| Health Financial Systems | FRANCISCAN HEALTH M | | | u of Form CMS-2552-10 |
|--------------------------------------------------------------------------------------------------|----------------------------------------------------|-------------------------------------------------|----------------------------|----------------------------|
| This report is required by law (42 USC 1395g; | | | | |
| payments made since the beginning of the cost | reporting period being (| deemed overpayments (4 | 12 USC 1395g). | OMB NO. 0938-0050 |
| | | | | EXPIRES 09-30-2025 |
| HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COS | T REPORT CERTIFICATION | Provider CCN: 15-0057 | Period: From 01/01/2022 | Worksheet S Parts I-III |
| AND SETTLEMENT SUMMARY | | | To 12/31/2022 | Date/Time Prepared: |
| | | | 10 12/01/2022 | 5/29/2023 3:28 pm |
| PART I - COST REPORT STATUS | | | | |
| Provider 1. [X] Electronically prepared | | | Date: 5/29/202 | 23 Time: 3:28 pm |
| use only 2. [] Manually prepared cost | | | | |
| 3.[0]If this is an amended r 4.[F]Medicare Utilization. E | eport enter the number o nter "F" for full, "L" | of times the provider for low, or "N" for ne | resubmitted this co o. | ost report |
| | Date Received: | | NPR Date: | |
| use only (1) As Submitted 7. (2) Settled without Audit 8. | Contractor No. | 11. this Browider CCN 12 | Contractor's Vendo | or Code: 4 |
| (2) Settled without Audit 6. (3) Settled with Audit 9. | [N] Final Report for t | this Provider CCN | | es reopened = 0-9. |
| (4) Reopened | | | | |
| (5) Amended | | | | |
| | | | | |
| PART II - CERTIFICATION BY A CHIEF FINANCIAL | | | | |
| MISREPRESENTATION OR FALSIFICATION OF ANY INFO | | | | |
| ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMED PROVIDED OR PROCURED THROUGH THE PAYMENT DIREC | | | | |
| ADMINISTRATIVE ACTION. FINES AND/OR IMPRISONM | | KICKBACK OR WERE UTHER | WISE ILLEGAL, CRIW | IINAL, CIVIL AND |
| · · · · · · · · · · · · · · · · · · · | | | | |
| CERTIFICATION BY CHIEF FINANCIAL OFFI | CER OR ADMINISTRATOR OF | PROVI DER(S) | | |
| I HEREBY CERTIFY that I have read the | above certification sta | tement and that I have | e examined the acco | ompanyi ng |
| electronically filed or manually subm | | | | |
| Statement of Revenue and Expenses pre | | | | |
| period beginning 01/01/2022 and endin | | | | |
| statement are true, correct, complete applicable instructions, except as no | | | | |
| regarding the provision of health car | | | | |
| provided in compliance with such laws | | | in this cost report | were |
| | and i ogai att ono. | | | |

| | SIGNATURE OF CHIEF FINA | NCIAL OFFICER OR ADMINISTRATOR | CHECKBOX | ELECTRONI C | |
|---|-------------------------|--------------------------------|----------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---|
| | | 1 | 2 | SI GNATURE STATEMENT | |
| 1 | | | | I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature. | 1 |
| 2 | Signatory Printed Name | | | | 2 |
| 3 | Signatory Title | CFO | | | 3 |
| 4 | Date | | | | 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 | 823, 890 | -26, 472 | 0 | 0 | 1.00 |
| 2.00 | SUBPROVIDER - IPF | 0 | 0 | 0 | | 0 | 2.00 |
| 3.00 | SUBPROVIDER - IRF | 0 | 0 | 0 | | 0 | 3.00 |
| 5.00 | SWING BED - SNF | 0 | 0 | 0 | | 0 | 5.00 |
| 6.00 | SWING BED - NF | 0 | | | | 0 | 6.00 |
| 200.00 | TOTAL | 0 | 823, 890 | -26, 472 | 0 | 0 | 200.00 |

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

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.

|)SPI - | AL AND HOSPITAL HEALTH CARE COMPLEX I | DENTIFICATION DATA | Provi d | er CCN | | Period: | | Workshe | et S-2 | 2552- |
|----------|---------------------------------------------------------------------------------|----------------------------------------|-----------------|---------------|--------|--------------------------|--------|-------------------|---------|--------------|
| | | | | | | From 01/01/ To 12/31/ | | Part I Date/Ti | me Pre | pared |
| | 1.00 | 2.00 | | 3.00 | | | 4.00 | 5/29/20 |)23 3:2 | 8 pm |
| | Hospital and Hospital Health Care Com | | | 3.00 | | | +. 00 | | | |
| 00 | Street: 1201 HADLEY ROAD | P0 Box: | | | | | | | | 1. |
| 00 | City: MOORESVILLE | State: IN Component Name | Zip Code CCN | 1 | | y: Date | Doving | ent Syst | om (D | 2. |
| | | component name | Number | CBSA Numbe | | Certified | | , 0, or | | |
| | | | | | 511 | | V | XVIII | XIX | |
| | | 1.00 | 2.00 | 3.00 | 0 4.00 | 5.00 | 6.00 | 7.00 | 8.00 | |
| 00 | Hospital and Hospital-Based Component Hospital | : Identification: FRANCISCAN HEALTH | 150057 | 2690 | 0 1 | 07/01/1996 | N | Р | Р | 3. |
| 00 | | MOORESVILLE | 150057 | 2090 | | 0770171998 | IN | P | | 3. |
| 00 | Subprovider - IPF | | | | | | | | | 4. |
| 00 | Subprovider - IRF | | | | | | | | | 5. |
| 00 00 | Subprovider – (Other) Swing Beds – SNF | | | | | | | | | 6. 7. |
| 00 | Swing Beds - NF | | | | | | | | | 8. |
| 00 | Hospital-Based SNF | | | | | | | | | 9. |
| . 00 | Hospital-Based NF | | | | | | | | | 10. |
| . 00 | | | | | | | | | | 11. |
| . 00 | Hospital-Based HHA Separately Certified ASC | | | | | | | | | 12. 13. |
| | Hospi tal -Based Hospi ce | | | | | | | | | 14. |
| | Hospital -Based Health Clinic - RHC | | | | | | | | | 15. |
| . 00 | Hospital-Based Health Clinic - FQHC | | | | | | | | | 16. |
| . 00 | Hospital-Based (CMHC) I | | | | | | | | | 17. |
| | Renal Dialysis Other | | | | | | | | | 18. 19. |
| . 00 | | | | 1 | | From: | | То | : | 17. |
| | | | | | | 1.00 | | 2. (| | |
| | Cost Reporting Period (mm/dd/yyyy) Type of Control (see instructions) | | | | | 01/01/2 | 022 | 12/31/ | /2022 | 20. |
| . 00 | Type of control (see thist detroits) | | | | | 2 | | | | 21. |
| | | | | | 1.00 | 2.00 | | 3. (| 00 | |
| . 00 | Inpatient PPS Information Does this facility qualify and is it | currently receiving r | aumonts for | | Y | N | | | | 22. |
| . 00 | disproportionate share hospital adjus | 3 0 1 | 5 | | 1 | i N | | | | 22. |
| | §412.106? In column 1, enter "Y" for | | | | | | | | | |
| | facility subject to 42 CFR Section §4 | | amendment | | | | | | | |
| . 01 | hospital?) In column 2, enter "Y" for Did this hospital receive interim UCP | | ntal UCPc | for | Y | Y | | | | 22. |
| . 01 | this cost reporting period? Enter in | | | | 1 | | | | | 22. |
| | for the portion of the cost reporting | | | | | | | | | |
| | 1. Enter in column 2, "Y" for yes or | | | ie | | | | | | |
| | cost reporting period occurring on or | after October 1. (se | e | | | | | | | |
| 02 | instructions) Is this a newly merged hospital that | requires a final UCP | to be | | Ν | N | | | | 22. |
| 2 | determined at cost report settlement? | (see instructions) E | Inter in col | umn | | | | | | |
| | 1, "Y" for yes or "N" for no, for the | portion of the cost | reporti ng | | | | | | | |
| | period prior to October 1. Enter in of for the portion of the cost reporting | | | no, | | | | | | |
| 03 | Did this hospital receive a geographi | • | | , | Ν | N | | N | | 22. |
| | rural as a result of the OMB standard | | | | | | | | | |
| | adopted by CMS in FY2015? Enter in co | | | | | | | | | |
| | for the portion of the cost reporting | | | er | | | | | | |
| | in column 2, "Y" for yes or "N" for n reporting period occurring on or afte | | | | | | | | | |
| | Does this hospital contain at least 1 | | | is | | | | | | |
| | counted in accordance with 42 CFR 412 | .105)? Enter in colum | n 3, "Y" fo | or | | | | | | |
| 04 | yes or "N" for no. Did this hospital receive a geographi | c reclassification fr | om urban to | | | | | | | 22. |
| 04 | rural as a result of the revised OMB | | | | | | | | | 22. |
| | adopted by CMS in FY 2021? Enter in c | | | | | | | | | |
| | for the portion of the cost reporting | period prior to Octo | ber 1. Ente | | | | | | | |
| | in column 2, "Y" for yes or "N" for n | | | | | | | | | |
| | reporting period occurring on or after Does this hospital contain at least 1 | | | | | | | | | |
| | counted in accordance with 42 CFR 412 | | | | | | | | | |
| | yes or "N" for no. | | | | | | | | | |
| . 00 | Which method is used to determine Med | | | | | 3 N | | | | 23. |
| | below? In column 1, enter 1 if date c | r admission, 2 if cer | | | | | | | | |
| | if date of discharge le the method of | f identifying the day | in this o | nst ! | | | | | | |
| | if date of discharge. Is the method or reporting period different from the m | | | ost | | | | | | |

| Health Financial Systems FRANCISCA HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA | AN HEALTH MO | Provider CC | N: 15-0057 | | i od: | In Lieu | Worksh | eet S-2 | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|---------------------------------------------------------|--------------------------------------------|--------------------|---------------|---------------------------|--------|
| | | | | To | om 01/0 12/3 | | | ime Pre 023 3:2 | |
| | In-State Medicaid paid days | In-State Medicaid eligible unpaid days | Out-of State Medicaid paid days | St Med eli un | t-of ate i cai d gi bl e pai d | Medi ca HMO day | id (ys Me |)ther di cai d days | _ |
| 24.00 If this provider is an IPPS hospital, enter the | 1.00 | 2.00 | 3.00 | | . 00 4 | <u>5.00</u> 1, | 627 | <u>6.00</u> 87 | 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 | o | o | 0 | | 0 | | 0 | | 25. 00 |
| HMO paid and eligible but unpaid days in column 5. | | | | | Jrban/R | ural S | Date o | f Geoar | |
| 24.00 Enter your standard asserbable starting (| | ot the b | inning -f | | 1. (| | | 00 | |
| 26.00 Enter your standard geographic classification (not wa cost reporting period. Enter "1" for urban or "2" for | r rural. | | | | | I I | | | 26.00 |
| 27.00 Enter your standard geographic classification (not was reporting period. Enter in column 1, "1" for urban of enter the effective date of the geographic reclassifi 35.00 If this is a sole community hospital (SCH), enter the | r"2" for r ication in | ural. If ap column 2. | pl i cabl e, | | | 1 | | | 35.00 |
| effect in the cost reporting period. | | 2011003-30 | 5tatus 11 | • | D. 1 | | - · | | 33.00 |
| | | | | | Begi nı 1. (| | End 2. | i ng: 00 | |
| 36.00 Enter applicable beginning and ending dates of SCH s of periods in excess of one and enter subsequent date | | cript line | 36 for numb | ber | | | | | 36.00 |
| 37.00 f this is a Medicare dependent hospital (MDH), enter | | r of period | ds MDH statu | JS | | 0 | | | 37.00 |
| is in effect in the cost reporting period. 37.01 Is this hospital a former MDH that is eligible for th accordance with FY 2016 OPPS final rule? Enter "Y" fo instructions) | | | | | | | | | 37.01 |
| 38.00 If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of enter subsequent dates. | | | | | | | | | 38.00 |
| | | | | _ | Y/ 1. (| | | /N 00 | - |
| 39.00 Does this facility qualify for the inpatient hospital 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 (ii or "N" for no. (see instructions) |), (ii), or the mileage | (iii)? Ent requiremen | er in colur ts in | nn | Y | | | Y | 39.00 |
| 40.00 Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octol no in column 2, for discharges on or after October 1. | ber 1. Ente | r "Y" for y | | | N | | I | N | 40.00 |
| , · · · · · · · · · · · · · · · · | | | | | | V 1.00 | XVIII 2.00 | _ | _ |
| Prospective Payment System (PPS)-Capital | | | | | | | | | |
| 45.00 Does this facility qualify and receive Capital paymen with 42 CFR Section §412.320? (see instructions) 46.00 Is this facility eligible for additional payment exceeds | eption for | extraordi na | ary circumst | tance | S | N N | N N | N N | 45.00 |
| pursuant to 42 CFR §412.348(f)? If yes, complete Wks Pt. III. 47.00 Is this a new hospital under 42 CFR §412.300(b) PPS (| | | | | 0 | N | N | N | 47.00 |
| 48.00 Is the facility electing full federal capital payment | | | | | 110. | N | N | N | 48.00 |
| Teaching Hospitals 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 December the instructions. For column 2, if the response to co involved in training residents in approved GME progra and are you are impacted by CR 11642 (or applicable (| "Y" for yes r 27, 2020, olumn 1 is ams in the | or "N" for under 42 ("Y", or if prior year | r no in colu CFR 413.78(k this hospit or penultin | umn 1 c)(2) tal w mate | . For , see as year, | N | N | | 56.00 |
| "Y" for yes; otherwise, enter "N" for no in column 2. 57.00 For cost reporting periods beginning prior to December is this the first cost reporting period during which at this facility? Enter "Y" for yes or "N" for no in residents start training in the first month of this of "N" for no in column 2. If column 2 is "Y", complete complete Wkst. D, Parts III & IV and D-2, Pt. II, if beginning on or after December 27, 2020, under 42 CFF which month(s) of the cost report the residents were | er 27, 2020 residents n column 1. cost report e Worksheet applicable R 413.77(e | , if line 5 in approved If column ing period? E-4. If cc . For cost)(1)(iv) ar | 56, column d GME progra 1 is "Y", c 2 Enter "Y" olumn 2 is ' reporting p nd (v), rega | 1, is ams t did 'for 'N", perio ardle | yes, rained yesor ds ssof | - - | | | 57.00 |
| for yes, enter "Y" for yes in column 1, do not comple | | | | | | | | | 58.00 |

| HOSPI T | TAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA | TA | Provider CC | F | Period: From 01/01/2022 To 12/31/2022 | Date/Time Pre 5/29/2023 3:2 | pared: |
|---------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------|-------------------------------------------|------------------------------|---------------------------------------------|-------------------------------------------------------|-------------------------|
| | | | | | 1.0 | 0 2.00 3.00 | |
| 9.00 | Are costs claimed on line 100 of Worksheet A? If yes | s <u>, compl</u> | <u>ete Wkst. D-2</u> , | Pt. I. NAHE 413.85 Y/N | N Worksheet A Line # | Pass-Through Qual i fi cati on Cri teri on Code | |
| | L | | | 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 | |
| 51. 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 | N | | | 0.0 | d 0. 00 | 61. 0 61. 0 61. 0 |
| 1. 03 | FTE count (excluding OB/GYN, general surgery FTEs, 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) | | | | | | 61. C |
| | Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions). Enter the difference between the baseline primary and/or constructions | | | | | | 61. (|
| 1. 06 | 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. (|
| | | Pro | ogram Name | Program Code | Unweighted IME FTE Count | Unweighted Direct GME FTE Count | - |
| | | | 1.00 | 2.00 | 3.00 | 4.00 | 1 |
| | Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE | | | | 0.00 | | 61.1 |
| | 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. | | | | | 1.00 | |
| | ACA Provisions Affecting the Health Resources and Ser | | | | | | |
| | your hospital received HRSA PCRE funding (see instruct | ctions) | | | | | 62.0 |
| 2. 01 | Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC prog | gram. (s | see instruction | | your hospital | 0.00 | 62.0 |
| | | gram. (s er Setti ettings | see instruction ings during this co | ns) ost reporting | period? Enter | N | |

| <u>th Financial Systems</u> PITAL AND HOSPITAL HEALTH CARE COMPL | | N HEALTH MOORESVILLE | | eriod: | u of Form CMS- Worksheet S-2 | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|-------------------------------|--------------------------------|----------------------------------|---------|
| TTAL AND HOST TAL HEALTH OAKE OUM E | | | F | rom 01/01/2022 o 12/31/2022 | 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 | | | | | | |
| 00 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 n hospital. Enter in | -primary care all nonprovider non-primary care column 3 the ratio | 0.00 | 0.00 | 0. 000000 | 0 64.0 |
| of (column 1 divided by (column 1 | Program Name | Program Code | Unweighted | Unweighted | Ratio (col. 3/ | / |
| | r r ogr din Hamo | | FTEs | FTEs in | (col . 3 + col . | |
| | | | Nonprovi der | Hospi tal | 4)) | |
| _ | | | Si te | | | - |
| 00 Enter in column 1, if line 63 | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 0.000000 | |
| 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) | | | Unwei ghted | Unweighted | Ratio (col. 1, (col. 1 + col. | |
| | | | FTEs Nonprovi der Si te | FTEs in Hospital | 2)) | |
| Section 5504 of the ACA Current | lear FTE Residents in | Nonnrovidor Sottin | 1.00 | 2.00 | 3.00 | |
| beginning on or after July 1, 20 | | i nonprovider setting | JaLinective I | or cost reporti | ng perious | |
| 00 Enter in column 1 the number of u FTEs attributable to rotations of Enter in column 2 the number of u | nweighted non-primar curring in all nonpr | ovider settings. | 0.00 | 0.00 | 0. 000000 | 66. C |
| FTEs that trained in your hospita | | | | | | |
| (column 1 divided by (column 1 + | <u>column 2)). (see ins</u> Program Name | Program Code | Unweighted | Unweighted | Ratio (col. 3/ | / |
| | | | FTEs | FTEs in | (col. 3 + col. | |
| | | | Nonprovi der | Hospi tal | 4)) | |
| | 1.00 | 0.00 | Site | 4.00 | F 00 | - |
| 00 Enter in column 1, the program | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 0.00000 | 67 (|
| name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column | | | | | | |

| Health Financial Systems FRANCISCAN HEALTH MOORESVILLE In Li | eu of Form CMS-2 | 2552-10 |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|---------|
| HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0057 Period: From 01/01/202: | Worksheet S-2 Part I | |
| To 12/31/202 | 2 Date/Time Pre | |
| | 5/29/2023 3:2 | s pm |
| | 1.00 | |
| Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022) 68.00 For a cost reporting period beginning prior to October 1, 2022, did you obtain permission from your MAC to apply the new DGME formula in accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022)? | N | 68.00 |
| | 0 2.00 3.00 | |
| Inpatient Psychiatric Facility PPS | 0 2.00 3.00 | |
| 70.00 Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? N Enter "Y" for yes or "N" for no. | | 70.00 |
| 71.00 If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most | 0 | 71.00 |
| recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see | | |
| 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. | | |
| Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. | | |
| (see instructions) | | |
| Inpatient Rehabilitation Facility PPS 75.00 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF N | | 75.00 |
| subprovider? Enter "Y" for yes and "N" for no. | | 7/ 00 |
| 76.00 If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for | 0 | 76.00 |
| no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 | | |
| CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) | | |
| | | |
| Long Term Care Hospital PPS | 1.00 | |
| 80.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no. | N | 80.00 |
| 81.00 Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no. | N | 81.00 |
| TEFRA Provi ders | | |
| 85.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no. | N | 85.00 |
| 86.00 Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no. | | 86.00 |
| 87.00 Is this hospital an extended neoplastic disease care hospital classified under section | N | 87.00 |
| 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no. Approved for | Number of | |
| Permanent | Approved | |
| Adjustment (Y/N) | Permanent Adjustments | |
| 1.00 | 2.00 | |
| 88.00 Column 1: Is this hospital approved for a permanent adjustment to the TEFRA target amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete col. 2 and line | 0 | 88.00 |
| 89. (see instructions) | | |
| Column 2: Enter the number of approved permanent adjustments. Wkst. A Line Effective Dat | e Approved | |
| No. | Permanent | |
| | Adjustment Amount Per | |
| | Discharge | |
| 1.00 2.00 | 3.00 | |
| 89.00 Column 1: If line 88, column 1 is Y, enter the Worksheet A line number 0.00 on which the per discharge permanent adjustment approval was based. | 0 | 89.00 |
| 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. | XIX | |
| 1.00 | 2.00 | |
| Title V and XIX Services 90.00 Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for N | Y | 90.00 |
| yes or "N" for no in the applicable column. | | 90.00 |
| 91.00 Is this hospital reimbursed for title V and/or XIX through the cost report either in N full or in part? Enter "Y" for yes or "N" for no in the applicable column. | Y | 91.00 |
| 92.00 Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see | N | 92.00 |
| instructions) Enter "Y" for yes or "N" for no in the applicable column. 93.00 Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter N | N | 93.00 |
| "Y" for yes or "N" for no in the applicable column. | | |
| 94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the N applicable column. | N | 94.00 |
| 95.00 If line 94 is "Y", enter the reduction percentage in the applicable column. 0.00 | 0.00 | 95.00 |
| 96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the N applicable column. | N | 96.00 |
| 97.00 If line 96 is "Y", enter the reduction percentage in the applicable column. 0.00 | 0.00 | 97.00 |

| | | eriod: rom 01/01/2022 | Worksheet S | -2 |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|--------------------------|-------------|-------------------------------------------------------|
| | T | | | |
| | I | V | XI X | |
| 10.00 bass title V on VIV follow Medicana (title VVIII) for the interne and resi | danta naat | 1.00 N | 2.00 Y | 98.00 |
| 28.00 Does title V or XIX follow Medicare (title XVIII) for the interns and residuent stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" column 1 for title V, and in column 2 for title XIX. | | N | Y | 98.00 |
| 18.01 Does title V or XIX follow Medicare (title XVIII) for the reporting of cha C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in title XIX. | | N | Y | 98.01 |
| 8.02 Does title V or XIX follow Medicare (title XVIII) for the calculation of o bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no i | | N | Y | 98. 02 |
| for title V, and in column 2 for title XIX. 8.03 Does title V or XIX follow Medicare (title XVIII) for a critical access how reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no for title V, and in column 2 for title XIX. | | Ν | N | 98. 03 |
| 8.04 Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101 outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for | | N | N | 98.04 |
| <pre>in column 2 for title XIX. 8.05 Does title V or XIX follow Medicare (title XVIII) and add back the RCE dis Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for ti </pre> | | Ν | Y | 98. 0 |
| <pre>column 2 for title XIX. 8.06 Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V column 2 for title XIX.</pre> | | Ν | Y | 98.00 |
| Rural Providers | | N | | 105.00 |
| D5.00 Does this hospital qualify as a CAH? D6.00 If this facility qualifies as a CAH, has it elected the all-inclusive mether for outpatient services? (see instructions) | od of payment | N N | | 105.00 106.00 |
| 07.00 Column 1: If line 105 is Y, is this facility eligible for cost reimburseme training programs? Enter "Y" for yes or "N" for no in column 1. (see inst Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs approved medical education program in the CAH's excluded IPF and/or IRF u | ructions) in an | Ν | | 107. 0 |
| Enter "Y" for yes or "N" for no in column 2. (see instructions) 08.00 s this a rural hospital qualifying for an exception to the CRNA fee sched CFR Section §412.113(c). Enter "Y" for yes or "N" for no. | ule? See 42 | Ν | | 108. 0 |
| Physi cal | Occupational | Speech | Respiratory | У |
| 09.00 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 | 2.00 N | 3.00 N | 4.00 N | 109.00 |
| | | | 1.00 | 4 |
| 10.00 Did this hospital participate in the Rural Community Hospital Demonstration Demonstration)for the current cost reporting period? Enter "Y" for yes or complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, line applicable. | "N" for no. If | yes, | 1.00 N | 110. 0 |
| | | 1.00 | 2.00 | |
| | | | | |
| 11.00 If this facility qualifies as a CAH, did it participate in the Frontier Co | mmunitv | 1.00 N | 2.00 | 111 00 |
| 11.00 If this facility qualifies as a CAH, did it participate in the Frontier Con Health Integration Project (FCHIP) demonstration for this cost reporting p "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, e integration prong of the FCHIP demo in which this CAH is participating in the Enter all that apply: "A" for Ambulance services; "B" for additional beds; for tele-health services. | eriod? Enter nter the column 2. | N | 2.00 | 111.00 |
| Health Integration Project (FCHIP) demonstration for this cost reporting p "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, end integration prong of the FCHIP demo in which this CAH is participating in Enter all that apply: "A" for Ambulance services; "B" for additional beds; | eriod? Enter nter the column 2. and/or "C" | N | | 111.00 |
| Health Integration Project (FCHIP) demonstration for this cost reporting prive "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, existing and the four of the FCHIP demo in which this CAH is participating in the Enter all that apply: "A" for Ambulance services; "B" for additional beds; for tele-health services. 12.00 Did this hospital participate in the Pennsylvania Rural Health Model (PARHM) demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased | eriod? Enter nter the column 2. | | 3.00 | |
| Health Integration Project (FCHIP) demonstration for this cost reporting provided in the provided and the prependent and the provided and t | eriod? Enter nter the column 2. and/or "C" 1.00 | N | | 112. 0 |
| Health Integration Project (FCHIP) demonstration for this cost reporting prive "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, end integration prong of the FCHIP demo in which this CAH is participating in the Enter all that apply: "A" for Ambulance services; "B" for additional beds; for tele-health services. 12.00 Did this hospital participate in the Pennsylvania Rural Health Model (PARHM) demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participate in the Community Health Access and Rural Transformation (CHART) model for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no. Miscellaneous Cost Reporting Information 15.00 Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on | eriod? Enter nter the column 2. and/or "C" 1.00 | N | | 112.00 |
| Health Integration Project (FCHIP) demonstration for this cost reporting por "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, existence of the FCHIP demo in which this CAH is participating in the Enter all that apply: "A" for Ambulance services; "B" for additional beds; for tele-health services. 12.00 Did this hospital participate in the Pennsylvania Rural Health Model (PARHM) demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable. 13.00 Did this nospital participate in the Community Health Access and Rural Transformation (CHART) model for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no. Miscellaneous Cost Reporting Information 15.00 Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 2. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1. | eriod? Enter nter the column 2. and/or "C" <u>1.00</u> N | N | | 111. 00 112. 00 113. 00 0 115. 00 116. 00 |
| "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, et integration prong of the FCHIP demo in which this CAH is participating in the Enter all that apply: "A" for Ambulance services; "B" for additional beds; for tele-health services. 112.00 Did this hospital participate in the Pennsylvania Rural Health Model (PARHM) demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable. 113.00 Did this hospital participate in the Community Health Access and Rural Transformation (CHART) model for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no. Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub. 15-1, chapter 22, §2208.1. 116.00 Is this facility classified as a referral center? Enter "Y" for yes or | eri od? Enter nter the col umn 2. and/or "C" 1.00 N | N | | 112.00 113.00 0115.00 |

| alth Financial Systems FRANCISCAN HEALTH MOORESVIL OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider | | eriod: rom 01/01/2022 o 12/31/2022 | | repared: |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------|------------------------------------------|-----------|------------------|
| | Premi ums | Losses | Insurance | |
| | 1.00 | 2.00 | 3.00 | _ |
| 18.01 List amounts of malpractice premiums and paid losses: | 240, 838 | | | 0 118. 0 |
| | | 1.00 | 2.00 | _ |
| 18.02 Are malpractice premiums and paid losses reported in a cost center othe Administrative and General? If yes, submit supporting schedule listing and amounts contained therein. | | N | 2.00 | 118.0 |
| In a mount's contained therein. 19.00 DO NOT USE THIS LINE 20.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless p §3121 and applicable amendments? (see instructions) Enter in column 1, "N" for no. Is this a rural hospital with < 100 beds that qualifies for Hold Harmless provision in ACA §3121 and applicable amendments? (see in Enter in column 2, "Y" for yes or "N" for no. | "Y" for yes or the Outpatient | Ν | N | 119. 0 120. 0 |
| 21.00 Did this facility incur and report costs for high cost implantable devi patients? Enter "Y" for yes or "N" for no. | ces charged to | Y | | 121.0 |
| 22.00 Does the cost report contain healthcare related taxes as defined in §19 Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", en | | Y | 5.03 | 122.0 |
| the Worksheet A line number where these taxes are included. 23.00 Did the facility and/or its subproviders (if applicable) purchase professervices, e.g., legal, accounting, tax preparation, bookkeeping, payrol management/consulting services, from an unrelated organization? In colut for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., greater the professional services expenses, for services purchased from unrelated or located in a CBSA outside of the main hospital CBSA? In column 2, enter "N" for no. | l, and/or mn 1, enter "Y" nan 50% of total organizations | | | 123. (|
| Certified Transplant Center Information 25.00Does this facility operate a Medicare-certified transplant center? Ente | er "Y" for ves | N | | 125. 0 |
| and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below. 26.00 If this is a Medicare-certified kidney transplant program, enter the ce | 5 | | | 126. 0 |
| in column 1 and termination date, if applicable, in column 2. 27.00 If this is a Medicare-certified heart transplant program, enter the cer in column 1 and termination date, if applicable, in column 2. | tification date | | | 127.0 |
| 8.00 If this is a Medicare-certified liver transplant program, enter the cer in column 1 and termination date, if applicable, in column 2. | tification date | | | 128. (|
| 29.00 If this is a Medicare-certified lung transplant program, enter the cert in column 1 and termination date, if applicable, in column 2. | ification date | | | 129. (|
| 00.00 If this is a Medicare-certified pancreas transplant program, enter the date in column 1 and termination date, if applicable, in column 2. N1.00 If this is a Medicare-certified intestinal transplant program, enter th | | | | 130.0 |
| 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 cer in column 1 and termination date, if applicable, in column 2. | | | | 132. (|
| 33.00 Removed and reserved 44.00 If this is a hospital-based organ procurement organization (0P0), enter in column 1 and termination date, if applicable, in column 2. | the OPO number | | | 133. (134. (|
| All Providers | | | | |
| 0.00 Are there any related organization or home office costs as defined in C chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and ho are claimed, enter in column 2 the home office chain number. (see instr | ome office costs | Y | 158014 | 140. (|
| 1.00 2.00 If this facility is part of a chain organization, enter on lines 141 th | rough 142 the par | 3.00 | of the | |
| home office and enter the home office contractor name and contractor nu | | | or the | |
| 1.00 Name: FRANCISCAN ALLIANCE INC. AND Contractor's Name: WISCONSIN PHYS AFFILI SERVICE | SICIANS Contractor | 's Number: 0810 |)1 | 141.0 |
| 2.00 Street: 1515 W DRAGOON TRL PO Box: 1290 3.00 City: MI SHAWAKA State: I N | Zip Code: | 4654 | 14 | 142. (143. (|
| | | | 1.00 | _ |
| 14.00 Are provider based physicians' costs included in Worksheet A? | | | 1.00 Y | 144. (|
| | | 1.00 | 2.00 | _ |
| 15.00 If costs for renal services are claimed on Wkst. A, line 74, are the construction inpatient services only? Enter "Y" for yes or "N" for no in column 1. I no, does the dialysis facility include Medicare utilization for this constructed? Enter "Y" for yes or "N" for no in column 2. | fcolumn 1 is | 1.00 | 2.00 | 145. (|
| period? Enter "Y" for yes or "N" for no in column 2. 46.00 Has the cost allocation methodology changed from the previously filed c Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapte yes, enter the approval date (mm/dd/yyyy) in column 2. | | N | | 146. |

| Health Financial Systems | FRANCI SCAN | HEALTH | MOORESVI LLE | | | In Lie | u of Form CMS | -2552-10 |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------|--------------------|-------------------------------------|-------------------------|------------|--------------------------------|--------------------------------------------------------|--------------------|
| HOSPITAL AND HOSPITAL HEALTH CARE COMPLE | X IDENTIFICATION DATA | | Provider CC | N: 15-005 | From | d: 01/01/2022 12/31/2022 | Worksheet S- Part I Date/Time Pr 5/29/2023 3: | epared: |
| | | | | | | | 1.00 | - |
| 147.00 Was there a change in the statisti 148.00 Was there a change in the order of | allocation? Enter "Y | for | yes or "N" fo | r no. | | | N N | 147.00 148.00 |
| 149.00 Was there a change to the simplifi | ed cost finding metho | d? Ent | Part A | <u>s or "N"</u> Part | | Title V | N Title XIX | 149.00 |
| | | | 1,00 | 2.00 | | 3.00 | 4.00 | - |
| Does this facility contain a provi or charges? Enter "Y" for yes or ' 155.00Hospital | | | xemption from | the appl | ication of | of the lowe | er of costs | 155.00 |
| 155. 00 Subprovider – TPF | | | N | N | | N | N N | 155.00 |
| 157.00 Subprovider - IRF 158.00 SUBPROVIDER | | | N | N | | N | N | 157. 00 158. 00 |
| 159.00 SNF | | | N | Ν | | N | N | 159.00 |
| 160. 00 HOME HEALTH AGENCY | | | N | N | | N | N | 160.00 |
| 161.00 CMHC | | | | N | | N | N | 161.00 |
| | | | | | | | 1.00 | |
| Multicampus | | | | | | | | |
| 165.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no. | ampus hospital that ha | s one o | or more campu | ses in di | fferent (| BSAs? | N | 165.00 |
| | Name | | County | State | Zip Code | | FTE/Campus | |
| | 0 | | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | 01((00 |
| 166.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) | | | | | | | 0.0 | 0166.00 |
| | | | | | | | 1.00 | - |
| Health Information Technology (HI |) incentive in the Am | eri can | Recovery and | Rei nvest | tment Act | | 1.00 | |
| 167.00 Is this provider a meaningful user 168.00 If this provider is a CAH (line 10 reasonable cost incurred for the H | under §1886(n)? Ent D5 is "Y") and is a me | er "Y" ani ngfi | for yes or " ul user (line | N" for no |). | er the | Y | 167. 00 168. 00 |
| 168.01 If this provider is a CAH and is r exception under §413.70(a)(6)(ii)? | not a meaningful user, 'Enter "Y" for yes or | does "N" f | , this provider or no. (see i | nstructic | ons) | | | 168. 01 |
| 169.00 If this provider is a meaningful utransition factor. (see instruction | | and is | s not a CAH (| line 105 | is "N"), | enter the | 9.9 | 9169.00 |
| | | | | | В | egi nni ng | Endi ng | |
| 170 00 Entry in actions 1 and 2 the EUD h | | | + + | | | 1.00 | 2.00 | 170.00 |
| 170.00 Enter in columns 1 and 2 the EHR k period respectively (mm/dd/yyyy) | beginning date and end | ing da | te for the re | porting | | | | 170.00 |
| | | | | | | 1.00 | 2.00 | |
| 171.00 If line 167 is "Y", does this prov section 1876 Medicare cost plans r "Y" for yes and "N" for no in colu 1876 Medicare days in column 2. (s | eported on Wkst. S-3, mn 1. If column 1 is j | Pt. I | , line 2, col | . 6? Ente | | Ν | | 0 171. 00 |

| OSPI T. | AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider C | | Period: From 01/01/2022 To 12/31/2022 | Date/Time Pre | epared |
|----------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------|-----------------------|---------------------------------------------|---------------|----------|
| | | | | | 5/29/2023 3:2 | |
| | | | | Y/N | Date | |
| | PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURSE | | | 1.00 | 2.00 | |
| | General Instruction: Enter Y for all YES responses. Enter N mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS | | | r all dates in 1 | the | |
| | Provider Organization and Operation | | | | | |
| . 00 | Has the provider changed ownership immediately prior to the | | | N | | 1. (|
| | reporting period? If yes, enter the date of the change in c | column 2. (see | Y/N | Date | V/I | - |
| | | | 1.00 | 2.00 | 3.00 | |
| . 00 | Has the provider terminated participation in the Medicare F yes, enter in column 2 the date of termination and in colum | | N | 2.00 | 0.00 | 2. |
| 00 | voluntary or "I" for involuntary. Is the provider involved in business transactions, includin 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 othe 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 | 05/06/2022 | 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 | Legal Oper. | _ |
| | Approved Educational Activities | | | 1.00 | 2.00 | |
| . 00 | Column 1: Are costs claimed for a nursing program? Column the legal operator of the program? | 2: If yes, is | s the provider | N | | 6. |
| 00 00 | Are costs claimed for Allied Health Programs? If "Y" see in Were nursing programs and/or allied health programs approve cost reporting period? If yes, see instructions. | | ved during the | N N | | 7. 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. |
| 0. 00 | Was an approved Intern and Resident GME program initiated c cost reporting period? If yes, see instructions. | | the current | N | | 10. |
| 1.00 | 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 | Ν | | 11. |
| | | | | | Y/N 1.00 | |
| | Bad Debts | | | | 1.00 | |
| 2.00 | Is the provider seeking reimbursement for bad debts? If yes | | | | Y | 12. |
| | If line 12 is yes, did the provider's bad debt collection p period? If yes, submit copy. | | | | Ν | 13. |
| | If line 12 is yes, were patient deductibles and/or coinsura instructions. Bed Complement | ance amounts wa | aived? If yes, | see | N | 14. |
| | Did total beds available change from the prior cost reporti | | yes, see inst rt A | | N T B | 15. |
| | | Y/N | Date | Y/N | Date | |
| | | 1.00 | 2.00 | 3.00 | 4.00 | |
| | PS&R Data | | | | | |
| . 00 | Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions) | N | | N | | 16. |
| . 00 | Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) | Y | 04/27/2023 | Y | 04/27/2023 | 17. |
| . 00 | 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 | | N | | 18. |
| . 00 | If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions. | N | | Ν | | 19. |

Health Financial Systems

In Lieu of Form CMS-2552-10

| ealth Financial Systems FRANCISCAN HEAL | TH MOORESVILLE | | In Lie | u of Form CMS | -2552-10 |
|-------------------------------------------------------------------------------------------------------------------------------------------------|-----------------|---------------|---------------------------------------------|------------------|----------|
| OSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider C | CN: 15-0057 | Period: From 01/01/2022 To 12/31/2022 | | |
| | | | | 5/29/2023 3:: | 28 pm |
| | | ption | Y/N | Y/N | |
| 0.00 If line 16 or 17 is yes, were adjustments made to PS&R | |) | 1.00 N | 3.00 N | 20.00 |
| Report data for Other? Describe the other adjustments: | | | | | |
| | Y/N | Date | Y/N | Date | |
| 1.00 Was the cost report prepared only using the provider's | 1.00 N | 2.00 | 3.00 N | 4.00 | 21.00 |
| records? If yes, see instructions. | IN | | IN | | 21.00 |
| | · | | | | |
| COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXC | EPT CHILDRENS H | Ο SPI ΤΔΙ S) | | 1.00 | |
| Capital Related Cost | | USIT TAES) | | | - |
| 2.00 Have assets been relifed for Medicare purposes? If yes, se | e instructions | | | Ν | 22.00 |
| 3.00 Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions. | due to apprais | als made duri | ng the cost | Ν | 23.00 |
| 4.00 Were new leases and/or amendments to existing leases enter If yes, see instructions | Ũ | | 0 1 | Ν | 24.00 |
| 5.00 Have there been new capitalized leases entered into during instructions. | | 0. | 5 | Ν | 25.00 |
| 6.00 Were assets subject to Sec. 2314 of DEFRA acquired during t instructions. | | 0 1 | 5 | N | 26.00 |
| 7.00 Has the provider's capitalization policy changed during th copy. | e cost reportin | g period? If | yes, submit | N | 27.00 |
| Interest Expense 8.00 Were new Loans, mortgage agreements or Letters of credit e period? If yes, see instructions. | ntered into dur | ing the cost | reporting | N | 28.00 |
| 9.00 Did the provider have a funded depreciation account and/or treated as a funded depreciation account? If yes, see inst | | bt Service Re | eserve Fund) | Ν | 29.00 |
| Has existing debt been replaced prior to its scheduled mat instructions. | | debt? If yes, | see | Ν | 30.00 |
| 1.00 Has debt been recalled before scheduled maturity without i instructions. | ssuance of new | debt? If yes, | see | Ν | 31.00 |
| Purchased Servi ces | | | | | |
| 2.00 Have changes or new agreements occurred in patient care se arrangements with suppliers of services? If yes, see instr | | d through cor | ntractual | Ν | 32.00 |
| 1.00 If line 32 is yes, were the requirements of Sec. 2135.2 ap | | g to competit | tive bidding? If | Ν | 33.00 |
| Provi der-Based Physi ci ans | | | | | |
| 4.00 Were services furnished at the provider facility under an If yes, see instructions. | arrangement wit | n provider-ba | ased physicians? | Y | 34.00 |
| 5.00 If line 34 is yes, were there new agreements or amended ex | isting agreemen | ts with the p | provi der-based | Ν | 35.0 |
| physicians during the cost reporting period? If yes, see i | | | | | |
| | | | Y/N | Date | |
| Home Office Costs | | | 1.00 | 2.00 | - |
| 6.00 Were home office costs claimed on the cost report? | | | Y | | 36.00 |
| 7.00 If line 36 is yes, has a home office cost statement been p If yes, see instructions. | 1 5 | | Y | | 37.00 |
| 8.00 If line 36 is yes, was the fiscal year end of the home of the provider? If yes, enter in column 2 the fiscal year en | d of the home o | ffi ce. | N | | 38.00 |
| 9.00 If line 36 is yes, did the provider render services to oth see instructions. | | 5 | | | 39.00 |
| 0.00 f ine 36 is yes, did the provider render services to the instructions. | home office? | It yes, see | Y | | 40.00 |
| | 1 | 00 | 2 | 00 | - |
| Cost Report Preparer Contact Information | | | | | |
| 1.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, | HONG | | YANG | | 41.00 |
| 2.00 Enter the employer/company name of the cost report | FRANCI SCAN HEA | LTH | | | 42.00 |
| preparer. 3.00 Enter the telephone number and email address of the cost | 219-407-6568 | | HONG. YANG@FRAN | CI SCANALLI ANCE | 43.00 |
| report preparer in columns 1 and 2, respectively. | | | . ORG | | |

| Heal th | Financial Systems FRANCIS | SCAN HEALT | TH MOORESVILLE | In Lie | u of Form CMS- | 2552-10 |
|---------|-----------------------------------------------------|------------|----------------------------|----------------------------------|----------------|---------|
| HOSPI T | AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONN | NAI RE | Provider CCN: 15-0057 | Peri od: | Worksheet S-2 | |
| | | | | From 01/01/2022 To 12/31/2022 | | |
| | | | | | | |
| | | | 3.00 | | | |
| | Cost Report Preparer Contact Information | | | | | |
| | Enter the first name, last name and the title/posi | | DIRIECTOR OF REIMBURSEMENT | | | 41.00 |
| | held by the cost report preparer in columns 1, 2, | and 3, | | | | |
| | respecti vel y. | | | | | |
| 42.00 | Enter the employer/company name of the cost report | | | | | 42.00 |
| | preparer. | | | | | |
| 43.00 | Enter the telephone number and email address of th | ne cost | | | | 43.00 |
| | report preparer in columns 1 and 2, respectively. | | | | | |

| IOSPI 1 | <u>Financial Systems</u> AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC | RANCI SCAN HEALT AL DATA | Provi der C | CN: 15-0057 | Peri od: | u of Form CMS-2 Worksheet S-3 | |
|--------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------|-------------|--------------------------|----------------------------------|------------------------------------------|-------|
| | | | | | From 01/01/2022 To 12/31/2022 | Part I Date/Time Pre 5/29/2023 3:2 | |
| | | | | | | I/P Days / O/P | |
| | Component | Worksheet A Line No. | No. of Beds | Bed Days Avai I abl e | CAH Hours | <u>Visits / Trips</u> Title V | |
| | | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | |
| | PART I – STATISTICAL DATA | | | | | | |
| . 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 | 70 | 25, 5 | 50 0.00 | 0 | 1.0 |
| 2.00 | HMO and other (see instructions) | | | | | | 2.0 |
| 8.00 | HMO IPF Subprovider | | | | | | 3.0 |
| I. 00 | HMO IRF Subprovider | | | | | | 4.0 |
| 5.00 | Hospital Adults & Peds. Swing Bed SNF | | | | | 0 | 5.0 |
| o. 00 | Hospital Adults & Peds. Swing Bed NF | | | | | 0 | 6.0 |
| . 00 | Total Adults and Peds. (exclude observation | | 70 | 25, 5 | 50 0.00 | 0 | 7.0 |
| 3. 00 | beds) (see instructions) | | | | | | 8.0 |
| 9.00 9.00 | I NTENSI VE CARE UNI T CORONARY CARE UNI T | | | | | | 9.0 |
| 0.00 | BURN INTENSIVE CARE UNIT | | | | | | 10.0 |
| 1.00 | SURGICAL INTENSIVE CARE UNIT | 34.00 | 10 | 3, 6 | 50 0.00 | 0 | |
| 2.00 | OTHER SPECIAL CARE (SPECIFY) | 34.00 | 10 | 5, 0. | 0.00 | 0 | 12.0 |
| 3.00 | NURSERY | 43.00 | | | | 0 | 13.0 |
| 4.00 | Total (see instructions) | 101 00 | 80 | 29, 20 | 0.00 | 0 | 14.0 |
| 5.00 | CAH visits | | | | | 0 | 15.0 |
| 6.00 | SUBPROVIDER - IPF | | | | | | 16.0 |
| 7.00 | SUBPROVIDER - IRF | | | | | | 17.0 |
| 8.00 | SUBPROVI DER | | | | | | 18. (|
| 9.00 | SKILLED NURSING FACILITY | | | | | | 19.0 |
| 0.00 | NURSING FACILITY | | | | | | 20.0 |
| 1.00 | OTHER LONG TERM CARE | | | | | | 21. (|
| 2.00 | HOME HEALTH AGENCY | | | | | | 22. (|
| 3.00 | AMBULATORY SURGICAL CENTER (D. P.) HOSPICE | | | | | | 23.0 |
| 4.00 4.10 | HOSPICE HOSPICE (non-distinct part) | 30.00 | | | | | 24. |
| 5.00 | CMHC - CMHC | 30.00 | | | | | 24. |
| 6.00 | RURAL HEALTH CLINIC | | | | | | 26. |
| 6. 25 | FEDERALLY QUALIFIED HEALTH CENTER | 89.00 | | | | 0 | |
| 7.00 | Total (sum of lines 14-26) | 07.00 | 80 | | | Ū | 27.0 |
| 8.00 | Observation Bed Days | | | | | 0 | |
| 9.00 | Ambul ance Trips | | | | | | 29. |
| 0.00 | Employee discount days (see instruction) | | | | | | 30. (|
| 1.00 | Employee discount days - IRF | | | | | | 31.0 |
| 2.00 | Labor & delivery days (see instructions) | | 0 | | 0 | | 32. (|
| 2. 01 | Total ancillary labor & delivery room outpatient days (see instructions) | | | | | | 32. (|
| 3. 00 | LTCH non-covered days | | | | | | 33.0 |
| 3. 01 | LTCH site neutral days and discharges | | | | | | 33.0 |
| 34.00 | Temporary Expansion COVID-19 PHE Acute Care | 30.00 | 0 | | 0 | 0 | 34.0 |

| IOSPI ⁻ | TAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC | AL DATA | Provider CO | CN: 15-0057 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-3 Part I Date/Time Pre 5/29/2023 3:2 | pared: |
|--------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------|--------------|-----------------------|---------------------------------------------|-----------------------------------------------------------|--------|
| | | I/P Days | / O/P Visits | / Trips | Full Time E | Equi val ents | |
| | Component | Title XVIII | Title XIX | Total All Patients | Total Interns & Residents | Employees On Payroll | |
| | PART I – STATISTICAL DATA | 6.00 | 7.00 | 8.00 | 9.00 | 10.00 | |
| . 00 | Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds) | 1, 986 | 34 | 5, 98 | 39 | | 1.0 |
| 2.00 | HMO and other (see instructions) | 1, 956 | 1, 650 | | | | 2.0 |
| 3.00 | HMO I PF Subprovi der | 0 | 0 | | | | 3.0 |
| l. 00 | HMO IRF Subprovider | 0 | 0 | | | | 4.0 |
| 5.00 | Hospital Adults & Peds. Swing Bed SNF | 0 | 0 | | 0 | | 5.0 |
| o. 00 | Hospital Adults & Peds. Swing Bed NF | | 0 | | 0 | | 6.0 |
| . 00 | Total Adults and Peds. (exclude observation beds) (see instructions) | 1, 986 | 34 | 5, 98 | 39 | | 7.0 |
| 3.00 | INTENSIVE CARE UNIT | | | | | | 8.0 |
| 0.00 | CORONARY CARE UNIT | | | | | | 9.0 |
| 0.00 | BURN INTENSIVE CARE UNIT | 492 | 0 | 1 4- | 70 | | 10. C |
| 2.00 | SURGI CAL INTENSI VE CARE UNI T OTHER SPECIAL CARE (SPECIFY) | 492 | 0 | 1, 47 | 10 | | 12.0 |
| 3.00 | NURSERY | | 1 | 58 | 24 | | 13.0 |
| 4.00 | Total (see instructions) | 2, 478 | 35 | | | 296.54 | |
| 5.00 | CAH visits | 2, 1, 0 | 0 | 0,00 | 0 | 270.01 | 15.0 |
| 6.00 | SUBPROVIDER - IPF | | | | - | | 16.0 |
| 7.00 | SUBPROVIDER - IRF | | | | | | 17. (|
| 8.00 | SUBPROVI DER | | | 1 | | | 18. (|
| 9.00 | SKILLED NURSING FACILITY | | | | | | 19.0 |
| 0.00 | NURSING FACILITY | | | | | | 20.0 |
| 1.00 | OTHER LONG TERM CARE | | | | | | 21. (|
| 2.00 | HOME HEALTH AGENCY | | | | | | 22. |
| 3.00 | AMBULATORY SURGICAL CENTER (D. P.) | | | | | | 23.0 |
| 4.00 | HOSPICE | | | | 0 | | 24. |
| 4.10 | HOSPICE (non-distinct part) | | | | 0 | | 24. |
| 5.00 6.00 | CMHC – CMHC RURAL HEALTH CLINIC | | | | | | 26. |
| 6.25 | FEDERALLY QUALIFIED HEALTH CENTER | 0 | 0 | | 0 0.00 | 0.00 | |
| 7.00 | Total (sum of lines 14-26) | 0 | 0 | | 0,00 | 296.54 | |
| 8.00 | Observation Bed Days | | 284 | 1, 75 | | 270101 | 28. |
| 9.00 | Ambul ance Trips | 0 | | , | - | | 29.0 |
| 0. 00 | Employee discount days (see instruction) | | | | 0 | | 30.0 |
| 1. 00 | Employee discount days - IRF | | | | 0 | | 31. |
| 2.00 | Labor & delivery days (see instructions) | 0 | 87 | 12 | 26 | | 32. |
| 2. 01 | Total ancillary labor & delivery room | | | | 0 | | 32. |
| | outpatient days (see instructions) | | | | | | |
| 3.00 | LTCH non-covered days | 0 | | | | | 33. |
| 33.01 | LTCH site neutral days and discharges | 0 | - | | | | 33.0 |
| 4.00 | Temporary Expansion COVID-19 PHE Acute Care | 0 | 0 | | 0 | | 34. |

| OSPI T | AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC | AL DATA | Provider CO | CN: 15-0057 | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-3 Part I Date/Time Prep 5/29/2023 3:28 | parec |
|--------|-----------------------------------------------|------------------|-------------|-------------|---------------------------------------------|-------------------------------------------------------------|-------|
| | | Full Time | | Di s | charges | | |
| | | Equi val ents | | | T I. I. VI.V | T | |
| | Component | Nonpai d | Title V | Title XVIII | Title XIX | Total All | |
| | | Workers 11.00 | 12.00 | 13.00 | 14.00 | Patients 15.00 | |
| | PART I - STATISTICAL DATA | 11.00 | 12.00 | 13.00 | 14.00 | 15.00 | |
| . 00 | Hospital Adults & Peds. (columns 5, 6, 7 and | | 0 | 73 | 32 13 | 2, 256 | 1. |
| | 8 exclude Swing Bed, Observation Bed and | | 0 | | | 2,200 | |
| | Hospice days) (see instructions for col. 2 | | | | | | |
| | for the portion of LDP room available beds) | | | | | | |
| . 00 | HMO and other (see instructions) | | | 39 | 97 642 | | 2. |
| 00 | HMO I PF Subprovider | | | | 0 | | 3. |
| 00 | HMO IRF Subprovider | | | | 0 | | 4. |
| .00 | Hospital Adults & Peds. Swing Bed SNF | | | | - | | 5. |
| . 00 | Hospital Adults & Peds. Swing Bed NF | | | | | | 6. |
| .00 | Total Adults and Peds. (exclude observation | | | | | | 7. |
| | beds) (see instructions) | | | | | | |
| . 00 | INTENSIVE CARE UNIT | | | | | | 8. |
| 00 | CORONARY CARE UNIT | | | | | | 9. |
|), 00 | BURN INTENSIVE CARE UNIT | | | | | | 10 |
| 1.00 | SURGICAL INTENSIVE CARE UNIT | | | | | | 11 |
| 2.00 | OTHER SPECIAL CARE (SPECIFY) | | | | | | 12 |
| 3.00 | NURSERY | | | | | | 13. |
| 4.00 | Total (see instructions) | 0, 00 | 0 | 73 | 32 13 | 2, 256 | 14 |
| 5.00 | CAH visits | | | | | , | 15. |
| 6.00 | SUBPROVIDER - IPF | | | | | | 16. |
| 7.00 | SUBPROVIDER - IRF | | | | | | 17. |
| B. 00 | SUBPROVIDER | | | | | | 18. |
| 9.00 | SKILLED NURSING FACILITY | | | | | | 19. |
| D. 00 | NURSING FACILITY | | | | | | 20. |
| 1.00 | OTHER LONG TERM CARE | | | | | | 21. |
| 2.00 | HOME HEALTH AGENCY | | | | | | 22 |
| 3.00 | AMBULATORY SURGICAL CENTER (D. P.) | | | | | | 23 |
| 1.00 | HOSPI CE | | | | | | 24 |
| 4. 10 | HOSPICE (non-distinct part) | | | | | | 24. |
| 5.00 | CMHC - CMHC | | | | | | 25. |
| 5.00 | RURAL HEALTH CLINIC | | | | | | 26 |
| 5. 25 | FEDERALLY QUALIFIED HEALTH CENTER | 0.00 | | | | | 26 |
| 1.00 | Total (sum of lines 14-26) | 0.00 | | | | | 27 |
| 3. 00 | Observation Bed Days | | | | | | 28 |
| 00 . | Ambulance Trips | | | | | | 29 |
| 0. 00 | Employee discount days (see instruction) | | | | | | 30. |
| 1.00 | Employee discount days - IRF | | | | | | 31. |
| 2.00 | Labor & delivery days (see instructions) | | | | | | 32. |
| 2. 01 | Total ancillary labor & delivery room | | | | | | 32. |
| | outpatient days (see instructions) | | | | | | |
| 3.00 | LTCH non-covered days | | | | 0 | | 33. |
| 3. 01 | LTCH site neutral days and discharges | | | | 0 | | 33. |
| 4 00 | Temporary Expansion COVID-19 PHE Acute Care | | | | | | 34. |

| PLL | AL WAGE INDEX INFORMATION | | | Provider CC | | Period: From 01/01/2022 To 12/31/2022 | | pare |
|----------|----------------------------------------------------------------|------------------------|--------------------|---------------------------------------------------------|---------------------------------------------|---------------------------------------------|---------------------------------------------|------|
| | | Wkst. A Line Number | Amount Reported | Reclassificati on of Salaries (from Wkst. A-6) | Adjusted Salaries (col.2 ± col. 3) | Related to | Average Hourly Wage (col. 4 ÷ col. 5) | |
| | | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | 6.00 | |
| | PART II - WAGE DATA SALARIES | | | | | | | 1 |
| 0 | Total salaries (see | 200. 00 | 25, 827, 798 | 3 0 | 25, 827, 79 | 8 629, 702. 00 | 41.02 | 1 |
| ~ | instructions) Non abuaician anasthatist Dant | | | | | 0 0 00 | 0.00 | |
| 0 | Non-physician anesthetist Part A | | C | 0 | | 0 0.00 | 0.00 | 2 |
| 0 | Non-physician anesthetist Part | | C | 0 | | 0.00 | 0.00 | |
| 0 | B Physician-Part A - | | C | | | 0.00 | 0. 00 | |
| 0 | Administrative | | Ĺ | | | 0.00 | 0.00 | |
| 1 | Physicians - Part A - Teaching | | C | - | | 0.00 | | |
| 0 | Physician and Non Physician-Part B | | C | 0 | | 0.00 | 0.00 | Ę |
| 0 | Non-physician-Part B for | | C | 0 | | 0.00 | 0.00 | 6 |
| | hospital-based RHC and FQHC | | | | | | | |
| 0 | services | 21 00 | C | | | 0.00 | 0.00 | 7 |
| U | Interns & residents (in an approved program) | 21.00 | Ĺ | , 0 | | 0 0.00 | 0.00 | |
| 1 | Contracted interns and | | C | 0 | | 0.00 | 0.00 | |
| | residents (in an approved programs) | | | | | | | |
| 0 | Home office and/or related | | C | 0 | | 0.00 | 0.00 | 8 |
| | organization personnel | | | | | | | |
| 0 00 | SNF Excluded area salaries (see | 44.00 | C 538, 575 | | 538, 57 | 0 0.00 5 13,521.00 | | |
| 00 | instructions) | | 556, 575 | | 556, 57 | 5 13, 521.00 | 57.03 | |
| | OTHER WAGES & RELATED COSTS | | | | | | | 1 |
| 00 | Contract Labor: Direct Patient Care | | 572, 805 | 0 | 572, 80 | 5 5, 254. 25 | 109. 02 | 1 |
| 00 | Contract Labor: Top Level | | C | 0 | | 0.00 | 0.00 | 1: |
| | management and other | | | | | | | |
| | management and administrative services | | | | | | | |
| 00 | Contract Labor: Physician-Part | | 88, 636 | 0 | 88, 63 | 6 594.06 | 149.20 | 1: |
| ~ ~ | A - Administrative | | | | | | | |
| 00 | Home office and/or related organization salaries and | | C | | | 0.00 | 0.00 | 14 |
| | wage-related costs | | | | | | | |
| | Home office salaries | | 3, 434, 152 | 1 | 3, 434, 15 | | | |
| 02 00 | Related organization salaries Home office: Physician Part A | | C | - | | 0 0.00 0 0.00 | | |
| | - Administrative | | | | | | | |
| 00 | Home office and Contract | | C | 0 0 | | 0.00 | 0.00 | 10 |
| 01 | Physicians Part A - Teaching Home office Physicians Part A | | C | 0 | | 0.00 | 0.00 | 1 |
| | - Teaching | | | | | | | |
| 02 | Home office contract Physicians Part A - Teaching | | C | 0 | | 0 0.00 | 0. 00 | 10 |
| | WAGE-RELATED COSTS | | | | | | | |
| 00 | Wage-related costs (core) (see | | 6, 908, 247 | 0 | 6, 908, 24 | 7 | | 17 |
| 00 | instructions) Wage-related costs (other) | | | | | | | 18 |
| | (see instructions) | | | | | | | |
| 00 | Excluded areas | | 147, 122 | 0 | 147, 12 | 2 | | 19 |
| 00 | Non-physician anesthetist Part A | | C | | | U | | 20 |
| 00 | Non-physician anesthetist Part | | C | 0 | | ο | | 2' |
| 00 | B Dhyci ci an Dart A | | ~ | | | n | | 1 |
| 00 | Physician Part A - Administrative | | Ĺ | | | | | 22 |
| 01 | Physician Part A - Teaching | | C | 0 | | 0 | | 2 |
| 00 | Physician Part B | | C | 0 | | 0 | | 2: |
| 00 00 | Wage-related costs (RHC/FQHC) Interns & residents (in an | | C | | | 0 | | 24 |
| | approved program) | | | | | | | |
| 50 | Home office wage-related | | 986, 940 | 0 | 986, 94 | 0 | | 2 |
| 51 | (core) Related organization | | C | | | 0 | | 2! |
| 51 | wage-related (core) | | C | | | | | |
| 52 | Home office: Physician Part A | | C | | | 0 | | 25 |
| | - Administrative - wage-related (core) | | | | | | | 1 |

