EXPIRES 05-31-2019
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION Provider CCN: 15-0172 Period: Worksheet S From 01/01/2018 To 12/31/2018 Date/Time Prepared: From 01/01/2018 Prepa

|                        |  |   |                       | To 12/31/2018  | Date/lime Pr<br>5/30/2019 5: |          |
|------------------------|--|---|-----------------------|--|------------------------------|----------|
| PART I - COST          | REPORT STATUS  |   |                       |  |                              |          |
| Provi der<br>use only  | 1. [ X ] Electronically filed cost<br>2. [ ] Manually submitted cost r   | • |                       | Date: 5/30/20  | 19 Time:                     | 5: 24 pr |
|                        | 3. [ 0 ] If this is an amended rep<br>4. [ F ] Medicare Utilization. Ent |   |                       | esubmitted this co   | ost report                   |          |
| Contractor<br>use only | (1) Ås Submitted 7. Co<br>(2) Settled without Audit 8.[                  |   | this Provider CCN 12. | NPR Date:<br>Contractor's Vendo<br>[ O ]If line 5, co<br>number of tim | olumn 1 is 4:                |          |

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by PHYSICIANS MEDICAL CENTER (15-0172) for the cost reporting period beginning 01/01/2018 and ending 12/31/2018 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

[ X ]I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification statement to be the legally binding equivalent of my original signature.

(Signed) DENNIS MEDLEY
Officer or Administrator of Provider(s)

CEO
Title

|                         |                               |         | Title XVIII |           |       |           |        |
|-------------------------|-------------------------------|---------|-------------|-----------|-------|-----------|--------|
| Cost Center Description |                               | Title V | Part A      | Part B    | HI T  | Title XIX |        |
|                         |                               | 1.00    | 2. 00       | 3. 00     | 4. 00 | 5. 00     |        |
|                         | PART III - SETTLEMENT SUMMARY |         |             |           |       |           |        |
| 1.00                    | Hospi tal                     | 0       | 0           | -105, 485 | 0     | -605, 755 | 1.00   |
| 2.00                    | Subprovi der - IPF            | 0       | 0           | 0         |       | 0         | 2.00   |
| 3.00                    | Subprovi der - I RF           | 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       | 0           | -105, 485 | 0     | -605, 755 | 200.00 |

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

Health Financial Systems PHYSICIANS MEDICAL CENTER In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0172 Peri od: Worksheet S-2 From 01/01/2018 Part I 12/31/2018 Date/Time Prepared: 5/30/2019 5:24 pm 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 4023 REES LANE 1.00 PO Box: 1.00 State: IN Zi p Code: 47150 2.00 City: NEW ALBANY County: FLOYD 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, O, or N)
V XVIII XIX Certi fi ed Number Number Type 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 Hospi tal PHYSICIANS MEDICAL 150172 31140 10/30/2008 3.00 CENTER Subprovi der - IPF 4.00 4 00 5.00 Subprovider - IRF 5.00 6.00 Subprovi der - (Other) 6.00 Swing Beds - SNF 7 00 7 00 Swing Beds - NF 8.00 8.00 9.00 Hospi tal -Based SNF 9.00 Hospi tal -Based NF 10.00 10.00 11.00 Hospi tal -Based OLTC 11.00 12.00 Hospi tal -Based HHA 12.00 Separately Certified ASC 13.00 13.00 14.00 Hospi tal -Based Hospi ce 14.00 Hospital -Based Health Clinic - RHC 15.00 15 00 16.00 Hospital-Based Health Clinic - FQHC 16.00 Hospital-Based (CMHC) I 17.00 17.00 17. 10 Hospi tal -Based (CORF) I 17. 10 18.00 Renal Dialysis 18.00 19.00 Other 19.00 From: To: 1.00 2.00 20.00 Cost Reporting Period (mm/dd/yyyy) 20.00 01/01/2018 12/31/2018 21.00 Type of Control (see instructions) 21.00 1. 00 2. 00 3.00 Inpatient PPS Information Does this facility qualify and is it currently receiving payments for N 22. 00 22.00 disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim uncompensated care payments for this 22. 01 N Ν cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1.

Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Is this a newly merged hospital that requires final uncompensated care Ν Ν 22.02 payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1 22.03 Did this hospital receive a geographic reclassification from urban to Ν Ν N 22.03 rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for 23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 Ν 23.00 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.

| roportring portion. The condition 2, critical in the year of   |            |            |            |            |            |            |        |
|--|------------|------------|------------|------------|------------|------------|--------|
|  | In-State   | In-State   | Out-of     | Out-of     | Medi cai d | 0ther      |        |
|  | Medi cai d | Medi cai d | State      | State      | HMO days   | Medi cai d |        |
|  | paid days  | eligible   | Medi cai d | Medi cai d |            | days       |        |
|  |            | unpai d    | paid days  | eligible   |            |            |        |
|  |            | days       |            | unpai d    |            |            |        |
|  | 1.00       | 2. 00      | 3. 00      | 4. 00      | 5. 00      | 6.00       |        |
| 24.00 If this provider is an IPPS hospital, enter the 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. | 0          | 0          | 0          | 0          | 0          | 0          | 24. 00 |

| Percent   Perc   | Health Financial Systems PHYSICI   | ANS MEDICAL  | _ CENTER                                      |                                |   | In Lie  | eu of F                | orm CMS-2                 | 2552-10                    |
|--|--|--|---|--------------------------------|---|---------|------------------------|---------------------------|----------------------------|
| Medical didays   Medi   |  |  |   |                                | From 01/0<br>To 12/3                    | 31/2018 | Part<br>Date/<br>5/30/ | I<br>Time Pre<br>2019 5:2 | pared:                     |
| 25.00   If this provider is an IRF, enter the in-state   Medical of paid days in column 2, the in-state   Medical of paid days in column 3, the in-state   Medical of eligible unpaid days in column 3.   Medical of eligible unpaid days in column 4. Medical of   Medical of eligible unpaid days in column 4. Medical of eligible unpaid days in column 5.     Interpretation of eligible unpaid days in column 4. Medical of eligible unpaid days in column 5.   |  | Medicaid<br>paid days                                | Medi cai d<br>el i gi bl e<br>unpai d<br>days | State<br>Medicaid<br>paid days | State<br>Medicaid<br>eligible<br>unpaid | HMO d   | ays M                  | edi cai d<br>days         |                            |
| Medicaid paid days in column 3, out-in-state Medicaid paid flight unpaid days in column 3, out-of-state Medicaid days in column 3, out-of-state Medicaid days in column 3, out-of-state Medicaid by the paid days in column 3, out-of-state Medicaid by the paid and eligible but unpaid days in column 5, out-of-state Medicaid by the paid and eligible but unpaid days in column 5, out-of-state Medicaid by the paid and eligible but unpaid days in column 5, out-of-state Medicaid by the paid and eligible but unpaid days in column 1. "If for unpaid column 1 and the paid of the cost reporting period. Enter "I" for unpaid column 1 and paid the end of the cost center the effective date of the geographic reclassification in column 2.  30.00 In this is a sole community hospital (SGN), enter the number of periods SGH status in effective the effective dependent hospital (SGN), enter the number of periods SGH status in effective the cost reporting period.  30.00 In this is a Medicare dependent hospital (MBH), enter the number of periods INDH status in excess of one and enter subsequent dates.  31.00 If this is a Medicare dependent hospital (MBH), enter the number of periods INDH status in excess of one and enter subsequent dates.  32.01 If this is a Medicare dependent hospital payment adjustment for Low volume hospitals in accordance with IV 2016 GMPS final rule? inter "I' for yes or "N" for no. (see Instructions).  33.00 If Tiles 31 is 1, enter the beginning and ending dates of MBH status. If I line 31 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.  34.00 Does this facility quality for the inpatient hospital payment adjustment for Low volume hospitals in accordance with IV 2016 GMPS final rule? inter "I' for yes or "N" for no. (see Instructions).  40.00 Is this hospital subject to the RAC program reduction adjustment? Enter "Y" for yes or "N" for no. In column 1, for discharges prior to october 1, Enter "Y" for yes or "N" for no. N N N N A 6.00 Is this facility decided | 25 00 lf this provider is an IPE enter the in-state  | +  |   |                                |   |         |                        | 6. 00                     | 25.00                      |
| 26.00   Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "I" for urban or "2" for rural.   26.00   27.00   | Medicaid paid days in column 1, the in-state<br>Medicaid eligible unpaid days in column 2,<br>out-of-state Medicaid days in column 3, out-of-state<br>Medicaid eligible unpaid days in column 4, Medicaid  |  | 0   | J                              |   |         |                        |                           | 23.00                      |
| 26.00 Enter your standard geographic classification (not wage) status at the beginning of the cost proporting period. Enter "I" for urban or "2" for rural. If applicable, enter the effective date of the geographic classification (not wage) status at the end of the cost proporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.  35.00 If this is a solic community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period. Enter in column 2.  36.00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods MDH status in proposed in excess of one and enter subsequent dates.  37.00 If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period. If the sis a many in the period in excess of one and enter subsequent dates.  38.00 If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is organized than 1, subscript this line for the number of periods MDH status. If line 37 is organized than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.  47.70 If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is organized than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.  47.70 If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is organized than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.  47.70 If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is organized than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.  47.70 If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is organized than 1, subscript this line for the number of periods in excess of one and enter subsequent dates |  |  |   |                                |   |         |                        |                           |                            |
|  | cost reporting period. Enter "1" for urban or "2" fo 27.00 Enter your standard geographic classification (not working period. Enter in column 1, "1" for urban of enter the effective date of the geographic reclassification (SCH), enter the standard geographic geographic reclassification (SCH), enter the standard geographic geographi | r rural.<br>age) status<br>r "2" for r<br>ication in | at the end<br>ural. If ap<br>column 2.        | d of the cospolicable,         | he<br>t                                 |         | 1                      |                           | 26. 00<br>27. 00<br>35. 00 |
| 36.00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.  37.00 If this is a Medicare dependent hospit al (MDN), enter the number of periods MDH status is in effect in the cost reporting period.  37.00 If this is a Medicare dependent hospit al (MDN), enter the number of periods MDH status is in effect in the cost reporting period.  37.01 Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see Instructions)  38.00 If I in 37 is 1, enter the beginning and ending dates of MDH status. If I line 37 is greater than 1, subscript this I line for the number of periods in excess of one and enter subsequent dates.  40.00 Dest this Facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR 8412.016(b) (2) (1), (11), or (11)? Enter in column 2 v" for yes or "N" for no. (see Instructions)  40.00 Is this hospital subject to the MAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "V" for yes or "N" for no in column 2, for discharges prior to October 1. Enter "V" for yes or "N" for no in column 2, for discharges prior to October 1. Enter "V" for yes or "N" for no in column 2, for discharges prior to October 1. Enter "V" for yes or "N" for no in column 2, for discharges prior to October 1. Enter "V" for yes or "N" for no in column 2, for discharges prior to October 1. Enter "V" for yes or "N" for no in column 2 visual payment exception for extraordinary circumstances N N N N N N N N N N N N N N N N N N N  | effect in the cost reporting period.   |  |   |                                | Dogin                                   | ni na.  | Го                     | di na.                    |                            |
| 36.00 Enter applicable beginning and ending dates of SOI status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.  37.00 If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status of is in effect in the cost reporting period.  37.01 Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)  38.00 If fine 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.    Y/N   |  |  |   |                                |   |         |                        |                           |                            |
| 37.00   Fithis is a Medicare dependent hospital (MDH), enter the number of periods MDH status   0  |  |  | cript line                                    | 36 for numb                    | er                                      |         |                        |                           | 36. 00                     |
| is in effect in the cost reporting period.  37.01 is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)  38.00 If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.  Y/N Y/N  39.00 Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR \$412.101(b)(2)(1), (ii), or (iii)? Enter in column 1. "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR \$412.101(b)(2)(1), (ii), or (iii)? Enter in column 2. "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)  Prospective Payment System (PPS)-Capital  45.00 Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR \$412.301(b) (20 (see instructions)  Prospective Payment System (PPS)-Capital  45.00 Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR \$412.301(b) (20 (see instructions)  Accordance with 42 CFR \$412.301(b) (20 (see instructions)  10.00 Is this facility qualify and receive Capital payment? Enter "Y" for yes or "N" for no. N N N N N N N N N N N N N N N N N N N  |  |  | r of period                                   | ds MDH statu                   | 5                                       | (       |                        |                           | 37.00                      |
| 38.00   If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.    Y/N   | 37.01 Is this hospital a former MDH that is eligible for the   |  |   |                                |   |         |                        |                           | 37. 01                     |
| 39.00   Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i). (ii), or (iii)? Enter in column 1."Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2."Y" for yes or "N" for no. See instructions)  40.00 Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges prior to October 1. (see instructions)    V  | instructions) 38.00   If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is   |  |   |                                |   |         |                        |                           | 38. 00                     |
| 39.00 Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR \$412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 'Y' for yes or 'N' for no. Does the facility meet the mileage requirements in accordance with 42 CFR \$412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 'Y' for yes or 'N' for no. (see instructions)  40.00 Is this hospital subject to the HAC program reduction adjustment? Enter "Y' for yes or 'N' for no in column 1, for discharges prior to October 1. Enter "Y' for yes or 'N' for no in column 1, for discharges prior to October 1. Enter "Y' for yes or 'N' for no in column 2, for discharges on or after October 1. See instructions)  45.00 Prospective Payment System (PPS)-Capital  45.00 Is this facility qualify and receive Capital payment for disproportionate share in accordance N N N N N N N N N N N N N N N N N N N  | enter subsequent dates.  |  |   |                                | V                                       | /NI     |                        | V /N                      |                            |
| hospitals in accordance with 42 CFR \$412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 'Y' for yes or 'N' for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)  40.00 Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges prior to October 1. (see instructions)  45.00 Prospective Payment System (PPS)-Capital  45.00 Set this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section \$412.320? (see instructions)  46.00 Is this facility eligible for additional payment exception for extraordinary circumstances with 42 CFR \$412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.  47.00 Is this a new hospital under 42 CFR \$412.300(b) PPS capital? Enter "Y for yes or "N" for no. N N N N N N N N N N N N N N N N N N N  |  |  |   |                                |   |         |                        |                           | -                          |
| 40.00   Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges prior to October 1. (see instructions)   V   XVIII   XIX   XIX | hospitals in accordance with 42 CFR §412.101(b)(2)(i 1 "Y" for yes or "N" for no. Does the facility meet accordance with 42 CFR 412.101(b)(2)(i), (ii), or (i  | ), (ii), or<br>the mileage                           | (iii)? Ent                                    | er in colum<br>nts in          | n                                       | I       |                        | N                         | 39. 00                     |
| ## Prospective Payment System (PPS)-Capital  ## Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)  ## 46.00 Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L., Pt. III and Wkst. L-1, Pt. I through Pt. III.  ## Ar.00 Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no.  ## In III. It is a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no.  ## In III. It is a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no.  ## In III. It is a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.  ## In III. It is a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.  ## In III. It is a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.  ## In III. It is a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.  ## In III. It is a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.  ## In III. It is a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.  ## In III. It is a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.  ## In III. It is a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.  ## In III. It is a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.  ## In III. It is a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.  ## In III. It is a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.  ## In III. It is a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.  ## In III. It is a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes o | "N" for no in column 1, for discharges prior to Octo   | ber 1. Ente  | r "Y" for y                                   |                                |   |         |                        |                           | 40. 00                     |
| Prospective Payment System (PPS)-Capital   |  |  |   |                                |   |         | _                      |                           | -                          |
| with 42 CFR Section §412.320? (see instructions)  46.00 Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.  47.00 Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no. N N N N N N N N N N N N N N N N N N N   | Prospective Payment System (PPS)-Capital   |  |   |                                |   |         | 0   2.0                | 0.00                      |                            |
| Pt. III.  47.00 Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no. N N N N N N N N N N N N N N N N N N N   | with 42 CFR Section §412.320? (see instructions) 46.00 Is this facility eligible for additional payment exce   | eption for   | extraordi na                                  | ary circumsta                  | ances                                   |         |                        |                           | 45. 00<br>46. 00           |
| 47.00 Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no. N N N N N N N N N N N N N N N N N N N   |  | τ. L, Pt. I  | ıı and Wkst                                   | . L-1, Pt.                     | ı through                               |         |                        |                           |                            |
| 56.00 Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.  57.00 If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D. Parts III & IV and D-2, Pt. II, if applicable.  58.00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.  59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.  N Pass-Through Qualification Criterion Code  NAHE 413.85 Y/N Line # Pass-Through Qualification Criterion Code  1.00 2.00 3.00   | 47.00 Is this a new hospital under 42 CFR §412.300(b) PPS 48.00 Is the facility electing full federal capital paymen   |  |   |                                |   |         |                        | 1                         | 47. 00<br>48. 00           |
| 57.00 If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.  58.00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.  59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.  NAHE 413.85 Worksheet A Line # Pass-Through Qualification Criterion Code  1.00 2.00 3.00  60.00 Are you claiming nursing and allied health education (NAHE) costs for N   | 56.00 Is this a hospital involved in training residents in   | approved G   | ME programs                                   | ? Enter "Y                     | " for yes                               | N       |                        |                           | 56. 00                     |
| for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.  58.00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.  59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.  NAHE 413.85 Worksheet A Line # Qualification Criterion Code  1.00 2.00 3.00  60.00 Are you claiming nursing and allied health education (NAHE) costs for N  | 57.00 If line 56 is yes, is this the first cost reporting GME programs trained at this facility? Enter "Y" fo  | r yes or "N  | " for no in                                   | n column 1.                    | lf column                               |         |                        |                           | 57. 00                     |
| 58.00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.  59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.  NAHE 413.85 Worksheet A Line # Qualification Criterion Code  1.00 2.00 3.00  60.00 Are you claiming nursing and allied health education (NAHE) costs for N   | for yes or "N" for no in column 2. If column 2 is "  | Y", complet  | e Worksheet                                   |                                |   | "       |                        |                           |                            |
| NAHE 413.85 Worksheet A Line # Pass-Through Qualification Criterion Code  1.00 2.00 3.00  Are you claiming nursing and allied health education (NAHE) costs for N 60.00  | defined in CMS Pub. 15-1, chapter 21, §2148? If yes,   | complete W   | kst. D-5.                                     |                                | s as                                    |         |                        |                           | 58. 00<br>59. 00           |
| 60.00 Are you claiming nursing and allied health education (NAHE) costs for N 60.00  | The second of the low of workshoet At 11 years   | _, complete  | et. b Z <sub>1</sub>                          | NAHE 413.8                     |   | neet A  | Qual i                 | fi cati on                |                            |
|  |  | *****  |   |                                | 2.                                      | 00      | 3                      | . 00                      |                            |
|  |  |  |   | N N                            |   |         |                        |                           | 60.00                      |

Health Financial Systems PHYSICIANS MEDICAL CENTER In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0172 Peri od: Worksheet S-2 From 01/01/2018 Part I Date/Time Prepared: 12/31/2018 5/30/2019 5:24 pm Y/N IME Direct GME IME Direct GME 3. 00 1. 00 2.00 4.00 5.00 0.00 61.00 61.00 Did your hospital receive FTE slots under ACA 0 00 section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) Enter the average number of unweighted primary care 61.01 FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions) 61.02 Enter the current year total unweighted primary care 61.02 FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions) 61.03 Enter the base line FTE count for primary care 61.03 and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions) Enter the number of unweighted primary care/or 61.04 surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions). 61.05 Enter the difference between the baseline primary 61.05 and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions) 61.06 Enter the amount of ACA \$5503 award that is being 61.06 used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions) Program Code Unweighted IME Unweighted Program Name FTE Count Direct GME FTE Count 1.00 2.00 3.00 4.00 61.10 Of the FTEs in line 61.05, specify each new program 0. 00 0.00 61.10 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. 61.20 Of the FTEs in line 61.05, specify each expanded 0.00 0.00 61.20 program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count 1.00 ACA Provisions Affecting the Health Resources and Services Administration (HRSA) Enter the number of FTE residents that your hospital trained in this cost reporting period for which 0.00 62.00 62.00 your hospital received HRSA PCRE funding (see instructions) Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital 62.01 0.00 62.01 during in this cost reporting period of HRSA THC program. (see instructions) Teaching Hospitals that Claim Residents in Nonprovider Settings 63.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions) 63.00 Ν Unwei ghted Unwei ghted Ratio (col. (col. 1 + col FTEs in FTEs Nonprovi der Hospi tal 2)) Si te 1. 00 2.00 3.00 Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. 64.00 Enter in column 1, if line 63 is yes, or your facility trained residents 0.00 0.00 0.000000 64.00 in the base year period, the number of unweighted non-primary care

resident FTEs attributable to rotations occurring in all nonprovider

settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)

| HUSPI I | AL AND HOSPITAL HEALTH CARE COMPL   | IA Provider Co   |  | eriod:<br>com 01/01/2018<br>o 12/31/2018                                |                                    | pared:  |        |  |  |  |  |
|---------|---|--|--|---|------------------------------------|---|--------|--|--|--|--|
|         |   | Program Name   | Program Code   | Unwei ghted<br>FTEs<br>Nonprovi der<br>Si te                            | Unwei ghted<br>FTEs in<br>Hospital | 5/30/2019 5: 2<br>Ratio (col. 3/<br>(col. 3 + col.<br>4)) |        |  |  |  |  |
|         |   | 1.00   | 2.00   | 3. 00   | 4. 00                              | 5. 00   |        |  |  |  |  |
| 65. 00  | Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care 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 + column 4)). (see instructions) |  |  | 0.00  | 0. 00                              | 0. 000000   | 65. 00 |  |  |  |  |
|         | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,   |  |  | Unwei ghted<br>FTEs<br>Nonprovi der<br>Si te                            | Unwei ghted<br>FTEs in<br>Hospital | Ratio (col. 1/<br>(col. 1 + col.<br>2))                   |        |  |  |  |  |
|         | C 11 5504 C 11 151 5  | Y  | N  | 1.00  | 2.00                               | 3. 00   |        |  |  |  |  |
|         | Section 5504 of the ACA Current beginning on or after July 1, 20  |  | n Nonprovider Setting  | ysEffective fo  | or cost reporti                    | ng peri ods   |        |  |  |  |  |
|         | Enter in column 1 the number of FTEs attributable to rotations of Enter in column 2 the number of FTEs that trained in your hospit. (column 1 divided by (column 1 +  | unweighted non-primar<br>ccurring in all nonpr<br>unweighted non-primar<br>al. Enter in column 3                         | ovider settings.<br>Ty care resident<br>The ratio of   | 0.00  | 0. 00                              | 0. 000000   | 66. 00 |  |  |  |  |
|         |   | Program Name   | Program Code   | Unwei ghted<br>FTEs<br>Nonprovi der<br>Si te                            | Unwei ghted<br>FTEs in<br>Hospital | Ratio (col. 3/<br>(col. 3 + col.<br>4))                   |        |  |  |  |  |
| 67. 00  | Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)  | 1.00   | 2.00   | 3.00  | 4. 00<br>0. 0c                     | 5. 00<br>0. 000000  | 67. 00 |  |  |  |  |
|         | .,,. (360 ) (31)  |  |  |   |                                    |   |        |  |  |  |  |
|         | Innationt Development - Facility S  | DC   |  |   | 1. 0                               | 0 2.00 3.00   |        |  |  |  |  |
| 70 00   | Inpatient Psychiatric Facility P<br>Is this facility an Inpatient Ps  |  | PF), or does it cont   | ain an IPF subn   | rovider? N                         |   | 70. 00 |  |  |  |  |
|         | Enter "Y" for yes or "N" for no<br>If line 70 is yes: Column 1: Did<br>recent cost report filed on or b<br>42 CFR 412. 424(d)(1)(iii)(c)) Co<br>program in accordance with 42 CF<br>Column 3: If column 2 is Y, indi-<br>(see instructions)   | the facility have an<br>efore November 15, 20<br>lumn 2: Did this faci<br>R 412.424 (d)(1)(iii)<br>cate which program ye | approved GME teachi<br>104? Enter "Y" for you<br>1 ity train residents<br>(D)? Enter "Y" for you | ng program in t<br>es or "N" for n<br>in a new teach<br>es or "N" for n | he most<br>o. (see<br>i ng<br>o.   | 0   | 71. 00 |  |  |  |  |
| 75. 00  |   |  | (IRF), or does it co   | ontain an IRF   | N                                  |   | 75. 00 |  |  |  |  |
| 76. 00  | Inpatient Rehabilitation Facility PPS  On Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF  No Insubprovider? Enter "Y" for yes and "N" for no.   |  |  |   |                                    |   |        |  |  |  |  |

| SPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA  | Provider C    | CN: 15-0172  | Peri od:<br>From 01/01/2018<br>To 12/31/2018 | Worksheet S-2<br>Part I<br>Date/Time Pro<br>5/30/2019 5:2 | epared:        |
|--|---------------|--------------|--|---|----------------|
|  |               |              |  | 1. 00   |                |
| Long Term Care Hospital PPS  |               |              |  |   | I              |
| .00 Is this a long term care hospital (LTCH)? Enter "Y" for yes a .00 Is this a LTCH co-located within another hospital for part or "Y" for yes and "N" for no.  TEFRA Providers   |               |              | ng period? Enter                             | N<br>N  | 80. C<br>81. C |
| .00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) 0 Did this facility establish a new Other subprovider (excluded §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.  |               |              |  | N   | 85. C          |
| .00 Is this hospital an extended neoplastic disease care hospital 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.  | cl assi fi ed | under sectio | n  | N   | 87. 0          |
| 1000(d)(1)(b)(VI)? EIITEI T TOI YES OI N TOI 110.  |               |              | V  | XI X  |                |
| E  |               |              | 1. 00  | 2.00  | 1              |
| Title V and XIX Services  .00 Does this facility have title V and/or XIX inpatient hospital  | servi ces? E  | nter "Y" for | N  | Υ   | 90.0           |
| yes or "N" for no in the applicable column.  ON Is this hospital reimbursed for title V and/or XIX through the   | e cost repor  | t either in  | N  | N   | 91. 0          |
| full or in part? Enter "Y" for yes or "N" for no in the applic<br>.00 Are title XIX NF patients occupying title XVIII SNF beds (dual   |               |              |  | N   | 92. 0          |
| instructions) Enter "Y" for yes or "N" for no in the applicable. OD Does this facility operate an ICF/IID facility for purposes of   |               | d XIX? Enter | N  | N   | 93. 0          |
| "Y" for yes or "N" for no in the applicable column.  .00 Does title V or XIX reduce capital cost? Enter "Y" for yes, an  | nd "N" for n  | o in the     | N  | N   | 94. 0          |
| applicable column.  .00   If line 94 is "Y", enter the reduction percentage in the appli   |               |              | 0. 00  | 0.00  | 95. 0          |
| .00 Does title V or XIX reduce operating cost? Enter "Y" for yes   |               |              | N N  | N N   | 96. 0          |
| applicable column.  .00   If line 96 is "Y", enter the reduction percentage in the appli   |               |              | 0. 00  | 0. 00   | 97. 0          |
| .00 Does title V or XIX follow Medicare (title XVIII) for the inte<br>stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for   |               |              | Y  | Y   | 98.0           |
| column 1 for title V, and in column 2 for title XIX. O1 Does title V or XIX follow Medicare (title XVIII) for the repx C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for titl title XIX.   |               |              |  | Y   | 98. 0          |
| .02 Does title V or XIX follow Medicare (title XVIII) for the calc<br>bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or<br>for title V, and in column 2 for title XIX.   |               |              | Y  | Y   | 98.0           |
| .03 Does title V or XIX follow Medicare (title XVIII) for a critic reimbursed 101% of inpatient services cost? Enter "Y" for yes for title V, and in column 2 for title XIX.   |               |              |  | N   | 98. 0          |
| .04 Does title V or XIX follow Medicare (title XVIII) for a CAH re<br>outpatient services cost? Enter "Y" for yes or "N" for no in a   |               |              | N<br>d                                       | N   | 98. 0          |
| in column 2 for title XIX.  .05 Does title V or XIX follow Medicare (title XVIII) and add back Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in col  |               |              |  | Y   | 98. 0          |
| column 2 for title XIX.  Does title V or XIX follow Medicare (title XVIII) when cost re Pts. I through IV? Enter "Y" for yes or "N" for no in column 2 column 2 for title XIX.   |               |              | Y  | Y   | 98. 0          |
| Rural Providers  |               |              |  |   | 4.             |
| 5.00 Does this hospital qualify as a CAH?<br>6.00 If this facility qualifies as a CAH, has it elected the all-in   | nclusive met  | nod of payme | nt N   |   | 105. C         |
| for outpatient services? (see instructions) 7.00 If this facility qualifies as a CAH, is it eligible for cost in training programs? Enter "Y" for yes or "N" for no in column 1 yes, the GME elimination is not made on Wkst. B, Pt. I, col. 2 | 1. (see inst  | ructions) If |  |   | 107. 0         |
| reimbursed. If yes complete Wkst. D-2, Pt. II.<br>8.00 Is this a rural hospital qualifying for an exception to the Cf  | ·             | · ·          |  |   | 108. (         |
| CFR Section §412.113(c). Enter "Y" for yes or "N" for no.  | Physi cal     | Occupati on  |  | Respi ratory  |                |
| 9.00  f this hospital qualifies as a CAH or a cost provider, are   | 1. 00<br>N    | 2.00<br>N    | 3. 00<br>N                                   | 4.00<br>N   | 109.0          |
| therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.   | IN            | IV.          | IN   | IN  | 109. 0         |
|  |               |              |  | 1. 00   | +              |
| 0.00 Did this hospital participate in the Rural Community Hospital Demonstration) for the current cost reporting period? Enter "Y' complete Worksheet E, Part A, lines 200 through 218, and Worksheet E.                                       | ' for yes or  | "N" for no.  | If yes,                                      | N N   | 110. 0         |

| ealth Financial Systems PHYSICIANS MEDICAL CENTER OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider   | CCN: 15-0172  | Peri od:                   |              | u of Form CM:<br>Worksheet S         |                      |
|---|---|----------------------------|--------------|--------------------------------------|----------------------|
| THE THE HOST THE HEALTH SHILL SOME EEX TRENTH SHITTSHIT | 0011. 10 0172   | From 01/01/2<br>To 12/31/2 | 2018<br>2018 | Part I<br>Date/Time P<br>5/30/2019 5 | repared              |
|   |   | 1.00                       |              | 0.00                                 |                      |
| 11.00 If this facility qualifies as a CAH, did it participate in the Frontier Health Integration Project (FCHIP) demonstration for this cost reportin "Y" for yes or "N" for no in column 1. If the response to column 1 is Y integration prong of the FCHIP demo in which this CAH is participating Enter all that apply: "A" for Ambulance services; "B" for additional befor tele-health services.   | g period? Enter<br>enter the<br>in column 2.                | 1.00<br>N                  |              | 2.00                                 | 111.                 |
|   |   |                            | 1. 00        | 2.00 3.0                             | 0                    |
| Miscellaneous Cost Reporting Information  15.00 Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no is yes, enter the method used (A, B, or E only) in column 2. If column 3 either "93" percent for short term hospital or "98" percent for long psychiatric, rehabilitation and long term hospitals providers) based on Pub. 15-1, chapter 22, §2208.1.   | 2 is "E", enter<br>term care (incl<br>the definition        | in column<br>udes          | N            | 0                                    | 115.                 |
| 16.00 s this facility classified as a referral center? Enter "Y" for yes or<br>17.00 s this facility legally-required to carry malpractice insurance? Enter<br>no.  |   | "N" for                    | N<br>Y       |                                      | 116.<br>117.         |
| 18.00 is the malpractice insurance a claims-made or occurrence policy? Enter claim-made. Enter 2 if the policy is occurrence.   | 1 if the policy   | /is                        | 2            |                                      | 118.                 |
| oracim made. Enter Enter the particly to coolar ones.   | Premi ums   | Losses                     | ,            | Insurance                            |                      |
|   | 1. 00   | 2.00                       |              | 3.00                                 |                      |
| 18.01 List amounts of malpractice premiums and paid losses:   | 112, 4  | 169                        | 0            |                                      | 0 118.               |
|   |   | 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.  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 instructions)  | cost centers  rovision in ACA 'Y" for yes or the Outpatient |                            |              | N                                    | 118.<br>119.<br>120. |
| Enter in column 2, "Y" for yes or "N" for no.<br>21.00Did this facility incur and report costs for high cost implantable devi   | ces charged to  | Υ                          |              |                                      | 121.                 |
| patients? Enter "Y" for yes or "N" for no.<br>22.00 Does the cost report contain healthcare related taxes as defined in §19.<br>Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", en<br>the Worksheet A line number where these taxes are included.  |   |                            |              |                                      | 122.                 |
| Transplant Center Information  25.00 Does this facility operate a transplant center? Enter "Y" for yes and "  | N" for no. If   | N                          |              |                                      | 125.                 |
| yes, enter certification date(s) (mm/dd/yyyy) below.  6.00  f this is a Medicare certified kidney transplant center, enter the cer  | tification date   | <b>&gt;</b>                |              |                                      | 126.                 |
| in column 1 and termination date, if applicable, in column 2. 7.00 If this is a Medicare certified heart transplant center, enter the cert in column 1 and termination date, if applicable, in column 2.  | fication date   |                            |              |                                      | 127.                 |
| 8.00 of this is a Medicare certified liver transplant center, enter the cert in column 1 and termination date, if applicable, in column 2.  | fication date   |                            |              |                                      | 128.                 |
| 9.00 If this is a Medicare certified lung transplant center, enter the certicolumn 1 and termination date, if applicable, in column 2.  | fication date i   | n                          |              |                                      | 129.                 |
| 0.00 If this is a Medicare certified pancreas transplant center, enter the condate in column 1 and termination date, if applicable, in column 2.  |   |                            |              |                                      | 130                  |
| 1.00 If this is a Medicare certified intestinal transplant center, enter the date in column 1 and termination date, if applicable, in column 2.   |   |                            |              |                                      | 131                  |
| 2.00 If this is a Medicare certified islet transplant center, enter the cert<br>in column 1 and termination date, if applicable, in column 2. 3.00 If this is a Medicare certified other transplant center, enter the cert  |   |                            |              |                                      | 132.                 |
| in column 1 and termination date, if applicable, in column 2.  4.00  f this is an organ procurement organization (0P0), enter the 0P0 numbe   |   |                            |              |                                      | 134                  |
| and termination date, if applicable, in column 2.  All Providers  |   |                            |              |                                      |                      |
| 0.00 Are there any related organization or home office costs as defined in Cl<br>chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and ho  |   | Y                          |              |                                      | 140.                 |

Health Financial Systems PHYSICIANS MEDICAL CENTER In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0172 Peri od: Worksheet S-2 From 01/01/2018 Part I То 12/31/2018 Date/Time Prepared: 5/30/2019 5:24 pm 3.00 If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number 141 00 Name: Contractor's Name: Contractor's Number: 141 00 142.00 Street: PO Box: 142.00 143. 00 Ci ty: State: Zip Code: 143. 00 1.00 144.00 Are provider based physicians' costs included in Worksheet A? γ 144. 00 1. 00 2.00 145.00 of costs for renal services are claimed on Wkst. A, line 74, are the costs for 145.00 inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2. 146.00 Has the cost allocation methodology changed from the previously filed cost report? 146.00 Ν Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2. 1.00 147.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no. 148.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no. 147. 00 Ν 148 00 N 149.00Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no Ν 149.00 Part A Part B Title V Title XIX 1.00 2.00 3.00 4.00 Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13) 155.00 Hospi tal Ν N 155.00 Ν Ν 156.00 Subprovider - IPF Ν Ν Ν Ν 156.00 157.00 Subprovi der - IRF 157 00 Ν Ν Ν N 158. 00 SUBPROVI DER 158. 00 159. 00 SNF Ν Ν Ν Ν 159. 00 160.00 HOME HEALTH AGENCY 160. 00 Ν Ν Ν Ν 161.00 CMHC Ν Ν N 161. 00 161. 10 CORF Ν Ν Ν 161. 10 1.00 Multicampus 165.00 s this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? N 165.00 Enter "Y" for yes or "N" for no. FTE/Campus Zi p Code Name CBSA County State 0 1.00 2.00 3.00 4.00 5.00 166.00 If line 165 is yes, for each 0 00 166 00 campus enter the name in column O, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)

|   |             | 1.00       |         |  |  |  |  |  |  |
|---|-------------|------------|---------|--|--|--|--|--|--|
| Health Information Technology (HIT) incentive in the American Recovery and Reinvestment   | Act         |            |         |  |  |  |  |  |  |
| 167.00 s this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.   |             | Υ          | 167. 00 |  |  |  |  |  |  |
| 168.00 If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), reasonable cost incurred for the HIT assets (see instructions)   | enter the   | (          | 168. 00 |  |  |  |  |  |  |
| 168.01 If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)   |             |            |         |  |  |  |  |  |  |
| 169.00 If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)  |             |            |         |  |  |  |  |  |  |
|   | Begi nni ng | Endi ng    |         |  |  |  |  |  |  |
|   | 1. 00       | 2.00       |         |  |  |  |  |  |  |
| 170.00 Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)   | 01/01/2018  | 12/31/2018 | 170. 00 |  |  |  |  |  |  |
|   |             |            |         |  |  |  |  |  |  |
|   | 1. 00       | 2.00       | 1       |  |  |  |  |  |  |
| 171.00 If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions) | N           | (          | 171.00  |  |  |  |  |  |  |

| 5PI I | Financial Systems PHYSICIANS ME<br>AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE   |                   |                 | Peri od:                         | wof Form CMS-<br>Worksheet S-2 |        |
|-------|--|-------------------|-----------------|----------------------------------|--------------------------------|--------|
|       |  |                   | F               | From 01/01/2018<br>Fo 12/31/2018 | Part II<br>Date/Time Pre       | epared |
|       |  |                   |                 | Y/N                              | 5/30/2019 5: 2<br>Date         | 24 pm  |
|       |  |                   |                 | 1. 00                            | 2.00                           | _      |
|       | General Instruction: Enter Y for all YES responses. Enter N  | N for all NO re   | sponses. Enter  |                                  |                                |        |
|       | mm/dd/yyyy format.   |                   | <u> </u>        |                                  |                                |        |
|       | COMPLETED BY ALL HOSPITALS   |                   |                 |                                  |                                |        |
|       | Provider Organization and Operation  | 1                 |                 | T                                |                                | ۱.,    |
| 00    | Has the provider changed ownership immediately prior to the reporting period? If yes, enter the date of the change in a  | e beginning of    | the cost        | N                                |                                | 1. (   |
|       | reporting period: IT yes, enter the date of the change in t  | Joi ullii 2. (See | Y/N             | Date                             | V/I                            |        |
|       |  |                   | 1.00            | 2. 00                            | 3. 00                          |        |
| 0C    | Has the provider terminated participation in the Medicare F  | Program? If       | N               |                                  |                                | 2. (   |
|       | yes, enter in column 2 the date of termination and in colum  | mn 3, "V" for     |                 |                                  |                                |        |
| 20    | voluntary or "I" for involuntary.  |                   |                 |                                  |                                | 1 .    |
| 00    | Is the provider involved in business transactions, including contracts, with individuals or entities (e.g., chain home of  |                   | Y               |                                  |                                | 3.     |
|       | or medical supply companies) that are related to the provide   |                   |                 |                                  |                                |        |
|       | officers, medical staff, management personnel, or members  |                   |                 |                                  |                                |        |
|       | of directors through ownership, control, or family and other   | er similar        |                 |                                  |                                |        |
|       | relationships? (see instructions)  |                   |                 | _                                |                                | _      |
|       |  |                   | 1. 00           | 7ype<br>2. 00                    | Date<br>3.00                   | _      |
|       | Financial Data and Reports   |                   | 1.00            | 2.00                             | 3.00                           |        |
| 00    | Column 1: Were the financial statements prepared by a Cer  | tified Public     | Υ               | A                                | 05/16/2019                     | 4.     |
|       | Accountant? Column 2: If yes, enter "A" for Audited, "C" 1   |                   |                 |                                  |                                | ''     |
|       | or "R" for Reviewed. Submit complete copy or enter date ava  |                   |                 |                                  |                                |        |
|       | column 3. (see instructions) If no, see instructions.  |                   |                 |                                  |                                | _      |
| 00    | Are the cost report total expenses and total revenues difference on the filed financial statements? If was submit real   |                   | N               |                                  |                                | 5.     |
|       | those on the filed financial statements? If yes, submit red  | conciliation.     |                 | Y/N                              | Legal Oper.                    |        |
|       |  |                   |                 | 1. 00                            | 2.00                           |        |
|       | Approved Educational Activities  |                   |                 |                                  |                                |        |
| 00    | Column 1: Are costs claimed for nursing school? Column 2:  | If yes, is th     | ne provider is  | N                                |                                | 6.     |
|       | the legal operator of the program?   |                   |                 |                                  |                                | l _    |
| 00    | Are costs claimed for Allied Health Programs? If "Y" see in  |                   | l duning the    | N                                |                                | 7.     |
| 00    | Were nursing school and/or allied health programs approved cost reporting period? If yes, see instructions.  | and/or renewed    | a during the    | N                                |                                | 8.     |
| 00    | Are costs claimed for Interns and Residents in an approved   | graduate medic    | al education    | N                                |                                | 9.     |
|       | program in the current cost report? If yes, see instruction  |                   |                 |                                  |                                |        |
| . 00  | Was an approved Intern and Resident GME program initiated o  | or renewed in t   | he current      | N                                |                                | 10.    |
| 00    | cost reporting period? If yes, see instructions.   | I 0 D : A         |                 | N                                |                                | 111    |
| . 00  | Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.   | ı & Rın an App    | rovea           | N                                |                                | 11.    |
|       | reaching Frogram on worksheet A: IT yes, see this tructions.   |                   |                 |                                  | Y/N                            |        |
|       |  |                   |                 |                                  | 1. 00                          |        |
|       | Bad Debts  |                   |                 |                                  |                                |        |
|       | Is the provider seeking reimbursement for bad debts? If yes  |                   |                 |                                  | Y                              | 12.    |
| 00    | If line 12 is yes, did the provider's bad debt collection  | policy change o   | luring this cos | st reporting                     | N                              | 13.    |
| 00    | period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or co-paymone.  | ants waived2 lf   | vas saa inst    | ructions                         | N                              | 14.    |
| 00    | Bed Complement   | ents warveu: Ti   | yes, see misi   | ir de trons.                     | IN .                           | 14.    |
| 00    | Did total beds available change from the prior cost reporti  | ing period? If    | yes, see instr  | ructions.                        | N                              | 15.    |
|       |  | Par               | t A             | Par                              | t B                            |        |
|       |  | Y/N               | Date            | Y/N                              | Date                           |        |
|       | DCAD D-+-  | 1.00              | 2. 00           | 3. 00                            | 4. 00                          |        |
|       | PS&R Data  | Υ                 | 04/22/2019      | Υ                                | 04/22/2019                     | 16.    |
|       |  |                   | 04/22/2019      | 1                                | 04/22/2019                     | 10.    |
|       | Was the cost report prepared using the PS&R Report only?   | '                 |                 |                                  |                                |        |
|       |  |                   |                 |                                  |                                |        |
|       | Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through  | '                 |                 |                                  |                                |        |
| 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) Was the cost report prepared using the PS&R Report for   | N                 |                 | N                                |                                | 17.    |
| 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) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If  |                   |                 | N                                |                                | 17.    |
| 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) 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   |                   |                 | N                                |                                | 17.    |
| 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) 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)  | N                 |                 |                                  |                                |        |
| 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) 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) If line 16 or 17 is yes, were adjustments made to PS&R   |                   |                 | N<br>N                           |                                |        |
| 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) 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)  | N                 |                 |                                  |                                |        |
| 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) 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) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed   | N                 |                 |                                  |                                | 18.    |
| 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) 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) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this | N                 |                 |                                  |                                | 18.    |

| Heal th          | Financial Systems PHYSICIANS MEI   | DICAL CENTER    |               | In Lie                                       | u of Form CMS-                                  | -2552-10         |
|------------------|--|-----------------|---------------|--|---|------------------|
| HOSPI T          | AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE  | Provi der C     | CN: 15-0172   | Peri od:<br>From 01/01/2018<br>To 12/31/2018 | Worksheet S-Part II Date/Time Pro 5/30/2019 5:3 | epared:          |
|                  |  | Descri          | ipti on       | Y/N  | Y/N   | 2 , p            |
|                  |  | (               | )             | 1. 00  | 3. 00   |                  |
| 20. 00           | If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:  |                 |               | N  | N   | 20. 00           |
|                  |  | Y/N             | Date          | Y/N  | Date  |                  |
|                  |  | 1.00            | 2. 00         | 3. 00  | 4. 00   |                  |
| 21. 00           | Was the cost report prepared only using the provider's records? If yes, see instructions.  | N               |               | N  |   | 21. 00           |
|                  |  |                 |               | •  | 1. 00   |                  |
|                  | COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE  | PT CHILDRENS H  | OSPLTALS)     |  | 1.00  |                  |
|                  | Capi tal Related Cost  |                 |               |  |   |                  |
| 22. 00           | Have assets been relifed for Medicare purposes? If yes, see  |                 |               |  |   | 22. 00           |
| 23. 00           | Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.   |                 | 23. 00        |  |   |                  |
| 24. 00           | Were new leases and/or amendments to existing leases entered of the second of the seco | ed into during  | this cost re  | eporting period?                             |   | 24. 00           |
| 25. 00           | Have there been new capitalized leases entered into during instructions.   | the cost repor  | ting period?  | 'If yes, see                                 |   | 25. 00           |
| 26. 00           | Were assets subject to Sec. 2314 of DEFRA acquired during the instructions.  | ne cost reporti | ng period? I  | f yes, see                                   |   | 26. 00           |
| 27. 00           | Has the provider's capitalization policy changed during the copy.  | e cost reportin | g period? If  | yes, submit                                  |   | 27. 00           |
| 28. 00           | Interest Expense Were new Loans, mortgage agreements or Letters of credit er   | atorod into dur | ing the cost  | roporting                                    |   | 28. 00           |
|                  | period? If yes, see instructions.  |                 | Ü             |  |   |                  |
| 29. 00           | Did the provider have a funded depreciation account and/or treated as a funded depreciation account? If yes, see instr   |                 | ebt Service k | Reserve Fund)                                |   | 29. 00           |
| 30. 00           | Has existing debt been replaced prior to its scheduled maturinstructions.  | urity with new  | debt? If yes  | s, see                                       |   | 30.00            |
| 31. 00           | Has debt been recalled before scheduled maturity without is instructions.  | ssuance of new  | debt? If yes  | s, see                                       |   | 31. 00           |
| 32. 00           | Purchased Services Have changes or new agreements occurred in patient care ser   | rvices furnishe | d through co  | ontractual                                   |   | 32. 00           |
| 33. 00           | arrangements with suppliers of services? If yes, see instru<br>If line 32 is yes, were the requirements of Sec. 2135.2 app<br>no, see instructions.  |                 | g to competi  | tive bidding? If                             |   | 33. 00           |
|                  | Provi der-Based Physi ci ans   |                 |               |  |   |                  |
| 34. 00           | Are services furnished at the provider facility under an ar If yes, see instructions.  | rrangement with | provi der-ba  | sed physicians?                              |   | 34. 00           |
| 35. 00           | If line 34 is yes, were there new agreements or amended exiphysicians during the cost reporting period? If yes, see in   |                 | its with the  | provi der-based                              |   | 35. 00           |
|                  | phrysrcrans durring the cost reporting perrous in yes, see in  | istructions.    |               | Y/N  | Date  |                  |
|                  |  |                 |               | 1. 00  | 2.00  |                  |
|                  | Home Office Costs  |                 |               |  |   |                  |
| 36. 00<br>37. 00 | Were home office costs claimed on the cost report?  If line 36 is yes, has a home office cost statement been pr  | repared by the  | home office?  | ,  |   | 36. 00<br>37. 00 |
| 38. 00           | If yes, see instructions. If line 36 is yes, was the fiscal year end of the home off   |                 |               |  |   | 38. 00           |
| 39. 00           | the provider? If yes, enter in column 2 the fiscal year end of line 36 is yes, did the provider render services to other   | d of the home o | ffi ce.       |  |   | 39. 00           |
| 40. 00           | see instructions.  If line 36 is yes, did the provider render services to the  |                 |               | 40.00  |   |                  |
|                  | instructions.  |                 |               | 10.00  |   |                  |
|                  |  | 1.              | 00            | 2.   | 00  |                  |
|                  | Cost Report Preparer Contact Information   | b               |               |  |   |                  |
| 41. 00           | Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.  | DANI EL         |               | SCHOENBAECHLER                               |   | 41.00            |
| 42. 00           | Enter the employer/company name of the cost report preparer.   | DEAN DORTON AL  | LEN FORD      |  |   | 42. 00           |
| 43. 00           |  | 5025661097      |               | DSCHOEN@DDAFHE                               | ALTHCARE. COM                                   | 43. 00           |

| Health Fina   | ancial Systems  | PHYSICIANS M   | EDI C     | AL CENTER   |       |  | In Lieu of Form CMS-2552-1                                 |        |  |        |  |
|---|---|----------------|-----------|-------------|-------|--|--|--------|--|--------|--|
| HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE |   |                | Provi der | CCN: 15-017 | F     | eriod:<br>rom 01/01/2018<br>o 12/31/2018 | Worksheet S-2<br>Part II<br>Date/Time Pre<br>5/30/2019 5:2 | pared: |  |        |  |
|   |   |                |           |             |       | 2 00                                     |  |        |  |        |  |
| Coct  | t Donart Dronarar Contact L   | aformation     |           |             | •     | 3. 00                                    |  |        |  |        |  |
| 41.00 Ente  | t Report Preparer Contact II er the first name, last nam d by the cost report prepar pectively. | e and the titl |           | MAN         | NAGER |  |  |        |  | 41. 00 |  |
|   | er the employer/company nam   | e of the cost  | report    |             |       |  |  |        |  | 42. 00 |  |
| 43. 00 Ent  | parer.<br>er the telephone number and<br>ort preparer in columns 1 a                            |                |           |             |       |  |  |        |  | 43. 00 |  |

| Period: | Worksheet S-3 | From 01/01/2018 | Part | To 12/31/2018 | Date/Time Prepared: Provider CCN: 15-0172

