467, 927	0	4. 00
5.00	Inpatient primary payer payments		0		5. 00
6.00	Outpatient primary payer payments			0	6. 00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		467, 927	0	7. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonable Charges				
8.00	Routine service charges		0		8. 00
9.00	Ancillary service charges		916, 541	0	
10. 00	Organ acquisition charges, net of revenue		0		10. 00
	Incentive from target amount computation		0		11. 00
12. 00	Total reasonable charges (sum of lines 8 through 11)		916, 541	0	12.00
	CUSTOMARY CHARGES				
13. 00	Amount actually collected from patients liable for payment for	services on a charge	0	0	13. 00
44.00	basis				44.00
14. 00	Amounts that would have been realized from patients liable for		0	0	14. 00
15. 00	a charge basis had such payment been made in accordance with 42 Ratio of line 13 to line 14 (not to exceed 1.000000)	2 CFR 9413. 13(e)	0. 000000	0. 000000	15. 00
16. 00	Total customary charges (see instructions)		916, 541	0.000000	•
17. 00	Excess of customary charges over reasonable cost (complete only	if line 16 eveneds	448, 614	0	
17.00	line 4) (see instructions)	, it time to exceeds	440, 014	O	17.00
18. 00	Excess of reasonable cost over customary charges (complete only	if line 4 exceeds line	0	0	18. 00
10.00	16) (see instructions)	The reaceds time		Ü	10.00
19. 00	Interns and Residents (see instructions)		0	0	19. 00
20. 00	Cost of physicians' services in a teaching hospital (see instru	ıctions)	0	0	20. 00
21.00	Cost of covered services (enter the lesser of line 4 or line 16		467, 927	0	21. 00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be c		ers.		
22.00	Other than outlier payments		0	0	22. 00
23.00	Outlier payments		0	0	23. 00
24.00	Program capital payments		0		24. 00
25. 00	Capital exception payments (see instructions)		0		25. 00
	Routine and Ancillary service other pass through costs		0	0	
27. 00	Subtotal (sum of lines 22 through 26)		0	0	27. 00
28. 00	Customary charges (title V or XIX PPS covered services only)		0	0	
29. 00	Titles V or XIX (sum of lines 21 and 27)		467, 927	0	29. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30. 00	Excess of reasonable cost (from line 18)		0	0	
31. 00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		467, 927	0	
32. 00	Deducti bl es		0	0	
33. 00	Coinsurance		0	0	
34.00	Allowable bad debts (see instructions)		0	0	34.00
35. 00 36. 00			467, 927	0	35. 00 36. 00
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	33)	407, 927	0	
	Subtotal (line 36 ± line 37)		467, 927	0	38.00
	,		407, 727	O	39.00
40. 00	Direct graduate medical education payments (from Wkst. E-4) Total amount payable to the provider (sum of lines 38 and 39)		467, 927	0	
41. 00	Interim payments		467, 968	0	
42. 00	Balance due provider/program (line 40 minus line 41)		-41	0	
43. 00	Protested amounts (nonallowable cost report items) in accordance	ce with CMS Pub 15-2	0	0	43. 00
	chapter 1, §115.2			Ŭ	
	· · · · · · · · · · · · · · · · · · ·		, '		•

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 01/01/2021 To 12/31/2021 Date/Time Prepared:

onl y)			'	0 12/31/2021	5/27/2022 5:0	
		General Fund	Speci fi c	Endowment Fund		
		1. 00	Purpose Fund 2.00	3. 00	4. 00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	-15, 029, 537		0	0	1.00
2. 00 3. 00	Temporary investments Notes receivable	0		-	0	2. 00 3. 00
4. 00	Accounts receivable	4, 431, 577	1	0	0	4. 00
5. 00	Other recei vable	0	o c	0	0	5. 00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6. 00
7.00	Inventory	770, 320	•	0	0	7. 00
8.00	Prepai d expenses	89, 252		0	0	
9. 00 10. 00	Other current assets Due from other funds	644, 488 83, 413		0	0	9. 00 10. 00
11. 00	Total current assets (sum of lines 1-10)	-9, 010, 487			0	11.00
11.00	FIXED ASSETS	- 7, 010, 407		9	0	11.00
12. 00	Land	675, 791	C	0	0	12. 00
13.00	Land improvements	509, 926	o C	0	0	13. 00
14. 00	Accumulated depreciation	0	0	0	0	14. 00
15. 00	Bui I di ngs	19, 176, 030	1	0	0	15.00
16. 00 17. 00	Accumulated depreciation Leasehold improvements	-15, 622, 336	1	-	0	16. 00 17. 00
18. 00	Accumul ated depreciation	613, 142		-	0	18.00
19. 00	Fi xed equipment	12, 094, 550			0	19.00
20.00	Accumul ated depreciation	0	o c	0	0	20.00
21. 00	Automobiles and trucks	0) C	0	0	21. 00
22. 00	Accumulated depreciation	0	0	0	0	22. 00
23. 00	Maj or movable equipment	0		0	0	23. 00
24. 00 25. 00	Accumulated depreciation	0		0	0	24. 00 25. 00
26. 00	Minor equipment depreciable Accumulated depreciation	0		-	0	26.00
27. 00	HIT designated Assets	Ö		-	0	27. 00
28. 00	Accumul ated depreciation	0	O	0	0	28. 00
29. 00	Mi nor equi pment-nondepreci abl e	0	0	0	0	29. 00
30.00	Total fixed assets (sum of lines 12-29)	17, 447, 103	C	0	0	30. 00
21 00	OTHER ASSETS	0	J 0	O	0	21 00
31. 00 32. 00	Investments Deposits on Leases	0			0	31. 00 32. 00
33. 00	Due from owners/officers	0		-	0	33.00
34. 00	Other assets	239, 914	. C	0	0	34. 00
35.00	Total other assets (sum of lines 31-34)	239, 914		0	0	35. 00
36. 00	Total assets (sum of lines 11, 30, and 35)	8, 676, 530	0	0	0	36. 00
07.00	CURRENT LI ABI LI TI ES	0 404 (00				07.00
37. 00 38. 00	Accounts payable Salaries, wages, and fees payable	2, 401, 688 1, 133, 462	1	0	0	37. 00 38. 00
39. 00	Payroll taxes payable	58, 861	1	0	0	39.00
40. 00	Notes and Loans payable (short term)	00,001		o	0	40.00
41. 00	Deferred income	0	o c	0	0	41.00
42.00	Accel erated payments	0				42. 00
43.00	Due to other funds	0	0	0	0	1
44. 00	Other current liabilities	5, 290, 558			0	
45. 00	Total current liabilities (sum of lines 37 thru 44) LONG TERM LIABILITIES	8, 884, 569) C	0	0	45. 00
46. 00	Mortgage payable	0		0	0	46. 00
47. 00	Notes payable	Ö		-	0	
48.00	Unsecured Loans	0	0	0	0	
49. 00	Other long term liabilities	23, 336, 895		0	0	1
50. 00	Total long term liabilities (sum of lines 46 thru 49)	23, 336, 895	1		0	50.00
51. 00	Total liabilities (sum of lines 45 and 50)	32, 221, 464	· C	0	0	51.00
52. 00	CAPITAL ACCOUNTS General fund balance	-23, 544, 934				52.00
53. 00	Specific purpose fund	25, 544, 754				53. 00
54. 00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55. 00
56. 00	Governing body created - endowment fund balance			0		56. 00
57. 00	Plant fund balance - invested in plant				0	
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)	-23, 544, 934		0	0	59. 00
60.00	Total liabilities and fund balances (sum of lines 51 and	8, 676, 530		0	0	
	59)	, , , , , , ,				
				·		

