This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 03-31-2022 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION | Provider CCN: 15-0097 Worksheet S Peri od: From 01/01/2020 Parts I-III AND SETTLEMENT SUMMARY 12/31/2020 Date/Time Prepared: 8/2/2021 2:11 pm PART I - COST REPORT STATUS Provi der 1. [ X ] Electronically prepared cost report Date: 8/2/2021 Ti me: 2:11 pm Manually prepared cost report use only ]If this is an amended report enter the number of times the provider resubmitted this cost report]Medicare Utilization. Enter "F" for full or "L" for low. 6. Date Received: 7. Contractor No. 10. NPR Date: Contractor ]Cost Report Status (1) As Submitted

7. Contractor No.

(2) Settled without Audit 8. [ N ] Initial Report for this Provider CCN 12. [ 0 ] If line 5, column 1 is 4: Enter (3) Settled with Audit

9. [ N ] Final Report for this Provider CCN | number of times reopened = 0-9. 11. Contractor's Vendor Code: use only (3) Settled with Audit number of times reopened = 0-9. (4) Reopened

## PART II - CERTIFICATION

(5) Amended

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by MAJOR HOSPITAL (15-0097) for the cost reporting period beginning 01/01/2020 and ending 12/31/2020 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

[ 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.

(Si gned) RALPH MERCURI
Officer or Administrator of Provider(s)

CF0 Title

(Dated when report is electronically signed.)
Date

|        |                               |         | Title    | XVIII       |       |           |        |
|--------|-------------------------------|---------|----------|-------------|-------|-----------|--------|
|        | Cost Center Description       | Title V | Part A   | Part B      | HIT   | Title XIX |        |
|        |                               | 1. 00   | 2.00     | 3. 00       | 4. 00 | 5. 00     |        |
|        | PART III - SETTLEMENT SUMMARY |         |          |             |       |           |        |
| 1.00   | Hospi tal                     | 0       | 274, 459 | -6, 803     | 0     | -220, 752 | 1.00   |
| 2.00   | Subprovider - IPF             | 0       | 0        | 0           |       | 0         | 2.00   |
| 3.00   | Subprovider - IRF             | 0       | 0        | 0           |       | 0         | 3.00   |
| 5.00   | Swing Bed - SNF               | 0       | 0        | 0           |       | 0         | 5.00   |
| 6.00   | Swing Bed - NF                | 0       |          |             |       | 0         | 6.00   |
| 9.00   | HOME HEALTH AGENCY I          | 0       | 0        | 0           |       | 0         | 9.00   |
| 10.00  | RURAL HEALTH CLINIC I         | 0       |          | 2, 108      |       | 0         | 10.00  |
| 10.01  | RURAL HEALTH CLINIC II        | 0       |          | 25, 456     |       | 0         | 10. 01 |
| 10.02  | RURAL HEALTH CLINIC III       | 0       |          | 1, 017, 657 |       | 0         | 10.02  |
| 200.00 | Total                         | 0       | 274, 459 | 1, 038, 418 | 0     | -220, 752 | 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.

Ν

N

3

Ν

Ν

Ν

22.02

22 03

23.00

N

22.02 Is this a newly merged hospital that requires final uncompensated care

22.03 Did this hospital receive a geographic reclassification from urban to

23.00 Which method is used to determine Medicaid days on lines 24 and/or 25

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

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

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.

October 1

yes or "N" for no.

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.

Ν

N

58.00

59.00

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.

|   | JOR HOS                      |                    |                   |  | u of Form CMS-2   |        |
|---|------------------------------|--------------------|-------------------|--|---|--------|
| OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA  | TA                           | Provi der CC       | CN: 15-0097       | Peri od:<br>From 01/01/2020<br>To 12/31/2020 | Worksheet S-2<br>Part I<br>Date/Time Pre<br>8/2/2021 2:11 | pared: |
|   |                              |                    | NAHE 413.8<br>Y/N | Worksheet A<br>Line #                        | Pass-Through<br>Qualification<br>Criterion<br>Code        |        |
| 0.00  | (NIALIE)                     |                    | 1.00              | 2. 00  | 3. 00   | (0.00  |
| 0.00 Are you claiming nursing and allied health education any programs that meet the criteria under 42 CFR 413. instructions) Enter "Y" for yes or "N" for no in colis "Y", are you impacted by CR 11642 (or subsequent (adjustement? Enter "Y" for yes or "N" for no in colu | 85? (s<br>umn 1.<br>CR) NAHE | see<br>If column 1 | N                 |  |   | 60.00  |
|   | Y/N                          | I ME               | Direct GME        | IME  | Direct GME  |        |
|   | 1.00                         | 2. 00              | 3. 00             | 4. 00  | 5. 00   |        |
| 1.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)  | N                            |                    |                   | 0.00   | 0.00  | 61.0   |
| 1.01 Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)   |                              |                    |                   |  |   | 61.0   |
| #1.02 Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)  |                              |                    |                   |  |   | 61.02  |
| 1.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)  |                              |                    |                   |  |   | 61.03  |
| 1.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).  |                              |                    |                   |  |   | 61.04  |
| 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. 0  |
| 1.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)  | _                            |                    |                   |  |   | 61.00  |
|   | Pro                          | ogram Name         | Program Coc       | IME FTE Count                                | Unweighted<br>Direct GME<br>FTE Count                     |        |
| 1.10 Of the FTEs in line 61.05, specify each new program  |                              | 1. 00              | 2. 00             | 3.00   | 4.00  | 61. 1  |
| 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                      |                              |                    |                   | 0.00   | 0.00  | 01. 1  |
| FTE unweighted count.  1.20 Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name.  |                              |                    |                   | 0.00   | 0. 00   | 61. 20 |
| Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.   |                              |                    |                   |  |   |        |
|   |                              |                    |                   |  | 1.00  |        |
| ACA Provisions Affecting the Health Resources and Ser<br>2.00 Enter the number of FTE residents that your hospital  | trai neo                     |                    |                   | period for which                             | 0.00  | 62.00  |
| your hospital received HRSA PCRE funding (see instruction 2.01 Enter the number of FTE residents that rotated from a  | ctions)<br>i Teachi          | ing Health Cen     | iter (THC) in     |  |   | 62. 0° |
| during in this cost reporting period of HRSA THC prog<br>Teaching Hospitals that Claim Residents in Nonprovide<br>3.00 Has your facility trained residents in nonprovider se  | er Setti                     | i ngs              |                   | ng neriod? Enter                             | N   | 63.00  |
|   |                              |                    | 67. (see ins      |  | l IN  | 05.0   |

| Health Financial Systems  | MA   | JOR HOSPITAL  |  | In Lie                            | u of Form CMS-2  | 2552-10 |
|---|--|---|--|-----------------------------------|--|---------|
| HOSPITAL AND HOSPITAL HEALTH CARE COMP  |  |   |  | eriod:<br>com 01/01/2020          | Worksheet S-2<br>Part I<br>Date/Time Pre                 | pared:  |
|   |  |   | Unwei ghted<br>FTEs<br>Nonprovi der<br>Si te | Unweighted<br>FTEs in<br>Hospital | 8/2/2021 2:11<br>Ratio (col.<br>1/ (col. 1 +<br>col. 2)) | pm      |
| Costion FEOA of the ACA Dage Ver  | on ETE Dooidonto in N  | annavi dan Catti nga  | 1. 00  | 2. 00                             | 3.00   |         |
| Section 5504 of the ACA Base Year period that begins on or after a  |  |   | - mis base year                              | is your cost                      | reporting  |         |
| 64.00 Enter in column 1, if line 63 is in the base year period, the num resident FTEs attributable to resettings. Enter in column 2 the resident FTEs that trained in your of (column 1 divided by (column)   | s yes, or your faciliaber of unweighted now<br>tations occurring in<br>a number of unweighted<br>our hospital. Enter in    | ty trained residents<br>n-primary care<br>all nonprovider<br>d non-primary care<br>n column 3 the ratio |  | 0.00                              | 0. 000000  | 64.00   |
|   | Program Name   | Program Code  | Unwei ghted                                  | Unwei ghted                       | Ratio (col.  |         |
|   |  |   | FTEs<br>Nonprovider<br>Site                  | FTEs in<br>Hospital               | 3/ (col. 3 + col. 4))                                    |         |
| (5.00   5.1   1.0 | 1. 00  | 2. 00   | 3.00   | 4. 00                             | 5. 00  | /F 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 divided by (column 3 + column 4)). (see instructions)  |  |   | 0.00   | 0.00                              | 0.000000<br>Ratio (col.                                  | 65. 00  |
|   |  |   | FTEs   | FTEs in                           | 1/ (col. 1 +   |         |
|   |  |   | Nonprovi der<br>Si te                        | Hospi tal                         | col. 2))   |         |
|   |  |   | 1. 00  | 2. 00                             | 3.00   |         |
| Section 5504 of the ACA Current   |  | n Nonprovider Settin  | gsEffective f                                | or cost report                    | ing periods  |         |
| beginning on or after July 1, 20 66.00 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 divided)   | unweighted non-priman<br>occurring in all nonpo<br>unweighted non-priman<br>cal. Enter in column (<br>column 2)). (see ins | rovider settings.<br>ry care resident<br>3 the ratio of<br>structions)                                  | 0.00   |                                   |  | 66.00   |
|   | Program Name   | Program Code  | Unwei ghted<br>FTEs<br>Nonprovi der<br>Si te | Unweighted<br>FTEs in<br>Hospital | Ratio (col.<br>3/ (col. 3 +<br>col. 4))                  |         |
|   | 1. 00  | 2. 00   | 3. 00  | 4. 00                             | 5. 00  |         |
| 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)   |  |   | 0.00   | 0.00                              | 0.000000   | 67. 00  |

|                  | AL AND HUSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA  | Vi dei CCN: 15-0097   | From 01/01/20<br>To 12/31/20   | 020   I<br>020   I | worksne<br>Part I<br>Date/Ti<br>8/2/202 | me Pre  | epared:            |
|------------------|--|---|--------------------------------|--------------------|---|---|--------------------|
|                  |  |   |                                | 1. 00              | 2. 00                                   | 3. 00   |                    |
| 70. 00           | Inpatient Psychiatric Facility PPS  Is this facility an Inpatient Psychiatric Facility (IPF), or does  | it contain an IDE si  | ıbnrovi der2                   | N                  |   |   | 70.00              |
| 70.00            | Enter "Y" for yes or "N" for no.   | Tt contain an iii 30  | abpi ovi dei :                 | IN                 |   |   | 70.00              |
| 71.00            | If line 70 is yes: Column 1: Did the facility have an approved GME recent cost report filed on or before November 15, 2004? Enter "Y 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train reprogram in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y Column 3: If column 2 is Y, indicate which program year began duri   | " for yes or "N" for<br>esidents in a new tea<br>" for yes or "N" for | no. (see achi ng no.           |                    |   | 0   | 71.00              |
|                  | (see instructions) Inpatient Rehabilitation Facility PPS   |   |                                |                    |   |   | -                  |
| 75. 00           | Is this facility an Inpatient Rehabilitation Facility (IRF), or do   | es it contain an IRI  | =                              | N                  |   |   | 75.0               |
| 76. 00           | subprovider? Enter "Y" for yes and "N" for no.  If line 75 is yes: Column 1: Did the facility have an approved GME recent cost reporting period ending on or before November 15, 2004 no. Column 2: Did this facility train residents in a new teaching CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Colum indicate which program year began during this cost reporting period | ?? Enter "Y" for yes<br>program in accordand<br>nn 3: If column 2 is  | or "N" for<br>ce with 42<br>Y, |                    |   | 0   | 76. 0              |
|                  |  |   |                                |                    | 1.0                                     | \ <u>\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\</u> |                    |
|                  | Long Term Care Hospital PPS  |   |                                |                    | 1. C                                    | )()   |                    |
| 80. 00<br>81. 00 | Is this a long term care hospital (LTCH)? Enter "Y" for yes and "Is this a LTCH co-located within another hospital for part or all "Y" for yes and "N" for no.  TEFRA Providers  |   | ng period? En                  | ter                | N<br>N                                  |   | 80. 00<br>81. 00   |
|                  | Is this a new hospital under 42 CFR Section $\S413.40(f)(1)(i)$ TEFRADIC Did this facility establish a new Other subprovider (excluded unit $\S413.40(f)(1)(ii)$ ? Enter "Y" for yes and "N" for no.   |   |                                | no.                | N                                       |   | 85. 00<br>86. 00   |
| 87. 00           | Is this hospital an extended neoplastic disease care hospital clas<br>1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.  | sified under section  | า                              |                    | N                                       |   | 87.00              |
|                  | 1000(d)(1)(b)(vi): Litter 1 10i yes or in 10i iio.   |   | V                              |                    | XL                                      | Χ   |                    |
|                  | THE WALL WAY COLUMN  |   | 1.00                           |                    | 2.0                                     | 00  |                    |
| 90. 00           | Title V and XIX Services  Does this facility have title V and/or XIX inpatient hospital serv   | vices? Enter "Y" for  | N                              |                    | Υ                                       |   | 90.00              |
| 91. 00           | yes or "N" for no in the applicable column.<br>Is this hospital reimbursed for title V and/or XIX through the cosfull or in part? Enter "Y" for yes or "N" for no in the applicable  |   | N                              |                    | Υ                                       |   | 91.00              |
| 92. 00           | Are title XIX NF patients occupying title XVIII SNF beds (dual cer   | tification)? (see   |                                |                    | N                                       |   | 92.00              |
| 93. 00           | instructions) Enter "Y" for yes or "N" for no in the applicable co<br>Does this facility operate an ICF/IID facility for purposes of tit<br>"Y" for yes or "N" for no in the applicable column.  |   | N                              |                    | N                                       |   | 93.00              |
| 94. 00           | Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N   | l" for no in the  | N                              |                    | N                                       |   | 94.00              |
| 95. 00<br>96. 00 | applicable column.  If line 94 is "Y", enter the reduction percentage in the applicabl Does title V or XIX reduce operating cost? Enter "Y" for yes or "North to be a limb   |   | 0. 00<br>N                     |                    | O. C<br>N                               |   | 95. 00<br>96. 00   |
| 97. 00<br>98. 00 | applicable column.  If line 96 is "Y", enter the reduction percentage in the applicabl Does title V or XIX follow Medicare (title XVIII) for the interns stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes  | and residents post  | 0. 00<br>Y                     |                    | 0. C<br>Y                               |   | 97. 00<br>98. 00   |
| 98. 01           | column 1 for title V, and in column 2 for title XIX.  Does title V or XIX follow Medicare (title XVIII) for the reportir C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, title XIX.   |   |                                |                    | Υ                                       |   | 98.0               |
| 98. 02           | Does title V or XIX follow Medicare (title XVIII) for the calculat<br>bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N"<br>for title V, and in column 2 for title XIX.   |   | Y                              |                    | Υ                                       |   | 98. 0              |
| 98. 03           | Does title V or XIX follow Medicare (title XVIII) for a critical a reimbursed 101% of inpatient services cost? Enter "Y" for yes or "for title V, and in column 2 for title XIX.   |   |                                |                    | N                                       |   | 98.0               |
| 98. 04           | Does title V or XIX follow Medicare (title XVIII) for a CAH reimbu<br>outpatient services cost? Enter "Y" for yes or "N" for no in colum<br>in column 2 for title XIX.   |   | N                              |                    | N                                       |   | 98.0               |
| 98. 05           | Does title V or XIX follow Medicare (title XVIII) and add back the Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column column 2 for title XIX.   |   |                                |                    | Υ                                       |   | 98.0               |
| 98. 06           | Does title V or XIX follow Medicare (title XVIII) when cost reimbu<br>Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for<br>column 2 for title XIX.<br>Rural Providers   |   | Y                              |                    | Y                                       |   | 98.0               |
|                  | Does this hospital qualify as a CAH?<br>If this facility qualifies as a CAH, has it elected the all-inclus   | sive method of paymen   | nt N                           |                    |   |   | 105. 00<br>106. 00 |
| 107. 00          | for outpatient services? (see instructions) Column 1: If line 105 is Y, is this facility eligible for cost rei training programs? Enter "Y" for yes or "N" for no in column 1. ( Column 2: If column 1 is Y and line 70 or line 75 is Y, do you tr approved medical education program in the CAH's excluded IPF and/ Enter "Y" for yes or "N" for no in column 2. (see instructions)           | (see instructions)<br>Tain I&Rs in an                                 | N                              |                    |   |   | 107. 00            |

| OSPITAL AND HOSPITAL HEALTH CARE COMPLEX  | MAJOR HO  |   |                 |                             |                         | u of Form CMS                  |                  |
|---|---|---|-----------------|-----------------------------|-------------------------|--------------------------------|------------------|
|   | ( IDENTIFICATION DATA   | Provi der CC  | CN: 15-0097     | Period:                     | 1/01/2020               | Worksheet S-<br>Part I         | -2               |
|   |   |   |                 |                             | 2/31/2020               | Date/Time Pi                   |                  |
|   |   |   |                 |                             |                         | 8/2/2021 2: 1                  | II pm            |
|   |   |   |                 |                             | 1. 00                   | 2. 00                          |                  |
| 30.00 If this is a Medicare certified par   |   |   | ti fi cati on   |                             |                         |                                | 130. (           |
| date in column 1 and termination da<br>31.00 If this is a Medicare certified in   | testinal transplant cente   | er, enter the c   | erti fi cati oı | n                           |                         |                                | 131. (           |
| date in column 1 and termination da<br>32.00  f this is a Medicare certified isl  |   |   | ication date    |                             |                         |                                | 132. (           |
| in column 1 and termination date, i   |   |   | ication date    |                             |                         |                                | 132.             |
| 33.00 Removed and reserved  |   |   |                 |                             |                         |                                | 133.             |
| 34.00  f this is an organ procurement organd termination date, if applicable  | . ,   | the OPO number  | in column 1     |                             |                         |                                | 134.             |
| All Providers 40.00 Are there any related organization  |   |   |                 |                             | Υ                       |                                | 140.             |
| chapter 10? Enter "Y" for yes or "Name claimed, enter in column 2 the   |   |   |                 | ts                          |                         |                                |                  |
| 1.00  | 2.0   |   | trons)          |                             | 3. 00                   |                                |                  |
| If this facility is part of a chair   |   |   | ough 143 the    | name an                     | d address               | of the home                    |                  |
| office and enter the home office co   |   | actor number.   |                 | l N                         |                         |                                |                  |
| 41. 00 Name:<br>42. 00 Street:  | Contractor's Name:<br>PO Box:   |   | Contrac         | tor's Nu                    | mber:                   |                                | 141. (           |
| 43. 00 Ci ty:   | State:  |   | Zi p Cod        | e:                          |                         |                                | 143.             |
|   |   |   |                 |                             |                         |                                |                  |
| 14 00 Are provider based physicians!  | to included in Westerbeat   | A 2   |                 |                             |                         | 1. 00<br>Y                     | 144. (           |
| 44.00 Are provider based physicians' cost   | ts included in worksheet  | A?  |                 |                             |                         | Y                              | 144.             |
|   |   |   |                 |                             | 1. 00                   | 2. 00                          |                  |
| 45.00 If costs for renal services are cla   |   |   |                 |                             |                         |                                | 145.             |
| inpatient services only? Enter "Y" no, does the dialysis facility incl  |   |   |                 |                             |                         |                                |                  |
| period? Enter "Y" for yes or "N" 1  |   | 1 TOT LITTS COST  | reporting       |                             |                         |                                |                  |
| 46.00 Has the cost allocation methodology   |   | ously filed cos   | t report?       |                             | N                       |                                | 146.             |
| Enter "Y" for yes or "N" for no in  |   | 15-2, chapter   | 40, §4020)      | lf                          |                         |                                |                  |
| yes, enter the approval date (mm/do   | d/yyyy) in column 2.  |   |                 |                             |                         |                                |                  |
|   |   |   |                 |                             |                         | 1. 00                          | -                |
| 47.00 Was there a change in the statistic   | cal basis? Enter "Y" for  | yes or "N" for  | no.             |                             |                         | N                              | 147. (           |
| 48.00 Was there a change in the order of  |   | ,   |                 |                             |                         | N                              | 148. (           |
| 49.00 Was there a change to the simplific   | ed cost finding method? E   | enter "Y" for y Part A  | es or "N" fo    |                             | itle V                  | N<br>Title XIX                 | 149. (           |
|   |   | 1.00  | 2. 00           | <u>'</u>                    | 3. 00                   | 4.00                           |                  |
| Does this facility contain a provi  |   |   |                 |                             |                         |                                |                  |
| or charges? Enter "Y" for yes or "I<br>55.00 Hospi tal  | N" for no for each compor   |   | and Part B<br>N | . (See 4                    | · <u>2 CFR §41</u><br>N |                                | 155              |
| 56.00 Subprovider - IPF   |   | N<br>N  | N N             |                             | N                       | N<br>N                         | 155.<br>156.     |
| 57. 00 Subprovi der – IRF   |   | N   | N               |                             | N                       | N                              | 157. (           |
| 58. 00 SUBPROVI DER   |   |   |                 |                             |                         |                                | 158. (           |
| 59. 00 SNF  |   | N   | N N             |                             | N                       | N                              | 159.             |
| 50. 00 HOME HEALTH AGENCY   |   | N   | l N<br>l N      |                             | N<br>N                  | N<br>N                         | 160. (<br>161. ( |
| ST COOK MHC   |   |   |                 |                             | IV                      | IV.                            | 101.             |
| 61. 00 CMHC   |   |   |                 |                             |                         |                                |                  |
| Multicampus   |   |   |                 |                             |                         | 1. 00                          |                  |
| Multicampus<br>65.00 s this hospital part of a Multicar   | npus hospital that has or   | ne or more camp   |                 | ferent C                    | BSAs?                   | 1. 00<br>N                     | 165. (           |
| Multicampus   | · · · · · · · · · · · · · · · · · · ·   | ne or more camp   | uses in dif     |                             |                         | N                              | 165.             |
| Multicampus<br>65.00 s this hospital part of a Multicar   | mpus hospital that has or  Name  0  | <u> </u>  | uses in dif     | ferent C<br>ip Code<br>3.00 | BSAs?  CBSA 4.00        | N<br>FTE/Campus<br>5.00        |                  |
| Multicampus 55.00 is this hospital part of a Multicam Enter "Y" for yes or "N" for no.  | Name  | County  | uses in dif     | ip Code                     | CBSA                    | N<br>FTE/Campus<br>5.00        |                  |
| Multicampus 05.00 Is this hospital part of a Multicar Enter "Y" for yes or "N" for no.  06.00 If line 165 is yes, for each campus enter the name in column  | Name  | County  | uses in dif     | ip Code                     | CBSA                    | N<br>FTE/Campus<br>5.00        |                  |
| Multicampus 05.00 Is this hospital part of a Multicar Enter "Y" for yes or "N" for no.  66.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in  | Name  | County  | uses in dif     | ip Code                     | CBSA                    | N<br>FTE/Campus<br>5.00        |                  |
| Multicampus  55.00 Is this hospital part of a Multicam Enter "Y" for yes or "N" for no.  66.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in   | Name  | County  | uses in dif     | ip Code                     | CBSA                    | N<br>FTE/Campus<br>5.00        |                  |
| Multicampus 55.00 Is this hospital part of a Multicar Enter "Y" for yes or "N" for no.  66.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3,  | Name  | County  | uses in dif     | ip Code                     | CBSA                    | N<br>FTE/Campus<br>5.00        |                  |
| Multicampus  55.00 Is this hospital part of a Multicam Enter "Y" for yes or "N" for no.  66.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in   | Name  | County  | uses in dif     | ip Code                     | CBSA                    | N<br>FTE/Campus<br>5.00        |                  |
| Multicampus 05.00 Is this hospital part of a Multicar Enter "Y" for yes or "N" for no. 06.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)   | Name 0  | County 1.00  can Recovery an  | uses in diff    | i p Code<br>3.00            | CBSA                    | N<br>FTE/Campus<br>5.00<br>0.0 | 00 166.          |
| Multicampus  55.00 Is this hospital part of a Multicam Enter "Y" for yes or "N" for no.  66.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)  Health Information Technology (HIT) 67.00 Is this provider a meaningful user   | Name 0  incentive in the American under §1886(n)? Enter "   | County  1.00  can Recovery an 'Y" for yes or  | uses in dif     | ip Code<br>3.00             | CBSA 4.00               | N<br>FTE/Campus<br>5.00        | 00 166.          |
| Multicampus  55.00 Is this hospital part of a Multicamenter "Y" for yes or "N" for no.  66.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)  Health Information Technology (HIT)  57.00 Is this provider a meaningful user 58.00 If this provider is a CAH (line 105)                                  | Name  O  incentive in the America under \$1886(n)? Enter " 5 is "Y") and is a meanir  | County  1.00  can Recovery an "Y" for yes or ngful user (lin                                    | uses in dif     | ip Code<br>3.00             | CBSA 4.00               | N<br>FTE/Campus<br>5.00<br>0.0 | 165. (           |
| Multicampus 65.00 Is this hospital part of a Multicar Enter "Y" for yes or "N" for no. 66.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)  Health Information Technology (HIT) 67.00 Is this provider a meaningful user 58.00 If this provider is a CAH (line 105 reasonable cost incurred for the HI | Name  O  incentive in the Americ under §1886(n)? Enter " 5 is "Y") and is a meanir IT assets (see instruction   | County 1.00  can Recovery an 'Y" for yes or ngful user (lin                                     | uses in diff    | ip Code<br>3.00<br>ent Act  | CBSA 4.00               | N<br>FTE/Campus<br>5.00<br>0.0 | 00 166. (        |
| Multicampus 65.00 Is this hospital part of a Multicamenter "Y" for yes or "N" for no. 66.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)  Health Information Technology (HIT) 67.00 Is this provider a meaningful user 68.00 If this provider is a CAH (line 108)                                     | Name  O  incentive in the Americ under §1886(n)? Enter " 5 is "Y") and is a meanir IT assets (see instructio ot a meaningful user, doe Enter "Y" for yes or "N" | County  1.00  can Recovery an 'Y" for yes or gful user (lin ons) es this provide ' for no. (see | uses in dif     | ent Act "), ente            | CBSA<br>4.00            | N<br>FTE/Campus<br>5.00<br>0.0 | 167.             |

| Health Financial Systems  | MAJOR HOSPI | TAL |                         | In Lieu of Form CMS-2552-10 |               |         |  |
|---|-------------|-----|-------------------------|-----------------------------|---------------|---------|--|
| HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION  | Peri        |     | Worksheet S-2<br>Part I | 2                           |               |         |  |
|   |             |     | To                      |                             | Date/Time Pro | anared: |  |
|   |             |     | 10                      | 12/31/2020                  | 8/2/2021 2:1  | 1_pm    |  |
|   |             |     |                         | Begi nni ng                 | Endi ng       |         |  |
|   |             |     |                         | 1. 00                       | 2.00          |         |  |
| 170.00 Enter in columns 1 and 2 the EHR beginning date and period respectively (mm/dd/yyyy)   |             |     |                         | 170. 00                     |               |         |  |
|   |             |     |                         |                             |               |         |  |
|   |             |     |                         | 1. 00                       | 2.00          |         |  |
| 171.00 If line 167 is "Y", does this provider have any day  |             |     |                         | N                           | (             | 171. 00 |  |
| section 1876 Medicare cost plans reported on Wkst. "Y" for yes and "N" for no in column 1. If column 1876 Medicare days in column 2. (see instructions) | 1 is yes, e |     | on                      |                             |               |         |  |

|  | R HOSPITAL        | 2011 15 2007  |  | u of Form CM |                  |
|--|-------------------|---------------|--|--------------|------------------|
| HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE  | Provider          | CCN: 15-0097  | Peri od:<br>From 01/01/2020<br>To 12/31/2020 |              | repared:         |
|  | Desc              | ription       | Y/N  | Y/N          |                  |
| 20.00   If line 16 or 17 is yes, were adjustments made to PS&R   |                   | 0             | 1. 00<br>N                                   | 3. 00<br>N   | 20.00            |
| Report data for Other? Describe the other adjustments:   |                   |               | IN   | IN           | 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 (  | EXCEPT CHILDRENS  | HOSPI TALS)   |  | 1.00         |                  |
| Capital Related Cost   |                   | ,             |  |              |                  |
| 22.00 Have assets been relifed for Medicare purposes? If yes, 23.00 Have changes occurred in the Medicare depreciation expe                              |                   |               | ring the cost                                | N<br>N       | 22. 00<br>23. 00 |
| reporting period? If yes, see instructions.  24.00 Were new leases and/or amendments to existing leases en   | itered into durin | g this cost r | eporting period?                             | N            | 24. 00           |
| If yes, see instructions 25.00 Have there been new capitalized leases entered into dur instructions.   | ing the cost rep  | orting period | ? If yes, see                                | N            | 25. 00           |
| 26.00 Were assets subject to Sec. 2314 of DEFRA acquired durin instructions.   | g the cost repor  | ting period?  | If yes, see                                  | N            | 26. 00           |
| 27.00 Has the provider's capitalization policy changed during copy.  | the cost report   | ing period? I | f yes, submit                                | N            | 27. 00           |
| Interest Expense 28.00 Were new loans, mortgage agreements or letters of credi   | t entered into d  | uring the cos | t reporting                                  | N            | 28. 00           |
| period? If yes, see instructions.  29.00 Did the provider have a funded depreciation account and treated as a funded depreciation account? If yes, see i |                   | Debt Service  | Reserve Fund)                                | N            | 29. 00           |
| 30.00 Has existing debt been replaced prior to its scheduled instructions.   |                   | w debt? If ye | s, see                                       | N            | 30.00            |
| 31.00 Has debt been recalled before scheduled maturity withou instructions.  | it issuance of ne | w debt? If ye | s, see                                       | N            | 31.00            |
| Purchased Services 32.00 Have changes or new agreements occurred in patient care   |                   | hed through c | ontractual                                   | N            | 32.00            |
| arrangements with suppliers of services? If yes, see in 33.00 If line 32 is yes, were the requirements of Sec. 2135.2 no, see instructions.              |                   | ing to compet | itive bidding? If                            | N            | 33. 00           |
| Provi der-Based Physi ci ans   |                   |               |  |              |                  |
| 34.00 Are services furnished at the provider facility under a  | n arrangement wi  | th provider-b | ased physicians?                             | Υ            | 34.00            |
| If yes, see instructions.<br>35.00 If line 34 is yes, were there new agreements or amended   |                   | ents with the | provi der-based                              | N            | 35. 00           |
| physicians during the cost reporting period? If yes, se  | e instructions.   |               | V (0)  | 5 .          |                  |
|  |                   |               | Y/N<br>1. 00                                 | 2. 00        |                  |
| Home Office Costs  |                   |               | 1.00   | 2.00         |                  |
| 36.00 Were home office costs claimed on the cost report?   |                   |               | N  |              | 36.00            |
| 37.00 If line 36 is yes, has a home office cost statement bee  | n prepared by th  | e home office |  |              | 37.00            |
| If yes, see instructions.<br>38.00 If line 36 is yes , was the fiscal year end of the home   |                   |               |  |              | 38. 00           |
| the provider? If yes, enter in column 2 the fiscal year 39.00 If line 36 is yes, did the provider render services to                                     | end of the home   | office.       |  |              | 39. 00           |
| see instructions.  40.00 If line 36 is yes, did the provider render services to instructions.  | the home office?  | If yes, see   | N  |              | 40.00            |
| That detrois.  | 1                 | 1.00          | 2  | 00           |                  |
| Cost Report Preparer Contact Information   |                   |               | ٤.   |              |                  |
| 41.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3                                     | KYLE              |               | SMI TH                                       |              | 41.00            |
| respectively. 42.00 Enter the employer/company name of the cost report preparer.   | BLUE & CO         |               |  |              | 42.00            |
| 43.00 Enter the telephone number and email address of the cos  | st 317-713-7957   |               | KCSMI TH@BLUEAN                              |              | 43.00            |

| Health Financial Systems         | JOLAM                          | R HOSI | PITAL                  | In Lieu                             | of Form CMS-2 | 2552-10 |
|----------------------------------|--------------------------------|--------|------------------------|-------------------------------------|---------------|---------|
| HOSPITAL AND HOSPITAL HEALTH CAR | E REIMBURSEMENT QUESTIONNAIRE  |        | Provi der CCN: 15-0097 | i od:<br>m 01/01/2020<br>12/31/2020 | Date/Time Pre | pared:  |
|                                  |                                |        |                        | <br>                                | 8/2/2021 2:11 | pm      |
|                                  |                                |        | 3.00                   |                                     |               |         |
| Cost Report Preparer Conta       | ct Information                 |        |                        |                                     |               |         |
| 41.00 Enter the first name, last | name and the title/position    | SI     | ENIOR MANAGER          |                                     |               | 41.00   |
| held by the cost report p        | reparer in columns 1, 2, and 3 | 3,     |                        |                                     |               |         |
| respecti vel y.                  |                                |        |                        |                                     |               |         |
| 42.00 Enter the employer/company | y name of the cost report      |        |                        |                                     |               | 42.00   |
| preparer.                        |                                |        |                        |                                     |               |         |
| 43.00 Enter the telephone number | and email address of the cos   | st     |                        |                                     |               | 43.00   |
| report preparer in columns       | s 1 and 2. respectively.       |        |                        |                                     |               |         |

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

|                  |   |             |     |         | ''           | 0 12/31/2020 | 8/2/2021 2:11 |                  |
|------------------|---|-------------|-----|---------|--------------|--------------|---------------|------------------|
|                  |   |             |     |         |              |              | I/P Days /    |                  |
|                  |   |             |     |         |              |              | 0/P Visits /  |                  |
|                  |   |             |     |         |              |              | Tri ps        |                  |
|                  | Component   | Worksheet A | No. | of Beds | Bed Days     | CAH Hours    | Title V       |                  |
|                  |   | Line Number |     |         | Avai I abl e |              |               |                  |
|                  |   | 1. 00       |     | 2.00    | 3.00         | 4. 00        | 5. 00         |                  |
| 1. 00            | Hospital Adults & Peds. (columns 5, 6, 7 and  | 30. 00      |     | 12      | 14, 640      | 0. 00        | 0             | 1.00             |
|                  | 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 |             |     |         |              |              |               |                  |
|                  | for the portion of LDP room available beds)   |             |     |         |              |              |               |                  |
| 2. 00            | HMO and other (see instructions)  |             |     |         |              |              |               | 2.00             |
| 3.00             | HMO IPF Subprovider   |             |     |         |              |              |               | 3.00             |
| 4. 00            | HMO IRF Subprovider   |             |     |         |              |              |               | 4.00             |
| 5. 00            | Hospital Adults & Peds. Swing Bed SNF   |             |     |         |              |              | О             |                  |
| 6. 00            | Hospital Adults & Peds. Swing Bed NF  |             |     |         |              |              | 0             | 6.00             |
| 7. 00            | Total Adults and Peds. (exclude observation   |             |     | 12      | 14, 640      | 0.00         | 0             | 7.00             |
|                  | beds) (see instructions)  |             |     |         |              |              |               |                  |
| 8. 00            | INTENSIVE CARE UNIT   | 31.00       |     | 6       | 2, 196       | 0.00         | 0             | 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   |             |     | 4.0     | 4, 00,       | 0.00         |               | 13.00            |
| 14. 00           | Total (see instructions)  |             |     | 18      | 16, 836      | 0. 00        | 0             |                  |
| 15. 00<br>16. 00 | CAH visits<br>SUBPROVIDER - IPF   |             |     |         |              |              | 0             | 15. 00<br>16. 00 |
| 17. 00           | SUBPROVIDER - IPF   |             |     |         |              |              |               | 17. 00           |
| 18. 00           | SUBPROVI DER  |             |     |         |              |              |               | 18.00            |
| 19. 00           | SKILLED NURSING FACILITY  |             |     |         |              |              |               | 19.00            |
| 20. 00           | NURSING FACILITY  |             |     |         |              |              |               | 20.00            |
| 21. 00           | OTHER LONG TERM CARE  |             |     |         |              |              |               | 21. 00           |
| 22. 00           | HOME HEALTH AGENCY  | 101. 00     |     |         |              |              | 0             | 22.00            |
| 23. 00           | AMBULATORY SURGICAL CENTER (D. P.)  |             |     |         |              |              |               | 23. 00           |
| 24. 00           | HOSPI CE  |             |     |         |              |              |               | 24.00            |
| 24. 10           | HOSPICE (non-distinct part)   | 30.00       |     |         |              |              |               | 24. 10           |
| 25. 00           | CMHC - CMHC   |             |     |         |              |              |               | 25. 00           |
| 26. 00           | RURAL HEALTH CLINIC   | 88. 00      |     |         |              |              | 0             |                  |
| 26. 01           | RURAL HEALTH CLINIC II  | 88. 01      |     |         |              |              | 0             |                  |
| 26. 02           | RURAL HEALTH CLINIC III   | 88. 02      |     |         |              |              | 0             |                  |
| 26. 25           | FEDERALLY QUALIFIED HEALTH CENTER   | 89. 00      |     |         |              |              | 0             |                  |
| 27. 00           | Total (sum of lines 14-26)  |             |     | 18      |              |              |               | 27. 00           |
| 28. 00           | Observation Bed Days  |             |     |         |              |              | 0             |                  |
| 29. 00           | Ambul ance Trips  |             |     |         |              |              |               | 29.00            |
| 30. 00<br>31. 00 | Employee discount days (see instruction) Employee discount days - IRF               |             |     |         |              |              |               | 30.00            |
| 32.00            | Labor & delivery days (see instructions)  |             |     | 0       | 0            |              |               | 32.00            |
| 32. 00           | Total ancillary labor & delivery room   |             |     | U       | 0            |              |               | 32.00            |
| JZ. UI           | outpatient days (see instructions)  |             |     |         |              |              |               | 32.01            |
| 33. 00           | LTCH non-covered days   |             |     |         |              |              |               | 33.00            |
|                  | LTCH site neutral days and discharges   |             |     |         | 1            |              |               | 33. 01           |
|                  | LICH SI LE HEULT AI UAYS AND DISCHALGES   |             |     |         |              |              |               | 33.01            |

Peri od: Worksheet S-3 From 01/01/2020 Part I To 12/31/2020 Date/Time Prepared: 8/2/2021 2:11 pm

|        |  |             |              | '         |               | 8/2/2021 2:11 | pm     |
|--------|--|-------------|--------------|-----------|---------------|---------------|--------|
|        |  | I/P Days    | / O/P Visits | / Trips   | Full Time I   | Equi val ents |        |
|        |  |             |              | 1         |               |               |        |
|        |  |             |              |           |               |               |        |
|        | 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 | 3, 102      | 326          | 8, 327    |               |               | 1.00   |
|        | 8 exclude Swing Bed, Observation Bed and     | ·           |              |           |               |               |        |
|        | Hospice days) (see instructions for col. 2   |             |              |           |               |               |        |
|        | for the portion of LDP room available beds)  |             |              |           |               |               |        |
| 2.00   | HMO and other (see instructions)             | 2, 214      | 1, 787       |           |               |               | 2.00   |
| 3.00   | HMO IPF Subprovider                          | O           | 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  | 3, 102      | 326          | 8, 327    |               |               | 7.00   |
|        | beds) (see instructions)                     |             |              |           |               |               |        |
| 8.00   | INTENSIVE CARE UNIT                          | 567         | 0            | 1, 611    |               |               | 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)                     | 3, 669      | 326          | 9, 938    | 0. 00         | 657. 87       | 14.00  |
| 15.00  | CAH visits                                   | 0           | 0            | 0         |               |               | 15.00  |
| 16.00  | SUBPROVIDER - IPF                            |             |              |           |               |               | 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                           | 5, 242      | 234          | 8, 795    | 0.00          | 12. 82        | 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 |
| 26.00  | RURAL HEALTH CLINIC                          | 45          | 9, 533       | 17, 751   | 0.00          | 20. 89        | 26.00  |
| 26. 01 | RURAL HEALTH CLINIC II                       | 235         | 835          |           |               |               |        |
| 26. 02 | RURAL HEALTH CLINIC III                      | 12, 135     | 2, 293       | 46, 816   |               |               | 1      |
| 26. 25 | FEDERALLY QUALIFIED HEALTH CENTER            | 0           | 0            | 0         |               |               |        |
| 27. 00 | Total (sum of lines 14-26)                   |             |              |           | 0. 00         | 784. 47       | 27.00  |
| 28. 00 | Observation Bed Days                         |             | 74           | 734       |               |               | 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)     | 0           | 49           | 87        |               |               | 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 |
|        |  |             |              |           |               |               |        |

Provider CCN: 15-0097

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

|                  |  |               |         | 10          | ) 12/31/2020 | 8/2/2021 2:11 |                |
|------------------|--|---------------|---------|-------------|--------------|---------------|----------------|
|                  |  | Full Time     |         | Di sch      | arges        |               |                |
|                  |  | Equi val ents |         |             | ŭ            |               |                |
|                  | 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       | 1, 015      | 72           | 2, 687        | 1.00           |
|                  | 8 exclude Swing Bed, Observation Bed and     |               |         |             |              |               |                |
|                  | Hospice days) (see instructions for col. 2   |               |         |             |              |               |                |
|                  | for the portion of LDP room available beds)  |               |         |             | 505          |               |                |
| 2.00             | HMO and other (see instructions)             |               |         | 555         | 505          |               | 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  |               |         |             |              |               | 7. 00          |
| 8. 00            | beds) (see instructions)                     |               |         |             |              |               | 8. 00          |
| 9. 00            | INTENSIVE CARE UNIT                          |               |         |             |              |               | 9.00           |
|                  | CORONARY CARE UNIT                           |               |         |             |              |               | ı              |
| 10. 00<br>11. 00 | BURN INTENSIVE CARE UNIT                     |               |         |             |              |               | 10.00<br>11.00 |
| 12.00            | SURGICAL INTENSIVE CARE UNIT                 |               |         |             |              |               | 12.00          |
| 13. 00           | OTHER SPECIAL CARE (SPECIFY) NURSERY         |               |         |             |              |               | 13.00          |
| 14. 00           | Total (see instructions)                     | 0.00          | 0       | 1, 015      | 72           | 2, 687        |                |
| 15. 00           | CAH visits                                   | 0.00          | U       | 1,015       | /2           | 2,007         | 15.00          |
| 16. 00           | SUBPROVIDER - IPF                            |               |         |             |              |               | 16.00          |
| 17. 00           | SUBPROVI DER - I RF                          |               |         |             |              |               | 17.00          |
| 18. 00           | SUBPROVI DER                                 |               |         |             |              |               | 18.00          |
| 19. 00           | SKILLED NURSING FACILITY                     |               |         |             |              |               | 19.00          |
| 20. 00           | NURSING FACILITY                             |               |         |             |              |               | 20.00          |
| 21. 00           | OTHER LONG TERM CARE                         |               |         |             |              |               | 21.00          |
| 22. 00           | HOME HEALTH AGENCY                           | 0.00          |         |             |              |               | 22. 00         |
| 23. 00           | AMBULATORY SURGICAL CENTER (D. P. )          | 0.00          |         |             |              |               | 23.00          |
| 24. 00           | HOSPI CE                                     |               |         |             |              |               | 24.00          |
| 24. 10           | HOSPICE (non-distinct part)                  |               |         |             |              |               | 24. 10         |
| 25. 00           | CMHC - CMHC                                  |               |         |             |              |               | 25. 00         |
| 26.00            | RURAL HEALTH CLINIC                          | 0.00          |         |             |              |               | 26.00          |
| 26. 01           | RURAL HEALTH CLINIC II                       | 0.00          |         |             |              |               | 26. 01         |
| 26. 02           | RURAL HEALTH CLINIC III                      | 0.00          |         |             |              |               | 26. 02         |
| 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 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)     |               |         |             |              |               | 32.00          |
| 32. 01           | Total ancillary labor & delivery room        |               |         |             |              |               | 32. 01         |
|                  | outpatient days (see instructions)           |               |         |             |              |               |                |
| 33. 00           | LTCH non-covered days                        |               |         | 0           |              |               | 33.00          |
| 33. 01           | LTCH site neutral days and discharges        |               |         | 0           |              |               | 33. 01         |

Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION Provider CCN: 15-0097

|                  |   |              |                         |                       | Ť                            | 0 12/31/2020              | Date/Time Pre<br>8/2/2021 2:11 | pared:           |
|------------------|---|--------------|-------------------------|-----------------------|------------------------------|---------------------------|--------------------------------|------------------|
|                  |   | Wkst. A Line | Amount                  | Recl assi fi cat      | Adj usted                    | Paid Hours                | Average                        | DIII             |
|                  |   | Number       | Reported                | i on of<br>Sal ari es | Sal ari es<br>(col. 2 ± col. | Related to<br>Salaries in | Hourly Wage<br>(col. 4 ÷       |                  |
|                  |   |              |                         | (from Wkst.           | 3)                           | col . 4                   | col . 5)                       |                  |
|                  |   | 1. 00        | 2. 00                   | A-6)<br>3. 00         | 4. 00                        | 5. 00                     | 6. 00                          |                  |
|                  | PART II - WAGE DATA   | 1.00         | 2.00                    | 3.00                  | 4.00                         | 5.00                      | 6.00                           |                  |
| 1. 00            | SALARIES Total salaries (see  | 200. 00      | 55, 061, 856            | 0                     | 55, 061, 856                 | 1, 631, 704. 00           | 33. 75                         | 1.00             |
| 1.00             | instructions)   | 200.00       | 55,001,650              |                       | 55, 001, 650                 | 1, 031, 704. 00           | 33. 73                         | 1.00             |
| 2. 00            | Non-physician anesthetist Part<br>A                                 |              | 0                       | 0                     | 0                            | 0. 00                     | 0. 00                          | 2.00             |
| 3.00             | Non-physician anesthetist Part                                      |              | 0                       | 0                     | 0                            | 0. 00                     | 0. 00                          | 3. 00            |
| 4. 00            | B<br>Physician-Part A -   |              | 554, 914                | 0                     | 554, 914                     | 2, 912. 00                | 190. 56                        | 4. 00            |
|                  | Admi ni strati ve   |              |                         |                       | _                            |                           |                                |                  |
| 4. 01<br>5. 00   | Physicians - Part A - Teaching<br>Physician and Non                 |              | 0<br>2, 264, 073        | 0                     | 0<br>2, 264, 073             | 0. 00<br>12, 055. 00      | 0. 00<br>187. 81               | 4. 01<br>5. 00   |
|                  | Physician-Part B  |              |                         |                       |                              |                           | 22.00                          | , 00             |
| 6. 00            | Non-physician-Part B for<br>hospital-based RHC and FQHC<br>services |              | 5, 415, 153             | 0                     | 5, 415, 153                  | 236, 680. 00              | 22. 88                         | 6.00             |
| 7. 00            | Interns & residents (in an  | 21. 00       | 0                       | 0                     | 0                            | 0.00                      | 0. 00                          | 7. 00            |
| 7. 01            | approved program) Contracted interns and                            |              | 0                       | 0                     | 0                            | 0. 00                     | 0. 00                          | 7. 01            |
|                  | residents (in an approved   |              |                         |                       | _                            |                           |                                |                  |
| 8. 00            | programs)<br>Home office and/or related                             |              | 0                       | 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        | 3, 819, 530             | 70, 131               | 3, 889, 661                  |                           | 54. 35                         |                  |
|                  | instructions) OTHER WAGES & RELATED COSTS                           |              |                         |                       |                              |                           |                                |                  |
| 11. 00           | Contract Labor: Direct Patient                                      |              | 225, 853                | 0                     | 225, 853                     | 4, 117. 00                | 54. 86                         | 11.00            |
| 12. 00           | Care<br>Contract Labor: Top Level                                   |              | 0                       | 0                     | 0                            | 0. 00                     | 0.00                           | 12.00            |
|                  | management and other  |              |                         |                       | _                            |                           |                                |                  |
|                  | management and administrative services                              |              |                         |                       |                              |                           |                                |                  |
| 13. 00           | Contract Labor: Physician-Part<br>A - Administrative                |              | 316, 323                | 0                     | 316, 323                     | 1, 379. 00                | 229. 39                        | 13.00            |
| 14. 00           | Home office and/or related  |              | 0                       | 0                     | 0                            | 0.00                      | 0. 00                          | 14.00            |
|                  | organization salaries and wage-related costs                        |              |                         |                       |                              |                           |                                |                  |
| 14. 01           | Home office salaries  |              | 0                       | О                     | 0                            |                           |                                | 14. 01           |
| 14. 02<br>15. 00 | Related organization salaries<br>Home office: Physician Part A      |              | 0                       | 0                     | 0                            | 0. 00<br>0. 00            | 0. 00<br>0. 00                 | 14. 02<br>15. 00 |
|                  | - Administrative  |              | -                       |                       | _                            |                           |                                |                  |
| 16. 00           | Home office and Contract Physicians Part A - Teaching               |              | 0                       | O                     | 0                            | 0. 00                     | 0. 00                          | 16. 00           |
| 16. 01           | Home office Physicians Part A                                       |              | 0                       | 0                     | 0                            | 0. 00                     | 0. 00                          | 16. 01           |
| 16. 02           | - Teaching<br>Home office contract                                  |              | 0                       | 0                     | 0                            | 0. 00                     | 0. 00                          | 16. 02           |
|                  | Physicians Part A - Teaching<br>WAGE-RELATED COSTS                  |              |                         |                       |                              |                           |                                |                  |
| 17. 00           | Wage-related costs (core) (see                                      |              | 10, 948, 308            | 0                     | 10, 948, 308                 |                           |                                | 17. 00           |
| 18. 00           | instructions) Wage-related costs (other)                            |              |                         |                       |                              |                           |                                | 18. 00           |
|                  | (see instructions)  |              | 7/4 50:                 | _                     | 7/4 ===                      |                           |                                |                  |
| 19. 00<br>20. 00 | Excluded areas Non-physician anesthetist Part                       |              | 761, 594<br>0           | 0                     | 761, 594<br>0                |                           |                                | 19. 00<br>20. 00 |
| 21. 00           | A<br>Non-physician anesthetist Part                                 |              | 0                       | 0                     | 0                            |                           |                                | 21.00            |
|                  | В   |              |                         |                       |                              |                           |                                |                  |
| 22. 00           | Physician Part A -<br>Administrative                                |              | 51, 946                 | O                     | 51, 946                      |                           |                                | 22. 00           |
| 22. 01           | Physician Part A - Teaching   |              | 0                       | 0                     | 0                            |                           |                                | 22. 01           |
| 23. 00<br>24. 00 | Physician Part B<br>Wage-related costs (RHC/FQHC)                   |              | 213, 551<br>1, 704, 288 |                       | 213, 551<br>1, 704, 288      |                           |                                | 23. 00<br>24. 00 |
| 25. 00           | Interns & residents (in an approved program)                        |              | 0                       | 0                     | 0                            |                           |                                | 25. 00           |
| 25. 50           | Home office wage-related  |              | 0                       | О                     | О                            |                           |                                | 25. 50           |
| 25. 51           | (core)<br>Related organization                                      |              | 0                       |                       | 0                            |                           |                                | 25. 51           |
|                  | wage-related (core)   |              | 0                       |                       |                              |                           |                                |                  |
| 25. 52           | Home office: Physician Part A<br>- Administrative -                 |              | 0                       | 0                     | 0                            |                           |                                | 25. 52           |
|                  | wage-related (core)   |              |                         |                       |                              |                           |                                |                  |
|                  |   |              |                         |                       |                              |                           |                                |                  |

In Lieu of Form CMS-2552-10
Period: Worksheet S-3
From 01/01/2020 Part II

|        |  |              |             |                  |               | o 12/31/2020 | Date/Time Pre<br>8/2/2021 2:11 |        |
|--------|--|--------------|-------------|------------------|---------------|--------------|--------------------------------|--------|
|        |  | Wkst. A Line | Amount      | Recl assi fi cat |               | Paid Hours   | Average                        |        |
|        |  | Number       | Reported    | ion of           | Sal ari es    | Related to   | Hourly Wage                    |        |
|        |  |              |             | Sal ari es       | (col.2 ± col. | Salaries in  | (col. 4 ÷                      |        |
|        |  |              |             | (from Wkst.      | 3)            | col. 4       | col. 5)                        |        |
|        |  |              |             | A-6)             |               |              |                                |        |
|        | 1  | 1. 00        | 2. 00       | 3. 00            | 4. 00         | 5. 00        | 6. 00                          |        |
| 25. 53 | Home office: Physicians Part A                 |              | 0           | 0                | 0             |              |                                | 25. 53 |
|        | - Teaching - wage-related                      |              |             |                  |               |              |                                |        |
|        | (core)   |              |             |                  |               |              |                                |        |
| 0, 00  | OVERHEAD COSTS - DIRECT SALARI                 |              |             |                  |               | 44.070.00    | 07.00                          |        |
| 26. 00 | Employee Benefits Department                   | 4.00         | 440, 180    |                  | 440, 180      | ,            |                                | 26.00  |
| 27. 00 | Administrative & General                       | 5. 00        | 8, 952, 213 | -127, 547        | 8, 824, 666   |              |                                | 27.00  |
| 28. 00 | Administrative & General under                 |              | 0           | 0                | 0             | 0. 00        | 0. 00                          | 28. 00 |
|        | contract (see inst.)                           |              | _           | _                | _             |              |                                |        |
| 29. 00 | Maintenance & Repairs                          | 6. 00        | 0           | 0                | 0             | 0.00         |                                | 29.00  |
| 30.00  | Operation of Plant                             | 7. 00        | 1, 229, 127 | 0                | 1, 229, 127   | · ·          | 27. 52                         |        |
| 31. 00 | Laundry & Linen Service                        | 8. 00        | 100, 557    |                  | 100, 557      |              | 20. 14                         |        |
| 32.00  | Housekeepi ng                                  | 9. 00        | 1, 454, 502 | 0                | 1, 454, 502   |              |                                | 32.00  |
| 33. 00 | Housekeeping under contract (see instructions) |              | 0           | 0                | 0             | 0. 00        | 0. 00                          | 33. 00 |
| 34.00  | Di etary                                       | 10.00        | 682, 383    | -541, 812        | 140, 571      | 8, 224. 00   | 17. 09                         | 34.00  |
| 35. 00 | Dietary under contract (see                    |              | 0           | 0                | 0             | 0.00         | 0. 00                          |        |
|        | instructions)                                  |              | _           | _                | _             |              | 2. 23                          |        |
| 36.00  | Cafeteri a                                     | 11. 00       | 0           | 541, 812         | 541, 812      | 32, 593. 00  | 16. 62                         | 36.00  |
| 37.00  | Maintenance of Personnel                       | 12. 00       | 0           | 0                | 0             | 0.00         | 0. 00                          | 37.00  |
| 38.00  | Nursing Administration                         | 13.00        | 1, 614, 387 | 0                | 1, 614, 387   | 41, 009. 00  | 39. 37                         | 38.00  |
| 39.00  | Central Services and Supply                    | 14. 00       | 262, 039    | -262, 039        | 0             | 0.00         | 0. 00                          | 39.00  |
| 40.00  | Pharmacy                                       | 15. 00       | 1, 156, 987 | 0                | 1, 156, 987   | 25, 591. 00  | 45. 21                         | 40.00  |
| 41.00  | Medical Records & Medical                      | 16. 00       | 1, 358, 816 | 0                | 1, 358, 816   | 55, 778. 00  | 24. 36                         | 41.00  |
|        | Records Library                                |              |             |                  |               |              |                                |        |
| 42.00  | Social Service                                 | 17. 00       | 0           | 0                | 0             | 0.00         | 0. 00                          | 42.00  |
| 43.00  | Other General Service                          | 18. 00       | 0           | 0                | 0             | 0. 00        | 0. 00                          | 43.00  |
|        |  | •            |             |                  |               |              |                                |        |

| Period: | Worksheet S-3 | From 01/01/2020 | Part III | To 12/31/2020 | Date/Time Prepared:

|       |                                |             |              |                  |               | 12/01/2020      | 8/2/2021 2:11 |       |
|-------|--------------------------------|-------------|--------------|------------------|---------------|-----------------|---------------|-------|
|       |                                | Worksheet A | Amount       | Recl assi fi cat | Adj usted     | Pai d Hours     | Average       |       |
|       |                                | Line Number | Reported     | ion of           | Sal ari es    | Related to      | Hourly Wage   |       |
|       |                                |             |              | Sal ari es       | (col.2 ± col. | Salaries in     | (col. 4 ÷     |       |
|       |                                |             |              | (from            | 3)            | col. 4          | col. 5)       |       |
|       |                                |             |              | Worksheet        |               |                 |               |       |
|       |                                |             |              | A-6)             |               |                 |               |       |
|       |                                | 1. 00       | 2. 00        | 3. 00            | 4. 00         | 5. 00           | 6. 00         |       |
|       | PART III - HOSPITAL WAGE INDEX | SUMMARY     |              |                  |               |                 |               |       |
| 1. 00 | Net salaries (see              |             | 47, 382, 630 | 0                | 47, 382, 630  | 1, 382, 969. 00 | 34. 26        | 1.00  |
|       | instructions)                  |             |              |                  |               |                 |               |       |
| 2. 00 | Excluded area salaries (see    |             | 3, 819, 530  | 70, 131          | 3, 889, 661   | 71, 573. 00     | 54. 35        | 2.00  |
|       | instructions)                  |             |              |                  |               |                 |               |       |
| 3.00  | Subtotal salaries (line 1      |             | 43, 563, 100 | -70, 131         | 43, 492, 969  | 1, 311, 396. 00 | 33. 17        | 3.00  |
|       | minus line 2)                  |             |              |                  |               |                 |               |       |
| 4. 00 | Subtotal other wages & related |             | 542, 176     | 0                | 542, 176      | 5, 496. 00      | 98. 65        | 4. 00 |
|       | costs (see inst.)              |             |              |                  |               |                 |               |       |
| 5. 00 | Subtotal wage-related costs    |             | 11, 000, 254 | 0                | 11, 000, 254  | 0. 00           | 25. 29        | 5.00  |
|       | (see inst.)                    |             |              |                  |               |                 |               |       |
| 6. 00 | Total (sum of lines 3 thru 5)  |             | 55, 105, 530 |                  |               |                 |               |       |
| 7. 00 | Total overhead cost (see       |             | 17, 251, 191 | -389, 586        | 16, 861, 605  | 546, 308. 00    | 30. 86        | 7. 00 |
|       | instructions)                  |             |              |                  |               |                 |               |       |

| Health Financial Systems    | MAJOR HOSPITAL     | In Lieu of Form CMS-2552-10                                |
|-----------------------------|--------------------|--|
| HOSPITAL WAGE RELATED COSTS | Provi der CCN: 15- | 0097   Period:   Worksheet S-3   From 01/01/2020   Part IV |
|                             |                    | To 12/31/2020 Part TV                                      |

|        | 10 12/31/2020   | Date/lime Pre<br>  8/2/2021 2:11 | pared: |
|--------|---|----------------------------------|--------|
|        |   | Amount                           |        |
|        |   | Reported                         |        |
|        |   | 1. 00                            |        |
|        | PART IV - WAGE RELATED COSTS  |                                  |        |
|        | Part A - Core List  |                                  |        |
|        | RETI REMENT COST  |                                  |        |
| 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)   | 2, 184, 500                      | 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)                                  | 7, 109, 146                      | 8. 01  |
| 8. 02  | Health Insurance (Self Funded with a Third Party Administrator)                                     | 0                                | 8. 02  |
| 8.03   | Health Insurance (Purchased)  | 0                                | 8. 03  |
| 9.00   | Prescription Drug Plan  | 0                                | 9. 00  |
| 10.00  | Dental, Hearing and Vision Plan   | 48, 268                          |        |
| 11. 00 |   | 95, 082                          |        |
| 12.00  |   | 0                                |        |
| 13.00  | 1   | 201, 538                         |        |
| 14.00  |   | 0                                |        |
| 15.00  |   | 92, 280                          |        |
| 16.00  | Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. | 0                                | 16.00  |
|        | Non cumulative portion)   |                                  |        |
|        | TAXES   |                                  |        |
| 17. 00 |   | 3, 787, 117                      |        |
| 18. 00 |   | 0                                | 18.00  |
| 19. 00 |   | 157, 090                         |        |
| 20.00  |   | 0                                | 20.00  |
|        | OTHER   |                                  |        |
| 21. 00 |   | 0                                | 21.00  |
|        | instructions))  | _                                |        |
| 22. 00 |   | 0                                |        |
| 23. 00 |   | 4, 667                           |        |
| 24. 00 |   | 13, 679, 688                     | 24.00  |
| 25 62  | Part B - Other than Core Related Cost   |                                  | 25 00  |
| 25.00  | OTHER WAGE RELATED COSTS (SPECIFY)  | I                                | 25.00  |

| Health Financial Systems                 | MAJOR HOSPITAL         | In Lieu of Form CMS-2552-10  |
|--|------------------------|------------------------------|
| HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provi der CCN: 15-0097 | Period: Worksheet S-3        |
|  |                        | From 01/01/2020 Part V       |
|  |                        | T- 10 /01 /0000   D-+- /T: D |

|        |   | o 12/31/2020 | Date/Time Pre<br>8/2/2021 2:11 |       |
|--------|---|--------------|--------------------------------|-------|
|        | Cost Center Description                               | Contract     | Benefit Cost                   | PIII  |
|        | cost center bescription                               | Labor        | belieff t 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      | 225, 853     | 13, 679, 688                   | 1.00  |
| 2.00   | Hospi tal   | 225, 853     | 13, 679, 688                   | 2.00  |
| 3.00   | Subprovi der - IPF                                    |              |                                | 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                                  | 0            | 0                              | 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                      | 0            | 0                              | 14.00 |
| 14. 01 | Hospital-Based Health Clinic RHC 1                    | 0            | 0                              | 14.01 |
| 14. 02 | Hospital-Based Health Clinic RHC 2                    | 0            | 0                              | 14.02 |
| 15.00  | Hospital-Based Health Clinic FQHC                     |              |                                | 15.00 |
| 16.00  | Hospi tal -Based-CMHC                                 |              |                                | 16.00 |
| 17.00  | Renal Dialysis  |              |                                | 17.00 |
| 18.00  | Other   | 0            | 0                              | 18.00 |

| Heal th          | Financial Systems   | MAJOR HO           | ISPI TAI                      |                | In lie                     | u of Form CMS-2 | 2552-10          |
|------------------|---|--------------------|-------------------------------|----------------|----------------------------|-----------------|------------------|
|                  | HEALTH AGENCY STATISTICAL DATA  | W/ SOR TIC         |                               |                | Period:<br>From 01/01/2020 | Worksheet S-4   |                  |
|                  |   |                    | Component                     |                | To 12/31/2020              |                 |                  |
|                  |   |                    |                               |                | Home Health                | PPS             | рш               |
|                  |   |                    |                               |                | Agency I                   |                 |                  |
| 0.00             | County  |                    |                               |                | 1.                         | 00              | 0.00             |
| 0. 00            | County  | Ti tle V           | Title XVIII                   | Title XIX      | Other                      | Total           | 0.00             |
|                  | HOME HEALTH AGENCY STATISTICAL DATA   | 1. 00              | 2. 00                         | 3.00           | 4. 00                      | 5. 00           |                  |
| 1. 00            | Home Health Aide Hours  | 0                  | , , , , ,                     |                |                            |                 |                  |
| 2. 00            | Unduplicated Census Count (see instructions)  | 0.00               | 179.00                        |                | 0.00<br>Toyees (Full Ti    |                 | 2.00             |
|                  |   |                    |                               |                |                            |                 |                  |
|                  |   |                    |                               |                |                            |                 |                  |
|                  |   |                    | er of hours in<br>I work week | Staff          | Contract                   | Total           |                  |
|                  |   | your norman        | WOLK WEEK                     |                |                            |                 |                  |
|                  |   |                    |                               |                |                            |                 |                  |
|                  | HOME HEALTH ACENOV - NUMBER OF ENDLOYEES  | (                  | 0                             | 1.00           | 2. 00                      | 3. 00           |                  |
| 3. 00            | HOME HEALTH AGENCY - NUMBER OF EMPLOYEES Administrator and Assistant Administrator(s) |                    | 0.00                          | 0.0            | 0.00                       | 0.00            | 3.00             |
| 4.00             | Director(s) and Assistant Director(s)   |                    |                               | 0.0            |                            | •               | 4.00             |
| 5. 00<br>6. 00   | Other Administrative Personnel Direct Nursing Service                                 |                    |                               | 2. 2           |                            | l               | 5. 00<br>6. 00   |
| 7. 00            | Nursi ng Supervi sor  |                    |                               | 0.0            |                            | l               | 7.00             |
| 8. 00<br>9. 00   | Physical Therapy Service<br>Physical Therapy Supervisor                               |                    |                               | 2.6            |                            |                 | 8. 00<br>9. 00   |
| 10.00            | Occupational Therapy Service  |                    |                               | 1. 2           |                            | l               | l                |
| 11. 00<br>12. 00 | Occupational Therapy Supervisor<br>Speech Pathology Service                           |                    |                               | 0.0            |                            | 1               | •                |
| 13. 00<br>14. 00 | Speech Pathology Supervisor<br>Medical Social Service                                 |                    |                               | 0.0            |                            | l               | 13. 00<br>14. 00 |
| 15. 00           | Medical Social Service Supervisor   |                    |                               | 0.0            |                            | l .             |                  |
| 16. 00<br>17. 00 | Home Heal th Ai de<br>Home Heal th Ai de Supervisor                                   |                    |                               | 1. 4<br>0. 0   |                            | l               | •                |
| 18. 00           | · ·   |                    |                               | 0.0            |                            |                 | 1                |
| 19. 00           | HOME HEALTH AGENCY CBSA CODES Enter in column 1 the number of CBSAs where             |                    |                               |                | 2                          |                 | 19. 00           |
| 17.00            | you provided services during the cost   |                    |                               |                |                            |                 | 17.00            |
| 20. 00           | reporting period. List those CBSA code(s) in column 1 serviced                        |                    |                               | 26900          |                            |                 | 20.00            |
|                  | during this cost reporting period (line 20  |                    |                               |                |                            |                 |                  |
| 20. 01           | contains the first code).   |                    |                               | 99915          |                            |                 | 20. 01           |
|                  |   |                    | oisodes<br>With Outliers      | LUDA Enicodos  | PEP Only                   | Total (cols     |                  |
|                  |   | Outliers           | with outriers                 | LUPA Epi sodes | Epi sodes                  | 1-4)            |                  |
|                  | PPS ACTIVITY DATA   | 1. 00              | 2. 00                         | 3.00           | 4. 00                      | 5. 00           |                  |
| 21. 00           | Skilled Nursing Visits  | 1, 633             |                               | 1              |                            |                 | 1                |
| 22. 00<br>23. 00 | Skilled Nursing Visit Charges Physical Therapy Visits                                 | 405, 958<br>1, 047 |                               |                | 4 19, 008<br>6 60          | 1               | 1                |
| 24.00            | Physical Therapy Visit Charges  | 235, 560           | 119, 780                      | 1, 50          | 0 13, 200                  | 370, 040        | 24. 00           |
| 25. 00<br>26. 00 | Occupational Therapy Visits Occupational Therapy Visit Charges                        | 313<br>68, 860     | l .                           | 1              | 4 20<br>0 4, 400           | l               | 1                |
| 27. 00           | Speech Pathology Visits   | 5                  | 10                            |                | 0                          | 15              | 27.00            |
| 28. 00<br>29. 00 | Speech Pathology Visit Charges<br>Medical Social Service Visits                       | 1, 100<br>15       |                               |                | 0<br>0 1                   | 3, 300<br>27    | 28. 00<br>29. 00 |
| 30.00            | Medical Social Service Visit Charges  | 3, 300             |                               |                | 0 220                      | i .             | 1                |
| 31. 00<br>32. 00 | Home Health Aide Visits Home Health Aide Visit Charges                                | 239<br>26, 768     | l .                           | 1              | 0 10<br>0 1, 120           | l .             | 31. 00<br>32. 00 |
| 33. 00           | Total visits (sum of lines 21, 23, 25, 27,  | 3, 252             | 1, 767                        | 5              | 6 167                      | 5, 242          | 33.00            |
| 34. 00           | 29, and 31)<br>Other Charges  | О                  | _                             |                | 0 0                        |                 | 34.00            |
| 35. 00           | Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)                           | 741, 546           | 381, 476                      | 15, 97         | 4 37, 948                  | 1, 176, 944     | 35.00            |
| 36. 00           | Total Number of Episodes (standard/non  | 284                |                               | 3              | 2 14                       | 330             | 36.00            |
| 37. 00           | outlier) Total Number of Outlier Episodes   |                    | 71                            |                | 4                          | 75              | 37. 00           |
|                  | Total Non-Routine Medical Supply Charges  | 161, 352           |                               | •              | 7, 137                     |                 |                  |

|              | Financial Systems   | MAJOR HO       |                 |              |                             | eu of Form CMS             |          | 552-1        |
|--------------|---|----------------|-----------------|--------------|-----------------------------|----------------------------|----------|--------------|
| IOSPI T      | TAL-BASED RHC/FQHC STATISTICAL DATA   |                |                 | CN: 15-0097  | Period:<br>From 01/01/2020  |                            |          |              |
|              |   |                | Component       | CCN: 15-8529 | To 12/31/2020               | Date/Time P<br>8/2/2021 2: |          |              |
|              |   |                |                 |              | RHC I                       |                            |          | •            |
|              |   |                |                 |              | 1                           | . 00                       | $\dashv$ |              |
|              | Clinic Address and Identification   |                |                 |              |                             | . 00                       |          |              |
| . 00         | Street  |                |                 |              | 2451 INTELLIPI<br>SUITE 240 | LEX DRIVE,                 |          | 1.0          |
|              |   |                | Ci              | ty           | State                       | ZIP Code                   |          |              |
|              |   |                |                 | 00           | 2. 00                       | 3. 00                      |          |              |
| . 00         | City, State, ZIP Code, County   |                | SHELBYVI LLE    |              |                             | 46176                      |          | 2.0          |
|              |   |                |                 |              |                             | 1.00                       |          |              |
| . 00         | HOSPITAL-BASED FQHCs ONLY: Designation - Ent  | er "R" for rur | al or "U" for   | urban        |                             |                            | 0        | 3.0          |
|              |   |                |                 |              | nt Award                    | Date                       |          |              |
|              | Course of Foderal Funda   |                |                 |              | 1. 00                       | 2. 00                      |          |              |
| . 00         | Source of Federal Funds Community Health Center (Section 330(d), PHS                            | Act)           |                 |              |                             | I                          |          | 4.0          |
| . 00         | Migrant Health Center (Section 329(d), PHS A  |                |                 |              |                             |                            | İ        | 5. 0         |
| . 00         | Health Services for the Homeless (Section 34)   | O(d), PHS Act) |                 |              |                             |                            |          | 6.0          |
| . 00<br>. 00 | Appalachian Regional Commission<br>Look-Alikes  |                |                 |              |                             |                            |          | 7.0          |
| . 00         | OTHER (SPECIFY)   |                |                 |              |                             |                            |          | 8. C<br>9. C |
| . 00         | Johner (or corresponding  |                |                 |              |                             |                            |          | 7. 0         |
|              |   |                |                 |              | 1. 00                       | 2.00                       |          |              |
| 0. 00        | Does this facility operate as other than a he   |                |                 |              | N                           |                            | 0        | 10. C        |
|              | yes or "N" for no in column 1. If yes, indica<br>2. (Enter in subscripts of line 11 the type of |                |                 |              |                             |                            |          |              |
|              | hours.)   | other operat   | Torres, and the | operating    |                             |                            |          |              |
|              |   |                | nday            |              | onday                       | Tuesday                    |          |              |
|              |   | from<br>1.00   | 2. 00           | from<br>3.00 | to                          | from<br>5.00               |          |              |
|              | Facility hours of operations (1)  | 1.00           | 2.00            | 3.00         | 4. 00                       | 5.00                       |          |              |
| 1. 00        | CLINIC  |                |                 | 07: 30       | 17: 00                      | 07: 30                     |          | 11.0         |
|              |   |                |                 |              | 1.00                        | 0.00                       | _        |              |
| 2. 00        | Have you received an approval for an exception  | on to the prod | luctivity stanc | lard?        | 1. 00<br>Y                  | 2. 00                      |          | 12. C        |
| 3. 00        | Is this a consolidated cost report as define  |                |                 |              | N N                         |                            |          | 13.0         |
|              | 30.8? Enter "Y" for yes or "N" for no in col  |                |                 |              |                             |                            |          |              |
|              | number of providers included in this report.  | List the name  | es of all provi | ders and     |                             |                            |          |              |
|              | numbers below.  |                |                 | Provi        | der name                    | CCN number                 |          |              |
|              |   |                |                 |              | 1. 00                       | 2.00                       |          |              |
| 4. 00        | RHC/FQHC name, CCN number   |                |                 | Va           |                             | T                          | T        | 14.0         |
|              |   | Y/N<br>1. 00   | V 2 00          | XVIII        | XI X                        | Total Visit                | S        |              |
| 5. 00        | Have you provided all or substantially all  | 1.00           | 2. 00           | 3. 00        | 4. 00                       | 5. 00                      |          | 15. 0        |
| 0.00         | GME cost? Enter "Y" for yes or "N" for no in  |                |                 |              |                             |                            |          | 10.0         |
|              | column 1. If yes, enter in columns 2, 3 and   |                |                 |              |                             |                            |          |              |
|              | 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and         |                |                 |              |                             |                            |          |              |
|              | XIX, as applicable. Enter in column 5 the   |                |                 |              |                             |                            |          |              |
|              | number of total visits for this provider.   |                |                 |              |                             |                            |          |              |
|              | (see instructions)  |                |                 |              |                             |                            |          |              |
|              |   |                |                 | unty<br>00   |                             |                            |          |              |
|              | City, State, ZIP Code, County   |                | SHELBY 4.       | 00           |                             |                            |          | 2. 0         |
| 2. 00        | , ., , ,,,  | Tuesday        | -               | esday        | Thu                         | rsday                      |          |              |
| . 00         |   |                |                 |              | C                           | 4                          |          |              |
| 2. 00        |   | to             | from            | to           | from                        | to                         | _        |              |
| 2. 00        | Facility hours of operations (1)  | to<br>6. 00    | 7.00            | 8.00         | 9.00                        | 10.00                      |          |              |

| Health Financial Systems                 | MAJOR HO | SPI TAL     |              | In Lie          | u of Form CMS- | 2552-10 |
|--|----------|-------------|--------------|-----------------|----------------|---------|
| HOSPITAL-BASED RHC/FQHC STATISTICAL DATA |          | Provi der ( | CCN: 15-0097 | Peri od:        | Worksheet S-8  | 3       |
|  |          |             |              | From 01/01/2020 |                |         |
|  |          | Component   | CCN: 15-8529 | To 12/31/2020   |                |         |
|  |          |             |              |                 | 8/2/2021 2: 11 | pm      |
|  |          |             |              | RHC I           |                |         |
|  | Fri      | day         | Sa           | turday          |                |         |
|  | from     | to          | from         | to              |                |         |
|  | 11. 00   | 12. 00      | 13. 00       | 14. 00          |                |         |
| Facility hours of operations (1)         |          |             |              |                 |                |         |
| 11. 00 CLINIC                            | 07: 30   | 17: 00      |              |                 |                | 11.00   |

|                | Financial Systems   | MAJOR H                         |                                 |  |   | eu of Form CMS       |        | 552-1        |
|----------------|---|---------------------------------|---------------------------------|--|---|----------------------|--------|--------------|
| IOSPI I        | AL-BASED RHC/FQHC STATISTICAL DATA  |                                 |                                 | CN: 15-0097<br>CCN: 15-8531              | Period:<br>From 01/01/2020<br>To 12/31/2020 | Date/Time P          | rep    |              |
|                |   |                                 |                                 |  | RHC II                                      | 8/2/2021 2:          | 11     | pm           |
|                |   |                                 |                                 |  | 1   |                      |        |              |
|                | Tanana and a same and a same and a same a   |                                 |                                 |  | 1   | . 00                 |        |              |
| 00             | Clinic Address and Identification   |                                 |                                 |  | 24E1 INTELLID                               | LEV DDLVE            | _      | 1 0          |
| . 00           | Street  |                                 |                                 |  | 2451 INTELLIPI<br>SUITE 230                 | LEX DRIVE,           |        | 1.0          |
|                |   |                                 | Ci                              | ty                                       | State                                       | ZIP Code             |        |              |
|                |   |                                 |                                 | 00                                       | 2. 00                                       | 3.00                 |        |              |
| . 00           | City, State, ZIP Code, County   |                                 | SHELBYVI LLE                    |  |   | N 46176              |        | 2.0          |
|                |   |                                 |                                 |  |   | 1. 00                | _      |              |
| . 00           | HOSPITAL-BASED FQHCs ONLY: Designation - Ent  | er "R" for rur                  | al or "U" for                   |  |   |                      | 0      | 3.0          |
|                |   |                                 |                                 |  | nt Award                                    | Date                 |        |              |
|                | Source of Federal Funds   |                                 |                                 |  | 1. 00                                       | 2. 00                |        |              |
| . 00           | Community Health Center (Section 330(d), PHS  | Act)                            |                                 |  |   | Τ                    |        | 4.0          |
| . 00           | Migrant Health Center (Section 329(d), PHS A  | ct)                             |                                 |  |   |                      |        | 5.0          |
| . 00           | Health Services for the Homeless (Section 34  | O(d), PHS Act)                  |                                 |  |   |                      |        | 6.0          |
| . 00<br>. 00   | Appalachian Regional Commission Look-Alikes   |                                 |                                 |  |   |                      |        | 7. C<br>8. C |
| . 00           | OTHER (SPECIFY)   |                                 |                                 |  |   |                      |        | 9.0          |
|                |   |                                 |                                 |  |   |                      |        |              |
| 0.00           | Described Control of the Control of |                                 | DUO - FOLIOO F                  | 11.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1 | 1.00  | 2. 00                |        | 10.0         |
| 0. 00          | Does this facility operate as other than a hyes or "N" for no in column 1. If yes, indic 2. (Enter in subscripts of line 11 the type o hours.)  | ate number of                   | other operation                 | ns in column                             |   |                      | 0      | 10.0         |
|                | 11041 01 /  | Sur                             | nday                            | N  | londay                                      | Tuesday              |        |              |
|                |   | from                            | to                              | from                                     | to  | from                 | $\Box$ |              |
|                | Facility hours of operations (1)  | 1. 00                           | 2. 00                           | 3.00                                     | 4. 00                                       | 5. 00                | +      |              |
| 1. 00          | CLINIC  |                                 |                                 | 08: 00                                   | 17: 00                                      | 08: 00               |        | 11.0         |
|                |   |                                 |                                 |  |   |                      |        |              |
| 2 00           |   | 4- 46                           |                                 | 10                                       | 1.00  | 2. 00                | _      | 10.0         |
| 2. 00<br>3. 00 | Have you received an approval for an excepti Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below.  | d in CMS Pub.<br>umn 1. If yes, | 100-04, chapte<br>enter in colu | r 9, section<br>mn 2 the                 | Y<br>N                                      |                      | 0      | 12. C        |
|                | 1   |                                 |                                 | Prov                                     | ider name                                   | CCN number           |        |              |
| 4 60           | DUO (FOUR   |                                 |                                 |  | 1. 00                                       | 2. 00                |        | 44 -         |
| 4.00           | RHC/FQHC name, CCN number   | Y/N                             | V                               | XVIII                                    | XIX   | Total Visit          | s      | 14.0         |
|                |   | 1.00                            | 2.00                            | 3.00                                     | 4. 00                                       | 5. 00                | 3      |              |
| 5. 00          | Have you provided all or substantially all  |                                 | 2.00                            | 3.00                                     | 1. 00                                       | 3. 00                |        | 15. 0        |
|                | GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and  |                                 |                                 |  |   |                      |        |              |
|                | 4 the number of program visits performed by   |                                 |                                 |  |   |                      |        |              |
|                | Intern & Residents for titles V, XVIII, and   |                                 |                                 |  |   |                      |        |              |
|                | XIX, as applicable. Enter in column 5 the   |                                 |                                 |  |   |                      |        |              |
|                | number of total violts for this constitution  |                                 |                                 |  |   |                      |        |              |
|                | number of total visits for this provider. (see instructions)  |                                 | 1                               |  |   | 1                    |        |              |
|                | number of total visits for this provider. (see instructions)  |                                 | Cou                             | ınty                                     |   |                      |        |              |
|                | (see instructions)  |                                 | 4.                              | 00<br>00                                 |   |                      |        |              |
| . 00           |   | Tuesday                         | 4.<br>SHELBY                    | 00                                       | 71  | rodo) (              | +      | 2.0          |
| 2. 00          | (see instructions)  | Tuesday                         | 4.<br>SHELBY<br>Wedn            | 00<br>esday                              |   | rsday                |        | 2.00         |
| 2. 00          | (see instructions)  | Tuesday<br>to<br>6.00           | 4.<br>SHELBY                    | 00                                       | Thu from 9.00                               | rsday<br>to<br>10.00 |        | 2.00         |

| Health Financial Systems                 | MAJOR HO | SPI TAL     |              | In Lie          | u of Form CMS-2                  | 2552-10 |
|--|----------|-------------|--------------|-----------------|----------------------------------|---------|
| HOSPITAL-BASED RHC/FQHC STATISTICAL DATA |          | Provi der C | CN: 15-0097  | Peri od:        | Worksheet S-8                    |         |
|  |          |             |              | From 01/01/2020 |                                  |         |
|  |          | Component   | CCN: 15-8531 | To 12/31/2020   | Date/Time Pre<br>  8/2/2021 2:11 |         |
|  |          |             |              | RHC II          |                                  |         |
|  | Fri      | day         | Sa           | turday          |                                  |         |
|  | from     | to          | from         | to              |                                  |         |
|  | 11. 00   | 12. 00      | 13. 00       | 14.00           |                                  |         |
| Facility hours of operations (1)         |          |             |              |                 |                                  |         |
| 11. 00 CLINIC                            | 08: 00   | 17: 00      |              |                 |                                  | 11.00   |

|         | Financial Systems   | MAJOR HO       |                 |              |                            | eu of Form CMS |               | 552-1        |
|---------|---|----------------|-----------------|--------------|----------------------------|----------------|---------------|--------------|
| IOSPI I | FAL-BASED RHC/FQHC STATISTICAL DATA   |                | Provi der C     | CN: 15-0097  | Period:<br>From 01/01/2020 | Worksheet S    | -8            |              |
|         |   |                | Component       | CCN: 15-8532 | To 12/31/2020              | O Date/Time P  |               |              |
|         |   |                |                 |              | RHC III                    | 8/2/2021 2:    | 11            | рш           |
|         |   |                | <del>- '</del>  |              |                            |                |               |              |
|         |   |                |                 |              | 1                          | . 00           | 4             |              |
| . 00    | Clinic Address and Identification Street  |                |                 |              | 2451 INTELLIP              | LEV DDLVE      | -             | 1. 0         |
| . 00    | Street  |                |                 |              | SULTE 260                  | LEX DRIVE,     |               | 1.0          |
|         |   |                | Ci              | ty           | State                      | ZIP Code       |               |              |
|         | Taran |                |                 | 00           | 2. 00                      | 3. 00          | _             |              |
| . 00    | City, State, ZIP Code, County   |                | SHELBYVI LLE    |              | I                          | N 46176        |               | 2. 0         |
|         |   |                |                 |              |                            | 1.00           | $\dashv$      |              |
| . 00    | HOSPITAL-BASED FQHCs ONLY: Designation - Ent  | er "R" for rur | al or "U" for   | urban        |                            |                | 0             | 3. 0         |
|         |   |                |                 |              | nt Award                   | Date           |               |              |
|         | Courses of Foderal Funda  |                |                 |              | 1. 00                      | 2. 00          | $\dashv$      |              |
| . 00    | Source of Federal Funds Community Health Center (Section 330(d), PHS  | Δct)           |                 | T            |                            | T              | -             | 4. 0         |
| 5. 00   | Migrant Health Center (Section 329(d), PHS A  |                |                 |              |                            |                |               | 5. 0         |
| . 00    | Health Services for the Homeless (Section 34)   | O(d), PHS Act) |                 |              |                            |                |               | 6.0          |
| . 00    | Appal achi an Regi onal Commissi on   |                |                 |              |                            |                |               | 7.0          |
| . 00    | Look-Alikes OTHER (SPECIFY)   |                |                 |              |                            |                |               | 8. 0<br>9. 0 |
| . 00    | OTILE (SELCTI)  |                |                 |              |                            |                | $\vdash$      | 7. 0         |
|         |   |                |                 |              | 1.00                       | 2.00           |               |              |
| 0. 00   | Does this facility operate as other than a h  |                |                 |              |                            |                | 0             | 10.0         |
|         | yes or "N" for no in column 1. If yes, indica<br>2. (Enter in subscripts of line 11 the type of   |                |                 |              |                            |                |               |              |
|         | hours.)   | i otner operat | .ron(s) and the | operating    |                            |                |               |              |
|         | (110di 3. )   | Sur            | nday            | N            | londay                     | Tuesday        |               |              |
|         |   | from           | to              | from         | to                         | from           | $\Box$        |              |
|         | [5  | 1. 00          | 2. 00           | 3. 00        | 4. 00                      | 5. 00          | 4             |              |
| 1 00    | Facility hours of operations (1)  |                |                 | 07: 00       | 17: 00                     | 07: 00         | _             | 11. 0        |
| 1.00    | OET III   O   |                |                 | 107.00       | 17.00                      | 07.00          |               | 11.0         |
|         |   |                |                 |              | 1. 00                      | 2. 00          |               |              |
| 12.00   | Have you received an approval for an exception  |                |                 |              | Y                          |                |               | 12.0         |
| 3. 00   | Is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in colu   |                |                 |              | N                          |                | 0             | 13. 0        |
|         | number of providers included in this report.  |                |                 |              |                            |                |               |              |
|         | numbers below.  |                |                 |              |                            |                |               |              |
|         |   |                |                 |              | ider name                  | CCN number     | $\perp$       |              |
| 4 00    | RHC/FQHC name, CCN number   |                |                 |              | 1. 00                      | 2. 00          | -             | 14. 0        |
| r. 00   | TATO T QUO TIGINO, OUN TIGINDET   | Y/N            | V               | XVIII        | XIX                        | Total Visit    |               | 17.0         |
|         |   | 1. 00          | 2.00            | 3. 00        | 4.00                       | 5. 00          |               |              |
| 5. 00   | Have you provided all or substantially all  |                |                 |              |                            |                | П             | 15. 0        |
|         | GME cost? Enter "Y" for yes or "N" for no in  |                |                 |              |                            |                |               |              |
|         | column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by   |                |                 |              |                            |                |               |              |
|         | Intern & Residents for titles V, XVIII, and   |                |                 |              |                            |                |               |              |
|         | XIX, as applicable. Enter in column 5 the   |                |                 |              |                            |                |               |              |
|         | number of total visits for this provider.   |                |                 |              |                            |                |               |              |
|         | (see instructions)  |                | Co              | l<br>unty    |                            |                | $\rightarrow$ |              |
|         |   |                |                 | unty<br>00   |                            |                |               |              |
|         | City, State, ZIP Code, County   |                | SHLEBY          |              |                            |                |               | 2. 0         |
| 2. 00   |   | Tuesday        |                 | esday        | Thu                        | rsday          |               |              |
| 2. 00   |   | Tuesday        |                 |              |                            |                |               |              |
| 2. 00   |   | to             | from            | to           | from                       | to             |               |              |
| . 00    | Facility hours of operations (1)  |                |                 | to<br>8.00   | 9.00                       | to<br>10.00    | $\exists$     |              |

| Health Financial Systems                 | MAJOR HO                                 | SPI TAL   |       | In Lie                           | u of Form CMS-2 | 2552-10 |
|--|--|-----------|-------|----------------------------------|-----------------|---------|
| HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | IOSPITAL-BASED RHC/FQHC STATISTICAL DATA |           |       | Peri od:                         | Worksheet S-8   |         |
|  |  | Component |       | From 01/01/2020<br>To 12/31/2020 |                 |         |
|  | _  |           |       | RHC III                          |                 |         |
|  | Fri                                      | day       | Sa    | turday                           |                 |         |
|  | from                                     | to        | from  | to                               |                 |         |
|  | 11. 00                                   | 12. 00    | 13.00 | 14.00                            |                 |         |
| Facility hours of operations (1)         |  |           |       |                                  |                 |         |
| 11. 00 CLINIC                            | 07: 00                                   | 17: 00    |       |                                  |                 | 11. 00  |