|                  |  |              |      |           |              | То | 12/31/2018 |                                |          |                  |
|------------------|--|--------------|------|-----------|--------------|----|------------|--------------------------------|----------|------------------|
|                  |  |              |      |           |              |    |            | 5/30/2019 5:<br>  /P Days / 0/ |          | рш               |
|                  |  |              |      |           |              |    |            | Visits / Trip                  |          |                  |
|                  | Component                                    | Worksheet A  | l No | of Beds   | Bed Days     |    | CAH Hours  | Title V                        | 25       |                  |
|                  | Component                                    | Li ne Number | INO  | . Of beus | Avai I abl e |    | CALL HOULS | II LIE V                       |          |                  |
|                  |  | 1.00         |      | 2. 00     | 3.00         |    | 4. 00      | 5. 00                          | $\dashv$ |                  |
| 1. 00            | Hospital Adults & Peds. (columns 5, 6, 7 and | 30.00        |      | 10        |              | 50 | 0.00       |                                | 0        | 1. 00            |
| 1.00             | 8 exclude Swing Bed, Observation Bed and     | 50.00        |      | 10        | 3, 5         |    | 0.00       |                                | Ĭ        | 1. 00            |
|                  | Hospice days) (see instructions for col. 2   |              |      |           |              |    |            |                                |          |                  |
|                  | for the portion of LDP room available beds)  |              |      |           |              |    |            |                                |          |                  |
| 2.00             | HMO and other (see instructions)             |              |      |           |              |    |            |                                | ı        | 2.00             |
| 3.00             | HMO IPF Subprovider                          |              |      |           |              |    |            |                                | ı        | 3.00             |
| 4.00             | HMO IRF Subprovider                          |              |      |           |              |    |            |                                | İ        | 4.00             |
| 5.00             | Hospital Adults & Peds. Swing Bed SNF        |              |      |           |              |    |            |                                | 0        | 5.00             |
| 6.00             | Hospital Adults & Peds. Swing Bed NF         |              |      |           |              |    |            |                                | 0        | 6.00             |
| 7.00             | Total Adults and Peds. (exclude observation  |              |      | 10        | 3, 6         | 50 | 0.00       |                                | 0        | 7.00             |
|                  | beds) (see instructions)                     |              |      |           |              |    |            |                                |          |                  |
| 8.00             | INTENSIVE CARE UNIT                          |              |      |           |              |    |            |                                |          | 8. 00            |
| 9.00             | CORONARY CARE UNIT                           |              |      |           |              |    |            |                                |          | 9. 00            |
| 10.00            | BURN INTENSIVE CARE UNIT                     |              |      |           |              |    |            |                                |          | 10.00            |
| 11. 00           | SURGICAL INTENSIVE CARE UNIT                 |              |      |           |              |    |            |                                |          | 11. 00           |
| 12. 00           | OTHER SPECIAL CARE (SPECIFY)                 |              |      |           |              |    |            |                                |          | 12. 00           |
| 13. 00           | NURSERY                                      |              |      |           |              |    |            |                                |          | 13.00            |
| 14. 00           | Total (see instructions)                     |              |      | 10        | 3, 6         | 50 | 0. 00      |                                | 0        | 14. 00           |
| 15. 00           | CAH visits                                   |              |      |           |              |    |            |                                | 0        | 15. 00           |
| 16.00            | SUBPROVI DER - I PF                          |              |      |           |              |    |            |                                |          | 16. 00           |
| 17. 00           | SUBPROVI DER - I RF                          |              |      |           |              |    |            |                                |          | 17. 00           |
| 18. 00           | SUBPROVI DER                                 |              |      |           |              |    |            |                                |          | 18. 00           |
| 19. 00           | SKILLED NURSING FACILITY                     |              |      |           |              |    |            |                                |          | 19. 00           |
| 20.00            | NURSING FACILITY                             |              |      |           |              |    |            |                                |          | 20. 00           |
| 21. 00<br>22. 00 | OTHER LONG TERM CARE HOME HEALTH AGENCY      |              |      |           |              |    |            |                                |          | 21. 00<br>22. 00 |
| 23. 00           | AMBULATORY SURGICAL CENTER (D. P.)           |              |      |           |              |    |            |                                | ł        | 23. 00           |
| 24. 00           | HOSPICE                                      |              |      |           |              |    |            |                                |          | 24. 00           |
| 24. 00           | HOSPICE (non-distinct part)                  | 30.00        |      |           |              |    |            |                                |          | 24. 10           |
| 25. 00           | CMHC - CMHC                                  | 30.00        |      |           |              |    |            |                                | ł        | 25. 00           |
| 25. 10           | CMHC - CORF                                  | 99. 10       |      |           |              |    |            |                                | o        | 25. 10           |
| 26. 00           | RURAL HEALTH CLINIC                          | 77.10        |      |           |              |    |            |                                | ~        | 26. 00           |
| 26. 25           | FEDERALLY QUALIFIED HEALTH CENTER            | 89. 00       |      |           |              |    |            |                                | o        | 26. 25           |
| 27. 00           | Total (sum of lines 14-26)                   | 07.00        |      | 10        | ,            |    |            |                                | Ĭ        | 27. 00           |
| 28. 00           | Observation Bed Days                         |              |      |           |              |    |            |                                | o        | 28. 00           |
| 29. 00           | Ambulance Trips                              |              |      |           |              |    |            |                                |          | 29. 00           |
| 30. 00           | Employee discount days (see instruction)     |              |      |           |              |    |            |                                |          | 30.00            |
| 31. 00           | Employee discount days - IRF                 |              |      |           |              |    |            |                                |          | 31. 00           |
| 32. 00           | Labor & delivery days (see instructions)     |              |      | 0         | ,            | 0  |            |                                |          | 32. 00           |
| 32. 01           | Total ancillary labor & delivery room        |              |      |           |              |    |            |                                |          | 32. 01           |
|                  | outpatient days (see instructions)           |              |      |           |              |    |            |                                |          |                  |
| 33.00            | LTCH non-covered days                        |              |      |           |              |    |            |                                |          | 33.00            |
| 33. 01           | LTCH site neutral days and discharges        |              |      |           |              |    |            |                                |          | 33. 01           |
|                  |  |              |      |           |              |    |            |                                |          |                  |

|        |  |             |            | '         | 0 12/31/2010  | 5/30/2019 5: 2 |        |
|--------|--|-------------|------------|-----------|---------------|----------------|--------|
|        |  | I/P Days    | 0/P Visits | / Trips   | Full Time     | Equi val ents  | , p    |
|        | Component  | Title XVIII | Title XIX  | Total All | Total Interns | Employees On   |        |
|        |  |             |            | Pati ents | & Residents   | Payrol I       |        |
|        |  | 6.00        | 7. 00      | 8. 00     | 9. 00         | 10.00          |        |
| 1.00   | Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) | 225         | 62         | 1, 257    |               |                | 1. 00  |
| 2.00   | HMO and other (see instructions)   | 6           | 0          |           |               |                | 2.00   |
| 3.00   | HMO IPF Subprovider  | 0           | 0          |           |               |                | 3. 00  |
| 4.00   | HMO IRF Subprovider  | o           | 0          |           |               |                | 4.00   |
| 5.00   | Hospital Adults & Peds. Swing Bed SNF  | o           | 0          | 0         |               |                | 5. 00  |
| 6.00   | Hospital Adults & Peds. Swing Bed NF   |             | 0          | 0         |               |                | 6.00   |
| 7. 00  | Total Adults and Peds. (exclude observation beds) (see instructions)   | 225         | 62         | 1, 257    |               |                | 7. 00  |
| 8.00   | INTENSIVE CARE UNIT  |             |            |           |               |                | 8. 00  |
| 9.00   | CORONARY CARE UNIT   |             |            |           |               |                | 9. 00  |
| 10.00  | BURN INTENSIVE CARE UNIT   |             |            |           |               |                | 10.00  |
| 11. 00 | SURGICAL INTENSIVE CARE UNIT   |             |            |           |               |                | 11. 00 |
| 12.00  | OTHER SPECIAL CARE (SPECIFY)   |             |            |           |               |                | 12. 00 |
| 13.00  | NURSERY  |             |            |           |               |                | 13. 00 |
| 14.00  | Total (see instructions)   | 225         | 62         | 1, 257    | 0.00          | 147. 16        | 14. 00 |
| 15. 00 | CAH visits   | 0           | 0          | 0         |               |                | 15. 00 |
| 16. 00 | SUBPROVI DER - I PF  |             |            |           |               |                | 16. 00 |
| 17. 00 | SUBPROVI DER - I RF  |             |            |           |               |                | 17. 00 |
| 18. 00 | SUBPROVI DER   |             |            |           |               |                | 18. 00 |
| 19. 00 | SKILLED NURSING FACILITY   |             |            |           |               |                | 19. 00 |
| 20.00  | NURSING FACILITY   |             |            |           |               |                | 20. 00 |
| 21.00  | OTHER LONG TERM CARE   |             |            |           |               |                | 21. 00 |
| 22. 00 | HOME HEALTH AGENCY   |             |            |           |               |                | 22. 00 |
| 23.00  | AMBULATORY SURGICAL CENTER (D. P.)   |             |            |           |               |                | 23. 00 |
| 24.00  | HOSPI CE   |             |            |           |               |                | 24. 00 |
| 24. 10 | HOSPICE (non-distinct part)  |             |            | 0         |               |                | 24. 10 |
| 25.00  | CMHC - CMHC  |             |            |           |               |                | 25. 00 |
| 25. 10 | CMHC - CORF  | 0           | 0          | 0         | 0.00          | 0.00           | 25. 10 |
| 26.00  | RURAL HEALTH CLINIC  |             |            |           |               |                | 26. 00 |
| 26. 25 | FEDERALLY QUALIFIED HEALTH CENTER  | 0           | 0          | 0         | 0.00          | 0.00           | 26. 25 |
| 27.00  | Total (sum of lines 14-26)   |             |            |           | 0.00          | 147. 16        | 27. 00 |
| 28. 00 | Observation Bed Days   |             | 90         | 1, 818    |               |                | 28. 00 |
| 29.00  | Ambul ance Trips   | 0           |            |           |               |                | 29. 00 |
| 30.00  | Employee discount days (see instruction)   |             |            | 0         |               |                | 30.00  |
| 31.00  | Employee discount days - IRF   |             |            | 0         |               |                | 31.00  |
| 32.00  | Labor & delivery days (see instructions)   | o           | 0          | 0         |               |                | 32.00  |
| 32. 01 | Total ancillary labor & delivery room  |             |            | 0         |               |                | 32. 01 |
|        | outpatient days (see instructions)   |             |            |           |               |                |        |
| 33. 00 | LTCH non-covered days  | 0           |            |           |               |                | 33. 00 |
| 33. 01 | LTCH site neutral days and discharges  | 0           |            |           |               |                | 33. 01 |

|        |  |               |         | To          | 12/31/2018 | Date/Time Prep<br>5/30/2019 5:24 |        |
|--------|--|---------------|---------|-------------|------------|----------------------------------|--------|
|        |  | Full Time     |         | Di sch      | arges      | 373072017 3.2                    | трііі  |
|        |  | Equi val ents |         |             | J          |                                  |        |
|        | Component  | Nonpai d      | Title V | Title XVIII | Title XIX  | Total All                        |        |
|        |  | Workers       |         |             |            | Pati ents                        |        |
|        |  | 11. 00        | 12.00   | 13.00       | 14. 00     | 15. 00                           |        |
| 1.00   | Hospital Adults & Peds. (columns 5, 6, 7 and                         |               | 0       | 113         | 119        | 473                              | 1.00   |
|        | 8 exclude Swing Bed, Observation Bed and                             |               |         |             |            |                                  |        |
|        | Hospice days) (see instructions for col. 2                           |               |         |             |            |                                  |        |
|        | for the portion of LDP room available beds)                          |               |         | _           | _          |                                  |        |
| 2.00   | HMO and other (see instructions)                                     |               |         | 3           | 0          |                                  | 2. 00  |
| 3.00   | HMO IPF Subprovider  |               |         |             | 0          |                                  | 3. 00  |
| 4.00   | HMO I RF Subprovi der  |               |         |             | 0          |                                  | 4. 00  |
| 5.00   | Hospital Adults & Peds. Swing Bed SNF                                |               |         |             |            |                                  | 5. 00  |
| 6.00   | Hospital Adults & Peds. Swing Bed NF                                 |               |         |             |            |                                  | 6. 00  |
| 7. 00  | Total Adults and Peds. (exclude observation beds) (see instructions) |               |         |             |            |                                  | 7. 00  |
| 8.00   | INTENSIVE CARE UNIT  |               |         |             |            |                                  | 8. 00  |
| 9. 00  | CORONARY CARE UNIT   |               |         |             |            |                                  | 9. 00  |
| 10.00  | BURN INTENSIVE CARE UNIT   |               |         |             |            |                                  | 10. 00 |
| 11. 00 | SURGICAL INTENSIVE CARE UNIT   |               |         |             |            |                                  | 11. 00 |
| 12. 00 | OTHER SPECIAL CARE (SPECIFY)   |               |         |             |            |                                  | 12. 00 |
| 13. 00 | NURSERY  |               |         |             |            |                                  | 13. 00 |
| 14. 00 | Total (see instructions)   | 0. 00         | 0       | 113         | 119        | 473                              |        |
| 15. 00 | CAH visits   | 0.00          | O       | 113         | 117        | 473                              | 15. 00 |
| 16. 00 | SUBPROVI DER - I PF  |               |         |             |            |                                  | 16. 00 |
| 17. 00 | SUBPROVI DER - I RF  |               |         |             |            |                                  | 17. 00 |
| 18. 00 | SUBPROVI DER   |               |         |             |            |                                  | 18. 00 |
| 19. 00 | SKILLED NURSING FACILITY   |               |         |             |            |                                  | 19. 00 |
| 20.00  | NURSING FACILITY   |               |         |             |            |                                  | 20.00  |
| 21.00  | OTHER LONG TERM CARE   |               |         |             |            |                                  | 21.00  |
| 22.00  | HOME HEALTH AGENCY   |               |         |             |            |                                  | 22.00  |
| 23.00  | AMBULATORY SURGICAL CENTER (D. P.)                                   |               |         |             |            |                                  | 23.00  |
| 24. 00 | HOSPI CE   |               |         |             |            |                                  | 24.00  |
| 24. 10 | HOSPICE (non-distinct part)  |               |         |             |            |                                  | 24. 10 |
| 25. 00 | CMHC - CMHC  |               |         |             |            |                                  | 25.00  |
| 25. 10 | CMHC - CORF  | 0. 00         |         |             |            |                                  | 25. 10 |
| 26. 00 | RURAL HEALTH CLINIC  |               |         |             |            |                                  | 26. 00 |
| 26. 25 | FEDERALLY QUALIFIED HEALTH CENTER                                    | 0. 00         |         |             |            |                                  | 26. 25 |
| 27. 00 | Total (sum of lines 14-26)   | 0. 00         |         |             |            |                                  | 27. 00 |
| 28. 00 | Observation Bed Days   |               |         |             |            |                                  | 28. 00 |
| 29. 00 | Ambul ance Tri ps  |               |         |             |            |                                  | 29. 00 |
| 30.00  | Employee discount days (see instruction)                             |               |         |             |            |                                  | 30.00  |
| 31. 00 | Employee discount days - IRF   |               |         |             |            |                                  | 31. 00 |
| 32.00  | Labor & delivery days (see instructions)                             |               |         |             |            |                                  | 32. 00 |
| 32. 01 | Total ancillary labor & delivery room                                |               |         |             |            |                                  | 32. 01 |
| 33. 00 | outpatient days (see instructions) LTCH non-covered days             |               |         | 0           |            |                                  | 33. 00 |
|        | LTCH site neutral days and discharges                                |               |         | 0           |            |                                  | 33. 00 |
| 55. 51 | 12.5 5. to floati at days and at sonal gos                           | 1             |         | ١           | ١          |                                  | 50.01  |

| Period: | Worksheet S-3 | From 01/01/2018 | Part II | To 12/31/2018 | Date/Time Prepared: Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION Provi der CCN: 15-0172

|                  |  |                |              |                               | To                             | 12/31/2018                | Date/Time Pre                     |                  |
|------------------|--|----------------|--------------|-------------------------------|--------------------------------|---------------------------|-----------------------------------|------------------|
|                  |  | Wkst. A Line   | Amount       | Recl assi fi cati             | ,                              |                           | 5/30/2019 5: 24<br>Average Hourly | 4 PIII           |
|                  |  | Number         | Reported     | on of Salaries<br>(from Wkst. | Sal ari es<br>(col . 2 ± col . | Related to<br>Salaries in | Wage (col. 4 ÷ col. 5)            |                  |
|                  |  |                |              | A-6)                          | 3)                             | col. 4                    | ŕ                                 |                  |
|                  | PART II - WAGE DATA  | 1. 00          | 2. 00        | 3.00                          | 4. 00                          | 5. 00                     | 6. 00                             |                  |
|                  | SALARI ES  |                |              |                               |                                |                           |                                   |                  |
| 1.00             | Total salaries (see instructions)                              | 200. 00        | 12, 806, 252 | 0                             | 12, 806, 252                   | 370, 116. 90              | 34. 60                            | 1. 00            |
| 2. 00            | Non-physician anesthetist Part                                 |                | C            | 0                             | 0                              | 0.00                      | 0. 00                             | 2. 00            |
| 3. 00            | A<br>Non-physician anesthetist Part                            |                | C            | 0                             | 0                              | 0.00                      | 0. 00                             | 3. 00            |
|                  | В  |                | C            | _                             |                                |                           |                                   |                  |
| 4. 00            | Physician-Part A -<br>Administrative                           |                | C            | 0                             | 0                              | 0. 00                     | 0. 00                             | 4. 00            |
| 4. 01            | Physicians - Part A - Teaching                                 |                | C            | О                             | _                              | 0.00                      |                                   | 4. 01            |
| 5. 00            | Physician and Non<br>Physician-Part B                          |                | С            | 0                             | 0                              | 0.00                      | 0. 00                             | 5. 00            |
| 6.00             | Non-physician-Part B for                                       |                | C            | О                             | 0                              | 0.00                      | 0. 00                             | 6. 00            |
|                  | hospital-based RHC and FQHC services                           |                |              |                               |                                |                           |                                   |                  |
| 7.00             | Interns & residents (in an                                     | 21. 00         | C            | 0                             | 0                              | 0.00                      | 0. 00                             | 7. 00            |
| 7. 01            | approved program) Contracted interns and                       |                | C            | 0                             | 0                              | 0.00                      | 0. 00                             | 7. 01            |
|                  | residents (in an approved                                      |                |              |                               |                                |                           |                                   |                  |
| 8. 00            | programs)<br>Home office and/or related                        |                | C            | 0                             | 0                              | 0.00                      | 0. 00                             | 8. 00            |
| 9. 00            | organization personnel<br>SNF                                  | 44. 00         |              | 0                             | 0                              | 0. 00                     | 0.00                              | 9. 00            |
| 10. 00           | Excluded area salaries (see                                    | 44.00          | 2, 835, 512  | 1                             | _                              | 64, 022. 44               |                                   |                  |
|                  | instructions) OTHER WAGES & RELATED COSTS                      |                |              |                               |                                |                           |                                   |                  |
| 11. 00           | Contract Labor: Direct Patient                                 |                | 96, 240      | 0                             | 96, 240                        | 1, 601. 25                | 60. 10                            | 11. 00           |
| 12. 00           | Care<br>Contract Labor: Top Level                              |                | C            | 0                             | 0                              | 0.00                      | 0.00                              | 12. 00           |
|                  | management and other   |                |              |                               |                                |                           |                                   |                  |
|                  | management and administrative services                         |                |              |                               |                                |                           |                                   |                  |
| 13. 00           | Contract Labor: Physician-Part                                 |                | C            | 0                             | 0                              | 0.00                      | 0. 00                             | 13. 00           |
| 14. 00           | A - Administrative<br>Home office and/or related               |                | C            | 0                             | 0                              | 0.00                      | 0.00                              | 14. 00           |
|                  | organization salaries and wage-related costs                   |                |              |                               |                                |                           |                                   |                  |
| 14. 01           | Home office salaries   |                | C            | 0                             | ١                              | 0.00                      |                                   | 14. 01           |
| 14. 02<br>15. 00 | Related organization salaries<br>Home office: Physician Part A |                | C            | 0                             | 0                              | 0. 00<br>0. 00            |                                   | 14. 02<br>15. 00 |
|                  | - Administrative   |                | -            |                               |                                |                           |                                   |                  |
| 16. 00           | Home office and Contract Physicians Part A - Teaching          |                | C            | 0                             | 0                              | 0.00                      | 0.00                              | 16. 00           |
| 17.00            | WAGE-RELATED COSTS   |                | 1 001 520    |                               | 1 001 520                      |                           |                                   | 17.00            |
| 17.00            | Wage-related costs (core) (see instructions)                   |                | 1, 901, 529  | 0                             | 1, 901, 529                    |                           |                                   | 17. 00           |
| 18. 00           | Wage-related costs (other) (see instructions)                  |                | C            | 0                             | 0                              |                           |                                   | 18. 00           |
| 19. 00           | Excluded areas   |                | 540, 763     | 0                             | 540, 763                       |                           |                                   | 19. 00           |
| 20. 00           | Non-physician anesthetist Part<br>A                            |                | C            | 0                             | 0                              |                           |                                   | 20. 00           |
| 21. 00           | Non-physician anesthetist Part                                 |                | C            | o                             | 0                              |                           |                                   | 21. 00           |
| 22. 00           | B<br>Physician Part A -  |                | C            | О                             | 0                              |                           |                                   | 22. 00           |
| 22. 01           | Administrative   |                |              | 0                             | 0                              |                           |                                   | 22. 01           |
| 23. 00           | Physician Part A - Teaching<br>Physician Part B                |                | C            | 0                             | 0                              |                           |                                   | 23. 00           |
| 24. 00<br>25. 00 | Wage-related costs (RHC/FQHC)<br>Interns & residents (in an    |                | C            | 0                             | 0                              |                           |                                   | 24. 00<br>25. 00 |
|                  | approved program)  |                | C            | ١                             | 0                              |                           |                                   |                  |
| 25. 50           | Home office wage-related (core)                                |                | C            | 0                             | 0                              |                           |                                   | 25. 50           |
| 25. 51           | Related organization   |                | C            | О                             | 0                              |                           |                                   | 25. 51           |
| 25. 52           | wage-related (core)<br>Home office: Physician Part A           |                | C            | 0                             | o                              |                           |                                   | 25. 52           |
|                  | - Administrative -   |                | ·            |                               |                                |                           |                                   |                  |
| 25. 53           | wage-related (core)<br>Home office & Contract                  |                | C            | О                             | 0                              |                           |                                   | 25. 53           |
|                  | Physicians Part A - Teaching - wage-related (core)             |                |              |                               |                                |                           |                                   |                  |
|                  | OVERHEAD COSTS - DIRECT SALARIE                                |                |              |                               |                                |                           |                                   |                  |
| 26. 00<br>27. 00 | Employee Benefits Department<br>Administrative & General       | 4. 00<br>5. 00 | 1, 958, 966  | _                             |                                | 0. 00<br>62, 676. 00      |                                   | 26. 00<br>27. 00 |
|                  | 1  | 3. 30          | 1, 750, 700  |                               | 1, 750, 760                    | 32, 370.00                | 31. 20                            |                  |

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet S-3 | From 01/01/2018 | Part II | To 12/31/2018 | Date/Time Prepared: | From CMS-2552-10 | Prepared: | Prepar

|        |                                |              |          |                   |               |             | 5/30/2019 5: 2 | 1 pm   |
|--------|--------------------------------|--------------|----------|-------------------|---------------|-------------|----------------|--------|
|        |                                | Wkst. A Line | Amount   | Recl assi fi cati | Adj usted     | Pai d Hours | Average Hourly |        |
|        |                                | Number       | Reported | on of Salaries    | Sal ari es    | Related to  | Wage (col. 4 ÷ |        |
|        |                                |              |          | (from Wkst.       | (col.2 ± col. | Salaries in | col . 5)       |        |
|        |                                |              |          | A-6)              | 3)            | col. 4      |                |        |
|        |                                | 1. 00        | 2. 00    | 3. 00             | 4. 00         | 5. 00       | 6. 00          |        |
| 28. 00 | Administrative & General under |              | C        | 0                 | 0             | 0.00        | 0.00           | 28. 00 |
|        | contract (see inst.)           |              |          |                   |               |             |                |        |
| 29. 00 | Maintenance & Repairs          | 6. 00        |          | 0                 | 0             | 0.00        |                | 29. 00 |
| 30.00  | Operation of Plant             | 7. 00        | 128, 440 | 0                 | 128, 440      | 4, 322. 00  | 29. 72         | 30.00  |
| 31.00  | Laundry & Linen Service        | 8. 00        | C        | 0                 | 0             | 0.00        | 0.00           | 31.00  |
| 32.00  | Housekeepi ng                  | 9. 00        | C        | 0                 | 0             | 0.00        | 0.00           | 32.00  |
| 33.00  | Housekeeping under contract    |              | C        | 256, 178          | 256, 178      | 8, 539. 00  | 30.00          | 33.00  |
|        | (see instructions)             |              |          |                   |               |             |                |        |
| 34.00  | Di etary                       | 10.00        | C        | 0                 | 0             | 0.00        | 0.00           | 34.00  |
| 35.00  | Dietary under contract (see    |              | C        | 6, 231            | 6, 231        | 145.00      | 42. 97         | 35.00  |
|        | instructions)                  |              |          |                   |               |             |                |        |
| 36.00  | Cafeteri a                     | 11. 00       | C        | 0                 | 0             | 0.00        | 0.00           | 36.00  |
| 37.00  | Maintenance of Personnel       | 12. 00       | C        | 0                 | 0             | 0.00        | 0.00           | 37.00  |
| 38.00  | Nursing Administration         | 13. 00       | 418, 939 | 0                 | 418, 939      | 8, 408. 00  | 49. 83         | 38.00  |
| 39.00  | Central Services and Supply    | 14. 00       | 293, 795 | 0                 | 293, 795      | 15, 106. 00 | 19. 45         | 39.00  |
| 40.00  | Pharmacy                       | 15. 00       | C        | 0                 | 0             | 0.00        | 0.00           | 40.00  |
| 41.00  | Medical Records & Medical      | 16. 00       | C        | 0                 | 0             | 0.00        | 0.00           | 41.00  |
|        | Records Li brary               |              |          |                   |               |             |                |        |
| 42.00  | Social Service                 | 17. 00       | C        | 0                 | 0             | 0.00        | 0.00           | 42.00  |
| 43.00  | Other General Service          | 18. 00       | C        | 0                 | 0             | 0.00        | 0.00           | 43.00  |

|      |                                |             |              |                  | ''            | 0 12/31/2010 | 5/30/2019 5: 24 |       |
|------|--------------------------------|-------------|--------------|------------------|---------------|--------------|-----------------|-------|
|      |                                | Worksheet A | Amount       | Reclassi fi cati | Adj usted     | Pai d Hours  | Average Hourly  |       |
|      |                                | Line Number | Reported     | on of Salaries   | Sal ari es    | Related to   | 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              |             | 12, 806, 252 | 262, 409         | 13, 068, 661  | 378, 800. 90 | 34. 50          | 1. 00 |
|      | instructions)                  |             |              |                  |               |              |                 |       |
| 2.00 | Excluded area salaries (see    |             | 2, 835, 512  | 0                | 2, 835, 512   | 64, 022. 44  | 44. 29          | 2. 00 |
|      | instructions)                  |             |              |                  |               |              |                 |       |
| 3.00 | Subtotal salaries (line 1      |             | 9, 970, 740  | 262, 409         | 10, 233, 149  | 314, 778. 46 | 32. 51          | 3. 00 |
|      | minus line 2)                  |             |              |                  |               |              |                 |       |
| 4.00 | Subtotal other wages & related |             | 96, 240      | 0                | 96, 240       | 1, 601. 25   | 60. 10          | 4. 00 |
|      | costs (see inst.)              |             |              |                  |               |              |                 |       |
| 5.00 | Subtotal wage-related costs    |             | 1, 901, 529  | 0                | 1, 901, 529   | 0.00         | 18. 58          | 5. 00 |
|      | (see inst.)                    |             |              |                  |               |              |                 |       |
| 6.00 | Total (sum of lines 3 thru 5)  |             | 11, 968, 509 | 262, 409         | 12, 230, 918  | 316, 379. 71 | 38. 66          | 6. 00 |
| 7.00 | Total overhead cost (see       |             | 2, 800, 140  | 262, 409         | 3, 062, 549   | 99, 196. 00  | 30. 87          | 7. 00 |
|      | instructions)                  |             |              |                  |               |              |                 |       |

| Health Financial Systems    | PHYSICIANS MEDICAL CENTER | In Lieu of Form CMS-2552-10  |
|-----------------------------|---------------------------|--|
| HOSPITAL WAGE RELATED COSTS | Provi der CCN: 15-0172    | Peri od: Worksheet S-3 Part IV Part IV Date/Time Prepared: 5/20/2019 5:24 pm |

|        | 10 12/31/20  | 18   Date/lime Prep<br>  5/30/2019 5:24 |        |
|--------|--|---|--------|
|        |  | Amount                                  | ,      |
|        |  | Reported                                |        |
|        |  | 1.00                                    |        |
|        | PART IV - WAGE RELATED COSTS   |   |        |
|        | Part A - Core List   |   | 1      |
|        | RETI REMENT COST   |   | 1      |
| 1.00   | 401K Employer Contributions  | 0                                       | 1.00   |
| 2.00   | Tax Sheltered Annuity (TSA) Employer Contribution  | 0                                       | 2. 00  |
| 3.00   | Nonqualified Defined Benefit Plan Cost (see instructions)  | 0                                       | 3. 00  |
| 4.00   | Qualified Defined Benefit Plan Cost (see instructions)   | 0                                       | 4. 00  |
|        | PLAN ADMINISTRATIVE COSTS (Paid to External Organization)  | ·                                       |        |
| 5.00   | 401K/TSA Plan Administration fees  | 0                                       | 5.00   |
| 6.00   | Legal /Accounting/Management Fees-Pension Plan   | 0                                       | 6.00   |
| 7.00   | Employee Managed Care Program Administration Fees  | 0                                       | 7. 00  |
|        | HEALTH AND INSURANCE COST  |   |        |
| 8.00   | Health Insurance (Purchased or Self Funded)  | 0                                       | 8. 00  |
| 8. 01  | Health Insurance (Self Funded without a Third Party Administrator)   | 0                                       | 8. 01  |
| 8. 02  | Health Insurance (Self Funded with a Third Party Administrator)  | 0                                       | 8. 02  |
| 8. 03  | Health Insurance (Purchased)   | 1, 322, 332                             | 8. 03  |
| 9.00   | Prescription Drug Plan   | 0                                       | 9. 00  |
| 10.00  | Dental, Hearing and Vision Plan  | 0                                       | 10.00  |
| 11.00  | Life Insurance (If employee is owner or beneficiary)   | 0                                       | 11. 00 |
| 12.00  | Accident Insurance (If employee is owner or beneficiary)   | 0                                       | 12.00  |
| 13.00  | Disability Insurance (If employee is owner or beneficiary)   | 0                                       | 13.00  |
| 14.00  | Long-Term Care Insurance (If employee is owner or beneficiary)   | 0                                       | 14.00  |
| 15. 00 | 'Workers' Compensation Insurance   | 143, 266                                | 15. 00 |
| 16.00  | Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.                | 0                                       | 16. 00 |
|        | Non cumulative portion)  |   |        |
|        | TAXES  |   |        |
|        | FICA-Employers Portion Only  | 930, 958                                | ı      |
|        | Medicare Taxes - Employers Portion Only  | 0                                       |        |
|        | Unemployment Insurance   | 0                                       | 19. 00 |
| 20. 00 | State or Federal Unemployment Taxes  | 0                                       | 20. 00 |
|        | OTHER  |   |        |
| 21. 00 | Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (seinstructions)) | ee 0                                    | 21. 00 |
| 22. 00 | Day Care Cost and Allowances   | 0                                       | 22. 00 |
|        | Tui ti on Rei mbursement   | 45, 736                                 |        |
|        | Total Wage Related cost (Sum of lines 1 -23)   | 2, 442, 292                             |        |
| 250    | Part B - Other than Core Related Cost  | 2,, 2, 2                                | 55     |
| 25. 00 | OTHER WAGE RELATED COSTS (SPECIFY)   | 0                                       | 25. 00 |
|        |  |   |        |

| Health Financial Systems                 | PHYSICIANS MEDICAL CENTER | In Lie                                       | u of Form CMS-2552-10   |
|--|---------------------------|--|---|
| HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provi der CCN: 15-0172    | Peri od:<br>From 01/01/2018<br>To 12/31/2018 | Worksheet S-3<br>Part V<br>Date/Time Prepared:<br>5/30/2019 5:24 pm |

|        |   | 0 12/31/2010   | 5/30/2019 5: 24 |        |
|--------|---|----------------|-----------------|--------|
|        | Cost Center Description                               | Contract Labor | Benefit Cost    |        |
|        | *   | 1. 00          | 2. 00           |        |
|        | PART V - Contract Labor and Benefit Cost              |                |                 |        |
|        | Hospital and Hospital-Based Component Identification: |                |                 |        |
| 1.00   | Total facility's contract labor and benefit cost      | 96, 240        | 2, 442, 292     | 1.00   |
| 2.00   | Hospi tal   | 96, 240        | 2, 442, 292     | 2.00   |
| 3.00   | Subprovi der - I PF                                   |                |                 | 3.00   |
| 4.00   | Subprovi der - I RF                                   |                |                 | 4.00   |
| 5. 00  | Subprovi der - (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  | Hospi tal -Based SNF                                  |                |                 | 8. 00  |
| 9. 00  | Hospi tal -Based NF                                   |                |                 | 9. 00  |
| 10. 00 | Hospi tal -Based OLTC                                 |                |                 | 10.00  |
| 11. 00 | Hospi tal -Based HHA                                  |                |                 | 11. 00 |
| 12. 00 | Separately Certified ASC                              |                |                 | 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 | Hospi tal -Based-CMHC                                 |                |                 | 16.00  |
| 16. 10 | Hospi tal -Based-CMHC 10                              | 0              | 0               | 16. 10 |
|        | Renal Di al ysi s                                     |                |                 | 17. 00 |
| 18. 00 | Other   | 0              | 0               | 18. 00 |

|  | TAL UNCOMPENSATED AND INDIGENT CARE DATA Prov  | vider CCN: 15-0172   | Period:<br>From 01/01/201                                       | Worksheet S-1   | 10  |
|--|--|--|---|---|---|
|  |  |  | To 12/31/2018   |   |   |
|  |  |  |   | 1.00  |   |
|  | Uncompensated and indigent care cost computation   |  |   | _   |   |
| 00   | Cost to charge ratio (Worksheet C, Part I line 202 column 3 divide   | d by line 202 col  | umn 8)  | 0. 196575   | 1.  |
| 00   | Medicaid (see instructions for each line) Net revenue from Medicaid  |  |   | 4, 338, 817   | 7 2.  |
| 00   | Did you receive DSH or supplemental payments from Medicaid?  |  |   | 4, 330, 617<br>N  | 3.  |
| 00   | If line 3 is yes, does line 2 include all DSH and/or supplemental  | payments from Med  | i cai d?  |   | 4.  |
| 00   | If line 4 is no, then enter DSH and/or supplemental payments from  | Medi cai d   |   | 0   | 5.  |
| 00   | Medi cai d charges   |  |   | 19, 435, 064  |   |
| 00   | Medicaid cost (line 1 times line 6)  | 7  |   | 3, 820, 448   |   |
| 00   | Difference between net revenue and costs for Medicaid program (lin < zero then enter zero)   | ie / minus sum or  | lines 2 and 5; if   | 0   | 8.  |
|  | Children's Health Insurance Program (CHIP) (see instructions for e   | ach line)  |   |   |   |
| 00   | Net revenue from stand-alone CHIP  | ,  |   | C   | 9.  |
| . 00   | Stand-alone CHIP charges   |  |   | 0   |   |
| . 00   | Stand-alone CHIP cost (line 1 times line 10)   | - 11 1: 0  | : 6 +   | 0   |   |
| . 00   | Difference between net revenue and costs for stand-alone CHIP (lin enter zero)   | e II minus IIne 9  | ; IT < zero then  |   | 12.   |
|  | Other state or local government indigent care program (see instruc   | tions for each li  | ne)   |   |   |
| . 00   | Net revenue from state or local indigent care program (Not include   |  |   | 0   | 13.   |
| . 00   | Charges for patients covered under state or local indigent care pr   | ogram (Not includ  | ed in lines 6 or  | 0   | 14.   |
| 00   | 10)  |  |   |   | 1   |
| . 00   | State or local indigent care program cost (line 1 times line 14) Difference between net revenue and costs for state or local indige  | ent care program (   | ling 15 minus ling  | 0   | 15.   |
| . 00   | 13; if < zero then enter zero)   | int care program (   | TITIC TO IIITIUS TITIC  |   | ] '0.   |
|  | Grants, donations and total unreimbursed cost for Medicaid, CHIP a   | nd state/local in  | digent care progra  | ams (see  |   |
|  |  |  |   |   |   |
| 00   | Instructions for each line)  Private grants, donations, or endowment income restricted to fundi  | ng charity care  |   | 1 0   | 17  |
|  | Private grants, donations, or endowment income restricted to fundi<br>Government grants, appropriations or transfers for support of hosp   | 9  |   | 0   |   |
| 3. 00  | Private grants, donations, or endowment income restricted to fundi<br>Government grants, appropriations or transfers for support of hosp<br>Total unreimbursed cost for Medicaid , CHIP and state and local in   | ital operations  | ams (sum of lines   | 0   | 18.   |
| . 00   | Private grants, donations, or endowment income restricted to fundi<br>Government grants, appropriations or transfers for support of hosp   | ital operations  | ·   | 0   | ) 18.<br>) 19.  |
| . 00   | Private grants, donations, or endowment income restricted to fundi<br>Government grants, appropriations or transfers for support of hosp<br>Total unreimbursed cost for Medicaid , CHIP and state and local in   | oital operations digent care progr Uninsure patient  | ed Insured<br>s patients  | Total (col. 1 + col. 2)   | ) 18.<br>) 19.  |
| . 00   | Private grants, donations, or endowment income restricted to fundi<br>Government grants, appropriations or transfers for support of hosp<br>Total unreimbursed cost for Medicaid , CHIP and state and local in<br>8, 12 and 16)  | oital operations digent care progr  Uninsure   | ed Insured  | Total (col. 1   | ) 18.<br>) 19.  |
| . 00   | Private grants, donations, or endowment income restricted to fundi<br>Government grants, appropriations or transfers for support of hosp<br>Total unreimbursed cost for Medicaid , CHIP and state and local in<br>8, 12 and 16)  Uncompensated Care (see instructions for each line)   | oital operations digent care progr  Uninsure patient 1.00  | ed Insured patients 2.00  | Total (col. 1 + col. 2) 3.00                                      | 18.   |
| . 00   | Private grants, donations, or endowment income restricted to fundi<br>Government grants, appropriations or transfers for support of hosp<br>Total unreimbursed cost for Medicaid , CHIP and state and local in<br>8, 12 and 16)  | oital operations digent care progr  Uninsure patient 1.00  | ed Insured patients 2.00  | Total (col. 1 + col. 2) 3.00                                      | 18.   |
| . 00   | Private grants, donations, or endowment income restricted to fundi Government grants, appropriations or transfers for support of hosp Total unreimbursed cost for Medicaid, CHIP and state and local in 8, 12 and 16)  Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facili (see instructions) Cost of patients approved for charity care and uninsured discounts  | uital operations digent care progr Uninsure patient 1.00   | ed Insured patients 2.00  | Total (col. 1 + col. 2) 3.00                                      | 18.   |
| . 00   | Private grants, donations, or endowment income restricted to fundi Government grants, appropriations or transfers for support of hosp Total unreimbursed cost for Medicaid, CHIP and state and local in 8, 12 and 16)  Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facili (see instructions) Cost of patients approved for charity care and uninsured discounts instructions)  | ital operations digent care progr  Uninsure patient 1.00  ty (see  | l Insured patients 2.00   | Total (col. 1 + col. 2) 3.00                                      | 20.   |
| . 00   | Private grants, donations, or endowment income restricted to fundi Government grants, appropriations or transfers for support of hosp Total unreimbursed cost for Medicaid, CHIP and state and local in 8, 12 and 16)  Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facili (see instructions) Cost of patients approved for charity care and uninsured discounts instructions) Payments received from patients for amounts previously written off   | ital operations digent care progr  Uninsure patient 1.00  ty (see  | ed Insured patients 2.00  | Total (col. 1 + col. 2) 3.00                                      | ) 18.<br>) 19.<br>) 20.   |
| . 00   | Private grants, donations, or endowment income restricted to fundi Government grants, appropriations or transfers for support of hosp Total unreimbursed cost for Medicaid, CHIP and state and local in 8, 12 and 16)  Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facili (see instructions) Cost of patients approved for charity care and uninsured discounts instructions) Payments received from patients for amounts previously written off charity care  | ital operations digent care progr  Uninsure patient 1.00  ty (see  | ed s Insured patients 2.00                                      | Total (col. 1 + col. 2) 3.00                                      | ) 18.<br>) 19.<br>) 20.<br>) 21.<br>) 22.                             |
| . 00   | Private grants, donations, or endowment income restricted to fundi Government grants, appropriations or transfers for support of hosp Total unreimbursed cost for Medicaid, CHIP and state and local in 8, 12 and 16)  Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facili (see instructions) Cost of patients approved for charity care and uninsured discounts instructions) Payments received from patients for amounts previously written off charity care  | ital operations digent care progr  Uninsure patient 1.00  ty (see  | ed Insured patients 2.00  | Total (col. 1 + col. 2) 3.00                                      | ) 18.<br>19.<br>0 20.<br>0 21.  |
| . 00   | Private grants, donations, or endowment income restricted to fundi Government grants, appropriations or transfers for support of hosp Total unreimbursed cost for Medicaid, CHIP and state and local in 8, 12 and 16)  Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facili (see instructions) Cost of patients approved for charity care and uninsured discounts instructions) Payments received from patients for amounts previously written off charity care Cost of charity care (line 21 minus line 22)   | Uninsure patient 1.00  ty  (see  | ed Insured patients 2.00  | Total (col. 1 + col. 2) 3.00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | 20.<br>20.<br>21.<br>22.<br>23.                                       |
| . 00   | Private grants, donations, or endowment income restricted to fundi Government grants, appropriations or transfers for support of hosp Total unreimbursed cost for Medicaid, CHIP and state and local in 8, 12 and 16)  Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facili (see instructions) Cost of patients approved for charity care and uninsured discounts instructions) Payments received from patients for amounts previously written off charity care Cost of charity care (line 21 minus line 22)  Does the amount on line 20 column 2, include charges for patient described to the support of the form of the support of t | Uninsure patient 1.00  ty  (see lays beyond a leng   | ed Insured patients 2.00  | Total (col. 1 + col. 2) 3.00                                      | 20.<br>20.<br>21.<br>22.<br>23.                                       |
| . 00 . 00 . 00 . 00 . 00   | Private grants, donations, or endowment income restricted to fundi Government grants, appropriations or transfers for support of hosp Total unreimbursed cost for Medicaid, CHIP and state and local in 8, 12 and 16)  Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facili (see instructions) Cost of patients approved for charity care and uninsured discounts instructions) Payments received from patients for amounts previously written off charity care Cost of charity care (line 21 minus line 22)  Does the amount on line 20 column 2, include charges for patient dimposed on patients covered by Medicaid or other indigent care pro If line 24 is yes, enter the charges for patient days beyond the i  | Uninsure patient 1.00  ty  (see Fas lays beyond a lenggram?  | Insured patients 2.00  0 0 0 0 th of stay limit                 | Total (col. 1 + col. 2) 3.00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | 20. 20. 21. 22. 23. 24.   |
| . 00 . 00 . 00 . 00 . 00 . 00 . 00   | Private grants, donations, or endowment income restricted to fundi Government grants, appropriations or transfers for support of hosp Total unreimbursed cost for Medicaid, CHIP and state and local in 8, 12 and 16)  Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facili (see instructions) Cost of patients approved for charity care and uninsured discounts instructions) Payments received from patients for amounts previously written off charity care Cost of charity care (line 21 minus line 22)  Does the amount on line 20 column 2, include charges for patient dimposed on patients covered by Medicaid or other indigent care pro   | ty  (see  lays beyond a lengigram? ndi gent care prog  | Insured patients 2.00  0 0 0 0 th of stay limit                 | Total (col. 1 + col. 2) 3.00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | 20. 20. 21. 22. 23. 24. 25.   |
| . 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00   | Private grants, donations, or endowment income restricted to fundi Government grants, appropriations or transfers for support of hosp Total unreimbursed cost for Medicaid, CHIP and state and local in 8, 12 and 16)  Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facili (see instructions) Cost of patients approved for charity care and uninsured discounts instructions) Payments received from patients for amounts previously written off charity care Cost of charity care (line 21 minus line 22)  Does the amount on line 20 column 2, include charges for patient dimposed on patients covered by Medicaid or other indigent care pro If line 24 is yes, enter the charges for patient days beyond the istay limit  | Uninsure patient 1.00  ty (see as as beyond a lenguagram? ndigent care prog  | Insured patients 2.00  0 0 0 0 th of stay limit                 | Total (col. 1 + col. 2) 3.00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | 0 18.<br>19.<br>0 20.<br>0 21.<br>0 23.<br>24.<br>24.<br>25.<br>6 26. |
| 0.00<br>0.00<br>0.00<br>0.00<br>0.00<br>0.00<br>0.00<br>0.0  | Private grants, donations, or endowment income restricted to fundi Government grants, appropriations or transfers for support of hosp Total unreimbursed cost for Medicaid, CHIP and state and local in 8, 12 and 16)  Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facili (see instructions) Cost of patients approved for charity care and uninsured discounts instructions) Payments received from patients for amounts previously written off charity care Cost of charity care (line 21 minus line 22)  Does the amount on line 20 column 2, include charges for patient dimposed on patients covered by Medicaid or other indigent care pro If line 24 is yes, enter the charges for patient days beyond the i stay limit Total bad debt expense for the entire hospital complex (see instru Medicare reimbursable bad debts for the entire hospital complex (see   | ty  alays beyond a leng gram? ndigent care prog  | Insured patients 2.00  0 0 0 0 th of stay limit                 | Total (col. 1 + col. 2) 3.00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | 0 20.<br>0 21.<br>0 22.<br>0 23.<br>0 25.<br>6 26.<br>0 27.<br>27.    |
| 3. 00<br>0. 00<br>0. 00<br>0. 00<br>0. 00<br>1. | Private grants, donations, or endowment income restricted to fundi Government grants, appropriations or transfers for support of hosp Total unreimbursed cost for Medicaid, CHIP and state and local in 8, 12 and 16)  Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facili (see instructions) Cost of patients approved for charity care and uninsured discounts instructions) Payments received from patients for amounts previously written off charity care Cost of charity care (line 21 minus line 22)  Does the amount on line 20 column 2, include charges for patient dimposed on patients covered by Medicaid or other indigent care pro If line 24 is yes, enter the charges for patient days beyond the i stay limit Total bad debt expense for the entire hospital complex (see instrumedicare allowable bad debts for the entire hospital complex (see Non-Medicare bad debt expense (see instructions)  | digent care progrations digent care progrations digent care progrations.  Uninsure patient 1.00  ty  (see as | Insured patients 2.00  0 0 0 0 th of stay limit ram's length of | Total (col. 1 + col. 2) 3.00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | 19. 19. 19. 19. 19. 19. 19. 19. 19. 19.                               |
|  | Private grants, donations, or endowment income restricted to fundi Government grants, appropriations or transfers for support of hosp Total unreimbursed cost for Medicaid, CHIP and state and local in 8, 12 and 16)  Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facili (see instructions) Cost of patients approved for charity care and uninsured discounts instructions) Payments received from patients for amounts previously written off charity care Cost of charity care (line 21 minus line 22)  Does the amount on line 20 column 2, include charges for patient dimposed on patients covered by Medicaid or other indigent care pro If line 24 is yes, enter the charges for patient days beyond the istay limit Total bad debt expense for the entire hospital complex (see instrumedicare reimbursable bad debts for the entire hospital complex (see Non-Medicare bad debt expense (see instructions) Cost of non-Medicare and non-reimbursable Medicare bad debt expense  | digent care progrations digent care progrations digent care progrations.  Uninsure patient 1.00  ty  (see as | Insured patients 2.00  0 0 0 0 th of stay limit ram's length of | Total (col. 1 + col. 2) 3.00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | 18. 19. 19. 19. 19. 19. 19. 19. 19. 19. 19                            |

| Heal th | Financial Systems                             | PHYSICIANS MEDI | CAL CENTER   |                      | In Lie                                       | u of Form CMS-2 | 2552-10 |
|---------|---|-----------------|--------------|----------------------|--|-----------------|---------|
|         | SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O |                 | Provi der CO | CN: 15-0172          | Peri od:                                     | Worksheet A     |         |
|         |   |                 |              | 1                    | rom 01/01/2018                               |                 |         |
|         |   |                 |              | -                    | Γο 12/31/2018                                |                 |         |
|         | 0 1 0 1 0 1 1                                 | 6.1.            | 011          | T     (   a          | D 1 : C: 1:                                  | 5/30/2019 5: 2  | 4 pm    |
|         | Cost Center Description                       | Sal ari es      | 0ther        |                      | Reclassificati                               | Reclassi fied   |         |
|         |   |                 |              | + col. 2)            | ons (See A-6)                                | Trial Balance   |         |
|         |   |                 |              |                      |  | (col. 3 +-      |         |
|         |   | 4.00            |              |                      | 4.00   | col . 4)        |         |
|         | OFFICE ASSESSMENT OF A SENTENCE               | 1.00            | 2. 00        | 3. 00                | 4. 00  | 5. 00           |         |
| 4 00    | GENERAL SERVICE COST CENTERS                  |                 | 0 705 577    |                      | 1 1 1 0 001                                  | 0.000.010       |         |
| 1.00    | 00100 CAP REL COSTS-BLDG & FIXT               |                 | 2, 735, 577  |                      |  | 2, 903, 968     | 1. 00   |
| 2.00    | 00200 CAP REL COSTS-MVBLE EQUIP               |                 | 1, 565, 213  |                      |  | 1, 565, 213     | 2. 00   |
| 3.00    | 00300 OTHER CAP REL COSTS                     |                 | 0            |                      | 0  | 0               | 3. 00   |
| 4.00    | 00400 EMPLOYEE BENEFITS DEPARTMENT            | 0               | 1, 872, 586  |                      |  | 2, 401, 939     | 4. 00   |
| 5.00    | 00500 ADMINISTRATIVE & GENERAL                | 1, 958, 966     | 6, 369, 361  | 8, 328, 32           |  | 8, 322, 096     | 5. 00   |
| 7.00    | 00700 OPERATION OF PLANT                      | 128, 440        | 1, 607, 111  | 1, 735, 55           | -256, 178                                    | 1, 479, 373     | 7. 00   |
| 8.00    | 00800 LAUNDRY & LINEN SERVICE                 | 0               | 328, 390     | 328, 390             | 0  | 328, 390        | 8.00    |
| 9.00    | 00900 HOUSEKEEPI NG                           | 0               | 0            | (                    | 256, 178                                     | 256, 178        | 9.00    |
| 10.00   | 01000 DI ETARY                                | o               | 55, 560      | 55, 560              | 6, 231                                       | 61, 791         | 10.00   |
| 13.00   | 01300 NURSING ADMINISTRATION                  | 418, 939        | 0            | 418, 939             |  | 418, 939        | 13. 00  |
| 14. 00  | 01400 CENTRAL SERVICES & SUPPLY               | 293, 795        | 39, 552      |                      |  | 333, 347        | 14. 00  |
| 15. 00  | 01500 PHARMACY                                | 2,3,7,0         | 07, 002      |                      |  | 0               | 15. 00  |
| 16. 00  | 01600 MEDICAL RECORDS & LIBRARY               | o o             | 77, 162      | 1                    | ٥ -  | 77, 162         | 16. 00  |
| 10.00   | I NPATI ENT ROUTI NE SERVI CE COST CENTERS    | <u> </u>        | 77, 102      | 77, 102              | <u>-                                    </u> | 77, 102         | 10.00   |
| 30. 00  | 03000 ADULTS & PEDIATRICS                     | 1, 144, 161     | 33, 526      | 1, 177, 68           | 7 0  | 1, 177, 687     | 30. 00  |
| 30.00   | ANCI LLARY SERVI CE COST CENTERS              | 1, 144, 101     | 33, 320      | 1, 177, 00           | , , , , ,                                    | 1, 177, 007     | 30.00   |
| 50.00   | 05000 OPERATING ROOM                          | 5, 333, 731     | 0            | 5, 333, 73           | 1 -96, 240                                   | 5, 237, 491     | 50. 00  |
| 53. 00  | 05300 ANESTHESI OLOGY                         | 563, 362        | 36, 900      |                      |  | 600, 262        | 53. 00  |
| 54. 00  | 05400 RADI OLOGY-DI AGNOSTI C                 | 129, 346        | 30, 700<br>0 | 129, 340             |  | 129, 346        | 54. 00  |
| 60. 00  | 06000 LABORATORY                              | 127, 340        | 0            | 127, 340             |  | 129, 340        | 60.00   |
| 63. 00  | 06300 BLOOD STORING, PROCESSING, & TRANS.     |                 | 0            | )                    |  | 0               | 63. 00  |
|         |   | 0               | 0            |                      | 0 0 0 10                                     | _               |         |
| 66. 00  | 06600 PHYSI CAL THERAPY                       | U               | 0            |                      | 96, 240                                      | 96, 240         | 66. 00  |
| 69. 00  | 06900 ELECTROCARDI OLOGY                      | 0               |              | . === 0              | 0  | 0               | 69. 00  |
| 71. 00  | 07100 MEDICAL SUPPLIES CHARGED TO PATIENT     | 0               | 4, 778, 258  |                      |  | 4, 778, 258     | 71. 00  |
| 72.00   | 07200 I MPL. DEV. CHARGED TO PATIENTS         | 0               | 6, 036, 535  |                      |  | 6, 036, 535     | 72. 00  |
| 73. 00  | 07300 DRUGS CHARGED TO PATIENTS               | 0               | 1, 720, 523  | 1, 720, 52           | 3  0   | 1, 720, 523     | 73. 00  |
|         | OUTPATIENT SERVICE COST CENTERS               |                 |              |                      |  |                 |         |
| 92. 00  | 09200 OBSERVATION BEDS (NON-DISTINCT PART     |                 |              |                      |  |                 | 92. 00  |
|         | OTHER REIMBURSABLE COST CENTERS               |                 |              |                      |  |                 |         |
| 99. 10  | 09910 CORF                                    | 0               | 0            | (                    | 0  | 0               | 99. 10  |
|         | SPECIAL PURPOSE COST CENTERS                  |                 |              |                      | _  |                 |         |
|         | 11300 INTEREST EXPENSE                        |                 | 168, 391     | 168, 39 <sup>-</sup> |  |                 | 113. 00 |
| 118.00  | 1 2 2 2 7                                     | 9, 970, 740     | 27, 424, 645 | 37, 395, 38          | 529, 353                                     | 37, 924, 738    | 118. 00 |
|         | NONREI MBURSABLE COST CENTERS                 |                 |              |                      |  |                 |         |
| 190.00  | 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN     | 0               | 0            | (                    | 0  |                 | 190. 00 |
| 190. 01 | 19001 SHELLED SPACE                           | 0               | 0            | (                    | 0  | 0               | 190. 01 |
|         | 19100 RESEARCH                                | o               | 0            |                      | 0  | 0               | 191. 00 |
| 192.00  | 19200 PHYSICIANS' PRIVATE OFFICES             | ol              | 0            |                      | 0  | 0               | 192. 00 |
|         | 19300 NONPALD WORKERS                         | l               | 0            |                      | ol o   |                 | 193. 00 |
|         | 07950 FREESTANDING REFERENCE LABORATORY       | o               | 8, 009, 875  | 8, 009, 87           | 5 0  | 8, 009, 875     |         |
|         | 07951 FREESTANDING URGENT CARE CENTERS        | 2, 835, 512     | 2, 571, 949  |                      |  | 4, 878, 108     |         |
| 200.00  |   | 12, 806, 252    | 38, 006, 469 |                      |  | 50, 812, 721    |         |
| _00.00  | 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1         | .2,000,202      | 30, 300, 107 | 1 00,0.2,72          | .1   | 33, 3.2, 721    |         |