Provider CCN: 15-1324

					To 12/31/2021	Date/Time Prep 5/27/2022 5:0	
		General	Fund	Speci al	Purpose Fund	Endowment Fund	•
		1.00	2. 00	3. 00	4. 00	5. 00	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) TEMPORARY RESTRICTED NET ASSETS Total additions (sum of line 4-9) Subtotal (line 3 plus line 10)	83, 413 0 0 0 0 0	-22, 357, 030 -1, 271, 318 -23, 628, 348 -23, 648, 348 -23, 544, 935		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00
12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00	Deductions (debit adjustments) (specify) Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0 0 0 0	0 -23, 544, 935		0 0 0 0 0 0	1	12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00
		Endowment Fund	PI ant	Fund			
		6.00	7. 00	8. 00			
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) TEMPORARY RESTRICTED NET ASSETS	0	0 0 0 0		0		1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00
9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 17. 00 18. 00 19. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0 0	0 0 0 0 0		0 0		9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00

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

			To 12/31/2021	Date/Time Pre 5/27/2022 5:0	
	Cost Center Description	I npati ent	Outpati ent	Total	ı pili
	out danta. Basar peran	1, 00	2.00	3. 00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				İ
1.00	Hospi tal	2, 692, 9	05	2, 692, 905	1.00
2. 00	SUBPROVI DER - I PF	2,0,2,,		2,0,2,,00	2. 00
3.00	SUBPROVI DER - I RF				3. 00
4.00	SUBPROVI DER				4.00
5. 00	Swi ng bed - SNF		0	0	5.00
6.00	Swing bed - NF		0	0	6.00
7. 00	SKILLED NURSING FACILITY			Ĭ	7. 00
8.00	NURSI NG FACI LI TY				8.00
9. 00	OTHER LONG TERM CARE				9. 00
10.00	Total general inpatient care services (sum of lines 1-9)	2, 692, 9	05	2, 692, 905	1
10.00	Intensive Care Type Inpatient Hospital Services	2,072,7	00	2,072,703	10.00
11. 00	INTENSIVE CARE UNIT	118, 6	18	118, 618	11.00
12. 00	CORONARY CARE UNIT	110,0	0	0	12. 00
13. 00	BURN INTENSIVE CARE UNIT		٥		13. 00
14. 00	SURGICAL INTENSIVE CARE UNIT				14. 00
15. 00	OTHER SPECIAL CARE (SPECIFY)				15. 00
16. 00	Total intensive care type inpatient hospital services (sum of lines	118, 6	10	118, 618	•
10.00	11-15)	110,0	10	110,010	10.00
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	2, 811, 5	23	2, 811, 523	17. 00
18. 00	Ancillary services	5, 299, 5			1
19. 00	Outpatient services	349, 2			1
20. 00	RURAL HEALTH CLINIC	347, 2	0 14, 343, 945		1
20. 00	BROOK RHC		0 244, 221		
21. 00	FEDERALLY QUALIFIED HEALTH CENTER		0 244, 221	l .	21. 00
22. 00	HOME HEALTH AGENCY			l e	22.00
23. 00	AMBULANCE SERVICES			0	23. 00
24. 00	CMHC			1	24.00
25. 00			0 0	0	25.00
26. 00	AMBULATORY SURGICAL CENTER (D. P.) HOSPICE			0	26.00
27. 00	NON-REI MBURSABLE		٥	_	27. 00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wk	0.440.2	0 984, 326 35 83, 460, 411		28.00
20.00	G-3, line 1)	st. 8, 460, 3	33 63, 400, 411	91, 920, 740	20.00
	PART II - OPERATING EXPENSES				
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		35, 924, 491		29. 00
30.00	ADD (SPECIFY)		0		30.00
31. 00	ADD (SFECTIT)		0		31. 00
32. 00			0		32.00
33. 00			0		33.00
34. 00			0		34.00
35. 00			0		35. 00
36. 00	Total additions (our of lines 20 25)		0		36.00
	Total additions (sum of lines 30-35)		0		
37. 00 38. 00	DEDUCT (SPECI FY)		0		37. 00 38. 00
			-		
39. 00 40. 00			0		39. 00 40. 00
			0		
41. 00	Total deductions (sum of lines 27 41)		٦		41.00
42.00	Total deductions (sum of lines 37-41)	nefor	25 024 401		42. 00 43. 00
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)(tra to Wkst. G-3, line 4)	1121.61	35, 924, 491		43.00
	10 WK31. 0-3, TITIE 4)	I .	T.	I	I

