	CAN HEALTH RENSSELAER	In Lieu of Form CMS-2552-10
This report is required by law (42 USC 1395g; 42 CFR 413.20		
payments made since the beginning of the cost reporting per	riod being deemed overpayments (4:	
		EXPI RES 09-30-2025
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERT	IFICATION Provider CCN: 15-1324	Period: Worksheet S From 01/01/2023 Parts I-III
AND SETTLEMENT SUMMARY		To 12/31/2023 Date/Time Prepared:
		5/29/2024 8:56 am
PART I – COST REPORT STATUS		
Provider 1. [X] Electronically prepared cost report		Date: 5/29/2024 Time: 8:56 am
use only 2. [] Manually prepared cost report		
3.[0]If this is an amended report enter t 4.[F]Medicare Utilization. Enter "F" for		
Contractor 5. [1] Cost Report Status 6. Date Receive		NPR Date:
use only (1) As Submitted 7. Contractor No	o. 11.	Contractor's Vendor Code: 4
(2) Settled without Audit 8. [N] Initial	Report for this Provider CCN 12.	
(3) Settled with Addit	Report for this Provider CCN	number of times reopened = $0-9$.
(4) Reopened		
(5) Amended		
PART II - CERTIFICATION BY A CHIEF FINANCIAL OFFICER OR AD	MINISTRATOR OR PROVIDER(S)	
MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONT	AINED IN THIS COST REPORT MAY BE	PUNISHABLE BY CRIMINAL, CIVIL AND
ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDEL		
PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIR		WISE ILLEGAL, CRIMINAL, CIVIL AND
ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT	Τ.	
CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINI	STRATOR OF PROVIDER(S)	
I HEREBY CERTIFY that I have read the above certif	ication statement and that I have	e examined the accompanying
electronically filed or manually submitted cost re	port and submitted cost report an	d the Balance Sheet and
Statement of Revenue and Expenses prepared by FRAN		
period beginning 01/01/2023 and ending 12/31/2023		
statement are true, correct, complete and prepared		
applicable instructions, except as noted. I furthe		
regarding the provision of health care services, a provided in compliance with such laws and regulati		n this cost report were
	0115.	

	SIGNATURE OF CHIEF FINA	NCIAL OFFICER OR ADMINISTRATOR	CHECKBOX	ELECTRONI C	
		1	2	SI GNATURE STATEMENT	
1	Jason Geddes		T	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	Jason Geddes			2
3	Signatory Title	CFO			3
4	Date	(Dated when report is electronica			4

			Title	XVIII			
		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	386, 272	-23, 710	0	-143, 289	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	186, 627	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		6, 012		0	10.00
10.01	RURAL HEALTH CLINIC II	0		2, 647		0	10.01
200.00	TOTAL	0	572, 899	-15, 051	0	-143, 289	200.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The number for this information collection is OMB 0938-0050 and the number for the Supplement to Form CMS 2552-10, Worksheet N95, is OMB 0938-1425. The time required to complete and review the information collection is estimated 675 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.

Heal th	Financial Systems	FRANCI SCAN HEALT	TH RENSSEI	_AER			١r	n Lieu	ı of For	m CMS-:	2552-10
	AL AND HOSPITAL HEALTH CARE COMPLEX	DENTIFICATION DATA	Provio	ler CC	N: 15-	F	Period: From 01/01/ To 12/31/		Workshe Part I Date/Ti	me Pre	pared:
	1.00	2.00		3.00			4	1.00	5/29/20	<u>)24 8:5</u>	6 am
	Hospital and Hospital Health Care Co			3.00				r. 00			
1.00	Street: 1104 EAST GRACE STREET	PO Box:									1.00
2.00	City: RENSSELAER	State: IN Component Name	Zip Cod CCN	e: 479 CBS		Provi der	y: JASPER Date	Daymo	nt Syst	om (D	2.00
		component Mame	Number	Numb		Type	Certified		0, or		
						211		V	XVIII		
		1.00	2.00	3.0	00	4.00	5.00	6.00	7.00	8.00	
3.00	Hospital and Hospital-Based Componen Hospital	FRANCI SCAN HEALTH	151324	238	4.4	1	02/03/2005	N	0	0	3.00
3.00		RENSSELAER	151524	230	44	1	02/03/2003	IN			3.00
4.00	Subprovider - IPF										4.00
5.00	Subprovider - IRF										5.00
6.00 7.00	Subprovider - (Other) Swing Beds - SNF	FRANCI SCAN HEALTH	15Z324	999	15		12/31/2005	Ν	0	N	6.00 7.00
7.00	Swirig beus - Swi	RENSSELAER	152524	777	15		12/31/2005	IN			7.00
8.00	Swing Beds - NF										8.00
9.00	Hospital-Based SNF										9.00
10. 00 11. 00	Hospital-Based NF Hospital-Based OLTC										10.00
12.00	Hospi tal -Based HHA										12.00
13.00	Separately Certified ASC										13.00
14.00	Hospital-Based Hospice										14.00
15.00 15.01	Hospital-Based Health Clinic - RHC Hospital-Based Health Clinic - RHC	WHEATFIELD CLINIC BROOK	153990 158502	999			10/07/1999 01/01/2005	N N	0	N N	15.00 15.01
15.01		BROOK	150502	777	15		01/01/2005	IN			15.01
16.00	Hospital-Based Health Clinic - FQHC										16.00
17.00	Hospital-Based (CMHC) I										17.00
18.00	Renal Dialysis Other										18.00 19.00
19.00	other						From:		То	:	19.00
							1.00		2.0	00	
	Cost Reporting Period (mm/dd/yyyy)						01/01/20	023	12/31/	2023	20.00
21.00	Type of Control (see instructions)						1				21.00
						1.00	2.00		3. 0	00	
	Inpatient PPS Information						-				
22.00	Does this facility qualify and is it					Ν	N				22.00
	disproportionate share hospital adju §412.106? In column 1, enter "Y" fo			κ –							
	facility subject to 42 CFR Section §										
	hospital?) In column 2, enter "Y" fo										
22. 01	Did this hospital receive interim UC this cost reporting period? Enter in					Ν	N				22.01
	for the portion of the cost reportin										
	1. Enter in column 2, "Y" for yes or		tion of th	ne							
	cost reporting period occurring on o instructions)	r after October 1. (see									
22.02	Is this a newly merged hospital that	requires a final UCP to	b be			Ν	N				22.02
	determined at cost report settlement	? (see instructions) Ent	ter in col	umn							-
	1, "Y" for yes or "N" for no, for th										
	period prior to October 1. Enter in for the portion of the cost reportin			no,							
22.03	Did this hospital receive a geograph			b		Ν	N		Ν		22.03
	rural as a result of the OMB standar	5									
	adopted by CMS in FY2015? Enter in c for the portion of the cost reportin										
	in column 2, "Y" for yes or "N" for			~							
	reporting period occurring on or aft	er October 1. (see instr	ructions)								
	Does this hospital contain at least counted in accordance with 42 CFR 41										
	yes or "N" for no.	2. TOJ: LITEL TH COLUMN	J, I I(//							
22.04	Did this hospital receive a geograph										22.04
	rural as a result of the revised OMB										
	adopted by CMS in FY 2021? Enter in for the portion of the cost reportin										
	in column 2, "Y" for yes or "N" for										
	reporting period occurring on or aft	er October 1. (see instr	ructions)								
	Does this hospital contain at least										
	counted in accordance with 42 CFR 41 yes or "N" for no.	2. TODE ENTER IN COLUME	т э, т 1								
23.00	Which method is used to determine Me						о				23.00
	below? In column 1, enter 1 if date										
	if date of discharge. Is the method reporting period different from the			JUSI							
	reporting period? In column 2, ente	•									

Health Financial Systems FRANCISC HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION D/	AN HEALTH R	ENSSELAER Provider CC	N: 15-1324	Perio	od:	In Lieu		rm CMS- eet S-2	
				From To		1/2023		ime Pre 024 8:5	
	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out- Sta Medic eligi unpa	te aid ble id	Medicai HMO day	ys Me)ther di cai d days	
24.00 If this provider is an IPPS hospital, enter the	1.00	2.00	3.00	4.0	0	5.00	0	6.00 (24.00
 in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6. 25.00 If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid 	c				0		0		25.00
HMO paid and eligible but unpaid days in column 5.									
				Ur	ban/R 1. 0	ural S		F Geogr 00	-
26.00 Enter your standard geographic classification (not w		at the beg	jinning of t	the	1.0	2	۷.	00	26.00
 cost reporting period. Enter "1" for urban or "2" fo 27.00 Enter your standard geographic classification (not w reporting period. Enter in column 1, "1" for urban o enter the effective date of the geographic reclassif 35.00 If this is a sole community hospital (SCH), enter th 	age) status or "2" for r ication in	ural. If ap column 2.	plicable,			2			27.00
effect in the cost reporting period.		perrous so		·		0			35.00
				E	Beginn 1. C		Endi 2	ng: 00	-
36.00 Enter applicable beginning and ending dates of SCH s		cript line	36 for numb	ber	1. 0		۷.	00	36.00
of periods in excess of one and enter subsequent dat 37.00 If this is a Medicare dependent hospital (MDH), ente		r of period	ls MDH statu	JS		o			37.00
is in effect in the cost reporting period. 37.01 Is this hospital a former MDH that is eligible for t accordance with FY 2016 OPPS final rule? Enter "Y" f	he MDH tran	sitional pa	ayment in						37. 01
instructions) 38.00 If line 37 is 1, enter the beginning and ending date greater than 1, subscript this line for the number o	s of MDH st	atus. Ifli	ne 37 is						38.00
enter subsequent dates.					Y/		۲		
39.00 Does this facility qualify for the inpatient hospita	l navment a	diustment f	for low volu	IMP	1. C			00	39.00
hospitals in accordance with 42 CFR §412.101(b)(2)(i 1 "Y" for yes or "N" for no. Does the facility meet accordance with 42 CFR 412.101(b)(2)(i), (ii), or (i or "N" for no. (see instructions)), (ii), or the mileage	(iii)? Ent requiremen	er in colur nts in	nn	, i			•	37.00
40.00 Is this hospital subject to the HAC program reductio "N" for no in column 1, for discharges prior to Octo no in column 2, for discharges on or after October 1	ber 1. Ente	r "Y" for y			N		1	N	40.00
	. (300 1131					V	XVIII		
Prospective Payment System (PPS)-Capital						1.00	2.00	3.00	
45.00 Does this facility qualify and receive Capital payme	ent for disp	roporti onat	e share in	accord	lance	N	N	N	45.00
 with 42 CFR Section §412.320? (see instructions) 46.00 Is this facility eligible for additional payment exc pursuant to 42 CFR §412.348(f)? If yes, complete Wks 			5		ough	N	N	N	46.00
Pt. III. 47.00 Is this a new hospital under 42 CFR §412.300(b) PPS	capital? E	nter "Y for	yes or "N'	' for n	10.	N	N	N	47.00
48.00 Is the facility electing full federal capital paymen						N	N	N	48.00
56.00 Is this a hospital involved in training residents in periods beginning prior to December 27, 2020, enter cost reporting periods beginning on or after Decembe	"Y" for yes	or "N" for	no in colu	umn 1.	For	N			56.00
the instructions. For column 2, if the response to c involved in training residents in approved GME progr and are you are impacted by CR 11642 (or applicable "Y" for yes; otherwise, enter "N" for no in column 2 For cost reporting periods beginning prior to Decemb is this the first cost reporting period during which at this facility? Enter "Y" for yes or "N" for no i residents start training in the first month of this "N" for no in column 2. If column 2 is "Y", complet complete Wkst. D, Parts III & IV and D-2, Pt. II, if beginning on or after December 27, 2020, under 42 CF which month(s) of the cost report the residents were	column 1 is ams in the CRs) MA dir ber 27, 2020 a residents n column 1. cost report a worksheet applicable R 413.77(e e on duty, i	"Y", or if prior year ect GME pay , if line 5 in approved If column ing period? E-4. If co . For cost)(1)(iv) ar f the respo	this hospit or penultin mment reduct 66, column 7 d GME progra 1 is "Y", c P Enter "Y" olumn 2 is " reporting p nd (v), rego	tal was mate ye tion? E 1, is y ams tra did ' for y 'N", beriods ardless e 56 is	s ear, inter ves, ined ves or s s of s "Y"	-			57.00
for yes, enter "Y" for yes in column 1, do not compl 58.00 f line 56 is yes, did this facility elect cost reim					4.	N			58.0

OSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	ТА	Provider C	F	Period: From 01/01/2023 Fo 12/31/2023	3 Date/Time Pre 5/29/2024 8:5	pared:
					1. (
9.00	<u>Are costs claimed on line 100 of Worksheet A? If yes</u>	<u>s, compl</u>	ete Wkst. D-2,	Pt. I. NAHE 413.85 Y/N	Worksheet A Line #		
				1.00	2.00	3.00	
0. 00	Are you claiming nursing and allied health education any programs that meet the criteria under 42 CFR 413. instructions) Enter "Y" for yes or "N" for no in col is "Y", are you impacted by CR 11642 (or subsequent C adjustment? Enter "Y" for yes or "N" for no in colum	85? (s umn 1. CR) NAHE	see If column 1	N			60.0
		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
1. 01	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions) Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs,	N			0.0	00 0. 00	61. C
	and primary care FTEs added under section 5503 of ACA). (see instructions) Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions) Enter the number of unweighted primary care/or						61. (
I. 05	surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions). Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions) 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)						61.0
	care or general surgery. (see first detrons)	Pr	ogram Name	Program Code	Unweighted IM		
					FTE Count	Direct GME FTE Count	-
			1.00	2.00	3.00	4.00	1
	Of the FTEs in line 61.05, specify each new program special ty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. Of the FTEs in line 61.05, specify each expanded program special ty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.0		61.1
						1.00	-
2. 00	ACA Provisions Affecting the Health Resources and Ser Enter the number of FTE residents that your hospital				iod for which		0 62. C
	your hospital received HRSA PCRE funding (see instruc Enter the number of FTE residents that rotated from a	cti ons) a Teachi	ng Health Cen	ter (THC) into			62.0
3 00	during in this cost reporting period of HRSA THC prog Teaching Hospitals that Claim Residents in Nonprovide Has your facility trained residents in nonprovider se	er Setti	i ngs		period? Enter		63. (

th Financial Systems PITAL AND HOSPITAL HEALTH CARE COMPL		AN HEALTH RENSSELAER	CCN: 15-1324 P	Period:	u of Form CMS- Worksheet S-2	
			F	rom 01/01/2023 o 12/31/2023	Part I	epared:
			Unwei ghted	Unwei ghted	Ratio (col. 1/	/
			FTEs	FTEs in	(col. 1 + col.	
			Nonprovi der Si te	Hospi tal	2))	
			1.00	2.00	3.00	-
Section 5504 of the ACA Base Year	FTE Residents in No	onprovider Settings-				
period that begins on or after Ju				-		
D0 Enter in column 1, if line 63 is in the base year period, the numb resident FTEs attributable to rot settings. Enter in column 2 the resident FTEs that trained in you	er of unweighted nor ations occurring in number of unweighted r hospital. Enter ir	-primary care all nonprovider d non-primary care n column 3 the ratio	0.00	0.00	0. 000000	0 64.0
of (column 1 divided by (column 1			Linua i sila da al	Linua i mindra al	Datia (asl. 2	/
	Program Name	Program Code	Unweighted FTEs	Unweighted FTEs in	Ratio (col. 3/ (col. 3 + col.	
			Nonprovi der	Hospi tal	(001: 3 + 001:	
			Site		.,,,	
	1.00	2.00	3.00	4.00	5.00	
20 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00 Unwei ghted FTEs	D 0. 00	0.000000 Ratio (col. 1/ (col. 1 + col.	
			Nonprovi der Si te 1.00	Hospi tal	2))	_
Section 5504 of the ACA Current	ear FTE Residents in	n Nonprovider Settin				
beginning on or after July 1, 201	0	•				
D0 Enter in column 1 the number of u FTEs attributable to rotations oc Enter in column 2 the number of u FTEs that trained in your hospita (column 1 divided by (column 1 +	curring in all nonpr nweighted non-primar I. Enter in column 3	rovider settings. ry care resident 3 the ratio of	0.00	0.00	0. 000000	J 66. U
	Program Name	Program Code	Unwei ghted	Unwei ghted	Ratio (col. 3/	/
			FTEs	FTEs in	(col. 3 + col.	
			Nonprovi der	Hospi tal	4))	
	1.00	2.00	Si te 3. 00	4.00	5.00	-
00 Enter in column 1, the program	1.00	2.00	0.00			0 67.0
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						

	Financial Systems FRANCISCAN HEALTH RENSSELAE AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider	CCN: 15-1324 F	In Li Period: From 01/01/202 Fo 12/31/202		2 epared:			
				1.00	-			
68.00	Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 FR 49065- For a cost reporting period beginning prior to October 1, 2022, did you MAC to apply the new DGME formula in accordance with the FY 2023 IPPS Fi (August 10, 2022)?	obtain permissi	on from your		68.00			
			1.	00 2.00 3.00	_			
	Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it com	tain an IPE sub	provi der?	N	70.00			
71.00	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 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			
76.00	subprovider? Enter "Y" for yes and "N" for no. If line 75 is yes: Column 1: Did the facility have an approved GME teach recent cost reporting period ending on or before November 15, 2004? Enter no. Column 2: Did this facility train residents in a new teaching progra CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: indicate which program year began during this cost reporting period. (see	er "Y" for yes o m in accordance f column 2 is Y	r "N" for with 42	0	76.00			
				1.00	_			
	Long Term Care Hospital PPS							
81.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for Is this a LTCH co-located within another hospital for part or all of the "Y" for yes and "N" for no. TEFRA Providers		period? Enter	~ N	80.00 81.00			
85. 00 86. 00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? En Did this facility establish a new Other subprovider (excluded unit) unde §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			N	85. 00 86. 00			
	Is this hospital an extended neoplastic disease care hospital classified 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	l under section		Ν	87.00			
			Approved fo Permanent Adjustment (Y/N) 1.00	r Number of Approved Permanent Adjustments 2.00	_			
	Column 1: Is this hospital approved for a permanent adjustment to the TI amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete 89. (see instructions)		N		0 88.00			
	Column 2: Enter the number of approved permanent adjustments.	Wkst. A Line	Effecti ve Da	te Approved				
		No.		Permanent Adjustment Amount Per Discharge				
89.00	Column 1: If line 88, column 1 is Y, enter the Worksheet A line number	1.00	2.00	3.00	0 89.00			
	on which the per discharge permanent adjustment approval was based. Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amount per discharge.							
	Column 3: Enter the amount of the approved permanent adjustment to the TEFRA target amount per discharge.							
			V 1.00	2.00	_			
	Title V and XIX Services	E 1 11/11 C						
	Does this facility have title V and/or XIX inpatient hospital services? yes or "N" for no in the applicable column.	Enter "Y" for	N	Y	90.00			
	Is this hospital reimbursed for title V and/or XIX through the cost report full or in part? Enter "Y" for yes or "N" for no in the applicable colur Are title XIX NF patients occupying title XVIII SNF beds (dual certifica	ın.	N	Y N	91.00 92.00			
	instructions) Enter "Y" for yes or "N" for no in the applicable column. Does this facility operate an ICF/IID facility for purposes of title V a	und XIX? Enter	N	N	93.00			
	"Y" for yes or "N" for no in the applicable column.							
	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for applicable column.		N	N	94.00			
96.00	If line 94 is "Y", enter the reduction percentage in the applicable colu Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for applicable column.	no in the	0. 00 N	0. 00 N	95.00 96.00			
97.00	If line 96 is "Y", enter the reduction percentage in the applicable colu	imn.	0.00	0.00	97.00			

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA					-2552-10
	Provider C		eriod: rom 01/01/2023 o 12/31/2023	Worksheet S- Part I Date/Time Pro 5/29/2024 8:	epared:
			V	XI X	
98.00 Does title V or XIX follow Medicare (title XVIII) for the insteadown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y"			1.00 Y	2.00 Y	98.00
 column 1 for title V, and in column 2 for title XIX. 98.01 Does title V or XIX follow Medicare (title XVIII) for the rec, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title XIX. 			Y	Y	98. 01
 98.02 Does title V or XIX follow Medicare (title XVIII) for the cabed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes of for title V, and in column 2 for title XIX. 			Y	Y	98. 02
 98.03 Does title V or XIX follow Medicare (title XIX) for a crive inbursed 101% of inpatient services cost? Enter "Y" for year for title V, and in column 2 for title XIX. 			N	Ν	98. 03
 98.04 Does title V or XIX follow Medicare (title XVIII) for a CAH outpatient services cost? Enter "Y" for yes or "N" for no in in column 2 for title XIX. 			N	N	98.04
98.05 Does title V or XIX follow Medicare (title XVIII) and add ba Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in a column 2 for title XIX.			Y	Y	98. 05
98.06 Does title V or XIX follow Medicare (title XVIII) when cost Pts. I through IV? Enter "Y" for yes or "N" for no in column column 2 for title XIX.	Y	Y	98.06		
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	hod of payment	Y N		105. 00 106. 00	
for outpatient services? (see instructions) 107.00 Column 1: If line 105 is Y, is this facility eligible for contraining programs? Enter "Y" for yes or "N" for no in column Column 2: If column 1 is Y and line 70 or line 75 is Y, do approved medical education program in the CAH's excluded II	N		107.00		
Enter "Y" for yes or "N" for no in column 2. (see instruct 107.01 If this facility is a REH (line 3, column 4, is "12"), is i reimbursement for I&R training programs? Enter "Y" for yes of			107. 01		
instructions) 108.00 Is this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	CRNA fee sche	dule? See 42	N		108.00
	Physi cal 1.00	Occupational 2.00	Speech 3.00	Respiratory 4.00	-
109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.		N	N N	N	109.00
			1	1.00	_
110.00 Did this hospital participate in the Rural Community Hospita Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and Wor applicable.	"Y" for yes or	"N" for no. If	° yes,	1.00 N	110.00
Demonstration)for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and Wo	"Y" for yes or	"N" for no. If	[°] yes, jh 215, as	N	110.00
Demonstration)for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and Wo	"Y" for yes or rksheet E-2, I the Frontier C ost reporting olumn 1 is Y, rticipating in	"N" for no. If i nes 200 throug ommunity period? Enter enter the column 2.	° yes,		110.00
Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and Wo applicable. 111.00 If this facility qualifies as a CAH, did it participate in the Health Integration Project (FCHIP) demonstration for this co "Y" for yes or "N" for no in column 1. If the response to co integration prong of the FCHIP demo in which this CAH is participate Enter all that apply: "A" for Ambulance services; "B" for an	"Y" for yes or rksheet E-2, I the Frontier C ost reporting olumn 1 is Y, rticipating in	"N" for no. If i nes 200 throug ommunity period? Enter enter the column 2.	² yes, ph 215, as 1.00	N	_
Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and Wo applicable. 111.00 If this facility qualifies as a CAH, did it participate in the Health Integration Project (FCHIP) demonstration for this co "Y" for yes or "N" for no in column 1. If the response to co integration prong of the FCHIP demo in which this CAH is participate Enter all that apply: "A" for Ambulance services; "B" for an	"Y" for yes or rksheet E-2, I the Frontier C ost reporting olumn 1 is Y, rticipating in dditional beds Ith Model eporting olumn 1 is pating in the	"N" for no. If i nes 200 throug ommunity period? Enter enter the column 2. ; and/or "C"	⁻ yes, _{ph} 215, as <u>1.00</u> N	N 2. 00	_
Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and Wo applicable. 111.00 If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this co "Y" for yes or "N" for no in column 1. If the response to co integration prong of the FCHIP demo in which this CAH is participate and For tele-health services. 112.00 Did this hospital participate in the Pennsylvania Rural Heal (PARHM) demonstration for any portion of the current cost ro period? Enter "Y" for yes or "N" for no in column 1. If co "Y", enter in column 2, the date the hospital began participate in the date the hospital cear integration. In column 3, enter the date the hospital cear	"Y" for yes or rksheet E-2, I the Frontier C ost reporting olumn 1 is Y, rticipating in dditional beds Ith Model eporting olumn 1 is pating in the ased r "N" for no B, or E only) 93" percent (includes	"N" for no. If i nes 200 throug ommuni ty period? Enter enter the column 2. ; and/or "C" 1.00	⁻ yes, _{ph} 215, as <u>1.00</u> N	N 2.00 3.00	111.00
 Demonstration) for the current cost reporting period? Enter from complete Worksheet E, Part A, lines 200 through 218, and Worapplicable. 111.00 If this facility qualifies as a CAH, did it participate in the Health Integration Project (FCHIP) demonstration for this contributed in the properties of the response to contribute of the the temperature of the temperature of the FCHIP demoin which this CAH is participate in the rele-health services. 112.00 Did this hospital participate in the Pennsylvania Rural Heal (PARHM) demonstration for any portion of the current cost respectively. The temperature of temperature of	"Y" for yes or rksheet E-2, I the Frontier C ost reporting olumn 1 is Y, rticipating in dditional beds Ith Model eporting olumn 1 is pating in the ased r "N" for no B, or E only) 93" percent (includes rs) based on for yes or	"N" for no. If i nes 200 throug ommuni ty period? Enter enter the column 2. ; and/or "C" 1.00 N	⁻ yes, _{ph} 215, as <u>1.00</u> N	N 2.00 3.00	111. 00 1112. 00 1115. 00 1116. 00
Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and Wo applicable. 111.00 If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this co "Y" for yes or "N" for no in column 1. If the response to co integration prong of the FCHIP demo in which this CAH is pai Enter all that apply: "A" for Ambulance services; "B" for a for tele-health services. 112.00 Did this hospital participate in the Pennsylvania Rural Heal (PARHM) demonstration for any portion of the current cost re period? Enter "Y" for yes or "N" for no in column 1. If co "Y", enter in column 2, the date the hospital began participid demonstration. In column 3, enter the date the hospital cest participation in the demonstration 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes on in column 1. If column 1 is yes, enter the method used (A, M in column 2. If column 2 is "E", enter in column 3 either "Y for short term hospital or "98" percent for long term care psychiatric, rehabilitation and long term hospitals provided the definition in CMS Pub. 15-1, chapter 22, §2208.1. 116.00 Is this facility classified as a referral center? Enter "Y"	"Y" for yes or rksheet E-2, I the Frontier C ost reporting olumn 1 is Y, rticipating in dditional beds I th Model eporting olumn 1 is pating in the ased r "N" for no B, or E only) 93" percent (includes rs) based on for yes or rance? Enter	"N" for no. If i nes 200 throug ommuni ty peri od? Enter enter the col umn 2. ; and/or "C" 1.00 N	⁻ yes, _{ph} 215, as <u>1.00</u> N	N 2.00 3.00	111. 00 111. 00 112. 00

AITH Financial Systems FRANCISCAN HEALTH RENSSEL SPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provid	ler CCN: 15-1324 Pe	eriod: rom 01/01/2023	u of Form CM Worksheet S Part I	
	Te			
	Premi ums	Losses	Insurance	
	1.00	2.00	3.00	_
18.01 List amounts of malpractice premiums and paid losses:	46, 989			20 118. 0
		1.00	2.00	-
18.02 Are malpractice premiums and paid losses reported in a cost center ot	ther than the	N		118. 0
Administrative and General? If yes, submit supporting schedule listi and amounts contained therein.	ng cost centers			
19.00 DO NOT USE THIS LINE 20.00 Lothic a SCH on EACH that qualifier for the Outpatient Hold Harmlord	novicion in ACA	N	N	119. 0 120. 0
20.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless §3121 and applicable amendments? (see instructions) Enter in column 1		IN	IN	120.0
"N" for no. Is this a rural hospital with < 100 beds that qualifies f				
Hold Harmless provision in ACA §3121 and applicable amendments? (see Enter in column 2, "Y" for yes or "N" for no.	instructions)			
21.00Did this facility incur and report costs for high cost implantable de patients? Enter "Y" for yes or "N" for no.	evices charged to	Y		121.0
22.00 Does the cost report contain healthcare related taxes as defined in §	§1903(w)(3) of the	Y	5.00	122.0
Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", the Worksheet A line number where these taxes are included.	enter in column 2			
23.00Did the facility and/or its subproviders (if applicable) purchase pro		N	N	123. (
services, e.g., legal, accounting, tax preparation, bookkeeping, payr management/consulting services, from an unrelated organization? In cc				
for yes or "N" for no.	Julin I, enter I			
If column 1 is "Y", were the majority of the expenses, i.e., greater professional services expenses, for services purchased from unrelated				
located in a CBSA outside of the main hospital CBSA? In column 2, ent				
"N" for no. Certified Transplant Center Information				_
25.00 Does this facility operate a Medicare-certified transplant center? Er		N		125. (
and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) belo 26.00 If this is a Medicare-certified kidney transplant program, enter the				126. (
in column 1 and termination date, if applicable, in column 2.				
27.00 f this is a Medicare-certified heart transplant program, enter the c in column 1 and termination date, if applicable, in column 2.	certification date			127.0
28.00 If this is a Medicare-certified liver transplant program, enter the c	certification date			128. 0
in column 1 and termination date, if applicable, in column 2. 29.00 If this is a Medicare-certified lung transplant program, enter the ce	ertification date			129. (
in column 1 and termination date, if applicable, in column 2.				
30.00 If this is a Medicare-certified pancreas transplant program, enter th date in column 1 and termination date, if applicable, in column 2.	ne certification			130. (
31.00 If this is a Medicare-certified intestinal transplant program, enter	the certification			131. (
date in column 1 and termination date, if applicable, in column 2. 32.00 If this is a Medicare-certified islet transplant program, enter the c	certification date			132. (
in column 1 and termination date, if applicable, in column 2.				100
33.00 Removed and reserved 34.00 If this is a hospital-based organ procurement organization (OPO), ent	ter the OPO number	_		133. (134. (
in column 1 and termination date, if applicable, in column 2.				_
All Providers 40.00 Are there any related organization or home office costs as defined in	CMS Pub. 15-1,	Y	158014	140. (
chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and are claimed, enter in column 2 the home office chain number. (see ins				
1.00 2.00	,	3.00		
If this facility is part of a chain organization, enter on lines 141 home office and enter the home office contractor name and contractor		ne and address	of the	
1.00 Name: FRANCISCAN ALLIANCE INC Contractor's Name: WPS		's Number: 0810)1	141. (
42.00 Street: 1515 W. DRAGOON TRAIL PO Box: 1290 43.00 City: MISHAWAKA State: IN	Zip Code:	465/	46-1290	142. (143. (
	21 p couc.			
14.00 Are provider based physicians' costs included in Worksheet A?			1.00 Y	144. (
45.00 If costs for renal services are claimed on Wkst. A, line 74, are the	costs for	1.00	2.00	145. (
inpatient services only? Enter "Y" for yes or "N" for no in column 1.	lf column 1 is			145.0
no, does the dialysis facility include Medicare utilization for this period? Enter "Y" for yes or "N" for no in column 2.				
46.00 Has the cost allocation methodology changed from the previously filed		N		146. 0
Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chap	nter 40 §4020) lf		1	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DATA	Provider CC	CN: 15-1324		1/01/2023	Worksheet S- Part I	2
					2/31/2023		
						1.00	_
47.00 Was there a change in the statisti						N	147.0
48.00 Was there a change in the order of				-		N	148.0
49.00 Was there a change to the simplifi	ed cost finding method?	Enter "Y" for ye	es or "N" Part I		itle V	N Title XIX	149.0
		1.00	2.00		3.00	4,00	-
Does this facility contain a provi	der that qualifies for						
or charges? Enter "Y" for yes or '							
55.00Hospi tal		N	N		Ν	N	155. (
56.00 Subprovider - IPF		N	N		N	N	156.0
57.00 Subprovider - IRF		N	N		N	N	157.0
58. 00 SUBPROVI DER 59. 00 SNF		N	N		N	N	158.0
60.00HOME HEALTH AGENCY		N	N N		N	N	160.0
61. OOCMHC		IN IN	N		N	N	161.0
							10110
						1.00	
Multicampus			<u> </u>		<u></u>		
65.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.	impus hospital that has (one or more campu	uses in di	rferent CB	SAS?	N	165.0
	Name	County	State	Zip Code	CBSA	FTE/Campus	
	0	1.00	2.00	3.00	4.00	5.00	
66.00 If line 165 is yes, for each						0.0	0 166. 0
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) incentive in the Amer	ican Recovery an	d Reinvest	ment Act		1.00	
67.00 Is this provider a meaningful user						Y	
68.00 If this provider is a CAH (line 10			e 167 is "'	Y"), enter	the		168. 0
reasonable cost incurred for the H							
68.01 If this provider is a CAH and is r exception under §413.70(a)(6)(ii)?					snip		168. 0
69.00 If this provider is a meaningful utransition factor. (see instruction	ıser (line 167 is "Y") aı	nd is not a CAH	(line 105 i	s"N"), e	nter the	0.0	0169. 0
	113)			Bee	gi nni ng	Endi ng	
					1.00	2.00	-
70.00 Enter in columns 1 and 2 the EHR k period respectively (mm/dd/yyyy)	eginning date and ending	g date for the re	eporting				170. 0
					1 00	2.00	-
71.00 fline 167 is "Y", does this prov	ider have any days for i	individuals enrol	ledin		1.00 N		0171.0
"Y" for yes and "N" for no in colu 1876 Medicare days in column 2. (s	eported on Wkst. S-3, P mn 1. If column 1 is ye	t. I, line 2, col	. 6? Ente		, u		

)SPI T.	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-1324	Period: From 01/01/2023 To 12/31/2023		
				Y/N	5/29/2024 8:	
				1.00	Date 2.00	
	PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURSE					
	General Instruction: Enter Y for all YES responses. Enter N mm/dd/yyyy format.	l for all NO re	esponses. Ente	er all dates in t	the	
	COMPLETED BY ALL HOSPITALS Provider Organization and Operation					-
	Has the provider changed ownership immediately prior to the	e beainnina of	the cost	N		1.(
	reporting period? If yes, enter the date of the change in o)		
			Y/N	Date	V/I	
00	Has the provider terminated participation in the Medicare F	Program2 lf	1.00 N	2.00	3.00	2.0
00	yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary.					2.
00	Is the provider involved in business transactions, includir contracts, with individuals or entities (e.g., chain home or or medical supply companies) that are related to the provid officers, medical staff, management personnel, or members of of directors through ownership, control, or family and other relationships? (see instructions)	offices, drug der or its of the board	Y			3. (
			Y/N	Туре	Date	
			1.00	2.00	3.00	
00	Financial Data and Reports Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" f or "R" for Reviewed. Submit complete copy or enter date ava column 3. (see instructions) If no, see instructions.	for Compiled,	Y	A	04/17/2024	4.
00	Are the cost report total expenses and total revenues diffe those on the filed financial statements? If yes, submit rec		N			5.
				Y/N 1.00	Legal Oper. 2.00	
	Approved Educational Activities Column 1: Are costs claimed for a nursing program? Column	2: If yes, is	s the provider	~ N		6.
00	the legal operator of the program? Are costs claimed for Allied Health Programs? If "Y" see in	nstructions.		N		7.
00	Were nursing programs and/or allied health programs approve cost reporting period? If yes, see instructions.	ed and/or renew	0	e N		8.
00	Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction		cal education	N		9.
	Was an approved Intern and Resident GME program initiated c cost reporting period? If yes, see instructions.			N		10.
I. 00	Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	& R in an App	proved	N	Y/N	11.
					1.00	
	Bad Debts		tiono		Y	1 1 2
	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. 13.
	If line 12 is yes, were patient deductibles and/or coinsura instructions.	ance amounts wa	aived? If yes,	see	Ν	14.
	Bed Complement Did total beds available change from the prior cost reporti	ng period?lf	yes, see inst		N	15.
			rt A		tВ	
		Y/N	Date 2,00	Y/N 3.00	Date	
	PS&R Data	1.00	2.00	3.00	4.00	
	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see	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	Y	03/12/2024	Y	03/12/2024	17.
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 cost report? If yes, see instructions.	Ν		Ν		18.
9. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report	Ν		Ν		19.

Health Financial Systems

FRANCISCAN HEALTH RENSSELAER

In Lieu of Form CMS-2552-10

II th Financial Systems FRANCISCAN HEAL	LTH RENSSELAER		In Lie	u of Form CMS-2	2552-
SPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CC	CN: 15-1324	Period: From 01/01/2023 To 12/31/2023		
				5/29/2024 8:5	
	Descri	iption	Y/N	Y/N	
	(0	1.00	3.00	
00 If line 16 or 17 is yes, were adjustments made to PS&R			N	N	20.
Report data for Other? Describe the other adjustments:				D -	
	Y/N	Date	Y/N	Date	
00 Was the cost report prepared only using the provider's	1.00 N	2.00	3.00 N	4.00	01
00 Was the cost report prepared only using the provider's records? If yes, see instructions.	IN		IN		21.
		1			
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	EPT CHILDRENS H	OSPI TALS)			
Capital Related Cost		,			1
00 Have assets been relifed for Medicare purposes? If yes, see	e instructions			N	22.
00 Have changes occurred in the Medicare depreciation expense	due to apprais	als made dur	ing the cost	N	23.
reporting period? If yes, see instructions.			-		
00 Were new leases and/or amendments to existing leases entered	ed into during	this cost re	porting period?	N	24.
If yes, see instructions	If yes, see instructions				
00 Have there been new capitalized leases entered into during	the cost repor	ting period?	lf yes, see	N	25
instructions.			<u> </u>		
00 Were assets subject to Sec. 2314 of DEFRA acquired during th instructions.	ne cost reporti	ng period? I	r yes, see	N	26
00 Has the provider's capitalization policy changed during the	a cost reportin	a period2 lf	ves submit	N	27
copy.		g period: II	yes, subili t	i v	2'
Interest Expense					1
00 Were new loans, mortgage agreements or letters of credit er	ntered into dur	ing the cost	reporting	N	28
period? If yes, see instructions.		5	1 3		
00 Did the provider have a funded depreciation account and/or		bt Service R	eserve Fund)	Y	29
treated as a funded depreciation account? If yes, see instr					
00 Has existing debt been replaced prior to its scheduled matu	urity with new	debt? If yes	, see	N	30
instructions.	N	1 21			
00 Has debt been recalled before scheduled maturity without is instructions.	ssuance or new	debt? IT yes	, see	N	31
Purchased Services					1
00 Have changes or new agreements occurred in patient care ser	rvices furnishe	d through co	ntractual	Y	32
arrangements with suppliers of services? If yes, see instru		a thi ough oo			02
00 If line 32 is yes, were the requirements of Sec. 2135.2 app		ig to competi	tive bidding? If	N	33
no, see instructions.		- ·	-		
Provi der-Based Physi ci ans					
00 Were services furnished at the provider facility under an a	arrangement wit	h provider-b	ased physicians?	Y	34
If yes, see instructions.					
00 If line 34 is yes, were there new agreements or amended exi		ts with the	provi der-based	Y	35
physicians during the cost reporting period? If yes, see in	nstructions.		Y/N	Date	
			1.00	2.00	
Home Office Costs			1.00	2.00	-
00 Were home office costs claimed on the cost report?			Y		36
00 If line 36 is yes, has a home office cost statement been pr	repared by the	home office?			37
If yes, see instructions.	,				
00 If line 36 is yes, was the fiscal year end of the home of	fice different	from that of	N		38
the provider? If yes, enter in column 2 the fiscal year end	d of the home o	offi ce.			
00 If line 36 is yes, did the provider render services to othe	er chain compon	ents? If yes	, N		39
see instructions.					
00 If line 36 is yes, did the provider render services to the	home office?	lf yes, see	N		40
instructions.	1				
	1	00	2	00	-
Cost Report Preparer Contact Information	1.	00	2.	00	
	HONG		YANG		41
			TANG		41
00 Enter the first name, last name and the title/position	10100		1		11
00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	nono				
00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.		LANCE			42
 00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. 00 Enter the employer/company name of the cost report 	FRANCI SCAN ALL	I ANCE			42.
 00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. 00 Enter the employer/company name of the cost report preparer. 		I ANCE	HONG. YANG@FRAN	CI SCANALLI ANCF	42.

Heal th	Financial Systems	FRANCI SCAN HEAL	TH RENSSELAE	R	In Lie	u of Form CMS-	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT	QUESTI ONNAI RE	Provi der	CCN: 15-1324	Period:	Worksheet S-2	
					From 01/01/2023 To 12/31/2023		pared: <u>6 am</u>
				3.00			
	Cost Report Preparer Contact Information						
41.00	Enter the first name, last name and the t	itle/position	ADMI NI STRATI '	VE DIRECTOR			41.00
	held by the cost report preparer in colum	ins 1, 2, and 3,					
	respecti vel y.						
42.00	Enter the employer/company name of the co	st report					42.00
	preparer.						
43.00	Enter the telephone number and email addr	ess of the cost					43.00
	report preparer in columns 1 and 2, respe	cti vel y.					

HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CC	CN: 15-1324	Period: From 01/01/2023	Worksheet S-3 Part I	
					To 12/31/2023	Date/Time Prep 5/29/2024 8:50	
						I/P Days / O/P	
	Component	Worksheet A Line No.	No. of Beds	Bed Days Available	CAH/REH Hours	<u>Visits / Trips</u> Title V	
		1.00	2.00	3.00	4.00	5.00	
	PART I – STATISTICAL DATA						
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)	30.00	25	9, 12	25 28, 824. 00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO I PF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		25	9, 12		0	7.00
8.00	INTENSIVE CARE UNIT	31.00	0		0 0.00	0	8.00
9.00	CORONARY CARE UNIT	32.00	0		0 0.00	0	9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGI CAL I NTENSI VE CARE UNI T						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 14.00	NURSERY		25	9, 12	25 28, 824. 00	0	13.00
14.00	Total (see instructions) CAH visits		20	9, 12	20, 024. 00	0	14.00
15.10	REH hours and visits				0.00	0	15.00
16.00	SUBPROVIDER - IPF				0.00	0	16.00
17.00	SUBPROVIDER - IRF						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		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	RURAL HEALTH CLINIC II	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	
29.00	Ambul ance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0		0		32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.00	LTCH site neutral days and discharges						33.00
	Eron or to noutrar days and drocharges				1		1 00.01

OSPI 1	TAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CC	CN: 15-1324	Period: From 01/01/202 To 12/31/202		epared
		I/P Days	/ O/P Visits	/ Trips	Full Time	Equi val ents	
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Payrol I	
		6.00	7.00	8.00	9.00	10.00	
00	PART I - STATISTICAL DATA	520	0	0(24	1	1
. 00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and	528	8	84	94		1.
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
00	HMO and other (see instructions)	206	67				2.
. 00	HMO IPF Subprovider	0	0				3.
00	HMO IRF Subprovider	0	0				4.
00	Hospital Adults & Peds. Swing Bed SNF	287	0		87		5.
00	Hospital Adults & Peds. Swing Bed NF		0		40		6.
00	Total Adults and Peds. (exclude observation	815	8	1, 32	21		7.
~~	beds) (see instructions)				-		
00	INTENSIVE CARE UNIT	0	0		0		8.
00 . 00	CORONARY CARE UNI T BURN INTENSI VE CARE UNI T	0	0		0		9.
. 00	SURGI CAL INTENSIVE CARE UNIT						11
. 00	OTHER SPECIAL CARE (SPECIFY)						12
. 00	NURSERY						13
. 00	Total (see instructions)	815	8	1, 32	0.0	0 118.01	
. 00	CAH visits	0	0	1, 0.	0	110.01	15
. 10	REH hours and visits	0	0		0		15
. 00	SUBPROVIDER - IPF						16
. 00	SUBPROVIDER - IRF						17
. 00	SUBPROVI DER						18
. 00	SKILLED NURSING FACILITY						19
. 00	NURSING FACILITY						20
. 00	OTHER LONG TERM CARE						21
. 00	HOME HEALTH AGENCY	0	0		0 0.0		
. 00	AMBULATORY SURGICAL CENTER (D. P.)				0.0		
. 00	HOSPI CE	0	0		0 0.0	0 0.00	
. 10	HOSPICE (non-distinct part) CMHC - CMHC				0		24
. 00	RURAL HEALTH CLINIC	254	418	7,	69 0.0	0 2.76	
. 00	RURAL HEALTH CLINIC II	204 504	508	1.69			
. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	1, 0	0 0.0		
. 00	Total (sum of lines 14-26)	0	0		0.0		
. 00	Observation Bed Days		117	60	02		28
00	Ambul ance Trips	0			-		29
. 00	Employee discount days (see instruction)				0		30
. 00	Employee discount days - IRF				0		31
. 00	Labor & delivery days (see instructions)	0	0		0		32
. 01	Total ancillary labor & delivery room				0		32
	outpatient days (see instructions)						
. 00	LTCH non-covered days	0					33
3. 01	LTCH site neutral days and discharges	0					33
1.00	Temporary Expansion COVID-19 PHE Acute Care	0	0		0		34

)SPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider C	CN: 15-1324	Period: From 01/01/2023 To 12/31/2023	Worksheet S-3 Part I Date/Time Pre 5/29/2024 8:5	pare
		Full Time	·	Di s	charges		
	Component	Equi val ents Nonpai d Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
~~	PART I - STATISTICAL DATA					070	
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)		()	92 3	378	1.
00	HMO and other (see instructions)				72 20		2.
00	HMO I PF Subprovi der				0		3
00	HMO I RF Subprovider				0		4
00 00	Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF						5
00	Total Adults and Peds. (exclude observation beds) (see instructions)						7
00	INTENSIVE CARE UNIT						8
00	CORONARY CARE UNIT						9
. 00 . 00	BURN INTENSIVE CARE UNIT						10
. 00	SURGI CAL I NTENSI VE CARE UNI T OTHER SPECIAL CARE (SPECI FY)						12
. 00	NURSERY						13
. 00	Total (see instructions)	0, 00	(10	92 3	378	
5.00	CAH visits	0.00			5	0/0	15
. 10	REH hours and visits						15
. 00	SUBPROVIDER - IPF						16
. 00	SUBPROVIDER - IRF						17
8. 00	SUBPROVI DER						18
. 00	SKILLED NURSING FACILITY						19
. 00	NURSING FACILITY						20
. 00	OTHER LONG TERM CARE						21
. 00	HOME HEALTH AGENCY	0.00					22
. 00	AMBULATORY SURGICAL CENTER (D. P.) HOSPICE	0. 00 0. 00					23
. 10	HOSPICE HOSPICE (non-distinct part)	0.00					24
5.00	CMHC - CMHC						25
. 00	RURAL HEALTH CLINIC	0.00					26
. 01	RURAL HEALTH CLINIC II	0.00					26
. 25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26
. 00	Total (sum of lines 14-26)	0.00					27
. 00	Observation Bed Days						28
. 00	Ambul ance Trips						29
). 00	Employee discount days (see instruction)						30
. 00	Employee discount days - IRF						31
2.00	Labor & delivery days (see instructions)						32
2. 01	Total ancillary labor & delivery room						32
8. 00	outpatient days (see instructions) LTCH non-covered days				0		33
s. 00 s. 01	LTCH non-covered days LTCH site neutral days and discharges				0		33
. 00	Temporary Expansi on COVID-19 PHE Acute Care				J J		34

Heal th	Financial Systems F	RANCI SCAN HEAL	TH RENSSELAER		In Li	eu of Form CMS-	2552-10
HOSPI T	AL-BASED RHC/FQHC STATISTICAL DATA		Provider C	CN: 15-1324	Period:	Worksheet S-8	3
			Component (CCN: 15-3990	From 01/01/202 To 12/31/202		
					RHC I	Cost	
					1	. 00	-
	Clinic Address and Identification						
1.00	Street		Ci	+\/	429 S BI ERMA State	ST ZIP Code	1.00
		-	1.		2.00	3.00	
2.00	City, State, ZIP Code, County	N	WHEATFIELD			N 47978	2.00
						1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Ente	er "R" for rura	l or "U" for u	rban		0	3.00
					nt Award	Date	
	Source of Federal Funds				1.00	2.00	-
4.00	Community Health Center (Section 330(d), PHS	Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Ac						5.00
6.00 7.00	Health Services for the Homeless (Section 340 Appalachian Regional Commission	(d), PHS Act)					6.00 7.00
8.00	Look-Alikes						8.00
9.00	OTHER (SPECIFY)						9.00
					1.00	2.00	
10.00						0	10.00
	yes or "N" for no in column 1. If yes, indica 2. (Enter in subscripts of line 11 the type of hours.)						
		Sund	day	Μ	londay	Tuesday	
		from	to	from	to	from	
	Facility hours of operations (1)	1.00	2.00	3.00	4.00	5.00	
11.00				07:00	16: 30	07:00	11.00
				•			
12.00	Have you received an approval for an exception	n to the produ	ctivity standa	rd?	1.00 Y	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 colu number of providers included in this report. numbers below.	lin CMS Pub. 1 mn 1. If yes,	00-04, chapter enter in colum	9, section n 2 the	N	С	
13. 01	If line 13, column 1, is "Y", are you reporti in CMS Pub. 100-02, chapter 13, section 80.2) yes, enter in column 2 the number of consolic separate Worksheet S-8 for each consolidated are comprised exclusively of grandfathered co comprised exclusively of new consolidated RHC	? Enter "Y" f lated RHC group RHC grouping. onsolidated RHC	or yes or "N" ings and compl Consolidated s in the group	for no. If ete a RHC grouping		c	13. 01
	· · · · · · · · · · · · · · · · · · ·	., .			ider name	CCN	
14.00					1.00	2.00	14.00
14.00	RHC/FQHC name, CCN	Y/N	V	XVIII	XI X	Total Visits	14.00
		1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)						15.00

Health Financial Systems	FRANCI SCAN HEALTH RENSSELAER			In Lie	2552-10	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider C	CN: 15-1324	Period: From 01/01/2023	Worksheet S-8	3
		Component	CCN: 15-3990	To 12/31/2023	Date/Time Pre 5/29/2024 8:5	epared: 66 am
		_		RHC I	Cost	
		Cou	unty			
		4.	00			
2.00 City, State, ZIP Code, County						2.00
	Tuesday	Wedn	Wednesday		sday	
	to	from	to	from	to	
	6.00	7.00	8.00	9.00	10.00	
Facility hours of operations (1)						
11.00 CLINIC	16: 30	07:00	16: 30			11.00
	Fri	day	Sa	turday		
	from	to	from	to		
	11.00	12.00	13.00	14.00		
Facility hours of operations (1)						
11.00 CLINIC	08: 00	16: 30				11.00

Heal th	Financial Systems F	RANCI SCAN HEAL	TH RENSSELAER		In Li	eu of Form CMS-	2552-10
HOSPI T	AL-BASED RHC/FQHC STATISTICAL DATA		Provider C		Period:	Worksheet S-8	3
			Component (From 01/01/202 To 12/31/202		
					RHC II	Cost	
							_
	Clinic Address and Identification				1	. 00	
1.00	Street				420 E. MAIN S	TREET	1.00
	· · ·			ty	State	ZIP Code	
2.00	City Chata 71D Cada County		1.	00	2.00	3.00	2.00
2.00	City, State, ZIP Code, County		BROOK			N 47922	2.00
						1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Ente	er "R" for rura	l or "U" for u			(3.00
					Award	Date	
	Source of Federal Funds			1.	. 00	2.00	
4.00	Community Health Center (Section 330(d), PHS	Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Ac	ct)					5.00
6.00	Health Services for the Homeless (Section 340	O(d), PHS Act)					6.00
7.00 8.00	Appalachian Regional Commission						7.00 8.00
9.00	OTHER (SPECIFY)						9.00
				•			
10.00					1.00	2.00	
10.00	Does this facility operate as other than a hore yes or "N" for no in column 1. If yes, indicated by the second sec				N	(0 10.00
	2. (Enter in subscripts of line 11 the type of						
	hours.)	Sund	dav	Мог	nday	Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
11 00	Facility hours of operations (1)			07.00	14.20	07.00	1 11 00
11.00	CLINIC			07:00	16: 30	07:00	11.00
					1.00	2.00	
	Have you received an approval for an exception				Y		12.00
13.00	Is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in colu				N	0	13.00
	number of providers included in this report.						
	numbers below.						
13.01	If line 13, column 1, is "Y", are you reporti in CMS Pub. 100-02, chapter 13, section 80.2)				N	(13.01
	yes, enter in column 2 the number of consolic						
	separate Worksheet S-8 for each consolidated						
	are comprised exclusively of grandfathered co			ing or			
	comprised exclusively of new consolidated RHC	s in the group	rng.	Provid	ler name	CCN	
					. 00	2.00	
14.00	RHC/FQHC name, CCN						14.00
		Y/N	V 2.00	XVIII	XI X	Total Visits	
15.00	Have you provided all or substantially all	1.00	2.00	3.00	4.00	5.00	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.						
	(see instructions)				1		

Health Financial Systems	FRANCI SCAN HEAL	TH RENSSELAER		In Lie	u of Form CMS-	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider C	CN: 15-1324	Period: From 01/01/2023	Worksheet S-8	3
		Component	CCN: 15-8502	To 12/31/2023	Date/Time Pre 5/29/2024 8:5	epared: 56 am
				RHC II	Cost	
		Col	inty			
		4.	00			
2.00 City, State, ZIP Code, County						2.00
	Tuesday	Wedn	Wednesday		sday	
	to	from	to	from	to	
	6.00	7.00	8.00	9.00	10.00	
Facility hours of operations (1)						
11.00 CLINIC	16: 30	07:00	16: 30	07:00	16: 30	11.00
	Fri	day	Sa	turday		
	from	to	from	to		
	11.00	12.00	13.00	14.00		
Facility hours of operations (1)			•			
11.00 CLINIC						11.00

Health Financial Systems	FRANCI SCAN HEALTH	RENSSELAER	In Lie	u of Form CMS-2	2552-10
HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 15-1324	Peri od:	Worksheet S-1	0
			From 01/01/2023	Parts I & II	
			To 12/31/2023	Date/Time Pre	pared:
				5/29/2024 8:5	6 am
				1.00	
PART I - HOSPITAL AND HOSPITAL COMPLEX DATA					
Uncompensated and Indigent Care Cost-to-Cha	rge Ratio				

	Uncompensated and Indigent Care Cost-to-Charge Ratio					
1.00	Cost to charge ratio (see instructions)			0. 319291	1.00	
	Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid			5, 085, 724	2.00	
3.00	Did you receive DSH or supplemental payments from Medicaid?			N	3.00	
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payment	s from Medicaid	1?		4.00	
5.00	5.00 If line 4 is no, then enter DSH and/or supplemental payments from Medicaid					
6.00	Medi cai d charges			18, 961, 059	6.00	
7.00	Medicaid cost (line 1 times line 6)			6, 054, 095	7.00	
8.00	Difference between net revenue and costs for Medicaid program (see instru	ictions)		968, 371		
	Children's Health Insurance Program (CHIP) (see instructions for each lin					
9.00	Net revenue from stand-al one CHIP			0	9.00	
10.00	Stand-al one CHIP charges			0	10.00	
11.00	Stand-alone CHIP cost (line 1 times line 10)			0	11.00	
12.00	Difference between net revenue and costs for stand-alone CHIP (see instru	ictions)		0	12.00	
	Other state or local government indigent care program (see instructions f	or each line)		_		
13.00	13.00 Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)					
14.00	Charges for patients covered under state or local indigent care program (Not included in	n lines 6 or	0	14.00	
	10)			0	15.00	
	15.00 State or local indigent care program cost (line 1 times line 14)					
16.00	Difference between net revenue and costs for state or local indigent care				16.00	
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and stat	e/local indiger	it care program	ns (see		
17 00	instructions for each line)					
	Government grants, appropriations or transfers for support of hospital op		our of Linco	0 0 0 271	18.00 19.00	
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent 8, 12 and 16)	care programs (sum of times	968, 371	19.00	
		Uni nsured	Insured	Total (col. 1		
		patients	patients	+ col . 2)		
		1.00	2.00	3.00		
	Uncompensated care cost (see instructions for each line)					
20.00	Charity care charges and uninsured discounts (see instructions)	2, 877, 577	0	2, 877, 577	20.00	
21.00	Cost of patients approved for charity care and uninsured discounts (see	918, 784	0	918, 784	21.00	
	instructions)					
22.00	Payments received from patients for amounts previously written off as	0	0	0	22.00	
	chari ty care					
23.00	Cost of charity care (see instructions)	918, 784	0	918, 784	23.00	
				1.00		
24.00	Does the amount on line 20 col. 2, include charges for patient days beyon	id a length of s	stay limit	N	24.00	
25 00	imposed on patients covered by Medicaid or other indigent care program?		longth of	0	25.00	
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent stav limit	care program s	s length of	0	25.00	
25.01	Charges for insured patients' liability (see instructions)			0	25.01	
	Bad debt amount (see instructions)			1, 020, 591		
	Medicare reimbursable bad debts (see instructions)			498, 078		
	Medicare allowable bad debts (see instructions)			766, 274		
	Non-Medicare bad debt amount (see instructions)			254, 317		
	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see	instructions)		349, 397		
	Cost of uncompensated care (line 23, col. 3, plus line 29)	11311 4011 0113)		1, 268, 181	30.00	
	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			2, 236, 552		
57.00				1 2,200,002	1 0 00	

Health Financial Systems	FRANCI SCAN HEALTH RENSSELAER	In Lieu	u of Form CMS-2552-10
HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 15-1324	From 01/01/2023 To 12/31/2023	Worksheet S-10 Parts I & II Date/Time Prepared:

	Worksheet	S-10
1/01/2023	Darte I &	11

	5/29/2024	8:56 am
31/2023	Date/Time	Prepared:
	1011310	

				1.00	
	PART II - HOSPITAL DATA			1.00	
	Uncompensated and Indigent Care Cost-to-Charge Ratio				-
1.00	Cost to charge ratio (see instructions)				1.00
1.00	Medicaid (see instructions for each line)				1.00
2.00	Net revenue from Medicaid			2.00	
3.00	Did you receive DSH or supplemental payments from Medicaid?				3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payment	s from Medicai	d?		4,00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicai				5.00
6.00	Medi cai d charges				6.00
7.00	Medicaid cost (line 1 times line 6)				7.00
8.00	Difference between net revenue and costs for Medicaid program (see instru	ictions)			8.00
	Children's Health Insurance Program (CHIP) (see instructions for each lin	e)		-	
9.00	Net revenue from stand-alone CHIP				9.00
10.00	Stand-al one CHIP charges				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 (see instru	/			12.00
12 00	Other state or local government indigent care program (see instructions f Net revenue from state or local indigent care program (Not included on li				13.00
13.00 14.00	Charges for patients covered under state or local indigent care program (Not included on in				13.00
14.00	10)		II THES 0 UI		14.00
15.00	State or local indigent care program cost (line 1 times line 14)				15.00
	Difference between net revenue and costs for state or local indigent care	e program (see	instructions)		16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and stat			ms (see	
	instructions for each line)	0			
17.00	Private grants, donations, or endowment income restricted to funding char	ity care			17.00
18.00	Government grants, appropriations or transfers for support of hospital op				18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent	care programs	(sum of lines		19.00
	8, 12 and 16)	Uni nsured	Insured	Total (col. 1	
		patients	patients	+ col . 2)	
		1.00	2.00	3.00	
	Uncompensated care cost (see instructions for each line)				
20.00	Charity care charges and uninsured discounts (see instructions)				20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see				21.00
	instructions)				
22.00	Payments received from patients for amounts previously written off as				22.00
	chari ty care				
23.00	Cost of charity care (see instructions)				23.00
				1.00	
24.00	Does the amount on line 20 col. 2, include charges for patient days beyon	d a length of	stav limit	1.00	24.00
21.00	imposed on patients covered by Medicaid or other indigent care program?	a a rongen or	otaj mint		2
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent	care program'	s length of		25.00
	stay limit		-		
25.01	Charges for insured patients' liability (see instructions)				25.01
26.00	Bad debt amount (see instructions)				26.00
27.00	Medicare reimbursable bad debts (see instructions)				27.00
27.01	Medicare allowable bad debts (see instructions)				27.01
28.00	Non-Medicare bad debt amount (see instructions)				28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see	instructions)			29.00
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29) Total unreimbursed and uncompensated care cost (line 19 plus line 30)				30.00 31.00
51.00	Total unicimparsed and uncompensated care cost (True 14 prus True 30)			I	1 31.00

Health Financial Systems RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	FRANCI SCAN HEALT	H RENSSELAER	CN: 15-1324 P	In Lie eriod:	u of Form CMS-: Worksheet A	2552-10
			F	rom 01/01/2023 o 12/31/2023	Date/Time Pre 5/29/2024 8:5	
Cost Center Description	Sal ari es	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
	1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS						
1.00 00100 CAP REL COSTS-BLDG & FIXT		1, 182, 616			1, 266, 450	•
2.00 00200 CAP REL COSTS-MVBLE EQUIP		0				•
3. 00 00300 OTHER CAP REL COSTS 4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT	17, 610	0 2, 661, 940	-	-	0 2, 679, 550	
5. 00 00500 ADMINI STRATI VE & GENERAL	833, 550	11, 257, 191			11, 898, 017	•
7.00 00700 OPERATION OF PLANT	500, 689	1, 293, 434			1, 742, 497	•
8.00 00800 LAUNDRY & LINEN SERVICE	6, 517	305			6, 822	
9. 00 00900 HOUSEKEEPI NG	395, 819	164, 337	560, 156	-28, 761	531, 395	9.00
10. 00 01000 DI ETARY	236, 198	231, 232			80, 178	
11. 00 01100 CAFETERIA	0	0	-		378, 901	
13. 00 01300 NURSI NG ADMI NI STRATI ON	150, 846	108, 372			157, 234 59, 253	
14. 00 01400 CENTRAL SERVICES & SUPPLY 15. 00 01500 PHARMACY	16, 150 352, 806	47, 250 3, 385, 219			398, 740	
16. 00 01600 MEDICAL RECORDS & LIBRARY	0	3, 303, 219			0	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	1, 796, 122	350, 409	2, 146, 531	-23, 843	2, 122, 688	30.00
31.00 03100 INTENSIVE CARE UNIT	0	0			0	
32. 00 03200 CORONARY CARE UNI T	0	0	0	0	0	32.00
ANCI LLARY SERVI CE COST CENTERS	7/7 570	220.002	1 10/ 5/5	174 077	022 100	50.00
50. 00 05000 OPERATI NG ROOM 54. 00 05400 RADI OLOGY-DI AGNOSTI C	767, 572 1, 206, 451	338, 993 372, 150			932, 188 1, 280, 474	•
60. 00 06000 LABORATORY	1, 200, 431	2, 423, 333				
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	2, 120, 000		37, 878		1
65. 00 06500 RESPI RATORY THERAPY	668, 700	33, 843			671, 768	1
66. 00 06600 PHYSI CAL THERAPY	480, 231	30, 152	510, 383	-9, 905	500, 478	66.00
66.01 06601 PHYSICAL THERAPY- WHEATFIELD	308, 857	8, 040			314, 590	
67. 00 06700 OCCUPATIONAL THERAPY	163, 480	4, 413			166, 909	
67. 01 06701 0CCUPATIONAL THERAPY- WHEATFIELD 68. 00 06800 SPEECH PATHOLOGY	90, 987 105, 885	5, 451 2, 366			96, 066 108, 251	•
68. 01 06800 SPEECH PATHOLOGY WHEATFIELD	154, 036	4, 806			158, 470	
69. 00 06900 ELECTROCARDI OLOGY	0	0			0	
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	•
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	694, 587	694, 587	0	694, 587	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	142, 011			142, 011	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	-		3, 410, 034	
74.00 07400 RENAL DIALYSIS	0	0	-	-	0	
77.00 07700 ALLOGENEIC HSCT ACQUISITION 78.00 07800 CAR T-CELL IMMUNOTHERAPY	0	0		-	0	
OUTPATIENT SERVICE COST CENTERS	<u> </u>	0	0	0	0	/0.00
88. 00 08800 RURAL HEALTH CLINIC	213, 448	51, 915	265, 363	-21, 823	243, 540	88.00
88.01 08801 RURAL HEALTH CLINIC II	276, 881	54, 055			284, 260	88.01
90. 00 09000 CLINIC	1, 014, 417	522, 830				
90. 01 09001 WOUND CARE	35, 444	12, 720				
91.00 09100 EMERGENCY	1, 228, 856	1, 349, 226	2, 578, 082	-18, 137	2, 559, 945	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS						92.00
95. 00 09500 AMBULANCE SERVICES	0	0	0	0	0	95.00
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0	0				98.00
101.00 10100 HOME HEALTH AGENCY	0	0	0	0		101.00
102.00 10200 OPIOLD TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS	1					
113.00 11300 INTEREST EXPENSE		0				113.00
115. 00 11500 AMBULATORY SURGI CAL CENTER (D. P.) 116. 00 11600 HOSPI CE	0	0	0	0		115.00 116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	11, 021, 552	26, 733, 423	37, 754, 975	-	37, 754, 975	
NONREI MBURSABLE COST CENTERS	11,021,002	20,700,120	07,701,770	0	07,701,770	110.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3, 015	3, 015	0	3, 015	190.00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	0		192.00
194. 00 07950 ALTERNACARE	0	0	0	0		194.00
194. 01 07951 SPORTS MEDI CI NE	0	0	0	0		194.01
194.02 07952 UNUSED_SPACE 194.03 07953 LAFAYETTE_HHA_BRANCH	0	0		0		194. 02 194. 03
200.00 TOTAL (SUM OF LINES 118 through 199)	11, 021, 552	26, 736, 438	37, 757, 990	-		
	, 52 1, 552	20, 00, 100		. 0		1-00.00

					ne Prepare
	Cost Center Description	Adjustments	Net Expenses	5/29/202	24 8:56 am
		(See A-8)	For Allocation		
		6.00	7.00		
	GENERAL SERVICE COST CENTERS				
00	00100 CAP REL COSTS-BLDG & FIXT	299, 445	1, 565, 895		1.
00	00200 CAP REL COSTS-MVBLE EQUIP	0	989, 286		2.
00	00300 OTHER CAP REL COSTS	0	0		3.
00	00400 EMPLOYEE BENEFITS DEPARTMENT	88, 104	2, 767, 654		4.
00	00500 ADMINI STRATI VE & GENERAL	-657,003	11, 241, 014		5.
00	00700 OPERATION OF PLANT	-11, 781	1, 730, 716		7.
00	00800 LAUNDRY & LINEN SERVICE	0			8.
00	00900 HOUSEKEEPI NG	0			9.
0. 00	01000 DI ETARY	0	80, 178		10.
	01100 CAFETERI A	-88, 577			11.
	01300 NURSI NG ADMI NI STRATI ON	192, 308			13.
	01400 CENTRAL SERVICES & SUPPLY	-84, 143			14.
	01500 PHARMACY	500, 782			15.
	01600 MEDICAL RECORDS & LIBRARY	0			16.
. 00		0	0		10.
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	-643, 979	1, 478, 709		30.
		-043, 979			
	03100 I NTENSI VE CARE UNI T	0	0		31
. 00	O3200 CORONARY CARE UNIT	0	0		32
	ANCI LLARY SERVICE COST CENTERS	445 011	E14 202		
	O5000 OPERATING ROOM	-415, 866			50
	05400 RADI OLOGY-DI AGNOSTI C	-30, 572			54
	06000 LABORATORY	0			60
	06300 BLOOD STORING, PROCESSING & TRANS.	0			63
	06500 RESPI RATORY THERAPY	-16, 519	655, 249		65
	06600 PHYSI CAL THERAPY	-1, 862	498, 616		66
	06601 PHYSI CAL THERAPY- WHEATFI ELD	0			66
. 00	06700 OCCUPATI ONAL THERAPY	-889	166, 020		67
. 01	06701 OCCUPATIONAL THERAPY- WHEATFIELD	0	96, 066		67
8.00	06800 SPEECH PATHOLOGY	0	108, 251		68
8. 01	06801 SPEECH PATHOLOGY- WHEATFIELD	0	158, 470		68.
00 .	06900 ELECTROCARDI OLOGY	0	0		69
0. 00	07000 ELECTROENCEPHALOGRAPHY	0	0		70
. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	694, 587		71
2. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	142, 011		72
8. 00	07300 DRUGS CHARGED TO PATIENTS	0	3, 410, 034		73
. 00	07400 RENAL DI ALYSI S	0	0		74
	07700 ALLOGENEIC HSCT ACQUISITION	0	o		77
	07800 CAR T-CELL IMMUNOTHERAPY	0	o		78
	OUTPATIENT SERVICE COST CENTERS				
3. 00	08800 RURAL HEALTH CLINIC	-7, 432	236, 108		88
	08801 RURAL HEALTH CLINIC II	-150			88
	09000 CLINIC	-413, 824			90
	09001 WOUND CARE	-413, 024	44, 278		90
	09100 EMERGENCY	-3, 571			91
	09200 OBSERVATION BEDS (NON-DISTINCT PART	-3, 371	2,000,014		92
. 00	OTHER REIMBURSABLE COST CENTERS				
00	09500 AMBULANCE SERVICES	0	0		95
	09850 OTHER REIMBURSABLE COST CENTERS	0	0		93
	10100 HOME HEALTH AGENCY	0			101
		0			
∠.00	10200 OPI OLD TREATMENT PROGRAM	0			102
2	SPECIAL PURPOSE COST CENTERS	^			
	11300 INTEREST EXPENSE	0	0		113
	11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0		115
		0			116
8.00		-1, 295, 529	36, 459, 446		118
_	NONREI MBURSABLE COST CENTERS		-		
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3, 015		190
	19200 PHYSICIANS' PRIVATE OFFICES	0	0		192
	07950 ALTERNACARE	0	0		194
4.01	07951 SPORTS MEDI CI NE	0	0		194
	07952 UNUSED SPACE	0	0		194
	07953 LAFAYETTE HHA BRANCH	0	0		194
4.00	TOTAL (SUM OF LINES 118 through 199)		36, 462, 461		200

 Health Financial Systems
 FRANCI SCAN HEALTH RENSSELAER
 In Lieu of Form CMS-2552-10

SI FI CATI ONS			Provider CCN: 15-1	324 Peri od: From 01/01/2023 To 12/31/2023	Worksheet A-6 Date/Time Prepare 5/29/2024 8:56 an
Cost Center	Increases Line #	Salary	Other		
2.00	3.00	4.00	5.00		
A – CAFETERIA					
CAFETERI A	<u>11.00</u>	19 <u>1, 0</u> 25	18 <u>7, 8</u> 76		1
		191, 025	187, 876		
B - PROPERTY INSURANCE CAP REL COSTS-BLDG & FIXT	1.00	0	46, 306		1
		0	46, 306		
C - HOUSEKEEPING	I	-1			
OPERATING ROOM	50.00	28, 492	0		1
0		28, 492	0		
D - DRUGS DRUGS CHARGED TO PATIENTS	73.00	0	3, 410, 034		1
DRUGS CHARGED TO PATTENTS	0.00	0	3, 410, 034		2
	0.00	o	0		3
	0.00	О	0		4
	0.00	0	0		5
	0.00	0	0		6
	0.00 0.00	0	0		7
	0.00	0	0		C
	0.00	0	0		10
	0.00	0	0		11
	0.00	0	0		12
		0	<u> </u>		13
E - DEPRECIATION		Ŋ	3, 410, 034		
CAP REL COSTS-BLDG & FIXT	1.00	0	37, 528		1
CAP REL COSTS-MVBLE EQUIP	2.00	0	845, 027		2
	0.00	0	0		3
	0.00 0.00	0	0		2
	0.00	0	0		
	0.00	o	0		
	0.00	О	0		8
	0.00	0	0		
	0.00 0.00	0	0		10
	0.00	0	0		1:
	0.00	o	0		1
	0.00	0	0		14
	0.00	0	0		15
	0.00 0.00	0	0		16
	0.00	0	0		18
	0.00	0	0		10
	0.00	0	0		20
	0.00	0	0		21
TOTALS	0.00	0	0		22
F - CAPITAL LEASE		U	882, 555		
CAP REL COSTS-MVBLE EQUIP	2.00	0	144, 259		1
	0.00	0	0		2
	0.00	0	0		3
	0.00 0.00	0	0		5
	0.00	0	0		
	0.00	o	0		7
TOTALS		0	144, 259		
G - BLOOD		_			
BLOOD STORING, PROCESSING &	63.00	32, 825	5, 280		1
TRANS.	0.00	о	0		2
	0.00	0	0		3
TOTALS		32, 825	5, 280		
Grand Total: Increases		252, 342	4, 676, 310		500

CLASSI F	nancial Systems TCATIONS		RANCI SCAN HEALT		CCN: 15-1324	Peri od:	u of Form CMS-2552 Worksheet A-6
						From 01/01/2023 To 12/31/2023	Date/Time Prepar
		Decreases				<u> </u>	5/29/2024 8:56 a
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref	<u>.</u>	
0	<u>6.00</u>	7.00	8.00	9.00	10.00		
	- CAFETERI A ETARY	10.00	191, 025	187, 876		0	1
0			191, 025	187, 876			
В	- PROPERTY INSURANCE						
00 AD	MI NI STRATI VE & GENERAL	5.00	0	46, 306		12	1
0			0	46, 306	b		
	- HOUSEKEEPING	0.00	20, 402			0	1
00 HO	DUSEKEEPING		2 <u>8, 492</u> 28, 492	0		0	1
D	- DRUGS		20, 472	(
	MINISTRATIVE & GENERAL	5.00	0	27	1	0	1
	NTRAL SERVICES & SUPPLY	14.00	0	379		0	2
)0 РН	IARMACY	15.00	0	3, 316, 941		0	3
	OULTS & PEDIATRICS	30.00	0	265		0	4
	PERATING ROOM	50.00	0	3, 892		0	5
	DI OLOGY-DI AGNOSTI C	54.00	0	34, 587		0	6
	BORATORY IYSI CAL THERAPY	60.00 66.00	0	187 188		0	7
	IYSICAL THERAPY - WHEATFIELD	66.01	0	367			9
	IRAL HEALTH CLINIC	88.00	o	21, 823		0	10
	IRAL HEALTH CLINIC II	88.01	0	30, 461		0	11
oo wo	UND CARE	90.01	О	213	3	0	12
00 EM	IERGENCY	<u>91.</u> 00	0	704	<u> </u>	Q	13
0			0	3, 410, 034	l		
	- DEPRECIATION			100 50			
	MINISTRATIVE & GENERAL	5.00	0	128, 526 35, 936		9 9	1
	PERATION OF PLANT	7.00 9.00	0	35, 936		0	2
	ETARY	10.00	0	8, 351		0	4
	IRSING ADMI NI STRATI ON	13.00	0	100, 860		0	5
DO CE	NTRAL SERVICES & SUPPLY	14.00	0	3, 768	3	0	6
	IARMACY	15.00	0	7,496	þ	0	7
	OULTS & PEDIATRICS	30.00	0	3, 672		0	8
	PERATING ROOM	50.00	0	107, 500		0	9
	ADI OLOGY-DI AGNOSTI C ABORATORY	54.00 60.00	0	263, 540 49, 646		0	10
	.00D STORING. PROCESSING &	63.00	0	49, 840		0	12
	ANS.	03.00	0	221		0	12
	SPIRATORY THERAPY	65.00	0	30, 775	5	0	13
00 PH	IYSI CAL THERAPY	66.00	0	8, 681		0	14
	IYSICAL THERAPY- WHEATFIELD	66. 01	0	1, 940		0	15
	CUPATIONAL THERAPY	67.00	0	984		0	16
	CCUPATIONAL THERAPY-	67.01	0	372	2	0	17
	IEATFIELD PEECH PATHOLOGY- WHEATFIELD	68.01	О	372))	0	18
	IRAL HEALTH CLINIC II	88.01	0	16, 215		0	19
	INIC	90.00	Ō	97, 212		0	20
	OUND CARE	90. 01	0	3, 673		0	21
	IERGENCY	91.00	0	12,540		Ō	22
			0	882, 555			
	- CAPITAL LEASE MINISTRATIVE & GENERAL	5.00	0	17, 865		10	1
	PERATION OF PLANT	5.00 7.00	0	17,865		0	2
	IRST NG ADMI NI STRATI ON	13.00	0	1, 124		0	3
	IARMACY	15.00	Ő	14, 848		0	4
	PERATING ROOM	50.00	0	91, 477	7	0	5
	IYSI CAL THERAPY	66.00	0	1, 036		0	6
	<u>INIC</u>	90.00	0	2, 219		Q	7
	DTALS		0	144, 259			
	- BLOOD DULTS & PEDIATRICS	30.00	15 740	A 147	1	0	1
	INIC	30.00 90.00	15, 742 13, 173	4, 164 133		o	1
	IERGENCY	90.00 91.00	3, 910	983		0	3
	DTALS		32, 825			-	
	and Total: Decreases		252, 342	4, 676, 310			500

Heal th	Financial Systems	FRANCI SCAN HEAL	TH RENSSELAER		In Li	eu of Form CMS-	2552-10
	ILIATION OF CAPITAL COSTS CENTERS		Provider CC	CN: 15-1324	Period: From 01/01/202 To 12/31/202		
				Acquisitions	s		
		Begi nni ng Bal ances	Purchases	Donati on	Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	T BALANCES			Į		
1.00	Land	675, 791	0		0	0 0	1.00
2.00	Land Improvements	509, 926	0		0	0 0	2.00
3.00	Buildings and Fixtures	20, 098, 672	1, 200, 656		0 1, 200, 65	6 0	3.00
4.00	Building Improvements	0	0		0	0 0	4.00
5.00	Fixed Equipment	0	0		0	0 0	5.00
6.00	Movable Equipment	11, 700, 733	23, 479		0 23, 47	9 4, 258, 473	6.00
7.00	HIT designated Assets	0	0		0	0 0	7.00
8.00	Subtotal (sum of lines 1-7)	32, 985, 122	1, 224, 135		0 1, 224, 13	5 4, 258, 473	8.00
9.00	Reconciling Items	-335, 831	0		0	0 0	9.00
10.00	Total (line 8 minus line 9)	33, 320, 953	1, 224, 135		0 1, 224, 13	5 4, 258, 473	10.00
		Endi ng Bal ance	Fully				
			Depreci ated				
			Assets				
		6.00	7.00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE			-			
1.00	Land	675, 791	0				1.00
2.00	Land Improvements	509, 926	0				2.00
3.00	Buildings and Fixtures	21, 299, 328	42, 854				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	7, 465, 739	3, 424, 105				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	29, 950, 784	3, 466, 959				8.00
9.00	Reconciling Items	-335, 831	-176, 678				9.00
10.00	Total (line 8 minus line 9)	30, 286, 615	3, 643, 637				10.00

Heal th	Financial Systems	FRANCI SCAN HEAL	TH RENSSELAER		In Lie	u of Form CMS-2	2552-10
RECONO	CILIATION OF CAPITAL COSTS CENTERS		Provider CO	CN: 15-1324	Peri od:	Worksheet A-7	
					From 01/01/2023		
					To 12/31/2023	Date/Time Pre 5/29/2024 8:50	
			SI	JMMARY OF CAP		372772024 0.3	
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see	Taxes (see	
	·				instructions)	instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORI	KSHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	196, 786	0		0 0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		0 0	0	2.00
3.00	Total (sum of lines 1-2)	196, 786			0 0	0	3.00
		SUMMARY O	F CAPITAL				
		0.1	T I I (4) (
	Cost Center Description		Total (1) (sum				
		Capital - Relate					
		d Costs (see instructions)	through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORI			nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	985, 830					1.00
2.00	CAP REL COSTS - MVBLE EQUIP	/03, 030	1, 102, 010				2.00
3.00	Total (sum of lines 1-2)	985, 830	1, 182, 616				3.00
0.00		, , , , , , , , , , , , , , , , , , , ,	., 102, 010	1			0.00

Health Financial Systems	RANCI SCAN HEAL	TH RENSSELAER		In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider C		Period: From 01/01/2023 To 12/31/2023	Worksheet A-7 Part III Date/Time Prep 5/29/2024 8:56	oared: 6 am
	COM	PUTATION OF RAT	-1 0S	ALLOCATION OF		
Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col 2)	instructions)	Insurance	
	1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS C	INTERS					
1.00 CAP REL COSTS-BLDG & FIXT	21, 284, 389	0	21, 284, 38	9 0. 645272	0	1.00
2.00 CAP REL COSTS-MVBLE EQUIP	11, 700, 733		,		0	2.00
3.00 Total (sum of lines 1-2)	32, 985, 122					3.00
	ALLOCA	TION OF OTHER (CAPITAL	SUMMARY O	F CAPITAL	
Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
		Capi tal -Rel ate				
		d Costs	through 7)			
	6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE	1	1	1	1		
1.00 CAP REL COSTS-BLDG & FIXT	0	0		0 242, 753		1.00
2.00 CAP REL COSTS-MVBLE EQUIP	0	0		0 845, 027	144, 259	2.00
3.00 Total (sum of lines 1-2)	0	0		0 1, 087, 780	144, 259	3.00
			IMMARY OF CAPI			
Cost Center Description	Interest	Insurance (see			Total (2) (sum	
		instructions)	instructions)	Capi tal -Rel ate		
				d Costs (see	through 14)	
	11.00	12.00	12.00	instructions)	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS C	11.00	12.00	13.00	14.00	15.00	
1.00 CAP REL COSTS-BLDG & FLXT	0	46, 306		0 1, 276, 836	1, 565, 895	1.00
2.00 CAP REL COSTS-BEDG & FIXT	0			0 1, 270, 830	989, 286	2.00
3.00 Total (sum of lines 1-2)	0	-		0 1, 276, 836		2.00
3.00 ± 0.00 (Sum of Thes $1-2$)	0	40,300	I	1, 270, 030	2, 333, 101	5.00

inancial Sy	ystems	FRA
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RANCISCAN HEALTH RENSSELAER

DJUST	MENTS TO EXPENSES			Provider CCN: 15-1324	Peri od:	Worksheet A-8	
					From 01/01/2023 To 12/31/2023	Date/Time Prep 5/29/2024 8:50	
				Expense Classification o		072972024 0.00	
				To/From Which the Amount is	s to be Adjusted		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
. 00	Investment income - CAP REL	1.00	2.00	3.00 CAP REL COSTS-BLDG & FIXT	4.00	5.00	1. (
	COSTS-BLDG & FIXT (chapter 2)						
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2. (
8. 00	Investment income - other (chapter 2)		0		0.00	0	3.
. 00	Trade, quantity, and time		0		0.00	0	4.
. 00	discounts (chapter 8) Refunds and rebates of	В	-84, 143	CENTRAL SERVICES & SUPPLY	14.00	0	5.
00	expenses (chapter 8) Rental of provider space by					0	,
b. 00	suppliers (chapter 8)		0		0.00	0	6.
. 00	Telephone services (pay stations excluded) (chapter 21)		O		0.00	0	7.
. 00	Television and radio service		0		0.00	0	8.
. 00	(chapter 21) Parking lot (chapter 21)		0		0.00	0	9.
0. 00	Provider-based physician adjustment	A-8-2	-1, 518, 339			0	10.
1. 00	Sale of scrap, waste, etc.		0		0.00	0	11.
2.00	(chapter 23) Related organization	A-8-1	2, 519, 542			0	12.
3. 00	transactions (chapter 10) Laundry and linen service		0		0.00	0	13.
4.00	Cafeteria-employees and guests	В	-70, 483	CAFETERI A	11.00	0	14.
5.00	Rental of quarters to employee and others		0		0.00	0	15.
6. 00	Sale of medical and surgical supplies to other than		0		0.00	0	16.
7.00	5		0		0.00	0	17.
8. 00	patients Sale of medical records and	В	0	MEDICAL RECORDS & LIBRARY	16.00	0	18.
9.00	abstracts Nursing and allied health		0		0.00	0	19.
9.00	education (tuition, fees, books, etc.)		U		0.00	0	19.
9. 01	Nursing and allied health education (tuition, fees,		0		0.00	0	19.
	books, etc.)						
0.00	Vending machines Income from imposition of	В	-2, 050 0	CAFETERI A	11.00 0.00	0	
	interest, finance or penal ty charges (chapter 21)		Ū				
2.00	Interest expense on Medicare		0		0.00	0	22.
	overpayments and borrowings to repay Medicare overpayments						
3. 00	Adjustment for respiratory	A-8-3	0	RESPI RATORY THERAPY	65.00		23.
	therapy costs in excess of limitation (chapter 14)						
4.00	Adjustment for physical therapy costs in excess of	A-8-3	0	PHYSI CAL THERAPY	66.00		24.
E 00	limitation (chapter 14)		~	*** Coct Conton D-1-+ ***	114.00		25
5.00	physicians' compensation		0	*** Cost Center Deleted ***	114.00		25.
6. 00	(chapter 21) Depreciation - CAP REL		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.
	COSTS-BLDG & FIXT						
7.00	Depreciation - CAP REL COSTS-MVBLE EQUIP			CAP REL COSTS-MVBLE EQUIP	2.00	0	27.
3.00 9.00			0	*** Cost Center Deleted ***	19.00 0.00	0	28. 29.
9.00 0.00	Adjustment for occupational	A-8-3	0	OCCUPATI ONAL THERAPY	67.00	0	30.
	therapy costs in excess of limitation (chapter 14)						
0. 99	Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30.00		30.
1. 00	instructions) Adjustment for speech	A-8-3	0	SPEECH PATHOLOGY	68.00		31.
	pathology costs in excess of limitation (chapter 14)						

<u>Heal</u> th	n Financial Systems	F	RANCI SCAN HEAL	TH RENSSELAER	In Lie	u of Form CMS-	<u>2552-10</u>
ADJUS	TMENTS TO EXPENSES				Period: From 01/01/2023 To 12/31/2023	Worksheet A-8 Date/Time Pre 5/29/2024 8:5	pared:
				Expense Classification o	n Worksheet A		
				To/From Which the Amount is			
					2		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center		Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
32.00			0		0.00	0	32.00
22.00	Depreciation and Interest		1 001 (07		F 00	0	
33.00		AB		ADMI NI STRATI VE & GENERAL	5.00		00.00
34.00		В		ADMI NI STRATI VE & GENERAL	5.00		
34. 01 34. 02	OTHER REVENUE OTHER REVENUE	В		RURAL HEALTH CLINIC PHARMACY	88.00 15.00		
34.02		В		EMERGENCY	91.00		
34.03	OTHER REVENUE	В		CAFETERIA	11.00		34.03
34.04	-	В		OPERATION OF PLANT	7.00		34.02
35.00		A		ADMINISTRATIVE & GENERAL	5.00		35.00
36.00		A		CAP REL COSTS-BLDG & FIXT	1.00		36.00
37.00		A		ADMINI STRATI VE & GENERAL	5.00		37.00
38.00	MARKETING / ADVERTISING	A		OPERATION OF PLANT	7.00		38.00
38.01	MARKETING / ADVERTISING	A		ADULTS & PEDIATRICS	30.00		38.0
38.02	MARKETING / ADVERTISING	A		EMERGENCY	91.00		38.02
38.03		A		RADI OLOGY-DI AGNOSTI C	54.00		
38.04		A		PHYSICAL THERAPY	66.00		38.04
38.05	MARKETING / ADVERTISING	A		OCCUPATI ONAL THERAPY	67.00		38.05
38.06	MARKETING / ADVERTISING	A		RURAL HEALTH CLINIC	88.00		38.06
38.07	MARKETING / ADVERTISING	A		RURAL HEALTH CLINIC II	88.01		38.07
38.08	MARKETING / ADVERTISING	A	-41	CLINIC	90.00	0	38. 08
39.00	PHYSICIAN RHC SALARY	A	0	RURAL HEALTH CLINIC	88.00	0	39.00
39.01	PHYSICIAN RHC SALARY	A	0	RURAL HEALTH CLINIC II	88. 01	0	39.01
40.00	PENSION	A	18, 915	EMPLOYEE BENEFITS DEPARTMEN	T 4.00	0	40.00
50.00	TOTAL (sum of lines 1 thru 49)		-1, 295, 529				50.00
	(Transfer to Worksheet A,						
	column 4 line 200)	1				1	1

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

(2) Basis for adjustment (see instructions).

