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: 15-4053 Worksheet S Peri od: From 07/01/2019 Parts I-III AND SETTLEMENT SUMMARY 06/30/2020 Date/Time Prepared: 11/20/2020 3:09 pm PART I - COST REPORT STATUS Provi der 1. [X] Electronically prepared cost report Date: 11/20/2020 Ti me: 3:09 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 (5) Amended

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by MERIDIAN HEALTH SERVICES CORP. (15-4053) for the cost reporting period beginning 07/01/2019 and ending 06/30/2020 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) SCOTT RIGGS
Officer or Administrator of Provider(s)

CFO

Title

(Dated when report is electronically signed.)

Date

			Title XVIII				
Cost Center Description		Title V	Part A	Part B	HI T	Title XIX	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	9, 635	515	0	13, 477	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	0	0		0	5. 00
6.00	Swing Bed - NF	0				0	6.00
200.00	Total	0	9, 635	515	0	13, 477	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.

From 07/01/2019 Part I Date/Time Prepared: 06/30/2020 11/20/2020 3:09 pm 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 240 N. TILLOTSON AVE 1.00 PO Box: 1.00 State: IN 2.00 City: MUNCIE Zip Code: 47304 County: DELAWARE 2.00 Component Name Payment System (P. CCN CBSA Provi der Date T, O, or N) Certi fi ed Number Number Type 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 MERIDIAN HEALTH 154053 34620 4 05/06/2008 Ν 0 3.00 SERVICES CORP Subprovi der - IPF 4.00 4.00 5.00 Subprovi der - IRF 5.00 6.00 Subprovider - (Other) 6.00 Swing Beds - SNF 7 00 7 00 Swing Beds - NF 8.00 8.00 9.00 Hospital-Based SNF 9.00 Hospi tal -Based NF 10.00 10.00 11.00 Hospi tal -Based OLTC 11.00 12.00 Hospital -Based HHA 12.00 Separately Certified ASC 13.00 13.00 Hospi tal -Based Hospi ce 14.00 14.00 Hospital-Based Health Clinic - RHC 15 00 15 00 16.00 Hospital -Based Health Clinic - FQHC 16.00 17.00 Hospital -Based (CMHC) I 17.00 18.00 Renal Dialysis 18.00 19.00 Other 19.00 From 1.00 2.00 20.00 Cost Reporting Period (mm/dd/yyyy) 07/01/2019 06/30/2020 20.00 21.00 Type of Control (see instructions) 2 21.00 1.00 2.00 3.00 Inpatient PPS Information 22.00 Does this facility qualify and is it currently receiving payments for Ν N 22.00 disproportionate share hospital adjustment, in accordance with 42 CFR \$412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim uncompensated care payments for this 22.01 Ν Ν cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) 22.02 Is this a newly merged hospital that requires final uncompensated care Ν Ν 22.02 payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after 22.03 Did this hospital receive a geographic reclassification from urban to 22.03 Ν rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for ves or "N" for no. 23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 3 Ν 23.00 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no. In-State In-State Out-of Out-of Medi cai d 0ther Medi cai d Medi cai d State State HMO days Medi cai d paid days el i gi bl e Medi cai d Medi cai d days el i gi bl e unpai d paid days days unpai d 1.00 5. 00 2.00 3.00 4.00 6.00 24.00 | If this provider is an IPPS hospital, enter the 24. 00 in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.

Health Financial Systems MERIDIAN	HEALTH SERV	I CES CORP.			In Lie	u of Foi	rm CMS−2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION D		Provi der CC	CN: 15-4053	Period: From 07/0			eet S-2	
					30/2020	Date/T	ime Pre 2020 3:	
	In-State	In-State	Out-of	Out-of	Medi ca	aid C	ther	O y piii
	Medicai d	Medicaid eligible	State Medi cai d	State Medi cai d	HMO da	J	di cai d days	
		unpai d	pai d days	el i gi bl e			,	
	1.00	2. 00	3.00	unpai d 4. 00	5. 00)	6. 00	
25.00 If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state	0	0	0	0		0		25. 00
Medicaid eligible unpaid days in column 2,								
out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid	9							
HMO paid and eligible but unpaid days in column 5.				Usban /	Dural C	Doto of	F Coogs	
				1.		Date of 2.	00	
26.00 Enter your standard geographic classification (not work cost reporting period. Enter "1" for urban or "2" for		s at the be	ginning of	the	1			26. 00
27.00 Enter your standard geographic classification (not w	vage) status			st	1			27. 00
reporting period. Enter in column 1, "1" for urban of enter the effective date of the geographic reclassing			іррі і сарі е,					
35.00 If this is a sole community hospital (SCH), enter the effect in the cost reporting period.	ne number of	f periods S	CH status i	n	0			35. 00
erreet in the cost reporting perred.				Begi n		Endi		
36.00 Enter applicable beginning and ending dates of SCH s	status. Subs	script line	36 for num	ber 1.	00	2.	00	36.00
of periods in excess of one and enter subsequent da 37.00 If this is a Medicare dependent hospital (MDH), enter	tes.	•			0			37.00
is in effect in the cost reporting period.		•		us	U			37.00
37.01 Is this hospital a former MDH that is eligible for accordance with FY 2016 OPPS final rule? Enter "Y" 1								37. 01
instructions)	-							20.00
38.00 If line 37 is 1, enter the beginning and ending date greater than 1, subscript this line for the number of								38.00
enter subsequent dates.								
				1.	00	2.	00	
39.00 Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(i					N	ľ	N	39. 00
1 "Y" for yes or "N" for no. Does the facility meet accordance with 42 CFR 412.101(b)(2)(i), (ii), or (i	the mileage	e requireme	ents in 2 "V" for v	AS				
or "N" for no. (see instructions)								
40.00 Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octo					N	ľ	V	40.00
no in column 2, for discharges on or after October	l. (see inst	tructions)			V	XVIII	XIX	
					1.00			
Prospective Payment System (PPS)-Capital 45.00 Does this facility qualify and receive Capital payment	ent for dis	oroporti ona	ite share in	accordance	e N	l N	T N	45. 00
with 42 CFR Section §412.320? (see instructions) 46.00 Is this facility eligible for additional payment exc	·	•			N	N	N	
pursuant to 42 CFR §412.348(f)? If yes, complete Wks	•		,		IN IN	IN	IN IN	46. 00
Pt. III. 47.00 Is this a new hospital under 42 CFR §412.300(b) PPS	capital? F	Enter "Y fo	or ves or "N	" for no.	N	N	N	47. 00
48.00 Is the facility electing full federal capital paymen					N	N	N	48. 00
Teaching Hospitals 56.00 Is this a hospital involved in training residents in								56. 00
"N" for no in column 1. If column 1 is "Y", are you GME payment reduction? Enter "Y" for yes or "N" for			(or subsequ	ent CR), M	A			
57.00 If line 56 is yes, is this the first cost reporting	peri od duri	ng which r	esidents in	approved	1			57. 00
GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mon	nth of this	cost repor	ting period	? Enter "`	Y"			
for yes or "N" for no in column 2. If column 2 is '"N", complete Wkst. D, Parts III & IV and D-2, Pt. I			et E-4. If c	olumn 2 is				
58.00 If line 56 is yes, did this facility elect cost rein	mbursement 1	for physici	ans' servi c	es as	N			58. 00
defined in CMS Pub. 15-1, chapter 21, §2148? If yes, 59.00 Are costs claimed on line 100 of Worksheet A? If ye			, Pt. I.		N			59.00
			NAHE 413.8 Y/N	35 Worksh Lin	neet A e #	Pass-T Oual i fi	hrough cation	
			.,	2.11		Cri te	eri on	
			1.00	2.	00		de 00	
60.00 Are you claiming nursing and allied health education any programs that meet the criteria under 42 CFR 413		sts for	N					60.00
instructions) Enter "Y" for yes or "N" for no in co	olumn 1. It							
is "Y", are you impacted by CR 11642 (or subsequent adjustement? Enter "Y" for yes or "N" for no in col		a payment						

Health Financial Systems MERIDIAN H	IEALTH S	ERVICES CORP.		In Lie	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA		Provi der Co	CN: 15-4053	Peri od: From 07/01/2019 To 06/30/2020	Worksheet S-2 Part I	pared:
	Y/N	I ME	Direct GME	IME	Direct GME	09 piii
	1. 00	2.00	3.00	4. 00	5. 00	
61.00 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	61.00
61.01 Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02 Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).						61.04
61.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.04 minus fine 61.05). (see first detrois) 61.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06
	Pro	gram Name	Program Cod	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
44 40 00 11 575 1 11 44 05		1. 00	2. 00	3.00	4. 00	(1.10
61.10 Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. 61.20 Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see				0. 00		61. 10
instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.						
					1. 00	
ACA Provisions Affecting the Health Resources and Se						/0.25
62.00 Enter the number of FTE residents that your hospital your hospital received HRSA PCRE funding (see instruc	ctions)					62.00
62.01 Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC progression. Teaching Hospitals that Claim Residents in Nonprovide	gram. (s er Setti	see instruction	ons)		0.00	62.01
63.00 Has your facility trained residents in nonprovider so "Y" for yes or "N" for no in column 1. If yes, comple	ettings	during this o			N	63.00
, , , , , , , , , , , , , , , , , , , ,		<i>J</i>	Unwei ghted		Ratio (col. 1/ (col. 1 +	

		FTEs	FTEs in	1/ (col. 1 +	1
		Nonprovi der	Hospi tal	col. 2))	
		Si te			
		1. 00	2. 00	3. 00	
	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings	This base year	is your cost	reporti ng	
	period that begins on or after July 1, 2009 and before June 30, 2010.				
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents	0.00	0.00	0. 000000	64.00
	in the base year period, the number of unweighted non-primary care				
	resident FTEs attributable to rotations occurring in all nonprovider				
	settings. Enter in column 2 the number of unweighted non-primary care				
	resident FTEs that trained in your hospital. Enter in column 3 the ratio				ĺ
	of (column 1 divided by (column 1 + column 2)). (see instructions)				l

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provi der CCN: 15-4053 Peri od: Worksheet S-2 From 07/01/2019 Part I Date/Time Prepared: 06/30/2020 11/20/2020 3:09 pm Program Name Program Code Unwei ghted Unwei ghted Ratio (col 3/ (col. 3 + FTEs FTEs in col. 4)) Nonprovi der Hospi tal Si te 1.00 2.00 3.00 4.00 5.00 65.00 Enter in column 1, if li is yes, or your facility 0.000000 65.00 0.00 0. 00 if line 63 trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) Unwei ghted Unwei ghted Ratio (col. 1/ (col . 1 + col . 2)) FTEs in FTFs Hospi tal Nonprovi der Si te 2. 00 3. 00 1 00 Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010 Enter in column 1 the number of unweighted non-primary care resident 0.00 0.00 0.000000 66.00 FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions) Program Name Program Code Unwei ghted Unwei ghted Ratio (col. FTEs FTEs in 3/(col. 3 +col. 4)) Nonprovi der Hospi tal Si te 1. 00 2.00 3. 00 4. 00 5. 00 67.00 Enter in column 1, the program 0. 00 0. 00 0.000000 67.00 name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) 1.00 2.00 3.00 Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? 70.00 70.00 Υ Enter "Y" for yes or "N" for no. If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most 71.00 Ν Ν 0 71.00 recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) Inpatient Rehabilitation Facility PPS 75.00 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF Ν 75.00 subprovider? Enter "Y" for yes and "N"

		From 07/01/2 To 06/30/2		Part I Date/Ti 11/20/2		
		-	1. 00	2. 00	3. 00	-
76.00 If line 75 is yes: Column 1: Did the facility have an approve recent cost reporting period ending on or before November 15, no. Column 2: Did this facility train residents in a new teac CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. indicate which program year began during this cost reporting	2004? Enter "Y" for yes hing program in accordan Column 3: If column 2 is	or "N" for ce with 42 Y,	N N	N N	0	76.00
			ŀ	1. 0	00	1
Long Term Care Hospital PPS						
80.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes also as LTCH co-located within another hospital for part or "Y" for yes and "N" for no. TEFRA Providers		ng period? E	nter	N N		80.00
85.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) 86.00 Did this facility establish a new Other subprovider (excluded §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.	3		no.	N		85. 00 86. 00
87.00 Is this hospital an extended neoplastic disease care hospital 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	classified under sectio	n		N		87. 00
		V		XI	X	
		1. 00		2. 0	00	
90.00 Does this facility have title V and/or XIX inpatient hospital yes or "N" for no in the applicable column.	services? Enter "Y" for	N		Υ		90.00
91.00 Is this hospital reimbursed for title V and/or XIX through th		N		Υ		91.00
full or in part? Enter "Y" for yes or "N" for no in the appliance of title XIX NF patients occupying title XVIII SNF beds (dual instructions) Enter "Y" for yes or "N" for no in the applicab	l certification)? (see			N		92.00
93.00 Does this facility operate an ICF/IID facility for purposes o "Y" for yes or "N" for no in the applicable column.	f title V and XIX? Enter	N		N		93.00
94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, a applicable column.	nd "N" for no in the	N		N		94.00
95.00 If line 94 is "Y", enter the reduction percentage in the appl 96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes applicable column.		0. 00 N		O. 0 N		95. 00 96. 00
97.00 If line 96 is "Y", enter the reduction percentage in the appl 98.00 Does title V or XIX follow Medicare (title XVIII) for the interest stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for column 1 for title V, and in column 2 for title XIX.	erns and residents post	0. 00 Y		0. 0 Y		97. 00 98. 00
98.01 Does title V or XIX follow Medicare (title XVIII) for the rep C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for tit title XIX.				Υ		98. 01
98.02 Does title V or XIX follow Medicare (title XVIII) for the called bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or for title V, and in column 2 for title XIX.		Y		Y		98. 02
98.03 Does title V or XIX follow Medicare (title XVIII) for a critic reimbursed 101% of inpatient services cost? Enter "Y" for yes for title V, and in column 2 for title XIX.	cal access hospital (CAH or "N" for no in column) N		N		98. 03
98.04 Does title V or XIX follow Medicare (title XVIII) for a CAH routpatient services cost? Enter "Y" for yes or "N" for no in in column 2 for title XIX.		d N		N		98. 04
98.05 Does title V or XIX follow Medicare (title XVIII) and add bac Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in co column 2 for title XIX.				Y		98. 05
98.06 Does title V or XIX follow Medicare (title XVIII) when cost represented by the property of the providers of the provide		Y		Y		98.06
105.00 Does this hospital qualify as a CAH? 106.00 of this facility qualifies as a CAH, has it elected the all-i	nclusive method of payme	nt N				105. 00 106. 00
for outpatient services? (see instructions) 107.00 Column 1: If line 105 is Y, is this facility eligible for cos training programs? Enter "Y" for yes or "N" for no in column Column 2: If column 1 is Y and line 70 or line 75 is Y, do y approved medical education program in the CAH's excluded IPF Enter "Y" for yes or "N" for no in column 2. (see instruction)	1. (see instructions) ou train I&Rs in an and/or IRF unit(s)?	N				107.00
108.00 Is this a rural hospital qualifying for an exception to the C CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	•	2 N				108. 00

ealth Financial Systems MERIDIAN HEALTH SE DSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA			<u> </u>	Worksheet S	
JOSETTAL AND HOSETTAL HEALTH CARL COMPLEX IDENTIFICATION DATA	Frovider		From 07/01/2019 To 06/30/2020	Part I	Prepare
	Physi cal 1.00	Occupati ona	Speech 3.00	Respi rator	
9.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N N	2. 00 N	N N	4.00 N	109
				1.00	
0.00 Did this hospital participate in the Rural Community Hospita Demonstration) for the current cost reporting period? Enter " complete Worksheet E, Part A, lines 200 through 218, and Wor applicable.	Y" for yes o	r "N" for no.	If yes,	N	110
1.00 If this facility qualifies as a CAH, did it participate in the Health Integration Project (FCHIP) demonstration for this compared for yes or "N" for no in column 1. If the response to contintegration prong of the FCHIP demo in which this CAH is part Enter all that apply: "A" for Ambulance services; "B" for additional for tele-health services.	st reporting lumn 1 is Y, ticipating i	period? Enter enter the n column 2.	1.00 N	2.00	111
		1. 00	2.00	3.00	
2.00 Did this hospital participate in the Pennsylvania Rural Heal demonstration for any portion of the current cost reporting Enter "Y" for yes or "N" for no in column 1. If column 1 is in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital cear participation in the demonstration, if applicable. Miscellaneous Cost Reporting Information	peri od? "Y", enter e	N			112
5.00 Is this an all-inclusive rate provider? Enter "Y" for yes or in column 1. If column 1 is yes, enter the method used (A, B in column 2. If column 2 is "E", enter in column 3 either "9 for short term hospital or "98" percent for long term care (psychiatric, rehabilitation and long term hospitals provider the definition in CMS Pub. 15-1, chapter 22, §2208.1.	, or E only) 3" percent includes	N			0115
6.00 Is this facility classified as a referral center? Enter "Y" " "N" for no.	for yes or	N			110
7.00 Is this facility legally-required to carry malpractice insur- "Y" for yes or "N" for no.	ance? Enter	Υ			113
3.00 Is the malpractice insurance a claims-made or occurrence pol			2		118
if the policy is claim-made. Enter 2 if the policy is occurre	ence.	Premi ums	Losses	Insurance	
		1. 00	2.00	3.00	
3.01 List amounts of malpractice premiums and paid losses:		142, 73	30 (0	0 11
200		The second second	1.00	2. 00	1.1
8. 02 Are malpractice premiums and paid losses reported in a cost of Administrative and General? If yes, submit supporting schedland amounts contained therein. 9. 00 D0 NOT USE THIS LINE			N		11:
0.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qu. Hold Harmless provision in ACA §3121 and applicable amendmen Enter in column 2, "Y" for yes or "N" for no.	column 1, " alifies for	Y" for yes or the Outpatient		N	120
1.00 Did this facility incur and report costs for high cost implain patients? Enter "Y" for yes or "N" for no.	ntable devic	es charged to	N		12
2.00 Does the cost report contain healthcare related taxes as def Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included.					12
Transplant Center Information 5.00 Does this facility operate a transplant center? Enter "Y" fo	r yes and "N	" for no. If	N		12
yes, enter certification date(s) (mm/dd/yyyy) below. 5.00 f this is a Medicare certified kidney transplant center, en	ter the cert	ification date			120
in column 1 and termination date, if applicable, in column 2 7.00 f this is a Medicare certified heart transplant center, ent					12
in column 1 and termination date, if applicable, in column 2					
3.00 f this is a Medicare certified liver transplant center, ent in column 1 and termination date, if applicable, in column 2					12
	r the certif	ication date i	n		129
9.00 f this is a Medicare certified lung transplant center, ente column 1 and termination date, if applicable, in column 2.					
9.00 f this is a Medicare certified lung transplant center, ente column 1 and termination date, if applicable, in column 2. 0.00 f this is a Medicare certified pancreas transplant center, date in column 1 and termination date, if applicable, in col		rti fi cati on			130

lealth Financial Systems	MERIDIAN HEALTH	SERVI CES CORP.			In Lie	u of Form CMS-	-2552-1
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE		Provi der CC	N: 15-4053			Worksheet S-	
					7/01/2019 6/30/2020		onaradi
				10 00	3/ 30/ 2020	11/20/2020 3	
					1. 00	2. 00	
in column 1 and termination date,			ication da	ite			132.00
133.00 Removed and reserved	i appircable, in column	۷.					133. 00
133.00 f this is an organ procurement of	coanization (NPN) enter t	he OPO number	in column	1			134.00
and termination date, if applicable		rie oro ridiliber	i ii coi aiiiii	'			134.0
All Providers							
140.00 Are there any related organization					N		140. 0
chapter 10? Enter "Y" for yes or '				sts			
are claimed, enter in column 2 the			tions)		0.00		
1.00 If this facility is part of a chai	2.0		142 +		3.00	of the home	
office and enter the home office			iugn 143 tr	ie name an	id addi ess	s of the nome	
41. 00 Name:	Contractor's Name:	ictor number.	Contra	actor's Nu	mber.		141.0
42. 00 Street:	PO Box:						142.0
43. 00 Ci ty:	State:		Zip Co	ode:			143.0
						1. 00	
44.00 Are provider based physicians' cos	sts included in Worksheet	A?				Y	144.0
							4
45 001 6			. 6		1. 00	2. 00	1.45.0
45.00 If costs for renal services are clinpatient services only? Enter "Y'	' for yes or "N" for no in	, are the cost	S TOT	_			145. 0
no, does the dialysis facility in							
period? Enter "Y" for yes or "N"		101 11113 0031	r opor tring	'			
46.00 Has the cost allocation methodolog		usly filed cos	t report?		N		146.0
Enter "Y" for yes or "N" for no in	n column 1. (See CMS Pub.	15-2, chapter	40, §4020)	lf			
yes, enter the approval date (mm/d	dd/yyyy) in column 2.						
							4
47 00 Was there a shange in the statist	and having Entar "V" for	voc or "N" for				1.00	147.0
47.00 Was there a change in the statisti 48.00 Was there a change in the order of						N N	147. 0 148. 0
49.00 Was there a change to the simplifi				for no		N N	149. 0
47. 00 was there a change to the shiphin	ca cost irriaring metrioa: E	Part A	Part 6		itle V	Title XIX	147.0
		1. 00	2. 00		3. 00	4.00	
Does this facility contain a provi	ider that qualifies for ar	exemption fro	m the appl	ication o	f the low	ver of costs	
or charges? Enter "Y" for yes or '	"N" for no for each compor	ent for Part A		B. (See 4			
55. 00 Hospi tal		N	N		N	N	155.0
56. 00 Subprovi der – IPF		N	N N		N	N N	156. 0
57. 00 Subprovi der – I RF 58. 00 SUBPROVI DER		N	N		N	N	157. 0 158. 0
59. 00 SNF		N	l N		N	N	159. 0
60.00HOME HEALTH AGENCY		N	N N		N	N	160. 0
61. OO CMHC		14	l N	-	N	N N	161. 0
5 11 5 5 5 m 15							10110
						1. 00	
Mul ti campus							
65.00 Is this hospital part of a Multica	ampus hospital that has on	e or more camp	uses in di	fferent C	BSAs?	N	165. 0
Enter "Y" for yes or "N" for no.	N	0		7' 0 '	0001	ETE (C	
	Name	County	State	Zi p Code	CBSA	FTE/Campus	-
66.00 f line 165 is yes, for each	0	1. 00	2. 00	3. 00	4. 00	5. 00	0 166. 0
						0.0	10 100. U
campus onter the name in column							
campus enter the name in column O county in column 1 state in					1		
0, county in column 1, state in							
O, county in column 1, state in column 2, zip code in column 3,							
O, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in							
O, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						1.00	
O, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Health Information Technology (HI							147.0
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 (HI 67.00) Is this provider a meaningful user	under §1886(n)? Enter "	Y" for yes or	"N" for no),	r, the	1.00 Y	
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 (HI 67.00 is this provider a meaningful use 68.00 if this provider is a CAH (line 10	under §1886(n)? Enter " O5 is "Y") and is a meanin	Y" for yes or gful user (lin	"N" for no),	r the		
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 (HI 67.00) is this provider a meaningful user 68.00 if this provider is a CAH (line 10 reasonable cost incurred for the I	runder §1886(n)? Enter " D5 is "Y") and is a meanin HIT assets (see instructio	Y" for yes or gful user (lin ns)	"N" for no e 167 is "	Y"), ente			167. 00 168. 00
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 (HI 67.00 is this provider a meaningful use 68.00 if this provider is a CAH (line 10	r under §1886(n)? Enter " D5 is "Y") and is a meanin HIT assets (see instructio not a meaningful user, doe	Y" for yes or gful user (lin ns) s this provide	"N" for no e 167 is " r qualify	Y"), ente for a hard			
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 (HI 67.00 is this provider a meaningful user 68.00 if this provider is a CAH (line 10 reasonable cost incurred for the 68.01 if this provider is a CAH and is 10 is	under §1886(n)? Enter " 5 is "Y") and is a meanin II assets (see instructio not a meaningful user, doe Enter "Y" for yes or "N" user (line 167 is "Y") and	Y" for yes or gful user (lin ns) s this provide for no. (see	"N" for no e 167 is " r qualify instructio	n. Y"), ente for a haro ons)	dshi p	Y	168. 0