| | Financial Systems | FF | RANCI SCAN HEAL | TH MOORESVILLE | | | u of Form CMS-2 | |
|-----------|-----------------------------------------------------------------------|------------------------|-----------------|---------------------------------------------------------|------------|---------------------------------------------|-------------------------------------------------------------|--------|
| HOSPI 1 | TAL WAGE INDEX INFORMATION | | | Provider C | | Period: From 01/01/2022 To 12/31/2022 | Worksheet S-3 Part II Date/Time Pre 5/29/2023 3:23 | pared: |
| | | Wkst. A Line Number | | Reclassificati on of Salaries (from Wkst. A-6) | | Related to | Average Hourly Wage (col. 4 ÷ col. 5) | |
| | | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | 6.00 | |
| 25.53 | Home office: Physicians Part A - Teaching - wage-related (core) | | 0 | 0 | | 0 | | 25.5 |
| o (o o | OVERHEAD COSTS - DI RECT SALARI E | | | | | 0 0 00 | 0.00 | |
| 26.00 | Employee Benefits Department | 4.00 | 0 | 0 | | 0 0.00 | | |
| 27.00 | Administrative & General | 5.00 | 686, 783 | | 686, 78 | | | |
| 28.00 | Administrative & General under | | 443, 360 | 0 | 443, 36 | 4, 105. 65 | 107. 99 | 28.00 |
| | contract (see inst.) | (00 | | | | | 0.00 | |
| 29.00 | Maintenance & Repairs | 6.00 | 0 | 0 | 1 100 00 | 0.00 | | 29.00 |
| 30.00 | Operation of Plant | 7.00 | 1, 198, 995 | | 1, 198, 99 | | | |
| 31.00 | Laundry & Linen Service | 8.00 | 46, 954 | | 46, 95 | | | |
| 32.00 | Housekeeping | 9.00 | 1, 247, 471 | 0 | 1, 247, 47 | | | |
| 33.00 | Housekeeping under contract (see instructions) | | 0 | 0 | | 0 0.00 | 0.00 | 33.00 |
| 34.00 | Dietary | 10. 00 | 438, 638 | -314, 318 | 124, 32 | 5, 440. 00 | 22.85 | |
| 35.00 | Dietary under contract (see instructions) | | 0 | 0 | | 0 0.00 | 0.00 | 35.00 |
| 36.00 | Cafeteri a | 11.00 | 37, 693 | 314, 318 | 352, 01 | 1 15, 634. 00 | 22. 52 | 36.00 |
| 37.00 | Maintenance of Personnel | 12.00 | 0 | 0 | | 0 0.00 | 0.00 | 37.00 |
| 38.00 | Nursing Administration | 13.00 | 589, 353 | 0 | 589, 35 | 3 11, 131. 00 | 52.95 | 38.00 |
| 39.00 | Central Services and Supply | 14.00 | 148, 753 | 0 | 148, 75 | 6, 429. 00 | 23. 14 | 39.00 |
| 40.00 | Pharmacy | 15.00 | 1,084,459 | | 1, 084, 45 | | | |
| 41.00 | Medical Records & Medical Records Library | 16.00 | 0 | 0 | | 0 0.00 | | 41.00 |
| 42.00 | Soci al Servi ce | 17.00 | 0 | 0 | | 0 0.00 | 0.00 | 42.00 |
| 43.00 | Other General Service | 18.00 | 0 | 0 | | 0 0.00 | | 43.00 |

| Heal th | Financial Systems | FI | RANCI SCAN HEAL | TH MOORESVILLE | | In Lie | eu of Form CMS-2 | 2552-10 |
|---------|--------------------------------------------------|-------------|-----------------|-------------------|---------------|---------------------------------------------|------------------|---------|
| HOSPI T | AL WAGE INDEX INFORMATION | | | Provider CC | | Period: From 01/01/2022 To 12/31/2022 | | |
| | | Worksheet A | | Recl assi fi cati | | | Average Hourly | |
| | | Line Number | Reported | on of Salaries | | | Wage (col. 4 ÷ | |
| | | | | (from | (col.2 ± col. | Salaries in | col. 5) | |
| | | | | Worksheet A-6) | 3) | col. 4 | | |
| | | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | 6.00 | |
| | PART III - HOSPITAL WAGE INDEX | SUMMARY | | | | | | |
| 1.00 | Net salaries (see | | 26, 271, 158 | 0 | 26, 271, 15 | 8 633, 807. 65 | 41.45 | 1.00 |
| | instructions) | | | | | | | |
| 2.00 | Excluded area salaries (see instructions) | | 538, 575 | 0 | 538, 57 | 5 13, 521. 00 | 39. 83 | 2.00 |
| 3.00 | Subtotal salaries (line 1 minus line 2) | | 25, 732, 583 | 0 | 25, 732, 58 | 3 620, 286. 65 | 41.48 | 3.00 |
| 4.00 | Subtotal other wages & related costs (see inst.) | | 4, 095, 593 | 0 | 4, 095, 59 | 3 104, 019. 31 | 39. 37 | 4.00 |
| 5.00 | Subtotal wage-related costs (see inst.) | | 7, 895, 187 | 0 | 7, 895, 18 | 7 0.00 | 30. 68 | 5.00 |
| 6.00 | Total (sum of lines 3 thru 5) | | 37, 723, 363 | 0 | 37, 723, 36 | 3 724, 305. 96 | 52.08 | 6.00 |
| 7.00 | Total overhead cost (see instructions) | | 5, 922, 459 | 0 | 5, 922, 45 | 9 191, 832. 65 | 30. 87 | 7.00 |

| | Financial Systems FRANCISCAN HEALT | | | u of Form CMS-2 | |
|--------|----------------------------------------------------------------------------------------|----------------------------|----------------------------------------------|-----------------|-------|
| OSPI T | AL WAGE RELATED COSTS | Provider CCN: 15-0057 | Peri od: From 01/01/2022 To 12/31/2022 | | pared |
| | | | | Amount | |
| | | | | Reported | |
| | PART IV - WAGE RELATED COSTS | | | 1.00 | |
| | Part A - Core List | | | | |
| | RETI REMENT COST | | | | |
| 00 | 401K Employer Contributions | | | 726, 923 | 1 1.0 |
| . 00 | Tax Sheltered Annuity (TSA) Employer Contribution | | | ,20, ,20 | |
| . 00 | Nonqualified Defined Benefit Plan Cost (see instructions) | | | 0 | |
| . 00 | Qualified Defined Benefit Plan Cost (see instructions) | | | 1, 343, 775 | |
| | PLAN ADMINISTRATIVE COSTS (Paid to External Organization) | | | | |
| . 00 | 401K/TSA Pl an Administration fees | | | 0 | 5.0 |
| . 00 | Legal /Accounting/Management Fees-Pension Plan | | | 0 | 6. (|
| . 00 | Employee Managed Care Program Administration Fees | | | 0 | 7.0 |
| | HEALTH AND INSURANCE COST | | | | |
| 00 | Health Insurance (Purchased or Self Funded) | | | 0 | 8. |
| 01 | Health Insurance (Self Funded without a Third Party Administ | | | 0 | l 0. |
| 02 | Health Insurance (Self Funded with a Third Party Administra | tor) | | 3, 208, 918 | |
| 03 | Health Insurance (Purchased) | | | 0 | - |
| 00 | Prescription Drug Plan | | | 0 | |
| 0. 00 | Dental, Hearing and Vision Plan | | | 119, 845 | |
| 1.00 | Life Insurance (If employee is owner or beneficiary) | | | 16, 379 | |
| 2.00 | Accident Insurance (If employee is owner or beneficiary) | | | | 12. |
| 3.00 | Disability Insurance (If employee is owner or beneficiary) | 、 、 | | 139, 522 | |
| 1.00 | Long-Term Care Insurance (If employee is owner or beneficial | ry) | | | 14. |
| 5.00 | 'Workers' Compensation Insurance | reardinery accruct require | d by FACD 10/ | 316, 827 | |
| 5.00 | Retirement Health Care Cost (Only current year, not the exti Noncumulative portion) | raordinary accruai require | ed by FASB 106. | 0 | 16. |
| | TAXES | | | | |
| 00 | FICA-Employers Portion Only | | | 2, 227, 117 | 17 |
| . 00 | Medicare Taxes - Employers Portion Only | | | 0 | |
| . 00 | Unemployment Insurance | | | 0 | |
| | State or Federal Unemployment Taxes | | | 0 | |
| | OTHER | | | | |
| . 00 | Executive Deferred Compensation (Other Than Retirement Cost instructions)) | Reported on lines 1 throu | ugh 4 above. (see | 0 | 21. |
| . 00 | Day Care Cost and Allowances | | | 0 | 22. |
| | Tuition Reimbursement | | | 0 | |
| l. 00 | Total Wage Related cost (Sum of lines 1 -23) | | | 8, 099, 306 | 24. |
| | Part B - Other than Core Related Cost | | | | 1 |
| 5 00 | OTHER WAGE RELATED COSTS (SPECIFY) | | | | 25.0 |

| Heal th | Financial Systems | FRANCI SCAN HEALTH | MOORESVI LLE | In Lie | u of Form CMS-2 | 2552-10 |
|---------|--------------------------------------------|--------------------|-----------------------|-----------------|--------------------------------|---------|
| HOSPI T | AL CONTRACT LABOR AND BENEFIT COST | | Provider CCN: 15-0057 | Peri od: | Worksheet S-3 | |
| | | | | From 01/01/2022 | | norod. |
| | | | | To 12/31/2022 | Date/Time Pre 5/29/2023 3:2 | |
| | Cost Center Description | | | Contract Labor | | |
| | | | | 1.00 | 2.00 | |
| | PART V - Contract Labor and Benefit Cost | | | | | |
| | Hospital and Hospital-Based Component Iden | ti fi cati on: | | | | |
| 1.00 | Total facility's contract labor and benefi | t cost | | 572, 805 | 6, 908, 247 | 1.00 |
| 2.00 | Hospi tal | | | 572, 805 | 6, 908, 247 | 2.00 |
| 3.00 | SUBPROVIDER - IPF | | | | | 3.00 |
| 4.00 | SUBPROVIDER – IRF | | | | | 4.00 |
| 5.00 | Subprovider - (Other) | | | 0 | 0 | 5.00 |
| 6.00 | Swing Beds - SNF | | | 0 | 0 | 6.00 |
| 7.00 | Swing Beds - NF | | | 0 | 0 | 7.00 |
| 8.00 | SKILLED NURSING FACILITY | | | | | 8.00 |
| 9.00 | NURSING FACILITY | | | | | 9.00 |
| 10.00 | OTHER LONG TERM CARE I | | | | | 10.00 |
| 11.00 | Hospital-Based HHA | | | | | 11.00 |
| 12.00 | AMBULATORY SURGICAL CENTER (D. P.) I | | | | | 12.00 |
| 13.00 | Hospi tal -Based Hospi ce | | | | | 13.00 |
| 14.00 | Hospital-Based Health Clinic RHC | | | | | 14.00 |
| 15.00 | Hospital-Based Health Clinic FQHC | | | | | 15.00 |
| 16.00 | Hospital-Based-CMHC | | | | | 16.00 |
| 17.00 | RENAL DIALYSIS I | | | 0 | 0 | 17.00 |
| 18.00 | Other | | | 0 | 0 | 18.00 |
| | | | | | | |

| Heal th | Financial Systems FRANCISCAN HEALTH MC | ORESVI LLE | | In Lie | eu of Form CMS-2 | 2552-10 |
|-----------------|------------------------------------------------------------------------------------------------|----------------------|---------|--------------------------------|------------------|---------------|
| HOSPI T | AL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-00 | | eri od: | Worksheet S-1 | 0 |
| | | | | rom 01/01/2022 o 12/31/2022 | | pared: |
| | | | - | | 5/29/2023 3:2 | |
| | | | | | 1.00 | |
| | Uncompensated and indigent care cost computation | | | | 1.00 | |
| 1.00 | Cost to charge ratio (Worksheet C, Part I line 202 column 3 div | ided by line 202 c | n n n | 8) | 0. 175148 | 1.00 |
| | Medicaid (see instructions for each line) | 1464 59 1116 262 6 | | 0) | 011/0110 | |
| 2.00 | Net revenue from Medicaid | | | | 14, 182, 892 | 2.00 |
| 3.00 | Did you receive DSH or supplemental payments from Medicaid? | | | | N | 3.00 |
| 4.00 | If line 3 is yes, does line 2 include all DSH and/or supplement | | edi cai | d? | N | 4.00 |
| 5.00 | If line 4 is no, then enter DSH and/or supplemental payments fr | om Medicaid | | | 0 | 5.00 |
| 6.00 | Medi cai d charges | | | | 95, 830, 516 | 6.00 |
| 7.00 | Medicaid cost (line 1 times line 6) | line 7 minus sum s | Fline | o D and E. if | 16, 784, 523 | 7.00 |
| 8.00 | Difference between net revenue and costs for Medicaid program (< zero then enter zero) | | TThe | | 2, 601, 631 | 8.00 |
| 0.00 | Children's Health Insurance Program (CHIP) (see instructions fo | r each line) | | | | 0.00 |
| 9. 00 10. 00 | Net revenue from stand-alone CHIP Stand-alone CHIP charges | | | | 0 | 9.00 10.00 |
| | Stand-alone CHIP cost (line 1 times line 10) | | | | 0 | 11.00 |
| | Difference between net revenue and costs for stand-alone CHIP (| line 11 minus line | 9∙if | < zero then | 0 | 12.00 |
| 12.00 | enter zero) | | , | | , o | 12.00 |
| | Other state or local government indigent care program (see inst | | | | | |
| 13.00 | Net revenue from state or local indigent care program (Not incl | | | | 0 | 13.00 |
| 14.00 | Charges for patients covered under state or local indigent care 10) | program (Not inclu | uded i | n lines 6 or | 0 | 14.00 |
| 15.00 | State or local indigent care program cost (line 1 times line 14 |) | | | 0 | 15.00 |
| 16.00 | Difference between net revenue and costs for state or local ind | igent care program | (line | 15 minus line | 0 | 16.00 |
| | 13; if < zero then enter zero) | | | | | |
| | Grants, donations and total unreimbursed cost for Medicaid, CHI | P and state/local i | ndi ge | nt care program | ns (see | |
| 17.00 | instructions for each line) Private grants, donations, or endowment income restricted to fu | nding charity care | | | 0 | 17.00 |
| | Government grants, appropriations or transfers for support of h | | | | 0 0 | 18.00 |
| | Total unreimbursed cost for Medicaid , CHIP and state and local 8, 12 and 16) | | grams | (sum of lines | 2, 601, 631 | 19. 00 |
| | | Uni nsu | ired | Insured | Total (col. 1 | |
| | | patie | | pati ents | + col. 2) | |
| | | 1.0 | 0 | 2.00 | 3.00 | |
| 20.00 | Uncompensated Care (see instructions for each line) | : : + 10.0 | 88, 488 | 3, 530, 791 | 15, 919, 279 | 20.00 |
| 20.00 | Charity care charges and uninsured discounts for the entire fac (see instructions) | 111Ly 12, 5 | 00, 400 | 3, 530, 791 | 15, 919, 279 | 20.00 |
| 21.00 | Cost of patients approved for charity care and uninsured discou instructions) | nts (see 2, 1 | 69, 819 | 3, 530, 791 | 5, 700, 610 | 21.00 |
| 22.00 | Payments received from patients for amounts previously written | off as | 0 | 0 | 0 | 22.00 |
| 23.00 | charity care Cost of charity care (line 21 minus line 22) | 2, 1 | 69, 819 | 3, 530, 791 | 5, 700, 610 | 23.00 |
| | | | | | 1.00 | |
| 24.00 | Does the amount on line 20 column 2, include charges for patien | t davic haviand a la | ath a | f ctov limit | 1.00 N | 24.00 |
| 24.00 | imposed on patients covered by Medicaid or other indigent care | | igtii 0 | i stay i i ilii t | IN | 24.00 |
| 25.00 | If line 24 is yes, enter the charges for patient days beyond th stay limit | | ogram' | s length of | 0 | 25.00 |
| 26.00 | Total bad debt expense for the entire hospital complex (see ins | tructions) | | | 1, 920, 576 | 26.00 |
| | Medicare reimbursable bad debts for the entire hospital complex | |) | | 134, 383 | |
| | Medicare allowable bad debts for the entire hospital complex (s | | | | 206, 743 | |
| 28.00 | Non-Medicare bad debt expense (see instructions) | , | | | 1, 713, 833 | |
| | Cost of non-Medicare and non-reimbursable Medicare bad debt exp | ense (see instructi | ons) | | 372, 534 | |
| | Cost of uncompensated care (line 23 column 3 plus line 29) | 20) | | | 6, 073, 144 | |
| 31.00 | Total unreimbursed and uncompensated care cost (line 19 plus li | ne 30) | | | 8, 674, 775 | 31.00 |

| | Financial Systems Ff SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF | RANCI SCAN_HEALTH = EXPENSES | Provi der CC | | eriod: | u of Form CMS-2 Worksheet A | 2552-10 |
|----------------------------|---------------------------------------------------------------------|---------------------------------|-------------------------|----------------------------|---------------------------------|--------------------------------------------------------|---------|
| | | | | | rom 01/01/2022 o 12/31/2022 | Date/Time Pre 5/29/2023 3:23 | |
| | 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 | |
| 1 00 | GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT | | 2 504 221 | 2 504 221 | 2 200 402 | E 704 700 | 1 1 00 |
| 1.00 2.00 | 00200 CAP REL COSTS-BLDG & FIXT | | 3, 584, 321 | 3, 584, 321 | | 5, 784, 723 160, 266 | |
| 4.00 | 00400 EMPLOYEE BENEFITS DEPARTMENT | o | 6, 233, 597 | - | | 6, 233, 597 | |
| 5.01 | 00570 ADMI TTI NG | Ö | 1, 643 | | | 24 | |
| 5.02 | 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE | 0 | 0 | 0 | | 0 | 5.02 |
| 5.03 | 00590 OTHER ADMIN & GENERAL | 686, 783 | 7,062,588 | 7, 749, 371 | -195, 714 | 7, 553, 657 | |
| 7.00 | 00700 OPERATION OF PLANT | 1, 198, 995 | 3, 243, 997 | 4, 442, 992 | | 4, 321, 827 | |
| 8.00 | 00800 LAUNDRY & LINEN SERVICE | 46, 954 | 98, 948 | | | 144, 833 | |
| 9.00 | 00900 HOUSEKEEPI NG 01000 DI ETARY | 1, 247, 471 | 307, 360 | | | 1, 515, 629 | 1 |
| 10.00 11.00 | 01100 CAFETERIA | 438, 638 37, 693 | 183, 786 135, 196 | | | 168, 207 573, 577 | |
| 13.00 | 01300 NURSI NG ADMI NI STRATI ON | 589, 353 | 17, 874 | | | 599, 578 | |
| 14.00 | 01400 CENTRAL SERVICES & SUPPLY | 148, 753 | 132, 684 | | | 260, 219 | |
| 15.00 | 01500 PHARMACY | 1, 084, 459 | 2, 307, 423 | | | 1, 110, 043 | |
| 16.00 | 01600 MEDICAL RECORDS & LIBRARY | 0 | 0 | 0 | 0 | 0 | 16.00 |
| 21.00 | 02100 I &R SERVICES-SALARY & FRINGES APPRV | 0 | 0 | 0 | | 0 | |
| 22.00 | 02200 I & R SERVI CES-OTHER PRGM COSTS APPRV | 0 | 0 | 0 | 0 | 0 | 22.00 |
| 20.00 | I NPATI ENT ROUTI NE SERVI CE COST CENTERS | F 100 700 | 2 207 021 | 0 525 720 | 0.774.040 | F 7(0 007 | 1 20 00 |
| 30.00 34.00 | 03000 ADULTS & PEDIATRICS 03400 SURGICAL INTENSIVE CARE UNIT | 5, 138, 708 1, 860, 982 | 3, 397, 031 623, 713 | | | 5, 760, 897 2, 302, 118 | |
| 43.00 | 04300 NURSERY | 1, 800, 982 | 023, 713 | 2,404,095 | | 505, 857 | |
| 45.00 | ANCI LLARY SERVICE COST CENTERS | <u> </u> | 0 | | 505,057 | 303, 037 | 40.00 |
| 50.00 | 05000 OPERATI NG ROOM | 2, 303, 787 | 13, 856, 805 | 16, 160, 592 | -13, 515, 080 | 2, 645, 512 | 50.00 |
| 52.00 | 05200 DELIVERY ROOM & LABOR ROOM | 1, 668 | 169 | 1, 837 | 1, 797, 427 | 1, 799, 264 | 52.00 |
| 54.00 | 05400 RADI OLOGY-DI AGNOSTI C | 2, 008, 801 | 796, 536 | 2, 805, 337 | | 2, 302, 836 | 54.00 |
| 55.00 | 05500 RADI OLOGY-THERAPEUTI C | 474, 156 | 4, 224, 476 | | | 4, 107, 581 | |
| 60.00 | | 0 | 3, 540, 242 | | | 3, 207, 345 | |
| 64.00 65.00 | 06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY | 755, 530 | 14, 509, 590 | | | 1,029,402 | |
| 66.00 | 06600 PHYSI CAL THERAPY | 1, 449, 657 1, 598, 502 | 300, 434 83, 312 | 1, 750, 091 1, 681, 814 | | 1, 500, 036 1, 616, 275 | |
| 67.00 | 06700 OCCUPATI ONAL THERAPY | 222, 437 | 14, 107 | | | 224, 468 | |
| 68.00 | 06800 SPEECH PATHOLOGY | 31, 992 | 3, 050 | | | 34, 877 | |
| 69.00 | 06900 ELECTROCARDI OLOGY | 277, 795 | 112, 124 | | | 369, 757 | |
| 70.00 | 07000 ELECTROENCEPHALOGRAPHY | 14, 898 | 57, 818 | 72, 716 | -46, 678 | 26, 038 | |
| | 07100 MEDICAL SUPPLIES CHARGED TO PATIENT | 0 | 0 | 0 | _/ • • · / = • · | 2, 861, 201 | |
| 72.00 | 07200 I MPL. DEV. CHARGED TO PATIENTS | 0 | 0 | 0 | | 10, 220, 623 | |
| | 07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS | 0 | 0 | | | 17, 736, 784 0 | 1 |
| | 07700 ALLOGENEIC STEM CELL ACQUISITION | 0 | 0 | | | 0 | |
| //.00 | OUTPATIENT SERVICE COST CENTERS | | | | 0 | 0 | //.00 |
| 90.00 | 09000 CLI NI C | 0 | 0 | 0 | 0 | 0 | 90.00 |
| | 09001 WOUND CARE INSTITUTE | 7, 192 | 1, 219 | | | 7, 192 | 90.01 |
| 90. 02 | 09002 OP NUTRITIONAL COUNSELING | 47, 381 | 832 | | | 47, 866 | |
| | 09100 EMERGENCY | 3, 616, 638 | 3, 343, 843 | 6, 960, 481 | -500, 344 | 6, 460, 137 | |
| 92.00 | 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART | | | | | | 92.00 |
| 102.00 | OTHER REIMBURSABLE COST CENTERS | 0 | 0 | 0 | 0 | 0 | 102.00 |
| 102.00 | SPECIAL PURPOSE COST CENTERS | U | 0 | 0 | 0 | 0 | 102.00 |
| 113.00 | 11300 I NTEREST EXPENSE | | -284, 588 | -284, 588 | 284, 588 | 0 | 113.00 |
| 118.00 | | 25, 289, 223 | 67, 890, 130 | | | 93, 192, 246 | |
| | NONREI MBURSABLE COST CENTERS | | | | | | |
| | 19000 GIFT FLOWER COFFEE SHOP & CANTEEN | 41, 677 | 64, 967 | | | 106, 644 | |
| | 19200 PHYSI CI ANS PRI VATE OFFI CES | 284, 506 | 172, 556 | | | 444, 520 | |
| 10/ 00 | 07950 COMMUNITY RELATIONS & MARKETING | 0 | 102,200 | 0 | - | | 194.00 |
| | 07951 PLAINFIELD RADIOLOGY & PHYSICAL THE | 212, 392 | 193, 299 | 405, 691 | 0 | 405, 691 | |
| 194.01 | | | <u>^</u> | | | ∩ | 1101 00 |
| 194.01 194.02 | 07952 JV MV ENDOSCOPY | 0 | 0 | | 0 | | 194.02 |
| 194.01 194.02 194.03 | | 0 0 0 | 0 0 17, 784, 413 | 0 0 17, 784, 413 | 0 0 -351 | | 194.03 |

| ECLASS | IFICATION AND ADJUSTMENTS OF TRIAL BALANCE O | F EXPENSES | Provider CCN: 15-005 | 7 Period: From 01/01/2022 To 12/31/2022 | Worksheet A Date/Time Prepare 5/29/2023 3:28 pt |
|--------|--------------------------------------------------------------------------|--------------------------|--------------------------------|-----------------------------------------------|-------------------------------------------------------|
| | Cost Center Description | Adjustments (See A-8) | Net Expenses For Allocation | | |
| | | 6.00 | 7.00 | | |
| | SENERAL SERVICE COST CENTERS | | | | |
| | 00100 CAP REL COSTS-BLDG & FIXT | 1, 266, 298 | | | 1 |
| | 00200 CAP REL COSTS-MVBLE EQUIP | C | 100,200 | | 2 |
| | 00400 EMPLOYEE BENEFITS DEPARTMENT | 1, 204, 023 | | | 4 |
| | 00570 ADMI TTI NG | C | | | 5 |
| | 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE | C | 0 | | 5 |
| | 00590 OTHER ADMIN & GENERAL | 25, 269, 263 | | | 5 |
| | 00700 OPERATION OF PLANT | 907, 801 | | | 7 |
| | 00800 LAUNDRY & LINEN SERVICE | -20, 871 | | | 8 |
| | 00900 HOUSEKEEPI NG | -21,038 | | | 9 |
| | D1000 DI ETARY | -1,068 | | | 10 |
| | 01100 CAFETERI A | -249, 091 | | | 11 |
| | 01300 NURSING ADMINISTRATION | 44, 460 | | | 13 |
| | 01400 CENTRAL SERVICES & SUPPLY | -260, 219 | 1 | | 14 |
| | 01500 PHARMACY | 101, 227 | | | 15 |
| | 01600 MEDI CAL RECORDS & LI BRARY | 23, 782 | | | 16 |
| | 02100 I &R SERVICES-SALARY & FRINGES APPRV | C | 1 | | 21 |
| | 02200 I &R SERVICES-OTHER PRGM COSTS APPRV | C | 0 | | 22 |
| | NPATIENT ROUTINE SERVICE COST CENTERS | 1 | 1 | | |
| | 03000 ADULTS & PEDIATRICS | - 4 | | | 30 |
| | 03400 SURGI CAL I NTENSI VE CARE UNI T | C | | | 34 |
| | 04300 NURSERY | C | 505, 857 | | 43 |
| | NCI LLARY SERVICE COST CENTERS | 4 500 7/5 | 4 057 747 | | |
| | 05000 OPERATING ROOM | -1, 588, 765 | | | 50 |
| | D5200 DELIVERY ROOM & LABOR ROOM | C | | | 52 |
| | 05400 RADI OLOGY-DI AGNOSTI C | 137,973 | | | 54 |
| | 05500 RADI OLOGY-THERAPEUTI C | -598, 054 | | | 55 |
| | | -65, 398 | | | 60 |
| | | -98, 407 | | | 64 |
| | 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY | -11, 361 | | | 65 |
| | | -6, 282 C | | | 66 |
| | 06700 OCCUPATIONAL THERAPY | | | | 67 |
| | 06800 SPEECH PATHOLOGY | - | , | | |
| | 06900 ELECTROCARDI OLOGY | C | | | 69 |
| | 07000 ELECTROENCEPHALOGRAPHY | -6, 495 | | | 70 |
| | 07100 MEDICAL SUPPLIES CHARGED TO PATIENT | C | | | 71 |
| | 07200 I MPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS | C | | | 72 |
| | 07400 RENAL DIALYSIS | | | | 73 |
| | 07700 ALLOGENEIC STEM CELL ACQUISITION | | | | 74 |
| | DUTPATIENT SERVICE COST CENTERS | C C | 0 | | // |
| | 09000 CLINIC | C | 0 | | 90 |
| | 09001 WOUND CARE INSTITUTE | | | | 90 |
| | 09002 OP NUTRITIONAL COUNSELING | | | | 90 |
| | 09100 EMERGENCY | -47, 415 | | | 91 |
| | 09200 OBSERVATION BEDS (NON-DISTINCT PART | | 0, 412, 722 | | 92 |
| | THER REIMBURSABLE COST CENTERS | | 1 | | |
| | 10200 OPI OI D TREATMENT PROGRAM | C | 0 | | 102 |
| | SPECIAL PURPOSE COST CENTERS | | 1 1 | | |
| 3.001 | 1300 INTEREST EXPENSE | C | 0 | | 113 |
| 8.00 | SUBTOTALS (SUM OF LINES 1 through 117) | 25, 980, 359 | 119, 172, 605 | | 118 |
| N | IONREI MBURSABLE COST CENTERS | | | | |
| | 19000 GIFT FLOWER COFFEE SHOP & CANTEEN | C | 106, 644 | | 190 |
| | 19200 PHYSICIANS PRIVATE OFFICES | C | 444, 520 | | 192 |
| | 07950 COMMUNITY RELATIONS & MARKETING | 4 | 4 | | 194 |
| | 07951 PLAINFIELD RADIOLOGY & PHYSICAL THE | C | 405, 691 | | 194 |
| | 07952 JV MV ENDOSCOPY | | o | | 194 |
| | 07953 SOUTHWEST CENTER FOR WOMENS HEALTH | | ō | | 194 |
| | 07954 OTHER NRCC | 4, 422, 209 | 22, 206, 271 | | 194 |
| | TOTAL (SUM OF LINES 118 through 199) | 30, 402, 572 | | | 200 |

Health Financial Systems In Lieu of Form CMS-2552-10 FRANCI SCAN HEALTH MOORESVILLE RECLASSI FI CATI ONS Provider CCN: 15-0057 Peri od: Worksheet A-6 From 01/01/2022 12/31/2022 То Date/Time Prepared: 5/29/2023 3:28 pm Increases Cost Center Sal ary 0ther Line # 2.00 3.00 4.00 5.00 - MEDICAL SUPPLIES 1.00 MEDICAL SUPPLIES CHARGED TO 71.00 0 2,861,201 1.00 PATI ENT 2.00 IMPL. DEV. CHARGED TO 72.00 0 10, 220, 623 2.00 PATI ENTS 3.00 INTRAVENOUS THERAPY 1, 399, 819 64.00 0 3.00 4.00 OTHER ADMIN & GENERAL 5.03 0 25, 354 4.00 0.00 0 5.00 0 5.00 0 6.00 6.00 0.00 0 0 0 7.00 0.00 7.00 8.00 0.00 0 0 8.00 9.00 0.00 0 0 9.00 0 10.00 0.00 0 10.00 11.00 0.00 0 0 11.00 12.00 0.00 0 0 12.00 0 0 13.00 0.00 13.00 0 0 0.00 14.00 14.00 15.00 0.00 0 0 15.00 0 0 16.00 0.00 16.00 0 0 17 00 0 00 17 00 0 19.00 0.00 19.00 20.00 0.00 0 0 20.00 0 0 21.00 0.00 21.00 0 0 0.00 22.00 22.00 0 23.00 0.00 0 23.00 0 0 24.00 0.00 24.00 0 25 00 0 00 0 25 00 0 0 27.00 0.00 0 27.00 TOTALS 14, 506, 997 B - DRUGS DRUGS CHARGED TO PATIENTS 1.00 1 00 73.00 0 17, 736, 784 0 2.00 0.00 0 2.00 3.00 0.00 0 0 3.00 0 4.00 0.00 0 4.00 0 0 5.00 0.00 5.00 6.00 0.00 0 0 6.00 8.00 0.00 0 0 8.00 0 0 0 9.00 0.00 9.00 10.00 0.00 10.00 11.00 0.00 0 0 11.00 12.00 0.00 0 0 12.00 0 0 14.00 0.00 14.00 0 16.00 0.00 16.00 17.00 0.00 0 0 17.00 18.00 0.00 0 0 18.00 TOTALS 17, 736, 784 - EQUI PMENT LEASE 1.00 CAP REL COSTS-MVBLE EQUIP 2.00 0 160, 266 1.00 0 2.00 HOUSEKEEPI NG 9.00 570 2.00 0.00 0 3.00 0 3.00 5.00 0.00 0 0 5.00 6.00 0.00 0 6.00 0 TOTALS 0 160, 836 D - DEPRECIATION 1.00 CAP REL COSTS-BLDG & FIXT 1.00 0 2, 484, 990 1.00 0 2.00 0.00 2.00 0 0 3.00 0.00 0 3.00 4.00 0.00 0 0 4.00 0 0 5.00 0.00 5.00 0 6.00 0.00 0 6.00 0 0 7.00 0.00 7.00 0 8.00 0.00 0 8.00 0 9.00 0.00 0 0 0 9.00 0 10 00 0 00 10 00 11.00 0.00 11.00 12.00 0.00 0 0 12.00 0 0 13.00 0.00 13.00 0 0.00 0 14.00 14.00 15.00 0.00 0 0 15.00 16.00 0.00 0 0 16.00 0 17.00 0.00 0 17.00 Ő 18.00 0.00 18.00 0 19.00 0.00 0 19.00

0.00

0

0

21.00

21.00

| RECLASSI FI CATI ONS Provi der CCN: 15-0057 Peri dt: From 01/01/2022 To 12/31/2020 Worksheet A-6 Date/Time Prepared: 5/29/2023 3: 28 pm Cost Center Line # Sal ary Other 2.00 0.00 0 0 22.00 2.00 24.00 2.484,990 2.484,990 22.00 24.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 2.00 2.00 2.00 2.00 2.00 22.00 24.00 22.00 24.00 22.00 24.00 24.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 | Heal th | Financial Systems | F | RANCI SCAN HEALT | H MOORESVILLE | | In Lie | u of Form CMS | 6-2552-10 |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|--------------------------|-----------|------------------|-------------------|------------|---------------|---------------|-----------|
| To 12/31/2022 Date/Time Prepared: 5/29/2023 3: 28 pm Cost Center Li ne # Sal ary Other 2.00 3.00 4.00 5.00 22.00 0.00 0 0 24.00 0.00 0 0 TOTALS 0.00 0 24.00 TOTALS 10.00 314,318 110,835 TOTALS 314,318 110,835 1.00 G - NURSERY 1.00 1.00 20.00 1.00 DELIVERY ROM & LABOR ROM 52.00 1.503,586 293,918 1.00 INTEREST 1.926,728 376, 633 1.00 <td>RECLAS</td> <td>SIFICATIONS</td> <td></td> <td></td> <td>Provider CC</td> <td>N: 15-0057</td> <td></td> <td>Worksheet A</td> <td>-6</td> | RECLAS | SIFICATIONS | | | Provider CC | N: 15-0057 | | Worksheet A | -6 |
| Increases 5/29/2023 3: 28 pm Cost Center Li ne # Sal ary Other 2.00 3.00 4.00 5.00 22.00 0.00 0 0 24.00 0.00 0 0 TOTALS 0.00 0 22.00 E - EMPLOYEE BENEFITS 0 0 24.00 TOTALS 0.00 0 0 24.00 F - CAFETERIA 0 0 0 0 1.00 CAFETERIA 11.00 314, 318 110, 835 1 1.00 CAFETERIA 11.00 314, 318 10.835 1 1 1.00 DELI VERY ROOM & LABOR ROOM 52.00 1, 503, 586 293, 918 2.00 2.00 1.00 INTEREST 1.926, 728 376, 633 1 1 00 1.00 INTEREST 1.926, 728 376, 633 1 1 00 1.00 INTEREST 1.926, 728 376, 633 1 1 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> | | | | | | | | | |
| Increases Cost Center Line # Salary Other 2.00 3.00 4.00 5.00 22.00 0.00 0 0 22.00 24.00 | | | | | | | lo 12/31/2022 | Date/lime Pi | repared: |
| Cost Center Line # Salary Other 22.00 2.00 3.00 4.00 5.00 22.00 0.00 0 0 22.00 24.00 0.00 0 0 24.00 TOTALS 0 0.00 0 24.00 E - EMPLOYEE BENEFITS 0 0.00 0 24.00 TOTALS 0 0 0 24.00 F - CAFETERIA 0 0 0 24.00 F - CAFETERIA 0 0 0 0 24.00 I.00 CAFETERIA 11.00 314,318 110,835 1 1 0 1 00 1 0 0 2.00 1 0 0 2.00 1 0 2.00 1 0 0 2.00 1 0 0 2.00 1 0 2.00 1 0 2.00 1 0 2.00 1 0 2.00 1 0< | | | Increases | | | | | 572972025 5. | |
| 2.00 3.00 4.00 5.00 22.00 0.00 0 0 22.00 24.00 0.00 0 0 24.00 TOTALS 0.00 0 24.00 24.00 E - EMPLOYEE BENEFITS 0 2.484,990 24.00 TOTALS 0 0 0 24.00 F - CAFETERIA 0 0 0 0 24.00 1.00 CAFETERIA 11.00 314,318 110,835 1.00 G - NURSERY 314,318 110,835 1.00 1.00 2.00 DELI VERY ROOM & LABOR ROOM 52.00 1,503,586 293,918 2.00 TOTALS 1,926,728 376,633 2.00 2.00 1.00 1.00 INTEREST EXPENSE 113.00 0 284,588 1.00 1.00 | | Cost Center | | Salary | Other | | | | |
| 24.00 | | 2.00 | 3.00 | | 5.00 | | | | |
| TOTALS 0 2, 484, 990 E - EMPLOYEE BENEFITS 1.00 TOTALS 0 0 0 F - CAFETERIA 0 0 0 0 1.00 CAFETERIA 11.00 314, 318 110, 835 1.00 G - NURSERY 314, 318 110, 835 1.00 1.00 2.00 DELI VERY ROOM & LABOR ROOM 52.00 1, 503, 586 293, 918 2.00 H - CAPITALIZED INTEREST 1.926, 728 376, 633 1.00 1.00 1.00 INTEREST EXPENSE 113.00 0 284, 588 1.00 | 22.00 | | 0.00 | 0 | 0 | | | | 22.00 |
| E - EMPLOYEE BENEFITS | 24.00 | | 0.00 | 0 | 0 | | | | 24.00 |
| 1.00 | | TOTALS | | 0 | 2, 484, 990 | | | | |
| TOTALS 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 <td></td> <td>E - EMPLOYEE BENEFITS</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> | | E - EMPLOYEE BENEFITS | | | | | | | |
| F - CAFETERIA | 1.00 | | 0.00 | 0 | 0 | | | | 1.00 |
| 1.00 CAFETERIA 11.00 314,318 110,835 1.00 TOTALS 314,318 110,835 1.00 1.00 1.00 G - NURSERY 43.00 423,142 82,715 1.00 1.00 NURSERY 43.00 423,142 82,715 1.00 2.00 DELI VERY ROOM & LABOR ROOM 52.00 1,503,586 293,918 2.00 H - CAPI TALI ZED INTEREST 1.926,728 376,633 2.00 1.00 1.00 1.00 INTEREST EXPENSE 113.00 0 284,588 1.00 1.00 | | TOTALS | | 0 | 0 | | | | |
| TOTALS 314,318 110,835 G - NURSERY 43.00 423,142 82,715 1.00 1.00 NURSERY 43.00 423,142 82,715 2.00 2.00 DELI VERY ROOM & LABOR ROOM 52.00 1,503,586 293,918 2.00 H - CAPI TALI ZED INTEREST 1.926,728 376,633 1.00 1.00 1.00 INTEREST EXPENSE 113.00 0 284,588 1.00 | | F – CAFETERIA | | | | | | | |
| G - NURSERY 43.00 423,142 82,715 1.00 2.00 DELI VERY ROOM & LABOR ROOM 52.00 1,503,586 293,918 2.00 TOTALS 1,926,728 376,633 2.00 1.00 2.00 H - CAPITALIZED INTEREST 113.00 0 284,588 1.00 1.00 | 1.00 | CAFETERI A | <u> </u> | <u>314, 3</u> 18 | 11 <u>0, 8</u> 35 | | | | 1.00 |
| 1.00 NURSERY 43.00 423,142 82,715 1.00 2.00 DELI VERY ROOM & LABOR ROOM 52.00 1,503,586 293,918 2.00 TOTALS 1,926,728 376,633 2.00 2.00 2.00 H - CAPI TALI ZED INTEREST 113.00 0 284,588 1.00 1.00 INTEREST EXPENSE 113.00 0 284,588 1.00 | | TOTALS | | 314, 318 | 110, 835 | | | | |
| 2.00 DELI VERY ROOM & LABOR ROOM 52.00 1,503,586 293,918 200 2.00 TOTALS 1,926,728 376,633 21,00 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 | | G – NURSERY | | | | | | | |
| TOTALS 1,926,728 376,633 H - CAPI TALI ZED INTEREST 113.00 0 284,588 1.00 INTEREST EXPENSE 0 284,588 | 1.00 | NURSERY | 43.00 | | 82, 715 | | | | 1.00 |
| H - CAPI TALI ZED INTEREST 1.00 INTEREST EXPENSE TOTALS 0 284, 588 1.00 | 2.00 | | 52.00 | | | | | | 2.00 |
| 1.00 <u>INTEREST EXPENSE</u> <u>113.00</u> <u>0</u> <u>284,588</u> 1.00 | | | | 1, 926, 728 | 376, 633 | | | | |
| TOTALS 0 284, 588 | | H – CAPITALIZED INTEREST | | | | | | | |
| | 1.00 | | 113.00 | 0 | | | | | 1.00 |
| 500.00 Grand Total: Increases 2, 241, 046 35, 661, 663 500.00 | | | | 0 | 284, 588 | | | | |
| | 500.00 | Grand Total: Increases | | 2, 241, 046 | 35, 661, 663 | | | | 500.00 |

Health Financial Systems RECLASSIFICATIONS

FRANCI SCAN_HEALTH_MOORESVILLE

Provider CCN: 15-0057

 Period:
 Worksheet A-6

 From 01/01/2022
 Date/Time Prepared:

 To
 12/31/2022
 Date/Time Prepared:

| | | | | | | 10 12/31/2022 | 5/29/2023 3:28 pm |
|------------------|------------------------------------------------|------------------|------------------------|--------------------|-------------------------|---------------|-------------------|
| | | Decreases | | | | I | |
| | Cost Center 6.00 | Li ne # 7.00 | <u>Sal ary</u> 8.00 | 0ther 9.00 | Wkst. A-7 Ref. 10.00 | | |
| | A - MEDICAL SUPPLIES | 7.00 | 8.00 | 9.00 | 10.00 | | |
| 1.00 | ADMI TTI NG | 5.01 | 0 | 1, 619 | 9 | | 1.00 |
| 2.00 | | 0.00 | 0 | | 0 | | 2.00 |
| 3.00 | OPERATION OF PLANT | 7.00 | 0 | | 0 | | 3.00 |
| 4.00 5.00 | HOUSEKEEPI NG | 0.00 9.00 | 0 | | 0 | | 4.00 5.00 |
| 6.00 | DI ETARY | 10.00 | 0 | | 0 | | 6.00 |
| 7.00 | CAFETERIA | 11.00 | 0 | -, .=- | 0 | | 7.00 |
| 8.00 | NURSING ADMINISTRATION | 13.00 | 0 | 2, 119 | 0 | | 8.00 |
| 9.00 | CENTRAL SERVICES & SUPPLY | 14.00 | 0 | | 0 | | 9.00 |
| 10.00 | PHARMACY ADULTS & PEDIATRICS | 15.00 30.00 | 0 | | 0 | | 10.00 |
| 11. 00 12. 00 | SURGICAL INTENSIVE CARE UNIT | 30.00 | 0 | | - | | 11.00 12.00 |
| 13.00 | OPERATING ROOM | 50.00 | 0 | | | | 13.00 |
| 14.00 | DELIVERY ROOM & LABOR ROOM | 52.00 | 0 | | 0 | | 14.00 |
| 15.00 | RADI OLOGY-DI AGNOSTI C | 54.00 | 0 | | 0 | | 15.00 |
| 16.00 | RADI OLOGY-THERAPEUTI C | 55.00 | 0 | | 0 | | 16.00 |
| 17.00 19.00 | LABORATORY RESPI RATORY THERAPY | 60.00 65.00 | 0 | | - | | 17.00 19.00 |
| 20.00 | PHYSI CAL THERAPY | 66.00 | 0 | | 0 | | 20.00 |
| 21.00 | OCCUPATI ONAL THERAPY | 67.00 | 0 | | 0 | | 21.00 |
| 22.00 | SPEECH PATHOLOGY | 68.00 | 0 | | | | 22.00 |
| 23.00 | ELECTROCARDI OLOGY | 69.00 | 0 | , | 0 | | 23.00 |
| 24.00 25.00 | ELECTROENCEPHALOGRAPHY WOUND CARE INSTITUTE | 70.00 90.01 | 0 | | 0 | | 24.00 25.00 |
| 25.00 | EMERGENCY | 90.01 | 0 | | - | | 27.00 |
| 27:00 | TOTALS | | <u> </u> | | | | 27.00 |
| | B – DRUGS | | | | | 1 | |
| 1.00 | OTHER ADMIN & GENERAL | 5.03 | 0 | | | | 1.00 |
| 2.00 3.00 | CENTRAL SERVICES & SUPPLY PHARMACY | 14.00 15.00 | 0 0 | | 0 | | 2.00 3.00 |
| 3.00 4.00 | ADULTS & PEDIATRICS | 30.00 | 0 | | 0 | | 4.00 |
| 5.00 | SURGICAL INTENSIVE CARE UNIT | 34.00 | 0 | -, | 0 | | 5.00 |
| 6.00 | OPERATING ROOM | 50.00 | 0 | 21, 105 | 0 | | 6.00 |
| 8.00 | RADI OLOGY-DI AGNOSTI C | 54.00 | 0 | | 0 | | 8.00 |
| 9.00 10.00 | RADI OLOGY-THERAPEUTI C | 55.00 60.00 | 0 | | 0 | | 9.00 10.00 |
| 11.00 | INTRAVENOUS THERAPY | 64.00 | 0 | - | 0 | | 11.00 |
| 12.00 | RESPI RATORY THERAPY | 65.00 | 0 | | 0 | | 12.00 |
| 14.00 | ELECTROCARDI OLOGY | 69.00 | 0 | 10 | 0 | | 14.00 |
| 16.00 | EMERGENCY | 91.00 | 0 | | 0 | | 16.00 |
| 17.00 18.00 | PHYSICIANS PRIVATE OFFICES OTHER NRCC | 192.00 194.04 | 0 | | 0 | | 17.00 18.00 |
| 16.00 | | 194.04 | 0 | | | | 18.00 |
| | C - EQUIPMENT LEASE | | | 1111001101 | <u> </u> | | |
| 1.00 | | 0.00 | | 0 | - | | 1.00 |
| 2.00 | DIETARY | 10.00 | | 4, 171 | | | 2.00 |
| 3.00 5.00 | PHARMACY RESPI RATORY THERAPY | 15.00 65.00 | | 150, 738 5, 625 | | | 3.00 5.00 |
| 6.00 | EMERGENCY | 91.00 | | 302 | 0 | | 6.00 |
| 0.00 | TOTALS | | | | | - | 0100 |
| | D - DEPRECIATION | | | | | | |
| 1.00 | OPERATION OF PLANT | 7.00 | 0 | | | | 1.00 |
| 2.00 3.00 | LAUNDRY & LI NEN SERVI CE HOUSEKEEPI NG | 8.00 9.00 | 0 0 | | | | 2.00 3.00 |
| 4.00 | DI ETARY | 10.00 | 0 | | | | 4.00 |
| 5.00 | CAFETERIA | 11.00 | 0 | 2, 995 | 0 | | 5.00 |
| 6.00 | NURSING ADMINISTRATION | 13.00 | 0 | | | | 6. 00 |
| 7.00 | CENTRAL SERVICES & SUPPLY | 14.00 | 0 | | 0 | | 7.00 |
| 8.00 9.00 | PHARMACY ADULTS & PEDIATRICS | 15.00 30.00 | 0 | | | | 8.00 9.00 |
| 10.00 | SURGICAL INTENSIVE CARE UNIT | 30.00 | 0 | | | | 10.00 |
| 11.00 | OPERATING ROOM | 50.00 | 0 | | - | | 11.00 |
| 12.00 | RADI OLOGY-DI AGNOSTI C | 54.00 | 0 | | 0 | | 12.00 |
| 13.00 | RADI OLOGY-THERAPEUTI C | 55.00 | 0 | | | | 13.00 |
| 14.00 15.00 | LABORATORY I NTRAVENOUS THERAPY | 60.00 64.00 | 0 | | 0 | | 14.00 15.00 |
| 15.00 16.00 | RESPIRATORY THERAPY | 65.00 | 0 | | | | 16.00 |
| 17.00 | PHYSI CAL THERAPY | 66.00 | 0 | | | | 17.00 |
| 18.00 | OTHER ADMIN & GENERAL | 5.03 | 0 | 220, 936 | 0 | | 18.00 |
| 19.00 | ELECTROENCEPHALOGRAPHY | 70.00 | 0 | | | | 19.00 |
| 21.00 | OP NUTRITIONAL COUNSELING | 90.02 | 0 | | 0 | | 21.00 |
| 22. 00 24. 00 | EMERGENCY | 91.00 0.00 | | | 0 | | 22.00 24.00 |
| 200 | 1 | 0.00 | 0 | 0 | , | 1 | 21.00 |

| Heal th | Financial Systems | F | RANCI SCAN HEALTI | H MOORESVILLE | | In Lie | u of Form CMS | -2552-10 |
|---------|---------------------------|-----------|-------------------|---------------|---------------|---------------------------------------------|------------------------------|----------|
| RECLAS | SIFICATIONS | | | Provider (| CCN: 15-0057 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A- Date/Time Pr | |
| | | | | | | | Date/Time Pr 5/29/2023 3: | 28 pm |
| | | Decreases | | | | | | |
| | Cost Center | Line # | Sal ary | Other | Wkst. A-7 Ref | - | | |
| | 6.00 | 7.00 | 8.00 | 9.00 | 10.00 | | | |
| | TOTALS | | 0 | 2, 484, 990 | | | | |
| | E - EMPLOYEE BENEFITS | | <u>.</u> | | | | | |
| 1.00 | | 0.00 | 0 | 0 | | 0 | | 1.00 |
| | TOTALS | | 0 | 0 | | 1 | | |
| | F - CAFETERIA | · · | | | | | | |
| 1.00 | DI ETARY | 10.00 | 314, 318 | 110, 835 | | 0 | | 1.00 |
| | TOTALS | | 314, 318 | 110, 835 | | 1 | | |
| | G - NURSERY | | | | | | | |
| 1.00 | ADULTS & PEDIATRICS | 30.00 | 1, 926, 728 | 376, 633 | | 0 | | 1.00 |
| 2.00 | | 0.00 | 0 | 0 | | 0 | | 2.00 |
| | TOTALS | | 1, 926, 728 | 376, 633 | | 1 | | |
| | H - CAPITALIZED INTEREST | | · · · · · | | | - 4 | | |
| 1.00 | CAP REL COSTS-BLDG & FIXT | 1.00 | 0 | 284, 588 | - | 1 | | 1.00 |
| | TOTALS | | | 284, 588 | | 1 | | 1 |
| 500.00 | Grand Total: Decreases | | 2, 241, 046 | 35, 661, 663 | | 1 | | 500.00 |

| Heal th | Financial Systems | RANCI SCAN HEALT | TH MOORESVILLE | | In Lie | eu of Form CMS-2 | 2552-10 |
|---------|----------------------------------------------|--------------------------|----------------|-------------|---------------------------------------------|------------------------------|---------|
| | ILIATION OF CAPITAL COSTS CENTERS | | Provider CO | | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-7 Part I | pared: |
| | | | | Acquisition | | | |
| | | 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 | | | | • | |
| 1.00 | Land | 0 | 0 | | 0 0 | 0 | 1.00 |
| 2.00 | Land Improvements | 2, 760, 270 | 0 | | 0 0 | 137, 618 | 2.00 |
| 3.00 | Buildings and Fixtures | 62, 794, 372 | 491, 262 | | 0 491, 262 | 0 | 3.00 |
| 4.00 | Building Improvements | 2, 965, 020 | 0 | | 0 0 | 790, 136 | 4.00 |
| 5.00 | Fixed Equipment | 46, 025, 820 | 308, 701 | | 0 308, 701 | 0 | 5.00 |
| 6.00 | Movable Equipment | 27, 982, 025 | 1, 695, 019 | | 0 1, 695, 019 | 36, 936 | 6.00 |
| 7.00 | HIT designated Assets | 0 | 0 | | 0 0 | 0 | 7.00 |
| 8.00 | Subtotal (sum of lines 1-7) | 142, 527, 507 | 2, 494, 982 | | 0 2, 494, 982 | 964, 690 | 8.00 |
| 9.00 | Reconciling Items | 0 | 0 | | 0 0 | 0 | 9.00 |
| 10.00 | Total (line 8 minus line 9) | 142, 527, 507 | 2, 494, 982 | | 0 2, 494, 982 | 964, 690 | 10.00 |
| | | Endi ng Bal ance | Fully | | | | |
| | | Ũ | Depreciated | | | | |
| | | | Assets | | | | |
| | | 6.00 | 7.00 | | | | |
| | PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE | T BALANCES | | | | | |
| 1.00 | Land | 0 | 0 | | | | 1.00 |
| 2.00 | Land Improvements | 2, 622, 652 | 0 | | | | 2.00 |
| 3.00 | Buildings and Fixtures | 63, 285, 634 | 0 | | | | 3.00 |
| 4.00 | Building Improvements | 2, 174, 884 | 0 | | | | 4.00 |
| 5.00 | Fixed Equipment | 46, 334, 521 | 0 | | | | 5.00 |
| 6.00 | Movable Equipment | 29, 640, 108 | 0 | | | | 6.00 |
| 7.00 | HIT designated Assets | 0 | 0 | | | | 7.00 |
| 8.00 | Subtotal (sum of lines 1-7) | 144, 057, 799 | 0 | | | | 8.00 |
| 9.00 | Reconciling Items | 0 | 0 | | | | 9.00 |
| 10.00 | Total (line 8 minus line 9) | 144,057,799 | 0 | | | | 10.00 |

| Heal th | Financial Systems F | In Lie | u of Form CMS-2 | 2552-10 | | | |
|---------|-----------------------------------------------|-------------------|-----------------|---------------|----------------------------------|--------------------------|-------|
| RECONC | ILIATION OF CAPITAL COSTS CENTERS | | Provider C | CN: 15-0057 | Period: | Worksheet A-7 | |
| | | | | | From 01/01/2022 To 12/31/2022 | Part II Date/Time Pre | narod |
| | | | | | 10 12/31/2022 | 5/29/2023 3:2 | 8 pm |
| | | | SI | JMMARY OF CAP | I TAL | · | |
| | | | | - | | | |
| | Cost Center Description | Depreciation | Lease | Interest | Insurance (see | • | |
| | | | | | | instructions) | |
| | | 9.00 | 10.00 | 11.00 | 12.00 | 13.00 | |
| | PART II - RECONCILIATION OF AMOUNTS FROM WORK | | | ind 2 | | | |
| 1.00 | CAP REL COSTS-BLDG & FIXT | 3, 584, 321 | 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) | 3, 584, 321 | | | 0 0 | 0 | 3.00 |
| | | SUMMARY O | F CAPITAL | | | | |
| | | | | | | | |
| | Cost Center Description | | Total (1) (sum | | | | |
| | | Capi tal -Rel ate | | | | | |
| | | d Costs (see | through 14) | | | | |
| | | instructions) | 15.00 | - | | | |
| | PART II - RECONCILIATION OF AMOUNTS FROM WORK | 14.00 | 15.00 | | | | |
| 1 00 | | SHEEL A, CULUM | | | | | 1 00 |
| 1.00 | CAP REL COSTS-BLDG & FLXT | 0 | 3, 584, 321 | | | | 1.00 |
| 2.00 | CAP REL COSTS-MVBLE EQUIP | 0 | 0 2 504 221 | | | | 2.00 |
| 3.00 | Total (sum of lines 1-2) | I U | 3, 584, 321 | 1 | | | 3.00 |