(2) basis for adjustment (see first definition).
A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
Note: See instructions for column 5 referencing to Worksheet A-7.

Heal th	Financial Systems	FRANCI SCAN HEA	LTH RENSSELAER	In Lie	eu of Form CMS-	2552-10
	ENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HOM		Peri od:	Worksheet A-8	8-1
OFFICE	COSTS			From 01/01/2023 To 12/31/2023		
	Line No.	Cost Center	Expense Items	Amount of	Amount	
				Allowable Cost		
					Wks. A, column	
					5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTN HOME OFFICE COSTS:	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED O	RGANIZATIONS OR	CLAIMED	
1.00	1.00	CAP REL COSTS-BLDG & FIXT	ALLOWABLE NEW CAPITAL COSTS	291,006	0	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	ADMIN & GENERAL	6, 459, 857	6, 520, 565	2.00
3.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	SHARED SERVICES	69, 189	0	3.00
3.02	5.00	ADMINISTRATIVE & GENERAL	SHARED SERVICES	1, 520, 509	0	3.02
3.04	13.00	NURSING ADMINISTRATION	SHARED SERVICES	192, 308	0	3.04
3.05	15.00	PHARMACY	SHARED SERVICES	507, 238	0	3.05
3.06	0.00			0	0	3.06
3.07	0.00			0	0	3.07
3.09	0.00			0	0	3.09
4.00	0.00			0	0	4.00
4.01	0.00			0	0	4.01
5.00	TOTALS (sum of lines 1-4).			9, 040, 107	6, 520, 565	5.00
	Transfer column 6, line 5 to					
	Worksheet A-8, column 2,					
	line 12.					

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

				Related Organization(s) and/	or Home Office			
	Symbol (1)	Name	Percentage of	Name	Percentage of			
			Ownershi p		Ownershi p			
	1.00	2.00	3.00	4.00	5.00			
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:								

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

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

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

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

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.B. Corporation, partnership, or other organization has financial interest in provider.

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

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

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

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

Health Financial Systems	FRANCI SCAN HEALTH RE	INSSELAER	In Lieu	of Form CMS-2552-10
STATEMENT OF COSTS OF SERVICES FROM I OFFICE COSTS	RELATED ORGANIZATIONS AND HOME PI		Period: From 01/01/2023	Worksheet A-8-1
				Date/Time Prepared:

					5/29/2024 8:56 am	
	Net	Wkst. A-7 Ref.				
	Adjustments					
	(col. 4 minus					
	col. 5)*					
	6.00	7.00				
	A. COSTS INCUR	RED AND ADJUST	MENTS REQUIRED AS A RESULT OF TRA	NSACTIONS WITH RELATED C	DRGANIZATIONS OR CLAIMED	
	HOME OFFICE CO					
1.00	291,006	14			1.0	00
2.00	-60, 708	0			2.0	00
3.00	69, 189	0			3.0	00
3.02	1, 520, 509	0			3.0	02
3.04	192, 308	0			3.0	04
3.05	507, 238	0			3.0	05
3.06	0	0			3.0	06
3.07	0	0			3.0	07
3.09	0	0			3.0	09
4.00	0	0			4.0	00
4.01	0	0			4.0	01
5.00	2, 519, 542				5.0	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

nas not	been posted to worksheet A,	COT UNITS	Ζ, Ι	ne anount	arrowabre	Shourd L	be murcateu	TH COLUMN 4 C	i this part.	
	Rel ated Organi zati on(s)									
	and/or Home Office									
	Type of Business	1								
	51									
	6, 00	1								

B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:

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

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

6.00	6.00
7.00	7.00
8.00	8.00
9.00	9.00
7.00 8.00 9.00 10.00	10.00
100.00	100.00

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

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

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

 C. Provider has financial interest in corporation, partnership, or other organization.
 D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organi zati on.

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

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

Heal th	Financial Syste	ems	FRANCI SCAN HEA	ITH RENSSELAE	R	Inlie	eu of Form CMS-	2552-10
	R BASED PHYSIC				CCN: 15-1324	Period: From 01/01/2023	Worksheet A-8	
						To 12/31/2023		epared: 56 am
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		Identi fi er	Remuneration	Component	Component		ider Component	
							Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00		ADMI NI STRATI VE & GENERAL	77, 777	(10.0	0 77,77		-	
2.00		ADULTS & PEDIATRICS	643, 946				-	
3.00		OPERATING ROOM	415, 866				0	
4.00			28, 225				0	
5.00			16, 519			- -	0	
6.00			413, 783			0 0	0	
7.00		WOUND CARE	8,609		0 8,60		0	
8.00		EMERGENCY	1, 033, 304		0 1,033,30		0	
9.00	0.00 0.00		0		0	0 0	0	
10.00	0.00			1 510 2	-		0	
200.00	Wkst. A Line #	Cast Canton (Dhusi si an	2, 638, 029			Provi der	0 Dhuci ci cn Cost	
	WKSL A LINE #	Cost Center/Physician Identifier	Unadjusted RCE Limit		E Memberships &		Physician Cost of Malpractice	
		rdentifier			Continuing	Share of col.		
					Education	12	Thou ance	
	1.00	2.00	8.00	9,00	12.00	13.00	14.00	
1.00		ADMI NI STRATI VE & GENERAL	0.00			0 0		1.00
2.00		ADULTS & PEDIATRICS	0			ol o	-	
3.00		OPERATING ROOM	0			0 0	-	
4.00		RADI OLOGY-DI AGNOSTI C	0			0 0	0	
5.00		RESPI RATORY THERAPY	0		0	0 0	0	
6.00		CLINIC	0		0	0 0	0	
7.00		WOUND CARE	0		0	0 0	0	
8.00	91.00	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			0		0	0 0	0	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RC	E RCE	Adjustment		
		Identi fi er	Component	Limit	Di sal I owance			
			Share of col.					
			14					
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00		ADMINISTRATIVE & GENERAL	0		-	0 0		1.00
2.00		ADULTS & PEDIATRICS	0			0 643, 946		2.00
3.00		OPERATING ROOM	0			0 415, 866		3.00
4.00		RADI OLOGY-DI AGNOSTI C	0		0	0 28, 225		4.00
5.00		RESPI RATORY THERAPY	0		-	0 16, 519		5.00
6.00		CLINIC	0		-	0 413, 783		6.00
7.00		WOUND CARE	0		-	0 0	1	7.00
8.00		EMERGENCY	0		-	0 0		8.00
9.00	0.00		0		-	0 0		9.00
10.00	0.00		0			0 0		10.00
200.00			0	1	0	0 1, 518, 339		200.00

	Financial Systems LLOCATION - GENERAL SERVICE COSTS	FRANCI SCAN HEAL	TH RENSSELAER Provider Co	F	In Lie eriod: rom 01/01/2023 o 12/31/2023	u of Form CMS- Worksheet B Part I Date/Time Pre	
						5/29/2024 8:5	
	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A	BLDG & FI XT	LATED COSTS	EMPLOYEE BENEFI TS DEPARTMENT	Subtotal	
		<u>col. 7)</u>	1.00	2.00	4.00	4A	
	GENERAL SERVICE COST CENTERS	0	1.00	2.00	4.00	48	
1.00	00100 CAP REL COSTS-BLDG & FIXT	1, 565, 895	1, 565, 895				1.00
2.00	00200 CAP REL COSTS-MVBLE EQUI P	989, 286		989, 286			2.00
4.00 5.00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL	2, 767, 654	9, 576 184, 830			11, 758, 141	4.00 5.00
7.00	00700 OPERATI ON OF PLANT	1, 730, 716				2, 184, 720	
8.00	00800 LAUNDRY & LINEN SERVICE	6, 822	18, 841	12, 380		39, 692	•
9.00	00900 HOUSEKEEPI NG	531, 395				664, 734	•
10.00	01000 DI ETARY	80, 178				128, 307	•
11.00 13.00	01100 CAFETERIA 01300 NURSING ADMINISTRATION	290, 324 349, 542	27, 748 1, 528			384, 626 390, 232	•
14.00	01400 CENTRAL SERVICES & SUPPLY	-24, 890			4, 085	64, 212	•
15.00	01500 PHARMACY	899, 522				1, 010, 432	
16.00	01600 MEDICAL RECORDS & LIBRARY	0	19, 211	12, 623	0	31, 834	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS	4 470 700	100 (04	00 (10	450.057	0 400 070	
30.00 31.00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	1, 478, 709	122, 694 0			2, 132, 378 0	30.00 31.00
31.00	03200 CORONARY CARE UNIT	0			-	0	•
	ANCI LLARY SERVI CE COST CENTERS	· · · · · ·			-		
50.00	05000 OPERATI NG ROOM	516, 322	109, 167			898, 589	•
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 249, 902	70, 051	46, 028		1, 671, 161	
60. 00 63. 00	06000 LABORATORY 06300 BLOOD STORING, PROCESSING & TRANS.	2, 373, 500 38, 105			0 8, 303	2, 429, 453 48, 426	•
65.00	06500 RESPI RATORY THERAPY	655, 249				902, 414	•
66.00	06600 PHYSI CAL THERAPY	498, 616	89, 657	58, 910	121, 478	768, 661	66.00
66.01	06601 PHYSI CAL THERAPY- WHEATFI ELD	314, 590		71, 871	78, 128	573, 970	•
67.00 67.01	06700 OCCUPATIONAL THERAPY 06701 OCCUPATIONAL THERAPY- WHEATFIELD	166, 020 96, 066			41, 353 23, 016	215, 900 158, 059	
68.00	06800 SPEECH PATHOLOGY	108, 251	4, 358			142, 257	1
68.01	06801 SPEECH PATHOLOGY- WHEATFIELD	158, 470				222, 719	1
69.00	06900 ELECTROCARDI OLOGY	0	0		0	0	
70.00	07000 ELECTROENCEPHALOGRAPHY	0 (04 597	0			0	70.00
71.00 72.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	694, 587 142, 011			-	694, 587 142, 011	•
73.00	07300 DRUGS CHARGED TO PATIENTS	3, 410, 034	0			3, 410, 034	•
74.00	07400 RENAL DIALYSIS	0	0			0	
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0	0			0	77.00
78.00	07800 CAR T-CELL IMMUNOTHERAPY OUTPATIENT SERVICE COST CENTERS	0	0	0	0	0	78.00
88.00	08800 RURAL HEALTH CLINIC	236, 108	17, 910	11, 768	53, 993	319, 779	88.00
88. 01	08801 RURAL HEALTH CLINIC II	284, 110				395, 143	
90.00	09000 CLINIC	1,010,686				1, 519, 702	
90. 01 91. 00	09001 WOUND CARE 09100 EMERGENCY	44, 278 2, 556, 374				74, 572 3, 016, 976	•
91.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	2, 550, 574	90,970	59,773	309, 639	3, 010, 970	1
	OTHER REIMBURSABLE COST CENTERS				II		
	09500 AMBULANCE SERVICES	0	0	0	-	0	
	09850 OTHER REIMBURSABLE COST CENTERS	0				0	
	10100 HOME HEALTH AGENCY	0					101. 00 102. 00
102.00	SPECIAL PURPOSE COST CENTERS		0	0	<u> </u>	0	102.00
113.00	11300 INTEREST EXPENSE						113.00
	11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	0	0		115.00
	11600 HOSPICE	0	0	0	0		116.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	36, 459, 446	1, 502, 327	987, 129	2, 783, 522	36, 393, 721	1118.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	3, 015	3, 283	2, 157	0	8, 455	190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0			192.00
	07950 ALTERNACARE	0	0	0	0		194.00
	07951 SPORTS MEDICINE 07952 UNUSED SPACE	0	0 40 305	0	0		194. 01 194. 02
	07952 UNUSED SPACE	0	60, 285 0		0		194.02
200.00				ĺ			200.00
201.00	5		0	0	0		201.00
202.00	TOTAL (sum lines 118 through 201)	36, 462, 461	1, 565, 895	989, 286	2, 783, 522	36, 462, 461	J202. 00

	Financial Systems I LOCATION - GENERAL SERVICE COSTS	FRANCI SCAN HEALT	Provider C	CN: 15-1324 P	eriod:	u of Form CMS-2 Worksheet B	2552-10
0001 74				F	rom 01/01/2023 o 12/31/2023	Part I	pared: 6 am
	Cost Center Description	ADMI NI STRATI VE & GENERAL	PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	
		5.00	7.00	8.00	9.00	10.00	
	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT						1.00
1	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT						2.00 4.00
	00500 ADMI NI STRATI VE & GENERAL	11, 758, 141					5.00
	00700 OPERATION OF PLANT	1,039,828	3, 224, 548				7.00
	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING	18, 892 316, 383	51, 752 67, 002				8.00 9.00
10.00	01000 DI ETARY	61, 068	60, 837	0	20, 531	270, 743	10.00
	01100 CAFETERIA 01300 NURSING ADMINISTRATION	183, 065 185, 733	76, 218 4, 198			0	11.00
	01400 CENTRAL SERVICES & SUPPLY	30, 562	140, 925			0	14.00
	01500 PHARMACY	480, 920	35, 912			0	15.00
	01600 MEDICAL RECORDS & LIBRARY INPATIENT ROUTINE SERVICE COST CENTERS	15, 152	52, 769	0	17,808	0	16.00
30. 00	03000 ADULTS & PEDI ATRI CS	1, 014, 916	337, 013	15, 040	113, 733	270, 743	30.00
	03100 I NTENSI VE CARE UNI T 03200 CORONARY CARE UNI T	0	0			0	31.00 32.00
H	ANCI LLARY SERVI CE COST CENTERS	0	0	0	<u> </u>	0	32.00
	05000 OPERATING ROOM	427, 688	299, 855			0	
	05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY	795, 397 1, 156, 310	192, 415 92, 747			0	54.00 60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	23, 049	3, 345			0	63.00
	06500 RESPI RATORY THERAPY	429, 508	129, 315			0	65.00
	06600 PHYSICAL THERAPY 06601 PHYSICAL THERAPY- WHEATFIELD	365, 848 273, 184	246, 266 300, 445			0	66.00 66.01
	06700 OCCUPATI ONAL THERAPY	102, 759	14, 135			0	67.00
	06701 OCCUPATIONAL THERAPY- WHEATFIELD	75, 229	64, 608			0	67.01
	06800 SPEECH PATHOLOGY 06801 SPEECH PATHOLOGY- WHEATFIELD	67, 708 106, 004	11, 971 41, 913	0		0	68.00 68.01
	06900 ELECTROCARDI OLOGY	0	0			0	69.00
	07000 ELECTROENCEPHALOGRAPHY	0	0	0	-	0	70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	330, 592 67, 591	0	0		0	71.00
	07300 DRUGS CHARGED TO PATIENTS	1, 623, 020	0	0	0	0	73.00
	07400 RENAL DI ALYSI S	0	0	-	-	0	74.00
	07700 ALLOGENEIC HSCT ACQUISITION 07800 CAR T-CELL IMMUNOTHERAPY	0	0		-	0	77.00
(OUTPATIENT SERVICE COST CENTERS	· · · ·					/0.00
	08800 RURAL HEALTH CLINIC 08801 RURAL HEALTH CLINIC II	152, 200 188, 070	49, 194 67, 954			0	
	09000 CLINIC	723, 310	423, 924	0		0	90.00
	09001 WOUND CARE	35, 493	35, 354			0	
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 435, 945	249, 874	813	84, 325	0	91.00 92.00
0	OTHER REIMBURSABLE COST CENTERS						/2.00
95.00	09500 AMBULANCE SERVICES 09850 OTHER REIMBURSABLE COST CENTERS	0	0	0	0		95.00 98.00
	10100 HOME HEALTH AGENCY	0	0	0	0		101.00
102.00	10200 OPI OI D TREATMENT PROGRAM	0	0	0	0		102.00
	SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE						113.00
115.00	11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	0	0	0	115.00
	11600 HOSPICE		2 040 041	110 226	080 104		116.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	11, 725, 424	3, 049, 941	110, 336	989, 194	270, 743	118.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	4,024	9, 019	0	3, 044		190.00
192.00	19200 PHYSI CI ANS' PRI VATE OFFI CES 07950 ALTERNACARE	0	0		0		192.00 194.00
	07950 ALTERNACARE 07951 SPORTS MEDICINE	0	0	0	0		194.00
194.00		28, 693	165, 588	0	55, 881		194.02
194.00 194.01 194.02	07952 UNUSED SPACE	20,075					
194. 00 194. 01 194. 02 194. 03	07953 LAFAYETTE HHA BRANCH	0	0	0	0	0	194.03
194.00 194.01 194.02	07953 LAFAYETTE HHA BRANCH Cross Foot Adjustments	0	0	0	0		194.03 200.00 201.00

Health Financial Systems	FRANCI SCAN HEAL	TH RENSSELAER		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC		Period: From 01/01/2023	Worksheet B Part I	
				To 12/31/2023	Date/Time Pre	pared:
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	5/29/2024 8:5 MEDI CAL	6 am
		ADMI NI STRATI ON	SERVICES &		RECORDS &	
	11.00	13.00	SUPPLY 14.00	15.00	LI BRARY 16.00	
GENERAL SERVICE COST CENTERS	11.00	13.00	14.00	15.00	10.00	
1.00 00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP 4.00 00400 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 10. 00 01000 DI ETARY						9.00 10.00
11. 00 01100 CAFETERI A	669, 631					11.00
13.00 01300 NURSI NG ADMI NI STRATI ON	11, 788					13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY 15. 00 01500 PHARMACY	1, 262		295, 74			14.00
15. 00 01500 PHARMACY 16. 00 01600 MEDI CAL RECORDS & LI BRARY	27, 569	1		0 1, 566, 952 0 0	117, 563	15.00 16.00
INPATIENT ROUTINE SERVICE COST CENTERS				-	,	
30. 00 03000 ADULTS & PEDI ATRI CS	140, 351			0 0	3, 542	
31. 00 03100 I NTENSI VE CARE UNI T 32. 00 03200 CORONARY CARE UNI T		1		0 0 0 0	0	
ANCI LLARY SERVICE COST CENTERS		<u> </u>		0 0	0	52.00
50. 00 05000 OPERATI NG ROOM	62, 207			0 0	3, 091	1
54. 00 05400 RADI OLOGY-DI AGNOSTI C 60. 00 06000 LABORATORY	94, 276			0 0 0 0	18, 121 15, 592	
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.		-		0 0	324	1
65. 00 06500 RESPI RATORY THERAPY	52, 254	0		0 0	3, 199	1
66.00 06600 PHYSI CAL THERAPY	37, 527	1		0 0	3, 370	
66. 01 06601 PHYSICAL THERAPY- WHEATFIELD 67. 00 06700 OCCUPATIONAL THERAPY	24, 135			0 0	2, 206 785	
67. 01 06701 0CCUPATI ONAL THERAPY- WHEATFI ELD	7, 110	1		0 0	379	1
68.00 06800 SPEECH PATHOLOGY	8, 274	1		0 0	325	1
68. 01 06801 SPEECH PATHOLOGY- WHEATFI ELD	12,037	1		0 0	682	1
69. 00 06900 ELECTROCARDI OLOGY 70. 00 07000 ELECTROENCEPHALOGRAPHY		0		0 0 0 0	0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	245, 54	-	5, 221	
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	C	0	50, 20		1, 867	1
73. 00 07300 DRUGS CHARGED TO PATIENTS 74. 00 07400 RENAL DIALYSIS		0		0 1, 566, 952	41, 343 0	1
77.00 07700 ALLOGENEIC HSCT ACQUISITION		0		0 0	0	1
78.00 07800 CAR T-CELL IMMUNOTHERAPY	C	0		0 0	0	1
OUTPATIENT SERVICE COST CENTERS					450	
88.00 08800 RURAL HEALTH CLINIC 88.01 08801 RURAL HEALTH CLINIC II		0		0 0 0 0	158 282	1
90. 00 09000 CLINIC	79, 270	-		0 0		90.00
90. 01 09001 WOUND CARE	2, 770			0 0		90. 01
91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	96, 026	158, 139		0 0	10, 303	91.00 92.00
OTHER REIMBURSABLE COST CENTERS		II				92.00
95. 00 09500 AMBULANCE SERVICES	C	0		0 0	0	1
98. 00 09850 OTHER REI MBURSABLE COST CENTERS	C	0		0 0		98.00
101. 00 10100 HOME HEALTH AGENCY 102. 00 10200 OPI 0I D TREATMENT PROGRAM		0		0 0 0 0		101. 00 102. 00
SPECIAL PURPOSE COST CENTERS				<u> </u>	0	102.00
113.00 11300 INTEREST EXPENSE						113.00
115. 00 11500 AMBULATORY SURGI CAL CENTER (D. P.) 116. 00 11600 H0SPI CE		0		0 0		115. 00 116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	669, 631	593, 368	295, 74	1 1, 566, 952	117, 563	
NONREI MBURSABLE COST CENTERS					•	
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0		190.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 194. 00 07950 ALTERNACARE		0				192. 00 194. 00
194. 01 07951 SPORTS MEDI CI NE		0		o o		194.00
194.0207952UNUSED SPACE	C	0		0 0		194. 02
194.03 07953 LAFAYETTE HHA BRANCH 200.00 Cross Foot Adjustments	C	0		0 0	0	194. 03 200. 00
200.00Cross Foot Adjustments201.00Negative Cost Centers	0	0		0 0	0	200.00
202.00 TOTAL (sum lines 118 through 201)	669, 631	593, 368	295, 74	1 1, 566, 952		

Heal th	Financial Systems F	RANCI SCAN HEAL	TH RENSSELAER		In Lieu	of Form CMS-2552-10
	LOCATION - GENERAL SERVICE COSTS		Provider CC	CN: 15-1324		Worksheet B Part I
					To 12/31/2023	Date/Time Prepared:
	Cost Center Description	Subtotal	Intern &	Total		5/29/2024 8:56 am
			Residents Cost			
			& Post Stepdown			
			Adjustments			
		24.00	25.00	26.00		
	GENERAL SERVICE COST CENTERS					1.00
	DO200 CAP REL COSTS-MVBLE EQUIP					2.00
4.00	DO400 EMPLOYEE BENEFITS DEPARTMENT					4.00
	20500 ADMINISTRATIVE & GENERAL					5.00
	DO700 OPERATION OF PLANT DO800 LAUNDRY & LINEN SERVICE					7.00
	00900 HOUSEKEEPING					9.00
	D1000 DI ETARY					10.00
						11.00
	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY					13.00
	D1500 PHARMACY					14.00
	01600 MEDICAL RECORDS & LI BRARY					16.00
	NPATIENT ROUTINE SERVICE COST CENTERS					
	03000 ADULTS & PEDIATRICS	4, 205, 490	0	4, 205, 4		30.00
	D3100 I NTENSI VE CARE UNI T D3200 CORONARY CARE UNI T	0	0		0 0	31.00 32.00
-	ANCI LLARY SERVICE COST CENTERS	0	0	<u> </u>	0	
50.00	D5000 OPERATING ROOM	1, 920, 299	0	1, 920, 2	299	50.00
	D5400 RADI OLOGY-DI AGNOSTI C	2,904,332		2, 904, 3		54.00
	06000 LABORATORY	3, 725, 402	0	3, 725, 4		60.00
	06300 BLOOD STORI NG, PROCESSI NG & TRANS. 06500 RESPI RATORY THERAPY	76, 273 1, 560, 330		76, 2 1, 560, 3		63.00 65.00
	D6600 PHYSI CAL THERAPY	1, 504, 780		1, 504, 5		66.00
	D6601 PHYSICAL THERAPY- WHEATFIELD	1, 275, 332	0	1, 275, 3		66. 01
	06700 OCCUPATIONAL THERAPY	351, 124		351, 1		67.00
	06701 OCCUPATIONAL THERAPY - WHEATFIELD	327, 189		327, 2		67. 01 68. 00
	06800 SPEECH PATHOLOGY 06801 SPEECH PATHOLOGY- WHEATFIELD	234, 575 397, 500	0	234, 5 397, 5		68.00
	06900 ELECTROCARDI OLOGY	0	0	0,,,,	0	69.00
	D7000 ELECTROENCEPHALOGRAPHY	0	0		0	70.00
	07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT	1, 275, 940	0	1, 275, 9		71.00
	07200 I MPL. DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS	261, 670 6, 641, 349	0	261, 6 6, 641, 3		72.00
	07400 RENAL DI ALYSI S	0, 041, 347	0	0, 041, 0	0	74.00
	D7700 ALLOGENEIC HSCT ACQUISITION	0	0		0	77.00
	07800 CAR T-CELL IMMUNOTHERAPY	0	0		0	78.00
-	DUTPATIENT SERVICE COST CENTERS D8800 RURAL HEALTH CLINIC	537, 933	0	537, 9	22	88.00
	08800 RURAL HEALTH CLINIC II	674, 381				88. 01
	09000 CLINIC	3, 040, 417		3, 040, 4		90.00
	D9001 WOUND CARE	160, 755	0	160, 7		90.01
	09100 EMERGENCY	5, 052, 401	0	5, 052, 4	101	91.00
	D9200 OBSERVATION BEDS (NON-DISTINCT PART DTHER REIMBURSABLE COST CENTERS		0			92.00
	09500 AMBULANCE SERVICES	0	0		0	95.00
	09850 OTHER REIMBURSABLE COST CENTERS	0	0		0	98.00
	10100 HOME HEALTH AGENCY	0	0		0	101.00
	10200 OPI OLD TREATMENT PROGRAM SPECIAL PURPOSE COST CENTERS	0	0		0	102.00
	11300 INTEREST EXPENSE					113.00
	11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0		0	115.00
	11600 HOSPI CE	0	0		0	116.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	36, 127, 472	0	36, 127, 4	172	118.00
	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	24, 542	0	24, 5	542	190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	24, 342	0	24, 5	0	190.00
	07950 ALTERNACARE	0	0		0	194.00
	07951 SPORTS MEDI CI NE	0	0		0	194.01
	07952 UNUSED SPACE	310, 447	0	310, 4	14 /	194.02
200.00	07953 LAFAYETTE HHA BRANCH Cross Foot Adjustments	0			0	194. 03 200. 00
200.00	Negative Cost Centers	0	0		Ō	201.00
202.00	TOTAL (sum lines 118 through 201)	36, 462, 461	0	36, 462, 4	161	202.00

Health Financial	Systems PITAL RELATED COSTS	FRANCI SCAN HEAL	TH RENSSELAER	CN: 15-1324 P	In Lie eriod:	u of Form CMS-: Worksheet B	2552-10
				Fi To	rom 01/01/2023	Part II Date/Time Pre	pared:
			CAPI TAL REI	LATED COSTS		5/29/2024 8:5	6 am
Cost	Center Description	Directly Assigned New Capital	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFI TS DEPARTMENT	
		Related Costs 0	1.00	2.00	2A	4.00	
	RVICE COST CENTERS						
2.00 00200 CAP IF 4.00 00400 EMPL0 5.00 00500 ADMI IF 7.00 00700 OPER 8.00 00800 LAUNI 9.00 00900 HOUSI 10.00 01000 DI ET/ 11.00 01100 CAFET 13.00 01300 NURSI 14.00 01400 CENTI 15.00 01500 PHARI 16.00 01600 MEDI	ARY TERIA ING ADMINISTRATION RAL SERVICES & SUPPLY		9, 576 184, 830 197, 548 18, 841 24, 393 22, 149 27, 748 1, 528 51, 306 13, 074 19, 211	121, 445 129, 803 12, 380 16, 028 14, 553 18, 233 1, 004 33, 711	15, 868 306, 275 327, 351 31, 221 40, 421 36, 702 45, 981 2, 532 85, 017 21, 665 31, 834	15, 868 1, 202 722 9 530 65 275 218 23 509 0	9.00 10.00 11.00 13.00 14.00 15.00
30.00 03000 ADUL	TS & PEDI ATRI CS	0	122, 694	80, 618	203, 312	2, 569	1
	NSIVE CARE UNIT NARY CARE UNIT	0	0	0	0	0	
ANCI LLARY	SERVICE COST CENTERS		0	0	0	0	52.00
50.00 05000 0PER/ 54.00 05400 RADI (ATI NG ROOM OLOGY-DI AGNOSTI C	0	109, 167 70, 051	46, 028	180, 897 116, 079	1, 148 1, 740	
60.00 06000 LABO	RATORY D STORING, PROCESSING & TRANS.	0	33, 766 1, 218		55, 953 2, 018	0 47	60.00 63.00
	I RATORY THERAPY	0	47, 079		78, 013	964	
	I CAL THERAPY	0	89, 657		148, 567	692	1
	ICAL THERAPY- WHEATFIELD PATIONAL THERAPY	0	109, 381 5, 146	71, 871 3, 381	181, 252 8, 527	445 236	1
	PATIONAL THERAPY PATIONAL THERAPY- WHEATFIELD	0	23, 522		8, 527 38, 977	131	
68.00 06800 SPEE	CH PATHOLOGY	0	4, 358		7, 222	153	
	CH PATHOLOGY- WHEATFIELD	0	15, 259		25, 285	222	
	TROCARDI OLOGY TROENCEPHALOGRAPHY	0	0	0	0	0	69.00 70.00
	CAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
	. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
	S CHARGED TO PATIENTS	0	0	0	0	0	
74.00 07400 RENAI 77.00 07700 ALL00	L DIALYSIS GENEIC HSCT ACQUISITION	0	0	0	0	0	74.00 77.00
	T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
OUTPATI ENT	SERVICE COST CENTERS		-	-			
		0	17, 910 24, 739				
88. 01 08801 RURAI 90. 00 09000 CLI NI	L HEALTH CLINIC II	0	24, 739 154, 335		40, 994 255, 744	399 1, 444	
90. 01 09001 WOUNI		0	12, 871		21, 328	51	90.01
91.00 09100 EMER		0	90, 970	59, 773	150, 743	1, 766	
	RVATION BEDS (NON-DISTINCT PART				0		92.00
	BURSABLE COST CENTERS LANCE SERVICES	0	0	0	0	0	95.00
	R REIMBURSABLE COST CENTERS	0	0	0	0	0	
101.00 10100 HOME		0	0	0	0		101.00
	I D TREATMENT PROGRAM RPOSE COST CENTERS	0	0	0	0	0	102.00
113.00 11300 I NTE							113.00
	LATORY SURGICAL CENTER (D. P.)	0	0	0	0	0	115.00
116.00 11600 H0SPI		0	0	0	0		116.00
	OTALS (SUM OF LINES 1 through 117) SABLE COST CENTERS	0	1, 502, 327	987, 129	2, 489, 456	15, 868	118.00
	, FLOWER, COFFEE SHOP & CANTEEN	0	3, 283	2, 157	5, 440	0	190.00
	ICIANS' PRIVATE OFFICES	0	0	0	0		192.00
194.0007950 ALTE		0	0	0	0		194.00
194. 01 07951 SPOR 194. 02 07952 UNUS		0	0 60, 285	0	0 60, 285		194. 01 194. 02
194. 02 07952 0NUSE 194. 03 07953 LAFA		0	00, 285 N	0	00, 285 N		194. 02 194. 03
200.00 Cross	s Foot Adjustments				0		200. 00
	tive Cost Centers		0	0	0		201.00
202.00 TOTAI	L (sum lines 118 through 201)	0	1, 565, 895	989, 286	2, 555, 181	15, 868	202.00

Heal th	Financial Systems	FRANCI SCAN HEALT	TH RENSSELAER		In Lie	u of Form CMS-:	2552-10
ALLOCA	TION OF CAPITAL RELATED COSTS		Provider C	F	eriod: rom 01/01/2023 o 12/31/2023	Worksheet B Part II Date/Time Pre 5/29/2024 8:5	pared: 6 am
	Cost Center Description	ADMI NI STRATI VE & GENERAL	PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	
		5.00	7.00	8.00	9.00	10.00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-BEDG & FIXT						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMI NI STRATI VE & GENERAL	307, 477					5.00
7.00	00700 OPERATION OF PLANT	27, 191	355, 264				7.00
8.00	00800 LAUNDRY & LINEN SERVICE	494	5, 702				8.00
9.00	00900 HOUSEKEEPI NG	8, 273	7, 382				9.00
10.00	01000 DI ETARY	1, 597	6, 703			46, 176	1
11.00	01100 CAFETERI A	4, 787	8, 397	0	1, 389	0	11.00
13.00	01300 NURSING ADMINISTRATION	4, 857	463		77	0	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	799	15, 526	3, 806	2, 568	0	14.00
15.00	01500 PHARMACY	12, 576	3, 957			0	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	396	5, 814	0	962	0	16.00
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	1 1		1			
30.00	03000 ADULTS & PEDIATRICS	26, 540	37, 130		6, 142	46, 176	
31.00	03100 I NTENSI VE CARE UNI T	0	0			0	
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	11, 184	33, 036	27, 540	5, 465	0	50.00
50.00 54.00	05400 RADI OLOGY-DI AGNOSTI C	20, 799	33, 036 21, 199			0	
60.00	06000 LABORATORY	30, 237	10, 218			0	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	603	369			0	
65.00	06500 RESPI RATORY THERAPY	11, 231	14, 247		-	0	
66.00	06600 PHYSI CAL THERAPY	9, 567	27, 132			0	
66. 01	06601 PHYSI CAL THERAPY- WHEATFI ELD	7, 144	33, 102	0		0	66. 01
67.00	06700 OCCUPATI ONAL THERAPY	2, 687	1, 557	0	258	0	67.00
67.01	06701 OCCUPATIONAL THERAPY- WHEATFIELD	1, 967	7, 118	0	1, 178	0	67.01
68.00	06800 SPEECH PATHOLOGY	1, 771	1, 319	0	218	0	68.00
68.01	06801 SPEECH PATHOLOGY- WHEATFIELD	2, 772	4, 618			0	
69.00	06900 ELECTROCARDI OLOGY	0	0			0	
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0			0	
71.00	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	8,645	0	0		0	
72.00 73.00	07200 I MPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	1, 767 42, 449	0		0	0	
74.00	07400 RENAL DI ALYSI S	42, 449	0	0	0	0	
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0	0	-	-	0	
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0	0			0	
	OUTPATIENT SERVICE COST CENTERS			-			
88.00	08800 RURAL HEALTH CLINIC	3, 980	5, 420	0	897	0	88.00
88. 01	08801 RURAL HEALTH CLINIC II	4, 918	7,487	0	1, 239	0	88. 01
90.00	09000 CLI NI C	18, 914	46, 705			0	
90.01	09001 WOUND CARE	928	3, 895			0	
91.00	09100 EMERGENCY	37, 549	27, 530	276	4, 554	0	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
05 00	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	95.00
	09850 OTHER REIMBURSABLE COST CENTERS	0	0				98.00
	10100 HOME HEALTH AGENCY	0	0	0	-		101.00
	10200 OPI OI D TREATMENT PROGRAM	0	0	0	-		102.00
102100	SPECIAL PURPOSE COST CENTERS			<u> </u>			102100
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		306, 622	336, 026	37, 426	53, 424	46, 176	118.00
	NONREI MBURSABLE COST CENTERS			-		-	
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	105	994	0	164		190.00
	19200 PHYSI CI ANS' PRI VATE OFFI CES 07950 ALTERNACARE	0	0	0	0		192.00
	07950 ALTERNACARE 07951 SPORTS MEDICINE		0				194. 00 194. 01
	07951 SPORTS MEDICINE 07952 UNUSED SPACE	750	18, 244		3, 018		194. 01 194. 02
	07952 UNUSED SPACE 07953 LAFAYETTE HHA BRANCH	/ 50	10, 244		3, 018		194. 02 194. 03
200.00		0	0		0	0	200.00
200.00		0	Ω	n	0	n	201.00
202.00		307, 477	355, 264	37, 426	56, 606		202.00
	- · ·						

Health Financial Systems F ALLOCATION OF CAPITAL RELATED COSTS	RANCI SCAN HEAL	TH RENSSELAER	CN: 15-1324 Pe	In Lie	u of Form CMS-: Worksheet B	2552-10
				rom 01/01/2023	Part II Date/Time Pre	
Cost Center Description	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY	5/29/2024 8:5 MEDI CAL RECORDS & LI BRARY	
	11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS	1	1				
1.00 00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						2.00 4.00
5. 00 00500 ADMI NI STRATI VE & GENERAL						5.00
7.00 00700 OPERATION OF PLANT						7.00
8.00 00800 LAUNDRY & LINEN SERVICE						8.00
9.00 00900 HOUSEKEEPI NG						9.00
10. 00 01000 DI ETARY	(0.000					10.00
11. 00 01100 CAFETERIA 13. 00 01300 NURSI NG ADMI NI STRATI ON	60, 829 1, 071					11.00 13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY	115					14.00
15.00 01500 PHARMACY	2, 504			41, 866		15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	0	0	0	0	39, 006	16.00
INPATIENT ROUTINE SERVICE COST CENTERS	10 754	0.7/4			4 474	0.00
30. 00 03000 ADULTS & PEDI ATRI CS 31. 00 03100 I NTENSI VE CARE UNI T	12, 754		0	0	1, 176 0	30.00 31.00
32. 00 03200 CORONARY CARE UNIT				0	0	32.00
ANCI LLARY SERVICE COST CENTERS						02.00
50.00 05000 OPERATI NG ROOM	5, 650	722	0	0	1, 026	50.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	8, 563			0	6, 017	1
	0		-	0	5, 177	1
63. 00 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 65. 00 06500 RESPI RATORY THERAPY	0 4, 746	-	0	0	108 1, 062	
66. 00 06600 PHYSI CAL THERAPY	3, 409		-	0	1, 119	
66.01 06601 PHYSI CAL THERAPY- WHEATFI ELD	2, 192		0	0	733	
67.00 06700 OCCUPATI ONAL THERAPY	1, 160	0	0	0	261	67.00
67.01 06701 OCCUPATIONAL THERAPY- WHEATFIELD	646		0	0	126	
68.00 06800 SPEECH PATHOLOGY	752		0	0	108	
68. 01 06801 SPEECH PATHOLOGY- WHEATFIELD 69. 00 06900 ELECTROCARDI OLOGY	1,093		0	0	226 0	68.01 69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY		0	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	82, 594	0	1, 734	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	16, 887	0	620	
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	41, 866	13, 697	73.00
74.00 07400 RENAL DIALYSIS 77.00 07700 ALLOGENEIC HSCT ACQUISITION			0	0	0	74.00 77.00
78.00 07800 CAR T-CELL IMMUNOTHERAPY			-	0	0	
OUTPATIENT SERVICE COST CENTERS						/0/00
88.00 08800 RURAL HEALTH CLINIC	0		-	0	52	88.00
88.01 08801 RURAL HEALTH CLINIC II	0	0	-	0	94	
90. 00 09000 CLINIC 90. 01 09001 WOUND CARE	7,200		0	0		90.00 90.01
90. 01 09001 WOOND CARE 91. 00 09100 EMERGENCY	252 8, 722		0	0	3, 421	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0,,22	2,107			0, 121	92.00
OTHER REIMBURSABLE COST CENTERS	1	1		1		
95. 00 09500 AMBULANCE SERVICES	0		-	0	0	•
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	0	-	0		98.00 101.00
102.0010200 OPI OI D TREATMENT PROGRAM		-	-	0		101.00
SPECIAL PURPOSE COST CENTERS				0		102.00
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	0	0		116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	60, 829	9, 218	99, 481	41, 866	39,006	118.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	Ō	0	192.00
194. 00 07950 ALTERNACARE	0	0	0	О		194.00
194. 01 07951 SPORTS MEDI CI NE	0	0	0	0		194.01
194.0207952 UNUSED SPACE		0	0	0		194. 02 194. 03
194.03 07953 LAFAYETTE HHA BRANCH 200.00 Cross Foot Adjustments		0	0	0	0	200.00
201.00 Negative Cost Centers	0	о	8, 373	О	0	200.00
202.00 TOTAL (sum lines 118 through 201)	60, 829	9, 218		41, 866		202.00