Health Financial Systems					
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX I	DENTIFICATION DATA	Period: From 07/01/2019 To 06/30/2020	Date/Time Pre	pared:	
				11/20/2020 3:	09 pm
			Begi nni ng	Endi ng	
			1.00	2.00	
170.00 Enter in columns 1 and 2 the EHR beginner period respectively (mm/dd/yyyy)			170. 00		
			1. 00	2. 00	
171.00 If line 167 is "Y", does this provide	N	0	171. 00		
section 1876 Medicare cost plans repo					
"Y" for yes and "N" for no in column		nter the number of section	on		
1876 Medicare days in column 2. (see	instructions)				

OSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C	CN: 15-4053	Peri od: From 07/01/2019 To 06/30/2020	11/20/2020 3	epared
				Y/N 1.00	2. 00	
	General Instruction: Enter Y for all YES responses. Enter N	for all NO re	esponses. En			
	mm/dd/yyyy format.		<u>'</u>			
	COMPLETED BY ALL HOSPITALS					
	Provider Organization and Operation					
00	Has the provider changed ownership immediately prior to the reporting period? If yes, enter the date of the change in co			N N		1.
	reporting period: 11 yes, enter the date of the change in co	Tulli 2. (3ee	Y/N	Date	V/I	
			1.00	2.00	3. 00	
00	Has the provider terminated participation in the Medicare Pr		N			2.
00	yes, enter in column 2 the date of termination and in column voluntary or "I" for involuntary. Is the provider involved in business transactions, including contracts, with individuals or entities (e.g., chain home of or medical supply companies) that are related to the provide officers, medical staff, management personnel, or members of of directors through ownership, control, or family and other relationships? (see instructions)	g management fices, drug er or its f the board	N			3.
			Y/N	Type	Date	
	Fr		1.00	2. 00	3. 00	
00	Financial Data and Reports Column 1: Were the financial statements prepared by a Certi Accountant? Column 2: If yes, enter "A" for Audited, "C" fo or "R" for Reviewed. Submit complete copy or enter date avai column 3. (see instructions) If no, see instructions. Are the cost report total expenses and total revenues differ	or Compiled, lable in	Y	A		4. (
	those on the filed financial statements? If yes, submit reco	onciliation.				
				Y/N	Legal Oper.	
			-	1. 00	2. 00	
00	Approved Educational Activities	16 ! - +	L	- N 1		٠,
00	Column 1: Are costs claimed for nursing school? Column 2: the legal operator of the program?	ii yes, is t	ne provider i	s N		6.
00	Are costs claimed for Allied Health Programs? If "Y" see ins	structions.		N		7.0
00	Were nursing school and/or allied health programs approved a		d during the	N		8.
00	cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved of	araduate medi	cal educatio	n N		9.
	program in the current cost report? If yes, see instructions	S.				
0. 00	Was an approved Intern and Resident GME program initiated or cost reporting period? If yes, see instructions.	renewed in	the current	N		10.
. 00	Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	& R in an Ap	proved	N		11.
					1. 00	
	Bad Debts				1.00	
	Is the provider seeking reimbursement for bad debts? If yes, If line 12 is yes, did the provider's bad debt collection po			cost reporting	Y N	12. 13.
1. 00	period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or co-paymer	nts waived? I	fyes, see ii	nstructi ons.	N	14.
: 00	Bed Complement Did total beds available change from the prior cost reportir	na pori od2 lf	vos socin	structions	N	15.
7. 00	pro total bods avairable change from the prior cost reporting		t A	Par		13.
		Y/N	Date	Y/N	Date	
		1. 00	2.00	3. 00	4. 00	
5. 00	PS&R Data Was the cost report prepared using the PS&R Report only?	Υ	09/17/2020	Y	09/17/2020	16.
. 00	If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 (see instructions)	·	677 177 2020		077 177 2020	
. 00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17.
8. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this	N		N		18.
	cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R	N		N		19.

Heal th	Financial Systems MERIDIAN HEALTH	SERVICES CORP		In lie	u of Form CMS-	2552-10
	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE			Peri od:	Worksheet S-2	
				From 07/01/2019 Fo 06/30/2020		epared:
					11/20/2020 3:	
			iption O	Y/N 1.00	Y/N 3. 00	
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R		0	N N	N N	20.00
	Report data for Other? Describe the other adjustments:					
		Y/N 1.00	2. 00	Y/N 3. 00	Date	
21. 00	Was the cost report prepared only using the provider's	1.00 N	2.00	3.00 N	4. 00	21.00
	records? If yes, see instructions.					
					1 00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXC	CEPT CHILDRENS	HOSPI TALS)		1. 00	
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, se				N	22.00
23. 00	Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.	e due to apprai	sals made duri	ng the cost	N	23. 00
24. 00	Were new leases and/or amendments to existing leases enter	red into during	this cost rep	orting period?	N	24. 00
	If yes, see instructions					
25. 00	Have there been new capitalized leases entered into during instructions.	g the cost repo	rting period?	If yes, see	N	25. 00
26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during t	the cost report	ing period? If	yes, see	N	26. 00
	instructions.	·	0 .			
27. 00	Has the provider's capitalization policy changed during the	ne cost reporti	ng period? If	yes, submit	N	27. 00
	copy. Interest Expense					
28. 00	Were new Loans, mortgage agreements or Letters of credit e	entered into du	ring the cost	reporti ng	N	28. 00
20.00	period? If yes, see instructions.	s band funda (D	obt Comileo Do	comic Fund)	N	20.00
29. 00	Did the provider have a funded depreciation account and/or treated as a funded depreciation account? If yes, see inst		ebt Service Re	serve Funa)	N	29. 00
30.00	Has existing debt been replaced prior to its scheduled mat		debt? If yes,	see	N	30.00
21 00	instructions.		4-1-40 16			21 00
31. 00	Has debt been recalled before scheduled maturity without i instructions.	ssuance or new	debt? IT yes,	see	N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care se		ed through con	tractual	N	32.00
33. 00	arrangements with suppliers of services? If yes, see instr If line 32 is yes, were the requirements of Sec. 2135.2 ap		na to competit	ive hidding? If	,	33.00
33. 00	no, see instructions.	opired pertain	ing to competit	ive brading: 11		33.00
	Provi der-Based Physi ci ans					
34. 00	Are services furnished at the provider facility under an a	arrangement wit	h provi der-bas	ed physicians?	Y	34.00
35. 00	If yes, see instructions. If line 34 is yes, were there new agreements or amended ex	xistina aareeme	nts with the p	rovi der-based	N	35. 00
	physicians during the cost reporting period? If yes, see i					
				Y/N	Date	
	Home Office Costs			1. 00	2. 00	
36. 00	Were home office costs claimed on the cost report?			N		36.00
	If line 36 is yes, has a home office cost statement been p	orepared by the	home office?			37. 00
38 00	If yes, see instructions. If line 36 is yes, was the fiscal year end of the home of	ffica different	from that of			38.00
30.00	the provider? If yes, enter in column 2 the fiscal year er					30.00
39. 00	If line 36 is yes, did the provider render services to oth					39. 00
40. 00	see instructions. If line 36 is yes, did the provider render services to the	home office?	If was soo			40.00
40.00	instructions.	e nome office:	ii yes, see			40.00
	Cost Depart Property Contact Information	1.	00	2.	00	
41. 00	Cost Report Preparer Contact Information Enter the first name, last name and the title/position	MI CHAEL		ALESSANDRI NI		41.00
00	held by the cost report preparer in columns 1, 2, and 3,	S				55
40.00	respectively.	DITIE 9 CO	C			40.00
42. 00	Enter the employer/company name of the cost report preparer.	BLUE & CO., LL	_C			42.00
43.00	Enter the telephone number and email address of the cost	3177137959		MALESSANDRI NI @	BLUEANDCO. COM	43. 00
	report preparer in columns 1 and 2, respectively.	I				

Health Financial Systems MERIDIAN HE	LTH SERVICES CORP.	In Lieu of Form CMS-2552-10				
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIR	Provider CCN: 15-4053	Peri od:	Worksheet S-2			
		From 07/01/2019 To 06/30/2020	Part II Date/Time Pre 11/20/2020 3:	pared: 09 pm_		
	2.22					
	3.00					
Cost Report Preparer Contact Information						
41.00 Enter the first name, last name and the title/position	DI RECTOR			41.00		
held by the cost report preparer in columns 1, 2, and	3,					
respecti vel y.						
42.00 Enter the employer/company name of the cost report				42.00		
preparer.						
43.00 Enter the telephone number and email address of the co	st			43.00		
report preparer in columns 1 and 2, respectively.						

| In Lieu of Form CMS-2552-10 | Period: | Worksheet S-3 | From 07/01/2019 | Part I | To 06/30/2020 | Date/Time Prepared: Heal th Fi nancial SystemsMERIDIAN HEALTH SERVICES CORP.HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATAProvider Complex Statistical Data Provi der CCN: 15-4053

						То	06/30/2020	Date/Time Pr 11/20/2020 3		
								I/P Days /	Ť	<i>y</i> piii
								0/P Visits /		
								Tri ps		
	Component	Worksheet A	No	. of Beds	Bed Days		CAH Hours	Title V		
		Line Number			Available				_	
1.00	The state Allie A Balance E. C. 7 and	1. 00		2.00	3.00	00	4. 00	5. 00	\perp	1 00
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00		12	4, 3	92	0. 00	(o	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)								1	2.00
3. 00	HMO IPF Subprovider								ı	3. 00
4. 00	HMO IRF Subprovider								ı	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			12	4, 3	92	0. 00	(0	7.00
	beds) (see instructions)									
8.00	INTENSIVE CARE UNIT									8.00
9. 00	CORONARY CARE UNIT									9. 00
10.00	BURN INTENSIVE CARE UNIT								- 1	10.00
11.00	SURGICAL INTENSIVE CARE UNIT									11.00
12.00	OTHER SPECIAL CARE (SPECIFY)									12.00
13. 00 14. 00	NURSERY			10	4, 3	00	0. 00	,	- 1	13. 00 14. 00
15. 00	Total (see instructions) CAH visits			12	4, 3	92	0.00			15.00
16. 00	SUBPROVIDER - IPF							,		16. 00
17. 00	SUBPROVI DER - I RF								- 1	17. 00
18. 00	SUBPROVI DER								- 1	18. 00
19. 00	SKILLED NURSING FACILITY								- 1	19. 00
20.00	NURSING FACILITY								1	20.00
21.00	OTHER LONG TERM CARE								1	21.00
22.00	HOME HEALTH AGENCY									22.00
23.00	AMBULATORY SURGICAL CENTER (D. P.)									23.00
24.00	HOSPI CE								- 1	24.00
24. 10	HOSPICE (non-distinct part)	30. 00							- 1	24. 10
25. 00	CMHC - CMHC								- 1	25. 00
26. 00	RURAL HEALTH CLINIC								- 1	26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00		40				(26. 25
27. 00	Total (sum of lines 14-26)			12				,	- 1	27. 00
28. 00	Observation Bed Days							(28. 00 29. 00
29. 00 30. 00	Ambulance Trips Employee discount days (see instruction)								- 1	29. 00 30. 00
31.00	Employee discount days (see Histruction)									31.00
32. 00	Labor & delivery days (see instructions)			0		0			- 1	32.00
32. 01	Total ancillary labor & delivery room			0					- 1	32. 00
02.01	outpatient days (see instructions)									
33.00	LTCH non-covered days									33.00
	LTCH site neutral days and discharges									33. 01

Heal th Fi nancial SystemsMERIDIAN HEALTH SERVICES CORP.HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATAProvider C Peri od: Worksheet S-3 From 07/01/2019 Part I Part I Prepared: 11/20/2020 3:09 pm Provider CCN: 15-4053

						11/20/2020 3:	09 pm
		I/P Days	/ O/P Visits	/ Trips	Full Time I	Equi val ents	
		,		'		•	
	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	1, 124	181	1, 998			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)	ol	119				2.00
3. 00	HMO IPF Subprovider	ام	0				3.00
4. 00	HMO IRF Subprovider	أما	0				4.00
5. 00	Hospital Adults & Peds. Swing Bed SNF	ام	0	О			5.00
6. 00	Hospital Adults & Peds. Swing Bed NF	١	0	Ö			6.00
7. 00	Total Adults and Peds. (exclude observation	1, 124	181	1, 998			7.00
7.00	beds) (see instructions)	1, 127	101	1, 770			7.00
8. 00	INTENSIVE CARE UNIT						8.00
9. 00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14. 00	1	1 124	181	1, 998	0.00	923. 79	
	Total (see instructions)	1, 124		1, 998	0.00	923. 79	
15.00	CAH visits	٩	0	0			15.00
16.00	SUBPROVIDER - I PF						16.00
17. 00	SUBPROVI DER - I RF						17.00
18.00	SUBPROVI DER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22. 00	HOME HEALTH AGENCY						22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24. 00	HOSPI CE						24. 00
24. 10	HOSPICE (non-distinct part)			0			24. 10
25. 00	CMHC - CMHC						25. 00
26. 00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0			
27.00	Total (sum of lines 14-26)				0. 00	923. 79	27. 00
28. 00	Observation Bed Days		0	0			28. 00
29. 00	Ambulance 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	0	0			32.00
32. 01	Total ancillary labor & delivery room			0			32. 01
	outpatient days (see instructions)						
33.00	LTCH non-covered days	o					33.00
33. 01	LTCH site neutral days and discharges	0					33. 01

| In Lieu of Form CMS-2552-10 | Period: | Worksheet S-3 | From 07/01/2019 | Part I | To 06/30/2020 | Date/Time Prepared: Heal th Fi nancial SystemsMERIDIAN HEALTH SERVICES CORP.HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATAProvider Complex Statistical Data Provi der CCN: 15-4053

				To	06/30/2020	Date/Time Pre 11/20/2020 3:	
		Full Time		Di sch	arges		•
	2	Equi val ents	T' 11 . 1/	T	T' 11 . VIV	T. I. I. Al I	
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers	12.00	12.00	14.00	Pati ents	
1 00	Hospital Adults & Peds. (columns 5, 6, 7 and	11. 00	12. 00	13. 00	14. 00	15. 00	1 00
1. 00	8 exclude Swing Bed, Observation Bed and		Ü	111	10	234	1.00
	Hospice days)(see instructions for col. 2						
	for the portion of LDP room available beds)						
2. 00	HMO and other (see instructions)			0	16		2.00
3. 00	HMO IPF Subprovider				0		3.00
4. 00	HMO IRF Subprovider				0		4. 00
5. 00	Hospital Adults & Peds. Swing Bed SNF				Ĭ		5.00
6. 00	Hospital Adults & Peds. Swing Bed NF						6. 00
7. 00	Total Adults and Peds. (exclude observation						7. 00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT						8. 00
9.00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	111	16	234	14.00
15.00	CAH visits						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						22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24. 00	HOSPI CE						24.00
24. 10	HOSPICE (non-distinct part)						24. 10
25. 00	CMHC - CMHC						25.00
26. 00	RURAL HEALTH CLINIC	0.00					26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0. 00 0. 00					26. 25
27. 00 28. 00	Total (sum of lines 14-26)	0.00					27. 00 28. 00
29. 00	Observation Bed Days Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31. 00	Employee discount days (see l'istruction)						31.00
32. 00	Labor & delivery days (see instructions)						32.00
32. 00	Total ancillary labor & delivery room						32.00
JZ. U1	outpatient days (see instructions)						32.01
33. 00	LTCH non-covered days			0			33.00
	LTCH site neutral days and discharges			l o			33. 01
	J			1			

Health Financial Systems	MERIDIAN HEALTH S	ERVICES CORP.		In Lie	u of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL	BALANCE OF EXPENSES	Provi der CC		Period: From 07/01/2019	Worksheet A	
					Date/Time Pre 11/20/2020 3:	
Cost Center Description	Sal ari es	0ther	Total (col. 1	Recl assi fi cat	Recl assi fi ed	
			+ col. 2)	i ons (See	Trial Balance	
				A-6)	(col. 3 +-	

ILLOLA	STITICATION AND ADSOSTMENTS OF TRIAL DALANCE O	I LAI LINGLO	Trovider C		From 07/01/2019	WOI KSHEEL A	
					To 06/30/2020	Date/Time Pre	pared:
						11/20/2020 3:	09 pm
	Cost Center Description	Sal ari es	0ther	Total (col. 1	Recl assi fi cat	Recl assi fi ed	
				+ col . 2)	ions (See	Trial Balance	
					A-6)	(col. 3 +-	
						col. 4)	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT		1		1 0	1	1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP		0		0	0	2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	738, 397	1, 056, 153	1, 794, 55	0	1, 794, 550	4.00
5.00	00500 ADMINISTRATIVE & GENERAL	12, 238, 340	10, 686, 840				
16. 00	01600 MEDICAL RECORDS & LIBRARY	341, 915	165, 712				1
	INPATIENT ROUTINE SERVICE COST CENTERS	311,710	100,712	007702	· <u> </u>	007,027	1
30 00	03000 ADULTS & PEDI ATRI CS	1, 155, 380	981, 448	2, 136, 82	-269, 737	1, 867, 091	30.00
00.00	ANCILLARY SERVICE COST CENTERS	1, 100, 000	701, 110	2, 100, 02	207, 101	1,007,071	00.00
60.00	06000 LABORATORY	ol	0		20, 569	20, 569	60.00
73.00	07300 DRUGS CHARGED TO PATIENTS	Ö	0		249, 168		1
73.00	OUTPATIENT SERVICE COST CENTERS	<u> </u>			247, 100	247, 100	73.00
00 00	09000 CLINIC	7, 269, 426	4, 207, 503	11, 476, 92	9 -9, 016, 443	2, 460, 486	90.00
90.00	SPECIAL PURPOSE COST CENTERS	7, 207, 420	4, 207, 303	11,470,72	- 7, 010, 443	2, 400, 400	70.00
118.00		21, 743, 458	17, 097, 657	38, 841, 11	-9, 016, 443	29, 824, 672	110 00
118.00	NONREIMBURSABLE COST CENTERS	21, 743, 458	17,097,657	38, 841, 11	-9, 016, 443	29, 824, 072	1118.00
100 00	19200 PHYSI CLANS' PRI VATE OFFI CES	10 774 000	10.052.00/	24 (27 22		24 (27 220	100.00
		13, 774, 332	10, 852, 906			., . ,	
	19201 DEL FOHC	2, 953, 658	3, 717, 903				1
	19202 RUSHVI LLE FQHC	543, 181	365, 544			,00,,20	
	19203 WAY FQHC	794, 582	377, 514			.,,	
	19204 JAY FOHC	91, 554	732, 828			824, 382	
	19205 HEN FQHC	392, 361	266, 397			658, 758	
	19206 WALNUT COMMONS	23, 466	19, 890				192. 06
	19207 DEL WOMEN'S CENTER FQHC	712, 422	318, 205			1,000,02	1
	19208 DEL SGC FQHC	375, 920	135, 046	510, 96	6 0	510, 966	
	19209 JAY CONVENIENCE CARE FQHC	28, 531	523, 503	552, 03		552, 034	
	19210 MRO	0	0	(9, 016, 443		
192.11	19211 WAY FQHC CHASE	204, 512	111, 950	316, 46	2 0	316, 462	192. 11
192. 12	19212 MAR FQHC	1, 434, 256	389, 787	1, 824, 04	3 0		
192. 13	19213 FAY FQHC	86, 515	39, 557	126, 07	2 0	126, 072	192. 13
192. 14	19214 DEL PSYCH FQHC	683, 182	252, 925	936, 10	7 0	936, 107	
192. 15	19215 LUH BMH 2ND FLOOR	1, 715, 245	836, 292			2, 551, 537	
	19216 ELW FQHC	491, 856	294, 748			786, 604	
	19217 ALX FQHC	0	52, 059				
	19218 MAD FQHC	1, 472, 554	1, 257, 089				
	19219 DEL PEDIATRIC REHAB FQHC	960	857, 062			858, 022	
	19300 NONPALD WORKERS	700	037, 002				193. 00
	19301 DEL SBHC FOHC	ĭ,	•		9		193.00
		26, 768	7, 232				
	19302 WEL PRIMARY	3, 553	622, 989				
	07950 RIVER BEND INPATIENT	2, 282, 474	1, 940, 121			.,,	
200.00	TOTAL (SUM OF LINES 118 through 199)	49, 835, 340	41, 069, 204	90, 904, 54	4 0	90, 904, 544	1200. 00

Health FinancialSystemsMERIDIAN HEALTH SERVICES CORP.RECLASSIFICATIONAND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSESProvider Co. Peri od: Worksheet A From 07/01/2019 Provi der CCN: 15-4053

			To 06/30/2020 Date/T	ime Prepared: 2020 3:09 pm
Cost Center Description	Adjustments	Net Expenses	117207	2020 3. 04 piii
	(See A-8)	For		
		Allocation		
	6. 00	7. 00		
GENERAL SERVICE COST CENTERS	1 -	T		
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT	0	1		1.00
2. 00 00200 NEW CAP REL COSTS-MVBLE EQUIP	0	1 "		2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	-113, 625			4.00
5.00 O0500 ADMINISTRATIVE & GENERAL	-3, 751, 654			5.00
16. 00 01600 MEDICAL RECORDS & LIBRARY INPATIENT ROUTINE SERVICE COST CENTERS	-14	507, 613		16. 00
30. 00 03000 ADULTS & PEDIATRICS	/ AE 7/1	1 221 220		30.00
ANCI LLARY SERVICE COST CENTERS	-645, 761	1, 221, 330		30.00
60. 00 06000 LABORATORY	1 0	20, 569		60.00
73. 00 07300 DRUGS CHARGED TO PATIENTS				73.00
OUTPATIENT SERVICE COST CENTERS		247, 100		/3.00
90. 00 09000 CLINIC	-95, 302	2, 365, 184		90.00
SPECIAL PURPOSE COST CENTERS	- 73, 302	2, 303, 104		70.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	-4, 606, 356	25, 218, 316		118.00
NONREI MBURSABLE COST CENTERS	1,000,000	20, 210, 010		110.00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	0	24, 627, 238		192. 00
192. 01 19201 DEL FQHC	0	6, 671, 561		192. 01
192. 02 19202 RUSHVI LLE FOHC	0	908, 725		192.02
192. 03 19203 WAY FQHC	0	1, 172, 096		192. 03
192. 04 19204 JAY FQHC	0	824, 382		192.04
192.05 19205 HEN FQHC	0	658, 758		192.05
192.06 19206 WALNUT COMMONS	0	43, 356		192.06
192.07 19207 DEL WOMEN'S CENTER FOHC	0	1, 030, 627		192. 07
192.08 19208 DEL SGC FQHC	0	510, 966		192. 08
192.09 19209 JAY CONVENIENCE CARE FOHC	0	552, 034		192. 09
192. 10 19210 MRO	0	9, 016, 443		192. 10
192.11 19211 WAY FQHC CHASE	0	316, 462		192. 11
192. 12 19212 MAR FQHC	0	1, 824, 043		192. 12
192. 13 19213 FAY FQHC	0	126, 072		192. 13
192.14 19214 DEL PSYCH FQHC	0	936, 107		192. 14
192.15 19215 IUH BMH 2ND FLOOR	0	2, 551, 537		192. 15
192. 16 19216 ELW FQHC	0	786, 604		192. 16
192. 17 19217 ALX FQHC	0	52, 059		192. 17
192. 18 19218 MAD FQHC	0	2, 729, 643		192. 18
192. 19 19219 DEL PEDI ATRI C REHAB FOHC	0	858, 022		192. 19
193. 00 19300 NONPALD WORKERS	0	0		193.00
193. 01 19301 DEL SBHC FQHC	0	34, 000		193. 01
193. 02 19302 WEL PRIMARY	0	626, 542		193. 02
194. 00 07950 RIVER BEND INPATIENT	4 (0(25)	4, 222, 595		194.00
200.00 TOTAL (SUM OF LINES 118 through 199)	-4, 606, 356	86, 298, 188		200.00