|                | Financial Systems MAJOR HOSPIT TAL UNCOMPENSATED AND INDIGENT CARE DATA   | Provi der CCI | N: 15_0097   | Peri od:         | u of Form CMS-2<br>Worksheet S-1 |       |  |
|----------------|---|---------------|--------------|------------------|----------------------------------|-------|--|
| 10321 1        | AL UNCOMPENSATED AND THUISENT CARE DATA   | Provider CC   | N. 13-0097   | From 01/01/2020  |                                  |       |  |
|                |   |               |              | To 12/31/2020    | Date/Time Pre<br>8/2/2021 2:11   | pm pm |  |
|                |   |               |              |                  | 1. 00                            |       |  |
|                | Uncompensated and indigent care cost computation  |               |              |                  |                                  | ١     |  |
| . 00           | Cost to charge ratio (Worksheet C, Part I line 202 column 3 div<br>Medicaid (see instructions for each line)                      | vided by li   | ne 202 colum | n 8)             | 0. 294515                        | 1.0   |  |
| 2. 00          | Net revenue from Medicaid   |               |              |                  | 7, 221, 788                      | 2.0   |  |
| 3. 00          | Did you receive DSH or supplemental payments from Medicaid?   |               |              |                  | Υ                                | 3.0   |  |
| . 00           | If line 3 is yes, does line 2 include all DSH and/or supplement   |               |              | ai d?            | Υ                                | 4.0   |  |
| . 00           | If line 4 is no, then enter DSH and/or supplemental payments fi   | rom Medicaio  | d            |                  | (1 720 212                       |       |  |
| . 00           | Medicaid charges Medicaid cost (line 1 times line 6)  |               |              |                  | 61, 739, 213<br>18, 183, 124     |       |  |
| . 00           | Difference between net revenue and costs for Medicaid program   | (line 7 minu  | us sum of li | nes 2 and 5: if  | 10, 961, 336                     | 1     |  |
|                | < zero then enter zero)   |               |              |                  | ., ,                             |       |  |
|                | Children's Health Insurance Program (CHIP) (see instructions for  | or each line  | e)           |                  |                                  | ļ     |  |
| 00             | Net revenue from stand-alone CHIP   |               |              |                  | 0                                |       |  |
| 0.00           | Stand-alone CHIP charges<br>  Stand-alone CHIP cost (line 1 times line 10)  |               |              |                  | 0                                | 1     |  |
| 2. 00          | Difference between net revenue and costs for stand-alone CHIP   | (line 11 mi   | nus line 9:  | if < zero then   | 0                                | 1     |  |
|                | enter zero)   |               |              |                  |                                  |       |  |
|                | Other state or local government indigent care program (see ins  |               |              |                  |                                  |       |  |
| 3. 00<br>4. 00 | Net revenue from state or local indigent care program (Not inc<br>Charges for patients covered under state or local indigent care | luded on li   | nes 2, 5 or  | 9)               | 0                                |       |  |
| 4.00           | 10)   | e program (i  | Not Theradea | III IIIles o oi  | U                                | 14.0  |  |
| 5. 00          | State or local indigent care program cost (line 1 times line 1  | 4)            |              |                  | 0                                | 15.0  |  |
| 6. 00          | 00 Difference between net revenue and costs for state or local indigent care program (line 15 minus line                          |               |              |                  |                                  |       |  |
|                | 13; if < zero then enter zero)  | D             | - /    :  :  |                  | (                                |       |  |
|                | Grants, donations and total unreimbursed cost for Medicaid, CHI instructions for each line)                                       | r and State   | e/Tocal Indi | gent care progra | IIIS (See                        |       |  |
|                | Private grants, donations, or endowment income restricted to for  |               |              |                  | 0                                |       |  |
| 8. 00<br>9. 00 | Government grants, appropriations or transfers for support of local unreimbursed cost for Medicaid, CHIP and state and local      |               |              | e (sum of lings  | 0<br>10, 961, 336                |       |  |
| 7. 00          | 8, 12 and 16)   | i margent (   | care program | 3 (3um of files  | 10, 701, 330                     | 17.0  |  |
|                |   |               | Uni nsured   | Insured          | Total (col. 1                    |       |  |
|                |   | -             | pati ents    | pati ents        | + col . 2)                       |       |  |
|                | Uncompensated Care (see instructions for each line)   |               | 1. 00        | 2.00             | 3. 00                            |       |  |
| 0.00           | Charity care charges and uninsured discounts for the entire far<br>(see instructions)   | cility        | 7, 569, 17   | 1, 851, 552      | 9, 420, 724                      | 20.0  |  |
| 1. 00          | Cost of patients approved for charity care and uninsured disco  | unts (see     | 2, 229, 23   | 1, 851, 552      | 4, 080, 787                      | 21.0  |  |
| 2. 00          | instructions) Payments received from patients for amounts previously written  | off as        |              | 0 0              | 0                                | 22. 0 |  |
| 3. 00          | charity care<br>Cost of charity care (line 21 minus line 22)  |               | 2, 229, 23   | 1, 851, 552      | 4, 080, 787                      | 23. C |  |
|                |   |               |              |                  | 1 00                             |       |  |
| 4. 00          | Does the amount on line 20 column 2, include charges for patien   | nt days bevo  | ond a Length | of stav limit    | 1. 00<br>N                       | 24.0  |  |
|                | imposed on patients covered by Medicaid or other indigent care If line 24 is yes, enter the charges for patient days beyond the   | program?      |              |                  | 0                                |       |  |
|                | stay limit  | · ·           | - 1 - 9 -    | 3 2 2            |                                  |       |  |
| 6. 00          | Total bad debt expense for the entire hospital complex (see in  | ,             |              |                  | 9, 573, 494                      |       |  |
| 7.00           | Medicare reimbursable bad debts for the entire hospital complex   |               |              |                  | 278, 375                         |       |  |
| 7. 01<br>8. 00 | Medicare allowable bad debts for the entire hospital complex (sometimes and debt expense (see instructions)                       | see instruc   | LI OHS)      |                  | 428, 270<br>9, 145, 224          |       |  |
| 9. 00          | Cost of non-Medicare and non-reimbursable Medicare bad debt expense   | pense (see i  | instructions | )                | 2, 843, 301                      | 1     |  |
|                | ·   |               |              |                  | 6, 924, 088                      |       |  |
| 0.00           | Cost of uncompensated care (line 23 column 3 plus line 29) Total unreimbursed and uncompensated care cost (line 19 plus li        |               |              |                  | 17, 885, 424                     |       |  |

|                  | FINANCIAL SYSTEMS<br>SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O | MAJOR HOSI<br>OF EXPENSES | Provider CC             | N: 15-0097 F               | eriod:                             | Worksheet A  | 2552-10 |
|------------------|---|---------------------------|-------------------------|----------------------------|------------------------------------|--|---------|
|                  |   |                           |                         | F                          | rom 01/01/2020<br>o 12/31/2020     |  |         |
|                  | Cost Center Description   | Sal ari es                | 0ther                   | Total (col. 1<br>+ col. 2) | Reclassificat<br>ions (See<br>A-6) | Reclassified<br>Trial Balance<br>(col. 3 +-<br>col. 4) |         |
|                  |   | 1. 00                     | 2.00                    | 3. 00                      | 4.00                               | 5. 00  |         |
|                  | GENERAL SERVICE COST CENTERS  |                           | 2.00                    | 0.00                       | 1.00                               | 0.00   |         |
| 1.00             | 00100 CAP REL COSTS-BLDG & FLXT                                     |                           | 11, 564, 131            | 11, 564, 131               | 0                                  | 11, 564, 131   | 1.00    |
| 3.00             | 00300 OTHER CAPITAL RELATED COSTS                                   |                           | 0                       | C                          | 0                                  | 0  | 3.00    |
| 4.00             | 00400 EMPLOYEE BENEFITS DEPARTMENT                                  | 440, 180                  | 10, 217, 370            | 10, 657, 550               | 0                                  | 10, 657, 550   | 4.00    |
| 5.00             | 00500 ADMINISTRATIVE & GENERAL                                      | 8, 952, 213               | 22, 947, 598            | 31, 899, 811               |                                    | 31, 619, 845   | 1       |
| 7.00             | 00700 OPERATION OF PLANT  | 1, 229, 127               | 1, 814, 673             | 3, 043, 800                | I .                                | 3, 043, 800  | 1       |
| 8. 00            | 00800 LAUNDRY & LINEN SERVICE                                       | 100, 557                  | 309, 366                | 409, 923                   | I .                                | 409, 923   | 1       |
| 9.00             | 00900 HOUSEKEEPI NG   | 1, 454, 502               | 846, 234                | 2, 300, 736                | I I                                | 2, 300, 736  | 1       |
| 10.00            | 01000 DI ETARY  | 682, 383                  | 955, 282                | 1, 637, 665                |                                    | 337, 359   |         |
| 11. 00<br>13. 00 | 01100 CAFETERI A<br>01300 NURSI NG ADMI NI STRATI ON                | 1 414 207                 | 621 620                 | 2, 246, 017                | .,,                                | 1, 300, 306<br>2, 246, 017                             |         |
| 14. 00           | 01400 CENTRAL SERVICES & SUPPLY                                     | 1, 614, 387<br>262, 039   | 631, 630<br>502, 627    | 2, 246, 017<br>764, 666    | I I                                | 2, 240, 017  | 1       |
| 15. 00           | 01500 PHARMACY  | 1, 156, 987               | 10, 861, 536            | 12, 018, 523               |                                    | 12, 018, 523   |         |
| 16. 00           | 01600 MEDICAL RECORDS & LIBRARY                                     | 1, 358, 816               | 508, 016                | 1, 866, 832                |                                    | 1, 866, 832  |         |
|                  | INPATIENT ROUTINE SERVICE COST CENTERS                              | .,,                       | ,                       | .,                         | -1                                 | .,, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,                | 1       |
| 30.00            | 03000 ADULTS & PEDI ATRI CS   | 5, 808, 989               | 1, 517, 379             | 7, 326, 368                | 21, 052                            | 7, 347, 420  | 30.00   |
| 31.00            | 03100 INTENSIVE CARE UNIT   | 1, 711, 330               | 464, 459                | 2, 175, 789                | 0                                  | 2, 175, 789  | 31.00   |
|                  | ANCILLARY SERVICE COST CENTERS                                      |                           |                         |                            |                                    |  |         |
| 50.00            | 05000 OPERATING ROOM  | 2, 372, 266               | 4, 122, 945             | 6, 495, 211                |                                    | 5, 142, 604  |         |
| 53.00            | 05300 ANESTHESI OLOGY   | 2, 908, 543               | 252, 221                | 3, 160, 764                |                                    | 3, 160, 764  |         |
| 54.00            | 05400 RADI OLOGY-DI AGNOSTI C                                       | 2, 862, 557               | 3, 319, 698             | 6, 182, 255                | I I                                | 6, 182, 255  |         |
| 56.00            | 05600 RADI OI SOTOPE  | 1 241 700                 | 1 404 050               | 2 744 746                  | - 1                                | 0 747 740  |         |
| 56. 01<br>57. 00 | 05601 ONCOLOGY<br>05700 CT SCAN                                     | 1, 341, 799<br>308, 339   | 1, 404, 950<br>541, 743 | 2, 746, 749<br>850, 082    | I I                                | 2, 746, 749<br>850, 082                                |         |
| 58. 00           | 05800 MAGNETIC RESONANCE IMAGING (MRI)                              | 370, 559                  | 482, 475                | 853, 034                   | I I                                | 853, 034   |         |
| 59. 00           | 05900 CARDI AC CATHETERI ZATI ON                                    | 0                         | 402, 475                | 055, 054                   | I I                                | 033, 034   |         |
| 60.00            | 06000 LABORATORY  | 2, 118, 426               | 4, 267, 430             | 6, 385, 856                | Ö                                  | 6, 385, 856  |         |
| 65.00            | 06500 RESPIRATORY THERAPY   | 1, 105, 824               | 232, 301                | 1, 338, 125                | I I                                | 1, 338, 125  |         |
| 65. 01           | 06501 SLEEP LAB   | 430, 362                  | 157, 834                | 588, 196                   | I I                                | 588, 196   | 1       |
| 66.00            | 06600 PHYSI CAL THERAPY   | 1, 689, 756               | 238, 455                | 1, 928, 211                | 0                                  | 1, 928, 211  | 66.00   |
| 69. 00           | 06900 ELECTROCARDI OLOGY  | 702, 164                  | 1, 585, 404             | 2, 287, 568                | 0                                  | 2, 287, 568  | 69.00   |
| 71. 00           | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS                          | 0                         | 0                       | C                          | -                                  | 0  |         |
| 72.00            | 07200 I MPL. DEV. CHARGED TO PATIENT                                | 0                         | 0                       | C                          | .,                                 | 1, 775, 682  | 1       |
| 73. 00           | 07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS     | 0                         | 0]                      | C                          | oj Oj                              | 0  | 73.00   |
| 88. 00           | 08800 RURAL HEALTH CLINIC   | 921, 880                  | 1, 417, 274             | 2, 339, 154                | 57, 416                            | 2, 396, 570  | 88. 00  |
| 88. 01           | 08801 RURAL HEALTH CLINIC II  | 607, 554                  | 1, 148, 390             | 1, 755, 944                |                                    | 1, 755, 944  |         |
| 88. 02           | 08802 RURAL HEALTH CLINIC III                                       | 3, 828, 303               | 4, 720, 071             | 8, 548, 374                |                                    | 8, 548, 374  |         |
| 90.00            | 09000 CLI NI C  | 1, 259, 043               | 1, 107, 639             | 2, 366, 682                |                                    | 2, 366, 682  |         |
| 91.00            | 09100 EMERGENCY   | 2, 405, 785               | 1, 519, 309             | 3, 925, 094                | 320, 539                           | 4, 245, 633  | 91.00   |
| 92.00            | 09200 OBSERVATION BEDS (NON-DISTINCT PART)                          |                           |                         |                            |                                    |  | 92.00   |
| 92. 01           | 09201 OBSERVATION BEDS (DISTINCT PART)                              | 1, 237, 656               | 364, 755                | 1, 602, 411                | 0                                  | 1, 602, 411  | 92.01   |
| 05 00            | OTHER REIMBURSABLE COST CENTERS                                     | ٥                         | ما                      |                            | ا                                  |  | 05 00   |
|                  | 09500   AMBULANCE SERVI CES<br>  10100   HOME   HEALTH   AGENCY     | 0<br>870, 601             | 0<br>186, 585           | 1, 057, 186                | 0 0                                |  | 95.00   |
| 101.00           | SPECIAL PURPOSE COST CENTERS  | 070,001                   | 100, 303                | 1,037,100                  | <u> </u>                           | 1,037,100  | 1101.00 |
| 113.00           | 11300 I NTEREST EXPENSE   |                           | 0                       | C                          | 0                                  | 0  | 113.00  |
| 118.00           |   | 52, 112, 927              | 90, 209, 780            | 142, 322, 707              | -222, 550                          |  |         |
|                  | NONREI MBURSABLE COST CENTERS                                       |                           |                         |                            |                                    |  | ]       |
|                  | 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN                           | 0                         | 0                       | C                          |                                    |  | 190.00  |
|                  | 19001 UROLOGY   | 849                       | 4, 598                  | 5, 447                     |                                    |  | 190. 01 |
|                  | 19005 MARKETI NG  | 0                         | 0                       | C                          | 279, 966                           | 279, 966   |         |
|                  | 19007 I -74 CAMPUS  | 0                         | 74 501                  | 140 713                    | 0                                  |  | 190.07  |
|                  | 3 19008 RAMPART<br>19009 INTELLIPLEX DEVELOPMENT                    | 66, 122<br>4, 890         | 74, 591<br>28, 296      | 140, 713<br>33, 186        | I .                                | 140, 713<br>33, 186                                    |         |
|                  | 19009 INTELLIPLEX DEVELOPMENT                                       | 31, 063                   | 42, 035                 | 73, 098                    |                                    | 73, 098  |         |
|                  | 19016 RENOVO  | 88, 650                   | 83, 943                 | 172, 593                   | I I                                | 172, 593   |         |
|                  | 19017 I MA  | 00,000                    | 00, 745                 | 172, 373                   |                                    |  | 190. 17 |
|                  | 19018 MD SOLUTIONS  | o                         | -131                    | -131                       |                                    |  | 190. 18 |
|                  | 19019 MHCD  | ó                         | O                       | C                          |                                    |  | 190. 19 |
|                  | 19200 PHYSICIANS' PRIVATE OFFICES                                   | О                         | o                       | C                          | o                                  |  | 192.00  |
|                  | 19201 HOSPI TALI ST   | 2, 567, 978               | 411, 561                | 2, 979, 539                |                                    | 2, 922, 123  |         |
|                  | 07950 UNAVI E   | 189, 377                  | 45, 331                 | 234, 708                   |                                    | 234, 708   |         |
| 200.00           | TOTAL (SUM OF LINES 118 through 199)                                | 55, 061, 856              | 90, 900, 004            | 145, 961, 860              | 0                                  | 145, 961, 860  | 200.00  |
|                  |   |                           |                         |                            |                                    |  |         |

Health Financial Systems MAJOR RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES Provi der CCN: 15-0097 

|   |   |   | To 12/31/2020 Date/Time Pro 8/2/2021 2:11 |                    |
|---|---|---|---|--------------------|
| Cost Center Description   | Adjustments                             | Net Expenses                            | 072720212.11                              |                    |
|   | (See A-8)                               | For                                     |   |                    |
|   | 4 00                                    | Allocation                              |   |                    |
| GENERAL SERVICE COST CENTERS  | 6. 00                                   | 7. 00                                   |   |                    |
| 1. 00 O0100 CAP REL COSTS-BLDG & FLXT   | -1, 714, 004                            | 9, 850, 127                             |   | 1.00               |
| 3.00 00300 OTHER CAPITAL RELATED COSTS  | 0                                       |   | l .                                       | 3.00               |
| 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT   | -10, 953                                | 10, 646, 597                            |   | 4.00               |
| 5. 00 00500 ADMINISTRATIVE & GENERAL  | -11, 448, 837                           | 20, 171, 008                            | •   | 5.00               |
| 7. 00 00700 OPERATION OF PLANT  | 0                                       |   | •   | 7.00               |
| 8. 00   00800   LAUNDRY & LI NEN SERVI CE<br>9. 00   00900   HOUSEKEEPI NG                    | 1 252                                   |   | •   | 8.00               |
| 10. 00   01000   DI ETARY   | -1, 252<br>-26, 099                     |   |   | 9.00               |
| 11. 00   01100   CAFETERI A   | -338, 433                               |   |   | 11.00              |
| 13. 00 01300 NURSI NG ADMI NI STRATI ON   | -33, 831                                |   | 1   | 13.00              |
| 14.00 01400 CENTRAL SERVICES & SUPPLY   | 0                                       |   | •   | 14.00              |
| 15. 00   01500   PHARMACY   | -18, 947                                | 11, 999, 576                            |   | 15.00              |
| 16.00 01600 MEDICAL RECORDS & LIBRARY   | 0                                       | 1, 866, 832                             |   | 16. 00             |
| INPATIENT ROUTINE SERVICE COST CENTERS  |   | 7 044 470                               |   |                    |
| 30. 00   03000   ADULTS & PEDI ATRI CS  | -5, 947                                 |   | 1   | 30.00              |
| 31. 00 03100 I NTENSI VE CARE UNIT ANCI LLARY SERVI CE COST CENTERS                           | 0                                       | 2, 175, 789                             |   | 31.00              |
| 50. 00 05000 OPERATING ROOM   | -99, 332                                | 5, 043, 272                             |   | 50.00              |
| 53. 00   05300   ANESTHESI OLOGY  | -2, 934, 511                            |   | •   | 53.00              |
| 54. 00   05400   RADI OLOGY-DI AGNOSTI C  | -1, 000, 133                            |   | •   | 54.00              |
| 56. 00   05600   RADI OI SOTOPE   | 0                                       | 0                                       |   | 56.00              |
| 56. 01   05601   0NCOLOGY   | -236, 252                               |   | •   | 56. 01             |
| 57. 00   05700   CT   SCAN  | -4, 668                                 |   | •   | 57.00              |
| 58.00   05800   MAGNETI C RESONANCE I MAGING (MRI) 59.00   05900   CARDI AC CATHETERI ZATI ON | 0                                       | 853, 034<br>0                           |   | 58. 00<br>59. 00   |
| 60. 00   06000   LABORATORY   | -114, 320                               | -                                       | l .                                       | 60.00              |
| 65. 00 06500 RESPIRATORY THERAPY  | 114, 320                                |   |   | 65.00              |
| 65. 01   06501   SLEEP LAB  | 0                                       |   | •   | 65. 01             |
| 66. 00 06600 PHYSI CAL THERAPY  | -73, 242                                |   | •   | 66.00              |
| 69. 00 06900 ELECTROCARDI OLOGY   | -82, 168                                | 2, 205, 400                             |   | 69. 00             |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS  | 0                                       |   |   | 71.00              |
| 72. 00 07200 IMPL. DEV. CHARGED TO PATIENT  | 0                                       |   |   | 72.00              |
| 73. 00 O7300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS                        | 0                                       | 0                                       |   | 73. 00             |
| 88. 00 08800 RURAL HEALTH CLINIC  | 943, 000                                | 3, 339, 570                             |   | 88. 00             |
| 88. 01   08801 RURAL HEALTH CLINIC II   | 64, 624                                 |   | •   | 88. 01             |
| 88.02 08802 RURAL HEALTH CLINIC III   | 2, 203, 637                             |   | •   | 88. 02             |
| 90. 00  09000   CLI NI C  | -787, 524                               | 1, 579, 158                             |   | 90.00              |
| 91. 00   09100   EMERGENCY  | -804, 127                               | 3, 441, 506                             |   | 91.00              |
| 92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART)   |   | 4 (00 444                               |   | 92.00              |
| 92. 01   09201   OBSERVATION BEDS (DISTINCT PART) OTHER REIMBURSABLE COST CENTERS             | 0                                       | 1, 602, 411                             |   | 92. 01             |
| 95. 00 09500 AMBULANCE SERVICES   | 0                                       | 0                                       |   | 95. 00             |
| 101. 00 10100 HOME HEALTH AGENCY  | -1, 836                                 |   | •   | 101.00             |
| SPECIAL PURPOSE COST CENTERS  | , | , |   |                    |
| 113.00 11300 INTEREST EXPENSE   | 0                                       |   |   | 113. 00            |
| 118.00 SUBTOTALS (SUM OF LINES 1 through 117)   | -16, 525, 155                           | 125, 575, 002                           |   | 118. 00            |
| NONREI MBURSABLE COST CENTERS   | 1                                       | 1 0                                     |   | 100.00             |
| 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN<br>190.01 19001 UROLOGY                      | 0                                       |   | I .                                       | 190. 00<br>190. 01 |
| 190. 05 19005 MARKETI NG  | 0                                       |   | •   | 190.01             |
| 190. 07 19007 I -74 CAMPUS  | 0                                       |   | l .                                       | 190.03             |
| 190. 08 19008 RAMPART   | 0                                       | 140, 713                                | l .                                       | 190. 08            |
| 190. 09 19009 I NTELLI PLEX DEVELOPMENT   | 0                                       | 33, 186                                 |   | 190. 09            |
| 190. 11 19011 MHP ADMIN BUILDING  | 0                                       | 73, 098                                 | •   | 190. 11            |
| 190. 16 19016 RENOVO  | 0                                       | 172, 593                                | l .                                       | 190. 16            |
| 190. 17 19017 I MA  | 0                                       | 0                                       | l .                                       | 190. 17            |
| 190. 18 19018 MD SOLUTI ONS<br>190. 19 19019 MHCD   |   | -131                                    |   | 190. 18<br>190. 19 |
| 190. 19 19019 MHCD<br>192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES                            |   |   |   | 190. 19            |
| 192. 01 19201 HOSPI TALI ST   |   | 2, 922, 123                             |   | 192.00             |
| 194. 00 07950 UNAVI E   | 0                                       |   |   | 194.00             |
| 200.00 TOTAL (SUM OF LINES 118 through 199)   | -16, 525, 155                           |   | •   | 200.00             |
|   |   |   |   |                    |

Health Financial Systems MAJOR HOSPITAL In Lieu of Form CMS-2552-10
RECLASSIFICATIONS Provider CCN: 15-0097 Period: From 01/01/2020 To 12/31/2020 Date/Time Prepared:

|        |                               |           |             |             | То | 12/31/2020 | Date/Time Pre 8/2/2021 2:11 |        |
|--------|-------------------------------|-----------|-------------|-------------|----|------------|-----------------------------|--------|
|        |                               | Increases |             |             |    |            | 0/2/2021 2.1                | Pill   |
|        | Cost Center                   | Li ne #   | Sal ary     | Other       |    |            |                             |        |
|        | 2. 00                         | 3. 00     | 4. 00       | 5. 00       |    |            |                             |        |
|        | A - CAFETERIA                 |           |             |             |    |            |                             |        |
| 1.00   | CAFETERI A                    | 11. 00    | 541, 812    | 758, 494    |    |            |                             | 1.00   |
|        | 0                             |           | 541, 812    | 758, 494    |    |            |                             | ]      |
|        | B - CS&R OTHER                |           |             |             |    |            |                             |        |
| 1.00   | ADULTS & PEDIATRICS           | 30.00     | 7, 214      | 13, 838     |    |            |                             | 1.00   |
| 2.00   | OPERATING ROOM                | 50.00     | 144, 981    | 278, 094    |    |            |                             | 2.00   |
| 3.00   | EMERGENCY                     | 91. 00    | 109, 844    | 210, 695    |    |            |                             | 3.00   |
|        | 0                             |           | 262, 039    | 502, 627    |    |            |                             |        |
|        | C - MARKETING                 |           |             |             |    |            |                             |        |
| 1.00   | MARKETI NG                    | 190. 05   | 127, 547    | 152, 419    |    |            |                             | 1.00   |
|        | 0                             |           | 127, 547    | 152, 419    |    |            |                             | ]      |
|        | D - IMPLANTABLE DEVICES RECLA | ISS       |             |             |    |            |                             |        |
| 1.00   | IMPL. DEV. CHARGED TO         | 72. 00    | 101, 941    | 1, 673, 741 |    |            |                             | 1.00   |
|        | PATI ENT                      |           |             |             |    |            |                             | ]      |
|        | 0                             |           | 101, 941    | 1, 673, 741 |    |            |                             |        |
|        | E - RHC RECLASS               |           |             |             |    |            |                             |        |
| 1.00   | RURAL HEALTH CLINIC           | 88. 00    | 57, 416     | 0           |    |            |                             | 1.00   |
|        | 0                             | - $  +$   | 57, 416     |             |    |            |                             |        |
| 500.00 | Grand Total: Increases        |           | 1, 090, 755 | 3, 087, 281 |    |            |                             | 500.00 |

Health Financial Systems

MAJOR HOSPITAL

In Lieu of Form CMS-2552-10

RECLASSIFICATIONS

Provider CCN: 15-0097

Period:
From 01/01/2020
To 12/31/2020 Date/Time Prepared:

|        |                               |           |                  |                     | То             | 12/31/2020 Date/Time Pr<br>8/2/2021 2:1 | epared:<br>1 pm |
|--------|-------------------------------|-----------|------------------|---------------------|----------------|---|-----------------|
|        |                               | Decreases |                  |                     |                |   |                 |
|        | Cost Center                   | Li ne #   | Sal ary          | Other               | Wkst. A-7 Ref. |   |                 |
|        | 6. 00                         | 7. 00     | 8. 00            | 9. 00               | 10. 00         |   |                 |
|        | A - CAFETERIA                 |           |                  |                     |                |   |                 |
| 1.00   | DI ETARY                      | 10.00     | 541, 812         | 75 <u>8, 4</u> 94   | 0              |   | 1.00            |
|        | 0                             |           | 541, 812         | 758, 494            |                |   |                 |
|        | B - CS&R OTHER                |           |                  |                     |                |   |                 |
| 1.00   | CENTRAL SERVICES & SUPPLY     | 14.00     | 262, 039         | 502, 627            | 0              |   | 1.00            |
| 2.00   |                               | 0.00      | 0                | 0                   | 0              |   | 2.00            |
| 3.00   |                               | 0.00      | 0_               | 0                   | 00             |   | 3.00            |
|        | 0                             |           | 262, 039         | 502, 627            |                |   |                 |
|        | C - MARKETING                 |           |                  |                     |                |   |                 |
| 1.00   | ADMINISTRATIVE & GENERAL      | 5. 00     | 127, 547         | 15 <u>2, 4</u> 19   | 0              |   | 1.00            |
|        | 0                             |           | 127, 547         | 152, 419            | )              |   |                 |
|        | D - IMPLANTABLE DEVICES RECLA | ASS       |                  |                     |                |   |                 |
| 1.00   | OPERATI NG ROOM               | 50.00     | 101, 941         | <u>1, 673, 7</u> 41 |                |   | 1.00            |
|        | 0                             |           | 101, 941         | 1, 673, 741         |                |   |                 |
|        | E - RHC RECLASS               |           |                  |                     |                |   |                 |
| 1.00   | HOSPI TALI ST                 | 192.01    | 5 <u>7, 4</u> 16 | 0                   | 00             |   | 1.00            |
|        | 0                             |           | 57, 416          |                     | )              |   |                 |
| 500.00 | Grand Total: Decreases        |           | 1, 090, 755      | 3, 087, 281         |                |   | 500.00          |

Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS MAJOR HOSPITAL Provider CCN: 15-0097

| Period: | Worksheet A-7 | From 01/01/2020 | Part | To 12/31/2020 | Date/Time Prepared:

|        |  |               |              | To              | 12/31/2020   | Date/Time Pre 8/2/2021 2:11 |       |
|--------|--|---------------|--------------|-----------------|--------------|-----------------------------|-------|
|        |  |               |              | Acqui si ti ons |              | 0/2/2021 2.11               | PIII  |
|        |  | Beginning     | Purchases    | Donati on       | Total        | Disposals and               |       |
|        |  | Bal ances     |              |                 |              | Retirements                 |       |
|        |  | 1.00          | 2.00         | 3.00            | 4. 00        | 5. 00                       |       |
|        | PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE | T BALANCES    |              |                 |              |                             |       |
| 1.00   | Land   | 2, 900, 662   | 0            | 0               | 0            | 0                           | 1.00  |
| 2.00   | Land Improvements                            | 12, 298, 052  | 0            | 0               | 0            | 0                           | 2.00  |
| 3.00   | Buildings and Fixtures                       | 116, 771, 310 | 12, 132, 174 | 0               | 12, 132, 174 | 0                           | 3.00  |
| 4.00   | Building Improvements                        | 0             | 268, 012     | 0               | 268, 012     | 0                           | 4. 00 |
| 5.00   | Fixed Equipment                              | 6, 969, 171   | 0            | 0               | 0            | 2, 318, 935                 | 5.00  |
| 6.00   | Movable Equipment                            | 61, 546, 259  | 1, 316, 471  | 0               | 1, 316, 471  | 0                           | 6.00  |
| 7.00   | HIT designated Assets                        | 0             | 0            | 0               | 0            | 0                           | 7.00  |
| 8. 00  | Subtotal (sum of lines 1-7)                  | 200, 485, 454 | 13, 716, 657 | 0               | 13, 716, 657 | 2, 318, 935                 |       |
| 9.00   | Reconciling Items                            | 0             | 0            | 0               | 0            | 0                           | ,     |
| 10.00  | Total (line 8 minus line 9)                  | 200, 485, 454 | 13, 716, 657 | 0               | 13, 716, 657 | 2, 318, 935                 | 10.00 |
|        |  | Endi ng       | Ful I y      |                 |              |                             |       |
|        |  | Bal ance      | Depreci ated |                 |              |                             |       |
|        |  |               | Assets       |                 |              |                             |       |
|        |  | 6. 00         | 7. 00        |                 |              |                             |       |
|        | PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE |               | _            |                 |              |                             |       |
| 1.00   | Land   | 2, 900, 662   | 0            |                 |              |                             | 1.00  |
| 2. 00  | Land Improvements                            | 12, 298, 052  | 0            |                 |              |                             | 2.00  |
| 3.00   | Buildings and Fixtures                       | 128, 903, 484 | 0            |                 |              |                             | 3.00  |
| 4. 00  | Building Improvements                        | 268, 012      | 0            |                 |              |                             | 4.00  |
| 5. 00  | Fi xed Equi pment                            | 4, 650, 236   | 0            |                 |              |                             | 5.00  |
| 6.00   | Movabl e Equi pment                          | 62, 862, 730  | 0            |                 |              |                             | 6.00  |
| 7.00   | HIT designated Assets                        | 014 000 47/   | 0            |                 |              |                             | 7.00  |
| 8.00   | Subtotal (sum of lines 1-7)                  | 211, 883, 176 | 0            |                 |              |                             | 8.00  |
| 9.00   | Reconciling Items                            | 011 002 17/   | 0            |                 |              |                             | 9.00  |
| 10. 00 | Total (line 8 minus line 9)                  | 211, 883, 176 | 0            |                 |              |                             | 10.00 |

| Health Financial Systems MAJOR HOSPITAL      |                  |               |               | In Lieu of Form CMS-2552-10                  |   |      |  |
|--|------------------|---------------|---------------|--|---|------|--|
| RECONCILIATION OF CAPITAL COSTS CENTERS      |                  | Provi der Co  | CN: 15-0097   | Peri od:<br>From 01/01/2020<br>To 12/31/2020 | Worksheet A-7<br>Part II<br>Date/Time Pre |      |  |
|  |                  |               |               |  | 8/2/2021 2:11                             |      |  |
|  |                  | SU            | JMMARY OF CAP | PI TAL                                       |   |      |  |
| Cost Center Description                      | Depreciation     | Lease         | Interest      | Insurance                                    | Taxes (see                                |      |  |
|  |                  |               |               | (see instructions)                           | instructions)                             |      |  |
|  | 9. 00            | 10. 00        | 11. 00        | 12.00  | 13.00                                     |      |  |
| PART II - RECONCILIATION OF AMOUNTS FROM WOR |                  |               | and 2         |  |   |      |  |
| 1.00 CAP REL COSTS-BLDG & FLXT               | 11, 564, 131     | l e           |               | 0 0  | 0   | 1.00 |  |
| 3.00   Total (sum of lines 1-2)              | 11, 564, 131     |               |               | 0 0  | 0   | 3.00 |  |
|  | SUMMARY 0        | F CAPITAL     |               |  |   |      |  |
| Cost Center Description                      | Other            | Total (1)     |               |  |   |      |  |
|  | Capi tal -Rel at |               |               |  |   |      |  |
|  | ed Costs (see    | 9 through 14) |               |  |   |      |  |
|  | instructions)    |               |               |  |   |      |  |
|  | 14. 00           | 15. 00        |               |  |   |      |  |
| PART II - RECONCILIATION OF AMOUNTS FROM WOR | KSHEET A, COLU   |               |               |  |   |      |  |
| 1.00 CAP REL COSTS-BLDG & FLXT               | 0                | 11, 564, 131  | 1             |  |   | 1.00 |  |
| 3.00  Total (sum of lines 1-2)               | 0                | 11, 564, 131  |               |  |   | 3.00 |  |

| Heal th                                 | Financial Systems                            | MAJOR HO      | SPITAL           |                        | In Lie                     | u of Form CMS-2                 | 2552-10 |
|---|--|---------------|------------------|------------------------|----------------------------|---------------------------------|---------|
| RECONCILIATION OF CAPITAL COSTS CENTERS |  |               | Provi der C      |                        | Period:<br>From 01/01/2020 |                                 |         |
|   |  |               |                  | -                      | Го 12/31/2020              | Date/Time Prep<br>8/2/2021 2:11 |         |
|   |  | COMF          | PUTATION OF RAT  | TI 0S                  | ALLOCATION OF              | OTHER CAPITAL                   |         |
|   | Cost Center Description                      | Gross Assets  | Capi tal i zed   | Gross Assets           | Ratio (see                 | Insurance                       |         |
|   |  |               | Leases           | for Ratio<br>(col. 1 - | instructions)              |                                 |         |
|   |  |               |                  | col . 2)               |                            |                                 |         |
|   |  | 1. 00         | 2. 00            | 3. 00                  | 4. 00                      | 5. 00                           |         |
|   | PART III - RECONCILIATION OF CAPITAL COSTS C |               |                  |                        |                            |                                 |         |
| 1.00                                    | CAP REL COSTS-BLDG & FIXT                    | 211, 883, 176 |                  | 211, 883, 176          |                            |                                 | 1.00    |
| 3.00                                    | Total (sum of lines 1-2)                     | 211, 883, 176 |                  | 211, 883, 176          |                            |                                 | 3.00    |
|   |  | ALLOCAT       | FION OF OTHER (  | CAPI TAL               | SUMMARY O                  | F CAPITAL                       |         |
|   | Cost Center Description                      | Taxes         | 0ther            | Total (sum of          | Depreciation               | Lease                           |         |
|   |  |               | Capi tal -Rel at |                        |                            |                                 |         |
|   |  |               | ed Costs         | through 7)             |                            |                                 |         |
|   |  | 6. 00         | 7. 00            | 8. 00                  | 9. 00                      | 10.00                           |         |
|   | PART III - RECONCILIATION OF CAPITAL COSTS C | ENTERS        |                  |                        |                            |                                 |         |
| 1.00                                    | CAP REL COSTS-BLDG & FIXT                    | 0             | 0                | (                      | 11, 546, 131               |                                 | 1. 00   |
| 3.00                                    | Total (sum of lines 1-2)                     | 0             | 0                | (                      | 11, 546, 131               | 0                               | 3.00    |
|   |  |               | Sl               | JMMARY OF CAPI         | TAL                        |                                 |         |
|   | Cost Center Description                      | Interest      | Insurance        | Taxes (see             | 0ther                      | Total (2)                       |         |
|   |  |               | (see             | instructions)          |                            |                                 |         |
|   |  |               | instructions)    |                        | ed Costs (see              | 9 through 14)                   |         |
|   |  |               |                  |                        | instructions)              |                                 |         |
|   |  | 11. 00        | 12. 00           | 13. 00                 | 14. 00                     | 15. 00                          |         |
|   | PART III - RECONCILIATION OF CAPITAL COSTS C |               |                  |                        |                            |                                 |         |
| 1.00                                    | CAP REL COSTS-BLDG & FIXT                    | -1, 696, 004  |                  | 1                      | 0                          | 9, 850, 127                     | 1. 00   |
| 3.00                                    | Total (sum of lines 1-2)                     | -1, 696, 004  | 0                | (                      | 0                          | 9, 850, 127                     | 3.00    |

In Lieu of Form CMS-2552-10 Provi der CCN: 15-0097 Worksheet A-8 From 01/01/2020 12/31/2020 Date/Time Prepared: 8/2/2021 2:11 pm Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted Basis/Code Cost Center Line # Wkst. A-7 Cost Center Description Amount (2) Ref. 1.00 2.00 3.00 4.00 5. 00 1.00 Investment income - CAP REL -1, 696, 004 CAP REL COSTS-BLDG & FIXT 1. 00 11 1.00 COSTS-BLDG & FIXT (chapter 2) 0 \*\*\* Cost Center Deleted \*\*\* 2.00 Investment income - CAP REL 2.00 2.00 COSTS-MVBLE EQUIP (chapter 2) 3.00 Investment income - other 0.00 3.00 (chapter 2) 4.00 Trade, quantity, and time 0.00 4.00 discounts (chapter 8) 5.00 Refunds and rebates of 5.00 0.00 expenses (chapter 8) Rental of provider space by 6.00 0.00 6.00 suppliers (chapter 8) 7.00 Tel ephone services (pay Α -3.727 ADMINISTRATIVE & GENERAL 5 00 7.00 stations excluded) (chapter 8.00 Television and radio service 0 0.00 8.00 (chapter 21) 9.00 Parking lot (chapter 21) 0.00 9.00 Provi der-based physici an -5, 823, 201 10.00 10.00 A-8-2 adjustment 11.00 Sale of scrap, waste, etc. 0.00 11.00 (chapter 23) Related organization 3, 238, 818 12.00 12.00 A-8-1 transactions (chapter 10) 13.00 Laundry and linen service 0.00 13.00 14.00 Cafeteria-employees and guests -338, 433 CAFETERI A Α 11.00 14.00 15.00 Rental of quarters to employee 0.00 15.00 and others Sale of medical and surgical 16.00 16.00 0 0.00 supplies to other than pati ents 17.00 Sale of drugs to other than 0.00 17.00 pati ents Sale of medical records and 18.00 0.00 18.00 abstracts 19.00 Nursing and allied health 0.00 19.00 education (tuition, fees, books, etc.) Nursing and allied health 19.01 0.00 19.01 education (tuition, fees, books, etc.) 20.00 Vending machines 0.00 20.00 Income from imposition of 21 00 0 00 21 00 interest, finance or penalty charges (chapter 21) 22.00 Interest expense on Medicare 0.00 22.00 overpayments and borrowings to repay Medicare overpayments Adjustment for respiratory ORESPIRATORY THERAPY 23.00 23.00 A-8-3 65.00 therapy costs in excess of limitation (chapter 14) Adjustment for physical OPHYSICAL THERAPY 24.00 24.00 A-8-3 66.00 therapy costs in excess of limitation (chapter 14) 0 \*\*\* Cost Center Deleted \*\*\* 25.00 Utilization review 114.00 25.00 physicians' compensation (chapter 21) 26, 00 Depreciation - CAP REL OCAP REL COSTS-BLDG & FIXT 1.00 Λ 26.00 COSTS-BLDG & FIXT 0 \*\*\* Cost Center Deleted \*\*\* Depreciation - CAP REL 27.00 27.00 2.00 COSTS-MVBLE EQUIP

0 \*\*\* Cost Center Deleted \*\*\*

0 \*\*\* Cost Center Deleted \*\*\*

19.00

0.00

67.00

28.00

29.00

30.00

29.00

30.00

Non-physician Anesthetist

Adjustment for occupational

therapy costs in excess of limitation (chapter 14)

A-8-3

Physicians' assistant

Health Financial Systems
ADJUSTMENTS TO EXPENSES In Lieu of Form CMS-2552-10
Worksheet A-8 Peri od: Worksheet A-8 From 01/01/2020 Date/Time Prepared: 0/2/2021 2:11 pm Provider CCN: 15-0097

|                  |   |                    |                      | To  | 12/31/2020        | Date/Time Pre<br>8/2/2021 2:11 |                  |
|------------------|---|--------------------|----------------------|---|-------------------|--------------------------------|------------------|
|                  |   |                    |                      | Expense Classification on To/From Which the Amount is t |                   | 07272021 2.11                  | Pini<br>         |
|                  |   |                    |                      |   | ,                 |                                |                  |
|                  |   |                    |                      |   |                   |                                |                  |
|                  |   |                    |                      |   |                   |                                |                  |
|                  | Cook Cooks Books at a                                     | D:-/0I-            | A                    | 0+ 0+   | 1: "              | W+ A 7                         |                  |
|                  | Cost Center Description                                   | Basi s/Code<br>(2) | Amount               | Cost Center   | Li ne #           | Wkst. A-7<br>Ref.              |                  |
| 20.00            |   | 1. 00              | 2. 00                | 3.00  | 4. 00             | 5. 00                          | 20.00            |
| 30. 99           | Hospice (non-distinct) (see instructions)                 |                    | 0                    | ADULTS & PEDIATRICS                                     | 30. 00            |                                | 30. 99           |
| 31. 00           | Adjustment for speech pathology costs in excess of        | A-8-3              | О                    | *** Cost Center Deleted ***                             | 68. 00            |                                | 31.00            |
| 32. 00           | limitation (chapter 14)<br>CAH HIT Adjustment for         |                    | О                    |   | 0. 00             | 0                              | 32.00            |
| 33. 00           | Depreciation and Interest OTHER ADJUSTMENTS (SPECIFY)     |                    | 0                    |   | 0. 00             | 0                              | 33. 00           |
| 34. 00           | (3)<br>OTHER ADJUSTMENTS (SPECIFY)                        |                    | 0                    |   | 0. 00             | 0                              | 34.00            |
| 34. 01           | (3)<br>OTHER ADJUSTMENTS (SPECIFY)                        |                    | 0                    |   | 0. 00             | 0                              | 34. 01           |
| 35. 00           | (3)<br>MAJ OTHER REVENUES RENTAL                          | В                  | -18, 000             | CAP REL COSTS-BLDG & FIXT                               | 1. 00             | 9                              | 35. 00           |
| 36. 00           | I NCOME MAJ TECHNOLOGY SERV CONTRACT                      | В                  |                      | ADMINISTRATIVE & GENERAL                                | 5. 00             | 0                              |                  |
| 37. 00           | LABOR MAJ PATIENT ACCESS CONTRACT                         | В                  | ·                    | ADMINISTRATIVE & GENERAL                                | 5. 00             | 0                              | 37.00            |
|                  | LABOR   |                    |                      |   |                   | _                              |                  |
| 38. 00<br>40. 00 | MAJ ACCOUNTING CONTRACT LABOR MAJ ADMINISTRATION CONTRACT | B<br>B             |                      | ADMINISTRATIVE & GENERAL ADMINISTRATIVE & GENERAL       | 5. 00<br>5. 00    | 0                              | 38. 00<br>40. 00 |
| 41. 00           | LABOR<br>MH EDUCATION CLASS REVENUE                       | В                  | 26, 760              | ADMINISTRATIVE & GENERAL                                | 5. 00             | 0                              | 41.00            |
| 42.00            | MAJ ACCOUNTING VENDOR REBATES                             | B<br>B             | -21, 593             | ADMINISTRATIVE & GENERAL                                | 5. 00             | 0                              | 42.00            |
| 44. 00           | MAJ OTHER REVENUES PURCHASE<br>DI SCOUNT                  |                    | ·                    | ADMINISTRATIVE & GENERAL                                | 5. 00             | 0                              |                  |
| 45. 00           | MAJ OTHER REVENUES<br>REAPPOINTMENT FEE                   | В                  | 4, 473               | ADMINISTRATIVE & GENERAL                                | 5. 00             | 0                              | 45.00            |
| 45. 01           | MAJ PATIENT FINANCI PHYSICIAN<br>BILLIN                   | В                  | -532, 255            | ADMINISTRATIVE & GENERAL                                | 5. 00             | 0                              | 45. 01           |
| 45. 02           | MAJ ENVIRONMENTAL S OTHER                                 | В                  | -1, 252              | HOUSEKEEPI NG   | 9. 00             | 0                              | 45. 02           |
| 45. 03           | MAJ FOOD AND NUTRIT OTHER                                 | В                  | 0                    | CAFETERI A  | 11. 00            | 0                              | 45. 03           |
| 45. 04<br>45. 05 | MAJ PHARMACY VENDOR REBATES MAJ OTHER REVENUES XEROX AND  | B<br>B             |                      | PHARMACY<br>ADMINISTRATIVE & GENERAL                    | 15. 00<br>5. 00   | 0                              | 45. 04<br>45. 05 |
|                  | COPYI NG  |                    |                      |   |                   | _                              |                  |
| 45. 06<br>45. 07 | MAJ INPATIENT-AMU OTHER INCOME MAJ RESPIRATORY CAR VENDOR | B<br>B             |                      | ADULTS & PEDIATRICS<br>RESPIRATORY THERAPY              | 30. 00<br>65. 00  | 0                              | 45. 06<br>45. 07 |
| 45. 08           | REBATES MAJ REHABILATION SE CONTRACT                      | В                  | -64, 968             | PHYSI CAL THERAPY                                       | 66. 00            | 0                              | 45. 08           |
| 45. 09           | LABOR MAJ CARDIAC DISEASE CONTRACT                        | В                  | -61, 992             | ELECTROCARDI OLOGY                                      | 69. 00            | 0                              | 45. 09           |
| 45. 10           | LABOR MAJ CENTRAL SUPPLY VENDOR                           | В                  | -4, 332              | OPERATING ROOM  | 50. 00            | 0                              | 45. 10           |
| 45. 11           | REBATES MH MHP FIM OTHER INCOME                           | В                  | -670                 | RURAL HEALTH CLINIC III                                 | 88. 02            | 0                              | 45. 11           |
| 45. 12<br>45. 13 | MAJ DISEASE MGT CLASS REVENUE MAJ MEDICAL SPECIAL RENTAL  | B<br>B             | -1, 750<br>-204, 675 | CLINIC  | 90. 00<br>90. 00  | 0                              |                  |
|                  | INCOME MAJ ONSITE SOLUTION OTHER                          | В                  |                      | ADMINISTRATIVE & GENERAL                                | 5. 00             | 0                              |                  |
|                  | I NCOME   |                    |                      |   |                   | _                              |                  |
| 45. 15           | MAJ OTHER REVENUES OTHER I NCOME                          | В                  | ·                    | ADMINISTRATIVE & GENERAL                                | 5. 00             | 0                              |                  |
| 45. 16<br>45. 17 | MAJ HOME HEALTH OTHER DISCOUNT<br>MEALS ON WHEELS         | B<br>A             |                      | HOME HEALTH AGENCY<br>DIETARY                           | 101. 00<br>10. 00 | 0                              | 45. 16<br>45. 17 |
| 45. 18           | PROMOTI ONAL GIFTS  | A                  |                      | ADMINISTRATIVE & GENERAL                                | 5. 00             | 0                              | 45. 18           |
| 45. 19           | PROMOTIONAL GIFTS   | Α                  | -284                 | NURSING ADMINISTRATION                                  | 13. 00            | 0                              | 45. 19           |
| 45. 20           | PROMOTIONAL GIFTS   | A                  |                      | ADULTS & PEDIATRICS                                     | 30.00             | 0                              | 45. 20           |
| 45. 21           | PROMOTIONAL GIFTS   | A                  |                      | RADI OLOGY-DI AGNOSTI C                                 | 54.00             | 0                              | 45. 21           |
| 45. 22           | PROMOTIONAL GIFTS   | A                  | · ·                  | ONCOLOGY  | 56. 01            | 0                              |                  |
| 45. 23           | PROMOTIONAL GIFTS   | A                  |                      | PHYSI CAL THERAPY                                       | 66.00             | 0                              |                  |
| 45. 24           | PROMOTIONAL GIFTS   | A                  |                      | RURAL HEALTH CLINIC                                     | 88. 00            | 0                              | 45. 24           |
| 45. 25<br>45. 26 | PROMOTIONAL GIFTS   | A                  |                      | RURAL HEALTH CLINIC II CLINIC                           | 88. 01<br>90. 00  | 0                              | 45. 25<br>45. 26 |
| 45. 26<br>45. 27 | PROMOTIONAL GIFTS MAJ MAJOR PEDIATRIC                     | A<br>A             |                      | RURAL HEALTH CLINIC                                     | 90. 00<br>88. 00  | 0                              | 45. 26           |
|                  | ADVERTI SI NG   | 73                 |                      | NOTICE HEALTH OLIVIO                                    | 55.00             | U                              | 75.21            |

From 01/01/2020 | To 12/31/2020 | Date/Time Prepared:

|        |                                       |             |               | To                           | 12/31/2020      | Date/Time Pre 8/2/2021 2:11 |         |
|--------|---------------------------------------|-------------|---------------|------------------------------|-----------------|-----------------------------|---------|
|        | ·                                     |             |               | Expense Classification on    | Worksheet A     | 0/2/2021 2.11               | Pili    |
|        |                                       |             |               | To/From Which the Amount is  |                 |                             |         |
|        |                                       |             |               | To the miner the miner has   | to be haj astea |                             |         |
|        |                                       |             |               |                              |                 |                             |         |
|        |                                       |             |               |                              |                 |                             |         |
|        |                                       |             |               |                              |                 |                             |         |
|        |                                       |             |               |                              |                 |                             |         |
|        |                                       |             |               |                              |                 |                             |         |
|        | Cost Center Description               | Basi s/Code | Amount        | Cost Center                  | Li ne #         | Wkst. A-7                   |         |
|        |                                       | (2)         |               |                              |                 | Ref.                        |         |
|        | T                                     | 1. 00       | 2. 00         | 3. 00                        | 4. 00           | 5. 00                       |         |
| 45. 28 | MAJ WOUND CARE ADVERTISING            | A           |               | CLINIC                       | 90. 00          | 0                           |         |
|        | MAJ HOME HEALTH ADVERTISING           | A           |               | HOME HEALTH AGENCY           | 101. 00         |                             |         |
| 45. 30 | MAJ MHP FIM ADVERTISING               | A           |               | RURAL HEALTH CLINIC III      | 88. 02          |                             |         |
| 45. 31 |                                       | A           | -9, 374       | ADMINISTRATIVE & GENERAL     | 5. 00           | 0                           | 45. 31  |
|        | ADVERTI SI NG                         |             |               |                              |                 |                             |         |
| 45. 32 | MAJ MARKETING ADVERTISING             | A           |               | ADMINISTRATIVE & GENERAL     | 5. 00           | 0                           | 1 .0.02 |
| 45. 33 |                                       | A           | -6, 899       | EMPLOYEE BENEFITS DEPARTMENT | 4. 00           | 0                           | 45. 33  |
|        | ADVERTI SI NG                         | _           |               |                              |                 | _                           |         |
| 45. 34 | MAJ MHP FIM OP/OTHER                  | В           |               | RURAL HEALTH CLINIC III      | 88. 02          | 0                           |         |
| 45. 35 |                                       | A           | -4, 137       | PHYSI CAL THERAPY            | 66. 00          | 0                           | 45. 35  |
| 45 07  | ADVERTI SI NG-SPOR                    |             | 055           | 5.15.1. 1.5.1. 5.1. 6.1.1.   | 00.04           |                             | 45.07   |
| 45. 36 |                                       | A           | -255          | RURAL HEALTH CLINIC II       | 88. 01          | 0                           | 45. 36  |
| 45 07  | ADVERTI SI NG                         |             | 252.054       | ADMINISTRATIVE & CENEDAL     | F 00            | 0                           | 45 07   |
| 45. 37 | COMMUNITY OUTREACH                    | A           |               | ADMINISTRATIVE & GENERAL     | 5. 00           |                             | 45. 37  |
| 45. 38 | HAF EXPENSE                           | A           |               | ADMINISTRATIVE & GENERAL     | 5. 00           | 0                           |         |
| 45. 39 | NON-ALLOWABLE RHC                     | A           |               | RURAL HEALTH CLINIC II       | 88. 01<br>5. 00 | 0                           |         |
| 45. 40 | LOBBYING % OF DUES                    | A           |               | ADMINISTRATIVE & GENERAL     |                 | 0                           | 1 .00   |
| 45. 41 | MISC PURCHASED SERVICES               | A           | -5, 231, 754  | ADMINISTRATIVE & GENERAL     | 5. 00           | 0                           | 1       |
| 45. 42 | OTHER ADJUSTMENTS (SPECIFY)           |             | 0             |                              | 0. 00           | 0                           | 45. 42  |
| 50. 00 | (3)<br>TOTAL (sum of lines 1 thru 49) |             | 16 525 155    |                              |                 |                             | 50.00   |
| 50.00  | (Transfer to Worksheet A,             |             | -16, 525, 155 |                              |                 |                             | 30.00   |
|        | column 6, line 200.)                  |             |               |                              |                 |                             |         |
|        | LOLUIIII O, TITIE 200.)               |             |               |                              |                 |                             |         |

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

<sup>(2)</sup> 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.

|      |   |                         |               | 10 12/31/2020  | 8/2/2021 2: 11 |      |  |  |  |
|------|---|-------------------------|---------------|----------------|----------------|------|--|--|--|
|      | Li ne No.   | Cost Center             | Expense Items | Amount of      | Amount         |      |  |  |  |
|      |   |                         | ·             | Allowable Cost | Included in    |      |  |  |  |
|      |   |                         |               |                | Wks. A, column |      |  |  |  |
|      |   |                         |               |                | 5              |      |  |  |  |
|      | 1. 00   | 2. 00                   | 3. 00         | 4. 00          | 5. 00          |      |  |  |  |
|      | A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME |                         |               |                |                |      |  |  |  |
|      | OFFICE COSTS:   |                         |               |                |                |      |  |  |  |
| 1.00 | 88.00   | RURAL HEALTH CLINIC     | MHP PEDS RHC  | 1, 749, 717    | 806, 577       | 1.00 |  |  |  |
| 2.00 | 88. 01  | RURAL HEALTH CLINIC II  | MHP OBGYN RHC | 818, 532       | 728, 534       | 2.00 |  |  |  |
| 3.00 | 88. 02  | RURAL HEALTH CLINIC III | MHP FIM RHC   | 5, 156, 478    | 2, 950, 798    | 3.00 |  |  |  |
| 4.00 | 0.00  |                         |               | 0              | 0              | 4.00 |  |  |  |
| 5.00 | TOTALS (sum of lines 1-4).  |                         |               | 7, 724, 727    | 4, 485, 909    | 5.00 |  |  |  |
|      | Transfer column 6, line 5 to  |                         |               |                |                |      |  |  |  |
|      | Worksheet A-8, column 2,  |                         |               |                |                |      |  |  |  |
|      | line 12.  |                         |               |                |                |      |  |  |  |

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

|                              |                               |               | Related Organization(s) and/or Home Office |               |  |
|------------------------------|-------------------------------|---------------|--|---------------|--|
|                              |                               |               |  |               |  |
|                              |                               |               |  |               |  |
| Symbol (1)                   | Name                          | Percentage of | Name                                       | Percentage of |  |
|                              |                               | Ownershi p    |  | Ownershi p    |  |
| 1. 00                        | 2. 00                         | 3. 00         | 4. 00                                      | 5. 00         |  |
| B. INTERRELATIONSHIP TO RELA | TED ORGANIZATION(S) AND/OR HO | ME OFFICE:    |  |               |  |

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

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

| 6. 00  | В                       | 0.00 MMG 100.00 | 6.00   |
|--------|-------------------------|-----------------|--------|
| 7. 00  |                         | 0.00            | 7. 00  |
| 8. 00  |                         | 0.00            | 8.00   |
| 9. 00  |                         | 0.00            | 9.00   |
| 10.00  |                         | 0.00            | 10.00  |
| 100.00 | G. Other (financial or  |                 | 100.00 |
|        | non-financial) specify: |                 |        |

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

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

| Heal th           | ealth Financial Systems |                 | MAJOR HOSPITAL |               |               |             |       | In Lieu of Form CMS-2552-1 |                             |                                |                 |
|-------------------|-------------------------|-----------------|----------------|---------------|---------------|-------------|-------|----------------------------|-----------------------------|--------------------------------|-----------------|
| STATEME<br>OFFICE | ENT OF COSTS OF         | SERVICES FROM   | RELATED        | ORGANI ZATI C | ONS AND HOME  | Provi der   | CCN:  | 15-0097                    | Peri od:<br>From 01/01/2020 | Worksheet A-8                  | 8-1             |
| OTTICE            | 00313                   |                 |                |               |               |             |       |                            | To 12/31/2020               | Date/Time Pre<br>8/2/2021 2:11 | epared:<br>1 pm |
|                   | Net                     | Wkst. A-7 Ref.  |                |               |               |             |       |                            |                             |                                |                 |
|                   | Adjustments             |                 |                |               |               |             |       |                            |                             |                                |                 |
|                   | (col. 4 minus           |                 |                |               |               |             |       |                            |                             |                                |                 |
|                   | col. 5)*                |                 |                |               |               |             |       |                            |                             |                                |                 |
|                   | 6. 00                   | 7. 00           |                |               |               |             |       |                            |                             |                                |                 |
|                   | A. COSTS INCUR          | RED AND ADJUSTI | MENTS RE       | QUI RED AS A  | RESULT OF TRA | ANSACTI ONS | WIT   | H RELATED                  | ORGANI ZATI ONS OR          | CLAIMED HOME                   |                 |
|                   | OFFICE COSTS:           |                 |                |               |               |             |       |                            |                             |                                |                 |
| 1.00              | 943, 140                | 0               |                |               |               |             |       |                            |                             |                                | 1.00            |
| 2.00              | 89, 998                 | 0               |                |               |               |             |       |                            |                             |                                | 2.00            |
| 3.00              | 2, 205, 680             | 0               |                |               |               |             |       |                            |                             |                                | 3.00            |
| 4.00              | 0                       | 0               |                |               |               |             |       |                            |                             |                                | 4.00            |
| 5.00              | 3, 238, 818             |                 |                |               |               |             |       |                            |                             |                                | 5.00            |
| * The             | amounts on line         | es 1-4 (and sub | scri pts       | as appropri   | ate) are tran | nsferred i  | n de  | tail to Wo                 | rksheet A, column           | 6, lines as                    |                 |
| appropr           | i ate. Positi ve        | amounts increas | se cost a      | and negative  | amounts decr  | ease cost   | . For | related o                  | rganization or ho           | me office cos                  | t which         |
| has not           | been posted to          | o Worksheet A,  | col umns       | 1 and/or 2,   | the amount a  | allowable   | shoul | ld be indi                 | cated in column 4           | of this part.                  |                 |
|                   | Related Orga            | ani zati on(s)  |                |               |               |             | •     |                            |                             | ·                              |                 |
|                   | and/or Ho               | me Office       |                |               |               |             |       |                            |                             |                                |                 |
|                   |                         |                 |                |               |               |             |       |                            |                             |                                |                 |
|                   |                         |                 |                |               |               |             |       |                            |                             |                                |                 |
|                   | Type of                 | Busi ness       |                |               |               |             |       |                            |                             |                                |                 |
|                   |                         |                 |                |               |               |             |       |                            |                             |                                |                 |
|                   | 6                       | 00              |                |               |               |             |       |                            |                             |                                |                 |

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              | PHYSI CI AN GROUP |    | 6.00   |
|-------------------|-------------------|----|--------|
| 7.00              |                   |    | 7.00   |
| 8.00              |                   |    | 8.00   |
| 9.00              |                   |    | 9.00   |
| 10.00             |                   |    | 10.00  |
| 10. 00<br>100. 00 |                   | 10 | 100.00 |

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

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

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

  D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organi zati on.
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provi der.

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

|        |                |                              |                |               |                 |               | 8/2/2021 2: 1    | l pm   |
|--------|----------------|------------------------------|----------------|---------------|-----------------|---------------|------------------|--------|
|        | Wkst. A Line # | Cost Center/Physician        | Total          | Professi onal | Provi der       | RCE Amount    | Physi ci an/Prov |        |
|        |                | I denti fi er                | Remuneration   | Component     | Component       |               | ider Component   |        |
|        |                |                              |                |               |                 |               | Hours            |        |
|        | 1.00           | 2. 00                        | 3. 00          | 4. 00         | 5. 00           | 6. 00         | 7. 00            |        |
| 1.00   | 4. 00          | EMPLOYEE BENEFITS DEPARTMENT | 29, 011        | 0             | 29, 011         | 179, 000      | 290              | 1.00   |
| 2.00   | 5. 00          | ADMINISTRATIVE & GENERAL     | 403            | 0             | 403             | 179, 000      | 4                | 2.00   |
| 3.00   | 13. 00         | NURSING ADMINISTRATION       | 33, 547        | 33, 547       | 0               | 0             | 0                | 3.00   |
| 4.00   | 50.00          | OPERATING ROOM               | 95, 000        | 95, 000       | 0               | 0             | 0                | 4.00   |
| 5.00   | 53.00          | ANESTHESI OLOGY              | 3, 269, 671    | 2, 616, 887   | 652, 784        | 239, 400      | 2, 912           | 5.00   |
| 6.00   | 54.00          | RADI OLOGY-DI AGNOSTI C      | 999, 637       | 999, 637      | 0               | 0             | 0                | 6.00   |
| 7.00   |                | ONCOLOGY                     | 252, 013       | 227, 013      | 25, 000         | 271, 900      | 150              | 7.00   |
| 8. 00  | 57. 00         | CT SCAN                      | 4, 668         | 4, 668        | 0               | 0             | 0                | 8. 00  |
| 9. 00  | 60.00          | LABORATORY                   | 135, 469       |               | 135, 469        | 260, 300      | 169              | 9. 00  |
| 10.00  | 69.00          | ELECTROCARDI OLOGY           | 20, 176        | 20, 176       | 0               | 0             | 0                | 10.00  |
| 11.00  | 90, 00         | CLINIC                       | 603, 244       | 556, 704      | 46, 540         | 179, 000      | 262              | 11.00  |
| 12.00  |                | EMERGENCY                    | 847, 500       |               | · ·             | 179, 000      |                  |        |
| 200.00 |                |                              | 6, 290, 339    |               | · ·             |               | 4, 291           | 200.00 |
|        | Wkst. A Line # | Cost Center/Physician        | Unadjusted RCE |               | Cost of         | Provi der     | Physician Cost   |        |
|        |                | I denti fi er                | Li mi t        |               | Memberships &   |               | of Mal practice  |        |
|        |                |                              |                | Limit         | Conti nui ng    | Share of col. | Insurance        |        |
|        |                |                              |                |               | Educati on      | 12            |                  |        |
|        | 1. 00          | 2.00                         | 8. 00          | 9. 00         | 12.00           | 13. 00        | 14.00            |        |
| 1. 00  | 4. 00          | EMPLOYEE BENEFITS DEPARTMENT | 24, 957        | 1, 248        | 0               | 0             | 0                | 1. 00  |
| 2.00   | 5. 00          | ADMINISTRATIVE & GENERAL     | 344            | 17            | 0               | 0             | 0                | 2.00   |
| 3.00   | 13. 00         | NURSING ADMINISTRATION       | 0              | 0             | 0               | 0             | 0                | 3.00   |
| 4.00   | 50. 00         | OPERATING ROOM               | 0              |               | 0               | 0             | 0                | 4.00   |
| 5.00   | 53. 00         | ANESTHESI OLOGY              | 335, 160       | 16, 758       | 0               | 0             | 0                | 5.00   |
| 6.00   | 54. 00         | RADI OLOGY-DI AGNOSTI C      | 0              |               | 0               | 0             | 0                | 6.00   |
| 7.00   | 56. 01         | ONCOLOGY                     | 19, 608        | 980           | 0               | 0             | 0                | 7.00   |
| 8.00   | 57. 00         | CT SCAN                      | 0              |               | 0               | 0             | 0                | 8. 00  |
| 9. 00  | 60.00          | LABORATORY                   | 21, 149        | 1, 057        | 0               | 0             | 0                | 9. 00  |
| 10.00  | 69. 00         | ELECTROCARDI OLOGY           | 0              |               | 0               | 0             | 0                | 10.00  |
| 11.00  | 90.00          | CLINIC                       | 22, 547        | 1, 127        | 0               | 0             | l 0              | 11.00  |
| 12.00  |                | EMERGENCY                    | 43, 373        |               |                 | 0             | 0                | 12.00  |
| 200.00 |                |                              | 467, 138       |               |                 | 0             | 0                | 200.00 |
|        | Wkst. A Line # | Cost Center/Physician        | Provi der      | Adjusted RCE  | RCE             | Adjustment    |                  |        |
|        |                | l denti fi er                | Component      | Limit         | Di sal I owance |               |                  |        |
|        |                |                              | Share of col.  |               |                 |               |                  |        |
|        |                |                              | 14             |               |                 |               |                  |        |
|        | 1.00           | 2. 00                        | 15. 00         | 16. 00        | 17. 00          | 18. 00        |                  |        |
| 1.00   | 4. 00          | EMPLOYEE BENEFITS DEPARTMENT | 0              | 24, 957       | 4, 054          | 4, 054        |                  | 1.00   |
| 2.00   | 5. 00          | ADMINISTRATIVE & GENERAL     | 0              | 344           | 59              | 59            |                  | 2.00   |
| 3.00   | 13. 00         | NURSING ADMINISTRATION       | 0              | 0             | 0               | 33, 547       |                  | 3.00   |
| 4.00   | 50.00          | OPERATING ROOM               | 0              | 0             | 0               | 95, 000       |                  | 4.00   |
| 5.00   | 53. 00         | ANESTHESI OLOGY              | 0              | 335, 160      | 317, 624        | 2, 934, 511   |                  | 5.00   |
| 6.00   | 54.00          | RADI OLOGY-DI AGNOSTI C      | 0              | O             | 0               | 999, 637      |                  | 6.00   |
| 7.00   | 56. 01         | ONCOLOGY                     | 0              | 19, 608       | 5, 392          | 232, 405      |                  | 7.00   |
| 8.00   | 57. 00         | CT SCAN                      | 0              | C             | 0               | 4, 668        |                  | 8. 00  |
| 9.00   | 60.00          | LABORATORY                   | 0              | 21, 149       | 114, 320        | 114, 320      |                  | 9. 00  |
| 10.00  | 69. 00         | ELECTROCARDI OLOGY           | 0              |               | 0               | 20, 176       |                  | 10.00  |
| 11.00  |                | CLINIC                       | 0              | 22, 547       | 23, 993         |               |                  | 11.00  |
| 12.00  |                | EMERGENCY                    | 0              |               |                 | 804, 127      |                  | 12.00  |
| 200.00 |                | •                            | Ö              |               |                 |               |                  | 200.00 |
|        | . '            |                              | '              |               |                 |               | •                |        |

| Period: | Worksheet B | From 01/01/2020 | Part | To | 12/31/2020 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0097

|  |                             |               | To                     | 12/31/2020                 |                     | pared:             |
|--|-----------------------------|---------------|------------------------|----------------------------|---------------------|--------------------|
|  |                             | CAPI TAL      |                        |                            | 0/2/2021 2.11       | Pili               |
|  |                             | RELATED COSTS |                        |                            |                     |                    |
| Cost Center Description  | Net Expenses                | BLDG & FIXT   | EMPLOYEE               | Subtotal                   | ADMI NI STRATI V    |                    |
|  | for Cost<br>Allocation      |               | BENEFITS<br>DEPARTMENT |                            | E & GENERAL         |                    |
|  | (from Wkst A                |               | DEFARTIVILINI          |                            |                     |                    |
|  | col. 7)                     |               |                        |                            |                     |                    |
|  | 0                           | 1.00          | 4. 00                  | 4A                         | 5. 00               |                    |
| GENERAL SERVICE COST CENTERS   | 0.050.107                   | 0.050.107     | ı                      |                            |                     | 1 00               |
| 1.00   00100 CAP REL COSTS-BLDG & FLXT 4.00   00400 EMPLOYEE BENEFLTS DEPARTMENT       | 9, 850, 127<br>10, 646, 597 | 1             | 10, 685, 438           |                            |                     | 1. 00<br>4. 00     |
| 5. 00 00500 ADMI NI STRATI VE & GENERAL  | 20, 171, 008                | l .           | 1, 989, 258            | 22, 965, 831               | 22, 965, 831        | 5.00               |
| 7.00 00700 OPERATION OF PLANT  | 3, 043, 800                 | l .           | 250, 875               | 3, 799, 279                | 819, 504            | 7. 00              |
| 8.00   00800   LAUNDRY & LINEN SERVICE   | 409, 923                    |               |                        | 474, 255                   |                     | 8. 00              |
| 9. 00   00900   HOUSEKEEPI NG  | 2, 299, 484                 |               |                        | 2, 683, 478                |                     | 9.00               |
| 10. 00   01000   DI ETARY<br>11. 00   01100   CAFETERI A                               | 311, 260<br>961, 873        | l .           |                        | 393, 429<br>1, 262, 197    | 84, 863<br>272, 256 | 10.00<br>11.00     |
| 13. 00 01300 NURSI NG ADMI NI STRATI ON  | 2, 212, 186                 | l .           |                        | 2, 434, 132                |                     | 13.00              |
| 14. 00 01400 CENTRAL SERVICES & SUPPLY   | 0                           | 107, 186      |                        | 107, 186                   |                     | 14.00              |
| 15. 00   01500   PHARMACY  | 11, 999, 576                | 102, 351      | 236, 150               | 12, 338, 077               | 2, 661, 357         | 15.00              |
| 16. 00 01600 MEDI CAL RECORDS & LI BRARY   | 1, 866, 832                 | 74, 007       | 277, 345               | 2, 218, 184                | 478, 462            | 16. 00             |
| I NPATI ENT ROUTI NE SERVI CE COST CENTERS  30. 00 03000 ADULTS & PEDI ATRI CS         | 7, 341, 473                 | 868, 314      | 1, 187, 134            | 9, 396, 921                | 2, 026, 916         | 30.00              |
| 31. 00   03100   NTENSI VE CARE UNI T  | 2, 175, 789                 |               |                        | 2, 661, 443                | 574, 073            | 31.00              |
| ANCI LLARY SERVICE COST CENTERS  | 2/1/0//0/                   | 1,00,000      | 3177270                | 270017110                  | 0717070             | 000                |
| 50.00 05000 OPERATING ROOM   | 5, 043, 272                 | 1             | 492, 983               | 6, 467, 518                |                     | 50.00              |
| 53. 00   05300   ANESTHESI OLOGY   | 226, 253                    | 1             |                        | 383, 449                   |                     | 53.00              |
| 54. 00   05400   RADI OLOGY-DI AGNOSTI C<br>56. 00   05600   RADI OI SOTOPE            | 5, 182, 122<br>0            | 305, 961<br>0 | 584, 271<br>0          | 6, 072, 354                | 1, 309, 807         | 54. 00<br>56. 00   |
| 56. 01   05601   0NCOLOGY  | 2, 510, 497                 | 660, 068      | ·                      | 3, 444, 437                | 742, 965            | 56. 01             |
| 57. 00   05700 CT SCAN   | 845, 414                    | 69, 172       | 62, 934                | 977, 520                   |                     | 57.00              |
| 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)   | 853, 034                    | 69, 768       | 75, 634                | 998, 436                   |                     |                    |
| 59. 00   05900   CARDI AC CATHETERI ZATI ON  | 0                           | 0             | 0                      | 0                          | 0                   | 59.00              |
| 60. 00   06000   LABORATORY<br>65. 00   06500   RESPI RATORY   THERAPY                 | 6, 271, 536<br>1, 338, 125  | l .           | 432, 388<br>225, 708   | 6, 894, 454<br>1, 716, 350 |                     | 60. 00<br>65. 00   |
| 65. 01   06501   SLEEP LAB   | 588, 196                    | 1             | 87, 840                | 676, 036                   |                     | 1                  |
| 66. 00   06600 PHYSI CAL THERAPY   | 1, 854, 969                 | ł             | 344, 893               | 2, 590, 823                |                     | 66.00              |
| 69. 00 06900 ELECTROCARDI OLOGY  | 2, 205, 400                 | 1             | 140, 072               | 2, 385, 869                |                     | 69. 00             |
| 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS                                     | 0                           | · -           | 0                      | 0                          | 0                   | 71.00              |
| 72.00   07200   MPL. DEV. CHARGED TO PATIENT 73.00   07300   DRUGS CHARGED TO PATIENTS | 1, 775, 682<br>0            | 0             | 20, 807<br>0           | 1, 796, 489                | 387, 503<br>0       | 72. 00<br>73. 00   |
| OUTPATIENT SERVICE COST CENTERS  |                             |               | <u> </u>               | <u> </u>                   |                     | 73.00              |
| 88.00 08800 RURAL HEALTH CLINIC  | 3, 339, 570                 | 242, 385      | 199, 882               | 3, 781, 837                | 815, 742            | 88. 00             |
| 88. 01   08801 RURAL HEALTH CLINIC II  | 1, 820, 568                 |               |                        | 2, 087, 787                | 450, 336            | 88. 01             |
| 88. 02   08802   RURAL HEALTH CLINIC III   | 10, 752, 011                | 799, 042      |                        | 12, 332, 440               |                     | 88. 02<br>90. 00   |
| 90. 00   09000   CLI NI C<br>91. 00   09100   EMERGENCY                                | 1, 579, 158<br>3, 441, 506  |               |                        | 2, 242, 432<br>4, 409, 106 |                     | 90.00              |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)                                       | 0, 111, 000                 | 101,110       | 010, 100               | 0                          | 7017,011            | 92.00              |
| 92.01 09201 OBSERVATION BEDS (DISTINCT PART)   | 1, 602, 411                 | 243, 544      | 252, 615               | 2, 098, 570                | 452, 662            | 92. 01             |
| OTHER REIMBURSABLE COST CENTERS  | _                           | _             |                        | _                          | _                   |                    |
| 95. 00   09500   AMBULANCE SERVI CES<br>101. 00   10100   HOME HEALTH AGENCY           | 1, 055, 350                 | 0<br>211, 623 | 0<br>177, 697          | 0<br>1, 444, 670           | 0<br>311, 615       |                    |
| SPECIAL PURPOSE COST CENTERS   | 1,055,350                   | 211,023       | 177,097                | 1, 444, 070                | 311,013             | 1101.00            |
| 113. 00 11300   NTEREST EXPENSE  |                             |               |                        |                            |                     | 113.00             |
| 118.00 SUBTOTALS (SUM OF LINES 1 through 117)  | 125, 575, 002               | 8, 425, 156   | 10, 070, 396           | 123, 534, 989              | 21, 692, 803        | 118.00             |
| NONREI MBURSABLE COST CENTERS  | 1                           | 04.040        |                        | 04.040                     | 5.074               | 1.00.00            |
| 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 190. 01 19001 UROLOGY                | 0<br>5, 447                 | 24, 868       | 0                      | 24, 868<br>5, 447          |                     | 190. 00<br>190. 01 |
| 190. 05 19005 MARKETI NG   | 279, 966                    | 26, 490       | ·                      | 332, 489                   |                     |                    |
| 190. 07 19007 I -74 CAMPUS   | 0                           | 0             | 0                      | 0                          |                     | 190. 07            |
| 190. 08 19008 RAMPART  | 140, 713                    |               | 13, 496                | 518, 548                   |                     |                    |
| 190. 09 19009 I NTELLI PLEX DEVELOPMENT  | 33, 186                     |               | 0                      | 328, 783                   |                     |                    |
| 190. 11 19011 MHP ADMI N BUI LDI NG<br>190. 16 19016  RENOVO                           | 73, 098<br>172, 593         | l .           |                        | 172, 153<br>513, 039       |                     |                    |
| 190. 17 19017 I MA   | 172, 373                    | 0 322, 332    | 10, 074                | 0 0 0 0 0                  |                     | 190. 17            |
| 190. 18 19018 MD SOLUTIONS   | -131                        | 0             | 0                      | -131                       |                     | 190. 18            |
| 190. 19 19019 MHCD   | 0                           | 0             | 0                      | 0                          |                     | 190. 19            |
| 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES   | 0 000 100                   | 0             | [ 0                    | 2 441 04                   |                     | 192.00             |
| 192. 01 19201 HOSPI TALI ST<br>194. 00 07950 UNAVI E                                   | 2, 922, 123<br>234, 708     |               |                        | 3, 441, 966<br>564, 554    |                     |                    |
| 200.00 Cross Foot Adjustments  | 234, 700                    | 2/1, 173      | 30, 033                | 0                          |                     | 200.00             |
| 201.00 Negative Cost Centers   |                             | 0             | 0                      | 0                          | 0                   | 201. 00            |
| 202.00   TOTAL (sum lines 118 through 201)   | 129, 436, 705               | 9, 850, 127   | 10, 685, 438           | 129, 436, 705              | 22, 965, 831        | 202.00             |
|  |                             |               |                        |                            |                     |                    |

Provider CCN: 15-0097 Peri od: Worksheet B From 01/01/2020 Part I To 12/31/2020 Date/Time Prepared:

|  |                     |               | To                 | 12/31/2020     | Date/Time Pre<br>8/2/2021 2:11 |                    |
|--|---------------------|---------------|--------------------|----------------|--------------------------------|--------------------|
| Cost Center Description  | OPERATION OF        | LAUNDRY &     | HOUSEKEEPI NG      | DI ETARY       | CAFETERI A                     | Dill.              |
|  | PLANT               | LINEN SERVICE |                    |                |                                |                    |
| CENEDAL CEDVICE COCT CENTEDS   | 7. 00               | 8. 00         | 9. 00              | 10.00          | 11. 00                         |                    |
| GENERAL SERVICE COST CENTERS  1.00 O0100 CAP REL COSTS-BLDG & FLXT                 |                     |               |                    |                |                                | 1.00               |
| 4. 00   00400 EMPLOYEE BENEFITS DEPARTMENT   |                     |               |                    |                |                                | 4.00               |
| 5. 00 00500 ADMINISTRATIVE & GENERAL   |                     |               |                    |                |                                | 5.00               |
| 7.00 00700 OPERATION OF PLANT  | 4, 618, 783         |               |                    |                |                                | 7.00               |
| 8.00   00800   LAUNDRY & LINEN SERVICE   | 23, 802             | 600, 354      |                    |                |                                | 8. 00              |
| 9. 00   00900   HOUSEKEEPI NG  | 47, 333             | ł             | -,,                |                |                                | 9. 00              |
| 10. 00   01000   DI ETARY  | 29, 055             | 0             | = .,               | 528, 492       | 4 740 540                      | 10.00              |
| 11. 00   01100   CAFETERI A<br>13. 00   01300   NURSI NG   ADMI NI STRATI ON       | 103, 086<br>46, 902 | 0             | 75, 023<br>34, 133 | 0              | 1, 712, 562<br>60, 481         | 11. 00<br>13. 00   |
| 14. 00 01400 CENTRAL SERVICES & SUPPLY   | 58, 236             | 0             | 42, 382            | 0              | 00, 461                        | 14.00              |
| 15. 00 01500 PHARMACY  | 55, 609             | ł             |                    | 0              | 37, 743                        | 15. 00             |
| 16. 00 01600 MEDI CAL RECORDS & LI BRARY   | 40, 209             | ł             | 29, 263            | o              | 82, 264                        | 16.00              |
| INPATIENT ROUTINE SERVICE COST CENTERS   |                     |               |                    |                |                                |                    |
| 30. 00   03000   ADULTS & PEDI ATRI CS   | 471, 768            |               |                    | 442, 821       | 245, 484                       | 30.00              |
| 31. 00 03100 I NTENSI VE CARE UNI T  | 74, 085             | 0             | 53, 917            | 85, 671        | 76, 179                        | 31.00              |
| ANCILLARY SERVICE COST CENTERS  50.00 OPERATING ROOM                               | FOF 040             | E0 207        | 240 222            | 0              | 107.070                        |                    |
| 50. 00   05000   OPERATI NG ROOM<br>53. 00   05300   ANESTHESI OLOGY               | 505, 968<br>9, 013  |               | 368, 232<br>6, 560 | 0              | 107, 079<br>25, 506            | 50. 00<br>53. 00   |
| 54. 00   05400   RADI OLOGY-DI AGNOSTI C   | 166, 233            | l e           |                    | 0              | 117, 105                       | 54.00              |
| 56. 00   05600   RADI OI SOTOPE  | 0                   | 0             | 0                  | o              | 0                              | 56.00              |
| 56. 01 05601 0NC0L0GY  | 358, 625            | 37, 686       | 260, 996           | 0              | 57, 233                        | 56. 01             |
| 57.00 05700 CT SCAN  | 37, 582             | 0             | 27, 351            | 0              | 11, 179                        |                    |
| 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)                                       | 37, 906             | 0             | 27, 587            | 0              | 13, 909                        | 58. 00             |
| 59. 00 05900 CARDI AC CATHETERI ZATI ON  | 0                   | 0             | 0                  | 0              | 0                              | 59.00              |
| 60. 00 06000 LABORATORY  | 103, 518            | 14 004        | 75, 337            | 0              | 117, 366                       | 60.00              |
| 65. 00   06500   RESPI RATORY   THERAPY<br>65. 01   06501   SLEEP   LAB            | 82, 865<br>0        | 14, 984       | 60, 306<br>0       | 0              | 47, 073<br>0                   | 65. 00<br>65. 01   |
| 66. 00   06600 PHYSI CAL THERAPY   | 212, 415            | 19, 063       | -                  | 0              | 62, 581                        | 66.00              |
| 69. 00 06900 ELECTROCARDI OLOGY  | 21, 949             | 0             | 15, 973            | o              | 22, 130                        | 69.00              |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS                                   | 0                   | 0             | 0                  | 0              | 0                              | 71.00              |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENT  | 0                   | 0             | 0                  | 0              | 8, 178                         | 72.00              |
| 73. 00 07300 DRUGS CHARGED TO PATIENTS   | 0                   | 0             | 0                  | 0              | 0                              | 73.00              |
| 88.00 OBSOO RURAL HEALTH CLINIC  | 121 (01             |               | OF 041             | 0              | 44.001                         | 00.00              |
| 88. 00   08800  RURAL HEALTH CLINIC<br>88. 01   08801  RURAL HEALTH CLINIC II      | 131, 691<br>77, 809 | 0             |                    | 0              | 64, 091<br>40, 070             | 88. 00<br>88. 01   |
| 88. 02 08802 RURAL HEALTH CLINIC III   | 434, 131            | 0             |                    | 0              | 244, 908                       | 88. 02             |
| 90. 00   09000   CLINIC  | 220, 745            | 1             | 160, 651           | o              | 47, 748                        | 90.00              |
| 91. 00 09100 EMERGENCY   | 246, 741            | 130, 936      |                    | 0              | 114, 161                       | 91.00              |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)                                   |                     |               |                    |                |                                | 92.00              |
| 92. 01 09201 OBSERVATION BEDS (DISTINCT PART)                                      | 132, 321            | 0             | 96, 299            | 0              | 49, 514                        | 92. 01             |
| OTHER REIMBURSABLE COST CENTERS  |                     |               |                    |                | 0                              | 05.00              |
| 95. 00   09500   AMBULANCE   SERVI CES<br>101. 00   10100   HOME   HEALTH   AGENCY | 0<br>114, 978       |               |                    | 0              | 0                              | 95. 00<br>101. 00  |
| SPECIAL PURPOSE COST CENTERS   | 114, 770            | 0             | 03,077             | O <sub>I</sub> | 0                              | 1101.00            |
| 113. 00 11300 I NTEREST EXPENSE  |                     |               |                    |                |                                | 113.00             |
| 118.00 SUBTOTALS (SUM OF LINES 1 through 117)                                      | 3, 844, 575         | 600, 354      | 2, 746, 194        | 528, 492       | 1, 651, 982                    | 118.00             |
| NONREI MBURSABLE COST CENTERS  |                     |               |                    |                |                                |                    |
| 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN                                  | 13, 511             | 0             | 9, 833             | 0              |                                | 190. 00            |
| 190. 01 19001 UROLOGY  | 0                   | 0             | 0                  | 0              |                                | 190. 01            |
| 190. 05 19005 MARKETING<br>190. 07 19007 I - 74 CAMPUS                             | 14, 392             | 0             | 10, 474            | 0              |                                | 190. 05<br>190. 07 |
| 190. 07 19007 1 - 74 CAMPUS<br>190. 08 19008 RAMPART                               | 197, 951            | 0             | 144, 062           | 0              |                                | 190. 07            |
| 190. 09 19009 INTELLIPLEX DEVELOPMENT  | 160, 602            | l o           | 116, 881           | Ö              |                                | 190. 09            |
| 190. 11 19011 MHP ADMIN BUILDING   | 50, 374             | l e           | 36, 660            | 0              |                                | 190. 11            |
| 190. 16 19016 RENOVO   | 175, 139            | 0             | 127, 460           | 0              |                                | 190. 16            |
| 190. 17 19017 I MA   | 0                   | 0             | 0                  | 0              |                                | 190. 17            |
| 190. 18 19018 MD SOLUTIONS   | 0                   | 0             | 0                  | 0              |                                | 190. 18            |
| 190. 19 19019 MHCD   |                     | ]             | 0                  | 0              |                                | 190. 19            |
| 192. 00 19200  PHYSI CI ANS' PRI VATE OFFI CES<br>192. 01 19201  HOSPI TALI ST     | 4, 030              |               | 2, 933             | 0              | 38, 898                        | 192.00             |
| 194. 00 07950  UNAVI E   | 158, 209            |               | 115, 140           | 0              |                                | 194. 00            |
| 200.00 Cross Foot Adjustments  | .55, 207            |               | 1.5, .10           | Ĭ              | Ü                              | 200.00             |
| 201.00 Negative Cost Centers   | 0                   | 0             | 0                  | О              |                                | 201. 00            |
| 202.00   TOTAL (sum lines 118 through 201)   | 4, 618, 783         | 600, 354      | 3, 309, 637        | 528, 492       | 1, 712, 562                    | 202. 00            |
|  |                     |               |                    |                |                                |                    |