Peri od: Worksheet A From 01/01/2018 Date/Time Prepared: 5/20/2019 5:24 pm

|        |   |                |                | 5/30/2019 5:   | 24 pm              |
|--------|---|----------------|----------------|--|--------------------|
|        | Cost Center Description                   | Adjustments    | Net Expenses   |  |                    |
|        |   | (See A-8)      | For Allocation |  |                    |
|        |   | 6.00           | 7.00           |  |                    |
|        | GENERAL SERVICE COST CENTERS              |                |                |  |                    |
| 1.00   | 00100 CAP REL COSTS-BLDG & FIXT           | -651, 948      | 2, 252, 020    |  | 1. 00              |
| 2.00   | 00200 CAP REL COSTS-MVBLE EQUIP           | 0              | 1, 565, 213    |  | 2. 00              |
| 3.00   | 00300 OTHER CAP REL COSTS                 | 0              | 0              |  | 3. 00              |
| 4.00   | 00400 EMPLOYEE BENEFITS DEPARTMENT        | 0              | 2, 401, 939    |  | 4. 00              |
| 5.00   | 00500 ADMINISTRATIVE & GENERAL            | -160, 077      | 8, 162, 019    |  | 5. 00              |
| 7.00   | 00700 OPERATION OF PLANT                  | 0              | 1, 479, 373    |  | 7. 00              |
| 8.00   | 00800 LAUNDRY & LINEN SERVICE             | 0              | 328, 390       |  | 8. 00              |
| 9.00   | 00900 HOUSEKEEPI NG                       | 0              | 256, 178       |  | 9. 00              |
| 10.00  | 01000 DI ETARY                            | 0              | 61, 791        |  | 10.00              |
| 13.00  | 01300 NURSING ADMINISTRATION              | 0              | 418, 939       |  | 13. 00             |
| 14. 00 | 01400 CENTRAL SERVICES & SUPPLY           | o              | 333, 347       | •  | 14.00              |
| 15. 00 | 01500 PHARMACY                            | 0              | 0              |  | 15. 00             |
| 16. 00 | 01600 MEDICAL RECORDS & LIBRARY           | -68, 224       | 8, 938         | l control of the cont | 16. 00             |
|        | INPATIENT ROUTINE SERVICE COST CENTERS    |                |                | 1  |                    |
| 30. 00 | 03000 ADULTS & PEDIATRICS                 | 0              | 1, 177, 687    | ,  | 30.00              |
| 00.00  | ANCI LLARY SERVI CE COST CENTERS          | <u> </u>       | 1,177,007      |  |                    |
| 50. 00 | 05000 OPERATING ROOM                      | -748, 969      | 4, 488, 522    |  | 50.00              |
| 53. 00 | 05300 ANESTHESI OLOGY                     | 0              | 600, 262       | ·  | 53. 00             |
| 54. 00 | 05400 RADI OLOGY-DI AGNOSTI C             | 0              | 129, 346       |  | 54. 00             |
| 60.00  | 06000 LABORATORY                          | 0              | .27,010        | 1  | 60.00              |
| 63. 00 | 06300 BLOOD STORING, PROCESSING, & TRANS. | 0              | 0              | 1  | 63. 00             |
| 66. 00 | 06600 PHYSI CAL THERAPY                   | 0              | 96, 240        |  | 66. 00             |
| 69. 00 | 06900 ELECTROCARDI OLOGY                  | 0              | 70, 210        |  | 69. 00             |
| 71. 00 | 07100 MEDICAL SUPPLIES CHARGED TO PATIENT | 0              | 4, 778, 258    |  | 71. 00             |
| 72. 00 | 07200 IMPL. DEV. CHARGED TO PATIENTS      | 0              | 6, 036, 535    |  | 72. 00             |
| 73. 00 | 07300 DRUGS CHARGED TO PATIENTS           | 0              | 1, 720, 523    |  | 73. 00             |
| 73.00  | OUTPATIENT SERVICE COST CENTERS           | 9              | 1, 720, 323    | <u>'</u>   | 75.00              |
| 92. 00 | 09200 OBSERVATION BEDS (NON-DISTINCT PART |                |                |  | 92. 00             |
| 72.00  | OTHER REIMBURSABLE COST CENTERS           |                |                |  | 72.00              |
| 99. 10 |   | O              | 0              |  | 99. 10             |
| 77. 10 | SPECIAL PURPOSE COST CENTERS              | O <sub>I</sub> |                | /  | 77.10              |
| 113 00 | 11300 I NTEREST EXPENSE                   | O              | 0              |  | 113. 00            |
| 118.00 |   | -1, 629, 218   | 36, 295, 520   |  | 118. 00            |
| 110.00 | NONREI MBURSABLE COST CENTERS             | -1,029,210     | 30, 293, 320   | /  | -110.00            |
| 100 00 | 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN |                | 0              | J  | 190. 00            |
|        |   | 0              |                | •  |                    |
|        | 19001 SHELLED SPACE<br>19100 RESEARCH     | 0              | 0              | •  | 190. 01<br>191. 00 |
|        |   | U              | ū              |  |                    |
|        | 19200 PHYSI CLANS' PRI VATE OFFI CES      | 0              | 0              |  | 192.00             |
|        | 19300 NONPALD WORKERS                     | 0              | 0 000 075      |  | 193. 00            |
|        | 07950 FREESTANDING REFERENCE LABORATORY   | 0              | 8, 009, 875    | ·  | 194. 00            |
|        | 07951 FREESTANDING URGENT CARE CENTERS    | 0              | 4, 878, 108    | l control of the cont | 194. 01            |
| 200.00 | TOTAL (SUM OF LINES 118 through 199)      | -1, 629, 218   | 49, 183, 503   | il   | 200. 00            |

| RECLASSIFICATIONS  Provider CCN: 15-0172 Period: From 01/01/2018 To 12/31/2018 Date/Time Priod: From 01/01/2018 To 12/31/2019 5: | epared:          |
|--|------------------|
| To 12/31/2018 Date/Time Pr   | epared:<br>24 pm |
| 37 307 2017 3.   |                  |
| Increases  |                  |
| Cost Center Line # Salary Other  |                  |
| 2.00 3.00 4.00 5.00  |                  |
| A - INTEREST   |                  |
| 1. 00 CAP REL COSTS-BLDG & FIXT 1. 00 0 168, 391   | 1. 00            |
| TOTALS 0 168, 391  |                  |
| B - CONTRACTED SERVICES  |                  |
| 1. 00 DI ETARY 10. 00 0 6, 231   | 1. 00            |
| 2. 00 HOUSEKEEPI NG 9. 00 0 256, 178   | 2. 00            |
| TOTALS 0 262, 409  |                  |
| C - PHYSICAL THERAPY   |                  |
| 1. 00 PHYSI CAL THERAPY 66. 00 0 96, 240   | 1. 00            |
| TOTALS 0 96, 240   |                  |
| D - UCC EMPLOYEE BENEFITS  |                  |
| 1. 00 EMPLOYEE BENEFITS DEPARTMENT   | 1. 00            |
| TOTALS 0 529, 353  |                  |
| 500.00 Grand Total: Increases 0 1,056,393  | 500.00           |

Health Financial Systems PHYSICIANS MEDICAL CENTER In Lieu of Form CMS-2552-10 RECLASSI FI CATI ONS Provi der CCN: 15-0172 Peri od: Worksheet A-6 From 01/01/2018 To 12/31/2018 Date/Time Prepared: 5/30/2019 5:24 pm Decreases Wkst. A-7 Ref. 10.00 Cost Center Sal ary 0ther Li ne # 8.00 6. 00 7.00 9.00 A - INTEREST 1.00 INTEREST EXPENSE 113.00 168, 391 11 1.00 168, 391 TOTALS B - CONTRACTED SERVICES 1.00 ADMINISTRATIVE & GENERAL 1.00 5.00 0 6, 231 0 0 2.00 OPERATION OF PLANT 7.00 256, 178 0 2.00 TOTALS 262, 409 C - PHYSICAL THERAPY
OPERATING ROOM 1.00 50.00 96, 240 0 1.00 TOTALS 96, 240 D - UCC EMPLOYEE BENEFITS

0

529, 353

529, 353

1, 056, 393

0

194. 01

1.00

500.00

FREESTANDING URGENT CARE

CENTERS TOTALS

500.00 Grand Total: Decreases

1.00

In Lieu of Form CMS-2552-10
Period: Worksheet A-7
From 01/01/2018 Part I Provider CCN: 15-0172

|        |   |                  |              |                 | rom 01/01/2018<br>To 12/31/2018 |                 | pared:<br>4 pm |
|--------|---|------------------|--------------|-----------------|---------------------------------|-----------------|----------------|
|        |   |                  |              | Acqui si ti ons |                                 |                 |                |
|        |   | Begi nni ng      | Purchases    | Donati on       | Total                           | Di sposal s and |                |
|        |   | Bal ances        |              |                 |                                 | Retirements     |                |
|        |   | 1.00             | 2. 00        | 3. 00           | 4. 00                           | 5. 00           |                |
|        | PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET | F BALANCES       |              |                 |                                 |                 |                |
| 1.00   | Land  | 0                | 0            | (               | 0                               | 0               | 1. 00          |
| 2.00   | Land Improvements                             | 0                | 0            | (               | 0                               | 0               | 2. 00          |
| 3.00   | Buildings and Fixtures                        | 0                | 0            | (               | 0                               | 0               | 3. 00          |
| 4.00   | Building Improvements                         | 3, 230, 853      | 0            | (               | 0                               | 372, 802        | 4. 00          |
| 5.00   | Fi xed Equipment                              | 618, 512         | 55, 434      |                 | 55, 434                         |                 | 5. 00          |
| 6.00   | Movable Equipment                             | 8, 399, 675      | 2, 152, 728  | (               | 2, 152, 728                     | 0               | 6. 00          |
| 7. 00  | HIT designated Assets                         | 0                | 0            | (               | 0                               | 0               | 7. 00          |
| 8.00   | Subtotal (sum of lines 1-7)                   | 12, 249, 040     | 2, 208, 162  | (               | 2, 208, 162                     | 372, 802        | 8. 00          |
| 9.00   | Reconciling Items                             | 0                | 0            | (               | 0                               | 0               | 9. 00          |
| 10.00  | Total (line 8 minus line 9)                   | 12, 249, 040     | 2, 208, 162  | C               | 2, 208, 162                     | 372, 802        | 10. 00         |
|        |   | Endi ng Bal ance | Fully        |                 |                                 |                 |                |
|        |   |                  | Depreci ated |                 |                                 |                 |                |
|        |   |                  | Assets       |                 |                                 |                 |                |
|        |   | 6. 00            | 7. 00        |                 |                                 |                 |                |
|        | PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET | F BALANCES       | _            |                 |                                 |                 |                |
| 1.00   | Land  | 0                | 0            |                 |                                 |                 | 1. 00          |
| 2.00   | Land Improvements                             | 0                | 0            |                 |                                 |                 | 2. 00          |
| 3.00   | Buildings and Fixtures                        | 0                | 0            |                 |                                 |                 | 3. 00          |
| 4.00   | Building Improvements                         | 2, 858, 051      | 0            |                 |                                 |                 | 4. 00          |
| 5.00   | Fixed Equipment                               | 673, 946         | 0            |                 |                                 |                 | 5. 00          |
| 6.00   | Movable Equipment                             | 10, 552, 403     | 0            |                 |                                 |                 | 6. 00          |
| 7. 00  | HIT designated Assets                         | 0                | 0            |                 |                                 |                 | 7. 00          |
| 8.00   | Subtotal (sum of lines 1-7)                   | 14, 084, 400     | 0            |                 |                                 |                 | 8. 00          |
| 9.00   | Reconciling Items                             | 0                | 0            |                 |                                 |                 | 9. 00          |
| 10. 00 | Total (line 8 minus line 9)                   | 14, 084, 400     | 0            |                 |                                 |                 | 10. 00         |

| Hool +b   | Financial Systems                                    | PHYSICIANS MED     | NICAL CENTED   |               | In Lieu of Form CMS-2552-10 |                |        |  |
|---|--|--------------------|----------------|---------------|-----------------------------|----------------|--------|--|
|   | Financial Systems CILIATION OF CAPITAL COSTS CENTERS | PHYSICIANS MEL     | Provider C     | N. 15 0170    | Peri od:                    | Worksheet A-7  |        |  |
| RECONC  | ILIAITUN OF CAPITAL COSTS CENTERS                    |                    | Provider Co    | JN: 15-01/2   | From 01/01/2018             |                |        |  |
|   |  |                    |                |               | To 12/31/2018               |                | pared· |  |
|   |  |                    |                |               | 12,01,2010                  | 5/30/2019 5: 2 | 4 pm   |  |
|   |  |                    | SL             | JMMARY OF CAP | I TAL                       |                |        |  |
|   |  |                    |                |               |                             |                |        |  |
|   | Cost Center Description                              | Depreciation       | Lease          | Interest      | Insurance (see              | Taxes (see     |        |  |
|   |  |                    |                |               | instructions)               | instructions)  |        |  |
|   |  | 9. 00              | 10. 00         | 11. 00        | 12.00                       | 13. 00         |        |  |
|   | PART II - RECONCILIATION OF AMOUNTS FROM WORK        | KSHEET A, COLUM    | N 2, LINES 1 a | nd 2          |                             |                |        |  |
| 1.00  | CAP REL COSTS-BLDG & FLXT                            | 716, 406           | 1, 847, 811    |               | 0 0                         | 171, 360       | 1. 00  |  |
| 2.00  | CAP REL COSTS-MVBLE EQUIP                            | 0                  | 1, 565, 213    |               | 0 0                         | 0              | 2. 00  |  |
| 3.00  | Total (sum of lines 1-2)                             | 716, 406           | 3, 413, 024    |               | 0 0                         | 171, 360       | 3. 00  |  |
|   |  | SUMMARY OF CAPITAL |                |               |                             |                |        |  |
|   |  |                    |                |               |                             |                |        |  |
|   | Cost Center Description                              | 0ther              | Total (1) (sum |               |                             |                |        |  |
|   |  | Capi tal -Relate   | of cols. 9     |               |                             |                |        |  |
|   |  | d Costs (see       | through 14)    |               |                             |                |        |  |
|   |  | instructions)      |                |               |                             |                |        |  |
|   |  | 14. 00             | 15. 00         |               |                             |                |        |  |
| PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2 |  |                    |                |               |                             |                |        |  |
| 1.00  | CAP REL COSTS-BLDG & FLXT                            | 0                  | 2, 735, 577    |               |                             | ļ              | 1. 00  |  |
| 2.00  | CAP REL COSTS-MVBLE EQUIP                            | 0                  | 1, 565, 213    |               |                             |                | 2. 00  |  |
| 0 00  | T 1 1 ( C 1: 4 O)                                    |                    | 4 000 700      | I             |                             |                |        |  |

0 0 0

2, 735, 577 1, 565, 213 4, 300, 790

1. 00 2. 00 3. 00

3.00 Total (sum of lines 1-2)

| Heal th | n Financial Systems                          | PHYSICIANS MEI                                 | DICAL CENTER     |                      | In Lieu of Form CMS-2552-10                 |                |       |
|---------|--|--|------------------|----------------------|---|----------------|-------|
| RECON   | CILIATION OF CAPITAL COSTS CENTERS           |  | Provider Co      |                      | Period:<br>From 01/01/2018<br>To 12/31/2018 |                |       |
|         |  | COMI   | PUTATION OF RAT  | TI 0S                | ALLOCATION OF                               | OTHER CAPITAL  | рш    |
|         | Cost Center Description                      | Gross Assets                                   | Capi tal i zed   | Gross Assets         |   | Insurance      |       |
|         |  |  | Leases           | for Ratio            | instructions)                               |                |       |
|         |  |  |                  | (col . 1 - col<br>2) |   |                |       |
|         |  | 1. 00  | 2.00             | 3.00                 | 4. 00                                       | 5. 00          |       |
|         | PART III - RECONCILIATION OF CAPITAL COSTS C |  | 2.00             | 0.00                 | 1. 00                                       | 0.00           |       |
| 1.00    | CAP REL COSTS-BLDG & FLXT                    | 3, 531, 997                                    | 0                | 3, 531, 99           | 7 0. 250774                                 | 0              | 1. 00 |
| 2.00    | CAP REL COSTS-MVBLE EQUIP                    | 10, 552, 403                                   | 0                | 10, 552, 40          |   | 0              | 2.00  |
| 3.00    | Total (sum of lines 1-2)                     | 14, 084, 400                                   |                  | 14, 084, 40          |   |                | 3. 00 |
|         |  | ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITAL |                  |                      |   |                |       |
|         | Cost Center Description                      | Taxes  | Other            | Total (sum of        | f Depreciation                              | Lease          |       |
|         |  |  | Capi tal -Relate |                      |   |                |       |
|         |  |  | d Costs          | through 7)           | 0.00  | 10.00          |       |
|         | PART III - RECONCILIATION OF CAPITAL COSTS C | 6. 00  | 7. 00            | 8. 00                | 9. 00                                       | 10. 00         |       |
| 1. 00   | CAP REL COSTS-BLDG & FIXT                    | ENTERS 0                                       |                  | 1                    | 0 716, 406                                  | 1, 199, 265    | 1. 00 |
| 2. 00   | CAP REL COSTS-BEDG & TTAT                    | 0  | 0                |                      | 0 710, 400                                  | 1, 565, 213    | 2. 00 |
| 3.00    | Total (sum of lines 1-2)                     | 0  | 0                |                      | 0 716, 406                                  |                | 3. 00 |
| 0.00    |  |  | SI               | JMMARY OF CAPI       |   | 2//01/170      | 0.00  |
|         |  |  |                  |                      |   |                |       |
|         | Cost Center Description                      |  | Insurance (see   |                      |   | Total (2) (sum |       |
|         |  |  | instructions)    | instructions)        | Capi tal -Relate                            |                |       |
|         |  |  |                  |                      | d Costs (see                                | through 14)    |       |
|         |  | 11 00  | 12.00            | 13.00                | instructions)                               | 15.00          |       |
|         | PART III - RECONCILIATION OF CAPITAL COSTS C | 11.00<br>ENTERS                                | 12. 00           | 13.00                | 14. 00                                      | 15. 00         |       |
| 1. 00   | CAP REL COSTS-BLDG & FLXT                    | 164, 989                                       | 0                | 171, 36              | 0 0   | 2, 252, 020    | 1. 00 |
| 2.00    | CAP REL COSTS-MVBLE EQUIP                    | 0  | Ö                |                      | 0 0   | 1, 565, 213    | 2. 00 |
| 3.00    | Total (sum of lines 1-2)                     | 164, 989                                       |                  | •                    | o o   |                |       |
|         |  |  |                  |                      | •   |                | ,     |

| Period: | Worksheet A-8 | From 01/01/2018 | To 12/31/2018 | Date/Time Prepared: Provi der CCN: 15-0172

|                  |   |                |           | To                                | 12/31/2018      | Date/Time Prep<br>5/30/2019 5: 24 |                  |
|------------------|---|----------------|-----------|-----------------------------------|-----------------|-----------------------------------|------------------|
|                  |   |                |           | Expense Classification on         |                 | 3/30/2019 5. 22                   | + piii           |
|                  |   |                |           | To/From Which the Amount is       | to be Adjusted  |                                   |                  |
|                  |   |                |           |                                   |                 |                                   |                  |
|                  |   |                |           |                                   |                 |                                   |                  |
|                  | Cost Center Description                                     | Basis/Code (2) | Amount    | Cost Center                       |                 | Wkst. A-7 Ref.                    |                  |
| 1.00             | Investment income - CAP REL                                 | 1. 00<br>B     | 2.00      | 3.00<br>CAP REL COSTS-BLDG & FIXT | 4. 00<br>1. 00  | 5. 00<br>11                       | 1. 00            |
| 1.00             | COSTS-BLDG & FLXT (chapter 2)                               |                | -3, 402   | CAL REE COSTS-BEDG & TTAT         | 1.00            | ''                                | 1.00             |
| 2.00             | Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)   |                | 0         | CAP REL COSTS-MVBLE EQUIP         | 2. 00           | 0                                 | 2. 00            |
| 3.00             | Investment income - other                                   |                | 0         |                                   | 0.00            | 0                                 | 3. 00            |
| 4. 00            | (chapter 2)<br>Trade, quantity, and time                    |                | 0         |                                   | 0. 00           | 0                                 | 4. 00            |
|                  | discounts (chapter 8)                                       |                |           |                                   |                 |                                   |                  |
| 5. 00            | Refunds and rebates of expenses (chapter 8)                 |                | 0         |                                   | 0. 00           | 0                                 | 5. 00            |
| 6.00             | Rental of provider space by                                 |                | 0         |                                   | 0. 00           | О                                 | 6. 00            |
| 7. 00            | suppliers (chapter 8) Telephone services (pay               |                | 0         |                                   | 0. 00           | 0                                 | 7. 00            |
|                  | stations excluded) (chapter                                 |                |           |                                   |                 |                                   |                  |
| 8. 00            | 21) Television and radio service                            |                | 0         |                                   | 0. 00           | 0                                 | 8. 00            |
| 0.00             | (chapter 21)  |                |           |                                   | 0.00            |                                   | 0.00             |
| 9. 00<br>10. 00  | Parking Lot (chapter 21) Provider-based physician           | A-8-2          | -748, 969 |                                   | 0. 00           | 0                                 | 9. 00<br>10. 00  |
| 11 00            | adjustment  |                | 0         |                                   | 0.00            | 0                                 | 11 00            |
| 11. 00           | Sale of scrap, waste, etc. (chapter 23)                     |                | 0         |                                   | 0. 00           | 0                                 | 11. 00           |
| 12. 00           | Related organization<br>transactions (chapter 10)           | A-8-1          | -648, 546 |                                   |                 | 0                                 | 12. 00           |
| 13. 00           | Laundry and Linen service                                   |                | 0         |                                   | 0.00            | О                                 | 13. 00           |
| 14. 00<br>15. 00 | Cafeteria-employees and guests                              | 1              | 0         |                                   | 0. 00<br>0. 00  | 0                                 | 14. 00<br>15. 00 |
| 15.00            | Rental of quarters to employee and others                   |                | 0         |                                   | 0.00            |                                   | 15.00            |
| 16. 00           | Sale of medical and surgical supplies to other than         |                | 0         |                                   | 0. 00           | 0                                 | 16. 00           |
|                  | pati ents   |                | _         |                                   |                 | _                                 |                  |
| 17. 00           | Sale of drugs to other than patients                        |                | 0         |                                   | 0. 00           | 0                                 | 17. 00           |
| 18. 00           | Sale of medical records and abstracts                       | В              | -68, 224  | MEDICAL RECORDS & LIBRARY         | 16. 00          | 0                                 | 18. 00           |
| 19. 00           | Nursing and allied health                                   |                | 0         |                                   | 0. 00           | О                                 | 19. 00           |
|                  | education (tuition, fees, books, etc.)                      |                |           |                                   |                 |                                   |                  |
| 20. 00           | Vending machines  |                | 0         |                                   | 0.00            | 0                                 | 20.00            |
| 21. 00           | Income from imposition of interest, finance or penalty      |                | 0         |                                   | 0. 00           | 0                                 | 21. 00           |
| 22.00            | charges (chapter 21)  |                |           |                                   | 0.00            |                                   | 22.00            |
| 22. 00           | Interest expense on Medicare overpayments and borrowings to |                | 0         |                                   | 0. 00           | 0                                 | 22. 00           |
| 23. 00           | repay Medicare overpayments                                 | 4.0.2          | 0         | *** Coot Conton Doloted ***       | /F 00           |                                   | 22.00            |
| 23.00            | Adjustment for respiratory therapy costs in excess of       | A-8-3          | 0         | *** Cost Center Deleted ***       | 65. 00          |                                   | 23. 00           |
| 24. 00           | limitation (chapter 14)<br>Adjustment for physical          | A-8-3          | 0         | PHYSI CAL THERAPY                 | 66. 00          |                                   | 24. 00           |
| 21.00            | therapy costs in excess of                                  | 7, 0, 0        |           | THISTORE THEIGHT                  | 66. 66          |                                   | 21.00            |
| 25. 00           | limitation (chapter 14)<br>Utilization review -             |                | 0         | *** Cost Center Deleted ***       | 114. 00         |                                   | 25. 00           |
| 20.00            | physicians' compensation                                    |                |           |                                   |                 |                                   | 20.00            |
| 26. 00           | (chapter 21) Depreciation - CAP REL                         |                | 0         | CAP REL COSTS-BLDG & FIXT         | 1. 00           | 0                                 | 26. 00           |
| 27. 00           | COSTS-BLDG & FIXT Depreciation - CAP REL                    |                | 0         | CAP REL COSTS-MVBLE EQUIP         | 2. 00           | 0                                 | 27. 00           |
|                  | COSTS-MVBLE EQUIP   |                |           |                                   |                 |                                   |                  |
| 28. 00<br>29. 00 | Non-physician Anesthetist<br>Physicians' assistant          |                | 0         | *** Cost Center Deleted ***       | 19. 00<br>0. 00 | 0                                 | 28. 00<br>29. 00 |
| 30. 00           | Adjustment for occupational                                 | A-8-3          | 0         | *** Cost Center Deleted ***       | 67. 00          | J                                 | 30.00            |
|                  | therapy costs in excess of limitation (chapter 14)          |                |           |                                   |                 |                                   |                  |
| 30. 99           | Hospice (non-distinct) (see                                 |                | 0         | ADULTS & PEDIATRICS               | 30. 00          |                                   | 30. 99           |
| 31. 00           | instructions) Adjustment for speech                         | A-8-3          | О         | *** Cost Center Deleted ***       | 68. 00          |                                   | 31. 00           |
|                  | pathology costs in excess of limitation (chapter 14)        |                |           |                                   |                 |                                   |                  |
| 32. 00           | CAH HIT Adjustment for                                      |                | 0         |                                   | 0. 00           | 0                                 | 32. 00           |
| 33 00            | Depreciation and Interest MARKETING EXPENSE                 | A              | -160 077  | ADMINISTRATIVE & GENERAL          | 5. 00           | n                                 | 33. 00           |
|                  | 1   | 1 "            | 100,011   | r                                 | 3.00            | ·                                 |                  |

| Health Financial Systems             |                | PHYSICIANS ME | DICAL CENTER                | In Lieu of Form CMS-2552-10      |                                |                |
|--------------------------------------|----------------|---------------|-----------------------------|----------------------------------|--------------------------------|----------------|
| ADJUSTMENTS TO EXPENSES              |                |               |                             | Peri od:                         | Worksheet A-8                  |                |
|                                      |                |               |                             | From 01/01/2018<br>To 12/31/2018 | Date/Time Pre<br>5/30/2019 5:2 | pared:<br>4 pm |
|                                      |                |               | Expense Classification or   |                                  |                                |                |
|                                      |                |               | To/From Which the Amount is | to be Adjusted                   |                                |                |
|                                      |                |               |                             |                                  |                                |                |
|                                      |                |               |                             |                                  |                                |                |
|                                      |                |               |                             |                                  |                                |                |
|                                      |                |               |                             | _                                |                                |                |
| Cost Center Description              | Basis/Code (2) | Amount        | Cost Center                 | Li ne #                          | Wkst. A-7 Ref.                 |                |
|                                      | 1.00           | 2.00          | 3. 00                       | 4. 00                            | 5. 00                          |                |
| 50.00 TOTAL (sum of lines 1 thru 49) |                | -1, 629, 218  |                             |                                  |                                | 50. 00         |
| (Transfer to Worksheet A,            |                |               |                             |                                  |                                |                |
| column 6, line 200.)                 |                |               |                             |                                  |                                |                |

- (1) Description all chapter references in this column pertain to CMS Pub. 15-1.(2) Basis for adjustment (see instructions).

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

  B. Amount Received if cost cannot be determined.

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

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

\* 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.

| <br>to her been posted to her keneet A, coramic rana, or 2, the amount arremable chear a be rhan dated in coramic remains parti |                               |               |                              |                |  |  |  |  |
|---|-------------------------------|---------------|------------------------------|----------------|--|--|--|--|
|   |                               |               | Related Organization(s) and/ | or Home Office |  |  |  |  |
|   |                               |               |                              |                |  |  |  |  |
|   |                               |               |                              |                |  |  |  |  |
|   |                               |               |                              |                |  |  |  |  |
| Symbol (1)  | Name                          | Percentage of | Name                         | Percentage of  |  |  |  |  |
|   |                               | Ownershi p    |                              | Ownershi p     |  |  |  |  |
| 1. 00   | 2. 00                         | 3. 00         | 4. 00                        | 5. 00          |  |  |  |  |
| B. INTERRELATIONSHIP TO RELAT   | TED ORGANIZATION(S) AND/OR HO | ME OFFICE:    |                              |                |  |  |  |  |
|   |                               |               |                              |                |  |  |  |  |

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

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

| 6.00   | A                       | PSP LLC | 100.00 | 0. 00 | 6. 00  |
|--------|-------------------------|---------|--------|-------|--------|
| 7.00   |                         |         | 0.00   | 0. 00 | 7.00   |
| 8.00   |                         |         | 0.00   | 0. 00 | 8.00   |
| 9.00   |                         |         | 0.00   | 0. 00 | 9.00   |
| 10.00  |                         |         | 0.00   | 0. 00 | 10.00  |
| 100.00 | G. Other (financial or  |         |        |       | 100.00 |
|        | non-financial) specify: |         |        |       |        |

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

Worksheet A-8, column 2,

line 12.

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

| Heal th | Financial System | ems            |          | PHY:           | SICIANS MEDI | CAL CENTER  |       |             | In Lie            | u of Form CMS- | 2552-10 |
|---------|------------------|----------------|----------|----------------|--------------|-------------|-------|-------------|-------------------|----------------|---------|
| STATEME | ENT OF COSTS OF  | SERVICES FROM  | RELATED  | ORGANI ZATI OI | NS AND HOME  | Provi der   | CCN:  | 15-0172     | Peri od:          | Worksheet A-8  | 3-1     |
| OFFICE  | COSTS            |                |          |                |              |             |       |             | From 01/01/2018   | 5              |         |
|         |                  |                |          |                |              |             |       |             | To 12/31/2018     |                |         |
|         | Net              | Wkst. A-7 Ref. |          |                |              |             | _     |             |                   | 5/30/2019 5: 2 | 24 piii |
|         |                  | WKSt. A-7 Kei. |          |                |              |             |       |             |                   |                |         |
|         | Adjustments      |                |          |                |              |             |       |             |                   |                |         |
|         | (col. 4 minus    |                |          |                |              |             |       |             |                   |                |         |
|         | col. 5)*         |                | _        |                |              |             |       |             |                   |                |         |
|         | 6. 00            | 7. 00          |          |                |              |             |       |             |                   |                |         |
|         | A. COSTS INCUR   | RED AND ADJUST | MENTS RE | QUIRED AS A    | RESULT OF TR | ANSACTI ONS | WITH  | I RELATED C | ORGANIZATIONS OR  | CLAI MED       |         |
|         | HOME OFFICE CO   | STS:           |          |                |              |             |       |             |                   |                |         |
| 1.00    | -648, 546        | 10             |          |                |              |             |       |             |                   |                | 1.00    |
| 2.00    |                  |                |          |                |              |             |       |             |                   |                | 2. 00   |
| 3.00    |                  |                |          |                |              |             |       |             |                   |                | 3. 00   |
| 4. 00   | 1                |                |          |                |              |             |       |             |                   |                | 4. 00   |
| 5. 00   | -648, 546        | ]              | 1        |                |              |             |       |             |                   |                | 5. 00   |
|         |                  |                |          |                |              |             |       |             |                   |                | 3.00    |
|         |                  |                |          |                |              |             |       |             | ksheet A, column  |                |         |
|         |                  |                |          | 9              |              |             |       |             | ganization or hom |                | whi ch  |
| has not | been posted t    | o Worksheet A, | col umns | 1 and/or 2,    | the amount a | allowable s | shoul | d be indic  | ated in column 4  | of this part.  |         |
|         | Related Org      | anization(s)   |          |                |              |             |       |             |                   |                |         |

Related Organization(s)
and/or Home Office

Type of Business

6.00

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

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

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

| 6.00   |  | 6. 00          |
|--|--|----------------|
| 7.00   |  | 7. 00          |
| 8.00   |  | 8. 00<br>9. 00 |
| 9.00   |  | 9. 00          |
| 10.00  |  | 10.00          |
| 7. 00<br>8. 00<br>9. 00<br>10. 00<br>100. 00 |  | 100.00         |

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

|                 |                 |                       |                |              |                  | To 12/31/2018 | B Date/Time Pre 5/30/2019 5:2 |                |
|-----------------|-----------------|-----------------------|----------------|--------------|------------------|---------------|-------------------------------|----------------|
|                 | Wkst. A Line #  | Cost Center/Physician | Total          | Professi ona | l Provi der      | RCE Amount    | Physi ci an/Prov              |                |
|                 |                 | Identifier            | Remuneration   | Component    | Component        |               | ider Component                |                |
|                 |                 |                       |                |              | '                |               | Hours                         |                |
|                 | 1. 00           | 2. 00                 | 3.00           | 4.00         | 5. 00            | 6. 00         | 7. 00                         |                |
| 1.00            | 50.00           | OPERATING ROOM        | 748, 969       | 748, 9       | 69               | 0 159, 800    | 0                             | 1. 00          |
| 2.00            | 0.00            |                       | 0              |              | 0                | 0 0           | 0                             | 2. 00          |
| 3.00            | 0.00            |                       | 0              |              | 0                | 0 0           | 0                             | 3. 00          |
| 4.00            | 0.00            |                       | 0              |              | 0                | 0 0           | 0                             | 4. 00          |
| 5.00            | 0.00            |                       | 0              |              | 0                | 0             | 0                             | 5. 00          |
| 6.00            | 0.00            |                       | 0              |              | 0                | 0             | 0                             | 6. 00          |
| 7.00            | 0.00            |                       | 0              |              | 0                | 0             | 0                             | 7. 00          |
| 8.00            | 0.00            |                       | 0              |              | 0                | 0             | 0                             | 8. 00          |
| 9. 00           | 0.00            |                       | 0              |              | 0                | 0             | 0                             | 9. 00          |
| 10.00           | 0.00            |                       | 0              |              | 0                | 0 0           | 0                             | 10.00          |
| 200.00          |                 |                       | 748, 969       |              |                  | 0             | 0                             | 200.00         |
|                 | Wkst. A Line #  |                       | Unadjusted RCE | 5 Percent o  |                  | Provi der     | Physician Cost                |                |
|                 |                 | Identi fi er          | Limit          |              | CE Memberships 8 |               | of Malpractice                |                |
|                 |                 |                       |                | Limit        | Conti nui ng     | Share of col. | Insurance                     |                |
|                 |                 | 0.00                  |                |              | Educati on       | 12            | 44.00                         |                |
| 1.00            | 1.00            | 2.00                  | 8.00           | 9. 00        | 12.00            | 13.00         | 14.00                         | 4.00           |
| 1.00            |                 | OPERATING ROOM        |                |              | -                | 0 0           |                               |                |
| 2.00            | 0.00            |                       |                |              | -                | -1            | 1                             | 2.00           |
| 3.00            | 0.00            |                       |                |              |                  | 0 0           |                               |                |
| 4.00            | 0.00            |                       |                |              | O .              | ۳  ۳          | 1                             | 4. 00          |
| 5.00            | 0. 00<br>0. 00  |                       |                |              | 0                | 0             |                               |                |
| 6.00            |                 |                       |                |              | 0                | 0             | 1                             | 6.00           |
| 7. 00<br>8. 00  | 0. 00<br>0. 00  |                       |                |              | 0                | 0 0           | -                             | 7. 00<br>8. 00 |
| 9. 00           | 0.00            |                       |                |              | 0                |               | 1                             | 9. 00          |
| 9. 00<br>10. 00 | 0.00            |                       |                |              | 0                |               | -                             | 10.00          |
| 200.00          | 0.00            |                       |                |              | 0                |               | 1                             | 1              |
| 200.00          | Wkst. A Line #  | Cost Center/Physician | Provi der      | Adjusted RC  | 0                | Adjustment    | 0                             | 200.00         |
|                 | WKSt. A LITTE # | I denti fi er         | Component      | Limit        | Di sal I owance  | , ,           |                               |                |
|                 |                 | r denti i i ei        | Share of col.  |              | Di Sai i Owance  |               |                               |                |
|                 |                 |                       | 14             |              |                  |               |                               |                |
|                 | 1. 00           | 2.00                  | 15. 00         | 16. 00       | 17. 00           | 18. 00        |                               |                |
| 1. 00           | 50.00           | OPERATING ROOM        | C              |              | 0                | 0 748, 969    | ,                             | 1. 00          |
| 2.00            | 0.00            |                       | 0              |              | 0                | ol o          |                               | 2. 00          |
| 3.00            | 0.00            |                       | 0              |              | 0                | o o           |                               | 3. 00          |
| 4.00            | 0.00            |                       | 0              |              | 0                | o o           |                               | 4. 00          |
| 5.00            | 0.00            |                       | 0              |              | 0                | 0             |                               | 5. 00          |
| 6.00            | 0.00            |                       | 0              |              | 0                | 0 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                | o  o          | )                             | 9. 00          |
| 10.00           | 0.00            |                       | 0              |              | -                | 0 0           | )                             | 10.00          |
| 200.00          |                 |                       | 0              |              | O                | 0 748, 969    | 1                             | 200. 00        |

COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0172 Peri od: Worksheet B From 01/01/2018 Part I Date/Time Prepared: 12/31/2018 5/30/2019 5:24 pm CAPITAL RELATED COSTS Cost Center Description Net Expenses BLDG & FIXT MVBLE EQUIP **EMPLOYEE** Subtotal for Cost **BENEFITS** DEPARTMENT Allocation (from Wkst A col. 7) 1.00 2.00 4. 00 4A GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS-BLDG & FIXT 1 00 2, 252, 020 2 252 020 2.00 00200 CAP REL COSTS-MVBLE EQUIP 1, 565, 213 1, 565, 213 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 2, 401, 939 2, 401, 939 4.00 00500 ADMINISTRATIVE & GENERAL 324, 816 242. 081 9, 096, 340 5.00 5 00 8, 162, 019 367 424 00700 OPERATION OF PLANT 7.00 1, 479, 373 84, 350 62,865 24, 090 1, 650, 678 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 328, 390 328, 390 8.00 9.00 00900 HOUSEKEEPI NG 256, 178 18, 744 13, 970 o 288, 892 9.00 61, 791 01000 DI FTARY 97, 383 10 00 20, 393 15, 199 10 00 0 13.00 01300 NURSING ADMINISTRATION 418, 939 78, 576 497, 515 13.00 01400 CENTRAL SERVICES & SUPPLY 333, 347 556, 475 414, 732 1, 359, 658 14.00 14.00 55, 104 15.00 01500 PHARMACY 5, 163 3, 848 9, 011 15.00 01600 MEDICAL RECORDS & LIBRARY <u>15, 4</u>57 16.00 8.938 20, 740 45, 135 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 1, 990, 686 30.00 1, 177, 687 342, 867 255, 533 214, 599 30.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 4, 488, 522 720, 447 536, 936 1,000,393 6, 746, 298 50 00 53.00 05300 ANESTHESI OLOGY 600, 262 105, 664 705, 926 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 129, 346 6, 161 4, 592 24, 260 164, 359 54.00 06000 LABORATORY 60.00 60.00 0 C 0 0 06300 BLOOD STORING, PROCESSING, & TRANS. 0 63.00 0 C 0 Λ 63.00 06600 PHYSI CAL THERAPY 0 0 96, 240 66.00 96, 240 0 66.00 06900 ELECTROCARDI OLOGY 0 69.00 0 0 69.00 Ω 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 4, 778, 258 0 0 4, 778, 258 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 6,036,535 C 0 0 6, 036, 535 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 1, 720, 523 0 1, 720, 523 73.00 OUTPATIENT SERVICE COST CENTERS 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 0 92.00 OTHER REIMBURSABLE COST CENTERS 99. 10 09910 CORF 0 0 0 0 0 99. 10 SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1 through 117) 36, 295, 520 2, 100, 156 1, 565, 213 1, 870, 110 35, 611, 827 118. 00 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190 00 0 0 190. 01 19001 SHELLED SPACE 0 0 0 0 0 190. 01 191. 00 19100 RESEARCH 0 0 0 0 191.00 0 o 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 192.00 Ω 193. 00 19300 NONPALD WORKERS 0 0 0 0 193.00 194. 00 07950 FREESTANDING REFERENCE LABORATORY 8,009,875 151, 864 0 8, 161, 739 194. 00 194. 01 07951 FREESTANDING URGENT CARE CENTERS 4, 878, 108 0 531, 829 5, 409, 937 194. 01 0 200. 00 200 00 Cross Foot Adjustments 201.00 Negative Cost Centers 0 201.00 202.00 TOTAL (sum lines 118 through 201) 49, 183, 503 2, 252, 020 1, 565, 213 2, 401, 939 49, 183, 503 202. 00