Heal th	Financial Systems	MERIDIAN HEALTH SERVICES CORP.				In Lieu of Form CMS-2552-10		
RECLAS:	SI FI CATI ONS			Provi der	CCN: 15-4053	Peri od:	Worksheet A-	6
						From 07/01/2019 To 06/30/2020	Date/Time Pr 11/20/2020 3	epared: :09 pm_
		Increases						
	Cost Center	Li ne #	Sal ary	Other				
	2. 00	3.00	4. 00	5. 00				
-	A - MRO RECLASS							
1.00	MRO	192. 10	<u>5, 710, 9</u> 67	3, 305, 476				1.00
	0		5, 710, 967	3, 305, 476				
	C - LABORATORY RECLASS							
1.00	LABORATORY	60.00	0	20, 569				1.00
	0 = = = = =		₀	20, 569				1
	D - PHARMACY RECLASS							
1.00	DRUGS CHARGED TO PATIENTS	73. 00	0	249, 168				1.00
	0 — — — — — —		<u> </u>	249, 168				1
500.00	Grand Total: Increases		5, 710, 967	3, 575, 213				500.00
	•							

MERIDIAN HEALTH SERVICES CORP. In Lieu of Form	CMS-2552-10
Provi der CCN: 15-4053 Peri od: Workshei	t A-6
From 07/01/2019 To 06/30/2020 Date/Time 11/20/20	e Prepared: 20 3:09 pm
<u>Decreases</u>	
ter Line # Salary Other Wkst. A-7 Ref.	
7. 00 8. 00 9. 00 10. 00	
90. 00 5, 710, 967 3, 305, 476 0	1.00
5, 710, 967 3, 305, 476	
CLASS	
CS 30.00 0 20,569 0	1.00
0 20, 569	
ASS	
CS 30.00 0 249,168 0	1.00
0 249, 168	
reases 5, 710, 967 3, 575, 213	500.00
ter Line # Salary Other Wkst. A-7 Ref. 7.00 8.00 9.00 10.00 90.00 5,710,967 3,305,476 0 5,710,967 3,305,476 CCLASS CS 30.00 0 20,569 0 ASS CS 30.00 0 249,168 0 0 249,168	50

In Lieu of Form CMS-2552-10

Worksheet A-7

Part I

30/2020 Date/Time Prepared:
11/20/2020 3: 09 pm Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS MERIDIAN HEALTH SERVICES CORP. Provider CCN: 15-4053 Peri od: From 07/01/2019 To 06/30/2020 Acqui si ti ons

				Acquisitions			
		Begi nni ng	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 ASSET	T BALANCES					
1.00	Land	1, 296, 255	92, 400	0	92, 400	0	1.00
2.00	Land Improvements	881, 111	0	0	C	1, 200	2.00
3.00	Buildings and Fixtures	27, 867, 370	2, 866, 803	0	2, 866, 803	78, 829	3.00
4.00	Building Improvements	0	0	0	C	0	4.00
5.00	Fixed Equipment	11, 096, 102	2, 391, 114	0	2, 391, 114	2, 955, 687	5.00
6.00	Movable Equipment	0	0	0	C	0	6.00
7.00	HIT designated Assets	0	0	0	C	0	7.00
8.00	Subtotal (sum of lines 1-7)	41, 140, 838	5, 350, 317	0	5, 350, 317	3, 035, 716	8.00
9.00	Reconciling Items	0	0	0	C	0	9. 00
10.00	Total (line 8 minus line 9)	41, 140, 838	5, 350, 317	0	5, 350, 317	3, 035, 716	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	1, 388, 655	0				1.00
2.00	Land Improvements	879, 911	0				2.00
3.00	Buildings and Fixtures	30, 655, 344	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	10, 531, 529	0				5.00
6.00	Movable Equipment	0	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	43, 455, 439	0				8.00
9.00	Reconciling Items	0	0				9.00
10. 00	Total (line 8 minus line 9)	43, 455, 439	0				10. 00

Health Financial Systems	MERIDIAN HEALTH	MERIDIAN HEALTH SERVICES CORP.			In Lieu of Form CMS-2552-10		
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der C		Peri od:	Worksheet A-7		
				From 07/01/2019		nonod.	
				To 06/30/2020	Date/Time Pre 11/20/2020 3:	ng nm	
		SI	JMMARY OF CAPI	TAL	1172072020 0.	0 / p	
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 W	ORKSHEET A, COLU	MN 2, LINES 1	and 2				
1. 00 NEW CAP REL COSTS-BLDG & FLXT	1	0		0	0	1.00	
2. 00 NEW CAP REL COSTS-MVBLE EQUIP		0		0	0	2.00	
3.00 Total (sum of lines 1-2)	CLIMMA DV. C	U CADITAL		0 0	0	3.00	
	SUMMARY	OF CAPITAL					
Cost Center Description	Other	Total (1)					
cost center bescription		(sum of cols.					
		9 through 14)					
	instructions)						
	14. 00	15. 00					
PART II - RECONCILIATION OF AMOUNTS FROM W	ORKSHEET A, COLU	MN 2, LINES 1	and 2				
1.00 NEW CAP REL COSTS-BLDG & FIXT	C	1				1.00	
2.00 NEW CAP REL COSTS-MVBLE EQUIP	C	0				2.00	
3.00 Total (sum of lines 1-2)	C) 1				3.00	

Heal th	n Financial Systems M	ERIDIAN HEALTH	SERVICES CORP.		In Lie	u of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der C		Period: From 07/01/2019 To 06/30/2020		pared:
		COMF	PUTATION OF RAT	TIOS	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets		Insurance	
			Leases	for Ratio	instructions)		
				(col . 1 -			
		1. 00	2.00	col . 2) 3.00	4.00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS O		2.00	3.00	4.00	J. 00	
1.00	NEW CAP REL COSTS-BLDG & FIXT	43, 455, 439	0	43, 455, 43	9 1.000000	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0		0. 000000		2.00
3.00	Total (sum of lines 1-2)	43, 455, 439		43, 455, 43			3.00
		ALLOCA	FION OF OTHER (CAPI TAL	SUMMARY C	OF CAPITAL	
	Cost Center Description	Taxes	0ther	Total (sum o	f Depreciation	Lease	
			Capi tal -Rel at				
			ed Costs	through 7)	0.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS O	6. 00	7. 00	8. 00	9. 00	10.00	
1. 00	NEW CAP REL COSTS-BLDG & FIXT	ENTERS	0		0 1	0	1.00
2. 00	NEW CAP REL COSTS-BEDG & TTXT	0	0		0 0	0	2.00
3. 00	Total (sum of lines 1-2)	0	0		0 1	Ö	3.00
			SL	JMMARY OF CAPI	TAL		
	Cost Center Description	Interest	Insurance	Taxes (see	Other	Total (2)	
			(see	i nstructi ons			
			instructions)			9 through 14)	
		11.00	12.00	12.00	instructions)	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS O	11. 00	12. 00	13. 00	14. 00	15. 00	
1. 00	NEW CAP REL COSTS-BLDG & FIXT	DENTERS 0	0		0 0	1	1.00
2. 00	NEW CAP REL COSTS-MVBLE EQUIP	0	0		0 0	Ö	2.00
3. 00	Total (sum of lines 1-2)	0	Ō		0 0	1	3.00
		•	=	•	*	•	•

				Expense Classification on V	Worksheet A	11/20/2020 3:	09 pm
				To/From Which the Amount is t			
	Cost Center Description	Basi s/Code	Amount	Cost Center	Li ne #	Wkst. A-7	
		(2) 1. 00	2. 00	3.00	4. 00	Ref. 5.00	
1. 00	Investment income - NEW CAP			NEW CAP REL COSTS-BLDG &	1.00	0	1.00
	REL COSTS-BLDG & FIXT (chapter 2)			FLXT			
2. 00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter		0	NEW CAP REL COSTS-MVBLE EQUIP	2. 00	0	2. 00
3. 00	2) Investment income - other (chapter 2)		0		0. 00	0	3. 00
4. 00	Trade, quantity, and time		0		0.00	0	4. 00
5. 00	discounts (chapter 8) Refunds and rebates of		0		0. 00	0	5. 00
5.00	expenses (chapter 8)		U		0.00	U	3.00
6. 00	Rental of provider space by		0		0. 00	0	6. 00
7. 00	suppliers (chapter 8) Telephone services (pay		0		0. 00	0	7. 00
	stations excluded) (chapter						
8. 00	21) Television and radio service		0		0.00	0	8.00
	(chapter 21)		· ·				
9. 00 10. 00	Parking Lot (chapter 21) Provider-based physician	A-8-2	-671, 385		0. 00	0	
10.00	adjustment	A-0-2	-0/1, 303			O	10.00
11. 00	Sale of scrap, waste, etc.		0		0. 00	0	11.00
12. 00	(chapter 23) Related organization	A-8-1	0			0	12.00
	transactions (chapter 10)					_	
13. 00 14. 00	Laundry and linen service Cafeteria-employees and guests		0		0. 00 0. 00	0	
15. 00	Rental of quarters to employee		0		0. 00	0	
16. 00	and others Sale of medical and surgical		0		0. 00	0	16. 00
10.00	supplies to other than		0		0.00	O	10.00
17 00	patients		0		0.00		17 00
17.00	Sale of drugs to other than patients		Ü		0.00	0	17. 00
18. 00	Sale of medical records and		0		0. 00	0	18. 00
19. 00	abstracts Nursing and allied health		0		0. 00	0	19.00
	education (tuition, fees,						
20. 00	books, etc.) Vending machines		0		0. 00	0	20.00
	Income from imposition of		Ö		0. 00	0	1
	interest, finance or penalty charges (chapter 21)						
22. 00	Interest expense on Medicare		0		0.00	0	22. 00
	overpayments and borrowings to						
23. 00	repay Medicare overpayments Adjustment for respiratory	A-8-3	0	*** Cost Center Deleted ***	65. 00		23. 00
	therapy costs in excess of						
24. 00	limitation (chapter 14) Adjustment for physical	A-8-3	0	*** Cost Center Deleted ***	66. 00	ļ	24.00
21.00	therapy costs in excess of		· ·	3551 55	33. 33		200
25. 00	limitation (chapter 14) Utilization review -		0	*** Cost Center Deleted ***	114. 00		25. 00
25.00	physicians' compensation		0	cost center bereted	114.00		25.00
04 00	(chapter 21)			NEW CAR REL COCTO DI RO A	1 00		0, 00
26. 00	Depreciation - NEW CAP REL COSTS-BLDG & FLXT		0	NEW CAP REL COSTS-BLDG & FLXT	1.00	0	26.00
27. 00	Depreciation - NEW CAP REL		0	NEW CAP REL COSTS-MVBLE	2. 00	0	27. 00
28. 00	COSTS-MVBLE EQUIP Non-physician Anesthetist		Ω	EQUIP *** Cost Center Deleted ***	19. 00	ļ	28.00
29. 00	Physicians' assistant		0		0. 00	0	29. 00
30. 00	Adjustment for occupational therapy costs in excess of	A-8-3	0	*** Cost Center Deleted ***	67. 00		30.00
	limitation (chapter 14)					ļ	
30. 99	Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30. 00		30. 99
	i nstructi ons)	ļ		ı	I	ļ	I

Heal th	Financial Systems	ME	RIDIAN HEALTH	SERVI CES CORP.	In Lie	u of Form CMS-2	2552-10
ADJUST	MENTS TO EXPENSES				Peri od:	Worksheet A-8	
					From 07/01/2019 To 06/30/2020	Date/Time Pre 11/20/2020 3:	
				Expense Classification on	Worksheet A		
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basis/Code	Amount	Cost Center	Li ne #	Wkst. A-7	
		(2)				Ref.	
	T	1. 00	2. 00	3. 00	4. 00	5. 00	
31. 00	Adjustment for speech	A-8-3	0	*** Cost Center Deleted ***	68. 00		31.00
	pathology costs in excess of						
	limitation (chapter 14)		_			_	
32.00	CAH HIT Adjustment for		0		0. 00	0	32. 00
	Depreciation and Interest	_				_	
33.00	OTHER REVENUE	В		EMPLOYEE BENEFITS DEPARTMENT		0	00.00
35.00	OTHER REVENUE	В	·	ADMINISTRATIVE & GENERAL	5. 00	0	35.00
35. 01	MEDICAL RECORDS REVENUE	В	-69, 678	1	90.00	0	35. 01
35. 02	OTHER REVENUE	В		MEDICAL RECORDS & LIBRARY	16.00	0	35. 02
35. 03	MEDICAL RECORD REVENUE	В		MEDI CAL RECORDS & LI BRARY	16. 00	0	35. 03
35. 04	OTHER I NCOME	В		ADMINISTRATIVE & GENERAL	5. 00	0	35. 04
36.00	HOSPITAL ASSESSMENT FEES	В	,	ADMINISTRATIVE & GENERAL	5. 00		36.00
38.00	PHYSI CI AN RECRUI TMENT	A		ADMI NI STRATI VE & GENERAL	5. 00	0	38.00
38. 01	PHYSI CI AN RECRUI TMENT	A		EMPLOYEE BENEFITS DEPARTMENT		0	38. 01
38. 02	INTEREST INCOME	A		ADMINISTRATIVE & GENERAL	5. 00	0	38. 02
50.00	TOTAL (sum of lines 1 thru 49)		-4, 606, 356				50. 00

column 6, line 200.) (1) Description - all chapter references in this column pertain to CMS Pub. 15-1.

(Transfer to Worksheet A,

⁽²⁾ Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT Provi der CCN: 15-4053

					-	To 06/30/2020	Date/Time Pro 11/20/2020 3:	epared: :09 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	30.00	ADULTS & PEDIATRICS	645, 761	645, 761	C	181, 300	0	1.00
2.00	90.00	CLINIC	25, 624	25, 624	C	181, 300	0	2.00
3.00	0.00)	0	0	C		0	3.00
4.00	0.00)	0	0	C	o o	0	4.00
5.00	0.00)	0	0	C	0	0	5.00
6.00	0.00)	0	0	C	0	0	6.00
7.00	0.00)	0	0	C	o o	0	7. 00
8.00	0.00)	0	0	C	o o	0	8. 00
9.00	0.00)	0	0	C	o o	0	9.00
10.00	0.00		0		C	0	0	10.00
200.00			671, 385	671, 385	C		0	200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of	Provi der	Physician Cost	
		I denti fi er	Limit	Unadjusted RCE	Memberships &	Component	of Mal practice	
				Limit	Continuing	Share of col.	Insurance	
					Educati on	12		
	1.00	2. 00	8. 00	9. 00	12. 00	13. 00	14.00	
1. 00		ADULTS & PEDIATRICS	0		_			
2. 00		CLINIC	0	0	C	0	0	
3.00	0.00		0	0	C	0	0	
4. 00	0.00	· I	0	0	C	0	0	
5.00	0.00		0	0	C) 0	0	
6. 00	0.00		0	0	C	0	0	0.00
7. 00	0.00		0	0	C	0	0	
8. 00	0.00		0	0	C	0	0	0.00
9. 00	0.00		0	0	C	0	0	
10.00	0.00		0	0	C	0	0	1
200.00			0	C	C		0	200.00
	Wkst. A Line #		Provi der	Adjusted RCE	RCE	Adjustment		
		I denti fi er	Component	Limit	Di sal I owance			
			Share of col.					
	1.00	2.00	14 15. 00	16. 00	17. 00	18. 00		
1. 00		ADULTS & PEDIATRICS	13.00					1.00
2. 00		CLINIC	0		_	1		2.00
3. 00	0.00		0		_	0	1	3.00
4. 00	0.00		0					4.00
5. 00	0.00		0					5.00
6. 00	0.00		0	0	0			6.00
7. 00	0.00	1	0	Ö		ol o		7.00
8. 00	0.00		1 0		_			8.00
9. 00	0.00	1	1 0		_			9.00
10. 00	0.00		1 0	0				10.00
200.00			l ő		_	1		200.00
200.00	I	T .	1	1		., 571,309	ı	, 200. 00

COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-4053 Peri od: Worksheet B From 07/01/2019 Part I Date/Time Prepared: 06/30/2020 11/20/2020 3:09 pm CAPITAL RELATED COSTS **EMPLOYEE** Cost Center Description Net Expenses NEW BLDG & NEW MVBLE Subtotal for Cost FIXT **FOULP** BENEFLTS DEPARTMENT Allocation (from Wkst A col. 7) 0 1.00 2.00 4. 00 4A GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 2.00 2.00 0 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 1, 680, 925 0 1, 680, 926 4.00 00500 ADMINISTRATIVE & GENERAL 0 19, 592, 530 5.00 19, 173, 526 C 419, 004 5.00 16.00 01600 MEDICAL RECORDS & LIBRARY 507, 613 0 0 11, 706 519, 319 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 1, 221, 330 0 0 39, 557 1, 260, 887 30.00 ANCILLARY SERVICE COST CENTERS 60.00 06000 LABORATORY 20, 569 n 0 0 20, 569 60.00 07300 DRUGS CHARGED TO PATIENTS 0 0 73.00 0 249, 168 73.00 249, 168 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 2, 365, 184 0 0 53, 357 2, 418, 541 90.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 25, 218, 316 1 0 523, 624 24, 061, 014 118. 00 118.00 NONREI MBURSABLE COST CENTERS 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 24, 627, 238 0 0 471, 586 25, 098, 824 192. 00 192. 01 19201 DEL FQHC 6, 772, 685 192. 01 6, 671, 561 0 0 101, 124 927, 322 192. 02 192. 02 19202 RUSHVI LLE FQHC 0 0 18, 597 908, 725 192.03 19203 WAY FQHC 0 1, 199, 300 192. 03 1, 172, 096 0 27, 204 192.04 19204 JAY FQHC 824, 382 0 0 827, 517 192. 04 3, 135 192.05 19205 HEN FQHC 658, 758 0 0 13, 433 672, 191 192. 05 192.06 19206 WALNUT COMMONS 0 43, 356 0 803 44, 159 192. 06 0 192. 07 19207 DEL WOMEN' S CENTER FQHC 1, 030, 627 0 24, 391 1, 055, 018 192. 07 12, 870 192.08 19208 DEL SGC FQHC 510, 966 0 0 523, 836 192. 08 192. 09 19209 JAY CONVENIENCE CARE FOHC 552, 034 0 0 977 553, 011 192. 09 9, 211, 969 192. 10 192. 10 19210 MRO 0 195, 526 9,016,443 0 192. 11 19211 WAY FQHC CHASE 0 316, 462 0 7,002 323, 464 192. 11 192. 12 19212 MAR FQHC 0 1, 873, 148 192. 12 1,824,043 49, 105 2, 962 192. 13 19213 FAY FQHC 126, 072 0 0 129, 034 192. 13 959, 497 192. 14 0 192. 14 19214 DEL PSYCH FQHC 0 936, 107 23.390 192. 15 19215 I UH BMH 2ND FLOOR 2, 551, 537 58, 725 2, 610, 262 192. 15 192. 16 19216 ELW FQHC 0 0 786, 604 16, 840 803, 444 192. 16 192. 17 19217 ALX FQHC 0 52, 059 192. 17 0 52,059 2, 780, 059 192. 18 192. 18 19218 MAD FQHC 0 50, 416 2, 729, 643 192. 19 19219 DEL PEDIATRIC REHAB FOHC 858, 022 0 0 33 858, 055 192. 19 193. 00 19300 NONPALD WORKERS 0 0 0 193.00 0 193. 01 19301 DEL SBHC FQHC 0 34,000 0 916 34, 916 193. 01 0 193. 02 19302 WEL PRIMARY 626, 542 0 122 626, 664 193. 02 194.00 07950 RIVER BEND INPATIENT 4, 222, 595 0 78, 145 4, 300, 740 194. 00 Cross Foot Adjustments 200.00 0 200.00 0 0 0 201, 00 201.00 Negative Cost Centers

86, 298, 188

1, 680, 926

86, 298, 188 202. 00

202.00

TOTAL (sum lines 118 through 201)

Health Financial Systems	MERIDIAN HEALTH	SERVICES CORP.		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der C	CN: 15-4053	Peri od: From 07/01/2019 To 06/30/2020		
Cost Center Description	ADMINISTRATIV E & GENERAL	MEDI CAL RECORDS & LI BRARY	Subtotal	Intern & Residents Cost & Post Stepdown	Total	

					11/20/2020 3:	09 pm
Cost Center Description	ADMI NI STRATI V	MEDI CAL	Subtotal	Intern &	Total	
	E & GENERAL	RECORDS &		Resi dents		
		LI BRARY		Cost & Post		
				Stepdown		
				Adjustments		
	5. 00	16. 00	24. 00	25. 00	26. 00	
GENERAL SERVICE COST CENTERS						
1.00 O0100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00 00500 ADMINI STRATI VE & GENERAL	19, 592, 530					5.00
16.00 01600 MEDICAL RECORDS & LIBRARY	152, 532	671, 851				16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	370, 343	216, 091	1, 847, 321	0	1, 847, 321	30.00
ANCILLARY SERVICE COST CENTERS						
60. 00 06000 LABORATORY	6, 041	2, 282	28, 892	0	28, 892	60.00
73.00 O7300 DRUGS CHARGED TO PATIENTS	73, 185	27, 647	350, 000	0	350, 000	73.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	710, 364	425, 831	3, 554, 736	0	3, 554, 736	90.00
SPECIAL PURPOSE COST CENTERS						
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	1, 312, 465	671, 851	5, 780, 949	0	5, 780, 949	118.00
NONREI MBURSABLE COST CENTERS						
192.00 19200 PHYSICIANS' PRIVATE OFFICES	7, 371, 937	0	32, 470, 761	0	32, 470, 761	192.00
192. 01 19201 DEL FQHC	1, 989, 246	0	8, 761, 931	0	8, 761, 931	192. 01
192. 02 19202 RUSHVI LLE FQHC	272, 369	0	1, 199, 691	0	1, 199, 691	192. 02
192.03 19203 WAY FQHC	352, 254	0	1, 551, 554	0	1, 551, 554	192. 03
192. 04 19204 JAY FQHC	243, 055	0	1, 070, 572	0	1, 070, 572	192. 04
192. 05 19205 HEN FQHC	197, 433	0	869, 624	O	869, 624	192. 05
192.06 19206 WALNUT COMMONS	12, 970	0	57, 129	O	57, 129	192.06
192.07 19207 DEL WOMEN'S CENTER FOHC	309, 876	o	1, 364, 894	o	1, 364, 894	192. 07
192.08 19208 DEL SGC FQHC	153, 859	o	677, 695	o	677, 695	192. 08
192. 09 19209 JAY CONVENIENCE CARE FQHC	162, 428	o	715, 439	o	715, 439	192. 09
192. 10 19210 MRO	2, 705, 703	o	11, 917, 672	O	11, 917, 672	192. 10
192. 11 19211 WAY FOHC CHASE	95, 007	o	418, 471	O	418, 471	192. 11
192. 12 19212 MAR FQHC	550, 174	o	2, 423, 322	o	2, 423, 322	
192. 13 19213 FAY FQHC	37, 899	o	166, 933	o	166, 933	
192. 14 19214 DEL PSYCH FQHC	281, 820	o	1, 241, 317	o	1, 241, 317	
192. 15 19215 I UH BMH 2ND FLOOR	766, 676	o	3, 376, 938	o	3, 376, 938	
192. 16 19216 ELW FQHC	235, 984	o	1, 039, 428	o	1, 039, 428	
192. 17 19217 ALX FQHC	15, 291	o	67, 350	0	67, 350	
192. 18 19218 MAD FQHC	816, 548	o	3, 596, 607	o	3, 596, 607	
192. 19 19219 DEL PEDIATRIC REHAB FQHC	252, 024	o	1, 110, 079	0	1, 110, 079	
193. 00 19300 NONPALD WORKERS	0	0	0	0		193. 00
193. 01 19301 DEL SBHC FQHC	10, 255	0	45, 171	o	45, 171	
193. 02 19302 WEL PRI MARY	184, 061	0	810, 725	o	810, 725	
194. 00 07950 RIVER BEND INPATIENT	1, 263, 196	0	5, 563, 936	0	5, 563, 936	
200.00 Cross Foot Adjustments	1, 203, 170	٩	3, 303, 730	0		200.00
201.00 Negative Cost Centers		0	0	0		200.00
202.00 TOTAL (sum lines 118 through 201)	19, 592, 530	671, 851	86, 298, 188	0	86, 298, 188	
202.00 TOTAL (Sum Titles 110 till ough 201)	17, 372, 330	371,031	00, 270, 100	Ч	00, 270, 100	LUZ. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS MERIDIAN HEALTH SERVICES CORP. Provider CCN: 15-4053