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

|  |   |                       | Io                | 12/31/2020            | 8/2/2021 2:11                             |                  |
|--|---|-----------------------|-------------------|-----------------------|---|------------------|
| Cost Center Description  | NURSI NG<br>ADMI NI STRATI O            | CENTRAL<br>SERVICES & | PHARMACY          | MEDI CAL<br>RECORDS & | Subtotal                                  | Pili             |
|  | N                                       | SUPPLY                |                   | LI BRARY              |   |                  |
|  | 13. 00                                  | 14. 00                | 15. 00            | 16. 00                | 24.00                                     |                  |
| GENERAL SERVICE COST CENTERS   |   |                       |                   |                       |   |                  |
| 1. 00   00100   CAP   REL   COSTS-BLDG   & FIXT                                |   |                       |                   |                       |   | 1.00             |
| 4. 00   00400   EMPLOYEE BENEFITS DEPARTMENT                                   |   |                       |                   |                       |   | 4.00             |
| 5.00   00500   ADMINISTRATIVE & GENERAL<br>7.00   00700   OPERATION OF PLANT   |   |                       |                   |                       |   | 5. 00<br>7. 00   |
| 8.00   00800   LAUNDRY & LINEN SERVICE   |   |                       |                   |                       |   | 8.00             |
| 9. 00   00900   HOUSEKEEPI NG  |   |                       |                   |                       |   | 9.00             |
| 10. 00   01000   DI ETARY  |   |                       |                   |                       |   | 10.00            |
| 11. 00   01100   CAFETERI A  |   |                       |                   |                       |   | 11.00            |
| 13.00 01300 NURSING ADMINISTRATION   | 3, 100, 690                             |                       |                   |                       |   | 13.00            |
| 14. 00   01400   CENTRAL SERVICES & SUPPLY                                     | 0                                       | 230, 924              | 45 400 054        |                       |   | 14.00            |
| 15. 00   01500  PHARMACY<br>16. 00   01600  MEDI CAL RECORDS & LI BRARY        | 0                                       | 0                     | 15, 133, 256<br>0 | 2 040 202             |   | 15. 00<br>16. 00 |
| INPATIENT ROUTINE SERVICE COST CENTERS   | <u> </u>                                | <u> </u>              | U                 | 2, 848, 382           |   | 16.00            |
| 30. 00 03000 ADULTS & PEDIATRICS   | 602, 776                                | 0                     | 0                 | 100, 873              | 13, 863, 893                              | 30.00            |
| 31. 00   03100   I NTENSI VE CARE UNI T  | 187, 055                                | Ö                     | 0                 | 46, 262               | 3, 758, 685                               | 31.00            |
| ANCILLARY SERVICE COST CENTERS   |   |                       |                   |                       |   |                  |
| 50.00 05000 OPERATING ROOM   | 262, 928                                | 127, 008              | 0                 | 473, 170              | 9, 766, 244                               | 50.00            |
| 53. 00   05300   ANESTHESI OLOGY   | 62, 629                                 | 0                     | 0                 | 3, 619                | 573, 486                                  | 53.00            |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C   | 0                                       | 0                     | 0                 | 200, 398              | 8, 092, 268                               | 54.00            |
| 56. 00   05600  RADI OI SOTOPE<br>56. 01   05601  ONCOLOGY                     | 0<br>140, 534                           | 0                     | 0                 | 159, 285              | 0<br>5, 201, 761                          | 56. 00<br>56. 01 |
| 57. 00 05700 CT SCAN   | 140, 534                                | 0                     | 0                 | 212, 521              | 1, 477, 004                               | 57.00            |
| 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)                                   |   | o                     | 0                 | 69, 336               | 1, 362, 537                               | 58.00            |
| 59. 00 05900 CARDI AC CATHETERI ZATI ON  | O                                       | 0                     | 0                 | 0                     | 0   | 59.00            |
| 60. 00   06000   LABORATORY  | 0                                       | 0                     | 0                 | 313, 518              | 8, 991, 327                               | 60.00            |
| 65. 00 06500 RESPI RATORY THERAPY  | 115, 586                                | 0                     | 0                 | 66, 067               | 2, 473, 448                               | 65.00            |
| 65. 01   06501   SLEEP LAB   | 42, 451                                 | 0                     | 0                 | 22, 927               | 887, 235                                  | 65. 01           |
| 66. 00   06600  PHYSI CAL THERAPY<br>69. 00   06900  ELECTROCARDI OLOGY        | 0<br>54, 340                            | 0                     | 0                 | 52, 304<br>98, 449    | 3, 650, 616<br>3, 113, 342                | 66. 00<br>69. 00 |
| 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS                              | 0                                       | 0                     | 0                 | 90, 449               | 3, 113, 342                               | 71.00            |
| 72. 00 07200 IMPL. DEV. CHARGED TO PATIENT                                     | o                                       | 103, 916              | 0                 | 65, 373               | 2, 361, 459                               | 72.00            |
| 73.00 07300 DRUGS CHARGED TO PATIENTS  | 0                                       | 0                     | 15, 133, 256      | 335, 447              | 15, 468, 703                              | 73.00            |
| OUTPATIENT SERVICE COST CENTERS  |   |                       |                   |                       |   |                  |
| 88. 00   08800   RURAL   HEALTH   CLINIC                                       | 157, 373                                | 0                     | 0                 | 26, 870               | 5, 073, 445                               | 88. 00           |
| 88. 01   08801 RURAL HEALTH CLINIC II  | 98, 391                                 | 0                     | 0                 | 19, 003               | 2, 830, 023                               | 1                |
| 88. 02   08802   RURAL HEALTH CLINIC III<br>90. 00   09000   CLINIC            | 601, 362<br>117, 244                    | 0                     | 0                 | 85, 774<br>35, 571    | 16, 674, 669<br>3, 308, 084               | 88. 02<br>90. 00 |
| 91. 00   09100   EMERGENCY   | 280, 318                                | 0                     | 0                 | 408, 029              | 6, 719, 906                               | 91.00            |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)                               | 200,010                                 | J                     |                   | 100, 027              | 3, 7, 7, 7, 7, 7, 7, 7, 7, 7, 7, 7, 7, 7, | 92.00            |
| 92.01 09201 OBSERVATION BEDS (DISTINCT PART)                                   | 121, 579                                | 0                     | 0                 | 37, 371               | 2, 988, 316                               | 92. 01           |
| OTHER REIMBURSABLE COST CENTERS  |   |                       |                   |                       |   |                  |
| 95. 00 09500 AMBULANCE SERVI CES   | 0                                       | 0                     | 0                 | 0                     | 0   | 95.00            |
| 101. 00 10100 HOME HEALTH AGENCY  SPECIAL PURPOSE COST CENTERS                 | 96, 530                                 | 0                     | 0                 | 16, 215               | 2, 067, 685                               | 101.00           |
| 113. 00 11300 INTEREST EXPENSE   |   |                       |                   |                       |   | 113. 00          |
| 118.00 SUBTOTALS (SUM OF LINES 1 through 117)                                  | 2, 941, 096                             | 230, 924              | 15, 133, 256      | 2, 848, 382           | 120, 704, 136                             |                  |
| NONREI MBURSABLE COST CENTERS  | , | , ,                   |                   | , ,                   |   |                  |
| 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN                               | 0                                       | 0                     | 0                 | 0                     | 53, 576                                   |                  |
| 190. 01 19001 UROLOGY  | 1, 869                                  | 0                     | 0                 | 0                     |   | 190. 01          |
| 190. 05 19005 MARKETI NG   | 0                                       | 0                     | 0                 | 0                     | 434, 397                                  | 1                |
| 190. 07 19007 I-74 CAMPUS<br>190. 08 19008 RAMPART                             | 14 500                                  | 0                     | 0                 | 0                     | 992, 817                                  | 190.07           |
| 190. 09 19009   NTELLI PLEX DEVELOPMENT  | 14, 500<br>909                          | 0                     | 0                 | 0                     | 678, 463                                  |                  |
| 190. 11 19011 MHP ADMIN BUILDING   | 0                                       | o                     | 0                 | ol o                  | 298, 703                                  |                  |
| 190. 16 19016 RENOVO   | 17, 039                                 | 0                     | 0                 | o                     | 950, 279                                  |                  |
| 190. 17 19017 I MA   | 0                                       | 0                     | 0                 | 0                     |   | 190. 17          |
| 190. 18 19018 MD SOLUTIONS   | 0                                       | 0                     | 0                 | 0                     |   | 190. 18          |
| 190. 19 19019 MHCD   | 0                                       | 0                     | 0                 | 0                     |   | 190. 19          |
| 192. 00 19200  PHYSI CI ANS' PRI VATE OFFI CES<br>192. 01 19201  HOSPI TALI ST | 95, 512                                 | 0                     | 0                 | 0                     | 0<br>4, 325, 771                          | 192.00           |
| 192. 01 19201 H0SP1TALTST<br>194. 00 07950  UNAVI E                            | 29, 765                                 | 0                     | 0                 | 0                     | 4, 325, 771<br>989, 442                   | 1                |
| 200.00 Cross Foot Adjustments  | 27,703                                  | ٩                     |                   | 9                     |   | 200.00           |
| 201.00 Negative Cost Centers   | 0                                       | О                     | 0                 | o                     |   | 201. 00          |
| 202.00 TOTAL (sum lines 118 through 201)                                       | 3, 100, 690                             | 230, 924              | 15, 133, 256      | 2, 848, 382           | 129, 436, 705                             | 202. 00          |
|  |   |                       |                   |                       |   |                  |

Health Financial Systems MAJOR HOSPITAL In Lieu of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0097 Period: Worksheet B

COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0097 Worksheet B From 01/01/2020 Part I Date/Time Prepared: 12/31/2020 8/2/2021 2:11 pm Cost Center Description Intern & Total Resi dents Cost & Post Stepdown Adjustments 25. 00 26.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4 00 4 00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 00700 OPERATION OF PLANT 7.00 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 00900 HOUSEKEEPI NG 9.00 9.00 10.00 01000 DI ETARY 10.00 11.00 01100 CAFETERI A 11.00 01300 NURSING ADMINISTRATION 13.00 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 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 13, 863, 893 30.00 03100 INTENSIVE CARE UNIT 31.00 0 3, 758, 685 31.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 9, 766, 244 50.00 05300 ANESTHESI OLOGY 573, 486 53.00 000000000000000 53.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 8,092,268 54.00 05600 RADI OI SOTOPE 56.00 C 56.00 56.01 05601 ONCOLOGY 5, 201, 761 56.01 57.00 05700 CT SCAN 1, 477, 004 57.00 58 00 05800 MAGNETIC RESONANCE IMAGING (MRI) 58 00 1, 362, 537 05900 CARDIAC CATHETERIZATION 59.00 59.00 60. 00 | 06000 | LABORATORY 8, 991, 327 60.00 65.00 06500 RESPIRATORY THERAPY 2, 473, 448 65.00 06501 SLEEP LAB 65 01 887, 235 65 01 06600 PHYSI CAL THERAPY 66.00 3, 650, 616 66.00 06900 ELECTROCARDI OLOGY 69.00 69.00 3, 113, 342 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 07200 I MPL. DEV. CHARGED TO PATIENT 72 00 2, 361, 459 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 15, 468, 703 73.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 5, 073, 445 88.00 0 08801 RURAL HEALTH CLINIC II 88.01 2, 830, 023 88.01 88.02 08802 RURAL HEALTH CLINIC III 0 16, 674, 669 88.02 90 00 09000 CLI NI C 0 3, 308, 084 90 00 09100 EMERGENCY 0 91.00 91.00 6, 719, 906 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 92.00 92.00 92.01 09201 OBSERVATION BEDS (DISTINCT PART) 2, 988, 316 92.01 OTHER REIMBURSABLE COST CENTERS 95 00 95. 00 09500 AMBULANCE SERVICES 0 101.00 10100 HOME HEALTH AGENCY 2, 067, 685 101.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 I NTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1 through 117) 0 120, 704, 136 118.00 118.00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 53, 576 190.00 0 190. 01 19001 UROLOGY 9, 252 190. 01 190. 05 19005 MARKETI NG 434, 397 190.05 190. 07 19007 I -74 CAMPUS 190.07 000000000000 190. 08 19008 RAMPART 992, 817 190.08 190. 09 19009 INTELLIPLEX DEVELOPMENT 190. 09 678, 463 190. 11 19011 MHP ADMIN BUILDING 298, 703 190. 11 190. 16 19016 RENOVO 190. 16 950, 279 190. 17 19017 I MA 190. 17 C 190. 18 19018 MD SOLUTIONS l190. 18 -131 190. 19 19019 MHCD C 190. 19 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 0 192.00 192. 01 19201 HOSPI TALI ST 4 325 771 192.01 194. 00 07950 UNAVI E 989, 442 194.00 200.00 Cross Foot Adjustments 200.00 C 0 201.00 Negative Cost Centers 201.00 202.00 TOTAL (sum lines 118 through 201) 129, 436, 705 202.00

| Peri od: | Worksheet B | From 01/01/2020 | Part | I | To | 12/31/2020 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0097

|                  |        |   |                           |                     | Ť             | o 12/31/2020           | Date/Time Pre<br>8/2/2021 2:11 |                    |
|------------------|--------|---|---------------------------|---------------------|---------------|------------------------|--------------------------------|--------------------|
|                  |        |   |                           | CAPI TAL            |               |                        | 0/2/2021 2.11                  | Pili               |
|                  |        |   |                           | RELATED COSTS       |               |                        |                                |                    |
|                  |        | Cost Center Description                               | Directly                  | BLDG & FIXT         | Subtotal      | EMPLOYEE               | ADMI NI STRATI V               |                    |
|                  |        |   | Assi gned New<br>Capi tal |                     |               | BENEFITS<br>DEPARTMENT | E & GENERAL                    |                    |
|                  |        |   | Related Costs             |                     |               | DEPARTMENT             |                                |                    |
|                  |        |   | 0                         | 1.00                | 2A            | 4. 00                  | 5. 00                          |                    |
|                  | GENER. | AL SERVICE COST CENTERS                               |                           | ,                   | ,             |                        |                                |                    |
| 1.00             |        | CAP REL COSTS-BLDG & FIXT                             | •                         | 20.044              | 20.044        | 20.044                 |                                | 1.00               |
| 4. 00<br>5. 00   |        | EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL | 0                         | 38, 841<br>805, 565 |               | 38, 841<br>7, 225      | 812, 790                       | 4. 00<br>5. 00     |
| 7. 00            | 1      | OPERATION OF PLANT                                    | 0                         | 504, 604            |               | 912                    | 29, 004                        | 7.00               |
| 8. 00            |        | LAUNDRY & LINEN SERVICE                               | 0                         | 43, 808             |               | 75                     | 3, 620                         | 8.00               |
| 9.00             |        | HOUSEKEEPI NG   | 0                         | 87, 119             |               | 1, 079                 | 20, 486                        | 1                  |
| 10.00            |        | DIETARY   | 0                         | 53, 477             |               | 104                    | 3, 003                         | 1                  |
| 11. 00<br>13. 00 |        | CAFETERIA<br>NURSING ADMINISTRATION                   | 0                         | 189, 736<br>86, 325 |               | 402<br>493             | 9, 636<br>18, 582              | 1                  |
| 14. 00           |        | CENTRAL SERVICES & SUPPLY                             | 0                         | 107, 186            |               | 0                      | 818                            | 1                  |
| 15. 00           |        | PHARMACY  | 0                         | 102, 351            |               | 858                    | 94, 179                        | •                  |
| 16.00            |        | MEDICAL RECORDS & LIBRARY                             | 0                         | 74, 007             | 74, 007       | 1, 008                 | 16, 934                        | 16. 00             |
| 20.00            |        | I ENT ROUTINE SERVICE COST CENTERS                    | ^                         | 0.00.014            | 0.0.011       | 4.047                  | 74 70/                         | 00.00              |
| 30. 00<br>31. 00 |        | ADULTS & PEDIATRICS<br>INTENSIVE CARE UNIT            | 0                         |                     |               | 4, 316<br>1, 270       | 71, 736<br>20, 317             | •                  |
| 31.00            |        | LARY SERVICE COST CENTERS                             | 0                         | 130, 330            | 130, 330      | 1,270                  | 20, 317                        | 31.00              |
| 50.00            |        | OPERATI NG ROOM                                       | 0                         | 931, 263            | 931, 263      | 1, 792                 | 49, 373                        | 50.00              |
| 53. 00           | 1      | ANESTHESI OLOGY                                       | 0                         |                     |               | 511                    | 2, 927                         | 53.00              |
| 54.00            |        | RADI OLOGY-DI AGNOSTI C                               | 0                         | 305, 961            |               | 2, 124                 | 46, 356                        |                    |
| 56. 00<br>56. 01 |        | RADI OI SOTOPE<br>ONCOLOGY                            | 0                         | 0<br>660, 068       | 1             | 0<br>996               | 0<br>26, 295                   | 56. 00<br>56. 01   |
| 57. 00           |        | CT SCAN   | 0                         | 69, 172             |               | 229                    | 7, 462                         | 1                  |
| 58.00            | 05800  | MAGNETIC RESONANCE IMAGING (MRI)                      | 0                         | 69, 768             |               | 275                    | 7, 622                         | ł                  |
| 59. 00           |        | CARDI AC CATHETERI ZATI ON                            | 0                         | 0                   | 1             | 0                      | 0                              | 59. 00             |
| 60.00            | 1      | LABORATORY THERABY                                    | 0                         | 190, 530            |               | 1, 572                 | 52, 632                        | 1                  |
| 65. 00<br>65. 01 |        | RESPI RATORY THERAPY<br>SLEEP LAB                     | 0                         | 152, 517<br>0       |               | 821<br>319             | 13, 103<br>5, 161              | 1                  |
| 66. 00           |        | PHYSI CAL THERAPY                                     | 0                         | 390, 961            |               | 1, 254                 | 19, 778                        | 1                  |
| 69. 00           | 1      | ELECTROCARDI OLOGY                                    | 0                         | 40, 397             |               | 509                    | 18, 214                        | ı                  |
| 71. 00           |        | MEDICAL SUPPLIES CHARGED TO PATIENTS                  | 0                         | 0                   | 1             | 0                      | 0                              | 71. 00             |
| 72.00            |        | I MPL. DEV. CHARGED TO PATIENT                        | 0                         | 0                   |               | 76                     | 13, 714                        | 1                  |
| 73. 00           |        | DRUGS CHARGED TO PATIENTS TIENT SERVICE COST CENTERS  | 0                         | 0                   | 0             | 0                      | 0                              | 73.00              |
| 88. 00           |        | RURAL HEALTH CLINIC                                   | 0                         | 242, 385            | 242, 385      | 727                    | 28, 871                        | 88. 00             |
| 88. 01           |        | RURAL HEALTH CLINIC II                                | 0                         |                     |               | 451                    | 15, 938                        | 88. 01             |
| 88. 02           |        | RURAL HEALTH CLINIC III                               | 0                         | 799, 042            |               | 2, 841                 | 94, 146                        | 1                  |
| 90. 00<br>91. 00 |        | CLINIC<br>EMERGENCY                                   | 0                         | 406, 293            |               | 934                    | 17, 119                        | 1                  |
| 91.00            |        | OBSERVATION BEDS (NON-DISTINCT PART)                  | U                         | 454, 140            | 454, 140      | 1, 867                 | 33, 659                        | 91.00              |
| 92. 01           |        | OBSERVATION BEDS (DISTINCT PART)                      | 0                         | 243, 544            | 243, 544      | 918                    | 16, 020                        | •                  |
|                  |        | REIMBURSABLE COST CENTERS                             |                           |                     |               |                        |                                |                    |
|                  |        | AMBULANCE SERVICES                                    | 0                         |                     |               |                        |                                |                    |
| 101.00           |        | HOME HEALTH AGENCY AL PURPOSE COST CENTERS            | 0                         | 211, 623            | 211, 623      | 646                    | 11, 029                        | 101.00             |
| 113.00           |        | INTEREST EXPENSE                                      |                           |                     |               |                        |                                | 113. 00            |
| 118.00           |        | SUBTOTALS (SUM OF LINES 1 through 117)                | 0                         | 8, 425, 156         | 8, 425, 156   | 36, 604                | 767, 734                       | 1                  |
|                  |        | IMBURSABLE COST CENTERS                               |                           |                     |               | _                      |                                |                    |
|                  | 1      | GIFT, FLOWER, COFFEE SHOP & CANTEEN UROLOGY           | 0                         | 24, 868             |               | 0                      |                                | 190.00             |
|                  |        | MARKETING   | 0                         | 26, 490             | 1             | 95                     |                                | 190. 01<br>190. 05 |
|                  | 1      | I -74 CAMPUS  | 0                         | 0                   | 0             | 0                      |                                | 190.07             |
|                  |        | RAMPART   | 0                         | 364, 339            |               | 49                     |                                | 190. 08            |
|                  | 1      | INTELLIPLEX DEVELOPMENT                               | 0                         | 295, 597            |               | 0                      |                                | 190. 09            |
|                  |        | MHP ADMIN BUILDING<br>RENOVO                          | 0                         | 92, 715             |               | 23                     | 1, 314                         | 190. 11<br>190. 16 |
| 190. 16          |        |   | 0                         | 322, 352<br>0       | 322, 352<br>0 | 66                     |                                | 190. 16            |
|                  |        | MD SOLUTIONS  | 0                         | 0                   | Ö             | Ö                      |                                | 190. 18            |
| 190. 19          | 19019  | MHCD  | 0                         | 0                   | 0             | 0                      | 0                              | 190. 19            |
|                  |        | PHYSICIANS' PRIVATE OFFICES                           | 0                         | 0                   | 0             | 0                      |                                | 192.00             |
|                  |        | HOSPI TALI ST<br>UNAVI E                              | 0                         | 7, 417<br>291, 193  |               | 1, 863<br>141          | 26, 276<br>4, 310              | 192. 01<br>194. 00 |
| 200.00           |        | Cross Foot Adjustments                                | U                         | 291, 193            | 291, 193<br>0 | 141                    | 4,310                          | 200.00             |
| 201.00           |        | Negative Cost Centers                                 |                           | 0                   |               | 0                      |                                | 201. 00            |
| 202.00           |        | TOTAL (sum lines 118 through 201)                     | 0                         | 9, 850, 127         | 9, 850, 127   | 38, 841                | 812, 790                       | 202. 00            |
|                  |        |   |                           |                     |               |                        |                                |                    |

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

|  |                    |               | To                                      | 12/31/2020 | Date/Time Pre<br>8/2/2021 2:11 |                    |
|--|--------------------|---------------|---|------------|--------------------------------|--------------------|
| Cost Center Description  | OPERATION OF       | LAUNDRY &     | HOUSEKEEPI NG                           | DI ETARY   | CAFETERI A                     | Pili               |
|  | PLANT              | LINEN SERVICE |   |            |                                |                    |
| CENEDAL CEDIMACE COCT CENTEDO  | 7. 00              | 8. 00         | 9. 00                                   | 10.00      | 11. 00                         |                    |
| GENERAL SERVICE COST CENTERS  1.00 O0100 CAP REL COSTS-BLDG & FIXT               |                    |               |   |            |                                | 1.00               |
| 4. 00   00400 EMPLOYEE BENEFITS DEPARTMENT                                       |                    |               |   |            |                                | 4.00               |
| 5.00 00500 ADMINISTRATIVE & GENERAL  |                    |               |   |            |                                | 5.00               |
| 7.00 00700 OPERATION OF PLANT  | 534, 520           |               |   |            |                                | 7. 00              |
| 8.00   00800   LAUNDRY & LINEN SERVICE   | 2, 754             |               |   |            |                                | 8. 00              |
| 9. 00   00900   HOUSEKEEPI NG  | 5, 478             |               | ,                                       |            |                                | 9. 00              |
| 10. 00   01000   DI ETARY  | 3, 362             | 0             | 729                                     | 60, 675    | 04.4.000                       | 10.00              |
| 11. 00   01100   CAFETERI A<br>13. 00   01300   NURSI NG   ADMI NI STRATI ON     | 11, 930            | l .           | 2, 588<br>1 177                         | 0          | 214, 292                       | 11. 00<br>13. 00   |
| 14. 00   01400   CENTRAL SERVICES & SUPPLY                                       | 5, 428<br>6, 739   |               | .,                                      | 0          | 7, 568<br>0                    |                    |
| 15. 00 01500 PHARMACY  | 6, 435             |               | .,                                      | o          | 4, 723                         | 1                  |
| 16. 00 01600 MEDICAL RECORDS & LIBRARY   | 4, 653             | Ō             | ,                                       | o          | 10, 294                        | 16.00              |
| INPATIENT ROUTINE SERVICE COST CENTERS   |                    |               |   |            |                                |                    |
| 30. 00   03000   ADULTS & PEDIATRICS   | 54, 596            |               | 11, 843                                 | 50, 839    | 30, 717                        | 30.00              |
| 31. 00 03100 I NTENSI VE CARE UNI T  | 8, 574             | 0             | 1, 860                                  | 9, 836     | 9, 532                         | 31.00              |
| ANCILLARY SERVICE COST CENTERS   | F0 FF/             | 1 0/4         | 10 700                                  | ٥          | 12, 200                        | F0 00              |
| 50. 00   05000   OPERATI NG ROOM<br>53. 00   05300   ANESTHESI OLOGY             | 58, 556<br>1, 043  |               | 12, 703<br>226                          | 0          | 13, 399<br>3, 192              | 50. 00<br>53. 00   |
| 54. 00   05400   RADI OLOGY-DI AGNOSTI C   | 19, 238            | l e           |   | 0          | 14, 653                        | 1                  |
| 56. 00 05600 RADI OI SOTOPE  | 17, 230            |               | 4, 179                                  | 0          | 0                              | 56.00              |
| 56. 01   05601   0NC0L0GY  | 41, 503            | 3, 155        | 9, 003                                  | o          | 7, 162                         | 56. 01             |
| 57. 00 05700 CT SCAN   | 4, 349             | 0             | 943                                     | 0          | 1, 399                         | 57.00              |
| 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)                                     | 4, 387             | 0             | 952                                     | 0          | 1, 740                         |                    |
| 59. 00 05900 CARDI AC CATHETERI ZATI ON  | 0                  | 0             | 0                                       | 0          | 0                              | 59.00              |
| 60. 00   06000   LABORATORY  | 11, 980            |               | 2, 599                                  | 0          | 14, 686                        | 1                  |
| 65. 00   06500  RESPI RATORY THERAPY<br>65. 01   06501  SLEEP LAB                | 9, 590             |               | 2, 080<br>0                             | O O        | 5, 890                         | 65. 00<br>65. 01   |
| 66. 00   06600 PHYSI CAL THERAPY   | 24, 582            | 1             | -                                       | 0          | 0<br>7, 831                    | 66.00              |
| 69. 00   06900   ELECTROCARDI OLOGY  | 2, 540             |               | 551                                     | 0          | 2, 769                         | 1                  |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS                                 | 0                  | Ō             | 0                                       | o          | 0                              | 71.00              |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENT  | 0                  | 0             | 0                                       | 0          | 1, 023                         | 72.00              |
| 73.00 O7300 DRUGS CHARGED TO PATIENTS  | 0                  | 0             | 0                                       | 0          | 0                              | 73.00              |
| OUTPATIENT SERVICE COST CENTERS  | 45.040             | 1 0           | 0.00/                                   | ام         | 0.000                          | 00.00              |
| 88.00   08800   RURAL HEALTH CLINIC<br>88.01   08801   RURAL HEALTH CLINIC II    | 15, 240<br>9, 005  |               |   | 0          | 8, 020<br>5, 014               |                    |
| 88. 02 08802 RURAL HEALTH CLINIC III   | 50, 241            |               |   | o          | 30, 645                        | 1                  |
| 90. 00   09000   CLI NI C  | 25, 546            |               | 5, 541                                  | 0          | 5, 975                         | 90.00              |
| 91. 00   09100   EMERGENCY   | 28, 555            |               | 6, 194                                  | o          | 14, 285                        | 1                  |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)                                 |                    |               |   |            |                                | 92.00              |
| 92.01 O9201 OBSERVATION BEDS (DISTINCT PART)                                     | 15, 313            | 0             | 3, 322                                  | 0          | 6, 196                         | 92. 01             |
| OTHER REIMBURSABLE COST CENTERS  |                    | 1             | 1 0                                     | ٠.         |                                |                    |
| 95. 00   09500   AMBULANCE SERVI CES<br>101. 00   10100   HOME   HEALTH   AGENCY | 12 204             |               |   | 0          | 0                              |                    |
| SPECIAL PURPOSE COST CENTERS   | 13, 306            |               | 2, 886                                  | 0          | 0                              | 101. 00            |
| 113. 00 11300 I NTEREST EXPENSE  |                    |               |   | T          |                                | 113.00             |
| 118.00 SUBTOTALS (SUM OF LINES 1 through 117)                                    | 444, 923           | 50, 257       | 94, 726                                 | 60, 675    | 206, 713                       | 1                  |
| NONREI MBURSABLE COST CENTERS  |                    |               | ·                                       |            |                                |                    |
| 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN                                 | 1, 564             |               |   | 0          |                                | 190. 00            |
| 190. 01 19001 UROLOGY  | 0                  | 1             |   | 0          |                                | 190. 01            |
| 190. 05 19005 MARKETI NG   | 1, 666             |               |   | 0          |                                | 190.05             |
| 190. 07 19007 I -74 CAMPUS   | 22 000             | 0             | _                                       | 0          |                                | 190. 07<br>190. 08 |
| 190. 08 19008 RAMPART<br>190. 09 19009 INTELLIPLEX DEVELOPMENT                   | 22, 908<br>18, 586 |               | , | 0          |                                | 190.08             |
| 190. 11 19011 MHP ADMIN BUILDING   | 5, 830             |               |   | 0          |                                | 190. 11            |
| 190. 16 19016 RENOVO   | 20, 268            |               |   | o          |                                | 190. 16            |
| 190. 17 19017 I MA   | 0                  | 0             | 0                                       | 0          |                                | 190. 17            |
| 190. 18 19018 MD SOLUTIONS   | 0                  | 0             | 0                                       | 0          |                                | 190. 18            |
| 190. 19 19019 MHCD   | 0                  | 0             |   | 0          |                                | 190. 19            |
| 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES                                     | 0                  | 0             | _                                       | 0          |                                | 192.00             |
| 192. 01 19201 HOSPI TALI ST<br>194. 00 07950 UNAVI E                             | 466<br>18, 309     |               | 101<br>3, 972                           | O          |                                | 192. 01<br>194. 00 |
| 200.00 Cross Foot Adjustments  | 10, 309            |               | 3, 9/2                                  | ٩          |                                | 200.00             |
| 201.00 Negative Cost Centers   | 0                  | 0             | О                                       | ol         |                                | 201.00             |
| 202.00 TOTAL (sum lines 118 through 201)   | 534, 520           | 50, 257       | 114, 162                                | 60, 675    | 214, 292                       |                    |
|  |                    |               |   |            |                                |                    |

|   |                  |               | 10            | 12/31/2020    | 8/2/2021 2:11        |                  |
|---|------------------|---------------|---------------|---------------|----------------------|------------------|
| Cost Center Description   | NURSI NG         | CENTRAL       | PHARMACY      | MEDI CAL      | Subtotal             |                  |
|   | ADMI NI STRATI O | SERVICES &    |               | RECORDS &     |                      |                  |
|   | N                | SUPPLY        | 45.00         | LI BRARY      |                      |                  |
| GENERAL SERVICE COST CENTERS  | 13. 00           | 14. 00        | 15. 00        | 16. 00        | 24. 00               |                  |
| 1.00 O0100 CAP REL COSTS-BLDG & FLXT  | Ι                | 1             |               | I             |                      | 1.00             |
| 4. 00   00400 EMPLOYEE BENEFITS DEPARTMENT  |                  |               |               |               |                      | 4.00             |
| 5. 00 00500 ADMINISTRATIVE & GENERAL  |                  |               |               |               |                      | 5.00             |
| 7.00 00700 OPERATION OF PLANT   |                  |               |               |               |                      | 7.00             |
| 8.00   00800 LAUNDRY & LINEN SERVICE  |                  |               |               |               |                      | 8. 00            |
| 9. 00   00900   HOUSEKEEPI NG   |                  |               |               |               |                      | 9. 00            |
| 10. 00  01000 DI ETARY  |                  |               |               |               |                      | 10.00            |
| 11. 00   01100   CAFETERI A   |                  |               |               |               |                      | 11.00            |
| 13. 00 01300 NURSING ADMINISTRATION   | 119, 573         | 444 005       |               |               |                      | 13.00            |
| 14. 00   01400   CENTRAL SERVI CES & SUPPLY<br>15. 00   01500   PHARMACY                        | 0                | 116, 205<br>0 | 200 042       |               |                      | 14.00            |
| 15. 00   01500   PHARMACY<br>16. 00   01600   MEDI CAL RECORDS & LI BRARY                       | 0                | 0             | 209, 942<br>0 | 107, 905      |                      | 15. 00<br>16. 00 |
| I NPATIENT ROUTINE SERVICE COST CENTERS   | <u> </u>         | <u>U</u>      | U             | 107, 905      |                      | 10.00            |
| 30. 00 03000 ADULTS & PEDIATRICS  | 23, 247          | 0             | 0             | 3, 817        | 1, 138, 929          | 30.00            |
| 31. 00 03100 I NTENSI VE CARE UNI T   | 7, 213           | ő             | Ö             | 1, 751        | 196, 711             | 31.00            |
| ANCILLARY SERVICE COST CENTERS  | ., = ,           | -,            | -,            | .,            | ,                    |                  |
| 50. 00 05000 OPERATING ROOM   | 10, 139          | 63, 913       | 0             | 18, 022       | 1, 164, 124          | 50.00            |
| 53. 00 05300 ANESTHESI OLOGY  | 2, 415           | 0             | 0             | 137           | 27, 040              | 53.00            |
| 54. 00   05400   RADI OLOGY-DI AGNOSTI C  | 0                | 0             | 0             | 7, 583        | 408, 911             | 54.00            |
| 56. 00   05600   RADI 01 SOTOPE   | 0                | 0             | 0             | 0             | 0                    | 56.00            |
| 56. 01   05601   0NCOLOGY   | 5, 419           | 0             | 0             | 6, 028        | 759, 629             | 56. 01           |
| 57. 00 05700 CT SCAN  | 0                | 0             | 0             | 8, 042        | 91, 596              | 57.00            |
| 58. 00   05800   MAGNETI C RESONANCE I MAGING (MRI)<br>59. 00   05900   CARDIAC CATHETERIZATION | 0                | 0             | 0             | 2, 624        | 87, 368<br>0         | 58. 00<br>59. 00 |
| 60. 00   06000   LABORATORY   | 0                | 0             | 0             | 11, 864       | 285, 863             | 60.00            |
| 65. 00 06500 RESPIRATORY THERAPY  | 4, 457           | 0             | 0             | 2, 500        | 192, 212             | 65.00            |
| 65. 01   06501   SLEEP LAB  | 1, 637           | ő             | Ö             | 868           | 7, 985               | 65. 01           |
| 66. 00   06600 PHYSI CAL THERAPY  | 0                | O             | 0             | 1, 979        | 453, 313             | 1                |
| 69. 00 06900 ELECTROCARDI OLOGY   | 2, 096           | 0             | 0             | 3, 725        | 70, 801              | 69. 00           |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS  | 0                | 0             | 0             | 0             | 0                    | 71.00            |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENT   | 0                | 52, 292       | 0             | 2, 474        | 69, 579              | 72.00            |
| 73. 00 07300 DRUGS CHARGED TO PATIENTS  | 0                | 0             | 209, 942      | 12, 694       | 222, 636             | 73.00            |
| OUTPATIENT SERVICE COST CENTERS   | 4 040            | ٥             |               | 1 017         | 205 (25              | 00.00            |
| 88. 00   08800   RURAL   HEALTH   CLINIC<br>88. 01   08801   RURAL   HEALTH   CLINIC   I        | 6, 069<br>3, 794 | 0             | 0             | 1, 017<br>719 | 305, 635<br>180, 086 | 88. 00<br>88. 01 |
| 88. 02 08802 RURAL HEALTH CLINIC III  | 23, 191          | 0             | 0             | 3, 246        | 1, 014, 250          | 88. 02           |
| 90. 00   09000   CLINI C  | 4, 521           | Ö             | 0             | 1, 346        | 467, 275             | 90.00            |
| 91. 00   09100   EMERGENCY  | 10, 810          | Ö             | 0             | 15, 441       | 575, 912             | 91.00            |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)  |                  |               |               |               |                      | 92.00            |
| 92.01 09201 OBSERVATION BEDS (DISTINCT PART)  | 4, 688           | 0             | 0             | 1, 414        | 291, 415             | 92. 01           |
| OTHER REIMBURSABLE COST CENTERS   |                  |               |               |               |                      |                  |
| 95. 00 09500 AMBULANCE SERVI CES  | 0                | 0             | 0             | 0             | 0                    | 95.00            |
| 101. 00 10100 HOME HEALTH AGENCY  | 3, 723           | 0             | 0             | 614           | 243, 827             | 101.00           |
| SPECIAL PURPOSE COST CENTERS  113. 00 11300   INTEREST EXPENSE                                  |                  |               |               |               |                      | 113. 00          |
| 118.00 SUBTOTALS (SUM OF LINES 1 through 117)   | 113, 419         | 116, 205      | 209, 942      | 107, 905      | 8, 255, 097          |                  |
| NONREI MBURSABLE COST CENTERS   | 110, 117         | 110, 200      | 207, 712      | 107, 700      | 0,200,077            | 1110.00          |
| 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN  | 0                | 0             | 0             | 0             | 26, 961              | 190.00           |
| 190. 01 19001 UROLOGY   | 72               | o             | 0             | 0             | 209                  | 190. 01          |
| 190. 05 19005 MARKETI NG  | 0                | 0             | 0             | 0             | 31, 816              |                  |
| 190.07 19007 I -74 CAMPUS   | 0                | 0             | 0             | 0             |                      | 190. 07          |
| 190. 08 19008 RAMPART   | 559              | 0             | 0             | 0             | 397, 522             | 1                |
| 190. 09 19009 I NTELLI PLEX DEVELOPMENT   | 35               | 0             | 0             | 0             | 320, 806             | 1                |
| 190. 11 19011 MHP ADMIN BUILDING  | 0                | 0             | 0             | 0             | 101, 445             |                  |
| 190. 16 19016  RENOVO<br>190. 17 19017  I MA  | 657              | 0             | 0             | 0             | 352, 525             | 190. 16          |
| 190. 18 19018 MD SOLUTIONS  |                  | 0             | 0             | 0             |                      | 190. 17          |
| 190. 19 19019 MHCD  | 0                | 0             | 0             | 0             |                      | 190. 19          |
| 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES  | 0                | ő             | n             | o o           |                      | 192.00           |
| 192. 01 19201 HOSPI TALI ST   | 3, 683           | o             | 0             | o             | 44, 673              |                  |
| 194. 00 07950 UNAVI E   | 1, 148           | o             | 0             | О             | 319, 073             |                  |
| 200.00 Cross Foot Adjustments   | 1                |               |               |               |                      | 200. 00          |
| 201.00 Negative Cost Centers  | 0                | 0             | 0             | 0             |                      | 201.00           |
| 202.00   TOTAL (sum lines 118 through 201)  | 119, 573         | 116, 205      | 209, 942      | 107, 905      | 9, 850, 127          | 202.00           |
|   |                  |               |               |               |                      |                  |

Health Financial Systems MAJOR HOSPITAL In Lieu of Form CMS-2552-10

ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0097 Peri od: Worksheet B From 01/01/2020 Part II Date/Time Prepared: 12/31/2020 8/2/2021 2:11 pm Cost Center Description Intern & Total Resi dents Cost & Post Stepdown Adjustments 25. 00 26.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4 00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 00700 OPERATION OF PLANT 7.00 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 00900 HOUSEKEEPI NG 9.00 9.00 10.00 01000 DI ETARY 10.00 11.00 01100 CAFETERI A 11.00 01300 NURSING ADMINISTRATION 13.00 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 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 1, 138, 929 30.00 03100 INTENSIVE CARE UNIT 31.00 0 196, 711 31.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 1, 164, 124 50.00 05300 ANESTHESI OLOGY 27, 040 53.00 000000000000000 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 408.911 54.00 05600 RADI OI SOTOPE 56.00 C 56.00 56.01 05601 ONCOLOGY 759, 629 56.01 57.00 05700 CT SCAN 91, 596 57.00 58 00 05800 MAGNETIC RESONANCE IMAGING (MRI) 87, 368 58 00 05900 CARDI AC CATHETERI ZATI ON 59.00 59.00 60.00 06000 LABORATORY 285, 863 60.00 06500 RESPIRATORY THERAPY 65.00 192, 212 65.00 06501 SLEEP LAB 65 01 7. 985 65 01 06600 PHYSI CAL THERAPY 66.00 453, 313 66.00 06900 ELECTROCARDI OLOGY 69.00 69.00 70,801 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 07200 I MPL. DEV. CHARGED TO PATIENT 69, 579 72 00 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 73.00 222, 636 OUTPATIENT SERVICE COST CENTERS 0 88.00 08800 RURAL HEALTH CLINIC 305, 635 88.00 08801 RURAL HEALTH CLINIC II 88.01 180, 086 88.01 0 88.02 08802 RURAL HEALTH CLINIC III 1,014,250 88.02 90 00 09000 CLI NI C 0 467, 275 90.00 0 09100 EMERGENCY 91.00 91.00 575, 912 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 92.01 09201 OBSERVATION BEDS (DISTINCT PART) 0 291, 415 92.01 OTHER REIMBURSABLE COST CENTERS 95 00 95. 00 09500 AMBULANCE SERVICES 0 101.00 10100 HOME HEALTH AGENCY 243, 827 101.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 I NTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1 through 117) 8, 255, 097 0 118.00 118.00 NONREIMBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 26, 961 190.00 0 190. 01 19001 UROLOGY 190. 01 209 190. 05 19005 MARKETI NG 31,816 190.05 190. 07 19007 I -74 CAMPUS 000000000000000 190.07 190. 08 19008 RAMPART 397, 522 190.08 190. 09 19009 INTELLIPLEX DEVELOPMENT 190. 09 320, 806 190. 11 19011 MHP ADMIN BUILDING 101, 445 190. 11 190. 16 19016 RENOVO 190. 16 352, 525 190. 17 19017 I MA 190. 17 0 190. 18 19018 MD SOLUTIONS l190. 18 0 190. 19 19019 MHCD 0 190. 19 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 0 192.00 192. 01 19201 HOSPI TALI ST 44 673 192.01 194. 00 07950 UNAVI E 319,073 194.00 200.00 Cross Foot Adjustments 200.00 C 201.00 Negative Cost Centers 201.00 9, 850, 127 202.00 TOTAL (sum lines 118 through 201) 202.00

|              | ancial Systems  | MAJOR HOS        |                         | CN 15 0007 D  |                            | u of Form CMS-2                |                  |
|--------------|---|------------------|-------------------------|---------------|----------------------------|--------------------------------|------------------|
| COST ALLOC   | CATION - STATISTICAL BASIS  |                  | Provi der C             |               | eriod:<br>rom 01/01/2020   | Worksheet B-1                  |                  |
|              |   |                  |                         | T             | o 12/31/2020               | Date/Time Pre<br>8/2/2021 2:11 | pared:           |
|              |   | CAPI TAL         |                         |               |                            | 0/2/2021 2.11                  | Pili             |
|              |   | RELATED COSTS    |                         |               |                            |                                |                  |
|              | Cost Center Description   | BLDG & FIXT      | EMPLOYEE                | Reconciliatio | ADMI NI STRATI V           | OPERATION OF                   |                  |
|              |   | (SQUARE FEET)    | BENEFI TS               | n             | E & GENERAL                | PLANT                          |                  |
|              |   |                  | DEPARTMENT              |               | (ACCUM. COST)              | (SQUARE FEET)                  |                  |
|              |   |                  | (GROSS                  |               |                            |                                |                  |
|              |   | 1. 00            | SALARI ES)<br>4. 00     | 5A            | 5. 00                      | 7. 00                          |                  |
| GENI         | ERAL SERVICE COST CENTERS   | 1.00             | 4.00                    | ] DA          | 5.00                       | 7.00                           |                  |
|              | 00 CAP REL COSTS-BLDG & FLXT  | 297, 473         |                         |               |                            |                                | 1.0              |
|              | OO EMPLOYEE BENEFITS DEPARTMENT   | 1, 173           | 52, 351, 864            |               |                            |                                | 4.0              |
| 5.00 005     | OO ADMINISTRATIVE & GENERAL   | 24, 328          | 9, 746, 081             | 1             | 106, 471, 005              |                                | 5.0              |
| 7. 00   007  | OO OPERATION OF PLANT   | 15, 239          | 1, 229, 127             | 0             | 3, 799, 279                | 256, 733                       | 7. C             |
|              | 00 LAUNDRY & LINEN SERVICE  | 1, 323           | 100, 557                | 1             |                            | 1, 323                         |                  |
| - 1          | 00 HOUSEKEEPI NG  | 2, 631           | 1, 454, 502             | i             | 2, 683, 478                |                                |                  |
|              | 00 DI ETARY   | 1, 615           | 140, 571                | 0             |                            | 1, 615                         |                  |
|              | OO CAFETERIA<br>OO NURSING ADMINISTRATION                                   | 5, 730<br>2, 607 | 541, 812<br>664, 455    | 1             | 1, 262, 197<br>2, 434, 132 | 5, 730<br>2, 607               | 1                |
|              | 00 CENTRAL SERVICES & SUPPLY  | 3, 237           | 004, 455                | 1             |                            | 3, 237                         | 14. 0            |
| - 1          | OO PHARMACY   | 3, 091           | 1, 156, 987             | _             |                            | 3, 091                         |                  |
|              | 00 MEDICAL RECORDS & LIBRARY  | 2, 235           | 1, 358, 816             | 1             |                            | 2, 235                         | 1                |
| I NP         | ATIENT ROUTINE SERVICE COST CENTERS   |                  |                         |               |                            | ·                              | 1                |
|              | 00 ADULTS & PEDIATRICS  | 26, 223          | 5, 816, 203             | 0             | 9, 396, 921                | 26, 223                        | 30.0             |
|              | 00 INTENSIVE CARE UNIT  | 4, 118           | 1, 711, 330             | 0             | 2, 661, 443                | 4, 118                         | 31.0             |
| ANC          | ILLARY SERVICE COST CENTERS   |                  |                         |               |                            |                                |                  |
|              | OO OPERATING ROOM   | 28, 124          | 2, 415, 306             | 1             |                            | 28, 124                        |                  |
|              | OO ANESTHESI OLOGY  | 501              | 688, 887                |               |                            | 501                            |                  |
|              | 00  RADI OLOGY-DI AGNOSTI C<br>00  RADI OI SOTOPE                           | 9, 240           | 2, 862, 557             | 0             | 6, 072, 354                | 9, 240<br>0                    | 54. 0<br>56. 0   |
|              | 01 ONCOLOGY   | 19, 934          | 1, 341, 799             |               | 3, 444, 437                | 19, 934                        | 1                |
|              | OO CT SCAN  | 2, 089           | 308, 339                | 1             | 977, 520                   | 2, 089                         | 1                |
|              | OO MAGNETIC RESONANCE IMAGING (MRI)   | 2, 107           | 370, 559                |               |                            | 2, 107                         | 1                |
| 4            | OO CARDI AC CATHETERI ZATI ON   | 0                | 0                       | 1             | l                          | 0                              | 59. (            |
| 0.00 060     | 00 LABORATORY   | 5, 754           | 2, 118, 426             | 0             | 6, 894, 454                | 5, 754                         | 60.0             |
|              | 00 RESPI RATORY THERAPY   | 4, 606           | 1, 105, 824             |               | 1, 716, 350                | 4, 606                         |                  |
|              | 01 SLEEP LAB  | 0                | 430, 362                |               | 676, 036                   | 0                              | 65.0             |
|              | 00 PHYSI CAL THERAPY  | 11, 807          | 1, 689, 756             | 1             | 2, 590, 823                | 11, 807                        |                  |
|              | 00 ELECTROCARDI OLOGY   | 1, 220           | 686, 264                | i             | 2, 385, 869                | 1, 220                         |                  |
|              | 00 MEDICAL SUPPLIES CHARGED TO PATIENTS 00 IMPL. DEV. CHARGED TO PATIENT    | 0                | 101, 941                | 0             | 1, 796, 489                | 0                              | 71. (            |
| 4            | OO DRUGS CHARGED TO PATIENTS  |                  | 101, 941                | 1             |                            | 0                              | 73.0             |
|              | PATIENT SERVICE COST CENTERS  | <u> </u>         |                         |               | <u>ا</u>                   |                                | 70.              |
|              | OO RURAL HEALTH CLINIC  | 7, 320           | 979, 296                | 0             | 3, 781, 837                | 7, 320                         | 88.0             |
| 88. 01   088 | 01 RURAL HEALTH CLINIC II   | 4, 325           | 607, 554                | 0             | 2, 087, 787                | 4, 325                         | 88.0             |
|              | 02 RURAL HEALTH CLINIC III  | 24, 131          | 3, 828, 303             | 1             | ,                          |                                |                  |
|              | 00 CLI NI C   | 12, 270          | 1, 259, 043             | 1             | 2, 242, 432                | 12, 270                        |                  |
| - 1          | OO EMERGENCY  | 13, 715          | 2, 515, 629             | 0             | 4, 409, 106                | 13, 715                        |                  |
| 1            | 00 OBSERVATION BEDS (NON-DISTINCT PART) 01 OBSERVATION BEDS (DISTINCT PART) | 7, 355           | 1, 237, 656             | О             | 2, 098, 570                | 7, 355                         | 92.0             |
|              | ER REIMBURSABLE COST CENTERS  | 7, 333           | 1, 237, 030             | 0             | 2,090,370                  | 7, 333                         | 72. (            |
|              | 00 AMBULANCE SERVICES   | 0                | 0                       | 0             | O                          | 0                              | 95. (            |
|              | OO HOME HEALTH AGENCY   | 6, 391           | 870, 601                |               |                            |                                |                  |
| SPE          | CLAL PURPOSE COST CENTERS   |                  |                         |               |                            |                                |                  |
|              | 00 I NTEREST EXPENSE  |                  |                         |               |                            |                                | 113. (           |
| 18. 00       | SUBTOTALS (SUM OF LINES 1 through 117)                                      | 254, 439         | 49, 338, 543            | -22, 965, 831 | 100, 569, 158              | 213, 699                       | ]118. (          |
|              | REIMBURSABLE COST CENTERS   | 754              |                         |               | 04.040                     | 754                            | 100              |
| 4            | 00 GIFT, FLOWER, COFFEE SHOP & CANTEEN 01 UROLOGY                           | 751<br>0         | 0                       |               | .,                         |                                | 190. (<br>190. ( |
|              | 05 MARKETI NG   | 800              | 127, 547                | _             |                            |                                | 190. (           |
|              | 07 I -74 CAMPUS   | 000              | 127, 547                | 0             | 332, 407                   |                                | 190.             |
|              | 08 RAMPART  | 11, 003          | 66, 122                 | · ·           | 518, 548                   | 11, 003                        |                  |
|              | 09 INTELLIPLEX DEVELOPMENT  | 8, 927           | 0                       | Ō             | 328, 783                   | 8, 927                         |                  |
| 90. 11 190   | 11 MHP ADMIN BUILDING   | 2, 800           | 31, 063                 | 0             | 172, 153                   | 2, 800                         | 190.             |
| 90. 16 190   | 16 RENOVO   | 9, 735           | 88, 650                 | 0             | 513, 039                   | 9, 735                         |                  |
| 90. 17 190   |   | 0                | 0                       | 0             | 0                          |                                | 190.             |
|              | 18 MD SOLUTIONS   | 0                | 0                       |               | 0                          |                                | 190.             |
| 90. 19 190   |   | 0                | 0                       | 0             | =                          | 0                              | 1                |
|              | 00 PHYSICIANS' PRIVATE OFFICES<br>01 HOSPITALIST                            | 0<br>224         | 0<br>2, 510, 562        | 0             |                            |                                | 192.<br>192.     |
|              | 50  UNAVI E   | 8, 794           | 2, 510, 562<br>189, 377 |               |                            | 8, 794                         |                  |
| 00.00        | Cross Foot Adjustments  | 0, 7,74          | 107, 377                |               | 304, 334                   | 0, 774                         | 200.             |
| 01.00        | Negative Cost Centers   |                  |                         |               |                            |                                | 201.             |
| 202.00       | Cost to be allocated (per Wkst. B,  | 9, 850, 127      | 10, 685, 438            |               | 22, 965, 831               | 4, 618, 783                    |                  |
|              | Part I)   |                  |                         |               |                            |                                |                  |
| 203. 00      | Unit cost multiplier (Wkst. B, Part I)                                      | 33. 112676       | 0. 204108               | 1             | 0. 215700                  |                                |                  |
|              | Cost to be allocated (per Wkst. B,  | 1                | 38, 841                 | I .           | 812, 790                   | 534, 520                       | 1204. C          |
| 204. 00      | Part II)  |                  | 30, 04 1                |               | 012, 790                   | 334, 320                       |                  |

| Health Financial Systems                                      | MAJOR HOS  | SPI TAL   |                | In Lie  | u of Form CMS-2                | 2552-10 |
|---|--|---|----------------|---|--------------------------------|---------|
| COST ALLOCATION - STATISTICAL BASIS                           |  | Provi der Co  |                | Peri od:<br>From 01/01/2020                   | Worksheet B-1                  |         |
|   |  |   |                | To 12/31/2020                                 | Date/Time Pre<br>8/2/2021 2:11 |         |
| Cost Center Description                                       | CAPITAL<br>RELATED COSTS<br>BLDG & FIXT<br>(SQUARE FEET) | EMPLOYEE<br>BENEFITS<br>DEPARTMENT<br>(GROSS<br>SALARIES) | Reconciliation | ADMINISTRATIV<br>E & GENERAL<br>(ACCUM. COST) | PLANT                          |         |
|   | 1. 00  | 4. 00   | 5A             | 5. 00   | 7. 00                          |         |
| 205.00 Unit cost multiplier (Wkst. B, Part                    |  | 0. 000742   |                | 0. 007634                                     | 2. 082007                      | 205. 00 |
| 206.00 NAHE adjustment amount to be allocated (per Wkst. B-2) |  |   |                |   |                                | 206. 00 |
| 207.00 NAHE unit cost multiplier (Wkst. D, Parts III and IV)  |  |   |                |   |                                | 207. 00 |

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS MAJOR HOSPITAL In Lieu of Form CMS-2552-10 Provider CCN: 15-0097 

|  |   |  |                                | Ic                             | 12/31/2020              | Date/lime Pre<br>  8/2/2021 2:11                |                     |
|--|---|--|--------------------------------|--------------------------------|-------------------------|---|---------------------|
|  | Cost Center Description   | LAUNDRY &<br>LINEN SERVICE<br>(POUNDS OF<br>LAUNDRY) | HOUSEKEEPI NG<br>(SQUARE FEET) | DI ETARY<br>(PATI ENT<br>DAYS) | CAFETERIA<br>(MANHOURS) | NURSI NG<br>ADMI NI STRATI O<br>N<br>(MANHOURS) | P                   |
|  |   | 8. 00  | 9. 00                          | 10.00                          | 11.00                   | 13.00   |                     |
|  | GENERAL SERVICE COST CENTERS  |  |                                |                                |                         |   |                     |
| 1.00   | 00100 CAP REL COSTS-BLDG & FIXT   |  |                                |                                |                         |   | 1.00                |
| 4.00   | 00400 EMPLOYEE BENEFITS DEPARTMENT  |  |                                |                                |                         |   | 4.00                |
| 5. 00<br>7. 00   | 00500 ADMINISTRATIVE & GENERAL<br>00700 OPERATION OF PLANT  |  |                                |                                |                         |   | 5. 00<br>7. 00      |
| 7. 00<br>8. 00   | 00800 LAUNDRY & LINEN SERVICE   | 412, 534   |                                |                                |                         |   | 8.00                |
| 9. 00  | 00900 HOUSEKEEPI NG   | 412, 334   | 252, 779                       |                                |                         |   | 9.00                |
| 10.00  | 01000 DI ETARY  |  | 1, 615                         |                                |                         |   | 10.00               |
| 11. 00   | 01100 CAFETERI A  | 0  | 5, 730                         |                                | 1, 161, 177             |   | 11.00               |
| 13. 00   | 01300 NURSING ADMINISTRATION  | 0  | 2, 607                         | 0                              | 41, 008                 | 856, 203  | 13.00               |
| 14. 00   | 01400 CENTRAL SERVICES & SUPPLY   | 0  | 3, 237                         |                                | 0                       | 0   | 14.00               |
| 15.00  | 01500 PHARMACY  | 0  | 3, 091                         | 0                              | 25, 591                 | 0   | 15.00               |
| 16. 00   | 01600 MEDI CAL RECORDS & LI BRARY   | ] 0  | 2, 235                         | 0                              | 55, 778                 | 0   | 16.00               |
| 30. 00   | INPATIENT ROUTINE SERVICE COST CENTERS   03000   ADULTS & PEDIATRICS  | 160, 104   | 26, 223                        | 8, 327                         | 166, 447                | 166, 447  | 30.00               |
| 31. 00   | 03100 I NTENSI VE CARE UNI T  | 0  | 4, 118                         |                                | 51, 652                 | 51, 652   | 31.00               |
| 01.00  | ANCI LLARY SERVI CE COST CENTERS  | <u> </u>   | 1, 110                         | 1,011                          | 01,002                  | 01,002  | 01.00               |
| 50.00  | 05000 OPERATI NG ROOM   | 40, 746  | 28, 124                        | 0                              | 72, 603                 | 72, 603   | 50.00               |
| 53. 00   | 05300 ANESTHESI OLOGY   | 0  | 501                            | 0                              | 17, 294                 | 17, 294   | 53.00               |
| 54. 00   | 05400 RADI OLOGY-DI AGNOSTI C   | 72, 420  | 9, 240                         |                                | 79, 401                 | 0   | 54.00               |
| 56.00  | 05600 RADI OI SOTOPE  | 0  | 0                              | 0                              | 0                       | 0   | 56.00               |
| 56. 01<br>57. 00   | O5601   ONCOLOGY   O5700   CT   SCAN  | 25, 896  | 19, 934                        |                                | 38, 806                 | 38, 806   | 56.0                |
| 58.00  | 05800 MAGNETIC RESONANCE IMAGING (MRI)  |  | 2, 089<br>2, 107               | 0                              | 7, 580<br>9, 431        | 0   | 57.00<br>58.00      |
| 59. 00   | 05900 CARDI AC CATHETERI ZATI ON  |  | 2, 107                         | _                              | 0, 431                  | 0   | 59.00               |
| 60.00  | 06000 LABORATORY  |  | 5, 754                         | _                              | 79, 578                 | 1   | 60.00               |
| 55.00  | 06500 RESPIRATORY THERAPY   | 10, 296  | 4, 606                         |                                | 31, 917                 | 31, 917   | 65.00               |
| 5. 01  | 06501 SLEEP LAB   | 0  | 0                              | 0                              | 0                       | 11, 722   | 65. 0°              |
| 6.00   | 06600 PHYSI CAL THERAPY   | 13, 099  | 11, 807                        | 0                              | 42, 432                 | 0   | 66.00               |
| 9. 00  | 06900 ELECTROCARDI OLOGY  | 0  | 1, 220                         |                                | 15, 005                 |   | 69.00               |
| 71.00  | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS  | 0  | 0                              |                                | 0                       | 0   | 71.00               |
| 72.00  | 07200 I MPL. DEV. CHARGED TO PATIENT  | 0  | 0                              |                                | 5, 545                  | l   | 72.00               |
| 73. 00   | 07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS   | J U  | U                              | 0                              | 0                       | 0   | 73.00               |
| 88. 00   | 08800 RURAL HEALTH CLINIC   | O  | 7, 320                         | 0                              | 43, 456                 | 43, 456   | 88. 00              |
| 38. 01   | 08801 RURAL HEALTH CLINIC II  |  | 4, 325                         |                                | 27, 169                 | 27, 169   | 88. 01              |
| 38. 02   | 08802 RURAL HEALTH CLINIC III   | o  | 24, 131                        | 0                              | 166, 056                | l   | 88. 02              |
| 90.00  | 09000 CLI NI C  | 0  | 12, 270                        | 0                              | 32, 375                 | 32, 375   | 90.00               |
| 91. 00   | 09100 EMERGENCY   | 89, 973  | 13, 715                        | 0                              | 77, 405                 | 77, 405   | 91.00               |
| 92.00  | 09200 OBSERVATION BEDS (NON-DISTINCT PART)  |  | 7 055                          |                                | 00 570                  | 00 570  | 92.00               |
| 92. 01   | O9201   OBSERVATION BEDS (DISTINCT PART)   OTHER REIMBURSABLE COST CENTERS  | 0  | 7, 355                         | 0                              | 33, 572                 | 33, 572   | 92.0                |
| 95 00  | 09500 AMBULANCE SERVICES  | T ol   | 0                              | 0                              | 0                       | 0   | 95.00               |
|  | 10100 HOME HEALTH AGENCY  | l o  | 6, 391                         | Ö                              | 0                       | <b>l</b>  |                     |
|  | SPECIAL PURPOSE COST CENTERS  |  |                                |                                |                         | ·   |                     |
|  | 11300 INTEREST EXPENSE  |  |                                |                                |                         | l   | 113.00              |
| 118. 00  | , , ,   | 412, 534   | 209, 745                       | 9, 938                         | 1, 120, 101             | 812, 134  | 118.0               |
| 100 00   | NONREI MBURSABLE COST CENTERS   |  | 754                            |                                |                         |   | 100 0               |
|  | 19000  GIFT, FLOWER, COFFEE SHOP & CANTEEN<br>  19001  UROLOGY  | 0  | 751<br>0                       |                                | 0<br>516                | l   | 190. 00<br>190. 01  |
|  | 1900   UROLOGY<br>19005 MARKETI NG  |  | 800                            |                                | 3, 610                  | l e   | 190. 0              |
|  | 19007 I -74 CAMPUS  |  | 0                              |                                | 0, 010                  | l .   | 190.0               |
|  | 19008 RAMPART   | 0  | 11, 003                        | 0                              | 4, 004                  |   | 190.08              |
|  | 19009 INTELLIPLEX DEVELOPMENT   | 0  | 8, 927                         |                                | 251                     |   | 190.0               |
| 90. 11   | 19011 MHP ADMIN BUILDING  | o  | 2, 800                         |                                | 1, 616                  | 0   | 190. 1 <sup>-</sup> |
|  | 19016 RENOVO  | 0  | 9, 735                         | 0                              | 4, 705                  |   | 190. 1              |
|  | 1 19017 I MA  | 0  | 0                              |                                | 0                       |   | 190. 1              |
|  | 19018 MD SOLUTIONS  | 0  | 0                              | 0                              | 0                       |   | 190. 1              |
|  | P 19019 MHCD<br> 19200 PHYSICIANS' PRIVATE OFFICES  |  | 0                              | 0                              | 0                       | l e   | 190. 1<br>192. 0    |
|  | 19200  PHYSICIANS   PRIVATE OFFICES   |  | 224                            | 0                              | 26, 374                 | l e   |                     |
| /L. UI   | 07950 UNAVI E   |  | 8, 794                         |                                | 20, 374                 | 8, 219  |                     |
| 94.00  | 1 1   |  | 2,                             |                                |                         | l   | 200. 0              |
|  | , ,   |  |                                |                                |                         |   | 201. 0              |
| 200.00   | Negative Cost Centers   |  | 3, 309, 637                    | 528, 492                       | 1, 712, 562             | 3, 100, 690                                     | 202. 00             |
| 200. 00<br>201. 00   | 1 1 3   | 600, 354   | 3, 307, 037                    |                                |                         |   | I                   |
| 200. 00<br>201. 00<br>202. 00                                  | Cost to be allocated (per Wkst. B, Part I)  |  |                                |                                |                         |   |                     |
| 200. 00<br>201. 00<br>202. 00<br>203. 00                       | Cost to be allocated (per Wkst. B, Part I) Unit cost multiplier (Wkst. B, Part I)   | 1. 455284  | 13. 093006                     | 53. 178909                     | 1. 474850               | i e   |                     |
| 194. 00<br>200. 00<br>201. 00<br>202. 00<br>203. 00<br>204. 00 | Cost to be allocated (per Wkst. B, Part I) Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B,          |  |                                | 53. 178909                     | 1. 474850<br>214, 292   |   |                     |
| 200. 00<br>201. 00<br>202. 00<br>203. 00                       | Cost to be allocated (per Wkst. B, Part I) Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B, Part II) | 1. 455284  | 13. 093006                     | 53. 178909<br>60, 675          |                         | 119, 573  | 204.00              |

| Heal th Finar | ncial Systems                          | MAJOR HO      | SPI TAL       |           | In Lie          | u of Form CMS-2                | 2552-10 |
|---------------|--|---------------|---------------|-----------|-----------------|--------------------------------|---------|
| COST ALLOCA   | TION - STATISTICAL BASIS               |               | Provi der C   |           | Peri od:        | Worksheet B-1                  |         |
|               |  |               |               |           | From 01/01/2020 |                                | norod.  |
|               |  |               |               |           | To 12/31/2020   | Date/Time Pre<br>8/2/2021 2:11 |         |
|               | Cost Center Description                | LAUNDRY &     | HOUSEKEEPI NG | DI ETARY  | CAFETERI A      | NURSI NG                       |         |
|               |  | LINEN SERVICE | (SQUARE FEET) | (PATI ENT | (MANHOURS)      | ADMI NI STRATI O               |         |
|               |  | (POUNDS OF    |               | DAYS)     |                 | N                              |         |
|               |  | LAUNDRY)      |               |           |                 | (MANHOURS)                     |         |
|               |  | 8. 00         | 9. 00         | 10.00     | 11. 00          | 13.00                          |         |
| 206.00        | NAHE adjustment amount to be allocated |               |               |           |                 |                                | 206.00  |
|               | (per Wkst. B-2)                        |               |               |           |                 |                                | 1       |
| 207. 00       | NAHE unit cost multiplier (Wkst. D,    |               |               |           |                 |                                | 207.00  |
|               | Parts III and IV)                      |               |               |           |                 |                                | 1       |

|                |   |                   |                             | '                           | o 12/31/2020 Date/lime Pi<br>8/2/2021 2:   |                    |
|----------------|---|-------------------|-----------------------------|-----------------------------|--|--------------------|
|                | Cost Center Description   | CENTRAL           | PHARMACY                    | MEDI CAL                    |  |                    |
|                |   | SERVICES & SUPPLY | (100% DRUGS<br>TO PATIENTS) | RECORDS &<br>LI BRARY       |  |                    |
|                |   | (100%             | 10 TATILINIS)               | (GROSS                      |  |                    |
|                |   | SUPPLI ES)        |                             | CHARGES)                    |  |                    |
|                |   | 14. 00            | 15. 00                      | 16. 00                      |  |                    |
| 4 00           | GENERAL SERVICE COST CENTERS  | 1                 | 1                           |                             |  | 4                  |
| 1. 00<br>4. 00 | 00100 CAP REL COSTS-BLDG & FIXT<br>00400 EMPLOYEE BENEFITS DEPARTMENT |                   |                             |                             |  | 1.00<br>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               |
|                | 01000 DI ETARY  |                   |                             |                             |  | 10.00              |
|                | 01100 CAFETERI A  |                   |                             |                             |  | 11.00              |
|                | 01300 NURSI NG ADMI NI STRATI ON                                      | 100               |                             |                             |  | 13.00              |
|                | 01400 CENTRAL SERVI CES & SUPPLY<br>01500 PHARMACY                    | 100               | 100                         |                             |  | 14. 00<br>15. 00   |
|                | 01600 MEDICAL RECORDS & LIBRARY                                       | 0                 | 0                           | 409, 840, 924               | 4  | 16.00              |
| 10.00          | INPATIENT ROUTINE SERVICE COST CENTERS                                | <u> </u>          | <u> </u>                    | 407, 040, 724               |  | - 10.00            |
| 30.00          | 03000 ADULTS & PEDIATRICS   | 0                 | 0                           | 14, 514, 070                |  | 30.00              |
| 31.00          | 03100 INTENSIVE CARE UNIT   | 0                 | 0                           | 6, 656, 379                 | )  | 31.00              |
|                | ANCILLARY SERVICE COST CENTERS  |                   |                             |                             |  |                    |
|                | 05000 OPERATING ROOM  | 55                | 0                           | 68, 083, 492                |  | 50.00              |
|                | 05300 ANESTHESI OLOGY   | 0                 | 0                           | 520, 745                    |  | 53.00              |
|                | 05400  RADI OLOGY-DI AGNOSTI C<br>05600  RADI OI SOTOPE               | 0                 | 0                           | 28, 834, 268<br>0           |  | 54.00<br>56.00     |
|                | 05601 ONCOLOGY  | 0                 | 0                           | 22, 918, 754                |  | 56. 00             |
|                | 05700 CT SCAN   | 0                 | o                           | 30, 578, 599                |  | 57. 00             |
|                | 05800 MAGNETIC RESONANCE IMAGING (MRI)                                | 0                 | 0                           | 9, 976, 474                 |  | 58.00              |
| 59.00          | 05900 CARDI AC CATHETERI ZATI ON                                      | 0                 | 0                           | C                           | )  | 59.00              |
|                | 06000 LABORATORY  | 0                 | 0                           | 45, 110, 564                |  | 60.00              |
|                | 06500 RESPIRATORY THERAPY   | 0                 | 0                           | 9, 505, 989                 |  | 65.00              |
|                | 06501 SLEEP LAB<br>06600 PHYSI CAL THERAPY                            | 0                 | 0<br>0                      | 3, 298, 832                 |  | 65. 01<br>66. 00   |
|                | 06900 ELECTROCARDI OLOGY  | 0                 | ol<br>Ol                    | 7, 525, 737<br>14, 165, 366 |  | 69.00              |
|                | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS                            | o                 | 0                           | 14, 103, 300                |  | 71.00              |
|                | 07200 IMPL. DEV. CHARGED TO PATIENT                                   | 45                | Ö                           | 9, 406, 258                 | 3  | 72.00              |
| 73.00          | 07300 DRUGS CHARGED TO PATIENTS                                       | 0                 | 100                         | 48, 265, 732                | <u>)</u>   | 73.00              |
|                | OUTPATIENT SERVICE COST CENTERS                                       |                   |                             |                             |  |                    |
|                | 08800 RURAL HEALTH CLINIC   | 0                 | 0                           | 3, 866, 121                 |  | 88.00              |
|                | 08801 RURAL HEALTH CLINIC II<br>08802 RURAL HEALTH CLINIC III         | 0                 | 0                           | 2, 734, 310<br>12, 341, 608 |  | 88. 01<br>88. 02   |
|                | 09000 CLINIC  | 0                 | 0                           | 5, 118, 059                 |  | 90.00              |
|                | 09100 EMERGENCY   | o                 | o                           | 58, 709, 255                |  | 91.00              |
|                | 09200 OBSERVATION BEDS (NON-DISTINCT PART)                            |                   |                             |                             |  | 92.00              |
| 92. 01         | 09201 OBSERVATION BEDS (DISTINCT PART)                                | 0                 | 0                           | 5, 377, 191                 |  | 92. 01             |
|                | OTHER REIMBURSABLE COST CENTERS                                       | . 1               |                             |                             |  |                    |
|                | 09500 AMBULANCE SERVI CES   | 0                 | 0                           | 2 222 121                   |  | 95.00              |
|                | 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS                 | 0                 | 0                           | 2, 333, 121                 |  | 101.00             |
|                | 11300 INTEREST EXPENSE  |                   |                             |                             |  | 113.00             |
| 118.00         | l   | 100               | 100                         | 409, 840, 924               | Į  | 118.00             |
|                | NONREI MBURSABLE COST CENTERS   |                   |                             |                             |  |                    |
|                | 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN                             | 0                 | 0                           | C                           |  | 190.00             |
|                | 19001 UROLOGY   | 0                 | 0                           | C                           |  | 190. 01            |
|                | 19005 MARKETI NG  | 0                 | 0                           | C                           |  | 190. 05            |
|                | 19007   -74 CAMPUS<br>19008 RAMPART                                   | 0                 | 0<br>0                      | C                           |  | 190. 07<br>190. 08 |
|                | 19009 INTELLIPLEX DEVELOPMENT   |                   | 0                           | C                           |  | 190.00             |
|                | 19011 MHP ADMIN BUILDING  |                   | 0                           | C                           |  | 190. 07            |
| 190. 16        | 19016 RENOVO  | o                 | o                           | C                           |  | 190. 16            |
|                | 19017 I MA  | o                 | 0                           | C                           | )  | 190. 17            |
|                | 19018 MD SOLUTIONS  | 0                 | 0                           | C                           |  | 190. 18            |
|                | 19019 MHCD  | 0                 | 0                           | C                           |  | 190. 19            |
|                | 19200 PHYSICIANS' PRIVATE OFFICES<br>19201 HOSPITALIST                |                   | 0                           | C                           | 7  | 192. 00<br>192. 01 |
|                | 07950 UNAVI E   |                   | 0                           | C                           | j  | 194. 00            |
| 200.00         |   |                   | ٥                           |                             | 1  | 200.00             |
| 201.00         |   |                   |                             |                             |  | 201.00             |
| 202.00         |   | 230, 924          | 15, 133, 256                | 2, 848, 382                 | 2  | 202.00             |
|                | Part I)   |                   |                             |                             |  |                    |
| 203.00         | Unit cost multiplier (Wkst. B, Part I)                                | 2, 309. 240000    | 151, 332. 56000             | 0. 006950                   |  | 203.00             |
| 203.00         |   |                   | (A)                         |                             | The state of the s | 1                  |
| 204. 00        | Cost to be allocated (per Wkst. B,                                    | 116, 205          | 209, 942                    | 107, 905                    | :  | 204.00             |

| Heal th Fi | inancial Systems                       | MAJOR HO       | SPI TAL        |           | In Lie                           | u of Form CMS-2552-10                   |
|------------|--|----------------|----------------|-----------|----------------------------------|---|
| COST ALL   | OCATION - STATISTICAL BASIS            |                | Provi der CO   |           | Peri od:                         | Worksheet B-1                           |
|            |  |                |                |           | From 01/01/2020<br>To 12/31/2020 | Date/Time Prepared:<br>8/2/2021 2:11 pm |
|            | Cost Center Description                | CENTRAL        | PHARMACY       | MEDI CAL  |                                  |   |
|            |  | SERVICES &     | (100% DRUGS    | RECORDS & |                                  |   |
|            |  | SUPPLY         | TO PATIENTS)   | LI BRARY  |                                  |   |
|            |  | (100%          |                | (GROSS    |                                  |   |
|            |  | SUPPLI ES)     |                | CHARGES)  |                                  |   |
|            |  | 14. 00         | 15. 00         | 16. 00    |                                  |   |
| 205.00     | Unit cost multiplier (Wkst. B, Part    | 1, 162. 050000 | 2, 099. 420000 | 0. 00026  | 53                               | 205. 00                                 |
|            | [11]                                   |                |                |           |                                  |   |
| 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                 | MAJOR HOSPITAL         | In Lieu of Form CMS-2552-10   |
|--|------------------------|---|
| COMPUTATION OF RATIO OF COSTS TO CHARGES | Provi der CCN: 15-0097 | Peri od: Worksheet C<br>From 01/01/2020 Part I<br>To 12/31/2020 Date/Time Prepared: |

| Title XVIII   Hospital   PPS   Cost   Center Description   Total Cost    |
|--|
| Cost Center Description  Total Cost (from Wkst. B, Part I, col. 26)  1.00  2.00  3.00  INPATIENT ROUTINE SERVICE COST CENTERS  30.00  03000 ADULTS & PEDIATRICS  13,863,893  3,758,685  0,3,758,685  0,3,758,685  0,3,758,685  13,863,893  30.00  30.00  ANCILLARY SERVICE COST CENTERS  50.00  05000 OPERATING ROOM  53.00  05300 ANESTHESI OLOGY  573,486  573,486  573,486  317,624  891,110  53.00  54.00  55.00  56.00  05600 RADI OLOGY-DI AGNOSTI C  8,092,268  8,092,268  8,092,268  9,766,244  0,9,766,244  1,477,044  1,477,004  1,477,004  1,477,004  1,477,004  1,477,004  1,477,004  1,362,537  1,362,537  1,362,537   |
| Total Cost Center Description  |
| Col. 26   Disallowance   Disallowa |
| INPATIENT ROUTINE SERVICE COST CENTERS   1.00   2.00   3.00   4.00   5.00  |
| INPATIENT ROUTINE SERVICE COST CENTERS   13, 863, 893   13, 863, 893   30.00   300   ADULTS & PEDIATRICS   13, 863, 893   3758, 685   3, 758, 685   30   3, 758, 685   31.00   ADULTS & PEDIATRICS   13, 863, 893   30.00   ADULTS & PEDIATRICS   3, 758, 685   3, 758, 685   0   3, 758, 685   31.00   ADULTS & PEDIATRICS   3, 758, 685   3, 758, 685   0   3, 758, 685   31.00   ADULTS & PEDIATRICS   3, 758, 685   0   3, 758, 685   31.00   ADULTS & PEDIATRICS   3, 758, 685   0   3, 758, 685   31.00   ADULTS & PEDIATRICS   3, 758, 685   0   3, 758, 685   31.00   ADULTS & PEDIATRICS   3, 758, 685   0   3, 758, 685   31.00   ADULTS & PEDIATRICS   3, 758, 685   0   3, 758, 685   31.00   ADULTS & PEDIATRICS   3, 758, 685   0   3, 758, 685   31.00   ADULTS & PEDIATRICS   3, 758, 685   0   3, 758, 685   31.00   ADULTS & PEDIATRICS   3, 758, 685   0   3, 758, 685   31.00   3, 758, 685   31.00   3, 758, 685   3.100   3, 758, 685   3.100   3, 758, 685   3.100   3, 758, 685   3.100   3, 758, 685   3, |
| INPATIENT ROUTINE SERVICE COST CENTERS   13, 863, 893   13, 863, 893   0 13, 863, 893   30. 00   3000   ADULTS & PEDIATRICS   13, 863, 893   30. 00   31. 00   03100   INTENSIVE CARE UNIT   3, 758, 685   3, 758, 685   0 3, 758, 685   31. 00   ANCILLARY SERVICE COST CENTERS   50. 00   05000   OPERATING ROOM   9, 766, 244   9, 766, 244   0   9, 766, 244   50. 00   53. 00   OS300   ANESTHESI OLOGY   573, 486   573, 486   317, 624   891, 110   53. 00   54. 00   OS400   RADI OLOGY-DI AGNOSTI C   8, 092, 268   8, 092, 268   0   8, 092, 268   56. 00   O5600   RADI OLOGY-DI AGNOSTI C   0   0   0   0   56. 00   O5601   ONCOLOGY   5, 201, 761   5, 201, 761   5, 392   5, 207, 153   56. 01   57. 00   05700   CT SCAN   1, 477, 004   1, 477, 004   0   1, 477, 004   57. 00   58. 00   O5800   MAGNETI C RESONANCE   MAGI NG (MRI )   1, 362, 537   1, 362, 537   58. 00   |
| 30. 00   03000   ADULTS & PEDI ATRI CS   13, 863, 893   13, 863, 893   0   13, 863, 893   30. 00   3100   INTENSI VE CARE UNI T   3, 758, 685   3, 758, 685   0   3, 758, 685   31. 00   ANCI LLARY SERVI CE COST CENTERS   50. 00   05000   OPERATI NG ROOM   9, 766, 244   9, 766, 244   0   9, 766, 244   50. 00   05300   ANESTHESI OLOGY   573, 486   573, 486   317, 624   891, 110   53. 00   05400   RADI OLOGY-DI AGNOSTI C   8, 092, 268   8, 092, 268   0   8, 092, 268   40. 00   0   0   0   0   0   0   0   0  |
| 31. 00   03100   INTENSIVE CARE UNIT   3,758,685   3,758,685   0 3,758,685   31.00   ANCILLARY SERVICE COST CENTERS   50.00   05000   OPERATING ROOM   9,766,244   50.00   53.00   05300   ANESTHESI OLOGY   573,486   573,486   317,624   891,110   53.00   05400   RADI OLOGY-DI AGNOSTI C   8,092,268   8,092,268   0   8,092,268   54.00   05600   RADI OLOGY-DI AGNOSTI C   0   0   0   0   56.00   05600   RADI OLOGY-DI AGNOSTI C   5,201,761   5,201,761   5,392   5,207,153   56.01   57.00   05700   CT SCAN   1,477,004   1,477,004   0   1,477,004   57.00   58.00   05800   MAGNETI C RESONANCE I MAGI NG (MRI )   1,362,537   1,362,537   58.00  |
| ANCI LLARY SERVI CE COST CENTERS  50. 00 05000 OPERATI NG ROOM 9, 766, 244 9, 766, 244 0 9, 766, 244 50. 00 53. 00 05300 ANESTHESI OLOGY 573, 486 573, 486 317, 624 891, 110 53. 00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 8, 092, 268 8, 092, 268 0 8, 092, 268 54. 00 56. 00 05600 RADI OLOGY-DI AGNOSTI C 0 0 0 0 0 56. 00 56. 01 05601 ONCOLOGY 5, 201, 761 5, 392 5, 207, 153 56. 01 57. 00 05700 CT SCAN 1, 477, 004 1, 477, 004 0 1, 477, 004 58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI ) 1, 362, 537 1, 362, 537 0 1, 362, 537 58. 00  |
| 50. 00         05000         OPERATI NG ROOM         9, 766, 244         9, 766, 244         0         9, 766, 244         50. 00           53. 00         05300         ANESTHESI OLOGY         573, 486         573, 486         317, 624         891, 110         53. 00           54. 00         05400         RADI OLOGY-DI AGNOSTI C         8, 092, 268         8, 092, 268         0         8, 092, 268         54. 00           56. 00         05600         RADI OLOGY         5, 201, 761         5, 201, 761         5, 392         5, 207, 153         56. 00           57. 00         05700         CT SCAN         1, 477, 004         1, 477, 004         0         1, 477, 004         57. 00         0         1, 362, 537         58. 00         1, 362, 537         58. 00         1, 362, 537         58. 00         1, 362, 537         58. 00         1, 362, 537         1, 362, 537         1, 362, 537         58. 00   |
| 53. 00     05300     ANESTHESI OLOGY     573, 486     573, 486     317, 624     891, 110     53. 00       54. 00     05400     RADI OLOGY-DI AGNOSTI C     8, 092, 268     8, 092, 268     0     8, 092, 268     54. 00       56. 00     05600     RADI OI SOTOPE     0     0     0     0     56. 00       57. 00     05700     CT SCAN     1, 477, 004     1, 477, 004     0     1, 477, 004     0     1, 362, 537     0     1, 362, 537     58. 00   |
| 54. 00     05400     RADI OLOGY DI AGNOSTI C     8, 092, 268     8, 092, 268     0     8, 092, 268     54. 00       56. 00     05600     RADI OI SOTOPE     0     0     0     0     56. 00       56. 01     05601     ONCOLOGY     5, 201, 761     5, 201, 761     5, 392     5, 207, 153     56. 01       57. 00     05700     CT SCAN     1, 477, 004     1, 477, 004     0     1, 477, 004     57. 00       58. 00     05800     MAGNETI C RESONANCE I MAGI NG (MRI)     1, 362, 537     1, 362, 537     0     1, 362, 537     58. 00   |
| 56. 00     05600     RADI OI SOTOPE     0     0     0     56. 00       56. 01     05601     0NCOLOGY     5, 201, 761     5, 201, 761     5, 392     5, 207, 153     56. 01       57. 00     05700     CT SCAN     1, 477, 004     1, 477, 004     0     1, 477, 004     57. 00       58. 00     05800     MAGNETI C RESONANCE I MAGI NG (MRI)     1, 362, 537     1, 362, 537     0     1, 362, 537     58. 00   |
| 56. 00     05600     RADI OI SOTOPE     0     0     0     56. 00       56. 01     05601     0NCOLOGY     5, 201, 761     5, 201, 761     5, 392     5, 207, 153     56. 01       57. 00     05700     CT SCAN     1, 477, 004     1, 477, 004     0     1, 477, 004     57. 00       58. 00     05800     MAGNETI C RESONANCE I MAGING (MRI)     1, 362, 537     1, 362, 537     0     1, 362, 537     58. 00  |
| 57. 00   05700   CT SCAN   |
| 58.00   05800   MAGNETIC RESONANCE IMAGING (MRI)   1,362,537   1,362,537   0   1,362,537   58.00   |
| 58.00   05800   MAGNETIC RESONANCE IMAGING (MRI)   1,362,537   1,362,537   0   1,362,537   58.00   |
|  |
| 59. 00   05900   CARDI AC CATHETERI ZATI ON   0   0   59. 00   |
| 60. 00   06000   LABORATORY   8, 991, 327   8, 991, 327   114, 320   9, 105, 647   60. 00  |
| 65. 00   06500   RESPI RATORY THERAPY   2, 473, 448   0   2, 473, 448   0   2, 473, 448   65. 00   |
| 65. 01   06501   SLEEP LAB   887, 235   0   887, 235   0   887, 235   65. 01   |
| 66. 00   06600   PHYSI CAL THERAPY   3,650,616   0   3,650,616   0   3,650,616   66.00   |
| 69. 00   06900   ELECTROCARDI OLOGY   3, 113, 342   3, 113, 342   0   3, 113, 342   69. 00   |
| 71.00 O7100 MEDICAL SUPPLIES CHARGED TO PATIENTS O O O 71.00   |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 2, 361, 459 2, 361, 459 0 2, 361, 459 72.00  |
| 73. 00   07300   DRUGS CHARGED TO PATIENTS   15, 468, 703   15, 468, 703   0 15, 468, 703   73. 00   |
| OUTPATIENT SERVICE COST CENTERS  |
| 88. 00   08800   RURAL HEALTH CLINIC   5, 073, 445   5, 073, 445   0 5, 073, 445   88. 00  |
| 88. 01   08801   RURAL HEALTH CLINIC I I   2, 830, 023   2, 830, 023   0   2, 830, 023   88. 01  |
| 88. 02   08802   RURAL HEALTH CLINIC III   16, 674, 669   16, 674, 669   0   16, 674, 669   88. 02   |
| 90. 00   09000   CLI NI C   3, 308, 084   3, 308, 084   23, 993   3, 332, 077   90. 00   |
| 91. 00   09100   EMERGENCY   6, 719, 906   6, 719, 906   19, 127   6, 739, 033   91. 00  |
| 92.00   09200   OBSERVATI ON BEDS (NON-DISTINCT PART)   1,123,064   1,123,064   1,123,064   92.00  |
| 92. 01   09201   0BSERVATI ON BEDS (DI STI NCT PART)   2, 988, 316   2, 988, 316   0   2, 988, 316   92. 01  |
| OTHER REIMBURSABLE COST CENTERS  |
| 95. 00   09500  AMBULANCE SERVI CES   0   0   0   95. 00   |
| 101. 00 10100 HOME HEALTH AGENCY 2, 067, 685 2, 067, 685 2, 067, 685 101. 00   |
| SPECIAL PURPOSE COST CENTERS   |
| 113. 00 11300   INTEREST EXPENSE 113. 00   |
| 200.00 Subtotal (see instructions) 121,827,200 0 121,827,200 480,456 122,307,656 200.00  |
| 201.00 Less Observation Beds 1, 123, 064 1, 123, 064 1, 123, 064 201.00  |
| 202.00 Total (see instructions) 120,704,136 0 120,704,136 480,456 121,184,592 202.00   |

| Health Financial Systems                 | MAJOR HOSPITAL         | In Lieu of Form CMS-2552-10 |
|--|------------------------|-----------------------------|
| COMPUTATION OF RATIO OF COSTS TO CHARGES | Provi der CCN: 15-0097 | Peri od: Worksheet C        |