Provider Provider Devider	Heal th	Financial Systems	RANCI SCAN HEAL	_TH RENSSELAER		In Li	eu of Form CMS-2552-10
Internet Cost Conter Description Subtoral Internet A Reliable Cost All attents (All attents) Internet (All attents) Internet (All attents) 1 Cost Conter Description Subtoral Reliable Cost (All attents) Internet (All attents) Internet (All attents) 2 Cost Conter Description Subtoral Reliable Cost (All attents) Internet (All attents) 1 Cost Conter Description Subtoral Reliable Cost (All attents) Subtoral Internet (All attents) 1 Cost Conter Description Subtoral Reliable Cost (All attents) Subtoral Subtoral Subtoral 1 Cost Conter Description Subtoral Subtoral Subtoral Subtoral Subtoral 1 Cost Conter Description Subtoral Subtoral Subtoral Subtoral Subtoral 1 Cost Conter Description Subtoral Subtoral Subtoral Subtoral Subtoral Subtoral 1 Cost Cost Cost Cost Cost Cost Cost Cost	ALLOCA	TION OF CAPITAL RELATED COSTS		Provider C	CN: 15-1324		
Desit Contor Disort ption Sublotat Intern & Registents Out, Strington Total Registents Out, Strington 1.00 DOSD SAMUEL COST CURTARS 24.00 75.00 76.00 1.00 1.00 DOSD SAMUEL COST CURTARS 72.00 75.00 20.00 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>3 Date/Time Prepared:</td>							3 Date/Time Prepared:
UNING STRATE CAST CONTENTS 1.00 COTOLOGYAP REL. COSTS JAVELE ESLIPATION 1.00 2.00 DOZOD CAP REL. COSTS JAVELE ESLIPATION 2.00 7.00 DOZOD CAP REL. COSTS JAVELE ESLIPATION 5.00 7.00 DOZOD CAP REL. COSTS JAVELE ESLIPATION 5.00 7.00 DOZOD COPERATION OF PLATI 8.00 8.00 DOZOD COPERATION OF PLATI 8.00 8.00 DOZOD CONTENTS LEXTURE SERVICE 8.00 9.00 DOZOD CONTENTS LEXTURE SERVICE 8.00 9.00 DOZOD CONTENTS LEXTURE SERVICE 9.00 9.00 DOZOD CORDINARY CONTENTION 11.00 11.00 DIADIA THE MUTHIN STRATION 11.00 11.00 DIADIA THE MUTHIN STRATION<		Cost Center Description		Residents Cost & Post Stepdown			
1.00 00100 (AP REL DOSTS-BUDG & FIXT 1.00 2.00 00200 (APREL DOSTS-PUBLE EQUIP 2.00 2.00 00200 (APREL DOSTS-PUBLE EQUIP 4.00 2.00 00200 (APREL DOSTS-PUBLE EQUIP 4.00 2.00 00200 (APREL DOSTS-PUBLE EQUIP 5.00 2.00 00200 (APREL DOSTS-PUBLE EQUIP 5.00 0.00 00200 (DISTS FIF)NO. FP HAT 7.00 0.00 00200 (DISTS FIF)NO. FP HAT 7.00 0.00 00200 (DISTS FIF)NO. FP HAT 7.00 0.0000 (DISTS FIF)NO. FP HAT 7.00 1.000 (DIDGO (DISTS FIF)NO. FP HAT 7.00 1.000 (DIDGO (DISTS FIF)NO. FP HAT 11.00 1.000 (DIDGO (DISTS FIF)NO. FOR ALTINKS 343, 661 343, 661 0.0000 (DIDTS FIF)NO. FP HAT 0 0 0 0.0000 (DIDTS FIF)NO. FP HAT 0 0 0 32.00 0.0000 (DIDTS FIF)NO. FP HAT 0 0 0 0 32.00 0.0000 (DIDTS FIF)NO. FP HAT 0 0 0 0 0 0 0 0 0		CENEDAL SEDVICE COST CENTEDS	24.00	25.00	26.00		
4. 00 00400_ENULOPE BENEFITS DEPARTMENT 4. 00 5.00 00500_0PERATION OF PLANT 7.00 5.00 00500_0PERATION OF PLANT 7.00 5.00 00500_0PERATION OF PLANT 7.00 5.00 00500_0PERATION OF PLANT 10.00 5.00 00500_0PERATION STRATION 11.00 5.00 00500_0PERATION STRATION 11.00 5.00 00500_0PERATION STRATION 11.00 5.00 00500_0PERATION STRATION 0 0 5.00 00500_0PERATION STRATION 0 0 0 5.00 00500_0PERATION STRATION 17.05 343.661 30.00 5.00 00500_0PERATION STRATION 17.05 343.661 30.00 5.00 05000_0PERATION STRATION 17.05 30.00 30.00 5.00 0	1.00						1.00
11.00 01100 CAFETERIA 11.00 13.00 01300 UNESING AMINISTRATION 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 14.00 15.00 01300 UNESING AMINISTRATION 14.00 16.00 01400 CENTRAL SERVICE COST CENTERS 343.601 343.601 30.00 03000 INTESIN VE CARE UNIT 0 0 0 31.00 03000 CORMARY CARE UNIT 0 0 0 32.00 03000 INTESIN VE CARE UNIT 0 0 0 32.00 32.00 03000 INTESIN VE CARE UNIT 0 0 0 32.00 32.00 03000 INTESIN VE CARE UNIT 0 0 0 32.00 32.00 03000 INTESIN VE CARE UNIT 0 0 0 32.00 3400 LLARY SERVICE COST CENTERS 0 110.627 64.00 66.00 6	4.00 5.00 7.00 8.00 9.00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING					4.00 5.00 7.00 8.00 9.00
14 00 0 1400 CENTRAL SERVICES & SUPPLY 14.00 14.00 14.00 15 00 0 1500 PHARMACY 15.00 15.00 15.00 15.00 16 00 0 1400 CENTRA NUCLES & SUPPLY 34.3,661 0 34.3,661 30.00<							
15.00 01500 PHARMARCY 15.00							
16.00 0 TAGO MEDICAL RECORDS & LIBRARY 10.00 10.00 10.00 0 33000 AUULTS & PEDIATRICS 343,661 0 33.00 32.06 0 32.06 0 32.06 0.00 32.06 0.00 32.06 0.00							
00.000 032000 AUULTS & PEDIATRICS 343,661 0 343,661 30.00 31.00 03200 CRROWARY CARE UNIT 0 0 0 32.00 33.00 CORROWARY CARE UNIT 0 0 0 0 32.00 MOLLIARY SERVICE COST CENTRES							
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54.00 0s400 RADIOLOGY - DI AGNOSTIC 179, 632 0 170, 632 54.00 60.00 0cool LABORATORY 103, 275 0 3.706 63.00 65.00 0c500 DESON STORING, PROCESSING & TRANS. 3.206 0 3.706 63.00 65.00 0c500 DESON ESPIR ATORY THERAPY 112, 620 0 112, 620 65.00 66.00 DEGOD ESPIR ATORY THERAPY 144, 674 0 93, 344 66.01 66.01 DEGOD OCUPATI ONAL THERAPY 14, 686 0 14, 686 67.00 67.01 DEGOD OCUPATI ONAL THERAPY 14, 686 0 14, 686 68.01 69.01 DEGOD SPEECH PATHOLOCY 11, 543 0 11, 543 68.01 69.00 DEGOD CLECTEROCARDI OLOCY 0 0 0 70.00 71.00 DELCTEROCARDI OLOCY 98, 012 98, 012 73.00 73.00 72.00 OT300 DRUGS CHARGED TO PATI ENTS 99, 274 19, 774 72.00 73.00	02.00			<u>, </u>			
60.00 0c000 LABORATORY 103,275 0 103,275 60.03,275 60.00 65.00 66.00 14.466 67.00 67.00 67.00 67.00 67.00 67.00 67.00 68.00 68.00 68.00 68.00 68.00 68.00 68.00 68.00 68.00 68.00 69.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00							
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67.01 06701 0CCUPATIONAL THERAPY- WHEATFIELD 50, 143 0 50, 143 67, 01 08.00 06800 SPECH PATHOLOGY WHEATFIELD 34, 980 0 34, 980 68, 01 09.00 06901 SPECH PATHOLOGY WHEATFIELD 34, 980 0 34, 980 68, 01 09.00 00 0 0 0 0 70, 00 70, 00 01.00 07000 ELECTROCARDIOLOGY WHEATFIELD 34, 980 0 34, 980 68, 01 07.00 07000 ELECTROCARDIOLOGY WHEATFIELD 92, 973 0 92, 973 71, 00 71, 00 01.00 07000 RELACTROCARDIOLOGY PATHENTS 98, 012 0 98, 012 73, 00							
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68.01 b68.01 SPECCH PATHOLOGY-WHEATFIELD 34,980 68.01 69.00 06900 ELCETROCARDIOLOGY 0 0 0 71.00 D010CAL SUPPLIES CHARGE TO PATIENT 92,973 71.00 72.00 72.00 7200 IMPL. DEV. CHARGE TO PATIENTS 99,012 73.00 73.00 72.00 7000 RELCETROCHARDE TO PATIENTS 99,012 73.00 73.00 73.00 700 RENAL DIALYSIS 98,012 98,012 73.00 74.00 7700 ALLOGENEIC HSCT ACQUISITION 0 0 0 74.00 77.00 0700 RENAL DIALYSIS 98,012 98,012 73.00 77.00 0800 0000 CART-CELL IMMUNDHERAPY 0 0 0 77.00 77.00 0001700 0000 CLL I MICONTERRAPY 0 0 0 78.00 001700 0000 CLL I MICONTERRAPY 0 0 0 79.00 00000 00000 CLL I MICONTERRAPY 0 0 0 0 0 00000 00000 CLL I MICONTERRAPY 0 0 0 0 0 0							
70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 70. 00 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 92, 973 0 92, 973 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 19, 274 0 19, 274 73. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 98, 012 98, 012 73. 00 73. 00 74. 00 7040 RINAL DALYSIS 0 0 0 74. 00 70. 00 7700 ALLOGENEIC HSCT ACQUISTION 0 0 0 77. 00 70. 00 7700 ALLOGENEIC HSCT ACQUISTION 0 0 0 78. 00 00. 000 00000 RURAL HEALTH CLINIC T 45, 131 05, 131 88. 00 88. 01 08801 RUBRAL HEALTH CLINIC T 342, 024 0 342, 024 90. 01 90. 01 090001 WOUND CARE 27, 309 0 27, 309 92. 00 92. 00 095000 AMBULANCE SERVICON							
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 92,973 0 92,973 71.00 72.00 07300 IMPL. DEV. CHARGED TO PATIENTS 19,274 0 19,274 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 98,012 0 96,012 73.00 74.00 07400 RENAL DIALYSIS 0 0 0 74.00 77.00 700 ALGGENIC HSC ACQUISITION 0 0 0 74.00 77.00 700 ALGGENIC HSC TACQUISITION 0 0 0 74.00 77.00 700 ALGGENIC CENTER S 88.00 0 88.00 88.01 90.00 90.01 90.00 0000 CLINIC 40,335 0 40,335 88.00 88.00 08801 RURAL HEALTH CLINIC I 342,024 342,024 90.00 90.01 90.01 90.01 90.01 91.00 9000 27,309 91.00 91.00 91.00 9000 EKENCY 237,018 0 237,018 237,018 92.00 92.00			C			0	
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DUTPATI ENT SERVICE COST CENTERS Image: Cost Centers 88.00 08800 RURAL HEALTH CLINIC 40,335 0 40,335 88.01 88.01 09000 CLINIC 1 55,131 0 55,131 90.00 09000 CLINIC 342,024 0 342,024 90.01 91.00 09010 ENERCENCY 27,309 27,309 90.01 90.01 92.00 09200 DBSERVATION BEDS (NON-DISTINCT PART 0 237,018 92.00 92.00 95.00 9500 ANBULANCE SERVICES 9 92.00 92.00 98.00 985.00 0 0 0 95.00 98.00 98.00 98.00 98.00 98.00 98.00 98.00 0 0 0 0 101.00 101.00 101.00 101.00 101.00 102.00 96.00 96.00 102.00 102.00 102.00 98.00 102.00 102.00 102.00 102.00 102.00 102.00 102.00 100.00 100.00<			-				
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194.03 07953 LAFAYETTE HHA BRANCH 0 0 0 194.03 200.00 Cross Foot Adjustments 0 0 0 200.00 200.00 200.00 200.00 200.00 200.00 200.00 201	194.01	07951 SPORTS MEDI CI NE	C	0 0)	0	194. 01
200.00 Cross Foot Adjustments 0 0 0 200.00 201.00 Negative Cost Centers 8, 373 0 8, 373 201.00			82, 297		82,	297	
201.00 Negative Cost Centers 8, 373 0 8, 373 201.00						0	
202.00 TOTAL (sum lines 118 through 201) 2,555,181 0 2,555,181 202.00			8, 373		8,	373	
	202.00	TOTAL (sum lines 118 through 201)	2, 555, 181	0	2, 555,	181	202.00

	Financial Systems ALLOCATION - STATISTICAL BASIS	FRANCI SCAN HEAL	Provider C		Period: From 01/01/2023	eu of Form CMS- Worksheet B-1	
					To 12/31/2023	Date/Time Pre 5/29/2024 8:5	
		CAPI TAL REI	LATED COSTS				
	Cost Center Description	BLDG & FI XT (SQUARE FEET)	MVBLE EQUI P (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS	Reconciliation	ADMI NI STRATI VE & GENERAL (ACCUM. COST)	
		1.00	2.00	SALARIES) 4.00	5A	5.00	
	GENERAL SERVICE COST CENTERS		2100		0.11	0100	
00 00 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUI P 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL	131, 148 802 15, 480	126, 099 802 15, 480	11, 003, 942 833, 550	-11, 758, 141		
00 00 00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA	16, 545 1, 578 2, 043 1, 855 2, 324	1, 578 2, 043 1, 855	6, 513 367, 323 45, 173	7 0 7 0 3 0	39, 692 664, 734 128, 307	8. (9. (10. (
00 00 00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	128 4, 297 1, 095 1, 609	128 4, 297 1, 095	150, 846 16, 150 352, 806	5 0 0 0 5 0	390, 232 64, 212 1, 010, 432	13. 14. 15.
00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS 03100 I NTENSI VE CARE UNI T	10, 276		1, 780, 380			
00	03200 CORONARY CARE UNIT ANCI LLARY SERVI CE COST CENTERS	0	0	(0 0	0	32.
00 00	05000 OPERATI NG ROOM 05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY 06300 BLOOD STORI NG, PROCESSI NG & TRANS.	9, 143 5, 867 2, 828 102	5, 867 2, 828	1, 206, 45 ⁻ (1 0 0 0	1, 671, 161 2, 429, 453	54. 60.
00 00	06500 PEOSID STORTING, PROCESSING & TRANS. 06500 PEYSI CAL THERAPY 06601 PHYSI CAL THERAPY- WHEATFI ELD	3, 943 7, 509 9, 161	3, 943	668, 700 480, 23	0 0 1 0	902, 414 768, 661	65. 66.
00 01 00	06700 OCCUPATIONAL THERAPY 06701 OCCUPATIONAL THERAPY- WHEATFIELD 06800 SPEECH PATHOLOGY 06801 SPEECH PATHOLOGY- WHEATFIELD	431 1, 970 365 1, 278	431 1, 970 365	163, 480 90, 987 105, 885	0 7 0 5 0	215, 900 158, 059	67. 67. 68.
00 00 00	06900 ELECTROCARDIOLOGY 07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0 0 0 0 0	0 0 694, 587	69. 70. 71.
00 00 00				(0 0	3, 410, 034 0 0	73. 74. 77.
	OUTPATIENT SERVICE COST CENTERS	0	0		<u> </u>	0	/0.
01	08801 RURAL HEALTH CLINIC II	1, 500 2, 072 12, 926	2, 072	276, 881	1 0	395, 143	88.
00	09001 WOUND CARE 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 078 7, 619					
00	OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 09850 OTHER REIMBURSABLE COST CENTERS	0	0	(-	-	
2.00	10100 HOME HEALTH AGENCY 10200 OPIOID TREATMENT PROGRAM SPECIAL PURPOSE COST CENTERS	0	0	(101. 102.
3. 00 5. 00	11300 INTEREST EXPENSE 11500 AMBULATORY SURGICAL CENTER (D. P.) 11600 HOSPICE	0	0				113. 115. 116.
3. 00	SUBTOTALS (SUM OF LINES 1 through 117 NONREIMBURSABLE COST CENTERS		125, 824	11, 003, 942	-11, 758, 141	24, 635, 580	118.
2.00 4.00 4.01 4.02	0 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 07950 ALTERNACARE 1 07951 SPORTS MEDI CI NE 2 07952 UNUSED SPACE	275 0 0 0 5, 049	0 0 0		0 0 0 0 0 0	0 0 0	192. 194. 194.
1.03 0.00 1.00 2.00	Negative Cost Centers	0 1, 565, 895	0 989, 286	2, 783, 522) O	0 11, 758, 141	194. 200. 201. 202.
3. 00 4. 00	Part I) Unit cost multiplier (Wkst. B, Part I				7	0. 475955 307, 477	203.

Health Financial Systems	FRANCI SCAN HEAL	TH RENSSELAER		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider C		Period: From 01/01/2023	Worksheet B-1	
				To 12/31/2023		
	CAPI TAL REI	LATED COSTS				
Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS	Reconciliation	ADMI NI STRATI VE & GENERAL	
			DEPARTMENT (GROSS		(ACCUM. COST)	
			SALARI ES)			
	1.00	2.00	4.00	5A	5.00	
205.00 Unit cost multiplier (Wkst. B, Part			0. 00144	2	0. 012446	205.00
206.00 NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207.00 NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00

Cost Center Description OPERATION OF PLANT (SOUARE FEED) LANNORY (SOUARE FEED) LANNORY (SOUARE FEED) HOUSEKEEPING (SOUARE FEED) 1.00 00000 (AP REL COSTS BLOS & TIXT 2.00 8.00 9.00 9.00 1.00 00000 (APR REL COSTS BLOS & TIXT 2.00 2.043 96.321 0.00 00000 (ANNIN STRATIVE & GURGAN 4.00 2.043 0 9.4,700 1.00 01000 (SEKEEPIN K) 2.043 0 2.324 0 2.324 1.00 01000 (SEKEEPING) 2.128 1.607 0 2.043 0 2.324 0 2.324 1.00 01000 (SEKEEPING) 2.18848Y 1.609 0 1.609 1.609 1.609 0.0000 (ANURSI KA ADMINISTRATION 1.128 0 0 0.000 1.609 1.609 1.609 1.609 1.609 1.609 1.609 1.609 1.609 1.609 1.609 1.609 1.609 </th <th>In Lie eriod:</th> <th>wof Form CMS-2</th> <th>2552-1</th>	In Lie eriod:	wof Form CMS-2	2552-1
Cost Center Description OPERATION OF PLANT LAUNDRY & LINEW SERVICE (SUMAR FEET) (SUMAR FEET	rom 01/01/2023		nared
CHART LINEN SERVICE (SQUARE FEET) (MOUNDRY) (SQUARE FEET) (MOUNDRY) 1.00 DOTOD CAP REL COST CENTERS 7.00 8.00 9.00 9.00 1.00 DOTOD CAP REL COST SHUELS EQUIP IT 9.00 9.00 9.00 1.00 DOTOD CAP REL COST SHUELS EQUIP IT 9.00 9.00 9.00 1.00 DOTOD OFFRATION OF PLANT 9.8,321 9.01 9.02 0.00 DOTOD OFFRATION OF PLANT 9.8,321 0 1.855 0.00 DOTOD OFFRATION OF PLANT 9.8,321 0 1.855 1.00 DITOD CAPETERIA 2.324 0 2.324 1.00 DITOD CAPETERIA 1.059 1.02 1.069 1.00 DITOD CAPETERIA 1.057 1.07 1.069 1.00 DITOD CAPETERIA 1.02,77 2.07 1.02,783 0.00 DOTOD OFFANT CONTROLES & LIBRARY 1.02,776 2.02,374 10.276 0.00 DOTOD OFFANT CONTROLES & LIBRARY 1.00,776 2.03,000 2.02,374 10.2		5/29/2024 8:56	
Image: Control of the contro	DI ETARY (MEALS SERVED)	CAFETERI A (GROSS	
Description 7.00 8.00 9.00 1.00 ODTOD CAP REL COSTS CENTERS		SALARI ES)	
1.00 00100 CAP REL COSTS-BLOG & FIXT 0.00 00200 CAPA REL COSTS-BLOG & FIXT 0.00 00200 CAPA REL COSTS-BLOG & FIXT 0.00 00200 CAMIN STRATI VE & GENERAL 0.00 00200 CAUNDRY & LINES SERVICE 1,578 11.00 01000 CAFETERI A 2,324 13.00 01300 CAFETERI A 2,324 13.00 01400 CENTRAL SERVICES & SUPPLY 4,297 15.00 01400 CENTRAL SERVICES & SUPPLY 1,059 14.00 01400 CENTRAL SERVICE COST CENTERS 0 10.01 01400 CENTRAL SERVICE COST CENTERS 0 10.01 03000 ADULIS & HEDI ATRICS 10,276 10.01 03000 CAROMARY CARE UNI T 0 0 10.01 03000 CAROMARY CARE UNI T 0 0 10.01 03000 CAROMARY CARE UNI T 0 0 11.01 03000 CAROMARY CARE UNI T 0 0 10.01 030	10.00	11.00	
2.00 002001 CAP REL COSTS-MVBLE EQUIP			1.0
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200.00Cross Foot Adjustments201.00Negative Cost Centers202.00Cost to be allocated (per Wkst. B,3, 224, 548110, 3361, 048, 119	0	0	194.0
Negative Cost Centers Addition Additing addition Addition <th< td=""><td>0</td><td></td><td>194.0</td></th<>	0		194.0
202.00 Cost to be allocated (per Wkst. B, 3, 224, 548 110, 336 1, 048, 119			200. 0 201. 0
	270, 743		
Part I)	AF 405005		
203.00 Unit cost multiplier (Wkst. B, Part I) 32.796127 0.672198 11.067782 204.00 Cost to be allocated (per Wkst. B, 355,264 37,426 56,606	25. 185395 46, 176		
Part II)			
205.00 Unit cost multiplier (Wkst. B, Part 3.613307 0.228010 0.597740	4. 295442	0. 007098	205. 0

Health Financial Systems	FRANCI SCAN HEAL	TH RENSSELAER		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider C		Period:	Worksheet B-1	
				From 01/01/2023 Fo 12/31/2023	Date/Time Pre 5/29/2024 8:5	
Cost Center Description	OPERATI ON OF		HOUSEKEEPI NG		CAFETERI A	
	PLANT	LINEN SERVICE	(SQUARE FEET)	(MEALS SERVED)	(GROSS	
	(SQUARE FEET)	(POUNDS OF			SALARI ES)	
		LAUNDRY)				
	7.00	8.00	9.00	10.00	11.00	
206.00 NAHE adjustment amount to be allocated						206.00
(per Wkst. B-2)						
207.00 NAHE unit cost multiplier (Wkst. D,						207.00
Parts III and IV)						

	LLOCATION - STATISTICAL BASIS		TH RENSSELAER Provider CC		Period: From 01/01/2023	u of Form CMS-2552-1 Worksheet B-1
					0 12/31/2023	Date/Time Prepared: 5/29/2024 8:56 am
	Cost Center Description	NURSI NG ADMI NI STRATI ON (DI RECT NRSI NG HRS) 13. 00	CENTRAL SERVI CES & SUPPLY (COSTED REQUI S.) 14.00	PHARMACY (COSTED REQUI S.) 15.00	MEDI CAL RECORDS & LI BRARY (GROSS CHARGES) 16.00	<u>3/2//2024 0.30 dim</u>
	GENERAL SERVICE COST CENTERS	13.00	14.00	15.00	10.00	
15.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY INPATIENT ROUTINE SERVICE COST CENTERS	103, 658 0 0 0	836, 598 0 0	100		1.0 2.0 4.0 5.0 7.0 8.0 9.0 10.0 11.0 13.0 14.0 15.0 16.0
30.00	03000 ADULTS & PEDIATRICS	31, 056	0	(3, 409, 151	30. 0
31.00	03100 I NTENSI VE CARE UNI T	0	0	(0	31. 0
32.00	03200 CORONARY CARE UNIT ANCILLARY SERVICE COST CENTERS	0	0		0 0	32.0
50.00	05000 OPERATI NG ROOM	8, 121	0	(50.0
54.00 60.00 63.00 65.00 66.01 67.00 67.01 68.00 68.01 69.00 70.00 71.00 72.00 73.00 73.00 74.00 73.00 73.00 73.00 73.00 73.00 73.00	05400 RADIOLOGY-DIAGNOSTIC 06000 LABORATORY 06300 BLOOD STORING, PROCESSING & TRANS. 06500 RESPIRATORY THERAPY 06600 PHYSICAL THERAPY 06601 PHYSICAL THERAPY- WHEATFIELD 06700 OCCUPATIONAL THERAPY- WHEATFIELD 06700 OCCUPATIONAL THERAPY- WHEATFIELD 06800 SPEECH PATHOLOGY 06801 SPEECH PATHOLOGY- WHEATFIELD 06900 ELECTROCARDIOLOGY 07000 ELECTROCARDIOLOGY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS 07700 ALLOGENEIC HSCT ACQUISITION 07800 CAR T-CELL IMMUNOTHERAPY 0UTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC II 09000 CLINIC	8, 121 11, 522 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		17, 440, 885 15, 006, 714 311, 667 3, 079, 178 3, 243, 245 2, 123, 207 755, 604 364, 836 312, 728 656, 463 0 0 5, 024, 666 1, 797, 133 39, 790, 173 0 0 15, 024, 666 1, 797, 133 39, 790, 173 0 0 152, 128 271, 411 5, 907, 977	54. 0 60. 0 63. 0 65. 0 66. 0 67. 0 67. 0 68. 0 68. 0 68. 0 69. 0 70. 0 71. 0 72. 0 73. 0 74. 0 77. 0 78. 0 88. 0 88. 0 88. 0 90. 0
91.00 92.00	09001 WOUND CARE 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS	27, 626	0	(9, 916, 283	90. 0 91. 0 92. 0
	09500 AMBULANCE SERVICES 09850 OTHER REIMBURSABLE COST CENTERS	0	0 0	(-	95. 0 98. 0
	10100 HOME HEALTH AGENCY	0	0	(-	101.0
102.00	10200 OPI OI D TREATMENT PROGRAM SPECIAL PURPOSE COST CENTERS	0	0	(0 0	102. 0
115.00	11300 I NTEREST EXPENSE 11500 AMBULATORY SURGI CAL CENTER (D. P.) 11600 HOSPI CE	0 0 103, 658	0 0 836, 598	((100	0 0	113. 0 115. 0 116. 0 118. 0
192.00 194.00 194.01 194.02	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES 07950 ALTERNACARE 07951 SPORTS MEDICINE 07952 UNUSED SPACE 07953 LAFAYETTE HHA BRANCH Cross Foot Adjustments Negative Cost Centers	0 0 0 0 0 0 593, 368	0 0 0 0 0 295, 741	(((((((((() () () () () (190. 0 192. 0 194. 0 194. 0 194. 0 194. 0 200. 0 201. 0 202. 0
203.00 204.00	Part I) Unit cost multiplier (Wkst. B, Part I)	5. 724286 9, 218	0. 353504 107, 854		0. 001039	203. 0 204. 0
204.00		1 1				

Health Financial Systems	FRANCI SCAN HEAL	TH RENSSELAER		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider C	CN: 15-1324	Peri od:	Worksheet B-1	
				From 01/01/2023 To 12/31/2023		narad
			_	10 12/31/2023	Date/Time Pre 5/29/2024 8:5	6 am
Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL		
	ADMI NI STRATI ON	SERVICES &	(COSTED	RECORDS &		
		SUPPLY	REQUIS.)	LI BRARY		
	(DI RECT NRSI NG	(COSTED		(GROSS		
	HRS)	REQUIS.)		CHARGES)		
	13.00	14.00	15.00	16.00		
206.00 NAHE adjustment amount to be allocated						206.00
(per Wkst. B-2)						
207.00 NAHE unit cost multiplier (Wkst. D,						207.00
Parts III and IV)						

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 01/01/2023 To 12/31/2023	Worksheet C Part I Date/Time Pre 5/29/2024 8:5	pared: 6 am
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	Costs RCE Di sal I owance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	4, 205, 490		4, 205, 49	0 0	0	30.00
31. 00 03100 INTENSIVE CARE UNIT	0			0 0	0	
32. 00 03200 CORONARY CARE UNI T	0			0 0	0	32.00
ANCI LLARY SERVI CE COST CENTERS	1 1			1		
50. 00 05000 OPERATING ROOM	1, 920, 299		1, 920, 29		0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 904, 332		2, 904, 33		0	
50. 00 06000 LABORATORY	3, 725, 402		3, 725, 40		0	
53. 00 06300 BLOOD STORING, PROCESSING & TRANS.	76, 273		76, 27		0	
55. 00 06500 RESPI RATORY THERAPY	1, 560, 330	0			0	
56. 00 06600 PHYSI CAL THERAPY	1, 504, 780	0			0	
56. 01 06601 PHYSI CAL THERAPY- WHEATFI ELD	1, 275, 332	0	1, 275, 33		0	
57.00 06700 OCCUPATIONAL THERAPY	351, 124	0			0	
57.01 06701 0CCUPATIONAL THERAPY- WHEATFIELD	327, 189	0	327, 18		0	
58.00 06800 SPEECH PATHOLOGY	234, 575	0	234, 57		0	
58. 01 06801 SPEECH PATHOLOGY- WHEATFIELD	397, 500	0	397, 50		0	
59. 00 06900 ELECTROCARDI OLOGY	0			0 0	0	
70. 00 07000 ELECTROENCEPHALOGRAPHY	9			0	0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 275, 940		1, 275, 94		-	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	261, 670		261, 67		0	
73.00 07300 DRUGS CHARGED TO PATIENTS	6, 641, 349		6, 641, 34		0	
74.00 07400 RENAL DIALYSIS	0			0 0	0	
77.00 07700 ALLOGENEIC HSCT ACQUISITION 78.00 07800 CAR T-CELL IMMUNOTHERAPY	0			0 0 0 0	0	
78. 00 07800 CAR T-CELL IMMUNOTHERAPY OUTPATI ENT SERVICE COST CENTERS	0			0 0	0	/8.00
38. 00 08800 RURAL HEALTH CLINIC	537, 933		537, 93	3 0	0	88.00
38. 01 08800 RURAL HEALTH CLINIC	674, 381		674, 38		0	
20. 00 09000 CLINIC	3, 040, 417		3, 040, 41		0	•
20. 01 09001 WOUND CARE	160, 755		160, 75		0	
91. 00 09100 EMERGENCY	5, 052, 401		5, 052, 40		0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 408, 078		1, 408, 07		0	•
OTHER REIMBURSABLE COST CENTERS	1,100,070		1, 100, 07			72.00
25. 00 09500 AMBULANCE SERVICES	0			0 0	0	95.00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0			0 0	0	
101.00 10100 HOME HEALTH AGENCY	0			0	0	101.00
102.00 10200 OPI OI D TREATMENT PROGRAM	0			0		102.00
SPECIAL PURPOSE COST CENTERS	, -,			I		1
113.0011300 INTEREST EXPENSE						113.00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0			0	0	115.00
116. 00 11600 HOSPI CE	0			o	0	116.00
200.00 Subtotal (see instructions)	37, 535, 550	0	37, 535, 55	o o	0	200.00
	1 100 070		1 100 07	d ا	0	201 00
201.00 Less Observation Beds	1, 408, 078		1, 408, 07	8 1	0	201.00