Heal th	Financial Systems FRANCISCAN HEALTH	RENSSELAER	In Lie	u of Form CMS-2	2552-10
STATE	ENT OF REVENUES AND EXPENSES	Provider CCN: 15-1324	Peri od:	Worksheet G-3	
			From 01/01/2021	D-+- /T: D	
			To 12/31/2021	Date/Time Prep 5/27/2022 5:0	
				372172022 3.0	ı pili
				1. 00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, lin	e 28)		91, 920, 746	1. 00
2.00	Less contractual allowances and discounts on patients' accoun			58, 218, 027	2. 00
3.00	Net patient revenues (line 1 minus line 2)			33, 702, 719	3. 00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line	43)		35, 924, 491	4. 00
5.00	Net income from service to patients (line 3 minus line 4)			-2, 221, 772	5. 00
	OTHER INCOME				
6.00	Contributions, donations, bequests, etc			0	6. 00
7.00	Income from investments			0	7. 00
8.00	Revenues from telephone and other miscellaneous communication	servi ces		0	8. 00
9.00	Revenue from television and radio service			0	9. 00
10.00	Purchase di scounts			95, 299	10.00
11. 00	Rebates and refunds of expenses			0	11. 00
12.00	Parking lot receipts			0	12.00
13.00	Revenue from Laundry and Linen service			0	13.00
14.00	Revenue from meals sold to employees and guests			49, 287	14.00
15.00	Revenue from rental of living quarters			0	15.00
16.00	Revenue from sale of medical and surgical supplies to other t	han patients		0	16.00
17.00	Revenue from sale of drugs to other than patients			0	17.00
18.00	Revenue from sale of medical records and abstracts			176	18. 00
19. 00	Tuition (fees, sale of textbooks, uniforms, etc.)			1, 035	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen			2, 962	
21.00	Rental of vending machines			3, 339	21. 00
22. 00	Rental of hospital space			6, 864	22. 00
23.00	Governmental appropriations			0	23.00
24.00	OTHER OPERATING REVENUE			14, 475	24. 00
24. 50	COVI D-19 PHE Fundi ng			773, 017	24. 50
25. 00	Total other income (sum of lines 6-24)			946, 454	25. 00
26.00	Total (line 5 plus line 25)			-1, 275, 318	26. 00
27 00	TOTAL NON OPERATING DEVENUE			-4 000	27 00

-4, 000 27. 00 -4, 000 28. 00 -1, 271, 318 29. 00

27.00 TOTAL NON OPERATING REVENUE
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)

			T DENOGE, 150			6.5. 010	
	Financial Systems F SIS OF HOSPITAL-BASED RHC/FQHC COSTS	FRANCISCAN HEAL	Provider C	CN: 15-1324	In Lie Period:	wof Form CMS- Worksheet M-1	
					From 01/01/2021 To 12/31/2021	Date/Time Pre 5/27/2022 5:0	pared:
					RHC I	Cost	
	·	Compensation	Other Costs	Total (col.	1 Reclassificati	Recl assi fi ed	
				+ col . 2)	ons	Trial Balance	
						(col. 3 + col.	
						4)	
		1. 00	2.00	3. 00	4. 00	5. 00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physi ci an	70, 677	0	70, 67	7 0	70, 677	1.00
2.00	Physician Assistant	ol	0	1	0 0	0	2.00
3.00	Nurse Practitioner	113, 462	0	113, 46	2 0	113, 462	3.00
4.00	Visiting Nurse	l ol	0		0 0	0	4.00
5.00	Other Nurse	19, 381	0	19, 38	1 0	19, 381	
6.00	Clinical Psychologist	0	0	,	0	0	1
7. 00	Clinical Social Worker	أم	0	1	0 0	0	1
8. 00	Laboratory Techni ci an	ol	0		0 0	0	1
9. 00	Other Facility Health Care Staff Costs	74, 312	75, 056	149, 36	.8 0	149, 368	1
10.00	Subtotal (sum of lines 1 through 9)	277, 832	75, 056	1		352, 888	
11. 00	Physician Services Under Agreement	277,032	73,030	332,00	0 0	0 0	1
12. 00	Physician Supervision Under Agreement		0		0 0	0	
13. 00	Other Costs Under Agreement		0		0	0	1
14. 00	Subtotal (sum of lines 11 through 13)	0	0		0	0	
15. 00	Medical Supplies	0	4, 782	4, 78	0	4, 782	
16. 00		٥	4, 702	4, /0	0	4, 762	1
17. 00	Transportation (Health Care Staff) Depreciation-Medical Equipment	٥	0		0	0	1
17.00	1 '	U	0		0	1	
	Professional Liability Insurance	U	F2 000	F2 00	0 12 420	0	
19.00	Other Health Care Costs	١	52, 000	52, 00	-12, 438	39, 562	
20.00	Allowable GME Costs		E / 700				20.00
21. 00	Subtotal (sum of lines 15 through 20)	0	56, 782		·		
22. 00	Total Cost of Health Care Services (sum of	277, 832	131, 838	409, 67	-12, 438	397, 232	22. 00
	lines 10, 14, and 21)						-
22.00	COSTS OTHER THAN RHC/FQHC SERVICES	O	0	ı	0 0		22 00
23. 00	Pharmacy	U	•		-1	0	
24. 00	Dental	U	0	1	0	0	
25. 00	Optometry	0	Ü	1	0	0	
25. 01	Tel eheal th	0	Ü	1	0	0	
25. 02	Chronic Care Management	0	Ü	1	0	0	
26. 00	All other nonreimbursable costs	0	Ü	1	0	0	
27. 00	Nonallowable GME costs	_	_			_	27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	O	1	0	0	28. 00
	through 27)						1
00.05	FACILITY OVERHEAD				al -		00.05
29. 00	Facility Costs	0	0	l .	0		
30.00	Administrative Costs	0	0	1	0	1	
31.00	Total Facility Overhead (sum of lines 29 and	0	0	1	0	0	31.00