In Lieu of Form CMS-2552-10

| Period: | Worksheet B |
| From 01/01/2018 | Part |
| To 12/31/2018 | Date/Time Prepared: |
| 5/30/2019 5:24 pm |

|        |  |                   |              |               |               | 5/30/2019 5: 2 | 4 pm    |
|--------|--|-------------------|--------------|---------------|---------------|----------------|---------|
|        | Cost Center Description                    | ADMI NI STRATI VE | OPERATION OF | LAUNDRY &     | HOUSEKEEPI NG | DI ETARY       |         |
|        |  | & GENERAL         | PLANT        | LINEN SERVICE |               |                |         |
|        |  | 5. 00             | 7. 00        | 8. 00         | 9. 00         | 10.00          |         |
|        | GENERAL SERVICE COST CENTERS               |                   |              |               |               |                |         |
| 1.00   | 00100 CAP REL COSTS-BLDG & FLXT            |                   |              |               |               |                | 1.00    |
| 2.00   | 00200 CAP REL COSTS-MVBLE EQUIP            |                   |              |               |               |                | 2.00    |
| 4.00   | 00400 EMPLOYEE BENEFITS DEPARTMENT         |                   |              |               |               |                | 4.00    |
| 5.00   | 00500 ADMINISTRATIVE & GENERAL             | 9, 096, 340       |              |               |               |                | 5. 00   |
| 7.00   | 00700 OPERATION OF PLANT                   | 566, 278          | 2, 216, 956  |               |               |                | 7. 00   |
| 8.00   | 00800 LAUNDRY & LINEN SERVICE              | 112, 657          | 0            | 441, 047      |               |                | 8. 00   |
| 9.00   | 00900 HOUSEKEEPI NG                        | 99, 107           | 24, 575      | . 0           | 412, 574      |                | 9.00    |
| 10.00  | 01000 DI ETARY                             | 33, 408           | 26, 736      | 1             |               | 162, 558       | 10.00   |
| 13.00  | 01300 NURSING ADMINISTRATION               | 170, 677          | 0            | 1             | 0             | 0              | 1       |
| 14. 00 | 01400 CENTRAL SERVICES & SUPPLY            | 466, 442          | 729, 561     | 0             | 137, 293      | 0              | 1       |
| 15. 00 | 01500 PHARMACY                             | 3, 091            | 6, 769       | 1             |               |                |         |
| 16. 00 | 01600 MEDI CAL RECORDS & LI BRARY          | 15, 484           | 27, 191      |               |               | 0              |         |
| 10.00  | I NPATI ENT ROUTI NE SERVI CE COST CENTERS | 13, 404           | 27, 171      |               | 5, 117        | 0              | 10.00   |
| 30. 00 | 03000 ADULTS & PEDIATRICS                  | 682, 921          | 449, 512     | 22, 052       | 84, 592       | 162, 558       | 30.00   |
| 30.00  | ANCILLARY SERVICE COST CENTERS             | 002, 721          | 447, 312     | 22,032        | 04, 372       | 102, 330       | 30.00   |
| 50. 00 | 05000 OPERATI NG ROOM                      | 2, 314, 359       | 944, 534     | 418, 995      | 177, 747      | 0              | 50.00   |
| 53. 00 | 05300 ANESTHESI OLOGY                      | 2, 314, 339       | 744, 554     | 1             |               | -              |         |
| 54. 00 | 05400 RADI OLOGY-DI AGNOSTI C              | 56, 385           | 8, 078       | 1             | _             | 0              |         |
| 60.00  | 06000 LABORATORY                           | 30, 363           | 0,070        |               | 1, 520        | 0              |         |
| 63. 00 | 06300 BLOOD STORING, PROCESSING, & TRANS.  | 0                 | 0            |               | 0             | 0              | 63.00   |
| 66. 00 | 06600 PHYSI CAL THERAPY                    | 33, 016           | 0            |               | 0             | 0              |         |
| 69. 00 | 06900 ELECTROCARDI OLOGY                   | 33,010            | 0            |               | 0             | 0              |         |
| 71. 00 |  | 1 (20 220         | 0            |               | 0             | 0              | 1       |
|        | 07100 MEDICAL SUPPLIES CHARGED TO PATIENT  | 1, 639, 220       | 0            |               | 0             | _              |         |
| 72.00  | 07200 I MPL. DEV. CHARGED TO PATIENTS      | 2, 070, 882       | 0            | 0             | 0             | 0              | 72.00   |
| 73. 00 | 07300 DRUGS CHARGED TO PATIENTS            | 590, 239          | U            | 0             | U             | 0              | 73. 00  |
| 00.00  | OUTPATIENT SERVICE COST CENTERS            |                   |              | 1             |               |                |         |
| 92. 00 | 09200 OBSERVATION BEDS (NON-DISTINCT PART  |                   |              |               |               |                | 92. 00  |
|        | OTHER REIMBURSABLE COST CENTERS            |                   |              | _             |               |                |         |
| 99. 10 |  | 0                 | 0            | 0             | 0             | 0              | 99. 10  |
|        | SPECIAL PURPOSE COST CENTERS               |                   |              | ı             |               |                |         |
|        | 11300 I NTEREST EXPENSE                    | 0.00/.040         | 0.04/.05/    |               |               | 4/0 ==0        | 113. 00 |
| 118.00 | 7 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2    | 9, 096, 340       | 2, 216, 956  | 441, 047      | 412, 574      | 162, 558       | 1118.00 |
|        | NONREI MBURSABLE COST CENTERS              | _                 | _            | 1             | _             |                | 4       |
|        | 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN  | 0                 | 0            |               | _             |                | 190. 00 |
|        | 19001 SHELLED SPACE                        | 0                 | 0            | 0             | 0             |                | 190. 01 |
|        | 19100 RESEARCH                             | 0                 | 0            | 0             | 0             |                | 191. 00 |
|        | 19200 PHYSICIANS' PRIVATE OFFICES          | 0                 | 0            | 0             | 0             |                | 192. 00 |
|        | 19300 NONPALD WORKERS                      | 0                 | 0            | 0             | 0             |                | 193. 00 |
| 194.00 | 07950 FREESTANDING REFERENCE LABORATORY    | 0                 | 0            | 0             | 0             |                | 194. 00 |
|        | 07951 FREESTANDING URGENT CARE CENTERS     | 0                 | 0            | 0             | 0             | 0              | 194. 01 |
| 200.00 |  |                   |              |               |               |                | 200. 00 |
| 201.00 | 1 3 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1    | 0                 | 0            | 0             | 0             |                | 201. 00 |
| 202.00 | TOTAL (sum lines 118 through 201)          | 9, 096, 340       | 2, 216, 956  | 441, 047      | 412, 574      | 162, 558       | 202. 00 |
|        |  |                   |              |               |               |                |         |

| Period: | Worksheet B | From 01/01/2018 | Part | To | 12/31/2018 | Date/Time Prepared: Provider CCN: 15-0172

|        |   |                               |                                 | To       | 12/31/2018                        | Date/Time Pre 5/30/2019 5:2 |         |
|--------|---|-------------------------------|---------------------------------|----------|-----------------------------------|-----------------------------|---------|
|        | Cost Center Description                   | NURSI NG<br>ADMI NI STRATI ON | CENTRAL<br>SERVICES &<br>SUPPLY | PHARMACY | MEDI CAL<br>RECORDS &<br>LI BRARY | Subtotal                    | ·       |
|        |   | 13.00                         | 14.00                           | 15. 00   | 16. 00                            | 24.00                       |         |
|        | GENERAL SERVICE COST CENTERS              | <u> </u>                      |                                 |          |                                   |                             |         |
| 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   |
| 5.00   | 00500 ADMINISTRATIVE & GENERAL            |                               |                                 |          |                                   |                             | 5. 00   |
| 7.00   | 00700 OPERATION OF PLANT                  |                               |                                 |          |                                   |                             | 7. 00   |
| 8.00   | 00800 LAUNDRY & LINEN SERVICE             |                               |                                 |          |                                   |                             | 8. 00   |
| 9. 00  | 00900 HOUSEKEEPI NG                       |                               |                                 |          |                                   |                             | 9. 00   |
| 10.00  | 01000 DI ETARY                            |                               |                                 |          |                                   |                             | 10.00   |
| 13. 00 | 01300 NURSING ADMINISTRATION              | 668, 192                      |                                 |          |                                   |                             | 13. 00  |
| 14. 00 | 01400 CENTRAL SERVICES & SUPPLY           | 0                             | 2, 692, 954                     |          |                                   |                             | 14.00   |
| 15. 00 | 01500 PHARMACY                            | o                             | 0                               | 20, 145  |                                   |                             | 15. 00  |
| 16. 00 | 01600 MEDICAL RECORDS & LIBRARY           | o                             | 0                               | 0        | 92, 927                           |                             | 16. 00  |
|        | INPATIENT ROUTINE SERVICE COST CENTERS    | -1                            | -                               | -1       | , ,                               |                             |         |
| 30.00  | 03000 ADULTS & PEDI ATRI CS               | 127, 938                      | 0                               | 0        | 9, 896                            | 3, 530, 155                 | 30.00   |
|        | ANCILLARY SERVICE COST CENTERS            | ,,                            | -                               | -1       | ,                                 |                             |         |
| 50.00  | 05000 OPERATI NG ROOM                     | 463, 242                      | 0                               | 0        | 45, 353                           | 11, 110, 528                | 50.00   |
| 53.00  | 05300 ANESTHESI OLOGY                     | 62, 451                       | 0                               | 0        | 10, 578                           | 1, 021, 129                 | 53. 00  |
| 54.00  | 05400 RADI OLOGY-DI AGNOSTI C             | 14, 561                       | 0                               | 0        | 302                               | 245, 205                    | 54.00   |
| 60.00  | 06000 LABORATORY                          | O                             | 0                               | 0        | 0                                 | 0                           | 1       |
| 63. 00 | 06300 BLOOD STORING, PROCESSING, & TRANS. | o                             | 0                               | 0        | o                                 | 0                           |         |
| 66. 00 | 06600 PHYSI CAL THERAPY                   | o                             | 0                               | 0        | 62                                | 129, 318                    | 66. 00  |
| 69. 00 | 06900 ELECTROCARDI OLOGY                  | o                             | 0                               | 0        | o                                 | 0                           | 1       |
| 71. 00 | 07100 MEDICAL SUPPLIES CHARGED TO PATIENT | o                             | 1, 189, 820                     | 0        | 9, 359                            | 7, 616, 657                 | 71.00   |
| 72. 00 | 07200 IMPL. DEV. CHARGED TO PATIENTS      | O                             | 1, 503, 134                     | 0        | 11, 132                           | 9, 621, 683                 | 72. 00  |
| 73. 00 | 07300 DRUGS CHARGED TO PATIENTS           | o                             | 0                               | 20, 145  | 6, 245                            | 2, 337, 152                 | 1       |
|        | OUTPATIENT SERVICE COST CENTERS           |                               | -                               |          | ., .,                             |                             |         |
| 92.00  | 09200 OBSERVATION BEDS (NON-DISTINCT PART |                               |                                 |          |                                   |                             | 92. 00  |
|        | OTHER REIMBURSABLE COST CENTERS           |                               |                                 | <u> </u> |                                   |                             |         |
| 99. 10 |   | 0                             | 0                               | 0        | 0                                 | 0                           | 99. 10  |
|        | SPECIAL PURPOSE COST CENTERS              |                               |                                 |          |                                   |                             |         |
| 113.00 | 11300   NTEREST EXPENSE                   |                               |                                 |          |                                   |                             | 113. 00 |
| 118.00 | SUBTOTALS (SUM OF LINES 1 through 117)    | 668, 192                      | 2, 692, 954                     | 20, 145  | 92, 927                           | 35, 611, 827                | 118. 00 |
|        | NONREI MBURSABLE COST CENTERS             | ,                             | , , , , ,                       | .,,      | , ,                               |                             |         |
| 190.00 | 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN | 0                             | 0                               | 0        | 0                                 | 0                           | 190. 00 |
|        | 19001 SHELLED SPACE                       | o                             | 0                               | 0        | o                                 | 0                           | 190. 01 |
|        | 19100 RESEARCH                            | o                             | 0                               | 0        | o                                 |                             | 191.00  |
|        | 19200 PHYSICIANS' PRIVATE OFFICES         | o                             | 0                               | 0        | o                                 |                             | 192. 00 |
|        | 19300 NONPALD WORKERS                     | o                             | 0                               | 0        | o                                 |                             | 193. 00 |
|        | 07950 FREESTANDING REFERENCE LABORATORY   | l                             | 0                               | 0        | ol                                | 8, 161, 739                 |         |
|        | 07951 FREESTANDING URGENT CARE CENTERS    | l                             | 0                               | 0        | ol                                | 5, 409, 937                 |         |
| 200.00 |   |                               |                                 |          | ٦                                 |                             | 200. 00 |
| 201.00 | 1 1                                       | 0                             | 0                               | 0        | o                                 |                             | 201. 00 |
| 202.00 | 1 1 3                                     | 668, 192                      | 2, 692, 954                     | 20, 145  | 92, 927                           | 49, 183, 503                |         |
|        |   | 1                             |                                 |          |                                   |                             | •       |

| Health Financial System | ns                | PHYSICIANS MEDICA | L CENTER              | In Lieu of Form CMS-2552-10 |             |  |
|-------------------------|-------------------|-------------------|-----------------------|-----------------------------|-------------|--|
| COST ALLOCATION - GENER | DAI SEDVICE COSTS |                   | Provider CCN: 15-0172 | Pari ad:                    | Workshoot R |  |

From 01/01/2018 Part I 12/31/2018 Date/Time Prepared: 5/30/2019 5:24 pm Cost Center Description Intern & Total Residents Cost & Post Stepdown Adjustments 25.00 26.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 9.00 00900 HOUSEKEEPI NG 9.00 10.00 01000 DI ETARY 10.00 01300 NURSING ADMINISTRATION 13.00 13 00 01400 CENTRAL SERVICES & SUPPLY 14.00 14.00 15.00 01500 PHARMACY 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 3, 530, 155 30.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 11, 110, 528 50.00 00000 53.00 05300 ANESTHESI OLOGY 1,021,129 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 245, 205 54.00 60.00 06000 LABORATORY 60.00 06300 BLOOD STORING, PROCESSING, & TRANS. 63 00 63 00 0 66.00 06600 PHYSI CAL THERAPY 129, 318 66.00 69.00 06900 ELECTROCARDI OLOGY 69.00 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 7, 616, 657 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72 00 9, 621, 683 72 00 73.00 07300 DRUGS CHARGED TO PATIENTS 2, 337, 152 73.00 OUTPATIENT SERVICE COST CENTERS 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 0 99. 10 09910 CORF 0 99. 10 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | INTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1 through 117) 0 35, 611, 827 118.00 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 190.01 19001 SHELLED SPACE 190. 00 000000000 190. 01 0 191. 00 191. 00 19100 RESEARCH 0 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 192.00 193. 00 19300 NONPALD WORKERS 193.00 194. 00 194. 00 07950 FREESTANDING REFERENCE LABORATORY 8, 161, 739 194. 01 07951 FREESTANDING URGENT CARE CENTERS 5, 409, 937 194. 01 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201.00 202.00 TOTAL (sum lines 118 through 201) 49, 183, 503 202. 00

In Lieu of Form CMS-2552-10
Period: Worksheet B
From 01/01/2018 Part II Provider CCN: 15-0172

|        |  |   |              | To          | 12/31/2018  | Date/Time Pre<br>5/30/2019 5:2     |         |
|--------|--|---|--------------|-------------|-------------|------------------------------------|---------|
|        |  |   | CAPI TAL REI | ATED COSTS  |             | 373072017 3.2                      | 4 pili  |
|        | Cost Center Description                    | Directly Assigned New Capital Related Costs | BLDG & FIXT  | MVBLE EQUIP | Subtotal    | EMPLOYEE<br>BENEFITS<br>DEPARTMENT |         |
|        |  | 0   | 1. 00        | 2.00        | 2A          | 4. 00                              |         |
|        | GENERAL SERVICE COST CENTERS               | 0   | 1.00         | 2.00        | ZA          | 4.00                               |         |
| 1.00   | 00100 CAP REL COSTS-BLDG & FLXT            |   |              |             |             |                                    | 1.00    |
| 2. 00  | 00200 CAP REL COSTS-MVBLE EQUIP            |   |              |             |             |                                    | 2.00    |
| 4.00   | 00400 EMPLOYEE BENEFITS DEPARTMENT         |   | 0            | 0           | 0           | 0                                  | 4.00    |
| 5. 00  | 00500 ADMINISTRATIVE & GENERAL             |   | 324, 816     | _           | 566, 897    | 0                                  | 5. 00   |
| 7. 00  | 00700 OPERATION OF PLANT                   |   | 84, 350      |             | 147, 215    | 0                                  | 7. 00   |
| 8. 00  | 00800 LAUNDRY & LINEN SERVICE              |   | 01,000       | 02,000      | 0           | 0                                  | 8.00    |
| 9. 00  | 00900 HOUSEKEEPING                         |   | 18, 744      | _           | 32, 714     | 0                                  | 9. 00   |
| 10. 00 | 01000 DI ETARY                             |   | 20, 393      |             | 35, 592     | 0                                  | 10.00   |
| 13. 00 | 01300 NURSING ADMINISTRATION               |   | 20, 070      | 0,177       | 00, 072     | 0                                  | 13. 00  |
| 14. 00 | 01400 CENTRAL SERVICES & SUPPLY            |   | 556, 475     | -           | 971, 207    | 0                                  | 14. 00  |
| 15. 00 | 01500 PHARMACY                             |   | 5, 163       | ·           | 9, 011      | 0                                  | 15. 00  |
|        | 01600 MEDICAL RECORDS & LIBRARY            |   | 20, 740      |             | 36, 197     | 0                                  | 16. 00  |
| 10.00  | I NPATI ENT ROUTI NE SERVI CE COST CENTERS | <u> </u>                                    | 20, 710      | 10, 107     | 00, 177     |                                    | 10.00   |
| 30. 00 | 03000 ADULTS & PEDI ATRI CS                | O   | 342, 867     | 255, 533    | 598, 400    | 0                                  | 30.00   |
| 00.00  | ANCILLARY SERVICE COST CENTERS             | 91  | 0.2,007      | 200,000     | 0707 100    |                                    | 00.00   |
| 50.00  | 05000 OPERATING ROOM                       | 0   | 720, 447     | 536, 936    | 1, 257, 383 | 0                                  | 50.00   |
| 53. 00 | 05300 ANESTHESI OLOGY                      | 0   | 0            | 0           | 0           | 0                                  | 53. 00  |
| 54.00  | 05400 RADI OLOGY-DI AGNOSTI C              | o   | 6, 161       | 4, 592      | 10, 753     | 0                                  | 54.00   |
| 60.00  | 06000 LABORATORY                           | O   | 0            | 0           | 0           | 0                                  | 60.00   |
| 63.00  | 06300 BLOOD STORING, PROCESSING, & TRANS.  | o   | 0            | О           | o           | 0                                  | 63. 00  |
| 66.00  | 06600 PHYSI CAL THERAPY                    | o   | 0            | О           | o           | 0                                  | 66. 00  |
| 69.00  | 06900 ELECTROCARDI OLOGY                   | O   | 0            | 0           | o           | 0                                  | 69. 00  |
| 71.00  | 07100 MEDICAL SUPPLIES CHARGED TO PATIENT  | O   | 0            | 0           | o           | 0                                  | 71. 00  |
| 72.00  | 07200 IMPL. DEV. CHARGED TO PATIENTS       | O   | 0            | 0           | o           | 0                                  | 72. 00  |
| 73.00  | 07300 DRUGS CHARGED TO PATIENTS            | 0   | 0            | 0           | 0           | 0                                  | 73. 00  |
|        | OUTPATIENT SERVICE COST CENTERS            |   |              |             |             |                                    |         |
| 92.00  | 09200 OBSERVATION BEDS (NON-DISTINCT PART  |   |              |             | 0           |                                    | 92. 00  |
|        | OTHER REIMBURSABLE COST CENTERS            |   |              |             |             |                                    |         |
| 99. 10 | 09910 CORF                                 | 0   | 0            | 0           | 0           | 0                                  | 99. 10  |
|        | SPECIAL PURPOSE COST CENTERS               |   |              |             |             |                                    |         |
|        | 11300 INTEREST EXPENSE                     |   |              |             |             |                                    | 113. 00 |
| 118.00 | 1 2 2 2 7                                  | 0   | 2, 100, 156  | 1, 565, 213 | 3, 665, 369 | 0                                  | 118. 00 |
|        | NONREI MBURSABLE COST CENTERS              |   |              |             |             |                                    |         |
|        | 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN  | 0   | 0            |             | 0           |                                    | 190. 00 |
|        | 19001 SHELLED SPACE                        | 0   | 0            | _           | 0           |                                    | 190. 01 |
|        | 19100 RESEARCH                             | 0   | 0            | 0           | 0           |                                    | 191. 00 |
|        | 19200 PHYSI CLANS' PRI VATE OFFI CES       | 0   | 0            | 0           | 0           |                                    | 192.00  |
|        | 19300 NONPAI D WORKERS                     | 0   | 0            | 0           | 0           |                                    | 193. 00 |
|        | 07950 FREESTANDING REFERENCE LABORATORY    | 0   | 151, 864     | 0           | 151, 864    |                                    | 194. 00 |
|        | 07951 FREESTANDING URGENT CARE CENTERS     | 0   | 0            | 0           | 0           | 0                                  | 194. 01 |
| 200.00 | ,  |   | =            | _           | 0           | =                                  | 200.00  |
| 201.00 |  |   | 0 050 000    | 0           | 0 047 000   |                                    | 201. 00 |
| 202.00 | TOTAL (sum lines 118 through 201)          | 0   | 2, 252, 020  | 1, 565, 213 | 3, 817, 233 | 0                                  | 202. 00 |

Provider CCN: 15-0172

| Peri od: | Worksheet B | From 01/01/2018 | Part | I | To 12/31/2018 | Date/Time Prepared: | From 12/31/2018 | Part | I | Prepared: | Pre

|        |   |                   |              | 10            | 0 12/31/2018  | 5/30/2019 5: 2 |         |
|--------|---|-------------------|--------------|---------------|---------------|----------------|---------|
|        | Cost Center Description                   | ADMI NI STRATI VE | OPERATION OF | LAUNDRY &     | HOUSEKEEPI NG | DI ETARY       | T PIII  |
|        | ,   | & GENERAL         | PLANT        | LINEN SERVICE |               |                |         |
|        |   | 5. 00             | 7. 00        | 8. 00         | 9. 00         | 10.00          |         |
|        | GENERAL SERVICE COST CENTERS              |                   |              |               |               |                |         |
| 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   |
| 5.00   | 00500 ADMINISTRATIVE & GENERAL            | 566, 897          |              |               |               |                | 5. 00   |
| 7.00   | 00700 OPERATION OF PLANT                  | 35, 291           | 182, 506     |               |               |                | 7. 00   |
| 8.00   | 00800 LAUNDRY & LINEN SERVICE             | 7, 021            | 0            | 7, 021        |               |                | 8. 00   |
| 9.00   | 00900 HOUSEKEEPI NG                       | 6, 177            | 2, 023       | 0             | 40, 914       |                | 9. 00   |
| 10.00  | 01000 DI ETARY                            | 2,082             | 2, 201       | 0             | 499           | 40, 374        | 10.00   |
| 13.00  | 01300 NURSI NG ADMI NI STRATI ON          | 10, 637           | 0            | 0             | 0             | 0              | 13.00   |
| 14.00  | 01400 CENTRAL SERVICES & SUPPLY           | 29, 069           | 60, 060      | 0             | 13, 615       | 0              | 14.00   |
| 15. 00 | 01500 PHARMACY                            | 193               | 557          |               | 126           | 0              | 15. 00  |
| 16, 00 | 01600 MEDICAL RECORDS & LIBRARY           | 965               | 2, 238       |               |               | 0              | 16.00   |
|        | INPATIENT ROUTINE SERVICE COST CENTERS    |                   | ,            |               |               |                |         |
| 30.00  | 03000 ADULTS & PEDI ATRI CS               | 42, 561           | 37, 005      | 351           | 8, 389        | 40, 374        | 30.00   |
|        | ANCILLARY SERVICE COST CENTERS            |                   | ·            |               |               |                | 1       |
| 50.00  | 05000 OPERATI NG ROOM                     | 144, 231          | 77, 757      | 6, 670        | 17, 627       | 0              | 50.00   |
| 53.00  | 05300 ANESTHESI OLOGY                     | 15, 093           | 0            |               | 0             | 0              | 53. 00  |
| 54.00  | 05400 RADI OLOGY-DI AGNOSTI C             | 3, 514            | 665          | 0             | 151           | 0              | 54. 00  |
| 60.00  | 06000 LABORATORY                          | 0                 | 0            | 0             | 0             | 0              | 60.00   |
| 63.00  | 06300 BLOOD STORING, PROCESSING, & TRANS. | 0                 | 0            | 0             | 0             | 0              | 63.00   |
| 66.00  | 06600 PHYSI CAL THERAPY                   | 2, 058            | 0            | 0             | 0             | 0              | 66. 00  |
| 69.00  | 06900 ELECTROCARDI OLOGY                  | 0                 | 0            | 0             | 0             | 0              | 69. 00  |
| 71.00  | 07100 MEDICAL SUPPLIES CHARGED TO PATIENT | 102, 159          | 0            | 0             | 0             | 0              | 71.00   |
| 72.00  | 07200 I MPL. DEV. CHARGED TO PATIENTS     | 129, 061          | 0            | 0             | 0             | 0              | 72.00   |
| 73.00  | 07300 DRUGS CHARGED TO PATIENTS           | 36, 785           | 0            | 0             | 0             | 0              | 73. 00  |
|        | OUTPATIENT SERVICE COST CENTERS           |                   |              |               |               |                |         |
| 92.00  | 09200 OBSERVATION BEDS (NON-DISTINCT PART |                   |              |               |               |                | 92. 00  |
|        | OTHER REIMBURSABLE COST CENTERS           |                   |              |               |               |                |         |
| 99. 10 | 09910 CORF                                | 0                 | 0            | 0             | 0             | 0              | 99. 10  |
|        | SPECIAL PURPOSE COST CENTERS              |                   |              |               |               |                |         |
|        | 11300 I NTEREST EXPENSE                   |                   |              |               |               |                | 113. 00 |
| 118.00 |   | 566, 897          | 182, 506     | 7, 021        | 40, 914       | 40, 374        | 118. 00 |
|        | NONREI MBURSABLE COST CENTERS             |                   |              |               |               |                |         |
|        | 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN | 0                 | 0            | _             |               |                | 190. 00 |
|        | 19001 SHELLED SPACE                       | 0                 | 0            | 0             | 0             |                | 190. 01 |
|        | 19100 RESEARCH                            | 0                 | 0            | 0             | 0             |                | 191. 00 |
|        | 19200 PHYSI CLANS' PRI VATE OFFI CES      | 0                 | 0            | 0             | 0             |                | 192. 00 |
|        | 19300 NONPALD WORKERS                     | 0                 | 0            | 0             | 0             |                | 193. 00 |
|        | 07950 FREESTANDING REFERENCE LABORATORY   | 0                 | 0            | 0             | 0             |                | 194. 00 |
|        | 07951 FREESTANDING URGENT CARE CENTERS    | 0                 | 0            | 0             | 0             | 0              | 194. 01 |
| 200.00 | 1 1                                       |                   |              |               |               |                | 200. 00 |
| 201.00 |   | 0                 | 0            | 0             | 0             |                | 201. 00 |
| 202.00 | TOTAL (sum lines 118 through 201)         | 566, 897          | 182, 506     | 7, 021        | 40, 914       | 40, 374        | 202. 00 |

In Lieu of Form CMS-2552-10
Period: Worksheet B
From 01/01/2018 Part II Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0172

|                  |  |                               |                        | To       | 12/31/2018            | Date/Time Pre<br>5/30/2019 5:2 |          |
|------------------|--|-------------------------------|------------------------|----------|-----------------------|--------------------------------|----------|
|                  | Cost Center Description  | NURSI NG<br>ADMI NI STRATI ON | CENTRAL<br>SERVI CES & | PHARMACY | MEDI CAL<br>RECORDS & | Subtotal                       |          |
|                  |  | 12.00                         | SUPPLY                 | 15.00    | LI BRARY              | 24.00                          |          |
|                  | GENERAL SERVICE COST CENTERS   | 13. 00                        | 14. 00                 | 15. 00   | 16. 00                | 24. 00                         |          |
| 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. 00            | 00500 ADMI NI STRATI VE & GENERAL  |                               |                        |          |                       |                                | 5. 00    |
| 7. 00            | 00700 OPERATION OF PLANT   |                               |                        |          |                       |                                | 7. 00    |
| 8. 00            | 00800 LAUNDRY & LINEN SERVICE  |                               |                        |          |                       |                                | 8. 00    |
| 9. 00            | 00900 HOUSEKEEPI NG  |                               |                        |          |                       |                                | 9. 00    |
| 10. 00           | 01000 DI ETARY   |                               |                        |          |                       |                                | 10.00    |
| 13. 00           | 01300 NURSI NG ADMI NI STRATI ON   | 10, 637                       |                        |          |                       |                                | 13. 00   |
| 14.00            | 01400 CENTRAL SERVICES & SUPPLY  | 0                             | 1, 073, 951            |          |                       |                                | 14.00    |
| 15.00            | 01500 PHARMACY   | O                             | 0                      | 9, 887   |                       |                                | 15. 00   |
| 16.00            | 01600 MEDICAL RECORDS & LIBRARY  | 0                             | 0                      | 0        | 39, 907               |                                | 16. 00   |
|                  | INPATIENT ROUTINE SERVICE COST CENTERS                                   |                               |                        |          |                       |                                |          |
| 30.00            | 03000 ADULTS & PEDI ATRI CS  | 2, 037                        | 0                      | 0        | 4, 244                | 733, 361                       | 30. 00   |
|                  | ANCILLARY SERVICE COST CENTERS   |                               |                        |          |                       |                                |          |
| 50. 00           | 05000 OPERATING ROOM   | 7, 374                        | 0                      | -        | 19, 505               | 1, 530, 547                    | 1        |
| 53. 00           | 05300 ANESTHESI OLOGY  | 994                           | 0                      |          | 4, 536                | 20, 623                        |          |
| 54.00            | 05400 RADI OLOGY-DI AGNOSTI C  | 232                           | 0                      | Ĭ        | 129                   | 15, 444                        | 1        |
| 60.00            | 06000 LABORATORY   | 0                             | 0                      | 0        | 0                     | 0                              |          |
| 63.00            | 06300 BLOOD STORING, PROCESSING, & TRANS.                                | 0                             | 0                      | 0        | 0                     | 0                              |          |
| 66.00            | 06600 PHYSI CAL THERAPY  | 0                             | 0                      | 0        | 27                    | 2, 085                         | 1        |
| 69. 00<br>71. 00 | 06900  ELECTROCARDIOLOGY<br>  07100  MEDICAL SUPPLIES CHARGED TO PATIENT | 0                             | 474 500                | 0        | 0<br>4, 014           | F00 473                        |          |
| 71.00            | 07200 I MPL. DEV. CHARGED TO PATIENTS                                    | 0                             | 474, 500<br>599, 451   | 0        | 4, 014                | 580, 673<br>733, 286           |          |
| 73. 00           | 07300 DRUGS CHARGED TO PATIENTS  | 0                             | 399, 431               | -        | 2, 678                | 49, 350                        | 1        |
| 73.00            | OUTPATIENT SERVICE COST CENTERS  | ı o                           | U                      | 7,007    | 2,070                 | 47, 330                        | 73.00    |
| 92. 00           | 09200 OBSERVATION BEDS (NON-DISTINCT PART                                |                               |                        |          |                       |                                | 92. 00   |
| 72.00            | OTHER REIMBURSABLE COST CENTERS  |                               |                        |          |                       |                                | 72.00    |
| 99 10            | 09910 CORF   | 0                             | 0                      | 0        | 0                     | 0                              | 99. 10   |
|                  | SPECIAL PURPOSE COST CENTERS   | -1                            | -                      |          | -1                    | -                              | 1        |
| 113.00           | 11300   NTEREST EXPENSE  |                               |                        |          |                       |                                | 113. 00  |
| 118.00           | SUBTOTALS (SUM OF LINES 1 through 117)                                   | 10, 637                       | 1, 073, 951            | 9, 887   | 39, 907               | 3, 665, 369                    | 118. 00  |
|                  | NONREI MBURSABLE COST CENTERS  |                               |                        |          |                       |                                |          |
| 190.00           | 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN                                | 0                             | 0                      | 0        | 0                     | 0                              | 190. 00  |
| 190. 01          | 19001 SHELLED SPACE  | 0                             | 0                      | 0        | o                     | 0                              | 190. 01  |
|                  | 19100 RESEARCH   | 0                             | 0                      | 0        | 0                     |                                | 191. 00  |
|                  | 19200 PHYSICIANS' PRIVATE OFFICES  | 0                             | 0                      | 0        | 0                     |                                | 192. 00  |
|                  | 19300 NONPALD WORKERS  | 0                             | 0                      | 0        | 0                     |                                | 193. 00  |
|                  | 07950 FREESTANDING REFERENCE LABORATORY                                  | 0                             | 0                      | 0        | 0                     | 151, 864                       |          |
|                  | 07951 FREESTANDING URGENT CARE CENTERS                                   | 0                             | 0                      | 0        | 0                     |                                | 194. 01  |
| 200.00           | , ,  |                               |                        |          |                       |                                | 200. 00  |
| 201.00           |  | 0                             | 0                      | 0        | 0                     |                                | 201.00   |
| 202.00           | TOTAL (sum lines 118 through 201)  | 10, 637                       | 1, 073, 951            | 9, 887   | 39, 907               | 3, 817, 233                    | J202. 00 |

| Health Financial Systems            | PHYSICIANS MEDICAL CENTER |                | In Lieu of Form CMS-2552-10 |
|-------------------------------------|---------------------------|----------------|-----------------------------|
| ALLOCATION OF CAPITAL RELATED COSTS | Provi der CCN: 1          | 5_0172 Period: | Worksheet R                 |

From 01/01/2018 | Part II 12/31/2018 Date/Time Prepared: 5/30/2019 5:24 pm Cost Center Description Intern & Total Residents Cost & Post Stepdown Adj ustments 25.00 26.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 9.00 00900 HOUSEKEEPI NG 9.00 10.00 01000 DI ETARY 10.00 01300 NURSING ADMINISTRATION 13.00 13 00 01400 CENTRAL SERVICES & SUPPLY 14.00 14.00 15.00 01500 PHARMACY 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 733, 361 30.00 ANCILLARY SERVICE COST CENTERS 1, 530, 547 50.00 05000 OPERATING ROOM 50.00 000000 53.00 05300 ANESTHESI OLOGY 20, 623 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 15, 444 54.00 60.00 06000 LABORATORY 60.00 06300 BLOOD STORING, PROCESSING, & TRANS. 63 00 63 00 Ω 66.00 06600 PHYSI CAL THERAPY 2,085 66.00 69.00 06900 ELECTROCARDI OLOGY 69.00 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 580, 673 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72 00 733, 286 72 00 73.00 07300 DRUGS CHARGED TO PATIENTS 49, 350 73.00 OUTPATIENT SERVICE COST CENTERS 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 0 99. 10 09910 CORF 0 99.10 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1 through 117) 0 3, 665, 369 118.00 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 190.01 19001 SHELLED SPACE 190. 00 000000000 190. 01 0 191. 00 191. 00 19100 RESEARCH 0 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 192.00 193. 00 19300 NONPALD WORKERS 193.00 194. 00 194. 00 07950 FREESTANDING REFERENCE LABORATORY 151, 864 194. 01 07951 FREESTANDING URGENT CARE CENTERS 0 194. 01 200.00 Cross Foot Adjustments 0 200.00 201.00 Negative Cost Centers 201.00 3, 817, 233 202.00 TOTAL (sum lines 118 through 201) 202. 00

From 01/01/2018 12/31/2018 Date/Time Prepared: 5/30/2019 5:24 pm CAPITAL RELATED COSTS Cost Center Description BLDG & FIXT MVBLE EQUIP **EMPLOYEE** Reconciliation ADMINISTRATIVE (SQUARE FEET) (SQUARE FEET) BENEFITS & GENERAL (ACCUM. COST) DEPARTMENT (GROSS SALARI ES) 1.00 2.00 5A 5. 00 GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS-BLDG & FLXT 51 902 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 48, 402 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 12, 806, 252 4.00 00500 ADMINISTRATIVE & GENERAL 7.486 7. 486 1, 958, 966 -9, 096, 340 5 00 26 515 487 5 00 00700 OPERATION OF PLANT 7.00 1,944 1,944 128, 440 1, 650, 678 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 328, 390 8.00 9.00 00900 HOUSEKEEPI NG 432 432 0 0 288, 892 9.00 0 01000 DI ETARY 97.383 10 00 10 00 470 470 0 13.00 01300 NURSING ADMINISTRATION 418, 939 0 497, 515 13.00 01400 CENTRAL SERVICES & SUPPLY 12, 825 12, 825 293, 795 1, 359, 658 14.00 14.00 01500 PHARMACY 119 0 9, 011 15.00 15.00 119 01600 MEDICAL RECORDS & LIBRARY 16.00 478 478 O 45, 135 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 30.00 7,902 7,902 1, 144, 161 0 1, 990, 686 30.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 16,604 16, 604 5. 333. 731 6, 746, 298 50 00 05300 ANESTHESI OLOGY 705, 926 53.00 563, 362 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 142 142 129, 346 0 164, 359 54.00 0 06000 LABORATORY 60.00 0 60.00 C 0 0 06300 BLOOD STORING, PROCESSING, & TRANS. 0 0 0 63.00 Ω Λ 63.00 06600 PHYSI CAL THERAPY 0 0 0 96, 240 66.00 0 66.00 0 69.00 06900 ELECTROCARDI OLOGY 0 0 69.00 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 71.00 0 0 4, 778, 258 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 C 0 0 6, 036, 535 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 0 0 1, 720, 523 73.00 OUTPATIENT SERVICE COST CENTERS 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 99. 10 09910 CORF 0 0 0 0 0 99. 10 SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1 through 117) 48, 402 48, 402 9, 970, 740 -9, 096, 340 26, 515, 487 118. 00 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190 00 0 0 190. 01 19001 SHELLED SPACE 0 0 0 0 0 190. 01 191. 00 19100 RESEARCH 0 0 0 0 191.00 o 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 0 192.00 Ω 0 193.00 193. 00 19300 NONPALD WORKERS 0 C 0 0 194. 00 07950 FREESTANDING REFERENCE LABORATORY 3,500 -8, 161, 739 0 194. 00 194. 01 07951 FREESTANDING URGENT CARE CENTERS 2, 835, 512 -5, 409, 937 0 194. 01 200 00 Cross Foot Adjustments 200 00 201.00 Negative Cost Centers 201.00 202.00 Cost to be allocated (per Wkst. B, 2, 252, 020 1, 565, 213 2, 401, 939 9, 096, 340 202. 00 Part I) 0. 343058 203. 00 203.00 Unit cost multiplier (Wkst. B, Part I) 43. 389850 32. 337775 0.187560 204.00 Cost to be allocated (per Wkst. B, 566, 897 204. 00 Part II) 205.00 Unit cost multiplier (Wkst. B, Part 0.000000 0. 021380 205. 00 II) 206, 00 NAHE adjustment amount to be allocated 206, 00 (per Wkst. B-2) 207.00 NAHE unit cost multiplier (Wkst. D, 207.00 Parts III and IV)

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Peri od: Worksheet B-1
From 01/01/2018
To 12/31/2018 Date/Time Prepa Provider CCN: 15-0172

|                  |   |                                   |  | Ť.                            | 0 12/31/2018              | Date/Time Pre 5/30/2019 5:2   |                    |
|------------------|---|-----------------------------------|--|-------------------------------|---------------------------|-------------------------------|--------------------|
|                  | Cost Center Description   | OPERATION OF PLANT (SOLIARE FEET) | LAUNDRY &<br>LINEN SERVICE<br>(PATIENT DAYS) | HOUSEKEEPING<br>(SQUARE FEET) | DIETARY<br>(PATIENT DAYS) | NURSI NG<br>ADMI NI STRATI ON |                    |
|                  |   | (SQUARE TELT)                     | (IAIIENI DAIS)                               |                               |                           | (NURSI NG                     |                    |
|                  |   |                                   |  |                               |                           | HOURS)                        |                    |
|                  | I   | 7. 00                             | 8. 00  | 9. 00                         | 10. 00                    | 13. 00                        |                    |
| 4 00             | GENERAL SERVI CE COST CENTERS   |                                   | T  | ı                             | I                         |                               | 1 00               |
| 1. 00<br>2. 00   | 00100 CAP REL COSTS-BLDG & FIXT<br>00200 CAP REL COSTS-MVBLE EQUIP                    |                                   |  |                               |                           |                               | 1.00               |
| 4.00             | 00400 EMPLOYEE BENEFITS DEPARTMENT  |                                   |  |                               |                           |                               | 4. 00              |
| 5. 00            | 00500 ADMI NI STRATI VE & GENERAL   |                                   |  |                               |                           |                               | 5. 00              |
| 7. 00            | 00700 OPERATION OF PLANT  | 38, 972                           |  |                               |                           |                               | 7. 00              |
| 8.00             | 00800 LAUNDRY & LINEN SERVICE   | 0                                 | 100  |                               |                           |                               | 8. 00              |
| 9.00             | 00900 HOUSEKEEPI NG   | 432                               | 0  | 38, 540                       |                           |                               | 9. 00              |
| 10.00            | 01000 DI ETARY  | 470                               | 0  | 470                           |                           |                               | 10.00              |
| 13.00            | 01300 NURSI NG ADMI NI STRATI ON  | 10.005                            | 0  | 0                             | _                         | 8, 581                        | 13.00              |
| 14.00            | 01400   CENTRAL SERVI CES & SUPPLY   01500   PHARMACY                                 | 12, 825                           |  | 12, 825                       |                           | 0                             |                    |
| 15. 00<br>16. 00 | 01600 MEDICAL RECORDS & LIBRARY   | 119<br>478                        |  | 119<br>478                    |                           | 0                             |                    |
| 10.00            | I NPATI ENT ROUTI NE SERVI CE COST CENTERS  | 470                               |  | 470                           |                           | 0                             | 10.00              |
| 30. 00           | 03000 ADULTS & PEDI ATRI CS   | 7, 902                            | 5  | 7, 902                        | 100                       | 1, 643                        | 30.00              |
|                  | ANCILLARY SERVICE COST CENTERS  |                                   | •  |                               |                           |                               | 1                  |
| 50.00            | 05000 OPERATI NG ROOM   | 16, 604                           | 95   | 16, 604                       | 0                         | 5, 949                        | 50.00              |
| 53.00            | 05300 ANESTHESI OLOGY   | 0                                 | 0  |                               | -                         | 802                           | 1                  |
| 54. 00           | 05400 RADI OLOGY-DI AGNOSTI C   | 142                               | 0  | 142                           |                           | 187                           | 1                  |
| 60.00            | 06000 LABORATORY  | 0                                 | 0  | 0                             | _                         | 0                             | 60.00              |
| 63. 00           | 06300 BLOOD STORING, PROCESSING, & TRANS.   | 0                                 | 0  | 0                             |                           | 0                             |                    |
| 66. 00<br>69. 00 | 06600   PHYSI CAL THERAPY   06900   ELECTROCARDI OLOGY                                |                                   |  | 0                             | 0                         | 0                             |                    |
| 71. 00           | 07100 MEDICAL SUPPLIES CHARGED TO PATIENT   |                                   |  | 0                             | 0                         | 0                             | 1                  |
| 72. 00           | 07200 IMPL. DEV. CHARGED TO PATIENTS  |                                   | Ö  | 0                             |                           | 0                             | 1                  |
| 73.00            | 07300 DRUGS CHARGED TO PATIENTS   | 0                                 | 0  | 0                             | 0                         | 0                             | 1                  |
|                  | OUTPATIENT SERVICE COST CENTERS   |                                   |  |                               |                           |                               |                    |
| 92. 00           | 09200 OBSERVATION BEDS (NON-DISTINCT PART   |                                   |  |                               |                           |                               | 92.00              |
| 00.40            | OTHER REIMBURSABLE COST CENTERS   | Ι .                               | 1  | Ι                             |                           |                               | 00.40              |
| 99. 10           | 09910 CORF  | 0                                 | 0  | 0                             | 0                         | 0                             | 99. 10             |
| 113 00           | SPECIAL PURPOSE COST CENTERS 11300   NTEREST EXPENSE                                  |                                   |  |                               |                           |                               | 113. 00            |
| 118.00           | 1   | 38, 972                           | 100  | 38, 540                       | 100                       | 8 581                         | 118. 00            |
| 110.00           | NONREI MBURSABLE COST CENTERS   | 30,772                            | 100  | 00,010                        | 100                       | 0,001                         | 1110.00            |
| 190.00           | 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN   | 0                                 | 0  | 0                             | 0                         | 0                             | 190. 00            |
| 190. 01          | 19001 SHELLED SPACE   | 0                                 | 0  | 0                             | 0                         | 0                             | 190. 01            |
|                  | 19100 RESEARCH  | 0                                 | 0  | 0                             | 0                         |                               | 191. 00            |
|                  | 19200 PHYSI CI ANS' PRI VATE OFFI CES   | 0                                 | 0  | 0                             | 0                         |                               | 192. 00            |
|                  | 19300 NONPALD WORKERS   | 0                                 | 0  | 0                             | 0                         |                               | 193. 00            |
|                  | 07950  FREESTANDING REFERENCE LABORATORY<br>  07951  FREESTANDING URGENT CARE CENTERS |                                   | 0  | 0                             | 0                         |                               | 194. 00<br>194. 01 |
| 200.00           |   |                                   |  | 0                             | U                         | U                             | 200. 00            |
| 201.00           | 1 1   |                                   |  |                               |                           |                               | 201.00             |
| 202.00           | 9   | 2, 216, 956                       | 441, 047                                     | 412, 574                      | 162, 558                  | 668, 192                      |                    |
|                  | Part I)   |                                   |  | ·                             |                           |                               |                    |
| 203.00           |   | 56. 885867                        |  |                               |                           |                               |                    |
| 204.00           |   | 182, 506                          | 7, 021                                       | 40, 914                       | 40, 374                   | 10, 637                       | 204. 00            |
| 205.00           |   | 4. 683003                         | 70. 210000                                   | 1. 061598                     | 403. 740000               | 1. 239599                     | 205. 00            |
| 206.00           |   |                                   |  |                               |                           |                               | 206. 00            |
| 207. 00          | (per Wkst. B-2)  NAHE unit cost multiplier (Wkst. D,  Parts III and IV)               |                                   |  |                               |                           |                               | 207. 00            |

Provider CCN: 15-0172

|                    |   |                          |                       |                      | o 12/31/2018 | Date/Time Prepared: 5/30/2019 5:24 pm |
|--------------------|---|--------------------------|-----------------------|----------------------|--------------|---------------------------------------|
|                    | Cost Center Description   | CENTRAL                  | PHARMACY              | MEDI CAL             |              | 37 307 2017 3. 24 pm                  |
|                    |   | SERVICES &               | (COSTED               | RECORDS &            |              |                                       |
|                    |   | SUPPLY<br>(COSTED        | REQUISI)              | LI BRARY<br>(GROSS   |              |                                       |
|                    |   | REQUIS.)                 |                       | CHARGES)             |              |                                       |
|                    |   | 14.00                    | 15. 00                | 16.00                | _            |                                       |
|                    | RAL SERVICE COST CENTERS  |                          |                       |                      |              |                                       |
|                    | O CAP REL COSTS-BLDG & FIXT   |                          |                       |                      |              | 1. 00                                 |
|                    | O CAP REL COSTS-MVBLE EQUIP   |                          |                       |                      |              | 2.00                                  |
|                    | O EMPLOYEE BENEFITS DEPARTMENT O ADMINISTRATIVE & GENERAL                 |                          |                       |                      |              | 4. 00<br>5. 00                        |
|                    | O OPERATION OF PLANT  |                          |                       |                      |              | 7.00                                  |
|                    | O LAUNDRY & LINEN SERVICE   |                          |                       |                      |              | 8. 00                                 |
|                    | O HOUSEKEEPI NG   |                          |                       |                      |              | 9. 00                                 |
| 10. 00 0100        | O DI ETARY  |                          |                       |                      |              | 10.00                                 |
|                    | O NURSING ADMINISTRATION  |                          |                       |                      |              | 13. 00                                |
|                    | O CENTRAL SERVICES & SUPPLY   | 10, 814, 793             | 100                   |                      |              | 14.00                                 |
|                    | O PHARMACY  | 0                        | 100<br>0              | 101 141 241          |              | 15. 00<br>16. 00                      |
|                    | O MEDICAL RECORDS & LIBRARY TIENT ROUTINE SERVICE COST CENTERS            | U U                      | <u> </u>              | 181, 161, 341        | l e          | 16.00                                 |
|                    | O ADULTS & PEDIATRICS   | 0                        | 0                     | 19, 290, 280         |              | 30.00                                 |
|                    | LLARY SERVICE COST CENTERS  | <u> </u>                 | <u> </u>              | 17/270/200           | 1            | 55. 55                                |
|                    | O OPERATING ROOM  | 0                        | 0                     | 88, 423, 321         |              | 50.00                                 |
|                    | O ANESTHESI OLOGY   | 0                        | 0                     | 20, 619, 418         | 3            | 53. 00                                |
|                    | O RADI OLOGY-DI AGNOSTI C   | 0                        | 0                     | 588, 058             |              | 54.00                                 |
| •                  | LABORATORY  | 0                        | 0                     | (                    |              | 60.00                                 |
| 1                  | O BLOOD STORING, PROCESSING, & TRANS.                                     | 0                        | 0                     | 101 [/               |              | 63. 00                                |
| 1                  | IO PHYSI CAL THERAPY<br>IO ELECTROCARDI OLOGY                             | 0                        | 0                     | 121, 565<br>(        |              | 66. 00<br>69. 00                      |
|                    | O MEDICAL SUPPLIES CHARGED TO PATIENT                                     | 4, 778, 258              | 0                     | 18, 244, 612         |              | 71.00                                 |
|                    | O I MPL. DEV. CHARGED TO PATIENTS   | 6, 036, 535              | o                     | 21, 700, 730         |              | 72. 00                                |
| 73. 00 0730        | DRUGS CHARGED TO PATIENTS   | o                        | 100                   | 12, 173, 357         |              | 73. 00                                |
|                    | ATIENT SERVICE COST CENTERS   |                          |                       |                      |              |                                       |
|                    | O OBSERVATION BEDS (NON-DISTINCT PART                                     |                          |                       |                      |              | 92. 00                                |
|                    | R REI MBURSABLE COST CENTERS  | O                        | ما                    |                      | \[ \ \       | 00.10                                 |
| 99. 10 0991        | I AL PURPOSE COST CENTERS   | U U                      | 0                     | (                    | )            | 99. 10                                |
|                    | O INTEREST EXPENSE  |                          |                       |                      |              | 113. 00                               |
| 118. 00            | SUBTOTALS (SUM OF LINES 1 through 117)                                    | 10, 814, 793             | 100                   | 181, 161, 341        |              | 118.00                                |
| NONR               | EI MBURSABLE COST CENTERS   |                          |                       |                      |              |                                       |
|                    | O GIFT, FLOWER, COFFEE SHOP & CANTEEN                                     | 0                        | 0                     | (                    |              | 190. 00                               |
|                    | 1 SHELLED SPACE   | 0                        | 0                     | (                    |              | 190. 01                               |
| 191. 00 1910       |   | 0                        | 0                     | (                    |              | 191. 00                               |
|                    | IO PHYSICIANS' PRIVATE OFFICES IO NONPAID WORKERS                         | 0                        | 0                     | (                    |              | 192. 00<br>193. 00                    |
|                    | O FREESTANDING REFERENCE LABORATORY                                       | 0                        | 0                     | (                    |              | 194. 00                               |
|                    | 1 FREESTANDING URGENT CARE CENTERS  | o                        | o                     | (                    |              | 194. 01                               |
| 200. 00            | Cross Foot Adjustments  |                          |                       |                      |              | 200. 00                               |
| 201. 00            | Negative Cost Centers   |                          |                       |                      |              | 201. 00                               |
| 202. 00            | Cost to be allocated (per Wkst. B,  | 2, 692, 954              | 20, 145               | 92, 927              | '            | 202. 00                               |
| 202 00             | Part I)   | 0.240007                 | 201 450000            | 0.000513             | ,            | 203. 00                               |
| 203. 00<br>204. 00 | Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B, | 0. 249007<br>1, 073, 951 | 201. 450000<br>9, 887 | 0. 000513<br>39, 907 |              | 203. 00                               |
| 204.00             | Part II)  | 1,0/3,731                | 7, 00/                | 37, 901              |              | 204.00                                |
| 205. 00            | Unit cost multiplier (Wkst. B, Part                                       | 0. 099304                | 98. 870000            | 0. 000220            |              | 205. 00                               |
|                    | 11)   |                          |                       |                      |              |                                       |
| 206. 00            | NAHE adjustment amount to be allocated                                    |                          |                       |                      |              | 206. 00                               |
| 207. 00            | (per Wkst. B-2) NAHE unit cost multiplier (Wkst. D,                       |                          |                       |                      |              | 207. 00                               |
| 207.00             | Parts III and IV)   |                          |                       |                      |              | 207.00                                |
| ı                  | 1   | ' '                      |                       |                      | T .          | ı                                     |

|        | Financial Systems                         | PHYSICIANS MEI                                      |                       |             |   | eu of Form CMS-2 | 2552-10        |
|--------|---|---|-----------------------|-------------|---|------------------|----------------|
| COMPUT | ATION OF RATIO OF COSTS TO CHARGES        |   | Provider Co           |             | Period:<br>From 01/01/2018<br>To 12/31/2018 |                  | pared:<br>4 pm |
|        |   |   | Title                 | XVIII       | Hospi tal                                   | PPS              |                |
|        |   |   | ·                     |             | Costs                                       |                  |                |
|        | Cost Center Description                   | Total Cost<br>(from Wkst. B,<br>Part I, col.<br>26) | Therapy Limit<br>Adj. | Total Costs | RCE<br>Di sal I owance                      | Total Costs      |                |
|        |   | 1.00  | 2. 00                 | 3.00        | 4. 00                                       | 5. 00            |                |
|        | INPATIENT ROUTINE SERVICE COST CENTERS    |   | <u> </u>              | •           | <u> </u>                                    |                  |                |
| 30.00  | 03000 ADULTS & PEDI ATRI CS               | 3, 530, 155   |                       | 3, 530, 15  | 5 0   | 3, 530, 155      | 30.00          |
|        | ANCILLARY SERVICE COST CENTERS            |   |                       |             |   |                  | 1              |
| 50.00  | 05000 OPERATING ROOM                      | 11, 110, 528  |                       | 11, 110, 52 | 8 0   | 11, 110, 528     | 50.00          |
| 53.00  | 05300 ANESTHESI OLOGY                     | 1, 021, 129   |                       | 1, 021, 12  | 9 0   | 1, 021, 129      | 53. 00         |
| 54.00  | 05400 RADI OLOGY-DI AGNOSTI C             | 245, 205  |                       | 245, 20     | 5 0   | 245, 205         | 54.00          |
| 60.00  | 06000 LABORATORY                          | 0   |                       |             | 0   | 0                | 60.00          |
| 63.00  | 06300 BLOOD STORING, PROCESSING, & TRANS. | 0   |                       |             | 0   | 0                | 63.00          |
| 66.00  | 06600 PHYSI CAL THERAPY                   | 129, 318  | 0                     | 129, 31     | 8 0   | 129, 318         | 66. 00         |
| 69. 00 | 06900 ELECTROCARDI OLOGY                  | 0   |                       |             | 0   | 0                | 69. 00         |
|        | 07100 MEDICAL SUPPLIES CHARGED TO PATIENT | 7, 616, 657   |                       | 7, 616, 65  | 7 0   | 7, 616, 657      | 71. 00         |
| 72.00  | 07200 I MPL. DEV. CHARGED TO PATIENTS     | 9, 621, 683   |                       | 9, 621, 68  | 3 0   | 9, 621, 683      | 72. 00         |
| 73.00  | 07300 DRUGS CHARGED TO PATIENTS           | 2, 337, 152   |                       | 2, 337, 15  | 2 0   | 2, 337, 152      | 73. 00         |
|        | OUTPATIENT SERVICE COST CENTERS           |   |                       |             |   |                  |                |
| 92.00  | 09200 OBSERVATION BEDS (NON-DISTINCT PART | 2, 087, 100   |                       | 2, 087, 10  | 0   | 2, 087, 100      | 92. 00         |
|        | OTHER REIMBURSABLE COST CENTERS           |   |                       |             |   |                  |                |
| 99. 10 | 09910 CORF                                | 0   |                       |             | 0   | 0                | 99. 10         |
|        | SPECIAL PURPOSE COST CENTERS              |   |                       |             |   |                  |                |
| 113.00 | 11300 I NTEREST EXPENSE                   |   |                       |             |   |                  | 113. 00        |
| 200 00 | Subtotal (soo instructions)               | 27 600 027  | 1                     | 27 600 02   | 7 0   | 27 600 027       |                |