To 12/31/2020 Date/Time Prepared: 8/2/2021 2:11 pm Title XVIII Hospi tal PPS Charges Total (col. 6 Cost or Other Cost Center Description Inpati ent Outpati ent TEFRA + col. 7) Ratio I npati ent Ratio 6. 00 7.00 8.00 9.00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 13, 368, 717 13, 368, 717 30.00 31.00 03100 INTENSIVE CARE UNIT 6, 656, 379 6, 656, 379 31.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 11, 783, 177 56, 300, 315 68, 083, 492 0.143445 0.000000 50.00 05300 ANESTHESI OLOGY 520, 745 520, 745 0.000000 53.00 1.101280 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 2, 809, 569 26, 024, 699 28, 834, 268 0. 280648 0.000000 54.00 56.00 05600 RADI OI SOTOPE 0.000000 0.000000 56.00 22, 746, 141 22, 918, 754 05601 ONCOLOGY 172, 613 0.226965 0.000000 56.01 56.01 24, 847, 362 30, 578, 599 57 00 05700 CT SCAN 5, 731, 237 0.048302 0.000000 57 00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 954, 261 9, 022, 213 9, 976, 474 0.136575 0.000000 58.00 59.00 05900 CARDI AC CATHETERI ZATI ON 0.000000 0.000000 59.00 60.00 36, 994, 228 0. 199318 06000 LABORATORY 45, 110, 564 0.000000 8, 116, 336 60.00 65.00 06500 RESPIRATORY THERAPY 8, 473, 129 1, 032, 860 9, 505, 989 0.260199 0.000000 65.00 06501 SLEEP LAB 0.000000 65.01 5, 247 3, 293, 585 3, 298, 832 0.268954 65.01 7, 525, 737 06600 PHYSI CAL THERAPY 1, 223, 530 6, 302, 207 0.485084 0.000000 66.00 66,00 69 00 06900 ELECTROCARDI OLOGY 2, 272, 961 11, 892, 405 14, 165, 366 0.219785 0.000000 69 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.000000 0.000000 71.00 71.00 3, 978, 692 72.00 07200 I MPL. DEV. CHARGED TO PATIENT 5, 427, 566 9, 406, 258 0.251052 0.000000 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 13, 112, 518 35, 153, 214 48, 265, 732 0. 320490 0.000000 73.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 3, 866, 121 3, 866, 121 88.00 08801 RURAL HEALTH CLINIC II 0 2, 734, 310 2, 734, 310 88.01 88.01 08802 RURAL HEALTH CLINIC III 12, 341, 608 88 02 0 12, 341, 608 88 02 90.00 09000 CLI NI C 28, 831 5, 089, 228 5, 118, 059 0.646355 0.000000 90.00 09100 EMERGENCY 47, 637, 165 58, 709, 255 91.00 11, 072, 090 0.114461 0.000000 91.00 1, 131, 709 09200 OBSERVATION BEDS (NON-DISTINCT PART) 1, 145, 353 0.980540 0.000000 92.00 92.00 13.644 09201 OBSERVATION BEDS (DISTINCT PART) 1, 582, 019 92.01 3, 795, 172 5, 377, 191 0.555739 0.000000 92.01 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 0.000000 0.000000 95.00 101.00 10100 HOME HEALTH AGENCY 0 2, 333, 121 2, 333, 121 101.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 200.00 Subtotal (see instructions) 91, 354, 950 318, 485, 974 409, 840, 924 200.00 201.00 201.00 Less Observation Beds Total (see instructions) 91, 354, 950 318, 485, 974 202.00 409, 840, 924 202.00

| Health Financial Systems                 | MAJOR HOSPITAL         | In Lieu                          | u of Form CMS-2552-10                                   |
|--|------------------------|----------------------------------|---|
| COMPUTATION OF RATIO OF COSTS TO CHARGES | Provi der CCN: 15-0097 | From 01/01/2020<br>To 12/31/2020 | Worksheet C Part I Date/Time Prepared: 8/2/2021 2:11 pm |

| Cost Center Description  |  |                                       |             | 10 12/01/2020 | 8/2/2021 2: 11 pm |
|--|--|---------------------------------------|-------------|---------------|-------------------|
| Ratio   11.00  |  |                                       | Title XVIII | Hospi tal     |                   |
| INPATI ENT ROUTI NE SERVI CE COST CENTERS   30.00   330.00   3000   ADULTS & PEDI ATRICS   30.00   31.00   31.00   31.00   ANDITENSI VE CARE UNIT   31.00   31.00   31.00   31.00   31.00   ANDITENSI VE CARE UNIT   31.00     | Cost Center Description                          | PPS Inpatient                         |             |               |                   |
| INPATI ENT ROUTI NE SERVICE COST CENTERS   30.00   30.00   30.00   ADULTS & PEDI ATRIC S   31.00   3   |  | Ratio                                 |             |               |                   |
| 30.00   03000   ADULTS & PEDIATRICS   30.00   30.00   31.00   ADULTS & PEDIATRICS   31.00   31.00   ANCILLARY SERVICE COST CENTERS   31.00   ANCILLARY SERVICE COST CENTERS   31.00   ANCILLARY SERVICE COST CENTERS   31.00   36.00   05.00   |  | 11. 00                                |             |               |                   |
| 31.00   03100   INTERSIVE CARE UNIT  | INPATIENT ROUTINE SERVICE COST CENTERS           |                                       |             |               |                   |
| ANCILLARY SERVICE COST CENTERS   50.00   | 30. 00 03000 ADULTS & PEDIATRICS                 |                                       |             |               | 30.00             |
| SO. 00   050000   050000   050000   050000   050000   050000   050000   0500   | 31.00 03100 INTENSIVE CARE UNIT                  |                                       |             |               | 31.00             |
| 53.00   05300   AMBSTHESIOLOGY   1. 711221   53.00   | ANCILLARY SERVICE COST CENTERS                   |                                       |             |               |                   |
| 54.00   05400   RADI OLOGY_DI AGNOSTI C   0.280648   54.00   0.5600   RADI OLSOTOPE   0.000000   56.01   05601   0XCOLOGY   0.227201   56.01   05601   0XCOLOGY   0.227201   56.01   05601   0XCOLOGY   0.227201   56.01   05601   0XCOLOGY   0.000000   0.048302   57.00   0.0000000   0.0000000   0.000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.00000000   | 50.00   05000   OPERATING ROOM                   | 0. 143445                             |             |               | 50.00             |
| 56. 00 05600 RADI OI SOTOPE 0. 0,000000 56. 01 05601 0KOLDGY 0. 227201 56. 01 05601 0KOLDGY 0. 0,000000 55. 00 05700 CT SCAN 0. 048302 57. 00 05700 CT SCAN 0. 0,048302 57. 00 05900 CARDIAC CATHETERI ZATI ON 0. 000000 59. 00 05900 CARDIAC CATHETERI ZATI ON 0. 000000 59. 00 05000 CARDIAC CATHETERI ZATI ON 0. 000000 59. 00 06000 LABORATORY 0. 201852 60. 00 05600 RESPI RATORY THERAPY 0. 260199 65. 00 06501 RESPI RATORY THERAPY 0. 269954 65. 00 06501 RESPI RATORY THERAPY 0. 269954 65. 00 06600 PHYSI CAL THERAPY 0. 489584 65. 01 06600 PHYSI CAL THERAPY 0. 2489584 65. 01 06600 PHYSI CAL THERAPY 0. 219785 69. 00 07300 PRICE SUPPLIES CHARGED TO PATIENTS 0. 000000 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0. 000000 72. 00 07200 IMPL DEV. CHARGED TO PATIENT 0. 251052 72. 00 07300 PRICE SUPPLIES CHARGED TO PATIENT 0. 251052 72. 00 07300 PRICE SUPPLIES CHARGED TO PATIENT 0. 320490 07300 PRICE SUPPLIES S | 53. 00   05300   ANESTHESI OLOGY                 | 1. 711221                             |             |               | 53.00             |
| 56. 01   05601   0NCOLOGY   0.227201   56. 01  | 54. 00   05400   RADI OLOGY-DI AGNOSTI C         | 0. 280648                             |             |               | 54.00             |
| 57. 00   05700   CT SCAN   0.048302   55. 00   05800   MAGNETIC RESONANCE IMAGING (MRI)   0.136575   58. 00   05900   CARDIAC CATHETERIZATION   0.000000   60. 00   06000   LABORATORY   0.201852   66. 00   06500   RESPIRATORY THERAPY   0.260199   65. 01   06501   SLEEP LAB   0.268954   65. 01   06501   SLEEP LAB   0.268954   66. 00   06600   PHYSICAL THERAPY   0.485084   66. 00   06600   PHYSICAL THERAPY   0.485084   66. 00   06900   ELECTROCARDIOLOGY   0.219785   69. 00   07100   MEDICAL SUPPLIES CHARGED TO PATIENTS   0.000000   0.07200   IMPL. DEV. CHARGED TO PATIENTS   0.251052   72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   0.320490   001704   DEV. CHARGED TO PATIENTS   0.320490   0.3204   | 56. 00   05600   RADI 01 SOTOPE                  | 0. 000000                             |             |               | 56.00             |
| 58. 00   05800   MAGNETIC RESONANCE IMAGING (MRI)   0. 136575   59. 00   05900   CARDIA CATHETERIZATION   0. 0000000   59. 00   05900   CARDIA CATHETERIZATION   0. 0000000   0. 201852   60. 00   65. 00   06500   RESPIRATORY THERAPY   0. 260199   65. 00   06500   RESPIRATORY THERAPY   0. 260199   65. 00   06501   SLEEP LAB   0. 268954   66. 00   06600   PHYSI CAL THERAPY   0. 485084   66. 00   06600   PHYSI CAL THERAPY   0. 269954   0. 219785   0. 2000000   0. 2019785   0. 219785   0. 2000000000000000000000000000000000  | 56. 01   05601   ONCOLOGY                        | 0. 227201                             |             |               | 56. 01            |
| 59.00   05900   CARDI AC CATHETERIZATION   0.000000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.0000000   0.0000000   0.0000000   0.00000000   | 57.00   05700   CT   SCAN                        | 0. 048302                             |             |               | 57.00             |
| 60. 00   06000   LABORATORY   0. 201852   60. 00   05500   RESPIRATORY THERAPY   0. 260199   65. 01   06501   SLEEP LAB   0. 268954   66. 00   06600   PHYSI CAL THERAPY   0. 485084   66. 00   06900   ELECTROCARDI OLOGY   0. 219785   69. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   0. 2000000   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   0. 251052   72. 00   07300   DRUGS CHARGED TO PATIENTS   0. 320490   07300   DRUGS CHARGED TO PATIENTS   0. 320490   07300   DRUGS CHARGED TO PATIENTS   0. 320490   08800   RURAL HEALTH CLINIC   88. 01   08801   RURAL HEALTH CLINIC   11   88. 02   08902   RURAL HEALTH CLINIC   11   88. 02   09000   09000   CLINIC   0. 651043   99. 00   09000   DRUGS CHARGED TO PATIENT   0. 980540   99. 00   09000   DRUGS CHARGED TO PATIENT   0. 980540   99. 00   09000   OBSERVATION BEDS (NON-DISTINCT PART)   0. 980540   99. 00   09000   OBSERVATION BEDS (DISTINCT PART)   0. 980540   99. 00   09000   OBSERVATION BEDS (DISTINCT PART)   0. 980540   99. 00   09500   AMBULANCE SERVICES   0. 000000   000000   DTHER REIMBURSABLE COST CENTERS   95. 00   00000   NURL HEALTH AGENCY   0. 11300   THEREST EXPENSE   95. 00   00000   NURL HEALTH AGENCY   0. 000000   0000000000   00000000000  | 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)     | 0. 136575                             |             |               | 58.00             |
| 65. 00   06500   RESPIRATORY THERAPY   0. 260199   65. 00   66. 01   06501   SLEEP LAB   0. 268954   66. 00   06600   PHYSI CAL THERAPY   0. 485084   66. 00   06900   ELECTROCARDI OLOGY   0. 219785   69. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   0. 000000   71. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   0. 251052   72. 00   07300   DRUGS CHARGED TO PATIENTS   0. 320490   07300   DRUGS CHARGED TO PATIENTS   0. 320490   0017PATIENT SERVICE COST CENTERS   88. 01   08801   RURAL HEALTH CLINIC   11   88. 01   08802   RURAL HEALTH CLINIC   11   88. 02   08802   RURAL HEALTH CLINIC   11   88. 02   09000   CLINIC   90. 00   09000   CLINIC   0. 651043   90. 00   91. 00   09000   EMERGENCY   0. 114787   91. 00   91. 00   09200   0BSERVATION BEDS (NON-DISTINCT PART)   0. 980540   92. 00   09200   0BSERVATION BEDS (DISTINCT PART)   0. 555739   92. 01   071ER REIMBURSABLE COST CENTERS   99. 00   09100   MBULANCE SERVICES   0. 000000   010100   HOME HEALTH AGENCY   0. 113. 00   010100   HOME HEALTH AGENCY   0. 000000   010100   HOME HEALTH AGENCY   0. 130. 00   010100   HOME HEALTH AGENCY   0. 130. 00   010100   HOME HEALTH AGENCY   0. 000000   010100   HOME HEALTH AGENCY   0. 0000000   010100   000000000000000   | 59. 00 05900 CARDI AC CATHETERI ZATI ON          | 0. 000000                             |             |               | 59.00             |
| 65. 01   06501   SLEEP LAB   0. 268954   0. 485084   65. 01  | 60. 00   06000   LABORATORY                      | 0. 201852                             |             |               | 60.00             |
| 66. 00 06600 PHYSICAL THERAPY 0. 485084 66. 00 69. 00 06900 ELECTROCARDI OLOGY 0. 219785 69. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0. 000000 71. 00 72. 00 07200 I MPL. DEV. CHARGED TO PATI ENT 0. 251052 72. 00 073. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 320490 73. 00 00TPATI ENT SERVICE COST CENTERS  88. 00 08800 RURAL HEALTH CLINIC II 88. 00 88. 01 08801 RURAL HEALTH CLINIC II 88. 02 90. 00 09000 CLINIC 0. 651043 90. 00 91. 00 09000 CLINIC 0. 0. 651043 90. 00 92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART) 0. 980540 92. 00 92. 01 09201 0BSERVATI ON BEDS (DISTINCT PART) 0. 555739 92. 01 0THER REI MBURSABLE COST CENTERS  95. 00 09500 AMBULANCE SERVICES 0. 0. 000000 101.00 HOME HEALTH AGENCY 95. 00 101.00 10100 HOME HEALTH AGENCY 95. 00 101.00 11300 I NTEREST EXPENSE 113. 00 200. 00 Less Observation Beds 113. 00 201. 00 Less Observation Beds 201. 00  | 65. 00 06500 RESPIRATORY THERAPY                 | 0. 260199                             |             |               | 65.00             |
| 69. 00 06900 ELECTROCARDIOLOGY 0. 219785 69. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0. 000000 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENT 0. 251052 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 320490 73. 00  0UTPATIENT SERVICE COST CENTERS  88. 00 08800 RURAL HEALTH CLINIC II 88. 01 88. 01 08801 RURAL HEALTH CLINIC III 88. 01 89. 00 09000 CLINIC 88. 00 91. 00 09000 CLINIC 99. 00 91. 00 09000 CLINIC 99. 00 92. 01 09200 0BSERVATION BEDS (NON-DISTINCT PART) 0. 980540 92. 00 92. 01 09201 0BSERVATION BEDS (DISTINCT PART) 0. 555739 92. 01  075. 00 09500 AMBULANCE SERVICES 0. 0. 000000 95. 00 101. 00 09500 AMBULANCE SERVICES 0. 0. 000000 10100 HOME HEALTH AGENCY 101. 00 113. 00 11300 INTEREST EXPENSE 113. 00 200. 00 Subtotal (see instructions) Less Observation Beds 113. 00 201. 00 Less Observation Beds  | 65. 01   06501   SLEEP LAB                       | 0. 268954                             |             |               | 65. 0             |
| 71. 00   | 66. 00 06600 PHYSI CAL THERAPY                   | 0. 485084                             |             |               | 66.00             |
| 72. 00   | 69. 00 06900 ELECTROCARDI OLOGY                  | 0. 219785                             |             |               | 69.00             |
| 73. 00   07300   DRUGS CHARGED TO PATIENTS   0.320490   | 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0. 000000                             |             |               | 71.00             |
| SERVICE COST CENTERS   SERVICE COST CENTERS  | 72.00 07200 IMPL. DEV. CHARGED TO PATIENT        | 0. 251052                             |             |               | 72.00             |
| 88. 00   | 73.00 07300 DRUGS CHARGED TO PATIENTS            | 0. 320490                             |             |               | 73.00             |
| 88. 01 08801 RURAL HEALTH CLINIC III 88. 02 08802 RURAL HEALTH CLINIC III 90. 00 09000 CLINIC 0 0. 651043 90. 00 09100 EMERGENCY 91. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0. 980540 92. 01 09201 OBSERVATION BEDS (DISTINCT PART) 0. 555739 92. 01 09201 OBSERVATION BEDS (DISTINCT PART) 0. 555739 92. 01 09500 AMBULANCE SERVICES 0. 000000 95. 00 09500 AMBULANCE SERVICES 0. 000000 95. 00 10100 HOME HEALTH AGENCY 95. 00 10100 HOME HEALTH AGENCY 95. 00 10100 HOME HEALTH AGENCY 95. 00 113.00 INTEREST EXPENSE 95. 00 000 Subtotal (see instructions) Less Observation Beds 201. 00 201. 00   | OUTPATIENT SERVICE COST CENTERS                  |                                       |             |               |                   |
| 88. 02   | 88. 00 08800 RURAL HEALTH CLINIC                 |                                       |             |               | 88. 00            |
| 90. 00   09000   CLINIC   0. 651043   90. 00   91. 00   09100   EMERGENCY   0. 114787   91. 00   92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART)   0. 980540   92. 01   09201   OBSERVATION BEDS (DISTINCT PART)   0. 555739   92. 01   07HER REIMBURSABLE COST CENTERS   095. 00   OBSERVATION BEDS (DISTINCT PART)   0. 5000   OBSERVATION BEDS (DISTINCT PART)   0. 555739   92. 01   OTHER REIMBURSABLE COST CENTERS   0. 000000   95. 00   OBSERVATION BEDS (DISTINCT PART)   0. 555739   92. 01   OTHER REIMBURSABLE COST CENTERS   101. 00   OSSERVATION BEDS (DISTINCT PART)   0. 555739   95. 00   OSSERVATION BEDS (DISTINCT PART)   OTHER REIMBURSABLE COST CENTERS   101. 00   OSSERVATION BEDS (DISTINCT PART)   OTHER REIMBURSABLE COST CENTERS   101. 00   OSSERVATION BEDS (DISTINCT PART)   OTHER REIMBURSABLE COST CENTERS   101. 00   OSSERVATION BEDS (DISTINCT PART)   OTHER REIMBURSABLE COST CENTERS   101. 00   OSSERVATION BEDS (DISTINCT PART)   OTHER REIMBURSABLE COST CENTERS   101. 00   OSSERVATION BEDS (DISTINCT PART)   OTHER REIMBURSABLE COST CENTERS   101. 00   OSSERVATION BEDS (DISTINCT PART)   OTHER REIMBURSABLE COST CENTERS   101. 00   OSSERVATION BEDS (DISTINCT PART)   OTHER REIMBURSABLE COST CENTERS   101. 00   OSSERVATION BEDS (DISTINCT PART)   OTHER REIMBURSABLE COST CENTERS   101. 00   OSSERVATION BEDS (DISTINCT PART)   OTHER REIMBURSABLE COST CENTERS   101. 00   OSSERVATION BEDS (DISTINCT PART)   OTHER REIMBURSABLE COST CENTERS   OTHER PART   OTHER PA | 88.01 08801 RURAL HEALTH CLINIC II               |                                       |             |               | 88. 01            |
| 91. 00   09100   EMERGENCY   0. 114787   0. 980540   92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART)   0. 980540   92. 00   09201   OBSERVATION BEDS (DISTINCT PART)   0. 555739   92. 01   074500   ODES   OD | 88.02 08802 RURAL HEALTH CLINIC III              |                                       |             |               | 88. 02            |
| 92. 00   09200   0BSERVATI ON BEDS (NON-DISTINCT PART)   0. 980540   92. 01   09201   0BSERVATI ON BEDS (DISTINCT PART)   0. 555739   92. 01   071   0 | 90. 00  09000   CLI NI C                         | 0. 651043                             |             |               | 90.00             |
| 92. 01   09201   0BSERVATI ON BEDS (DISTINCT PART)   0. 555739   92. 01  | 91. 00 09100 EMERGENCY                           | 0. 114787                             |             |               | 91.00             |
| OTHER REIMBURSABLE COST CENTERS   O. 000000   95. 00   | 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 0. 980540                             |             |               | 92.00             |
| 95. 00   | 92.01 09201 OBSERVATION BEDS (DISTINCT PART)     | 0. 555739                             |             |               | 92.0              |
| 101. 00  | OTHER REIMBURSABLE COST CENTERS                  |                                       |             |               |                   |
| SPECIAL PURPOSE COST CENTERS   113.00   11300   INTEREST EXPENSE   200.00   Subtotal (see instructions)   200.00   201.00   Less Observation Beds   201.00   | 95. 00 09500 AMBULANCE SERVICES                  | 0. 000000                             |             |               | 95.00             |
| 113. 00  | 101.00 10100 HOME HEALTH AGENCY                  |                                       |             |               | 101.00            |
| 200.00       Subtotal (see instructions)       200.00         201.00       Less Observation Beds       201.00  | SPECIAL PURPOSE COST CENTERS                     | · · · · · · · · · · · · · · · · · · · |             |               |                   |
| 201.00 Less Observation Beds 201.00  | 113. 00 11300 I NTEREST EXPENSE                  |                                       |             |               | 113.00            |
| 201.00 Less Observation Beds 201.00  | 200.00 Subtotal (see instructions)               |                                       |             |               | 200. 00           |
| 202.00 Total (see instructions) 202.00   | 201.00 Less Observation Beds                     |                                       |             |               | 201.00            |
|  | 202.00 Total (see instructions)                  |                                       |             |               | 202. 00           |

| Health Financial Systems                 | MAJOR HOSPITAL | In Lieu              | of Form CMS-2552-10 |
|--|----------------|----------------------|---------------------|
| COMPUTATION OF RATIO OF COSTS TO CHARGES | Provi der Co   | CN: 15-0097 Peri od: | Worksheet C         |
|  |                | From 01/01/2020      |                     |
| COMPONATION OF NATIO OF COSTS TO CHARGES | Trovider ex    | From 01/01/2020      |                     |

|        |  |               |               | Ť             | o 12/31/2020    | Date/Time Pre<br>8/2/2021 2:11 |         |
|--------|--|---------------|---------------|---------------|-----------------|--------------------------------|---------|
|        |  |               | Ti tl         | e XIX         | Hospi tal       | Cost                           | рш      |
|        |  |               | 11 61         | C ALK         | Costs           | 0031                           |         |
|        | Cost Center Description                    | Total Cost    | Therapy Limit | Total Costs   | RCE             | Total Costs                    |         |
|        | 300 t 30.1101 20001 Pt 1 0.1               | (from Wkst.   | Adj .         | 1014. 00010   | Di sal I owance | .014. 00010                    |         |
|        |  | B, Part I,    |               |               |                 |                                |         |
|        |  | col. 26)      |               |               |                 |                                |         |
|        |  | 1. 00         | 2.00          | 3.00          | 4. 00           | 5. 00                          |         |
|        | INPATIENT ROUTINE SERVICE COST CENTERS     |               |               |               |                 |                                |         |
| 30.00  | 03000 ADULTS & PEDIATRICS                  | 13, 863, 893  |               | 13, 863, 893  | 0               | 13, 863, 893                   | 30.00   |
| 31.00  | 03100 INTENSIVE CARE UNIT                  | 3, 758, 685   |               | 3, 758, 685   | O               | 3, 758, 685                    | 31.00   |
|        | ANCILLARY SERVICE COST CENTERS             |               |               |               |                 |                                |         |
| 50.00  | 05000 OPERATING ROOM                       | 9, 766, 244   |               | 9, 766, 244   | 0               | 9, 766, 244                    | 50.00   |
| 53.00  | 05300 ANESTHESI OLOGY                      | 573, 486      |               | 573, 486      | 317, 624        | 891, 110                       | 53.00   |
| 54.00  | 05400 RADI OLOGY-DI AGNOSTI C              | 8, 092, 268   |               | 8, 092, 268   | 0               | 8, 092, 268                    | 54.00   |
| 56.00  | 05600 RADI OI SOTOPE                       | 0             |               | 0             | 0               | 0                              | 56.00   |
| 56. 01 | 05601 ONCOLOGY                             | 5, 201, 761   |               | 5, 201, 761   | 5, 392          | 5, 207, 153                    | 56. 01  |
| 57.00  | 05700 CT SCAN                              | 1, 477, 004   |               | 1, 477, 004   | o               | 1, 477, 004                    | 57.00   |
| 58.00  | 05800 MAGNETIC RESONANCE IMAGING (MRI)     | 1, 362, 537   |               | 1, 362, 537   | o               | 1, 362, 537                    | 58.00   |
| 59.00  | 05900 CARDI AC CATHETERI ZATI ON           | 0             |               | 0             | o               | 0                              | 59.00   |
| 60.00  | 06000 LABORATORY                           | 8, 991, 327   |               | 8, 991, 327   | 114, 320        | 9, 105, 647                    | 60.00   |
| 65.00  | 06500 RESPIRATORY THERAPY                  | 2, 473, 448   | 0             | 2, 473, 448   | o               | 2, 473, 448                    | 65.00   |
| 65. 01 | 06501 SLEEP LAB                            | 887, 235      | 0             | 887, 235      | 0               | 887, 235                       | 65. 01  |
| 66.00  | 06600 PHYSI CAL THERAPY                    | 3, 650, 616   | 0             | 3, 650, 616   | 0               | 3, 650, 616                    | 66.00   |
| 69.00  | 06900 ELECTROCARDI OLOGY                   | 3, 113, 342   |               | 3, 113, 342   | 0               | 3, 113, 342                    | 69.00   |
| 71.00  | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0             |               | 0             | 0               | 0                              | 71.00   |
| 72.00  | 07200 I MPL. DEV. CHARGED TO PATIENT       | 2, 361, 459   |               | 2, 361, 459   | 0               | 2, 361, 459                    | 72.00   |
| 73.00  | 07300 DRUGS CHARGED TO PATIENTS            | 15, 468, 703  |               | 15, 468, 703  | 0               | 15, 468, 703                   | 73.00   |
|        | OUTPATIENT SERVICE COST CENTERS            |               |               |               |                 |                                |         |
|        | 08800 RURAL HEALTH CLINIC                  | 5, 073, 445   |               | 5, 073, 445   | 0               | 5, 073, 445                    |         |
| 88. 01 | 08801 RURAL HEALTH CLINIC II               | 2, 830, 023   |               | 2, 830, 023   |                 | 2, 830, 023                    | 88. 01  |
|        | 08802 RURAL HEALTH CLINIC III              | 16, 674, 669  |               | 16, 674, 669  |                 | 16, 674, 669                   |         |
| 90.00  | 09000 CLI NI C                             | 3, 308, 084   |               | 3, 308, 084   | 23, 993         | 3, 332, 077                    |         |
| 91.00  | 09100 EMERGENCY                            | 6, 719, 906   |               | 6, 719, 906   | 19, 127         | 6, 739, 033                    | 91.00   |
| 92.00  | 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 1, 123, 064   |               | 1, 123, 064   |                 | 1, 123, 064                    |         |
| 92.01  | 09201 OBSERVATION BEDS (DISTINCT PART)     | 2, 988, 316   |               | 2, 988, 316   | 0               | 2, 988, 316                    | 92. 01  |
|        | OTHER REIMBURSABLE COST CENTERS            |               |               |               |                 |                                |         |
|        | 09500 AMBULANCE SERVICES                   | 0             |               | C             |                 | 0                              |         |
| 101.00 | 10100 HOME HEALTH AGENCY                   | 2, 067, 685   |               | 2, 067, 685   |                 | 2, 067, 685                    | 101. 00 |
|        | SPECIAL PURPOSE COST CENTERS               |               |               |               |                 |                                |         |
|        | 11300 INTEREST EXPENSE                     |               |               |               |                 |                                | 113.00  |
| 200.00 |  | 121, 827, 200 | 0             | , ,           |                 | 122, 307, 656                  |         |
| 201.00 |  | 1, 123, 064   |               | 1, 123, 064   |                 | 1, 123, 064                    |         |
| 202.00 | Total (see instructions)                   | 120, 704, 136 | 0             | 120, 704, 136 | 480, 456        | 121, 184, 592                  | 202.00  |
|        |  |               |               |               |                 |                                |         |

| Health Financial Systems                 | MAJOR HOSPITAL        | In Lieu of Form CMS-2552-10                   |
|--|-----------------------|---|
| COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0097 | Period: Worksheet C<br>From 01/01/2020 Part I |

To 12/31/2020 Date/Time Prepared: 8/2/2021 2:11 pm Title XIX Hospi tal Cost Charges Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other **TFFRA** + col. 7) Ratio I npati ent Ratio 6. 00 7.00 8.00 9.00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 13, 368, 717 30.00 13, 368, 717 31.00 03100 INTENSIVE CARE UNIT 6, 656, 379 6, 656, 379 31.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 11, 783, 177 56, 300, 315 68, 083, 492 0.143445 0.000000 50.00 05300 ANESTHESI OLOGY 520, 745 0.000000 53.00 520, 745 1.101280 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 2, 809, 569 26, 024, 699 28, 834, 268 0. 280648 0.000000 54.00 56.00 05600 RADI 0I S0T0PE 0.000000 0.000000 56.00 22, 746, 141 22, 918, 754 05601 ONCOLOGY 0.000000 56.01 172, 613 0.226965 56.01 24, 847, 362 30, 578, 599 57 00 05700 CT SCAN 5, 731, 237 0.048302 0.000000 57 00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 954, 261 9,022,213 9, 976, 474 0.136575 0.000000 58.00 59.00 05900 CARDI AC CATHETERI ZATI ON 0.000000 0.000000 59.00 36, 994, 228 0. 199318 60.00 06000 LABORATORY 45, 110, 564 0.000000 8, 116, 336 60.00 65.00 06500 RESPIRATORY THERAPY 8, 473, 129 1, 032, 860 9, 505, 989 0.260199 0.000000 65.00 3, 293, 585 65.01 06501 SLEEP LAB 5, 247 3, 298, 832 0.268954 0.000000 65.01 06600 PHYSI CAL THERAPY 1, 223, 530 6, 302, 207 7, 525, 737 0.485084 0.000000 66.00 66,00 69 00 06900 ELECTROCARDI OLOGY 2, 272, 961 11, 892, 405 14, 165, 366 0.219785 0.000000 69 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.000000 0.000000 71.00 71.00 3, 978, 692 72.00 07200 I MPL. DEV. CHARGED TO PATIENT 5, 427, 566 9, 406, 258 0.251052 0.000000 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 13, 112, 518 35, 153, 214 48, 265, 732 0.320490 0.000000 73.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 3, 866, 121 3, 866, 121 1.312283 0.000000 88.00 08801 RURAL HEALTH CLINIC II 0 2, 734, 310 2, 734, 310 1.035004 0.000000 88.01 88.01 08802 RURAL HEALTH CLINIC III 12, 341, 608 88 02 0 12, 341, 608 1.351094 0.000000 88 02 90.00 09000 CLI NI C 28, 831 5, 089, 228 5, 118, 059 0.646355 0.000000 90.00 09100 EMERGENCY 47, 637, 165 58, 709, 255 91.00 11, 072, 090 0.114461 0.000000 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 1, 145, 353 0.980540 0.000000 92.00 92.00 13.644 1, 131, 709 09201 OBSERVATION BEDS (DISTINCT PART) 1, 582, 019 92.01 3, 795, 172 5, 377, 191 0.555739 0.000000 92.01 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 0.000000 0.000000 95.00 101.00 10100 HOME HEALTH AGENCY 0 2, 333, 121 2, 333, 121 101.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 200.00 Subtotal (see instructions) 91, 354, 950 318, 485, 974 409, 840, 924 200.00 201.00 201.00 Less Observation Beds 91, 354, 950 318, 485, 974 202.00 Total (see instructions) 409, 840, 924 202.00

| Health Financial Systems                 | MAJOR HOSPITAL         | In Lieu                          | u of Form CMS-2552-10                                   |
|--|------------------------|----------------------------------|---|
| COMPUTATION OF RATIO OF COSTS TO CHARGES | Provi der CCN: 15-0097 | From 01/01/2020<br>To 12/31/2020 | Worksheet C Part I Date/Time Prepared: 8/2/2021 2:11 pm |

| INPATE LIT ROUTINE SERVICE COST CENTERS   11.00  |  |               |           | 10 12/31/2020 | 8/2/2021 2: 11 |        |
|--|--|---------------|-----------|---------------|----------------|--------|
| Ratio  |  |               | Title XIX | Hospi tal     |                |        |
| INPATIENT ROUTINE SERVICE COST CENTERS   30.00   330.00   | Cost Center Description                          | PPS Inpatient |           |               |                |        |
| INPATIENT ROUTINE SERVICE COST CENTERS   30.00   300.00   |  | Ratio         |           |               |                |        |
| 30.00  |  | 11. 00        |           |               |                |        |
| 31.00   03100   INTENSIVE CARE UNIT  | INPATIENT ROUTINE SERVICE COST CENTERS           |               |           |               |                |        |
| ANCILLARY SERVICE COST CENTERS   50.00   | 30. 00   03000   ADULTS & PEDIATRICS             |               |           |               |                | 30.00  |
| 50.00  | 31.00 03100 INTENSIVE CARE UNIT                  |               |           |               |                | 31.00  |
| 53.00   05300   AMESTHESI OLOGY   0.000000   54.00   05400   RADI OLOGY-DI AGNOSTI C   0.000000   55.00   05600   RADI OLOGY-DI AGNOSTI C   0.000000   56.00   05600   RADI OLOGY-DI AGNOSTI C   0.000000   56.00   05601   05601   000000   55.00   05700   CT SCAN   0.000000   57.00   05700   CT SCAN   0.000000   57.00   05700   CT SCAN   0.000000   57.00   05700   CT SCAN   0.000000   58.00   05800   MAGNETI C RESONANCE IMAGI NG (MRI ) 0.000000   59.00   05900   CARDI AC CATHETERI ZATI ON   0.000000   59.00   06000   LABORATORY   0.000000   065.00   06500   RESPI RATORY THERAPY   0.000000   065.01   05601   SLEEP LAB   0.000000   065.01   05601   SLEEP LAB   0.000000   065.01   05601   SLEEP LAB   0.000000   065.01   06501   SLEEP LAB   0.000000   065.00   06900   ELECTROCARDI OLOGY   0.000000   069.00   06900   ELECTROCARDI OLOGY   0.000000   071.00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0.000000   071.00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0.000000   071.00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENT   0.000000   071.   | ANCILLARY SERVICE COST CENTERS                   |               |           |               |                |        |
| 54.00   05400   RADI OLOGY-DI AGNOSTI C   0.000000   56.00   05600   RADI OI SOTOPE   0.000000   56.00   056.01   05601   0NCOLOGY   0.000000   55.00   056.01   05601   0NCOLOGY   0.000000   57.00   05700   CT SCAN   0.000000   58.00   05800   MAGNETI C RESONANCE I MAGI NG (MRI )   0.000000   58.00   05800   MAGNETI C RESONANCE I MAGI NG (MRI )   0.000000   58.00   05800   MAGNETI C RESONANCE I MAGI NG (MRI )   0.000000   58.00   05900   CARDI AC CATHETERI ZATI ON   0.000000   59.00   06.00   06000   LABORATORY   0.000000   06.000   06000   LABORATORY   0.000000   065.00   06500   RESPIRATORY THERAPY   0.000000   065.00   06500   RESPIRATORY THERAPY   0.000000   065.00   06600   PHYSI CAL THERAPY   0.000000   06900   ELECTROCARDI OLOGY   0.000000   06900   ELECTROCARDI OLOGY   0.000000   06900   ELECTROCARDI OLOGY   0.000000   071.00   071.00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0.000000   072.00   07   | 50.00   05000   OPERATING ROOM                   | 0. 000000     |           |               |                | 50.00  |
| 56. 00   05600   RADI OI SOTOPE   0.000000   56. 01  | 53. 00   05300   ANESTHESI OLOGY                 | 0. 000000     |           |               |                | 53.00  |
| 56. 01   05601   0NCOLOGY   0.000000   55. 00   05700   CT SCAN   0.000000   55. 00   05800   MAGNETIC RESONANCE IMAGING (MRI ) 0.000000   59. 00   05900   CARDIAC CATHETERI ZATION   0.000000   59. 00   05900   CARDIAC CATHETERI ZATION   0.000000   59. 00   06500   RESPIRATORY THERAPY   0.000000   0.60000   CABDIAC CATHETERI ZATION   0.000000   0.65. 01   06501   SLEEP LAB   0.000000   0.65. 01   06501   SLEEP LAB   0.000000   0.66. 00   06600   PHYSIC AL THERAPY   0.000000   0.60000   0.6000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.000000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.0000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.00000000   | 54. 00   05400   RADI OLOGY-DI AGNOSTI C         | 0. 000000     |           |               |                | 54.00  |
| 57, 00   05700   CT SCAN   0,00000   55,00   | 56. 00   05600   RADI 01 SOTOPE                  | 0. 000000     |           |               |                | 56.00  |
| 58. 00   05800   MAGNETIC RESONANCE IMAGING (MRI)   0.000000   59. 00   05900   CARDIAC CATHETERIZATION   0.000000   59. 00   06000   LABORATORY   0.000000   60. 00   06500   RESPIRATORY THERAPY   0.000000   65. 00   06500   RESPIRATORY THERAPY   0.000000   65. 00   06501   SLEEP LAB   0.000000   66. 00   06600   PHST CAL THERAPY   0.000000   66. 00   06600   PHST CAL THERAPY   0.000000   06900   ELECTROCARDIOLOGY   0.000000   071. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   0.000000   772. 00   772. 00   772. 00   772.00   MEDI CAL SUPPLIES CHARGED TO PATIENTS   0.000000   773. 00   07300   DRUGS CHARGED TO PATIENTS   0.000000   773. 00   07300   DRUGS CHARGED TO PATIENTS   0.000000   07300   DRUGS CHARGED TO PATIENTS   0.000000   773. 00   08800   RURAL HEALTH CLINIC   11   0.000000   88. 01   08800   RURAL HEALTH CLINIC   11   0.000000   88. 01   08800   RURAL HEALTH CLINIC   11   0.000000   88. 01   08800   RURAL HEALTH CLINIC   11   0.000000   99. 00   99. 00   99000   CLINIC   0.000000   99. 00   99. 00   99000   05800   RURAL HEALTH CLINIC   11   0.000000   99. 00   99. 00   09900   CLINIC   0.000000   99. 00   99. 00   09900   CLINIC   0.000000   99. 00   99. 00   09900   CLINIC   0.000000   99. 00   09900   0.0000   0.00000   0.00000   99. 00   0.000000   0.000000   99. 00   0.000000   0.000000   99. 00   0.000000   0.000000   99. 00   0.000000   0.000000   99. 00   0.000000   99. 00   0.000000   99. 00   0.000000   99. 00   0.000000   99. 00   0.000000   99. 00   0.000000   99. 00   0.000000   99. 00   0.000000   99. 00   0.000000   99. 00   0.00000000   99. 00   0.000000   99. 00   0.0000000   99. 00   0.00000000   99. 00   0.0000000   99. 00   0.0000000   99. 00   0.0000000000   | 56. 01   05601   0NCOLOGY                        | 0. 000000     |           |               |                | 56.01  |
| 59, 00   05900   CARDI AC CATHETERIZATION   0,000000   0,00000   0,00000   0,00000   0,00000   0,00000   0,00000   0,000000   0,000000   0,000000   0,000000   0,000000   0,000000   0,000000   0,000000   0,000000   0,000000   0,000000   0,000000   0,000000   0,000000   0,000000   0,000000   0,000000   0,000000   0,0000000   0,0000000   0,000000   0,0000000   0,0000000   0,0000000   0,0000000   0,0000000   0,0000000   0,0000000   0,0000000   0,0000000   0,0000000   0,0000000   0,0000000   0,0000000   0,0000000   0,00000000  | 57.00 05700 CT SCAN                              | 0. 000000     |           |               |                | 57.00  |
| 60. 00   06000   LABORATORY   0.000000   65. 00   06500   RESPIRATORY THERAPY   0.000000   065. 01   06501   SLEEP LAB   0.000000   065. 01   06501   SLEETROCARDI OLOGY   0.000000   06900   ELECTROCARDI OLOGY   0.000000   071. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   0.000000   072. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   0.000000   072. 00   07300   DRUGS CHARGED TO PATIENTS   0.000000   072. 00   07300   DRUGS CHARGED TO PATIENTS   0.000000   0.000000   0.000000   0.00000   0.000000   0.00000   0.0000000   0.0000000   0.0000000   0.00000000  | 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)     | 0. 000000     |           |               |                | 58.00  |
| 65. 00   06500   RESPIRATORY THERAPY   0.000000   65. 00   65. 01   06501   SLEEP LAB   0.000000   66. 01   66. 00   06600   PHYSI CAL THERAPY   0.000000   66. 00   67. 00   06900   ELECTROCARDI OLOGY   0.000000   69. 00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   0.000000   71. 00   72. 00   07200   IMPL DEV. CHARGED TO PATIENTS   0.000000   72. 00   73. 00   07300   DRUGS CHARGED TO PATIENTS   0.000000   73. 00   0017PATIENT SERVICE COST CENTERS   0.000000   73. 00   88. 01   08800   RURAL HEALTH CLINIC   0.000000   88. 01   88. 02   08800   RURAL HEALTH CLINIC   11   0.000000   88. 01   88. 02   08800   CLINIC   0.000000   88. 02   90. 00   09000   CLINIC   0.000000   90. 00   91. 00   09100   EMERGENCY   0.000000   91. 00   92. 01   09200   085ERVATION BEDS (NON-DISTINCT PART)   0.000000   92. 01   071ERE REIMBURSABLE COST CENTERS   0.000000   92. 01   071ERE REIMBURSABLE COST CENTERS   0.000000   92. 01   071ERE REIMBURSABLE COST CENTERS   0.000000   92. 01   071EREST EXPENSE   0.000000   113. 00   110100   HOME HEALTH AGENCY   0.000000   92. 01   071EREST EXPENSE   113. 00   1000   1000   INTEREST EXPENSE   113. 00   1000   Less Observation Beds   200. 00   201. 00   Less Observation Beds   201. 00   | 59. 00 05900 CARDI AC CATHETERI ZATI ON          | 0. 000000     |           |               |                | 59.00  |
| 65. 01   06501   SLEEP LAB   | 60. 00 06000 LABORATORY                          | 0. 000000     |           |               |                | 60.00  |
| 66. 00   | 65. 00 06500 RESPIRATORY THERAPY                 | 0. 000000     |           |               |                | 65.00  |
| 69. 00   | 65. 01 06501 SLEEP LAB                           | 0. 000000     |           |               |                | 65.01  |
| 71. 00   | 66. 00 06600 PHYSI CAL THERAPY                   | 0. 000000     |           |               |                | 66.00  |
| 72. 00   | 69. 00 06900 ELECTROCARDI OLOGY                  | 0. 000000     |           |               |                | 69.00  |
| 73. 00   07300   DRUGS CHARGED TO PATIENTS   0.000000   0   0   0   0   0   0   0  | 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0. 000000     |           |               |                | 71.00  |
| SECOND   S   | 72.00 07200 IMPL. DEV. CHARGED TO PATIENT        | 0. 000000     |           |               |                | 72.00  |
| 88. 00   08800   RURAL HEALTH CLINIC   0.000000   88. 01   88. 01   88. 02   08801   RURAL HEALTH CLINIC II   0.000000   88. 01   88. 02   08802   RURAL HEALTH CLINIC III   0.000000   88. 02   09000   CLINIC   0.000000   90. 00  | 73.00 07300 DRUGS CHARGED TO PATIENTS            | 0. 000000     |           |               |                | 73.00  |
| 88. 01 08801 RURAL HEALTH CLINIC II 0.000000 88. 02 90. 00 09000 CLINIC 0.000000 99. 00 91. 00 09100 EMERGENCY 0.000000 99. 00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.000000 92. 01 092. 01 09201 OBSERVATION BEDS (DISTINCT PART) 0.000000 92. 01 071. 00 09500 AMBULANCE SERVICES 0.000000 95. 00 101. 00 10100 HOME HEALTH AGENCY 95. 00 101. 00 10100 HOME HEALTH AGENCY 95. 01 113. 00 11300 INTEREST EXPENSE 113. 00 200. 00 Subtotal (see instructions) Less Observation Beds 201. 00  | OUTPATIENT SERVICE COST CENTERS                  |               |           |               |                |        |
| 88. 02   08802   RURAL HEALTH CLINIC III   0.000000   90.00   90.00   90.00   90.00   90.00   91.00   91.00   91.00   92.00   92.00   92.00   92.01   09201   08SERVATION BEDS (NON-DISTINCT PART)   0.000000   92.01   09201   08SERVATION BEDS (DISTINCT PART)   0.000000   92.01   07HER REIMBURSABLE COST CENTERS   0.000000   95.00   095.00   AMBULANCE SERVICES   0.000000   95.00   10100   HOME HEALTH AGENCY   5PECIAL PURPOSE COST CENTERS   113.00   1300   1NTEREST EXPENSE   113.00   200.00   201.00   Less Observation Beds   201.00   | 88. 00 08800 RURAL HEALTH CLINIC                 | 0. 000000     |           |               |                | 88.00  |
| 90. 00   990.0   CLINIC   0.000000   991. 00   991. 00   991. 00   992. 00   992. 00   992. 00   992. 01   09201   OBSERVATION BEDS (NON-DISTINCT PART)   0.000000   992. 01   OTHER REIMBURSABLE COST CENTERS   95. 00   O9500   AMBULANCE SERVICES   0.000000   95. 00   O10100   HOME   HEALTH   AGENCY   SPECIAL   PURPOSE COST CENTERS   113. 00   11300   INTEREST   EXPENSE   Subtotal (see instructions)   Less Observation   Beds   201. 00   201. 00   CLINIC   90. 000000   91. 00   92. 01   92. 01   92. 01   93. 00   94. 00   94. 00   95. 00    | 88.01 08801 RURAL HEALTH CLINIC II               | 0. 000000     |           |               |                | 88. 01 |
| 91. 00   09100   EMERGENCY   0. 0000000   92. 00   09200   0BSERVATI ON BEDS (NON-DISTINCT PART)   0. 0000000   92. 00   09201   0BSERVATI ON BEDS (DISTINCT PART)   0. 0000000   92. 01   0THER REIMBURSABLE COST CENTERS   09500   AMBULANCE SERVICES   0. 0000000   95. 00   10100   HOME HEALTH AGENCY   SPECIAL PURPOSE COST CENTERS   101. 00   1300   1 NTEREST EXPENSE   113. 00   1000   1 | 88.02 08802 RURAL HEALTH CLINIC III              | 0. 000000     |           |               |                | 88.02  |
| 91. 00   09100   EMERGENCY   0. 0000000   92. 00   09200   0BSERVATI ON BEDS (NON-DISTINCT PART)   0. 0000000   92. 00   09201   0BSERVATI ON BEDS (DISTINCT PART)   0. 0000000   92. 01   0THER REIMBURSABLE COST CENTERS   09500   AMBULANCE SERVICES   0. 0000000   95. 00   10100   HOME HEALTH AGENCY   SPECIAL PURPOSE COST CENTERS   101. 00   1300   1 NTEREST EXPENSE   113. 00   1000   1 | 90. 00  09000   CLI NI C                         | 0. 000000     |           |               |                | 90.00  |
| 92. 01   09201   0BSERVATI ON BEDS (DISTINCT PART)   0.000000   92. 01   |  | 0. 000000     |           |               |                | 91.00  |
| OTHER REI MBURSABLE COST CENTERS   95.00   09500   AMBULANCE SERVI CES   0.000000   95.00   101.00   10100   HOME HEALTH AGENCY   101.00   SPECI AL PURPOSE COST CENTERS   113.00   1NTEREST EXPENSE   113.00   200.00   Subtotal (see instructions)   200.00   Less Observation Beds   201.00      | 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 0. 000000     |           |               |                | 92.00  |
| OTHER REI MBURSABLE COST CENTERS   95.00   09500   AMBULANCE SERVI CES   0.000000   95.00   101.00   10100   HOME HEALTH AGENCY   101.00   SPECI AL PURPOSE COST CENTERS   113.00   1NTEREST EXPENSE   113.00   200.00   Subtotal (see instructions)   200.00   Less Observation Beds   201.00      | 92. 01 09201 OBSERVATION BEDS (DISTINCT PART)    | 0. 000000     |           |               |                | 92.01  |
| 101. 00  |  |               |           |               |                |        |
| SPECIAL PURPOSE COST CENTERS   113.00   11300   INTEREST EXPENSE   200.00   Subtotal (see instructions)   200.00   201.00   Less Observation Beds   201.00   | 95. 00 09500 AMBULANCE SERVICES                  | 0. 000000     |           |               |                | 95.00  |
| SPECIAL PURPOSE COST CENTERS   113.00   11300   INTEREST EXPENSE   200.00   Subtotal (see instructions)   200.00   201.00   Less Observation Beds   201.00   | 101.00 10100 HOME HEALTH AGENCY                  |               |           |               | -              | 101.00 |
| 113. 00   11300   INTEREST EXPENSE   |  |               |           |               |                |        |
| 200. 00       Subtotal (see instructions)       200. 00         201. 00       Less Observation Beds       201. 00  |  |               |           |               |                | 113.00 |
| 201.00 Less Observation Beds 201.00  |  |               |           |               |                |        |
| 202.00   Total (see instructions)   202.00   |  |               |           |               | [2             | 201.00 |
|  | 202.00 Total (see instructions)                  |               |           |               | [2             | 202.00 |

| Health Financial Systems                           | MAJOR HO     | SPI TAL      |              | In Lie                                      | u of Form CMS-2 | 2552-10 |
|--|--------------|--------------|--------------|---|-----------------|---------|
| APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL | COSTS        | Provi der (  |              | Period:<br>From 01/01/2020<br>To 12/31/2020 |                 | narodi  |
|  |              |              |              | 10 12/31/2020                               | 8/2/2021 2:11   |         |
|  |              | Ti tl        | e XVIII      | Hospi tal                                   | PPS             |         |
| Cost Center Description                            | Capi tal     | Swing Bed    | Reduced      | Total Patient                               |                 |         |
|  | Related Cost | Adjustment   | Capi tal     | Days  | (col. 3 /       |         |
|  | (from Wkst.  |              | Related Cost |   | col. 4)         |         |
|  | B, Part II,  |              | (col. 1 -    |   |                 |         |
|  | col. 26)     |              | col . 2)     |   |                 |         |
|  | 1. 00        | 2.00         | 3. 00        | 4. 00                                       | 5. 00           |         |
| INPATIENT ROUTINE SERVICE COST CENTERS             |              |              |              |   |                 |         |
| 30.00 ADULTS & PEDIATRICS                          | 1, 138, 929  | (            | 1, 138, 92   | 9, 061                                      | 125. 70         | 30.00   |
| 31.00   INTENSIVE CARE UNIT                        | 196, 711     |              | 196, 71      | 1, 611                                      | 122. 10         | 31.00   |
| 200.00 Total (lines 30 through 199)                | 1, 335, 640  |              | 1, 335, 64   | 0 10, 672                                   |                 | 200.00  |
| Cost Center Description                            | I npati ent  | I npati ent  |              |   |                 |         |
|  | Program days | Program      |              |   |                 |         |
|  |              | Capital Cost |              |   |                 |         |
|  |              | (col. 5 x    |              |   |                 |         |
|  |              | col. 6)      |              |   |                 |         |
|  | 6. 00        | 7. 00        |              |   |                 |         |
| INPATIENT ROUTINE SERVICE COST CENTERS             |              |              |              |   |                 |         |
| 30. 00 ADULTS & PEDIATRICS                         | 3, 102       | 389, 92°     |              | ·   |                 | 30.00   |
| 31.00 INTENSIVE CARE UNIT                          | 567          | 69, 23°      | 1            |   |                 | 31.00   |
| 200.00 Total (lines 30 through 199)                | 3, 669       | 459, 152     | 2            |   |                 | 200. 00 |

| Health Financial Systems   | MAJOR HO                                | SPI TAL       |              | In Lie                           | u of Form CMS-2                | 2552-10          |
|--|---|---------------|--------------|----------------------------------|--------------------------------|------------------|
| APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA                          | AL COSTS                                | Provi der Co  |              | Peri od:                         | Worksheet D                    |                  |
|  |   |               |              | From 01/01/2020<br>To 12/31/2020 |                                | narad.           |
|  |   |               |              | To 12/31/2020                    | Date/Time Pre<br>8/2/2021 2:11 | pareu.<br>nm     |
|  |   | Title         | XVIII        | Hospi tal                        | PPS                            |                  |
| Cost Center Description  | Capi tal                                | Total Charges | Ratio of Cos | t Inpatient                      | Capital Costs                  |                  |
|  | Related Cost                            | (from Wkst.   | to Charges   | Program                          | (column 3 x                    |                  |
|  | (from Wkst.                             | C, Part I,    | (col. 1 ÷    | Charges                          | column 4)                      |                  |
|  | B, Part II,                             | col. 8)       | col. 2)      |                                  |                                |                  |
|  | col. 26)                                |               |              |                                  |                                |                  |
|  | 1. 00                                   | 2. 00         | 3. 00        | 4. 00                            | 5. 00                          |                  |
| ANCILLARY SERVICE COST CENTERS   | 1                                       |               |              |                                  |                                |                  |
| 50. 00   05000   OPERATING ROOM  | 1, 164, 124                             | 68, 083, 492  | 0. 01709     |                                  | 68, 559                        | 50.00            |
| 53. 00   05300   ANESTHESI OLOGY   | 27, 040                                 | 520, 745      |              |                                  | 0                              | 53.00            |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C   | 408, 911                                | 28, 834, 268  |              |                                  | 17, 581                        | 54.00            |
| 56. 00   05600   RADI 0I SOTOPE  | 750 (20                                 | 0             | 0.00000      |                                  | 0                              | 56.00            |
| 56. 01   05601   0NCOLOGY<br>57. 00   05700   CT   SCAN                      | 759, 629                                | 22, 918, 754  | 0. 03314     |                                  | 523                            | 56. 01<br>57. 00 |
| 58.00   05700   CT SCAN<br>58.00   05800   MAGNETIC RESONANCE I MAGING (MRI) | 91, 596<br>87, 368                      | 30, 578, 599  |              |                                  | 7, 102                         | 57.00            |
| 59. 00   05900   CARDI AC CATHETERI ZATI ON                                  | 87, 308                                 | 9, 976, 474   | 0.00875      |                                  | 3, 707<br>0                    | 58. 00<br>59. 00 |
| 60. 00   06000   LABORATORY  | 285, 863                                | 45, 110, 564  |              |                                  | 20, 892                        | 60.00            |
| 65. 00   06500   RESPI RATORY   THERAPY                                      | 192, 212                                | 9, 505, 989   |              |                                  | 63, 823                        | 65.00            |
| 65. 01   06501   SLEEP LAB   | 7, 985                                  | 3, 298, 832   |              |                                  | 03, 023                        | 65. 01           |
| 66. 00 06600 PHYSI CAL THERAPY   | 453, 313                                | 7, 525, 737   |              |                                  | 38, 495                        | 66. 00           |
| 69. 00 06900 ELECTROCARDI OLOGY  | 70, 801                                 | 14, 165, 366  |              |                                  | 4, 973                         | 69. 00           |
| 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS                            | 0                                       | 0.17.007      | 0. 00000     |                                  | 0                              | 71. 00           |
| 72. 00 07200 I MPL. DEV. CHARGED TO PATIENT                                  | 69, 579                                 | 9, 406, 258   |              |                                  | 16, 353                        | 72.00            |
| 73.00 07300 DRUGS CHARGED TO PATIENTS  | 222, 636                                | 48, 265, 732  |              |                                  |                                | 73. 00           |
| OUTPATIENT SERVICE COST CENTERS  | , |               |              | ., ., ., .,                      | ,                              |                  |
| 88. 00 08800 RURAL HEALTH CLINIC   | 305, 635                                | 3, 866, 121   | 0. 07905     | 55 0                             | 0                              | 88. 00           |
| 88.01 08801 RURAL HEALTH CLINIC II   | 180, 086                                | 2, 734, 310   | 0. 06586     | 0                                | 0                              | 88. 01           |
| 88.02 08802 RURAL HEALTH CLINIC III  | 1, 014, 250                             | 12, 341, 608  | 0. 08218     | 0                                | 0                              | 88. 02           |
| 90. 00  09000   CLI NI C   | 467, 275                                | 5, 118, 059   | 0. 09129     | 13, 515                          | 1, 234                         | 90.00            |
| 91. 00 09100 EMERGENCY   | 575, 912                                | 58, 709, 255  | 0. 00981     | 0 4, 473, 784                    | 43, 888                        | 91.00            |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)                             | 92, 261                                 | 1, 145, 353   | 0. 08055     | 7, 335                           | 591                            | 92.00            |
| 92.01 09201 OBSERVATION BEDS (DISTINCT PART)                                 | 291, 415                                | 5, 377, 191   | 0. 05419     | 829, 383                         | 44, 948                        | 92.01            |
| OTHER REIMBURSABLE COST CENTERS  |   |               |              |                                  |                                |                  |
| 95. 00 09500 AMBULANCE SERVICES  |   |               |              |                                  |                                | 95.00            |
| 200.00   Total (lines 50 through 199)  | 6, 767, 891                             | 387, 482, 707 |              | 28, 427, 031                     | 354, 557                       | 200. 00          |

| Nursing School   Post-Stepdown Adjustments   Nursing School   Post-Stepdown Adjustment   Nursing School   Post-Stepdown Adjustment   Nursing School   Post-Stepdown Adjustment   Nursing School   Nursing School   Post-Stepdown Adjustment   Nursing School   Nu | Health Financial Systems                         | MAJOR HO         | SPI TAL        |               | In Lie          | u of Form CMS-            | 2552-10 |
|--|--|------------------|----------------|---------------|-----------------|---------------------------|---------|
| Nursing School Post-Stepdown Adjustments   Nursing School Post-Ste | APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER | PASS THROUGH COS | STS Provider C |               | From 01/01/2020 | Part III<br>Date/Time Pre | epared: |
| School   Post-Stepdown   Adjustments   Cost   Education   Cost   Cost   Education   Cost   Table   T |  |                  | Title          | XVIII         | Hospi tal       | PPS                       |         |
| NPATIENT ROUTINE SERVICE COST CENTERS   1.00   2A   2.00   3.00   30 | Cost Center Description                          |                  |                |               |                 |                           |         |
| INPATIENT ROUTINE SERVICE COST CENTERS   |  | School           | School         | Post-Stepdown | Cost            | Medi cal                  |         |
| INPATIENT ROUTINE SERVICE COST CENTERS   1A  |  | Post-Stepdown    |                | Adjustments   |                 | Educati on                |         |
| INPATIENT ROUTINE SERVICE COST CENTERS   0   0   0   0   0   0   0   0   0   |  | Adjustments      |                |               |                 |                           |         |
| 30.00   30.0 |  | 1A               | 1.00           | 2A            | 2. 00           | 3. 00                     |         |
| 31.00  | INPATIENT ROUTINE SERVICE COST CENTERS           |                  |                |               |                 |                           |         |
| Total (lines 30 through 199)   | 30.00 03000 ADULTS & PEDIATRICS                  | 0                | 0              |               | 0               | 0                         | 30.00   |
| Cost Center Description  | 31.00 03100 INTENSIVE CARE UNIT                  | 0                | 0              |               | 0               | 0                         | 31.00   |
| Adjustment Amount (see instructions) minus col. 4)    NPATIENT ROUTINE SERVICE COST CENTERS  | 200.00 Total (lines 30 through 199)              | 0                | 0              | (             | 0               | 0                         | 200.00  |
| Amount (see instructions) minus col. 4)    Amount (see instructions) minus col. 4)   | Cost Center Description                          | Swi ng-Bed       | Total Costs    | Total Patient | Per Diem        | I npati ent               |         |
| INPATIENT ROUTINE SERVICE COST CENTERS   |  | Adjustment       | (sum of cols.  | Days          | (col. 5 ÷       | Program Days              |         |
| 1.00    |  | Amount (see      | 1 through 3,   |               | col. 6)         |                           |         |
| INPATIENT ROUTINE SERVICE COST CENTERS   30.00   3000   ADULTS & PEDIATRICS   0   0   1,611   0.00   3,102   30.00   31.00   |  |                  |                |               |                 |                           |         |
| 30. 00   03000   ADULTS & PEDIATRICS   0   0   9, 061   0. 00   3, 102   30. 00   31. 00   03100   INTENSIVE CARE UNIT   0   0   1, 611   0. 00   567   31. 00   200. 00   Total (Lines 30 through 199)   Inpatient Program Pass-Through Cost (col. 7   x col. 8)   9. 00  |  | 4. 00            | 5. 00          | 6. 00         | 7. 00           | 8. 00                     |         |
| 31.00   03100   INTENSIVE CARE UNIT   0   1,611   0.00   567   31.00   200.00   Total (lines 30 through 199)   0   10,672   3,669   200.00        Cost Center Description   Inpatient Program Pass-Through Cost (col. 7   x col. 8)   9.00   |  |                  |                |               |                 |                           |         |
| Total (lines 30 through 199)   0   10,672   3,669 200.00   |  | 0                | 0              | 9, 06         | 0.00            | 3, 102                    | 30.00   |
| Cost Center Description  | 31.00  03100   INTENSIVE CARE UNIT               |                  | 0              | 1, 61         | 0.00            |                           |         |
| Program Pass-Through Cost (col. 7 x col. 8) 9.00    INPATIENT ROUTINE SERVICE COST CENTERS   O3000   ADULTS & PEDIATRICS   O31.00   INTENSIVE CARE UNIT   O   31.00  | 200.00 Total (lines 30 through 199)              |                  | 0              | 10, 67:       | 2               | 3, 669                    | 200.00  |
| Pass-Through   Cost (col . 7   x col . 8)   9.00   | Cost Center Description                          |                  |                |               |                 |                           |         |
| Cost (col. 7   x col. 8)   9.00  |  |                  |                |               |                 |                           |         |
| X COİ . 8)   9.00  |  |                  |                |               |                 |                           |         |
| 9.00    INPATIENT ROUTINE SERVICE COST CENTERS  30.00   03000   ADULTS & PEDIATRICS   0   30.00 31.00   03100   INTENSIVE CARE UNIT   0   31.00  |  | Cost (col. 7     |                |               |                 |                           |         |
| INPATIENT ROUTINE SERVICE COST CENTERS   30.00   3000  ADULTS & PEDIATRICS   0   31.00   3100  INTENSIVE CARE UNIT   0   31.00   |  |                  |                |               |                 |                           |         |
| 30. 00 03000 ADULTS & PEDIATRICS 0 30. 00 31. 00 1NTENSI VE CARE UNIT 0 31. 00   |  | 9. 00            |                |               |                 |                           |         |
| 31. 00   03100   INTENSIVE CARE UNIT   0   31. 00  |  |                  |                |               |                 |                           |         |
|  |  | 0                |                |               |                 |                           |         |
| 200.00   Total (lines 30 through 199)   0   200.00   |  | 0                |                |               |                 |                           |         |
|  | 200.00   Total (lines 30 through 199)            | 0                |                |               |                 |                           | 200.00  |

In Lieu of Form CMS-2552-10

Period: Worksheet D
From 01/01/2020 Part IV
To 12/31/2020 Date/Time Prepared: 8/2/2021 2:11 pm THROUGH COSTS

|        |  |               |               |          |               | 8/2/2021 2:11 | pm      |
|--------|--|---------------|---------------|----------|---------------|---------------|---------|
|        |  |               | Title         | XVIII    | Hospi tal     | PPS           |         |
|        | Cost Center Description                    | Non Physician | Nursi ng      | Nursi ng | Allied Health | Allied Health |         |
|        |  | Anesthetist   | School        | School   | Post-Stepdown |               |         |
|        |  | Cost          | Post-Stepdown |          | Adjustments   |               |         |
|        |  |               | Adjustments   |          |               |               |         |
|        |  | 1. 00         | 2A            | 2.00     | 3A            | 3. 00         |         |
|        | ANCILLARY SERVICE COST CENTERS             |               |               |          |               |               |         |
| 50.00  | 05000 OPERATING ROOM                       | 0             | 0             | )        | 0             | 0             | 50.00   |
| 53.00  | 05300 ANESTHESI OLOGY                      | 0             | 0             |          | 0             | 0             | 53.00   |
| 54.00  | 05400 RADI OLOGY-DI AGNOSTI C              | 0             | 0             |          | 0             | 0             | 54.00   |
| 56.00  | 05600 RADI OI SOTOPE                       | 0             | 0             | )        | 0 0           | 0             | 56.00   |
| 56. 01 | 05601 ONCOLOGY                             | 0             | 0             |          | 0 0           | 0             | 56. 01  |
| 57.00  | 05700 CT SCAN                              | 0             | 0             |          | 0 0           | 0             | 57.00   |
| 58.00  | 05800 MAGNETIC RESONANCE IMAGING (MRI)     | 0             | 0             |          | 0 0           | 0             | 58. 00  |
| 59.00  |  | 0             | 0             |          | 0 0           | 0             | 59.00   |
| 60.00  | 06000 LABORATORY                           | 0             | 0             |          | 0 0           | 0             | 60.00   |
| 65.00  | 06500 RESPIRATORY THERAPY                  | 0             | 0             | o        | 0 0           | 0             | 65.00   |
| 65. 01 | 06501 SLEEP LAB                            | 0             | 0             |          | 0 0           | 0             | 65. 01  |
| 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 PATIENTS | 0             | 0             |          | 0 0           | 0             | 71.00   |
| 72.00  | 07200 IMPL. DEV. CHARGED TO PATIENT        | 0             | 0             |          | 0 0           | 0             | 72.00   |
| 73.00  | 07300 DRUGS CHARGED TO PATIENTS            | 0             | l             |          | 0 0           | 0             | 73.00   |
|        | OUTPATIENT SERVICE COST CENTERS            |               |               |          |               |               |         |
| 88. 00 | 08800 RURAL HEALTH CLINIC                  | 0             | 0             | )        | 0 0           | 0             | 88. 00  |
| 88. 01 | 08801 RURAL HEALTH CLINIC II               | 0             | 0             |          | 0 0           | 0             | 88. 01  |
| 88. 02 | 08802 RURAL HEALTH CLINIC III              | 0             | 0             |          | 0 0           | 0             | 88. 02  |
| 90.00  | 09000 CLI NI C                             | 0             | 0             |          | 0 0           | 0             | 90.00   |
| 91.00  | 09100 EMERGENCY                            | 0             | 0             |          | 0 0           | 0             | 91.00   |
| 92.00  | 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 0             |               |          | 0             | 0             | 92.00   |
| 92. 01 | 09201 OBSERVATION BEDS (DISTINCT PART)     | 0             | 0             |          | 0 0           | 0             | 92. 01  |
|        | OTHER REIMBURSABLE COST CENTERS            | •             |               | •        |               |               |         |
| 95.00  | 09500 AMBULANCE SERVICES                   |               |               |          |               |               | 95.00   |
| 200.00 | Total (lines 50 through 199)               | 0             | 0             |          | 0 0           | 0             | 200. 00 |

| Health Financial Systems                   | MAJOR HOSPITAL                                   | In Lieu of Form CMS-2552-10 |
|--|--|-----------------------------|
| APPORTIONMENT OF INPATIENT/OUTPATIENT ANCI | LLARY SERVICE OTHER PASS   Provider CCN: 15-0097 | Period: Worksheet D         |
| THROUGH COSTS                              |  | From 01/01/2020 Part IV     |

|        |  |            |               | T            | o 12/31/2020  | Date/Time Pre 8/2/2021 2:11 |        |
|--------|--|------------|---------------|--------------|---------------|-----------------------------|--------|
|        |  |            | Title         | XVIII        | Hospi tal     | PPS                         | piii   |
|        | Cost Center Description                    | All Other  | Total Cost    | Total        | Total Charges | Ratio of Cost               |        |
|        | ·  | Medi cal   | (sum of cols. | Outpati ent  | (from Wkst.   | to Charges                  |        |
|        |  | Educati on | 1, 2, 3, and  | Cost (sum of | C, Part I,    | (col. 5 ÷                   |        |
|        |  | Cost       | 4)            | col s. 2, 3, | col. 8)       | col. 7)                     |        |
|        |  |            |               | and 4)       |               | (see                        |        |
|        |  |            |               |              |               | instructions)               |        |
|        |  | 4. 00      | 5. 00         | 6. 00        | 7. 00         | 8. 00                       |        |
|        | ANCILLARY SERVICE COST CENTERS             | -          | 1             |              |               |                             |        |
|        | 05000 OPERATING ROOM                       | 0          | 0             | 0            | ,,            | 0.000000                    |        |
|        | 05300 ANESTHESI OLOGY                      | 0          | 0             | 0            | ,             |                             | 1      |
|        | 05400 RADI OLOGY-DI AGNOSTI C              | 0          | 0             | 0            | 28, 834, 268  |                             |        |
|        | 05600 RADI OI SOTOPE                       | 0          | 0             | 0            | 0             | 0. 000000                   |        |
|        | 05601 ONCOLOGY                             | 0          | 0             | 0            | 22, 918, 754  | 0. 000000                   |        |
|        | 05700 CT SCAN                              | 0          | 0             | 0            | 30, 578, 599  |                             |        |
|        | 05800 MAGNETIC RESONANCE IMAGING (MRI)     | 0          | 0             | 0            | 9, 976, 474   | 0. 000000                   |        |
|        | 05900 CARDI AC CATHETERI ZATI ON           | 0          | 0             | 0            | 0             | 0. 000000                   |        |
|        | 06000 LABORATORY                           | 0          | 0             | 0            | 45, 110, 564  | 0.000000                    |        |
|        | 06500 RESPI RATORY THERAPY                 | 0          | 0             | 0            | 9, 505, 989   |                             |        |
|        | 06501 SLEEP LAB                            | 0          | 0             | 0            | 3, 298, 832   |                             |        |
|        | 06600 PHYSI CAL THERAPY                    | 0          | 0             | 0            | 7, 525, 737   |                             |        |
|        | 06900 ELECTROCARDI OLOGY                   | 0          | 0             | 0            | 14, 165, 366  |                             |        |
|        | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0          | 0             | 0            | 0             | 0.000000                    | 71.00  |
|        | 07200 IMPL. DEV. CHARGED TO PATIENT        | 0          | 0             | 0            | 9, 406, 258   | 0.000000                    | 72.00  |
| 73.00  | 07300 DRUGS CHARGED TO PATIENTS            | 0          | 0             | C            | 48, 265, 732  | 0.000000                    | 73.00  |
|        | OUTPATIENT SERVICE COST CENTERS            |            |               |              |               |                             |        |
|        | 08800 RURAL HEALTH CLINIC                  | 0          | 0             | 0            | 3, 866, 121   | 0.000000                    |        |
|        | 08801 RURAL HEALTH CLINIC II               | 0          | 0             | 0            | 2, 734, 310   |                             |        |
|        | 08802 RURAL HEALTH CLINIC III              | 0          | 0             | 0            | 12, 341, 608  | 0.000000                    | 88. 02 |
|        | 09000 CLI NI C                             | 0          | 0             | 0            | 5, 118, 059   | 0.000000                    | 90.00  |
|        | 09100 EMERGENCY                            | 0          | 0             | 0            | 58, 709, 255  | 0.000000                    | 91.00  |
|        | 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 0          | 0             | 0            | 1, 145, 353   | 0.000000                    | 92.00  |
|        | 09201 OBSERVATION BEDS (DISTINCT PART)     | 0          | 0             | C            | 5, 377, 191   | 0.000000                    | 92. 01 |
|        | OTHER REIMBURSABLE COST CENTERS            |            |               |              |               |                             |        |
|        | 09500 AMBULANCE SERVICES                   |            |               |              |               | ļ                           | 95.00  |
| 200.00 | Total (lines 50 through 199)               | 0          | 0             | 0            | 387, 482, 707 |                             | 200.00 |

| Health Financial Systems MAJOR |                         |               | JOR HOSPI  | TAL      |             | In Lieu of Form CMS-2552-10 |  |   |
|--------------------------------|-------------------------|---------------|------------|----------|-------------|-----------------------------|--|---|
| APPORTIONMENT OF THROUGH COSTS | I NPATI ENT/OUTPATI ENT | ANCI LLARY SE | ERVICE OTH | IER PASS | Provi der ( | CCN: 15-0097                | Peri od:<br>From 01/01/2020<br>To 12/31/2020 | Worksheet D<br>Part IV<br>Date/Time Prepared: |

|  |                    |               |              |               | To 12/31/2020  | Date/Time Pre<br>8/2/2021 2:11 |          |
|--|--------------------|---------------|--------------|---------------|----------------|--------------------------------|----------|
|  |                    |               | Title        | XVIII         | Hospi tal      | PPS                            | <u> </u> |
| Cost Center Descrip                      | oti on             | Outpati ent   | I npati ent  | I npati ent   | Outpati ent    | Outpati ent                    |          |
|  |                    | Ratio of Cost | Program      | Program       | Program        | Program                        |          |
|  |                    | to Charges    | Charges      | Pass-Through  | Charges        | Pass-Through                   |          |
|  |                    | (col. 6 ÷     |              | Costs (col. 8 | 3              | Costs (col. 9                  |          |
|  |                    | col. 7)       |              | x col. 10)    |                | x col. 12)                     |          |
|  |                    | 9. 00         | 10. 00       | 11.00         | 12.00          | 13.00                          |          |
| ANCILLARY SERVICE COST C                 | ENTERS             |               |              |               |                |                                |          |
| 50.00   05000   OPERATING ROOM           |                    | 0. 000000     | 4, 009, 747  |               | 0 10, 339, 195 | <b>l</b>                       |          |
| 53. 00   05300   ANESTHESI OLOGY         |                    | 0. 000000     | 0            |               | 0 517, 154     | <b>l</b>                       | 53.00    |
| 54. 00   05400   RADI OLOGY-DI AGNOSTI   | C                  | 0. 000000     | 1, 239, 772  |               | 0 5, 117, 096  | 0                              | 54.00    |
| 56. 00   05600 RADI 0I SOTOPE            |                    | 0. 000000     | 0            |               | 0              | 0                              | 56.00    |
| 56. 01   05601   ONCOLOGY                |                    | 0. 000000     | 15, 787      |               | 0 7, 551, 297  | 0                              | 56. 01   |
| 57.00 05700 CT SCAN                      |                    | 0. 000000     | 2, 371, 401  |               | 0 5, 761, 622  | 0                              | 57.00    |
| 58.00 05800 MAGNETIC RESONANCE           |                    | 0. 000000     | 423, 359     |               | 0 2, 336, 960  | 0                              | 58. 00   |
| 59. 00   05900   CARDI AC   CATHETERI ZA | ATI ON             | 0. 000000     | 0            |               | 0              | 0                              | 59.00    |
| 60. 00   06000   LABORATORY              |                    | 0. 000000     | 3, 296, 826  |               | 0 3, 102, 287  | 0                              | 60.00    |
| 65. 00 06500 RESPIRATORY THERAPY         | (                  | 0. 000000     | 3, 156, 435  |               | 0 910, 109     | 0                              | 65.00    |
| 65. 01   06501   SLEEP LAB               |                    | 0. 000000     | 0            |               | 0 0            | 0                              | 65. 01   |
| 66.00 06600 PHYSI CAL THERAPY            |                    | 0. 000000     | 639, 075     |               | 0 13, 364      | 0                              | 66.00    |
| 69. 00 06900 ELECTROCARDI OLOGY          |                    | 0. 000000     | 994, 999     |               | 0 3, 322, 806  | 0                              | 69.00    |
| 71.00 07100 MEDICAL SUPPLIES CH          | HARGED TO PATIENTS | 0. 000000     | 0            |               | 0              | 0                              | 71.00    |
| 72.00 07200 I MPL. DEV. CHARGED          | TO PATIENT         | 0. 000000     | 2, 210, 715  |               | 0 1, 247, 388  | 0                              | 72.00    |
| 73.00 07300 DRUGS CHARGED TO PA          | ATI ENTS           | 0. 000000     | 4, 744, 898  |               | 0 11, 442, 436 | 0                              | 73.00    |
| OUTPATIENT SERVICE COST                  | CENTERS            |               |              |               | _              |                                |          |
| 88.00 08800 RURAL HEALTH CLINIC          |                    | 0. 000000     | 0            |               | 0 0            | 0                              | 88. 00   |
| 88.01 08801 RURAL HEALTH CLINIC          | C 11               | 0. 000000     | 0            |               | 0              | 0                              | 88. 01   |
| 88.02 08802 RURAL HEALTH CLINIC          | C 111              | 0. 000000     | 0            |               | 0              | 0                              | 88. 02   |
| 90. 00 09000 CLINIC                      |                    | 0. 000000     | 13, 515      |               | 0 2, 092, 032  | 0                              | 90.00    |
| 91.00 09100 EMERGENCY                    |                    | 0. 000000     | 4, 473, 784  |               | 0 7, 249, 659  | 0                              | 91.00    |
| 92.00 09200 OBSERVATION BEDS (N          | NON-DISTINCT PART) | 0. 000000     | 7, 335       |               | 0 492, 287     | 0                              | 92.00    |
| 92.01 09201 OBSERVATION BEDS (I          | DISTINCT PART)     | 0. 000000     | 829, 383     |               | 0 771, 775     | 0                              | 92. 01   |
| OTHER REIMBURSABLE COST                  | CENTERS            |               |              |               |                |                                |          |
| 95. 00 09500 AMBULANCE SERVICES          |                    |               |              |               |                |                                | 95.00    |
| 200.00 Total (lines 50 thr               | ough 199)          |               | 28, 427, 031 |               | 0 62, 267, 467 | 0                              | 200. 00  |
|  |                    |               |              |               |                |                                |          |

Health Financial Systems MAJOR HOAPPORTLONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provi der CCN: 15-0097

|             |  |              | Title         | : XVIII       | Hospi tal     | PPS          |        |
|-------------|--|--------------|---------------|---------------|---------------|--------------|--------|
|             |  |              | ·             | Charges       |               | Costs        |        |
|             | Cost Center Description                | Cost to      | PPS           | Cost          | Cost          | PPS Services |        |
|             |  | Charge Ratio | Rei mbursed   | Rei mbursed   | Rei mbursed   | (see inst.)  |        |
|             |  | From         | Services (see | Servi ces     | Services Not  |              |        |
|             |  | Worksheet C, | inst.)        | Subject To    | Subject To    |              |        |
|             |  | Part I, col. |               | Ded. & Coins. | Ded. & Coins. |              |        |
|             |  | 9            |               | (see inst.)   | (see inst.)   |              |        |
|             |  | 1. 00        | 2.00          | 3. 00         | 4. 00         | 5. 00        |        |
|             | LLARY SERVICE COST CENTERS             |              |               |               |               |              |        |
|             | O OPERATING ROOM                       | 0. 143445    |               |               | 0             | 1, 483, 106  |        |
|             | O ANESTHESI OLOGY                      | 1. 101280    |               |               | 0             | 569, 531     |        |
|             | O RADI OLOGY-DI AGNOSTI C              | 0. 280648    |               | [ C           | 0             | 1, 436, 103  |        |
|             | O RADI OI SOTOPE                       | 0. 000000    |               | C             | 0             | 0            |        |
|             | 1 ONCOLOGY                             | 0. 226965    | 7, 551, 297   | C             | 0             | 1, 713, 880  | 56. 01 |
| 57.00 0570  | O CT SCAN                              | 0. 048302    | 5, 761, 622   | C             | 0             | 278, 298     | 57.00  |
| 58.00 0580  | O MAGNETIC RESONANCE IMAGING (MRI)     | 0. 136575    | 2, 336, 960   | C             | 0             | 319, 170     | 58.00  |
| 59.00 0590  | O CARDI AC CATHETERI ZATI ON           | 0. 000000    | 0             | C             | 0             | 0            | 59.00  |
| 60.00 0600  | O LABORATORY                           | 0. 199318    | 3, 102, 287   | [ c           | 0             | 618, 342     | 60.00  |
| 65. 00 0650 | O RESPI RATORY THERAPY                 | 0. 260199    | 910, 109      | l c           | 0             | 236, 809     | 65.00  |
| 65. 01 0650 | 1 SLEEP LAB                            | 0. 268954    | 0             | l c           | 0             | 0            | 65. 01 |
| 66. 00 0660 | O PHYSI CAL THERAPY                    | 0. 485084    | 13, 364       | l c           | 0             | 6, 483       | 66.00  |
| 69. 00 0690 | O ELECTROCARDI OLOGY                   | 0. 219785    | 3, 322, 806   | l c           | 0             | 730, 303     | 69.00  |
| 71.00 0710  | O MEDICAL SUPPLIES CHARGED TO PATIENTS | 0. 000000    | 0             | l c           | 0             | 0            | 71.00  |
| 72.00 0720  | OIMPL. DEV. CHARGED TO PATIENT         | 0. 251052    | 1, 247, 388   |               | 0             | 313, 159     | 72.00  |
| 73.00 0730  | O DRUGS CHARGED TO PATIENTS            | 0. 320490    | 11, 442, 436  |               | 13, 341       | 3, 667, 186  | 73.00  |
|             | ATIENT SERVICE COST CENTERS            |              |               |               |               |              | 1      |
| 88. 00 0880 | O RURAL HEALTH CLINIC                  |              |               |               |               |              | 88. 00 |
| 88. 01 0880 | 1 RURAL HEALTH CLINIC II               |              |               |               |               |              | 88. 01 |
| 88. 02 0880 | 2 RURAL HEALTH CLINIC III              |              |               |               |               |              | 88. 02 |
| 90.00 0900  | O CLI NI C                             | 0. 646355    | 2, 092, 032   | C             | 0             | 1, 352, 195  | 90.00  |
| 91.00 0910  | O EMERGENCY                            | 0. 114461    | 7, 249, 659   | l c           | 0             | 829, 803     | 91.00  |
| 92.00 0920  | O OBSERVATION BEDS (NON-DISTINCT PART) | 0. 980540    | 492, 287      |               | 0             | 482, 707     | 92.00  |
| 92. 01 0920 | 1 OBSERVATION BEDS (DISTINCT PART)     | 0. 555739    | 771, 775      | l c           | 0             | 428, 905     | 92. 01 |
| OTHE        | R REIMBURSABLE COST CENTERS            | •            |               | •             | •             |              | 1      |
| 95. 00 0950 | O AMBULANCE SERVICES                   | 0. 000000    |               | C             | )             |              | 95.00  |
| 200.00      | Subtotal (see instructions)            |              | 62, 267, 467  |               | 13, 341       | 14, 465, 980 | 200.00 |
| 201.00      | Less PBP Clinic Lab. Services-Program  | 1            |               |               | 0             |              | 201.00 |
|             | Only Charges                           |              |               |               |               |              |        |
| 202. 00     | Net Charges (line 200 - line 201)      |              | 62, 267, 467  | C             | 13, 341       | 14, 465, 980 | 202.00 |
| '           |  | •            | •             | •             | '             | •            | •      |

|  |               |            |            | To | 12/31/2020 | Date/Time Pr<br>8/2/2021 2:1 |        |
|--|---------------|------------|------------|----|------------|------------------------------|--------|
|  |               | Т          | itle XVIII |    | Hospi tal  | PPS                          |        |
|  | Cos           | sts        |            |    |            |                              |        |
| Cost Center Description                          | Cost          | Cost       |            |    |            |                              |        |
|  | Rei mbursed   | Reimburs   | ed         |    |            |                              |        |
|  | Servi ces     | Servi ces  | Not        |    |            |                              |        |
|  | Subject To    | Subj ect   | То         |    |            |                              |        |
|  | Ded. & Coins. | Ded. & Coi | ns.        |    |            |                              |        |
|  | (see inst.)   | (see inst  | i.)        |    |            |                              |        |
|  | 6. 00         | 7. 00      |            |    |            |                              |        |
| ANCILLARY SERVICE COST CENTERS                   |               |            |            |    |            |                              |        |
| 50.00   05000   OPERATING ROOM                   | 0             |            | 0          |    |            |                              | 50.00  |
| 53. 00   05300   ANESTHESI OLOGY                 | 0             |            | 0          |    |            |                              | 53.00  |
| 54. 00   05400   RADI OLOGY-DI AGNOSTI C         | 0             |            | 0          |    |            |                              | 54.00  |
| 56. 00   05600   RADI OI SOTOPE                  | 0             |            | o          |    |            |                              | 56.00  |
| 56. 01   05601   0NCOLOGY                        | 0             |            | o          |    |            |                              | 56. 01 |
| 57. 00  05700 CT SCAN                            | 0             |            | o          |    |            |                              | 57.00  |
| 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)     | 0             |            | o          |    |            |                              | 58.00  |
| 59. 00 05900 CARDI AC CATHETERI ZATI ON          | 0             |            | o          |    |            |                              | 59.00  |
| 60. 00 06000 LABORATORY                          | 0             |            | o          |    |            |                              | 60.00  |
| 65. 00 06500 RESPIRATORY THERAPY                 | 0             |            | o          |    |            |                              | 65.00  |
| 65. 01   06501   SLEEP LAB                       | 0             |            | o          |    |            |                              | 65. 01 |
| 66. 00 06600 PHYSI CAL THERAPY                   | 0             |            | o          |    |            |                              | 66.00  |
| 69. 00 06900 ELECTROCARDI OLOGY                  | 0             |            | o          |    |            |                              | 69. 00 |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0             |            | o          |    |            |                              | 71.00  |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENT        | 0             |            | o          |    |            |                              | 72.00  |
| 73. 00 07300 DRUGS CHARGED TO PATIENTS           | 0             | 4          | , 276      |    |            |                              | 73.00  |
| OUTPATIENT SERVICE COST CENTERS                  | <b>'</b>      | •          | <u> </u>   |    |            |                              |        |
| 88. 00 08800 RURAL HEALTH CLINIC                 |               |            |            |    |            |                              | 88. 00 |
| 88.01 08801 RURAL HEALTH CLINIC II               |               |            |            |    |            |                              | 88. 01 |
| 88.02 08802 RURAL HEALTH CLINIC III              |               |            |            |    |            |                              | 88. 02 |
| 90. 00  09000   CLI NI C                         | 0             |            | o          |    |            |                              | 90.00  |
| 91. 00 09100 EMERGENCY                           | 0             |            | o          |    |            |                              | 91.00  |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 0             |            | o          |    |            |                              | 92.00  |
| 92. 01 09201 OBSERVATION BEDS (DISTINCT PART)    | 0             |            | o          |    |            |                              | 92. 01 |
| OTHER REIMBURSABLE COST CENTERS                  |               |            |            |    |            |                              |        |
| 95. 00 09500 AMBULANCE SERVICES                  | 0             |            |            |    |            |                              | 95.00  |
| 200.00 Subtotal (see instructions)               | 0             | 4          | , 276      |    |            |                              | 200.00 |
| 201.00 Less PBP Clinic Lab. Services-Program     | 0             |            | · -        |    |            |                              | 201.00 |
| Only Charges                                     |               |            |            |    |            |                              |        |
| 202.00 Net Charges (line 200 - line 201)         | 0             | 4          | , 276      |    |            |                              | 202.00 |
| , ,  | •             | '          | 1          |    |            |                              | •      |

| Health Financial Systems                | MAJOR HOSPITAL         | In Lieu of Form CMS-2552-10 |                                |  |  |
|---|------------------------|-----------------------------|--------------------------------|--|--|
| COMPUTATION OF INPATIENT OPERATING COST | Provi der CCN: 15-0097 | Peri od:<br>From 01/01/2020 | Worksheet D-1                  |  |  |
|   |                        | To 12/31/2020               | Date/Time Pre<br>8/2/2021 2:11 |  |  |
|   | Title XVIII            | Hospi tal                   | PPS                            |  |  |
|   |                        |                             |                                |  |  |

|                  |  | Title XVIII   | Hospi tal        | PPS                       | - Piii           |  |  |
|------------------|--|---|------------------|---------------------------|------------------|--|--|
|                  | Cost Center Description  |   |                  |                           |                  |  |  |
|                  | PART I - ALL PROVIDER COMPONENTS   |   |                  | 1. 00                     |                  |  |  |
|                  | INPATIENT DAYS   |   |                  |                           |                  |  |  |
| 1.00             | Inpatient days (including private room days and swing-bed day  | s, excluding newborn)   |                  | 9, 061                    | 1.00             |  |  |
| 2.00             |  |   |                  |                           |                  |  |  |
| 3. 00            | Private room days (excluding swing-bed and observation bed da  | ys). If you have only pr  | ivate room days, | 0                         | 3.00             |  |  |
| 4. 00            | do not complete this line.<br>Semi-private room days (excluding swing-bed and observation b                                    | od days)  |                  | 8, 327                    | 4.00             |  |  |
| 5. 00            | Total swing-bed SNF type inpatient days (including private ro  |   | r 31 of the cost | 0, 327                    | 5.00             |  |  |
|                  | reporting period   |   |                  |                           |                  |  |  |
| 6. 00            | Total swing-bed SNF type inpatient days (including private ro  | om days) after December   | 31 of the cost   | 0                         | 6. 00            |  |  |
| 7. 00            | reporting period (if calendar year, enter 0 on this line)  | m days) through Docombor  | 21 of the cost   | 0                         | 7.00             |  |  |
| 7.00             | Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period          |   |                  |                           |                  |  |  |
| 8.00             | Total swing-bed NF type inpatient days (including private roo  | m days) after December 3  | 1 of the cost    | 0                         | 8.00             |  |  |
|                  | reporting period (if calendar year, enter 0 on this line)  |   |                  |                           |                  |  |  |
| 9. 00            | Total inpatient days including private room days applicable t newborn days) (see instructions)                                 | o the Program (excluding  | swing-bed and    | 3, 102                    | 9. 00            |  |  |
| 10.00            | Swing-bed SNF type inpatient days applicable to title XVIII o  | nlv (including private r  | oom days)        | 0                         | 10.00            |  |  |
|                  | through December 31 of the cost reporting period (see instruc  |   |                  |                           |                  |  |  |
| 11. 00           | Swing-bed SNF type inpatient days applicable to title XVIII o  |   | oom days) after  | 0                         | 11.00            |  |  |
| 12. 00           | December 31 of the cost reporting period (if calendar year, e<br>Swing-bed NF type inpatient days applicable to titles V or XI |   | o room days)     | 0                         | 12.00            |  |  |
| 12.00            | through December 31 of the cost reporting period   | A only (Therduring privat   | e room days)     | U                         | 12.00            |  |  |
| 13.00            | Swing-bed NF type inpatient days applicable to titles V or XI  | X only (including privat  | e room days)     | 0                         | 13.00            |  |  |
|                  | after December 31 of the cost reporting period (if calendar y  |   |                  |                           |                  |  |  |
| 14.00            | Medically necessary private room days applicable to the Progr<br>Total nursery days (title V or XIX only)                      | am (excluding swing-bed   | days)            | 0                         | 14. 00<br>15. 00 |  |  |
| 15. 00<br>16. 00 | Nursery days (title V or XIX only)   |   |                  | 0                         | 16.00            |  |  |
| 10.00            | SWING BED ADJUSTMENT   |   |                  |                           | 10.00            |  |  |
| 17. 00           | Medicare rate for swing-bed SNF services applicable to servic  | es through December 31 o  | f the cost       | 0. 00                     | 17. 00           |  |  |
| 10.00            | reporting period<br>Medicare rate for swing-bed SNF services applicable to servic  | oo often December 21 of   | the cost         | 0.00                      | 10.00            |  |  |
| 16.00            | reporting period   | es al tel December 31 01  | the cost         | 0.00                      | 18. 00           |  |  |
| 19.00            | Medicaid rate for swing-bed NF services applicable to service  | s through December 31 of  | the cost         | 0.00                      | 19.00            |  |  |
|                  | reporting period   |   |                  |                           |                  |  |  |
| 20.00            | Medicaid rate for swing-bed NF services applicable to service reporting period   | s after December 31 of t  | ne cost          | 0.00                      | 20.00            |  |  |
| 21. 00           | Total general inpatient routine service cost (see instruction  | s)  |                  | 13, 863, 893              | 21.00            |  |  |
| 22. 00           | Swing-bed cost applicable to SNF type services through Decemb  | er 31 of the cost report  | ing period (line | 0                         | 22. 00           |  |  |
| 22.00            | 5 x line 17)   | 21 of the cost reportin   | a ported (line ( | 0                         | 22.00            |  |  |
| 23. 00           | Swing-bed cost applicable to SNF type services after December x line 18)   | 31 of the cost reportin   | g period (iine o | U                         | 23. 00           |  |  |
| 24.00            |  | r 31 of the cost reporti  | ng period (line  | 0                         | 24.00            |  |  |
|                  | 7 x line 19)   |   |                  |                           |                  |  |  |
| 25. 00           | Swing-bed cost applicable to NF type services after December x line 20)  | 31 of the cost reporting  | period (line 8   | 0                         | 25. 00           |  |  |
| 26. 00           |  |   |                  | 0                         | 26. 00           |  |  |
| 27. 00           | General inpatient routine service cost net of swing-bed cost   | (line 21 minus line 26)   |                  | 13, 863, 893              | 27.00            |  |  |
| 00.00            | PRI VATE ROOM DI FFERENTI AL ADJUSTMENT  | Landa de la landa |                  |                           | 00.00            |  |  |
|                  | General inpatient routine service charges (excluding swing-be<br>Private room charges (excluding swing-bed charges)            | d and observation bed ch  | arges)           | 0                         | 28. 00<br>29. 00 |  |  |
| 30. 00           | Semi -private room charges (excluding swing-bed charges)   |   |                  | 0                         | 30.00            |  |  |
| 31.00            | General inpatient routine service cost/charge ratio (line 27   | ÷ line 28)  |                  | 0.000000                  | 1                |  |  |
| 32.00            | Average private room per diem charge (line 29 ÷ line 3)  |   |                  | 0.00                      | 1                |  |  |
| 33. 00           | Average semi-private room per diem charge (line 30 ÷ line 4)   |   |                  | 0.00                      | 1                |  |  |
| 34.00            | Average per diem private room charge differential (line 32 mi  |   | tions)           | 0.00                      | 1                |  |  |
| 35.00            | Average per diem private room cost differential (line 34 x li  | ne 31)  |                  | 0.00                      |                  |  |  |
| 36. 00<br>37. 00 | Private room cost differential adjustment (line 3 x line 35)<br>General inpatient routine service cost net of swing-bed cost   | and private room cost di  | fferential (line | _                         | 36. 00<br>37. 00 |  |  |
|                  | 27 minus line 36)  | p   |                  |                           |                  |  |  |
|                  | PART II - HOSPITAL AND SUBPROVIDERS ONLY   | HOTHENTO  |                  |                           |                  |  |  |
| 20 00            | PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ  |   | ı                | 1 520 04                  | 20 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, 530. 06<br>4, 746, 246 |                  |  |  |
| 40. 00           | Medically necessary private room cost applicable to the Progr  | •   |                  | 0                         | 1                |  |  |
| 41.00            | Total Program general inpatient routine service cost (line 39  |   |                  | 4, 746, 246               | 41.00            |  |  |
|                  |  |   |                  |                           |                  |  |  |