131, 838

277, 832

409, 670

-12, 438

32.00

397, 232

32.00 Total facility costs (sum of lines 22, 28

and 31)

Health Financial Systems	FRANCI SCAN HEALTH RENSSELAER	In Lie	u of Form CMS-2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS	Provi der CCN: 15-1324	Peri od: From 01/01/2021	Worksheet M-1
	Component CCN: 15-3990	To 12/31/2021	Date/Time Prepared: 5/27/2022 5:01 pm
		RHC I	Cost

			Component	CCIN. 13-3	1770	10	12/31/2021	5/27/2022 5:	
							RHC I	Cost	
		Adjustments	Net Expenses						
		,	for Allocation	ı					
			(col. 5 + col.						
			6)						
		6. 00	7. 00						
	FACILITY HEALTH CARE STAFF COSTS								
1.00	Physi ci an	-46, 619	24, 058	8					1. 00
2.00	Physician Assistant	0	0						2. 00
3.00	Nurse Practitioner	0	113, 462	2					3. 00
4.00	Visiting Nurse	0	0	ol					4. 00
5.00	Other Nurse	O	19, 381						5. 00
6.00	Clinical Psychologist	O	0	ol					6.00
7.00	Clinical Social Worker	0	0	ol					7. 00
8.00	Laboratory Techni ci an	0	0	ol					8. 00
9.00	Other Facility Health Care Staff Costs	0	149, 368	3					9. 00
10.00	Subtotal (sum of lines 1 through 9)	-46, 619	306, 269	ol					10.00
11.00	Physician Services Under Agreement	0	0	1					11.00
12.00	Physician Supervision Under Agreement	0	0	ol					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	4, 782						15. 00
16. 00	Transportation (Health Care Staff)	0	0	1					16. 00
17. 00	Depreciation-Medical Equipment	0	0	1					17. 00
18. 00	Professional Liability Insurance	0	0	1					18. 00
19. 00	Other Health Care Costs	-14, 864	24, 698	1					19. 00
20. 00	Allowable GME Costs	,	2.7070						20.00
21. 00	Subtotal (sum of lines 15 through 20)	-14, 864	29, 480						21. 00
22. 00	Total Cost of Health Care Services (sum of	-61, 483	335, 749	1					22. 00
22.00	lines 10, 14, and 21)	01, 100	000,717						22.00
	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	-61, 483	335, 749						32. 00
	and 31)		•						
	•	· '							•

Heal th	Financial Systems F	FRANCISCAN HEAL	TH RENSSELAER		In Lie	eu of Form CMS-	2552-10
ANALYS	SIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provi der C	CN: 15-1324	Peri od:	Worksheet M-1	
			Component		From 01/01/2021 To 12/31/2021	Date/Time Pre 5/27/2022 5:0	
					RHC II	Cost	
		Compensation	Other Costs	Total (col.	1 Reclassificati	Recl assi fi ed	
				+ col . 2)	ons	Trial Balance	
						(col. 3 + col.	
						4)	
		1.00	2. 00	3.00	4. 00	5. 00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physi ci an	72, 510	C	72, 51		72, 510	
2.00	Physi ci an Assi stant	0	C		0	0	2. 00
3.00	Nurse Practitioner	107, 119	C	107, 11	9 0	107, 119	
4.00	Visiting Nurse	0	C		0	0	
5.00	Other Nurse	49, 962	C	49, 96	2 0	49, 962	
6.00	Clinical Psychologist	0	C		0	0	0.00
7.00	Clinical Social Worker	0	C		0	0	1
8.00	Laboratory Techni ci an	0	C		0	0	0.00
9.00	Other Facility Health Care Staff Costs	81, 434	78, 598	1		160, 032	
10.00	Subtotal (sum of lines 1 through 9)	311, 025	78, 598	389, 62	3 0	389, 623	10.00
11. 00	Physician Services Under Agreement	0	C		0	0	
12. 00	Physician Supervision Under Agreement	0	C		0	0	12. 00
13.00	Other Costs Under Agreement	0	C		0	0	1 .0.00
14. 00	Subtotal (sum of lines 11 through 13)	0	C		0	0	14. 00
15. 00	The second secon	0	4, 043	4, 04	3 0	4, 043	
16. 00		0	C		0	0	1
17. 00		0	C		0	0	
18. 00	9	0	C		0	0	
19. 00		0	23, 368	23, 36	-16, 030	7, 338	
20. 00							20.00
21. 00		0	27, 411		· ·		1
22. 00	Total Cost of Health Care Services (sum of	311, 025	106, 009	417, 03	-16, 030	401, 004	22. 00
	lines 10, 14, and 21)						
	COSTS OTHER THAN RHC/FQHC SERVICES			J			
23. 00		0	C	1	0 0	0	
24. 00	Dental	0	C	1	0 0	0	
25. 00	Optometry	0	C		0 0	0	
25. 01	Tel eheal th	0	C		0	0	
25. 02	Chronic Care Management	0	C		0	0	20.02
26. 00	All other nonreimbursable costs	0	C)	0	0	
27. 00	Nonallowable GME costs				0		27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	U	C	7	0	0	28. 00
	through 27)						+
29. 00	FACILITY OVERHEAD Facility Costs	O	C	1	0 0	0	29. 00
	Administrative Costs	0	C	1	0 0	1	
	Total Facility Overhead (sum of lines 29 and	- 1		1	0 0		