37, 698, 927 2, 087, 100

35, 611, 827

37, 698, 927 200. 00 2, 087, 100 201. 00 35, 611, 827 202. 00

0

37, 698, 927 2, 087, 100

35, 611, 827

0

200.00

201.00

202.00

Subtotal (see instructions)

Less Observation Beds

Total (see instructions)

| Health Financial Systems                        | PHYSICIANS MED | I CAL CENTER  |              | In Lie          | u of Form CMS-2                | 2552-10        |
|---|----------------|---------------|--------------|-----------------|--------------------------------|----------------|
| COMPUTATION OF RATIO OF COSTS TO CHARGES        |                | Provi der Co  |              | Peri od:        | Worksheet C                    |                |
|   |                |               |              | From 01/01/2018 |                                |                |
|   |                |               |              | To 12/31/2018   | Date/Time Prep 5/30/2019 5: 24 | parea:<br>4 nm |
| -   |                | Title         | XVIII        | Hospi tal       | PPS                            | т рііі         |
|   |                | Charges       |              |                 |                                |                |
| Cost Center Description                         | Inpati ent     | Outpati ent   | Total (col.  | Cost or Other   | TEFRA                          |                |
| ·   | ·              | ·             | + col. 7)    | Ratio           | Inpati ent                     |                |
|   |                |               |              |                 | Ratio                          |                |
|   | 6.00           | 7. 00         | 8. 00        | 9. 00           | 10.00                          |                |
| INPATIENT ROUTINE SERVICE COST CENTERS          |                |               |              |                 |                                |                |
| 30. 00 03000 ADULTS & PEDIATRICS                | 613, 262       |               | 613, 26      | 2               |                                | 30. 00         |
| ANCILLARY SERVICE COST CENTERS                  |                |               |              |                 |                                |                |
| 50.00   05000   OPERATING ROOM                  | 6, 062, 358    |               |              |                 |                                |                |
| 53. 00 05300 ANESTHESI OLOGY                    | 2, 309, 867    | 18, 309, 551  |              |                 |                                |                |
| 54. 00   05400   RADI OLOGY-DI AGNOSTI C        | 27, 542        | 560, 516      | 588, 05      |                 |                                |                |
| 60. 00   06000   LABORATORY                     | 0              | 0             |              | 0. 000000       |                                |                |
| 63.00 06300 BLOOD STORING, PROCESSING, & TRANS. | 0              | 0             |              | 0. 000000       |                                |                |
| 66. 00 06600 PHYSI CAL THERAPY                  | 77, 965        | 43, 600       | 121, 56      |                 |                                |                |
| 69. 00   06900   ELECTROCARDI OLOGY             | 0              | 0             |              | 0. 000000       |                                |                |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT | 2, 403, 741    | 15, 840, 871  |              |                 |                                |                |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS      | 6, 723, 802    | 14, 976, 928  |              |                 | 0. 000000                      | 72. 00         |
| 73.00 07300 DRUGS CHARGED TO PATIENTS           | 970, 984       | 11, 202, 373  | 12, 173, 35  | 7 0. 191989     | 0.000000                       | 73. 00         |
| OUTPATIENT SERVICE COST CENTERS                 |                |               |              |                 |                                |                |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART | 8, 050         | 18, 668, 968  | 18, 677, 01  | 8 0. 111747     | 0.000000                       | 92. 00         |
| OTHER REIMBURSABLE COST CENTERS                 |                |               |              |                 |                                |                |
| 99. 10 09910 CORF                               | 0              | 0             |              | 0               |                                | 99. 10         |
| SPECIAL PURPOSE COST CENTERS                    |                |               |              |                 |                                |                |
| 113.00 11300 INTEREST EXPENSE                   |                |               |              |                 |                                | 113. 00        |
| 200.00 Subtotal (see instructions)              | 19, 197, 571   | 161, 963, 770 | 181, 161, 34 | 1               |                                | 200. 00        |
| 201.00 Less Observation Beds                    |                |               |              |                 |                                | 201. 00        |
| 202.00   Total (see instructions)               | 19, 197, 571   | 161, 963, 770 | 181, 161, 34 | 1               |                                | 202. 00        |

| Haalah Sigaraial Contant  | DUVELCI AND MEDIA | NAL CENTED            | 1 1:                        | £ F CMC 2F            | FO 10  |
|---|-------------------|-----------------------|-----------------------------|-----------------------|--------|
| Heal th Financial Systems   | PHYSICIANS MEDIC  |                       |                             | u of Form CMS-25      | 52-10  |
| COMPUTATION OF RATIO OF COSTS TO CHARGES  |                   | Provider CCN: 15-0172 | Peri od:<br>From 01/01/2018 | Worksheet C<br>Part I |        |
|   |                   |                       | To 12/31/2018               | Date/Time Prepa       | ared:  |
|   |                   |                       |                             | 5/30/2019 5: 24       |        |
|   |                   | Title XVIII           | Hospi tal                   | PPS                   |        |
| Cost Center Description   | PPS Inpatient     |                       |                             |                       |        |
|   | Rati o            |                       |                             |                       |        |
|   | 11. 00            |                       |                             |                       |        |
| I NPATI ENT ROUTI NE SERVI CE COST CENTERS                                      | T                 |                       |                             |                       |        |
| 30. 00 03000 ADULTS & PEDIATRICS  |                   |                       |                             | {                     | 30. 00 |
| ANCILLARY SERVICE COST CENTERS  | 0.405(50          |                       |                             |                       |        |
| 50. 00   05000   OPERATI NG ROOM  | 0. 125652         |                       |                             |                       | 50. 00 |
| 53. 00   05300   ANESTHESI OLOGY  | 0. 049523         |                       |                             |                       | 53. 00 |
| 54. 00   05400   RADI OLOGY-DI AGNOSTI C  | 0. 416974         |                       |                             |                       | 54.00  |
| 60. 00 06000 LABORATORY   | 0.000000          |                       |                             |                       | 60.00  |
| 63. 00 06300 BLOOD STORING, PROCESSING, & TRANS.                                | 0.000000          |                       |                             |                       | 63. 00 |
| 66. 00 06600 PHYSI CAL THERAPY  | 1. 063777         |                       |                             |                       | 66. 00 |
| 69. 00 06900 ELECTROCARDI OLOGY   | 0.000000          |                       |                             |                       | 69. 00 |
| 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT                                | 0. 417474         |                       |                             |                       | 71. 00 |
| 72.00 O7200 MPL. DEV. CHARGED TO PATIENTS 73.00 O7300 DRUGS CHARGED TO PATIENTS | 0. 443381         |                       |                             |                       | 72. 00 |
| OUTPATIENT SERVICE COST CENTERS   | 0. 191989         |                       |                             |                       | 73. 00 |
| 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART                                | 0. 111747         |                       |                             |                       | 92. 00 |
| OTHER REIMBURSABLE COST CENTERS   | 0. 111747         |                       |                             | •                     | 92.00  |
| 99. 10 09910 CORF   |                   |                       |                             |                       | 99. 10 |
| SPECIAL PURPOSE COST CENTERS  |                   |                       |                             |                       | 77. 10 |
| 113. 00 11300 I NTEREST EXPENSE   |                   |                       |                             | 1.                    | 13. 00 |
| 200.00 Subtotal (see instructions)  |                   |                       |                             |                       | 00.00  |
| 201. 00 Less Observation Beds   |                   |                       |                             |                       | 00.00  |
| 202.00 Total (see instructions)   |                   |                       |                             |                       | 01.00  |
| 202.00    10tal (300 1113t) dott 0113)  | I I               |                       |                             | J20                   | JZ. 00 |

| Heal th | Financial Systems                         | PHYSICIANS MED                                      | DICAL CENTER          |              | In lie                                       | u of Form CMS-2       | 2552-10 |
|---------|---|---|-----------------------|--------------|--|-----------------------|---------|
|         | ATION OF RATIO OF COSTS TO CHARGES        | THE GIVE WEE  | Provider Co           |              | Peri od:<br>From 01/01/2018<br>To 12/31/2018 | Worksheet C<br>Part I | pared:  |
|         |   |   | Ti tl                 | e XIX        | Hospi tal                                    | PPS                   |         |
|         |   |   |                       |              | Costs  |                       |         |
|         | Cost Center Description                   | Total Cost<br>(from Wkst. B,<br>Part I, col.<br>26) | Therapy Limit<br>Adj. | Total Costs  | RCE<br>Di sal I owance                       | Total Costs           |         |
|         |   | 1, 00   | 2.00                  | 3.00         | 4. 00  | 5. 00                 |         |
|         | INPATIENT ROUTINE SERVICE COST CENTERS    |   |                       | •            |  |                       |         |
| 30.00   | 03000 ADULTS & PEDIATRICS                 | 3, 530, 155   |                       | 3, 530, 15!  | 0  | 3, 530, 155           | 30.00   |
|         | ANCILLARY SERVICE COST CENTERS            |   |                       |              | *  |                       |         |
| 50.00   | 05000 OPERATING ROOM                      | 11, 110, 528  |                       | 11, 110, 528 | 3 0  | 11, 110, 528          | 50.00   |
| 53.00   | 05300 ANESTHESI OLOGY                     | 1, 021, 129   |                       | 1, 021, 129  | 9 0  | 1, 021, 129           | 53.00   |
| 54.00   | 05400 RADI OLOGY-DI AGNOSTI C             | 245, 205  |                       | 245, 20!     | 0  | 245, 205              | 54.00   |
| 60.00   | 06000 LABORATORY                          | 0   |                       |              | 0  | 0                     | 60.00   |
| 63.00   | 06300 BLOOD STORING, PROCESSING, & TRANS. | 0   |                       |              | 0  | 0                     | 63.00   |
| 66.00   | 06600 PHYSI CAL THERAPY                   | 129, 318  | 0                     | 129, 318     | 0  | 129, 318              | 66. 00  |
| 69.00   | 06900 ELECTROCARDI OLOGY                  | 0   |                       |              | 0  | 0                     | 69. 00  |
| 71.00   | 07100 MEDICAL SUPPLIES CHARGED TO PATIENT | 7, 616, 657   |                       | 7, 616, 65   | 7 0  | 7, 616, 657           | 71. 00  |
| 72.00   | 07200 IMPL. DEV. CHARGED TO PATIENTS      | 9, 621, 683   |                       | 9, 621, 683  | 0  | 9, 621, 683           | 72. 00  |
| 73.00   | 07300 DRUGS CHARGED TO PATIENTS           | 2, 337, 152   |                       | 2, 337, 152  | 0  | 2, 337, 152           | 73. 00  |
|         | OUTPATIENT SERVICE COST CENTERS           |   |                       |              |  |                       |         |
| 92.00   | 09200 OBSERVATION BEDS (NON-DISTINCT PART | 2, 087, 100   |                       | 2, 087, 100  |  | 2, 087, 100           | 92. 00  |
|         | OTHER REIMBURSABLE COST CENTERS           |   |                       |              |  |                       |         |
| 00 10   | 00010 CODE                                | 0   |                       |              | 1  | 0                     | 00 10   |

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37, 698, 927 200. 00 2, 087, 100 201. 00 35, 611, 827 202. 00

200.00

201.00

202.00

99. 10 09910 CORF SPECIAL PURPOSE COST CENTERS 113. 00 11300 | INTEREST EXPENSE

Subtotal (see instructions)

Less Observation Beds

Total (see instructions)

|        | 51 1 1 0 1                                 | DUNG           |               |               |                            | 6.5. 0110             |         |
|--------|--|----------------|---------------|---------------|----------------------------|-----------------------|---------|
|        | Financial Systems                          | PHYSICIANS MED |               | N 45 0470     |                            | eu of Form CMS-2      | 2552-10 |
| COMPUT | ATION OF RATIO OF COSTS TO CHARGES         |                | Provi der CC  |               | Period:<br>From 01/01/2018 | Worksheet C<br>Part I |         |
|        |  |                |               |               | To 12/31/2018              |                       | nared·  |
|        |  |                |               |               | 12,01,2010                 | 5/30/2019 5: 2        |         |
|        |  |                | Ti tl         | e XIX         | Hospi tal                  | PPS                   |         |
|        |  |                | Charges       |               |                            |                       |         |
|        | Cost Center Description                    | I npati ent    | Outpati ent   | Total (col. ( | Cost or Other              | TEFRA                 |         |
|        |  |                |               | + col. 7)     | Ratio                      | Inpati ent            |         |
|        |  |                |               |               |                            | Ratio                 |         |
|        |  | 6. 00          | 7. 00         | 8. 00         | 9. 00                      | 10.00                 |         |
|        | I NPATI ENT ROUTI NE SERVI CE COST CENTERS | 1              |               |               | _1                         |                       |         |
| 30. 00 | 03000 ADULTS & PEDIATRICS                  | 613, 262       |               | 613, 26       | 2                          |                       | 30.00   |
|        | ANCI LLARY SERVI CE COST CENTERS           |                |               |               |                            |                       |         |
|        | 05000 OPERATING ROOM                       | 6, 062, 358    | 82, 360, 963  |               |                            |                       |         |
| 53. 00 | 05300 ANESTHESI OLOGY                      | 2, 309, 867    | 18, 309, 551  |               |                            | l e                   |         |
| 54.00  | 05400 RADI OLOGY-DI AGNOSTI C              | 27, 542        | 560, 516      | 588, 05       |                            | 0.000000              | 1       |
| 60.00  | 06000 LABORATORY                           | 0              | 0             |               | 0. 000000                  | 0.000000              |         |
| 63.00  | 06300 BLOOD STORING, PROCESSING, & TRANS.  | 0              | 0             |               | 0. 000000                  |                       |         |
| 66.00  | 06600 PHYSI CAL THERAPY                    | 77, 965        | 43, 600       | 121, 56       |                            | 0. 000000             | 66. 00  |
| 69. 00 | 06900 ELECTROCARDI OLOGY                   | 0              | 0             |               | 0. 000000                  | 0. 000000             | 69. 00  |
| 71. 00 | 07100 MEDICAL SUPPLIES CHARGED TO PATIENT  | 2, 403, 741    | 15, 840, 871  | 18, 244, 61   | 2 0. 417474                | 0.000000              | 71. 00  |
| 72.00  | 07200 I MPL. DEV. CHARGED TO PATIENTS      | 6, 723, 802    | 14, 976, 928  | 21, 700, 73   | 0. 443381                  | 0.000000              | 72. 00  |
| 73.00  | 07300 DRUGS CHARGED TO PATIENTS            | 970, 984       | 11, 202, 373  | 12, 173, 35   | 7 0. 191989                | 0.000000              | 73. 00  |
|        | OUTPATIENT SERVICE COST CENTERS            |                |               |               |                            |                       |         |
| 92.00  | 09200 OBSERVATION BEDS (NON-DISTINCT PART  | 8, 050         | 18, 668, 968  | 18, 677, 01   | 8 0. 111747                | 0.000000              | 92. 00  |
|        | OTHER REIMBURSABLE COST CENTERS            |                |               |               |                            |                       |         |
| 99. 10 | 09910 CORF                                 | 0              | 0             |               | 0                          |                       | 99. 10  |
|        | SPECIAL PURPOSE COST CENTERS               |                |               |               |                            |                       |         |
|        | 11300 I NTEREST EXPENSE                    |                |               |               |                            |                       | 113. 00 |
| 200.00 | 1 '  | 19, 197, 571   | 161, 963, 770 | 181, 161, 34  | 1                          |                       | 200. 00 |
| 201.00 |  |                |               |               |                            | l                     | 201. 00 |
| 202 00 | Total (see instructions)                   | 10 107 571     | 161 963 770   | 181 161 34    | 1                          | i                     | 202 00  |

19, 197, 571

161, 963, 770

181, 161, 341

113. 00 200. 00 201. 00 202. 00

202.00

Total (see instructions)

| Health Financial Systems                        | PHYSICIANS MEDI           | CAL CENTED            | In Lio                                       | u of Form CMS-2  | 2552 10 |
|---|---------------------------|-----------------------|--|--|---------|
| COMPUTATION OF RATIO OF COSTS TO CHARGES        | PHISICIANS WEDI           | Provider CCN: 15-0172 | Peri od:<br>From 01/01/2018<br>To 12/31/2018 | Worksheet C<br>Part I<br>Date/Time Pre<br>5/30/2019 5:24 | pared:  |
|   |                           | Title XIX             | Hospi tal                                    | PPS  |         |
| Cost Center Description                         | PPS Inpatient Ratio 11.00 |                       |  |  |         |
| INPATIENT ROUTINE SERVICE COST CENTERS          | 11.00                     |                       |  |  |         |
| 30. 00 03000 ADULTS & PEDIATRICS                |                           |                       |  |  | 30.00   |
| ANCILLARY SERVICE COST CENTERS                  |                           |                       |  |  |         |
| 50. 00 05000 OPERATI NG ROOM                    | 0. 125652                 |                       |  |  | 50.00   |
| 53. 00   05300   ANESTHESI OLOGY                | 0. 049523                 |                       |  |  | 53. 00  |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C            | 0. 416974                 |                       |  |  | 54.00   |
| 60. 00   06000   LABORATORY                     | 0. 000000                 |                       |  |  | 60.00   |
| 63.00 06300 BLOOD STORING, PROCESSING, & TRANS. | 0. 000000                 |                       |  |  | 63. 00  |
| 66. 00 06600 PHYSI CAL THERAPY                  | 1. 063777                 |                       |  |  | 66. 00  |
| 69. 00 06900 ELECTROCARDI OLOGY                 | 0. 000000                 |                       |  |  | 69. 00  |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT | 0. 417474                 |                       |  |  | 71. 00  |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS      | 0. 443381                 |                       |  |  | 72. 00  |
| 73.00 07300 DRUGS CHARGED TO PATIENTS           | 0. 191989                 |                       |  |  | 73. 00  |
| OUTPATIENT SERVICE COST CENTERS                 |                           |                       |  |  |         |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART | 0. 111747                 |                       |  |  | 92. 00  |
| OTHER REIMBURSABLE COST CENTERS                 |                           |                       |  |  |         |
| 99. 10 09910 CORF                               |                           |                       |  |  | 99. 10  |
| SPECIAL PURPOSE COST CENTERS                    |                           |                       |  |  |         |
| 113. 00 11300 I NTEREST EXPENSE                 |                           |                       |  |  | 113. 00 |
| 200.00 Subtotal (see instructions)              |                           |                       |  |  | 200. 00 |
| 201.00 Less Observation Beds                    |                           |                       |  |  | 201. 00 |
| 202.00 Total (see instructions)                 |                           |                       |  |  | 202. 00 |

| Health Financial Systems   | PHYSICIANS MEDICA          | AL CENTER              | In Lieu | u of Form CMS-2552-10                                     |
|--|----------------------------|------------------------|---------|---|
| CALCULATION OF OUTPATIENT SERVICE COREDUCTIONS FOR MEDICALD ONLY | ST TO CHARGE RATIOS NET OF | Provi der CCN: 15-0172 |         | Worksheet C Part II Date/Time Prepared: 5/30/2019 5:24 pm |

|        |   |                |              |                |            | 5/30/2019 5: 2 | 4 pm    |
|--------|---|----------------|--------------|----------------|------------|----------------|---------|
|        |   |                | Ti tl        | e XIX          | Hospi tal  | PPS            |         |
|        | Cost Center Description                   | Total Cost     | Capital Cost | Operating Cost | Capi tal   | Operating Cost |         |
|        |   | (Wkst. B, Part |              | Net of Capital | Reducti on | Reduction      |         |
|        |   | I, col. 26)    | II col. 26)  | Cost (col. 1 - |            | Amount         |         |
|        |   |                |              | col. 2)        |            |                |         |
|        |   | 1.00           | 2. 00        | 3. 00          | 4. 00      | 5. 00          |         |
|        | ANCILLARY SERVICE COST CENTERS            |                |              |                |            |                |         |
| 50.00  | 05000  OPERATI NG ROOM                    | 11, 110, 528   | 1, 530, 547  | 9, 579, 981    | 0          | 0              | 50.00   |
| 53.00  | 05300 ANESTHESI OLOGY                     | 1, 021, 129    | 20, 623      | 1, 000, 506    | 0          | 0              | 53. 00  |
| 54.00  | 05400  RADI OLOGY-DI AGNOSTI C            | 245, 205       | 15, 444      | 229, 761       | 0          | 0              | 54.00   |
| 60.00  | 06000 LABORATORY                          | 0              | C            | 0              | 0          | 0              | 60.00   |
| 63.00  | 06300 BLOOD STORING, PROCESSING, & TRANS. | 0              | C            | 0              | 0          | 0              | 63. 00  |
| 66.00  | 06600 PHYSI CAL THERAPY                   | 129, 318       | 2, 085       | 127, 233       | 0          | 0              | 66. 00  |
| 69.00  | 06900 ELECTROCARDI OLOGY                  | 0              | C            | 0              | 0          | 0              | 69. 00  |
| 71.00  | 07100 MEDICAL SUPPLIES CHARGED TO PATIENT | 7, 616, 657    | 580, 673     | 7, 035, 984    | 0          | 0              | 71. 00  |
| 72.00  | 07200 I MPL. DEV. CHARGED TO PATIENTS     | 9, 621, 683    | 733, 286     | 8, 888, 397    | 0          | 0              | 72. 00  |
| 73.00  | 07300 DRUGS CHARGED TO PATIENTS           | 2, 337, 152    | 49, 350      | 2, 287, 802    | 0          | 0              | 73. 00  |
|        | OUTPATIENT SERVICE COST CENTERS           |                |              |                |            |                |         |
| 92.00  | 09200 OBSERVATION BEDS (NON-DISTINCT PART | 2, 087, 100    | 433, 578     | 1, 653, 522    | 0          | 0              | 92. 00  |
|        | OTHER REIMBURSABLE COST CENTERS           |                |              |                |            |                |         |
| 99. 10 | 09910 CORF                                | 0              | C            | 0              | 0          | 0              | 99. 10  |
|        | SPECIAL PURPOSE COST CENTERS              |                |              |                |            |                |         |
| 113.00 | 11300   I NTEREST EXPENSE                 |                |              |                |            |                | 113. 00 |
| 200.00 | Subtotal (sum of lines 50 thru 199)       | 34, 168, 772   | 3, 365, 586  | 30, 803, 186   | 0          | 0              | 200. 00 |
| 201.00 | Less Observation Beds                     | 2, 087, 100    | 433, 578     | 1, 653, 522    | 0          | 0              | 201. 00 |
| 202.00 | Total (line 200 minus line 201)           | 32, 081, 672   | 2, 932, 008  | 29, 149, 664   | 0          | 0              | 202. 00 |
|        |   |                |              |                |            |                |         |

| Health Financial Systems   | PHYSICIANS MEDICA          | AL CENTER              | In Lieu | u of Form CMS-2552-10                                     |
|--|----------------------------|------------------------|---------|---|
| CALCULATION OF OUTPATIENT SERVICE COREDUCTIONS FOR MEDICALD ONLY | ST TO CHARGE RATIOS NET OF | Provi der CCN: 15-0172 |         | Worksheet C Part II Date/Time Prepared: 5/30/2019 5:24 pm |

|        |   |                |                |             |           | 5/30/2019 5: 2 | 24 pm   |
|--------|---|----------------|----------------|-------------|-----------|----------------|---------|
|        |   |                | Ti tl          | e XIX       | Hospi tal | PPS            |         |
|        | Cost Center Description                   | Cost Net of    | Total Charges  | Outpati ent |           |                |         |
|        |   | Capital and    | (Worksheet C,  |             |           |                |         |
|        |   | Operating Cost | Part I, column |             |           |                |         |
|        |   | Reduction      | 8)             | / col. 7)   |           |                |         |
|        |   | 6. 00          | 7. 00          | 8. 00       |           |                |         |
|        | ANCILLARY SERVICE COST CENTERS            |                |                |             |           |                |         |
| 50.00  | 05000 OPERATI NG ROOM                     | 11, 110, 528   | 88, 423, 321   | 0. 125652   | 2         |                | 50.00   |
| 53.00  | 05300 ANESTHESI OLOGY                     | 1, 021, 129    | 20, 619, 418   | 0. 049523   | 3         |                | 53.00   |
| 54.00  | 05400  RADI OLOGY-DI AGNOSTI C            | 245, 205       | 588, 058       | 0. 416974   | 1         |                | 54.00   |
| 60.00  | 06000 LABORATORY                          | 0              | 0              | 0. 000000   |           |                | 60.00   |
| 63.00  | 06300 BLOOD STORING, PROCESSING, & TRANS. | 0              | 0              | 0.000000    |           |                | 63.00   |
| 66.00  | 06600 PHYSI CAL THERAPY                   | 129, 318       | 121, 565       | 1. 063777   | 7         |                | 66. 00  |
| 69.00  | 06900 ELECTROCARDI OLOGY                  | 0              | 0              | 0.000000    |           |                | 69. 00  |
| 71.00  | 07100 MEDICAL SUPPLIES CHARGED TO PATIENT | 7, 616, 657    | 18, 244, 612   | 0. 417474   | 1         |                | 71. 00  |
| 72.00  | 07200 I MPL. DEV. CHARGED TO PATIENTS     | 9, 621, 683    | 21, 700, 730   | 0. 443381   |           |                | 72. 00  |
| 73.00  | 07300 DRUGS CHARGED TO PATIENTS           | 2, 337, 152    | 12, 173, 357   | 0. 191989   |           |                | 73. 00  |
|        | OUTPATIENT SERVICE COST CENTERS           |                |                |             |           |                |         |
| 92.00  | 09200 OBSERVATION BEDS (NON-DISTINCT PART | 2, 087, 100    | 18, 677, 018   | 0. 111747   | 7         |                | 92. 00  |
|        | OTHER REIMBURSABLE COST CENTERS           |                |                |             |           |                |         |
| 99. 10 | 09910 CORF                                | 0              | 0              | 0.000000    |           |                | 99. 10  |
|        | SPECIAL PURPOSE COST CENTERS              |                |                |             |           |                |         |
| 113.00 | 11300 INTEREST EXPENSE                    |                |                |             |           |                | 113. 00 |
| 200.00 | Subtotal (sum of lines 50 thru 199)       | 34, 168, 772   | 180, 548, 079  |             |           |                | 200.00  |
| 201.00 | Less Observation Beds                     | 2, 087, 100    | 0              |             |           |                | 201. 00 |
| 202.00 | Total (line 200 minus line 201)           | 32, 081, 672   | 180, 548, 079  |             |           |                | 202. 00 |

| Health Financial Systems   | PHYSICIANS ME  | DICAL CENTER  |  | In Lie                                      | u of Form CMS-                | 2552-10           |
|--|--|---|--|---|-------------------------------|-------------------|
| APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL               | COSTS  | Provi der C   |  | Period:<br>From 01/01/2018<br>To 12/31/2018 |                               |                   |
|  |  | Ti tl e   | XVIII  | Hospi tal                                   | PPS                           |                   |
| Cost Center Description  | Capital<br>Related Cost<br>(from Wkst. B,<br>Part II, col. | Swing Bed<br>Adjustment                               | Reduced<br>Capital<br>Related Cost<br>(col. 1 - col. | Days  | Per Diem (col.<br>3 / col. 4) |                   |
|  | 26)<br>1.00  | 2.00  | 2)<br>3. 00  | 4. 00                                       | 5. 00                         |                   |
| INPATIENT ROUTINE SERVICE COST CENTERS                           | 1.00   | 2.00  | 3.00   | 4.00  | 3.00                          |                   |
| 30. 00 ADULTS & PEDIATRICS                                       | 733, 361   | C   | 733, 36  | 1 3, 075                                    | 238. 49                       | 30.00             |
| 200.00 Total (lines 30 through 199)                              | 733, 361   |   | 733, 36  | 1 3, 075                                    |                               | 200. 00           |
| Cost Center Description  | Inpatient<br>Program days<br>6.00                          | Inpatient Program Capital Cost (col. 5 x col. 6) 7.00 |  |   |                               |                   |
| INPATIENT ROUTINE SERVICE COST CENTERS                           | •  |   | •  |   |                               |                   |
| 30.00 ADULTS & PEDIATRICS<br>200.00 Total (lines 30 through 199) | 225<br>225   |   | 1  |   |                               | 30. 00<br>200. 00 |

| Health Financial Systems PHYSICIANS MEDICAL CENTER In Lieu of Form CMS-2552-10 |   |   |             |   |   |                |
|--|---|---|-------------|---|---|----------------|
| APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA                            | L COSTS                                   | Provi der C                                     | CN: 15-0172 | Period:<br>From 01/01/2018<br>To 12/31/2018 |   | pared:<br>4 pm |
|  |   | Titl∈   | XVIII       | Hospi tal                                   | PPS                                       |                |
| Cost Center Description  | Capital<br>Related Cost<br>(from Wkst. B, | Total Charges<br>(from Wkst. C,<br>Part I, col. | to Charges  | Program                                     | Capital Costs<br>(column 3 x<br>column 4) |                |
|  | Part II, col.                             | 8)  | 2)          | . Charges                                   | COLUMN 4)                                 |                |
|  | 1. 00                                     | 2.00  | 3.00        | 4. 00                                       | 5. 00                                     |                |
| ANCILLARY SERVICE COST CENTERS   |   |   | •           |   |   |                |
| 50. 00 05000 OPERATING ROOM  | 1, 530, 547                               | 88, 423, 321                                    | 0. 01730    | 1, 326, 859                                 | 22, 967                                   | 50.00          |
| 53. 00 05300 ANESTHESI OLOGY   | 20, 623                                   | 20, 619, 418                                    | 0. 00100    | 534, 498                                    | 534                                       | 53. 00         |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C   | 15, 444                                   | 588, 058  | 0. 02626    | 9, 554                                      | 251                                       | 54.00          |
| 60. 00   06000   LABORATORY  | 0   | 0   | 0.00000     | 0 0   | 0   | 60.00          |
| 63.00 06300 BLOOD STORING, PROCESSING, & TRANS.                                | 0   | 0   | 0.00000     | 00  | 0   | 63. 00         |
| 66. 00 06600 PHYSI CAL THERAPY   | 2, 085                                    | 121, 565  | 0. 01715    | 19, 956                                     | 342                                       | 66. 00         |
| 69. 00 06900 ELECTROCARDI OLOGY  | 0   | O   | 0.00000     | 00  | 0   | 69. 00         |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT                                | 580, 673                                  | 18, 244, 612                                    | 0. 03182    | 509, 603                                    | 16, 219                                   | 71. 00         |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS                                     | 733, 286                                  | 21, 700, 730                                    | 0. 03379    | 1, 757, 436                                 | 59, 386                                   | 72. 00         |
| 73.00 07300 DRUGS CHARGED TO PATIENTS  | 49, 350                                   | 12, 173, 357                                    | 0.00405     | 206, 773                                    | 838                                       | 73. 00         |
| OUTPATIENT SERVICE COST CENTERS  |   |   |             |   |   |                |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART                                | 433, 578                                  | 18, 677, 018                                    | 0. 02321    | 5 3, 817                                    | 89  | 92.00          |
| 200.00 Total (lines 50 through 199)  | 3, 365, 586                               | 180, 548, 079                                   | 1           | 4, 368, 496                                 | 100, 626                                  | 200. 00        |

| Health Financial Systems  | PHYSICIANS MED  | DICAL CENTER   |               | In Lie                           | u of Form CMS- | 2552-10  |
|---|-----------------|----------------|---------------|----------------------------------|----------------|----------|
| APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA                       | SS THROUGH COST | TS Provider CO |               | Peri od:                         | Worksheet D    |          |
|   |                 |                |               | From 01/01/2018<br>To 12/31/2018 |                | narod:   |
|   |                 |                |               | 10 12/31/2010                    | 5/30/2019 5: 2 |          |
|   |                 | Title          | XVIII         | Hospi tal                        | PPS            |          |
| Cost Center Description   | Nursing School  | Nursing School | Allied Health | Allied Health                    | All Other      |          |
|   | Post-Stepdown   |                | Post-Stepdowr | Cost                             | Medi cal       |          |
|   | Adjustments     |                | Adjustments   |                                  | Education Cost |          |
|   | 1A              | 1. 00          | 2A            | 2. 00                            | 3. 00          |          |
| INPATIENT ROUTINE SERVICE COST CENTERS                                    |                 |                |               |                                  |                |          |
| 30. 00 03000 ADULTS & PEDIATRICS  | 0               | 0              |               | 0                                | 0              | 00.00    |
| 200.00 Total (lines 30 through 199)                                       | 0               | 0              |               | 0                                |                | 200. 00  |
| Cost Center Description   | Swi ng-Bed      | Total Costs    |               | Per Diem (col.                   |                |          |
|   | Adjustment      | (sum of cols.  | Days          | 5 ÷ col. 6)                      | Program Days   |          |
|   | Amount (see     | 1 through 3,   |               |                                  |                |          |
|   |                 | minus col. 4)  |               |                                  |                |          |
|   | 4. 00           | 5. 00          | 6. 00         | 7. 00                            | 8. 00          |          |
| INPATIENT ROUTINE SERVICE COST CENTERS                                    |                 |                |               |                                  |                |          |
| 30. 00   03000   ADULTS & PEDI ATRI CS                                    | 0               | 0              | 3, 07         |                                  |                |          |
| 200.00   Total (lines 30 through 199)                                     |                 | 0              | 3, 07         | 5                                | 225            | 200. 00  |
| Cost Center Description   | I npati ent     |                |               |                                  |                |          |
|   | Program         |                |               |                                  |                |          |
|   | Pass-Through    |                |               |                                  |                |          |
|   | Cost (col. 7 x  |                |               |                                  |                |          |
|   | col . 8)        |                |               |                                  |                |          |
| INDATIENT DOUTINE CEDVICE COCT CENTERS                                    | 9. 00           |                |               |                                  |                |          |
| I NPATIENT ROUTINE SERVICE COST CENTERS  30. 00 03000 ADULTS & PEDIATRICS |                 |                |               |                                  |                | 30.00    |
| 200.00 Total (lines 30 through 199)                                       |                 |                |               |                                  |                | 200.00   |
| 200.00   Total (Tries 30 through 199)                                     | l 0             | 1              |               |                                  |                | J200. 00 |

| Heal th | Financial Systems  | PHYSICIANS MED   | DI CAL CENTER  |                | In Lie                                       | eu of Form CMS-2            | 2552-10 |
|---------|--|------------------|----------------|----------------|--|-----------------------------|---------|
| APPORT  | IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF<br>H COSTS | RVICE OTHER PASS |                |                | Peri od:<br>From 01/01/2018<br>To 12/31/2018 | Date/Time Pre 5/30/2019 5:2 |         |
|         |  |                  |                | XVIII          | Hospi tal                                    | PPS                         |         |
|         | Cost Center Description                                  | Non Physician    | Nursing School | Nursing School | Allied Health                                | Allied Health               |         |
|         |  | Anesthetist      | Post-Stepdown  |                | Post-Stepdown                                |                             |         |
|         |  | Cost             | Adjustments    |                | Adjustments                                  |                             |         |
|         |  | 1.00             | 2A             | 2.00           | 3A   | 3. 00                       |         |
|         | ANCILLARY SERVICE COST CENTERS                           |                  |                |                |  |                             |         |
| 50.00   | 05000 OPERATING ROOM                                     | 0                | 0              | )              | 0 0  | 0                           | 50.00   |
| 53.00   | 05300 ANESTHESI OLOGY                                    | 0                | 0              |                | 0 0  | 0                           | 53. 00  |
| 54.00   | 05400 RADI OLOGY-DI AGNOSTI C                            | 0                | O              |                | 0 0  | 0                           | 54.00   |
| 60.00   | 06000 LABORATORY   | 0                | O              |                | 0 0  | ĺ                           | 60.00   |
| 63.00   | 06300 BLOOD STORING, PROCESSING, & TRANS.                | 0                | 0              |                | 0 0  | 0                           | 63.00   |
| 66.00   | 06600 PHYSI CAL THERAPY                                  | 0                | 0              |                | 0 0  | 0                           | 66. 00  |
| 69. 00  | 06900 ELECTROCARDI OLOGY                                 | 0                | 0              |                | 0 0  | 0                           | 69.00   |
| 71. 00  | 07100 MEDICAL SUPPLIES CHARGED TO PATIENT                | 0                | Ö              |                | 0 0  | 0                           | 71. 00  |
| 72.00   | 07200 I MPL. DEV. CHARGED TO PATIENTS                    | 0                | 0              |                | 0 0  | i o                         | 72. 00  |
| 73. 00  | 07300 DRUGS CHARGED TO PATIENTS                          | 0                | Ô              |                | 0 0  | ĺ                           | 73. 00  |
| , 0. 00 | OUTPATIENT SERVICE COST CENTERS                          |                  |                | 1              | <u> </u>                                     |                             | 1 .0.00 |
| 92. 00  | 09200 OBSERVATION BEDS (NON-DISTINCT PART                | 0                |                |                | 0  | 0                           | 92. 00  |
| 200.00  | ,  |                  | 0              |                | o o  | 1                           | 200. 00 |
| 200.00  | Trotal (Tries so through 177)                            | 1                |                | 1              | 0  | ,                           | 1200.00 |

| Health Financial Systems                            | PHYSICIANS MEI   | DICAL CENTER  |              | In Li∈                           | eu of Form CMS-2 | 2552-10 |
|---|------------------|---------------|--------------|----------------------------------|------------------|---------|
| APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER | RVICE OTHER PASS | S Provider CO |              | Peri od:                         | Worksheet D      |         |
| THROUGH COSTS                                       |                  |               |              | From 01/01/2018<br>To 12/31/2018 |                  | pared:  |
|   |                  |               |              |                                  | 5/30/2019 5: 2   |         |
|   |                  |               | XVIII        | Hospi tal                        | PPS              |         |
| Cost Center Description                             | All Other        | Total Cost    | Total        |                                  | Ratio of Cost    |         |
|   | Medi cal         | (sum of cols. |              | (from Wkst. C,                   |                  |         |
|   | Education Cost   | 1, 2, 3, and  | Cost (sum of |                                  | (col. 5 ÷ col.   |         |
|   |                  | 4)            | col s. 2, 3, | 8)                               | 7)               |         |
|   |                  |               | and 4)       |                                  |                  |         |
|   | 4. 00            | 5. 00         | 6. 00        | 7. 00                            | 8. 00            |         |
| ANCILLARY SERVICE COST CENTERS                      |                  |               |              |                                  |                  |         |
| 50. 00   05000   OPERATI NG ROOM                    | 0                | 0             |              | 0 88, 423, 321                   |                  |         |
| 53. 00  05300  ANESTHESI OLOGY                      | 0                | 0             |              | 0 20, 619, 418                   | 0.000000         | 53. 00  |
| 54. 00   05400   RADI OLOGY-DI AGNOSTI C            | 0                | 0             |              | 0 588, 058                       | 0.000000         | 54.00   |
| 60. 00  06000 LABORATORY                            | 0                | 0             |              | 0 0                              | 0.000000         | 60.00   |
| 63.00 06300 BLOOD STORING, PROCESSING, & TRANS.     | 0                | 0             |              | 0 0                              | 0.000000         | 63. 00  |
| 66. 00 06600 PHYSI CAL THERAPY                      | 0                | 0             |              | 0 121, 565                       | 0.000000         | 66. 00  |
| 69. 00 06900 ELECTROCARDI OLOGY                     | 0                | 0             |              | 0 0                              | 0.000000         | 69. 00  |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT     | 0                | 0             |              | 0 18, 244, 612                   | 0.000000         | 71. 00  |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS          | 0                | 0             |              | 0 21, 700, 730                   | 0.000000         | 72. 00  |
| 73.00 07300 DRUGS CHARGED TO PATIENTS               | 0                | 0             |              | 0 12, 173, 357                   | 0.000000         | 73. 00  |
| OUTPATIENT SERVICE COST CENTERS                     |                  |               |              |                                  |                  |         |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART     | 0                | 0             |              | 0 18, 677, 018                   | 0.000000         | 92. 00  |
| 200.00 Total (lines 50 through 199)                 | 0                | 0             |              | 0 180, 548, 079                  |                  | 200. 00 |
|   | •                | •             | •            | *                                | •                |         |

| Health Financial Systems  | PHYSICIANS MED  | I CAL CENTER |              | In Lie                                       | eu of Form CMS-2 | 2552-10 |
|---|-----------------|--------------|--------------|--|------------------|---------|
| APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER THROUGH COSTS | VICE OTHER PASS | Provi der CC | CN: 15-0172  | Peri od:<br>From 01/01/2018<br>To 12/31/2018 |                  |         |
|   |                 | Title        | XVIII        | Hospi tal                                    | PPS              |         |
| Cost Center Description   | Outpati ent     | I npati ent  | I npati ent  | Outpati ent                                  | Outpati ent      |         |
|   | Ratio of Cost   | Program      | Program      | Program                                      | Program          |         |
|   | to Charges      | Charges      | Pass-Through |  | Pass-Through     |         |
|   | (col. 6 ÷ col.  |              | Costs (col.  | 8  | Costs (col. 9    |         |
|   | 7)              |              | x col. 10)   |  | x col. 12)       |         |
|   | 9. 00           | 10. 00       | 11. 00       | 12. 00                                       | 13. 00           |         |
| ANCILLARY SERVICE COST CENTERS                                    |                 |              | •            |  |                  |         |
| 50. 00   05000   OPERATI NG ROOM                                  | 0. 000000       | 1, 326, 859  |              | 0 18, 810, 340                               | 1                | 50. 00  |
| 53. 00   05300   ANESTHESI OLOGY                                  | 0. 000000       | 534, 498     |              | 0 3, 561, 604                                | 0                | 53. 00  |
| 54. 00   05400   RADI OLOGY-DI AGNOSTI C                          | 0. 000000       | 9, 554       |              | 0 147, 580                                   | 0                | 54. 00  |
| 60. 00  06000  LABORATORY   | 0. 000000       | 0            |              | 0  | 0                | 60. 00  |
| 63.00 06300 BLOOD STORING, PROCESSING, & TRANS.                   | 0. 000000       | 0            |              | 0  | 0                | 63. 00  |
| 66. 00  06600 PHYSI CAL THERAPY                                   | 0. 000000       | 19, 956      |              | 0 92   | 0                | 66. 00  |
| 69. 00   06900   ELECTROCARDI OLOGY                               | 0. 000000       | 0            |              | 0 0  | 0                | 69. 00  |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT                   | 0. 000000       | 509, 603     |              | 0 3, 411, 311                                | 0                | 71.00   |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS                        | 0. 000000       | 1, 757, 436  |              | 0 5, 227, 724                                | 0                | 72.00   |
| 73.00 07300 DRUGS CHARGED TO PATIENTS                             | 0. 000000       | 206, 773     |              | 0 3, 141, 460                                | 0                | 73. 00  |
| OUTPATIENT SERVICE COST CENTERS                                   |                 |              |              |  |                  |         |
| 92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART                   | 0. 000000       | 3, 817       |              | 0 6, 399, 448                                | 0                | 92. 00  |
| 200.00 Total (lines 50 through 199)                               |                 | 4, 368, 496  |              | 0 40, 699, 559                               | 0                | 200. 00 |

| Health Financial Systems   | DUVELCI AND MEI                | DICAL CENTED   |                             | ا ما  | u of Form CMC | 2552 10 |
|--|--------------------------------|----------------|-----------------------------|---|---------------|---------|
| Health Financial Systems APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND | PHYSICIANS MEI<br>VACCINE COST | Provider Co    |                             | Period:<br>From 01/01/2018<br>To 12/31/2018 |               | pared:  |
|  |                                | Title          | XVIII                       | Hospi tal                                   | PPS           |         |
|  |                                |                | Charges                     |   | Costs         |         |
| Cost Center Description  | Cost to Charge                 |                |                             | Cost  | PPS Services  |         |
|  |                                | Servi ces (see |                             | Rei mbursed                                 | (see inst.)   |         |
|  | Worksheet C,                   | inst.)         | Servi ces                   | Services Not                                |               |         |
|  | Part I, col. 9                 |                | Subject To<br>Ded. & Coins. | Subject To<br>Ded. & Coins.                 |               |         |
|  |                                |                | (see inst.)                 | (see inst.)                                 |               |         |
|  | 1.00                           | 2.00           | 3.00                        | 4. 00                                       | 5. 00         |         |
| ANCILLARY SERVICE COST CENTERS   | 1.00                           | 2.00           | 0.00                        | 1. 00                                       | 0.00          |         |
| 50. 00 05000 OPERATING ROOM  | 0. 125652                      | 18, 810, 340   |                             | 0   | 2, 363, 557   | 50.00   |
| 53. 00 05300 ANESTHESI OLOGY   | 0. 049523                      |                |                             | 0   | 176, 381      | 1       |
| 54. 00   05400 RADI OLOGY-DI AGNOSTI C                                       | 0. 416974                      |                |                             | 0   | 61, 537       |         |
| 60. 00 06000 LABORATORY  | 0. 000000                      | 0              |                             | 0   | 0             | 60.00   |
| 63.00 06300 BLOOD STORING, PROCESSING, & TRANS.                              | 0. 000000                      | 0              |                             | 0 0   | 0             | 63.00   |
| 66. 00 06600 PHYSI CAL THERAPY   | 1. 063777                      | 92             |                             | 0   | 98            | 66. 00  |
| 69. 00 06900 ELECTROCARDI OLOGY  | 0. 000000                      | 0              |                             | 0 0   | 0             | 69. 00  |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT                              | 0. 417474                      | 3, 411, 311    |                             | 0 0   | 1, 424, 134   | 71. 00  |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS                                   | 0. 443381                      | 5, 227, 724    |                             | 0   | 2, 317, 873   | 72.00   |
| 73.00 07300 DRUGS CHARGED TO PATIENTS  | 0. 191989                      | 3, 141, 460    |                             | 0 0   | 603, 126      | 73. 00  |
| OUTPATIENT SERVICE COST CENTERS  |                                |                |                             |   |               |         |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART                              | 0. 111747                      |                |                             | 0   | 715, 119      |         |
| 200.00 Subtotal (see instructions)   |                                | 40, 699, 559   |                             | 0   | 7, 661, 825   |         |
| 201.00 Less PBP Clinic Lab. Services-Program                                 |                                |                |                             | 0   |               | 201. 00 |
| Only Charges<br>202.00 Net Charges (line 200 - line 201)                     |                                | 40, 699, 559   |                             | 0   | 7, 661, 825   | 202 00  |
| 202. 00  | I                              | 10,077,007     | '                           | ٥   | 7,001,023     | 1202.00 |

| Heal th | Financial Systems                              | PHYSICIANS ME | DICAL CENTER  |              | In lie                           | u of Form CMS-                           | 2552_10 |
|---------|--|---------------|---------------|--------------|----------------------------------|--|---------|
|         | TIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND |               |               | CCN: 15-0172 | Peri od:                         | Worksheet D                              | 2332 10 |
|         |  |               |               |              | From 01/01/2018<br>To 12/31/2018 | Part V<br>Date/Time Pre<br>5/30/2019 5:2 |         |
|         |  |               | Ti tl         | e XVIII      | Hospi tal                        | PPS                                      |         |
|         |  | Co:           | sts           |              |                                  |  |         |
|         | Cost Center Description                        | Cost          | Cost          |              |                                  |  |         |
|         |  | Rei mbursed   | Reimbursed    |              |                                  |  |         |
|         |  | Servi ces     | Services Not  |              |                                  |  |         |
|         |  | Subject To    | Subject To    |              |                                  |  |         |
|         |  |               | Ded. & Coins. |              |                                  |  |         |
|         |  | (see inst.)   | (see inst.)   | 4            |                                  |  |         |
|         | ANCILLARY SERVICE COST CENTERS                 | 6. 00         | 7. 00         | 1            |                                  |  |         |
| 50. 00  |  |               |               |              |                                  |  | 50.00   |
| 53. 00  | 05300 OFERATING ROOM                           |               |               |              |                                  |  | 53. 00  |
| 54.00   | 05400 RADI OLOGY-DI AGNOSTI C                  |               |               |              |                                  |  | 54. 00  |
| 60.00   | 06000 LABORATORY                               |               |               |              |                                  |  | 60.00   |
| 63. 00  | 06300 BLOOD STORING, PROCESSING, & TRANS.      |               |               |              |                                  |  | 63.00   |
| 66. 00  | 06600 PHYSI CAL THERAPY                        |               |               |              |                                  |  | 66.00   |
| 69. 00  |  | 0             |               |              |                                  |  | 69.00   |
| 71. 00  | 07100 MEDICAL SUPPLIES CHARGED TO PATIENT      | 0             |               |              |                                  |  | 71. 00  |
| 72. 00  | 07200 I MPL. DEV. CHARGED TO PATIENTS          | 0             |               |              |                                  |  | 72. 00  |
| 73.00   | 07300 DRUGS CHARGED TO PATIENTS                | 0             |               | ol           |                                  |  | 73. 00  |
|         | OUTPATIENT SERVICE COST CENTERS                |               |               |              |                                  |  |         |
| 92.00   | 09200 OBSERVATION BEDS (NON-DISTINCT PART      | 0             |               |              |                                  |  | 92. 00  |
| 200.00  |  | 0             |               | 0            |                                  |  | 200. 00 |
| 201.00  |  | 0             |               |              |                                  |  | 201. 00 |
|         | Only Charges                                   |               |               |              |                                  |  |         |
| 202.00  | Net Charges (line 200 - line 201)              | 0             | 1             | 0            |                                  |  | 202. 00 |

| Health Financial Systems   | PHYSICIANS ME  | DICAL CENTER  |  | In Lie                                      | u of Form CMS-                | 2552-10           |
|--|--|---|--|---|-------------------------------|-------------------|
| APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL               | COSTS  | Provi der C   |  | Period:<br>From 01/01/2018<br>To 12/31/2018 |                               |                   |
|  |  | Ti tl   | e XIX  | Hospi tal                                   | PPS                           |                   |
| Cost Center Description  | Capital<br>Related Cost<br>(from Wkst. B,<br>Part II, col. | Swing Bed<br>Adjustment                               | Reduced<br>Capital<br>Related Cost<br>(col. 1 - col. | Days  | Per Diem (col.<br>3 / col. 4) |                   |
|  | 26)<br>1. 00   | 2.00  | 2)<br>3.00   | 4. 00                                       | 5. 00                         |                   |
| INPATIENT ROUTINE SERVICE COST CENTERS                           | 1.00   | 2.00  | 3.00   | 4.00  | 3.00                          |                   |
| 30. 00 ADULTS & PEDI ATRI CS                                     | 733, 361   | C   | 733, 36  | 1 3, 075                                    | 238. 49                       | 30. 00            |
| 200.00 Total (lines 30 through 199)                              | 733, 361   |   | 733, 36  | 1 3, 075                                    |                               | 200. 00           |
| Cost Center Description  | Inpatient<br>Program days<br>6.00                          | Inpatient Program Capital Cost (col. 5 x col. 6) 7.00 |  |   |                               |                   |
| INPATIENT ROUTINE SERVICE COST CENTERS                           |  | •   | •  |   |                               |                   |
| 30.00 ADULTS & PEDLATRICS<br>200.00 Total (lines 30 through 199) | 62<br>62   |   | 1  |   |                               | 30. 00<br>200. 00 |