		CAPI TAL REI	ATED COSTS		1172072020 3.	D) piii
Cost Center Description	Directly	NEW BLDG &	NEW MVBLE	Subtotal	EMPLOYEE	
cost center bescription	Assigned New	FLXT	EQUI P	Jubtotai	BENEFI TS	
	Capi tal	1170	2011		DEPARTMENT	
	Related Costs					
	0	1.00	2.00	2A	4. 00	
GENERAL SERVICE COST CENTERS						
1.00 O0100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2. 00 00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT	852	1		853	853	1
5. 00 00500 ADMI NI STRATI VE & GENERAL	1, 393, 069	0		1, 393, 069	208	1
16. 00 01600 MEDICAL RECORDS & LIBRARY	0	0	0	0	6	16.00
INPATIENT ROUTINE SERVICE COST CENTERS	F7 F01			EZ E01	20	20.00
30. 00 03000 ADULTS & PEDIATRICS	57, 581	0	0	57, 581	20	30.00
ANCILLARY SERVICE COST CENTERS 60. 00 06000 LABORATORY	l	0	O	o	0	60.00
73.00 O7300 DRUGS CHARGED TO PATIENTS		0		ol Ol	0	
OUTPATIENT SERVICE COST CENTERS	l d	0	U	<u> </u>	0	73.00
90. 00 09000 CLINIC	3, 780	0	0	3, 780	26	90.00
SPECIAL PURPOSE COST CENTERS	3, 700		0	3, 700	20	70.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	1, 455, 282	1	0	1, 455, 283	260	118. 00
NONREI MBURSABLE COST CENTERS	17 1007 202	<u> </u>	<u> </u>	., .00, 200	200	1
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	102, 649	0	0	102, 649	255	192. 00
192.01 19201 DEL FQHC	136, 624	0	0	136, 624		192. 01
192. 02 19202 RUSHVI LLE FQHC	39, 541	0	0	39, 541	9	192. 02
192.03 19203 WAY FQHC	1, 161	0	0	1, 161	14	192. 03
192.04 19204 JAY FQHC	6, 979	0	0	6, 979	2	192. 04
192.05 19205 HEN FQHC	507	0	0	507	7	192. 05
192.06 19206 WALNUT COMMONS	2, 808	0	0	2, 808	0	192. 06
192.07 19207 DEL WOMEN'S CENTER FQHC	0	0	0	0		192. 07
192.08 19208 DEL SGC FQHC	0	0	0	0		192. 08
192. 09 19209 JAY CONVENIENCE CARE FQHC	1, 475	0		1, 475		192. 09
192. 10 19210 MRO	13, 996	0	0	13, 996		192. 10
192. 11 19211 WAY FOHC CHASE	0	0	· · · · · · · · · · · · · · · · · · ·	0		192. 11
192. 12 19212 MAR FQHC	0	0		0		192. 12
192. 13 19213 FAY FQHC	1, 111	0	_	1, 111		192. 13
192. 14 19214 DEL PSYCH FOHC	44	0	· ·	44		192. 14
192. 15 19215 I UH BMH 2ND FLOOR	0	0		0		192. 15
192. 16 19216 ELW FQHC	48, 423	0	_	48, 423		192. 16
192. 17 19217 ALX FQHC	12, 533	0	_	12, 533		192. 17
192. 18 19218 MAD FQHC	281, 832	0	_	281, 832		192. 18
192. 19 19219 DEL PEDI ATRI C REHAB FQHC	567	0		567		192. 19
193. 00 19300 NONPALD WORKERS 193. 01 19301 DEL SBHC FOHC	0	0	_	0		193. 00 193. 01
193.01 19301 DEL SBHC FQHC 193.02 19302 WEL PRIMARY	424	0		424		193. 01
193.02 19302 WEL PRIMARY 194.00 07950 RIVER BEND INPATIENT	424	0		424		194. 00
200.00 Cross Foot Adjustments	١	U		0	39	200.00
201.00 Negative Cost Centers		0	0	0	Λ	200.00
202.00 TOTAL (sum lines 118 through 201)	2, 105, 956	1	0	2, 105, 957		202.00
202.00 TOTAL (Suil TITIES TTO THE OUGH 201)	2, 103, 730	'	ı	2, 103, 737	000	1202.00

Health Financial Systems M	ERIDIAN HEALTH S	ERVICES CORP.		In Lie	u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der Co	CN: 15-4053	Period: From 07/01/2019 To 06/30/2020	Worksheet B Part II	epared:
Cost Center Description	ADMI NI STRATI V E & GENERAL	MEDI CAL RECORDS & LI BRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	·
	5. 00	16. 00	24. 00	25. 00	26. 00	
GENERAL SERVICE COST CENTERS						
1. 00 00100 NEW CAP REL COSTS-BLDG & FIXT 2. 00 00200 NEW CAP REL COSTS-MVBLE EQUIP 4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 5. 00 00500 ADMINISTRATIVE & GENERAL 16. 00 01600 MEDICAL RECORDS & LIBRARY	1, 393, 277 10, 847	10, 853				1.00 2.00 4.00 5.00
INPATIENT ROUTINE SERVICE COST CENTERS	10,017	10,000				10.00
30. 00 03000 ADULTS & PEDIATRICS ANCI LLARY SERVICE COST CENTERS	26, 336	3, 490	87, 42	7 0	87, 427	30.00
60. 00 06000 LABORATORY 73. 00 07300 DRUGS CHARGED TO PATIENTS	430 5, 204	37 446			467 5, 650	
OUTPATIENT SERVICE COST CENTERS				.1		
90. 00 09000 CLI NI C	50, 516	6, 880	61, 20	2 0	61, 202	90.00
SPECIAL PURPOSE COST CENTERS	93, 333	10, 853	154.74	6 0	154 744	110 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	93, 333	10, 853	154, 74	0 0	154, 746	1118.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	524, 237	0	627, 14	1 0	627, 141	102 00
192. 01 19201 DEL FQHC	141, 461	0			278, 135	
192. 02 19202 RUSHVI LLE FQHC	19, 369	0	58, 91			192.02
192. 03 19203 WAY FOHC	25, 050	0				192. 03
192. 04 19204 JAY FOHC	17, 284	0				192.04
192. 05 19205 HEN FQHC	14, 040	0	14, 55			192.05
192. 06 19206 WALNUT COMMONS	922	0	3, 73			192.06
192.07 19207 DEL WOMEN'S CENTER FQHC	22, 036	0	22, 04	8 0	22, 048	192.07
192.08 19208 DEL SGC FQHC	10, 941	0	10, 94	.7		192. 08
192.09 19209 JAY CONVENIENCE CARE FOHC	11, 551	0				192. 09
192. 10 19210 MRO	192, 410	0			206, 503	
192.11 19211 WAY FQHC CHASE	6, 756	0	6, 75			192. 11
192. 12 19212 MAR FOHC	39, 124	0				192. 12
192. 13 19213 FAY FOHC	2, 695	0	3, 80			192. 13
192. 14 19214 DEL PSYCH FQHC	20, 041	0				192. 14
192.15 19215 I UH BMH 2ND FLOOR 192.16 19216 ELW FQHC	54, 521 16, 782	0				192. 15 192. 16
192. 17 19217 ALX FQHC	1, 087	0				192. 10
192. 18 19218 MAD FQHC	58, 067	0			339, 924	
192. 19 19219 DEL PEDIATRI C REHAB FQHC	17, 922	0	18, 48			192. 19
193. 00 19300 NONPALD WORKERS	0	0		0		193.00
193. 01 19301 DEL SBHC FQHC	729	0	72	9 0		193. 01
193. 02 19302 WEL PRIMARY	13, 089	0	13, 51			193. 02
194.00 07950 RIVER BEND INPATIENT	89, 830	0	89, 86			194. 00
200.00 Cross Foot Adjustments				0 0	0	200.00
201.00 Negative Cost Centers	0	0		0 0		201. 00
202.00 TOTAL (sum lines 118 through 201)	1, 393, 277	10, 853	2, 105, 95	7 0	2, 105, 957	202.00

COST ALLOCATION - STATISTICAL BASIS Provider COX: 15-4053 Portion (7/107/2070) To month (7/107			RIDIAN HEALTH S			In Lie	u of Form CMS-	
CAPITAL RELATED COSTS CAPITAL RELATED COSTS TAPACON TAPACON	COST ALLOCA	ATION - STATISTICAL BASIS		Provi der Co			Worksheet B-1	
COST Center Description						From 07/01/2019	Data/Timo Dro	narod.
COST Center Description						10 00/30/2020		
Cost Center Description			CAPITAL REL	ATED COSTS			1172072020 01	U 7 DIII
FIXT COURT								
COUNTRY COUN		Cost Center Description	NEW BLDG &	NEW MVBLE	EMPLOYEE	Reconciliatio	ADMI NI STRATI V	
COUNTRY COUN		·	FLXT	EQUI P	BENEFITS	n	E & GENERAL	
SALARIES			(SQUARE	(DOLLAR	DEPARTMENT		(ACCUM.	
SALARLES				•	(GROSS			
ENERAL SERVICE COST CENTERS			,	ŕ	SALARI ES)		,	
1.00 0.0100 NEW CAP REL COSTS-BUBLE & FIXT 1 0 49,096,943			1. 00	2.00	4.00	5A	5. 00	
2.00 00200 NEW CAP REL COSTS-MBULE EQUIP 1 0 49,096,943 -19,592,530 66,705,658 50,00 00500 ADMINISTRATIVE & GENERAL 0 0 0 1,238,340 -19,592,530 66,705,658 50,00 00500 ADMINISTRATIVE & GENERAL 0 0 0 1,155,380 0 1,260,897 10,00 10,00 00,00 0 0 0 0 0 0 0								
4.00 0.0400 EMPLOYEE BENEFITS DEPARTMENT 1			1					1.00
0.000 0.000 DMIN ISTRATIVE & GENERAL 0 0 341,915 0 519,379 16.00	2.00 0020	NEW CAP REL COSTS-MVBLE EQUIP		0				2.00
16.00	4.00 0040	O EMPLOYEE BENEFITS DEPARTMENT	1	0	49, 096, 94	3		4.00
INPATI ENT ROUTINE SERVICE COST CENTERS 0 0 1,155,380 0 1,260,887 30.0 0.00 0.0 0.0 0.0 0 0 0	5.00 0050	O ADMINISTRATIVE & GENERAL	0	0	12, 238, 340	-19, 592, 530	66, 705, 658	5.00
0.00 0.3000 ADULTS & PEDIATRICS 0 0 1,155,380 0 1,260,887 30.00	16. 00 0160	O MEDICAL RECORDS & LIBRARY	0	0	341, 91	5 0	519, 319	16. 00
## AMCILLARY SERVICE COST CENTERS 0	I NPA	TIENT ROUTINE SERVICE COST CENTERS						
0.000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0			0	0	1, 155, 380	0	1, 260, 887	30.00
173.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 249,168 73.00								
OUTPATIENT SERVICE COST CENTERS 0 0 1,558,459 0 2,418,541 90.00	60.00 06000	O LABORATORY	0	0				60.00
90.00	73.00 0730	D DRUGS CHARGED TO PATIENTS	0	0		0	249, 168	73.00
SPECIAL PURPOSE COST CENTERS	OUTP	ATIENT SERVICE COST CENTERS						
18.00 SUBTOTALS (SUM OF LINES 1 through 117) 1 0 15,294,094 -19,592,530 4,468,484 18.00			0	0	1, 558, 459	9 0	2, 418, 541	90.00
NONREI MBURSABLE COST CENTERS 10	SPECI							
192.00 19200 PHYSI CIANS' PRIVATE OFFICES 0 0 0 2, 933, 668 0 6, 772, 685 192, 00 192.01 19201 DEL FOHC 0 0 0 543, 181 0 927, 322 192.02 192.02 19202 RUSHVILLE FOHC 0 0 0 744, 582 0 1, 199, 300 192.03 192.04 19204 JAY FOHC 0 0 0 91, 554 0 827, 517 192.04 192.05 19206 HEN FOHC 0 0 0 392, 361 0 672, 191 192.05 192.06 19206 WALNUT COMMONS 0 0 0 392, 361 0 672, 191 192.05 192.06 19206 WALNUT COMMONS 0 0 0 392, 361 0 672, 191 192.05 192.07 192.07 DEL WOMEN'S CENTER FOHC 0 0 0 375, 920 0 523, 836 192.08 192.09 19209 JAY CONVENI ENCE CARE FOHC 0 0 0 375, 920 0 523, 836 192.08 192.09 19209 JAY CONVENI ENCE CARE FOHC 0 0 0 28, 531 0 553, 101 192.09 192.10 19210 MRO 192.10 19210	118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	1	0	15, 294, 09	4 -19, 592, 530	4, 468, 484	118. 00
192.0 1 19201 DEL FONC 192.0 2 19202 RISHVILLE FORC 10 0 0 543, 181 0 927, 322 192.02 192.0 3 19203 WAY FORC 10 0 0 794, 582 0 1, 199, 300 192.03 192.0 4 19204 JAY FORC 10 0 0 91, 554 0 827, 517 192.04 192.0 6 19205 HEN FOHC 10 0 0 92, 346 0 44, 159 192.06 192.0 6 19206 WALNUT COMMONS 192.0 6 19206 WALNUT COMMONS 192.0 6 19207 DEL WOMEN'S CENTER FOHC 192.0 6 19209 WAY CONVENI ENCE CARE FOHC 192.0 19209 JAY CONVENI ENCE CARE FOHC 192.0 1 19210 WR0 192.1 19210 WR0 192.1 19211 WAY FOHC CHASE 10 0 0 375, 920 192.1 19211 WAY FOHC CHASE 10 0 0 5, 710, 967 192.1 19212 WAR FOHC 192.1 19212 WAR FOHC 192.1 19212 WAR FOHC 192.1 19213 FAY FOHC 192.1 19214 DEL PSYCH FOHC 10 0 0 86, 515 192.4 19214 DEL PSYCH FOHC 10 0 0 86, 515 192.4 19215 LUH BMH 2ND FLOOR 10 0 0 683, 182 192.6 19215 ELW FOHC 10 0 0 0 491, 856 10 0 0 0 52, 780, 590 192.18 192.1 19217 ALX FOHC 192.1 19217 ALX FOHC 192.1 19217 DEL WOMEN'S CENTER FOHC 193.0 19300 NONPAID WORKERS 10 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	NONRI	EIMBURSABLE COST CENTERS						
192.02 19202 RUSHVI LLE FOHC 192.03 19203 WAY FOHC 192.04 19204 JAY FOHC 192.05 19205 HEN FOHC 192.05 19205 HEN FOHC 192.05 19205 HEN FOHC 192.05 19205 HEN FOHC 192.07 1920 JAY FOHC 192.06 19206 WALNUT COMMONS 1000 375, 366 192.07 1920 JAY FOHC 192.07 1920 JAY FOHC 192.07 1920 JAY FOHC 192.07 1920 JAY FOHC 192.08 19206 WALNUT COMMONS 192.08 19206 WALNUT COMMONS 192.09 JAY CONVENI ENCE CORTER FOHC 192.08 1920 JAY CONVENI ENCE CARE FOHC 192.08 1920 JAY CONVENI ENCE CARE FOHC 192.08 1920 JAY CONVENI ENCE CARE FOHC 192.10 1921 JAY FOHC CHASE 192.10 1921 JAY FOHC CHASE 192.11 1921 JAY FOHC CHASE 192.12 1921 JAY FOHC CHASE 192.13 1921 JAY FOHC CHASE 192.13 1921 JAY FOHC CHASE 192.14 1921 JAY FOHC CHASE 192.15 1921 JAY FOHC 192.15 1921 JAY FOHC 192.16 JAY FOHC 192.16 JAY FOHC 192.17 1921 JAY FOHC 192.17 1921 JAY FOHC 192.18 1921 JAY FOHC 193.00 JAY JAY JAY FOHC 193.00 JAY	192. 00 1920	O PHYSICIANS' PRIVATE OFFICES	0	0	13, 774, 33	2 0	25, 098, 824	192. 00
192.03 19203 WAY FOHC 192.05 19205 HEN FOHC 192.06 19206 WALNUT COMMONS 192.06 19206 WALNUT COMMONS 192.06 19206 WALNUT COMMONS 192.06 19207 DEL WOMEN'S CENTER FOHC 192.07 19207 DEL WOMEN'S CENTER FOHC 192.08 19208 DEL SGC FOHC 192.08 19209 JAY CONVENIENCE CARE FOHC 192.09 19209 JAY CONVENIENCE CARE FOHC 192.11 19210 WAR 192.11 19211 WAY FOHC CHASE 192.11 19211 WAY FOHC CHASE 192.12 19212 WAR FOHC 192.11 19211 WAY FOHC CHASE 192.11 19212 WAR FOHC 192.11 19212 WAR FOHC 192.11 19215 WAR FOHC 192.11 19218 WAR FOHC CHASE 192.11 19219 WAR FOHC 192.11 19219 WAY FOHC CHASE 192.11 19219 WAY FOHC CHASE 192.11 19219 WAY FOHC CHASE 192.11 19219 WAY FOHC 192.1	192. 01 1920	1 DEL FQHC	0	0	2, 953, 658	8 0	6, 772, 685	192.01
192.0d 1920d JAY FOHC 192.05 19205 HEN FOHC 0 0 0 392, 361 0 672, 191 192.05 192.06 19206 WALNUT COMMONS 0 0 0 372, 466 0 44, 159 192.06 192.07 19207 DEL WOMEN'S CENTER FOHC 0 0 0 712, 422 0 1, 055, 018 192.07 192.09 19209 JAY CONVENIENCE CARE FOHC 0 0 0 375, 920 0 523, 3836 192.08 192.09 19209 JAY CONVENIENCE CARE FOHC 0 0 0 28, 531 0 553, 011 192.09 192.11 19211 WAY FOHC CHASE 0 0 0 0 204, 512 192.31 19213 FAY FOHC 0 0 0 1, 434, 256 0 1, 873, 148 192.12 192.13 19213 FAY FOHC 0 0 0 683, 182 0 959, 497 192.14 192.15 19215 IUH BMI A2ND FLOOR 0 0 0 683, 182 0 959, 497 192.14 192.16 19216 ELW FOHC 0 0 0 1, 715, 245 0 2, 610, 262 192.15 192.18 19218 MAD FOHC 0 0 0 1, 72, 554 0 2, 800, 599 192.18 192.19 19219 DELE PEDIATRIC REHAB FOHC 0 0 0 1, 72, 554 0 2, 800, 599 192.18 192.19 19219 DELE SHC FOHC 0 0 0 1, 680, 926 193.00 19300 NOMPALD WORKERS 0 0 0 0 0, 355, 301 193.01 19301 DELE SHC FOHC 0 0 0 0 1, 680, 926 193.00 19300 NOMPALD WORKERS 0 0 0 0 0, 52, 059 192.17 193.00 19300 NOMPALD WORKERS 0 0 0 0 0, 355, 300 193.01 19301 DELE SHC FOHC 0 0 0 0 0, 365, 768 0 34, 916 193.01 193.02 19302 WEL PRI MARY 0 0 0 2, 282, 474 0 4, 300, 740 194.00 200.00 202.00 Cost to be all ocated (per Wkst. B, Part I) 205.00 Unit cost multiplier (Wkst. B, Part II) 205.00 WAHE adjustment amount to be all ocated (per Wkst. B, Part II) 206.00 NAHE adjustment amount to be all ocated (per Wkst. B, Part II) 207.00 NAHE adjustment amount to be all ocated (per Wkst. B, Part II) 208.00 NAHE adjustment amount to be all ocated (per Wkst. B, Part II) 207.00 NAHE adjustment amount to be all ocated (per Wkst. B, Part II) 208.00 NAHE adjustment amount to be all ocated (per Wkst. B, Part II) 209.00 NAHE adjustment amount to be all ocated (per Wkst. B, Part II) 209.00 NAHE adjustment amount to be all ocated (per Wkst. B, Part II) 209.00 NAHE adjustment amount to be all ocated (per Wkst. B, Part II) 209.00 NAHE adjustment amount to be all ocated (per Wkst. B, Part II) 209.00 NAHE adjustment amount to be all ocated (per Wkst. B, Part II) 209.00 NAHE adjustm	192. 02 1920:	2 RUSHVI LLE FQHC	0	0	543, 18 ⁻	1 0	927, 322	192.02
192.05 192.06 192.06 192.06 192.06 192.06 192.06 192.06 192.06 192.06 192.06 192.06 192.07 192.07 192.07 192.07 192.07 192.08 1	192. 03 1920	3 WAY FQHC	0	0	794, 582	2 0	1, 199, 300	192.03
192.06 192.06 192.06 MALNUIT COMMONS 0 0 0 23, 466 0 44, 159 192.06 192.07 192.07 192.07 192.07 192.07 192.08 192.09 192.08 192.09 192.08 192.09 192.08 192.09 192.08 192.08 192.08 192.08 192.09 192.08	192. 04 1920	4 JAY FQHC	0	0	91, 55	4 0	827, 517	192.04
192.07 192.07 192.07 192.07 192.08 192.08 192.08 192.08 192.08 192.08 192.08 192.08 192.08 192.08 192.08 192.08 192.09 1	192. 05 1920	5 HEN FQHC	0	0	392, 36	1 0	672, 191	192.05
192.08 19208 DEL SGC FOHC 0 0 375, 920 0 523, 836 192.08 192.09 19209 JAY CONVENIENCE CARE FOHC 0 0 0 0 28, 531 0 553, 011 192.01 192.10 192.10 192.10 192.10 MRO 0 0 0 5, 710, 967 0 9, 211, 969 192. 10 192.11 192.11 192.11 192.11 192.12 MAR FOHC 0 0 0 0 204, 512 0 323, 464 192. 11 192.13 192.13 FAY FOHC 0 0 0 86, 515 0 129, 034 192. 13 192.13 192.13 FAY FOHC 0 0 0 86, 515 0 129, 034 192. 13 192.13 192.15 1UH BMIN 2ND FLOOR 0 0 683, 182 0 959, 497 192. 14 192.15 1UH BMIN 2ND FLOOR 0 0 0 1, 715, 245 0 2, 610, 262 192. 15 192.16 192.16 192.16 192.16 192.17 14	192.06 1920	6 WALNUT COMMONS	0	0	23, 46	6 0	44, 159	192.06
192. 09 1920 JAY CONVENI ENCE CARE FOHC 0 0 28, 531 0 553, 011 192. 09 192. 10 1921 0 MRO 0 0 0 5,710, 967 0 9, 211, 969 192. 10 192. 10 192. 11 1921 11 WAY FOHC CHASE 0 0 0 0 204, 512 0 333, 464 192. 11 192. 12 19212 MAR FOHC 0 0 0 0 1, 434, 256 0 1, 873, 148 192. 12 192. 13 19213 FAV FOHC 0 0 0 0 86, 515 0 129, 034 192. 13 192. 13 19213 FAV FOHC 0 0 0 683, 182 0 959, 47 192. 14 192. 15 19215 IUH BMH 2ND FLOOR 0 0 0 1,715, 245 0 2,610, 262 192. 15 192. 16 EUR FOHC 0 0 0 491, 856 0 803, 444 192. 16 192. 17 192. 17 192. 17 192. 17 192. 17 192. 17 192. 17 192. 19 192. 19 DEL PEDI ATRI C REHAB FOHC 0 0 0 0 52, 059 192. 17 192. 19 19219 DEL PEDI ATRI C REHAB FOHC 0 0 0 0 0 858, 055 192. 19 193. 00 19300 NONPAI D WORKERS 0 0 0 0 0 0 0 193. 00 19300 NONPAI D WORKERS 0 0 0 0 0 3, 553 0 626, 664 193. 02 193. 02 193. 02 193. 02 WEL PRI MARY 0 0 0 2, 282, 474 0 4, 300, 740 194. 00 200. 00 0 0 0 0 0 0 0 0	192. 07 1920	7 DEL WOMEN'S CENTER FQHC	0	0	712, 42	2 0	1, 055, 018	192.07
192. 10 19210 MRP 19210 MRP 19210 MRP 192. 10 192. 11 19211 MAY FORC CHASE 0 0 0 204, 512 0 323, 469 192. 10 192. 12 19212 MAR FORC 0 0 0 1, 434, 256 0 1, 873, 148 192. 12 192. 12 19212 MAR FORC 0 0 0 0 86, 515 0 129, 034 192. 13 192. 14 19214 DEL PSYCH FORC 0 0 0 0 683, 182 0 959, 497 192. 14 192. 15 UBMH 2ND FLOOR 0 0 0 1, 715, 245 0 2, 610, 262 192. 15 192. 16 19216 ELW FORC 0 0 0 0 491, 856 0 803, 444 192. 16 192. 16 19216 ELW FORC 0 0 0 0 491, 856 0 803, 444 192. 16 192. 18 19218 MAD FORC 0 0 0 0 1, 472, 554 0 2, 800, 599 192. 17 192. 19 19219 DEL PEDI ATRI C REHAB FORC 0 0 0 0 0 0 1, 472, 554 0 2, 800, 599 192. 18 193. 00 19300 NONPALD WORKERS 0 0 0 0 0 0 0 0 0 0 193. 00 1930. 00 1	192. 08 1920	8 DEL SGC FQHC	0	0	375, 920	0	523, 836	192.08
192. 11 19211 WAY FOHC CHASE 0 0 204, 512 0 323, 464 192. 11 192. 12 19212 MAR FOHC 0 0 0 1, 434, 256 0 1, 873, 148 192. 12 192. 13 19213 FAY FOHC 0 0 0 683, 182 0 959, 497 192. 14 192. 14 192. 14 192. 14 192. 14 192. 15 19215 IUH BMH 2ND FLOOR 0 0 0 683, 182 0 959, 497 192. 14 192. 16	192. 09 1920	9 JAY CONVENIENCE CARE FQHC	0	0	28, 53°	1 0	553, 011	192.09
192. 12 1921 MAR FOHC	192. 10 19210	O MRO	0	0	5, 710, 96	7 0	9, 211, 969	192. 10
192. 13 19213 FAY FOHC 192. 14 19214 DEL PSYCH FOHC 192. 15 19215 IUH BMH 2ND FLOOR 192. 16 19216 ELW FOHC 192. 16 19216 ELW FOHC 192. 17 19217 ALX FOHC 192. 17 19217 ALX FOHC 192. 19 19219 DEL PEDI ATRI C REHAB FOHC 193. 01 19301 NONPAID WORKERS 193. 01 19301 DEL SBHC FOHC 193. 02 19302 WEL PRI MARY 194. 00 07950 RI VER BEND INPATI ENT 200. 00 202. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 NAHE adjustment amount to be allocated (per Wkst. B, Part I) 100. 00 207. 00 207. 00 NAHE adjustment amount to be allocated (per Wkst. D, NAHE unit cost multiplier (Wkst. D, Part II) 207. 00 NAHE unit cost multiplier (Wkst. D, Part II) 1.000000 10 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	192. 11 1921	1 WAY FQHC CHASE	0	0	204, 51	2 0	323, 464	192. 11
192.14 19214 DEL PSYCH FOHC 0 0 683, 182 0 959, 497 192. 14 192. 15 19215 19215 19216 EUW FOHC 0 0 0 0 1,715, 245 0 2,610, 262 192. 15 192. 16 192. 16 192. 16 192. 16 192. 16 192. 16 192. 16 19216 EUW FOHC 0 0 0 0 0 52, 059 192. 17 192. 18 19218 MAD FOHC 0 0 0 0 52, 059 192. 18 192. 18 19218 MAD FOHC 0 0 0 0 0 0 0 0 0	192. 12 1921:	2 MAR FQHC	0	0	1, 434, 25	6 0	1, 873, 148	192. 12
192.15 19215 IUH BMH 2ND FLOOR 0 0 0 1,715,245 0 2,610,262 192.15 192.16 19216 ELW FOHC 0 0 0 0 0 0 0 52,059 192.17 192.17 1217 ALX FOHC 0 0 0 0 0 0 0 0 0	192. 13 1921:	3 FAY FQHC	0	0	86, 51	5 0	129, 034	192. 13
192.16 19216 ELW FQHC 192.17 19217 ALX FQHC 0 0 0 0 52,059 192.17 192.18 19218 DEL PEDI ATRI C REHAB FQHC 192.19 19219 DEL PEDI ATRI C REHAB FQHC 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	192. 14 1921	4 DEL PSYCH FQHC	0	0	683, 183	2 0	959, 497	192. 14
192. 17 19217 ALX FOHC 192. 18 19218 MAD FOHC 192. 18 19218 MAD FOHC 193. 19 19219 DEL PEDI ATRIC REHAB FOHC 193. 00 19300 NONPAI D WORKERS 193. 01 19301 DEL SBHC FOHC 193. 01 19301 DEL SBHC FOHC 193. 02 19302 WEL PRI MARY 194. 00 07950 RI VER BEND I NPATI ENT 190. 00 Nonpai ive Cost Centers 190. 00 Cost to be allocated (per Wkst. B, Part I) 190. 00 Unit cost multiplier (Wkst. B, Part II) 190. 00 NAHE adjustment amount to be allocated (per Wkst. D, NAHE unit cost multiplier (Wkst. D, Unit cost multiplier (Wkst.	192. 15 1921	5 IUH BMH 2ND FLOOR	0	0	1, 715, 24	5 0	2, 610, 262	192. 15
192. 18 19218	192. 16 1921	6 ELW FQHC	0	0	491, 85	6 0	803, 444	192. 16
192.19 19219 DEL PEDIATRIC REHAB FOHC 0 0 960 0 958,055 192.19 19302 19302 NONPAID WORKERS 0 0 0 0 0 0 193.00 193.01 19301 DEL SBHC FOHC 0 0 26,768 0 34,916 193.01 193.02 19302 WEL PRIMARY 0 0 0 3,553 0 626,664 193.02 200.00 Cross Foot Adjustments Negative Cost Centers 201.00 Cost to be allocated (per Wkst. B, Part I) Unit cost multiplier (Wkst. B, Part II) 1.000000 0 0.000000 0.034237 0.293716 203.00 204.00 Cost to be allocated (per Wkst. B, Part II) 0.000001 0.0000017 0.0000017 0.0000017 0.0000017 0.0000017 0.0000017 0.0000017 0.0000017 0.0000017 0.0000017 0.0000017 0.0000017 0.0000017 0.0000017 0.0000017 0.0000017 0.0000017 0.000000017 0.00000017 0.00000017 0.00000017 0.00000017 0.00000017 0.000000017 0.00000017 0.00000017 0.00000017 0.00000017 0.00000017 0.000000017 0.00000017 0.00000017 0.00000017 0.00000017 0.000000017 0.00000017 0.00000017 0.000000017 0.000000017 0.000000017 0.00000017 0.00000017 0.000000017 0.000000017 0.000000017 0.00000000017 0.0000000000	192. 17 1921	7 ALX FQHC	0	0		0	52, 059	192. 17
193.00 19300 NONPAID WORKERS 193.01 19301 DEL SBHC FOHC 0 0 0 26,768 0 34,916 193.01 193.02 19302 WEL PRI MARY 0 0 0 3,553 0 626,664 193.02 200.00 Cross Foot Adjustments Negative Cost Centers 201.00 Negative Cost Centers 202.00 Cost to be allocated (per Wkst. B, Part I) 203.00 Unit cost multiplier (Wkst. B, Part II) 205.00 Unit cost multiplier (Wkst. B, Part III) 205.00 Unit cost multiplier (Wkst. B, Part III) 206.00 NAHE adjustment amount to be allocated (per Wkst. D, NAHE unit cost multiplier (Wkst. D, NAHE unit	192. 18 1921	8 MAD FQHC	0	0	1, 472, 55	4 0	2, 780, 059	192. 18
193.01 19301 DEL SBHC FOHC 0 0 26,768 0 34,916 193.01 193.01 193.02 19302 WEL PRIMARY 0 0 0 3,553 0 626,664 193.02 194.00 07950 RIVER BEND INPATIENT 0 0 0 2,282,474 0 4,300,740 194.00 200.00 Coss Foot Adjustments 201.00 Negative Cost Centers 202.00 Cost to be allocated (per Wkst. B, Part I) 1.000000 0.000000 0.034237 0.293716 203.00 Unit cost multiplier (Wkst. B, Part II) 1.000000 0.000000 0.034237 0.293716 203.00 204.00 Cost to be allocated (per Wkst. B, Part II) 0.000001 0.0000001 0.000001 0.000001 0.000001 0.000001 0.000001 0.000001 0.0000001 0.000001 0.000001 0.000001 0.000001 0.000001 0.000001 0.0000001 0.000001 0.000001 0.000001 0.000001 0.000001 0.000001 0.000001 0.000001 0.000001 0.000001 0.000001 0.000001 0.000001 0.0000001 0.000001 0.000001 0.000001 0.000001 0.000001 0.0000001 0.0000001 0.000001 0.000001 0.000001 0.000001 0.000001 0.000001 0.000	192. 19 1921	9 DEL PEDIATRIC REHAB FOHC	0	0	960	0	858, 055	192. 19
193.02 19302 WEL PRIMARY 194.00 07950 RIVER BEND INPATIENT 0 0 0 3,553 0 626,664 193.02 194.00 07950 RIVER BEND INPATIENT 0 0 0 2,282,474 0 4,300,740 194.00 200.00 Cross Foot Adjustments Negative Cost Centers 202.00 Cost to be allocated (per Wkst. B, Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 204.00 Cost to be allocated (per Wkst. B, Part II) 205.00 Unit cost multiplier (Wkst. B, Part III) 205.00 Unit cost multiplier (Wkst. B, Part III) 206.00 NAHE adjustment amount to be allocated (per Wkst. B, Part III) 207.00 NAHE unit cost multiplier (Wkst. D, 207.00	193. 00 1930	O NONPALD WORKERS	0	0		0	0	193.00
194.00 07950 RIVER BEND INPATIENT 0 0 2, 282, 474 0 4, 300, 740 194.00 200.00 Cross Foot Adjustments 200.00 Negative Cost Centers 202.00 Cost to be allocated (per Wkst. B, Part I) 1.000000 0.000000 0.034237 0.293716 203.00 Unit cost multiplier (Wkst. B, Part II) 1.000000 0.000000 0.034237 0.293716 203.00 204.00 Cost to be allocated (per Wkst. B, Part II) 0.000001 0.0000001 0.000001 0.0000001 0.000001 0.000001 0.000001 0.000001 0.00	193. 01 1930	1 DEL SBHC FQHC	0	0	26, 76	8 0	34, 916	193. 01
200.00 201.00 Negative Cost Centers 202.00 Cost to be allocated (per Wkst. B, Part I) 203.00 Unit cost multiplier (Wkst. B, Part II) 205.00 Unit cost multiplier (Wkst. B, Part III) 206.00 NAHE adjustment amount to be allocated (per Wkst. D, 207.00 NAHE unit cost multiplier (Wkst. D, 200.00 201.00 1, 680, 926 19, 592, 530 202.00 201.00 0, 0000000 0, 0000000 0, 0000000 0, 0000000 0, 00000000	193. 02 1930	2 WEL PRIMARY	0	0	3, 55	3 0	626, 664	193. 02
201.00 Negative Cost Centers 201.00 202.00 Cost to be allocated (per Wkst. B, Part I) 1.000000 0.000000 0.034237 0.293716 203.00 204.00 Cost to be allocated (per Wkst. B, Part II) 205.00 Unit cost multiplier (Wkst. B, Part II) 206.00 NAHE adjustment amount to be allocated (per Wkst. B, Part II) 207.00 NAHE unit cost multiplier (Wkst. D, Part II) 207.00 NAHE unit cost multiplier (Wkst. D, Part II) 207.00 208.00 207.00	194. 00 07950	O RIVER BEND INPATIENT	O	0	2, 282, 47	4 0	4, 300, 740	194.00
202.00 Cost to be allocated (per Wkst. B, Part I) 1.000000 0.000000 0.034237 0.293716 203.00 204.00 Cost to be allocated (per Wkst. B, Part II) 1.000000 0.000000 0.000000 0.034237 0.293716 203.00 0.293716 203.00 0.293716 203.00 0.0000000 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 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.00000000	200. 00	Cross Foot Adjustments						200.00
Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 204.00 Cost to be allocated (per Wkst. B, Part II) 205.00 Unit cost multiplier (Wkst. B, Part III) 206.00 NAHE adjustment amount to be allocated (per Wkst. B, Part III) 207.00 NAHE unit cost multiplier (Wkst. D, Part III) 207.00 NAHE unit cost multiplier (Wkst. D, Part IIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII	201. 00	Negative Cost Centers						201.00
203.00 Unit cost multiplier (Wkst. B, Part I) 1.000000 0.000000 0.034237 0.293716 203.00 (204.00 Cost to be allocated (per Wkst. B, Part II) Unit cost multiplier (Wkst. B, Part II) 0.000017 0.000017 0.000017 0.020887 205.00 (per Wkst. B-2) NAHE unit cost multiplier (Wkst. D, 207.00	202.00	Cost to be allocated (per Wkst. B,	1	0	1, 680, 92	5	19, 592, 530	202.00
204.00 Cost to be allocated (per Wkst. B, Part II) Unit cost multiplier (Wkst. B, Part II) Unit cost multiplier (Wkst. B, Part II) 0.000017 0.020887 205.00		Part I)						
Part II) Unit cost multiplier (Wkst. B, Part II) 206.00 NAHE adjustment amount to be allocated (per Wkst. B-2) NAHE unit cost multiplier (Wkst. D, 207.00	203.00	Unit cost multiplier (Wkst. B, Part I)	1. 000000	0. 000000	0. 03423	7	0. 293716	203.00
205.00 Unit cost multiplier (Wkst. B, Part II) 206.00 NAHE adjustment amount to be allocated (per Wkst. B-2) 207.00 NAHE unit cost multiplier (Wkst. D, 207.00	204.00	Cost to be allocated (per Wkst. B,			853	3	1, 393, 277	204.00
206.00 NAHE adjustment amount to be allocated (per Wkst. B-2) NAHE unit cost multiplier (Wkst. D, 207.00								
206.00 NAHE adjustment amount to be allocated (per Wkst. B-2) 207.00 NAHE unit cost multiplier (Wkst. D, 207.00	205.00	Unit cost multiplier (Wkst. B, Part			0. 00001	7	0. 020887	205.00
(per Wkst. B-2) 207.00 NAHE unit cost multiplier (Wkst. D, 207.00		[11]						
207.00 NÄHE unit cost multiplier (Wkst. D, 207.00	206. 00							206.00
Parts III and IV)	207. 00							207.00
		Parts III and IV)			l			