106, 009

311, 025

32.00

0 31.00

401, 004

0 0 0

417, 034

0

-16, 030

31.00 Total Facility Overhead (sum of lines 29 and

32.00 Total facility costs (sum of lines 22, 28

and 31)

Health Financial Systems	FRANCISCAN HEALTH RENSSELAER	In Lieu of Form CMS-2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS	Provider CCN: 15-1324	Period: Worksheet M-1 From 01/01/2021
	Component CCN: 15-8502	To 12/31/2021 Date/Time Prepared: 5/27/2022 5:01 pm

			Componer	11 CCN. 13-0302	10	12/31/2021	5/27/2022 5:0	
						RHC II	Cost	
		Adjustments	Net Expens	es				
		,	for Allocat	i on				
			(col. 5 + c	ol .				
			6)					
		6. 00	7. 00					
	FACILITY HEALTH CARE STAFF COSTS							
1.00	Physi ci an	-49, 362	23,	148				1.00
2.00	Physi ci an Assi stant	. 0		ol				2.00
3.00	Nurse Practitioner	0	107,	119				3.00
4.00	Visiting Nurse	0	,	o				4.00
5.00	Other Nurse	0	49,	962				5. 00
6.00	Clinical Psychologist	0		o				6.00
7.00	Clinical Social Worker	0		o				7. 00
8.00	Laboratory Techni ci an	0		0				8.00
9. 00	Other Facility Health Care Staff Costs	0	160,	032				9.00
10.00	Subtotal (sum of lines 1 through 9)	-49, 362						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	4.	043				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	-4, 000	3.	338				19.00
20. 00	Allowable GME Costs	.,						20.00
21. 00	Subtotal (sum of lines 15 through 20)	-4, 000	7.	381				21.00
22. 00	Total Cost of Health Care Services (sum of	-53, 362						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		О				26. 00
27.00	Nonallowable GME costs							27. 00
28.00	Total Nonreimbursable Costs (sum of lines 23	0		O				28. 00
	through 27)							
	FACILITY OVERHEAD			•				
29.00	Facility Costs	0		0				29. 00
30.00	Administrative Costs	0		o				30.00
31.00	Total Facility Overhead (sum of lines 29 and	0		О				31. 00
	30)							
32.00	Total facility costs (sum of lines 22, 28	-53, 362	347,	642				32. 00
	and 31)							

Heal th	Financial Systems	FRANCI SCAN HEAL	TH RENSSELAER		In Lie	u of Form CMS-2	2552-10
	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC	SERVI CES	Provider Component (Period: From 01/01/2021 To 12/31/2021	Worksheet M-2 Date/Time Pre	
			·			5/27/2022 5:0	1 pm
					RHC I	Cost	
		Number of FTE	Total Visits		Minimum Visits		
		Personnel		Standard (1)	(col. 1 x col. 3)	coi. 2 or coi. 4	
		1.00	2.00	3.00	4. 00	5. 00	
	VISITS AND PRODUCTIVITY						
	Posi ti ons						
1.00	Physi ci an	0. 08	38	4, 20	0 336		1. 00
2.00	Physician Assistant	0.00		_,			2. 00
3.00	Nurse Practitioner	1. 00					3. 00
4.00	Subtotal (sum of lines 1 through 3)	1. 08			2, 436	2, 436	1
5.00	Visiting Nurse	0.00				0	
6.00	Clinical Psychologist	0. 00				0	6. 00
7.00	Clinical Social Worker	0. 00				0	
7. 01	Medical Nutrition Therapist (FQHC only)	0. 00				0	
7. 02	Diabetes Self Management Training (FQHC only)	0. 00	0			0	7. 02
8.00	Total FTEs and Visits (sum of lines 4	1. 08	1, 344			2, 436	8. 00
	through 7)						
9.00	Physician Services Under Agreements		0			0	9. 00
						4 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE	TO LICEDITAL DACE	D DUC/FOUR CED	VILOEC		1. 00	
10 00	Total costs of health care services (from W			VICES		335, 749	10 00
11. 00						335, 749	•
12. 00	Cost of all services (excluding overhead) (335, 749	
13. 00	Ratio of hospital-based RHC/FQHC services (1. 000000	1
14. 00	Total hospital-based RHC/FQHC overhead - (f			ne 31)		0.00000	14. 00
15. 00	Parent provider overhead allocated to facil			110 31)		274, 870	
16. 00	Total overhead (sum of lines 14 and 15)	ity (see institut	211 0113)			274, 870	
17. 00						0	•
	Enter the amount from line 16					274, 870	1
	Overhead applicable to hospital-based RHC/F	QHC services (li	ne 13 x line 1	8)		274, 870	l
	Total allowable cost of hospital-based RHC/					610, 619	
		·		•		•	•