|         | Financial Systems  | MAJOR HOS       |                 | CN: 15 0007       |  | u of Form CMS-2             |                  |  |
|---------|--|-----------------|-----------------|-------------------|--|-----------------------------|------------------|--|
| COMPULA | TION OF INPATIENT OPERATING COST   |                 | Provi der C     |                   | Peri od:<br>From 01/01/2020<br>To 12/31/2020 | Worksheet D-1 Date/Time Pre |                  |  |
|         |  |                 | T: 11           |                   |  | 8/2/2021 2:11               |                  |  |
|         | Cost Center Description  | Total           | Total           | XVIII Average Per | Hospital Program Days                        | PPS<br>Program Cost         |                  |  |
|         |  | I npati ent     | I npati ent     | Diem (col. 1      |  | (col. 3 x                   |                  |  |
|         |  | Cost            | Days            | ÷ col . 2)        | 4.00   | col . 4)                    |                  |  |
| 42 00   | NURSERY (title V & XIX only)   | 1. 00           | 2. 00           | 3. 00             | 4.00   | 5. 00                       | 42.00            |  |
|         | Intensive Care Type Inpatient Hospital Units   |                 |                 |                   |  |                             | 72.00            |  |
| 43.00   | INTENSIVE CARE UNIT  | 3, 758, 685     | 1, 611          | 2, 333. 1         | 4 567  | 1, 322, 890                 |                  |  |
| 4       | CORONARY CARE UNIT   |                 |                 |                   |  |                             | 44.00            |  |
|         | BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT  |                 |                 |                   |  |                             | 45. 00<br>46. 00 |  |
|         | OTHER SPECIAL CARE (SPECIFY)   |                 |                 |                   |  |                             | 47.00            |  |
|         | Cost Center Description  |                 |                 |                   |  |                             |                  |  |
| 48. 00  | Program inpatient ancillary service cost (Wk   | ct D 2 col 3    | 2 line 200)     |                   |  | 1. 00<br>6, 180, 670        | 40.00            |  |
|         | Total Program inpatient costs (sum of lines  |                 |                 | ons)              |  | 12, 249, 806                |                  |  |
| Ī       | PASS THROUGH COST ADJUSTMENTS  | , ,             |                 | ,                 |  |                             |                  |  |
|         | Pass through costs applicable to Program inpa  | atient routine  | services (fro   | m Wkst. D, su     | m of Parts I and                             | 459, 152                    | 50.00            |  |
| 1       | III)<br>Pass through costs applicable to Program inpa  | ationt ancillar | ry sarvicas (f  | rom Wkst D        | sum of Darts II                              | 354, 557                    | 51.0             |  |
|         | and TV)  | acrone uncrital | y 301 V1 CE3 (1 | om wast. D,       | Jam Of Farts II                              | 334, 337                    | 31.0             |  |
|         | Total Program excludable cost (sum of lines!   |                 |                 |                   |  | 813, 709                    |                  |  |
|         | Total Program inpatient operating cost exclud  | 9 1             | elated, non-ph  | ysician anest     | hetist, and                                  | 11, 436, 097                | 53.00            |  |
|         | medical education costs (line 49 minus line !<br>FARGET AMOUNT AND LIMIT COMPUTATION           | 52)             |                 |                   |  |                             | <br>             |  |
|         | Program di scharges  |                 |                 |                   |  | 0                           | 54.0             |  |
|         | Target amount per discharge  |                 |                 |                   |  |                             | 55.0             |  |
|         | Target amount (line 54 x line 55)<br>Difference between adjusted inpatient operati             | ing cost and to | ract amount (   | lino E4 minus     | lino E2)                                     | 0                           | 56. 0<br>57. 0   |  |
|         | Bonus payment (see instructions)   | ing cost and ta | inger amount (  | illie 56 iiillius | 111le 53)                                    | 0                           | 58.0             |  |
|         | Lesser of lines 53/54 or 55 from the cost re   | porting period  | endi ng 1996,   | updated and c     | ompounded by the                             |                             | 59.0             |  |
|         | market basket  |                 |                 |                   |  |                             |                  |  |
|         | Lesser of lines 53/54 or 55 from prior year o<br>If line 53/54 is less than the lower of line: |                 |                 |                   |  | 0.00                        | 60. 0<br>61. 0   |  |
|         | which operating costs (line 53) are less than  |                 |                 |                   |  | O                           | 01.0             |  |
|         | amount (line 56), otherwise enter zero (see i  | instructions)   |                 |                   | Ü  |                             |                  |  |
|         | Relief payment (see instructions)  | ont (ooo i nots | unti ana)       |                   |  | 0                           | 62. 0<br>63. 0   |  |
| -       | Allowable Inpatient cost plus incentive paymo<br>PROGRAM INPATIENT ROUTINE SWING BED COST      | ent (see mstrt  | ictions)        |                   |  | 0                           | 03.00            |  |
| 64.00   | Medicare swing-bed SNF inpatient routine cos   | ts through Dece | ember 31 of th  | e cost report     | ing period (See                              | 0                           | 64.00            |  |
|         | instructions)(title XVIII only)  | +£+ D           | 21 -6 +1-       |                   |  | 0                           | / - 0            |  |
|         | Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)                    | ts after Decemb | per 31 or the   | cost reportin     | g period (see                                | 0                           | 65.0             |  |
|         | Total Medicare swing-bed SNF inpatient routin  | ne costs (line  | 64 plus line    | 65)(title XVI     | II only). For                                | 0                           | 66.0             |  |
|         | CAH (see instructions)   |                 |                 |                   |  | _                           |                  |  |
|         | Title V or XIX swing-bed NF inpatient routing<br>(line 12 x line 19)                           | e costs through | December 31     | of the cost r     | eporting period                              | 0                           | 67.0             |  |
|         | Title V or XIX swing-bed NF inpatient routing  | e costs after D | December 31 of  | the cost rep      | orting period                                | 0                           | 68.0             |  |
| 1       | (line 13 x line 20)  |                 |                 | •                 | 3 1  |                             |                  |  |
| H       | Total title V or XIX swing-bed NF inpatient  |                 | •               |                   |  | 0                           | 69.0             |  |
|         | PART III - SKILLED NURSING FACILITY, OTHER NU<br>Skilled nursing facility/other nursing facili |                 |                 |                   | )  |                             | 70.0             |  |
|         | Adjusted general inpatient routine service co  |                 |                 |                   | ,  |                             | 71.0             |  |
| 1       | Program routine service cost (line 9 x line  | ,               | . (1) 44        | 25)               |  |                             | 72.0             |  |
| 1       | Medically necessary private room cost applica<br>Total Program general inpatient routine servi |                 | •               | ,                 |  |                             | 73. 0<br>74. 0   |  |
| - 1     | Capital-related cost allocated to inpatient  |                 |                 |                   | Part II, column                              |                             | 75.0             |  |
|         | 26, line 45)   |                 | •               |                   |  |                             |                  |  |
|         | Per diem capital-related costs (line 75 ÷ lin  |                 |                 |                   |  |                             | 76.0             |  |
| 1       | Program capital-related costs (line 9 x line<br>Inpatient routine service cost (line 74 minu:  |                 |                 |                   |  |                             | 77. 0<br>78. 0   |  |
|         |  |                 |                 |                   |  |                             |                  |  |
|         |  |                 |                 |                   |  |                             |                  |  |
| 1       |  |                 |                 |                   |  |                             |                  |  |
| 1       | Reasonable inpatient routine service costs (:  |                 | •               |                   |  |                             | 82. 0<br>83. 0   |  |
| 84. 00  | Program inpatient ancillary services (see in   | structions)     |                 |                   |  |                             | 84.0             |  |
|         | Utilization review - physician compensation  |                 |                 |                   |  |                             | 85.0             |  |
|         | Total Program inpatient operating costs (sum<br>PART IV - COMPUTATION OF OBSERVATION BED PASS  |                 | rough 85)       |                   |  |                             | 86.0             |  |
| -       | Total observation bed days (see instructions)  |                 |                 |                   |  | 734                         | 87. O            |  |
|         | Adjusted general inpatient routine cost per o  |                 | - line 2)       |                   |  | 1, 530. 06                  |                  |  |
| 1       | Observation bed cost (line 87 x line 88) (see  | •               |                 |                   |  | 1, 123, 064                 |                  |  |

| Health Financial Systems                    | MAJOR HOSPITAL |              |            | In Lieu of Form CMS-2552-10      |               |       |
|---|----------------|--------------|------------|----------------------------------|---------------|-------|
| COMPUTATION OF INPATIENT OPERATING COST     |                | Provi der CC |            | Peri od:                         | Worksheet D-1 |       |
|   |                |              |            | From 01/01/2020<br>To 12/31/2020 |               |       |
|   |                | Title        | XVIII      | Hospi tal                        | PPS           |       |
| Cost Center Description                     | Cost           | Routine Cost | column 1 ÷ | Total                            | Observation   |       |
|   |                | (from line   | column 2   | Observati on                     | Bed Pass      |       |
|   |                | 21)          |            | Bed Cost                         | Through Cost  |       |
|   |                |              |            | (from line                       | (col. 3 x     |       |
|   |                |              |            | 89)                              | col. 4) (see  |       |
|   |                |              |            |                                  | instructions) |       |
|   | 1. 00          | 2.00         | 3. 00      | 4. 00                            | 5. 00         |       |
| COMPUTATION OF OBSERVATION BED PASS THROUGH | COST           |              |            |                                  |               |       |
| 90.00 Capital -related cost                 | 1, 138, 929    | 13, 863, 893 | 0. 08215   | 1 1, 123, 064                    | 92, 261       | 90.00 |
| 91.00 Nursing School cost                   | 0              | 13, 863, 893 | 0.00000    | 0 1, 123, 064                    | 0             | 91.00 |
| 92.00 Allied health cost                    | 0              | 13, 863, 893 | 0.00000    | 0 1, 123, 064                    | 0             | 92.00 |
| 93.00 All other Medical Education           | o              | 13, 863, 893 | 0. 00000   | 0 1, 123, 064                    | 0             | 93.00 |

| Health Financial Systems                | MAJOR HOSPITAL         | In Lieu                                      | u of Form CMS-2             | 552-10 |
|---|------------------------|--|-----------------------------|--------|
| COMPUTATION OF INPATIENT OPERATING COST | Provi der CCN: 15-0097 | Peri od:<br>From 01/01/2020<br>To 12/31/2020 | Worksheet D-1 Date/Time Pre | pared: |
|   |                        |  | 8/2/2021 2:11               |        |
|   | Title XIX              | Hospi tal                                    | Cost                        |        |
| Cost Center Description                 |                        |  |                             |        |

|                  |  | Title XIX                  | Hospi tal          | 8/2/2021 2:11<br>Cost | pm             |  |  |
|------------------|--|----------------------------|--------------------|-----------------------|----------------|--|--|
|                  | Cost Center Description  | THE XIX                    | поэрг саг          |                       |                |  |  |
|                  | PART I - ALL PROVIDER COMPONENTS   |                            |                    | 1. 00                 |                |  |  |
|                  | I NPATI ENT DAYS   |                            |                    |                       | 1              |  |  |
| 1. 00            | Inpatient days (including private room days and swing-bed day  |                            |                    | 9, 061                | 1.00           |  |  |
| 2. 00<br>3. 00   | Inpatient days (including private room days, excluding swing-<br>Private room days (excluding swing-bed and observation bed da |                            | sivata room dave   | 9, 061<br>0           | 2. 00<br>3. 00 |  |  |
| 3.00             | do not complete this line.   | lys). If you have only pr  | i vate i oom days, |                       | 3.00           |  |  |
| 4.00             | Semi-private room days (excluding swing-bed and observation b  |                            |                    | 8, 327<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         |                            |                    |                       |                |  |  |
| 6. 00            | Total swing-bed SNF type inpatient days (including private ro  | om days) after December    | 31 of the cost     | 0                     | 6.00           |  |  |
|                  | reporting period (if calendar year, enter 0 on this line)  | 3 ,                        |                    |                       |                |  |  |
| 7. 00            | Total swing-bed NF type inpatient days (including private roo reporting period   | m days) through December   | 31 of the cost     | 0                     | 7.00           |  |  |
| 8. 00            | Total swing-bed NF type inpatient days (including private roo  | m days) after December 3   | 31 of the cost     | 0                     | 8.00           |  |  |
|                  | reporting period (if calendar year, enter 0 on this line)  |                            |                    |                       |                |  |  |
| 9. 00            | Total inpatient days including private room days applicable t newborn days) (see instructions)                                 | o the Program (excluding   | g swing-bed and    | 326                   | 9. 00          |  |  |
| 10.00            | Swing-bed SNF type inpatient days applicable to title XVIII o  | nly (including private r   | room days)         | 0                     | 10.00          |  |  |
|                  | through December 31 of the cost reporting period (see instruc  |                            |                    |                       |                |  |  |
| 11. 00           | Swing-bed SNF type inpatient days applicable to title XVIII o<br>December 31 of the cost reporting period (if calendar year, e |                            | room days) after   | 0                     | 11.00          |  |  |
| 12.00            | Swing-bed NF type inpatient days applicable to titles V or XI  |                            | te room days)      | 0                     | 12.00          |  |  |
|                  | through December 31 of the cost reporting period   |                            |                    |                       |                |  |  |
| 13.00            | Swing-bed NF type inpatient days applicable to titles V or XI after December 31 of the cost reporting period (if calendar y    |                            |                    | 0                     | 13.00          |  |  |
| 14. 00           | Medically necessary private room days applicable to the Progr  |                            |                    | 0                     | 14.00          |  |  |
| 15. 00           | Total nursery days (title V or XIX only)   |                            | -                  | 0                     |                |  |  |
| 16. 00           | Nursery days (title V or XLX only) SWING BED ADJUSTMENT  |                            |                    | 0                     | 16. 00         |  |  |
| 17. 00           | Medicare rate for swing-bed SNF services applicable to servic  | es through December 31 o   | of the cost        | 0.00                  | 17.00          |  |  |
|                  | reporting period   |                            |                    |                       |                |  |  |
| 18. 00           | Medicare rate for swing-bed SNF services applicable to service reporting period  | es after December 31 of    | the cost           | 0.00                  | 18.00          |  |  |
| 19. 00           | Medicaid rate for swing-bed NF services applicable to service  | s through December 31 of   | the cost           | 0.00                  | 19.00          |  |  |
| 00.00            | reporting period   | Cl D                       |                    |                       | 00.00          |  |  |
| 20. 00           | Medicaid rate for swing-bed NF services applicable to service reporting period   | s after December 31 of 1   | rne cost           | 0. 00                 | 20.00          |  |  |
| 21.00            | Total general inpatient routine service cost (see instruction  |                            |                    | 13, 863, 893          | 21.00          |  |  |
| 22. 00           | Swing-bed cost applicable to SNF type services through Decemb $5 \times 1$ ine 17)   | er 31 of the cost report   | ting period (line  | 0                     | 22.00          |  |  |
| 23. 00           | Swing-bed cost applicable to SNF type services after December  | 31 of the cost reportir    | ng period (line 6  | 0                     | 23. 00         |  |  |
|                  | x line 18)   | ·                          |                    |                       |                |  |  |
| 24. 00           | Swing-bed cost applicable to NF type services through Decembe $7 \times 1$ ine 19)   | er 31 of the cost reporti  | ng period (line    | 0                     | 24.00          |  |  |
| 25. 00           | Swing-bed cost applicable to NF type services after December   | 31 of the cost reporting   | period (line 8     | 0                     | 25. 00         |  |  |
|                  | x line 20)   |                            |                    | _                     |                |  |  |
| 26. 00<br>27. 00 | Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost                           | (line 21 minus line 26)    |                    | 0<br>13, 863, 893     |                |  |  |
| 27.00            | PRIVATE ROOM DIFFERENTIAL ADJUSTMENT   | (Trice 21 mirius Trice 20) |                    | 13, 003, 073          | 27.00          |  |  |
|                  | General inpatient routine service charges (excluding swing-be  | d and observation bed ch   | narges)            | 0                     |                |  |  |
| 29. 00<br>30. 00 | Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)                     |                            |                    | 0<br>0                |                |  |  |
| 31. 00           | General inpatient routine service cost/charge ratio (line 27   | ÷ line 28)                 |                    | 0. 000000             |                |  |  |
| 32.00            | Average private room per diem charge (line 29 ÷ line 3)  | ,                          |                    | 0.00                  |                |  |  |
| 33.00            | Average semi-private room per diem charge (line 30 ÷ line 4)   |                            |                    | 0.00                  | 33.00          |  |  |
| 34.00            | Average per diem private room charge differential (line 32 mi  |                            | ctions)            | 0.00                  |                |  |  |
| 35. 00           | Average per diem private room cost differential (line 34 x li  | ne 31)                     |                    | 0.00                  |                |  |  |
| 36.00            | Private room cost differential adjustment (line 3 x line 35)   |                            | 66                 | 0                     | 36.00          |  |  |
| 37. 00           | General inpatient routine service cost net of swing-bed cost 27 minus line 36)   | and private room cost di   | fferential (line   | 13, 863, 893          | 37.00          |  |  |
|                  | PART II - HOSPITAL AND SUBPROVIDERS ONLY   |                            |                    |                       | 1              |  |  |
|                  | PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ  |                            |                    |                       |                |  |  |
|                  | Adjusted general inpatient routine service cost per diem (see  |                            |                    | 1, 530. 06            |                |  |  |
| 39.00            | Program general inpatient routine service cost (line 9 x line  | •                          |                    | 498, 800              |                |  |  |
|                  | Medically necessary private room cost applicable to the Progr<br>Total Program general inpatient routine service cost (line 39 |                            |                    | 0<br>498, 800         |                |  |  |
|                  | 1.1.1. 1.1.1. golden 1.1.pat. 3.1. 1 od 1110 301 1100 3031 (11110 37   |                            |                    | 1,75,500              | , 50           |  |  |

| UMDLIT         | Financial Systems ATION OF INPATIENT OPERATING COST  | MAJOR HO          | Provi der C       | CN: 15 0007             | Peri od:                         | u of Form CMS-:<br>  Worksheet D-1 |            |
|----------------|--|-------------------|-------------------|-------------------------|----------------------------------|------------------------------------|------------|
| OWPUT          | ATION OF INPATIENT OPERATING COST  |                   | Provider C        | CN: 15-0097             | From 01/01/2020<br>To 12/31/2020 | Date/Time Pre                      | epared     |
|                |  |                   | T; +1             | e XIX                   | Hospi tal                        | 8/2/2021 2: 11<br>Cost             | pm         |
|                | Cost Center Description  | Total             | Total             | Average Per             |                                  | Program Cost                       |            |
|                |  | Inpatient<br>Cost | Inpatient<br>Days | Diem (col.<br>+ col. 2) |                                  | (col. 3 x<br>col. 4)               |            |
| 2 00           | NURSERY (title V & XIX only)   | 1. 00             | 2. 00             | 3. 00                   | 4. 00                            | 5. 00                              | 42.0       |
| 2.00           | Intensive Care Type Inpatient Hospital Units   |                   |                   |                         |                                  |                                    | 72.        |
| 3. 00          | INTENSIVE CARE UNIT  | 3, 758, 685       | 1, 611            | 2, 333.                 | 14 0                             | 0                                  |            |
| 4. 00<br>5. 00 | CORONARY CARE UNIT BURN INTENSIVE CARE UNIT  |                   |                   |                         |                                  | ı                                  | 44.0       |
| 6. 00          | 1  |                   |                   |                         |                                  | ı                                  | 46.0       |
|                | OTHER SPECIAL CARE (SPECIFY)   |                   |                   |                         |                                  |                                    | 47. (      |
|                | Cost Center Description  |                   |                   |                         |                                  | 1. 00                              |            |
| 8. 00          | Program inpatient ancillary service cost (Wk   | st. D-3, col. 3   | 3, line 200)      |                         |                                  | 430, 355                           | 48.        |
| 9. 00          | Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS                    | 41 through 48)(   | (see instructi    | ons)                    |                                  | 929, 155                           | 49.        |
| 0. 00          | Pass through costs applicable to Program inp   | atient routine    | services (fro     | m Wkst. D, su           | um of Parts I and                | 0                                  | 50.        |
| 1. 00          |  | ationt ancillar   | rv sarvicas (f    | rom Wkst D              | sum of Darts II                  | 0                                  | 51.        |
|                | and IV)  |                   | , 501 VI 003 (I   | . Jiii WKJt. D,         | Sam Of Furts II                  | _                                  |            |
| 2.00           | Total Program excludable cost (sum of lines  |                   | طع مم ماماد       | ualalan anaat           | thatiat and                      | 0                                  | 1 .        |
| 3. 00          | Total Program inpatient operating cost exclumedical education costs (line 49 minus line      |                   | ziateu, ποπ-ph    | ysician anest           | inetist, and                     | 0                                  | 53.        |
|                | TARGET AMOUNT AND LIMIT COMPUTATION  |                   |                   |                         |                                  |                                    | ļ          |
|                | Program discharges Target amount per discharge   |                   |                   |                         |                                  | 0<br>0. 00                         |            |
| 6. 00          | Target amount (line 54 x line 55)  |                   |                   |                         |                                  | 0.00                               | 1          |
|                | Difference between adjusted inpatient operat   | ing cost and ta   | arget amount (    | line 56 minus           | s line 53)                       | 0                                  | 1          |
| 8.00           | Bonus payment (see instructions)   |                   |                   |                         |                                  | 0                                  |            |
| 9. 00          | Lesser of lines 53/54 or 55 from the cost re<br>market basket                                | porting period    | ending 1996,      | updated and d           | compounaea by the                | 0.00                               | 59.        |
| 0. 00          | Lesser of lines 53/54 or 55 from prior year  |                   |                   |                         |                                  | 0. 00                              | 60.        |
| 1. 00          | If line 53/54 is less than the lower of line   |                   |                   |                         |                                  | 0                                  | 61.        |
|                | which operating costs (line 53) are less tha amount (line 56), otherwise enter zero (see     |                   | is (Tines 54 x    | 60), OF 1% (            | or the target                    | ı                                  |            |
| 2. 00          | Relief payment (see instructions)  | •                 |                   |                         |                                  | 0                                  | 62.        |
| 3. 00          | Allowable Inpatient cost plus incentive paym<br>PROGRAM INPATIENT ROUTINE SWING BED COST     | ent (see instru   | uctions)          |                         |                                  | 0                                  | 63.        |
| 4. 00          | Medicare swing-bed SNF inpatient routine cos   | ts through Dece   | ember 31 of th    | e cost report           | ting period (See                 | 0                                  | 64.        |
| F 00           | instructions)(title XVIII only)  |                   |                   |                         |                                  |                                    | 4.5        |
| 5.00           | Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)                 | its after becenik | ber 31 of the     | cost reportir           | ig period (see                   | 0                                  | 65.        |
| 6. 00          | Total Medicare swing-bed SNF inpatient routi   | ne costs (line    | 64 plus line      | 65)(title XVI           | II only). For                    | 0                                  | 66.        |
| 7. 00          | CAH (see instructions) Title V or XIX swing-bed NF inpatient routin                          | e costs through   | n December 31     | of the cost r           | reporting period                 | 0                                  | 67.        |
|                | (line 12 x line 19)  | 9                 |                   |                         |                                  |                                    |            |
| 8. 00          | Title V or XIX swing-bed NF inpatient routin<br>(line 13 x line 20)                          | e costs after [   | December 31 of    | the cost rep            | porting period                   | 0                                  | 68.        |
| 9. 00          | Total title V or XIX swing-bed NF inpatient  |                   | •                 |                         |                                  | 0                                  | 69.        |
| 0. 00          | PART III - SKILLED NURSING FACILITY, OTHER N<br>Skilled nursing facility/other nursing facil |                   |                   |                         | 7)                               |                                    | 70.        |
| 1. 00          | Adjusted general inpatient routine service of  |                   |                   |                         |                                  | l                                  | 71.        |
| 2. 00          | Program routine service cost (line 9 x line  |                   |                   |                         |                                  | ı                                  | 72.        |
| 3. 00<br>4. 00 | Medically necessary private room cost applic<br>Total Program general inpatient routine serv | 9                 | •                 | ,                       |                                  | ı                                  | 73.<br>74. |
| 5. 00          | Capital -related cost allocated to inpatient   | •                 |                   | •                       | Part II, column                  | ı                                  | 75.        |
| 4 00           | 26, line 45)   |                   | -                 |                         |                                  | ı                                  | ١,,        |
| 6. 00<br>7. 00 | Per diem capital-related costs (line 75 ÷ li<br>Program capital-related costs (line 9 x line | ,                 |                   |                         |                                  | ı                                  | 76.<br>77. |
| 8. 00          | Inpatient routine service cost (line 74 minu   |                   |                   |                         |                                  | 1                                  | 78.        |
| 9. 00          | Aggregate charges to beneficiaries for exces   | ,                 |                   | *.                      | >                                | ı                                  | 79.        |
| 0. 00<br>1. 00 | Total Program routine service costs for comp<br>Inpatient routine service cost per diem limi |                   | cost limitatio    | n (IIne 78 mi           | nus line 79)                     | ı                                  | 80.<br>81. |
| 2. 00          | Inpatient routine service cost per drem from   |                   | 1)                |                         |                                  | 1                                  | 82.        |
| 3. 00          | Reasonable inpatient routine service costs (   | see instruction   | * .               |                         |                                  | 1                                  | 83.        |
| 4.00           | Program inpatient ancillary services (see in   |                   | >                 |                         |                                  | ı                                  | 84.        |
| 5. 00<br>6. 00 | Utilization review - physician compensation<br>Total Program inpatient operating costs (sum  | •                 |                   |                         |                                  | 1                                  | 85.<br>86. |
| 5. 00          | PART IV - COMPUTATION OF OBSERVATION BED PAS   |                   | ough oo)          |                         |                                  |                                    | 1 00.      |
|                |  |                   |                   |                         |                                  | 734                                | T 87.      |
| 7. 00<br>8. 00 | Total observation bed days (see instructions Adjusted general inpatient routine cost per     | •                 |                   |                         |                                  | 1, 530. 06                         |            |

| Health Financial Systems                    | MAJOR HOSPITAL |              |            | In Lie                           | eu of Form CMS-2552-10 |        |  |
|---|----------------|--------------|------------|----------------------------------|------------------------|--------|--|
| COMPUTATION OF INPATIENT OPERATING COST     |                | Provi der CC |            | Peri od:                         | Worksheet D-1          |        |  |
|   |                |              |            | From 01/01/2020<br>To 12/31/2020 |                        |        |  |
|   |                | Ti tl        | e XIX      | Hospi tal                        | Cost                   |        |  |
| Cost Center Description                     | Cost           | Routine Cost | column 1 ÷ | Total                            | Observation            |        |  |
|   |                | (from line   | column 2   | Observati on                     | Bed Pass               |        |  |
|   |                | 21)          |            | Bed Cost                         | Through Cost           |        |  |
|   |                |              |            | (from line                       | (col. 3 x              |        |  |
|   |                |              |            | 89)                              | col. 4) (see           |        |  |
|   |                |              |            |                                  | instructions)          |        |  |
|   | 1. 00          | 2.00         | 3.00       | 4. 00                            | 5. 00                  |        |  |
| COMPUTATION OF OBSERVATION BED PASS THROUGH | COST           |              |            |                                  |                        |        |  |
| 90.00 Capital -related cost                 | 1, 138, 929    | 13, 863, 893 | 0. 08215   | 1 1, 123, 064                    | 92, 261                | 90.00  |  |
| 91.00 Nursing School cost                   | 0              | 13, 863, 893 | 0.00000    | 0 1, 123, 064                    | 0                      | 91.00  |  |
| 92.00 Allied health cost                    | 0              | 13, 863, 893 | 0.00000    | 0 1, 123, 064                    | 0                      | 92.00  |  |
| 93.00 All other Medical Education           | 0              | 13, 863, 893 | 0. 00000   | 0 1, 123, 064                    | 0                      | 93. 00 |  |

|         | Financial Systems ENT ANCILLARY SERVICE COST APPORTIONMENT                 |                            |              | Peri od:        | u of Form CMS-:<br>Worksheet D-3 |        |
|---------|--|----------------------------|--------------|-----------------|----------------------------------|--------|
| NPATI   | ENT ANCILLARY SERVICE COST APPORTIONMENT                                   | Provider C                 | CN: 15-0097  | From 01/01/2020 | worksneet D-3                    | 3      |
|         |  |                            |              | To 12/31/2020   | Date/Time Pre                    | epared |
|         |  |                            |              |                 | 8/2/2021 2:11                    |        |
|         |  | Title                      | XVIII        | Hospi tal       | PPS                              |        |
|         | Cost Center Description  |                            | Ratio of Cos |                 | Inpati ent                       |        |
|         |  |                            | To Charges   | Program         | Program Costs                    |        |
|         |  |                            |              | Charges         | (col . 1 x                       |        |
|         |  |                            | 1.00         | 2.00            | col . 2)                         |        |
|         | INPATIENT ROUTINE SERVICE COST CENTERS                                     |                            | 1.00         | 2. 00           | 3. 00                            |        |
| 80. 00  | 03000 ADULTS & PEDIATRICS  |                            |              | 4, 019, 371     |                                  | 30.0   |
| 31. 00  | 03100 INTENSIVE CARE UNIT  |                            |              | 1, 852, 600     |                                  | 31.0   |
| 1.00    | ANCI LLARY SERVICE COST CENTERS  |                            |              | 1, 632, 600     |                                  | 1 31.0 |
| 0.00    | 05000 OPERATING ROOM   |                            | 0. 14344     | 45 4, 009, 747  | 575, 178                         | 50.0   |
| 3. 00   | 05300 ANESTHESI OLOGY  |                            | 1. 71122     |                 | 0 373, 170                       |        |
| 4. 00   | 05400 RADI OLOGY-DI AGNOSTI C  |                            | 0. 28064     |                 | 347, 940                         |        |
| 6. 00   | 05600 RADI OI SOTOPE   |                            | 0. 00000     |                 | 0                                | 1      |
| 6. 01   | 05601 ONCOLOGY   |                            | 0. 22720     |                 | 3, 587                           |        |
| 7. 00   | 05700 CT SCAN  |                            | 0. 04830     |                 | 114, 543                         |        |
| 8. 00   | 05800 MAGNETIC RESONANCE I MAGING (MRI)                                    |                            | 0. 1365      |                 | 57, 820                          |        |
| 9. 00   | 05900 CARDI AC CATHETERI ZATI ON   |                            | 0.00000      |                 | 0                                |        |
| 0.00    | 06000 LABORATORY   |                            | 0. 2018      |                 | 665, 471                         | 60.0   |
| 5. 00   | 06500 RESPI RATORY THERAPY   |                            | 0. 26019     | 99 3, 156, 435  | 821, 301                         |        |
| 5. 01   | 06501 SLEEP LAB  |                            | 0. 2689      | 54 0            | 0                                | 65.0   |
| 6.00    | 06600 PHYSI CAL THERAPY  |                            | 0. 48508     | 639, 075        | 310, 005                         | 66.0   |
| 9. 00   | 06900 ELECTROCARDI OLOGY   |                            | 0. 21978     | 994, 999        | 218, 686                         | 69.0   |
| 1. 00   | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS                                 |                            | 0.00000      | 00              | 0                                | 71.0   |
| 2. 00   |  |                            | 0. 2510      |                 |                                  |        |
| 3. 00   | 07300 DRUGS CHARGED TO PATIENTS  |                            | 0. 32049     | 90 4, 744, 898  | 1, 520, 692                      | 73.0   |
|         | OUTPATIENT SERVICE COST CENTERS  |                            |              |                 |                                  |        |
| 8. 00   |  |                            | 0.00000      |                 | 0                                |        |
| 8. 01   | 08801 RURAL HEALTH CLINIC II   |                            | 0.00000      |                 | 0                                |        |
| 8. 02   | 08802 RURAL HEALTH CLINIC III  |                            | 0.00000      |                 | 0                                | 1      |
| 0.00    | 09000 CLINIC   |                            | 0.65104      | · ·             | · ·                              |        |
| 1.00    | 09100 EMERGENCY  |                            | 0. 11478     |                 | 513, 532                         | 1      |
| 2.00    | 09200 OBSERVATION BEDS (NON-DISTINCT PART)                                 |                            | 0. 98054     |                 |                                  | 1      |
| 2. 01   | O9201   OBSERVATION BEDS (DISTINCT PART)   OTHER REIMBURSABLE COST CENTERS |                            | 0. 55573     | 39 829, 383     | 460, 920                         | 92.0   |
| 5 00    | 09500 AMBULANCE SERVICES   |                            |              |                 |                                  | 95.0   |
| 00.00   |  | through 08)                |              | 28, 427, 031    | 6, 180, 670                      |        |
| 201. 00 |  |                            |              | 20, 427, 031    | 0, 100, 070                      | 201.0  |
| -01.00  | Net charges (line 200 minus line 201)                                      | am only charges (Title 01) | 1            | 28, 427, 031    |                                  | 202.0  |

| Alth Financial Systems MAJOR HOSPI PATIENT ANCILLARY SERVICE COST APPORTIONMENT         | Provi der C |                      | Peri od:        | u of Form CMS-2<br>Worksheet D-3 |       |
|---|-------------|----------------------|-----------------|----------------------------------|-------|
|   |             |                      | From 01/01/2020 |                                  |       |
|   |             |                      | To 12/31/2020   | Date/Time Pre<br>8/2/2021 2:11   |       |
|   | Ti tl       | e XIX                | Hospi tal       | Cost                             | ГРШ   |
| Cost Center Description   |             | Ratio of Cos         |                 | I npati ent                      |       |
|   |             | To Charges           | Program         | Program Costs                    |       |
|   |             |                      | Charges         | (col . 1 x                       |       |
|   |             |                      |                 | col . 2)                         |       |
| LABATI ENT. DOUTINE OFFICE OF COOT OFFITEDO   |             | 1. 00                | 2. 00           | 3. 00                            |       |
| INPATIENT ROUTINE SERVICE COST CENTERS  |             | 1                    | /10.005         |                                  | ١     |
| . 00   03000   ADULTS & PEDI ATRI CS  |             |                      | 618, 895        |                                  | 30.   |
| . 00 O3100 I NTENSI VE CARE UNI T   |             |                      | 223, 661        |                                  | 31.   |
| ANCILLARY SERVICE COST CENTERS  |             | 0.1424               | 400 (00         | (0.220                           | ٠,    |
| . 00   05000   OPERATING ROOM   |             | 0. 14344             |                 | 69, 230                          |       |
| . 00   05300   ANESTHESI OLOGY  |             | 1. 10128             |                 | 0                                |       |
| . 00   05400   RADI OLOGY-DI AGNOSTI C  |             | 0. 28064             |                 | 22, 777                          |       |
| . 00   05600   RADI 0I SOTOPE   |             | 0.00000              |                 | 0                                |       |
| 01   05601   0NC0L0GY   |             | 0. 22696             |                 | 93                               |       |
| .00   05700   CT SCAN<br>.00   05800   MAGNETIC RESONANCE IMAGING (MRI)                 |             | 0. 04830<br>0. 13657 |                 | 7, 991<br>4, 248                 |       |
| .00   05800   MAGNETIC RESONANCE IMAGING (MRI)<br>.00   05900   CARDIAC CATHETERIZATION |             | 0. 1365              |                 |                                  |       |
| 00 06000 LABORATORY   |             | 0.0000               |                 | 0<br>61, 031                     |       |
| . 00   06500   RESPI RATORY THERAPY   |             | 0. 1993              |                 | 67, 054                          |       |
| . 01   06501   SLEEP LAB  |             | 0. 26895             |                 | 07,034                           |       |
| . 00   06600  PHYSI CAL THERAPY   |             | 0. 48508             |                 | 9, 247                           |       |
| . 00   06900   ELECTROCARDI OLOGY   |             | 0. 40300             |                 | 13, 955                          |       |
| .00   007100   MEDI CAL SUPPLIES CHARGED TO PATIENTS                                    |             | 0. 00000             |                 | 13, 733                          |       |
| . 00 07200 IMPL. DEV. CHARGED TO PATIENT  |             | 0. 25105             |                 | 0                                |       |
| . 00 O7300 DRUGS CHARGED TO PATIENTS  |             | 0. 32049             |                 | 131, 180                         |       |
| OUTPATIENT SERVICE COST CENTERS   |             | 0.3204               | 70 407, 312     | 131, 100                         | 1 / 3 |
| . 00 O8800 RURAL HEALTH CLINIC  |             | 1. 31228             | 33 0            | 0                                | 88    |
| 01   08801 RURAL HEALTH CLINIC II   |             | 1. 03500             |                 | Ō                                |       |
| 02 08802 RURAL HEALTH CLINIC III  |             | 1. 35109             | 94 0            | 0                                | 88    |
| . 00   09000   CLINIC   |             | 0. 64635             |                 | 0                                | 90    |
| 00 09100 EMERGENCY  |             | 0. 11446             | 380, 473        | 43, 549                          | 91    |
| 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)   |             | 0. 98054             |                 | 0                                |       |
| . 01   09201 OBSERVATION BEDS (DISTINCT PART)   |             | 0. 55573             |                 | 0                                | 92    |
| OTHER REIMBURSABLE COST CENTERS   |             |                      |                 |                                  |       |
| 00 09500 AMBULANCE SERVICES   |             |                      |                 |                                  | 95    |
| 0.00 Total (sum of lines 50 through 94 and 96 through 98)                               |             |                      | 2, 196, 963     | 430, 355                         |       |
| 1.00 Less PBP Clinic Laboratory Services-Program only charges                           | (line 61)   |                      | 0               |                                  | 201   |
| 2.00 Net charges (line 200 minus line 201)  | . ,         |                      | 2, 196, 963     |                                  | 202   |

| Health Financial Systems                | MAJOR HOSPITAL         | In Lieu of Form CMS-2552-10  |
|---|------------------------|--|
| CALCULATION OF REIMBURSEMENT SETTLEMENT | Provi der CCN: 15-0097 | Peri od: Worksheet E From 01/01/2020 Part A Date/Time Prepared: 8/2/2021 2:11 pm |

| PART A - IMPATIENT HOSPITAL SERVICES UNDER IPPS   1.00   |        |   |                             | 10 12/31/2020     | 8/2/2021 2:11 |          |
|--|--------|---|-----------------------------|-------------------|---------------|----------|
| MART A INDITITIEST HOSE TALL STRUCTS UNDITE IPPS   |        |   | Title XVIII                 | Hospi tal         |               |          |
| MART A INDITITIEST HOSE TALL STRUCTS UNDITE IPPS   |        |   |                             |                   |               |          |
| 1.00   BRG Amounts other than outli or payments for discharges occurring prior to October 1 (see   5,958, 28)   1.00   1.01   1.01   1.01   1.02          |        |   |                             |                   | 1. 00         |          |
| 1.01   DRG amounts other than outlier payments for discharges occurring prior to October 1 (see   5.98, 38)   1.01   |        |   |                             |                   |               |          |
| Instructions)  1.02 Refigurations system than outlier payments for discharges occurring on or after October 1 (see 1.03 Refigurations) 1.04 Refigurations specific operating payment for Model 4 BPCI for discharges occurring prior to October 1.03 Refigurations specific operating payment for Model 4 BPCI for discharges occurring prior to October 1.04 October 1 (see instructions) 2.00 Outlier payments for discharges. (see instructions) 2.00 Outlier payments for discharges occurring prior to October 1 (see instructions) 3.00 Outlier payments for discharges occurring on or after October 1 (see instructions) 3.00 Outlier payments for discharges occurring on or after October 1 (see instructions) 3.00 Outlier payments for discharges occurring on or after October 1 (see instructions) 3.00 Outlier payments for discharges occurring on or after October 1 (see instructions) 3.00 Outlier payments for discharges occurring on or after October 1 (see instructions) 3.00 Outlier payments for discharges occurring on or after October 1 (see instructions) 3.00 Outlier payments for discharges occurring on or after October 1 (see instructions) 3.00 Outlier payments for discharges occurring on or after October 1 (see instructions) 3.00 Outlier payments for discharges occurring on or after October 1 (see instructions) 3.00 Outlier payments for discharges occurring on or after October 1 (see instructions) 3.00 Outlier payments for discharges occurring on or after October 1 (see instructions) 3.00 Outlier payments for discharges occurring on or after October 1 (see instructions) 3.00 Outlier payments for discharges occurring on or after October 1 (see instructions) 3.00 Outlier payments for discharges occurring on or after October 1 (see instructions) 3.00 Outlier payments for discharges occurring on or after October 1 (see instructions) 3.00 Outlier payments for discharges occurring on or after October 1 (see instructions) 3.00 Outlier occurring on or after See Instructions 1 (see instructions) 3.00 Outlier occurring on or after See Instr     |        |   |                             | ,                 | - 1           |          |
| DRS amounts other than outlier payment for discharges occurring on or after October 1 (see   2,760,658   1.02   Instructions)   DRR for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October   0   1.03   | 1.01   |   | ing prior to uctober i      | see               | 5, 958, 381   | 1.01     |
| Instructions   1.03   Ref For Rederal specific operating payment for Wodel 4 BPCI for discharges occurring prior to October   0   1.03   | 1 02   |   | ing on or after October     | 1 (600            | 2 760 650     | 1 02     |
| DRG For Federal Specific operating payment for Model 4 BPCL for discharges occurring prior to October 1 (see instructions)   1.04  | 1.02   |   | 2, 700, 036                 | 1.02              |               |          |
| 1 (see instructions)   1.04   Story Tederal specific operating payment for Model 4 BPCI for discharges occurring on or after   0   1.04  | 1 03   |   | or discharges occurring     | nrior to October  | 0             | 1 03     |
| 1.04   ORC for Federal specific operating payment for Model 4 BPCI for discharges occurring on or after   0.0   1.04   | 1.00   |   | or discharges occurring     | piror to october  | ١             | 1.03     |
| October 1 (see Instructions)   | 1. 04  |   | or discharges occurring     | on or after       | 0             | 1.04     |
| 2.01   Outlier reconcilitation amount   0   2.01   |        |   | in an earner goe color ring |                   | -             |          |
| 2.02   Outlier payment for discharges for Model 4 BPCI (see instructions)   2.202   2.03   Outlier payments for discharges occurring prior to October 1 (see instructions)   29.202   2.04   2.05   2.05   2.04   2.05          | 2.00   | Outlier payments for discharges. (see instructions)                 |                             |                   |               | 2.00     |
| 2.03   Outlier payments for discharges occurring or on a fater October 1 (see instructions)   22,920   2.04   Outlier payments for discharges occurring on an after October 1 (see instructions)   29,025   2.04   Outlier payments for discharges occurring on an after October 1 (see instructions)   29,025   20,03   20,       | 2.01   | Outlier reconciliation amount                                       |                             |                   | 0             | 2. 01    |
| 2.04   Outlier payments for discharges occurring on or after October 1 (see instructions)   29.05   2.04   | 2.02   | Outlier payment for discharges for Model 4 BPCI (see instruct       | i ons)                      |                   | 0             | 2. 02    |
| Managed Car's Simulated Payments   | 2.03   | Outlier payments for discharges occurring prior to October 1        | (see instructions)          |                   | 82, 920       | 2. 03    |
| Bed days available divided by number of days in the cost reporting period (see instructions)   43.99   4.00  | 2.04   | Outlier payments for discharges occurring on or after October       | 1 (see instructions)        |                   | 29, 025       | 2. 04    |
| Indirect   Medical   Education   Adjustment  | 3.00   | Managed Care Simulated Payments                                     |                             |                   | 0             | 3.00     |
| Indirect Medical Education Adjustment  | 4.00   | Bed days available divided by number of days in the cost repo       | rting period (see instru    | uctions)          | 43. 99        | 4.00     |
| or before 12/31/1996. (see instructions) 6. 00 FTE count for all lopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413. 79(e) 7. 00 MMA Section 422 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions) 8. 00 Adjustment (increase or decrease) to the FTE count for all opathic and osteopathic programs for affiliated programs in accordance with 42 CFR 813.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002). 8. 01 The amount of increase if the hospital was awarded FTE cap slots under \$ 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions. 8. 02 The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under \$ 5506 of ACA. (see instructions) 9. 00 Sum of lines \$ plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8, 01 and 8, 02) (see 0.00 9. 00 9. 00 FTE count for all opathic and osteopathic programs in the current year from your records 9. 00 If the count for residents in dental and podial stric programs. 9. 01 Current year all owable FTE (see instructions) 9. 02 Current year all owable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero. 9. 03 Current year residents in dental and podial stric programs. 9. 02 Current year residents in count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero. 9. 03 Current year residents of splaced by program or hospital closure 9. 03 Current year resident to bed ratio (see instructions) 9. 04 Current year resident to bed ratio (see instructions) 9. 05 Current year resident to bed ratio (see instructions) 9. 06 Current year resident to bed ratio (see instructions) 9. 07 Current year resident to bed ratio (see instructions) 9. 08 Current year resident to bed ratio (see instructions) 9. 08 Current year resident to bed ratio |        |   | 31                          | <u> </u>          |               |          |
| or before 12/31/1996. (see instructions) 6. 00 FTE count for all lopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413. 79(e) 7. 00 MMA Section 422 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions) 8. 00 Adjustment (increase or decrease) to the FTE count for all opathic and osteopathic programs for affiliated programs in accordance with 42 CFR 813.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002). 8. 01 The amount of increase if the hospital was awarded FTE cap slots under \$ 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions. 8. 02 The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under \$ 5506 of ACA. (see instructions) 9. 00 Sum of lines \$ plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8, 01 and 8, 02) (see 0.00 9. 00 9. 00 FTE count for all opathic and osteopathic programs in the current year from your records 9. 00 If the count for residents in dental and podial stric programs. 9. 01 Current year all owable FTE (see instructions) 9. 02 Current year all owable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero. 9. 03 Current year residents in dental and podial stric programs. 9. 02 Current year residents in count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero. 9. 03 Current year residents of splaced by program or hospital closure 9. 03 Current year resident to bed ratio (see instructions) 9. 04 Current year resident to bed ratio (see instructions) 9. 05 Current year resident to bed ratio (see instructions) 9. 06 Current year resident to bed ratio (see instructions) 9. 07 Current year resident to bed ratio (see instructions) 9. 08 Current year resident to bed ratio (see instructions) 9. 08 Current year resident to bed ratio | 5.00   | FTE count for allopathic and osteopathic programs for the mos       | t recent cost reporting     | period ending on  | 0.00          | 5.00     |
| new programs in accordance with 42 CFR 413.79(e)  7.00 MMA Section 422 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.  8.00 Adjustment (increase or decrease) to the FTE count for all opathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).  8.01 The amount of increase if the hospital was awarded FTE cap slots under \$ 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.  8.02 The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under \$ 5506 of ACA. (see instructions)  9.00 Sum of lines \$ plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see  |        |   |                             |                   |               |          |
| 7.00         MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.         0.00         7.00           8.00         Adjustment (increase or decrease) to the FIE count for all opathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50009 (August 1, 2002).         0.00         8.00           8.01         The amount of increase if the hospital was awarded FIE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.         0.00         8.01           8.02         The amount of increase if the hospital was awarded FIE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)         0.00         1.00           9.00         Sum of Lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8, 01 and 8, 02) (see instructions)         0.00         1.00           10.00         FIE count for allopathic and osteopathic programs in the current year from your records         0.00         1.00           10.00         FIE count for allowable FIE (see instructions)         0.00         1.00           10.00         FIE count for allowable FIE count for the prior year.         0.00         1.00           10.00         Current year allowable FIE count for the prior year.         0.00         1.00           15.00         Sum of lines 12 through 14 divided by 3.   | 6.00   | FTE count for allopathic and osteopathic programs that meet t       | he criteria for an add-d    | on to the cap for | 0. 00         | 6.00     |
| 7.01         ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(i)(B)(2) IF the cost report straddles July 1, 2011 then see instructions.         0.00         7.01           8.00         Adjustment (Increase or decrease) to the FTE count for all opathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).         0.00         8.00           8.01         The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.         0.00         8.01           9.00         Sum of I lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see under § 5506 of ACA. (see instructions)         0.00         10.00           9.00         Sum of I lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see Instructions)         0.00         10.00           10.00         FTE count for residents in dental and podiatric programs.         0.00         11.00           10.00         FTE count for residents in dental and podiatric programs.         0.00         12.00           10.01         Total all owable FTE count for the prior year.         0.00         12.00           10.02         Total all owable FTE count for the penul timate year if that year ended on or after September 30, 1997, otherwise enter zero.         0.00         15.00           10.00         TEC co   |        | new programs in accordance with 42 CFR 413.79(e)                    |                             | · l               |               |          |
| cost report straddles July 1, 2011 then see instructions.  | 7.00   | MMA Section 422 reduction amount to the IME cap as specified        | under 42 CFR §412.105(f)    | (1)(iv)(B)(1)     | 0. 00         | 7.00     |
| Adjustment (increase or decrease) to the FTE count for all lopathic and osteopathic programs for affiliated programs in accordance with 42 CER 413.75(b). 413.79(c)(2)(iv), 64 FR 26340 (Way 12, 1998), and 67 FR 50069 (August 1, 2002).  | 7. 01  | ACA § 5503 reduction amount to the IME cap as specified under       | 42 CFR §412.105(f)(1)(i     | v)(B)(2) If the   | 0. 00         | 7. 01    |
| affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 2634Ö (May 12, 1998), and 67 FR 50069 (August 1, 2002).  8.01 The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions:  8.02 The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA (see instructions)  9.00 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 instructions)  10.00 FTE count for allopathic and osteopathic programs in the current year from your records 0.00 11.00 records of the count for residents in dental and podiatric programs.  10.00 Current year allowable FTE (see instructions) 0.00 12.00 rotherwise enter zero.  10.10 The count for residents in the count for the prior year.  10.00 Sum of lines 12 through 14 divided by 3.  10.00 Adjustment for residents in initial years of the program 0.00 Adjustment for residents in initial years of the program 0.00 Adjustment for residents in initial years of the program 0.00 Adjustment for residents in initial years of the program 0.00 Adjustment for residents in initial years of the program 0.00 Adjustment for residents in initial years of the program 0.00 Adjustment for residents in initial years of the program 0.00 Adjustment for residents in initial years of the program 0.00 Adjustment for residents in initial years of the program 0.00 Adjustment for residents in initial years of the program 0.00 Adjustment for residents in initial years of the program 0.00 Adjustment for residents in initial years of the program 0.00 Adjustment for residents in initial years of the program 0.00 Adjustment for residents in initial years of the program 0.00 Adjustment for residents in initial years of the program 0.00 Adjustment for residents in initial years of the program 0.00 Adjustment for residents in initial years of the program or hospital closure 0.00 Adjustment for residents in initial y     |        | cost report straddles July 1, 2011 then see instructions.           |                             |                   |               |          |
| 1998), and 67 FR 50069 (August 1, 2002).   | 8.00   | Adjustment (increase or decrease) to the FTE count for allopa       | thic and osteopathic pro    | ograms for        | 0. 00         | 8.00     |
| 8.01 The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost roport stradile sully 1, 2011, see instructions and represent the properties of ACA. (See Instructions)  9.00 The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (See instructions)  9.00 Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8, 01 and 8, 02) (see instructions)  10.00 FTE count for legidents in dental and podiatric programs in the current year from your records  9.00 10.00 Current year allowable FTE (see instructions)  13.00 Current year allowable FTE count for the prior year.  13.01 Total allowable FTE count for the prior year.  13.02 Current year allowable FTE count for the prior year.  13.03 Total allowable FTE count for the prior year.  13.04 Total allowable FTE count for the prior year.  13.05 Total allowable FTE count for the prior year.  14.00 Total allowable FTE count for the prior year.  15.00 Sum of lines 12 through 14 divided by 3.  16.00 Adjustment for residents in initial years of the program or hospital closure  18.00 Adjustment for residents in initial years of the program or hospital closure  18.00 Adjustment for residents in linitial years of the program or hospital closure  18.00 Adjustment for residents in linitial years of the program or hospital closure  18.00 Adjustment for residents in linitial years of the program or hospital closure  18.00 Adjustment for residents in linitial years of the program or hospital closure  18.00 Adjustment for resident in linitial years of the program or hospital closure  18.00 Adjustment for resident in linitial years of the program or hospital closure  18.00 Adjustment for resident in linitial years of the program or hospital closure  18.00 Adjustment for resident in linitial years of the program or hospital closure  18.00 Adjustment for residents displaced by program or hospital closure  18.00 Adjustment for residents in linitial years of the program or hosp     |        | affiliated programs in accordance with 42 CFR 413.75(b), 413.       | 79(c)(2)(iv), 64 FR 2634    | 10 (May 12,       |               |          |
| report straddles July 1, 2011, see instructions.   |        | 1998), and 67 FR 50069 (August 1, 2002).                            |                             |                   |               |          |
| S. 02  | 8. 01  | The amount of increase if the hospital was awarded FTE cap sl       | ots under § 5503 of the     | ACA. If the cost  | 0. 00         | 8. 01    |
| under \$ 5506 of ACA. (see instructions)   |        | report straddles July 1, 2011, 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   9.00   10.00   FTE count for all opathic and osteopathic programs in the current year from your records   0.00   10.00   11.00   FTE count for residents in dental and podiatric programs.   0.00   12.00   12.00   13.00   10.01   12.00   13.00   10.01          | 8.02   | The amount of increase if the hospital was awarded FTE cap sl       | ots from a closed teachi    | ng hospi tal      | 0. 00         | 8. 02    |
| Instructions   |        | under § 5506 of ACA. (see instructions)                             |                             |                   |               |          |
| 10.00   FTE count for allopathic and osteopathic programs in the current year from your records   0.00   10.00   | 9.00   | Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lin       | es (8, 8,01 and 8,02)       | (see              | 0. 00         | 9. 00    |
| 11.00   FTE count for residents in dental and podiatric programs.   0.00   11.00   11.00   12.00   12.00   13.00   10.00   12.00   13.00   10.01   10.00   13.00   10.00   13.00   10.00   1       |        | instructions)   |                             |                   |               |          |
| 12.00   Current year allowable FTE (see instructions)   0.00   12.00   13.00       | 10.00  | FTE count for allopathic and osteopathic programs in the curr       | ent year from your recor    | rds               | 0. 00         | 10.00    |
| 13.00   Total allowable FTE count for the prior year.   0.00   13.00   14.00   15.00   15.00   16.00       | 11.00  | FTE count for residents in dental and podiatric programs.           |                             |                   | 0.00          | 11. 00   |
| 14.00   Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.   15.00   Sum of lines 12 through 14 divided by 3.   0.00   15.00   Adjustment for residents in initial years of the program   0.00   16.00   16.00   Adjustment for residents displaced by program or hospital closure   0.00   17.00   18.00   Adjustment for residents displaced by program or hospital closure   0.00   18.00   Adjustment for residents displaced by program or hospital closure   0.00   18.00   19.00   1       | 12.00  | Current year allowable FTE (see instructions)                       |                             |                   | 0.00          | 12.00    |
| Otherwise enter zero.   Othe       | 13.00  | Total allowable FTE count for the prior year.                       |                             |                   | 0. 00         | 13.00    |
| 15.00   Sum of lines 12 through 14 divided by 3.   0.00   15.00   16       | 14.00  | Total allowable FTE count for the penultimate year if that ye       | ar ended on or after Sep    | otember 30, 1997, | 0. 00         | 14.00    |
| 16.00  |        | otherwise enter zero.   |                             |                   |               |          |
| 17.00  | 15.00  | Sum of lines 12 through 14 divided by 3.                            |                             |                   | 0.00          | 15. 00   |
| 18.00   Adjusted rolling average FTE count   0.00   18.00   19.00          | 16.00  | Adjustment for residents in initial years of the program            |                             |                   | 0. 00         | 16.00    |
| 18.00   Adjusted rolling average FTE count   0.00   18.00   19.00          | 17.00  | Adjustment for residents displaced by program or hospital clo       | sure                        |                   | 0.00          | 17.00    |
| 19.00   Current year resident to bed ratio (line 18 divided by line 4).   0.000000   19.00   20.00         | 18.00  | Adjusted rolling average FTE count                                  |                             |                   | 0.00          | 18. 00   |
| 21.00   Enter the lesser of lines 19 or 20 (see instructions)   0.000000   21.00     22.00   IME payment adjustment (see instructions)   0   22.00     IME payment adjustment - Managed Care (see instructions)   0   22.01     Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA     23.00   Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105   0.00   23.00     (f)(1)(iv)(c) .   |        |   | ).                          |                   | 0. 000000     | 19. 00   |
| 21.00   Enter the lesser of lines 19 or 20 (see instructions)   0.000000   21.00     22.00   IME payment adjustment (see instructions)   0   22.00     IME payment adjustment - Managed Care (see instructions)   0   22.01     Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA     23.00   Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105   0.00   23.00     (f)(1)(iv)(c) .   | 20.00  | Prior year resident to bed ratio (see instructions)                 | •                           |                   | 0. 000000     | 20.00    |
| 22.00 IME payment adjustment (see instructions)  1   |        | ,                             |                             |                   |               |          |
| 22. 01   IME payment adjustment - Managed Care (see instructions)   0   22. 01   Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA   23. 00   0   0   0   0   0   0   0   0   0  |        |   |                             |                   |               |          |
| Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA  23.00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 0.00 (f) (1) (iv) (C).  24.00 IME FTE Resident Count Over Cap (see instructions) 0.00 24.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see 0.00 25.00 instructions)  26.00 Resident to bed ratio (divide line 25 by line 4) 0.000000 26.00 27.00 IME payments adjustment factor. (see instructions) 0.000000 27.00 IME payments adjustment amount (see instructions) 0.28.01 IME add-on adjustment amount (see instructions) 0.28.01 IME add-on adjustment amount - Managed Care (see instructions) 0.28.01 Total IME payment (sum of lines 22 and 28) 0.29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) 0.29.01 Disproportionate Share Adjustment  30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 3.04 0.00 24.00 24.61 32.00 33.00 Allowable disproportionate share percentage (see instructions) 9.52 33.00  |        | IME payment adjustment - Managed Care (see instructions)            |                             |                   |               |          |
| Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105  23.00  (f)(1)(iv)(C).  24.00  IME FTE Resident Count Over Cap (see instructions)  1If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)  26.00  Resident to bed ratio (divide line 25 by line 4)  27.00  IME payments adjustment factor. (see instructions)  1ME add-on adjustment amount (see instructions)  28.00  IME add-on adjustment amount - Managed Care (see instructions)  29.00  Total IME payment (sum of lines 22 and 28)  Total IME payment - Managed Care (sum of lines 22.01 and 28.01)  Disproportionate Share Adjustment  30.00  Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)  31.00  Sum of lines 30 and 31  Allowable disproportionate share percentage (see instructions)  9.52  33.00   |        |   | 2 of the MMA                |                   | -             |          |
| (f)(1)(iv)(C).  24.00   IME FTE Resident Count Over Cap (see instructions) 25.00   If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions) 26.00   Resident to bed ratio (divide line 25 by line 4) 27.00   IME payments adjustment factor. (see instructions) 28.00   IME add-on adjustment amount (see instructions) 28.01   IME add-on adjustment amount (see instructions) 29.00   Total IME payment (sum of lines 22 and 28) 29.01   Total IME payment - Managed Care (see instructions) 30.00   Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 31.00   Percentage of Medicaid patient days (see instructions) 32.00   Sum of lines 30 and 31   24.61 32.00   33.00   Allowable disproportionate share percentage (see instructions) 32.00   Allowable disproportionate share percentage (see instructions) 32.00   Percentage of SSI recipient patient days (see instructions) 33.00   Allowable disproportionate share percentage (see instructions) 34.00   Percentage of Medicaid patient days (see instructions) 35.00   Allowable disproportionate share percentage (see instructions)   | 23. 00 |   |                             | CFR 412, 105      | 0.00          | 23. 00   |
| 24.00 IME FTE Resident Count Over Cap (see instructions)  25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see 0.00 25.00 instructions)  26.00 Resident to bed ratio (divide line 25 by line 4)  27.00 IME payments adjustment factor. (see instructions)  28.00 IME add-on adjustment amount (see instructions)  28.01 IME add-on adjustment amount - Managed Care (see instructions)  29.00 Total IME payment (sum of lines 22 and 28)  29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01)  Disproportionate Share Adjustment  30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)  31.00 Percentage of Medicaid patient days (see instructions)  32.00 Sum of lines 30 and 31  33.00 Allowable disproportionate share percentage (see instructions)  9.52 33.00   |        | i i   |                             |                   |               |          |
| 25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see  0.00 instructions)  26.00 Resident to bed ratio (divide line 25 by line 4)  27.00 IME payments adjustment factor. (see instructions)  28.00 IME add-on adjustment amount (see instructions)  28.01 IME add-on adjustment amount - Managed Care (see instructions)  29.00 Total IME payment (sum of lines 22 and 28)  29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01)  Disproportionate Share Adjustment  30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)  31.00 Percentage of Medicaid patient days (see instructions)  32.00 Sum of lines 30 and 31  33.00 Allowable disproportionate share percentage (see instructions)  9.52 33.00  | 24.00  |   |                             |                   | 0.00          | 24.00    |
| instructions   Resident to bed ratio (divide line 25 by line 4)   0.000000   26.00     26.00   IME payments adjustment factor. (see instructions)   0.000000   27.00     28.00   IME add-on adjustment amount (see instructions)   0.28.00     28.01   IME payment (sum of lines 22 and 28)   0.29.00     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)   0.29.01     29.01   Disproportionate Share Adjustment     29.01   Disproportionate Share Adjustment     29.01   Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)   3.04   30.00     31.00   Percentage of Medicaid patient days (see instructions)   21.57   31.00     32.00   Sum of lines 30 and 31   24.61   32.00     33.00   Allowable disproportionate share percentage (see instructions)   9.52   33.00  |        | . ,   | lower of line 23 or line    | e 24 (see         |               |          |
| 26.00       Resident to bed ratio (divide line 25 by line 4)       0.000000       26.00         27.00       IME payments adjustment factor. (see instructions)       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)       0       29.01         Disproportionate Share Adjustment       29.01         30.00       Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)       3.04       30.00         31.00       Percentage of Medicaid patient days (see instructions)       21.57       31.00         32.00       Sum of lines 30 and 31       24.61       32.00         33.00       Allowable disproportionate share percentage (see instructions)       9.52       33.00   |        |   |                             | (                 |               |          |
| 27. 00       IME payments adjustment factor. (see instructions)       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       Disproportionate Share Adjustment       29. 01         30. 00       Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)       3. 04       30. 00         31. 00       Percentage of Medicaid patient days (see instructions)       21. 57       31. 00         32. 00       Sum of lines 30 and 31       24. 61       32. 00         33. 00       Allowable disproportionate share percentage (see instructions)       9. 52       33. 00   | 26 00  |   |                             |                   | 0 000000      | 26 00    |
| 28.00 IME add-on adjustment amount (see instructions)  28.01 IME add-on adjustment amount - Managed Care (see instructions)  29.00 IME add-on adjustment amount - Managed Care (see instructions)  29.01 Total IME payment (sum of lines 22 and 28)  29.01 Disproportionate Share Adjustment  30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)  30.00 Percentage of Medicaid patient days (see instructions)  31.00 Sum of lines 30 and 31  32.00 Allowable disproportionate share percentage (see instructions)  32.00 Allowable disproportionate share percentage (see instructions)  32.00 Allowable disproportionate share percentage (see instructions)  32.00 Sum of lines 30 and 31  |        | , , , , , , , , , , , , , , , , , , ,                               |                             |                   |               |          |
| 28. 01 IME add-on adjustment amount - Managed Care (see instructions)  29. 00 Total IME payment (sum of lines 22 and 28)  29. 01 Disproportionate Share Adjustment  30. 00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)  31. 00 Percentage of Medicaid patient days (see instructions)  32. 00 Sum of lines 30 and 31  33. 00 Allowable disproportionate share percentage (see instructions)  9. 52 33. 00  |        |   |                             |                   |               |          |
| 29.00 Total IME payment (sum of lines 22 and 28) 0 29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) 0 29.01 Disproportionate Share Adjustment - Managed Care (sum of lines 22.01 and 28.01) 0 29.01   |        |   | )                           |                   |               |          |
| 29. 01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01)  30. 00 Disproportionate Share Adjustment  Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)  31. 00 Percentage of Medicaid patient days (see instructions)  32. 00 Sum of lines 30 and 31  33. 00 Allowable disproportionate share percentage (see instructions)  30. 01 29. 01  30. 02 30. 00  31. 00 32. 00  32. 00 Allowable disproportionate share percentage (see instructions)  33. 04 30. 00  34. 05 30. 06 30.     |        | · · · · · · · · · · · · · · · · · · ·                               | ,                           |                   |               |          |
| Disproportionate Share Adjustment  30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)  31.00 Percentage of Medicaid patient days (see instructions)  32.00 Sum of lines 30 and 31  33.00 Allowable disproportionate share percentage (see instructions)  30.00 Percentage of Medicaid patient days (see instructions)  31.00 Sum of lines 30 and 31  32.00 Percentage of Medicaid patient days (see instructions)  32.00 Sum of lines 30 and 31  33.00 Allowable disproportionate share percentage (see instructions)  30.00 Percentage of Medicaid patient days (see instructions)  30.00 Percentage of Medicaid patient days (see instructions)  30.00 Percentage of Medicaid patient days (see instructions)  31.00 Percentage of Medicaid patient days (see instructions)  31.00 Percentage of Medicaid patient days (see instructions)  32.00 Sum of lines 30 and 31  33.00 Percentage of Medicaid patient days (see instructions)   |        |   | 1)                          |                   |               |          |
| 30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 31.00 Percentage of Medicaid patient days (see instructions) 32.00 Sum of lines 30 and 31 33.00 Allowable disproportionate share percentage (see instructions) 3.04 30.00 21.57 31.00 24.61 32.00 33.00 Allowable disproportionate share percentage (see instructions) 9.52 33.00  | Z7. U1 |   |                             |                   | U             | Z 7. U I |
| 31.00 Percentage of Medicaid patient days (see instructions) 21.57 31.00 32.00 Sum of lines 30 and 31 24.61 32.00 33.00 Allowable disproportionate share percentage (see instructions) 9.52 33.00  | 30 00  |   | atient days (see instru     | ctions)           | 2 04          | 30 00    |
| 32.00 Sum of lines 30 and 31 24.61 32.00 Allowable disproportionate share percentage (see instructions) 9.52 33.00   |        |   | arrent days (see firstfuc   | LI UIIS)          |               |          |
| 33.00 Allowable disproportionate share percentage (see instructions) 9.52 33.00  |        |   |                             |                   |               |          |
|  |        |   | `                           |                   |               |          |
| 34. 00   Di spi opoi tronate snare auj ustillent (see l'instructions)  |        |   | )                           |                   |               |          |
|  | 34.00  | pri spri opor ti ona te isna re laujus tillent (See Tristructi ons) |                             | I                 | 207, 514      | 34.00    |

| ALCUL   | ATION OF REIMBURSEMENT SETTLEMENT  | Provi der CCN: 15-0097   | Peri od:                         | Worksheet E                 |  |
|---|--|--|----------------------------------|-----------------------------|--|
|   |  |  | From 01/01/2020<br>To 12/31/2020 |                             | pared:   |
|   |  | Title XVIII  | Hospi tal                        | PPS                         | рш   |
|   |  |  | Prior to 10/1                    |                             |  |
|   | Ille a sure and a company of the com |  | 1. 00                            | 2. 00                       |  |
| 5. 00   | Uncompensated Care Adjustment Total uncompensated care amount (see instructions)   |  | 8 350 599 096                    | 8, 290, 014, 521            | 35. 00   |
| 5. 01   | Factor 3 (see instructions)  |  | 0. 000158965                     |                             | 35. 01   |
| 5. 02   | Hospital uncompensated care payment (If line 34 is zero, einstructions)  | nter zero on this line) (se  | ee 1, 327, 454                   | 1, 160, 779                 | 35. 02   |
| 5. 03<br>6. 00  | Total uncompensated care (sum of columns 1 and 2 on line 3   | 5. 03)   | 993, 777                         |                             | 35. 03<br>36. 00   |
| 0. 00   | Additional payment for high percentage of ESRD beneficiary Total Medicare discharges, excluding MS-DRGs 652, 682, 683  |  | ugn 46)                          |                             | 40. 00   |
| 0. 00   | instructions)  | , 661 and 666. (566  |                                  |                             | 10.00  |
| 1. 00   | Total ESRD Medicare discharges excluding MS-DRGs 652, 682 instructions)  | •  | 0                                |                             | 41. 00   |
|   | Total ESRD Medicare covered and paid discharges excluding an 685. (see instructions)   |  |                                  |                             | 41. 01   |
| 2.00  | Divide line 41 by line 40 (if less than 10%, you do not qu<br>Total Medicare ESRD inpatient days excluding MS-DRGs 652,  |  | 0.00                             |                             | 42. 00<br>43. 00   |
| 4. 00   | instructions) Ratio of average length of stay to one week (line 43 divid   | •  | 0. 000000                        |                             | 44.00  |
| 5. 00   | days) Average weekly cost for dialysis treatments (see instructi   | ons)   | 0.00                             |                             | 45. 00   |
| 6. 00   | Total additional payment (line 45 times line 44 times line   |  | 0                                |                             | 46. 00   |
| 7.00  | Subtotal (see instructions)  |  | 10, 324, 855                     |                             | 47.00  |
| 8. 00   | Hospital specific payments (to be completed by SCH and MDH only. (see instructions)  | , smail rurai nospitais  | 0                                |                             | 48. 00   |
|   |  |  |                                  | Amount<br>1.00              |  |
| 9. 00   | Total payment for inpatient operating costs (see instructi   | ons)   |                                  | 10, 324, 855                | 49. 00   |
| 0. 00   | Payment for inpatient program capital (from Wkst. L, Pt. I   | and Pt. II, as applicable  | )                                | 672, 693                    | 50.00  |
| 1.00  | Exception payment for inpatient program capital (Wkst. L,  |  |                                  | 0                           | 51.00  |
| 2.00  | Direct graduate medical education payment (from Wkst. E-4, Nursing and Allied Health Managed Care payment  | Title 49 See Thistructions).   |                                  | 0                           | 52. 00<br>53. 00   |
| 4. 00   | Special add-on payments for new technologies   |  |                                  | Ö                           | 54.00  |
| 4. 01   | 1 3  |  |                                  | 0                           | 54. 01   |
| 5.00  | Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, lin   | · ·  |                                  | 0                           | 55.00  |
| 6. 00<br>7. 00  | Cost of physicians' services in a teaching hospital (see i<br>Routine service other pass through costs (from Wkst. D, Pt   |  | through 35)                      | 0                           | 56. 00<br>57. 00   |
| 8. 00   | Ancillary service other pass through costs from Wkst. D, P   | · · · · · · · · · · · · · · · · · · ·  | till odgir 55).                  | 0                           | 58.00  |
| 9. 00   | Total (sum of amounts on lines 49 through 58)  | •  |                                  | 10, 997, 548                | 59.00  |
| 0.00  | Primary payer payments   |  |                                  | 7, 531                      | 60.00  |
| 1.00  | Total amount payable for program beneficiaries (line 59 mi Deductibles billed to program beneficiaries   | nus line 60)   |                                  | 10, 990, 017<br>1, 072, 544 | 61. 00<br>62. 00   |
|   | 1 9  |  |                                  | 5, 984                      |  |
| 3. UU   | Allowable bad debts (see instructions)   |  |                                  | 120, 117                    |  |
| 3. 00<br>4. 00  | Adjusted reimbursable bad debts (see instructions)   |  |                                  | 78, 076                     | 65.00  |
|   | Allowable bad debts for dual eligible beneficiaries (see i   | nstructions)   |                                  | 51, 307                     | 66.00  |
| 4. 00<br>5. 00<br>6. 00   | · ·  |  |                                  | 9, 989, 565                 | 67. 00<br>68. 00   |
| 4. 00<br>5. 00<br>6. 00<br>7. 00  | Subtotal (line 61 plus line 65 minus lines 62 and 63)  | for applicable to MS DDCs (  |                                  | 0                           |  |
| 4. 00<br>5. 00<br>6. 00<br>7. 00<br>8. 00   | Subtotal (line 61 plus line 65 minus lines 62 and 63)<br>Credits received from manufacturers for replaced devices f  |  |                                  | 0                           |  |
| 4. 00<br>5. 00<br>6. 00<br>7. 00  | Subtotal (line 61 plus line 65 minus lines 62 and 63)  |  |                                  | 0                           | 69.00<br>70.00   |
| 4. 00<br>5. 00<br>6. 00<br>7. 00<br>8. 00<br>9. 00<br>0. 00<br>0. 50  | Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices f Outlier payments reconciliation (sum of lines 93, 95 and 9 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demo  | 6).(For SCH see instruction nstration) adjustment (see   | ns)                              | 0                           | 70. 00<br>70. 50   |
| 4. 00<br>5. 00<br>6. 00<br>7. 00<br>8. 00<br>9. 00<br>0. 00<br>0. 50<br>0. 87   | Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices f Outlier payments reconciliation (sum of lines 93, 95 and 9 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demo Demonstration payment adjustment amount before sequestrati   | <ol> <li>(For SCH see instruction nstration) adjustment (see on</li> </ol>                                   | ns)                              | 0                           | 70. 00<br>70. 50<br>70. 87   |
| 4. 00<br>5. 00<br>6. 00<br>7. 00<br>8. 00<br>9. 00<br>0. 00<br>0. 50<br>0. 87<br>0. 88  | Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices f Outlier payments reconciliation (sum of lines 93, 95 and 9 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demo Demonstration payment adjustment amount before sequestrati SCH or MDH volume decrease adjustment (contractor use only  | <ol> <li>(For SCH see instruction<br/>nstration) adjustment (see<br/>on</li> </ol>                           | ns)                              | 0                           | 70. 00<br>70. 50<br>70. 87<br>70. 88   |
| 4. 00<br>5. 00<br>6. 00<br>7. 00<br>8. 00<br>9. 00<br>0. 00<br>0. 50<br>0. 87<br>0. 88<br>0. 89                                     | Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices f Outlier payments reconciliation (sum of lines 93, 95 and 9 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demo Demonstration payment adjustment amount before sequestrati SCH or MDH volume decrease adjustment (contractor use only Pioneer ACO demonstration payment adjustment amount (see i   | <ol> <li>(For SCH see instruction)</li> <li>nstration) adjustment (see on )</li> <li>nstructions)</li> </ol> | ns)                              | 0 0 0                       | 70. 00<br>70. 50<br>70. 87<br>70. 88<br>70. 89                               |
| 4. 00<br>5. 00<br>6. 00<br>7. 00<br>8. 00<br>9. 00<br>0. 00<br>0. 50<br>0. 87<br>0. 88  | Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices f Outlier payments reconciliation (sum of lines 93, 95 and 9 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demo Demonstration payment adjustment amount before sequestrati SCH or MDH volume decrease adjustment (contractor use only  | <ol> <li>(For SCH see instruction)</li> <li>nstration) adjustment (see on )</li> <li>nstructions)</li> </ol> | ns)                              | 0                           | 70. 00<br>70. 50<br>70. 87<br>70. 88<br>70. 89                               |
| 4. 00<br>5. 00<br>6. 00<br>7. 00<br>8. 00<br>9. 00<br>0. 00<br>0. 50<br>0. 87<br>0. 88<br>0. 89<br>0. 90                            | Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices f Outlier payments reconciliation (sum of lines 93, 95 and 9 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demo Demonstration payment adjustment amount before sequestrati SCH or MDH volume decrease adjustment (contractor use only Pioneer ACO demonstration payment adjustment amount (see i HSP bonus payment HVBP adjustment amount (see instructions)   | <ol> <li>(For SCH see instruction)</li> <li>nstration) adjustment (see on )</li> <li>nstructions)</li> </ol> | ns)                              | 0<br>0<br>0<br>0            | 70. 00<br>70. 50<br>70. 87   |
| 4. 00<br>5. 00<br>6. 00<br>7. 00<br>8. 00<br>9. 00<br>0. 00<br>0. 50<br>0. 87<br>0. 88<br>0. 89<br>0. 90<br>0. 91<br>0. 92<br>0. 93 | Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices f Outlier payments reconciliation (sum of lines 93, 95 and 9 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demo Demonstration payment adjustment amount before sequestrati SCH or MDH volume decrease adjustment (contractor use only Pioneer ACO demonstration payment adjustment amount (see i HSP bonus payment HVBP adjustment amount (see instructions) HSP bonus payment HRR adjustment amount (see instructions) Bundled Model 1 discount amount (see instructions)   | <ol> <li>(For SCH see instruction)</li> <li>nstration) adjustment (see on )</li> <li>nstructions)</li> </ol> | ns)                              | 0<br>0<br>0<br>0            | 70. 00<br>70. 50<br>70. 87<br>70. 88<br>70. 99<br>70. 91<br>70. 92<br>70. 93 |

| 96.00 Time value of money for capital related expenses (see instructions)   |                    | 0             | 96.00              |
|---|--------------------|---------------|--------------------|
|   | Prior to 10/1      | On/After 10/1 |                    |
|   | 1. 00              | 2. 00         |                    |
| HSP Bonus Payment Amount  |                    |               |                    |
| 100.00 HSP bonus amount (see instructions)  | 0                  | 0             | 100. 00            |
| HVBP Adjustment for HSP Bonus Payment   |                    |               |                    |
| 101.00 HVBP adjustment factor (see instructions)  | 0. 0000000000      | l .           |                    |
| 102.00 HVBP adjustment amount for HSP bonus payment (see instructions)  | 0                  | 0             | 102. 00            |
| HRR Adjustment for HSP Bonus Payment  |                    |               |                    |
| 103.00 HRR adjustment factor (see instructions)   | 0. 0000            |               |                    |
| 104.00 HRR adjustment amount for HSP bonus payment (see instructions)   | 0                  | 0             | 104. 00            |
| Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment   |                    |               |                    |
| 200.00 Is this the first year of the current 5-year demonstration period under the 21st   |                    |               | 200.00             |
| Century Cures Act? Enter "Y" for yes or "N" for no.   |                    |               |                    |
| Cost Reimbursement  |                    |               |                    |
| 201.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)   |                    |               | 201.00             |
| 202.00 Medicare discharges (see instructions)   |                    |               | 202. 00            |
| 203.00 Case-mix adjustment factor (see instructions)  |                    |               | 203. 00            |
| Computation of Demonstration Target Amount Limitation (N/A in first year of the curr  | rent 5-year demons | strati on     |                    |
| peri od)  |                    |               | 004.00             |
| 204.00 Medicare target amount   |                    |               | 204.00             |
| 205. 00 Case-mix adjusted target amount (line 203 times line 204)   |                    |               | 205.00             |
| 206.00 Medicare inpatient routine cost cap (line 202 times line 205)  |                    |               | 206. 00            |
| Adjustment to Medicare Part A Inpatient Reimbursement   |                    |               | 007.00             |
| 207.00 Program reimbursement under the §410A Demonstration (see instructions)   |                    |               | 207.00             |
| 208.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)   |                    |               | 208.00             |
| 209.00 Adjustment to Medicare IPPS payments (see instructions)  |                    | l .           | 209.00             |
| 210.00 Reserved for future use  |                    |               | 210.00             |
| 211. 00 Total adjustment to Medicare IPPS payments (see instructions)   |                    |               | 211. 00            |
| Comparision of PPS versus Cost Reimbursement  |                    |               | 1212 00            |
| 212.00 Total adjustment to Medicare Part A IPPS payments (from line 211)  |                    |               | 212. 00<br>213. 00 |
| 213.00 Low-volume adjustment (see instructions)   |                    | l .           | 213.00             |
| 218.00 Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions) |                    |               | 218.00             |
| (Title 212 millus Title 213) (See Thistructions)  |                    | 1             | 1                  |

Provider CCN: 15-0097 Peri od: Worksheet E From 01/01/2020 Part A Exhibit 4 To 12/31/2020 Date/Time Prepared: 8/2/2021 2:11 pm

|                  |   |                         |                          |                         | 10                       | 12/31/2020          | 8/2/2021 2:11              |        |
|------------------|---|-------------------------|--------------------------|-------------------------|--------------------------|---------------------|----------------------------|--------|
|                  |   | lw (0 5 5               |                          |                         | XVIII                    | Hospi tal           | PPS                        |        |
|                  |   | W/S E, Part A<br>  line | Amounts (from E, Part A) | Pre/Post<br>Entitlement | Period Prior<br>to 10/01 | Peri od<br>On/After | Total (Col 2<br>through 4) |        |
|                  |   | Title                   | E, rait A)               | LITTI TI CINCITE        | 10 10/01                 | 10/01               | till odgir 4)              |        |
|                  |   | 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                   | 5, 958, 381              | 0                       | 5, 958, 381              |                     | 5, 958, 381                | 1. 01  |
| 1. 02            | occurring prior to October 1 DRG amounts other than outlier payments for discharges occurring on or after October | 1. 02                   | 2, 760, 658              | 0                       |                          | 2, 760, 658         | 2, 760, 658                | 1. 02  |
| 1. 03            | 1<br>DRG for Federal specific<br>operating payment for Model 4<br>BPCI occurring prior to                         | 1. 03                   | 0                        | 0                       | 0                        |                     | 0                          | 1. 03  |
| 1. 04            | October 1 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                   |                          |                         |                          |                     |                            | 2.00   |
| 2. 01            | Outlier payments for discharges for Model 4 BPCI  | 2. 02                   | 0                        | 0                       | 0                        | 0                   | 0                          | 2. 01  |
| 2. 02            | Outlier payments for discharges occurring prior to  | 2. 03                   | 82, 920                  | 0                       | 82, 920                  |                     | 82, 920                    | 2. 02  |
| 2. 03            | October 1 (see instructions) Outlier payments for discharges occurring on or after October 1 (see                 | 2. 04                   | 29, 025                  | 0                       |                          | 29, 025             | 29, 025                    | 2.03   |
| 3. 00            | instructions) Operating outlier   | 2. 01                   | 0                        | 0                       | 0                        | 0                   | 0                          | 3. 00  |
| 4. 00            | reconciliation Managed care simulated payments  | 3. 00                   | 0                        | 0                       | 0                        | 0                   | 0                          | 4. 00  |
|                  | Indirect Medical Education Adj  | ustment                 |                          |                         |                          |                     |                            |        |
| 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  | 22. 01                  | 0                        | 0                       | 0                        | 0                   | 0                          | 6. 01  |
|                  | instructions) Indirect Medical Education Adj  | L<br>ustment for the    | e Add-on for Se          | ection 422 of 1         | the MMA                  |                     |                            | 1      |
| 7. 00            | IME payment adjustment factor (see instructions)  | 27. 00                  | 0. 000000                | 0. 000000               | 0. 000000                | 0. 000000           |                            | 7.00   |
| 8. 00            | IME adjustment (see instructions)   | 28. 00                  | 0                        | 0                       | 0                        | 0                   | 0                          | 8. 00  |
| 8. 01            | IME payment adjustment add on for managed care (see   | 28. 01                  | 0                        | 0                       | 0                        | 0                   | 0                          | 8. 01  |
| 9. 00            | <pre>instructions) Total IME payment (sum of lines 6 and 8)</pre>   | 29. 00                  | 0                        | 0                       | 0                        | 0                   | 0                          | 9. 00  |
| 9. 01            | Total IME payment for managed care (sum of lines 6.01 and   | 29. 01                  | 0                        | 0                       | 0                        | 0                   | 0                          | 9. 01  |
|                  | 8.01)   | ont                     |                          |                         |                          |                     |                            | 1      |
| 10. 00           | Disproportionate Share Adjustm<br>Allowable disproportionate<br>share percentage (see                             | 33. 00                  | 0. 0952                  | 0. 0952                 | 0. 0952                  | 0. 0952             |                            | 10.00  |
| 11. 00           | instructions)<br>Disproportionate share   | 34. 00                  | 207, 514                 | 0                       | 141, 810                 | 65, 704             | 207, 514                   | 11.00  |
| 11. 01           | adjustment (see instructions)<br>Uncompensated care payments  | 36. 00                  | 1, 286, 357              | 0                       | 993, 777                 | 292, 580            | 1, 286, 357                | 11. 01 |
| 12.00            | Additional payment for high pe<br>Total ESRD additional payment   |                         | RD beneficiary           |                         |                          |                     | ^                          | 12.00  |
| 12. 00<br>13. 00 | (see instructions) Subtotal (see instructions)  | 46. 00<br>47. 00        | 0<br>10, 324, 855        | 0                       | 0<br>7, 176, 888         | 0<br>3, 147, 967    | 0<br>10, 324, 855          |        |
| 14. 00           | Hospital specific payments<br>(completed by SCH and MDH,<br>small rural hospitals only.)                          | 48. 00                  | 0                        | 0                       | 0                        | 0                   | 0                          | 14.00  |
| 15. 00           | (see instructions) Total payment for inpatient operating costs (see instructions)                                 | 49. 00                  | 10, 324, 855             | 0                       | 7, 176, 888              | 3, 147, 967         | 10, 324, 855               | 15. 00 |
|                  |   |                         | ,                        |                         | '                        | '                   |                            |        |

|                  | ZEUME CAEGUEATION EATHBIT 4  |                       |                          | Trovider C              |                          | From 01/01/2020<br>To 12/31/2020 |                            | pared:           |
|------------------|--|-----------------------|--------------------------|-------------------------|--------------------------|----------------------------------|----------------------------|------------------|
|                  |  |                       |                          | Title                   | XVIII                    | Hospi tal                        | PPS                        |                  |
|                  |  | W/S E, Part A<br>line | Amounts (from E, Part A) | Pre/Post<br>Entitlement | Period Prior<br>to 10/01 | Peri od<br>On/After<br>10/01     | Total (Col 2<br>through 4) |                  |
|                  |  | 0                     | 1.00                     | 2. 00                   | 3.00                     | 4. 00                            | 5. 00                      |                  |
| 16. 00           | Payment for inpatient program  | 50.00                 | 672, 693                 | 0                       | 473, 70                  |                                  | 672, 693                   | 16. 00           |
| 17. 00           | capital (from Wkst. L, Pt. I, if applicable) Special add-on payments for                     | 54. 00                | O                        | 0                       |                          |                                  | 0                          | 17. 00           |
|                  | new technologies   | 54.00                 | U                        | U                       | '                        | J                                | 0                          |                  |
| 17. 01           | Net organ aquisition cost  | 40.00                 | 0                        | 0                       |                          |                                  | _                          | 17. 01           |
| 17. 02           | Credits received from manufacturers for replaced devices for applicable MS-DRGs              | 68. 00                | 0                        | 0                       | '                        | 0                                | 0                          | 17. 02           |
| 18. 00           | Capital outlier reconciliation adjustment amount (see instructions)                          |                       | O                        | 0                       | 1                        | 0                                | О                          | 18. 00           |
| 19.00            | SUBTOTAL   |                       |                          | 0                       | 7, 650, 59               | 2 3, 346, 956                    | 10, 997, 548               | 19.00            |
|                  |  | W/S L, line           | (Amounts from L)         |                         |                          |                                  |                            |                  |
|                  |  | 0                     | 1. 00                    | 2.00                    | 3.00                     | 4. 00                            | 5. 00                      |                  |
| 20.00            | Capital DRG other than outlier   | 1.00                  | 665, 282                 | 0                       | 466, 32                  | 9 198, 953                       | 665, 282                   | 20.00            |
| 20. 01           | Model 4 BPCI Capital DRG other than outlier  | 1. 01                 | 0                        | 0                       |                          | 0                                | 0                          |                  |
| 21.00            | Capital DRG outlier payments   | 2. 00                 | 7, 411                   | 0                       | 7, 37                    | 5 36                             | 7, 411                     | 21.00            |
| 21. 01           | Model 4 BPCI Capital DRG outlier payments  | 2. 01                 | 0                        | 0                       |                          | 0                                | 0                          | 21.01            |
| 22. 00           | Indirect medical education percentage (see instructions)                                     | 5. 00                 | 0. 0000                  | 0. 0000                 | 0. 000                   | 0.0000                           |                            | 22. 00           |
| 23. 00           | Indirect medical education adjustment (see instructions)                                     | 6. 00                 | 0                        | 0                       |                          | 0                                | 0                          | 23. 00           |
| 24. 00           | Allowable disproportionate share percentage (see instructions)                               | 10.00                 | 0. 0000                  | 0. 0000                 | 0.000                    | 0.0000                           |                            | 24.00            |
| 25. 00           | Disproportionate share adjustment (see instructions)   | 11. 00                | 0                        | 0                       |                          | 0                                | 0                          | 25. 00           |
| 26. 00           | Total prospective capital payments (see instructions)  | 12. 00                | 672, 693                 | 0                       | 473, 70                  | 198, 989                         | 672, 693                   | 26. 00           |
|                  |  | W/S E, Part A         | (Amounts to              |                         |                          |                                  |                            |                  |
|                  |  | line                  | E, Part A)               |                         |                          |                                  |                            |                  |
|                  | 1  | 0                     | 1. 00                    | 2. 00                   | 3.00                     | 4. 00                            | 5. 00                      |                  |
| 27. 00<br>28. 00 | Low volume adjustment factor Low volume adjustment (transfer amount to Wkst. E, Pt. A, line) | 70. 96                |                          |                         | 0. 07962<br>609, 14      |                                  | 609, 148                   | 27. 00<br>28. 00 |
| 29. 00           | Low volume adjustment<br>(transfer amount to Wkst. E,<br>Pt. A, line)                        | 70. 97                |                          |                         |                          | 233, 273                         | 233, 273                   | 29. 00           |
| 100.00           | Transfer low volume<br>adjustments to Wkst. E, Pt. A.  |                       | Y                        |                         |                          |                                  |                            | 100.00           |