| Health Financial Systems F | RANCI SCAN HEAL | TH MOORESVILLE | | In Lie | u of Form CMS-2 | 2552-10 |
|---------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------|---------------------------------------|---------------------------------------------------|----------------------------------------------------------|---------------------------------------------|----------------------|
| RECONCILIATION OF CAPITAL COSTS CENTERS | | Provider C | F | Period: From 01/01/2022 To 12/31/2022 | | pared: 3 pm |
| | COMI | PUTATION OF RAT | FI 0S | ALLOCATION OF | OTHER CAPITAL | |
| Cost Center Description | Gross Assets | Capi tal i zed Leases | Gross Assets for Ratio (col. 1 - col. 2) | Ratio (see instructions) | Insurance | |
| PART III - RECONCILIATION OF CAPITAL COSTS C | | 2.00 | 3.00 | 4.00 | 5.00 | |
| 1.00 CAP REL COSTS-BLDG & FIXT 2.00 CAP REL COSTS-MVBLE EQUIP 3.00 Total (sum of lines 1-2) | 111, 795, 040 29, 640, 108 141, 435, 148 | 1, 538, 522 | 139, 896, 626 | 0. 200874 | | 1.00 2.00 3.00 |
| Cost Center Description | Taxes | Other Capi tal -Rel ate d Costs | Total (sum of cols. 5 through 7) | Depreciation | Lease | |
| | 6.00 | 7.00 | 8.00 | 9.00 | 10.00 | |
| PART III - RECONCILIATION OF CAPITAL COSTS C 1.00 CAP REL COSTS-BLDG & FIXT | | | | (407 070 | | 1.00 |
| 1.00 CAP REL COSTS-BLDG & FIXT 2.00 CAP REL COSTS-MVBLE EQUIP 3.00 Total (sum of lines 1-2) | 0 | | | 6, 197, 973 0 6, 197, 973 | 0 160, 266 160, 266 | 2.00 3.00 |
| | | SL | JMMARY OF CAPIT | | 1007 200 | 0100 |
| Cost Center Description | Interest | Insurance (see instructions) | | Other Capital-Relate d Costs (see instructions) | Total (2) (sum of cols. 9 through 14) | |
| | 11.00 | 12.00 | 13.00 | 14.00 | 15.00 | |
| PART III - RECONCILIATION OF CAPITAL COSTS C 1.00 CAP REL COSTS-BLDG & FIXT 2.00 CAP REL COSTS-MVBLE EQUIP 3.00 Total (sum of lines 1-2) | ENTERS 853, 048 0 853, 048 | 0 | C | | 7, 051, 021 160, 266 7, 211, 287 | 1.00 2.00 3.00 |

| Health Financial Sys | | FR | ANCI SCAN HEALT | | | u of Form CMS-2 | |
|-----------------------------------------------------------|-----------------------------------------------------|-----------------|-------------------|----------------------------------------------------------|---------------------------------------------|--------------------------------------------------|----------------|
| ADJUSTMENTS TO EXPEN | ISES | | | | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-8 Date/Time Pre 5/29/2023 3:23 | pared: |
| | | | | Expense Classification of To/From Which the Amount is | | | |
| Cost Cei | nter Description | Basi s/Code (2) | Amount | Cost Center | Line # | Wkst. A-7 Ref. | |
| | come - CAP REL | 1.00 | 2.00 | 3.00 CAP REL COSTS-BLDG & FIXT | 4.00 | 5.00 | 1.00 |
| COSTS-BLDG & | FIXT (chapter 2) | | | | | | |
| | COME - CAP REL COULP (chapter 2) COME - other | | 0 | CAP REL COSTS-MVBLE EQUIP | 2.00 0.00 | | |
| (chapter 2) 4.00 Trade, quanti | ty, and time | | 0 | | 0.00 | 0 | 4.00 |
| di scounts (ch 5.00 Refunds and r | apter 8) | В | 09 407 | INTRAVENOUS THERAPY | 64.00 | | 5.00 |
| expenses (cha | pter 8) | D | -98, 407 | TNTRAVENOUS THERAPT | | | |
| 6.00 Rental of pro suppliers (ch | vider space by apter 8) | | 0 | | 0.00 | 0 | 6.00 |
| 7.00 Tel ephone ser stations excl 21) | vices (pay uded) (chapter | | 0 | | 0.00 | 0 | 7.00 |
| 8.00 Television an (chapter 21) | d radio service | А | -24, 236 | OPERATION OF PLANT | 7.00 | 0 | 8. 00 |
| 9.00 Parking lot (10.00 Provider-base adjustment | | A-8-2 | 0 -2, 983, 924 | | 0.00 | 0 | |
| 11.00 Sale of scrap (chapter 23) | , waste, etc. | | 0 | | 0.00 | 0 | 11.00 |
| 12.00 Related organ transactions | (chapter 10) | A-8-1 | 38, 669, 403 | | | 0 | |
| 13.00 Laundry and I 14.00 Cafeteria-emp | inen service loyees and guests | В | 0 -260, 783 | CAFETERI A | 0.00 | | |
| | rters to employee | | 0 | | 0.00 | | |
| 16.00 Sale of medic supplies to o | al and surgical ther than | | 0 | | 0.00 | 0 | 16.00 |
| 17.00 Sale of drugs patients | to other than | | о | | 0.00 | 0 | 17.00 |
| 18.00 Sale of medic | al records and | | 0 | | 0.00 | 0 | 18.00 |
| abstracts 19.00 Nursing and a education (tu | | | 0 | | 0.00 | 0 | 19. 00 |
| books, etc.) 20.00 Vending machi | nes | В | -8, 467 | CAFETERI A | 11.00 | 0 | 20.00 |
| 21.00 Income from i interest, fin charges (chap | ance or penalty | | 0 | | 0.00 | 0 | 21.00 |
| 22.00 Interest expe | ense on Medicare and borrowings to | | 0 | | 0.00 | 0 | 22.00 |
| 23.00 Adjustment fo | e overpayments or respiratory in excess of | A-8-3 | 0 | RESPI RATORY THERAPY | 65.00 | | 23. 00 |
| 24.00 Adjustment fo therapy costs | | A-8-3 | 0 | PHYSI CAL THERAPY | 66.00 | | 24.00 |
| 25.00 Utilization r physicians' c | eview - | | 0 | *** Cost Center Deleted *** | 114.00 | | 25.00 |
| (chapter 21) 26.00 Depreciation | - CAP REL | | 0 | CAP REL COSTS-BLDG & FIXT | 1.00 | 0 | 26. 00 |
| 27.00 COSTS-BLDG & 27.00 Depreciation COSTS-MVBLE E | - CAP REL | | 0 | CAP REL COSTS-MVBLE EQUIP | 2.00 | 0 | 27.00 |
| 28.00 Non-physician | Anesthetist | | 0 | *** Cost Center Deleted *** | | | 28.00 |
| therapy costs | r occupational in excess of | A-8-3 | 0 | OCCUPATI ONAL THERAPY | 0.00 67.00 | | 29.00 30.00 |
| 30.99 Hospice (non- | hapter 14) distinct) (see | | 0 | ADULTS & PEDIATRICS | 30.00 | | 30.99 |
| instructions) 31.00 Adjustment fo | r speech | A-8-3 | | SPEECH PATHOLOGY | 68.00 | | 31.00 |
| pathology cos limitation (c 32.00 CAH HIT Adjus | | | 0 | | 0.00 | 0 | 32.00 |
| Depreciation | and Interest | | 0 | | | | |
| 33.00 CAFETERIA-EMP | LUYEES AND GUESTS | В | 0 | ADULTS & PEDIATRICS | 30.00 | 0 | 33.00 |

| | Financial Systems MENTS TO EXPENSES | | | H MOORESVILLE | | u of Form CMS-2 | |
|------------------|-------------------------------------------------------------|-----------------|------------------------|----------------------------------------|----------------------------|-----------------|--------|
| ADJUSI | MENTS TO EXPENSES | | | Provider CCN: 15-0057 | Period: From 01/01/2022 | Worksheet A-8 | |
| | | | | | To 12/31/2022 | | |
| | | | | Expense Classification o | n Worksheet A | 5/29/2023 3:2 | |
| | | | • | To/From Which the Amount is | | | |
| | | | | | 2 | | |
| | | | | | | | |
| | | | | | | | |
| | Cost Center Description | Pasis(Codo (2)) | Amount | Cost Center | Line # | Wkst. A-7 Ref. | |
| | cost center bescription | 1.00 | 2.00 | 3.00 | 4,00 | 5.00 | |
| 33.01 | CAFETERIA-EMPLOYEES AND GUESTS | В | | OPERATING ROOM | 50.00 | 0.00 | 33.01 |
| 33.02 | CAFETERIA-EMPLOYEES AND GUESTS | | | RADI OLOGY-DI AGNOSTI C | 54.00 | 0 | |
| 33.03 | MISC INCOME | В | -1, 920, 952 | OTHER ADMIN & GENERAL | 5.03 | 0 | 33.03 |
| 33.04 | MISC INCOME | В | -81, 089 | OPERATION OF PLANT | 7.00 | 0 | 33.04 |
| 33.05 | MISC INCOME | В | -20, 871 I | LAUNDRY & LINEN SERVICE | 8.00 | 0 | 33.05 |
| 33.06 | MISC INCOME | В | | HOUSEKEEPI NG | 9.00 | 0 | 00.00 |
| 33.07 | MISC INCOME | В | -1, 068 <mark>(</mark> | | 10.00 | 0 | |
| 33.08 | MISC INCOME | В | | CAFETERI A | 11.00 | 0 | |
| 33.09 | MI SC I NCOME | В | | PHARMACY | 15.00 | 0 | |
| 33.10 | MI SC I NCOME | В | | ADULTS & PEDIATRICS | 30.00 | 0 | |
| 33.11 | MI SC I NCOME | В | | SURGICAL INTENSIVE CARE UNI | | 0 | |
| 33. 12 33. 13 | MISC INCOME MISC INCOME | B | | DPERATING ROOM RADIOLOGY-DIAGNOSTIC | 50.00 54.00 | 0 | |
| 33.13 | MI SC I NCOME | В | | RADI OLOGY - DI AGNOSTI C | 55.00 | 0 | |
| 33.14 | MI SC I NCOME | В | | RESPIRATORY THERAPY | 65.00 | 0 | |
| 33.15 | MI SC I NCOME | B | | PHYSICAL THERAPY | 66.00 | 0 | |
| 33.17 | DI SCOUNTS | B | | CENTRAL SERVICES & SUPPLY | 14.00 | 0 | |
| 33. 18 | VENDING MACHINES | B | | DI ETARY | 10.00 | 0 | |
| 33.19 | NEUROLOGY TESTING EXPENSES | A | | ELECTROENCEPHALOGRAPHY | 70.00 | 0 | |
| 33. 20 | ON CALL COVERAGE | A | | OTHER ADMIN & GENERAL | 5.03 | 0 | 33.20 |
| 33. 21 | ON CALL COVERAGE | A | o | ADULTS & PEDIATRICS | 30.00 | 0 | 33. 21 |
| 33. 22 | NON ALLOWABLE INTEREST | A | | CAP REL COSTS-BLDG & FIXT | 1.00 | 11 | 33. 22 |
| 33. 23 | HAF OFFSET | A | | OTHER ADMIN & GENERAL | 5.03 | 0 | |
| 33. 24 | PENSION ADJ PER REGS 2142.5 | A | | EMPLOYEE BENEFITS DEPARTMEN | | 0 | |
| 33.25 | ADVERTI SI NG | A | | OTHER ADMIN & GENERAL | 5.03 | 0 | |
| 33.26 | DUES AND SUBSCRIPTIONS | A | | EMERGENCY | 91.00 | 0 | |
| 33.27 | DUES AND SUBSCRIPTIONS | A | | OTHER ADMIN & GENERAL | 5.03 | 0 | |
| 33. 28 33. 29 | MI SC EXPENSE MI SC EXPENSE | A | | DPERATION OF PLANT HOUSEKEEPING | 7.00 | 0 | |
| 33.30 | MI SC EXPENSE | A | | NURSING ADMINISTRATION | 13.00 | 0 | |
| 33.31 | MI SC EXPENSE | A | | RADI OLOGY-DI AGNOSTI C | 54.00 | 0 | 1 |
| 33. 32 | MI SC EXPENSE | A | | PHYSICAL THERAPY | 66.00 | 0 | 1 |
| 33.33 | DUES AND SUBSCRIPTIONS | A | | NURSING ADMINISTRATION | 13.00 | 0 | |
| 34.00 | OTHER HOSP LOCATION | A | | CAP REL COSTS-BLDG & FIXT | 1.00 | 9 | |
| 34.01 | OTHER HOSP LOCATION | A | 0 | | 0.00 | 0 | |
| 34.02 | OTHER HOSP LOCATION | A | Ō | | 0.00 | 0 | |
| 34.03 | OTHER HOSP LOCATION | A | 0 | | 0.00 | 0 | 34.03 |
| 34.04 | OTHER HOSP LOCATION | A | 0 | | 0.00 | 0 | 34.04 |
| 34.05 | OTHER HOSP LOCATION | A | 0 | | 0.00 | 0 | |
| 35.00 | NON-HOSP LOCATION | В | | OTHER ADMIN & GENERAL | 5.03 | 0 | |
| 35.01 | NON-HOSP LOCATION | А | | OTHER ADMIN & GENERAL | 5.03 | 0 | |
| 35.02 | NON-HOSP LOCATION | A | | CENTRAL SERVICES & SUPPLY | 14.00 | 0 | |
| 35.03 | NON-HOSP LOCATION | A | | _ABORATORY | 60.00 | 0 | 00.00 |
| 50.00 | TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, | | 30, 402, 572 | | | | 50.00 |
| | | | | | | | |

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.
(2) Additional environment of the second perturbation of the second perturbatio

(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 MOORESVILLE | In Lie | eu of Form CMS-2 | 2552-10 |
|--------------|-------------------------------|-----------------------------------------------------|---------------------------|----------------------------------|------------------|--------------|
| | ENT OF COSTS OF SERVICES FROM | RELATED ORGANIZATIONS AND HO | ME Provider CCN: 15-0057 | Peri od: | Worksheet A-8 | -1 |
| OFFI CE | COSTS | | | From 01/01/2022 To 12/31/2022 | | narod |
| | | | | 10 12/31/2022 | 5/29/2023 3:2 | |
| | Li ne No. | Cost Center | Expense Items | Amount of | Amount | |
| | | | | Allowable Cost | Included in | |
| | | | | | Wks. A, column | |
| | | | | | 5 | |
| | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | |
| | A. COSTS INCURRED AND ADJUST | MENTS REQUIRED AS A RESULT OF | TRANSACTIONS WITH RELATED | ORGANIZATIONS OR | CLAIMED | |
| 1.00 | HOME OFFICE COSTS: | CAP REL COSTS-BLDG & FIXT | SHARED SERVICE ALLOCATION | 100.017 | 0 | 1.00 |
| 2.00 | | | SHARED SERVICE ALLOCATION | 128, 817 | 0 | 2.00 |
| 2.00 | | | | 204, 014 | 0 | |
| 3.00 4.00 | | OTHER ADMIN & GENERAL OPERATION OF PLANT | SHARED SERVICE ALLOCATION | 13, 283, 429 | 0 | 3.00 4.00 |
| | | | | 1,014,251 | 0 | |
| 4.01 4.02 | | NURSING ADMINISTRATION MEDICAL RECORDS & LIBRARY | SHARED SERVICE ALLOCATION | 47,094 | 0 | 4.01 |
| | | | | 23, 782 | 0 | 4.02 |
| 4.03 | | RADI OLOGY-DI AGNOSTI C | SHARED SERVICE ALLOCATION | 195, 732 | 0 | 4.03 |
| 4.04 | 0.00 | | | 0 | 0 | 4.04 |
| 4.05 | | | SHARED SERVICE ALLOCATION | 4 | 0 | 4.05 |
| 4.06 | | OTHER NRCC | SHARED SERVICE ALLOCATION | 4, 422, 209 | | 4.06 |
| 4.07 | | LABORATORY | SHARED SERVICE ALLOCATION | 3, 149, 818 | 3, 215, 216 | 4.07 |
| 4.08 | | OTHER ADMIN & GENERAL | FRANCI SCAN HOME OFFICE | 16, 540, 989 | 0 | 4.08 |
| 4.09 | | CAP REL COSTS-BLDG & FIXT | FRANCI SCAN HOME OFFICE | 1, 137, 636 | | 4.09 |
| 4.10 | | OTHER ADMIN & GENERAL | FRANCI SCAN HOME OFFICE | 935, 972 | 0 | 4.10 |
| 4.11 | | OTHER ADMIN & GENERAL | FRANCI SCAN HOME OFFICE | 657, 806 | 0 | 4.11 |
| 4.12 | | PHARMACY | FRANCISCAN HOME OFFICE | 143, 066 | | 4.12 |
| 5.00 | TOTALS (sum of lines 1-4). | | | 41, 884, 619 | 3, 215, 216 | 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

| 1103 110 | t been posted to worksheet A, | corumns ranu/or z, the amount | it allowable si | | or this part. | | |
|---------------------------------------------------------------------|-------------------------------|-------------------------------|-----------------|------------------------------|----------------|---|--|
| | | | | Related Organization(s) and/ | or Home Office | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | L | |
| | 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.

| rermour | | | | | |
|---------|-------------------------|-----------------|-------------------------|--------|--------|
| 6.00 | В | HOME OFFICE | 100.00 FRANC. ALLI ANCE | 100.00 | 6.00 |
| 7.00 | В | APHL | 100. 00 APHL | 100.00 | 7.00 |
| 8.00 | G | FH CENTRAL INDY | 100.00 FRANC. HEALTH | 100.00 | 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 | MOORESVI LLE | In Lieu of Form CMS-2552- | | |
|---------------------------------------|-------------------------------|-----------------------|---------------------------------------------|----------------------------------------|--|
| STATEMENT OF COSTS OF SERVICES FROM R | ELATED ORGANIZATIONS AND HOME | Provider CCN: 15-0057 | Period: From 01/01/2022 To 12/31/2022 | Worksheet A-8-1 Date/Time Prepared: | |
| | | | | 5 (20 (2022 2 20 mm | |

| | | | | | | | | | 5/29/202 | 33:28 pm |
|-------|----------------|--------------------|----------------|--------------|---------|-------------|---------------|-----------------|-------------|----------|
| | Net | Wkst. A-7 Ref. | | | | | | | | |
| | Adjustments | | | | | | | | | |
| | (col. 4 minus | | | | | | | | | |
| | col. 5)* | | | | | | | | | |
| | 6.00 | 7.00 | | | | | | | | |
| | | RED AND ADJUSTM | NTS REQUIRED A | S A RESULT (| OF TRAN | SACTIONS W | TH RELATED | ORGANI ZATI ONS | OR CLAIMED | |
| | HOME OFFICE CO | | | | | | | | | |
| 1.00 | 128, 817 | | | | | | | | | 1.00 |
| 2.00 | 204, 014 | | | | | | | | | 2.00 |
| 3.00 | 13, 283, 429 | | | | | | | | | 3.00 |
| 4.00 | 1, 014, 251 | | | | | | | | | 4.00 |
| 4.01 | 47,094 | | | | | | | | | 4. 01 |
| 4.02 | 23, 782 | 0 | | | | | | | | 4. 02 |
| 4.03 | 195, 732 | 0 | | | | | | | | 4.03 |
| 4.04 | 0 | 0 | | | | | | | | 4.04 |
| 4.05 | 4 | 0 | | | | | | | | 4.05 |
| 4.06 | 4, 422, 209 | 0 | | | | | | | | 4.06 |
| 4.07 | -65, 398 | 0 | | | | | | | | 4.07 |
| 4.08 | 16, 540, 989 | 0 | | | | | | | | 4.08 |
| 4.09 | 1, 137, 636 | 11 | | | | | | | | 4.09 |
| 4.10 | 935, 972 | 0 | | | | | | | | 4.10 |
| 4.11 | 657, 806 | 0 | | | | | | | | 4.11 |
| 4.12 | 143, 066 | 0 | | | | | | | | 4.12 |
| 5.00 | 38, 669, 403 | | | | | | | | | 5.00 |
| * The | amounts on Lin | es $1-4$ (and subs | rinte as annro | nriato) arc | transt | Forrod in c | letail to Wor | -kshoot A col | ump 6 lines | 25 |

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

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

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

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

| reriibui | Sement under title AVIII. | |
|----------|--------------------------------|--------------------------------------------------|
| 6.00 | HEALTH SYSTEM | 6.00 |
| 7.00 | SHARED LAB | 7.00 |
| 8.00 | HOSPI TAL | 8.00 |
| 9.00 | | 9.00 |
| 10.00 | | 10.00 |
| 100.00 | | 100.00 |
| (1) Use | e the following symbols to inc | icate interrelationship to related organizations |

(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 I | Financial Syste | ems | FRANCI SCAN HEAL | _TH MOORESVILLE | | In Lie | eu of Form CMS- | 2552-10 |
|-----------|-----------------|------------------------|------------------|-----------------|------------------|---------------------------------------------|-----------------------------------------|---------------|
| PROVI DE | R BASED PHYSIC | I AN ADJUSTMENT | | Provider C | | Period: From 01/01/2022 To 12/31/2022 | 2 Date/Time Pre | pared: |
| | Wkst. A Line # | Cost Center/Physician | Total | Professi onal | Provi der | RCE Amount | 5/29/2023 3: 2 Physi ci an/Prov | 8 pili |
| | WKSL A LINE # | I denti fi er | Remuneration | Component | Component | RGE AMOUNT | ider Component | |
| | | | | | | | Hours | |
| | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | 6.00 | 7.00 | |
| 1.00 | | OTHER ADMIN & GENERAL | 1, 350, 121 | 1, 350, 121 | (| | | 1.00 |
| 2.00 | | OPERATION OF PLANT | 1, 125 | | (| | | 2.00 |
| 3.00 | | OPERATING ROOM | 1, 575, 333 | | (| 179,000 | | 3.00 |
| 4.00 | | RESPI RATORY THERAPY | 8, 850 | | (| 0 0 | - | 4.00 |
| 5.00 | | ELECTROENCEPHALOGRAPHY | 6, 495 | | (| 0 0 | | 5.00 |
| 6.00 | | EMERGENCY | 42,000 | 42, 000 | (| 0 0 | J J | 6.00 |
| 7.00 | 0.00 | | 0 | 0 | (| 0 0 | 0 | 7.00 |
| 8.00 | 0.00 | | 0 | 0 | (| 0 0 | , i i i i i i i i i i i i i i i i i i i | 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 | | | 2, 983, 924 | | (|) | 0 | 200.00 |
| | Wkst. A Line # | Cost Center/Physician | Unadjusted RCE | | Cost of | Provi der | Physician Cost | |
| | | Identifier | Limit | Unadjusted RCE | | | of Malpractice | |
| | | | | Limit | Conti nui ng | Share of col. | Insurance | |
| | 1.00 | 0.00 | 0.00 | 0.00 | Education | 12 | 11.00 | |
| 1 00 | 1.00 | 2.00 | 8.00 | 9.00 | 12.00 | 13.00 | 14.00 | 1 00 |
| 1.00 | | OTHER ADMIN & GENERAL | 0 | 0 | | 0 | - | 1.00 |
| 2.00 | | OPERATION OF PLANT | 0 | 0 | (| | - | 2.00 |
| 3.00 | | OPERATING ROOM | 0 | 0 | l | ° | , s | 3.00 |
| 4.00 | | | 0 | 0 | l | 0 | Ŭ | 4.00 |
| 5.00 | | ELECTROENCEPHALOGRAPHY | 0 | 0 | l | 0 | - | 5.00 |
| 6.00 | | EMERGENCY | 0 | 0 | l | | 0 | 6.00 |
| 7.00 | 0.00 | | 0 | 0 | (| | 0 | 7.00 |
| 8.00 | 0.00 | | 0 | 0 | (| 0 | 0 | 8.00 |
| 9.00 | 0.00 | | 0 | 0 | l | | 0 | 9.00 |
| 10.00 | 0.00 | | 0 | 0 | l | 0 | - | 10.00 |
| 200.00 | Wkst. A Line # | Cost Center/Physician | Provi der | Adjusted RCE | RCE | | 0 | 200.00 |
| | WKSL A LINE # | I denti fi er | Component | Limit | Di sal l owance | Adj ustment | | |
| | | rdentifier | Share of col. | LI IIII L | DI Sal I Owalice | | | |
| | | | 14 | | | | | |
| | 1.00 | 2.00 | 15.00 | 16.00 | 17.00 | 18.00 | | |
| 1.00 | | OTHER ADMIN & GENERAL | 0 | 0 | | | | 1.00 |
| 2.00 | | OPERATION OF PLANT | 0 | 0 | | 1, 125 | | 2.00 |
| 3.00 | | OPERATING ROOM | 0 | 0 | (| .,.== | | 3.00 |
| 4.00 | | RESPI RATORY THERAPY | 0 | 0 | (| 8,850 | | 4.00 |
| 5.00 | | ELECTROENCEPHALOGRAPHY | n 0 | 0 | (| | | 5.00 |
| 6.00 | | EMERGENCY | 0 | 0 | (| 42,000 | | 6.00 |
| 7.00 | 0.00 | | 0 | 0 | (| 0 42,000 | 1 1 | 7.00 |
| 8.00 | 0.00 | | | 0 | | | | 8.00 |
| 9.00 | 0.00 | | 0 0 | 0 | (| | | 9,00 |
| 10.00 | 0.00 | | | 0 | (| | | 9.00 10.00 |
| 200.00 | 0.00 | | | 0 | (| 2, 983, 924 | | 200.00 |
| 200.00 | l l | | 0 | | | 1 2,700,724 | I I | 200.00 |

| | Financial Systems Fi LOCATION - GENERAL SERVICE COSTS | RANCI SCAN HEALT | Provider C | CN: 15-0057 P | eri od: | u of Form CMS-2 Worksheet B | 2552-10 |
|----------------------------|-------------------------------------------------------------------------------------------|-------------------------------------------------------------------|-------------------|---------------|-------------------------------------|--------------------------------|--------------------|
| | | | | | rom 01/01/2022 | Part I Date/Time Pre | pared: |
| | | | CAPI TAL REL | ATED COSTS | | 5/29/2023 3:2 | 8 pm |
| | Cost Center Description | Net Expenses for Cost Allocation (from Wkst A col. 7) | BLDG & FIXT | MVBLE EQUIP | EMPLOYEE BENEFI TS DEPARTMENT | ADMI TTI NG | |
| | | 0 | 1.00 | 2.00 | 4.00 | 5.01 | |
| | GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT | 7, 051, 021 | 7,051,021 | | | | 1.00 |
| | 00200 CAP REL COSTS-MUBLE EQUIP | 160, 266 | 7,031,021 | 160, 266 | | | 2.00 |
| | 00400 EMPLOYEE BENEFITS DEPARTMENT | 7, 437, 620 | 0 | 0 | 7, 437, 620 | | 4.00 |
| | | 24 | 61, 653 | 1, 401 | 0 | 63, 078 | |
| | 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 00590 OTHER ADMI N & GENERAL | 0 32, 822, 920 | 0 173, 821 | 3, 951 | 0 197, 773 | 0 | |
| | 00700 OPERATION OF PLANT | 5, 229, 628 | 1, 476, 668 | 33, 564 | | 0 | |
| | 00800 LAUNDRY & LINEN SERVICE | 123, 962 | 22, 773 | 518 | | 0 | 8.00 |
| | 00900 HOUSEKEEPI NG | 1, 494, 591 | 112, 299 | 2, 552 | | 0 | |
| | 01000 DI ETARY | 167, 139 | 86, 780 | 1, 972 | | 0 | |
| | 01100 CAFETERIA 01300 NURSING ADMINISTRATION | 324, 486 644, 038 | 74, 517 2, 772 | 1, 694 63 | | 0 | 11.00 13.00 |
| | 01400 CENTRAL SERVICES & SUPPLY | 044,030 | 49, 338 | 1, 121 | 42, 836 | 0 | 14.00 |
| | 01500 PHARMACY | 1, 211, 270 | 52, 110 | 1, 184 | | 0 | |
| | 01600 MEDICAL RECORDS & LIBRARY | 23, 782 | 0 | 0 | 0 | 0 | |
| | 02100 I &R SERVICES-SALARY & FRINGES APPRV | 0 | 0 | 0 | - | 0 | |
| | 02200 I &R SERVI CES-OTHER PRGM COSTS APPRV I NPATI ENT ROUTI NE SERVI CE COST CENTERS | 0 | 0 | 0 | 0 | 0 | 22.00 |
| | 03000 ADULTS & PEDIATRICS | 5, 760, 893 | 934, 785 | 21, 247 | 924, 954 | 8, 777 | 30.00 |
| 34.00 | 03400 SURGI CAL I NTENSI VE CARE UNI T | 2, 302, 118 | 206, 975 | 4, 704 | 535, 907 | 3, 047 | 34.00 |
| | 04300 NURSERY | 505, 857 | 0 | 0 | 121, 852 | 670 | 43.00 |
| | ANCI LLARY SERVI CE COST CENTERS 05000 OPERATI NG ROOM | 1 057 747 | E74 244 | 12 100 | ((2,422) | 10 412 | 50.00 |
| | 05200 DELIVERY ROOM & LABOR ROOM | 1, 056, 747 1, 799, 264 | 576, 344 0 | 13, 100 0 | 663, 422 433, 468 | 10, 412 2, 938 | |
| | 05400 RADI OLOGY-DI AGNOSTI C | 2, 440, 809 | 215, 551 | 4, 899 | | 2, 921 | |
| | 05500 RADI OLOGY-THERAPEUTI C | 3, 509, 527 | 180, 331 | 4, 099 | | 166 | 55.00 |
| | 06000 LABORATORY | 3, 141, 947 | 101, 526 | 2, 308 | | 4, 141 | |
| | 06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY | 930, 995 1, 488, 675 | 0 58, 542 | 0 1, 331 | 217, 570 417, 458 | 446 2, 203 | |
| | 06600 PHYSI CAL THERAPY | 1, 609, 993 | 181, 508 | 4, 126 | | 1, 144 | |
| | 06700 OCCUPATI ONAL THERAPY | 224, 468 | 106, 651 | 2, 424 | 64, 055 | 127 | 67.00 |
| | 06800 SPEECH PATHOLOGY | 34, 877 | 0 | 0 | 9, 213 | 70 | |
| | | 369, 757 | 24, 970 | 568 | | 752 | |
| | 07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT | 19, 543 2, 861, 201 | 81, 655 0 | 1, 856 0 | | 46 7, 211 | |
| | 07200 IMPL. DEV. CHARGED TO PATIENTS | 10, 220, 623 | 0 | 0 | 0 | 6, 640 | |
| | 07300 DRUGS CHARGED TO PATIENTS | 17, 736, 784 | 0 | 0 | 0 | 4, 783 | |
| | 07400 RENAL DI ALYSI S | 0 | 0 | | - | 0 | |
| | 07700 ALLOGENEIC STEM CELL ACQUISITION | 0 | 0 | 0 | 0 | 0 | 77.00 |
| | OUTPATIENT SERVICE COST CENTERS | 0 | 70, 674 | 1, 606 | 0 | 13 | 90.00 |
| | 09001 WOUND CARE INSTITUTE | 7, 192 | 0 | 0 | 2,071 | 4 | 90.01 |
| | 09002 OP NUTRITIONAL COUNSELING | 47, 866 | 0 | 0 | 13, 644 | 0 | 90. 02 |
| | 09100 EMERGENCY | 6, 412, 722 | 336, 451 | 7, 647 | 1, 041, 471 | 6, 567 | |
| | 09200 OBSERVATION BEDS (NON-DISTINCT PART | | | | | | 92.00 |
| | OTHER REIMBURSABLE COST CENTERS 10200 OPI OI D TREATMENT PROGRAM | 0 | 0 | 0 | 0 | 0 | 102.00 |
| | SPECIAL PURPOSE COST CENTERS | | 0 | | | | 102.00 |
| 113.00 | 11300 INTEREST EXPENSE | | | | | | 113.00 |
| 118.00 | SUBTOTALS (SUM OF LINES 1 through 117) | 119, 172, 605 | 5, 188, 694 | 117, 935 | 7, 282, 526 | 63, 078 | 118.00 |
| | NONREIMBURSABLE COST CENTERS 19000 GIFT FLOWER COFFEE SHOP & CANTEEN | 106, 644 | 20.010 | / | 12, 002 | | 190. 00 |
| | 19200 PHYSICIANS PRIVATE OFFICES | 444, 520 | 28, 813 0 | 655 0 | 81, 929 | | 190.00 |
| | 07950 COMMUNITY RELATIONS & MARKETING | 4 | 0 | 0 | 01, 729 | | 192.00 |
| 194.01 | 07951 PLAI NFI ELD RADI OLOGY & PHYSI CAL THE | 405, 691 | 0 | 0 | 61, 163 | 0 | 194.01 |
| | 07952 JV MV ENDOSCOPY | 0 | 0 | 0 | 0 | | 194.02 |
| 194.03 | 07953 SOUTHWEST CENTER FOR WOMENS HEALTH 07954 OTHER NRCC | | 1 000 514 | 0 | 0 | | 194.03 |
| 104 04 | | 22, 206, 271 | 1, 833, 514 | 41, 676 | 0 | 0 | 194.04 |
| | | | | | | | 200 00 |
| 194.04 200.00 201.00 | Cross Foot Adjustments Negative Cost Centers | | 0 | 0 | 0 | | 200. 00 201. 00 |

| Health Financial Systems I COST ALLOCATION - GENERAL SERVICE COSTS | FRANCI SCAN HEALTI | Provider C | CN: 15-0057 F | Period: | u of Form CMS-2 Worksheet B | 2002-10 |
|----------------------------------------------------------------------------------------------------|------------------------------------------|-----------------------------|--------------------------|---------------------------------|------------------------------------------|------------------|
| | | | F | From 01/01/2022 0 12/31/2022 | Part I Date/Time Pre 5/29/2023 3:2 | |
| Cost Center Description | CASHI ERI NG/ACC OUNTS RECEI VABLE | Subtotal | OTHER ADMIN & GENERAL | OPERATION OF PLANT | LAUNDRY & LINEN SERVICE | |
| | 5.02 | 5A. 02 | 5.03 | 7.00 | 8.00 | |
| GENERAL SERVICE COST CENTERS | 1 | | 1 | | | |
| 1.00 00100 CAP REL COSTS-BLDG & FIXT | | | | | | 1.00 |
| 2. 00 00200 CAP REL COSTS-MVBLE EQUIP | | | | | | 2.00 |
| 4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 5. 01 00570 ADMITTING | | | | | | 4.00 5.01 |
| 5. 02 00580 CASHI ERING/ACCOUNTS RECEIVABLE | 0 | | | | | 5.01 |
| 5. 03 00590 OTHER ADMIN & GENERAL | 0 | 33, 198, 465 | 33, 198, 465 | | | 5.02 |
| 7. 00 00700 OPERATION OF PLANT | 0 | 7, 085, 135 | | | | 7.00 |
| 8.00 00800 LAUNDRY & LINEN SERVICE | 0 | 160, 774 | | | 249, 096 | 8.00 |
| 9. 00 00900 HOUSEKEEPI NG | 0 | 1, 968, 676 | 598, 852 | 194, 363 | 0 | 9.00 |
| 10. 00 01000 DI ETARY | 0 | 291, 691 | 88, 729 | 150, 196 | 0 | 10.00 |
| 11. 00 01100 CAFETERI A | 0 | 502, 066 | | | 0 | 11.00 |
| 13.00 01300 NURSI NG ADMI NI STRATI ON | 0 | 816, 589 | | | 0 | 13.00 |
| 14.00 01400 CENTRAL SERVICES & SUPPLY | 0 | 93, 295 | | | 0 | 14.00 |
| 15. 00 01500 PHARMACY 16. 00 01600 MEDICAL RECORDS & LIBRARY | 0 | 1, 576, 856 | | | 0 | 15.00 |
| 21. 00 02100 I&R SERVICES-SALARY & FRINGES APPRV | 0 | 23, 782 0 | | | 0 | 21.00 |
| 22. 00 02200 I & SERVICES-OTHER PRGM COSTS APPRV | 0 | 0 | | | 0 | 21.00 |
| INPATIENT ROUTINE SERVICE COST CENTERS | <u> </u> | | 1 | <u> </u> | | 22.00 |
| 30. 00 03000 ADULTS & PEDIATRICS | 0 | 7, 650, 656 | 2, 327, 253 | 1, 617, 896 | 53, 120 | 30.00 |
| 34.00 03400 SURGICAL INTENSIVE CARE UNIT | 0 | 3, 052, 751 | | | 18, 007 | 34.00 |
| 43. 00 04300 NURSERY | 0 | 628, 379 | 191, 147 | 0 | 0 | 43.00 |
| ANCI LLARY SERVI CE COST CENTERS | 1 1 | | | | | |
| 50. 00 O5000 OPERATING ROOM | 0 | 2, 320, 025 | | | 46, 100 | |
| 52. 00 05200 DELIVERY ROOM & LABOR ROOM 54. 00 05400 RADIOLOGY-DIAGNOSTIC | 0 | 2, 235, 670 | | | 0 25 947 | 52.00 54.00 |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C 55. 00 05500 RADI OLOGY-THERAPEUTI C | 0 | 3, 242, 654 3, 830, 666 | | | 35, 867 183 | |
| 60. 00 06000 LABORATORY | 0 | 3, 249, 922 | | | 20 | |
| 64. 00 06400 I NTRAVENOUS THERAPY | 0 | 1, 149, 011 | | | 0 | 64.00 |
| 65. 00 06500 RESPI RATORY THERAPY | 0 | 1, 968, 209 | | | 0 | 65.00 |
| 66. 00 06600 PHYSI CAL THERAPY | 0 | 2, 257, 092 | 686, 585 | 5 314, 148 | 6, 688 | 66.00 |
| 67.00 06700 OCCUPATI ONAL THERAPY | 0 | 397, 725 | | | 1, 905 | |
| 68.00 06800 SPEECH PATHOLOGY | 0 | 44, 160 | | | 0 | 68.00 |
| 69. 00 06900 ELECTROCARDI OLOGY | 0 | 476, 044 | | | 3, 481 | 69.00 |
| 70. 00 07000 ELECTROENCEPHALOGRAPHY 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT | 0 | 107, 390 | | | 284 | 70.00 |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS | 0 | 2, 868, 412 10, 227, 263 | | | 0 | |
| 73. 00 07300 DRUGS CHARGED TO PATIENTS | 0 | 17, 741, 567 | | | 0 | 73.00 |
| 74. 00 07400 RENAL DI ALYSI S | 0 | 0 | | | 0 | 74.00 |
| 77.00 07700 ALLOGENEIC STEM CELL ACQUISITION | 0 | 0 | (| | 0 | • |
| OUTPATIENT SERVICE COST CENTERS | | | | F | | |
| 90. 00 09000 CLINIC | 0 | 72, 293 | | | 0 | |
| 90. 01 09001 WOUND CARE INSTITUTE | 0 | 9, 267 | | | Ũ | |
| 90. 02 09002 OP NUTRI TI ONAL COUNSELING | 0 | 61, 510 | | | 0 | |
| 91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART | 0 | 7, 804, 858 | 2, 374, 160 | 582, 319 | 54, 388 | 91.00 92.00 |
| OTHER REIMBURSABLE COST CENTERS | | 0 | 1 | | | 92.00 |
| 102. 00 10200 OPI OI D TREATMENT PROGRAM | 0 | 0 | (| 0 0 | 0 | 102.00 |
| SPECIAL PURPOSE COST CENTERS | | | <u> </u> | <u> </u> | | 102.00 |
| 113.00 11300 INTEREST EXPENSE | | | | | | 113.00 |
| 118.00 SUBTOTALS (SUM OF LINES 1 through 117) | 0 | 117, 112, 853 | 25, 525, 916 | 6, 017, 106 | 220, 043 | 118.00 |
| NONREI MBURSABLE COST CENTERS | 1 | | | - | | |
| 190. 00 19000 GI FT FLOWER COFFEE SHOP & CANTEEN | 0 | 148, 114 | | | | 190.00 |
| 192. 00 19200 PHYSI CLANS PRI VATE OFFICES | 0 | 526, 449 | 160, 141 | 0 | | 192.00 |
| 194. 00 07950 COMMUNITY RELATIONS & MARKETING 194. 01 07951 PLAINFIELD RADIOLOGY & PHYSICAL THE | 0 | 4 122 051 | 140.017 | 0 | | 194.00 194.01 |
| 194. 02 07952 JV MV ENDOSCOPY | | 466, 854 | 142, 012 | | | 194.01 |
| 194. 03 07953 SOUTHWEST CENTER FOR WOMENS HEALTH | 0 | 0 | | 0 0 | | 194.02 |
| 194. 04 07954 OTHER NRCC | 0 | 24, 081, 461 | 7, 325, 340 | 3, 173, 387 | | 194.04 |
| 200.00 Cross Foot Adjustments | | 0 | | | | 200.00 |
| 201.00 Negative Cost Centers | 0 | 0 | 0 | 0 0 | | 201.00 |
| 202.00 TOTAL (sum lines 118 through 201) | 0 | 142, 335, 735 | 33, 198, 465 | 9, 240, 362 | 249, 096 | 202.00 |
| | | | | | | |

| COST # | ALLOCATION - GENERAL SERVICE COSTS | RANCI SCAN HEALTI | Provider CC | F | Period: From 01/01/2022 Fo 12/31/2022 | u of Form CMS- Worksheet B Part I Date/Time Pre 5/29/2023 3:2 | epared: |
|----------------|--------------------------------------------|-------------------|---------------|----------------------|---------------------------------------------|---------------------------------------------------------------------------|----------------|
| | Cost Center Description | HOUSEKEEPING | DI ETARY | CAFETERI A | NURSI NG ADMI NI STRATI ON | CENTRAL SERVI CES & SUPPLY | |
| | | 9.00 | 10.00 | 11.00 | 13.00 | 14.00 | |
| | GENERAL SERVICE COST CENTERS | I | | | | | |
| 1.00 | 00100 CAP REL COSTS-BLDG & FIXT | | | | | | 1.00 |
| 2.00 | 00200 CAP REL COSTS-MVBLE EQUIP | | | | | | 2.00 |
| 4.00 | 00400 EMPLOYEE BENEFITS DEPARTMENT | | | | | | 4.00 |
| 5. 01 5. 02 | 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE | | | | | | 5. 01 5. 02 |
| 5.02 | 00590 OTHER ADMIN & GENERAL | | | | | | 5.02 |
| 7.00 | 00700 OPERATI ON OF PLANT | | | | | | 7.00 |
| 8.00 | 00800 LAUNDRY & LINEN SERVICE | | | | | | 8.00 |
| 9.00 | 00900 HOUSEKEEPI NG | 2, 761, 891 | | | | | 9.00 |
| 10.00 | 01000 DI ETARY | 46, 058 | 576, 674 | | | | 10.00 |
| 11.00 | 01100 CAFETERI A | 39, 550 | 0 | 823, 31 | 1 | | 11.00 |
| 13.00 | 01300 NURSING ADMINISTRATION | 1, 471 | 0 | 21, 033 | 1, 092, 288 | | 13.00 |
| 14.00 | 01400 CENTRAL SERVICES & SUPPLY | 26, 186 | 0 | (| 0 0 | 233, 253 | 14.00 |
| 15.00 | 01500 PHARMACY | 27,657 | 0 | 42, 243 | 3 314 | 192 | 15.00 |
| 16.00 | 01600 MEDICAL RECORDS & LIBRARY | 0 | 0 | (| 0 0 | 0 | 16.00 |
| 21.00 | 02100 I &R SERVICES-SALARY & FRINGES APPRV | 0 | 0 | (| 0 0 | 0 | |
| 22.00 | 02200 I &R SERVICES-OTHER PRGM COSTS APPRV | 0 | 0 | (| 0 0 | 0 | 22.00 |
| | INPATIENT ROUTINE SERVICE COST CENTERS | T | | | | | |
| 30.00 | 03000 ADULTS & PEDIATRICS | 496, 132 | 428, 977 | 215, 582 | | 379 | 1 |
| 34.00 | 03400 SURGI CAL I NTENSI VE CARE UNI T | 109, 851 | 105, 866 | 64, 485 | | 116 | 1 |
| 43.00 | 04300 NURSERY | 0 | 41, 831 | (| 0 0 | 0 | 43.00 |
| 50.00 | ANCI LLARY SERVICE COST CENTERS | 305, 892 | 0 | 89, 579 | 127, 124 | 1, 671 | 50.00 |
| 52.00 | 05200 DELIVERY ROOM & LABOR ROOM | 305, 892 | 0 | 69, 57 | | 1, 0/1 | 1 |
| 52.00 | 05400 RADI OLOGY-DI AGNOSTI C | 114, 402 | 0 | 98, 352 | | 122 | 1 |
| 55.00 | 05500 RADI OLOGY-THERAPEUTI C | 95, 710 | 0 | 15, 018 | | 19 | 1 |
| 60.00 | 06000 LABORATORY | 53, 885 | 0 | | 0 | 0 | 1 |
| 64.00 | 06400 I NTRAVENOUS THERAPY | 0 | 0 | (| | 125 | 1 |
| 65.00 | 06500 RESPI RATORY THERAPY | 31, 071 | 0 | 46, 270 | | 19 | 1 |
| 66.00 | 06600 PHYSI CAL THERAPY | 96, 334 | 0 | 73, 285 | | 108 | 1 |
| 67.00 | 06700 OCCUPATI ONAL THERAPY | 56, 604 | 0 | 10, 102 | | 17 | 67.00 |
| 68.00 | 06800 SPEECH PATHOLOGY | 0 | 0 | 1, 245 | 5 0 | 2 | 68.00 |
| 69.00 | 06900 ELECTROCARDI OLOGY | 13, 253 | 0 | 8, 673 | 3 0 | 23 | 69.00 |
| 70.00 | 07000 ELECTROENCEPHALOGRAPHY | 43, 338 | 0 | 518 | 3 0 | 7 | 70.00 |
| 71.00 | 07100 MEDICAL SUPPLIES CHARGED TO PATIENT | 0 | 0 | (| 0 0 | 71, 137 | |
| 72.00 | 07200 IMPL. DEV. CHARGED TO PATIENTS | 0 | 0 | (| 0 0 | 158, 888 | |
| 73.00 | 07300 DRUGS CHARGED TO PATIENTS | 0 | 0 | (| - - | 0 | |
| 74.00 | 07400 RENAL DI ALYSI S | 0 | 0 | | 0 0 | 0 | |
| 77.00 | 07700 ALLOGENEIC STEM CELL ACQUISITION | 0 | 0 | (| 0 0 | 0 | 77.00 |
| 90.00 | OUTPATI ENT SERVICE COST CENTERS | 37, 510 | 0 | | 0 0 | 0 | 90.00 |
| | 09001 WOUND CARE INSTITUTE | 37, 510 | 0 | | 687 | | 90.00 |
| | 09002 OP NUTRITIONAL COUNSELING | | 0 | ((| 0 0 | 0 | |
| | 09100 EMERGENCY | 178, 570 | 0 | 132, 565 | - | | 91.00 |
| 92.00 | | 170,070 | Ŭ | 102,000 | 020, 110 | 070 | 92.00 |
| /2:00 | OTHER REIMBURSABLE COST CENTERS | I | | | | | /2:00 |
| 102.00 | 10200 OPI OI D TREATMENT PROGRAM | 0 | 0 | (| 0 0 | 0 | 102.00 |
| | SPECIAL PURPOSE COST CENTERS | · · · · | | | | | |
| 113.00 | 11300 INTEREST EXPENSE | | | | | | 113.00 |
| 118.00 | SUBTOTALS (SUM OF LINES 1 through 117) | 1, 773, 474 | 576, 674 | 818, 973 | 3 1, 092, 147 | 233, 201 | 118.00 |
| | NONREI MBURSABLE COST CENTERS | | | | | | |
| | 19000 GIFT FLOWER COFFEE SHOP & CANTEEN | 15, 292 | 0 | 4, 338 | | | 190. 00 |
| | 19200 PHYSICIANS PRIVATE OFFICES | 0 | 0 | (| 141 | | 192.00 |
| | 07950 COMMUNITY RELATIONS & MARKETING | 0 | 0 | (| 0 0 | | 194.00 |
| | 07951 PLAINFIELD RADIOLOGY & PHYSICAL THE | 0 | 0 | (| 0 0 | | 194.01 |
| | 2 07952 JV MV ENDOSCOPY | 0 | 0 | (| 0 0 | | 194.02 |
| | 07953 SOUTHWEST CENTER FOR WOMENS HEALTH | 0 | 0 | (| 0 | | 194.03 |
| | 07954 OTHER NRCC | 973, 125 | 0 | (| 0 0 | 14 | 194.04 |
| 200.00 | | | | | | | 200.00 |
| | | | | | | | |
| 200.00 | 0 | 0 2, 761, 891 | 0 576, 674 | 823, 31 ⁻ | 0 1 1, 092, 288 | 0 233, 253 | 201.00 |

| | | RANCI SCAN HEALT | | | | eu of Form CMS- | 2552-10 |
|---------|-------------------------------------------------------------------------------------------|------------------|-----------------------|----------------|---------------------------------------------|----------------------------|------------------|
| CUST AI | LLOCATION - GENERAL SERVICE COSTS | | Provider C | CN: 15-0057 | Period: From 01/01/2022 To 12/31/2022 | | |
| | | | L | I NTERNS | & RESI DENTS | | |
| | Cost Center Description | PHARMACY | MEDI CAL RECORDS & | Y & FRINGES | | Subtotal | |
| | | 15.00 | LI BRARY 16.00 | APPRV 21.00 | APPRV 22.00 | 24.00 | |
| | GENERAL SERVICE COST CENTERS | I | | · | T | 1 | |
| | 00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP | | | | | | 1.00 |
| | 00400 EMPLOYEE BENEFITS DEPARTMENT | | | | | | 4.00 |
| | 00570 ADMI TTI NG | | | | | | 5.01 |
| | 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 00590 OTHER ADMI N & GENERAL | | | | | | 5. 02 5. 03 |
| | 00700 OPERATION OF PLANT | | | | | | 7.00 |
| | 00800 LAUNDRY & LINEN SERVICE | | | | | | 8.00 |
| | 00900 HOUSEKEEPI NG | | | | | | 9.00 |
| | 01000 DI ETARY 01100 CAFETERI A | | | | | | 10.00 |
| | 01300 NURSI NG ADMI NI STRATI ON | | | | | | 13.00 |
| | 01400 CENTRAL SERVICES & SUPPLY | | | | | | 14.00 |
| | 01500 PHARMACY | 2, 217, 116 | | | | | 15.00 |
| | 01600 MEDICAL RECORDS & LIBRARY | 0 | 31, 016 C | 1 | 0 | | 16.00 |
| | 02100 I & SERVI CES-SALARY & FRI NGES APPRV 02200 I & SERVI CES-OTHER PRGM COSTS APPRV | 0 | C | | 0 | | 21.00 |
| | INPATIENT ROUTINE SERVICE COST CENTERS | | | · | | | |
| | 03000 ADULTS & PEDI ATRI CS | 0 | 1, 268 | | 0 0 | | |
| | 03400 SURGI CAL I NTENSI VE CARE UNI T 04300 NURSERY | 0 | 305 67 | | 0 0 | | |
| | ANCI LLARY SERVI CE COST CENTERS | 0 | 07 | 1 | 0 0 | 861, 424 | 43.00 |
| | 05000 OPERATI NG ROOM | 0 | 2, 740 | | 0 0 | 4, 596, 378 | 50.00 |
| | 05200 DELIVERY ROOM & LABOR ROOM | 0 | 296 | | 0 0 | 2, 916, 123 | |
| | 05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C | 0 | 3, 459 2, 029 | | 0 0 | 4, 854, 307 5, 429, 303 | |
| | 06000 LABORATORY | 0 | 2,029 | 1 | 0 0 | | |
| | 06400 I NTRAVENOUS THERAPY | 0 | 651 | 1 | 0 0 | 1, 549, 366 | |
| | 06500 RESPI RATORY THERAPY | 0 | 458 | 1 | 0 0 | | |
| | 06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY | 0 | 674 112 | | 0 0 | 3, 434, 914 772, 037 | |
| | 06800 SPEECH PATHOLOGY | 0 | 16 | 1 | 0 0 | 58, 856 | |
| | 06900 ELECTROCARDI OLOGY | 0 | 868 | | 0 0 | 690, 367 | 1 |
| | 07000 ELECTROENCEPHALOGRAPHY | 0 | 102 | | 0 0 | | |
| | 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS | 0 | 1, 710 | | 0 0 | | |
| | 07300 DRUGS CHARGED TO PATIENTS | 2, 217, 116 | 2, 021 6, 262 | | 0 0 | | |
| | 07400 RENAL DI ALYSI S | 0 | C | | 0 0 | | 1 |
| | 07700 ALLOGENEIC STEM CELL ACQUISITION | 0 | C | | 0 0 | 0 | 77.00 |
| | OUTPATIENT SERVICE COST CENTERS | 0 | Z | | 0 0 | 254, 120 | 90.00 |
| | 09001 WOUND CARE INSTITUTE | 0 | 1 | | 0 0 | 12, 774 | |
| | 09002 OP NUTRITIONAL COUNSELING | 0 | 4 | Ļ | 0 0 | | |
| | 09100 EMERGENCY | 0 | 5, 872 | 2 | 0 0 | 11, 456, 550 | |
| | 09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS | | | | | | 92.00 |
| | 10200 OPI OI D TREATMENT PROGRAM | 0 | C | b | 0 0 | 0 | 102.00 |
| | SPECIAL PURPOSE COST CENTERS | | | · | | | 102100 |
| | 11300 INTEREST EXPENSE | | | | | | 113.00 |
| 118.00 | | 2, 217, 116 | 31, 016 | | 0 0 | 105, 195, 047 | 118.00 |
| | NONREI MBURSABLE COST CENTERS 19000 GIFT FLOWER COFFEE SHOP & CANTEEN | 0 | C | | 0 0 | 262, 668 | 190.00 |
| 192.00 | 19200 PHYSICIANS PRIVATE OFFICES | 0 | C | | 0 0 | 686, 781 | 1 |
| | 07950 COMMUNITY RELATIONS & MARKETING | 0 | C | | 0 0 | | 194.00 |
| | 07951 PLAINFIELD RADIOLOGY & PHYSICAL THE | 0 | C | | 0 0 | 608, 870 | |
| | 07952 JV MV ENDOSCOPY 07953 SOUTHWEST CENTER FOR WOMENS HEALTH | 0 | | | | | 194.02 194.03 |
| | 07954 OTHER NRCC | 0 | C | | 0 0 | 35, 582, 364 | |
| 200.00 | | | | | 0 0 | 0 | 200.00 |
| 201.00 | | 0 | 21 01/ |) | 0 0 | | 201.00 |
| 202.00 | TOTAL (sum lines 118 through 201) | 2, 217, 116 | 31, 016 | 4 | 0 0 | 142, 335, 735 | 202.00 |

| | Financial Systems Fi | RANCI SCAN HEALTH | H MOORESVILLE Provider CC | N: 15 0057 | In Lie Period: | worksheet B | 2552-10 |
|--------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|----------------------------------------------------------------------------------------|------------|----------------------------------|-------------|---------------------------------------------------------------------|
| CUST A | LLUCATION - GENERAL SERVICE COSTS | | Frovider cc | N. 13-0037 | From 01/01/2022 To 12/31/2022 | Part I | |
| | Cost Center Description | Intern & Residents Cost & Post Stepdown Adjustments | Total | | | | |
| | GENERAL SERVICE COST CENTERS | 25.00 | 26.00 | | | | |
| $\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 4.\ 00\\ 5.\ 01\\ 5.\ 02\\ 5.\ 03\\ 7.\ 00\\ 8.\ 00\\ \end{array}$ | 00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUI P 00400 EMPLOYEE BENEFITS DEPARTMENT 00570 ADMITTING 00580 CASHI ERI NG/ACCOUNTS RECEIVABLE 00590 OTHER ADMIN & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE | | | | | | 1.00 2.00 4.00 5.01 5.02 5.03 7.00 8.00 |
| 9.00 10.00 11.00 13.00 14.00 15.00 16.00 21.00 | 00900 HOUSEKEEPI NG 01000 DI ETARY 01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY 02100 I & SERVI CES-SALARY & FRI NGES APPRV | | | | | | 9.00 10.00 11.00 13.00 14.00 15.00 16.00 21.00 |
| 22.00 | 02200 I &R SERVICES-OTHER PRGM COSTS APPRV | | | | | | 22.00 |
| 30.00 34.00 43.00 | I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS 03400 SURGI CAL I NTENSI VE CARE UNI T 04300 NURSERY | 0 0 0 | 13, 214, 274 4, 797, 348 861, 424 | | | | 30.00 34.00 43.00 |
| | ANCILLARY SERVICE COST CENTERS | | | | | | |
| 50.00 52.00 54.00 55.00 60.00 64.00 | 05000 OPERATING ROOM 05200 DELIVERY ROOM & LABOR ROOM 05400 RADIOLOGY-DIAGNOSTIC 05500 RADIOLOGY-THERAPEUTIC 06000 LABORATORY 06400 INTRAVENOUS THERAPY | | 4, 596, 378 2, 916, 123 4, 854, 307 5, 429, 303 4, 470, 235 1, 549, 366 | | | | 50.00 52.00 54.00 55.00 60.00 64.00 |
| 65.00 66.00 67.00 68.00 69.00 70.00 | 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY | 0 0 0 0 0 | 2, 746, 058 3, 434, 914 772, 037 58, 856 690, 367 325, 632 | | | | 65.00 66.00 67.00 68.00 69.00 70.00 |
| 71.00 72.00 73.00 74.00 77.00 | 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS 07700 ALLOGENEIC STEM CELL ACQUISITION | 0 0 0 0 | 3, 813, 801 13, 499, 203 25, 361, 752 0 0 | | | | 71.00 72.00 73.00 74.00 77.00 |
| 90.00 | OUTPATIENT SERVICE COST CENTERS | 0 | 254, 120 | | | | 90.00 |
| 90. 01 90. 02 91. 00 | 09001 WOUND CARE INSTITUTE 09002 OP NUTRITIONAL COUNSELING 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART | 0 0 0 0 | 12, 774 80, 225 11, 456, 550 | | | | 90. 01 90. 02 91. 00 92. 00 |
| 102.00 | OTHER REIMBURSABLE COST CENTERS 10200 OPI 0I D TREATMENT PROGRAM | 0 | 0 | | | | 102.00 |
| | SPECIAL PURPOSE COST CENTERS | | | | | | |
| 113.00 118.00 | 11300 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS | 0 | 105, 195, 047 | | | | 113.00 118.00 |
| 192.00 194.00 194.01 194.02 | 19000 GIFT FLOWER COFFEE SHOP & CANTEEN 19200 PHYSI CLANS PRI VATE OFFICES 07950 COMMUNI TY RELATIONS & MARKETING 07951 PLAINFIELD RADIOLOGY & PHYSI CAL THE 07952 JV MV ENDOSCOPY | 0 0 0 0 | 262, 668 686, 781 5 608, 870 0 | | | | 190.00 192.00 194.00 194.01 194.02 |
| | Negative Cost Centers | | 0 35, 582, 364 0 0 142, 335, 735 | | | | 194.03 194.04 200.00 201.00 202.00 |