Heal th	Financial Systems	FRANCISCAN HEAL	TH RENSSELAER		In lie	u of Form CMS-2	2552-10
	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC S		Provi der CO		Peri od:	Worksheet M-2	
			C		From 01/01/2021	Date/Time Pre	
	Component CCN: 15-8502 To 12/31/2021 D 5						
					RHC II	Cost	
		Number of FTE	Total Visits		Minimum Visits		
		Personnel		Standard (1)	(col. 1 x col.		
		1.00	2.00	3.00	3) 4. 00	5. 00	
	VISITS AND PRODUCTIVITY	1. 00	2.00	3.00	4.00	5.00	
	Posi ti ons						
1. 00	Physi ci an	0.08	80	4, 20	0 336		1. 00
2. 00	Physician Assistant	0.00	l	2, 10			2. 00
3. 00	Nurse Practitioner	1. 00					3. 00
4.00	Subtotal (sum of lines 1 through 3)	1. 08			2, 436		4. 00
5.00	Visiting Nurse	0.00	0			0	5. 00
6.00	Clinical Psychologist	0.00	0			0	6. 00
7.00	Clinical Social Worker	0.00	0			0	7. 00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7. 01
7.02	Diabetes Self Management Training (FQHC	0.00	0			0	7. 02
	only)						
8. 00	Total FTEs and Visits (sum of lines 4	1. 08	1, 833			2, 436	8. 00
9. 00	through 7) Physician Services Under Agreements		0			0	9. 00
9.00	Prhysician Services under Agreements		0			U	9.00
						1. 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE T	O HOSPI TAL-BASE	D RHC/FQHC SER	VICES			
10.00	Total costs of health care services (from Wk	st. M-1, col. 7	', line 22)			347, 642	10. 00
11. 00	Total nonreimbursable costs (from Wkst. M-1,	col. 7, line 2	28)			0	11. 00
12.00	Cost of all services (excluding overhead) (s	um of lines 10	and 11)			347, 642	12.00
13.00	Ratio of hospital-based RHC/FQHC services (I					1. 000000	
14. 00	Total hospital-based RHC/FQHC overhead - (fr			ne 31)		0	14.00
15. 00	Parent provider overhead allocated to facili	ty (see instruc	ctions)			417, 250	
16. 00	Total overhead (sum of lines 14 and 15)					417, 250	
17. 00						0	
	Enter the amount from line 16		10 1! 1	0)		417, 250	
	Overhead applicable to hospital based RHC/FO					417, 250 764, 892	
20.00	Total allowable cost of hospital-based RHC/F	unc services (s	sum of fines to	and 19)		/04, 892	∠0. 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		
SERVI (CES	Component CCN: 15-3990	From 01/01/2021 To 12/31/2021	Date/Time Prep 5/27/2022 5:0		
	Title XVIII RHC I					
				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)		610, 619	1.00	
2. 00	Cost of injections/infusions and their administration (from W			22, 889	2. 00	
3.00	Total allowable cost excluding injections/infusions (line 1 m	inus line 2)		587, 730	3. 00	
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			2, 436	1	
5.00	Physicians visits under agreement (from Wkst. M-2, column 5,	line 9)		0	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, 436 241. 27	6. 00 7. 00	
7.00	Adjusted cost per visit (Time 3 divided by Time 0)		Cal cul ati on		7.00	
			our cur a tron	01 21 1111 2 (1)		
				Rate Period 2		
			(01/01/2021	(04/01/2021		
			through	through		
			03/31/2021)	12/31/2021) 2. 00		
8. 00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20	.6 or your contractor)	87. 52	100.00	8. 00	
9.00	Rate for Program covered visits (see instructions)		241. 27	100. 00	9. 00	
	CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from		35	106	1	
11. 00 12. 00	Program cost excluding costs for mental health services (line Program covered visits for mental health services (from contr.	•	8, 444 11	10, 600 35	1	
13. 00	Program covered cost from mental health services (line 9 x li	•	2, 654	3, 500	1	
14. 00	Limit adjustment for mental health services (see instructions		2, 654	3, 500		
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	25, 198	1	
16. 01	Total program charges (see instructions)(from contractor's re	•		15, 251	1	
16. 02 16. 03	Total program preventive charges (see instructions) (from prov	-		8, 211	ı	
16. 03	Total program preventive costs ((line 16.02/line 16.01) times Total Program non-preventive costs ((line 16 minus lines 16.0)			13, 566 6, 039	ı	
10.01	(Titles V and XIX see instructions.)	o and roy trines . ooy		0,007	10.01	
16. 05	Total program cost (see instructions)		0	19, 605	16. 05	
17. 00	Primary payer amounts			0	17. 00	
18. 00	Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		4, 083	18. 00	
19. 00	records) Beneficiary coinsurance for RHC/FQHC services (see instruction	ns) (from contractor		2, 234	19. 00	
17.00	records)	ns) (110m contractor		2, 201	17.00	
20.00	Net Medicare cost excluding vaccines (see instructions)			19, 605	20. 00	
21. 00	Program cost of vaccines and their administration (from Wkst.	M-4, line 16)		9, 485	1	
22. 00	, , , , , , , , , , , , , , , , , , , ,			29, 090	1	
23. 00 23. 01	Allowable bad debts (see instructions)			0	ł	
24. 00	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	ructions)		0		
25. 00		r de trons)		0	ı	
	Pioneer ACO demonstration payment adjustment (see instruction	s)		0		
25. 99	Demonstration payment adjustment amount before sequestration			0	25. 99	
26. 00	Net reimbursable amount (see instructions)			29, 090		
26. 01	Sequestration adjustment (see instructions)			0	26. 01	
26. 02 27. 00				0 32, 484	ı	
28. 00	1 . 3			32, 464	28.00	
29. 00	,	02, 27, and 28)		-3, 394	ı	
30. 00	Protested amounts (nonallowable cost report items) in accorda			0	1	
	chapter I, §115.2				l	