| Health Financial Systems                            | PHYSICIANS MEI | DICAL CENTER   |             | In Lie                      | eu of Form CMS-2       | 2552-10 |
|---|----------------|----------------|-------------|-----------------------------|------------------------|---------|
| APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA | L COSTS        | Provi der C    | CN: 15-0172 | Peri od:<br>From 01/01/2018 | Worksheet D<br>Part II |         |
|   |                |                |             | To 12/31/2018               | Date/Time Pre          |         |
|   |                |                |             |                             | 5/30/2019 5: 2         | 4 pm    |
|   |                |                | e XIX       | Hospi tal                   | PPS                    |         |
| Cost Center Description                             | Capi tal       | Total Charges  |             |                             | Capital Costs          |         |
|   |                | (from Wkst. C, |             | Program                     | (column 3 x            |         |
|   | (from Wkst. B, | · ·            | l *         | . Charges                   | column 4)              |         |
|   | Part II, col.  | 8)             | 2)          |                             |                        |         |
|   | 26)            |                |             |                             |                        |         |
|   | 1. 00          | 2. 00          | 3. 00       | 4. 00                       | 5. 00                  |         |
| ANCILLARY SERVICE COST CENTERS                      |                |                |             |                             |                        |         |
| 50.00   05000   OPERATING ROOM                      | 1, 530, 547    | 88, 423, 321   | 0. 01730    | 09 613, 287                 | 10, 615                | 50.00   |
| 53. 00   05300   ANESTHESI OLOGY                    | 20, 623        | 20, 619, 418   | 0. 00100    | 235, 955                    | 236                    | 53. 00  |
| 54. 00   05400   RADI OLOGY-DI AGNOSTI C            | 15, 444        | 588, 058       | 0. 02626    | 1, 106                      | 29                     | 54.00   |
| 60. 00   06000   LABORATORY                         | 0              | 0              | 0. 00000    | 00                          | 0                      | 60.00   |
| 63.00 06300 BLOOD STORING, PROCESSING, & TRANS.     | 0              | 0              | 0. 00000    | 00                          | 0                      | 63.00   |
| 66. 00 06600 PHYSI CAL THERAPY                      | 2, 085         | 121, 565       | 0. 01715    | 3, 440                      | 59                     | 66. 00  |
| 69. 00 06900 ELECTROCARDI OLOGY                     | 0              | 0              | 0. 00000    | 00                          | 0                      | 69. 00  |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT     | 580, 673       | 18, 244, 612   | 0. 03182    | 27 264, 772                 | 8, 427                 | 71.00   |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS          | 733, 286       | 21, 700, 730   | 0. 03379    | 436, 260                    | 14, 742                | 72.00   |
| 73.00 07300 DRUGS CHARGED TO PATIENTS               | 49, 350        | 12, 173, 357   | 0.00405     | 101, 966                    | 413                    | 73. 00  |
| OUTPATIENT SERVICE COST CENTERS                     |                |                |             |                             |                        | İ       |
| 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART    | 433, 578       | 18, 677, 018   | 0. 0232     | 15 0                        | 0                      | 92.00   |
| 200.00 Total (lines 50 through 199)                 | 3, 365, 586    |                | 1           | 1, 656, 786                 | 34, 521                | •       |
| ,             |                | 1              | 1           |                             | ,                      |         |

| Health Financial Systems                            | PHYSICIANS MED                                 | OLCAL CENTER   |   | In Lie                                      | In Lieu of Form CMS-2552-10                               |                |  |
|---|--|----------------|---|---|---|----------------|--|
| APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA | SS THROUGH COST                                |                |   | Period:<br>From 01/01/2018<br>To 12/31/2018 | Worksheet D<br>Part III<br>Date/Time Pre<br>5/30/2019 5:2 | pared:<br>4 pm |  |
|   |  |                | e XIX   | Hospi tal                                   | PPS   |                |  |
| Cost Center Description                             | Nursing School<br>Post-Stepdown<br>Adjustments | Nursing School | Allied Health<br>Post-Stepdown<br>Adjustments |   | All Other<br>Medical<br>Education Cost                    |                |  |
|   | 1A   | 1. 00          | 2A  | 2.00  | 3. 00   |                |  |
| INPATIENT ROUTINE SERVICE COST CENTERS              | IA   | 1.00           | 211   | 2.00  | 3.00  |                |  |
| 30. 00 03000 ADULTS & PEDIATRICS                    | 0  | 0              |   | 0   | 0   | 30.00          |  |
| 200.00 Total (lines 30 through 199)                 |  | 0              |   | 0 0   | J   | 200.00         |  |
| Cost Center Description                             | Swi ng-Bed                                     | Total Costs    | Total Patien                                  | t Per Diem (col.                            | Inpati ent  |                |  |
|   | Adjustment                                     | (sum of cols.  | Days  | 5 ÷ col . 6)                                | Program Days  |                |  |
|   | Amount (see                                    | 1 through 3,   |   | Í   |   |                |  |
|   | instructions)                                  | minus col. 4)  |   |   |   |                |  |
|   | 4. 00  | 5. 00          | 6.00  | 7. 00                                       | 8. 00   |                |  |
| INPATIENT ROUTINE SERVICE COST CENTERS              |  |                |   |   |   |                |  |
| 30. 00   03000   ADULTS & PEDI ATRI CS              | 0  | 0              | 3, 07   | 5 0.00                                      | 62  | 30. 00         |  |
| 200.00 Total (lines 30 through 199)                 |  | 0              | 3, 07   | 5   | 62  | 200. 00        |  |
| Cost Center Description                             | Inpatient Program Pass-Through                 |                |   |   |   |                |  |
|   | Cost (col. 7 x                                 |                |   |   |   |                |  |
|   | col. 8)<br>9.00                                |                |   |   |   |                |  |
| INPATIENT ROUTINE SERVICE COST CENTERS              |  |                |   |   |   |                |  |
| 30. 00 03000 ADULTS & PEDIATRICS                    | 0  |                |   |   |   | 30. 00         |  |
| 200.00   Total (lines 30 through 199)               | 0  |                |   |   |   | 200. 00        |  |

| Heal th  | Financial Systems                            | PHYSICIANS ME   | DICAL CENTER   |                | In Li∈                     | eu of Form CMS-2       | 2552-10 |
|----------|--|-----------------|----------------|----------------|----------------------------|------------------------|---------|
|          | ONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER | RVICE OTHER PAS | S Provider C   | CN: 15-0172    | Period:<br>From 01/01/2018 | Worksheet D<br>Part IV |         |
| TTIKOOGI | 1 60313                                      |                 |                |                | To 12/31/2018              |                        |         |
|          |  |                 | Ti tl          | e XIX          | Hospi tal                  | PPS                    |         |
|          | Cost Center Description                      | Non Physician   | Nursing School | Nursing School | Allied Health              | Allied Health          |         |
|          |  | Anesthetist     | Post-Stepdown  |                | Post-Stepdown              |                        |         |
|          |  | Cost            | Adjustments    |                | Adjustments                |                        |         |
|          |  | 1.00            | 2A             | 2.00           | 3A                         | 3. 00                  |         |
| μ.       | ANCILLARY SERVICE COST CENTERS               |                 |                |                |                            |                        |         |
| 50.00    | 05000 OPERATING ROOM                         | 0               | C              | )              | 0                          | 0                      | 50. 00  |
| 53.00    | 05300 ANESTHESI OLOGY                        | 0               | C              |                | 0                          | 0                      | 53. 00  |
| 54.00    | 05400 RADI OLOGY-DI AGNOSTI C                | 0               | C              |                | 0                          | 0                      | 54.00   |
| 60.00    | 06000 LABORATORY                             | 0               | C              |                | 0                          | 0                      | 60.00   |
| 63.00    | 06300 BLOOD STORING, PROCESSING, & TRANS.    | 0               | C              |                | 0 0                        | 0                      | 63.00   |
| 66.00    | 06600 PHYSI CAL THERAPY                      | 0               | C              |                | 0                          | 0                      | 66. 00  |
| 69.00    | 06900 ELECTROCARDI OLOGY                     | 0               | C              |                | 0 0                        | 0                      | 69. 00  |
| 71. 00   | 07100 MEDICAL SUPPLIES CHARGED TO PATIENT    | 0               | C              |                | 0 0                        | 0                      | 71. 00  |
| 72. 00   | 07200 IMPL. DEV. CHARGED TO PATIENTS         | 0               | C              |                | 0 0                        | 0                      | 72.00   |
| 73. 00   | 07300 DRUGS CHARGED TO PATIENTS              | 0               | C              |                | 0 0                        | 0                      | 73. 00  |
| Ī        | OUTPATIENT SERVICE COST CENTERS              |                 |                |                |                            |                        |         |
| 92. 00   | 09200 OBSERVATION BEDS (NON-DISTINCT PART    | 0               |                |                | 0                          | 0                      | 92.00   |
| 200.00   | Total (lines 50 through 199)                 | 0               | C              |                | 0 0                        | 0                      | 200. 00 |
|          |  |                 |                |                |                            |                        |         |

| Health Financial Systems                |                           | PHYSICIANS ME   | DICAL CENTER  |              | In Li∈                           | eu of Form CMS-2 | 2552-10 |
|---|---------------------------|-----------------|---------------|--------------|----------------------------------|------------------|---------|
| APPORTIONMENT OF INPATIENT              | T/OUTPATIENT ANCILLARY SE | RVICE OTHER PAS | S Provider C  |              | Peri od:                         | Worksheet D      |         |
| THROUGH COSTS                           |                           |                 |               |              | From 01/01/2018<br>To 12/31/2018 |                  | pared:  |
|   |                           |                 |               |              |                                  | 5/30/2019 5: 2   |         |
|   |                           |                 |               | e XIX        | Hospi tal                        | PPS              |         |
| Cost Center D                           | escription                | All Other       | Total Cost    | Total        |                                  | Ratio of Cost    |         |
|   |                           | Medi cal        | (sum of cols. |              | (from Wkst. C,                   |                  |         |
|   |                           | Education Cost  | 1, 2, 3, and  | ,            |                                  | (col. 5 ÷ col.   |         |
|   |                           |                 | 4)            | col s. 2, 3, | 8)                               | 7)               |         |
|   |                           |                 |               | and 4)       |                                  |                  |         |
|   |                           | 4. 00           | 5. 00         | 6.00         | 7. 00                            | 8. 00            |         |
| ANCILLARY SERVICE C                     |                           |                 |               |              |                                  |                  |         |
| 50. 00   05000   OPERATI NG ROO         | M                         | 0               | 0             |              | 0 88, 423, 321                   | 0.000000         | 50. 00  |
| 53. 00   05300   ANESTHESI OLOG         | Υ                         | 0               | 0             |              | 0 20, 619, 418                   | 0.000000         | 53.00   |
| 54. 00   05400   RADI OLOGY-DI A        | GNOSTI C                  | 0               | 0             |              | 0 588, 058                       | 0.000000         | 54.00   |
| 60. 00   06000   LABORATORY             |                           | 0               | 0             |              | 0 0                              | 0.000000         | 60.00   |
| 63. 00 06300 BLOOD STORING              | , PROCESSING, & TRANS.    | 0               | 0             |              | 0 0                              | 0.000000         | 63.00   |
| 66. 00 06600 PHYSI CAL THER             | APY                       | 0               | 0             |              | 0 121, 565                       | 0.000000         | 66. 00  |
| 69. 00 06900 ELECTROCARDI 0             | LOGY                      | 0               | 0             |              | 0 0                              | 0. 000000        | 69. 00  |
| 71.00 07100 MEDICAL SUPPL               | IES CHARGED TO PATIENT    | 0               | 0             |              | 0 18, 244, 612                   | 0.000000         | 71. 00  |
| 72.00 07200 I MPL. DEV. CH              | ARGED TO PATIENTS         | 0               | 0             |              | 0 21, 700, 730                   | 0. 000000        | 72. 00  |
| 73. 00 07300 DRUGS CHARGED              | TO PATIENTS               | 0               | 0             |              | 0 12, 173, 357                   | 0. 000000        | 73.00   |
| OUTPATIENT SERVICE                      | COST CENTERS              | •               |               | •            |                                  |                  | ĺ       |
| 92. 00 09200 OBSERVATI ON B             | EDS (NON-DISTINCT PART    | 0               | 0             |              | 0 18, 677, 018                   | 0.000000         | 92.00   |
|   | 50 through 199)           | 0               | 0             |              | 0 180, 548, 079                  | 1                | 200. 00 |
| 1 | ,                         | -               | ·             | 1            |                                  | '                |         |

| Health Financial Systems   | PHYSICIANS MEDI  | CAL CENTER   |              | In Lie                                       | u of Form CMS-2 | 2552-10 |
|--|------------------|--------------|--------------|--|-----------------|---------|
| APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SET<br>THROUGH COSTS | RVICE OTHER PASS | Provi der CC | CN: 15-0172  | Peri od:<br>From 01/01/2018<br>To 12/31/2018 |                 |         |
|  |                  | Titl         | e XIX        | Hospi tal                                    | PPS             |         |
| Cost Center Description  | Outpati ent      | I npati ent  | I npati ent  | Outpati ent                                  | Outpati ent     |         |
|  | Ratio of Cost    | Program      | Program      | Program                                      | Program         |         |
|  | to Charges       | Charges      | Pass-Through | n Charges                                    | Pass-Through    |         |
|  | (col. 6 ÷ col.   |              | Costs (col.  | 8  | Costs (col. 9   |         |
|  | 7)               |              | x col. 10)   |  | x col. 12)      |         |
|  | 9. 00            | 10.00        | 11. 00       | 12.00  | 13. 00          |         |
| ANCILLARY SERVICE COST CENTERS                                       |                  |              |              |  |                 |         |
| 50. 00   05000   OPERATING ROOM                                      | 0. 000000        | 613, 287     |              | 0 0  | 0               | 50.00   |
| 53. 00   05300   ANESTHESI OLOGY                                     | 0. 000000        | 235, 955     |              | 0 0  | 0               | 53.00   |
| 54. 00   05400   RADI OLOGY-DI AGNOSTI C                             | 0. 000000        | 1, 106       |              | 0  | 0               | 54.00   |
| 60. 00   06000   LABORATORY  | 0. 000000        | 0            |              | 0 0  | 0               | 60.00   |
| 63.00 06300 BLOOD STORING, PROCESSING, & TRANS.                      | 0. 000000        | 0            |              | 0 0  | 0               | 63.00   |
| 66. 00   06600 PHYSI CAL THERAPY                                     | 0. 000000        | 3, 440       |              | 0 0  | 0               | 66. 00  |
| 69. 00 06900 ELECTROCARDI OLOGY                                      | 0. 000000        | 0            |              | 0 0  | 0               | 69. 00  |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT                      | 0. 000000        | 264, 772     |              | 0 0  | 0               | 71. 00  |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS                           | 0. 000000        | 436, 260     |              | 0 0  | 0               | 72. 00  |
| 73.00 07300 DRUGS CHARGED TO PATIENTS                                | 0. 000000        | 101, 966     |              | 0 0  | 0               | 73. 00  |
| OUTPATIENT SERVICE COST CENTERS                                      |                  |              |              |  |                 |         |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART                      | 0. 000000        | 0            |              | 0 0  | 0               | 92. 00  |
| 200.00   Total (lines 50 through 199)                                |                  | 1, 656, 786  |              | 0 0  | 0               | 200. 00 |

| Health Financial Systems                            | PHYSICIANS MED   | ICAL CENTER    |               | In Lie          | u of Form CMS-2                | 2552-10        |
|---|------------------|----------------|---------------|-----------------|--------------------------------|----------------|
| APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND | VACCINE COST     | Provi der Co   |               | Peri od:        | Worksheet D                    |                |
|   |                  |                |               | From 01/01/2018 |                                |                |
|   |                  |                |               | To 12/31/2018   | Date/Time Prep 5/30/2019 5: 24 | pared:<br>4 nm |
|   |                  | Ti tl          | e XIX         | Hospi tal       | PPS                            | т рііі         |
|   |                  | 11 (1          | Charges       | nospi tui       | Costs                          |                |
| Cost Center Description                             | Cost to Charge F | PPS Reimbursed |               | Cost            | PPS Services                   |                |
| 555t 5511t61 55551 Ft1 511                          |                  | Services (see  |               | Rei mbursed     | (see inst.)                    |                |
|   | Worksheet C,     | inst.)         | Servi ces     | Services Not    | (,                             |                |
|   | Part I, col. 9   | ,              | Subject To    | Subject To      |                                |                |
|   | ·                |                | Ded. & Coins. |                 |                                |                |
|   |                  |                | (see inst.)   | (see inst.)     |                                |                |
|   | 1.00             | 2. 00          | 3.00          | 4. 00           | 5. 00                          |                |
| ANCILLARY SERVICE COST CENTERS                      |                  |                |               |                 |                                |                |
| 50.00   05000   OPERATING ROOM                      | 0. 125652        | 0              |               | 0 9, 566, 582   | 0                              | 50. 00         |
| 53. 00 05300 ANESTHESI OLOGY                        | 0. 049523        | 0              |               | 0 2, 384, 286   | 0                              | 53. 00         |
| 54. 00   05400   RADI OLOGY-DI AGNOSTI C            | 0. 416974        | 0              |               | 0 70, 446       | 0                              | 54.00          |
| 60. 00   06000   LABORATORY                         | 0. 000000        | 0              |               | 0 0             | 0                              | 60.00          |
| 63.00 06300 BLOOD STORING, PROCESSING, & TRANS.     | 0. 000000        | 0              |               | 0 0             | 0                              | 63. 00         |
| 66. 00 06600 PHYSI CAL THERAPY                      | 1. 063777        | 0              |               | 0 10, 805       | 0                              | 66. 00         |
| 69. 00 06900 ELECTROCARDI OLOGY                     | 0. 000000        | 0              |               | o o             | 0                              | 69. 00         |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT     | 0. 417474        | 0              |               | 0 1, 924, 855   | 0                              | 71. 00         |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS          | 0. 443381        | 0              |               | 0 993, 592      | 0                              | 72. 00         |
| 73.00 07300 DRUGS CHARGED TO PATIENTS               | 0. 191989        | 0              |               | 0 1, 318, 700   | 0                              | 73. 00         |
| OUTPATIENT SERVICE COST CENTERS                     |                  |                |               |                 |                                |                |
| 92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART     | 0. 111747        | 0              |               | 0 1, 558, 972   | 0                              | 92. 00         |
|   | I I              |                |               | 0 47 000 000    | ο'                             | 000            |

Subtotal (see instructions)
Less PBP Clinic Lab. Services-Program
Only Charges
Net Charges (line 200 - line 201)

200. 00 201. 00

202.00

0 0 0

17, 828, 238

17, 828, 238

0 92.00 0 200.00 201.00

0 202. 00

| Health Financial Systems                           | PHYSICIANS ME  | DICAL CENTER  |             | In Lie                                       | u of Form CMS- | 2552-10 |
|--|----------------|---------------|-------------|--|----------------|---------|
| APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AN | D VACCINE COST | Provi der C   | CN: 15-0172 | Peri od:<br>From 01/01/2018<br>To 12/31/2018 |                |         |
|  | _              | Ti tl         | e XIX       | Hospi tal                                    | PPS            |         |
|  | Co:            | sts           |             |  |                |         |
| Cost Center Description                            | Cost           | Cost          |             |  |                |         |
|  | Rei mbursed    | Rei mbursed   |             |  |                |         |
|  | Servi ces      | Services Not  |             |  |                |         |
|  | Subject To     | Subject To    |             |  |                |         |
|  | Ded. & Coins.  | Ded. & Coins. |             |  |                |         |
|  | (see inst.)    | (see inst.)   |             |  |                |         |
|  | 6. 00          | 7. 00         |             |  |                |         |
| ANCILLARY SERVICE COST CENTERS                     |                | ,             |             |  |                |         |
| 50.00   05000   OPERATING ROOM                     | 0              | 1, 202, 060   |             |  |                | 50.00   |
| 53. 00   05300   ANESTHESI OLOGY                   | 0              | 118, 077      | 1           |  |                | 53. 00  |
| 54. 00   05400   RADI OLOGY-DI AGNOSTI C           | 0              | 29, 374       |             |  |                | 54. 00  |
| 60. 00   06000   LABORATORY                        | 0              | 0             | )           |  |                | 60.00   |
| 63.00 06300 BLOOD STORING, PROCESSING, & TRANS.    | 0              | 0             |             |  |                | 63. 00  |
| 66. 00 06600 PHYSI CAL THERAPY                     | 0              | 11, 494       |             |  |                | 66.00   |
| 69. 00 06900 ELECTROCARDI OLOGY                    | 0              | 0             |             |  |                | 69.00   |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT    | 0              | 803, 577      | '           |  |                | 71. 00  |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS         | 0              | 440, 540      | )           |  |                | 72.00   |
| 73.00 07300 DRUGS CHARGED TO PATIENTS              |                | 253, 176      |             |  |                | 73.00   |

0

174, 210

3, 032, 508

3, 032, 508

92.00

200. 00

202. 00

OUTPATIENT SERVICE COST CENTERS

92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART

200. 00 201. 00

202.00

Subtotal (see instructions)
Less PBP Clinic Lab. Services-Program
Only Charges
Net Charges (line 200 - line 201)

| Health Financial Systems                | PHYSICIANS MEDICAL CENTER | In Lieu of Form CMS-2552    |                             |  |  |
|---|---------------------------|-----------------------------|-----------------------------|--|--|
| COMPUTATION OF INPATIENT OPERATING COST | Provi der CCN: 15-0172    | Peri od:<br>From 01/01/2018 | Worksheet D-1               |  |  |
|   |                           | To 12/31/2018               | Date/Time Pre 5/30/2019 5:2 |  |  |
|   | Title XVIII               | Hospi tal                   | PPS                         |  |  |
| Cost Center Description                 |                           |                             |                             |  |  |

|                  |   | Title XVIII                  | Hospi tal        | PPS                | 4 PIII           |
|------------------|---|------------------------------|------------------|--------------------|------------------|
|                  | Cost Center Description   |                              |                  |                    |                  |
|                  | DART I ALL PROVIDED COMPONENTS  |                              |                  | 1. 00              |                  |
|                  | PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS   |                              |                  |                    |                  |
| 1. 00            | Inpatient days (including private room days and swing-bed days  | s. excluding newborn)        |                  | 3, 075             | 1.00             |
| 2.00             | Inpatient days (including private room days, excluding swing-b  |                              |                  | 3, 075             |                  |
| 3.00             | Private room days (excluding swing-bed and observation bed day  | ys). If you have only pri    | vate room days,  | 0                  | 3. 00            |
| 4 00             | do not complete this line.  | - d - d \                    |                  | 1 057              | 4 00             |
| 4. 00<br>5. 00   | Semi-private room days (excluding swing-bed and observation be<br>Total swing-bed SNF type inpatient days (including private room |                              | 31 of the cost   | 1, 257<br>0        | 4. 00<br>5. 00   |
| 0.00             | reporting period  | om days) trii odgir becember | 01 01 110 0031   | · ·                | 0.00             |
| 6.00             | Total swing-bed SNF type inpatient days (including private roof   | om days) after December 3    | 31 of the cost   | 0                  | 6. 00            |
| 7.00             | reporting period (if calendar year, enter 0 on this line)   |                              | 04 6 11          |                    | 7.00             |
| 7. 00            | Total swing-bed NF type inpatient days (including private room reporting period   | n days) through December     | 31 of the cost   | 0                  | 7. 00            |
| 8. 00            | Total swing-bed NF type inpatient days (including private room  | n davs) after December 31    | of the cost      | 0                  | 8. 00            |
|                  | reporting period (if calendar year, enter 0 on this line)   | 3 /                          |                  |                    |                  |
| 9. 00            | Total inpatient days including private room days applicable to  | the Program (excluding       | swing-bed and    | 225                | 9. 00            |
| 10. 00           | <pre>newborn days) Swing-bed SNF type inpatient days applicable to title XVIII or</pre>   | alv (i neludi na privato re  | nom days)        | 0                  | 10. 00           |
| 10.00            | through December 31 of the cost reporting period (see instructions)   |                              | olii days)       | U                  | 10.00            |
| 11. 00           | Swing-bed SNF type inpatient days applicable to title XVIII or  | nly (including private ro    | oom days) after  | 0                  | 11. 00           |
|                  | December 31 of the cost reporting period (if calendar year, er  |                              |                  | _                  |                  |
| 12. 00           | Swing-bed NF type inpatient days applicable to titles V or XIX through December 31 of the cost reporting period                   | Conly (including private     | e room days)     | 0                  | 12. 00           |
| 13. 00           | Swing-bed NF type inpatient days applicable to titles V or XI)  | Conty (including private     | room days)       | 0                  | 13. 00           |
| .0.00            | after December 31 of the cost reporting period (if calendar ye  |                              |                  |                    | 10.00            |
| 14. 00           | Medically necessary private room days applicable to the Progra  | am (excluding swing-bed o    | lays)            | 0                  | 14. 00           |
| 15.00            | Total nursery days (title V or XIX only)  |                              |                  | 0                  | 15. 00           |
| 16. 00           | Nursery days (title V or XLX only) SWING BED ADJUSTMENT   |                              |                  | 0                  | 16. 00           |
| 17. 00           | Medicare rate for swing-bed SNF services applicable to service  | es through December 31 of    | the cost         | 0.00               | 17. 00           |
|                  | reporting period  | G                            |                  |                    |                  |
| 18. 00           | Medicare rate for swing-bed SNF services applicable to service  | es after December 31 of t    | the cost         | 0. 00              | 18. 00           |
| 19. 00           | reporting period Medicaid rate for swing-bed NF services applicable to services   | through Docombor 21 of       | the cost         | 0.00               | 19. 00           |
| 19.00            | reporting period  | s through becember 31 of     | the cost         | 0.00               | 17.00            |
| 20.00            | Medicaid rate for swing-bed NF services applicable to services  | s after December 31 of th    | ne cost          | 0.00               | 20. 00           |
|                  | reporting period  | 0.500.455                    |                  |                    |                  |
| 21. 00<br>22. 00 | Total general inpatient routine service cost (see instructions Swing-bed cost applicable to SNF type services through Decembe     |                              | ng poriod (line  | 3, 530, 155<br>0   | 21. 00<br>22. 00 |
| 22.00            | 5 x line 17)  | er 31 of the cost reporti    | ng perrou (Trile | U                  | 22.00            |
| 23. 00           | Swing-bed cost applicable to SNF type services after December   | 31 of the cost reporting     | period (line 6   | 0                  | 23. 00           |
|                  | x line 18)  |                              |                  | _                  |                  |
| 24. 00           | Swing-bed cost applicable to NF type services through December $7 \times 1$ ine 19)   | 1 31 of the cost reporting   | ng period (line  | 0                  | 24. 00           |
| 25. 00           | Swing-bed cost applicable to NF type services after December 3  | 31 of the cost reporting     | period (line 8   | 0                  | 25. 00           |
|                  | x line 20)  |                              |                  |                    |                  |
|                  | Total swing-bed cost (see instructions)   | (1: 21 -: 1: 2/)             |                  | 0                  | 26. 00           |
| 27. 00           | General inpatient routine service cost net of swing-bed cost (<br>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT                            | (Trie 21 minus Trie 26)      |                  | 3, 530, 155        | 27.00            |
| 28. 00           | General inpatient routine service charges (excluding swing-bed  | d and observation bed cha    | irges)           | 0                  | 28. 00           |
| 29. 00           | Private room charges (excluding swing-bed charges)  |                              |                  | 0                  | 29. 00           |
| 30.00            | Semi -pri vate room charges (excluding swing-bed charges)   |                              |                  | 0                  | 30.00            |
| 31. 00<br>32. 00 | General inpatient routine service cost/charge ratio (line 27 - Average private room per diem charge (line 29 ÷ line 3)            | ÷ 11 ne 28)                  |                  | 0. 000000<br>0. 00 |                  |
| 33. 00           | Average semi-private room per diem charge (line 30 ÷ line 4)  |                              |                  | 0.00               |                  |
| 34. 00           | Average per diem private room charge differential (line 32 mir  | nus line 33)(see instruct    | i ons)           | 0.00               |                  |
| 35. 00           | Average per diem private room cost differential (line 34 x lin  | ne 31)                       |                  | 0. 00              |                  |
| 36.00            | Private room cost differential adjustment (line 3 x line 35)  |                              |                  | 0                  | 36. 00           |
| 37. 00           | General inpatient routine service cost net of swing-bed cost a  | and private room cost dif    | rerential (line  | 3, 530, 155        | 37. 00           |
|                  | 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY  |                              |                  |                    |                  |
|                  | PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU  | JSTMENTS                     |                  |                    |                  |
| 38. 00           | Adjusted general inpatient routine service cost per diem (see   | instructions)                |                  | 1, 148. 02         |                  |
| 39. 00           | Program general inpatient routine service cost (line 9 x line   | •                            |                  | 258, 305           |                  |
| 40. 00<br>41 00  | Medically necessary private room cost applicable to the Progra<br>Total Program general inpatient routine service cost (line 39   | ,                            |                  | 0<br>258, 305      | 40. 00<br>41. 00 |
| 41.00            | Trotal Trogram general impatrent routine service cost (ITHE 39  | 11116 40)                    |                  | 250, 505           | 1 41.00          |

| Heal th          | Financial Systems   | PHYSICIANS MED    | ICAL CENTER     |                      | In lie                      | eu of Form CMS-2      | 2552-10          |
|------------------|---|-------------------|-----------------|----------------------|-----------------------------|-----------------------|------------------|
|                  | ATION OF INPATIENT OPERATING COST   |                   |                 | CN: 15-0172          | Peri od:<br>From 01/01/2018 | Worksheet D-1         |                  |
|                  |   |                   |                 |                      | To 12/31/2018               |                       |                  |
|                  |   |                   | Title           | e XVIII              | Hospi tal                   | 5/30/2019 5: 2<br>PPS | 4 pm             |
|                  | Cost Center Description   | Total             | Total           | Average Per          | Program Days                | Program Cost          |                  |
|                  |   | Inpatient Cost    | npatient Days   | Diem (col. 1 col. 2) | ÷                           | (col. 3 x col.<br>4)  |                  |
|                  |   | 1.00              | 2. 00           | 3.00                 | 4. 00                       | 5. 00                 |                  |
| 42. 00           | NURSERY (title V & XIX only)  |                   |                 |                      |                             |                       | 42. 00           |
| 43. 00           | Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT  |                   |                 |                      |                             |                       | 43. 00           |
| 44. 00           | CORONARY CARE UNIT  |                   |                 |                      |                             |                       | 44. 00           |
| 45. 00           | BURN INTENSIVE CARE UNIT  |                   |                 |                      |                             |                       | 45. 00           |
| 46. 00<br>47. 00 | SURGICAL INTENSIVE CARE UNIT<br>OTHER SPECIAL CARE (SPECIFY)  |                   |                 |                      |                             |                       | 46. 00<br>47. 00 |
|                  | Cost Center Description   | <u> </u>          |                 | '                    |                             |                       |                  |
| 48. 00           | Program inpatient ancillary service cost (Wk  | st D-3 col 3      | line 200)       |                      |                             | 1. 00<br>1, 250, 490  | 48. 00           |
|                  | Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS   |                   |                 | ons)                 |                             | 1, 508, 795           | •                |
| 50. 00           | Pass through costs applicable to Program inp.   | atient routine :  | services (from  | n Wkst. D, sun       | n of Parts I and            | 53, 660               | 50. 00           |
| 51. 00           | Pass through costs applicable to Program inpland IV)  | atient ancillar   | y services (fr  | om Wkst. D, s        | sum of Parts II             | 100, 626              | 51. 00           |
| 52.00            | Total Program excludable cost (sum of lines   |                   | oted '          | olole ''             | atiot                       | 154, 286              | 1                |
| 53. 00           | Total Program inpatient operating cost exclumedical education costs (line 49 minus line                                 | 9 1               | ated, non-phy   | sıcıan anestr        | netist, and                 | 1, 354, 509           | 53. 00           |
|                  | TARGET AMOUNT AND LIMIT COMPUTATION   | ,                 |                 |                      |                             |                       |                  |
| 54. 00<br>55. 00 | Program discharges Target amount per discharge  |                   |                 |                      |                             | 0.00                  |                  |
| 56. 00           |   |                   | 0.00            | 56.00                |                             |                       |                  |
| 57. 00           | Difference between adjusted inpatient operat  | 0                 | 1               |                      |                             |                       |                  |
| 58. 00<br>59. 00 | Bonus payment (see instructions)<br>Lesser of lines 53/54 or 55 from the cost re  | norting period    | andina 1006 i   | indated and co       | omnounded by the            | 0.00                  |                  |
| 37.00            | market basket   | portring period t | sharing 1770, c | ipuateu anu co       | inpounded by the            | 0.00                  | 37.00            |
| 60.00            | 1   |                   |                 |                      | the emount by               | 0.00                  | •                |
| 61.00            | If line 53/54 is less than the lower of line which operating costs (line 53) are less than                              |                   |                 |                      | •                           | 0                     | 61. 00           |
|                  | amount (line 56), otherwise enter zero (see   |                   |                 | ,                    | 3                           | 0                     | 62. 00           |
| 62. 00<br>63. 00 | 62.00   Relief payment (see instructions)<br>63.00   Allowable Inpatient cost plus incentive payment (see instructions) |                   |                 |                      |                             |                       |                  |
|                  | PROGRAM INPATIENT ROUTINE SWING BED COST  |                   |                 |                      |                             | 0                     |                  |
| 64. 00           | Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)  | ts through Dece   | mber 31 of the  | e cost reporti       | ng period (See              | 0                     | 64. 00           |
| 65. 00           | Medicare swing-bed SNF inpatient routine cos<br>instructions)(title XVIII only)   | ts after Decemb   | er 31 of the d  | cost reportino       | g period (See               | 0                     | 65. 00           |
| 66. 00           | Total Medicare swing-bed SNF inpatient routi  | ne costs (line    | 64 plus line 6  | 5)(title XVII        | I only). For                | 0                     | 66. 00           |
| 67. 00           | 9 1   | e costs through   | December 31 c   | of the cost re       | eporting period             | 0                     | 67. 00           |
| 68. 00           | (line 12 x line 19) Title V or XIX swing-bed NF inpatient routin  | e costs after Do  | ecember 31 of   | the cost repo        | orting period               | 0                     | 68. 00           |
| 69. 00           | (line 13 x line 20) Total title V or XIX swing-bed NF inpatient   |                   |                 |                      |                             | 0                     | 69. 00           |
| 70. 00           | PART III - SKILLED NURSING FACILITY, OTHER NU<br>Skilled nursing facility/other nursing facil                           |                   |                 |                      |                             |                       | 70. 00           |
| 71. 00           | Adjusted general inpatient routine service c  | ost per diem (li  |                 |                      |                             |                       | 71. 00           |
| 72. 00<br>73. 00 | Program routine service cost (line 9 x line Medically necessary private room cost applic                                |                   | (line 14 v li   | ne 35)               |                             |                       | 72. 00<br>73. 00 |
| 74. 00           | Total Program general inpatient routine serv  |                   |                 |                      |                             |                       | 74. 00           |
| 75. 00           | Capital-related cost allocated to inpatient 26, line 45)  | routine service   | costs (from V   | Vorksheet B, F       | Part II, column             |                       | 75. 00           |
| 76. 00           | Per diem capital related costs (line 75 ÷ li  |                   |                 |                      |                             |                       | 76.00            |
| 77. 00<br>78. 00 | Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minu                               | ,                 |                 |                      |                             |                       | 77. 00<br>78. 00 |
| 79. 00           | Aggregate charges to beneficiaries for exces  | s costs (from p   |                 |                      |                             |                       | 79. 00           |
| 80. 00<br>81. 00 | Total Program routine service costs for comp. Inpatient routine service cost per diem limi                              |                   | ost limitation  | n (line 78 mir       | nus line 79)                |                       | 80. 00<br>81. 00 |
| 82.00            | Inpatient routine service cost per drem from  |                   | )               |                      |                             |                       | 82.00            |
| 83. 00           | Reasonable inpatient routine service costs (  | see instruction   |                 |                      |                             |                       | 83. 00           |
| 84. 00<br>85. 00 | Program inpatient ancillary services (see in Utilization review - physician compensation                                |                   | ns)             |                      |                             |                       | 84. 00<br>85. 00 |
| 86.00            |   |                   |                 |                      |                             |                       | 86.00            |
| 07.00            | PART IV - COMPUTATION OF OBSERVATION BED PASS   |                   |                 |                      |                             | 4 040                 | 07.00            |
| 87. 00<br>88. 00 | Total observation bed days (see instructions Adjusted general inpatient routine cost per                                |                   | line 2)         |                      |                             | 1, 818<br>1, 148. 02  | 1                |
|                  | Observation bed cost (line 87 x line 88) (se  |                   | ,               |                      |                             | 2, 087, 100           | •                |
|                  |   |                   |                 |                      |                             |                       |                  |

| Health Financial Systems                      | PHYSICIANS MED | DI CAL CENTER  |            | In Lie                           | u of Form CMS-2 | 2552-10        |
|---|----------------|----------------|------------|----------------------------------|-----------------|----------------|
| COMPUTATION OF INPATIENT OPERATING COST       |                | Provi der CC   |            | Peri od:                         | Worksheet D-1   |                |
|   |                |                |            | From 01/01/2018<br>To 12/31/2018 |                 | oared:<br>4 pm |
|   |                | Title          | XVIII      | Hospi tal                        | PPS             |                |
| Cost Center Description                       | Cost           | Routine Cost   | column 1 ÷ | Total                            | Observation     |                |
|   |                | (from line 21) | column 2   | Observati on                     | Bed Pass        |                |
|   |                |                |            | Bed Cost (from                   | Through Cost    |                |
|   |                |                |            | line 89)                         | (col. 3 x col.  |                |
|   |                |                |            |                                  | 4) (see         |                |
|   |                |                |            |                                  | instructions)   |                |
|   | 1.00           | 2.00           | 3. 00      | 4. 00                            | 5. 00           |                |
| COMPUTATION OF OBSERVATION BED PASS THROUGH ( | COST           |                |            |                                  |                 |                |
| 90.00 Capital -related cost                   | 733, 361       | 3, 530, 155    | 0. 20774   | 2, 087, 100                      | 433, 578        | 90.00          |
| 91.00 Nursing School cost                     | 0              | 3, 530, 155    | 0.00000    | 2, 087, 100                      | 0               | 91.00          |
| 92.00 Allied health cost                      | 0              | 3, 530, 155    | 0.00000    | 2, 087, 100                      | 0               | 92.00          |
| 93.00 All other Medical Education             | 0              | 3, 530, 155    | 0.00000    | 2, 087, 100                      | 0               | 93. 00         |

| Health Financial Systems                | PHYSICIANS MEDICAL CENTER | In Lieu of Form CMS-2552-10 |                             |  |
|---|---------------------------|-----------------------------|-----------------------------|--|
| COMPUTATION OF INPATIENT OPERATING COST | Provi der CCN: 15-0172    | Peri od:<br>From 01/01/2018 | Worksheet D-1               |  |
|   |                           |                             | Date/Time Pre 5/30/2019 5:2 |  |
|   | Title XIX                 | Hospi tal                   | PPS                         |  |
| Cost Conton Decement on                 |                           |                             |                             |  |

|                  |   | Title XIX                | Hospi tal                                | PPS                   | + piii           |
|------------------|---|--------------------------|--|-----------------------|------------------|
|                  | Cost Center Description   |                          |  | 1. 00                 |                  |
|                  | PART I - ALL PROVIDER COMPONENTS  |                          |  |                       |                  |
| 4 00             | I NPATI ENT DAYS  |                          |  |                       | 4 00             |
| 1. 00<br>2. 00   | Inpatient days (including private room days and swing-bed days, excluding newborn) Inpatient days (including private room days, excluding swing-bed and newborn days) |                          |  | 3, 075<br>3, 075      | 1. 00<br>2. 00   |
| 3. 00            | Private room days (excluding swing-bed and observation bed day  |                          | vate room days,                          | 0,079                 | 3. 00            |
|                  | do not complete this line.  | . 3                      | , ,                                      |                       |                  |
| 4. 00<br>5. 00   |   |                          |  | 1, 257<br>0           | 4. 00<br>5. 00   |
| 5.00             | Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period  |                          |  | U                     | 5.00             |
| 6.00             | Total swing-bed SNF type inpatient days (including private roo  | m days) after December 3 | 31 of the cost                           | 0                     | 6. 00            |
| 7. 00            | reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room  | days) through Docombor   | 21 of the cost                           | 0                     | 7. 00            |
| 7.00             | reporting period  | days) through becember   | 31 Of the Cost                           | U                     | 7.00             |
| 8.00             | Total swing-bed NF type inpatient days (including private room  | days) after December 3   | of the cost                              | 0                     | 8. 00            |
| 9. 00            | reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to  | the Dreamen (eveluding   | cwing had and                            | 62                    | 9. 00            |
| 9.00             | newborn days)   | the Program (excruding   | Swifig-bed and                           | 02                    | 9.00             |
| 10.00            | Swing-bed SNF type inpatient days applicable to title XVIII on  |                          | oom days)                                | 0                     | 10. 00           |
| 11. 00           | through December 31 of the cost reporting period (see instruct<br>Swing-bed SNF type inpatient days applicable to title XVIII or                                      |                          | om days) after                           | 0                     | 11. 00           |
| 11.00            | December 31 of the cost reporting period (if calendar year, en  |                          | Join days) arter                         | O                     | 11.00            |
| 12. 00           | Swing-bed NF type inpatient days applicable to titles V or XIX  |                          | e room days)                             | 0                     | 12. 00           |
| 13. 00           | through December 31 of the cost reporting period<br>Swing-bed NF type inpatient days applicable to titles V or XIX  | only (including private  | room days)                               | 0                     | 13. 00           |
| 13.00            | after December 31 of the cost reporting period (if calendar ye  |                          |  | O                     | 13.00            |
| 14. 00           | Medically necessary private room days applicable to the Progra  | m (excluding swing-bed o | lays)                                    | 0                     | 14. 00           |
| 15. 00<br>16. 00 | Total nursery days (title V or XIX only)<br>Nursery days (title V or XIX only)  |                          |  | 0                     | 15. 00<br>16. 00 |
| 10.00            | SWING BED ADJUSTMENT  |                          |  | 0                     | 10.00            |
| 17. 00           | Medicare rate for swing-bed SNF services applicable to service  | s through December 31 of | the cost                                 | 0.00                  | 17. 00           |
| 18. 00           | reporting period<br>Medicare rate for swing-bed SNF services applicable to service  | s after December 21 of t | ho cost                                  | 0.00                  | 18. 00           |
| 18.00            | reporting period  | s after becember 31 of   | .ne cost                                 | 0.00                  | 18.00            |
| 19. 00           | Medicaid rate for swing-bed NF services applicable to services  | through December 31 of   | the cost                                 | 0. 00                 | 19. 00           |
| 20. 00           | 11  |                          |  | 0.00                  | 20. 00           |
| 21. 00           | reporting period  Total general inpatient routine service cost (see instructions)   |                          |  | 3, 530, 155           | 21. 00           |
| 22. 00           | , ,   |                          |  | 0                     | 22. 00           |
| 23. 00           | 5 x line 17)  | 21 of the cost reporting | noried (line 4                           | 0                     | 23. 00           |
| 23.00            | Swing-bed cost applicable to SNF type services after December $x$ line 18)  | 31 OF THE COST TEPOFTING | g perrod (Trile 6                        |                       | 23.00            |
| 24. 00           | Swing-bed cost applicable to NF type services through December $7 \times 1$ ine 19)   | 31 of the cost reportir  | ng period (line                          | 0                     | 24. 00           |
| 25. 00           | Swing-bed cost applicable to NF type services after December 3 x line 20)   | 1 of the cost reporting  | period (line 8                           | 0                     | 25. 00           |
| 26. 00           | Total swing-bed cost (see instructions)   |                          |  | 0                     | 26. 00           |
| 27. 00           | General inpatient routine service cost net of swing-bed cost (  | line 21 minus line 26)   |  | 3, 530, 155           | 27. 00           |
| 28. 00           | PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed   | and observation bed cha  | arges)                                   | 0                     | 28. 00           |
| 29. 00           | Pri vate room charges (excluding swing-bed charges)   |                          | 9/                                       | 0                     | 29. 00           |
| 30.00            | Semi-private room charges (excluding swing-bed charges)   |                          |  | 0                     | 30. 00           |
| 31. 00           | General inpatient routine service cost/charge ratio (line 27 ÷  | line 28)                 |  | 0. 000000             | 31.00            |
| 32. 00           | Average private room per diem charge (line 29 ÷ line 3)   |                          |  | 0.00                  | 32. 00           |
| 33. 00           | Average semi-private room per diem charge (line 30 ÷ line 4)  | 1: 22) ( :+              | .:>                                      | 0.00                  | 33. 00           |
| 34. 00           | Average per diem private room charge differential (line 32 min  |                          | Tions)                                   | 0.00                  | 34. 00<br>35. 00 |
| 35. 00<br>36. 00 | Average per diem private room cost differential (line 34 x line Private room cost differential adjustment (line 3 x line 35)  | E 31)                    |  | 0.00                  | 36.00            |
| 37. 00           | General inpatient routine service cost net of swing-bed cost a  | nd private room cost dif | ferential (line                          | 3, 530, 155           | 37. 00           |
| 57.00            | 27 minus line 36)   | pri vato 100m 003t di i  | . c. | J, 550, 155           | 37.00            |
|                  | PART II - HOSPITAL AND SUBPROVIDERS ONLY  | CTMENTO                  |  |                       |                  |
| 20 00            | PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU  |                          | T  | 1 140 00              | 38. 00           |
| 38. 00<br>39. 00 | Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line   |                          |  | 1, 148. 02<br>71, 177 | 38.00            |
| 40. 00           | Medically necessary private room cost applicable to the Progra  |                          |  | 71, 177               | 40. 00           |
|                  | 41.00 Total Program general inpatient routine service cost (line 39 + line 40)  71,177  |                          |  |                       | 41. 00           |
|                  |   | •                        | '  |                       |                  |