| | Financial Systems F TION OF CAPITAL RELATED COSTS | RANCI SCAN HEALT | Provider CC | | eri od: | u of Form CMS-2 Worksheet B | 2552-10 |
|-------------------------------|---------------------------------------------------------------------------|------------------------------------------------------|-----------------------|-------------------|--------------------------------|------------------------------------|--------------------------------------|
| | | | | Fr Tc | rom 01/01/2022 0 12/31/2022 | Part II Date/Time Pre | |
| | | | CAPI TAL REL | ATED COSTS | | 5/29/2023 3:2 | |
| | Cost Center Description | Directly Assigned New Capital Related Costs | BLDG & FIXT | MVBLE EQUIP | Subtotal | EMPLOYEE BENEFITS DEPARTMENT | |
| | | 0 | 1.00 | 2.00 | 2A | 4.00 | |
| | GENERAL SERVICE COST CENTERS | | | | | | 1 1 00 |
| | 00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP | | | | | | 1.00 |
| | 00400 EMPLOYEE BENEFITS DEPARTMENT | 0 | 0 | 0 | 0 | 0 | |
| | 00570 ADMI TTI NG | 0 | 61, 653 | 1, 401 | 63, 054 | 0 | |
| | 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE | 0 | 0 | 0 | 0 | 0 | 5.02 |
| 5.03 | 00590 OTHER ADMIN & GENERAL | 0 | 173, 821 | 3, 951 | 177, 772 | 0 | 5.03 |
| 7.00 | 00700 OPERATION OF PLANT | 0 | 1, 476, 668 | 33, 564 | 1, 510, 232 | 0 | 7.00 |
| 1 | 00800 LAUNDRY & LINEN SERVICE | 0 | 22, 773 | 518 | 23, 291 | 0 | |
| | 00900 HOUSEKEEPI NG | 0 | 112, 299 | 2, 552 | 114, 851 | 0 | |
| | 01000 DI ETARY | 0 | 86, 780 | 1, 972 | 88, 752 | 0 | 10.00 |
| | 01100 CAFETERIA | 0 | 74, 517 | 1, 694 | 76, 211 | 0 | |
| | 01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY | 0 | 2, 772 49, 338 | 63 1, 121 | 2, 835 50, 459 | 0 | 13.00 |
| | 01400 CENTRAL SERVICES & SUFFET | 0 | 49, 338 52, 110 | 1, 121 | 53, 294 | 0 | 14.00 |
| | 01600 MEDI CAL RECORDS & LI BRARY | 0 | 02,110 | 1, 104 | 0,2,4 | 0 | 16.00 |
| | 02100 I &R SERVICES-SALARY & FRINGES APPRV | 0 | 0 | 0 | Ő | 0 | 21.00 |
| | 02200 I&R SERVICES-OTHER PRGM COSTS APPRV | 0 | 0 | 0 | 0 | 0 | 22.00 |
| | INPATIENT ROUTINE SERVICE COST CENTERS | | | | | | |
| | 03000 ADULTS & PEDIATRICS | 0 | 934, 785 | 21, 247 | 956, 032 | 0 | |
| | 03400 SURGICAL INTENSIVE CARE UNIT | 0 | 206, 975 | 4, 704 | 211, 679 | 0 | |
| 43.00 | 04300 NURSERY | 0 | 0 | 0 | 0 | 0 | 43.00 |
| 50.00 | ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM | 0 | E74 244 | 12 100 | 589, 444 | 0 | 50.00 |
| | 05200 DELIVERY ROOM & LABOR ROOM | 0 | 576, 344 | 13, 100 | 007, 444 | 0 | 52.00 |
| | 05400 RADI OLOGY-DI AGNOSTI C | 0 | 215, 551 | 4, 899 | 220, 450 | 0 | • |
| | 05500 RADI OLOGY-THERAPEUTI C | 0 | 180, 331 | 4, 099 | 184, 430 | 0 | 55.00 |
| | 06000 LABORATORY | 0 | 101, 526 | 2, 308 | 103, 834 | 0 | 60.00 |
| 64.00 | 06400 INTRAVENOUS THERAPY | 0 | 0 | 0 | 0 | 0 | 64.00 |
| | 06500 RESPI RATORY THERAPY | 0 | 58, 542 | 1, 331 | 59, 873 | 0 | 65.00 |
| | 06600 PHYSI CAL THERAPY | 0 | 181, 508 | 4, 126 | 185, 634 | 0 | 66.00 |
| | 06700 OCCUPATI ONAL THERAPY | 0 | 106, 651 | 2, 424 | 109, 075 | 0 | 67.00 |
| | 06800 SPEECH PATHOLOGY | 0 | 0 | 0 | 0 | 0 | 68.00 |
| 1 | | 0 | 24, 970 | 568 | 25, 538 | 0 | 69.00 |
| | 07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT | 0 | 81, 655 | 1, 856 | 83, 511 | 0 | 70.00 |
| | 07200 IMPL. DEV. CHARGED TO PATIENTS | 0 | 0 | 0 | 0 | 0 | |
| | 07300 DRUGS CHARGED TO PATIENTS | 0 | 0 | 0 | 0 | 0 | 73.00 |
| | 07400 RENAL DIALYSIS | 0 | o | 0 | 0 | 0 | • |
| 77.00 | 07700 ALLOGENEIC STEM CELL ACQUISITION | 0 | 0 | 0 | 0 | 0 | 77.00 |
| | OUTPATIENT SERVICE COST CENTERS | | | | | | |
| | 09000 CLI NI C | 0 | 70, 674 | 1, 606 | 72, 280 | 0 | |
| | 09001 WOUND CARE INSTITUTE | 0 | 0 | 0 | 0 | 0 | 90.01 |
| | 09002 OP NUTRITIONAL COUNSELING | 0 | 0 | 0 | 0 | 0 | |
| | 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART | 0 | 336, 451 | 7, 647 | 344, 098 | 0 | 91.00 92.00 |
| | OTHER REIMBURSABLE COST CENTERS | | | | U | | 92.00 |
| | 10200 OPI OI D TREATMENT PROGRAM | 0 | 0 | 0 | 0 | 0 | 102.00 |
| 102100 | SPECIAL PURPOSE COST CENTERS | | | | | | 1.02.00 |
| 113.00 | 11300 INTEREST EXPENSE | | | | | | 113.00 |
| 118.00 | | 0 | 5, 188, 694 | 117, 935 | 5, 306, 629 | 0 | 118.00 |
| | NONREI MBURSABLE COST CENTERS | | | | | | |
| | 19000 GIFT FLOWER COFFEE SHOP & CANTEEN | 0 | 28, 813 | 655 | 29, 468 | | 190.00 |
| | 19200 PHYSI CLANS PRI VATE OFFICES | 0 | 0 | 0 | 0 | | 192.00 |
| 194.00 | 07950 COMMUNITY RELATIONS & MARKETING | 0 | 0 | 0 | 0 | | 194.00 |
| 101 01 | 07951 PLAINFIELD RADIOLOGY & PHYSICAL THE | 0 | 0 | 0 | 0 | | 194. 01 194. 02 |
| | | | 0 | 0 | 0 | | |
| 194.02 | 07952 JV MV ENDOSCOPY 07953 SOUTHWEST CENTER FOR WOMENS HEALTH | _ | ~ | | | ∩ | 110/ 02 |
| 194. 02 194. 03 | 07953 SOUTHWEST CENTER FOR WOMENS HEALTH | 0 | 0 1 822 514 | 0 11 676 | 0 1 875 100 | | |
| 194. 02 194. 03 194. 04 | 07953 SOUTHWEST CENTER FOR WOMENS HEALTH 07954 OTHER NRCC | 0 | 0 1, 833, 514 | 0 41, 676 | 0 1, 875, 190 0 | | 194.04 |
| 194. 02 194. 03 | 07953 SOUTHWEST CENTER FOR WOMENS HEALTH | 0 | 0 1, 833, 514 0 | 0 41, 676 0 | 0 1, 875, 190 0 0 | 0 | 194.03 194.04 200.00 201.00 |

| LLOCA | TION OF CAPITAL RELATED COSTS | | Provider C | F | eriod: rom 01/01/2022 | Worksheet B Part II Date (Time Dre | no |
|--------------|--------------------------------------------------------------------------|------------------|------------------------------------------|--------------------------|--------------------------|------------------------------------------|------|
| | | 1 | | | 0 12/31/2022 | Date/Time Pre 5/29/2023 3:2 | |
| | Cost Center Description | ADMI TTI NG | CASHI ERI NG/ACC OUNTS RECEI VABLE | OTHER ADMIN & GENERAL | OPERATION OF PLANT | LAUNDRY & LINEN SERVICE | |
| | | 5.01 | 5.02 | 5.03 | 7.00 | 8.00 | |
| | GENERAL SERVICE COST CENTERS | | 1 | | | | |
| | 00100 CAP REL COSTS-BLDG & FIXT | | | | | | 1. |
| . 00 . 00 | 00200 CAP REL COSTS-MVBLE EQUIP | | | | | | 2. |
| | 00400 EMPLOYEE BENEFITS DEPARTMENT | (2. OF 4 | | | | | 4. |
| 01 02 | 00570 ADMITTING | 63, 054 0 | | | | | 5. |
| 02 | 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 00590 OTHER ADMI N & GENERAL | 0 | 0 | 177, 772 | | | 5. |
| | 00700 OPERATION OF PLANT | 0 | | 11, 542 | | | 7. |
| | 00800 LAUNDRY & LINEN SERVICE | 0 | 0 | 262 | | 30, 044 | |
| | 00900 HOUSEKEEPING | 0 | 0 | 3, 207 | | 00,011 | |
| | 01000 DI ETARY | 0 | 0 | 475 | | 0 | |
| | 01100 CAFETERI A | 0 | 0 | 818 | | 0 | 11. |
| - | 01300 NURSI NG ADMI NI STRATI ON | 0 | 0 | 1, 330 | | 0 | 13. |
| . 00 | 01400 CENTRAL SERVICES & SUPPLY | 0 | 0 | 152 | 14, 063 | 0 | 14 |
| 5.00 | 01500 PHARMACY | 0 | 0 | 2, 569 | 14, 853 | 0 | 15 |
| | 01600 MEDICAL RECORDS & LIBRARY | 0 | 0 | 39 | | 0 | |
| | 02100 I &R SERVICES-SALARY & FRINGES APPRV | 0 | 0 | | | 0 | |
| 2.00 | 02200 I &R SERVICES-OTHER PRGM COSTS APPRV | 0 | 0 | 0 | 0 | 0 | 22 |
| | INPATIENT ROUTINE SERVICE COST CENTERS | | - | | | | |
| | 03000 ADULTS & PEDIATRICS | 8,777 | | | | 6, 407 | |
| | 03400 SURGI CAL I NTENSI VE CARE UNI T | 3,047 | | | | 2, 172 | |
| | 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS | 670 | 0 | 1, 024 | 0 | 0 | 43 |
| | 05000 OPERATING ROOM | 10, 388 | 0 | 3, 779 | 164, 279 | 5, 560 | 50 |
| | 05200 DELIVERY ROOM & LABOR ROOM | 2, 938 | | | | 0,000 | |
| | 05400 RADI OLOGY-DI AGNOSTI C | 2, 921 | 0 | | | 4, 326 | |
| | 05500 RADI OLOGY-THERAPEUTI C | 166 | 0 | 6, 240 | | 22 | |
| . 00 | 06000 LABORATORY | 4, 141 | 0 | 5, 294 | | 2 | 60 |
| . 00 | 06400 INTRAVENOUS THERAPY | 446 | 0 | 1, 872 | 0 | 0 | 64 |
| . 00 | 06500 RESPI RATORY THERAPY | 2, 203 | 0 | 3, 206 | 16, 687 | 0 | 65 |
| | 06600 PHYSI CAL THERAPY | 1, 144 | 0 | 3, 677 | | 807 | 66 |
| | 06700 OCCUPATI ONAL THERAPY | 127 | | 648 | | 230 | |
| | 06800 SPEECH PATHOLOGY | 70 | | 72 | | 0 | |
| | 06900 ELECTROCARDI OLOGY | 752 | | 775 | | 420 | |
| | 07000 ELECTROENCEPHALOGRAPHY | 46 | 0 | 175 | | 34 | |
| | 07100 MEDICAL SUPPLIES CHARGED TO PATIENT | 7, 211 6, 640 | 0 | 4, 673 16, 660 | | 0 | |
| | 07200 I MPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS | 4, 783 | | 28, 901 | 0 | 0 | |
| | 07400 RENAL DIALYSIS | 4,783 | | | - | 0 | |
| | 07700 ALLOGENEIC STEM CELL ACQUISITION | 0 | | | | 0 | |
| | OUTPATIENT SERVICE COST CENTERS | | | | | | 1 |
| . 00 | 09000 CLI NI C | 13 | 0 | 118 | 20, 145 | 0 | |
| | 09001 WOUND CARE INSTITUTE | 4 | 0 | 15 | 0 | 0 | |
| . 02 | 09002 OP NUTRITIONAL COUNSELING | 0 | 0 | | | 0 | 90 |
| | 09100 EMERGENCY | 6, 567 | 0 | 12, 714 | 95, 901 | 6, 560 | |
| | 09200 OBSERVATION BEDS (NON-DISTINCT PART | | | | | | 92 |
| | OTHER REIMBURSABLE COST CENTERS | | | | | 0 | 1100 |
| | 10200 OPI OI D TREATMENT PROGRAM | 0 | 0 | 0 | 0 | 0 | 102 |
| | SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE | | | | | | 113 |
| 8.00 | | 63, 054 | 0 | 136, 697 | 990, 943 | 26, 540 | |
| | NONREI MBURSABLE COST CENTERS | . 55, 654 | . 0 | 100,077 | ,,0,,+3 | 20, 340 | 1.10 |
| | 19000 GIFT FLOWER COFFEE SHOP & CANTEEN | 0 | 0 | 241 | 8, 213 | 0 | 190 |
| | 19200 PHYSICIANS PRIVATE OFFICES | 0 | 0 | 858 | | | 192 |
| | 07950 COMMUNITY RELATIONS & MARKETING | 0 | 0 | 0 | | | 194 |
| | 07951 PLAINFIELD RADIOLOGY & PHYSICAL THE | 0 | 0 | 761 | 0 | 0 | 194 |
| | 07952 JV MV ENDOSCOPY | 0 | 0 | 0 | 0 | | 194 |
| | 07953 SOUTHWEST CENTER FOR WOMENS HEALTH | 0 | 0 | 0 | 0 | | 194 |
| | 07954 OTHER NRCC | 0 | 0 | 39, 215 | 522, 618 | 3, 502 | |
| 0.00 | | | | | | | 200 |
| 1.00 | | 0 | 0 | 0 | 0 | 0 | 201 |
| 2.00 | TOTAL (sum lines 118 through 201) | 63, 054 | 0 | 177, 772 | 1, 521, 774 | 30, 044 | 202 |

| Heal th Fi | nancial Systems F | RANCI SCAN HEALT | H MOORESVILLE | | In Lie | u of Form CMS- | 2552-10 |
|--------------------|----------------------------------------------------------------------------------------|-------------------|--------------------|-------------|---------------------------------------------|----------------------------------|-------------------------|
| ALLOCATIO | ON OF CAPITAL RELATED COSTS | | Provider CC | F | Period: From 01/01/2022 Fo 12/31/2022 | Date/Time Pre 5/29/2023 3:2 | pared: 8 pm |
| | Cost Center Description | HOUSEKEEPI NG | DI ETARY | CAFETERI A | NURSI NG ADMI NI STRATI ON | CENTRAL SERVI CES & SUPPLY | |
| 0.5 | | 9.00 | 10.00 | 11.00 | 13.00 | 14.00 | |
| | NERAL SERVICE COST CENTERS 100 CAP REL COSTS-BLDG & FIXT | | | | | | 1 1 00 |
| 2.00 00 4.00 00 | 200 CAP REL COSTS-MVBLE EQUIP 400 EMPLOYEE BENEFITS DEPARTMENT | | | | | | 1.00 2.00 4.00 |
| 5.02 00 | 570 ADMI TTI NG 580 CASHI ERI NG/ACCOUNTS RECEI VABLE 590 OTHER ADMI N & GENERAL | | | | | | 5. 01 5. 02 5. 03 |
| | 700 OPERATION OF PLANT | | | | | | 7.00 |
| | 800 LAUNDRY & LINEN SERVICE | 450.047 | | | | | 8.00 |
| | 900 HOUSEKEEPING | 150, 067 | 11/ 4/5 | | | | 9.00 |
| | 000 DI ETARY 100 CAFETERI A | 2, 503 2, 149 | 116, 465 0 | | 2 | | 10.00 |
| | 300 NURSI NG ADMI NI STRATI ON | 2, 149 | 0 | 2, 565 | | | 13.00 |
| | 400 CENTRAL SERVICES & SUPPLY | 1, 423 | 0 | 2,000 | | 66, 097 | 14.00 |
| | 500 PHARMACY | 1, 503 | 0 | 5, 152 | 2 2 | 54 | 1 |
| 16.00 01 | 600 MEDICAL RECORDS & LIBRARY | 0 | 0 | (| 0 0 | 0 | 16.00 |
| | 100 I&R SERVICES-SALARY & FRINGES APPRV | 0 | 0 | | 0 0 | 0 | |
| | 200 I &R SERVICES-OTHER PRGM COSTS APPRV | 0 | 0 | (| 0 0 | 0 | 22.00 |
| | PATIENT ROUTINE SERVICE COST CENTERS | 26.057 | 04 424 | 26.201 | 2.045 | 107 | 20.00 |
| | 000 ADULTS & PEDIATRICS 400 SURGICAL INTENSIVE CARE UNIT | 26, 957 5, 969 | 86, 636 21, 381 | | | 107 | 30.00 34.00 |
| | 300 NURSERY | 0 | 8, 448 | | | 0 | |
| | CI LLARY SERVICE COST CENTERS | <u> </u> | 0, 110 | | <u> </u> | | 101.00 |
| | 000 OPERATING ROOM | 16, 621 | 0 | 10, 926 | 6 884 | 473 | 50.00 |
| 52.00 05 | 200 DELIVERY ROOM & LABOR ROOM | 0 | 0 | | 3 0 | 0 | 52.00 |
| | 400 RADI OLOGY-DI AGNOSTI C | 6, 216 | 0 | | | 35 | 1 |
| | 500 RADI OLOGY-THERAPEUTI C | 5, 200 | 0 | 1, 832 | | 5 | |
| | | 2, 928 | 0 | | | 0 | |
| | 400 I NTRAVENOUS THERAPY 500 RESPI RATORY THERAPY | 0 1, 688 | 0 | (5, 643 | | 35 | 1 |
| | 600 PHYSI CAL THERAPY | 5, 234 | 0 | 8, 938 | | 31 | 66.00 |
| | 700 OCCUPATI ONAL THERAPY | 3,076 | 0 | 1, 232 | | 5 | |
| | 800 SPEECH PATHOLOGY | 0 | 0 | 152 | | 1 | 68.00 |
| 69.00 06 | 900 ELECTROCARDI OLOGY | 720 | 0 | 1, 058 | 3 0 | 6 | 69.00 |
| | 000 ELECTROENCEPHALOGRAPHY | 2, 355 | 0 | 63 | | 2 | |
| | 100 MEDICAL SUPPLIES CHARGED TO PATIENT | 0 | 0 | (| - | 20, 157 | |
| | 200 IMPL. DEV. CHARGED TO PATIENTS | 0 | 0 | (| - | 45, 027 | |
| | 300 DRUGS CHARGED TO PATIENTS 400 RENAL DIALYSIS | 0 | 0 | | 0 | 0 | |
| | 700 ALLOGENEIC STEM CELL ACQUISITION | 0 | 0 | | | 0 | 1 |
| | TPATIENT SERVICE COST CENTERS | 0 | 0 | | 0 | 0 | //.00 |
| | 000 CLINIC | 2, 038 | 0 | (| 0 0 | | 90.00 |
| 90.01 09 | 001 WOUND CARE INSTITUTE | 0 | 0 | (| 5 5 | 0 | 90.01 |
| | 002 OP NUTRITIONAL COUNSELING | 0 | 0 | | 0 0 | 0 | |
| | 100 EMERGENCY | 9, 703 | 0 | 16, 169 | 2, 250 | 106 | 91.00 |
| | 200 OBSERVATION BEDS (NON-DISTINCT PART | | | | | | 92.00 |
| | HER REIMBURSABLE COST CENTERS 200 OPI OI D TREATMENT PROGRAM | 0 | 0 | (| 0 0 | 0 | 102.00 |
| | ECIAL PURPOSE COST CENTERS | <u> </u> | 0 | | 0 | 0 | 102.00 |
| | 300 I NTEREST EXPENSE | | | | | | 113.00 |
| 118.00 | SUBTOTALS (SUM OF LINES 1 through 117) | 96, 363 | 116, 465 | 99, 889 | 7, 599 | 66, 082 | 118.00 |
| NOI | NREIMBURSABLE COST CENTERS | | | | | | |
| | 000 GIFT FLOWER COFFEE SHOP & CANTEEN | 831 | 0 | - | | | 190.00 |
| | 200 PHYSICIANS PRIVATE OFFICES | 0 | 0 | (| 1 | | 192.00 |
| | 950 COMMUNITY RELATIONS & MARKETING | 0 | 0 | | 0 | | 194.00 |
| | 951 PLAINFIELD RADIOLOGY & PHYSICAL THE | 0 | 0 | | 0 | | 194.01 |
| | 952 JV MV ENDOSCOPY 953 SOUTHWEST CENTER FOR WOMENS HEALTH | 0 | 0 | | | | 194. 02 194. 03 |
| | 953 SOUTHWEST CENTER FOR WOMENS HEALTH 954 OTHER NRCC | 52, 873 | 0 | | | | 194. 03 194. 04 |
| 200.00 | Cross Foot Adjustments | 52,075 | 0 | | | 4 | 200.00 |
| 201.00 | Negative Cost Centers | 0 | 0 | | o o | 0 | 201.00 |
| 202.00 | TOTAL (sum lines 118 through 201) | 150, 067 | 116, 465 | 100, 418 | 7,600 | | 202.00 |
| | | | | | | | |

| LOCATI (| ON OF CAPITAL RELATED COSTS | | Provider C | CN: 15-0057 | Peri od: From 01/01/2022 To 12/31/2022 | Worksheet E Part II Date/Time F 5/29/2023 3 | repare |
|----------------|---------------------------------------------|----------|-----------------------------------|---------------------------------------|----------------------------------------------|------------------------------------------------------|---------|
| | | | L | I NTERNS | & RESIDENTS | 0,2,,2020 | |
| | Cost Center Description | PHARMACY | MEDI CAL RECORDS & LI BRARY | SERVI CES-SAI Y & FRI NGE APPRV | LAR SERVI CES-OTHER S PRGM COSTS APPRV | Subtotal | |
| | | 15.00 | 16.00 | 21.00 | 22.00 | 24.00 | |
| GE | NERAL SERVICE COST CENTERS | | | | | | |
| 00 00 | 100 CAP REL COSTS-BLDG & FIXT | | | | | | 1. |
| | 200 CAP REL COSTS-MVBLE EQUIP | | | | | | 2. |
| | 400 EMPLOYEE BENEFITS DEPARTMENT | | | | | | 4. |
| | 570 ADMI TTI NG | | | | | | 5. |
| | 580 CASHI ERI NG/ACCOUNTS RECEI VABLE | | | | | | 5. |
| | 590 OTHER ADMIN & GENERAL | | | | | | 5. |
| | 700 OPERATION OF PLANT | | | | | | 7. |
| | 800 LAUNDRY & LINEN SERVICE | | | | | | 8. |
| | 900 HOUSEKEEPI NG | | | | | | 9. |
| | 000 DI ETARY | | | | | | 10. |
| | 100 CAFETERI A | | | | | | 11. |
| | 300 NURSING ADMINISTRATION | | | | | | 13. |
| | 400 CENTRAL SERVICES & SUPPLY | | | | | | 14. |
| | 500 PHARMACY | 77, 427 | | | | | 15. |
| | 600 MEDICAL RECORDS & LIBRARY | 0 | 39 | | | | 16. |
| | 100 I &R SERVICES-SALARY & FRINGES APPRV | 0 | (| | 0 | | 21. |
| | 200 I &R SERVICES-OTHER PRGM COSTS APPRV | 0 | (| y | 0 | | 22. |
| | PATIENT ROUTINE SERVICE COST CENTERS | 0 | | 1 | | 1 202 0 | 47 20 |
| | 000 ADULTS & PEDIATRICS | 0 | (| | | 1, 393, 0 | |
| | 400 SURGI CAL I NTENSI VE CARE UNI T | 0 | (| | | 317, 2 | |
| | 300 NURSERY CILLARY SERVICE COST CENTERS | 0 | | <u>и</u> | | 10, 1 | 42 43. |
| | 000 OPERATI NG ROOM | 0 | (| | | 802, 3 | 54 50. |
| | 200 DELIVERY ROOM & LABOR ROOM | 0 | (| | | 6, 5 | |
| | 400 RADI OLOGY - DI AGNOSTI C | 0 | (| | | 312, 6 | |
| | 500 RADI OLOGY-THERAPEUTI C | 0 | (| | | 249, 3 | |
| | 000 LABORATORY | 0 | (| | | 145, 1 | |
| | 400 I NTRAVENOUS THERAPY | 0 | (| | | 2, 7 | |
| | 500 RESPI RATORY THERAPY | 0 | (| | | 89, 3 | |
| | 600 PHYSI CAL THERAPY | 0 | (| | | 257, 2 | |
| | 700 OCCUPATI ONAL THERAPY | 0 | (| | | 144, 7 | |
| | 800 SPEECH PATHOLOGY | 0 | (| | | | 95 68. |
| | 900 ELECTROCARDI OLOGY | 0 | (| | | | 86 69. |
| | 000 ELECTROENCEPHALOGRAPHY | 0 | (| | | 109, 4 | |
| | 100 MEDICAL SUPPLIES CHARGED TO PATIENT | 0 | C | | | 32, 0 | |
| | 200 IMPL. DEV. CHARGED TO PATIENTS | 0 | (| | | 68, 3 | |
| | 300 DRUGS CHARGED TO PATIENTS | 77, 427 | 39 | | | 111, 1 | |
| . 00 07 | 400 RENAL DIALYSIS | 0 | (| | | | 0 74. |
| . 00 07 | 700 ALLOGENEIC STEM CELL ACQUISITION | 0 | (| | | | 0 77. |
| OU | TPATIENT SERVICE COST CENTERS | | | | | | |
| | 000 CLINIC | 0 | (| | | 94, 5 | 94 90. |
| | 001 WOUND CARE INSTITUTE | 0 | (| | | | 24 90. |
| | 002 OP NUTRITIONAL COUNSELING | 0 | (| | | | 00 90. |
| | 100 EMERGENCY | 0 | (| | | 494, 0 | 68 91. |
| | 200 OBSERVATION BEDS (NON-DISTINCT PART | | | | | | 92. |
| | HER REIMBURSABLE COST CENTERS | - | - | .1 | | | |
| | 200 OPI OI D TREATMENT PROGRAM | 0 | (|) | | | 0 102. |
| | ECIAL PURPOSE COST CENTERS | | | 1 | | | 110 |
| | 300 INTEREST EXPENSE | | 20 | | | 4 (7(0 | 113. |
| 8.00 | SUBTOTALS (SUM OF LINES 1 through 117) | 77, 427 | 39 | 1 | 0 0 | 4, 676, 9 | 10118. |
| | NREIMBURSABLE COST CENTERS | | | | | 20.0 | 02 100 |
| | 000 GIFT FLOWER COFFEE SHOP & CANTEEN | 0 | (| | | | 82 190. |
| | 200 PHYSICIANS PRIVATE OFFICES | 0 | (| | | 8 | 71 192. |
| | 950 COMMUNITY RELATIONS & MARKETING | 0 | (| | | - | 0 194. |
| | 951 PLAINFIELD RADIOLOGY & PHYSICAL THE | 0 | (| | | / | 62 194. |
| | 952 JV MV ENDOSCOPY | 0 | (| | | | 0 194. |
| | 953 SOUTHWEST CENTER FOR WOMENS HEALTH | 0 | (| | | 2 402 4 | 0 194. |
| 4.0407 0.00 | 954 OTHER NRCC | 0 | (| / / | | 2, 493, 4 | |
| | Cross Foot Adjustments | | | | 0 0 | | 0 200. |
| 1.00 | Negative Cost Centers | | (| | 0 0 | | 0 201. |

| ALLUCA | TION OF CADITAL DELATED COSTS | | Drout day 00 | N. 1E 00E7 | Dariad | Workehest D | 2552-10 |
|----------------------------|---------------------------------------------------------------------------|-----------------------------------------------------------------|---------------------|------------|---------------------------------------------|------------------------------------------------------------|--------------------|
| | TION OF CAPITAL RELATED COSTS | | Provider CC | N: 15-0057 | Period: From 01/01/2022 To 12/31/2022 | Worksheet B Part II Date/Time Prep 5/29/2023 3:28 | pared: 8 pm |
| | Cost Center Description | Intern & Residents Cost & Post Stepdown Adjustments | Total | | | | |
| | | 25.00 | 26.00 | | | | |
| | GENERAL SERVICE COST CENTERS | 1 | | | | | 1 00 |
| | 00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP | | | | | | 1.00 2.00 |
| | 00400 EMPLOYEE BENEFITS DEPARTMENT | | | | | | 4.00 |
| | 00570 ADMI TTI NG | | | | | | 5.01 |
| 5.02 | 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE | | | | | | 5.02 |
| 5.03 | 00590 OTHER ADMIN & GENERAL | | | | | | 5.03 |
| | 00700 OPERATION OF PLANT | | | | | | 7.00 |
| | 00800 LAUNDRY & LINEN SERVICE | | | | | | 8.00 |
| | 00900 HOUSEKEEPING | | | | | | 9.00 |
| | 01000 DI ETARY | | | | | | 10.00 |
| | 01100 CAFETERIA 01300 NURSI NG ADMI NI STRATI ON | | | | | | 11.00 13.00 |
| | 01400 CENTRAL SERVICES & SUPPLY | | | | | | 13.00 |
| | 01500 PHARMACY | | | | | | 15.00 |
| | 01600 MEDICAL RECORDS & LIBRARY | | | | | | 16.00 |
| | 02100 I &R SERVICES-SALARY & FRINGES APPRV | | | | | | 21.00 |
| | 02200 I &R SERVICES-OTHER PRGM COSTS APPRV | | | | | | 22.00 |
| | INPATIENT ROUTINE SERVICE COST CENTERS | | | | | | |
| 30.00 | 03000 ADULTS & PEDIATRICS | 0 | 1, 393, 067 | | | | 30.00 |
| | 03400 SURGICAL INTENSIVE CARE UNIT | 0 | 317, 221 | | | | 34.00 |
| | 04300 NURSERY | 0 | 10, 142 | | | | 43.00 |
| | ANCI LLARY SERVICE COST CENTERS | | 000.054 | | | | 50.00 |
| | 05000 OPERATING ROOM 05200 DELIVERY ROOM & LABOR ROOM | 0 | 802, 354 6, 583 | | | | 50.00 52.00 |
| | 05400 RADI OLOGY-DI AGNOSTI C | 0 | 312, 666 | | | | 52.00 |
| | 05500 RADI OLOGY-THERAPEUTI C | 0 | 249, 354 | | | | 55.00 |
| | 06000 LABORATORY | 0 | 145, 138 | | | | 60.00 |
| | 06400 INTRAVENOUS THERAPY | 0 | 2, 701 | | | | 64.00 |
| 65.00 | 06500 RESPI RATORY THERAPY | 0 | 89, 305 | | | | 65.00 |
| 66.00 | 06600 PHYSI CAL THERAPY | 0 | 257, 201 | | | | 66.00 |
| | 06700 OCCUPATI ONAL THERAPY | 0 | 144, 792 | | | | 67.00 |
| | 06800 SPEECH PATHOLOGY | 0 | 295 | | | | 68.00 |
| | | 0 | 36, 386 | | | | 69.00 |
| | 07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT | 0 | 109, 461 32, 041 | | | | 70.00 71.00 |
| | 07200 IMPL. DEV. CHARGED TO PATIENTS | 0 | 68, 327 | | | | 72.00 |
| | 07300 DRUGS CHARGED TO PATIENTS | 0 | 111, 150 | | | | 73.00 |
| | 07400 RENAL DI ALYSI S | 0 | 0 | | | | 74.00 |
| 77.00 | 07700 ALLOGENEIC STEM CELL ACQUISITION | 0 | 0 | | | | 77.00 |
| | OUTPATIENT SERVICE COST CENTERS | 1 | | | | | |
| | | 0 | 94, 594 | | | | 90.00 |
| | 09001 WOUND CARE INSTITUTE | 0 | 24 | | | | 90.01 |
| | 09002 OP NUTRITIONAL COUNSELING | 0 | 100 | | | | 90.02 |
| | 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART | 0 | 494, 068 | | | | 91.00 92.00 |
| | OTHER REIMBURSABLE COST CENTERS | <u> </u> | | | | | 92.00 |
| | 10200 OPI OI D TREATMENT PROGRAM | 0 | 0 | | | | 102.00 |
| 102100 | SPECIAL PURPOSE COST CENTERS | <u> </u> | | | | | |
| 113.00 | 11300 INTEREST EXPENSE | | | | | · · · · · · · · · · · · · · · · · · · | 113.00 |
| 118.00 | SUBTOTALS (SUM OF LINES 1 through 117) | 0 | 4, 676, 970 | | | | 118.00 |
| | NONREI MBURSABLE COST CENTERS | <u>_</u> | | | | | |
| | 19000 GIFT FLOWER COFFEE SHOP & CANTEEN | 0 | 39, 282 | | | | 190. 00 |
| | 19200 PHYSICIANS PRIVATE OFFICES | 0 | 871 | | | | 192.00 |
| | 07950 COMMUNITY RELATIONS & MARKETING | 0 | 0 | | | | 194.00 |
| | 07951 PLAINFIELD RADIOLOGY & PHYSICAL THE | 0 | 762 | | | | 194.01 |
| | 07952 JV MV ENDOSCOPY | 0 | 0 | | | | 194.02 |
| 194.03 | 07953 SOUTHWEST CENTER FOR WOMENS HEALTH 07954 OTHER NRCC | | 2, 493, 402 | | | | 194. 03 194. 04 |
| 10/ 0/ | | 0 | 2,473,402 | | | | 174.04 |
| | | | ol | | | | 200 00 |
| 194.04 200.00 201.00 | Cross Foot Adjustments | 0 | 0 | | | | 200. 00 201. 00 |

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

FRANCISCAN HEALTH MOORESVILLE In Lieu of Form CMS-2552-10

| | * | RANCI SCAN HEAL | | | | U OT FORM CMS | 2552-10 |
|------------------|---------------------------------------------------------|-------------------|-----------------------------------------|---------------------------------------|-----------------------------|-----------------------------|--------------------|
| COSTA | LLOCATION - STATISTICAL BASIS | | Provider CC | | eriod: rom 01/01/2022 | Worksheet B-1 | |
| | | | | To | | | |
| | | | | | | 5/29/2023 3:2 | 8 pm |
| | | CAPITAL RE | LATED COSTS | | | | |
| | Cost Center Description | BLDG & FIXT | MVBLE EQUIP | EMPLOYEE | ADMI TTI NG | CASHI ERI NG/ACC | |
| | | (SQUARE FEET) | (SQUARE FEET) | BENEFITS | (INPATI ENT | OUNTS | |
| | | () | | DEPARTMENT | CHARGES) | RECEI VABLE | |
| | | | | (GROSS | | (GROSS | |
| | | | | SALARI ES) | | CHARGES) | |
| | | 1.00 | 2.00 | 4.00 | 5. 01 | 5.02 | |
| | GENERAL SERVICE COST CENTERS | 1 | | | | | |
| 1.00 | 00100 CAP REL COSTS-BLDG & FIXT | 269, 675 | | | | | 1.00 |
| 2.00 | 00200 CAP REL COSTS-MVBLE EQUIP | | 269, 675 | | | | 2.00 |
| 4.00 | 00400 EMPLOYEE BENEFITS DEPARTMENT | 0 | 0 | 25, 827, 798 | | | 4.00 |
| 5.01 | 00570 ADMI TTI NG | 2, 358 | 2, 358 | 0 | 121, 608, 032 | | 5.01 |
| 5.02 | 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE | 0 | 0 | 0 | 0 | 600, 605, 494 | 5.02 |
| 5.03 7.00 | 00590 OTHER ADMIN & GENERAL 00700 OPERATION OF PLANT | 6, 648 56, 477 | | 686, 783 1, 198, 995 | 0 | 0 | 5.03 7.00 |
| 7.00 8.00 | 00800 LAUNDRY & LINEN SERVICE | 871 | | 46, 954 | 0 | 0 | 8.00 |
| 9.00 | 00900 HOUSEKEEPING | 4, 295 | | | 0 | 0 | 9.00 |
| 10.00 | 01000 DI ETARY | 3, 319 | | | 0 | 0 | 10.00 |
| 11.00 | 01100 CAFETERIA | 2, 850 | | | 0 | 0 | 11.00 |
| 13.00 | 01300 NURSI NG ADMI NI STRATI ON | 106 | | | 0 | 0 | 13.00 |
| 14.00 | 01400 CENTRAL SERVICES & SUPPLY | 1, 887 | 1, 887 | 148, 753 | 0 | 0 | 14.00 |
| 15.00 | 01500 PHARMACY | 1, 993 | 1, 993 | 1, 084, 459 | 0 | 0 | 15.00 |
| 16.00 | 01600 MEDICAL RECORDS & LIBRARY | 0 | 0 | 0 | 0 | 0 | 16.00 |
| 21.00 | 02100 I &R SERVICES-SALARY & FRINGES APPRV | 0 | - | 0 | 0 | 0 | 21.00 |
| 22.00 | 02200 I &R SERVI CES-OTHER PRGM COSTS APPRV | 0 | 0 | 0 | 0 | 0 | 22.00 |
| | INPATIENT ROUTINE SERVICE COST CENTERS | | | | | | |
| 30.00 | 03000 ADULTS & PEDIATRICS | 35, 752 | | | 16, 911, 907 | | 30.00 |
| 34.00 | 03400 SURGICAL INTENSIVE CARE UNIT | 7, 916 | | | 5, 870, 900 | 5, 870, 900 | 34.00 |
| 43.00 | 04300 NURSERY | 0 | 0 0 | 423, 142 | 1, 291, 146 | 1, 291, 146 | 43.00 |
| 50.00 | ANCI LLARY SERVI CE COST CENTERS | 22,043 | 22.042 | 2, 303, 787 | 20 122 440 | E2 404 127 | 50.00 |
| 52.00 | 05200 DELIVERY ROOM & LABOR ROOM | 22, 043 | | 1, 505, 254 | 20, 132, 649 5, 661, 483 | 52, 694, 137 5, 689, 284 | |
| 54.00 | 05400 RADI OLOGY - DI AGNOSTI C | 8, 244 | , i i i i i i i i i i i i i i i i i i i | | 5, 627, 278 | 66, 516, 452 | |
| 55.00 | 05500 RADI OLOGY-THERAPEUTI C | 6, 897 | | 474, 156 | 319, 728 | | 55.00 |
| 60.00 | 06000 LABORATORY | 3, 883 | | | 7, 978, 950 | 40, 288, 271 | 60.00 |
| 64.00 | 06400 I NTRAVENOUS THERAPY | 0,000 | | 755, 530 | 859, 923 | 12, 524, 228 | 64.00 |
| 65.00 | 06500 RESPI RATORY THERAPY | 2, 239 | - | | 4, 244, 313 | 8, 809, 308 | 65.00 |
| 66.00 | 06600 PHYSI CAL THERAPY | 6, 942 | | | 2, 205, 075 | 12, 969, 374 | |
| 67.00 | 06700 OCCUPATIONAL THERAPY | 4,079 | | | 244, 082 | 2, 162, 671 | 67.00 |
| 68.00 | 06800 SPEECH PATHOLOGY | 0 | 0 | 31, 992 | 134, 547 | 311, 856 | 68.00 |
| 69.00 | 06900 ELECTROCARDI OLOGY | 955 | 955 | 277, 795 | 1, 449, 587 | 16, 686, 687 | 69.00 |
| 70.00 | 07000 ELECTROENCEPHALOGRAPHY | 3, 123 | 3, 123 | 14, 898 | 89, 080 | 1, 963, 054 | |
| 71.00 | 07100 MEDICAL SUPPLIES CHARGED TO PATIENT | 0 | 0 | 0 | 13, 893, 336 | | |
| 72.00 | 07200 I MPL. DEV. CHARGED TO PATIENTS | 0 | 0 0 | 0 | 12, 792, 958 | 38, 868, 522 | 72.00 |
| 73.00 | 07300 DRUGS CHARGED TO PATIENTS | 0 | 0 | 0 | 9, 215, 726 | | |
| 74.00 | 07400 RENAL DI ALYSI S | 0 | 0 | 0 | 0 | 0 | 74.00 |
| 77.00 | 07700 ALLOGENEIC STEM CELL ACQUISITION | 0 | 0 0 | 0 | 0 | 0 | 77.00 |
| 90.00 | OUTPATIENT SERVICE COST CENTERS | 2, 703 | 2, 703 | 0 | 24, 529 | 123, 863 | 90.00 |
| 90.00 90.01 | 09001 WOUND CARE INSTITUTE | 2,703 | 2,703 | 7, 192 | 7, 684 | | 90.00 |
| 90.01 | 09002 OP NUTRITIONAL COUNSELING | 0 | | 47, 381 | 7,084 | 67, 994 | |
| 91.00 | 09100 EMERGENCY | 12, 868 | 12, 868 | | 12, 653, 151 | 112, 916, 019 | |
| 92.00 | 09200 OBSERVATION BEDS (NON-DISTINCT PART | 12,000 | 12,000 | 0,010,000 | 12,000,101 | 112, 710, 017 | 92.00 |
| | OTHER REIMBURSABLE COST CENTERS | | 1 | 1 | | | |
| 102.00 | 10200 OPI OI D TREATMENT PROGRAM | 0 | 0 | 0 | 0 | 0 | 102.00 |
| | SPECIAL PURPOSE COST CENTERS | | · · · · · · · · · · · · · · · · · · · | · · · · · · · · · · · · · · · · · · · | | | 1 |
| 113.00 | 11300 INTEREST EXPENSE | | | | | | 113.00 |
| 118.00 | SUBTOTALS (SUM OF LINES 1 through 117) | 198, 448 | 198, 448 | 25, 289, 223 | 121, 608, 032 | 600, 605, 494 | 118.00 |
| | NONREI MBURSABLE COST CENTERS | | | | | | |
| | 19000 GIFT FLOWER COFFEE SHOP & CANTEEN | 1, 102 | 1, 102 | | 0 | | 190.00 |
| | 19200 PHYSICIANS PRIVATE OFFICES | 0 | 0 | 284, 506 | 0 | | 192.00 |
| | 07950 COMMUNITY RELATIONS & MARKETING | 0 | 0 0 | 0 | 0 | | 194.00 |
| | 07951 PLAINFIELD RADIOLOGY & PHYSICAL THE | 0 | 0 | 212, 392 | 0 | | 194.01 |
| | 07952 JV MV ENDOSCOPY | 0 | 0 | 0 | 0 | | 194.02 |
| | 07953 SOUTHWEST CENTER FOR WOMENS HEALTH | | | 0 | 0 | | 194.03 |
| 194.04 200.00 | 07954 OTHER NRCC | 70, 125 | 70, 125 | 0 | 0 | 0 | 194. 04 200. 00 |
| 200.00 | 5 | | | | | | 200.00 |
| 201.00 | | 7, 051, 021 | 160, 266 | 7, 437, 620 | 63, 078 | 0 | 201.00 |
| 202.00 | Part I) | 7,031,021 | 100, 200 | 7,437,020 | 03,076 | | 202.00 |
| 203.00 | | 26. 146365 | 0. 594293 | 0. 287970 | 0. 000519 | 0.000000 | 203.00 |
| 200.00 | | | | 0 | 63, 054 | | 204.00 |
| | Part II) |] | | | | | |
| 205.00 | | | | 0. 000000 | 0. 000519 | 0.000000 | 205.00 |
| | 11) | | | | | | |
| | | | | | | | |

| Health Financial Systems F | RANCI SCAN HEAL | TH MOORESVILLE | | In Lieu of Form CMS-2552-10 | | | |
|-----------------------------------------------------------------|------------------------------|------------------------------|------------------------------------|-----------------------------|-----------------------------------|----------------|--|
| COST ALLOCATION - STATISTICAL BASIS | | Provider CO | | Period: From 01/01/2022 | Worksheet B-1 | | |
| | | | | To 12/31/2022 | | pared: 8 pm | |
| | CAPI TAL REI | LATED COSTS | | | | | |
| Cost Center Description | BLDG & FIXT (SQUARE FEET) | MVBLE EQUIP (SQUARE FEET) | | (INPATI ENT | CASHI ERI NG/ACC OUNTS | | |
| | | | DEPARTMENT (GROSS SALARI ES) | CHARGES) | RECEI VABLE (GROSS CHARGES) | | |
| | 1.00 | 2.00 | 4.00 | 5. 01 | 5.02 | | |
| 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 | |

| ST ALLOCATION - STATISTICAL BAS | 15 | | Provider C | | eriod: rom 01/01/2022 o 12/31/2022 | Worksheet B-1 Date/Time Pre 5/29/2023 3:2 | epare |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|---------------------------------|---------------------------------------------------------------------------------|----------------------------------------|--------------------------------------------------------|------------------------------------------------------------|----------------------------------|
| Cost Center Descripti | on R | econciliation | OTHER ADMIN & GENERAL (ACCUM. COST) | OPERATION OF PLANT (SQUARE FEET) | LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY) | HOUSEKEEPING (SQUARE FEET) | |
| | | 5A. 03 | 5.03 | 7.00 | 8.00 | 9.00 | |
| GENERAL SERVICE COST CENTER | | | | 1 | I | | 4 |
| 00 00100 CAP REL COSTS-BLDG & 00 00200 CAP REL COSTS-MVBLE E 00 00400 EMPLOYEE BENEFITS DEP 01 00570 ADMI TTING 02 00580 CASHI ERING/ACCOUNTS R 03 00590 OTHER ADMI & GENERAL 00 00700 OPERATION OF PLANT 00 00800 LAUNDRY & LINEN SERVI 00 00900 HOUSEKEEPING NG DOUST | QUI P PARTMENT RECEI VABLE | -33, 198, 465 0 0 0 | 109, 137, 270 7, 085, 135 160, 774 1, 968, 676 | 204, 192 871 4, 295 | 367, 212 0 | 199, 026 | |
| .00 01000 DI ETARY .00 01100 CAFETERIA .00 01300 NURSI NG ADMI NI STRATI O .00 01400 CENTRAL SERVI CES & SU .00 01500 PHARMACY .00 01600 MEDI CAL RECORDS & LI B .00 02100 I & SERVI CES-SALARY & | IPPLY SRARY RFINGES APPRV SGM COSTS APPRV | 0 0 0 0 0 0 0 | 291, 691 502, 066 816, 589 93, 295 1, 576, 856 23, 782 0 0 | 106 1, 887 | 0 0 0 0 0 0 0 | 3, 319 2, 850 106 1, 887 1, 993 0 0 0 | 11 13 14 15 16 21 |
| I NPATI ENT ROUTI NE SERVI CE C .00 03000 ADULTS & PEDI ATRI CS .00 03400 SURGI CAL INTENSI VE CA .00 04300 NURSERY | RE UNI T | 0 0 0 | 7, 650, 656 3, 052, 751 628, 379 | 35, 752 7, 916 0 | 78, 309 26, 545 0 | 35, 752 7, 916 0 | 34 |
| ANCILLARY SERVICE COST CENT 00 05000 OPERATING ROOM 00 05200 DELIVERY ROOM & LABOR | | 0 | 2, 320, 025 2, 235, 670 | 22, 043 | 67, 959 0 | 22, 043 0 | 50 52 |
| 00 05400 RADI OLOGY-DI AGNOSTI C 00 05500 RADI OLOGY-THERAPEUTI C 00 06000 LABORATORY 00 06000 LABORATORY | | 0 0 0 | 3, 242, 654 3, 830, 666 3, 249, 922 | 6, 897 3, 883 | 52, 875 270 29 | 8, 244 6, 897 3, 883 | 55 60 |
| 00 06400 I NTRAVENOUS THERAPY 00 06500 RESPI RATORY THERAPY 00 06600 PHYSI CAL THERAPY 00 06700 OCCUPATI ONAL THERAPY | | 0 0 0 0 | 1, 149, 011 1, 968, 209 2, 257, 092 397, 725 | | 0 0 9, 859 2, 809 | 0 2, 239 6, 942 4, 079 | 65 66 |
| 00 06800 SPEECH PATHOLOGY 00 06900 ELECTROCARDI OLOGY 00 00 07000 ELECTROENCEPHALOGRAPH | | 0 0 0 | 44, 160 476, 044 107, 390 | 955 3, 123 | 0 5, 131 418 0 | 0 955 3, 123 | 69 70 |
| 00 07100 MEDI CAL SUPPLI ES CHAR 00 07200 I MPL. DEV. CHARGED TO 00 07300 DRUGS CHARGED TO PATI 00 07400 RENAL DI ALYSI S S | PATI ENTS | 0 0 0 0 | 2, 868, 412 10, 227, 263 17, 741, 567 0 | 0 0 0 0 | 0 0 0 | 0 0 0 0 | 72 |
| 00 07700 ALLOGENEIC STEM CELL 00TPATIENT SERVICE COST CEN 00 09000 CLINIC | | 00 | 72, 293 | 2, 703 | 0 | 2, 703 | |
| 01 09001 WOUND CARE INSTITUTE 02 09002 OP NUTRITIONAL COUNSE 00 09100 EMERGENCY 00 09200 OBSERVATION BEDS (NON | I-DISTINCT PART | 0 0 0 | 9, 267 61, 510 7, 804, 858 | 0 0 | 0 0 80, 178 | 0 0 12, 868 | 9(9(|
| OTHER REIMBURSABLE COST CEN 2. 00 10200 OPI 0I D TREATMENT PROG SPECIAL PURPOSE COST CENTER | RAM | 0 | 0 | 0 | 0 | 0 | 10: |
| OO 11300 INTEREST EXPENSE OO 11300 INTEREST EXPENSE SUBTOTALS (SUM OF LIN NONREI MBURSABLE COST CENTER | IES 1 through 117) | -33, 198, 465 | 83, 914, 388 | 132, 965 | 324, 382 | 127, 799 | 11: |
| D. 00 19000 GI FT FLOWER COFFEE 2. 00 19200 PHYSI CI ANS PRI VATE OF 4. 00 07950 COMMUNI TY RELATI ONS & 4. 01 07951 PLAI NFI ELD RADI OLOGY | SHOP & CANTEEN FICES MARKETING | 0 0 0 0 | 148, 114 526, 449 4 466, 854 | | 0 24 0 0 | 0 | 190 192 193 194 |
| 1.02 07952 JV MV ENDOSCOPY 1.03 07953 SOUTHWEST CENTER FOR 1.04 07954 OTHER NRCC 0.00 Cross Foot Adjustment | s | 0 0 0 | 0 0 24, 081, 461 | 0 0 70, 125 | 0 0 42, 806 | | 200 |
| 1.00 Negative Cost Centers 2.00 Cost to be allocated Part I) | | | 33, 198, 465 | 9, 240, 362 | 249, 096 | 2, 761, 891 | 20 ² 202 |
| 8.00 Unit cost multiplier Cost to be allocated Part II) | | | 0. 304190 177, 772 | | 0. 678344 30, 044 | 13. 877036 150, 067 | |
| 5.00 Unit cost multiplier II) 6.00 NAHE adjustment amoun | | | 0. 001629 | 7. 452662 | 0. 081816 | 0. 754007 | 205 206 |
| 7.00 (per Wkst. B-2) NAHE unit cost multip Parts III and IV) | olier (Wkst. D, | | | | | | 207 |

| | Financial Systems F LLOCATION - STATISTICAL BASIS | RANCI SCAN HEALT | Provider C | | <u>In Lie</u> eriod: rom 01/01/2022 | u of Form CMS-2 Worksheet B-1 | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------|----------------------------------------------------|---------------------------------------------------------|----------------------------------------------------------|-----------------------------------------------------|--------------------|
| | | | | T | | Date/Time Pre | |
| | Cost Center Description | DI ETARY (GROSS PATI ENT DAYS) | CAFETERI A (FTES) | NURSI NG ADMI NI STRATI ON (DI RECT NUR SI NG) | CENTRAL SERVI CES & SUPPLY (COSTED REQUI S.) | 5/29/2023 3: 2 PHARMACY (COSTED REQUI S.) | |
| | 1 | 10.00 | 11.00 | 13.00 | 14.00 | 15.00 | |
| 1 00 | GENERAL SERVICE COST CENTERS | 1 | | | | | 1 1 00 |
| $\begin{array}{c} 1. \ 00\\ 2. \ 00\\ 4. \ 00\\ 5. \ 01\\ 5. \ 02\\ 5. \ 03\\ 7. \ 00\\ 8. \ 00\\ 9. \ 00\\ 10. \ 00\\ 11. \ 00\\ 11. \ 00\\ 13. \ 00\\ 14. \ 00\\ 15. \ 00\\ 16. \ 00\\ 21. \ 00\\ 22. \ 00\\ \end{array}$ | 00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00570 ADMITTING 00580 CASHIERING/ACCOUNTS RECEIVABLE 00590 OTHER ADMIN & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DI ETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 02100 I & SERVICES-SALARY & FRINGES APPRV 02200 I & SERVICES-OTHER PRGM COSTS APPRV INPATIENT ROUTINE SERVICE COST CENTERS | 8, 051 0 0 0 0 0 0 0 0 | 435, 713 11, 131 0 22, 356 0 0 0 | 202, 023 0 58 0 0 | 15, 004, 291 12, 321 0 0 0 | 100 0 0 0 | 16.00 21.00 |
| 30. 00 | 03000 ADULTS & PEDIATRICS | 5, 989 | 114, 090 | 78, 238 | 24, 387 | 0 | 30.00 |
| 34.00 | 03400 SURGICAL INTENSIVE CARE UNIT | 1, 478 | 34, 127 | | 7, 491 | 0 | 34.00 |
| 43.00 | 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS | 584 | 0 | 0 | 0 | 0 | 43.00 |
| 50. 00 52. 00 | 05000 OPERATING ROOM 05200 DELIVERY ROOM & LABOR ROOM | 0 | 47, 407 12 | | 107, 473 76 | 0 | 50. 00 52. 00 |
| 54.00 | 05400 RADI OLOGY-DI AGNOSTI C | 0 | 52, 050 | | 7,877 | 0 | 54.00 |
| 55.00 60.00 | 05500 RADI OLOGY-THERAPEUTI C 06000 LABORATORY | 0 | 7, 948 0 | | 1, 224 0 | 0 | 55.00 60.00 |
| 64.00 | 06400 I NTRAVENOUS THERAPY | 0 | 0 | - | 8, 021 | 0 | 64.00 |
| 65.00 | 06500 RESPI RATORY THERAPY | 0 | 24, 487 | | 1, 227 | 0 | 65.00 |
| 66.00 | 06600 PHYSI CAL THERAPY | 0 | 38, 784 | | 6, 976 | 0 | 66.00 |
| 67.00 68.00 | 06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY | 0 | 5, 346 659 | | 1, 109 146 | 0 | 67.00 68.00 |
| 69.00 | 06900 ELECTROCARDI OLOGY | 0 | 4, 590 | | 1, 467 | 0 | 69.00 |
| 70.00 | 07000 ELECTROENCEPHALOGRAPHY | 0 | 274 | | 482 | 0 | 70.00 |
| 71.00 | 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT | 0 | 0 | - | 4, 575, 916 | 0 | 71.00 |
| 72.00 73.00 | 07200 I MPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS | 0 | 0 | 0 | 10, 220, 623 0 | 0 100 | 72.00 |
| 74.00 | 07400 RENAL DIALYSIS | 0 | 0 | | 0 | 0 | 74.00 |
| 77.00 | 07700 ALLOGENEIC STEM CELL ACQUISITION | 0 | 0 | | 0 | 0 | |
| | OUTPATIENT SERVICE COST CENTERS | - | | 1 | | | |
| 90.00 90.01 | 09000 CLINIC 09001 WOUND CARE INSTITUTE | 0 | 0 | | 13 0 | | |
| 90.01 | 09002 OP NUTRITIONAL COUNSELING | 0 | 0 | 127 | 26 | 0 | |
| 91.00 | 09100 EMERGENCY | 0 | 70, 156 | 59, 822 | 24, 108 | | 91.00 |
| 92.00 | 09200 OBSERVATION BEDS (NON-DISTINCT PART | | | | | | 92.00 |
| 102 00 | OTHER REIMBURSABLE COST CENTERS | 0 | C | 0 | 0 | 0 | 102.00 |
| 102.00 | SPECIAL PURPOSE COST CENTERS | <u> </u> | 0 | 0 | 0 | 0 | 1102.00 |
| 113.00 118.00 | | 8, 051 | 433, 417 | 201, 997 | 15, 000, 963 | 100 | 113. 00 118. 00 |
| 190 00 | NONREIMBURSABLE COST CENTERS | 0 | 2, 296 | 0 | 0 | 0 | 190. 00 |
| | 19200 PHYSICIANS PRIVATE OFFICES | 0 | 2, 270 | 26 | 2, 190 | | 192.00 |
| 194.00 | 07950 COMMUNITY RELATIONS & MARKETING | 0 | C | 0 | 0 | 0 | 194.00 |
| | 07951 PLAINFIELD RADIOLOGY & PHYSICAL THE | 0 | 0 | 0 | 257 | | 194.01 |
| | 07952 JV MV ENDOSCOPY 07953 SOUTHWEST CENTER FOR WOMENS HEALTH | 0 | 0 | 0 | 0 | | 194. 02 194. 03 |
| | 07954 OTHER NRCC | 0 | 0 | 0 | 881 | | 194.04 |
| 200.00 | | | | | | | 200.00 |
| 201.00 202.00 | Cost to be allocated (per Wkst. B, | 576, 674 | 823, 311 | 1, 092, 288 | 233, 253 | 2, 217, 116 | 201.00 202.00 |
| 203.00 204.00 | | 71. 627624 116, 465 | 1. 889572 100, 418 | | 0. 015546 66, 097 | 22, 171. 160000 77, 427 | 1 |
| 205.00 | Part II) Unit cost multiplier (Wkst. B, Part | 14. 465905 | 0. 230468 | | | | |
| 206.00 | NAHE adjustment amount to be allocated | | | | | | 206. 00 |
| | | 1 | | 1 | | | 121111 11 |

| Health Financial Systems | FRANCI SCAN HEALT | TH MOORESVILLE | | In Lieu of Form CMS-2552-10 | | | |
|-----------------------------------------------------------------|---------------------------|----------------|------------------|-----------------------------|---------------|--------|--|
| COST ALLOCATION - STATISTICAL BASIS | · STATI STI CAL BASI S Pr | | | Period: From 01/01/2022 | Worksheet B-1 | | |
| | | | | To 12/31/2022 | | | |
| Cost Center Description | DI ETARY | CAFETERI A | NURSI NG | CENTRAL | PHARMACY | | |
| | (GROSS PATIENT | (FTES) | ADMI NI STRATI O | N SERVICES & | (COSTED | | |
| | DAYS) | . , | | SUPPLY | REQUIS.) | | |
| | | | (DI RECT NUR | (COSTED | , | | |
| | | | SING) | REQUIS.) | | | |
| | 10.00 | 11.00 | 13.00 | 14.00 | 15.00 | | |
| 207.00 NAHE unit cost multiplier (Wkst. D, Parts III and IV) | | | | | | 207.00 | |
| | | | | | | | |