Health Financial Systems MERIDIAN HEALTH		CES CORP.		In Lieu of Form CMS-2552-10	
COST ALLOCATION - STATISTICAL BASIS	Pr	ovi der CCN: 15-4053	Peri od:	Worksheet B-1	

From 07/01/2019 06/30/2020 Date/Time Prepared: 11/20/2020 3:09 pm Cost Center Description MEDI CAL RECORDS & LI BRARY (TIME SPENT) 16.00 GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 1.00 2 00 00200 NEW CAP REL COSTS-MVBLE EQUIP 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 7, 095, 849 16.00 01600 MEDICAL RECORDS & LIBRARY 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 2, 282, 277 30.00 ANCILLARY SERVICE COST CENTERS 60.00 06000 LABORATORY 24. 105 60.00 07300 DRUGS CHARGED TO PATIENTS 73.00 291, 995 73.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 4, 497, 472 90.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 7, 095, 849 118.00 118.00 NONREI MBURSABLE COST CENTERS 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 0 192.00 0 192. 01 19201 DEL FQHC 192.01 192. 02 19202 RUSHVI LLE FQHC 192.02 192.03 19203 WAY FQHC 192. 03 0000000000000000000 192.04 19204 JAY FQHC 192.04 192.05 19205 HEN FQHC 192.05 192.06 19206 WALNUT COMMONS 192.06 192.07 19207 DEL WOMEN'S CENTER FOHC 192.07 192.08 19208 DEL SGC FQHC 192. 08 192. 09 19209 JAY CONVENIENCE CARE FOHC 192. 09 192. 10 19210 MRO 192. 10 192. 11 19211 WAY FOHC CHASE 192. 11 192. 12 19212 MAR FQHC 192, 12 192. 13 19213 FAY FQHC 192. 13 192. 14 19214 DEL PSYCH FQHC 192. 14 192. 15 19215 I UH BMH 2ND FLOOR 192. 15 192. 16 19216 ELW FQHC 192. 16 192. 17 19217 ALX FQHC 192. 17 192. 18 19218 MAD FQHC 192. 18 192. 19 19219 DEL PEDIATRIC REHAB FOHC 192. 19 193. 00 19300 NONPALD WORKERS 193.00 193. 01 19301 DEL SBHC FQHC 193. 01 193. 02 19302 WEL PRIMARY 0 193.02 194.00 07950 RIVER BEND INPATIENT 194 00 0 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201.00 Cost to be allocated (per Wkst. B, 671, 851 202.00 202.00 Part I) 0. 094682 203.00 203.00 Unit cost multiplier (Wkst. B, Part I) 204.00 Cost to be allocated (per Wkst. B, 10, 853 204.00 Part II) 205.00 Unit cost multiplier (Wkst. B, Part 0.001529 205. 00 Π 206.00 NAHE adjustment amount to be allocated 206.00 (per Wkst. B-2) 207.00 207.00 NAHE unit cost multiplier (Wkst. D, Parts III and IV)

Health Fina	ncial Systems	MERIDIAN HEALTH	SERVICES CORP.		In Lie	u of Form CMS-2	2552-10
COMPUTATI OI	N OF RATIO OF COSTS TO CHARGES		Provider Co	F	Period: From 07/01/2019 To 06/30/2020	Date/Time Pre 11/20/2020 3:	
			Title	XVIII	Hospi tal	PPS	
					Costs		
	Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
		1. 00	2.00	3.00	4.00	5. 00	
I NPA	TIENT ROUTINE SERVICE COST CENTERS						
30.00 0300	O ADULTS & PEDIATRICS	1, 847, 321		1, 847, 321	0	1, 847, 321	30.00
ANCI	LLARY SERVICE COST CENTERS						
60.00 0600	O LABORATORY	28, 892		28, 892	0	28, 892	60.00
73.00 0730	O DRUGS CHARGED TO PATIENTS	350, 000		350, 000	0	350, 000	73.00
OUTP	ATIENT SERVICE COST CENTERS						
90.00 0900	O CLI NI C	3, 554, 736		3, 554, 736	0	3, 554, 736	90.00
200.00	Subtotal (see instructions)	5, 780, 949	0	5, 780, 949	0	5, 780, 949	200. 00
201.00	Less Observation Beds	0		()	0	201.00
202. 00	Total (see instructions)	5, 780, 949	0	5, 780, 949	0	5, 780, 949	202. 00

Health Financial Systems	MERIDIAN HEALTH S	SERVICES CORP.		In Lieu of Form CMS-2552-10			
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provider CCN:			Period: From 07/01/2019 To 06/30/2020	Worksheet C Part I Date/Time Pre	narodi	
				10 06/30/2020	11/20/2020 3:		
	_	Title	XVIII	Hospi tal	PPS		
		Charges					
Cost Center Description	I npati ent	Outpati ent	Total (col. (Cost or Other	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	2, 282, 277		2, 282, 27	7		30.00	
ANCILLARY SERVICE COST CENTERS							
60. 00 06000 LABORATORY	24, 105	0	24, 10	5 1. 198590	0.000000	60.00	
73.00 O7300 DRUGS CHARGED TO PATIENTS	291, 995	0	291, 99	5 1. 198651	0. 000000	73.00	
OUTPATIENT SERVICE COST CENTERS							
90. 00 09000 CLI NI C	0	4, 497, 472	4, 497, 47	0. 790385	0.000000	90.00	
200.00 Subtotal (see instructions)	2, 598, 377	4, 497, 472	7, 095, 84	9		200.00	
201.00 Less Observation Beds						201.00	
202.00 Total (see instructions)	2, 598, 377	4, 497, 472	7, 095, 84	9		202. 00	

Health Financial Systems	MERIDIAN HEALTH SE	RVICES CORP.	In Lieu of Form CMS-2552-10		
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der CCN: 15-4053	Peri od: From 07/01/2019 To 06/30/2020		epared:
		Title XVIII	Hospi tal	PPS	
Cost Center Description	PPS Inpatient				
	Ratio				
	11. 00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS					30.00
ANCILLARY SERVICE COST CENTERS					
60. 00 06000 LABORATORY	1. 198590				60.00
73.00 07300 DRUGS CHARGED TO PATIENTS	1. 198651				73.00
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLI NI C	0. 790385				90.00
200.00 Subtotal (see instructions)					200.00
201.00 Less Observation Beds					201.00
202.00 Total (see instructions)					202.00

Health Finar	ncial Systems	MERIDIAN HEALTH	SERVICES CORP.		In Lie	u of Form CMS-2	2552-10
COMPUTATION	OF RATIO OF COSTS TO CHARGES		Provider Co	F	Period: From 07/01/2019 To 06/30/2020	Date/Time Pre 11/20/2020 3:	pared: 09 pm
			Ti tl	e XIX	Hospi tal	Cost	
					Costs		
	Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
		1. 00	2.00	3.00	4. 00	5. 00	
I NPAT	TENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	1, 847, 321		1, 847, 321	0	1, 847, 321	30.00
ANCI L	LARY SERVICE COST CENTERS						
60.00 06000	LABORATORY	28, 892		28, 892	0	28, 892	60.00
73.00 07300	DRUGS CHARGED TO PATIENTS	350, 000		350, 000	0	350, 000	73.00
OUTPA	TIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	3, 554, 736		3, 554, 736	0	3, 554, 736	90.00
200.00	Subtotal (see instructions)	5, 780, 949	0	5, 780, 949	0	5, 780, 949	200.00
201.00	Less Observation Beds	0		0)	0	201.00
202. 00	Total (see instructions)	5, 780, 949	0	5, 780, 949	0	5, 780, 949	202. 00

Health Financial Systems N	MERIDIAN HEALTH SERVICES CORP.			In Lieu of Form CMS-2552-10		
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der CO		Period: From 07/01/2019 To 06/30/2020		pared: 09 pm_
		Ti tl	e XIX	Hospi tal	Cost	
		Charges				
Cost Center Description	Inpatient	Outpati ent	Total (col. 6	Cost or Other	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	2, 282, 277		2, 282, 27	7		30.00
ANCILLARY SERVICE COST CENTERS						
60. 00 06000 LABORATORY	24, 105	0	24, 10	5 1. 198590	0.000000	60.00
73.00 07300 DRUGS CHARGED TO PATIENTS	291, 995	0	291, 99	5 1. 198651	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	4, 497, 472	4, 497, 47	2 0. 790385	0.000000	90.00
200.00 Subtotal (see instructions)	2, 598, 377	4, 497, 472	7, 095, 84	9		200. 00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	2, 598, 377	4, 497, 472	7, 095, 84	9		202. 00

Health Fina	ncial Systems	MERIDIAN HEALTH SI	ERVICES CORP.	In Lieu of Form CMS-2552-10		
COMPUTATI Of	N OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-4053	Peri od: From 07/01/2019 To 06/30/2020		
			Title XIX	Hospi tal	Cost	
	Cost Center Description	PPS Inpatient				
		Ratio				
		11. 00				
I NPA	TIENT ROUTINE SERVICE COST CENTERS					
30.00 0300	O ADULTS & PEDIATRICS					30.00
ANCI	LLARY SERVICE COST CENTERS					
60.00 0600	O LABORATORY	0. 000000				60.00
73.00 0730	O DRUGS CHARGED TO PATIENTS	0. 000000				73.00
OUTP.	ATIENT SERVICE COST CENTERS					
90.00 0900	O CLI NI C	0. 000000				90.00
200. 00	Subtotal (see instructions)					200.00
201.00	Less Observation Beds					201.00
202. 00	Total (see instructions)					202.00
•						•