Health Financial SystemsMAJOR HOSEHOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 Provider CCN: 15-0097

|                  |   |                         |                                 | 10                 | ) 12/31/2020             | 8/2/2021 2:11            |                  |
|------------------|---|-------------------------|---------------------------------|--------------------|--------------------------|--------------------------|------------------|
|                  |   |                         | Title                           | XVIII              | Hospi tal                | PPS                      |                  |
|                  |   | Wkst. E, Pt.<br>A, line | Amt. from<br>Wkst. E, Pt.<br>A) | Period to<br>10/01 | Period on<br>after 10/01 | Total (cols.<br>2 and 3) |                  |
|                  |   | 0                       | 1.00                            | 2.00               | 3. 00                    | 4. 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 | 1. 00<br>1. 01          | 5, 958, 381                     | 5, 958, 381        |                          | 5, 958, 381              | 1. 00<br>1. 01   |
| 1. 02            | DRG amounts other than outlier payments for discharges occurring on or after October 1                                      | 1. 02                   | 2, 760, 658                     |                    | 2, 760, 658              | 2, 760, 658              | 1. 02            |
| 1. 03            | DRG for Federal specific operating payment<br>for Model 4 BPCI occurring prior to October                                   | 1. 03                   | O                               | 0                  |                          | 0                        | 1. 03            |
| 1. 04            | DRG for Federal specific operating payment<br>for Model 4 BPCI occurring on or after<br>October 1                           | 1. 04                   | 0                               |                    | 0                        | 0                        | 1. 04            |
| 2. 00            | Outlier payments for discharges (see instructions)  | 2. 00                   |                                 |                    |                          |                          | 2. 00            |
| 2. 01            | Outlier payments for discharges for Model 4<br>BPCI   | 2. 02                   | 0                               | 0                  | 0                        | 0                        | 2. 01            |
| 2. 02            | Outlier payments for discharges occurring prior to October 1 (see instructions)   | 2. 03                   | 82, 920                         | 82, 920            |                          | 82, 920                  | 2. 02            |
| 2. 03            | Outlier payments for discharges occurring on or after October 1 (see instructions)  |                         | 29, 025                         |                    | 29, 025                  | 29, 025                  | 2. 03            |
| 3. 00<br>4. 00   | Operating outlier reconciliation Managed care simulated payments  | 2. 01<br>3. 00          | 0                               | 0<br>0             | 0                        | 0                        | 3. 00<br>4. 00   |
| 5. 00            | Indirect Medical Education Adjustment Amount from Worksheet E, Part A, line 21 (see instructions)                           | 21. 00                  | 0. 000000                       | 0. 000000          | 0. 000000                |                          | 5. 00            |
| 6. 00            | IME payment adjustment (see instructions)   | 22. 00                  | 0                               | 0                  | o                        | 0                        | 6. 00            |
| 6. 01            | IME payment adjustment for managed care (see instructions)  |                         | 0                               | 0                  | 0                        | 0                        | 6. 01            |
| 7.00             | Indirect Medical Education Adjustment for the   |                         |                                 |                    |                          |                          | 7.00             |
| 7. 00            | IME payment adjustment factor (see instructions)  | 27. 00                  | 0. 000000                       | 0. 000000          | 0. 000000                |                          | 7. 00            |
| 8.00             | IME adjustment (see instructions)   | 28. 00                  | 0                               | 0                  | o                        | 0                        | 8. 00            |
| 8. 01            | IME payment adjustment add on for managed care (see instructions)   | 28. 01                  | 0                               | 0                  | 0                        | 0                        | 8. 01            |
| 9. 00<br>9. 01   | Total IME payment (sum of lines 6 and 8) Total IME payment for managed care (sum of lines 6.01 and 8.01)                    | 29. 00<br>29. 01        | 0                               | 0                  | 0<br>0                   | 0                        | 9. 00<br>9. 01   |
|                  | Disproportionate Share Adjustment   |                         |                                 |                    |                          |                          |                  |
| 10. 00           | Allowable disproportionate share percentage   | 33. 00                  | 0. 0952                         | 0. 0952            | 0. 0952                  |                          | 10. 00           |
| 11. 00           | (see instructions) Disproportionate share adjustment (see instructions)   | 34. 00                  | 207, 514                        | 141, 810           | 65, 704                  | 207, 514                 | 11. 00           |
| 11. 01           | Uncompensated care payments   | 36. 00                  | 1, 286, 357                     | 993, 777           | 292, 580                 | 1, 286, 357              | 11. 01           |
|                  | Additional payment for high percentage of ESF   |                         | di scharges                     |                    |                          |                          |                  |
| 12. 00           | Total ESRD additional payment (see instructions)  | 46. 00                  | 0                               | 0                  | 0                        | 0                        | 12. 00           |
| 13.00            | Subtotal (see instructions)   | 47. 00                  | 10, 324, 855                    | 7, 176, 888        | 3, 147, 967              | 10, 324, 855             | 13.00            |
| 14. 00           | Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see                                     | 48. 00                  | 0                               | 0                  | 0                        | 0                        | 14. 00           |
| 15. 00           | instructions) Total payment for inpatient operating costs (see instructions)  | 49. 00                  | 10, 324, 855                    | 7, 176, 888        | 3, 147, 967              | 10, 324, 855             | 15. 00           |
| 16. 00           | Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)  | 50. 00                  | 672, 693                        | 473, 704           | 198, 989                 | 672, 693                 | 16. 00           |
| 17. 00<br>17. 01 | Special add-on payments for new technologies<br>Net organ acquisition cost  | 54. 00                  | 0                               | 0                  | 0                        | 0                        | 17. 00<br>17. 01 |
| 17. 02           | Credits received from manufacturers for replaced devices for applicable MS-DRGs   | 68. 00                  | 0                               | 0                  | 0                        | 0                        |                  |
| 18. 00           | Capital outlier reconciliation adjustment amount (see instructions)   | 93. 00                  | 0                               | 0                  | 0                        | 0                        | 18. 00           |
| 19. 00           | SUBTOTAL  |                         |                                 | 7, 650, 592        | 3, 346, 956              | 10, 997, 548             | 19. 00           |

| HOST THE ACCOUNT COUNTY TON (HAC) REDUCTION CALCULA                    | ATTON EXITED TO | Trovider co            | [        | From 01/01/2020<br>Fo 12/31/2020 |                          | 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           | 665, 282               | 466, 329 | 198, 953                         | 665, 282                 | 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           | 7, 411                 | 7, 37    | 36                               | 7, 411                   | 21.00   |
| 21.01 Model 4 BPCI Capital DRG outlier payments                        | 2. 01           | 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                        | 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                        | 25. 00  |
| 26.00 Total prospective capital payments (see instructions)            | 12. 00          | 672, 693               | 473, 704 | 198, 989                         | 672, 693                 | 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          | 609, 148               |          |                                  | 609, 148                 |         |
| 29.00 Low volume adjustment on or after October 1                      | 70. 97          | 233, 273               |          | 233, 273                         |                          | 29. 00  |
| 30.00 HVBP payment adjustment (see instructions)                       | 70. 93          | 44, 314                | 28, 094  | 16, 220                          | 44, 314                  | 30.00   |
| 30.01 HVBP payment adjustment for HSP bonus payment (see instructions) | 70. 90          | 0                      | (        | 0                                | 0                        | 30. 01  |
| 31.00 HRR adjustment (see instructions)                                | 70. 94          | -30, 822               | -25, 02  | -5, 797                          | -30, 822                 | 31.00   |
| 31.01 HRR adjustment for HSP bonus payment (see instructions)          | 70. 91          | 0                      | (        | 0                                | 0                        | 31. 01  |
|  |                 |                        |          |                                  | (Amt. to<br>Wkst. E, Pt. |         |
|  |                 |                        |          |                                  | A)                       |         |
|  | 0               | 1.00                   | 2.00     | 3. 00                            | 4. 00                    |         |
| 32.00 HAC Reduction Program adjustment (see instructions)              | 70. 99          |                        | (        |                                  |                          | 32.00   |
| 100.00 Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.    |                 | N                      |          |                                  |                          | 100. 00 |

| Health Financial Systems                | MAJOR HOSPITAL         | In Lieu                                      | u of Form CMS-2552-10                                   |
|---|------------------------|--|---|
| CALCULATION OF REIMBURSEMENT SETTLEMENT | Provi der CCN: 15-0097 | Peri od:<br>From 01/01/2020<br>To 12/31/2020 | Worksheet E Part B Date/Time Prepared: 8/2/2021 2:11 pm |
|   | T: +1 - V(// L I       | Hanni kal                                    | DDC   |

| BAST S.   MEDICAL MIN OTHER WEATTH SERVICES   1.00   1.4   2.75   1.00   |        |  | Title XVIII            | Hospi tal      | 8/2/2021 2: 11<br>PPS | pm     |
|--|--------|--|------------------------|----------------|-----------------------|--------|
| Medit call and other services (see instructions)   |        |  |                        |                |                       |        |
| Medical and other services (see instructions)  |        | DADT B MEDICAL AND OTHER HEALTH SERVICES                         |                        |                | 1. 00                 |        |
| Bedical and other services relatureed under Gives (see Instructions)   14, 46, 590   2.00   OVPR pagnets (see Instructions)   65, 124   4.00   | 1 00   |  |                        |                | 4 276                 | 1 00   |
| 3.00   GPPS payments   9,888,114   3.00      |        | ,  | ns)                    |                |                       |        |
| 0.01   For reconcilitation amount (see instructions)   0.000   0.000   |        |  | -,                     |                |                       |        |
| Enter the hospit full specific payment to cost ratio (see instructions)  | 4.00   | Outlier payment (see instructions)                               |                        |                | 65, 124               | 4.00   |
| Line 2 tieses line 5   0   6.00  |        | · · · · · · · · · · · · · · · · · · ·                            |                        |                | _                     |        |
| Sum of Filines 3, 4, and 4.01, divided by Filine 6   0.00   7.00   |        |  | ons)                   |                |                       |        |
| Transit tional corridor payment (see instructions)   0   8.00   0.00     |        |  |                        |                | _                     |        |
| Ancil Hary service other pass through costs from West D, Pt. IV, col. 13, Hine 200    0  |        |  |                        |                |                       |        |
| 10.00   Grgam acquist irons   4, 276   11.00   Total cost (sam of lines 1 and 10) (see instructions)   4, 276   11.00   Total cost (sam of lines 1 and 10) (see instructions)   4, 276   11.00   20.   |        | ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' '                            | col 13 line 200        |                | _                     |        |
| 1.00   Total cost (sum of lines 1 and 10) (see instructions)   4,276   1.00  |        |  | 0011 107 11110 200     |                | _                     |        |
| Reasonable charges   12.00   Ancil lary service charges   13.441   12.00   Ancil lary service charges   13.441   13.00   15.00   13.00   15.   | 11.00  |  |                        |                | 4, 276                | 11.00  |
| 12.00   Ancillary service charges   13.41   12.00   13.00   Organ acquisition charges (from Wist. D-4, Pt. III, col. 4, line 69)   13.41   13.00   1   |        | COMPUTATION OF LESSER OF COST OR CHARGES                         |                        |                |                       |        |
| 13.00   Organ acquisition charges (crom Wist. D-4, Pt. III. col. 4, line 69)   |        |  |                        |                |                       |        |
| 14.00   Total reasonable charges (sum of lines 12 and 13)   14.00   20.00      |        |  | (0)                    |                | · .                   |        |
| Customary_charges  |        |  | 69)                    |                |                       |        |
| 15.00   Aggregate amount actually collected from patients liable for payment for services on a charge basis   0   15.00  | 14.00  |  |                        |                | 13, 341               | 14.00  |
| 16.00   Amounts that would have been roal ized from patients liable for payment for services on a chargebasis   0   16.00   Nation payment been made in accordance with 42 CFR \$413.13(e)   0.000000   17.00  | 15. 00 |  | ment for services on   | a charge basis | 0                     | 15.00  |
| 17.00   Batio of Line 15 to Line 16 (not to exceed 1.000000)   17.00   |        |  |                        |                | 0                     | 16.00  |
| 18.00   Intal customary charges (see instructions)   13.341   18.00   20.00   Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)   9.005   19.00   20.00   |        |  |                        | Ü              |                       |        |
| 9.00   Excess of customary charges over reasonable cost (complete only if file 18 exceeds line 11) (see Instructions)   20.00   Excess of reasonable cost over customary charges (complete only if file 11 exceeds line 18) (see   0   20.00   Excess of reasonable cost over customary charges (complete only if file 11 exceeds line 18) (see   0   20.00   Excess of reasonable cost over customary charges (complete only if file 11 exceeds line 18) (see   0   21.00   Excess of cost or charges (see instructions)   0   22.00   22.00   Cost of physicians' services in a teaching hospital (see instructions)   0   22.00   Cost of physicians' services in a teaching hospital (see instructions)   0   23.00   Computation of Retibuors Services in a teaching hospital (see instructions)   0   25.00   Computation of Retibuors Services in a teaching hospital (see instructions)   0   25.00   Computation of Retibuors Services in a teaching hospital (see instructions)   1.826,530   26.00   Computation of Retibuors Services in a teaching hospital (see instructions)   1.826,530   26.00   Computation of Retibuors Services in a teaching hospital (see instructions)   1.826,530   26.00      |        |  |                        |                |                       | 1      |
| Instructions   |        | ,  |                        | 44) (          |                       | 1      |
| 20.00   Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see   0   20.00   | 19. 00 |  | if line 18 exceeds li  | ne 11) (see    | 9, 065                | 19.00  |
| instructions   | 20 00  | · · · · · · · · · · · · · · · · · · ·                            | if line 11 evceeds li  | ne 18) (see    | 0                     | 20 00  |
| 21.00   Lesser of cost or charges (see instructions)   0.22.00   | 20.00  |  | II TITIC II CACCCUS II | 110 10) (300   |                       | 20.00  |
| 22.00   Interns and residents (see instructions)   0 22.00   0 23.00   0 23.00   0 25 of physicians' services in a teaching hospital (see instructions)   9,923,638   24.00   25.00    | 21.00  |  |                        |                | 4, 276                | 21.00  |
| 24. 00   Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)   9, 923, 638   24. 00   | 22.00  | Interns and residents (see instructions)                         |                        |                | 0                     | 22. 00 |
| COMPUTATION OF RELIMBURSEMENT SETTLEMENT   |        | , , ,  | tions)                 |                |                       |        |
| 25.00   Deductibles and coinsurance amounts (for CAH, see instructions)   0.25.00  | 24. 00 |  |                        |                | 9, 923, 638           | 24.00  |
| 26. 00   Deductible sand Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)   1,826,530   26. 00   27. 00   28. 00   29. 00   28. 00   29. 00   28. 00   29. 00   28. 00   29. 00   28. 00   29. 00   28. 00   29. 00   28. 00   29. 00   28. 00   29. 00   28. 00   29. 00   28. 00   29. 00   29. 00   28. 00   29. 00   29. 00   28. 00   29. 00   29. 00   29. 00   28. 00   29. 00   29. 00   29. 00   28. 00   29. 00   29. 00   29. 00   28. 00   29. 00   2   | 25 00  |  |                        |                | 0                     | 25 00  |
| 27. 00   Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23   (see   8.101.384   27. 00  |        |  | 1 (for CAH see instr   | ructions)      |                       |        |
| Instructions   |        |  |                        |                |                       | 1      |
| 28.00   Direct graduate medical education payments (From Wkst. E-4, line 50)   0   28.00   0   29.00   | 27.00  |  | 5 the 54m of 111165 22 | ana 20] (300   | 0, 101, 001           | 27.00  |
| Subtotal (sum of lines 27 through 29)  | 28.00  | Direct graduate medical education payments (from Wkst. E-4, line | 50)                    |                | 0                     | 28. 00 |
| 31.00   Subtotal (line 30 minus line 31)   8.099,934   32.00   ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)   33.00   Composite rate ESRD (from Wkst. 1-5, line 11)   0.33.00     |        | · · · · · · · · · · · · · · · · · · ·                            |                        |                | _                     |        |
| Subtotal (line 30 minus line 31)   ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)   33.00   Composite rate ESRD (from Wkst. 1-5, line 11)   0   33.00   33.00   33.00   33.00   34.00   3   |        | ,  |                        |                |                       | 1      |
| ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)   0   0   33.00   0   0   0   0   0   0   0   0   0  |        |  |                        |                |                       |        |
| 33.00   Composite rate ESRD (from Wkst. I-5, line 11)   0   33.00   34.00   All lowable bad debts (see instructions)   308,153   34.00   35.00   Adjusted reimbursable bad debts (see instructions)   200,299   35.00   36.00   All lowable bad debts (see instructions)   167,577   36.00   37.00   38.00   MSP-LCC reconciliation amount from PS&R   188   30.00   39.00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0   39.00   39.00   39.50   39   | 32.00  |  | )                      |                | 8, 099, 934           | 32.00  |
| 34.00  | 33 00  | ,  | )                      |                | 0                     | 33 00  |
| 35.00   Adjusted reimbursable bad debts (see instructions)   200,299   35.00   Adjusted reimbursable bad debts for dual eligible beneficiaries (see instructions)   167,577   36.00   37.00   Subtotal (see instructions)   8,300,233   37.00   38.00   MSP-LCC reconciliation amount from PS&R   38.00   39.00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   9.00   0.   |        |  |                        |                |                       |        |
| 37.00   Subtotal (see instructions)   8, 300, 233   37.00   38.00   MSP-LCC reconciliation amount from PS&R   198   38.00   39.00   39.50   0THER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0   39.50   39.50   0THER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   39.50   39.50   0THER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   39.50   39.50   39.90   0THER ADJUSTMENTS (SEE INSTRUCTIONS)   39.50   39.90   0THER ADJUSTMENTS (SEE INSTRUCTIONS)   39.50   39.90   0THER ADJUSTMENTS (SEE INSTRUCTIONS)   0   39.90   0   0   0   0   0   0   0   0   0  |        |  |                        |                | •                     |        |
| 38. 00   MSP-LCC reconciliation amount from PS&R   198   38. 00   39. 00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0   39. 00   39. 00   39. 50   39. 50   39. 50   39. 97   Demonstration payment adjustment amount before sequestration   0   39. 97   39. 98   Partial or full credits received from manufacturers for replaced devices (see instructions)   0   39. 98   39. 98   RECOVERY OF ACCELERATED DEPRECIATION   0   39. 98   40. 00   Subtotal (see instructions)   8, 300, 035   40. 00   40. 01   Sequestration adjustment (see instructions)   54, 780   40. 01   40. 02   Demonstration payment adjustment amount after sequestration   40. 03   Sequestration adjustment-PARHM pass-throughs   40. 03   40. 04   40. 04   40. 04   40. 04   40. 04   40. 04   40. 04   40. 04   40. 05   40. 0   | 36.00  | Allowable bad debts for dual eligible beneficiaries (see instruc | tions)                 |                | 167, 577              | 36.00  |
| 39.00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   39.50   90.00   39.50   90.00   39.50   90.00   39.50   90.00   39.50   39.50   90.00   39.50   39.   |        |  |                        |                |                       |        |
| 39.50   Pi oneer ACO demonstration payment adjustment (see instructions)   39.50   39.97   Demonstration payment adjustment amount before sequestration   0   39.98   39.98   Partial or full credits received from manufacturers for replaced devices (see instructions)   0   39.98   39.99   40.00   Subtotal (see instructions)   8,300,035   40.00   40.01   40.02   40.02   40.03   40.00   40.02   40.03   40.00   40.02   40.03   40.00   40.02   40.03   40.00   40.02   40.03   40.00   40.02   40.03   40.00   40.02   40.03   40.00   40.02   40.03   40.00   40.02   40.03   40.00   40.02   40.03   40.00   40.02   40.03   40.00   40.02   40.03   40.00   40.02   40.03   40.00   40.02   40.03   40.00   40.02   40.03   40.03   40.00   40.02   40.03   40.03   40.03   40.00   40.02   40.03   40.03   40.03   40.03   40.03   40.03   40.00   40.02   40.03   40.03   40.03   40.03   40.03   40.03   40.00   40.03   40   |        |  |                        |                |                       |        |
| 39.97   Demonstration payment adjustment amount before sequestration   0   39.97   |        | , , , , ,  |                        |                | 0                     |        |
| 39. 98       Partial or full credits received from manufacturers for replaced devices (see instructions)       0       39. 98         39. 99       RECOVERY OF ACCELERATED DEPRECIATION       0       39. 99         40. 00       Subtotal (see instructions)       8, 300, 035       40. 00         40. 01       Sequestration adjustment (see instructions)       54, 780       40. 01         40. 02       Demonstration payment adjustment amount after sequestration       0       40. 02         40. 03       Sequestration adjustment-PARHM pass-throughs       40. 03         41. 01       Interim payments       8, 252, 058       41. 00         41. 01       Interim payments - PARHM       1       41. 01         42. 01       Tentative settlement (for contractors use only)       0       42. 01         43. 00       Bal ance due provider/program (see instructions)       -6, 803       43. 00         43. 01       Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0       44. 00         41. 02       To BE COMPLETED BY CONTRACTOR       0       90. 00         90. 00       Outlier reconciliation adjustment amount (see instructions)       0       90. 00         91. 00       Outlier reconciliation adjustment amount (see instructions)       0       90. 00   |        |  |                        |                |                       |        |
| 39. 99 40. 00 5ubtotal (see instructions) 8, 300, 035 40. 00 40. 01 5equestration adjustment (see instructions) 5equestration payment adjustment amount after sequestration 5equestration adjustment-PARHM pass-throughs 1nterim payments 1nterim payments-PARHM 1nterim payments-PARHM 1nterim payments-PARHM 1nterim payments-PARHM 1nterim payments-PARHM 1nterim payments-PARHM 2nterim payments-PARHM 2nterim payments-PARHM 3nterim payments-PARHM 3nterim payments-PARHM 4nterim payments-P |        |  | dovices (see instru    | etions)        |                       |        |
| 40.00   Subtotal (see instructions)   8, 300, 035   40.00   40.01   Sequestration adjustment (see instructions)   54, 780   40.01   40.02   Demonstration payment adjustment amount after sequestration   0   40.02   40.03   Sequestration adjustment-PARHM pass-throughs   0   40.03   41.00   Interim payments   8, 252, 058   41.00   41.01   Interim payments-PARHM   41.01   42.00   Tentative settlement (for contractors use only)   0   42.00   42.01   Tentative settlement-PARHM (for contractor use only)   42.01   43.00   Bal ance due provider/program (see instructions)   -6, 803   43.01   Bal ance due provider/program-PARHM (see instructions)   43.00   44.00   Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0   44.00   45.01   Tentative settlement (for contractors use only)   0   0   40.01   0   0   0   0   0   40.02   0   0   0   0   0   40.02   0   0   0   0   40.03   0   0   0   0   40.03   0   0   0   0   40.04   0   0   0   40.05   0   0   0   40.06   0   0   0   40.07   0   0   0   40.08   0   0   40.09   0   0   0   40.00  |        | ·  | devices (see ilistiud  | ti ons)        | _                     |        |
| 40.01       Sequestration adjustment (see instructions)       54,780       40.01         40.02       Demonstration payment adjustment amount after sequestration       0 40.02         40.03       Sequestration adjustment-PARHM pass-throughs       40.03         41.00       Interim payments       8,252,058       41.00         41.01       Interim payments-PARHM       41.01         42.00       Tentative settlement (for contractors use only)       0 42.00         42.01       Tentative settlement-PARHM (for contractor use only)       42.01         43.00       Balance due provider/program (see instructions)       -6,803       43.00         43.01       Balance due provider/program-PARHM (see instructions)       43.01         44.00       Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00       44.00         90.00       Original outlier amount (see instructions)       0 90.00         91.00       Outlier reconciliation adjustment amount (see instructions)       0 90.00         92.00       The rate used to calculate the Time Value of Money       0.00         93.00       Time Value of Money (see instructions)       0 93.00  |        |  |                        |                |                       | 1      |
| 40. 02 Demonstration payment adjustment amount after sequestration  40. 03 Sequestration adjustment-PARHM pass-throughs  41. 00 Interim payments  41. 01 Interim payments-PARHM  42. 00 Tentative settlement (for contractors use only)  42. 01 Tentative settlement-PARHM (for contractor use only)  43. 00 Balance due provider/program (see instructions)  43. 01 Balance due provider/program-PARHM (see instructions)  44. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44. 00 \$\frac{1}{5}\$115.2  TO BE COMPLETED BY CONTRACTOR  90. 00 Original outlier amount (see instructions)  91. 00 Outlier reconciliation adjustment amount (see instructions)  92. 00 The rate used to calculate the Time Value of Money  93. 00 Time Value of Money (see instructions)  0 40. 02 40. 03  41. 00  41. 01  42. 01  42. 01  43. 00  43. 01  44. 00  90. 00  91. 00  92. 00  93. 00  1 ime Value of Money (see instructions)  0 93. 00   |        |  |                        |                |                       |        |
| 40. 03   Sequestration adjustment-PARHM pass-throughs   40. 03   41. 00   Interim payments   8, 252, 058   41. 00   41. 01   Interim payments-PARHM   42. 00   Tentative settlement (for contractor use only)   42. 01   Tentative settlement-PARHM (for contractor use only)   42. 01   43. 00   Balance due provider/program (see instructions)   43. 01   Balance due provider/program-PARHM (see instructions)   43. 01   44. 00   Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0   44. 00   91. 00   0   0   0   0   0   0   0   0   0   |        |  |                        |                |                       | 1      |
| 1.01   Interim payments-PARHM  |        |  |                        |                |                       | 1      |
| 42.00 Tentative settlement (for contractors use only) 42.01 Tentative settlement-PARHM (for contractor use only) 43.00 Balance due provider/program (see instructions) 43.01 Balance due provider/program-PARHM (see instructions) 43.01 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5115.2 TO BE COMPLETED BY CONTRACTOR  90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 Time Value of Money (see instructions) 94.00 Value of Money (see instructions) 95.00 Value of Money (see instructions) 96.00 Value of Money (see instructions) 97.00 Value of Money (see instructions)   | 41.00  | Interim payments   |                        |                | 8, 252, 058           | 41.00  |
| 42.01 Tentative settlement-PARHM (for contractor use only) 43.00 Balance due provider/program (see instructions) 43.01 Balance due provider/program-PARHM (see instructions) 43.01 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5115.2  TO BE COMPLETED BY CONTRACTOR  90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 Time Value of Money (see instructions) 93.00 Time Value of Money (see instructions) 94.00 Time Value of Money (see instructions) 95.00 Time Value of Money (see instructions) 97.00 Time Value of Money (see instructions) 97.00 Time Value of Money (see instructions)   |        |  |                        |                |                       | 1      |
| 43.00 Balance due provider/program (see instructions)  43.01 Balance due provider/program-PARHM (see instructions)  43.01 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 protested amounts (nonallowable cost report items) in accordan |        |  |                        |                | 0                     | 1      |
| 43.01 Balance due provider/program-PARHM (see instructions)  44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00 \$\frac{115.2}{5115.2}\$  70 BE COMPLETED BY CONTRACTOR  90.00 Original outlier amount (see instructions)  91.00 Outlier reconciliation adjustment amount (see instructions)  92.00 The rate used to calculate the Time Value of Money  93.00 Time Value of Money (see instructions)  93.00 O 93.00   |        | ,  |                        |                | 4 000                 | 1      |
| 44.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$\frac{1}{5115.2}\$ \frac{10 \text{ BE COMPLETED BY CONTRACTOR}}{\text{70 BE completed amount (see instructions)}} 0 90.00 Outlier reconciliation adjustment amount (see instructions) 0 91.00 Outlier reconciliation adjustment amount (see instructions) 0 92.00 The rate used to calculate the Time Value of Money (see instructions) 0 93.00   |        | ,                          |                        |                | -6, 803               | 1      |
| \$115.2 TO BE COMPLETED BY CONTRACTOR  90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0 93.00  |        |  | with CMS Pub 15-2      | chanter 1      | 0                     |        |
| 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 92.00  93.00 Time Value of Money (see instructions) 0 93.00  | 11.00  |  | 11 OMO 1 UD. 10-2,     | J. 1,          |                       | ' 55   |
| 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0 90.00 91.00 92.00 93.00   |        |  |                        |                |                       | ]      |
| 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0.00 92.00 93.00   |        | Original outlier amount (see instructions)                       |                        |                | 0                     | 1      |
| 93.00 Time Value of Money (see instructions) 0 93.00   |        | ,  |                        |                |                       |        |
|  |        | l  |                        |                |                       | 1      |
| 94.00   TOTAL (SUIII OF TITIES 91 AND 93)  |        |  |                        |                |                       |        |
|  | 74. UU | Total (Sum of Files 71 diu 73)                                   |                        |                | 0                     | 74.00  |

Peri od: From 01/01/2020 To 12/31/2020 Worksheet E-1 Part I Date/Time Prepared: 8/2/2021 2:11 pm Provider CCN: 15-0097

|       |   |            |              |              | 8/2/2021 2: 11 | pm    |
|-------|---|------------|--------------|--------------|----------------|-------|
|       |   | Title      | XVIII        | Hospi tal    | PPS            |       |
|       |   | I npati en | it Part A    | Pai          | rt B           |       |
|       |   | mm/dd/yyyy | Amount       | mm/dd/yyyy   | Amount         |       |
|       |   | 1. 00      | 2.00         | 3.00         | 4.00           |       |
| 1. 00 | Total interim payments paid to provider   |            | 10, 460, 00  | 5            | 8, 046, 572    | 1.00  |
| 2. 00 | Interim payments payable on individual bills, either submitted or to be submitted to the contractor for |            |              |              | 0              | 2. 00 |
|       | services rendered in the cost reporting period. If none, write "NONE" or enter a zero                   |            |              |              |                |       |
| 3.00  | List separately each retroactive lump sum adjustment  |            |              |              |                | 3.00  |
|       | amount based on subsequent revision of the interim rate   |            |              |              |                |       |
|       | for the cost reporting period. Also show date of each   |            |              |              |                |       |
|       | payment. If none, write "NONE" or enter a zero. (1)   |            |              |              |                |       |
|       | Program to Provider   |            |              |              |                |       |
| 3. 01 | ADJUSTMENTS TO PROVIDER   | 12/31/2020 | 39, 43       | 4 12/31/2020 | 205, 486       | 3.01  |
| 3. 02 |   |            |              | O            | 0              | 3.02  |
| 3.03  |   |            |              | )            | 0              | 3.03  |
| 3.04  |   |            |              | )            | 0              | 3.04  |
| 3.05  |   |            |              | O            | 0              | 3.05  |
|       | Provider to Program   |            |              |              |                |       |
| 3.50  | ADJUSTMENTS TO PROGRAM  |            | (            | )            | 0              | 3.50  |
| 3. 51 |   |            |              | )            | l ol           | 3.51  |
| 3. 52 |   |            |              | o            | o              | 3.52  |
| 3. 53 |   |            |              |              | l ol           | 3.53  |
| 3. 54 |   |            |              | )            | o              | 3.54  |
| 3. 99 | Subtotal (sum of lines 3.01-3.49 minus sum of lines   |            | 39, 43       | 4            | 205, 486       | 3. 99 |
|       | 3. 50-3. 98)  |            |              |              |                |       |
| 4. 00 | Total interim payments (sum of lines 1, 2, and 3.99)  |            | 10, 499, 439 | 7            | 8, 252, 058    | 4. 00 |
|       | (transfer to Wkst. E or Wkst. E-3, line and column as   |            |              |              |                |       |
|       | appropri ate)   |            |              |              |                |       |
|       | TO BE COMPLETED BY CONTRACTOR   |            | ı            |              |                |       |
| 5. 00 | List separately each tentative settlement payment after   |            |              |              |                | 5.00  |
|       | desk review. Also show date of each payment. If none,   |            |              |              |                |       |
|       | write "NONE" or enter a zero. (1)   |            |              |              |                |       |
|       | Program to Provider   |            |              |              |                |       |
| 5. 01 | TENTATI VE TO PROVI DER   |            |              |              | 0              | 5. 01 |
| 5. 02 |   |            |              |              | 0              | 5. 02 |
| 5. 03 |   |            |              | 0            | 0              | 5. 03 |
|       | Provi der to Program  |            |              |              |                |       |
| 5. 50 | TENTATI VE TO PROGRAM   |            |              |              | 0              | 5. 50 |
| 5. 51 |   |            |              |              | 0              | 5. 51 |
| 5. 52 |   |            |              | O            | 0              | 5. 52 |
| 5. 99 | Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)  |            | (            | D            | 0              | 5. 99 |
| 6. 00 | Determined net settlement amount (balance due) based on the cost report. (1)                            |            |              |              |                | 6. 00 |
| 6. 01 | SETTLEMENT TO PROVIDER  |            | 274, 459     | 9            | o              | 6.01  |
| 6. 02 | SETTLEMENT TO PROGRAM   | •          |              | o            | 6, 803         | 6. 02 |
| 7. 00 | Total Medicare program liability (see instructions)   |            | 10, 773, 898 | 3            | 8, 245, 255    | 7.00  |
|       |   |            |              | Contractor   | NPR Date       |       |
|       |   |            |              | Number       | (Mo/Day/Yr)    |       |
|       |   | (          | )            | 1. 00        | 2. 00          |       |
| 8. 00 | Name of Contractor  |            |              |              |                | 8. 00 |

| CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT  Provider CCN: 15-0097    Period: From 01/01/2020   To 12/31/2020   Period: Provider CCN: 15-0097   Period: To 12/31/2020   Provider CCN: 15-0097   Period: To 12/31/2020   Provider CCN: 15-0097   Period: To 12/31/2020   Provider CCN: 15-0097   Period: To 12/31/2020   Provider CCN: 15-0097   Period: To 12/31/2020   Provider CCN: 15-0097   Period: To 12/31/2020   Provider CCN: 15-0097   Period: To 12/31/2020   Provider CCN: 15-0097   Period: To 12/31/2020   Provider CCN: 15-0097   Period: To 12/31/2020   Provider CCN: 15-0097   Period: To 12/31/2020   Provider CCN: 15-0097   Period: To 12/31/2020   Period: To 12/31/2020   Provider CCN: 15-0097   Period: To 12/31/2020   Period: 110   Period: 110   Period: 12/31/2020   Period: 12 | Heal th | Financial Systems MAJOR HOSP   | I TAL                    | In Lie           | u of Form CMS- | 2552-10 |
|--|---------|--|--------------------------|------------------|----------------|---------|
| To 12/31/2020 Date/Time Prepared: 8/2/2021 2: 11 pm  Title XVIII Hospital PPS  To BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION  1.00 Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14  2.00 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12  3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2  4.00 Total inpatient days from Wkst. C, Pt. I, col. 8 line 20  5.00 Total hospital charges from Wkst. C, Pt. I, col. 8 line 200  7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I  8.00 Calculation of the HIT incentive payment (see instructions)  9.00 Sequestration adjustment amount (see instructions)  10.00 INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH  30.00 Other Adjustment (specify)  31.00 Other Adjustment (specify)  | CALCUL  | ATION OF REIMBURSEMENT SETTLEMENT FOR HIT  | Provider CCN: 15-0097    |                  |                |         |
| TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS  HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION  1.00 Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14  2.00 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12  3.00 Medicare HMO days from Wkst. S-3, Pt. I col. 8 sum of lines 1, 8-12  4.00 Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12  5.00 Total hospital charges from Wkst C, Pt. I, col. 8 line 200  6.00 Total hospital charity care charges from Wkst. S-10, col. 3 line 20  7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I  8.00 Calculation of the HIT incentive payment (see instructions)  9.00 Sequestration adjustment amount (see instructions)  10.00 Calculation of the HIT incentive payment after sequestration (see instructions)  10.00 INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH  30.00 Other Adjustment (specify)  31.00   |         |  |                          |                  |                |         |
| Title XVIII Hospital PPS  TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION  1.00 Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14  2.00 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12  3.00 Medicare HMO days from S-3, Pt. I col. 8 sum of lines 1, 8-12  4.00 Total inpatient days from S-3, Pt. I col. 8 line 20  5.00 Total hospital charges from Wkst C, Pt. I, col. 8 line 200  6.00 Total hospital charity care charges from Wkst. S-10, col. 3 line 20  7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I round in the HIT incentive payment (see instructions)  8.00 Calculation of the HIT incentive payment (see instructions)  9.00 Sequestration adjustment amount (see instructions)  10.00 Initial interim HIT payment adjustment (see instructions)  30.00 Initial interim HIT payment adjustment (see instructions)  30.00 Other Adjustment (specify)   |         |  |                          | 10 12/31/2020    |                |         |
| TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS  HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION  1.00 Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14  2.00 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12  3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2  4.00 Total inpatient days from Wkst C, Pt. I, col. 8 sum of lines 1, 8-12  5.00 Total hospital charges from Wkst C, Pt. I, col. 8 line 200  6.00 Total hospital charity care charges from Wkst. S-10, col. 3 line 20  7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I ine 168  8.00 Calculation of the HIT incentive payment (see instructions)  9.00 Sequestration adjustment amount (see instructions)  10.00 Calculation of the HIT incentive payment after sequestration (see instructions)  10.00 Initial/interim HIT payment adjustment (see instructions)  30.00 Initial/interim HIT payment adjustment (see instructions)  31.00 Other Adjustment (specify)  |         |  | Title XVIII              | Hospi tal        |                | рш      |
| TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION  1.00 Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14  2.00 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12  3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2  Total inpatient days from S-3, Pt. I, col. 8 sum of lines 1, 8-12  3.00 Total hospital charges from Wkst C, Pt. I, col. 8 line 200  6.00 Total hospital charity care charges from Wkst. S-10, col. 3 line 20  CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168  8.00 Calculation of the HIT incentive payment (see instructions) Sequestration adjustment amount (see instructions)  9.00 Calculation of the HIT incentive payment after sequestration (see instructions) INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH  Initial/interim HIT payment adjustment (see instructions) 30.00 Other Adjustment (specify)  31.00  |         |  |                          | 110001 101       |                |         |
| HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION  1.00 Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14 2.00 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12 3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2 7.01 Total inpatient days from Wkst. S-3, Pt. I col. 8 sum of lines 1, 8-12 7.02 Total hospital charges from Wkst. C, Pt. I, col. 8 line 200 7.03 Total hospital charity care charges from Wkst. S-10, col. 3 line 20 7.04 Total hospital charity care charges from Wkst. S-10, col. 3 line 20 7.05 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I 7.00 Total hospital charity care charges from Wkst. S-10, col. 3 line 20 7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I 7.00 Calculation of the HIT incentive payment (see instructions) 8.00 Sequestration adjustment amount (see instructions) 9.00 TINPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH  30.00 Initial/interim HIT payment adjustment (see instructions) 30.00 Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14 2.00 3.00 Total hospital discharges as defined in AARA §4102 from Wkst. S-12, Pt. I col. 8 line 20 3.00 5.00 Total hospital charges from Wkst. S-3, Pt. I, col. 6. line 2 3.00 5.00 Total hospital charges from Wkst. S-3, Pt. I, col. 6. line 2 3.00 5.00 Total hospital charges from Wkst. S-3, Pt. I, col. 6. line 2 3.00 5.00 Total hospital charges from Wkst. S-3, Pt. I, col. 6. line 2 3.00 Total hospital charges from Wkst. S-3, Pt. I, col. 6. line 2 3.00 Total hospital charges from Wkst. S-10, col. 3 line 20 5.00 5.00 Total hospital charges from Wkst. S-10, col. 8 line 20 5.00 5.00 5.00 Total hospital charges from Wkst. S-10, col. 8 line 20 5.00 5.00 5.00 Total hospital charges from Wkst. S-10, col. 8 line 20 5.00 5.00 5.00 5.00 Total hospital charges from Wkst. S-10, col. 8 line 20 5.00 5.00 5.00 Total hospital charges from Wkst. S-10, col. |         |  |                          |                  | 1. 00          |         |
| Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14  2.00 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12  3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2  4.00 Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12  5.00 Total hospital charges from Wkst C, Pt. I, col. 8 line 200  6.00 Total hospital charity care charges from Wkst. S-10, col. 3 line 20  7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168  8.00 Calculation of the HIT incentive payment (see instructions)  9.00 Sequestration adjustment amount (see instructions)  10.00 Calculation of the HIT incentive payment after sequestration (see instructions)  INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH  30.00 Other Adjustment (specify)  1.00   |         | TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS                                   |                          |                  |                |         |
| 2.00  Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12  3.00  Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2  4.00  Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12  5.00  Total hospital charges from Wkst C, Pt. I, col. 8 line 200  6.00  Total hospital charity care charges from Wkst. S-10, col. 3 line 20  CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168  8.00  Calculation of the HIT incentive payment (see instructions)  Sequestration adjustment amount (see instructions)  10.00  Calculation of the HIT incentive payment after sequestration (see instructions)  INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH  30.00  Other Adjustment (specify)  30.00  31.00   |         | HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION                                | V                        |                  |                |         |
| 3.00  Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2  Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12  Total hospital charges from Wkst C, Pt. I, col. 8 line 200  Total hospital charity care charges from Wkst. S-10, col. 3 line 20  CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168  8.00 Calculation of the HIT incentive payment (see instructions)  Sequestration adjustment amount (see instructions)  Calculation of the HIT incentive payment after sequestration (see instructions)  INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH  30.00 Other Adjustment (specify)  30.00  31.00  | 1.00    | .00 Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14 |                          |                  |                |         |
| 4.00 Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12 Total hospital charges from Wkst C, Pt. I, col. 8 line 200 5.00 Total hospital charity care charges from Wkst. S-10, col. 3 line 20 7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168 8.00 Calculation of the HIT incentive payment (see instructions) 9.00 Sequestration adjustment amount (see instructions) 10.00 Calculation of the HIT incentive payment after sequestration (see instructions) 1NPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH  30.00 Initial/interim HIT payment adjustment (see instructions) 30.00 31.00 Other Adjustment (specify) 31.00  | 2.00    | 2.00   Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12                      |                          |                  |                | 2.00    |
| Total hospital charges from Wkst C, Pt. I, col. 8 line 200  Total hospital charity care charges from Wkst. S-10, col. 3 line 20  CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I   | 3.00    | 3.00   Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2                               |                          |                  |                | 3.00    |
| Total hospital charity care charges from Wkst. S-10, col. 3 line 20  7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I  | 4.00    | Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8                                | 8-12                     |                  |                | 4.00    |
| 7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168  8.00 Calculation of the HIT incentive payment (see instructions)  9.00 Sequestration adjustment amount (see instructions)  10.00 Calculation of the HIT incentive payment after sequestration (see instructions)  INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH  30.00 Initial/interim HIT payment adjustment (see instructions)  30.00 Other Adjustment (specify)  31.00  | 5.00    | Total hospital charges from Wkst C, Pt. I, col. 8 line 200                                   |                          |                  |                | 5.00    |
| line 168   | 6.00    | Total hospital charity care charges from Wkst. S-10, col. 3                                  | line 20                  |                  |                | 6.00    |
| 8.00 Calculation of the HIT incentive payment (see instructions) 9.00 Sequestration adjustment amount (see instructions) 9.00 Calculation of the HIT incentive payment after sequestration (see instructions) 10.00 INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH  30.00 Initial/interim HIT payment adjustment (see instructions) 30.00 Other Adjustment (specify) 31.00   | 7.00    |  | certified HIT technology | Wkst. S-2, Pt. I |                | 7. 00   |
| 9.00 Sequestration adjustment amount (see instructions) 10.00 Calculation of the HIT incentive payment after sequestration (see instructions) 10.00 INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH  30.00 Initial/interim HIT payment adjustment (see instructions) 30.00 Other Adjustment (specify) 31.00   |         | 1  |                          |                  |                |         |
| 10.00 Calculation of the HIT incentive payment after sequestration (see instructions)  INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH  30.00 Initial/interim HIT payment adjustment (see instructions)  30.00 Other Adjustment (specify)   |         |  |                          |                  |                |         |
| INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH  30.00 Initial/interim HIT payment adjustment (see instructions)  30.00 Other Adjustment (specify)  31.00   |         |  |                          |                  |                |         |
| 30.00 Initial/interim HIT payment adjustment (see instructions) 30.00 31.00 Other Adjustment (specify) 31.00   | 10. 00  |  | (see instructions)       |                  |                | 10.00   |
| 31.00 Other Adjustment (specify)   |         |  |                          |                  |                | 4       |
|  |         |  |                          |                  |                |         |
| 32.00  Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)   32.00   |         |  |                          |                  |                |         |
|  | 32. 00  | Balance due provider (line 8 (or line 10) minus line 30 and                                  | line 31) (see instructio | ns)              |                | 32.00   |

| Health Financial Systems                | MAJOR HOSPITAL         | In Lieu         | of Form CMS-2552-10 |
|---|------------------------|-----------------|---------------------|
| CALCULATION OF REIMBURSEMENT SETTLEMENT | Provi der CCN: 15-0097 | Peri od:        | Worksheet E-3       |
|   |                        | From 01/01/2020 |                     |
|   |                        | T- 10/01/0000   | D-+- /T! D          |

|        |  |                       | Fo 12/31/2020 |             |        |
|--------|--|-----------------------|---------------|-------------|--------|
|        |  | Title XIX             | Hospi tal     | Cost        |        |
|        |  |                       | I npati ent   | Outpati ent |        |
|        |  |                       | 1. 00         | 2. 00       |        |
|        | PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICE | ES FOR TITLES V OR XI | X SERVICES    |             |        |
|        | COMPUTATION OF NET COST OF COVERED SERVICES                        |                       |               |             |        |
| 1.00   | Inpatient hospital/SNF/NF services                                 |                       | 929, 155      |             | 1.00   |
| 2.00   | Medical and other services   |                       |               | 0           | 2.00   |
| 3.00   | Organ acquisition (certified transplant centers only)              |                       | o             |             | 3.00   |
| 4.00   | Subtotal (sum of lines 1, 2 and 3)                                 |                       | 929, 155      | 0           | 4.00   |
| 5.00   | Inpatient primary payer payments                                   |                       | o             |             | 5.00   |
| 6.00   | Outpatient primary payer payments                                  |                       |               | 0           | 6.00   |
| 7.00   | Subtotal (line 4 less sum of lines 5 and 6)                        |                       | 929, 155      | 0           | 7.00   |
|        | COMPUTATION OF LESSER OF COST OR CHARGES                           |                       |               |             |        |
|        | Reasonable Charges   |                       |               |             |        |
| 8.00   | Routine service charges  |                       | 842, 556      |             | 8.00   |
| 9. 00  | Ancillary service charges  |                       | 2, 196, 963   | 0           | 9.00   |
| 10.00  | Organ acquisition charges, net of revenue                          |                       | 0             |             | 10.00  |
| 11.00  | Incentive from target amount computation                           |                       | 0             |             | 11.00  |
| 12.00  | Total reasonable charges (sum of lines 8 through 11)               |                       | 3, 039, 519   | 0           | 12.00  |
|        | CUSTOMARY CHARGES  |                       |               |             |        |
| 13.00  | Amount actually collected from patients liable for payment for ser | rvices on a charge    | 0             | 0           | 13.00  |
|        | basis  |                       |               |             |        |
| 14. 00 | Amounts that would have been realized from patients liable for pay |                       | 0             | 0           | 14. 00 |
|        | a charge basis had such payment been made in accordance with 42 CF | FR §413.13(e)         |               |             |        |
|        | Ratio of line 13 to line 14 (not to exceed 1.000000)               |                       | 0. 000000     | 0.000000    |        |
|        | Total customary charges (see instructions)                         |                       | 3, 039, 519   | 0           | 16. 00 |
| 17. 00 | Excess of customary charges over reasonable cost (complete only it | f line 16 exceeds     | 2, 110, 364   | 0           | 17. 00 |
| 40.00  | line 4) (see instructions)   | 6.11                  |               | 0           | 10.00  |
| 18. 00 | Excess of reasonable cost over customary charges (complete only it | r irne 4 exceeds irne |               | 0           | 18. 00 |
| 10 00  | 16) (see instructions) Interns and Residents (see instructions)    |                       |               | 0           | 19. 00 |
|        | Cost of physicians' services in a teaching hospital (see instructi | i one)                | 0             | 0           | 20.00  |
|        |  | 1 0115)               | 929, 155      | 0           |        |
| 21.00  | PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be comp | nleted for PPS provid |               | 0           | 21.00  |
| 22 00  | Other than outlier payments  | preted for 113 provid | 0             | 0           | 22. 00 |
|        | Outlier payments   |                       | 0             | 0           | 23. 00 |
|        | Program capital payments   |                       | 0             | Ü           | 24.00  |
|        | Capital exception payments (see instructions)                      |                       | o             |             | 25. 00 |
|        | Routine and Ancillary service other pass through costs             |                       | o             | 0           | 26.00  |
|        | Subtotal (sum of lines 22 through 26)                              |                       | o             | 0           | 27. 00 |
|        | Customary charges (title V or XIX PPS covered services only)       |                       | o             | 0           | 28. 00 |
|        | Titles V or XIX (sum of lines 21 and 27)                           |                       | 929, 155      | 0           |        |
|        | COMPUTATION OF REIMBURSEMENT SETTLEMENT                            |                       | 1217 133      |             |        |
| 30.00  | Excess of reasonable cost (from line 18)                           |                       | 0             | 0           | 30.00  |
|        | Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)     |                       | 929, 155      | 0           | 31.00  |
|        | Deducti bl es  |                       | o             | 0           | 32.00  |
| 33.00  | Coinsurance  |                       | o             | 0           | 33.00  |
| 34.00  | Allowable bad debts (see instructions)                             |                       | o             | 0           | 34.00  |
|        | Utilization review   |                       | o             |             | 35.00  |
| 36.00  | Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) | )                     | 929, 155      | 0           | 36.00  |
| 37.00  | OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)                     |                       | O             | 0           | 37.00  |
| 38.00  | Subtotal (line 36 ± line 37)                                       |                       | 929, 155      | 0           | 38.00  |
| 39.00  | Direct graduate medical education payments (from Wkst. E-4)        |                       | o             |             | 39.00  |
| 40.00  | Total amount payable to the provider (sum of lines 38 and 39)      |                       | 929, 155      | 0           | 40.00  |
| 41.00  | Interim payments   |                       | 1, 149, 907   | 0           | 41.00  |
| 42.00  | Balance due provider/program (line 40 minus line 41)               |                       | -220, 752     | 0           | 42.00  |
| 43.00  | Protested amounts (nonallowable cost report items) in accordance w | with CMS Pub 15-2,    | 0             | 0           | 43.00  |
|        | chapter 1, §115.2  |                       |               |             |        |
|        |  |                       |               |             |        |

Health Financial Systems

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

Provider CCN: 15-0097

Peri od: Worksheet G From 01/01/2020 To 12/31/2020 Date/Ti me Prepared: 8/2/2021 2:11 pm

| <u>y</u> ,       |  | General Fund                   | Specific<br>Purpose Fund | Endowment<br>Fund | 8/2/2021 2: 11<br>  Plant Fund | pm     |
|------------------|--|--------------------------------|--------------------------|-------------------|--------------------------------|--------|
|                  |  | 1.00                           | 2.00                     | 3. 00             | 4. 00                          |        |
| 1 00             | CURRENT ASSETS   | 14 204 427                     |                          | ما                | 0                              | 1.00   |
| 1. 00<br>2. 00   | Cash on hand in banks Temporary investments  | 16, 304, 627                   | 0                        | 0                 | 0                              | 1      |
| 3. 00            | Notes receivable   | 0                              | 0                        | 0                 | 0                              | 1      |
| 4. 00            | Accounts recei vabl e  | 42, 176, 281                   | 0                        | Ö                 | 0                              |        |
| 5.00             | Other recei vable  | 10, 634, 242                   | 0                        | o                 | 0                              | 5.00   |
| 6. 00            | Allowances for uncollectible notes and accounts receivable                         | -29, 072, 978                  | 0                        | 0                 | 0                              |        |
| 7. 00            | Inventory  | 5, 446, 190                    | 1                        | 0                 | 0                              |        |
| 8. 00            | Prepai d expenses  | 3, 392, 559                    | 0                        | 0                 | 0                              |        |
| 9. 00<br>10. 00  | Other current assets Due from other funds  | 4, 221                         |                          | U<br>O            | 0                              |        |
| 11. 00           | Total current assets (sum of lines 1-10)   | 48, 885, 142                   | 1                        | ol                | 0                              |        |
| 11.00            | FIXED ASSETS   | 1 40,000,142                   |                          | <u></u>           |                                | 11.00  |
| 12.00            | Land   | 2, 900, 662                    | 0                        | 0                 | 0                              | 12.00  |
| 13.00            | Land improvements  | 12, 298, 052                   | 0                        | o                 | 0                              | 13.00  |
| 14.00            | Accumulated depreciation   | -4, 641, 265                   | 0                        | 0                 | 0                              |        |
| 15. 00           | Bui I di ngs   | 128, 903, 484                  | 1                        | 0                 | 0                              |        |
| 16.00            | Accumulated depreciation   | -24, 928, 346                  | 1                        | 0                 | 0                              |        |
| 17.00            | Leasehold improvements Accumulated depreciation                                    | 268, 012                       | 1                        | 0                 | 0                              |        |
| 18. 00<br>19. 00 | Fixed equipment  | -247, 057<br>4, 650, 236       | 1                        | 0                 | 0                              | 1      |
| 20. 00           | Accumul ated depreciation  | 4, 030, 230                    | 0                        | 0                 | 0                              | 1      |
| 21. 00           | Automobiles and trucks   | 0                              | ő                        | ő                 | 0                              | 1      |
| 22. 00           | Accumulated depreciation   | 0                              | 0                        | o                 | 0                              | 1      |
| 23.00            | Maj or movable equipment   | 62, 862, 730                   | 0                        | o                 | 0                              | 23.00  |
| 24.00            | Accumulated depreciation   | -38, 644, 275                  | 0                        | 0                 | 0                              | 1      |
| 25. 00           | Mi nor equipment depreciable   | 0                              | 0                        | 0                 | 0                              |        |
| 26. 00           | Accumul ated depreciation  | 0                              | 0                        | 0                 | 0                              |        |
| 27. 00<br>28. 00 | HIT designated Assets  | 0                              | 0                        | 0                 | 0                              | 1      |
| 29.00            | Accumulated depreciation Minor equipment-nondepreciable                            | 0                              | 0                        | 0                 | 0                              |        |
| 30. 00           | Total fixed assets (sum of lines 12-29)  | 143, 422, 233                  |                          | 0                 | 0                              |        |
| 00.00            | OTHER ASSETS   | 110, 122, 200                  | <u> </u>                 | <u></u>           |                                | 30.00  |
| 31.00            | Investments  | 848, 792                       | 0                        | 0                 | 0                              | 31.00  |
| 32.00            | Deposits on Leases   | 0                              | 0                        | 0                 | 0                              |        |
| 33.00            | Due from owners/officers   | 0                              | 0                        | 0                 | 0                              |        |
| 34.00            | Other assets   | 281, 994, 744                  | 1                        | 0                 | 0                              |        |
| 35. 00<br>36. 00 | Total other assets (sum of lines 31-34) Total assets (sum of lines 11, 30, and 35) | 282, 843, 536<br>475, 150, 911 | 0                        | 0                 | 0                              |        |
| 30.00            | CURRENT LIABILITIES  CURRENT LIABILITIES   | 475, 150, 911                  | J O                      | <u> </u>          | 0                              | 30.00  |
| 37. 00           | Accounts payable   | 6, 779, 366                    | 0                        | ol                | 0                              | 37. 00 |
| 38. 00           | Salaries, wages, and fees payable  | 10, 551, 970                   |                          | o                 | 0                              |        |
| 39.00            | Payroll taxes payable  | 0                              | 0                        | o                 | 0                              | 39.00  |
| 40.00            | Notes and Loans payable (short term)   | 0                              | 0                        | 0                 | 0                              | 1      |
| 41. 00           | Deferred income  | 0                              | 0                        | 0                 | 0                              |        |
| 42.00            | Accel erated payments  | 0                              |                          |                   |                                | 42.00  |
| 43. 00<br>44. 00 | Due to other funds   | 0<br>4E 424 014                |                          | 0                 | 0                              | 1      |
| 45.00            | Other current liabilities Total current liabilities (sum of lines 37 thru 44)      | 45, 636, 916<br>62, 968, 252   |                          | 0                 |                                |        |
| 43.00            | LONG TERM LIABILITIES  | 02, 700, 232                   | 0                        | <u>U</u>          |                                | 43.00  |
| 46. 00           | Mortgage payable   | 0                              | 0                        | ol                | 0                              | 46. 00 |
| 47.00            | Notes payable  | 0                              | 0                        | o                 | 0                              | 1      |
| 48.00            | Unsecured Loans  | 0                              | 0                        | 0                 | 0                              | 48. 00 |
| 49. 00           | Other long term liabilities  | 99, 039, 051                   | 1                        | 0                 | 0                              | 1      |
| 50.00            | Total long term liabilities (sum of lines 46 thru 49)                              | 99, 039, 051                   | 1                        | 0                 | 0                              | 1      |
| 51. 00           | Total liabilities (sum of lines 45 and 50)   | 162, 007, 303                  | 0                        | 0                 | 0                              | 51.00  |
| 52. 00           | CAPITAL ACCOUNTS  General fund balance   | 313, 143, 608                  | 1                        | 1                 |                                | 52.00  |
| 53. 00           | Specific purpose fund  | 313, 143, 000                  | 0                        |                   |                                | 53.00  |
| 54. 00           | Donor created - endowment fund balance - restricted                                |                                | Ĭ                        | ol                |                                | 54.00  |
| 55.00            | Donor created - endowment fund balance - unrestricted                              |                                |                          | o                 |                                | 55.00  |
| 56.00            | Governing body created - endowment fund balance                                    |                                |                          | 0                 |                                | 56.00  |
| 57. 00           | Plant fund balance - invested in plant   |                                |                          |                   | 0                              | 1      |
| 58. 00           | Plant fund balance - reserve for plant improvement,                                |                                |                          |                   | 0                              | 58. 00 |
| 59. 00           | replacement, and expansion Total fund balances (sum of lines 52 thru 58)           | 313, 143, 608                  | o                        | 0                 | 0                              | 59.00  |
| 60.00            | Total liabilities and fund balances (sum of lines 51 and                           | 475, 150, 911                  | 1                        | ol<br>Ol          | 0                              |        |
| 55. 55           | [59]   | 1,0,100,711                    |                          | ٩                 | O                              | 55.55  |
|                  |  | •                              | . '                      | '                 |                                | •      |

Provider CCN: 15-0097

|                  |   |           |               | '          | 0 12/31/2020 | 8/2/2021 2:11 |                  |
|------------------|---|-----------|---------------|------------|--------------|---------------|------------------|
|                  |   | Genera    | l Fund        | Special Pu | rpose Fund   | Endowment     |                  |
|                  |   |           |               |            |              | Fund          |                  |
|                  |   | 1. 00     | 2. 00         | 3.00       | 4. 00        | 5. 00         |                  |
| 1. 00            | Fund balances at beginning of period        | 1.00      | 319, 409, 410 |            | 4.00         | 5.00          | 1.00             |
| 2. 00            | Net income (loss) (from Wkst. G-3, line 29) |           | -6, 265, 802  |            |              |               | 2.00             |
| 3.00             | Total (sum of line 1 and line 2)            |           | 313, 143, 608 |            | 0            |               | 3.00             |
| 4.00             | Additions (credit adjustments) (specify)    | 0         |               | O          |              | 0             | 4.00             |
| 5.00             |   | 0         |               | 0          |              | 0             | 5. 00            |
| 6. 00            |   | 0         |               | 0          |              | 0             | 6. 00            |
| 7.00             |   | 0         |               | 0          |              | 0             | 7.00             |
| 8. 00<br>9. 00   |   | 0         |               | 0          |              | 0             | 8. 00<br>9. 00   |
| 10.00            | Total additions (sum of line 4-9)           |           | 0             |            | 0            | U             | 10.00            |
| 11. 00           | Subtotal (line 3 plus line 10)              |           | 313, 143, 608 |            | o            |               | 11.00            |
| 12.00            | Deductions (debit adjustments) (specify)    | 0         |               | C          |              | 0             | 12.00            |
| 13.00            | ADJUSTMENT                                  | 0         |               | C          |              | 0             | 13.00            |
| 14.00            | ROUNDI NG                                   | 0         |               | 0          |              | 0             | 14.00            |
| 15.00            |   | 0         |               | 0          |              | 0             | 15.00            |
| 16. 00<br>17. 00 |   | 0         |               |            |              | 0             | 16. 00<br>17. 00 |
| 18.00            | Total deductions (sum of lines 12-17)       | U         | 0             |            | 0            | U             | 18.00            |
| 19. 00           | Fund balance at end of period per balance   |           | 313, 143, 608 |            | 0            |               | 19.00            |
| 17.00            | sheet (line 11 minus line 18)               |           | 0.07.107000   |            |              |               | 17100            |
|                  |   | Endowment | PI ant        | Fund       |              |               |                  |
|                  |   | Fund      |               |            | -            |               |                  |
|                  |   | 6. 00     | 7. 00         | 8. 00      | -            |               |                  |
| 1. 00            | Fund balances at beginning of period        | 0.00      | 7.00          | 0.00       |              |               | 1.00             |
| 2.00             | Net income (loss) (from Wkst. G-3, line 29) |           |               |            |              |               | 2.00             |
| 3.00             | Total (sum of line 1 and line 2)            | 0         |               | O          |              |               | 3. 00            |
| 4.00             | Additions (credit adjustments) (specify)    |           | 0             |            |              |               | 4. 00            |
| 5.00             |   |           | 0             |            |              |               | 5.00             |
| 6.00             |   |           | 0             |            |              |               | 6.00             |
| 7. 00<br>8. 00   |   |           | 0             |            |              |               | 7. 00<br>8. 00   |
| 9. 00            |   |           | 0             |            |              |               | 9.00             |
| 10.00            | Total additions (sum of line 4-9)           | 0         | 0             |            |              |               | 10.00            |
| 11.00            | Subtotal (line 3 plus line 10)              | 0         |               | C          |              |               | 11.00            |
| 12.00            | Deductions (debit adjustments) (specify)    |           | 0             |            |              |               | 12.00            |
| 13.00            | ADJUSTMENT                                  |           | 0             |            |              |               | 13.00            |
| 14.00            | ROUNDI NG                                   |           | 0             |            |              |               | 14.00            |
| 15.00            |   |           | 0             |            |              |               | 15. 00<br>16. 00 |
| 16. 00<br>17. 00 |   |           | 0             |            |              |               | 17.00            |
| 18.00            | Total deductions (sum of lines 12-17)       | 0         | 0             | l o        |              |               | 18.00            |
| 19. 00           | Fund balance at end of period per balance   | ő         |               | Ö          |              |               | 19.00            |
|                  | sheet (line 11 minus line 18)               |           |               |            |              |               |                  |
|                  |   |           |               |            |              |               |                  |

Provider CCN: 15-0097

Peri od: Worksheet G-2 From 01/01/2020 Parts I & II To 12/31/2020 Date/Time Prepared: 8/2/2021 2:11 pm

|        |  |                  |              |               | 8/2/2021 2:11 | pm     |
|--------|--|------------------|--------------|---------------|---------------|--------|
|        | Cost Center Description  |                  | I npati ent  | Outpati ent   | Total         |        |
|        |  |                  | 1. 00        | 2. 00         | 3. 00         |        |
|        | PART I - PATIENT REVENUES                                      |                  |              |               |               |        |
|        | General Inpatient Routine Services                             |                  |              | 1             |               |        |
| 1. 00  | Hospi tal  |                  | 14, 177, 715 |               | 14, 177, 715  | 1.00   |
| 2. 00  | SUBPROVIDER - IPF  |                  |              |               |               | 2.00   |
| 3. 00  | SUBPROVI DER - I RF  |                  |              |               |               | 3.00   |
| 4. 00  | SUBPROVI DER   |                  |              |               |               | 4.00   |
| 5. 00  | Swing bed - SNF  |                  | 0            |               | 0             | 5.00   |
| 6. 00  | Swing bed - NF   |                  | 0            |               | 0             | 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)       |                  | 14, 177, 715 |               | 14, 177, 715  | 10.00  |
|        | Intensive Care Type Inpatient Hospital Services                |                  |              | T             |               |        |
| 11.00  | INTENSIVE CARE UNIT  |                  | 6, 992, 734  |               | 6, 992, 734   |        |
| 12.00  | CORONARY CARE UNIT   |                  |              |               |               | 12.00  |
| 13.00  | BURN INTENSIVE CARE UNIT                                       |                  |              |               |               | 13.00  |
| 14.00  | SURGI CAL INTENSIVE CARE UNIT                                  |                  |              |               |               | 14.00  |
| 15.00  | OTHER SPECIAL CARE (SPECIFY)                                   |                  | , ,,,,,      |               | , ,,,,        | 15.00  |
| 16. 00 | Total intensive care type inpatient hospital services (sum of  | lines            | 6, 992, 734  |               | 6, 992, 734   | 16. 00 |
| 47.00  | 11-15)   |                  | 04 470 440   |               | 04 470 440    | 47.00  |
| 17.00  | Total inpatient routine care services (sum of lines 10 and 16) | )                | 21, 170, 449 |               | 21, 170, 449  |        |
| 18.00  | Ancillary services   |                  | 58, 633, 270 |               |               |        |
| 19.00  | Outpati ent servi ces  |                  | 12, 682, 940 |               |               |        |
| 20.00  | RURAL HEALTH CLINIC  |                  | 0            | -,,           | 3, 866, 121   |        |
| 20. 01 | RURAL HEALTH CLINIC II   |                  | 0            |               |               |        |
| 20. 02 |  |                  | 0            | , ,           |               |        |
| 21. 00 |  |                  | C            | _             |               | 21.00  |
| 22. 00 | HOME HEALTH AGENCY   |                  |              | 2, 333, 121   | l             |        |
| 23. 00 | AMBULANCE SERVICES   |                  | O O          | 0             | 0             | 23.00  |
| 24.00  | CMHC   |                  |              |               |               | 24.00  |
| 25. 00 | AMBULATORY SURGICAL CENTER (D. P. )                            |                  |              |               |               | 25.00  |
| 26.00  | HOSPI CE   |                  |              | 4 00/ 044     | 4 00/ 044     | 26.00  |
| 27. 00 | PHYSI CI AN / OTHER  | 1 . 14/1 . 1     | 00 407 750   | 4, 306, 041   |               |        |
| 28. 00 | Total patient revenues (sum of lines 17-27)(transfer column 3  | to WKST.         | 92, 486, 659 | 324, 394, 217 | 416, 880, 876 | 28. 00 |
|        | G-3, line 1) PART II - OPERATING EXPENSES                      |                  |              |               |               |        |
| 29. 00 | Operating expenses (per Wkst. A, column 3, line 200)           |                  |              | 145, 961, 860 |               | 29. 00 |
| 30.00  | ADD (SPECIFY)  |                  | o            |               |               | 30.00  |
| 31. 00 | ADD (SPECIFF)  |                  |              |               |               | 31.00  |
| 32.00  |  |                  |              |               |               | 32.00  |
| 33. 00 |  |                  |              |               |               | 33.00  |
| 34. 00 |  |                  |              |               |               | 34.00  |
| 35. 00 |  |                  |              |               |               | 35.00  |
| 36. 00 | Total additions (sum of lines 30-35)                           |                  |              | 0             |               | 36.00  |
| 37. 00 | DEDUCT (SPECIFY)   |                  | O            |               |               | 37.00  |
| 38. 00 | DEDUCT (SPECITI)   |                  |              |               |               | 38.00  |
| 39. 00 |  |                  |              |               |               | 39.00  |
| 40. 00 |  |                  |              |               |               | 40.00  |
| 41. 00 |  |                  |              |               |               | 41.00  |
| 42.00  | Total deductions (sum of lines 37-41)                          |                  | ١            | 0             |               | 42.00  |
| 43. 00 | ,  | 2)(transfer      |              | 145, 961, 860 |               | 43.00  |
| 73.00  | to Wkst. G-3, line 4)  | 2) ( 11 41131 61 |              | 175, 701, 000 |               | 75.00  |
|        | 120 mat. 0 0, 1110 1)  |                  | ı            | l .           | ı             | ı      |

| Heal th | Financial Systems MAJOR HOSE                                  | PI TAL                 | In Lie          | u of Form CMS-2             | 2552-10 |
|---------|---|------------------------|-----------------|-----------------------------|---------|
|         | IENT OF REVENUES AND EXPENSES                                 | Provi der CCN: 15-0097 | Peri od:        | Worksheet G-3               |         |
|         |   |                        | From 01/01/2020 | 5 . (7) 5                   |         |
|         |   |                        | To 12/31/2020   | Date/Time Pre 8/2/2021 2:11 |         |
|         |   |                        |                 | 0/2/2021 2.11               | Pili    |
|         |   |                        |                 | 1. 00                       |         |
| 1. 00   | Total patient revenues (from Wkst. G-2, Part I, column 3, Ii  | ne 28)                 |                 | 416, 880, 876               | 1.00    |
| 2.00    | Less contractual allowances and discounts on patients' accou  |                        |                 | 292, 732, 279               | 2.00    |
| 3. 00   | Net patient revenues (line 1 minus line 2)                    |                        |                 | 124, 148, 597               | 3. 00   |
| 4.00    | Less total operating expenses (from Wkst. G-2, Part II, line  | 43)                    |                 | 145, 961, 860               |         |
| 5.00    | Net income from service to patients (line 3 minus line 4)     | ,                      |                 | -21, 813, 263               |         |
|         | OTHER I NCOME   |                        |                 |                             |         |
| 6.00    | Contributions, donations, bequests, etc                       |                        |                 | 0                           | 6.00    |
| 7.00    | Income from investments                                       |                        |                 | 0                           | 7. 00   |
| 8.00    | Revenues from telephone and other miscellaneous communication | n services             |                 | 0                           | 8. 00   |
| 9.00    | Revenue from television and radio service                     |                        |                 | 0                           | 9.00    |
| 10.00   | Purchase di scounts   |                        |                 | 0                           | 10.00   |
| 11.00   | Rebates and refunds of expenses                               |                        |                 | 0                           | 11.00   |
| 12.00   | Parking Lot receipts  |                        |                 | 0                           | 12.00   |
| 13.00   | Revenue from Laundry and Linen service                        |                        |                 | 0                           | 13.00   |
| 14.00   | Revenue from meals sold to employees and guests               |                        |                 | 0                           | 14.00   |
| 15.00   | Revenue from rental of living quarters                        |                        |                 | 0                           | 15.00   |
| 16.00   | Revenue from sale of medical and surgical supplies to other   | than patients          |                 | 0                           | 16.00   |
| 17.00   | Revenue from sale of drugs to other than patients             |                        |                 | 0                           | 17.00   |
| 18.00   | Revenue from sale of medical records and abstracts            |                        |                 | 0                           | 18.00   |
| 19.00   | Tuition (fees, sale of textbooks, uniforms, etc.)             |                        |                 | 0                           | 19.00   |
| 20.00   | Revenue from gifts, flowers, coffee shops, and canteen        |                        |                 | 0                           | 20.00   |
| 21.00   | Rental of vending machines                                    |                        |                 | 0                           | 21.00   |
| 22.00   | Rental of hospital space                                      |                        |                 | 0                           | 22.00   |
| 23.00   | Governmental appropriations                                   |                        |                 | 0                           | 23.00   |
| 24.00   | OTHER OPERATING REVENUE                                       |                        |                 | 4, 309, 802                 | 24.00   |
| 24.01   | OTHER REVENUE   |                        |                 | 14, 711, 135                | 24. 01  |
| 24.50   | COVI D-19 PHE Fundi ng  |                        |                 | 3, 102, 081                 | 24.50   |
| 25 00   | Total other income (sum of lines 6.24)                        |                        |                 | 22 122 010                  | 25 00   |

22, 123, 018 25. 00 309, 755 26. 00 6, 575, 557 27. 00 6, 575, 557 28. 00 -6, 265, 802 29. 00

24.50 COVID-19 PHE Funding
25.00 Total other income (sum of lines 6-24)
26.00 Total (line 5 plus line 25)
27.00 TRANSFERS
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)

Column, 6 line 24 should agree with the Worksheet A, column 3, line 101, or subscript as applicable.

1, 057, 186

-1, 836

1, 055, 350

24.00

24.00 Total (sum of lines 1-23)

| AI                         | LLOCATION - HHA GENERAL SERVICE  | : 0051   |                       | Provi der CO           | JN: 15-0097                         | Peri od:                         | Worksheet H-1           |                  |
|----------------------------|--|--|-----------------------|------------------------|-------------------------------------|----------------------------------|-------------------------|------------------|
|                            |  |  |                       | HHA CCN:               | 15-7418                             | From 01/01/2020<br>To 12/31/2020 | Part I<br>Date/Time Pre | epared:          |
|                            |  |  |                       |                        |                                     | Home Health                      | 8/2/2021 2: 11<br>PPS   | pm               |
|                            |  |  |                       |                        |                                     | Agency I                         | 113                     |                  |
|                            |  |  | Capital Rela          | ated Costs             |                                     |                                  |                         |                  |
|                            |  | Net Expenses<br>for Cost<br>Allocation<br>(from Wkst.<br>H, col. 10) | Bldgs &<br>Fixtures   | Movabl e<br>Equi pment | Plant<br>Operation &<br>Maintenance |                                  | Subtotal<br>(cols. 0-4) |                  |
|                            |  | 0  | 1. 00                 | 2.00                   | 3. 00                               | 4.00                             | 4A. 00                  |                  |
|                            | GENERAL SERVICE COST CENTERS Capital Related - Bldg. &   | 3, 198   | 3, 198                |                        |                                     |                                  | 0                       | 1.00             |
| 2. 00                      | Fixtures Capital Related - Movable Equipment   | 30, 753  | 5,5                   | 30, 753                |                                     |                                  | 0                       |                  |
| 3.00                       | Plant Operation & Maintenance  | 285  | O                     | 0                      | 2                                   | 85                               | 0                       |                  |
| 5.00                       | Transportation Administrative and General HHA REIMBURSABLE SERVICES  | 44, 401<br>263, 822  | 3, 198                | 30, 753                | 2                                   | 0 44, 401<br>85 44, 401          | 342, 459                | 4.00<br>5.00     |
| 6.00                       | Skilled Nursing Care   | 346, 114   | 0                     | 0                      |                                     | 0 0                              | 346, 114                | 1                |
|                            | Physical Therapy<br>Occupational Therapy   | 170, 486<br>109, 865   | 0                     | 0                      |                                     | 0 0                              | 170, 486<br>109, 865    |                  |
|                            | Speech Pathology   | 109, 865   | 0                     | 0                      |                                     |                                  | 109, 863                | 1                |
|                            | Medical Social Services  | 836  | 0                     | 0                      |                                     | 0 0                              | 836                     |                  |
|                            | Home Health Aide<br>Supplies (see instructions)  | 47, 347<br>38, 053   | 0                     | 0                      |                                     | 0 0                              | 47, 347<br>38, 053      | 1                |
|                            | Drugs  | 190  | Ö                     | 0                      |                                     | 0                                | 190                     |                  |
|                            | DME STATE OF THE S | 0  | 0                     | 0                      |                                     | 0 0                              | 0                       | 14.00            |
|                            | HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services   | 0  | 0                     | 0                      |                                     | 0 0                              | 0                       | 15.00            |
|                            | Respiratory Therapy  | 0  | Ö                     | 0                      |                                     | 0 0                              | 0                       | 1                |
|                            | Private Duty Nursing   | 0  | 0                     | 0                      |                                     | 0 0                              | 0                       |                  |
|                            | Clinic<br>Health Promotion Activities  | 0  | 0                     | 0                      |                                     | 0 0                              | 0                       |                  |
| 20. 00                     | Day Care Program   | 0  | ō                     | 0                      |                                     | 0 0                              | 0                       | 20.00            |
|                            | Home Delivered Meals Program<br>Homemaker Service  | 0  | 0                     | 0                      |                                     | 0 0                              | 0                       |                  |
|                            | All Others (specify)   | 0  | 0                     | 0                      |                                     |                                  | 0                       | 1                |
| 23. 50                     | Tel emedi ci ne  | 0  | 0                     | 0                      |                                     | 0 0                              | 0                       |                  |
| 24. 00                     | Total (sum of lines 1-23)  | 1, 055, 350<br>Admi ni strati v                                      | 3, 198<br>Total (cols | 30, 753                | 2                                   | 85 44, 401                       | 1, 055, 350             | 24.00            |
|                            |  | e & General  | 4A + 5)               |                        |                                     |                                  |                         |                  |
|                            | GENERAL SERVICE COST CENTERS   | 5. 00  | 6. 00                 |                        |                                     |                                  |                         |                  |
|                            | Capital Related - Bldg. &  |  |                       |                        |                                     |                                  |                         | 1.00             |
|                            | Fixtures Capital Related - Movable   |  |                       |                        |                                     |                                  |                         | 2.00             |
|                            | Equi pment   |  |                       |                        |                                     |                                  |                         |                  |
| 1                          | Plant Operation & Maintenance Transportation   |  |                       |                        |                                     |                                  |                         | 3. 00<br>4. 00   |
| 5.00                       | Administrative and General HHA REIMBURSABLE SERVICES   | 342, 459   |                       |                        |                                     |                                  |                         | 5.00             |
| 6.00                       | Skilled Nursing Care   | 166, 266   | 512, 380              |                        |                                     |                                  |                         | 6.00             |
|                            | Physical Therapy<br>Occupational Therapy   | 81, 898<br>52, 777   | 252, 384<br>162, 642  |                        |                                     |                                  |                         | 7. 00<br>8. 00   |
|                            | Speech Pathology   | 0  | 162, 642              |                        |                                     |                                  |                         | 9.00             |
| 10. 00                     | Medical Social Services  | 402  | 1, 238                |                        |                                     |                                  |                         | 10.00            |
|                            | Home Health Aide<br>Supplies (see instructions)  | 22, 745<br>18, 280   | 70, 092<br>56, 333    |                        |                                     |                                  |                         | 11.00            |
| 13. 00                     | Drugs  | 91   | 281                   |                        |                                     |                                  |                         | 13.00            |
| +                          | DME  | 0  | 0                     |                        |                                     |                                  |                         | 14.00            |
|                            | HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services   | 0  | 0                     |                        |                                     |                                  |                         | 15.00            |
| 16. 00                     | Respi ratory Therapy   | 0  | O                     |                        |                                     |                                  |                         | 16.00            |
| 1                          | Private Duty Nursing<br>Clinic   | 0  | 0                     |                        |                                     |                                  |                         | 17. 00<br>18. 00 |
|                            | Health Promotion Activities  | 0  | 0                     |                        |                                     |                                  |                         | 19.00            |
|                            | Day Care Program   | 0  | O                     |                        |                                     |                                  |                         | 20.00            |
| 04 0- '                    | Home Delivered Meals Program   | 0  | 0                     |                        |                                     |                                  |                         | 21.00            |
|                            | Homemaker Service  | ΩI   | OI.                   |                        |                                     |                                  |                         | 1 77 00          |
| 22. 00<br>23. 00           | Homemaker Service<br>All Others (specify)  | 0<br>0   | 0                     |                        |                                     |                                  |                         | 22. 00<br>23. 00 |
| 22. 00<br>23. 00<br>23. 50 |  | 0<br>0<br>0  | -1                    |                        |                                     |                                  |                         |                  |

|        |                                |               |             |               |             |               | 8/2/2021 2:11 | pm     |
|--------|--------------------------------|---------------|-------------|---------------|-------------|---------------|---------------|--------|
|        |                                |               |             |               |             | Home Health   | PPS           |        |
|        |                                |               |             |               |             | Agency I      |               |        |
|        |                                | Capital Rel   | ated Costs  |               |             |               |               |        |
|        |                                |               |             |               |             |               |               |        |
|        |                                | BI dgs &      | Movabl e    | PI ant        |             | Reconciliatio |               |        |
|        |                                | Fi xtures     | Equi pment  | Operation &   | n (MILEAGE) | n             | e & General   |        |
|        |                                | (SQUARE FEET) | (DOLLAR     | Mai ntenance  |             |               | (ACCUM. COST) |        |
|        |                                |               | VALUE)      | (SQUARE FEET) |             |               |               |        |
|        |                                | 1. 00         | 2. 00       | 3. 00         | 4.00        | 5A. 00        | 5. 00         |        |
|        | GENERAL SERVICE COST CENTERS   |               |             |               |             |               |               |        |
| 1.00   | Capital Related - Bldg. &      | 100           |             |               |             | 0             |               | 1.00   |
|        | Fixtures                       |               |             |               |             |               |               |        |
| 2.00   | Capital Related - Movable      |               | 100         |               |             | 0             |               | 2.00   |
|        | Equi pment                     |               |             |               |             |               |               |        |
| 3.00   | Plant Operation & Maintenance  | 0             | 0           | 100           |             | 0             |               | 3.00   |
| 4.00   | Transportation (see            | o             | 0           | 0             | 100         |               |               | 4.00   |
|        | instructions)                  |               |             |               |             |               |               |        |
| 5.00   | Administrative and General     | 100           | 100         | 100           | 100         | -342, 459     | 712, 891      | 5.00   |
|        | HHA REIMBURSABLE SERVICES      |               |             |               |             |               |               |        |
| 6.00   | Skilled Nursing Care           | 0             | 0           | 0             | C           | 0             | 346, 114      | 6.00   |
| 7.00   | Physical Therapy               | O             | 0           | 0             | d c         | 0             | 170, 486      | 7.00   |
| 8. 00  | Occupational Therapy           | l o           | 0           | 0             | l c         | 0             | 109, 865      | 8.00   |
| 9. 00  | Speech Pathology               | l o           | 0           | 0             | l c         | 0             | 0             | 9.00   |
| 10.00  | Medical Social Services        | l o           | 0           | 0             | l c         | 0             | 836           | 10.00  |
| 11. 00 | Home Health Aide               | o             | 0           | 0             |             | 0             | 47, 347       | 11.00  |
| 12.00  | Supplies (see instructions)    | o             | 0           | 0             |             | 0             | 38, 053       | 12.00  |
| 13. 00 | Drugs                          | 0             | 0           | 0             |             | 0             | 190           |        |
| 14. 00 | DME                            | l ol          | 0           | 0             |             | 0             |               |        |
|        | HHA NONREI MBURSABLE SERVI CES | -,            |             |               | _           |               | _             |        |
| 15. 00 | Home Dialysis Aide Services    | 0             | 0           | 0             | C           | 0             | 0             | 15.00  |
| 16. 00 | Respiratory Therapy            | l ol          | 0           | 0             | d           | 0             | 0             | 16.00  |
| 17. 00 | Private Duty Nursing           | l ol          | 0           | 0             | d           | 0             | 0             | 17. 00 |
| 18. 00 | Clinic                         |               | 0           | 0             | l c         | o o           | l o           | 18.00  |
| 19. 00 | Health Promotion Activities    |               | 0           | 0             |             |               | l ő           | 19.00  |
| 20. 00 | Day Care Program               |               | 0           | ĺ             | ]           | o o           | l o           | 20.00  |
| 21. 00 | Home Delivered Meals Program   |               | 0           | 0             |             |               | l o           | 21.00  |
| 22. 00 | Homemaker Service              |               | 0           | 0             |             |               | 0             | 22.00  |
| 23. 00 | All Others (specify)           |               | 0           | 0             |             |               |               | 23.00  |
| 23. 50 | Tel emedi ci ne                |               | 0           | 0             |             |               |               | 23.50  |
| 24. 00 | Total (sum of lines 1-23)      | 100           | 100         | 100           | 100         | -342, 459     | 712, 891      | 24.00  |
| 25. 00 | Cost To Be Allocated (per      | 3, 198        | 30, 753     | 285           |             |               | 342, 459      |        |
| 25.00  | Worksheet H-1, Part I)         | 3, 198        | 30, 753     | 283           | 44, 401     |               | 342, 459      | 25.00  |
| 26 00  | Unit Cost Multiplier           | 31. 980000    | 307. 530000 | 2. 850000     | 444. 010000 |               | 0. 480381     | 26 00  |
| 20.00  | Tour Cost Martipire            | ] 31. 900000  | 307. 330000 | 2. 000000     | 444.010000  | <b>'</b> I    | 0. 400381     | 20.00  |