MCRI F32 - 15. 5. 166. 1

| Heal th          | Financial Systems   | PHYSICIANS MED  | ICAL CENTER     |                      | In lie                           | eu of Form CMS-2                        | 2552-10          |
|------------------|---|-----------------|-----------------|----------------------|----------------------------------|---|------------------|
|                  | Health Financial Systems PHYSICIANS MEDICAL CENTER  COMPUTATION OF INPATIENT OPERATING COST Provider CCN: 15-0172   |                 | CN: 15-0172     | Peri od:             | Worksheet D-1                    | 10                                      |                  |
|                  |   |                 |                 |                      | From 01/01/2018<br>To 12/31/2018 |   | pared:           |
|                  |   |                 | Ti +I           | e XIX                | Hospi tal                        | 5/30/2019 5: 2<br>PPS                   | 4 pm             |
|                  | Cost Center Description   | Total           | Total           | Average Per          |                                  | Program Cost                            |                  |
|                  |   | Inpatient Cost  | Inpatient Days  |                      | ÷                                | (col. 3 x col.                          |                  |
|                  |   | 1. 00           | 2. 00           | col . 2)<br>3.00     | 4. 00                            | 4)<br>5. 00                             |                  |
| 42. 00           | NURSERY (title V & XIX only)  |                 |                 |                      |                                  |   | 42. 00           |
| 43. 00           | Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT  |                 |                 | <u> </u>             |                                  | I                                       | 43. 00           |
| 44. 00           | CORONARY CARE UNIT  |                 |                 |                      |                                  |   | 44. 00           |
| 45. 00           | BURN INTENSIVE CARE UNIT  |                 |                 |                      |                                  |   | 45. 00           |
| 46. 00<br>47. 00 | SURGICAL INTENSIVE CARE UNIT<br>OTHER SPECIAL CARE (SPECIFY)  |                 |                 |                      |                                  |   | 46. 00<br>47. 00 |
|                  | Cost Center Description   |                 |                 | •                    |                                  |   |                  |
| 48. 00           | Program inpatient ancillary service cost (Wk  | st D-3 col 3    | Line 200)       |                      |                                  | 1. 00<br>416, 406                       | 48. 00           |
|                  | Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS   |                 |                 | ons)                 |                                  | 487, 583                                | •                |
| 50. 00           | Pass through costs applicable to Program inp.   | atient routine  | services (from  | n Wkst. D, sun       | n of Parts I and                 | 14, 786                                 | 50. 00           |
| 51. 00           | Pass through costs applicable to Program inpand IV)   |                 | y services (fr  | om Wkst. D, s        | sum of Parts II                  | 34, 521                                 |                  |
| 52. 00<br>53. 00 | Total Program excludable cost (sum of lines<br>Total Program inpatient operating cost exclu   | ,               | lated non-phy   | /sician anesth       | netist, and                      | 49, 307<br>438, 276                     | 1                |
| 00.00            | medical education costs (line 49 minus line   |                 |                 | , 51 51 411 41155 11 |                                  | 100, 270                                | 00.00            |
| 54. 00           | TARGET AMOUNT AND LIMIT COMPUTATION Program discharges  |                 |                 |                      |                                  | 0                                       | 54.00            |
| 55.00            | Target amount per discharge   |                 |                 |                      |                                  | 0.00                                    | •                |
| 56. 00<br>57. 00 | Target amount (line 54 x line 55) Difference between adjusted inpatient operat  | ing cost and ta | raot amount (   | ino 56 minus         | lino 52)                         | 0                                       | 56. 00<br>57. 00 |
| 58. 00           | Bonus payment (see instructions)  | ing cost and ta | rget amount (i  | The 50 minus         | 111le 53)                        | 0                                       | •                |
| 59. 00           |   |                 |                 |                      |                                  | 0.00                                    | 59. 00           |
| 60. 00           | market basket<br>0.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket   |                 |                 |                      | 0.00                             | 60. 00                                  |                  |
|                  | 1.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by  |                 |                 |                      |                                  | 0                                       | 61. 00           |
|                  | which operating costs (line 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           | 52.00 Relief payment (see instructions)   |                 |                 |                      |                                  | 0                                       |                  |
| 63. 00           | 3.00 Allowable Inpatient cost plus incentive payment (see instructions) PROGRAM INPATIENT ROUTINE SWING BED COST  |                 |                 |                      |                                  | 0                                       | 63. 00           |
| 64. 00           | 64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See  |                 |                 |                      |                                  | 0                                       | 64. 00           |
| 65. 00           |   |                 |                 |                      | 0                                | 65. 00                                  |                  |
| 66. 00           |   |                 |                 | 0                    | 66. 00                           |   |                  |
| 67. 00           | CAH (see instructions) 7.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period  |                 |                 |                      | 0                                | 67. 00                                  |                  |
| 68. 00           | (line 12 x line 19) 68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period  |                 |                 |                      |                                  | 0                                       | 68. 00           |
| 69. 00           | (line 13 x line 20)   |                 |                 |                      | 0                                | 69. 00                                  |                  |
| 70. 00           | PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY  .00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) |                 |                 |                      |                                  | 70. 00                                  |                  |
| 71. 00           | Adjusted general inpatient routine service c  | -               |                 |                      |                                  |   | 71.00            |
| 72.00            | , ,   |                 |                 |                      |                                  |   | 72.00            |
| 73. 00<br>74. 00 | Medically necessary private room cost application. Total Program general inpatient routine serv   |                 |                 |                      |                                  |   | 73. 00<br>74. 00 |
| 75. 00           | Capital-related cost allocated to inpatient 26, line 45)  |                 |                 |                      | Part II, column                  |   | 75. 00           |
| 76. 00           | .00 Per diem capital-related costs (line 75 ÷ line 2)   |                 |                 |                      |                                  | 76. 00                                  |                  |
| 77. 00<br>78. 00 | Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minu   | ,               |                 |                      |                                  |   | 77. 00<br>78. 00 |
| 79. 00           | Aggregate charges to beneficiaries for exces  |                 | rovi der record | ds)                  |                                  |   | 79. 00           |
| 80.00            | Total Program routine service costs for comp  | arison to the c |                 |                      | nus line 79)                     |   | 80.00            |
| 81. 00<br>82. 00 |   |                 |                 |                      |                                  | 81. 00<br>82. 00                        |                  |
| 83. 00           | Reasonable inpatient routine service costs (  |                 |                 |                      |                                  |   | 83. 00           |
| 84. 00           | Program inpatient ancillary services (see in  | structions)     |                 |                      |                                  |   | 84. 00           |
| 85. 00<br>86. 00 |   |                 |                 |                      |                                  |   | 85. 00<br>86. 00 |
| 50.00            | 6.00   Total Program inpatient operating costs (sum of lines 83 through 85)   PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST                                  |                 |                 |                      |                                  | 50.00                                   |                  |
| 87.00            | 77.00 Total observation bed days (see instructions)   |                 |                 |                      | 1, 818                           | 1                                       |                  |
| 88. 00<br>89. 00 | Adjusted general inpatient routine cost per Observation bed cost (line 87 x line 88) (se  |                 | iine 2)         |                      |                                  | 1, 148. 02<br>2, 087, 100               | 1                |
|                  | (30)  |                 |                 |                      |                                  | , |                  |

| Health Financial Systems                      | PHYSICIANS MEDICAL CENTER |                |            | In Lieu of Form CMS-2552-10      |                |                |
|---|---------------------------|----------------|------------|----------------------------------|----------------|----------------|
| COMPUTATION OF INPATIENT OPERATING COST       |                           | Provi der CC   |            | Peri od:                         | Worksheet D-1  |                |
|   |                           |                |            | From 01/01/2018<br>To 12/31/2018 |                | oared:<br>4 pm |
|   |                           | Ti tl          | e XIX      | Hospi tal                        | PPS            |                |
| Cost Center Description                       | Cost                      | Routine Cost   | column 1 ÷ | Total                            | Observation    |                |
|   |                           | (from line 21) | column 2   | Observati on                     | Bed Pass       |                |
|   |                           |                |            | Bed Cost (from                   | Through Cost   |                |
|   |                           |                |            | line 89)                         | (col. 3 x col. |                |
|   |                           |                |            |                                  | 4) (see        |                |
|   |                           |                |            |                                  | instructions)  |                |
|   | 1.00                      | 2.00           | 3. 00      | 4. 00                            | 5. 00          |                |
| COMPUTATION OF OBSERVATION BED PASS THROUGH ( | COST                      |                |            |                                  |                |                |
| 90.00 Capital -related cost                   | 733, 361                  | 3, 530, 155    | 0. 20774   | 2, 087, 100                      | 433, 578       | 90.00          |
| 91.00 Nursing School cost                     | 0                         | 3, 530, 155    | 0.00000    | 0 2, 087, 100                    | 0              | 91.00          |
| 92.00 Allied health cost                      | 0                         | 3, 530, 155    | 0.00000    | 0 2, 087, 100                    | 0              | 92.00          |
| 93.00 All other Medical Education             | 0                         | 3, 530, 155    | 0.00000    | 2, 087, 100                      | 0              | 93. 00         |

| Health Financial Systems   | PHYSICIANS MEDICAL CENTER    |              | In Lie                           | u of Form CMS-2                  | 2552-10 |
|--|------------------------------|--------------|----------------------------------|----------------------------------|---------|
| INPATIENT ANCILLARY SERVICE COST APPORTIONMENT                                 | Provi der C                  |              | Peri od:                         | Worksheet D-3                    |         |
|  |                              |              | From 01/01/2018<br>To 12/31/2018 | Date/Time Prep<br>5/30/2019 5:24 |         |
|  | Title                        | XVIII        | Hospi tal                        | PPS                              |         |
| Cost Center Description  |                              | Ratio of Cos |                                  | I npati ent                      |         |
|  |                              | To Charges   |                                  | Program Costs                    |         |
|  |                              |              | Charges                          | (col. 1 x col.                   |         |
|  |                              | 4.00         | 0.00                             | 2)                               |         |
| INDATIONE DOUTING CODYLOG COCT CONTEDC   |                              | 1.00         | 2. 00                            | 3. 00                            |         |
| I NPATI ENT ROUTI NE SERVI CE COST CENTERS  30. 00 03000 ADULTS & PEDI ATRI CS |                              |              | 151, 107                         |                                  | 30. 00  |
| ANCI LLARY SERVI CE COST CENTERS   |                              |              | 131, 107                         |                                  | 30.00   |
| 50. 00 05000 OPERATING ROOM  |                              | 0. 12565     | 2 1, 326, 859                    | 166, 722                         | 50. 00  |
| 53. 00   05300   ANESTHESI OLOGY   |                              | 0. 04952     |                                  | ·                                |         |
| 54. 00   05400   RADI OLOGY - DI AGNOSTI C                                     |                              | 0. 41697     |                                  |                                  |         |
| 60. 00 06000 LABORATORY  |                              | 0.00000      |                                  | 0,751                            | 60. 00  |
| 63.00 06300 BLOOD STORING, PROCESSING, & TRANS.                                |                              | 0.00000      |                                  | Ö                                | 63. 00  |
| 66. 00 06600 PHYSI CAL THERAPY   |                              | 1. 06377     |                                  | 21, 229                          | 66. 00  |
| 69. 00 06900 ELECTROCARDI OLOGY  |                              | 0.00000      |                                  | 0                                | 69. 00  |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT                                |                              | 0. 41747     | 4 509, 603                       | 212, 746                         | 71. 00  |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS                                     |                              | 0. 44338     | 1, 757, 436                      | 779, 214                         | 72.00   |
| 73.00 07300 DRUGS CHARGED TO PATIENTS  |                              | 0. 19198     | 9 206, 773                       | 39, 698                          | 73.00   |
| OUTPATIENT SERVICE COST CENTERS  |                              |              |                                  |                                  |         |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART                                |                              | 0. 11174     | 7 3, 817                         | 427                              | 92.00   |
| 200.00 Total (sum of lines 50 through 94 and                                   |                              |              | 4, 368, 496                      |                                  |         |
| 201.00 Less PBP Clinic Laboratory Services-Pro                                 | ogram only charges (line 61) |              | 0                                |                                  | 201. 00 |
| 202.00   Net charges (line 200 minus line 201)                                 |                              |              | 4, 368, 496                      |                                  | 202. 00 |

| Health Fi | nancial Systems                         | PHYSICIANS MEDICAL CENTER     |              | In lie                           | u of Form CMS-2                 | 2552-10        |
|-----------|---|-------------------------------|--------------|----------------------------------|---------------------------------|----------------|
|           | F ANCILLARY SERVICE COST APPORTIONMENT  |                               | CN: 15-0172  | Peri od:                         | Worksheet D-3                   | 1002 10        |
|           |   |                               |              | From 01/01/2018<br>To 12/31/2018 | Date/Time Pre<br>5/30/2019 5: 2 | pared:<br>4 pm |
|           |   | Ti tl                         | e XIX        | Hospi tal                        | PPS                             |                |
|           | Cost Center Description                 |                               | Ratio of Cos |                                  | Inpati ent                      |                |
|           |   |                               | To Charges   |                                  | Program Costs                   |                |
|           |   |                               |              | Charges                          | (col. 1 x col.                  |                |
|           |   |                               |              |                                  | 2)                              |                |
|           |   |                               | 1.00         | 2. 00                            | 3. 00                           |                |
|           | PATIENT ROUTINE SERVICE COST CENTERS    |                               |              | 50.017                           |                                 |                |
|           | 000 ADULTS & PEDI ATRI CS               |                               |              | 58, 217                          |                                 | 30. 00         |
|           | CILLARY SERVICE COST CENTERS            |                               | 0.405/       | -0 (40.007                       | 77.0/4                          | F0 00          |
|           | OOO OPERATING ROOM                      |                               | 0. 12565     |                                  |                                 | 50.00          |
|           | 300 ANESTHESI OLOGY                     |                               | 0. 04952     |                                  |                                 | 53. 00         |
|           | 400 RADI OLOGY-DI AGNOSTI C             |                               | 0. 41697     |                                  |                                 | 54.00          |
|           | 000 LABORATORY                          |                               | 0.00000      |                                  | 0                               | 60.00          |
|           | 300 BLOOD STORING, PROCESSING, & TRANS. |                               | 0.00000      |                                  | 0                               | 63. 00         |
|           | 600 PHYSI CAL THERAPY                   |                               | 1. 06377     |                                  | 3, 659                          |                |
|           | 900 ELECTROCARDI OLOGY                  |                               | 0.00000      |                                  | 0                               | 69. 00         |
|           | 100 MEDICAL SUPPLIES CHARGED TO PATIENT |                               | 0. 41747     |                                  |                                 | 71. 00         |
|           | 200 IMPL. DEV. CHARGED TO PATIENTS      |                               | 0. 44338     |                                  |                                 |                |
|           | 300 DRUGS CHARGED TO PATIENTS           |                               | 0. 19198     | 39 101, 966                      | 19, 576                         | 73. 00         |
|           | TPATIENT SERVICE COST CENTERS           |                               |              | 1                                |                                 |                |
|           | 200 OBSERVATION BEDS (NON-DISTINCT PART |                               | 0. 11174     |                                  | 0                               | 92. 00         |
| 200.00    | Total (sum of lines 50 through 94 and   |                               |              | 1, 656, 786                      |                                 |                |
| 201.00    | Less PBP Clinic Laboratory Services-Pr  | rogram only charges (line 61) |              | 0                                |                                 | 201. 00        |
| 202. 00   | Net charges (line 200 minus line 201)   |                               |              | 1, 656, 786                      |                                 | 202. 00        |

| Health Financial Systems                | PHYSICIANS MEDICAL CENTER | In Lie                                       | u of Form CMS-2552-10   |
|---|---------------------------|--|---|
| CALCULATION OF REIMBURSEMENT SETTLEMENT | Provi der CCN: 15-0172    | Peri od:<br>From 01/01/2018<br>To 12/31/2018 | Worksheet E<br>Part A<br>Date/Time Prepared:<br>5/30/2019 5:24 pm |

|                  | Title XVIII Hospit:  | al    | 5/30/2019 5: 2<br>PPS | 4 pm             |
|------------------|--|-------|-----------------------|------------------|
|                  |  |       | 1. 00                 |                  |
|                  | PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS  |       | 1.00                  |                  |
| 1. 00<br>1. 01   | DRG Amounts Other than Outlier Payments DRG amounts other than outlier payments for discharges occurring prior to October 1 (see   |       | 0<br>814, 792         | 1. 00<br>1. 01   |
|                  | instructions)  |       |                       |                  |
| 1. 02            | DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)  |       | 368, 192              | 1. 02            |
| 1.03             | DRG for federal specific operating payment for Model 4 BPCl for discharges occurring prior to Oc 1 (see instructions)  | tober | 0                     | 1. 03            |
| 1. 04            | DRG for federal specific operating payment for Model 4 BPCl for discharges occurring on or after October 1 (see instructions)  |       | 0                     | 1. 04            |
| 2. 00<br>2. 01   | Outlier payments for discharges. (see instructions) Outlier reconciliation amount  |       | 8, 101<br>0           | 2. 00<br>2. 01   |
| 2. 02            | Outlier payment for discharges for Model 4 BPCI (see instructions)   |       | 0                     | 2. 02            |
| 3.00             | Managed Care Simulated Payments  |       | 0                     | 3. 00            |
| 4. 00            | Bed days available divided by number of days in the cost reporting period (see instructions) Indirect Medical Education Adjustment   |       | 5. 02                 | 4. 00            |
| 5.00             | FTE count for allopathic and osteopathic programs for the most recent cost reporting period endior before 12/31/1996. (see instructions)   | ng on | 0. 00                 | 5. 00            |
| 6. 00            | FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the canew programs in accordance with 42 CFR 413.79(e)   | p for | 0.00                  | 6. 00            |
| 7. 00            | MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(   |       | 0. 00                 | 7. 00            |
| 7. 01            | ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If cost report straddles July 1, 2011 then see instructions.   | the   | 0. 00                 | 7. 01            |
| 8. 00            | Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1202)   | 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 under § 5503 of the ACA. If the  | 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 from a closed teaching hospital was a formal for | 0. 00 | 8. 02                 |                  |
| 9. 00            | under § 5506 of ACA. (see instructions) Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see  | 0.00  | 9. 00                 |                  |
| 10. 00           | instructions)   FTE count for allopathic and osteopathic programs in the current year from your records  | 0.00  | 10. 00                |                  |
|                  | FTE count for residents in dental and podiatric programs.  |       |                       | 11.00            |
| 12. 00<br>13. 00 | Current year allowable FTE (see instructions) Total allowable FTE count for the prior year.  |       | 0.00                  | 12. 00<br>13. 00 |
| 14. 00           | Total allowable FTE count for the penultimate year if that year ended on or after September 30,  | 1997, | 0.00                  |                  |
| 15. 00           | otherwise enter zero. Sum of lines 12 through 14 divided by 3.   |       | 0.00                  | 15. 00           |
|                  | Adjustment for residents in initial years of the program   |       |                       | 16. 00           |
|                  | Adjustment for residents displaced by program or hospital closure  |       |                       | 17. 00           |
|                  | Adjusted rolling average FTE count   |       |                       | 18. 00           |
|                  | Current year resident to bed ratio (line 18 divided by line 4).  |       | 0. 000000             |                  |
|                  | Prior year resident to bed ratio (see instructions)  |       | 0.000000              |                  |
| 21. 00           | Enter the lesser of lines 19 or 20 (see instructions)  IME payment adjustment (see instructions)   | ŀ     | 0.000000              | 21. 00<br>22. 00 |
|                  | IME payment adjustment - Managed Care (see instructions)   |       | 0                     | 22. 00           |
| 22.01            | Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA  |       | 0                     | 22.01            |
| 23. 00           | Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 $(f)(1)(iv)(C)$ .  |       | 0. 00                 | 23. 00           |
| 24. 00           | IME FTE Resident Count Over Cap (see instructions)   |       | 0. 00                 | 24. 00           |
|                  | If the amount on line 24 is greater than -O-, then enter the lower of line 23 or line 24 (see instructions)  |       | 0. 00                 |                  |
| 26. 00           | Resident to bed ratio (divide line 25 by line 4)   |       | 0. 000000             | 26. 00           |
| 27.00            |  |       | 0.000000              | 27. 00           |
| 28. 00           | IME add-on adjustment amount (see instructions)  | 0     | 28. 00                |                  |
| 28. 01           | IME add-on adjustment amount - Managed Care (see instructions)   | 0     | 28. 01                |                  |
| 29. 00           | Total IME payment ( sum of lines 22 and 28)  |       | 0                     | 29. 00           |
| 29. 01           | Total IME payment - Managed Care (sum of lines 22.01 and 28.01) Disproportionate Share Adjustment  |       | 0                     | 29. 01           |
| 30.00            | Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)  |       | 4. 67                 | 30. 00           |
| 31. 00           | Percentage of Medicaid patient days (see instructions)   | l     | 0.00                  | 31.00            |
| 32.00            | Sum of lines 30 and 31   |       | 4. 67                 |                  |
| 33. 00           | Allowable disproportionate share percentage (see instructions)   |       | 0. 00                 |                  |
| 34. 00           | Disproportionate share adjustment (see instructions)   | ļ     | 0                     | 34. 00           |

|  | Financial Systems PHYSICIANS MEDICATION OF REIMBURSEMENT SETTLEMENT   | Provider CCN: 15-0172                 | Peri od:<br>From 01/01/2018<br>To 12/31/2018 | u of Form CMS-2<br>Worksheet E<br>Part A<br>Date/Time Prep<br>5/30/2019 5:24 | pared          |
|--|---|---------------------------------------|--|--|----------------|
|  |   | Title XVIII                           | Hospi tal                                    | PPS  |                |
|  |   |                                       | Prior to 10/1                                |  |                |
|  | Uncompensated Care Adjustment   |                                       | 1. 00  | 2. 00  |                |
| 00                                     | Total uncompensated care amount (see instructions)  |                                       | 6, 766, 695, 163                             | 8, 665, 920, 509   | 35. (          |
| 01                                     | Factor 3 (see instructions)   |                                       | 0. 000000578                                 | 0. 000006860   |                |
| 02                                     | Hospital uncompensated care payment (If line 34 is zero, enteinstructions)  | er zero on this line) (se             | е 0  | 0  | 35. (          |
|  | Pro rata share of the hospital uncompensated care payment amo<br>Total uncompensated care (sum of columns 1 and 2 on line 35.0  | 03)                                   | 0  | 0  | 35. (<br>36. ( |
| 00                                     | Additional payment for high percentage of ESRD beneficiary di   |                                       |  |  | 1,0 /          |
| 00                                     | Total Medicare discharges on Worksheet S-3, Part I excluding 652, 682, 683, 684 and 685 (see instructions)  | discharges for MS-DRGS                | 0  |  | 40.0           |
| 00                                     | Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 6 instructions)  | 683, 684 an 685. (see                 | 0  |  | 41. (          |
| 01                                     | Total ESRD Medicare covered and paid discharges excluding MS-an 685. (see instructions)   |                                       | 0  |  | 41.            |
| 00<br>00                               | Divide line 41 by line 40 (if less than 10%, you do not quali<br>Total Medicare ESRD inpatient days excluding MS-DRGs 652, 68<br>instructions)                            |                                       | 0.00   |  | 42.<br>43.     |
| 00                                     | · ·   |                                       |  |  |                |
| 00                                     | Average weekly cost for dialysis treatments (see instructions   | ,                                     | 0.00   |  | 45.            |
| 00                                     | Total additional payment (line 45 times line 44 times line 41   | . 01)                                 | 1 101 005                                    |  | 46.            |
| 00                                     | Subtotal (see instructions) Hospital specific payments (to be completed by SCH and MDH, s   | small rural hospitals                 | 1, 191, 085<br>0                             |  | 47.<br>48.     |
| 00                                     | only. (see instructions)  | mari rurar nospitars                  |  |  | 40.            |
|  |   |                                       | 1  | Amount   |                |
|  |   |                                       |  | 1. 00  |                |
| 00                                     | Total payment for inpatient operating costs (see instructions   |                                       |  | 1, 191, 085  | 1              |
| 00                                     | Payment for inpatient program capital (from Wkst. L, Pt. I an Exception payment for inpatient program capital (Wkst. L, Pt.   |                                       |  | 95, 406<br>0   | 1              |
|  | Direct graduate medical education payment (from Wkst. E-4, li   |                                       |  | Ö  |                |
| 00                                     | Nursing and Allied Health Managed Care payment  | ,                                     |  | 0  | 1              |
| 00                                     | Special add-on payments for new technologies  |                                       |  | 0  |                |
| 01                                     | Islet isolation add-on payment  |                                       |  | 0  |                |
| 00                                     | Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 6   | •                                     |  | 0  |                |
| 00                                     | Cost of physicians' services in a teaching hospital (see intr<br>Routine service other pass through costs (from Wkst. D, Pt. I  |                                       | hrough 35)                                   | 0  | 56.<br>57.     |
| 00                                     | Ancillary service other pass through costs from Wkst. D, Pt.  |                                       | ili ougir 33).                               | 0  |                |
| 00                                     | Total (sum of amounts on lines 49 through 58)   | ,                                     |  | 1, 286, 491  |                |
|  | ,   |                                       |  | 7, 040   |                |
| 00                                     | Total amount payable for program beneficiaries (line 59 minus   | s line 60)                            |  | 1, 279, 451  |                |
| 00                                     | Deductibles billed to program beneficiaries   |                                       |  | 142, 040   |                |
| 00                                     | Coinsurance billed to program beneficiaries   |                                       |  | 0  |                |
|  |   |                                       |  | 0  |                |
| 00                                     | Allowable bad debts for dual eligible beneficiaries (see inst   | ructions)                             |  | 0  | 1              |
| 00                                     | Subtotal (line 61 plus line 65 minus lines 62 and 63)   | · · · · · · · · · · · · · · · · · · · |  | 1, 137, 411  |                |
| 00                                     | Credits received from manufacturers for replaced devices for  |                                       | · · · · · · · · · · · · · · · · · · ·        | 0  | 68.            |
| 00                                     | Outlier payments reconciliation (sum of lines 93, 95 and 96).   | (For SCH see instruction              | s)   | 0  | 1              |
| 00                                     | OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  | ration) adjustment (                  | i netruoti ana                               | 0  | 1              |
|  | Rural Community Hospital Demonstration Project (§410A Demonst Demonstration payment adjustment amount before sequestration  | .ration, adjustment (see              | i nsti ucti 00\$)                            | 0  |                |
| 50                                     | SCH or MDH volume decrease adjustment (contractor use only)   |                                       |  | 0  | 1              |
| 50<br>87                               | 1   | ructions)                             |  |  | 70.            |
| 50                                     | Pioneer ACO demonstration payment adjustment amount (see inst   | •                                     |  | 0  | 70.            |
| 50<br>87<br>88                         | HSP bonus payment HVBP adjustment amount (see instructions)   |                                       |  |  |                |
| 50<br>87<br>88<br>89<br>90             | HSP bonus payment HVBP adjustment amount (see instructions) HSP bonus payment HRR adjustment amount (see instructions)  |                                       |  | 0  | 1              |
| 50<br>87<br>88<br>89<br>90<br>91<br>92 | HSP bonus payment HVBP adjustment amount (see instructions) HSP bonus payment HRR adjustment amount (see instructions) Bundled Model 1 discount amount (see instructions) |                                       |  | 0  | 70.            |
| 50<br>87<br>88<br>89<br>90<br>91<br>92 | HSP bonus payment HVBP adjustment amount (see instructions) HSP bonus payment HRR adjustment amount (see instructions)  |                                       |  |  | 70.<br>70.     |

| Health Financial Systems  | PHYSICIANS MEDICAL | CENTER      |             | In Lie                                       | u of Form CMS-2   | 2552-10 |
|---|--------------------|-------------|-------------|--|---|---------|
| CALCULATION OF REIMBURSEMENT SETTLEMENT   | P                  | rovi der CC | CN: 15-0172 | Peri od:<br>From 01/01/2018<br>To 12/31/2018 | Worksheet E<br>Part A<br>Date/Time Pre<br>5/30/2019 5:2 |         |
|   |                    | Title       | XVIII       | Hospi tal                                    | PPS   |         |
| ·   |                    |             | FFY         | (уууу)                                       | Amount  |         |
|   |                    |             |             | 0  | 1. 00   |         |
| 70.96 Low volume adjustment for federal fiscal year the corresponding federal year for the period |                    | column 0    |             | 0  | 0   | 70. 96  |
| 70.97 Low volume adjustment for federal fiscal year the corresponding federal year for the period |                    |             |             | 0  | 0   | 70. 97  |
| 70.98 Low Volume Payment-3  | G                  | ŕ           |             |  | 0   | 70. 98  |
| 70 99 HAC adjustment amount (see instructions)  |                    |             |             |  | 0   | 70 99   |

|     |       | the corresponding federal year for the period prior to 10/1)   |         |                |             |         |
|-----|-------|--|---------|----------------|-------------|---------|
| 70  | ). 97 | Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0                                | 0       |                | 0           | 70. 97  |
|     |       | the corresponding federal year for the period ending on or after 10/1)                                 |         |                |             |         |
| 70  | ). 98 | Low Volume Payment-3   |         |                | 0           | 70. 98  |
|     | ). 99 | HAC adjustment amount (see instructions)   |         |                | 0           | 70. 99  |
|     | 1. 00 | Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)                                  |         |                | -           |         |
|     |       |  |         |                | 1, 135, 781 |         |
|     | 1. 01 | Sequestration adjustment (see instructions)  |         |                | 22, 716     |         |
|     | 1. 02 | Demonstration payment adjustment amount after sequestration  |         |                | 0           | 71. 02  |
| 72  | 2. 00 | Interim payments   |         |                | 1, 113, 065 | 72. 00  |
| 73  | 3. 00 | Tentative settlement (for contractor use only)   |         |                | 0           | 73. 00  |
| 74  | 1. 00 | Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)                            |         |                | 0           | 74. 00  |
| 75  | 5. 00 | Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2 |         |                | 0           | 75. 00  |
|     |       |  |         |                |             | ł       |
|     |       | TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)  |         |                |             |         |
| 90  | 0. 00 | Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03                                   |         |                | 0           | 90. 00  |
|     |       | plus 2.04 (see instructions)   |         |                |             |         |
| 91  | 1.00  | Capital outlier from Wkst. L, Pt. I, line 2  |         |                | 0           | 91.00   |
| 92  | 2. 00 | Operating outlier reconciliation adjustment amount (see instructions)                                  |         |                | 0           | 92.00   |
| 93  | 3. 00 | Capital outlier reconciliation adjustment amount (see instructions)                                    |         |                | 0           | 93. 00  |
|     | 1. 00 | The rate used to calculate the time value of money (see instructions)                                  |         |                | 0.00        |         |
|     |       | Time value of money for operating expenses (see instructions)  |         |                | 0.00        | 95. 00  |
|     |       |  |         |                |             | 1       |
| 96  | 5. 00 | Time value of money for capital related expenses (see instructions)                                    |         |                |             | 96. 00  |
|     |       |  | _       | Prior to 10/1  |             |         |
|     |       |  |         | 1. 00          | 2. 00       |         |
|     |       | HSP Bonus Payment Amount   |         |                |             |         |
| 10  | 00.00 | HSP bonus amount (see instructions)  |         | 0              | 0           | 100.00  |
|     |       | HVBP Adjustment for HSP Bonus Payment  | *       | ,              |             | İ       |
| 10  |       | HVBP adjustment factor (see instructions)  |         | 0. 0000000000  | 0.000000000 | 101 00  |
|     |       | HVBP adjustment amount for HSP bonus payment (see instructions)  |         | 0.0000000000   |             | 102.00  |
| 10  | 12.00 |  |         | <u> </u>       | <u> </u>    | 102.00  |
|     |       | HRR Adjustment for HSP Bonus Payment   |         |                |             |         |
|     |       | HRR adjustment factor (see instructions)   |         | 0. 0000        | 0.0000      |         |
| 10  | 04.00 | HRR adjustment amount for HSP bonus payment (see instructions)   |         | 0              | 0           | 104. 00 |
|     |       | Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment                        |         |                |             |         |
| 20  | 00.00 | Is this the first year of the current 5-year demonstration period under the 21st                       | t       |                |             | 200. 00 |
|     |       | Century Cures Act? Enter "Y" for yes or "N" for no.  |         |                |             |         |
|     |       | Cost Reimbursement   |         |                |             | l       |
| 20  | 1 00  | Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)                                     |         |                |             | 201. 00 |
|     |       |  |         |                |             |         |
|     |       | Medicare discharges (see instructions)   |         |                |             | 202. 00 |
| 20  | 03.00 | Case-mix adjustment factor (see instructions)  |         |                |             | 203. 00 |
|     |       | Computation of Demonstration Target Amount Limitation (N/A in first year of the period)                | current | 5-year demonst | ration      |         |
| 20  | 04.00 | Medicare target amount   |         |                |             | 204. 00 |
|     |       | Case-mix adjusted target amount (line 203 times line 204)  |         |                |             | 205. 00 |
|     |       | Medicare inpatient routine cost cap (line 202 times line 205)  |         |                |             | 206. 00 |
| 20  | 0.00  |  |         |                |             | 200.00  |
|     |       | Adjustment to Medicare Part A Inpatient Reimbursement  |         |                |             |         |
|     |       | Program reimbursement under the §410A Demonstration (see instructions)                                 |         |                |             | 207. 00 |
|     |       | Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)                                 |         |                |             | 208. 00 |
| 20  | 9. 00 | Adjustment to Medicare IPPS payments (see instructions)  |         |                |             | 209. 00 |
|     |       | Reserved for future use  |         |                |             | 210. 00 |
|     |       | Total adjustment to Medicare IPPS payments (see instructions)  |         |                |             | 211. 00 |
| ۱ ک |       | Comparision of PPS versus Cost Reimbursement   |         |                |             |         |
| 24  |       |  |         | Ţ              |             | 212 00  |
|     |       | Total adjustment to Medicare Part A IPPS payments (from line 211)                                      |         |                |             | 212. 00 |
|     |       | Low-volume adjustment (see instructions)   |         |                |             | 213. 00 |
| 21  | 18.00 | Net Medicare Part A IPPS adjustment (difference between PPS and cost reimburseme                       | ent)    |                |             | 218. 00 |
|     |       | (line 212 minus line 213) (see instructions)   |         |                |             |         |
|     |       |  |         | '              |             |         |
|     |       |  |         |                |             |         |

Health Financial Systems

LOW VOLUME CALCULATION EXHIBIT 4 Provider CCN: 15-0172

|                  |  |                  |                  | T' 11          | V0/11.1            |                      | 5/30/2019 5: 2      | 4 pm             |
|------------------|--|------------------|------------------|----------------|--------------------|----------------------|---------------------|------------------|
|                  |  | W/S F Part A     | Amounts (from    | Pre/Post       | XVIII Period Prior | Hospi tal<br>Peri od | PPS<br>Total (Col 2 |                  |
|                  |  | line             | E, Part A)       | Entitlement    | to 10/01           | On/After 10/01       | through 4)          |                  |
|                  | To a second seco | 0                | 1.00             | 2.00           | 3. 00              | 4. 00                | 5. 00               |                  |
| 1. 00            | DRG amounts other than outlier   | 1. 00            | 0                | 0              | 0                  | 0                    | 0                   | 1. 00            |
| 1. 01            | payments DRG amounts other than outlier payments for discharges  | 1. 01            | 814, 792         | 0              | 814, 792           |                      | 814, 792            | 1. 01            |
| 1. 02            | occurring prior to October 1<br>DRG amounts other than outlier<br>payments for discharges<br>occurring on or after October   | 1. 02            | 368, 192         | 0              |                    | 368, 192             | 368, 192            | 1. 02            |
| 1. 03            | DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1   | 1. 03            | 0                | 0              | 0                  |                      | 0                   | 1. 03            |
| 1.04             | DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1  | 1. 04            | 0                | 0              |                    | 0                    | 0                   | 1. 04            |
| 2. 00            | Outlier payments for discharges (see instructions)   | 2. 00            | 8, 101           | 0              | 8, 101             | 0                    | 8, 101              | 2. 00            |
| 2. 01            | Outlier payments for discharges for Model 4 BPCI   | 2. 02            | О                | 0              | 0                  | 0                    | 0                   | 2. 01            |
| 3. 00            | Operating outlier reconciliation   | 2. 01            | 0                | 0              | 0                  | 0                    | 0                   | 3. 00            |
| 4. 00            | Managed care simulated payments  | 3. 00            | 0                | 0              | 0                  | 0                    | 0                   | 4. 00            |
|                  | Indirect Medical Education Adju  |                  |                  |                |                    |                      |                     |                  |
| 5. 00            | Amount from Worksheet E, Part A, line 21 (see instructions)  | 21. 00           | 0. 000000        | 0. 000000      | 0. 000000          | 0. 000000            |                     | 5. 00            |
| 6. 00            | IME payment adjustment (see instructions)  | 22. 00           | 0                | 0              | 0                  | 0                    | 0                   | 6. 00            |
| 6. 01            | IME payment adjustment for managed care (see instructions)   | 22. 01           | О                | 0              | О                  | 0                    | 0                   | 6. 01            |
|                  | Indirect Medical Education Adju  | ustment for the  | Add-on for Sec   | ction 422 of t | he MMA             |                      |                     |                  |
| 7.00             | IME payment adjustment factor  | 27. 00           | 0. 000000        | 0. 000000      | 0. 000000          | 0. 000000            |                     | 7. 00            |
| 8. 00            | (see instructions) IME adjustment (see   | 28. 00           | 0                | 0              | 0                  | 0                    | 0                   | 8. 00            |
| 8. 01            | instructions) IME payment adjustment add on for managed care (see  | 28. 01           | 0                | 0              | 0                  | 0                    | 0                   | 8. 01            |
| 9. 00            | instructions) Total IME payment (sum of  | 29. 00           | 0                | 0              | 0                  | 0                    | 0                   | 9. 00            |
| 9. 01            | lines 6 and 8) Total IME payment for managed   | 29. 01           | 0                | 0              | 0                  | 0                    | 0                   | 9. 01            |
|                  | care (sum of lines 6.01 and 8.01)  |                  |                  |                |                    |                      |                     |                  |
| 10. 00           | Disproportionate Share Adjustme  | ant 33. 00       | 0. 0000          | 0. 0000        | 0.0000             | 0.0000               |                     | 10.00            |
| 10.00            | share percentage (see  | 33.00            | 0.0000           | 0.0000         | 0.0000             | 0.0000               |                     | 10.00            |
| 11. 00           | instructions)<br>Disproportionate share  | 34. 00           | O                | 0              | 0                  | 0                    | 0                   | 11. 00           |
| 11. 01           | adjustment (see instructions) Uncompensated care payments  | 36. 00           | o                | 0              | 0                  | 0                    | 0                   | 11. 01           |
|                  | Additional payment for high per  |                  | D beneficiary o  |                |                    |                      |                     |                  |
| 12. 00           | Total ESRD additional payment (see instructions)   | 46. 00           | 0                | 0              | 0                  | 0                    | 0                   | 12. 00           |
| 13. 00<br>14. 00 | Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH,  | 47. 00<br>48. 00 | 1, 191, 085<br>0 | 0              | 822, 893<br>0      | 368, 192<br>0        | 1, 191, 085<br>0    | 13. 00<br>14. 00 |
| 15. 00           | small rural hospitals only.) (see instructions) Total payment for inpatient operating costs (see   | 49. 00           | 1, 191, 085      | 0              | 822, 893           | 368, 192             | 1, 191, 085         | 15. 00           |
| 16. 00           | instructions) Payment for inpatient program capital (from Wkst. L, Pt. I,  | 50. 00           | 95, 406          | 0              | 65, 763            | 29, 643              | 95, 406             | 16. 00           |
| 17. 00           | if applicable)<br>Special add-on payments for  | 54. 00           | 0                | 0              | 0                  | 0                    | 0                   | 17. 00           |
| 17. 01<br>17. 02 | new technologies Net organ aquisition cost Credits received from manufacturers for replaced  | 68. 00           | 0                | 0              | 0                  | 0                    | 0                   | 17. 01<br>17. 02 |
|                  | devices for applicable MS-DRGs   |                  |                  |                |                    |                      |                     |                  |

|        |                                |              |                |             |              | From 01/01/2018<br>To 12/31/2018 | Date/Time Pre         | pared:  |
|--------|--------------------------------|--------------|----------------|-------------|--------------|----------------------------------|-----------------------|---------|
|        |                                |              |                | Ti +Lo      | : XVIII      | Hospi tal                        | 5/30/2019 5: 2<br>PPS | 4 pm    |
|        |                                | W/C E Dort A | Amounts (from  | Pre/Post    | Period Prior | Peri od                          | Total (Col 2          |         |
|        |                                | l line       | E, Part A)     | Entitlement | to 10/01     | On/After 10/01                   | through 4)            |         |
|        |                                | 0            | 1.00           | 2. 00       | 3.00         | 4. 00                            | 5. 00                 |         |
| 18. 00 | Capital outlier reconciliation |              | 0              | 0.00        |              | 1.00                             | 0.00                  | 18. 00  |
| 10.00  | adjustment amount (see         | 75.00        | Ĭ              | 0           |              | 5                                |                       | 10.00   |
|        | instructions)                  |              |                |             |              |                                  |                       |         |
| 19 00  | SUBTOTAL                       | •            |                | 0           | 888, 65      | 6 397, 835                       | 1, 286, 491           | 19 00   |
| 17.00  | SOBTOTALE                      | W/S L, line  | (Amounts from  |             | 000,00       | 377,000                          | 1,200,171             | 17.00   |
|        |                                | W/3 E, TITIC | L)             |             |              |                                  |                       |         |
|        |                                | 0            | 1.00           | 2. 00       | 3.00         | 4. 00                            | 5. 00                 |         |
| 20. 00 | Capital DRG other than outlier | 1, 00        | 95, 265        | 0           | 65, 62       | 2 29, 643                        | 95, 265               | 20. 00  |
| 20. 01 | Model 4 BPCI Capital DRG other |              | 0              | 0           |              | 0                                | 0                     | 20. 01  |
|        | than outlier                   |              |                |             |              |                                  |                       |         |
| 21.00  | Capital DRG outlier payments   | 2. 00        | 141            | 0           | 14           | 1 0                              | 141                   | 21.00   |
| 21. 01 | Model 4 BPCI Capital DRG       | 2. 01        | o              | 0           |              | 0                                | 0                     | 21. 01  |
|        | outlier payments               |              |                |             |              |                                  |                       |         |
| 22.00  | Indirect medical education     | 5. 00        | 0. 0000        | 0.0000      | 0.000        | 0.0000                           |                       | 22. 00  |
|        | percentage (see instructions)  |              |                |             |              |                                  |                       |         |
| 23.00  | Indirect medical education     | 6. 00        | 0              | 0           |              | 0                                | 0                     | 23. 00  |
|        | adjustment (see instructions)  |              |                |             |              |                                  |                       |         |
| 24.00  | Allowable disproportionate     | 10.00        | 0.0000         | 0.0000      | 0.000        | 0.0000                           |                       | 24. 00  |
|        | share percentage (see          |              |                |             |              |                                  |                       |         |
|        | instructions)                  |              |                |             |              |                                  |                       |         |
| 25.00  | Di sproporti onate share       | 11. 00       | 0              | 0           |              | 0                                | 0                     | 25. 00  |
|        | adjustment (see instructions)  |              |                |             |              |                                  |                       |         |
| 26. 00 | Total prospective capital      | 12.00        | 95, 406        | 0           | 65, 76       | 3 29, 643                        | 95, 406               | 26. 00  |
|        | payments (see instructions)    |              |                |             |              |                                  |                       |         |
|        |                                |              | (Amounts to E, |             |              |                                  |                       |         |
|        |                                | line         | Part A)        |             |              |                                  |                       |         |
|        | I                              | 0            | 1. 00          | 2. 00       | 3.00         | 4. 00                            | 5. 00                 |         |
| 27. 00 | Low volume adjustment factor   |              |                |             | 0. 25000     |                                  |                       | 27. 00  |
| 28. 00 | Low volume adjustment          | 70. 96       |                |             | 222, 16      | 4                                | 222, 164              | 28. 00  |
|        | (transfer amount to Wkst. E,   |              |                |             |              |                                  |                       |         |
|        | Pt. A, line)                   |              |                |             |              |                                  |                       |         |
| 29. 00 | Low volume adjustment          | 70. 97       |                |             |              | 99, 459                          | 99, 459               | 29. 00  |
|        | (transfer amount to Wkst. E,   |              |                |             |              |                                  |                       |         |
| 400    | Pt. A, line)                   |              |                |             |              |                                  |                       |         |
| 100.00 | Transfer low volume            |              | N              |             |              |                                  |                       | 100. 00 |
|        | adjustments to Wkst. E, Pt. A. | I            |                |             | l            | I                                |                       | I       |

 
 Heal th Financial
 Systems
 PHYSICIANS MEDICAL CENTER

 HOSPITAL
 ACQUIRED
 CONDITION (HAC)
 REDUCTION CALCULATION EXHIBIT 5
 Provider
 Provider CCN: 15-0172

|                |  |               |                 | 10        | ) 12/31/2018 | 5/30/2019 5: 24 |                |
|----------------|--|---------------|-----------------|-----------|--------------|-----------------|----------------|
|                |  |               | Title           | XVIII     | Hospi tal    | PPS             |                |
|                |  | Wkst. E, Pt.  | Amt. from       | Period to | Peri od on   | Total (cols. 2  |                |
|                |  | A, line       | Wkst. E, Pt.    | 10/01     | after 10/01  | and 3)          |                |
|                |  |               | A)              |           |              |                 |                |
|                |  | 0             | 1. 00           | 2. 00     | 3. 00        | 4. 00           |                |
| 1.00           | DRG amounts other than outlier payments  | 1. 00         |                 |           |              |                 | 1. 00          |
| 1. 01          | DRG amounts other than outlier payments for  | 1. 01         | 814, 792        | 814, 792  |              | 814, 792        | 1. 01          |
|                | discharges occurring prior to October 1  | 4.00          | 0.0.100         |           | 0.40 400     | 0.0.400         | 4 00           |
| 1. 02          | DRG amounts other than outlier payments for  | 1. 02         | 368, 192        |           | 368, 192     | 368, 192        | 1. 02          |
| 1 02           | discharges occurring on or after October 1   | 1 02          |                 | 0         |              | 0               | 1 02           |
| 1. 03          | DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October | 1. 03         | 0               | U         |              | U               | 1. 03          |
|                | 1  |               |                 |           |              |                 |                |
| 1. 04          | DRG for Federal specific operating payment   | 1. 04         | 0               |           | 0            | 0               | 1. 04          |
| 1.01           | for Model 4 BPCI occurring on or after   | 1.01          | J               |           | J            | Ü               | 1.01           |
|                | October 1  |               |                 |           |              |                 |                |
| 2.00           | Outlier payments for discharges (see   | 2. 00         | 8, 101          | 8, 101    | 0            | 8, 101          | 2. 00          |
|                | instructions)  |               | ·               |           |              | ·               |                |
| 2.01           | Outlier payments for discharges for Model 4  | 2. 02         | 0               | 0         | 0            | 0               | 2. 01          |
|                | BPCI   |               |                 |           |              |                 |                |
| 3.00           | Operating outlier reconciliation   | 2. 01         | 0               | 0         | 0            | 0               | 3. 00          |
| 4.00           | Managed care simulated payments  | 3. 00         | 0               | 0         | 0            | 0               | 4. 00          |
|                | Indirect Medical Education Adjustment  | 04.00         |                 |           |              |                 |                |
| 5.00           | Amount from Worksheet E, Part A, line 21   | 21. 00        | 0. 000000       | 0. 000000 | 0. 000000    |                 | 5. 00          |
|                | (see instructions)   | 22. 00        | 0               | 0         | 0            | 0               | / 00           |
| 6. 00<br>6. 01 | IME payment adjustment (see instructions) IME payment adjustment for managed care (see | 22. 00        | 0               | 0         | 0            | 0               | 6. 00<br>6. 01 |
| 0.01           | instructions)  | 22.01         | U               | U         | U            | U               | 0.01           |
|                | Indirect Medical Education Adjustment for the  | Add-on for Se | ection 422 of t | he MMA    |              |                 |                |
| 7. 00          | IME payment adjustment factor (see   | 27. 00        | 0. 000000       | 0. 000000 | 0. 000000    |                 | 7. 00          |
| 7.00           | instructions)  | 27.00         | 0.00000         | 0.00000   | 0.00000      |                 | 7.00           |
| 8.00           | IME adjustment (see instructions)  | 28. 00        | 0               | 0         | 0            | 0               | 8. 00          |
| 8. 01          | IME payment adjustment add on for managed  | 28. 01        | 0               | 0         | 0            | 0               | 8. 01          |
|                | care (see instructions)  |               |                 |           |              |                 |                |
| 9.00           | Total IME payment (sum of lines 6 and 8)   | 29. 00        | 0               | 0         | 0            | 0               | 9. 00          |
| 9. 01          | Total IME payment for managed care (sum of   | 29. 01        | 0               | 0         | 0            | 0               | 9. 01          |
|                | lines 6.01 and 8.01)   |               |                 |           |              |                 |                |
|                | Disproportionate Share Adjustment  |               |                 |           |              |                 | 40.00          |
| 10. 00         | Allowable disproportionate share percentage  | 33. 00        | 0.0000          | 0. 0000   | 0. 0000      |                 | 10. 00         |
| 11. 00         | (see instructions) Disproportionate share adjustment (see                              | 34. 00        | 0               | 0         | 0            | o               | 11. 00         |
| 11.00          | instructions)  | 34.00         | U               | U         | U            | U               | 11.00          |
| 11. 01         | Uncompensated care payments  | 36. 00        | 0               | 0         | 0            | 0               | 11. 01         |
|                | Additional payment for high percentage of ESR  |               |                 | <u> </u>  | <u> </u>     | Ü               |                |
| 12.00          | Total ESRD additional payment (see   | 46. 00        | 0               | 0         | 0            | 0               | 12. 00         |
|                | instructions)  |               |                 |           |              |                 |                |
| 13.00          | Subtotal (see instructions)  | 47.00         | 1, 191, 085     | 822, 893  | 368, 192     | 1, 191, 085     | 13.00          |
| 14.00          | Hospital specific payments (completed by SCH   | 48.00         | 0               | 0         | 0            | 0               | 14.00          |
|                | and MDH, small rural hospitals only.) (see   |               |                 |           |              |                 |                |
|                | instructions)  |               |                 |           |              |                 |                |
| 15. 00         | Total payment for inpatient operating costs  | 49. 00        | 1, 191, 085     | 822, 893  | 368, 192     | 1, 191, 085     | 15. 00         |
| 1/ 00          | (see instructions)   | FO 00         | OF 404          | /E 7/2    | 20 (42       | OF 404          | 1/ 00          |
| 16. 00         | Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)             | 50. 00        | 95, 406         | 65, 763   | 29, 643      | 95, 406         | 16. 00         |
| 17. 00         | Special add-on payments for new technologies   | 54.00         | 0               | 0         | 0            | 0               | 17. 00         |
| 17. 01         | Net organ acquisition cost   | 54.00         |                 | O         | O            |                 | 17. 00         |
| 17. 01         | Credits received from manufacturers for  | 68. 00        | 0               | O         | O            | o               |                |
| 02             | replaced devices for applicable MS-DRGs  | 33.00         | ]               |           | J            |                 | 02             |
| 18. 00         | Capital outlier reconciliation adjustment  | 93.00         | 0               | 0         | 0            | 0               | 18. 00         |
|                | amount (see instructions)  |               |                 |           |              |                 |                |
| 19. 00         | SUBTOTAL   |               |                 | 888, 656  | 397, 835     | 1, 286, 491     | 19. 00         |
|                |  |               |                 |           |              |                 |                |

| Health Financial Systems                            | PHYSICIANS MED | DICAL CENTER           |        | In Lie                                      | u of Form CMS-2  | 2552-10 |
|---|----------------|------------------------|--------|---|--|---------|
| HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULA | TION EXHIBIT 5 | Provider CO            |        | Period:<br>From 01/01/2018<br>Fo 12/31/2018 | Worksheet E<br>Part A Exhibi<br>Date/Time Pre<br>5/30/2019 5:2 | pared:  |
|   |                | Title                  | XVIII  | Hospi tal                                   | PPS  |         |
|   | Wkst. L, line  | (Amt. from<br>Wkst. L) |        |   |  |         |
|   | 0              | 1.00                   | 2.00   | 3. 00                                       | 4. 00  |         |
| 20.00 Capital DRG other than outlier                | 1. 00          | 95, 265                | 65, 62 | 29, 643                                     | 95, 265  | 20. 00  |
| 20.01 Model 4 BPCI Capital DRG other than outlier   | 1. 01          | 0                      | (      | 0   | 0  | 20. 01  |
| 21.00 Capital DRG outlier payments                  | 2. 00          | 141                    | 14     | 1 0   | 141  | 21. 00  |
| 21.01 Model 4 BPCI Capital DRG outlier payments     | 2. 01          | 0                      | (      | ol o  | 0  | 21. 01  |

|        |  | mitst: E, Tille | Wi+ 1)             |         |         |                             |         |
|--------|--|-----------------|--------------------|---------|---------|-----------------------------|---------|
|        |  | 0               | Wkst. L)<br>1.00   | 2.00    | 3. 00   | 4. 00                       |         |
| 20. 00 | Capital DRG other than outlier                                   | 1, 00           | 95, 265            | 65, 622 | 29, 643 |                             | 20. 00  |
|        | Model 4 BPCI Capital DRG other than outlier                      | 1. 01           | 0                  | 0       | 0       | 0                           |         |
|        | Capital DRG outlier payments                                     | 2. 00           | 141                | 141     | 0       | 141                         |         |
|        | 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. 0000 | 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. 0000 | 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          | 95, 406            | 65, 763 | 29, 643 | 95, 406                     | 26. 00  |
|        |  | Wkst. E, Pt.    | (Amt. from         |         |         |                             |         |
|        |  | A, line         | Wkst. E, Pt.<br>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          | 0                  | 0       |         | 0                           | 28. 00  |
| 29. 00 | Low volume adjustment on or after October 1                      | 70. 97          | 0                  |         | 0       | 0                           | 29. 00  |
| 30.00  | HVBP payment adjustment (see instructions)                       | 70. 93          | 0                  | 0       | 0       | 0                           | 30.00   |
| 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, 630            | -1, 630 | 0       | -1, 630                     | 31.00   |
| 31. 01 | HRR adjustment for HSP bonus payment (see instructions)          | 70. 91          | 0                  | 0       | 0       | 0                           | 31. 01  |
|        |  |                 |                    |         |         | (Amt. to Wkst.<br>E, Pt. A) |         |
|        |  | 0               | 1.00               | 2.00    | 3. 00   | 4. 00                       |         |
|        | HAC Reduction Program adjustment (see instructions)              | 70. 99          |                    | 0       | 0       | 0                           |         |
| 100.00 | Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.     |                 | Y                  |         |         |                             | 100. 00 |

| Health Financial Systems                | PHYSICIANS MEDICAL CENTER | In Lie | u of Form CMS-2552-10   |
|---|---------------------------|--------|---|
| CALCULATION OF REIMBURSEMENT SETTLEMENT | Provi der CCN: 15-0172    |        | Worksheet E<br>Part B<br>Date/Time Prepared:<br>5/30/2019 5:24 pm |

|        |   |                            | 12/01/2010      | 5/30/2019 5: 24 |        |
|--------|---|----------------------------|-----------------|-----------------|--------|
|        |   | Title XVIII                | Hospi tal       | PPS             |        |
|        |   |                            |                 |                 |        |
|        |   |                            |                 | 1. 00           |        |
|        | PART B - MEDICAL AND OTHER HEALTH SERVICES  |                            |                 |                 |        |
| 1.00   | Medical and other services (see instructions)   |                            |                 | 0               | 1.00   |
| 2.00   | Medical and other services reimbursed under OPPS (see instruct  | ti ons)                    |                 | 7, 661, 825     | 2.00   |
| 3.00   | OPPS payments   |                            |                 | 11, 139, 229    | 3. 00  |
| 4.00   | Outlier payment (see instructions)  |                            |                 | 2, 592          | 4. 00  |
| 4.01   | Outlier reconciliation amount (see instructions)  |                            |                 | 0               | 4. 01  |
| 5.00   | Enter the hospital specific payment to cost ratio (see instruc  | ctions)                    |                 | 0.000           | 5. 00  |
| 6.00   | Line 2 times line 5   |                            |                 | 0               | 6. 00  |
| 7.00   | Sum of lines 3, 4, and 4.01, divided by line 6  |                            |                 | 0.00            | 7. 00  |
| 8.00   | Transitional corridor payment (see instructions)  |                            |                 | 0               | 8. 00  |
| 9.00   | Ancillary service other pass through costs from Wkst. D, Pt. I  | V, col. 13, line 200       |                 | 0               | 9. 00  |
| 10.00  | Organ acqui si ti ons   |                            |                 | 0               | 10.00  |
| 11. 00 | Total cost (sum of lines 1 and 10) (see instructions)   |                            |                 | 0               | 11. 00 |
|        | COMPUTATION OF LESSER OF COST OR CHARGES  |                            |                 |                 |        |
|        | Reasonabl e charges   |                            |                 |                 |        |
| 12.00  | Ancillary service charges   |                            |                 | 0               | 12.00  |
| 13.00  | Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, Ii  | ne 69)                     |                 | 0               |        |
| 14.00  | Total reasonable charges (sum of lines 12 and 13)   |                            |                 | 0               | 14. 00 |
|        | Customary charges   |                            |                 |                 |        |
| 15. 00 | Aggregate amount actually collected from patients liable for p  | 3                          | •               | 0               |        |
| 16. 00 | Amounts that would have been realized from patients liable for  |                            | n a chargebasis | 0               | 16. 00 |
|        | had such payment been made in accordance with 42 CFR §413.13(   | e)                         |                 |                 |        |
| 17. 00 | Ratio of line 15 to line 16 (not to exceed 1.000000)  |                            |                 | 0. 000000       |        |
| 18. 00 | Total customary charges (see instructions)  |                            |                 | 0               |        |
| 19. 00 | Excess of customary charges over reasonable cost (complete onl  | y if line 18 exceeds li    | ne 11) (see     | 0               | 19. 00 |
|        | instructions)   |                            |                 | _               |        |
| 20. 00 | Excess of reasonable cost over customary charges (complete onl  | y if line 11 exceeds li    | ne 18) (see     | 0               | 20. 00 |
| 21 00  | instructions)   |                            |                 | ا               | 21 00  |
| 21. 00 | Lesser of cost or charges (see instructions)  |                            |                 | 0               |        |
| 22. 00 | Interns and residents (see instructions)  | quati ana)                 |                 | 0               |        |
| 23. 00 | Cost of physicians' services in a teaching hospital (see instr  | uctions)                   |                 | 11 141 021      | 23. 00 |
| 24. 00 | Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)  |                            |                 | 11, 141, 821    | 24. 00 |
| 25. 00 | COMPUTATION OF REIMBURSEMENT SETTLEMENT  Deductibles and coinsurance amounts (for CAH, see instructions | -)                         |                 | 0               | 25. 00 |
| 26. 00 | Deductibles and Coinsurance amounts relating to amount on line  | •                          | uctions)        | 2, 027, 355     |        |
| 27. 00 | Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) p  |                            |                 | 9, 114, 466     |        |
| 27.00  | instructions)   | or us the sum of filles 22 | and 23] (See    | 7, 114, 400     | 27.00  |
| 28. 00 | Direct graduate medical education payments (from Wkst. E-4, Li  | ne 50)                     |                 | o               | 28. 00 |
| 29. 00 | ESRD direct medical education costs (from Wkst. E-4, line 36)   | 110 30)                    |                 | Ö               | 29. 00 |
| 30.00  | Subtotal (sum of lines 27 through 29)   |                            |                 | 9, 114, 466     |        |
| 31. 00 | Pri mary payer payments   |                            |                 | 5, 136          |        |
| 32. 00 | Subtotal (line 30 minus line 31)  |                            |                 | 9, 109, 330     |        |
| 02.00  | ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE   | CFS)                       |                 | 77 1077 000     | 02.00  |
| 33. 00 | Composite rate ESRD (from Wkst. I-5, line 11)   | /                          |                 | 0               | 33. 00 |
| 34. 00 | Allowable bad debts (see instructions)  |                            |                 | o               |        |
| 35. 00 | Adjusted reimbursable bad debts (see instructions)  |                            |                 | 0               | 35. 00 |
| 36. 00 | Allowable bad debts for dual eligible beneficiaries (see instr  | ructions)                  |                 | 0               | 36. 00 |
| 37. 00 | Subtotal (see instructions)   | ,                          |                 | 9, 109, 330     |        |
| 38.00  | MSP-LCC reconciliation amount from PS&R   |                            |                 | 192             |        |
| 39.00  | OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  |                            |                 | 0               | 39. 00 |
| 39. 50 | Pioneer ACO demonstration payment adjustment (see instructions  | s)                         |                 |                 | 39. 50 |
| 39. 97 | Demonstration payment adjustment amount before sequestration  |                            |                 | 0               | 39. 97 |
| 39. 98 | Partial or full credits received from manufacturers for replace   | ced devices (see instruc   | tions)          | 0               | 39. 98 |
| 39. 99 | RECOVERY OF ACCELERATED DEPRECIATION  |                            | ,               | 0               | 39. 99 |
| 40.00  | Subtotal (see instructions)   |                            |                 | 9, 109, 138     | 40. 00 |
| 40.01  | Sequestration adjustment (see instructions)   |                            |                 | 182, 183        | 40. 01 |
| 40.02  | Demonstration payment adjustment amount after sequestration   |                            |                 | 0               | 40. 02 |
| 41.00  | Interim payments  |                            |                 | 9, 032, 440     | 41.00  |
| 42.00  | Tentative settlement (for contractors use only)   |                            |                 | 0               | 42.00  |
| 43.00  | Balance due provider/program (see instructions)   |                            |                 | -105, 485       | 43.00  |
| 44.00  | Protested amounts (nonallowable cost report items) in accordar  | nce with CMS Pub. 15-2, (  | chapter 1,      | 0               | 44. 00 |
|        | §115. 2   |                            |                 |                 |        |
|        | TO BE COMPLETED BY CONTRACTOR   |                            |                 |                 |        |
| 90.00  | Original outlier amount (see instructions)  |                            |                 | 0               | 90. 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            |        |
| 93. 00 | Time Value of Money (see instructions)  |                            |                 | 0               |        |
| 94. 00 | Total (sum of lines 91 and 93)  |                            |                 | , 0             | 94. 00 |
|        |   |                            |                 |                 |        |