Health Financial Systems ME	ERIDIAN HEALTH	SERVICES CORP.		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der C		Peri od:	Worksheet D	
				From 07/01/2019 To 06/30/2020	Date/Time Pre	pared:
		T: +1 -	WILL	11! 4-1	11/20/2020 3:	09 pm
			XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem	
	Related Cost	Adjustment	Capi tal	Days	(col. 3 /	
	(from Wkst.		Related Cost		col. 4)	
	B, Part II,		(col. 1 -		ĺ	
	col. 26)		col. 2)			
	1. 00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS				<u>.</u>		
30.00 ADULTS & PEDIATRICS	87, 427	0	87, 42	7 1, 998	43. 76	30.00
200.00 Total (lines 30 through 199)	87, 427		87, 42	7 1, 998	I	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	1			İ
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	1, 124	49, 186				30.00
200.00 Total (lines 30 through 199)	1, 124	49, 186				200. 00

Health Financial Systems ME	ERIDIAN HEALTH	SERVICES CORP.		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provider CO		Period: From 07/01/2019 To 06/30/2020		
		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						
60. 00 06000 LABORATORY	467	24, 105	0. 01937	4 0	0	60.00
73.00 07300 DRUGS CHARGED TO PATIENTS	5, 650	291, 995	0. 01935	0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	61, 202	4, 497, 472	0. 01360	0 8	0	90.00
200.00 Total (lines 50 through 199)	67, 319	4, 813, 572		0	0	200. 00

Heal th Finar	ncial Systems	MERIDIAN HEALTH	SERVICES CORP.		In Lie	u of Form CMS-	2552-10
APPORTI ONME	NT OF INPATIENT ROUTINE SERVICE OTHER	PASS THROUGH COS	STS Provider C		Period: From 07/01/2019 To 06/30/2020		epared: 09 pm
				e XVIII	Hospi tal	PPS	
	Cost Center Description	Nursi ng School Post-Stepdown	Nursi ng School	Allied Health Post-Stepdowr Adjustments	Allied Health Cost	All Other Medical Education	
		Adjustments				Cost	
		1A	1. 00	2A	2. 00	3. 00	
	IENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 200. 00	ADULTS & PEDIATRICS Total (lines 30 through 199)	0	C C		0 0 0	0 0	30. 00 200. 00
	Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
		4. 00	5. 00	6.00	7. 00	8. 00	
I NPAT	TENT ROUTINE SERVICE COST CENTERS	<u> </u>		•			
30. 00 03000 200. 00	ADULTS & PEDIATRICS Total (lines 30 through 199)	0	C	1, 99 1, 99		1, 124 1, 124	30. 00 200. 00
	Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00					
	I ENT ROUTINE SERVICE COST CENTERS ADULTS & PEDIATRICS	0					30.00
200. 00	Total (lines 30 through 199)	0	ŀ				200.00

Health Fin	ancial Systems	MERIDIAN HEALTH	SERVICES CORP.		In Lie	u of Form CMS-2	2552-10
APPORTI ONN THROUGH CO	ENT OF INPATIENT/OUTPATIENT ANCILLAR STS	Y SERVICE OTHER PAS	SS Provider Co	CN: 15-4053	Peri od: From 07/01/2019 To 06/30/2020		
			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	
ANCI	LLARY SERVICE COST CENTERS	·					
60.00 0600	OO LABORATORY	0	0		0 0	0	60.00
73.00 0730	DO DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00
OUTI	PATIENT SERVICE COST CENTERS						
90.00 0900	OO CLI NI C	0	0		0 0	0	90.00
200. 00	Total (lines 50 through 199)	0	0		0 0	0	200.00

Health Financial Systems ME	ERIDIAN HEALTH	SERVICES CORP.		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SET THROUGH COSTS	RVICE OTHER PAS	S Provider C		Period: From 07/01/2019 To 06/30/2020	Date/Time Pre	
		Title	XVIII	Hospi tal	11/20/2020 3: PPS	09 pm
Cost Center Description	All Other	Total Cost	Total		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						
60. 00 06000 LABORATORY	0	0	(24, 105	0.000000	60.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	(291, 995	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS				_		
90. 00 09000 CLI NI C	0	0		4, 497, 472	0.000000	90.00
200.00 Total (lines 50 through 199)	0	0	(4, 813, 572		200. 00
200.00 Total (Tines 50 through 199)	0	0		0 4, 813, 572		200.00

Health Financial Systems	MERIDIAN HEALTH SE	RVICES CORP.		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SI	ERVICE OTHER PASS	Provi der C	CN: 15-4053	Peri od:	Worksheet D	
THROUGH COSTS				From 07/01/2019 To 06/30/2020		narod:
				10 00/30/2020	11/20/2020 3:	09 pm
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Outpati ent	I npati ent	Inpatient	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through		Pass-Through	
	(col. 6 ÷		Costs (col.	8	Costs (col. 9	
	col. 7)		x col. 10)		x col. 12)	
	9. 00	10. 00	11.00	12. 00	13.00	
ANCILLARY SERVICE COST CENTERS						
60. 00 06000 LABORATORY	0. 000000	0		0 0	0	60.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	0		0 0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0. 000000	0		0 16, 665	0	90.00
200.00 Total (lines 50 through 199)		0		0 16, 665	0	200. 00

Health Financial Systems	ME	ERIDIAN HEALTH	SERVICES CORP.		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER	HEALTH SERVICES AND	O VACCINE COST	Provi der Co		Period: From 07/01/2019 To 06/30/2020		
			Title	XVIII	Hospi tal	PPS	
				Charges	_	Costs	
Cost Center Descrip	ti on	Cost to	PPS	Cost	Cost	PPS Services	
		Charge Ratio	Rei mbursed	Rei mbursed	Rei mbursed	(see inst.)	
		From	Services (see	Servi ces	Servi ces 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	
ANCILLARY SERVICE COST CE	INTERS						
60. 00 06000 LABORATORY		1. 198590	0		0 0	0	60.00
73.00 07300 DRUGS CHARGED TO PA	TI ENTS	1. 198651	0		o o	0	73.00
OUTPATIENT SERVICE COST (CENTERS						
90. 00 09000 CLI NI C		0. 790385	16, 665		0 0	13, 172	90.00
200.00 Subtotal (see instr	uctions)		16, 665		o o	13, 172	200.00
201.00 Less PBP Clinic Lab					0	·	201.00
Only Charges							
202.00 Net Charges (line 2	00 - line 201)		16, 665		0 0	13, 172	202. 00

Health Financial Systems M	ERIDIAN HEALTH	SERVICES CORP.		In Lie	of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AN	D VACCINE COST	Provi der Co	CN: 15-4053	Peri od: From 07/01/2019 To 06/30/2020	Worksheet D Part V Date/Time Pre	epared:
					11/20/2020 3:	09 pm
			XVIII	Hospi tal	PPS	
	Cos	ts				
Cost Center Description	Cost	Cost				
	Rei mbursed	Rei mbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
	6. 00	7. 00				
ANCILLARY SERVICE COST CENTERS						
60. 00 06000 LABORATORY	0	0				60.00
73.00 O7300 DRUGS CHARGED TO PATIENTS	0	0				73.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	0				90.00
200.00 Subtotal (see instructions)	0	0				200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)	0	0				202. 00

	Financial Systems MERIDIAN HEALTH SER			u of Form CMS-2	
COMPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-4053	Peri od: From 07/01/2019	Worksheet D-1	
				Date/Time Pre	
		Title XVIII	Hospi tal	11/20/2020 3: PPS	09 pm
	Cost Center Description	II tie XVIII	поѕрі таі	PPS	
				1. 00	
	PART I - ALL PROVIDER COMPONENTS				
4 00	INPATIENT DAYS	The state of the s		4 000	4 00
1.00	Inpatient days (including private room days and swing-bed day			1, 998	1.00
2.00	Inpatient days (including private room days, excluding swing- Private room days (excluding swing-bed and observation bed days)		rivata room dave	1, 998 0	
3.00	do not complete this line.	iys). IT you have only p	iivate room days,	U	3.00
4.00	Semi-private room days (excluding swing-bed and observation b	ed davs)		1, 998	4.00
5.00	Total swing-bed SNF type inpatient days (including private ro		er 31 of the cost	0	5.00
	reporting period				
6. 00	Total swing-bed SNF type inpatient days (including private ro	oom days) after December	31 of the cost	0	6.00
7. 00	reporting period (if calendar year, enter 0 on this line)	m daya) through Dagamba	r 21 of the cost	0	7.00
7.00	Total swing-bed NF type inpatient days (including private roc reporting period	om days) through becembe	i 31 of the cost	U	7.00
8. 00	Total swing-bed NF type inpatient days (including private roo	om davs) after December	31 of the cost	0	8.00
	reporting period (if calendar year, enter 0 on this line)				
9. 00	Total inpatient days including private room days applicable t	1, 124	9. 00		
10.00	newborn days) (see instructions)				40.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII of through December 31 of the cost reporting period (see instruc		room days)	0	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII of		room days) after	0	11.00
11.00	December 31 of the cost reporting period (if calendar year, e		days) area	· ·	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			0	13. 00
14. 00	after December 31 of the cost reporting period (if calendar y Medically necessary private room days applicable to the Progr			0	14. 00
15. 00	Total nursery days (title V or XIX only)	alli (excluding swing-bed	uays)	0	
16. 00	Nursery days (title V or XIX only)			0	
	SWING BED ADJUSTMENT				
17. 00	Medicare rate for swing-bed SNF services applicable to service	ces through December 31	of the cost	0.00	17. 00
40.00	reporting period	Class Bassalas 24 a C		0.00	40.00
18. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	ces after December 31 of	tne cost	0. 00	18. 00
19. 00	Medicaid rate for swing-bed NF services applicable to service	es through December 31 o	f the cost	0.00	19.00
17.00	reporting period	s through becomber of o	the cost	0.00	17.00
20.00	Medicaid rate for swing-bed NF services applicable to service	es after December 31 of	the cost	0.00	20.00
	reporting period				
21.00	Total general inpatient routine service cost (see instruction			1, 847, 321	
22.00	Swing-bed cost applicable to SNF type services through Decemb 5×1 ine 17)	per 31 of the cost repor	ting period (line	0	22. 00
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reporti	na period (line A	0	23.00
25.00	x line 18)	or or the cost reporting	ing porroa (riffe o	. 0	25.00
24. 00	Swing-bed cost applicable to NF type services through December	er 31 of the cost report	ing period (line	0	24.00
	7 x line 19)	•			
25. 00	Swing-bed cost applicable to NF type services after December	31 of the cost reporting	g period (line 8	0	25.00
26 00	x line 20) Total swing-bed cost (see instructions)			0	26 00

International Content of the Conte		PART I - ALL PROVIDER COMPONENTS		
Impattent days (including private room days, excluding safing-bed and newborn days) 1,998 2,00	4 00	INPATIENT DAYS	1 000	1 00
9.00 Private room days (excluding swing-bed and observation bed days). If you have only private room days, do do not complete this line. 4.00 Semi-private room days (excluding swing-bed and observation bed days). 5.00 Total swing-bed SW type inpatient days (including private room days) after December 31 of the cost reporting period (if cale andary year, enter 0 on this line). 7.00 Total swing-bed W type inpatient days (including private room days) after December 31 of the cost reporting period (if cale andary year, enter 0 on this line). 7.00 Total swing-bed W type inpatient days (including private room days) after December 31 of the cost reporting period (if cale andary year, enter 0 on this line). 8.00 Total swing-bed W type inpatient days (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (see instructions). 8.00 Swing-bed SW type inpatient days applicable to the Program (excluding saing-bed and newborn days) (see instructions). 9.00 Swing-bed SW type inpatient days applicable to title XVII only (including private room days) after December 31 of the cost reporting period (see instructions). 9.01 Swing-bed SW type inpatient days applicable to title XVII only (including private room days) after December 31 of the cost reporting period (if calendary year, enter 0 on this line). 9.01 Swing-bed SW type inpatient days applicable to title XVII only (including private room days). 9.02 Swing-bed SW type inpatient days applicable to title XVII only (including private room days). 9.03 Swing-bed SW type inpatient days applicable to title XVII only (including private room days). 9.04 Torough December 31 of the cost reporting period (if calendary year, enter 0 on this line). 9.05 Swing-bed W type Inpatient days applicable to title SV or XIX only (including private room days). 9.06 Total annusery days (title V or XIX only). 9.07 Swing-bed was type-bed SW services applicable to services after December 31 of				
do not complete this line. 4. 00 Semi-private room days (excelding swing-bed and observation bed days) 1. 10 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost 1. 10 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost 1. 10 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost 1. 10 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost 1. 10 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost 1. 10 Total Inpatient days including private room days after December 31 of the cost 1. 10 SNING-bed SNF type inpatient days applicable to the Program (excluding swing-bed and newton days) (see instructions) 1. 10 SNING-bed SNF type inpatient days applicable to title XNIII only (including private room days) 1. 10 SNING-bed SNF type inpatient days applicable to title XNIII only (including private room days) 1. 10 SNING-bed SNF type inpatient days applicable to title XNIII only (including private room days) 1. 10 SNING-bed SNF type inpatient days applicable to title XNIII only (including private room days) 1. 10 SNING-bed SNF type inpatient days applicable to title SNIII only (including private room days) 1. 10 SNING-bed SNF type inpatient days applicable to title SNIII only (including private room days) 1. 10 SNING-bed SNF type inpatient days applicable to title SNIII only (including private room days) 1. 10 SNING-bed SNF type inpatient days applicable to title SNIII only (including private room days) 1. 10 SNING-bed SNF type inpatient days applicable to title SNIII only (including private room days) 1. 10 SNING-bed SNF type inpatient days applicable to SNI only (including private room days) 1. 10 SNING-bed SNF type inpatient days applicable to SNI only (including private room days) 1. 10 SNING-bed SNF type inpatient days applicable to SNI only (including private room day				
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reporting period (if calendar year, including private room days) after December 31 of the cost reporting period (if calendar year, including private room days) after December 31 of the cost reporting period (if calendar year, including private room days) through December 31 of the cost reporting period (if calendar year, enter 0 on this line) 7.00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 7.01 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions) 7.01 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions) 7.02 Swing-bed SWF type inpatient days applicable to title XVIII only (including private room days) after through December 31 of the cost reporting period (see instructions) 7.02 Swing-bed SWF type inpatient days applicable to title XVIII only (including private room days) after through December 31 of the cost reporting period (see instructions) 7.03 Swing-bed SWF type inpatient days applicable to title XVIII only (including private room days) after through December 31 of the cost reporting period (see instructions) 7.03 Swing-bed MF type inpatient days applicable to title XVIII only (including private room days) 7.04 Swing-bed WF type inpatient days applicable to title XVIII only (including private room days) 7.05 Swing-bed WF type inpatient days applicable to title XVIII only (including private room days) 7.06 Swing-bed WF type inpatient days applicable to title XVIII only (including private room days) 7.07 Swing-bed WF type inpatient days applicable to title XVIII only (including private room days) 7.08 Swing-bed WF type inpatient days applicable to title XVIII only (including private room days) 7.08 Swing-bed WF type inpatient days applicable to title XVIII only (including private room days) 7.09 Swing-bed WF type inpatient d				
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28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Average private room per diem charge (line 27 ÷ line 28) 30.00 Average private room per diem charge (line 29 ÷ line 3) 30.00 Average semi-private room per diem charge (line 30 ÷ line 4) 30.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 30.00 Average per diem private room cost differential (line 34 x line 31) 30.00 Average per diem private room cost differential (line 34 x line 31) 30.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 1, 847, 321) 30.00 Adj usted general inpatient routine service cost per diem (see instructions) 30.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			., ,	
29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 1,847,321) 37.00 PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 30.00 30.00 30.00 30.00 31.00 0.00 32.00 3	28 00		0	28 00
30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 1, 847, 321) 37.00 PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 0.000000000000000000000000000000000				
31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 1,847,321) 37.00 PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 924.59 38.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0.00 000 32.00 20.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 33.00 34.00 35.00 36.00 36.00 37.00 37.00 38.00 39.00 40.00				
32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 924.59 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0.00 32.0				
33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 924.59 39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 0 0 33.00 37.00 35.00 37.00 35.00 37.00 36.				
34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 924.59 39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 .00 34.00 37.00 35.00 37.00 36.00 37.00 37.00 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 1,039,239 40.00				
35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 1,847,321) 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 924.59 39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				
36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 924.59 39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 36.00 37.00 37.00 37.00 38.00 40.00				
37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 924.59 38.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00		, , ,		
27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 924.59 97.00 Program general inpatient routine service cost (line 9 x line 38) 97.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 98.00 delication of the program (line 14 x line 35) 99.00 delication of the program (line 14 x line 35) 99.00 delication of the program (line 14 x line 35)				
PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 924.59 38.00 Program general inpatient routine service cost (line 9 x line 38) 1,039,239 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00	37. 00	, , , , , , , , , , , , , , , , , , , ,	1, 847, 321	37. 00
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 924.59 38.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00				
38.00 Adjusted general inpatient routine service cost per diem (see instructions) 924.59 38.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 924.59 38.00 1,039,239 39.00 40.00				
39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 1,039,239 39.00 40.00				
40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00				
		, , ,		
41.00 Total Program general inpatient routine service cost (line 39 + line 40) 1,039,239 41.00				
	41.00		1, 039, 239	41.00

	Financial Systems ME	RIDIAN HEALTH		CN: 15-4053 F	In Lie Period:	u of Form CMS-2 Worksheet D-1	2552-10
		From 07/01/2019 To 06/30/2020		Date/Time Pre			
			Ti tl e	e XVIII	Hospi tal	11/20/2020 3: PPS	09 рііі
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1. 00	2.00	3.00	4. 00	5. 00	
42.00	NURSERY (title V & XIX only)						42.00
42.00	Intensive Care Type Inpatient Hospital Units	I	I	1			42.00
43. 00 44. 00	CORONARY CARE UNIT						43. 00 44. 00
45. 00	BURN INTENSIVE CARE UNIT						45. 00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47. 00	OTHER SPECIAL CARE (SPECIFY)						47.00
	Cost Center Description					1. 00	
48. 00	Program inpatient ancillary service cost (Wk	st. D-3. col.	3. Line 200)			1.00	48. 00
49.00	Total Program inpatient costs (sum of lines			ons)		1, 039, 239	
	PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inp	atient routine	services (fro	m Wkst. D, sum	of Parts I and	49, 186	50.00
51. 00	<pre> </pre>	ationt ancilla	ry sorvicos (f	rom Wkst D s	um of Darte II	0	51. 00
31.00	and IV)	attent ancitra	ry services (i	I OIII WKSt. D, S	uiii 01 Pai tS 11	U	31.00
52.00	Total Program excludable cost (sum of lines	50 and 51)				49, 186	52.00
53.00	Total Program inpatient operating cost exclu		elated, non-ph	ysician anesth	etist, and	990, 053	53.00
	medical education costs (line 49 minus line	52)					
54 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54. 00
	Target amount per discharge					0.00	
	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operat	line 53)	0	57. 00			
58.00	Bonus payment (see instructions)		0	58.00			
59. 00	Lesser of lines 53/54 or 55 from the cost re market basket	mpounaea by the	0.00	59. 00			
60.00	60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						
	If line 53/54 is less than the lower of line	s 55, 59 or 60	enter the les	ser of 50% of		0	61.00
	which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target						
62. 00	amount (line 56), otherwise enter zero (see Relief payment (see instructions)	instructions)				0	62. 00
	63.00 Allowable Inpatient cost plus incentive payment (see instructions)						
	PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00	Medicare swing-bed SNF inpatient routine cos	ts through Dec	ember 31 of th	e cost reporti	ng period (See	0	64.00
65. 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	to after Decemb	har 21 of the	cost roporting	pariod (Saa	0	65. 00
65.00	instructions)(title XVIII only)	ts arter becein	bei 31 01 the	cost reporting	perrou (see	U	65.00
66.00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line	65)(title XVII	l only). For	0	66.00
	CAH (see instructions)						
67.00	Title V or XIX swing-bed NF inpatient routin (line 12 x line 19)	e costs through	h December 31	of the cost re	porting period	0	67. 00
68. 00	Title V or XIX swing-bed NF inpatient routin	e costs after l	December 31 of	the cost repo	rting period	0	68. 00
	(line 13 x line 20)				r tring partice	_	
69. 00	Total title V or XIX swing-bed NF inpatient		•			0	69. 00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER N						70. 00
70.00	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service c						70.00
72. 00	Program routine service cost (line 9 x line	, ,		,			72.00
73. 00	Medically necessary private room cost applic		•				73.00
74.00	Total Program general inpatient routine serv			•			74.00
75. 00	Capital-related cost allocated to inpatient 26, line 45)	routine service	e costs (from	worksneet B, P	art II, column		75. 00
76. 00	Per diem capital-related costs (line 75 ÷ li	ne 2)					76. 00
77. 00	Program capital-related costs (line 9 x line	,					77. 00
	Inpatient routine service cost (line 74 minu			-1-1			78.00
79. 00 80. 00	Aggregate charges to beneficiaries for exces Total Program routine service costs for comp			,	us line 79)		79. 00 80. 00
81.00	Inpatient routine service costs for comp			(1.76 70 11111	11110 /7)		81.00
82.00	Inpatient routine service cost limitation (I	ine 9 x line 8	,				82.00
83.00	Reasonable inpatient routine service costs (ns)				83.00
84.00	Program inpatient ancillary services (see in		one)				84. 00 85. 00
	Utilization review - physician compensation Total Program inpatient operating costs (sum	•					85. 00 86. 00
55. 55	PART IV - COMPUTATION OF OBSERVATION BED PASS		3ug 00)				55.00
87.00	Total observation bed days (see instructions)				0	
88. 00	Adjusted general inpatient routine cost per	•					88.00
07.00	Observation bed cost (line 87 x line 88) (se	e mistructions,	,			0	89. 00

Health Financial Systems M	ERIDIAN HEALTH	SERVICES CORP.		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
				From 07/01/2019 To 06/30/2020		pared: 09 pm_
		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	87, 427	1, 847, 321	0. 04732	26 0	0	90.00
91.00 Nursing School cost	0	1, 847, 321	0.00000	00	0	91.00
92.00 Allied health cost	0	1, 847, 321	0.00000	00	0	92.00
93.00 All other Medical Education	0	1, 847, 321	0. 00000	00 0	0	93. 00