Health Financial Systems
ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS Worksheet H-2 Part I Date/Time Prepared: 8/2/2021 2:11 pm PPS Provider CCN: 15-0097 Peri od: From 01/01/2020 To 12/31/2020 HHA CCN: 15-7418 Home Health

|  |   |   |  |   |  | Agency I  | 113  |  |
|--|---|---|--|---|--|---|--|--|
|  |   |   | CAPI TAL   |   |  | .,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,   |  |  |
|  |   |   | RELATED COSTS  |   |  |   |  |  |
|  | Cost Center Description   | HHA Trial   | BLDG & FIXT  | EMPLOYEE  | Subtotal   | ADMI NI STRATI V  | OPERATION OF   |  |
|  |   | Bal ance (1)  |  | BENEFITS<br>DEPARTMENT  |  | E & GENERAL   | PLANT  |  |
|  |   | 0   | 1. 00  | 4. 00   | 4A   | 5. 00   | 7. 00  |  |
| 1. 00  | Administrative and General  | 0   | 211, 623   | 177, 697  | 389, 320   |   | 114, 978   | 1. 00  |
| 2.00   | Skilled Nursing Care  | 512, 380  | 0  | o   | 512, 380   | 110, 520  | 0  | 2.00   |
| 3.00   | Physi cal Therapy   | 252, 384  | 0  | 0   | 252, 384   |   | 0  | 3.00   |
| 4. 00  | Occupational Therapy  | 162, 642  | 0  | 0   | 162, 642   | 35, 082   | 0  | 4.00   |
| 5.00   | Speech Pathology  | 0   | 0  | 0   | 4 000  | 0   | 0  | 5.00   |
| 6. 00<br>7. 00   | Medical Social Services Home Health Aide  | 1, 238<br>70, 092   | 0  | 0   | 1, 238<br>70, 092  |   | 0  | 6. 00<br>7. 00   |
| 8. 00  | Supplies (see instructions)   | 56, 333   |  | 0   | 56, 333  | · ·   | 0  | 8. 00  |
| 9. 00  | Drugs   | 281   | o  | Ö   | 281  |   | o  | 9. 00  |
| 10.00  | DME   | 0   | o  | Ö   | 0  |   | 0  | 10.00  |
| 11.00  | Home Dialysis Aide Services   | 0   | O  | O   | 0  | 0   | 0  | 11.00  |
| 12.00  | Respi ratory Therapy  | 0   | 0  | 0   | 0  | 0   | 0  | 12.00  |
| 13.00  | Private Duty Nursing  | 0   | 0  | 0   | 0  | 0   | 0  | 13.00  |
| 14.00  | Clinic  | 0   | 0  | 0   | 0  | 0   | 0  | 14.00  |
| 15. 00<br>16. 00   | Health Promotion Activities Day Care Program  | 0   | 0  | 0   | 0  | 0   | 0  | 15. 00<br>16. 00   |
| 17. 00   | Home Delivered Meals Program  | 0   | o o  | Ö   | 0  | 0   | 0  | 17. 00   |
| 18. 00   | Homemaker Service   | 0   | o  | o   | 0  | 0   | 0  | 18. 00   |
| 19. 00   | All Others (specify)  | 0   | o  | О   | 0  | 0   | 0  | 19. 00   |
| 19. 50   | Tel emedi ci ne   | 0   | 0  | 0   | 0  | 0   | 0  | 19. 50   |
| 20.00  | Total (sum of lines 1-19) (2)   | 1, 055, 350   | 211, 623   | 177, 697  | 1, 444, 670  |   | 114, 978   |  |
| 21. 00   | Unit Cost Multiplier: column  |   |  |   | 0. 000000  |   |  | 21. 00   |
|  | 26, line 1 divided by the sum of column 26, line 20 minus   |   |  |   |  |   |  |  |
|  | column 26, line 1, rounded to   |   |  |   |  |   |  |  |
|  |   |   |  |   |  |   |  |  |
|  | 6 decimal places.   |   |  |   |  |   |  |  |
|  |   | LAUNDRY &   | HOUSEKEEPI NG  | DI ETARY  | CAFETERI A   | NURSI NG  | CENTRAL  |  |
|  | 6 decimal places.   | LAUNDRY &<br>LINEN SERVICE  | HOUSEKEEPI NG  | DI ETARY  | CAFETERI A   | ADMI NI STRATI O  | SERVICES &   |  |
|  | 6 decimal places.   |   | HOUSEKEEPI NG  | DI ETARY  | CAFETERI A   |   |  |  |
| 1.00   | 6 decimal places.   | LINEN SERVICE   |  |   |  | ADMI NI STRATI 0<br>N<br>13. 00   | SERVICES & SUPPLY  | 1.00   |
| 2.00   | 6 decimal places. Cost Center Description   | LI NEN SERVI CE<br>8. 00  | 9. 00  | 10. 00  | 11. 00   | ADMI NI STRATI 0<br>N<br>13. 00   | SERVI CES &<br>SUPPLY<br>14.00                               | 2.00   |
| 2. 00<br>3. 00   | Administrative and General Skilled Nursing Care Physical Therapy  | LI NEN SERVI CE<br>8. 00  | 9. 00<br>83, 677   | 10. 00  | 11. 00   | ADMI NI STRATI 0<br>N<br>13. 00   | SERVI CES & SUPPLY  14. 00  0 0 0                            | 2. 00<br>3. 00   |
| 2. 00<br>3. 00<br>4. 00  | Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy   | LI NEN SERVI CE<br>8. 00  | 9. 00<br>83, 677<br>0<br>0   | 10. 00  | 11. 00   | ADMI NI STRATI 0<br>N<br>13. 00   | SERVI CES & SUPPLY 14. 00 0 0 0 0 0                          | 2. 00<br>3. 00<br>4. 00  |
| 2. 00<br>3. 00<br>4. 00<br>5. 00   | Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology  | LI NEN SERVI CE<br>8. 00  | 9.00<br>83,677<br>0<br>0<br>0  | 10. 00<br>0<br>0<br>0<br>0  | 11. 00<br>0<br>0<br>0<br>0   | ADMI NI STRATI 0<br>N<br>13. 00<br>96, 530<br>0<br>0                                    | SERVI CES & SUPPLY 14. 00 0 0 0 0 0 0 0 0                    | 2. 00<br>3. 00<br>4. 00<br>5. 00   |
| 2. 00<br>3. 00<br>4. 00<br>5. 00<br>6. 00  | Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services  | LI NEN SERVI CE<br>8. 00  | 9. 00<br>83, 677<br>0<br>0   | 10. 00  | 11. 00   | ADMI NI STRATI 0<br>N<br>13. 00<br>96, 530<br>0<br>0                                    | SERVI CES & SUPPLY 14. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0  | 2.00<br>3.00<br>4.00<br>5.00<br>6.00   |
| 2. 00<br>3. 00<br>4. 00<br>5. 00   | Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide   | LI NEN SERVI CE<br>8. 00  | 9.00<br>83,677<br>0<br>0<br>0<br>0   | 10. 00<br>0<br>0<br>0<br>0  | 11. 00<br>0<br>0<br>0<br>0   | ADMI NI STRATI 0<br>N<br>13. 00<br>96, 530<br>0<br>0<br>0<br>0                          | SERVI CES & SUPPLY 14. 00 0 0 0 0 0 0 0 0                    | 2. 00<br>3. 00<br>4. 00<br>5. 00   |
| 2. 00<br>3. 00<br>4. 00<br>5. 00<br>6. 00<br>7. 00<br>8. 00<br>9. 00   | Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs   | LI NEN SERVI CE<br>8. 00  | 9.00<br>83,677<br>0<br>0<br>0<br>0<br>0  | 10. 00<br>0<br>0<br>0<br>0<br>0<br>0                              | 11. 00<br>0<br>0<br>0<br>0<br>0  | ADMI NI STRATI 0<br>N<br>13. 00<br>96, 530<br>0<br>0<br>0<br>0                          | SERVI CES & SUPPLY 14. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0  | 2. 00<br>3. 00<br>4. 00<br>5. 00<br>6. 00<br>7. 00   |
| 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   | Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME   | LI NEN SERVI CE<br>8. 00  | 9. 00<br>83, 677<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0   | 10. 00<br>0<br>0<br>0<br>0<br>0<br>0                              | 11. 00<br>0<br>0<br>0<br>0<br>0<br>0<br>0  | ADMI NI STRATI 0<br>N<br>13. 00<br>96, 530<br>0<br>0<br>0<br>0                          | SERVI CES & SUPPLY 14. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 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   |
| 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   | Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services   | LI NEN SERVI CE<br>8. 00  | 9.00<br>83,677<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0  | 10. 00<br>0<br>0<br>0<br>0<br>0<br>0                              | 11. 00<br>0<br>0<br>0<br>0<br>0<br>0<br>0  | ADMI NI STRATI 0<br>N<br>13. 00<br>96, 530<br>0<br>0<br>0<br>0                          | SERVI CES & SUPPLY 14.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 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   |
| 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   | Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy   | LI NEN SERVI CE<br>8. 00  | 9.00<br>83,677<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0  | 10. 00<br>0<br>0<br>0<br>0<br>0<br>0                              | 11. 00<br>0<br>0<br>0<br>0<br>0<br>0<br>0  | ADMI NI STRATI 0<br>N<br>13. 00<br>96, 530<br>0<br>0<br>0<br>0                          | SERVI CES & SUPPLY 14. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 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  |
| 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   | Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing  | LI NEN SERVI CE<br>8. 00  | 9.00<br>83,677<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0                                    | 10. 00<br>0<br>0<br>0<br>0<br>0<br>0                              | 11. 00<br>0<br>0<br>0<br>0<br>0<br>0<br>0  | ADMI NI STRATI 0<br>N<br>13. 00<br>96, 530<br>0<br>0<br>0<br>0                          | SERVI CES & SUPPLY 14. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 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   |
| 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   | Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy   | LI NEN SERVI CE<br>8. 00  | 9.00<br>83,677<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0  | 10. 00<br>0<br>0<br>0<br>0<br>0<br>0                              | 11. 00<br>0<br>0<br>0<br>0<br>0<br>0<br>0  | ADMI NI STRATI 0<br>N<br>13. 00<br>96, 530<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0      | SERVI CES & SUPPLY 14. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 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  |
| 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<br>14. 00   | Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic   | 8. 00<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0 | 9.00<br>83,677<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0                               | 10. 00<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0          | 11. 00<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0                               | ADMI NI STRATI 0  N  13. 00  96, 530  0  0  0  0  0  0  0  0  0  0  0  0                | SERVI CES & SUPPLY 14. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 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<br>14. 00   |
| 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<br>14. 00<br>15. 00<br>16. 00<br>17. 00                               | Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program   | 8. 00<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0 | 9.00<br>83,677<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0                          | 10.00<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0 | 11. 00<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0 | ADMI NI STRATI 0<br>N<br>13. 00<br>96, 530<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0 | SERVI CES & SUPPLY 14.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | 2. 00<br>3. 00<br>4. 00<br>5. 00<br>6. 00<br>7. 00<br>9. 00<br>10. 00<br>11. 00<br>12. 00<br>13. 00<br>14. 00<br>15. 00<br>16. 00<br>17. 00                    |
| 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<br>14. 00<br>15. 00<br>17. 00<br>18. 00                               | Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service   | 8. 00<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0 | 9.00<br>83,677<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0                     | 10.00<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0      | 11. 00<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0                               | ADMI NI STRATI 0<br>N<br>13. 00<br>96, 530<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0 | SERVI CES & SUPPLY 14.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 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<br>14. 00<br>15. 00<br>16. 00<br>17. 00<br>18. 00 |
| 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>12. 00<br>13. 00<br>14. 00<br>15. 00<br>17. 00<br>18. 00<br>19. 00                               | Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify)  | 8. 00<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0 | 9.00<br>83,677<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0                     | 10.00<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0 | 11. 00<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0 | ADMI NI STRATI 0<br>N<br>13. 00<br>96, 530<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0 | SERVI CES & SUPPLY 14.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 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<br>12. 00<br>13. 00<br>14. 00<br>15. 00<br>17. 00<br>18. 00<br>19. 00           |
| 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>12. 00<br>13. 00<br>14. 00<br>15. 00<br>16. 00<br>17. 00<br>18. 00<br>19. 00<br>19. 50           | Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine   | 8. 00<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0 | 9.00<br>83,677<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0 | 10.00<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0 | 11. 00<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0 | ADMI NI STRATI 0  N  13. 00  96, 530  0  0  0  0  0  0  0  0  0  0  0  0                | SERVI CES & SUPPLY 14.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 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>14. 00<br>15. 00<br>16. 00<br>17. 00<br>18. 00<br>19. 50 |
| 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>12. 00<br>13. 00<br>14. 00<br>15. 00<br>17. 00<br>18. 00<br>19. 00                               | Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify)  | 8. 00<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0 | 9.00<br>83,677<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0                     | 10.00<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0 | 11. 00<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0 | ADMI NI STRATI 0<br>N<br>13. 00<br>96, 530<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0 | SERVI CES & SUPPLY 14.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 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<br>12. 00<br>13. 00<br>14. 00<br>15. 00<br>17. 00<br>18. 00<br>19. 00           |
| 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>13. 00<br>14. 00<br>15. 00<br>16. 00<br>17. 00<br>18. 00<br>19. 00<br>19. 50<br>20. 00 | Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2)   | 8. 00<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0 | 9.00<br>83,677<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0 | 10.00<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0 | 11. 00<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0 | ADMI NI STRATI 0  N  13. 00  96, 530  0  0  0  0  0  0  0  0  0  0  0  0                | SERVI CES & SUPPLY 14.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | 2. 00<br>3. 00<br>4. 00<br>5. 00<br>6. 00<br>9. 00<br>10. 00<br>11. 00<br>12. 00<br>13. 00<br>14. 00<br>15. 00<br>17. 00<br>18. 00<br>19. 50<br>20. 00         |
| 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>13. 00<br>14. 00<br>15. 00<br>16. 00<br>17. 00<br>18. 00<br>19. 00<br>19. 50<br>20. 00 | Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus  | 8. 00<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0 | 9.00<br>83,677<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0 | 10.00<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0 | 11. 00<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0 | ADMI NI STRATI 0  N  13. 00  96, 530  0  0  0  0  0  0  0  0  0  0  0  0                | SERVI CES & SUPPLY 14.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | 2. 00<br>3. 00<br>4. 00<br>5. 00<br>6. 00<br>9. 00<br>10. 00<br>11. 00<br>12. 00<br>13. 00<br>14. 00<br>15. 00<br>17. 00<br>18. 00<br>19. 50<br>20. 00         |
| 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>13. 00<br>14. 00<br>15. 00<br>16. 00<br>17. 00<br>18. 00<br>19. 00<br>19. 50<br>20. 00 | Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to | 8. 00<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0 | 9.00<br>83,677<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0 | 10.00<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0 | 11. 00<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0 | ADMI NI STRATI 0  N  13. 00  96, 530  0  0  0  0  0  0  0  0  0  0  0  0                | SERVI CES & SUPPLY 14.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | 2. 00<br>3. 00<br>4. 00<br>5. 00<br>6. 00<br>9. 00<br>10. 00<br>11. 00<br>12. 00<br>13. 00<br>14. 00<br>15. 00<br>17. 00<br>18. 00<br>19. 50<br>20. 00         |
| 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>13. 00<br>14. 00<br>15. 00<br>16. 00<br>17. 00<br>18. 00<br>19. 00<br>19. 50<br>20. 00 | Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus  | 8. 00<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0 | 9.00<br>83,677<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0 | 10.00<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0 | 11. 00<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0 | ADMI NI STRATI 0  N  13. 00  96, 530  0  0  0  0  0  0  0  0  0  0  0  0                | SERVI CES & SUPPLY 14.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | 2. 00<br>3. 00<br>4. 00<br>5. 00<br>6. 00<br>9. 00<br>10. 00<br>11. 00<br>12. 00<br>13. 00<br>14. 00<br>15. 00<br>17. 00<br>18. 00<br>19. 50<br>20. 00         |

<sup>(1)</sup> Column O, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns O through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

8/2/2021 2:11 pm

PPS Home Health Agency I Cost Center Description **PHARMACY** MEDI CAL Subtotal Intern & Subtotal Allocated HHA A&G (see Part RECORDS & Resi dents LI BRARY Cost & Post II) Stepdown Adjustments 26.00 15. 00 16. 00 24. 00 25.00 27.00 1.00 Administrative and General 1.00 16, 215 784.696 784.696 0 2.00 Skilled Nursing Care 622, 900 622, 900 380, 976 2.00 Physical Therapy 0 0 0 306, 823 187, 658 3.00 306, 823 3.00 0 Occupational Therapy 0 0 120, 931 4.00 197, 724 197, 724 4.00 Speech Pathology 5.00 0 5.00 6.00 Medical Social Services 0 1, 505 0 1,505 920 6.00 7.00 Home Heal th Aide 0 000000000000 85, 211 85, 211 52, 116 7.00 Supplies (see instructions) 41, 886 0 0 68. 484 8.00 8 00 68, 484 0 9.00 Drugs 342 342 209 9.00 10.00 DMF 10.00 0 0 11.00 Home Dialysis Aide Services 0 0 11.00 0 Respiratory Therapy 0 0 0 12 00 12 00 0 13.00 Private Duty Nursing 0 0 13.00 14.00 0 0 0 14.00 Clinic Health Promotion Activities 0 0 0 0 0 15.00 15.00 0 Day Care Program 16.00 16.00 Ω 17.00 Home Delivered Meals Program 0 0 17.00 Homemaker Service 0 0 0 o 18.00 0 18.00 All Others (specify) 0 0 0 o 19 00 19 00 C 0 0 19.50 Tel emedi ci ne 0 0 19.50 Total (sum of lines 1-19) (2) 16, 215 2, 067, 685 2, 067, 685 784, 696 20.00 20.00 21.00 Unit Cost Multiplier: column 0. 611616 21.00 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places Cost Center Description Total HHA Costs 28.00 1.00 Administrative and General 1.00 2.00 Skilled Nursing Care 1,003,876 2.00 Physical Therapy 494, 481 3.00 3.00 4.00 Occupational Therapy 318, 655 4 00 Speech Pathology 5.00 5.00 6.00 Medical Social Services 2, 425 6.00 Home Health Aide 137, 327 7.00 7.00 8.00 Supplies (see instructions) 110, 370 8.00 9.00 551 9.00 Drugs 10.00 DME 10.00 11.00 0 Home Dialysis Aide Services 11.00 12.00 Respiratory Therapy 0 12.00 13.00 Private Duty Nursing 13.00 0 14.00 14.00 Clinic 0 15.00 Health Promotion Activities 15.00 Day Care Program 16.00 16.00 0 17.00 Home Delivered Meals Program 17.00 0 18.00 Homemaker Service 18.00 0 19.00 All Others (specify) 19.00 Tel emedi ci ne 0 19.50 19.50 Total (sum of lines 1-19) (2) 2,067,685 20.00 20.00 Unit Cost Multiplier: column 21.00 21.00 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.

<sup>(1)</sup> Column O, line 20 must agree with Wkst. A, column 7, line 101.(2) Columns O through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

BASIS HHA CCN: 15-7418

|  |  |  |                            |                            |   | Home Health<br>Agency I | PPS                         |  |
|--|--|--|----------------------------|----------------------------|---|-------------------------|-----------------------------|--|
|  |  | CAPI TAL   |                            |                            |   | Agency                  |                             |  |
|  |  | RELATED COSTS  |                            |                            |   |                         |                             |  |
|  | Cost Center Description  | BLDG & FIXT  | EMPLOYEE                   | Reconciliatio              |   | OPERATION OF            | LAUNDRY &                   |  |
|  |  | (SQUARE FEET)  | BENEFITS<br>DEPARTMENT     | n                          | E & GENERAL<br>(ACCUM. COST)                | PLANT<br>(SQUARE FEET)  | LINEN SERVICE<br>(POUNDS OF |  |
|  |  |  | (GROSS                     |                            | (ACCOM: COST)                               | (SQUARE TEET)           | LAUNDRY)                    |  |
|  |  |  | SALARI ES)                 |                            |   |                         |                             |  |
|  | Taran Santa Santa Santa Santa Santa Santa Santa Santa Santa Santa Santa Santa Santa Santa Santa Santa Santa S  | 1. 00  | 4. 00                      | 5A                         | 5. 00                                       | 7. 00                   | 8. 00                       |  |
| 1. 00<br>2. 00   | Administrative and General   | 6, 391   | 870, 601<br>0              | 0                          |   |                         | 0                           | 1.00   |
| 3. 00  | Skilled Nursing Care<br>Physical Therapy   |  | 0                          | _                          |   |                         | 0                           | 2. 00<br>3. 00   |
| 4. 00  | Occupational Therapy   | l ő  | 0                          | _                          |   |                         | Ö                           | 4. 00  |
| 5.00   | Speech Pathology   | 0  | 0                          | 0                          |   | 0                       | 0                           | 5.00   |
| 6.00   | Medical Social Services  | 0  | 0                          | _                          | ., ====                                     |                         | 0                           | 6.00   |
| 7. 00<br>8. 00   | Home Health Aide<br>Supplies (see instructions)  | 0  | 0                          |                            |   |                         | 0                           | 7. 00<br>8. 00   |
| 9. 00  | Drugs  |  | 0                          |                            |   | 0                       | 0                           | 9. 00  |
| 10.00  | DME  | Ö  | 0                          |                            |   | Ö                       | Ö                           | 10.00  |
| 11. 00   | Home Dialysis Aide Services  | 0  | 0                          | _                          |   | 0                       | 0                           | 11.00  |
| 12.00  | Respiratory Therapy  | 0  | 0                          |                            |   | _                       | 0                           | 12.00  |
| 13. 00<br>14. 00   | Private Duty Nursing   | 0  | 0                          |                            |   | _                       | 0                           | 13. 00<br>14. 00   |
| 15. 00   | Health Promotion Activities  |  | 0                          |                            |   | 0                       | 0                           | 15.00  |
| 16. 00   | Day Care Program   | O  | 0                          | Ō                          | Ö   | 0                       | o                           | 16.00  |
| 17. 00   | Home Delivered Meals Program   | 0  | 0                          | 0                          | 0   | 0                       | 0                           | 17.00  |
|  | Homemaker Service  | 0  | 0                          | 0                          | 0   | 0                       | 0                           | 18.00  |
| 19. 00<br>19. 50   | All Others (specify) Telemedicine  | 0  | 0                          | 0                          | 0   | 0                       | 0                           | 19. 00<br>19. 50   |
| 20. 00   | Total (sum of lines 1-19)  | 6, 391   | 870, 601                   |                            | 1, 444, 670                                 | 6, 391                  | l o                         | 20.00  |
| 21.00  | Total cost to be allocated   | 211, 623   | 177, 697                   |                            | 311, 615                                    | · ·                     | 0                           | 21.00  |
| 22. 00   |  | 33. 112658   | 0. 204108                  |                            | 0. 215700                                   |                         |                             | 22.00  |
|  | Cost Center Description  | HOUSEKEEPING<br>(SQUARE FEET)                                      | DI ETARY<br>(PATI ENT      | CAFETERIA<br>(MANHOURS)    | NURSI NG<br>ADMI NI STRATI O                | CENTRAL<br>SERVICES &   | PHARMACY<br>(100% DRUGS     |  |
|  |  | (SQUARE TELT)  | DAYS)                      | (WANTOOKS)                 | N N   | SUPPLY                  | TO PATIENTS)                |  |
|  |  |  | ŕ                          |                            | (MANHOURS)                                  | (100%                   | ,                           |  |
|  |  | 0.00   | 10.00                      | 11 00                      | 12.00                                       | SUPPLIES)               | 15.00                       |  |
| 1. 00  | Administrative and General   | 9. 00  | 10. 00                     | 11. 00                     | 13. 00<br>26, 655                           | 14. 00                  | 15. 00<br>0                 | 1.00   |
| 2. 00  | Skilled Nursing Care   | 0,071  | 0                          |                            | 0   |                         | ő                           | 2. 00  |
| 3.00   | Physi cal Therapy  | 0  | 0                          | 0                          | 0   | 0                       | 0                           | 3.00   |
| 4.00   | Occupational Therapy   | 0  | 0                          | _                          | 1   | 0                       | 0                           | 4.00   |
| 5. 00<br>6. 00   | Speech Pathology Medical Social Services   | 0  | 0                          | _                          | 1   | _                       | 0                           | 5. 00<br>6. 00   |
| 7. 00  | Home Heal th Ai de   |  | 0                          |                            |   |                         | o o                         | 7. 00  |
| 8.00   | Supplies (see instructions)  | 0  | 0                          | 0                          | 0   | 0                       | 0                           | 8.00   |
| 9. 00  | Drugs  | 0  | 0                          | 0                          | 0   | 0                       | 0                           | 9.00   |
| 10.00  | DME  | 0  | 0                          | 0                          | 0   | 0                       | 0                           | 10.00  |
| 11. 00<br>12. 00   | Home Dialysis Aide Services<br>Respiratory Therapy   |  | 0                          | 0                          | 0   | 0                       | 0                           | 11. 00<br>12. 00   |
| 13. 00   |  |  | 0                          | Ö                          | 0   | 0                       | o o                         | 13.00  |
|  |  |  | 0                          | 0                          | 0   | 0                       | 0                           | 14.00  |
| 14.00  | Clinic   | 1  |                            |                            |   |                         |                             | 15 00  |
| 15.00  | Health Promotion Activities  | Ö  | 0                          |                            | 0   | 0                       | 0                           | 15.00  |
| 15. 00<br>16. 00   | Health Promotion Activities Day Care Program   | 0  | 0                          |                            | 0   | 0                       | 0                           | 16.00  |
| 15. 00<br>16. 00<br>17. 00   | Health Promotion Activities<br>Day Care Program<br>Home Delivered Meals Program  | 0 0  |                            |                            | 0 0   | 0 0                     | 0                           | 16. 00<br>17. 00   |
| 15. 00<br>16. 00   | Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service  | 0 0  |                            |                            | 0 0 0                                       | 0 0 0                   | 0 0                         | 16.00  |
| 15. 00<br>16. 00<br>17. 00<br>18. 00<br>19. 00                     | Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service  | 0 0 0  |                            |                            | 0 0 0                                       | 0 0 0                   | 0<br>0<br>0                 | 16. 00<br>17. 00<br>18. 00   |
| 15. 00<br>16. 00<br>17. 00<br>18. 00<br>19. 00<br>19. 50<br>20. 00 | Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19)                            | 0<br>0<br>0<br>0<br>0<br>0<br>0<br>6, 391                          |                            |                            | 0<br>0<br>0<br>0<br>0<br>26, 655            |                         | 0<br>0<br>0<br>0<br>0       | 16. 00<br>17. 00<br>18. 00<br>19. 00<br>19. 50<br>20. 00           |
| 15. 00<br>16. 00<br>17. 00<br>18. 00<br>19. 00<br>19. 50           | Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) Total cost to be allocated | 0<br>0<br>0<br>0<br>0<br>0<br>0<br>6, 391<br>83, 677<br>13. 092943 | 0<br>0<br>0<br>0<br>0<br>0 | 0<br>0<br>0<br>0<br>0<br>0 | 0<br>0<br>0<br>0<br>0<br>26, 655<br>96, 530 | 0                       | 0<br>0<br>0<br>0<br>0<br>0  | 16. 00<br>17. 00<br>18. 00<br>19. 00<br>19. 50<br>20. 00<br>21. 00 |

|                  | Financial Systems                           |                    | MAJOR HOSPI      |              |             |                                  | u of Form CMS-                            |                  |
|------------------|---|--------------------|------------------|--------------|-------------|----------------------------------|---|------------------|
|                  | TION OF GENERAL SERVICE COSTS T             | O HHA COST CEN     | TERS STATISTICAL | Provi der Co | CN: 15-0097 | Peri od:                         | Worksheet H-2                             | 2                |
| BASIS            |   |                    |                  | HHA CCN:     | 15-7418     | From 01/01/2020<br>To 12/31/2020 | Part II<br>Date/Time Pre<br>8/2/2021 2:11 |                  |
|                  |   |                    |                  |              |             | Home Health                      | PPS                                       |                  |
|                  |   |                    |                  |              |             | Agency I                         |   |                  |
|                  | Cost Center Description                     | MEDI CAL           |                  |              |             |                                  |   |                  |
|                  |   | RECORDS &          |                  |              |             |                                  |   |                  |
|                  |   | LI BRARY           |                  |              |             |                                  |   |                  |
|                  |   | (GROSS<br>CHARGES) |                  |              |             |                                  |   |                  |
|                  |   | 16. 00             |                  |              |             |                                  |   | -                |
| 1. 00            | Administrative and General                  | 2, 333, 121        |                  |              |             |                                  |   | 1.00             |
| 2. 00            | Skilled Nursing Care                        | 0                  |                  |              |             |                                  |   | 2.00             |
| 3. 00            | Physi cal Therapy                           | 0                  |                  |              |             |                                  |   | 3.00             |
| 4.00             | Occupational Therapy                        | 0                  |                  |              |             |                                  |   | 4.00             |
| 5.00             | Speech Pathology                            | 0                  |                  |              |             |                                  |   | 5.00             |
| 6.00             | Medical Social Services                     | 0                  |                  |              |             |                                  |   | 6. 00            |
| 7.00             | Home Health Aide                            | 0                  |                  |              |             |                                  |   | 7.00             |
| 8.00             | Supplies (see instructions)                 | 0                  |                  |              |             |                                  |   | 8. 00            |
| 9.00             | Drugs                                       | 0                  |                  |              |             |                                  |   | 9. 00            |
| 10.00            | DME   | 0                  |                  |              |             |                                  |   | 10.00            |
| 11. 00<br>12. 00 | Home Dialysis Aide Services                 | 0                  |                  |              |             |                                  |   | 11. 00<br>12. 00 |
| 12.00            | Respiratory Therapy<br>Private Duty Nursing | 0                  |                  |              |             |                                  |   | 13.00            |
| 14. 00           | Clinic                                      | 0                  |                  |              |             |                                  |   | 14.00            |
| 15. 00           | Health Promotion Activities                 | 0                  |                  |              |             |                                  |   | 15.00            |
| 16. 00           | Day Care Program                            | 0                  |                  |              |             |                                  |   | 16.00            |
| 17. 00           | Home Delivered Meals Program                | 0                  |                  |              |             |                                  |   | 17. 00           |
| 18. 00           | Homemaker Service                           | 0                  |                  |              |             |                                  |   | 18.00            |
| 19.00            | All Others (specify)                        | 0                  |                  |              |             |                                  |   | 19.00            |
| 19. 50           | Tel emedi ci ne                             | 0                  |                  |              |             |                                  |   | 19. 50           |
| 20.00            | Total (sum of lines 1-19)                   | 2, 333, 121        |                  |              |             |                                  |   | 20.00            |
| 21. 00           | Total cost to be allocated                  | 16, 215            |                  |              |             |                                  |   | 21.00            |
| 22. 00           | Unit cost multiplier                        | 0. 006950          |                  |              |             |                                  |   | 22.00            |

|                                  | Financial Systems                              |               | MAJOR HO        |                 | 011 45 5555                   |   | u of Form CMS-2       |                         |
|----------------------------------|--|---------------|-----------------|-----------------|-------------------------------|---|-----------------------|-------------------------|
| APPORT                           | IONMENT OF PATIENT SERVICE COST                | ΓS            |                 | Provider C      |                               | Period:<br>From 01/01/2020<br>To 12/31/2020 | Date/Time Pre         | pared:                  |
|                                  |  |               |                 | Title           | xVIII                         | Home Health                                 | 8/2/2021 2: 11<br>PPS | pm                      |
|                                  | Cost Center Description                        | From, Wkst.   | Facility        | Shared          | Total HHA                     | Agency I<br>Total Visits                    | Average Cost          |                         |
|                                  | cost center bescription                        | H-2, Part I,  | Costs (from     | Ancillary       | Costs (cols.                  | Total Visits                                | Per Visit             |                         |
|                                  |  | col. 28, line |                 | Costs (from     | 1 + 2)                        |   | (col. 3 ÷             |                         |
|                                  |  |               | Part I)         | Part II)        | ŕ                             |   | col. 4)               |                         |
|                                  |  | 0             | 1. 00           | 2. 00           | 3. 00                         | 4. 00                                       | 5. 00                 |                         |
|                                  | PART I - COMPUTATION OF LESSER COST LIMITATION | OF AGGREGATE  | PROGRAM COST, A | AGGREGATE OF TI | HE PROGRAM LII                | MITATION COST, C                            | R BENEFICIARY         |                         |
|                                  | Cost Per Visit Computation                     |               | _               |                 |                               | _   |                       |                         |
| . 00                             | Skilled Nursing Care                           | 2.00          |                 |                 | 1, 003, 87                    | ·   | 248. 24               |                         |
| . 00                             | Physi cal Therapy                              | 3.00          |                 | 0               | 1,                            |   | 176. 85               |                         |
| . 00                             | Occupational Therapy                           | 4.00          |                 | 0               |                               |   | 250. 32               |                         |
| . 00                             | Speech Pathology                               | 5.00          |                 | 0               |                               | 0 24  | 0.00                  |                         |
| . 00                             | Medical Social Services                        | 6.00          |                 |                 | 2, 42                         |   | 55. 11                |                         |
| . 00                             | Home Heal th Ai de                             | 7.00          | 1               |                 | 137, 32                       |   | 223. 66               |                         |
| 7. 00                            | Total (sum of lines 1-6)                       |               | 1, 956, 764     | 0               | 1, 956, 76<br>Program Vi si t |   |                       | 7.00                    |
|                                  |  |               |                 |                 |                               |   |                       |                         |
|                                  |  |               |                 |                 |                               | rt B  |                       |                         |
|                                  | Cost Center Description                        | Cost Limits   | CBSA No. (1)    | Part A          | Not Subject                   | Subject to                                  |                       |                         |
|                                  |  |               |                 |                 | to Deductibles 8              | Deductibles                                 |                       |                         |
|                                  |  |               |                 |                 | Coi nsurance                  | x   |                       |                         |
|                                  |  | 0             | 1. 00           | 2. 00           | 3. 00                         | 4. 00                                       | 5. 00                 |                         |
|                                  | Limitation Cost Computation                    |               |                 |                 |                               |   |                       |                         |
| 3. 00                            | Skilled Nursing Care                           |               | 26900           | 0               | 2, 25                         | 5   |                       | 8.00                    |
| 3. 01                            | Skilled Nursing Care                           |               | 99915           | 0               | 10                            | 1   |                       | 8.0°                    |
| 0. 00                            | Physi cal Therapy                              |               | 26900           | 0               | 1, 50                         |   |                       | 9.00                    |
| 9. 01                            | Physi cal Therapy                              |               | 99915           | 0               | 15                            |   |                       | 9.0                     |
| 0.00                             | Occupational Therapy                           |               | 26900           | 0               | 69                            |   |                       | 10.00                   |
| 0. 01                            | Occupational Therapy                           |               | 99915           | 0               | 4                             |   |                       | 10.0                    |
| 1.00                             | Speech Pathology                               |               | 26900           | 0               | 1                             |   |                       | 11.00                   |
| 1. 01                            | Speech Pathology                               |               | 99915           | 0               | 1                             | 0   |                       | 11.0                    |
| 2.00                             | Medical Social Services                        |               | 26900           | 0               | 2                             |   |                       | 12.00                   |
| 2. 01                            | Medical Social Services<br>Home Health Aide    |               | 99915<br>26900  | 0               | 1                             | 2   |                       | 12. 0<br>13. 0          |
| 3. 00                            | Home Health Aide                               |               | 99915           | 0               | 43                            | 6   |                       | 13.0                    |
|                                  | Total (sum of lines 8-13)                      |               | 99913           | 0               | 5, 24                         |   |                       | 14.0                    |
| 4.00                             | Cost Center Description                        | From Wkst.    | Facility        | Shared          | Total HHA                     | Total Charges                               | Ratio (col 3          | 14.00                   |
|                                  | 2001 3011to: 20001 Pt. 311                     | H-2 Part I,   | Costs (from     | Ancillary       | Costs (cols.                  | (from HHA                                   | ÷ col . 4)            |                         |
|                                  |  | col. 28, line |                 | Costs (from     | 1 + 2)                        | Records)                                    | .,                    |                         |
|                                  |  |               | Part I)         | Part II)        | <b>_</b>                      | ,   |                       |                         |
|                                  |  | 0             | 1. 00           | 2. 00           | 3.00                          | 4. 00                                       | 5. 00                 |                         |
|                                  | Supplies and Drugs Cost Comput                 |               |                 |                 | T                             |   |                       |                         |
|                                  | Cost of Medical Supplies                       | 8.00          |                 |                 |                               |   | 0. 324097             |                         |
| 6.00                             | Cost of Drugs                                  | 9.00          |                 | 0               | 55                            | 1 0   | 0. 000000             | 16.00                   |
|                                  |  |               | Program Visits  |                 | Cost of<br>Services           |   |                       |                         |
|                                  |  |               | Par             | t B             | j services                    | Part B                                      |                       |                         |
|                                  | Cost Center Description                        | Part A        | Not Subject     | Subject to      | Part A                        | Not Subject                                 | Subject to            |                         |
|                                  | cost center beserretion                        | I di t A      | to              | Deductibles &   |                               | to  | Deductibles &         |                         |
|                                  |  |               | Deductibles &   | Coi nsurance    |                               | Deductibles &                               | Coi nsurance          |                         |
|                                  |  |               | Coi nsurance    | 0011104141100   |                               | Coi nsurance                                | 00111041 41100        |                         |
|                                  |  | 6. 00         | 7. 00           | 8. 00           | 9. 00                         | 10.00                                       | 11. 00                |                         |
|                                  | PART I - COMPUTATION OF LESSER COST LIMITATION |               | PROGRAM COST, A |                 |                               | MITATION COST, C                            |                       |                         |
|                                  | Cost Per Visit Computation                     |               |                 |                 |                               |   |                       |                         |
| . 00                             | Skilled Nursing Care                           | 0             | 2, 356          |                 |                               | 0 584, 853                                  |                       | 1.0                     |
|                                  | Physical Therapy                               | 0             | 1, 655          |                 |                               | 0 292, 687                                  |                       | 2.0                     |
| . 00                             | Occupational Therapy                           | 0             | 733             |                 |                               | 0 183, 485                                  |                       | 3.0                     |
|                                  |  |               |                 |                 | 1                             |   |                       |                         |
| . 00                             | Speech Pathology                               | 0             | 15              |                 |                               | 0   |                       | 4.0                     |
| 2. 00<br>3. 00<br>4. 00<br>5. 00 | Speech Pathology<br>Medical Social Services    | 0 0           | 27              |                 |                               | 0 1, 488                                    |                       |                         |
| 3. 00<br>1. 00                   | ,        | 0 0           |                 |                 |                               | -   |                       | 4. 00<br>5. 00<br>6. 00 |

| Health Financial Systems<br>APPORTIONMENT OF PATIENT SERVICE COS   | TS  |                 | Provi der CO    | CN: 15-0097   | Peri od:                         | Worksheet H-3  | 3   |
|--|---|-----------------|-----------------|---------------|----------------------------------|----------------|---|
|  |   |                 | HHA CCN:        | 15-7418       | From 01/01/2020<br>To 12/31/2020 |                | epared<br>1 pm  |
|  |   |                 | Title           | XVIII         | Home Health<br>Agency I          | PPS            | -   |
| Cost Center Description  | 6. 00   | 7. 00           | 8. 00           | 9. 00         | 10.00                            | 11. 00         |   |
| Limitation Cost Computation  | 0.00  | 7.00            | 0.00            | 7.00          | 10.00                            | 11.00          |   |
| .00 Skilled Nursing Care   |   |                 |                 |               |                                  |                | 8.0   |
| .01 Skilled Nursing Care   |   |                 |                 |               |                                  |                | 8.0   |
| . 00 Physical Therapy  |   |                 |                 |               |                                  |                | 9. (  |
| . 01 Physi cal Therapy   |   |                 |                 |               |                                  |                | 9.0   |
| 0.00 Occupational Therapy  |   |                 |                 |               |                                  |                | 10.0  |
| 0.01 Occupational Therapy  |   |                 |                 |               |                                  |                | 10.0  |
| 1.00 Speech Pathology  |   |                 |                 |               |                                  |                | 11.0  |
| 1.01 Speech Pathology  |   |                 |                 |               |                                  |                | 11.   |
| 2.00 Medical Social Services   |   |                 |                 |               |                                  |                | 12. (   |
| 2.01 Medical Social Services   |   |                 |                 |               |                                  |                | 12.0  |
| 3.00 Home Health Aide  |   |                 |                 |               |                                  |                | 13.0  |
| 3.01 Home Health Aide  |   |                 |                 |               |                                  |                | 13.   |
| 4.00 Total (sum of lines 8-13)   |   |                 |                 |               |                                  |                | 14. (   |
|  | Progi   | ram Covered Cha | ırges           | Cost of       |                                  |                |   |
|  |   |                 |                 | Servi ces     |                                  |                |   |
|  |   | Par             | † R             |               | Part B                           |                |   |
| Cost Center Description  | Part A  | Not Subject     | Subject to      | Part A        | Not Subject                      | Subject to     |   |
| Seet Senter Beserr ptron   |   | to              | Deductibles &   |               | to                               | Deductibles &  |   |
|  |   | Deductibles &   | Coi nsurance    |               | Deductibles &                    | Coi nsurance   |   |
|  |   | Coi nsurance    |                 |               | Coi nsurance                     |                |   |
|  | 6. 00   | 7. 00           | 8. 00           | 9. 00         | 10.00                            | 11. 00         |   |
| Supplies and Drugs Cost Comput 5.00 Cost of Medical Supplies   | ations<br>1 o   | 227 702         | O               |               | 0 73, 827                        | (              | 15.0  |
| 6.00 Cost of Drugs   |   | 227, 793<br>0   | 0               |               | 0 73, 827                        |                | 1   |
| Cost Center Description  | Total Program   |                 |                 |               |                                  |                |   |
|  |   |                 |                 |               |                                  |                |   |
|  | Cost (sum of  |                 |                 |               |                                  |                |   |
|  | col s. 9-10)  |                 |                 |               |                                  |                |   |
| PART I - COMPUTATION OF LESSEF   | col s. 9-10)<br>12.00   | PROGRAM COST, A | AGGREGATE OF TH | HE PROGRAM L  | MITATION COST, C                 | R BENEFICIARY  |   |
| COST LIMITATION  | col s. 9-10)<br>12.00   | PROGRAM COST, A | AGGREGATE OF TH | HE PROGRAM L  | MITATION COST, C                 | OR BENEFICIARY |   |
| COST LIMITATION Cost Per Visit Computation   | col s. 9-10)<br>12.00<br>OF AGGREGATE                                       |                 | AGGREGATE OF TH | HE PROGRAM L  | MITATION COST, C                 | R BENEFICIARY  | 1.0   |
| COST LIMITATION  Cost Per Visit Computation  OO Skilled Nursing Care   | col s. 9-10)<br>12.00<br>OF AGGREGATE                                       |                 | AGGREGATE OF TH | HE PROGRAM L  | MITATION COST, C                 | R BENEFICIARY  |   |
| COST LIMITATION  Cost Per Visit Computation  OO Skilled Nursing Care  Physical Therapy   | col s. 9-10)<br>12.00<br>3 OF AGGREGATE<br>584, 853<br>292, 687             |                 | AGGREGATE OF TH | HE PROGRAM L  | MITATION COST, C                 | R BENEFICIARY  | 2.0   |
| COST LIMITATION  Cost Per Visit Computation  OO Skilled Nursing Care  Physical Therapy  Occupational Therapy   | col s. 9-10) 12. 00 0F AGGREGATE 584, 853 292, 687 183, 485                 |                 | AGGREGATE OF TH | HE PROGRAM L  | MITATION COST, C                 | R BENEFICIARY  | 2. (<br>3. (  |
| COST LIMITATION  Cost Per Visit Computation  OO Skilled Nursing Care  Physical Therapy  Occupational Therapy  Speech Pathology   | col s. 9-10)<br>12. 00<br>0 F AGGREGATE<br>584, 853<br>292, 687<br>183, 485 |                 | AGGREGATE OF TH | HE PROGRAM L  | MITATION COST, C                 | OR BENEFICIARY | 2. 0<br>3. 0<br>4. 0  |
| COST LIMITATION Cost Per Visit Computation  Skilled Nursing Care  OO Physical Therapy  OCcupational Therapy  Speech Pathology  Medical Social Services   | 584, 853<br>292, 687<br>183, 485<br>1, 488                                  |                 | AGGREGATE OF TH | HE PROGRAM LI | MITATION COST, C                 | R BENEFICIARY  | 2. (<br>3. (<br>4. (<br>5. (  |
| COST LIMITATION Cost Per Visit Computation  OO Skilled Nursing Care  OO Physical Therapy  OO Occupational Therapy  OO Speech Pathology  Medical Social Services  Home Health Aide  | 584, 853<br>292, 687<br>183, 485<br>0 1, 488<br>101, 989                    |                 | AGGREGATE OF TH | HE PROGRAM LI | MITATION COST, C                 | R BENEFICIARY  | 2. (<br>3. (<br>4. (<br>5. (<br>6. (  |
| COST LIMITATION Cost Per Visit Computation  .00 Skilled Nursing Care .00 Physical Therapy .00 Occupational Therapy .00 Speech Pathology .00 Medical Social Services .00 Home Health Aide .00 Total (sum of lines 1-6)  | 584, 853<br>292, 687<br>183, 485<br>1, 488                                  |                 | AGGREGATE OF TH | HE PROGRAM LI | MITATION COST, C                 | R BENEFICIARY  | 1. (2. (3. (4. (5. (6. (6. (7. (6. (6. (6. (6. (6. (6. (6. (6. (6. (6   |
| COST LIMITATION Cost Per Visit Computation  .00 Skilled Nursing Care .00 Physical Therapy .00 Occupational Therapy .00 Speech Pathology .00 Medical Social Services .00 Home Health Aide .00 Total (sum of lines 1-6) Cost Center Description  | 584, 853<br>292, 687<br>183, 485<br>0 1, 488<br>101, 989                    |                 | AGGREGATE OF TH | HE PROGRAM LI | MITATION COST, C                 | OR BENEFICIARY | 2. (<br>3. (<br>4. (<br>5. (<br>6. (  |
| COST LIMITATION Cost Per Visit Computation  Skilled Nursing Care  OO Physical Therapy  OO Occupational Therapy  OO Speech Pathology  OO Medical Social Services  OO Home Health Aide  Cost Center Description  | 584, 853<br>292, 687<br>183, 485<br>0<br>1, 488<br>101, 989<br>1, 164, 502  |                 | AGGREGATE OF TH | HE PROGRAM LI | MITATION COST, C                 | OR BENEFICIARY | 2. (<br>3. (<br>4. (<br>5. (<br>6. (<br>7. (  |
| COST LIMITATION Cost Per Visit Computation  Skilled Nursing Care  OO Physical Therapy  OO Occupational Therapy  OO Speech Pathology  OO Medical Social Services  OO Home Health Aide  OO Total (sum of lines 1-6)  Cost Center Description  Limitation Cost Computation  Skilled Nursing Care  | 584, 853<br>292, 687<br>183, 485<br>0<br>1, 488<br>101, 989<br>1, 164, 502  |                 | AGGREGATE OF TH | HE PROGRAM LI | MITATION COST, C                 | OR BENEFICIARY | 2. (<br>3. (<br>4. (<br>5. (<br>6. (<br>7. (  |
| COST LIMITATION Cost Per Visit Computation  Skilled Nursing Care  OO Physical Therapy  OO Occupational Therapy  OO Speech Pathology  OO Medical Social Services  OO Home Health Aide  OO Total (sum of lines 1-6)  Cost Center Description  Limitation Cost Computation  Skilled Nursing Care  OI Skilled Nursing Care   | 584, 853<br>292, 687<br>183, 485<br>0<br>1, 488<br>101, 989<br>1, 164, 502  |                 | AGGREGATE OF TH | HE PROGRAM LI | MITATION COST, C                 | R BENEFICIARY  | 2. (<br>3. (<br>4. (<br>5. (<br>6. (<br>7. (<br>8. (<br>8. (  |
| COST LIMITATION Cost Per Visit Computation  Skilled Nursing Care  OO Physical Therapy OO Cocupational Therapy  OO Speech Pathology  OO Medical Social Services  OO Home Health Aide  OO Total (sum of lines 1-6)  Cost Center Description  Limitation Cost Computation  Skilled Nursing Care  OO Physical Therapy  | 584, 853<br>292, 687<br>183, 485<br>0<br>1, 488<br>101, 989<br>1, 164, 502  |                 | AGGREGATE OF TH | HE PROGRAM LI | MITATION COST, C                 | R BENEFICIARY  | 2. (<br>3. (<br>4. (<br>5. (<br>7. (<br>7. (<br>8. (<br>9. (  |
| COST LIMITATION Cost Per Visit Computation  OO Skilled Nursing Care OO Physical Therapy OO Occupational Therapy OO Speech Pathology OO Medical Social Services OO Home Health Aide OO Total (sum of lines 1-6) Cost Center Description  Limitation Cost Computation OO Skilled Nursing Care OO Physical Therapy OI Physical Therapy  | 584, 853<br>292, 687<br>183, 485<br>0<br>1, 488<br>101, 989<br>1, 164, 502  |                 | AGGREGATE OF TH | HE PROGRAM L  | MITATION COST, C                 | OR BENEFICIARY | 2. (3. )<br>4. (5. )<br>5. (6. )<br>7. (9. )<br>8. (9. )<br>9. (9. )  |
| COST LIMITATION Cost Per Visit Computation  OO Skilled Nursing Care OO Physical Therapy OO Occupational Therapy OO Speech Pathology OO Medical Social Services OO Home Health Aide OO Total (sum of lines 1-6) Cost Center Description  Limitation Cost Computation OO Skilled Nursing Care OO Physical Therapy OO OCcupational Therapy OO OCCUPATIONAL  | 584, 853<br>292, 687<br>183, 485<br>0<br>1, 488<br>101, 989<br>1, 164, 502  |                 | AGGREGATE OF TH | HE PROGRAM LI | MITATION COST, C                 | OR BENEFICIARY | 2. 3. 4. 5. 6. 7. 8. 8. 9. 9. 10.   |
| COST LIMITATION Cost Per Visit Computation  Skilled Nursing Care  OO Physical Therapy OO Occupational Therapy  OO Medical Social Services OO Home Health Aide OO Total (sum of lines 1-6)  Cost Center Description  Limitation Cost Computation  Skilled Nursing Care OO Physical Therapy OO Physical Therapy OCCUPATIONAL   | 584, 853<br>292, 687<br>183, 485<br>0<br>1, 488<br>101, 989<br>1, 164, 502  |                 | AGGREGATE OF TH | HE PROGRAM LI | MITATION COST, C                 | OR BENEFICIARY | 2. 3. 4. 5. 6. 7. 8. 8. 9. 9. 10. 10.   |
| COST LIMITATION Cost Per Visit Computation  Skilled Nursing Care  OO Physical Therapy  OO Occupational Therapy  OO Medical Social Services  OO Home Health Aide  OO Total (sum of lines 1-6)  Cost Center Description  Limitation Cost Computation  Skilled Nursing Care  OO Skilled Nursing Care  OO Physical Therapy  OO Occupational Therapy  OCCUPATIONAL  | 584, 853<br>292, 687<br>183, 485<br>0<br>1, 488<br>101, 989<br>1, 164, 502  |                 | AGGREGATE OF TH | HE PROGRAM LI | MITATION COST, C                 | OR BENEFICIARY | 2.<br>3.<br>4.<br>5.<br>6.<br>7.<br>8.<br>8.<br>9.<br>9.<br>10.<br>11.  |
| COST LIMITATION Cost Per Visit Computation  Skilled Nursing Care  OO Physical Therapy OO Occupational Therapy  OO Medical Social Services OO Home Health Aide OO Total (sum of lines 1-6) Cost Center Description  Limitation Cost Computation  Skilled Nursing Care OO Skilled Nursing Care OO Physical Therapy OO Occupational Therapy OO Occupational Therapy OCCUPATIONAL  | 584, 853<br>292, 687<br>183, 485<br>0<br>1, 488<br>101, 989<br>1, 164, 502  |                 | AGGREGATE OF TH | HE PROGRAM LI | MITATION COST, C                 | OR BENEFICIARY | 2. (<br>3. (<br>4. (<br>5. (<br>6. (<br>7. (<br>8. (<br>8. (<br>9. (<br>10. (<br>11. (<br>11. (                             |
| COST LIMITATION Cost Per Visit Computation  Skilled Nursing Care Physical Therapy Cocupational Therapy Computation  Speech Pathology Medical Social Services Computation  Cost Center Description  Limitation Cost Computation  Skilled Nursing Care Computation  Skilled Nursing Care Computation  Skilled Nursing Care Computation  Skilled Nursing Care Computation  Cost Center Description  Cost Center Description  Cost Computation  Skilled Nursing Care Computation  Computation  Skilled Nursing Care Computation  Computation  Skilled Nursing Care Computa | 584, 853<br>292, 687<br>183, 485<br>0<br>1, 488<br>101, 989<br>1, 164, 502  |                 | AGGREGATE OF TH | HE PROGRAM L  | MITATION COST, C                 | OR BENEFICIARY | 2.(<br>3.(<br>4.(<br>5.(<br>6.(<br>7.(<br>8.(<br>9.(<br>9.(<br>10.(<br>11.(<br>11.(<br>12.(                                 |
| COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy 3.00 Occupational Therapy 5.00 Medical Social Services 6.00 Home Health Aide 7.00 Total (sum of lines 1-6) Cost Center Description  Limitation Cost Computation Skilled Nursing Care 9.00 Physical Therapy 9.01 Physical Therapy 9.01 Physical Therapy 9.00 Occupational Therapy 9.01 Occupational Therapy 9.01 Occupational Therapy 9.01 Speech Pathology 1.01 Speech Pathology 1.01 Medical Social Services   | 584, 853<br>292, 687<br>183, 485<br>0<br>1, 488<br>101, 989<br>1, 164, 502  |                 | AGGREGATE OF TH | HE PROGRAM L  | MITATION COST, C                 | OR BENEFICIARY | 2. (<br>3. (<br>4. (<br>5. (<br>6. (<br>7. (<br>8. (<br>9. (<br>10. (<br>11. (<br>12. (<br>12. (<br>12. (                   |
| COST LIMITATION Cost Per Visit Computation  Skilled Nursing Care  Physical Therapy Cooper Pathology Cooper P | 584, 853<br>292, 687<br>183, 485<br>0<br>1, 488<br>101, 989<br>1, 164, 502  |                 | AGGREGATE OF TH | HE PROGRAM LI | MITATION COST, C                 | OR BENEFICIARY | 2. (<br>3. (<br>4. (<br>5. (<br>6. (<br>7. (<br>8. (<br>9. (<br>10. (<br>11. (<br>11. (<br>12. (<br>12. (<br>13. (<br>13. ( |
| COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy 3.00 Occupational Therapy 5.00 Medical Social Services 6.00 Home Health Aide 7.00 Total (sum of lines 1-6) Cost Center Description  Limitation Cost Computation Skilled Nursing Care 9.00 Physical Therapy 9.01 Physical Therapy 9.01 Physical Therapy 9.00 Occupational Therapy 9.00 Occupational Therapy 9.01 Speech Pathology 1.01 Speech Pathology 1.01 Speech Pathology 9.00 Medical Social Services   | 584, 853<br>292, 687<br>183, 485<br>0<br>1, 488<br>101, 989<br>1, 164, 502  |                 | AGGREGATE OF TH | HE PROGRAM LI | MITATION COST, C                 | OR BENEFICIARY | 2.1<br>3.1<br>4.1<br>5.1<br>6.1<br>7.1<br>8.1<br>9.1<br>10.1<br>11.1<br>12.1<br>12.1  |

| Health Financial Systems             | SPI TAL         |                 | In Lie         | u of Form CMS-2 | 2552-10                          |               |        |
|--------------------------------------|-----------------|-----------------|----------------|-----------------|----------------------------------|---------------|--------|
| APPORTIONMENT OF PATIENT SERVICE COS | TS              |                 | Provi der C    | CN: 15-0097     | Peri od:                         | Worksheet H-3 |        |
|                                      |                 |                 | HHA CCN:       | 15-7418         | From 01/01/2020<br>To 12/31/2020 |               | narod: |
|                                      | TITIA CCN.      | 13-7410         | 10 12/31/2020  | 8/2/2021 2:11   |                                  |               |        |
|                                      |                 |                 | Title          | XVIII           | Home Health                      | PPS           | -      |
|                                      |                 |                 |                |                 | Agency I                         |               |        |
| Cost Center Description              | From Wkst. C,   | Cost to         | Total HHA      | HHA Shared      | Transfer to                      |               |        |
|                                      | Part I, col.    | Charge Ratio    | Charge (from   | Ancillary       | Part I as                        |               |        |
|                                      | 9, line         |                 | provi der      | Costs (col.     | 1 Indicated                      |               |        |
|                                      |                 |                 | records)       | x col. 2)       |                                  |               |        |
|                                      | 0               | 1. 00           | 2. 00          | 3.00            | 4. 00                            |               |        |
| PART II - APPORTIONMENT OF COS       | ST OF HHA SERVI | CES FURNISHED E | BY SHARED HOSP | TAL DEPARTME    | NTS                              |               |        |
| 1.00 Physical Therapy                | 66.00           | 0. 485084       | 0              |                 | 0 col. 2, line 2                 | . 00          | 1.00   |
| 2.00 Occupational Therapy            |                 |                 |                |                 |                                  |               | 2.00   |
| 3.00 Speech Pathology                |                 |                 |                |                 |                                  |               | 3.00   |
| 4.00 Cost of Medical Supplies        | 71.00           | 0. 000000       | 0              |                 | 0 col. 2, line 1                 | 5. 00         | 4.00   |
| 5.00 Cost of Drugs                   | 73.00           | 0. 320490       | 0              |                 | 0 col. 2, line 1                 | 6. 00         | 5.00   |

|                  | Financial Systems MA. ATION OF HHA REIMBURSEMENT SETTLEMENT   | JOR HOSPITAL Provider CO | ^N, 1E 0007 | In Lie                           | u of Form CMS-2<br>Worksheet H-4 |      |
|------------------|---|--------------------------|-------------|----------------------------------|----------------------------------|------|
| ALCUL            | ATION OF HHA REIMBURSEMENT SETTLEMENT   | HHA CCN:                 | 15-7418     | From 01/01/2020<br>To 12/31/2020 | Part I-II<br>Date/Time Pre       | pare |
|                  |   | Title                    | XVIII       | Home Health                      | 8/2/2021 2: 11<br>PPS            | pm   |
|                  |   |                          |             | Agency I                         | t B                              |      |
|                  |   |                          | Part A      | Not Subject<br>to                | Subject to<br>Deductibles &      |      |
|                  |   |                          | 1.00        | Deductibles & Coinsurance        | Coi nsurance                     |      |
|                  | PART I - COMPUTATION OF THE LESSER OF REASONABLE COST   | OR CUSTOMARY CHARGE      | 1.00        | 2. 00                            | 3. 00                            |      |
|                  | Reasonable Cost of Part A & Part B Services   | OK GGGTOMPHET GTWHEE     |             |                                  |                                  | 1    |
| . 00             | Reasonable cost of services (see instructions)  |                          |             | 0 0                              | 0                                | 1.   |
| . 00             | Total charges   |                          |             | 0 0                              | 0                                | 2.   |
| . 00             | Customary Charges  Amount actually collected from patients liable for pa  | yment for services       |             | 0 0                              | 0                                | 3.   |
|                  | on a charge basis (from your records)   |                          |             |                                  |                                  |      |
| . 00             | Amount that would have been realized from patients li<br>for services on a charge basis had such payment been<br>with 42 CFR §413.13(b) |                          |             | 0 0                              | 0                                | 4.   |
| . 00             | Ratio of line 3 to line 4 (not to exceed 1.000000)  |                          | 0. 0000     | 0. 000000                        | 0.000000                         | 1    |
| . 00             | Total customary charges (see instructions) Excess of total customary charges over total reasonab  | le cost (complete        |             | 0 0                              | 0                                |      |
|                  | only if line 6 exceeds line 1)  |                          |             |                                  |                                  |      |
| . 00             | Excess of reasonable cost over customary charges (com 1 exceeds line 6)   | plete only if line       |             | 0 0                              | 0                                | 8.   |
| . 00             | Primary payer amounts   |                          |             | 0 0                              |                                  | 9.   |
|                  |   |                          |             | Part A<br>Services               | Part B<br>Services               |      |
|                  | PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT   |                          |             | 1. 00                            | 2. 00                            |      |
| 0. 00            | Total reasonable cost (see instructions)  |                          |             | 0                                | 0                                | 10.  |
| 1. 00            | Total PPS Reimbursement - Full Episodes without Outli   |                          |             | 0                                | 615, 237                         | 1    |
| 2.00             | Total PPS Reimbursement - Full Episodes with Outliers   |                          |             | 0                                | 152, 543                         | 1    |
| 3. 00<br>4. 00   | Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes  |                          |             | 0                                | 9, 686<br>20, 810                | 1    |
| 5. 00            | Total PPS Outlier Reimbursement - Full Episodes with  | Outliers                 |             | 0                                | 58, 963                          |      |
| 5. 00            | Total PPS Outlier Reimbursement - PEP Episodes  | outificis                |             | 0                                | 1, 234                           |      |
| 7. 00            | Total Other Payments  |                          |             | 0                                | 0                                | 1    |
| 3. 00            | DME Payments  |                          |             | 0                                | 0                                | 18   |
| 9. 00            | Oxygen Payments   |                          |             | 0                                | 0                                |      |
| 0. 00            |   |                          |             | 0                                | 0                                |      |
| 1.00             | Part B deductibles billed to Medicare patients (exclu   | de coi nsurance)         |             |                                  | 0                                |      |
| 2. 00<br>3. 00   | Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8)   |                          |             | 0                                | 858, 473<br>0                    | 1    |
| 4. 00            | Subtotal (line 22 minus line 23)  |                          |             | 0                                | 858, 473                         |      |
| 5. 00            | Coinsurance billed to program patients (from your red   | ords)                    |             |                                  | 030, 473                         |      |
| 6. 00            | Net cost (line 24 minus line 25)  | 0. 40)                   |             | 0                                |                                  |      |
| 7. 00            | Reimbursable bad debts (from your records)  |                          |             |                                  |                                  | 27   |
| 3. 00            | Reimbursable bad debts for dual eligible beneficiarie   |                          | )           |                                  |                                  | 28   |
| 9. 00            | Total costs - current cost reporting period (line 26  | plus line 27)            |             | 0                                |                                  |      |
| 0.00             | OTHER ADJ   | +                        |             | 0                                |                                  |      |
| 0.50             | Pioneer ACO demonstration payment adjustment (see ins   | •                        |             | 0                                |                                  | 1    |
| 0. 99<br>1. 00   | Demonstration payment adjustment amount before seques Subtotal (see instructions)   | 11 411 011               |             | 0                                |                                  |      |
| 1. 00            | Sequestration adjustment (see instructions)   |                          |             | 0                                |                                  |      |
| 1. 02            | Demonstration payment adjustment amount after sequest   | rati on                  |             | Ö                                |                                  |      |
| 2. 00            | Interim payments (see instructions)   |                          |             | 0                                |                                  |      |
| 3.00             | Tentative settlement (for contractor use only)  |                          |             | 0                                | 0                                |      |
|                  | In. I   | 01 22 and 22)            |             | 0                                | 0                                | 34.  |
| 34. 00<br>35. 00 | Balance due provider/program (line 31 minus lines 31. Protested amounts (nonallowable cost report items) in                             |                          |             | 0                                | Ö                                | 1    |

Health Financial Systems MAJOR HOST ANALYSIS OF PAYMENTS TO HOSPITAL-BASED HHAS FOR SERVICES RENDERED MAJOR HOSPITAL In Lieu of Form CMS-2552-10 Provider CCN: 15-0097

Peri od: From 01/01/2020 To 12/31/2020 Date/Ti me Prepared: 8/2/2021 2:11 pm PPS TO PROGRAM BENEFICIARIES HHA CCN: 15-7418

|                |   |            |          | Home Health<br>Agency I | PPS                     |                |
|----------------|---|------------|----------|-------------------------|-------------------------|----------------|
|                |   | Inpatien   | t Part A |                         | t B                     |                |
|                |   | mm/dd/yyyy | Amount   | mm/dd/yyyy              | Amount                  |                |
|                |   | 1. 00      | 2. 00    | 3. 00                   | 4. 00                   |                |
| 1. 00<br>2. 00 | Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none,  |            |          | 0                       | 850, 618<br>0           | 1. 00<br>2. 00 |
| 3.00           | write "NONE" or enter a zero List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider |            |          |                         |                         | 3.00           |
| 3. 01          |   |            |          | 0                       | 0                       | 3. 01          |
| 3. 02          |   |            |          | 0                       | 0                       | 3.02           |
| 3. 03          |   |            |          | 0                       | 0                       | 3. 03          |
| 3. 04          |   |            |          | 0                       | 0 0                     | 3.04           |
| 3. 05          | Provider to Program   |            |          | 0                       | 0                       | 3. 05          |
| 3. 50          | 110vi dei 10 110gi alli   |            |          | ol                      | 0                       | 3.50           |
| 3. 51          |   |            |          | 0                       | 0                       | 3. 51          |
| 3. 52          |   |            |          | O                       | 0                       | 3. 52          |
| 3.53           |   |            |          | o                       | 0                       | 3.53           |
| 3.54           |   |            |          | 0                       | 0                       | 3.54           |
| 3. 99          | Subtotal (sum of lines 3.01-3.49 minus sum of lines   |            |          | 0                       | 0                       | 3. 99          |
| 4 00           | 3. 50-3. 98)  |            |          |                         | 050 (40                 | 4 00           |
| 4. 00          | Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate,  |            |          | 0                       | 850, 618                | 4. 00          |
|                | TO BE COMPLETED BY CONTRACTOR   |            |          |                         |                         |                |
| 5. 00          | List separately each tentative settlement payment after   |            |          |                         |                         | 5.00           |
| 3. 00          | desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)   |            |          |                         |                         | 3.00           |
|                | Program to Provider   |            |          |                         |                         |                |
| 5. 01          |   |            |          | 0                       | 0                       | 5. 01          |
| 5. 02<br>5. 03 |   |            |          | 0                       | 0 0                     | 5. 02<br>5. 03 |
| 5.05           | Provider to Program   |            |          | U <u>l</u>              | 0                       | 5.05           |
| 5. 50          | Trovidor to Frogram   |            |          | ol                      | 0                       | 5. 50          |
| 5. 51          |   |            |          | 0                       | 0                       | 5. 51          |
| 5.52           |   |            |          | 0                       | 0                       | 5.52           |
| 5. 99          | Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)  |            |          | 0                       | 0                       | 5. 99          |
| 6. 00          | Determined net settlement amount (balance due) based on the cost report. (1)  |            |          |                         |                         | 6. 00          |
| 6. 01          | SETTLEMENT TO PROVIDER  |            |          | 0                       | 0                       | 6. 01          |
| 6. 02          | SETTLEMENT TO PROGRAM   |            |          | 0                       | 0                       | 6. 02          |
| 7. 00          | Total Medicare program liability (see instructions)   |            |          | 0                       | 850, 618                | 7.00           |
|                |   |            |          | Contractor<br>Number    | NPR Date<br>(Mo/Day/Yr) |                |
| 0.00           | Name of Contractor  | (          | )        | 1. 00                   | 2. 00                   | 0.00           |
| 8. 00          | Name of Contractor  |            |          | 1                       | ı l                     | 8. 00          |

| CALCIII  | Financial Systems MAJOR HOSE ATION OF CAPITAL PAYMENT  | Provider CCN: 15-0097  | Period:                                  | u of Form CMS-2<br>Worksheet L | 200Z-10  |
|--|--|--|--|--------------------------------|--|
| CALCUL   | ATTON OF CAPITAL PATWENT   | Frovider Con. 13-0097  | From 01/01/2020<br>To 12/31/2020         | Parts I-III                    |  |
|  |  | Title XVIII  | Hospi tal                                | PPS                            | pili   |
|  |  |  |  |                                |  |
|  | DART I FULLY PROCRECTIVE METHOD  |  |  | 1. 00                          |  |
|  | PART I - FULLY PROSPECTIVE METHOD  CAPITAL FEDERAL AMOUNT  |  |  |                                | 1  |
| 1. 00  | Capital DRG other than outlier   |  |  | 665, 282                       | 1.00   |
| 1. 01  | Model 4 BPCI Capital DRG other than outlier  |  |  | 0                              |  |
| 2.00   | Capital DRG outlier payments   |  |  | 7, 411                         | 2.00   |
| 2. 01  | Model 4 BPCI Capital DRG outlier payments  |  |  | 0                              |  |
| 3.00   | Total inpatient days divided by number of days in the cost r   | reporting period (see ins  | tructions)                               | 27. 39                         |  |
| 4.00   | Number of interns & residents (see instructions)   | 0.00   |  |                                |  |
| 5.00   | Indirect medical education percentage (see instructions)   | 0.00   |  |                                |  |
| 6. 00  | Indirect medical education adjustment (multiply line 5 by th 1.01) (see instructions)  | 0  |  |                                |  |
| 7. 00  | Percentage of SSI recipient patient days to Medicare Part A 30) (see instructions)   |  | E, part A line                           | 0. 00                          |  |
| 8. 00  | Percentage of Medicaid patient days to total days (see instr   | ructions)  |  | 0.00                           |  |
| 9.00   | Sum of lines 7 and 8   |  |  | 0.00                           |  |
| 10. 00<br>11. 00   | Allowable disproportionate share percentage (see instruction Disproportionate share adjustment (see instructions)  | ns)  |  | 0.00                           |  |
| 12. 00   | ,  |  |  | 672, 693                       |  |
| 12.00  | Total prospective capital payments (see mistructions)  |  |  | 072, 073                       | 12.00  |
|  |  |  |  | 1. 00                          |  |
|  | PART II - PAYMENT UNDER REASONABLE COST  |  |  |                                |  |
| 1. 00  | Program inpatient routine capital cost (see instructions)  |  |  | 0                              |  |
| 2.00   | Program inpatient ancillary capital cost (see instructions)  |  |  | 0                              |  |
| 3. 00<br>4. 00   | Total inpatient program capital cost (line 1 plus line 2) Capital cost payment factor (see instructions)   |  |  | 0                              |  |
| 5. 00  | Total inpatient program capital cost (line 3 x line 4)   |  |  | 0                              | 1  |
| 0.00   | Trotal Tipatrone program capital cost (Time o x Time 1)  |  |  |                                | 0.00   |
|  | PART III - COMPUTATION OF EXCEPTION PAYMENTS   |  |  | 1. 00                          |  |
| 1.00   | Program inpatient capital costs (see instructions)   |  |  | 0                              | 1.00   |
| 2.00   | Program inpatient capital costs for extraordinary circumstar   | nces (see instructions)  |  | 0                              | 2.00   |
| 3.00   | Net program inpatient capital costs (line 1 minus line 2)  |  |  | 0                              |  |
| 0.00   | Applicable exception percentage (see instructions)   |  |  | 0.00                           |  |
| 4. 00  | Capital cost for comparison to payments (line 3 x line 4)  |  |  | 0                              |  |
| 4. 00<br>5. 00   |  |  |  | 0.00                           |  |
| 4. 00<br>5. 00<br>6. 00  | Percentage adjustment for extraordinary circumstances (see i   | •  |  |                                | 1 7 0  |
| 4. 00<br>5. 00<br>6. 00<br>7. 00   | Adjustment to capital minimum payment level for extraordinar   | •  | x line 6)                                | 0                              |  |
| 4. 00<br>5. 00<br>6. 00<br>7. 00<br>8. 00  | Adjustment to capital minimum payment level for extraordinar Capital minimum payment level (line 5 plus line 7)  | ry circumstances (line 2   | x line 6)                                | 0                              | 8.00   |
| 4. 00<br>5. 00<br>6. 00<br>7. 00<br>8. 00<br>9. 00   | Adjustment to capital minimum payment level for extraordinar Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as appl   | ry circumstances (line 2 icable)   |  | 0 0                            | 8. 00<br>9. 00   |
| 4. 00<br>5. 00<br>6. 00<br>7. 00<br>8. 00<br>9. 00<br>10. 00   | Adjustment to capital minimum payment level for extraordinar Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as appl Current year comparison of capital minimum payment level to Carryover of accumulated capital minimum payment level over   | ry circumstances (line 2<br>icable)<br>capital payments (line 8  | less line 9)                             | 0                              | 8. 00<br>9. 00<br>10. 00   |
| 4. 00<br>5. 00<br>6. 00<br>7. 00<br>8. 00<br>9. 00<br>10. 00<br>11. 00                               | Adjustment to capital minimum payment level for extraordinar Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as appl Current year comparison of capital minimum payment level to Carryover of accumulated capital minimum payment level over Worksheet L, Part III, line 14)   | ry circumstances (line 2<br>icable)<br>capital payments (line 8<br>capital payment (from pr  | less line 9)<br>ior year                 | 0<br>0<br>0                    | 8. 00<br>9. 00<br>10. 00<br>11. 00                               |
| 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           | Adjustment to capital minimum payment level for extraordinar Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as appl Current year comparison of capital minimum payment level to Carryover of accumulated capital minimum payment level over Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital payment level payment level to capital payment level pay | ry circumstances (line 2 icable) capital payments (line 8 capital payment (from propayments (line 10 plus li                           | less line 9)<br>ior year<br>ne 11)       | 0<br>0<br>0<br>0               | 8. 00<br>9. 00<br>10. 00<br>11. 00                               |
| 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           | Adjustment to capital minimum payment level for extraordinar Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as appl Current year comparison of capital minimum payment level to Carryover of accumulated capital minimum payment level over Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital payment year exception payment (if line 12 is positive, enter Carryover of accumulated capital minimum payment level over  | ry circumstances (line 2 icable) capital payments (line 8 capital payment (from propayments (line 10 plus lier the amount on this line | less line 9)<br>ior year<br>ne 11)<br>e) | 0<br>0<br>0<br>0<br>0          | 8. 00<br>9. 00<br>10. 00<br>11. 00<br>12. 00<br>13. 00           |
| 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<br>14. 00 | Adjustment to capital minimum payment level for extraordinar Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as appl Current year comparison of capital minimum payment level to Carryover of accumulated capital minimum payment level over Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital gurrent year exception payment (if line 12 is positive, enter Carryover of accumulated capital minimum payment level over (if line 12 is negative, enter the amount on this line)  | icable) capital payments (line 8 capital payment (from pr payments (line 10 plus li er the amount on this lin capital payment for the  | less line 9)<br>ior year<br>ne 11)<br>e) | 0<br>0<br>0<br>0<br>0          | 8. 00<br>9. 00<br>10. 00<br>11. 00<br>12. 00<br>13. 00<br>14. 00 |
| 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<br>14.00            | Adjustment to capital minimum payment level for extraordinar Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as appl Current year comparison of capital minimum payment level to Carryover of accumulated capital minimum payment level over Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital payment year exception payment (if line 12 is positive, enter Carryover of accumulated capital minimum payment level over  | icable) capital payments (line 8 capital payment (from pr payments (line 10 plus li er the amount on this lin capital payment for the  | less line 9)<br>ior year<br>ne 11)<br>e) | 0<br>0<br>0<br>0<br>0          | 8. 00<br>9. 00<br>10. 00<br>11. 00<br>12. 00<br>13. 00<br>14. 00 |

| Health Financial Systems                  | MAJOR HO     | SPI TAL     |              | In Lie            | u of Form CMS-2 | 2552-10 |
|---|--------------|-------------|--------------|-------------------|-----------------|---------|
| ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS |              | Provi der C |              | Peri od:          | Worksheet M-1   |         |
|   |              |             |              | From 01/01/2020   |                 |         |
|   |              | Component   | CCN: 15-8529 | To 12/31/2020     |                 |         |
|   |              |             |              |                   | 8/2/2021 2: 11  | pm      |
|   |              |             |              | RHC I             |                 |         |
|   | Compensation | Other Costs | Total (col.  | 1 Reclassi fi cat | Recl assi fi ed |         |
|   |              |             | + col . 2)   | i ons             | Trial Balance   |         |
|   |              |             |              |                   | (col. 3 +       |         |
|   |              |             |              |                   |                 |         |

|        |  |              |             |             | RHC I            |               |        |
|--------|--|--------------|-------------|-------------|------------------|---------------|--------|
|        |  | Compensation | Other Costs |             | Recl assi fi cat | Reclassi fied |        |
|        |  |              |             | + col . 2)  | i ons            | Trial Balance |        |
|        |  |              |             |             |                  | (col. 3 +     |        |
|        |  |              |             |             |                  | col. 4)       |        |
|        |  | 1. 00        | 2. 00       | 3. 00       | 4. 00            | 5. 00         |        |
|        | FACILITY HEALTH CARE STAFF COSTS             |              |             |             |                  |               |        |
| 1.00   | Physi ci an                                  | 0            | 806, 577    | 806, 577    | 57, 416          | 863, 993      | 1.00   |
| 2.00   | Physi ci an Assi stant                       | 0            | 0           | 0           | 0                | 0             | 2.00   |
| 3.00   | Nurse Practitioner                           | 102, 231     | 0           | 102, 231    | 0                | 102, 231      | 3.00   |
| 4.00   | Visiting Nurse                               | 0            | 0           | 0           | 0                | 0             | 4.00   |
| 5.00   | Other Nurse                                  | 0            | 0           | 0           | 0                | 0             | 5.00   |
| 6.00   | Clinical Psychologist                        | 0            | 0           | 0           | 0                | ol            | 6.00   |
| 7.00   | Clinical Social Worker                       | 27, 837      | l o         | 27, 837     | 0                | 27, 837       | 7. 00  |
| 8. 00  | Laboratory Techni ci an                      | 0            | 0           | 0           | 0                | 0             | 8. 00  |
| 9. 00  | Other Facility Health Care Staff Costs       | 609, 255     | 0           | 609, 255    | 0                | 609, 255      | 9. 00  |
| 10.00  | Subtotal (sum of lines 1 through 9)          | 739, 323     |             |             |                  |               | 10.00  |
| 11. 00 | Physician Services Under Agreement           | 707, 020     | 000, 077    | 1,010,700   | 07, 110          | 0             | 11. 00 |
| 12.00  | Physician Supervision Under Agreement        | 0            | 0           | ١           | 0                | 0             | 12.00  |
| 13. 00 | Other Costs Under Agreement                  | 0            | 0           |             | 0                | 0             | 13. 00 |
| 14. 00 | Subtotal (sum of lines 11 through 13)        | 0            | 0           |             | 0                | 0             | 14. 00 |
|        |  | 0            | 427 220     | 427 220     | 0                |               |        |
| 15.00  | Medical Supplies                             | 0            | 437, 230    | 437, 230    | 0                | 437, 230      | 15.00  |
| 16.00  | Transportation (Health Care Staff)           | 0            | 0           | 0           | 0                | 0             | 16.00  |
| 17.00  | Depreciation-Medical Equipment               | 0            | 0           | 0           | 0                | 0             | 17.00  |
| 18.00  | ,  | 0            | 0           | 0           | 0                | 0             | 18.00  |
|        | Other Health Care Costs                      | 0            | 0           | 0           | 0                | 0             | 19. 00 |
| 20.00  | Allowable GME Costs                          | _            |             |             | _                |               | 20.00  |
| 21. 00 | Subtotal (sum of lines 15 through 20)        | 0            | 437, 230    |             |                  | 437, 230      | 21.00  |
| 22. 00 | Total Cost of Health Care Services (sum of   | 739, 323     | 1, 243, 807 | 1, 983, 130 | 57, 416          | 2, 040, 546   | 22. 00 |
|        | lines 10, 14, and 21)                        |              |             |             |                  |               |        |
|        | COSTS OTHER THAN RHC/FQHC SERVICES           |              |             |             |                  |               |        |
| 23. 00 |  | 0            | 0           | _           | _                |               | 23.00  |
| 24. 00 | Dental                                       | 0            | 0           | 0           | 0                | 0             | 24.00  |
| 25. 00 | Optometry                                    | 0            | 0           | 0           | 0                | 0             | 25.00  |
| 25. 01 | Tel eheal th                                 | 0            | 0           | 0           | 0                | 0             | 25. 01 |
| 25. 02 | Chronic Care Management                      | 0            | 0           | 0           | 0                | 0             | 25. 02 |
| 26.00  | All other nonreimbursable costs              | 0            | 0           | 0           | 0                | 0             | 26.00  |
| 27.00  | Nonallowable GME costs                       |              |             |             |                  |               | 27.00  |
| 28.00  | Total Nonreimbursable Costs (sum of lines 23 | 0            | 0           | 0           | 0                | 0             | 28.00  |
|        | through 27)                                  |              |             |             |                  |               |        |
|        | FACILITY OVERHEAD                            |              |             |             |                  |               |        |
| 29.00  | Facility Costs                               | 0            | 84, 973     | 84, 973     | 0                | 84, 973       | 29.00  |
| 30.00  | Administrative Costs                         | 182, 558     | 88, 494     | 271, 052    | 0                | 271, 052      | 30.00  |
| 31.00  | Total Facility Overhead (sum of lines 29 and | 182, 558     | 173, 467    | 356, 025    | 0                | 356, 025      | 31.00  |
|        | 30)  |              |             |             |                  |               |        |
| 32.00  | Total facility costs (sum of lines 22, 28    | 921, 881     | 1, 417, 274 | 2, 339, 155 | 57, 416          | 2, 396, 571   | 32.00  |
|        | and 31)                                      |              |             |             |                  |               |        |
|        | •  | •            | •           | •           | •                | . '           | •      |

| Health Financial Systems                  | MAJOR HOSPITAL         | In Lieu of Form CMS-2552-10 |   |  |  |
|---|------------------------|-----------------------------|---|--|--|
| ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS |                        | Peri od:<br>From 01/01/2020 | Worksheet M-1                           |  |  |
|   | Component CCN: 15-8529 |                             | Date/Time Prepared:<br>8/2/2021 2:11 pm |  |  |

|        |  |             | 00p0110111   | 00.11 10 0027 | 10 12/01/2020 | 8/2/2021 2:11 | l pm   |
|--------|--|-------------|--------------|---------------|---------------|---------------|--------|
|        |  |             |              |               | RHC I         |               |        |
|        |  | Adjustments | Net Expenses |               |               |               |        |
|        |  |             | for          |               |               |               |        |
|        |  |             | Allocation   |               |               |               |        |
|        |  |             | (col. 5 +    |               |               |               |        |
|        |  |             | col. 6)      |               |               |               |        |
|        |  | 6. 00       | 7. 00        |               |               |               |        |
|        | FACILITY HEALTH CARE STAFF COSTS             |             |              |               |               |               |        |
| 1.00   | Physi ci an                                  | 0           | 863, 993     | •             |               |               | 1.00   |
| 2.00   | Physician Assistant                          | 209, 338    |              |               |               |               | 2.00   |
| 3.00   | Nurse Practitioner                           | 411, 451    | 513, 682     |               |               |               | 3.00   |
| 4.00   | Visiting Nurse                               | 0           | 0            | )             |               |               | 4.00   |
| 5.00   | Other Nurse                                  | 0           | 0            | )             |               |               | 5.00   |
| 6.00   | Clinical Psychologist                        | 0           | 0            | )             |               |               | 6. 00  |
| 7.00   | Clinical Social Worker                       | 0           | 27, 837      | '             |               |               | 7. 00  |
| 8.00   | Laboratory Techni ci an                      | 0           | 0            | )             |               |               | 8. 00  |
| 9.00   | Other Facility Health Care Staff Costs       | 0           | 609, 255     | i             |               |               | 9. 00  |
| 10.00  | Subtotal (sum of lines 1 through 9)          | 620, 789    | 2, 224, 105  | 5             |               |               | 10.00  |
| 11. 00 | Physician Services Under Agreement           | 0           | 0            |               |               |               | 11.00  |
| 12.00  | Physician Supervision Under Agreement        | 0           | 0            |               |               |               | 12.00  |
| 13.00  | Other Costs Under Agreement                  | 0           | 0            |               |               |               | 13.00  |
| 14.00  | Subtotal (sum of lines 11 through 13)        | 0           | 0            |               |               |               | 14.00  |
| 15.00  | Medical Supplies                             | 0           | 437, 230     |               |               |               | 15. 00 |
| 16.00  | Transportation (Health Care Staff)           | 0           | 0            |               |               |               | 16.00  |
| 17.00  | Depreciation-Medical Equipment               | 0           | 0            |               |               |               | 17. 00 |
| 18.00  | Professional Liability Insurance             | 0           | 0            |               |               |               | 18. 00 |
| 19.00  | Other Health Care Costs                      | 0           | 0            |               |               |               | 19. 00 |
| 20.00  | Allowable GME Costs                          |             |              |               |               |               | 20.00  |
| 21.00  | Subtotal (sum of lines 15 through 20)        | 0           | 437, 230     |               |               |               | 21.00  |
| 22.00  | Total Cost of Health Care Services (sum of   | 620, 789    | 2, 661, 335  | i             |               |               | 22. 00 |
|        | lines 10, 14, and 21)                        |             |              |               |               |               |        |
|        | COSTS OTHER THAN RHC/FQHC SERVICES           |             |              |               |               |               |        |
| 23.00  | Pharmacy                                     | 0           | 0            |               |               |               | 23. 00 |
| 24.00  | Dental                                       | 0           | 0            |               |               |               | 24.00  |
| 25.00  | Optometry                                    | 0           | 0            |               |               |               | 25. 00 |
| 25. 01 | Tel eheal th                                 | 0           | 0            |               |               |               | 25. 01 |
| 25. 02 | Chronic Care Management                      | 0           | 0            | )             |               |               | 25. 02 |
| 26.00  | All other nonreimbursable costs              | 0           | 0            |               |               |               | 26. 00 |
| 27.00  | Nonallowable GME costs                       |             |              |               |               |               | 27. 00 |
| 28.00  | Total Nonreimbursable Costs (sum of lines 23 | 0           | 0            |               |               |               | 28. 00 |
|        | through 27)                                  |             |              |               |               |               |        |
|        | FACILITY OVERHEAD                            |             |              |               |               |               |        |
|        | Facility Costs                               | 0           | 84, 973      | •             |               |               | 29. 00 |
| 30.00  | Administrative Costs                         | 322, 210    | 593, 262     |               |               |               | 30.00  |
| 31.00  | Total Facility Overhead (sum of lines 29 and | 322, 210    | 678, 235     | 5             |               |               | 31.00  |
|        | 30)  |             |              |               |               |               |        |
| 32.00  | Total facility costs (sum of lines 22, 28    | 942, 999    | 3, 339, 570  | )             |               |               | 32.00  |
|        | and 31)                                      |             |              |               |               |               |        |
|        |  |             |              |               |               |               |        |

| Health Financial Systems                  | MAJOR HOSPITAL         | In Lieu of Form CMS-2552-10 |  |  |
|---|------------------------|-----------------------------|--|--|
| ANALYSIS OF HOSPITAL-BASED RHC/FOHC COSTS | Provi der CCN: 15-0097 | Period: Worksheet M-1       |  |  |

| ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS |  | Provider CCN: 15-0097   Period:   Worksheet M-1 |             |              |                 |                 |        |
|---|--|---|-------------|--------------|-----------------|-----------------|--------|
|   |  |   |             |              | From 01/01/2020 |                 |        |
|   |  |   | Component   | CCN: 15-8531 | To 12/31/2020   |                 |        |
|   |  |   |             |              | RHC II          | 8/2/2021 2:11   | pm     |
|   |  | Compensation                                    | Other Costs | Total (col   | 1 Reclassificat | Recl assi fi ed |        |
|   |  | Compensation                                    | Other Costs | + col . 2)   | ions            | Trial Balance   |        |
|   |  |   |             | + (01. 2)    | 1 0113          | (col. 3 +       |        |
|   |  |   |             |              |                 | col . 4)        |        |
|   |  | 1. 00   | 2. 00       | 3. 00        | 4. 00           | 5. 00           |        |
|   | FACILITY HEALTH CARE STAFF COSTS                         |   |             |              |                 |                 |        |
| 1.00                                      | Physi ci an  | 0   | 728, 534    | 728, 53      | 34 0            | 728, 534        | 1.00   |
| 2.00                                      | Physici an Assistant                                     | 0   | 0           | ·            | 0 0             | 0               | 2.00   |
| 3.00                                      | Nurse Practitioner                                       | 104, 277  | 0           | 104, 27      | 77 0            | 104, 277        | 3.00   |
| 4.00                                      | Visiting Nurse   | 0   | 0           |              | 0 0             | 0               | 4.00   |
| 5.00                                      | Other Nurse  | 0   | 0           |              | 0 0             | 0               | 5.00   |
| 6.00                                      | Clinical Psychologist                                    | 0   | 0           |              | 0 0             | 0               | 6.00   |
| 7.00                                      | Clinical Social Worker                                   | 26, 567   | 0           | 26, 56       | 0 0             | 26, 567         | 7.00   |
| 8.00                                      | Laboratory Techni ci an                                  | 0   | 0           |              | 0 0             | 0               | 8. 00  |
| 9.00                                      | Other Facility Health Care Staff Costs                   | 325, 841  | 0           | 325, 84      | 11 0            | 325, 841        | 9.00   |
| 10.00                                     | Subtotal (sum of lines 1 through 9)                      | 456, 685  | 728, 534    | 1, 185, 21   | 9 0             | 1, 185, 219     | 10.00  |
| 11.00                                     | Physician Services Under Agreement                       | 0   | 0           |              | 0 0             | 0               | 11.00  |
| 12.00                                     | Physician Supervision Under Agreement                    | 0   | 0           |              | 0               | 0               | 12.00  |
| 13.00                                     | Other Costs Under Agreement                              | 0   | 0           |              | 0               | 0               | 13.00  |
| 14.00                                     | Subtotal (sum of lines 11 through 13)                    | 0   | 0           |              | 0               | 0               | 14.00  |
| 15.00                                     | Medical Supplies   | 0   | 333, 903    | 333, 90      | 0               | 333, 903        | 15. 00 |
| 16.00                                     | Transportation (Health Care Staff)                       | 0   | 0           |              | 0               | 0               |        |
| 17. 00                                    | Depreciation-Medical Equipment                           | 0   | 0           |              | 0               | 0               |        |
| 18. 00                                    | Professional Liability Insurance                         | 0   | 0           |              | 0               | 0               |        |
| 19. 00                                    | Other Health Care Costs                                  | 0   | 0           |              | 0               | 0               |        |
| 20.00                                     | Allowable GME Costs                                      |   |             |              |                 |                 | 20.00  |
| 21. 00                                    | Subtotal (sum of lines 15 through 20)                    | 0   | 333, 903    |              |                 | 333, 903        |        |
| 22. 00                                    | Total Cost of Health Care Services (sum of               | 456, 685  | 1, 062, 437 | 1, 519, 12   | 22 0            | 1, 519, 122     | 22. 00 |
|   | lines 10, 14, and 21)                                    |   |             |              |                 |                 |        |
| 00.00                                     | COSTS OTHER THAN RHC/FQHC SERVICES                       |   |             | ı            |                 |                 | 00.00  |
| 23. 00                                    | Pharmacy   | 0   | 0           |              | 0               | l               |        |
| 24. 00                                    | Dental   | 0   | 0           |              | 0               | 1               |        |
| 25. 00                                    | Optometry  | 0   | 0           |              | 0               | 0               |        |
| 25. 01<br>25. 02                          | Tel eheal th   | 0   | 0           |              | 0               | 1               |        |
|   | Chronic Care Management                                  | 0   | 0           |              | 0               | 0               |        |
| 26.00                                     | All other nonreimbursable costs                          | U   | U           |              | U U             | 0               |        |
| 27. 00<br>28. 00                          | Nonallowable GME costs                                   | 0   |             |              | 0 0             | 0               | 27.00  |
| 28.00                                     | Total Nonreimbursable Costs (sum of lines 23 through 27) | U   | U           |              | U U             | 0               | 28. 00 |
|   | FACILITY OVERHEAD  |   |             |              |                 |                 |        |
| 29. 00                                    | Facility Costs   | 0   | 24, 539     | 24, 53       | 39 0            | 24, 539         | 29. 00 |
| 30.00                                     | Administrative Costs                                     | 150, 869  | 61, 414     |              |                 | 212, 283        |        |
| 31.00                                     | Total Facility Overhead (sum of lines 29 and             |   | 85, 953     |              |                 | l '             |        |
| 31.00                                     | 30)  | 130, 809  | 05, 755     | 230, 62      |                 | 230, 622        | 31.00  |
| 32. 00                                    | Total facility costs (sum of lines 22, 28                | 607, 554  | 1, 148, 390 | 1, 755, 94   | 14 0            | 1, 755, 944     | 32. 00 |
| 52. 50                                    | and 31)  | 337,334   | 1, 110, 370 | 1, , 55, ,   | · ·             | 1, 700, 744     | 32.00  |
|   |  | '   |             | 1            | T .             | 1               |        |

| Health Financial Systems                  | MAJOR HOSPITAL         | In Lieu of Form CMS-2552-1                         |
|---|------------------------|--|
| ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS | Provi der CCN: 15-0097 | Peri od: Worksheet M-1 From 01/01/2020             |
|   | Component CCN: 15-8531 | To 12/31/2020 Date/Time Prepared: 8/2/2021 2:11 pm |