	Financial Systems FRANCISCAN HEALTH			u of Form CMS-2	
	ATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC	Provider CCN: 15-1324	Peri od: From 01/01/2021	Worksheet M-3	
SERVI C	ES	Component CCN: 15-8502	To 12/31/2021	Date/Time Pre	pared:
				5/27/2022 5:0	
		Title XVIII	RHC II	Cost	
				1. 00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES		<u> </u>	1.00	
1. 00	Total Allowable Cost of hospital-based RHC/FQHC Services (from	m Wkst. M-2. line 20)		764, 892	1.00
2. 00	Cost of injections/infusions and their administration (from W			30, 706	2. 00
3. 00	Total allowable cost excluding injections/infusions (line 1 m			734, 186	
4. 00	Total Visits (from Wkst. M-2, column 5, line 8)			2, 436	4.00
5. 00	Physicians visits under agreement (from Wkst. M-2, column 5,	line 9)		0	5. 00
6. 00	Total adjusted visits (line 4 plus line 5)			2, 436	6.00
7. 00	Adjusted cost per visit (line 3 divided by line 6)			301. 39	7.00
			Cal cul ati on	of Limit (1)	
			Rate Period 1	Rate Period 2	
			(01/01/2021	(04/01/2021	
			through	through	
			03/31/2021)	12/31/2021)	
0.00	D 111 11 (C 0NC D 1 400 04 1 1 0 000		1.00	2. 00	0.00
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20	.6 or your contractor)	87. 52 301. 39	100.00	
9. 00	Rate for Program covered visits (see instructions) CALCULATION OF SETTLEMENT		301.39	100.00	9.00
10. 00	Program covered visits excluding mental health services (from	contractor records)	102	307	10.00
11. 00	Program cost excluding costs for mental health services (line	•	30, 742	30, 700	
12. 00	Program covered visits for mental health services (from contra		10	31	
13. 00	Program covered cost from mental health services (line 9 x li	•	3, 014	3, 100	
14. 00	Limit adjustment for mental health services (see instructions)	3, 014	3, 100	14.00
15. 00	Graduate Medical Education Pass Through Cost (see instruction	s)			15.00
16. 00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2	and 3) *	0	67, 556	16.00
16. 01	Total program charges (see instructions)(from contractor's re	•		44, 475	
16. 02	Total program preventive charges (see instructions)(from prov	-		6, 456	
16. 03	Total program preventive costs ((line 16.02/line 16.01) times			9, 806	
16. 04	Total Program non-preventive costs ((line 16 minus lines 16.0	3 and 18) times .80)		38, 498	16. 04
16. 05	(Titles V and XIX see instructions.) Total program cost (see instructions)		0	48, 304	16 0
17. 00	Primary payer amounts		U	48, 304	17. 00
18. 00	Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		9, 628	
	records)	(.,	
19. 00	Beneficiary coinsurance for RHC/FQHC services (see instruction	ns) (from contractor		6, 969	19.00
00.00	records)			40.004	00.00
20. 00	Net Medicare cost excluding vaccines (see instructions)	W 4 11 443		48, 304	
21. 00	Program cost of vaccines and their administration (from Wkst. Total reimbursable Program cost (line 20 plus line 21)	M-4, TINE 16)		8, 546 56, 850	
22. 00 23. 00	Allowable bad debts (see instructions)			0 30, 630	23.00
23. 00	Adjusted reimbursable bad debts (see instructions)			0	23.00
	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		Ö	24. 00
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	. 401. 66)		0	
	Pioneer ACO demonstration payment adjustment (see instruction	s)		0	25. 50
25. 99	Demonstration payment adjustment amount before sequestration	•			25. 9
26. 00	Net reimbursable amount (see instructions)			56, 850	26.00
26. 01	Sequestration adjustment (see instructions)			0	
26. 02	Demonstration payment adjustment amount after sequestration			0	
	Interim payments			97, 794	
28. 00	Tentative settlement (for contractor use only)	00 07 100		0	28. 0
	Balance due component/program (line 26 minus lines 26.01, 26.			-40, 944	
30. 00	Protested amounts (nonallowable cost report items) in accorda	nce with CMS Pub. 15-11,		0	30.00

Heal th	Financial Systems FRANCISCAN HEAD	_TH_RENSSELAER		In Lie	u of Form CMS-2	2552-10
COMPUT	TATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST	Provi der CO		Peri od:	Worksheet M-4	
				From 01/01/2021		
		Component	CCN: 15-3990	To 12/31/2021	Date/Time Prep 5/27/2022 5:0	
		Ti +l o	XVIII	RHC I	Cost	Ι μιι
	· · · · · · · · · · · · · · · · · · ·	PNEUMOCOCCAL	INFLUENZA	COVI D-19	MONOCLONAL	
		VACCINES	VACCI NES	VACCINES	ANTI BODY	
		VACCINES	VACCINES	VACCINES	PRODUCTS	
		1.00	2.00	2. 01	2. 02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	306, 269	306, 26	9 306, 269	306, 269	1. 00
2.00	Ratio of injection/infusion staff time to total health	0. 003089	0. 00688	3 0.000000	0.000000	2. 00
	care staff time					
3.00	Injection/infusion health care staff cost (line 1 x line	946	2, 10	8 0	0	3. 00
	2)					
4.00	Injections/infusions and related medical supplies costs	6, 790	2, 74	2 0	0	4. 00
	(from your records)					
5.00	Direct cost of injections/infusions (line 3 plus line 4)	7, 736	4, 85	0 0	0	5. 00
6.00	Total direct cost of the hospital-based RHC/FQHC (from	335, 749	335, 74	9 335, 749	335, 749	6. 00
	Worksheet M-1, col. 7, line 22)					
7.00	Total overhead (from Wkst. M-2, line 19)	274, 870				7. 00
8.00	Ratio of injection/infusion direct cost to total direct	0. 023041	0. 01444	5 0. 000000	0. 000000	8. 00
	cost (line 5 divided by line 6)					
9.00	Overhead cost - injection/infusion (line 7 x line 8)	6, 333	· ·		0	9. 00
10. 00	Total injection/infusion costs and their administration	14, 069	8, 82	0	0	10. 00
	costs (sum of lines 5 and 9)					
11. 00	Total number of injections/infusions (from your records)	70	15		0	11. 00
12. 00	Cost per injection/infusion (line 10/line 11)	200. 99				12. 00
13. 00	Number of injection/infusion administered to Program	32	5	4 0	0	13. 00
	benefi ci ari es					

6, 432

3,053

22, 889

9, 485

0 13.01

14.00

15.00

16.00

13.01 Number of COVID-19 vaccine injections/infusions

and 13.01, as applicable)
15.00 Total cost of injections/infusions and their

Program cost of injections/infusions and their

administration costs (line 12 times the sum of lines 13

administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2)

16.00 Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)

administered to MA enrollees

Health Financial Systems	FRANCI SCAN HEALTH	RENSSELAER	In Lie	u of Form CMS-2552-10
COMPUTATION OF HOSPITAL-BASED RHC/FQHC	VACCINE COST	Provider CCN: 15-1324		Worksheet M-4
		Component CCN: 15-8502	From 01/01/2021 To 12/31/2021	Date/Time Prepared:
				5/27/2022 5:01 pm
		Title XVIII	RHC II	Cost