| COST A | Financial Systems F NLLOCATION - STATISTICAL BASIS | NANUI SUAN HEAL | TH MOORESVILLE Provider C | | Period: | u of Form CM Worksheet B | |
|----------------|-----------------------------------------------------------------------------------------------|-------------------------------|-------------------------------|-----------------------------|----------------------------------|-----------------------------|------------------|
| | | | | | From 01/01/2022 To 12/31/2022 | Date/Time P | repared: |
| | | | INTERNS & | RESI DENTS | | 5/29/2023 3 | :28 pm |
| | | | | | _ | | |
| | Cost Center Description | MEDICAL RECORDS & | SERVICES-SALAR Y & FRINGES | SERVICES-OTHE PRGM COSTS | R | | |
| | | LI BRARY | APPRV | APPRV | | | |
| | | (GROSS | (ASSI GNED | (ASSI GNED | | | |
| | | CHARGES) 16.00 | TI ME) 21.00 | TIME) 22.00 | _ | | |
| | GENERAL SERVICE COST CENTERS | 10.00 | 21.00 | | | | |
| 1.00 | 00100 CAP REL COSTS-BLDG & FIXT | | | | | | 1.00 |
| 2.00 4.00 | 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT | | | | | | 2.00 |
| 5.01 | 00570 ADMI TTI NG | | | | | | 5. 01 |
| 5.02 | 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE | | | | | | 5. 02 |
| 5.03 | 00590 OTHER ADMIN & GENERAL | | | | | | 5.03 |
| 7.00 8.00 | 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE | | | | | | 7.00 |
| 9.00 | 00900 HOUSEKEEPING | | | | | | 9.00 |
| 10.00 | 01000 DI ETARY | | | | | | 10.00 |
| 11.00 | | | | | | | 11.00 |
| 13.00 14.00 | 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY | | | | | | 13.00 |
| 15.00 | 01500 PHARMACY | | | | | | 15.00 |
| 16.00 | 01600 MEDI CAL RECORDS & LI BRARY | 600, 605, 494 | | | | | 16.00 |
| 21.00 22.00 | 02100 I & R SERVI CES-SALARY & FRI NGES APPRV 02200 I & R SERVI CES-OTHER PRGM COSTS APPRV | | | | 0 | | 21.00 |
| 22.00 | INPATIENT ROUTINE SERVICE COST CENTERS | | 1 | | 0 | | 22.00 |
| 30.00 | 03000 ADULTS & PEDI ATRI CS | 24, 383, 690 | 0 | 1 | 0 | | 30.00 |
| 34.00 | 03400 SURGICAL INTENSIVE CARE UNIT | 5, 870, 900 | | | 0 | | 34.00 |
| 43.00 | 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS | 1, 291, 146 | 0 | | 0 | | 43.00 |
| 50.00 | | 52, 694, 137 | 0 | | 0 | | 50.00 |
| 52.00 | 05200 DELIVERY ROOM & LABOR ROOM | 5, 689, 284 | | | 0 | | 52.00 |
| 54.00 | 05400 RADI OLOGY-DI AGNOSTI C | 66, 516, 452 | | | 0 | | 54.00 |
| 55.00 60.00 | 05500 RADI OLOGY-THERAPEUTI C 06000 LABORATORY | 39, 018, 603 40, 288, 271 | | | 0 | | 55.00 60.00 |
| 64.00 | 06400 I NTRAVENOUS THERAPY | 12, 524, 228 | | | 0 | | 64.00 |
| 65.00 | 06500 RESPI RATORY THERAPY | 8, 809, 308 | | | 0 | | 65.00 |
| 66.00 | 06600 PHYSI CAL THERAPY | 12, 969, 374 | | | 0 | | 66.00 |
| 67.00 68.00 | 06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY | 2, 162, 671 311, 856 | | | 0 | | 67.00 68.00 |
| 69.00 | 06900 ELECTROCARDI OLOGY | 16, 686, 687 | | | 0 | | 69.00 |
| 70.00 | 07000 ELECTROENCEPHALOGRAPHY | 1, 963, 054 | 0 | | 0 | | 70.00 |
| 71.00 | 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT | 32, 875, 486 | | 1 | 0 | | 71.00 |
| 72.00 | 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS | 38, 868, 522 124, 558, 646 | | | 0 | | 72.00 |
| | 07400 RENAL DI ALYSI S | 0 | | | 0 | | 74.00 |
| | 07700 ALLOGENEIC STEM CELL ACQUISITION | 0 | 0 | | 0 | | 77.00 |
| 90.00 | OUTPATIENT SERVICE COST CENTERS | 123, 863 | 0 | | 0 | | 90.00 |
| 90.00 90.01 | 09001 WOUND CARE INSTITUTE | 123, 803 | | | 0 | | 90.00 |
| | 09002 OP NUTRITIONAL COUNSELING | 67, 994 | | | 0 | | 90.02 |
| 91.00 | | 112, 916, 019 | 0 | | 0 | | 91.00 |
| 92.00 | 09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS | | | | | | 92.00 |
| 102.00 | 10200 OPI OI D TREATMENT PROGRAM | C | 0 | 1 | 0 | | 102.00 |
| | SPECIAL PURPOSE COST CENTERS | | | | | | |
| | 11300 INTEREST EXPENSE | | | | | | 113.00 |
| 118.00 | SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS | 600, 605, 494 | 0 | 1 | 0 | | 118.00 |
| 190.00 | 19000 GIFT FLOWER COFFEE SHOP & CANTEEN | 0 | 0 | | 0 | | 190.00 |
| 192.00 | 19200 PHYSICIANS PRIVATE OFFICES | 0 | 0 | | 0 | | 192.00 |
| | 07950 COMMUNITY RELATIONS & MARKETING | 0 | 0 | 1 | 0 | | 194.00 |
| | 07951 PLAINFIELD RADIOLOGY & PHYSICAL THE 07952 JV MV ENDOSCOPY | 0 | 0 | | 0 | | 194.01 194.02 |
| | 07952 SOUTHWEST CENTER FOR WOMENS HEALTH | 0 | 0 | | ŏ | | 194.02 |
| 194.04 | 07954 OTHER NRCC | 0 | 0 | | о | | 194.04 |
| 200.00 | | | | | | | 200.00 |
| 201.00 | | 31, 016 | 0 | | 0 | | 201.00 |
| 202.00 | Part I) | 31,010 | | | Ĭ | | 202.00 |
| 203.00 | Unit cost multiplier (Wkst. B, Part I) | 0. 000052 | | 0. 00000 | 0 | | 203.00 |
| 204.00 | | 39 | 0 | 1 | 0 | | 204.00 |
| 205.00 | Part II) Unit cost multiplier (Wkst. B, Part | 0. 000000 | 0. 000000 | 0. 00000 | o | | 205.00 |
| | | 0.00000 | 0.00000 | 0.00000 | -1 | | 1-00.00 |

| Health Financial Systems F | RANCI SCAN HEAL | TH MOORESVILLE | | In Lieu of Form CMS-2552-10 | | | |
|------------------------------------------------------------------------------------|------------------------------------------------------------------|---------------------------------------------------------------------------|------------------------------------------------------------------------|-----------------------------|--------------------------------|------------------|--|
| COST ALLOCATION - STATISTICAL BASIS | | Provider CO | | Period: From 01/01/2022 | Worksheet B-1 | | |
| | | _ | | To 12/31/2022 | Date/Time Pre 5/29/2023 3:2 | epared: 28 pm | |
| | | INTERNS & | RESI DENTS | | | | |
| Cost Center Description | MEDI CAL RECORDS & LI BRARY (GROSS CHARGES) 16.00 | SERVI CES-SALAR Y & FRI NGES APPRV (ASSI GNED TI ME) 21.00 | SERVI CES-OTHE PRGM COSTS APPRV (ASSI GNED TI ME) 22.00 | R | | | |
| 206.00 NAHE adjustment amount to be allocated | | | | | | 206.00 | |
| (per Wkst. B-2) 207.00 NAHE unit cost multiplier (Wkst. D, Parts III and IV) | | | | | | 207.00 | |

| Health Financial Systems | FRANCI SCAN HEAL | TH MOORESVILLE | | In Lie | u of Form CMS- | 2552-10 |
|-----------------------------------------------------|-----------------------------------------------------|-----------------------|----------------|---------------------------------------------|---------------------------------------------------------|---------|
| COMPUTATION OF RATIO OF COSTS TO CHARGES | | Provider C | | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part I Date/Time Pre 5/29/2023 3:2 | pared: |
| | | Title | XVIII | Hospi tal | PPS | |
| | | | | Costs | | |
| Cost Center Description | Total Cost (from Wkst. B, Part I, col. 26) | Therapy Limit Adj. | Total Costs | RCE Di sal I owance | Total Costs | |
| | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | |
| INPATIENT ROUTINE SERVICE COST CENTERS | | | 1 | | | |
| 30. 00 03000 ADULTS & PEDI ATRI CS | 13, 214, 274 | | 13, 214, 27 | | 13, 214, 274 | 1 |
| 34.00 03400 SURGI CAL INTENSI VE CARE UNIT | 4, 797, 348 | | 4, 797, 34 | 8 0 | 4, 797, 348 | 34.00 |
| 43. 00 04300 NURSERY | 861, 424 | | 861, 42 | 4 0 | 861, 424 | 43.00 |
| ANCILLARY SERVICE COST CENTERS | | | | | | |
| 50.00 05000 OPERATING ROOM | 4, 596, 378 | | 4, 596, 37 | 8 0 | 4, 596, 378 | 50.00 |
| 52.00 05200 DELIVERY ROOM & LABOR ROOM | 2, 916, 123 | | 2, 916, 12 | 3 0 | 2, 916, 123 | 52.00 |
| 54.00 05400 RADI OLOGY-DI AGNOSTI C | 4, 854, 307 | | 4, 854, 30 | 7 0 | 4, 854, 307 | 54.00 |
| 55. 00 05500 RADI OLOGY-THERAPEUTI C | 5, 429, 303 | | 5, 429, 30 | 3 0 | 5, 429, 303 | 55.00 |
| 60. 00 06000 LABORATORY | 4, 470, 235 | | 4, 470, 23 | 5 0 | 4, 470, 235 | 60.00 |
| 64.00 06400 INTRAVENOUS THERAPY | 1, 549, 366 | | 1, 549, 36 | 6 0 | 1, 549, 366 | 64.00 |
| 65. 00 06500 RESPI RATORY THERAPY | 2, 746, 058 | 0 | | | 2, 746, 058 | 65.00 |
| 66. 00 06600 PHYSI CAL THERAPY | 3, 434, 914 | C | | | 3, 434, 914 | 66.00 |
| 67.00 06700 OCCUPATI ONAL THERAPY | 772,037 | C | 772, 03 | 7 0 | 772, 037 | 67.00 |
| 68.00 06800 SPEECH PATHOLOGY | 58, 856 | C | 58, 85 | | 58, 856 | |
| 69.00 06900 ELECTROCARDI OLOGY | 690, 367 | | 690, 36 | | 690, 367 | 1 |
| 70.00 07000 ELECTROENCEPHALOGRAPHY | 325, 632 | | 325, 63 | | 325, 632 | |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT | 3, 813, 801 | | 3, 813, 80 | | 3, 813, 801 | |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS | 13, 499, 203 | | 13, 499, 20 | | 13, 499, 203 | |
| 73.00 07300 DRUGS CHARGED TO PATIENTS | 25, 361, 752 | | 25, 361, 75 | | 25, 361, 752 | 1 |
| 74. 00 07400 RENAL DI ALYSI S | 0 | | | 0 0 | 0 | 1 |
| 77.00 07700 ALLOGENEIC STEM CELL ACQUISITION | 0 | | | 0 0 | 0 | 1 |
| OUTPATIENT SERVICE COST CENTERS | | | | <u> </u> | | |
| 90. 00 09000 CLINIC | 254, 120 | | 254, 12 | 0 0 | 254, 120 | 90.00 |
| 90. 01 09001 WOUND CARE INSTITUTE | 12, 774 | | 12, 77 | | 12, 774 | 1 |
| 90. 02 09002 OP NUTRI TI ONAL COUNSELING | 80, 225 | | 80, 22 | | 80, 225 | |
| 91. 00 09100 EMERGENCY | 11, 456, 550 | | 11, 456, 55 | | 11, 456, 550 | |
| 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART | 3, 018, 408 | | 3, 018, 40 | | 3, 018, 408 | 1 |
| OTHER REIMBURSABLE COST CENTERS | 3,010,400 | | 3,010,40 | 0 | 3, 010, 400 | /2.00 |
| 102. 00 10200 OPI OI D TREATMENT PROGRAM | 0 | | | 0 | 0 | 102.00 |
| SPECIAL PURPOSE COST CENTERS | 0 | | | 0 | 0 | 102.00 |
| 113. 00 11300 I NTEREST EXPENSE | | | 1 | | | 113.00 |
| 200.00 Subtotal (see instructions) | 108, 213, 455 | C | 108, 213, 45 | 5 0 | 108, 213, 455 | 1 |
| 201.00 Less Observation Beds | 3, 018, 408 | | 3, 018, 40 | | 3, 018, 408 | 1 |
| 202.00 Total (see instructions) | 105, 195, 047 | | | | | |
| | 103, 173, 047 | | 1 105, 175, 04 | vi u | 105, 175, 047 | 1202.00 |

| COMPUTATION OF RATIO OF COSTS TO CHARGES | | Provider C | | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part I Date/Time Pre | anarod: |
|------------------------------------------------|------------------|---------------|--------------|---------------------------------------------|----------------------------------------|---------|
| | | | | 10 12/31/2022 | 5/29/2023 3:2 | 28 pm |
| | | Title | e XVIII | Hospi tal | PPS | |
| | | Charges | | | | |
| Cost Center Description | I npati ent | Outpati ent | Total (col. | 6 Cost or Other | TEFRA | |
| | | | + col. 7) | Ratio | Inpati ent | |
| | | | | | Rati o | |
| | 6.00 | 7.00 | 8.00 | 9.00 | 10.00 | |
| INPATIENT ROUTINE SERVICE COST CENTE | | | 15 500 00 | | | |
| 30. 00 03000 ADULTS & PEDI ATRI CS | 15, 589, 382 | | 15, 589, 38 | | | 30.00 |
| 34.00 03400 SURGICAL INTENSIVE CARE UNIT | 5, 870, 900 | | 5, 870, 90 | | | 34.00 |
| 43. 00 04300 NURSERY | 1, 291, 146 | | 1, 291, 14 | 6 | | 43.00 |
| ANCI LLARY SERVICE COST CENTERS | 00,400,440 | 00 5/4 400 | 50 (04.40 | 2 0 007000 | 0.00000 | |
| 50. 00 05000 OPERATING ROOM | 20, 132, 649 | 32, 561, 488 | | | 0. 000000 | |
| 52. 00 05200 DELIVERY ROOM & LABOR ROOM | 5, 661, 483 | 27, 801 | | | 0. 000000 | |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C | 5, 627, 278 | 60, 889, 174 | | | 0. 000000 | |
| 55. 00 05500 RADI OLOGY-THERAPEUTI C | 319, 728 | 38, 698, 875 | | | 0. 000000 | |
| 60. 00 06000 LABORATORY | 7, 978, 950 | 32, 309, 321 | | | 0. 000000 | |
| 64. 00 06400 I NTRAVENOUS THERAPY | 859, 923 | 11, 664, 305 | | | 0. 000000 | |
| 65. 00 06500 RESPI RATORY THERAPY | 4, 244, 313 | 4, 564, 995 | | | 0. 000000 | |
| 66. 00 06600 PHYSI CAL THERAPY | 2, 205, 075 | 10, 764, 299 | | | 0. 000000 | |
| 67. 00 06700 OCCUPATI ONAL THERAPY | 244, 082 | 1, 918, 589 | | | 0. 000000 | |
| 68. 00 06800 SPEECH PATHOLOGY | 134, 547 | 177, 309 | | | 0. 000000 | |
| 69. 00 06900 ELECTROCARDI OLOGY | 1, 449, 587 | 15, 237, 100 | | | 0. 000000 | |
| 70. 00 07000 ELECTROENCEPHALOGRAPHY | 89, 080 | 1, 873, 974 | | | 0. 000000 | |
| 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PAT | | 18, 982, 150 | | | 0. 000000 | |
| 72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS | 12, 792, 958 | 26, 075, 564 | | | 0. 000000 | |
| 73. 00 07300 DRUGS CHARGED TO PATIENTS | 9, 215, 726 | 115, 342, 920 | | | 0. 000000 | |
| 74.00 07400 RENAL DI ALYSI S | 0 | 0 | | 0 0.00000 | 0. 000000 | |
| 77.00 07700 ALLOGENEIC STEM CELL ACQUISITIC | ON O | 0 | 1 | 0 0.00000 | 0. 000000 | 77.00 |
| OUTPATIENT SERVICE COST CENTERS | 0.4.500 | | 100.00 | 0 051(00 | 0.00000 | |
| 90. 00 09000 CLINIC | 24, 529 | 99, 334 | | | 0. 000000 | |
| 90. 01 09001 WOUND CARE INSTITUTE | 7,684 | 7,619 | | | 0. 000000 | |
| 90. 02 09002 OP NUTRITIONAL COUNSELING | 10 (50 151 | 67, 994 | | | 0. 000000 | |
| 91.00 09100 EMERGENCY | 12, 653, 151 | 100, 262, 868 | | | 0. 000000 | |
| 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT | PART 1, 322, 525 | 7, 471, 783 | 8, 794, 30 | 0. 343223 | 0. 000000 | 92.00 |
| OTHER REI MBURSABLE COST CENTERS | | | 1 | | | 1100 00 |
| 102.00 10200 OPI OI D TREATMENT PROGRAM | 0 | 0 | 1 | 0 | | 102.00 |
| SPECIAL PURPOSE COST CENTERS | | | 1 | | | 1110 01 |
| 113.00 11300 INTEREST EXPENSE | 101 (00 000 | 470 007 4/0 | | | | 113.00 |
| 200.00 Subtotal (see instructions) | 121, 608, 032 | 478, 997, 462 | 600, 605, 49 | 4 | | 200.00 |
| 201.00 Less Observation Beds | 101 (00 000 | 470 007 440 | 400 (0F 11 | | | 201.00 |
| 202.00 Total (see instructions) | 121, 608, 032 | 478, 997, 462 | 600, 605, 49 | 4 | | 202.00 |

| leal th Financial Systems | FRANCI SCAN HEALTH | | | u of Form CMS-2552 |
|-----------------------------------------------------------|--------------------|-----------------------|---------------------------------------------|--------------------------|
| COMPUTATION OF RATIO OF COSTS TO CHARGES | | Provider CCN: 15-0057 | Period: From 01/01/2022 To 12/31/2022 | |
| | | Title XVIII | Hospi tal | 5/29/2023 3:28 pn PPS |
| Cost Center Description | PPS Inpatient | | nospi tai | ггэ |
| cost center bescription | Ratio | | | |
| | 11.00 | | | |
| INPATIENT ROUTINE SERVICE COST CENTERS | 11100 | | | |
| 0. 00 03000 ADULTS & PEDIATRICS | | | | 30 |
| 4.00 03400 SURGI CAL INTENSI VE CARE UNI T | | | | 34 |
| 3. 00 04300 NURSERY | | | | 43 |
| ANCI LLARY SERVI CE COST CENTERS | | | | |
| 0. 00 05000 OPERATI NG ROOM | 0. 087228 | | | 50 |
| 2.00 05200 DELIVERY ROOM & LABOR ROOM | 0. 512564 | | | 52 |
| 4. 00 05400 RADI OLOGY-DI AGNOSTI C | 0. 072979 | | | 54 |
| 5. 00 05500 RADI OLOGY-THERAPEUTI C | 0. 139147 | | | 55 |
| 0. 00 06000 LABORATORY | 0. 110956 | | | 60 |
| 4. 00 06400 I NTRAVENOUS THERAPY | 0. 123710 | | | 64 |
| 5. 00 06500 RESPI RATORY THERAPY | 0. 311722 | | | 65 |
| 6. 00 06600 PHYSI CAL THERAPY | 0. 264848 | | | 66 |
| 7.00 06700 OCCUPATI ONAL THERAPY | 0. 356983 | | | 67 |
| B. 00 06800 SPEECH PATHOLOGY | 0. 188728 | | | 68 |
| 9. 00 06900 ELECTROCARDI OLOGY | 0. 041372 | | | 69 |
| 0. 00 07000 ELECTROENCEPHALOGRAPHY | 0. 165880 | | | 70 |
| 1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT | 0. 116007 | | | 71 |
| 2.00 07200 IMPL. DEV. CHARGED TO PATIENTS | 0. 347304 | | | 72 |
| 3. 00 07300 DRUGS CHARGED TO PATIENTS | 0. 203613 | | | 73 |
| 4. 00 07400 RENAL DIALYSIS | 0. 000000 | | | 74 |
| 7.00 07700 ALLOGENEIC STEM CELL ACQUISITION | 0. 000000 | | | |
| OUTPATIENT SERVICE COST CENTERS | | | | |
| 0. 00 09000 CLINIC | 2. 051622 | | | 90 |
| 0.01 09001 WOUND CARE INSTITUTE | 0. 834738 | | | 90 |
| 0.02 09002 OP NUTRITIONAL COUNSELING | 1. 179884 | | | 90 |
| 1.00 09100 EMERGENCY | 0. 101461 | | | 91 |
| 2. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART | 0. 343223 | | | 92 |
| OTHER REIMBURSABLE COST CENTERS | | | | |
| 02. 00 10200 OPI OI D TREATMENT PROGRAM | | | | 102 |
| SPECIAL PURPOSE COST CENTERS | | | | 110 |
| 13.00 11300 INTEREST EXPENSE | | | | 113 |
| 00.00 Subtotal (see instructions) | | | | 200 |
| 201.00Less Observation Beds202.00Total (see instructions) | | | | 201 202 |
| | I I | | | 202 |

| Health Financial Systems | FRANCI SCAN HEALT | TH MOORESVILLE | | In Lie | u of Form CMS-: | 2552-10 |
|---------------------------------------------------------------------|-----------------------------------------------------|-----------------------|----------------|---------------------------------------------|-----------------------|---------|
| COMPUTATION OF RATIO OF COSTS TO CHARGES | | Provider C | | Period: From 01/01/2022 To 12/31/2022 | Worksheet C Part I | pared: |
| | | Ti tl | e XIX | Hospi tal | PPS | |
| | | | | Costs | | |
| Cost Center Description | Total Cost (from Wkst. B, Part I, col. 26) | Therapy Limit Adj. | Total Costs | RCE Di sal I owance | Total Costs | |
| | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | |
| INPATIENT ROUTINE SERVICE COST CENTERS | | | | - | | |
| 30. 00 03000 ADULTS & PEDI ATRI CS | 13, 214, 274 | | 13, 214, 27 | | 13, 214, 274 | |
| 34.00 03400 SURGICAL INTENSIVE CARE UNIT | 4, 797, 348 | | 4, 797, 34 | | 4, 797, 348 | |
| 43. 00 04300 NURSERY | 861, 424 | | 861, 42 | 4 0 | 861, 424 | 43.00 |
| ANCI LLARY SERVI CE COST CENTERS | | | 1 | | | |
| 50.00 05000 OPERATI NG ROOM | 4, 596, 378 | | 4, 596, 37 | | 4, 596, 378 | |
| 52.00 05200 DELIVERY ROOM & LABOR ROOM | 2, 916, 123 | | 2, 916, 12 | | 2, 916, 123 | |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C | 4, 854, 307 | | 4, 854, 30 | | 4, 854, 307 | |
| 55. 00 05500 RADI OLOGY-THERAPEUTI C | 5, 429, 303 | | 5, 429, 30 | | 5, 429, 303 | 1 |
| 60. 00 06000 LABORATORY | 4, 470, 235 | | 4, 470, 23 | | 4, 470, 235 | |
| 64.00 06400 I NTRAVENOUS THERAPY | 1, 549, 366 | | 1, 549, 36 | 6 0 | 1, 549, 366 | 64.00 |
| 65. 00 06500 RESPI RATORY THERAPY | 2, 746, 058 | C | 2, 746, 05 | 8 0 | 2, 746, 058 | 65.00 |
| 66. 00 06600 PHYSI CAL THERAPY | 3, 434, 914 | C | 3, 434, 91 | 4 0 | 3, 434, 914 | 66.00 |
| 67.00 06700 OCCUPATI ONAL THERAPY | 772, 037 | 0 | 772, 03 | 7 0 | 772, 037 | 67.00 |
| 68.00 06800 SPEECH PATHOLOGY | 58, 856 | C | 58, 85 | 6 0 | 58, 856 | 68.00 |
| 69. 00 06900 ELECTROCARDI OLOGY | 690, 367 | | 690, 36 | 7 0 | 690, 367 | 69.00 |
| 70.00 07000 ELECTROENCEPHALOGRAPHY | 325, 632 | | 325, 63 | | 325, 632 | 70.00 |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT | 3, 813, 801 | | 3, 813, 80 | 1 0 | 3, 813, 801 | 71.00 |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS | 13, 499, 203 | | 13, 499, 20 | 3 0 | 13, 499, 203 | 72.00 |
| 73.00 07300 DRUGS CHARGED TO PATIENTS | 25, 361, 752 | | 25, 361, 75 | | 25, 361, 752 | |
| 74.00 07400 RENAL DIALYSIS | 0 | | | 0 0 | 0 | |
| 77.00 07700 ALLOGENEIC STEM CELL ACQUISITION | 0 | | | 0 0 | 0 | |
| OUTPATI ENT SERVICE COST CENTERS | | | 1 | - | | |
| 90. 00 09000 CLINIC | 254, 120 | | 254, 12 | 0 0 | 254, 120 | 90.00 |
| 90. 01 09001 WOUND CARE INSTITUTE | 12, 774 | | 12, 77 | | 12, 774 | |
| 90. 02 09002 OP NUTRI TI ONAL COUNSELI NG | 80, 225 | | 80, 22 | | 80, 225 | |
| 91. 00 09100 EMERGENCY | 11, 456, 550 | | 11, 456, 55 | | 11, 456, 550 | |
| 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART | 3, 018, 408 | | 3, 018, 40 | | 3, 018, 408 | |
| OTHER REIMBURSABLE COST CENTERS | 3,010,400 | | 3,010,40 | 0 | 3, 010, 400 | 72.00 |
| 102. 00 10200 OPI OI D TREATMENT PROGRAM | 0 | | 1 | 0 | 0 | 102.00 |
| SPECIAL PURPOSE COST CENTERS | 0 | | | 0 | 0 | 102.00 |
| 113. 00 11300 I NTEREST EXPENSE | | | 1 | 1 | | 113.00 |
| 200.00 Subtotal (see instructions) | 108, 213, 455 | C | 108, 213, 45 | 5 0 | 108, 213, 455 | |
| 200.00 Subtotal (see first dctrons) 201.00 Less Observation Beds | 3, 018, 408 | | 3, 018, 40 | | 3, 018, 408 | |
| 201.00 Less observation Beds 202.00 Total (see instructions) | 3, 018, 408 | | | | | |
| zuz. uuj [Tutal (see Enstructions) | 105, 195, 047 | | 1 105, 195, 04 | VI U | 105, 195, 047 | 202.00 |

| COMPUTATION OF RATIO OF COSTS TO CHARGES | | th Financial Systems FRANCISCAN HEALTH | | | | u of Form CMS-2552- Worksheet C | |
|------------------------------------------|------------------------------------------|----------------------------------------|---------------|--------------|----------------------------|------------------------------------|--------|
| COMPUTAT | TON OF RAILO OF COSTS TO CHARGES | | Provider C | | Period: From 01/01/2022 | Part I | |
| | | | | | To 12/31/2022 | Date/Time Pre | pared: |
| | | | | o. VI.V | llooni tol | 5/29/2023 3:2 | 28 pm |
| | | | Charges | e XIX | Hospi tal | PPS | |
| | Cost Center Description | Inpatient | Outpatient | Total (col | 6 Cost or Other | TEFRA | |
| | Cost center bescription | Inpatrent | outpatrent | + col. 7 | Ratio | Inpati ent | |
| | | | | | hatro | Ratio | |
| | | 6.00 | 7.00 | 8.00 | 9.00 | 10.00 | |
| 11 | NPATIENT ROUTINE SERVICE COST CENTERS | | | | | | |
| 30.00 0 | 3000 ADULTS & PEDI ATRI CS | 15, 589, 382 | | 15, 589, 38 | 32 | | 30. 00 |
| 34.00 03 | 3400 SURGI CAL INTENSI VE CARE UNI T | 5, 870, 900 | | 5, 870, 90 | 00 | | 34.00 |
| 43.00 04 | 4300 NURSERY | 1, 291, 146 | | 1, 291, 14 | | | 43.00 |
| A | NCILLARY SERVICE COST CENTERS | | | • | | | |
| 50.00 0 | 5000 OPERATING ROOM | 20, 132, 649 | 32, 561, 488 | 52, 694, 13 | 0. 087228 | 0.00000 | 50.00 |
| 52.00 0 | 5200 DELIVERY ROOM & LABOR ROOM | 5, 661, 483 | 27, 801 | 5, 689, 28 | 0. 512564 | 0. 000000 | 52.00 |
| 54.00 0 | 5400 RADI OLOGY-DI AGNOSTI C | 5, 627, 278 | 60, 889, 174 | 66, 516, 45 | 0. 072979 | 0. 000000 | 54.00 |
| 55.00 0 | 5500 RADI OLOGY-THERAPEUTI C | 319, 728 | 38, 698, 875 | 39, 018, 60 | 0. 139147 | 0. 000000 | 55.00 |
| 60.00 00 | 6000 LABORATORY | 7, 978, 950 | 32, 309, 321 | 40, 288, 27 | 0. 110956 | 0. 000000 | 60.00 |
| 64.00 00 | 6400 INTRAVENOUS THERAPY | 859, 923 | 11, 664, 305 | 12, 524, 22 | 0. 123710 | 0. 000000 | 64.00 |
| 65.00 00 | 6500 RESPI RATORY THERAPY | 4, 244, 313 | 4, 564, 995 | | | 0. 000000 | 65.00 |
| 66.00 00 | 6600 PHYSI CAL THERAPY | 2, 205, 075 | 10, 764, 299 | 12, 969, 37 | 0. 264848 | 0. 000000 | 66.00 |
| 67.00 00 | 6700 OCCUPATIONAL THERAPY | 244, 082 | 1, 918, 589 | 2, 162, 67 | 0. 356983 | 0. 000000 | 67.00 |
| 68.00 00 | 6800 SPEECH PATHOLOGY | 134, 547 | 177, 309 | 311, 85 | 0. 188728 | 0. 000000 | 68.00 |
| 69.00 00 | 6900 ELECTROCARDI OLOGY | 1, 449, 587 | 15, 237, 100 | 16, 686, 68 | 0. 041372 | 0. 000000 | 69.00 |
| 70.00 0 | 7000 ELECTROENCEPHALOGRAPHY | 89, 080 | 1, 873, 974 | 1, 963, 05 | 0. 165880 | 0. 000000 | 70.00 |
| | 7100 MEDICAL SUPPLIES CHARGED TO PATIENT | 13, 893, 336 | 18, 982, 150 | 32, 875, 48 | 0. 116007 | 0. 000000 | 71.00 |
| 72.00 0 | 7200 IMPL. DEV. CHARGED TO PATIENTS | 12, 792, 958 | 26, 075, 564 | 38, 868, 52 | 0. 347304 | 0. 000000 | 72.00 |
| | 7300 DRUGS CHARGED TO PATIENTS | 9, 215, 726 | 115, 342, 920 | 124, 558, 64 | 6 0. 203613 | 0. 000000 | 73.00 |
| 74.00 0 | 7400 RENAL DIALYSIS | 0 | 0 | | 0 0.000000 | 0. 000000 | 74.00 |
| 77.00 0 | 7700 ALLOGENEIC STEM CELL ACQUISITION | 0 | 0 | | 0 0.000000 | 0. 000000 | 77.00 |
| οι | UTPATIENT SERVICE COST CENTERS | · · · | | | | | 1 |
| 90.00 0 | 9000 CLI NI C | 24, 529 | 99, 334 | 123, 86 | 2. 051622 | 0.00000 | 90.00 |
| 90.01 0 | 9001 WOUND CARE INSTITUTE | 7, 684 | 7, 619 | 15, 30 | 0. 834738 | 0. 000000 | 90.01 |
| 90.02 0 | 9002 OP NUTRITIONAL COUNSELING | 0 | 67, 994 | 67, 99 | 1. 179884 | 0. 000000 | 90.02 |
| 91.00 0 | 9100 EMERGENCY | 12, 653, 151 | 100, 262, 868 | 112, 916, 01 | 9 0. 101461 | 0. 000000 | 91.00 |
| 92.00 0 | 9200 OBSERVATION BEDS (NON-DISTINCT PART | 1, 322, 525 | 7, 471, 783 | 8, 794, 30 | 0. 343223 | 0. 000000 | 92.00 |
| 0 | THER REIMBURSABLE COST CENTERS | | | | | | |
| 102.0010 | 0200 OPI OI D TREATMENT PROGRAM | 0 | 0 | | 0 | | 102.00 |
| | PECIAL PURPOSE COST CENTERS | | | | | | |
| 113.001 | 1300 INTEREST EXPENSE | | | | | | 113.00 |
| 200.00 | Subtotal (see instructions) | 121, 608, 032 | 478, 997, 462 | 600, 605, 49 | 4 | | 200.00 |
| 201.00 | Less Observation Beds | | | | | | 201.00 |
| 202.00 | Total (see instructions) | 121, 608, 032 | 478, 997, 462 | 600, 605, 49 | 24 | | 202.00 |

| ealth Financial Systems | FRANCI SCAN HEALTH | | | u of Form CMS-255 |
|------------------------------------------------------------------------------------|--------------------|-----------------------|----------------------------|--------------------------------------|
| OMPUTATION OF RATIO OF COSTS TO CHARGES | | Provider CCN: 15-0057 | Period: From 01/01/2022 | Worksheet C Part I |
| | | | To 12/31/2022 | Date/Time Prepar 5/29/2023 3:28 p |
| | | Title XIX | Hospi tal | PPS |
| Cost Center Description | PPS Inpatient | | incopi cui | |
| | Ratio | | | |
| | 11.00 | | | |
| INPATIENT ROUTINE SERVICE COST CENTERS | | | | |
| D. 00 03000 ADULTS & PEDIATRICS | | | | 30 |
| 4.00 03400 SURGICAL INTENSIVE CARE UNIT | | | | 34 |
| 3. 00 04300 NURSERY | | | | 43 |
| ANCI LLARY SERVI CE COST CENTERS | | | | |
| D. 00 05000 OPERATI NG ROOM | 0. 087228 | | | 50 |
| 2. 00 05200 DELIVERY ROOM & LABOR ROOM | 0. 512564 | | | 52 |
| 4. 00 05400 RADI OLOGY-DI AGNOSTI C | 0. 072979 | | | 54 |
| 5. 00 05500 RADI OLOGY-THERAPEUTI C | 0. 139147 | | | 55 |
| D. 00 06000 LABORATORY | 0. 110956 | | | 60 |
| 4. 00 06400 I NTRAVENOUS THERAPY | 0. 123710 | | | 64 |
| 5. 00 06500 RESPI RATORY THERAPY | 0. 311722 | | | 6 |
| 5. 00 06600 PHYSI CAL THERAPY | 0. 264848 | | | 60 |
| 7.00 06700 OCCUPATI ONAL THERAPY | 0. 356983 | | | 6 |
| 3. 00 06800 SPEECH PATHOLOGY | 0. 188728 | | | 68 |
| 9. 00 06900 ELECTROCARDI OLOGY | 0. 041372 | | | 69 |
| D. 00 07000 ELECTROENCEPHALOGRAPHY | 0. 165880 | | | 70 |
| 1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT | 0. 116007 | | | 71 |
| 2.00 07200 I MPL. DEV. CHARGED TO PATIENTS | 0. 347304 | | | 72 |
| 3. 00 07300 DRUGS CHARGED TO PATIENTS | 0. 203613 | | | 7: |
| 4. 00 07400 RENAL DI ALYSI S | 0. 000000 | | | 74 |
| 7. 00 07700 ALLOGENEIC STEM CELL ACQUISITION | 0. 000000 | | | 7 |
| OUTPATIENT SERVICE COST CENTERS | 0.054(00 | | | |
| D. 00 09000 CLINIC | 2.051622 | | | 90 |
| D. 01 09001 WOUND CARE INSTITUTE | 0. 834738 | | | |
| D. 02 09002 OP NUTRITIONAL COUNSELING | 1. 179884 | | | 90 |
| 1.00 09100 EMERGENCY | 0. 101461 | | | 9 |
| 2. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS | 0. 343223 | | | 92 |
| 02.00 10200 OPI 0I D TREATMENT PROGRAM | | | | 102 |
| SPECIAL PURPOSE COST CENTERS | | | | 10. |
| 13. 00 11300 INTEREST EXPENSE | | | | 11; |
| 00.00 Subtotal (see instructions) | | | | 200 |
| 01.00 Less Observation Beds | | | | 200 |
| 02.00 Total (see instructions) | | | | 20 |

| Health Financial Systems | FRANCI SCAN HEAL | TH MOORESVILLE | | In Lie | eu of Form CMS- | 2552-10 |
|----------------------------------------------------|------------------|----------------|--------------|-----------------|--------------------------------|--------------------|
| CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE F | ATIOS NET OF | Provider C | | Peri od: | Worksheet C | |
| REDUCTIONS FOR MEDICAID ONLY | | | | From 01/01/2022 | | |
| | | | | To 12/31/2022 | Date/Time Pre 5/29/2023 3:2 | pared: 8 pm |
| | | Titl | e XIX | Hospi tal | PPS | <u> </u> |
| Cost Center Description | Total Cost | Capital Cost | | | Operating Cost | |
| | (Wkst. B, Part | (Wkst. B, Part | | | Reduction | |
| | I, col. 26) | II col. 26) | Cost (col. 1 | - | Amount | |
| | | | col. 2) | | | |
| | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | |
| ANCI LLARY SERVI CE COST CENTERS | | | | - | | |
| 50. 00 05000 OPERATI NG ROOM | 4, 596, 378 | | | | - | |
| 52.00 05200 DELIVERY ROOM & LABOR ROOM | 2, 916, 123 | | | | - | |
| 54.00 05400 RADI OLOGY-DI AGNOSTI C | 4, 854, 307 | | | | 0 | |
| 55. 00 05500 RADI OLOGY-THERAPEUTI C | 5, 429, 303 | | | | 0 | 55.00 |
| 60. 00 06000 LABORATORY | 4, 470, 235 | | | | 0 | 60.00 |
| 64.00 06400 INTRAVENOUS THERAPY | 1, 549, 366 | | | | 0 | 64.00 |
| 65. 00 06500 RESPI RATORY THERAPY | 2, 746, 058 | | | | 0 | 65.00 |
| 66.00 06600 PHYSI CAL THERAPY | 3, 434, 914 | | | | 0 | 66.00 |
| 67.00 06700 OCCUPATI ONAL THERAPY | 772, 037 | | | | 0 | 67.00 |
| 68.00 06800 SPEECH PATHOLOGY | 58, 856 | | | | 0 | 68.00 |
| 69.00 06900 ELECTROCARDI OLOGY | 690, 367 | | | | 0 | 69.00 |
| 70.00 07000 ELECTROENCEPHALOGRAPHY | 325, 632 | | | | 0 | 70.00 |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT | 3, 813, 801 | | | | 0 | 71.00 |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS | 13, 499, 203 | | | | 0 | 72.00 |
| 73.00 07300 DRUGS CHARGED TO PATIENTS | 25, 361, 752 | | | 02 0 | 0 | 73.00 |
| 74.00 07400 RENAL DIALYSIS | 0 | 0 | | 0 0 | 0 | 74.00 |
| 77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION | 0 | 0 | | 0 0 | 0 | 77.00 |
| OUTPATIENT SERVICE COST CENTERS | | | | - | - | |
| 90. 00 09000 CLINIC | 254, 120 | | | | | |
| 90. 01 09001 WOUND CARE INSTITUTE | 12, 774 | | | | 0 | |
| 90. 02 09002 OP NUTRI TI ONAL COUNSELI NG | 80, 225 | | | | 0 | 90.02 |
| 91.00 09100 EMERGENCY | 11, 456, 550 | | | | 0 | 91.00 |
| 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART | 3, 018, 408 | 318, 204 | 2, 700, 20 | 04 0 | 0 | 92.00 |
| OTHER REIMBURSABLE COST CENTERS | 1 | | | | | 1.0.0.00 |
| 102.00 10200 OPI OI D TREATMENT PROGRAM | 0 | 0 | | 0 0 | 0 | 102.00 |
| SPECIAL PURPOSE COST CENTERS | - | | 1 | | | 110.00 |
| 113.00 11300 INTEREST EXPENSE | 00 040 400 | 2 274 744 | | - | | 113.00 |
| 200.00 Subtotal (sum of lines 50 thru 199) | 89, 340, 409 | | | | | 200. 00 201. 00 |
| 201.00 Less Observation Beds | 3, 018, 408 | | | | | |
| 202.00 Total (line 200 minus line 201) | 86, 322, 001 | 2, 956, 540 | 83, 365, 46 | 01 0 | I 0 | 202.00 |

| Health Financial Systems | FRANCI SCAN HEALT | H MOORESVILLE | | In Lie | eu of Form CMS-2552-10 |
|----------------------------------------------------------------------------|-----------------------------|---------------|-------------|----------------------------------|------------------------|
| CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE R | ATIOS NET OF | Provider C | CN: 15-0057 | Peri od: | Worksheet C |
| REDUCTIONS FOR MEDICAID ONLY | | | | From 01/01/2022 To 12/31/2022 | |
| | | | | 10 12/31/2022 | 5/29/2023 3:28 pm |
| | | | e XIX | Hospi tal | PPS |
| Cost Center Description | | Total Charges | | | |
| | Capital and | (Worksheet C, | | | |
| | Operating Cost | | | 6 | |
| | Reduction | 8) | / col . 7) | | |
| | 6.00 | 7.00 | 8.00 | | |
| ANCI LLARY SERVI CE COST CENTERS | 4 504 270 | F0 (04 107 | 0.0070 | 20 | F0.00 |
| 50.00 05000 OPERATING ROOM | 4, 596, 378 | | | | 50.00 |
| 52. 00 05200 DELIVERY ROOM & LABOR ROOM | 2, 916, 123 | | | | 52.00 |
| 54. 00 05400 RADI OLOGY - DI AGNOSTI C | 4, 854, 307 | 66, 516, 452 | | | 54.00 |
| 55. 00 05500 RADI OLOGY - THERAPEUTI C | 5, 429, 303 | 39, 018, 603 | | | 55.00 |
| | 4, 470, 235 | 40, 288, 271 | | | 60.00 |
| 64. 00 06400 I NTRAVENOUS THERAPY | 1, 549, 366 | 12, 524, 228 | | | 64.00 |
| 65. 00 06500 RESPIRATORY THERAPY | 2, 746, 058 | 8, 809, 308 | | | 65.00 |
| 66. 00 06600 PHYSI CAL THERAPY | 3, 434, 914 | 12, 969, 374 | | | 66.00 |
| 67. 00 06700 OCCUPATIONAL THERAPY | 772, 037 | 2, 162, 671 | | | 67.00 |
| 68. 00 06800 SPEECH PATHOLOGY | 58, 856 | 311, 856 | | | 68.00 |
| 69. 00 06900 ELECTROCARDI OLOGY | 690, 367 | 16, 686, 687 | | | 69.00 |
| 70. 00 07000 ELECTROENCEPHALOGRAPHY | 325, 632 | 1, 963, 054 | | | 70.00 |
| 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT | 3, 813, 801 | 32, 875, 486 | | | 71.00 |
| 72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS | 13, 499, 203 | 38, 868, 522 | | | 72.00 |
| 73. 00 07300 DRUGS CHARGED TO PATIENTS | 25, 361, 752 | 124, 558, 646 | | | 73.00 |
| 74.00 07400 RENAL DIALYSIS | 0 | 0 | | | 74.00 |
| 77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION | 0 | 0 | 0.0000 | 00 | 77.00 |
| | 254 120 | 100.0(0 | 2.051(| 22 | |
| 90. 00 09000 CLINIC | 254, 120 | | | | 90.00 |
| 90. 01 09001 WOUND CARE INSTITUTE | 12, 774 | 15, 303 | | | 90.01 |
| 90. 02 09002 OP NUTRITIONAL COUNSELING | 80, 225 | 67, 994 | | | 90.02 |
| 91.00 09100 EMERGENCY | 11, 456, 550 | | | | 91.00 |
| 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART | 3, 018, 408 | 8, 794, 308 | 0.3432 | 23 | 92.00 |
| OTHER REI MBURSABLE COST CENTERS | | | 0.0000 | 00 | 102.00 |
| 102.00 10200 OPI OI D TREATMENT PROGRAM | 0 | 0 | 0.0000 | 00 | 102.00 |
| SPECIAL PURPOSE COST CENTERS 113. 00 11300 I NTEREST EXPENSE | 1 | | | | 113.00 |
| 200.00 Subtotal (sum of lines 50 thru 199) | 00 240 400 | 577, 854, 066 | | | 200.00 |
| 200.00 Subtotal (sum of lines 50 thru 199) 201.00 Less Observation Beds | 89, 340, 409 3, 018, 408 | | | | 200.00 |
| 202.00 Total (line 200 minus line 201) | 86, 322, 001 | | | | 201.00 |
| | 00, 322, 001 | 577, 054, 000 | 1 | | 1202.00 |

| Health Financial Systems | RANCI SCAN HEAL | TH MOORESVILLE | | In Lie | u of Form CMS-: | 2552-10 |
|----------------------------------------------------|-----------------|----------------|---------------|-----------------|--------------------------------|----------------|
| APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL | COSTS | Provider C | | Peri od: | Worksheet D | |
| | | | | From 01/01/2022 | Part I | |
| | | | | To 12/31/2022 | Date/Time Pre 5/29/2023 3:2 | pared: 8 nm |
| | | Title | e XVIII | Hospi tal | PPS | |
| Cost Center Description | Capi tal | Swing Bed | Reduced | | Per Diem (col. | |
| | Related Cost | Adjustment | Capi tal | Days | 3 / col. 4) | |
| | (from Wkst. B, | - | Related Cost | - | | |
| | Part II, col. | | (col. 1 - col | | | |
| | 26) | | 2) | | | |
| | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | |
| INPATIENT ROUTINE SERVICE COST CENTERS | | | | | | |
| 30. 00 ADULTS & PEDIATRICS | 1, 393, 067 | C | 1, 393, 06 | 7 7, 762 | 179.47 | 30.00 |
| 34.00 SURGICAL INTENSIVE CARE UNIT | 317, 221 | | 317, 22 | 1 1, 478 | 214.63 | 34.00 |
| 43.00 NURSERY | 10, 142 | | 10, 14 | 2 584 | 17.37 | 43.00 |
| 200.00 Total (lines 30 through 199) | 1, 720, 430 | | 1, 720, 43 | 0 9, 824 | | 200.00 |
| Cost Center Description | I npati ent | I npati ent | | | | |
| | Program days | Program | | | | |
| | | Capital Cost | | | | |
| | | (col. 5 x col. | | | | |
| | | 6) | | | | |
| | 6.00 | 7.00 | | | | |
| INPATIENT ROUTINE SERVICE COST CENTERS | | | | | | |
| 30. 00 ADULTS & PEDIATRICS | 1, 986 | | | | | 30.00 |
| 34.00 SURGICAL INTENSIVE CARE UNIT | 492 | 105, 598 | | | | 34.00 |
| 43.00 NURSERY | 0 | (C | | | | 43.00 |
| 200.00 Total (lines 30 through 199) | 2,478 | 462, 025 | j | | | 200. 00 |

| Health Financial Systems | FRANCI SCAN HEAL | TH MOORESVILLE | | In Lie | u of Form CMS-2 | 2552-10 |
|----------------------------------------------------|------------------|----------------|---------------|---------------------------------------------|----------------------------------------------------------|---------|
| APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT | AL COSTS | Provider C | CN: 15-0057 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part II Date/Time Pre 5/29/2023 3:2 | |
| | | Title | XVIII | Hospi tal | PPS | |
| Cost Center Description | Capi tal | Total Charges | Ratio of Cos | t Inpatient | Capital Costs | |
| | Related Cost | (from Wkst. C, | to Charges | Program | (column 3 x | |
| | (from Wkst. B, | Part I, col. | (col. 1 ÷ col | . Charges | column 4) | |
| | Part II, col. | 8) | 2) | | | |
| | 26) | | | | | |
| | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | |
| ANCI LLARY SERVICE COST CENTERS | | | | | | |
| 50.00 05000 OPERATING ROOM | 802, 354 | 52, 694, 137 | 0. 01522 | 7, 511, 044 | 114, 371 | |
| 52.00 05200 DELIVERY ROOM & LABOR ROOM | 6, 583 | 5, 689, 284 | 0.00115 | 57 13, 232 | 15 | 52.00 |
| 54.00 05400 RADI OLOGY-DI AGNOSTI C | 312, 666 | 66, 516, 452 | 0.00470 | 2, 185, 368 | 10, 273 | 54.00 |
| 55. 00 05500 RADI OLOGY-THERAPEUTI C | 249, 354 | 39, 018, 603 | 0.00639 | 138, 117 | 883 | 55.00 |
| 60. 00 06000 LABORATORY | 145, 138 | 40, 288, 271 | 0.00360 | 3, 280, 119 | 11, 815 | 60.00 |
| 64.00 06400 INTRAVENOUS THERAPY | 2, 701 | 12, 524, 228 | 0.0002 | 6 0 | 0 | 64.00 |
| 65. 00 06500 RESPI RATORY THERAPY | 89, 305 | 8, 809, 308 | 0. 01013 | 1, 222, 322 | 12, 392 | 65.00 |
| 66. 00 06600 PHYSI CAL THERAPY | 257, 201 | 12, 969, 374 | 0. 01983 | 958, 248 | 19, 003 | 66.00 |
| 67.00 06700 OCCUPATI ONAL THERAPY | 144, 792 | 2, 162, 671 | 0.06695 | 51 92, 770 | 6, 211 | 67.00 |
| 68.00 06800 SPEECH PATHOLOGY | 295 | 311, 856 | 0.00094 | 6 51, 530 | 49 | 68.00 |
| 69.00 06900 ELECTROCARDI OLOGY | 36, 386 | 16, 686, 687 | 0.00218 | 574, 774 | 1, 254 | 69.00 |
| 70.00 07000 ELECTROENCEPHALOGRAPHY | 109, 461 | 1, 963, 054 | 0.05576 | 38, 269 | 2, 134 | 70.00 |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT | 32,041 | 32, 875, 486 | 0.00097 | 4, 481, 231 | 4, 369 | 71.00 |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS | 68, 327 | 38, 868, 522 | 0.00175 | 58 7, 191, 866 | 12, 643 | 72.00 |
| 73.00 07300 DRUGS CHARGED TO PATIENTS | 111, 150 | 124, 558, 646 | 0.00089 | | 2,603 | 73.00 |
| 74.00 07400 RENAL DIALYSIS | 0 | 0 | 0.0000 | | 0 | 74.00 |
| 77.00 07700 ALLOGENEIC STEM CELL ACQUISITION | 0 | c | 0.0000 | | 0 | 77.00 |
| OUTPATIENT SERVICE COST CENTERS | - | | | - <u>-</u> | | |
| 90. 00 09000 CLINIC | 94, 594 | 123, 863 | 0.76369 | 0 | 0 | 90.00 |
| 90.01 09001 WOUND CARE INSTITUTE | 24 | | | 0 8 | 0 | 90.01 |
| 90. 02 09002 OP NUTRITIONAL COUNSELING | 100 | | | | 0 | 90.02 |
| 91. 00 09100 EMERGENCY | 494, 068 | | | | 19, 838 | |
| 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART | 318, 204 | | 1 | | | |
| 200.00 Total (lines 50 through 199) | 3, 274, 744 | | | 35, 817, 383 | | |

| Health Financial Systems | FRANCI SCAN HEALT | TH MOORESVILLE | | In Lie | eu of Form CMS- | 2552-10 |
|--------------------------------------------------|-------------------|----------------|--------------|---------------------------------------------|-----------------|---------|
| APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER | PASS THROUGH COST | | | Period: From 01/01/2022 To 12/31/2022 | | |
| | | Title | e XVIII | Hospi tal | PPS | |
| Cost Center Description | Nursi ng | Nursi ng | Allied Healt | h Allied Health | All Other | |
| | Program | Program | Post-Stepdow | n Cost | Medi cal | |
| | Post-Stepdown | Ŭ | Adjustments | | Education Cost | |
| | Adjustments | | | | | |
| | 1A | 1.00 | 2A | 2.00 | 3.00 | |
| INPATIENT ROUTINE SERVICE COST CENTERS | | | | | | |
| 30. 00 03000 ADULTS & PEDI ATRI CS | 0 | C |) | 0 0 | 0 | 30.00 |
| 34.00 03400 SURGICAL INTENSIVE CARE UNIT | 0 | C |) | 0 0 | 0 | 34.00 |
| 43. 00 04300 NURSERY | 0 | 0 | | 0 0 | 0 | |
| 200.00 Total (lines 30 through 199) | 0 | 0 | | 0 0 | 0 | 200.00 |
| Cost Center Description | Swing-Bed | Total Costs | Total Patien | t Per Diem (col. | I npati ent | 200100 |
| | Adjustment | (sum of cols. | Days | 5 ÷ col. 6) | Program Days | |
| | Amount (see | 1 through 3, | buys | 0 000000 | l rogram bays | |
| | | minus col. 4) | | | | |
| | 4,00 | 5.00 | 6,00 | 7.00 | 8.00 | |
| INPATIENT ROUTINE SERVICE COST CENTERS | 4.00 | 3.00 | 0.00 | 7.00 | 0.00 | |
| 30. 00 03000 ADULTS & PEDI ATRI CS | 0 | 0 | 7,76 | 0.00 | 1, 986 | 30.00 |
| 34. 00 03400 SURGICAL INTENSIVE CARE UNIT | 0 | | 1, 47 | | | |
| 43. 00 04300 NURSERY | | | 58 | | | |
| 200.00 Total (lines 30 through 199) | | | 9,82 | | | 200.00 |
| Cost Center Description | I npati ent | 0 | 7,02 | .4 | 2,470 | 200.00 |
| cost center bescription | Program | | | | | |
| | | | | | | |
| | Pass-Through | | | | | |
| | Cost (col. 7 x | | | | | |
| | <u>col. 8)</u> | | | | | |
| | 9.00 | | | | | |
| I NPATI ENT ROUTI NE SERVI CE COST CENTERS | | | | | | 20.00 |
| 30. 00 03000 ADULTS & PEDIATRICS | 0 | | | | | 30.00 |
| 34. 00 03400 SURGI CAL I NTENSI VE CARE UNI T | 0 | | | | | 34.00 |
| 43. 00 04300 NURSERY | 0 | | | | | 43.00 |
| 200.00 Total (lines 30 through 199) | 0 | | | | | 200.00 |

| Health Financial Systems F | RANCI SCAN HEALT | H MOORESVILLE | | In Lie | eu of Form CMS-: | 2552-10 |
|----------------------------------------------------------------------|------------------|---------------|-------------|---------------------------------------------|------------------|---------|
| APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEE THROUGH COSTS | RVICE OTHER PASS | 6 Provider CC | CN: 15-0057 | Period: From 01/01/2022 To 12/31/2022 | | |
| | | Title | XVIII | Hospi tal | PPS | |
| Cost Center Description | Non Physician | Nursi ng | Nursi ng | Allied Health | Allied Health | |
| | Anestheti st | Program | Program | Post-Stepdown | | |
| | Cost | Post-Stepdown | | Adjustments | | |
| | | Adjustments | | | | |
| | 1.00 | 2A | 2.00 | 3A | 3.00 | |
| ANCI LLARY SERVI CE COST CENTERS | | | | | | |
| 50.00 05000 OPERATING ROOM | 0 | 0 | | 0 0 | 0 | 50.00 |
| 52.00 05200 DELIVERY ROOM & LABOR ROOM | 0 | 0 | | 0 0 | 0 | 52.00 |
| 54.00 05400 RADI OLOGY-DI AGNOSTI C | 0 | 0 | 1 | 0 0 | 0 | 54.00 |
| 55. 00 05500 RADI OLOGY-THERAPEUTI C | 0 | 0 | 1 | 0 0 | 0 | 55.00 |
| 60. 00 06000 LABORATORY | 0 | 0 | | 0 0 | 0 | 60.00 |
| 64.00 06400 I NTRAVENOUS THERAPY | 0 | 0 | | 0 0 | 0 | 64.00 |
| 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 |
| 67.00 06700 OCCUPATI ONAL THERAPY | 0 | 0 | | 0 0 | 0 | 67.00 |
| 68.00 06800 SPEECH PATHOLOGY | 0 | 0 | | 0 0 | 0 | 68.00 |
| 69.00 06900 ELECTROCARDI OLOGY | 0 | 0 | | 0 0 | 0 | 69,00 |
| 70.00 07000 ELECTROENCEPHALOGRAPHY | 0 | 0 | | 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 STEM CELL ACQUISITION | 0 | 0 | | 0 0 | 0 | 77.00 |
| OUTPATIENT SERVICE COST CENTERS | | | I | | <u> </u> | |
| 90, 00 09000 CLINIC | 0 | 0 | | 0 0 | 0 | 90.00 |
| 90.01 09001 WOUND CARE INSTITUTE | 0 | 0 | | 0 0 | 0 | 90.01 |
| 90. 02 09002 OP NUTRITIONAL COUNSELING | 0 | 0 | | 0 0 | 0 | 90.02 |
| 91. 00 09100 EMERGENCY | 0 | 0 | | 0 0 | 0 | 91.00 |
| 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART | 0 | 0 | | 0 | 0 | 92.00 |
| 200.00 Total (lines 50 through 199) | 0 | 0 | | 0 0 | 0 | 200.00 |
| ······································ | | - | 1 | - 1 | | |