Cost Center Description Inpatient Outpatie 1 Inpatient Outpatie 6.00 7.00 03000 ADULTS & PEDIATRICS 2,217,477 0 03000 ADULTS & PEDIATRICS 0 0.00 03000 CORNARY CARE UNIT 0 0.00 05000 PERATING ROOM 151,373 2,82 4.00 05400 RADI OLOGY-DI AGNOSTIC 394,513 17,04 0.00 06000 LABORATORY 1,196,842 13,80 3.00 064000 RESPI RATORY THERAPY 344,761 2,73 0.00 06000 PHYSI CAL THERAPY 149,168 3,09 5.01 06600 PHYSI CAL THERAPY 165,407 59 0.01 06701 OCUPATI ONAL THERAPY 165,407 59 0.01 06601 PHYSI CAL THERAPY 165,407 59 0.00 06800 SPEECH PATHOLOGY 0 36 0.00 06801 SPEECH PATHOLOGY 0 55 <		Period: From 01/01/2023 To 12/31/2023	Worksheet C Part I Date/Time Pre 5/29/2024 8:5	pared: 6 am
Cost Center Description Inpatient Outpatie 6.00 7.00 100 03000 ADULTS & PEDIATRICS 2, 217, 477 00 03200 CORNARY CARE UNIT 0 ANCILLARY SERVICE COST CENTERS 0 394, 513 17, 04 00 05000 OPERATING ROOM 151, 373 2, 82 00 05400 RADIOLOGY-DIAGNOSTIC 394, 513 17, 04 00 66300 BLOOD STORING, PROCESSING & TRANS. 31, 337 28 00 06500 RESPIRATORY THERAPY 149, 168 3, 09 0.00 06500 PESPIRATORY THERAPY 164, 07 59 0.00 06600 PHYSICAL THERAPY 164, 07 59 0.00 06600 SEPI RATORY THERAPY 164, 07 59 0.00 06600 PECH PATHOLOGY 20, 322 29 0.00 06600 SEECH PATHOLOGY 0 36 0.00 06800 SEECH PATHOLOGY 0 65 0.00	Title XVIII	Hospi tal	Cost	
INPATI ENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 2,217,477 0 03100 INTENSIVE CARE UNIT 0 00 03000 (CRONARY CARE UNIT 0 00 05000 (DERATING ROOM 151,373 2,82 00 04000 (RDIOLOGY-DIAGNOSTIC 394,513 17,04 00 06000 (LABORATORY 1,196,842 13,80 00 06300 (RESPI RATORY THERAPY 344,761 2,73 00 06600 (RESPI RATORY THERAPY 344,761 2,73 00 06600 PHYSI CAL THERAPY 149,168 3,09 00 06600 PHYSI CAL THERAPY 149,168 3,09 00 06600 PHYSI CAL THERAPY 149,168 3,09 00 06701 OCCUPATI ONAL THERAPY 165,407 59 00 06600 SPEECH PATHOLOGY 0 36 00 06800 SPEECH PATHOLOGY 0 36 00 07000 ELECTROCARDIOLOGY 0 0 00 07300 DRUGS CHARGED TO PATIENTS 1,149,549 38,64 00		6 Cost or Other Ratio	TEFRA I npati ent Rati o	
0.00 03000 ADULTS & PEDIATRICS 2, 217, 477 0.00 03100 INTENSIVE CARE UNIT 0 ANCILLARY SERVICE COST CENTERS 0 0 ANCILLARY SERVICE COST CENTERS 394, 513 17, 04 0.00 05400 RADIOLOGY-DI AGNOSTIC 394, 513 17, 04 0.00 06300 BLOOD STORING, PROCESSING & TRANS. 31, 337 28 0.00 06000 LABORATORY 344, 761 2, 73 0.00 06000 PHYSICAL THERAPY 344, 761 2, 73 0.00 06000 PHYSICAL THERAPY 165, 407 59 0.01 06601 PHYSICAL THERAPY WHEATFIELD 25 2, 12 0.00 06700 0CCUPATIONAL THERAPY WHEATFIELD 0 36 0.00 06801 SPEECH PATHOLOGY 20, 322 29 3.01 06801 SPEECH PATHOLOGY 0 0 0 0.00 70000 ELCTROENCEPHALOGRAPHY 0 0 0 0.00	00 8. 00	9.00	10.00	
I. 00 03100 INTENSI VE CARE UNIT 0 ANCI LLARY SERVI CE COST CENTERS 0 ANCI LLARY SERVI CE COST CENTERS 394, 513 0. 00 05400 PADI OLOGY-DI AGNOSTI C 394, 513 0. 00 06000 LABORATORY 1, 196, 842 13, 80 0. 00 06000 BLOOD STORI NG, PROCESSI NG & TRANS. 31, 337 288 0. 00 06500 RESPI RATORY THERAPY 344, 761 2, 73 0. 00 06600 PHYSI CAL THERAPY 149, 168 3, 09 5. 00 06600 PHYSI CAL THERAPY 165, 407 59 0. 0 06700 OCUPATI ONAL THERAPY 165, 407 59 7. 01 06701 OCUPATI ONAL THERAPY 465, 407 59 0. 0 06800 SPEECH PATHOLOGY 20, 322 29 3. 00 06801 SPEECH PATHOLOGY 0 65 0. 0 07000 ELECTROCARDI OLOGY 0 62 1, 74 3. 00 07300 DRUGS CHARGED TO PATI ENTS <t< td=""><td></td><td>-1</td><td></td><td></td></t<>		-1		
0 03200 CORONARY CARE UNIT 0 ANCI LLARY SERVICE COST CENTERS	2, 217, 47			30.0
ANCI LLARY SERVICE COST CENTERS 00 05000 OPERATING ROOM 151,373 2,82 00 05400 RADI OLOGY-DI AGNOSTI C 394,513 17,04 00 06000 LABORATORY 1,196,842 13,80 3.00 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 31,337 28 0.00 06600 PHYSI CAL THERAPY 344,761 2,73 0.00 06600 PHYSI CAL THERAPY 149,168 3,09 0.01 06601 PHYSI CAL THERAPY WHEATFIELD 225 2,12 7.00 06700 OCCUPATI ONAL THERAPY WHEATFIELD 0 36 0.00 06800 SPEECH PATHOLOGY 20,322 29 3.01 06801 SPEECH PATHOLOGY 0 37,253 4,73 0.00 07000 ELCTROCARDI OLOGY 0 0 0 0.00 07000 RUGS CHARGED TO PATI ENTS 1,149,549 38,64 4.00 07400 RENAL DI ALYSIS 0 0 <td></td> <td>0</td> <td></td> <td>31.0</td>		0		31.0
0.00 05000 OPERATING ROOM 151, 373 2, 82 4.00 05400 RADI OLOGY-DI AGNOSTI C 394, 513 17, 04 0.00 06000 LABORATORY 1, 196, 842 13, 80 0.00 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 311, 337 28 0.00 06500 RESPI RATORY THERAPY 344, 761 2, 73 5.00 06600 PHYSI CAL THERAPY 149, 168 3, 09 5.01 06601 PHYSI CAL THERAPY WHEATFIELD 225 2, 12 0.00 06700 OCCUPATI ONAL THERAPY WHEATFIELD 0 36 0.00 06600 SPEECH PATHOLOGY 20, 322 29 3.01 06801 SPEECH PATHOLOGY 0 0 0 0.00 06900 ELECTROCARDI OLOGY 0 0 0 0.00 07000 ELECTROCARDI OLOGY 0 0 0 0.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 287, 253 4, 73		0		32.0
4. 00 05400 RADI OLOGY-DI AGNOSTI C 394, 513 17, 04 0.00 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 31, 337 28 0.00 06500 RESPI RATORY 14, 196, 842 13, 80 0.00 06500 RESPI RATORY 344, 761 2, 73 0.00 06600 PHYSI CAL THERAPY 149, 168 3, 09 0.01 06601 PHYSI CAL THERAPY HEATFI ELD 225 2, 12 0.00 06600 PCUPATI ONAL THERAPY WHEATFI ELD 0 36 0.01 06701 OCCUPATI ONAL THERAPY WHEATFI ELD 0 36 0.00 06800 SPEECH PATHOLOGY 20, 322 29 3.01 06801 SPEECH PATHOLOGY 0 0 0.00 07000 ELECTROCARDI OLOGY 0 0 0.00 07000 BECTROENCEPHALOGRAPHY 0 0 1.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 1, 149, 549 38, 644 0.00 07000 RUGS CHARGED TO PATI ENTS 1, 149, 549 38, 644 <t< td=""><td>22 454 2 074 02</td><td>0 0 (4551(</td><td>0,00000</td><td></td></t<>	22 454 2 074 02	0 0 (4551(0,00000	
0.00 06000 LABORATORY 1, 196, 842 13, 80 3.00 06300 BLODD STORING, PROCESSING & TRANS. 31, 337 28 5.00 06500 RESPIRATORY THERAPY 344, 761 2, 73 5.00 06600 PHYSICAL THERAPY 149, 168 3, 09 5.01 06601 PHYSICAL THERAPY WHEATFIELD 225 2, 12 7.00 06700 0CCUPATIONAL THERAPY- WHEATFIELD 0 36 8.00 06600 SPEECH PATHOLOGY 20, 322 29 7.01 06701 0CCUPATIONAL THERAPY- WHEATFIELD 0 65 8.00 06800 SPEECH PATHOLOGY WHEATFIELD 0 65 9.00 06900 ELECTROENCEPHALOGRAPHY 0 0 65 9.00 07200 IMPL. DEV. CHARGED TO PATIENTS 49, 662 1, 74 8.00 07300 DRUGS CHARGED TO PATIENTS 1, 149, 549 38, 64 9.00 07400 RENAL DI ALYSIS 0 7 9.00 <			0.000000 0.000000	
3. 00 06300 BLOOD STORING, PROCESSING & TRANS. 31,337 28 5. 00 06500 RESPIRATORY THERAPY 344,761 2,73 5. 00 06600 PHYSICAL THERAPY 149,168 3,09 5. 01 06601 PHYSICAL THERAPY 149,168 3,09 5. 01 066701 PCCUPATIONAL THERAPY 165,407 59 7. 01 06701 0CCUPATIONAL THERAPY 165,407 59 7. 01 06701 0CCUPATIONAL THERAPY 0 36 8. 00 06800 SPEECH PATHOLOGY 0 36 9. 01 06801 SPEECH PATHOLOGY 0 0 9. 00 06900 ELECTROCARDIOLOGY 0 0 9. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 287,253 4,73 9. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 1,149,549 38,64 0. 00 07300 DRUGS CHARGED TO PATIENTS 1,149,549 38,64 0. 00 07400 RENAL THEALTH CLINIC 0 15 3. 00 07800 CAR T-CELL IMMUNOTHERAPY			0.000000	
5. 00 06500 RESPI RATORY THERAPY 344, 761 2, 73 5. 00 06600 PHYSI CAL THERAPY 149, 168 3, 09 5. 01 06601 PHYSI CAL THERAPY 165, 407 59 7. 01 06701 0CCUPATI ONAL THERAPY 165, 407 59 7. 01 06701 0CCUPATI ONAL THERAPY WHEATFI ELD 0 36 8. 00 06800 SPEECH PATHOLOGY WEATFI ELD 0 65 0. 00 06900 ELECTROCARDI OLOGY 0 0 65 0. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 287, 253 4, 73 2. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 1, 149, 549 38, 64 4. 00 07300 DRUGS CHARGED TO PATI ENTS 1, 149, 549 38, 64 4. 00 07400 RENAL DI ALYSI S 0 0 7.00 07100 ALLOGENEI C HSCT ACOUI SI TI ON 0 27 3.00 08800 RURAL HEALTH CLINI C II 0 27 3.00 08800 RURAL HEALTH CLINI C II 0 27	39, 872 15, 008, 71 80, 330 311, 66		0.000000	
5. 00 06600 PHYSI CAL THERAPY 149, 168 3, 09 5. 01 06601 PHYSI CAL THERAPY- WHEATFIELD 225 2, 12 7. 00 06700 OCCUPATI ONAL THERAPY- WHEATFIELD 0 36 8. 00 06800 SPEECH PATHOLOGY 20, 322 29 8. 01 06801 SPEECH PATHOLOGY 0 65 9. 00 06900 ELECTROCARDI OLOGY 0 0 9. 00 07000 ELECTROCARDI OLOGY 0 0 9. 00 07000 ELECTROCARDE OLOGRAPHY 0 0 9. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 287, 253 4, 73 9. 00 07300 DRUGS CHARGED TO PATI ENTS 1, 149, 549 38, 64 4. 00 07400 RENAL DI ALYSI S 0 0 7. 00 0700 ALLOGENEI C HSCT ACQUI SI TI ON 0 0 8. 00 07800 CART - CELL I MUNOTHERAPY 0 0 0. 017000 ALLOGENEI C HSCT ACQUI SI TI ON 0 15 0 3. 01 08801 RURAL HEALTH CLINI C II			0.000000	
5. 01 06601 PHYSI CAL THERAPY - WHEATFIELD 225 2, 12 7. 00 06700 0CCUPATI ONAL THERAPY - WHEATFIELD 0 36 7. 01 06701 0CCUPATI ONAL THERAPY - WHEATFIELD 0 36 8. 00 06800 SPEECH PATHOLOGY 20, 322 29 8. 01 06801 SPEECH PATHOLOGY 0 65 9. 00 06900 ELECTROCARDI OLOGY 0 0 9. 00 07000 ELECTROCARDI OLOGY 0 0 9. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 287, 253 4, 73 9. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 1, 149, 549 38, 64 10. 00 07400 RENAL DI ALYSI S 0 0 7. 00 07400 RENAL DI ALYSI S 0 0 8. 00 08800 RURAL HEALTH CLINI C 0 15 8. 00 08800 RURAL HEALTH CLINI C 0 61 1. 00 09100 EMERGENCY 242, 692 9, 67 2. 00 09200 DESERVATI ON BEDS (NON-DI STI NCT PART			0.000000	
7.00 06700 0CCUPATIONAL THERAPY 165,407 59 7.01 06701 0CCUPATIONAL THERAPY- WHEATFIELD 0 36 3.00 06800 SPEECH PATHOLOGY 20,322 29 3.01 06801 SPEECH PATHOLOGY 0 65 0.00 06900 ELECTROCARDI OLOGY 0 0 0.00 07000 ELECTROENCEPHALOGRAPHY 0 0 1.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 287,253 4,73 2.00 07200 IMPL. DEV. CHARGED TO PATIENTS 49,662 1,74 3.00 07300 DRUGS CHARGED TO PATIENTS 1,149,549 38,644 0.00 07400 RENAL DI ALYSIS 0 0 7.00 07400 RENAL DI ALYSIS 0 0 8.00 07800 CAR T-CELL I MUNOTHERAPY 0 0 9.00 07800 RURAL HEALTH CLINIC 1 0 27 9.00 08801 RURAL HEALTH CLINIC II 0 61 1.00 09000 CLINIC 242,692			0.000000	
7. 01 06701 0CCUPATIONAL THERAPY- WHEATFIELD 0 36 8. 00 06800 SPEECH PATHOLOGY 20, 322 29 8. 01 06801 SPEECH PATHOLOGY 0 65 9. 00 06900 ELECTROCARDI OLOGY 0 65 9. 00 07000 ELECTROCARDI OLOGY 0 0 1. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 287, 253 4, 73 2. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 49, 662 1, 74 3. 00 07300 DRUGS CHARGED TO PATIENTS 1, 149, 549 38, 64 4. 00 07400 RENAL DI ALYSI S 0 0 7. 00 0700 ALLOGENEI C HSCT ACQUI SI TI ON 0 8. 00 07800 CAR T-CELL I MUNOTHERAPY 0 0017801 RURAL HEALTH CLINI C 0 15 3. 01 08801 RURAL HEALTH CLINI C 0 61 3. 00 09000 CLINI C 21, 233 5, 88 0. 01 09010 WOUND CARE 0 61 0. 09200 <td>90, 197 755, 60</td> <td></td> <td>0.000000</td> <td></td>	90, 197 755, 60		0.000000	
3. 00 06800 SPEECH PATHOLOGY 20, 322 29 3. 01 06801 SPEECH PATHOLOGY- WHEATFIELD 0 65 9. 00 06900 ELECTROCARDIOLOGY- WHEATFIELD 0 65 9. 00 07000 ELECTROCARDIOLOGY- WHEATFIELD 0 65 9. 00 07000 ELECTROCARDIOLOGY 0 0 9. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 287, 253 4, 73 9. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 49, 662 1, 74 3. 00 07300 DRUGS CHARGED TO PATIENTS 1, 149, 549 38, 64 4. 00 07400 RENAL DI ALYSIS 0 0 7. 00 07700 ALLOGENEIC HSCT ACQUISITION 0 0 8. 00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 9. 00 OUTPATIENT SERVICE COST CENTERS 0 15 3. 01 08801 RURAL HEALTH CLINIC II 0 27 0. 00 09000 CLINIC 21, 233 5, 88 0. 01 09000 BERERCY 242, 692 9	64, 836 364, 83		0.000000	
3. 01 06801 SPEECH PATHOLOGY- WHEATFIELD 0 65. 9. 00 06900 ELECTROCARDIOLOGY 0 0 1. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 1. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 287, 253 4, 73 2. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 49, 662 1, 74 3. 00 07300 DRUGS CHARGED TO PATIENTS 1, 149, 549 38, 64 4. 00 07400 RENAL DIALYSIS 0 0 7. 00 07700 ALLOGENEIC HSCT ACQUISITION 0 0 8. 00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 15 9. 00 07900 RURAL HEALTH CLINIC II 0 27 9. 00 0800 RURAL HEALTH CLINIC II 0 27 9. 01 09001 WOUND CARE 0 61 9. 01 09000 BENERVATION BEDS (NON-DISTINCT PART 67, 344 1, 12 01 09100 BENERVICES 0 61 9. 00 09500 AMBULANCE SERVICE	92, 406 312, 72		0.000000	
P. 00 06900 ELECTROCARDI OLOGY 0 0.00 07000 ELECTROENCEPHALOGRAPHY 0 1.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 287, 253 4, 73 2.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 49, 662 1, 74 3.00 07300 DRUGS CHARGED TO PATI ENTS 1, 149, 549 38, 64 4.00 07400 RENAL DI ALYSI S 0 0 7.00 07100 ALLOGENEI C HSCT ACQUI SI TI ON 0 8.00 07800 CAR T-CELL IMMUNOTHERAPY 0 0UTPATI ENT SERVICE COST CENTERS 0 27 0.00 09000 CLI NI C 0 27 0.01 09001 WOUND CARE 0 61 0.01 09001 WOUND CARE 0 61 0.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 67, 344 1, 12 0 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 67, 344 1, 12 0 09200 OBSERVATI ON BEDS (COST	56, 463 656, 46		0.000000	
0.00 07000 ELECTROENCEPHALOGRAPHY 0 1.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 287, 253 4, 73 2.00 07200 IMPL. DEV. CHARGED TO PATIENTS 49, 662 1, 74 3.00 07300 DRUGS CHARGED TO PATIENTS 1, 149, 549 38, 64 4.00 07400 RENAL DIALYSIS 0 0 7.00 07700 ALLOGENEIC HSCT ACQUISITION 0 0 7.00 07800 CAR T-CELL IMMUNOTHERAPY 0 15. 0.01 08801 RURAL HEALTH CLINIC 0 27 0.01 08801 RURAL HEALTH CLINIC II 0 27 0.01 09001 WOUND CARE 0 61 0.01 09001 WOUND CARE 0 61 0.01 09100 EMERGENCY 242, 692 9, 67 0.00 09200 DESERVATION EDS (NON-DISTINCT PART 67, 344 1, 12 0THER REIMBURSABLE COST CENTERS 0 61 61		0 0.000000	0.000000	
1. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 287, 253 4, 73 2. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 49, 662 1, 74 3. 00 07300 DRUGS CHARGED TO PATIENTS 1, 149, 549 38, 64 4. 00 07400 RENAL DI ALYSI S 0 0 7. 00 07700 ALLOGENEI C HSCT ACQUISITION 0 0 8. 00 07800 CAR T-CELL I MUNOTHERAPY 0 0 00TPATIENT SERVICE COST CENTERS 0 15. 3. 1, 149, 549 8. 00 08801 RURAL HEALTH CLINIC 0 15. 8. 01 08801 RURAL HEALTH CLINIC II 0 27. 9. 00 09000 CLINIC 21, 233 5, 88. 0. 01 09000 WOUND CARE 0 611. 0. 09200 0BSERVATION BEDS (NON-DI STINCT PART 67, 344 1, 12. 0 09200 OBSERVATION BEDS (NON-DI STINCT PART 67, 344 1, 12. 0 09200 0BSERVATION BEDS (NON-DI STINCT PART 67, 344 1, 12. 0 09200 OB	0	0 0.000000	0. 000000	
2. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 49,662 1,74 3. 00 07300 DRUGS CHARGED TO PATIENTS 1,149,549 38,64 4. 00 07400 RENAL DI ALYSI S 0 0 7. 00 07700 ALLOGENEI C HSCT ACQUI SI TI ON 0 0 8. 00 07800 CAR T-CELL I MUNOTHERAPY 0 0 00TPATIENT SERVICE COST CENTERS 0 15 3.00 08801 RURAL HEALTH CLINIC 0 15 3. 01 08801 RURAL HEALTH CLINIC II 0 27 0 611 0. 09000 CLINIC 21,233 5,88 0 611 0 611 0. 09200 ØBSERVATION BEDS (NON-DI STINCT PART 67,344 1,12 0 611 0 612 0. 09200 ØBSERVATION BEDS (NON-DI STINCT PART 67,344 1,12 0 11100 112 0 67 344 1,12 0 1149 100 1100 100 0 0 0 0	37, 413 5, 024, 66		0. 000000	
3. 00 07300 DRUGS CHARGED TO PATIENTS 1,149,549 38,64 4. 00 07400 RENAL DIALYSIS 0 7. 00 07700 ALLOGENEI C HSCT ACQUISITION 0 8. 00 07800 CAR T-CELL IMMUNOTHERAPY 0 0UTPATIENT SERVICE COST CENTERS 0 15 3. 00 08800 RURAL HEALTH CLINIC 0 3. 01 08801 RURAL HEALTH CLINIC II 0 0. 00 09000 CLINIC 21, 233 5, 88 0. 01 09001 WOUND CARE 0 61 0. 09200 DBSERVATION BEDS (NON-DISTINCT PART 67, 344 1, 12 01HER REI MBURSABLE COST CENTERS 0 67, 344 1, 12 01HER REI MBURSABLE COST CENTERS 0 0 0 01. 00 10100 HOME HEALTH AGENCY 0 0 02. 00 09550 OTHER REI MBURSABLE COST CENTERS 0 03. 00 09850 OTHER REI MBURSABLE COST CENTERS 0 01. 00 10100 HOME HEALTH AGENCY 0 0 02. 00 0PI 0I D TREATMENT P	47, 471 1, 797, 13		0. 000000	
4. 00 07400 RENAL DIALYSIS 0 7. 00 07700 ALLOGENEIC HSCT ACQUISITION 0 8. 00 07800 CAR T-CELL IMMUNOTHERAPY 0 0UTPATIENT SERVICE COST CENTERS 0 15 3. 00 08800 RURAL HEALTH CLINIC 0 15 3. 01 08801 RURAL HEALTH CLINIC II 0 27 0. 00 09000 CLINIC 21, 233 5, 88 0. 01 09001 WOUND CARE 0 61 0. 01 09001 BEDS (NON-DISTINCT PART 67, 344 1, 12 0THER REI MBURSABLE COST CENTERS 0 0 67, 344 1, 12 01100 HOME HEALTH AGENCY 0 0 0 02:00 09500 AMBULANCE SERVICES 0 0 0 01:00 0100 HOME HEALTH AGENCY 0 0 0 02:00 09550 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 02:00 091010 TREATMENT PROGRAM 0 0 0 0 0 0	40, 624 39, 790, 17		0. 000000	
3. 00 07800 CAR T-CELL IMMUNOTHERAPY 0 OUTPATI ENT SERVICE COST CENTERS 0 15 3. 00 08800 RURAL HEALTH CLINIC 0 27 3. 01 08801 RURAL HEALTH CLINIC II 0 27 0. 00 09000 CLINIC 21,233 5,88 0. 01 09001 WOUND CARE 0 61 0. 00 09000 ELINIC 242,692 9,67 2. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 67,344 1,12 0THER REI MBURSABLE COST CENTERS 0 3.00 9850 OTHER REI MBURSABLE COST CENTERS 0 5. 00 09500 AMBULANCE SERVICES 0 0 0 0 01. 00 1000 HOME HEALTH AGENCY 0 0 0 0 02. 00 0PI OI D TREATMENT PROGRAM 0 0 0 0 02. 00 10200 OPI OI D TREATMENT PROGRAM 0 0 0 010200 OPI OI D TR	0	0 0.000000	0.000000	
OUTPATI ENT SERVICE COST CENTERS 3. 00 08800 RURAL HEALTH CLINIC 0 15. 3. 01 08801 RURAL HEALTH CLINIC 0 27 3. 01 08801 RURAL HEALTH CLINIC 0 27 3. 01 08801 RURAL HEALTH CLINIC 0 27 3. 01 09001 CLINIC 21,233 5,88 0. 01 09000 CLINIC 21,233 5,88 0. 01 09001 WOUND CARE 0 611 1. 00 09100 EMERGENCY 242,692 9,67 2. 00 09200 DESERVATI ON BEDS (NON-DI STINCT PART 67,344 1,12 OTHER REI MBURSABLE COST CENTERS 0 3.00 09850 OTHER REI MBURSABLE COST CENTERS 0 3. 00 09850 OTHER REI MBURSABLE COST CENTERS 0 01. 00 10100 HOME HEALTH ARENY PROGRAM 0 0 02. 00 0PI OI D TREATMENT PROGRAM 0 0 0	0	0 0.000000	0.000000	
3. 00 08800 RURAL HEALTH CLINIC 0 15. 3. 01 08801 RURAL HEALTH CLINIC II 0 27 0. 00 09000 CLINIC 21,233 5,88 0. 01 09000 CLINIC 21,233 5,88 0. 01 09000 ELINIC 0 61 1. 00 09100 EMERGENCY 242,692 9,67 2. 00 09200 DSERVATION BEDS (NON-DISTINCT PART 67,344 1,12 0THER REIMBURSABLE COST CENTERS 0 3. 00 09850 OTHER REI MBURSABLE COST CENTERS 0 3. 00 09850 OTHER REI MBURSABLE COST CENTERS 0 3. 00 09850 OTHER REI MBURSABLE COST CENTERS 0 01. 00 10100 HOME HEALTH AGENCY 0 02. 00 10200 OPI OI D TREATMENT PROGRAM 0 02. 00 OPI OI D TREATMENT PROGRAM 0 02. 01 1300 INTEREST <t< td=""><td>0</td><td>0 0.000000</td><td>0.000000</td><td></td></t<>	0	0 0.000000	0.000000	
3. 01 08801 RURAL HEALTH CLINICII 0 27 0. 00 09000 CLINIC 21, 233 5, 88 0. 01 09001 WOUND CARE 0 61 1. 00 09100 EMERGENCY 242, 692 9, 67 2. 00 09200 DBSERVATION BEDS (NON-DISTINCT PART 67, 344 1, 12 0THER REI MBURSABLE COST CENTERS 0 3.00 09500 AMBULANCE SERVICES 0 5. 00 09500 AMBULANCE SERVICES 0 0 0 0 5. 00 09500 OHER REI MBURSABLE COST CENTERS 0 0 0 0 01. 00 10100 HOME HEALTH AGENCY 0 0 0 0 02. 00 0P10 ID TREATMENT PROGRAM 0 0 0 0 02. 00 0P10 ID TREATMENT PROGRAM 0 0 0 0 13.00 11300 INTEREST EXPENSE 1300 11300 AMBULATORY SURGICAL CENTER (D. P.) 0				1
0.00 09000 CLINIC 21,233 5,88 0.01 09001 WOUND CARE 0 611 1.00 09100 EMERGENCY 242,692 9,67 2.00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART 67,344 1,12 0THER REI MBURSABLE COST CENTERS 0 300 09500 AMBULANCE SERVICES 0 3.00 09500 OTHER REI MBURSABLE COST CENTERS 0 0 300 09500 0THER REI MBURSABLE COST CENTERS 0 <	52, 128 152, 12	8		88. (
0.01 09001 WOUND CARE 0 611 1.00 09100 EMERGENCY 242, 692 9, 67 2.00 09200 0BSERVATI ON BEDS (NON-DI STINCT PART 67, 344 1, 12 0THER REI MBURSABLE COST CENTERS 0 0 0.00 09500 AMBULANCE SERVI CES 0 0.00 09500 OTHER REI MBURSABLE COST CENTERS 0 0.100 07100 HOME HEALTH AGENCY 0 0.100 10100 HOME HEALTH AGENCY 0 0.200 0PI 0I D TREATMENT PROGRAM 0 SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE 13.00 11300 AMBULATORY SURGI CAL CENTER (D. P.) 0	71, 411 271, 41	1		88.0
1. 00 09100 EMERGENCY 242, 692 9, 67 2. 00 09200 0BSERVATI ON BEDS (NON-DI STINCT PART 67, 344 1, 12 OTHER REI MBURSABLE COST CENTERS 0	86, 744 5, 907, 97	7 0. 514629	0.00000	90.0
22.00 09200 0BSERVATI ON BEDS (NON-DI STINCT PART 67, 344 1, 12 OTHER REI MBURSABLE COST CENTERS 0 <td>10, 760 610, 76</td> <td>0 0. 263205</td> <td>0.00000</td> <td>90. (</td>	10, 760 610, 76	0 0. 263205	0.00000	90. (
OTHER REIMBURSABLE COST CENTERS 5. 00 09500 AMBULANCE SERVICES 0 3. 00 09850 OTHER REIMBURSABLE COST CENTERS 0 01. 00 10100 HOME HEALTH AGENCY 0 02. 00 10200 OPI OI D TREATMENT PROGRAM 0 SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE 13. 00 11300 AMBULATORY SURGICAL CENTER (D. P.) 0	73, 591 9, 916, 28		0. 000000	
5. 00 09500 AMBULANCE SERVICES 0 3. 00 09850 OTHER REIMBURSABLE COST CENTERS 0 01. 00 10100 HOME HEALTH AGENCY 0 02. 00 0PI 0I D TREATMENT PROGRAM 0 SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE 15. 00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0	24, 330 1, 191, 67	4 1. 181597	0.00000	92.0
3. 00 09850 OTHER REIMBURSABLE COST CENTERS 0 01.00 10100 HOME HEALTH AGENCY 0 02.00 10200 OPI 0I D TREATMENT PROGRAM 0 SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE 15.00 11500 AMBULATORY SURGI CAL CENTER (D. P.) 0		-		
01.00 10100 HOME HEALTH AGENCY 0 02.00 10200 OPI 0I D TREATMENT PROGRAM 0 SPECIAL PURPOSE COST CENTERS 13.00 11300 INTEREST EXPENSE 15.00 11500 AMBULATORY SURGI CAL CENTER (D. P.) 0		0 0.000000	0. 000000	
D2. 00 10200 OPI 0I D TREATMENT PROGRAM 0 SPECIAL PURPOSE COST CENTERS 13. 00 11300 INTEREST EXPENSE 15. 00 11500 AMBULATORY SURGI CAL CENTER (D. P.) 0	0	0 0.000000	0.00000	
SPECIAL PURPOSE COST CENTERS 13.00 INTEREST EXPENSE 15.00 AMBULATORY SURGICAL CENTER (D. P.)	0	0		101. (
13.00 11300 INTEREST EXPENSE 15.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0	0	0		102. (
15.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0				110 0
				113. (
10. UU 116UU HUSPI (E 0	0	0		115.
		U		116.
OD. 00 Subtotal (see instructions) 6, 489, 158 106, 65 01 00 0	59, 880 113, 149, 03	в		200.
01.00 Less Observation Beds 02.00 Total (see instructions) 6,489,158 106,65	59, 880 113, 149, 03			201. 202.

	inancial Systems	FRANCI SCAN HEALTH	Provider CCN: 15-1324	Peri od:	u of Form CMS- Worksheet C	2552-1
CUMPUTAT	TUN OF KAILU OF CUSIS TO CHARGES		Provider CCN: 15-1324	From 01/01/2023 To 12/31/2023	Part I Date/Time Pre 5/29/2024 8:5	
			Title XVIII	Hospi tal	Cost	_
	Cost Center Description	PPS Inpatient				
		Ratio				
		11.00				
	IPATIENT ROUTINE SERVICE COST CENTERS					
	3000 ADULTS & PEDIATRICS					30.00
	3100 INTENSIVE CARE UNIT					31.00
	3200 CORONARY CARE UNIT					32.00
	ICI LLARY SERVI CE COST CENTERS					
	5000 OPERATING ROOM	0. 000000				50.00
	5400 RADI OLOGY-DI AGNOSTI C	0. 000000				54.00
	5000 LABORATORY	0. 000000				60.00
63.00 06	5300 BLOOD STORING, PROCESSING & TRANS.	0. 000000				63.00
65.00 06	5500 RESPI RATORY THERAPY	0. 000000				65.00
66.00 06	5600 PHYSI CAL THERAPY	0. 000000				66.0
66.01 06	5601 PHYSICAL THERAPY- WHEATFIELD	0. 000000				66.0
67.00 06	5700 OCCUPATI ONAL THERAPY	0. 000000				67.0
67.01 06	5701 OCCUPATIONAL THERAPY- WHEATFIELD	0. 000000				67.0
68.00 06	5800 SPEECH PATHOLOGY	0. 000000				68.0
68.01 06	5801 SPEECH PATHOLOGY- WHEATFIELD	0. 000000				68.0
69.00 06	5900 ELECTROCARDI OLOGY	0. 000000				69.0
70.00 07	7000 ELECTROENCEPHALOGRAPHY	0. 000000				70.0
71.00 07	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000				71.0
72.00 07	7200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000				72.0
	7300 DRUGS CHARGED TO PATIENTS	0. 000000				73.0
74.00 07	7400 RENAL DIALYSIS	0. 000000				74.0
77.00 07	7700 ALLOGENEIC HSCT ACQUISITION	0. 000000				77.0
78.00 07	7800 CAR T-CELL IMMUNOTHERAPY	0. 000000				78.0
OU	JTPATIENT SERVICE COST CENTERS					
88.00 08	3800 RURAL HEALTH CLINIC					88. 0
88. 01 08	3801 RURAL HEALTH CLINIC II					88.0
90.00 09	2000 CLINIC	0. 000000				90.0
90.01 09	9001 WOUND CARE	0. 000000				90.0
91.00 09	9100 EMERGENCY	0. 000000				91.0
92.00 09	9200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000				92.0
OT	THER REIMBURSABLE COST CENTERS					1
95.00 09	9500 AMBULANCE SERVI CES	0. 000000				95.0
98.00 09	9850 OTHER REIMBURSABLE COST CENTERS	0. 000000				98.00
101.0010	D100 HOME HEALTH AGENCY					101.00
102.0010	0200 OPI OI D TREATMENT PROGRAM					102.00
	PECIAL PURPOSE COST CENTERS	· ·				1
113.0011	1300 INTEREST EXPENSE					113.00
	1500 AMBULATORY SURGICAL CENTER (D.P.)					115.00
	1600 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

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-1324	Period: From 01/01/2023 To 12/31/2023	Worksheet C Part I Date/Time Pre 5/29/2024 8:5	pared: 6 am
		Titl	e XIX	Hospi tal	Cost	
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	Costs RCE Di sal I owance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	4, 205, 490		4, 205, 49	90 0	4, 205, 490	30.00
31. 00 03100 I NTENSI VE CARE UNI T	0			0 0	0	31.00
32. 00 03200 CORONARY CARE UNI T	0			0 0	0	32.00
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	1, 920, 299		1, 920, 29		1, 920, 299	•
54. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 904, 332		2, 904, 33		2, 904, 332	
50. 00 06000 LABORATORY	3, 725, 402		3, 725, 40		3, 725, 402	•
33.00 06300 BLOOD STORING, PROCESSING & TRANS.	76, 273		76, 27		76, 273	
55. 00 06500 RESPI RATORY THERAPY	1, 560, 330	0	.,		1, 560, 330	
6. 00 06600 PHYSI CAL THERAPY	1, 504, 780	0			1, 504, 780	
56.01 06601 PHYSICAL THERAPY- WHEATFIELD	1, 275, 332	0			1, 275, 332	
7.00 06700 OCCUPATIONAL THERAPY	351, 124	0			351, 124	
7.01 06701 OCCUPATIONAL THERAPY- WHEATFIELD	327, 189	0			327, 189	
58.00 06800 SPEECH PATHOLOGY	234, 575	0	234, 57		234, 575	
58.01 06801 SPEECH PATHOLOGY- WHEATFIELD	397, 500	0	397, 50		397, 500	
59. 00 06900 ELECTROCARDI OLOGY	0			0 0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0			0 0	0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 275, 940		1, 275, 94		1, 275, 940	
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	261, 670		261, 67		261, 670	
73.00 07300 DRUGS CHARGED TO PATIENTS	6, 641, 349		6, 641, 34		6, 641, 349	
74.00 07400 RENAL DIALYSIS	0			0 0	0	
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0			0 0	0	
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0			0 0	0	78.0
OUTPATIENT SERVICE COST CENTERS	507.000		507.00		507.000	
88.00 08800 RURAL HEALTH CLINIC	537, 933		537, 93		537, 933	
8.01 08801 RURAL HEALTH CLINIC II	674, 381		674, 38		674, 381	
20. 00 09000 CLINIC	3, 040, 417		3, 040, 41		3, 040, 417	
20. 01 09001 WOUND CARE	160, 755		160, 75		160, 755	
21.00 09100 EMERGENCY	5,052,401		5, 052, 40		5, 052, 401	
22. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 408, 078		1, 408, 07	/8	1, 408, 078	92.0
0THER REIMBURSABLE COST CENTERS 05.00 09500 AMBULANCE SERVICES	0		1	0 0	0	95.0
28.00 09850 OTHER REIMBURSABLE COST CENTERS	-					
01.00 10100 HOME HEALTH AGENCY	0			0 0	0	98.0
102.00 10200 OPI OI D TREATMENT PROGRAM	0			0		102.00
SPECIAL PURPOSE COST CENTERS	0		1	U	0	1102.00
113. 00 11300 I NTEREST EXPENSE	I					113.00
15.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0			0	0	115.0
16. 00 11600 HOSPI CE	0			0		116.0
200.00 Subtotal (see instructions)	37, 535, 550	0	37, 535, 55	~	37, 535, 550	
201.00 Less Observation Beds	1, 408, 078	0	1, 408, 07		1, 408, 078	
202.00 Total (see instructions)		0	1			
	36, 127, 472	0	36, 127, 47	v∠ 0	30, 127, 472	1202.

DMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 01/01/2023 To 12/31/2023	Worksheet C Part I Date/Time Pre 5/29/2024 8:5	pared 6 am
			e XIX	Hospi tal	Cost	
Cost Center Description	I npati ent	Charges Outpatient	Total (col. 6 + col. 7)	6 Cost or Other Ratio	TEFRA I npati ent Rati o	
	6.00	7.00	8.00	9.00	10.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0.047.477		0.017.17	-		
D. 00 03000 ADULTS & PEDIATRICS	2, 217, 477		2, 217, 47			30.0
1. 00 03100 I NTENSI VE CARE UNI T	0			0		31.0
2. 00 03200 CORONARY CARE UNI T	0			0		32.0
ANCI LLARY SERVI CE COST CENTERS	151 272	2 022 454	2 074 02	0 0 (4551 (0,000000	1 50 0
D. 00 05000 OPERATI NG ROOM 4. 00 05400 RADI OLOGY-DI AGNOSTI C	151, 373 394, 513	2, 823, 456 17, 046, 372			0. 000000 0. 000000	
2. 00 06000 LABORATORY	1, 196, 842	13, 809, 872			0. 000000	
3. 00 06300 BLOOD STORING, PROCESSING & TRANS.	31, 337	280, 330			0. 000000	
5. 00 06500 RESPIRATORY THERAPY	344, 761	2, 734, 417			0.000000	
5. 00 06600 PHYSI CAL THERAPY	149, 168	3, 094, 077			0. 000000	
5. 01 06601 PHYSI CAL THERAPY- WHEATFIELD	225	2, 122, 982			0. 000000	
7. 00 06700 OCCUPATI ONAL THERAPY	165, 407	590, 197			0. 000000	
7.01 06701 OCCUPATIONAL THERAPY- WHEATFIELD	0	364, 836			0. 000000	
B. 00 06800 SPEECH PATHOLOGY	20, 322	292, 406			0. 000000	
3.01 06801 SPEECH PATHOLOGY- WHEATFIELD	0	656, 463			0.000000	68.0
9. 00 06900 ELECTROCARDI OLOGY	0	0		0 0.000000	0.000000	69.0
D. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0.000000	0. 000000	70.0
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	287, 253	4, 737, 413	5, 024, 66	6 0. 253935	0. 000000	71.0
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS	49, 662	1, 747, 471	1, 797, 13	3 0. 145604	0.000000	72.0
3.00 07300 DRUGS CHARGED TO PATIENTS	1, 149, 549	38, 640, 624	39, 790, 17	3 0. 166909	0.000000	73.0
4. 00 07400 RENAL DIALYSIS	0	0		0 0.000000	0. 000000	
7.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0		0 0. 000000	0. 000000	
3. 00 07800 CAR T-CELL I MMUNOTHERAPY	0	0		0 0.000000	0.00000	78.0
OUTPATIENT SERVICE COST CENTERS	-					
B. OO 08800 RURAL HEALTH CLINIC	0	152, 128			0.00000	
3. 01 08801 RURAL HEALTH CLINIC II	0	271, 411			0.00000	
0.00 09000 CLINIC	21, 233	5, 886, 744			0.00000	
0.01 09001 WOUND CARE	0	610, 760			0.00000	
1.00 09100 EMERGENCY 2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	242, 692 67, 344	9, 673, 591 1, 124, 330			0. 000000 0. 000000	
OTHER REIMBURSABLE COST CENTERS	07, 344	1, 124, 330	1, 191, 07	4 1. 181597	0.00000	92.0
5. 00 09500 AMBULANCE SERVICES	0	0		0 0. 000000	0. 000000	95. (
3. 00 09300 AMBDEANCE SERVICES 3. 00 09850 OTHER REIMBURSABLE COST CENTERS	0	0		0 0.000000	0. 000000	
D1. 00 10100 HOME HEALTH AGENCY	0	0		0 0.000000	0.000000	101. 0
D2. 00 10200 OPI OI D TREATMENT PROGRAM	0	0		0		102.0
SPECIAL PURPOSE COST CENTERS	<u> </u>	0		-1		1.02.0
13. 00 11300 I NTEREST EXPENSE						113. (
15.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0		0		115.
16. 00 11600 HOSPI CE	0	0		0		116.
00.00 Subtotal (see instructions)	6, 489, 158	106, 659, 880	113, 149, 03	8		200.
D1.00 Less Observation Beds						201.
D2.00 Total (see instructions)	6, 489, 158	106, 659, 880	113, 149, 03	8		202.

ealth Financial Systems COMPUTATION OF RATIO OF COSTS TO CHARGES	FRANCI SCAN HEALTH	Provider CCN: 15-1324	Peri od:	u of Form CMS-255 Worksheet C
UMPUTATION OF RATIO OF CUSIS TO CHARGES		Provider CCN. 15-1324	From 01/01/2023 To 12/31/2023	Part I Date/Time Prepar 5/29/2024 8:56 a
		Title XIX	Hospi tal	Cost
Cost Center Description	PPS Inpatient			
	Ratio			
	11.00			
INPATIENT ROUTINE SERVICE COST CENTERS				
0. 00 03000 ADULTS & PEDIATRICS				3
1.00 03100 INTENSIVE CARE UNIT				3
2.00 03200 CORONARY CARE UNIT				3
ANCI LLARY SERVI CE COST CENTERS				
0.00 05000 OPERATING ROOM	0. 000000			5
4.00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000			5
0. 00 06000 LABORATORY	0. 000000			6
3.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000			6
5. 00 06500 RESPI RATORY THERAPY	0. 000000			6
6. 00 06600 PHYSI CAL THERAPY	0. 000000			6
6.01 06601 PHYSI CAL THERAPY- WHEATFI ELD	0. 000000			6
7.00 06700 OCCUPATI ONAL THERAPY	0. 000000			6
7.01 06701 OCCUPATIONAL THERAPY- WHEATFIELD	0. 000000			6
8.00 06800 SPEECH PATHOLOGY	0. 000000			6
8.01 06801 SPEECH PATHOLOGY- WHEATFIELD	0. 000000			6
9. 00 06900 ELECTROCARDI OLOGY	0. 000000			6
0. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000			7
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000			7
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000			7
3. 00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			7
4.00 07400 RENAL DIALYSIS	0. 000000			7
7.00 07700 ALLOGENEIC HSCT ACQUISITION	0. 000000			7
8.00 07800 CAR T-CELL IMMUNOTHERAPY	0. 000000			7
OUTPATIENT SERVICE COST CENTERS				
8.00 08800 RURAL HEALTH CLINIC	0. 000000			8
8.01 08801 RURAL HEALTH CLINIC II	0. 000000			8
0. 00 09000 CLINIC	0. 000000			9
0.01 09001 WOUND CARE	0. 000000			9
1.00 09100 EMERGENCY	0. 000000			9
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000			9
OTHER REIMBURSABLE COST CENTERS				
5. 00 09500 AMBULANCE SERVICES	0. 000000			9
8.00 09850 OTHER REIMBURSABLE COST CENTERS	0. 000000			9
01.00 10100 HOME HEALTH AGENCY				10
02.00 10200 OPI OI D TREATMENT PROGRAM				10
SPECIAL PURPOSE COST CENTERS				
13.00 11300 INTEREST EXPENSE				11
15.00 11500 AMBULATORY SURGICAL CENTER (D.P.)				11
16. 00 11600 HOSPI CE				11
00.00 Subtotal (see instructions)				20
01.00 Less Observation Beds				20
02.00 Total (see instructions)				20

Health Financial Systems	FRANCI SCAN HEAL	TH RENSSELAER		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provider CO	CN: 15-1324	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part II	pared:
			XVIII	Hospi tal	Cost	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
	Related Cost	(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,	Part I, col.	(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS	- F					
50.00 05000 OPERATING ROOM	266, 668					
54. 00 05400 RADI OLOGY-DI AGNOSTI C	179, 632					•
60. 00 06000 LABORATORY	103, 275					
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	3, 206					
65. 00 06500 RESPI RATORY THERAPY	112, 620	3, 079, 178			4, 259	65.00
66. 00 06600 PHYSI CAL THERAPY	194, 974				2, 876	
66.01 06601 PHYSICAL THERAPY- WHEATFIELD	230, 344	2, 123, 207	0. 10848	39 0	0	66. 01
67.00 06700 OCCUPATI ONAL THERAPY	14, 686	755, 604	0. 01943	36 52, 349	1, 017	67.00
67.01 06701 OCCUPATIONAL THERAPY- WHEATFIELD	50, 143	364, 836	0. 13744	10 0	0	67.01
68.00 06800 SPEECH PATHOLOGY	11, 543	312, 728	0. 03691	6, 426	237	68.00
68.01 06801 SPEECH PATHOLOGY- WHEATFIELD	34, 980	656, 463	0. 05328	36 0	0	68.01
69. 00 06900 ELECTROCARDI OLOGY	0	0	0.0000	0 0	0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	0.0000	0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	92, 973	5, 024, 666	0. 01850	03 147, 665	2, 732	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	19, 274	1, 797, 133	0. 01072	45, 836	492	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	98, 012			460, 696	1, 135	73.00
74.00 07400 RENAL DIALYSIS	0	0	0. 00000	0 0	0	74.00
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0	0.0000	0 0	0	77.00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0	0	0. 00000	0 0	0	78.00
OUTPATIENT SERVICE COST CENTERS						1
88.00 08800 RURAL HEALTH CLINIC	40, 335	152, 128	0. 26513	39 0	0	88.00
88.01 08801 RURAL HEALTH CLINIC II	55, 131	271, 411	0. 20312	27 0	0	88.01
90. 00 09000 CLINIC	342, 024	5, 907, 977	0.05789	15, 272	884	90.00
90.01 09001 WOUND CARE	27, 309	610, 760	0.04471	0	0	90.01
91.00 09100 EMERGENCY	237,018	9, 916, 283	0. 02390	76, 536	1, 829	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	115,064					
OTHER REIMBURSABLE COST CENTERS						1
95. 00 09500 AMBULANCE SERVICES						95.00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	0	0.0000	0 0	0	98.00
200.00 Total (lines 50 through 199)	2, 229, 211	110, 931, 561		1, 796, 177	26, 247	200. 00

Health Financial Systems	FRANCI SCAN HEAL	TH RENSSELAER		In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE THROUGH COSTS	RVICE OTHER PASS			Period: From 01/01/2023 To 12/31/2023		
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Non Physician Anesthetist	Nursing Program	Nursing Program	Allied Health Post-Stepdown	Allied Health	
		Post-Stepdown	i i ogi alli	Adjustments		
	1.00	Adjustments 2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS	1.00	28	2.00	58	3.00	
50. 00 05000 OPERATI NG ROOM	0	0		0 0	0	50.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	54.00
60. 00 06000 LABORATORY	0	0		0 0	0	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0 0	0	63.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 0	0	66.00
66. 01 06601 PHYSI CAL THERAPY- WHEATFI ELD	0	0		0 0	0	66.01
67.00 06700 OCCUPATIONAL THERAPY	0	0		0 0	0	67.00
67.01 06701 OCCUPATIONAL THERAPY- WHEATFIELD	0	0		0 0	0	67.01
68.00 06800 SPEECH PATHOLOGY	0	0	1	0 0	0	68.00
68.01 06801 SPEECH PATHOLOGY- WHEATFIELD	0	0	1	0 0	0	68.01
69. 00 06900 ELECTROCARDI OLOGY	0	0	1	0 0	0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	1	0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00
74.00 07400 RENAL DIALYSIS	0	0		0 0	0	74.00
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0		0 0	0	77.00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0	0		0 0	0	78.00
OUTPATIENT SERVICE COST CENTERS					_	
88.00 08800 RURAL HEALTH CLINIC	0	0		0 0	0	88.00
88.01 08801 RURAL HEALTH CLINIC II	0	0		0 0	0	88.01
90. 00 09000 CLINIC	0	0		0 0	0	90.00
90. 01 09001 WOUND CARE	0	0		0 0	0	90.01
91. 00 09100 EMERGENCY	0	0		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0			0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES						95.00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	0		0 0		
200.00 Total (lines 50 through 199)	0	0		0 0		200.00

Health Financial Systems	FRANCI SCAN HEAL	TH RENSSELAER		In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEI THROUGH COSTS	RVICE OTHER PAS	S Provider C		Period: From 01/01/2023 To 12/31/2023	Worksheet D Part IV Date/Time Pre	nared [.]
					5/29/2024 8:5	
			XVIII	Hospi tal	Cost	
Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,		
	Education Cost		Cost (sum of		(col. 5 ÷ col.	
		4)	col s. 2, 3,	8)	7)	
			and 4)		(see	
	4.00	F 00	(00	7 00	instructions)	
	4.00	5.00	6.00	7.00	8.00	
ANCI LLARY SERVI CE COST CENTERS	0	0		0 0 074 000	0.00000	50.00
50. 00 05000 OPERATING ROOM	0	-		0 2, 974, 829		
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 17, 440, 885		
	0	0		0 15,006,714		
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0 311, 667		
65. 00 06500 RESPI RATORY THERAPY	0	0		0 3, 079, 178		
66.00 06600 PHYSI CAL THERAPY	0	0		0 3, 243, 245		
66. 01 06601 PHYSI CAL THERAPY- WHEATFIELD	0	0		0 2, 123, 207		
67.00 06700 OCCUPATIONAL THERAPY	0	0		0 755, 604		
67. 01 06701 0CCUPATI ONAL THERAPY- WHEATFI ELD	0	0		0 364, 836		•
68.00 06800 SPEECH PATHOLOGY	0	0		0 312, 728		•
68. 01 06801 SPEECH PATHOLOGY- WHEATFIELD	0	0		0 656, 463		
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 0	0.000000	
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0			0.000000	•
71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 72.00 07200 I MPL. DEV. CHARGED TO PATI ENTS	0			0 5, 024, 666		
72.00 07200 TMPL. DEV. CHARGED TO PATIENTS 73.00 07300 DRUGS CHARGED TO PATIENTS	0			0 1, 797, 133 0 39, 790, 173		•
73.00 07300 DRUGS CHARGED TO PATTENTS 74.00 07400 RENAL DIALYSIS	0			0 39, 790, 173	0.000000	•
74.00 07700 ALLOGENEIC HSCT ACQUISITION	0				0.000000	
78. 00 07700 ALLOGENETC HSCT ACCUTSTITION 78. 00 07800 CAR T-CELL IMMUNOTHERAPY	0					•
OUTPATIENT SERVICE COST CENTERS	0	0		0 0	0.000000	78.00
88.00 08800 RURAL HEALTH CLINIC	0	0		0 152, 128	0. 000000	88.00
88. 01 08801 RURAL HEALTH CLINIC II	0			0 271, 411		•
90. 00 09000 CLINIC	0			0 5, 907, 977		•
90. 01 09001 WOUND CARE	0			0 610, 760		•
91. 00 09100 EMERGENCY	0			0 9, 916, 283		
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0			0 1, 191, 674		•
OTHER REI MBURSABLE COST CENTERS	0	0	1	1, 171, 074	0.00000	/2.00
95. 00 09500 AMBULANCE SERVICES						95.00
98. 00 09850 OTHER REI MBURSABLE COST CENTERS	0	0		0 0	0. 000000	•
200.00 Total (lines 50 through 199)	0			0 110, 931, 561		200.00
	1		I		I	