|        |  |             |              |         | 8/2/2021 2:11 pm |
|--------|--|-------------|--------------|---------|------------------|
|        |  |             |              | RHC I I |                  |
|        |  | Adjustments | Net Expenses |         |                  |
|        |  | •           | for          |         |                  |
|        |  |             | Allocation   |         |                  |
|        |  |             | (col. 5 +    |         |                  |
|        |  |             | col. 6)      |         |                  |
|        |  | 6. 00       | 7.00         |         |                  |
|        | FACILITY HEALTH CARE STAFF COSTS             | 0.00        | 7.00         |         |                  |
| 1 00   |  | 04 020      | 442 EQ4      |         | 1.00             |
| 1.00   | Physi ci an                                  | -84, 938    | · I          |         |                  |
| 2. 00  | Physician Assistant                          | 0           | 0            |         | 2.00             |
| 3. 00  | Nurse Practitioner                           | 0           | 104, 277     |         | 3.00             |
| 4.00   | Visiting Nurse                               | 0           | 0            |         | 4.00             |
| 5.00   | Other Nurse                                  | 0           | 0            |         | 5.00             |
| 6.00   | Clinical Psychologist                        | 0           | 0            |         | 6.00             |
| 7.00   | Clinical Social Worker                       | 0           | 26, 567      |         | 7.00             |
| 8.00   | Laboratory Techni ci an                      | 0           | o            |         | 8.00             |
| 9.00   | Other Facility Health Care Staff Costs       | 0           | 325, 841     |         | 9.00             |
| 10.00  | Subtotal (sum of lines 1 through 9)          | -84, 938    |              |         | 10.00            |
| 11. 00 | Physician Services Under Agreement           | 0.,         | 0            |         | 11.00            |
| 12. 00 | Physician Supervision Under Agreement        | 0           | o            |         | 12.00            |
| 13. 00 | Other Costs Under Agreement                  | 0           | 0            |         | 13.00            |
|        |  | 0           | 0            |         |                  |
| 14.00  | Subtotal (sum of lines 11 through 13)        | 0           | - 1          |         | 14.00            |
| 15.00  | Medical Supplies                             | 0           | 333, 903     |         | 15. 00           |
| 16. 00 | ' ' '  | 0           | 0            |         | 16.00            |
|        | Depreciation-Medical Equipment               | 0           | 0            |         | 17. 00           |
|        | Professional Liability Insurance             | 0           | 0            |         | 18. 00           |
| 19. 00 | Other Health Care Costs                      | 0           | 0            |         | 19.00            |
| 20.00  | Allowable GME Costs                          |             |              |         | 20.00            |
| 21.00  | Subtotal (sum of lines 15 through 20)        | 0           | 333, 903     |         | 21.00            |
| 22.00  | Total Cost of Health Care Services (sum of   | -84, 938    | 1, 434, 184  |         | 22.00            |
|        | lines 10, 14, and 21)                        |             |              |         |                  |
|        | COSTS OTHER THAN RHC/FQHC SERVICES           |             | ,            |         |                  |
| 23. 00 | Pharmacy                                     | 0           | 0            |         | 23.00            |
| 24. 00 | Dental                                       | 0           | 0            |         | 24.00            |
| 25. 00 | Optometry                                    | 0           |              |         | 25. 00           |
| 25. 01 | Tel eheal th                                 | 0           | Ŏ            |         | 25.00            |
| 25. 01 | 4  | 0           | 0            |         | 25. 02           |
|        |  | 0           | 0            |         | 25.02            |
| 26.00  | All other nonreimbursable costs              | Ü           | ١            |         |                  |
| 27. 00 | Nonallowable GME costs                       | _           | _            |         | 27.00            |
| 28. 00 | Total Nonreimbursable Costs (sum of lines 23 | 0           | 0            |         | 28. 00           |
|        | through 27)                                  |             |              |         |                  |
|        | FACILITY OVERHEAD                            |             |              |         |                  |
|        | Facility Costs                               | 0           | .,           |         | 29. 00           |
| 30.00  | Administrative Costs                         | 149, 562    | 361, 845     |         | 30.00            |
| 31.00  | Total Facility Overhead (sum of lines 29 and | 149, 562    | 386, 384     |         | 31.00            |
|        | 30)  |             |              |         |                  |
| 32.00  | Total facility costs (sum of lines 22, 28    | 64, 624     | 1, 820, 568  |         | 32.00            |
|        | and 31)                                      |             |              |         |                  |
|        | · · · · · · · · · · · · · · · · · · ·        |             | •            |         | •                |

| Health Financial Systems                  | MAJOR HOSPITAL         | In Lieu of Form CMS-2552-10                        |
|---|------------------------|--|
| ANALYSIS OF HOSPITAL-BASED RHC/FOHC COSTS |                        | Period: Worksheet M-1<br>From 01/01/2020           |
|   | Component CCN: 15-8532 | To 12/31/2020 Date/Time Prepared: 8/2/2021 2:11 pm |

|        |  |              | Component   | CCN: 15-8532   10 | 0 12/31/2020    | 8/2/2021 2:11   |        |
|--------|--|--------------|-------------|-------------------|-----------------|-----------------|--------|
|        |  |              |             |                   | RHC III         | 0/2/2021 2:11   | РШ     |
|        |  | Compensation | Other Costs | Total (col. 1     | Reclassi fi cat | Recl assi fi ed |        |
|        |  |              |             | + col . 2)        | i ons           | Trial Balance   |        |
|        |  |              |             | ,                 |                 | (col. 3 +       |        |
|        |  |              |             |                   |                 | col . 4)        |        |
|        |  | 1. 00        | 2. 00       | 3. 00             | 4. 00           | 5. 00           |        |
|        | FACILITY HEALTH CARE STAFF COSTS                   |              |             |                   |                 |                 |        |
| 1.00   | Physi ci an  | 0            | 2, 953, 448 | 2, 953, 448       | 0               | 2, 953, 448     | 1.00   |
| 2.00   | Physician Assistant                                | 0            | 0           | _                 | 0               | 0               | 2.00   |
| 3.00   | Nurse Practitioner                                 | 126, 541     | 240         | 126, 781          | 0               | 126, 781        | 3.00   |
| 4.00   | Visiting Nurse                                     | 0            | 0           | 0                 | 0               | 0               | 4. 00  |
| 5.00   | Other Nurse  | 0            | 0           | 0                 | 0               | 0               | 5.00   |
| 6.00   | Clinical Psychologist                              | 0            | 3, 048      |                   |                 | 3, 048          |        |
| 7.00   | Clinical Social Worker                             | 49, 509      | 0           | 49, 509           | 0               | 49, 509         | 7.00   |
| 8.00   | Laboratory Techni ci an                            | 0            | 0           | 0                 | 0               | 0               | 8.00   |
| 9.00   | Other Facility Health Care Staff Costs             | 2, 255, 856  | 0           | 2, 255, 856       | 0               | 2, 255, 856     |        |
| 10.00  | Subtotal (sum of lines 1 through 9)                | 2, 431, 906  | 2, 956, 736 | 5, 388, 642       | 0               | 5, 388, 642     | 10.00  |
| 11. 00 | Physician Services Under Agreement                 | 0            | 0           | 0                 | 0               | 0               | 11.00  |
| 12.00  | Physician Supervision Under Agreement              | 0            | 0           | 0                 | 0               | 0               | 12.00  |
| 13.00  | Other Costs Under Agreement                        | 0            | 0           | 0                 | 0               | 0               | 13.00  |
| 14.00  | Subtotal (sum of lines 11 through 13)              | 0            | 0           | 0                 | 0               | 0               | 14.00  |
| 15.00  | Medical Supplies                                   | 186, 801     | 704, 917    | 891, 718          | 0               | 891, 718        | 15.00  |
| 16.00  | Transportation (Health Care Staff)                 | 0            | 0           | 0                 | 0               | 0               | 16.00  |
| 17.00  | Depreciation-Medical Equipment                     | 0            | 0           | 0                 | 0               | 0               | 17.00  |
| 18.00  | Professional Liability Insurance                   | 0            | 0           | 0                 | 0               | 0               | 18. 00 |
| 19. 00 | Other Health Care Costs                            | 0            | 0           | 0                 | 0               | 0               | 19.00  |
| 20.00  | Allowable GME Costs                                |              |             |                   |                 |                 | 20.00  |
| 21. 00 | Subtotal (sum of lines 15 through 20)              | 186, 801     | 704, 917    | · ·               | 0               | 891, 718        |        |
| 22.00  | Total Cost of Health Care Services (sum of         | 2, 618, 707  | 3, 661, 653 | 6, 280, 360       | 0               | 6, 280, 360     | 22.00  |
|        | lines 10, 14, and 21)                              |              |             |                   |                 |                 |        |
|        | COSTS OTHER THAN RHC/FQHC SERVICES                 |              |             | _                 | _               |                 |        |
| 23. 00 | Pharmacy   | 0            | 0           |                   |                 |                 |        |
| 24.00  | Dental   | 0            | 0           | 0                 | 0               | 0               | 24.00  |
| 25. 00 | Optometry  | 0            | 0           | 0                 | 0               | 0               |        |
| 25. 01 | Tel eheal th                                       | 0            | 0           | 0                 | 0               | 0               | 25. 01 |
| 25. 02 | Chronic Care Management                            | 0            | 0           | 0                 | 0               | 0               | 25. 02 |
| 26. 00 | All other nonreimbursable costs                    | 0            | 0           | 0                 | 0               | 0               | 26.00  |
| 27. 00 | Nonallowable GME costs                             | _            | _           | _                 | _               | _               | 27.00  |
| 28. 00 | Total Nonreimbursable Costs (sum of lines 23       | 0            | 0           | 0                 | 0               | 0               | 28. 00 |
|        | through 27)  |              |             |                   |                 |                 |        |
| 20.00  | FACILITY OVERHEAD                                  | ام           | F07 242     | F07 242           |                 | F07 242         | 20.00  |
| 29. 00 | Facility Costs                                     | 1 200 504    | 597, 343    |                   | 0               |                 |        |
| 30.00  | Administrative Costs                               | 1, 209, 596  | 461, 075    |                   | 0               | 1, 670, 671     | 30.00  |
| 31. 00 | Total Facility Overhead (sum of lines 29 and       | 1, 209, 596  | 1, 058, 418 | 2, 268, 014       | 0               | 2, 268, 014     | 31.00  |
| 32. 00 | 30)<br>  Total facility costs (sum of lines 22, 28 | 3, 828, 303  | 4, 720, 071 | 0 5/0 27/         | _               | 8, 548, 374     | 32.00  |
| 32.00  | and 31)  | 3, 020, 303  | 4, 720, 071 | 8, 548, 374       |                 | 0, 340, 374     | 32.00  |
|        | Julia 01)  | l            |             | I                 | I               | I               |        |

| Health Financial Systems                  | MAJOR HOSPITAL | In Lieu of Form CMS-2552-10              |
|---|----------------|--|
| ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS |                | Period: Worksheet M-1<br>From 01/01/2020 |
|   |                |  |

| Adjustments  |        |  |              |               |   |         | 8/2/2021 2: 1 | l pm   |
|--|--------|--|--------------|---------------|---|---------|---------------|--------|
| FACILITY HEALTH CARE STAFF COSTS   |        |  |              |               |   | RHC III |               |        |
| FACILITY HEALTH CARE STAFF COSTS   |        |  | Adjustments  | Net Expenses  |   |         |               |        |
| All location   Col 5 + Col 6   Col 5 + Col 6   Col 7   Col 6   Col 6   Col 7   Col 6   Col 6   Col 7   |        |  |              |               |   |         |               |        |
| Col. 5   col. 6   c   |        |  |              |               |   |         |               |        |
| FACILITY HEALTH CARE STAFF COSTS   |        |  |              |               |   |         |               |        |
| FACILITY HEALTH CARE STAFF COSTS   |        |  |              | ,             |   |         |               |        |
| FACILITY HEALTH CARE STAFF COSTS   1.00  |        |  |              |               |   |         |               |        |
| 1.00   |        |  | 6. 00        | 7.00          |   |         |               |        |
| 2.00   |        | FACILITY HEALTH CARE STAFF COSTS   |              |               |   |         |               |        |
| 2.00   | 1.00   | Physi ci an  | -58, 227     | 2, 895, 221   |   |         |               | 1.00   |
| 3.00   | 2.00   | Physician Assistant  |              |               |   |         |               | 2.00   |
| 4.00   |        |  | · ·          |               |   |         |               |        |
| 5.00   |        |  | 1,117,070    |               |   |         |               |        |
| 6.00   |        |  | 0            | _             |   |         |               |        |
| 7.00   |        |  | 0            | _             |   |         |               |        |
| 8. 00  |        |  | 0            |               |   |         |               |        |
| 9. 00 Obter Facility Health Care Staff Costs   | 7. 00  |  | 0            | 49, 509       |   |         |               | 7.00   |
| 10.00   Subtotal (sum of lines 1 through 9)   1,243,238   6,631,880   10.00  | 8.00   | Laboratory Techni ci an  | 0            | 0             |   |         |               | 8.00   |
| 10.00   Subtotal (sum of lines 1 through 9)   1,243,238   6,631,880   10.00  | 9.00   | Other Facility Health Care Staff Costs   | 0            | 2, 255, 856   |   |         |               | 9.00   |
| 11.00   Physician Services Under Agreement   | 10 00  |  | 1 243 238    |               |   |         |               | 10 00  |
| 12.00   Phýsici an Supervision Under Agreement   0   0   0   0   13.00   |        |  | 1, 2 10, 200 |               | 1 |         |               |        |
| 13. 00   Other Costs Under Agreement   0   0   0   0   14. 00   14. 00   14. 00   15. 00   Medical Supplies   0   891,718   15. 00   16. 00   Transportation (Heal th Care Staff)   0   0   0   0   16. 00   17. 00   0   0   0   17. 00   0   0   18. 00   0   0   0   0   0   0   0   0   0  |        |  | 0            |               |   |         |               |        |
| 14.00   Subtotal (sum of lines 11 through 13)   0   0   0   0   15.00   Medical Supplies   0   891,718   15.00   16.00   17.700   Depreciation (Health Care Staff)   0   0   0   0   17.00   Depreciation Medical Equipment   0   0   0   0   0   0   0   0   0  |        |  | 0            | _             |   |         |               |        |
| 15.00   Medical Supplies   |        |  | 0            |               |   |         |               | 1      |
| 16. 00 17. 00 17. 00 17. 00 17. 00 17. 00 17. 00 18. 00 17. 00 18. 00 18. 00 19. 00 18. 00 19. 00 10 | 14. 00 | Subtotal (sum of lines 11 through 13)  | 0            |               |   |         |               |        |
| 17. 00   Depreciation-Medical Equipment   0   0   0   0   18. 00   18. 00   Professional Liability Insurance   0   0   0   0   18. 00   19. 00   0   19. 00   0   19. 00   0   19. 00   0   19. 00   0   19. 00   20. 00   21. 00   21. 00   21. 00   21. 00   22. 00   21. 00   22. 00   21. 00   22. 00   22. 00   23. 00   23. 00   24. 00   24. 00   24. 00   25. 00   24. 00   25. 00   25. 00   25. 00   25. 00   25. 00   25. 00   25. 00   25. 00   25. 00   26. 00   26. 00   27. 00    | 15. 00 | Medical Supplies   | 0            | 891, 718      |   |         |               | 15.00  |
| 18. 00       Professional Liability Insurance       0       0       18. 00         19. 00       Other Heal th Care Costs       0       0       0       19. 00         20. 00       All lowable GME Costs       20. 00       20. 00       20. 00       20. 00         21. 00       Subtotal (sum of lines 15 through 20)       0       891, 718       21. 00         22. 00       Total Cost of Health Care Services (sum of lines 10, 14, and 21)       11, 243, 238       7, 523, 598       22. 00         23. 00       Pharmacy       0       0       22. 00       22. 00         24. 00       Dental       0       0       24. 00       24. 00         25. 01       Tel eheal th       0       0       25. 01       25. 01         25. 02       Chronic Care Management       0       0       25. 01       25. 02         26. 02       All other nonrel mbursable costs       0       0       26. 00       26. 00       26. 00       27. 00         28. 00       Total Nonrel mbursable Costs (sum of lines 23 through 27)       0       0       0       28. 00       27. 00       28. 00       28. 00         40. 00       Total Facility Costs       0       597, 343       29. 00       30. 00 <td< td=""><td>16.00</td><td>Transportation (Health Care Staff)</td><td>0</td><td>0</td><td></td><td></td><td></td><td>16.00</td></td<>   | 16.00  | Transportation (Health Care Staff)   | 0            | 0             |   |         |               | 16.00  |
| 18. 00       Professional Liability Insurance       0       0       18. 00         19. 00       Other Heal th Care Costs       0       0       0       19. 00         20. 00       All lowable GME Costs       20. 00       20. 00       20. 00       20. 00         21. 00       Subtotal (sum of lines 15 through 20)       0       891, 718       21. 00         22. 00       Total Cost of Health Care Services (sum of lines 10, 14, and 21)       11, 243, 238       7, 523, 598       22. 00         23. 00       Pharmacy       0       0       22. 00       22. 00         24. 00       Dental       0       0       24. 00       24. 00         25. 01       Tel eheal th       0       0       25. 01       25. 01         25. 02       Chronic Care Management       0       0       25. 01       25. 02         26. 02       All other nonrel mbursable costs       0       0       26. 00       26. 00       26. 00       27. 00         28. 00       Total Nonrel mbursable Costs (sum of lines 23 through 27)       0       0       0       28. 00       27. 00       28. 00       28. 00         40. 00       Total Facility Costs       0       597, 343       29. 00       30. 00 <td< td=""><td>17.00</td><td>Depreciation-Medical Equipment</td><td>0</td><td>0</td><td></td><td></td><td></td><td>17.00</td></td<>   | 17.00  | Depreciation-Medical Equipment   | 0            | 0             |   |         |               | 17.00  |
| 19.00   Other Health Care Costs   0   0   0   0   20.00     20.00   Allowable GME Costs   20.00     21.00   Subtotal (sum of lines 15 through 20)   0   891,718   21.00     22.00   Total Cost of Health Care Services (sum of lines 10, 14, and 21)   |        |  | 0            | 0             |   |         |               |        |
| 20.00   21.00   22.00   22.00   22.00   22.00   23.00   24.00   25.00   25.00   25.00   25.00   26.0   |        | , and the second | 0            |               |   |         |               |        |
| 21.00   Subtotal (sum of lines 15 through 20)   0   891,718   7,523,598   22.00   Total Cost of Heal th Care Services (sum of lines 10, 14, and 21)   COSTS OTHER THAN RHC/FOHC SERVICES   |        | · ·  | 0            |               |   |         |               |        |
| 22.00   Total Cost of Health Care Services (sum of lines 10, 14, and 21)   COSTS OTHER THAN RHC/FOHC SERVICES    23.00   Pharmacy   0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0  |        | i i  |              | 004 740       |   |         |               |        |
| Lines 10, 14, and 21)   COSTS OTHER THAN RHC/FOHC SERVICES   |        |  | 0            |               |   |         |               |        |
| COSTS OTHER THAN RHC/FQHC SERVICES   23.00   Pharmacy   0   0   0   0   0   24.00   Dental   0   0   0   0   0   25.00   Optometry   0   0   0   0   0   25.01   Tel eheal th   0   0   0   0   25.01   25.02   Chronic Care Management   0   0   0   0   25.02   26.00   All other nonrelimbursable costs   0   0   0   0   25.02   26.00   All other nonrelimbursable costs   0   0   0   0   26.00   27.00   28.00   Total Nonrelimbursable Costs (sum of lines 23   0   0   0   0   0   0   0   0   0  | 22. 00 |  | 1, 243, 238  | 7, 523, 598   |   |         |               | 22.00  |
| 23.00 Pharmacy   |        |  |              |               |   |         |               |        |
| 24.00 Dental 0 0 0 0 0 25.00 Optometry 0 0 0 0 0 0 25.00 Tel eheal th 0 0 0 0 0 0 25.01 Tel eheal th 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0   |        | COSTS OTHER THAN RHC/FQHC SERVICES   |              |               |   |         |               |        |
| 25. 00 Optometry 0 0 0 0 0 25. 00 25. 01 Tel eheal th 0 0 0 0 0 25. 01 25. 02 Chronic Care Management 0 0 0 0 25. 02 26. 00 All other nonreimbursable costs 0 0 0 26. 00 27. 00 Nonallowable GME costs 20 27. 00 Total Nonreimbursable Costs (sum of lines 23 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0  | 23.00  | Pharmacy   | 0            | 0             |   |         |               | 23.00  |
| 25. 00 Optometry 0 0 0 0 0 25. 00 25. 01 Tel eheal th 0 0 0 0 0 25. 01 25. 02 Chronic Care Management 0 0 0 0 25. 02 26. 00 All other nonreimbursable costs 0 0 0 26. 00 27. 00 Nonallowable GME costs 20 27. 00 Total Nonreimbursable Costs (sum of lines 23 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0  | 24.00  | Dental   | 0            | 0             |   |         |               | 24.00  |
| 25. 01 Telehealth 0 0 0 0 25. 02 26. 00 All other nonreimbursable costs 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0  |        | i i  | 0            | 0             |   |         |               | 25 00  |
| 25. 02 Chronic Care Management 0 0 0 0 25. 02 26. 00 All other nonreimbursable costs 0 0 0 0 27. 00 Nonallowable GME costs 27. 00 Total Nonreimbursable Costs (sum of lines 23 0 0 0 28. 00 27. 00 28. 00 Excility Overhead (sum of lines 23 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0   |        | 1 '  | 0            | _             |   |         |               |        |
| 26.00  |        | i i  | 0            | _             |   |         |               |        |
| 27. 00   Nonallowable GME costs   27. 00   28. 00   Total Nonreimbursable Costs (sum of lines 23   0   0   0   0   28. 00   28. 00   28. 00   28. 00   29. 00   8. 00   29. 00   29. 00   30. 00   Administrative Costs   960, 399   2, 631, 070   30. 00   31. 00   Total Facility Overhead (sum of lines 29 and 30)   32. 00   Total facility costs (sum of lines 22, 28   2, 203, 637   10, 752, 011   32. 00   32. 00   33. 00   34. 00   34. 00   35. 0 |        |  | 0            | _             |   |         |               |        |
| 28.00 Total Nonreimbursable Costs (sum of lines 23 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0   |        | i i  | 0            | 1 0           |   |         |               |        |
| through 27) FACILITY OVERHEAD  29.00 Facility Costs 30.00 Administrative Costs 31.00 Total Facility Overhead (sum of lines 29 and 30) 32.00 Total facility costs (sum of lines 22, 28 2, 203, 637 10, 752, 011 32.00   |        |  |              |               |   |         |               |        |
| FACILITY OVERHEAD  29. 00 Facility Costs 30. 00 Administrative Costs 31. 00 Total Facility Overhead (sum of lines 29 and 30) 32. 00 Total facility costs (sum of lines 22, 28 2, 203, 637 10, 752, 011 32.00   | 28. 00 | Total Nonreimbursable Costs (sum of lines 23   | 0            | 0             |   |         |               | 28. 00 |
| 29.00 Facility Costs 0 597,343 29.00 30.00 Administrative Costs 960,399 2,631,070 30.00 31.00 Total Facility Overhead (sum of lines 29 and 30) 32.00 Total facility costs (sum of lines 22, 28 2,203,637 10,752,011 32.00  |        | through 27)  |              |               |   |         |               |        |
| 29.00 Facility Costs 0 597,343 29.00 30.00 Administrative Costs 960,399 2,631,070 30.00 31.00 Total Facility Overhead (sum of lines 29 and 30) 32.00 Total facility costs (sum of lines 22, 28 2,203,637 10,752,011 32.00  |        | FACILITY OVERHEAD  |              |               |   |         |               |        |
| 30.00 Administrative Costs 960,399 2,631,070 31.00 Total Facility Overhead (sum of lines 29 and 30) 70tal facility costs (sum of lines 22, 28 2,203,637 10,752,011 32.00   | 29. 00 |  | 0            | 597, 343      |   |         |               | 29.00  |
| 31.00 Total Facility Overhead (sum of lines 29 and 30) 32.00 Total facility costs (sum of lines 22, 28 2, 203, 637 10, 752, 011 32.00  |        |  | _            |               |   |         |               |        |
| 30)<br>32.00 Total facility costs (sum of lines 22, 28 2, 203, 637 10, 752, 011 32.00  |        |  |              | , , , , , , , |   |         |               |        |
| 32.00 Total facility costs (sum of lines 22, 28 2, 203, 637 10, 752, 011 32.00   | 31.00  |  | 700, 399     | 3, 220, 413   |   |         |               | 31.00  |
|  | 22.00  |  | 2 202 427    | 10 750 014    |   |         |               | 22.00  |
| and 31)  | 32.00  | ,  | 2, 203, 637  | 10, /52, 011  |   |         |               | 32.00  |
|  |        | and 31)  |              | I             |   |         |               | 1      |

| Heal th        | Financial Systems                             | MAJOR HO        | ISPI TAL        |              | In Lie                           | u of Form CMS-2 | 2552-10 |
|----------------|---|-----------------|-----------------|--------------|----------------------------------|-----------------|---------|
| ALLOCA         | TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC S | SERVI CES       | Provi der C     | CN: 15-0097  | Peri od:                         | Worksheet M-2   |         |
|                |   |                 | Component       | CCN: 15-8529 | From 01/01/2020<br>To 12/31/2020 |                 |         |
|                |   |                 |                 |              | RHC I                            |                 |         |
|                |   | Number of FTE   | Total Visits    |              |                                  | Greater of      |         |
|                |   | Personnel       |                 | Standard (1) |                                  | col. 2 or       |         |
|                |   |                 |                 |              | 1 x col. 3)                      | col. 4          |         |
|                |   | 1. 00           | 2. 00           | 3. 00        | 4. 00                            | 5. 00           |         |
|                | VISITS AND PRODUCTIVITY                       |                 |                 |              |                                  |                 |         |
|                | Posi ti ons                                   | 0.45            |                 | ı            | <u>.</u>                         | Γ               |         |
| 1.00           | Physi ci an                                   | 3. 65           |                 |              | 1 4                              |                 | 1.00    |
| 2.00           | Physician Assistant                           | 0.70            | •               | l .          |                                  |                 | 2.00    |
| 3. 00<br>4. 00 | Nurse Practitioner                            | 3. 60           |                 |              | 1 4                              | 17 22/          | 3.00    |
| 4. 00<br>5. 00 | Subtotal (sum of lines 1 through 3)           | 7. 95           | •               |              | 9                                | 17, 236         |         |
| 6. 00          | Visiting Nurse<br>Clinical Psychologist       | 0. 00<br>0. 00  | l e             | l .          |                                  | 0               | 6.00    |
| 7. 00          | Clinical Social Worker                        | 0.00            |                 |              |                                  | 515             |         |
| 7. 00<br>7. 01 | Medical Nutrition Therapist (FQHC only)       | 0.37            | l .             |              |                                  | 0               | 7.00    |
| 7. 01          | Diabetes Self Management Training (FQHC       | 0.00            | l .             |              |                                  | 0               | 7.01    |
| 7.02           | only)   | 0.00            | ٥               |              |                                  |                 | 7.02    |
| 8. 00          | Total FTEs and Visits (sum of lines 4         | 8. 32           | 17, 751         |              |                                  | 17, 751         | 8.00    |
| 0.00           | through 7)                                    | 0.02            | .,,,,,,,        |              |                                  | .,,,,           | 0.00    |
| 9.00           | Physician Services Under Agreements           |                 | 0               |              |                                  | 0               | 9.00    |
|                | <u> </u>                                      | •               |                 |              | •                                |                 |         |
|                |   |                 |                 |              |                                  | 1. 00           |         |
|                | DETERMINATION OF ALLOWABLE COST APPLICABLE T  | O HOSPITAL-BASE | ED RHC/FQHC SEI | RVI CES      |                                  |                 |         |
|                | Total costs of health care services (from Wk  |                 |                 |              |                                  | 2, 661, 335     | 10.00   |
| 11.00          | Total nonreimbursable costs (from Wkst. M-1,  |                 |                 |              |                                  | 0               | 11. 00  |
| 12.00          | Cost of all services (excluding overhead) (s  |                 |                 |              |                                  | 2, 661, 335     |         |
| 13.00          | Ratio of hospital-based RHC/FQHC services (I  |                 |                 |              |                                  | 1. 000000       |         |
| 14.00          | Total hospital-based RHC/FQHC overhead - (fr  |                 |                 | ine 31)      |                                  | 678, 235        |         |
| 15.00          | Parent provider overhead allocated to facili  | ty (see instru  | ctions)         |              |                                  | 1, 733, 875     |         |
| 16. 00         | Total overhead (sum of lines 14 and 15)       |                 |                 |              |                                  | 2, 412, 110     |         |
| 17. 00         | Allowable GME overhead (see instructions)     |                 |                 |              |                                  | 0               |         |
|                | Enter the amount from line 16                 |                 |                 | 4.0)         |                                  | 2, 412, 110     |         |
|                | Overhead applicable to hospital-based RHC/FC  |                 |                 |              |                                  | 2, 412, 110     |         |
| 20.00          | Total allowable cost of hospital-based RHC/F  | ·UHC SETVICES ( | sum of lines 1  | u and 19)    |                                  | 5, 073, 445     | J 20.00 |

| Heal th | Financial Systems                               | MAJOR HO        | OSPI TAL       |              | In Li∈                           | eu of Form CMS-: | 2552-10 |
|---------|---|-----------------|----------------|--------------|----------------------------------|------------------|---------|
| ALLOCA  | TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC S   | SERVI CES       | Provi der C    | CN: 15-0097  | Peri od:                         | Worksheet M-2    | !       |
|         |   |                 | Component      | CCN: 15-8531 | From 01/01/2020<br>To 12/31/2020 |                  |         |
|         |   |                 |                |              | RHC II                           |                  |         |
|         |   | Number of FTE   | Total Visits   |              |                                  | Greater of       |         |
|         |   | Personnel       |                | Standard (1) | ) Visits (col.                   | col. 2 or        |         |
|         |   |                 |                |              | 1 x col. 3)                      | col. 4           |         |
|         |   | 1. 00           | 2.00           | 3. 00        | 4. 00                            | 5. 00            |         |
|         | VISITS AND PRODUCTIVITY                         |                 |                |              |                                  |                  |         |
|         | Posi ti ons                                     |                 | 1              |              |                                  |                  |         |
| 1. 00   | Physi ci an                                     | 1. 70           |                |              | 1 2                              |                  | 1.00    |
| 2. 00   | Physician Assistant                             | 0.00            |                | - 1          | 1 0                              |                  | 2.00    |
| 3.00    | Nurse Practitioner                              | 0. 88           |                |              | 1 1                              |                  | 3.00    |
| 4.00    | Subtotal (sum of lines 1 through 3)             | 2. 58           |                | 1            | 3                                | 6, 366           | •       |
| 5. 00   | Visiting Nurse                                  | 0.00            |                | 9            |                                  | 0                |         |
| 6.00    | Clinical Psychologist                           | 0.00            | l .            | 9            |                                  | 0                |         |
| 7. 00   | Clinical Social Worker                          | 0.00            | l .            | 9            |                                  | 0                | 1       |
| 7. 01   | Medical Nutrition Therapist (FQHC only)         | 0.00            | l .            | 9            |                                  | 0                | 1       |
| 7. 02   | Diabetes Self Management Training (FQHC         | 0. 00           | (              |              |                                  | 0                | 7. 02   |
|         | onl y)  | 0.50            |                |              |                                  |                  |         |
| 8. 00   | Total FTEs and Visits (sum of lines 4           | 2. 58           | 6, 366         |              |                                  | 6, 366           | 8. 00   |
| 0.00    | through 7)                                      |                 |                |              |                                  |                  | 0.00    |
| 9. 00   | Physician Services Under Agreements             |                 |                | <u> </u>     |                                  | 0                | 9. 00   |
|         |   |                 |                |              |                                  | 1. 00            |         |
|         | DETERMINATION OF ALLOWABLE COST APPLICABLE T    | O HUSDITAL BASI | ED DUC/EDUC SE | DVICES       |                                  | 1.00             |         |
| 10.00   |   |                 |                | IKVICLS      |                                  | 1, 434, 184      | 10.00   |
| 11. 00  |   |                 |                |              |                                  | 1, 434, 104      |         |
| 12.00   | Cost of all services (excluding overhead) (s    | · ·             | ,              |              |                                  | 1, 434, 184      | 1       |
| 13. 00  | Ratio of hospital-based RHC/FQHC services (I    |                 |                |              |                                  | 1, 000000        |         |
| 14. 00  | Total hospital-based RHC/FQHC overhead - (fr    |                 |                | ine 31)      |                                  | 386, 384         |         |
| 15. 00  | Parent provider overhead allocated to facili    |                 |                | 1110 31)     |                                  | 1, 009, 455      |         |
| 16. 00  | Total overhead (sum of lines 14 and 15)         | cy (See Tristiu | 011 0113)      |              |                                  | 1, 395, 839      |         |
| 17. 00  | Allowable GME overhead (see instructions)       |                 |                |              |                                  | 1, 373, 037      | 1       |
|         | Enter the amount from line 16                   |                 |                |              |                                  | 1, 395, 839      |         |
|         | Overhead applicable to hospital-based RHC/FC    | HC services (   | ine 13 x line  | 18)          |                                  | 1, 395, 839      |         |
|         | Total allowable cost of hospital-based RHC/F    |                 |                |              |                                  | 2, 830, 023      |         |
| 20.00   | 1. Sta. a Shabi S SSSC ST HOSPI tar basea kno/1 | 2 33. VI 003 (  |                | 0 4.14 17)   |                                  | 2,000,020        | 1 20.00 |

| Heal th        | Financial Systems                             | MAJOR HO         | SPI TAL         |                | In Lie                           | u of Form CMS-2                | 2552-10        |
|----------------|---|------------------|-----------------|----------------|----------------------------------|--------------------------------|----------------|
| ALLOCA         | TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC S | SERVI CES        | Provi der C     | CN: 15-0097    | Peri od:                         | Worksheet M-2                  |                |
|                |   |                  | Component       | CCN: 15-8532   | From 01/01/2020<br>To 12/31/2020 | Date/Time Pre<br>8/2/2021 2:11 |                |
|                |   |                  |                 |                | RHC III                          |                                |                |
|                |   | Number of FTE    | Total Visits    | Producti vi ty |                                  | Greater of                     |                |
|                |   | Personnel        |                 | Standard (1)   | Visits (col.                     | col. 2 or                      |                |
|                |   |                  |                 |                | 1 x col. 3)                      | col. 4                         |                |
|                |   | 1. 00            | 2. 00           | 3. 00          | 4. 00                            | 5. 00                          |                |
|                | VISITS AND PRODUCTIVITY                       |                  |                 |                |                                  |                                |                |
|                | Posi ti ons                                   |                  | T               | Т              |                                  |                                |                |
| 1.00           | Physi ci an                                   | 8. 67            |                 |                | 1 9                              |                                | 1.00           |
| 2.00           | Physician Assistant                           | 0. 95            |                 |                | 1 1                              |                                | 2.00           |
| 3.00           | Nurse Practitioner                            | 9. 35            |                 |                | 1 9                              | 47.700                         | 3.00           |
| 4.00           | Subtotal (sum of lines 1 through 3)           | 18. 97           |                 |                | 19                               | 46, 799                        |                |
| 5.00           | Visiting Nurse                                | 0.00             |                 |                |                                  | 0                              | 5.00           |
| 6.00           | Clinical Psychologist                         | 0.00             |                 |                |                                  | 0                              | 6.00           |
| 7.00           | Clinical Social Worker                        | 0. 98            |                 |                |                                  | 17<br>0                        | 7.00           |
| 7. 01<br>7. 02 | Medical Nutrition Therapist (FOHC only)       | 0.00             |                 |                |                                  | 0                              | 7. 01<br>7. 02 |
| 7.02           | Diabetes Self Management Training (FQHC only) | 0.00             | 0               |                |                                  | 0                              | 7.02           |
| 8. 00          | Total FTEs and Visits (sum of lines 4         | 19. 95           | 46, 816         |                |                                  | 46, 816                        | 8.00           |
| 0.00           | through 7)                                    | 17. 73           | 40,010          |                |                                  | 40,010                         | 0.00           |
| 9. 00          | Physician Services Under Agreements           |                  | 0               |                |                                  | 0                              | 9.00           |
| 7. 00          | Trijst of all set vices offact rigi coments   |                  |                 |                |                                  | Ü                              | 7.00           |
|                |   |                  |                 |                |                                  | 1. 00                          |                |
|                | DETERMINATION OF ALLOWABLE COST APPLICABLE T  | O HOSPI TAL-BASI | ED RHC/FQHC SEI | RVI CES        |                                  |                                |                |
| 10.00          | Total costs of health care services (from Wk  | st. M-1, col.    | 7, line 22)     |                |                                  | 7, 523, 598                    | 10.00          |
| 11.00          | Total nonreimbursable costs (from Wkst. M-1,  | col. 7, line     | 28)             |                |                                  | 0                              | 11.00          |
| 12.00          | Cost of all services (excluding overhead) (s  |                  |                 |                |                                  | 7, 523, 598                    | 12.00          |
| 13.00          | Ratio of hospital-based RHC/FQHC services (I  | ine 10 divided   | by line 12)     |                |                                  | 1. 000000                      | 13.00          |
| 14.00          | Total hospital-based RHC/FQHC overhead - (fr  | om Worksheet.    | M-1, col. 7, I  | ine 31)        |                                  | 3, 228, 413                    | 14.00          |
| 15.00          | Parent provider overhead allocated to facili  | ty (see instru   | ctions)         |                |                                  | 5, 922, 658                    | 15.00          |
| 16.00          | Total overhead (sum of lines 14 and 15)       |                  |                 |                |                                  | 9, 151, 071                    |                |
| 17.00          | Allowable GME overhead (see instructions)     |                  |                 |                |                                  | 0                              |                |
|                | Enter the amount from line 16                 |                  |                 |                |                                  | 9, 151, 071                    |                |
|                | Overhead applicable to hospital-based RHC/FQ  |                  |                 |                |                                  | 9, 151, 071                    |                |
| 20.00          | Total allowable cost of hospital-based RHC/F  | QHC services (   | sum of lines 1  | o and 19)      |                                  | 16, 674, 669                   | 20.00          |

| Health Financial Systems   | MAJOR HOSPI  | TAL                     | In Lie                           | u of Form CMS-2                | <u> 2552-1</u> 0 |
|--|--|-------------------------|----------------------------------|--------------------------------|------------------|
|  | EMENT FOR HOSPITAL-BASED RHC/FQHC  | Provider CCN: 15-0097   | Peri od:                         | Worksheet M-3                  |                  |
| SERVI CES  |  | Component CCN: 15-8529  | From 01/01/2020<br>To 12/31/2020 | Date/Time Pre<br>8/2/2021 2:11 |                  |
|  |  | Title XVIII             | RHC I                            |                                |                  |
|  |  |                         |                                  | 1. 00                          |                  |
| DETERMINATION OF RATE FOR H  | OSPITAL-BASED RHC/FQHC SERVICES  |                         |                                  | 1.00                           |                  |
| 1  | pital-based RHC/FQHC Services (fro                                       |                         |                                  | 5, 073, 445                    |                  |
| 4  | administration (from Wkst. M-4, li                                       | ne 15)                  |                                  | 714, 778                       |                  |
| 3.00   Total allowable cost exclud<br>4.00   Total Visits (from Wkst. M- | ing vaccine (line 1 minus line 2)  |                         |                                  | 4, 358, 667<br>17, 751         | 3. 00<br>4. 00   |
|  | eement (from Wkst. M-2, column 5,  | line 9)                 |                                  | 0                              | 5.00             |
| 6.00 Total adjusted visits (line   |  | •                       |                                  | 17, 751                        | 6.00             |
| 7.00 Adjusted cost per visit (li   | ne 3 divided by line 6)  |                         |                                  | 245. 54                        | 7. 00            |
|  |  |                         | Cal cul ati on                   | of Limit (1)                   |                  |
|  |  |                         | Pri or to Jan.                   | On or After                    |                  |
|  |  |                         | 1 (Rate<br>Period 1)             | Jan. 1 (Rate<br>Period 2)      |                  |
|  |  |                         | 1.00                             | 2. 00                          |                  |
| 8.00 Per visit payment limit (fr   | om CMS Pub. 100-04, chapter 9, §20                                       | .6 or your contractor)  | 0.00                             | 0.00                           | 8.00             |
| 9.00 Rate for Program covered vi   | sits (see instructions)  |                         | 245. 54                          | 245. 54                        | 9.00             |
| 10.00 CALCULATION OF SETTLEMENT Program covered visits excl              | uding mental health services (from                                       | contractor records)     | 0                                | 45                             | 10.00            |
| S .  | s for mental health services (line                                       | •                       | 0                                | 11, 049                        |                  |
|  | mental health services (from contr                                       |                         | 0                                | 0                              |                  |
| 13.00 Program covered cost from m  | ental health services (line 9 x li                                       | ne 12)                  | 0                                | 0                              | 13.00            |
| 1  | health services (see instructions  | •                       | 0                                | 0                              | 14.00            |
|  | Pass Through Cost (see instruction                                       | · ·                     |                                  | 44 040                         | 15.00            |
|  | lines 11, 14, and 15, columns 1, 2<br>instructions)(from contractor's re |                         | 0                                | 11, 049<br>8, 060              |                  |
| , , ,  | arges (see instructions)(from prov                                       | *                       |                                  | 0,000                          | 16. 02           |
|  | sts ((line 16.02/line 16.01) times                                       |                         |                                  | 0                              | 16. 03           |
|  | e costs ((line 16 minus lines 16.0                                       | 3 and 18) times .80)    |                                  | 8, 522                         | 16. 04           |
| (Titles V and XIX see instr<br>16.05 Total program cost (see in          | · · · · · · · · · · · · · · · · · · ·                                    |                         | 0                                | 8, 522                         | 16.05            |
| 17.00 Primary payer amounts  | Structions)  |                         | U                                | 0, 322                         | 17.00            |
| , , ,  | le for RHC only (see instructions)                                       | (from contractor        |                                  | 396                            |                  |
| records)   | DU0 (F0U0  |                         |                                  | 4 500                          | 40.00            |
| 19.00 Beneficiary coinsurance for records)                               | RHC/FQHC services (see instruction                                       | ns) (from contractor    |                                  | 1, 533                         | 19.00            |
| <u> </u>   | vaccines (see instructions)  |                         |                                  | 8, 522                         |                  |
| , ,  | d their administration (from Wkst.                                       | M-4, line 16)           |                                  | 0                              |                  |
| 22.00   Total reimbursable Program 23.00   Allowable bad debts (see in   |  |                         |                                  | 8, 522<br>0                    | 22. 00<br>23. 00 |
| 23.00 Allowable bad debts (see 11)                                       |  |                         |                                  | 0                              | 23. 00           |
|  | l eligible beneficiaries (see inst                                       | ructions)               |                                  | 0                              | 24.00            |
| 25.00 OTHER ADJUSTMENTS (SEE INST  | RUCTIONS) (SPECIFY)  |                         |                                  | 0                              | 25.00            |
|  | ayment adjustment (see instruction                                       | s)                      |                                  | 0                              |                  |
| 25.99 Demonstration payment adjus  |  |                         |                                  | 0<br>9 522                     |                  |
| 26.00   Net reimbursable amount (se 26.01   Sequestration adjustment (s  | · · · · · · · · · · · · · · · · · · ·                                    |                         |                                  | 8, 522<br>56                   | 26. 00<br>26. 01 |
| 1 .  | tment amount after sequestration   |                         |                                  | 0                              | 1                |
| 27.00 Interim payments   |  |                         |                                  | 6, 358                         |                  |
| 28.00 Tentative settlement (for o  | 3,   |                         |                                  | 0                              | 28.00            |
|  | am (line 26 minus lines 26.01, 26.                                       |                         |                                  | 2, 108                         |                  |
| 30.00 Protested amounts (nonallow chapter I, §115.2                      | able cost report items) in accorda                                       | nce with CMS Pub. 15-11 | '                                | 0                              | 30.00            |

| Title XVIII   RHC II   | EEO 10           | , of Form CMC ( | la li o         | TAI                     | Financial Customs   |
|--|------------------|-----------------|-----------------|-------------------------|---|
| Component CN: 15-8531   To 12/31/2020   Date/Time Pro 8/2/2021 2: 11   Title XVIII   Title XVIII   RHC II  | 332-10           |                 |                 |                         | <u> </u>  |
| DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FOHC SERVICES   1.00   1.00   |                  | Date/Time Pre   | From 01/01/2020 |                         |   |
| DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FOHC SERVICES   Total Allowable Cost of hospital-based RHC/FOHC Services (from Wkst. M-2, line 20)   2,830,023   2.00   Cost of vaccines and their administration (from Wkst. M-4, line 15)   12,263   2,817,760   1.0   | <u></u>          |                 | RHC II          | Title XVIII             |   |
| DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FOHC SERVICES   Total Allowable Cost of hospital based RHC/FOHC Services (from Wkst. M-2, line 20)   2,830,023   2.00   Cost of vaccines and their administration (from Wkst. M-4, line 15)   12,263   2,817,760   1.0   |                  |                 |                 |                         |   |
| Total Allowable Cost of hospital-based RHC/FOHC Services (from Wkst. M-2, line 20)   2,830,023   20  |                  | 1.00            |                 |                         | DETERMINATION OF DATE FOR HOCKLIAL DACED DUO/FOUR CEDIMORE    |
| 2.00   | 1. 00            | 2 920 022       |                 | m Wkst M 2 lino 20)     |   |
| Total allowable cost excluding vaccine (line 1 minus line 2)   | 2. 00            |                 |                 |                         | ·   |
| A 0.0  | 3. 00            |                 |                 | 110 10)                 | ·   |
| 6.00 Total adjusted visits (line 4 plus line 5) Adjusted cost per visit (line 3 divided by line 6) Adjusted cost per visit (line 3 divided by line 6) Adjusted cost per visit (line 3 divided by line 6)  Calculation of Limit (1)  Prior to Jan. 1 (Rate Period 1) Period 2 0  1.00 2.00  Rate for Program covered visits (see instructions)  CALCULATION OF SETTLEMENT  10.00 Program covered visits excluding mental health services (from contractor records)  Adv. 63 442.63  Adv. 64 64 64 64 64 64 64 64 64 64 64 64 64   | 4.00             | 6, 366          |                 |                         | g ,   |
| Adjusted cost per visit (line 3 divided by line 6)   Calculation of Limit (1)  | 5.00             | 0               |                 | line 9)                 | Physicians visits under agreement (from Wkst. M-2, column 5,  |
| Calculation of Limit (1)   Prior to Jan. 1 (Rate Period 1)   Prior to Jan. 1 (Rate Period 1)   Program covered visits (see instructions)   1.00   2.00   0   | 6.00             | 6, 366          |                 |                         |   |
| Prior to Jan. 1 (Rate Period 1)   Prior to Jan. 1 (Rate Period 1)   Prior to Jan. 1 (Rate Period 1)   Prior to Jan. 1 (Rate Period 1)   Prior to Jan. 1 (Rate Period 1)   Prior to Jan. 1 (Rate Period 1)   Program covered visits (see instructions)   Adv. 63   Adv. 6   | 7. 00            |                 |                 |                         | Adjusted cost per visit (line 3 divided by line 6)            |
| 8.00 Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor) 9.00 Rate for Program covered visits (see instructions) CALCULATION OF SETTLEMENT  10.00 Program covered visits excluding mental health services (from contractor records) 11.00 Program covered visits for mental health services (line 9 x line 10) 12.00 Program covered visits for mental health services (line 9 x line 10) 13.00 Program covered visits for mental health services (line 9 x line 12) 14.00 Limit adjustment for mental health services (line 9 x line 12) 15.00 Graduate Medical Education Pass Through Cost (see instructions) 16.00 Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) * 16.01 Total program preventive charges (see instructions) (from provider's records) 16.02 Total program preventive costs ((line 16 minus lines 16.03 and 18) times .80) 16.03 Total program preventive costs ((line 16 minus lines 16.03 and 18) times .80) 17.00 Primary payer amounts 18.00 Beneficiary coinsurance for RHC/FOHC services (see instructions) (from contractor records) 19.00 Rate for Program and their administration (from Wkst. M-4, line 16) 10.00 Rate for Program cost of vaccines and their administration (from Wkst. M-4, line 16) 10.00 Rate for Program cost of vaccines and their administration (from Wkst. M-4, line 16) 10.00 Rate for Program cost of vaccines and their administration (from Wkst. M-4, line 16) 10.00 Rate for Program cost of vaccines and their administration (from Wkst. M-4, line 16) 10.00 Rate for Program cost of vaccines and their administration (from Wkst. M-4, line 16) 10.00 Rate for Program cost of vaccines and their administration (from Wkst. M-4, line 16) 10.00 Rate for Program cost of vaccines and their administration (from Wkst. M-4, line 16) 10.00 Rate for Program cost of vaccines and their administration (from Wkst. M-4, line 16)  |                  | of Limit (1)    | Calculation     |                         |   |
| 8.00   Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)   0.00    |                  |                 |                 |                         |   |
| 8.00 Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor) 9.00 Rate for Program covered visits (see instructions)  CALCULATION OF SETTLEMENT 10.00 Program covered visits excluding mental health services (from contractor records) 11.00 Program covered visits excluding mental health services (line 9 x line 10) 12.00 Program covered visits for mental health services (line 9 x line 10) 13.00 Program covered visits for mental health services (line 9 x line 12) 14.00 Limit adjustment for mental health services (line 9 x line 12) 15.00 Graduate Medical Education Pass Through Cost (see instructions) 16.01 Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) * 16.01 Total program charges (see instructions) (from contractor's records) 16.02 Total program preventive charges (see instructions) (from provider's records) 16.03 Total program preventive costs ((line 16.02/line 16.01) times line 16) 16.04 Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) 17.00 Total program cost (see instructions) 18.00 Primary payer amounts 19.00 Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records) 19.00 Beneficiary coinsurance for RHC/FQHC services (see instructions) 19.00 Program cost of vaccines and their administration (from Wkst. M-4, line 16) 10.00 Program cost of vaccines and their administration (from Wkst. M-4, line 16)   |                  |                 | ,               |                         |   |
| Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)   0.00   0.00     Rate for Program covered visits (see instructions)   442.63   442.63     CALCULATION OF SETTLEMENT   |                  |                 |                 |                         |   |
| Rate for Program covered visits (see instructions)  Rate for Program covered visits (see instructions)  CALCULATION OF SETTLEMENT  10.00 Program covered visits excluding mental health services (from contractor records)  11.00 Program covered visits excluding mental health services (line 9 x line 10)  12.00 Program covered visits for mental health services (line 9 x line 10)  13.00 Program covered cost from mental health services (line 9 x line 10)  14.00 Limit adjustment for mental health services (line 9 x line 12)  15.00 Graduate Medical Education Pass Through Cost (see instructions)  16.00 Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *  16.01 Total program charges (see instructions) (from contractor's records)  16.02 Total program preventive charges (see instructions) (from provider's records)  16.03 Total program preventive costs ((line 16.02/line 16.01) times line 16)  16.04 Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80)  17.00 Total program cost (see instructions)  18.00 Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)  19.00 Beneficiary coinsurance for RHC/FOHC services (see instructions)  20.00 Net Medicare cost excluding vaccines (see instructions)  Program cost of vaccines and their administration (from Wkst. M-4, line 16)  23.437  24.00 Program cost of vaccines and their administration (from Wkst. M-4, line 16)   | 8. 00            |                 |                 | . 6 or your contractor) | Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20 |
| 10.00 Program covered visits excluding mental health services (from contractor records)  11.00 Program cost excluding costs for mental health services (line 9 x line 10)  12.00 Program covered visits for mental health services (from contractor records)  13.00 Program covered visits for mental health services (from contractor records)  14.00 Program covered cost from mental health services (line 9 x line 12)  15.00 Covered visits for mental health services (line 9 x line 12)  16.00 Covered visits for mental health services (line 9 x line 12)  16.00 Covered visits for mental health services (line 9 x line 12)  16.00 Covered visits for mental health services (line 9 x line 12)  16.00 Covered visits for mental health services (line 9 x line 12)  16.00 Covered visits for mental health services (line 9 x line 12)  16.00 Covered visits for mental health services (line 9 x line 12)  16.00 Covered visits for mental health services (line 9 x line 12)  16.00 Covered visits for mental health services (line 9 x line 12)  17.00 Covered visits for mental health services (see instructions)  18.00 Covered visits for mental health services (see instructions)  18.00 Covered visits for mental health services (see instructions)  18.00 Covered visits for mental health services (see instructions)  18.00 Covered visits for mental health services (see instructions)  18.00 Covered visits for mental health services (see instructions)  18.00 Covered visits for mental health services (see instructions)  18.00 Covered visits for mental health services (see instructions)  18.00 Covered visits for mental health services (see instructions)  18.00 Covered visits for mental health services (see instructions)  18.00 Covered visits for mental health services (see instructions)  18.00 Covered visits for mental health services (see instructions)  18.00 Covered visits for mental health services (see instructions)  18.00 Covered visits for mental health services (see instructions)  18.00 Covered visits for mental health services (see instructions)  18 | 9. 00            | 442. 63         |                 |                         | ,                       |
| 11.00 Program cost excluding costs for mental health services (line 9 x line 10) 12.00 Program covered visits for mental health services (from contractor records) 13.00 Program covered cost from mental health services (line 9 x line 12) 14.00 Limit adjustment for mental health services (see instructions) 15.00 Graduate Medical Education Pass Through Cost (see instructions) 16.00 Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) * 16.01 Total program charges (see instructions) (from contractor's records) 16.02 Total program preventive charges (see instructions) (from provider's records) 16.03 Total program preventive costs ((line 16.02/line 16.01) times line 16) 17.04 Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) 17.00 Primary payer amounts 18.00 Less: Beneficiary deductible for RHC only (see instructions) (from contractor records) 19.00 Beneficiary coinsurance for RHC/FOHC services (see instructions) 20.00 Net Medicare cost excluding vaccines (see instructions) 20.00 Program cost of vaccines and their administration (from Wkst. M-4, line 16)   |                  |                 |                 |                         | CALCULATION OF SETTLEMENT                                     |
| 12.00 Program covered visits for mental health services (from contractor records)  13.00 Program covered cost from mental health services (line 9 x line 12)  14.00 Limit adjustment for mental health services (see instructions)  15.00 Graduate Medical Education Pass Through Cost (see instructions)  16.01 Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *  16.02 Total program charges (see instructions)(from contractor's records)  16.03 Total program preventive charges (see instructions)(from provider's records)  16.04 Total Program non-preventive costs ((line 16.02/line 16.01) times line 16)  16.05 Total Program cost (see instructions)  16.06 Total program cost (see instructions)  17.00 Primary payer amounts  18.00 Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)  19.00 Beneficiary coinsurance for RHC/FQHC services (see instructions)  20.00 Net Medicare cost excluding vaccines (see instructions)  Program cost of vaccines and their administration (from Wkst. M-4, line 16)  | 10.00            | 235             |                 | contractor records)     | Program covered visits excluding mental health services (from |
| 13.00 Program covered cost from mental health services (line 9 x line 12)  14.00 Limit adjustment for mental health services (see instructions)  15.00 Graduate Medical Education Pass Through Cost (see instructions)  16.00 Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *  16.01 Total program charges (see instructions) (from contractor's records)  16.02 Total program preventive charges (see instructions) (from provider's records)  16.03 Total program preventive costs ((line 16.02/line 16.01) times line 16)  16.04 Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80)  (Titles V and XIX see instructions.)  16.05 Total program cost (see instructions)  17.00 Primary payer amounts  Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)  19.00 Beneficiary coinsurance for RHC/FOHC services (see instructions) (from contractor records)  Net Medicare cost excluding vaccines (see instructions)  Program cost of vaccines and their administration (from Wkst. M-4, line 16)   | 11.00            | 104, 018        |                 | •                       | · ·   |
| 14.00 Limit adjustment for mental health services (see instructions)  15.00 Graduate Medical Education Pass Through Cost (see instructions)  16.00 Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *  16.01 Total program charges (see instructions) (from contractor's records)  16.02 Total program preventive charges (see instructions) (from provider's records)  16.03 Total program preventive costs ((line 16.02/line 16.01) times line 16)  16.04 Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80)  (Titles V and XIX see instructions.)  16.05 Total program cost (see instructions)  17.00 Primary payer amounts  18.00 Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)  19.00 Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)  20.00 Net Medicare cost excluding vaccines (see instructions)  Program cost of vaccines and their administration (from Wkst. M-4, line 16)  | 12.00            |                 |                 | •                       | · · · · · · · · · · · · · · · · · · ·                         |
| 15.00 Graduate Medical Education Pass Through Cost (see instructions) 16.00 Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) * 16.01 Total program charges (see instructions) (from contractor's records) 16.02 Total program preventive charges (see instructions) (from provider's records) 16.03 Total program preventive costs ((line 16.02/line 16.01) times line 16) 16.04 Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) 16.05 Total program cost (see instructions.) 16.05 Total program cost (see instructions) 17.00 Primary payer amounts 18.00 Less: Beneficiary deductible for RHC only (see instructions) (from contractor records) 19.00 Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records) 20.00 Net Medicare cost excluding vaccines (see instructions) 10.40 104,018 45,251 10.41 2 and 3) *  0 104,018 45,251 10.91 2 and 3) *  0 86,187   | 13. 00<br>14. 00 |                 | -               | •                       | · · · · · · · · · · · · · · · · · · ·                         |
| 16.00 Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *  16.01 Total program charges (see instructions) (from contractor's records)  16.02 Total program preventive charges (see instructions) (from provider's records)  16.03 Total program preventive costs ((line 16.02/line 16.01) times line 16)  16.04 Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80)  16.05 Total program cost (see instructions)  17.00 Primary payer amounts  18.00 Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)  19.00 Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)  20.00 Net Medicare cost excluding vaccines (see instructions)  Program cost of vaccines and their administration (from Wkst. M-4, line 16)   | 15. 00           | o l             | U U             | •                       | · · · · · · · · · · · · · · · · · · ·                         |
| 16.01 Total program charges (see instructions) (from contractor's records) 16.02 Total program preventive charges (see instructions) (from provider's records) 16.03 Total program preventive costs ((line 16.02/line 16.01) times line 16) 16.04 Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.) 16.05 Total program cost (see instructions) 17.00 Primary payer amounts 18.00 Less: Beneficiary deductible for RHC only (see instructions) (from contractor records) 19.00 Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records) 20.00 Net Medicare cost excluding vaccines (see instructions) 21.00 Program cost of vaccines and their administration (from Wkst. M-4, line 16)  45, 251 10, 196 23, 437 62, 750 62, 750 62, 750 62, 750 65, 187 66, 187 67, 187 68, 187 69, 187 60, 187 60, 187 61, 197 62, 251 62, 251 62, 251 63, 251 64, 251 65, 251 66, 251 66, 251 66, 251 66, 251 66, 251 66, 251 66, 251 66, 251 66, 251 66, 251 66, 251 66, 251 66, 251 66, 251 66, 25 | 16. 00           | 104, 018        | 0               | •                       | 9 ,   |
| Total program preventive costs ((line 16.02/line 16.01) times line 16)  16.04 Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80)  16.05 Total program cost (see instructions.)  17.00 Primary payer amounts  18.00 Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)  19.00 Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)  20.00 Net Medicare cost excluding vaccines (see instructions)  Program cost of vaccines and their administration (from Wkst. M-4, line 16)  23, 437  62, 750  62, 750  62, 750  63, 187  64, 187  65, 582  66, 187   | 16. 01           | 45, 251         |                 |                         |   |
| Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80)  (Titles V and XIX see instructions.)  Total program cost (see instructions)  Primary payer amounts  Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)  Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)  20.00 Net Medicare cost excluding vaccines (see instructions)  Program cost of vaccines and their administration (from Wkst. M-4, line 16)  62,750  86,187  0  86,187   | 16.02            | 10, 196         |                 | i der's records)        | Total program preventive charges (see instructions)(from prov |
| (Titles V and XIX see instructions.)  16.05 Total program cost (see instructions)  17.00 Primary payer amounts  Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)  19.00 Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)  20.00 Net Medicare cost excluding vaccines (see instructions)  Program cost of vaccines and their administration (from Wkst. M-4, line 16)  0 86, 187  | 16. 03           | 23, 437         |                 |                         |   |
| 16.05 Total program cost (see instructions)  17.00 Primary payer amounts  Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)  19.00 Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)  20.00 Net Medicare cost excluding vaccines (see instructions)  Program cost of vaccines and their administration (from Wkst. M-4, line 16)  0 86, 187  0 6, 582  | 16. 04           | 62, 750         |                 | 3 and 18) times .80)    |   |
| 17.00 Primary payer amounts  18.00 Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)  19.00 Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)  20.00 Net Medicare cost excluding vaccines (see instructions)  21.00 Program cost of vaccines and their administration (from Wkst. M-4, line 16)  | 1/ 05            | 04 107          |                 |                         |   |
| 18.00 Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)  19.00 Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)  20.00 Net Medicare cost excluding vaccines (see instructions)  Program cost of vaccines and their administration (from Wkst. M-4, line 16)  2,144  6,582   | 16. 05<br>17. 00 |                 | ٩               |                         |   |
| records)  19.00 Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor coords)  20.00 Net Medicare cost excluding vaccines (see instructions)  Program cost of vaccines and their administration (from Wkst. M-4, line 16)  0   | 18. 00           | -               |                 | (from contractor        |   |
| records)  20.00 Net Medicare cost excluding vaccines (see instructions)  21.00 Program cost of vaccines and their administration (from Wkst. M-4, line 16)  0  |                  | _,              |                 | (                       |   |
| 20.00 Net Medicare cost excluding vaccines (see instructions) 21.00 Program cost of vaccines and their administration (from Wkst. M-4, line 16) 86,187   | 19. 00           | 6, 582          |                 | ns) (from contractor    |   |
| 21.00 Program cost of vaccines and their administration (from Wkst. M-4, line 16)  | 20.00            | 86, 187         |                 |                         |   |
|  | 21.00            | 0               |                 | M-4, line 16)           | Program cost of vaccines and their administration (from Wkst. |
|  | 22.00            | 86, 187         |                 |                         |   |
|  | 23.00            | 0               |                 |                         | ,   |
|  | 23. 01           | 0               |                 | rusti ana)              | · · · · · · · · · · · · · · · · · · ·                         |
|  | 24. 00<br>25. 00 | 0               |                 | ructions)               |   |
|  | 25. 50           | 0               |                 | as)                     |   |
|  | 25. 99           | ő               |                 | /                       | , ,   |
|  | 26. 00           | 86, 187         |                 |                         | . ,   |
|  | 26. 01           | 569             |                 |                         | , ,   |
|  | 26. 02           | 0               |                 |                         | . ,   |
|  | 27. 00           | 60, 162         |                 |                         | 1 3   |
|  | 28. 00<br>29. 00 | 0<br>25, 456    |                 | 02 27 and 29)           | ,   |
|  | 30.00            | 25, 456         |                 |                         |   |
| chapter I, §115. 2   | 30.00            | ٩               |                 |                         | · · · · · · · · · · · · · · · · · · ·                         |

| Heal th          | Financial Systems MAJOR HOSPI  | TAL                    | In Lie                           | u of Form CMS-2                | 2552-10          |
|------------------|--|------------------------|----------------------------------|--------------------------------|------------------|
|                  | ATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC  | Provi der CCN: 15-0097 | Peri od:                         | Worksheet M-3                  |                  |
| SERVI C          | EES  | Component CCN: 15-8532 | From 01/01/2020<br>To 12/31/2020 | Date/Time Pre<br>8/2/2021 2:11 |                  |
|                  |  | Title XVIII            | RHC III                          |                                |                  |
|                  |  |                        |                                  |                                |                  |
|                  | DETERMINATION OF DATE FOR HOORI TAL DAGED DUG (FOUG CERVILOFC  |                        |                                  | 1. 00                          |                  |
| 1. 00            | DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES  Total Allowable Cost of hospital-based RHC/FQHC Services (from   | m Wkst M 2 lino 20)    |                                  | 16, 674, 669                   | 1.00             |
| 2. 00            | Cost of vaccines and their administration (from Wkst. M-4, li  |                        |                                  | 754, 743                       | 1                |
| 3.00             | Total allowable cost excluding vaccine (line 1 minus line 2)   | ne 10)                 |                                  | 15, 919, 926                   |                  |
| 4.00             | Total Visits (from Wkst. M-2, column 5, line 8)  |                        |                                  | 46, 816                        |                  |
| 5.00             | Physicians visits under agreement (from Wkst. M-2, column 5,   | line 9)                |                                  | 0                              | 5.00             |
| 6.00             | Total adjusted visits (line 4 plus line 5)   |                        |                                  | 46, 816                        |                  |
| 7. 00            | Adjusted cost per visit (line 3 divided by line 6)   |                        |                                  | 340. 05                        | 7. 00            |
|                  |  |                        | Cal cul ati on                   | of Limit (1)                   |                  |
|                  |  |                        | Pri or to Jan.                   | On or After                    |                  |
|                  |  |                        | 1 (Rate                          | Jan. 1 (Rate                   |                  |
|                  |  |                        | Peri od 1)                       | Peri od 2)<br>2.00             |                  |
| 8. 00            | Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20  | 6 or your contractor)  | 1.00                             | 0.00                           | 8. 00            |
| 9. 00            | Rate for Program covered visits (see instructions)   | e or your contractor)  | 340. 05                          | 340. 05                        |                  |
| 7. 00            | CALCULATION OF SETTLEMENT  |                        | 0.0.00                           | 0.101.00                       | 7.00             |
| 10.00            | Program covered visits excluding mental health services (from  | contractor records)    | 0                                | 12, 135                        | 10.00            |
| 11.00            | Program cost excluding costs for mental health services (line  | 9 x line 10)           | 0                                | 4, 126, 507                    | 11.00            |
| 12.00            | Program covered visits for mental health services (from contra   | •                      | 0                                | 0                              |                  |
| 13.00            | Program covered cost from mental health services (line 9 x li  | •                      | 0                                | 0                              |                  |
| 14.00            | Limit adjustment for mental health services (see instructions)   |                        | 0                                | 0                              |                  |
| 15. 00<br>16. 00 | Graduate Medical Education Pass Through Cost (see instruction: Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 | •                      | 0                                | 4, 126, 507                    | 15. 00<br>16. 00 |
| 16. 00           | Total program charges (see instructions)(from contractor's re  | •                      | U                                | 2, 784, 859                    |                  |
| 16. 02           | Total program preventive charges (see instructions)(from provi   | •                      |                                  | 409, 692                       |                  |
| 16. 03           | Total program preventive costs ((line 16.02/line 16.01) times  |                        |                                  | 607, 067                       |                  |
| 16.04            | Total Program non-preventive costs ((line 16 minus lines 16.0)   |                        |                                  | 2, 656, 066                    | 16. 04           |
|                  | (Titles V and XIX see instructions.)   |                        |                                  |                                |                  |
| 16. 05           | Total program cost (see instructions)  |                        | 0                                | 3, 263, 133                    |                  |
| 17.00            | Primary payer amounts  | (6                     |                                  | 46                             |                  |
| 18. 00           | Less: Beneficiary deductible for RHC only (see instructions) records)  | (from contractor       |                                  | 199, 358                       | 18. 00           |
| 19. 00           | Beneficiary coinsurance for RHC/FQHC services (see instruction records)  | ns) (from contractor   |                                  | 430, 207                       | 19. 00           |
| 20. 00           | Net Medicare cost excluding vaccines (see instructions)  |                        |                                  | 3, 263, 087                    | 20.00            |
| 21. 00           | Program cost of vaccines and their administration (from Wkst.  | M-4, line 16)          |                                  | 239, 777                       |                  |
|                  | Total reimbursable Program cost (line 20 plus line 21)   | ,                      |                                  | 3, 502, 864                    |                  |
| 23.00            | Allowable bad debts (see instructions)   |                        |                                  | 0                              | 23. 00           |
| 23. 01           | Adjusted reimbursable bad debts (see instructions)   |                        |                                  | 0                              |                  |
| 24. 00           | Allowable bad debts for dual eligible beneficiaries (see inst  | ructions)              |                                  | 0                              |                  |
| 25. 00           | OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   |                        |                                  | 0                              |                  |
| 25. 50<br>25. 99 | Pioneer ACO demonstration payment adjustment (see instruction:   | 5)                     |                                  | 0                              | 1                |
| 26. 00           | Demonstration payment adjustment amount before sequestration<br>Net reimbursable amount (see instructions)                   |                        |                                  | 3, 502, 864                    | 1                |
| 26. 01           | Sequestration adjustment (see instructions)  |                        |                                  | 23, 119                        |                  |
| 26. 02           | Demonstration payment adjustment amount after sequestration  |                        |                                  | 0                              | 1                |
| 27. 00           | Interim payments   |                        |                                  | 2, 462, 088                    |                  |
| 28. 00           | Tentative settlement (for contractor use only)   |                        |                                  | 0                              | 28. 00           |
|                  | Balance due component/program (line 26 minus lines 26.01, 26.0   | 02, 27, and 28)        |                                  | 1, 017, 657                    | 29.00            |
| 29. 00<br>30. 00 | Protested amounts (nonallowable cost report items) in accordan   |                        |                                  | 0                              | 30.00            |

| Health Financial Systems                            | MAJOR HOSPI                | TAL                    | In Lieu                     | u of Form CMS-2552-10                   |
|---|----------------------------|------------------------|-----------------------------|---|
| COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST | PNEUMOCOCCAL AND INFLUENZA | Provider CCN: 15-0097  | Peri od:<br>From 01/01/2020 | Worksheet M-4                           |
| VACCINE COST  |                            | Component CCN: 15-8529 |                             | Date/Time Prepared:<br>8/2/2021 2:11 pm |
|   |                            | Title XVIII            | RHC I                       | •                                       |

|        |   | Title XVIII               | RHC I        |             |        |
|--------|---|---------------------------|--------------|-------------|--------|
|        |   |                           | Pneumococcal | l nfl uenza |        |
|        |   |                           | 1. 00        | 2. 00       |        |
| 1.00   | Health care staff cost (from Wkst. M-1, col. 7, line 10)        |                           | 2, 224, 105  | 2, 224, 105 | 1.00   |
| 2.00   | Ratio of pneumococcal and influenza vaccine staff time to total | al health care staff time | 0. 009618    | 0. 006913   | 2.00   |
| 3.00   | Pneumococcal and influenza vaccine health care staff cost (li   | ne 1 x line 2)            | 21, 391      | 15, 375     | 3.00   |
| 4.00   | Medical supplies cost - pneumococcal and influenza vaccine (fi  | rom your records)         | 249, 369     | 88, 811     | 4.00   |
| 5.00   | Direct cost of pneumococcal and influenza vaccine (line 3 plus  | s line 4)                 | 270, 760     | 104, 186    | 5.00   |
| 6.00   | Total direct cost of the hospital-based RHC/FQHC (from Worksho  | eet M-1, col. 7, line 22) | 2, 661, 335  | 2, 661, 335 | 6.00   |
| 7.00   | Total overhead (from Wkst. M-2, line 19)                        |                           | 2, 412, 110  | 2, 412, 110 | 7.00   |
| 8.00   | Ratio of pneumococcal and influenza vaccine direct cost to to   | tal direct cost (line 5   | 0. 101738    | 0. 039148   | 8.00   |
|        | divided by line 6)  |                           |              |             |        |
| 9.00   | Overhead cost - pneumococcal and influenza vaccine (line 7 x l  | line 8)                   | 245, 403     | 94, 429     | 9.00   |
| 10.00  | Total pneumococcal and influenza vaccine cost and its (their)   | administration (sum of    | 516, 163     | 198, 615    | 10.00  |
|        | lines 5 and 9)  |                           |              |             |        |
| 11. 00 | Total number of pneumococcal and influenza vaccine injections   |                           | 2, 510       | •           | 11.00  |
| 12.00  | Cost per pneumococcal and influenza vaccine injection (line 10  | 0/line 11)                | 205. 64      | 110. 10     | 12.00  |
| 13.00  | Number of pneumococcal and influenza vaccine injections admini  | istered to Program        | 0            | 0           | 13.00  |
|        | benefi ci ari es  |                           |              |             |        |
| 14.00  | Program cost of pneumococcal and influenza vaccine and its (the | heir) administration      | 0            | 0           | 14.00  |
|        | (line 12 x line 13)   |                           |              |             |        |
| 15. 00 | Total cost of pneumococcal and influenza vaccine and its (thei  |                           |              | 714, 778    | 15.00  |
|        | of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3,  |                           |              |             |        |
| 16. 00 | Total Program cost of pneumococcal and influenza vaccine and i  |                           |              | 0           | 16. 00 |
|        | administration (sum of cols. 1 and 2, line 14) (transfer this   | amount to Wkst. M-3,      |              |             |        |
|        | line 21)  |                           |              |             |        |

| Health Financial Systems                            | MAJOR HOSPI                | TAL                    | In Lieu                     | u of Form CMS-2552-10                |
|---|----------------------------|------------------------|-----------------------------|--------------------------------------|
| COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST | PNEUMOCOCCAL AND INFLUENZA | Provider CCN: 15-0097  | Peri od:<br>From 01/01/2020 | Worksheet M-4                        |
|   |                            | Component CCN: 15-8531 | To 12/31/2020               | Date/Time Prepared: 8/2/2021 2:11 pm |
|   |                            | T: +1 - \/\/I I I      | DUC 11                      |                                      |

|        |   | Title XVIII               | RHC II       |             |        |
|--------|---|---------------------------|--------------|-------------|--------|
|        |   |                           | Pneumococcal | I nfl uenza |        |
|        |   |                           | 1.00         | 2. 00       |        |
| 1.00   | Health care staff cost (from Wkst. M-1, col. 7, line 10)  |                           | 1, 100, 281  | 1, 100, 281 | 1.00   |
| 2.00   | Ratio of pneumococcal and influenza vaccine staff time to tota  | al health care staff time | 0.000000     | 0. 000906   | 2.00   |
| 3.00   | Pneumococcal and influenza vaccine health care staff cost (lir  | ne 1 x line 2)            | 0            | 997         | 3.00   |
| 4.00   | Medical supplies cost - pneumococcal and influenza vaccine (fr  | rom your records)         | 0            | 5, 218      | 4.00   |
| 5.00   | Direct cost of pneumococcal and influenza vaccine (line 3 plus  | s line 4)                 | 0            | 6, 215      | 5.00   |
| 6.00   | Total direct cost of the hospital-based RHC/FQHC (from Worksho  | eet M-1, col. 7, line 22) | 1, 434, 184  | 1, 434, 184 | 6.00   |
| 7.00   | Total overhead (from Wkst. M-2, line 19)  |                           | 1, 395, 839  | 1, 395, 839 | 7.00   |
| 8.00   | Ratio of pneumococcal and influenza vaccine direct cost to to   | tal direct cost (line 5   | 0.000000     | 0. 004333   | 8.00   |
|        | divided by line 6)  |                           |              |             |        |
| 9. 00  | Overhead cost - pneumococcal and influenza vaccine (line 7 x l  | line 8)                   | 0            | 6, 048      | 9.00   |
| 10. 00 | Total pneumococcal and influenza vaccine cost and its (their) lines 5 and 9)  | administration (sum of    | 0            | 12, 263     | 10.00  |
| 11.00  | Total number of pneumococcal and influenza vaccine injections   | (from your records)       | 0            | 106         | 11.00  |
| 12.00  | Cost per pneumococcal and influenza vaccine injection (line 10  | 0/line 11)                | 0.00         | 115. 69     | 12.00  |
| 13. 00 | Number of pneumococcal and influenza vaccine injections admini<br>beneficiaries   | istered to Program        | 0            | 0           | 13.00  |
| 14. 00 | Program cost of pneumococcal and influenza vaccine and its (the (line 12 x line 13)   | heir) administration      | 0            | 0           | 14.00  |
| 15. 00 | Total cost of pneumococcal and influenza vaccine and its (theiof cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3,          | ,                         |              | 12, 263     | 15. 00 |
| 16. 00 | Total Program cost of pneumococcal and influenza vaccine and i administration (sum of cols. 1 and 2, line 14) (transfer this line 21) |                           |              | 0           | 16. 00 |

| Health Financial Systems                            | MAJOR HOSPI                | TAL                    | In Lieu                     | of Form CMS-2552-10                  |
|---|----------------------------|------------------------|-----------------------------|--------------------------------------|
| COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST | PNEUMOCOCCAL AND INFLUENZA | Provi der CCN: 15-0097 | Peri od:<br>From 01/01/2020 | Worksheet M-4                        |
| VACCINE COST  |                            | Component CCN: 15-8532 |                             | Date/Time Prepared: 8/2/2021 2:11 pm |
|   |                            | Title XVIII            | RHC III                     | •                                    |

| Title XVIII RHC III  |               |
|--|---------------|
|  |               |
| Pneumococcal Influer   | 1             |
| 1.00 2.00  |               |
| 1.00 Health care staff cost (from Wkst. M-1, col. 7, line 10) 6,631,880 6,63                               | 880 1.00      |
| 2.00 Ratio of pneumococcal and influenza vaccine staff time to total health care staff time 0.001401 0.0   | 859 2.00      |
| 3.00 Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2) 9,291 3                   | 224 3.00      |
| 4.00 Medical supplies cost - pneumococcal and influenza vaccine (from your records) 109,980 18             | 043 4.00      |
| 5.00 Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4) 119,271 22                     | 267 5.00      |
| 6.00 Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22) 7,523,598 7,52 | 598 6.00      |
| 7.00 Total overhead (from Wkst. M-2, line 19) 9,151,071 9,15   | 7.00          |
| 8.00 Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 0.015853 0.0     | 410 8.00      |
| divided by line 6)   |               |
| 9.00 Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8) 145,072 26                       | 133 9.00      |
| 10.00 Total pneumococcal and influenza vaccine cost and its (their) administration (sum of 264,343 49      | 400 10.00     |
| lines 5 and 9)   |               |
| 11.00 Total number of pneumococcal and influenza vaccine injections (from your records) 1,088              | 800 11.00     |
| 12.00 Cost per pneumococcal and influenza vaccine injection (line 10/line 11) 242.96 1                     | . 05   12. 00 |
| 13.00 Number of pneumococcal and influenza vaccine injections administered to Program 409                  | 088 13.00     |
| benefi ci ari es   |               |
| 14.00 Program cost of pneumococcal and influenza vaccine and its (their) administration 99,371 14          | 406 14.00     |
| (line 12 x line 13)  |               |
| 15.00 Total cost of pneumococcal and influenza vaccine and its (their) administration (sum 75              | 743 15.00     |
| of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)                                     |               |
| 16.00 Total Program cost of pneumococcal and influenza vaccine and its (their)                             | 777 16.00     |
| administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3,                         |               |
| line 21)   |               |

| Health Financial Systems   | MAJOR HOSPI      | TAL   | In Lie          | u of Form CMS-2552-10                              |
|--|------------------|---|-----------------|--|
| ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/F<br>SERVICES RENDERED TO PROGRAM BENEFICIARIES | QHC PROVIDER FOR | Provider CCN: 15-0097<br>Component CCN: 15-8529 | From 01/01/2020 | Worksheet M-5 Date/Time Prepared: 8/2/2021 2:11 pm |

|       |  |                             |            | 8/2/2021 2:11 | pm    |
|-------|--|-----------------------------|------------|---------------|-------|
|       |  |                             |            |               |       |
|       |  |                             |            | t B           |       |
|       |  |                             | mm/dd/yyyy | Amount        |       |
|       |  |                             | 1. 00      | 2. 00         |       |
| 1.00  |  |                             |            | 6, 358        | 1.00  |
| 2.00  |  |                             |            | 0             | 2.00  |
|       |  | period. If none, write      |            |               |       |
|       | Total interim payments paid to hospital-based RHC/FQHC Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "MONE" or enter a zero List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)  Program to Provider  Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27) TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)  Program to Provider  Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) Determined net settlement amount (balance due) based on the cost report. (1) SETTLEMENT TO PROVIDER SETTLEMENT TO PROVGRAM |                             |            |               |       |
| 3. 00 |  |                             |            |               | 3.00  |
|       |  | Also show date of each      |            |               |       |
|       |  |                             |            |               |       |
|       | Program to Provider  |                             |            |               |       |
| 3. 01 |  |                             |            | 0             | 3. 01 |
| 3. 02 |  |                             |            | 0             | 3. 02 |
| 3. 03 |  |                             |            | 0             | 3. 03 |
| 3.04  |  |                             |            | 0             | 3. 04 |
| 3. 05 |  |                             |            | 0             | 3.05  |
|       | Provider to Program  |                             |            |               |       |
| 3.50  |  |                             |            | 0             | 3.50  |
| 3. 51 |  |                             |            | 0             | 3. 51 |
| 3. 52 |  |                             |            | 0             | 3. 52 |
| 3. 53 |  |                             |            | 0             | 3. 53 |
| 3.54  |  |                             |            | 0             | 3.54  |
| 3. 99 |  |                             |            | 0             | 3. 99 |
| 4.00  |  | fer to Worksheet M-3, line  |            | 6, 358        | 4.00  |
|       |  |                             |            |               |       |
|       |  |                             | - [        |               |       |
| 5. 00 |  | k review. Also show date of |            |               | 5.00  |
|       |  |                             |            |               |       |
|       | Program to Provider  |                             |            |               |       |
| 5. 01 |  |                             |            | 0             | 5. 01 |
| 5. 02 |  |                             |            | 0             | 5. 02 |
| 5. 03 |  |                             |            | 0             | 5. 03 |
|       | Provider to Program  |                             | T          |               |       |
| 5. 50 |  |                             |            | 0             | 5. 50 |
| 5. 51 |  |                             |            | 0             | 5. 51 |
| 5. 52 |  | 20)                         |            | 0             | 5. 52 |
| 5. 99 |  |                             |            | 0             | 5. 99 |
| 6.00  | ` ,  | cost report. (1)            |            | 2 400         | 6.00  |
| 6. 01 |  |                             |            | 2, 108        | 6. 01 |
| 6. 02 |  |                             |            | 0             | 6.02  |
| 7. 00 | Total Medicare program liability (see instructions)  |                             | C          | 8, 466        | 7.00  |
|       |  |                             | Contractor | NPR Date      |       |
|       |  | 0                           | Number     | (Mo/Day/Yr)   |       |
| 0.00  | News of Contractor   | 0                           | 1. 00      | 2. 00         | 0.00  |
| 8. 00 | Name of Contractor   |                             |            |               | 8. 00 |

| Health Financial Systems   | MAJOR HOSPI | ΓAL   | In Lieu                          | u of Form CMS-2552-10                               |
|--|-------------|---|----------------------------------|---|
| ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RESERVICES RENDERED TO PROGRAM BENEFICIARIE | ES .        | Provider CCN: 15-0097<br>Component CCN: 15-8531 | From 01/01/2020<br>To 12/31/2020 | Worksheet M-5  Date/Time Prepared: 8/2/2021 2:11 pm |
|  |             |   |                                  |   |

|   | '                         |            | 8/2/2021 2:11 | 'pm |
|---|---------------------------|------------|---------------|-----|
|   |                           | RHC II     |               |     |
|   |                           |            | rt B          |     |
|   |                           | mm/dd/yyyy | Amount        |     |
|   |                           | 1. 00      | 2. 00         |     |
| OO   Total interim payments paid to hospital-based RHC/FQHC       |                           |            | 60, 162       | 1   |
| OO  Interim payments payable on individual bills, either submitte |                           |            | 0             | 2   |
| the contractor for services rendered in the cost reporting p      | eriod. If none, write     |            |               |     |
| "NONE" or enter a zero  |                           |            |               |     |
| OO List separately each retroactive lump sum adjustment amount    |                           |            |               | 3   |
| revision of the interim rate for the cost reporting period.       | Also show date of each    |            |               |     |
| payment. If none, write "NONE" or enter a zero. (1)               |                           |            |               |     |
| Program to Provider   |                           |            |               |     |
| 01  |                           |            | 0             |     |
| )2<br>)3  |                           |            | 0             |     |
|   |                           |            | 0             |     |
| 04  |                           |            | 0             | 3   |
| 05  |                           |            | 0             | ] 3 |
| Provider to Program   |                           |            |               |     |
| 50  |                           |            | 0             |     |
| 1   |                           |            | 0             |     |
| 2   |                           |            | 0             | 3   |
| 3   |                           |            | 0             |     |
| 4   |                           |            | 0             | 3   |
| 9 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.96   |                           |            | 0             | 1 - |
| OO   Total interim payments (sum of lines 1, 2, and 3.99) (transf | er to Worksheet M-3, line |            | 60, 162       | 4   |
| 27)   |                           |            |               |     |
| TO BE COMPLETED BY CONTRACTOR                                     |                           |            |               |     |
| OU List separately each tentative settlement payment after desk   | review. Also show date of |            |               | 5   |
| each payment. If none, write "NONE" or enter a zero. (1)          |                           |            |               |     |
| Program to Provider   |                           | 1          |               |     |
| 01  |                           |            | 0             |     |
| 02  |                           |            | 0             | 5   |
| 13  |                           |            | 0             | 5   |
| Provider to Program   |                           |            | _             |     |
| 0   |                           |            | 0             |     |
| 1   |                           |            | 0             |     |
| 2   | 0)                        |            | 0             |     |
| 9 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.90   |                           |            | 0             | 5   |
| O Determined net settlement amount (balance due) based on the     | cost report. (1)          |            |               | 6   |
| 1 SETTLEMENT TO PROVIDER  |                           |            | 25, 456       |     |
| 2 SETTLEMENT TO PROGRAM   |                           |            | 0             | 6   |
| OD   Total Medicare program liability (see instructions)          |                           |            | 85, 618       | 7   |
|   |                           | Contractor | NPR Date      |     |
|   |                           | Number     | (Mo/Day/Yr)   |     |
|   | 0                         | 1. 00      | 2. 00         |     |
| 00 Name of Contractor   |                           | 1          | 1             | l 8 |

| Health Financial Systems   | MAJOR HOSPIT | ΓAL   | In Lieu         | u of Form CMS-2552-10                              |
|--|--------------|---|-----------------|--|
| ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RI<br>SERVICES RENDERED TO PROGRAM BENEFICIARII | ES           | Provider CCN: 15-0097<br>Component CCN: 15-8532 | From 01/01/2020 | Worksheet M-5 Date/Time Prepared: 8/2/2021 2:11 pm |

|                          |   |                                |             | 8/2/2021 2: 11 | pn  |
|--------------------------|---|--------------------------------|-------------|----------------|-----|
|                          |   |                                | RHC III     |                | _   |
|                          |   |                                |             | t B            |     |
|                          |   |                                | mm/dd/yyyy  | Amount         |     |
|                          |   |                                | 1. 00       | 2.00           |     |
| 00 Total interim pa      | yments paid to hospital-based RHC/FQHC    |                                |             | 2, 254, 688    |     |
|                          | payable on individual bills, either subm  |                                |             | 0              | 2   |
|                          | or services rendered in the cost reportir | ng period. If none, write      |             |                |     |
| "NONE" or enter          |   |                                |             |                |     |
| 00 List separately       | each retroactive lump sum adjustment amou | int based on subsequent        |             |                | :   |
|                          | interim rate for the cost reporting perio | d. Also show date of each      |             |                |     |
|                          | , write "NONE" or enter a zero. (1)       |                                |             |                |     |
| Program to Provi         | der                                       |                                |             |                |     |
| 1                        |   |                                | 08/31/2020  | 207, 400       |     |
| 2                        |   |                                |             | 0              |     |
| 03                       |   |                                |             | 0              |     |
| 4                        |   |                                |             | 0              |     |
| )5                       |   |                                |             | 0              | ] ; |
| Provider to Prog         | ram                                       |                                |             |                |     |
| 0                        |   |                                |             | 0              |     |
| 1                        |   |                                |             | 0              |     |
| 2                        |   |                                |             | 0              |     |
| 3                        |   |                                |             | 0              | :   |
| 4                        |   |                                |             | 0              |     |
|                          | Flines 3.01-3.49 minus sum of lines 3.50- |                                |             | 207, 400       |     |
|                          | yments (sum of lines 1, 2, and 3.99) (tra | insfer to Worksheet M-3, line  |             | 2, 462, 088    |     |
| 27)                      |   |                                |             |                |     |
| TO BE COMPLETED          |   |                                |             |                |     |
|                          | each tentative settlement payment after o | lesk review. Also show date of |             |                | !   |
|                          | none, write "NONE" or enter a zero. (1)   |                                |             |                |     |
| Program to Provi         | der                                       |                                |             |                |     |
| 1                        |   |                                |             | 0              |     |
| 2                        |   |                                |             | 0              |     |
| 3                        |   |                                |             | 0              |     |
| Provider to Prog         | ram                                       |                                |             | _              | ١.  |
| 0                        |   |                                |             | 0              |     |
| 1                        |   |                                |             | 0              | !   |
| 2                        |   |                                |             | 0              |     |
|                          | lines 5.01-5.49 minus sum of lines 5.50-  |                                |             | 0              | !   |
|                          |   |                                |             |                | '   |
| 1 SETTLEMENT TO PROVIDER |   |                                | 1, 017, 657 | '              |     |
| 2 SETTLEMENT TO PR       |   |                                |             | 0              |     |
| O Total Medicare p       | rogram liability (see instructions)       |                                | 2           | 3, 479, 745    | _   |
|                          |   |                                | Contractor  | NPR Date       |     |
|                          |   |                                | Number      | (Mo/Day/Yr)    |     |
|                          |   | 0                              | 1. 00       | 2. 00          | 8   |
| 00 Name of Contract      |   |                                |             |                |     |