Heal th	Financial Systems MERIDIAN HEALTH SE	RVICES CORP	Inlie	u of Form CMS-2)552 <u>-</u> 10
	ATION OF INPATIENT OPERATING COST	Provi der CCN: 15-4053	Peri od:	Worksheet D-1	
	on the second of		From 07/01/2019 To 06/30/2020	Date/Time Pre	pared:
		Title XIX	Hooni tal	11/20/2020 3:	09 pm
	Cost Center Description	I II II E XIX	Hospi tal	Cost	
	COST CENTER DESCRIPTION			1. 00	
	PART I - ALL PROVIDER COMPONENTS			11 00	
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed day			1, 998	1.00
2.00	Inpatient days (including private room days, excluding swing-			1, 998	2.00
3.00	Private room days (excluding swing-bed and observation bed days	ays). If you have only p	rivate room days,	0	3.00
	do not complete this line.				
4.00	Semi-private room days (excluding swing-bed and observation between the semi-private room days (excluding swing-bed and observation between the semi-private room days).			1, 998	4.00
5.00	Total swing-bed SNF type inpatient days (including private ro	oom days) through Decembe	er 31 of the cost	0	5.00
	reporting period				
6. 00	Total swing-bed SNF type inpatient days (including private ro	oom days) after December	31 of the cost	0	6.00
	reporting period (if calendar year, enter 0 on this line)				
7. 00	Total swing-bed NF type inpatient days (including private roo	om days) through Decembe	[~] 31 of the cost	0	7.00
	reporting period				
8.00	Total swing-bed NF type inpatient days (including private roo	om days) after December :	31 of the cost	0	8.00
	reporting period (if calendar year, enter 0 on this line)			181	9. 00
9. 00					
40.00	newborn days) (see instructions)				
10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)					10.00
through December 31 of the cost reporting period (see instructions)					44 00
11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after					11. 00
December 31 of the cost reporting period (if calendar year, enter 0 on this line)					12. 00
12.00	12.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)				
13. 00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XI	V only (including prive	to room days)	0	13. 00
13.00	after December 31 of the cost reporting period (if calendary			U	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)	all (excluding swing-bed	uays)	0	15.00
16. 00	Nursery days (title V or XIX only)			0	16.00
10.00	SWING BED ADJUSTMENT			0	10.00
17. 00	Medicare rate for swing-bed SNF services applicable to service	res through December 31 (of the cost	0. 00	17. 00
17.00	reporting period	ces through becomber 51 to	i the cost	0.00	17.00
18. 00	Medicare rate for swing-bed SNF services applicable to service	ces after December 31 of	the cost	0. 00	18.00
	reporting period	see a. te. Beeember e. e.		0.00	
19. 00	Medicaid rate for swing-bed NF services applicable to service	es through December 31 o	f the cost	0.00	19.00
	reporting period				
20.00	Medicaid rate for swing-bed NF services applicable to service	es after December 31 of	the cost	0. 00	20.00
	reporting period				
21. 00	Total general inpatient routine service cost (see instruction	ns)		1, 847, 321	21.00
22.00	Swing-bed cost applicable to SNF type services through December	per 31 of the cost repor	ting period (line	0	22.00
	5 x line 17)	·			
23.00	Swing-bed cost applicable to SNF type services after December	31 of the cost reporti	ng period (line 🛭	0	23.00
	x line 18)	·			
24.00	Swing-bed cost applicable to NF type services through Decembe	er 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	31 of the cost reporting	g period (line 8	0	25.00
	x line 20)				
26. 00	Total swing-bed cost (see instructions)			0	26.00
27. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		1, 847, 321	27. 00

	PART I - ALL PROVIDER COMPONENTS		
1 00	INPATIENT DAYS	1 000	1 00
1. 00 2. 00	Inpatient days (including private room days and swing-bed days, excluding newborn) Inpatient days (including private room days, excluding swing-bed and newborn days)	1, 998 1, 998	1.00 2.00
3. 00	Private room days (excluding swing-bed and observation bed days). If you have only private room days,	1, 998	3.00
3.00	do not complete this line.	U	3.00
4. 00	Semi-private room days (excluding swing-bed and observation bed days)	1, 998	4.00
5. 00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost	1, 998	5.00
5.00	reporting period	U	3.00
6. 00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	0	6. 00
0.00	reporting period (if calendar year, enter 0 on this line)	U	0.00
7. 00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost	0	7. 00
7.00	reporting period	O	7.00
8. 00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	0	8. 00
8.00	reporting period (if calendar year, enter 0 on this line)	U	0.00
9. 00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and	181	9. 00
7. 00	newborn days) (see instructions)	101	7.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	0	10.00
.0.00	through December 31 of the cost reporting period (see instructions)	· ·	
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after	0	11.00
	December 31 of the cost reporting period (if calendar year, enter 0 on this line)	· ·	
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	12.00
	through December 31 of the cost reporting period	_	
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	13.00
	after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		
14. 00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15. 00	Total nursery days (title V or XIX only)	0	15.00
	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17. 00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost	0.00	17.00
	reporting period		
18. 00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost	0.00	18. 00
	reporting period		
19. 00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost	0.00	19.00
	reporting period		
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost	0.00	20.00
	reporting period		
21. 00	Total general inpatient routine service cost (see instructions)	1, 847, 321	21.00
22. 00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line	0	22.00
	5 x line 17)		
23. 00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6	0	23. 00
	x line 18)		
24. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	0	24. 00
	7 x line 19)	_	
25. 00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	0	25. 00
0, 00	x line 20)		
	Total swing-bed cost (see instructions)	0	
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	1, 847, 321	27.00
00.00	PRI VATE ROOM DI FFERENTI AL ADJUSTMENT	0	00.00
	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	
	Pri vate room charges (excluding swing-bed charges)	0	
	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0. 000000	
31.00	Average private room per diem charge (line 29 ÷ line 3)		
			32.00
	Average semi-private room per diem charge (line 30 ÷ line 4)		33. 00 34. 00
	Average per diem private room charge differential (line 32 minus line 33) (see instructions)	0.00	
	Average per diem private room cost differential (line 34 x line 31)	0. 00	35. 00 36. 00
	Private room cost differential adjustment (line 3 x line 35) Constal invations routing cost and private room cost differential (line	1 047 221	
37. 00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line	1, 847, 321	37. 00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY		
20 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS Adjusted general inpatient routing convice cost per diem (see instructions)	024 50	38. 00
	Adjusted general inpatient routine service cost per diem (see instructions)	924. 59	
	Program general inpatient routine service cost (line 9 x line 38) Medically necessary private room cost applicable to the Program (line 14 x line 35)	167, 351 0	
	Total Program general inpatient routine service cost (line 39 + line 40)	167, 351	
41.00	rotal frogram general impatrent routine service cost (fille 37 + fille 40)	107, 331	41.00

	Financial Systems ME TATION OF INPATIENT OPERATING COST	RIDIAN HEALTH S	SERVICES CORP.	CN: 15-4053	In Lie Period:	u of Form CMS-2 Worksheet D-1	
					From 07/01/2019 To 06/30/2020		pared:
			Ti tl	e XIX	Hospi tal	Cost	оэ рііі
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
42.00	NUDCEDY (+: +1 - V 0 VIV1)	1. 00	2. 00	3. 00	4. 00	5. 00	42.00
42.00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units						42.00
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45. 00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						46. 00 47. 00
17.00	Cost Center Description						17.00
40.00	Description to the control of the co	-+ D 2I 2	2 1: 200)			1.00	40.00
48.00	Program inpatient ancillary service cost (Wk Total Program inpatient costs (sum of lines			ons)		0 167, 351	
17.00	PASS THROUGH COST ADJUSTMENTS	: ougo) ((000 111011 4011			1077001	17.00
50.00	Pass through costs applicable to Program inp	atient routine	services (fro	m Wkst. D, sur	m of Parts I and	0	50.00
51. 00		atient ancillar	rv services (f	rom Wkst D	sum of Parts II	0	51.00
31.00	and IV)	attent ancitrai	y services (i	TOII WKSt. D, .	sum or rarts in	O	31.00
52.00	Total Program excludable cost (sum of lines					0	
53.00	Total Program inpatient operating cost exclu		elated, non-ph	ysician anestl	netist, and	0	53.00
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)					
	Program di scharges					0	54.00
	Target amount per discharge						55.00
	Target amount (line 54 x line 55)	ing cost and to	wast smount (lina E/ minua	Line E2)	0	
57. 00 58. 00	, , , , , , , , , , , , , , , , , , , ,	ing cost and ta	inger amount (TITIE 56 IIITIUS	11 ne 53)	0	1
59. 00	, ,	porting period	endi ng 1996,	updated and co	ompounded by the		59.00
	market basket					0.00	
	60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket 61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by						60. 00 61. 00
01.00	which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target						01.00
	amount (line 56), otherwise enter zero (see	instructions)		•	G		
62.00	, , ,	ont (ooo i notsu	unti ana)			0	62. 00 63. 00
63.00 Allowable Inpatient cost plus incentive payment (see instructions) PROGRAM INPATIENT ROUTINE SWING BED COST						0] 63.00
64.00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	ember 31 of th	e cost reporti	ing period (See	0	64.00
4E 00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos</pre>	to after Decemb	or 21 of the	cost roportin	a ported (See	0	65. 00
65. 00	instructions)(title XVIII only)	ts after becenic	ber 31 of the	cost reporting	g perrou (see	U	05.00
66.00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line	65)(title XVI	II only). For	0	66.00
47.00	CAH (see instructions)	4- 41	. D	- <i>e</i> +l+		0	67.00
67. 00	Title V or XIX swing-bed NF inpatient routin (line 12 x line 19)	e costs through	i beceiliber 31	or the cost re	eporting period	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routin	e costs after D	December 31 of	the cost repo	orting period	0	68. 00
40.00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient	routino costs (lino 47 : lin	o 49)		0	69. 00
09.00	PART III - SKILLED NURSING FACILITY, OTHER N		•			0	09.00
70. 00	Skilled nursing facility/other nursing facil)		70.00
71. 00	Adjusted general inpatient routine service c	,	ine 70 ÷ line	2)			71.00
72. 00 73. 00	Program routine service cost (line 9 x line Medically necessary private room cost applic	,	n (line 14 x l	ine 35)			72.00 73.00
74. 00	Total Program general inpatient routine serv	•	•				74.00
75. 00	Capital-related cost allocated to inpatient	routine service	e costs (from	Worksheet B, I	Part II, column		75. 00
76. 00	26, line 45) Per diem capital-related costs (line 75 ÷ li	ne 2)					76. 00
77. 00	Program capital -related costs (line 9 x line	,					77. 00
	Inpatient routine service cost (line 74 minu						78.00
79. 00 80. 00	Aggregate charges to beneficiaries for exces Total Program routine service costs for comp				nus line 79)		79. 00 80. 00
81.00	Inpatient routine service costs for comp		IIIII tati U	(1116 /0 1111	11110 17)		81.00
82.00	Inpatient routine service cost limitation (I	ine 9 x line 81	•				82.00
83.00	Reasonable inpatient routine service costs (ns)				83.00
84. 00 85. 00	Program inpatient ancillary services (see in Utilization review - physician compensation		ons)				84. 00 85. 00
	Total Program inpatient operating costs (sum	•					86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS	S THROUGH COST					
87. 00 88. 00	Total observation bed days (see instructions Adjusted general inpatient routine cost per		- line 2)			0 00	87. 00 88. 00
	Observation bed cost (line 87 x line 88) (se	•					89.00
		ŕ					•

Health Financial Systems M	ERIDIAN HEALTH	SERVICES CORP.		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
				From 07/01/2019 To 06/30/2020		pared: 09 pm_
		Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observation	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	87, 427	1, 847, 321	0. 04732	26 0	0	90.00
91.00 Nursing School cost	0	1, 847, 321	0.00000	00	0	91.00
92.00 Allied health cost	0	1, 847, 321	0. 00000	00	ol	92.00
93.00 All other Medical Education	0	1, 847, 321	0. 00000	00 0	0	93. 00

Health Financial Systems	MERIDIAN HEALTH SERVICES CORP.		In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der CC		Peri od:	Worksheet D-3	
			From 07/01/2019 To 06/30/2020		
	Title	XVIII	Hospi tal	PPS	
Cost Center Description		Ratio of Cost	I npati ent	I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x	
				col . 2)	
		1. 00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS			1, 191, 440		30.00
ANCILLARY SERVICE COST CENTERS					
60. 00 06000 LABORATORY		1. 19859	0	0	60.00
73.00 07300 DRUGS CHARGED TO PATIENTS		1. 19865	1 0	0	73.00
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLINIC		0. 79038	5 0	0	90.00
200.00 Total (sum of lines 50 through 94 a	nd 96 through 98)		0	0	200.00
201.00 Less PBP Clinic Laboratory Services	-Program only charges (line 61)		0		201.00
202.00 Net charges (line 200 minus line 20	1)		0		202.00

Health Financial Systems	MERIDIAN HEALTH SERVICES CORP.		In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C		Peri od:	Worksheet D-3	
			From 07/01/2019 To 06/30/2020		
	Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description		Ratio of Cost		I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x	
				col . 2)	
		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS			191, 860		30.00
ANCILLARY SERVICE COST CENTERS					
60. 00 06000 LABORATORY		1. 19859	0 0	0	60.00
73.00 07300 DRUGS CHARGED TO PATIENTS		1. 19865	1 0	0	73.00
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLINIC		0. 79038	5 0	0	90.00
200.00 Total (sum of lines 50 through 94 ar	nd 96 through 98)		0	0	200.00
201.00 Less PBP Clinic Laboratory Services-	Program only charges (line 61)		0		201.00
202.00 Net charges (line 200 minus line 201			0		202. 00

Health Financial Systems	MERIDIAN HEALTH SERVICES (CORP.	In Lieu	of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi c	der CCN: 15-4053	Peri od: From 07/01/2019 To 06/30/2020	Worksheet E Part B Date/Time Prepared: 11/20/2020 3:09 pm

	1	Title XVIII	Hospi tal	11/20/2020 3: PPS	09 pm
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1. 00	
1. 00	Medical and other services (see instructions)			0	1.00
2. 00	Medical and other services reimbursed under OPPS (see instructions)			13, 172	
3.00	OPPS payments			17, 743	1
4.00	Outlier payment (see instructions)			0	4.00
4. 01	Outlier reconciliation amount (see instructions)			0	
5.00	Enter the hospital specific payment to cost ratio (see instructions)			0.000	1
6.00	Line 2 times line 5			0 00	
7. 00 8. 00	Sum of lines 3, 4, and 4.01, divided by line 6 Transitional corridor payment (see instructions)			0.00	1
9. 00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col	13 line 200		0	1
10.00	Organ acquisitions	. 10, 11110 200		ő	
11.00	Total cost (sum of lines 1 and 10) (see instructions)			0	1
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonable charges				
12.00	Ancillary service charges			0	
13. 00 14. 00				0	
14.00	Customary charges			0	14.00
15. 00	Aggregate amount actually collected from patients liable for payment	for services on	a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payme			0	16.00
	had such payment been made in accordance with 42 CFR §413.13(e)		-		
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0. 000000	
18.00	Total customary charges (see instructions)		44) (0	
19. 00	Excess of customary charges over reasonable cost (complete only if linstructions)	ine 18 exceeds li	ne 11) (see	0	19.00
20. 00	Excess of reasonable cost over customary charges (complete only if I	ine 11 exceeds Li	ne 18) (see	0	20.00
20.00	instructions)		(555	Ü	20.00
21.00	Lesser of cost or charges (see instructions)			0	21.00
	Interns and residents (see instructions)			0	
		.s)		0	
24. 00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			17, 743	24.00
25. 00	COMPUTATION OF REIMBURSEMENT SETTLEMENT Deductibles and coinsurance amounts (for CAH, see instructions)			4, 583	25. 00
26. 00		or CAH see instr	ructions)	4, 303	1
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus th			13, 160	1
	instructions)		- ,		
28. 00	Direct graduate medical education payments (from Wkst. E-4, line 50)			0	
	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	
30.00	Subtotal (sum of lines 27 through 29)			13, 160	1
31.00	Primary payer payments Subtotal (line 30 minus line 31)			13, 160	31.00
32.00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)			13, 100	32.00
33. 00	Composite rate ESRD (from Wkst. I-5, line 11)			0	33.00
	Allowable bad debts (see instructions)			754	34.00
35.00	Adjusted reimbursable bad debts (see instructions)			490	35.00
	Allowable bad debts for dual eligible beneficiaries (see instruction	is)		754	
37. 00				13, 650	
	MSP-LCC reconciliation amount from PS&R			0	
39. 00 39. 50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Diopeer ACO demonstration payment adjustment (see instructions)			0	
39. 50 39. 97	Pioneer ACO demonstration payment adjustment (see instructions) Demonstration payment adjustment amount before sequestration			0	39. 50 39. 97
	Partial or full credits received from manufacturers for replaced dev	ices (see instru	ctions)	0	1
39. 99	RECOVERY OF ACCELERATED DEPRECIATION	(220 111011 00	/	Ö	1
	Subtotal (see instructions)			13, 650	1
40. 01	Sequestration adjustment (see instructions)			228	1
40. 02	Demonstration payment adjustment amount after sequestration			0	
	Sequestration adjustment-PARHM pass-throughs				40.03
	Interim payments			12, 907	1
41.01	Interim payments-PARHM			0	41.01
	Tentative settlement (for contractors use only) Tentative settlement-PARHM (for contractor use only)				42.00
43. 00	Balance due provider/program (see instructions)			515	
43. 01	Balance due provider/program-PARHM (see instructions)				43. 01
44.00	Protested amounts (nonallowable cost report items) in accordance wit	h CMS Pub. 15-2,	chapter 1,	0	1
	§115. 2				1
00 00	TO BE COMPLETED BY CONTRACTOR			^	00.00
	Original outlier amount (see instructions) Outlier reconciliation adjustment amount (see instructions)			0	
	The rate used to calculate the Time Value of Money			0.00	
	Time Value of Money (see instructions)			0.00	1
	Total (sum of lines 91 and 93)				94.00
			<u>'</u>		

ANALYS	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provi der C		Period: From 07/01/2019 To 06/30/2020	Worksheet E-1 Part I Date/Time Pre 11/20/2020 3:0	
			XVIII	Hospi tal	PPS	
		I npati en	it Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2. 00	3. 00	4. 00	
1. 00 2. 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		907, 28	2 0	12, 907 0	1. 00 2. 00
3. 00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					3. 00
3. 01	ADJUSTMENTS TO PROVIDER		I	ol	0	3. 01
3. 02 3. 03 3. 04	ADJUSTWENTS TO PROVIDER			0	0 0	3. 02 3. 03 3. 04
3. 05				0	0	3. 05
5. 05	Provider to Program			0	J	3.03
3. 50	ADJUSTMENTS TO PROGRAM			o	0	3. 50
3. 51				O	0	3. 51
3.52				0	0	3. 52
3.53				0	0	3.53
3.54				0	0	3.54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			0	0	3. 99
4. 00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		907, 28	2	12, 907	4. 00
	TO BE COMPLETED BY CONTRACTOR					
5. 00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5. 00
F 01	Program to Provider		1		0	F 01
5. 01	TENTATI VE TO PROVI DER			0	0	5. 01
5. 02 5. 03				0	0	5. 02 5. 03
5.05	Provider to Program			U _I	U	5.03
5. 50	TENTATI VE TO PROGRAM			ol	0	5. 50
5. 51	TENTATI VE TO TROOKSWI		1	0	0	5. 51
5. 52				Ö	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		9, 63	5	515	6. 01
6. 02	SETTLEMENT TO PROGRAM			o	0	6. 02
7.00	Total Medicare program liability (see instructions)		916, 91	7	13, 422	7.00

NPR Date

(Mo/Day/Yr)

2.00

8. 00

Contractor

Number 1.00

8.00 Name of Contractor

Heal th	Financial Systems MERIDIAN HEALTH SEI	RVICES CORP.	In Lie	u of Form CMS-	2552-10
To 06/30/2020			Worksheet E-7 Part II Date/Time Pro 11/20/2020 3:	epared:	
		Title XVIII	Hospi tal	PPS	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS			1.00	
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION	I			
1.00	Total hospital discharges as defined in AARA §4102 from Wkst.		e 14		1.00
2.00	2.00 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12				2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8	3-12			4. 00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 I				6. 00
7. 00	CAH only - The reasonable cost incurred for the purchase of cline 168	certified HIT technology	Wkst. S-2, Pt. I		7. 00
8.00	Calculation of the HIT incentive payment (see instructions)				8. 00
9.00	Sequestration adjustment amount (see instructions)				9.00
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
31.00	Other Adjustment (specify)				31.00
32. 00	Balance due provider (line 8 (or line 10) minus line 30 and l	ine 31) (see instruction	ns)		32.00

Health Financial Systems	MERIDIAN HEALTH SERVICES CORP.	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-	From 07/01/2019	Worksheet E-3 Part II Date/Time Prepared: 11/20/2020 3:09 pm
	T: +1 - \/\/\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		1172072020 3. 07 piii

		Title XVIII	Hospi tal	PPS	09 pm
			noopi tai		
				1. 00	
	PART II - MEDICARE PART A SERVICES - IPF PPS			1, 010, 901	
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)				1.00
2.00	Net IPF PPS Outlier Payments			17, 168	2.00
3. 00 4. 00	Net IPF PPS ECT Payments	ant rement filed on an h	oforo November	0 00	3.00
4.00	Unweighted intern and resident FTE count in the most recent c 15, 2004. (see instructions)	ost report fired on or t	berore november	0. 00	4. 00
4. 01	Cap increases for the unweighted intern and resident FTE coun program or hospital closure, that would not be counted withou		'	0. 00	4. 01
	CFR §412. 424(d)(1)(iii)(F)(1) or (2) (see instructions)	t a temporary cap adjust	illerit drider 42		
5.00	New Teaching program adjustment. (see instructions)			0.00	5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in	the new program growth p	eriod of a "new	0. 00	6.00
	teaching program" (see instuctions)				
7. 00	Current year's unweighted I&R FTE count for residents within teaching program" (see instuctions)	the new program growth p	period of a "new	0. 00	7. 00
8.00	Intern and resident count for IPF PPS medical education adjus	tment (see instructions)		0. 00	8.00
9.00	Average Daily Census (see instructions)			5. 459016	
10.00	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to	the power of .5150 -1}.		0. 000000	
11. 00	Teaching Adjustment (line 1 multiplied by line 10).			0	11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)			1, 028, 069	12.00
13.00	Nursing and Allied Health Managed Care payment (see instructi	on)		0	13.00
14. 00 15. 00	Organ acquisition (DO NOT USE THIS LINE) Cost of physicians' services in a teaching hospital (see inst	ructions)		0	14. 00 15. 00
16. 00	Subtotal (see instructions)	ructions)		1, 028, 069	
17. 00	Primary payer payments			1, 020, 009	17. 00
18. 00	Subtotal (line 16 less line 17).			1, 028, 069	
19. 00	Deducti bl es			87, 608	
20.00	Subtotal (line 18 minus line 19)			940, 461	20.00
21.00	Coinsurance			14, 663	21.00
22.00	Subtotal (line 20 minus line 21)			925, 798	22.00
23. 00			10, 295		
24. 00	Adjusted reimbursable bad debts (see instructions)			6, 692	
25. 00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		10, 295	
26.00	Subtotal (sum of lines 22 and 24)			932, 490	
27. 00	Direct graduate medical education payments (see instructions)			0	27. 00
28. 00 29. 00	Other pass through costs (see instructions) Outlier payments reconciliation			0	28. 00 29. 00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
30. 50	Pioneer ACO demonstration payment adjustment (see instruction	s)		0	30. 50
30. 99	Demonstration payment adjustment amount before sequestration	<i>-</i>		0	30. 99
31.00	Total amount payable to the provider (see instructions)			932, 490	31.00
31. 01	Sequestration adjustment (see instructions)			15, 573	31.01
31. 02	Demonstration payment adjustment amount after sequestration			0	31.02
32.00	Interim payments			907, 282	
33. 00	Tentative settlement (for contractor use only)			0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 31.0			9, 635	
35. 00	Protested amounts (nonallowable cost report items) in accorda	nce with CMS Pub. 15-2,	chapter 1,	0	35. 00
	§115. 2 TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Worksheet E-3, Part II, line 2		T	17, 168	50 00
51.00	Outlier reconciliation adjustment amount (see instructions)			17, 108	51.00
52. 00	The rate used to calculate the Time Value of Money			0. 00	
	Time Value of Money (see instructions)				53.00
			·	·	

Health Financial Systems	MERIDIAN HEALTH SERVICES CORP.	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-4053	Period: From 07/01/2019 To 06/30/2020	Worksheet E-3 Part VII Date/Time Prepared: 11/20/2020 3:09 pm