Health Financial Systems	FRANCI SCAN HEALTH	H RENSSELAER		In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PASS	Provider CO	CN: 15-1324	Period: From 01/01/2023	Worksheet D Part IV	
				To 12/31/2023		
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Outpati ent	Inpati ent	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Throug		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	
ANCI LLARY SERVI CE COST CENTERS	1 1				1	
50.00 05000 OPERATI NG ROOM	0. 000000	51, 728		0 0	0	
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	143, 585		0 0		54.00
60. 00 06000 LABORATORY	0. 000000	607, 653		0 0	0	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	21, 362		0 0	0	63.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	116, 449		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	47, 847		0 0	0	66.00
66.01 06601 PHYSICAL THERAPY- WHEATFIELD	0. 000000	0		0 0	0	66. 01
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000	52, 349		0 0	0	67.00
67.01 06701 OCCUPATIONAL THERAPY- WHEATFIELD	0. 000000	0		0 0	0	67.01
68.00 06800 SPEECH PATHOLOGY	0. 000000	6, 426		0 0	0	68.00
68.01 06801 SPEECH PATHOLOGY- WHEATFIELD	0. 000000	0		0 0	0	68.01
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	0		0 0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	0		0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	147, 665		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	45, 836		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	460, 696		0 0	0	73.00
74.00 07400 RENAL DIALYSIS	0. 000000	0		0 0	0	74.00
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0. 000000	0		0 0	0	77.00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0. 000000	0		0 0	0	78.00
OUTPATIENT SERVICE COST CENTERS			•			1
88.00 08800 RURAL HEALTH CLINIC	0.000000	0		0 0	0	88.00
88.01 08801 RURAL HEALTH CLINIC II	0. 000000	0		0 0	0	88.01
90. 00 09000 CLINIC	0. 000000	15, 272		0 0	0	90.00
90. 01 09001 WOUND CARE	0. 000000	0		0 0	0	90.01
91. 00 09100 EMERGENCY	0. 000000	76, 536		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	2, 773		0 0	0	92.00
OTHER REIMBURSABLE COST CENTERS					,	1
95. 00 09500 AMBULANCE SERVICES						95.00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0. 000000	0		0 0	0	98.00
200.00 Total (lines 50 through 199)		1, 796, 177		0 0		200.00

Health Fi	nancial Systems	FRANCI SCAN HEAL	TH RENSSELAER		In Lie	eu of Form CMS-	2552-10
APPORTI ON	IMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der C	CN: 15-1324	Peri od:	Worksheet D	
					From 01/01/2023	Part V	
					To 12/31/2023		
			Ti +1 c	xviii	Hospi tal	5/29/2024 8:5 Cost	
				Charges	позрітаі	Costs	
	Cost Center Description	Cost to Charge	DDS Doimburgod		Cost	PPS Services	
	cost center bescription	Ratio From	Services (see	Reimbursed	Reimbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9	· · ·	Subject To	Subject To		
				Ded. & Coins	5		
				(see inst.)	(see inst.)		
		1.00	2.00	3.00	4.00	5.00	
	CILLARY SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
	DOO OPERATING ROOM	0. 645516	C	929, 76	9 0	C	50,00
	400 RADI OLOGY-DI AGNOSTI C	0. 166524					
						-	
	000 LABORATORY	0. 248249				-	
	300 BLOOD STORING, PROCESSING & TRANS.	0. 244726		201707		-	
	500 RESPI RATORY THERAPY	0. 506736		946, 95		, s	
	600 PHYSI CAL THERAPY	0. 463974				-	
	601 PHYSICAL THERAPY- WHEATFIELD	0. 600663					
	700 OCCUPATIONAL THERAPY	0. 464693		78, 76		-	
	701 OCCUPATIONAL THERAPY- WHEATFIELD	0. 896811	0	20,07		0	
	800 SPEECH PATHOLOGY	0. 750093		24, 10	9 0	0	
	801 SPEECH PATHOLOGY- WHEATFIELD	0. 605518		4, 23	0 0	0	
	900 ELECTROCARDI OLOGY	0. 000000	0		0 0	0	69.00
70.00 070	DOO ELECTROENCEPHALOGRAPHY	0. 000000	0		0 0	0	70.00
71.00 07	100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 253935	0	1, 277, 43	8 0	0	
72.00 072	200 IMPL. DEV. CHARGED TO PATIENTS	0. 145604	0	668, 40	2 0	0	72.00
73.00 073	300 DRUGS CHARGED TO PATIENTS	0. 166909	0	13, 831, 57	5 0	0	73.00
74.00 074	400 RENAL DIALYSIS	0. 000000	0		0 0	0	74.00
77.00 07	700 ALLOGENEIC HSCT ACQUISITION	0. 000000	0		0 0	0	77.00
78.00 078	800 CAR T-CELL IMMUNOTHERAPY	0. 000000	0		0 0	0	78.00
OU	TPATIENT SERVICE COST CENTERS		•				
88.00 08	800 RURAL HEALTH CLINIC						88.00
88.01 08	801 RURAL HEALTH CLINIC II						88.01
90.00 090	DOOCLINIC	0. 514629	c c	2, 106, 98	1 0	l o	90.00
90.01 090	001 WOUND CARE	0. 263205	l a	364, 91	8 0	l a	90.01
	100 EMERGENCY	0. 509506				l d	91.00
	200 OBSERVATION BEDS (NON-DISTINCT PART	1. 181597					92.00
	HER REIMBURSABLE COST CENTERS		-		-	-	
	500 AMBULANCE SERVICES	0. 000000			0		95.00
	850 OTHER REIMBURSABLE COST CENTERS	0. 000000			0 0	l o	
200.00	Subtotal (see instructions)	0.00000					200.00
200.00	Less PBP Clinic Lab. Services-Program			01,004,70	0 0		200.00
201.00	Only Charges				0		201.00
202.00	Net Charges (line 200 - line 201)		c	31, 654, 98	7 0	0	202.00
202.00		I	1 0	1 51,054,70	0	1 0	1202.00

Health Financial Systems	FRANCI SCAN HEAL	TH RENSSELAER		In Lie	u of Form CMS	-2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	O VACCINE COST	Provider C		Peri od: From 01/01/2023 To 12/31/2023	Worksheet D Part V Date/Time Pr 5/29/2024 8:	epared: 56 am
		Ti tl e	XVIII	Hospi tal	Cost	
	Cos					
Cost Center Description	Cost	Cost				
	Reimbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
		Ded. & Coins.				
	(see inst.)	(see inst.)	-			
ANCI LLARY SERVI CE COST CENTERS	6.00	7.00				
50. 00 05000 OPERATING ROOM	600, 181					50,00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	745, 558					50.00
60. 00 06000 LABORATORY	596, 999					60.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	61, 641					63.00
65. 00 06500 RESPIRATORY THERAPY	479, 856					65.00
66. 00 06600 PHYSI CAL THERAPY	479,838		1			66,00
66. 01 06601 PHYSI CAL THERAPY WHEATFI ELD	389, 068					66.01
67. 00 06700 OCCUPATI ONAL THERAPY	36, 603		1			67.00
67. 01 06700 OCCUPATIONAL THERAPY	25, 644					67.00
68. 00 06800 SPEECH PATHOLOGY	18, 084					68.00
68. 01 06800 SPEECH PATHOLOGY 68. 01 06801 SPEECH PATHOLOGY- WHEATFIELD	2, 561					68.00
69. 00 06900 ELECTROCARDI OLOGY	2, 501					69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0					70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	324, 386					71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	97, 322					72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	2, 308, 614		1			73.00
74. 00 07400 RENAL DI ALYSI S	2, 300, 014					74.00
77. 00 07700 ALLOGENEIC HSCT ACQUISITION	0					77.00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0		1			78.00
OUTPATIENT SERVICE COST CENTERS			1			
88. 00 08800 RURAL HEALTH CLINIC						88.00
88.01 08801 RURAL HEALTH CLINIC II						88.01
90. 00 09000 CLINIC	1,084,314	l o				90.00
90. 01 09001 WOUND CARE	96,048					90.01
91.00 09100 EMERGENCY	1, 163, 054					91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	404,033					92.00
OTHER REIMBURSABLE COST CENTERS		-	1			
95. 00 09500 AMBULANCE SERVICES	0					95.00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	C				98.00
200.00 Subtotal (see instructions)	8, 891, 893					200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)	8, 891, 893	c				202.00

Heal th	Financial Systems	FRANCI SCAN HEAL	TH RENSSELAER		In Lie	eu of Form CMS-	2552-10
APPORT	IONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C		Peri od:	Worksheet D	
					From 01/01/2023	Part V	
					To 12/31/2023	Date/Time Pre 5/29/2024 8:5	
			Ti +1	e XIX	Hospi tal	Cost	
			1111	Charges	nospi tai	Costs	
	Cost Center Description	Cost to Charge	DDS Doimbursod		Cost	PPS Services	-
	cost center bescription	Ratio From	Services (see	Reimbursed	Reimbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Servi ces Not		
		Part I, col. 9	· · ·	Subject To	Subject To		
				Ded. & Coi ns			
				(see inst.)	(see inst.)		
		1.00	2.00	3.00	4.00	5.00	
	ANCI LLARY SERVI CE COST CENTERS	1.00	2.00	0.00	1.00	0.00	
50.00	05000 OPERATI NG ROOM	0. 645516	0	401, 31	2 0	0	50.00
54.00	05400 RADI OLOGY - DI AGNOSTI C	0. 166524				-	
	06000 LABORATORY	0. 248249		3, 157, 14		0	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 244726		10, 06		0	
	06500 RESPI RATORY THERAPY	0. 506736		475, 05		0	
	06600 PHYSI CAL THERAPY	0. 463974		422, 38		0	
66.01	06601 PHYSI CAL THERAPY- WHEATFI ELD	0. 600663		393, 57		0	
67.00	06700 OCCUPATI ONAL THERAPY	0. 464693		200, 05			
67.00	06701 OCCUPATIONAL THERAPT	0. 896811		126, 91			
68.00	06800 SPEECH PATHOLOGY	0. 750093		120, 91			1
68. 00 68. 01	06801 SPEECH PATHOLOGY WHEATFIELD	0. 605518		169, 62			
	06900 ELECTROCARDI OLOGY	0. 000000		109,02	.9 0		
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000			0 0		1
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 253935		691, 68			1
	07200 IMPL. DEV. CHARGED TO PATIENTS						1
	07200 TMPL. DEV. CHARGED TO PATIENTS	0. 145604 0. 166909		224,65			1
	07400 RENAL DIALYSIS	0. 188909		4, 708, 79	0 0		1
	07700 ALLOGENEIC HSCT ACQUISITION				0 0		
	07800 CAR T-CELL IMMUNOTHERAPY	0. 000000			0 0	-	
78.00	OUTPATIENT SERVICE COST CENTERS	0.00000		4	0 0	0	/8.00
88.00	08800 RURAL HEALTH CLINIC			1			88.00
	08801 RURAL HEALTH CLINIC II						88.00
	09000 CLINIC	0. 514629		615, 37		0	1
	09001 WOUND CARE	0. 263205		6, 87			
	09100 EMERGENCY	0. 203203				-	
	09200 OBSERVATION BEDS (NON-DISTINCT PART	1. 181597				-	
92.00	OTHER REIMBURSABLE COST CENTERS	1. 181597		301, 40	02 0	0	92.00
95.00	09500 AMBULANCE SERVICES	0. 000000	0		0		95.00
	09850 OTHER REIMBURSABLE COST CENTERS	0.000000			0 0	0	
		0.000000					
200.00				18, 531, 82	0 0		200.00
201.00	5				0		201.00
202.00	Only Charges Net Charges (line 200 - line 201)		c	18, 531, 82	.4 0		202.00
202.00	I met ondriges (The 200 - The 201)	T		1 10, 551, 62	ט וד.	1 0	1202.00

Health Financial Systems	FRANCI SCAN HEAL	TH RENSSELAER		In Lie	u of Form CMS	-2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND) VACCINE COST	Provider C		Peri od: From 01/01/2023 To 12/31/2023	Worksheet D Part V Date/Time Pr 5/29/2024 8:	epared: 56 am
			e XIX	Hospi tal	Cost	
		sts	_			
Cost Center Description	Cost	Cost				
	Reimbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins. (see inst.)	Ded. & Coins. (see inst.)				
	6.00	7.00	-			
ANCI LLARY SERVI CE COST CENTERS	0.00	7.00				
50. 00 05000 OPERATING ROOM	259, 053	C				50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	572, 777		•			54.00
60. 00 06000 LABORATORY	783, 758		•			60.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	2, 463					63.00
65. 00 06500 RESPI RATORY THERAPY	240, 728					65.00
66. 00 06600 PHYSI CAL THERAPY	195, 977					66.00
66. 01 06601 PHYSI CAL THERAPY- WHEATFI ELD	236, 408					66.01
67. 00 06700 OCCUPATI ONAL THERAPY	92, 963		•			67.00
67.01 06701 OCCUPATIONAL THERAPY- WHEATFIELD	113, 815					67.01
68. 00 06800 SPEECH PATHOLOGY	124, 652		•			68.00
68. 01 06801 SPEECH PATHOLOGY- WHEATFIELD	102, 713		1			68.01
69. 00 06900 ELECTROCARDI OLOGY	0		•			69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0					70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	175, 644	c c				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	32, 711	c c				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	785, 941	c c				73.00
74.00 07400 RENAL DIALYSIS	0	l c				74.00
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	c c				77.00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0	c c				78.00
OUTPATIENT SERVICE COST CENTERS		•				
88.00 08800 RURAL HEALTH CLINIC						88.00
88.01 08801 RURAL HEALTH CLINIC II						88.01
90. 00 09000 CLINIC	316, 690	C				90.00
90. 01 09001 WOUND CARE	1,809					90.01
91. 00 09100 EMERGENCY	1, 539, 267	C				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	356, 136	C				92.00
OTHER REIMBURSABLE COST CENTERS	1					
95.00 09500 AMBULANCE SERVICES	0					95.00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	C				98.00
200.00 Subtotal (see instructions)	5, 933, 505	C				200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201.00
Only Charges	F 000 505	_				
202.00 Net Charges (line 200 - line 201)	5, 933, 505	C	n i i i i i i i i i i i i i i i i i i i			202.00

	Financial Systems FRANCI SCAN HEALTH		In Lie	u of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-1324	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Prep 5/29/2024 8:50	
		Title XVIII	Hospi tal	Cost	
	Cost Center Description			1.00	
	PART I - ALL PROVIDER COMPONENTS				
1.00	INPATIENT DAYS Inpatient days (including private room days and swing-bed day	s. excluding newborn)		1, 923	1.00
2.00	Inpatient days (including private room days, excluding swing-	bed and newborn days)		1, 496	2.00
3.00	Private room days (excluding swing-bed and observation bed da do not complete this line.	ys). If you have only p	rivate room days,	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation b	ed days)		894	4.00
5.00	Total swing-bed SNF type inpatient days (including private ro	om days) through Decembe	er 31 of the cost	287	5.00
6.00	reporting period Total swing-bed SNF type inpatient days (including private ro	om days) after December	31 of the cost	0	6.00
7 00	reporting period (if calendar year, enter 0 on this line)	-		1.10	7 00
7.00	Total swing-bed NF type inpatient days (including private roo reporting period	m days) through December	r 31 of the cost	140	7.00
8.00	Total swing-bed NF type inpatient days (including private roo	m days) after December 3	31 of the cost	0	8.00
9.00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable t	o the Program (excluding	n swing-bed and	528	9.00
	newborn days) (see instructions)	0			
10.00	Swing-bed SNF type inpatient days applicable to title XVIII o through December 31 of the cost reporting period (see instruc		room days)	287	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII o	nly (including private i	room days) after	0	11.00
12.00	December 31 of the cost reporting period (if calendar year, e Swing-bed NF type inpatient days applicable to titles V or XI		te room days)	0	12.00
12.00	through December 31 of the cost reporting period				
13.00	Swing-bed NF type inpatient days applicable to titles V or XI after December 31 of the cost reporting period (if calendar y			0	13.00
14.00	Medically necessary private room days applicable to the Progr			0	14.00
15.00	Total nursery days (title V or XIX only)			0	
16.00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			0	16.00
17.00	Medicare rate for swing-bed SNF services applicable to servic	es through December 31 (of the cost		17.00
18.00	reporting period Medicare rate for swing-bed SNF services applicable to servic	es after December 31 of	the cost		18.00
19.00	reporting period Medicaid rate for swing-bed NF services applicable to service	s through December 31 o	f the cost	250. 44	19 00
	reporting period	0			
20.00	Medicaid rate for swing-bed NF services applicable to service reporting period		the cost	250.44	20.00
21.00 22.00	Total general inpatient routine service cost (see instruction Swing-bed cost applicable to SNF type services through Decemb		ting pariod (line	4, 205, 490 0	
22.00	5 x line 17)	er si or the cost repor	ting period (inte	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reportion	ng period (line 6	0	23.00
24.00	Swing-bed cost applicable to NF type services through Decembe	r 31 of the cost reporti	ng period (line	35, 062	24.00
25.00	7 x line 19) Swing-bed cost applicable to NF type services after December	31 of the cost reporting	g period (line 8	0	25.00
26.00	x line 20) Total swing-bed cost (see instructions)			706, 352	26.00
27.00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		3, 499, 138	
20.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	d and abaamiation had a		0	20.00
	General inpatient routine service charges (excluding swing-be Private room charges (excluding swing-bed charges)	a and observation bed ci	larges)	0	28.00 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)		0.00000	
32. 00 33. 00	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	32.00 33.00
	Average per diem private room charge differential (line 32 mi	nus line 33)(see instru	ctions)		34.00
35.00	Average per diem private room cost differential (line 34 x li	, .			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 27 minus line 36)	and private room cost di	fferential (line	3, 499, 138	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ				
	Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line	-		2,338.99	
	Medically necessary private room cost applicable to the Progr	-		1, 234, 987 0	40.00
	Total Program general inpatient routine service cost (line 39			1, 234, 987	

COMPUT	Financial Systems F ATION OF INPATIENT OPERATING COST	RANCI SCAN HEALTH	Provi der CC	CN: 15-1324	Peri od:	eu of Form CMS- Worksheet D-1	
					From 01/01/2023 To 12/31/2023		
			Title	XVIII	Hospi tal	Cost	
	Cost Center Description	Total Inpatient CostIr	Total patient Days			Program Cost (col. 3 x col. 4)	
		1.00	2.00	<u>col.2)</u> 3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
43.00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	0	0	0	00 0	0	43.00
43.00 44.00	CORONARY CARE UNIT	0	0		00 0		
45.00	BURN INTENSIVE CARE UNIT	Ŭ	0	0.			45.00
	SURGI CAL I NTENSI VE CARE UNI T						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
	Cost Center Description					1.00	
48.00	Program inpatient ancillary service cost (Wks	st. D-3, col. 3,	line 200)			494, 930	48.00
48.01	Program inpatient cellular therapy acquisitio			III, line 10), column 1)	0	
49.00	Total Program inpatient costs (sum of lines 4	41 through 48.01)	(see instruc	tions)		1, 729, 917	49.00
50.00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inpa	tiont routing co	ruloos (from	What D an	m of Dorte L and	0	50.00
50.00	(111)		ervices (from	WKSL D, SU	ini of Farts Fanu		30.00
51.00	Pass through costs applicable to Program inpa and IV)	atient ancillary	services (fro	om Wkst. D,	sum of Parts II	0	51.00
52.00	Total Program excludable cost (sum of lines !	50 and 51)				0	52.00
53.00	Total Program inpatient operating cost exclud		ated, non-phys	si ci an anest	hetist, and	0	53.00
	medical education costs (line 49 minus line 5 TARGET AMOUNT AND LIMIT COMPUTATION	52)					-
54.00	Program di scharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
55.01	Permanent adjustment amount per discharge					0.00	
55.02	Adjustment amount per discharge (contractor u	5.				0.00	
56.00 57.00	Target amount (line 54 x sum of lines 55, 55. Difference between adjusted inpatient operati		net amount (Li	ino 56 minus	line 53)		
58.00	Bonus payment (see instructions)				TTHE 55)	0	
59.00	Trended costs (lesser of line 53 ÷ line 54, o	or line 55 from 1	he cost repo	rting period	l endi ng 1996,	0.00	
	updated and compounded by the market basket)						
60.00	Expected costs (lesser of line 53 ÷ line 54, market basket)	or line 55 from	prior year co	ost report,	updated by the	0.00	60.00
61.00	Continuous improvement bonus payment (if line 55.01, or line 59, or line 60, enter the less 53) are less than expected costs (lines 54 x	ser of 50% of the	e amount by w	hich operati	ng costs (line	0	61.00
(2.00	enter zero. (see instructions)					0	62.00
	Relief payment (see instructions) Allowable Inpatient cost plus incentive payme	ent (see instruct	ions)			0	
	PROGRAM INPATIENT ROUTINE SWING BED COST	•				1	
64.00	Medicare swing-bed SNF inpatient routine cos	ts through Decemb	per 31 of the	cost report	ing period (See	671, 290	64.00
65 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	ts after December	31 of the c	ost reportin	a neriod (See	0	65.00
00.00	instructions) (title XVIII only)						00.00
66.00	Total Medicare swing-bed SNF inpatient routin	ne costs (line 64	plus line 6	5)(title XVI	ll only); for	671, 290	66.00
67.00	CAH, see instructions Title V or XIX swing-bed NF inpatient routing	o costs through [)ocombor 21 o	f the cost r	concrting poriod	0	67.00
07.00	(line 12 x line 19)		Jecember 31 0	i the cost i	eporting period		07.00
68.00	Title V or XIX swing-bed NF inpatient routine (line 13 x line 20)	e costs after Dec	cember 31 of	the cost rep	orting period	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient (PART III - SKILLED NURSING FACILITY, OTHER NU					0	69.00
70.00	Skilled nursing facility/other nursing facili				')		70.00
71.00	Adjusted general inpatient routine service co	ost per diem (lir					71.00
72.00	Program routine service cost (line 9 x line			25)			72.00
73.00 74.00	Medically necessary private room cost applica Total Program general inpatient routine servi			ne 35)			73.00
74.00	Capital -related cost allocated to inpatient	•		orksheet B.	Part II, column		75.00
	26, line 45)		,		,		
76.00	Per diem capital-related costs (line 75 ÷ lin						76.00
77.00 78.00	Program capital-related costs (line 9 x line						77.00
78.00 79.00	Inpatient routine service cost (line 74 minus Aggregate charges to beneficiaries for excess	,	vider record	s)			78.00
	Total Program routine service costs for compa				nus line 79)		80.00
81.00	Inpatient routine service cost per diem limi	tation					81.00
82.00	Inpatient routine service cost limitation (li	· · · · · · · · · · · · · · · · · · ·					82.00
83.00 84.00	Reasonable inpatient routine service costs (Program inpatient ancillary services (see ins						83.00 84.00
84.00 85.00	Utilization review - physician compensation		5)				84.00
86.00	Total Program inpatient operating costs (sum						86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS	S THROUGH COST				1	
87.00 88.00	Total observation bed days (see instructions)		ino 2)			602	
	Adjusted general inpatient routine cost per o	ue⊪ (iine ∠/÷I	nie Z)			2, 339. 00	88.00

Health Financial Systems	FRANCI SCAN HEAL	TH RENSSELAER		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period:	Worksheet D-1	
				From 01/01/2023 To 12/31/2023	Date/Time Pre 5/29/2024 8:5	
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	343, 661	4, 205, 490	0. 08171	7 1, 408, 078	115, 064	90.00
91.00 Nursing Program cost	0	4, 205, 490	0.00000	0 1, 408, 078	0	91.00
92.00 Allied health cost	0	4, 205, 490	0.00000	0 1, 408, 078	0	92.00
93.00 All other Medical Education	0	4, 205, 490	0. 00000			93.00

	Financial Systems FRANCISCAN HEALTH ATION OF INPATIENT OPERATING COST	Provider CCN: 15-1324	Period: From 01/01/2023	u of Form CMS-2 Worksheet D-1	
			To 12/31/2023	Date/Time Prep 5/29/2024 8:50	
	Cost Conton Decemintian	Title XIX	Hospi tal	Cost	1
	Cost Center Description			1.00	
	PART I - ALL PROVIDER COMPONENTS				-
1.00	Inpatient days (including private room days and swing-bed day			1, 923	1.00
2.00	Inpatient days (including private room days, excluding swing-	5,	iveta naom dava	1, 496 0	•
3.00	Private room days (excluding swing-bed and observation bed da do not complete this line.	ays). It you have only pr	Tvate room days,	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation b			894	
5.00	Total swing-bed SNF type inpatient days (including private ro reporting period	oom days) through Decembe	er 31 of the cost	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private ro	oom days) after December	31 of the cost	0	6.00
7 00	reporting period (if calendar year, enter 0 on this line)	m dava) thrawah Dacambar	21 of the east	140	7 00
7.00	Total swing-bed NF type inpatient days (including private roc reporting period	m days) through becember	31 OF the COST	140	7.00
8.00	Total swing-bed NF type inpatient days (including private roc	om days) after December 3	31 of the cost	0	8.00
9.00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable t	to the Drearon (oveluding	, cwing bod and	8	9.00
9.00	newborn days) (see instructions)	to the Program (excruding	j swing-beu anu	0	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII o		room days)	0	10.00
11.00	through December 31 of the cost reporting period (see instruc Swing-bed SNF type inpatient days applicable to title XVIII of		room days) after	0	11.00
11.00	December 31 of the cost reporting period (if calendar year, e	enter 0 on this line)	5,7	0	
12.00	Swing-bed NF type inpatient days applicable to titles V or XI through December 31 of the cost reporting period	X only (including privat	e room days)	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XI	X only (including privat	e room days)	0	13.00
	after December 31 of the cost reporting period (if calendar y				
14.00 15.00	Medically necessary private room days applicable to the Progr Total nursery days (title V or XIX only)	ram (excluding swing-bed	days)	0	
16.00	Nursery days (title V or XIX only)			0	•
17 00	SWING BED ADJUSTMENT	and the second proceedings of a			1 1 7 00
17.00	Medicare rate for swing-bed SNF services applicable to servic reporting period	ces through December 31 c	on the cost		17.00
18.00	Medicare rate for swing-bed SNF services applicable to servic	ces after December 31 of	the cost		18.00
19.00	reporting period Medicaid rate for swing-bed NF services applicable to service	es through December 31 of	the cost	0.00	19.00
20.00	reporting period Medicaid rate for swing-bed NF services applicable to service	as after December 31 of t	he cost	0.00	20.00
20.00	reporting period		the cost	0.00	20.00
21.00	Total general inpatient routine service cost (see instruction	<i>.</i>		4, 205, 490	•
22.00	Swing-bed cost applicable to SNF type services through Decemb 5 x line 17)	per 31 of the cost report	ing period (line	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December	- 31 of the cost reportir	ng period (line 6	0	23.00
	x line 18)				
24.00	ISwing-bed cost applicable to NE type services through Decembe	er 31 of the cost reporti	na period (line	0	24.00
24.00	Swing-bed cost applicable to NF type services through December 7 x line 19)		0, .	-	
24. 00 25. 00	7 x line 19) Swing-bed cost applicable to NF type services after December		0, .	0	
	7 x line 19)		0, .	-	25.00
25. 00	7 x line 19) Swing-bed cost applicable to NF type services after December x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost	31 of the cost reporting	0, .	0	25. 00 26. 00
25. 00 26. 00 27. 00	7 x line 19) Swing-bed cost applicable to NF type services after December x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	31 of the cost reporting (line 21 minus line 26)	g period (line 8	0 0 4, 205, 490	25.00 26.00 27.00
25. 00 26. 00	7 x line 19) Swing-bed cost applicable to NF type services after December x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost	31 of the cost reporting (line 21 minus line 26)	g period (line 8	0	25.00 26.00 27.00 28.00
25.00 26.00 27.00 28.00 29.00 30.00	7 x line 19) Swing-bed cost applicable to NF type services after December x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)	31 of the cost reporting (line 21 minus line 26) ed and observation bed ch	g period (line 8	0 4, 205, 490 0 0 0	25.00 26.00 27.00 28.00 29.00 30.00
25.00 26.00 27.00 28.00 29.00 30.00 31.00	7 x line 19) Swing-bed cost applicable to NF type services after December x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27	31 of the cost reporting (line 21 minus line 26) ed and observation bed ch	g period (line 8	0 4, 205, 490 0 0 0 0 0. 000000	25.00 26.00 27.00 28.00 29.00 30.00 31.00
25.00 26.00 27.00 28.00 29.00 30.00 31.00 32.00	7 x line 19) Swing-bed cost applicable to NF type services after December x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 ÷ line 3)	31 of the cost reporting (line 21 minus line 26) ed and observation bed ch	g period (line 8	0 4, 205, 490 0 0 0 0. 000000 0. 00	25.00 26.00 27.00 28.00 29.00 30.00 31.00 32.00
25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00	7 x line 19) Swing-bed cost applicable to NF type services after December x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)	31 of the cost reporting (line 21 minus line 26) ed and observation bed ch ÷ line 28)	period (line 8 harges)	0 4, 205, 490 0 0 0 0. 000000 0. 000000 0. 00 0. 00	25.00 26.00 27.00 28.00 29.00 30.00 31.00 32.00 33.00
25.00 26.00 27.00 28.00 29.00 30.00 31.00 32.00 33.00 34.00	7 x line 19) Swing-bed cost applicable to NF type services after December x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge differential (line 32 mi	31 of the cost reporting (line 21 minus line 26) ed and observation bed ch ÷ line 28) nus line 33)(see instruct	period (line 8 harges)	0 4, 205, 490 0 0 0. 000000 0. 000000 0. 00 0. 00 0. 00 0. 00	25.00 26.00 27.00 28.00 29.00 30.00 31.00 32.00 33.00 34.00
25.00 26.00 27.00 28.00 29.00 30.00 31.00 32.00 33.00 34.00 35.00	7 x line 19) Swing-bed cost applicable to NF type services after December x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-be Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room cost differential (line 34 x li	31 of the cost reporting (line 21 minus line 26) ed and observation bed ch ÷ line 28) nus line 33)(see instruct	period (line 8 harges)	0 4, 205, 490 0 0 0 0. 000000 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00	25.00 26.00 27.00 28.00 29.00 30.00 31.00 32.00 33.00 34.00 35.00
25.00 26.00 27.00 28.00 29.00 30.00 31.00 32.00 33.00 34.00	7 x line 19) Swing-bed cost applicable to NF type services after December x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge differential (line 32 mi	31 of the cost reporting (line 21 minus line 26) ed and observation bed ch ÷ line 28) nus line 33)(see instruct ne 31)	period (line 8 marges)	0 4, 205, 490 0 0 0. 000000 0. 000000 0. 00 0. 00 0. 00 0. 00	25.00 26.00 27.00 28.00 29.00 30.00 31.00 33.00 33.00 34.00 35.00 36.00
25.00 26.00 27.00 28.00 29.00 30.00 31.00 32.00 33.00 34.00 35.00 36.00	7 x line 19) Swing-bed cost applicable to NF type services after December x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 mi Average per diem private room cost differential (line 34 x li Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost 27 minus line 36)	31 of the cost reporting (line 21 minus line 26) ed and observation bed ch ÷ line 28) nus line 33)(see instruct ne 31)	period (line 8 marges)	0 4, 205, 490 0 0 0 0 0.000000 0.00 0.00 0.00 0.00	25.00 26.00 27.00 28.00 29.00 30.00 31.00 33.00 33.00 34.00 35.00 36.00
25.00 26.00 27.00 28.00 29.00 30.00 31.00 32.00 33.00 34.00 35.00 36.00	7 x line 19) Swing-bed cost applicable to NF type services after December x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 20 ÷ line 4) Average per diem private room cost differential (line 34 x li Private room cost differential djustment (line 34 x line 35) General inpatient routine service cost net of swing-bed cost	31 of the cost reporting (line 21 minus line 26) ed and observation bed cf ÷ line 28) nus line 33)(see instruct ne 31) and private room cost di	period (line 8 marges)	0 4, 205, 490 0 0 0 0 0.000000 0.00 0.00 0.00 0.00	25.00 26.00 27.00 28.00 29.00 30.00 31.00 33.00 33.00 34.00 35.00 36.00
25.00 26.00 27.00 28.00 29.00 30.00 31.00 32.00 33.00 34.00 35.00 36.00	7 x line 19) Swing-bed cost applicable to NF type services after December x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 mi Average per diem private room cost differential (line 34 x li Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY	31 of the cost reporting (line 21 minus line 26) ed and observation bed ch ÷ line 28) nus line 33)(see instruct ne 31) and private room cost di	period (line 8 marges)	0 4, 205, 490 0 0 0 0 0.000000 0.00 0.00 0.00 0.00	25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00
25.00 26.00 27.00 28.00 29.00 30.00 31.00 32.00 33.00 34.00 35.00 36.00 37.00	7 x line 19) Swing-bed cost applicable to NF type services after December x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room cost differential (line 32 mi Average per diem private room cost differential (line 34 x li Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ	31 of the cost reporting (line 21 minus line 26) ed and observation bed cf ÷ line 28) nus line 33)(see instruct ne 31) and private room cost di USTMENTS è instructions) ÷ 38)	period (line 8 marges)	0 4, 205, 490 0 0 0 0.000000 0.00 0.00 0.00 0.00 0	25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00

					From 01/01/2023		
					To 12/31/2023		
			Titl	e XIX	Hospi tal	Cost	<u>, , , , , , , , , , , , , , , , , , , </u>
	Cost Center Description	Total Inpatient Costlr	Total npatient Days			Program Cost (col. 3 x col. 4)	
	-	1.00	2.00	col. 2) 3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units	0	0	0	00 0	0	43.00
	CORONARY CARE UNIT	0	0				
	BURN INTENSIVE CARE UNIT	Ŭ	0	0.			45.00
46.00	SURGI CAL I NTENSI VE CARE UNI T						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
	Cost Center Description					1.00	+
48.00	Program inpatient ancillary service cost (Wks	t. D-3, col. 3,	line 200)			132, 779	48.00
48.01	Program inpatient cellular therapy acquisitio	n cost (Workshee	et D-6, Part		, column 1)	0	48. 01
	Total Program inpatient costs (sum of lines 4	1 through 48.01)	(see instruc	tions)		155, 268	3 49.00
-	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inpa	tiont routing so	rules (from	What D au	m of Parts L and	0	50.00
50.00	Tass through costs appreadre to Frogram theat []])			WKSL D, SU	iii Ul Falts I aliu		1 50.00
51.00	Pass through costs applicable to Program inpa and IV)	tient ancillary	services (fr	om Wkst. D,	sum of Parts II	C	51.00
52.00	Total Program excludable cost (sum of lines 5	0 and 51)				c d	52.00
	Total Program inpatient operating cost exclud		ated, non-phy	si ci an anest	hetist, and	0	53.00
-	medical education costs (line 49 minus line 5 FARGET AMOUNT AND LIMIT COMPUTATION	2)					-
	Program discharges					C	54.00
	Target amount per discharge					0.00	55.00
	Permanent adjustment amount per discharge					0.00	
	Adjustment amount per discharge (contractor u	5.				0.00	
	Target amount (line 54 x sum of lines 55, 55. Difference between adjusted inpatient operati		net amount (l	ino 56 minus	line 53)		
	Bonus payment (see instructions)				TTHE 33)		
	Trended costs (lesser of line 53 ÷ line 54, o	r line 55 from t	the cost repo	rting period	endi ng 1996,	0.00	
(0.00	updated and compounded by the market basket)						
	Expected costs (lesser of line 53 ÷ line 54, market basket)	or line 55 from	prior year c	ost report,	updated by the	0.00	60.00
	Continuous improvement bonus payment (if line 55.01, or line 59, or line 60, enter the less 53) are less than expected costs (lines 54 x	er of 50% of the	e amount by w	hich operati	ng costs (line	С	61.00
	enter zero. (see instructions) Relief payment (see instructions)					c c	62.00
	Allowable Inpatient cost plus incentive payme	nt (see instruct	tions)				
+	PROGRAM INPATIENT ROUTINE SWING BED COST						
	Medicare swing-bed SNF inpatient routine cost	s through Decemb	per 31 of the	cost report	ing period (See	0	64.00
	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cost	s after December	31 of the c	ost reportin	a period (See	c	65.00
	instructions)(title XVIII only)				3 (
66.00	Total Medicare swing-bed SNF inpatient routin	e costs (line 64	1 plus line 6	5)(title XVI	ll only); for	0	66.00
67.00	CAH, see instructions Title V or XIX swing-bed NF inpatient routine	costs through [December 31 o	f the cost r	eporting period	l c	67.00
	(line 12 x line 19)	0					
68.00	Title V or XIX swing-bed NF inpatient routine (line 13 x line 20)	costs after Dec	cember 31 of	the cost rep	orting period	C	68.00
t i i i i i i i i i i i i i i i i i i i	Total title V or XIX swing-bed NF inpatient r			,		0	69.00
t i i i i i i i i i i i i i i i i i i i	PART III - SKILLED NURSING FACILITY, OTHER NU Skilled nursing facility/other nursing facili)		70.00
	Adjusted general inpatient routine service co	5					71.00
72.00	Program routine service cost (line 9 x line 7	1)					72.00
	Medically necessary private room cost applica			ne 35)			73.00 74.00
	Total Program general inpatient routine servi Capital-related cost allocated to inpatient r			orksheet B	Part II column		74.00
/0.00	26, line 45)			or Koncot D,			/ 0.00
76.00	Per diem capital-related costs (line 75 ÷ lin	e 2)					76.00
	Program capital-related costs (line 9 x line						77.00
	Inpatient routine service cost (line 74 minus Aggregate charges to beneficiaries for excess		wider record	e)			78.00 79.00
	Total Program routine service costs for compa				nus line 79)		80.00
	Inpatient routine service cost per diem limit				/		81.00
	Inpatient routine service cost limitation (li	· · · · · · · · · · · · · · · · · · ·					82.00
	Reasonable inpatient routine service costs (s)				83.00
	Program inpatient ancillary services (see ins Utilization review - physician compensation (,	5)				84.00 85.00
	Total Program inpatient operating costs (sum						86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS	THROUGH COST	<u> </u>				
/	Total observation bed days (see instructions) Adjusted general inpatient routine cost per d					602 2, 811. 16	

Health Financial Systems	FRANCI SCAN HEAL	TH RENSSELAER		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period:	Worksheet D-1	
				From 01/01/2023 To 12/31/2023	Date/Time Pre 5/29/2024 8:5	
		Titl	e XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	343, 661	4, 205, 490	0. 08171	7 1, 692, 318	138, 291	90.00
91.00 Nursing Program cost	0	4, 205, 490	0.00000	0 1, 692, 318	0	91.00
92.00 Allied health cost	0	4, 205, 490	0.00000	0 1, 692, 318	0	92.00
93.00 All other Medical Education	0	4, 205, 490	0. 00000	0 1, 692, 318	0	93.00

eal th Financial Systems FRANCI SCAN HEALTH R				u of Form CMS-	
NPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CC	CN: 15-1324	Peri od:	Worksheet D-3	3
			From 01/01/2023 To 12/31/2023	Date/Time Pre	narod
			10 12/31/2023	5/29/2024 8:5	6 am
	Title	XVIII	Hospi tal	Cost	
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges	Program	Program Costs	
		Ŭ	Charges	(col. 1 x col.	
				2)	
		1.00	2.00	3.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS					
0. 00 03000 ADULTS & PEDIATRICS			796, 508		30.0
1. 00 03100 I NTENSI VE CARE UNI T			0		31.0
2.00 03200 CORONARY CARE UNI T			0		32.0
ANCI LLARY SERVI CE COST CENTERS					
0.00 05000 OPERATING ROOM		0.6455			
4. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 1665			
0. 00 06000 LABORATORY		0. 2482			
3. 00 06300 BLOOD STORING, PROCESSING & TRANS.		0. 2447			
5. 00 06500 RESPI RATORY THERAPY		0. 5067			
6. 00 06600 PHYSI CAL THERAPY		0.4639		22, 200	
6. 01 06601 PHYSI CAL THERAPY- WHEATFI ELD		0.6006			
7. 00 06700 OCCUPATI ONAL THERAPY		0.4646		24, 326	
7.01 06701 OCCUPATIONAL THERAPY- WHEATFIELD		0.8968		0	
8.00 06800 SPEECH PATHOLOGY		0.7500		4, 820	
8.01 06801 SPEECH PATHOLOGY- WHEATFIELD		0.6055		0	
9. 00 06900 ELECTROCARDI OLOGY		0.0000		-	
0.00 07000 ELECTROENCEPHALOGRAPHY		0.0000		0	1
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 2539			
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 1456			
3.00 07300 DRUGS CHARGED TO PATIENTS		0. 1669		76, 894	73.0
4. 00 07400 RENAL DIALYSIS		0.0000	00 0	0	74.0
7.00 07700 ALLOGENEIC HSCT ACQUISITION		0.0000			77.
8.00 07800 CAR T-CELL IMMUNOTHERAPY		0.0000	00 0	0	78.
OUTPATI ENT SERVICE COST CENTERS					
8.00 08800 RURAL HEALTH CLINIC		0.0000		0	
8.01 08801 RURAL HEALTH CLINIC II		0.0000		0	
0. 00 09000 CLINIC		0. 5146		7, 859	
0. 01 09001 WOUND CARE		0. 2632		0	
1.00 09100 EMERGENCY		0.5095			
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART		1. 1815	97 2, 773	3, 277	92.
OTHER REIMBURSABLE COST CENTERS					
5. 00 09500 AMBULANCE SERVICES					95.
8.00 09850 OTHER REIMBURSABLE COST CENTERS		0.0000		-	
00.00 Total (sum of lines 50 through 94 and 96 through 98)			1, 796, 177		
01.00 Less PBP Clinic Laboratory Services-Program only charges	(line 61)		0		201.0
02.00 Net charges (line 200 minus line 201)			1, 796, 177		202. (