		Component (o 12/31/2021	Date/Time Prep 5/27/2022 5:0	
			XVIII	RHC II	Cost	
		PNEUMOCOCCAL VACCI NES	I NFLUENZA VACCI NES	COVI D-19 VACCI NES	MONOCLONAL ANTI BODY PRODUCTS	
		1. 00	2. 00	2. 01	2. 02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	340, 261		· ·	340, 261	1. 00
2. 00	Ratio of injection/infusion staff time to total health care staff time	0. 001596	0. 007089	0. 000000	0. 000000	2. 00
3. 00	Injection/infusion health care staff cost (line 1 x line 2)	543	2, 412	0	0	3. 00
4. 00	Injections/infusions and related medical supplies costs (from your records)	3, 298	7, 703	0	0	4. 00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	3, 841	10, 115	0	0	5.00
6. 00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	347, 642	347, 642	347, 642	347, 642	6. 00
7.00	Total overhead (from Wkst. M-2, line 19)	417, 250	417, 250	417, 250	417, 250	7.00
8. 00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0. 011049	0. 029096	0. 000000	0. 000000	8. 00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	4, 610	12, 140	0	0	9.00
10. 00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	8, 451	22, 255	0	0	10. 00
11.00	Total number of injections/infusions (from your records)	34	151	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	248. 56	147. 38	0.00	0.00	12.00
13. 00	Number of injection/infusion administered to Program beneficiaries	16	31	0	0	13. 00
13. 01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13. 01
14. 00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	3, 977	4, 569	0	0	14. 00
15. 00	Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2)		30, 706			15. 00
16. 00	Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)		8, 546			16. 00

Health Financial Systems	FRANCI SCAN HEALTH	RENSSELAER	In Lie	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED SERVICES RENDERED TO PROGRAM BENEFICIA		Provider CCN: 15-1324 Component CCN: 15-3990	Peri od: From 01/01/2021	
		Component Con. 15-3440	10 12/31/2021	5/27/2022 5:01 pm

		Component CCN: 15-3990	10 12/31/2021	5/27/2022 5: 01	
			RHC I	Cost	. р
			Par	t B	
			mm/dd/yyyy	Amount	
			1. 00	2. 00	
. 00	Total interim payments paid to hospital-based RHC/FQHC			32, 484	1.0
2. 00	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		0	2. 0
. 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. 0
. 01	Frogram to Frovider			0	3. C
. 02				0	3. 0
. 02					3. (
. 03					3. (
. 05					3. (
. 03	Provider to Program			0	٥. ١
50	11 ovi dei 10 11 ogi din			0	3.
51				ol ol	3.
52				ol ol	3.
53				ol.	3.
54				ol.	3.
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.	98)		ol.	3.
00	Total interim payments (sum of lines 1, 2, and 3.99) (trans 27)			32, 484	4.
	TO BE COMPLETED BY CONTRACTOR				
. 00	List separately each tentative settlement payment after deseach payment. If none, write "NONE" or enter a zero. (1)	k review. Also show date o	f		5. (
	Program to Provider				
01				0	5.
. 02				0	5.
03				0	5.
	Provider to Program				
50				0	5.
51				0	5.
52				0	5.
99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.			0	5.
00	Determined net settlement amount (balance due) based on the	cost report. (1)			6.
01	SETTLEMENT TO PROVIDER			0	6.
02	SETTLEMENT TO PROGRAM			3, 394	6.
00	Total Medicare program liability (see instructions)			29, 090	7.
			Contractor	NPR Date	
		0	Number 1.00	(Mo/Day/Yr) 2.00	

Health Financial Systems	FRANCI SCAN HEALTH	RENSSELAER	In Lie	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASEI SERVICES RENDERED TO PROGRAM BENEFICIA		Provider CCN: 15-1324 Component CCN: 15-8502		Worksheet M-5 Date/Time Prepared: 5/27/2022 5:01 pm

		Component CCN: 15-8502	10 12/31/2021	5/27/2022 5:0	
			RHC II	Cost	
			Par	t B	
			mm/dd/yyyy	Amount	
			1. 00	2. 00	
1.00	Total interim payments paid to hospital-based RHC/FQHC			97, 794	1. 0
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero			0	2. 0
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)				3. 0
	Program to Provider				
3. 01				0	3. 0
3. 02				0	3. 0
3. 03					3. 0
3. 04 3. 05				0	3. 0 3. 0
3.03	Provider to Program			U	3.0
3. 50	11 ovi dei 10 11 ogi alli			0	3. 5
3. 51				o l	3. 5
3. 52				o l	3. 5
3. 53				ol	3. 5
3.54				o	3. 5
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.	98)		0	3. 9
4. 00	Total interim payments (sum of lines 1, 2, and 3.99) (trans: 27)	fer to Worksheet M-3, line		97, 794	4. C
	TO BE COMPLETED BY CONTRACTOR				
5. 00	List separately each tentative settlement payment after des each payment. If none, write "NONE" or enter a zero. (1)	k review. Also show date o	f		5. C
	Program to Provider				
5. 01				0	5.0
5. 02				0	5.0
5. 03	Durani dan da Durangan			0	5.0
5. 50	Provider to Program			0	5. 5
5. 50 5. 51				0	5. 5
5. 52				0	5. 5
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	5. 9
5. 00	Determined net settlement amount (balance due) based on the	•		Ĭ	6. 0
6. 01	SETTLEMENT TO PROVIDER			0	6. 0
6. 02	SETTLEMENT TO PROGRAM			40, 944	6. 0
7. 00	Total Medicare program liability (see instructions)			56, 850	7. C
			Contractor	NPR Date	
			Number	(Mo/Day/Yr)	
		0	1. 00	2. 00	
8.00	Name of Contractor			1	8. 0