| Health Financial Systems | RANCI SCAN HEALT | TH MOORESVILLE | | In Lie | eu of Form CMS- | 2552-10 |
|----------------------------------------------------------------------|------------------|----------------|--------------|---------------------------------------------|-----------------|---------|
| APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF THROUGH COSTS | RVICE OTHER PASS | 6 Provider C | | Period: From 01/01/2022 To 12/31/2022 | | |
| | | Title | XVIII | Hospi tal | PPS | |
| Cost Center Description | All Other | Total Cost | Total | Total Charges | Ratio of Cost | |
| | Medi cal | (sum of cols. | Outpati ent | (from Wkst. C, | to Charges | |
| | Education Cost | 1, 2, 3, and | Cost (sum of | Part I, col. | (col. 5 ÷ col. | |
| | | 4) | col s. 2, 3, | 8) | 7) | |
| | | | and 4) | | (see | |
| | | | | | instructions) | |
| | 4.00 | 5.00 | 6.00 | 7.00 | 8.00 | |
| ANCILLARY SERVICE COST CENTERS | | | | - | | |
| 50.00 05000 OPERATING ROOM | 0 | 0 | | 0 52, 694, 137 | | |
| 52.00 05200 DELIVERY ROOM & LABOR ROOM | 0 | 0 | | 0 5, 689, 284 | | |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C | 0 | 0 | | 0 66, 516, 452 | | |
| 55. 00 05500 RADI OLOGY-THERAPEUTI C | 0 | 0 | | 0 39, 018, 603 | | |
| 60. 00 06000 LABORATORY | 0 | 0 | | 0 40, 288, 271 | | • |
| 64.00 06400 INTRAVENOUS THERAPY | 0 | 0 | | 0 12, 524, 228 | 0. 000000 | 64.00 |
| 65. 00 06500 RESPI RATORY THERAPY | 0 | 0 | | 0 8, 809, 308 | 0.000000 | |
| 66. 00 06600 PHYSI CAL THERAPY | 0 | 0 | | 0 12, 969, 374 | 0.000000 | 66.00 |
| 67.00 06700 OCCUPATI ONAL THERAPY | 0 | 0 | | 0 2, 162, 671 | 0.000000 | 67.00 |
| 68.00 06800 SPEECH PATHOLOGY | 0 | 0 | | 0 311, 856 | 0.000000 | 68.00 |
| 69. 00 06900 ELECTROCARDI OLOGY | 0 | 0 | | 0 16, 686, 687 | 0.000000 | 69.00 |
| 70. 00 07000 ELECTROENCEPHALOGRAPHY | 0 | 0 | | 0 1, 963, 054 | 0.000000 | 70.00 |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT | 0 | 0 | | 0 32, 875, 486 | 0.000000 | 71.00 |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS | 0 | 0 | | 0 38, 868, 522 | 0.000000 | 72.00 |
| 73.00 07300 DRUGS CHARGED TO PATIENTS | 0 | 0 | | 0 124, 558, 646 | 0.000000 | 73.00 |
| 74.00 07400 RENAL DIALYSIS | 0 | 0 | | 0 0 | 0.000000 | 74.00 |
| 77.00 07700 ALLOGENEIC STEM CELL ACQUISITION | 0 | 0 | | 0 0 | 0.000000 | 77.00 |
| OUTPATIENT SERVICE COST CENTERS | | | | | | |
| 90. 00 09000 CLINIC | 0 | 0 | | 0 123, 863 | 0.000000 | 90.00 |
| 90.01 09001 WOUND CARE INSTITUTE | 0 | 0 | | 0 15, 303 | 0.000000 | 90.01 |
| 90.02 09002 OP NUTRITIONAL COUNSELING | 0 | 0 | | 0 67, 994 | 0.000000 | 90.02 |
| 91.00 09100 EMERGENCY | 0 | 0 | | 0 112, 916, 019 | 0.000000 | 91.00 |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART | 0 | 0 | | 0 8, 794, 308 | 0.000000 | 92.00 |
| 200.00 Total (lines 50 through 199) | 0 | 0 | | 0 577, 854, 066 | | 200. 00 |

| Health Financial Systems F | RANCI SCAN HEALTH | H MOORESVILLE | | In Lie | u of Form CMS-2 | 2552-10 |
|----------------------------------------------------------------------|-------------------|---------------|---------------|---------------------------------------------|----------------------------------------------------------|---------|
| APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF THROUGH COSTS | RVICE OTHER PASS | Provider CO | | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part IV Date/Time Pre 5/29/2023 3:2 | |
| | | Title | XVIII | Hospi tal | PPS | |
| Cost Center Description | Outpati ent | Inpati ent | Inpati ent | Outpati ent | Outpati ent | |
| | Ratio of Cost | Program | Program | Program | Program | |
| | to Charges | Charges | Pass-Through | | Pass-Through | |
| | (col. 6 ÷ col. | | Costs (col. 8 | 3 | 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 | | | | - | | |
| 50. 00 05000 OPERATI NG ROOM | 0. 000000 | 7, 511, 044 | | 0 10, 337, 398 | 0 | 50.00 |
| 52.00 05200 DELIVERY ROOM & LABOR ROOM | 0. 000000 | 13, 232 | | 0 0 | 0 | 52.00 |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C | 0. 000000 | 2, 185, 368 | | 0 12, 606, 234 | 0 | 54.00 |
| 55. 00 05500 RADI OLOGY-THERAPEUTI C | 0. 000000 | 138, 117 | | 0 11, 217, 542 | 0 | 55.00 |
| 60. 00 06000 LABORATORY | 0. 000000 | 3, 280, 119 | | 0 1, 369, 982 | 0 | 60.00 |
| 64.00 06400 I NTRAVENOUS THERAPY | 0. 000000 | 0 | | 0 3, 026, 629 | 0 | 64.00 |
| 65. 00 06500 RESPI RATORY THERAPY | 0.000000 | 1, 222, 322 | | 0 1, 185, 399 | 0 | 65.00 |
| 66. 00 06600 PHYSI CAL THERAPY | 0.000000 | 958, 248 | | 0 464, 733 | 0 | 66.00 |
| 67.00 06700 OCCUPATIONAL THERAPY | 0. 000000 | 92, 770 | | 0 36, 042 | 0 | 67.00 |
| 68.00 06800 SPEECH PATHOLOGY | 0. 000000 | 51, 530 | | 0 1, 828 | 0 | 68.00 |
| 69. 00 06900 ELECTROCARDI OLOGY | 0. 000000 | 574, 774 | | 0 1, 404, 069 | 0 | 69.00 |
| 70.00 07000 ELECTROENCEPHALOGRAPHY | 0. 000000 | 38, 269 | | 0 661, 925 | 0 | 70.00 |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT | 0. 000000 | 4, 481, 231 | | 0 5, 144, 406 | 0 | 71.00 |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS | 0. 000000 | 7, 191, 866 | | 0 8, 730, 774 | 0 | 72.00 |
| 73.00 07300 DRUGS CHARGED TO PATIENTS | 0. 000000 | 2, 918, 088 | | 0 39, 663, 836 | 0 | 73.00 |
| 74.00 07400 RENAL DIALYSIS | 0. 000000 | 0 | | 0 0 | 0 | 74.00 |
| 77.00 07700 ALLOGENEIC STEM CELL ACQUISITION | 0. 000000 | 0 | | 0 0 | 0 | 77.00 |
| OUTPATIENT SERVICE COST CENTERS | | | | | | |
| 90. 00 09000 CLI NI C | 0. 000000 | 0 | | 0 266 | 0 | 90.00 |
| 90.01 09001 WOUND CARE INSTITUTE | 0. 000000 | 0 | | 0 3, 074 | 0 | 90.01 |
| 90. 02 09002 OP NUTRI TI ONAL COUNSELI NG | 0. 000000 | 0 | | 0 0 | 0 | 90. 02 |
| 91.00 09100 EMERGENCY | 0. 000000 | 4, 533, 449 | | 0 15, 684, 042 | 0 | 91.00 |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART | 0. 000000 | 626, 956 | | 0 1, 172, 559 | 0 | 92.00 |
| 200.00 Total (lines 50 through 199) | | 35, 817, 383 | | 0 112, 710, 738 | 0 | 200. 00 |
| | | | | | | |

| | RANCI SCAN HEAL | TH MOORESVILLE | | In Lie | u of Form CMS- | 2552-10 |
|-----------------------------------------------------|-----------------|----------------|---------------|---------------------------------------------|---------------------------------------------------------|---------|
| APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND | O VACCINE COST | Provider CO | | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part V Date/Time Pre 5/29/2023 3:2 | epared: |
| | | Titlo | XVIII | Hospi tal | PPS | |
| | | Intre | Charges | nospi tai | Costs | |
| Cost Center Description | Cost to Charge | DDS Daimbursad | | Cost | PPS Services | |
| cost center bescription | Ratio From | Services (see | Reimbursed | Reimbursed | (see inst.) | |
| | Worksheet C, | inst.) | Servi ces | Servi ces Not | (366 1131.) | |
| | Part I, col. 9 | | Subject To | Subject To | | |
| | | | Ded. & Coins. | | | |
| | | | (see inst.) | (see inst.) | | |
| | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | |
| ANCI LLARY SERVI CE COST CENTERS | | | | | | |
| 50.00 05000 OPERATING ROOM | 0. 087228 | 10, 337, 398 | | 0 0 | 901, 711 | 50.00 |
| 52.00 05200 DELIVERY ROOM & LABOR ROOM | 0. 512564 | 0 | | 0 0 | 0 | 52.00 |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C | 0. 072979 | 12, 606, 234 | | 0 0 | 919, 990 | 54.00 |
| 55. 00 05500 RADI OLOGY-THERAPEUTI C | 0. 139147 | 11, 217, 542 | | 0 0 | 1, 560, 887 | 55.00 |
| 60. 00 06000 LABORATORY | 0. 110956 | 1, 369, 982 | | 0 0 | 152, 008 | 60.00 |
| 64.00 06400 INTRAVENOUS THERAPY | 0. 123710 | 3, 026, 629 | | 0 0 | 374, 424 | 64.00 |
| 65. 00 06500 RESPI RATORY THERAPY | 0. 311722 | 1, 185, 399 | | 0 0 | 369, 515 | 65.00 |
| 66. 00 06600 PHYSI CAL THERAPY | 0. 264848 | 464, 733 | | 0 0 | 123, 084 | 66.00 |
| 67.00 06700 OCCUPATI ONAL THERAPY | 0. 356983 | 36, 042 | | 0 0 | 12, 866 | 67.00 |
| 68.00 06800 SPEECH PATHOLOGY | 0. 188728 | 1, 828 | | 0 0 | 345 | 68.00 |
| 69. 00 06900 ELECTROCARDI OLOGY | 0. 041372 | 1, 404, 069 | | 0 0 | 58, 089 | 69.00 |
| 70.00 07000 ELECTROENCEPHALOGRAPHY | 0. 165880 | 661, 925 | | 0 0 | 109, 800 | 70.00 |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT | 0. 116007 | 5, 144, 406 | 11 | 2 0 | 596, 787 | 71.00 |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS | 0. 347304 | 8, 730, 774 | | 0 0 | 3, 032, 233 | 72.00 |
| 73.00 07300 DRUGS CHARGED TO PATIENTS | 0. 203613 | 39, 663, 836 | 15, 20 | 4 1, 927 | 8, 076, 073 | 73.00 |
| 74.00 07400 RENAL DIALYSIS | 0. 000000 | 0 | | 0 0 | 0 | 74.00 |
| 77.00 07700 ALLOGENEIC STEM CELL ACQUISITION | 0. 000000 | 0 | | 0 0 | 0 | 77.00 |
| OUTPATIENT SERVICE COST CENTERS | | | | | | 1 |
| 90. 00 09000 CLI NI C | 2. 051622 | 266 | | 0 0 | 546 | 90.00 |
| 90.01 09001 WOUND CARE INSTITUTE | 0. 834738 | 3, 074 | | 0 0 | 2, 566 | 90.01 |
| 90.02 09002 OP NUTRITIONAL COUNSELING | 1. 179884 | 0 | | 0 0 | 0 | 90.02 |
| 91.00 09100 EMERGENCY | 0. 101461 | 15, 684, 042 | | 0 0 | 1, 591, 319 | 91.00 |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART | 0. 343223 | 1, 172, 559 | | 0 0 | 402, 449 | |
| 200.00 Subtotal (see instructions) | | 112, 710, 738 | 15, 31 | 6 1, 927 | 18, 284, 692 | 200.00 |
| 201.00 Less PBP Clinic Lab. Services-Program | | | | 0 0 | | 201.00 |
| Only Charges | | | | | | |
| 202.00 Net Charges (line 200 - line 201) | | 112, 710, 738 | 15, 31 | 6 1, 927 | 18, 284, 692 | 202.00 |

| APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-0057 Period: From 01/01/2022 Worksheet D Part V Title XVIII Hospital PPS | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------|
| | |
| | |
| Costs | |
| Cost Center Description Cost Cost | |
| Reimbursed Reimbursed | |
| Services Services Not | |
| Subject To Subject To | |
| Ded. & Coins. Ded. & Coins. | |
| (see inst.) (see inst.) | |
| 6.00 7.00 | |
| ANCI LLARY SERVICE COST CENTERS | |
| 50. 00 05000 OPERATING ROOM 0 0 | 50.00 |
| 52. 00 05200 DELIVERY ROOM & LABOR ROOM 0 0 | 52.00 |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 0 | 54.00 |
| 55. 00 05500 RADI OLOGY-THERAPEUTI C 0 0 | 55.00 |
| 60. 00 06000 LABORATORY 0 0 | 60.00 |
| 64. 00 06400 I NTRAVENOUS THERAPY 0 0 | 64.00 |
| 65. 00 06500 RESPI RATORY THERAPY 0 0 | 65.00 |
| 66. 00 06600 PHYSI CAL THERAPY 0 0 | 66.00 |
| 67. 00 06700 OCCUPATI ONAL THERAPY 0 0 | 67.00 |
| 68. 00 06800 SPEECH PATHOLOGY 0 0 | 68.00 |
| 69. 00 06900 ELECTROCARDI OLOGY 0 0 | 69.00 |
| 70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 | 70.00 |
| 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 13 0 | 71.00 |
| 72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS 0 0 | 72.00 |
| 73. 00 07300 DRUGS CHARGED TO PATIENTS 3, 096 392 | 73.00 |
| 74. 00 07400 RENAL DI ALYSI S 0 0 | 74.00 |
| 77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION 0 0 | 77.00 |
| OUTPATIENT SERVICE COST CENTERS | |
| 90. 00 09000 CLINIC 0 0 | 90.00 |
| 90. 01 09001 WOUND CARE INSTITUTE 0 0 | 90.01 |
| 90. 02 09002 OP NUTRITIONAL COUNSELING 0 0 | 90.02 |
| 91.00 09100 EMERGENCY 0 0 | 91.00 |
| 92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART 0 0 | 92.00 |
| 200.00 Subtotal (see instructions) 3,109 392 | 200.00 |
| 201.00 Less PBP Clinic Lab. Services-Program 0 | 201.00 |
| Only Charges | |
| 202.00 Net Charges (line 200 - line 201) 3,109 392 | 202.00 |

| Health Financial Systems | FRANCI SCAN HEALT | H MOORESVILLE | | In Lie | u of Form CMS- | 2552-10 |
|----------------------------------------------------|-------------------|----------------|---------------|-----------------|----------------|---------|
| APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL | COSTS | Provider C | | Peri od: | Worksheet D | |
| | | | | From 01/01/2022 | | |
| | | | | To 12/31/2022 | | pared: |
| | | | | | 5/29/2023 3:2 | 8 pm |
| | | | e XIX | Hospi tal | PPS | |
| Cost Center Description | Capi tal | Swing Bed | Reduced | Total Patient | | |
| | Related Cost | Adjustment | Capi tal | Days | 3 / col. 4) | |
| | (from Wkst. B, | | Related Cost | | | |
| | Part II, col. | | (col. 1 - col | | | |
| | 26) | | 2) | | | |
| | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | |
| INPATIENT ROUTINE SERVICE COST CENTERS | | | | | | |
| 30. 00 ADULTS & PEDIATRICS | 1, 393, 067 | 0 | 1, 393, 06 | 7 7, 762 | 179.47 | 30.00 |
| 34.00 SURGICAL INTENSIVE CARE UNIT | 317, 221 | | 317, 22 | 1 1, 478 | 214.63 | 34.00 |
| 43.00 NURSERY | 10, 142 | | 10, 14 | 2 584 | 17.37 | 43.00 |
| 200.00 Total (lines 30 through 199) | 1, 720, 430 | | 1, 720, 43 | 0 9, 824 | | 200.00 |
| Cost Center Description | I npati ent | Inpati ent | | | | |
| | Program days | Program | | | | |
| | | Capital Cost | | | | |
| | | (col. 5 x col. | | | | |
| | | 6) | | | | |
| | 6.00 | 7.00 | 1 | | | |
| INPATIENT ROUTINE SERVICE COST CENTERS | | | | | | |
| 30. 00 ADULTS & PEDIATRICS | 34 | 6, 102 | | | | 30.00 |
| 34.00 SURGICAL INTENSIVE CARE UNIT | 0 | C | | | | 34.00 |
| 43.00 NURSERY | 1 | 17 | | | | 43.00 |
| 200.00 Total (lines 30 through 199) | 35 | 6, 119 | , | | | 200.00 |
| (| | 0/11/ | 1 | | | |

| Health Financial Systems | RANCI SCAN HEAL | TH MOORESVILLE | | In Lie | u of Form CMS-2 | 2552-10 |
|-----------------------------------------------------|-----------------|----------------|---------------|---------------------------------------------|-----------------|---------|
| APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA | AL COSTS | Provider C | | Period: From 01/01/2022 To 12/31/2022 | 5/29/2023 3:2 | |
| | | | e XIX | Hospi tal | PPS | |
| Cost Center Description | Capi tal | Total Charges | Ratio of Cos | t Inpatient | Capital Costs | |
| | Related Cost | (from Wkst. C, | to Charges | Program | (column 3 x | |
| | (from Wkst. B, | Part I, col. | (col. 1 ÷ col | . Charges | column 4) | |
| | Part II, col. | 8) | 2) | | | |
| | 26) | | | | | |
| | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | |
| ANCI LLARY SERVI CE COST CENTERS | | | | | | |
| 50.00 05000 OPERATI NG ROOM | 802, 354 | | | | 3, 059 | |
| 52.00 05200 DELIVERY ROOM & LABOR ROOM | 6, 583 | 5, 689, 284 | | | | 52.00 |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C | 312, 666 | 66, 516, 452 | 0.00470 | 65, 437 | 308 | 54.00 |
| 55. 00 05500 RADI OLOGY-THERAPEUTI C | 249, 354 | 39, 018, 603 | 0.00639 | 0 0 | 0 | 55.00 |
| 60. 00 06000 LABORATORY | 145, 138 | 40, 288, 271 | 0.00360 | 190, 568 | 686 | 60.00 |
| 64.00 06400 I NTRAVENOUS THERAPY | 2, 701 | 12, 524, 228 | 0.0002 | 6 9, 641 | 2 | 64.00 |
| 65. 00 06500 RESPI RATORY THERAPY | 89, 305 | 8, 809, 308 | 0. 01013 | 62, 515 | 634 | 65.00 |
| 66. 00 06600 PHYSI CAL THERAPY | 257, 201 | 12, 969, 374 | 0. 01983 | 12, 634 | 251 | 66.00 |
| 67.00 06700 OCCUPATI ONAL THERAPY | 144, 792 | 2, 162, 671 | 0. 06695 | 2, 167 | 145 | 67.00 |
| 68.00 06800 SPEECH PATHOLOGY | 295 | 311, 856 | 0.00094 | 6 13, 735 | 13 | 68.00 |
| 69.00 06900 ELECTROCARDI OLOGY | 36, 386 | 16, 686, 687 | 0. 00218 | 12, 829 | 28 | 69.00 |
| 70.00 07000 ELECTROENCEPHALOGRAPHY | 109, 461 | 1, 963, 054 | 0. 05576 | 207 | 12 | 70.00 |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT | 32, 041 | 32, 875, 486 | 0.00097 | 5 114, 527 | 112 | 71.00 |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS | 68, 327 | 38, 868, 522 | 0. 00175 | 90, 301 | 159 | 72.00 |
| 73.00 07300 DRUGS CHARGED TO PATIENTS | 111, 150 | 124, 558, 646 | 0.00089 | 155, 339 | 139 | 73.00 |
| 74.00 07400 RENAL DIALYSIS | 0 | 0 | 0.0000 | 0 0 | 0 | 74.00 |
| 77.00 07700 ALLOGENEIC STEM CELL ACQUISITION | 0 | 0 | 0.0000 | 0 0 | 0 | 77.00 |
| OUTPATIENT SERVICE COST CENTERS | | | | | | |
| 90. 00 09000 CLINIC | 94, 594 | 123, 863 | 0. 76369 | 9 1, 392 | 1,063 | 90.00 |
| 90.01 09001 WOUND CARE INSTITUTE | 24 | 15, 303 | 0.00156 | 8 21 | 0 | 90.01 |
| 90. 02 09002 OP NUTRITIONAL COUNSELING | 100 | 67, 994 | 0.00147 | '1 0 | 0 | 90.02 |
| 91.00 09100 EMERGENCY | 494,068 | 112, 916, 019 | 0.00437 | 146, 432 | 641 | 91.00 |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART | 318, 204 | | | 6, 280 | 227 | 92.00 |
| 200.00 Total (lines 50 through 199) | 3, 274, 744 | | | 1, 406, 032 | 7, 851 | 200. 00 |

| Health Financial Systems | FRANCI SCAN HEALT | H MOORESVILLE | | In Lie | u of Form CMS- | 2552-10 |
|-----------------------------------------------|-----------------------|---------------|---------------|---------------------------------------------|-----------------|---------|
| APPORTIONMENT OF INPATIENT ROUTINE SERVICE OT | HER PASS THROUGH COST | | | Period: From 01/01/2022 To 12/31/2022 | 5/29/2023 3:2 | |
| | | Titl | e XIX | Hospi tal | PPS | |
| Cost Center Description | Nursi ng | Nursi ng | Allied Health | Allied Health | All Other | |
| | Program | Program | Post-Stepdowr | n Cost | Medi cal | |
| | Post-Stepdown | - | Adjustments | | Education Cost | |
| | Adjustments | | | | | |
| | 1A | 1.00 | 2A | 2.00 | 3.00 | |
| INPATIENT ROUTINE SERVICE COST CENTERS | | | | | | |
| 30. 00 03000 ADULTS & PEDIATRICS | 0 | C | | 0 0 | 0 | 30.00 |
| 34.00 03400 SURGICAL INTENSIVE CARE UNIT | 0 | C | | o o | 0 | 34.00 |
| 43. 00 04300 NURSERY | 0 | 0 | | 0 0 | 0 | |
| 200.00 Total (lines 30 through 199) | 0 | 0 | | 0 0 | 0 | 200.00 |
| Cost Center Description | Swing-Bed | Total Costs | Total Patient | Per Diem (col. | Inpati ent | 2001.00 |
| | Adjustment | (sum of cols. | Days | $5 \div col. 6)$ | Program Days | |
| | Amount (see | 1 through 3, | l sujo | 0 0000000000000000000000000000000000000 | l'i ogi am bayo | |
| | | minus col. 4) | | | | |
| | 4.00 | 5.00 | 6,00 | 7.00 | 8,00 | |
| INPATIENT ROUTINE SERVICE COST CENTERS | 1.00 | 0.00 | 0.00 | 7.00 | 0.00 | |
| 30. 00 03000 ADULTS & PEDI ATRI CS | 0 | 0 | 7,76 | 2 0.00 | 34 | 30.00 |
| 34. 00 03400 SURGICAL INTENSIVE CARE UNIT | Ŭ | 0 | 1,47 | | | |
| 43. 00 04300 NURSERY | | 0 | 58 | | | 43.00 |
| 200.00 Total (lines 30 through 199) | | 0 | 9, 82 | | | 200.00 |
| Cost Center Description | I npati ent | 0 | 7,02 | 4 | | 200.00 |
| cost center bescription | Program | | | | | |
| | Pass-Through | | | | | |
| | Cost (col. 7 x | | | | | |
| | col. 8) | | | | | |
| | | | | | | |
| INPATIENT ROUTINE SERVICE COST CENTERS | 9.00 | | | | | |
| 30. 00 03000 ADULTS & PEDIATRICS | 0 | | | | | 30,00 |
| | 0 | | | | | |
| 34.00 03400 SURGI CAL I NTENSI VE CARE UNI T | 0 | | | | | 34.00 |
| 43. 00 04300 NURSERY | 0 | | | | | 43.00 |
| 200.00 Total (lines 30 through 199) | 0 | | | | | 200.00 |

| Health Financial Systems F | FRANCISCAN HEALTH MOORESVILLE | | | In Lieu of Form CMS-2552-10 | | |
|-------------------------------------------------------------------------------------|-------------------------------|---------------|-----------|-----------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|---------|
| APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | | | | Period: Worksheet D From 01/01/2022 Part IV To 12/31/2022 Date/Time Prepar 5/29/2023 3:28 p | | |
| | | Ti tl | Title XIX | | Hospital PPS | |
| Cost Center Description | Non Physician | Nursi ng | Nursi ng | Allied Health | Allied Health | |
| | Anestheti st | Program | Program | Post-Stepdown | | |
| | Cost | Post-Stepdown | | Adjustments | | |
| | | Adjustments | | | | |
| | 1.00 | 2A | 2.00 | 3A | 3.00 | |
| ANCILLARY SERVICE COST CENTERS | | | | | | |
| 50.00 05000 OPERATI NG ROOM | 0 | 0 | | 0 0 | 0 | 50.00 |
| 52.00 05200 DELIVERY ROOM & LABOR ROOM | 0 | 0 | | 0 0 | 0 | 52.00 |
| 54.00 05400 RADI OLOGY-DI AGNOSTI C | 0 | 0 | | 0 0 | 0 | 54.00 |
| 55. 00 05500 RADI OLOGY-THERAPEUTI C | 0 | 0 | | 0 0 | 0 | 55.00 |
| 60. 00 06000 LABORATORY | 0 | 0 | | 0 0 | 0 | 60.00 |
| 64.00 06400 INTRAVENOUS THERAPY | 0 | 0 | | 0 0 | 0 | 64.00 |
| 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 |
| 67.00 06700 OCCUPATI ONAL THERAPY | 0 | 0 | | 0 0 | 0 | 67.00 |
| 68.00 06800 SPEECH PATHOLOGY | 0 | 0 | | 0 0 | 0 | 68.00 |
| 69.00 06900 ELECTROCARDI OLOGY | 0 | 0 | | 0 0 | 0 | 69.00 |
| 70.00 07000 ELECTROENCEPHALOGRAPHY | 0 | 0 | | 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 STEM CELL ACQUISITION | 0 | 0 | | 0 0 | 0 | 77.00 |
| OUTPATIENT SERVICE COST CENTERS | | | | | | |
| 90. 00 09000 CLINIC | 0 | 0 | | 0 0 | 0 | 90.00 |
| 90.01 09001 WOUND CARE INSTITUTE | 0 | 0 | | 0 0 | 0 | 90. 01 |
| 90. 02 09002 OP NUTRITIONAL COUNSELING | 0 | 0 | | 0 0 | 0 | 90.02 |
| 91.00 09100 EMERGENCY | 0 | 0 | | 0 0 | 0 | 91.00 |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART | 0 | | | 0 | 0 | 92.00 |
| 200.00 Total (lines 50 through 199) | 0 | 0 | | 0 0 | 0 | 200. 00 |
| | | | | | | |

| Health Financial Systems | RANCI SCAN HEALT | TH MOORESVILLE | | In Lie | eu of Form CMS-: | 2552-10 |
|----------------------------------------------------------------------|------------------|----------------|--------------|---------------------------------------------|------------------|---------|
| APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF THROUGH COSTS | RVICE OTHER PASS | 6 Provider C | | Period: From 01/01/2022 To 12/31/2022 | | |
| | | Titl | e XIX | Hospi tal | PPS | |
| Cost Center Description | All Other | Total Cost | Total | Total Charges | | |
| | Medi cal | (sum of cols. | Outpati ent | (from Wkst. C, | to Charges | |
| | Education Cost | 1, 2, 3, and | Cost (sum of | Part I, col. | (col. 5 ÷ col. | |
| | | 4) | col s. 2, 3, | 8) | 7) | |
| | | | and 4) | | (see | |
| | | | | | instructions) | |
| | 4.00 | 5.00 | 6.00 | 7.00 | 8.00 | |
| ANCI LLARY SERVI CE COST CENTERS | | | | | | |
| 50.00 05000 OPERATI NG ROOM | 0 | 0 | | 0 52, 694, 137 | | |
| 52.00 05200 DELIVERY ROOM & LABOR ROOM | 0 | 0 | | 0 5, 689, 284 | | |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C | 0 | 0 | | 0 66, 516, 452 | | |
| 55. 00 05500 RADI OLOGY-THERAPEUTI C | 0 | 0 | | 0 39, 018, 603 | | |
| 60. 00 06000 LABORATORY | 0 | 0 | | 0 40, 288, 271 | | |
| 64.00 06400 INTRAVENOUS THERAPY | 0 | 0 | | 0 12, 524, 228 | 0.000000 | 64.00 |
| 65. 00 06500 RESPI RATORY THERAPY | 0 | 0 | | 0 8, 809, 308 | 0. 000000 | 65.00 |
| 66. 00 06600 PHYSI CAL THERAPY | 0 | 0 | | 0 12, 969, 374 | 0. 000000 | 66.00 |
| 67.00 06700 OCCUPATI ONAL THERAPY | 0 | 0 | | 0 2, 162, 671 | 0. 000000 | 67.00 |
| 68.00 06800 SPEECH PATHOLOGY | 0 | 0 | | 0 311, 856 | 0. 000000 | 68.00 |
| 69. 00 06900 ELECTROCARDI OLOGY | 0 | 0 |) | 0 16, 686, 687 | 0.000000 | 69.00 |
| 70.00 07000 ELECTROENCEPHALOGRAPHY | 0 | 0 |) | 0 1, 963, 054 | 0.000000 | 70.00 |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT | 0 | 0 |) | 0 32, 875, 486 | 0.000000 | 71.00 |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS | 0 | 0 |) | 0 38, 868, 522 | 0.000000 | 72.00 |
| 73.00 07300 DRUGS CHARGED TO PATIENTS | 0 | 0 |) | 0 124, 558, 646 | 0.000000 | 73.00 |
| 74.00 07400 RENAL DIALYSIS | 0 | 0 |) | 0 0 | 0.000000 | 74.00 |
| 77.00 07700 ALLOGENEIC STEM CELL ACQUISITION | 0 | 0 |) | 0 0 | 0.000000 | 77.00 |
| OUTPATIENT SERVICE COST CENTERS | | | | | | |
| 90. 00 09000 CLINIC | 0 | 0 |) | 0 123, 863 | 0.000000 | 90.00 |
| 90.01 09001 WOUND CARE INSTITUTE | 0 | 0 |) | 0 15, 303 | 0.000000 | 90.01 |
| 90. 02 09002 OP NUTRITIONAL COUNSELING | 0 | 0 |) | 0 67, 994 | 0.000000 | 90.02 |
| 91.00 09100 EMERGENCY | 0 | 0 |) | 0 112, 916, 019 | 0. 000000 | 91.00 |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART | 0 | 0 |) | 0 8, 794, 308 | 0. 000000 | 92.00 |
| 200.00 Total (lines 50 through 199) | 0 | 0 | | 0 577, 854, 066 | | 200. 00 |

| Health Financial Systems F | RANCI SCAN HEALTH | H MOORESVILLE | | In Lie | u of Form CMS-: | 2552-10 |
|----------------------------------------------------------------------|-------------------|---------------|---------------|---------------------------------------------|----------------------------------------------------------|---------|
| APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF THROUGH COSTS | RVICE OTHER PASS | Provider CO | | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part IV Date/Time Pre 5/29/2023 3:2 | |
| | | Ti tl | e XIX | Hospi tal | PPS | |
| Cost Center Description | Outpati ent | Inpati ent | Inpati ent | Outpati ent | Outpati ent | |
| | Ratio of Cost | Program | Program | Program | Program | |
| | to Charges | Charges | Pass-Through | | Pass-Through | |
| | (col. 6 ÷ col. | | Costs (col. 8 | 3 | 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 | | | - | | |
| 50.00 05000 OPERATI NG ROOM | 0. 000000 | 200, 911 | | 0 0 | 0 | 50.00 |
| 52.00 05200 DELIVERY ROOM & LABOR ROOM | 0. 000000 | 321, 096 | | 0 0 | 0 | 52.00 |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C | 0. 000000 | 65, 437 | | 0 0 | 0 | 54.00 |
| 55. 00 05500 RADI OLOGY-THERAPEUTI C | 0.000000 | 0 | | 0 0 | 0 | 55.00 |
| 60. 00 06000 LABORATORY | 0.000000 | 190, 568 | | 0 0 | 0 | 60.00 |
| 64.00 06400 I NTRAVENOUS THERAPY | 0.000000 | 9, 641 | | 0 0 | 0 | 64.00 |
| 65. 00 06500 RESPI RATORY THERAPY | 0. 000000 | 62, 515 | | 0 0 | 0 | 65.00 |
| 66. 00 06600 PHYSI CAL THERAPY | 0.000000 | 12, 634 | | 0 0 | 0 | 66.00 |
| 67.00 06700 OCCUPATI ONAL THERAPY | 0. 000000 | 2, 167 | | 0 0 | 0 | 67.00 |
| 68.00 06800 SPEECH PATHOLOGY | 0. 000000 | 13, 735 | | 0 0 | 0 | 68.00 |
| 69. 00 06900 ELECTROCARDI OLOGY | 0. 000000 | 12, 829 | | 0 0 | 0 | 69.00 |
| 70.00 07000 ELECTROENCEPHALOGRAPHY | 0. 000000 | 207 | | 0 0 | 0 | 70.00 |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT | 0. 000000 | 114, 527 | | 0 0 | 0 | 71.00 |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS | 0.000000 | 90, 301 | | 0 0 | 0 | 72.00 |
| 73.00 07300 DRUGS CHARGED TO PATIENTS | 0.000000 | 155, 339 | | 0 0 | 0 | 73.00 |
| 74.00 07400 RENAL DI ALYSI S | 0.000000 | 0 | | 0 0 | 0 | 74.00 |
| 77.00 07700 ALLOGENEIC STEM CELL ACQUISITION | 0.000000 | 0 | | 0 0 | 0 | 77.00 |
| OUTPATIENT SERVICE COST CENTERS | | | • | | | |
| 90. 00 09000 CLI NI C | 0.000000 | 1, 392 | | 0 0 | 0 | 90.00 |
| 90.01 09001 WOUND CARE INSTITUTE | 0.000000 | 21 | | 0 0 | 0 | 90.01 |
| 90. 02 09002 OP NUTRI TI ONAL COUNSELI NG | 0.000000 | 0 | | 0 0 | 0 | 90.02 |
| 91.00 09100 EMERGENCY | 0.000000 | 146, 432 | | 0 0 | 0 | 91.00 |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART | 0. 000000 | 6, 280 | | 0 0 | 0 | 92.00 |
| 200.00 Total (lines 50 through 199) | | 1, 406, 032 | | 0 0 | 0 | 200.00 |
| | | | | | | • |

| Health Financial Systems | FRANCI SCAN HEALTH | H MOORESVILLE | | In Lie | u of Form CMS-: | 2552-10 |
|----------------------------------------------------------------------------|--------------------|---------------|--------------|----------------------------------|-------------------------|---------|
| APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AN | D VACCINE COST | Provider CO | CN: 15-0057 | Peri od: | Worksheet D | |
| | | | | From 01/01/2022 To 12/31/2022 | Part V Date/Time Pre | narad |
| | | | | 10 12/31/2022 | 5/29/2023 3:2 | 8 pm |
| | | Titl | e XIX | Hospi tal | PPS | |
| | | | Charges | | Costs | |
| Cost Center Description | Cost to Charge | PS Reimbursed | Cost | Cost | PPS Services | |
| | Ratio From | Services (see | Reimbursed | Reimbursed | (see inst.) | |
| | Worksheet C, | inst.) | Servi ces | Services Not | | |
| | Part I, col. 9 | | Subject To | Subject To | | |
| | | | Ded. & Coins | | | |
| | | | (see inst.) | (see inst.) | | |
| | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | |
| ANCI LLARY SERVI CE COST CENTERS | 0.007000 | | | | 0 | 50.00 |
| 50.00 O5000 OPERATING ROOM | 0.087228 | 0 | | 0 0 | 0 | |
| 52. 00 05200 DELIVERY ROOM & LABOR ROOM | 0. 512564 | 0 | | 0 0 | 0 | |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C | 0.072979 | 0 | | 0 0 | 0 | |
| 55. 00 05500 RADI OLOGY-THERAPEUTI C | 0. 139147 | 0 | | 0 0 | 0 | |
| | 0. 110956 | 0 | | 0 0 | 0 | |
| 64.00 06400 I NTRAVENOUS THERAPY | 0. 123710 | 0 | | 0 0 | 0 | |
| 65. 00 06500 RESPI RATORY THERAPY | 0. 311722 | 0 | | 0 0 | 0 | |
| 66.00 06600 PHYSI CAL THERAPY | 0. 264848 | 0 | | 0 0 | 0 | |
| 67.00 06700 OCCUPATI ONAL THERAPY | 0. 356983 | 0 | | 0 0 | 0 | |
| 68. 00 06800 SPEECH PATHOLOGY | 0. 188728 | 0 | | 0 0 | 0 | 00.00 |
| 69. 00 06900 ELECTROCARDI OLOGY | 0.041372 | 0 | | 0 0 | 0 | |
| 70. 00 07000 ELECTROENCEPHALOGRAPHY | 0. 165880 | 0 | | 0 0 | 0 | |
| 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT | 0. 116007 | 0 | | 0 0 | 0 | |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS | 0.347304 | 0 | | 0 0 | 0 | |
| 73. 00 07300 DRUGS CHARGED TO PATIENTS | 0. 203613 | 0 | | 0 0 | 0 | |
| 74.00 07400 RENAL DIALYSIS 77.00 07700 ALLOGENEIC STEM CELL ACQUISITION | 0.000000 | 0 | | 0 0 | 0 | |
| OUTPATIENT SERVICE COST CENTERS | 0. 000000 | 0 | | 0 0 | 0 | //.00 |
| 90. 00 09000 CLINIC | 2. 051622 | 0 | | 0 0 | 0 | 90.00 |
| 90. 00 09000 CEINIC 90. 01 09001 WOUND CARE INSTITUTE | 0. 834738 | 0 | | 0 0 | 0 | |
| 90. 02 09002 OP NUTRITIONAL COUNSELING | 1. 179884 | 0 | | 0 0 | 0 | |
| 91. 00 09100 EMERGENCY | 0. 101461 | 0 | | 0 0 | 0 | |
| 91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART | 0. 343223 | 0 | | | 0 | |
| 200.00 Subtotal (see instructions) | 0. 343223 | 0 | | 0 0 | - | 200.00 |
| 201.00 Less PBP Clinic Lab. Services-Program | | 0 | | | 0 | 200.00 |
| Only Charges | | | | 0 | | 201.00 |
| 202.00 Net Charges (line 200 - line 201) | | 0 | | 0 0 | 0 | 202.00 |
| | ! I | 0 | I | S ₁ 0 | 0 | 1202.00 |

| Health Financial Systems | RANCI SCAN HEAL | TH MOORESVILLE | | In Lie | u of Form CMS-2552 | 2-10 |
|-----------------------------------------------------|-----------------|----------------|-------------|---------------------------------------------|-----------------------------------------------------------------|----------|
| APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND | O VACCINE COST | Provider C | CN: 15-0057 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D Part V Date/Time Prepare 5/29/2023 3:28 pm | ed: m |
| | | Ti tl | e XIX | Hospi tal | PPS | |
| | Cos | sts | | | | |
| Cost Center Description | Cost | Cost | | | | |
| | Reimbursed | Reimbursed | | | | |
| | Servi ces | Services Not | | | | |
| | Subject To | Subject To | | | | |
| | | Ded. & Coins. | | | | |
| | (see inst.) | (see inst.) | _ | | | |
| | 6.00 | 7.00 | | | | |
| ANCI LLARY SERVI CE COST CENTERS | | | | | | |
| 50. 00 05000 OPERATI NG ROOM | 0 | C | | | | 0. 00 |
| 52.00 05200 DELIVERY ROOM & LABOR ROOM | 0 | 0 | | | | 2.00 |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C | 0 | 0 | | | | 4.00 |
| 55. 00 05500 RADI OLOGY-THERAPEUTI C | 0 | 0 | | | | 5.00 |
| 60. 00 06000 LABORATORY | 0 | 0 | | | | 0. 00 |
| 64.00 06400 INTRAVENOUS THERAPY | 0 | 0 | | | | 1.00 |
| 65. 00 06500 RESPI RATORY THERAPY | 0 | 0 | | | 65. | 5.00 |
| 66. 00 06600 PHYSI CAL THERAPY | 0 | 0 | | | 66. | 5.00 |
| 67.00 06700 OCCUPATI ONAL THERAPY | 0 | 0 | | | 67. | 7.00 |
| 68.00 06800 SPEECH PATHOLOGY | 0 | 0 | | | 68. | 3.00 |
| 69. 00 06900 ELECTROCARDI OLOGY | 0 | 0 | | | 69. | 9.00 |
| 70.00 07000 ELECTROENCEPHALOGRAPHY | 0 | 0 | | | 70. | 0. 00 |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT | 0 | 0 | | | 71. | I. 00 |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS | 0 | 0 | | | 72. | 2.00 |
| 73.00 07300 DRUGS CHARGED TO PATIENTS | 0 | 0 | | | 73. | 3.00 |
| 74.00 07400 RENAL DIALYSIS | 0 | 0 | | | 74. | 1.00 |
| 77.00 07700 ALLOGENEIC STEM CELL ACQUISITION | 0 | 0 | | | 77. | 7.00 |
| OUTPATIENT SERVICE COST CENTERS | | | | | | |
| 90. 00 09000 CLINIC | 0 | 0 |) | | 90. | 0. 00 |
| 90.01 09001 WOUND CARE INSTITUTE | 0 | 0 | | | 90. | 0. 01 |
| 90.02 09002 OP NUTRITIONAL COUNSELING | 0 | 0 | | | 90. | 0. 02 |
| 91.00 09100 EMERGENCY | 0 | 0 | | | 91. | I. 00 |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART | 0 | 0 | | | | 2.00 |
| 200.00 Subtotal (see instructions) | 0 | 0 | | | | 0. 00 |
| 201.00 Less PBP Clinic Lab. Services-Program | 0 | | | | 201. | . 00 |
| Only Charges | | | | | | |
| 202.00 Net Charges (line 200 - line 201) | 0 | 0 | | | 202. | 2.00 |
| | 1 | | | | 1 - | |

| Heal th | Fi nan | ci al | Systems | | |
|---------|--------|-------|-------------|-------------------|-----|
| COMPUT | ATI ON | 0F | I NPATI ENT | OPERATI NG | COS |

| FRANCI SCAN | HEALTH | MOORESVI LLE | |
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In Lieu of Form CMS-2552-10

| 00 Private room days (excluding swing-bed and observation bed days). If you have only private room days, do of control on the second days (excluding swing-bed and observation bed days) through December 31 of the cost reporting period. The period international days (including private room days) after December 31 of the cost reporting period. The lenderar year, onter 0 on this line) 5.969 4.00 0.00 Total swing-bed SF type inpattent days (including private room days) after December 31 of the cost reporting period. (The calendar year, onter 0 on this line) 0.00 0.00 0.01 Total swing-bed SF type inpattent days (including private room days) after December 31 of the cost reporting period. (The calendar year, including private room days) after December 31 of the cost reporting period. (The calendar year, enter 0 on this line) 0.00 0.01 Swing-bed SF type inpattent days applicable to the Tite XVII only (including private room days) through December 31 of the cost reporting period (the alendar year, enter 0 on this line) 0.00 0.01 Swing-bed SF type inpattent days applicable to the SV XX and y (including private room days) 0.10 1.00 Swing-bed SF type inpattent days applicable to the Program (excluding swing-bed days) 0.10 1.00 Swing-bed SF type inpattent days applicable to the Program (excluding swing-bed days) 0.10 1.00 Swing-bed SF type inpattent days applicable to the Program (excluding swing-bed days) 0.10 1.00 Swing-bed SF type inpattent day | Heal th | Financial Systems FRANCI SCAN HEALTH | MOORESVILLE | In Lie | u of Form CMS-2 | 2552-10 |
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| 28.00General inpatient routine service charges (excluding swing-bed and observation bed charges)028.0029.00Private room charges (excluding swing-bed charges)029.0030.00Semi-private room charges (excluding swing-bed charges)030.0031.00General inpatient routine service cost/charge ratio (line 27 + line 28)0.00000031.0032.00Average private room per diem charge (line 29 + line 3)0.0032.0033.00Average semi-private room per diem charge (line 30 + line 4)0.0033.0034.00Average per diem private room charge differential (line 34 x line 31)0.0034.0035.00Average per diem private room cost differential (line 3 x line 35)00.0035.0037.00General inpatient routine service cost net of swing-bed cost and private room cost differential (line 13, 214, 27437.0027 minus line 36)PART 11 - HOSPITAL AND SUBPROVIDERS ONLY1, 702.4338.0038.00Adj usted general inpatient routine service cost (line 9 x line 38)3, 381, 02639.0039.00Program general inpatient routine service cost (line 9 x line 38)3, 381, 02639.0040.00Medically necessary private room cost applicable to the Program (line 14 x line 35)040.00 | 27.00 | | (line 21 minus line 26) | | 13, 214, 274 | 27.00 |
| 29.00Private room charges (excluding swing-bed charges)029.0030.00Semi-private room charges (excluding swing-bed charges)030.0031.00General inpatient routine service cost/charge ratio (line 27 + line 28)0.00000031.0032.00Average private room per diem charge (line 30 + line 3)0.0032.0033.00Average per diem private room cost gifferential (line 32 minus line 33) (see instructions)0.0032.0034.00Average per diem private room cost differential (line 34 x line 31)0.0035.0035.00Average per diem private room cost differential (line 3 x line 35)0.0035.0037.00General inpatient routine service cost net of swing-bed cost and private room cost differential (line 13, 214, 27437.0027 minus line 36)PART 11 - HOSPITAL AND SUBPROVIDERS ONLY1, 702.4338.0038.00Adj usted general inpatient routine service cost per diem (see instructions)1, 702.4338.0039.00Program general inpatient routine service cost (line 9 x line 38)3, 381,02639.0040.00Medically necessary private room cost applicable to the Program (line 14 x line 35)040.00 | ~~ ~~ | | | | | |
| 30.00 Semi-private room charges (excluding swing-bed charges) 0 30.00 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 0.000000 31.00 32.00 Average private room per diem charge (line 29 ÷ line 3) 0.00 32.00 33.00 Average private room per diem charge (line 30 ÷ line 4) 0.00 32.00 34.00 Average per diem private room cost differential (line 32 minus line 33) (see instructions) 0.00 34.00 35.00 Average per diem private room cost differential (line 3 x line 31) 0.00 34.00 35.00 Average per diem private room cost differential (line 3 x line 35) 0.00 35.00 36.00 Private room cost differential adjustment (line 3 x line 35) 0 36.00 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 13, 214, 274 37.00 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY 1.702.43 38.00 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1,702.43 38.00 39.00 Program general inpatient routine service cost (line 9 x line 38) 3,381,026 39.00 40.00 Medically neces | | | d and observation bed cr | narges) | | |
| 31.00General inpatient routine service cost/charge ratio (line 27 + line 28)0.00000031.0032.00Average private room per diem charge (line 29 + line 3)0.0032.0033.00Average semi-private room per diem charge (line 30 + line 4)0.0033.0034.00Average per diem private room charge differential (line 32 minus line 33) (see instructions)0.0034.0035.00Average per diem private room cost differential (line 34 x line 31)0.0035.0036.00Private room cost differential adjustment (line 3 x line 35)0036.0037.00General inpatient routine service cost net of swing-bed cost and private room cost differential (line 13, 214, 27437.0027 minus line 36)PART II - HOSPITAL AND SUBPROVIDERS ONLY13, 214, 27437.00PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS1, 702.4338.0039.00Program general inpatient routine service cost (line 9 x line 38)3, 381, 02639.0040.00Medically necessary private room cost applicable to the Program (line 14 x line 35)040.00 | | | | | | |
| 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 0.00 33.00 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 0.00 34.00 35.00 Average per diem private room cost differential (line 34 x line 31) 0.00 35.00 36.00 Private room cost differential adjustment (line 3 x line 35) 0 0.00 36.00 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3.2 | 31.00 | | ÷line 28) | | - | |
| 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 0.00 34.00 35.00 Average per diem private room cost differential (line 34 x line 31) 0.00 35.00 36.00 Private room cost differential adjustment (line 3 x line 35) 0.00 36.00 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 32 minus line 36) 13, 214, 274 37.00 9 PART 11 HOSPITAL AND SUBPROVIDERS ONLY 13, 214, 274 37.00 9 PART 11 HOSPITAL AND SUBPROVIDERS ONLY 14, 702, 43 38.00 83.00 Adjusted general inpatient routine service cost per diem (see instructions) 1, 702, 43 38.00 39.00 Program general inpatient routine service cost (line 9 x line 38) 3, 381, 026 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00 | 32.00 | Average private room per diem charge (line 29 ÷ line 3) | | | 0.00 | 32.00 |
| 35.00 Average per diem private room cost differential (line 34 x line 31) 0.00 35.00 36.00 Private room cost differential adjustment (line 3 x line 35) 0 36.00 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 13, 214, 274 27 minus line 36) 13, 214, 274 37.00 PART 11 HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1, 702.43 38.00 39.00 Program general inpatient routine service cost (line 9 x line 38) 3, 381, 026 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00 | 33.00 | | | | | |
| 36.00 Private room cost differential adjustment (line 3 x line 35) 0 36.00 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36) 0 13, 214, 274 37.00 PART 11 - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 0 1,702.43 38.00 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1,702.43 38.00 3,381,026 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00 | | | | ctions) | | |
| 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 13, 214, 274 27 minus line 36) 37.00 PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1,702.43 38.00 39.00 Program general inpatient routine service cost (line 9 x line 38) 3,381,026 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00 | | | ne 31) | | | |
| 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1,702.43 38.00 39.00 Program general inpatient routine service cost (line 9 x line 38) 3,381,026 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00 | 37.00 | | and private room cost di | fferential (line | - | 37.00 |
| PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1,702.43 38.00 39.00 Program general inpatient routine service cost (line 9 x line 38) 3,381,026 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00 | | | | | | |
| 38.00Adjusted general inpatient routine service cost per diem (see instructions)1,702.4338.0039.00Program general inpatient routine service cost (line 9 x line 38)3,381,02639.0040.00Medically necessary private room cost applicable to the Program (line 14 x line 35)040.00 | | PART II - HOSPITAL AND SUBPROVIDERS ONLY | | | | |
| 39.00Program general inpatient routine service cost (line 9 x line 38)3, 381, 02639.0040.00Medically necessary private room cost applicable to the Program (line 14 x line 35)040.00 | | | | | 4 700 :- | 00.07 |
| 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00 | | | | | | |
| | | | - | | | • |
| | | , , , , , , , , , , , , , , , , , , , | . , | | | |

| | Financial Systems FRANCISCAN HEALTH MOORESVILLE In Lie ATION OF INPATIENT OPERATING COST Provider CCN: 15-0057 Period: | u of Form CMS-2 Worksheet D-1 | |
|------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|----------------|
| _ | From 01/01/2022 To 12/31/2022 | Date/Time Pre 5/29/2023 3:2 | |
| | Title XVIII Hospital Cost Center Description Total Average Per Program Days | PPS Program Cost | |
| | | (col. 3 x col. | |
| | | <u>4)</u> 5. 00 | |
| 42.00 | 1.00 2.00 3.00 4.00 NURSERY (title V & XIX only) 0 0 0 0 | | 42.00 |
| 121 00 | Intensive Care Type Inpatient Hospital Units | | 12100 |
| 43.00 | INTENSIVE CARE UNIT | | 43.00 |
| 44.00 45.00 | CORONARY CARE UNIT BURN INTENSIVE CARE UNIT | | 44.00 45.00 |
| | SURGI CAL I NTENSI VE CARE UNI T 4, 797, 348 1, 478 3, 245. 84 492 | 1, 596, 953 | |
| 47.00 | OTHER SPECIAL CARE (SPECIFY) | | 47.00 |
| | Cost Center Description | 1.00 | |
| 48.00 | Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200) | 6, 199, 327 | 48.00 |
| 48.01 | Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1) | 0 | |
| 49.00 | Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions) | 11, 177, 306 | 49.00 |
| 50.00 | PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and | 462, 025 | 50.00 |
| 50.00 | | 402, 023 | 50.00 |
| 51.00 | Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV) | 240, 538 | 51.00 |
| 52.00 | Total Program excludable cost (sum of lines 50 and 51) | 702, 563 | 52.00 |
| 53.00 | Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and | 10, 474, 743 | 53.00 |
| | medical education costs (line 49 minus line 52) TARGET AMOUNT AND LIMIT COMPUTATION | | |
| 54.00 | Program di scharges | 0 | 54.00 |
| 55.00 | Target amount per discharge | 0.00 | |
| 55.01 | Permanent adjustment amount per di scharge | 0.00 | |
| 55. 02 56. 00 | Adjustment amount per discharge (contractor use only) Target amount (line 54 x sum of lines 55, 55.01, and 55.02) | 0.00 | |
| 57.00 | Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) | 0 | 1 |
| 58.00 | Bonus payment (see instructions) | 0 | |
| 59.00 | Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket) | 0.00 | 59.00 |
| 60.00 | Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the | 0.00 | 60.00 |
| 61.00 | market basket) Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line | 0 | 61.00 |
| | 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions) | | |
| 62.00 | Relief payment (see instructions) | 0 | 62.00 |
| 63.00 | Allowable Inpatient cost plus incentive payment (see instructions) | 0 | 63.00 |
| 64.00 | PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See | 0 | 64.00 |
| 65.00 | instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See | 0 | 65.00 |
| | instructions)(title XVIII only) | 0 | |
| 66.00 | Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions | 0 | 66.00 |
| 67.00 | Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19) | 0 | 67.00 |
| 68.00 | Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20) | 0 | 68.00 |
| | Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY | 0 | |
| 70.00 71.00 | Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2) | | 70.00 71.00 |
| 72.00 | Program routine service cost (line 9 x line 71) | | 72.00 |
| 73.00 | Medically necessary private room cost applicable to Program (line 14 x line 35) | | 73.00 |
| 74.00 | Total Program general inpatient routine service costs (line 72 + line 73) | | 74.00 75.00 |
| 75.00 | Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) | | / 3. 00 |
| 76.00 | Per diem capital-related costs (line 75 ÷ line 2) | | 76.00 |
| 77.00 | Program capital-related costs (line 9 x line 76) | | 77.00 |
| 78.00 79.00 | Inpatient routine service cost (line 74 minus line 77) Aggregate charges to beneficiaries for excess costs (from provider records) | | 78.00 79.00 |
| 80.00 | Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) | | 80.00 |
| 81.00 | Inpatient routine service cost per diem limitation | | 81.00 |
| 82.00 83.00 | Inpatient routine service cost limitation (line 9 x line 81) Reasonable inpatient routine service costs (see instructions) | | 82.00 83.00 |
| 83.00 84.00 | Program inpatient ancillary services (see instructions) | | 83.00 |
| 85.00 | Utilization review - physician compensation (see instructions) | | 85.00 |
| 86.00 | Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST | | 86.00 |
| 87.00 | Total observation bed days (see instructions) | 1, 773 | 87.00 |
| 88.00 | Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) | 1, 702. 43 | 88.00 |
| 89.00 | Observation bed cost (line 87 x line 88) (see instructions) | 3, 018, 408 | 89.00 |

| Health Financial Systems F | RANCI SCAN HEAL | TH MOORESVILLE | | In Lie | u of Form CMS-2 | 2552-10 |
|---------------------------------------------|-----------------|----------------|------------|----------------------------------|--------------------------------|---------|
| COMPUTATION OF INPATIENT OPERATING COST | | Provider CO | | Period: | Worksheet D-1 | |
| | | | | From 01/01/2022 To 12/31/2022 | Date/Time Pre 5/29/2023 3:2 | |
| | | Title | XVIII | Hospi tal | PPS | |
| Cost Center Description | Cost | Routine Cost | column 1 ÷ | Total | Observati on | |
| | | (from line 21) | column 2 | Observati on | Bed Pass | |
| | | | | Bed Cost (from | Through Cost | |
| | | | | line 89) | (col. 3 x col. | |
| | | | | | 4) (see | |
| | | | | | instructions) | |
| | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | |
| COMPUTATION OF OBSERVATION BED PASS THROUGH | COST | | | | | |
| 90.00 Capital-related cost | 1, 393, 067 | 13, 214, 274 | 0. 10542 | 1 3, 018, 408 | 318, 204 | 90.00 |
| 91.00 Nursing Program cost | 0 | 13, 214, 274 | 0.00000 | 3, 018, 408 | 0 | 91.00 |
| 92.00 Allied health cost | 0 | 13, 214, 274 | 0.00000 | 3, 018, 408 | 0 | 92.00 |
| 93.00 All other Medical Education | 0 | 13, 214, 274 | 0.00000 | 3, 018, 408 | 0 | 93.00 |