			To 06/30/2020	Date/Time Pre 11/20/2020 3:	
		Title XIX	Hospi tal	Cost	<u> </u>
		·	Inpati ent	Outpati ent	
			1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SER	VICES FOR TITLES V OR XI	X SERVICES		
	COMPUTATION OF NET COST OF COVERED SERVICES				1
1.00	Inpatient hospital/SNF/NF services		167, 351		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)		167, 351	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		167, 351	0	7. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				1
	Reasonable Charges				1
8.00	Routine service charges		191, 860		8.00
9.00	Ancillary service charges		0	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)		191, 860	0	12.00
	CUSTOMARY CHARGES		<u> </u>		1
13.00	Amount actually collected from patients liable for payment for	services on a charge	0	0	13.00
	basis				
14.00	Amounts that would have been realized from patients liable for	payment for services or	1 0	0	14.00
	a charge basis had such payment been made in accordance with 4	12 CFR §413.13(e)			
15. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0. 000000	0. 000000	1
16. 00	Total customary charges (see instructions)		191, 860	0	
17. 00	Excess of customary charges over reasonable cost (complete onl	y if line 16 exceeds	24, 509	0	17. 00
40.00	line 4) (see instructions)				40.00
18. 00	Excess of reasonable cost over customary charges (complete onl	y if line 4 exceeds line	0	0	18. 00
10 00	16) (see instructions)			0	10.00
19. 00	Interns and Residents (see instructions)		0	0	
20. 00 21. 00	Cost of physicians' services in a teaching hospital (see instr		147 251	0	
21.00	Cost of covered services (enter the lesser of line 4 or line 1 PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be		167, 351	U	21.00
22 00	Other than outlier payments	compreted for 113 provid	0	0	22. 00
	Outlier payments		Ö	0	
	Program capital payments		0	U	24.00
	Capital exception payments (see instructions)		0		25.00
	Routine and Ancillary service other pass through costs		0	0	
	Subtotal (sum of lines 22 through 26)		0	0	
	Customary charges (title V or XIX PPS covered services only)		0	0	
29. 00	Titles V or XIX (sum of lines 21 and 27)		167, 351	Ö	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
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)		167, 351	0	31.00
32.00	Deducti bl es		0	0	32.00
33.00	Coinsurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		o	0	34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	1 33)	167, 351	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38.00	Subtotal (line 36 ± line 37)		167, 351	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39. 00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		167, 351	0	40.00
41.00	Interim payments		153, 874	0	
42.00	Balance due provider/program (line 40 minus line 41)		13, 477	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordan	nce with CMS Pub 15-2,	0	0	43.00
	chapter 1, §115.2				
	Cnapter 1, §115.2		1		I

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

Provi der CCN: 15-4053

Number Sector S	oni y)					11/20/2020 3:	09 pm
Cash on hard in Debits			General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
Cash on hand in banks			1.00			4. 00	
Temporary Investments	1 00		17 047 547		0	0	1 00
Notice receivable				1	0		
4.00 Accounts receivable 2,993,851 0 0 4.00 6.00 All lorances for uncollectible notes and accounts receivable 12,440,237 0 0 0 5.00 6.00 All lorances for uncollectible notes and accounts receivable 0 0 0 0 0 6.00 All lorances for uncollectible notes and accounts receivable 0 0 0 0 0 6.00 Oberfrom control (and the control of			3, 7,3, 6,1		0		
A Downces for uncol lectible notes and accounts receivable 0			2, 993, 851	1	0		4.00
1.00 1.00 1.00 0 0 0 0 0 0 0 0 0	5.00	Other recei vable		0	0	0	5.00
8.00 Prepaid éxpenses 0 0 0 0 8.00			0	0	0		
9.00 Other current asserts 1.757,991 O O O 0.00 10.00 Die From other finds 0 O O O O O 0.00 11.00 Total current asserts (sum of lines 1-10) 10.00 Die From other finds 0 O O O O O O O O O O O O O O O O O O O			0	0	0		7.00
10.00 Due From other Funds 0			1 757 001	_	0		
11.00 Cotal current assets (sum of lines 1-10) 40,833,517 0 0 0 11.00			1, 757, 991 	1	0		
FIXED ASSETS			40. 833. 517	- 1	0		11.00
13.00 Land improvements				-	-		1
14.00 Accumulated depreciation 0 0 0 14.00	12.00	Land	20, 022, 954	0	0	0	12.00
15.00 Bail dings		•	0	_	-		
10.00 Accumul ated depreciation 0 0 0 0 16.00			0	1	0		14.00
17.00 Leasehold Improvements			0		0		
18.00 Accumul ated depreciation 0 0 0 0 18.00			0	_	0		
19.00 Fixed equipment			0	1	0		
20.00 Accumulated depreciation 0 0 0 0 0 2.0 CC			Ö	Ö	0		19.00
22.00 Accumulated depreciation 0 0 0 0 0 22.00		, ' '	0	0	0		20.00
23.00 Maj or movable equipment 0 0 0 0 23.00	21.00	Automobiles and trucks	0	0	0	0	21.00
24.00 Accumul ated depreciation 0 0 0 0 0 24.00 26.00 Accumul ated depreciation 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0	_	0		22.00
		, ,	0		0		23.00
26.00 Accumul ated depreciation 0 0 0 0 26.00 27.00 HT designated Assets 0 0 0 0 0 27.00 28.00 Accumul ated depreciation 0 0 0 0 0 27.00 Old Total fixed assets (sum of lines 12-29) 0 0 0 0 0 27.00 Old Total fixed assets (sum of lines 12-29) 0 0 0 0 0 29.00 Old Total fixed assets (sum of lines 12-29) 0 0 0 0 0 29.00 Old Total fixed assets (sum of lines 12-29) 0 0 0 0 0 29.00 Old There Assets 0 0 0 0 0 0 21.00 Deposits on leases 0 0 0 0 0 0 23.00 Due from owners/officers 0 0 0 0 0 23.00 Due from owners/officers 0 0 0 0 0 23.00 Other assets 0 0 0 0 0 23.00 Other assets (sum of lines 31-34) 1,178.557 0 0 0 0 25.00 Other assets (sum of lines 11, 30, and 35) 62,035,028 0 0 0 26.00 Old Total assets (sum of lines 31-34) 1,178.557 0 0 0 27.00 Old Total assets (sum of lines 31-34) 1,178.557 0 0 0 28.00 Salaries, wages, and fees payable 2,102,419 0 0 0 29.00 Old Total assets (sum of lines 31-34) 0 0 0 29.00 Old Total assets (sum of lines 31-34) 0 0 0 0 29.00 Old Total assets (sum of lines 31-34) 0 0 0 0 29.00 Old Total expapable 7,419,477 0 0 0 29.00 Old Total expapable 0 0 0 0 29.00 Old Total expapable 0 0 0 0 29.00 Old Total current liabilities 0 0 0 0 29.00 Old Total current liabilities 0 0 0 0 29.00 Old Total long term liabilities 0 0 0 0 29.00 Old Total long term liabilities 0 0 0 0 29.00 Old Total long term liabilities 0 0 0 0 29.00 Old Total long term liabilities 0 0 0 0 29.00 Old Total long term liabilities 0 0 0 0 29.00 Old Total long term liabilities 0 0 0 29.00 Old Total long term liabilities 0 0 0 29.00 Old Total long term liabilities 0 0 0 29.00 Old Total long term liabilities 0 0 0 29.0		•	0	_	0		
17.00 HIT designated Assets 0 0 0 0 27.00		Milinor equipment depreciable	0	0	0		
28.00 Accumulated depreciation			0		0		
29.00 Minor equipment-nondepreciable 0 0 0 0 0 29.00			0		0		28.00
30. 00 Total fixed assets (sum of lines 12-29) 20,022,954 0 0 0 30. 00		·	Ö		0		
31.00 Investments	30.00		20, 022, 954	0	0	0	30.00
32.00 Deposits on leases							
33 00 Due from owners/officers 0 0 0 0 0 0 0 0 0			0	1	0		31.00
34. 00 Other assets 1,178,557 0 0 0 34. 00 35. 00 Total other assets (sum of lines 31-34) 1,178,557 0 0 0 0 35. 00 36. 00 Total assets (sum of lines 11, 30, and 35) 62,035,028 0 0 0 0 37. 00 Occurrent LABILITIES			0	1	0		
35.00 Total other assets (sum of lines 31-34) 1,178,557 0 0 0 35.00			U 1 179 557	1	0		
Total assets (sum of lines 11, 30, and 35) 62, 035, 028 0 0 0 0 36. 00					0		
CURRENT LIABILITIES		,			0		36.00
38.00 Salaries, wages, and fees payable 7, 419, 477 0 0 0 338.00 9ayroll taxes payable 0 0 0 0 0 39.00 40.00 Notes and loans payable (short term) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		CURRENT LIABILITIES					
39.00 Payroll taxes payable 0 0 0 0 39.00				0	0		37.00
40.00 Notes and loans payable (short term) 0 0 0 0 0 40.00			7, 419, 477		0		38.00
41.00 Deferred income 42.00 Accelerated payments 42.00 Accelerated payments 43.00 Due to other funds 45.00 Other current liabilities 46.00 Total current liabilities (sum of lines 37 thru 44) 47.00 Nortgage payable 46.00 Notes payable 47.00 Other long term liabilities 48.00 Unsecured loans 48.00 Other long term liabilities 50.00 Other long term liabilities 50.00 Other long term liabilities (sum of lines 46 thru 49) 50.00 Other long term liabilities (sum of lines 45 and 50) 50.00 Other long term liabilities (sum of lines 45 and 50) 50.00 Other long term liabilities (sum of lines 45 and 50) 50.00 Other long term liabilities (sum of lines 45 and 50) 50.00 Other long term liabilities (sum of lines 45 and 50) 50.00 Other long term liabilities (sum of lines 45 and 50) 50.00 Other long term liabilities (sum of lines 55 thru 58) 50.00 Other long term liabilities (sum of lines 50 thru 58) 50.00 Other long term liabilities (sum of lines 50 thru 58) 60.00 Other long term liabilities (sum of lines 51 and 62,035,028 60.00 Other long term liabilities (sum of lines 51 and 62,035,028 60.00 Other long term liabilities (sum of lines 51 and 62,035,028 60.00 Other long term liabilities (sum of lines 51 and 62,035,028 60.00 Other long term liabilities (sum of lines 51 and 62,035,028 60.00 Other long term liabilities (sum of lines 51 and 62,035,028 60.00 Other long term liabilities (sum of lines 51 and 62,035,028 60.00 Other long term liabilities (sum of lines 10 thru 40			0	0	0		
42.00 Accelerated payments 0 Due to other funds 0 Outer current liabilities 3,372,347 0 O Outer current liabilities 3,372,347 0 O O Outer current liabilities 45.00 Total current liabilities (sum of lines 37 thru 44) 14,724,409 0 O Outer liabilities 46.00 Mortage payable 46.00 Mortage payable 46.00 Unsecured loans 46.00 Unsecured loans 47.00 Outer long term liabilities 48.00 Unsecured loans 49.00 Other long term liabilities 49.00 Other long term liabilities (sum of lines 46 thru 49) 50.00 Total long term liabilities (sum of lines 46 thru 49) 50.00 Total liabilities (sum of lines 45 and 50) 50.00 Eapital Accounts 50.00 Specific purpose fund 50.00 Donor created - endowment fund balance - restricted 50.00 Donor created - endowment fund balance 50.00 Donor created - endowment fund balance 50.00 Plant fund balance - invested in plant 50.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 50.00 Total liabilities and fund balances (sum of lines 52 thru 58) 50.00 Total liabilities and fund balances (sum of lines 51 and 62,035,028 50 O O Total liabilities and fund balances (sum of lines 51 and 62,035,028			1 930 166		0		
43.00 Due to other funds 0 0 0 0 0 43.00			1, 030, 100		O	O	
45.00		, ,	Ö	О	0	0	
LONG TERM LIABILITIES	44.00	Other current liabilities	3, 372, 347	0	0	0	44.00
46. 00 Mortgage payable 461,181 0 0 0 46.00 47. 00 Notes payable 0 0 0 0 0 0 47.00 48. 00 Unsecured Loans 0 0 0 0 0 0 48.00 49. 00 Other Long term Liabilities 234,085 0 0 0 49.00 50. 00 Total Liabilities (sum of Lines 46 thru 49) 695,266 0 0 0 0 0 50.00 0 0 0 0 50.00 0 0 50.00 0 0 50.00 0 0 50.00 0 0 50.00 0 0 51.00 0 0 51.00 0 0 52.00 0 0 52.00 0 0 52.00 0 52.00 0 52.00 0 53.00 0 52.00 0 53.00 0 54.00 0 55.00 0 55.00 0 0 55.00 0 55.00 0 56.00 0 56.00 0	45.00		14, 724, 409	0	0	0	45.00
47. 00 Notes payable					_	_	
48.00 Unsecured Loans 0 0 0 0 0 48.00 49.00 Other Long term Liabilities 50.00 Total Long term Liabilities (sum of Lines 46 thru 49) 50.00 Total Liabilities (sum of Lines 46 thru 49) 50.00 Total Liabilities (sum of Lines 45 and 50) 51.00 CAPITAL ACCOUNTS 52.00 General fund balance 53.00 Specific purpose fund 54.00 Donor created - endowment fund balance - restricted 55.00 Donor created - endowment fund balance 56.00 Governing body created - endowment fund balance 57.00 Plant fund balance - invested in plant 58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 59.00 Total Liabilities and fund balances (sum of Lines 51 and 62,035,028) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			461, 181	_	-		
49.00 Other long term liabilities 234,085 0 0 49.00 50.00 Total long term liabilities (sum of lines 46 thru 49) 695,266 0 0 0 50.00 51.00 Total liabilities (sum of lines 45 and 50) 15,419,675 0 0 51.00 52.00 General fund balance 46,615,353 0 52.00 53.00 Specific purpose fund 0 53.00 54.00 Donor created - endowment fund balance - restricted 0 54.00 55.00 Donor created - endowment fund balance 0 55.00 56.00 Governing body created - endowment fund balance 0 56.00 57.00 Plant fund balance - invested in plant 0 57.00 58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 0 58.00 59.00 Total fund balances (sum of lines 52 thru 58) 46,615,353 0 0 0 59.00 60.00 Total liabilities and fund balances (sum of lines 51 and 62,035,028 0 0 0 60.00			0		-		
50. 00 Total long term liabilities (sum of lines 46 thru 49) 695, 266 0 0 0 50. 00 51. 00 Total liabilities (sum of lines 45 and 50) 15, 419, 675 0 0 0 51. 00 CAPITAL ACCOUNTS 52. 00 General fund balance 46, 615, 353 0 52. 00 53. 00 Specific purpose fund 0 53. 00 54. 00 Donor created - endowment fund balance - restricted 0 54. 00 55. 00 Governing body created - endowment fund balance 0 55. 00 57. 00 Plant fund balance - invested in plant 0 57. 00 58. 00 Plant fund balance - reserve for plant improvement, replacement, and expansi on 0 58. 00 59. 00 Total fund balances (sum of lines 52 thru 58) 46, 615, 353 0 0 0 59. 00 60. 00 Total liabilities and fund balances (sum of lines 51 and 62, 035, 028 0 0 0 60. 00			234 085	_			
51.00 Total liabilities (sum of lines 45 and 50) 15, 419, 675 0 0 0 51.00				1	_		
52. 00 General fund balance 46,615,353 53. 00 Specific purpose fund 0 54. 00 Donor created - endowment fund balance - restricted 0 55. 00 Donor created - endowment fund balance - unrestricted 0 56. 00 Governing body created - endowment fund balance 0 57. 00 Plant fund balance - invested in plant 0 58. 00 Plant fund balance - reserve for plant improvement, replacement, and expansion 0 59. 00 Total fund balances (sum of lines 52 thru 58) 46,615,353 0 0 0 59.00 60. 00 Total liabilities and fund balances (sum of lines 51 and 62,035,028 0 0 0 60.00		,		1	0	0	
53.00 Specific purpose fund 54.00 Donor created - endowment fund balance - restricted 55.00 Donor created - endowment fund balance - unrestricted 65.00 Governing body created - endowment fund balance 67.00 Plant fund balance - invested in plant 68.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 69.00 Total fund balances (sum of lines 52 thru 58) 60.00 Total liabilities and fund balances (sum of lines 51 and 62,035,028 60.00 Total liabilities and fund balances (sum of lines 51 and							
54.00 Donor created - endowment fund balance - restricted 55.00 Donor created - endowment fund balance - unrestricted 56.00 Governing body created - endowment fund balance 57.00 Plant fund balance - invested in plant 58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 59.00 Total fund balances (sum of lines 52 thru 58) 60.00 Total liabilities and fund balances (sum of lines 51 and 62,035,028 64.00 54.00 55.00 56.00 57.00 60.00 60.00 60.00 60.00			46, 615, 353	1			52.00
55.00 Donor created - endowment fund balance - unrestricted 66.00 Governing body created - endowment fund balance 57.00 Plant fund balance - invested in plant 58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 59.00 Total fund balances (sum of lines 52 thru 58) 60.00 Total liabilities and fund balances (sum of lines 51 and 62,035,028 65.00 56.00 56.00 57.00 60.00 60.00 60.00		1		0			
56.00 Governing body created - endowment fund balance 57.00 Plant fund balance - invested in plant 58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 59.00 Total fund balances (sum of lines 52 thru 58) 60.00 Total liabilities and fund balances (sum of lines 51 and 62,035,028 56.00 56.00 56.00 57.00 58.00 58.00 59.00 60.00 60.00		1			0		
57.00 Plant fund balance - invested in plant 58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 59.00 Total fund balances (sum of lines 52 thru 58) 60.00 Total liabilities and fund balances (sum of lines 51 and 62,035,028 0 57.00 0 57.00 0 58.00 0 0 0 59.00 0 0 60.00		1			0		
58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 59.00 Total fund balances (sum of lines 52 thru 58) 60.00 Total liabilities and fund balances (sum of lines 51 and 62,035,028 0 0 0 60.00					O	0	
replacement, and expansion 59.00 Total fund balances (sum of lines 52 thru 58) 46,615,353 0 0 0 59.00 60.00 Total liabilities and fund balances (sum of lines 51 and 62,035,028 0 0 0 60.00		•					58.00
60.00 Total Liabilities and fund balances (sum of lines 51 and 62,035,028 0 0 0 60.00							
			l '	1	0		59.00
[54]	60.00		62, 035, 028	0	0	0	60.00
		(46)	I	1			I

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES Peri od: Worksheet G-1 From 07/01/2019 Provi der CCN: 15-4053

					To 06/30/2020	Date/Time Pre 11/20/2020 3:	
		General	Fund	Speci al	Purpose Fund	Endowment Fund	
		1. 00	2.00	3. 00	4. 00	5. 00	
1. 00 2. 00 3. 00 4. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	0	43, 863, 296 2, 752, 057 46, 615, 353		0	0 0	1. 00 2. 00 3. 00 4. 00
5. 00 6. 00 7. 00 8. 00 9. 00		0 0 0 0			0 0 0 0	0 0 0	5. 00 6. 00 7. 00 8. 00 9. 00
10. 00 11. 00 12. 00 13. 00 14. 00 15. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)	0 0 0	0 46, 615, 353			0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	10. 00 11. 00 12. 00 13. 00 14. 00 15. 00
17. 00 18. 00 19. 00	Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0	0 46, 615, 353			0	17. 00 18. 00 19. 00
		Endowment Fund	PI ant	Fund			
		6. 00	7. 00	8. 00			
1. 00 2. 00 3. 00 4. 00 5. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	0	0		0		1. 00 2. 00 3. 00 4. 00 5. 00
6. 00 7. 00 8. 00 9. 00 10. 00	Total additions (sum of line 4-9)		0 0 0		0		6. 00 7. 00 8. 00 9. 00 10. 00
10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00	Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)	0	0 0 0 0		0		10.00 11.00 12.00 13.00 14.00 15.00 16.00
18. 00 19. 00	Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0			0		18. 00 19. 00

Health Financial Systems MERI STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provi der CCN: 15-4053

			10	06/30/2020	Date/IIme Pre 11/20/2020 3:0	
	Cost Center Description	I npati ent		Outpati ent	Total	O 9 DIII
	500t 50nton 500011 pt 1 011	1.00		2.00	3. 00	
	PART I - PATIENT REVENUES					
	General Inpatient Routine Services					
1.00	Hospi tal	2, 282, 2	277		2, 282, 277	1.00
2.00	SUBPROVI DER - I PF					2.00
3.00	SUBPROVI DER - I RF					3.00
4.00	SUBPROVI DER					4.00
5.00	Swing bed - SNF		0		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)	2, 282, 2	277		2, 282, 277	10.00
	Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT					11.00
12.00	CORONARY CARE UNIT					12.00
13.00	BURN INTENSIVE CARE UNIT					13.00
14.00	SURGI CAL INTENSI VE CARE UNIT					14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				0	15.00
16. 00	Total intensive care type inpatient hospital services (sum of lines		0		0	16. 00
17 00	11-15)	2, 282, 2	.77		2, 282, 277	17. 00
17. 00 18. 00	Total inpatient routine care services (sum of lines 10 and 16) Ancillary services	316, 1		0		
19.00	Outpatient services	310,	0	4, 497, 472	316, 100 4, 497, 472	19.00
20.00	RURAL HEALTH CLINIC		0	4, 497, 472	4, 497, 472	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER		0	0	0	21. 00
22. 00	HOME HEALTH AGENCY		U	٥	O	22. 00
23. 00	AMBULANCE SERVICES					23. 00
24. 00	CMHC					24.00
25. 00	AMBULATORY SURGICAL CENTER (D. P.)					25. 00
26. 00	HOSPI CE					26. 00
27. 00	NRCC REVENUE	438, 8	364	100, 333, 883	100, 772, 747	27. 00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wks			104, 831, 355	107, 868, 596	28. 00
	G-3, line 1)			, ,	,,	
	PART II - OPERATING EXPENSES	<u>'</u>		'		
29.00	Operating expenses (per Wkst. A, column 3, line 200)			90, 904, 544		29. 00
30.00	ADD (SPECIFY)		0			30.00
31.00			0			31.00
32.00			0			32.00
33.00			0			33.00
34.00			0			34.00
35.00			0			35.00
36.00	Total additions (sum of lines 30-35)			0		36.00
37. 00	DEDUCT (SPECIFY)		0			37. 00
38. 00			0			38. 00
39. 00			0			39. 00
40. 00			0			40.00
41. 00			0			41.00
42.00	Total deductions (sum of lines 37-41)			0		42.00
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)(tran	nster		90, 904, 544		43. 00
	to Wkst. G-3, line 4)	I	-			

	<u> </u>	DI AN HEALTH SERVICES CORP.		u of Form CMS-2	
STATE	MENT OF REVENUES AND EXPENSES	Provi der CCN: 15-4053	Peri od:	Worksheet G-3	
			From 07/01/2019 To 06/30/2020	Date/Time Pre	nared.
			10 00/30/2020	11/20/2020 3:	
		· ·			
				1. 00	
1.00	Total patient revenues (from Wkst. G-2, Part I	, column 3, line 28)		107, 868, 596	1.00
2.00	Less contractual allowances and discounts on p	atients' accounts		48, 363, 719	2.00
3.00	Net patient revenues (line 1 minus line 2)			59, 504, 877	3.00
4.00	Less total operating expenses (from Wkst. G-2,	Part II, line 43)		90, 904, 544	4.00
5.00	Net income from service to patients (line 3 mi	nus line 4)		-31, 399, 667	5.00
	OTHER I NCOME				
6.00	Contributions, donations, bequests, etc			0	6.00
7.00	Income from investments			0	7.00
8.00	Revenues from telephone and other miscellaneou	s communication services		0	8.00
9.00	Revenue from television and radio service			0	9.00
10.00	Purchase di scounts			0	10.00
11.00	Rebates and refunds of expenses			0	11.00
12.00	Parking lot receipts			0	12.00
13.00	Revenue from Laundry and Linen service			0	13.00
14.00	Revenue from meals sold to employees and guest	S		0	14.00
15.00	Revenue from rental of living quarters			0	15.00
16.00	Revenue from sale of medical and surgical supp	lies to other than patients		0	16.00
17.00	Revenue from sale of drugs to other than patie	ents		0	17.00
18.00	Revenue from sale of medical records and abstr	acts		0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, et	c.)		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 REVENUE			13, 741, 824	24.00
24.01	GRANTS			6, 954, 942	24. 01
24.02	COUNTY PROPERTY TAXES			1, 012, 099	24. 02
24.03	CONTRI BUTI ONS			173, 060	24.03
24.04	I FRP			7, 538, 719	24.04
24.05	INTEREST/CONTRIBUTION INTEREST			468, 654	24. 05
24.06	BMH REIMBURSEMENT			1, 408, 050	24.06
24 50	COVED 10 DUE Funding			2 054 277	24 50

2, 854, 377

34, 151, 725

2, 752, 058

2, 752, 057 29. 00

24.50

25. 00 26. 00 27. 00

28.00

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 OTHER EXPENSE

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)