Health Financial Systems FRANCISCAN HEALTH R				u of Form CMS-	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CO	CN: 15-1324	Peri od:	Worksheet D-3	5
	Component (CCN: 15-Z324	From 01/01/2023 To 12/31/2023	Date/Time Pre	nared
	oomponent v			5/29/2024 8:5	6 am
	Ti tl e	XVIII	Swing Beds - SNF	Cost	
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS 31. 00 03100 I NTENSI VE CARE UNI T					30.00
					31.00
32. 00 03200 CORONARY CARE UNIT ANCI LLARY SERVI CE COST CENTERS					32.00
50. 00 OS000 OPERATING ROOM		0. 6455	16 5, 878	3, 794	50.00
54. 00 05400 0PERATING ROOM 54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 8455			
60. 00 06000 LABORATORY		0. 2482			
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.		0. 2482			
65. 00 06500 RESPI RATORY THERAPY		0. 5067			
66. 00 06600 PHYSI CAL THERAPY		0. 4639			
66. 01 06601 PHYSI CAL THERAPY- WHEATFI ELD		0. 6006			
67. 00 06700 OCCUPATI ONAL THERAPY		0. 4646			
67. 01 06701 0CCUPATI ONAL THERAPY- WHEATFI ELD		0. 8968			
68. 00 06800 SPEECH PATHOLOGY		0.7500			
68. 01 06801 SPEECH PATHOLOGY- WHEATFIELD		0.6055			
69. 00 06900 ELECTROCARDI OLOGY		0.0000			
70. 00 07000 ELECTROENCEPHALOGRAPHY		0.0000		0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 2539		5, 808	
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS		0. 1456		0	
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 1669	09 105, 157	17, 552	73.00
74.00 07400 RENAL DIALYSIS		0.0000	00 00		
77.00 07700 ALLOGENEIC HSCT ACQUISITION		0.0000	00 00	0	77.00
78.00 07800 CAR T-CELL IMMUNOTHERAPY		0. 0000	00 00	0	78.00
OUTPATIENT SERVICE COST CENTERS					
88.00 08800 RURAL HEALTH CLINIC		0.0000	00	0	88.00
88.01 08801 RURAL HEALTH CLINIC II		0.0000	00	0	88. 01
90. 00 09000 CLINIC		0. 5146	29 0	0	90.00
90. 01 09001 WOUND CARE		0. 2632	05 0	0	90.0
91. 00 09100 EMERGENCY		0. 5095	06 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART		1. 1815	97 95	112	92.00
OTHER REIMBURSABLE COST CENTERS					
95. 00 09500 AMBULANCE SERVICES					95.00
98. 00 09850 OTHER REI MBURSABLE COST CENTERS		0.0000		-	
200.00 Total (sum of lines 50 through 94 and 96 through 98)			350, 965		
201.00 Less PBP Clinic Laboratory Services-Program only charges	(line 61)		0		201.00
202.00 Net charges (line 200 minus line 201)			350, 965		202.00

	ALTH RENSSELAER			u of Form CMS-	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-1324	Peri od:	Worksheet D-3	3
			From 01/01/2023 To 12/31/2023	Date/Time Pre	narod
			10 12/31/2023	5/29/2024 8:5	spareu 56 am
	Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
			Ũ	2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		1			
30. 00 03000 ADULTS & PEDIATRICS			109, 312		30.0
31. 00 03100 I NTENSI VE CARE UNI T			0		31.0
32. 00 03200 CORONARY CARE UNI T			0		32.0
ANCI LLARY SERVI CE COST CENTERS		1		1	
50. 00 05000 OPERATING ROOM		0.6455			
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 1665			
60. 00 06000 LABORATORY		0. 2482			
53.00 06300 BLOOD STORING, PROCESSING & TRANS.		0. 2447			
65. 00 06500 RESPI RATORY THERAPY		0. 5067			
56. 00 06600 PHYSI CAL THERAPY		0. 4639			
56. 01 06601 PHYSI CAL THERAPY- WHEATFI ELD		0.6006			
57.00 06700 OCCUPATI ONAL THERAPY		0. 4646			
67.01 06701 0CCUPATIONAL THERAPY- WHEATFIELD		0. 8968		-	
58.00 06800 SPEECH PATHOLOGY		0. 7500		200	
68. 01 06801 SPEECH PATHOLOGY- WHEATFIELD		0.6055		-	
59. 00 06900 ELECTROCARDI OLOGY		0.0000		-	
70. 00 07000 ELECTROENCEPHALOGRAPHY		0.0000		e e e e e e e e e e e e e e e e e e e	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 2539			
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 1456		0	
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 1669		16, 594	
74. 00 07400 RENAL DI ALYSI S		0.0000			
77.00 07700 ALLOGENEIC HSCT ACQUISITION		0.0000		-	1
78.00 07800 CAR T-CELL IMMUNOTHERAPY		0.0000	0 00	0	78.0
OUTPATIENT SERVICE COST CENTERS		0.50(0)			
38. 00 08800 RURAL HEALTH CLINIC		3. 5360			
38.01 08801 RURAL HEALTH CLINIC II		2.4847		-	
20. 00 09000 CLINIC		0.5146			
20. 01 09001 WOUND CARE		0. 2632			1
91.00 09100 EMERGENCY		0.5095			
22. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS		1. 1815	97 25, 191	29, 766	92.0
25. 00 09500 AMBULANCE SERVICES		1			95. (
95. 00 09500 AMBULANCE SERVICES 98. 00 09850 OTHER REIMBURSABLE COST CENTERS		0.0000	00 0	0	
200.00 Total (sum of lines 50 through 94 and 96 through 98	\ \	0.0000		-	1
200.00 Total (sum of lines 50 through 94 and 96 through 98 201.00 Less PBP Clinic Laboratory Services-Program only cha			386, 070		200.0
	arges (ITTE OT)		Ű		201.0
202.00 Net charges (line 200 minus line 201)		I	386, 070	I	1202. (

	ATION OF REIMBURSEMENT SETTLEMENT	RENSSELAER Provi der CCN: 15-1324	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part B	
		Title XVIII	Hospi tal	Cost	
				1.00	
1 00	PART B - MEDICAL AND OTHER HEALTH SERVICES			0 001 002	1 1 00
1.00 2.00	Medical and other services (see instructions) Medical and other services reimbursed under OPPS (see instruc	tions)		8, 891, 893 0	1.00 2.00
3.00	OPPS or REH payments			0	
4.00	Outlier payment (see instructions)			0	
4.01 5.00	Outlier reconciliation amount (see instructions) Enter the hospital specific payment to cost ratio (see instru	ctions)		0.000	
6.00	Line 2 times line 5			0.000	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	
8.00 9.00	Transitional corridor payment (see instructions) Ancillary service other pass through costs including REH dire	at anaduata madi cal adur	nation costs from	0	8.00 9.00
9.00	Wkst. D, Pt. IV, col. 13, line 200	et graduate medical educ		0	9.00
10.00	Organ acqui si ti ons			0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			8, 891, 893	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges				-
12.00	Ancillary service charges			0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, I	ine 69)		0	
14.00	Total reasonable charges (sum of lines 12 and 13)			0	14.00
15.00	Customary charges Aggregate amount actually collected from patients liable for	payment for services on	a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable fo			0	
47 00	had such payment been made in accordance with 42 CFR §413.13(e)	-	0,000000	17.00
17.00 18.00	Ratio of line 15 to line 16 (not to exceed 1.000000) Total customary charges (see instructions)			0. 000000 0	
19.00	Excess of customary charges over reasonable cost (complete on	ly if line 18 exceeds li	ne 11) (see	0	
	instructions)	5	<i>,</i> .		
20.00	Excess of reasonable cost over customary charges (complete on instructions)	ly if line 11 exceeds li	ne 18) (see	0	20.00
21.00	Lesser of cost or charges (see instructions)			8, 980, 812	21.00
22.00	Interns and residents (see instructions)			0	
23.00	Cost of physicians' services in a teaching hospital (see inst	ructions)		0	
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) COMPUTATION OF REIMBURSEMENT SETTLEMENT			0	24.00
25.00	Deductibles and coinsurance amounts (for CAH, see instruction	s)		78, 294	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on lin	•		5, 818, 486	
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) instructions)	plus the sum of lines 22	2 and 23] (see	3, 084, 032	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, I	ine 50)		0	28.00
28.50	REH facility payment amount (see instructions)				28.50
29.00 30.00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0 3, 084, 032	
	Subtotal (sum of lines 27, 28, 28.50 and 29) Primary payer payments				30.00
32.00	Subtotal (line 30 minus line 31)			3, 082, 584	
22.00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVI)	CES)		0	22.00
33.00 34.00	Composite rate ESRD (from Wkst. 1-5, line 11) Allowable bad debts (see instructions)			0 755, 328	
35.00	Adjusted reimbursable bad debts (see instructions)			490, 963	
36.00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		540, 505	
37.00 38.00	Subtotal (see instructions) MSP-LCC reconciliation amount from PS&R			3, 573, 547 0	37.00 38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instruction	s)			39.50
39.75	N95 respirator payment adjustment amount (see instructions)			0	
39. 97 39. 98	Demonstration payment adjustment amount before sequestration Partial or full credits received from manufacturers for repla	ced devices (see instru	tions)	0	39.97 39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION			0	1
40.00	Subtotal (see instructions)			3, 573, 547	
40.01	Sequestration adjustment (see instructions)			71, 471	
40. 02 40. 03	Demonstration payment adjustment amount after sequestration Sequestration adjustment-PARHM pass-throughs			0	40.02
41.00	Interim payments			3, 525, 786	
41.01	Interim payments-PARHM			-	41.01
42.00 42.01	Tentative settlement (for contractors use only) Tentative settlement-PARHM (for contractor use only)			0	42.00 42.01
42.01	Balance due provider/program (see instructions)			-23, 710	
43.01	Balance due provider/program-PARHM (see instructions)				43.01
44.00	Protested amounts (nonallowable cost report items) in accorda	nce with CMS Pub. 15-2,	chapter 1,	0	44.00
	§115.2 TO BE COMPLETED BY CONTRACTOR				1
90.00	Original outlier amount (see instructions)			0	
91.00 92.00	Outlier reconciliation adjustment amount (see instructions)			0	
	The rate used to calculate the Time Value of Money			0.00	92.00

Health Financial Systems	FRANCI SCAN HEALTH	RENSSELAER	In Lie	u of Form CMS	-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-1324	Period:	Worksheet E	
			From 01/01/2023 To 12/31/2023		epared:
				5/29/2024 8:	56 am
		Title XVIII	Hospi tal	Cost	
				1.00	
94.00 Total (sum of lines 91 and 93)				(94.00
				1.00	
MEDICARE PART B ANCILLARY COSTS					
200.00 Part B Combined Billed Days				(200. 00

ANALY	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC	CN: 15-1324	Period: From 01/01/2023 To 12/31/2023		
		Title		Hospi tal	Cost	
		I npati en	t Part A	Par	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, 103, 69	95 0	3, 525, 786 0	1.00
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	3.0
3.02				0	0	3.02
3.03				0	0	3.03
3.04 3.05				0	0	3.04 3.05
5.05	Provider to Program	<u> </u>				5.00
3.50	ADJUSTMENTS TO PROGRAM			0	0	3.50
3.51				0	0	3.5
3.52				0	0	3.5
3.53 3.54				0	0	3.53 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) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1, 103, 69	95	3, 525, 786	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					5.00
5.01	TENTATI VE TO PROVIDER			0	0	5. 0 ⁻
5.02				0	0	5.02
5.03				0	0	5.03
	Provider to Program					
5.50	TENTATI VE TO PROGRAM			0	0	5.50
5.51 5.52				0	0	5.5 5.52
5.99	Subtotal (sum of lines 5.01–5.49 minus sum of lines 5.50–5.98)			0	0	5.9
5.00	Determined net settlement amount (balance due) based on the cost report. (1)		00/ 00	70		6.0
5. 01 5. 02	SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM		386, 27	0	0 23, 710	6.0 6.0
5.02 7.00	Total Medicare program liability (see instructions)		1, 489, 96	-	3, 502, 076	7.0
			· · ·	Contractor Number	NPR Date (Mo/Day/Yr)	7.0
		C)	1.00	2.00	

ANALY	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC Component C	CN: 15-1324 CCN: 15-Z324	Period: From 01/01/2023 To 12/31/2023	Date/Time Pre	pared:
					5/29/2024 8:5	6 am
				Swing Beds - SN	F <u>Cost</u> rtB	
		Inpatien	LPAILA	Pa	ιв	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		548, 5	34	0	1.00
2.00	Interim payments payable on individual bills, either			0	0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
3.00	write "NONE" or enter a zero List separately each retroactive lump sum adjustment					3.00
5.00	amount based on subsequent revision of the interim rate					3.00
	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	09/26/2023	35, 7		0	
3.02				0	0	
3.03				0	0	
3.04				0	0	
3.05	Dura di dara da Dura suran			0	0	3.05
3.50	Provider to Program ADJUSTMENTS TO PROGRAM		[0	0	3.50
3.50	ADJUSTMENTS TO PROGRAM			0	0	
3.52				0	0	
3.53				0	0	
3.54				0	0	
3.99	Subtotal (sum of lines 3.01–3.49 minus sum of lines		35, 7	00	0	3.99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		584, 2	84	0	4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropriate) TO BE COMPLETED BY CONTRACTOR					-
5.00	List separately each tentative settlement payment after					5.00
5.00	desk review. Also show date of each payment. If none,					3.00
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5.01	TENTATI VE TO PROVI DER			0	0	
5.02				0	0	
5.03				0	0	5.03
	Provider to Program			0		
5.50 5.51	TENTATI VE TO PROGRAM			0	0	
5.51 5.52				0	0	
5.99	Subtotal (sum of lines 5.01–5.49 minus sum of lines			0	0	
0. 77	5. 50-5. 98)			0	j ő	0. //
6.00	Determined net settlement amount (balance due) based on					6.00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVIDER		186, 6	27	0	
6. 02	SETTLEMENT TO PROGRAM			0	0	
7.00	Total Medicare program liability (see instructions)		770, 9		0	7.00
				Contractor	NPR Date	
)	<u>Number</u> 1.00	(Mo/Day/Yr) 2.00	
)	1.00	2.00	

Heal th	Financial Systems	FRANCI SCAN HEALTH	RENSSELAER	In Lie	u of Form CMS-	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 15-1324	Period: From 01/01/2023 To 12/31/2023		epared:
			Title XVIII	Hospi tal	Cost	
					1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDA					_
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTI					1 4 44
1.00	Total hospital discharges as defined in AA	RA §4102 from Wkst.	S-3, Pt. I col. 15 line	e 14		1.00
2.00	Medicare days (see instructions)					2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, co	ol. 6. line 2				3.00
4.00	Total inpatient days (see instructions)					4.00
5.00	Total hospital charges from Wkst C, Pt. I,					5.00
6.00	Total hospital charity care charges from W					6.00
7.00	CAH only - The reasonable cost incurred for line 168	r the purchase of co	ertified HIT technology	Wkst. S-2, Pt. I		7.00
8.00	Calculation of the HIT incentive payment (see instructions)				8.00
9.00	Sequestration adjustment amount (see instru	uctions)				9.00
10.00	Calculation of the HIT incentive payment a	fter sequestration	(see instructions)			10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS					
30.00	Initial/interim HIT payment adjustment (see	e instructions)				30.00
31.00	Other Adjustment (specify)					31.00
32.00	Balance due provider (line 8 (or line 10)	minus line 30 and li	ine 31) (see instruction	is)		32.00

	inancial Systems FRANCISCAN HEALTH RE TION OF REIMBURSEMENT SETTLEMENT - SWING BEDS Pr	rovider CCN: 15-1324	Peri od:	u of Form CMS-2 Worksheet E-2	
	Ca	omponent CCN: 15-Z324	From 01/01/2023 To 12/31/2023	Date/Time Prep 5/29/2024 8:50	
		Title XVIII	Swing Beds - SNF	Cost	
			Part A 1.00	Part B	
C	OMPUTATION OF NET COST OF COVERED SERVICES		1.00	2.00	
	npatient routine services - swing bed-SNF (see instructions)		678, 003	0	1.0
	npatient routine services - swing bed-NF (see instructions)				2.0
	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A		115, 641	0	3.0
	Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-	bed pass-through, see			
	nstructions) Nursing and allied health payment-PARHM (see instructions)				3. (
	Per diem cost for interns and residents not in approved teaching	program (see		0.00	
	nstructions)	program (666		0100	
	Program days		287	0	5.0
	nterns and residents not in approved teaching program (see inst			0	6.0
	Itilization review - physician compensation - SNF optional metho	d only	702 (14	0	7.0
	Subtotal (sum of lines 1 through 3 plus lines 6 and 7) Primary payer payments (see instructions)		793, 644	0	8. (9. (
	Subtotal (line 8 minus line 9)		793, 644	0	10.0
	Deductibles billed to program patients (exclude amounts applicab	le to physician	0	0	11.0
	professional services)				
1	Subtotal (line 10 minus line 11)		793, 644	0	
	Coinsurance billed to program patients (from provider records) (exclude coinsurance	7, 000	0	13.0
	for physician professional services) 30% of Part B costs (line 12 x 80%)			0	14. (
	Subtotal (see instructions)		786, 644	0	15.0
	DTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	16.0
	Pioneer ACO demonstration payment adjustment (see instructions)				16. !
	Rural community hospital demonstration project (§410A Demonstrat	ion) payment	0		16.
	adjustment (see instructions)			0	1/1
	Demonstration payment adjustment amount before sequestration Allowable bad debts (see instructions)		0	0	16.9 17.0
	Adjusted reimbursable bad debts (see instructions)		0	0	17.0
	Allowable bad debts for dual eligible beneficiaries (see instruc	tions)	0	0	
	Fotal (see instructions)		786, 644	0	19. (
	Sequestration adjustment (see instructions)		15, 733	0	
	Demonstration payment adjustment amount after sequestration)		0	0	
	Sequestration adjustment-PARHM pass-throughs		0	0	19.0
	Sequestration for non-claims based amounts (see instructions) nterim payments		584, 284	0	19.1 20.0
	nterim payments-PARHM		001,201	0	20.0
	Fentative settlement (for contractor use only)		0	0	
1. 01 1	Fentative settlement-PARHM (for contractor use only)				21. (
1	Balance due provider/program (line 19 minus lines 19.01, 19.02,	19.25, 20, and 21)	186, 627	0	22.0
1	Balance due provider/program-PARHM (see instructions)	with CMC Dub 15 0	0	0	22.0
	Protested amounts (nonallowable cost report items) in accordance chapter 1, §115.2	WITH CMS PUD. 15-2,	0	0	23.0
	ural Community Hospital Demonstration Project (§410A Demonstrat	ion) Adjustment			
	s this the first year of the current 5-year demonstration perio				200. (
	Century Cures Act? Enter "Y" for yes or "N" for no.				
	ost Reimbursement Medicare swing-bed SNF inpatient routine service costs (from Wks	+ D 1 D+ II line			201 0
	66 (title XVIII hospital))	a. D-T, PL. IT, TIME			201. (
	Medicare swing-bed SNF inpatient ancillary service costs (from W	/kst. D-3. col. 3. lin	е		202. (
	200 (title XVIII swing-bed SNF))				
	Total (sum of lines 201 and 202)				203. (
	Medicare swing-bed SNF discharges (see instructions)	- C 11			204. (
	omputation of Demonstration Target Amount Limitation (N/A in fieriod)	rst year of the curre	nt 5-year demonst	ration	
	Medicare swing-bed SNF target amount				205. (
	Medicare swing-bed SNF inpatient routine cost cap (line 205 time	s line 204)			206. (
	djustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursem				
	Program reimbursement under the §410A Demonstration (see instruc	-			207. (
	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2,	col. 1, sum of lines	1		208. (
	and 3) Naturation of the Medicare swing-bed SNE PPS navments (see instruction	one)			209. (
	Adjustment to Medicare swing-bed SNF PPS payments (see instructi Reserved for future use	(CIIO)			209. 0 210. 0
	omparision of PPS versus Cost Reimbursement				0. 0
	fotal adjustment to Medicare swing-bed SNF PPS payment (line 209	plus line 210) (see			215. (

ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1324	Period: From 01/01/2023 To 12/31/2023	Worksheet E-3 Part V Date/Time Prep	
				5/29/2024 8:50	
		Title XVIII	Hospi tal	Cost	
				1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDIC			1.00	<u> </u>
00	Inpatient services	ARE PART A SERVICES - COST	KETWOUKSEWENT	1, 729, 917	1 1
00	Nursing and Allied Health Managed Care payment (see instru	uctions)		1, 729, 917	
00	Organ acquisition	ictions)		0	
00	Cellular therapy acquisition cost (see instructions)			0	3
00	Subtotal (sum of lines 1 through 3.01)			1, 729, 917	4
00	Primary payer payments			1, 729, 917	5
00	Total cost (line 4 less line 5). For CAH (see instructions	•)		1, 747, 216	
00	COMPUTATION OF LESSER OF COST OR CHARGES	·)		1, 747, 210	
	Reasonable charges				1
00	Routi ne servi ce charges			0	1 7
00	Ancillary service charges			0	
00	Organ acquisition charges, net of revenue			0	9
0.00	Total reasonable charges			Ő	
	Customary charges				1
. 00	Aggregate amount actually collected from patients liable f	for payment for services on	a charge basis	0	1 11
. 00	Amounts that would have been realized from patients liable	1 5	U U	0	
	had such payment been made in accordance with 42 CFR 413.1	1 5	J		
. 00	Ratio of line 11 to line 12 (not to exceed 1.000000)	- (-)		0.00000	13
. 00	Total customary charges (see instructions)			0	14
. 00	Excess of customary charges over reasonable cost (complete	only if line 14 exceeds li	ne 6) (see	0	15
	instructions)	5	, ,		
b. 00	Excess of reasonable cost over customary charges (complete	only if line 6 exceeds lir	ne 14) (see	0	16
	instructions)				
. 00	Cost of physicians' services in a teaching hospital (see i	nstructions)		0	17
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
. 00	Direct graduate medical education payments (from Worksheet	E-4, line 49)		0	
. 00	Cost of covered services (sum of lines 6, 17 and 18)			1, 747, 216	
. 00	Deductibles (exclude professional component)			233, 556	
. 00	Excess reasonable cost (from line 16)			0	
. 00	Subtotal (line 19 minus line 20 and 21)			1, 513, 660	
. 00	Coinsurance			400	
. 00	Subtotal (line 22 minus line 23)			1, 513, 260	
. 00	Allowable bad debts (exclude bad debts for professional se	ervices) (see instructions)		10, 946	
. 00	Adjusted reimbursable bad debts (see instructions)			7, 115	
. 00	Allowable bad debts for dual eligible beneficiaries (see i	nstructions)		4, 794	
. 00	Subtotal (sum of lines 24 and 25, or line 26)			1, 520, 375	
. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
. 50	Pioneer ACO demonstration payment adjustment (see instruct	i ons)		0	29
. 98	Recovery of accel erated depreciation.			0	
. 99	Demonstration payment adjustment amount before sequestrati	on		0	
. 00	Subtotal (see instructions)			1, 520, 375	
. 01	Sequestration adjustment (see instructions)			30, 408	
	Demonstration payment adjustment amount after sequestration	лт 1		0	
. 03	Sequestration adjustment-PARHM			1 100 /05	30
. 00	Interim payments			1, 103, 695	
. 01	Interim payments-PARHM			_	31
. 00	Tentative settlement (for contractor use only)			0	
. 01	Tentative settlement-PARHM (for contractor use only)	(0, 0, 2, 2, 1) and $(2, 2)$		204 272	32
B. 00	Balance due provider/program (line 30 minus lines 30.01, 3	· · · · ·	and 22 01)	386, 272	
. 01 . 00	Balance due provider/program-PARHM (lines 2, 3, 18, and 26 Protested amounts (nonallowable cost report items) in acco			~	33
	LE DIESTED AMOUNTS CHONALLOWADLE COST LEDOLT LIEMS) EN ACCO	n uance with two Pub. 15-2,	chapter I,	0	34

	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1324	Peri od: From 01/01/2023 To 12/31/2023		pare
		Title XIX	Hospi tal	Cost	
			Inpati ent	Outpati ent	
			1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERV	ICES FOR ITILES V OR >	(TX SERVICES		-
00	COMPUTATION OF NET COST OF COVERED SERVICES		155 2/0		1 1
. 00 . 00	Inpatient hospital/SNF/NF services		155, 268		1
00	Medical and other services Organ acquisition (certified transplant programs only)		0	5, 933, 505	
00	Subtotal (sum of lines 1, 2 and 3)		155, 268	5, 933, 505	
00	Inpatient primary payer payments		100, 200	3, 733, 303	5
00	Outpatient primary payer payments		0	0	6
.00	Subtotal (line 4 less sum of lines 5 and 6)		155, 268	5, 933, 505	
	COMPUTATION OF LESSER OF COST OR CHARGES			i	1
	Reasonable Charges				
. 00	Routine service charges		0		8
00	Ancillary service charges		386, 070	18, 531, 824	9
0. 00	Organ acquisition charges, net of revenue		0		10
1.00	Incentive from target amount computation		0		11
2.00	Total reasonable charges (sum of lines 8 through 11)		386, 070	18, 531, 824	12
	CUSTOMARY CHARGES				1 1 2
3.00	Amount actually collected from patients liable for payment for basis	services on a charge	0	0	13
4.00	Amounts that would have been realized from patients liable for	navment for services (on 0	0	14
f. 00	a charge basis had such payment been made in accordance with 42		0		114
5.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0. 000000	15
5.00	Total customary charges (see instructions)		386, 070		
7.00	Excess of customary charges over reasonable cost (complete only	/ifline 16 exceeds	230, 802		17
	line 4) (see instructions)				
8.00	Excess of reasonable cost over customary charges (complete only	/ifline 4 exceeds lir	ne O	0	18
	16) (see instructions)				
9.00	Interns and Residents (see instructions)		0	0	19
0.00	Cost of physicians' services in a teaching hospital (see instru		155 0(0		20
1. 00	Cost of covered services (enter the lesser of line 4 or line 16		155, 268	5, 933, 505	21
2. 00	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be c Other than outlier payments	compreted for PPS provi	ders.	0	22
3.00	Outlier payments		0	0	23
4.00	Program capital payments		0		24
5.00	Capital exception payments (see instructions)		0		25
6.00	Routine and Ancillary service other pass through costs		0	0	
7.00	Subtotal (sum of lines 22 through 26)		0	0	27
B. 00	Customary charges (title V or XIX PPS covered services only)		0	0	28
9.00	Titles V or XIX (sum of lines 21 and 27)		155, 268	5, 933, 505	29
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
0. 00	Excess of reasonable cost (from line 18)		0	0	30
1.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		155, 268		
2.00	Deducti bl es		0	0	32
3.00	Coinsurance		0	0	
1.00 5.00	Allowable bad debts (see instructions)		0	0	34
5.00	Utilization review Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	33)	155, 268	5, 933, 505	
7.00	ADJUST SETTLEMENT TO ZERO	557	-136, 581	-6, 095, 481	
3.00	Subtotal (line 36 ± line 37)		18, 687	-161, 976	
9.00	Direct graduate medical education payments (from Wkst. E-4)		, 0, 007 O	101, 770	39
). 00). 00	Total amount payable to the provider (sum of lines 38 and 39)		18, 687	-161, 976	
1.00	Interim payments		.0, 507	0	41
	Balance due provider/program (line 40 minus line 41)		18, 687	-161, 976	
2.00					

nd-ty y)	ype accounting records, complete the General Fund column	1				
V 1				rom 01/01/2023 0 12/31/2023	Date/Time Pre	par
					5/29/2024 8:5	
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS		1			
	Cash on hand in banks	1, 100			0	
	Temporary investments Notes receivable	4, 655, 932		-	0	
	Accounts receivable	4,055,952		0	0	
	Other recei vabl e	0		0	0	
0	Allowances for uncollectible notes and accounts receivable	0	c	0	0	
	Inventory	837, 288	C	0	0	
	Prepaid expenses	190, 738	C	0	0	
	Other current assets Due from other funds	452, 659 83, 413		-	0	
	Total current assets (sum of lines 1-10)	6, 221, 130			0	
	FIXED ASSETS	0,221,130		0	0	1'
	Land	675, 791	C	0	0	12
00	Land improvements	509, 926	C	0	0	13
	Accumulated depreciation	0	C	0	0	1
	Buildings	21, 089, 230	C	0	0	
	Accumulated depreciation Leasehold improvements	-15, 514, 593			0	
	Accumulated depreciation	0		-	0	
	Fixed equipment	8, 011, 668		-	0	
	Accumulated depreciation	0	C	0	0	
00	Automobiles and trucks	0	C	0	0	2
	Accumulated depreciation	0	C	0	0	
	Major movable equipment	0	C	0	0	
	Accumulated depreciation Minor equipment depreciable	0		0	0	
	Accumulated depreciation	0		0	0	
	HIT designated Assets	0		0	0	
	Accumulated depreciation	0	C	0	0	
00	Minor equipment-nondepreciable	0	C	0	0	29
	Total fixed assets (sum of lines 12-29)	14, 772, 022	C	0	0	30
	OTHER ASSETS	0			0	1
	Investments Deposits on Leases	0			0	
	Due from owners/officers	0		-	0	
	Other assets	99, 821	C	0	0	
00	Total other assets (sum of lines 31-34)	99, 821	C	0	0	35
	Total assets (sum of lines 11, 30, and 35)	21, 092, 973	C	0	0	36
	CURRENT_LIABILITIES	1 001 100				
	Accounts payable Salaries, wages, and fees payable	1, 321, 132 697, 082			0	
	Payroll taxes payable	429, 932			0	
	Notes and Loans payable (short term)	0		0	0	
	Deferred income	0	c	0	0	41
00	Accelerated payments	0				42
	Due to other funds	0	C	-	0	
	Other current liabilities	4, 369, 422	C		0	
	Total current liabilities (sum of lines 37 thru 44)	6, 817, 568	C	0	0	45
	Mortgage payable	0	C	0	0	46
	Notes payable	0		-	0	
	Unsecured Loans	0	c	0	0	
	Other long term liabilities	45, 241, 377	c	-	0	49
	Total long term liabilities (sum of lines 46 thru 49)	45, 241, 377	C	-	0	
	Total liabilities (sum of lines 45 and 50)	52, 058, 945	C	0	0	5
	CAPITAL ACCOUNTS General fund balance	-30, 965, 972				52
	Specific purpose fund	-30, 903, 972	0			53
	Donor created - endowment fund balance - restricted			0		54
	Donor created - endowment fund balance - unrestricted			0		55
	Governing body created - endowment fund balance			0		56
	Plant fund balance - invested in plant				0	
	Plant fund balance - reserve for plant improvement,				0	58
	replacement, and expansion Total fund balances (sum of lines 52 thru 58)	-30, 965, 972	l c	_	0	59
						1 33

Heal th	Financial Systems	RANCI SCAN HEALT	H RENSSELAER			In Lie	u of Form CMS	-25	52-10
	ENT OF CHANGES IN FUND BALANCES		Provider CC	CN: 15-1324	Peri From To		Worksheet G- Date/Time Pr 5/29/2024 8:	1 epa	ared:
		General	Fund	Speci al	Purpo	se Fund	Endowment Fun	d	
1.00	Fund balances at beginning of period	1.00	2.00 -31,141,086	3.00		4.00	5.00		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		175, 115			0			2.00
3.00 4.00	Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	0	-30, 965, 971		0	0		0	3.00 4.00
4.00 5.00	Additions (credit adjustments) (specify)	0			0			0	4.00 5.00
6.00		0			0			0	6.00
7.00 8.00		0			0			0	7.00 8.00
9.00		0			0			0	9.00
10.00	Total additions (sum of line 4-9)		0			0			10.00
11.00 12.00	Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)	o	-30, 965, 971		0	0			11.00 12.00
13.00	ROUNDING	2			0				13.00
14.00 15.00		0			0				14.00 15.00
16.00		0			0				16.00
17.00		0	2		0	0			17.00 18.00
18. 00 19. 00	Total deductions (sum of lines 12–17) Fund balance at end of period per balance		ے 30, 965, 973-			0			18.00 19.00
	sheet (line 11 minus line 18)				_				
		Endowment Fund	Pl ant	Fund					
	1	6.00	7.00	8.00					
1.00 2.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29)	0			0				1.00 2.00
3.00	Total (sum of line 1 and line 2)	0			0				3.00
4.00	Additions (credit adjustments) (specify)		0						4.00
5.00 6.00			0						5.00 6.00
7.00			0						7.00
8.00 9.00			0						8.00 9.00
10.00	Total additions (sum of line 4-9)	0	Ŭ		0				10.00
11.00 12.00	Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)	0	0		0				11. 00 12. 00
12.00	ROUNDING		0						12.00
14.00			0						14.00
15. 00 16. 00			0						15.00 16.00
			0					-	17.00
17.00									
18.00	Total deductions (sum of lines 12-17)	0			0				18.00
	Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0 0			0 0				18.00 19.00

STATEN	ENT OF PATIENT REVENUES AND OPERATING EXPENSES					
		Provider CC	CN: 15-1324	Period: From 01/01/2023 To 12/31/2023	Worksheet G-2 Parts I & II Date/Time Pre 5/29/2024 8:5	pared:
	Cost Center Description		Inpati ent	Outpati ent	Total	
			1.00	2.00	3.00	
	PART I – PATIENT REVENUES					
	General Inpatient Routine Services					
1.00	Hospi tal		1, 983, 28	37	1, 983, 287	1.00
2.00	SUBPROVIDER - IPF					2.00
3.00	SUBPROVIDER - IRF					3.00
4.00	SUBPROVIDER					4.00
5.00	Swing bed - SNF			0	0	
6.00	Swing bed - NF			0	0	
7.00	SKILLED NURSING FACILITY					7.00
8.00	NURSING FACILITY					8.00
9.00	OTHER LONG TERM CARE					9.00
10.00	Total general inpatient care services (sum of lines 1-9)		1, 983, 28	37	1, 983, 287	10.00
	Intensive Care Type Inpatient Hospital Services			-1	-	
11.00	INTENSIVE CARE UNIT			0	0	1
12.00	CORONARY CARE UNIT			0	0	
13.00	BURN I NTENSI VE CARE UNI T					13.00
14.00	SURGI CAL I NTENSI VE CARE UNI T					14.00
15.00	OTHER SPECIAL CARE (SPECIFY)					15.00
16.00	Total intensive care type inpatient hospital services (sum of	lines		0	0	16.00
47.00			4 000 0		4 000 007	17.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)		1, 983, 28		1, 983, 287	
18.00	Ancillary services		4, 066, 47		106, 110, 225	1
19.00	Outpatient services			0 175, 489	175, 489	
20.00	RURAL HEALTH CLINIC			0 293, 978	293, 978	
20.01	RURAL HEALTH CLINIC II			0 5, 883, 942	5, 883, 942	
21.00	FEDERALLY QUALIFIED HEALTH CENTER			0 0	0	
22.00	HOME HEALTH AGENCY			0	0	
23.00	AMBULANCE SERVICES			0 0	0	
24.00				0	0	24.00
25.00	AMBULATORY SURGICAL CENTER (D. P.)			0 0	0	
26.00				0 0	0	
27.00	OTHER (SPECIFY)	+- WI+	(040 7)	0 0	0	
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 G-3, line 1)	LO WKSL.	6, 049, 76	108, 397, 161	114, 446, 921	28.00
	PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)			37, 757, 990		29.00
30.00	ADD (SPECIFY)			0		30.00
31.00				0		31.00
32.00				0		32.00
33.00				0		33.00
34.00				0		34.00
35.00				0		35.00
36.00	Total additions (sum of lines 30-35)			0		36.00
37.00	DEDUCT (SPECIFY)			0		37.00
37.00				0		38.00
39.00				0		39.00
40.00				0		40.00
40.00				0		40.00
41.00	Total deductions (sum of lines 37–41)			0		41.00
42.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfor		37, 757, 990		42.00
-5.00	to Wkst. G-3, line 4)	., (1 4131 61		51,151,190		-5.00

Health Financial Systems FRANCISCAN HEALTH RENSSELAER In	ieu of Form CMS-2552-10
STATEMENT OF REVENUES AND EXPENSES Provider CCN: 15-1324 Period:	Worksheet G-3
From 01/01/20 To 12/31/20	
	5/29/2024 8:56 am
	1.00
1.00 Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	114, 446, 921 1. 00
2.00 Less contractual allowances and discounts on patients' accounts	76, 953, 893 2.00
3.00 Net patient revenues (line 1 minus line 2)	37, 493, 028 3. 00
4.00 Less total operating expenses (from Wkst. G-2, Part II, line 43)	37, 757, 990 4.00
5.00 Net income from service to patients (line 3 minus line 4)	-264, 962 5.00
OTHER I NCOME	
6.00 Contributions, donations, bequests, etc	0 6.00
7.00 Income from investments	0 7.00
8.00 Revenues from telephone and other miscellaneous communication services	0 8.00
9.00 Revenue from television and radio service	0 9.00
10.00 Purchase di scounts	0 10.00
11.00 Rebates and refunds of expenses	0 11.00
12.00 Parking lot receipts	0 12.00
13.00 Revenue from Laundry and Linen service	0 13.00
14.00 Revenue from meals sold to employees and guests	0 14.00
15.00 Revenue from rental of living quarters	0 15.00
16.00 Revenue from sale of medical and surgical supplies to other than 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	0 18.00
19.00 Tuition (fees, sale of textbooks, uniforms, etc.)	0 19.00
20.00 Revenue from gifts, flowers, coffee shops, and canteen	0 20.00
21.00 Rental of vending machines	0 21.00
22.00 Rental of hospital space	0 22.00
23.00 Governmental appropriations	0 23.00
24. 00 OTHER OPERATING REVENUE	440, 117 24.00
24. 50 COVI D-19 PHE Funding	0 24.50
25.00 Total other income (sum of lines 6-24)	440, 117 25. 00
26.00 Total (line 5 plus line 25)	175, 155 26. 00
27. OO NON OPERATING REVENUE	40 27.00
28.00 Total other expenses (sum of line 27 and subscripts)	40 28.00
29.00 Net income (or loss) for the period (line 26 minus line 28)	175, 115 29. 00

ANALYS	LC OF HOCDITAL DACED DUO (FOUG OOCTO						2552-10
	IS OF HOSPITAL-BASED RHC/FQHC COSTS		Provider CO	CN: 15-1324	Peri od:	Worksheet M-1	
			Component	CON. 15 2000	From 01/01/2023	Data /Tima Dra	norod.
			component (CCN: 15-3990	To 12/31/2023	Date/Time Pre 5/29/2024 8:50	
					RHC I	Cost	
		Compensation	Other Costs	Total (col.	1 Reclassi fi cati	Recl assi fi ed	
				+ col. 2)	ons	Trial Balance	
						(col. 3 + col.	
						4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
	Physi ci an	3, 148	0	3, 14	18 0	3, 148	1.00
2.00	Physi ci an Assi stant	0	0		0 0	0	2.00
3.00	Nurse Practitioner	113, 001	0	113, 00	01 0	113, 001	3.00
4.00	Visiting Nurse	0	0		0 0	0	4.00
5.00	Other Nurse	35, 520	0	35, 52	20 0	35, 520	5.00
6.00	Clinical Psychologist	0	0		0 0	0	6.00
7.00	Clinical Social Worker	0	0		0 0	0	7.00
7.10	Marriage and Family Therapist						7.10
7.11	Mental Health Counselor						7.11
8.00	Laboratory Techni ci an	0	0		0 0	0	8.00
9.00	Other Facility Health Care Staff Costs	31, 170	0	31, 17	0 0	31, 170	9.00
10.00	Subtotal (sum of lines 1 through 9)	182, 839	0	182, 83	39 0	182, 839	10.00
	Physician Services Under Agreement	0	0		0 0	0	11.00
12.00	Physician Supervision Under Agreement	0	0		0 0	0	12.00
13.00	Other Costs Under Agreement	0	0		0 0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		0 0	0	14.00
15.00	Medical Supplies	0	293	29	93 0	293	15.00
16.00	Transportation (Health Care Staff)	0	0		0 0	0	16.00
17.00	Depreciation-Medical Equipment	0	0		0 0	0	17.00
	Professional Liability Insurance	0	0		0 0	0	18.00
	Other Health Care Costs	o	0		0 0	0	19.00
	Allowable GME Costs	-					20.00
21.00	Subtotal (sum of lines 15 through 20)	o	293	29	93 0	293	21.00
	Total Cost of Health Care Services (sum of	182, 839	293		32 0	183, 132	
	lines 10, 14, and 21)	- ,					
1	COSTS OTHER THAN RHC/FQHC SERVICES						
	Pharmacy	0	0		0 0	0	23.00
24.00	Dental	0	0		0 0	0	24.00
25.00	Optometry	0	0		0 0	0	25.00
	Tel eheal th	0	0		0 0	0	25.01
	Chronic Care Management	0	0		0 0	0	25.02
	All other nonreimbursable costs	0	0		0 0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23	0	0		0 0	0	28.00
	through 27)	-	-		-	-	
ļ	FACILITY OVERHEAD						1
	Facility Costs	0	16, 859	16, 85	59 0	16, 859	29.00
	Administrative Costs	30, 609	5, 508			36, 117	
	Total Facility Overhead (sum of lines 29 and	30, 609	22, 367	52, 97		52, 976	
· · · · · · · · · · · · · · · · · · ·	30)						
1					1		
32.00	Total facility costs (sum of lines 22, 28	213, 448	22, 660	236, 10	0 8	236, 108	32.00