Health Financial Systems

| FRANCI SCAN | HEALTH | MOORESVI LLE | |
|-------------|--------|--------------|--|
| | | | |

In Lieu of Form CMS-2552-10

| eal th | Financial Systems FRANCI SCAN HEALTH | MOORESVILLE | In Lie | u of Form CMS-2 | 2552- |
|--------|--------------------------------------------------------------------------------------------------------------------------------|----------------------------|---------------------------------------------|--------------------------------|-------|
| OMPUT | ATION OF INPATIENT OPERATING COST | Provider CCN: 15-0057 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-1 Date/Time Pre | pare |
| | | Title XIX | Hospi tal | 5/29/2023 3: 2 PPS | 8 pm |
| | Cost Center Description | | поѕріта | PP3 | |
| | | | | 1.00 | |
| | PART I - ALL PROVIDER COMPONENTS | | | | |
| | INPATIENT DAYS | | | | |
| | Inpatient days (including private room days and swing-bed day | | | 7, 762 | |
| | Inpatient days (including private room days, excluding swing- | | divete reem deve | 7, 762 | |
| 00 | Private room days (excluding swing-bed and observation bed da do not complete this line. | ays). If you have only p | rivate room days, | 0 | 3. |
| 00 | Semi-private room days (excluding swing-bed and observation b | ped days) | | 5, 989 | 4. |
| 00 | Total swing-bed SNF type inpatient days (including private ro | | er 31 of the cost | 0, 707 | |
| | reporting period | 3, 3 | | | |
| 00 | Total swing-bed SNF type inpatient days (including private ro | oom days) after December | 31 of the cost | 0 | 6 |
| | reporting period (if calendar year, enter 0 on this line) | | | | |
| 00 | Total swing-bed NF type inpatient days (including private roo | om days) through Decembe | r 31 of the cost | 0 | 7 |
| 00 | reporting period Total swing-bed NF type inpatient days (including private roo | m dave) after December | 21 of the cost | 0 | 8 |
| 00 | reporting period (if calendar year, enter 0 on this line) | on days) at let becenber | ST OF THE COST | 0 | 0 |
| 00 | Total inpatient days including private room days applicable t | to the Program (excluding | a swing-bed and | 34 | 9 |
| | newborn days) (see instructions) | | 9 | | |
| 0. 00 | Swing-bed SNF type inpatient days applicable to title XVIII o | | room days) | 0 | 10 |
| | through December 31 of the cost reporting period (see instruc | | | | |
| . 00 | Swing-bed SNF type inpatient days applicable to title XVIII o | | room days) after | 0 | 11 |
| . 00 | December 31 of the cost reporting period (if calendar year, e Swing-bed NF type inpatient days applicable to titles V or XI | | to room days) | 0 | 12 |
| . 00 | through December 31 of the cost reporting period | x only (including priva | te room uays) | 0 | '2 |
| 3. 00 | Swing-bed NF type inpatient days applicable to titles V or XI | X only (including priva | te room davs) | 0 | 13 |
| | after December 31 of the cost reporting period (if calendar y | | | - | |
| | Medically necessary private room days applicable to the Progr | am (excluding swing-bed | days) | 0 | |
| | Total nursery days (title V or XIX only) | | | 584 | |
| | Nursery days (title V or XIX only) | | | 1 | 16 |
| | SWING BED ADJUSTMENT | and through December 21 | of the east | 0.00 | 1 1 7 |
| . 00 | Medicare rate for swing-bed SNF services applicable to servic reporting period | ces through becember 31 o | of the cost | 0.00 | 17 |
| 3. 00 | Medicare rate for swing-bed SNF services applicable to servic | es after December 31 of | the cost | 0.00 | 18 |
| | reporting period | | | | |
| 9.00 | Medicaid rate for swing-bed NF services applicable to service | es through December 31 o | f the cost | 0.00 | 19 |
| | reporting period | | | | |
| 0.00 | Medicaid rate for swing-bed NF services applicable to service | es after December 31 of | the cost | 0.00 | 20 |
| 1.00 | reporting period Total general inpatient routine service cost (see instruction | | | 13, 214, 274 | 21 |
| | Swing-bed cost applicable to SNF type services through Decemb | | ting period (line | 13, 214, 274 | |
| . 00 | 5 x line 17) | Ser St of the cost repor | ting period (inte | 0 | 22 |
| 3.00 | Swing-bed cost applicable to SNF type services after December | - 31 of the cost reportion | ng period (line 6 | 0 | 23 |
| | x line 18) | | | | |
| 4.00 | Swing-bed cost applicable to NF type services through Decembe | er 31 of the cost report | ng period (line | 0 | 24 |
| | 7 x line 19) | | | 0 | 0 |
| 5.00 | Swing-bed cost applicable to NF type services after December | 31 of the cost reporting | g period (line 8 | 0 | 25 |
| 6. 00 | x line 20) Total swing-bed cost (see instructions) | | | 0 | 26 |
| | General inpatient routine service cost net of swing-bed cost | (line 21 minus line 26) | | 13, 214, 274 | |
| | PRIVATE ROOM DIFFERENTIAL ADJUSTMENT | / | | | |
| 3. 00 | General inpatient routine service charges (excluding swing-be | ed and observation bed c | narges) | 0 | 28 |
| | Private room charges (excluding swing-bed charges) | | | 0 | |
| | Semi-private room charges (excluding swing-bed charges) | | | 0 | |
| | General inpatient routine service cost/charge ratio (line 27 | ÷ IINE 28) | | 0.000000 | |
| | Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4) | | | 0.00 0.00 | |
| | Average per diem private room charge differential (line 32 mi | nus line 33)(see instru | ctions) | 0.00 | |
| | Average per diem private room cost differential (line 34 x li | | , | 0.00 | |
| | Private room cost differential adjustment (line 3 x line 35) | ~ | | 0 | |
| | General inpatient routine service cost net of swing-bed cost | and private room cost d | fferential (line | 13, 214, 274 | 37 |
| | 27 minus line 36) | | | | 1 |
| + | PART II - HOSPITAL AND SUBPROVIDERS ONLY | | | | |
| | PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ | | | 1 700 /2 | 1 |
| | Adjusted general inpatient routine service cost per diem (see | | | 1,702.43 | |
| | Program general inpatient routine service cost (line 9 x line | - | | 57, 883 | |
| | Medically necessary private room cost applicable to the Progr | ram (line 14 x line 35) | | 0 | 40 |

| | Financial Systems FRANC | ISCAN HEAL | TH MOORESVILLE | CN: 15-0057 F | In Lie Period: | eu of Form CMS- Worksheet D-1 | |
|------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|-----------------|----------------------|--------------------------------|----------------------------------|----------------|
| | | | | | rom 01/01/2022 o 12/31/2022 | | |
| | Cost Center Description | Total | Ti tl Total | e XIX Average Per | Hospital Program Days | PPS Program Cost | |
| | | | Inpatient Days | Diem (col. 1 - | | (col. 3 x col. | |
| | | 1.00 | 2.00 | col. 2) 3.00 | 4.00 | 4) 5.00 | |
| 42.00 | NURSERY (title V & XIX only) | 861, 424 | | | | | 42.00 |
| 10.00 | Intensive Care Type Inpatient Hospital Units | | | | | | 40.00 |
| 43.00 44.00 | INTENSIVE CARE UNIT CORONARY CARE UNIT | | | | | | 43.00 44.00 |
| 45.00 | BURN INTENSIVE CARE UNIT | | | | | | 45.00 |
| | SURGI CAL I NTENSI VE CARE UNI T | 4, 797, 348 | 1, 478 | 3, 245. 84 | ۱ O | 0 | |
| 47.00 | OTHER SPECIAL CARE (SPECIFY) Cost Center Description | | | | | | 47.00 |
| | · · · · · · · · · · · · · · · · · · · | | | | | 1.00 | |
| 48.00 | Program inpatient ancillary service cost (Wkst. | | | | | 332, 148 | • |
| 48. 01 49. 00 | Program inpatient cellular therapy acquisition c Total Program inpatient costs (sum of lines 41 t | | | | column I) | 0 391, 506 | |
| 17100 | PASS THROUGH COST ADJUSTMENTS | in ough for e | | | | | |
| 50.00 | Pass through costs applicable to Program inpatie | nt routine | services (from | Wkst. D, sum | of Parts I and | 6, 119 | 50.00 |
| 51.00 |) Pass through costs applicable to Program inpatie | nt ancillar | y services (fr | om Wkst. D, su | m of Parts II | 7, 851 | 51.00 |
| | and IV) | | 5 | | | | |
| 52.00 53.00 | Total Program excludable cost (sum of lines 50 a Total Program inpatient operating cost excluding | | lated non nhy | cician anactha | tict and | 13, 970 377, 536 | • |
| 55.00 | medical education costs (line 49 minus line 52) | Capital It | erateu, non-pny | SI CI all'alles the | erist, anu | 377, 550 | 55.00 |
| | TARGET AMOUNT AND LIMIT COMPUTATION | | | | | - | |
| 54.00 55.00 | Program discharges Target amount per discharge | | | | | 0.00 | |
| 55. 00 55. 01 | Permanent adjustment amount per discharge | | | | | 0.00 | • |
| | Adjustment amount per discharge (contractor use | | | | | 0.00 | • |
| 56.00 57.00 | Target amount (line 54 x sum of lines 55, 55.01, Difference between adjusted inpatient operating | | | ing 56 minus l | ine 53) | 0 | |
| 58.00 | Bonus payment (see instructions) | | inger amount (i | The 50 minus i | The 33) | 0 | • |
| 59.00 | Trended costs (lesser of line 53 ÷ line 54, or l | ine 55 from | n the cost repo | rting period e | endi ng 1996, | 0.00 | 59.00 |
| 60.00 | updated and compounded by the market basket) Expected costs (lesser of line 53 ÷ line 54, or | line 55 fro | om prior vear c | ost report ur | dated by the | 0.00 | 60.00 |
| 00100 | market basket) | | jiii jour o | | dated by the | | |
| 61.00 | Continuous improvement bonus payment (if line 53 55.01, or line 59, or line 60, enter the lesser 53) are less than expected costs (lines 54 \times 60) | of 50% of t | the amount by w | hich operating | costs (line | 0 | 61.00 |
| 62.00 | enter zero. (see instructions) Relief payment (see instructions) | | | | | 0 | 62.00 |
| 63.00 | Allowable Inpatient cost plus incentive payment | (see instru | uctions) | | | 0 | |
| <u> </u> | PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine costs t | brough Door | mbor 21 of the | cost roportir | a pariod (Saa | 0 | 64.00 |
| 64.00 | instructions) (title XVIII only) | ni ougri Dece | | cost reportin | ig period (see | | 04.00 |
| 65.00 | Medicare swing-bed SNF inpatient routine costs a | fter Decemb | per 31 of the c | ost reporting | period (See | 0 | 65.00 |
| 66.00 | instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routine c | osts (line | 64 nlus line 6 | 5)(title XVIII | only) for | 0 | 66.00 |
| 00100 | CAH, see instructions | | | | • | | |
| 67.00 | Title V or XIX swing-bed NF inpatient routine co | sts through | n December 31 o | f the cost rep | orting period | 0 | 67.00 |
| 68.00 | (line 12 x line 19) Title V or XIX swing-bed NF inpatient routine co | sts after [| December 31 of | the cost repor | ting period | 0 | 68.00 |
| (0.00 | (line 13 x line 20) | | | | | _ | (0.00 |
| 69.00 | Total title V or XIX swing-bed NF inpatient rout PART III - SKILLED NURSING FACILITY, OTHER NURSI | | • | , | | 0 | 69.00 |
| 70.00 | Skilled nursing facility/other nursing facility/ | ICF/IID rou | utine service c | ost (line 37) | | | 70.00 |
| 71.00 72.00 | Adjusted general inpatient routine service cost | per diem (I | ine 70 ÷ line | 2) | | | 71.00 |
| 72.00 73.00 | Program routine service cost (line 9 x line 71) Medically necessary private room cost applicable | to Program | n (line 14 x li | ne 35) | | | 72.00 73.00 |
| 74.00 | Total Program general inpatient routine service | 0 | • | | | | 74.00 |
| 75.00 | Capital-related cost allocated to inpatient rout 26, line 45) | ine service | e costs (from W | orksheet B, Pa | rt II, column | | 75.00 |
| 76.00 | Per diem capital-related costs (line 75 ÷ line 2 |) | | | | | 76.00 |
| 77.00 | Program capital-related costs (line 9 x line 76) | | | | | | 77.00 |
| 78.00 79.00 | Inpatient routine service cost (line 74 minus li Aggregate charges to beneficiaries for excess co | | rovider record | s) | | | 78.00 79.00 |
| 80.00 | Total Program routine service costs for comparis | • • | | · · · | ıs line 79) | | 80.00 |
| 81.00 | Inpatient routine service cost per diem limitati | | | | | | 81.00 |
| 82.00 83.00 | Inpatient routine service cost limitation (line Reasonable inpatient routine service costs (see | | | | | | 82.00 83.00 |
| 84.00 | Program inpatient ancillary services (see instru | | 137 | | | | 84.00 |
| 85.00 | Utilization review - physician compensation (see | instructio | | | | | 85.00 |
| 86.00 | Total Program inpatient operating costs (sum of PART IV - COMPUTATION OF OBSERVATION BED PASS TH | | nrough 85) | | | I | 86.00 |
| 87.00 | Total observation bed days (see instructions) | | | | | 1, 773 | 87.00 |
| 88.00 | Adjusted general inpatient routine cost per diem | | , | | | 1, 702. 43 | • |
| 07.00 | Observation bed cost (line 87 x line 88) (see in | structrons) | 1 | | | 3, 018, 408 | 09.00 |

| Health Financial Systems F | RANCI SCAN HEAL | TH MOORESVILLE | | In Lie | u of Form CMS-2 | 2552-10 |
|---------------------------------------------|-----------------|----------------|------------|----------------------------------|-----------------|---------|
| COMPUTATION OF INPATIENT OPERATING COST | | Provider CO | | Period: | Worksheet D-1 | |
| | | | | From 01/01/2022 To 12/31/2022 | | |
| | | Titl | e XIX | Hospi tal | PPS | |
| Cost Center Description | Cost | Routine Cost | column 1 ÷ | Total | Observati on | |
| | | (from line 21) | column 2 | Observati on | Bed Pass | |
| | | | | Bed Cost (from | Through Cost | |
| | | | | line 89) | (col. 3 x col. | |
| | | | | | 4) (see | |
| | | | | | instructions) | |
| | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | |
| COMPUTATION OF OBSERVATION BED PASS THROUGH | COST | | | | | |
| 90.00 Capital-related cost | 1, 393, 067 | 13, 214, 274 | 0. 10542 | 1 3, 018, 408 | 318, 204 | 90.00 |
| 91.00 Nursing Program cost | 0 | 13, 214, 274 | 0.00000 | 3, 018, 408 | 0 | 91.00 |
| 92.00 Allied health cost | 0 | 13, 214, 274 | 0.00000 | 3, 018, 408 | 0 | 92.00 |
| 93.00 All other Medical Education | 0 | 13, 214, 274 | 0.00000 | 3, 018, 408 | 0 | 93.00 |

| INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | MOORESVI LLE | | In Lie | u of Form CMS- | 2552-10 |
|-------------------------------------------------------------------------------------------------------|--------------|----------------------------|---------------------------------------------|----------------------------------------------------|-------------------------|
| INFATIENT ANGLEEART SERVICE COST AFFORTIONWENT | Provider C | | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-3 Date/Time Pre 5/29/2023 3:2 | pared: |
| | Title | XVIII | Hospi tal | PPS | |
| Cost Center Description | | Ratio of Cos To Charges | Program Charges | Inpatient Program Costs (col. 1 x col. 2) | |
| | | 1.00 | 2.00 | 3.00 | |
| INPATIENT ROUTINE SERVICE COST CENTERS | | | | | |
| 30. 00 03000 ADULTS & PEDIATRICS 34. 00 03400 SURGICAL INTENSIVE CARE UNIT 43. 00 04300 NURSERY | | | 5, 293, 778 1, 820, 470 | | 30.00 34.00 43.00 |
| ANCI LLARY SERVI CE COST CENTERS | | | L | | 1 |
| 50.00 05000 0PERATING ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM | | 0. 08722 0. 51256 | | | |
| | | 0. 07297 | | | |
| | | 0. 13914 | | | |
| 55. 00 05500 RADI OLOGY-THERAPEUTI C 60. 00 06000 LABORATORY | | 0. 13912 | | 19, 219 363, 949 | |
| 64. 00 06400 INTRAVENOUS THERAPY | | 0. 11090 | | 303, 949 | |
| 65. 00 06500 RESPIRATORY THERAPY | | 0. 31172 | | 381, 025 | |
| 66. 00 06600 PHYSI CAL THERAPY | | 0. 31172 | | 253, 790 | |
| 67. 00 06700 OCCUPATI ONAL THERAPY | | 0. 35698 | | 33, 117 | |
| 68. 00 06800 SPEECH PATHOLOGY | | 0. 18872 | | | |
| 69. 00 06900 ELECTROCARDI OLOGY | | 0. 04137 | | 23, 780 | |
| 70. 00 07000 ELECTROENCEPHALOGRAPHY | | 0. 16588 | | 6, 348 | |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT | | 0. 11600 | | 519, 854 | |
| 72.00 07200 I MPL. DEV. CHARGED TO PATIENTS | | 0. 34730 | | | |
| 73.00 07300 DRUGS CHARGED TO PATIENTS | | 0. 20361 | | 594, 161 | |
| 74.00 07400 RENAL DI ALYSI S | | 0.00000 | | 0 | |
| 77.00 07700 ALLOGENEIC STEM CELL ACQUI SI TI ON | | 0.00000 | | 0 | |
| OUTPATIENT SERVICE COST CENTERS | | | - - | | |
| 90. 00 09000 CLINIC | | 2.05162 | 22 0 | 0 | 90.00 |
| 90.01 09001 WOUND CARE INSTITUTE | | 0.83473 | | 0 | 90.01 |
| 90. 02 09002 OP NUTRI TI ONAL COUNSELI NG | | 1. 17988 | | 0 | |
| 91.00 09100 EMERGENCY | | 0. 10146 | | 459, 968 | |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART | | 0. 34322 | | | |
| 200.00 Total (sum of lines 50 through 94 and 96 through 98) | | | 35, 817, 383 | 6, 199, 327 | |
| 201.00 Less PBP Clinic Laboratory Services-Program only charges | (line 61) | | 0 | | 201.00 |
| 202.00 Net charges (line 200 minus line 201) | | | 35, 817, 383 | | 202.00 |

| Health Financial Systems FRANCISCAN HEALTH M | 100RESVI LLE | | In Lie | eu of Form CMS- | 2552-10 |
|-----------------------------------------------------------------|--------------|--------------|---------------------------------------------|-------------------------------------------------|---------|
| INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CC | CN: 15-0057 | Period: From 01/01/2022 To 12/31/2022 | Worksheet D-3 Date/Time Pre 5/29/2023 3:2 | epared: |
| | Ti tl | e XIX | Hospi tal | PPS | |
| Cost Center Description | | Ratio of Cos | | Inpatient | |
| | | 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 | | | 188, 819 | | 30.00 |
| 34. 00 03400 SURGI CAL I NTENSI VE CARE UNI T | | | 108, 366 | | 34.00 |
| 43. 00 04300 NURSERY | | | 123, 029 | | 43.00 |
| ANCI LLARY SERVI CE COST CENTERS | | | - i | | |
| 50.00 05000 OPERATING ROOM | | 0. 0872 | | | |
| 52.00 05200 DELIVERY ROOM & LABOR ROOM | | 0. 5125 | | | |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C | | 0. 0729 | | | |
| 55. 00 05500 RADI OLOGY-THERAPEUTI C | | 0. 1391 | | | |
| 60. 00 06000 LABORATORY | | 0. 1109 | | | |
| 64. 00 06400 I NTRAVENOUS THERAPY | | 0. 1237 | | | |
| 65. 00 06500 RESPI RATORY THERAPY | | 0. 3117 | | | |
| 66. 00 06600 PHYSI CAL THERAPY | | 0. 2648 | | | |
| 67. 00 06700 OCCUPATI ONAL THERAPY | | 0. 3569 | | | |
| 68.00 06800 SPEECH PATHOLOGY | | 0. 1887 | | | |
| 69. 00 06900 ELECTROCARDI OLOGY | | 0.0413 | 72 12, 829 | 531 | |
| 70. 00 07000 ELECTROENCEPHALOGRAPHY | | 0. 1658 | 80 207 | 34 | 70.00 |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT | | 0. 1160 | | | |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS | | 0. 3473 | | 31, 362 | |
| 73.00 07300 DRUGS CHARGED TO PATIENTS | | 0. 2036 | | 31, 629 | |
| 74. 00 07400 RENAL DIALYSIS | | 0.0000 | | 0 | |
| 77.00 07700 ALLOGENEIC STEM CELL ACQUISITION | | 0.0000 | 00 00 | 0 | 77.00 |
| OUTPATIENT SERVICE COST CENTERS | | | - | | |
| 90. 00 09000 CLINIC | | 2.0516 | 22 1, 392 | 2, 856 | 90.00 |
| 90.01 09001 WOUND CARE INSTITUTE | | 0. 8347 | 38 21 | 18 | 90.01 |
| 90. 02 09002 OP NUTRITIONAL COUNSELING | | 1. 1798 | | Ű | |
| 91. 00 09100 EMERGENCY | | 0. 1014 | 61 146, 432 | | |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART | | 0. 3432 | | | |
| 200.00 Total (sum of lines 50 through 94 and 96 through 98) | | | 1, 406, 032 | 332, 148 | |
| 201.00 Less PBP Clinic Laboratory Services-Program only charges | (line 61) | | 0 | | 201.00 |
| 202.00 Net charges (line 200 minus line 201) | | | 1, 406, 032 | | 202.00 |

| Heal th | Financial Systems FRANCISCAN HEALTH MOD | RESVI LLE | In Lie | u of Form CMS-2 | 2552-10 |
|------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------|---------------------------------------------|----------------------------------------|----------------|
| | | rovider CCN: 15-0057 | Period: From 01/01/2022 To 12/31/2022 | Worksheet E Part A Date/Time Pre | |
| | | Title XVIII | Hospi tal | 5/29/2023 3: 2 PPS | 8 pm |
| | | | | 1 00 | |
| | PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS | | | 1.00 | |
| 1.00 1.01 | DRG Amounts Other than Outlier Payments DRG amounts other than outlier payments for discharges occurring | prior to October 1 (| see | 0 5, 613, 889 | 1. 00 1. 01 |
| 1.02 | instructions) DRG amounts other than outlier payments for discharges occurring | 1 (see | 2, 160, 606 | 1. 02 | |
| 1.03 | instructions) DRG for federal specific operating payment for Model 4 BPCI for 1 (see instructions) | prior to October | 0 | 1. 03 | |
| 1.04 | DRG for federal specific operating payment for Model 4 BPCI for October 1 (see instructions) | di scharges occurri ng | on or after | 0 | 1. 04 |
| 2. 00 2. 01 | Outlier payments for discharges. (see instructions) Outlier reconciliation amount | | | 0 | 2. 00 2. 01 |
| 2.02 2.03 | Outlier payment for discharges for Model 4 BPCI (see instruction | | | 0 79,677 | 2.02 2.03 |
| 2.03 | Outlier payments for discharges occurring prior to October 1 (se Outlier payments for discharges occurring on or after October 1 | | | 4,878 | |
| 3.00 | Managed Care Simulated Payments | | | 0 | 3.00 |
| 4.00 | Bed days available divided by number of days in the cost reporti Indirect Medical Education Adjustment | ng period (see instru | ctions) | 75.14 | 4.00 |
| 5.00 | FTE count for allopathic and osteopathic programs for the most r or before 12/31/1996. (see instructions) | | | 0.00 | |
| 5. 01 6. 00 | FTE cap adjustment for qualifing hospitals under §131 of the CAA FTE count for allopathic and osteopathic programs that meet the | | | 0.00 0.00 | |
| 6.26 | new programs in accordance with 42 CFR 413.79(e) Rural track program FTE cap limitation adjustment after the cap- the CAA 2021 (see instructions) | building window close | d under §127 of | 0.00 | 6. 26 |
| 7.00 | MMA Section 422 reduction amount to the IME cap as specified und | er 42 CFR §412.105(f) | (1) (i v) (B) (1) | 0.00 | 7.00 |
| 7.01 | ACA § 5503 reduction amount to the IME cap as specified under 42 cost report straddles July 1, 2011 then see instructions. | v)(B)(2) If the | 0.00 | 7. 01 | |
| 7.02 | Adjustment (increase or decrease) to the hospital's rural track track programs with a rural track for Medicare GME affiliated pr | 0.00 | 7. 02 | | |
| 8.00 | and 87 FR 49075 (August 10, 2022) (see instructions) Adjustment (increase or decrease) to the FTE count for allopathi affiliated programs in accordance with 42 CFR 413.75(b), 413.79(| | | 0.00 | 8.00 |
| 8.01 | 1998), and 67 FR 50069 (August 1, 2002). The amount of increase if the hospital was awarded FTE cap slots | 0.00 | 8. 01 | | |
| 8. 02 | report straddles July 1, 2011, see instructions. The amount of increase if the hospital was awarded FTE cap slots | 0.00 | 8. 02 | | |
| 8. 21 | under § 5506 of ACA. (see instructions) The amount of increase if the hospital was awarded FTE cap slots instructions) | A 2021 (see | 0.00 | 8. 21 | |
| 9.00 | Sum of lines 5 and 5.01, plus line 6, plus lines 6.26 through 6. minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.27 | | 7.01, plus or | 0.00 | 9.00 |
| 10.00 | FTE count for allopathic and osteopathic programs in the current | | ds | | 10.00 |
| | FTE count for residents in dental and podiatric programs. Current year allowable FTE (see instructions) | | | | 11.00 12.00 |
| 12.00 | Total allowable FTE count for the prior year. | | | | 13.00 |
| 14.00 | Total allowable FTE count for the penultimate year if that year otherwise enter zero. | ended on or after Sep | tember 30, 1997, | | 14.00 |
| 15.00 | Sum of lines 12 through 14 divided by 3. | | | | 15.00 |
| 16. 00 17. 00 | Adjustment for residents in initial years of the program (see in Adjustment for residents displaced by program or hospital closur | | | 0.00 | 16.00 17.00 |
| 18.00 | Adjusted rolling average FTE count | C | | 0.00 | |
| 19.00 | Current year resident to bed ratio (line 18 divided by line 4). | | | 0.000000 | |
| 20.00 | Prior year resident to bed ratio (see instructions) | | | 0.000000 | |
| 21. 00 22. 00 | Enter the lesser of lines 19 or 20 (see instructions) IME payment adjustment (see instructions) | | | 0. 000000 0 | |
| 22.01 | IME payment adjustment - Managed Care (see instructions) | | | 0 | 22.01 |
| 23.00 | Indirect Medical Education Adjustment for the Add-on for § 422 or Number of additional allopathic and osteopathic IME FTE resident | | FR 412.105 | 0.00 | 23.00 |
| | (f)(1)(iv)(C). | | | | |
| 24. 00 25. 00 | IME FTE Resident Count Over Cap (see instructions) If the amount on line 24 is greater than -O-, then enter the low | er of line 23 or line | 24 (see | | 24.00 25.00 |
| 26.00 | instructions) Resident to bed ratio (divide line 25 by line 4) | | | 0.000000 | 26.00 |
| 27.00 | IME payments adjustment factor. (see instructions) | | | 0.000000 | |
| 28.00 | IME add-on adjustment amount (see instructions) | | | 0 | |
| 28. 01 29. 00 | IME add-on adjustment amount - Managed Care (see instructions) | | | 0 | 28.01 29.00 |
| 29.00 29.01 | Total IME payment (sum of lines 22 and 28) Total IME payment - Managed Care (sum of lines 22.01 and 28.01) Disproportionate Share Adjustment | | | 0 | 29.00 29.01 |
| 30.00 | Percentage of SSI recipient patient days to Medicare Part A pati | ent days (see instruc | tions) | 1.41 | 30.00 |
| 31.00 | Percentage of Medicaid patient days (see instructions) | | | 21.67 | 31.00 |
| 32.00 | Sum of lines 30 and 31 Allowable disproportionate share percentage (see instructions) | | | 23.08 | |
| 33.00 34.00 | Allowable disproportionate share percentage (see instructions) Disproportionate share adjustment (see instructions) | | | 8. 26 160, 544 | |
| 5 F. 00 | | | | 100, 344 | 1 57.00 |

| Heal th | Financial Systems FRANCI SCAN HEALTH | MOORESVI LLE | In Lie | u of Form CMS-2 | 2552-10 | |
|------------------|------------------------------------------------------------------------------------------------------------------------------|----------------------------|----------------------------------|-------------------------|------------------|--|
| CALCUL | ATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0057 | Period: | Worksheet E | | |
| | | | From 01/01/2022 To 12/31/2022 | Part A Date/Time Pre | nared | |
| | | | 10 12/01/2022 | 5/29/2023 3: 28 | | |
| | | Title XVIII | Hospi tal | PPS | | |
| | | | Prior to 10/1 | | | |
| | Uncompensated Care Payment Adjustment | | 1.00 | 2.00 | | |
| 35.00 | Total uncompensated care amount (see instructions) | | 7, 192, 008, 710 | 6, 874, 403, 459 | 35.00 | |
| 35.01 | Factor 3 (see instructions) | | 0. 000266342 | 0. 000251949 | | |
| 35.02 | Hospital UCP, including supplemental UCP (If line 34 is zero, | enter zero on this line) | 1, 915, 533 | 1, 731, 996 | 35.02 | |
| | (see instructions) | - / | | | | |
| 35.03 | Pro rata share of the hospital UCP, including supplemental UC | P (see instructions) | 1, 432, 713 | 436, 558 | | |
| 36.00 | Total UCP adjustment (sum of columns 1 and 2 on line 35.03) Additional payment for high percentage of ESRD beneficiary di | scharges (lines 40 throug | 1, 869, 271 h 46) | | 36.00 | |
| 40.00 | Total Medicare discharges (see instructions) | senarges (Trites to throug | 0 | | 40.00 | |
| 41.00 | Total ESRD Medicare discharges (see instructions) | | 0 | | 41.00 | |
| 41.01 | Total ESRD Medicare covered and paid discharges (see instruct | i ons) | 0 | | 41.01 | |
| 42.00 | Divide line 41 by line 40 (if less than 10%, you do not quali | fy for adjustment) | 0.00 | | 42.00 | |
| 43.00 | Total Medicare ESRD inpatient days (see instructions) | | 0 | | 43.00 | |
| 44.00 | Ratio of average length of stay to one week (line 43 divided days) | by line 41 divided by / | 0. 000000 | | 44.00 | |
| 45.00 | Average weekly cost for dialysis treatments (see instructions | | 0.00 | | 45.00 | |
| 46.00 | Total additional payment (line 45 times line 44 times line 41 | | 0 | | 46.00 | |
| 47.00 | Subtotal (see instructions) | | 9, 888, 865 | | 47.00 | |
| 48.00 | Hospital specific payments (to be completed by SCH and MDH, s | mall rural hospitals | 0 | | 48.00 | |
| | only. (see instructions) | | | Amount | | |
| | | | | Amount 1.00 | | |
| 49.00 | Total payment for inpatient operating costs (see instructions | .) | | 9, 888, 865 | 49.00 | |
| 50.00 | | | | | | |
| 51.00 | Exception payment for inpatient program capital (Wkst. L, Pt. | | | 0 | 51.00 | |
| 52.00 | Direct graduate medical education payment (from Wkst. E-4, li | ne 49 see instructions). | | 0 | 52.00 | |
| 53.00 54.00 | Nursing and Allied Health Managed Care payment | | | 0 35, 507 | | |
| 54.00 54.01 | Special add-on payments for new technologies Islet isolation add-on payment | | | 35, 507 | | |
| 55.00 | Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 6 | 9) | | 0 | 55.00 | |
| 55.01 | Cellular therapy acquisition cost (see instructions) | , , | | 0 | 55.01 | |
| 56.00 | Cost of physicians' services in a teaching hospital (see intr | uctions) | | 0 | 56.00 | |
| 57.00 | Routine service other pass through costs (from Wkst. D, Pt. I | | rough 35). | 0 | 57.00 | |
| 58.00 | Ancillary service other pass through costs from Wkst. D, Pt. | IV, col. 11 line 200) | | 0 | | |
| 59.00 60.00 | Total (sum of amounts on lines 49 through 58) Primary payer payments | | | 10, 520, 808 0 | 59.00 60.00 | |
| 61.00 | Total amount payable for program beneficiaries (line 59 minus | line 60) | | 10, 520, 808 | | |
| 62.00 | Deductibles billed to program beneficiaries | | | 883, 232 | | |
| 63.00 | Coinsurance billed to program beneficiaries | | | 4, 279 | 63.00 | |
| 64.00 | Allowable bad debts (see instructions) | | | 53, 624 | | |
| 65.00 | Adjusted reimbursable bad debts (see instructions) | | | 34, 856 | | |
| 66.00 | Allowable bad debts for dual eligible beneficiaries (see inst | ructions) | | 14, 577 | | |
| 67.00 68.00 | Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for | applicable to MS-DRGs (se | e instructions) | 9, 668, 153 0 | 68.00 | |
| 69.00 | Outlier payments reconciliation (sum of lines 93, 95 and 96). | | | | 69.00 | |
| 70.00 | OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) | | , | 0 | 70.00 | |
| 70.50 | Rural Community Hospital Demonstration Project (§410A Demonst | ration) adjustment (see i | nstructions) | 0 | 70.50 | |
| 70.75 | N95 respirator payment adjustment amount (see instructions) | | | 0 | 70.75 | |
| 70.87 | Demonstration payment adjustment amount before sequestration | | | 0 | 70.87 | |
| 70. 88 70. 89 | SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see inst | ructions) | | 0 | 70. 88 70. 89 | |
| 70.89 | HSP bonus payment HVBP adjustment amount (see instructions) | | | 0 | 70.89 | |
| 70.91 | HSP bonus payment HRR adjustment amount (see instructions) | | | 0 | | |
| 70. 92 | Bundled Model 1 discount amount (see instructions) | | | 0 | 70. 92 | |
| 70. 93 | HVBP payment adjustment amount (see instructions) | | | 0 | 70. 93 | |
| 70.94 | HRR adjustment amount (see instructions) | | | -1, 130 | | |
| 70.95 | Recovery of accelerated depreciation | | | | 70. 95 | |

| | ATION OF REIMBURSEMENT SETTLEMENT | Provider CC | CN: 15-0057 | Period: From 01/01/2022 To 12/31/2022 | Worksheet E Part A Date/Time Prep 5/29/2023 3:28 | oared: 8 pm |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------|--------------|---------------------------------------------|-----------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| | | Title | XVIII | Hospi tal | PPS | |
| | | | FFY | (уууу) | Amount | |
| | | | | 0 | 1.00 | |
| 0. 96 | Low volume adjustment for federal fiscal year (yyyy) (Enter in | n column O | | 2021 | 814, 301 | 70.9 |
| 0. 97 | the corresponding federal year for the period prior to 10/1) | | | 2022 | 222 522 | 70.0 |
| 0.97 | Low volume adjustment for federal fiscal year (yyyy) (Enter in the corresponding federal year for the period ending on or af | | | 2022 | 332, 523 | 70.9 |
| 0. 98 | Low Volume Payment-3 | | | | 0 | 70.9 |
| 0.99 | HAC adjustment amount (see instructions) | | | | 0 | 70.9 |
| 1.00 | Amount due provider (line 67 minus lines 68 plus/minus lines (| 69 & 70) | | | 10, 813, 847 | 71.0 |
| 1.01 | Sequestration adjustment (see instructions) | | | | 136, 255 | |
| 1. 02 | Demonstration payment adjustment amount after sequestration | | | | 0 | 71.0 |
| 1. 03 | Sequestration adjustment-PARHM or CHART pass-throughs | | | | | 71.0 |
| 2.00 | Interim payments | | | | 9, 853, 702 | |
| 2.01 | Interim payments-PARHM or CHART | | | | | 72.0 |
| 3.00 | Tentative settlement (for contractor use only) | | | | 0 | 73.0 |
| 3.01 | Tentative settlement-PARHM or CHART (for contractor use only) | | | | | 73.0 |
| 4.00 | Balance due provider/program (line 71 minus lines 71.01, 71.02 | 2, 72, and | | | 823, 890 | 74.0 |
| 4. 01 | 73) Balance due provider/program-PARHM or CHART (see instructions) | | | | | 74.0 |
| 5.00 | Protested amounts (nonallowable cost report items) in accorda | | | | 126, 530 | |
| 0.00 | CMS Pub. 15-2, chapter 1, §115.2 | | | | 120, 330 | 75.0 |
| | TO BE COMPLETED BY CONTRACTOR (lines 90 through 96) | | | | | |
| 0. 00 | Operating outlier amount from Wkst. E, Pt. A, line 2, or sum (| of 2.03 | | | 0 | 90.0 |
| | plus 2.04 (see instructions) | | | | | |
| 1.00 | Capital outlier from Wkst. L, Pt. I, line 2 | | | | 0 | 91.0 |
| 2.00 | Operating outlier reconciliation adjustment amount (see instru | | | | 0 | 92.0 |
| 3.00 | Capital outlier reconciliation adjustment amount (see instruc | | | | 0 | 93.0 |
| 4.00 | The rate used to calculate the time value of money (see instru | uctions) | | | 0.00 | |
| 5.00 6.00 | Time value of money for operating expenses (see instructions) Time value of money for capital related expenses (see instructions) | tions) | | | 0 | 95. 0 96. 0 |
| 0.00 | The value of money for capital related expenses (see this truc | (TOHS) | | Prior to 10/1 | | 90.0 |
| | | | | 1.00 | 2.00 | |
| | HSP Bonus Payment Amount | | | | | |
| 00.00 | HSP bonus amount (see instructions) | | | 0 | 0 | 100. 0 |
| | HVBP Adjustment for HSP Bonus Payment | | | | | |
| 01 00 | HVBP adjustment factor (see instructions) | | | 0.000000000 | | 101. 0 |
| | | | | 0.000000000 | | |
| | HVBP adjustment amount for HSP bonus payment (see instructions | s) | | 0 | | 102.0 |
| 02.00 | HVBP adjustment amount for HSP bonus payment (see instruction: HRR Adjustment for HSP Bonus Payment | s) | | 0 | 0 | |
| 02. 00 03. 00 | HVBP adjustment amount for HSP bonus payment (see instructions HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) | | | 0.0000 | 0.0000 | 103. 0 |
| 02. 00 03. 00 | HVBP adjustment amount for HSP bonus payment (see instructions HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) |) | stmont | 0 | 0.0000 | 103. C |
| 02.00 03.00 04.00 | HVBP adjustment amount for HSP bonus payment (see instructions HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr |) ration) Adju | | 0.0000 | 0.0000 | 103. 0 104. 0 |
| 02.00 03.00 04.00 | HVBP adjustment amount for HSP bonus payment (see instructions HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per |) ration) Adju | | 0.0000 | 0.0000 | 103. 0 104. 0 |
| 02.00 03.00 04.00 | HVBP adjustment amount for HSP bonus payment (see instructions HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr |) ration) Adju | | 0.0000 | 0.0000 | 103. 0 104. 0 |
| 02.00 03.00 04.00 00.00 | HVBP adjustment amount for HSP bonus payment (see instructions HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. |) ration) Adju riod under t | | 0.0000 | 0.0000 | 102. 0 103. 0 104. 0 200. 0 201. 0 |
| 02.00 03.00 04.00 00.00 01.00 02.00 | HVBP adjustment amount for HSP bonus payment (see instructions HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) |) ration) Adju riod under t | | 0.0000 | 0.0000 | 103. 0 104. 0 200. 0 201. 0 202. 0 |
| 02.00 03.00 04.00 00.00 01.00 02.00 | HVBP adjustment amount for HSP bonus payment (see instructions HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) |) ration) Adju riod under t e 49) | he 21st | 0.0000 | 0.0000 | 103. 0 104. 0 200. 0 201. 0 |
| 02.00 03.00 04.00 00.00 01.00 02.00 | HVBP adjustment amount for HSP bonus payment (see instructions HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in |) ration) Adju riod under t e 49) | he 21st | 0.0000 | 0.0000 | 103. 0 104. 0 200. 0 201. 0 202. 0 |
| 02.00 03.00 04.00 00.00 01.00 02.00 03.00 | HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) |) ration) Adju riod under t e 49) | he 21st | 0.0000 | 0.0000 0 | 103. C 104. C 200. C 201. C 202. C 203. C |
| 02.00 03.00 04.00 00.00 01.00 02.00 03.00 | HVBP adjustment amount for HSP bonus payment (see instructions HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount |) ration) Adju riod under t e 49) | he 21st | 0.0000 | 0.0000 0 | 103. 0 104. 0 200. 0 201. 0 202. 0 203. 0 203. 0 |
| 02.00 03.00 04.00 00.00 01.00 02.00 03.00 04.00 05.00 | HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) |) ration) Adju riod under t e 49) | he 21st | 0.0000 | 0.0000 0 | 103. 0 104. 0 200. 0 201. 0 202. 0 203. 0 203. 0 204. 0 205. 0 |
| 02.00 03.00 04.00 00.00 01.00 02.00 03.00 03.00 | HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) |) ration) Adju riod under t e 49) | he 21st | 0.0000 | 0.0000 0 | 103. C 104. C 200. C 201. C 202. C 203. C 203. C 204. C 205. C |
| 02.00 03.00 04.00 00.00 01.00 02.00 03.00 04.00 05.00 06.00 | HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement |) ration) Adju riod under t e 49) first year | he 21st | 0.0000 | 0 0.0000 0 | 103. C 104. C 200. C 201. C 202. C 203. C 203. C |
| 02.00 03.00 04.00 00.00 01.00 02.00 03.00 04.00 05.00 05.00 06.00 | HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) |) ration) Adju riod under t e 49) first year ructions) | he 21st | 0.0000 | 0.0000 0 | 103. 0 104. 0 200. 0 201. 0 202. 0 203. 0 204. 0 205. 0 206. 0 |
| 02.00 03.00 04.00 00.00 01.00 02.00 03.00 04.00 05.00 06.00 07.00 08.00 | HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstri Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions) |) ration) Adju riod under t e 49) first year ructions) | he 21st | 0.0000 | 0.0000 0 | 103. 0 104. 0 200. 0 201. 0 202. 0 203. 0 204. 0 205. 0 206. 0 207. 0 |
| 02.00 03.00 04.00 00.00 00.00 01.00 02.00 03.00 03.00 04.00 05.00 06.00 07.00 08.00 09.00 | HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstri Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instruction Medicare Part A inpatient service costs (from Wkst. E, Pt. A, |) ration) Adju riod under t e 49) first year ructions) | he 21st | 0.0000 | 0.0000 0 | 103. (104. (200. (201. (202. (203. (203. (205. (206. (206. (207. (208. (209. (|
| 02.00 03.00 04.00 00.00 01.00 02.00 03.00 03.00 04.00 05.00 05.00 06.00 07.00 08.00 09.00 10.00 | HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions) Redicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions) |) ration) Adju riod under t e 49) first year ructions) | he 21st | 0.0000 | 0.0000 0 | 103. (104. (200. (201. (202. (203. (204. (205. (206. (207. (208. (|
| 22. 00 33. 000 34. 00 44. 00 50. 00 50. | HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement |) ration) Adju riod under t e 49) first year ructions) line 59) | he 21st | 0.0000 | 0 0.0000 0 | 103. (104. (200. (202. (203. (203. (205. (206. (208. (209. (209. (209. (201. (201. (|
| 02.00 03.00 04.00 00.00 01.00 02.00 03.00 04.00 05.00 06.00 07.00 08.00 00.00 01.00 01.00 01.00 01.00 02.00 01.00 02.00 01.00 02.00 03.00 04.00 05.00 05.00 06.00 06.00 07.00 06.00 07.00 06.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 07.00 00 | HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement Total adjustment to Medicare Part A IPPS payments (from line 203) |) ration) Adju riod under t e 49) first year ructions) line 59) | he 21st | 0.0000 | 0.0000 0 | 103. (104. (200. (202. (203. (203. (205. (206. (207. (208. (209. (211. (211. (211. (|
| 32. 00 33. 00 44. 00 50. 0 | HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement |) ration) Adju riod under t e 49) first year ructions) line 59) 211) | of the curre | 0.0000 | 0.0000 0 | 103. 104. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209. 210. 211. |

| VO | LUME CALCULATION EXHIBIT 4 | | | Provider CC | F | Period: From 01/01/2022 Fo 12/31/2022 | Worksheet E Part A Exhibi Date/Time Pre 5/29/2023 3:23 | pare |
|----------|-------------------------------------------------------------------------------------------------------------------------|-----------------|---------------------------------------|-------------------------|-----------------------------------|---------------------------------------------|-----------------------------------------------------------------|------|
| | | line | Amounts (from E, Part A) | Pre/Post Entitlement | XVIII Period Prior to 10/01 | On/After 10/01 | PPS Total (Col 2 through 4) | |
|)) | DRG amounts other than outlier | 0 | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | 1 |
| 1 | payments DRG amounts other than outlier | | 5, 613, 889 | 0 | | | 5, 613, 889 | |
| 2 | payments for discharges occurring prior to October 1 DRG amounts other than outlier | 1. 02 | 2, 160, 606 | 0 | | 2, 160, 606 | 2, 160, 606 | 1 |
| | payments for discharges occurring on or after October 1 | | | | | | | |
| 3 | DRG for Federal specific operating payment for Model 4 BPCl occurring prior to October 1 | 1. 03 | 0 | 0 | (| 0 | 0 | 1 |
| 4 | DRG for Federal specific operating payment for Model 4 BPCl occurring on or after October 1 | 1. 04 | 0 | 0 | | 0 | 0 | 1 |
| C | Outlier payments for | 2.00 | | | | | | 2 |
| 1 | discharges (see instructions) Outlier payments for discharges for Model 4 BPCI | 2. 02 | О | 0 | (| 0 0 | 0 | 2 |
| 2 | Outlier payments for discharges occurring prior to October 1 (see instructions) | 2. 03 | 79, 677 | 0 | 79, 67 | 7 | 79, 677 | 2 |
| 3 | Outlier payments for discharges occurring on or after October 1 (see instructions) | 2.04 | 4, 878 | 0 | | 4, 878 | 4, 878 | 2 |
| С | Operating outlier | 2. 01 | 0 | 0 | (| 0 0 | 0 | 3 |
| C | reconciliation Managed care simulated payments | 3. 00 | 0 | 0 | (| 0 0 | 0 | 4 |
| | Indirect Medical Education Adju | | 1 | | 1 | 1 | | 1 |
| с С | Amount from Worksheet E, Part A, line 21 (see instructions) IME payment adjustment (see | 21.00 22.00 | 0. 000000 | 0. 000000 | | | Ο | 5 |
| 1 | instructions) IME payment adjustment for managed care (see | 22. 01 | 0 | 0 | (| 0 0 | 0 | 6 |
| | instructions) Indirect Medical Education Adju | ictmont for the | Add on for So | ation 199 of t | | | | |
| C | IME payment adjustment factor | 27.00 | 0. 000000 | 0. 000000 | | 0.000000 | | 7 |
| C | (see instructions) IME adjustment (see | 28.00 | 0 | 0 | (| 0 0 | 0 | 8 |
| 1 | instructions) IME payment adjustment add on for managed care (see | 28.01 | 0 | 0 | (| 0 0 | 0 | 8 |
| С | instructions) Total IME payment (sum of lines 6 and 8) | 29.00 | 0 | 0 | (| 0 0 | 0 | 9 |
| 1 | Total IME payment for managed care (sum of lines 6.01 and | 29. 01 | 0 | 0 | (| 0 0 | 0 | 9 |
| | 8.01) Disproportionate Share Adjustme | ent | · · · · · · · · · · · · · · · · · · · | | I | | | |
| 00 | Allowable disproportionate share percentage (see instructions) | 33.00 | 0. 0826 | 0. 0826 | 0. 0826 | 0. 0826 | | 10 |
| 00 | Disproportionate share adjustment (see instructions) | 34.00 | 160, 544 | 0 | | | 160, 544 | |
| 21 | Uncompensated care payments Additional payment for high per | 36.00 | 1,869,271 | 0 di scharges | 1, 432, 713 | 3 436, 558 | 1, 869, 271 | 11 |
| 00 | Total ESRD additional payment (see instructions) | 46.00 | | or scharges 0 | (| 0 0 | 0 | 12 |
| 00 00 | Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) | 47.00 48.00 | 9, 888, 865 0 | 0 0 | 7, 242, 206 | 5 2, 646, 659 D 0 | 9, 888, 865 0 | |
| 00 | (see instructions) Total payment for inpatient operating costs (see | 49.00 | 9, 888, 865 | 0 | 7, 242, 206 | 5 2, 646, 659 | 9, 888, 865 | 15 |
| 00 | instructions) Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable) | 50.00 | 596, 436 | 0 | 433, 037 | 7 163, 399 | 596, 436 | 16 |

| | Financial Systems | F | RANCI SCAN HEAL | | | | eu of Form CMS-2 | 2552-10 |
|--------|-----------------------------------------------------------------------|---------------|-----------------|-------------|-----------------------------------------|---------------------------------------------|------------------|---------|
| LOW VO | LUME CALCULATION EXHIBIT 4 | | | Provider CO | CN: 15-0057 | Period: From 01/01/2022 To 12/31/2022 | | pared: |
| | | | | Title | XVIII | Hospi tal | PPS | |
| | | W/S E, Part A | Amounts (from | Pre/Post | Period Prior | Period | Total (Col 2 | |
| | | line | E, Part A) | Entitlement | to 10/01 | On/After 10/01 | | |
| | | 0 | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | |
| 17.00 | Special add-on payments for new technologies | 54.00 | 35, 507 | 0 | 35, 50 | 07 0 | 35, 507 | |
| 17.01 | Net organ aquisition cost | | | | | | | 17.01 |
| 17.02 | Credits received from | 68.00 | 0 | 0 | | 0 0 | 0 | 17.02 |
| | manufacturers for replaced | | | | | | | |
| 10.00 | devices for applicable MS-DRGs | | | | | | | 10.00 |
| 18.00 | Capital outlier reconciliation | 93.00 | 0 | 0 | | 0 0 | 0 | 18.00 |
| | adjustment amount (see | | | | | | | |
| 19 00 | instructions) SUBTOTAL | | | 0 | 7, 710, 75 | 2, 810, 058 | 10, 520, 808 | 19 00 |
| 171.00 | | W/S L, line | (Amounts from | | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | 2/010/000 | 10/020/000 | 17100 |
| | | | L) | | | | | |
| | | 0 | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | |
| 20.00 | Capital DRG other than outlier | 1.00 | 587, 166 | 0 | 424, 37 | 72 162, 794 | 587, 166 | 20.00 |
| 20. 01 | Model 4 BPCI Capital DRG other than outlier | 1.01 | 0 | 0 | | 0 0 | 0 | 20. 01 |
| 21.00 | Capital DRG outlier payments | 2.00 | 9, 270 | 0 | 8, 66 | 605 605 | 9, 270 | 21.00 |
| 21.01 | Model 4 BPCI Capital DRG outlier payments | 2. 01 | 0 | 0 | | 0 0 | 0 | 21.01 |
| 22.00 | Indirect medical education percentage (see instructions) | 5.00 | 0. 0000 | 0.0000 | 0.000 | 0.0000 | | 22.00 |
| 23.00 | Indirect medical education adjustment (see instructions) | 6.00 | 0 | 0 | | 0 0 | 0 | 23.00 |
| 24.00 | Allowable disproportionate share percentage (see instructions) | 10.00 | 0. 0000 | 0.0000 | 0.000 | 0.0000 | | 24.00 |
| 25.00 | Disproportionate share adjustment (see instructions) | 11.00 | 0 | 0 | | 0 0 | 0 | 25.00 |
| 26.00 | Total prospective capital payments (see instructions) | 12.00 | 596, 436 | 0 | 433, 03 | 37 163, 399 | 596, 436 | 26.00 |
| | | | (Amounts to E, | | | | | |
| | | line | Part A) | | | | | |
| | | 0 | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | |
| 27.00 | Low volume adjustment factor | | | | 0. 10560 | 0. 118333 | | 27.00 |
| 28.00 | Low volume adjustment (transfer amount to Wkst. E, Pt. A, line) | 70.96 | | | 814, 30 | 01 | 814, 301 | 28.00 |
| 29.00 | Low volume adjustment (transfer amount to Wkst. E, | 70. 97 | | | | 332, 523 | 332, 523 | 29.00 |
| 100.00 | Pt. A, line) Transfer low volume adjustments to Wkst. E, Pt. A. | | Y | | | | | 100. 00 |

| | Financial Systems Financial Systems Financial Condition (HAC) REDUCTION CALCULA | RANCISCAN HEAL TION EXHIBIT 5 | | CN: 15-0057 | In Lie Period: From 01/01/2022 | worksheet E Part A Exhibi | |
|------------------|----------------------------------------------------------------------------------------------------------------|----------------------------------|---------------------------|-----------------------------|--------------------------------------|---------------------------------|----------------|
| | | | | | To 12/31/2022 | Date/Time Pre 5/29/2023 3:2 | pared: |
| | | Wkst. E, Pt. A, line | Amt. from Wkst. E, Pt. | XVIII Period to 10/01 | Hospital Period on after 10/01 | PPS Total (cols. 2 and 3) | |
| | | 0 | A) 1.00 | 2.00 | 3.00 | 4.00 | |
| 1.00 | DRG amounts other than outlier payments | 1.00 | 1.00 | 2.00 | 3.00 | 4.00 | 1.00 |
| 1.01 | DRG amounts other than outlier payments for discharges occurring prior to October 1 | 1.01 | 5, 613, 889 | 5, 613, 88 | 9 | 5, 613, 889 | |
| 1. 02 | DRG amounts other than outlier payments for discharges occurring on or after October 1 | 1.02 | 2, 160, 606 | | 2, 160, 606 | 2, 160, 606 | 1. 02 |
| 1.03 | DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1 | 1.03 | 0 | | 0 | 0 | 1. 03 |
| 1.04 | DRG for Federal specific operating payment for Model 4 BPCI occurring on or after | 1.04 | 0 | | 0 | 0 | 1. 04 |
| 2.00 | October 1 Outlier payments for discharges (see instructions) | 2.00 | | | | | 2.00 |
| 2. 01 | Outlier payments for discharges for Model 4 BPCI | 2.02 | 0 | | 0 0 | 0 | 2. 01 |
| 2.02 | Outlier payments for discharges occurring prior to October 1 (see instructions) | 2.03 | 79, 677 | 79, 67 | 7 | 79, 677 | 2. 02 |
| 2.03 | Outlier payments for discharges occurring on or after October 1 (see instructions) | 2.04 | 4, 878 | | 4, 878 | 4, 878 | 2. 03 |
| 3.00 | Operating outlier reconciliation | 2.01 | 0 | | 0 0 | | 3.00 |
| 4.00 | Managed care simulated payments Indirect Medical Education Adjustment | 3.00 | 0 | | 0 0 | 0 | 4.00 |
| 5.00 | Amount from Worksheet E, Part A, Line 21 (see instructions) | 21.00 | 0. 000000 | 0.0000 | 0.00000 | | 5.00 |
| 6. 00 6. 01 | IME payment adjustment (see instructions) IME payment adjustment for managed care (see instructions) | 22.00 22.01 | 0 | | 0 0 0 0 | 0 | 6. 00 6. 01 |
| | Indirect Medical Education Adjustment for the | Add-on for Se | ection 422 of t | he MMA | | | |
| 7.00 | IME payment adjustment factor (see instructions) | 27.00 | 0. 000000 | 0.00000 | 0.00000 | | 7.00 |
| 8. 00 8. 01 | IME adjustment (see instructions) IME payment adjustment add on for managed care (see instructions) | 28.00 28.01 | 0 | | 0 0 0 0 | | |
| 9. 00 9. 01 | Total IME payment (sum of lines 6 and 8) Total IME payment for managed care (sum of lines 6.01 and 8.01) | 29.00 29.01 | 0 | | 0 0 0 0 | - | |
| | Di sproporti onate Share Adjustment | | <u> </u> | <u> </u> | | <u>I</u> | |
| 10. 00 | Allowable disproportionate share percentage (see instructions) | 33.00 | 0. 0826 | 0. 082 | . 0. 0826 | | 10.00 |
| 11. 00 | Disproportionate share adjustment (see instructions) | 34.00 | 160, 544 | 115, 92 | 44, 617 | 160, 544 | 11.00 |
| 11. 01 | Uncompensated care payments | 36.00 | 1, 869, 271 | 1, 432, 71 | 3 436, 558 | 1, 869, 271 | 11.01 |
| 12.00 | Additional payment for high percentage of ESF Total ESRD additional payment (see instructions) | 46.00 | di scharges 0 | | 0 0 | 0 | 12.00 |
| 13.00 | Subtotal (see instructions) | 47.00 | 9, 888, 865 | 7, 242, 20 | 2, 646, 659 | 9, 888, 865 | 13.00 |
| 14.00 | Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions) | 48.00 | 0 | | 0 0 | 0 | 14.00 |
| 15.00 | Total payment for inpatient operating costs (see instructions) | 49.00 | 9, 888, 865 | 7, 242, 20 | 2, 646, 659 | 9, 888, 865 | 15.00 |
| 16. 00 | Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable) | 50.00 | 596, 436 | 433, 03 | 163, 399 | 596, 436 | 16.00 |
| 17. 00 17. 01 | Special add-on payments for new technologies Net organ acquisition cost | 54.00 | 35, 507 | 35, 50 | 07 0 | 35, 507 | 17.00 17.01 |
| 17.02 | Credits received from manufacturers for replaced devices for applicable MS-DRGs | 68.00 | 0 | | 0 0 | 0 | 17.02 |
| 18.00 | Capital outlier reconciliation adjustment amount (see instructions) | 93.00 | 0 | | 0 0 | 0 | 18.00 |
| 19. 00 | SUBTOTAL | | | 7, 710, 75 | 2, 810, 058 | 10, 520, 808 | 19.00 |

| Health Financial Systems | FRANCI SCAN HEAL | TH MOORESVILLE | | In Lie | u of Form CMS- | 2552-10 |
|------------------------------------------------------------------------|-------------------------|----------------------------------|---------|---------------------------------------------|----------------|---------|
| HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCUL | ATION EXHIBIT 5 | | | Period: From 01/01/2022 To 12/31/2022 | | pared: |
| | | Title | XVIII | Hospi tal | PPS | |
| | Wkst. L, line | (Amt. from Wkst. L) | | | | |
| | 0 | 1.00 | 2.00 | 3.00 | 4.00 | |
| 20.00 Capital DRG other than outlier | 1.00 | 587, 166 | | | 587, 166 | 20.00 |
| 20.01 Model 4 BPCI Capital DRG other than outlier | 1.01 | 0 | | 0 0 | 0 | |
| 21.00 Capital DRG outlier payments | 2.00 | 9, 270 | 8, 60 | 605 | 9, 270 | 21.00 |
| 21.01 Model 4 BPCI Capital DRG outlier payments | 2.01 | 0 | | 0 0 | 0 | 21.01 |
| 22.00 Indirect medical education percentage (see instructions) | 5.00 | 0.0000 | 0.000 | 0. 0000 | | 22.00 |
| 23.00 Indirect medical education adjustment (see instructions) | 6.00 | 0 | | 0 0 | 0 | 23.00 |
| 24.00 Allowable disproportionate share percentage (see instructions) | 10.00 | 0.0000 | 0.000 | 0. 0000 | | 24.00 |
| 25.00 Disproportionate share adjustment (see instructions) | 11.00 | 0 | | 0 0 | 0 | 25.00 |
| 26.00 Total prospective capital payments (see instructions) | 12.00 | 596, 436 | 433, 03 | 37 163, 399 | 596, 436 | 26.00 |
| | Wkst. E, Pt. A, line | (Amt. from Wkst. E, Pt. A) | | | | |
| | 0 | 1.00 | 2.00 | 3, 00 | 4,00 | |
| 27.00 | - | | | | | 27.00 |
| 28.00 Low volume adjustment prior to October 1 | 70.96 | 814, 301 | 814, 30 | 01 | 814, 301 | 28.00 |
| 29.00 Low volume adjustment on or after October 1 | 70.97 | 332, 523 | | 332, 523 | 332, 523 | 29.00 |
| 30.00 HVBP payment adjustment (see instructions) | 70.93 | 0 | | 0 0 | 0 | |
| 30.01 HVBP payment adjustment for HSP bonus payment (see instructions) | 70. 90 | 0 | | 0 0 | 0 | 30. 01 |
| 31.00 HRR adjustment (see instructions) | 70.94 | -1, 130 | -1, 1; | 30 0 | -1, 130 | 31.00 |
| 31.01 HRR adjustment for HSP bonus payment (see instructions) | 70. 91 | 0 | | 0 0 | 0 | |
| | | | | | (Amt. to Wkst. | |
| | | | | | E, Pt. A) | |
| | 0 | 1.00 | 2.00 | 3.00 | 4.00 | |
| 32.00 HAC Reduction Program adjustment (see instructions) | 70. 99 | | | 0 0 | 0 | 32.00 |
| 100.00 Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A. | | N | | | | 100. 00 |