Health Financial Systems PHYS
ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provider CCN: 15-0172

|                |  |            |            |                | 5/30/2019 5: 24 | 4 pm           |
|----------------|--|------------|------------|----------------|-----------------|----------------|
|                |  |            | XVIII      | Hospi tal      | PPS             |                |
|                |  | Inpatien   | t Part A   | Par            | ⁻t B            |                |
|                |  | mm/dd/yyyy | Amount     | mm/dd/yyyy     | Amount          |                |
|                |  | 1.00       | 2. 00      | 3. 00          | 4. 00           |                |
| 1.00           | Total interim payments paid to provider  |            | 1, 113, 06 | 5              | 9, 032, 440     | 1. 00          |
| 2.00           | Interim payments payable on individual bills, either   |            |            | 0              | 0               | 2. 00          |
|                | submitted or to be submitted to the contractor for   |            |            |                |                 |                |
|                | services rendered in the cost reporting period. If none,   |            |            |                |                 |                |
| 2 00           | write "NONE" or enter a zero   |            |            |                |                 | 2 00           |
| 3. 00          | List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate |            |            |                |                 | 3. 00          |
|                | for the cost reporting period. Also show date of each  |            |            |                |                 |                |
|                | payment. If none, write "NONE" or enter a zero. (1)  |            |            |                |                 |                |
|                | Program to Provider  |            |            |                |                 |                |
| 3. 01          | ADJUSTMENTS TO PROVIDER  |            |            | 0              | 0               | 3. 01          |
| 3.02           |  |            |            | 0              | 0               | 3. 02          |
| 3.03           |  |            |            | 0              | 0               | 3. 03          |
| 3.04           |  |            |            | 0              | 0               | 3. 04          |
| 3.05           |  |            |            | 0              | 0               | 3.05           |
|                | Provider to Program  |            |            |                |                 |                |
| 3.50           | ADJUSTMENTS TO PROGRAM   |            |            | 0              | 0               | 3. 50          |
| 3. 51          |  |            |            | 0              | 0               | 3. 51          |
| 3. 52          |  |            |            | 0              | 0               | 3. 52          |
| 3.53           |  |            |            | 0              | 0               | 3. 53          |
| 3.54           | Cubatatal (aum af linna 2 01 2 40 minus aum af linna   |            |            | 0              | 0               | 3. 54          |
| 3. 99          | Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)   |            |            | 0              | 0               | 3. 99          |
| 4. 00          | Total interim payments (sum of lines 1, 2, and 3.99)   |            | 1, 113, 06 | 5              | 9, 032, 440     | 4. 00          |
| 4.00           | (transfer to Wkst. E or Wkst. E-3, line and column as  |            | 1, 113, 00 | ,5             | 7, 032, 440     | 4.00           |
|                | appropriate)   |            |            |                |                 |                |
|                | TO BE COMPLETED BY CONTRACTOR  |            |            | · '            |                 |                |
| 5.00           | List separately each tentative settlement payment after  |            |            |                |                 | 5. 00          |
|                | desk review. Also show date of each payment. If none,  |            |            |                |                 |                |
|                | write "NONE" or enter a zero. (1)  |            |            |                |                 |                |
|                | Program to Provider  |            | Т          |                |                 |                |
| 5. 01          | TENTATI VE TO PROVI DER  |            |            | 0              | 0               | 5. 01          |
| 5. 02<br>5. 03 |  |            |            | 0              | 0               | 5. 02<br>5. 03 |
| 5.03           | Provider to Program  |            |            | U              | U               | 5. 03          |
| 5. 50          | TENTATI VE TO PROGRAM  |            |            | 0              | 0               | 5. 50          |
| 5. 51          | TENTITIVE TO TROOWIN   |            |            | o              | 0               | 5. 51          |
| 5. 52          |  |            |            | o              | 0               | 5. 52          |
| 5. 99          | Subtotal (sum of lines 5.01-5.49 minus sum of lines  |            |            | o              | l ol            | 5. 99          |
|                | 5. 50-5. 98)   |            |            |                |                 |                |
| 6.00           | Determined net settlement amount (balance due) based on  |            |            |                |                 | 6. 00          |
|                | the cost report. (1)   |            |            |                |                 |                |
| 6. 01          | SETTLEMENT TO PROVIDER   |            |            | 0              | 0               | 6. 01          |
| 6. 02          | SETTLEMENT TO PROGRAM  |            |            | 0              | 105, 485        | 6. 02          |
| 7. 00          | Total Medicare program liability (see instructions)  |            | 1, 113, 06 |                | 8, 926, 955     | 7. 00          |
|                |  |            |            | Contractor     | NPR Date        |                |
|                |  | ,          | )          | Number<br>1.00 | (Mo/Day/Yr)     |                |
| 8. 00          | Name of Contractor   |            | J          | 1.00           | 2. 00           | 8. 00          |
| 0.00           | Ivalie of contractor   |            |            |                | ı l             | 0.00           |

| Heal th | Financial Systems PHYSICIANS MI                             | EDICAL CENTER               | In Lie                      | u of Form CMS- | 2552-10 |
|---------|---|-----------------------------|-----------------------------|----------------|---------|
| CALCUI  | ATION OF REIMBURSEMENT SETTLEMENT FOR HIT                   | Provider CCN: 15-0172       | Peri od:<br>From 01/01/2018 | Worksheet E-1  | l       |
|         |   |                             | To 12/31/2018               | Date/Time Pre  |         |
|         |   |                             |                             | 5/30/2019 5: 2 | 24 pm   |
|         |   | Title XVIII                 | Hospi tal                   | PPS            |         |
|         |   |                             |                             |                |         |
|         |   |                             |                             | 1. 00          |         |
|         | TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS  |                             |                             |                | 4       |
|         | HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULAT  |                             |                             |                | 4       |
| 1.00    | Total hospital discharges as defined in AARA §4102 from Wk  |                             | e 14                        | 1              | 1. 00   |
| 2.00    | Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1  | , 8-12                      |                             | 1              | 2. 00   |
| 3.00    | Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2     |                             |                             | 1              | 3. 00   |
| 4.00    | Total inpatient days from S-3, Pt. I col. 8 sum of lines 1  |                             |                             | 1              | 4. 00   |
| 5.00    | Total hospital charges from Wkst C, Pt. I, col. 8 line 200  |                             |                             | 1              | 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 of | f certified HIT technology  | Wkst. S-2, Pt. I            | 1              | 7. 00   |
|         | line 168  |                             |                             | 1              |         |
| 8.00    | Calculation of the HIT incentive payment (see instructions  | )                           |                             | 1              | 8. 00   |
| 9.00    | Sequestration adjustment amount (see instructions)          |                             |                             | 1              | 9. 00   |
| 10.00   | Calculation of the HIT incentive payment after sequestrati  | on (see instructions)       |                             |                | 10. 00  |
|         | INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH            |                             |                             |                |         |
| 30.00   | Initial/interim HIT payment adjustment (see instructions)   |                             |                             | i              | 30.00   |
| 31.00   | Other Adjustment (specify)                                  |                             |                             | i              | 31.00   |
| 32. 00  | Balance due provider (line 8 (or line 10) minus line 30 ar  | d line 31) (see instruction | ns)                         |                | 32. 00  |

| Health Financial Systems                | PHYSICIANS MEDICAL CENTER | In Lie | u of Form CMS-2552-10   |
|---|---------------------------|--------|---|
| CALCULATION OF REIMBURSEMENT SETTLEMENT | Provi der CCN: 15-0172    |        | Worksheet E-3<br>Part VII<br>Date/Time Prepared:<br>5/30/2019 5:24 pm |

|        |  |                            | o 12/31/2018 | Date/lime Pre<br>5/30/2019 5:2 |        |
|--------|--|----------------------------|--------------|--------------------------------|--------|
|        |  | Title XIX                  | Hospi tal    | PPS                            | Трш    |
|        |  | 11 61 5 71 7               | Inpati ent   | Outpati ent                    |        |
|        |  |                            | 1, 00        | 2. 00                          |        |
|        | PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SER | PVICES FOR TITLES V OR XIX |              | 2.00                           |        |
|        | COMPUTATION OF NET COST OF COVERED SERVICES                    | THE STOR THEES VOR XIX     | . JERVI CES  |                                | l      |
| 1.00   | Inpatient hospital/SNF/NF services                             |                            | 0            |                                | 1.00   |
| 2. 00  | Medical and other services                                     |                            | ı o          | 3, 032, 508                    | 2.00   |
| 3. 00  | Organ acquisition (certified transplant centers only)          |                            | 0            | 3, 032, 300                    | 3.00   |
| 4. 00  | Subtotal (sum of lines 1, 2 and 3)                             |                            | 0            | 3, 032, 508                    | 4.00   |
| 5. 00  | Inpatient primary payer payments                               |                            | 0            | 3, 032, 300                    | 5.00   |
| 6. 00  | Outpatient primary payer payments                              |                            |              | 0                              | 6.00   |
| 7. 00  | Subtotal (line 4 less sum of lines 5 and 6)                    |                            | 0            |                                | 7.00   |
| 7.00   | COMPUTATION OF LESSER OF COST OR CHARGES                       |                            | U            | 3, 032, 508                    | 7.00   |
|        | Reasonable Charges   |                            |              |                                |        |
| 8. 00  |  |                            | FO 217       |                                | 8.00   |
|        | Routine service charges  |                            | 58, 217      | 17 000 000                     |        |
| 9.00   | Ancillary service charges                                      |                            | 1, 656, 786  | 17, 828, 238                   | 9.00   |
| 10.00  | Organ acquisition charges, net of revenue                      |                            | 0            |                                | 10.00  |
| 11.00  | Incentive from target amount computation                       |                            | 4 745 000    | 47 000 000                     | 11.00  |
| 12. 00 | Total reasonable charges (sum of lines 8 through 11)           |                            | 1, 715, 003  | 17, 828, 238                   | 12. 00 |
| 40.00  | CUSTOMARY CHARGES  |                            |              |                                |        |
| 13. 00 | Amount actually collected from patients liable for payment for | services on a charge       | 0            | 0                              | 13. 00 |
|        | basis  |                            |              |                                |        |
| 14. 00 | Amounts that would have been realized from patients liable for |                            | 0            | 0                              | 14. 00 |
| 45.00  | a charge basis had such payment been made in accordance with   | 12 CFR §413.13(e)          | 0.000000     | 0.00000                        | 45.00  |
| 15.00  | Ratio of line 13 to line 14 (not to exceed 1.000000)           |                            | 0.000000     | 0.000000                       | 15.00  |
| 16.00  | Total customary charges (see instructions)                     | 1611 4                     | 1, 715, 003  | 17, 828, 238                   | 16.00  |
| 17. 00 | Excess of customary charges over reasonable cost (complete onl | y if line 16 exceeds       | 1, 715, 003  | 14, 795, 730                   | 17. 00 |
| 10.00  | line 4) (see instructions)                                     |                            |              |                                | 40.00  |
| 18. 00 | Excess of reasonable cost over customary charges (complete onl | y if line 4 exceeds line   | 0            | 0                              | 18. 00 |
| 40.00  | 16) (see instructions)   |                            |              |                                | 40.00  |
| 19. 00 | Interns and Residents (see instructions)                       |                            | 0            | 0                              | 19.00  |
| 20.00  | Cost of physicians' services in a teaching hospital (see instr |                            | 0            | 0                              | 20.00  |
| 21. 00 | Cost of covered services (enter the lesser of line 4 or line 1 |                            | 0            | 3, 032, 508                    | 21. 00 |
|        | PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be  | completed for PPS provide  |              | _                              |        |
| 22. 00 | Other than outlier payments                                    |                            | 0            | 0                              | 22. 00 |
| 23. 00 | Outlier payments   |                            | 0            | 0                              | 23. 00 |
| 24. 00 | Program capital payments                                       |                            | 0            |                                | 24. 00 |
| 25. 00 | Capital exception payments (see instructions)                  |                            | 0            |                                | 25. 00 |
| 26. 00 | Routine and Ancillary service other pass through costs         |                            | 0            | 0                              | 26. 00 |
| 27. 00 | Subtotal (sum of lines 22 through 26)                          |                            | 0            | 0                              | 27. 00 |
| 28. 00 | Customary charges (title V or XIX PPS covered services only)   |                            | 0            | 0                              | 28. 00 |
| 29. 00 | Titles V or XIX (sum of lines 21 and 27)                       |                            | 0            | 3, 032, 508                    | 29. 00 |
|        | COMPUTATION OF REIMBURSEMENT SETTLEMENT                        |                            |              |                                |        |
| 30. 00 | Excess of reasonable cost (from line 18)                       |                            | 0            |                                | 30. 00 |
| 31. 00 | Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) | 1                          | 0            | 3, 032, 508                    |        |
| 32. 00 | Deducti bl es  |                            | 0            | 0                              | 32. 00 |
| 33. 00 | Coinsurance  |                            | 0            | 0                              | 33. 00 |
| 34.00  | Allowable bad debts (see instructions)                         |                            | 0            | 0                              | 34.00  |
| 35. 00 | Utilization review   |                            | 0            |                                | 35. 00 |
| 36.00  | Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and | 1 33)                      | 0            | 3, 032, 508                    | 36. 00 |
| 37.00  | OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)                 |                            | 0            | 0                              | 37. 00 |
| 38. 00 | Subtotal (line 36 ± line 37)                                   |                            | 0            | 3, 032, 508                    |        |
| 39. 00 | Direct graduate medical education payments (from Wkst. E-4)    |                            | 0            |                                | 39. 00 |
| 40.00  | Total amount payable to the provider (sum of lines 38 and 39)  |                            | 0            | 3, 032, 508                    | 40. 00 |
| 41.00  | Interim payments   |                            | 319, 273     | 3, 318, 990                    | 41.00  |
| 42.00  | Balance due provider/program (line 40 minus line 41)           |                            | -319, 273    | -286, 482                      | 42. 00 |
| 43.00  | Protested amounts (nonallowable cost report items) in accordan | nce with CMS Pub 15-2,     | 0            | 0                              | 43. 00 |
|        | chapter 1, §115.2  |                            |              |                                |        |
|        |  |                            | ·            |                                |        |

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

Provider CCN: 15-0172 | Period: From 01/01/20

| oni y)           |  |                             |                      |                | 5/30/2019 5: 2 | 4 pm             |
|------------------|--|-----------------------------|----------------------|----------------|----------------|------------------|
|                  |  | General Fund                |                      | Endowment Fund | Plant Fund     |                  |
|                  |  | 1.00                        | Purpose Fund<br>2.00 | 3. 00          | 4. 00          |                  |
|                  | CURRENT ASSETS   |                             |                      |                |                |                  |
| 1.00             | Cash on hand in banks  | 904, 312                    | 1                    |                | 0              |                  |
| 2.00             | Temporary investments Notes receivable   |                             | 0                    | 0              | 0              | 2.00             |
| 3. 00<br>4. 00   | Accounts receivable  | 92, 114, 062                | 0                    | 0              | 0              |                  |
| 5. 00            | Other recei vable  | 1, 020, 090                 | 1                    | 0              | 0              |                  |
| 6. 00            | Allowances for uncollectible notes and accounts receivable                     | -82, 173, 164               | 1                    | 0              | 0              |                  |
| 7.00             | Inventory  | 1, 213, 380                 | 1                    | 0              | 0              | 7. 00            |
| 8.00             | Prepai d expenses  | 692, 659                    | 0                    | 0              | 0              | 8. 00            |
| 9.00             | Other current assets   | 0                           | 0                    | _              | 0              |                  |
| 10.00            | Due from other funds   | 0                           | 0                    | -              | 0              | 1                |
| 11. 00           | Total current assets (sum of lines 1-10)                                       | 13, 771, 339                | 0                    | 0              | 0              | 11. 00           |
| 12. 00           | FI XED ASSETS Land   |                             | 0                    | 0              | 0              | 12.00            |
| 13. 00           | Land improvements  |                             | 1                    |                | 0              | 1                |
| 14. 00           | Accumul ated depreciation  |                             | Ö                    | 0              | 0              |                  |
| 15. 00           | Bui I di ngs   | 0                           | 0                    | 0              | 0              | 15. 00           |
| 16. 00           | Accumulated depreciation   | C                           | 0                    | 0              | 0              | 16. 00           |
| 17. 00           | Leasehold improvements   | 2, 858, 051                 | 1                    | 0              | 0              | 17. 00           |
| 18. 00           | Accumulated depreciation   | -151, 133                   | 1                    | 0              | 0              |                  |
| 19.00            | Fixed equipment  | 673, 946                    | i                    | 0              | 0              |                  |
| 20. 00<br>21. 00 | Accumulated depreciation Automobiles and trucks                                | -362, 852                   | 1                    | 0              | 0              |                  |
| 22. 00           | Accumulated depreciation   |                             | Ö                    | _              | 0              |                  |
| 23. 00           | Major movable equipment  | 6, 555, 943                 |                      |                | 0              |                  |
| 24. 00           | Accumulated depreciation   | -5, 998, 359                | 1                    | 0              | 0              | 24. 00           |
| 25. 00           | Mi nor equi pment depreci abl e  | 0                           | 0                    | 0              | 0              | 25. 00           |
| 26. 00           | Accumulated depreciation   | 0                           | 0                    | 0              | 0              | 26. 00           |
| 27. 00           | HIT designated Assets  | 3, 996, 460                 | I                    | 0              | 0              |                  |
| 28. 00           | Accumulated depreciation   | 0                           | 1                    | -              | 0              |                  |
| 29. 00<br>30. 00 | Minor equipment-nondepreciable Total fixed assets (sum of lines 12-29)         | 7, 572, 056                 | 0                    | -              | 0              |                  |
| 30.00            | OTHER ASSETS   | 1,372,030                   | <u> </u>             | <u> </u>       | 0              | 30.00            |
| 31. 00           | Investments  | С                           | 0                    | 0              | 0              | 31. 00           |
| 32.00            | Deposits on Leases   | 0                           | 0                    | 0              | 0              | 32. 00           |
| 33. 00           | Due from owners/officers   | 0                           | 0                    | 0              | 0              | 33. 00           |
| 34. 00           | Other assets   | 7, 600, 131                 | 1                    | 0              | 0              |                  |
| 35. 00           | Total other assets (sum of lines 31-34)  | 7, 600, 131                 | 1                    |                | 0              |                  |
| 36. 00           | Total assets (sum of lines 11, 30, and 35) CURRENT LIABILITIES                 | 28, 943, 526                | 0                    | 0              | 0              | 36. 00           |
| 37. 00           | Accounts payable   | 1, 611, 680                 | 0                    | 0              | 0              | 37. 00           |
| 38. 00           | Salaries, wages, and fees payable  | 1, 005, 450                 |                      |                | 0              | 1                |
| 39. 00           | Payroll taxes payable  | 40, 083                     | 0                    | 0              | 0              | 39. 00           |
| 40.00            | Notes and Loans payable (short term)   | 2, 455, 003                 | 0                    | 0              | 0              | 40. 00           |
| 41. 00           | Deferred income  | 0                           | 0                    | 0              | 0              |                  |
| 42.00            | Accel erated payments  | 0                           |                      |                |                | 42. 00           |
| 43.00            | Due to other funds Other current liabilities                                   | F 0/2 F12                   | 0                    |                | 0              |                  |
| 44. 00<br>45. 00 | Total current liabilities (sum of lines 37 thru 44)                            | 5, 062, 513<br>10, 174, 729 |                      | _              |                | 44. 00<br>45. 00 |
| 43.00            | LONG TERM LIABILITIES  | 10, 174, 727                |                      | J              |                | 1 43.00          |
| 46. 00           | Mortgage payable   | 0                           | 0                    | 0              | 0              | 46. 00           |
| 47. 00           | Notes payable  | 4, 173, 279                 | 0                    | 0              | 0              | 47. 00           |
| 48. 00           | Unsecured Loans  | 0                           | 0                    |                | 0              | 1                |
| 49. 00           | Other long term liabilities  | 0                           | 0                    | 0              | 0              | 1                |
| 50.00            | Total long term liabilities (sum of lines 46 thru 49)                          | 4, 173, 279                 | 1                    |                | 0              | 1                |
| 51. 00           | Total liabilities (sum of lines 45 and 50) CAPITAL ACCOUNTS                    | 14, 348, 008                | 0                    | U              |                | 51.00            |
| 52. 00           | General fund balance   | 14, 595, 518                |                      |                |                | 52. 00           |
| 53. 00           | Specific purpose fund  | ,,                          | 0                    |                |                | 53. 00           |
| 54.00            | Donor created - endowment fund balance - restricted                            |                             |                      | 0              |                | 54. 00           |
| 55. 00           | Donor created - endowment fund balance - unrestricted                          |                             |                      | 0              |                | 55. 00           |
| 56. 00           | Governing body created - endowment fund balance                                |                             |                      | 0              |                | 56. 00           |
| 57. 00           | Plant fund balance - invested in plant   |                             |                      |                | 0              |                  |
| 58. 00           | Plant fund balance - reserve for plant improvement, replacement, and expansion |                             |                      |                | 0              | 58. 00           |
| 59. 00           | Total fund balances (sum of lines 52 thru 58)                                  | 14, 595, 518                | o                    | 0              | 0              | 59. 00           |
| 60. 00           | Total liabilities and fund balances (sum of lines 51 and                       | 28, 943, 526                | 1                    | 0              | 0              | 60.00            |
|                  | 59)  |                             |                      |                |                |                  |
|                  |  |                             |                      | ·              |                |                  |

STATEMENT OF CHANGES IN FUND BALANCES

sheet (line 11 minus line 18)

Provider CCN: 15-0172

Peri od: Worksheet G-1 From 01/01/2018

Date/Time Prepared: 5/30/2019 5:24 pm 12/31/2018 General Fund Special Purpose Fund Endowment Fund 1.00 2.00 3.00 4. 00 5. 00 1.00 Fund balances at beginning of period 11, 893, 639 0 1.00 2.00 Net income (loss) (from Wkst. G-3, line 29) 7, 820, 204 2.00 Total (sum of line 1 and line 2) 3.00 19, 713, 843 0 3.00 4.00 0 Additions (credit adjustments) (specify) 0 4.00 0 0 0 0 5.00 0 5.00 6.00 6.00 0 7.00 0 7.00 0 8.00 0 8.00 0 9.00 0 9.00 10.00 Total additions (sum of line 4-9) 10.00 Subtotal (line 3 plus line 10) 19, 713, 843 11.00 0 11.00 NET ADJUSTMENT TO EQUITY 12.00 5, 118, 325 0 12.00 13.00 13.00 14.00 0 0 14.00 0 15.00 15.00 0 0 16.00 0 16.00 17.00 17.00 5, 118, 325 18.00 Total deductions (sum of lines 12-17) 18.00 Fund balance at end of period per balance 19.00 14, 595, 518 19.00 sheet (line 11 minus line 18) Endowment Fund Plant Fund 7. 00 8.00 6. 00 1.00 Fund balances at beginning of period 0 0 1.00 Net income (loss) (from Wkst. G-3, line 29) 2.00 2.00 3.00 Total (sum of line 1 and line 2) 0 0 3.00 4.00 Additions (credit adjustments) (specify) 4.00 5.00 0 5.00 0 6.00 6.00 7.00 0 7 00 8.00 0 8.00 9.00 9.00 10.00 Total additions (sum of line 4-9) 0 0 10.00 11.00 0 0 Subtotal (line 3 plus line 10) 11.00 12.00 NET ADJUSTMENT TO EQUITY 12.00 13.00 13.00 14.00 0 14.00 0 15.00 15.00 16.00 16.00 17.00 17.00 Total deductions (sum of lines 12-17) 18.00 18.00 0 Fund balance at end of period per balance 0 0 19.00 19.00

Health Financial Systems FATTEMENT OF PATLENT REVENUES AND OPERATING EXPENSES Provider CCN: 15-0172

|        |   |            | 1            | 0 12/31/2018  | Date/IIme Prep<br>  5/30/2019 5:24 |        |
|--------|---|------------|--------------|---------------|------------------------------------|--------|
|        | Cost Center Description   |            | Inpatient    | Outpati ent   | Total                              | ı pııı |
|        | 555 551151 5555 FET 611   |            | 1. 00        | 2.00          | 3. 00                              |        |
|        | PART I - PATIENT REVENUES                                       |            |              |               | 0.00                               |        |
|        | General Inpatient Routine Services                              |            |              |               |                                    |        |
| 1.00   | Hospi tal   |            | 613, 262     |               | 613, 262                           | 1.00   |
| 2.00   | SUBPROVI DER - I PF   |            |              |               |                                    | 2.00   |
| 3.00   | SUBPROVI DER - I RF   |            |              |               |                                    | 3.00   |
| 4.00   | SUBPROVI DER  |            |              |               |                                    | 4.00   |
| 5.00   | Swing bed - SNF   |            | 0            |               | o                                  | 5.00   |
| 6.00   | Swing bed - NF  |            | 0            |               | o                                  | 6.00   |
| 7.00   | SKILLED NURSING FACILITY  |            |              |               |                                    | 7.00   |
| 8.00   | NURSING FACILITY  |            |              |               |                                    | 8.00   |
| 9.00   | OTHER LONG TERM CARE  |            |              |               |                                    | 9.00   |
| 10.00  | Total general inpatient care services (sum of lines 1-9)        |            | 613, 262     |               | 613, 262                           | 10.00  |
|        | Intensive Care Type Inpatient Hospital Services                 |            |              |               |                                    |        |
| 11.00  | INTENSIVE CARE UNIT   |            |              |               |                                    | 11.00  |
| 12.00  | CORONARY CARE UNIT  |            |              |               |                                    | 12.00  |
| 13.00  | BURN INTENSIVE CARE UNIT  |            |              |               |                                    | 13.00  |
| 14.00  | SURGICAL INTENSIVE CARE UNIT                                    |            |              |               |                                    | 14.00  |
| 15.00  | OTHER SPECIAL CARE (SPECIFY)                                    |            |              |               |                                    | 15.00  |
| 16.00  | Total intensive care type inpatient hospital services (sum of I | ines       | 0            |               | 0                                  | 16.00  |
|        | 11-15)  |            |              |               |                                    |        |
| 17.00  | Total inpatient routine care services (sum of lines 10 and 16)  |            | 613, 262     |               | 613, 262                           | 17.00  |
| 18.00  | Ancillary services  |            | 18, 576, 258 | 143, 294, 804 | 161, 871, 062                      | 18.00  |
| 19.00  | Outpati ent servi ces   |            | 8, 050       | 18, 668, 968  | 18, 677, 018                       | 19.00  |
| 20.00  | RURAL HEALTH CLINIC   |            | 0            | 0             | 0                                  | 20.00  |
| 21.00  | FEDERALLY QUALIFIED HEALTH CENTER                               |            | 0            | 0             | 0                                  | 21.00  |
| 22.00  | HOME HEALTH AGENCY  |            |              |               |                                    | 22.00  |
| 23.00  | AMBULANCE SERVICES  |            |              |               |                                    | 23.00  |
| 24.00  | CMHC  |            |              |               |                                    | 24.00  |
| 24. 10 | CORF  |            | 0            | 0             | 0                                  | 24. 10 |
| 25.00  | AMBULATORY SURGICAL CENTER (D. P. )                             |            |              |               |                                    | 25.00  |
| 26.00  | HOSPI CE  |            |              |               |                                    | 26.00  |
| 27. 00 | OTHER (SPECIFY)   |            | 0            | 0             | 0                                  | 27.00  |
| 28. 00 | Total patient revenues (sum of lines 17-27)(transfer column 3 t | to Wkst.   | 19, 197, 570 | 161, 963, 772 | 181, 161, 342                      | 28.00  |
|        | G-3, line 1)  |            |              |               |                                    |        |
|        | PART II - OPERATING EXPENSES                                    |            |              |               |                                    |        |
| 29. 00 | Operating expenses (per Wkst. A, column 3, line 200)            |            |              | 50, 812, 721  |                                    | 29. 00 |
| 30. 00 | ADD (SPECIFY)   |            | 0            |               |                                    | 30.00  |
| 31. 00 |   |            | 0            |               |                                    | 31. 00 |
| 32. 00 |   |            | 0            |               |                                    | 32.00  |
| 33. 00 |   |            | 0            |               |                                    | 33. 00 |
| 34. 00 |   |            | 0            |               |                                    | 34.00  |
| 35. 00 |   |            | 0            |               |                                    | 35. 00 |
| 36. 00 | Total additions (sum of lines 30-35)                            |            |              | 0             |                                    | 36. 00 |
| 37. 00 | FREE STANDING REF LABORATORY                                    |            | 8, 009, 875  |               |                                    | 37. 00 |
| 38. 00 | URGENT CARE CENTERS   |            | 5, 407, 461  |               |                                    | 38. 00 |
| 39. 00 |   |            | 0            |               |                                    | 39. 00 |
| 40.00  |   |            | 0            |               |                                    | 40.00  |
| 41.00  | 7   |            | 0            | 40 447        |                                    | 41.00  |
| 42. 00 | Total deductions (sum of lines 37-41)                           | \ (+==== 6 |              | 13, 417, 336  |                                    | 42.00  |
| 43. 00 | Total operating expenses (sum of lines 29 and 36 minus line 42) | (transfer  |              | 37, 395, 385  |                                    | 43.00  |
|        | to Wkst. G-3, line 4)   | I          |              | l l           | I                                  |        |

| Heal th | Financial Systems                             | PHYSICIANS MEDICAL CENTER  | ₹              | In Lie                           | u of Form CMS-2 | 2552-10 |
|---------|---|----------------------------|----------------|----------------------------------|-----------------|---------|
| STATEM  | ENT OF REVENUES AND EXPENSES                  | Provi de                   | r CCN: 15-0172 | Peri od:                         | Worksheet G-3   |         |
|         |   |                            |                | From 01/01/2018<br>To 12/31/2018 | Date/Time Pre   | nared:  |
|         |   |                            |                | 10 12/31/2010                    | 5/30/2019 5: 2  |         |
|         |   |                            |                | •                                |                 |         |
|         |   |                            |                |                                  | 1. 00           |         |
| 1.00    | Total patient revenues (from Wkst. G-2, Part  | I, column 3, line 28)      |                |                                  | 181, 161, 342   | 1. 00   |
| 2.00    | Less contractual allowances and discounts on  | patients' accounts         |                |                                  | 137, 439, 787   | 2. 00   |
| 3.00    | Net patient revenues (line 1 minus line 2)    |                            |                |                                  | 43, 721, 555    | 3. 00   |
| 4.00    | Less total operating expenses (from Wkst. G-2 | 2, Part II, line 43)       |                |                                  | 37, 395, 385    | 4.00    |
| 5.00    | Net income from service to patients (line 3 r | ninus line 4)              |                |                                  | 6, 326, 170     | 5. 00   |
|         | OTHER INCOME                                  |                            |                |                                  |                 |         |
| 6.00    | Contributions, donations, bequests, etc       |                            |                |                                  | 0               | 6. 00   |
| 7.00    | Income from investments                       |                            |                |                                  | 3, 402          |         |
| 8.00    | Revenues from telephone and other miscellaneo | ous communication services | 5              |                                  | 0               | 8. 00   |
| 9.00    | Revenue from television and radio service     |                            |                |                                  | 0               | 9. 00   |
| 10.00   | Purchase di scounts                           |                            |                |                                  | 0               | 10.00   |
| 11. 00  | Rebates and refunds of expenses               |                            |                |                                  | 0               |         |
|         | Parking Lot receipts                          |                            |                |                                  | 0               |         |
| 13.00   | Revenue from Laundry and Linen service        |                            |                |                                  | 0               |         |
| 14.00   | Revenue from meals sold to employees and gues | sts                        |                |                                  | 0               | 14. 00  |
|         | Revenue from rental of living quarters        |                            |                |                                  | 0               | 1       |
|         | Revenue from sale of medical and surgical sup |                            | ents           |                                  | 0               | 16. 00  |
|         | Revenue from sale of drugs to other than pati |                            |                |                                  | 0               | 17. 00  |
| 18. 00  | Revenue from sale of medical records and abs  |                            |                |                                  | 68, 224         |         |
| 19.00   | Tuition (fees, sale of textbooks, uniforms, e | etc.)                      |                |                                  | 0               | 19. 00  |
|         | Revenue from gifts, flowers, coffee shops, ar | nd canteen                 |                |                                  | 0               |         |
|         | Rental of vending machines                    |                            |                |                                  | 0               |         |
| 22. 00  | Rental of hospital space                      |                            |                |                                  | 0               |         |
| 23.00   | Governmental appropriations                   |                            |                |                                  | 0               | 23. 00  |
| 24.00   | FREESTANDING REFERENCE LAB                    |                            |                |                                  | 5, 188, 809     | 24. 00  |
| 24. 01  | FREESTANDING REFERENCE LAB                    |                            |                |                                  | 0               | 24. 01  |
| 24. 02  | OTHER (SPECIFY)                               |                            |                |                                  | 0               | 24. 02  |
| 25. 00  | Total other income (sum of lines 6-24)        |                            |                |                                  | 5, 260, 435     |         |
|         | Total (line 5 plus line 25)                   |                            |                |                                  | 11, 586, 605    |         |
| 27. 00  |   |                            |                |                                  | 3, 013, 631     |         |
|         | LOSS ON SALE OF ASSET                         |                            |                |                                  | 752, 769        |         |
| 27 02   | ROTINDI NG                                    |                            |                |                                  | 1 1             | 27 02   |

27. 02

3, 766, 401 28. 00 7, 820, 204 29. 00

27. 02 ROUNDI NG

28.00 Total other expenses (sum of line 27 and subscripts)
29.00 Net income (or loss) for the period (line 26 minus line 28)

|   |  | EDI CAL CENTER  |  | u of Form CMS-2   | 2552-1  |
|---|--|---|--|---|---|
| CALCU   | LATION OF CAPITAL PAYMENT  | Provi der CCN: 15-0172  | Peri od:<br>From 01/01/2018<br>To 12/31/2018 | Worksheet L<br>Parts I-III<br>Date/Time Pre<br>5/30/2019 5:24 |   |
|   |  | Title XVIII   | Hospi tal                                    | PPS   |   |
|   |  |   |  | 1. 00   |   |
|   | PART I - FULLY PROSPECTIVE METHOD  |   | <u> </u>                                     | 1.00  |   |
|   | CAPITAL FEDERAL AMOUNT   |   |  |   | 1   |
| 1. 00   | Capital DRG other than outlier   |   |  | 95, 265   | 1.0   |
| 1. 01   | Model 4 BPCI Capital DRG other than outlier  |   |  | 0   | 1.0   |
| 2. 00   | Capital DRG outlier payments   |   |  | 141   | 2. 0  |
| 2. 01   | Model 4 BPCI Capital DRG outlier payments  |   |  | 0   |   |
| 3.00  | Total inpatient days divided by number of days in the cos  | t reporting period (see inst  | ructions)                                    | 3. 44   |   |
| 4. 00<br>5. 00  | Number of interns & residents (see instructions)   |   |  | 0. 00<br>0. 00  |   |
| 6. 00   | Indirect medical education percentage (see instructions) Indirect medical education adjustment (multiply line 5 by   | the sum of lines 1 and 1 01   | columns 1 and                                | 0.00  | 6.0   |
| 3. 00   | 1. 01) (see instructions)  | the sum of fittes fand f. of  | , corumns r and                              | O   | 0.0   |
| 7. 00   | Percentage of SSI recipient patient days to Medicare Part  | A patient days (Worksheet E   | , part A line                                | 0.00  | 7.0   |
|   | 30) (see instructions)   | , , ,   | •  |   |   |
| 3. 00   | Percentage of Medicaid patient days to total days (see in:   | structions)   |  | 0.00  |   |
| 9. 00   | Sum of lines 7 and 8   |   |  | 0. 00   |   |
| 10.00   |  | ons)  |  | 0.00  |   |
| 11.00   |  |   |  | 0<br>0<br>0<br>0  | 11.0  |
| 12. 00  | Total prospective capital payments (see instructions)  |   |  | 95, 406   | 12.0  |
|   |  |   |  | 1. 00   |   |
|   | PART II - PAYMENT UNDER REASONABLE COST  |   |  |   |   |
| 1. 00   | Program inpatient routine capital cost (see instructions)  |   |  | 0   | 1.0   |
| 2. 00   | Program inpatient ancillary capital cost (see instruction  | s)  |  | 0   |   |
| 3.00  | Total inpatient program capital cost (line 1 plus line 2)  |   |  | 0   | 1   |
| 4. 00<br>5. 00  | Capital cost payment factor (see instructions) Total inpatient program capital cost (line 3 x line 4)  |   |  | 0   |   |
| 3.00  | Total Theatrent program capital cost (Title 3 x Title 4)   |   |  | 0   | 3.0   |
|   |  |   |  | 4 00  |   |
|   |  |   |  | 1. 00   |   |
|   | PART III - COMPUTATION OF EXCEPTION PAYMENTS   |   |  |   |   |
|   | Program inpatient capital costs (see instructions)   | topogo (ogo i potruoti opo)   |  | 0   |   |
| 2. 00   | Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circums   | tances (see instructions)   |  | 0   | 2.0   |
| 2. 00<br>3. 00  | Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circums Net program inpatient capital costs (line 1 minus line 2)   | tances (see instructions)   |  | 0 0   | 2. C  |
| 2. 00<br>3. 00<br>4. 00   | Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circums Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions)  | tances (see instructions)   |  | 0   | 2. 0<br>3. 0<br>4. 0  |
| 2.00<br>3.00<br>4.00<br>5.00  | Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circums Net program inpatient capital costs (line 1 minus line 2)   | ,   |  | 0<br>0<br>0<br>0.00   | 2. 0<br>3. 0<br>4. 0<br>5. 0  |
| 2. 00<br>3. 00<br>4. 00<br>5. 00<br>6. 00   | Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circums Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4)  | e instructions)   | (line 6)                                     | 0<br>0<br>0<br>0.00   | 2. 0<br>3. 0<br>4. 0<br>5. 0<br>6. 0  |
| 2. 00<br>3. 00<br>4. 00<br>5. 00<br>6. 00<br>7. 00  | Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circums Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see Adjustment to capital minimum payment level for extraordical capital minimum payment level (line 5 plus line 7)   | e instructions)<br>nary circumstances (line 2 x   | cline 6)                                     | 0<br>0<br>0<br>0.00<br>0<br>0.00                              | 2. 0<br>3. 0<br>4. 0<br>5. 0<br>6. 0<br>7. 0  |
| 2. 00<br>3. 00<br>4. 00<br>5. 00<br>7. 00<br>3. 00<br>9. 00   | Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circums Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see Adjustment to capital minimum payment level for extraordicapital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as a   | e instructions)<br>nary circumstances (line 2 x   | ŕ  | 0<br>0<br>0<br>0.00<br>0<br>0.00<br>0                         | 2. 0<br>3. 0<br>4. 0<br>5. 0<br>6. 0<br>7. 0<br>8. 0<br>9. 0                                      |
| 2. 00<br>3. 00<br>4. 00<br>5. 00<br>6. 00<br>7. 00<br>3. 00<br>9. 00  | Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circums Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see Adjustment to capital minimum payment level for extraordi Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as a Current year comparison of capital minimum payment level   | e instructions)<br>nary circumstances (line 2 x<br>oplicable)<br>to capital payments (line 8  | less line 9)                                 | 0<br>0<br>0<br>0.00<br>0<br>0.00<br>0                         | 2. 0<br>3. 0<br>4. 0<br>5. 0<br>6. 0<br>7. 0<br>8. 0<br>9. 0<br>10. 0                             |
| 2. 00<br>3. 00<br>4. 00<br>5. 00<br>6. 00<br>7. 00<br>3. 00<br>9. 00  | Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circums Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see Adjustment to capital minimum payment level for extraordic Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as a Current year comparison of capital minimum payment level Carryover of accumulated capital minimum payment level over  | e instructions)<br>nary circumstances (line 2 x<br>oplicable)<br>to capital payments (line 8<br>er capital payment (from pri  | less line 9)<br>or year                      | 0<br>0<br>0.00<br>0<br>0.00<br>0<br>0<br>0                    | 2. 0<br>3. 0<br>4. 0<br>5. 0<br>6. 0<br>7. 0<br>8. 0<br>9. 0                                      |
| 2. 00<br>3. 00<br>4. 00<br>5. 00<br>6. 00<br>7. 00<br>8. 00<br>9. 00<br>11. 00  | Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circums Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see Adjustment to capital minimum payment level for extraordic Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as a Current year comparison of capital minimum payment level Carryover of accumulated capital minimum payment level ove Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital  | e instructions) nary circumstances (line 2 x oplicable) to capital payments (line 8 er capital payment (from pri  | less line 9)<br>or year<br>ne 11)            | 0<br>0<br>0<br>0.00<br>0<br>0.00<br>0<br>0                    | 2. 0<br>3. 0<br>4. 0<br>5. 0<br>6. 0<br>7. 0<br>8. 0<br>9. 0<br>10. 0<br>11. 0                    |
| 2. 00<br>3. 00<br>4. 00<br>5. 00<br>6. 00<br>7. 00<br>8. 00<br>9. 00<br>10. 00<br>11. 00<br>12. 00<br>13. 00          | Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circums Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see Adjustment to capital minimum payment level for extraordicapital minimum payment level for extraordicapital minimum payments (from Part I, line 12, as a Current year comparison of capital minimum payment level carryover of accumulated capital minimum payment level over Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital current year exception payment (if line 12 is positive, etc.)  | e instructions) nary circumstances (line 2 x oplicable) to capital payments (line 8 er capital payment (from pri  | less line 9)<br>or year<br>ne 11)            | 0<br>0<br>0.00<br>0.00<br>0.00<br>0<br>0                      | 2. C<br>3. C<br>4. C<br>5. C<br>6. C<br>7. C<br>9. C<br>10. C<br>11. C                            |
| 2. 00<br>3. 00<br>4. 00<br>5. 00<br>6. 00<br>7. 00<br>8. 00<br>9. 00<br>10. 00<br>11. 00<br>12. 00<br>13. 00          | Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circums Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see Adjustment to capital minimum payment level for extraordicapital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as and Current year comparison of capital minimum payment level over Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital Current year exception payment (if line 12 is positive, etcarryover of accumulated capital minimum payment level over Carryover of | e instructions) nary circumstances (line 2 x oplicable) to capital payments (line 8 er capital payment (from pri  | less line 9)<br>or year<br>ne 11)            | 0<br>0<br>0<br>0.00<br>0<br>0.00<br>0<br>0                    | 2. C<br>3. C<br>4. C<br>5. C<br>6. C<br>7. C<br>9. C<br>10. C<br>11. C                            |
| 1. 00<br>2. 00<br>3. 00<br>4. 00<br>5. 00<br>6. 00<br>7. 00<br>8. 00<br>9. 00<br>11. 00<br>12. 00<br>13. 00<br>14. 00 | Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circums Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see Adjustment to capital minimum payment level for extraordinary Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as an Current year comparison of capital minimum payment level Carryover of accumulated capital minimum payment level ove Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital Current year exception payment (if line 12 is positive, en Carryover of accumulated capital minimum payment level ove (if line 12 is negative, enter the amount on this line)  | e instructions) nary circumstances (line 2 x oplicable) to capital payments (line 8 er capital payment (from pri l payments (line 10 plus line of the amount on this line er capital payment for the f                | less line 9)<br>or year<br>ne 11)            | 0<br>0<br>0<br>0.00<br>0<br>0.00<br>0<br>0<br>0               | 3. 0<br>4. 0<br>5. 0<br>6. 0<br>7. 0<br>8. 0<br>9. 0<br>10. 0<br>11. 0<br>12. 0<br>13. 0<br>14. 0 |
| 2. 00<br>3. 00<br>4. 00<br>5. 00<br>6. 00<br>7. 00<br>8. 00<br>9. 00<br>10. 00<br>11. 00<br>12. 00<br>13. 00          | Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circums Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see Adjustment to capital minimum payment level for extraordic Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as a Current year comparison of capital minimum payment level Carryover of accumulated capital minimum payment level ove Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital Current year exception payment (if line 12 is positive, et Carryover of accumulated capital minimum payment level ove (if line 12 is negative, enter the amount on this line) Current year allowable operating and capital payment (see  | e instructions) nary circumstances (line 2 x oplicable) to capital payments (line 8 er capital payment (from pri l payments (line 10 plus lir nter the amount on this line er capital payment for the f instructions) | less line 9)<br>or year<br>ne 11)            | 0<br>0<br>0.00<br>0.00<br>0.00<br>0<br>0                      | 2. 0<br>3. 0<br>4. 0<br>5. 0<br>6. 0<br>7. 0<br>8. 0<br>9. 0<br>10. 0<br>11. 0                    |