		RANCI SCAN HEAL				u of Form CMS-	
ANALYS	IS OF HOSPITAL-BASED RHC/FQHC COSTS		Provider C	CN: 15-1324	Period: From 01/01/2023	Worksheet M-1	1
			Component (CCN: 15-3990	To 12/31/2023	Date/Time Pre 5/29/2024 8:5	
			_		RHC I	Cost	
		Adjustments	Net Expenses				
			for Allocation				
			(col. 5 + col. 6)				
		6.00	7.00				
	FACILITY HEALTH CARE STAFF COSTS	0.00	7.00				
1.00	Physi ci an	0	3, 148				1.0
2.00	Physician Assistant	0	0				2.0
3.00	Nurse Practitioner	0	113, 001				3.0
4.00	Visiting Nurse	0	0				4.0
5.00	Other Nurse	0	35, 520				5.0
5.00	Clinical Psychologist	0	0				6.0
7.00	Clinical Social Worker	0	0				7.0
7.10 7.11	Marriage and Family Therapist Mental Health Counselor						7.1
7.11 3.00	Laboratory Techni ci an	0	0				8.0
9.00 9.00	Other Facility Health Care Staff Costs	0	31, 170				9.0
10.00	Subtotal (sum of lines 1 through 9)	0	182, 839				10.0
11.00	Physician Services Under Agreement	0	0				11.0
12.00	Physician Supervision Under Agreement	0	0				12.0
13.00	Other Costs Under Agreement	0	0				13.0
14.00	Subtotal (sum of lines 11 through 13)	0	0				14.0
15.00	Medical Supplies	0	293				15.0
16.00	Transportation (Health Care Staff)	0	0				16.0
17.00	Depreciation-Medical Equipment	0	0				17.0
18.00	Professional Liability Insurance	0	0				18.0
19.00 20.00	Other Health Care Costs Allowable GME Costs	0	0				19.0
20.00	Subtotal (sum of lines 15 through 20)	0	293				20.0
22.00	Total Cost of Health Care Services (sum of	0					22.0
22.00	lines 10, 14, and 21)	0	105, 152				22.0
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0				23.0
24.00	Dental	0					24.0
25.00	Optometry	0	0				25.0
25.01	Tel eheal th	0	0				25.0
25.02	Chronic Care Management	0	0				25.0
26.00	All other nonreimbursable costs	0	0				26.0
27.00 28.00	Nonallowable GME costs Total Nonreimbursable Costs (sum of lines 23	0	0				27.0
28.00	through 27)	0	0				28.0
	FACILITY OVERHEAD		1	1			
29.00	Facility Costs	0	16, 859				29.0
30.00	Administrative Costs	0					30.0
31.00	Total Facility Overhead (sum of lines 29 and	0	52, 976				31.0
	30)						
32.00	Total facility costs (sum of lines 22, 28	0	236, 108				32.0
	and 31)						

		RANCI SCAN HEAL	TH RENSSELAER			In Lie	u of Form CMS-2	2552-10
ANALYS	IS OF HOSPITAL-BASED RHC/FQHC COSTS		Provider C	CN: 15-1324		ri od:	Worksheet M-1	
			Component	CCN: 15-8502	To	om 01/01/2023 12/31/2023	Date/Time Prep 5/29/2024 8:50	
						RHC II	Cost	
		Compensation	Other Costs	Total (col.	1 R	ecl assi fi cati	Recl assi fi ed	
				+ col. 2)		ons	Trial Balance	
				· · ·			(col. 3 + col.	
							4)	
		1.00	2.00	3.00		4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS							
1.00	Physi ci an	3, 351	0	3, 35		0	3, 351	1.00
2.00	Physician Assistant	0	0		0	0	0	2.00
3.00	Nurse Practitioner	149, 982	0	149, 98	82	0	149, 982	3.00
4.00	Visiting Nurse	0	0		0	0	0	4.00
5.00	Other Nurse	49, 717	0	49, 7 ⁻		0	49, 717	5.00
6.00	Clinical Psychologist	0	0		0	0	0	6.00
7.00	Clinical Social Worker	0	0		0	0	0	7.00
7.10	Marriage and Family Therapist							7.10
7.11	Mental Health Counselor	0	0		0		0	7.11
8.00 9.00	Laboratory Technician Other Facility Health Care Staff Costs	40 444	0	40.44	0	0	0 40, 464	8.00 9.00
	5	40, 464	0	40, 40		0		
10. 00 11. 00	Subtotal (sum of lines 1 through 9) Physician Services Under Agreement	243, 514 0	0	243, 51	0	0	243, 514 0	10.00 11.00
12.00	Physician Supervision Under Agreement	0	0		0	0	0	12.00
12.00	Other Costs Under Agreement	0	0		0	0	0	12.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		0	0	0	14.00
14.00	Medical Supplies	0	0		0	0	0	15.00
16.00	Transportation (Health Care Staff)	0	0		0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0		0	0	0	17.00
18.00	Professional Liability Insurance	0	0		0	0	0	18.00
19.00	Other Health Care Costs	0	0		0	0	0	19.00
20.00	Allowable GME Costs	Ū	0		Ŭ	Ű		20.00
21.00	Subtotal (sum of lines 15 through 20)	0	0		0	0	0	21.00
22.00	Total Cost of Health Care Services (sum of	243, 514	0	243, 5 ⁻	14	0	243, 514	
	lines 10, 14, and 21)					-		
	COSTS OTHER THAN RHC/FQHC SERVICES			_				
23.00	Pharmacy	0	0		0	0	0	23.00
24.00	Dental	0	0		0	0	0	24.00
25.00	Optometry	0	0		0	0	0	25.00
25.01	Tel eheal th	0	0		0	0	0	25.01
25.02	Chronic Care Management	0	0		0	0	0	25.02
26.00	All other nonreimbursable costs	0	0		0	0	0	26.00
27.00	Nonallowable GME costs							27.00
28.00	Total Nonreimbursable Costs (sum of lines 23	0	0		0	0	0	28.00
	through 27)							
20.00	FACILITY OVERHEAD		~		0			20.00
29.00	Facility Costs	0	0		0	0	0	
30.00	Administrative Costs	33, 368	23, 443			-16, 215	40, 596	
31.00	Total Facility Overhead (sum of lines 29 and 30)	33, 368	23, 443	56, 8 ⁻	11	-16, 215	40, 596	31.00
32.00	Total facility costs (sum of lines 22, 28	276, 882	23, 443	300, 32	25	-16, 215	284, 110	32.00
JZ. UU	and 31)	270,082	23, 443	300, 32	20	-10,215	204, 110	32.00
		I		I	I	I	I	I

		RANCI SCAN HEAL				u of Form CMS-	
NALYS	IS OF HOSPITAL-BASED RHC/FQHC COSTS		Provider CO	CN: 15-1324	Period: From 01/01/2023	Worksheet M-1	1
			Component (CCN: 15-8502	To 12/31/2023	Date/Time Pre 5/29/2024 8:5	
					RHC II	Cost	_
		Adjustments	Net Expenses				
			for Allocation				
			(col. 5 + col. 6)				
		6.00	7.00				
	FACILITY HEALTH CARE STAFF COSTS	0.00	7.00				
. 00	Physi ci an	0	3, 351				1.0
2.00	Physician Assistant	0					2.0
8.00	Nurse Practitioner	0	149, 982				3.0
l. 00	Visiting Nurse	0	0				4.0
5.00	Other Nurse	0	49, 717				5.0
o. 00	Clinical Psychologist	0	0				6.0
. 00	Clinical Social Worker	0	0				7.0
7.10	Marriage and Family Therapist						7.1
7.11	Mental Health Counselor	0					7.1
3.00 9.00	Laboratory Technician Other Facility Health Care Staff Costs	0	0				8.0
0.00	Subtotal (sum of lines 1 through 9)	0	40, 464 243, 514				9.0
1.00	Physician Services Under Agreement	0	243, 514				11.0
2.00	Physician Supervision Under Agreement	0	0				12.0
3.00	Other Costs Under Agreement	0	0				13.0
4.00	Subtotal (sum of lines 11 through 13)	0	0				14.0
5.00	Medical Supplies	0	0				15.0
6.00	Transportation (Health Care Staff)	0	0				16.0
7.00	Depreciation-Medical Equipment	0	0				17.0
8.00	Professional Liability Insurance	0	0				18.0
9.00	Other Health Care Costs	0	0				19.0
20.00	Allowable GME Costs						20.0
21.00	Subtotal (sum of lines 15 through 20)	0	0				21.0
22.00	Total Cost of Health Care Services (sum of	0	243, 514				22.0
	Li nes 10, 14, and 21) COSTS OTHER THAN RHC/FQHC SERVICES						1
23.00	Pharmacy	0	0				23.0
24.00	Dental	0					24.0
5.00	Optometry	0	0				25.0
25.01	Tel eheal th	0	0				25.0
25.02	Chronic Care Management	0	0				25.0
26.00	All other nonreimbursable costs	0	0				26.0
27.00	Nonallowable GME costs						27.0
28.00	Total Nonreimbursable Costs (sum of lines 23	0	0				28.0
	through 27)						-
0.00	FACILITY OVERHEAD						1 20 0
29.00 30.00	Facility Costs Administrative Costs	0					29.0
30.00 31.00	Total Facility Overhead (sum of lines 29 and	0					30.0
1.00	30)	0	40, 590				31.0
32.00	Total facility costs (sum of lines 22, 28	0	284, 110				32.0
	and 31)	0					1

alth Financial Systems		FRANCI SCAN HEAL	TH RENSSELAER		In Lie	eu of Form CMS-2	2552-1
LOCATION OF OVERHEAD TO HOSPITA	AL-BASED RHC/FQHC	SERVI CES	Provider CC	CN: 15-1324	Peri od:	Worksheet M-2	
			Component (CCN: 15-3990	From 01/01/2023 To 12/31/2023		nared
			oomponente (50N. 10 0770		5/29/2024 8:5	
					RHC I	Cost	
		Number of FTE	Total Visits	Productivity			
		Personnel		Standard (1)			
		1.00	2.00	3.00	3)	4	
VISITS AND PRODUCTIVITY		1.00	2.00	3.00	4.00	5.00	
Posi ti ons							1
00 Physi ci an		0.00	0		1 0		1.0
00 Physician Assistant		0.00	0		1 0		2.0
00 Nurse Practitioner		0.85	769		1 1		3.0
00 Subtotal (sum of lines 1 t	hrough 3)	0.85	769		1	769	4.0
00 Visiting Nurse		0.00	0			0	5.0
00 Clinical Psychologist		0.00				0	6.0
00 Clinical Social Worker		0.00				0	7.0
01 Medical Nutrition Therapis		0.00				0	7.0
02 Diabetes Self Management T only)	0	0. 00	0			0	7.0
03 Marriage and Family Therap	ist						7.0
04 Mental Health Counselor							7.0
00 Total FTEs and Visits (sum	of lines 4	0.85	769			769	8. (
through 7)							
00 Physician Services Under A	greements		0			0	9. (
						1.00	
DETERMINATION OF ALLOWABLE	COST APPLI CABLE	TO HOSPI TAL-BASE	D RHC/FQHC SER	VICES			
0.00 Total costs of health care	services (from \	Vkst. M-1, col. 7	, line 22)			183, 132	10.0
.00 Total nonreimbursable cost	s (from Wkst. M-'	1, col. 7, line 2	8)			0	11. (
	Cost of all services (excluding overhead) (sum of lines 10 and 11)					183, 132	
							13.0
	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)						14.0
0 Parent provider overhead allocated to facility (see instructions)						301, 825 354, 801	
Total overhead (sum of lines 14 and 15)							
.00 Allowable GME overhead (se						0	
8.00 Enter the amount from line				- >		354, 801	
9.00 Overhead applicable to hos	pital-based RHC/I	-QHC services (li	ne 13 x line 1	8)		354, 801	19.

 20.00
 Total allowable cost of hospital -based RHC/FQHC services (sum of lines 10 and 19)
 537, 933
 20.00

leal th F	inancial Systems	FRANCI SCAN HEAL	TH RENSSELAER			eu of Form CMS-2	2552-1
ALLOCATI	ON OF OVERHEAD TO HOSPITAL-BASED RHC/FQ	HC SERVI CES	Provider C	CN: 15-1324	Peri od:	Worksheet M-2	
			Component	CCN: 15-8502	From 01/01/2023 To 12/31/2023		nared
			oomponent	0002		5/29/2024 8:5	
					RHC II	Cost	
		Number of FTE	Total Visits	Productivity			
		Personnel		Standard (1)			
		1.00	2.00	3.00	3)	4 5.00	
V	ISITS AND PRODUCTIVITY	1.00	2.00	3.00	4.00	5.00	
	osi ti ons						1
.00 P	Physi ci an	0.00	0		1 0		1.0
00 P	Physician Assistant	0.00	0		1 0		2.0
00 N	lurse Practitioner	1.09	1, 697		1 1		3.0
	Subtotal (sum of lines 1 through 3)	1.09	1, 697		1	1, 697	4.0
	'isiting Nurse	0.00				0	5.0
	linical Psychologist	0.00				0	6.0
	Clinical Social Worker	0.00				0	7.0
	ledical Nutrition Therapist (FQHC only)	0.00				0	7.0
	<pre>biabetes Self Management Training (FQHC only)</pre>	0.00	0			0	7.0
	larriage and Family Therapist						7.0
	lental Health Counselor						7.0
	otal FTEs and Visits (sum of lines 4	1.09	1, 697			1, 697	8. C
	hrough 7)						
00 P	Physician Services Under Agreements		0			0	9. (
						1.00	
DI	ETERMINATION OF ALLOWABLE COST APPLICABL	E TO HOSPI TAL-BASE	ED RHC/FQHC SER	VICES			
). 00 T	otal costs of health care services (from	n Wkst. M-1, col. 7	7, line 22)			243, 514	10.0
	otal nonreimbursable costs (from Wkst. N					0	
	Cost of all services (excluding overhead) (sum of lines 10 and 11)					243, 514 1, 000000	
							14. (
							15. (16. (
	llowable GME overhead (see instructions)					0	
	inter the amount from line 16	VE010 (11	10 11	0)		430, 867	
9.000	verhead applicable to hospital-based RHC	/FUHC SERVICES ([]	ne 13 x 11 ne 1	8)		430, 867	19.0

20.00Total allowable cost of hospital based RHC/FQHC services (sum of lines 10 and 19)674, 38120.00

al th Financial Systems FRANCISCAN HEALTH LCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC	RENSSELAER Provi der CCN: 15-1324	Peri od:	u of Form CMS-2 Worksheet M-3	
RVI CES	Component CCN: 15-3990	From 01/01/2023 To 12/31/2023	Date/Time Pre 5/29/2024 8:5	pare
	Title XVIII	RHC I	Cost	o um
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FOHC SERVICES			1.00	
00 Total Allowable Cost of hospital-based RHC/FQHC Services (fro	m Wkst. M-2, line 20)		537, 933	1 1.
00 Cost of injections/infusions and their administration (from W			10, 810	2.
00 Total allowable cost excluding injections/infusions (line 1 m	inus line 2)		527, 123	3.
00 Total Visits (from Wkst. M-2, column 5, line 8)			769	4.
00 Physicians visits under agreement (from Wkst. M-2, column 5,	line 9)		0	
00 Total adjusted visits (line 4 plus line 5)			769	
00 Adjusted cost per visit (line 3 divided by line 6)		Cal cul ati on	685.47	7.
			Rate Period 1	
		N/A	(01/01/2023	
			through	
		1.00	<u>12/31/2023)</u> 2.00	<u> </u>
00 Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20	.6 or your contractor)	0.00	303.29	8.
00 Rate for Program covered visits (see instructions)		0.00	303.29	9.
CALCULATION OF SETTLEMENT				
0.00 Program covered visits excluding mental health services (from		0	254	
. 00 Program cost excluding costs for mental health services (line	-	0	77,036	
.00 Program covered visits for mental health services (from contr .00 Program covered cost from mental health services (line 9 x li		0	0	
.00 Limit adjustment for mental health services (see instructions	· · · · · · · · · · · · · · · · · · ·	0	0	14
6.00 Graduate Medical Education Pass Through Cost (see instruction		Ŭ	0	15
0.00 Total Program cost (sum of lines 11, 14, and 15, columns 1, 2	2	0	77, 036	
0.01 Total program charges (see instructions)(from contractor's re	-		33, 202	
0.02 Total program preventive charges (see instructions)(from prov	ider's records)		10, 316	16
0.03 Total program preventive costs ((line 16.02/line 16.01) times	-		23, 935	
0.04 Total Program non-preventive costs ((line 16 minus lines 16.0 (Titles V and XIX see instructions.)	3 and 18) times .80)		37, 973	16
0.05 Total program cost (see instructions)		0	61, 908	16
.00 Primary payer amounts			0	
0.00 Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		5, 635	18
records)				
 00 Beneficiary coinsurance for RHC/FQHC services (see instructio records) 	ns) (from contractor		3, 450	19
0. 00 Net program cost excluding injections/infusions (see instruct	i ons)		61, 908	20
.00 Program cost of vaccines and their administration (from Wkst.	-		4, 440	
.50 Total program IOP OPPS payments (see instructions)				21
.55 Total program IOP Costs (see instructions)				21
. 60 Program IOP deductible and coinsurance (see instructions)				21
.00 Total reimbursable Program cost (sum of lines 20, 21, 21.50,	minus line 21.60)		66, 348	
Allowable bad debts (see instructions) Allowable teimbursable bad debts (see instructions)			0	
. 00 Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		0	
. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
. 50 Pioneer ACO demonstration payment adjustment (see instruction	s)		0	
. 99 Demonstration payment adjustment amount before sequestration			0	25
0.00 Net reimbursable amount (see instructions)			66, 348	
0.01 Sequestration adjustment (see instructions)			1, 327	
0.02 Demonstration payment adjustment amount after sequestration			0	
2.00 Interim payments			59,009	
 D0 Tentative settlement (for contractor use only) D0 Balance due component/program (line 26 minus lines 26.01, 26. 	$02 \ 27 \ and \ 29$		0 6, 012	
0.00 Protested amounts (nonallowable cost report items) in accorda	· · · · ·		6, U12 0	
	nee with one rub. ru-fr	1	0	1 30

LCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC	RENSSELAER Provider CCN: 15-1324	Peri od:	u of Form CMS-2 Worksheet M-3	
RVI CES	Component CCN: 15-8502	From 01/01/2023 To 12/31/2023	Date/Time Pre 5/29/2024 8:5	pare
	Title XVIII	RHC II	Cost	o um
			1.00	
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			1.00	
00 Total Allowable Cost of hospital-based RHC/FQHC Services (from	m Wkst. M-2, line 20)		674, 381	1 1.
00 Cost of injections/infusions and their administration (from W			8, 233	2.
00 Total allowable cost excluding injections/infusions (line 1 m	inus line 2)		666, 148	3.
00 Total Visits (from Wkst. M-2, column 5, line 8)			1, 697	
00 Physicians visits under agreement (from Wkst. M-2, column 5, 1	line 9)		0	
00 Total adjusted visits (line 4 plus line 5)			1,697	6.
00 Adjusted cost per visit (line 3 divided by line 6)		Cal cul ati on	392.54	7.
			Rate Period 1	
		N/A	(01/01/2023 through	
			12/31/2023)	
		1.00	2.00	
00 Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20	.6 or your contractor)	0.00	229.47	
00 Rate for Program covered visits (see instructions)		0.00	229.47	9
CALCULATION OF SETTLEMENT			F04	1 10
.00 Program covered visits excluding mental health services (from .00 Program cost excluding costs for mental health services (line	· · · · · · · · · · · · · · · · · · ·	0	504 115, 653	
.00 Program covered visits for mental health services (from contra		0	115, 055	12
.00 Program covered cost from mental health services (line 9 x lin		0	0	
.00 Limit adjustment for mental health services (see instructions	2	0	0	14
.00 Graduate Medical Education Pass Through Cost (see instruction	s)			15
.00 Total Program cost (sum of lines 11, 14, and 15, columns 1, 2	-	0	115, 653	
01 Total program charges (see instructions)(from contractor's re			64, 734	
. 02 Total program preventive charges (see instructions) (from prov			8, 784	
. 03 Total program preventive costs ((line 16.02/line 16.01) times . 04 Total Program non-preventive costs ((line 16 minus lines 16.0.	-		15, 693 71, 889	
(Titles V and XIX see instructions.)	S and Toy trines . 60)		71,007	
. 05 Total program cost (see instructions)		0	87, 582	16
.00 Primary payer amounts			0	17
.00 Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		10, 099	18
records)			0 470	10
 .00 Beneficiary coinsurance for RHC/FQHC services (see instruction records) 	ns) (from contractor		9, 170	19
00 Net program cost excluding injections/infusions (see instruct	ions)		87, 582	20
.00 Program cost of vaccines and their administration (from Wkst.			1, 721	
.50 Total program IOP OPPS payments (see instructions)				21
.55 Total program IOP Costs (see instructions)				21
. 60 Program IOP deductible and coinsurance (see instructions)				21
.00 Total reimbursable Program cost (sum of lines 20, 21, 21.50, 1	minus line 21.60)		89, 303	
.00 Allowable bad debts (see instructions) .01 Adjusted reimbursable bad debts (see instructions)			0	
.00 Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		0	
00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
.50 Pioneer ACO demonstration payment adjustment (see instructions	s)		0	25
. 99 Demonstration payment adjustment amount before sequestration			0	25
.00 Net reimbursable amount (see instructions)			89, 303	
01 Sequestration adjustment (see instructions)			1, 786	
. 02 Demonstration payment adjustment amount after sequestration . 00 Interim payments			0 84, 870	26 27
.00 Interim payments .00 Tentative settlement (for contractor use only)			84,870	
. 00 Balance due component/program (line 26 minus lines 26.01, 26.0	02, 27, and 28)		2,647	
00 Protested amounts (nonallowable cost report items) in accorda			2, 047	
				1

Component CON: 15-3990 From 01/01/2023 To Date:Tim 5/29/202 Title XVIII Rtic L Covid-19 No Health care staff cost (from Wkst. M-1, col. 7, line 10) Neuroid (Stress) Neuroid (Stres) Neuroid (Stress) Ne		u of Form CMS-2 Worksheet M-4					eri od:	D	CN: 15-1324	H RENSSELAER Provider CO	HOSPITAL-BASED RHC/FQHC VACCINE COST	
Component CCN: 15-3990 To 12/31/2023 Date/Time It Le XVIII RHC I Component CCN: 15-3990 To 12/31/2023 Date/Time It Le XVIII RHC I RHC I Component CCN: 15-3990 RC I RC I CO It Le XVIII RHC I RHC I RC I RC I RC I ANT IB0 It le XVIII RHC I INFLEMENZA CON D1-19 VACCI NES VACCI NES VACCI NES ANT IB0 1.00 1.00 2.00 2.01 2.02 2.02 2.02 2.02 2.02 2.01 2.02 2.01 2.02 0 0.00000 0.00000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000130 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000130 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0	et M-4	WULKSHEEL W-4	UIRSHEEL W-4						5N. 15-1524	FIOVIDELCO	HOSFITAL-DASED RIGHTONE VACCINE COST	
PNEUMCCOCCAL VACCINESINFLUENZA VACCINESCOVID-19 VACCINESMODCLO ANTIBO PRODUC1.00Heal th care staff cost (from Wkst. M-1, col. 7, line 10)182,839183,832183,132183,132183,132183,132183,132183,132183,132183,132183,132183,132183,132183,132183,132183,132183,132183,132183,132183,13218		Date/Time Prep 5/29/2024 8:56		Date/Time Prep	Date/Time Pre	Date/Time P	12/31/2023			1		
VACCI NES VACCI NES VACCI NES VACCI NES VACCI NES PRODUC PRODUC 1.00 1.00 2.00 2.01 2.02 2.01 2.02 2.01 2.02 2.01 2.02 2.01 2.02 2.01 2.02 2.01 2.02 2.01 2.02 2.01 2.02 2.01 2.02 2.01 2.02 2.01 2.02 2.01 2.02 2.01 2.00 2.01 2.02 2.01 2.00 2.01 2.02 2.01 2.02 2.01 2.00 2.01 2.00 2.01 2.00 2.01 2.00 2.01 2.00 2.01 2.00 2.01 2.01 2.00 2.01 2.01 2.01 2.00 2.01 2.01 2.01 2.00 0.00 0.000000 0.00 <td>Cost</td> <td></td>	Cost											
Image: Note of the staff cost (from Wkst. M-1, col. 7, line 10) 1.00 2.00 2.01 2.00 1.00 Ratio of injection/infusion staff time to total heal th care staff time 0.000130 0.000130 0.000000 0.0 3.00 Injection/infusion sand related medical supplies costs (from your records) 5.84 3,048 0 6.00 Total corect cost of the hospital-based RHC/FOHC (from 183,132 183,00 0,00000<		MONOCLONAL										
1.00Heal th care staff cost (from Wkst. M-1, col. 7, line 10) Ratio of injection/infusion staff time to total heal th care staff time 2)182,839<		ANTI BODY PRODUCTS					VACCINES	S	VACCI NES	VACCI NES		
2.00Ratio of injection/infusion staff time to total health care staff time0.0001300.0001300.0000000.03.00Injection/infusion health care staff cost (line 1 x line 2)242404.00Injections/infusions and related medical supplies costs (from your records)5843.04805.00Direct cost of injections/infusions (line 3 plus line 4) 	2	2.02	2.02	2.02	2.02	2.02	2.01		2.00	1.00		
a. 00 Injection/infusion health care staff cost (line 1 x line 2) 24 24 0 b. 00 Injections/infusions and related medical supplies costs (from your records) 584 3,048 0 b. 00 Direct cost of injections/infusions (line 3 plus line 4) 608 3,072 0 b. 00 Total direct cost of the hospital-based RHC/FOHC (from Worksheet M-1, col. 7, line 22) 183,132 183,132 183,132 c. 00 Total overhead (from Wkst. M-2, line 19) 354,801 354,801 354,801 354,801 b. 00 Overhead cost - injection/infusion (line 7 x line 8) 1,178 5,952 0 c. 00 Total injection/infusion costs and their administration cost (sum of lines 5 and 9) 1,178 5,952 0 0. 00 Vorehead cost - injections/infusions (from your records) 2 17 0 2.00 Cost per injection/infusion administered to Program beneficiaries 2 5 0 3.01 Number of injections/infusions and their administered to MA enrollees 0 0 0 4.00 Program cost of injections/infusions and their administered to MA enrollees 0 0 0 4.00 Program cost of	82, 839	182, 839	182, 839	182, 839	182, 839	182, 8	182, 839	, 839	182, 8	182, 839		. 00
2)* 1	000000	0. 000000	0.000000	0.000000	0.000000	0.0000	0. 000000	0130	0.0001	0. 000130		2.00
1.00 Injections/infusions and related medical supplies costs (from your records) 584 3,048 0 0.00 Direct cost of injections/infusions (line 3 plus line 4) 608 3,072 0 5.00 Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22) 183,132 <	0	0	0	0	0		0	24	,	24	n/infusion health care staff cost (line 1 x line	. 00
00 Direct cost of injections/infusions (line 3 plus line 4) Total direct cost of the hospital-based RHC/FOHC (from Worksheet M-1, col. 7, line 22) 0 0.00 Total overhead (from Wkst. M-2, line 19) 354,801 354,801 354,801 0.00 Total overhead (from Wkst. M-2, line 19) 354,801 354,801 354,801 0.00 Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6) 0.003320 0.016775 0.000000 0.00 Overhead cost - injection/infusion (line 7 x line 8) 1,178 5,952 0 0.00 Total number of injections/infusions (from your records) 2 17 0 0.00 Cost per injection/infusion administered to Program beneficiaries 2 0 0 3.01 Number of COVID-19 vaccine injections/infusions administered to MA enrollees 0 0 0 4.00 Program cost of injections/infusions and their and 13.01, as applicable) 1 1,786 2,654 0 5.00 Total cost of injections/infusions and their administration costs (sum of columns 1, 1.00 2.00	0	0	0	0	0		0	, 048	3, 0	584		. 00
0.00 Total direct cost of the hospital-based RHC/FOHC (from Worksheet M-1, col. 7, line 22) 183,132 163,135 10,10 10,10 <td>o</td> <td>o</td> <td>o</td> <td>ol</td> <td>с</td> <td></td> <td>0</td> <td>. 072</td> <td>3.0</td> <td>608</td> <td></td> <td>. 00</td>	o	o	o	ol	с		0	. 072	3.0	608		. 00
2.00 Total overhead (from Wkst. M-2, line 19) 354,801 0 <td< td=""><td>33, 132</td><td>183, 132</td><td>183, 132</td><td>183, 132</td><td>183, 132</td><td>183, 13</td><td>183, 132</td><td></td><td></td><td>183, 132</td><td>rect cost of the hospital-based RHC/FQHC (from</td><td>. 00</td></td<>	33, 132	183, 132	183, 132	183, 132	183, 132	183, 13	183, 132			183, 132	rect cost of the hospital-based RHC/FQHC (from	. 00
cost (line 5 divided by line 6) Overhead cost - injection/infusion (line 7 x line 8) Otal injection/infusion costs and their administration costs (sum of lines 5 and 9)1,178 5,952 00,024 01.00Total number of injections/infusions (from your records) 2 00217 02.00Cost per injection/infusion (line 10/line 11) 893.00893.00530.82 0.003.00Number of injection/infusion administered to Program beneficiaries250 0 03.01Number of COVID-19 vaccine injections/infusions administered to MA enrollees administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)1,786 2,6542,654 00COST O INJECTIO INJECTIO INJECTIO 05.00Total cost of injections/infusions and their administration costs (sum of columns 1,1.002.00	54, 801	354, 801	354, 801	354, 801	354, 801	354, 80	354, 801	, 801	354, 8	354, 801		. 00
0.00 Total injection/infusion costs and their administration costs (sum of lines 5 and 9) 1,786 9,024 0 1.00 Total number of injections/infusions (from your records) 2 177 0 2.00 Cost per injection/infusion (line 10/line 11) 893.00 530.82 0.00 3.00 Number of injections/infusion administered to Program beneficiaries 2 5 0 3.01 Number of COVID-19 vaccine injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable) 0 0 4.00 Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable) 0 0 0 5.00 Total cost of injections/infusions and their administration costs (sum of columns 1, 1.00 2.00	000000	0. 000000	0.000000	0.000000	0. 000000	0.0000	0. 000000	6775	0. 0167	0. 003320		8. 00
costs (sum of lines 5 and 9) 1.00 Total number of injections/infusions (from your records) 2 1.7 0 2.00 Cost per injection/infusion (line 10/line 11) 893.00 530.82 0.00 3.00 Number of injection/infusion administered to Program beneficiaries 2 5 0 3.01 Number of COVID-19 vaccine injections/infusions administered to MA enrollees 0 0 0 4.00 Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable) 1,786 2,654 0 COST Of INJECTION 5.00 5.00 5.00 Total cost of injections/infusions and their administration costs (sum of columns 1,	0	0	0	0	0		0	, 952	5,9	1, 178	cost - injection/infusion (line 7 x line 8)	. 00
2.00 Cost per injection/infusion (line 10/line 11) 893.00 530.82 0.00 3.00 Number of injection/infusion administered to Program beneficiaries 2 5 0 3.01 Number of COVID-19 vaccine injections/infusions administered to Program cost of injections/infusions and their administered to MA enrollees 0 0 4.00 Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable) 1,786 2,654 0 COST C INJECTIO 5.00 Total cost of injections/infusions and their administration costs (sum of columns 1,	0	0	0	0	0		0	, 024	9,0	1, 786		0. 00
3.00 Number of injection/infusion administered to Program beneficiaries 2 5 0 3.01 Number of COVID-19 vaccine injections/infusions administered to MA enrol lees 0 0 0 3.00 Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable) 1,786 2,654 0 5.00 Total cost of injections/infusions and their administration costs (sum of columns 1, 1.00 2.00	0	0	0	-			°.	17		2	<pre>mber of injections/infusions (from your records)</pre>	1.00
beneficiaries 3.01 Number of COVID-19 vaccine injections/infusions administered to MA enrollees 4.00 Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable) COST O INJECTIO INJECTIO 1.00 2.00 5.00 Total cost of injections/infusions and their administration costs (sum of columns 1,	0.00					0.0	0.00	0. 82	530.	893.00		
administered to MA enrollees Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable) 1,786 2,654 0 Image: Strain Strate Strate Strain Strate Strain Strate Strain Strate	0	0	0	0	0		0	5		2		3.00
administration costs (line 12 times the sum of lines 13 and 13.01, as applicable) COST O INJECTIO INFUSIONS ADMINISTR 1.00 2.00 5.00 Total cost of injections/infusions and their administration costs (sum of columns 1,	0	0	0	0	0		0					3. 01
5.00 Total cost of injections/infusions and their administration costs (sum of columns 1, 1.00 2.00	0	0	0	0	0		0	, 654	2,6	1, 786	ration costs (line 12 times the sum of lines 13	4.00
INFUSIONS ADMINISTR 1.00 2.00 5.00 Total cost of injections/infusions and their administration costs (sum of columns 1, 1		COST OF										
ADMI NI STR. 1.00 2.00 5.00 Total cost of injections/infusions and their administration costs (sum of columns 1, 1		INJECTIONS /										
1.00 2.00 5.00 Total cost of injections/infusions and their administration costs (sum of columns 1, 1				INFUSIONS AND								
5.00 Total cost of injections/infusions and their administration costs (sum of columns 1, 1				ADMI NI STRATI ON								
							1.00					
			10, 810					,		-3, line 2)	and 2.02, line 10) (transfer this amount to Wkst	5.00
6.00 Total Program cost of injections/infusions and their administration costs (sum of	4,440	4, 440	4, 440	4, 440	4, 440	4,4			; (sum of	tration costs	ogram cost of injections/infusions and their admi	6.00

COMPUT	Financial Systems FRANCI SCAN HEAL ATI ON OF HOSPI TAL-BASED RHC/FQHC VACCI NE COST	Provider CC	CN: 15-1324	Period:	u of Form CMS-2 Worksheet M-4	
		Component (CCN: 15-8502	From 01/01/2023 To 12/31/2023	Date/Time Prep 5/29/2024 8:50	
		Title	XVIII	RHC II	Cost	_
		PNEUMOCOCCAL	I NFLUENZA	COVI D-19	MONOCLONAL	
		VACCI NES	VACCI NES	VACCINES	ANTI BODY PRODUCTS	
		1.00	2.00	2. 01	2.02	
. 00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	243, 514	243, 5	14 243, 514	243, 514	1.0
. 00	Ratio of injection/infusion staff time to total health care staff time	0. 000140	0.0001	40 0. 000000	0. 000000	2.0
. 00	Injection/infusion health care staff cost (line 1 x line 2)	34	:	34 0	0	3. C
. 00	Injections/infusions and related medical supplies costs (from your records)	533	2, 3	72 0	0	4. C
. 00	Direct cost of injections/infusions (line 3 plus line 4)	567	2, 40	0 0	0	5.0
. 00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	243, 514	243, 5	14 243, 514	243, 514	6.0
. 00	Total overhead (from Wkst. M-2, line 19)	430, 867	430, 8	430, 867	430, 867	7.0
. 00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0. 002328	0.0098	0. 000000	0. 000000	8.0
. 00	Overhead cost - injection/infusion (line 7 x line 8)	1, 003	4, 2	57 0	0	9.0
0. 00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	1, 570	6, 6	63 0	0	10. (
1.00	Total number of injections/infusions (from your records)	8	!	54 0	0	11.0
2.00	Cost per injection/infusion (line 10/line 11)	196.25	123. 3	39 0.00	0.00	12.0
3. 00	Number of injection/infusion administered to Program beneficiaries	5		6 0		13.0
3. 01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13. (
4.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	981	74	40 0	0	14. C
					COST OF	
					INJECTIONS /	
					ADMI NI STRATI ON	
				1.00	2.00	
5.00	Total cost of injections/infusions and their administration		columns 1,	1.00	8, 233	15. (
6.00	2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. Total Program cost of injections/infusions and their admini		(1, 721	14

ANALYSI	Financial Systems FRANCISCAN HEALT S OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR S RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 15-1324	Peri od:	u of Form CMS-2 Worksheet M-5	
			From 01/01/2023 To 12/31/2023		
			RHC I	Cost	
				T B	
			mm/dd/yyyy	Amount	
			1,00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC			59,009	1.00
	Interim payments payable on individual bills, either submitt	ted or to be submitted to		0	2.00
	the contractor for services rendered in the cost reporting p				2.00
	"NONE" or enter a zero				
	List separately each retroactive lump sum adjustment amount	based on subsequent			3.00
	revision of the interim rate for the cost reporting period.				
	payment. If none, write "NONE" or enter a zero. (1)				
F	Program to Provider				
3.01	- V			0	3.01
3.02				0	3. 02
3.03				0	3.03
3.04				0	3.04
3.05				0	3.05
	Provider to Program				
3.50				0	3.50
3.51				0	3.51
3.52				0	3.52
3.53				0	3.53
3.54				0	3.54
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.9	98)		0	3.99
	Total interim payments (sum of lines 1, 2, and 3.99) (transf			59,009	4.00
	27)			0,,00,	1.00
	TO BE COMPLETED BY CONTRACTOR				
	List separately each tentative settlement payment after desk	<pre>< review. Also show date of</pre>	F		5.00
	each payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider				
5.01	3			0	5.01
5.02				0	5.02
5.03				0	5.03
	Provider to Program				
5.50	3			0	5.50
5.51				0	5.51
5.52				0	5.52
	Subtotal (sum of lines 5.01–5.49 minus sum of lines 5.50–5.9	7 8)		0	5.99
	Determined net settlement amount (balance due) based on the				6.00
	SETTLEMENT TO PROVIDER			6, 012	6.01
	SETTLEMENT TO PROGRAM			0	6.02
	Total Medicare program liability (see instructions)			65, 021	7.00
			Contractor	NPR Date	
			Number	(Mo/Day/Yr)	
		0	1.00	2.00	

ANALYSIS OF PAVHENTS TO HOSPITAL-BASED RHC/FOHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES Provider CCN: 15-1324 Component CCN: 15-8502 Period :: From 01/01/2023 To 12/31/2023 Worksheet N Date/Time F 1.00 Total interim payments paid to hospital-based RHC/FOHC RHC II Cosponent CCN: 15-8502 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 84,8 0.01 Is 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) Provider Provider to Program	S-2552-1
SERVICES RENDERED TO PROGRAM BENEFICIARIES Component CCN: 15-802 From 01/01/2023 To 12/31/2024 Date/Time F 5/29/2024 Imm/dd/yyyy Amount 1.00 Total interim payments paid to hospital-based RHC/FOHC RHC II Cost 2.00 Interim payments payable on individual bills, either submitted or to be submitted to trevision of the interim rate for the cost reporting period. If none, write "NONE" or enter a zero. 84,8 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 9 Provider to Program 5 3.04 3.05 3.04 3.04 3.04 3.04 3.04 3.04 3.04 3.05 3.04 3.05 3.04 3.05 3.04 3.05	
RtC II Cost 1.00 Total interim payments paid to hospital-based RHC/FOHC mm/dd/yyyy Amount 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 84,8 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 9.00 Program to Provider 9 Program to Provider 84,8 1.02 3.03 9 Subtotal (sum of lines 3.01-3,49 minus sum of lines 3.50-3.98) 84,8 3.01 Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line zro. 84,8 2.00 Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line zro. 84,8 3.01 Exception the notative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) 9 70 DE COMPLETED BY CONTRACTOR 1 84,8 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) 9	repared:
Part B 1.00 Total interim payments paid to hospital-based RHC/FOHC 1.00 2.00 1.00 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 1.00 84,8 3.00 List separately each retroactive lump sum adjustment amount based on subsequent eysis on of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 3.01 3.01 3.03 3.04 3.05 Provider to Program 1.00 84,8 3.50 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) 84,8 4.00 Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27) 84,8 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) Program to Provider 1.00 84,8 1.00 Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27) 84,8 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) Program to Provider Program to Provider	
Imm/dd/yyyy Amount 1.00 Total interim payments paid to hospital-based RHC/FOHC 1.00 2.00 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 84,8 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 3.01	
1.00 Total interim payments paid to hospital-based RHC/FOHC 1.00 2.00 1.00 Total 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 84,8 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 3.01 3.02 3.02 9 Program to Provider 9 9 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) 1.00 DE comPLETED BY CONTRACTOR 5.00 List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) 9 Foundation of lines 1.2. and 3.99 9 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) 10 BE comPLETED BY CONTRACTOR <t< td=""><td>_</td></t<>	_
1.00 Total interim payments paid to hospital-based RHC/FOHC 84,8 2.00 Interim payments payable on individual bills, either submitted to the contractor for services rendered in the cost reporting period. If none, write 84,8 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) 84,8 Program to Provider 9 3.01 3.02 3.02 3.03 3.04 3.04 3.05 9 Provider to Program 9 7.0 Total (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) 8.00 10 tai therim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27) TO BE COMPLETED BY CONTRACTOR 9 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) Program to Provider 9 7.0 10 BE COMPLETED BY CONTRACTOR 5.00 11 ts separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 9 5.50 9 <	
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 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 Proyider to Program 3.01 3.03 3.04 3.05 3.04 3.05 3.04 3.05 3.06 3.07 3.08 3.09 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line zn) 27) TO BE COMPLETED BY CONTRACTOR 5.00 List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 5.01 5.02 5.03 5.04 </td <td>70 1.00</td>	70 1.00
the contractor for services rendered in the cost reporting period. If none, write 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 Provider to Program 3.01 Provider to Program 5.01 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) 7.02 Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27) 70 BE COMPLETED BY CONTRACTOR 5.01 Erovider to Program 5.01 Provider to Program	0 2.00
"NONE" or enter a zero 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 3.01 3.02 3.03 3.04 3.05 Provider to Program 3.50 3.51 3.52 3.53 3.54 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27) To BE COMPLETED BY CONTRACTOR 5.00 List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 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) Program to Provider 5.01 5.02 5.03 Provider to Program	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 3.01 3.02 3.03 3.04 3.05 Provider to Program 7.01 3.02 3.03 3.04 3.05 Provider to Program 7.01 7.02 7.03 7.04 7.05 7.05 7.06 7.07 7.07 7.08 7.09 8.00 7.01 7.02 7.03 7.03 7.04 7.05 7.05 7.06 7.07 7.07 7.08 7.09 7.09 7.00 7.00 7.01 7.02 7.03 7.03	
revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 3.01 3.02 3.03 3.04 3.05 Provider to Program 7.50 9 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) 7.51 0.52 3.53 3.54 9 Subtotal (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27) TO BE COMPLETED BY CONTRACTOR 5.00 Provider to Provider 5.01 5.02 Provider to Program	3.00
payment. If none, write "NONE" or enter a zero. (1) Program to Provider 3.01 3.02 3.03 3.04 3.05 Provider to Program Provider to Program 70 70 70 70 80 70 70 70 70 70 70 70 70 70 70 70 70 70 70 70 70 70 71 70 70 70 70 70 71 70 70 70 70 71 72 73 74 75 70 70 70 70 7	0.0
Program to Provider 3. 01 3. 02 3. 03 3. 04 3. 05 Provider to Program 3. 50 9 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) 4.00 Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27) TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 5.01 5.03 Provider to Program	
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5. 50 5. 51	0 5.0
5. 50 5. 51	
5. 51	0 5.50
	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
6.00 Determined net settlement amount (balance due) based on the cost report. (1)	6.00
6.01 SETTLEMENT TO PROVIDER 2,6	
6.02 SETTLEMENT TO PROGRAM	0 6.0
7.00 Total Medicare program liability (see instructions) 87,5	
Contractor NPR Date	
Number (Mo/Day/Yr)	
0 1.00 2.00	
8.00 Name of Contractor	8.00