| CLUCILATION OF STITUTION OF STITUT | | FINANCI SUSTEMS FRANCI SCAN HEALTH | | | eu of Form CMS-2 | 2552-10 |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------|----------------------------------------------------------------|--------------------------|-----------------|------------------|---------|
| Ittle XUII Hoge tal PPS 10 Ref a - McDicAL ADD Chick (MALTI SERVICES 100 10 Medical and other services (see instructions) 13, 34, 452 2.00 10 Medical and other services (see instructions) 13, 34, 452 2.00 10 Duting respent (see instructions) 13, 34, 452 2.00 10 Duting respent (see instructions) 0, 004 64 10 District for other pass through costs from Mst D, Pt. IV, col 13, line 200 0 0 10 District for other pass through costs from Mst D, Pt. IV, col 13, line 200 17, 225 12, 20 10 District for other pass through costs from Mst D, Pt. IV, col 13, line 200 17, 224 14, 00 10 District for other pass through costs from Mst D, Pt. IV, col 13, line 200 17, 224 14, 00 < | CALCUL | ATTON OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0057 | | Date/Time Pre | |
| NULL E - MEDICAL AUD OFFIC HEALT SHOTCES 1.00 100 Marical and other services (sen instructions) 15,769 3,700 1,00 100 Marical and other services (sen instructions) 15,789 22,00 4,00 100 Decision other services (sen instructions) 15,789 22,00 4,00 100 Definition other services (sen instructions) 0,00 5,00 4,00 100 Decision other services (sen instructions) 0,00 6,00 4,00 100 Direct instructions) 0,00 0,00 0,00 0,00 100 Direct instructions) 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 | | | Title XVIII | Hospi tal | | 8 pm |
| Herr F Martin Aun OTHE HERD IS SERVICES 1.00 Medical and other services (see instructions) 15,286 (22,20) 100 Medical and other services (see instructions) 16,286 (22,20) 100 Duritier reconcil lation amount (see instructions) 16,286 (22,20) 100 Duritier reconcil lation amount (see instructions) 0.00 100 Thermole contine contine prevention (see instructions) 0.00 100 Thermole contine contine prevention (see instructions) 0.00 100 Thermole contine contine prevention (see instructions) 0.00 100 Total costext (see instructions) 1.00 100 Marcine context (see instructions) 1.00 100 Total costext | | | | noopritai | | |
| 1.00 Redical and other services (see instructions) 8.360 1.00 0.00 Redical and other services relevance under OPPS (see instructions) 18.24,622 2.00 1.00 Redical and other services relevance under OPPS (see instructions) 18.24,622 2.00 1.00 There the respect of a service relevance under OPPS (see instructions) 0.000 5.00 1.00 There the respect of a service relevance under OPPS (see instructions) 0.000 0.000 1.00 There the respect of a service relevance under OPPS (see instructions) 0.000 0.000 1.00 There the respect of a service relevance under OPPS (see instructions) 3.001 1.00 1.00 There the respect of a service relevance under OPPS (see instructions) 3.001 1.00 1.00 There the respect of a service relevance under OPPS (see instructions) 3.001 1.00 1.00 There the respect of a service relevance under OPPS (see instructions) 3.001 1.00 1.00 There the respect of a service relevance on a charge basis (see instructions) 1.00 1.00 1.00 There the respect of a service relevance on a charge basis (see instructions) 1.00 | | | | | 1.00 | |
| 2.00 Hedical and other services relations of the services instructions) 18, 284, 892 2.00 4.00 Outlier pagenti (see instructions) 54, 243 4.00 5.00 Outlier pagenti (see instructions) 0.00 5.00 5.4, 243 4.00 5.00 Direct the bog tat specific pagenti fac cost ratio (see instructions) 0.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 | 1.00 | | | | 3, 501 | 1.00 |
| 4.00 Outlin' payment (see instructions) 64, 42 4.00 10 Dullin' reconciliation march (see instructions) 0.000 6.00 10 Dullin' reconciliation march (see instructions) 0.000 6.00 10 Dullin' reconciliation march (see instructions) 0.000 6.00 10 Department (see instructions) 0.00 7.00 10 Organ acquisitions 1.00 9.00 10 Organ acquisitions 1.00 9.00 10 Organ acquisitions 1.00 1.00 10 Organ acquisition therpes 1.00 1.00 1.00 11 Organ acquisition therpes 1.00 1.00 1.00 12 Organ acquisition therpes (from setters 1.00 1.00 1.00 1.00 12 Organ acquisition therpes (from setters 1.00 1.00 1.00 1.00 1.00 13 Organ acquisition therpes (from setters 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 | | | tions) | | | 2.00 |
| 4.01 Outlier reconstitution amount (see instructions) 0.04 0.45 0.00 Determine the hospital system (is give instructions) 0.00 0.00 0.00 Determine the hospital system (is give instructions) 0.00 0.00 0.00 Optimizational corridors plot, divided by line 4 0.00 0.00 0.00 0.00 Optimizational corridors (is give instructions) 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 | | | | | | |
| 5.00 Enter the hospital specific payment to cost ratio (see instructions) 0.000 5.00 7.00 Sun of lines 3, 4, and 4, 01, divided by line 6 0.00 0.00 7.00 Sun of lines 3, 4, and 4, 01, divided by line 6 0.00 0.00 0.00 Additing sortic on the pass through costs from Nest. D, Pt. IV, col. 13, line 200 0.00 0.00 0.00 Total cost (sum of lines 1 and 10) (see instructions) 0.00 0.00 1.00 Total cost (sum of lines 1 and 10) (see instructions) 0.00 0.00 1.00 Total cost (sum of lines 1 and 13) 17,243 12.00 1.00 Aggregate smout actualty coll acted from patients liable for payment for services on a charge basis 0 15.00 1.00 Aggregate smout actualty coll acted from patients liable for payment for services on a charge basis 0 15.00 1.00 Rotic of line 15 to line for to line cost over customer on the co | | | | | | |
| 7.00 Sum of lines 3, 4, and 4.01, divided by line 6 0.00 7.00 8.00 8.00 Iransh tional corridor paysent (see instructions) 0.00 8.00 9.00 Ancil lary service other pass funcuing costs from West, D. Pt. IV, col. 13, line 200 0.00 8.00 9.00 Ancil lary service other pass funcuing costs from West, D. Pt. IV, col. 13, line 200 0.00 8.00 9.00 Ancil lary service charges 1.1.0 1.1.0 1.1.0 1.1.0 1.1.0 1.1.0 1.1.0 1.1.0 1.1.0 1.1.0 1.1.0 1.1.0 1.1.0 1.1.0 1.1.0 1.1.0 1.1.0 1.1.0 1.1.0 1.1.0 1.1.0 1.1.0 1.1.0 1.1.0 1.1.0 1.1.0 1.1.0 1.1.0 1.1.0 1.1.0 1.1.0 1.1.0 1.1.0 1.1.0 1.1.0 1.1.0 1.1.0 1.1.0 1.1.0 1.1.0 1.1.0 1.1.0 1.1.0 1.1.0 1.1.0 1.1.0 1.1.0 1.1.0 1.1.0 1.1.0 1.1.0 1.1.0 1.1.0 1.1.0 1.1.0 1.1.0 1.1.0 1.1.0 1.1.0 1.1.0 1.1.0 1.1.0 <td>5.00</td> <td>Enter the hospital specific payment to cost ratio (see instrue</td> <td>ctions)</td> <td></td> <td>0.000</td> <td>5.00</td> | 5.00 | Enter the hospital specific payment to cost ratio (see instrue | ctions) | | 0.000 | 5.00 |
| 0.00 Transitional corridor payment (see instructions) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 < | | | | | - | |
| 9.00 Anciliary service other pass through costs from West. D. Pt. IV. col. 13. Line 200 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | | | | | | |
| 11.00 Torial cost (sum of lines 1 and 10) (see instructions) 3,501 11.00 OWNERSES Measonable charges 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 11.00 12.00 12.00 12.00 12.00 12.00 11.00 11.00 11.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 | | | IV, col. 13, line 200 | | 0 | |
| DOMPUTATION OF LESSER OF COST OR CHARGES 12.00 Ancillary service charges 12.01 Ancillary services 12.02 Ancounts that would have been realized from patients liable for payment for services on a chargebasis 12.01 Ancounts that would have been realized from patients 12.02 Batio of line 15 to line 16 (not to exceed) 1.000000 12.03 Batio of line 15 to line 16 (not to exceed) 1.000000 12.04 Batio of cast or clarges care may charges (complete only if line 11 exceeds line 18) (see instructions) 12.05 Descess of reasonable cast over customer customer lines 3.4.4.01 (see instructions) 12.00 Descess of reasonable cast in a teaching hospital (see instructions) 12.00 Deductiles and clansurance amounts rol ating to amount on line 24 (nor CAH, see instructions) 13.843.9464 Cost of physicians' services (rom West, E-4, line 50) 10.00 Deductiles and clansurance amounts rol ating to amount on line 24 (nor CAH, see instructions) 10 | | o i | | | - | |
| Reasonable charges Image: Comparison of Compar | 11.00 | | | | 3, 501 | 11.00 |
| 13.00 Organ acquisition chargies (com of lines 12 and 13) 0 13.00 0.00 Destinary charges (com of lines 12 and 13) 17.243 14.00 16.01 Anounts that acquid have been realized from patients Hable for payment for services on a chargebasis 0 15.00 16.02 Anounts that acquid have been realized from patients Hable for payment for services on a chargebasis 0 16.00 16.03 Anounts that acquid have been realized from patients Hable for payment for services on a chargebasis 0 16.00 16.04 Anounts that acquid have been realized from patients Hable for payment for services on a chargebasis 0 16.00 17.041 Macuts State services for a charges (see instructions) 17.243 18.00 17.041 Instructions) 13.00 17.243 14.00 10.02 Excess of reasonable cost over castomary charges (complete only if line 18 exceeds line 18) (see instructions) 13.02 10.02 11.03 Instructions) 13.02 12.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> | | | | | | |
| 14.00 Total reasonable charges (sum of lines 12 and 13) 17,243 14.00 15.00 Aggregate amount actually collected from patients liable for payment for services on a charge basis hed sup optimum is the method for patients liable for payment for services on a charge basis hed sup optimum is the method for patients liable for payment for services on a charge basis hed sup optimum is the method for patients liable for payment for services on a charge basis hed sup optimum is the method for payment for services on a charge basis hed sup optimum is the method for payment for services on a charge basis hed sup optimum is the method for payment for services on a charge basis hed sup optimum is the method for payment for services on a charge basis hed sup optimum is the method for payment for services on a charge basis hed sup optimum is the sup optimum is the sup of the services of services on a charge (see instructions) the instructions of the services in a teaching hospital (see instructions) total prospective payment (sup of lines 3, 4, 401, 8 and 9) total prospective payment (sup of lines 3, 4, 401, 8 and 9) total prospective payment (sup of lines 2 and 26) plus the sup of lines 22 and 23] (see total (sup of lines 21 and 24 mus the sup of lines 25 and 26) plus the sup of lines 22 and 23] (see total (sup of lines 27 through 29) total strate sup optimum is line 31) total (sup of lines 27 through 29) total (see instructions) total see instructions) total (see instructions) total see instructions) total see instructions) total see instructions) total see instructions) total sequential payment adjustment anount (see instructions) total (see instructions) total sequential payment adjustment anount (see instructions) total sequential payment adjustment anount (see | | | | | | |
| Customary charges Control of the program Contro of the program | | | ine 69) | | - | |
| 16.00 miounis that would have been realized from patients i lable for payment for services on a chargebasis has been made in accordance with 42 CFR \$43.13(e) 0 10.00 17.00 Ratio of line 15 to line 16 (not to exceed 1.000000) 17.00 17.00 810 of Clain customary charges (see instructions) 0.000001 17.00 19.00 Excess of reasonable cost (complete only if line 18 exceeds line 11) (see instructions) 0.20 0.00000 17.00 21.00 20.00 Instructions; services in a teaching hospital (see instructions) 0.21.00 22.00 12.842.946 24.00 21.00 Lessen of cost or charges (see instructions) 0.22.00 0.22.00 0.22.00 0.22.00 0.22.00 0.22.00 0.22.00 0.23.00 0.23.00 0.23.00 0.23.00 0.23.00 0.23.00 0.23.00 0.23.00 0.23.00 0.23.00 0.23.00 0.23.00 0.23.00 0.23.00 0.23.00 0.23.00 0.23.00 0.24.00 11.65.13.843.946 24.00 0.00.00 11.65.13.843.946 24.00 0.00.00 11.65.13.843.946 24.00 0.00.00 11.65.13.843.946 24.00 0.00.00 11.65.13.843.946 24.00 0.00.00 11.65.13.841 20.00 </td <td>11.00</td> <td></td> <td></td> <td></td> <td>17,210</td> <td>11.00</td> | 11.00 | | | | 17,210 | 11.00 |
| Ind Such payment been made in accordance with 42 CFR \$413.13(e) 0 100 Ratio of line 15 to line 16 (on to exceed 1.000000) 17.00 18:00 Ital customary charges (see instructions) 0.000000 10:00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 13) (see instructions) 0 10:00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 13) (see instructions) 0 10:00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 13) (see instructions) 0 10:00 Instructions) 3.501 21.00 10:00 Instructions) 0 22.00 10:00 Instructions) 0 22.00 10:00 Deductibles and coinsurance amounts (for CAL, see instructions) 2.25.00 10:00 Deductibles and coinsurance amounts (for CAL, see instructions) 2.285.01 10:00 Direct graduate medical education payments (from Wkst. E-4, line 50) 0 2.800 10:00 Subtotal (sum of lines 21 through 29) 11.551.814 30.00 2.980.01 10:00 Subtotal (sum of lines 21 through 29) 11.551.814 30.00 30.00 30.00 | | | | | | |
| 17.00Batic of Line 15 to Line 16 (not to exceed 1.00000)0.00000017.0018.00Total customary charges (see instructions)17.243 18.0019.00Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see17.243 18.0010.00Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see0.0010.00Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see0.0020.00Excess of reasonable cost over customary charges (see instructions)3.501 21.0021.00Instructions)3.501 21.0022.00Interns and residents (see instructions)0.22.0023.00Cost of physic lane's services in a teaching hospital (see instructions)2.25, 61.22.25, 61.22.25, 61.22.25, 61.22.25, 61.22.25, 61.22.25, 61.22.25, 61.22.25, 61.22.25, 61.22.25, 61.22.25, 61.22.25, 61.22.25, 61.22.25, 61.22.25, 61.22.25, 61.22.25, 61.22.25, 61.22.25, 61.22.25, 61.22.25, 61.22.25, 61.22.25, 61.22.25, 61.22.25, 61.22.25, 61.22.25, 61.22.25, 61.22.25, 61.22.25, 61.22.25, 61.22.25, 61.22.25, 61.22.25, 61.22.25, 61.22.25, 61.22.25, 61.22.25, 61.22.25, 61.22.25, 61.22.25, 61.22.25, 61.22.25, 61.22.25, 61.22.25, 61.22.25, 61.22.25, 61.22.25, 61.22.25, 61.22.25, 61.22.25, 61.22.25, 61.22.25, 61.22.25, 61.22.25, 61.22.25, 61.22.25, 61.22.25, 61.22.25, 61.22.25, 61.22.25, 61.22.25, 61.22.25, 61.22.25, 61.22.25, 61.22.25, 61.22.25, 61.22.25, 61.22.25, 61.22.25, 61.22.25, 61.22.25, 61.22.25, 61.22.25, 61.22.25, 61.22.25, 61.22.25, 61.22.25, 61.22.25, 61.22.25, 61.22.25, 61.22.25, 61.22.25, 61.25.2.25, 61.25.2.25, 61.25.2.25, 61.25.2.25, 61.25.2.25, 61.25.2.25, 61.25.2.25, 61.25.2.25, 61.25.2.25, 61.25.2.25, 61.25.2.25, 61.25.2.25, 61.25.2.25, 61.25.2.25, 61.25.2.25, 61.25.2 | 16.00 | | | n a chargebasis | 0 | 16.00 |
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| 38.00MSP-LCC reconciliation amount from PS&R038.0039.00OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)039.0039.50OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)039.5039.57N95 respirator payment adjustment amount (see instructions)039.5039.75N95 respirator payment adjustment amount before sequestration039.9739.97Demonstration payment adjustment amount before sequestration039.9739.99RECOVERY OF ACCELERATED DEPRECIATION039.9840.00Subtotal (see instructions)11,650,45240.0040.01Sequestration adjustment (see instructions)146.79640.0140.02Demonstration payment adjustment amount after sequestration040.0240.03Sequestration adjustment (for contractors use only)11,530,12841.0041.01Interim payments11,530,12841.0041.01Interim payments (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, st115.2043.0043.00Bal ance due provider/program (see instructions)090.0043.0143.00Der det reconciliation adjustment secont report items) in accordance with CMS Pub. 15-2, chapter 1, st115.2090.0090.00Original outlier amount (see instructions)090.0091.0091.00Outlier reconciliation adjustment amount (see instructions)091.0092.00The rate used to calculate the Time Value of Money0.0092.00 <td< td=""><td></td><td></td><td>ructions)</td><td></td><td></td><td></td></td<> | | | ructions) | | | |
| 39.00OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)039.0039.50Pioneer ACO demonstration payment adjustment (see instructions)39.5039.75N95 respirator payment adjustment amount (see instructions)039.97Demonstration payment adjustment amount before sequestration039.98Partial or full credits received from manufacturers for replaced devices (see instructions)039.99RECOVERY OF ACCELERATED DEPRECIATION040.00Subtotal (see instructions)11,650,45240.01Sequestration adjustment (see instructions)146,79640.02Demonstration payments djustment amount after sequestration041.00Interim payments11,530,12841.01Interim payments41.0142.00Tentative settlement (for contractors use only)042.0043.00Bal ance due provi der/program (see instructions)-26,47243.0043.01Bal ance due provi der/program -NARHM or CHART (for contractor use only)-26,47243.0044.00Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, of BE COMPLETED BY CONTRACTOR90.0090.00Original outlier amount (see instructions)091.0092.00The rate used to calculate the Time Value of Money0,0092.00Time Value of Money (see instructions)091.0092.00Time Value of Money (see instructions)092.0093.00Time Value of Money (see instructions)093.0093.00 </td <td></td> <td>•</td> <td></td> <td></td> <td></td> <td></td> | | • | | | | |
| 39.50Pioneer ACO demonstration payment adjustment (see instructions)39.5039.75N95 respirator payment adjustment amount (see instructions)039.75N95 respirator payment adjustment amount before sequestration039.77Demonstration payment adjustment amount before sequestration039.98Partial or full credits received from manufacturers for replaced devices (see instructions)039.99RECOVERY OF ACCELERATED DEPRECIATION000Subtotal (see instructions)001Sequestration adjustment (see instructions)002Demonstration payment adjustment amount after sequestration003Sequestration adjustment-PARHM or CHART pass-throughs11, 650, 452040.03Sequestration adjustment-PARHM or CHART pass-throughs11, 530, 128041.00Interim payments11, 530, 128041.01Interim payments (see instructions)42.00042.01Tentative settlement (for contractors use only)42.00130.00Bal ance due provi der/program (see instructions)-26, 472141.00Protested amounts (nonal owable cost report items) in accordance with CMS Pub. 15-2, chapter 1, st115.243.01142.00Tentative settlement (see instructions)0144.00St115.20155.20010.00Orliginal outlier amount (see instructions)015.20015.20015.20015.20015.20 <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td></t<> | | | | | | |
| 39. 97Demonstration payment adjustment amount before sequestration039. 9739. 98Partial or full credits received from manufacturers for replaced devices (see instructions)039. 9839. 99RECOVERY OF ACCELERATED DEPRECIATION039. 9940. 00Subtotal (see instructions)11, 650, 45240. 0040. 01Sequestration adjustment (see instructions)146, 79640. 0140. 02Demonstration payment adjustment amount after sequestration040. 0240. 03Sequestration adjustment-PARHM or CHART pass-throughs11, 530, 12841. 0041. 01Interim payments11, 530, 12841. 0142. 00Tentative settlement (for contractors use only)41. 0142. 0043. 01Balance due provider/program (see instructions)-26, 47243. 0044. 00Stil5.2To BE COMPLETED BY CONTRACTOR090. 0090. 00Original outlier amount (see instructions)090. 0091. 00Driginal outlier amount (see instructions)090. 0092. 00There used to calculate the Time Value of Money090. 0093. 00Time Value of Money (see instructions)090. 00 | | | s) | | | |
| 39. 98Partial or full credits received from manufacturers for replaced devices (see instructions)039. 9839. 99RECOVERY OF ACCELERATED DEPRECIATION039. 9940. 00Subtotal (see instructions)11, 650, 45240. 0040. 01Demonstration payment adjustment amount after sequestration146, 79640. 0140. 03Sequestration adjustment-PARHM or CHART pass-throughs111, 530, 12841. 0041. 01Interim payments41. 0141. 0141. 0142. 01Tentative settlement (for contractors use only)042. 0043. 00Bal ance due provider/program (see instructions)-26, 47243. 0043. 01Bal ance due provider/program (see instructions)-26, 47243. 0044. 00Sitis.2-26, 47243. 0070. 00Origi nal outlier amount (see instructions)090. 0090. 00Origi nal outlier amount (see instructions)091. 0092. 00The rate used to calculate the Time Value of Money092. 0093. 00Time Value of Money (see instructions)093. 00 | | | | | | |
| 39. 99RECOVERY OF ACCELERATED DEPRECIATION039. 9940. 00Subtotal (see instructions)11, 650, 45240. 0140. 01Sequestration adjustment (see instructions)146, 79640. 0140. 02Demonstration payment adjustment amount after sequestration040. 0240. 03Sequestration adjustment-PARHM or CHART pass-throughs040. 0241. 00Interim payments11, 530, 12841. 0041. 01Interim payments-PARHM or CHART41. 0142. 0042. 01Tentative settlement (for contractors use only)042. 0142. 00Balance due provider/program (see instructions)-26, 47243. 0043. 01Balance due provider/program-PARHM (see instructions)-26, 47243. 0144. 00Stits.2TO BE COMPLETED BY CONTRACTOR090. 0090. 00Original outlier amount (see instructions)090. 0091. 0092. 00The rate used to calculate the Time Value of Money00.0093. 0093. 00Time Value of Money (see instructions)093. 00 | | 1 3 3 | red devices (see instruc | tions) | | |
| 40.01Sequestration adjustment (see instructions)146,79640.0140.02Demonstration payment adjustment amount after sequestration040.0240.03Sequestration adjustment-PARHM or CHART pass-throughs11,530,12841.0041.01Interim payments11,530,12841.0042.00Tentative settlement (for contractors use only)042.0142.01Tentative settlement-PARHM or CHART (for contractor use only)42.0143.00Balance due provider/program (see instructions)-26,47243.0043.01Balance due provider/program-PARHM (see instructions)43.0144.00Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$11.5.2090.0090.00Original outlier amount (see instructions)090.0091.00Outlier reconciliation adjustment amount (see instructions)091.0092.00The rate used to calculate the Time Value of Money0.0093.0093.00Time Value of Money (see instructions)093.00 | | · · · · · · · · · · · · · · · · · · · | | | - | |
| 40.02Demonstration payment adjustment amount after sequestration40.0240.03Sequestration adjustment-PARHM or CHART pass-throughs40.0341.00Interim payments11,530,12841.01Interim payments-PARHM or CHART41.0042.00Tentative settlement (for contractors use only)42.0142.01Tentative settlement-PARHM or CHART (for contractor use only)42.0143.00Balance due provider/program (see instructions)-26,47243.01Balance due provider/program (see instructions)43.0144.00Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, s115.244.0090.00Original outlier amount (see instructions)90.0091.00Outlier reconciliation adjustment amount (see instructions)092.00The rate used to calculate the Time Value of Money0.0093.00Time Value of Money (see instructions)093.00Time Value of Money (see instructions)093.00Time Value of Money (see instructions)093.00Time Value of Money (see instructions)0 | | | | | | |
| 40.03Sequestration adjustment-PARHM or CHART pass-throughs40.0341.00Interim payments11,530,12841.01Interim payments-PARHM or CHART41.0142.00Tentative settlement (for contractors use only)42.0142.01Tentative settlement-PARHM or CHART (for contractor use only)42.0143.00Balance due provider/program (see instructions)-26,47243.01Balance due provider/program (see instructions)43.0144.00Protested amounts (nonal I owable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$115.244.0090.00Original outlier amount (see instructions)90.0091.00Outlier reconciliation adjustment amount (see instructions)90.0092.00The rate used to calculate the Time Value of Money0.0093.00Time Value of Money (see instructions)093.00Time Value of Money (see instructions)0 | | | | | | |
| 41.00Interim payments11, 530, 12841.0041.01Interim payments-PARHM or CHART41.0142.00Tentative settlement (for contractors use only)042.01Tentative settlement-PARHM or CHART (for contractor use only)42.0043.00Balance due provider/program (see instructions)-26, 47243.01Balance due provider/program-PARHM (see instructions)43.0144.00Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, S115.2070DEE COMPLETED BY CONTRACTOR090.00Original outlier amount (see instructions)091.00Outlier reconciliation adjustment amount (see instructions)092.00The rate used to calculate the Time Value of Money0.0093.00Time Value of Money (see instructions)093.00Time Value of Money (see instructions)0 | | | | | 0 | |
| 42.00Tentative settlement (for contractors use only)042.0042.01Tentative settlement-PARHM or CHART (for contractor use only)42.0143.00Balance due provider/program (see instructions)-26,47243.01Balance due provider/program-PARHM (see instructions)-26,47244.00Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,044.00Silt5.2-26,472TO BE COMPLETED BY CONTRACTOR090.00Original outlier amount (see instructions)091.00Outlier reconciliation adjustment amount (see instructions)092.00The rate used to calculate the Time Value of Money0.0093.00Time Value of Money (see instructions)093.00Time Value of Money (see instructions)0 | | | | | 11, 530, 128 | |
| 42.01Tentative settlement-PARHM or CHART (for contractor use only)42.0143.00Balance due provider/program (see instructions)-26,47243.01Balance due provider/program-PARHM (see instructions)-26,47244.00Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2070BE COMPLETED BY CONTRACTOR90.0090.00Original outlier amount (see instructions)091.00Outlier reconciliation adjustment amount (see instructions)092.00The rate used to calculate the Time Value of Money0.0093.00Time Value of Money (see instructions)093.00Time Value of Money (see instructions)0 | | | | | 0 | |
| 43.00 Balance due provider/program (see instructions) -26,472 43.00 43.01 Balance due provider/program-PARHM (see instructions) 43.01 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00 5115.2 TO BE COMPLETED BY CONTRACTOR 0 90.00 Original outlier amount (see instructions) 0 91.00 Outlier reconciliation adjustment amount (see instructions) 0 92.00 The rate used to calculate the Time Value of Money 0.00 93.00 Time Value of Money (see instructions) 0 | | | | | 0 | |
| 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 515.2 0 44.00 TO BE COMPLETED BY CONTRACTOR 0 90.00 90.00 90.00 Original outlier amount (see instructions) 0 91.00 91.00 Outlier reconciliation adjustment amount (see instructions) 0 91.00 92.00 The rate used to calculate the Time Value of Money 0.00 92.00 93.00 Time Value of Money (see instructions) 0 93.00 | 43.00 | Balance due provider/program (see instructions) | | | -26, 472 | 43.00 |
| §115.2TO BE COMPLETED BY CONTRACTOR90.00Original outlier amount (see instructions)001.0092.0092.0093.000001010203040505060707080909000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000 <td></td> <td></td> <td>and with CNC Dub 15 2</td> <td>obantar 1</td> <td></td> <td></td> | | | and with CNC Dub 15 2 | obantar 1 | | |
| TO BE COMPLETED BY CONTRACTOR90.00Original outlier amount (see instructions)090.0091.00Outlier reconciliation adjustment amount (see instructions)091.0092.00The rate used to calculate the Time Value of Money0.0092.0093.00Time Value of Money (see instructions)093.00 | 44. UU | | nce with two PUD. 15-2, | chapter I, | 0 | 44.00 |
| 91.00Outlier reconciliation adjustment amount (see instructions)091.0092.00The rate used to calculate the Time Value of Money0.0092.0093.00Time Value of Money (see instructions)093.00 | | TO BE COMPLETED BY CONTRACTOR | | | | |
| 92.00The rate used to calculate the Time Value of Money0.0092.0093.00Time Value of Money (see instructions)093.00 | | 5 · · · · · · · · · · · · · · · · · · · | | | | |
| 93.00 Time Value of Money (see instructions) 0 93.00 | | 3 , , , , , , , , , , , , , , , , | | | | |
| 94.00 Total (sum of lines 91 and 93) 0 94.00 | 93.00 | Time Value of Money (see instructions) | | | 0 | 93.00 |
| | 94.00 | lotal (sum of lines 91 and 93) | | | 0 | 94.00 |

| Health Financial Systems | u of Form CMS-2 | 2552-10 | | |
|-----------------------------------------|---------------------|----------------------------------|---------------|---------|
| CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-00 | | Worksheet E | |
| | | From 01/01/2022 To 12/31/2022 | Date/Time Pre | |
| | | | 5/29/2023 3:2 | 8 pm |
| | Title XVIII | Hospi tal | PPS | |
| | | | | |
| | | | 1.00 | |
| MEDICARE PART B ANCILLARY COSTS | | | | |
| 200.00 Part B Combined Billed Days | | | 0 | 200. 00 |

| ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | | Provider CO | CN: 15-0057 | Period: From 01/01/2022 To 12/31/2022 | Worksheet E-1 Part I Date/Time Prep 5/29/2023 3:28 | parec B pm |
|---------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------|-------------|---------------------------------------------|-------------------------------------------------------------|---------------|
| | | Title | XVIII | Hospi tal | PPS | |
| | | I npati en | t Part A | Par | tВ | |
| | | mm/dd/yyyy | Amount | mm/dd/yyyy | Amount | |
| | | 1.00 | 2.00 | 3.00 | 4.00 | |
| 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 | | 9, 813, 2 | 58 0 | 11, 399, 444 0 | 1. (2. (|
| 00 | List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider | | | | | 3. (|
| 01 | ADJUSTMENTS TO PROVIDER | 12/31/2022 | 40, 44 | 44 12/31/2022 | 130, 684 | 3.1 |
| 02 | | | | 0 | 0 | 3. |
| 03 | | | | 0 | 0 | 3. |
| 04 | | | | 0 | 0 | 3. |
| 05 | Description to Description | | | 0 | 0 | 3. |
| 50 | Provider to Program ADJUSTMENTS TO PROGRAM | | | 0 | 0 | 3. |
| 51 | | | | 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 3.50-3.98) | | 40, 44 | | 130, 684 | 3. |
| 00 | Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR | | 9, 853, 70 | 02 | 11, 530, 128 | 4. |
| 00 | List separately each tentative settlement payment after | | | | | 5. |
| 00 | desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider | | | | | 5. |
| 01 | TENTATI VE TO PROVIDER | | | 0 | 0 | 5. |
| 02 | | | | 0 | 0 | 5. |
| 03 | | | | 0 | 0 | 5. |
| | Provider to Program | | | -1 | | |
| 50 | TENTATI VE TO PROGRAM | | | 0 | 0 | 5 |
| 51 52 | | | | 0 | 0 | 5 5 |
| 99 | Subtotal (sum of lines 5.01–5.49 minus sum of lines 5.50–5.98) | | | 0 | 0 | 5 |
| 00 | Determined net settlement amount (balance due) based on the cost report. (1) | | | | | 6 |
| D1 | SETTLEMENT TO PROVIDER | | 823, 89 | 90 | 0 | 6 |
| 02 | SETTLEMENT TO PROGRAM | | | 0 | 26, 472 | 6 |
| 00 | Total Medicare program liability (see instructions) | | 10, 677, 59 | | 11, 503, 656 | 7 |
| | | | | Contractor Number | NPR Date (Mo/Day/Yr) | |
| | | (|) | 1.00 | 2.00 | |

| Heal th | Financial Systems FRANCISCAN HE | ALTH MOORESVILLE | In Lie | u of Form CMS- | 2552-10 |
|---------|---------------------------------------------------------------------|-------------------------------|----------------------------------------------|----------------|---------|
| CALCUL | ATION OF REIMBURSEMENT SETTLEMENT FOR HIT | Provider CCN: 15-0057 | Peri od: From 01/01/2022 To 12/31/2022 | | epared: |
| | | Title XVIII | Hospi tal | PPS | |
| | | | | | |
| | | | | 1.00 | |
| | TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPOR | | | | _ |
| | HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCUL | | | | _ |
| 1.00 | Total hospital discharges as defined in AARA §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, col. 6. line 2 | | | | 3.00 |
| 4.00 | Total inpatient days (see instructions) | | | | 4.00 |
| 5.00 | Total hospital charges from Wkst C, Pt. I, col. 8 line 20 | | | | 5.00 |
| 6.00 | Total hospital charity care charges from Wkst. S-10, col | | | | 6.00 |
| 7.00 | CAH only - The reasonable cost incurred for the purchase line 168 | of certified HIT technology | Wkst. S-2, Pt. I | | 7.00 |
| 8.00 | Calculation of the HIT incentive payment (see instruction | ns) | | | 8.00 |
| 9.00 | Sequestration adjustment amount (see instructions) | | | | 9.00 |
| 10.00 | Calculation of the HIT incentive payment after sequestra | tion (see instructions) | | | 10.00 |
| | INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH | | · · · · · · · · · · · · · · · · · · · | | |
| 30.00 | Initial/interim HIT payment adjustment (see instructions) |) | | | 30.00 |
| 31.00 | Other Adjustment (specify) | | | | 31.00 |
| 32.00 | Balance due provider (line 8 (or line 10) minus line 30 a | and line 31) (see instructior | ns) | | 32.00 |

| ALCUL | ATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0057 | Peri od: | Worksheet E-3 | |
|--------------|-----------------------------------------------------------------------------------------------------------------------------------|------------------------|----------------------------------|-------------------------------------------------|-------|
| | | | From 01/01/2022 To 12/31/2022 | Part VII Date/Time Pre 5/29/2023 3:23 | |
| | | Title XIX | Hospi tal | PPS | |
| | | | I npati ent | Outpati ent | |
| | | | 1.00 | 2.00 | |
| | PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERV | ICES FOR TITLES V OR 2 | XIX SERVICES | | |
| | COMPUTATION OF NET COST OF COVERED SERVICES | | | | |
| 00 | Inpatient hospital/SNF/NF services | | 0 | | 1 |
| 00 | Medical and other services | | | 0 | 2 |
| 00 | Organ acquisition (certified transplant programs only) | | 0 | | 3 |
| 00 | Subtotal (sum of lines 1, 2 and 3) | | 0 | 0 | 4 |
| 00 | Inpatient primary payer payments | | 0 | | 5 |
| 00 00 | Outpatient primary payer payments | | 0 | 0 | 6 |
| 00 | Subtotal (line 4 less sum of lines 5 and 6) COMPUTATION OF LESSER OF COST OR CHARGES | | 0 | 0 | - ' |
| | Reasonable Charges | | | | + |
| 00 | Routi ne servi ce charges | | 420, 214 | | 8 |
| 00 | Ancillary service charges | | 1, 406, 032 | 0 | |
| | Organ acquisition charges, net of revenue | | 0 | 0 | 10 |
| | Incentive from target amount computation | | 0 | | 11 |
| 2.00 | Total reasonable charges (sum of lines 8 through 11) | | 1, 826, 246 | 0 | 12 |
| | CUSTOMARY CHARGES | | | | 1 |
| 3.00 | Amount actually collected from patients liable for payment for | services on a charge | 0 | 0 | 13 |
| | basis Amounto that would have been realized from notionto lights for | normant for convious | | | 11 |
| . 00 | Amounts that would have been realized from patients liable for a charge basis had such payment been made in accordance with 42 | | on 0 | 0 | 14 |
| 5. 00 | Ratio of line 13 to line 14 (not to exceed 1.000000) | CIR 9413. 13(e) | 0.000000 | 0,000000 | 15 |
| | Total customary charges (see instructions) | | 1, 826, 246 | 0.000000 | 16 |
| 7.00 | Excess of customary charges over reasonable cost (complete only | if line 16 exceeds | 1, 826, 246 | 0 | |
| | line 4) (see instructions) | | 1, 020, 210 | | ., |
| 3. 00 | Excess of reasonable cost over customary charges (complete only | if line 4 exceeds lin | ne 0 | 0 | 18 |
| | 16) (see instructions) | | | | |
| 9.00 | Interns and Residents (see instructions) | | 0 | 0 | 19 |
| | Cost of physicians' services in a teaching hospital (see instru | | 0 | 0 | |
| I. 00 | Cost of covered services (enter the lesser of line 4 or line 16 | | 0 | 0 | 21 |
| | PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be c | ompleted for PPS provi | | | 4 |
| | Other than outlier payments | | 606, 067 | 0 | |
| | Outlier payments | | 0 | 0 | |
| 1.00 | Program capital payments | | 0 | | 24 |
| 5.00 | Capital exception payments (see instructions) | | 0 | 0 | 25 |
| | Routine and Ancillary service other pass through costs Subtotal (sum of lines 22 through 26) | | 606, 067 | 0 | 26 |
| | Customary charges (title V or XIX PPS covered services only) | | 000,007 | 0 | |
| | Titles V or XIX (sum of lines 21 and 27) | | 606, 067 | 0 | |
| . 00 | COMPUTATION OF REIMBURSEMENT SETTLEMENT | | 000,007 | | 1 - 1 |
| 0. 00 | Excess of reasonable cost (from line 18) | | 0 | 0 | 30 |
| | Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) | | 606, 067 | 0 | 31 |
| 2.00 | Deducti bl es | | 6, 170 | 0 | 32 |
| . 00 | Coinsurance | | 5, 483 | 0 | 33 |
| . 00 | Allowable bad debts (see instructions) | | 0 | 0 | 34 |
| 5.00 | Utilization review | | 0 | | 35 |
| 5.00 | Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and | 33) | 594, 414 | 0 | 36 |
| | OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) | | 0 | 0 | |
| | Subtotal (line 36 ± line 37) | | 594, 414 | 0 | |
| | Direct graduate medical education payments (from Wkst. E-4) | | 0 | | 39 |
|). 00 | Total amount payable to the provider (sum of lines 38 and 39) | | 594, 414 | 0 | 40 |
| I. 00 | Interim payments | | 594, 414 | 0 | 41 |
| | Balance due provider/program (line 40 minus line 41) | | 0 | 0 | 42 |
| 2.00 3.00 | Protested amounts (nonallowable cost report items) in accordance | | 0 | 0 | 43 |

| Health Financial Systems FRANCISCAN HEALTH MOORESVILLE In Lieu | | | | | | 552-10 |
|--------------------------------------------------------------------------------|--------------------------------------------|---------------------|--------------------------|----------------------------------|----------------------------------|----------------|
| OUTLIER F | Worksheet E-5 | | | | | |
| | | | | From 01/01/2022 To 12/31/2022 | Date/Time Prep 5/29/2023 3:28 | bared: 3 pm |
| Title XVIII | | | | | | |
| | | | | | | |
| | | | | | 1.00 | |
| ТО |) BE COMPLETED BY CONTRACTOR | | | | | |
| 1.00 Op | perating outlier amount from Wkst. E, Pt. | A, line 2, or sum o | of 2.03 plus 2.04 (see i | nstructions) | 0 | 1.00 |
| 2.00 Ca | apital outlier from Wkst. L, Pt. I, line 2 | | | | 0 | 2.00 |
| 3.00 Operating outlier reconciliation adjustment amount (see instructions) | | | | | 0 | 3.00 |
| 4.00 Capital outlier reconciliation adjustment amount (see instructions) | | | 0 | 4.00 | | |
| 5.00 The rate used to calculate the time value of money (see instructions) | | | 0.00 | 5.00 | | |
| 6.00 Time value of money for operating expenses (see instructions) | | | 0 | 6.00 | | |
| 7.00 Time value of money for capital related expenses (see instructions) | | | | 0 | 7.00 | |
| | | | | | | |

| | Systems FRANCI SCAN HEAL f you are nonproprietary and do not maintain | Provider C | | Period: | u of Form CMS-2 Worksheet G | |
|------------------------------|-------------------------------------------------------------------------------------------------|----------------------------|--------------------------|----------------------------------|--------------------------------|-------------|
| nd-type accoun ly) | ting records, complete the General Fund column | | | From 01/01/2022 To 12/31/2022 | | epar |
| | | General Fund | Specific Purpose Fund | Endowment Fund | 5/29/2023 3:2 Plant Fund | <u>28 p</u> |
| | | 1.00 | 2.00 | 3.00 | 4.00 | |
| CURRENT AS | | - | 1 | | | |
| | and in banks | 19, 637, 184 | | 0 0 | 0 | |
| | investments | 0 | | 0 0 | 0 | |
| 00 Notes rec | | 0 | | 0 0 | 0 | |
| | recei vabl e | 79, 738, 179 | | 0 0 | 0 | |
| 00 Other rec | | 597, 537 | | 0 0 | 0 | |
| | s for uncollectible notes and accounts receivable | -58, 517, 697 | | 0 0 | 0 | |
| 00 Inventory 00 Prepaid e | | 3, 312, 791 | | 0 0 | 0 | |
| | rent assets | 53, 991 | | 0 0 | 0 | |
| | other funds | | | 0 0 | 0 | |
| | | 44 001 005 | | 0 0 | 0 | |
| FI XED ASSE | rent assets (sum of lines 1-10) | 44, 821, 985 | 2 | 0 0 | 0 | 4 ' |
| 00 Land | 15 | 922, 177 | , | 0 0 | 0 | 1: |
| .00 Land impr | ovements | 2, 764, 457 | | 0 0 | 0 | |
| | ed depreciation | -1, 891, 153 | | 0 0 | 0 | |
| 00 Bui I di ngs | | 74, 840, 399 | | | 0 | |
| 5 | ed depreciation | -30, 632, 539 | | 0 0 | 0 | |
| | improvements | 2, 854, 691 | | 0 0 | 0 | |
| | ed depreciation | -2, 093, 602 | | 0 0 | 0 | |
| . 00 Fixed equ | | 2,070,002 | | 0 0 | 0 | |
| | ed depreciation | 0 | | 0 0 | 0 | |
| | es and trucks | 0 | | 0 0 | 0 | |
| | ed depreciation | 0 | | 0 0 | 0 | |
| | able equipment | 91, 573, 514 | | 0 0 | 0 | |
| | ed depreciation | -43, 402, 917 | , | 0 0 | 0 | |
| | ipment depreciable | C | | 0 0 | 0 | 2 |
| | ed depreciation | C | | 0 0 | 0 | 20 |
| | nated Assets | C | | 0 0 | 0 | 2 |
| . 00 Accumul at | ed depreciation | C | | 0 0 | 0 | 28 |
| .00 Minor equ | ipment-nondepreciable | C | | 0 0 | 0 | 2 |
| .00 Total fix | ed assets (sum of lines 12-29) | 94, 935, 027 | r | 0 0 | 0 | 30 |
| OTHER ASSE | TS | | | | | |
| .00 Investmen | ts | 2, 534, 311 | | 0 0 | 0 | 3 |
| .00 Deposits | on Leases | C |) | 0 0 | 0 | 32 |
| .00 Due from | owners/officers | C |) | 0 0 | 0 | 33 |
| .00 Other ass | ets | 45, 640 | | 0 0 | 0 | 34 |
| .00 Total oth | er assets (sum of lines 31-34) | 2, 579, 951 | | 0 0 | 0 | 3! |
| | ets (sum of lines 11, 30, and 35) | 142, 336, 963 | 6 | 0 0 | 0 | 30 |
| | ABILITIES | | | | | |
| .00 Accounts | | 10, 701, 261 | | 0 0 | 0 | |
| | wages, and fees payable | 1, 968, 461 | | 0 0 | 0 | 1 - |
| | axes payable | 350, 710 | | 0 0 | 0 | |
| | loans payable (short term) | 0 | | 0 0 | 0 | |
| .00 Deferred | | C | | 0 0 | 0 | |
| | ed payments | 0 | | | | 42 |
| . 00 Due to ot | | | | 0 0 | 0 | |
| | rent liabilities | 447, 957 | | 0 0 | 0 | |
| | rent liabilities (sum of lines 37 thru 44) | 13, 468, 389 | 1 | 0 0 | 0 | 4 |
| | LI ABI LI TI ES | | J | | | |
| .00 Mortgage | | | | 0 0 | 0 | |
| . 00 Notes pay | | | | 0 0 | 0 | |
| . 00 Unsecured | | 182,082 | | 0 0 | 0 | |
| | g term liabilities g term liabilities (sum of lines 46 thru 49) | 1, 255, 466 1, 437, 548 | | 0 0 | 0 | |
| | bilities (sum of lines 45 and 50) | 1, 437, 548 | | 0 0 | | |
| CAPITAL AC | | 14, 700, 937 | L | <u> </u> | 0 | |
| | und bal ance | 127, 431, 026 | J | | | 5 |
| | purpose fund | 121, 431, 020 | | 0 | | 5 |
| | ated - endowment fund balance - restricted | | | <u></u> | | 54 |
| | ated - endowment fund balance - restricted | | | 0 | | 5! |
| | body created - endowment fund balance | | | 0 | | 50 |
| 0 | d balance - invested in plant | | | 0 | 0 | |
| | d balance - reserve for plant improvement, | | | | 0 | |
| | nt, and expansion | | | | | |
| | d balances (sum of lines 52 thru 58) | 127, 431, 026 | | 0 0 | 0 | 5 |
| | bilities and fund balances (sum of lines 51 and | 142, 336, 963 | | | 0 | |
| | Sin tres and rand barances (sum of times of and | 172, 330, 703 | T | - U | 0 | 1 00 |

| Heal th | Financial Systems F | RANCI SCAN HEALT | H MOORESVILLE | | In Lie | eu of Form CMS-2 | 2552-10 |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|-----------------------------------------------------------------|----------|---------------------------------------------|-------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| | ENT OF CHANGES IN FUND BALANCES | | Provider CC | | Period: From 01/01/2022 To 12/31/2022 | Worksheet G-1 Date/Time Pre 5/29/2023 3:2 | pared: |
| | | General | Fund | Speci al | Purpose Fund | Endowment Fund | |
| | | 1.00 | 0.00 | 0.00 | 4.00 | 5.00 | |
| 1.00 | Fund balances at beginning of period | 1.00 | 2.00 75,869,132 | 3.00 | 4.00 | 5.00 | 1.00 |
| $\begin{array}{c} 2. \ 00\\ 3. \ 00\\ 4. \ 00\\ 5. \ 00\\ 6. \ 00\\ 7. \ 00\\ 8. \ 00\\ 9. \ 00\\ 10. \ 00\\ 11. \ 00\\ 12. \ 00\\ 13. \ 00\\ 14. \ 00\\ 15. \ 00\\ 16. \ 00\\ 17. \ 00\\ \end{array}$ | Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) RECONCILIATION Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Total deductions (sum of lines 12-17) | 0 374,002 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | 51, 187, 893 127, 057, 025 374, 002 127, 431, 027 0 | | | | $\begin{array}{c} 2. \ 00\\ 3. \ 00\\ 4. \ 00\\ 5. \ 00\\ 6. \ 00\\ 7. \ 00\\ 8. \ 00\\ 9. \ 00\\ 10. \ 00\\ 11. \ 00\\ 12. \ 00\\ 13. \ 00\\ 14. \ 00\\ 15. \ 00\\ 16. \ 00\\ 17. \ 00\\ 18. \ 00\\ \end{array}$ |
| | Fund balance at end of period per balance sheet (line 11 minus line 18) | | 127, 431, 027 | | C |) | 19.00 |
| | | Endowment Fund | PI ant | Fund | | | |
| | | 6.00 | 7.00 | 8.00 | | | |
| 2.00 3.00 4.00 | Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) RECONCILIATION | 0 | 0 0 0 0 0 | | 0 | | 1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 |
| 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00 | Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18) | 0 0 0 0 | 0 0 0 0 0 0 | | 0 0 0 0 | | 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00 |

| STATE | Financial Systems FRANCISCAN HEALTH | Provider CO | N. 15 0057 | Peri od: | u of Form CMS-2 Worksheet G-2 | |
|------------------|---------------------------------------------------------------|-------------|-------------|----------------------------------|----------------------------------|--------|
| STATE | IENT OF PATTENT REVENUES AND UPERATING EXPENSES | | JN. 13-005/ | From 01/01/2022 To 12/31/2022 | Parts I & II | 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 | | 16, 880, 5 | 28 | 16, 880, 528 | 1.00 |
| 2.00 | SUBPROVIDER - IPF | | | | | 2.00 |
| 3.00 | SUBPROVIDER - IRF | | | | | 3.00 |
| 4.00 | SUBPROVI DER | | | 0 | 0 | 4.00 |
| 5.00 6.00 | Swing bed - SNF Swing bed - NF | | | 0 | 0 | 5.00 |
| 7.00 | SKILLED NURSING FACILITY | | | 0 | 0 | 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) | | 16, 880, 5 | 28 | 16, 880, 528 | |
| | Intensive Care Type Inpatient Hospital Services | | | = -1 | | 1 |
| 11.00 | INTENSIVE CARE UNIT | | | | | 11.00 |
| 12.00 | CORONARY CARE UNI T | | | | | 12.00 |
| 13.00 | BURN INTENSIVE CARE UNIT | | | | | 13.00 |
| 14.00 | SURGI CAL I NTENSI VE CARE UNI T | | 5, 870, 9 | 00 | 5, 870, 900 | 14.00 |
| 15.00 | OTHER SPECIAL CARE (SPECIFY) | | | | | 15.00 |
| 16.00 | Total intensive care type inpatient hospital services (sum of | °lines | 5, 870, 9 | 00 | 5, 870, 900 | 16.00 |
| | 11-15) | | | | | |
| 17.00 | Total inpatient routine care services (sum of lines 10 and 16 |) | 22, 751, 4 | | 22, 751, 428 | |
| 18.00 | Ancillary services | | 84, 796, 5 | | 441, 266, 168 | |
| 19.00 20.00 | Outpatient services RURAL HEALTH CLINIC | | 14, 007, 8 | 89 107, 909, 598 0 0 | 121, 917, 487 0 | |
| 20.00 | FEDERALLY QUALIFIED HEALTH CENTER | | | 0 0 | | • |
| 21.00 | HOME HEALTH AGENCY | | | 0 | 0 | 21.00 |
| 23.00 | AMBULANCE SERVICES | | | | | 23.00 |
| 24.00 | CMHC | | | | | 24.00 |
| 25.00 | AMBULATORY SURGICAL CENTER (D. P.) | | | | | 25.00 |
| 26.00 | HOSPI CE | | | | | 26.00 |
| 27.00 | OTHER REVENUE | | 89, 8 | 22 48, 217, 057 | 48, 306, 879 | 27.00 |
| 28.00 | Total patient revenues (sum of lines 17-27)(transfer column 3 | 3 to Wkst. | 121, 645, 7 | 34 512, 596, 228 | 634, 241, 962 | 28.00 |
| | G-3, line 1) | | | | | |
| ~~ ~~ | PART II - OPERATING EXPENSES | | | | | |
| 29.00 | Operating expenses (per Wkst. A, column 3, line 200) | | | 111, 933, 163 | | 29.00 |
| 30. 00 31. 00 | ADD (SPECIFY) | | | 0 | | 30.00 |
| 31.00 | | | | 0 | | 31.00 |
| 32.00 | | | | 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 |
| 38.00 | | | | 0 | | 38.00 |
| 39.00 | | | | 0 | | 39.00 |
| 40.00 | | | | 0 | | 40.00 |
| 41.00 | | | | 0 | | 41.00 |
| 42.00 | Total deductions (sum of lines 37-41) | | | 0 | | 42.00 |
| 43.00 | Total operating expenses (sum of lines 29 and 36 minus line 4 | 2)(transfer | | 111, 933, 163 | | 43.00 |
| | to Wkst. G-3, line 4) | | | | | |

| | Financial Systems FRANCISCAN HEALTH | | | u of Form CMS-2 | |
|--------|---------------------------------------------------------------|-----------------------|----------------------------------|-----------------|-------|
| STATEM | ENT OF REVENUES AND EXPENSES | Provider CCN: 15-0057 | Peri od: | Worksheet G-3 | |
| | | | From 01/01/2022 To 12/31/2022 | Date/Time Pre | nared |
| | | | 10 12/31/2022 | 5/29/2023 3:2 | |
| | | | | | |
| | | | | 1.00 | |
| 1.00 | Total patient revenues (from Wkst. G-2, Part I, column 3, lin | | | 634, 241, 962 | |
| 2.00 | Less contractual allowances and discounts on patients' accoun | ts | | 481, 667, 683 | |
| 3.00 | Net patient revenues (line 1 minus line 2) | | | 152, 574, 279 | |
| 4.00 | Less total operating expenses (from Wkst. G-2, Part II, line | 43) | | 111, 933, 163 | |
| 5.00 | Net income from service to patients (line 3 minus line 4) | | | 40, 641, 116 | 5.00 |
| | OTHER INCOME | | | | |
| 6.00 | Contributions, donations, bequests, etc | | | 45, 156 | |
| 7.00 | Income from investments | | | 4, 198, 167 | |
| 8.00 | Revenues from telephone and other miscellaneous communication | servi ces | | 0 | |
| 9.00 | Revenue from television and radio service | | | 0 | |
| 10.00 | Purchase di scounts | | | 0 | |
| | Rebates and refunds of expenses | | | 417, 410 | |
| | Parking lot receipts | | | 0 | |
| | Revenue from Laundry and Linen service | | | 0 | |
| | Revenue from meals sold to employees and guests | | | 261, 058 | 14.00 |
| | Revenue from rental of living quarters | | | 0 | 15.00 |
| | Revenue from sale of medical and surgical supplies to other t | han patients | | 0 | 16.00 |
| | 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 | | | 8, 467 | 21.00 |
| 22.00 | Rental of hospital space | | | 1, 698, 753 | 22.00 |
| 23.00 | Governmental appropriations | | | 0 | 23.00 |
| 24.00 | OTHER OPERATING REVENUE | | | 3, 917, 766 | 24.00 |
| 24.01 | OTHER (SPECIFY) | | | 0 | 24.01 |
| 24.02 | OTHER (SPECIFY) | | | 0 | 24.02 |
| | COVI D-19 PHE Funding | | | 0 | 24.50 |
| 25.00 | Total other income (sum of lines 6-24) | | | 10, 546, 777 | 25.00 |
| 26.00 | Total (line 5 plus line 25) | | | 51, 187, 893 | |
| 27.00 | OTHER EXPENSES (SPECIFY) | | | 0 | |
| | Total other expenses (sum of line 27 and subscripts) | | | 0 | 28.00 |
| | Net income (or loss) for the period (line 26 minus line 28) | | | 51, 187, 893 | 29 00 |

| Health Financial Systems FRANCISCAN HEAL | TH MOORESVILLE | In Lieu of Form CMS-2552-10 | | | |
|------------------------------------------|-----------------------|---------------------------------------------|--------------------------------------------------------------|---------------|--|
| CALCULATION OF CAPITAL PAYMENT | Provider CCN: 15-0057 | Period: From 01/01/2022 To 12/31/2022 | Worksheet L Parts I-III Date/Time Pre 5/29/2023 3:2 | | |
| | Title XVIII | Hospi tal | PPS | <u>o piii</u> | |

| | | | | 5/29/2023 3:2 | 8 pm |
|-------|-------------------------------------------------------------------------------------------------------------------------------|--------------------------|-----------------|---------------|-------|
| | | Title XVIII | Hospi tal | PPS | |
| | | | | | |
| | · · · · · · · · · · · · · · · · · · · | | | 1.00 | |
| | PART I - FULLY PROSPECTIVE METHOD | | | | |
| | CAPITAL FEDERAL AMOUNT | | | | |
| | Capital DRG other than outlier | | | 587, 166 | 1.00 |
| | Model 4 BPCI Capital DRG other than outlier | | | 0 | 1.01 |
| | Capital DRG outlier payments | | | 9, 270 | 2.00 |
| | Model 4 BPCI Capital DRG outlier payments | | | 0 | 2.01 |
| | Total inpatient days divided by number of days in the cost rep | porting period (see inst | ructions) | 20.80 | 3.00 |
| | Number of interns & residents (see instructions) | | | 0.00 | 4.00 |
| | Indirect medical education percentage (see instructions) | | | 0.00 | 5.00 |
| | Indirect medical education adjustment (multiply line 5 by the | sum of lines 1 and 1.01 | , columns 1 and | 0 | 6.00 |
| | 1.01)(see instructions) Percentage of SSI recipient patient days to Medicare Part A pa | tiont dave (Warkshoot F | part A lina | 0, 00 | 7.00 |
| 7.00 | 30) (see instructions) | trient days (worksheet L | , part A THE | 0.00 | 7.00 |
| 8.00 | Percentage of Medicaid patient days to total days (see instruc | tions) | | 0.00 | 8.00 |
| | Sum of lines 7 and 8 | | | 0.00 | |
| | Allowable disproportionate share percentage (see instructions) | | | 0.00 | |
| | Disproportionate share adjustment (see instructions) | | | 0.00 | 11.00 |
| | Total prospective capital payments (see instructions) | | | 596, 436 | |
| | | | | | |
| | PART II - PAYMENT UNDER REASONABLE COST | | | 1.00 | |
| | Program inpatient routine capital cost (see instructions) | | | 0 | 1.00 |
| | Program inpatient ancillary capital cost (see instructions) | | | 0 | 2.00 |
| | Total inpatient program capital cost (line 1 plus line 2) | | | 0 | 3.00 |
| | Capital cost payment factor (see instructions) | | | 0 | 4.00 |
| | Total inpatient program capital cost (line 3 x line 4) | | | 0 | 5.00 |
| 5.00 | | | | 0 | 5.00 |
| | | | | 1.00 | |
| | PART III - COMPUTATION OF EXCEPTION PAYMENTS | | | | |
| | Program inpatient capital costs (see instructions) | | | 0 | 1.00 |
| | Program inpatient capital costs for extraordinary circumstance | es (see instructions) | | 0 | 2.00 |
| | Net program inpatient capital costs (line 1 minus line 2) | | | 0 | 3.00 |
| | Applicable exception percentage (see instructions) | | | 0.00 | 4.00 |
| | Capital cost for comparison to payments (line 3 x line 4) | | | 0 | 5.00 |
| | Percentage adjustment for extraordinary circumstances (see ins | | | 0.00 | 6.00 |
| | Adjustment to capital minimum payment level for extraordinary | circumstances (line 2 x | line 6) | 0 | 7.00 |
| | Capital minimum payment level (line 5 plus line 7) | | | 0 | 8.00 |
| | Current year capital payments (from Part I, line 12, as applic | | | 0 | 9.00 |
| | Current year comparison of capital minimum payment level to ca | | | 0 | 10.00 |
| | Carryover of accumulated capital minimum payment level over ca | apital payment (from pri | or year | 0 | 11.00 |
| 1 | Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital payments (line 10 plus line 11) | | | 0 | 12.00 |
| | Current year exception payment (if line 12 is positive, enter | | | 0 | 13.00 |
| | Carryover of accumulated capital minimum payment level over ca | | | 0 | 14.00 |
| 15 00 | (if line 12 is negative, enter the amount on this line) | | | | 15 00 |
| | Current year allowable operating and capital payment (see inst | ructions) | | 0 | 15.00 |
| | Current year operating and capital costs (see instructions) | | | 0 | 16.00 |
| | Current year exception offset amount (see instructions) | | | I () | 17.00 |